FÓRSA

Morale among Health and Social Care Workers

Findings from a mixed-methods study with members from Fórsa's Health and Welfare Division

tasc
Think-tank for action on social change
Prepared by TASC for Fórsa

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Acknowledgements

The research would not have been possible without the members of our Health and Welfare Division who took the time to complete the survey and / or participate in the focus groups. We are indebted to them for sharing their experience of working in the health and social care system so generously and hope that the report helps to move the dial so that morale for all workers improves.

The research was commissioned, funded and overseen by the Divisional Executive Committee (DEC) of the Health and Welfare Division alongside the National Health Office (NHO) Team. In addition to the DEC and NHO teams, we are also grateful to colleagues Kevin Donoghue and Aisling Cusack who provided invaluable support throughout the research process.

This report has prepared by TASC for Fórsa. Our thanks to the report author and primary researcher, Tiarnán McDonough.

TASC receives support under the Scheme to Support National Organisations (SSNO) which is funded by the Government of Ireland through the Department of Rural and Community Development.

Introduction

A word from Clodagh Kavanagh, Chairperson of the Health and Welfare Division

The past several years have been very challenging for our members in the Health and Social Care Sector. As a Divisional Executive Committee, we have heard the feedback consistently from members about burnout, about stress related illness and the near constant feeling of being under pressure to deliver in an impossible situation.

It has been incredibly important for us as a committee, to capture that feedback in this formal research by TASC. The level of response from members to the research, the results of what they have to say and the need for change in the sector is laid out in the report before you.

What is clear from the research is the commitment from members to their work and the populations they serve. Everyone wants to provide the best care, in the right place at the right time as envisioned by Sláintecare. It is incumbent on all of us to make that a reality by paying heed to the very stark results of the research and the recommendations contained in the report.

I look forward to working with all stakeholders to ensure the recommendations laid out in this report are implemented for our members.

In solidarity,

Clodagh Kavanagh

Clodagh Kavanagh

A stark reality check for Sláintecare

The voice of workers in the health and social care sector being heard at all levels of decision making is central to the effective delivery of Sláintecare. That is one of the key takeaways from this important research into morale in the Irish Health Sector.

Whether it's evidence-based staffing, replacement of maternity leave, staff retention measures, pay and recognition, or service improvements – workers should be at the centre of all the conversations that need to take place to improve our national health service.

The voices contained in this report paint a stark reality of the current state of play for the health and social care sector in Ireland. It should be a serious concern to all employers, political leaders, and sector stakeholders. It is our hope that the research, and the accompanying recommendations serve as a wake-up call to address the systemic issues outlined in the report which are leading to such poor outcomes on morale.

It is incumbent on all of us, who have a vested interest in the delivery of high quality, accessible, public healthcare services, to work together over the coming years to ensure that the recommendations are implemented fully.

In solidarity,

Ashley Connolly

Ashley Connolly,
Head of Division

Linda Kelly

Linda Kelly
National Secretary

Executive summary

At a time when Ireland's health and social care system is undergoing huge changes, morale among workers is of vital importance. The Sláintecare report promised universal healthcare and offered a vision of a more community-centred model of provision that can both offset the strain on acute care and better suit the needs of our growing and ageing population. Instead, the workers needed to deliver these changes feel unsupported and underappreciated at the front line of a health and social care system that continues to underperform by international standards. The current situation is a result of Ireland's long-term failure to invest properly in public health and social care, exacerbated by a recent series of crises, from the cuts made in the aftermath of the 2008 financial crash, to the 2020 Covid-19 pandemic and 2021 ransomware attack.

This report is based on research conducted by Think Tank for Action on Social Change (TASC) with members of the Fórsa Health and Welfare Division. In March and April 2025, 3,775 workers responded to an online survey, and 24 workers from across the country took part in focus groups. The division's membership represents a wide range of workers, within the health and social care sector. This includes clerical and administrative roles, as well as health and social care professionals in clinical and therapeutic roles, pharmacy staff and individuals working in patient and client care services.[1]

Understaffing and pressure on workers

In our survey, almost half of the workers who responded reported that they often or always felt burnt out by work. 68% reported experiencing illness due to work-related stress. Focus group participants explained that a major source of their stress was inadequate staffing levels, largely attributed to the Pay and Numbers Strategy (PNS), introduced in 2024. The PNS approach to setting service numbers was considered arbitrary by workers, who argued that an evidence-based approach based on assessed local needs was needed to determine appropriate staffing levels. Shortages of administrative and support staff further added to stress by requiring clinical staff to handle basic administrative tasks. The overall sentiment was that political decisions were overriding the essential prerequisites for adequate delivery of health and social care.

Top-down communication

Our research identified that a primary driver of low morale was a perceived disconnect between senior executive management and front-line workers. Study participants described a top-heavy management structure within the HSE, characterized by a one-way flow of communication where front-line perspectives are often unheard, leaving workers feeling as though they are "shouting into a void." Decision-making, participants reported, is often detached from the practicalities of service delivery, with planning often lacking adequate consultation and failing to account for impacts on workload. As a consequence, workers felt undervalued, with 54% reporting that they were dissatisfied with the recognition they receive for work and 62% reporting that they were dissatisfied with the extent to which their organisations value their work.

1 Encompassing HSE, Section 38 Organisations, Voluntary sector organisations and Tusla.

Low morale and retention – a vicious circle

Stress from understaffing and poor retention in the health and social care sector contribute to a vicious circle that is draining the service, particularly of more senior, experienced workers. More than three quarters of survey respondents reported that they often think about leaving their current role. Workers that remain in post feel under greater pressure, particularly due to the loss of more experienced staff, which adds to existing pressures on more junior staff. 67% of workers reported that they are considering leaving their role.

Staffing issues are negatively impacting quality of service

Our research suggests that retention issues in the sector are negatively affecting service provision. Participants reported instances where local network areas established under the new Sláintecare model have already had to cut services in some areas due to insufficient staff cover. In areas where the service has been preserved, workers reported having to cover a larger caseload across a wider geographical area, leaving them feeling even more over-stretched.

Understaffing is contributing to longer wait times for patients, compounded by a lack of referral options. Participants reported that services are being outsourced to private providers where insufficient provision exists to provide crucial services in a timely manner. The long wait times experienced by many patients are seen to undermine principles of preventative care and workers described how they felt further demoralised by having to deliver substandard service levels. A common view was that the public had come to accept an unacceptably low standard of health and social care provision.

Negative outlook for delivery of Sláintecare

Workers perceived Sláintecare as hitherto having been implemented as a top-down managerial exercise. They described the rollout so far as marked by poor communication, lack of consultation, and little understanding of the practical implications entailed by service changes. This led some to view the changes implemented under the strategy as unnecessary restructuring with little benefit for improving patient care. Over half of respondents disagreed that they felt confident delivering the changes needed to implement Sláintecare reforms. A slightly larger proportion of respondents disagreed that they felt supported by their employer to deliver Sláintecare. 78% felt that staffing levels were inadequate to deliver the community-centred model of care that Sláintecare aspires to.

Learning for decision makers, funders and employers

Our research identifies key areas for improvement to improve worker morale in the health and social care sector. Echoing a wider evidence base that demonstrates the importance of worker morale for retaining skilled workers and delivering a high standard of care, our recommendations include:

- **Ensure appropriate staffing levels** by basing service levels on localised, assessed needs; providing routine cover for maternity leave as well as streamlining recruitment services.
- **Enhance strategies to boost retention** and keep skilled workers in post. Key to this is ensuring that workloads/caseloads for individual workers are appropriate and sustainable.
- E**nsure continued improvements in pay equity** for those employed in the community and voluntary sector.
- **Amplify worker voice within the Health and Social Care sector** by encouraging a more consultative culture where decision-making at the top is informed by input from workers and robust evidence. In the process, improve accountability and transparency.

1 Introduction

Ireland's health sector is the sector with the highest level of employees at risk of experiencing job stress, due to higher-than-average exposure to emotional and physical work demands, bullying and harassment, and greater imbalance between effort and job reward (Russell et al., 2018). While it is challenging to measure the economic cost of work-related stress, high stress levels are known to lead to poor performance in the short term, and serious health problems in the long-term and can lead to higher costs for employers through absenteeism and employee turnover (European Agency for Safety and Health at Work et al., 2014).

Ireland's growing and ageing population means there will be a greater demand on our health and care services over the coming years (Keegan et al., 2022). Following the 2017 Sláintecare report, the plan for Ireland's health and social care sector is to end the two-tiered public/private healthcare model we currently have and to instead establish universal provision. This will include a shift toward prioritising preventative, community-based care as a way of alleviating pressure on acute care settings. However, Ireland's long-term failure to date to invest properly in public healthcare, exacerbated by post-2008 cuts to public services and various crises such as the 2020 Covid-19 Pandemic and 2021 HSE ransomware attack, have left workers struggling on the front line of a system that remains underperforming by international standards.

To explore the impact of current health employer policies within this context, Fórsa commissioned Think Tank for Action on Social Change (TASC) to conduct research with members of its Health and Welfare Division. This research employs a mixed-methods approach to address the following research questions:

- What is the current level of morale across the health and social care workforce, and how has it changed over the past two years? What key factors influence/d these morale levels?
- To what extent do health and care workers have confidence in the delivery and implementation of Sláintecare, and what factors contribute to this?

1.1 Challenges for the health and social care sector in Ireland

The health and social care sector is a major employer in Ireland. CSO figures show 368,500 individuals were employed in 'Human health and social work activities' (NACE category Q) in the first quarter of 2025, around 13% of the overall number of people in employment during that quarter. The HSE's Health Sector Employment Report for April 2025 shows that this amounted to 149,045 Whole Time Equivalents in the HSE at the time of publication. This number is in addition to a considerable number of staff working for Tusla and voluntary sector organisations.

Challenges ahead for the health and social care sector mean the size of this workforce will need to grow even more in the coming years. These challenges, including a growing and ageing population, and the shift under Sláintecare to a community-based model of provision, are undermined by long-term challenges with recruiting and retaining appropriate staffing levels.

1.1.1 A growing and ageing population

Ireland's population has grown considerably since the 1990s, following a lengthy period of stagnation and periodic decline throughout the 20th Century. This population growth that accompanied the 'Celtic Tiger' period slowed during the global recession that followed the 2008 financial crash. Since 2016, however, Ireland has seen the sharpest increase in population growth in its history. This trend is set to continue, with the population set to grow from 5.4 million[2] to between 5.9 and 6.3 million in 2040. Falling fertility rates

2 Estimated number of people usually resident in April 2025, CSO PEA01.

and increased life expectancy mean that Ireland's population is aging rapidly, and the number of people aged 65+ is set grow from 1/7 of the population to 1/5 in the next 15 years. As people age, they are more likely to experience ill health, and an aging population has major implications for the number of workers that will be needed to respond the health and care needs of this cohort. The ESRI estimate that between 4,400 and 6,800 additional beds will be needed in public acute hospitals by 2040 (Brick et al., 2025)

