The COVID-19 Pandemic's Impact on UK Older People's Social Workers: A Mixed-Methods Study

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Abstract

The social work profession was heavily impacted by the COVID-19 pandemic. In this study, we examined the well-being, working conditions and intentions to leave the social work profession among a sample of UK older people's social workers. This was a cross-sectional mixed methods study analysing data from 426 social workers who worked in older people's services in the UK at five time points of the pandemic spanning 2020–2022. Data were collected using anonymous online surveys which included both quantitative and qualitative questions. The mental well-being of participants decreased as the pandemic progressed and this decline was associated with intentions to leave the profession. Thematic analysis of qualitative data revealed two major themes:

Practice challenges and Staff well-being. The findings highlight the nature of stressors related to internal related practice demands, and external health and social care service stressors encountered during the COVID-19 pandemic and have implications for policy, practice and research in older people's social work.

Introduction

There is increasing concern that social work support for older people in many countries is insufficient and ineffective (Beltran and Miller, 2020; Brennan *et al.*, 2020). Such concerns about older people's social services, interchangeably referred to as gerontological social work, have been amplified with the advent of the COVID-19 pandemic (Seifert, 2020; Chan *et al.*, 2022).

Within the UK, social workers faced imperatives to minimise COVID-19 contagion risks to people with pre-existing health conditions or disabilities as well as to respond to the needs of people whose support networks or well-being were negatively affected by the pandemic (Abrams and Dettlaff, 2020; Miller and Lee, 2020; Morley and Vellas, 2020; Ratzon *et al.*, 2022). To reduce infections among groups such as older people facing high mortality risks, face-to-face social contact was limited, including with other professionals, and health and social work support contacts moved online where possible (McFadden *et al.*, 2022) for activities such as assessments and reviews (Baginsky *et al.*, 2023). Whilst the impact of the pandemic on older people and their carers has been widely reported (Byrne *et al.*, 2021), less is known about possible impacts on social workers whose clients are mainly from these groups.

Prior to the outbreak of COVID-19, there was growing evidence that some social workers in many jurisdictions faced occupational risks of developing mental health and well-being-related problems (Ravalier, 2019; Savaya *et al.*, 2021). Causation was generally attributed to workplace demands giving rise to stress (Kim and Lee, 2009; Johnson *et al.*, 2019) and burnout (McFadden *et al.*, 2015). Whilst social work is emotionally and intellectually demanding (Burns *et al.*, 2020), the positives of making a difference to individuals can be outweighed by the pressures.

However, following the outbreak, many social workers have since been critical of government and agency policies and regulations, especially newly created operating procedures implemented during the pandemic that restricted service users' rights to services and assessments or

to agree to interventions (Banks *et al.*, 2020). One of the major problems according to researchers was how to protect the profession's independence whilst countering the dangers of managerialism, increased bureaucracy and changes to practice that may be more controlling than enabling and thus might go against the ethical principles of the profession, and the profession's historical dedication, in part, to social justice and human rights as well as the insistence on the value of interpersonal relationships (Amadasun, 2020; Banks *et al.*, 2020).

Ensuring sustainability of social workers to counter the substantial psycho-social challenges related to COVID-19 necessitates awareness of their professional and personal impact (Ashcroft *et al.*, 2022). The profession experienced both personal and professional problems because of COVID-19 regulations and even though there have been some positive outcomes from innovative service delivery methods, these were not always without cost and concern. Stress, fatigue and burnout were some of the costs incurred by many social workers due to practising throughout the pandemic and have added to the extensive list of job-related pressures within this profession (Ashcroft *et al.*, 2022).

Job-related pressures may account for low retention rates in the social work profession in many developed countries (Ravalier *et al.*, 2022) and these countries' efforts to recruit internationally (Tham and Meagher, 2009). They undermine service quality, workforce stability and practice development (McLaughlin *et al.*, 2022). High levels of turnover and absence involve a carousel of changes to clients designated or named social workers, disruptions to relationship-based practice and undermining of trust (Ravalier *et al.*, 2021). The UK experiences retention problems across health and social care services, with 15 per cent turnover of social workers employed by English local authorities (LAs) in adult services (Skills for Care, 2022). Whilst some of this exit from the profession is caused by predictable retirement, there is increasing interest in the concept of turnover intention or a person's desire to leave their current job since this is one of the strongest predictors of actually leaving (Griffeth *et al.*, 2000; Acker, 2018). By examining turnover intentions among all age groups, researchers can highlight reasons behind desires to leave with the aim of informing employers of possible remediable actions to decrease turnover (Astvik *et al.*, 2020; McFadden *et al.*, 2020; McLaughlin *et al.*, 2022).

