Health and social care workers' **quality of working life and coping** while working during the COVID-19 pandemic November 2020 - January 2021

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Findings from a UK Survey

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Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic: Findings from a UK Survey

Phase 2: 17th November 2020 – 1st February 2021

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FOREWORD

This research was inspired by the research interests of the research team, who have engaged in several research projects together over recent years. Interests from this group centre on workforce wellbeing, resilience and burnout research. This area of research interest can be viewed as workforce epidemiology, with a focus on health and wellbeing at work.

The COVID-19 pandemic has tested the resilience of the health and social care workforce, like no other time known to those of us from the Baby Boomer generation upwards. We know that prior to this pandemic, the health and social care workforce were already stretched and working under pressures evolving from 'business as usual' periods. The results of this, the second of three phases of this study, (November – January 2021) provides evidence of increasing pressures and simultaneous decline in workforce wellbeing since the first survey period (May - July 2020). Whilst this is not surprising, and is already known anecdotally, we provide some detail in the analysis about what factors contributed to increased or decreased wellbeing, work-related quality of life, and burnout during this period (November – January 2021).

The qualitative responses to questions about experiences of working during the pandemic provided a rich context that helped with the interpretation of results from the quantitative findings, so the research team could discuss the main messages, recurring themes and any outlier findings from the data. From these results we have confirmed that the over-arching themes of Changing Conditions, Connections and Communication remain relevant.

In order to share the headlines from the results, we have provided an overview of the qualitative results and integrated, where relevant, some of the quantitative findings and Focus Group data (with managers and frontline workers) to illustrate specific findings. Not all the quantitative results are in the main section of the report, but all results can be found in the appendices. This is due to the extensive reporting we have done.

We have provided an appendix, with both 'weighted' and 'unweighted' quantitative results. The 'weighted' results have been analysed to allow for distributions according to country and professional group and enable statistical comparisons to be made. The raw (unweighted) data is also provided for completeness.

At the time of writing, the latest UK COVID-19 pandemic surge appears to be in decline. Reports on reducing hospital admissions, reduction to Intensive Care Units (ICUs), reduction in deaths, decline in positive cases, and increases in vaccination roll-out coupled with a prolonged lock-down, show some promise. However, no-one can predict how the virus will mutate and provide new challenges. Notwithstanding, unknown spikes or future surges, the current narrative is now about recovery, rebuilding and resetting the workforce. We hope our research has assisted in those efforts and our Good Practice Recommendations will contribute to guidance that is based on the workforce 'voice', as provided from this research effort.

We thank those that participated in this study during the most challenging and difficult period we ever imagined. We are grateful to you for the time you have given, and we promise to ensure your voice is heard as we disseminate these results.

Dr Paula McFadden

Principle Investigator

The research team would like to thank all participants who contributed to this research.

INDEX

1. Background

One of the top causes of death globally is lower respiratory infections with new diseases continuing to emerge (Bradley & Bryan, 2019; Koh, Hegney, & Drury, 2011). Indeed, the first 20 years of this century has seen newly recognised coronaviruses appear, spreading quickly across the world (Bradley & Bryan, 2019). These include the severe acute respiratory syndrome virus (SARS) and the Middle Eastern respiratory syndrome virus (MERS). In 2009, a novel H1N1 pandemic influenza strain caused considerable morbidity and mortality around the world and continues to occur on a seasonal basis. In December 2019, a novel coronavirus emerged in China (COVID-19), and within a matter of weeks was designated a pandemic with all countries urged to take 'urgent and aggressive action' (WHO, 2020). Globally, this pandemic has led to great social and economic disruption for governments and their citizens with a rising death toll and attempts to prepare, protect and treat citizens impacting across all sectors in society. While it has been made clear that trying to fight this pandemic is everybody's business (WHO, 2020), the main burden of caring and treating often falls to an understaffed and underfunded health and social care sector and those who work in it.

Prior to the outbreak of this pandemic, it had been recognised that Brexit was adding to the many skills shortages in the health and social care sector in the UK. In addition, increasing numbers of people with complex disabilities and an ageing population with co-morbidities have seen the National Health Service (NHS) under increasing strain (ONS, 2017). Even before the pandemic became apparent, thought had already been given to how health and social care sector employers could encourage not only their older, but also their younger staff to stay healthy and to reduce the risk of health problems, or to recover from or cope with problems once they have occurred (McFadden et al., 2020; Manthorpe & Moriarty, 2009; Ryan et al., 2017).

Previous studies undertaken with health care staff during a SARS and Middle East respiratory syndrome coronavirus (MERS-CoV) highlight their stress and coping strategies. While staff nurses admitted worrying about infecting their families and colleagues, they were able to cope due to a number of strategies including deriving support from colleagues, recognition by employers of their efforts and receiving infection control guidance and equipment (Lee et al., 2005; Khalid et al., 2015). Chen (2020) also found in interviews with medical staff from a hospital in China that staff were reluctant to engage with psychological support and were more concerned about how to deal with patients' anxieties, staff's need for uninterrupted sleep, and having sufficient personal protective equipment.

Despite our experience of pandemics, there is limited reporting in the literature about how health and social care workers cope with meeting the challenges of caring for patients/service users, in both hospital and community settings, while potentially putting their own health at risk. This report builds upon the findings from Phase 1 of the *'Health and social care workers' quality of working life and coping while working during a COVID-19 Pandemic'* study, which ran between May – July 2020. The report from Phase 1 contains a series of good practice recommendations based on learning from the COVID-19 Pandemic (McFadden et al., 2020, 2021), with most recent publications and conference presentations available on the Study website: https://www.hscworkforcestudy.co.uk/

1.1 Aim

This study builds upon the findings from the Phase 1 survey (data collected between May – July 2020) to further explore the impact of providing health and social care during the COVID-19 pandemic in UK. The study focuses specifically on the experiences of nurses, midwives, allied health professionals (AHPs), social care workers and social workers.

1.2 Objectives

1. To gather demographic and work-related information from a cross-sectional convenience sample of nurses, midwives, AHPs, social care workers and social workers in the UK
2. To examine the perspectives of nurses, midwives, AHPs, social care workers and social workers on the challenges they are facing while providing health and social care during the COVID-19 pandemic, including their perspectives on employers' supports and potential ways to improve these
3. To assess wellbeing, quality of working life and levels of burnout in this population
4. To find out what coping strategies are used by this population to deal with work-related stressors and the effect of these on respondents' wellbeing, quality of working life and levels of burnout.

2. Methodology

2.1 Primary Research Instrument

The data for the current report was collected using an online survey questionnaire, which was adapted from the questionnaire used in the Phase 1 of the Health and Social Care Workforce Study. The majority of the questions remained the same, but some were amended, others were removed and some new ones were added to gain more insights into the effects of COVID-19 on the workforce and to reflect the rapidly changing COVID-19 situation in the UK. The questionnaire was predominantly quantitative, but contained three open-ended qualitative questions. The main parts of the questionnaire were as follows:

- ***Demographic and work-related information***: age, sex, country of work, occupational group, ethnicity, disability status, relationship status, caring responsibilities, job tenure, hours of work, working overtime, considering changing one's occupation and/or employer, the effects of the pandemic on one's place of work
- ***Mental wellbeing***: Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS; NHS Health Scotland, 2008)
- ***Quality of working life***: Work-Related Quality of Life scale (WRQOL; Easton & van Laar, 2018)
- ***Burnout***: Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen, & Christensen, 2005)
- ***Coping with COVID-19-related occupational demands***: 20 items from Brief COPE (Carver, 1997)
- ***Coping with work-related stressors***: 15 items from Clark, Michel, Early and Baltes (2014)
- ***Open-ended questions:*** three questions related to 1) the impact of COVID-19 on respondents' place of work; 2) employer supports during the pandemic; and 3) anything else respondents would like to share.

2.1.1 Mental Wellbeing

Mental wellbeing was assessed using the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS; NHS Health Scotland, 2008). It contains seven items which ask respondents to indicate how often over the last two weeks they had feelings or thoughts described in the items (e.g., I've been feeling useful). The items are rated using a five-point Likert scale ranging from 1 = 'None of the time' to 5 = 'All of the time'. The item scores are summed to provide an overall wellbeing score, which can range from 7 to 35. Higher scores indicate better mental wellbeing. We used cut-off points shown in Table 2.1 to categorise respondents into those who were *probable* or *possible* cases of depression or anxiety (Warwick Medical School, 2021):

Table 2.1: Cut-off points for SWEMWBS scores

Case of anxiety/depression	SWEMWBS scores
Probable (Likely)	7-17
Possible	18-20

2.1.2 Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life scale (WRQOL; Easton & van Laar, 2018), which consists of 24 items. These assess six different domains of working life: Job career satisfaction (six items), Stress at work (two items), General wellbeing (six items), Home-work interface (three items), Control at work (three items), and Working conditions (three items). The last item measures overall wellbeing and does not contribute to the domain scores. Respondents used a five-point Likert scale ranging from 1 = 'Strongly disagree' to 5 = 'Strongly agree' to indicate their agreement or disagreement with the work-related statements (e.g., I have a clear set of goals and aims to enable me to do my job). The overall quality of working life score is calculated by summing the 23 items. Total scores can range from 23 to 115 and higher scores indicate better quality of working life. Domain scores are calculated by summing the scores for the items belonging to each domain. The Stress at Work items are reverse scored, so higher stress at work is presented by lower scores for this domain only. The overall and domain scores can be categorised into Lower, Average, and Higher quality of working life using the cut-off points shown in Table 2.2, which were developed from health service norms (Easton & van Laar, 2018):

Table 2.2: Cut-off points for WRQOL scores

Level of quality of working life	WRQOL domain						Overall WRQOL score
	Job career satisfaction	Stress at work	General wellbeing	Home-work interface	Control at work	Working conditions	
Lower	6-19	2-4	6-20	3-9	3-8	3-9	23-71
Average	20-22	5	21-23	10-11	9-10	10-11	72-82
Higher	23-30	6-10	24-30	12-15	11-15	12-15	83-115

2.1.3 Burnout

Burnout was assessed using the Copenhagen Burnout Inventory (CBI; Kristensen et al., 2005), which is a 19-item measure of three different areas of burnout: personal (six items), work-related (seven items) and client-related (six items). The items (e.g., Does your work frustrate you?) are rated on a five-point Likert scale (wording differs across items) scored from 0 to 100. For each area of burnout, a mean score (ranging from 0 to 100) is calculated. Higher scores indicate greater burnout. The three areas of burnout are defined as follows:

- Personal burnout: *"state of prolonged physical and psychological exhaustion"*
- Work-related burnout: *"state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work"*
- Client-related burnout: *"state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients"*

In the current report, we categorised the burnout scores in each burnout area into Low, Moderate, High, and Severe burnout using the cut-off scores (see Table 2.3) frequently cited in the literature (e.g., Creedy, Sidebotham, Gamble, Pallant, & Fenwick, 2017).

Table 2.3: Cut-off points for Burnout scores

Level of burnout	Burnout cut-off scores
Low	0-49
Moderate	50-74
High	75-99
Severe	100

2.1.4 Coping with COVID-19 Related Occupational Demands

Coping with COVID-19 related occupational demands was assessed using 20 items selected from the 28-item BRIEF Cope scale (Carver, 1997). These items assessed ten coping strategies, including Active coping, Planning, Positive reframing, Acceptance, Emotional support, Instrumental support, Venting, Substance use, Behavioural disengagement, and Self-blame. Each coping strategy is assessed with two items, which are summed to give a total score. Respondents were asked to indicate how often they have been using the strategies described in the items using a four-point Likert scale ranging from 1 = 'I haven't been doing this at all' to 4 = 'I've been doing this a lot'. Scores for each coping strategy can range from 2 to 8 and higher scores indicate that respondents use the specific coping strategy more often.

2.1.5 Coping with Work-Related Stressors

Coping with work-related stressors was also assessed using 15 items from the 81-item scale assessing work and family stressor coping strategies, developed by Clark et al. (2014). The 15 items assessed five specific coping strategies (three items per strategy), including Family-work segmentation, Work-family segmentation, Working to improve skills/efficiency, Recreation and relaxation, and Exercise. Respondents were asked to use a six-point Likert scale ranging from 1 = 'Never have done this' to 6 = 'Almost always do this' to indicate how often they have been doing what is described by the items to cope with work stressors. The scores for each item are averaged and can range from 1 to 6. Higher scores indicate that respondents use the specific coping strategy more often.

2.1.6 Open-Ended Questions

The three open-ended questions asked of respondents were:

1. What was the impact of COVID-19 on your specific place of work, so far, in relation to patient/service user numbers and service demand since July 2020?
2. Can you describe what employer supports have worked well during the COVID-19 pandemic and what could be improved?
3. Is there anything else you would like to share with us about working in health and social care during the COVID-19 pandemic?

2.2 Study Respondents: Sampling, Access and Recruitment

Respondents were nurses, midwives, AHPs, social care workers and social workers in the UK who were working in health and social care during the COVID-19 pandemic during the Phase 2 study period (November 2020 – January 2021). A wide variety of recruitment channels and methods was utilised in order to reach as many potential respondents as possible. These included Northern Ireland Social Care Council (NISCC), Social Care Wales, the five Northern Ireland Health and Social Care Trusts, Community Care ©, Nursing and Midwifery Council (NMC), the Health and Care Professions Council (HCPC),

Northern Ireland Practice and Education Council (NIPEC), Royal College of Midwives, Royal College of Nursing, AHP Federation and AHPs Professional Associations such as the Royal College of Occupational Therapists (RCOT), and College of Podiatry. Support was also provided by the Chief Nursing and AHP Officers from across the UK. These regulatory bodies, unions, associations and Chief professionals used a variety of methods to disseminate the study information, including newsletters, direct emails, or social media platforms. The study website was also used to raise awareness about the study among the health and social care staff.

The final sample was a convenience sample of those who chose to participate in the study following receipt of communication from the above-mentioned bodies, associations and individuals. Respondents completed the survey online by accessing a dedicated weblink or using a QR code. The survey was completely anonymous to encourage honest responses and was available in both English and Welsh.

2.2.1 Sample Profile

There was a total of 3499 respondents to the survey. Most of the responses came from Northern Ireland (n = 1189), followed by Wales (n = 1095), England (n = 756) and then Scotland (n = 459). Most of the sample were social care workers and social workers (see Figure 2.1).

Table 2.4 below shows that 59.3% of nurses were from Northern Ireland, 22.4% were from England, 13.9% from Wales and 4.4% from Scotland. Seventy-five midwives responded to the survey. The majority of these (85.3%) were from Northern Ireland, 6.7% were from England and Scotland each and only 1.3% were from Wales. The majority of AHPs were again from Northern Ireland (48.7%), followed by Wales (29.2%), England (17.9%) and the smallest number were from Scotland (4.2%). A total of 41.3% of social care workers were from Wales, 27.1% were from Scotland, 21.0% from Northern Ireland and the remaining 10.6% were from England. The largest proportion of social workers in the sample were from England (36.1%), followed by Wales (29.1%), Northern Ireland (28.8%) and Scotland (6.1%).

Figure 2.1: Occupation of Respondents (Unweighted)

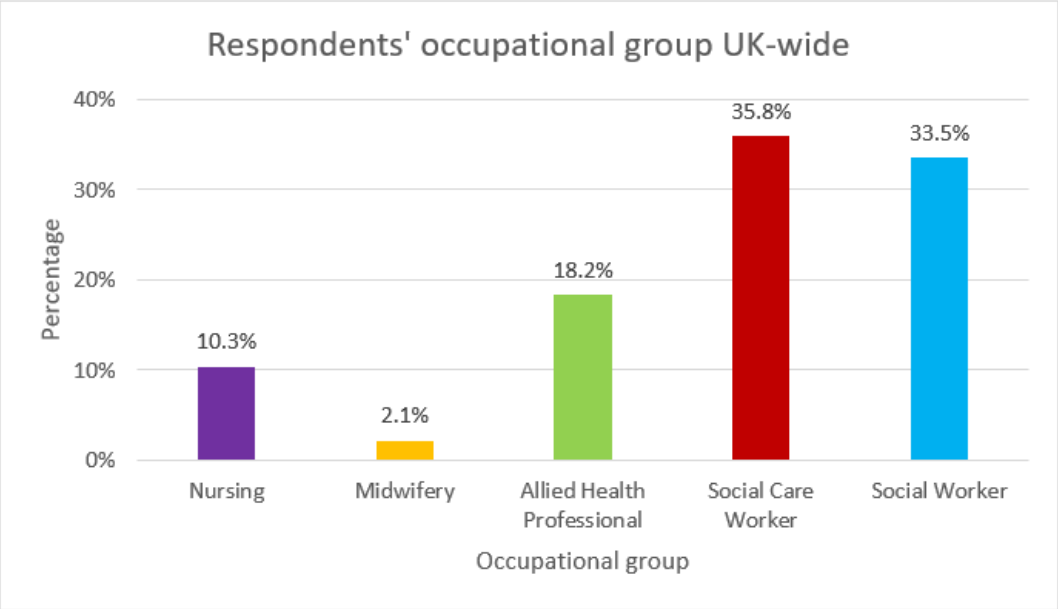


Table 2.4: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	81 (22.4%)	16 (4.4%)	50 (13.9%)	214 (59.3%)	**361 (100%)**
Midwifery	5 (6.7%)	5 (6.7%)	1 (1.3%)	64 (85.3%)	**75 (100%)**
AHP	114 (17.9%)	27 (4.2%)	186 (29.2%)	311 (48.7%)	**638 (100%)**
Social Care Worker	133 (10.6%)	340 (27.1%)	517 (41.3%)	263 (21.0%)	**1253 (100%)**
Social Worker	423 (36.1%)	71 (6.1%)	341 (29.1%)	337 (28.8%)	**1172 (100%)**

Most respondents were female (88.8% UK-wide) with a similar sex distribution across countries. All midwives in the sample were female and AHPs had the highest proportion of males (15.1% within AHPs). Respondents were primarily from the 30-59 age group (73.2% UK-wide), with only a small proportion from the 16-19 and the 66+ age groups. Scotland had the highest proportion of respondents from the 50-59 age group (40.9% within Scotland). The vast majority of respondents were of white ethnic origin (92.1% UK-wide). England had the highest proportion of respondents who identified as not white (11% within England) and social work was the most diverse occupational group, with 12.4% of social workers identifying as not white. England had the highest proportion of respondents with a disability (12.9% within England) and social care workers were the most likely ones to report having a disability (14.6% within social care work). The vast majority of respondents UK-wide were married (47.2%) or cohabiting (20.7%). UK-wide, 46.8% of respondents considered themselves to be a carer outside of work and 47.8% did not. Northern Ireland had the highest proportion of respondents who were carers outside of work (59.7% within Northern Ireland).

Almost half of all the respondents worked in the community (47.5% UK-wide), but 21.4% (UK-wide) worked in a hospital. Most worked in the statutory health and social care sector (70.2% UK-wide), but almost a half of social care workers (52.1% of social care workers) worked in other sectors. For respondents working in the NHS/HSC Trust, the most frequently reported pay scale was Band 6 (36% UK-wide), followed by Band 7 (22.5% UK-wide) and Band 5 (18.9% UK-wide). Social care workers were more likely to be paid at the lower end of the pay scale, with Band 2 being the most frequently reported category (23.2% of social care workers working in the NHS/HSC Trust).

UK-wide, 13.9% of respondents had been redeployed due to COVID-19, but 62.6% of these felt unprepared for their new role. Only 0.9% of respondents UK-wide came out of retirement to support the workforce during the pandemic and these were either nurses or social workers.

Most respondents were employed on a permanent basis (89.8% UK-wide) and the majority were employed full-time (71.0% UK-wide), typically working 37.5 hours per week (62.8% UK-wide). Scotland had the highest proportion of respondents employed on a part-time basis (37.1% within Scotland). A total of 45.0% of respondents UK-wide typically do not work overtime, but since the start of the pandemic, 35.0% UK-wide did not do any overtime. Overall, respondents have been working significantly more hours of overtime since the start of the pandemic compared to before. Only half of the respondents (50.8% UK-wide) have taken one or more sick days in the previous 12 months and 41.1% (UK-wide) of these said that at least some of their sickness absence was related to COVID-19. When sick, most respondents (65% UK-wide) reported getting pay from their employer in addition to statutory sick pay. Nurses were the most likely to report not getting sick pay when off sick (15.1% of nurses).

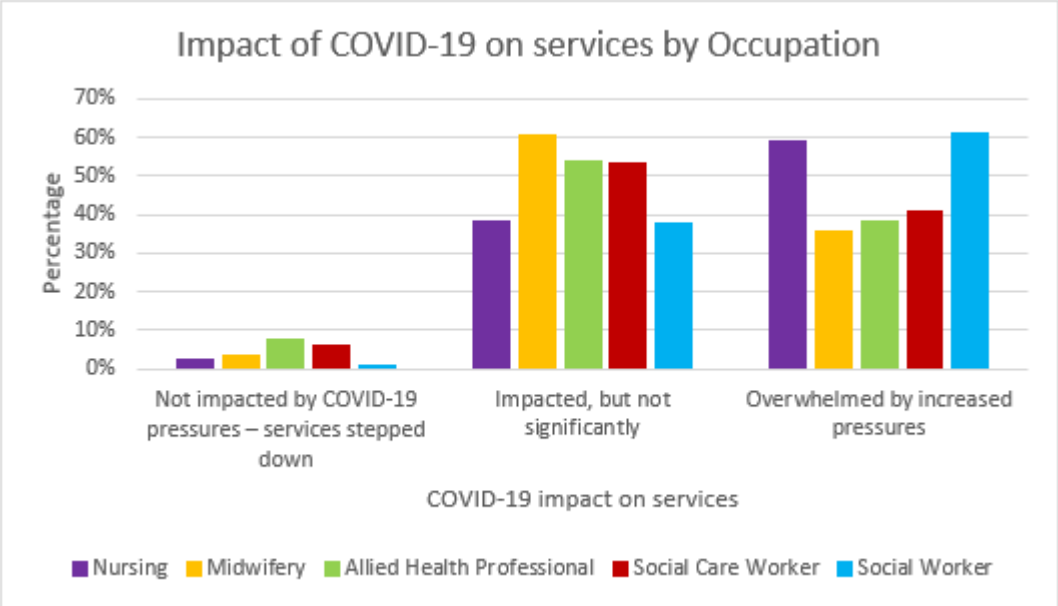
A large proportion of respondents UK-wide had either 11-20 years of work experience (26.8%) or more than 30 years (23.5%). Scotland had the highest proportion of those with 11-20 years of experience (37.5% within Scotland) and those with more than 30 years of experience were primarily nurses (48.8% of nurses) and midwives (21.1% of midwives). The main area of practice for most respondents were

adults (36.7% UK-wide) and older people (21.9% UK-wide), but in Scotland, the most commonly reported areas were older people (36.9% within Scotland) and learning disability (18.3% within Scotland) services. Of those who were carers, most respondents cared for their children (56.5% UK-wide) or parents (36.8% UK-wide) and 65.2% (UK-wide) reported that their caring responsibilities had changed during the COVID-19 pandemic.

Respondents were also asked about the impact of COVID-19 on their work. UK-wide, only 4.6% reported that their service had not been impacted (services stepped down due to COVID-19) with 49.3% reporting feeling overwhelmed by increased pressures. As shown in Figure 2.2, social work and nursing were the most impacted occupational groups (61.3% of social workers and 59.2% of nurses). That said, significant percentages expressed feeling overwhelmed in all occupational groups.

Respondents were also asked whether they had considered changing their employer or occupation since the start of the pandemic. Over a half of the respondents UK-wide (53.8%) had not considered changing their employer, with the highest proportion of these being from Wales (70.8% within Wales). Similarly, over a half of the respondents UK-wide (56.4%) had not considered changing their occupation and again, Wales had the highest proportion of these (64.1% within Wales).

Figure 2.2: Impact of COVID-19 on Services by Occupation (Weighted)



2.3 Focus Groups

Two focus groups were conducted to gain deeper insights into the health and social care workers' experiences; one with managers (December 2020) and one with frontline workers (January 2021). Participants were recruited through the first and second online surveys, where respondents were asked to contact the research team if they wished to participate in further research. Word of mouth and social media were also used to recruit participants. There were three participants in the managers' focus group and six participants in the frontline workers' focus group. Table 2.5 below shows the country and occupational group of participants.

Table 2.5: Focus Group Participants

Focus group	Country	Occupational group
Managers	Northern Ireland	Social care
	Northern Ireland	Social work
	Northern Ireland	Nursing
Frontline workers	England	AHP
	England	AHP
	England	AHP
	England	Social worker
	Northern Ireland	Social care worker
	Northern Ireland	Social worker/Mental health practitioner

2.4 Data Analysis

The survey data was analysed using SPSS 26 ©. Presented are primarily descriptive statistics, specifically frequencies, percentages, mean values of the measured constructs, and some correlations. Sub-groups were compared using analyses of variance (ANOVA), independent samples t-tests and chi-square tests. Multiple regression analyses were used to examine the association between coping strategies and mental wellbeing, quality of working life and burnout, and also to compare findings from Phase 1 and Phase 2 of the study.

Analyses were conducted both with raw and weighted data. The data was weighted using respondents' country of work and occupational group. The main findings (weighted) are presented in Section 3. Appendices provide more detailed results, including the unweighted findings.

The analyses were conducted with all available data. Some participants had missing data and therefore the sample total for the different analyses differs throughout this report.

Qualitative questions from the survey were analysed using thematic analysis. Initial coding was based on respondents' identification of groups, according to those who were 'overwhelmed', 'impacted but not significantly' and 'not impacted at all'. The qualitative research team read responses to identify recurring themes and outliers across professional groups, and countries.

Thematic analysis was also used to analyse data from the focus groups. The results of these are presented together with the survey findings in the main part of this report, with further insights provided in Appendix 10.

2.5 Ethical Considerations

Data collection took place during an exceptionally busy period for health and social care staff, when numbers of new COVID-19 cases, deaths and hospital admissions were rising in the UK. The research team was aware of this, but felt it was important to conduct this research at this time to gain a better understanding of staff's wellbeing, quality of working life and burnout rates in order to formulate recommendations for supporting the workforce during busy times such as these ones. The completion of the survey was voluntary, however, respondents were provided with contact details for support organisations in case they became distressed whilst completing the survey. All permissions for the use of the measurement scales were obtained prior to the study commencing.

3. Findings: Changing Conditions, Connections, Communication

Responses to the open-ended questions were examined using a thematic analysis approach. Members of the research team familiarised themselves with the data, generated initial codes, agreed and reviewed common themes, and then collated and presented the data as outlined below. Also included in this analysis were data from two focus groups that were conducted with managers and frontline workers in December and January respectively.

The overarching themes that emerged in Phase 2 (November 2020 – January 2021) are the same themes identified in Phase 1 (April – July 2020) of the study: **Changing Conditions, Connections, and Communication (the three Cs).** Responses to the open-ended questions generated useful insights into the respondents' emotions and experiences when working through Phase 2 of the survey period, with evidence of commonalities and differences emerging across countries and disciplines. Furthermore, by continuing to adopt the analytical framework of the three Cs, a comparison of Phase 1 and Phase 2 responses also demonstrates how the workforce's general perceptions relating to changing conditions, connections and communications remained unchanged or altered as the pandemic progressed.

3.1 CHANGING CONDITIONS

Service provision continued to be widely disrupted in Phase 2, causing continued implications for the working conditions of the health and social care workforce. Respondents reported a range of concerns relating to the accessibility and availability of both COVID and non-COVID-related services and the implications this had for the wellbeing of service users and patients. Respondents also described how changes in service provision and service demand affected their working conditions throughout the pandemic. Respondents raised a number of concerns relating to changes in **workload, work roles, and working safely** but some positive developments were also noted, particularly by those in occupations that benefited from greater flexibility by **working from home**.

3.1.1 Changes to Service Provision and Service Demand

Concerns about the current and future state of service provision and service demands were a common thread across all occupations and countries. Respondents expressed concerns about how the needs of service users and patients were being met during the pandemic. Several nurses and AHPs described how patients have been negatively impacted by delayed diagnoses and treatment of non-COVID related conditions. This was explained by the reluctance of some service users/patients to attend hospital but also by the increased pressure on community services staff to prevent hospital admissions. One Community AHP commented:

> *"We have been working hard to try prevent hospital admissions. We have found we have less COVID-19 patients but we are seeing the indirect results of COVID-19 on our patients - those that have not had timely diagnosis or treatment for conditions, and now some of their conditions are so advanced that they are entering palliative stages of care". (AHP, Community, Northern Ireland)*

Many respondents gave specific examples of how the changes in service provision affected the health and wellbeing of their service users and families. An AHP from Wales explained *"Some learning disability clients have significantly deteriorated in terms of their posture, functional abilities, mental*

health and well being" (AHP, Community, Wales). Social workers reported on their concerns for families when respite care was halted:

> *"lack of respite opportunities since March 2020, particularly overnight has meant individuals and families have found it harder to cope" (Social Worker, Community, England)*

while others also outlined concerns about how the experience of the pandemic was impacting on demand for mental health services. A community nurse from NI reported concerns about increasing instances of *"suicidal ideation"* among patients and "*a number of people relapsing, triggered by the stress associated to COVID" (Nursing, Community, Northern Ireland).*

Many respondents further commented about their concerns relating to staff shortages and the impact on service users. For example, a nurse from NI described the outcomes of her ward being understaffed and with limited staff training for treating COVID patients:

> *"My workplace was turned into a COVID ward, we had limited training and were under increased pressures due to this. The ward is constantly short staffed, patients suffer due to this. We are unable to provide 1-2-1 for those who need it, so there has been an increase in falls". (Nursing, Hospital, Northern Ireland)*

Responses revealed additional pressures in Phase 2 that seemed less overt in Phase 1. Not only were respondents continuing to meet the demands for COVID-related care, but many were reengaging services that were either halted or curtailed in Phase 1. This part of the workforce was therefore playing 'catch up' to address waiting lists and meet increasing demand. In many cases they were doing so under increasingly stretched resources, as one AHP from Northern Ireland described:

> *"Increased patient numbers quickly to pre-COVID levels by end October/November and simultaneously running overtime clinics to reduce waiting times, with staff sickness and long term sickness reducing staff numbers. Demand on service high with increased numbers of patients attending for appointments compared to normal expected levels - clinics booked on basis of SMART clinics which overbook based on expected numbers, currently more clients attending than ever came before". (AHP, Hospital, Northern Ireland)*

Inevitability, respondents who faced increasing demands for services experienced increased stress and work intensification. An AHP from Wales explained how "*Community health teams have an overwhelming wait list which has impacted the workload of Social Services. All team members are working to capacity and are feeling pressured" (AHP, Community, Wales).*

An AHP from NI described additional pressures experienced in Phase 2 as families and patients seemed more willing to express dissatisfaction about the provision of services and staff felt unsupported by authorities in addressing these concerns, leading to further feelings of stress:

> *"families are becoming less understanding of not receiving support and this is resulting in more complaints and families taking concerns to MLAs* [elected representatives] *who increase stress on NHS staff by asking why services are not in place. Very little support for NHS staff and community services from local government, we are the ignored services". (AHP, Community, Northern Ireland)*

The pressures experienced in phase 2 seemed to be further exasperated by the lack of time to reflect and learn from the first wave of the virus. The demands to resume normal services were perceived by some to detract from the opportunity to fully consolidate any learning from the first phase. And although there was a brief period for reflection, recovery and reset, it was not deemed sufficient. A

participant from the managers' focus group explained how their service simply repeated some of the practices in the second wave they should have learned from after the first wave:

> *"if you worked in one of the Trusts, you were straight back in and then once your reset plan was in place, so once we got that bit of lull, … into June, you know, straight back in and then the normal business the next day. And it was A, B, C, D, and E and you know, it was like, did that just happen? … there was a bit of learning, we looked at what we could have learned, but within health organisations, there just wasn't that time I feel. And then before we know it, we're in September ... community services have worse than ... in the first surge, em, so we're back to ... doing all them things we stopped again, that we thought we learned to manage the first time. And you know, we still have Christmas to go and after Christmas, so we didn't really get time to reset and reflect and all that, all those things that we should have done really". (Managers' Focus Group)*

3.1.2 Workload

Some services were redesigned to work within COVID-19 restrictions and were also altered to respond to changes in service demands. While this was necessary for service provision, many respondents reported its impact on workload and thereafter on staff health and wellbeing. An AHP from Northern Ireland stated: *"Our service has been redesigned to be delivered virtually. Since this change our capacity has been increased & our daily target is higher & workload has significantly increased. There is no consideration given to additional demands of screen time & comfort breaks" (AHP, Hospital/Community, Northern Ireland).*

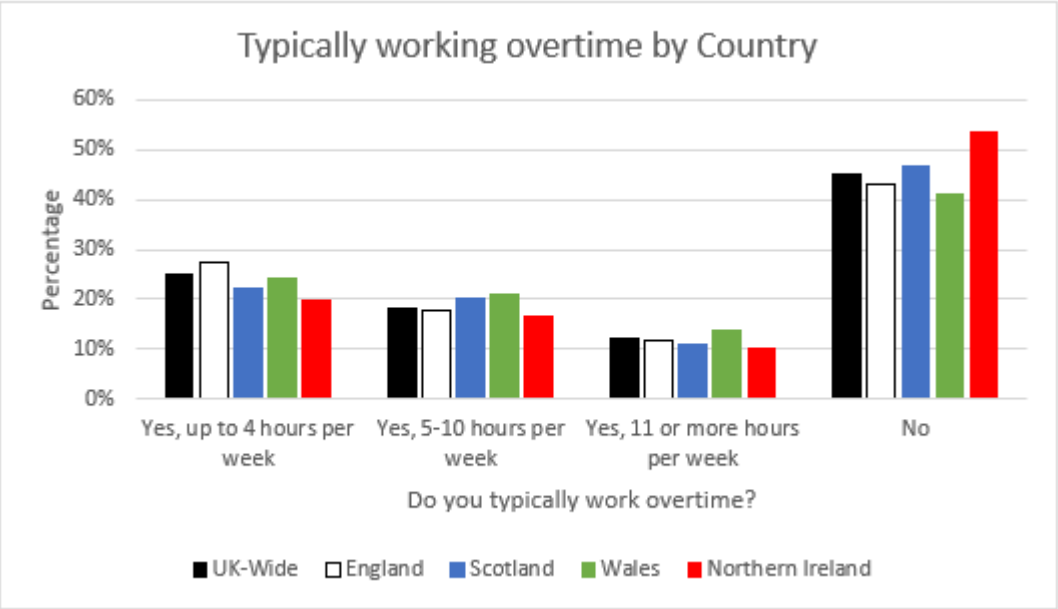
A social worker from Wales also highlighted how the pressure from adapting to workplace changes alongside having to balance other 'life' changes led to poor health and wellbeing outcomes for many staff. Respondents linked this to a vicious cycle of workforce absence increasing pressure on existing staff, which inevitably caused morale and wellbeing amongst colleagues to decline.

