Contact Officer:
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To: Cllr Hilary McGuill (Chair)

Councillors: Mike Allport, Marion Bateman, Paul Cunningham, Jean Davies, Carol Ellis, Gladys Healey, Cindy Hinds, Mike Lowe, Dave Mackie, Michelle Perfect and David Wisinger

27 November 2020

Dear Sir/Madam

NOTICE OF REMOTE MEETING
SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE
THURSDAY, 3 DECEMBER, 2020 at **2.00 PM**

Yours faithfully

Robert Robins
Democratic Services Manager

Please note: Due to the current restrictions on travel and the requirement for physical distancing, this meeting will not be held at its usual location. This will be a remote meeting and 'attendance' will be restricted to Committee Members. The meeting will be recorded.

If you have any queries regarding this, please contact a member of the Democratic Services Team on 01352 702345.

A G E N D A

1 **APOLOGIES**

Purpose: To receive any apologies.

2 **DECLARATIONS OF INTEREST (INCLUDING WHIPPING DECLARATIONS)**

Purpose: To receive any Declarations and advise Members accordingly.

3 **MINUTES** (Pages 5 - 18)

Purpose: To confirm as a correct record the minutes of the meetings held on 22 October and 11 November 2020.

4 **EMERGENCY SITUATION BRIEFING (VERBAL)**

Purpose: To update on the latest position and the risks and implications for Flintshire and service and business continuity.

5 **FORWARD WORK PROGRAMME AND ACTION TRACKING** (Pages 19 - 26)

Report of Social and Health Care Overview & Scrutiny Facilitator

Purpose: To consider the Forward Work Programme of the Social & Health Care Overview & Scrutiny Committee and to inform the Committee of progress against actions from previous meetings.

6 **RECOVERY STRATEGY UPDATE** (Pages 27 - 44)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To provide oversight on the recovery planning for the Committee's respective portfolio(s).

7 **MID-YEAR PERFORMANCE INDICATORS FOR RECOVERY, PORTFOLIO AND PUBLIC ACCOUNTABILITY MEASURES** (Pages 45 - 58)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To review the levels of progress in the achievement of activities, performance levels and current risk levels as identified in the Council Plan.

8 **SAFEGUARDING ADULTS AND CHILDREN'S ANNUAL REPORT TO INCLUDE THE "NEW SAFEGUARDING PROCEDURES"** (Pages 59 - 74)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To provide Members with statistical information in relation to Safeguarding - Adults and Children. To provide an overview of the new Safeguarding Procedures and information on the launch and use of the new procedures within the Council.

9 **COMMUNITY TRANSFORMATION PROJECT UPDATE** (Pages 75 - 88)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To report progress and future delivery plans, for a Project to secure transformational change across health and social care.

10 **SUPPORTING THE SOCIAL WORK WORKFORCE** (Pages 89 - 212)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To provide an overview of the work being undertaken to support newly qualified social workers who's programme of study was disrupted by COVID-19 and to provide detail of the programme of learning and development created to support social workers from their first year in practice through to experienced practitioner.

FOR INFORMATION ONLY

11 **ANNUAL REPORT ON THE SOCIAL SERVICES COMPLAINTS AND COMPLIMENTS PROCEDURE 2019-20** (Pages 213 - 236)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To report to members the number of complaints received by Social Services during the period 2019/20 including their broad themes and outcomes and any lessons learned.

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SOCIAL AND HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE
22 OCTOBER 2020

Minutes of the remote meeting of the Social and Health Care Overview & Scrutiny Committee of Flintshire County Council held on Thursday, 22 October 2020

PRESENT: Councillor Hilary McGuill (Chair)
Councillors: Mike Allport, Marion Bateman, Paul Cunningham, Jean Davies, Carol Ellis, Gladys Healey, Cindy Hinds, Mike Lowe, Dave Mackie, Michelle Perfect and David Wisinger

APOLOGIES: Chief Executive

CONTRIBUTORS: Councillor Christine Jones (Cabinet Member for Social Services), Chief Officer (Social Services), Senior Manager: Integrated Services, Lead Adults, Senior Manager: Children and Workforce, and Senior Manager: Safeguarding and Commissioning. (For minute no. 6 Donna Watts, Multi Systematic Therapy Team Manager

IN ATTENDANCE: Environment and Social Care Overview & Scrutiny Facilitator, Community and Education Overview & Scrutiny Facilitator and Democratic Services Officer

01. DECLARATIONS OF INTEREST

None.

02. MINUTES

The minutes of the meeting held on 22 September 2020 were approved, as moved by Councillor David Wisinger and seconded by Councillor Carol Ellis.

RESOLVED:

That the minutes be approved as a correct record.

03. EMERGENCY SITUATION BRIEFING (VERBAL)

The Chief Officer (Social Services) gave an update on the current situation and said that the Health Protection Zone, which included Flintshire County Council as one of the four local Authorities which formed the zone, had made a positive impact on Covid-19 locally. He explained that the Authority was in readiness for the national “firebreak” which comes into force in Wales at 18.00 hours on Friday 23 October. The Chief Officer reported on the arrangements for Social Services during the lockdown which were in compliance with the requirements and spirit of the Welsh Government’s recent announcement. He gave a brief update on the position around Care Homes and key services in other social care establishments in Flintshire in terms of the impact of Covid-19.

The Chief Officer advised that services were being maintained and admissions to hospital prevented wherever possible to keep individuals safe and health and social care systems working effectively. He reported that national, regional and local preparations were being made on an 'exit plan' for when the lockdown ended on 9 November, and the Leader and Chief Executive were fully involved in discussions.

Councillor Carol Ellis asked if the flu vaccination programme for children in primary schools was underway. She also asked if data was available on the number of Covid-19 cases currently being treated in the Maelor Hospital, Wrexham. The Chief Officer said he would consult with colleagues in the Education service and provide an update on the flu vaccination programme in schools to Councillor Ellis following the meeting. He also commented on the fluctuating situation in hospitals due to Covid-19 and said an increase in the number of cases in North East Wales had put some pressure on the Maelor hospital as a result.

RESOLVED:

Noted.

04. FORWARD WORK PROGRAMME AND ACTION TRACKING

The Facilitator presented the Forward Work Programme and drew attention to the next meeting of the Committee to be held on 11 November, to consider the Medium Term Financial Strategy: Council Fund Revenue Budget 2021/22 outline. The Facilitator also referred to the meeting of the Committee scheduled for 3 December and advised that the item on Young Carers – NEWCIS Contract would be deferred to the following meeting scheduled on 21 January 2021. She also said that the Community Transformation Project update may be deferred to a future meeting. She invited Members to contact her or the Chair with any further items they wished to add to the Forward Work Programme.

The Overview & Scrutiny Facilitator presented the progress report on actions arising from previous meetings. She advised that the action arising from the meeting held on 22 September had been completed and no other actions were outstanding.

The recommendations in the report were moved by Councillor Michelle Perfect and seconded by Councillor Marion Bateman.

RESOLVED:

(a) That the draft Forward Work programme as submitted be approved;

(b) That the Facilitator, in consultation with the Chair of the Committee be authorised to vary the Forward Work Programme between meetings, as the need arises; and

(c) That the progress made in completing the outstanding actions be noted.

05. RECOVERY STRATEGY

The Chief Officer (Social Services) introduced a report to provide an oversight on the recovery planning for the Committee's respective portfolio. He provided background information and said an update on the portfolio risk register and risk mitigation actions were shown in Appendices 1 and 2 of the report. He advised that an update on the recovery objectives for the service portfolio for the Committee were detailed in paragraph 1.05 of the report and reported on the key considerations.

The Chief Officer explained that where services had been partially resumed, the return to normal operating hours and usage would be in line with Public Health Wales and Welsh Government advice. He referred to the current lockdown and said that during the 'firebreak' period some services would be discontinued but some would be ongoing for people and children with high vulnerability.

The Chair expressed thanks on behalf of the Committee to the Chief Officer and his team for their hard work and commitment to continue provision of services during the pandemic. She also congratulated the Chief Officer on the achievements made by Adult and Children's Social Services throughout the challenges faced this year.

Councillor Cindy Hinds commented on the issue of mental health and asked if there had been an increase in individuals suffering mental illness as a result of the impact of Covid-19. The Chief Officer responded that there had been an increase in the number of people who suffered mental health issues during the last seven months as some people struggled with the psychological effects of a lockdown. In terms of support for the workforce the Senior Manager: Integrated Services, Lead Adults explained that the Service was working closely with MIND and there was a programme of support to assist all individuals who required help in the workforce.

Councillor Dave Mackie endorsed the Chair's comments regarding how well Social Services was performing to mitigate the impact of Covid-19 and suggested that the recommendation in the report be amended to read That the Committee supports the latest updated risk register and risk mitigation actions within the Social Services portfolio. This was agreed by the Committee.

The recommendation in the report was moved by Councillor David Wisinger and seconded by Councillor Jean Davies.

RESOLVED:

That the Committee supports the latest updated risk register and risk mitigation actions within the Social Services portfolio.

06. CHILDREN'S TRANSFORMATION PROJECT UPDATE

The Senior Manager Children and Workforce introduced a report on progress and future plans for a project to secure transformational change across health and social care. He advised that North Wales had secured £3m grant funding for a regional Transformation Programme for children's social care. Working on a regional footprint the programme was delivered on an Area basis. The East Area project was a partnership between Flintshire County Council, Betsi Cadwaladr University and Wrexham Borough Council. The Senior Manager explained that the project would help parents with low/moderate mental health needs; bring health and social care staff together to provide intensive assessment and therapeutic support for young people who didn't meet the thresholds for CAMHS but were displaying significant needs and required support; and develop a local residential Care Home to meet the needs of young people whilst seeking family reunification or a longer term local fostering/residential placement.

The Senior Manager reported on the main considerations regarding the above workstreams within the Children's Transformation Project. With reference to the second workstream he explained that during the pandemic a Multi Systematic Therapy (MST) team had been appointed, trained, and launched. The Team provided direct support to build the resilience of families between 3 and 5 months. The focus was on preventing family breakdown and reducing the need for children to unnecessarily enter the care system. He introduced Donna Watts, Manager of the Multi Systematic Therapy team and asked her to give an overview of the Service.

The Multi Systematic Therapy Manager explained that the Team had met the criteria to operate MST under strict licensing requirements including competency to practice through intensive training. MST was a clinical model that worked will all systems surrounding the child including education, community influences, and any significant adults/others in the family. The service was a bespoke package of care which offered home based treatment 24 hours, 365 days a year. During her presentation the Manager cited examples of how MST had successfully changed
the lives of individuals as a result of the treatment and support provided. The Authority was the first in Wales to adopt it.

In response to a question from the Chair regarding how a referral was made into the MST Service the Manager explained that all referrals had to be made via Children's Services whether received from Flintshire County Council or Betsi Cadwaladr University As awareness of the service increased more referrals were being made. The Senior Manager Children and Workforce, gave a brief overview of the referral pathway and said each referral made to Social Services was scrutinised by a panel to determine the best pathway for each case to obtain maximum benefit from the MST service.

Councillor Dave Mackie spoke in support of the MST service and congratulated the MST Manager and officers on their management of the project. In response to the concerns and comments expressed by Councillor Mackie around education, the MST Manager confirmed that school involvement was part

of the model and any problematic behaviours in school would be picked up. The Senior Manager, Children and Workforce explained that officers from the Education Service and Youth Justice Service were included on the Steering Group to capture all that was happening in a child's life.

In conclusion the Senior Manager reported on the third work stream around the ambitions and progress on the development of a local residential Care Home for young people. He explained that young people could stay for a short period and be given intensive MST assessment and support work to prevent the need for placements to be made in a crisis situation. The Chair referred to the Phoenix project provided by the North Wales Fire Service and suggested that a possible link be explored between the two services. The Senior Manager agreed to look into this.

Councillor Gladys Healey spoke in support of the projects and initiatives and suggested that a presentation on the MST Service be made to a future meeting of the Education & Youth Overview & Scrutiny Committee. The Education & Youth Facilitator informed that a joint meeting of the Education, Youth & Culture and Social & Health Care Overview & Scrutiny Committee was scheduled to be held on 17 June 2021 and said she would include an item on the MST Service on the agenda for the meeting.

The recommendations in the report were moved by Councillor Paul Cunningham and seconded by Councillor David Wisinger.

RESOLVED:

(a) That the Committee endorses the work to safely reduce the number of children in need of care through early help and intensive targeted support for families;

(b) That the Committee supports the establishment of a local authority Children's Residential Care Home as part of an approach to rebalance care provision for children, with a focus on ensuring an affordable and sufficient range of local high quality placements; and

(c) That a report on the Multi Systematic Therapy project be considered at the joint meeting of the Education, Youth & Culture and Social & Health Care Overview & Scrutiny Committee to be held on 17 June 2021.

07. PROJECT SEARCH IN FLINTSHIRE

The Senior Manager: Integrated Services, Lead Adults, introduced a report to give an update on the success of last year's interns on Project Search and provide information on next year's cohort. She explained that Project SEARCH was an internationally recognised programme dedicated to building a workforce that includes people with disabilities. Designed as a nine month unpaid internship program Project SEARCH places interns (young people aged 18-24 with a Learning Disability) in real-world work settings where they learn all aspects of gaining and maintaining employment. A series of three internships lasting 10-12

weeks allows interns to explore careers and develop marketable job skills. The interns receive support from department mentors, skills trainers, and worksite accommodations and adaptations. The goal being for each individual to secure competitive employment within their community and many of the interns have secured paid employment in Flintshire.

The Senior Manager reported on plans going forward. She advised that in preparation for the second year of Project SEARCH a number of new internship opportunities were being sought and secured. The Service was also scoping the development of a programme to support people over 25 years who may not have been able to access an opportunity in the past. She advised that this would be the first programme of its type in Europe.

Councillor Christine Jones spoke in support of the Project and said the young people had greatly enjoyed their time on the programme and had gained confidence and experience through the variety of opportunities they participated in. She said Project SEARCH in Flintshire was provided between Flintshire County Council, Hft, Clwyd Alyn Housing Association and Coleg Cambria, and expressed her thanks for the hard work and commitment of all involved.

Councillor Carol Ellis asked how many people with a learning disability were employed directly by Flintshire County Council and also employed in the Flintshire area. The Senior Manager agreed to provide the information to the Committee following the meeting.

Councillor Gladys Healey commented that only 2% of young people with a learning disability in Wales were in paid employment and said there was a need to encourage employers to do more to help people gain employment. The Senior Manager reported on progress made to date to engage with local employers, citing employment in Deeside Industrial Park as an example, and said employers were keen to support people with learning difficulties.

Following a suggestion from Councillor Paul Cunningham that Deeside Business Forum be contacted it was agreed that following the meeting, the Senior Manager would request an update from the Chairman of Deeside Business Forum and make a request for further support going forward.

Councillor Dave Mackie expressed appreciation to the Chief Officer, Senior Managers, and their teams for their initiative in taking forward new and innovative schemes to support and develop people within the County.

The recommendations in the report were moved by Councillor David Wisinger and seconded by Councillor Mike Lowe.

RESOLVED:

(a) That the progress made through the service partnership with Hft and the success of the interns in year 1 of the programme be noted; and

(b) That the Committee champions the programme and supports and encourages the development of internship opportunities across the Council.

08. MEMBERS OF THE PUBLIC AND PRESS IN ATTENDANCE

There was one member of the press in attendance.

(The meeting started at 10.00 am and ended at 11.24 am)

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Chair

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SOCIAL AND HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE
11 NOVEMBER 2020

Minutes of the remote meeting of the Social and Health Care Overview & Scrutiny Committee of Flintshire County Council held on Wednesday, 11 November 2020

PRESENT: Councillor Hilary McGuill (Chair)
Councillors: Mike Allport, Marion Bateman, Paul Cunningham, Jean Davies, Carol Ellis, Gladys Healey, Mike Lowe, Dave Mackie, Michelle Perfect and David Wisinger

CONTRIBUTORS: Councillor Christine Jones (Cabinet Member for Social Services), Chief Executive; Chief Officer (Social Services), Senior Manager (Integrated Services, Lead Adults); Senior Manager (Children and Workforce); Senior Manager (Safeguarding and Commissioning); Strategic Finance Manager (Financial Strategy and Insurance) and Principal Accountant

IN ATTENDANCE: Environment and Social Care Overview & Scrutiny Facilitator, Community and Education Overview & Scrutiny Facilitator and Democratic Services Officer

9. DECLARATIONS OF INTEREST

None.

10. BUDGET 2021/22 – STAGE 1

The Chief Executive and Strategic Finance Manager (Financial Strategy and Insurance) introduced the first budget stage report which detailed the forecast and the cost pressures which would make-up the total budget requirement.

A report to Cabinet in October had provided an update on the financial forecast for 2021/22 and the following two financial years. A full review of the forecast had been undertaken to build an accurate and robust baseline of cost pressure which needed to be funded. The review had taken into account the ongoing impacts of the emergency situation including the speed of recovery of income against set targets.

This report set out the limited solutions available to fund the cost pressures with the funding strategy highly dependent on sufficient national funding for local government. The details of the cost pressures for Social & Health Care were included in the report.

The Chief Executive and Strategic Finance Manager (Financial Strategy and Insurance) gave a detailed presentation which covered the following areas:-

- Financial Forecast for 2021/22;
- The Future – What we advised back in February;
- Summary Totals of Cost Pressures;
- Three Part Solutions and Risk-Taking;

- National Position and Funding;
- Potential Funding Scenarios;
- Budget Timetable;
- Support and Challenge Today

Additional details around specific Social Services cost pressures were provided by the Principal Accountant as part of the presentation.

The Chair commented on the cost pressures showing for the expansion of Marleyfield Residential Care Home and asked whether this pressure related to additional staff costs. The Chair also asked if the role of the Missing from Home Coordinator also involved working with children who were missing from school. The Senior Manager (Integrated Services, Lead Adults) explained that the cost pressure for the expansion of Marleyfield Residential Care Home included staffing costs to support the additional beds but would also include the funding for additional cleaning, food and utility costs required. The Senior Manager (Children and Workforce) explained that the Missing from Home Coordinator was a prescribed role with clear criteria outlining what constituted a missing child. Their role would include visiting a child who had returned to their home/placement to better understand why the child had been missing and share information with the Police to better understand patterns where children were at risk of being exploited. There would be a link with education, if a child was missing in the evenings and also not attending school. The Chief Executive added his support to the creation of this post which had been highlighted as a regional issue by North Wales Police to ensure greater resilience.

Councillor Dave Mackie thanked officers for their work in preparing the budget report and his comments were echoed by a number of Members of the Committee. He commented on the summary of cost pressure and asked what percentage of the overall budget this equated to and why out of county placements had not been included as a cost pressure at this stage. He also suggested that further information around the consideration to treat some risks as 'Open Risks' in order to manage the budget in-year be provided to the Committee and commented on the Adoption Service, asking whether the cost could be reduced if this Service was provided in-house.

The Chief Executive highlighted the negotiation of commissioning costs as an example of a 'Open Risk' which had become high level due to the emergency situation, in relation to higher overheads, additional hygiene and changes to staff rotas. If Welsh Government (WG) did not continue to provide additional funding to meet this need, the cost would have to be met by the Council. The Chief Officer (Social Services) explained that the cost pressures outlined in the presentation and report were the equivalent of 5%-7% of the overall portfolio budget. Increasing costs for Out of County Placements continued to be monitored with the Council being pro-active in addressing this cost pressure which remained variable. The approach taken by the Council over a number of years had been comprehensive and reasonable to support this risk with the additional provision of in-house children's services as an example of managing this risk in the medium term.

The Senior Manager (Children and Workforce) advised that North Wales were the first region to establish a regional Adoption Service and it had been recognised that as a region some of the pace of the service had been lost. A review of the service was commissioned which had resulted in a revised structure and services being expanded. He also reported that Internal Audit had been commissioned to carry out an audit of the Adoption Service to test whether the re-designed service was working and delivering good outcomes. It was agreed that the outcome of the audit review be presented to the Committee following its completion.

Councillor David Wisinger commented on the increasing pressure at Wrexham Maelor Hospital and asked whether additional resources would be provided to the Council if additional support was requested to assist them. He also asked whether the possible cost pressure for the Sleep in Pay Ruling included payment being backdated. The Senior Manager (Integrated Services, Lead Adults) explained that where patients already in receipt of services were currently in Wrexham Maelor Hospital due to ill health the funding to continue their service once they had left hospital was accounted for in the core budget arrangements. A bid had been recently been submitted to WG jointly with Betsi Cadwaladr University Health Board (BCUHB) for winter pressure funding to assist with additional step down facilities, domiciliary care support, social work and occupational therapy support. The Senior Manager (Safeguarding and Commissioning) explained that the cost pressure for the Sleep in Pay Ruling applied to Flintshire County Council staff and staff within the independent sector who were commissioned to deliver sleep in services. A decision had previously been taken to hold back any increase for commissioned services until the Court ruling and the cost pressure includes backdated costs.

In response to a further question around the Sleep in Pay Ruling, the Senior Manager (Safeguarding and Commissioning) explained that the ruling, if approved, would see all sleep-in staff paid the national minimum wage for hour working even if asleep.

The recommendations, as outlined within the report and presentation slides were proposed to the Committee. Councillor Dave Mackie suggested an additional recommendation thanking officers for the work undertaken in preparing the budget information. The recommendations were moved by Councillor David Wisinger and seconded by Councillor Gladys Healey.

RESOLVED:

(a) That the Committee support the overall budget strategy;

(b) That the Committee re-affirm the Council's position on local taxation policy;

(c) That the Committee support the Council's expectations of Governments, as outlined within the presentation provided;

(d) That the Social & Health Care cost pressures, as outlined within the report, be noted;

(e) That no further cost efficiency areas be proposed by the Committee to be explored further; and

(f) That the Committee expresses its thanks to all Officers involved in the preparation of the budget so far.

EMERGENCY SITUATION

The Chief Executive provided a short update on the emergency situation. He advised that the incident rate had reduced slightly from the previous day with daily cases generally lower than a few weeks ago. The advice received was that it would take around 3 weeks from the start of the firebreak to see a full impact trend and it was hoped that the overall picture for Wales would be much improved. The First Minister had indicated that a review of the position would be taken two weeks after the end of the firebreak in order to see if the figures remained stable and avoid another intervention until the New Year at the earliest.

The Council were on track to double Test, Trace and Protect capacity, and all affected services had resumed on 9 November as planned. All attention was currently on the resilience of health and social care across the winter months and a vaccination plan for North Wales was in place in readiness for one of more vaccines as they became available. A further Member briefing paper would be circulated later in the week.

Councillor Gladys Healey raised concerns around the possibility of intensive care nurses having to look after more than one patient across the border in England and sought assurance that this would not be implemented in hospitals in Wales. The Chief Executive said that whilst scrutinising the BCUHB Quarter 3 Plan, he would enquire on safety and staff ratios.

SOCIAL CARE ACCOLADE AWARDS

The Chief Officer (Social Services) reported that the Social Care Accolade Awards had been held on 10 November, 2020 where Flintshire Services had won both first and second place awards. NEWCIS had successfully won the first place award for Community Support, with HfT coming in a very close second place. Representatives from both services would be invited to attend the County Council meeting on 8 December to allow for formal congratulations. The Chair asked that the Chief Officer pass on the thanks and congratulations of the Committee to all staff involved.

In commemoration of Armistice Day the Committee observed a two minute silence at 11.00 am.

11. MEMBERS OF THE PUBLIC AND PRESS IN ATTENDANCE

There were no members of the press or public present.

(The meeting started at 10.00 am and ended at 11.03 am)

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Chair

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SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE

Date of Meeting	3 December 2020
Report Subject	Forward Work Programme and Action Tracking
Report Author	Social & Health Care Overview & Scrutiny Facilitator
Type of Report	Operational

EXECUTIVE SUMMARY

Overview & Scrutiny presents a unique opportunity for Members to determine the Forward Work programme of the Committee of which they are Members. By reviewing and prioritising the Forward Work Programme Members are able to ensure it is Member-led and includes the right issues. A copy of the Forward Work Programme is attached at Appendix 1 for Members' consideration which has been updated following the last meeting.

The Committee is asked to consider, and amend where necessary, the Forward Work Programme for the Social & Health Care Overview & Scrutiny Committee.

The report also shows actions arising from previous meetings of the Social & Health Care Overview & Scrutiny Committee and the progress made in completing them. Any outstanding actions will be continued to be reported to the Committee as shown in Appendix 2.

RECOMMENDATION	
1	That the Committee considers the draft Forward Work Programme and approve/amend as necessary.
2	That the Facilitator, in consultation with the Chair of the Committee be authorised to vary the Forward Work Programme between meetings, as the need arises.
3	That the Committee notes the progress made in completing the outstanding actions.

REPORT DETAILS

1.00	EXPLAINING THE FORWARD WORK PROGRAMME AND ACTION TRACKING
1.01	Items feed into a Committee's Forward Work Programme from a number of sources. Members can suggest topics for review by Overview & Scrutiny Committees, members of the public can suggest topics, items can be referred by the Cabinet for consultation purposes, or by County Council or Chief Officers. Other possible items are identified from the Cabinet Work Programme and the Improvement Plan.
1.02	In identifying topics for future consideration, it is useful for a 'test of significance' to be applied. This can be achieved by asking a range of questions as follows: 1. Will the review contribute to the Council's priorities and/or objectives? 2. Is it an area of major change or risk? 3. Are there issues of concern in performance? 4. Is there new Government guidance of legislation? 5. Is it prompted by the work carried out by Regulators/Internal Audit? 6. Is the issue of public or Member concern?
1.03	In previous meetings, requests for information, reports or actions have been made. These have been summarised as action points. Following a meeting of the Corporate Resources Overview & Scrutiny Committee in July 2018, it was recognised that there was a need to formalise such reporting back to Overview & Scrutiny Committees, as 'Matters Arising' was not an item which can feature on an agenda.
1.04	It was suggested that the 'Action tracking' approach be trialled for the Corporate Resources Overview & Scrutiny Committee. Following a successful trial, it was agreed to extend the approach to all Overview & Scrutiny Committees.
1.05	The Action Tracking details including an update on progress is attached at Appendix 2.

2.00	RESOURCE IMPLICATIONS
2.01	None as a result of this report.

3.00	CONSULTATIONS REQUIRED / CARRIED OUT
3.01	In some cases, action owners have been contacted to provide an update on their actions.

4.00	RISK MANAGEMENT
4.01	None as a result of this report.

5.00	APPENDICES
5.01	Appendix 1 – Draft Forward Work Programme Appendix 2 – Action Tracking for the Social & Health Care OSC.

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	Minutes of previous meetings of the Committee as identified in Appendix 2. **Contact Officer:** Margaret Parry-Jones Overview & Scrutiny Facilitator **Telephone:** 01352 702427 **E-mail:** Margaret.parry-jones@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	**Improvement Plan:** the document which sets out the annual priorities of the Council. It is a requirement of the Local Government (Wales) Measure 2009 to set Improvement Objectives and publish an Improvement Plan.

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Forward Work Programme

Date of meeting	Subject	Purpose of Report	Scrutiny Focus	Responsible / Contact Officer	Submission Deadline
21 January 21 10.00 am	**Young Carers – NEWCIS Contract**	To scrutinise performance and outcomes being delivered for Young Carers through a new contract and service model with NEWCIS	Assurance	Senior Manager: Children	
	Plas yr Ywen (Holywell Extra Care)	Progress report	Assurance	Chief Officer	
	Marleyfield House update	To receive a progress report	Assurance	Chief Officer	
	Arosfa update	To receive a progress report	Assurance	Chief Officer	
	Part 9 Regional Partnership Board Annual Report: 2019/20	To consider the Annual Report	Joint working	Chief Officer	
4 March 2.00 pm	**Mockingbird – update on the programme**	To receive a progress report	Assurance	Chief Officer	
15 April 2.00 pm	**North Wales Adoption Service Update**	To receive a progress report	Assurance	Chief Officer	

27 May 10.00 am	**Directors Annual Report**	To consider the draft report prior to consideration at Cabinet	Pre-decision scrutiny	Chief Officer	
17 June 2.00 pm Joint with Education & Youth OSC	**Educational Attainment of Looked After Children** **Corporate Parenting**	To receive the annual attainment report. To review the Corporate Parenting Strategy	Assurance Assurance	Chief Officers Chief Officers	
1 July 10.00 am	**Year-end Council Plan Monitoring Report**	To enable members to fulfil their scrutiny role in relation to performance monitoring.	Assurance	Facilitator	

Regular Items

Month	Item	Purpose of Report	Responsible/Contact Officer
Nov/Dec	**Safeguarding**	To provide Members with statistical information in relation to Safeguarding - & Adults & Children	Chief Officer (Social Services)
May	**Educational Attainment of Looked After Children**	Education officers offered to share the annual educational attainment report with goes to Education & Youth OSC with this Committee.	Chief Officer (Social Services)
May	**Corporate Parenting**	Report to Social & Health Care and Education & Youth Overview & Scrutiny.	Chief Officer (Social Services)
	Comments, Compliments and Complaints	To consider the Annual Report	Chief Officer (Social Services)
	Betsi Cadwaladr University Health Board Update	BCUHB are invited to attend on an annual basis – partnership working.	Facilitator

Suggestions for reports to be tabled at a BCUHB Scrutiny when that is convened:-

- General Mental Health services (including Workforce Mental Health)
- Perinatal Mental Health

ACTION TRACKING FOR THE SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE

Meeting Date	Agenda Item	Action Required	Action Officer(s)	Action taken	Timescale
22/10/20	Children's Transformation Project	Item to be included on agenda of joint meeting on 17 June 2021 on the MST Service.	Ceri Shotton	Added to Forward Work Programme	Ongoing
11/11/20	Social Care Accolades	Letter of congratulations on the successes of NEWIS and Hft sent on behalf of the Chair & Committee	Margaret Parry-Jones	Actioned	Completed.

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SOCIAL & HEALTH CARE OVERVIEW AND SCRUTINY COMMITTEE

Date of Meeting	Thursday 3rd December, 2020
Report Subject	Recovery Strategy Update
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer (Social Services)
Type of Report	Strategic

EXECUTIVE SUMMARY

The Council has developed a corporate Recovery Strategy for the pandemic emergency situation which was endorsed at a special Cabinet meeting on 15 September.

Cabinet requested each of the Overview and Scrutiny Committees to support recovery in their respective portfolio areas, and specifically to have oversight of:-

1. The portfolio risk register(s) and the risk mitigation actions, both live and planned;
2. The objectives for recovery for the portfolio(s);
3. The immediate strategic priorities for recovery for the portfolio(s) extracted from the draft Council Plan for 2020/21; and
4. The set of revised performance indicator targets for the portfolio(s) for 2020/21.

The above were considered by the Committee at its meeting on 22 September, 2020.

This report provides the Committee with an update on the portfolio risk register and risk mitigation actions (shown at Appendix 1 and 2).

RECOMMENDATIONS	
1	That the Committee review the latest updated risk register and risk mitigation actions within the Social Services portfolio.

REPORT DETAILS

1.00	**EMERGENCY RECOVERY**
1.01	The Council is developing a corporate Recovery Strategy for the pandemic emergency situation. The Strategy covers:- 1. The chronology of the emergency response phase and transition to recovery 2. The handover arrangements or recovery 3. Organisational recovery of the corporate organisation 4. Community recovery of the communities we serve 5. Strategic priorities and performance for the remainder of 2020/21 6. The roles the Council will play in regional recovery 7. The democratic governance of recovery
1.02	The development of the Recovery Strategy been led by the Chief Executive and Leader and overseen by a cross-party Member Recovery Board. The Board, which is an advisory sub-committee of Cabinet, has completed its work and has stood down. The Board has met seven times in quick succession and has received multiple reports and presentations. Cabinet is due to endorse the Recovery Strategy at a special meeting on 15 September.
1.03	Cabinet will be inviting each of the Overview and Scrutiny Committees to support recovery in their respective portfolio areas, and specifically to have oversight of:- 1. The portfolio risk register(s) and the risk mitigation actions both live and planned; 2. The objectives for recovery for the portfolio(s);
1.04	The latest version of the risk register (Appendix 1) and table of risk mitigations (Appendix 2) for the Social Services portfolio are attached.
1.05	An update on the recovery objectives for the service portfolio for this Committee is shown below. Where services have been partially resumed, the return to normal operating hours and usage will be in line with Public Health Wales and Welsh Government advice:- • **Adult Services - Return to normal operating hours and usage Older People's Day and Respite services:** Croes Atti Day Centre has reopened following the Fire-break and operates 6 days per week providing a limited number of places for a max of 4 people each day. It provides day time support for individuals with the most challenging and complex dementias. Operating well and we are reviewing daily. Respite for Older People is usually overnight support in care home for a period up to 7 days. The current COVID-19 restrictions make this challenging as it required the individual to have a negative COVID-19 test prior to moving in to the short-term care arrangements and the individuals is also required to self-isolate in the care home for 14 days, this means the person on respite isn't able to fully engage in the activities of the homes. As a result, the request for this type of respite

	is much reduced. To support families we are continuing to look at providing respite in different ways including providing overnight respite at a person's home. • **Adult Services - Open Plas Yr Ywen Extra Care:** The opening of Play yr Ywen is planned for January 2021, it is recognised that there is a delay in opening due to PHW guidance in bringing groups of older people together. People remain interested in moving in, but are seeking reassurance. In the meantime, we have deployed Plas yr Ywen staff into Tŷ Treffynnon to provide step down support. • **Adult Services - Return to normal operating hours and usage for Adult Mental Health Services:** We have reopened Mental Health Support Services, including Growing Places and Double Click. The services were temporarily closed during the Fire-break but have since resumed. These services provide a limited number of placements for individuals with the most complex needs. We continually review the situation as it develops. • **Adult Services - Adults social work and occupational therapy services is operating as normal, Including joint mental health and substance misuse servce.** • **Adult Services - Return to normal operating hours and usage for Learning Disability services:** Respite for Learning Disability Services has reopened with Hafod and Woodlea, our short term care houses, now open and operating a limited service supporting one individual to stay in the property at any one time. Again there was a temporary closure during the Fire-break and the service has since reopened on the same operating model prior to Fire-break. This support is being offered to individuals with the most complex needs. • **Adult Services - Return to normal operating hours and usage for Disability Day and Respite services:** Disability Day and Work Services are operating with a reduced number of individuals and in accordance with PHW guidance. These provisions includes Tri Ffordd, Abbey Metal and Hwb Cyfle. • **Children's Services – Return to normal operation for Respite services:** Arosfa continues to provide respite support for children with disabilities. One child is supported a night as opposed to three children. Additional direct payments have been used creatively to support carers. Respite for foster carers is being provided where there is a significant risk of placement breakdown.

- **Children's Services - Resume normal social work services:**
  Social workers have continued their assessment and support work. Direct visits to households with risk based safety measures are in place.

- **Early Years and Family Support - Return to normal operation for Flying Start services:**
  The annual Delivery Plan for Flying Start has been revised to realign provision until 31/3/21. Essential services have recommenced including the opening of Family Centres to provide specific services.

- **Early Years and Family Support - Reopen Flintshire Crèche:**
  The crèche primarily supports children whilst their Parents/carers take part in parenting programmes. As these programmes have not yet recommenced there has currently not been the need for the crèche.

- **Workforce - Resumption of face to face training courses:**
  The QCF Induction sessions resume in October but ceased over the Fire-break, these have now restarted. Essential face to face has now resumed with Observed Moving and positioning training being delivered twice weekly from the 26th November. All other training remains online with a mixture of e-learning and online training sessions. This is constantly being reviewed.

- **Adult Safeguarding - Continue with business as usual:**
  Strategy Meetings are continuing to operate virtually as well as Case Conferences. The work of the Adult at Risk Social Workers and Support Worker continues virtually, with some face to face meetings (observing COVID-19 regulations) where this is essential.

- **Independent Reviewing Officers - Continue with business as usual:**
  The majority of meetings have been taking place virtually, with occasional face to face meetings in exceptional circumstances, and following COVID-19 regulations. This is being reviewed regularly and it is anticipated that there will be a blend of virtual and face to face meetings in the future, once COVID019 restrictions ease.

- **Deprivation of Liberty Safeguards - Return to normal assessment process:**
  The majority of meetings to undertake Best Interest Assessments are being undertaken virtually, however, where there is a need for a face to face meeting these have taken place and been compliant with COVID-19 regulations. This is being reviewed regularly and will continue in this way for the time-being.

- **Children's Safeguarding - Continue with business as usual:**
  A number of Conferences are taking place virtually or a blended approach with some individuals in the office and others dialling in over

	Webex. The system is working well and is being constantly reviewed. • **IT / Administrative systems - Business as usual:** The IT Systems Team continue to work from home providing helpdesk cover, training and delivering ongoing planned work. This will continue for the foreseeable future. The administrative teams have a limited number of staff attending the office from each team (1 or 2) with the majority of staff working from home. This will continue for the foreseeable future. • **Financial Assessment and Charging - Resume normal services:** The service is operating as normal, with a small number of staff working from the office and the remaining staff team working remotely. The Welfare benefit Officers are undertaking visits virtually in the main, with the occasional face to face visit where this is essential. All COVID-19 regulations are being adhered to. • **Deputyship - Resume normal services:** The services is operating as normal with all staff working from home. This will continue for the foreseeable future.

2.00	**RESOURCE IMPLICATIONS**
2.01	There are no specific resource implications from this report.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	None specific as this report is based on documented response and recovery work.

4.00	**RISK MANAGEMENT**
4.01	This report specifically covers emergency situation risk management.

5.00	**APPENDICES**
5.01	Appendix 1 – Updated Social Services Recovery Risk Register Appendix 2 – Updated Social Services Risk Mitigation Actions Appendix 3 – Presentation Slides

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	None.

7.00	CONTACT OFFICER DETAILS
7.01	**Contact Officer:** Neil Ayling **Telephone:** 01352 704500 **E-mail:** neil.ayling@flintshire.gov.uk

Social Services Portfolio Risk Register

Version 6

Published: 20/11/2020

Key		
Underlying Risk Rating	The risk rating before any mitigating actions	
Current Risk Rating	This risk rating following the planned mitigation actions	
Target Risk Rating	The risk rating which is realistically achievable and by when	
Risk Trend	The trend of the risk since the last review date	
NC ↔	No change in risk trend since last review	
Risk Status	Open denotes a live risk	Closed denotes a closed risk
*Denotes the risk is specific to the 'Recovery'		
SS	Social Services	

Risk Register - Part 1 (Portfolio Management)

Financial

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
SS01 Updated Nov 2020	Expenditure on out of county placements increases as placement costs increase in a demand led market. Note: risk trend amended to increasing; risk rating remains the same but under review due to financial impact of recent placements not yet reflected in budget monitoring	**Strategic**	**Craig Macleod**	**Peter Robson**	**R**	**A**	**A Q4 2020/21**	**R ↑**	**Open**
***SS02**	Expenditure on experienced agency workers increases due to the reduction in opportunities for face to face training and development for existing / new staff	**Operational**	**Jane Davies**	**-**	**A**	**G**	**Y Q1 2021/22**	**NC ↔**	**Open**
***SS03** Updated Nov 2020	Failure to meet conditions of grant funding where the terms of the grant provision cannot be renegotiated with the provider Note: Revised Delivery Plan has been approved; Risk to be closed	**Operational**	**Craig Macleod**	**Gail Bennett**	**G**	**G**	**G Q4 2020/21**	**G ↓**	**Closed**

Workforce

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
SS04	It becomes increasingly difficult to recruit and retain staff in the residential sector due to the significant requirements for the registration of care staff under the Regulation and Inspection of Social Care Act	**Strategic**	**Jane Davies**	**Dawn Holt**	**A**	**Y**	**Y Q4 2020/21**	**NC ↔**	**Open**
***SS05**	Workforce depleted by sickness due to long term impact of working under extremely stressful conditions	**Operational**	**Jane Davies**		**A**	**Y**	**Y Q4 2020/21**	**NC ↔**	**Open**

External Regulation

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
SS06	Some individuals are illegally detained awaiting Liberty Protection assessments because there is insufficient capacity to absorb the introduction of Community assessments	**Strategic**	**Jane Davies**	**Jayne Belton**	**A**	**Y**	**Y Q3 2020/21**	**NC ↔**	**Open**

ICT Systems

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
SS08	Failure of the Clipper Finance system due to the age of the software and its incompatibility with new server technology	Project	Dawn Holt	Emma Murphy	G	G	G Q4 2020/21	NC ↔	Open

Risk Register - Part 2 (Portfolio Service & Performance)

Adult Services

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
SS09	Insufficient numbers of residential and nursing beds to meet demand because of the long term fragility and instability of the care home sector	Strategic	Jane Davies	Dawn Holt	R	Y	Y Open	NC ↔	Open
SS10	Insufficient capacity to provide the quantities and levels of care to clients at home and in the community because of challenges in recruitment of direct care workers and instability in the care market	Strategic	Jane Davies	Dawn Holt	R	A	Y Q4 2020/21	NC ↔	Open
*SS11	Unpreparedness to meet the needs of clients discharged from hospital because they have been discharged prematurely and without a full assessment	Operational	Susie Lunt	Janet Bellis	R	G	Y Q4 2020/21	NC ↔	Open
SS15	Opening of Plas Yr Ywen Extra Care will be delayed due to redeployment of staff to support critical services	Project	Mark Holt	Carol Dove	Y	Y	G Q4 2020/21	NC ↔	Open
SS17	The redevelopment of Marleyfield Care Home will not be achieved within budget and timescales because of delays in the construction supply chain and risk of infection for residents	Project	Dawn Holt	Gareth Jones	G	G	G Q4 2020/21	NC ↔	Open

Children's Services / Early Years

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
SS19	More children and families experience ACE's (Adverse Childhood Experiences) as family relationships breakdown, or become strained, due to the pressures of lockdown and rising financial pressures	Strategic	Craig Macleod	Gail Bennett	A	A	Y Q4 2020/21	NC ↔	Open
*SS20	We will not meet our ambition to safely reduce our identified cohort of children looked after due to delays in the court process	Project	Peter Robson	Craig Macleod	R	Y	Y Q1 2021/22	NC ↔	Open
*SS21	Targets for Mockingbird are missed due to a failure to recruit foster carers to the scheme given the constraints on completing assessments for carers and providing training	Project	Craig Macleod	Peter Robson	A	Y	Y Q1 2021/22	NC ↔	Open
SS22	An insufficient supply of placements leads to young people being placed in unregulated settings.	Strategic	Craig Macleod	Peter Robson	R	A	A Q4 2020/21	NC ↔	Open

Adult & Children's Services

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
*SS23	Impacts on vulnerable people through a withdrawal of resources from non-essential services to prioritise meeting demand in essential services	Operational	Susie Lunt	Craig Macleod	R	Y	Y Q4 2020/21	NC ↔	Open
*SS24	Pressures on the care system as unpaid carers and families are not able to continue in their caring role due to the reductions in respite and day services	Operational	Dawn Holt	Jo Taylor	R	Y	Y Q1 2021/22	NC ↔	Open
*SS26	Adults and children are not effectively safeguarded due to restrictions in their visibility during shielding/social isolation and targeted criminal activity designed to exploit vulnerable people	Operational	Jane Davies	Craig Macleod	R	Y	Y Q3 2020/21	NC ↔	Open
*SS27	Insufficient capacity to cope with a sharp increase in referrals to child and adult services	Operational	Craig Macleod	Dawn Holt	R	Y	A Open	NC ↔	Open
*SS28	Individuals with a learning disability or autism are unable to access services due to the suspension of transformation programmes	Project	Susie Lunt	Jo Taylor	R	Y	Y Q3 2020/21	NC ↔	Open

Previously Closed Risks

Risk Ref.	Risk Title	Risk Type	Lead Officer	Supporting Officers	Underlying Risk Rating	Current Risk Rating	Target Risk Rating	Risk Trend	Risk Status
*SS07	We are unable to progress with the processing of complaints and Information Requests due to physical distancing requirements and travel restrictions	Operational	Jane Davies	Jacque Slee	Y	G	G Q2 2020/21	NC ↔	Closed
SS12	Objectives for the Alternative Delivery Model (ADM) Learning Disability Day and Work Opportunities (Hft) project will not be achieved because of physical distancing requirements and the reduction in face to face delivery	Project	Dawn Holt	Emma Murphy	A	G	A Q1 2021/22	NC ↔	Closed
SS13	Development of Microcare will not progress due to difficulties recruiting and training potential carers	Project	Dawn Holt	Rob Loudon	Y	G	G Q4 2020/21	NC ↔	Closed
SS14	Objectives for the development of Ty Tryffynnon will not be achieved due to very tight timescales	Project	Dawn Holt	Christy Hoskings	Y	G	G Q2 2020/21	NC ↔	Closed
SS16	The re-commissioning of Supported Living Properties will not achieve continuity of care through TUPE for the individuals concerned	Project	Dawn Holt	Carol Dove	Y	G	G Q4 2020/21	NC ↔	Closed
SS18	Objectives in the project plan for Person Shaped Support (PSS) Trio and Short Break Care will not be achieved due to physical distancing requirements and the reduction in face to face care	Project	Dawn Holt	Emma Murphy	Y	G	G Q1 2021/22	NC ↔	Closed
*SS25	Insufficiency in the supplies of equipment for people to keep themselves safe due to the diversion of equipment to temporary hospital facilities, and the supply of PPE	Operational	Susie Lunt	Steve Featherstone	R	G	Y Q2 2020/21	NC ↔	Closed

Risk Matrix

Impact Severity	Catastrophic	Y	A	R	R	B	B
	Critical	Y	A	A	R	R	R
	Significant	G	G	Y	A	A	R
	Marginal	G	G	G	Y	Y	A
		Unlikely	Very Low	Low	High	Very High	Extremely High
		Likelihood of risk happening					

Social Service Portfolio Recovery Risk Register

Version 6

Published: 20/11/2020

Mitigation Urgency Key	
IM – Immediate	Now
ST – Short Term	Within 1 month
MT – Medium Term	1 month plus
Upward arrow	Risk increasing
Downward arrow	Risk decreasing
Sideways arrow	No change in risk
*Denotes the risk is specific to 'Recovery'	

Part 1 (Portfolio Management)

Financial

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
***SS02**	Expenditure on experienced agency workers increases due to the reduction in opportunities for face to face training and development for existing / new staff	↔	ST	Workforce Development are developing online training modules to deliver Core Training and Refresher Training for staff through e-learning and online interactive sessions. We are able to utilise the Social Care Wales Workforce Development Programme (SCWWDP) Grant, having had confirmation of change of use away from the training plan submitted to Welsh Government (WG). Work will continue around the employment of final year student social workers who have demonstrated competency in their placement, into assistant positions pending their approval as qualified social workers. We are retaining a small number of agency staff to assist with the skill mix of the staff cohort, and in preparation for winter pressures. The risk of a possible spike in referrals in Children's Services is being mitigated by some recruitment to permanent posts which is currently ongoing.
***SS03** Updated Nov 2020	Failure to meet conditions of grant funding where the terms of the grant provision cannot be renegotiated with the provider	↓	ST	Risk to be closed Revised Delivery Plan has been submitted to WG and is awaiting approval.

Workforce

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
***SS05**	Workforce depleted by sickness due to long term impact of working under extremely stressful conditions	↔	IM	We are ensuring that staff can and are supported to access help for mental health, including Carefirst, Mind / Blue Light support for staff exhibiting symptoms of PTSD, and Social Care Wales trauma support. We are ensuring that wherever possible staff are taking their annual leave and not accruing unmanageable flexi-time hours, and we are following HR guidance around the revised staff sickness procedures. We have opened up some of our internal courses to staff in the independent sector, and

				this is being funded by the Council. There are still some issues in Children's Services which may impact in the future – managers are monitoring this closely with their staff.

Part 2 (Portfolio Service & Performance)

Adult Services

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
*SS11	Unpreparedness to meet the needs of clients discharged from hospital because they have been discharged prematurely and without a full assessment	↔	IM	We continue to work within the guidance for testing, and to work with information gathered in partnership with BCUHB. We are conducting "arms length" proportionate assessments followed up with more detailed assessments in Discharge to Assess facilities. A dedicated team of social workers and occupational therapists has been set up to follow individuals through the discharge process and back home – this is working well. Telephone and Skype are being utilised for some assessments to support discharge, and we have proportionate paperwork in place to assist in rapid safe discharge. Each service user is being risk assessed; the most complex may still receive a visit with appropriate precautions. A testing regime is in place to ensure that people do not have COVID19 before they are discharged. Hospital discharges are being processed effectively through the new step down facilities.

Children's Services / Early Years

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
*SS20	We will not meet our ambition to safely reduce our identified cohort of children looked after due to delays in the court process	↔	MT	We are completing targeted assessment work for increased Special Guardianship Orders and discharge of care orders ready for court consideration in the Autumn. Recruitment of additional staff has created capacity in the Courts, allowing the potential for a higher throughput of cases.
*SS21	Targets for Mockingbird are missed due to a failure to recruit foster carers to the scheme given the constraints on completing assessments for carers and providing training	↔	MT	Our first Mockingbird group is in place. Progress during COVID-19 has also been impacted by the resignation of the dedicated social worker. Social Worker recruitment has now been completed. With the support of the Fostering Network we have been working with a consortia of Mockingbird sites across the UK to share experience, learning, and approaches to mitigating risk and recovery planning. This Group will help us learn from sites that are fully operational and embedded which will inform a revised plan. .

Adult & Children's Services

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
***SS23**	Impacts on vulnerable people through a withdrawal of resources from non-critical services to prioritise meeting demand in critical services	↔	MT	We need to be able to comply with our legislative requirements to promote the well-being of individuals, with reference to statutory guidance. To achieve this we are using triage processes in the Single Point of Access for Adults and in Children's First Contact, which ensure that all enquiries are dealt with on a case by case basis. We have risk assessments in place to direct services to the individuals who are at highest risk. We have a Virtual Early Help Hub in operation to provide telephone advice and assistance to help prevent problems from escalating and additional demand on statutory services. In response to the reduction in advocacy services for adults, we are working with Flintshire Local Voluntary Council and carers' organisations to ensure that the voices of individuals are heard. Service users in supported living accommodation are accessing day services through technology. We have an agreement in place with Pharmacists and BCUHB for the management of substance misuse services. We are ensuring the safety of our workforce and the public through the use of telephone and secure video conferencing facilities, and we have introduced a rota for staff in line with 2 metre distancing in office and clinical areas, and a plan is being developed to roll this out to the wider workforce in Ty Dewi Sant. Assessment and support for young people is wherever possible being carried out via telephone or video conferencing calls. Contact with care leavers, parents and carers, and foster carers is being maintained with one to one remote sessions, with appropriate frequency determined on a case by case basis.
***SS24**	Pressures on the care system as unpaid carers and families are not able to continue in their caring role due to the reductions in respite and day services	↔	ST	We are working with commissioned services for carers to ensure that PPE is available for those staff and unpaid carers who need it. We have reminded staff to consider the carer when undertaking the discharge assessment. We have started 'Keeping in touch' calls to carers, shifting provision to supporting mental, physical and emotional well-being of carers remotely. Carers Week was 8-14th June and the Carers Strategy Group has focused activities on awareness raising and sharing some stories to increase the visibility of unpaid carers. Consideration is being given to re-introducing support services for carers, i.e. respite and day care, even on a phased or priority basis to mitigate carer breakdowns/ burn-out over the coming months. We are expanding direct payment options for families with disabled children, and are working with Action for Children to provide domiciliary support through Arosfa. We are working with specialist schools to provide childcare as part of Resilience Hub provision and are looking to maximise opportunities for families to use resources across the Council portfolio to undertake activities to provide respite.

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
***SS26**	Adults and children are not effectively safeguarded due to restrictions in their visibility during shielding/social isolation and targeted criminal activity designed to exploit vulnerable people	↔	IM	We are ensuring that all safeguarding processes can continue, by circulating information about revised working practices to partners and testing out virtual meetings technology. Assessments are in place to determine the potential for increased risk to individuals. We are ensuring the safety of our workforce and the public through the use of telephone and secure video conferencing facilities. Virtual Missing, Exploitation, Trafficking (MET) meetings are in place to share intelligence across agencies and the associated action plans. Vulnerable children supported through Resilience School Hubs. Virtual Early Help Hub is operating to assist in identifying and supporting families before problems escalate. Systems and protocols need to be established for supporting vulnerable families in partnership with schools/ Resilience Hubs. We are working with Health visitors to ensure shared clarity on processes for escalation of concerns about vulnerable children. We have rebalanced capacity in the Safeguarding Unit to account for a temporary reduction in Safeguarding Referrals and an increase in Adult at Risk work, to include an increase in requests from professional for advice on mental capacity and liberty safeguards as people are shielding or self-isolating. The national launch of the new regulations on Liberty Protection Safeguards has been officially delayed. We are continuing to promote safeguarding awareness to the general public and publicise referral routes, with enhanced reporting to track child protection and adult safeguarding referrals. Corporate Safeguarding will play a role in ensuring our systems and processes are working effectively. Cases are still being prioritised according to need. Visibility has improved now that children are back in school. Still some challenges with adults in the community however.
***SS27**	Insufficient capacity to cope with a sharp increase in referrals to child and adult services	↔	ST	We are establishing a multi-agency group to monitor trends in referrals and anticipated areas of demand for partner agencies and 3rd sector support. The Group will work to support partners to ensure services are accessible and resilient. Work with police and 3rd sector to understand incidents of domestic violence and service demand and work to support service resilience and sufficiency of support. We are providing early help support for parents with low/moderate mental health needs through the Early Help Hub and signposting to support through Family Information Service. We are also developing strong social media and promotion tools about the Early Help Hub and how to access support. Support options are being identified for families of children that are shielding and therefore unable to access traditional community based support. Funding has been secured from the regional Transformation Fund to invest in early help as part of our recovery planning. We are working with Action for Children to extend existing therapeutic support service for children and young people experience trauma. No spike is in evidence; trend is reducing.

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
***SS28**	Individuals with a learning disability or autism are unable to access services due to the suspension of transformation programmes	↔	MT	We are seeking clarification on funding availability post December 2020. The transformation project is going ahead, albeit that we are still awaiting confirmation of the funding criteria. Waiting list for health assessments remains still high

Previously Closed Risks

Risk Ref.	Risk Title	Risk Trend	Mitigation Urgency	Mitigating Actions
***SS07**	We are unable to progress with the processing of complaints and Information Requests due to physical distancing requirements and travel restrictions	↓	ST	-
***SS25**	Insufficiency in the supplies of equipment for people to keep themselves safe due to the diversion of equipment to temporary hospital facilities, and the supply of PPE	↓	IM	-

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Social Services Risks (v6 Nov 2020)

- 20 open risks split over Financial, Workforce, External Regulation, ICT & Systems; Adult Services, Children's Services/Early Years, Adult & Children's Services
- Specific Recovery risks shown as *
- No red risks remain
- 96% of our risks now static, decreasing or closed.
- Risks that have changed since Version 5 are noted below:

Financial

Risk	Current Status	Trend Status	Explanation
SS01 Expenditure on out of county placements for children	A	R	Risk level rising; risk rating remains the same but under review due to financial impact of recent placements not yet reflected in budget monitoring
SS03 Failure to meet conditions of grant funding where the terms of the grant provision cannot be renegotiated with the provider	G	G	Revised Delivery Plan has been approved; RISK CLOSED

SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE

Date of Meeting	Thursday 3rd December, 2020
Report Subject	Mid-year Performance Indicators for Recovery, Portfolio and Public Accountability Measures
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer (Social Services)
Type of Report	Strategic

EXECUTIVE SUMMARY

Flintshire County Council Reporting Measures 2020/21 were identified by portfolios and approved by Cabinet in September 2020. This report presents a summary of performance at the mid-year point for the priorities relevant to the Social & Health Care Overview & Scrutiny Committee.

This mid-year performance monitoring report for the 2020/21 Reporting Measures shows that 69% of the performance indicators have met or exceeded their targets. Where performance can be measured against last year there has been a 64% downturn in trend, with 31% of measures improving on last year's performance and 5% maintaining stable performance.

This report is an exception-based report and concentrates on under-performance against target.

RECOMMENDATIONS	
1.	That the Committee consider the Mid-Year Performance Indicators for Recovery, Portfolio and Public Accountability Measures to monitor areas of under performance and request further information as appropriate.

REPORT DETAILS

1.00	EXPLAINING THE PERFORMANCE AT MID YEAR 2020/2021
1.01	The mid-year performance monitoring reports provide explanation of the progress being made toward the agreed measures set out in the Flintshire County Council Reporting Measures 2020/21. These measures were approved by Cabinet after targets for 2020/21 were re-assessed for forecasted performance due to the disruptions caused during the response phase of the pandemic.
1.02	This report is an exception-based report and concentrates on under-performance against in-year targets.
1.03	**Monitoring our Performance** Analysis of performance against the performance indicators is undertaken using the RAG status. This is defined as: • RED - under-performance against target. • AMBER - where improvement may have been made but performance has missed the target. • GREEN - positive performance against target.
1.04	Analysis of current levels of performance against target shows the following: • 33 (69%) have achieved a green RAG status • 1 (2%) have an amber RAG status • 14 (29%) have a red RAG status
1.05	There are no performance indicators (PIs) which show a red RAG status for current performance against targets relevant to the Social & Health Care Overview & Scrutiny Committee.

2.00	RESOURCE IMPLICATIONS
2.01	There are no specific resource implications for this report.

3.00	IMPACT ASSESSMENT AND RISK MANAGEMENT
3.01	**Ways of Working (Sustainable Development) Principles Impact**

Long-term	Throughout all of the Mid-Year Monitoring Report there are demonstrable actions and activities which relate to all of the
Prevention	
Integration	

Collaboration Involvement	Sustainable Development Principles. Specific case studies will be included in the Annual Performance Report for 2020/21.

Well-being Goals Impact

Prosperous Wales	Throughout the Mid-Year Monitoring Report there is evidence of alignment with the Well-being Goals. Specific strategic and policy reports include impact and risk assessments.
Resilient Wales	
Healthier Wales	
More equal Wales	
Cohesive Wales	
Vibrant Wales	
Globally responsible Wales	

Council's Well-being Objectives
The Council's Well-being objectives will be included in the Annual Performance Report for 2020/21. We are currently in the process of reviewing our Well-being objectives alongside the development of the Council Plan 2021/22.

4.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
4.01	The Reporting Measures are monitored by the respective Overview and Scrutiny Committees according to the priority area of interest.
4.02	Chief Officers have contributed towards reporting of relevant information.

5.00	**APPENDICES**
5.01	Appendix 1 - Mid-year progress report against 2020/21 Reporting Measures.

6.00	**LIST OF ACCESSIBLE BACKGROUND DOCUMENTS**
6.01	Flintshire County Council Reporting Measures 2020/21.

7.00	**CONTACT OFFICER DETAILS**
7.01	**Contact Officer:** Margaret Parry-Jones, Overview & Scrutiny Facilitator **Telephone:** 01352 702427 **E-mail:** Margaret.parry-jones@flintshire.gov.uk

8.00	GLOSSARY OF TERMS
8.01	**Reporting Measures:** The document which sets out the performance indicators of the Council. This document provides a set of measures to support recovery and selected portfolio measures. **CAMMS –** An explanation of the report headings. **Measures (Key Performance Indicators - KPIs)** New indicator – A new measure that has been identified for reporting against. Pre. Year Period Actual – The period actual at the same point in the previous year. If the KPI is a new KPI for the year then this will show as 'no data'. Period Actual – The data for this mid-year point. Baseline Year – As a new indicator, a target has not been established. This will be monitored and targets established for the following year. Period Target – The target for this mid-year point as set at the beginning of the year. Perf. RAG – This measures performance for the period against the target. It is automatically generated according to the data. Red = a position of under performance against target; Amber = a mid-position where improvement may have been made but performance has missed the target; and Green = a position of positive performance against the target. Perf. Indicator Trend – Trend arrows give an impression of the direction the performance is heading compared to the same period of the previous year: • A 'downward arrow' always indicates poorer performance regardless of whether a KPI figure means that less is better (e.g. the amount of days to deliver a grant or undertake a review) or if a KPI figure means that more is better (e.g. number of new jobs in Flintshire). • Similarly an 'upward arrow' always indicates improved performance. Outcome RAG – The level of confidence of meeting the target by the end of the year. Low – lower level of confidence in the achievement of the target (Red), Medium – uncertain level of confidence in the achievement of the target (Amber) and High - full confidence in the achievement of the target (Green).