1.1.2 Sláintecare and the shift to community-based care

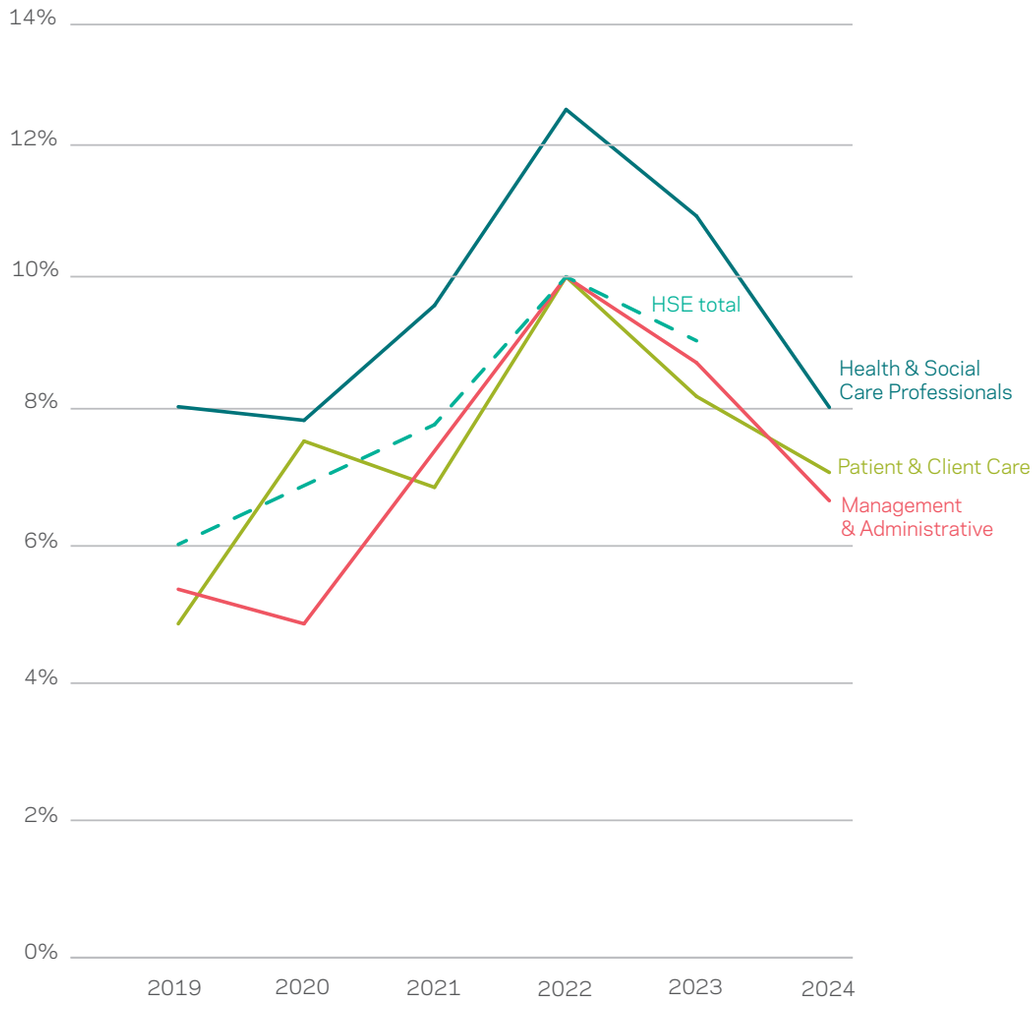
The 2017 Sláintecare report sets out an ambitious redesign of health provision in Ireland, intended to create an Irish health and social care system comparable to other European countries (Committee on the Future of Healthcare, 2017). The report's authors recommended a community-based model of care that expands primary care, social care, dentistry, and public hospital activity. The Sláintecare model was intended to reduce waiting list times, end the two-tiered model of provision that sees private healthcare services delivered in public hospitals. The ultimate goal of Sláintecare is universal healthcare provision, with a strong emphasis on prevention and improved public health. The report recognised that this would involve "careful workforce planning to meet current and future staffing needs, and measures to ensure that public hospitals (as well as all service provision units and centres) are/become an attractive place to work for experienced, high-quality staff." This will need to include additional investment in staffing and infrastructure as well as facilitating workers to retrain where appropriate in the interest of ensuring requisite numbers of workers are available regionally and locally to deliver the Sláintecare model. Subsequent studies have anticipated that removing financial barriers to primary and GP care in Ireland will unlock currently unmet need, requiring further additional staffing and funding to meet additional demand (Connolly et al., 2022).

1.1.3 Staffing and retention in the health and social care sector

Shortages of health and social care workers exist across Europe, currently the World Health Organisation (WHO) estimated a shortage of 1.6 million health and social care workers across the 27 EU Member states in 2023 (Zapata et al., 2023). Despite the need to increase the number of health and social care workers in Ireland to meet the needs of a growing population, turnover rates are consistently high. Figure 1 below summarises turnover rates across different staff categories since 2019 and shows that turnover rates among HSCPs are consistently higher than across the service as a whole. A 2024 report by Áine Kelly, National HSCP Lead for Critical Care, identified workforce gaps between current staffing levels of Health and Social Care Professionals (HSCPs) in critical care units and national/international workforce standards (Kelly, 2024) .

3 Workforce staffing gaps between those recorded in critical care units and appropriate standards ranged from 14.3% for Speech and language therapists, 22.5% for Physiotherapy and 24.3% for Dietetics, to 41.8% for Pharmacy, 78% for Medical Social Work and 88.6% for Psychology.

Figure 1: HSE turnover rates 2019-2024



Large cuts were made to public sector pay in Ireland in the wake of the global recession that followed the 2008 financial crash. These cuts were part of the programme of austerity that was a condition of the 'bailout' negotiated between Ireland and the European Commission, European Central Bank, and International Monetary Fund. Thomas et al (2013) report that during this period a moratorium on recruitment formed part of a strategy to reduce workers numbers by a total of 6,000 whole-time equivalents between 2009 and 2013. 43% of public sector staff cuts were delivered in the HSE, which reduced spending by 22% (Williams and Thomas, 2017). Clerical and administrative workers experienced the largest cuts in terms of proportion, with whole-time equivalent posts reduced by 9.6%. Pay cuts and freezes (both directly and through Pension Related Deductions) have significantly impacted pay.

Staffing reached its lowest levels in 2014, and subsequently recovered between 2015 and 2019, however analysis by Fleming et al. (2022) has demonstrated that in spite of Sláintecare aims, by 2021, the number of those working in community care settings remained below 2008 numbers.

Years of weak capital investment prior to 1990s, exacerbated by subsequent cuts after 2008, mean that Ireland's public health system is characterised by understaffing, outdated hospital infrastructure, and small numbers of hospital beds (resulting in occupancy rates well in excess of international safety standards) (Sicari and Sutherland, 2023). The lack of investment in IT infrastructure is highlighted by the May 2021 cyber-attack on public services, a period that resulted in significant stress and additional workload, in part due to its co-occurrence with Covid-19 (Moore et al., 2023).

Together these factors have made recruitment and working conditions less favourable than in other healthcare systems leading to recruitment and retention challenges arising in part from health workers migrating to other countries with more attractive pay and working conditions (Sicari and Sutherland, 2023). In a survey of social care workers conducted by Social Care Ireland in 2021, over 30% of respondents reported pay and conditions the largest contributing factors to retention and recruitment in the sector (Power and Burke, n.d.).

In response to cost overspends in 2023, and driven by inflation and increased demand for services, the HSE chief executive Bernard Gloster announced a freeze in April 2023 on new and replacement workers above Grade VIII, taking effect in May 2023. The hiring freeze was extended in early October to include home help, non-consultant hospital doctors (NCHD), general support, and agency staffing. The memo stated that "there will be no further growth of the workforce in 2024", other than an estimated 2,000 posts for which there are "pre-existing commitments." (Pepper, 2023) By November, the freeze was extended to all staff categories, except consultants, doctors in training, and 2023 graduate nurses and midwives (Pierce, 2024). This moratorium ended in July 2024 with the announcement of the 'Pay and Numbers Strategy' which set a ceiling on the number of workers.

1.2 Morale and productivity in the health and social care workforce

The concept of job morale first emerged in studies of military personnel during WW1 and has subsequently become a widespread concern across civilian workforces (Sabitova et al., 2020). Concern with low worker morale within healthcare systems arises from concern for employee wellbeing arising from employers duty of care to employees, but also the potential impact of low morale on productivity across retention, motivation, and quality of care (Kessler et al., 2021). Morale can be defined as "a general term encompassing the main aspects of work-related well-being and satisfaction and engagement with work" (Johnson et al., 2012). Work-related wellbeing encompasses pay and conditions as well as mental and physical-health outcomes for workers, including stress.

Numerous studies have found that low morale can lead to negative health and mental health outcomes among health and social care workers (European Agency for Safety and Health at Work et al., 2014; Milner et al., 2016). In addition to the importance of addressing these negative impacts on the sizeable number of people who staff our health and social care systems, evidence reviews have consistently found that low morale and burnout among health and social care workers leads to negative outcomes in patient safety and the quality of care (Salyers et al., 2017; Tawfik et al., 2019), as well as exacerbating challenges in workers retention, with long-term implications for sustainably maintaining costs and standards.

Globally, experts have highlighted the urgency of monitoring morale among health and care workers and the importance of conducting research to identify factors that lead to burnout and identify successful interventions to address individual, role-related, organisational and systemic factors that contribute to poor outcomes among health and social care workers (Dyrbye et al., 2017). Following calls to do so, including recommendations from the King's Fund 'Counting the Smiles' report in 2002 (Finlayson, 2002), the UK National Health Service (NHS) began conducting an annual survey of morale among health workers.[4] To date, no similar monitoring has been introduced in Ireland to monitor the impact of occupational, organisational, and systemic factors on worker satisfaction and engagement and to understand impacts on health, mental-health, and burnout.

4 NHS Staff survey methodology and report findings are available at: https://www.nhsstaffsurveys.com/

2 Reseach with Fórsa members

TASC conducted research with members of Fórsa's Health and Welfare Division to understand the factors shaping morale in the Irish health and social care sector, and their implications for service provision. To do so, we asked the following research questions:

- What is the current level of morale across the health and social care workforce, and how has it changed over the past two years? What key factors influence these morale levels?
- To what extent do health and social care workers have confidence in the delivery and implementation of Sláintecare, and what factors contribute to this?

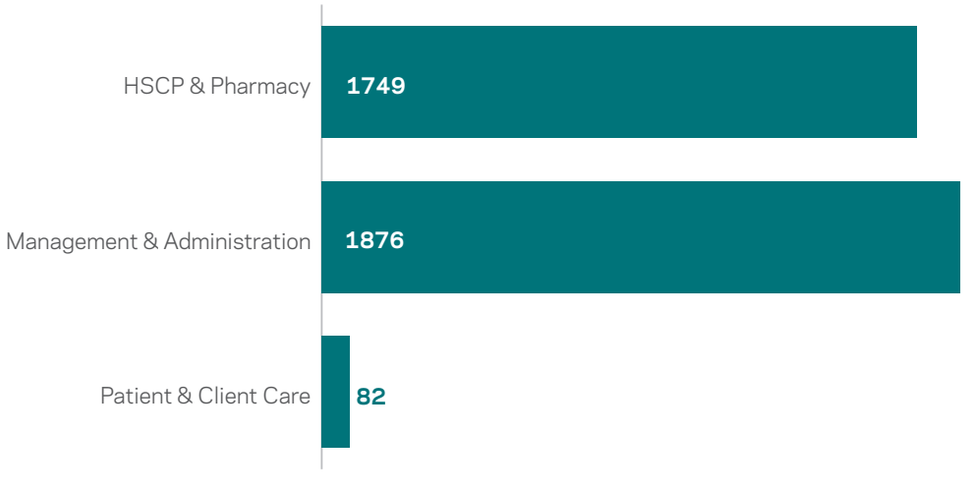
The Fórsa Health and Welfare Division includes HSE workers and health and social care sector workers employed by Section 38 Organisations, Voluntary sector organisations, and Tusla. This encompasses a wide variety of workers across clerical and administrative roles, as well as health and social care professionals in clinical and therapeutic roles, and individuals working in patient and client care services.

An online survey was circulated among the 30,000+ members of the Fórsa Health and Welfare Division to measure self-reported morale and productivity among health and social care workers, including how their morale had changed over the past two years and what factors had caused any changes. The survey received **3,775** responses during the two weeks it was active.

Four focus groups, held both online and in-person, explored in depth factors influencing workers' feelings of morale, including experiences of changes introduced in the last two years. Participants discussed the impacts of morale on service provision and productivity within the last two years and offered reflections on how to respond to the challenge of low morale. In total, **24** participants took part in this qualitative research.

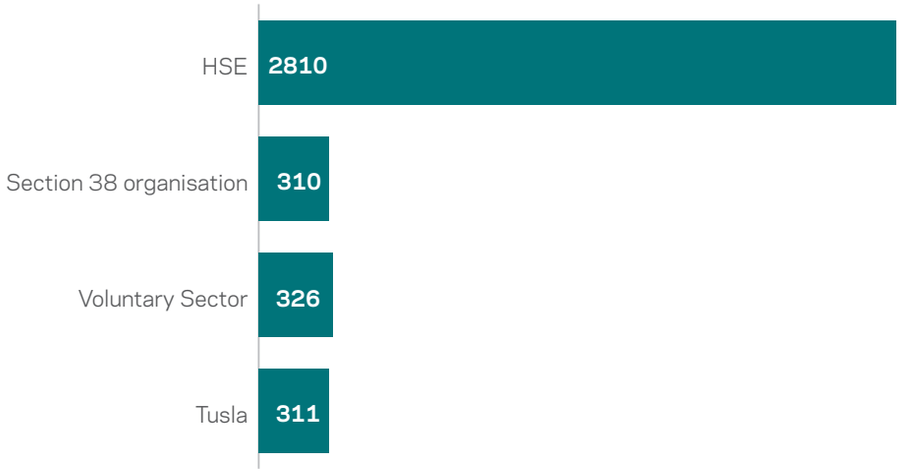
As figure 2 shows, survey responses were close to evenly split between Health and Social Care Professional and Pharmacy grades, and those working in clerical, management, and administrative roles. A smaller group of responses were also received from workers in Patient and Client care roles. A complete breakdown is included as Appendix A.