Work intensification during the pandemic often manifested in some health and social care staff having to work increasing hours of overtime just to cope with service demand:

> *"Contract is 36 hours per week. Have worked 50 - 70 hours per week since March 2020. Demands on the service are very high. Impact of staff shielding and staff self-isolating has been overwhelming at times". (Social Care Worker, Community, Scotland)*

Figure 3.1 below presents the overtime levels reported across countries. A total of 45.0% of respondents UK-wide typically do not work overtime, but since the start of the pandemic, 35.0% UK-wide did not do any overtime. Overall, respondents have been working significantly more hours of overtime since the start of the pandemic compared to before.

Figure 3.1: Typically Working Overtime by Country (Weighted)



In addition, many respondents expressed frustrations at what were perceived to be their manager's/employer's unrealistic expectations during the pandemic. For example, a social worker from Wales commented on what was perceived to be contradictory messages from employers, where on one hand it was recognised that staff were experiencing heightened pressure and were recognised for their hard work, but on the other hand managers *"continue to pile the work without understanding the impact of this on myself and others" (Social Worker, Community, Wales).* Another respondent described the futility of employers offering additional supports when *"every support offered comes after a request to do more" (Social Worker, Community, Northern Ireland).*

Respondents also reported the pressure of ongoing change and unpredictability:

> *"Uncertainty and constant change is really hard to deal with, can be frustrating and stressful keeping up with this". (Nursing, Hospice, England)*

Many responses revealed the toll the additional workload was having on workers and efforts to keep on top of the work exasperated the impact on health and wellbeing. For example, even though taking annual leave was deemed important for workers' wellbeing, many felt it was 'difficult' to do this considering the increased workload waiting for them on their return. A social worker from England adopted the metaphor of juggling balls to describe the situation:

> *"It's a bit like juggling with several balls and people keep throwing additional ones in to the mix. It can be hard to keep track of each and every ball especially when they keep changing direction and speed and at times it would be great if you could just press a suspended animation button just for a moment. But you know if you do, e.g. take a couple of days leave, when you get back the majority of your balls won't be where you left them and it will take such a long time to get them all in the right place again, taking time off feels like a punishment almost, so it easier not too". (Social Worker, England)*

There were also several respondents who reported frustrations about having to undertake tasks that they deemed unnecessary and which only added to the pressure they were experiencing. For example,

a social worker from Wales queried the necessity of auditing case files, whilst another queried why appraisals were continuing during high periods of demand:

> *"My employer has also started auditing case files in the middle of a pandemic and has started to threaten performance management procedures if staff are behind in their work". (Social Worker, Community, Wales)*
>
> *"It has really perplexed me how in the middle of a pandemic managers are fixated on ensuring processes are followed i.e. Appraisals, seriously". (Social Worker, Community, Northern Ireland)*

Other respondents expressed their frustrations with the 'pushing' of budget tasks, or other corporate requirements. Administration pressures, such as monitoring and dealing with commissioners, were also viewed as excessive by some, especially when facing increased caseloads. Furthermore, a constant barrage of emails about COVID and other generic subjects was described as a *"pain in the neck" (Social Worker, Hospital/Community, England).*

However, in contrast to experiences of increased service demands and increased workloads, a few respondents noted a downturn in demand when their wards were cleared for an 'influx' of COVID-19 patients who then did not materialise:

> *"The threat of COVID-19 meant that few people came into hospital for treatment, which meant my work load has been minimal since half way through March, when we cleared the hospitals on the expectation that there would be an influx of sick patients. There wasn't, we sat around eating pizzas. Since July the hospital has been quiet due to people fearing for their lives, not attending hospitals for treatment and many outpatient services cancelled. Patient contacts were minimal again throughout October and November as this time we didn't clear the wards like in the Spring, so all the sick patients caught COVID-19, which meant they shut the wards which in turn meant no one could be admitted to onto the wards = less work load". (AHP, Hospital, Wales)*

3.1.3 Work Roles

Many respondents described how their roles had changed, whether through direct redeployment to other services, or because teams and individuals took on new COVID-related responsibilities:

> *"My usual role now only has about 5% of my time. I now work on the COVID-19 response team advising and supporting care homes, schools, local authority and local businesses". (Nursing, Public Health, England)*

The stress of adapting to new roles or accepting additional responsibilities was highlighted again across the professions with reports of increased pressure and exhaustion. This seemed to be further compounded by a perceived loss of control over decisions relating to their roles. For example, a social care worker from Scotland reported that *"one minute they had red and green teams for people willing to go to COVID service users which was fine but now they state we all have to go now" (Social Care Worker, Community, Scotland).*

Others expressed how their concerns and fears about redeployment were being overlooked by employers, leaving little choice but to take annual leave:

> *"I feel like my Local Authority do not listen to staff who are scared and concerned about their work roles. There are very few alternatives in place for people to re-deploy to a*

position where they feel safe, instead people are told to take annual leave". (Social Worker, Community, England)

Some respondents had a number of redeployment positions with varying support and lack of consideration about where they were already familiar with. Indeed, respondents felt that their managers purposefully placed them in new areas instead of places with which they were more familiar leading to increased stress:

"During my redeployment my own manager & the first 2 places I was sent were supportive but on my 3rd , 4th , 5th & 6th places there was little to no support from line manager and above despite my verbal mention of being stressed, unsettled and feeling overwhelmed by new areas of work where I had never been before and where the work was new to me. Much more support or sending me to a place of work I was familiar with which could have been done but I was actively blocked from this". (Nursing, Hospital, Northern Ireland)

"It's the first time I've truly felt like just a number within the Trust. The way I had been treated during redeployment has left me very jaded with management approach. Minimal planning and zero consideration was given to my personal needs and circumstances. Wasn't sure where I'd be one day to the next and could be moved at any time during a shift. Current staff issues in the areas I had been redeployed. I ignore requests from management to help support those areas and feel no sense of camaraderie". (Nursing, Hospital, Northern Ireland)

Also coming through in Phase 2 were concerns from some AHPs in Northern Ireland about when they could return to their normal jobs. They expressed anxiety about the back-log of cases that would be waiting for them when they eventually return. One respondent explained how they were still in redeployment after 10 months and wanted to know when they would be able to return, while another respondent explained:

"Being moved in to a new role and being unable to get back to my own job has been very difficult after such a long time - the new role is very busy with over-time every week since March and not being able to get much annual leave. My old job is backing up until I get back and it will take a long time to get through the back - log". (AHP, Hospital/Community, Northern Ireland)

3.1.4 Working Safely

A majority of respondents indicated satisfaction with how employers adapted working conditions and practices and offered training to protect workers from the virus. However, despite these measures, the data revealed that many workers remained fearful about the risk they were still exposed to, and were at times quite dissatisfied with how employers responded to their concerns:

"We had to move offices and now we are working in an unsuitable office where the chairs are 27 inches apart". (Social Worker, Hospital, Wales)

"I have not felt looked after. I have lost my desk space. Hot desking is difficult when the equipment is not set up for me. I have felt exposed". (Nursing, Community, England)

However, most concerns about safe working conditions emanated from the social care workforce and those working in the community and care homes. This group of workers felt the risk they faced was not appreciated by employers and therefore had to tolerate what they perceived to be insufficient protective measures:

"The reality is that the community-based teams are at an equally high risk of coming into contact with COVID 19 but very few of our roles are considered 'high risk', meaning insufficient PPE, lack of training, and - from the looks of things - bottom of the priority list for the vaccines. As an example - we are supposed to go into and deliver services in a variety of environment, including private homes and care homes". (AHP, Community, Northern Ireland)

"PPE introduced in April 2020 but inadequate supply & quality. E.g. masks. No provided visors, have to get our own. Aprons thin, rip easily. Glove supply ok but if run out have to wear bigger size than your hands". (Nursing, Care Home, Scotland)

A community social care worker also commented that:

"Home care staff have been left to get on with it. We've not been able to socially distance. We have to go into people's houses when everyone else is told not to. We're not working in clean or sanitised houses. A lot of staff are off sick with COVID-19". (Social Care Worker, Community, Scotland)

Furthermore, even when there is now access to 'endless PPE', some social care workers expected additional measures be taken to protect them from the virus. For example, a social care worker from Scotland expressed their anxiety over information regarding COVID-19 positive service users:

"I am anxious at work as we are never told what service users are COVID positive! It's as if employers don't want us to know. If a colleague is positive and we are working with them prior we are told we don't need to isolate as we had on PPE!" (Social Care Worker, Community, Scotland)

The disgruntlement from social care workers about the safety of working conditions was further compounded by their perception that the risk they tolerated was unrecognised and undervalued by employers. Many responses reflected the sentiment expressed below:

"We feel underappreciated for what we do. We put ourselves at risk every shift and put our family at risk after every shift, for minimum wage and no appreciation. We are expected to just keep quiet and just get on with things". (Social Care Worker, Care Home, Northern Ireland)

3.1.5 Working from Home

The mandate or option to work from home, and the enhanced flexibility it offered, was received positively by most respondents who experienced this change to their work environment and working practice. This option seemed mostly available to social workers, although several social workers worked from the office and some continued to make home visits. Many respondents enjoyed working at home, saving time commuting, and not having to find a car parking place was welcomed by one respondent. Others suggested that working from home made it easy to attend meetings online which were also perceived to be more structured and efficient by some. And although there were some exceptions, many respondents reported their satisfaction with the provision of IT equipment, phones, desks, chairs and other essentials for working from home. However, despite the overall positive sentiments about these new working arrangements, several respondents reflected on what could be improved.

Respondents communicated the importance of being able to access managerial support whilst working online and in isolation. Several respondents suggested that clear guidance and direction were

needed to ensure they still felt supported by management. Respondents also mentioned that having structured meetings with teams and among peers was essential for sustaining adequate communication about service-related problems and changes. A few respondents commented on concerns about surveillance of their online engagement, suggesting that workers should be *"allowed to step away from the computer" (Social Worker, Community, Northern Ireland)*. It was also widely noted that when working from home, flexibility around working hours should be discussed, with respondents wishing for more acknowledgement of the difficulties *"when working 9am - 5pm from home with childcare issues to manage" (Social Worker, Community, Northern Ireland)* and what was considered *"poor flexibility with changing working patterns i.e. staying 9-5" (Nursing, Community, Northern Ireland).*

Furthermore, as Phase 2 progressed and the national COVID-19 restrictions increased again to the 'stay at home' message, several respondents who felt they could do their job from home expressed difficulties in reconciling the national message with their employers' mandate to remain working from the office. Respondents commented that:

> *"Working in the NHS I have struggled with the fact that my job role can predominantly be done from home. However despite Government guidance my employer has insisted in the team being office based. At a time when people are losing their jobs/homes/lives in an effort to 'stay at home... protect the NHS' I find this morally wrong that we are not adhering to the same rules and expectations". (Social Worker, Community, England)*

> *"I'm a little confused, given the 'work at home if you can' message by recent requests that we have more of a presence in the office. I'm not sure of the purpose of this". (Social Worker, Learning and Development, Northern Ireland)*

Some respondents also reported being negatively impacted when working from home. An AHP from Wales expressed concerns about the costs of working from home which seemed not to be acknowledged by employers, while others raised concerns about the impact on health and wellbeing from *"homemade workstations"*. Caution was also raised about balancing the home-life dynamic when working from home:

> *"My home is now my offices and while that does have its advantages I don't think it's healthy in the long term". (Social Worker, Community, Wales)*

The effects of poor practices when working from home were acutely felt by one respondent who stated that "*working from home has been a disaster, led to burn out and being on long term sick leave" (Social Worker, Community, Northern Ireland).*

3.1.6 Recognition and Feeling Acknowledged

Given the demanding changes to working conditions that many respondents experienced, it is not surprising that many questioned how they were valued by employers for their commitment and hard work throughout the pandemic. While some felt supported by their manager:

> *"Regularly checking on staff's welfare and stress level with lots of reassurance" (Nursing, Community, England),*

others were disgruntled about pay and rewards across all occupations (particularly in recognition of the risks they were exposed to). For some individuals, their responses also indicated strong grievances about the simple lack of acknowledgement for their efforts during the pandemic:

> *"Employers could praise staff more for their hard work and risking their lives coming into work, this is not done enough. Feel taken for granted a lot". (Social Care Worker, Care Home, Northern Ireland)*

Such feelings were more often expressed by social care workers and were compounded by practices that further affected their pay. For example, many respondents commented that their pay was withheld when they were off work awaiting COVID testing. Many public sector staff, such as local authority social workers, also expressed anger and disillusionment about the government's announcement of pay freeze "*after being through so much" (Social Worker, Hospital, England)*.

On the other hand, many respondents were extremely satisfied with their employers' response during the pandemic, feeling extremely supported. They welcomed how their employers expressed their appreciation for their hard work, albeit in simple ways. For example, one respondent thought the new practice of nominating an 'employee of the month' was a good development, while others in social care appreciated thank you cards, free pizza, supplies of beverages and snacks and vouchers to the value of £15. Another respondent reported that their annual Christmas bonus of £10 had been increased to £100.

3.2 CONNECTIONS

As with Phase 1, the theme of connection emerged as a strong feature across responses from all occupations and countries. This theme conceptualises the importance workers placed on sustaining relationships and connections with the people they work with, whether that be service users/patients, team members or managers. Overall, experiences of sustaining these relationships varied, particularly with managers and team members, and as one respondent stated:

> *"I've had a super, supportive service manager, but could as easily have had a poor one. I think it all comes down to relationships - knowing who you can trust as a boss, as a colleague, as a staff member". (Social Worker, Triage team, England)*

Another respondent highlighted varying levels of support from management:

> *"I feel my direct line managers have been very supportive throughout but more senior management have not and have not been supporting us as a department". (AHP, Hospital, Wales)*

3.2.1 Connection with Service Users

A repeated theme emerging from respondents related to concerns about service users and their experience of care. This concern was often more prevalent than the concern they held for themselves as practitioners and was noted across professions and related to work with both children and adults. The concerns raised often centred on the emotional and psychological wellbeing of service users, more so than physical needs:

> *"The mental implications for patients is far worse than the physical; the isolation for patients and then staff not having the time to meet their emotional needs, over and above their physical needs is heart-breaking!" (AHP, Care Home, Northern Ireland)*

Respondents noted levels of their own emotional distress and feelings of helplessness in trying to support service recipients. Examples included references to barriers that social distancing restrictions had imposed in levels of young people's engagement with services, to online case conferences, and

also included references to the heartache at observing older residents in a care home unable to see loved ones. As one social worker from Scotland stated, "*It has been emotionally demanding being on the frontline of the emotional impact of lockdown" (Social Worker, Community, Scotland)*. Another social worker from Child and Adolescent Mental Health service (CAMHS) spoke of anxiety and fear about levels of disengagement from services. Young people were not finding online contact as meaningful and therefore not getting the support they needed:

> *"There is very little job satisfaction and a constant anxiety that some of our patients' mental health will deteriorate or that they may attempt to end their lives". (Social Worker, Community, Northern Ireland)*

Working online was also considered as particularly difficult in emotionally charged case conferences. Losing the ability to engender a personal touch caused an already stressful event for service users to become much worse:

> *"Chairing meetings when people are highly stressed, sometime very distressed on a screen means the personal touch, compassion and empathy can get lost as can meaning". (Social Worker, Community, Northern Ireland)*

These examples give insight to social work practice concerns about the impact of the service changes on families and children and how engagement and relationship building were sometimes made more difficult. Concerns were also raised about the impact that changes to care services had on adult care. A care home worker reflected on their experience:

> *"…what I will always remember is the feeling of helplessness at the inability to do more to help our residents and having to watch them degrade from the lack of social contact/visits with their loved ones". (Social Care Worker, Care Home, Northern Ireland)*

Midwives also recognised how changes in service provision affected women even when staff tried to adapt care to compensate for the way care was provided:

> *"Women have complained they don't see their midwife until 24 weeks face to face, they do have our work mobile to call us from the booking assessment as well as contact points with professionals 4 times before 24 weeks. Sometimes women can be ungracious with their demands and expectations, our commitment to the role patient facing hasn't changed throughout the pandemic. We still go to work, wear PPE & care for women as always". (Midwifery, Hospital, England)*

> *"The pressure at times feels relentless, service users can often become critical and voice their opinions with staff they come in contact even though that department is not theirs. e.g. criticism of waiting times for ED or for cancer treatment is not something we in maternity services can respond to other than to acknowledge that currently there is widespread pressure within the NHS". (Midwifery, Community, Northern Ireland)*

Some positive experiences were noted, with connections to service users being improved with having the space now to work at a slower pace, and having more time to listen:

> *"Life was at a slower pace which helped me reset my goals & realise how important it was to take time to listen patients & let them talk about their issues with no pressure to move on to next patient". (AHP, Hospital/Community, Northern Ireland)*

3.2.2 Connection with Team Members and Colleagues

Contact with colleagues was appreciated whether this was formally organised as a meeting or in a more informal and social capacity. Regardless of the nature of these interactions, respondents overwhelmingly agreed that having mechanisms to sustain supportive relationships with colleagues and team members was important for helping each other cope, and to address the concerns, fears and isolation associated with working on the frontline through the pandemic. Many respondents noted the importance of working as a team, sharing ideas and information, and supporting each other when working through what some described as a "war zone" or "rollercoaster ride". Respondents appreciated the camaraderie and closeness that developed within teams which seemed instrumental in supporting their resilience and individual wellbeing at work:

> *"I have learned that personally I am resilient and can adapt to difficult working environments. My work colleagues have been an incredible support and we have helped each other through this and will continue to do so". (AHP, Community, Northern Ireland)*
>
> *"Being able to discuss with colleagues the things that are bothering us, we are a close team and we have all been there for each other during the rollercoaster ride". (Social Care Worker, Community, Wales)*
>
> *"My line manager recognising and appreciating the changes I willingly made during redeployment has been a good support". (Nursing, Hospital, Northern Ireland)*

Engendering this peer to peer connection was deemed particularly important for new recruits. The managers' focus group revealed concerns about the ability to effectively induct and develop new employees, especially social workers, when they are isolated from their team of peers. As one manager explained:

> *"they* [newly appointed social workers] *felt very isolated. And particularly for newly qualified social workers, I felt for them, because they learn by watching, observing and hearing the conversations and, and they find out quickly who they can go to if you have an issue, you're worried about something and they're generally very well looked after, protected. So that wasn't as available to them as, as normal". (Managers' Focus Group)*

In the absence of normal working conditions, where teams could come together in person, several alternative means were used to maintain connections. Many respondents across all occupations (generally excluding home care) made references to the usefulness of formal peer and group supervision meetings, as well as more informal contacts using MS Teams, Zoom and WhatsApp. Online contact was viewed as mostly positive with only a few respondents complaining about the barrier created by IT in maintaining good connections. However, it emerged that the frequency and usefulness of how workers connected varied across occupations.

There was some indication that the nature and frequency of the meetings had changed since the start of the pandemic with some respondents mentioning the impact this had on how connected they felt to the team. One respondent noted how they *"started with morning team check in's but this has drifted and the team feel very separate" (Social Worker, Wales*). Other respondents mentioned that the decrease in frequency was due to a lack of time available to meet in addition to daily work (and life) responsibilities:

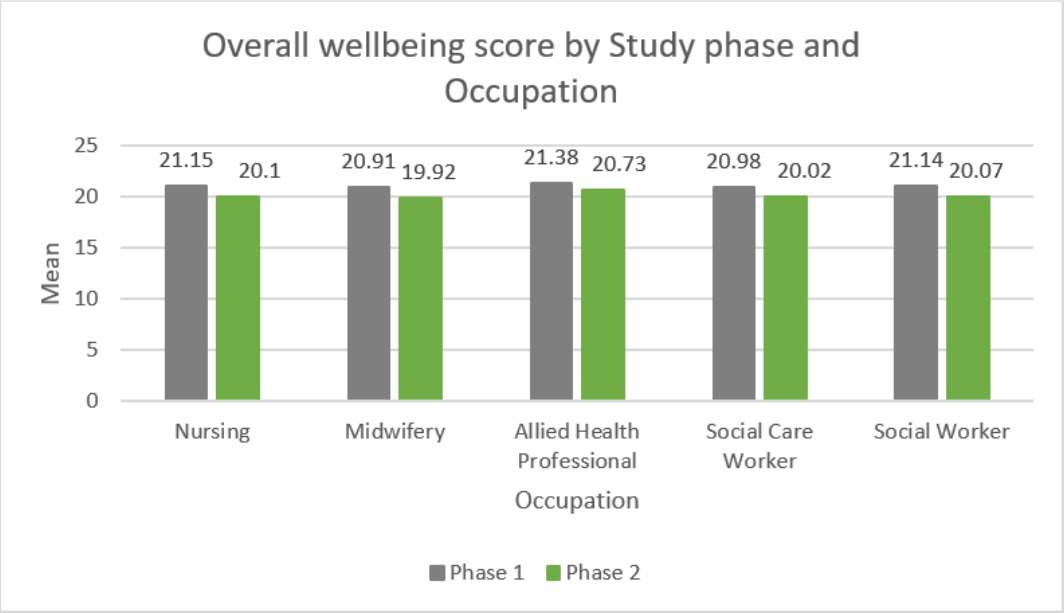
> *"meetings have come and gone, all lip service, everyone is too busy to afford an hour of their time for a meeting". (Social Worker, Hospital/Community, Wales)*

However, if the mechanisms for "staying in touch" were missing, then individuals reported feeling more isolated:

"I have found working from home the majority of the time very difficult due to feeling isolated and missing the informal peer support and social aspect of working physically within a team". (Social Worker, Hospital/Community, Wales)

Figure 3.2 below shows that across all occupations, average wellbeing scores reduced between Phase 1 and Phase 2. At both time points, average wellbeing scores were under population norms of wellbeing of 23.6 (Health Survey for England, 2011).

Figure 3.2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)



3.2.3 Connection with Managers and Supervisors

Managers were instrumental in creating the conditions for how connected workers felt, and how relationships could be maintained, particularly when working from home, where many felt increasingly isolated. However, the experiences of how this was facilitated varied considerably across the respondents. On one hand, many respondents commented positively about the support offered by managers, appreciating regular 'check-ins' that focused on their wellbeing. In frontline working, telephone calls from managers and an 'open door policy' were appreciated. Regular meetings, ranging from weekly to daily, some of them being more informal, were all welcomed. For example, respondents mentioned 'Wednesday wellbeing meetings', 'Friday catch ups', 'brew and chat meetings' or a 'weekly zoom coffee break'. A social worker from Wales explained the importance of using these meetings to explore how workers were genuinely coping:

"The understanding that everyone has been impacted personally and emotionally by the pandemic and to make a point of exploring this with each individual rather than asking "are you ok" which generates the standard response "yes thanks are you?"". (Social Care Worker, Wales)

Furthermore, rather than large team meetings, smaller meetings, where personal and individual-specific issues could be discussed and clarified, were deemed important. For example, one to one "*honest talks"* where there are "*genuine expressions of compassion/understanding.." (Social Worker, Care Management, Wales)* were preferred by some. The perceived authenticity of these 'check-ins'

was also critical for the emotional wellbeing of workers as they tried to cope through the pandemic. One respondent noted that they received *"lots of virtue signalling"* with *"not much substance"*. This respondent then suggests that "*No one cares; management just want shifts covered. Depressing..." (Social Care Worker, Supported Living, Northern Ireland).*

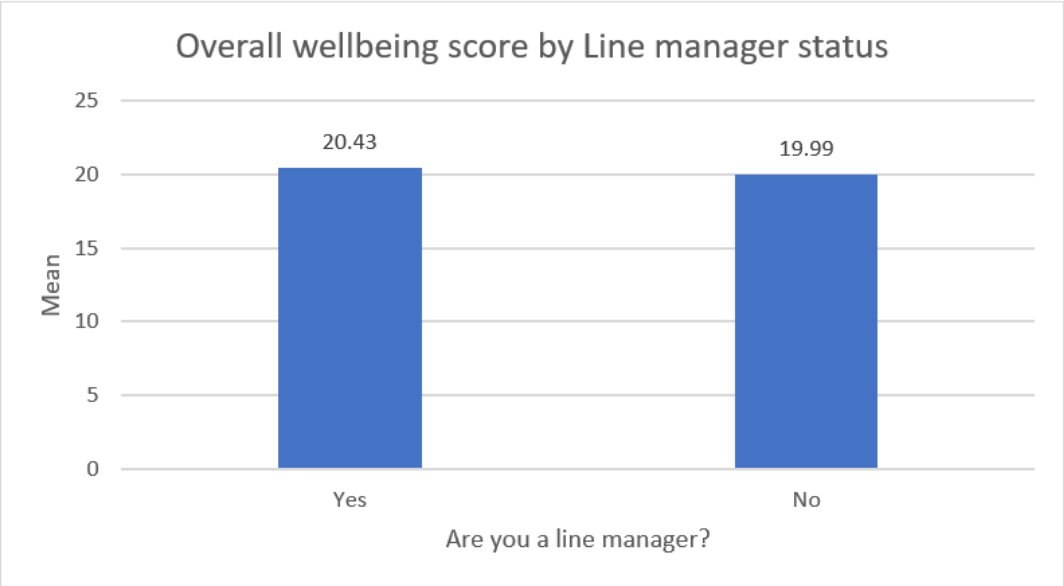
The absence of support, whether within teams or facilitated by management, was also noted as problematic. If this was the case, many respondents felt disconnected and abandoned:

> *"I have never felt this deflated, not listened to, disposable or not in control in 27 years of working in the health service. Decisions are being made by those sitting at home with no idea of the workplace." (AHP, Hospital/Community, Northern Ireland)*

However, concerning implications of the added responsibility on managers to facilitate and maintain connections with their team members were also noted. A manager reported feeling exhausted by all their efforts to keep in touch with staff:

> *"I have undertaken a survey of my staff team (150 staff) to check in with staff and how they feel and are experiencing our employer/senior manager support. I have initiated and led regular staff meetings and get togethers and communication to make sure that I hear all staff worries and that our organisation responds. No staff have suffered financial detriment and I have been working flat out to support them and our young people (service users) … This has been an almost intolerable load to carry and I have been deeply distressed and stressed for the last ten months". (Social Worker, Scotland)*

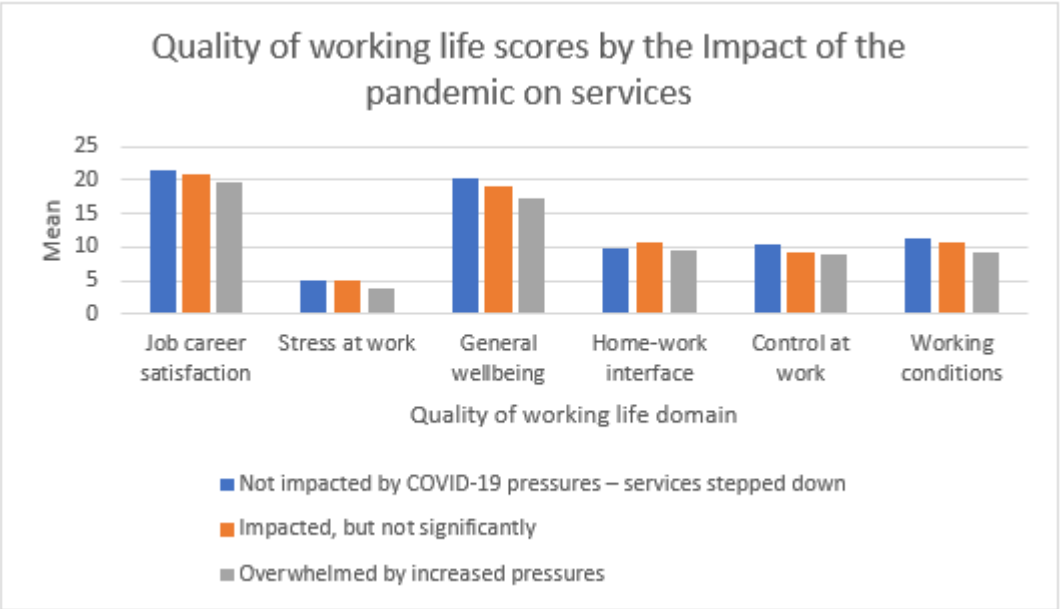
Figure 3.3: Mean Overall Wellbeing Score by Line Manager Status (Weighted)



Related to the analysis of manager and frontline worker differences, it is important to note that there was a significant difference in the overall mean wellbeing scores between respondents who were line managers and those who were not ($t = 3.164$, $df = 30.92$, $p = .002$). Specifically, line managers scored significantly higher than those who were not line managers (see Figure 3.3). Although managers' scores are higher for wellbeing than frontline workers', the scores were still lower than population norms of 23.6 (Health Survey for England, 2011).

Figure 3.4 below presents the levels of pressures on the workforce, impacting on Work-Related Quality of Life scores. There were significant differences in the overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 83.608$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures had a significantly lower overall WRQOL score than those who only felt some impact or those who felt no impact. Higher scores indicate better quality of life across the WRQOL domains, but stress at work is reverse scored, so lower stress scores indicate higher stress at work. Those not impacted by the pandemic have higher work-related quality of life scores in all areas except home-work interface.

Figure 3.4: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)[1]



3.3 COMMUNICATION

Communication was a critical area that some respondents raised concerns about or noted as a strength. There were less concerns about poor communication in Phase 2 compared to what was reported in Phase 1, but having clear guidance and information continued to be cited as being important to both managers and staff. Respondents also noted the importance of being actively involved in communication and decision-making processes, citing frustrations about not 'being listened to' and only being passive recipients of information. Online or in-person, communication remains a central issue.

3.3.1 Guidance and Information

Given how the scientific understanding of the virus and its management continued to evolve, there continued to be changes and updates to guidance given to managers and frontline staff. Although this was expected, daily changes were cited as being sometimes overwhelming – with one person

[1] Scores are comparable within domains, but not across them due to different numbers of questionnaire items contributing to the score in each domain

reporting this as *"scary, confusing"* and leading to *"inconsistency" (Social Worker, Hospital/ Community, Scotland)*. Another respondent explained:

> *"The continuous stream of emails and updates on changing processes is anxiety provoking for managers, particularly receiving information which is not directly relevant. Although I acknowledge this communication is to provide reassurance as a lack of information and communication is often cited as a problem". (AHP, Community, Northern Ireland)*

On the other hand, other respondents bemoaned not having enough relevant information to enable them to do their jobs well and this was compounded by what seemed to be conflicting guidance from managers, from local authorities and from government and how it translated to the frontline:

> *"There seems to be a complete disconnect between all of management and the front line workers with very poor communication about things that matter like things that are going on in the service and that we need to know about to provide a service". (Social Worker, Hospital/Community, Scotland)*

> *"We have not had so much detailed advice/information about how to manage the job on a day to day basis as the pandemic has progressed, we have had to work it out ourselves a bit". (AHP, Community, Wales)*

Not only was this felt on the front line, but also by managers. For example, from the perspective of service providers working with Health and Social Care Trusts (Northern Ireland), one participant in the managers' focus group described their frustrations about the disorganisation and inconsistencies in how information was developed and disseminated to service providers and called from a more centralised and coordinated approach to avoid inconsistencies and confusion.