Study aims

Few studies have explored the health and well-being of UK social workers working with older people during the pandemic although some have reported the impacts on their practice (Mali, 2021; Neill *et al.*, 2022a; Manthorpe *et al.*, 2022b). This study aimed to examine the impact of the

COVID-19 pandemic period on the well-being of this group at five time points from May 2020 until July 2022. We hypothesised declining levels of well-being as the pandemic progressed. We also investigated whether levels of well-being, age, gender, hours of overtime worked and country of work predicted intentions to leave their profession. The study also enabled some examination of these social workers' views on the pandemic's impact on their practice and working conditions using qualitative data to assist in contextualising the quantitative findings.

Materials and methods

Design and participants

This study used a mixed-methods approach selected to amplify the voice of social workers working with older people and to ensure quantitative findings from the surveys were grounded in respondents' experiences. It was part of an ongoing, larger multiple-phase research programme entitled 'Health and Social Care Workers' (HSC) quality of working life and coping whilst working during the COVID-19 pandemic (McFadden *et al.*, 2020). The overall research examines the impact of providing health and social care amidst the COVID-19 pandemic on nurses, midwives, allied health professionals, social care workers and social workers in the UK employed in a range of settings such as hospitals, care homes (including nursing homes), community and day services (McFadden *et al.*, 2020). Qualitative and quantitative methods were used to examine mental well-being, quality of working life, coping strategies and burnout throughout the COVID-19 pandemic and beyond (McGrory *et al.*, 2022; McFadden *et al.*, 2023).

The study utilised a cross-sectional design, with data collection at approximately six-month intervals. Data for the current analysis were collected across five time points during the pandemic: Phase 1: May–July 2020; Phase 2: November 2020 to February 2021; Phase 3: May to July 2021, Phase 4: November 2021 to February 2022 and Phase 5: May–July 2022. The research consisted of an online survey incorporating reliable and validated measures. Each survey contained a small number of open-ended questions offering opportunities to highlight experiences or views.

The survey drew on an opportunity sample recruited through social media platforms (Facebook and Twitter) and via professional associations, unions, professional communications, employers and regulatory bodies. For this article, only data from social workers who reported working with older people (exclusively or predominantly) were selected for analysis. Ethical approval was attained from the Research Ethics Filter Committee of the School of Nursing Ulster University (Ref No: 2020/5/3.1, 23 April 2020, Ulster University, IRAS Ref No. 20/0073) for

the study and Trust Governance approval (for Northern Ireland only) was gained from the Health and Social Care Trusts.

Measures

Demographic and work-related variables

The survey sought demographic and work-related information. Variables included were gender, age, ethnicity, country of work (Northern Ireland (NI), Scotland, England, Wales), place of work, sick days, overtime and intention to leave their profession.

Mental well-being

Mental well-being was measured using the seven-item Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS; Stewart-Brown *et al.*, 2009). Using a five-point Likert scale ranging from 1 to 5, respondents were asked to report how they felt over the previous two weeks. The item scores were summed and converted to metric scores to enable comparison with other samples. Scores ranged from 7 to 35, with higher scores indicating better well-being. The scale is considered to have excellent psychometric properties (Neill *et al.*, 2022b). Within this study, the internal consistency coefficient tested using Cronbach's alpha indicated $\alpha = 0.86$.

COVID-19-related working conditions

Working conditions were assessed with one open-ended qualitative question in phases 2–5: 'What was the impact of COVID-19 on your specific place of work, so far, in relation to patient/user numbers and service demand?'.

Data analysis

Collated data were coded, cleaned and prepared for analysis. Extraneous data were separated to only include responses from social workers working exclusively or predominantly with older people ($n = 426$). To ensure data accuracy, pre-analysis was conducted to assess any missing data and extreme values. Descriptive statistics were generated using SPSS version 28. Data stemming from the qualitative questions were analysed using reflective thematic analysis centred on Braun and Clarke's six-phase framework (Braun and Clarke, 2021). This framework incorporates flexible

methodology and has the potential to provide enriched understanding of the survey data.

Findings

Demographics

The sample across all five phases consisted of 426 social workers working predominantly or exclusively with older people (Phase 1: $n = 128$; Phase 2: $n = 105$; Phase 3: $n = 78$; Phase 4: $n = 54$; Phase 5: $n = 61$). Descriptive statistics covered gender and age range, ethnicity, country of work, place of work, sick days taken in the past year, overtime undertaken and intention to leave their profession (Table 1). Most respondents were female (82.6 per cent). Ages ranged from twenty-one to twenty-nine (12.7 per cent), thirty to thirty-nine (22.1 per cent), forty to forty-nine (27.7 per cent), fifty to fifty-nine (28.4 per cent) and sixty plus years old (9.2 per cent). Most (94.1 per cent) were White British. Just over half worked in Northern Ireland (52.3 per cent) and half were community-based (65.5 per cent). Just over half had taken days off from sickness within the past year (53.2 per cent), and nearly two-thirds typically worked overtime (63.2 per cent). Half declared their intentions to leave their profession (50.2 per cent). As is common in the UK, very few were employed in care home or day-care settings.