Appendix 1

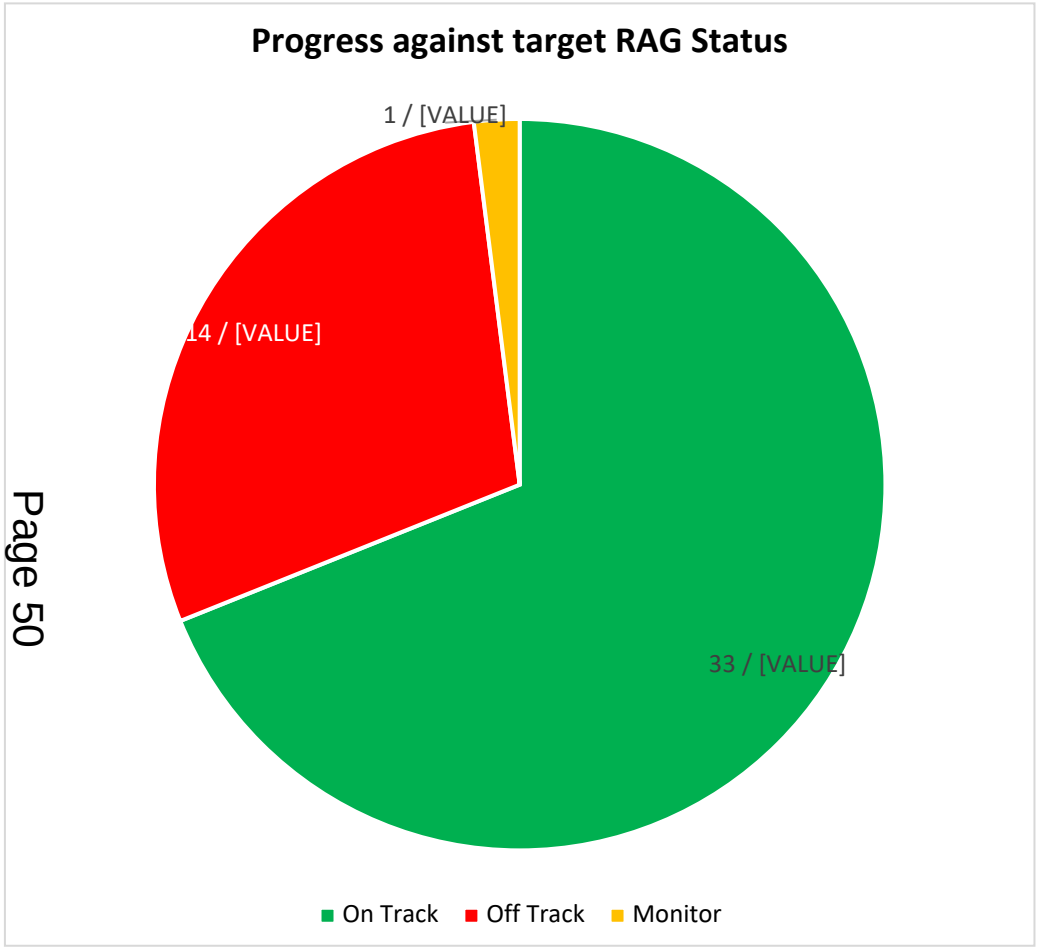
Performance Progress Report

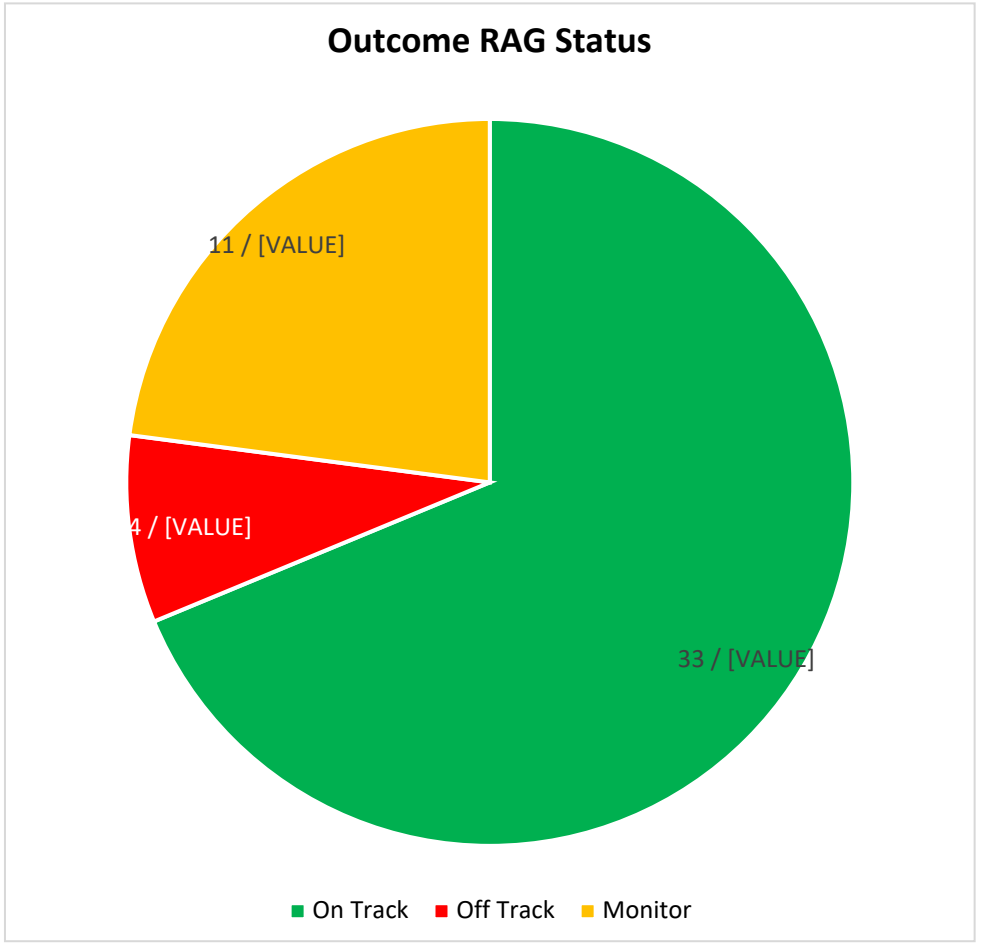
Flintshire County Council

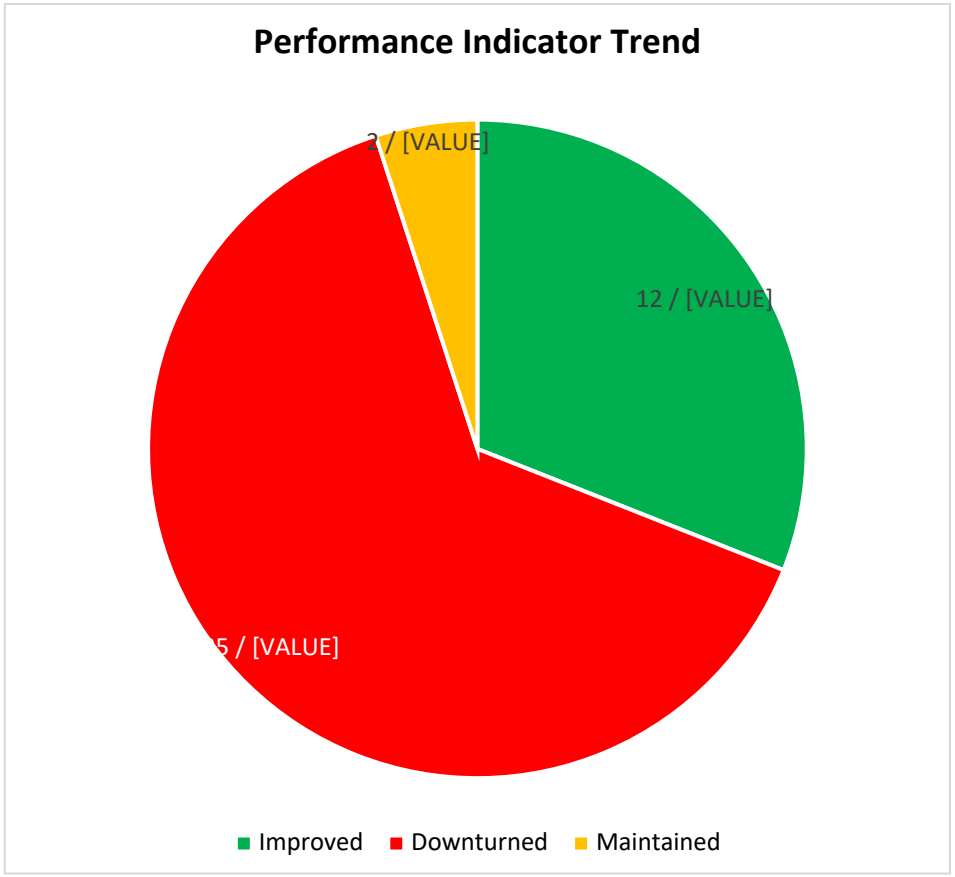
Mid-Year Reporting Measures 2020/21 Progress Report

Performance Analysis

Analysis is only carried out on measures that have targets or previous existing data.






Performance Indicator Trend
2 / [VALUE]
12 / [VALUE]
5 / [VALUE]
Improved
Downturned
Maintained

Performance Indicators – Social Services

Recovery Measures

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.1.3M04 (SS015) (RM) Percentage of urgent requests for equipment that meet or exceed the national 1 Day response standards	93	100	98	GREEN	↑	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Liz Barron - Performance Officer
Progress Comment: Equipment is managed by the North East Wales Community Equipment Service.
Last Updated: 08-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.1.3M05 (SS016) (RM) Percentage of requests for equipment that meet or exceed the national 7 Day standard	100	100	80	GREEN	↔	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Liz Barron - Performance Officer
Progress Comment: The National standard for the provision of equipment requests within 7 days is 80%.
Last Updated: 08-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.2.3M01 (SS003) (RM) Number of new foster carer approvals in the year	9	4	4	GREEN	↓	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Claire Latham - Performance Officer
Progress Comment: Four approvals for connected person foster carers have been processed.
Last Updated: 13-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.2.4M01 (SS004) (RM) Number of referrals to the Family Group Meeting Service	182	144	140	GREEN	↓	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Claire Latham - Performance Officer
Progress Comment: 20 families are currently awaiting allocation for a Family Group Meeting.
Last Updated: 12-Oct-2020

Portfolio Measures

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.1.3M01 / CP5.1.1M01 (SS010) (PM) The number of people who access the social prescribing / 3rd sector service through the Single Point of access.	202	1036	145	GREEN	↑	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Liz Barron - Performance Officer
Progress Comment: Numbers were significantly higher, particularly in April due to the pandemic. There was a 700% increase in calls/referrals to the service through April and subsequent high demands following.
Last Updated: 14-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.1.3M02 (SS011) (PM) The number of admissions to step up / step down beds.	108	102	N/A	N/A	↓	N/A

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Liz Barron - Performance Officer
Progress Comment: Admissions between April and September are comparable with the same period last year (108 between April and September 2019). Betsi Caldwaladr University Health Board (BCuHB) does not set a target for this measure; it is a measure of activity only.
Last Updated: 14-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.1.3M06 (SS017) (PM) Percentage of equipment that is re-used	91	90	70	GREEN	↓	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Liz Barron - Performance Officer
Progress Comment: The National standard for the reuse of equipment is 70%.
Last Updated: 08-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
(PM) [SEP] The percentage of adult safeguarding enquiries that met the 7 day timescale	96	97	94	GREEN	↑	GREEN

Lead Officer: Jayne Belton - Children's Safeguarding Manager
Reporting Officer: Jacque Slee - Team Manager Performance
Progress Comment: The Safeguarding Unit continue to prioritise enquiries within the 7 day timescale
Last Updated: 13-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.2.2M01 (SS001) (PM) The percentage pre-birth assessments completed within timescales.	100	93.33	90	GREEN	↓	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Claire Latham - Performance Officer
Progress Comment: Pre-birth assessments are carried out in line with the North Wales Multi-Agency Pre-Birth Pathway. One assessment in quarter one was complete outside the timescales indicated by the Pathway.
Last Updated: 14-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.2.2M02 (SS002) (PM)The percentage of children who were reported as having run away or gone missing from home who had a return interview	New Collection Method	80	Baseline Year	N/A	N/A	N/A

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Claire Latham - Performance Officer
Progress Comment: Baseline year - All children are offered a return interview after a period of going missing. All children who did not have an interview in timescales did not have one because they declined to attend. Some children go missing more than once; in quarter two there were 24 missing incidents, relating to 19 children.
Last Updated: 14-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.2.2M03 (SCC/034) (PM) The percentage of reviews of children on the Child Protection Register due in the year that were carried out within the statutory timescales	100	99.39	98	GREEN	⬇	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Claire Latham - Performance Officer
Progress Comment: Child Protection conferences can be delayed for a number of reasons, including the availability of family and professionals, court decisions, or in the interests of the children. All delays are approved by a manger prior to the conference taking place.
Last Updated: 08-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.2.2M04 (SCC/014) (PM) The percentage of initial child protection conferences that were due in the year and were held within 15 working days of the strategy discussion	100	95.83	95	GREEN	↓	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Claire Latham - Performance Officer
Progress Comment: Child Protection conferences can be delayed for a number of reasons, including the availability of family and professionals, court decisions, or in the interests of the children. All delays are approved by a manger prior to the conference taking place.
Last Updated: 13-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.2.4M02 (SS005) (PM) Number of Special Guardianship Orders made	5	3	1	GREEN	↓	GREEN

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Claire Latham - Performance Officer
Progress Comment: So far this year, three children have been prevented from entering the care system through the award of Special Guardianship Orders to family members.
Last Updated: 12-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.3.1M01 / CP2.1.6M02 (SS013) (PM) People with a learning disability accessing Project Search to improve their employability skills (number)	9	7	N/A	N/A	↓	N/A

Lead Officer: Jacque Slee - Team Manager Performance
Reporting Officer: Liz Barron - Performance Officer
Progress Comment: Seven young people enrolled in Project Search in the September intake. There is no target set for this measure as it is an activity measure.
Last Updated: 08-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.5.3M01 (PM) Number of children who access the Childcare offer	1298	1240	312.5	GREEN	⬇	GREEN

Lead Officer: Byra Foulkes - Early Years Support Manager
Reporting Officer: Jacque Slee - Team Manager Performance
Progress Comment: Data provided indicates the number of children who accessed the Childcare Offer between 1 April and 30 September 2020.
Last Updated: 09-Oct-2020

KPI Title	Pre. Year Period Actual	Period Actual	Period Target	Perf. RAG	Perf. Indicator Trend	Outcome RAG
CP1.5.3M02 (PM) Number of childcare providers	189	167	N/A	N/A	⬇	N/A

Lead Officer: Byra Foulkes - Early Years Support Manager
Reporting Officer: Jacque Slee - Team Manager Performance
Progress Comment: There are 337 childcare providers registered; this measure indicates the number of providers taking part. There is no target set for this measure as it is an activity measure.
Last Updated: 09-Oct-2020

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SOCIAL AND HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE

Date of Meeting	Thursday 3rd December 2020
Report Subject	Safeguarding Adults and Children's Annual Report to include the "New Safeguarding Procedures"
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer (Social Services)
Type of Report	Operational

EXECUTIVE SUMMARY

To provide members with information in relation to the Joint Adults and Children's Safeguarding provision within the county boundaries.

In line with the Council's strategy for developing a systematic Performance Management Framework, Social Services routinely collate safeguarding activity for all aspects of safeguarding. This report is to inform Members of key statistical and performance related information about children and adults at risk for whom the Authority has significant safeguarding and corporate safeguarding responsibilities.

This report is also to highlight the variety of work covered by the Safeguarding Unit and the activity it undertakes, including the response to the COVID 19 pandemic.

The report will also update members with brief details about the new Wales Safeguarding procedures.

This report will also summarise some key learning from Child and Adult Practice reviews and Domestic Homicide Reviews.

RECOMMENDATIONS	
1	That members accept this report as relevant information in relation to Flintshire Safeguarding for the period 1st April 2019 to 31st March 2020 and additional information provided.
2	That members take due regard to the variety of activity across the Safeguarding Unit and the continuing development and improvement in service provision.

REPORT DETAILS

1.00	EXPLAINING THE ACTIVITY OF THE SAFEGUARDING UNIT
1.01	The Flintshire Safeguarding Unit has been a single unified team since early 2016. The Safeguarding Unit Service Manager reports directly to the Senior Manager for Safeguarding and Commissioning. The team currently comprises 23 people and is based in County Offices Flint. They have close working relationships with Children and Adult Social Care and key partner agencies both locally and regionally.
1.02	The Safeguarding Unit oversees all aspects of work related to their core responsibilities which are: • Child Protection (CP) • Adult Safeguarding • Adults at Risk • Deprivation of Liberty Safeguards (DOLS) • Children Looked After (CLA) The Safeguarding Unit team are also involved in Regional Safeguarding Board sub-groups including delivery groups, policy and procedures, performance and quality audit groups; delivery of training for both adults and children, child practice review and adult practice reviews when required and investigations. In addition to our own internal case file audits, the team have completed audits to support practice and development of internal teams within Children's Services and Adult Services.
1.03	**Impact of COVID 19 and response of the Safeguarding Unit** Whilst this report focuses on the data analysis and narrative of the period April 2019 – March 2020, the period since late March 2020 to date has brought many challenges to the Unit as processes have adapted to working under local and National restrictions linked to the pandemic. The Safeguarding Unit in its entirety moved to a 'working from home' model which is still in place at the current time. Processes were swiftly adapted to ensure business as usual was maintained and statutory responsibilities were met. The team were fortunate to be able to continue their work remotely and have adapted to the use of dial in facilities or video conferencing facilities for all aspects of their work. High standards have been maintained, timescales have been adhered to and professional partnerships and business relationships have continued. Flintshire were one of the first areas in North Wales to move their entire child protection case conferencing and Children Looked After Reviews to a remote platform within the first week of lockdown restrictions. Adult Safeguarding Strategy meetings have continued using dial in or Webex facilities and our Best Interest Assessors have maintained a presence, within government guidelines, in the Care Homes in order to fulfil their duties under DOLs. Social workers within the Adult Safeguarding and Adult at Risk teams have followed local and government guidelines and

	supported people in the community, safeguarded individuals and continued their community work where needed.
1.04	**Adult Safeguarding under COVID 19** In the early part of April and May 2020, the adult safeguarding team experienced a sharp reduction in the amount of referrals from care homes and the general public. This was reflected across the region. There was however an increase in requests for assistance and advice directly linked to COVID anxiety and concern, including referrals from carers under increasing amounts of stress due to respite services in lockdown. S126 enquiries under Adult Safeguarding processes continued however, enquiries, particularly where health were involved, were more time consuming. Strategy meetings convened using virtual facilities were well attended and it was noted that participation improved. Although Welsh Government have paused performance reporting for the recent period, the Safeguarding Unit have continued to meet all relevant targets and monitor their performance. Between 1st April and 30th September 2020, of the 291 referrals received since the pandemic commenced 282 have had their enquiries completed within 7 working days (97%) In mid-Summer it was noted that referrals were back on a par with those from last year and this pattern has continued.
1.05	**Child Protection and Children Looked After Under COVID 19** For child protection and Children Looked After, COVID did not substantially reduce the work coming through the front door. Numbers on the register were already high at the start of lockdown and continued to rise as referrals for those needing the highest protection continued to be sent into the Local Authority. The Safeguarding Unit quickly adapted their processes to meet statutory responsibilities whilst always being mindful to ensure children and families could engage with virtual processes safely. Independent Reviewing Officers were innovative in their communication with children and young people using virtual means to ensure their voice was heard.
1.06	**Positive learning from COVID 19** Whilst nobody would choose to work under such challenging circumstances as has been experienced over the past few months, the Safeguarding Unit never lost focus on protecting children, young people and adults at risk and ensuring our processes adapted and evolved in the continually changing work environment of the pandemic. The Safeguarding Unit have learned they are able to work in a dynamic way using technology to ensure statutory responsibilities are fulfilled. It is anticipated that the team will continue to work remotely for the immediate future however, it is hoped that at some point the team will be able to combine a more physical presence with a remote platform.

	Maintaining good performance under such unprecedented circumstances is a testament to the Safeguarding Unit's priority of ensuring the most vulnerable adults, children and families are safeguarded.
1.07	**New National Safeguarding Procedures** In November 2019, Wales become the first part of the UK to introduce a single set of safeguarding guidelines to help protect children and adults at risk, with the launch of the new Wales Safeguarding Procedures mobile app. Launched at the start of National Safeguarding Week, November 11th – 15th 2019, the Wales Safeguarding Procedures hoped to standardise safeguarding practice across Wales and between agencies and sectors. The procedures set out what to do if anyone working with children or adults suspect an individual is experiencing, or at risk of, abuse, neglect or other kinds of harm. Uniquely there are no printed copies of the procedures. Instead they are available to everyone online, either via the dedicated Wales Safeguarding Procedures website or a mobile app. This means that there will always be a single up-to-date version available to all practitioners. It will also make finding information quick and easy. 'Pointers for practice' are featured throughout both the web and app versions of the procedures and provide simple 'how to' guidance for practitioners. These draw on the latest research and practice developments. Both platforms feature a searchable glossary which makes it easier for people to work in partnership by ensuring that every practitioner is using the same terminology in the same way, irrespective of their sector or professional discipline. Training on the key changes in the procedures commenced in January across Wales with regional and local implementation expected from 1st April 2020. However, due to the pandemic, National implementation of the procedures was delayed until 1st September 2020. Flintshire fully adopted the procedures from this date. Many of the changes within the children's procedures are about practice. The procedures place an emphasis on aspects such as co- production, person centered approaches, advocacy, use of reflective practice and practitioner judgement. Importantly, there is a strong focus on the 'daily lived experience of the child and their carer' which forms an integral part of information gathering, assessments and recording. The procedures refer to the Social Worker "seeing the child", not just setting eyes on them. Safeguarding processes remain largely consistent to the previous All Wales Procedures with some key changes. The Regional Safeguarding Board has produced a 'quick guide' to the key changes for both adults and children and these can be found in the appendix. Flintshire produced a Practice Directive to ensure changes were understood locally.
1.08	**Deprivation of Liberty Safeguards (DOLS)** The Safeguarding Unit has two full-time Best Interest Assessors (BIAs) and a part time BIA who between them are responsible for undertaking Best Interest Assessments for individuals who meet criteria in accordance with

	the Mental Capacity Act Deprivation of Liberty Safeguards. The Safeguards apply to people in care homes and hospitals, and the local authority is responsible for assessing Flintshire residents in care homes. A person is deprived of their liberty if they: • Lack mental capacity to agree to live in the care home and • Are under continuous supervision and control and • Would be prevented from leaving the care home if they were to try to do so. Deprivations of Liberty in Flintshire care homes are assessed by a BIA and by a specialist doctor. Numbers of applications have increased year on year from 13 applications in 2013-2014 (before a significant new judgement, known as Cheshire West, widened the scope of DoLS) to the number of applications received in 2019/20 being 383. This includes only a week of the first lockdown in Wales. The number of referrals received means that careful prioritisation is need to ensure that those most in need receive assessments. The impact of the lockdown was felt in the subsequent months when access to people residing in care homes was restricted or in many cases, not allowed at all. All of the applications received in the period came from Care Homes. The majority of people were located in Flintshire homes, however a substantial amount of people were in placements outside the reporting authority, which made assessments more difficult to obtain after March 2020. Whilst travel was legitimate, access to people in Care Homes was limited. The data available shows that 30% of those applications received are in progress with 35% having been approved. Over 33% were withdrawn either due to people moving or sadly dying before the applications could be processed. The majority of Relevant Person's Representatives are paid representatives, with the other 45% being a family member, friend or carer. Throughout the period of Covid-19 restrictions, assessors have been working imaginatively to gather the best information they can about the person they are assessing. This has included, where appropriate, video calls, meeting people outside, telephone calls and even interviewing people through windows. In each case the assessors have based their approach on an individual assessment of the communication skills of the person, and on the safety requirements of the home. Keeping the person at the centre of the assessment has been a priority and the supervisory body gratefully acknowledges the support of the care homes and our assessors in making sure we have been able to continue to provide this person-centred response.
1.09	**New Liberty Protection Safeguards (LPS)** It has been recognised nationally that DoLS is "not fit for purpose", as the numbers of people deprived of their liberty exceed the resources available to manage the assessments required. In 2018 the UK Government published a Mental Capacity (Amendment) Bill which became law in April 2019 and was due to be implemented in October 2020. The Bill set out a new model, the Liberty Protection Safeguards, which will replace DoLS in

	England and Wales. The new implementation timescales will now take place in April 2022, with an implementation period of 6 months to follow.
1.10	The Liberty Protection Safeguards will: • Cover people of sixteen years and over (DoLS applied to people of eighteen and over) • Apply to people living in the community as well as to people in care homes and hospitals • Put more responsibility on the providers and commissioners of care to gather together the assessments required and to send them into the responsible body. • Expect the responsible body (which will in many cases be the local authority) either to authorise the deprivation of liberty or, if the person being assessed appears to be objecting to the placement, to arrange for a more in-depth assessment from an Approved Mental Capacity Professional. • Give people the right to appeal to the Court of Protection if they wish to appeal against the deprivation of their liberty. The LPS scheme applies to community settings, as well as to care homes and hospitals. It also applies to anyone from 16 years old and above, rather than 18 as is the case with DoLS. LPS will introduce a two-tier system of protection. This means that in most cases the 'responsible body' (the Local Authority for social care cases and the NHS for hospitals) would rely on a number of assessments to establish whether the planned care arrangements are 'necessary and proportionate' to meet the individual's needs. In most cases the responsible body will scrutinise the assessments and, if appropriate, authorise the deprivation of liberty. In complex cases an Approved Mental Capacity Practitioner will be appointed to carry out a more detailed assessment, which will include an interview with the person in question. The Safeguarding Unit continue to work to current DoLS guidance while preparing for the implementation of LPS.
1.11	**Adult Safeguarding and Adults at Risk** The Social Services and Wellbeing (Wales) Act 2014 (SSWBA) expects the Local Authority to undertake relevant enquiries and decide on next steps within 7 working days of receipt of an adult safeguarding report. Between 1st April 2019 and 31st March 2020, 602 adult safeguarding reports that met the threshold for enquiries under Section 126 were completed, with 95% of enquiries being completed within seven days. This reflected an increase in demand from 551 reports the previous year, when 95% of enquiries were completed within seven days. Over the six months from April 1st 2020 to 30th September 2020, 288 reports have been received at the Single Point of Access (SPOA), reflecting a reduction in reports during the early pandemic period. However, the referral rate has now recovered to near normal. Referrals are becoming more complex and financial abuse is an increasing trend within Adult Safeguarding. The number of Adult Safeguarding reports have continued to increase putting pressure on the

	team to screen initial referrals and undertake our duty to enquire. Year on year the number of safeguarding referrals has increased from 440 in 2016/17, 526 in 2017/18, 679 in 2018/19 and 736 2019/20.
1.12	The Adult Safeguarding Team have convened 201 strategy meetings between 1st April 2019 and 31st March 2020. The Adult Safeguarding Team undertake internal audits on a regular basis to identify areas for development and ensure consistency of approach. Flintshire employs an Adult Safeguarding Social Worker whose role is to enquire and investigate referrals as required and to work closely with families and individuals to keep them informed of the process, the actions being undertaken and the outcomes. As a result of this work we have noticed that very few individual or families ask to be involved with Case Conferences as they have already been a part of the process and fully engaged. The increase in staff for the Adult Safeguarding Unit will also allow us to ensure that all families and adults at risk are informed at each stage of the process. Our numbers for adult safeguarding conferences remain low. The team are continuing to promoting the use of advocates to allow those with no voice to be engaged in the process. The role of advocates is integral to a number of areas of work within safeguarding. Advocacy Services are used as Relevant Person's Representatives (RPRs) when undertaking DOLS assessments. When Adult Safeguarding reports are received, consideration is always given to the subject of the referral and whether they require independent advocacy services to ensure their needs are met and their voice is heard.
1.13	**Children's Safeguarding and the Child Protection Register** The purpose of the Child Protection Register (CPR) is to keep a confidential list of all children in Flintshire who have been identified as being at risk of significant harm in accordance with the categories of abuse within the All Wales Child Protection Procedures (AWCPP) 2008. The same categories are reflected in the new Wales Safeguarding Procedures. The Safeguarding Unit are responsible for maintaining the CPR, providing information to relevant partner agencies about children on the register and ensuring that Child Protection plans are formally reviewed in accordance with the Wales Safeguarding Procedures .
1.14	**Number on the Register** Numbers on the register fluctuate as cases progress through the system. If risk reduces, children may be removed from the register and supported through more informal means. If risk increases, cases can progress into court proceedings and children can be taken into care. The Safeguarding Unit have no control over the number of referrals into First Contact nor do they have influence over which cases come to conference. At the end of March 2019 there were **131 children** on the register, **111** of them Flintshire children.

	At the end of March 2020 there were 201 **children** on the register. By the end of September 2020 there were **209 Flintshire children** on the register, with 33 temporary registrations totalling 242 children. As of 23rd November there were **197** children on the register, comprising **176** Flintshire children, 21 temporary registrations. It should be noted that other areas in North Wales have experienced similar high levels of registered children. An internal audit was undertaken earlier in the year to determine whether there were any trends or reasons for the high numbers. Over the past 12 months we have had large number of multiple sibling families which has increased the overall total. The audit did not identify any concerns in practice. The numbers now are starting to decrease as children who have been registered for a period of time are supported in non-statutory ways.
1.15	**Categories of Risk** For the past two years the highest category has been emotional abuse as a single category with the next highest being Physical and Emotional abuse. This year the highest category currently is Neglect. Emotional Abuse unfortunately continues to be linked with high levels of reported Domestic Abuse, usually linked to alcohol and/or drug misuse.
1.16	**Length of time on the register** Children on the register are reviewed in line with AWCPP guidelines. Initially at 3 months and thereafter within 6 months. Children reaching their 3rd review are automatically reviewed under the County and Public Law Outline and are subject to a Legal Advice Meeting (LAM) to identify whether the case should be moving into court proceedings. Children's Safeguarding Managers regularly review cases that have been on the register for 12 months or more. The findings are reported to Senior Managers and discussed within Regional Safeguarding Delivery Groups. On 30 September 2020 14 young people from 9 families had been on the CPR for more than 12 months, the longest being 56 months There are processes in place with Children's Services Service Managers to ensure such cases are reviewed within Legal Advice Meetings and Senior Managers meetings to ensure there is no drift. All cases of re-registration within 12 months of de-registration are audited on behalf of the Safeguarding Board each year. During the period 01/04/2020 to 30/09/2020, there was one child registered to the Child Protection Register within 12 months of their previous.
1.17	**Number of Child Protection Case Conferences held** The breakdown for the number of case conferences held is given below. Up to 8 conferences a week are chaired and minuted by the Safeguarding Unit. Initial case conferences are convened within 15 working days of the strategy decision to come to conference and reviews are held as stated in above.

	From April 2019 to March 2020, 93.5% of initial child protection conferences and 99.3% of review conferences were carried out within statutory timescales. From 1st April 2020 to 30th September 2020 during the pandemic, 94.5% of initials and 99% of reviews were held in timescales, all using remote virtual facilities. Any conferences that have to go outside timescales are agreed with the Service Manager for Social Care and Safeguarding. In the interim, Children's Social Services ensure immediate safeguarding issues are managed with relevant partner agencies. 700 Child Protection Conferences were held between 1st April 2019 and 31 March 2020.
1.18	**Looked After Children** The number of Looked After Children has previously remained relatively steady but has been increasing both locally, regionally and nationally. At the end of September 2020 there were 285 children being looked after by the Local Authority, 81 with Flintshire Foster Carers and 120 living with their parents or with relatives under connected person arrangements. Three Special Guardianship Orders have been made so far this year. Between 1st April 2019 and 31st March 2020, 42 children started to be looked after. Between 1st April 2020 and 30th September 2020, 32 children started to be looked after, 23 have left care and there have been 39 placement moves. Children can leave care for a number of reasons, either going home to their families, becoming adopted or reaching 18 years of age where they no longer need to be reviewed under looked after procedures. Children can receive support and services up to the age of 19 from transition services. Young people can also be supported through Pathway Plans up until they are 24 years old should they need this input. There are 3 Independent Reviewing Officers (IROs), within the Safeguarding Unit who review Care Plans and ensure placements are appropriately supporting the children. Flintshire Children are in the main located with Flintshire Foster Carers or at home under Placement with Parents regulations. However, IROs do have cases as far as South Coast of England, North of England and Ireland and they are expected to travel to the placement address to hold their reviews. This has an evident impact on available resources. During the pandemic, travel has been restricted and the IROs have not been ravelling to placements addresses unless absolutely necessary. Contact with children, families and foster carers has been maintained using virtual platforms.
1.19	**Links to the Regional Safeguarding Board** The Strategic shared priorities of the Board are: (1) Exploitation (2) Domestic Abuse and (3) Improving Awareness and Compliance around the Adults at risk process in North Wales

	Exploitation ICF Funding was secured for a social worker and two support workers to expand the Adults at Risk team. The new posts are supporting Flintshire's Single Point of Access to identify appropriate support for adults at risk of abuse, including victims of exploitation and domestic abuse. Flintshire Safeguarding Unit have a regular presence at monthly VARM (Vulnerable and Risk Management) meetings to ensure individuals who may require support outside normal criteria are picked up. Flintshire also attend the relatively new Modern Slavery and Human Trafficking MARAC meeting. This is a police led regional meeting supported by various agencies and has links to the NRM unit. The forum seeks to ensure the right support is in place for those individuals at risk of exploitation in any form. **Domestic Abuse** There has been a steady increase in the numbers of adults at risk linked to incidences of Domestic Abuse over the last year. This was particularly noticeable following local restrictions put in place following the outbreak of the Covid pandemic. Flintshire Safeguarding Unit have a regular presence at the monthly MARAC meeting and have robust processes in place to ensure all referrals linked to any form of Domestic Abuse are actioned appropriately. The new support staff within the Unit will develop links to DASU and work with victims to access support through Women's Aid, Housing, benefits and other services where required. **Awareness** There are three levels of awareness raising training in Flintshire. A Corporate Safeguarding e-learning module was launched in September 2019 providing employees with basic awareness of safeguarding, and 179 staff from all departments of the Council participated and were asked to share their awareness with colleagues. There is also a day's general training in adult and children's safeguarding available for staff working in the care sector, and a half day advanced day in using the procedures provided by the adult safeguarding manager Another role of the Safeguarding Unit is to ensure partner agencies and social work colleagues are fully aware of safeguarding processes so that they can fulfil their duties under the Social Services and Well-Being Act. This is a priority of the Corporate Safeguarding Panel and also the Regional Safeguarding Board. A number of training sessions have taken place over the last year to ensure the message about Adult and Children's Safeguarding is delivered effectively and consistently with training moving to a virtual platform due to the pandemic.
1.20	**Learning from Child Practice Review (CPR), Adult Practice Reviews (APR) and Domestic Homicide Reviews (DHR)** In accordance with the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 (which came into force 6 April 2016), Safeguarding Boards have a statutory responsibility to undertake multi-agency practice reviews in circumstances of a significant incident where abuse or neglect of an adult at risk is known or suspected and the adult or child has died, sustained potentially life threatening injury or serious and permanent impairment of health or development.

	Practice guidance for completing practice reviews has been issued under section 145 Social Services and Well-Being (Wales) Act 2014. The purpose of practice reviews is to learn lessons, to inform and improve practice. The outcome of a review is intended to generate professional and organisational learning and promote improvement in future inter agency protection guidance. Practice reviews do not seek to apportion blame. There are two types of review: • Concise Practice Reviews – when the person was not referred to services for protection within 6 months of the incident or death • Extended Practice Reviews – when the person was referred to services in the 6 months prior to the incident or death If the criteria for the above is not met, a decision can be made to hold a Multi-Agency Professional Forum (MAPF) which is a learning event that sits outside the Regional Safeguarding Board APR/CPR review sub group. MAPF utilise case information, findings from audits, inspections and reviews to develop and disseminate learning to improve local knowledge and practice and also inform the Safeguarding Board's future audit and training priorities. Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. Community Safety Partnerships are required to undertake them. The Community Safety Partnership then monitors the action plan. The purpose of a DHR is to examine the circumstances that led to a reported death and review the contact that organisations had with the victim and offender also identifying lessons to be learnt.
1.21	**Flintshire APRs, CPRs and DHRs** When cases come to the attention of safeguarding, consideration is always given to whether a case should be recommended for APR or MAPF. This consideration is also part of the safeguarding audit tool. Adult Locality teams can also refer cases to the APR subgroup as can any agency. Consideration for a CPR is usually determined within a PRUDIC (Procedural Response for Unexplained Death in Children) meeting however, again any agency can refer to the CPR subgroup. Currently in Flintshire there is work on a CPR ongoing which is due for publication soon. The process has been delayed by the pandemic. There is a report due for an APR and also there is a DHR in progress. The CPR is about the Flintshire mother who was convicted of the manslaughter, by drowning, of her baby daughter in July 2015. She was just over 1 year old and was a twin. A CPR was commenced initially, however, was put on hold until the criminal proceedings were complete. The report is due for ratification by the Regional Board hopefully this year. The APR is about an adult without capacity who was resident in a local care home. Some of the issues were linked to professionals having problems

	dealing with his challenging behaviour, questions about whether he was in the correct support placement and subsequent questions about care received when transferred to hospital following a fall. The investigation has been completed and the report is due ratification by the Regional Board this year. Following the death of woman in Flintshire in October 2018 a DHR was commissioned by the Flintshire Community Safety Partnership. The review is still on-going and FCC are fully committed to supporting the requirements of the DHR, and provide information as and when required. The review is in its final stages. This was the case of Theresa Garner, killed in a Domestic Homicide (October 2018) by her husband John Garner. He was later convicted in May 2019 of her murder. The North Wales Region has been adhering to the SSWBA by actively considering cases that would fit the criteria for APR/CPR. This means that North Wales has the correct number of active cases, particularly with APRs. This has a resource impact on all agencies and there has been an issue with delays in commencing reviews due to scarcity of trained reviewers, however, the Board has addressed this issue through recent training.
1.22	**Learning from CPRs and APRs** • When relevant CPRs are published nationally, Practice Directives are drafted by Flintshire's Children's Services Team Managers with summaries of the key issues and these are shared with all teams • The Regional Safeguarding Board send out weekly bulletins highlighting published CPRs and APRs regionally • Learning events are held following CPRs and APRs where practitioners meet to discuss key themes and lessons from the investigations. • Action Plans emanating from CPRs and APRs are monitored locally and regionally through the Safeguarding Board and through the Flintshire & Wrexham Children's Delivery Group and the Flintshire & Wrexham Adult Delivery Group, subgroups of the Children's and Adults Regional Boards • Specific recommendations from other Local Authority CPRs/APRs can come from other agencies for action within Social Services. All CPR and APR Final Reports are published on the Welsh Government website and North Wales APR and CPR Reports are also published on the North Wales Safeguarding Board website. Social Services managers and staff are acutely aware that the key messages from National, Regional and Local APRs/CPRs are usually about lack of information sharing and poor communication between partner agencies. Flintshire Social Services are well informed about current themes and trends in outcomes of APRS/CPRs. Case file audits, supervision, legal advice meetings, multi-agency case management meetings, learning and training workshops, access to online research and case discussion are all tools to ensure outcomes from APRs/CPRs are at the forefront of the work that is undertaken in Flintshire to safeguard children, adults and families.

2.00	RESOURCE IMPLICATIONS
2.01	There are no resource implication arising from this report.

3.00	CONSULTATIONS REQUIRED/CARRIED OUT
3.01	N/A

5.00	APPENDICES
5.01	None

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	**Wales National Safeguarding Procedures** http://www.safeguarding.wales/ http://www.diogelu.cymru/ **Wales National Safeguarding Procedures FAQs** https://www.northwalessafeguardingboard.wales/wp-content/uploads/2019/11/Wales-Safeguarding-Procedures-Frequently-Asked-Questions.pdf https://www.bwrdddiogelugogleddcymru.cymru/wp-content/uploads/2019/11/Cwestiynau-Cyffredin-am-Weithdrefnau-Diogelu-Cymru.pdf **Wales National Safeguarding Procedures What has changed Adults** https://www.northwalessafeguardingboard.wales/wp-content/uploads/2020/06/Whats-Changed-Adults-Eng.pdf https://www.bwrdddiogelugogleddcymru.cymru/wp-content/uploads/2020/06/Beth-syn-Wahanol-Diogelu-Oedolion.pdf **Wales National Safeguarding Procedures What has changed Adults** https://www.northwalessafeguardingboard.wales/wp-content/uploads/2020/06/Whats-Changed-Children-Eng.pdf https://www.bwrdddiogelugogleddcymru.cymru/wp-content/uploads/2020/06/Beth-syn-Wahanol-Diogelu-Plant.pdf

7.00	CONTACT OFFICER DETAILS
7.01	**Contact Officer:** Jayne Belton, Safeguarding Unit Service Manager **Telephone:** 01352 702600 **E-mail:** Jayne.Belton@flintshire.gov.uk

8.00	GLOSSARY OF TERMS
	(1) Looked After Child: Looked after children are children and young people who are in public care and looked after by the state. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care. The term is also used to describe 'accommodated' children and young people who are looked after on a voluntary basis at the request of, or by agreement with, their parents. (2) Section 47 Investigation Where information gathered during a Referral or an Assessment results in the social worker suspecting that the child is suffering or likely to suffer Significant Harm, a Strategy Discussion Meeting should be held to decide whether to initiate enquiries under Section 47 of the Children Act 1989. Strategy Discussions/Meetings should be held as soon as possible, bearing in mind the needs of the child. A Section 47 Enquiry will decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm. (3) Section 126 Enquiry Section 126 (2) of the SSWBA sets out that 'if a local authority has reasonable cause to suspect that a person within its area (whether or not ordinarily resident there) is an adult at risk, it must; a) Make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken (whether under the Act or otherwise) and if so, what, and by whom; and b) Decide whether any such action should be taken.' (4) Liberty Protection Safeguards: The Liberty Protection Safeguards will replace DoLS and is due to be implemented in October 2020. LPS will: • Cover people of sixteen years and over (DoLS applied to people of eighteen and over) • Apply to people living in the community as well as to people in care homes and hospitals • Put more responsibility on the providers and commissioners of care to gather together the assessments required and to send them into the responsible body. • Expect the responsible body (which will in many cases be the local authority) either to authorise the deprivation of liberty or, if the person being assessed appears to be objecting to the placement, to arrange for a more in-depth assessment from an Approved Mental Capacity Professional.

	• Give people the right to appeal to the Court of Protection if they wish to appeal against the deprivation of their liberty.

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SOCIAL AND HEALTH CARE OVERVIEW AND SCRUTINY COMMITTEE

Date of Meeting	Thursday, 3 December 2020
Report Subject	Community Transformation Project Update
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer (Social Services)
Type of Report	Operational

EXECUTIVE SUMMARY

As one of four national Transformation Programmes funded in 20/21 by the Welsh Government (WG), the Community Services Transformation Programme (CSTP) is focussed on the delivery of new ways of working which will improve the experience and outcomes of people who receive both health and social care services in the community.

The majority of work undertaken to date and planned in the short term is focussed on people aged 65+.

The CTSP Programme is managed and delivered on an Area basis. The East Area Programme focusses on Flintshire and Wrexham. This report refers to East Area developments with a more detailed focus on the impact from a Flintshire perspective.

The CSTP is funded until March 2021, with work taking place to secure funds from WG for further work to be undertaken until March 2022.

The impact of the Global Covid-19 Pandemic has been significant on in year developments, with both workforce and financial resources being diverted to respond to the initial emergency response phase and requirements.

As this update demonstrates, work has since been restarted on a number of key developments, bringing health and social care providers together to agree new ways of working, most notably:

- The potential for development of a Trusted Assessor Role to support safe discharges from acute and community hospitals into the new Marleyfield House Short Term Service.

- The development of combined health and social care support packages for residents within short term care beds

- The introduction of a new Emergency Dementia Respite Support Worker Service to test the impact and inform future planning

- Planning for the introduction of new Multidisciplinary Teams working in each of the 3 Health and Social Care localities in Flintshire to improve the way that professionals work together to meet the needs of individuals with more complex needs in the community.

The impact of the anticipated significant reduction in funding available from April 2021 is being considered at the time of writing this report.

The incremental approach to planning and implementation of developments along with use of existing resources in a different way to date has minimised any risks to the council from a financial or workforce perspective.

RECOMMENDATIONS	
1	The Committee supports and is assured that the keys areas being developed as part of the of Transformation programme are appropriate and will support local needs in Flintshire.
2	The Committee acknowledges that the impact of the CSTP will be affected by a reduced level of funding for 2021/22 and that the detail to prioritise activity in 2021/22 is ongoing at the time of writing this report.

REPORT DETAILS

1.00	**EXPLAINING THE BACKGROUND AND CONTEXT OF THE COMMUNITY SERVICES TRANSFORMATION PROGRAMME**
1.01	The Community Services Transformation Programme (CSTP) is one of four Transformation Programmes funded by Welsh Government (WG) providing funding and impetus for delivery against the national WG plan for health and social care, "A Healthier Wales".
1.02	Within "A Healthier Wales", the Welsh Government has stated what it wants health and social care to be like in the future. These statements are listed below and resonate with the policy and operational imperatives that drive the way that we work with local partners for example in response to the Social Services and Wellbeing Act (Wales) 2014. (ii) We want services which support people to stay well, not just treat them when they become ill. (iii) When people need help, health and social care services will work with them and their loved ones to find out what is best for them and agree how to make those things happen. (iv) More services will be provided outside of hospitals, closer to home, or at home, and people will only go into hospital for treatment that cannot be provided safely anywhere else. This 'community-based approach' will help take pressure off our hospitals, reduce the time people have to wait to be treated, and the time they spend in hospital when they have to go there. (v) Our health and social care services will use the latest technology and medicines to help people get better, or to live the best life possible if they are not able to get better.
1.03	The CSTP in North Wales is primarily focused on the development of integrated community based health and social care services and support for adults aged 65+.
1.04	At a North Wales level, the aims of the CSTP are designed to ensure we all work towards the commitments made to WG within the regional bid for funding as illustrated in Appendix 5.01.
1.05	A key intent referenced within that regional bid for funding was to develop more ways for organisations and teams to work within combined Health and Social Care Localities based around the geographies of the Primary Care Clusters, of which there are 3 in Flintshire.
1.06	The CSTP is currently funded until March 2021, with the total allocation of funds available for use in Flintshire in 2019-2021 being £821,732. At the time of writing, work is ongoing to confirm funding into the CSTP for the next financial year although it is anticipated that it will be at a significantly reduced level.

1.07	All Transformation Programmes are overseen by the North Wales Regional Partnership Board which is accountable to WG for delivery. The East Area Strategic Transformation (EAST) Group comprised of Chief and Senior Officers from across Health and Social Care in Flintshire and Wrexham are responsible for the setting and performance management of the CSTP delivery within Flintshire and Wrexham.
1.08	The East Area Programme is supported by a full-time Programme Manager, hosted by Flintshire CC who works across the East, one full-time Project Manager for Flintshire (currently vacant from end of October 2020) and one for Wrexham. Initial recruitment into the full Programme Management Team was completed in December 2019.
1.10	Until early March 2020, work had been focusing on early planning for the implementation of a Dementia Respite Service, described in paragraphs 1.23 – 1.26, researching models of integrated care and support, development of locality level health and wellbeing profiles and early discussions relating to the service model for Marleyfield House.
1.11	Since March 2020, the impact of the Global Covid-19 Pandemic has been significant on the Programme. The need to focus initially on an emergency response and then on recovery from the first wave of cases whilst preparing for an anticipated second wave, has diverted workforce and financial capacity away from the initial Programme.
1.12	The Programme Management team were deployed into response driven activity and in Flintshire, the primary focus for the team was to : Open a new independent sector care home in Shotton (The Oaks) to provide for the anticipated surge in demand for support within community. The Oaks Residential Care Home opened on 3rd April providing up to an additional 26 short stay beds for residents coming out of hospital who were medically fit but needed some additional support or assessment. Open a second care home within Flintshire to occupy the vacant premises on the site of a former care home in Holywell. Tŷ Treffynnon Residential Care Home opened on 29th May, providing beds to support up to 18 residents. The Home is run directly by Flintshire County Council and remains open as at November 2020. Undertake preparatory work for how Social Services could work in partnership with Flintshire Local Voluntary Council to ensure that community volunteers could support the emergency response. Undertake early work to support the development of a plan for Social Services relating to how it would recover from the impact of the Pandemic on service delivery.
1.13	The Programme Team were stood down from Covid-19 response focused activity in June 2020. Discussions at an EAST Group level then took place to “reset” the programme in a way that was fully cognisant of the ongoing impact of the Pandemic as well as being based on some valuable learning that had come from the emergency response.

	The refreshed model for Community Based Health and Social Care that has been developed through the CSTP is illustrated in Appendix 5.02, with priority areas of work for the CSTP for the remainder of 2020/21 being as follows: • To develop the model for integrated care and support for short term residents within Marleyfield House Care Home when it opens its expanded service and provision in Spring 2021. • To propose how a new way of working to support safe discharge from hospital through use of a "Trusted Assessor" could be part of the new Marleyfield House model • To develop an agreed model for Multidisciplinary Team (MDT) working in Localities to support any future funding decisions. • To introduce a new emergency overnight Dementia Respite Support Worker Service to test whether this approach could support carers and prevent the escalation of needs necessitating a hospital admission. A summary of each of this work follows in the paragraphs below.
1.14	**Integrated Care and Support for Marleyfield House** When the newly expanded Marleyfield House opens in late Spring 2021, it will provide a minimum of 16 beds for short term use by Flintshire residents coming out of a community or acute hospital (step down) or to avoid admission (step up).
1.15	The primary purpose of admitting residents into these short term beds will be to help them to regain the skills, confidence and some physical conditioning to help them return to their own home. In addition, this environment is recognized as being one which is more conducive than a hospital environment to make decisions about the longer term needs of those residents; this approach often being referred to as a "Discharge to Assess" model.
1.16	An integrated model of care and support is being developed through the CSTP which means that professionals from across health and social care will actively work with those individuals whilst they are in the short term beds to maximize their independence and reduce demand for unplanned care such as an emergency admission to hospital.
1.17	**Trusted Assessor Role** The role of a defined Trusted Assessor for the purpose of ensuring safe and appropriate discharge from hospital into care homes is new in North Wales, although it has an evidence base for being effective in other parts of the UK.

1.18	Once a Social Worker has identified that a patient requires support in a care home setting on discharge, a Trusted Assessor (TA), with the consent of a Care Home Manager, considers the needs of the individual and makes a recommendation as to whether admission to a home (or one of a number of homes when the model is fully operational) would be appropriate.
1.19	Within this model, the statutory duty of the Care Home Manager to make a final decision on the appropriateness of an admission remains paramount. There is however a real advantage to the Care Home Manager in being able to rely on a "trusted" individual to be able to recommend an admission for their consideration.
1.20	The model prevents the need for the Care Home Manager to undertake a full, often onsite assessment themselves for every potential admission, which is demanding for the Manager and a contributing factor to a number of delayed discharges from hospital.
1.21	**Development of Locality Level Multi-Disciplinary Teams (MDT)** Work is ongoing to identify the potential benefit, resource requirements and proposed model for a dedicated MDT within each Locality consisting of representatives from Health and Social Care that can meet regularly to discuss the needs of the most complex residents and agree joint plans for improving the management of their care and support needs.
1.22	With a focus on the prevention of unscheduled care or escalating needs, the MDT approach will aim to improve direct communication links between professionals, reduce any barriers that can exist between organisations and provide practical solutions for which every member of the MDT takes responsibility for delivering.
1.23	**Dementia Respite Support Service** Carers of people living with Dementia have told us that they do not always want the person that they care for to go into bed based respite care. We also recognise that one impact of the current Pandemic is that this is not an option in most cases.
1.24	Carers have also told us that it is the inability to rest in the evening and to get a good night's sleep that they desperately need in order to continue to fulfil their caring role in addition to maintaining a maximum level of wellbeing for themselves.
1.25	The new service means that a Dementia Respite Support Worker (DRSW) will be able to spend the evening and overnight in an individual's own home when their needs are escalating. They will provide all the practical support necessary during the night providing the opportunity for the carer to rest for up to 2 consecutive nights.
1.26	The service will only be available to a limited number of people as part of a pilot phase and therefore only those assessed as being in the most urgent need can be supported. It is also not a solution that will be available or suitable in all cases. It is however anticipated that it will provide some

	welcome respite for those who do access the service. Evaluation of the impact will be necessary in order to inform longer term planning.

2.00	**RESOURCE IMPLICATIONS**
2.01	**Revenue:** All the work to date within the CSTP has been resourced by external grant funding, with no direct impact therefore on council revenue or capital funds.
2.02	CSTP funding in 20/21 has been diverted with the agreement of WG to fund some of the system wide requirements resulting from the Pandemic, namely care home bed capacity increases and additional capacity within the Health Board's Home First Team.
2.03	The Programme Manager and Project Manager are fully funded by the CSTP Fund
2.04	The Dementia Respite Support Workers are being funded via the Integrated Care Fund until March 2022 subject to ongoing evaluation of impact.
2.05	No decisions have been made that would result in any revenue pressure from April 2021. The allocation of funds into the programme from April is not known at the time of writing this report, however scenario planning is ensuring that no revenue commitments for the council are included where any revenue requirements cannot already be met from existing resources if necessary.
2.06	**Capital:** there are no implications for the approved capital programme for either the current financial year or for future financial years
2.07	**Human Resources:** None currently identified other than as described in paragraphs 2.03 -2.05 above.

3.00	**IMPACT ASSESSMENT AND RISK MANAGEMENT**
3.01	Sustainability is a key risk where external funds are used to fund posts or new service developments. Exit planning for each development will be undertaken should any work be initiated in 2021/22. Existing work within the council relating to the CSTP have exit points and/or sustainability plans either established or currently being finalised for the end of March should funding not be continued next year.

3.02	The appointment of a Programme Manager and Project Manager posts in Flintshire represents no risk to the council. The appointments have been achieved through secondment from other internal roles. The establishment number has not therefore been impacted and when funding ends, all post holders affected can return to substantive roles.
3.03	The appointment of Dementia Respite Support Workers represents minimal risk to the council. In the event that external funding is not available beyond March 2022, the post holders will be transferred into the Home Care Service where there are ongoing recruitment needs.
3.04	The CSTP is directed primarily at meeting the needs of adults aged over 65, with a significant focus being placed on those with the most complex needs.

4.00	**CONSULTATIONS REQUIRED/CARRIED OUT**
4.01	No consultations undertaken or currently required outside of the partnership arrangements already in place for the Programme.

5.00	**APPENDICES**
5.01	North Wales bid on a page
5.02	East Area Community Model

6.00	**LIST OF ACCESSIBLE BACKGROUND DOCUMENTS**
6.01	A Healthier Wales. Welsh Government, 2019. https://gov.wales/healthier-wales-long-term-plan-health-and-social-care Transformation Fund Website, Welsh Government. https://gov.wales/health-and-social-services-transformation-fund-projects Transformation Programme Website, North Wales Collaborative https://www.northwalescollaborative.wales/transformation-programme/ Social Services and Wellbeing Act (Wales), 2014. https://www.flintshire.gov.uk/en/Resident/Social-Services/Social-Services-and-Well-being-Wales-Act-2014.aspx

7.00	CONTACT OFFICER DETAILS	
7.01	**Contact Officer:** **Telephone:** **E-mail:**	Karen Chambers, Community Services Transformation Programme Manager. 01352 702536 (main office line) Karen.Chambers@flintshire.gov.uk

8.00	GLOSSARY OF TERMS
8.01	A Healthier Wales, 2019 The national plan for Health and Social Care in Wales
8.02	Social Services and Wellbeing Act (Wales), 2014 The new Act which is a national driver for our service delivery and service commissioning shaping
8.03	Health and Social Care Localities A way of ensuring that health and social care providers work together to plan and deliver care to residents in geographical areas typically of 50,000-80,000 people. The intent is that a focus on local needs will help ensure systems and services are best able to meet those needs.
8.04	North Wales Regional Partnership Board The Board was established to meet the requirements of Part 9 of the Social Services and Well-being (Wales) Act 2014 to oversee Partnerships and Integration of Services. The North Wales Regional Partnership Board was established in April 2016 and met in shadow form until the Board became fully operational in September 2016. Flintshire is represented by the Cabinet Member for Social Services and the Chief Officer for Social Services
8.05	Locality Level Health and Wellbeing Profiles Information about the health and wellbeing status of a local population and factors which may impact on people's ability to maintain good health and wellbeing.

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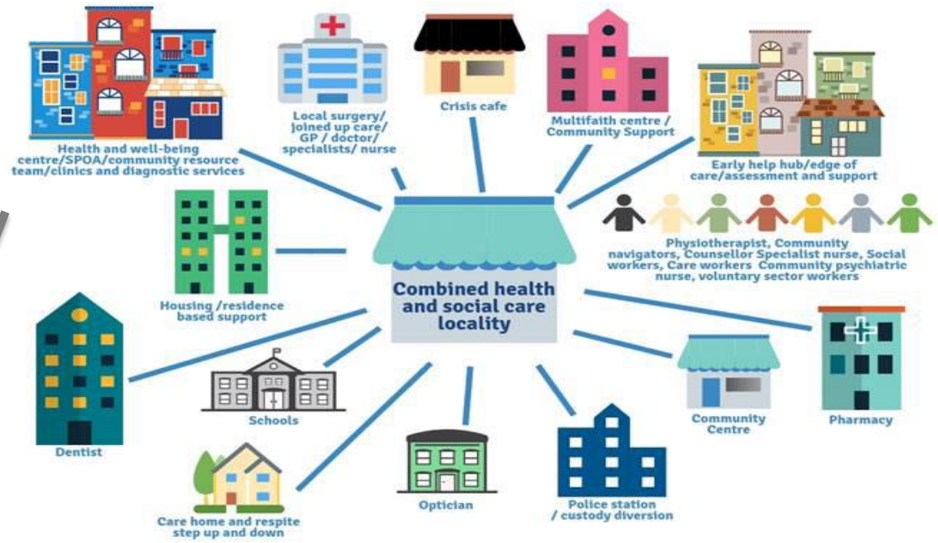
North Wales Community Services Transformation Bid on a Page

These elements are to be brought together to develop combined health and social care localities based on the geographies of Primary Care Clusters

Local population needs assessments identify local needs

Scale up services that are achieving good outcomes

Reviewing and developing CRTs – away from a team to a service response



- Establish a fully integrated cluster model with dedicated management board, staff and pooled budget arrangements
- Develop learning from the Frome compassionate communities model within our localities
- Develop collaboration with CotE clinicians so that older people in the community are supported appropriately in their homes

To support this work, proposals submitted to develop 3 specific priority areas

Outcomes

Navigation:

- Linking people to the right community support
- Provision of information, advice and assistance
- Linking into local area co-ordination models
- Enable self-management, reducing need over time for service and hospital intervention
- Roll out of DEWIS Cymru
- Individuals are involved and independent

Co-ordination:

- Seamless co-ordination of care between partners
- Care co-ordinator development
- Single documentation and integrated assessment
- Outcome focussed 'what matters' conversations

Managed Care and Support:

- Ready access to care provision
- Agreed governance for allocation of resources
- Commissioned step up/ down beds
- Ease of transfer of care from hospital
- Ethos of 'own bed instead', 'care closer to home'

Crisis Response:

- Comprehensive services through alignment and extension of hours supported, including overnight access to rapid care
- Effective co-ordination with other agencies outside of the CRT's

1 Workforce

Development of a sustainable workforce model to meet the community transformation agenda, to include work around:

- Skills development across the whole health and social care community system, exploring skill mixes and the new roles required to deliver on this model
- Joint training frameworks and carer structure/ progression opportunities
- Joint workforce planning, asset mapping, recruitment and promotional activity
- extend working hours
- explore opportunities for further roles hosted by the third and independent sectors
- programme of culture change and risk management
- Build links with FE colleagues and Universities
- Use of community development roles

2 Digital

Technology is recognised as a critical enabler of both good communication and information sharing across the whole health and social care sector.

Requirement to promote bilingual solutions.

Need to increase the pace of work to create a comprehensive standard corpus of terminology to support technology.

As a region we need to increase our use of telecare, telehealth, apps and other digital solutions to enable people to remain at home as well as ensure specialist advice can be provided without the need for a visit to an acute hospital site.

Proposal to establish dedicated capacity to work alongside the integrated locality development programme to support identification of a model of digitally enabled care, support and well-being.

3 Developing Community Networks

A key element of our integrated service model is the contribution of the third sector in supporting well-being services, promoting inclusion and participation and co-ordinating social prescription.

We will develop establish a Community of Practice for social prescribing, that will link to the All wales Social Prescribing Research Network, and the educational programmes being developed by Wrexham Glyndwr University.

Each cluster to develop its own approach based on community assets. Current service development need to be scaled up and linked into the integrated approach we are developing.

Establish a flexible fund to support the further development of community-based assets as required in cluster areas, to develop the range of activities available for people, linking in social prescribing as required.

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Our Model for Community Based Health and Social Care

- Citizen focussed , based around achieving “What Matters” to them
- GP Practices working as part of mature Clusters to meet need and build resilience
- Building and relying on a strong and resilient communities
- Workforce models which support local need
- Estates and use of digital technology supports integration and improved co-ordination
- Care sector is sustainable and able to be flexible to meet demand
- 7 day extended hours model of integrated care
- Focus on prudent use of resources across the health and social care economy

HOSPITAL IN-REACH

Proactive work to pull people out of hospital and back into the community.

Focus on Discharge to Assess principles and “Home First” approach.

- Home First Bureau and CRT (Step Down)
- Hospital Social Workers
- Step Down Services
- Trusted Assessor for formal care arrangements
- CHC
- Primary Care
- Community Mental Health
- Care Providers

LONG TERM MANAGEMENT AND SUPPORT OF INDIVIDUALS IN THE COMMUNITY

Integrated support and care to individuals at home. Increased focus on the use of shared approaches to the use of data and systems to facilitate joint working. Focus on promotion of independence and carer support.