> *"one of the things that we were not prepared for was the disorganization from some of the Trusts in the dissipation of information. We expected that the Trusts would be taking the lead on it, they would be dissipating from the outset, em, clear guidance, action charged, action plans. And one, one Trust was telling you one thing, and the other Trust was telling you another. We are over four five trusts in Northern Ireland, and there was absolutely no continuity whatsoever and the information dissipated, some Trusts were ahead of their game, and they had, em, very good information prepared to put out to providers, other Trusts, even till now, we still haven't received that information". (Managers' Focus Group)*

Furthermore, from the perspective of some managers who participated in the focus group, the uncertainty regarding information about the virus seemed to be further compounded by the media's presentation of the virus, leading to employees feeling more stressed and therefore creating more stress-related absence. They explained that staff absence seemed to spike at the start of the pandemic when workers were particularly worried about the uncertainty of the situation, and that having little escape from the media's portrayal made this worse. However, they did comment that absence then improved after a while:

> *"once it started to settle in the media, the staff began to come back to work. So, I think the initial media portrayal, um, didn't help things in regards to the mental health and the promotion of mental ill-health among the media. And then when the good news stories started to come out, regard COVID, we had found that staff were returning to work quicker". (Managers' Focus Group).*

Having regular check-ins with managers or having an open channel for communication with managers was noted as important for helping to interpret the guidance for frontline workers and to reassure

workers of their concerns. One respondent welcomed the "*Regular factual updates on the presenting situation and regular focused team meetings with manager and peers" (Social Care Worker, Community, Day Care, England)*. However, some respondents were unsure about who to ask when they had questions, particularly when detached from their team while working from home:

> *"Difficult to know who to ask whilst working from home. Manager very busy often in meeting or bogged down with a million emails - don't want to disturb her". (Social Worker, Local Authority, Wales)*

3.3.2 Decision Making and Consultation

Respondents not only noted the importance of being kept informed on a regular basis, but a process for two-way communication was also deemed integral to protecting the wellbeing of workers and their families, and for providing quality services for service users. Many respondents commented on the importance of "*management being open to new ideas and solutions" (Social Worker, Social Services Training, Northern Ireland)* and being able "to experiment" (Social Worker, Children's Services, Northern Ireland) to address problems. Others commented on the utility of team discussions to share ideas for how to address problems they were experiencing. There were also instances where staff felt relieved that there was less oversight by managers:

> *"We have been left to get on with our job as managers have been so busy during the pandemic, less interference". (Nursing, Community, Northern Ireland)*

However, on the other hand, and despite regular meetings with management, many also felt they were not being listened to and that their concerns were being ignored. For example, a social worker from England commented that *"Decisions are being made by senior management which impact on both staff and our families with no consultation from frontline staff" (Social Worker, Community, England)*. A social care worker from Northern Ireland mentioned "*We had very regular meeting with Senior Management/CEO but if you brought up something remotely negative, you were shut down" (Social Care Worker, Community, Northern Ireland)*.

From the managers' perspective, frustrations arose when, despite listening to and understanding the concerns that employees raised, they were at times powerless to address issues. For example, when employees raised concerns about accessibility to IT equipment for working from home, there seemed to be very little understanding of the bigger picture and that the efforts to facilitate these changes required centralised planning and organising. Managers from the focus group suggested that it is important to communicate more effectively about the strategic challenges being presented so that workers on the ground have an idea of the bigger picture and the efforts being made in the background to make things work.

> *"Everybody wanted IT, everybody wanted, you know, for their own service. So, in the scheme of the bigger picture, but nobody, you know, it's quite hard then to relay that to staff, you know, we're all in, we're all trying to get the best for our service, you know, our, our staff, but I mean, it was just mass everybody on board to try and get people set up to work from home and stuff. But it was just about educating people that we, we were requesting it, giving them information, you know, but as I say, people sometimes don't see outside their own wee silo, you know?". (Managers' Focus Group)*

Another manager added that even when there is little further information about how issues and concerns will be resolved, it is still important to keep communicating:

"Even if you have no further information to impart, you still need to communicate that. Because it's a lack of information that has people wondering what's happening, and it does increase their anxiety". (Managers' Focus Group)

There were also variable reports of how the autonomy of workers had changed in response to the new working conditions and how this affected their emotional wellbeing. Some felt their autonomy was reduced and felt less trusted by management. For example, some reported being micromanaged when working from home, and others reported changes to routines that indicated management did not trust their team members, which was "draining":

"There is a lot more auditing of staffs work, signing in and out, looking where they are which can be draining and a concern that staff don't feel trusted". (Social Worker, Community/Day Care, Wales)

On the other hand, others reported how their autonomy had improved, often connected to decisions to work more flexibly:

"My employer … have offered amazing support and flexibility to enable me to deliver our service which is funded by the Trust. This has included being able to manage my own diary and be flexible when I log on and off (sometimes my day will start at 6am recording to allow me to finish early)". (Social Worker, Family Support, Northern Ireland)

3.3.3 Supportive Communication

Perceptions of management support and communication varied across occupations, with several respondents stating flatly they did not "feel supported" or did not benefit from any offer of management support, whereas many others acknowledged how management "could not do enough" to make employees feel supported or that managers were doing all that "they could reasonably do" during the pandemic:

"Direct support from frontline managers is good and senior managers are visible and regularly in touch. There's little they can do to mitigate the volume and complexity of the work and how draining this is during a pandemic when we are all facing personal pressures too". (Social Worker, Community, England)

However, a strong theme emerging from responses was that there was greater appreciation of local or team managers who communicated well compared to corporate pronouncements. And even if workers reported feeling satisfied with their line manager's support and communication, there still seemed to be desire for more visible support or personal acknowledgement from senior management:

"My line manager is incredibly supportive but that's where it ends. She protects me a lot but no-one in Senior Management has ever contacted myself and the team to acknowledge the impact of COVID". (Social Worker, Northern Ireland)

"Organisationally the supports have been less effective. The supports from the Senior Leadership Team have mostly seemed like a paper exercise with few meaningful efforts to engage or support services or staff". (Social Care Worker, Community, Northern Ireland).

Respondents also described a disconnection between what they experienced on the frontline, and how that was being recognised and communicated by senior management:

"... A better understanding of our service from our employer would help improve the situation". (Nursing, Community, Wales)

"My direct manager has been very supportive but senior management often seem out of touch with the reality that front line workers are dealing with" (Social Worker, Community, England).

Addressing the individual circumstances of some workers also seemed to be unaligned between how it was managed at line and organisational level. One respondent commented that "*My local Managers have tried to be flexible to accommodate child care etc. I do not feel however that the Trust at large have been flexible or accommodating" (Social Worker, Community, Northern Ireland).*

3.4 Coping

3.4.1 Instances of Stress

Unsurprisingly, most respondents reported on how they felt increased stress and pressure while working through the pandemic. Responses revealed feelings of fatigue and burnout and many expressed concern about the sustainability of the workforce, particularly when staff need to "keep going" despite the pressures, low morale and exhaustion:

> *"The NHS staff initially banded together and there was a real sense of unity. Now we are in the second wave and possibly approaching a third, people's morale and determination is starting to lessen. People are feeling more mentally fatigued and emotionally drained, but the patients still need our 100% effort and care. I'm worried what state the workforce will be in once the pandemic is over." (AHP, Hospital, Northern Ireland)*

> *"In the whole of my career spanning over 20+ years in Social Services, I have never known stress like this". (Social Worker, Community, Wales)*

> *"It has been one of the most stressful times in my life. I think that the impact is not fully felt as yet. I believe there should also be additional support for those working in mental health. The assumption is that the staff working within mental health know what to do to look after themselves... Yes they do but they don't do it and don't feel they have permission to. Very frustrating that their voices are not being heard". (Nursing, Community, Northern Ireland)*

However, there were several factors that seemed to compound these feelings. What was highly criticised was any suggestion or even accusation of blame or poor practice. One respondent felt "disgusted" by the inspectorate and public health staff who had visited a care home after an outbreak and were perceived to be blaming staff for the outbreak (Social Care Worker, Care Home, Scotland). Another respondent described their distress at having been told by their line manager that they had *"brought COVID into our building and killed one of our tenants" (Social Care Worker, Community, Scotland)*. Such examples were in the minority but demonstrate the impact and stress that poor communications can have on frontline workers, highlighting the need for more civil and constructive communication to avoid unnecessary stress. As a nurse from England noted:

> *"The biggest issue is the way staff treat other staff … More awareness and communication skills workshops and 'customer service' course to teach all staff to be polite, have good manners and be welcoming to each other. This will enhance staff wellbeing and staff morale". (Nursing, England)*

Also of note were the individual circumstances that workers faced outside of work, which further heightened experiences of stress and anxiety. For example, many respondents not only faced challenges relating to their work, but also faced many personal challenges such as increased caring

responsibilities at home, the task of home schooling, bereavement, and isolation from family and friends and experiencing COVID-19 in their own family:

> *"One of my sons, his wife and two adorable young children have just recovered from COVID-19. We are all Key workers in health or education. This anonymous survey is the first time I have voiced a tiny bit of my feelings all be it in writing. I love my work and I am so proud to be a nurse but I never thought the time would come when I would be frightened to go to work, wondering if the patient was telling the truth and not waiting until after their examination to say thinking about I have been in contact with someone with COVID-19 but I thought if you checked me out you could tell me if I had it or not... Thank you for this survey I actually cried as I was completing as I faced some of my real feelings". (Nursing, GP Practice, England)*

Participants from the frontline focus group described how their own personal circumstances impacted on their wellbeing (see Appendix 10). These stories highlight the magnitude of some of the experiences that individuals have had to tolerate throughout the pandemic, and how it has affected their wellbeing. What is evident from these stories is that individual circumstances can vary widely but that throughout the pandemic it was important to acknowledge the different experiences of health and social care staff at work, and also how this experience intersects with personal challenges. As one survey respondent stated:

> *"For those supporting emotional and psychological needs it has been exhausting ... as own personal lives in parallel (rare for personal and professional to collide so much, for so long)". (AHP, England)*

Measuring burnout was an important area of the second phase of this study due to the increasing context of pressure on the health and social care workforce. The Copenhagen Burnout Inventory was the measure used, as this separated personal burnout, work-related burnout and client-related burnout, with all areas relating to energy levels associated with each specific area. We found significant differences between occupational groups in mean burnout scores across all three domains (see Figure 3.5 below). In the personal burnout area, AHPs scored lower (i.e., had lower levels of burnout) than nurses and social workers, and social care workers scored lower than social workers. Social care workers scored significantly lower than nurses, midwives and social workers and AHPs scored significantly lower than social workers. In relation to client-related burnout, social workers scored significantly higher (i.e., had higher levels of burnout) than social care workers. Compared to the other two areas of burnout (personal and work-related), client-related burnout was lower overall. The burnout scores found for the occupational groups in this study are generally higher than those reported in the wider literature (pre-COVID-19 period) for personal and work-related burnout. Scores on client-related burnout are comparable (e.g., Jeon, You, Kim, Kim, & Cho, 2019; Kristensen et al., 2005; Messias et al., 2019).

When the burnout scores were converted into Low/Moderate/High/Severe burnout, using the cut-off scores from the literature, we found that moderate, high or severe levels of burnout were common across the occupational groups for both personal and work-related burnout, as shown in Figure 3.6.

Figure 3.5: Mean Burnout Scores by Occupation (Weighted)

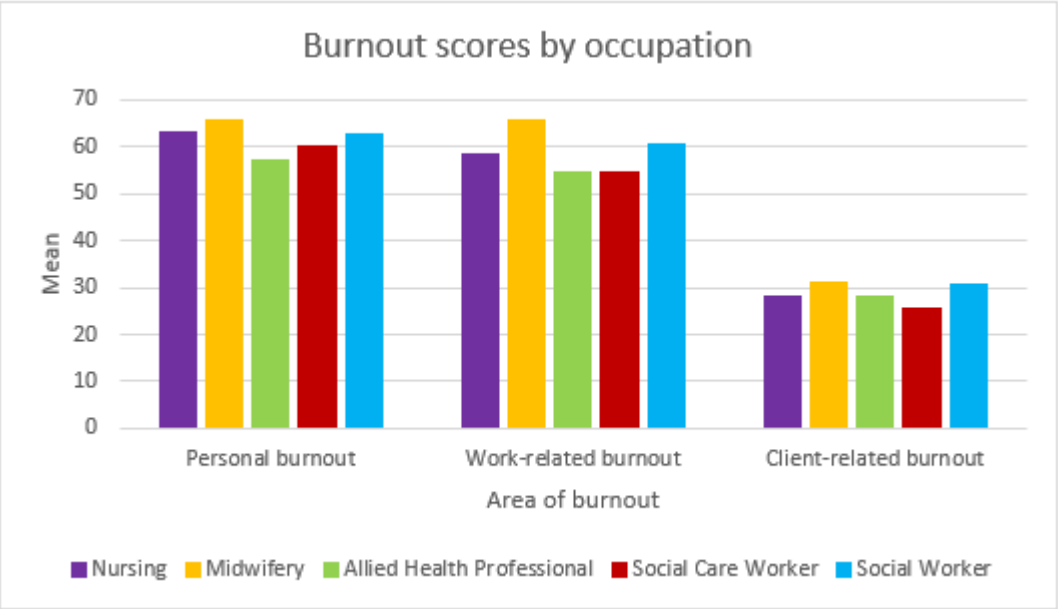
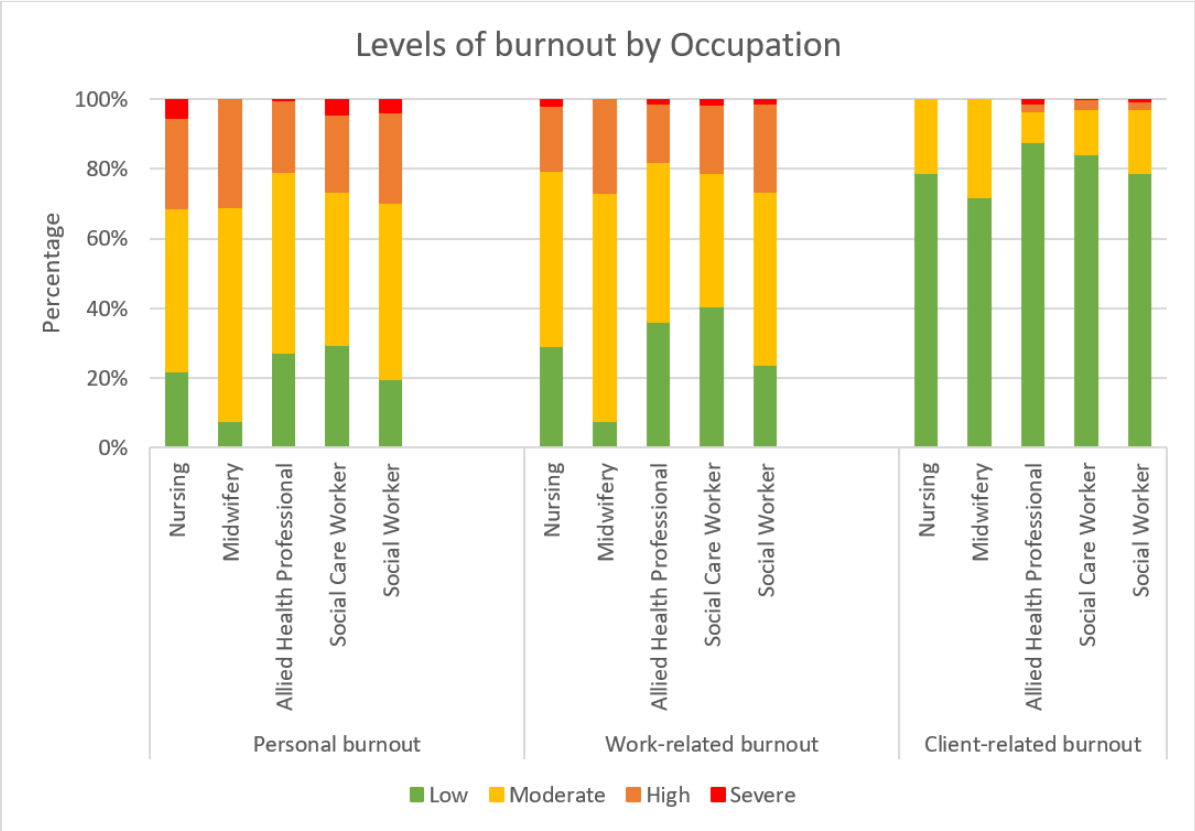


Figure 3.6: Levels of Burnout (Weighted)



3.4.2 Wellbeing Interventions

The survey responses revealed several initiatives and interventions that organisations were using to help address the health and wellbeing of staff. Any efforts that recognised and tried to address the impact of the pandemic on the wellbeing of staff seemed to be welcomed and appreciated.

Several respondents acknowledged and praised the introduction of wellbeing hubs or similar services for staff. These appeared to be a key development that had happened since our Phase 1 survey and, for some, indicated that their organisations recognised and valued their efforts when times were so difficult. Specific examples of initiatives included Psychological Resilience Hubs and counselling services, availability of coaching, online yoga and exercise classes, a virtual choir, meditation sessions, online quizzes and mental health and lifestyle webinars. Indeed one person said that the amount of support on offer could now seem *"overwhelming" (Social Worker, Community, England),* while another cautioned about the importance of all staff, including those who work various shift patterns, to have access to the range of wellbeing supports offered by their employer (Social Care Worker, Northern Ireland). Of course, those without good internet access may not find these so accessible.

The responses also revealed the importance of complementing the availability of these services and initiatives with more informal support from line managers. Line managers were identified as having an extremely important role in signposting to wellbeing services and intervening in a more informal capacity where necessary. For example, one respondent noted how their manager suggested they take a short walk every day (Social Worker, Community, England) and others mentioned being encouraged to take breaks.

However, despite the introduction of these wellbeing interventions, concerns emerged about the opportunities for the workforce to take advantage of them when they are time poor:

> *"There is a counselling service, it feels tokenistic as there is no time away from the job is provided to attend". (Social Worker, Community, Wales)*

Having time to address individual wellbeing seemed more acutely felt by senior managers in particular, and is a concerning theme given the continued stress and pressure managers are experiencing:

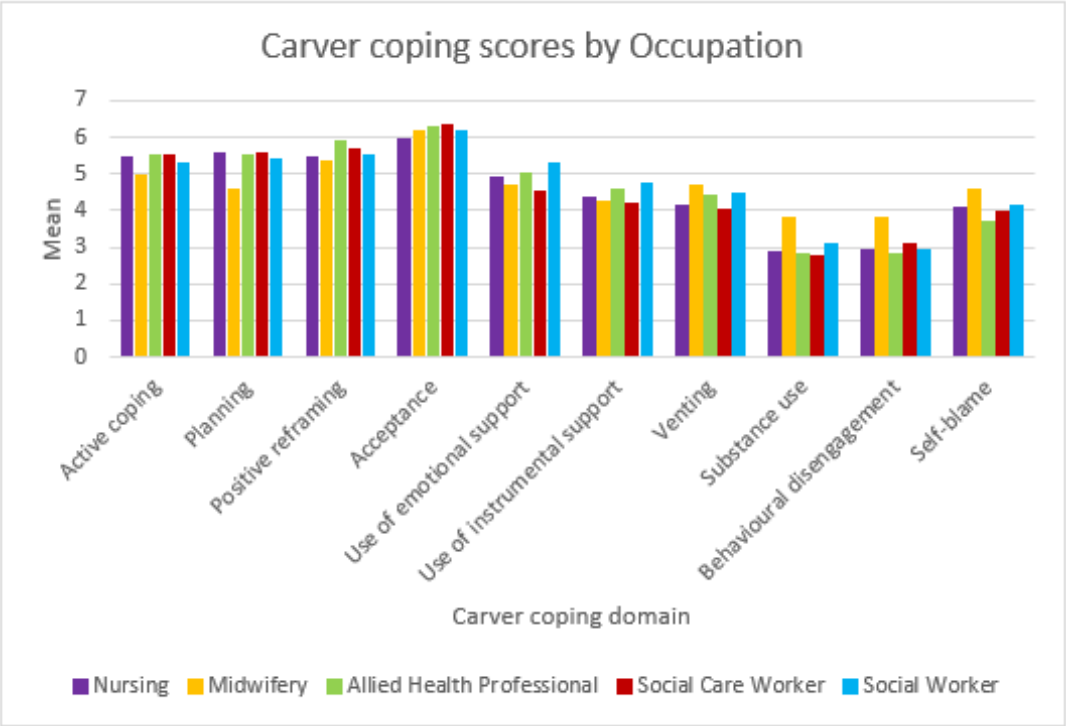
> *"As a senior manager there is an expectation that we work the hours needed which are often excessive during the week and can include weekends so little time to consider our own well-being whilst looking after the work force". (Social Worker, Adult Social Care, England)*

> *"I have not had the time to access many of the great initiatives I tell my staff to use. It's something I am working on". (AHP, Community, England)*

To address the problem of lack of time, one respondent noted how they welcomed their employer's support to build in time for focusing on own wellbeing during working hours, which has *"made a real difference" (Social Worker, Northern Ireland)*.

Varied experiences were offered in the qualitative responses, which were mirrored in the quantitative findings related to coping methods of staff (see Figure 3.7). There were significant differences between the occupational groups in mean scores in nine out of the ten examined Carver coping domains. These differences were in relation to active coping, positive re-framing, acceptance, emotional support, instrumental support, venting, substance use, behavioural disengagement and self-blame. There was no difference between the occupational groups in the use of planning. Between the first survey phase and the second one, we found a reduction in levels of positive coping methods reported by respondents.

Figure 3.7: Carver Coping Scores by Occupation (Weighted)



3.4.3 Perceptions of Unequal Treatment Between Sectors and Services

Feelings of low morale and dissatisfaction seemed to emerge from respondents who perceived inequalities in terms of how different sectors and services were treated and valued. For example, many social care workers felt that they were less important than healthcare staff. One respondent suggested that *"the social care sector has largely been ignored by governments, the press and the public. The NHS and care homes have all the publicity and support" (Social Care Worker, Community/ Day Care, Scotland)* and they objected that they were not offered the same perks as NHS staff even though social care staff are routinely at risk. Feelings of inequalities were further exasperated when considering the vaccination roll out:

> *"Not to be seen as selfish … It now looks like with vaccinations the social care sector is once again working it's way down the list of priorities". (Social Care Worker, Community/ Day Care, Scotland)*

Further dissatisfaction was identified from those working in community services who felt they were less recognised than hospital staff. From Wales, a care home nurse respondent felt that there was a focus on the 'glamour' of ICU work and that the care sector was ignored *(Nursing, Care Home, Wales).* Furthermore, some of those working in privately run organisations also seemed to be aggrieved by how they were treated compared to NHS or local authority staff:

> *"Private care homes were left to fend for themselves and were totally dumped on. I experienced this first hand. Seeing how some other nursing homes encouraged their staff and showed how they valued staff. Seeing managers, again in other nursing homes, put on scrubs and help out the nurses and carers. Strategic methods used to approach the COVID situation in the home I work in were terrible and pointless". (Social Care Worker, Care Home, Northern Ireland)*

Perceptions of inequalities about how different grades and roles were treated also emerged, particularly in terms of the flexibility and autonomy offered, and how they were acknowledged:

> *"What needs to improve is that staff in lower bands (3 & 4) such as admin, Personal Advisors in 16+, family support workers etc., could also have the flexibility to work from home. Currently a 2 tier system with some managers showing very poor leadership". (Social Worker, Social Care Governance, Northern Ireland)*

Navigating this dynamic between various workers with a service was deemed tricky. Managers who participated in the focus groups discussed the need for open and transparent explanations about why some workers were treated differently, particularly in relation to working from home or other flexibility policies. As one manager explained:

> *"we had staff saying, Oh, well, she's been at home for three months. But she's been at home working flat out for three months, you know, she was a shielder. So, you know, people interpreted things differently. Em, so it was about reinforcing why people had to stay at home, they had no choice. That was a directive from the government'. (Managers' Focus Group)*

3.5 Quantitative Findings

This section provides a summary of the quantitative findings from the wellbeing, quality of working life, burnout and coping questionnaires. Full details are provided in appendices 3 through 9.

3.5.1 Mental Wellbeing

Mental wellbeing was assessed using the Warwick-Edinburgh Mental Wellbeing Scale. The overall mean wellbeing score in our sample was 20.10, which is more than three points below the population mean of 23.61 (NHS Health Survey for England, 2011) and it is also lower than the mean score of 20.95 reported in Phase 1 of the study. Multiple regression analysis revealed that this was a **significant difference in wellbeing from Phase 1 to Phase 2**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -0.872$, $p < .001$). As shown in Tables 3.1 and 3.2 below, the decrease in wellbeing was observed across all four countries and all five occupational groups.

Table 3.1: Mean Overall Wellbeing Score by Study Phase and Country (Weighted)

	Country				
Study phase	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1	20.95	21.15	20.74	21.25	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76

Table 3.2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)

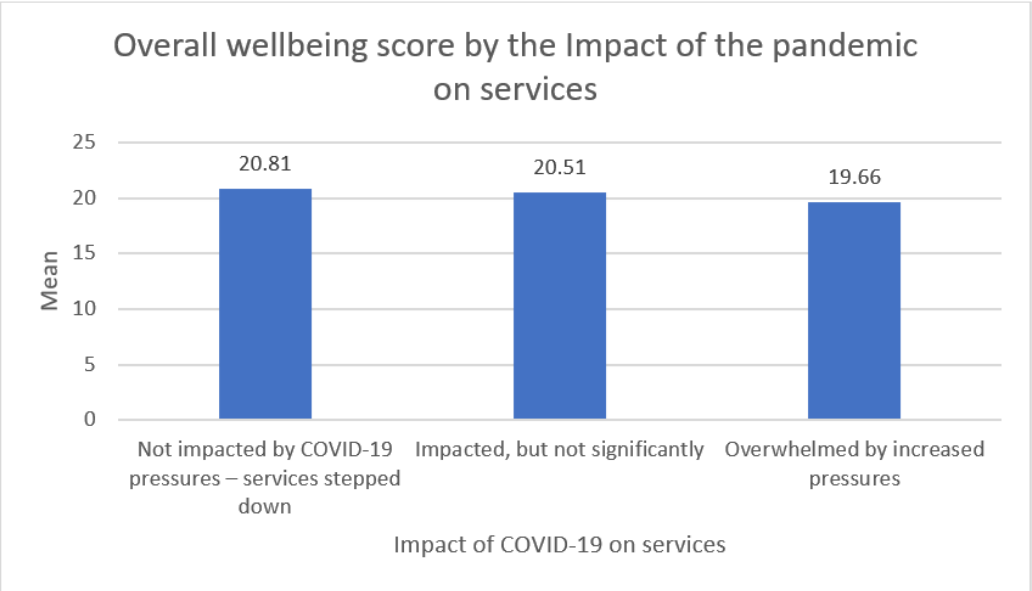
	Occupation				
Study phase	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1	21.15	20.91	21.38	20.98	21.14
Phase 2	20.10	19.92	20.73	20.02	20.07

When the wellbeing scores were converted to indicate probable or possible cases of depression/anxiety, it was found that UK-wide, 17.7% of respondents were probable (likely) cases of anxiety or depression and a further 22.0% were possible cases of anxiety or depression. In Phase 1 of the study, these numbers were 9% and 33% respectively, suggesting an increase in the severity of problems.

We also looked at the effects of other variables on mental wellbeing and we found the following:

- Males reported significantly higher wellbeing than females
- Older respondents had significantly better wellbeing than younger respondents
- Respondents from the black ethnic group scored significantly higher on wellbeing than those from the other three ethnic groups; and respondents from the Asian ethnic group scored significantly lower than those from the other ethnic groups
- Respondents who were not sure whether or not they had a disability had significantly lower wellbeing scores than those who did and those who did not have a disability
- Line managers scored significantly higher on wellbeing than those who were not line managers
- Respondents who felt that their service was overwhelmed by increased pressures scored significantly lower on wellbeing than those who felt no impact or only some impact (see Figure 3.8)

Figure 3.8: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Weighted)



Similar to the Phase 1 report, we used multiple regressions to examine which coping strategies impacted upon the mental wellbeing scores. *It is important to note, however, that some of the variables used in Phase 2 of the study were different from those used in Phase 1, which means that these regression results are not directly comparable between the two Phases.* In Phase 2, we found that after controlling for the effects of respondents' age, sex, disability status, ethnicity, country of work, occupational group, number of sick days in previous 12 months, line manager status and the effects of the pandemic on services, the following coping strategies were significantly associated with wellbeing scores:

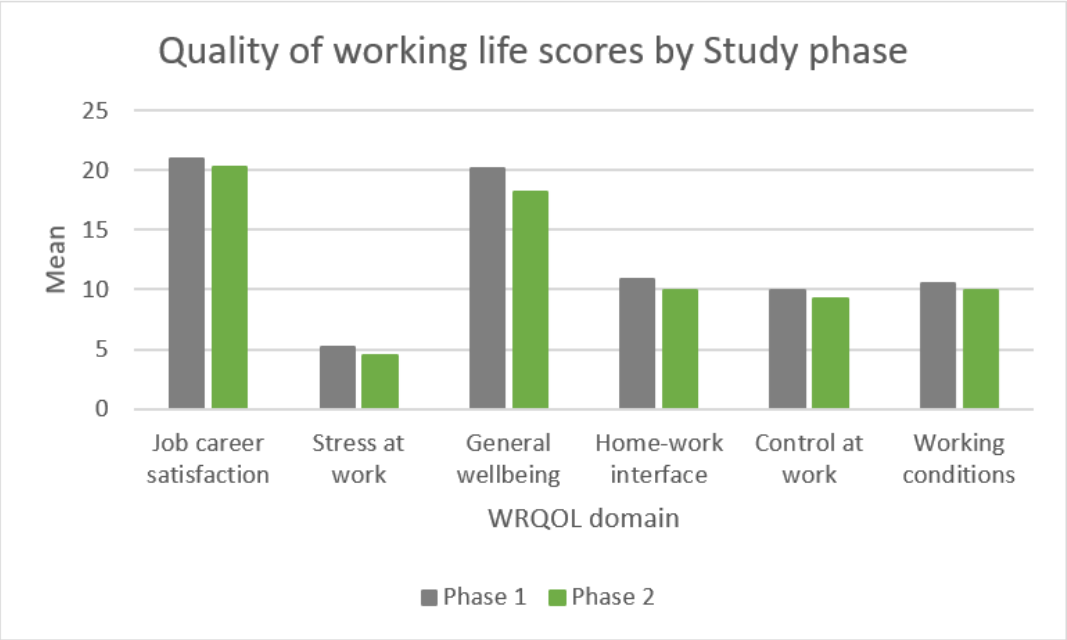
- Active coping, Positive reframing, Acceptance, Use of emotional support, Work-family segmentation, Working to improve skills/efficiency, Recreation and relaxation, and Exercise, all of which predicted higher wellbeing scores
- Planning, Venting, Substance use, Behavioural disengagement, Self-blame, and Family-work segmentation, all of which predicted lower wellbeing scores

Detailed breakdown of wellbeing scores across different variables is provided in Appendix 3 and detailed results of the multiple regression analysis are provided in Appendix 8.

3.5.2 Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life (WRQOL) Scale. The overall WRQOL score across the UK was 72.13, which is lower compared to the 77.59 in Phase 1 of the study and a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed that this **decrease in quality of working life from Phase 1 to Phase 2 of the study was statistically significant** ($\beta = -3.489$, $p < .001$). As shown in Figure 3.9, there was also a decrease from Phase 1 to Phase 2 on all domains of the quality of working life and these decreases were again statistically significant.

Figure 3.9: UK-wide Mean Quality of Working Life Scores by Study phase (Weighted)



As shown in Tables 3.3 and 3.4 below, the decrease in WRQOL scores was observed across all four countries and all five occupational groups.

Table 3.3: Mean Quality of Working Life Score by Study Phase and Country (Weighted)

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	77.59	79.33	73.07	80.35	76.63
Phase 2	72.13	72.21	70.37	79.46	74.06

Table 3.4: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted)

Study phase	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 1	72.54	78.56	81.16	78.34	80.63
Phase 2	70.01	66.95	74.41	73.24	73.67

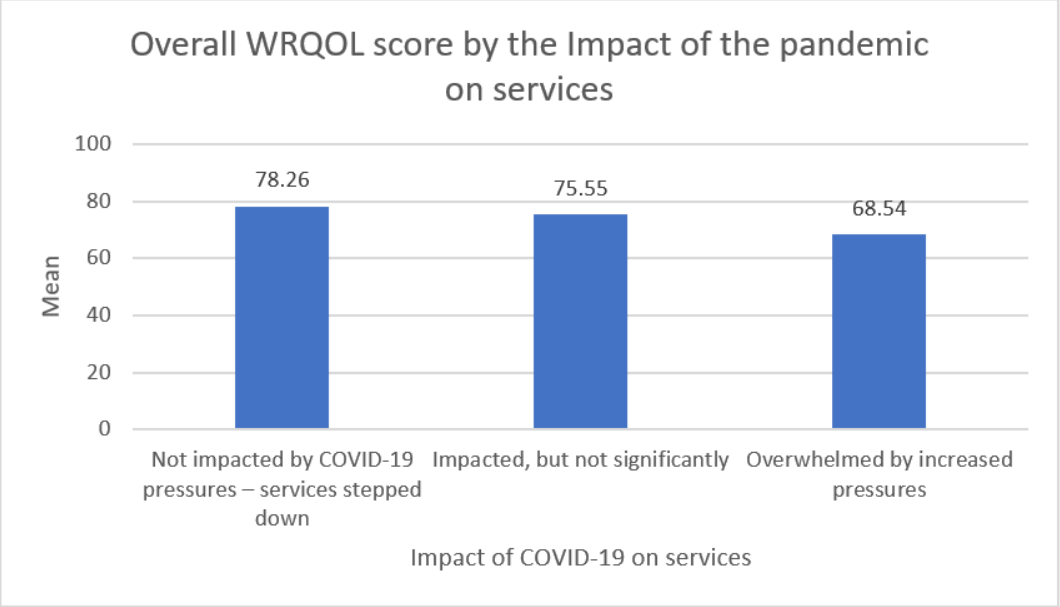
When the WRQOL scores were converted to Lower, Average, or Higher quality of working life, we found that UK-wide, 46.7% of respondents had lower quality of working life, 26.0% had average quality of working life and 27.3% had higher quality of working life. This compares to 30.4%, 27.1%, and 42.5% for higher, average and lower quality of working life respectively in Phase 1 of the study[2].