Quantitative findings

A series of independent sample t-tests examined differences in well-being scores between each of the five phases (Figure 1). There was a significant negative decline in well-being scores from phase 1 ($n = 114$, $M = 21.74$, $SD = 3.46$) to phase 2 ($n = 90$, $M = 20.11$, $SD = 2.95$), $t\ (202) = 3.56$, $p < 0.001$; 95% CI 0.73–2.53. There was no significant difference from Phases 2 through 5 in SWEMWBS; however, mental well-being remained significantly lower than Phase 1 throughout the latter phases of the project.

Next, a logistic regression (Table 2) was performed to determine the effects of well-being scores on intentions to leave social work, controlled for gender, age, overtime, country of work and phase. This showed that lower well-being scores were associated with greater intention to leave ($OR = 0.79$, $p < 0.001$; 95% $CI = 0.708$–0.875). The model correctly classified 65.8 per cent of the cases. Respondents in the twenty-one to twenty-nine age bracket ($b = 2.02$, $p < 0.01$), the thirty to thirty-nine age bracket ($b = 2.03$, $p < 0.01$), the forty to forty-nine age bracket ($b = 1.70$, $p = 0.01$) and the fifty to fifty-nine age bracket ($b = 1.74$, $p = 0.01$), were

Table 1. Sociodemographic details of social workers working with older people ($n = 426$).

Variable	Phase 1, n (%) (May–July 2020)	Phase 2, n (%) (November 2020 to February 2021)	Phase 3, n (%) (May–July 2021)	Phase 4, n (%) (November 2021 to –February 2022)	Phase 5, n (%) (May–July 2022)
Gender					
Female	101 (78.9)	91 (86.7)	64 (82.1)	45 (83.3)	51 (83.6)
Age					
21–29	20 (15.6)	14 (13.3)	10 (12.8)	4 (7.4)	6 (9.8)
30–39	20 (15.6)	28 (26.7)	22 (28.2)	11 (20.4)	13 (21.3)
40–49	35 (27.3)	27 (25.7)	16 (20.5)	19 (35.2)	21 (34.4)
50–59	39 (30.5)	25 (23.8)	23 (29.5)	14 (25.9)	20 (32.8)
60+	14 (10.9)	11 (10.5)	7 (9.0)	6 (11.1)	1 (1.6)
Ethnicity					
White	115 (89.8)	101 (96.2)	77 (98.7)	48 (88.9)	59 (98.3)
Black	9 (7.0)	2 (1.9)	0 (0.0)	2 (3.7)	0 (0.0)
Asian	2 (1.6)	1 (1.0)	1 (1.3)	1 (1.8)	1 (1.7)
Mixed	2 (1.6)	1 (1.0)	0 (0.0)	3 (5.6)	0 (0.0)
Country of work					
England	46 (35.9)	26 (24.8)	16 (20.5)	27 (50.0)	9 (14.8)
Scotland	3 (2.3)	6 (5.7)	15 (19.2)	2 (3.7)	3 (4.9)
Wales	6 (4.7)	34 (32.4)	8 (10.3)	2 (3.7)	0 (0.0)
Northern Ireland	73 (57.0)	39 (37.1)	39 (50.0)	23 (42.6)	49 (80.3)
Place of work					
Hospital	21 (16.4)	12 (11.4)	3 (3.8)	7 (13.0)	14 (23.0)
Community	88 (68.8)	68 (64.8)	53 (67.9)	32 (59.3)	38 (62.3)
Care home	1 (0.8)	8 (7.6)	7 (9.0)	3 (5.6)	1 (1.6)
Day care	1 (0.8)	3 (2.9)	1 (1.3)	1 (1.9)	2 (3.3)
Other	17 (13.3)	14 (13.4)	14 (17.9)	11 (20.4)	6 (9.8)
Sick days taken in past year					
None	64 (50)	46 (44.7)	42 (53.8)	24 (44.4)	22 (36.7)
≤10	47 (36.7)	31 (30.1)	22 (28.2)	11 (20.4)	15 (25.0)
11–20	8 (6.3)	8 (7.8)	2 (2.6)	3 (5.6)	11 (18.3)
21+	9 (7.0)	18 (17.5)	12 (15.4)	16 (29.7)	16 (20.1)
Overtime undertaken					
≤4 h	N/A	57 (55.3)	33 (42.3)	22 (40.7)	25 (41.0)
5–10 h	N/A	14 (13.6)	12 (15.4)	10 (18.5)	11 (18.0)
≥11 h	N/A	7 (6.8)	8 (10.3)	5 (9.3)	4 (6.6)
No	N/A	46 (44.7)	25 (32.1)	17 (31.5)	21 (34.4)
Considering leaving occupation					
Yes	N/A	48 (49.0)	34 (47.9)	34 (63.0)	25 (43.1)