- Locality Social Workers
- Therapies
- CRT (Step Up)
- Primary Care
- Third Sector, Social Prescribing and Community Agents
- Community Mental Health
- Emergency Duty
- Care Providers

NAVIGATION & CO-ORDINATION

County level access and referral points into Adult Social Services and the step up CRT

- Adult Social Services
- CRT
- Social Prescribing

LOCALITY LED MDT WORKING

MDT for care planning and delivery led by locality based team members. Rapid triage Into MDT after referrals made into County level SPOA. Focus on frailty/ complex needs to avoid escalation and/or admission to hospital/long term care

- Primary Care
- Community Nursing (DNs)
- COTE
- Mental Health
- Locality Social Workers
- Third Sector, Social Prescribers, Community Agents
- Consultant access
- Medicines Mgt/Pharmacy

ANTICIPATORY CARE PLANNING / PREVENTION

Preventative activity at population level based on intelligence driven planning and risk stratification. Focus on management of care needs for an individual through a co-ordinated approach to care planning with engagement of the patient and family.

- Care Providers - GPs and Out of Hours
- Meds Mgt/Pharmacies - Social Prescribers
- Social Workers - Community Agents
- District Nursing
- Therapies
- Third Sector
- Mental Health

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SOCIAL AND HEALTH CARE OVERVIEW AND SCRUTINY COMMITTEE

Date of Meeting	Thursday 3 December, 2020
Report Subject	Supporting the Social Work Workforce
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer (Social Services)
Type of Report	Operational

EXECUTIVE SUMMARY

The sudden onset of the coronavirus global pandemic has impacted on how the education and training of social worker students this academic year and those social workers in their first year in practice has been managed. As part of the social work degree, students are expected to undertake and pass at least 200 days of assessed practice learning. This is a requirement of Social Care Wales who are the regulators of social work training.

Unfortunately, this year many final practice learning opportunity placements were ended before the full number of days were completed to ensure both the safety and wellbeing of students and those individuals receiving our services. This has meant that students have had to evidence how they have met the requirements of the degree in different ways than would normally be expected. It is recognised that although they have still had to meet the required standards set down in the framework above, they will not have had the same opportunities to put theory into practice through work placements.

This report provides an overview of the additional work being undertaken to support the Council's newly qualified social workers, whose programme of study has been disrupted by COVID-19.

The report also provides details of the programme of learning and development created to further support social workers from their first year in practice through to experienced practitioner. This programme follows The First Three Years in Practice Guidance document developed by Social Care Wales and Care Inspectorate Wales to support with social workers' development after qualifying.

A link to the framework for the Social Work degree in Wales and Supplementary Guidance to the Rules which accompany it, is provided in the list of Accessible Background Documents (section 6.0).

RECOMMENDATIONS	
1	Members are informed of the impact of the COVID pandemic on social work learning and development.
2	Members note the Council's work supporting the current newly qualified social workers.
3	Members are informed of our proposal for the development of First Year in Practice Social Workers through to Experienced Practitioners.

REPORT DETAILS

1.00	EXPLAINING THE IMPACT OF THE COVID PANDEMIC ON SOCIAL WORKER PRACTICE
1.01	**Newly Qualified Social Workers**
1.02	The majority of social workers employed by Flintshire County Council achieve their BA (Hons) Social Work degree through Glyndŵr University in Wrexham. To complete the degree, students will have undertaken 3 work placements (known as Practice Learning Opportunities) arranged and hosted by the three local authorities affiliated to the university (Flintshire, Wrexham and Denbighshire). We do also have students undertaking their degrees via the Open University but these students are fewer in number.
1.03	The Practice Learning Opportunities amount to 200 days over the 3 years of the degree and are a substantial part of the student's programme of learning, equating to half of the required learning hours .Each year the placement days at the learning opportunity increases so that in the final year 100 days are completed on placement, (year 1: 20 days, year 2: 80 days and year 3: 100 days).
1.04	Similarly, the degree with the Open University has a practice learning opportunity each year, (year 1: 20 days, year 2: 90 days and year 3: 90 days).
1.05	The COVID-19 pandemic restrictions this year meant that in particular third year Practice Learning Opportunities for social work students were interrupted.
1.06	Universities across the UK took differing approaches to supporting final 3rd year students towards tackling the impact of the COVID-19 pandemic on their placements.
1.07	Glyndŵr University assessed all students on their 3rd year placement using course work and observations by appropriate staff. This evidence was measured against the National Occupational Standards (NOS) to ascertain if they met the requirements. Those students with insufficient evidence were then asked to provide further reflective case study examples around work that they had undertaken. If the case studies were still deemed as insufficient evidence towards the NOS then the students

	have been asked to complete a final Practice Learning Opportunity. The Practice Learning Opportunities have recently commenced.
1.08	The Open University took a different approach and after briefly suspending the Practice Learning Opportunities, the university then recommenced the completion of virtual work to complete the course.
1.09	A fundamental part of the social worker role is the personal element, meeting with individuals face-to-face, promoting positive communications and building positive relationships. The idea of 'virtual' or 'remote' practice, for some practitioners is perplexing and thought-provoking. Newly qualified social workers who would have delivered face to face services during their 1st and 2nd year placements, have had to adapt in order to provide these services virtually, since starting work as new Social Workers.
1.10	To assist these new staff as they work from home, managers and supervisors are supporting individuals with the technical aspects of home working and the increased confidentiality requirements.
1.11	As a newly qualified social worker the support offered by the team is invaluable. In these different times these social workers are being helped to keep in touch with team members through weekly virtual meetings, the setting up 'buddy systems' where workers have colleagues that they can ring or message to discuss queries, team chat facilities using WhatsApp, messenger groups, and mentors to work alongside new members of the team.
1.12	Isolation can be difficult and stressful and all our workers have access to mental health and wellbeing support through Occupation Health as well as the mental wellbeing programme commissioned by Flintshire Social Services, Mindline and the national Social Care Wales COVID-19 Health & Social Care Wellbeing Resources are available to staff.
1.13	To embed practices and support with the practical work, all newly qualified social workers have been out shadowing with their supervisors to give an opportunity for them to engage in wider discussion, increase their confidence and identify learning. Supervisors have also made arrangements for virtual visits with other teams and agencies to get to know them and their work.
1.14	Finally, to support professional development, the Service Managers have worked with Community Care Inform to launch a dedicated Flintshire County Council pages specifically for the use of the authority's social workers. The pages brings together relevant case law, legislation and practice as well as access to Flintshire staffing structures, help individuals identify key staff in their services areas and provide contact details.
1.15	**Developing our Social Workers**
1.16	The recruitment of experienced social workers remains a challenge and the Council has taken steps to develop our own social workers by putting in place a programme of development to support newly qualified social workers to become experienced practitioners.
1.17	The Council has an opportunity to get to know the students during their Practice Learning Opportunities in both years 2 and 3 of their Social Work

	degrees. Offering these individuals work opportunities means that the students come to us already familiar with the authority's processes, procedures and culture.
1.18	During the first year in practice, the newly qualified social worker's learning needs, as identified in their final year as a student, are carried forward into their First Year in Practice. Newly qualified social workers meet with their managers and a member of the Workforce Development Team to review these development needs and build a programme of induction around them. Newly qualified social workers are expected to bring their portfolio to the workplace and share with their team manager, as this is where the learning and development recommendations are found. This plan is then reviewed as recommended in the framework at 6 months and then 12 months
1.19	To support social workers in their First Year in Practice, peer group sessions have been organised and commenced in September 2020, giving opportunity to share experiences, share good practice, and reflect on their first working experiences. These were originally planned to be available quarterly but due to the impact of the COVID-19 pandemic, group sessions are now be offered monthly.
1.20	Training that is usually completed in face to face has been transferred online with the majority of the courses now being provided via Webex or Zoom.
1.21	The First Year in Practice personal development and learning plan allows practioners to demonstrate their progression and evidence their readiness to progress onto the Consolidation Programme.
1.22	The Consolidation Programme is a course of study which has to be completed before a newly qualified social worker can re-register after their 3rd year in practice.

2.00	**RESOURCE IMPLICATIONS**
2.01	For newly qualified social workers there will be an increase of mentors required resulting in more staff time necessary to support the new workforce. Additional IT equipment will also be required.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	N/A

4.00	**RISK MANAGEMENT**
4.01	N/A

5.00	APPENDICES
5.01	Appendix 1 – Executive Summary COVID Survey Appendix 2 – COVID-19 Workforce Survey

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	The framework for the Social Work degree in Wales and Supplementary Guidance to the Rules which accompany it. https://socialcare.wales/learning-and-development/regulation-of-social-work-education-and-training First Three Years In Practice Guidance Document https://socialcare.wales/resources/the-first-three-years-in-practice Social Care Wales – COVID 19 Health and Wellbeing Resources https://socialcare.wales/service-improvement/health-and-well-being-resources-to-support-you-during-the-coronavirus-covid-19-pandemic Health and Social care workers' quality of working life and coping while working during the Covid-19 pandemic 7th May – 3rd July 2020, findings from UK Survey: www.ulster.ac.uk

7.00	CONTACT OFFICER DETAILS
7.01	**Contact Officer:** Allison Lowry-Phillips **Telephone:** 01352 702951 **E-mail:** Allison.lowry-phillips@flintshire.gov.uk

8.00	GLOSSARY OF TERMS
8.01	**(1) Social Care Wales** the regulator for the social care workforce since April 2017. Sets standards for the care and support workforce, making them accountable for their work. Developing the workforce so they have the knowledge and skills to protect, empower and support those who need help. **(2) Practice Learning Opportunities** provide students with the opportunity to work with service users and build professional relationships. These opportunities can be statutory, voluntary or independent sector agencies. **(3) Mentors** provide motivation, emotional support, goal setting, developing contacts and identifying resources. **(4) Onsite Supervisor Role** is the link into the site of practice, and so is responsible for organising an induction programme for the student. Supervisors also choose relevant work for their student and give them day to day guidance and advice.

	(5) Practice Educator role is to teach, supervise and assess social worker students on their placements during training to become a social worker. They improve standards in social work education, maintaining the quality of practice placements for social work students. **(6) Practice Assessment Panel** membership is drawn from experienced Practice Educators, stakeholders and Link Tutors from the social work programme. **(7) Continuing Professional Education and Learning Framework (CPEL)** describes the minimum arrangements for the ongoing education and learning of social workers in Wales. It is designed to support social workers as they progress and take on new roles and responsibilities, through their career as social work professionals. **(8) Consolidation Programme** (for all newly qualified social workers). This is the first part of the Continuing Professional Education and Learning Framework. It also forms part of the first 3 years in practice framework, which aims to support social workers as they make transition from graduate to competent practitioner. The Consolidation Programme provides opportunities for newly qualified social workers to consolidate and further develop their knowledge and skills in three core areas; a) Applying analysis during assessments to inform interventions b) Working collaboratively with people who receive care and support, carers and other professionals c) Intervening and applying professional judgement in increasingly complex situations **(8) Care First Employee Assistance Programme** is a comprehensive set of services designed to help employers provide a balanced and healthy working environment. Employee services include; Counselling, information and advice and health and wellbeing. **(9) Mindline** is a specially commissioned programme for the Flintshire Social Care Workforce (in-house and independent sector) it offers a range of support services, from team virtual yoga, to individual trauma support services.

COVID-19 Health and Social Care Workforce Study May-July 2020

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Executive Summary

In December 2019, a novel coronavirus emerged (COVID-19) which was quickly designated a pandemic with all countries urged to take 'urgent and aggressive action' (WHO 2020). Worldwide social and economic disruption for governments and their citizens followed with a rising death toll and efforts to prepare, protect and treat citizens impacting across all sectors in society. While it was clear that trying to fight this pandemic is everybody's business (WHO 2020), the task of caring for affected individuals and their families in the UK has fallen to an already greatly pressured, understaffed and underfunded health and social care sector, and those who work within it.

In April 2020, funding was secured from Northern Ireland Social Care Council (NI SCC) and the Southern Health and Social Care Trust to support the dissemination of an online survey to nurses, midwives, Allied Health Professionals (AHPs), social care workers and social workers in the UK, with support from other funders following. The aim was to explore the impact of providing health and social care during a pandemic on the UK health and social care workforce. A survey questionnaire measured Well-being, Quality of Working Life, and ways of coping whilst working during the pandemic. Work and home life segmentation was also explored. Additional open-ended questions sought further detail from respondents on how the pandemic had affected their work and work setting, what employers had done to support their staff, lessons that could be learned for future pandemics and 'normal' health and social care provision. The perceptions of health and social care workers about the 'Clap for Carers' initiative were also garnered.

Key Findings:

The survey received 3290 responses; of the responses 1897 were from Northern Ireland, 1062 were from England, 146 were from Scotland and 185 were from Wales. Most of the sample were social workers (1282) and social care workers (1245), followed by AHPs (388), nurses (199) and midwives (190). The difference between the country responses rates and professional occupational rates are explained by some respondents not indicating which country they were from.

https://www.oecd.org/gender/data/women-are-well-represented-in-health-and-long-term-care-professions-but-often-in-jobs-with-poor-working-conditions.htm

In line with OECD (2020) figures on the over-representation of women in the health and social care workforce, most of the respondents were female across all professions, and all midwives that responded were female. Respondents were mainly in the 30-59 age bracket. The fewest number of respondents were aged 16-19 or over 60 years. Respondents in Scotland were generally younger than those in the other countries of the UK, whereas those from England and Wales were older. The majority of AHP and social worker respondents fell into the 50-59 age bracket, whilst the other professions were mainly in the younger 40-49 age range.

Almost one quarter (24.1%) of the respondents worked with older people. These were mainly based in Scotland, however nearly a third of respondents from Northern Ireland worked with older people. Very few (0.5%) respondents reported that they had come out of retirement to support the workforce during the COVID-19 pandemic. Most respondents were employed on a permanent basis although Northern Ireland had the largest proportion of agency staff at 6.2% while Wales had the lowest level of agency workers at 0.5%. Scotland had the highest number of part-time workers, making up just under one third (31.2%). Midwives were most likely to be employed part-time than other professionals. Most respondents worked full-time, typically 37.5 hours per week. Respondents in Northern Ireland worked the highest number of hours' overtime. Nurses and social care workers worked the most overtime.

Free text responses were analyzed to identify themes which related to 'Changing Conditions', 'Connections' and 'Communication' associated with working during the pandemic. These themes related to work context and working conditions as well as relationships with managers, colleagues and service users/patients, and in particular to the ways in which communication took place. A full report of findings is included in the main report and the key 'Good Practice' recommendations that have emerged from those findings and included in the main report.

Good Practice Recommendations:

Improving Work Context and Conditions

1. Employers need to provide as far as possible increased flexibility around working hours, location of working, and recognition of additional childcare or other caring responsibilities to support the workforce during a pandemic or other crisis. The nature of a pandemic means that these are not easy to provide, of course, but communication and understanding of their importance will help staff feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about this would be one first step.

2. Training and development to equip staff with the ability to, where possible, perform multiple or new roles should be commissioned and rolled out. While this form of skill mix might be thought vital during times of high service demand where low staff levels affect the availability of critical skills within teams, it might also be helpful during 'normal' service delivery. This will need attention from employers, professional bodies, regulators, educational and training bodies, and service users and patient groups.

3. Some respondents called for more involvement in decision making, more autonomy and flatter hierarchies to equip staff with the ability to make faster, well-informed decisions in times of crisis. This was also thought to improve service delivery during normal service delivery times. Research is needed on patient/service user outcomes to see whether this view is borne out by the evidence. It would need to be integrated with the current reliance on evidence-based guidelines.

4. Policies about working from home (if appropriate) should be developed and equitably applied to avoid division and discontent and undermining of leadership and organisational commitment. If staff request or are asked to work from home, they should be able to access equipment and technology support, to have relevant expenses met, and to be assured of supervision and peer support.

5. For those staff who need to be in the workplace steps should be taken to ensure social distancing, handwashing, use of sanitisers for shared equipment and use of large spaces to reduce the risk of viral spread. Workplaces need to ensure that there are plans for any crisis, such as fire and flood, not just pandemics. The flexible use of rota systems could assist in the number of employees needing to be present at one time and could be undertaken quickly in any crisis with the development of technology.

6. The "Clap for Carers" campaign may be an opportunity to re-examine both the societal recognition of the work done by health and social care workers but to also increase funding and the deployment of NHS and social care services, as well as the pay of health and social care workers (and making pay, terms and conditions fair for all).

7. Employers in the health and social care sector should ensure that their staff should not have to solely rely on Statutory Sick Pay in the event of illness. Policy and practice around staff sick pay should be reviewed and ameliorated urgently where necessary by employers.

8. Further consideration is needed about the most effective way of supporting and deploying temporary or agency staff who may have limited sick pay entitlements to Statutory Sick Pay (SSP). This could reduce the risks of staff going to work when unwell or infectious and does not, of course, apply only to the COVID-19 context.

9. Plans to obtain and sustain supplies, and to deploy appropriate PPE, should be developed by employers and public health bodies at times of crises such as pandemics for staff in direct contact with people. Such plans should be regularly reviewed by a regulator.

Improving Connections and Communication

1. Connection to colleagues and managers is critical during a pandemic or any other crisis, and regular and frequent communication is required, in person or virtual, to increase personal and professional connection and employee engagement and organisational commitment. This needs to be tailored to the needs of the service, the team or individuals. There should be development of evidence-based good practice guidance that meets the broad range of health and social care services by national bodies.

2. Employers are accountable and hold corporate responsibility for ensuring that employees are provided with up to date guidelines. Any change to guidelines should be monitored by those holding management responsibility to interpret changes and guide staff and other managers on best practice recommendations. This should result in clear messages and reduce the risk of contradictory or confusing guidance.

3. Managers should be visible, either in person (if possible) or virtually, so that workers feel they are as valued as those in management positions.

4. Staff concerns for service user or patient wellbeing needs to be taken seriously by management and evidenced by opportunities to discuss individual concerns in peer or one to one supervision. Staff empathy is an important driver for motivation, job satisfaction and commitment and needs fostering.

5. Managers need to ensure where possible that staff are supported and encouraged to take leave if possible or to carry it over without penalty in crisis situations.
6. Staff concerns about contracting infections should be viewed as an indication of their commitment to their job and concern for the wellbeing of their families and themselves. Staff's concerns should be listened to and reasonable actions taken to alleviate concerns.

Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic 7th May – 3rd July 2020: findings from a UK Survey

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FOREWORD

Working during a pandemic was not generally anticipated in the United Kingdom (UK). The UK health and social care workforce is the focus of this report which sets out findings from a UK wide survey that measured aspects around quality of working life, well-being and coping whilst working during the height of the COVID-19 pandemic. The survey opened on 7th May and data collection ran until 3rd July 2020. This is the first of three surveys to be conducted by this research team focusing on the work experiences and coping of health and social care staff in relation to the COVID-19 emergency.

The target professions for this study included nurses, midwives, Allied Health Professionals (AHPs), social workers and social care workers (working in home care and care homes). Potential participants were accessed with the support of professional bodies and regulators including Royal College of Midwives, Royal College of Nursing, Unison, Unite, Allied Health Professions Federation, the Royal College of Occupational Therapists, Northern Ireland Practice and Education Council, and Northern Ireland Social Care Council. The online magazine Community Care © helped publicise the survey among UK social workers.

The survey asked both quantitative and qualitative questions and responses have enabled us to undertake both statistical analysis and analysis of free text responses. The measurement scales used for the quantitative side of the study were first from the Work-Related Quality of Life Scale (WRQoL). This measured general wellbeing, home-work interface, stress at work, control at work, working conditions, and job and career satisfaction. The second scale, the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWB), measured mental well-being. Both these scales were used in a previous UK study of social workers by the research team in 2018, so this has enabled comparison of findings collected pre-COVID about working conditions and well-being with this present survey.

A third scale, the Carver Brief Cope Scale measured several coping strategies: self-distraction, active coping, denial, substance use, using emotional support, using instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. Lastly, the Clark Work and Family Stressors Scale captured information about strategies for dealing with family and work segmentation, areas to improve skills, recreation, relaxation and exercise.

The qualitative questions included in the survey asked people about their work experiences during this time and assisted in the development of the study's 'Good Practice Guidance and Recommendations' which are provided in our summary conclusions.

The research team plans to conduct two further surveys in November 2020 and May 2021. We are committed to providing stakeholders with results in a timely manner to inform employers and policy makers in real time, about the needs of the workforce during a 12-month period of great uncertainty from May 2020 until May 2021 and beyond.

The research team would like to extend our sincere thanks to all those who participated in this survey and those who provided support for its dissemination and our funders who enabled this research to happen in such a timely manner.

“The daily "Rock around the pond" that takes place every day gets everybody moving and it has boosted the staff morale no end. The service users spectate from balconies and Windows or participate by dancing round the ponds edge. Party favourites are YMCA Music man and Agadoo. We even performed the social distancing Conga. Absolutely outstanding. I feel that the daily briefings/meetings straight after the party are brilliant. All information and updates are passed over and in full to all staff. It allows everyone to take it all in and support each other through this.”

(Social Care Worker)

INDEX

1. Background

One of the top causes of death globally are lower respiratory infections, with new diseases continuing to emerge (Bradley and Bryan, 2019; Koh, 2011). These include the severe acute respiratory syndrome virus (SARS) and the Middle Eastern respiratory syndrome virus (MERS). During December 2019, a novel coronavirus emerged (COVID-19), and by was March 2020, was designated a global pandemic, and all countries were urged to take 'urgent and aggressive action' to manage the risk to public health and risk to life (WHO 2020). While it has been made clear that trying to fight this pandemic is everybody's business (WHO 2020), the main burden for caring for and treating people who are ill in the UK falls to the understaffed and underfunded health and social care sector and those who work in it.

Previous studies undertaken with health care staff during a SARS and Middle East respiratory syndrome coronavirus (MERS-CoV) highlighted their stress and revealed some coping strategies (Khalid, et al 2015). While staff nurses admitted worrying about infecting their families and colleagues, they were able to cope by adopting certain strategies, such as deriving support from colleagues, benefiting from their employer's recognition of their efforts, and receiving infection control guidance and equipment (Lee et al, 2005; Khalid et al, 2015). With the context of the COVID-19 pandemic, Chen (2020) found that hospital medical staff in China were reluctant to engage with psychological support and were more concerned about how to deal with patients' anxieties, staff's need for uninterrupted sleep, and having sufficient personal protective equipment. A study in England of domiciliary social care personal assistants found considerable uncertainty, questions of parity, and anxiety about the wellbeing of their employers/clients (Woolham et al 2020). Again, in relation to nurses, the first wave of a major longitudinal study of nurses (the ICON study) conducted through the Royal College of Nursing (2020), reported that 88% of nurses continue to worry about risks to their family due to their clinical role and about risks to their own health. Some of these respondents also reported experiences of continued depression, anxiety, and stress, with some emerging signs of post-traumatic stress disorders.

There is limited evidence about how wider health and social care workers cope with meeting the challenges of caring for patients or service users, while potentially putting their own health at risk, although more is emerging from some groups (see also West et al 2020 in relation to nurses and midwives). It is for this reason that we undertook this survey.

1.1 Aim

This study explored the impact of providing health and social care during the COVID-19 pandemic on nurses, midwives, Allied Health Professionals (AHPs), social care workers and social workers working in the UK.

1.2 Objectives

1. To gather relevant demographic information from a cross sectional convenience sample of nurses, midwives, AHPs, social care workers and social workers in the UK.
2. To determine the perspectives of nurses, midwives, AHPs, social care workers and social workers on the challenges they are facing while providing health and social care during a declared pandemic.
3. To measure wellbeing, quality of working life and home and work interface.
4. To find out what coping strategies are used by frontline staff during the time of a pandemic.
5. To explore health and care workers' perspectives on employers' supports, improvements on employer supports and suggestions for employers' support for future pandemics based on their experience and learning from the current COVID-19 pandemic.

2. Methodology:

2.1 Research Instrument

An online survey questionnaire designed to meet the objectives of the study was developed after reviewing the relevant literature. This was predominantly a quantitative questionnaire that contained valid and reliable scales, and comprised 6 sections including:

1. Demographics: age, gender, ethnicity, disability status, marital/partner status, caring responsibilities, professional area of work, job tenure and role, time of gaining professional qualification, hours of work, additional working hours/overtime
2. Quality of Working Life Scale (WRQoL) addressing Objective 2 of this study (24 items).
3. Short Warwick Edinburgh Mental Well-being Scale (SWEWBS) addressing Objective 3 (7 items).
4. Brief COPE Scale addressing Objective 4 (28 Items)
5. Clark et al. Coping with Work and Family Stressors Scale addressing Objective 4 (15 items)
6. Qualitative questions to explore workforce perspective in greater detail addressing Objective 5 (7 questions)

The Work-Related Quality of Life Scale (WRQoL) (Van Laar, 2007) gauged the perceived quality of life of respondents. The Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS) enabled the monitoring of mental wellbeing and the Brief COPE Scale (Carver 1997) measured 14 different coping strategies. The Brief COPE scale rates how respondents coped while working in health and social care during the COVID-19 pandemic. A further 15 selected items, from Clark et al's (2014) 'Coping with Work and Family Stressors Scale', captured information about strategies for dealing with family and work segmentation, improving skills/efficiency (training), recreation/relaxation and exercise.

There were seven additional open-ended questions with an option for respondents to add any additional information they wished to tell us about working in health and social care services during the COVID-19 pandemic in the UK.

2.2 Study Respondents: Sampling, Access and Recruitment

Participants were nurses, midwives, AHPs, social care workers and social workers in the UK who had signed up to receive newsletters or journals from professional associations, workplace unions and regulators such as Royal College of Nursing (RCN), Royal College of Midwives (RCM), the Northern Ireland Practice and Education Council (NIPEC), Northern Ireland Social Care Council (NISCC), the Royal College of Occupational Therapists and the British Dietetic Association, and the social work journal Community Care. In order to reach as many respondents as possible, social media platforms such as Twitter and Facebook were also used to advertise the survey and provided an electronic link to the Participant Information Sheet, consent and survey.

The survey drew on a convenience sample of those who choose to participate following receipt of communication in a newsletter/journal from RCN/RCM/NIPEC/ NI SCC and other professional associations and workplace unions or those who accessed the survey through social media. Submitted survey data were anonymized prior to analysis. Respondents were advised that their details would not be shared, nor be identifiable to researchers in any subsequent publications. For this reason, respondents were informed that withdrawal of individual response data on request was not possible after submission of their response.

NB: The original study Protocol can be viewed in Appendix 1.

2.2.1 Sample Profile

There were 3290 responses with most of the responses (n=1897) coming from Northern Ireland, while n=1062 responses were from England, n=146 were from Scotland, and n=185 were from Wales. Most of the sample were social workers and social care workers, followed by AHPs.

Figure 2.1: Occupation of Respondents

Table 2.1 below shows that 76.8% of nurses were from Northern Ireland (NI), whilst 18.7% were from England and 2.5% Wales and the lowest number of nursing respondents were from Scotland (2%). Most midwifery respondents were from NI (45%), followed by Wales (29.4%), England (22.8%) and Scotland (2.8%). The majority of AHPs were from NI (45.2%), followed by England (43.2%) and Wales and Scotland at the lowest end of participation with 6.7% and 4.9% respectively. Most social care workers were from NI (74.3%) and England (15.4%), while Scotland and Wales had 6.8% and 3.5% respectively. Most social worker respondents were from England at 48.8% and NI at 44.1% with 2.6% from Scotland and 4.5% Wales.

Table 2.1 Country of Respondents by Occupation

Occupation	England	Scotland	Wales	NI	Total
Nursing	18.7%	2.0%	2.5%	76.8%	100%
Midwifery	22.8%	2.8%	29.4%	45.0%	100%
Allied Health Professional	43.2%	4.9%	6.7%	45.2%	100%
Social Care Work	15.4%	6.8%	3.5%	74.3%	100%
Social Work	48.8%	2.6%	4.5%	44.1%	100%

Most respondents were female across all professions, and all midwives who responded were female. Respondents were mainly from the 30-59 age bracket. The fewest number of respondents were aged 16-19 and over 60 years of age. In Scotland, respondents were generally younger than in the other countries, whereas those from England and Wales were older. The majority of AHP and social worker respondents fell into the 50-59 age bracket, whilst the other professions were mainly in the younger 40-49 age range. Respondents from England reported the highest prevalence of disability. Social workers and AHP respondents were most likely to report a disability. Most of the sample were in the Band 6 pay band across all countries of the UK, with the exception of Northern Ireland respondents who were mostly in Bands 2 or 3, and the majority of these were midwives.

Overall, most respondents were married. Those in NI were more likely to be single or divorced than the rest of the UK. As noted, over half, 57%, of respondents were from NI, 33% were from England and 5% were from Scotland and Wales. Almost all respondents were of white ethnic origin in all four countries, but England was the most ethnically diverse. Social work was the most ethnically diverse profession in this sample. Overall, most respondents worked in the community. AHPs, social workers and social care workers mainly worked in community settings, but most nurses and midwife respondents were working in a hospital setting. Most respondents had 11-20 years' work experience while those with over 30 years' experience were nurses. Just over half (51%) of all respondents across all countries worked with older people or other adults, followed closely by those who worked with children, in mental health services or midwifery (see Figure 2.2).

Figure 2.2: Area of Practice by Country

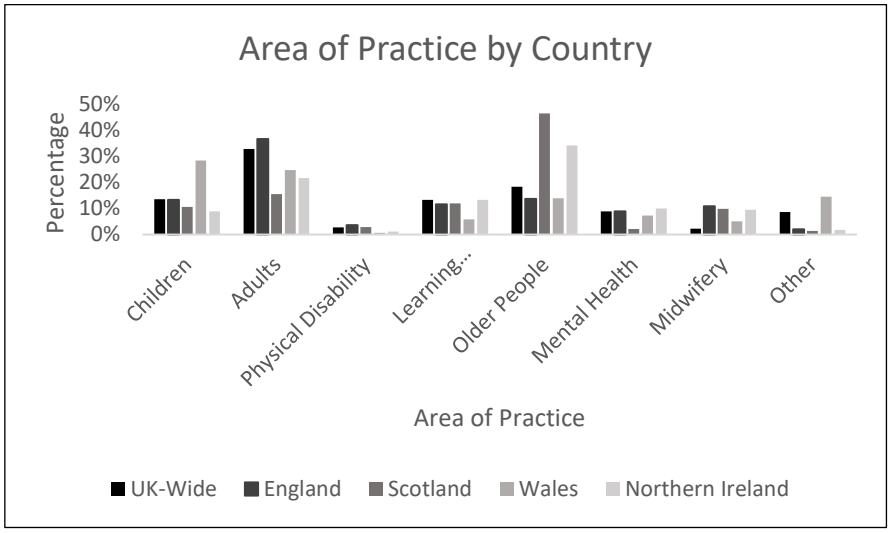


Table 2.2: Area of Practice by Country

Area of Practice	UK-Wide	England	Scotland	Wales	NI
Children	13.5%	13.3%	10.5%	28.3%	8.8%
Adults	32.7%	36.4%	15.4%	24.6%	21.6%
Physical Disability	2.7%	3.6%	2.8%	0.7%	1.1%
Learning Disability	13.3%	11.5%	11.9%	5.8%	13.2%
Older People	18.3%	13.6%	46.2%	13.8%	34.0%
Mental Health	8.9%	8.8%	2.1%	7.2%	10.0%
Midwifery	2.2%	10.8%	9.8%	5.1%	9.5%
Other	8.6%	2.0%	1.4%	14.5%	1.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Only 0.5% of respondents reported that they had come out of retirement to support the workforce during the COVID-19 pandemic. Respondents from all occupations included staff who had come out of retirement, but this was a low percentage ranging from 0.3% for social care workers and AHPs, 0.5% nurses and 0.6% for midwives and social workers. Most respondents were employed on a permanent basis with NI having the largest proportion of agency (temporary) staff at 6.2%, while Wales had the lowest level of agency workers at 0.5%. Scotland had the highest number of part-timers employed, making up just under one third (31.2%). Most respondents worked full-time, typically 37.5 hours per week. This was the case across occupations, but midwives were most likely to work part-time hours. Respondents in NI worked the highest number of hours' overtime. Nurses and social care workers worked the most overtime.

2.3 Data Analysis

The survey results were analysed using SPSS 24 ©. Descriptive statistics provide frequency distribution for both nominal and ordinal data along with percentages and cumulative percentages. A series of inferential statistics was analysed. Qualitative data were analysed for emerging themes. In total, seven open-ended questions were included in the survey asking about the impact of COVID-19 on work and family life, asking about the nature of and amount of employer support expected and offered, and the type of employer support deemed "good practice" for future pandemics as well as normal day-to-day practice.

2.4 Ethical Considerations

The research team was aware that health and social care workers employed on the front line during a pandemic were already under pressure. However, it was important to carry out this research at this time to find out what their work life was like and what coping strategies they used.

While completion of the survey was on a voluntary basis, it was possible that during the completion of the survey that respondents, may have become distressed. Therefore, respondents were provided with relevant support contact information.

Respondents were assured that as their data were anonymous, no identifiable information would be available publicly.

All permissions for use of survey scales were obtained.

Please Note: The full Protocol for this study is included in Appendix 1.

***NB**: Appendices provide Tables and Figures to illustrate the demographic findings, scale analysis and multiple regression analysis.*

3. Findings: Changing Conditions, Connections, Communication

Responses to open-ended questions were read by country and analysed using thematic analysis across the disciplines: nursing, midwifery, AHPs, social care workers and social workers. The recurring responses were evidenced across all countries and disciplines, showing dominant themes under three broad areas of "conditions", "connection", and communication". Three groups were identified across all responses. These include those who had generally positive accounts, those who admitted some work-related challenges during the pandemic whilst also citing areas for improvement. A final group reported generally negative experiences relating to working during the pandemic.

We are presenting the qualitative results under the emerging themes of changing conditions, connection and communication. These initial sections give an insight into the respondents' emotions and experiences when working through the pandemic. The following sections then use descriptive, scale analysis and multiple regression analysis to report the quantitative results that relate to respondents' outcomes for coping strategies during the pandemic and their Quality of Working Life, and Wellbeing.

What was the experience of health and social care staff through the pandemic?

3.1 Changing Conditions

The onset of the virus rapidly brought several changing conditions that impacted the health and wellbeing of respondents. Respondents commented on the stress associated with changes to safety risk, work routines, work intensity and work/ home life.

3.1.1 Safety

Many respondents reported additional concerns about safety and noted their fear of contracting the virus themselves and/or passing it on to family members or those they were caring for. One respondent talked of being in "*Extremely stressful situations and fear of contacting COVID due to the amount of exposure*." (Northern Ireland, Social Care Worker).

In relation to staff safety, many respondents reported that it "*has been very carefully considered and prioritised*" (England, social worker), and in particular expressed appreciation for the opportunity to work from home to enable social distancing and alleviate safety concerns. On the other hand, many raised concerns about safety, particularly around the provision of personal protective equipment (PPE). This was particularly true for health and care staff working in residential care and those who provided domiciliary (home based) services. One respondent noted:

> "*I feel that risk is massively undervalued and under discussed, with regards to our own personal safety. This has been highline more under Covid with regards to PPE….. our PPE did not reflect our role and the risk we face*" (England, Social Worker).

Some had purchased their own PPE as provision was delayed and then rationed or was only provided sporadically.

There were also safety concerns raised about availability of sick pay for some groups of health and social care workers, and the associated risk of spreading the virus if these workers were not covered. It was identified that contracting COVID-19 or having to self-isolate would have different impacts on agency (temporarily employed) compared to non-agency (permanent) staff as their entitlements to Statutory Sick Pay (SSP) differed. One respondent reported that agency staff with COVID-19 continued to work as they could not afford to take time off, placing service recipients and colleagues at greater risk, and causing further stress for their colleagues

3.1.2 Work Routines and Redeployment

Work routines also changed significantly for many respondents. One respondent mentioned that there was a "*new way of working total change in service delivery*" (Northern Ireland, Midwifery). This was often due to the restrictions associated with COVID-19 and some staff's inability to visit service users face-to-face. Instead, IT (phones and computers) were used to stay in touch: *"Change in the operation of the service with a significant increase in videocalls rather than face to face contacts*." (Northern Ireland, Allied Health Professional).

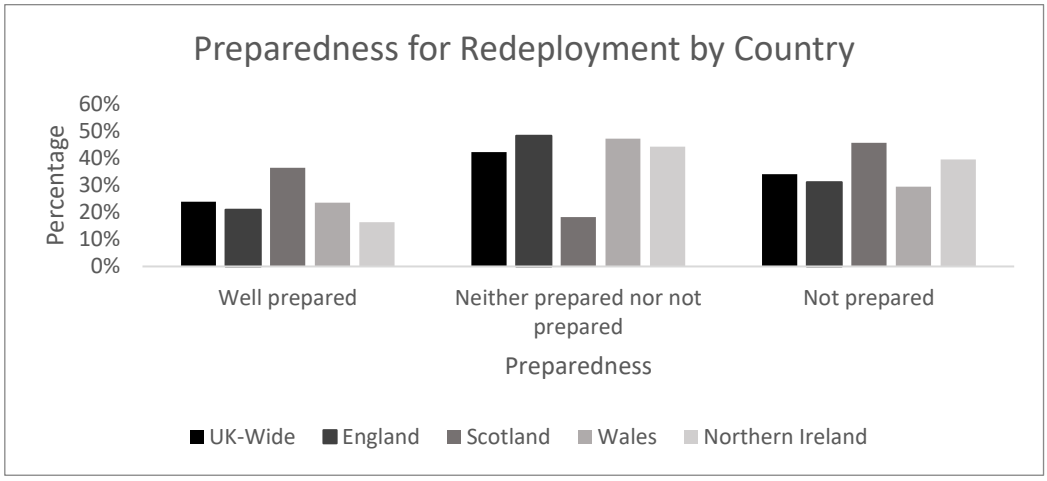
When asked about changes to the respondents' place of work, the impact of working from home was also a dominant theme. Many respondents noted how they valued the opportunity to work from home because it enabled additional flexibility. On the other hand, working from home was also thought to cause feelings of isolation and many respondents did not feel prepared to work from home. A lack of IT, office equipment and IT support were cited as important practical challenges. Some employers had, however, provided equipment and some financial support to set up home working, but this was not consistent across the workforce. The working from home policies had also the potential to raise contention, particularly among frontline care home and hospital staff who were unable to work from home due to the nature of their jobs. This had given rise to some resentment and was thought to require careful management.

Many respondents also reported significant changes to their work because of redeployment across services. At least one in ten of all respondents had been redeployed due to the pandemic. AHPs, Nurses and Midwives were most likely to be redeployed, with social workers and care workers least likely. For those who were redeployed, between 20-40% felt unprepared for redeployment.

Table 3.1: Percentage of Respondents who were Redeployed by Occupation

Occupation	Percentage
Nursing	16.5%
Midwifery	28.2%
Allied Health Professional (AHP)	16.6%
Social Care Worker	10.5%
Social Worker	11.1%

Figure 3.1: Preparedness for Redeployment by Country



Respondents noted their appreciation for staff who were redeployed to their teams to give additional support, but it was also noted that the redeployment of staff created additional challenges for those who remained in post and lost team members through redeployment.

Many respondents explained the additional stress they experienced when 'skeleton' teams were left behind.

> "*Some staff are being redeployed to other roles which places an increased demand in other staff case load and the intensity of work they can complete the patients"* (England, Social Worker).

3.1.3 Work Intensity

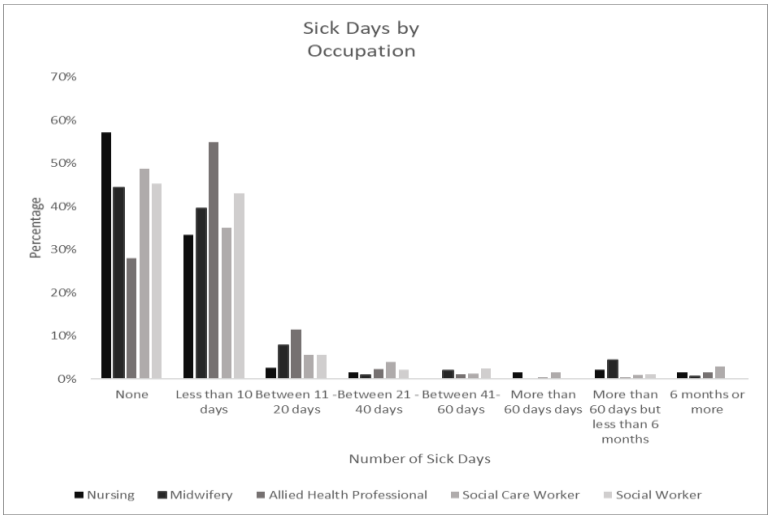
Changes to the intensity of work were also explained by several other factors and differed across occupations and care settings. For example, different experiences were often due to front-line versus non front-line status of the workplace and the prioritisation of certain services at the start of the pandemic. Unsurprisingly, those individuals working in acute COVID-19 response settings experienced a significant increase in demand while those in auxiliary areas experienced significant reductions. High service demand was also often discussed in the context of exposure to COVID-19 which led to high staff absence levels as illustrated by the following quote:

> "*We have been running with a depleted team due to staff off due to illness, shielding, stress due to the service demand*" (Northern Ireland, Social Worker).

In consequence, the increase in service demand and reduction in staff levels in many areas led to work intensification and longer working hours for those still in work. Supporting these findings, around one-fifth of respondents took a COVID-19 related sickness absence with nurses more likely than any other profession to have a COVID-19 related absence. One respondent commented on rapid decision making by senior managers without consideration or staff consultation, and how this impacted on staff absence and the service. Around one-fifth of respondents had a COVID-19 related sickness absence. Nurses were more likely than any other profession to have a COVID-19 related sickness absence but absence was experienced across the health and social care sector at least at a rate of one in ten.

> *"…..clear and concise guidance for staff and inform and consult before decisions are made at the highest level and communicated to all staff which have a large impact on operation service, for example our Chief Exec sent a mass email (before lockdown) in the evening informing staff who fell into an at risk category not to attend work. This wiped out over 20% of workforce without prior warning."* (Social Care Manager, England).

Figure 3.2: Sick Days by Occupation



3.1.4 Work/Home Life

Respondents also reported on stress in their private lives related to increased caring responsibilities, childcare and/or the addition of home schooling. NI respondents had the highest prevalence of simultaneously being family carers in their private lives as well as being employed in health and social care. Social care workers were most likely to have family or friend caring responsibilities alongside their job, whilst midwives were the least likely. Approximately two-thirds of all respondents reported that their caring responsibilities changed due to the pandemic. Social worker respondents were slightly more likely to have their caring role change due to the pandemic. Home life and work therefore had simultaneously changed for many respondents. One respondent commented on what additional employer supports would be helpful.

> ***"****More understanding of the impact on family life - for example of working from home and having caring responsibilities; of financial uncertainty; of worry about being unwell or dying; of the responsibility for staff, volunteers and recipients of services well-being****…"*** (Scotland, Social Worker).

3.2 Connections with employers, service users and the public

The findings suggest that emotional and psychological support was important to help mitigate negative effects from working during the pandemic. These supports included employers' and managers' overall recognition for their employees' work under these unusual circumstances. They also included regular contact, including checks on staff welfare, which were described as 'keeping in touch' as well as more formal supervision and opportunities for case discussions: *"Having very supportive leaders that I can approach at any time with any problem, they have gone that extra mile to enable me to cope in the toughest of times and in very difficult circumstances."* (Scotland, Social Care Worker)

However, it was suggested that the level of support was often down to individual line managers. Some respondents were very satisfied with their line managers' support. Other respondents were very dissatisfied, noting low or poor responses from managers when issues arose, leaving a feeling of being abandoned without leadership or direction:

> *"PPE and all is great for the physical ability to feel safe…. but emotional support by senior management has lacked. No one has visited us… even if they stand in the car park, it would have shown staff they were supported."* (Northern Ireland, Social Worker)
>
> *"We haven't heard of our manager barely at all through the pandemic. We have had no direction or advice on our job roles through this all."* (Wales, Nursing)

This created a 'them and us' feeling between management and frontline staff, with the latter in particular feeling undervalued.

While relationships with managers were discussed in both negative and positive ways, a large majority of respondents voiced concerns about the people they were working with. There were extensive responses on how the pandemic had affected service users/patients, and how the changes had affected interactions and relationships with them, as outlined in the following quote:

> *"I am working from home. No face to face contact, so can't physically see if children are safe. Most vulnerable are at risk and numbers have increased"* (Scotland, Social Worker)

One respondent commented on how the lockdown had affected their service users, which in turn increased work-related stress for the staff:

> *"Service users all have learning disabilities, and some have no understanding of what's going on or why they can't go to shops etc. therefore results in frustration and challenging behaviour which can be stressful for staff"* (Northern Ireland, Social Care Worker).

Respondents were also asked about their thoughts relating to the 'Clap for Carers' which was initiated for the public to express their appreciation to health and social care workers. While most respondents recognised that the initiative was well intentioned by the public, some felt that the campaign was being used by politicians as a diversion from the real problems of underfunding of health and social care sector,

> *"Completely futile and a political stunt designed to shift focus away from chronic underfunding and poor handling of the pandemic."* (England, Social Worker)

There were also feelings that this initiative overlooked the contribution of some health and social care workers and that some workers were still not being recognised for their role in society.

> *"It felt like it was only for NHS workers and carers, care home staff and social workers were not talked about as being who the clap was for." (*England, Social Worker).

3.3 Communication

Communication was highlighted as an important factor in the assessment of the respondents' experiences throughout the pandemic, however the effectiveness of communication from management and between team members was variable across occupations and across countries. When respondents reported positive feelings and experiences of support, they noted the importance and impact of regular and timely communication from management and senior leadership. Some respondents also noted that communication from management and amongst teams had become more effective during the pandemic, often citing how IT enabled this. Some noted how they welcomed the increased 'check ins' from managers and how IT enabled this effectively. On the other hand, respondents also raised frustrations about IT platforms for communication, particularly when they started working from home.

Respondents further highlighted frustrations about the communication from management and senior leadership about changes to guidelines and work routines. Some respondents noted that managers and employers expected frontline workers to keep up to date with the changing government guidance themselves. In addition, for many respondents, communication was not sufficiently tailored and/or specific to their occupation and place of work. Respondents further thought that communication often caused confusion rather than clarity, as outlined in the two quotes below.

> *"For example- we had resuscitation protocols sent to us…for someone with suspected COVID-19. It said if someone was collapsed to ring the call bell (where are call bells in patient homes??) to not attempt resuscitation until you were gowned in full PPE (which has to be done with a buddy and in the community we work alone and when this protocol came out we still didn't have any PPE to use). This is one of many examples where guidelines had been written by someone who has clearly never worked outside of the hospital setting and quite frankly it gets frustrating, demoralising and exhausting."* (England, Nursing)

This type of frustration was not only attributed to the pandemic context, but from the perspective of some respondents, was identified as an underlying problem that existed pre-COVID and was then exacerbated throughout COVID, as explained below:

> *"They may not fully understand how their decisions impact us or the people we support, this seemed more apparent during Covid. This creates flawed decisions,*

something we often see when we have new administration cycle….. Communication and collaboration must improve, and could be achieved by having more front line workers partaking in executive discussions to inform their decision making process" (England, Social Worker).

To improve the timeliness and effectiveness of decision making, many respondents also called for greater autonomy. However, there was simultaneously a sense of realism and understanding that the pandemic was unprecedented, and that managers were also having to react daily to changing government guidelines. The quote below describes a further stressor associated with a lack of clear communication:

"Sometimes the information sent out…was contradictory so that at times I felt supported to work remotely and other times I didn't. This was extremely stressful and worrying." (England, AHP)

Rapid decision making that was not informed by those delivering services became a recurring theme that respondents highlighted, and they asked for more consultation with front line workers and clear and timely information.

"Clear and timely information - there has been lots of last minute decisions made with what feels like little thought or consideration for the staff and the impact these decisions might have." (AHP, England)

3.3.1 What were Respondents Coping Mechanisms?

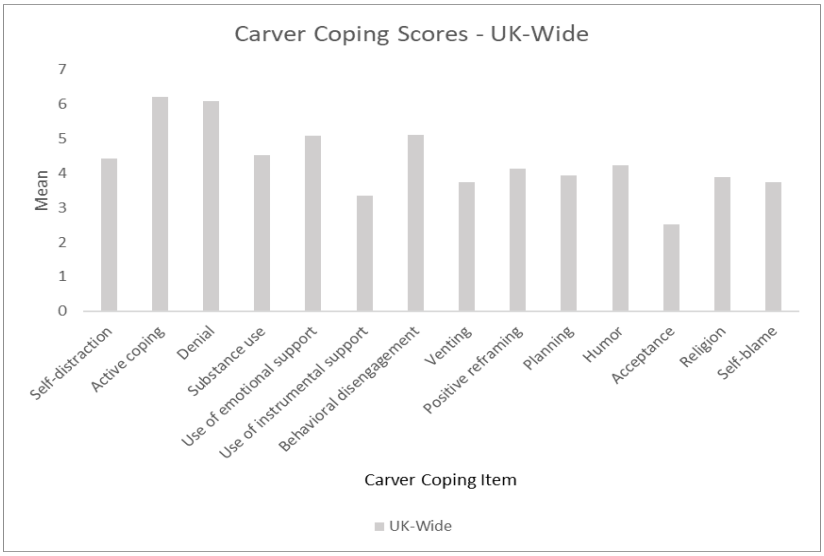
Coping is a diverse concept; therefore, a range of possible coping methods was measured. Social support and the need to connect with others were a recurring thread in the qualitative findings, especially for those feeling isolated from colleagues and managers. Survey respondents completed a series of questions about ways they might cope with stress, called the Carver COPE. This asks about 14 coping types, each measured by response to two statements. For example, the statement "I've been trying to get help or advice from people about what to do" measures coping by use of *Instrumental Support*. Participants tick a box to say if they have been doing this a lot, a little, a medium amount or not at all. Advice seeking is one of the support seeking behaviours, which also includes expressing emotions. Coping can also be proactive, such as positive reframing, or trying to view stresses in a new light. There are also examples of avoidance coping, such as turning to work as a means of self-distraction, or of altering consciousness, which can range from prayer or meditation on one hand, to substance use on the other.

We found significant differences in all but 5 of the 14 Carver Coping Scale domains across countries. These differences were in: Use of instrumental support; Self-distraction; Denial; Substance use; Use of instrumental support; Positive reframing; Humour; Acceptance; Religion; and Self-blame. In Northern Ireland, substance use and positive reframing scored highest as coping mechanisms. This compares to Scotland where more people turned to religion and used self-distraction. In Wales, people used instrumental support, acceptance and self-blame to cope. In England, people were less likely than other parts of the UK to use self-distraction or acceptance as a coping mechanism.

There were significant gender differences in all but two of the Carver Coping domains. The two that did not show significant differences were Behavioural disengagement and Positive reframing. Females scored significantly higher than males on use of active coping, denial, substance use and use of emotional support.

There were also significant differences across age groups in all of the Carver Coping domains. Those aged 16-19 scored higher than any of the other age groups on use of self-distraction, instrumental support, positive reframing, humour, acceptance and religion as coping mechanisms.

Figure 3.3: UK-wide Carver Coping Scores



There were significant differences across occupations in all but three of the Carver Coping domains, these are Active Coping; Use of Emotional Support and Acceptance. Nurses scored higher on the use of Self-Distraction, Venting and Religion but significantly lower on use of Acceptance as a coping mechanism. Use of Denial, Active Coping and Emotional support showed higher mean scores across all professional groups.

Table 3.2: Mean Carver Coping Scores by Occupation

Carver Domain	Nursing	Midwifery	AHP	Social Care	Social Worker
Self-distraction	4.56	4.42	4.27	4.45	4.29
Active coping	6.43	6.04	6.20	6.22	6.21
Denial	6.32	6.05	6.19	5.96	6.02
Substance use	4.44	4.30	4.98	4.53	4.62
Use of emotional support	5.25	5.22	5.17	5.09	5.16
Use of instrumental support	3.43	3.52	3.61	3.21	3.51
Behavioural disengagement	5.12	5.02	5.37	5.16	5.27
Venting	4.00	3.79	3.95	3.71	3.87
Positive reframing	4.13	4.10	4.56	4.10	4.31
Planning	4.04	4.23	4.06	3.86	4.03
Humour	4.47	4.58	4.22	4.11	4.21
Acceptance	2.52	2.55	2.54	2.52	2.53
Religion	4.06	4.00	3.74	3.65	3.91
Self-blame	3.92	3.69	3.98	3.61	3.93

3.3.2 Clark Coping Scores by Country, Gender and Age

The Clark Coping Scale measures Family Work Segmentation, Work Family Segmentation, Work to improve Skills/Efficiency, Recreation, Relaxation and Exercise. This scale asks more specific questions about coping with work stress and interaction with one's work environment and organisational structure. For example, participants are asked about efforts they have made to improve their efficiency, such as through investing time in self-organisation and verbalising and sharing work pressures with others. These questions also capture the spillover

of work pressure to personal wellbeing such as through exercise, as well as to family functioning and the ability to devote time to family.

There were significant differences in three of the Clark Coping Scale domains across countries: Work to improve skills/efficiency; Recreation /relaxation; and Exercise. People in England scored higher on use of Recreation and Relaxation. Those in Wales scored higher on working to improve Skills/Efficiency and Exercise and Work Family Segmentation. In NI, respondents scored higher on using Family Work segmentation than any other country. There were significant differences in mean scores across all Clark Coping Domains by gender. Females were more likely than males to work to improve skills/efficiency, whilst males were more likely to cope using exercise.

There were significant differences across all Clark Coping domains between age groups. Those aged 60-65 scored higher than any other age group in the use of Recreation/Relaxation to cope, whilst younger people were more likely to work to Improve skills or Exercise.

Figure 3.4: Clark Coping Scores by Country

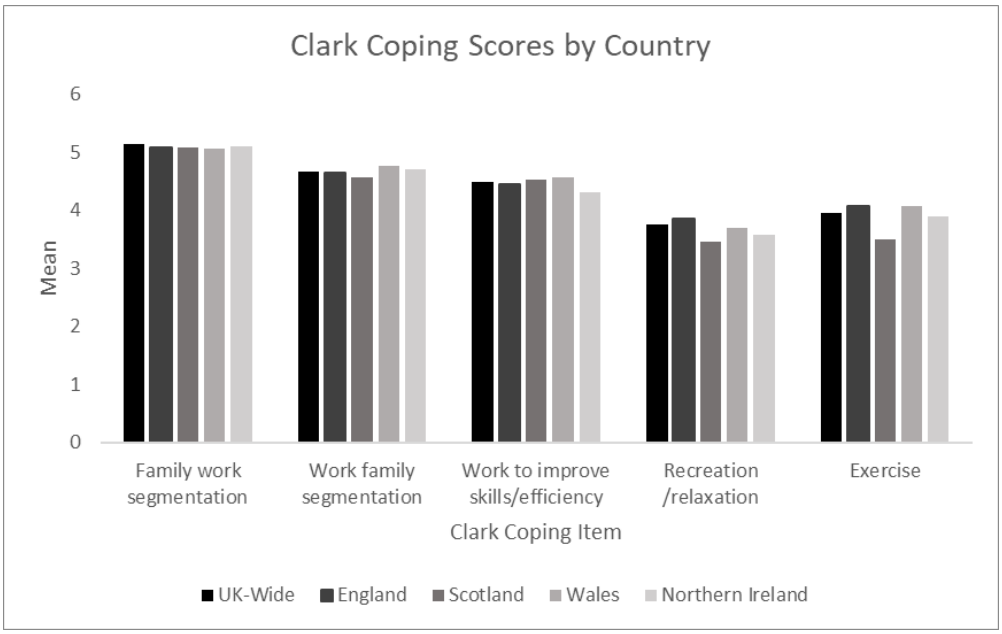


Table 3.3: Clark Coping Scores by Country

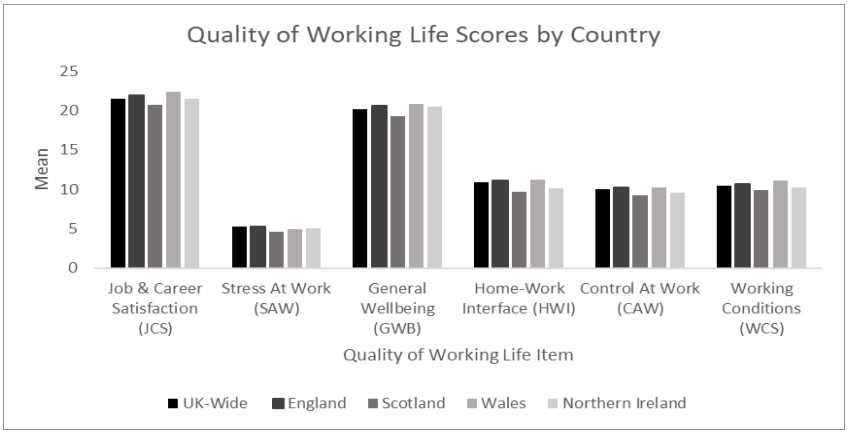
Clark Domain	Mean Clark Scores				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family work segmentation	5.14	5.08	5.09	5.07	5.11
Work family segmentation	4.68	4.65	4.58	4.78	4.71
Work to improve skills/efficiency	4.48	4.46	4.53	4.56	4.31
Recreation /relaxation	3.75	3.87	3.47	3.70	3.57
Exercise	3.96	4.07	3.51	4.07	3.89

3.3.3 How was Quality of Working Life Impacted?

The day to day quality of working life was captured in qualitative responses and also by the results from the WRQoL scale results. This measures Job and Career Satisfaction, Stress at Work, General Well-being, Home-Work Interface, Control at Work and Working Conditions. The questions give an in-depth picture of working life, examining the following key aspects. Control at Work assesses whether respondents feel they are involved in key decisions (e.g., "I feel able to voice opinions and influence changes in my area of work"); Job Career Satisfaction (JCS) looks at whether organisations provide a roadmap and direction of travel for employees, as opposed to firefighting each problem as it arises (e.g., "I have a clear set of goals and aims to enable me to do my job"); Stress at Work (SAW) asks for responses to statements such as "I often feel under pressure at work"; Working Conditions (WCS) asks about the safety and appropriateness of the work environment; and Home-Work Interface concerns the organization's active efforts to understand and adjust for pressures outside of work (e.g., "My employer provides adequate facilities and flexibility for me to fit work in around my family life"). All statements are responded to on a 5-point scale from Strongly Agree to Strongly Disagree, and can be aggregated to six discrete measures or one composite measure.

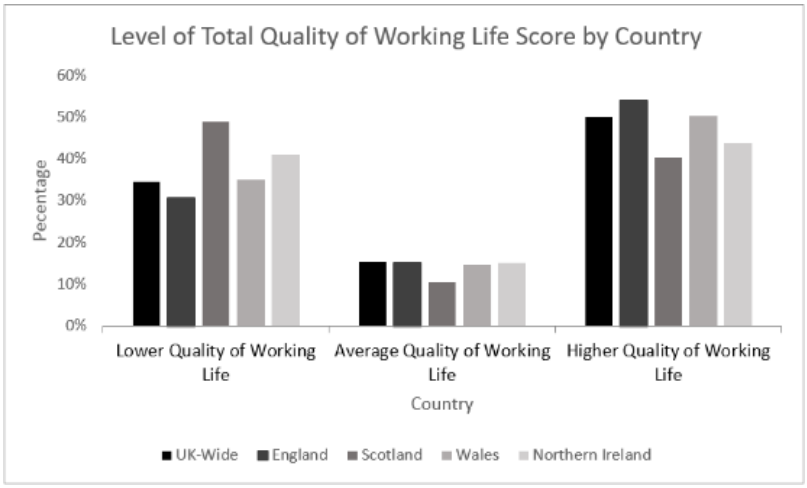
There were significant differences in all the quality of working life areas across countries. England respondents scored highest in Stress at Work, whilst those in Wales scored highest in Job and Career Satisfaction, General Well-being, and Working Conditions. Respondents from Scotland scored lowest for all quality of working life items. The highest total score for quality of working life was in Wales (83.94). The Stress at Work responses were reverse scored for consistency with the other WRQoL scales so that a high score on this domain implies lower stress.

Figure 3.5 Quality of Working Life Scores by Country



We explored levels of quality of working life by country, lower, average and high scores across percentages of respondents who scored across these levels. UK wide levels of quality of working life were in the higher category and England had the highest level of respondents reporting higher quality of work life, followed by Wales and then Northern Ireland. More respondents from Scotland reported a lower level of quality of working life than the other countries. There were significant gender differences across all the quality of working life domains with males reporting a significantly higher total quality of working life score than females.

Figure 3.6 Total Quality of Working Life Score by Country



Additionally, more UK wide respondents reported higher quality of working life in levels of Job and Career Satisfaction, Home-Work Interface, and marginally in Working Conditions. This figure shows that across all respondents there is a mixed picture of quality of working life, across all the domains. (See also Table 3.4 for a further breakdown of this variation.)