Figure 2: Survey respondent roles



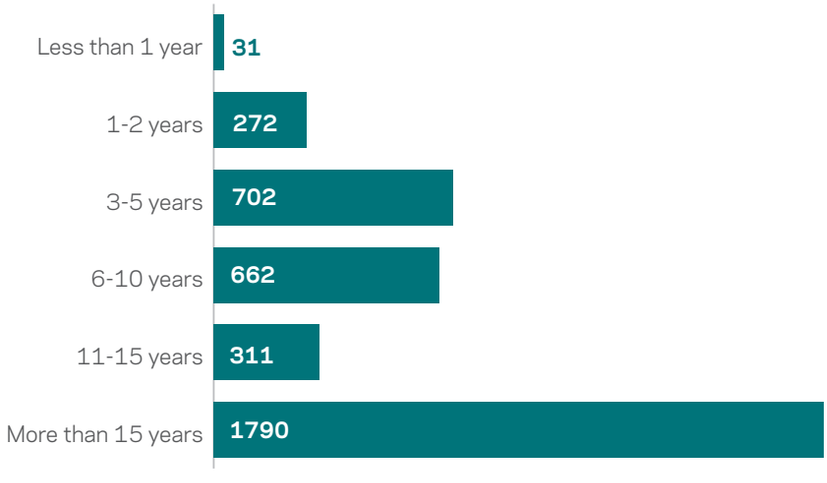
Around three quarters of respondents who took part in the survey were HSE workers, the remainder roughly evenly split between Section 38 workers, voluntary sector workers, and Tusla employees.

Figure 3: Respondent by employer



Respondents tended to be more experienced, with over half of all respondents reporting at least fifteen years of experience.

Figure 4: Respondent experience level



2.1 How Irish health and social care workers understand morale

When reflecting upon their experiences of working in the health and social care sector, focus group participants indicated that their own understandings of morale echoed findings in the broader literature. Participants emphasised the importance of feeling valued and supported in their role and being able to take pride in the impacts on their work among colleagues or patients/service users.

Participants tended to emphasise the collective aspect of morale, something that is not always discussed in the broader literature. Participants described the importance for them of feeling motivated and inspired by colleagues, and enabling colleagues to progress their skills, knowledge, and careers.

> *"Feeling that when you're going to work, you're heading in the right direction. Everybody there has the absolute best intentions to give the best service they can and that's what we're working towards."*

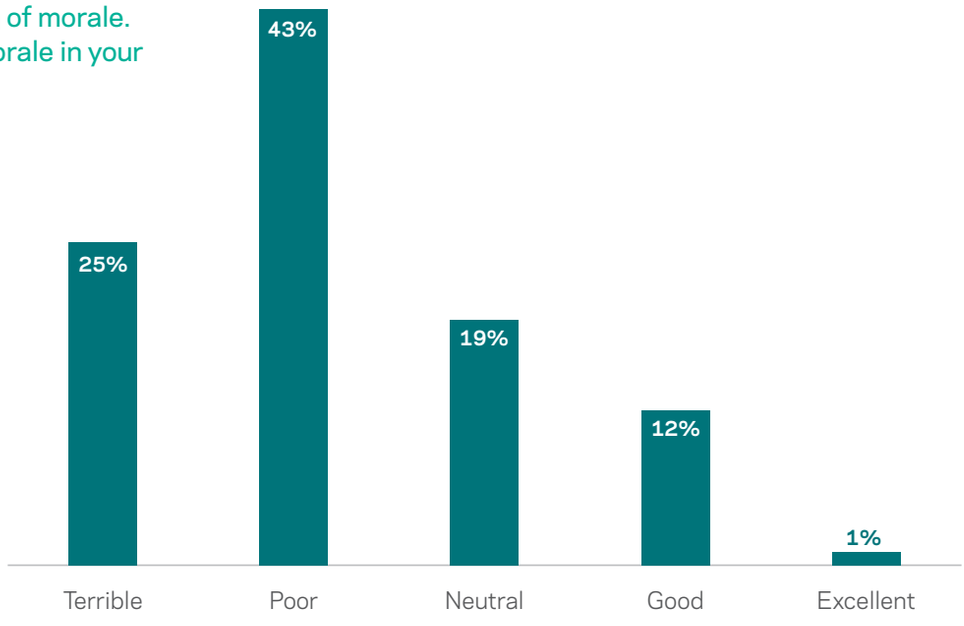
For participants, the collective nature of morale held the consequent implication that teams could become demoralised as a whole, and that once a team became collectively demoralised this would disrupt the working of that team and 'drag down' the morale of individuals working within it.

> *"It works in waves, if you're down in the doldrums, someone is there to pull you back up, but when everyone's down in the doldrums. There's no one to do that"*

2.2 How health and social care workers rate morale

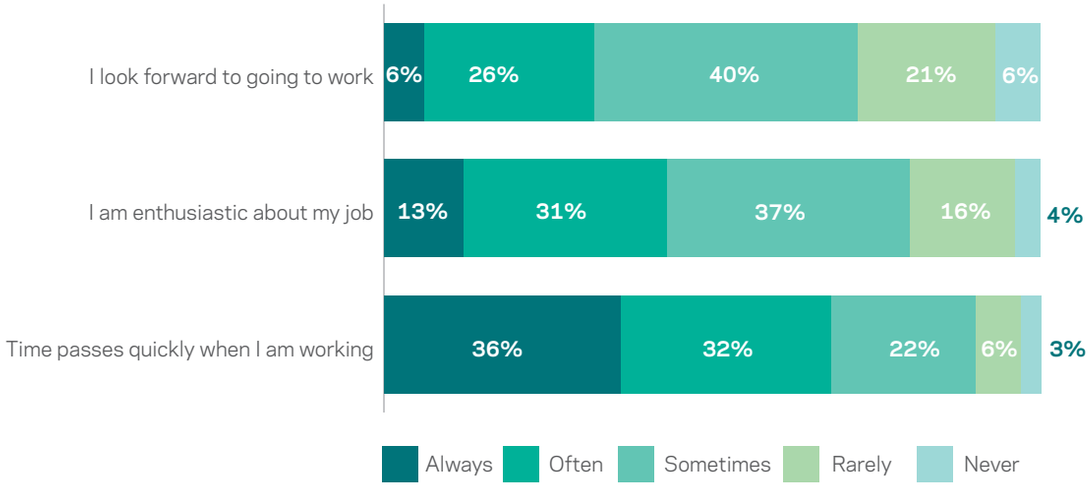
Most (68%) survey respondents gave a negative rating to morale in their department or service, with 43% describing it as 'poor' and 25% describing it as 'terrible.'

Figure 5: Respondent rating of morale. How would you rate staff morale in your department/service?



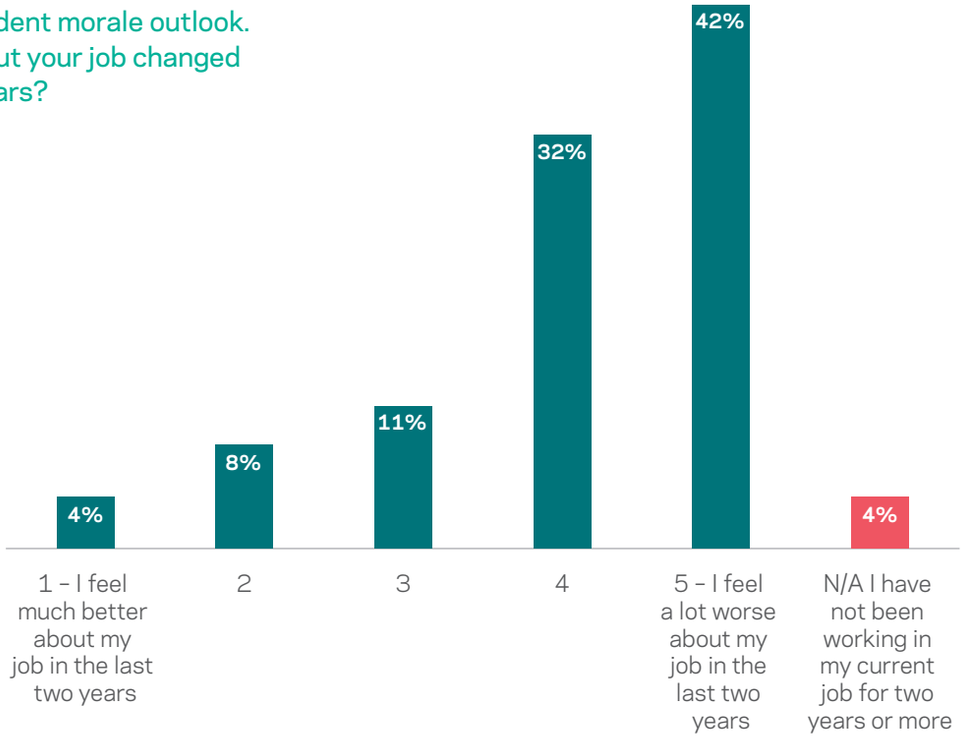
Despite this, respondents did report a large degree of enthusiasm for their roles. More respondents reported that they 'always' or 'often' looked forward to going to work or were enthusiastic than those who reported that they 'rarely' or 'never' did. 36% of respondents reported that time always passed quickly when they were working and a further 32% reported that it often did.

Figure 6: Respondent enthusiasm ratings



Survey respondents were pessimistic about recent changes to their role. Almost three in four (74%) of respondents reported that they felt 'somewhat worse' (32%) or 'a lot worse' 42% about their job in the last two years.

Figure 7: Respondent morale outlook. How you feel about your job changed in the last two years?



The sense that things were getting much worse within the health and social care sector was affirmed by focus group participants, with some citing fatigue over repeating cycles of crisis (from austerity, to COVID-19) as well as contemporary challenges, such as understaffing arising from the recent Pay and Numbers strategy. These factors are discussed in the next section.

2.3 Factors impacting low morale

Participants described a range of factors that negatively affect morale in the health and care sector, including understaffing, poor communication, systems, and management. Workers reported that they feel under-recognised and underappreciated and feel further demoralised by what they describe as an increasingly negative view of the health and social care sector among the public at large.

2.3.1 Understaffing and resulting pressure on workers

Study participants consistently cited inadequate staffing levels throughout discussions, highlighting the negative impact of the Pay and Numbers Strategy (PNS) which was described by participants as having 'decimated' the service. The PNS was initiated by HSE chief executive Bernard Gloster in 2024, capping the number of whole-time equivalent (WTE) positions at the number of filled posts on 31st December 2023, thereby abolishing unfilled vacancies (Wall, 2024) (See 1.1.3 Staffing and retention in the health and social care sector).

Participants highlighted the arbitrary nature of the PNS strategy, and argued that appropriate staffing should be evidence-based, and grounded in localised needs assessments and established best practices for deciding on appropriate caseloads for individual workers and clinicians. Some participants cited relevant examples, such as audits conducted by the Health Information and Quality Authority (HIQA) and

the Health Assets and Needs Assessment (HANA) conducted in Tallaght, while recognising that broader institutional failures to systematically develop the appropriate evidence base presented a barrier. Participants felt that the urgency of developing this knowledge base was supported by imminent challenges the country faces in light of our rapidly growing and ageing population.

> *"The CEO would give you the impression that the HSE was tripping over staff and that we were overrun with staff and yes, the HSE has expanded in its services over the years but so too has our population. [Anyone] can look at the media and at the health service around us and see there are glaring holes in that health service where people's needs are not being met."*

Participants perceived that political and budgetary considerations had taken precedence over evidence-informed prerequisites for adequate health and social care delivery. They felt that elements in government were hostile to any increases in public expenditure on principal, notably the Department of Public Expenditure and Reform, and that restricting staffing was the only mechanism the HSE could feasibly implement to bring down costs. In illustration of this point, some participants reported that, prior to its introduction, it was widely rumoured within the health and social care sector that the PNS strategy was a gamble by the HSE chief executive to 'call the government's bluff,' by introducing a policy that would have such negative consequences on patient outcomes that politicians would be forced to apply less budgetary pressure on the sector.