The analyses of the effects of other variables on the overall quality of working life revealed the following:

- Males had significantly higher quality of working life than females
- The older age groups report significantly better quality of working life than some of the younger age groups
- Respondents from the Asian ethnic group had significantly lower quality of working life than all the other ethnic groups
- Respondents without a disability had significantly higher quality of working life than those with a disability or those who were unsure of whether or not they had a disability
- Line managers and those who were not line managers did not differ significantly in their quality of working life scores
- Respondents who felt that their service was overwhelmed by increased pressures scored significantly lower on quality of working life than those who felt no impact or only some impact (see Figure 3.10)

[2] Please note that the Phase 1 percentages reported here were calculated in a different way from those reported in the Phase 1 report in order to make them comparable to Phase 2.

Figure 3.10: Mean Overall WRQOL Score by the Impact of the Pandemic on Services (Weighted)



We used multiple regressions to examine which coping strategies impact upon the quality of working life scores. *Again, it is important to note, that some of the variables used in Phase 2 of the study were different from those used in Phase 1, which means that these regression results are not directly comparable between the two Phases of the study.* In Phase 2, we found that after controlling for the effects of respondents' age, sex, disability status, ethnicity, country of work, occupational group, number of sick days in previous 12 months, line manager status and the effects of the pandemic on services, the following coping strategies were significantly associated with WRQOL scores:

- Positive reframing, Acceptance, Use of emotional support, Work-family segmentation, Working to improve skills/efficiency, and Recreation and relaxation, all of which predicted higher quality of working life scores
- Planning, Venting, Behavioural disengagement, Self-blame, and Family-work segmentation, all of which predicted lower quality of working life scores

Detailed breakdown of the WRQOL scores across different variables is provided in Appendix 4 and detailed results of the multiple regression analysis are provided in Appendix 8.

3.5.3 Burnout

As mentioned above, in Phase 2 of the study we also measured burnout, using the Copenhagen Burnout Inventory, which assesses personal, work-related and client-related burnout. Overall, we found that client-related burnout was much lower than personal and work-related burnout, suggesting that clients or service users are rarely the reason for staff burnout. We also found some significant differences in the burnout scores across countries. The most consistent finding was that respondents from England scored significantly higher (i.e., experienced more burnout) than

respondents from Wales on all three areas of burnout (see Table 3.5). Comparing the occupational groups on their burnout scores, the findings were more mixed[3] (see Table 3.6).

Table 3.5: Mean Burnout Scores by Country (Weighted)

	Country				
Burnout	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Personal burnout	61.40	61.53	60.68	58.26	60.39
Work-related burnout	56.73	57.36	55.78	52.53	57.43
Client-related burnout	27.97	28.58	25.12	23.61	25.93

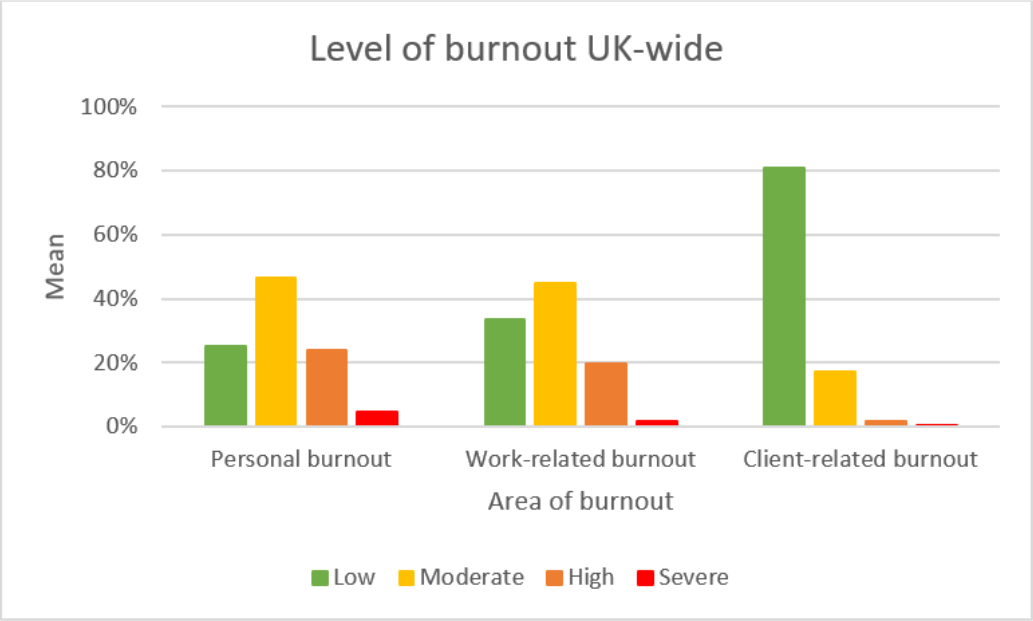
Table 3.6: Mean Burnout Scores by Occupation (Weighted)

	Occupation				
Burnout	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Personal burnout	63.32	65.73	57.32	59.98	62.87
Work-related burnout	58.61	65.78	54.77	54.49	60.63
Client-related burnout	28.19	31.02	28.01	25.58	30.68

When the burnout scores were converted to Low, Moderate, High or Severe burnout, we found that UK-wide, on personal burnout, 28.3% of respondents experienced high or severe burnout and a further 46.4% experienced moderate burnout. In relation to work-related burnout, 21.3% experienced high or severe burnout and a further 45.0% experienced moderate burnout. Finally, in relation to client-related burnout, 2.0% experienced high or severe burnout and 17.1% experienced moderate burnout (see Figure 3.11).

[3] The number of midwives in the sample was relatively small, which explains why they did not differ significantly from the other occupational groups, despite their high burnout scores.

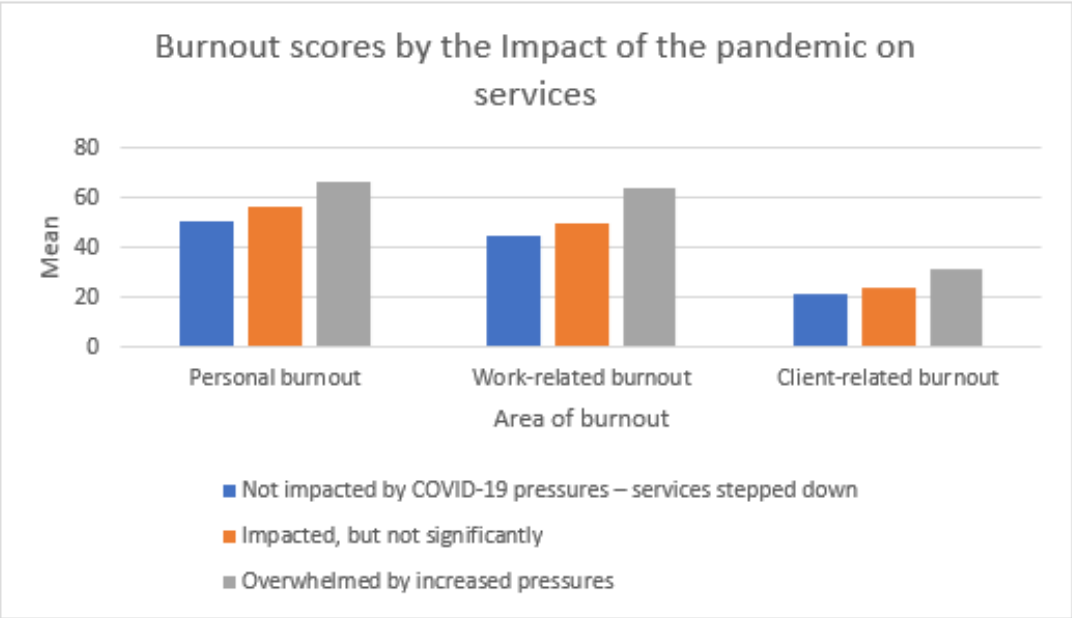
Figure 3.11: Level of burnout UK-wide



The analyses of the effects of other variables on burnout scores revealed the following:

- Females experienced significantly higher levels of personal and work-related burnout than males, but no statistically significant sex differences were found for client-related burnout
- The older age groups generally experienced significantly lower personal and work-related burnout than the younger age groups, but no significant differences were observed for client-related burnout
- Respondents from the black ethnic group experienced significantly less personal burnout than all the other ethnic groups; and respondents from the Asian ethnic group experienced significantly more work-related burnout than the other ethnic groups
- Respondents without a disability experienced significantly less personal and work-related burnout than those with a disability or those who were unsure of whether they had a disability
- Line managers experienced significantly more work-related burnout and significantly less client-related burnout than respondents who were not line managers
- Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more burnout in all three areas than those who felt no impact or only some impact (see Figure 3.12)

Figure 3.12: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)



Considering the prolonged pressures on the UK health and social care system since the start of the pandemic, an area of interest is the association between burnout, wellbeing and quality of working life, as well as whether respondents have considered leaving their current employer. As shown in Table 3.7, we found moderate negative correlations between personal burnout and wellbeing scores, and personal burnout and quality of working life scores, and strong negative correlations between work-related burnout and wellbeing scores, and work-related burnout and quality of working life scores. There were also weak, but statistically significant, negative correlations between client-related burnout and wellbeing scores, and client-related burnout and quality of working life scores. This means that as burnout in any area increased, respondents' wellbeing and quality of working life decreased.

Table 3.7: Correlations between Burnout Scores and Wellbeing and WRQOL Scores

Burnout area	Wellbeing	Quality of working life
Personal	-.591	-.584
Work-related	-.610	-.727
Client-related	-.298	-.374

In relation to respondents having considered changing their employer since the start of the pandemic, we found significant associations between all areas of burnout and respondents considering this option (Personal burnout: $\chi^2 = 426.120$, df = 10, $p < .001$; Work-related burnout: $\chi^2 = 583.570$, df = 10, $p < .001$; Client-related burnout: $\chi^2 = 224.934$, df = 10, $p < .001$). Specifically, respondents who were experiencing high/severe levels of personal burnout were very likely to report having considered changing their employer since the start of the pandemic for two specific reasons; 1) the job being very stressful, and 2) the job impacting on their health and wellbeing. Those experiencing low levels of personal burnout were less likely to have considered changing their employer for these reasons. The same was found for work-related burnout. In relation to client-related burnout, respondents experiencing high/severe levels were very likely to report having considered changing their employer

because the job was impacting upon their health and wellbeing. Those with low levels of client-related burnout were less likely to have considered changing their employer for this reason.

Using multiple regressions to examine which coping strategies impact upon the burnout scores, we found that after controlling for the effects of respondents' age, sex, disability status, ethnicity, country of work, occupational group, number of sick days in previous 12 months, line manager status and the effects of the pandemic on services, the following coping strategies were significantly associated with burnout scores:

Personal burnout:

- Active coping, Acceptance, Use of emotional support, Working to improve skills/efficiency, Recreation and relaxation, and Exercise, all of which predicted less burnout
- Planning, Use of instrumental support, Venting, Substance use, Behavioural disengagement, Self-blame, and Family-work segmentation, all of which predicted more burnout

Work-related burnout:

- Active coping, Use of emotional support, Work-family segmentation, Working to improve skills/efficiency, and Exercise, all of which predicted less burnout
- Planning, Use of instrumental support, Venting, Behavioural disengagement, Self-blame, and Family-work segmentation, all of which predicted more burnout

Client-related burnout:

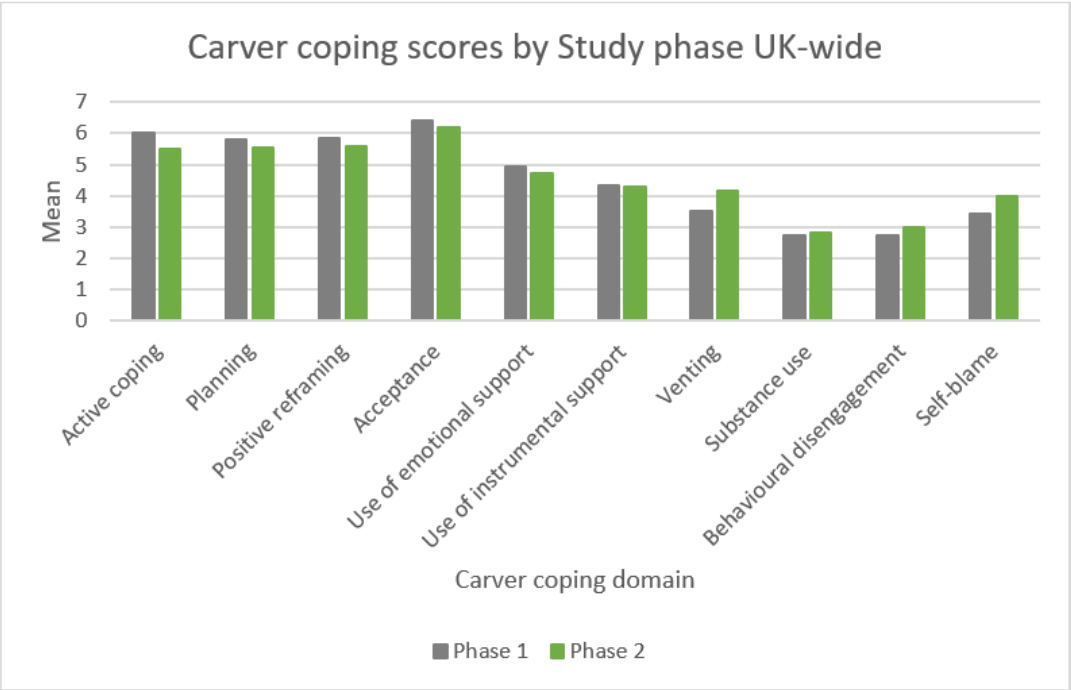
- Use of emotional support, and Working to improve skills/efficiency, which predicted less burnout
- Venting, Substance use, Behavioural disengagement, and Self-blame, which predicted more burnout

Detailed breakdown of the burnout scores across different variables is provided in Appendix 5 and detailed results of the multiple regression analysis are provided in Appendix 8.

3.5.4 Coping

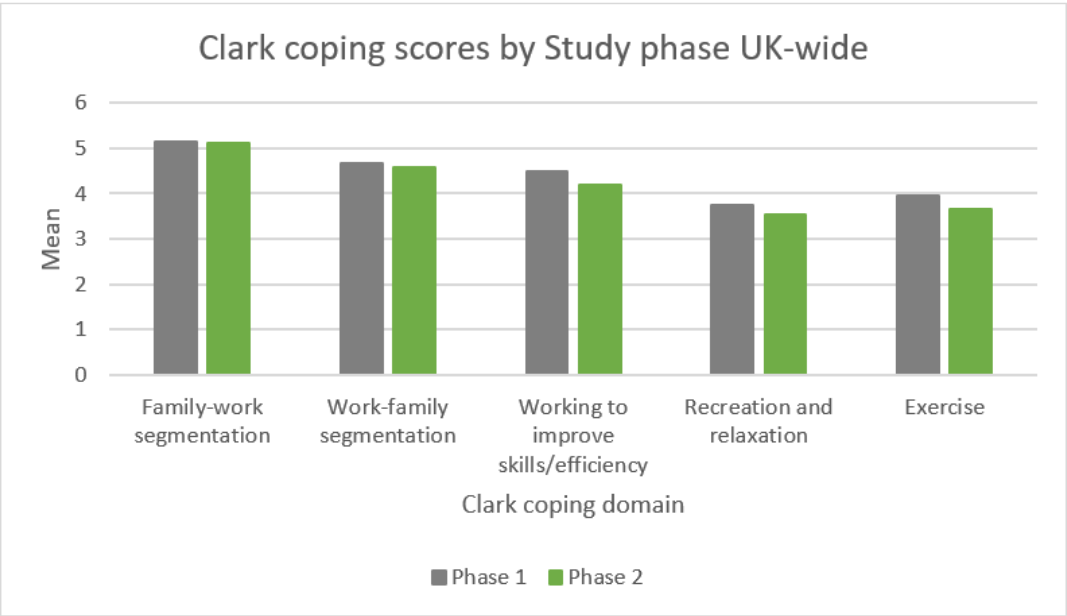
UK-wide, there seemed to be **an overall decrease in the use of positive coping strategies and an increase in the use of negative coping strategies from Phase 1 to Phase 2 of the study**, as shown in Figure 3.13. A multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status, showed that the decrease in respondents' use of active coping, planning, positive reframing, acceptance and emotional support was statistically significant; and the increase in the use of venting, substance use, behavioural disengagement and self-blame was also statistically significant. The use of instrumental support as a coping strategy remained unchanged from Phase 1 to Phase 2 of the study.

Figure 3.13: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)



Looking at Clark et al.'s coping strategies, a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed a **significant decrease in respondents' use of work-family segmentation, working to improve skills/efficiency, recreation and relaxation, and exercise from Phase 1 to Phase 2 of the study**. There was no significant change in respondents' use of family-work segmentation (see Figure 3.14).

Figure 3.14: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)



4. Discussion: Interpreting the Main Messages

Main Messages

The results from the second survey period are drawn from UK-wide health and social care worker responses, from the beginning of November 2020 until the end of January 2021, at a time when normal 'winter pressures' were usurped by a surge in COVID-19 transmission rates, resulting in more hospital admissions, more ventilated patients, more admissions to Intensive Care Units and sadly, more deaths. This context placed greater pressures on the health and social care workforce (The Conversation, 9th December 2020). Reports of the extent of pressures included doubling of hospital admissions rates, which exceeded April 2020 pressures on acute services (The Guardian, 17th December 2020). This period of pressure on services was felt at varying levels across the UK and the four countries, with a range of measures in place to 'Protect the NHS' including variable lockdown rules, with intense political debate about how to manage 'Christmas' in the middle of a pandemic. Whilst this was going on, the health and social care workforce continued to work and provide services to the most vulnerable populations. Our study, amongst others (McFadden et al., 2021; Ayling et al., 2020; Greenberg et al., 2020) sought to measure the impact of working in health and social care during the pandemic, and to provide evidence-based insights to wellbeing and coping levels. Despite the pressures that are well documented, our survey during May-July 2020 received 3290 responses, and November to end of January received 3499 responses. This study attempts to inform employers, regulators, policy makers and professional bodies about what the workforce impact has been and what it will need to recover from the sustained period of pressures during this pandemic period. The results also provide insights into how learning may be applied for workforce preparation for service as usual periods, and preparation for future pandemics or disasters. Critical to our reporting of the results is the extent that findings are expected, and a normal reaction to extreme pressures, and to what extent the results are indicating concerning levels of wellbeing and the need for therapeutic interventions to manage burnout and psychological distress in the workforce.

COVID-19 Impact on Service Pressures

We have heard anecdotally that service pressures have impacted on levels of stress and wellbeing of the workforce, but now our study findings show the extent of this across a range of important areas, as evidenced in the tables and figures in this report. Although pressures were not uniformly felt, the variation was categorised into three groups. The majority of respondents indicated high levels of impact on their services and were either overwhelmed (47%) or their service was impacted but not significantly (49%) and only a small number of respondents (4%) said their services were not impacted at all. Those indirectly affected by pressures reported vicarious impact through qualitative examples of observing impact on service users/patients, or by the impact on their wellbeing as indicated in the quantitative results. The occupational groups most impacted were nursing (59.2%) and social work (61.3%) which provides evidence relating to pressures in these sectors that we know existed long before the COVID-19 pandemic. The over-riding themes arising from qualitative responses remained consistent between the two data collection points, and were (1) changing conditions, (2) connection with co-workers and employers, and (3) communication. These three critical areas remain central to workforce wellbeing, as getting communication frequency and precision right has a direct impact on staff wellbeing. There were many accounts of email overload, and misdirected guidance during both survey periods, while some employers tended to work harder to ensure communication was proportionate and relevant. Connection with service users/patients and colleagues remains

paramount, showing compassion and concern for service users/patients and colleagues. This is evidenced in the qualitative results we have shared, as well as the lower client-related burnout levels reported, relative to personal and work-related burnout.

Work-Related Quality of Life

Work-related quality of life results provide insights into several areas, including stress, control, working conditions, home-work interface and job and career satisfaction, which were evidentially impacted by levels of service pressures. Lower quality of working life was evidenced for those who felt overwhelmed by increased pressures, and scores for those who felt impacted but not significantly, or those who felt no impact, were higher. Higher scores indicate better quality of life across all work-related quality of life domains, but stress at work is reverse scored, so lower stress scores indicate higher stress at work. Stress levels were high for all occupational groups, both in the May - July 2020 and the November - January 2021 surveys. Additionally, there was a decrease in all the work-related quality of life domains between the two survey timepoints.

Conversely, those not impacted by the pandemic have higher work-related quality of life scores in all areas, except for home-work interface. This could indicate the general population impact of COVID-19, and changes to normal routines, such as caring responsibilities which changed rapidly due to the pandemic for many respondents at both survey data collection points when most said they were caring for children or parents.

Wellbeing

Overall wellbeing has decreased across all occupational groups from the first survey. During May - July 2020, we reported that the average wellbeing scores were below population norms and during the second survey period, they fell further. Wellbeing scores indicate an increase in the levels of depression and anxiety, which increased from 9% of respondents in the 'likely' category and 33% in the 'possible' category in the May - July 2020 survey, to 18% in the 'likely' and a further 22% in the 'possible' category in the November - January 2021 survey.

When we consider the details of the questions respondents were answering in relation to their wellbeing, we get a real sense of perspective of their mental wellbeing. For example, consider the following items that respondents were asked to rate:

I've been feeling optimistic about the future.

I've been feeling useful.

I've been feeling relaxed.

I've been dealing with problems well.

I've been thinking clearly.

I've been feeling close to other people.

I've been able to make up my own mind about things.

The items were rated on a five-point Likert scale as follows: 1 = None of the time, 2 = Rarely, 3 = Some of the time, 4 = Often, and 5 = All of the time. The Health Survey for England found population norms to be 23.6. Individuals who score between 7-17 are at a risk of probable depression or anxiety due to the selection of low scores (most in the 'None of the time' or 'Rarely' categories), and those who score

between 18-20 have possible depression or anxiety and have likely selected occasional 3's but mainly 2's. It is understandable that wellbeing levels were at their lowest in those who indicated their services were overwhelmed by increased pressures. Analysis of the qualitative data also confirmed reduced wellbeing, making this the main recurring message during the second phase of the study.

Coping Mechanisms

Coping methods were analysed using regression analysis to ascertain which coping factors predicted better wellbeing and work-related quality of life scores. Positive coping strategies (e.g., active coping, positive reframing, acceptance, exercise) were associated with higher mental wellbeing, better quality of working life and lower burnout scores. Negative coping strategies (e.g., venting, substance use, self-blame) were associated with lower mental wellbeing, worse quality of working life and higher burnout scores. Ways of coping changed between the first and second surveys. Respondents appeared to be using positive coping strategies less and negative coping strategies more in the second phase. (Multiple regression results are presented in Appendix 8). This change of coping methods may be related to fatigue and exhaustion, as indicated in the qualitative results and may also be considered in the context of classic stress and coping theory. Lazarus (1991) describes emotion and adaptation, in terms of primary and secondary appraisal of a stressful event. Primary appraisal includes individual relevance and ego involvement, and secondary appraisal involves blame, responsibility and coping potential. Coping is therefore based on cognitive appraisal of the stressor, and is conceptualised as a coping *process*, defined by Folkman and Lazarus (1980, p. 223) as "cognitive and behavioural efforts made to master, tolerate or reduce external and internal demands, and conflicts amongst them". A "process of coping" conceptualises coping methods as changing, adapting and having differing sequencing, over time, with potential for positive or negative trajectories dependent on risk and protective factors available to individuals.

Burnout and Intention to Leave

We thought it was relevant to use the Copenhagen Burnout Inventory, due to the way in which burnout is segmented into personal, work-related and client-related burnout. This was especially true, due to the nature of the pandemic, impacting on the lives of the general population as well as the workforce. There was a sense of shock by the rapid changes to all areas of life, and therefore a 'shared traumatic reality' as described by Dekel and Baum (2010), that was inescapable in personal as well as work life for the health and social care workforce.

We found that respondents who were experiencing high or severe levels of personal burnout were very likely to report having considered changing their employer since the start of the pandemic for two specific reasons: 1) the job being very stressful and 2) the job impacting on respondents' health and wellbeing. Those experiencing low levels of personal burnout were less likely to have considered changing their employer for these reasons. The same was found for work-related burnout. In relation to client-related burnout, respondents experiencing high/severe levels were very likely to report having considered changing their employer because the job was impacting upon their health and wellbeing. Those with low levels of client-related burnout were less likely to have considered changing their employer for this reason.

Implications

A systems level approach is required to support the workforce to *rebuild, re-set and recover* from the impact of prolonged exposure to work related job pressures due to the pandemic. This requires individual, team, organizational and policy level wellbeing interventions. Learning from this period can be applied to 'business as usual' service delivery periods, and for planning for future pandemics or disasters.

4.1 Limitations and Strengths

This was a cross-sectional survey based on a convenience sample of health and social care workers and therefore the results cannot be interpreted as being representative of all health and social care workers in the UK. There was also an uneven distribution of responses across the four UK countries and across the work settings and types, so the results cannot be considered representative across countries nor occupational groups or types of employers. Another limitation associated with the convenience sample for the survey is that some participants may have been motivated to complete the survey due to personal bias or specific negative/positive experiences, which could potentially skew the results. It is also important to note that any comparisons between Phase 1 (May – July 2020) and Phase 2 (current survey) of the study and conclusions drawn from these are tentative, as the two samples consisted of different individuals (although some may have been the same).

However, there are several strengths in this study, such as (1) data is being collected in 'real time' during pre-defined periods of the COVID-19 pandemic and (2) levels of response have been consistently very good in both Phases of the study, and (3) whilst the study results cannot be generalised, results are a snap shot in time provided by respondents, and therefore this data has its own value. A further strength (4), is that the study is UK wide and cross disciplinary, allowing statistical comparison across countries and disciplines to be made. Finally, (5) the data has been analysed through the lens of 'good practice recommendations' which enables the voice of participants to shape key messages to employers, about what might improve their working conditions, not just in pandemic or disaster periods, but also in non-pandemic times.

4.3 Good Practice Recommendations: November 2020 – January 2021 Survey

The 15 Good Practice Recommendations from Survey 1 were reviewed in the context of findings from Survey 2, in the second phase of this study. These Good Practice Recommendations are organised under the main themes that emerged from the analysis of the data: Changing Conditions, Connections and Communication. They are then further categorised at an individual, organisational and policy level.

4.3.1 CHANGING CONDITIONS

Organisational and Individual Level

1. HEALTH AND SAFETY: Our first survey noted that for those staff who need to be in the workplace, social distancing, hand washing, and appropriate Personal Protective Equipment (PPE) should be available. We are now at a time where other virus risk, such as flu, is being considered as also possible to emerge in the coming months. We suggest that employers will need to help alleviate concerns about spreading infection in workplaces and through contact with members of the public and patients/service users. Workplaces need to ensure that there

are plans for any unforeseen developments and possible crises, such as fire and flood, as well as national or local outbreaks of viral infections.

Organisational Level

2. PUTTING INTO PRACTICE THE ADVANTAGES OF MORE FLEXIBILITY IN EMPLOYMENT: During the pandemic most employers have provided, as far as possible, increased flexibility around working hours, location of working, while recognising additional childcare or other caring responsibilities of individual members of staff to support the workforce. For some, they were not easy to provide, but our surveys have revealed that flexibility was valued when it could be offered. As the level of the pandemic subsides, we hope, staff will need to feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about long-term flexibilities must now start to happen at pace.

3. TRAINING FOR REDEPLOYMENT, SKILL MIX AND SKILL ACQUISITION: We found that training and development to equip staff with the ability to, where possible, perform multiple or new roles, were under-developed and suggest that this becomes a matter for employers to prioritise as a strategy. This will need to involve employers, professional bodies, regulators, workplace unions, educational and training bodies, and service users and patient groups. Good evidence about what sort of training and development works well would be further helpful.

4. EQUITY IN HOME WORKING WHEN POSSIBLE: We noted that policies about working from home (if appropriate) should be fair and seen to be fair in our first report. Home working will need to be considered as well as office or care/treatment settings' impact on outcomes and productivity. Our survey identified a risk that the connections with managers, supervisors and colleagues were declining in amount and quality when the initial novelty of home working wore off. Employers will need to address not only choices among individual workers but also the team or work unit effect. This will apply to managers as well as professionals working in desk or face to face patient/service user engagement. Our findings of increasing levels of anxiety and depression may impact on staff willingness to go back to offices and attend in person large meetings as well as individual face to face encounters. Human Resources (HR) staff will need to support managers in addressing a positive return of being physically present at work where necessary.

Policy and Organisational Level

5. TERMS AND CONDITIONS GENERAL: We noted in our first report that employers in the health and social care sector should address the coverage of Statutory Sick Pay for their staff. This recommendation stands.

6. FLATTER HIERARCHIES: In our first survey report we called for research on patient and service user outcomes to see whether greater autonomy and flatter hierarchies make a positive difference to service quality. We suggest that local forum and national planning consider the right balance between clinical or professional judgment and guidelines. We recommend that any inquiry into the management of the pandemic consider these questions.

7. STAFF WELLBEING AND RETENTION: Our second survey confirms that a large proportion of staff are experiencing moderate to severe levels of burnout with a need for time to recover from a prolonged period of unprecedented stress and pressure. Taking holidays, being

recognised and feeling appreciated will remain important. This survey indicates that the setting up of wellbeing services has been appreciated and their continuance should be assured if they are proving promising. There is a high risk that some staff will leave prematurely owing to stress or reduced work-based quality of life. This may be permanent but there would seem room for employers to remain in touch with such staff and to offer 'exit interviews' or similar in which other alternatives to exit could be mooted.

4.3.2 CONNECTIONS

Organisational and Individual Level

1. ANNUAL LEAVE AND REGULAR BREAKS: Managers need to ensure, where possible, that staff are supported and encouraged to take leave and breaks, and where possible, arrange for their work and responsibilities to be covered.

2. CONNECTION: There should be development of evidence-based good practice guidance on communication that meets the broad range of health and social care services by national bodies with strong input from the frontline. Our survey was electronic, and we recognise that staff with limited IT skills may need support in developing online communication skills – this could be audited by employers.

Organisational Level

3. COMMUNICATION: There is room now to consider corporate and employer communications – our findings show that these are appreciated but timing and amount can seem onerous.

4. MANAGEMENT VISIBILITY: Managers should be visible, either in person (if possible) or virtually, so that workers feel they are valued and that work pressures are understood. They, the managers, should also be valued explicitly.

5. SUPPORTIVE SUPERVISION: Staff concerns need to be addressed whether they are individual concerns or those that can be discussed in peer or group supervision. This point applies to managers and those who supervise managers.

4.3.3 COMMUNICATION

Organisational and Individual Level

1. Respondents provided several accounts of employers and managers signposting staff to organisational supports, counselling, mentoring or coaching supports, or Occupational Health (if required). These resources appear to need sustaining if they are to enable staff to manage the aftermath and emotional impact of working during the pandemic and its legacy.

2. Team support and camaraderie are noted by the workforce as critical to their coping and wellbeing. Ideas about positive team culture and climate should be nurtured and cultivated to provide support to all team members including managers whose needs appear often over-looked but who, our survey shows, have been under considerable stress themselves.

Policy and Organisational Level

3. The unprecedented demand on the health and social care sectors has shone a light on the chronic under-resourcing of staff and infrastructure. Concerted efforts are required to make work within the Nursing, Midwifery, AHP, social care and social work sectors an attractive option, with pay and working conditions requiring sustained attention.

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6. Appendices

LIST OF FIGURES

LIST OF TABLES

Appendix 1: Weighting Representativeness for Country, Region and Occupation

Given the uneven representation of participants from across the four countries and five occupational disciplines in the sample, a two-factor weighting by occupation and region (i.e., country of work) procedure was utilised. Comparisons by occupation were weighted by region only and comparisons by region were weighted by occupation only.

Estimating the true population

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

Social Work

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

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

http://www.socialcaredata.wales/IAS/login?ReturnUrl=%2fIAS%2fresource%2fview%3fresou%20rceId%3d2447&resourceId=2447

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

https://niscc.info/app/uploads/2020/06/20200729_Final_AnnReport2019-20_Laid-04-Aug-2020_SubmitttedToNIAO_AMcK.pdf

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

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

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

Social Care

Northern Ireland is the only region for which we were able to obtain a comprehensive estimate of social care employment. NISCC report 37,779 social care workers, compared to 6,357 social workers (a ratio of 5.94). We estimated social care numbers in all other regions using the social work estimates for the region and multiplying by this ratio. **This assumes the ratio of social workers to social care workers is homogenous across the UK and that NISCC's reporting accurately captures this ratio.**

Nurses and Midwives

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

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

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

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

Table A1.1: Regional aggregation for NHS Digital

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

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

To estimate a breakdown in the smaller regions used in the survey, we used the ratio of adult social services social workers in the regions. For example, of the combined 2,915 social workers in Yorkshire and North-East, 1,850 are in Yorkshire (63%). **We assume the same distribution for nurses and midwives in these regions.** Note that effect of this assumption on the final weighting is quite small, as these regions are recombined and further combined with other regions in order to adjust for very small survey responses in sub-categories (further details below).