Figure 3.7 Level of Quality of Working Life Scores – UK Wide

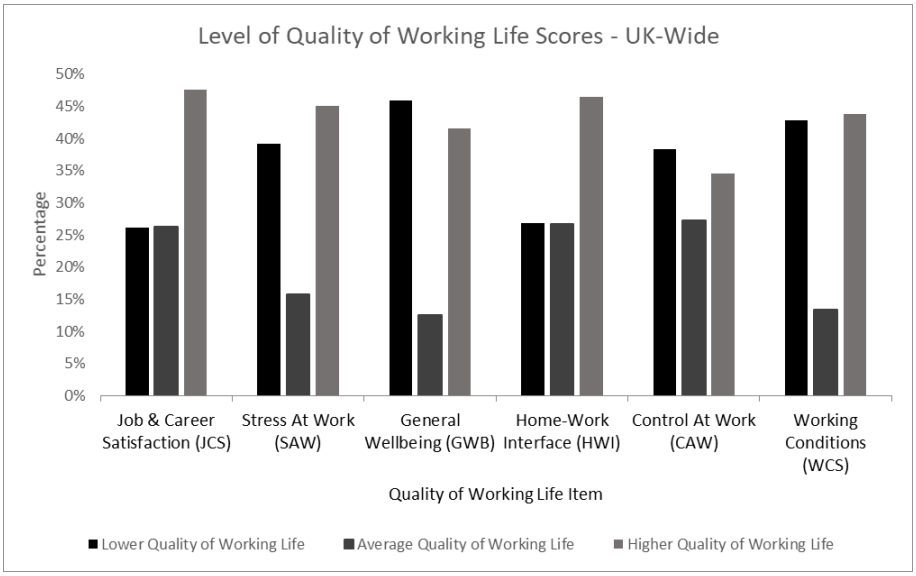


Table 3.4: Level of Quality of Working Life Scores - UK-Wide

Quality of Working Life Domain	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
Job & Career Satisfaction (JCS)	26.1%	26.3%	47.6%	**100%**
Stress At Work (SAW)	39.2%	15.7%	45.1%	**100%**
General Wellbeing (GWB)	45.9%	12.5%	41.6%	**100%**
Home-Work Interface (HWI)	26.8%	26.7%	46.5%	**100%**
Control At Work (CAW)	38.3%	27.2%	34.5%	**100%**
Working Conditions (WCS)	42.8%	13.4%	43.8%	**100%**
Quality of Working Life Total	34.6%	15.4%	50.0%	**100%**

There were significant differences across all quality of working life domains between age groups. There was also a significant difference in the quality of working life total scores between age groups. Scores tend to increase as people get older, so this correlates with the wellbeing scale results and is aligned to McFadden, et al's (2019) findings in the ageing social work workforce study, showing a significant positive correlation between age, wellbeing and quality of working life.

3.3.4 How was Wellbeing Impacted?

The relationship between sickness levels and well-being is important to consider in the current context. We measured wellbeing using a scale called Warwick-Edinburgh. Seven statements are presented, each referring to a positive state of mind (e.g. "I have been feeling relaxed) and respondents are asked to check a box along a five-point scale to indicate how often in the past two weeks this statement reflects their experience (e.g. 'Rarely', or 'All of the Time'). These five-point responses can then be summed. Scores of 7-17 signify *likely* cases of either depression or anxiety, while 18-20 indicates *possible* cases of depression or anxiety (Shah, et al 2018). A small number (9%) of our respondents to our survey registered in the *likely* range, while a further 33% fell in the *possible* range. The overall average score in our population was almost two points below published population averages. This, along with the cumulative 42% of respondents at sub-20 scores (compared to around 17% in the general population), suggests that our sample had considerably lower wellbeing than the general population. For example, a population mean for well-being using the Short Warwick Edinburgh Wellbeing Scale was found to be 23.61 (Health Survey for England, 2011).

We found that overall mean wellbeing scores were slightly higher for the NI sample than UK wide. There was a significant difference in mean total wellbeing scores across countries ($F=3.767$, $df=3$, $p<0.05$). There was no significant difference in mean total wellbeing scores across occupations ($F=1.932$, $df=4$, $p>0.05$).

Table 3.5: Total Wellbeing Score by Occupation

Occupation	Mean Wellbeing Score
Nursing	21.15
Midwifery	20.91
Allied Health Professional	21.51
Social Care Worker	21.14
Social Worker	21.14

Figure 3.8: Wellbeing Scores by Country

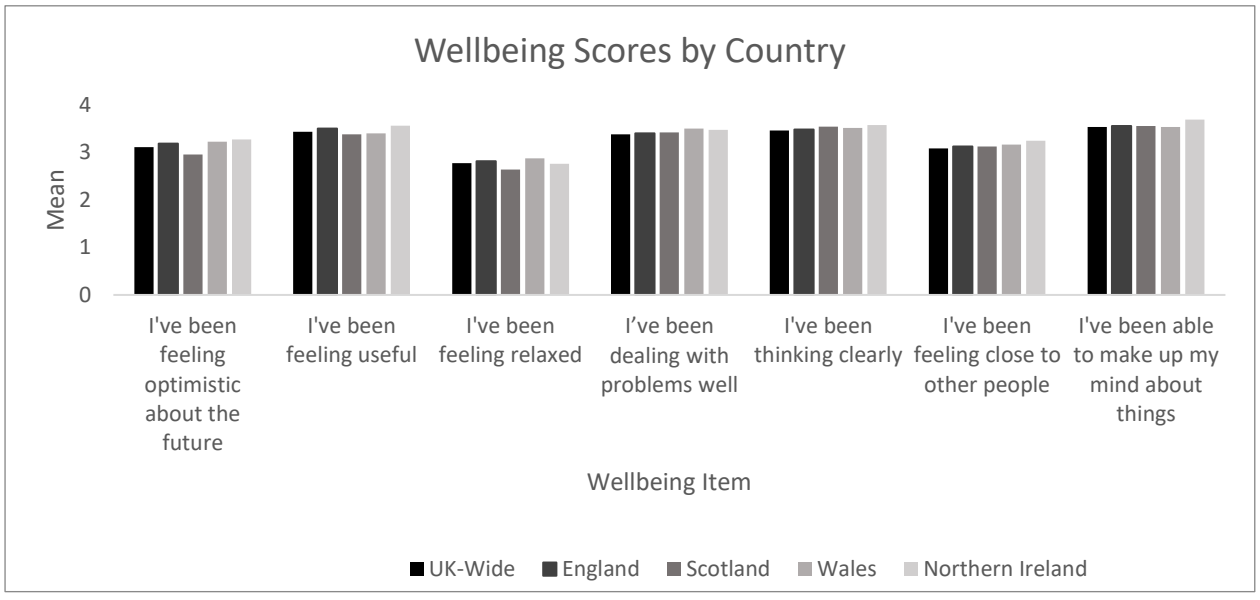


Table 3.6: Wellbeing Scores by Country

Wellbeing Item	UK-Wide	England	Scotland	Wales	NI
I've been feeling optimistic about the future	3.11	3.18	2.95	3.22	3.27
I've been feeling useful	3.43	3.50	3.38	3.40	3.56
I've been feeling relaxed	2.77	2.81	2.64	2.87	2.76
I've been dealing with problems well	3.38	3.40	3.42	3.50	3.47
I've been thinking clearly	3.46	3.48	3.54	3.51	3.57
I've been feeling close to other people	3.08	3.12	3.12	3.16	3.24
I've been able to make up my mind about things	3.53	3.55	3.55	3.53	3.69
Overall mean Wellbeing Score	20.95	21.15	20.74	21.25	21.61

3.3.5 Wellbeing by Gender, Age, Ethnicity and Disability

Males reported a higher level of wellbeing than females and this difference in wellbeing scores across gender was significant. There was also a significant difference in wellbeing scores across age groups. As noted above, as people age, they generally report higher wellbeing scores. There was a significant difference in mean total wellbeing scores across ethnicities, with Black people reporting the highest wellbeing scores. There was a significant difference in wellbeing scores by disability. Those who reported no disability had a higher well-being score. This was the same for the McFadden et al (2019) study. Further information on the analysis of well-being across gender, disability, ethnicity and age is reported in the Appendix.

3.4 Multiple Regression Results

3.4.1 Multiple Regression Model Predicting Wellbeing Score

Multiple regression modelling was used to examine the coping factors that predict Mental Wellbeing (SWEMWBS) scores whilst controlling for various demographic variables (age, gender, ethnicity, disability), as well as country of work, occupational group and number of sick day absences in the previous 12 months.

The results indicated that the model accounted for approximately 34% of the variance in Mental Wellbeing scores. The following coping variables each uniquely predicted higher Wellbeing scores, namely, use of Active Coping, Emotional Support, Work Family Segmentation, Relaxation and Exercise. Lower Wellbeing scores were associated with higher Disengagement and Substance Use. No group differences emerged in terms of age, disability or ethnicity but males reported higher scores than females. Preparedness for re-deployment was added to the model but was not significantly associated with changes in Mental Wellbeing scores (see appendix 8 for more details).

3.4.2 Multiple Regression Model Predicting Quality of Working Life Score

In the same way multiple regression modelling was used to predict Work Related Quality of Life (WRQoL) scores using the same predictor variables as in the previous analysis.

The results indicated that the model accounted for approximately 25% of the variance in WRQoL scores. The following variables each uniquely predicted higher WRQoL scores,

namely, use of Active Coping, Emotional Support, Work Family Segmentation, Family Work Segmentation and Relaxation. Lower WRQoL scores were associated with higher Disengagement and higher Family Work Segmentation. No differences were evident in relation to age, occupational group or gender but those with a disability recorded lower WRQol scores on average. The number of days absent due to sickness in the previous 12 months was associated with lower WRQoL scores. Adding the experience of re-deployment to the model showed that those who felt prepared for re-deployment tended to report higher WRQol scores than those who felt unprepared or unsure (see appendix 8 for more details).

4. Interpreting the Main Messages

The research questions addressed in this report focused on the challenges that nurses, midwives, AHPs, social care workers and social workers faced, working in health and social care during the first wave of the COVID-19 pandemic, and examined what they were doing to cope with these challenges. We asked questions to identify the challenges, what has mitigated or exacerbated them, and how staff have coped. We were interested in positive and negative coping and how a range of factors impacted on feelings of wellbeing and quality of working life. We used statistical regression modelling to find out if coping mechanisms predicted wellbeing and if coping methods were related to working quality of life. We accounted for this across occupational groups and regions of the UK so that we can draw comparisons and learning to share with employers, professional bodies, regulators and relevant stakeholders.

4.1 Limitations

This cross-sectional survey was based on a convenience sample of health and social care workers and therefore the results cannot be interpreted as a representative sample. Furthermore, there is not an even distribution of responses across the four UK countries nor across work settings and types, so the results cannot be considered representative across countries nor occupational groups. Another limitation worth noting is the self-report nature of the survey as participants may have been motivated to complete the survey due to personal bias or negative experiences which have the potential to skew the results. Results should be read with these limitations in mind.

4.2 Discussion and Recommendations

Overall, COVID-19 has amplified some of the strengths of the UK health and social care workforce. They have risen to the challenge but at some cost. The recommendations from this study therefore reflect not just learning from the COVID-19 pandemic but also sheds light on some wider rewards from health and social care working conditions and some endemic problems. While a global pandemic may be a rare but catastrophic event, there are crises at times (of different proportions) and multiple everyday difficult contexts for which the health and social care workforce always needs to be well-prepared, resilient, and well-supported. These recommendations are specific to COVID-19 however for employers and policy makers. Many apply across health and social care in the context of increased interest in working together from across the UK.

Our survey has revealed the considerable commonalities of human service work but also differences. These apply particularly to the location of work; being on the frontline means different things if a person is working on a hospital unit or in a care home, generally with people who are very ill or at some risk of death. There are different tensions and risks from using the home as an office and yet further differences when working in other people's homes and travelling. Commonalities among the workforce are their stated altruistic concerns for service users and patients; the very reason why most people work in health and social care. While others have rightly suggested that compassion is important in relation to human services work (West et al 2020), our survey also points to the importance of employment rights, terms and conditions (equipment, safety, sick pay, communications and information).

Our survey is not the final word, of course, but suggests some new areas for workforce thinking and HR practice. For example, what enabled some people to view their experiences during the first wave of COVID-19 as generally positive; did this relate to their disposition or to their work context? There may be much to learn from this group and to find out whether they were generally satisfied with work pre-COVID-19 or if they were particularly impressed by their managers' actions or local contexts. For example, in some cases, respondents noted how practices and routines for line management and team communication had become more effective in response to the pandemic, leading to feelings of being better supported than before. It is important for employers and managers to identify where changes to their approach led to more beneficial outcomes for workers, and evaluate how these changes can be

sustained in a post-COVID-19 work environment. We were able to compare results from McFadden (et al 2019) that shows a consistent level of social worker well-being prior to and during the COVID-19 pandemic. This was in terms of age band and gender.

We have noted some differences between groups in terms of their coping mechanisms that may be of interest to HR and employers more generally. For example, while not all younger staff are keen on exercise, we found that younger staff and men reported this was important to their wellbeing; is there room to offer rewards around this such as discounts or incentives? While IT proved so valuable in terms of communications and support, can we be confident that all workers are IT literate and not further disadvantaged by limits of access or capability. Has COVID-19 prompted new skills in this area? Again, there is room for employers to consider these points in their After-Action Reviews or Lessons Learned reviews following the first wave of the virus.

Our findings suggest that emotional and psychological support for staff was important in helping reduce the risks of negative work effects during the pandemic. For employers this means enabling this to be part of workplace culture since it is unlikely to manifest itself during a pandemic or crisis if not already existing. Such skills have to be learned, infuse an organisation and its work units or teams. There are potential needs to explore if they are provided and received by staff at all levels. This would seem a corporate responsibility, not just an individual responsibility. As noted above, the provision of emotional and psychological support for staff is not just needed during a pandemic but should be the hallmarks of human service work.

Other findings throw a light on the redeployment of staff, which one in ten of our respondents overall had experienced, although this was not evenly spread with redeployment relating to one in five of our health respondents. While many felt neither unprepared or prepared there are questions to explore about team and individual working when under pressure or in extreme circumstances and what is to be adopted or rejected from new ways of working. While implementation scientists are likely to be working on such questions, it may take time for the evidence to come forward about patient/service user outcomes. In the meantime, some practices are likely to become widely adopted regardless of evidence but because they have improved work or services. Our study suggests however, the importance of taking care of those who took on extra work when their colleagues were redeployed or on sick leave and the possible risk of burnout or exhaustion. Trends in applications for early retirement may be a way of monitoring if these stresses have become overlooked. Employers also could take advantage of aspects of redeployment which seemed to have been interesting if not exciting. This experience may have given rise to new ambitions that could be harnessed.

Finally, our study raises the linked importance of family and work; unsurprising in the largely female dominated sectors of health and social care employment. We have no quick answers here but our findings suggest that for some staff the process of ‘segmenting’ work and family life was a positive coping practice. The long-term implications of this will need to be explored.

4.3 Good Practice Guidance

4.3.1 Improving Work Context and Conditions

1. Employers need to provide as far as possible increased flexibility around working hours, location of working, and recognition of additional childcare or other caring responsibilities to support the workforce during a pandemic or other crisis. The nature of a pandemic means that these are not easy to provide, of course, but communication and understanding of their importance will help staff feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about this would be one first step.

2. Training and development to equip staff with the ability to, where possible, perform multiple or new roles should be commissioned and rolled out. While this form of skill mix might be thought vital during times of high service demand where low staff levels affect the availability of critical skills within teams, it might also be helpful during 'normal' service delivery. This will need attention from employers, professional bodies, regulators, educational and training bodies, and service users and patient groups.

3. Some respondents called for more involvement in decision making, more autonomy and flatter hierarchies to equip staff with the ability to make faster, well-informed decisions in times of crisis. This was also thought to improve service delivery during normal service delivery times. Research is needed on patient/service user outcomes to see whether this view is borne out by the evidence. It would need to be integrated with the current reliance on evidence-based guidelines.

4. Policies about working from home (if appropriate) should be developed and equitably applied to avoid division and discontent and undermining of leadership and organisational commitment. If staff request or are asked to work from home, they should be able to access equipment and technology support, to have relevant expenses met, and to be assured of supervision and peer support.

5. For those staff who need to be in the workplace steps should be taken to ensure social distancing, handwashing, use of sanitisers for shared equipment and use of large spaces to reduce the risk of viral spread. Workplaces need to ensure that there are plans for any crisis, such as fire and flood, not just pandemics. The flexible use of rota systems could assist in the number of employees needing to be present at one time and could be undertaken quickly in any crisis with the development of technology.

6. The "Clap for Carers" campaign may be an opportunity to re-examine both the societal recognition of the work done by health and social care workers but to also increase funding and the deployment of NHS and social care services, as well as the pay of health and social care workers (and making pay, terms and conditions fair for all).

7. Employers in the health and social care sector should ensure that their staff should not have to solely rely on Statutory Sick Pay in the event of illness. Policy and practice around staff sick pay should be reviewed and ameliorated urgently where necessary by employers.

8. Further consideration is needed about the most effective way of supporting and deploying temporary or agency staff who may have limited sick pay entitlements to Statutory Sick Pay (SSP). This could reduce the risks of staff going to work when unwell or infectious and does not, of course, apply only to the COVID-19 context.

9. Plans to obtain and sustain supplies, and to deploy appropriate PPE, should be developed by employers and public health bodies at times of crises such as pandemics for staff in direct contact with people. Such plans should be regularly reviewed by a regulator.

4.3.2 Improving Connections and Communication

1. Connection to colleagues and managers is critical during a pandemic or any other crisis, and regular and frequent communication is required, in person or virtual, to increase personal and professional connection and employee engagement and organisational commitment. This needs to be tailored to the needs of the service, the team or individuals. There should be development of evidence-based good practice guidance that meets the broad range of health and social care services by national bodies.

2. Employers are accountable and hold corporate responsibility for ensuring that employees are provided with up to date guidelines. Any change to guidelines should be monitored by those holding management responsibility to interpret changes and guide staff and other managers on best practice recommendations. This should result in clear messages and reduce the risk of contradictory or confusing guidance.

3. Managers should be visible, either in person (if possible) or virtually, so that workers feel they are as valued as those in management positions.

4. Staff concerns for service user or patient wellbeing needs to be taken seriously by management and evidenced by opportunities to discuss individual concerns in peer or one to one supervision. Staff empathy is an important driver for motivation, job satisfaction and commitment and needs fostering.

5. Managers need to ensure where possible that staff are supported and encouraged to take leave if possible or to carry it over without penalty in crisis situations.

6. Staff concerns about contracting infections should be viewed as an indication of their commitment to their job and concern for the wellbeing of their families and themselves. Staff's concerns should be listened to and reasonable actions taken to alleviate concerns.

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6. Appendices

Appendix 1: Original Study Research Protocol

Health and social care workers' quality of working life and coping while working during a Covid-19 Pandemic

Research Question: 'What are the challenges that nurses, midwives, AHPs, social care workers and social workers face working in health and social care during a pandemic and what are they doing to cope with them?

Aim: This study aims to explore the impact of providing health and social care during a pandemic on nurses, midwives, AHPs, social care workers and social workers.

Objectives:

1. To gather relevant demographic information from a cross sectional convenience sample of nurses, midwives, AHPS, social care workers and social workers in the UK.
2. To determine nurses, midwives, AHPs, social care workers and social workers perspectives on the challenges they are facing while providing health and social care during a pandemic.
3. To measure mental health and wellbeing, quality of working life and home and work interface.
4. To find out what coping strategies are used by frontline staff during the time of a pandemic.
5. To explore health care workers perspectives on employers supports, improvements on employer supports and suggestions for employers' support for future pandemics based on their experience and learning from the current COVID-19 pandemic.

Methodology:

The chosen method is an online survey which affords anonymous responses, at low cost and is easily distributed to a large number of participants across a wide geographical area (Sarantakos, 2005). The survey is designed to meet the objectives of the study and is informed by a review of the literature. This predominantly quantitative questionnaire will contain validated and reliable standardised scales, and will comprise 6 sections (See Appendix 1 for Scale information):

1. Demographics: age, gender, ethnicity, disability, marital/partner status, caring responsibilities, professional area of work, job tenure and role, time of professional qualification, hours of work, additional hours (over contracted hours) (Objective 1 – 17 items).
2. Quality of Working Life Scale (QOWLS) Objective 2 – 24 items
3. Short Warwick Edinburgh Mental Well-being Scale (SWEMWS) Objective 3 – 7 items
4. Brief COPE Scale [iii] Objective 4 - 28 Items
5. Clark et al. Coping with Work and Family Stressors Scale [iv]- Objective 4-15 items
6. Qualitative questions to explore workforce perspective- Objective 5- 4 items

The Quality of Working Life Scale (QOWLS) contains 24 items, each using a Likert scale measure which gauges the perceived quality of life of employees as measured through six psychosocial sub-factors. The Short Warwick Edinburgh Mental Well-being Scale (SWEWS) (7 items) enables the monitoring of mental wellbeing. Carver (1997) originally developed the brief COPE to measure 14 different coping strategies: self-distraction, active coping, denial, substance use, using emotional support, using instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. Brief COPE has been used widely (Meyer, 2001; Welbourne et al., 2007) and has

acceptable reliability (Carver, 1997; Muhonen & Torkelson, 2005). Respondents rate each item on a 4-point scale from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot) to indicate how they coped while working in health and social care during the COVID-19 pandemic. A further 15 selected items from Clark' et al's (2014) Coping with Work and Family Stressors Scale will capture information about strategies for dealing with family and work segmentation, work to improve skills/efficiency, recreation /relaxation and exercise.

There are some additional open-ended questions and at the end of the survey, participants can add any additional information or perspectives that they may have about working in health and social care during COVID-19.

Participants:

Nurses, midwives, AHPs, social care workers and social workers in the UK who have signed up to receive newsletters or journals from professional associations, workplace unions and regulators such as Royal College of Nursing (RCN), Royal College of Midwives (RCM), the Northern Ireland Practice and Education Council (NIPEC), Northern Ireland Social Care Council (NISCC), the Royal College of Occupational Therapists, British Dietetic Association and others. In order to reach as wide a population of nurses, midwives, AHPs, social care workers and social workers in the UK as possible who are working in health and social care during the COVID-19 pandemic, social media platforms such as Twitter and Facebook will also be used to advertise the survey and provide an electronic link to the Participant Information Sheet, consent and survey.

Inclusion criteria:

Nurses, midwives, AHPS, social care workers and social workers at any band who are currently employed or self-employed (including agency workers), within any area of health and social care in the UK during the COVID-19 Pandemic.

Exclusion Criteria:

Health and social care professionals who are not nurses, midwives, AHPS, social care workers and social workers at any band who are currently employed or self-employed (including agency workers), working in Health and Social Care in the United Kingdom during the COVID-19 Pandemic.

Sampling:

The survey will draw on a convenience sample of those who choose to participate following receipt of communication in a newsletter/journal from RCN/RCM/NIPEC/ NI SCC and other professional associations and workplace Unions or those who have accessed the survey on social media. The number of nurses and midwives in the UK is 660,213 and 37,255 respectively (NMC Register 2019). Using the Raosoft sample calculator (http://www.raosoft.com/samplesize.html) with a confidence interval of 95%, the sample we would like to recruit is 384 nurses and 381 midwives. The number of AHPs working in health and social care in the UK is 152,000 (Allied Health Professions Federation, 2020). Using the Raosoft sample calculator (http://www.raosoft.com/samplesize.html) with a confidence interval of 95%, the sample we would like to recruit is 384. The number of social care workers and social workers in Northern Ireland is 37779 and 6357 respectively. Using the Raosoft sample calculator (http://www.raosoft.com/samplesize.html) with a confidence interval of 95%, the sample we would like to recruit 381 social care workers and 363 social workers.

Access and Recruitment:

Nurses, midwives, AHPs, social care workers and social workers who have signed up to receive professional newsletters or journals from professional associations, workplace unions and regulators will have access to information about the research and can open a link to the survey from the invitation to take part in the research. In addition, nurses, midwives, AHPs,

social care workers and social workers will be able to access information about the research and can open a link to the survey via social media such as Twitter and Facebook. All participants will be encouraged to share the invitation to the research with nursing, midwifery, AHPs, social care workers and social worker colleagues who work in the UK.

Submitted survey data will be anonymous as the Qualtrics © software on which the survey is hosted, enables the IP address of the survey respondent to be deleted. The participants will be advised that their details will not be shared, nor be identifiable to researchers in any subsequent publications. They will able to withdraw from the study at any time by not completing the survey. Clicking on the arrow to proceed after the PIS and completion of the survey will indicate consent.

Data Collection:

A short invitation to take part in the survey will include a link to the Participant Information Sheet and the survey. Participants will be requested to indicate that they have read the Participant Information prior to completing the survey by clicking on an arrow that will take them to the survey. The survey will be open for 4 weeks. The guidance provided by INVOLVE (2014) re the use of social media to actively involve people in research has been followed.

Development of the questionnaire:

The survey has been informed by a review of the literature and is made up of a combination of 4 previously validated questionnaires with open ended questions which are specifically designed to elicit the quality of working life and coping strategies of the participants who were working in health and social care during a pandemic. The draft survey has been reviewed and commented on by academics with expertise in questionnaire development, nurses, midwives, AHPs, social care workers and Social workers. Amendments have been made in response to that feedback.

Data Analysis:

The survey results will be analysed using SPSS 24. Descriptive statistics will provide frequency distribution for both nominal and ordinal data along with percentages and cumulative percentages. A series of inferential statistics will be analysed to examine findings. Qualitative data will be analysed for themes Braun and Clarke's (2006) thematic analysis framework.

Ethical Considerations:

The research team is aware that health and social care workers employed on the front line during a pandemic are already under pressure. However, it is important to carry out this research at this time as we need to find out what their work life is like at this time and what coping strategies they are using. The findings of this study will produce an evidence base that UK employers can use to make evidence informed, organisational level policy adjustments which will impact on the decisions about the support needs of the workforce, particularly during a pandemic. All permissions for use of scales have been sought.

While staff will be volunteering to undertake the survey, it is possible that during the completion of the survey that they may become distressed. Therefore, at both the bottom of the Participant Information Sheet and the end of the survey, the participants are provided with information about who to contact if they need support via a Distress Protocol.

Consent:

As this survey is online, participants will be requested to indicate that they have read the Participant Information prior to completing the questionnaire by clicking on an arrow at the end of the Participant Information Sheet, which will bring them to the first page of the survey.

Completion of the survey will be considered to be an indication of participants' voluntary consent.

Anonymity and Confidentiality:

The participants will access the survey through an anonymised link. Care will be taken when using the demographic information to ensure that no participant can be identified. No personal identification such as name or address will be collected.

Data Storage and Protection:

All of the electronic research materials and data will be anonymously stored on a password protected computer in a room in Ulster University, for 10 years. The materials will then be destroyed in line with the University policy. https://internal.ulster.ac.uk/research/rg/0613%20data%20handling%20procedure%20V1.pdf

All paper-based research materials will be stored in a locked filing cabinet in the University for 10 years and then destroyed in line with University GDPR and Data Protection legislation and policy.

Appendix 2: Weighting Representativeness for Country, Region and Occupation
Given the high level of representation of participants from Northern Ireland and of social workers in the sample, a two-factor weighting by occupation and region was applied to all summary statistics of the sample. Comparisons by occupation are weighted by region and comparisons by region are weighted by occupation.

Estimating the true population

We used professional registration to estimate the true number of participants in each category of health and social care worker surveyed where available:

Social Work

Social Work England, Social Care Wales, the Scottish Social Services Council and the Northern Ireland Social Care Council each publish registration numbers for social work.

https://www.socialworkengland.org.uk/media/2992/social-work-england-board-meeting-21-feb-2020.pdf

http://www.socialcaredata.wales/IAS/login?ReturnUrl=%2fIAS%2fresource%2fview%3fresourceId%3d2447&resourceId=2447

https://data.sssc.uk.com/images/WDR/WDR2018_AllTables.xlsx

https://niscc.info/storage/resources/boc-niscc-reportv02-1-1.pdf

98,210 social workers were registered in England. The only regional distribution of social workers we could obtain was for adult social services, published by NHS Digital.

https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-staff-of-social-services-departments/england-2018/content

The total number of adult social services SWs enumerated in England was 17,005. Regional numbers were multiplied by 98,210/17,005 to estimate total SW distribution within England. **This assumes that other services are similarly geographically distributed as adult social services.**

Social Care

Northern Ireland is the only region for which we were able to obtain a comprehensive estimate of social care employment. NISCC report 37779 social care workers, compared to 6357 social care workers (a ratio of 5.94). We estimated social care numbers in all other regions using the social work estimates for the region and multiplying by this ratio. **This assumes the ratio of social workers to social care workers is homogenous across the UK and that NISCC's reporting accurately captures this ratio.**

Nurses and Midwives

The Nursing and Midwifery Council publishes nurse and midwife registrant numbers for England, Wales, Scotland and NI.

https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/

NHS Digital publishes nurse and midwife numbers for England at regional level. There are 525,073 nurses registered and 337,092 NHS workers. Therefore, each regional nurse figure in the NHS Digital reporting was multiplied by a weighting of 525,073/337,092= 1.56. An identical procedure was followed for midwives.

Note in this instance that the English regions are aggregated differently from social services.

Table A2.1: Regional aggregation for NHS Digital

Social Services Reporting	NHS Reporting
London	London
South East	South East
South West	South West
East of England	East of England
East Midlands	Midlands
West Midlands	
Yorkshire & Humber	Yorkshire & North East
North East	
North West	North West

West and East Midlands are combined into Midlands; and North-East and Yorkshire are combined.

To estimate a breakdown in the smaller regions used on the survey, we used the ratio of adult social services social workers in the regions. For example, of the combined 2915 social workers in Yorkshire and North-East, 1,850 are in Yorkshire (63%). **We assume the same distribution for nurses and midwives in these regions.** Note that effect of this assumption on the final weighting is quite small, as these regions are recombined and further combined with other regions in order to adjust for very small survey responses in sub-categories (further details below).

Allied Health Professionals

The Health and Care Professions Council publishes a summary of registrants by profession, totaling 281,461 covering the entire UK. We subtracted biomedical and clinical scientists as these workers were not within the rubric of the study target (i.e., patient-facing workers). This gave a total of 252,053.

https://www.hcpc-uk.org/about-us/insights-and-data/the-register/registrant-snapshot-1-apr-2020/

Given the diversity of occupation, it was difficult to obtain any regional breakdown AHPs. Therefore, we distributed this numbers regionally using the combined average of the other professions (social work, nursing and midwifery).

Regional Aggregation for Weighting

There were instances in the survey where coverage of professions was low or zero in specific regions. Furthermore, the underlying population was largely calculated using NHS reporting of nursing and midwifery numbers, which aggregated regions to a higher level than was asked of survey responses.

Therefore, the following regions were combined for the calculation of weights:

Table A2.2: Regions for Calculation of Weights

Social Services Reporting	NHS Reporting	Aggregation for Weighting
London	London	London
South East	South East	South
South West	South West	
East of England	East of England	East & Midlands
East Midlands	Midlands	
West Midlands		
Yorkshire & Humber	Yorkshire & North East	North & Yorkshire
North East		
North West	North West	

Table A2.3: Final Estimated Population and Distribution

	London	South	Midlands and East	North & Yorkshire	England Total	Scotland	Wales	Northern Ireland	Total
Nursing	91845.6	117972.1	147743.6	167606.8	525168.0	66084.0	34661.0	23953.0	649866.0
	5.18%	6.66%	8.34%	9.46%	29.63%	3.73%	1.96%	1.35%	36.67%
Midwifery	5760.5	7327.6	9100.5	9036.6	31225.2	3360.0	1663.0	1212.0	37460.2
	0.33%	0.41%	0.51%	0.51%	1.76%	0.19%	0.09%	0.07%	2.11%
Allied Health Professional	37638.1	47468.8	60194.7	69215.4	214517.0	17624.0	11819.0	8093.0	252053.0
	2.12%	2.68%	3.40%	3.91%	12.10%	0.99%	0.67%	0.46%	14.22%
Social Care Worker	102452.3	127336.0	163202.9	190660.8	583652.0	63274.0	37220.4	37779.0	721925.4
	5.78%	7.19%	9.21%	10.76%	32.93%	3.57%	2.10%	2.13%	40.74%
Social Worker	2985.0	3710.0	4755.0	5555.0	17005.0	10647.0	6263.0	6357.0	40272.0
	0.97%	1.21%	1.55%	1.81%	5.54%	0.60%	0.35%	0.36%	6.85%
	254130.4	**320506.5**	**406431.0**	**467338.1**	1448406.0	**157629.0**	**89963.4**	**76182.0**	**1772180.4**

Table A2.4 Observations by Region and Occupation (where responses were provided by participants)

	London	South	Midlands and East	North & Yorkshire	England (Region Not Specified)	Scotland	Wales	Northern Ireland	Total
Nursing	8.0	9.0	5.0	7.0	29.0	4.0	5.0	152.0	190.0
	0.26%	0.29%	0.16%	0.23%	0.95%	0.13%	0.16%	4.98%	6.22%
Midwifery	15.0	7.0	1.0	3.0	26.0	5.0	53.0	81.0	165.0
	0.49%	0.23%	0.03%	0.10%	0.85%	0.16%	1.74%	2.65%	5.40%
AHP	23.0	40.0	46.0	28.0	137.0	19.0	26.0	175.0	357.0
	0.75%	1.31%	1.51%	0.92%	4.49%	0.62%	0.85%	5.73%	11.69%
Social Care Worker	21.0	48.0	26.0	59.0	154.0	55.0	34.0	925.0	1168.0
	0.69%	1.57%	0.85%	1.93%	5.04%	1.80%	1.11%	30.29%	38.24%
Social Worker	111.0	130.0	103.0	175.0	519.0	33.0	58.0	564.0	1174.0
	5.83%	7.66%	5.93%	8.91%	28.32%	3.80%	5.76%	62.12%	100.00%

Weights were calculated by dividing the observed percentage by the estimated true percentage within cells for two-factor weights, within rows for occupational weights and within columns for regional weights.

Appendix 3: Descriptive Results – Tables and Charts

A3.1 Gender of Respondents

The majority of respondents are female. The gender distribution across country is similar. All midwifery respondents are female, whilst Nursing has the highest percentage of males.

Figure A3.1: Gender by Country

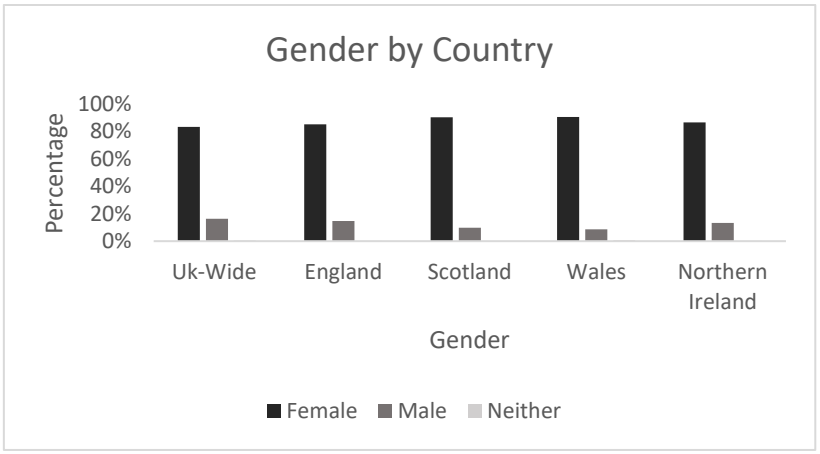


Table A3.1: Gender by Country

Gender	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	83.3%	85.1%	90.3%	90.6%	86.5%
Male	16.3%	14.6%	9.7%	8.7%	13.4%
Neither	0.4%	0.3%	0.0%	0.7%	0.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.2: Gender by Occupation

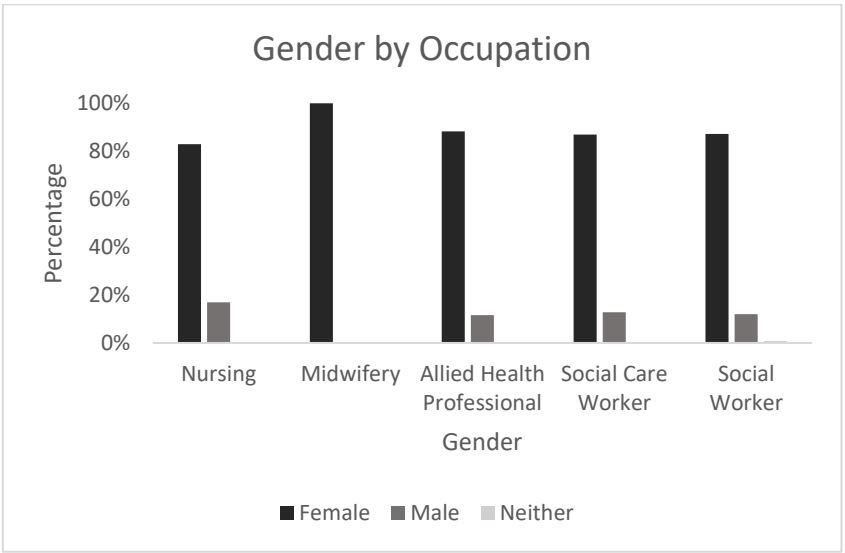


Table A3.2: Gender by Occupation

Occupation	Female	Male	Neither	Total
Nursing	83.0%	17.0%	0.0%	**100%**
Midwifery	100.0%	0.0%	0.0%	**100%**
Allied Health Professional	88.3%	11.6%	0.1%	**100%**
Social Care Worker	86.9%	12.8%	0.3%	**100%**
Social Worker	87.2%	12.0%	0.8%	**100%**

A3.2 Age of Respondents

The respondents were mainly from the 30-59 age bracket. The fewest number of respondents were 16-19 and 60+. Respondents in Scotland are generally younger than in the other countries in the UK, whereas England and Wales are older.

Figure A3.3: Age of Respondents by Country

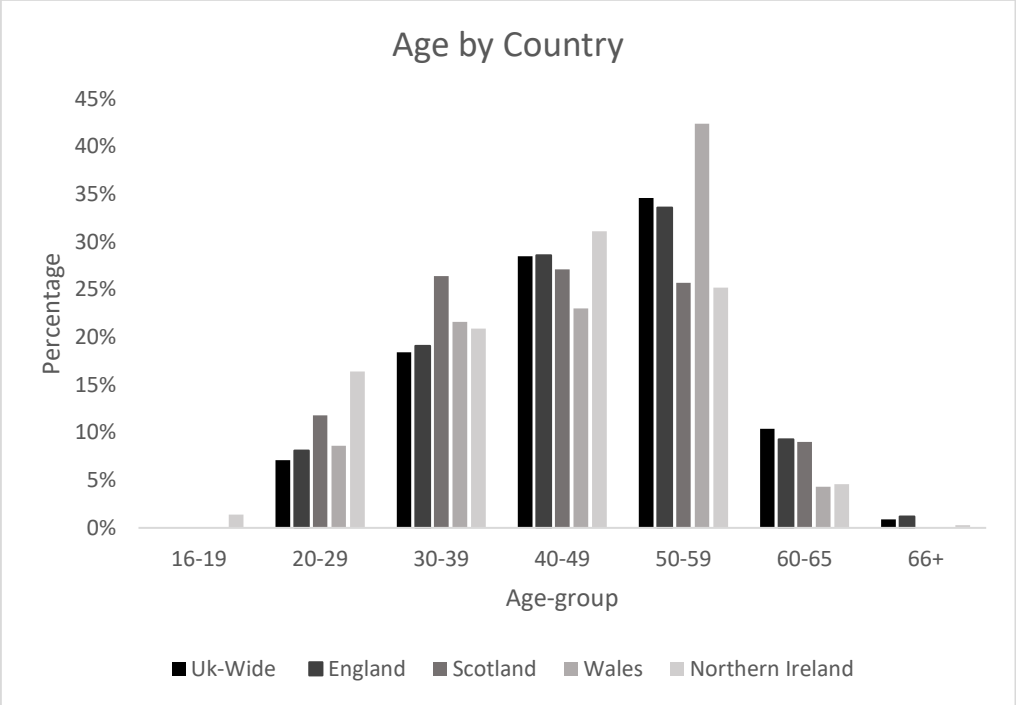


Table A3.3: Age of Respondents by Country

Age-group	UK-Wide	England	Scotland	Wales	Northern Ireland
16-19	0.1%	0.0%	0.0%	0.0%	1.4%
20-29	7.1%	8.1%	11.8%	8.6%	16.4%
30-39	18.4%	19.1%	26.4%	21.6%	20.9%
40-49	28.5%	28.6%	27.1%	23.0%	31.1%
50-59	34.6%	33.6%	25.7%	42.4%	25.2%
60-65	10.4%	9.3%	9.0%	4.3%	4.6%
66+	0.9%	1.2%	0.0%	0.0%	0.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The majority of Nursing and Social Worker respondents fall into the 50-59 age bracket, whilst the other professions are mainly in the younger 40-49 age range.

Figure A3.4: Age of Respondents by Occupation

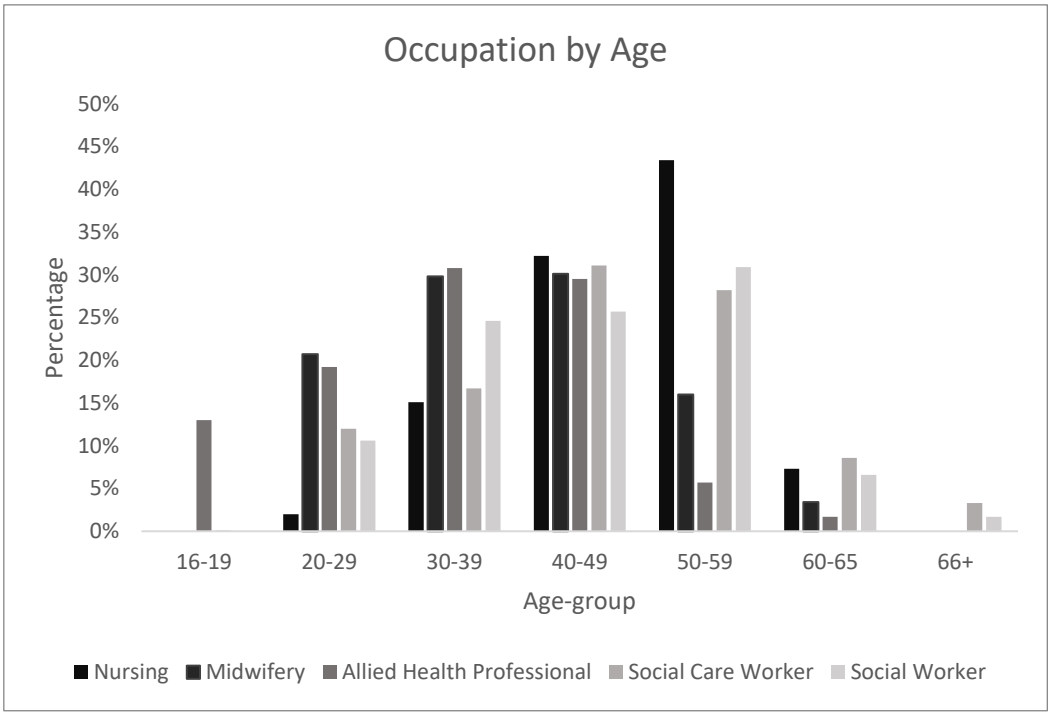


Table A3.4: Age of Respondents by Occupation

Occupation	16-19	20-29	30-39	40-49	50-59	60-65	66+	Total
Nursing	0.0%	2.0%	15.1%	32.2%	43.4%	7.3%	0.0%	**100%**
Midwifery	0.0%	20.7%	29.8%	30.1%	16.0%	3.4%	0.0%	**100%**
Allied Health Professional	0.0%	13.0%	19.2%	30.8%	29.5%	5.7%	1.7%	**100%**
Social Care Worker	0.1%	12.0%	16.7%	31.1%	28.2%	8.6%	3.3%	**100%**
Social Worker	0.0%	10.6%	24.6%	25.7%	30.9%	6.6%	1.7%	**100%**

A3.3 Ethnic Origin of Respondents

Almost all participants were white in all four countries of the UK and England was the most ethnically diverse.

Figure A3.5: Ethnic Origin of Respondents by Country

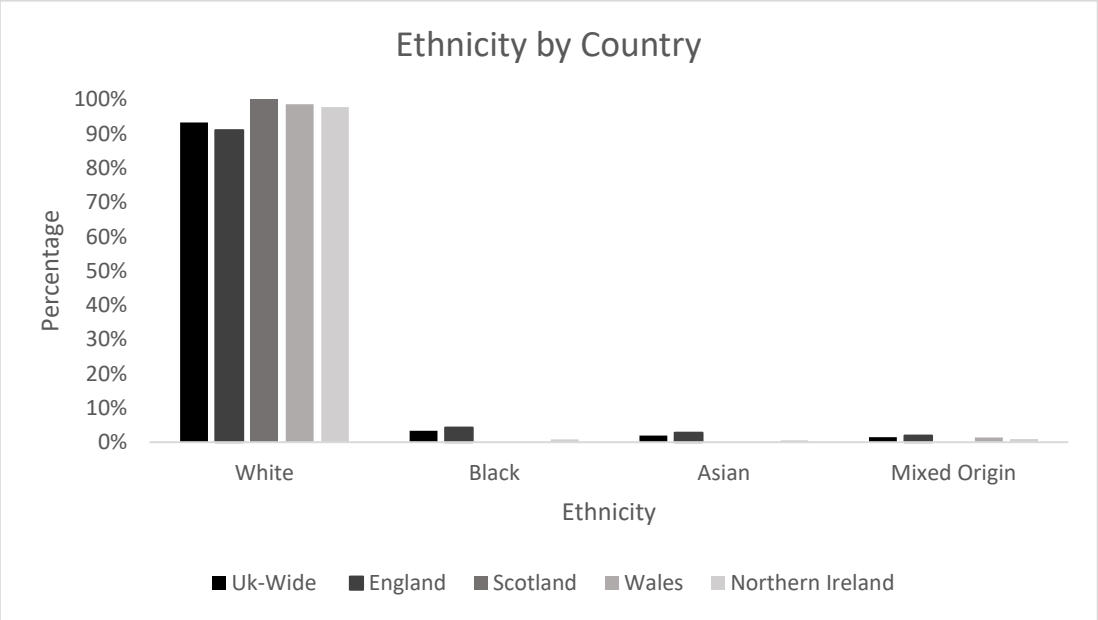


Table A3.5: Ethnic Origin of Respondents by Country

Ethnicity	UK-Wide	England	Scotland	Wales	Northern Ireland
White	93.3%	91.1%	100.0%	98.6%	97.8%
Black	3.3%	4.3%	0.0%	0.0%	0.8%
Asian	1.9%	2.8%	0.0%	0.0%	0.5%
Mixed Origin	1.5%	1.9%	0.0%	1.4%	0.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.6: Ethnicity by Occupation

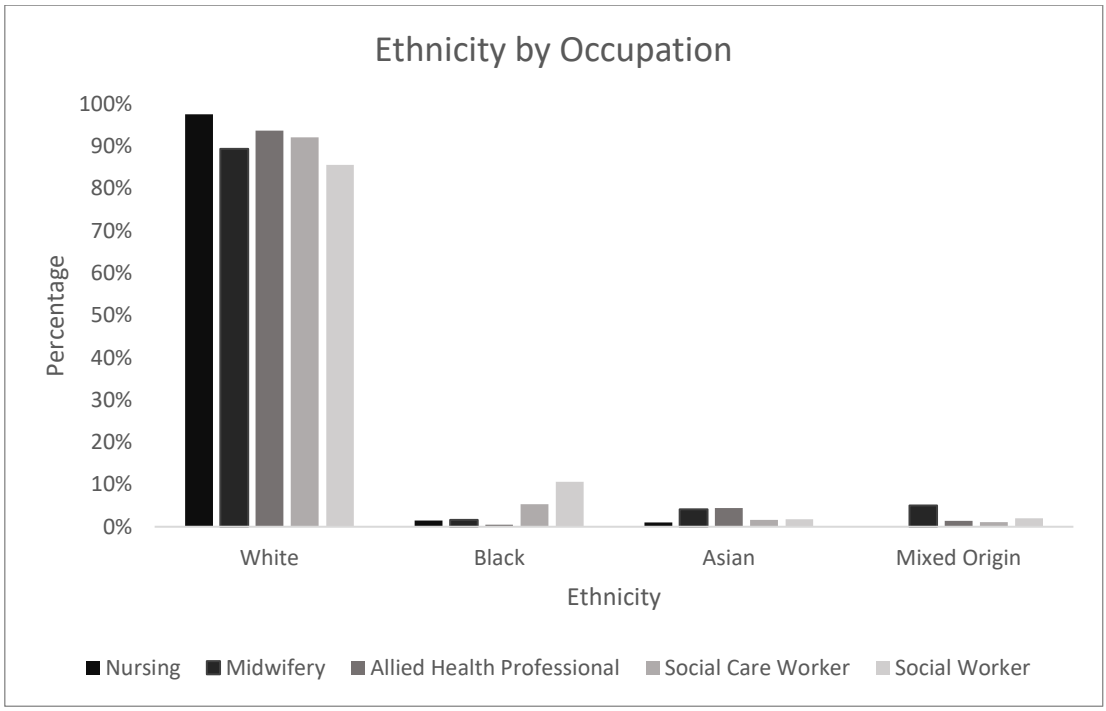


Table A3.6: Ethnicity by Occupation

Occupation	White	Black	Asian	Mixed Origin	Total
Nursing	97.6%	1.5%	1.0%	0.0%	**100%**
Midwifery	89.4%	1.6%	4.1%	5.0%	**100%**
Allied Health Professional	93.7%	0.5%	4.4%	1.4%	**100%**
Social Care Worker	92.1%	5.3%	1.6%	1.1%	**100%**
Social Worker	85.6%	10.6%	1.8%	2.0%	**100%**

A3.4 Country of Respondents

Over half (57%) of the respondents were from Northern Ireland. Given the skewedness towards respondents from Northern Ireland, as well as Social Workers and Social Care Workers, the results presented in this report have been weighted by Region and Occupation.

Figure A3.7: Country of Respondents

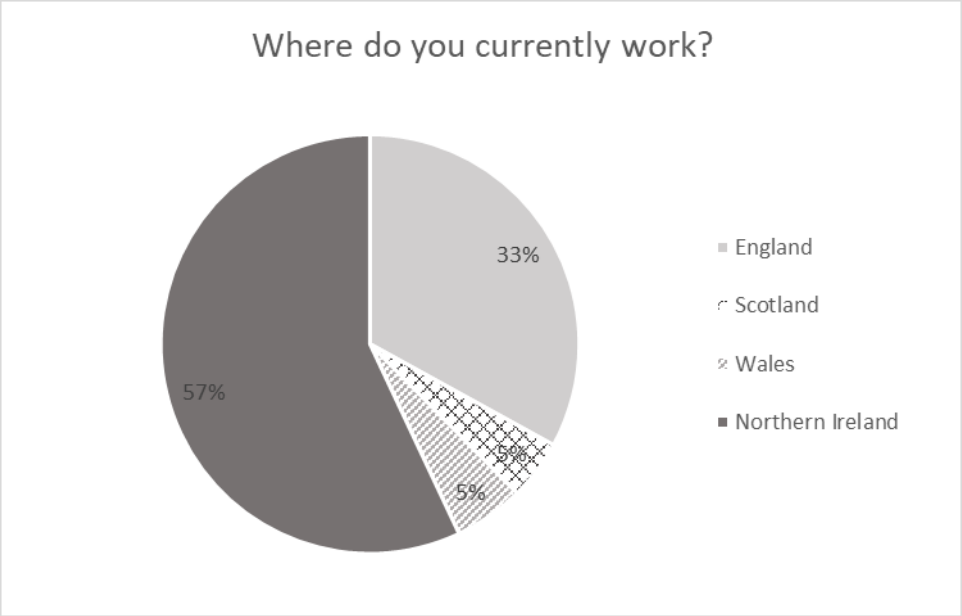
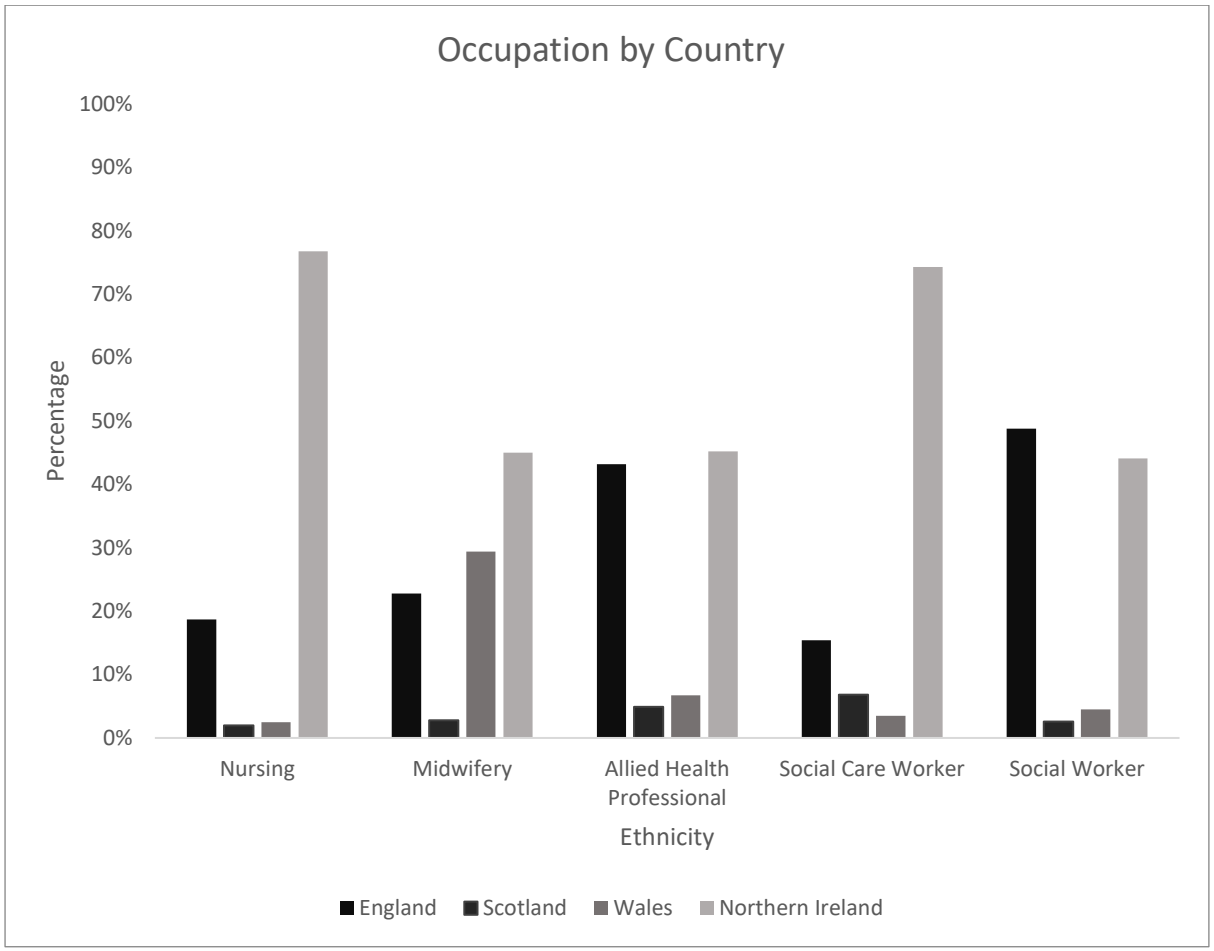


Table A3.7: Country of Respondents by Occupation

Occupation	England	Scotland	Wales	Northern Ireland	Total
Nursing	18.7%	2.0%	2.5%	76.8%	**100%**
Midwifery	22.8%	2.8%	29.4%	45.0%	**100%**
Allied Health Professional	43.2%	4.9%	6.7%	45.2%	**100%**
Social Care Worker	15.4%	6.8%	3.5%	74.3%	**100%**
Social Worker	48.8%	2.6%	4.5%	44.1%	**100%**

Figure A3.8: Occupation by Country



A3.5 Respondents working in Hospital, Community-Based, or Both

The majority of respondents work in the community.

Figure A3.9: Hospital, Community-Based, or Both by Country

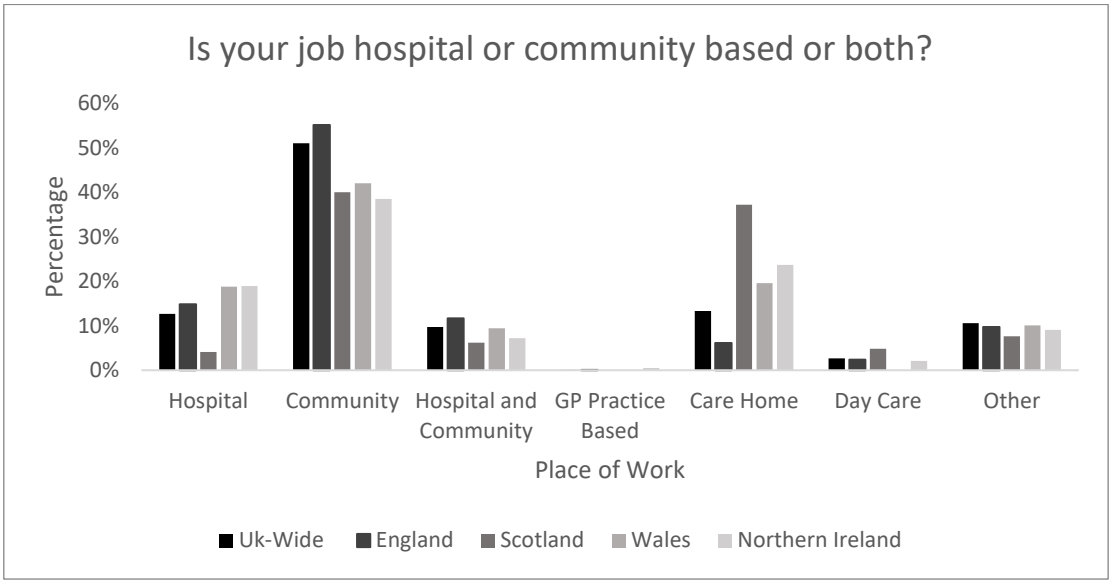


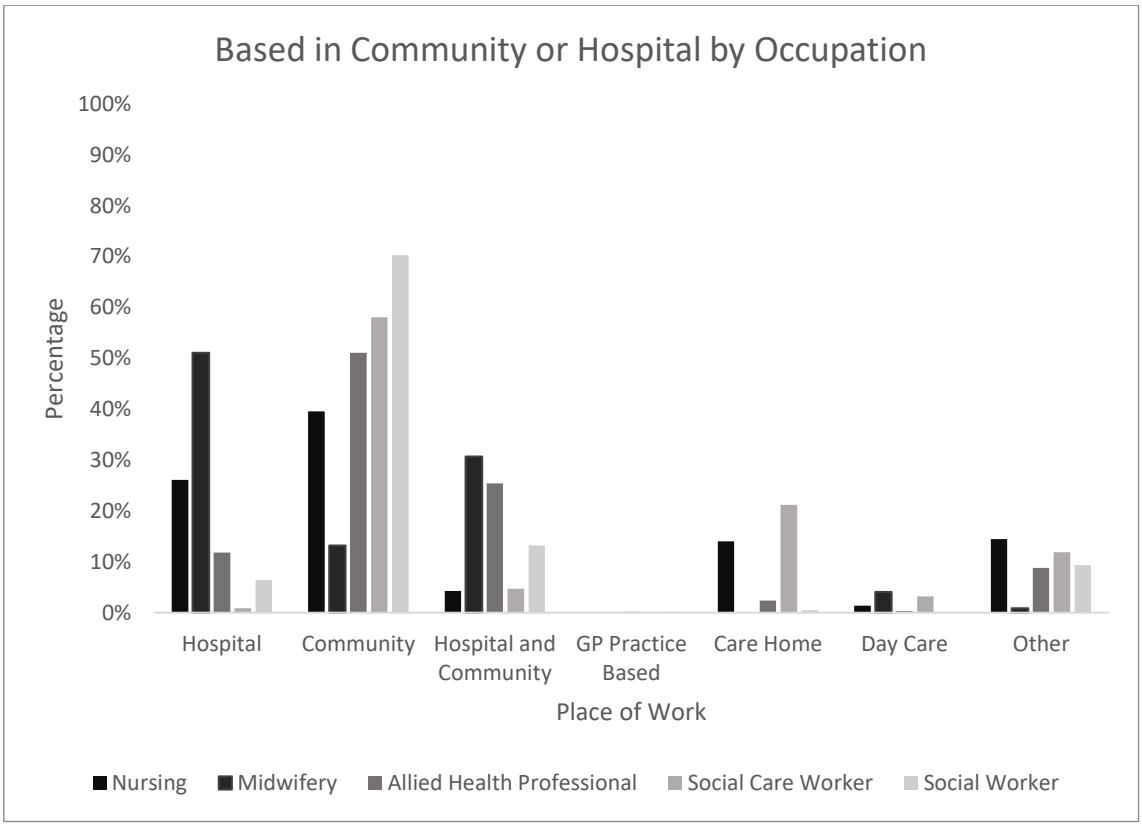
Table A3.8: Hospital, Community-Based, or Both by Country

Is your job hospital or community based or both?	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	12.7%	14.8%	4.1%	18.8%	18.9%
Community	51.0%	55.1%	40.0%	42.0%	38.5%
Hospital and Community	9.7%	11.7%	6.2%	9.4%	7.2%
GP Practice Based	0.1%	0.1%	0.0%	0.0%	0.5%
Care Home	13.3%	6.1%	37.2%	19.6%	23.7%
Day Care	2.7%	2.4%	4.8%	0.0%	2.1%
Other	10.6%	9.7%	7.6%	10.1%	9.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.9: Hospital, Community-Based, or Both by Occupation

Occupation	Hospital	Community	Hospital and Community	GP Practice Based	Care Home	Day Care	Other	Total
Nursing	26.1%	39.6%	4.3%	0.0%	14.0%	1.4%	14.5%	**100%**
Midwifery	51.1%	13.2%	30.7%	0.0%	0.0%	4.1%	0.9%	**100%**
Allied Health Professional	11.8%	51.1%	25.4%	0.2%	2.4%	0.3%	8.8%	**100%**
Social Care Worker	0.9%	58.1%	4.7%	0.0%	21.2%	3.2%	11.9%	**100%**
Social Worker	6.4%	70.3%	13.2%	0.2%	0.5%	0.1%	9.4%	**100%**

Figure A3.10: Hospital, Community-Based, or Both by Place of Occupation



The majority of midwives work in hospitals. Respondents from all other professions are most likely to work in the community.