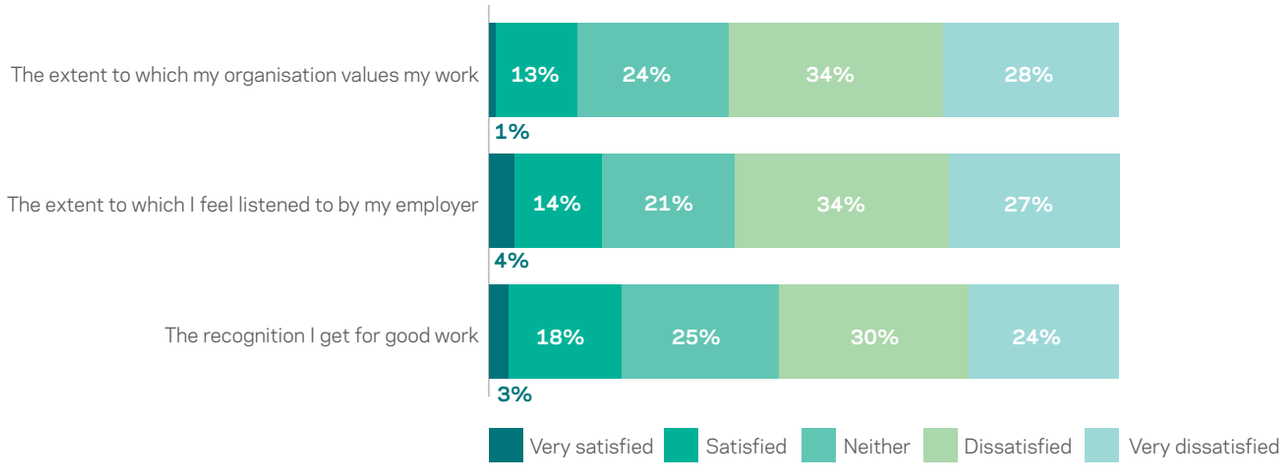
Participants reported that maternity leave and sick leave were rarely covered, leading to further pressures on existing workers.

Workers worried that the prevalence of temporary workers in administrative and clerical roles suggested a pessimistic outlook for the future of those roles, with some reporting that they were "waiting for these positions to be pulled" and subsequently less likely to be reinstated than clinical roles.

2.3.2 Lack of recognition and under appreciation of workers

Survey responses indicated high levels of dissatisfaction among workers with the level of recognition and appreciation from their organisation and employer that they experienced as part of their role.

Figure 8: Respondent satisfaction rating



Over half of all respondents reported that they were dissatisfied or very dissatisfied with the extent to which their organisation values their work, the extent to which they were listened to, and the recognition they received for good work.

For focus group participants, this was reflective of the broader culture in which senior management were disconnected from frontline challenges. In this context, inadequate initiatives to improve morale, such as 'thank you' emails from HSE executive management, were seen as 'insulting' and thus counter-productive. An example of this is the Employee Assistance Programme (EAP). Participants explained that the EAP tends to frame challenges faced by workers in a highly individualised way, encouraging employees to work on their mental resilience rather than challenging organisation-level shortcomings that give rise to low morale.

Participants reported what seemed to be less appreciation for individuals working in administrative and clerical roles. It was felt that there was a broader hostility among the public to employing clerical and administrative workers, who were seen as inessential.

> *"Whenever there's any comment about the HSE online or anything like that, no one ever likes admin staff. We're always the bad guys. We're seen perhaps as a waste of money"*

However, participants in clinical roles described the importance of maintaining appropriate administrative support and that current administrative shortages meant that those in clinical roles were spending a larger portion of their time doing administrative work.

> *"I've had that conversation with people who work as ADONs or pharmacy managers, that it probably makes more sense for them to have a clerical officer to do that part of their job. They'll probably do it better because it's what they're good at and you're not taking up someone who's highly paid and highly trained to do something that they don't need to be doing."*

> *"Colleagues in admin are so overburdened anyway. [Clinical staff] are picking up little bits of slack. You don't want to bother somebody to do a job if you can do it yourself quickly. It's covering up a crack in the support. [Clinical staff are doing it for the sake of getting the job done and it's not fixing anything."*

Some participants also voiced frustration with lack of recognition of individual achievements.

> *"What I hear a lot from other people is 'I work really hard. I do a really good job. The person who sits beside me or who works in the ward beside me isn't putting the same level of effort in and we get rewarded in the same way.' I hear that a lot from people in different ways and I don't have an answer for them."*

As part of this, participants described weak incentives for trying to improve services.

2.3.3 Poor systems and management

Participants highlighted poor managerial and technical systems as a challenge to morale. For example, participants discussed how Ireland continues to lag behind other EU countries in developing and resourcing digital systems. The shortage of administrative workers meant that clinical workers were left by themselves to administer systems characterised as 'primitive.' Participants who had worked abroad described their experiences in other countries of using database systems designed for healthcare settings, with simplified front-ends. They contrasted this with their experience in the HSE of having to make do with managing Excel spreadsheets and other tools they did not feel were fit for purpose. Here the theme of short-staffing reoccurred (discussed in 2.3.1 Understaffing and resulting pressure on workers) here referring to practices of hiring fewer workers in auxiliary roles, such as security workers and cleaning/maintenance workers. Participants described how the absence of this type of auxiliary support created day-to-day stresses and interruptions, degrading patient care experiences, and further eroding staff morale.

Participants also cited a lack of career development opportunities and supports, describing how HSE HR departments were almost wholly focussed on recruiting workers rather than retaining them or developing their capacity.

It was felt that managers lacked training in how to coach junior workers, and that many senior team members were spread too thinly in supporting large numbers of more junior workers. For some participants, this resulted in a lack of clear targets and goals, as well as inadequate one-to-one engagement and feedback from line managers.

Among administrative workers, precarity was seen a barrier to workers developing skills, with participants highlighting the shortage of permanent roles and reliance on temporary workers to support this claim. It was felt there was a general reluctance among senior managers to promote workers in clinical roles away from the front-line and that this hindered opportunities for progression. Clinical staff did highlight examples of positive experiences, discussing how they valued opportunities for Continuous Professional Development (CPD), especially when they were able to ring-fence time to engage with them. Participants also rated highly the Spark innovation programme, which provides funding and mentoring to develop small service-improvement projects.

2.3.4 Disconnect between executive management and front-line workers

A key theme throughout focus groups was inadequate communication between senior executive management and front-line workers. The HSE in particular was described as having a top-heavy management structure characterised by a one-way flow of communication between senior-management and front-line workers and focussed on recalibrating high-level organisational structures. Participants felt this left them feeling as though they were "shouting into a void."

> *"[The people] who sit at the top don't actually understand what's going on down on the floor, where we're actually trying to do the best we can and we're scraping together to make a clinic work. And we're like, you know, running from one room to the other, trying to not to cancel patients"*

> *"You can't get talking to anyone above your level, you know no one is listening there."*

It was felt that the HSE had continued to hire executive-level managers at the same time that front-line workers roles had been cut, despite the larger pay-packets of those in executive management roles. One participant was left asking "who will they have left to manage?"

The lack of consultation with workers meant decision-making was not adequately informed by practical, front-line considerations. Participants felt this was due to the limited clinical and other front-line experience among senior executive management.

> *"We're the ones with that experience. If we say we need more of something, we're not just saying it for the craic. You know, we're saying it because we know what's needed."*

Participants felt this disconnect was evident in high-level strategies that lack sufficient detail on implementation and delivery and reflected in wasteful deployment of resources. Examples of this included building a new primary care centre, but hiring staff in such small numbers that a large open-plan office ended up being used by only one admin worker.

Participants were critical in their assessment of external consultants with little knowledge of the sector who they reported were sometimes brought in to advise experienced workers. They voiced frustration with what was seen as an increasing emphasis on 'management solutions' and trivial administrative protocols. Policies were described as having become increasingly complex and inflexible over time, hindering front-line workers' autonomy when it came to advancing service-delivery improvements.

> *"There's always that element of 'Things have to be done a certain way because that's a national process and you can't step outside it.' Even when we struggle at times to recruit certain grades [...] there's very strict rules around that'"*

> *"The ability for me to effect change has been almost eliminated because to try and get an initiative off the ground is so much more difficult. There's so much more management now; There's so many more hoops to jump through. There's so many more roadblocks trying to get funding for anything."*

Senior executive management were felt to be insufficiently accountable for the effectiveness of policy-level changes. Participants cited failings in the previous record of key senior figures within the HSE. They also highlighted a tendency to draw on implementation and delivery models advanced in other countries, such as the UK, without critically assessing whether those models had been successful. Participants expressed cynicism around 'change for the sake of change' and suggested that reorganisation projects were often vehicles for advancing the careers of individual senior managers.

2.3.5 Increasingly poor public perceptions of health and social care systems

Focus group participants perceived an escalating negativity in how the health and social care sector are depicted and viewed by the public, and cited this as a significant factor in their declining morale.

In discussing this topic, participants highlighted the role of both national and local media. They felt that national media outlets prefer to highlight scandals and flaws in delivering large-scale programmes and routinely overlook the importance of reporting on positive developments as well.

This focus on negative news stories about the health and social care sector was also felt to be evident at the local level. Participants described how members of the public who had negative experiences of accessing care were increasingly organising social media campaigns to highlight their experience. Individual health and social care workers were sometimes named in these campaigns, which had the potential to spread to local media. When this happens, it amplifies negative stories and some participants felt it was unfair not to have any right of reply when social media narratives contain inaccurate information about them.

Participants expressed alarm at the reticence of the HSE to push back on these types of depictions and advance more positive narratives celebrating the important work done by health and social care workers. This perceived lack of support by their organisation meant that workers felt increasingly exposed and anxious as well as disrespected by senior HSE management.

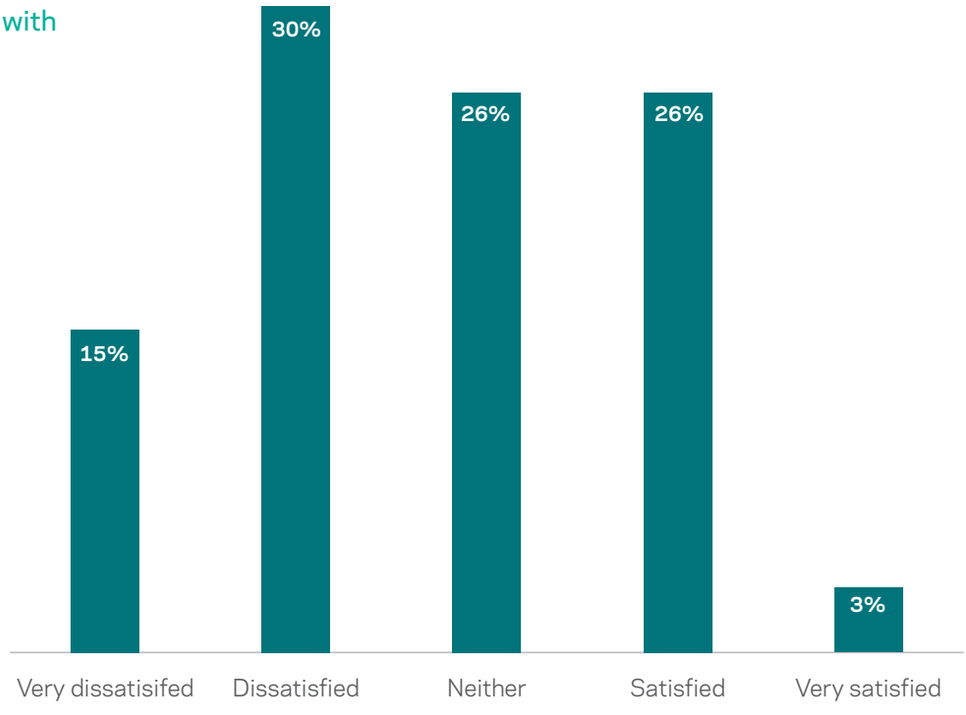
> *"There is less protection available for staff than would have been when I started and certainly less visibility of managers minding their staff."*

At the same time, participants felt some negative perceptions of the health system were justified, with some expressing alarm that public had become too accepting of widespread failures such as unacceptably long waiting lists. Participants wanted patients to make complaints in the hopes of pushing for improvements within the system but felt that many patients were reluctant to do so because they would feel as though they were making complaints against workers treating them, and with whom they had good relationships.