Allied Health Professionals

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

https://www.hcpc-uk.org/about-us/insights-and-data/the-register/

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

Regional Aggregation for Weighting

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

Table A1.2: Regions for Calculation of Weights

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

Table A1.3: Final Estimated Population and Distribution

	London	South	Midlands & East	North & Yorkshire	England Total	Scotland	Wales	Northern Ireland	Total
Nursing	91845.6	117972.1	147743.6	167606.8	525168.0	66084.0	34661.0	23953.0	649866.0
	5.18%	6.66%	8.34%	9.46%	29.63%	3.73%	1.96%	1.35%	36.67%
Midwifery	5760.5	7327.6	9100.5	9036.6	31225.2	3360.0	1663.0	1212.0	37460.2
	0.33%	0.41%	0.51%	0.51%	1.76%	0.19%	0.09%	0.07%	2.11%
Allied Health Professional	37638.1	47468.8	60194.7	69215.4	214517.0	17624.0	11819.0	8093.0	252053.0
	2.12%	2.68%	3.40%	3.91%	12.10%	0.99%	0.67%	0.46%	14.22%
Social Care Worker	102452.3	127336.0	163202.9	190660.8	583652.0	63274.0	37220.4	37779.0	721925.4
	5.78%	7.19%	9.21%	10.76%	32.93%	3.57%	2.10%	2.13%	40.74%
Social Worker	2985.0	3710.0	4755.0	5555.0	17005.0	10647.0	6263.0	6357.0	40272.0
	0.97%	1.21%	1.55%	1.81%	5.54%	0.60%	0.35%	0.36%	6.85%
TOTAL[4]	**254130.4**	**320506.5**	**406431.0**	**467338.1**	1448406.0	**157629.0**	**89963.4**	**76182.0**	**1772180.4**

[4] The population estimates used in this report are the same as those used in the first report, as we found no evidence of major changes in staffing levels between May and November of 2020.

Appendix 2: Descriptive Results (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of respondents' demographic and work-related characteristics. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**. The reported percentages are valid percentages, as some participants had missing data on specific questions. Percentages may not add up to 100% due to rounding.

A2.1 Country and Occupation of Respondents

Summary (Weighted results):

Not reported

Summary (Unweighted results):

Just over one third of respondents (n = 1189, 34.0%) indicated that they currently work in Northern Ireland and almost a third (n = 1095, 31.3%) work in Wales. Another 21.6% (n = 756) work in England, with respondents working in Scotland representing the smallest proportion of all survey respondents (n = 459, 13.1%).

Most of the respondents worked as social care workers (35.8%) and social workers (33.5%), followed by AHPs (18.2%) and nurses (10.3%). Midwives represented the smallest proportion of respondents (2.1%).

Figure A2.1: Country of Respondents (Unweighted)

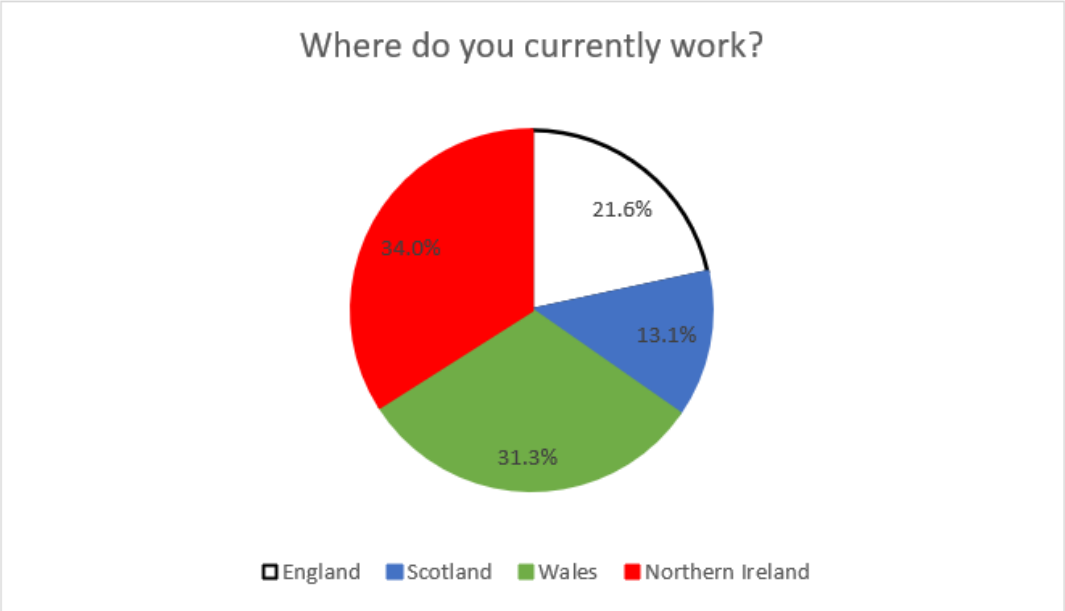

Table A2.1: Country of Respondents (Unweighted)

Country	n (%)
England	756 (21.6%)
Scotland	459 (13.1%)
Wales	1095 (31.3%)
Northern Ireland	1189 (34.0%)
Total	**3499 (100%)**

Figure A2.2: Occupation of Respondents (Unweighted)

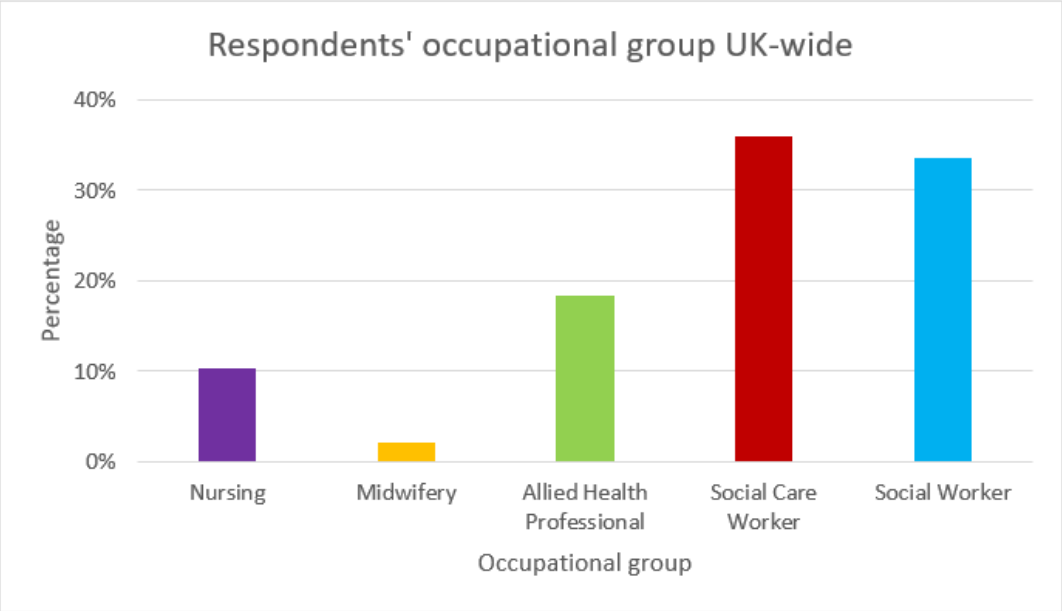

Table A2.2: Occupation of Respondents (Unweighted)

Occupation	UK-Wide n (%)
Nursing	361 (10.3%)
Midwifery	75 (2.1%)
AHP	638 (18.2%)
Social Care Worker	1253 (35.8%)
Social Worker	1172 (33.5%)
Total	**3499 (100%)**

Figure A2.3: Country of Respondents by Occupation (Unweighted)

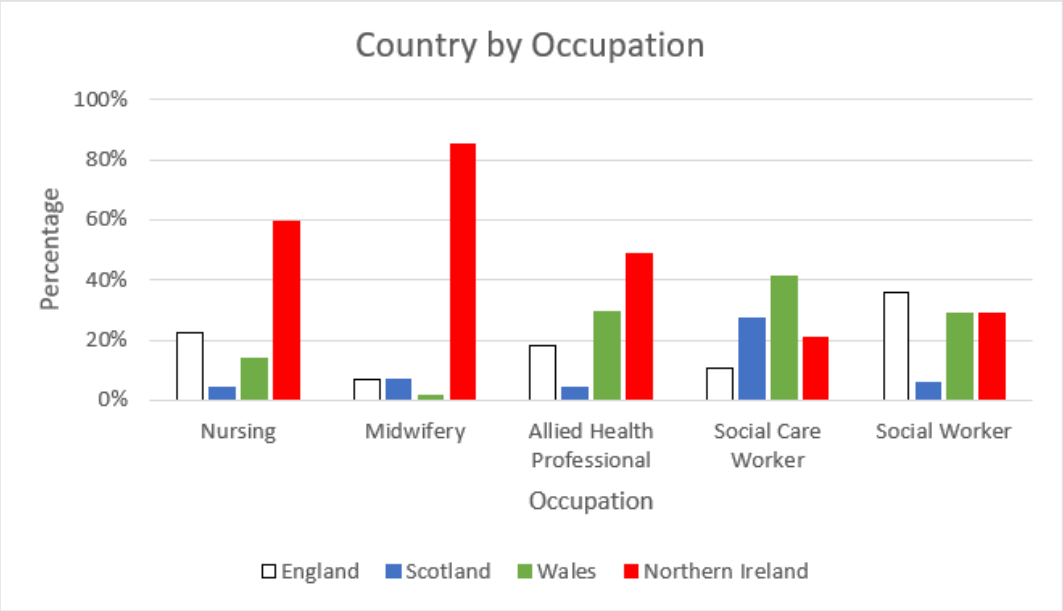

Table A2.3: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	81 (22.4%)	16 (4.4%)	50 (13.9%)	214 (59.3%)	**361 (100%)**
Midwifery	5 (6.7%)	5 (6.7%)	1 (1.3%)	64 (85.3%)	**75 (100%)**
AHP	114 (17.9%)	27 (4.2%)	186 (29.2%)	311 (48.7%)	**638 (100%)**
Social Care Worker	133 (10.6%)	340 (27.1%)	517 (41.3%)	263 (21.0%)	**1253 (100%)**
Social Worker	423 (36.1%)	71 (6.1%)	341 (29.1%)	337 (28.8%)	**1172 (100%)**

A2.2 Sex of Respondents

Summary (Weighted results):

The vast majority of respondents were female, with a similar sex distribution across countries. All midwifery respondents were female. AHPs had the highest proportion of males (15.1%).

Summary (Unweighted results):

The vast majority of respondents were female, with a similar sex distribution across countries. All midwifery respondents were female. Social workers had the highest proportion of males (14.4%).

Figure A2.4: Sex by Country (Weighted)

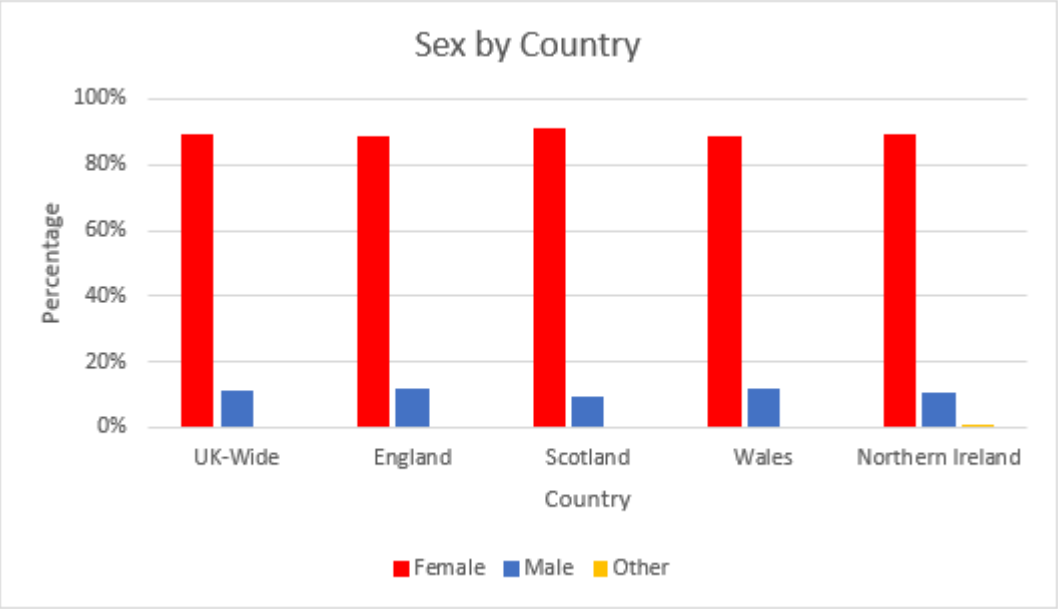

Figure A2.5: Sex by Country (Unweighted)

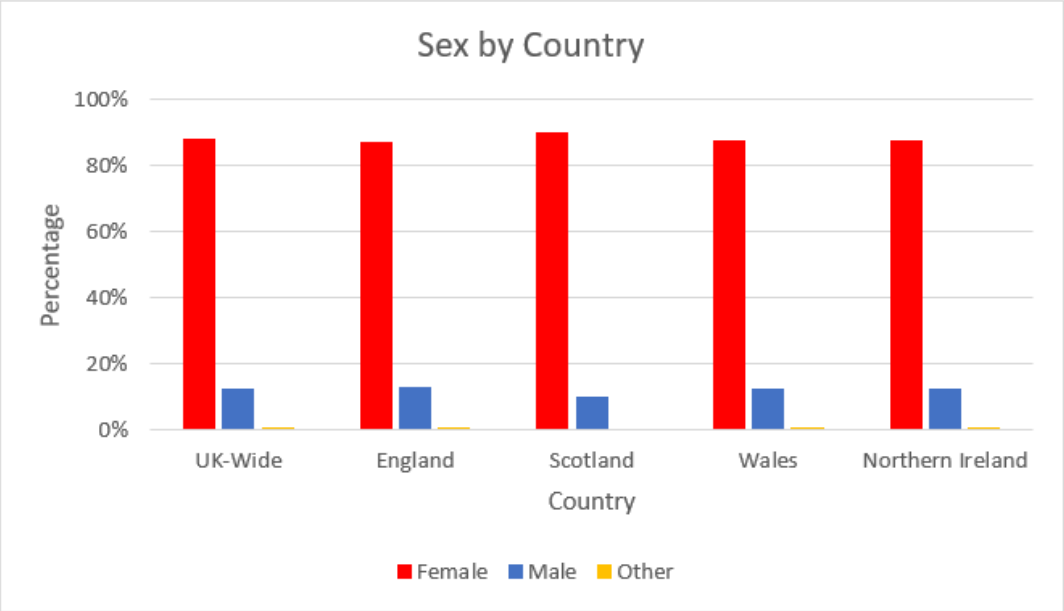

Table A2.4: Sex by Country (Weighted)

	Country				
Sex	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Female	88.8%	88.2%	91.1%	88.2%	89.2%
Male	11.2%	11.8%	8.9%	11.8%	10.5%
Other	0.0%	0.0%	0.0%	0.0%	0.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.5: Sex by Country (Unweighted)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	3072 (87.8%)	659 (87.2%)	413 (90.0%)	958 (87.6%)	1042 (87.6%)
Male	423 (12.1%)	96 (12.7%)	46 (10.0%)	135 (12.3%)	146 (12.3%)
Other	3 (0.1%)	1 (0.1%)	0 (0.0%)	1 (0.1%)	1 (0.1%)
Total	**3498 (100%)**	**756 (100%)**	**459 (100%)**	**1094 (100%)**	**1189 (100%)**

Figure A2.6: Sex by Occupation (Weighted)

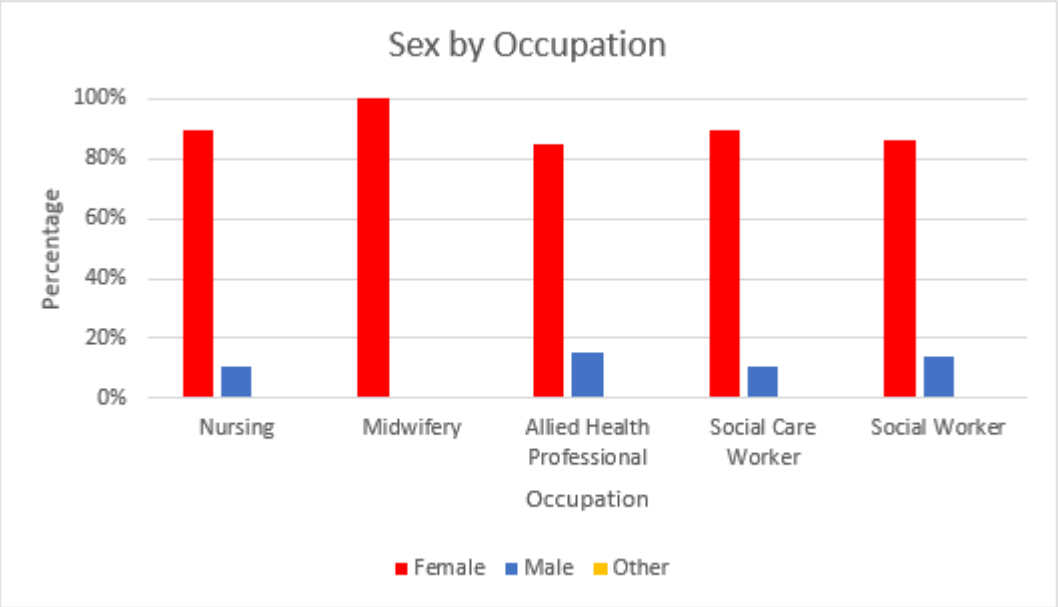

Figure A2.7: Sex by Occupation (Unweighted)

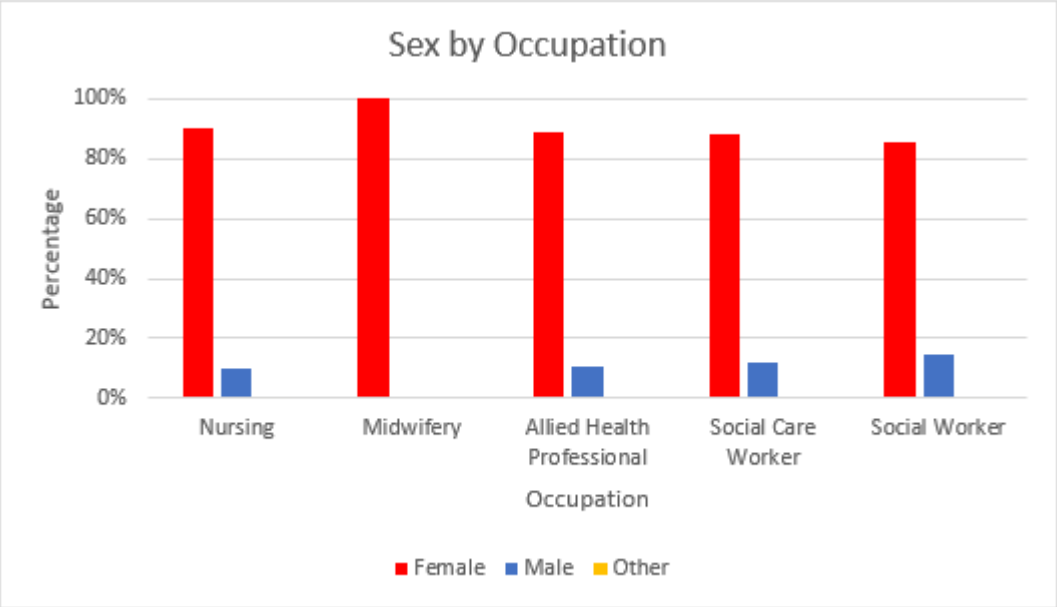

Table A2.6: Sex by Occupation (Weighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	89.7%	10.3%	0.0%	**100%**
Midwifery	100.0%	0.0%	0.0%	**100%**
AHP	84.9%	15.1%	0.0%	**100%**
Social Care Worker	89.8%	10.2%	0.0%	**100%**
Social Worker	86.3%	13.6%	0.1%	**100%**

Table A2.7: Sex by Occupation (Unweighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	325 (90.0%)	35 (9.7%)	1 (0.3%)	**361 (100%)**
Midwifery	75 (100.0%)	0 (0.0%)	0 (0.0%)	**75 (100%)**
AHP	569 (89.2%)	69 (10.8%)	0 (0.0%)	**638 (100%)**
Social Care Worker	1102 (88.0%)	150 (12.0%)	0 (0.0%)	**1252 (100%)**
Social Worker	1001 (85.4%)	169 (14.4%)	2 (0.2%)	**1172 (100%)**

A2.3 Age of Respondents

Summary (Weighted results):

The majority of respondents were aged 30-59 years, with only a small proportion from the 16-19 and the 66+ age groups. The nurses in the 16-19 age group were most likely students on placements. Scotland had the highest proportion of the 50-59 year-old respondents (40.9%).

Summary (Unweighted results):

The majority of respondents were aged 30-59 years, with only a small proportion from the 16-19 and the 66+ age groups. The nurses, AHPs and social workers in the 16-19 age group were most likely students on placements. Scotland had the highest proportion of the 50-59 year-old respondents (39.4%).

Figure A2.8: Age of Respondents by Country (Weighted)

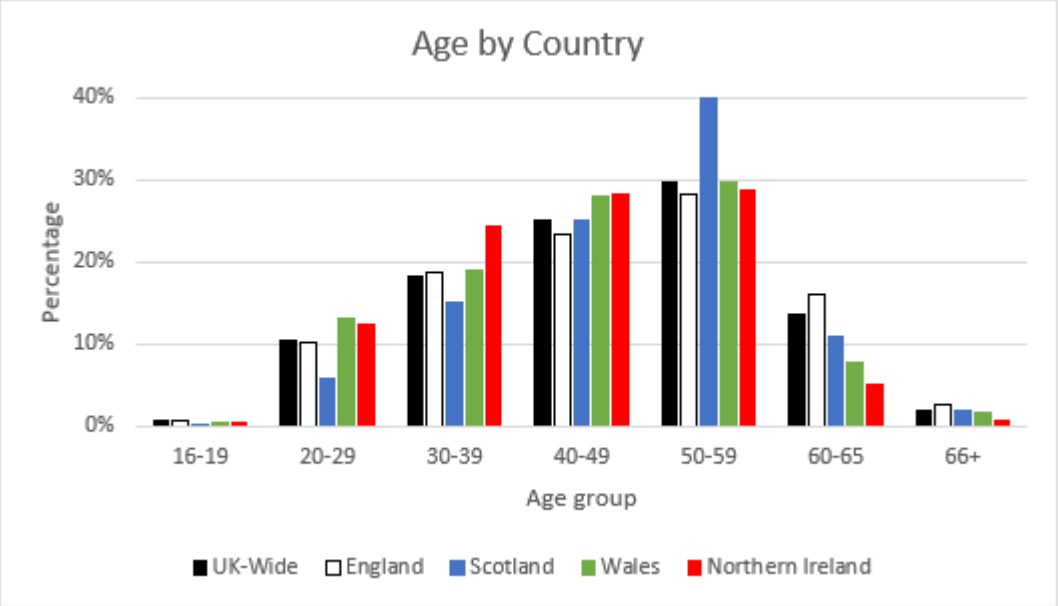

Figure A2.9: Age of Respondents by Country (Unweighted)

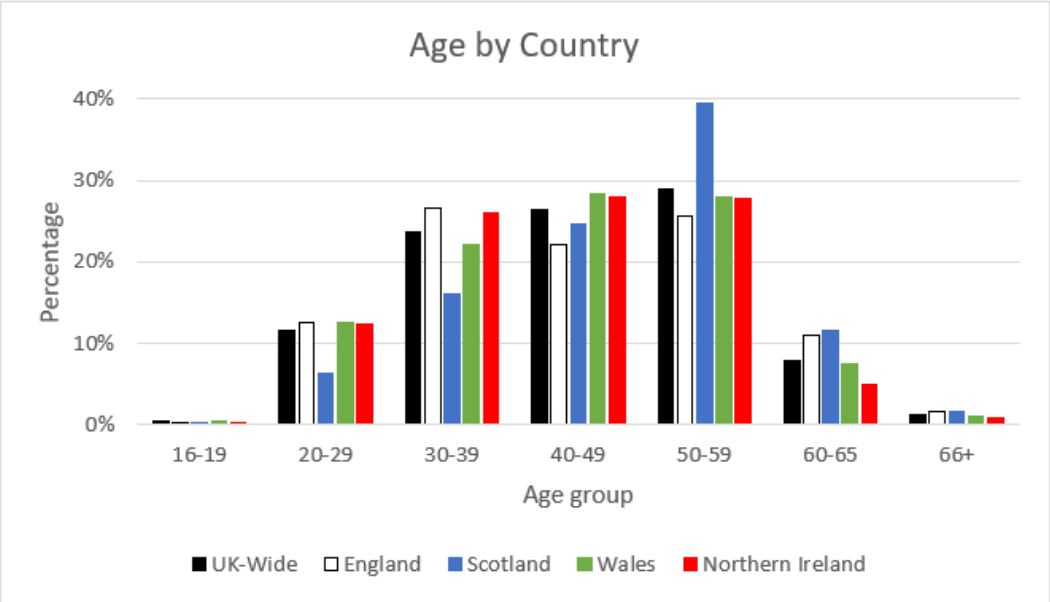

Table A2.8: Age of Respondents by Country (Weighted)

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-19	0.7%	0.8%	0.2%	0.4%	0.5%
20-29	10.4%	10.2%	5.8%	13.1%	12.3%
30-39	18.3%	18.7%	15.1%	19.1%	24.3%
40-49	25.2%	23.4%	25.2%	28.0%	28.2%
50-59	29.7%	28.2%	40.9%	29.8%	28.8%
60-65	13.7%	16.1%	11.0%	7.8%	5.1%
66+	2.0%	2.6%	1.9%	1.6%	0.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.9: Age of Respondents by Country (Unweighted)

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-19	13 (0.4%)	2 (0.3%)	1 (0.2%)	6 (0.5%)	4 (0.3%)
20-29	407 (11.6%)	95 (12.6%)	29 (6.3%)	137 (12.5%)	146 (12.3%)
30-39	827 (23.6%)	201 (26.6%)	74 (16.1%)	242 (22.1%)	310 (26.1%)
40-49	923 (26.4%)	168 (22.2%)	113 (24.6%)	310 (28.3%)	332 (27.9%)
50-59	1012 (28.9%)	194 (25.7%)	181 (39.4%)	307 (28.0%)	330 (27.8%)
60-65	275 (7.9%)	83 (11.0%)	53 (11.5%)	81 (7.4%)	58 (4.9%)
66+	42 (1.2%)	13 (1.7%)	8 (1.7%)	12 (1.1%)	9 (0.8%)
Total	**3499 (100%)**	**756 (100%)**	**459 (100%)**	**1095 (100%)**	**1189 (100%)**

Figure A2.10: Age of Respondents by Occupation (Weighted)

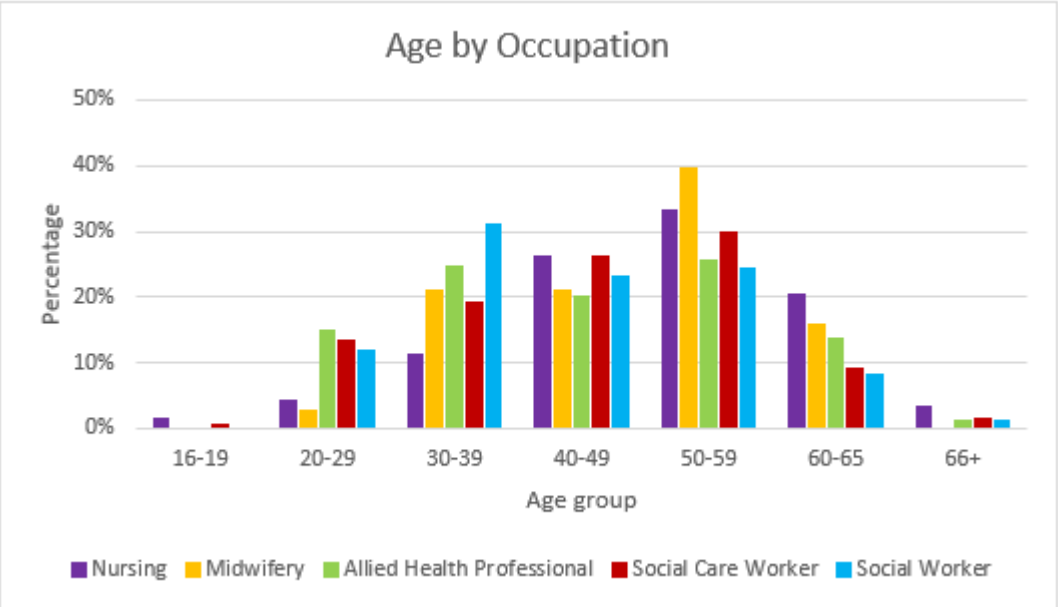

Figure A2.11: Age of Respondents by Occupation (Unweighted)

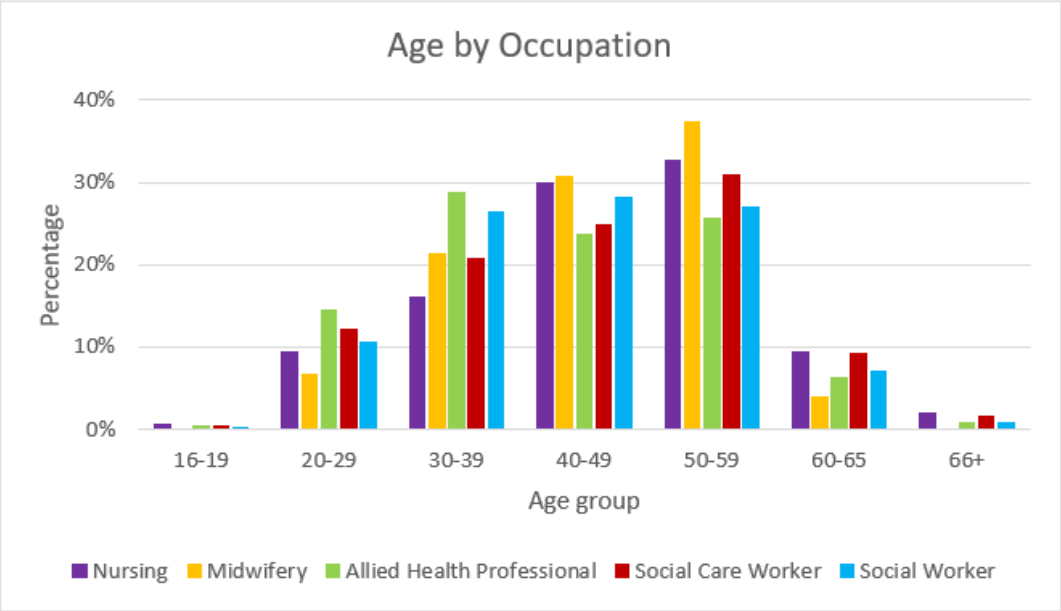

Table A2.10: Age of Respondents by Occupation (Weighted)

	Age group							
Occupation	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**	**Total**
Nursing	1.6%	4.3%	11.1%	26.3%	33.1%	20.3%	3.3%	**100%**
Midwifery	0.0%	2.6%	21.1%	21.1%	39.5%	15.8%	0.0%	**100%**
AHP	0.0%	14.8%	24.7%	20.1%	25.5%	13.8%	1.1%	**100%**
Social Care Worker	0.5%	13.5%	19.2%	26.2%	30.0%	9.0%	1.6%	**100%**
Social Worker	0.0%	12.0%	31.2%	23.2%	24.3%	8.1%	1.2%	**100%**

Table A2.11: Age of Respondents by Occupation (Unweighted)

	Age group							
Occupation	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**	**Total**
Nursing	2 (0.6%)	34 (9.4%)	58 (16.1%)	108 (29.9%)	118 (32.7%)	34 (9.4%)	7 (1.9%)	**361 (100%)**
Midwifery	0 (0.0%)	5 (6.7%)	16 (21.3%)	23 (30.7%)	28 (37.3%)	3 (4.0%)	0 (0.0%)	**75 (100%)**
AHP	3 (0.5%)	92 (14.4%)	183 (28.7%)	151 (23.7%)	164 (25.7%)	40 (6.3%)	5 (0.8%)	**638 (100%)**
Social Care Worker	6 (0.5%)	152 (12.1%)	261 (20.8%)	312 (24.9%)	387 (30.9%)	115 (9.2%)	20 (1.6%)	**1253 (100%)**
Social Worker	2 (0.2%)	124 (10.6%)	309 (26.4%)	329 (28.1%)	315 (26.9%)	83 (7.1%)	10 (0.9%)	**1172 (100%)**

A2.4 Ethnic Origin of Respondents

Summary (Weighted results):

The vast majority of respondents were of white ethnic origin. England was the most ethnically diverse country, with 11% of respondents identifying as not white. All midwives were of white ethnic origin and social workers were the most ethnically diverse occupational group, with 12.4% identifying as not white.

Summary (Unweighted results):

The vast majority of respondents were of white ethnic origin. England was the most ethnically diverse country, with 12.8% of respondents identifying as not white. All midwives were of white ethnic origin and social workers were the most ethnically diverse occupational group, with 6.6% identifying as not white.