A3.6 Occupation of Respondents

Most of the sample are Social Work and Social Care Workers, followed by AHPs.

Figure A3.11: Occupation of Respondents

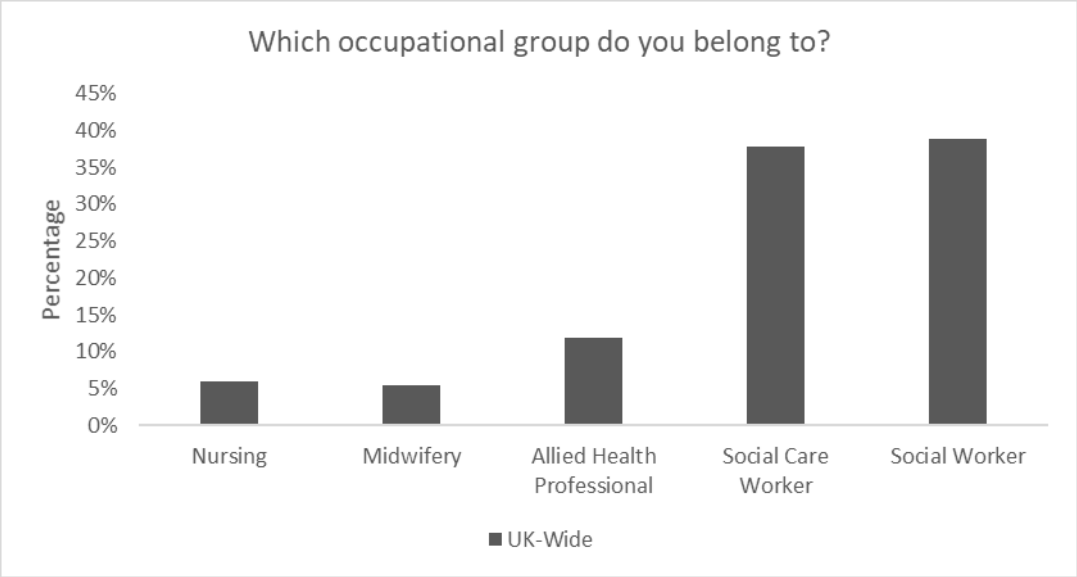


Table A3.10: Occupation of Respondents

Occupation	UK-Wide	No
Nursing	6.0%	199
Midwifery	5.5%	180
Allied Health Professional	11.8%	388
Social Care Worker	37.8%	1245
Social Worker	38.9%	1282
Total	**100%**	**3294**

NB: The survey received 3290 responses; of the responses 1897 were from Northern Ireland, 1062 were from England, 146 were from Scotland and 185 were from Wales. Most of the sample were social workers (1282) and social care workers (1245), followed by AHPs (388), nurses (199) and midwives (190). The difference between the country responses rates and professional occupational rates are explained by some respondents not indicating which country they were from.

A3.7 Banding of Respondents

The majority of the sample are in Band 6 across all countries of the UK, with the exception of NI which had most in Bands 2 or 3, and the majority of these are midwives.

Figure A3.12: Banding of Respondents by Country

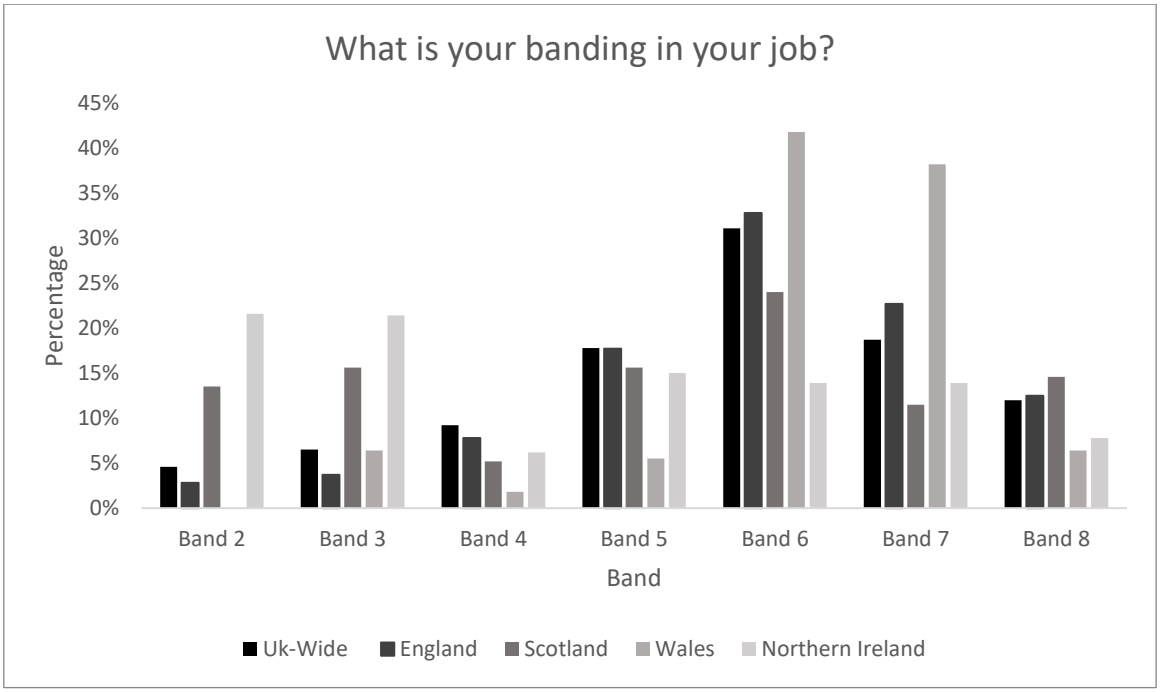


Table A3.11: Banding of Respondents by Country

Band	UK-Wide	England	Scotland	Wales	Northern Ireland
Band 2	4.6%	2.8%	13.5%	0.0%	21.6%
Band 3	6.5%	3.7%	15.6%	6.4%	21.4%
Band 4	9.2%	7.8%	5.2%	1.8%	6.2%
Band 5	17.8%	17.7%	15.6%	5.5%	15.0%
Band 6	31.1%	32.8%	24.0%	41.8%	13.9%
Band 7	18.7%	22.7%	11.5%	38.2%	13.9%
Band 8	12.0%	12.5%	14.6%	6.4%	7.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.13: Banding of Respondents by Occupation

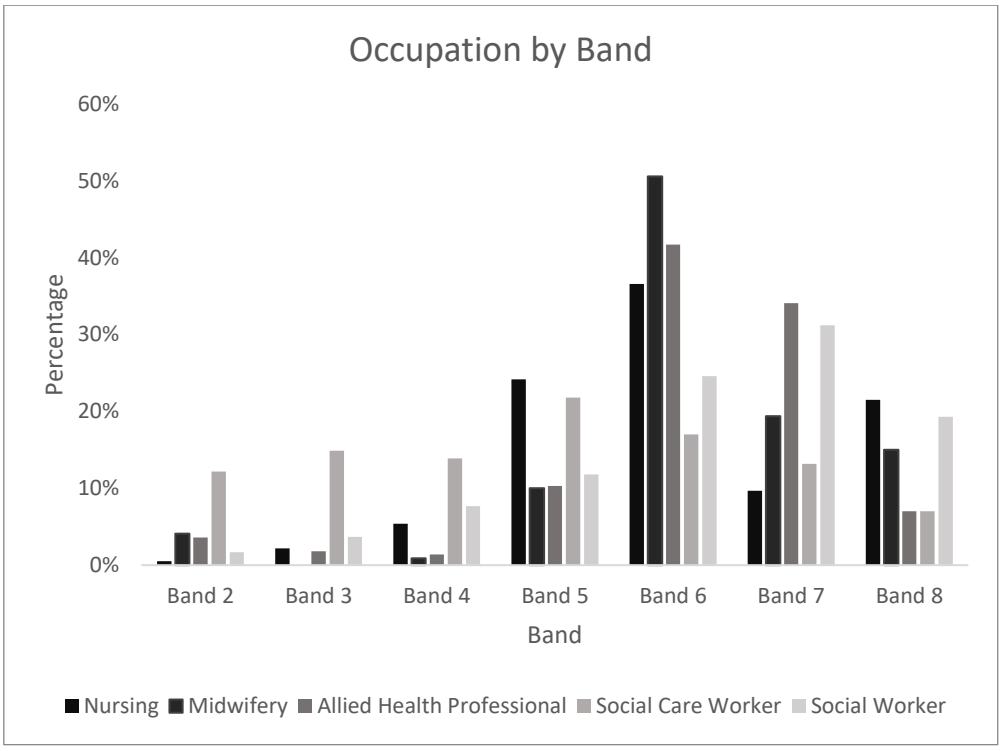


Table A3.12: Banding by Occupation

Occupation	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Total
Nursing	0.5%	2.2%	5.4%	24.2%	36.6%	9.7%	21.5%	**100%**
Midwifery	4.1%	0.0%	0.9%	10.0%	50.6%	19.4%	15.0%	**100%**
Allied Health Professional	3.6%	1.8%	1.4%	10.3%	41.7%	34.1%	7.0%	**100%**
Social Care Worker	12.2%	14.9%	13.9%	21.8%	17.0%	13.2%	7.0%	**100%**
Social Worker	1.7%	3.7%	7.7%	11.8%	24.6%	31.2%	19.3%	**100%**

A3.8 Respondents Redeployed due to COVID-19

The vast majority were not redeployed due to Covid-19. Those redeployed were mainly midwives.

Figure A3.14: Redeployment by Country

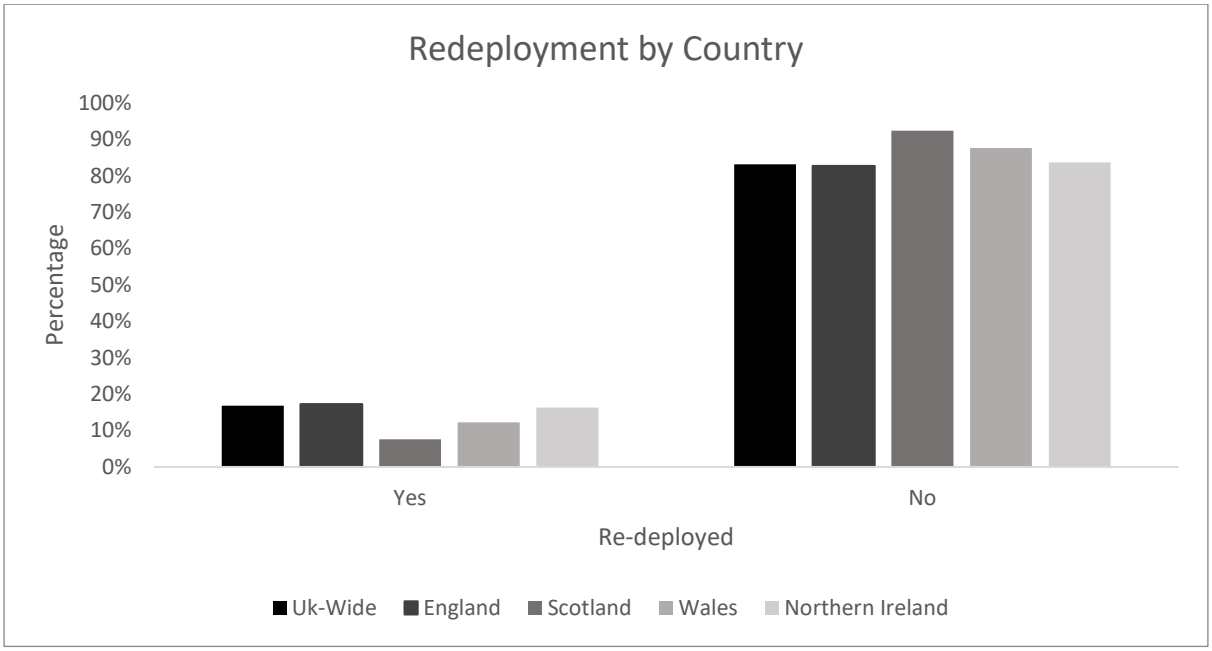


Table A3.13: Redeployment by Country

Redeployed	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	16.8%	17.3%	7.6%	12.3%	16.3%
No	83.2%	82.7%	92.4%	87.7%	83.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.15: Redeployment by Occupation

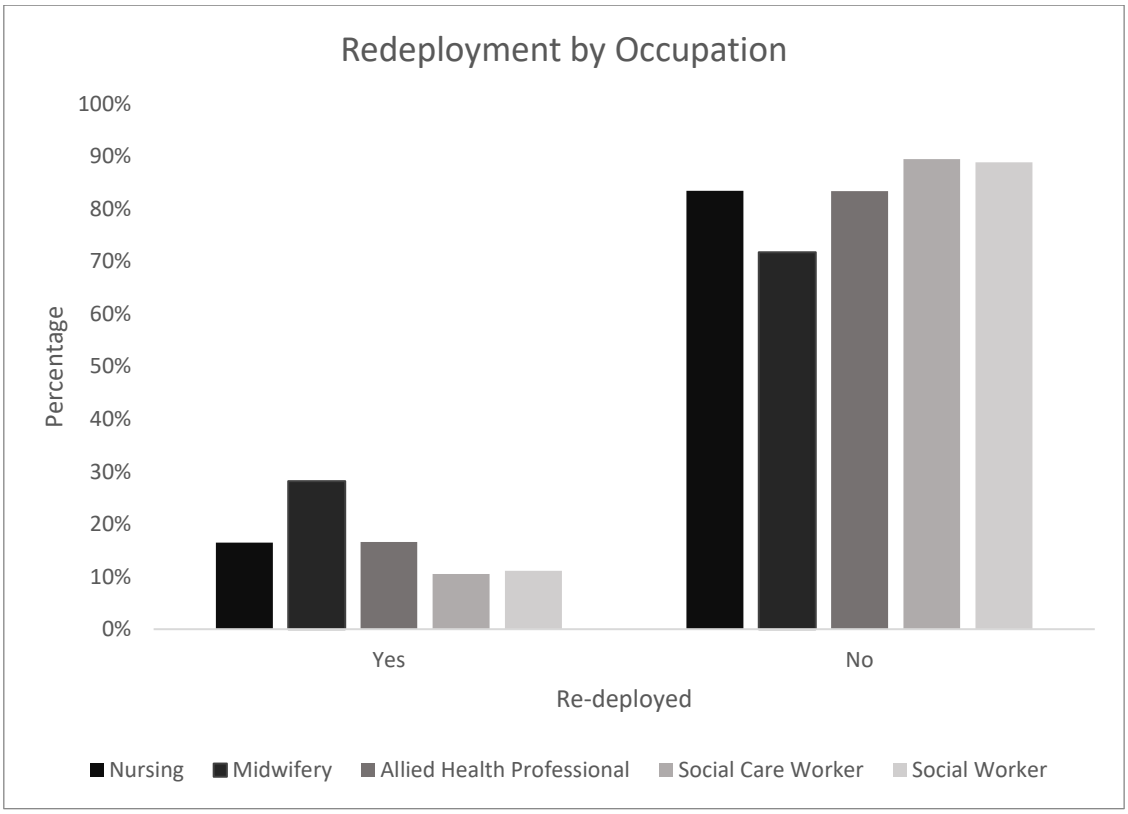


Table A3.14: Redeployment by Occupation

Occupation	Yes	No	Total
Nursing	16.5%	83.5%	**100%**
Midwifery	28.2%	71.8%	**100%**
Allied Health Professional	16.6%	83.4%	**100%**
Social Care Worker	10.5%	89.5%	**100%**
Social Worker	11.1%	88.9%	**100%**

A3.9 Preparedness of Redeployed Respondents

Respondents from Scotland reported feeling least prepared for redeployment. Nurses were least prepared of all the professions.

Figure A3.16: Preparedness for Redeployment by Country

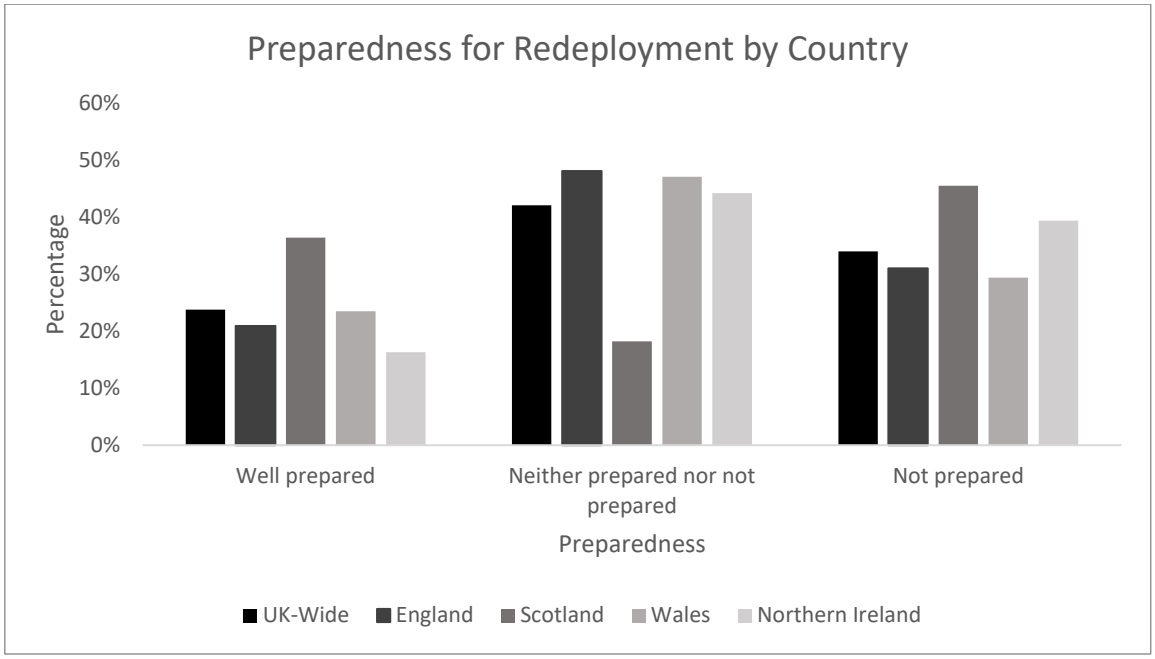


Table A3.15: Preparedness for Redeployment by Country

Prepared	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	23.8%	20.9%	36.4%	23.5%	16.3%
Neither prepared nor not prepared	42.1%	48.1%	18.2%	47.1%	44.2%
Not prepared	34.0%	31.0%	45.5%	29.4%	39.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.17: Preparedness for Redeployment by Occupation

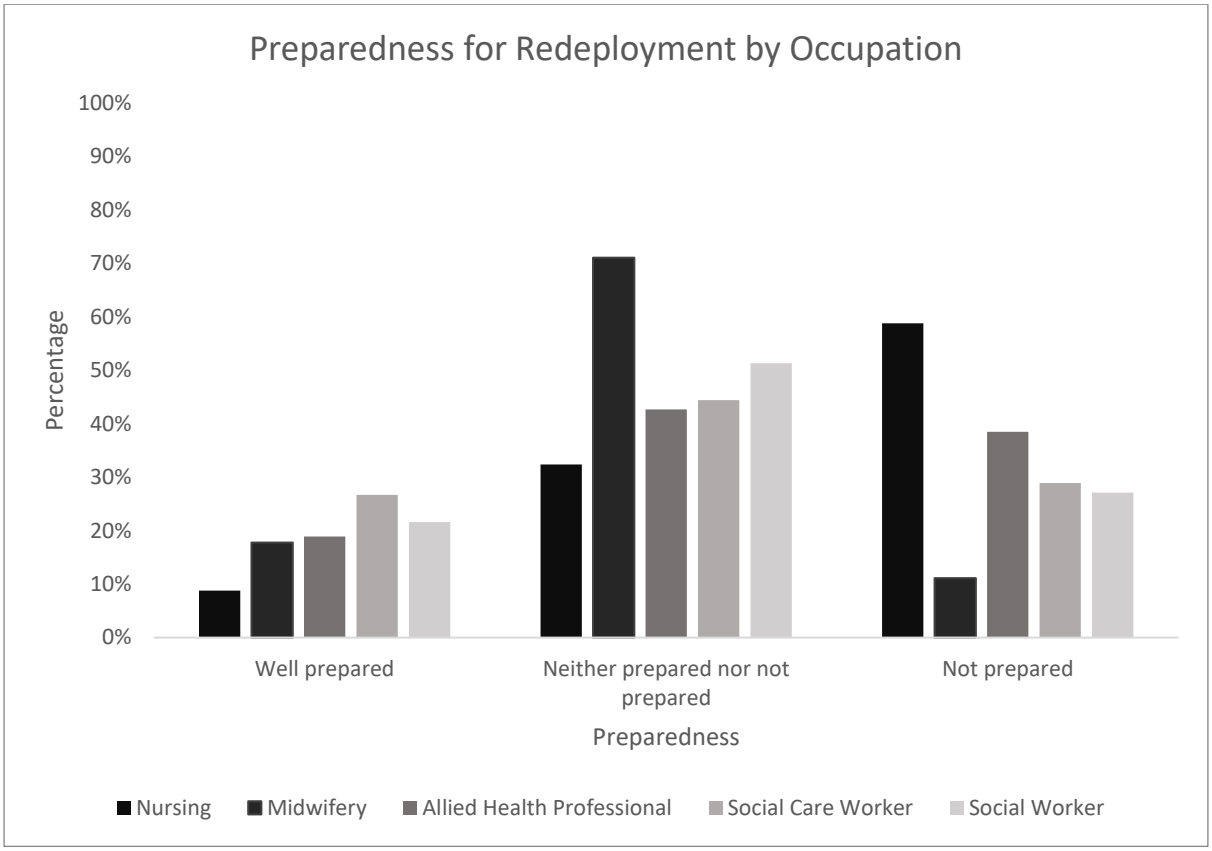


Table A3.16: Preparedness for Redeployment by Occupation

Occupation	Well prepared	Neither prepared nor not prepared	Not prepared	Total
Nursing	8.8%	32.4%	58.8%	**100%**
Midwifery	17.8%	71.1%	11.1%	**100%**
Allied Health Professional	18.9%	42.7%	38.5%	**100%**
Social Care Worker	26.7%	44.4%	28.9%	**100%**
Social Worker	21.6%	51.3%	27.1%	**100%**

A3.10 Respondents Coming Out of Retirement to Support Workforce during COVID-19

Only 0.4% of respondents reported that they had come out of retirement to support the workforce during the COVID-19 pandemic.

Figure A3.18: Respondents that Came Out of Retirement to Support the Workforce during COVID-19 by Country

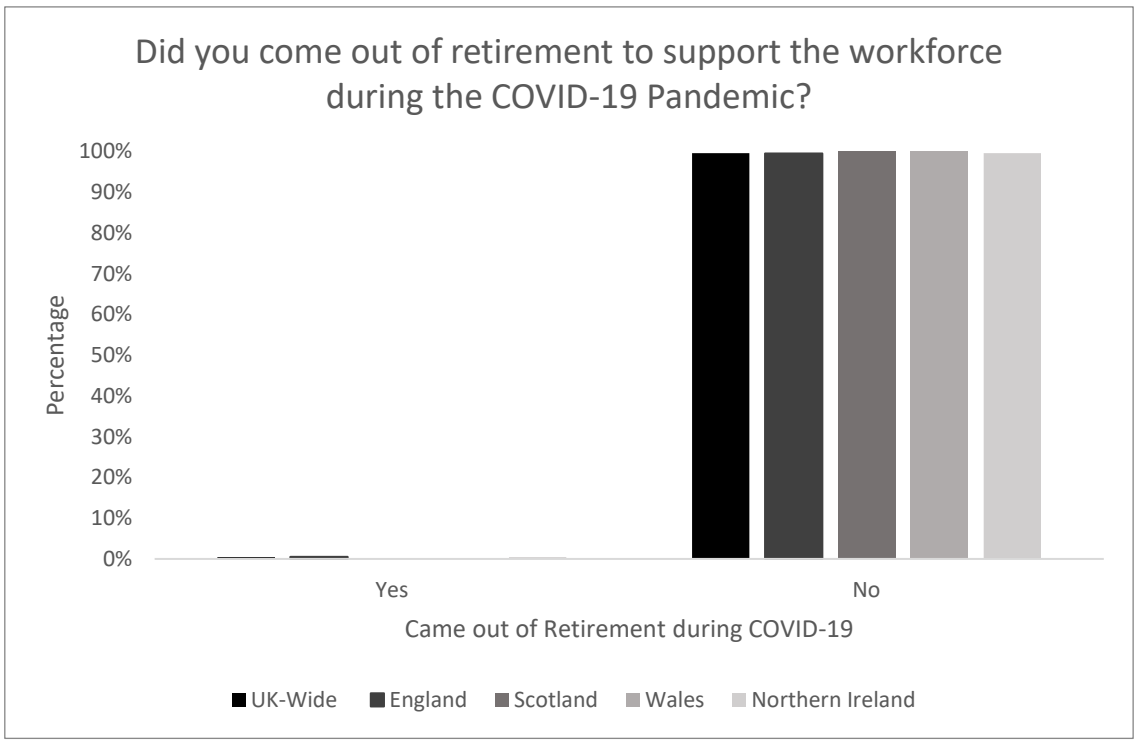


Table A3.17: Out of Retirement by Country

Did you come out of retirement	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	0.4%	0.5%	0.0%	0.0%	0.4%
No	99.6%	99.5%	100.0%	100.0%	99.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.19: Respondents that Came Out of Retirement to Support the Workforce during COVID-19 by Occupation

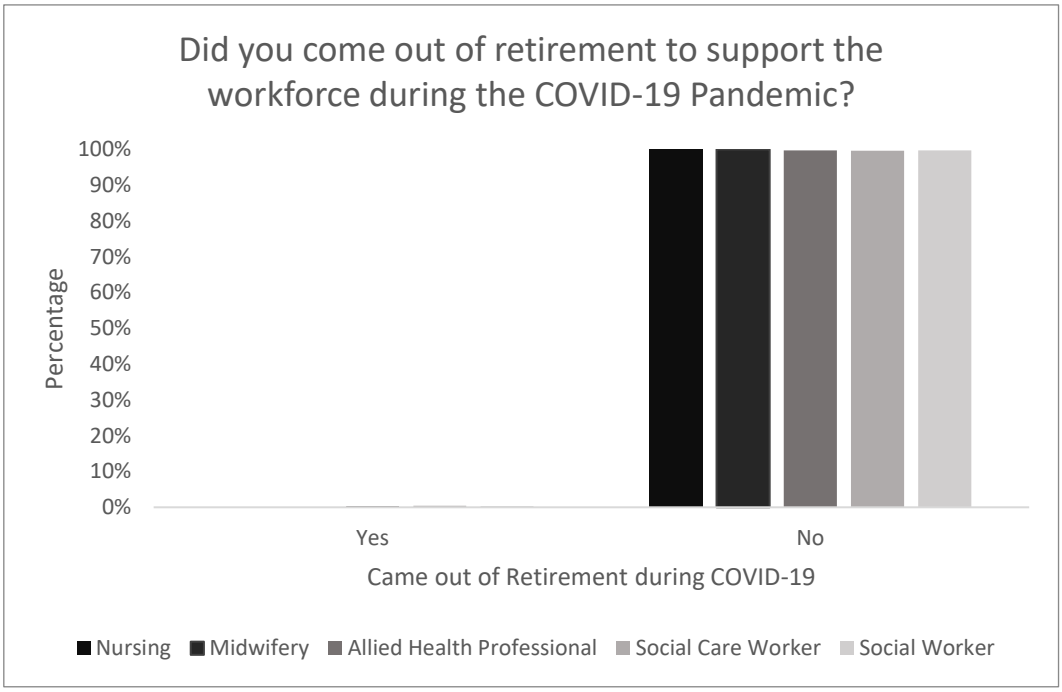


Table A3.18: Out of Retirement by Occupation

Occupation	Yes	No	Total
Nursing	0.0%	100.0%	**100%**
Midwifery	0.0%	100.0%	**100%**
Allied Health Professional	0.3%	99.7%	**100%**
Social Care Worker	0.4%	99.6%	**100%**
Social Worker	0.3%	99.7%	**100%**

A3.11 Job Tenure of Respondents

Most respondents are employed on a permanent basis. NI has the largest proportion of agency staff.

Figure A3.20: Tenure by Country

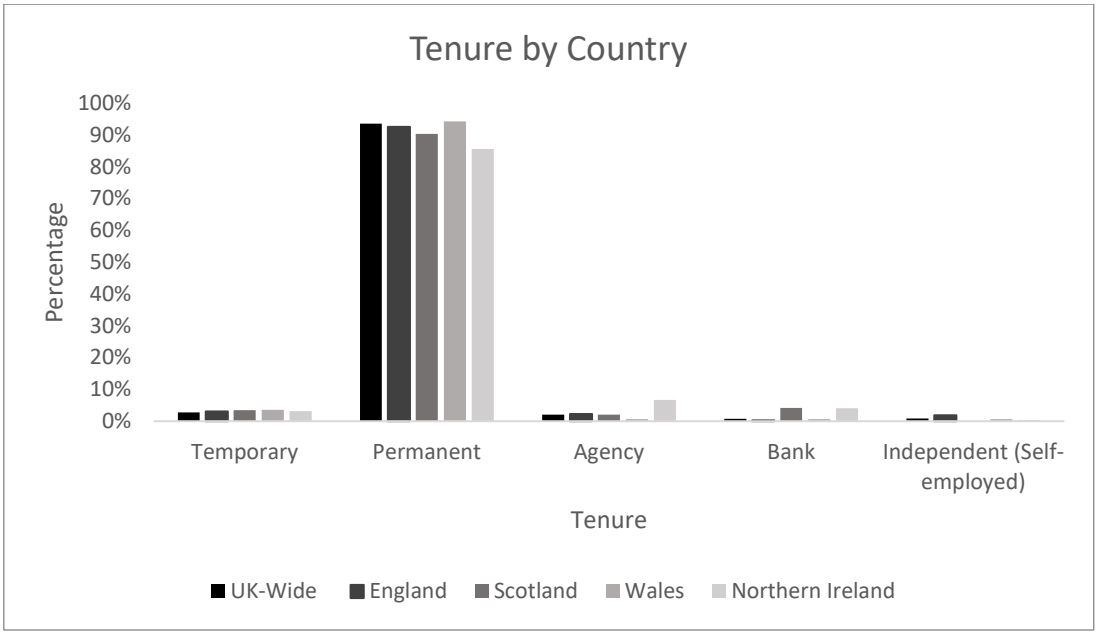


Table A3.19: Tenure by Country

Tenure	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary	2.8%	3.1%	3.5%	3.6%	3.2%
Permanent	93.5%	92.5%	90.3%	94.2%	85.6%
Agency	2.1%	2.3%	2.1%	0.7%	6.7%
Bank	0.8%	0.3%	4.2%	0.7%	4.1%
Independent (Self-employed)	0.9%	1.9%	0.0%	0.7%	0.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.21: Tenure by Occupation

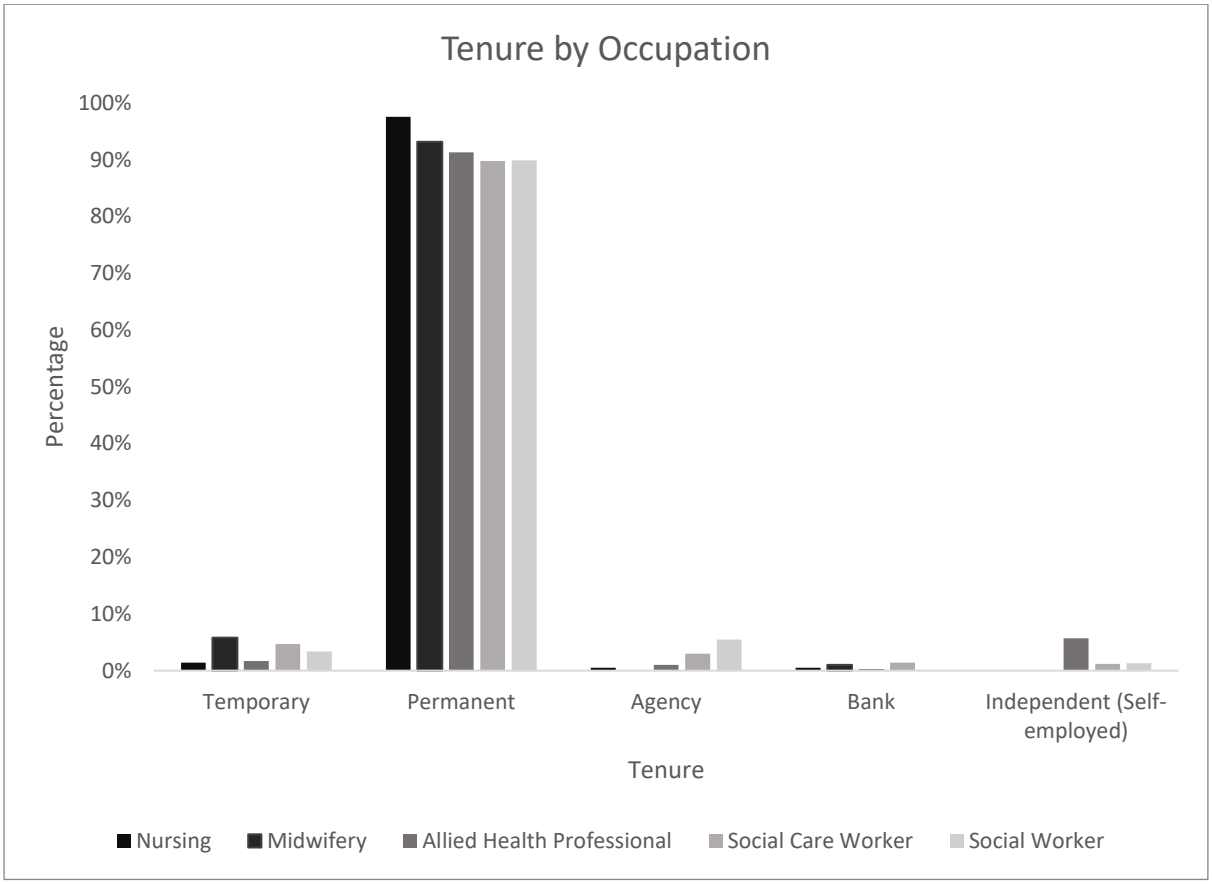


Table A3.20: Tenure by Occupation

Occupation	Temporary	Permanent	Agency	Bank	Independent (Self-employed)	Total
Nursing	1.4%	97.6%	0.5%	0.5%	0.0%	**100%**
Midwifery	5.8%	93.2%	0.0%	1.0%	0.0%	**100%**
Allied Health Professional	1.7%	91.3%	1.0%	0.3%	5.7%	**100%**
Social Care Worker	4.7%	89.8%	3.0%	1.4%	1.2%	**100%**
Social Worker	3.4%	89.9%	5.5%	0.0%	1.3%	**100%**

A3.12 Respondents' Years of Experience

The majority of respondents have 11-20 years' work experience. Of those with over 30 years' experience, many of these are nurses.

Figure A3.22: Years' Experience by Country

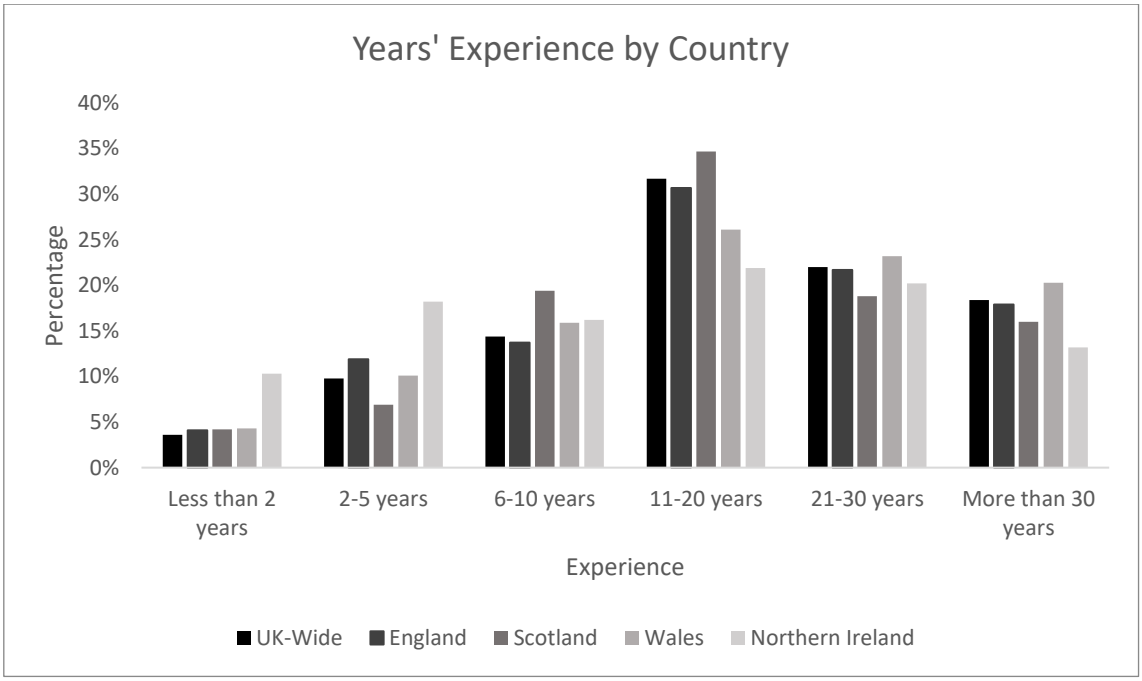


Table A3.21: Years of Experience by Country

Years' Experience	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	3.6%	4.1%	4.2%	4.3%	10.3%
2-5 years	9.8%	11.9%	6.9%	10.1%	18.2%
6-10 years	14.4%	13.7%	19.4%	15.9%	16.2%
11-20 years	31.7%	30.7%	34.7%	26.1%	21.9%
21-30 years	22.0%	21.7%	18.8%	23.2%	20.2%
More than 30 years	18.4%	17.9%	16.0%	20.3%	13.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.22: Years of Experience by Occupation

Occupation	Less than 2 years	2-5 years	6-10 years	11-20 years	21-30 years	More than 30 years	Total
Nursing	0.5%	1.9%	8.3%	33.0%	21.4%	35.0%	**100%**
Midwifery	11.4%	7.8%	41.4%	19.2%	10.1%	10.1%	**100%**
Allied Health Professional	5.4%	14.3%	17.3%	28.0%	18.5%	16.5%	**100%**
Social Care Worker	6.0%	19.8%	13.0%	26.9%	25.3%	9.0%	**100%**
Social Worker	8.9%	15.2%	15.7%	27.9%	21.5%	10.9%	**100%**

Figure A3.23: Years' Experience by Occupation

A3.13 Respondents' Area of Practice

Almost one third (32.7%) of the respondents work with Adults. These were mainly based in England.

Figure A3.24: Area of Practice by Country

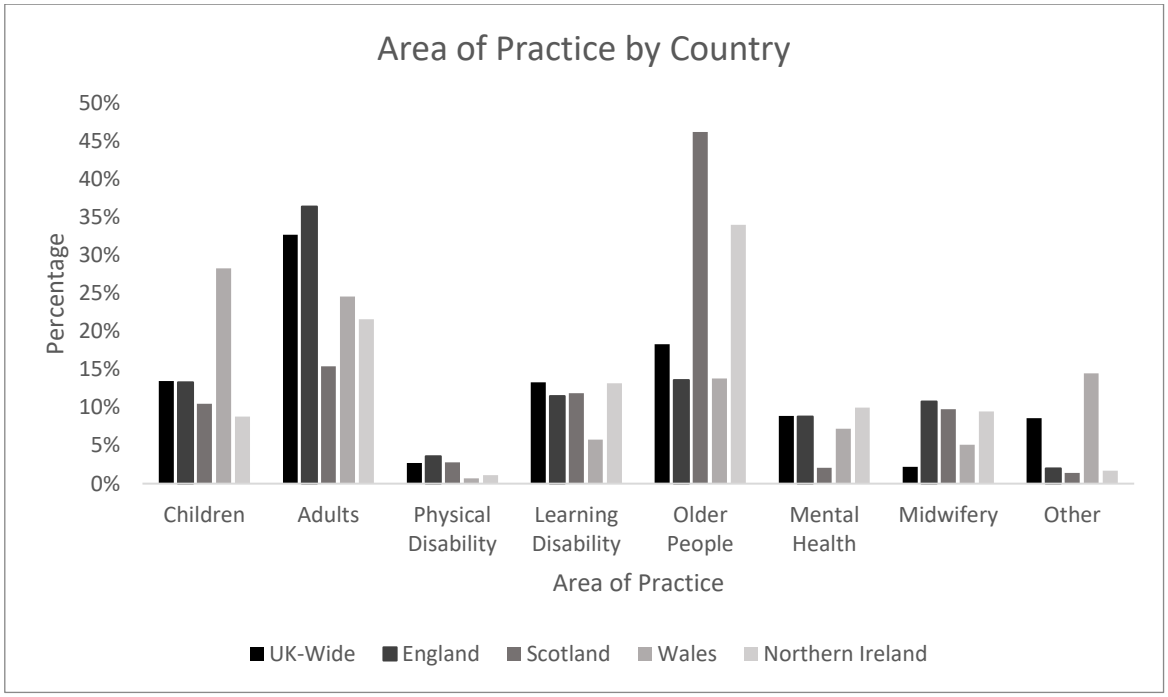


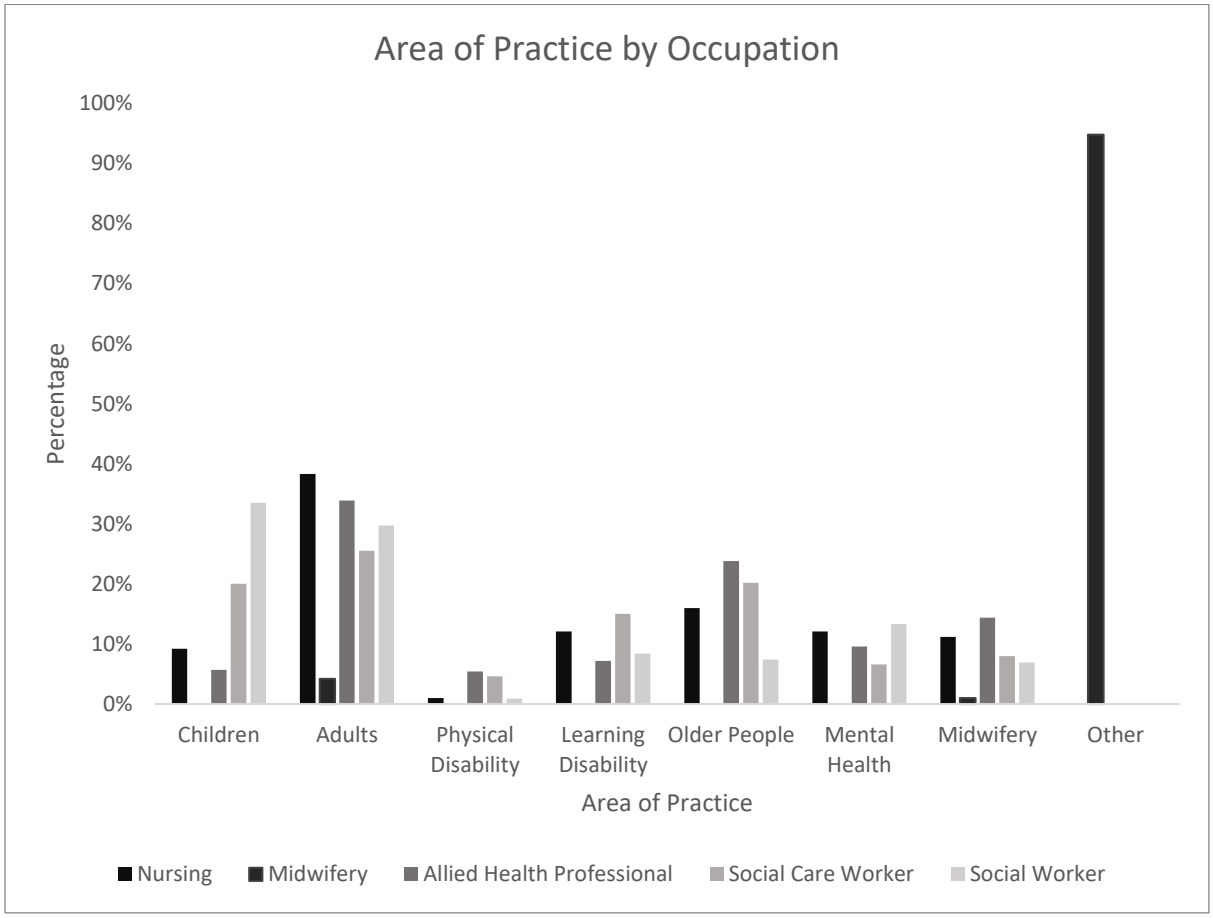
Table A3.23: Area of Practice by Country

Area of Practice	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	13.5%	13.3%	10.5%	28.3%	8.8%
Adults	32.7%	36.4%	15.4%	24.6%	21.6%
Physical Disability	2.7%	3.6%	2.8%	0.7%	1.1%
Learning Disability	13.3%	11.5%	11.9%	5.8%	13.2%
Older People	18.3%	13.6%	46.2%	13.8%	34.0%
Mental Health	8.9%	8.8%	2.1%	7.2%	10.0%
Midwifery	2.2%	10.8%	9.8%	5.1%	9.5%
Other	8.6%	2.0%	1.4%	14.5%	1.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.24: Area of Practice by Occupation

Occupation	Children	Adults	Physical Disability	Learning Disability	Older People	Mental Health	Midwifery	Other
Nursing	9.2%	38.3%	1.0%	12.1%	16.0%	12.1%	11.2%	0.0%
Midwifery	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	1.0%	94.8%
Allied Health Professional	5.7%	33.9%	5.4%	7.2%	23.8%	9.6%	14.4%	0.0%
Social Care Worker	20.0%	25.5%	4.6%	15.0%	20.2%	6.6%	8.0%	0.0%
Social Worker	33.5%	29.7%	0.9%	8.4%	7.4%	13.3%	6.9%	0.0%

Figure A3.25: Area of Practice by Occupation



A3.14 Respondents Employed Full- or Part-Time

Scotland has the highest number of part-time employed, making up over one third (36.2%) Allied Health Professionals are most likely to be employed part-time than other professions.

Figure A3.26: Employed Full- or Part-Time by Country

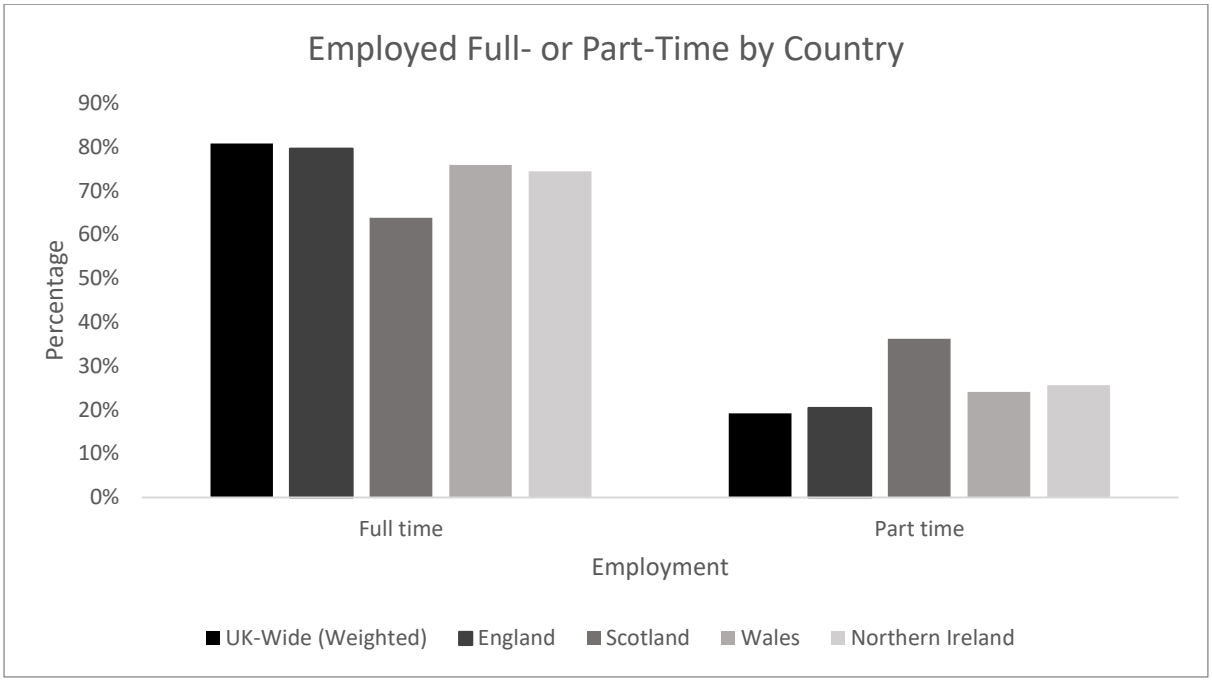


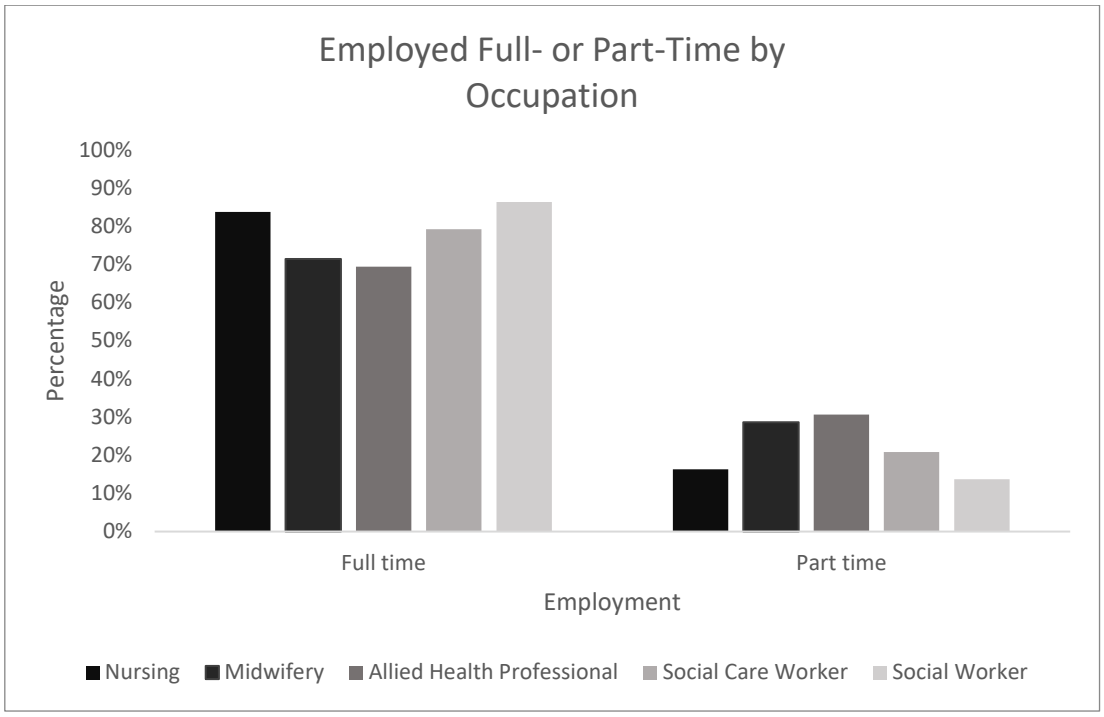
Table A3.25: Employed Full- or Part-Time by Country

Employed	UK-Wide	England	Scotland	Wales	Northern Ireland
Full time	80.8%	79.6%	63.8%	75.9%	74.4%
Part time	19.2%	20.4%	36.2%	24.1%	25.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.26: Employed Full- or Part-Time by Occupation

Occupation	Full time	Part time	Total
Nursing	83.7%	16.3%	**100%**
Midwifery	71.4%	28.6%	**100%**
Allied Health Professional	69.4%	30.6%	**100%**
Social Care Worker	79.2%	20.8%	**100%**
Social Worker	86.3%	13.7%	**100%**

Figure A3.27: Employed Full- or Part-Time by Occupation



A3.15 Respondents' Hours Worked Per Week

The majority of respondents work full-time, typically 37.5 hours per week. This is also the case across occupations but midwives are most likely to work part -time hours.

Figure A3.28: Hours Worked Per Week by Country

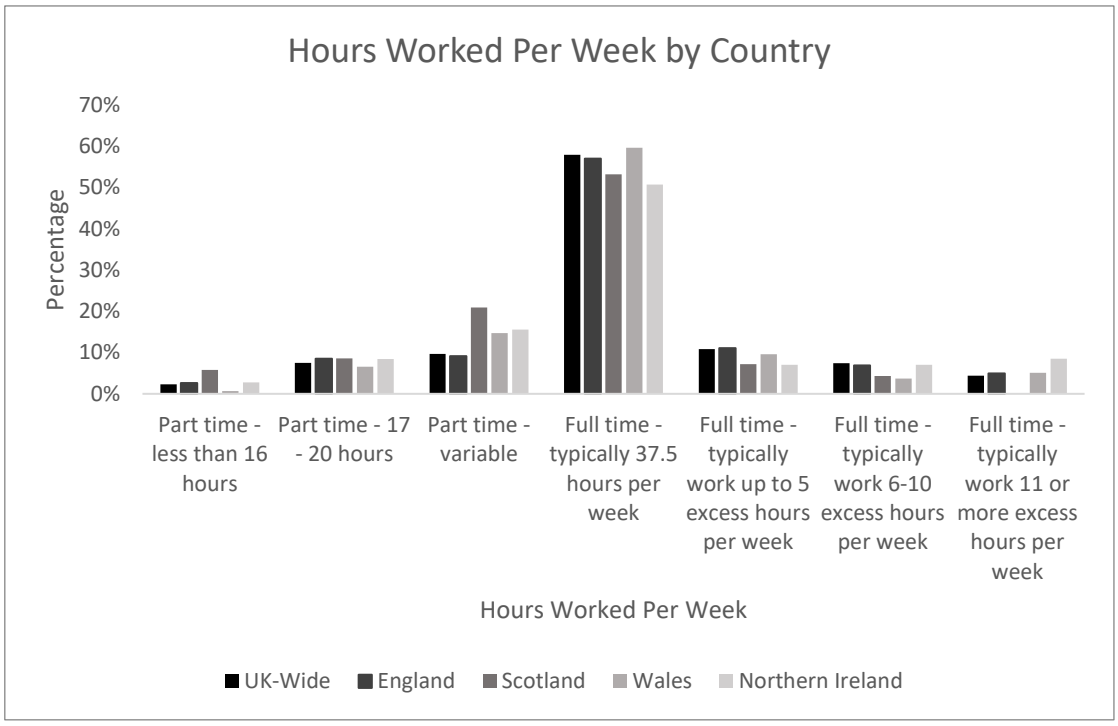


Table A3.27: Hours Worked Per Week by Country

Hours	UK-Wide	England	Scotland	Wales	Northern Ireland
Part time - less than 16 hours	2.3%	2.6%	5.8%	0.7%	2.8%
Part time - 17 - 20 hours	7.5%	8.5%	8.6%	6.6%	8.4%
Part time - variable	9.7%	9.1%	20.9%	14.7%	15.6%
Full time - typically 37.5 hours per week	57.9%	57.0%	53.2%	59.6%	50.7%
Full time - typically work up to 5 excess hours per week	10.8%	11.1%	7.2%	9.6%	7.0%
Full time - typically work 6-10 excess hours per week	7.4%	6.9%	4.3%	3.7%	7.0%
Full time - typically work 11 or more excess hours per week	4.4%	4.9%	0.0%	5.1%	8.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.29: Hours Worked Per Week by Occupation

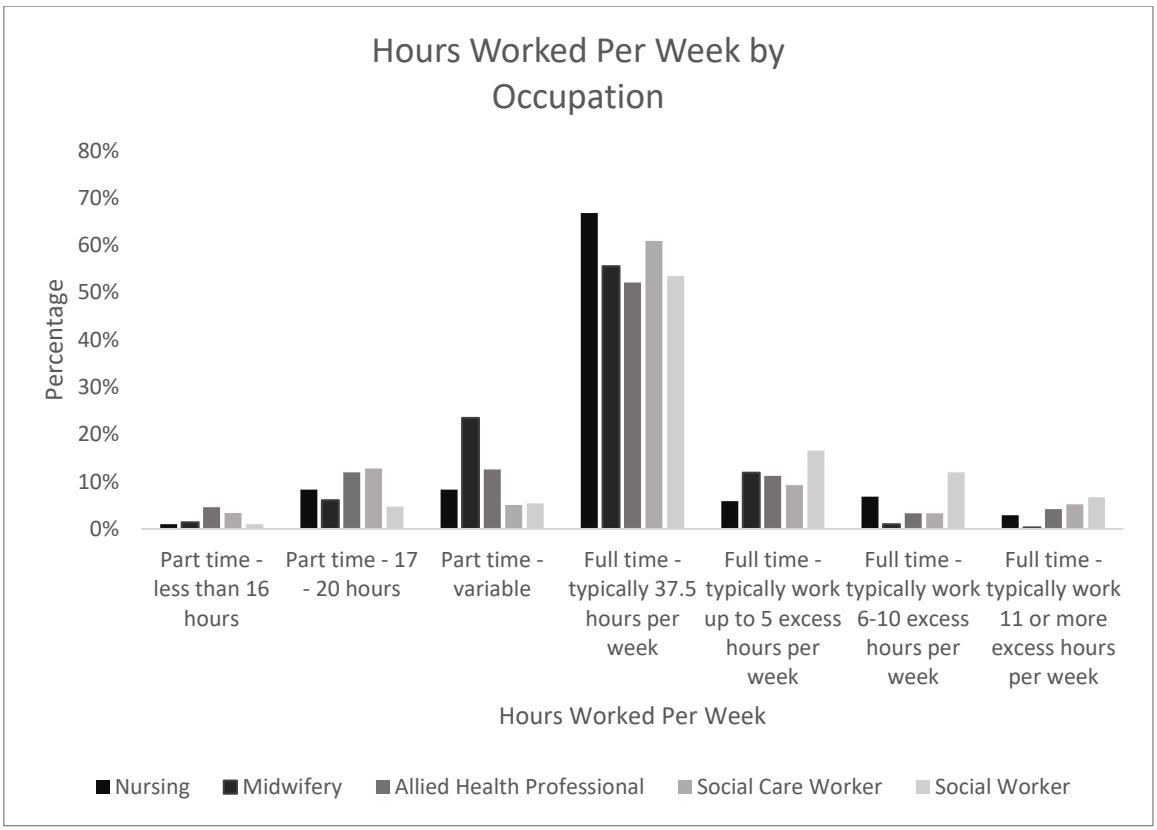


Table A3.28: Hours Worked Per Week by Occupation

Occupation	Part time - less than 16 hours	Part time - 17 - 20 hours	Part time - variable	Full time - typical 37.5 hours per week	Full time - typical work up to 5 excess hours per week	Full time - typical work 6-10 excess hours per week	Full time - typical work 11 or more excess hours per week	Total
Nursing	1.0%	8.3%	8.3%	66.8%	5.9%	6.8%	2.9%	**100%**
Midwifery	1.4%	6.1%	23.5%	55.6%	11.9%	1.0%	0.3%	**100%**
Allied Health Professional	4.6%	12.0%	12.6%	52.1%	11.2%	3.3%	4.2%	**100%**
Social Care Worker	3.4%	12.8%	5.1%	60.9%	9.3%	3.3%	5.2%	**100%**
Social Worker	1.0%	4.7%	5.4%	53.5%	16.6%	12.0%	6.7%	**100%**

A3.16 Respondents' Overtime Hours

Respondents in Northern Ireland work the highest number of hours overtime. Nurses and Social Care Workers work the most overtime.