2.3.6 Pay disparities

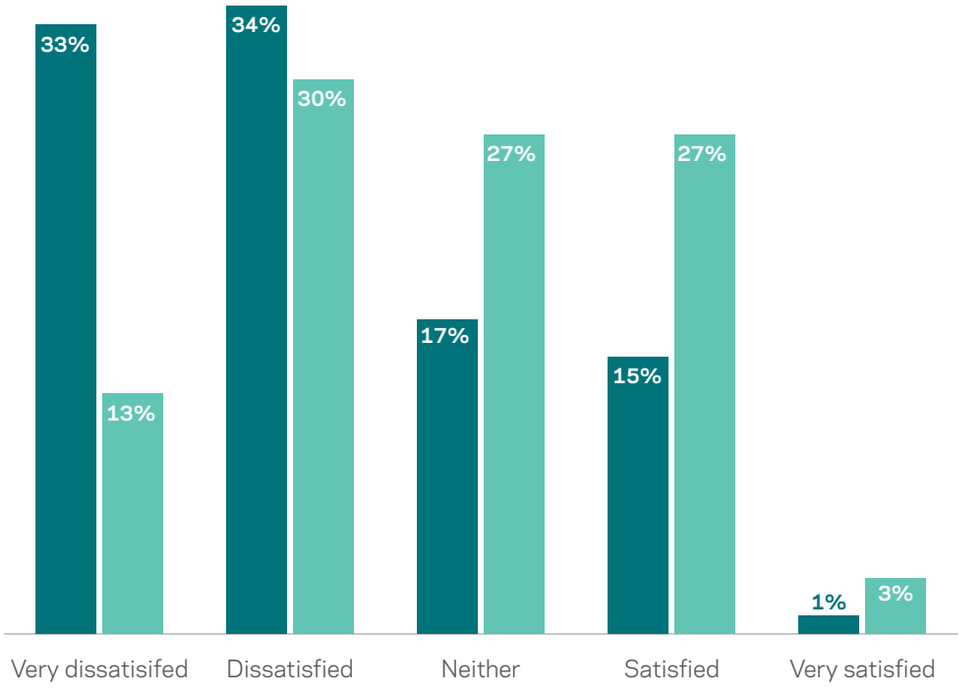
Respondents were more likely to be dissatisfied with pay than satisfied, with 45% of respondents reporting being "dissatisfied" or "very dissatisfied" compared with 29% who reported that they were "satisfied" or "very satisfied".

Figure 9: Satisfaction with pay levels



Voluntary sector workers were 2.9 times more likely to report lower levels of satisfaction compared with HSE workers.[5] This difference is illustrated below in Figure 10 which shows that while 13% of HSE workers reported being very dissatisfied with their pay level, this rose to 33% for voluntary sector health and social care workers.

Figure 10: Satisfaction with pay levels (comparing by employer)

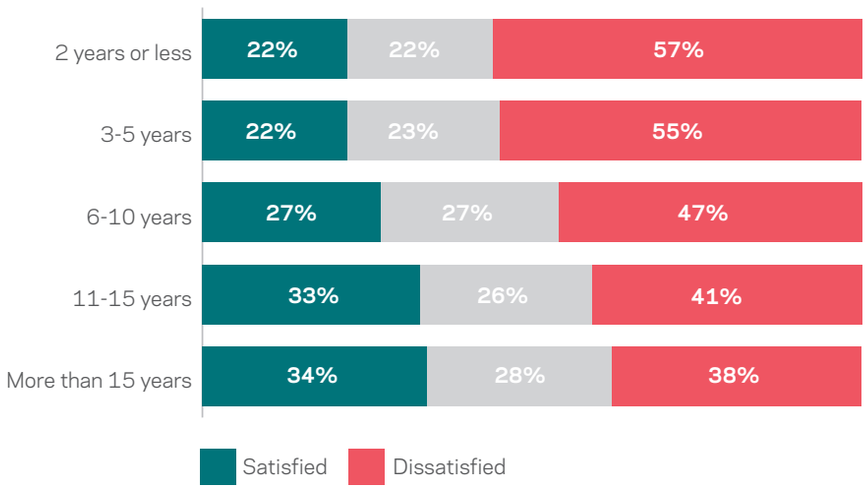


5 Based on simple logistic regression analysis.

Focus group participants discussed what they characterised as an unfair disparity between voluntary sector workers and others in equivalent public sector roles. For some voluntary sector workers who had been in post for longer, they described how they had seen their pay and benefits dwindle in comparison to their public sector counterparts, and described frustrations with long gaps between pay rises. Participants described that this sometimes led to frictions between workers on each side of this pay divide when working together. They noted that this pay-disparity made voluntary sector organisation roles less attractive than equivalent HSE roles and asserted that this was likely to have implications for recruitment.

Similarly, satisfaction with pay was lower among those with less experience in the sector, which would likely include younger workers and those on lower pay grades. In focus groups participants also discussed frustration that private sector experience did not contribute toward initial pay calculations for new entrants, who under current rules must begin at the start of the pay scale. More than half of participants with five or less years of experience reported dissatisfaction with their current level of pay.

Figure 11: Satisfaction with pay levels (comparing age brackets)



Younger workers, or those who have arrived from other countries, are also more likely to live in rented accommodation. Consequently, those with less experience are more likely to experience financial and work-life balance challenges related to finding adequate housing and paying high rents. Some younger focus group participants discussed how despite having a 'dream job' with the HSE, they struggled with money or had to live at home with their parents.

2.4 Impacts on workforce morale

This section describes the impact of low morale on participants' morale and that of their colleagues. Low morale affects workers themselves but also creates a knock-on effect that threatens the retention of skilled workers and service capacity.

2.4.1 Impacts of low morale on worker wellbeing

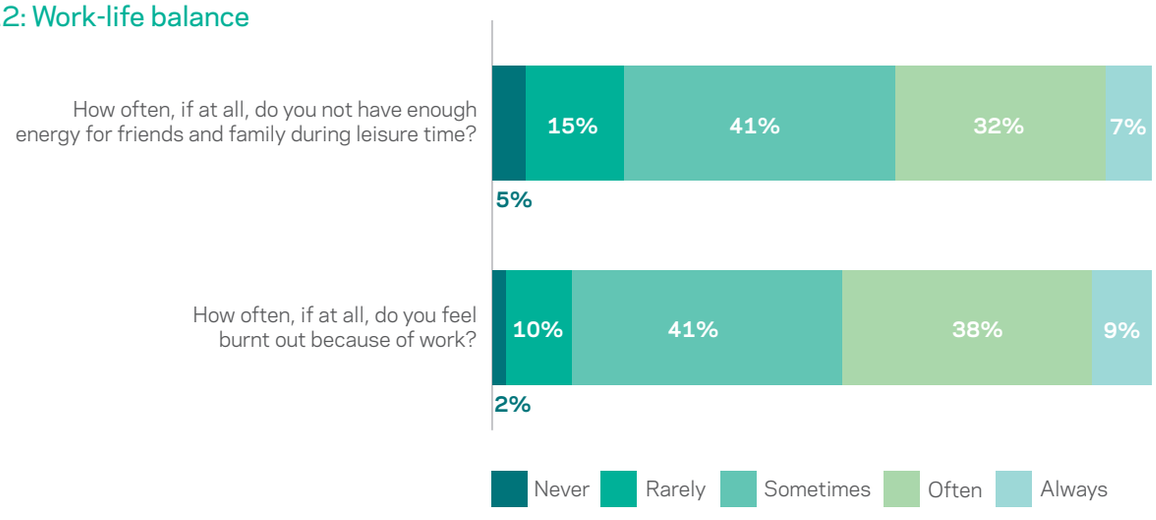
Participants described the impact on workers of teams being under-resourced. They reported that many workers felt over-extended as a result, travelling longer distances to cover a wider geographical area, or acting in ways that were above their pay grade. Workers described a sense of being constantly pushed to their limits, and feeling that the expectation for them to do so had become a norm within the sector.

Participants reported that the health and social care sector was staffed by people keenly motivated to help others, and that they were most likely to respond to lack of employer support by over-extending themselves. Newly hired workers found themselves 'swamped' and unsupported by adequate numbers of senior staff, concluding that the job they had been hired for was 'unachievable.' Faced with the cumulative effect of these workplace conditions, participants reported that younger staff especially were in danger of burnout. Participants reported that demoralised workers were less likely to be willing to go above and beyond for the organisation.

"If you feel valued in your workplace, you will give more and you will perform better."

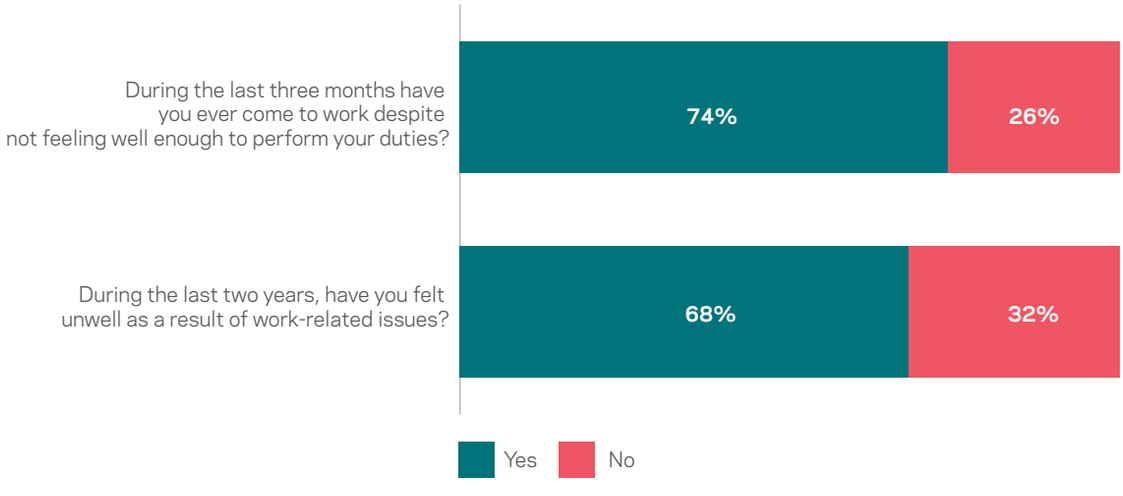
Survey respondents reported that work often left them feeling burnt out. 47% reported that they often or always felt burnt out because of work and 39% of participants reported that they often or always did not have enough energy for family and friends during leisure time.

Figure 12: Work-life balance



Survey responses indicated that burnout experienced by workers was impacting their capacity to fulfil their roles. 74% of survey respondents reported that they had come to work in the last three months despite not feeling well enough to perform their duties. 68% reported that they had felt unwell in the last two years as a result of work-related stress.

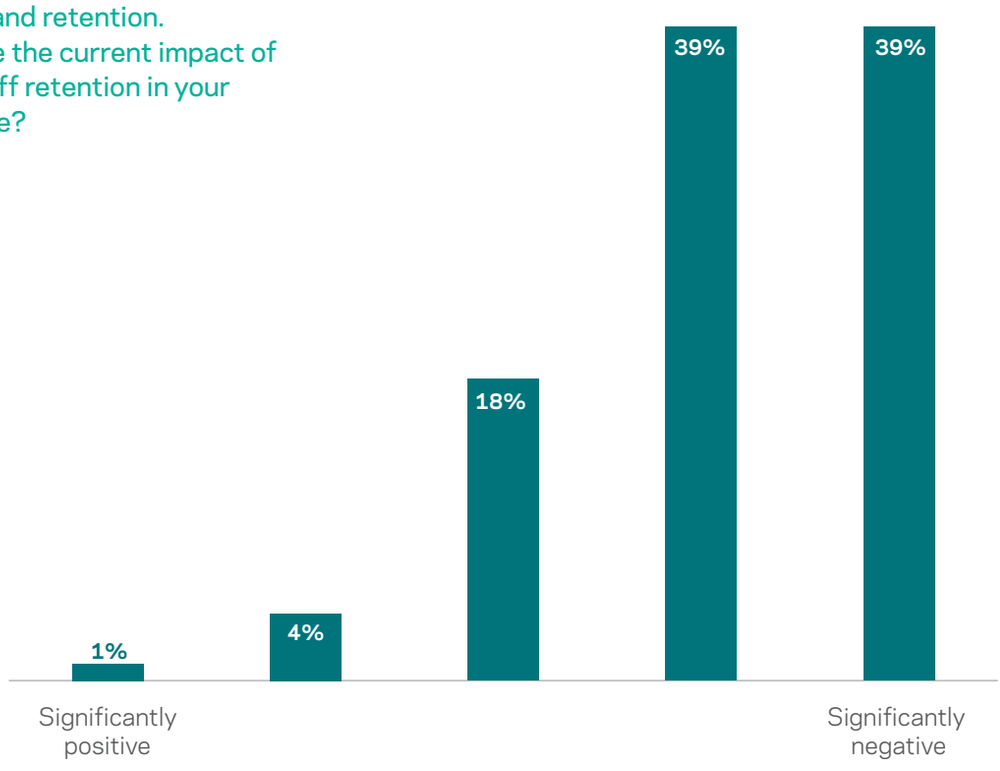
Figure 13: Work-related illness



2.4.2 Retention

Survey respondents overwhelmingly felt that current levels of morale were having a negative effect on retaining workers. 78% of respondents reported that morale had a somewhat negative (39%) or significantly negative (39%) effect on retention in their department or service.