Figure A2.12: Ethnic Origin of Respondents by Country (Weighted)

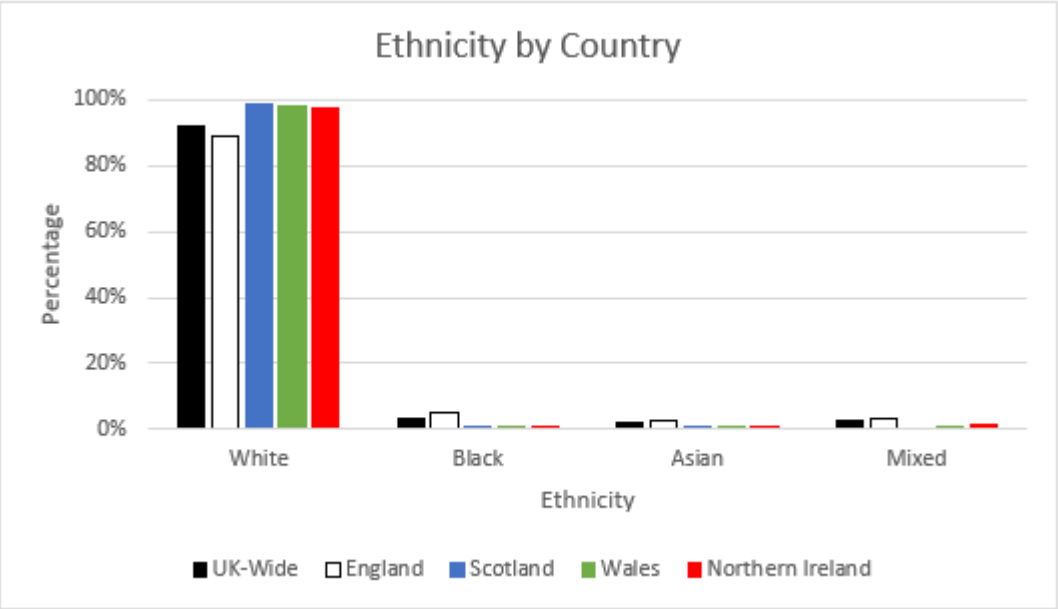

Figure A2.13: Ethnic Origin of Respondents by Country (Unweighted)

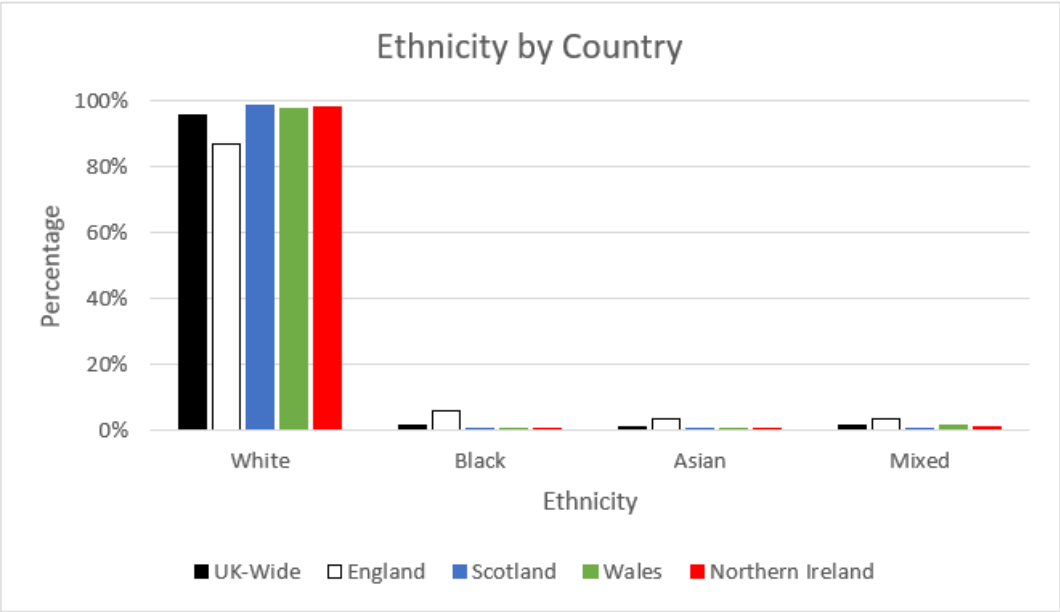

Table A2.12: Ethnic Origin of Respondents by Country (Weighted)

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	92.1%	89.0%	98.6%	98.1%	97.8%
Black	3.5%	5.2%	0.8%	0.4%	0.7%
Asian	2.0%	2.7%	0.6%	0.6%	0.3%
Mixed	2.4%	3.1%	0.0%	0.9%	1.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.13: Ethnic Origin of Respondents by Country (Unweighted)

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	3344 (95.8%)	659 (87.2%)	454 (98.9%)	1066 (97.6%)	1165 (98.3%)
Black	56 (1.6%)	44 (5.8%)	1 (0.2%)	6 (0.5%)	5 (0.4%)
Asian	34 (1.0%)	25 (3.3%)	3 (0.7%)	4 (0.4%)	2 (0.2%)
Mixed	58 (1.7%)	28 (3.7%)	1 (0.2%)	16 (1.5%)	13 (1.1%)
Total	**3492 (100%)**	**756 (100%)**	**459 (100%)**	**1092 (100%)**	**1185 (100%)**

Figure A2.14: Ethnic Origin of Respondents by Occupation (Weighted)

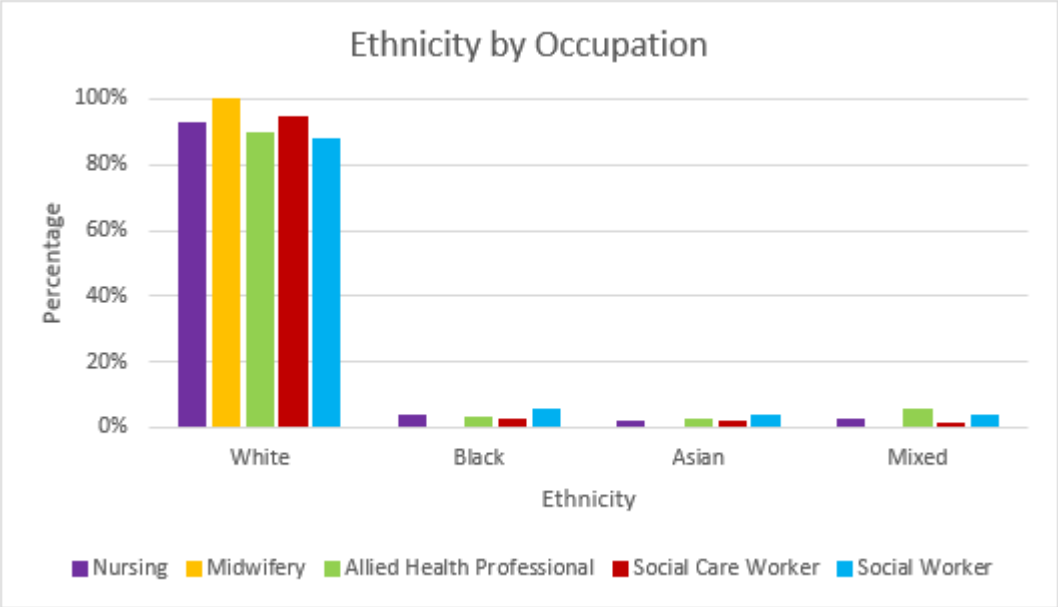

Figure A2.15: Ethnic Origin of Respondents by Occupation (Unweighted)

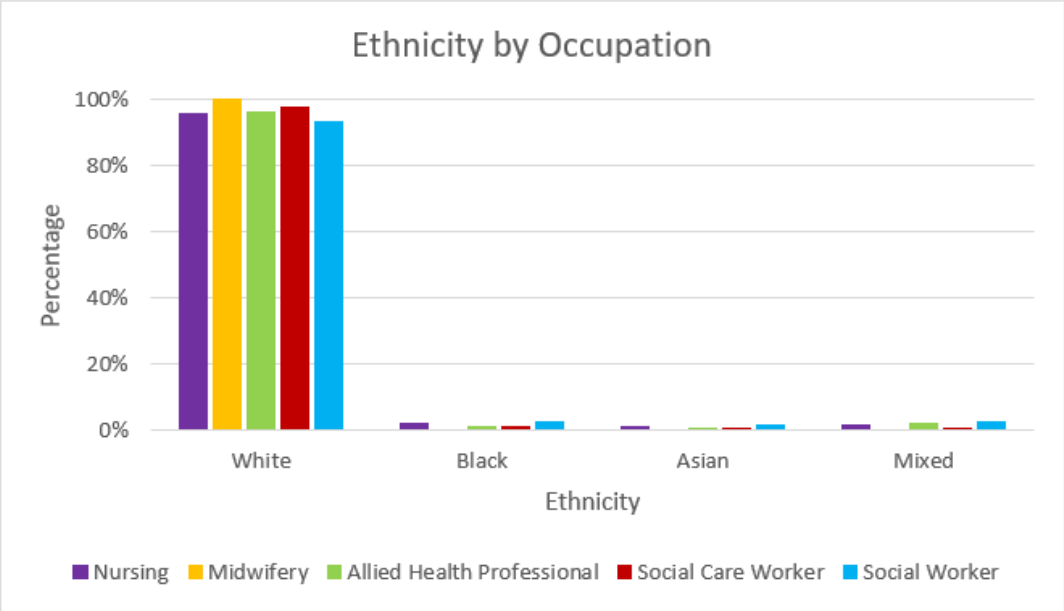

Table A2.14: Ethnic Origin of Respondents by Occupation (Weighted)

	Ethnicity				
Occupation	**White**	**Black**	**Asian**	**Mixed**	**Total**
Nursing	92.7%	3.3%	1.6%	2.4%	**100%**
Midwifery	100.0%	0.0%	0.0%	0.0%	**100%**
AHP	89.7%	3.1%	2.1%	5.2%	**100%**
Social Care Worker	94.7%	2.3%	1.9%	1.2%	**100%**
Social Worker	87.6%	5.3%	3.8%	3.3%	**100%**

Table A2.15: Ethnic Origin of Respondents by Occupation (Unweighted)

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	345 (95.6%)	7 (1.9%)	4 (1.1%)	5 (1.4%)	**361 (100%)**
Midwifery	75 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	**75 (100%)**
AHP	612 (96.2%)	6 (0.9%)	4 (0.6%)	14 (2.2%)	**636 (100%)**
Social Care Worker	1218 (97.5%)	12 (1.0%)	9 (0.7%)	10 (0.8%)	**1249 (100%)**
Social Worker	1094 (93.4%)	31 (2.6%)	17 (1.5%)	29 (2.5%)	**1171 (100%)**

A2.5 Respondents with a Disability

Summary (Weighted results):

England had the highest proportion of respondents with a disability (12.9%). Of the different professions, social care workers were the most likely ones to report having a disability (14.6%).

Summary (Unweighted results):

England had the highest proportion (13.6%) of respondents with a disability. Of the different professions, social workers (11.8%) were the most likely ones to report having a disability.

Figure A2.16: Disability by Country (Weighted)

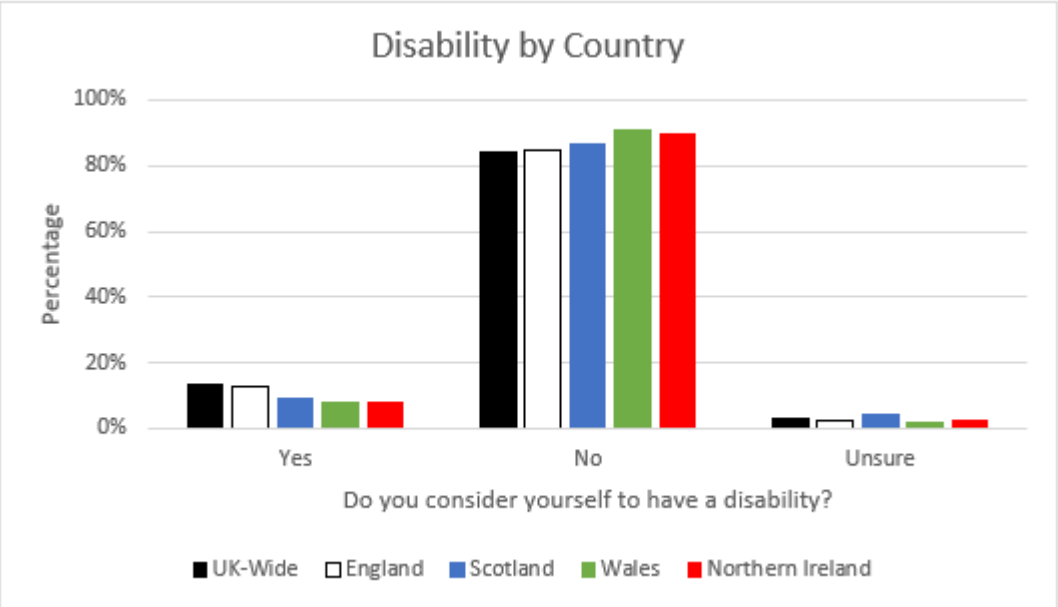

Figure A2.17: Disability by Country (Unweighted)

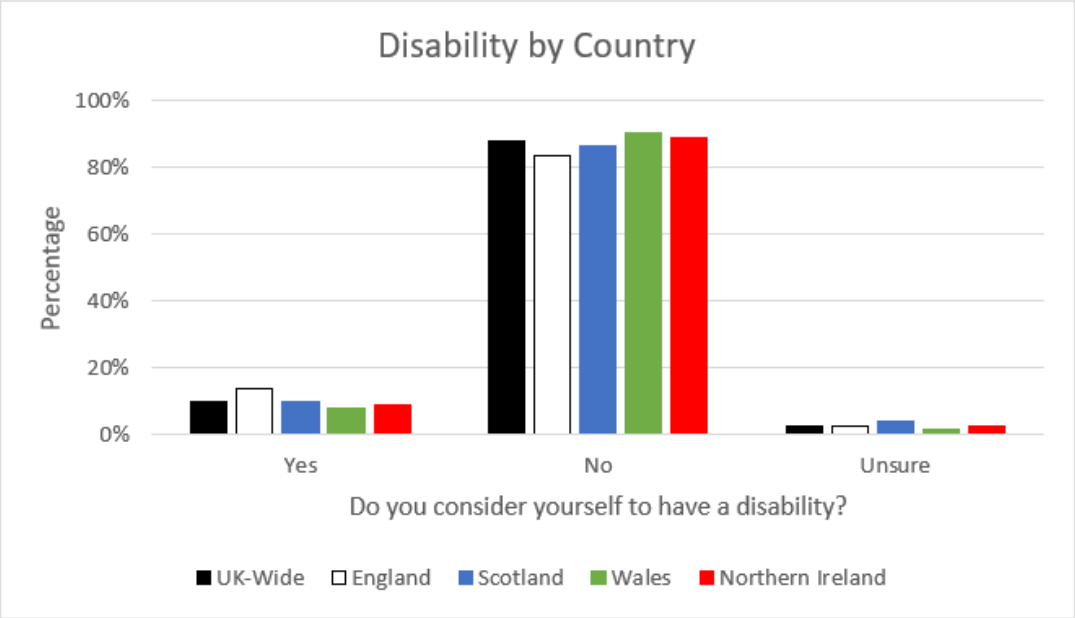

Table A2.16: Disability by Country (Weighted)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	13.3%	12.9%	9.2%	7.6%	8.0%
No	84.0%	85.0%	86.7%	90.8%	89.8%
Unsure	2.7%	2.1%	4.1%	1.6%	2.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.17: Disability by Country (Unweighted)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	305 (9.7%)	96 (13.6%)	39 (9.7%)	76 (7.7%)	94 (8.8%)
No	2778 (87.9%)	591 (83.8%)	347 (86.3%)	892 (90.6%)	948 (88.8%)
Unsure	76 (2.4%)	18 (2.6%)	16 (4.0%)	17 (1.7%)	25 (2.3%)
Total	**3159 (100%)**	**705 (100%)**	**402 (100%)**	**985 (100%)**	**1067 (100%)**

Figure A2.18: Disability by Occupation (Weighted)

Figure A2.19: Disability by Occupation (Unweighted)

Table A2.18: Disability by Occupation (Weighted)

	Do you consider yourself to have a disability?			
Occupation	**Yes**	**No**	**Unsure**	**Total**
Nursing	12.2%	86.9%	0.9%	**100%**
Midwifery	3.7%	96.3%	0.0%	**100%**
AHP	6.8%	91.1%	2.1%	**100%**
Social Care Worker	14.6%	81.2%	4.2%	**100%**
Social Worker	14.1%	83.2%	2.7%	**100%**

Table A2.19: Disability by Occupation (Unweighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	27 (8.5%)	284 (89.9%)	5 (1.6%)	**316 (100%)**
Midwifery	6 (8.8%)	62 (91.2%)	0 (0.0%)	**68 (100%)**
AHP	38 (6.6%)	531 (91.7%)	10 (1.7%)	**579 (100%)**
Social Care Worker	108 (9.6%)	986 (87.4%)	34 (3.0%)	**1128 (100%)**
Social Worker	126 (11.8%)	915 (85.7%)	27 (2.5%)	**1068 (100%)**

A2.6 Respondents' Relationship Status

Summary (Weighted results):

The majority of respondents reported being married.

Summary (Unweighted results):

The majority of respondents reported being married.

Figure A2.20: Relationship Status by Country (Weighted)

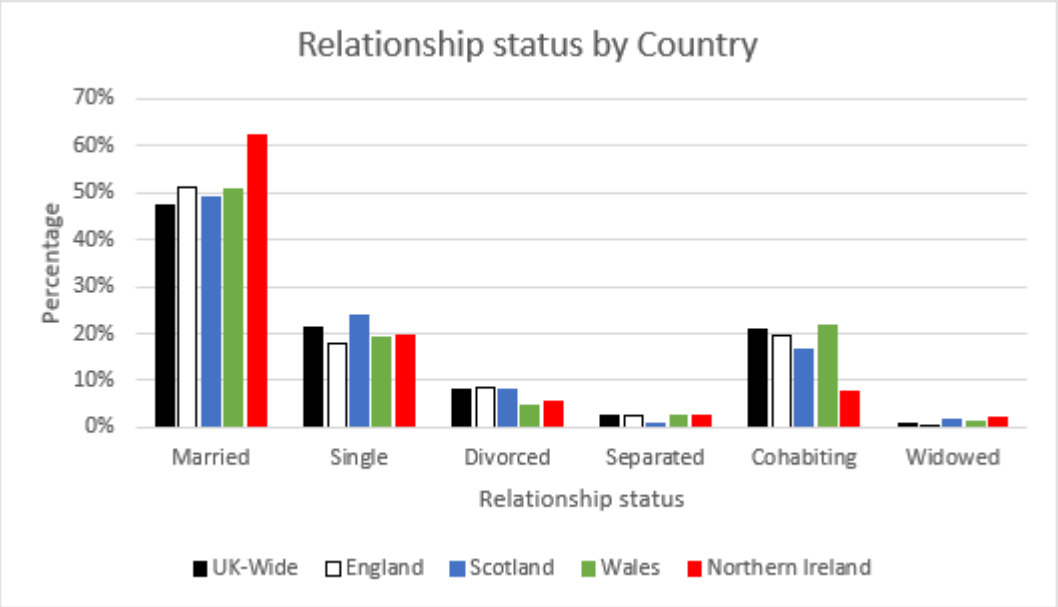

Figure A2.21: Relationship Status by Country (Unweighted)

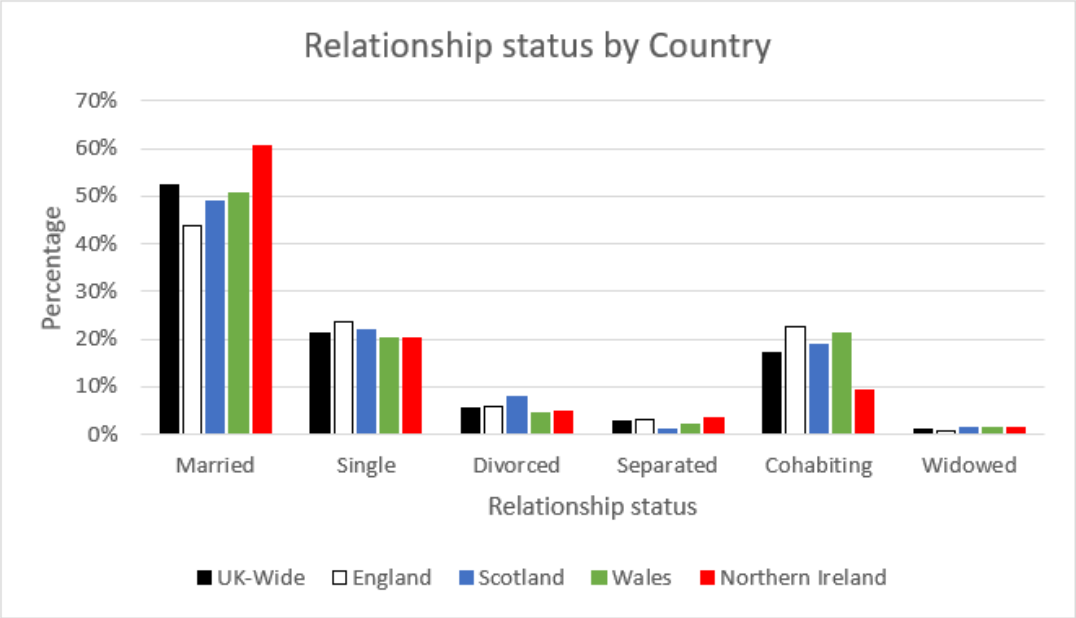

Table A2.20: Relationship Status by Country (Weighted)

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	47.2%	51.1%	49.0%	50.6%	62.5%
Single	21.1%	18.0%	24.0%	19.1%	19.5%
Divorced	7.9%	8.6%	8.0%	4.8%	5.4%
Separated	2.4%	2.6%	1.0%	2.4%	2.7%
Cohabiting	20.7%	19.4%	16.5%	21.8%	7.8%
Widowed	0.8%	0.3%	1.5%	1.3%	2.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.21: Relationship Status by Country (Unweighted)

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	1645 (52.4%)	305 (43.8%)	195 (48.9%)	499 (50.8%)	646 (60.7%)
Single	663 (21.1%)	164 (23.6%)	87 (21.8%)	198 (20.2%)	214 (20.1%)
Divorced	171 (5.4%)	41 (5.9%)	32 (8.0%)	45 (4.6%)	53 (5.0%)
Separated	84 (2.7%)	23 (3.3%)	4 (1.0%)	20 (2.0%)	37 (3.5%)
Cohabiting	539 (17.2%)	157 (22.6%)	75 (18.8%)	207 (21.1%)	100 (9.4%)
Widowed	39 (1.2%)	6 (0.9%)	6 (1.5%)	13 (1.3%)	14 (1.3%)
Total	**3141 (100%)**	**696 (100%)**	**399 (100%)**	**982 (100%)**	**1064 (100%)**

Figure A2.22: Relationship Status by Occupation (Weighted)

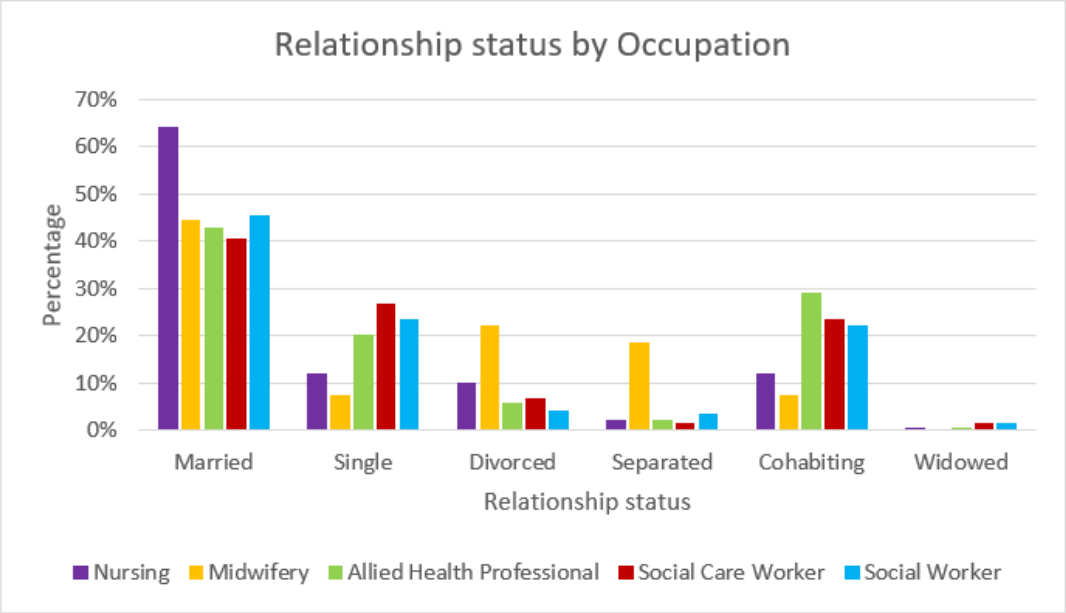

Figure A2.23: Relationship Status by Occupation (Unweighted)

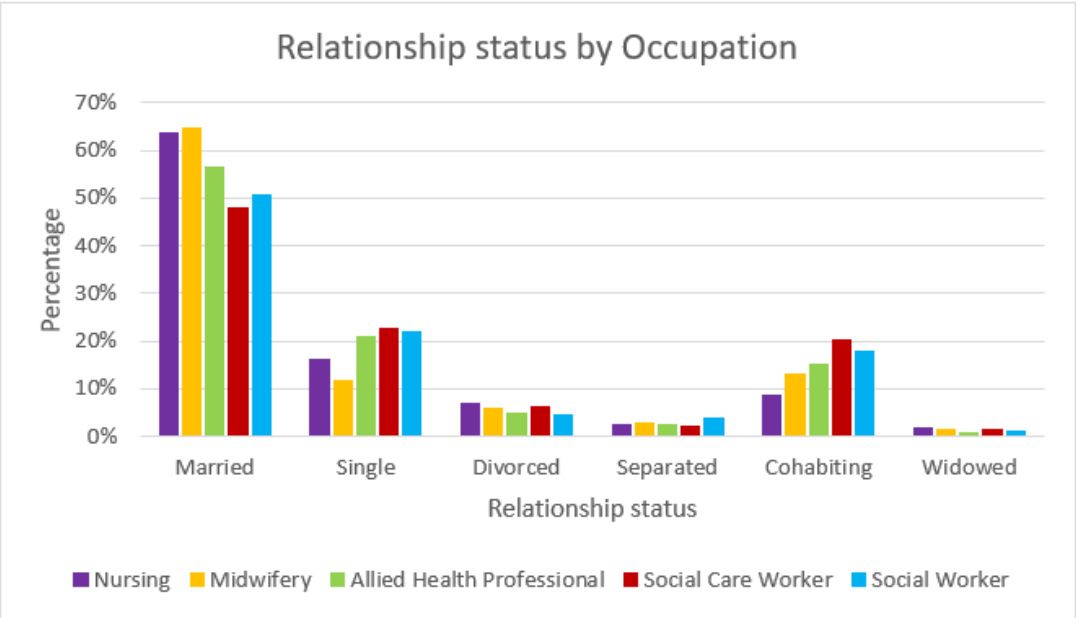

Table A2.22: Relationship Status by Occupation (Weighted)

	Relationship status						
Occupation	**Married**	**Single**	**Divorced**	**Separated**	**Cohabiting**	**Widowed**	**Total**
Nursing	64.0%	11.8%	10.0%	2.1%	11.8%	0.3%	**100%**
Midwifery	44.4%	7.4%	22.2%	18.5%	7.4%	0.0%	**100%**
AHP	42.8%	20.1%	5.7%	2.1%	29.0%	0.2%	**100%**
Social Care Worker	40.6%	26.6%	6.8%	1.5%	23.3%	1.3%	**100%**
Social Worker	45.5%	23.3%	4.2%	3.5%	22.2%	1.3%	**100%**

Table A2.23: Relationship Status by Occupation (Unweighted)

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	200 (63.7%)	51 (16.2%)	22 (7.0%)	8 (2.5%)	27 (8.6%)	6 (1.9%)	**314 (100%)**
Midwifery	44 (64.7%)	8 (11.8%)	4 (5.9%)	2 (2.9%)	9 (13.2%)	1 (1.5%)	**68 (100%)**
AHP	323 (56.3%)	120 (20.9%)	27 (4.7%)	13 (2.3%)	86 (15.0%)	5 (0.9%)	**574 (100%)**
Social Care Worker	539 (47.9%)	253 (22.5%)	70 (6.2%)	22 (2.0%)	226 (20.1%)	15 (1.3%)	**1125 (100%)**
Social Worker	539 (50.8%)	231 (21.8%)	48 (4.5%)	39 (3.7%)	191 (18.0%)	12 (1.1%)	**1060 (100%)**

A2.7 Respondents working in Hospital, Community, or Other Settings

Respondents were asked to indicate whether their job is based in the hospital, community (e.g., home care/domiciliary care), GP practice, care home, day care or other. Multiple responses were allowed, which means that the percentages do not add up to 100%.

Summary (Weighted results):

Across the different countries, working in the community was the most frequently reported setting. The majority of midwives worked in the hospital, but over a half also worked in the community. Social care workers, social workers and AHPs also frequently reported working in the community.

Summary (Unweighted results):

Across the different countries, working in the community was the most frequently reported setting. The majority of midwives worked in the hospital and working in the community was most frequently reported by social workers, followed by social care workers and AHPs.

Figure A2.24: Work Setting by Country (Weighted)

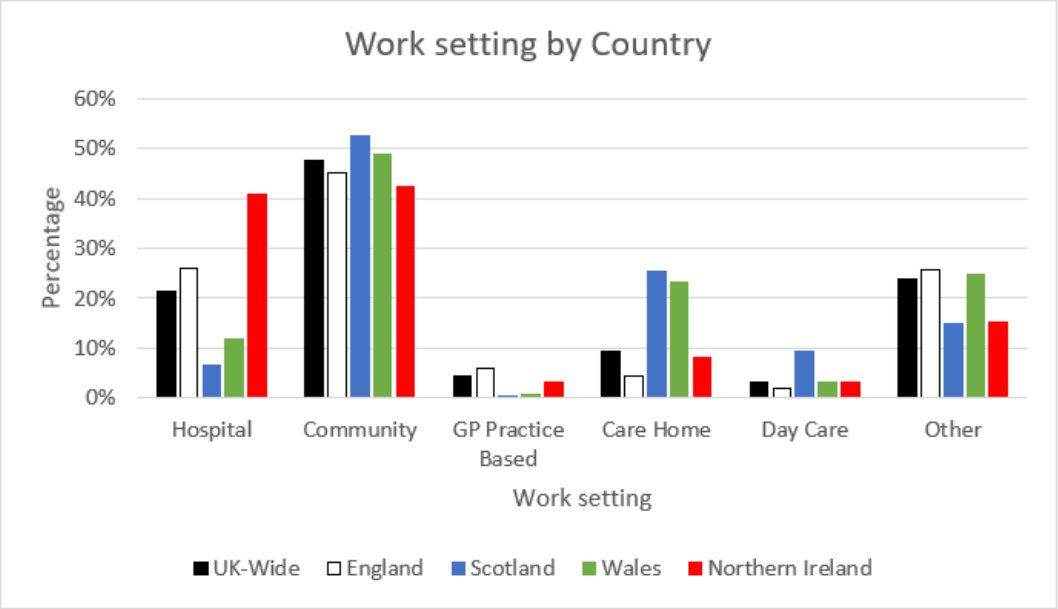

Figure A2.25: Work Setting by Country (Unweighted)

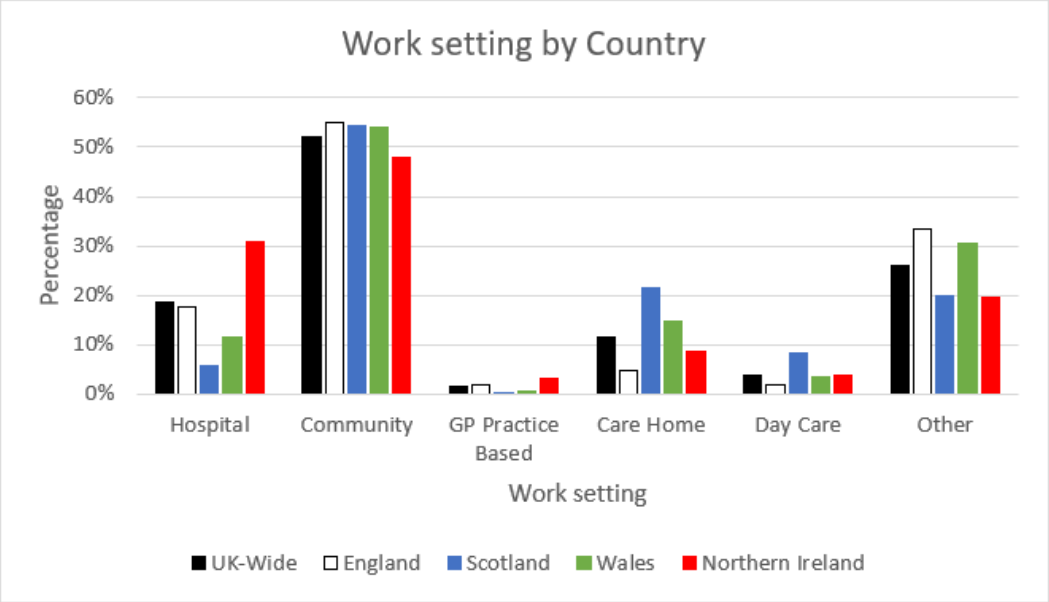

Table A2.24: Work Setting by Country (Weighted)

Work setting	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	21.4%	25.9%	6.6%	11.8%	40.7%
Community	47.5%	45.0%	52.7%	48.9%	42.5%
GP Practice Based	4.4%	5.8%	0.2%	0.7%	3.3%
Care Home	9.2%	4.5%	25.4%	23.3%	8.1%
Day Care	3.2%	1.8%	9.3%	3.2%	3.1%
Other	24.0%	25.7%	14.9%	24.7%	15.1%

Note. Presented are percentages within countries, which do not add up to 100%, because some respondents work in more than one setting.