Figure A3.30: Hours Overtime by Country

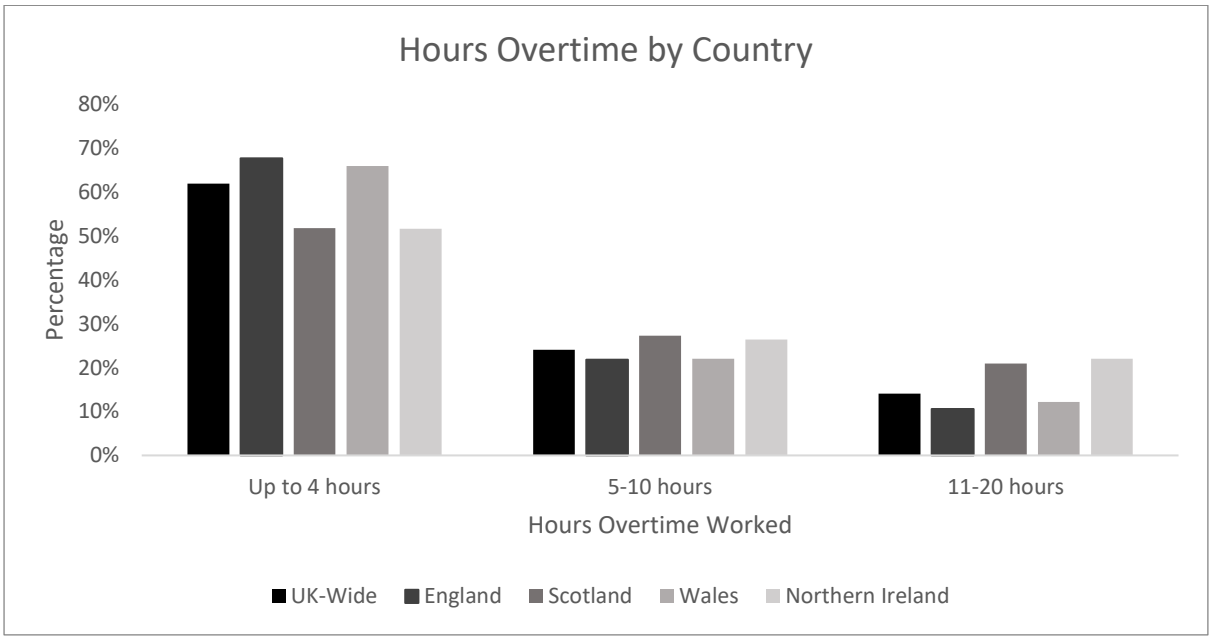


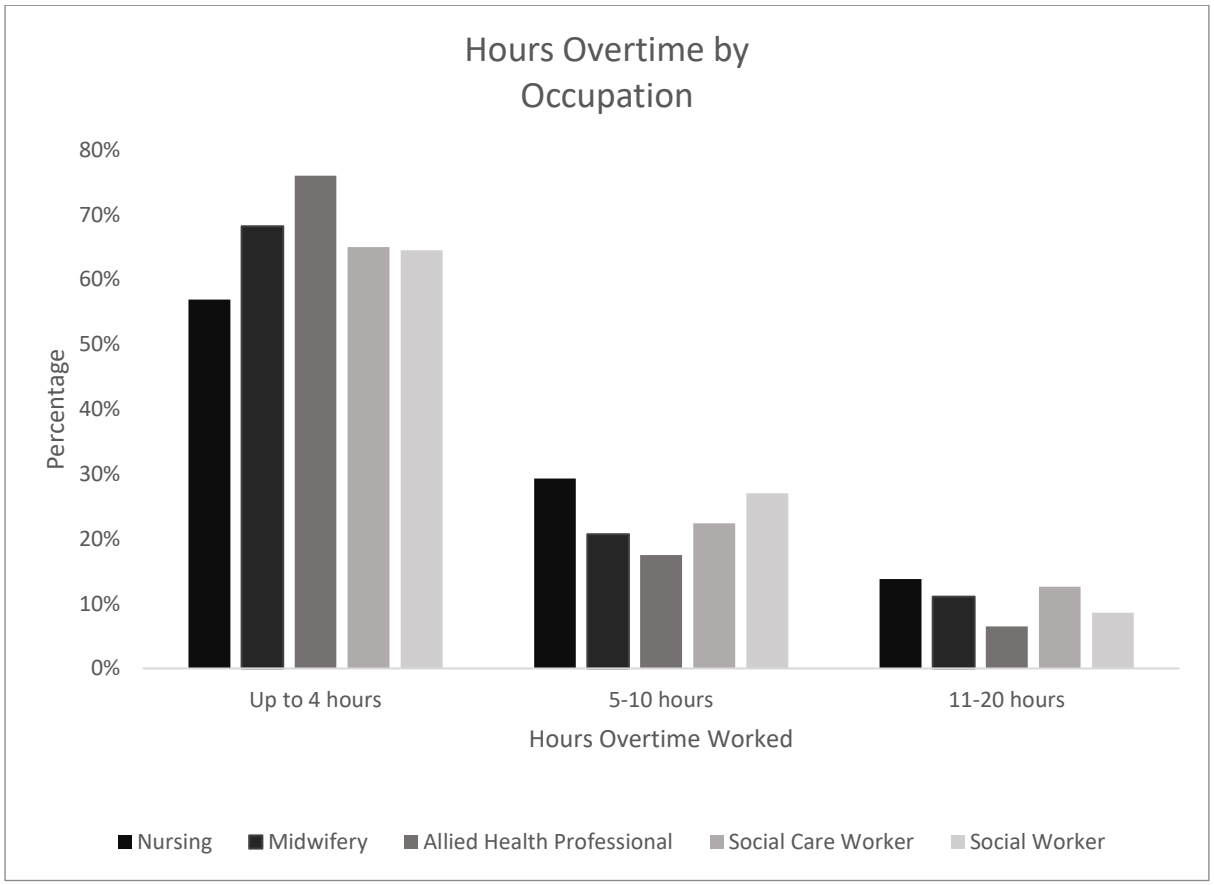
Table A3.29: Hours Overtime by Country

Hours Overtime	UK-Wide	England	Scotland	Wales	Northern Ireland
Up to 4 hours	61.9%	67.7%	51.8%	65.9%	51.6%
5-10 hours	24.1%	21.8%	27.3%	22.0%	26.4%
11-20 hours	14.1%	10.6%	20.9%	12.2%	22.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.30: Hours Overtime by Occupation

Occupation	Up to 4 hours	5-10 hours	11-20 hours	Total
Nursing	56.9%	29.3%	13.8%	**100%**
Midwifery	68.2%	20.7%	11.1%	**100%**
Allied Health Professional	76.0%	17.5%	6.5%	**100%**
Social Care Worker	65.0%	22.4%	12.6%	**100%**
Social Worker	64.5%	27.0%	8.6%	**100%**

Figure A3.31: Hours Overtime by Occupation



A3.17 Respondents' Number of Sick Days

Respondents in Scotland were the least likely to take days off sick.

Figure A3.32: Sick Days by Country

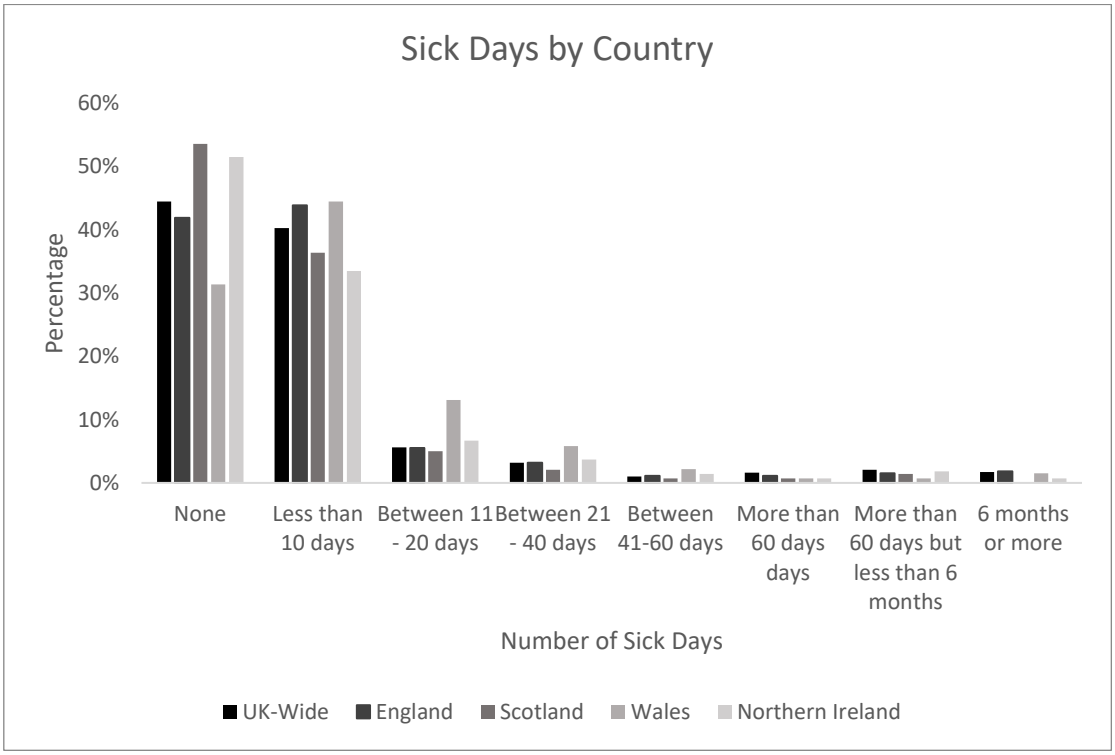


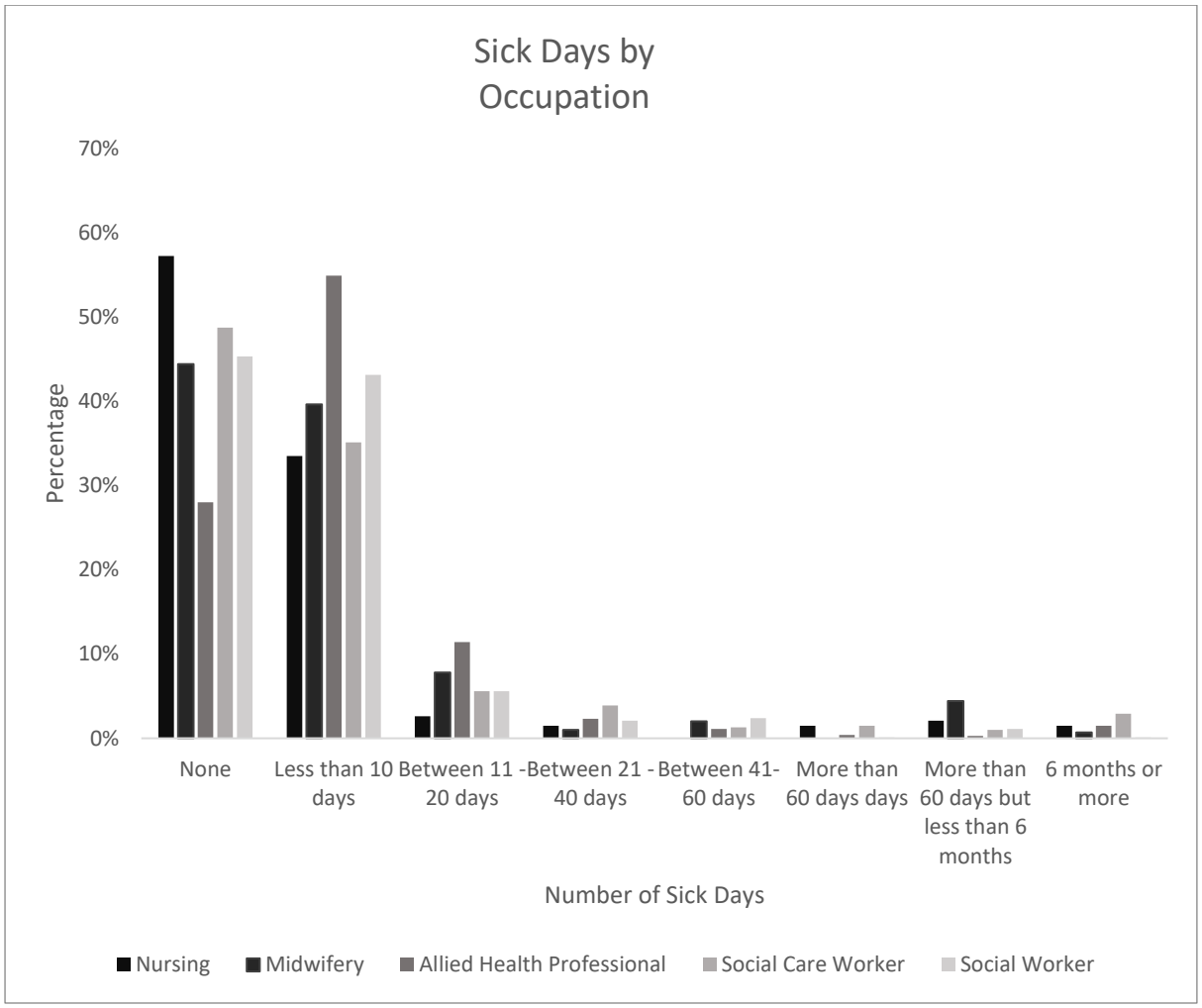
Table A3.31: Sick Days by Country

Sick days	UK-Wide	England	Scotland	Wales	Northern Ireland
None	44.5%	41.9%	53.6%	31.4%	51.5%
Less than 10 days	40.3%	43.9%	36.4%	44.5%	33.5%
Between 11 - 20 days	5.6%	5.5%	5.0%	13.1%	6.7%
Between 21 - 40 days	3.2%	3.2%	2.1%	5.8%	3.7%
Between 41-60 days	1.0%	1.1%	0.7%	2.2%	1.4%
More than 60 days	1.6%	1.1%	0.7%	0.7%	0.7%
More than 60 days but less than 6 months	2.1%	1.5%	1.4%	0.7%	1.8%
6 months or more	1.7%	1.8%	0.0%	1.5%	0.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.32: Sick Days by Occupation

Occupation	None	Less than 10 days	Between 11 - 20 days	Between 21 - 40 days	Between 41-60 days	More than 60 days	More than 60 days but less than 6 months	6 months or more	%
Nursing	57.2%	33.5%	2.6%	1.5%	0.0%	1.5%	2.1%	1.5%	100
Midwifery	44.4%	39.6%	7.8%	1.0%	2.0%	0.0%	4.4%	0.7%	100
Allied Health Professional	28.0%	54.9%	11.4%	2.3%	1.1%	0.4%	0.3%	1.5%	100
Social Care Worker	48.7%	35.1%	5.6%	3.9%	1.3%	1.5%	1.0%	2.9%	100
Social Worker	45.3%	43.1%	5.6%	2.1%	2.4%	0.1%	1.1%	0.1%	100

Figure A3.33: Sick Days by Occupation



A3.18 Sickness Absence Related to COVID-19

Around one-fifth of respondents had a COVID-19 related sickness absence. Nurses were more likely than any other profession to have a COVID-19 related sickness absence.

Figure A3.34: Sickness Absence Related to COVID-19 by Country

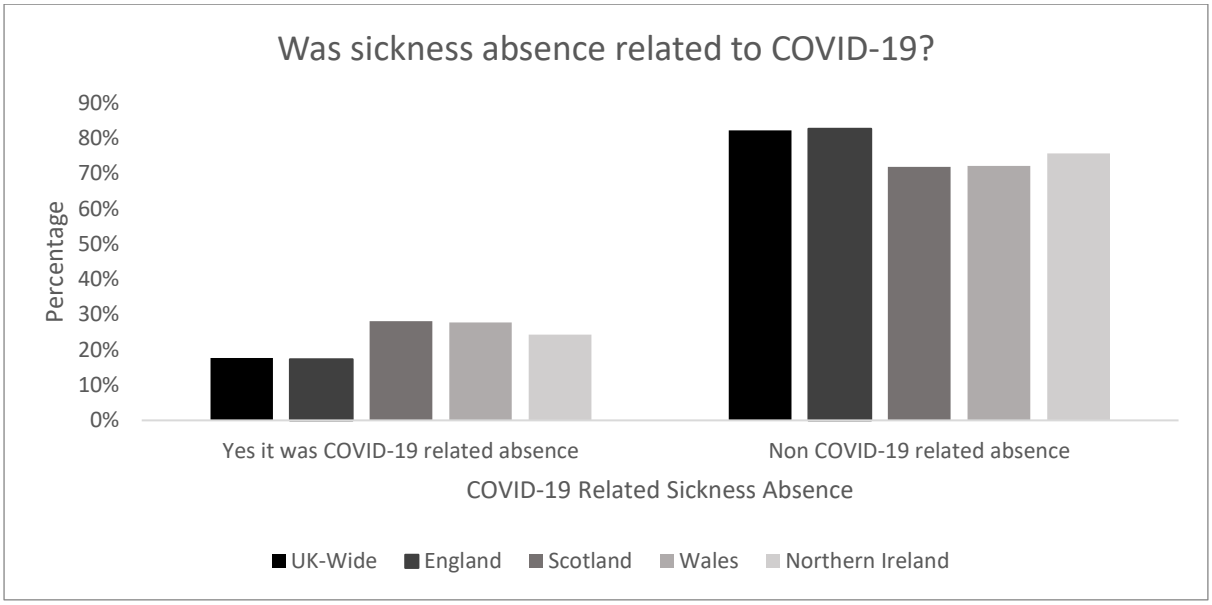


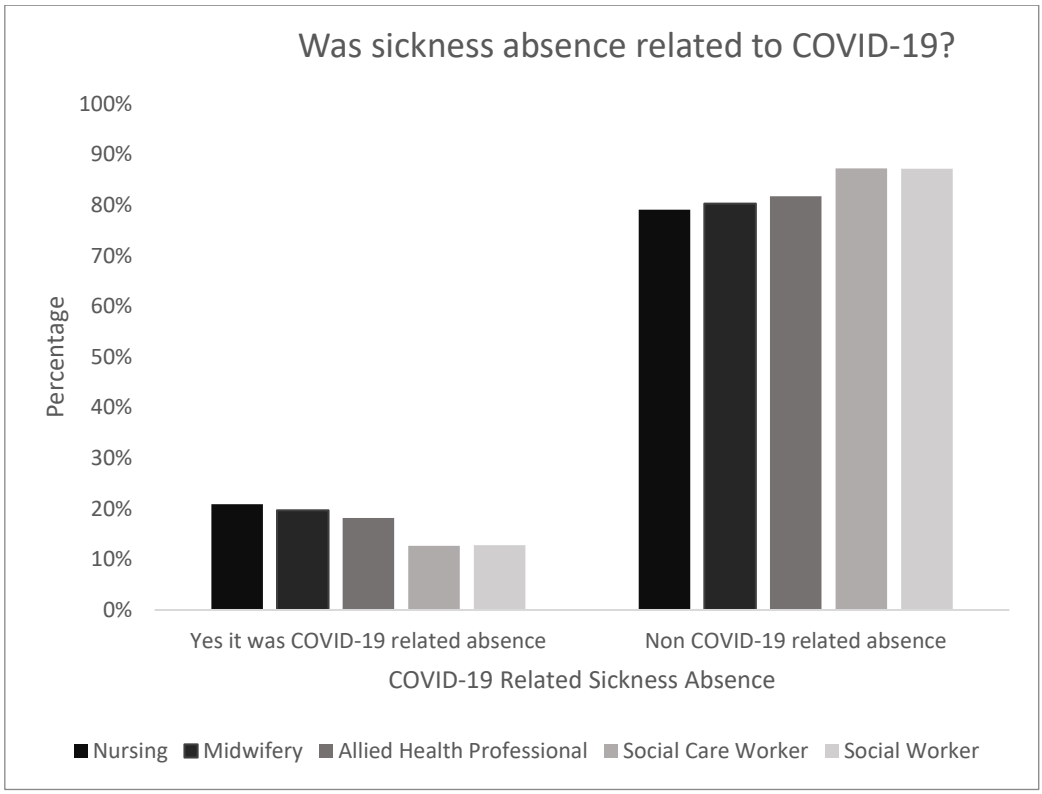
Table A3.33: Absence Due to COVID-19 by Country

Sickness related to COVID-19	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, it was COVID-19 related absence	17.7%	17.3%	28.1%	27.8%	24.3%
Non COVID-19 related absence	82.3%	82.7%	71.9%	72.2%	75.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.34: Absence Due to COVID-19 by Occupation

Occupation	Yes, it was COVID-19 related absence	Non COVID-19 related absence	Total
Nursing	20.9%	79.1%	**100%**
Midwifery	19.7%	80.3%	**100%**
Allied Health Professional	18.2%	81.8%	**100%**
Social Care Worker	12.7%	87.3%	**100%**
Social Worker	12.8%	87.2%	**100%**

Figure A3.35: Sickness Absence Related to COVID-19 by Occupation



A3.19 Respondents with a Disability

Respondents in England reported the highest prevalence of disability. Social Care Workers and Allied Health Professionals respondents are most likely to report a disability.

Figure A3.36: Disability by Country

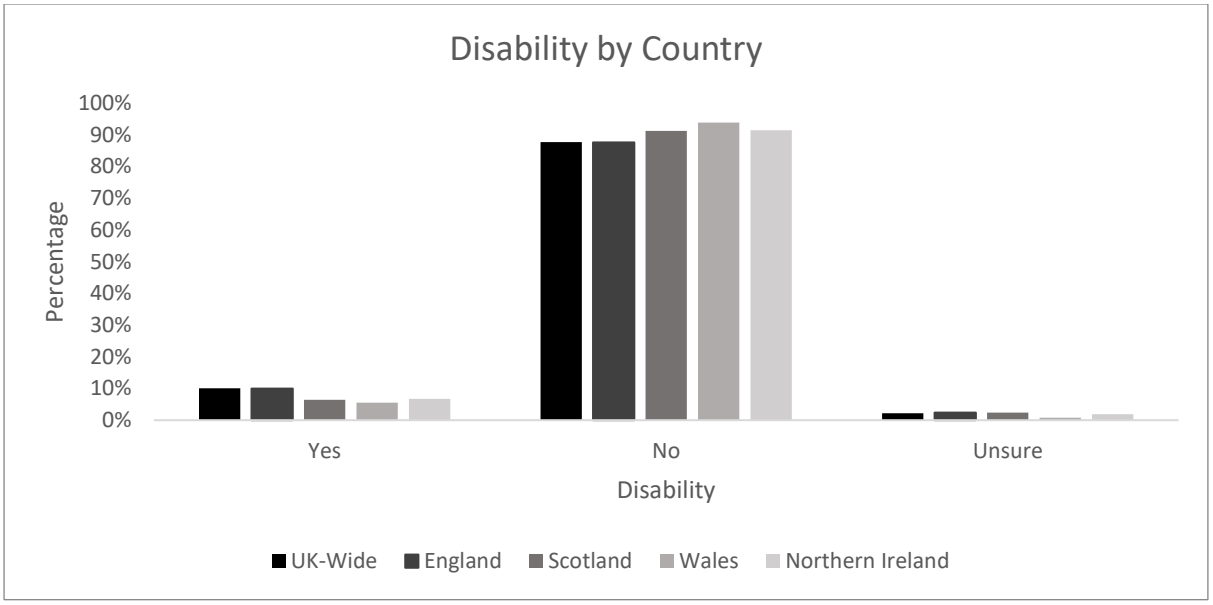


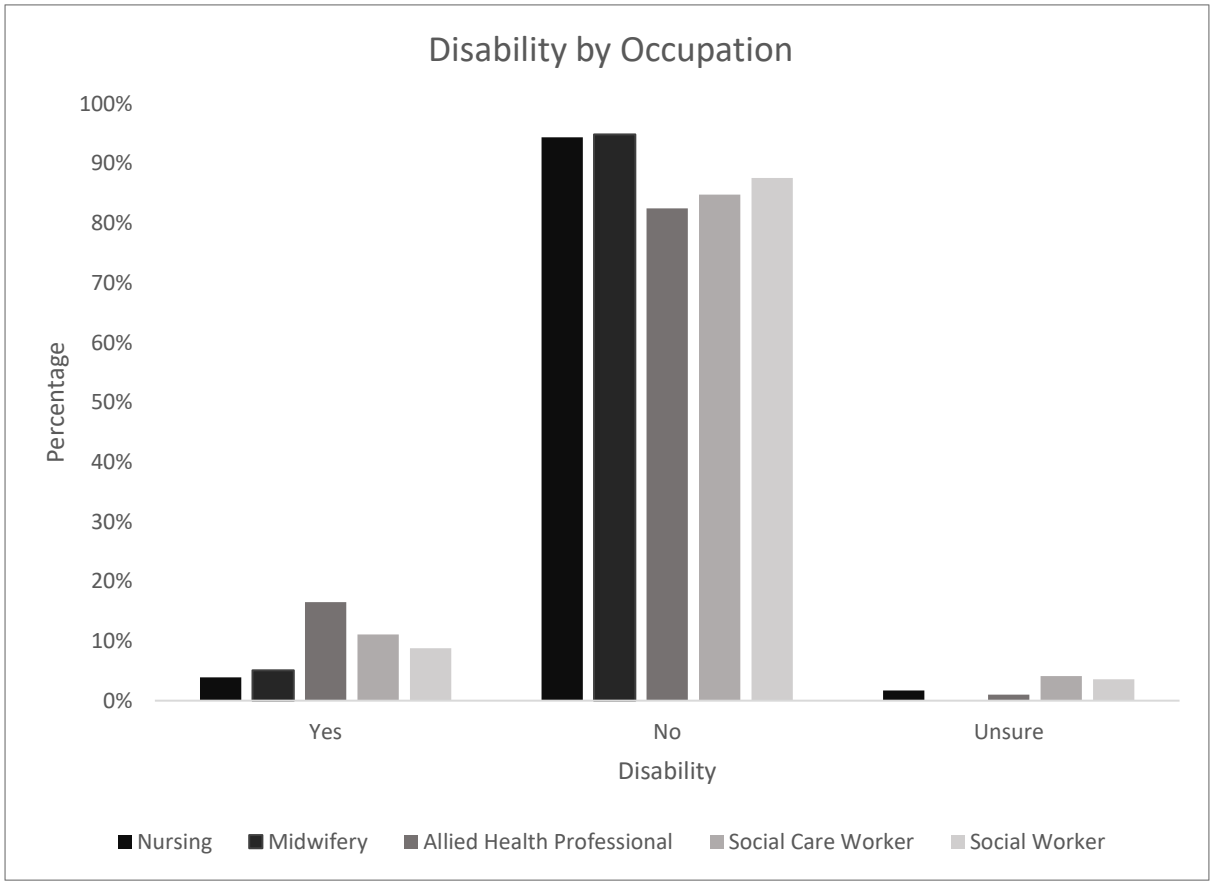
Table A3.35: Disability by Country

Disability	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	10.1%	10.0%	6.4%	5.5%	6.7%
No	87.7%	87.6%	91.2%	93.8%	91.4%
Unsure	2.2%	2.4%	2.4%	0.8%	1.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.36: Disability by Occupation

Occupation	Yes	No	Unsure	Total
Nursing	3.9%	94.4%	1.7%	**100%**
Midwifery	5.1%	94.9%	0.0%	**100%**
Allied Health Professional	16.5%	82.5%	1.0%	**100%**
Social Care Worker	11.1%	84.8%	4.1%	**100%**
Social Worker	8.8%	87.6%	3.6%	**100%**

Figure A3.37: Disability by Occupation



A3.20 Respondents' Relationship Status

Overall, the majority of respondents are married. Those in Wales are more likely to be single than the rest of the UK.

Figure A3.38: Relationship Status by Country

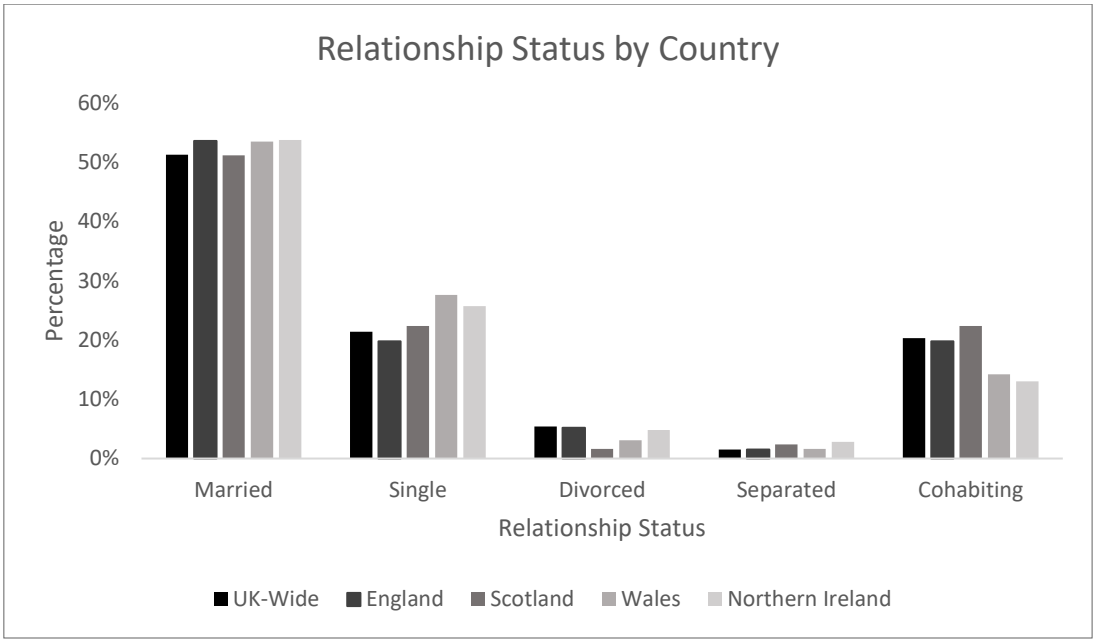


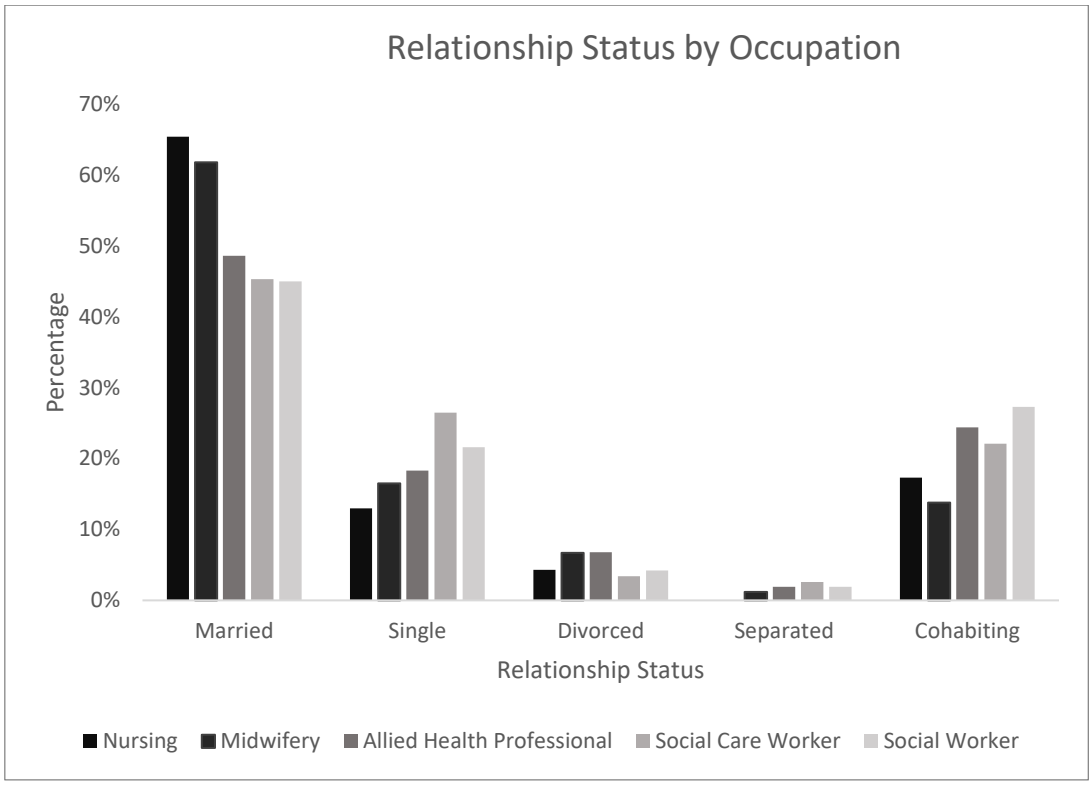
Table A3.37: Relationship Status by Country

Relationship Status	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	51.3%	53.6%	51.2%	53.5%	53.8%
Single	21.4%	19.8%	22.4%	27.6%	25.7%
Divorced	5.4%	5.2%	1.6%	3.1%	4.8%
Separated	1.5%	1.5%	2.4%	1.6%	2.8%
Cohabiting	20.3%	19.8%	22.4%	14.2%	13.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.38: Relationship Status by Occupation

Occupation	Married	Single	Divorced	Separated	Cohabiting	Total
Nursing	65.4%	13.0%	4.3%	0.0%	17.3%	**100%**
Midwifery	61.8%	16.5%	6.7%	1.2%	13.8%	**100%**
Allied Health Professional	48.6%	18.3%	6.8%	1.9%	24.4%	**100%**
Social Care Worker	45.3%	26.5%	3.4%	2.6%	22.1%	**100%**
Social Worker	45.0%	21.6%	4.2%	1.9%	27.3%	**100%**

Figure A3.39: Relationship Status by Occupation



A3.21 Caring Responsibilities of Respondents

NI have the highest prevalence of Carers. Social Care Workers are most likely to have caring responsibilities, whilst Nurses are the least likely.

Figure A3.40: Caring Responsibilities by Country

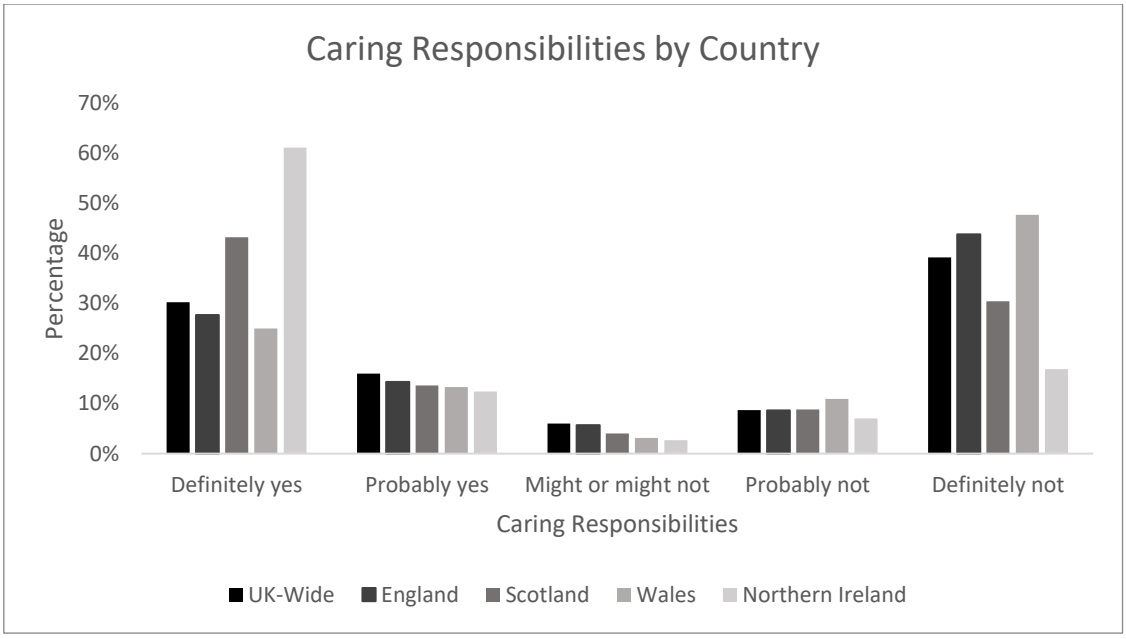


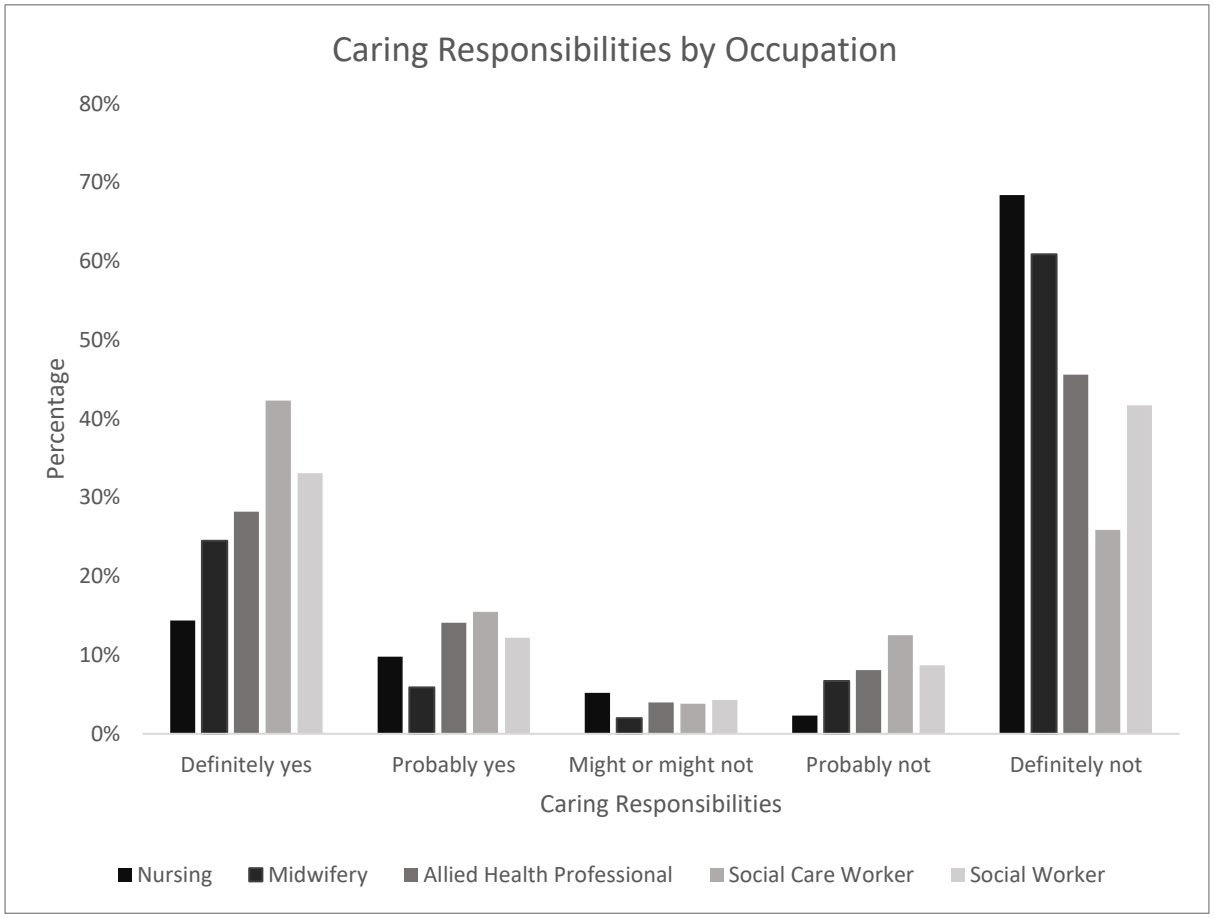
Table A3.39: Caring Responsibilities by Country

Carer	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	30.2%	27.7%	43.2%	25.0%	61.1%
Probably yes	16.0%	14.3%	13.6%	13.3%	12.4%
Might or might not	6.0%	5.7%	4.0%	3.1%	2.7%
Probably not	8.7%	8.6%	8.8%	10.9%	7.0%
Definitely not	39.2%	43.8%	30.4%	47.7%	16.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.40: Caring responsibilities by Occupation

Occupation	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	Total
Nursing	14.4%	9.8%	5.2%	2.3%	68.4%	**100%**
Midwifery	24.5%	5.9%	2.0%	6.7%	60.9%	**100%**
Allied Health Professional	28.2%	14.1%	4.0%	8.1%	45.6%	**100%**
Social Care Worker	42.3%	15.5%	3.8%	12.5%	25.9%	**100%**
Social Worker	33.1%	12.2%	4.3%	8.7%	41.7%	**100%**

Figure A3.41: Caring Responsibilities by Occupation



A3.22 Respondents' Change in Caring Responsibilities During COVID-19

Around two-thirds of all respondents reported that their caring responsibilities did change due to the pandemic. Social Worker respondents were slightly more likely to have caring role change due to the pandemic.

Figure A3.42: Change in Caring Responsibilities During the Pandemic by Country

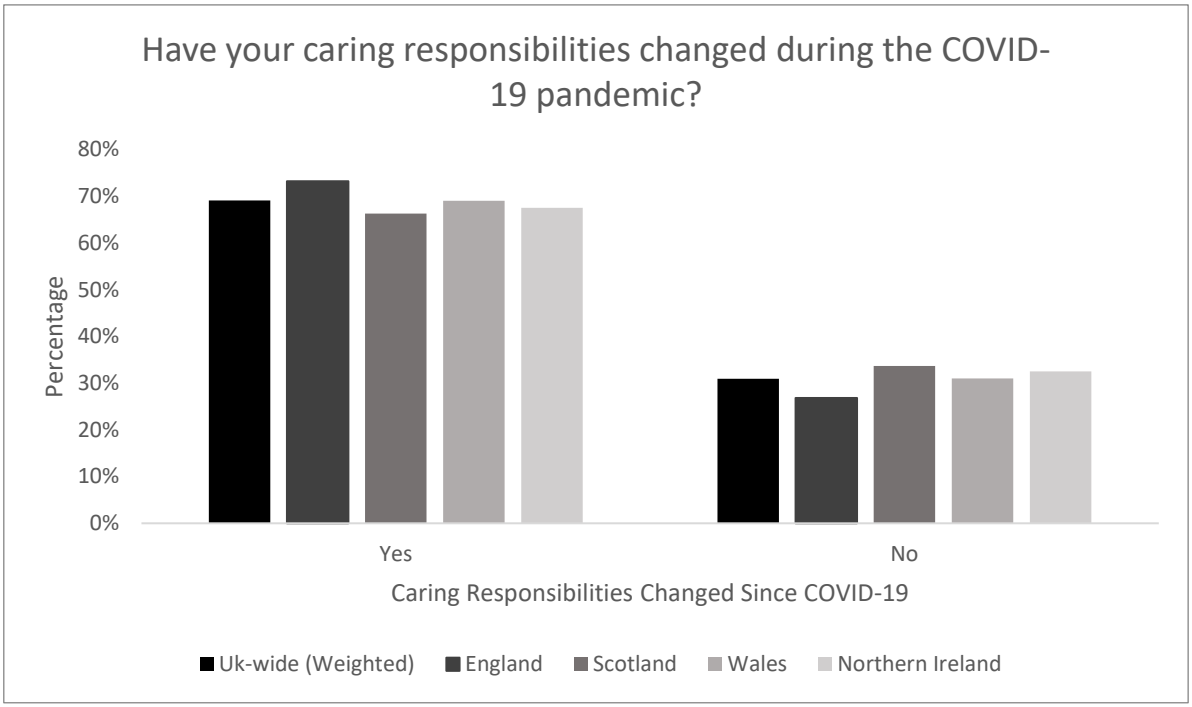


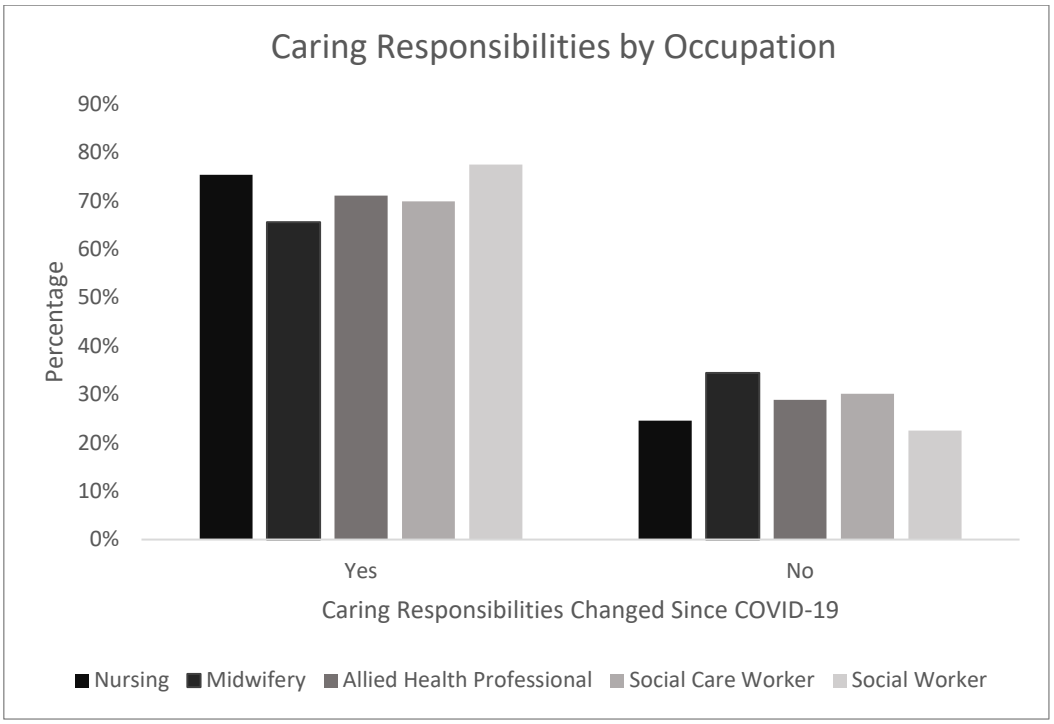
Table A3.41: Caring Responsibility Change by Country

Caring responsibilities changed	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	69.1%	73.2%	66.3%	69.0%	67.5%
No	30.9%	26.8%	33.7%	31.0%	32.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.42: Caring Responsibility Change by Occupation

Occupation	Yes	No	Total
Nursing	75.4%	24.6%	**100%**
Midwifery	65.6%	34.4%	**100%**
Allied Health Professional	71.1%	28.9%	**100%**
Social Care Worker	69.9%	30.1%	**100%**
Social Worker	77.5%	22.5%	**100%**

Figure A3.43: Change in Caring Responsibilities During the Pandemic by Occupation



A3.23 Respondents' Opinion on Helpfulness of the 'Clap for Carers'

Around one third believed that the 'Clap for Carers' was a helpful response, whilst 14% thought it was not. The majority had other comments which will be analysed through the qualitative analysis. Midwives were least likely to say that this was a positive response.

Figure A3.44: Opinion of 'Clap for Carers' by Country

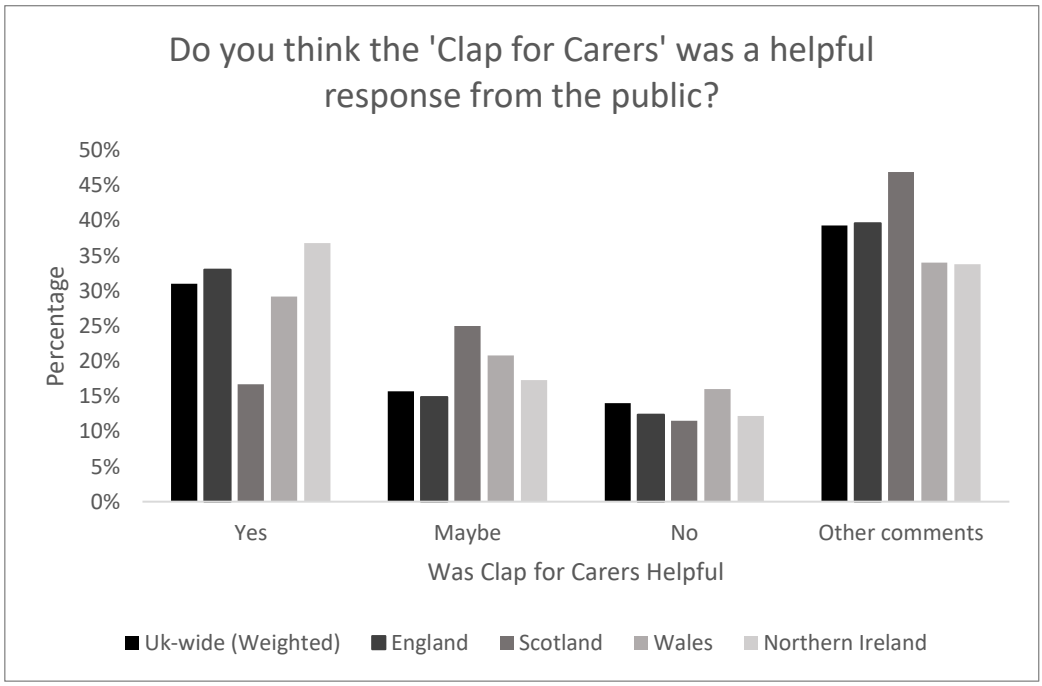


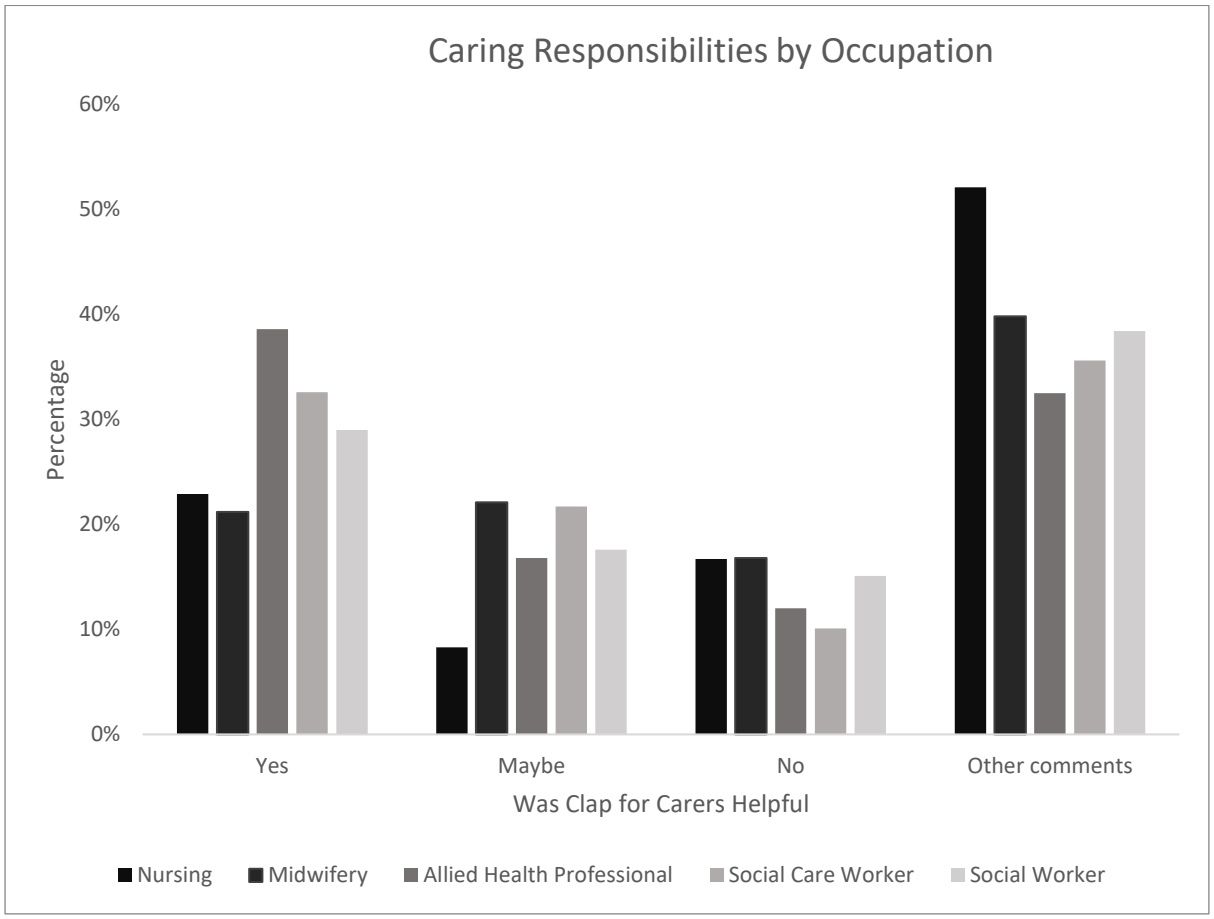
Table A3.43: Opinion of ‘Clap for Carers’ by Country

Do you think the 'Clap for Carers' was a helpful response from the public?	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	31.0%	33.0%	16.7%	29.2%	36.8%
Maybe	15.7%	14.9%	25.0%	20.8%	17.3%
No	14.0%	12.4%	11.5%	16.0%	12.2%
Other comments	39.3%	39.6%	46.9%	34.0%	33.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.44: Opinion of ‘Clap for Carers’ by Occupation

Occupation	Yes	Maybe	No	Other comments	Total
Nursing	22.9%	8.3%	16.7%	52.1%	**100%**
Midwifery	21.2%	22.1%	16.8%	39.8%	**100%**
Allied Health Professional	38.6%	16.8%	12.0%	32.5%	**100%**
Social Care Worker	32.6%	21.7%	10.1%	35.6%	**100%**
Social Worker	29.0%	17.6%	15.1%	38.4%	**100%**

Figure A3.45: Opinion of ‘Clap for Carers’ by Occupation



A3.24 Respondents' Region of Work

Figure A3.46: Responses by Region

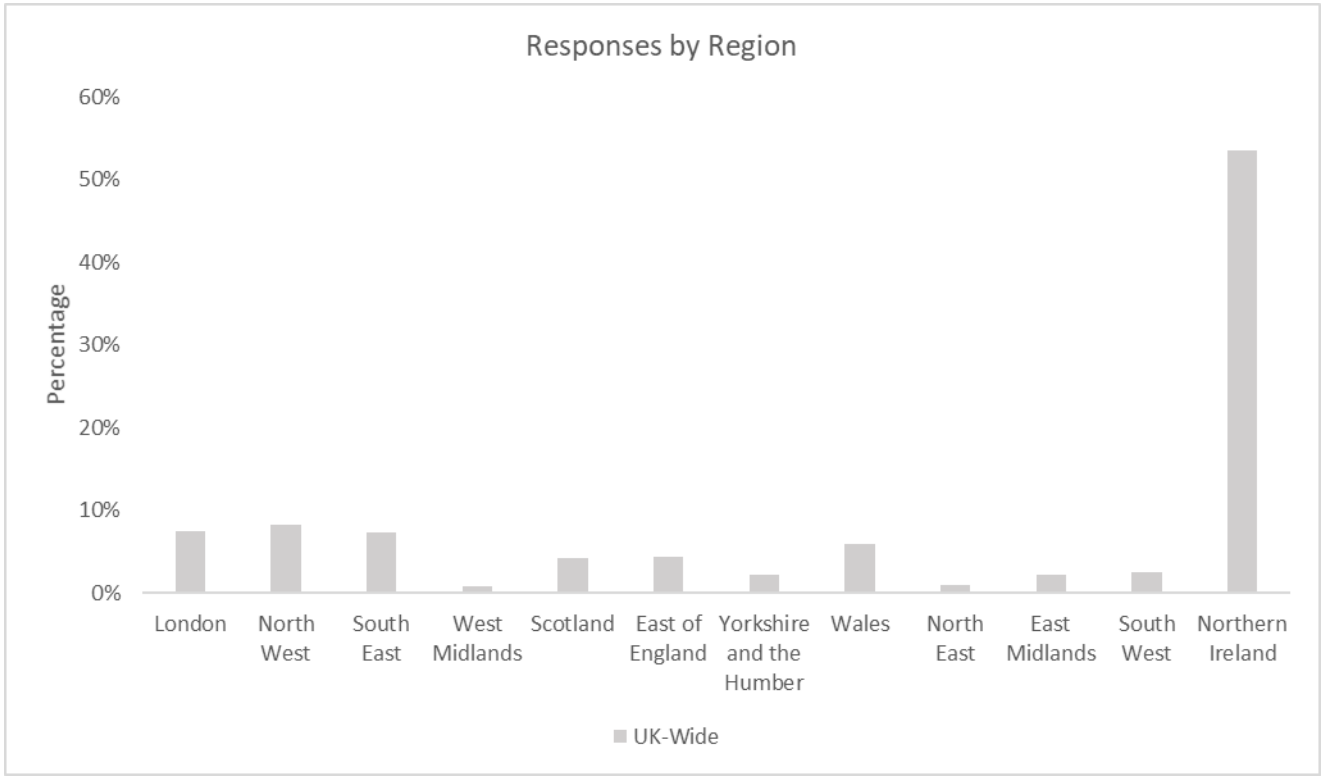


Table A3.45: Responses by Region

Region	UK-Wide
London	7.5%
North West	8.3%
South East	7.4%
West Midlands	0.8%
Scotland	4.3%
East of England	4.4%
Yorkshire and the Humber	2.2%
Wales	5.9%
North East	1.0%
East Midlands	2.3%
South West	2.5%
Northern Ireland	53.5%
Total	**100%**

Figure A3.47: Region by Occupation

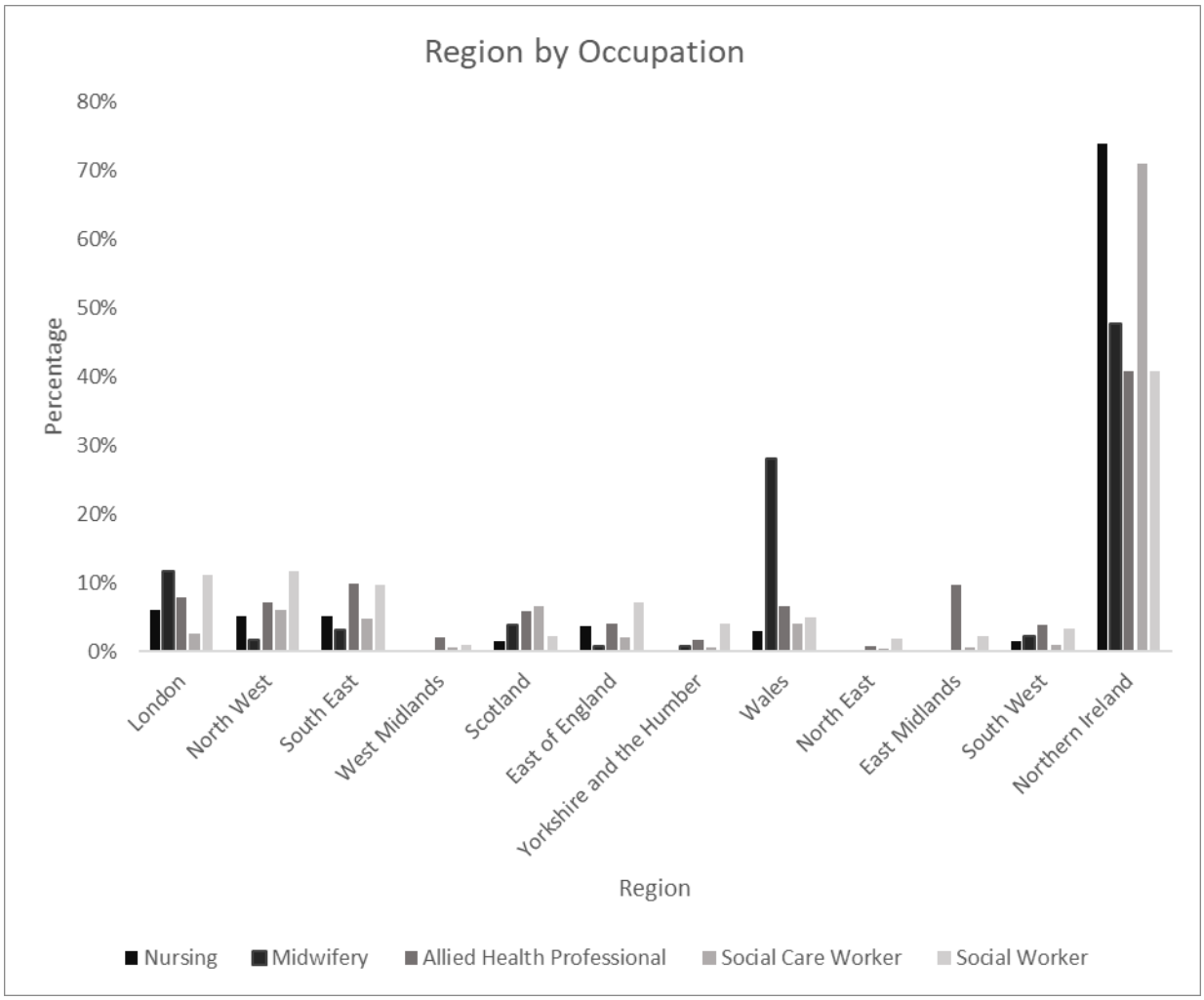


Table A3.46: Region by Occupation

Occupation	London	North West	South East	West Midlands	Scotland	East of England	Yorkshire and the Humber	Wales	North East	East Midlands	South West	Northern Ireland	Total
Nursing	6.0%	5.2%	5.2%	0.0%	1.5%	3.7%	0.0%	3.0%	0.0%	0.0%	1.5%	73.9%	**100%**
Midwifery	11.7%	1.6%	3.1%	0.0%	3.9%	0.8%	0.8%	28.1%	0.0%	0.0%	2.3%	47.7%	**100%**
Allied Health Professional	7.9%	7.2%	9.9%	2.1%	5.8%	4.1%	1.7%	6.5%	0.7%	9.6%	3.8%	40.8%	**100%**
Social Care Worker	2.5%	6.1%	4.8%	0.5%	6.6%	2.0%	0.6%	4.1%	0.4%	0.6%	1.0%	70.9%	**100%**
Social Worker	11.1%	11.7%	9.7%	1.0%	2.3%	7.1%	4.0%	4.9%	1.8%	2.2%	3.3%	40.7%	**100%**

Appendix 4: Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) – Tables and Charts

A4.1 Wellbeing Scores by Country

Overall mean wellbeing scores are slightly higher for the NI sample than UK wide. There is a significant difference in mean total wellbeing scores across countries (F=3.767, df=3, p<0.05).