Note. Presented are column percentages, which are valid percentages to account for missing data. N/A = Not Applicable; OR = Odds Ratio.

7.57, 7.59, 5.47 and 5.70 times more likely, respectively, to have intentions to leave social work compared to the sixty plus group. When comparing NI responses (where most respondents were situated) to each of the other UK regions/countries there was no significant difference in intentions to leave. Likewise, there was no significant difference in intentions to leave by phase or by number of hours of overtime worked per week.

	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	21.74	21.81	18.71	20.38	21.97
Phase 2	20.11	20.69	19.89	20.35	19.54
Phase 3	20.18	19.7	20.45	18.79	20.63
Phase 4	19.62	19.84	19.49	15.83	19.72
Phase 5	19.97	20.12	19.99	0	19.94
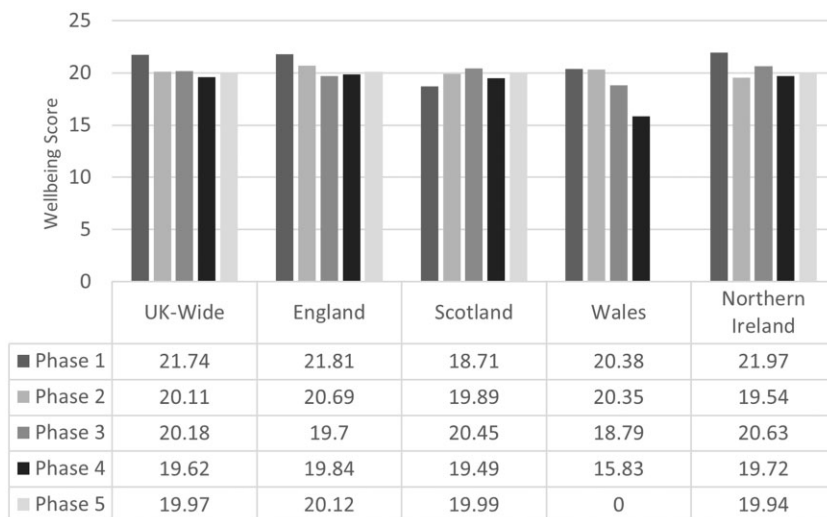
Figure 1: Overall wellbeing scores by study phase and country. *Note*: 23.6 population norms for wellbeing (Ng Fat *et al.*, 2017).

Table 2. Logistic regression: mental well-being on intention to leave social work

Item	Unstandardised Estimate (*b*)	S.E.	Exp(B)	95% CI	*p*
Well-being	−0.24	0.05	0.79	0.71/0.88	<0.001
Age					
21–29	2.02	0.74	7.57	1.78/32.24	0.006
30–39	2.03	0.68	7.59	1.99/28.99	0.003
40–49	1.70	0.67	5.47	1.47/20.38	0.011
50–59	1.74	0.68	5.70	1.51/21.48	0.010

Note: Age reference category 60+.

Table 3. Qualitative analysis; themes and sub-themes.

Themes	Practice challenges	Staff wellbeing
Subthemes	Changes in practice Increased pressures Staffing levels/absences	Feeling unsupported Staff mental health Home/work balance Intention to leave

Thematic analysis

Two themes incorporating seven subthemes were identified from the open-ended responses which are presented in Table 3.

Practice challenges

The first theme identified practice challenges with subthemes of changes to practice, increased pressures, staffing levels/absences.