Table A2.25: Work Setting by Country (Unweighted)

Work setting	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	652 (18.7%)	132 (17.6%)	26 (5.7%)	128 (11.7%)	366 (30.8%)
Community	1818 (52.1%)	411 (54.8%)	249 (54.2%)	587 (53.9%)	571 (48.0%)
GP Practice Based	60 (1.7%)	14 (1.9%)	2 (0.4%)	7 (0.6%)	37 (3.1%)
Care Home	399 (11.4%)	36 (4.8%)	99 (21.6%)	159 (14.6%)	105 (8.8%)
Day Care	133 (3.8%)	14 (1.9%)	38 (8.3%)	37 (3.4%)	44 (3.7%)
Other	907 (26.0%)	250 (33.3%)	91 (19.8%)	333 (30.6%)	233 (19.6%)
No. of respondents who answered the question	**3488**	**750**	**459**	**1090**	**1189**

Note. Presented are percentages within countries, which do not add up to 100%, because some respondents work in more than one setting.

Figure A2.26: Work Setting by Occupation (Weighted)

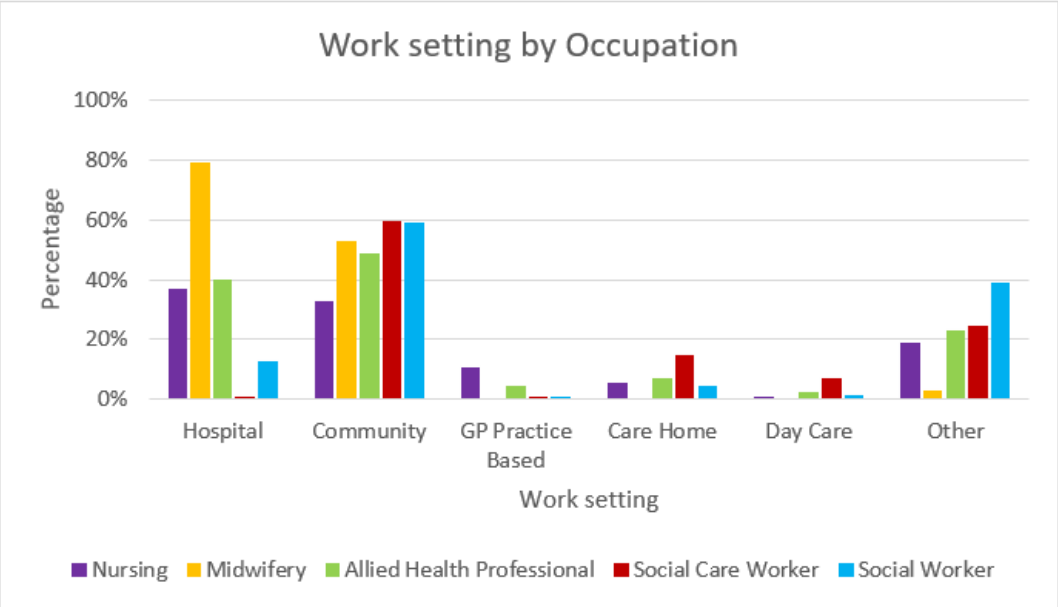

Figure A2.27: Work Setting by Occupation (Unweighted)

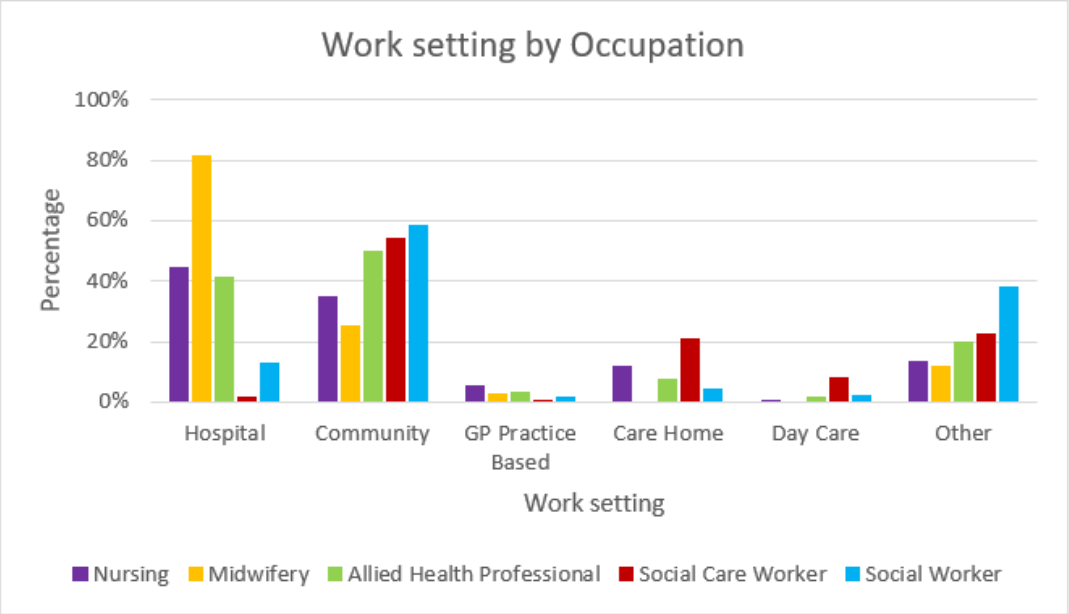

Table A2.26: Work Setting by Occupation (Weighted)

	Work setting					
Occupation	**Hospital**	**Community**	**GP Practice Based**	**Care Home**	**Day Care**	**Other**
Nursing	36.8%	32.4%	10.3%	5.4%	0.3%	18.9%
Midwifery	78.9%	52.6%	0.0%	0.0%	0.0%	2.6%
AHP	39.6%	48.6%	4.0%	6.7%	2.3%	22.8%
Social Care Worker	0.7%	59.3%	0.3%	14.4%	6.7%	24.3%
Social Worker	12.7%	58.7%	0.2%	4.0%	1.2%	38.8%

Note. Presented are percentages within occupational groups, which do not add up to 100%, because some respondents work in more than one setting.

Table A2.27: Work Setting by Occupation (Unweighted)

Occupation	Work setting						No. of respondents who answered the question
	Hospital	Community	GP Practice Based	Care Home	Day Care	Other	
Nursing	161 (44.6%)	125 (34.6%)	19 (5.3%)	43 (11.9%)	2 (0.6%)	48 (13.3%)	**361**
Midwifery	61 (81.3%)	19 (25.3%)	2 (2.7%)	0 (0.0%)	0 (0.0%)	9 (12.0%)	**75**
AHP	264 (41.4%)	319 (50.0%)	21 (3.3%)	48 (7.5%)	9 (1.4%)	125 (19.6%)	**638**
Social Care Worker	20 (1.6%)	678 (54.2%)	2 (0.2%)	260 (20.8%)	99 (7.9%)	282 (22.5%)	**1252**
Social Worker	146 (12.6%)	677 (58.3%)	16 (1.4%)	48 (4.1%)	23 (2.0%)	443 (38.1%)	**1162**

Note. Presented are percentages within occupational groups, which do not add up to 100%, because some respondents work in more than one setting.

A2.8 Health and Social Care Sector of Respondents

Respondents were asked what health and social care sector they work in. Multiple responses were allowed, which means that the percentages do not add up to 100%.

Summary (Weighted results):

Most respondents worked in the statutory health and social care sector (i.e., NHS, HSCT, Local Authority). Compared to the other occupational groups, social care workers were the most likely to be working in the private and voluntary and not for profit sectors.

Summary (Unweighted results):

Most respondents, both across the countries and across the occupational groups, worked in the statutory health and social care sector (i.e., NHS, HSCT, Local Authority). Social care workers were the most likely occupational group to be working in the private and voluntary and not for profit sectors.

Figure A2.28: Health and Social Care Sector of Respondents by Country (Weighted)

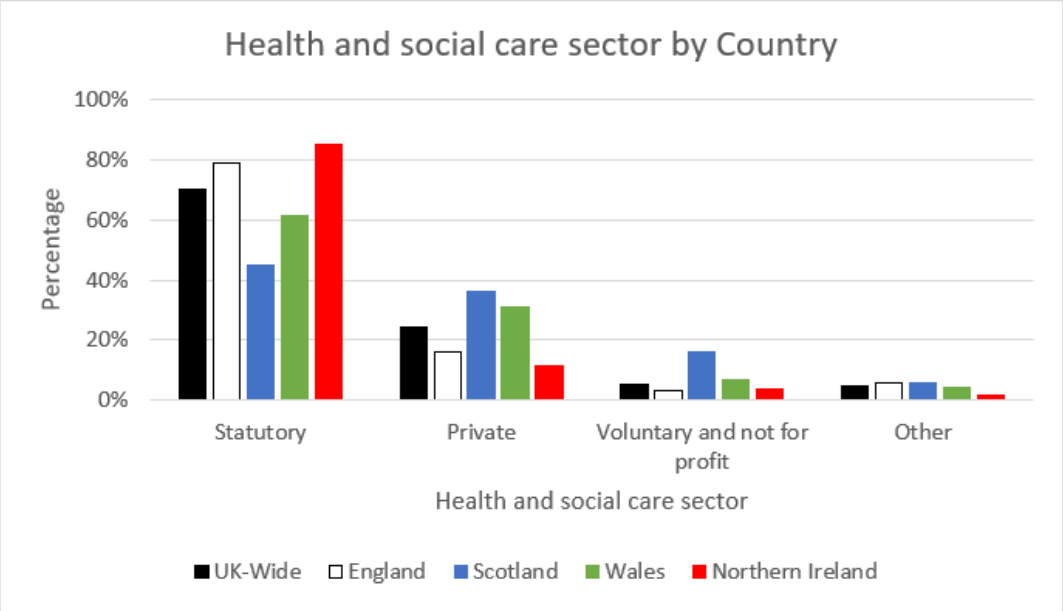

Figure A2.29: Health and Social Care Sector of Respondents by Country (Unweighted)

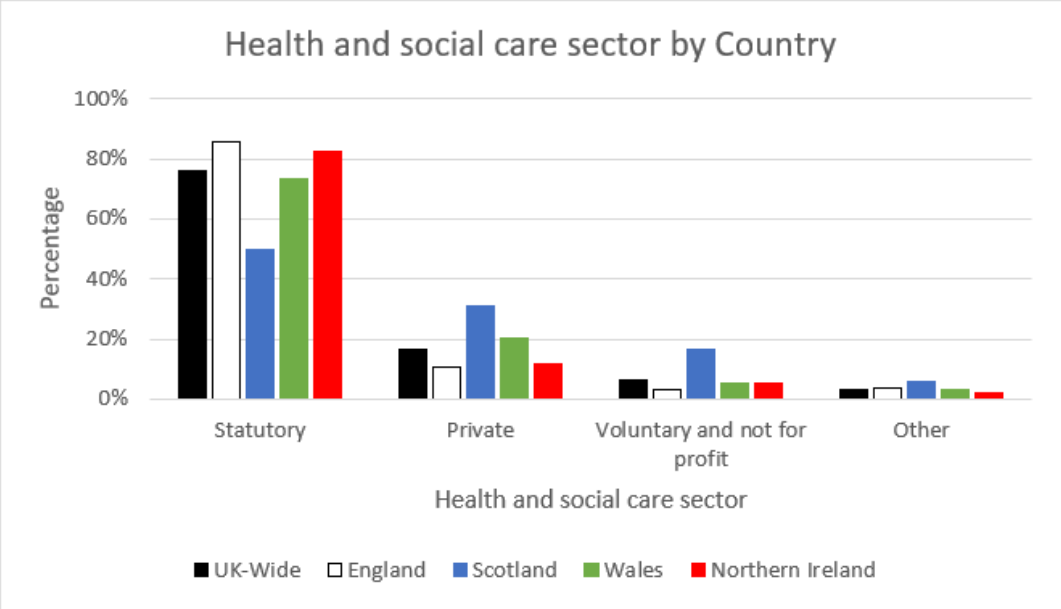

Table A2.28: Health and Social Care Sector of Respondents by Country (Weighted)

Health and social care sector	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Statutory	70.2%	79.0%	45.0%	61.5%	85.1%
Private	24.2%	16.0%	36.2%	30.9%	11.3%
Voluntary and not for profit	5.4%	3.2%	16.1%	6.6%	3.5%
Other	4.8%	5.6%	6.0%	4.3%	1.9%

Note. Presented are percentages within countries, which do not add up to 100%, because some respondents work in more than one sector.

Table A2.29: Health and Social Care Sector of Respondents by Country (Unweighted)

Health and social care sector	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Statutory	2659 (76.0%)	647 (85.6%)	228 (49.7%)	803 (73.5%)	981 (82.5%)
Private	584 (16.7%)	82 (10.8%)	143 (31.2%)	221 (20.2%)	138 (11.6%)
Voluntary and not for profit	222 (6.3%)	23 (3.0%)	76 (16.6%)	58 (5.3%)	65 (5.5%)
Other	118 (3.4%)	28 (3.7%)	28 (6.1%)	37 (3.4%)	25 (2.1%)
No. of respondents who answered the question	**3497**	**756**	**459**	**1093**	**1189**

Note. Presented are percentages within countries, which do not add up to 100%, because some respondents work in more than one sector.

Figure A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)

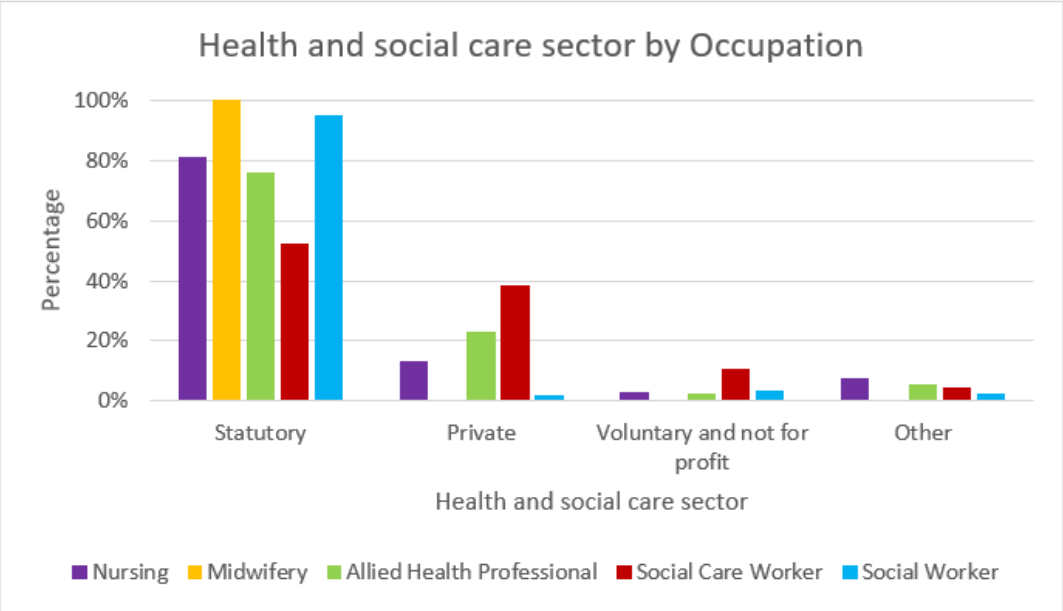

Figure A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)

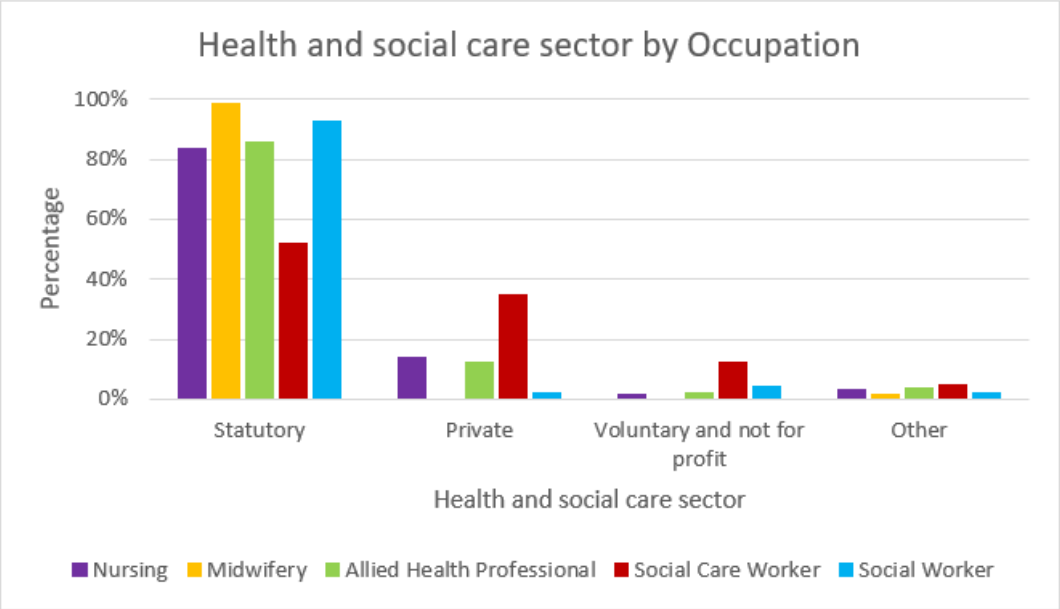

Table A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)

	Health and social care sector			
Occupation	**Statutory**	**Private**	**Voluntary and not for profit**	**Other**
Nursing	80.8%	13.0%	2.7%	7.3%
Midwifery	100%	0.0%	0.0%	0.0%
AHP	75.9%	22.6%	2.1%	5.2%
Social Care Worker	52.1%	38.0%	10.3%	4.4%
Social Worker	94.8%	1.5%	3.3%	2.3%

Note. Presented are percentages within occupational groups, which do not add up to 100%, because some respondents work in more than one sector.

Table A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)

	Health and social care sector				No. of respondents who answered the question
Occupation	**Statutory**	**Private**	**Voluntary and not for profit**	**Other**	
Nursing	302 (83.7%)	51 (14.1%)	5 (1.4%)	12 (3.3%)	**361**
Midwifery	74 (98.7%)	0 (0.0%)	0 (0.0%)	1 (1.3%)	**75**
AHP	547 (85.9%)	77 (12.1%)	14 (2.2%)	22 (3.5%)	**637**
Social Care Worker	647 (51.7%)	433 (34.6%)	154 (12.3%)	58 (4.6%)	**1252**
Social Worker	1089 (92.9%)	23 (2.0%)	49 (4.2%)	25 (2.1%)	**1172**

Note. Presented are percentages within occupational groups, which do not add up to 100%, because some respondents work in more than one sector.

A2.9 Line Manager Status of Respondents

Respondents were asked if they are a line manager with responsibility for one or more staff.

Summary (Weighted results):

The majority of respondents were not line managers.

Summary (Unweighted results):

The majority of respondents were not line managers.

Figure A2.32: Line Manager Status of Respondents by Country (Weighted)

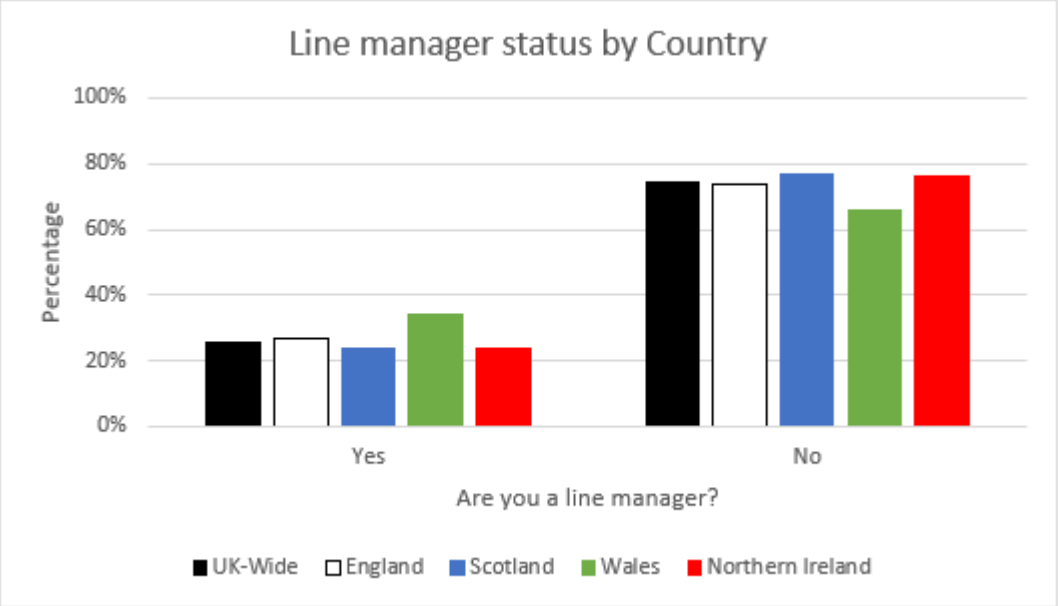

Figure A2.33: Line Manager Status of Respondents by Country (Unweighted)

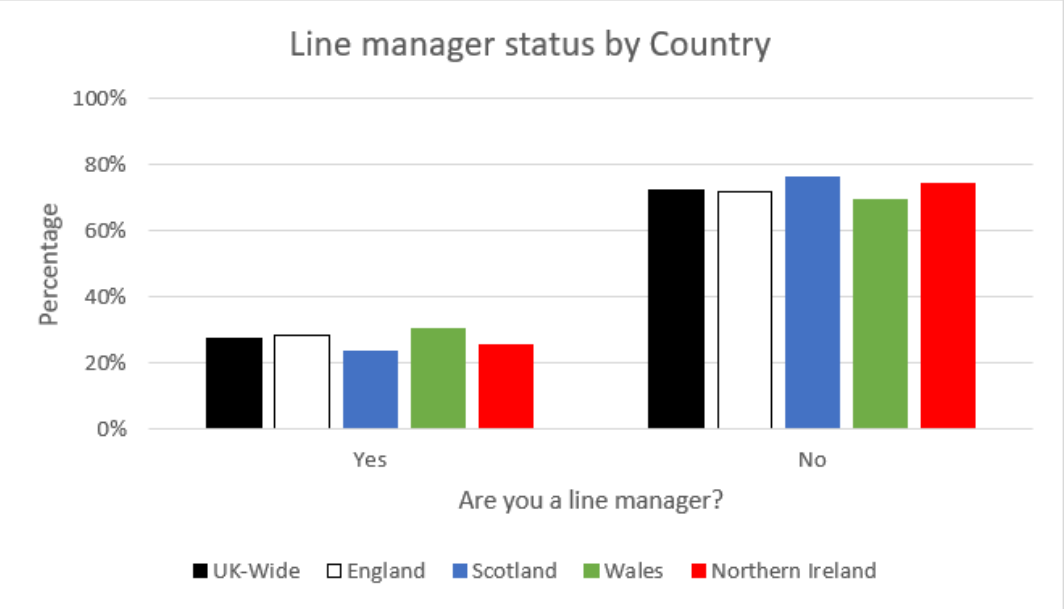

Table A2.32: Line Manager Status of Respondents by Country (Weighted)

Are you a line manager?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	25.6%	26.5%	23.5%	34.0%	23.8%
No	74.4%	73.5%	76.5%	66.0%	76.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.33: Line Manager Status of Respondents by Country (Unweighted)

Are you a line manager?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	962 (27.5%)	214 (28.3%)	109 (23.7%)	335 (30.6%)	304 (25.6%)
No	2537 (72.5%)	542 (71.7%)	350 (76.3%)	760 (69.4%)	885 (74.4%)
Total	**3499 (100%)**	**756 (100%)**	**459 (100%)**	**1095 (100%)**	**1189 (100%)**

Figure A2.34: Line Manager Status of Respondents by Occupation (Weighted)

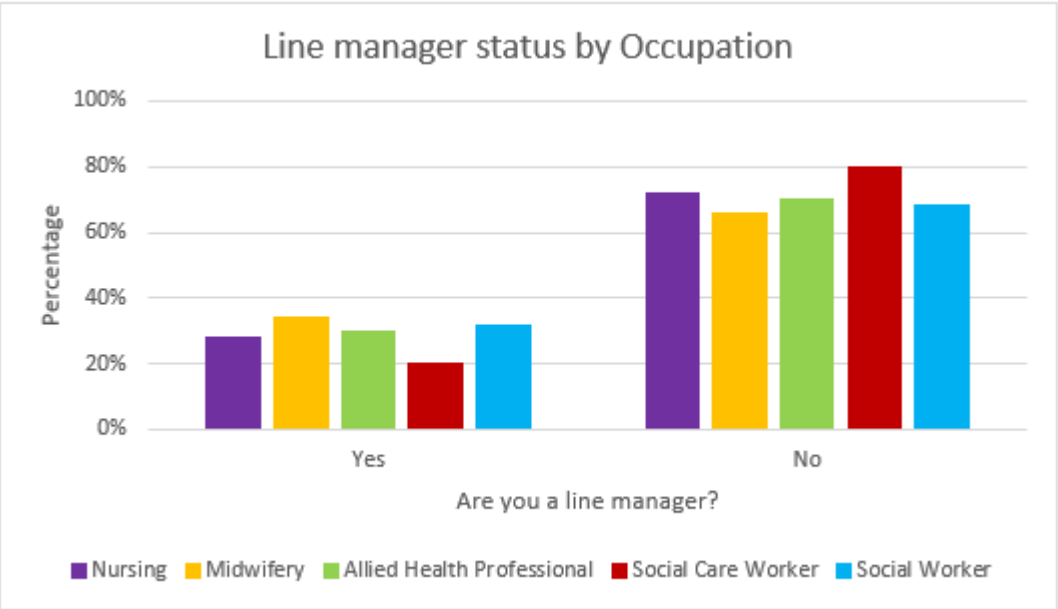

Figure A2.35: Line Manager Status of Respondents by Occupation (Unweighted)

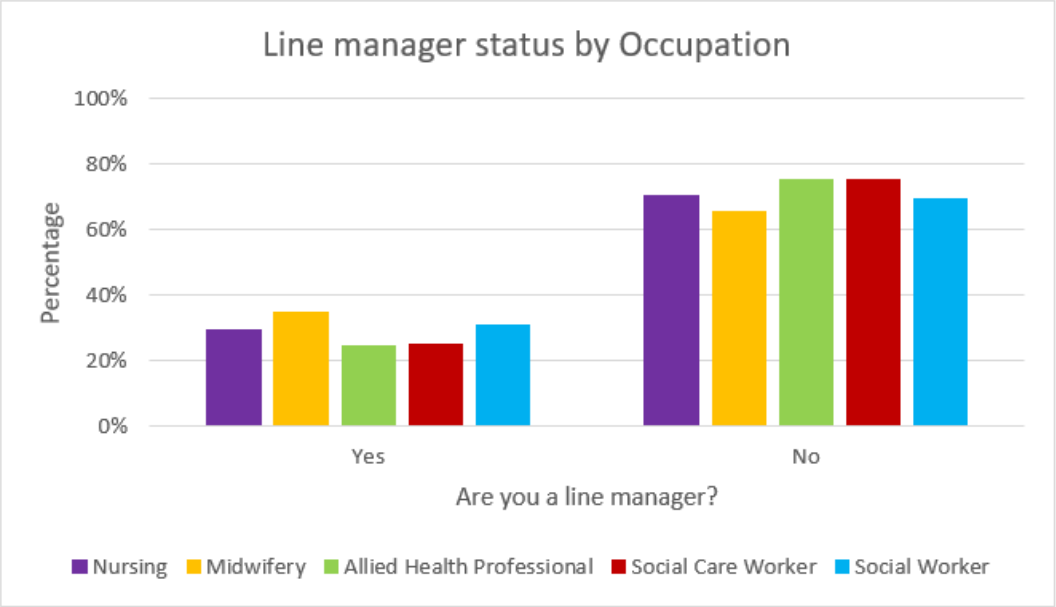

Table A2.34: Line Manager Status of Respondents by Occupation (Weighted)

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	27.9%	72.1%	**100%**
Midwifery	34.2%	65.8%	**100%**
AHP	29.8%	70.2%	**100%**
Social Care Worker	20.1%	79.9%	**100%**
Social Worker	31.7%	68.3%	**100%**

Table A2.35: Line Manager Status of Respondents by Occupation (Unweighted)

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	106 (29.4%)	255 (70.6%)	**361 (100%)**
Midwifery	26 (34.7%)	49 (65.3%)	**75 (100%)**
AHP	157 (24.6%)	481 (75.4%)	**638 (100%)**
Social Care Worker	312 (24.9%)	941 (75.1%)	**1253 (100%)**
Social Worker	361 (30.8%)	811 (69.2%)	**1172 (100%)**

A2.10 Pay Scale of Respondents

Summary (Weighted results):

Participants were divided into those who worked for the NHS or the HSC Trust (40.1%) and those who did not (59.9%) and were subsequently asked questions about their pay scale. Across the countries, the most frequently reported pay scale for NHS/HSC Trust staff was Band 6, followed by Band 7 and

Band 5. For staff outside of the NHS/HSC Trust, the results were more varied. In terms of the different occupational groups, Band 6 was most frequently reported by nurses, midwives and AHPs, for social workers it was Band 7 followed by Band 6, and social care workers most frequently reported Band 2. The results were again more varied for the non-NHS/HSC Trust staff.

Summary (Unweighted results):

Participants were divided into those who worked for the NHS or the HSC Trust (n = 1350, 38.6%) and those who did not (n = 2145, 61.4%) and were subsequently asked questions about their pay scale. Across the countries, the most frequently reported pay scale for NHS/HSC Trust staff was Band 6, followed by Band 7. For staff outside of the NHS/HSC Trust, the results were more varied. In terms of the different occupational groups, Band 6 was most frequently reported by all groups except for the social care workers, the majority of whom were in Band 3. The results were again more varied for the non-NHS/HSC Trust staff.

Please note that only one midwife indicated that she did not work in the NHS/HSC Trust, which explains why 100% of midwives in Figure A2.39 earn more than £45,000. This midwife stated that she worked in academia.