Figure A4.1: Wellbeing Scores by Country

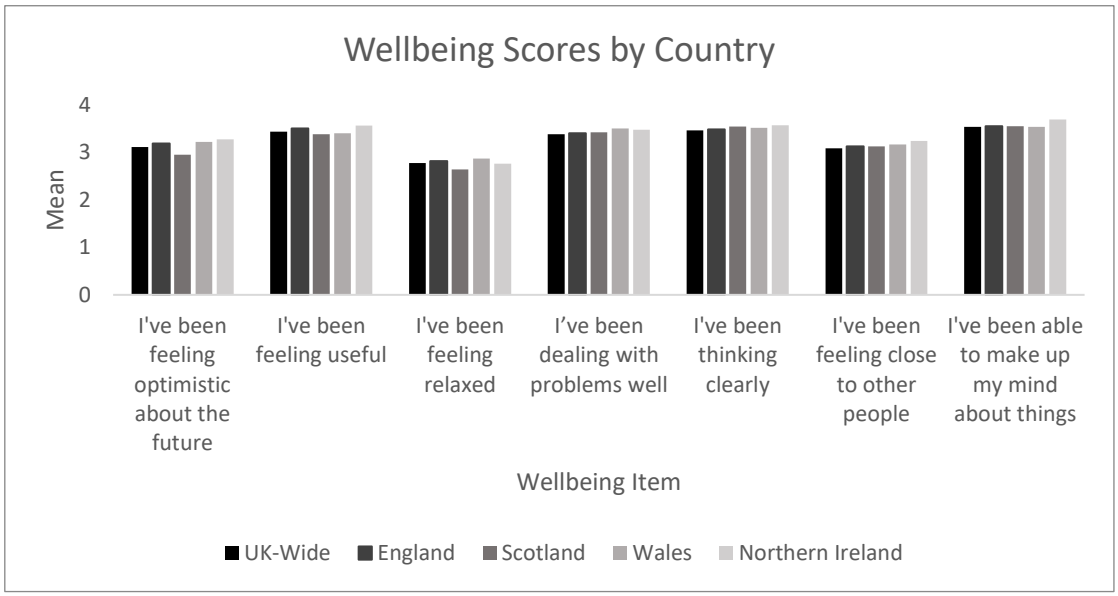


Figure A4.2: Total Wellbeing Score by Country

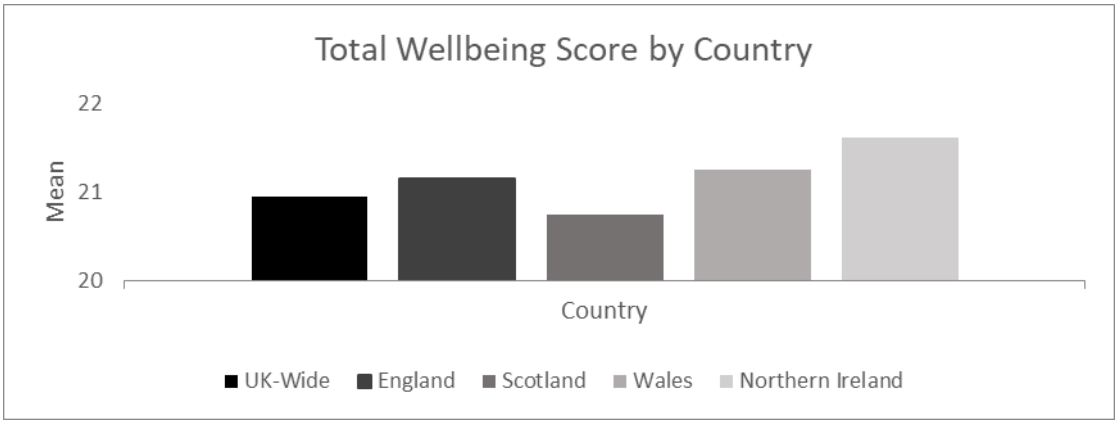


Table A4.1: Wellbeing Scores by Country

Wellbeing Item	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	3.11	3.18	2.95	3.22	3.27
I've been feeling useful	3.43	3.50	3.38	3.40	3.56
I've been feeling relaxed	2.77	2.81	2.64	2.87	2.76
I've been dealing with problems well	3.38	3.40	3.42	3.50	3.47
I've been thinking clearly	3.46	3.48	3.54	3.51	3.57
I've been feeling close to other people	3.08	3.12	3.12	3.16	3.24
I've been able to make up my mind about things	3.53	3.55	3.55	3.53	3.69
Overall mean Wellbeing Score	20.95	21.15	20.74	21.25	21.61

A4.2 Wellbeing Scores by Occupation

There is no significant difference in mean total wellbeing scores across occupations ($F=1.932$, $df=4$, $p>0.05$).

Figure A4.3: Total Wellbeing Score by Occupation

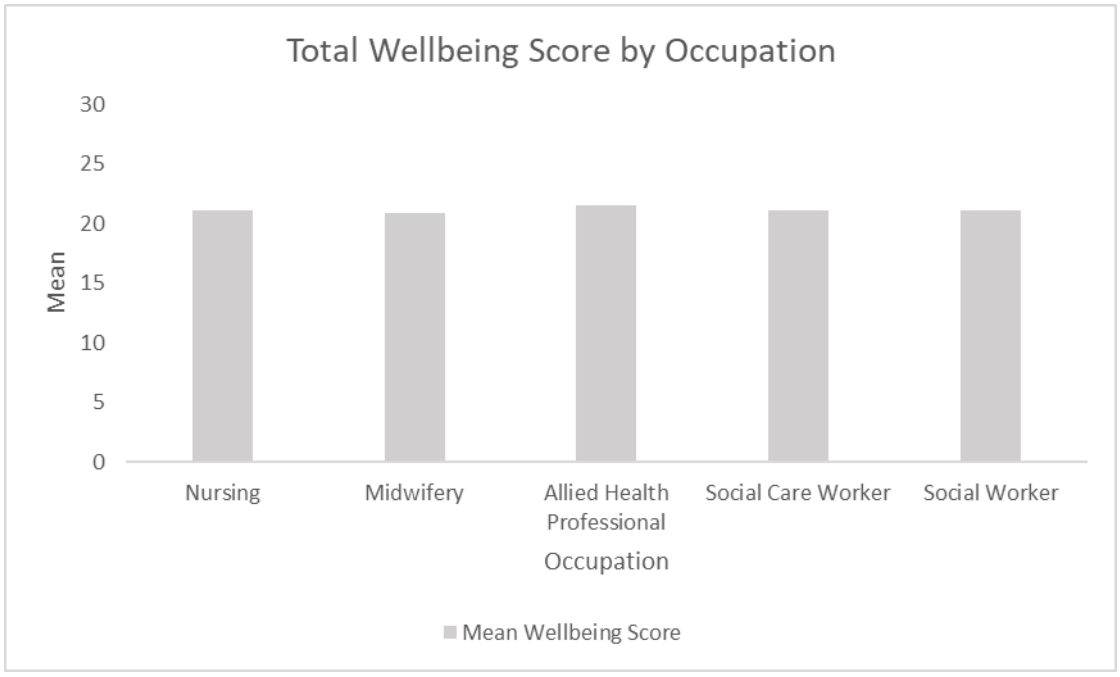


Table A4.2: Total Wellbeing Score by Occupation

Occupation	Mean Wellbeing Score
Nursing	21.15
Midwifery	20.91
Allied Health Professional	21.51
Social Care Worker	21.14
Social Worker	21.14

A2.3 Wellbeing Scores by Gender

Males report a higher level of wellbeing than female and this difference in wellbeing scores across gender is significant (F=15.342, df=2, p<0.001).

Figure A4.4: Total Wellbeing Score by gender

Table A4.3: Comparing 2018 and 2020 Wellbeing Scores by Gender

Gender	Mean Wellbeing Score		
	COVID-19 Study 2020	SWAS - UK Social Workers	SWAS - NI Social Workers
Male	21.41	21.00	21.53
Female	20.88	21.09	21.77
Neither	16.14	-	-

A4.4 Wellbeing Scores by Age

There is a significant difference in wellbeing scores across age-groups (F=24.418, df=6, p<0.001). As people get older, they generally report higher well-being scores. This was the same in the 2018 ageing workforce study.

Figure A4.5: Total Wellbeing Score by Age

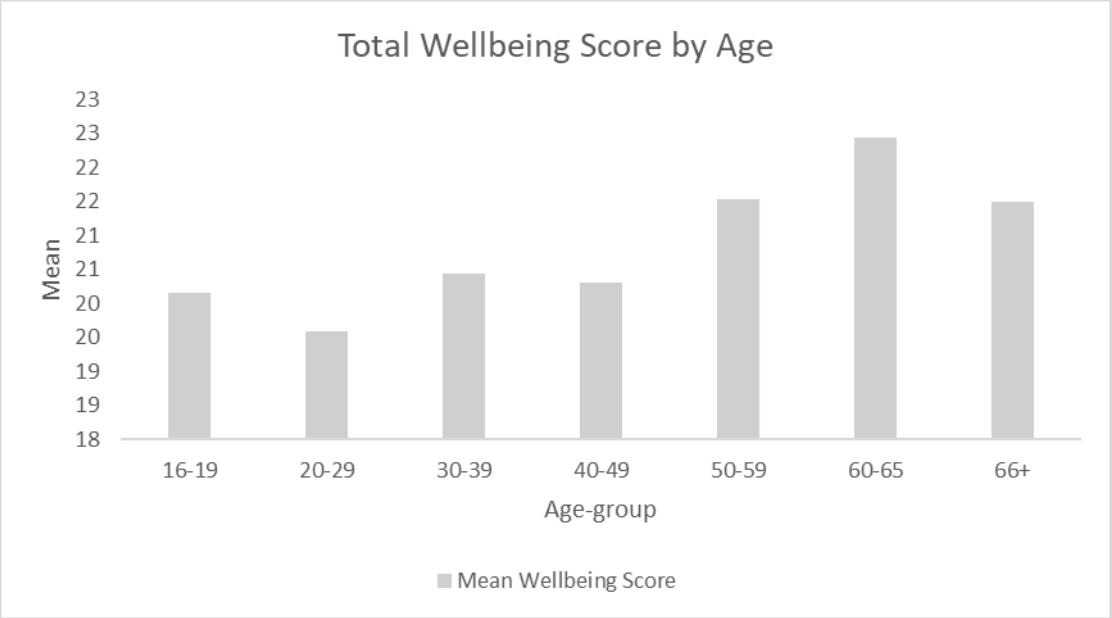


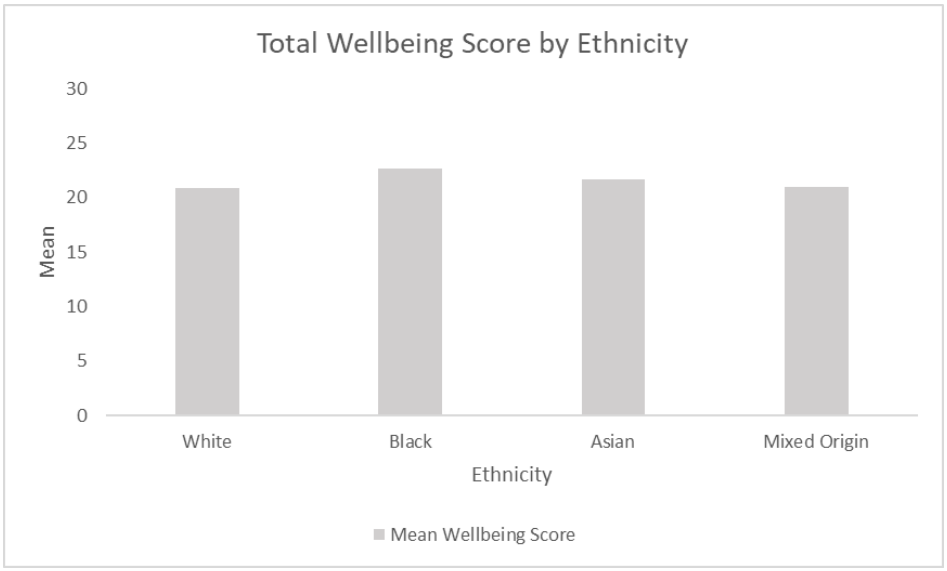
Table A4.4: Comparing 2018 and 2020 Wellbeing Scores by Age

Age group	Mean Wellbeing Score		
	COVID-19 Study 2020	SWAS – UK Social Workers 2018	SWAS – NI Social Workers 2018
18-24	20.16	19.23	20.85
25-34	19.59	20.90	21.78
35-44	20.44	20.85	21.09
45-54	20.30	21.15	21.81
55-59	21.53	20.77	21.78
60-64	22.44	21.45	23.26
65+	21.50	22.76	24.75

A4.5 Wellbeing Scores by Ethnicity

There is a significant difference in mean total wellbeing scores across ethnicities, with Black people reporting the highest scores (F=8.303, df=3, p<0.001).

Figure A4.6: Total Wellbeing Score by Ethnicity



A4.5 Wellbeing Scores by Disability

There is a significant difference in wellbeing scores by disability ($F=57.475$, $df=2$, $p<0.001$). Those who reported no disability had a higher well-being score. This was the same for the 2018 study.

Figure A4.7: Total Wellbeing Score by Disability

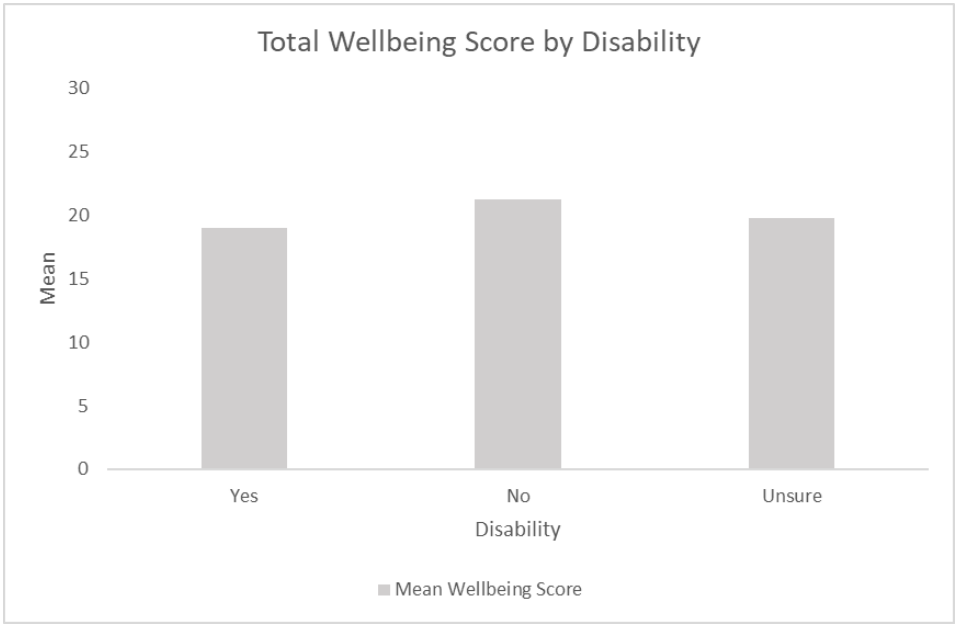


Table A4.5: Comparing 2018 and 2020 Wellbeing Scores by Disability

Disability	Mean Wellbeing Score		
	COVID-19 Study 2020	**SWAS - UK Social Workers**	**SWAS - NI Social Workers**
Yes	18.99	19.88	20.49
No	21.22	21.28	21.86
Unsure	19.76	-	-

A4.6 Wellbeing Scores by Job Area

There is a significant difference in wellbeing scores across job areas (F=27.760, df=7, p<0.001). Those who work in Midwifery report the lowest wellbeing scores (18.42) and those who work with Children report the highest (21.93). Looking at these figures by occupation, Nurses who work with Physical Disabilities report the lowest wellbeing scores (17.43), whilst those who work in Midwifery report the highest (25.03).

Figure A4.8: Total Wellbeing Score by Job Area

Table A4.6: Wellbeing Scores by Job Area

Area of Practice	Mean Wellbeing Score
Children	21.93
Adults	21.52
Physical Disability	19.38
Learning Disability	19.31
Older People	21.23
Mental Health	20.50
Midwifery	18.42
Other	20.69

Appendix 5: Quality of Working Life Scale (WRQoL) – Tables and Charts

A5.1 Quality of Working Life Scores by Country

There are significant differences in all of the quality of working life domains across countries. England score highest in Stress at Work (SAW), whilst Wales score highest in Job & Career Satisfaction (JCS), General Wellbeing (GWB), and Working Conditions WCS. It should be noted that a high SAW score means lower stress at work. Scotland scores lowest in all quality of working life items. The highest total score for quality of working life was in Wales (83.94).

Figure A5.1: Quality of Working Life Scores by Country

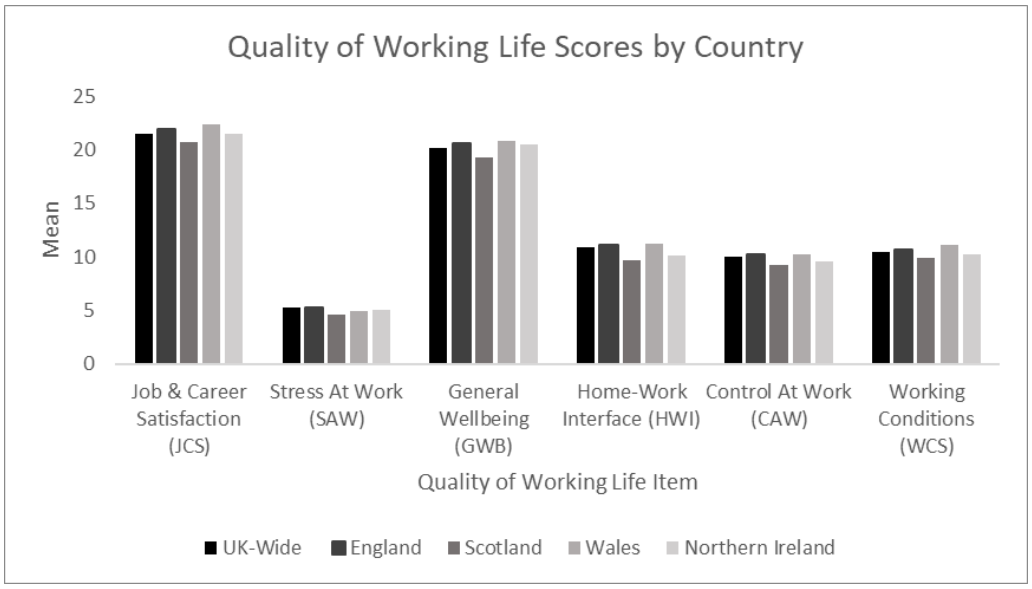


Figure A5.2: Total Quality of Working Life Score by Country

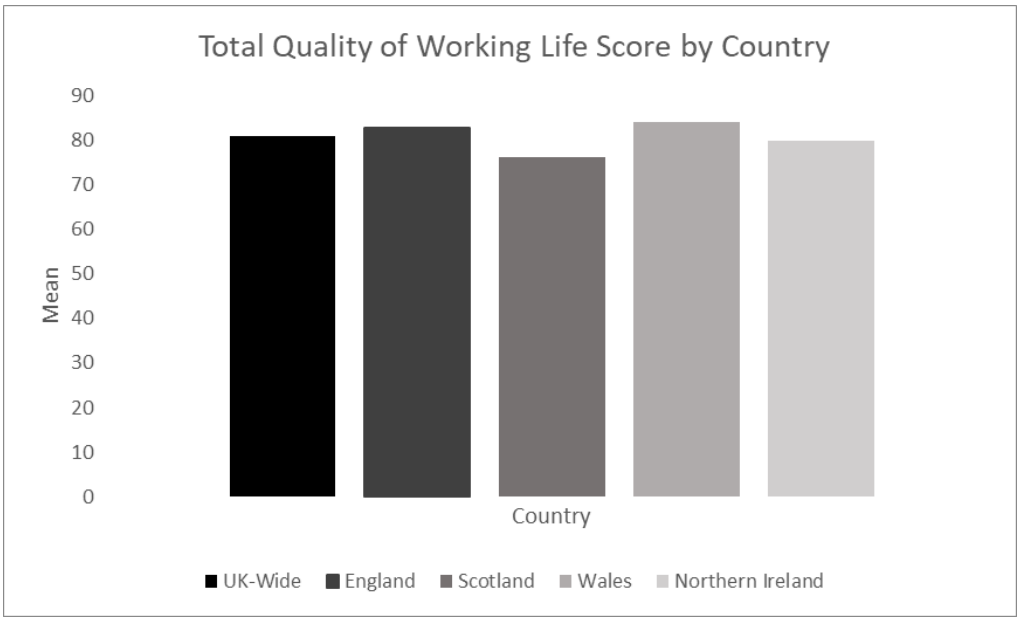


Table A5.1: Quality of Working Life Scores by Country

WRQL Domain	UK-Wide	England	Scotland	Wales	Northern Ireland
Job & Career Satisfaction (JCS)	21.48	21.95	20.77	22.38	21.48
Stress At Work (SAW)	5.23	5.22	4.57	4.98	5.06
General Wellbeing (GWB)	20.17	20.65	19.32	20.85	20.55
Home-Work Interface (HWI)	10.84	11.11	9.71	11.26	10.18
Control At Work (CAW)	9.97	10.27	9.22	10.26	9.57
Working Conditions (WCS)	10.49	10.71	9.87	11.13	10.23
Total Mean Quality of Working Life Score	80.94	82.74	76.22	83.94	79.94

Figure A5.3: Level of Quality of Working Life Scores - UK-Wide

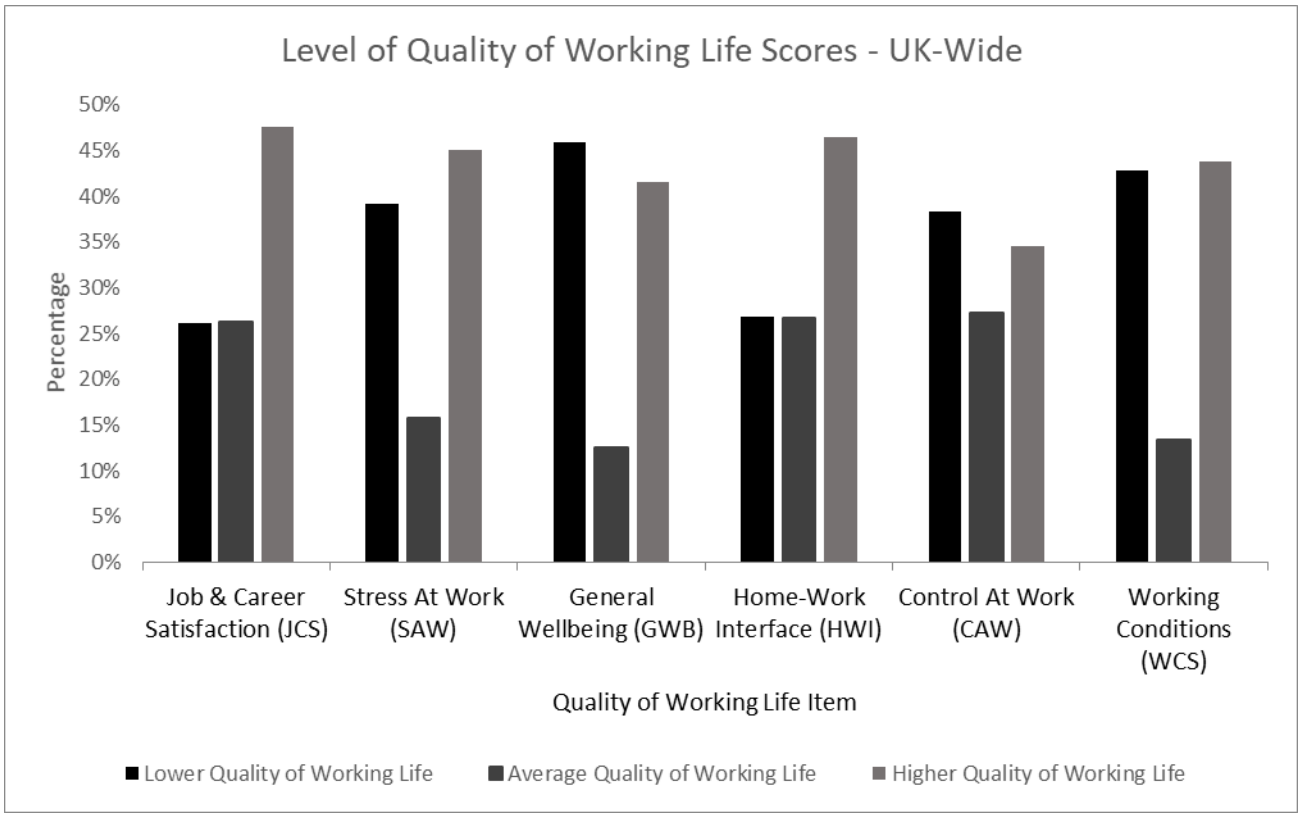


Table A5.2: Level of Quality of Working Life Scores - UK-Wide

Quality of Working Life Domain	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
Job & Career Satisfaction (JCS)	26.1%	26.3%	47.6%	**100%**
Stress At Work (SAW)	39.2%	15.7%	45.1%	**100%**
General Wellbeing (GWB)	45.9%	12.5%	41.6%	**100%**
Home-Work Interface (HWI)	26.8%	26.7%	46.5%	**100%**
Control At Work (CAW)	38.3%	27.2%	34.5%	**100%**
Working Conditions (WCS)	42.8%	13.4%	43.8%	**100%**
Quality of Working Life Total	34.6%	15.4%	50.0%	**100%**

Figure A5.4: Level of Total Quality of Working Life Score by Country

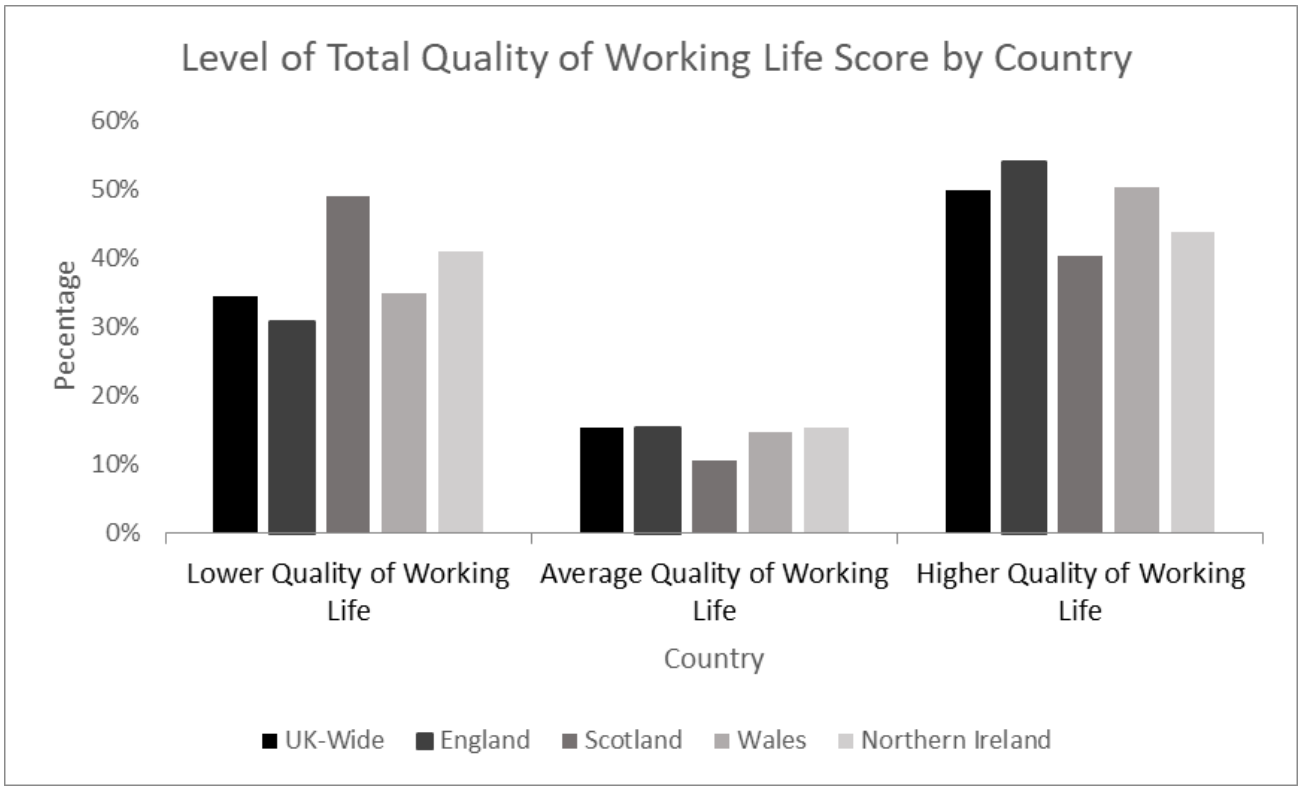


Table A5.3: Level of Total Quality of Working Life Score by Country

Level of Quality of Working Life	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower Quality of Working Life	34.6%	30.7%	49.0%	35.0%	41.0%
Average Quality of Working Life	15.4%	15.3%	10.6%	14.7%	15.3%
Higher Quality of Working Life	50.0%	54.0%	40.4%	50.4%	43.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

A5.2 Quality of Working Life Scores by Gender

There are significant gender differences across all of the quality of working life domains. Males report a significantly higher total quality of working life score ($F=13.292$, $df=2$, $p<0.001$).

Figure A5.5: Quality of Working Life Scores by Gender

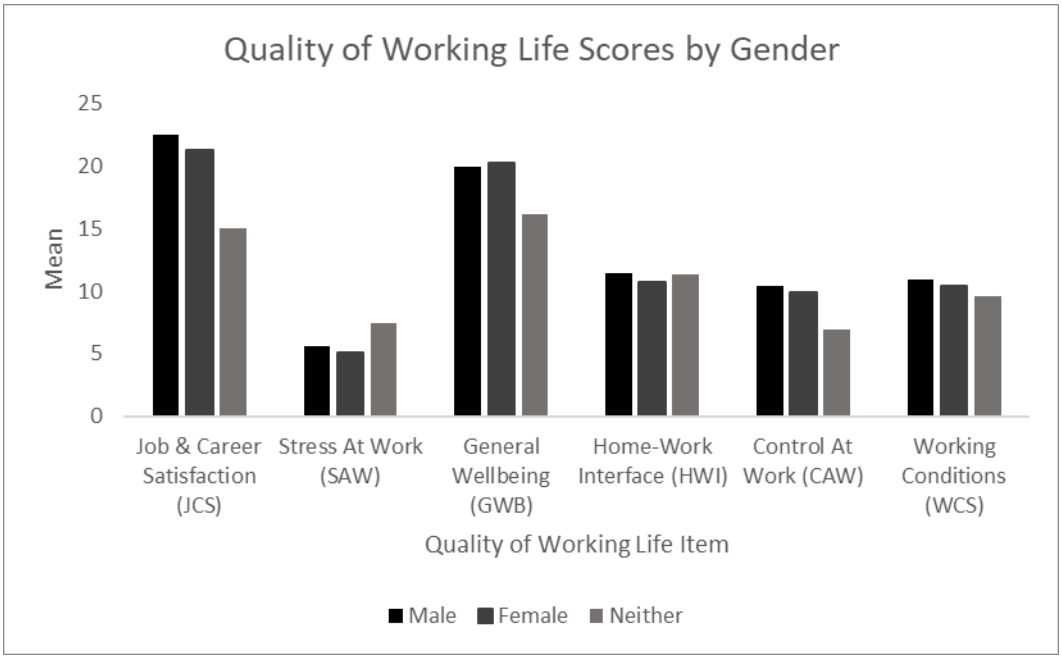


Table A5.4: Quality of Working Life Scores by Gender

Quality of Working Life Domain	Mean Quality of Working Life						
	COVID-19 Study 2020			SWAS – UK Social Workers 2018		SWAS – NI Social Workers 2018	
	Male	Female	Neither	Male	Female	Male	Female
JCS	22.50	21.29	15.08	20.48	20.04	20.75	20.48
SAW	5.64	5.13	7.44	4.58	4.37	4.75	4.32
GWB	19.96	20.23	16.21	19.59	19.16	20.03	20.04
HWI	11.43	10.71	11.34	10.15	9.47	10.06	9.69
CAW	10.43	9.89	6.97	10.06	9.34	10.15	9.65
WCS	10.89	10.41	9.63	9.53	9.28	9.88	9.52
Quality of Working Life Total	84.06	80.31	67.12	74.44	71.71	75.92	73.75

Figure A5.6: Total Quality of Working Life Score by Gender

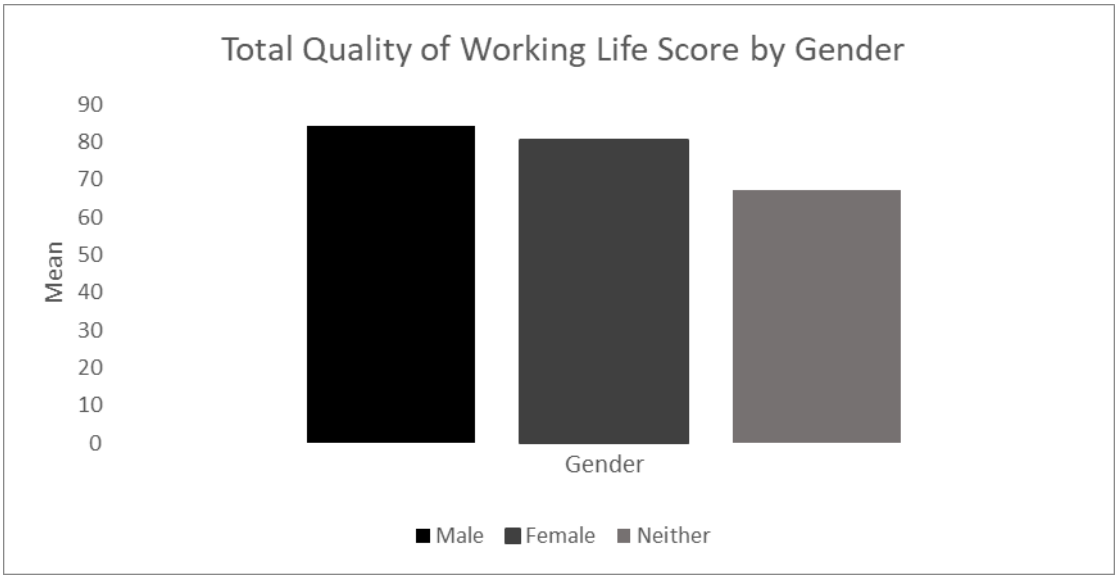


Figure A5.7: Level of Total Quality of Working Life Score by Gender

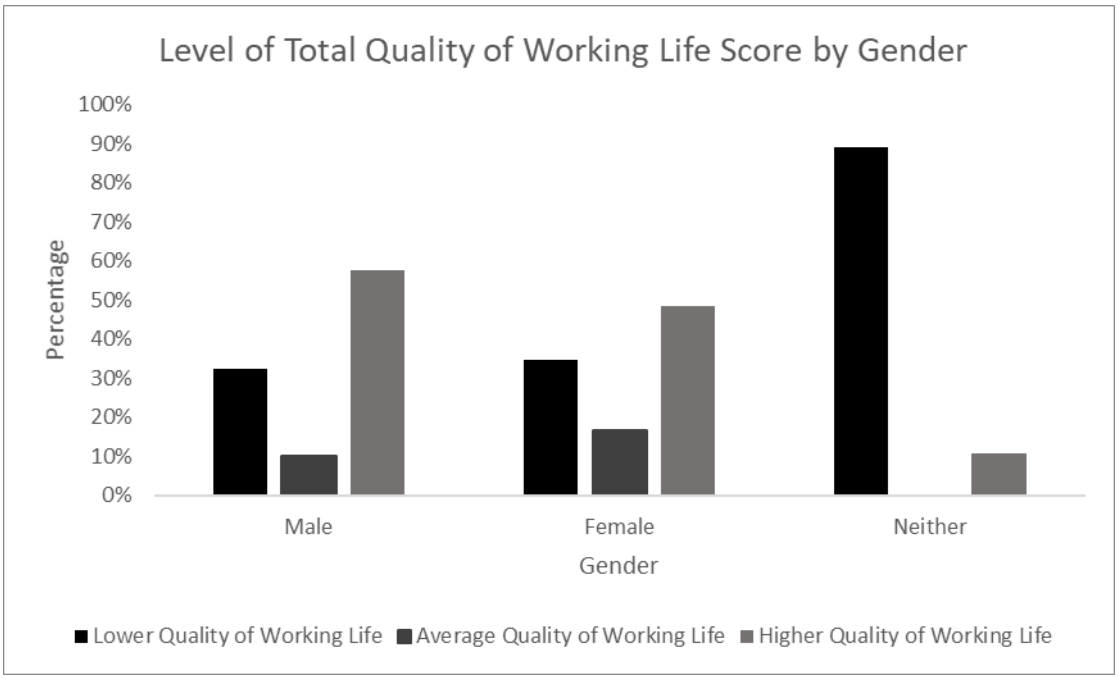


Table A5.5: Level of Total Quality of Working Life Score by Gender

Level of Quality of Working Life	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
Male	32.3%	10.0%	57.7%	**100%**
Female	34.8%	16.6%	48.6%	**100%**
Neither	89.2%	0.0%	10.8%	**100%**

A5.3 Quality of Working Life Scores by Age

There are significant differences across all quality of working life domains between age groups. There is also a significant difference in the quality of working life total between age groups (F=31.028, df=6, p<0.001). Scores tend to increase as people get older, so this should correlate with the wellbeing scale results and is aligned to 2018 findings for social workers in the ageing social work workforce study. These scores align to the findings in the 2018 Social Work Study showing that there is a significant positive correlation (0.556) between wellbeing and quality of working life.

Figure A5.8: Quality of Working Life Scores by Age

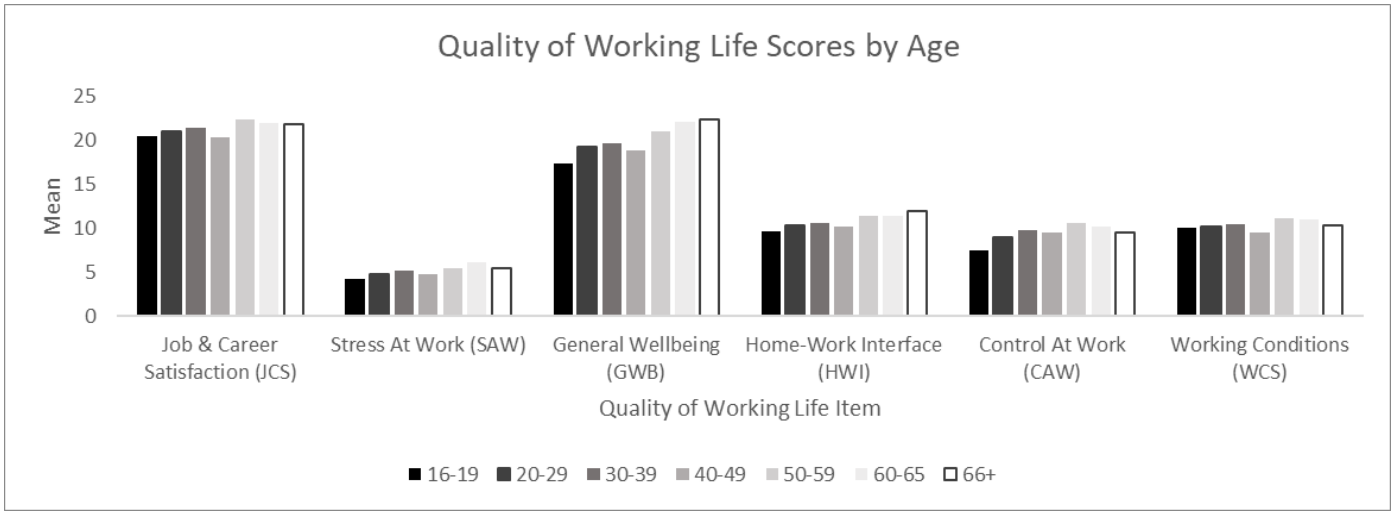


Table A5.6: Quality of Working Life Scores by Age

	Mean Quality of Working Life			
Age group	**COVID-19 Study 2020**	**Age group**	**SWAS – UK Social Workers 2018**	**SWAS – NI Social Workers 2018**
16-19	71.67	**18-24**	69.25	71.20
20-29	77.10	**25-34**	69.87	70.81
30-39	79.95	**35-44**	71.47	72.48
40-49	75.32	**45-54**	72.49	74.54
50-59	85.31	**55-59**	70.99	76.36
60-65	85.92	**60-64**	75.47	79.71
66+	83.99	**65+**	77.23	82.33

Figure A5.9: Total Quality of Working Life Score by Age

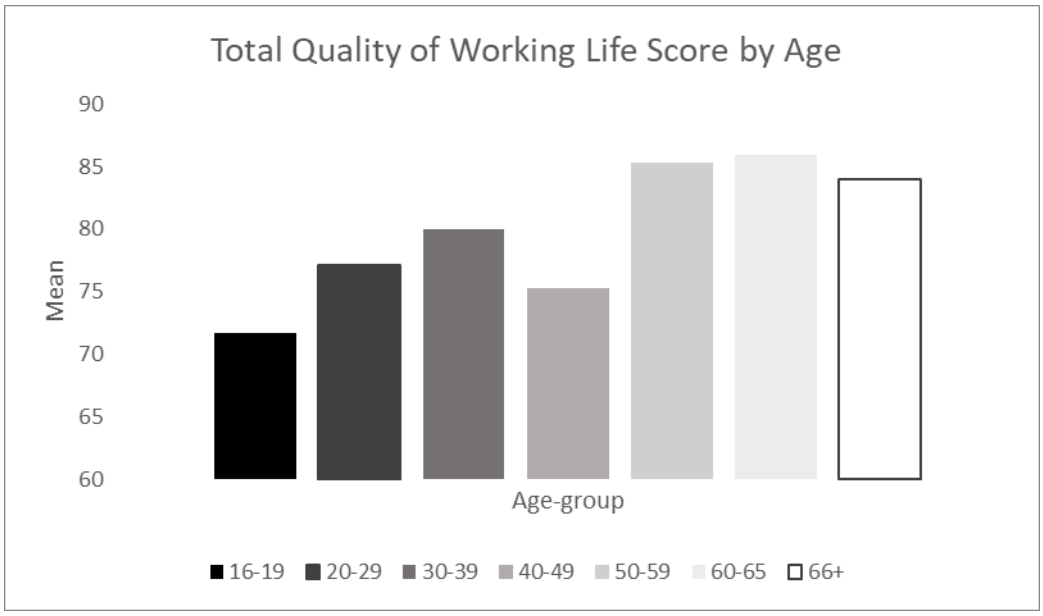


Figure A5.10: Level of Total Quality of Working Life Score by Age

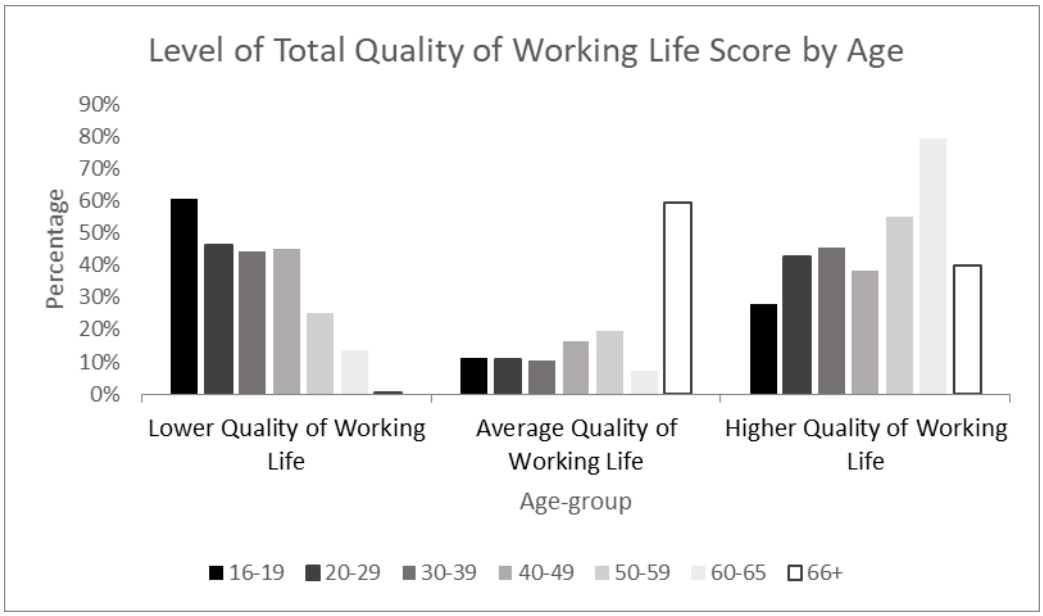


Table A5.7: Level of Total Quality of Working Life Score by Age

Quality of Working Life Domain	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
16-19	60.8%	11.2%	28.0%	**100%**
20-29	46.4%	10.8%	42.8%	**100%**
30-39	44.2%	10.4%	45.4%	**100%**
40-49	45.0%	16.5%	38.4%	**100%**
50-59	25.3%	19.6%	55.1%	**100%**
60-65	13.4%	7.2%	79.3%	**100%**
66+	0.6%	59.4%	40.0%	**100%**

A5.4 Quality of Working Life Scores by Occupation

There are significant differences in all of the quality of working life domains across occupations and also the total quality of working life. Allied Health Professionals score highest in the four of the domains and have the highest overall quality of working life score (84.91).

Allied Health Workers reported high JCS than other professions. Midwives reported most stress at work (lowest score), followed by Social Workers, then Allied Health Workers.

Figure A5.11: Quality of Working Life Scores by Occupation

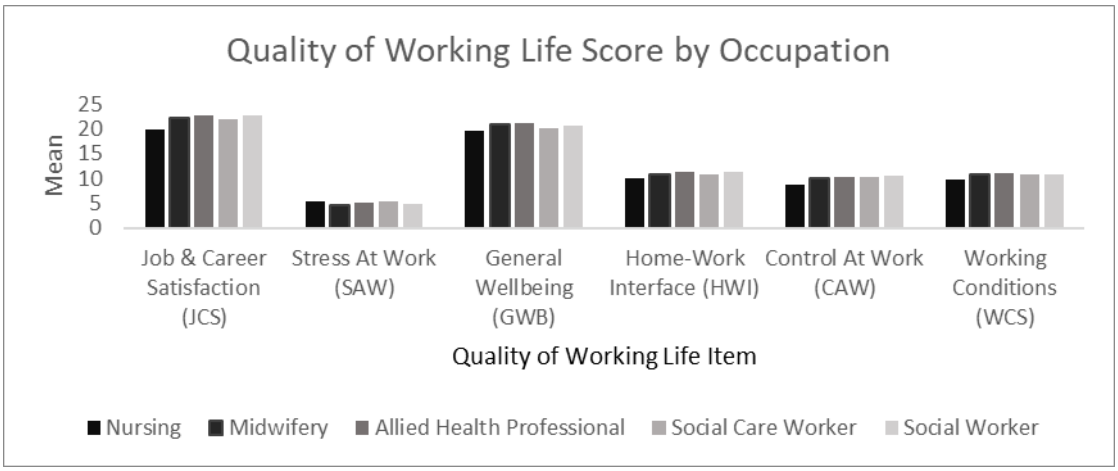


Table A5.8: Quality of Working Life Scores by Occupation

Quality of Working Life Domain	Mean Quality of Working Life				
	Nursing	Midwifery	Allied Health Professional	Social Care Worker	Social Worker
Job & Career Satisfaction (JCS)	19.85	22.21	22.73	21.92	22.70
Stress At Work (SAW)	5.25	4.55	5.13	5.29	4.82
General Wellbeing (GWB)	19.77	20.91	21.32	20.16	20.75
Home-Work Interface (HWI)	10.11	10.68	11.26	10.92	11.34
Control At Work (CAW)	8.79	9.96	10.41	10.40	10.63
Working Conditions (WCS)	9.82	10.79	11.02	10.68	10.85
Quality of Working Life Total	75.63	82.12	84.91	82.31	84.43

Figure A5.12: Total Quality of Working Life Score by Occupation

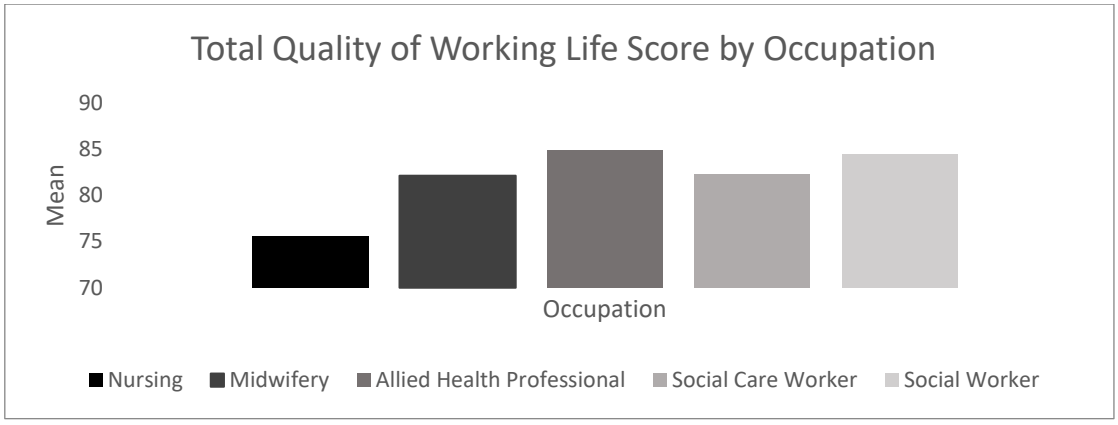
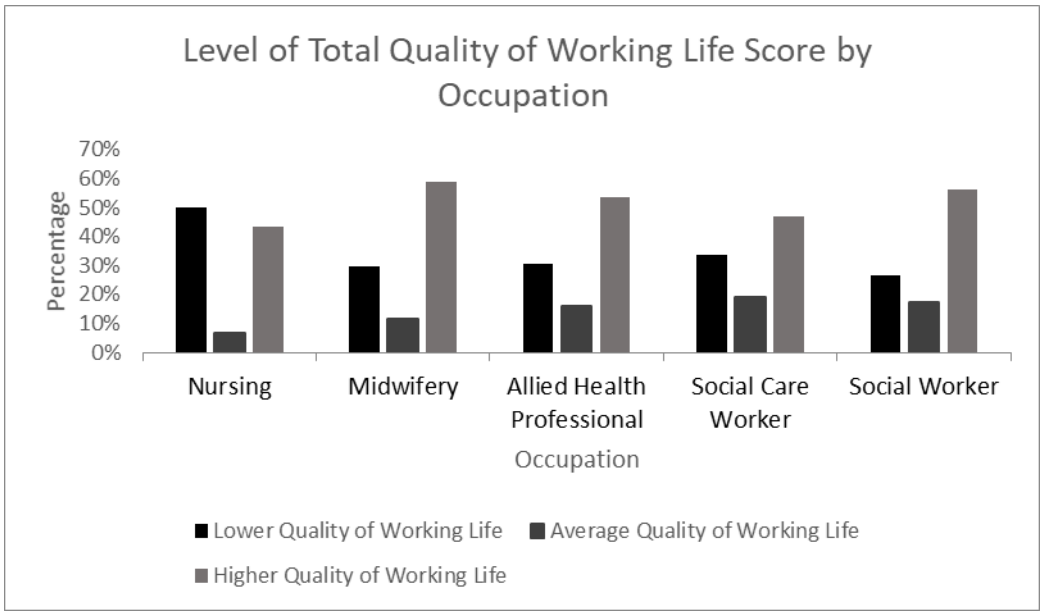


Table A5.9: Level of Total Quality of Working Life Score by Occupation

Quality of Working Life Domain	Nursing	Midwifery	Allied Health Professional	Social Care Worker	Social Worker
Lower Quality of Working Life	49.9%	29.7%	30.4%	33.7%	26.6%
Average Quality of Working Life	6.8%	11.3%	15.9%	19.2%	17.2%
Higher Quality of Working Life	43.3%	59.0%	53.7%	47.1%	56.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A5.13: Level of Total Quality of Working Life Score by Occupation



Appendix 6: Carver Coping Scale – Tables and Charts

A6.1 Carver Coping Scores by Country

There are significant differences in all but five of the Carver Coping Scale domains across countries. These differences were in: Self-distraction; Denial; Substance use; Use of instrumental support; Positive reframing; Humour; Acceptance; Religion; and Self-blame.

In Northern Ireland, substance use (5.14) and positive reframing (4.75) scored highest as coping mechanisms. This compares to Scotland where people turned to religion (4.37) and used self-distraction (4.79). In Wales, people use instrumental support (3.60), acceptance (2.69) and self-blame to cope (3.96). In England, people were less likely than other parts of the UK to use self-distraction (4.31) or acceptance (2.50) as a coping mechanism.

Figure A6.1: UK-wide Carver Coping Scores

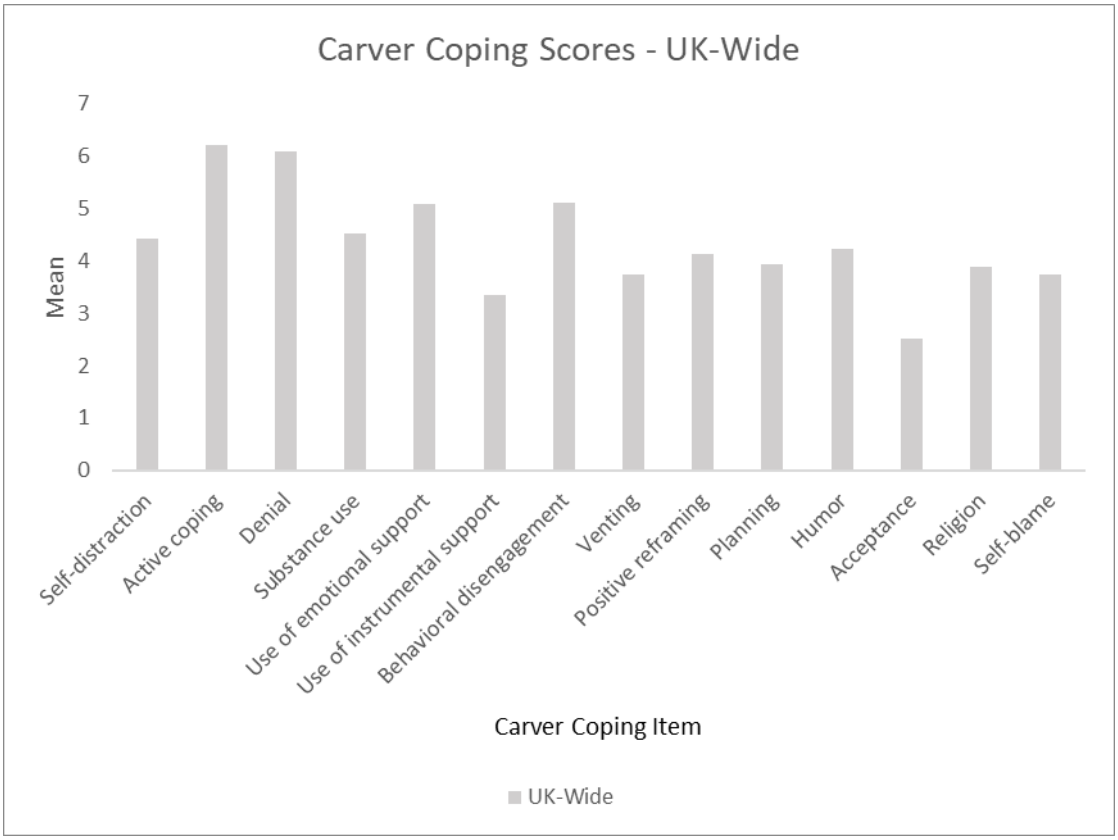


Table A6.1: Carver Coping Scores by Country

Carver Domain	UK-Wide	England	Scotland	Wales	Northern Ireland
Self-distraction	4.42	4.31	4.79	4.58	4.73
Active coping	6.21	6.24	6.61	6.38	6.30
Denial	6.10	6.13	6.26	6.41	6.06
Substance use	4.53	4.62	4.72	4.41	5.14
Use of emotional support	5.08	5.09	5.36	5.33	5.15
Use of instrumental support	3.36	3.41	3.42	3.60	3.26
Behavioural disengagement	5.12	5.21	5.08	5.40	5.15
Venting	3.75	3.76	3.97	3.84	3.71
Positive reframing	4.14	4.26	4.27	3.93	4.75
Planning	3.93	3.98	3.76	4.04	3.89
Humour	4.24	4.14	4.81	4.09	4.19
Acceptance	2.52	2.50	2.57	2.69	2.65
Religion	3.89	3.79	4.37	4.02	3.64
Self-blame	3.73	3.81	3.62	3.96	3.63

A6.2 Carver Coping Scores by Gender

There are significant gender differences in all but two of the Carver Coping domains. The two that did not show significant differences were Behavioural disengagement and Positive reframing. Females are more likely than females to use active coping, denial, substance use and use of emotional support than males.

Figure A6.2: Carver Coping Scores by Gender

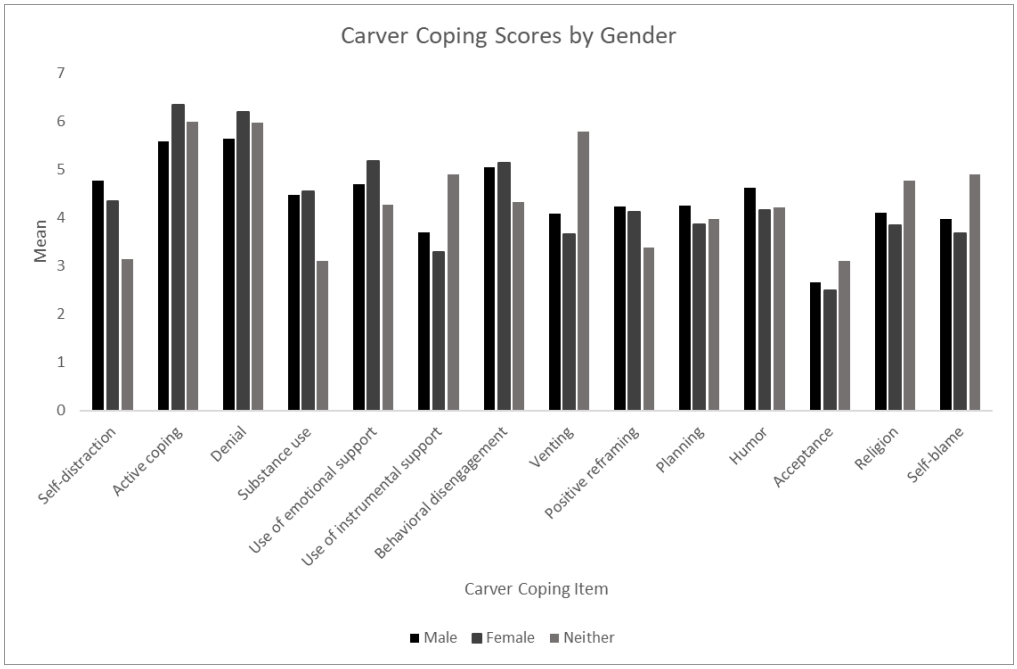


Table A6.2: Carver Coping Scores by Gender

Carver Domain	Mean Carver Score		
	Male	Female	Neither
Self-distraction	4.77	4.35	3.14
Active coping	5.58	6.35	6.00
Denial	5.64	6.20	5.97
Substance use	4.47	4.55	3.11
Use of emotional support	4.70	5.17	4.27
Use of instrumental support	3.69	3.28	4.89
Behavioural disengagement	5.05	5.14	4.33
Venting	4.08	3.66	5.79
Positive reframing	4.22	4.13	3.38
Planning	4.25	3.86	3.98
Humour	4.62	4.16	4.21
Acceptance	2.65	2.49	3.09
Religion	4.10	3.83	4.76
Self-blame	3.97	3.67	4.90

A6.3 Carver Coping Scores by Age

There are significant differences across age groups all of the Carver Coping domains. Those aged 16-19 were more likely than any other age group to use self-distraction (4.77), instrumental support (3.99), positive reframing (5.11), humour (5.43), acceptance (3.10) and religion (5.10) as coping mechanisms.