Changes to practice

Reports of frustration by social workers in their practice with older people became more pronounced across the five study phases. At Phase 1, several respondents working in the community highlighted how reduced face-to-face contact through home visits was giving less scope for person-centred approaches to prevention, assessment or monitoring:

> It's changed the way we work completely; we cannot visit clients unless there is an urgent need or a safeguarding issue. It has taken away the ability to humanise ourselves, build rapport and bridges and do any preventative work. (Phase 1, Female, Community, England)

Changes to hospital processes following the early profound impacts of the pandemic on their in-patient services were felt by one respondent to have placed unnecessary demands and stress on the hospital's social work team:

> My employer chose this time as an opportunity to completely restructure the department and reorganise our own procedures which has resulted in confusion, chaos, unclear job descriptions, conflict between departments, delays in the provision of care / delayed discharges and duplication of work. (Phase 1, Female, Hospital, Wales)

By Phase 2, considerable impact on caseloads due to changes in both their own and other services as well as dwindling social care services was reported:

> Partner teams e.g., CMHTOP [Community Mental Health for Older People Teams] and Permanent Placement teams closed their doors to new referrals meaning those in the Community Care Teams had to carry higher caseloads than normal and those who needed to be transferred elsewhere couldn't be. (Phase 2, Female, Community, N. Ireland)
> Older people's services seem to keep cutting the services we can offer; caseloads are getting bigger every week and there is such a shortage of carers [care workers] it is impossible to do the job properly and meet clients' assessed needs. (Phase 2, Male, Hospital, N. Ireland)

Virtual or online contacts were becoming the norm but with older people, they were not always an effective means of communication or assessment:

> Increased difficulty in completing comprehensive assessments/capacity assessments as we try and complete all we can virtually where possible. (Phase 2, Male, Community, Wales)

By Phase 3, further frustrations could be detected in some respondents' comments:

> There have been so many frequent changes to either discharge processes or funding that it has been difficult to keep up to date. Trying to gather information from the hospital wards has been very difficult. Trying to speak to patients to involve them in the decision-making process has almost been impossible, especially if the person has a hearing/sight impairment or a cognitive impairment. (Phase 3, Female, Community, England)

A small number directed their irritation towards how their managers were supporting them throughout the pandemic:

> As a result of other services decreasing their availability, extra pressure and demands are being placed on community social work teams adding to the impossibility of the job. The demands and responsibility are endless confounded by our own professional management who are unwilling to listen, or act using the powers they have. Senior managers seem to not understand what the front line is like. The profession needs a complete review to retain staff. (Phase 4. Male, Community, N. Ireland)

By Phase 5, some respondents voiced particular exasperation with hospital discharge decisions, inferring some patients were still infected with COVID-19 when discharged from hospital and not ready for discharge but that they, as social workers, had to work within this imperative:

> Numbers were about the same but increased work to manage the risks around hospital patients being discharged with covid, not medically optimised, little, or incorrect information on their situation. (Phase 5, Female, Community, England)

Increased pressures

Social workers who contributed to the open-ended questions reported feeling overwhelmed by increased pressures during all study phases. These feelings were illustrated by a variety of factors particularly changes to hospital discharge practice mentioned above and the reduced availability of other services:

> The pressure to discharge people from hospital, has at times been overwhelming. With working from home, it has been difficult to gather information from hospital staff to facilitate discharge. (Phase 2, Male, Hospital, England)
>
> Staff are incredibly stressed and often blamed for short falls in the system. For example, if we can't get people discharged quick enough, health colleagues state we are 'dragging our feet', though the facts remain that the availability of care placements is dire at present. The pressure in the system is immense. (Phase 2, Male, Community, Wales)

By Phase 3, some respondents were finding themselves unable to meet the surge in demand for social care services as early hospital discharges became routinised without the time for assessments and planning:

> I manage a hospital social work team. Service demand was low during the first 'peak' as people were too ill to be discharged. We then saw a huge surge in discharges which nearly overwhelmed our care capacity in the community. The speed at which discharges was happening also increased with less time for discharge planning. Individual workers caseloads increased manifold. (Phase 3, Male, Hospital, England)

Even by Phase 5, expressions continued of particular exasperation with hospital discharge practices for older patients whom respondents considered not ready for discharge. Most respondents completing the open-ended question reported being under considerable personal pressure during this time, feeling tired, sometimes facing abuse from clients' families and some indicated signs of burnout:

> I just have to keep going but I am completely worn out and am having to take a month off work unpaid to get a proper break. I am afraid to go off sick as I don't think I would go back to work! (Phase 3, Female, Community, N. Ireland)

Finally, by Phase 5, anger with the personal impact of increased pressure was being directed by a few respondents at senior managers:

> The higher management are completely out of touch. I have seen grown women cry with pressure trying to keep their area right. I have cried many times and had sleepless nights. Money isn't enough at this stage, we need time off, rewards, more staff replacement so we can do our jobs effectively, instead of choosing which problem or situation needs to be done first. We are not just managers we are counsellors, risk assessors, quality controllers, supervisors, and training managers, and that's only the tip of the iceberg of daily duties. (Phase 5, Female, Community, N. Ireland)