Figure 14: Morale and retention.
How would you rate the current impact of staff morale on staff retention in your department/service?



Focus group participants reported that staffing shortages were negatively impacting retention in the health and social care sector by increasing the burden on existing workers leading to worsening morale among existing workers and initiating a vicious circle that is leading to a loss of skills and experience in the existing workforce.

Figure 15:
Satisfaction/retention cycle

"We've had people leave. They haven't been replaced, which means that there's a bigger workload than on the people who are already really, really stressed out. [...] There's no question it's impacting on the service and on our energy to provide a really good service. We feel that ourselves."

Participants reported that colleagues seemed to be taking retirement progressively when faced with the stresses and pressures created by worker shortages. It was felt that morale had reached a low-point that depleted worker resilience was depleted. Workers were being asked by those in charge to operate with a 'blitz mentality' but reported that large-scale challenges (including COVID-19) had already taken their total and that workers were finding it more difficult to bounce back. Emotional resilience was already under strain due to the 'emotional intensity' of working in the health and social care sector, which often involved supporting people in crisis.

> *"The number of people off on stress leave the number of people off on sick leave. The number of people off on long term sick leave all of that to my mind, seems to be increasing "*

Participants described how the worsening of morale over time left them feeling exhausted and hopeless.

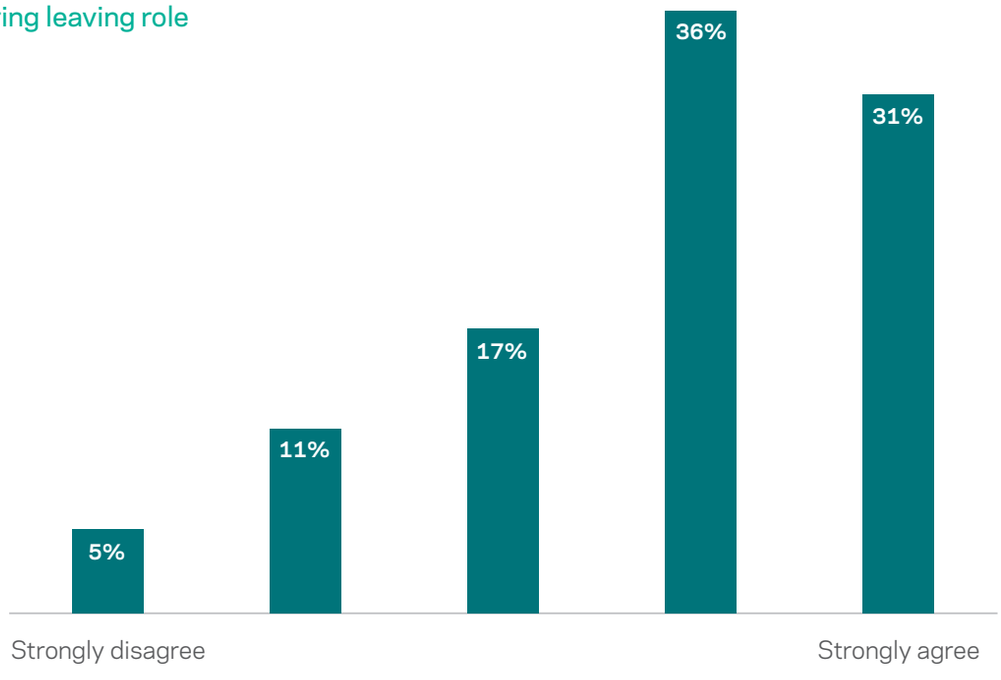
> *"They were supposed to put two more into community [home care services] [in response to] the influx of orders that were coming through, and it's just not happening. But it is very, very degrading. It's very tiring and you just get so tired because you have the clients coming in and they're frustrated [as well]"*

Participants reported that despite an increase in the number of training courses relevant to health and social care sector posts, many were leaving for other careers, including emigrating to countries with better pay and conditions such as Australia, New Zealand and Dubai, draining the sector of skills from workers trained in the Irish education system at the same time that the sector is increasingly having to rely on recruiting workers from abroad.

Challenges in converting temporary administrative positions to permanent ones were reportedly so significant that many workers were leaving to take jobs in other government departments and public sector bodies.

> *"Staff are burnt out to a degree that I have never seen before and it is no wonder then that we're losing them to private care and to other careers."*

Figure 16: Considering leaving role

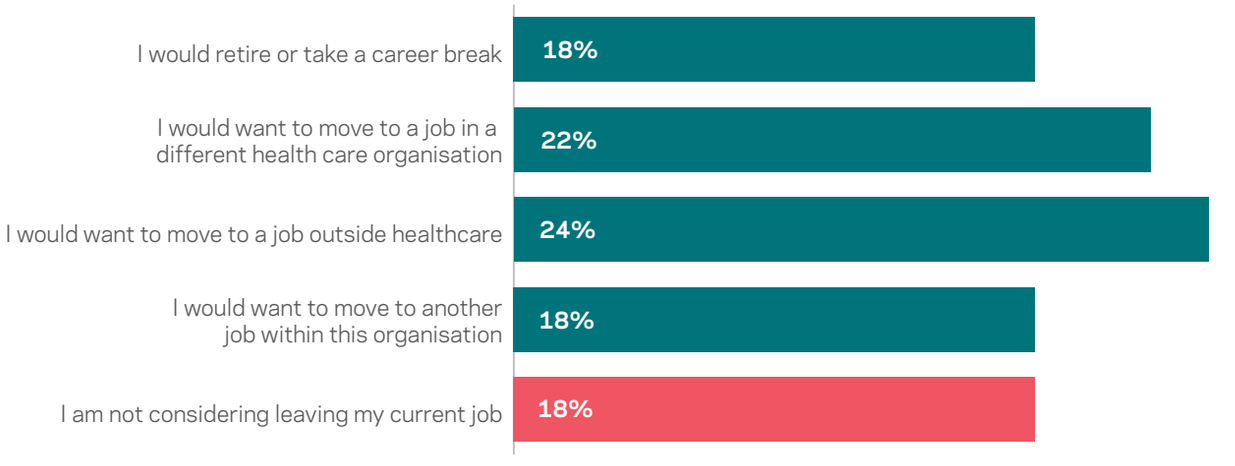


67% of respondents somewhat or strongly agreed with the statement that they sometimes think about leaving their current role.

42% of respondents reported that they would like to leave the health and social care sector altogether, with 18% reporting that they would retire or take a career break and 24% moving to job outside health care.

18% reported that they would move to another job within their organisation, and 22% to a job in a different health care organisation.

Figure 17: Alternatives to current role



2.4.3 Impacts of low morale on teamwork

Participants reported that low morale, primarily driven by understaffing and poor systems and management, undermined effective teamwork at both the team and systemic levels.

The loss of experienced workers, and their replacement with new graduates and workers hired abroad from international talent pools, meant a loss of institutional knowledge and experience. Institutional knowledge from experienced workers was seen as vital to navigating health and social care systems that are often complex, opaque, and poorly mapped. Senior-level workers were also felt to be more likely to understand shortcomings in proposed managerial solutions (particular when these were rehashed versions of initiatives that had previously failed) and be able to push back effectively. Senior and experienced workers were described as being spread too thinly as line-managers to provide effective support, which was seen as vital, especially in the initial stages where recent recruits and those in junior roles needed mentorship to meet the challenges of their new role.

> *"It's not about my individual caseload anymore. It's also about the resource I am to other members of the team"*

Participants reported that work across the sector had become more siloed, with diminished communication between different services (such as disability, primary care services, hospitals, etc). Despite shared challenges, participants felt that units within the sector were being pitted against each other by senior management.

> *"Disability services are being told that primary care have shorter waiting lists. Primary care are being told that disability services have all these specialist services that you guys don't have. [...] If we keep all the little cogs in the machine at each other's throats, they're not going to work together to try and find a solution. "*

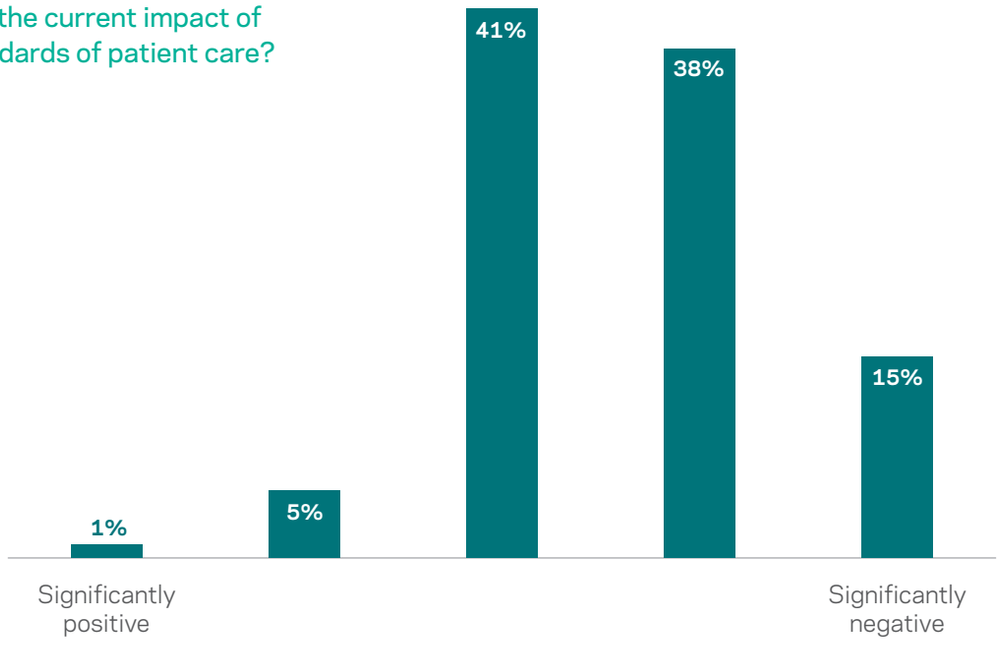
The negative consequences for teamwork within the health and social care sector had left workers feeling more vulnerable and exposed to risk.

"What I'm feeling at the minute is [...] that nobody's going to save me afterwards like that, I could be left hanging out on my own."

2.4.4 Impact on patient care

Over half of survey respondents reported that current staff morale was having a somewhat negative (38%) or significantly negative (15%) impact on standards of patient care.

Figure 18: Impact on patient care.
How would you rate the current impact of staff morale on standards of patient care?



In focus groups, participants tended to focus on interactions between morale, staffing, and long waiting list times. They reported that staff shortages were directly impacting patient wait times and explained that the negative effect on patient outcomes was a source of distress for workers.

Participants described how long waiting lists were rendering the process of making referrals unworkable, describing how long wait times had forced some services to close their doors and refuse additional referrals. They reported that this led to various impasses, as services often rely on accessing other services within the health and social care sector such as diagnostics and psychological assessments.

Participants working in social care flagged how they sometimes faced challenges accessing referral services from public providers, even when these had been ordered by judges. In these instances, workers had to instead rely on private provision to ensure compliance with court orders. Participants reported that long waiting lists were caused by a shortage of administrative workers as well as a shortage of those in clinical roles. They highlighted the importance of having adequate numbers of administrative workers to efficiently schedule appointments and clinics.

"If you don't have an admin person there the clinics are not booked, clinics are not cancelled. If somebody goes on maternity leave, they're not replaced. If they're out sick, they're not covered."

Participants felt that the parlous state of primary care waiting lists was directly at odds with the aim of expanding community-based care under Sláintecare. While workers are being advised to use systems for managing waiting lists, they explained that they ultimately cannot reduce waiting lists without having adequate clinical staff to see patients. Participants explained that long waiting-list times were undermining preventative care, with patient and client outlooks worsening the longer they wait to be seen.

> *"If you're talking about, say, a child with a disability, if they come to us at two [years old], there are certain needs that they will have. But if we don't get to see them for eight years [this will affect] the number of maladaptive behaviours concerning their ability to engage in academic programmes, their ability to engage socially in the community, all of that stuff. If you're talking about maximising efficiency and cost effectiveness. The time to intervene is early, not late."*

This was seen as cost-inefficient as poor primary care provision will likely contribute to greater pressure on urgent and acute care services in the long-term. Participants reported that by the time individuals are seen symptoms may have progressed, in which case more resources are needed and patients are already on the way to worsened outcomes.