Figure A6.3: Carver Coping scores by Age

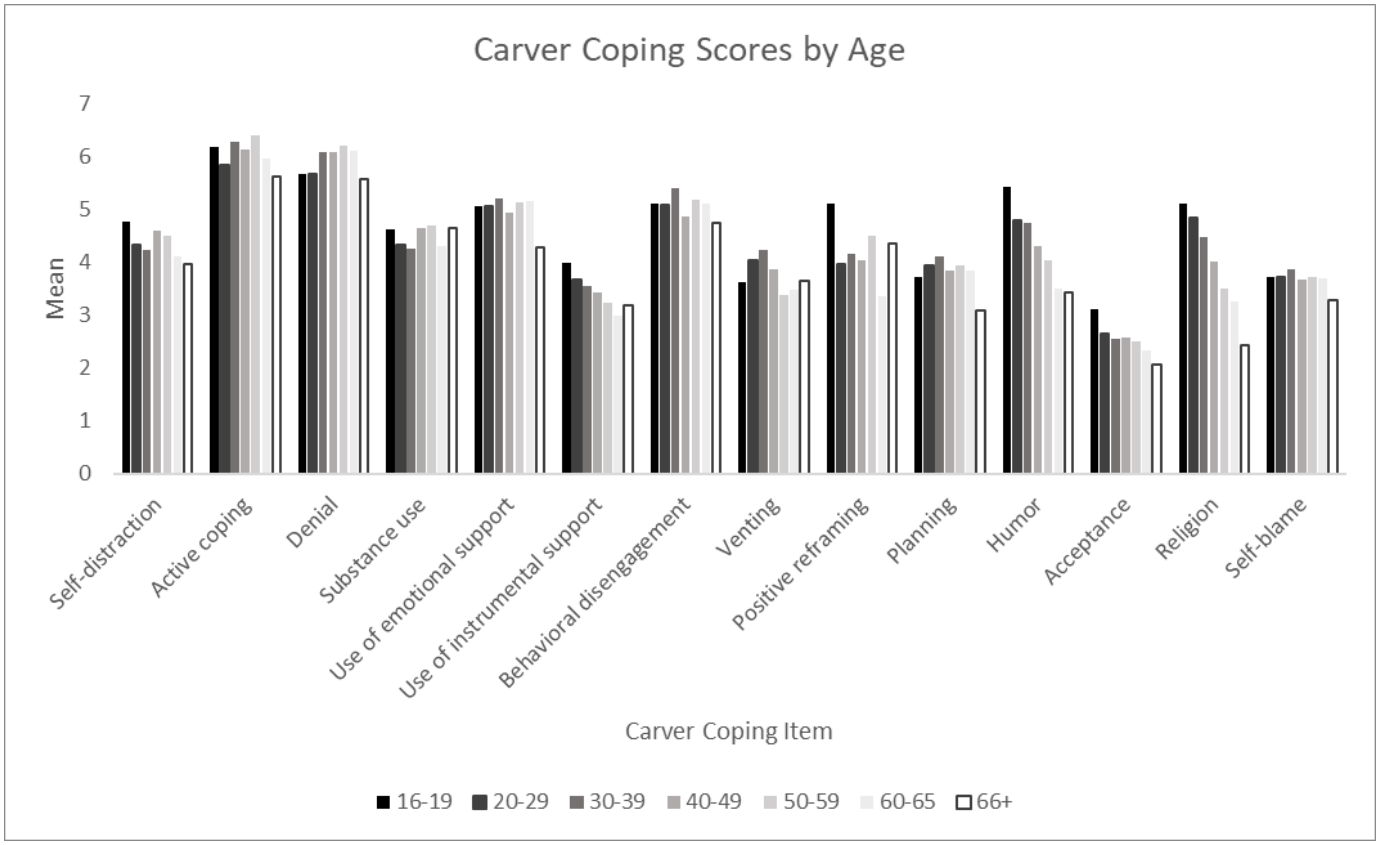


Table A6.3: Carver Coping scores by Age

Carver Domain	Mean Carver Score						
	16-19	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Self-distraction	4.77	4.32	4.23	4.60	4.50	4.12	3.96
Active coping	6.17	5.85	6.27	6.13	6.40	5.97	5.62
Denial	5.67	5.66	6.09	6.08	6.21	6.10	5.57
Substance use	4.62	4.32	4.25	4.64	4.70	4.29	4.65
Use of emotional support	5.06	5.06	5.20	4.94	5.13	5.16	4.28
Use of instrumental support	3.99	3.68	3.55	3.44	3.23	2.99	3.18
Behavioural disengagement	5.11	5.09	5.39	4.87	5.19	5.10	4.75
Venting	3.62	4.03	4.24	3.87	3.39	3.48	3.64
Positive reframing	5.11	3.96	4.16	4.03	4.49	3.35	4.35
Planning	3.73	3.93	4.11	3.85	3.94	3.83	3.09
Humour	5.43	4.78	4.75	4.31	4.04	3.51	3.42
Acceptance	3.10	2.66	2.54	2.58	2.50	2.33	2.08
Religion	5.10	4.83	4.48	4.02	3.49	3.25	2.43
Self-blame	3.73	3.71	3.87	3.68	3.72	3.70	3.28

A6.4 Carver Coping Scores by Occupation

There are significant differences across occupations in all but three of the Carver Coping domains, these are Active coping; Use of emotional support and Acceptance. Nurses are most likely to use self-distraction (4.56), venting (4.00) and religion (4.06) and least likely to use Acceptance as a coping mechanism (2.52).

Figure A6.4: Carver Coping Scores by Occupation

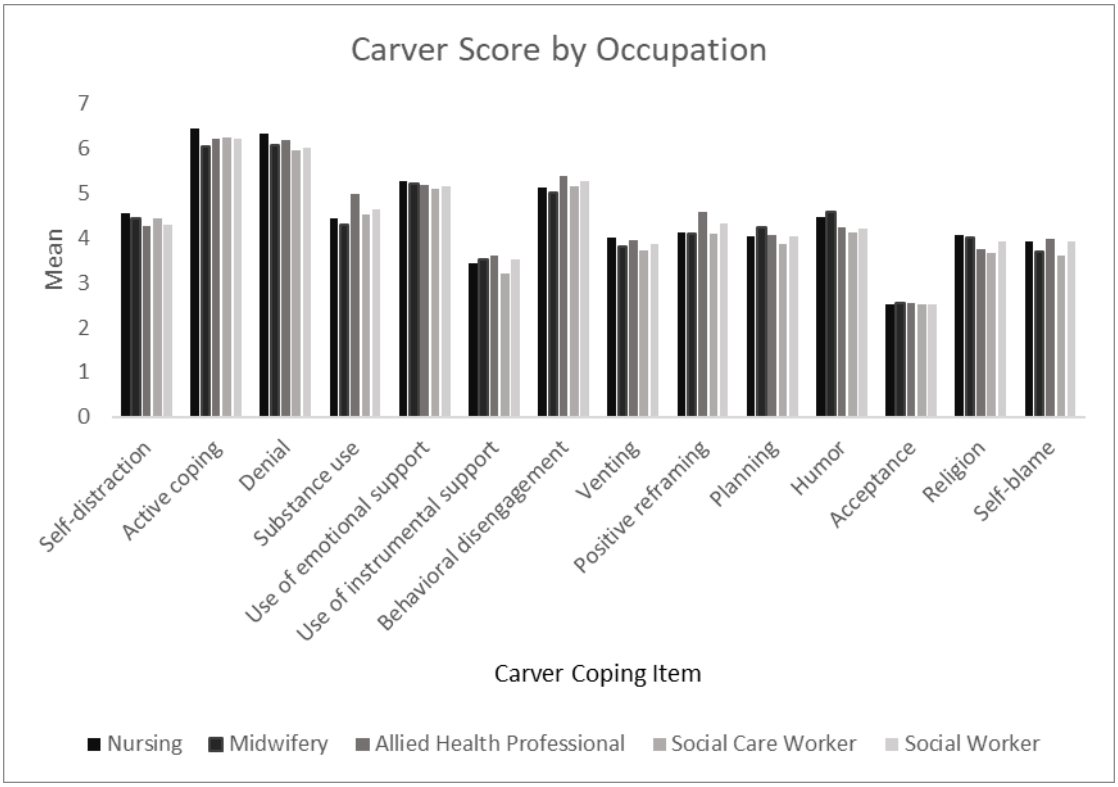


Table A6.4: Carver Coping Scores by Occupation

Carver Domain	Mean Carver Score				
	Nursing	Midwifery	Allied Health Professional	Social Care Worker	Social Worker
Self-distraction	4.56	4.42	4.27	4.45	4.29
Active coping	6.43	6.04	6.20	6.22	6.21
Denial	6.32	6.05	6.19	5.96	6.02
Substance use	4.44	4.30	4.98	4.53	4.62
Use of emotional support	5.25	5.22	5.17	5.09	5.16
Use of instrumental support	3.43	3.52	3.61	3.21	3.51
Behavioural disengagement	5.12	5.02	5.37	5.16	5.27
Venting	4.00	3.79	3.95	3.71	3.87
Positive reframing	4.13	4.10	4.56	4.10	4.31
Planning	4.04	4.23	4.06	3.86	4.03
Humour	4.47	4.58	4.22	4.11	4.21
Acceptance	2.52	2.55	2.54	2.52	2.53
Religion	4.06	4.00	3.74	3.65	3.91
Self-blame	3.92	3.69	3.98	3.61	3.93

Appendix 7: Clark Coping Scale – Tables and Charts

A7.1 Clark Coping Scores by Country

There are significant differences in three of the Clark Coping Scale domains across countries: Work to improve skills/efficiency; Recreation /relaxation; and Exercise. People in England were more likely to use were most likely to use recreation and relaxation (3.87). Those in Wales were most likely to work to improve skills/efficiency (4.56) and exercise (4.07).

Figure A7.1: Clark Coping Scores by Country

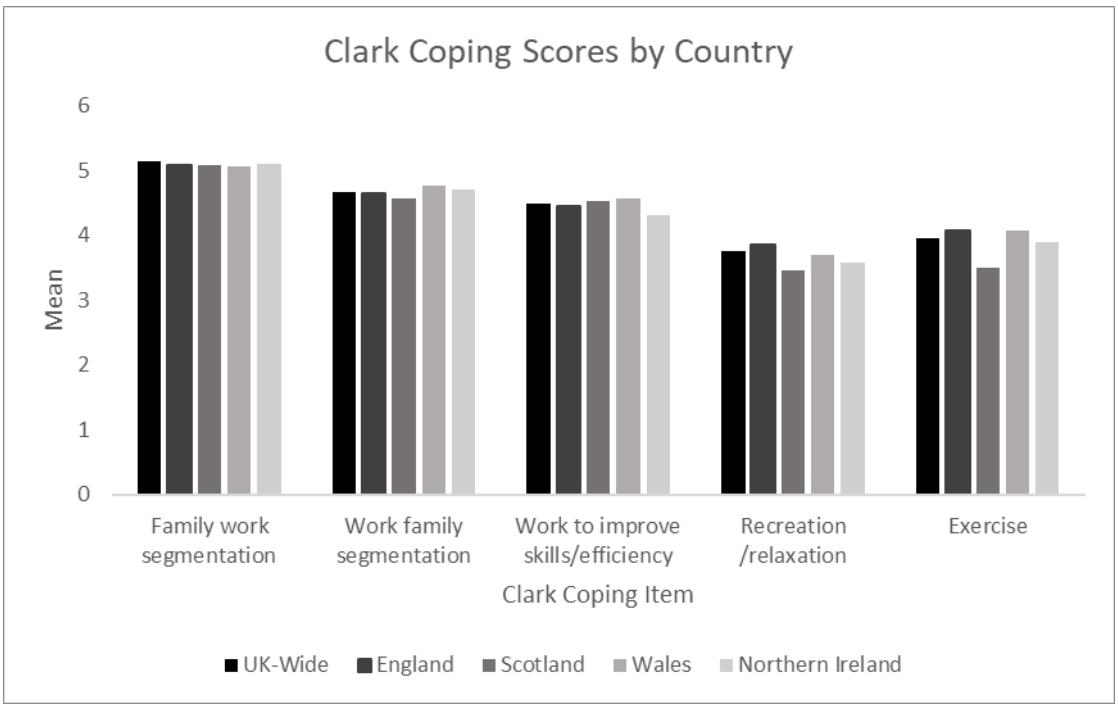


Table A7.1: Clark Coping Scores by Country

	Mean Clark Score				
Clark Domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Family work segmentation	5.14	5.08	5.09	5.07	5.11
Work family segmentation	4.68	4.65	4.58	4.78	4.71
Work to improve skills/efficiency	4.48	4.46	4.53	4.56	4.31
Recreation /relaxation	3.75	3.87	3.47	3.70	3.57
Exercise	3.96	4.07	3.51	4.07	3.89

A7.2 Clark Coping Scores by Gender

There were significant differences in mean scores across all Clark Coping Domains by gender. Females were more likely than males to work to improve skills/efficiency (4.53), whilst males were more likely to cope using exercise (4.29).

Figure A7.2: Clark Coping Scores by Gender

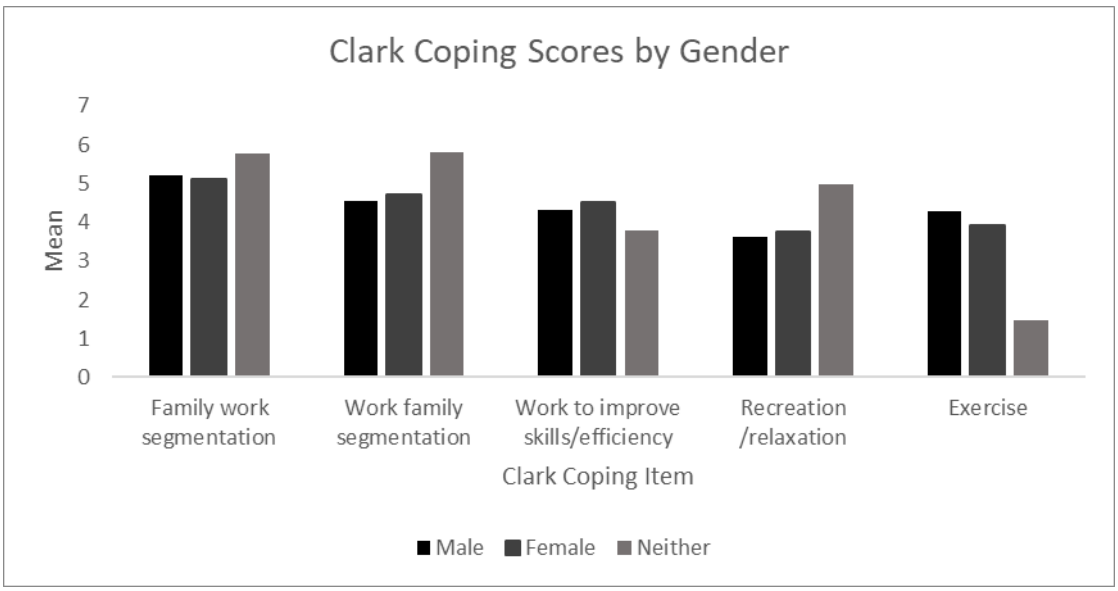


Table A7.2: Clark Coping Scores by Gender

	Mean Clark Score		
Clark Domain	**Male**	**Female**	**Neither**
Family work segmentation	5.22	5.12	5.77
Work family segmentation	4.55	4.70	5.81
Work to improve skills/efficiency	4.30	4.53	3.80
Recreation /relaxation	3.64	3.77	4.97
Exercise	4.29	3.90	1.47

A7.3 Clark Coping Scores by Age

There are significant differences across all Clark Coping domains between age groups. Those aged 60-65 were more likely than any other age group to use recreation/relaxation to cope, whilst younger people were more likely to work to improve skills or exercise.

Figure A7.3: Clark Coping scores by Age

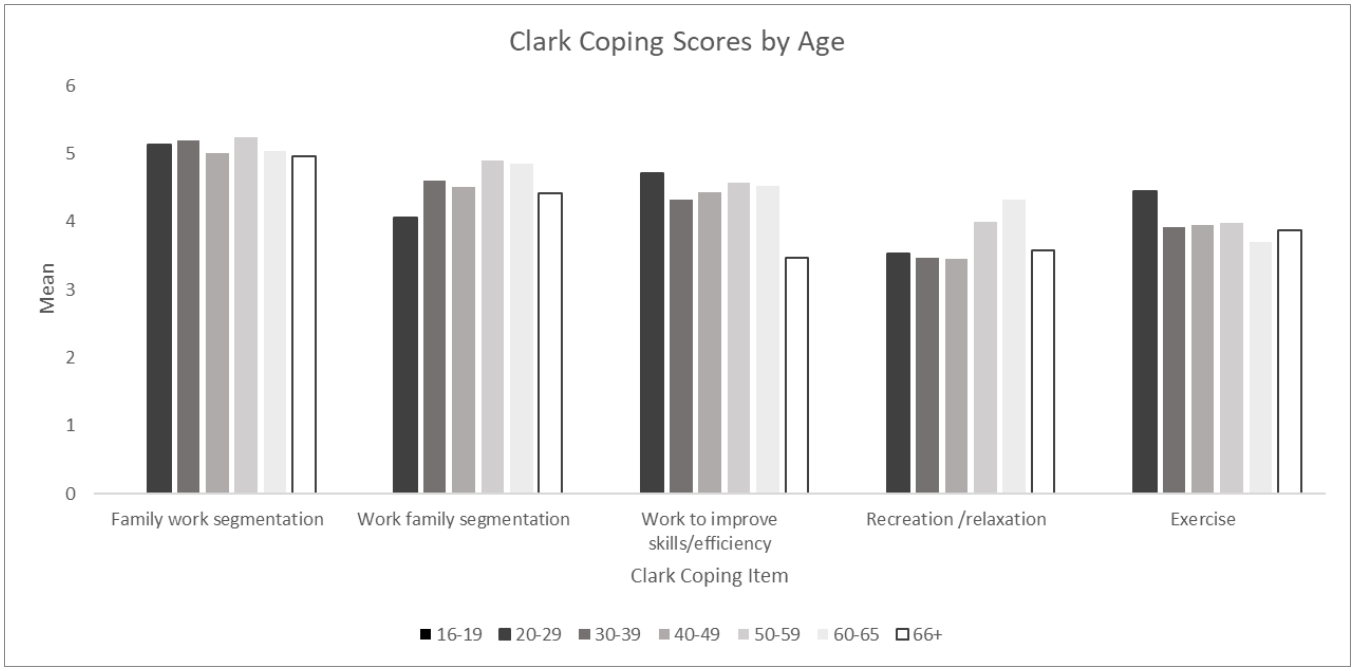


Table A7.3: Clark Coping Scores by Age

	Mean Clark Score						
Clark Domain	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Family work segmentation	-	5.14	5.19	5.01	5.24	5.03	4.96
Work family segmentation	-	4.06	4.61	4.52	4.91	4.86	4.42
Work to improve skills/efficiency	-	4.72	4.33	4.43	4.58	4.53	3.46
Recreation /relaxation	-	3.53	3.47	3.46	4.01	4.33	3.58
Exercise	-	4.45	3.93	3.96	3.98	3.71	3.88

A7.4 Clark Coping Scores by Occupation

There are significant differences in all of the Clark Coping Scale domains across occupations. Social Workers were more likely than any other occupation group to use recreation/relaxation (4.014) as a coping mechanism. Social Care workers tend to use work-family segmentation, whilst Allied Health Workers use exercise.

Figure A7.4: Clark Coping Scores by Occupation

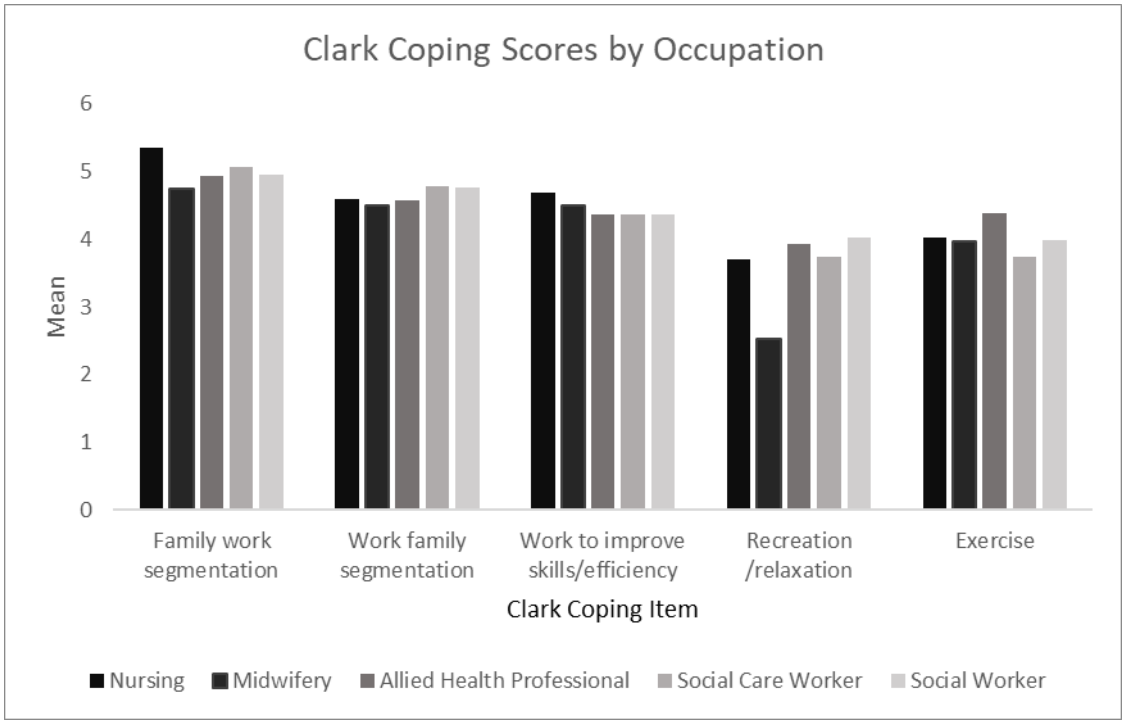


Table A7.4: Clark Coping Scores by Occupation

	Mean Clark Score				
Clark Domain	**Nursing**	**Midwifery**	**Allied Health Professional**	**Social Care Worker**	**Social Worker**
Family work segmentation	5.36	4.74	4.93	5.06	4.96
Work family segmentation	4.59	4.50	4.58	4.78	4.77
Work to improve skills/efficiency	4.68	4.50	4.37	4.37	4.37
Recreation /relaxation	3.70	2.54	3.93	3.75	4.04
Exercise	4.04	3.97	4.39	3.75	4.00

Appendix 8: Multiple Regression Results

A8.1 Multiple Regression Model Predicting Wellbeing Score

Research Question: Do coping mechanisms predict Wellbeing scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with SWEMHS scores as the outcome variable using the following variables as covariates:

- Age (dummy coded)
- Gender (dummy coded)
- Disability status
- Ethnic group (dummy coded)
- Country of work (dummy coded)
- Professional group (dummy coded)
- Number of sick days in previous 12 months (dummy coded)
- Carver Coping sub-scales
- Clark Coping sub-scales

  plus
- How prepared employees felt about their redeployment role (dummy coded).

The results indicated that the model explained 35% of the variance (adj. R^2=.34, F(34, 2356)= 36.5, p<0.001). It was found that the following significantly predicted total wellbeing score (SWEMWBS):

1. No overall differences were observed in SWEMHS wellbeing scores across occupational groups, age, ethnic groups or disability status.
2. Respondents from Northern Ireland reported higher Wellbeing scores on average than those from England (β=0.05, p=.021).

Coping Strategies

3. Carver Active Coping scale - Those who reported higher Active Coping scores reported significantly higher wellbeing scores (β = 0.19, p<0.001).
4. Carver Disengagement scale - Those who reported higher Disengagement scores reported significantly lower Wellbeing scores (β = -0.34, p<0.001).
5. Carver Emotional Support - Higher scores on use of Emotional Support were associated with higher wellbeing scores (β = 0.15, p<0.001).
6. Carver Substance Abuse - Higher Substance Use as a form of coping was linked to lower Wellbeing scores (β = -0.08, p<0.001).
7. Clark Relaxation - Those who reported higher scores on use of Relaxation tended to report significantly higher Wellbeing scores (β = 0.08, p<0.001).
8. Clark Exercise - Those who reported higher scores on use of Exercise likewise tended to report higher Wellbeing scores (β = 0.07, p<0.001).

Note: Not all employees were redeployed. When added to the model, reported feelings of preparedness for re-deployment did not significantly explain variation in Mental Wellbeing scores.

A8.2 Multiple Regression Model Predicting Quality of Working Life Score

Research Question: Do coping mechanisms predict Work Related Quality of Life (WRQol) scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with WRQoL scores as the outcome variable using the following variables as covariates:

- Age (dummy coded)
- Gender (dummy coded)
- Disability status
- Ethnic group (dummy coded)
- Country of work (dummy coded)
- Professional group (dummy coded)
- Number of sick days in previous 12 months (dummy coded)
- Carver Coping sub-scales
- Clark Coping sub-scales
  plus
- How prepared employees felt about their redeployment role (dummy coded).

The results indicated that the model explained 26% of the variance (adj. R^2 =.25, F(33, 2315)= 24.07, p<0.001).

1. No overall differences were observed in WRQoL scores when compared by age, gender, occupational group or ethnicity.
2. Respondents from Northern Ireland (β= -0.14, p<.001) and Scotland (β= -0.06, p=.003) reported lower average WRQoL scores than those from England.
3. Those with a disability tended to report lower scores (β= -0.06, p<.001).
4. The number of absences due to sickness (past 12 months) were associated with lower WRQoL scores.

Coping Strategies

5. Carver Active Coping scale - Those who reported higher Active Coping scores reported significantly higher WRQoL scores (β = 0.10, p<0.001).
6. Carver Disengagement scale - Those who reported higher Disengagement scores reported significantly lower WRQoL scores (β = -0.31, p<0.001).
7. Carver Emotional Support - Higher scores on use of Emotional Support were associated with higher WRQoL scores (β = 0.14, p<0.001).
8. Clark Relaxation/recreation - Those who reported higher scores on use of Relaxation/recreation tended to report higher WRQoL scores on average (β = 0.15, p<0.001).
9. Work Family Segmentation – Higher scores on Work Family Segmentation were associated with higher WRQoL scores (β = 0.13, p<.001).
10. Family Work Segmentation – Higher scores on Family Work Segmentation were associated with lower WRQoL scores (β = -0.08, p<.001).

Note: Not all employees experienced re-deployment. Those who were re-deployed were asked about how prepared they felt for redeployment. Those respondents who felt prepared

showed higher WRQoL scores than those who felt unprepared (β = -0.29, p<.001) and those who felt unsure (β = -0.14, p=.027).

SOCIAL AND HEALTH CARE OVERVIEW AND SCRUTINY COMMITTEE

Date of Meeting	Thursday, 3rd December 2020
Report Subject	Annual report on the Social Services Complaints and Compliments Procedure 2019-20
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer for Social Services
Type of Report	Operational

EXECUTIVE SUMMARY

The Social Services and Wellbeing Act (Wales) 2014 and Social Services Complaints Procedure Regulations 2014, requires Local Authorities to maintain a representations and complaints procedure for social services functions (referred to as the "procedure" from now on). The Welsh Government expects each Local Authority to report annually on its operation of the procedure.

There was a slight increase in complaints made about Adult Social Care this year. Of the 4,020 adults who received care and support during 2019-20 from Adult Social Care, 60 individuals complained about the service they received (1.4%). This compares to 51 complaints last year (2018-19) and 80 complaints during 2017-18. There was an increase in the number of compliments recorded this year.

30 complaints were received during the year regarding Children's Social Services from the total of 2,346 children and families who received care and support (1%).

This compares to 55 complaints received last year (2018-19) and 49 complaints during 2017-18. The number of complaints received in Children's Social Services has previously been comparable year on year so this year's decrease is significant and again highlights the work staff do to avoid complaints being made.

All complaints are scrutinised and used to improve both services as part of a 'lessons learned' process.

RECOMMENDATIONS	
1	That Members scrutinise the effectiveness of the complaints procedure with lessons being learnt to improve service provision.

REPORT DETAILS

1.00	**EXPLAINING THE NUMBER OF COMPLAINTS RECEIVED, THE ISSUES RAISED AND THEIR OUTCOMES**
1.01	Feedback in the form of compliments and complaints from service users, their family or carers can highlight where services are working well or where services need changing. Flintshire County Council wants to learn from this feedback and use the experiences to improve services for everyone who uses them.
1.02	As part of our day to day business staff deal with questions, concerns, problems, dissatisfaction, and general feedback which frequently includes praise. We encourage staff to listen to people, to explain decisions, to clarify where misunderstandings have arisen and to take action to put things right where they can. This approach enables us to provide a responsive and effective service. However, we recognise that there will also be complaints that we need to listen to, address and learn from.
1.03	Our assessment is that Social Services has a robust complaints procedure in place. We welcome complaints and want to ensure service users, carers and families are listened to, their views acted upon, and that receive a timely and open response. Staff and Managers work hard to resolve problems as soon as they arise, and advocacy is actively promoted. As part of our wider approach to quality assurance all complaints are reviewed to bring together information about the overall quality of services, to identify trends, and action required including any lessons learned to avoid similar issues arising again.
1.04	**Overview of complaints: Adult Social Care**
1.05	60 complaints were received in the year, a small increase to last year's 51 complaints that were received and a comparable drop compared to 2017-18 when 80 complaints were received. This number of 60 complaints should also be considered against the context that 4,020 adults who received care and support from the Service during the year. The Act is now firmly embedded in practice and the decrease can partly be attributed to improving our advice and communication with service users and their families, and managing their expectations.
1.06	All complaints received across the Service are scrutinised to see if anything further could have been done to alleviate a complaint being made in the first place: broadly speaking there were no such instances where a complaint could have been avoided. Every effort is made by social work staff and Managers to resolve issues/concerns quickly with service users and families. See Appendix 1 for a summary of complaints grouped into themes.
1.07	The number of complaints in relation to Older People Localities is higher than other areas as it is the largest part of the Service, but numbers are comparative year on year. This year did see an increase in complaints made about Older People Provider Services. Complaints about Local Authority and privately registered providers are shared with the Contracts Monitoring Team who visit on a regular basis to ensure their contractual

	obligations are being fulfilled. A multi-agency information sharing meeting takes place between the Department, Health and the Care Inspectorate for Wales (C.I.W.) where complaints information is shared and considered together with other information collated by agencies.
1.08	

Service	**2019-20**	**2018-19**	**2017-18**
Older People – Localities	17	19	21
Older People – Provider	12	2	7
Learning Disability Community Team	3	6	8
Learning Disability Provider	0	2	10
Mental Health and Substance Misuse	3	4	7
Disability Service inc. Transition	4	5	4
Safeguarding	2	0	3
Other (inc. Business Support etc.)	7	2	3
Registered Residential Provider	7	6	10
Registered Domiciliary Providers	4	4	7
***Integrated Autism Svc.**	1	1	n/a
Total number of complaints	**60**	**51**	**80**

** The Integrated Autism Service was formed in July 2018.*

<table>
<tr><td>1.09</td><td>Broadly speaking the complaint themes are broken down into the following areas (with the number received in brackets).
Dignity (3 complaints)
Communication (16 complaints)
Timeliness of our decisions or actions (8 complaints)
Disagreements with our decisions or actions (8 complaints)
Quality of care from a home or carer (12 complaints)
Charges applied or financial issues (14 complaints)
Hospital discharges (3 complaints)
Process issues (13 complaints)
Lack of advice/assistance (6 complaints)
Staff issues (7 complaints)
* Note that often one complaint contains more than one theme</td></tr>
<tr><td>1.10</td><td>A range of methods are used to resolve complaints including:
a. A meeting or conversation with the complainant to discuss their concerns
b. Involving Advocates and self-advocacy groups
c. A written explanation as to the reasons for a decision
d. An apology where appropriate
e. Action taken to review a decision
f. Independent investigation (Stage 2 of the procedure)</td></tr>
<tr><td>1.11</td><td>The Regulations place a duty to discuss and resolve any complaint within 10 working days and write formally to the complainant confirming the outcomes. There is a 25 working day timescale for Stage 2 complaints.<table><tr><th>Adult Social Care</th><th>2019-20</th><th>2018-19</th><th>2017-18</th></tr><tr><td>Within timescale at Stage 1</td><td>87%</td><td>98%</td><td>86%</td></tr></table></td></tr>
<tr><td>1.12</td><td>The Service has seen a consistent and high number of responses to complaints made within the statutory timescale. The cause of the drop in timescales this period is largely attributed to their complexity but complainants were kept informed. This is against the backdrop of busy workloads and competing demands.</td></tr>
</table>

1.13	**Stage 2 (Independent Investigation)**
1.14	3 complaints were investigated at Stage 2 of the complaints procedure (Independent Investigation), the same as the last two years (2018-19 and 2017-18). All complaints that progress to Stage 2 are scrutinised to see if anything further could have been done to resolve the complaint formally at Stage 1: there was no option but to progress these 3 complaints to Stage 2 due to their nature or complexity. This relatively small number reflects the time and effort that Managers put into reviewing what has happened and effectively responding. See appendix 3 for a summary of the Stage 2 investigations and their outcomes.
1.15	**Ombudsman**
1.16	Two complaints were opened for investigation this year. One complaint regarding the Older People Localities and Contract and Commissioning Service was not upheld. One complaint regarding a Privately Registered Residential Provider remains outstanding at this point in time. The Ombudsman has no statutory timescales to adhere to in terms of investigating complaints.
1.17	**Lessons Learned**
1.18	Learning from complaints is important and we use the findings and outcomes to inform policy and practice in delivering services (known as the 'lessons learned' process). Examples of action taken on issues raised as a result of complaints to Adult Social Care include: • Older People Locality Teams were reminded that when arranging any residential or respite placement, they must advise family of charges, share the relevant information booklet with them and record on PARIS they have informed family of such charges and family have understood.
1.19	**Compliments**
1.20	It is pleasing to report that Adult Social Care received 280 compliments during the year (285 received last year and 204 received during 2017-18). Compliments are received in the form of cards, letters or emails from service users or their families when they recognise staff have done "over and above" what is expected. See Appendix 4 for a summary of some of the compliments received across service areas.
1.21	**Overview of Complaints: Children's Social Services**
1.22	30 complaints were received during the course of the year, a significant drop compared to last year's 55 complaints that were received and 49 during 2017-18. Again this number should be considered against the number of 2,346 (1%) children and families who received care and support from the Service. The number of complaints relating to Children's Social Services has been consistent over a number of years so this decrease

illustrates the effort made by social work staff and Managers to resolve issues/concerns quickly with service users and families. See appendix 2 for further details about these complaints.

1.23 2 young people complained during the year. 1 young person was supported by their Advocate, the other was offered but did not want the services of an Advocate.

Service	**2019-20**	**2018-19**	**2017-18**
First Contact, FIT, PACT and TAF	24	43	39
Fostering Service	1	4	3
Child to Adult Team (also formerly C.I.D.S.)	2	3	2
Safeguarding Unit	1	1	2
Flying Start	0	1	0
Other (including commissioned providers)	2	3	3
Total Number of Complaints	**30**	**55**	**49**

As explained earlier, a range of methods are used to resolve complaints. These include:

a. A meeting or conversation with the complainant to discuss their concerns

b. Involving Advocates and self-advocacy groups

c. A written explanation as to the reasons for a decision

d. An apology where appropriate

e. Action taken to review a decision

f. Independent investigation (Stage 2 of the procedure)

<table>
<tr><td>1.24</td><td>Of the 30 Stage 1 complaints received, 27 out of 30 complaints were responded to within timescale (90%). The 3 late complaints were responded shortly outside timescale.

<table><tr><th>Social Services for Children</th><th>2019-20</th><th>2018-19</th><th>2017-18</th></tr><tr><td>Within timescale at Stage 1</td><td>90%</td><td>93%</td><td>80%</td></tr></table></td></tr>
<tr><td>1.25</td><td><u>Stage 2 (Independent Investigation</u></td></tr>
<tr><td>1.26</td><td>2 complaints proceeded to Stage 2 and independent investigation during the year, a decrease compared to last year’s 5 complaints. These were complex cases involving difficult family or personal dynamics. A summary of these Stage 2 complaints is described in Appendix 3.</td></tr>
<tr><td>1.27</td><td><u>Ombudsman</u></td></tr>
<tr><td>1.28</td><td>It is pleasing to note that no investigations were opened by the Ombudsman’s office this year.</td></tr>
<tr><td>1.29</td><td><u>Lessons Learned</u></td></tr>
<tr><td>1.30</td><td>Given the low number (2) of Stage 2 investigations during the year, there were few lessons learned to be gleaned from complaints, but included:

• Practice directive issued setting out expectations re. following up enquiries with individuals or agencies when an allegation is made to them and that the outcome of such enquiries are recorded. The practice directive reminded staff of the recording policy and that casenotes should be recorded as soon as possible but no longer than five working days after an event of observation.

• Review that we ensure referrers are informed of the associated outcome in addition to the automated acknowledged email response. We also need to review the term “No Further Action” which is misleading to referrers and implies we have done nothing with the information.

• Drawing up an adoption checklist for a casefile which will assist staff if the caseholder is on leave, sickness absence etc.</td></tr>
</table>

1.31	**Compliments**
1.32	Children's Social Services recorded 121 compliments during the year from families, the Courts and other public bodies. They were in the form of cards, emails, texts or letters. See appendix 4 for a summary of some of the messages received.

	2019-21	2018-19	2017-18
Social Services for Children	**121**	**75**	**82**

2.00	**RESOURCE IMPLICATIONS**
2.01	The Regulations state all Stage 2 complaints involving both Adult and Children's Social Services are commissioned to Independent Investigators (and an Independent Person for Children's Social Services as set out in the Children Act, 1989). The cost for Stage 2 complaints for the period 2019-2020 was £12,5552.25. The cost for last year was £11,031.02.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	None undertaken.

4.00	**RISK MANAGEMENT**
4.01	No risks identified.

5.00	**APPENDICES**
5.01	Appendix 1: Summary of complaints categorised into themes (Adult Social Care) Appendix 2: Summary of complaints categorised into themes (Children's Social Services) Appendix 3: Summary of Stage 2 independent complaint investigations and their outcomes (both Children and Adult Social Services) Appendix 4: Summary of compliments received across service areas (both Children and Adult Social Services).

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	'A guide to handling complaints and representations by Local Authority Social Services', August 2014 (Welsh Government). **Contact Officer:** Ian Maclaren, Complaints Officer for Social Services **Telephone:** 01352 702623 **E-mail:** ian.maclaren@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	Stage 2 complaint: the Regulations stipulate that where a complainant remains dissatisfied with their response from the Council, consideration must be given to progressing the complaint further in the statutory procedure, i.e. to Stage 2. An independent investigation is commissioned using a shared North Wales 'pool' of retired social care Officers.

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Appendix 1

Adult Social Care

Summary of complaints by theme (2019-20)

Complaints relating to dignity (3 complaints)

X complained their sister was only wearing a t-shirt, cotton blanket and elastic knickers when attended to by Paramedics following a fall in the home. There was a lack of dignity and it was also a cold night.

The home explained sister had been in bed with nightwear provided by family when she was found on the floor. Paramedics advised staff not to move her. When Y was transported into the ambulance a blanket was placed over her to keep her warm and maintain her dignity.

Complaints relating to communication (16 complaints)

X challenged our decision that their mother had deliberately deprived herself of her assets. X also complained the idea of the home caring for their mother had been mis-sold/mis-communicated to family as the home are no longer able to care for her.

We upheld our original decision about DoA as Reablement commenced before mother's house was sold and proceeds divided between her family. Family were informed about concerns with mother living at the home and that they could no longer meet her needs. Our message at the time would not have been it was 'a home for life' as suggested by family and this is reinforced with the Service User Guide that was shared at the time. There were delays moving mother because family had PoA and the desired home had no bed spaces (as well as the DoA issues to consider).

X complained of a lack of communication and misinformation with regards to charges for their mother. X couldn't understand why their mother required a further mental health assessment to inform the C.H.C. funding process.

We apologised if there had been a lack of clarity and that advised agreement could not be reached about C.H.C. funding for their mother. A C.P.N. assessment has been requested to inform the D.S.T. review so a final decision about C.H.C. funding can be reached. Funding in the meantime is 50/50 between us and Health, and mother will be charged for her residential fees as per her financial assessment.

Complaints relating to timeliness of our decisions or actions (8 complaints)

X complained about the waiting time for their assessment and at the poor communication when seeking updates from us.

We explained the part of the Service concerned operates a waiting list that was around 40 weeks (at the time). We were mistakenly advised that X was a service user with the C.M.H.T. As we do not duplicate work, we were waiting for C.M.H.T to complete an assessment. This was rectified and we apologised for any oversight. Process now in place whereby all cases referred to the part of the Service concerned are fully triaged

and if insufficient information is not included in the application, these will now be returned to the referrer to request accurate data. This enables this part of the Service to avoid situations such as what happened in this case.

X complained why their son's broken bath has been treated as a low priority for nine months. X was also concerned how long it will take for ourselves, the care provider and the housing association to agree who funds a new bath once assessed.

We explained the case was treated as low priority as son's carers were able to wash and clean him in another shower in his home whilst there were a shortage of O.T.s. A replacement specialist bath has been ordered but will be subject to the usual timescale for fitting etc.

Complaints relating to disagreements with our decisions or actions (8 complaints)

X complained against our decision to transfer their mother's care from Homecare to a private provider. They believed we provided a better standard of care and our carers were better skilled and experienced.

The package of care transferred as planned. We sought to reassure X and their mother that the provider was regulated, subject to contract monitoring visits and their carers can access our in-house training. The transfer was needed to free up resources so others could benefit with their support.

X complained the suggestions we were making about adaptations to their kitchen weren't meeting her needs due to her physical difficulties and height.

We reviewed X's circumstances and the suggestions made by O.T., but concluded the proposals made were proportionate and reasonable. They included lowering a wall mounted cupboard, repositioning electrical sockets and shelves so X could access them more easily.

Complaints relating to charges applied or financial issues (14 complaints)

X complained we had originally agreed by letter to fund their father Y care at a home following his discharge from hospital. However, we then went back on this agreement and the matter of funding hasn't been resolved in the months since.

Following receipt of Legal advice in which the Act stipulates assistance should be explored, we agreed to cover the residential costs incurred during Y's stay at a home in the form of a loan basis until family are awarded Deputyship. We can recover the costs then. Cases such as these will be reviewed on a case by case basis to ensure families will be in a position to repay the Local Authority.

X complained she hadn't been informed of emergency respite charges.

We could find no clear record of the emergency respite placement being explained to X as being chargeable. Although X's mother received chargeable day services, we could not assume X knew she would be charged for emergency respite as well. We therefore agreed to remove the charge

Complaints relating to hospital discharges (3 complaints)

Family complained their father had been waiting in hospital for several weeks for a package of care at home to be discharged. They believe there had been an initial mix up in communication meaning the planned package of support was withdrawn some weeks ago.

We explained the current situation and the wait for packages of care, particularly with double manned care, and unfortunately we couldn't give an indication how long identifying a suitable package would take. In the meantime, therapy staff have been working with father at hospital and he is making positive progress meaning a couple of visits can be single manned. Family will consider direct payments alongside reablement therapy. There was miscommunication from the hospital about father's discharge resulting in our cancelling his package of care.

X complained about the home's management of events during and after their mother's hospital stay. X was initially told their mother was critically ill but was then medically fit for discharge when they attended the hospital. X was then advised the home could not take mother back and they cancelled their contract breaching their agreement.

The home provided a comprehensive response that they communicated appropriately at the time of hospital admission. The home confirmed a nursing assessment and mental health assessment were requested as hospital reported they were struggling to manage mother's behaviour and they were also experiencing challenging behaviours. The home advised family they would need to undertake a reassessment as to mother's suitability to return there. Mother was subsequently assessed for EMI care and the family were advised mother's room would need be vacated in line with the terms of contract. We confirmed the home's response was appropriate.

Complaints relating to the quality of care from a home or carer (12 complaints)

X complained about the standard of care provided to their brother and was concerned about staffing levels at the home.

Although X's brother is a combination of self-funding and Funded Nursing Care, we sought to reassure X about the staffing levels and the home being clean and odour free. A Monitoring Officer is to complete a pre-arranged joint visit to the home with Health where X's concerns about his brother eating alone and being a choke hazard will be shared with Health to take forward.

X complained that their mother was clinically dehydrated upon admission to hospital which may have contributed to her cause of death. This complaint followed a report from Health following mother's admission to hospital.

The home responded with evidence that mother was continually offered drinks for the whole period up to her hospital admission. On her last night at the home fluids were

given overnight. Mother was later observed as confused but she was communicating clearly, though groggy. Her vital observations were recorded by the duty nurse and an ambulance called. The home believed they did everything to support mother up to her hospital admission and we had no further observations to make about the records the home provided.

Complaints relating to process issues (13 complaints)

X complained about the unsuitability of their mother being placed at a local home as part of a step down, the appropriateness of completing an assessment whilst her mother was in hospital and the lack of communication during this stressful period.

We reassured X we followed process in terms of the step down and there was no evidence to suggest the home was unsuitable. Their mother had capacity and was agreeable to the proposal. Mother was deemed to be medically fit and able to make a decision according to Ward Sister prior to her discharge. Although there was good communication throughout most of the case, the issue of admin. staff leaving messages for social work staff has been revisited with them.

X complained we had taken over as their nephews' Appointee without their knowledge or say so.

We met with family to explain the Appointeeship process and the reasons behind our actions. We explained that as their nephews' former Appointee had suddenly passed away we had to act quickly to safeguard their finances and ensure they had access to money. We also had to safeguard their nephews as vulnerable adults.

Complaints relating to staff (7 complaints)

X complained their support worker was stealing money from them.

We reviewed the case and confirmed staff did not have direct access to X's monies and there were no unaccounted purchases from reading bank statements. Appointees oversee X's accounts and no concerns have been raised about staff before. X has history of making similar allegations.

X complained about the way we treated and spoke with them whilst they were in receipt of our services.

We explained to X we had never raised a voice to them. We have had to have honest conversations with them and we had to give X information and advice that they may not have liked. However, our conversations have always been respectful. Our role is to help individuals weigh up financial decisions, and as part of this we need to give individuals all of the information available.

Appendix 2

Children's Social Services

Summary of complaints by theme (2019-20)

Complaints relating to contact (4 complaints)

X was unhappy with arrangements put in place to drop off their children after contact. X also believes the Family Group Co-ordinator was biased toward their ex-partner and advised them separately about contact arrangements.

X was advised that as he has shared parental responsibility with their ex-partner, it was down to them both to consider what was in the best interests of the children, but we would not intervene. Instead X was directed to seek legal advice. We assured that Co-ordinators are independent and do not take sides, but another Co-ordinator was allocated the family's case.

Complaints relating to communication (2 complaints)

X complained via their Advocate that we were lying to X about contact with their mum, X's voice wasn't being heard throughout the process and their relationship with their Social Worker had broken down.

We met with X and their Advocate and suggested weekly unsupervised contact would be able to start from next week. We had already discussed this with mum and she was happy with this proposal. In the meantime the Social Worker will continue in her role for the purposes of continuity during this important time in X's life until everyone is clear about what is happening with the planned Special Guardianship Order.

Complaints relating to a lack of advice or support (4 complaints)

X complained they were not given the correct information by ourselves in the lead up to the adoption of their child in 2006, who is now displaying challenging behaviour and the placement has sadly broken down. This lack of information has had a significant impact on themselves and on their son.

We advised we could find no clear rationale as to why additional information was not shared with them at the time of their son's adoption. We explained by reflecting on adoptive parents' experiences on a nationwide basis processes have adapted and changed over the years and indeed continue to do so, giving a couple of examples. The approach to information sharing is also very different and more transparent and open (including family history, life experiences etc.) so adoptive parents can make better informed decisions. After a lengthy but productive meeting, X were satisfied a similar situation happening again will have reduced and everyone is focussed on mediation between family and son.

Complaints relating to the timeliness of our decisions or actions (4 complaints)

X complained contact review meetings were not being held as originally agreed, X received little or no communication from us about their children who are looked after, and X wasn't receiving paperwork in a timely manner.

We acknowledged we haven't been proactive in terms of arranging meetings and we gave a commitment to meet every several weeks as well as weekly telephone contact to update X about his children. Outstanding paperwork had previously been shared. We advised about future contact arrangements and the longer term plan for rehabilitation.

Complaints relating to disagreements with our decisions or actions (7 complaints)

X complained about the inaccurate information provided to case conference about them by ALL the agencies present. X did not, however, wish to appeal the decision that their children remain on the Register.

Much of X's correspondence were their views about our management of their children's case and we advised these would be added to PARIS for future reference. It is our professional opinion that both parents were consulted about the enquiries etc. Throughout the Part 2 (separate) meeting with X, the Chair checked after each professional's report and X either stated he agreed or intimated that he agreed with their presentation. X did not raise any objections to any professional opinion raised at Conference.

Complaints relating to staff (7 complaints)

X complained that they had been painted as an abuser toward their ex-partner in the social work report to Court and X wanted a change in Social Worker.

We had agreed to change the original Social Worker late last year as we needed an effective working relationship with X. We explained we will not be changing Social Worker again. X's son remains on the child protection register and the case is subject to ongoing legal proceedings so continuity is important. Instead we agreed for an independent social work assessment to be completed as part of these legal proceedings, being mindful of X's concerns and provide them with some reassurance that we are listening to their views.

Complaints relating to our processes (9 complaints)

X complained about our failure to follow Placement with Parents guidance, our not reacting to potential risks and concerns and the lack of progress in terms of their son's immediate future. Their son was also without a P.A. for several months.

We met with X and agreed to make a request to the Housing Department for a single person's accommodation with support. We apologised for the absence of a Placement with Parents Agreement and agreed in future that any such arrangement of this type of care will receive the same process to which all P.W.P. are subject, i.e. the completion of all relevant documentation should be completed at the same time a P.W.P. meeting is to be arranged. There were some gaps earlier in the year re. P.A.s but we reassured X at no time was their son not under appropriate overview and monitoring.

Complaints relating to foster placements (1 complaints)

X complained we had gone behind their backs and allowed a family member recently released from prison for violent offences to stay at their children's placement.

There are no plans to change the placement. We advised X that the conversation he had with his eldest daughter about a family member's history was inappropriate. We have no concerns re. the family membr. We confirmed what we spoke with daughter about and because of the adult conversations that were taking place within the family, it was hard to establish daughter's wishes and feelings. If X was unhappy with matters, they can take the case back to Court. We also met separately with both sets of parents.

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Appendix 3

Summary of independent investigations and their outcomes at Stage 2

Social Services for Adults

1. X complained against our decision not to pay their daughter's carers via a direct payment whilst she was in hospital.

Every effort was made to explain our reasons at Stage 1 but our explanation wasn't accepted. An independent review did not uphold the complaint and confirmed the rationale for our decision was indeed correct, i.e. that direct payments cannot be used to deliver care and support in a hospital setting as it is a Health/N.H.S. environment. Support staff are not covered by any insurance or employment regulations which can leave them open to legal action if anything went wrong whilst they were supporting an individual.

2. X complained about our management of her mother's case following discharge from hospital and the confusion about cross-boundary charges between Wales and England.

The complaint was partially upheld on the basis that there was:

- A delay on our part in identifying the error that Cheshire were required to fund mother's care and not Flintshire.
- A lack of information to enable families to make informed decisions regarding cross boundary placements and financial thresholds.
- A lack of clarity on our part and with Health.

However the investigation found there was no evidence family were deliberately misled or misinformed about their mother's care funding. Once the error was identified attempts were made by staff to clarify the situation with family and we made an immediate referral to Cheshire Social Services, who are responsible for meeting their mother's care costs.

3. X complained about a range of issues relating to the support she previously received after her package of care was stopped.

The complaint was not upheld. There was no evidence to support X's view that she "fell" from her sling whilst being hoisted: it was a managed incident and X was safely lowered back onto a sofa. Staff were working in a challenging home environment given the space and X was not being forthcoming with suggestions to improve her lifting and handling. Appropriate and timely action was taken to respond to risks. A separate independent O.T. assessment advised X she needed to work with us. Delays with X's package of care were not deemed unreasonable given the circumstances and there were numerous attempts to get X the care she needed.

Children's Social Services

1. X complained a recent child protection investigation did not take into account her daughter's Autism and therefore was in breach of the All Wales Child Protection Procedures.

The complaint was partially upheld in terms of: i) our not following up enquiries with individuals whom daughter had made allegations to and ii) in terms of some of our recording discussions we had with partner agencies. These will be taken forward as lessons learned. However we did take into account daughter's Autism prior to interview and X confirmed her daughter could communicate and understand what was being said and asked. The interview would have been stopped by ourselves or Police had there been any concerns otherwise. X's daughter will not be re-interviewed about the allegations she made.

2. X complained we did not proceed with further child protection enquiries following problems being experienced by her daughter at school.

The complaint was partly upheld on the basis that the actions from the referral X made did not take place, and information provided in our letter of response was inaccurate as discussions with Police and the school had not taken place. We apologised for this and agreed to review our processes in terms of lessons learned.

Appendix 4

Examples of compliments received during 2019-20

Compliments received are shared with all staff via email and a selection are included in the staff bulletin.

Adult Social Services:

Single Point of Access: “I can’t thank you enough for your care, concern and empathy. I would have really struggled with mum if you hadn’t been there as when she is like that it’s very difficult to bring her round but you were able to do that brilliantly, thank you so much.”

Older People Localities: : “… would just like to say a huge thank you for all the help and support you have provided our family. Putting up with our family dynamic will never be easy but you have always remained professional with Mum's needs being the focus.”

O.T.: “Thank you from the bottom of my shriveled old heart for everything you have done it’s such a help both physically and mentally as I can now move around house cook sleep in proper bed wash and soon shower all downstairs I can’t thank you enough”.

Older People Provider Service:

Llys Gwenffrwed: After a visit by the Mayoress, she wrote: “I wanted to say how impressed I was with this home… This was the best I have seen. I met a lot of residents who wanted us to know what a fantastic place it was to live and how kind and helpful the staff were. Residents looked very well cared for and happy.”

Llys Raddington: “'I just wanted to come to say how much Mum has improved since living here. She's started to clean and do things she hasn't done for many years. Now she is able to do all these and other things independently and with ease. I feel that living here is not just slowing down her dementia but actually reversing it!”

Llys Eleanor: “We were always comforted knowing she was in such good hands and definitely couldn’t have managed without you.”

Marleyfield home: “All the staff are fantastic. The staff are so patient with X. She always looks well and well presented. She has her hair done every week. The staff take pride in their work and always keep mum's dignity and respect."

Croes Atti: “There really are no words that can express the depth of our gratitude. Mum was truly blessed and fortunate to have spent her last few weeks with you in your beautiful home from home. You are an amazing and inspirational team of people. You deserve the very highest accolade.”

Llys Jasmine: “Thank you for all your tender kindness and care for mum and dad and for making their final years so much more comfortable. We are very grateful.”

Homecare: “I have nothing but the highest praise for the help they gave me. They were calm, kind and helpful with everything they did for me.”

Reablement: “We can’t thank you all enough for the wonderful help you gave mum. You all do a wonderful job, each and every one of you. It was very difficult to come to terms with but you soon put our minds at ease.”

Learning Disability Community Team: “Each individual is full of knowledge and passion for what they do. Their help and support has been immeasurable and they are so passionate about their work. I am truly grateful.”

Learning Disability Provider Service:
Station House were all thanked by family: “I would just like to say how grateful we are as a family for all the support that you & Flintshire County Council have provided X over the years... but seeing how happy & healthy X is these days you must never forget what a wonderful job you do.”

Ty Banc Cerrig were complimented by a parent: “She was full of praise for the staff team at and said that she “could not want or receive any better care and support for my son.… I cannot praise the Flintshire team enough”.

Woodlea were thanked by a parent who was very complimentary about the staff and support that her son has received at Woodlee over the last 20+ years. She wanted to thank everybody on behalf of herself and her son.

Child to Adult Team: The Tea were thanked by a service user. They had been homeless and living in interim accommodation which did not meet his needs. With support he has now just moved into a bungalow with his own tenancy. He wanted to say a big thank you for their support in making this happen.

Mental Health and Substance Team: The Team were all thanked by an individual they helped through a serious period of depression which kept the individual off work: “I am very grateful… for their support, understanding and flexibility during a very difficult time for me. I’ve been well and back at work”.

Integrated Autism Service: “Without the IAS involvement X wouldn’t be where he is today and he is taking pride in what he is doing and loves to tell family members, something that he would shy away from previously.”

N.E.W.C.E.S.: I was treated with respect throughout. Every request for further aids was granted, immediately- no long waiting times. I was shown in hospital (when assessed) and at home how to use the equipment. I cannot fault your service- Thankyou. The drivers were polite and respectful also!”

Care and Repair were complimented and an individual wanted to say a big thank you as the staff were very friendly and completed the job quickly, and wanted to thank the team for their amazing work.

Safeguarding: "(Daughter) said she was very grateful to be asked her opinion and to be able to talk about how her Mum's dementia had affected her, she thanked X for listening to her and being interested in her Mum's life some of which she hadn't thought about for years. Daughter said she felt relieved that someone else had seen her Mum and had taken a genuine interest in her well-being."

Financial Assessment and Charging Team: : "We have been provided with an excellent account of the work and measures implemented to protect X from Y that are alleged to be financially abusing X. We have been informed that X's finances were speedily secured immediately upon receipt of the Court Order to prevent further financial abuse."

Contracts Monitoring Team: "Thank you for your support over this difficult time. I am heartened to work with an understanding Council working in conjunction rather than using the situation as an opportunity to hit us with a stick."

Children's Social Services:

Permanency and Court Team received a colourful, hand drawn card that read: "We want to say a big thank you. We could not have done this without you. You helped to give me strength and open my eyes. Me and X are the happiest we've ever been."

Family Intervention Team: "Can I just say that you have been so helpful and thorough! I left the planning meeting feeling quite reassured. You are like a breath of fresh air in our current stale environment and I feel you deserve every praise given to her. Could you pass on our great thanks and gratefulness to all please?"

Targeted Support Team: "Just wanted to let you know we appreciate the time, care and effort from all the sessional workers. They have always been kind supportive and lovely to work with and be around it's been and will continue to be a pleasure working alongside them. Thank you."

Children's First Contact Team: "She in my view has been instrumental in bringing this case to Court and ensuring X's safety. It is clear to me that since being allocated this case she has worked extremely hard to achieve positive outcomes for X, and I have been impressed by her enthusiasm and her child focused approach in keeping X at the centre of her planning.

Fostering Service: The work of the Service was recognised by carers in their exit interview: "We have found the support offered by the family placement team very helpful and been very glad of the advice and experience."

Team Around the Family: "She and her son were supported by TAF in the past. If it weren't for TAF, her life and her home would be gone. She stated that until TAF

supported her, she was shoplifting food to feed her son, was about to lose her home and was in a dark phase of depression."

The Mentoring Service was thanked by a parent. They made huge positive effects on their daughter's wellbeing and X is an excellent communicator with the family. Dad feels he has been listened to and the team knows the family well, making them very easy to talk to.

Mockingbird Initiative: "It was good to hear about and appreciated by all the delegates as well as being an example of doing things differently to share across Wales. The enthusiasm you brought was infectious and helped make it such a positive and productive day as well as underlining the importance and power of collaborative fostering endeavours across Wales."

Safeguarding: ""So I would just really like to thank you and the Authorities especially X for giving me what I needed and never giving up on me and helping me through this tough stage in my life."

The Young Voices Out Loud group were thanked: "Thank you so much for all of the help you have given us with Mockingbird so far! Your views and feedback have been included in our work and I'm really pleased to say that we have now appointed our first Hub Carer."

Family Information Service: "Can I thank you too, for all the hard work that went into organising the fabulous awards afternoon last week at Ruthin Castle… thoroughly enjoyed the venue, the wonderful food, meeting up with other colleagues, the fabulous speaker and best of all, hearing about the fantastic work that childcare workers are doing throughout Wales. I have found the help and support from FIS extremely valuable and much appreciated.

Flying Start: "I just wanted to get in touch and thank you personally for helping me to sort out X's funding, it has been the biggest relief and will make such a difference to our family. I truly appreciate your kindness and the fact you went out of your way to help."