Staffing levels/absences

Many of the pressures highlighted above were seemingly exacerbated by staffing pressures, in particular, colleagues' absences. Absences, whether due to COVID-19, infection control management, stress and anxiety linked to fear of contagion, added pressure on remaining staff by increasing their caseloads and responsibilities. This continued throughout the phases of the study with many of those providing their views describing feeling overwhelmed and under relentless stress but was already evident at Phase 1:

> The workforce was severely impacted by COVID-19 infection. Team of eleven reduced to four overnight. Managing workload on reduced resources overwhelming. (Phase 1, Male, Community, N. Ireland)

By Phase 2, a combination of increased demand as families returned to work and continued staff absences was emerging:

> Main impact has been when family members who have been caring for someone in the community and they need to return to work. This has put a strain on resources. Staff have left the team and not been replaced. The workload I now have was previously done by 3 of us. (Phase 2, Female, Community, England)

Others voiced disappointment and some resentment that their managers were not perceived to be accepting, or responsive to concerns about staffing:

> I have felt overwhelming pressure to pick up other people's work when they are ill or isolating and not feeling as though I can take leave as we have been so low on staff with management not even trying to fill in the gaps. (Phase 2, Female, Community, Wales)

By Phase 5, staffing pressures within the social work teams and in wider adult social care services were continuing, despite the lowering of pandemic restrictions and decreases in deaths and severe infections:

> I am a social work lead with [adult safeguarding] responsibilities. Main issues, staffing levels, shortage across all pay bands critical in domiciliary care and mental health. Reduction in safe provision of day care. (Phase 5, Female, Other, N. Ireland)
> Staff shortages due to people leaving and staff with covid/ shielding/ close contact. Massive backlog of unallocated cases as no staff to allocate to. Increase in complaints. Constantly firefighting. (Phase 5, Female, Community, N. Ireland)

Staff well-being

The second main theme identified from the qualitative data covered staff well-being with subthemes of feeling unsupported, staff mental health, home/work balance and intention to leave.

Feeling unsupported

In Phase 1, some respondents reported feeling unsupported in these new circumstances:

> Don't feel that supported - going to leave soon - disappointed that there is lack of support but same demands to get job done and meet targets. (Phase 1, Female, Community, N. Ireland)

By Phase 2, a few respondents were feeling frustrated by the perceived lack of support with some indicating how this was affecting their mental health especially feelings of burnout:

> I am lucky to be a part of a very supportive friendly team, but the pandemic has taken that away and left me feeling isolated. I find change hard to cope with and this has overwhelmed me to such an extent that I became mentally ill. (Phase 2, Female, Community, Wales)
>
> Feel unsupported to cope with the additional physical and mental impact in dealing with the volume of additional pressures that COVID has placed on an already highly pressurised service. Team morale remains low and unacceptable. Very challenging situation where professionals now feel at 'burn out'. (Phase 2, Female, Community, N. Ireland)

By Phase 4 and also in Phase 5, some respondents signalled feelings of disillusionment due to the increased pressure to work under conditions framed by a lack of resources and lack of perceived support within the system:

> During the pandemic it has been made apparent that staff are just a 'number'. Work pressures which existed prior to COVID-19 have increased with more and more being placed on staff within a context of depleting services. As a result of other services decreasing their availability, extra pressure and demands are being placed on community social work teams adding to the impossibility of the job. Senior managers seem to not understand what the so-called front line is like. (Phase 4, Male, Community, N. Ireland)

Staff mental health

This sub-theme not only highlights how the handling of the pandemic was impacting some respondents' mental health but also relates to other sub-themes such as intention to leave the profession. Some drew comparisons between pre-pandemic stresses and the current situation:

> Management of the crisis has greatly worsened a very difficult situation. I think almost every day that I can't take this anymore and if I had an alternative I would leave. I do very much blame the government for how difficult my job has become, this was not inevitable, there is a whole department who are meant to plan for emergencies. The service is only surviving on the goodwill of staff. It is austerity and endless cuts that have caused this problem......I will leave the profession, it has taken too much from me. (Phase 2, Female, Community, Wales)

Reflecting on the pressures, a few respondents saw the pandemic as amplifying pre-existing problems and some had made the decision to leave the profession:

> Overall, the handling of this pandemic has been appalling and has shown the lack of investment in our public services. I have now decided to leave the social work profession. (Phase 2, Male, Community, N. Ireland)

Whilst few social workers had been redeployed to other services, some hospital social workers had been redeployed into more unfamiliar and stressful clinical settings. Although efforts were being made to address particular stressors, such as continuing recruitment and training of new staff, this was not easy amidst a pandemic and could compound stress:

> Social work staffing crisis led to increased pressures. Training of new staff in the pandemic has been challenging. Burn-out has led me to seek alternative employment. (Phase 2, Female, Community, N. Ireland)

Similarly, in Phase 5, some respondents described feeling burned out, mentally and emotionally exhausted and being at breaking point:

> I find the back log from the pandemic and burnout among professionals makes work more difficult. I do not have the energy to pursue leisure activities. I often feel vacant at home due to exhaustion. (Phase 5, Female, Hospital, N. Ireland)
> Staffing levels are low within the area and caseloads of an ever-increasing ageing population are climbing constantly, creating unmanageable caseloads that cause stress and burnout. (Phase 5, Female, Community, N. Ireland)

Home–work balance

Due to the risk of virus transmission in office settings, most social workers had moved at the start of the UK national lockdown (March 2020) to work from home. Whilst none disputed this step, some expressed concern about the impact of their job on their home–life and their capacity to weather the intrusion of work into the family environment. Some respondents reported on the implications for them of working from home such as isolation, lack of support and blurred boundaries:

> I have found working from home the majority of the time very difficult due to feeling isolated. (Phase 2, Female, Community, Wales)

Likewise, others reported being unable to switch off from work because the boundary between home and work was indistinct, and so were rethinking their employment:

> I feel isolated, stressed and emotionally exhausted working from home…My work and home life overlap much more, and I often feel I can't escape. My home is no longer a relaxing place and is tainted by me spending so much time here doing stressful work. I am re-evaluating

what I want from life/career and feel I will probably leave social work soon. (Phase 5, Female, Community, England)

Discussion

This study examined the impact of COVID-19 on the well-being of older people's social workers in the UK at five time points of the pandemic. Our first hypothesis was partially supported as findings revealed a significant decline in older people's social workers' mental well-being, UK-wide at later phases of the pandemic. This decline, found from Phase 2 through to Phase 5, remained significantly lower than the responses of Phase 1. This finding may suggest that during the initial lockdown the well-being of the workforce, though low in comparison to the population norms for well-being (Ng Fat *et al.*, 2017), retained some buoyancy, possibly due to popular support in the form of governmental and media messaging suggesting 'we are all in this together' which included higher social worker well-being at Phase 1, than existed prior to the pandemic (Nolan, 2021; Manthorpe *et al.*, 2022a). However, as alluded to in the qualitative analysis, as the pandemic progressed some social workers experienced increased pressures stemming from changes to services, lack of resources to cope with increased workloads, staffing problems and feeling unsupported with a skewed home/work balance, all of which are likely to have contributed to lower levels of well-being.

Our second hypothesis was also supported as we investigated whether levels of well-being predicted respondents' intentions to leave their profession, controlling for age, gender, hours of overtime worked and country of work. We found a significant negative relationship between well-being and intentions to leave the profession. Our findings suggest that for every point increase in well-being, participants were 21 per cent less likely to have intentions to leave. Bolstering workforce well-being may therefore help to maintain and improve retention. In addition to the importance of well-being, age was also a significant predictor of intentions to leave the profession. We found that the older (sixty plus) age group was less likely to currently intend to leave social work. This may be because they were close to retirement and changing professions would not be economically sensible in terms of the security of their income and pension arrangements (McFadden *et al.*, 2020). Alternatively, those with many years of experience may have garnered the necessary skills to deal with the cognitive demands of the job and find that their work offers the autonomy and intellectual stimulation that provide greater job satisfaction (Johnson *et al.*, 2011). Several years ago, Hayward *et al.* (1989) suggested that those in considerably complex occupations retire later than those with more mundane, less demanding jobs. Notwithstanding, our

findings demonstrate the difficulties employers face in securing and keeping social workers aged below fifty-nine years. Finally, we did not find any significant difference between country of work, or gender, in relation to intention to leave; moreover, working overtime was also not a significant predictor of intention to leave one's profession.

Respondents' narratives support these quantitative findings since many described being under considerable stress. Some voiced concerns over staffing levels/absences, feelings of being unsupported and isolated, a blurring of home–work boundaries, similar to other studies of social workers during COVID-19 (Kingstone *et al.*, 2022). Prior to the pandemic, a study of Swedish social workers who had indicated thoughts of leaving the profession and had or had not done so one year later, found that predictors of staying were low degrees of conflicting demands and quantitative demands; high degrees of openness and human resource orientation; and a high degree of perceived service quality (Astvik *et al.*, 2020). These predictors appear to resonate with the experiences voiced by some of our respondents, namely increased demands, feelings that they lacked employer or managerial support and concerns about service quality.