> *"The number of concerns and the number of teams and numbers of staff and the amount of resources that then have to be marshalled to try and meet a need which could have been easily addressed by a member of staff over a six-week period, eight years prior."*

Participants felt that there was a lack of political will to address the urgency of long wait times for primary and community care services, where waiting lists continue to grow. It was felt that among senior executives and politicians, more urgency was attached to improving acute care services as associated metrics (e.g. number of beds, hospital wait times) were more easily legible to the public. By contrast, preventative care contributes to long-term improvements that happen over a period much longer than an election cycle, for instance the population-level impact of successfully reducing smoking or improving diets.

Participants highlighted the extent to which health and social care professionals are forced to look to private provision to access services where clients cannot wait for waiting lists. They reported that many public providers are having to rely on private services when faced with long waiting lists for services such as psychological assessments. They described a lucrative and growing market for private provision of many such services, and that there was also a time-cost involved in administering this, with individual social care workers or clinicians needing to spend additional time sourcing suitable providers and set them up as vendors.

2.4.5 Service closures

Some participants reported that a shortage of workers had also left some geographical areas without the same level of health care provision as others. In some areas where staff posts have been abolished since December 2024, network managers had made the decision to withdraw services from the unstaffed network areas, rather than attempting to spread workers out over a too-wide geographic area.

Due to a shortage of workers, and the abolition of some staff posts since December 2024, network managers made the difficult decision to withdraw services from certain unstaffed geographic areas. Participants reported this was done to avoid spreading the remaining staff too thinly, which has resulted in uneven health care provision.

> *"My staff can stretch if there's light at the end of the tunnel, but that light has gone out. So those staff are no longer going to cover those three networks. We're now going to close the service in those three networks. Our goodwill had ended."*

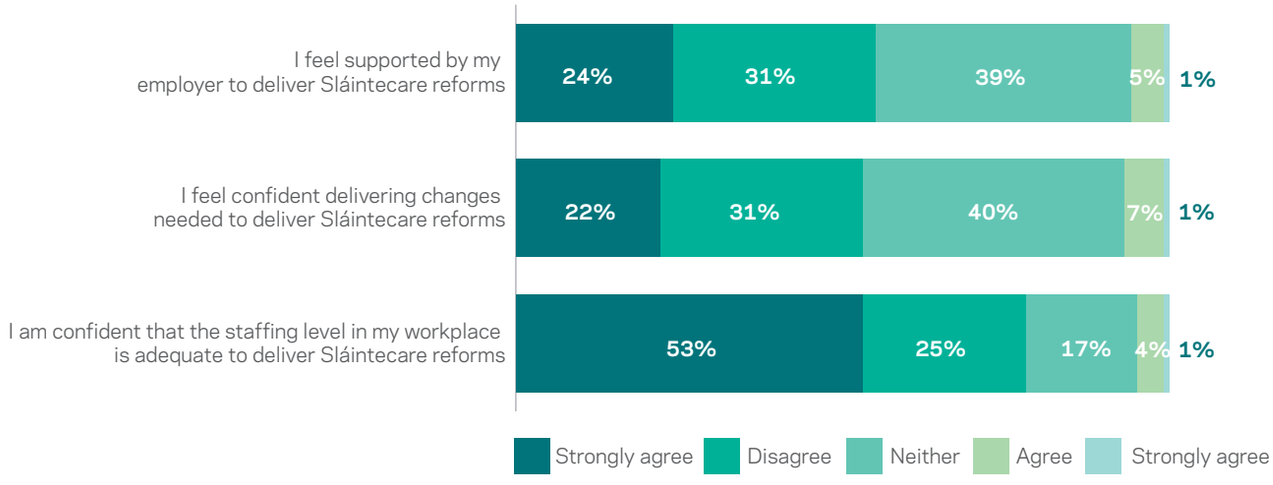
> *"We have closed down our service in some parts. Speech and language therapy have closed down their service in some parts, physiotherapy have closed down their service in some parts because of the obliteration of posts in the pay and number strategy."*

However, participants reported that the impact of the strategy on service provision was not captured and reported by the HSE under current metrics.

2.4.6 Sláintecare

Respondents demonstrated significant concerns regarding the delivery of Sláintecare reforms. Over half felt a lack of support from their employer (55% total disagreement) and a lack of confidence in delivery (53% total disagreement). The most critical finding, however, was that 78% of respondents strongly disagreed or disagreed that current staffing levels are adequate to deliver Sláintecare, with 53% falling into the 'strongly disagreed' category alone.

Figure 19: Confidence delivering Sláintecare



The implementation of Sláintecare was felt by participants to be symptomatic of the disconnect between senior management and front-line workers (as discussed in Section 2.3.4).

> *"Sláintecare is like a swan, all the focus is on the managerial structure but underneath frontline staff are the ones paddling away while senior management sail along hoping everything will work out okay."*

Participants reported that communication within the sector around Sláintecare had been typified by a lack of consultation with workers and little explanation of its implications for them.

> *"The failure of the enhanced community care was lack of consultation with the staff on the ground, lack of workforce planning in order to achieve it and I suppose clarity of rules, so they brought in network managers but they didn't speak to the heads of discipline in advance in terms of how that would change our roles in terms of managing staff on the ground."*

It was reported that there was little understanding among health and social care sector workers about what changes were entailed by Sláintecare and what it might mean for them. Some reported that the way it was communicated was paradoxical, both 'a big transformational change' but also something that would not impact provision of services day-to-day. Some participants had subsequently formed the impression that Sláintecare was little more than a managerial exercise, and felt that this was implicit in the way it had been communicated as happening at "a much higher level and you wouldn't understand."

> *"We hear a lot about the regional organisation and what seems like it's recreating the old health boards, but maybe I'm misunderstanding something…"*

Some workers had come to the conclusion that much of what Sláintecare involved in practice was unnecessary managerial restructuring and that its main purpose was a vehicle for staff in senior executive roles to demonstrate leadership and characterised by one participant as "like shifting deckchairs on the Titanic."

"They spend all this time strategizing. They come up with this new strategy; they invest a lot into it. Its half done and then they come up with another strategy and they start doing the same thing again but nothing actually changes on the ground. It actually gets worse. So now I have more managers. As I said, telling less frontline people, they have to try and do more."

"a new manager comes in and reorganises things and brings everything into one organisation. Then someone else comes along a couple of years later and undoes all of that. And that's management because things are happening. "

3 Conclusion and recommendations

The importance of supporting staff was recognised in the HSE Corporate Plan 2021-24 (HSE, 2021). This plan, which set out key actions to improve health and well-being provision in Ireland, included a section on supporting workers, which acknowledges the impact on them of working on the frontline throughout the Covid-19 pandemic and commits to:

- **Demonstrating to staff that they are valued** including improving flexibility for workers
- **Empowering staff to deliver change** by equipping staff with appropriate skills, supports, and resources
- **Developing a strategic workforce plan** and improve HR services to enable better recruitment and retention of staff
- **Improve career development and training opportunities**

However, the research presented in this report demonstrates that many workers feel undervalued and disempowered by their experience of working in the health and social care sector. These findings, conducted with members from Fórsa's Health and Welfare division echo existing research conducted with doctors and nurses. Studies have shown that stressful conditions and poor work-life balance among those healthcare workers in Ireland are exacerbated by years of underinvestment in the health service and the additional strain this puts on workers. Multiple studies with doctors and nurses by Humphries et al. (2019, 2015, 2015) have found similar findings to ours, that poor management and perceived lack of voice and consequent inability to effect positive change is influencing healthcare professionals to emigrate in search of better working conditions. Our findings also echo research findings with doctors and nurses showing that 'institutional deafness' to the voices of healthcare workers discourages them from remaining engaged with their organisation and role and that this has an undermining effect on teamwork, which is vital to sustaining morale (Creese et al., 2025).

In a 2019 review of the factors that impact the mental health and wellbeing of medical students and doctors, Professor Michael West and Dame Denise Coia concluded that health and social care workers need a stronger voice in decision-making processes.

> *"Having a voice and influencing decisions within a team or organisation is fundamental to autonomy/control. Equally, we feel more in control when we see our work environments as fair and just. Doctors are among the most skilled and motivated people in any industry, yet they frequently reported not having influence at work and feeling unfairly treated in workplaces that emphasised blame rather than learning. This reduces the pool of knowledge, creative ideas, and experience available to decision makers overseeing our healthcare organisations. It also reduces doctors' engagement, motivation, and wellbeing. The challenge for clinical and all other leaders is to empower doctors to influence the direction of their organisations and to implement their ideas for better ways of doing things, in psychologically safe and supportive environments."* (West and Coia, 2019)

The recommendations set out in the Sláintecare report are ambitious ones, and require a radical transformation to enable the core aim of the reform programme: establishing a universal public system grounded in community-based diagnosis and treatment and enhanced preventative care. However, our findings suggest that a 'top-down' approach to systems change is showing signs of 'institutional deafness,' leaving it unresponsive to the voices of those on the front-line. Bate et al. (2004) argue that healthcare reformers need to look to social movements to understand how to mobilise a 'grassroots-style' movement of workers to advance a collective vision of sectoral reform. Our research finds that workers are frustrated that their insights into the challenges on the front-line of the health and social care sector, and how those challenges could be addressed, consistently go unheeded by executive management within the sector.

Considered in this light, our research findings support the need to more attentively listen to the voices of healthcare workers. In the coming years, the Sláintecare model, together with Ireland's growing population, will require greater numbers of workers in primary care settings to alleviate stresses and shortages in acute care. Allied health and administrative workers will be crucial to this transformation, but their contribution continues to be under recognised, with this group of workers feeling perhaps even less seen and respected than their colleague doctors and nurses.

Trade unions play a decisive role in enabling workers to speak to the challenges for our health and social care sector. Sláintecare provides a positive vision for transforming services, and this will require a healthy and happy workforce to deliver it. Drawing on suggestions from focus group participants, we present a number of recommendations below. These recommendations outline how a range of stakeholders with responsibility for overseeing the sector can ensure higher levels of morale and in doing so support a sustainable working culture for all health and social care workers.

3.1 Learning for decision makers, funders, and employers

3.1.1 Ensure appropriate staffing levels

The pressures on workers as a result of understaffing was evident. Our research suggests a greater need for staffing strategies to be grounded in evidence-based approach that ensures appropriate service levels. This should involve comprehensive mapping of localised need for health and social services nationally.

Routine cover should be provided for maternity leave and HR and recruitment strategies should be streamlined to reduce unnecessary delays to ensuring vacant posts are filled.

3.1.2 Enhance strategies to boost retention

The skill and knowledge of experienced staff are invaluable to health services, and provide important support and guidance to more junior workers. Improving retention will help ensure consistent service provision and help keep skilled workers in post.

Workloads and caseloads for individuals should be appropriate and sustainable to avoid overwork and burnout.

3.1.3 Ensure continued improvements in pay equity

Pay disparities create challenges within the health and social care sector, exacerbating recruitment challenges in some areas. Despite working similar or identical roles, workers on lower pay scales can feel underappreciated and undervalued, which can undermine worker morale and cohesive team working.

Those responsible for resourcing the health and social care sector should continue to reduce disparities experienced by community and voluntary sector workers.

3.1.4 Amplify worker voice within the health and social care sector

The health and social care sector faces critical challenges in implementing Sláintecare and providing for our growing and aging population. Successfully navigating the changes that lie ahead demands the essential insight and input of front-line workers.

Policymakers and sector employers should foster a more consultative culture where high-level decision-making is consistently informed by worker experience and robust evidence. Adopting this approach will improve accountability and transparency, leading directly to more efficient resource allocation, higher staff morale, and, ultimately, better health outcomes for the public.

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Appendix A Sample breakdown

Health & Social Care Professionals	Health Science/ Diagnostics	78	
	Pharmacy	98	
	Psychologists	100	
	Social Care	252	
	Social Workers	197	
	Therapy Professions	736	
	Health & Social Care, Other	288	
	Subtotal		**1749**
Management and Administrative	Clerical (III & IV)	964	
	Grade (V-VII)	678	
	Management (VIII & above)	228	
	Management & Administrative NA	6	
	Subtotal		**1876**
Patient & Client Care	Ambulance Staff	1	
	Health Promotion	47	
	Home Care Services	19	
	Home Help	4	
	Pastoral Care	2	
	Patient and client care, Other	9	
	Subtotal		**82**
Total valid responses			**3707**

Appendix B Fórsa Health and Welfare Division members' survey

DRAFT VERSION

Information about the survey

This survey is being conducted by the **Think Tank for Action on Social Change** (TASC) on behalf of Fórsa to understand levels of morale among workers represented by the Fórsa Health and Welfare Division. TASC is an independent, not-for-profit organisation whose mission is to address inequality and sustain democracy by translating analysis into action.