Respondents who commented on the impact of the pandemic on their older clients made observations that have been borne out in other studies about older people restricting their activities by staying at home, reducing exercise and limiting social engagement, resulting for some in a decline in cognitive, mobility and communication function (Wong *et al.*, 2022). The shift to virtual practice created additional challenges for social workers who reported difficulties in making and sustaining meaningful relationships with their clients or the public (Kingstone *et al.*, 2022).

Another sub-theme of workforce challenges developed from the analysis concerned staffing levels, including absences through sickness. All LAs in England and Wales had difficulties recruiting and retaining social workers during COVID-19, although no data is available for those working with older people specifically (Local Government Association, 2021). Social workers in our study sample reported increased pressures stemming from their colleagues' sickness absences, isolating due to contagion anxiety or leaving the profession altogether. Social worker well-being decreased, and at Phase 5 of our study, well-being had not returned to pre-pandemic levels.

Strengths and limitations

The main strength of this study is that the survey was administered at five time points throughout the pandemic. This enabled examination of trends in changes and pressures of work as well as well-being over time. The main limitation involves the study's cross-sectional methodology, as

different social workers may have participated across the five phases of study. However, because the survey was anonymous, it is not possible to link responses. The study relied on an opportunistic sample; therefore, it is probable that the recruitment methods did not reach some potential participants, this was evident in relation to homogeneity with respect to ethnicity in the sample. Another limitation is that the four regions/countries of the UK surveyed were not evenly represented. As such, our findings should not be considered representative of all older people's social workers. It is likely that those who responded to the invitation to provide extra information in the open-ended questions were feeling particularly strongly about certain matters.

Implications and future directions

Notwithstanding the limitations, the study has important implications. First, well-being levels reported by respondents were well below the national average for the general population. This may negatively affect clients, and as our findings suggest, increase the likelihood of younger social workers leaving the profession. In England, the commitment to a new fast-track social work qualifying route for social workers working with adults may help address the staffing problems identified here (Department of Health and Social Care, 2022) as may the increase in recruitment of internationally qualified social workers. From England, Higgs (2022) recently summarised the development of degree apprenticeships in social work education, noting their potential for widening access to the profession. In the first cohort study of such apprenticeships, Stone and Worsley (2022) reported that 651 apprentices were enrolled in the first two years of the initiative, with slightly higher numbers of men than usually enrolling on social work programmes. This route appears to have financial advantages for LAs since it can make use of their Apprenticeship Levy but evidence for retention or other important areas is yet to emerge. In Northern Ireland, the Social Work Workforce Review (2022) plans several actions to address workforce concerns. These include a proposed prohibition on the use of agency (locum) staff from June 2023, and policy developments in Safe Staffing in Social Work, in advance of this being legislated for, aiming to address workforce pressures by measuring caseloads in terms of workforce capacity. This, with more stability and less use of agency social workers, aims to contribute to better working conditions for social workers and improved outcomes for clients. Finally, future research may consider comparing older people's social workers' well-being and their intention to leave the profession to other sectors of social work and indeed other occupations, as well as considering variations between the retention rates of different LA or NHS employers of social workers.

Conclusion

This study demonstrated a decline in older people's social workers' mental well-being from Phase 1 through to Phase 5. The study also investigated whether levels of well-being predicted intentions to leave the social work profession. Findings showed a negative relationship between well-being and intentions to leave and indicate a need to dissuade younger staff from leaving the profession. Collated narratives provided some indications of the dual nature of stressors related to internal or employment-related practice demands and wider tensions from hospital discharge imperatives and social care service stressors that are particularly relevant to those working with older people.

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Authors' contributions

All authors contributed to the study conception and design. Data analyses were performed by J.M.L. and J.M. The first draft of the manuscript was written by J.M.L. and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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Institutional review board statement

Ethical approval was attained from the Research Ethics Filter Committee of the School of Nursing Ulster University (Ref No: 2020/5/3.1, 23 April 2020, Ulster University, IRAS Ref No. 20/0073) for the study and Trust Governance approval (for Northern Ireland only) was

gained from the Health and Social Care Trusts for Phase 2. Permission for the use of the scales used in the questionnaire was provided by the original authors, and consent and confidentiality were addressed in Participant Information Sheets provided at the start of the survey.

Informed consent statement

Informed consent has been obtained from all participants.

Data availability statement

Not applicable.

Conflicts of interest statement

The authors declare no conflict of interest. The funders had no role in the design of the study; in the collection, analyses or interpretation of data; in the writing of the manuscript, or in the decision to publish the results. The views expressed are those of the authors and not necessarily those of the funders, or the NIHR or Department of Health and Social Care.

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