The survey should take around **15 minutes** to complete and will be live until **7th April 2025**. Taking part is **totally voluntary**, you do not have to take part if you do not want to. The survey is open to all staff that make up the membership of Fórsa's Health and Welfare Division, including:

- Clerical and administrative workers
- Health and social care professionals
- Pharmacy Staff
- Tusla staff
- Section 38 workers
- Section 39 community and voluntary workers delivering health services

This survey is part of a larger study exploring current morale among the health and care workforce; how this has changed over the last two years; and staff confidence in delivering Sláintecare reforms.

The purpose of this study is to provide insights into the experiences of healthcare workers to support your union's efforts to improve working conditions for you and your colleagues.

All data will be held securely by TASC in accordance with **GDPR**. You can read more about how TASC process personal data by reading our Privacy Policy, available **here**. This data will only be accessible to the TASC research team and will be used for research purposes only.

Survey responses will be anonymised and presented in aggregate form so that they cannot be linked back to individuals who take part. Findings will be presented in a report to Fórsa and we will not share information about individual respondents.

If you are happy to take part in this survey and understand all data will be held by TASC in accordance with GDPR, please click next.

If you have any further questions about the study, please contact Tiarnán McDonough, Democracy researcher at TASC: **tmcdonough@tasc.ie**.

About you

Which of these job titles best describes your current role?

- Category
- Role

Who is your employer?

- HSE
- Tusla
- Section 38 organisation
- Community and voluntary sector organisation

How long have you been working in the provision of healthcare services in one of the named employers?

- Less than 1 year
- 1-2 years
- 3-5 years
- 6-10 years
- 11-15 years
- More than 15 years

How you feel about your job?

For each of the statements below, how often do you feel this way about your job?

- I look forward to going to work
  Never
  Rarely
  Sometimes
  Often
  Always
- I am enthusiastic about my job
  Never
  Rarely
  Sometimes
  Often
  Always
- Time passes quickly when I am working
  Never
  Rarely
  Sometimes
  Often
  Always

Have your feelings about your current job changed over the last two years?

- I feel much better about my job in the last two years
- I feel somewhat better about my job in the last two years
- No change

- I feel somewhat worse about my job in the last two years
- I feel a lot worse about my job in the last two years
- N/A - I have not been working in my current job for two years or more
- What do you think has been the main contributing factor to the changes in how you feel about your job?: open text

Your job satisfaction

How satisfied are you with each of the following aspects of your job?

- The extent to which I feel listened to by my employer
  Very dissatisfied
  Dissatisfied
  Neither satisfied nor dissatisfied
  Satisfied
  Very satisfied
- The recognition I get for good work.
  Very dissatisfied
  Dissatisfied
  Neither satisfied nor dissatisfied
  Satisfied
  Very satisfied
- The extent to which my organisation values my work.
  Very dissatisfied
  Dissatisfied
  Neither satisfied nor dissatisfied
  Satisfied
  Very satisfied
- My level of pay.
  Very dissatisfied
  Dissatisfied
  Neither satisfied nor dissatisfied
  Satisfied
  Very satisfied
- The opportunities for me to develop my career in this organisation.
  Very dissatisfied
  Dissatisfied
  Neither satisfied nor dissatisfied
  Satisfied
  Very satisfied

Has your job satisfaction in your current job changed over the last two years?

- My job satisfaction has improved a lot in the last two years
- My job satisfaction has somewhat improved in the last two years
- No change
- My job satisfaction has gotten somewhat worse a lot in the last two years
- My job satisfaction has gotten a lot worse in the last two years
- NA - I have not been working in my current job for two years or more

Your health and wellbeing

- During the last two years have you felt unwell as a result of work-related stress?
  Yes
  No
- In the last three months have you ever come to work despite not feeling well enough to perform your duties?
  Yes
  No
- How often, if at all, do you feel burnt out because of your work?
  Never
  Rarely
  Sometimes
  Often
  Always
- How often, if at all, do you not have enough energy for family and friends during leisure time?
  Never
  Rarely
  Sometimes
  Often
  Always

Impacts on productivity

To what extent do you agree or disagree with the following?

- I feel supported by my employer to deliver Sláintecare reforms
  Strongly disagree
  Disagree
  Neither agree nor disagree
  Agree
  Strongly agree
- I feel confident delivering changes needed to deliver Sláintecare reforms
  Strongly disagree
  Disagree
  Neither agree nor disagree
  Agree
  Strongly agree
- I am confident that the staffing level in my workplace is adequate to deliver Sláintecare reforms.
  Strongly disagree
  Disagree
  Neither agree nor disagree
  Agree
  Strongly agree
- I often think about leaving my current role.
  Strongly disagree
  Disagree
  Neither agree nor disagree
  Agree
  Strongly agree

- If you are considering leaving your current job, what would be your most likely destination?
  I am not considering leaving my current job.
  I would want to move to another job within this organisation.
  I would want to move to a job in a different health care organisation.
  I would want to move to a job outside healthcare.
  I would retire or take a career break.

Morale in your department/service

How would you rate staff morale in your department/service?

- Excellent
- Good
- Neutral
- Poor
- Terrible

How would you compare current morale in your department/service compare with morale two years ago?

- Morale has improved a lot in the last two years
- Morale has somewhat improved in the last two years
- No change
- Morale has gotten somewhat worse a lot in the last two years
- Morale has gotten a lot worse in the last two years
- NA - I have not been working in my department/area/hospital for two years or more

How would you rate the current impact of staff morale on standards of patient care?

- Significantly negative impact
- Moderately negative impact
- No impact/Neutral
- Moderately positive impact
- Significantly positive impact

How would you rate the current impact of staff morale on staff retention in your department/service?

- Significantly negative impact
- Moderately negative impact
- No impact/Neutral
- Moderately positive impact
- Significantly positive impact

Is there anything else you would like to say in relation to the topics covered in this survey?

Opt-in to take part in a focus group

For this study we are hoping to speak to members in Fórsa's Health and Welfare Division. We are arranging a small number of focus groups taking place in the evening during the week beginning April 7th and between 5:30pm and 7pm.

These focus groups will last 90 minutes, two will take place online via Microsoft Teams while two will take place in person in central Dublin.

Unfortunately, we cannot guarantee that everyone who opts to take part will be invited to attend a focus group.

- I would like to take part in a focus group
  Yes
  No
- Please select any or all focus groups you would be available to attend (you will be invited to a maximum of one focus group).
  Focus Group 1 (Monday 7th April – Central Dublin)
  Focus Group 2 (Tuesday 8th April – Online)
  Focus Group 3 (Wednesday 9th April – Central Dublin)
  Focus Group 4 (Thursday 10th April – Online)
- Name*
- Email*
- Contact number*

Appendix C Fórsa Health and Welfare Division members' focus group topic guide

Overarching research objective

The Think Tank for Action for Social Change (TASC) is an independent, not-for-profit think-tank whose mission is to address inequality and sustain democracy by translating analysis into action. Fórsa have funded TASC to carry out research exploring morale among members of Fórsa's Health and Welfare Division.

Through this research Fórsa are hoping to gain a better understanding of levels of morale among health and welfare workers, factors contributing changes in levels of morale, and the impact on productivity including confidence implementing Sláintecare reforms.

In order to find this out, we will be conducting research with Fórsa Health and Welfare Division members, which includes management and administrative staff, health and social care professionals and individuals employed in patient and client care. Fórsa Health and Welfare Division members work for a number of employers within the health and social care sector, including the HSE, Tusla, Section 38 and Section 39 employers.

This topic guide is for use as part of focus groups with the above categories of workers, to explore factors impacting morale among these groups and whether these have changed in the last two years. As part of this we will explore how morale impacts worker's perceived productivity and confidence delivering Sláintecare reforms and recommendations for improving morale.

The topic guide

Topic guides ensure consistency in data collection by outlining key issues to explore with each participant. While they shape the interview content, they should be used flexibly and responsively. The order of topics and time spent on each will vary between interviews or focus groups. Qualitative research allows interviewers to delve into unexpected but relevant themes that arise during discussions.

Preparing topic guides as short phrases rather than questions encourages interviewers to formulate responsive questions and use terms tailored to the participant. Researchers will decide what and how to follow up based on their knowledge of the research objectives.

Text in square brackets and/or italics represents notes for researchers.

Introduction

- Introduce self and TASC
- Brief introduction to study:
  - TASC is an independent, not-for-profit think-tank. We have been funded to carry out an evaluation of the Northern Ireland Civic Initiative.
  - For this study we have been commissioned by Fórsa to carry out research exploring morale among Health and Welfare Division members.
  - The purpose of this study is to provide insights into the experiences of healthcare workers to support your union's efforts to improve working conditions for you and your colleagues.
  - We want to speak to you today about your views and experiences of working in the health and welfare sector.
- This research will explore:
  - A little bit about you
  - Your views and feelings about your work and whether, those views have changed in the last two years
  - Factors that impact your feelings about your work.
  - Whether your morale and wellbeing is affecting outcomes at your work, including confidence delivering Sláintecare reforms.
  - Recommendations for improving morale among Health and Welfare workers..
- The focus group should last around 90 minutes.
- Taking part in interviews is **voluntary**. You are free to skip any questions or bring the conversation to a close at any time.
- With permission focus groups will be audio recorded. Audio recordings and interview transcripts will be stored securely and only members of the research team will have access to the data.
- Information from interviews and transcripts will be analysed in to themes and summarised by TASC into a report shared with Fórsa, which may include some quotes from those who take part, but no identifying information (including, for examples names of individuals or places) will be included.
- Any personal or identifiable data will be removed, and the report will only include research findings. It may be possible that individual views could be identified by others familiar with your views. Though individuals will not be named, a high-level descriptor of participant roles will be included, e.g. 'HSE management and administrative staff' or 'Section 39 Social Care worker'.
- At the end of interview/focus group, participants will be given the opportunity to redact any information they do not wish to include as part of the report.
- Any questions?

Practicalities

- [For in-person FGs] toilets – fire exits.
- Ask that everyone respects confidentiality of focus group, not discuss other contributions outside of the group.
- Everyone should have the opportunity to speak, may directly ask some questions – this is to give opportunity, not compelled to answer anything not comfortable with.
- May be important to move conversation on at times to ensure we cover everything.
- Any questions?
- Are you happy to take part and be recorded?

About you

Aim: To understand the participant's role and general views about working in Health and social care

About you

- A bit about participants [Name, Role, Employer, how long working]
- Participants views on what they enjoy about working in Health and Welfare sector.
  - [Prompts: Things they find rewarding/motivating about working in the sector]
- What participants like about their current role.

Participant understanding of morale

Aim: to understand participants current feelings of morale at work.

Morale

- What 'morale' means to participants
  - Wellbeing [Prompts: Health, stress, other?]
  - Satisfaction [Prompts: Achievement, seeing patient/client outcomes, other?]
  - Other?
- [Summary: "a general term encompassing the main aspects of work-related well-being and satisfaction and engagement with work."]

Factors affecting employee morale

Aim: To understand factors impacting employee morale

Levels of morale

- Participants' views of their own current level of morale
- Participants' views of morale in their department/service

Factors affecting employee morale

- Factors affecting worker morale [Probe throughout: Participants own and/or among department/service]
  - Staffing levels
  - Pay [if not mentioned/relevant – section 39 pay disparity]
  - Workload
  - Relationship with employer [listened to, work recognised]

Changes in last two years

- Changes in morale [Participants own, colleagues]
  - Changes in conditions in last two years
  - Other changes
  - [If not mentioned – Pay and numbers strategy]

Impacts

Aim: To understand impacts of morale on outcomes

Impacts on patient outcomes

- Whether current levels or morale are affecting outcomes
  - Patient outcomes
  - Patient safety
  - Other
- Positive impacts and negative impacts
- Most important factors
- [if not discussed – Changes over last two years]

Impacts on productivity

- Whether current levels or morale are affecting productivity
  - Staffing/retention
  - Motivation
  - [IMPORTANT] Confidence delivering Sláintecare
  - Other
- Positive impacts and negative impacts
- Most important factors
- [if not discussed – Changes over last two years]

Recommendations

Aim: to explore participant recommendations for improving morale

Recommendations for improving morale

- Recommendations for improving morale in Health and Welfare sector.
- Recommending for ensuring confidence delivering Sláintecare
  - Staffing levels
  - Pay
  - Workload
  - Other
- Role of employers
- Role of unions
  - Most important
- Any suggestions for improvement?

Next steps and close

Final closing comments – anything else to add?

- Ask participant if they are happy with the content of the interview / group discussion (or if they would like to redact anything)
- Reaffirm confidentiality.
- Any questions?
- Thank participant

[End recording]

FÓRSA

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