Figure A2.36: Pay Scale of Respondents by Country (Weighted)

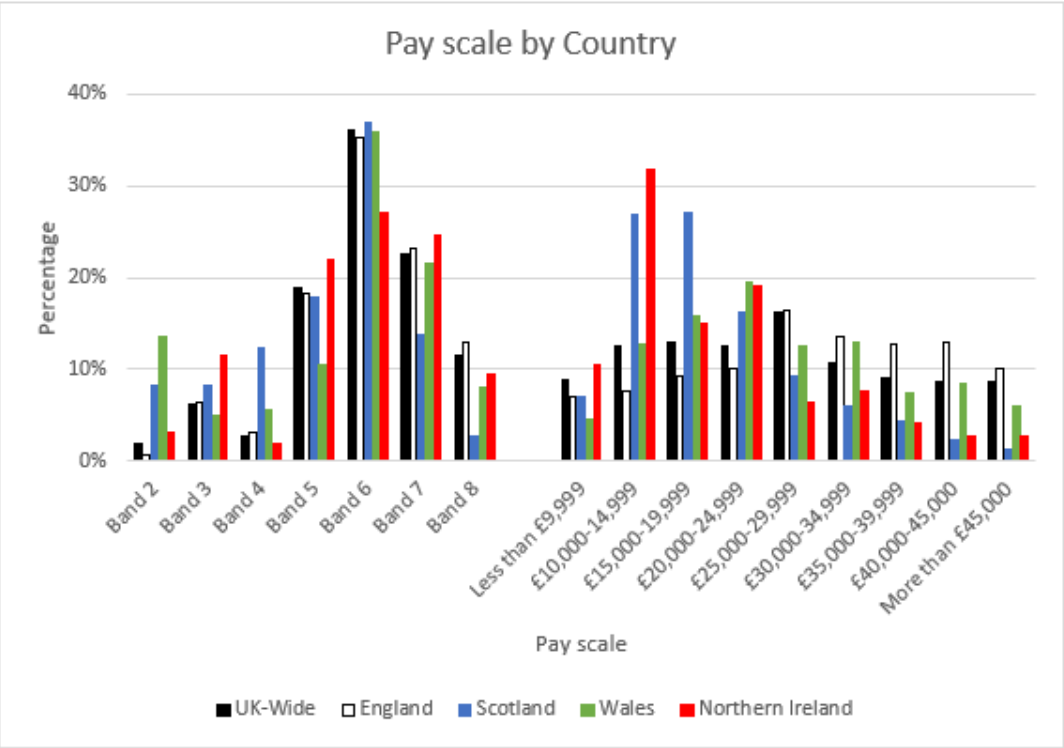

Figure A2.37: Pay Scale of Respondents by Country (Unweighted)

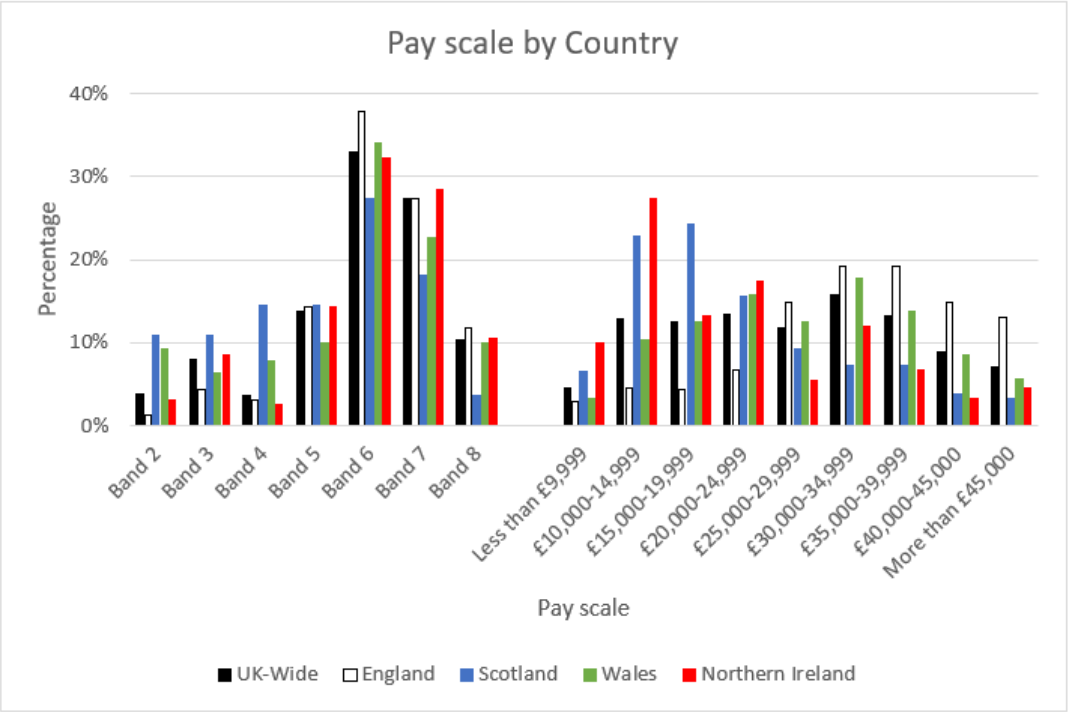

Table A2.36: Pay Scale of Respondents by Country (Weighted)

Pay scale	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
NHS or HSC Trust staff					
Band 2	2.0%	0.7%	8.2%	13.6%	3.2%
Band 3	6.3%	6.5%	8.2%	4.9%	11.6%
Band 4	2.8%	3.1%	12.3%	5.6%	2.0%
Band 5	18.9%	18.2%	17.8%	10.5%	22.0%
Band 6	36.0%	35.3%	37.0%	35.8%	27.0%
Band 7	22.5%	23.3%	13.7%	21.6%	24.7%
Band 8	11.5%	13.0%	2.7%	8.0%	9.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Other staff					
Less than £9,999	8.8%	7.1%	7.0%	4.5%	10.5%
£10,000-14,999	12.5%	7.7%	26.8%	12.8%	31.8%
£15,000-19,999	12.9%	9.3%	27.0%	15.8%	15.0%
£20,000-24,999	12.5%	10.2%	16.3%	19.6%	19.1%
£25,000-29,999	16.3%	16.4%	9.3%	12.5%	6.4%
£30,000-34,999	10.8%	13.6%	6.0%	12.9%	7.7%
£35,000-39,999	9.0%	12.7%	4.3%	7.4%	4.1%
£40,000-45,000	8.7%	13.0%	2.3%	8.4%	2.7%
More than £45,000	8.6%	10.2%	1.3%	6.1%	2.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.37: Pay Scale of Respondents by Country (Unweighted)

Pay scale	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
NHS or HSC Trust staff					
Band 2	51 (3.9%)	2 (1.2%)	6 (10.9%)	13 (9.2%)	30 (3.1%)
Band 3	105 (8.0%)	7 (4.3%)	6 (10.9%)	9 (6.4%)	83 (8.6%)
Band 4	49 (3.7%)	5 (3.1%)	8 (14.5%)	11 (7.8%)	25 (2.6%)
Band 5	182 (13.8%)	23 (14.3%)	8 (14.5%)	14 (9.9%)	137 (14.3%)
Band 6	434 (32.9%)	61 (37.9%)	15 (27.3%)	48 (34.0%)	310 (32.3%)
Band 7	360 (27.3%)	44 (27.3%)	10 (18.2%)	32 (22.7%)	274 (28.5%)
Band 8	137 (10.4%)	19 (11.8%)	2 (3.6%)	14 (9.9%)	102 (10.6%)
Total	**1318 (100%)**	**161 (100%)**	**55 (100%)**	**141 (100%)**	**961 (100%)**
Other staff					
Less than £9,999	96 (4.5%)	17 (2.9%)	26 (6.6%)	31 (3.3%)	22 (10.0%)
£10,000-14,999	272 (12.8%)	27 (4.6%)	89 (22.8%)	96 (10.3%)	60 (27.4%)
£15,000-19,999	266 (12.5%)	26 (4.4%)	95 (24.3%)	116 (12.5%)	29 (13.2%)
£20,000-24,999	285 (13.4%)	40 (6.8%)	61 (15.6%)	146 (15.7%)	38 (17.4%)
£25,000-29,999	251 (11.8%)	87 (14.8%)	36 (9.2%)	116 (12.5%)	12 (5.5%)
£30,000-34,999	333 (15.7%)	113 (19.3%)	28 (7.2%)	166 (17.8%)	26 (11.9%)
£35,000-39,999	283 (13.3%)	113 (19.3%)	28 (7.2%)	127 (13.7%)	15 (6.8%)
£40,000-45,000	188 (8.8%)	87 (14.8%)	15 (3.8%)	79 (8.5%)	7 (3.2%)
More than £45,000	152 (7.1%)	76 (13.0%)	13 (3.3%)	53 (5.7%)	10 (4.6%)
Total	**2126 (100%)**	**586 (100%)**	**391 (100%)**	**930 (100%)**	**219 (100%)**

Figure A2.38: Pay Scale of Respondents by Occupation (Weighted)

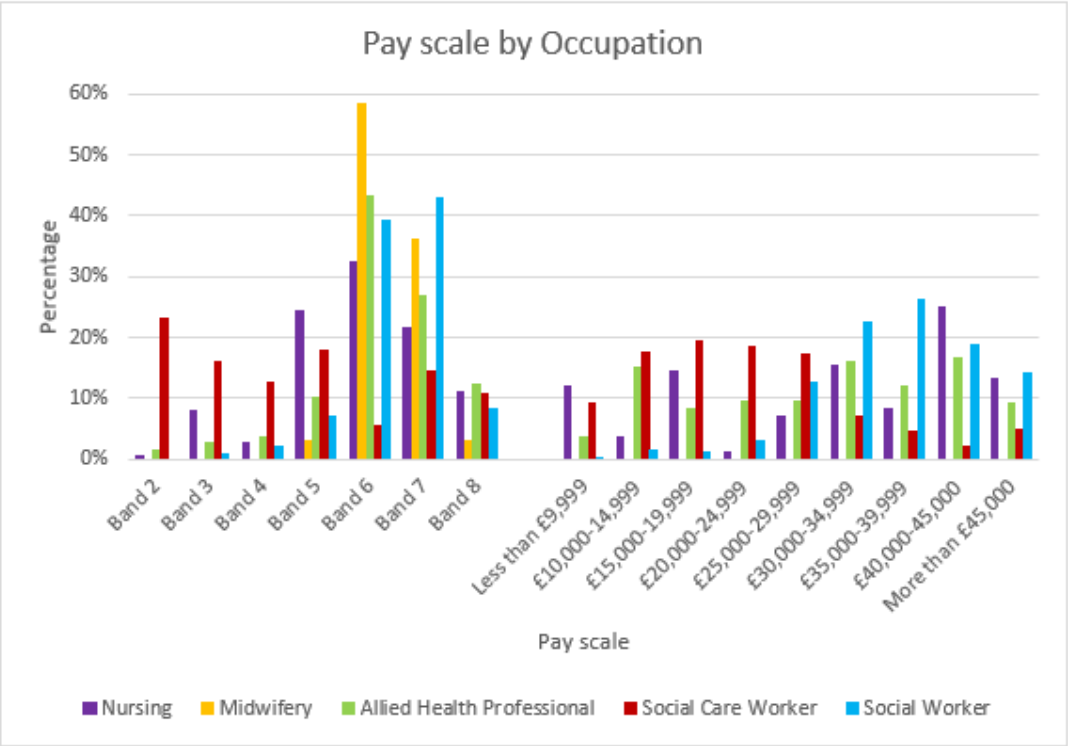

Figure A2.39: Pay Scale of Respondents by Occupation (Unweighted)

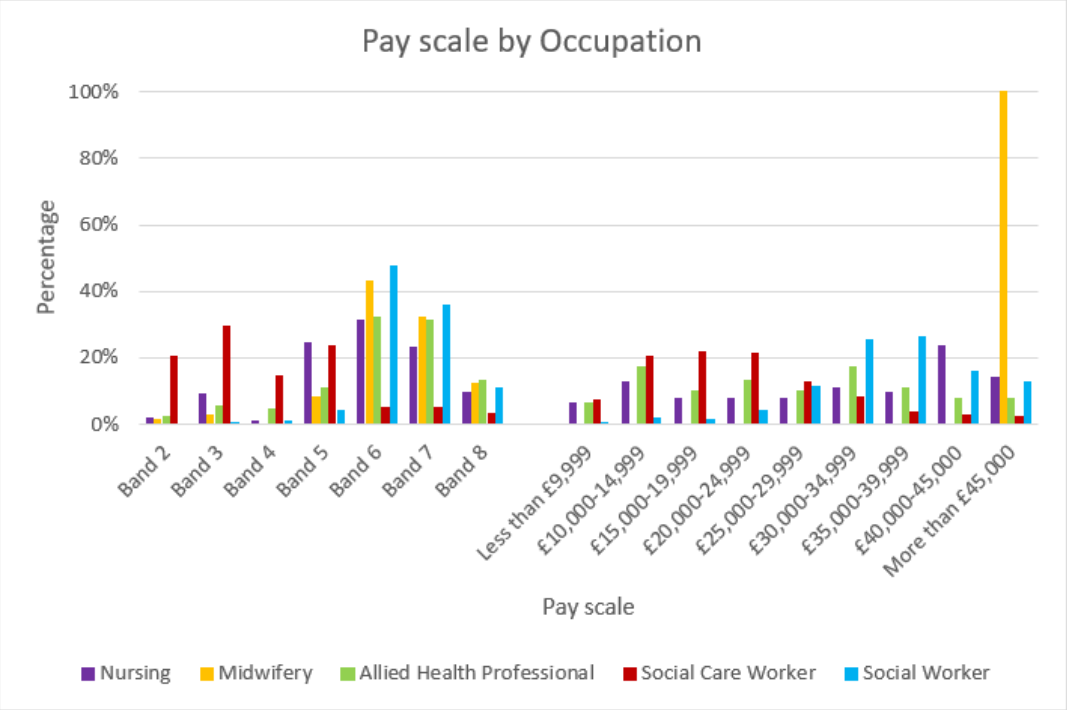

Table A2.38: Pay Scale of Respondents by Occupation (Weighted)

Pay scale	Occupation				
	Nursing	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
NHS or HSC Trust staff					
Band 2	0.4%	0.0%	1.3%	23.2%	0.0%
Band 3	7.8%	0.0%	2.7%	16.1%	0.7%
Band 4	2.5%	0.0%	3.7%	12.5%	2.1%
Band 5	24.4%	2.8%	10.1%	17.9%	6.9%
Band 6	32.5%	58.3%	43.3%	5.4%	39.3%
Band 7	21.6%	36.1%	26.8%	14.3%	42.8%
Band 8	11.0%	2.8%	12.1%	10.7%	8.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Other staff					
Less than £9,999	11.9%	-	3.7%	9.3%	0.2%
£10,000-14,999	3.6%	-	15.1%	17.4%	1.4%
£15,000-19,999	14.3%	-	8.3%	19.4%	1.2%
£20,000-24,999	1.2%	-	9.6%	18.3%	3.1%
£25,000-29,999	7.1%	-	9.6%	17.2%	12.5%
£30,000-34,999	15.5%	-	16.1%	7.0%	22.6%
£35,000-39,999	8.3%	-	11.9%	4.6%	26.3%
£40,000-45,000	25.0%	-	16.5%	2.0%	18.7%
More than £45,000	13.1%	-	9.2%	4.8%	14.0%
Total	**100%**	**-**	**100%**	**100%**	**100%**

Table A2.39: Pay Scale of Respondents by Occupation (Unweighted)

Pay scale	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
NHS or HSC Trust staff					
Band 2	6 (2.0%)	1 (1.4%)	10 (2.2%)	34 (20.4%)	0 (0.0%)
Band 3	27 (9.2%)	2 (2.7%)	25 (5.5%)	49 (29.3%)	2 (0.6%)
Band 4	2 (0.7%)	0 (0.0%)	20 (4.4%)	24 (14.4%)	3 (0.9%)
Band 5	72 (24.4%)	6 (8.1%)	51 (11.1%)	39 (23.4%)	14 (4.3%)
Band 6	92 (31.2%)	32 (43.2%)	148 (32.3%)	8 (4.8%)	154 (47.5%)
Band 7	68 (23.1%)	24 (32.4%)	144 (31.4%)	8 (4.8%)	116 (35.8%)
Band 8	28 (9.5%)	9 (12.2%)	60 (13.1%)	5 (3.0%)	35 (10.8%)
Total	**295 (100%)**	**74 (100%)**	**458 (100%)**	**167 (100%)**	**324 (100%)**
Other staff					
Less than £9,999	4 (6.3%)	0 (0.0%)	11 (6.4%)	76 (7.1%)	5 (0.6%)
£10,000-14,999	8 (12.5%)	0 (0.0%)	30 (17.3%)	219 (20.6%)	15 (1.8%)
£15,000-19,999	5 (7.8%)	0 (0.0%)	17 (9.8%)	231 (21.7%)	13 (1.6%)
£20,000-24,999	5 (7.8%)	0 (0.0%)	23 (13.3%)	224 (21.1%)	33 (4.0%)
£25,000-29,999	5 (7.8%)	0 (0.0%)	17 (9.8%)	135 (12.7%)	94 (11.4%)
£30,000-34,999	7 (10.9%)	0 (0.0%)	30 (17.3%)	85 (8.0%)	211 (25.6%)
£35,000-39,999	6 (9.4%)	0 (0.0%)	19 (11.0%)	39 (3.7%)	219 (26.5%)
£40,000-45,000	15 (23.4%)	0 (0.0%)	13 (7.5%)	29 (2.7%)	131 (15.9%)
More than £45,000	9 (14.1%)	1 (100%)	13 (7.5%)	25 (2.4%)	104 (12.6%)
Total	**64 (100%)**	**1 (100%)**	**173 (100%)**	**1063 (100%)**	**825 (100%)**

A2.11 Respondents Redeployed due to COVID-19

Summary (Weighted results):

The vast majority of participants were not redeployed due to COVID-19.

Summary (Unweighted results):

The vast majority of respondents were not redeployed due to COVID-19.

Figure A2.40: Redeployment by Country (Weighted)

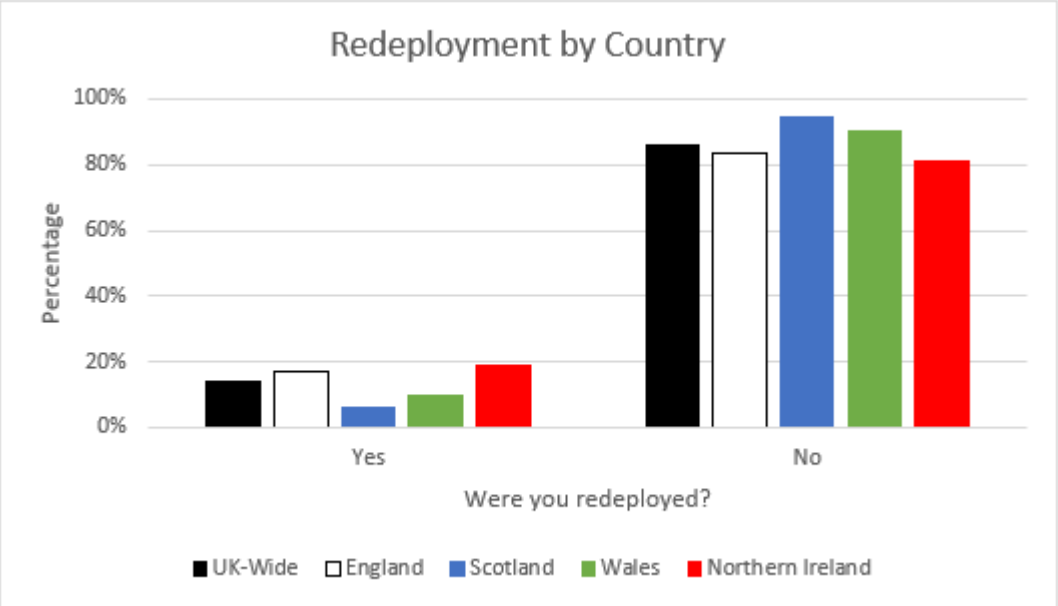

Figure A2.41: Redeployment by Country (Unweighted)

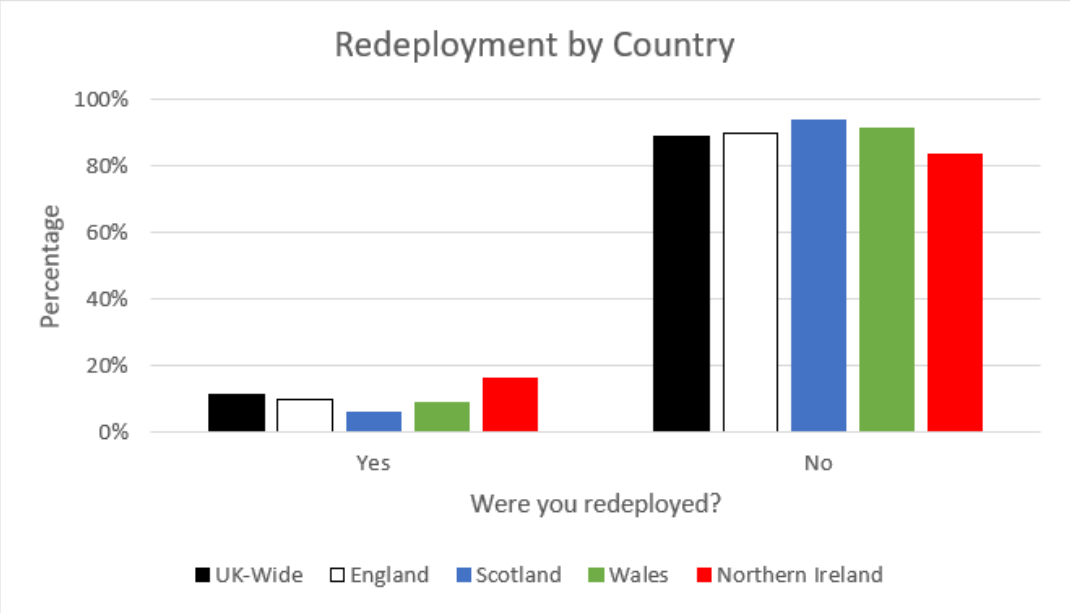

Table A2.40: Redeployment by Country (Weighted)

Were you redeployed?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	13.9%	16.8%	5.8%	9.6%	19.1%
No	86.1%	83.2%	94.2%	90.4%	80.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.41: Redeployment by Country (Unweighted)

Were you redeployed?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	391 (11.3%)	74 (9.9%)	28 (6.1%)	95 (8.8%)	194 (16.4%)
No	3084 (88.7%)	677 (90.1%)	428 (93.9%)	989 (91.2%)	990 (83.6%)
Total	**3475 (100%)**	**751 (100%)**	**456 (100%)**	**1084 (100%)**	**1184 (100%)**

Figure A2.42: Redeployment by Occupation (Weighted)

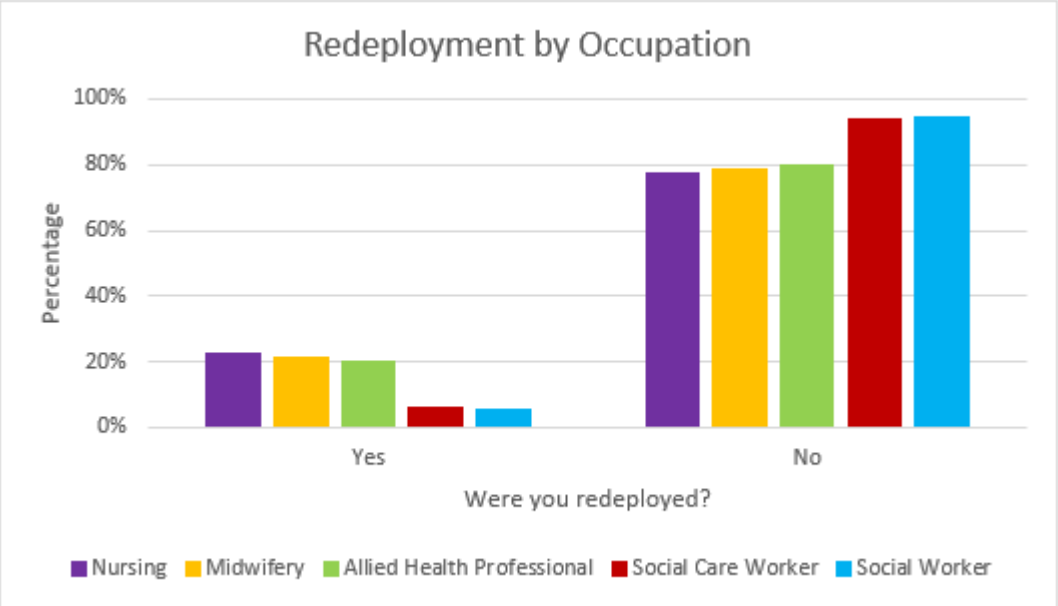

Figure A2.43: Redeployment by Occupation (Unweighted)

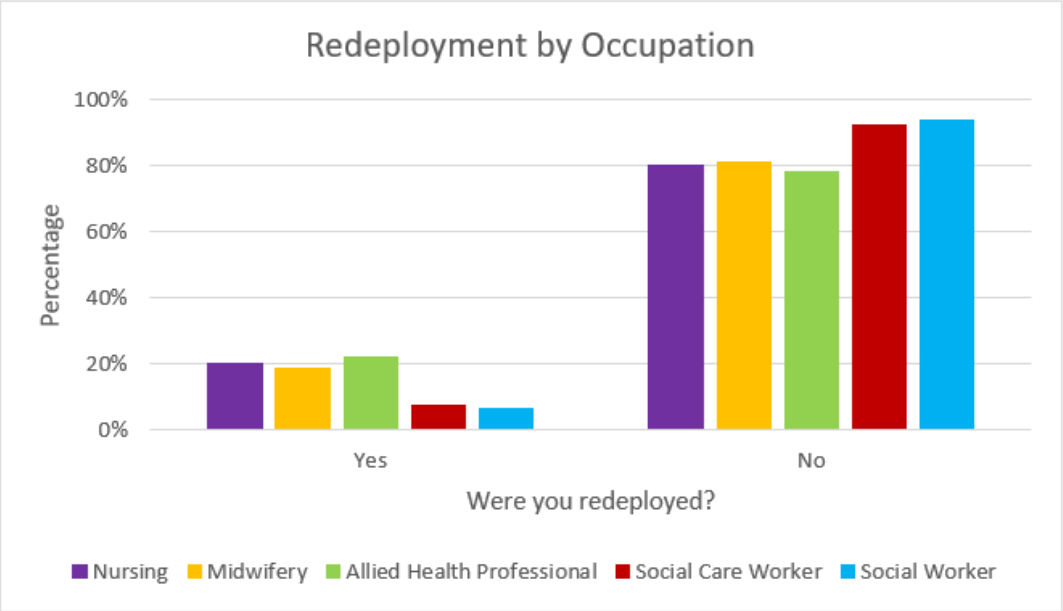

Table A2.42: Redeployment by Occupation (Weighted)

Occupation	Were you redeployed?		Total
	Yes	No	
Nursing	22.5%	77.5%	**100%**
Midwifery	21.1%	78.9%	**100%**
AHP	19.9%	80.1%	**100%**
Social Care Worker	6.3%	93.7%	**100%**
Social Worker	5.6%	94.4%	**100%**

Table A2.43: Redeployment by Occupation (Unweighted)

Occupation	Were you redeployed?		Total
	Yes	No	
Nursing	72 (20.1%)	287 (79.9%)	**359 (100%)**
Midwifery	14 (18.7%)	61 (81.3%)	**75 (100%)**
AHP	139 (21.9%)	497 (78.1%)	**636 (100%)**
Social Care Worker	93 (7.5%)	1152 (92.5%)	**1245 (100%)**
Social Worker	73 (6.3%)	1087 (93.7%)	**1160 (100%)**

A2.12 Preparedness of Redeployed Respondents

Participants who indicated that they had been redeployed were subsequently asked how prepared they felt for their new role.

Summary (Weighted results):

Almost half of the respondents from Scotland felt that they had been well prepared for redeployment. Overall, respondents from England felt the least prepared. Nurses were most likely to report that they felt unprepared.

Summary (Unweighted results):

Over a half of the respondents from Scotland felt that they had been well prepared for redeployment. Overall, respondents from England felt the least prepared. Nurses and midwives were most likely to report that they felt unprepared.

Figure A2.44: Preparedness for Redeployment by Country (Weighted)

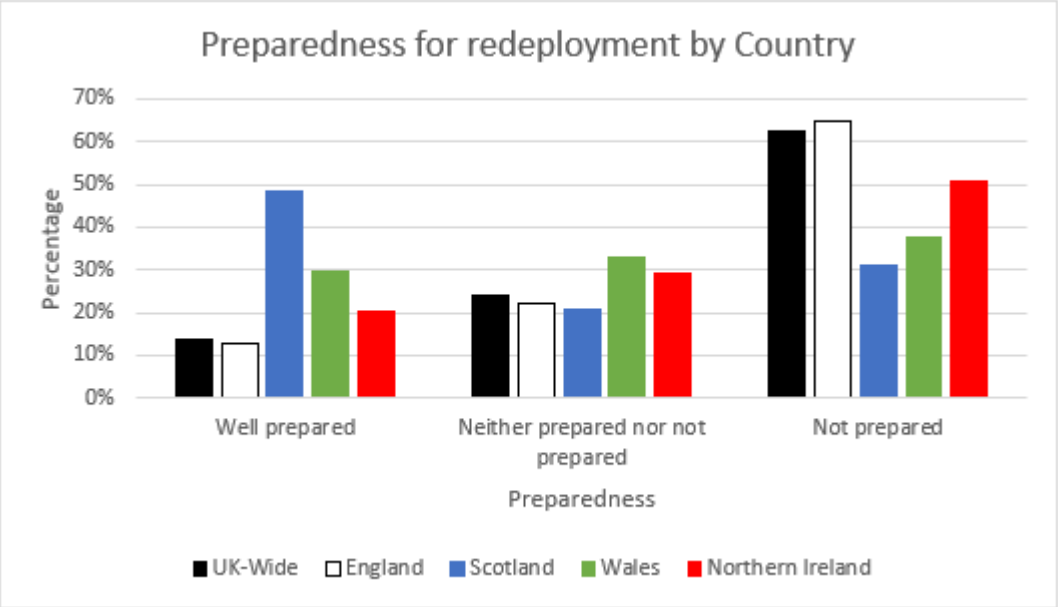

Figure A2.45: Preparedness for Redeployment by Country (Unweighted)

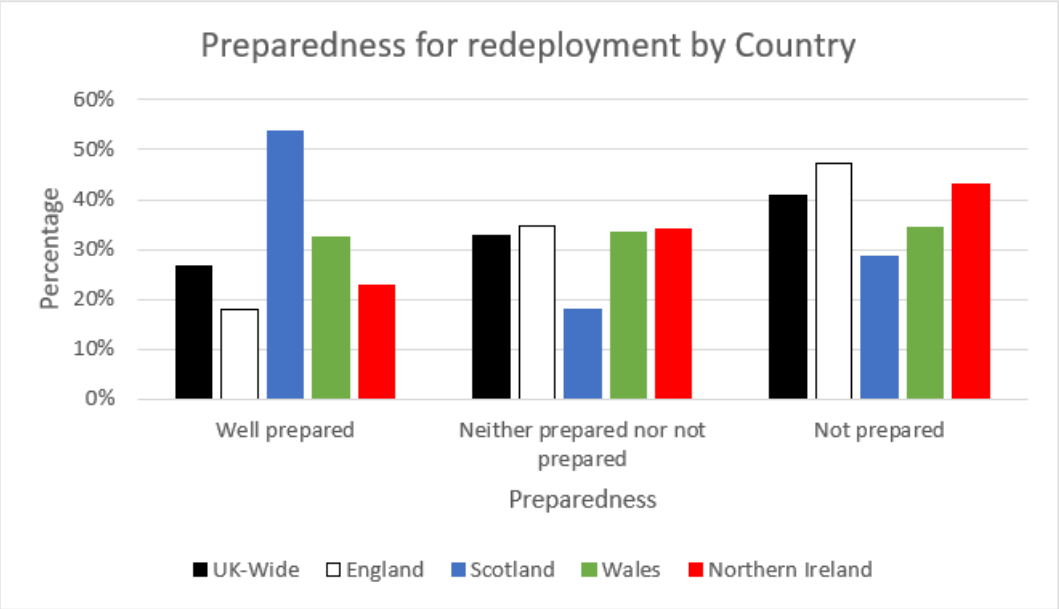

Table A2.44: Preparedness for Redeployment by Country (Weighted)

Preparedness for redeployment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	13.6%	12.6%	48.3%	29.7%	20.4%
Neither prepared nor not prepared	23.8%	22.3%	20.7%	33.0%	29.0%
Not prepared	62.6%	65.0%	31.0%	37.4%	50.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.45: Preparedness for Redeployment by Country (Unweighted)

Preparedness for redeployment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	102 (26.5%)	13 (18.1%)	15 (53.6%)	30 (32.3%)	44 (22.9%)
Neither prepared nor not prepared	126 (32.7%)	25 (34.7%)	5 (17.9%)	31 (33.3%)	65 (33.9%)
Not prepared	157 (40.8%)	34 (47.2%)	8 (28.6%)	32 (34.4%)	83 (43.2%)
Total	**385 (100%)**	**72 (100%)**	**28 (100%)**	**93 (100%)**	**192 (100%)**

Figure A2.46: Preparedness for Redeployment by Occupation (Weighted)

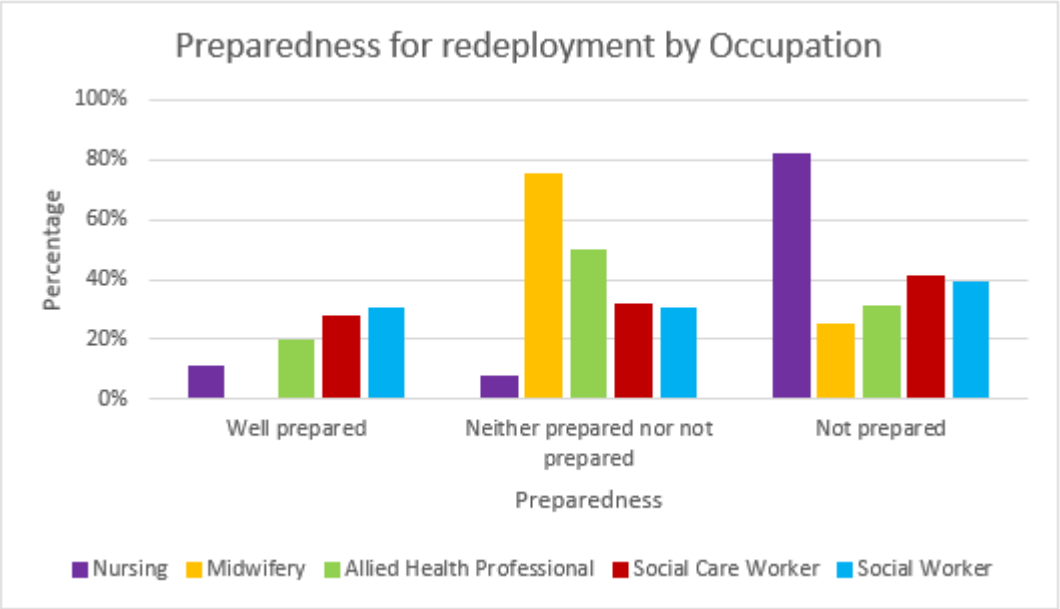

Figure A2.47: Preparedness for Redeployment by Occupation (Unweighted)

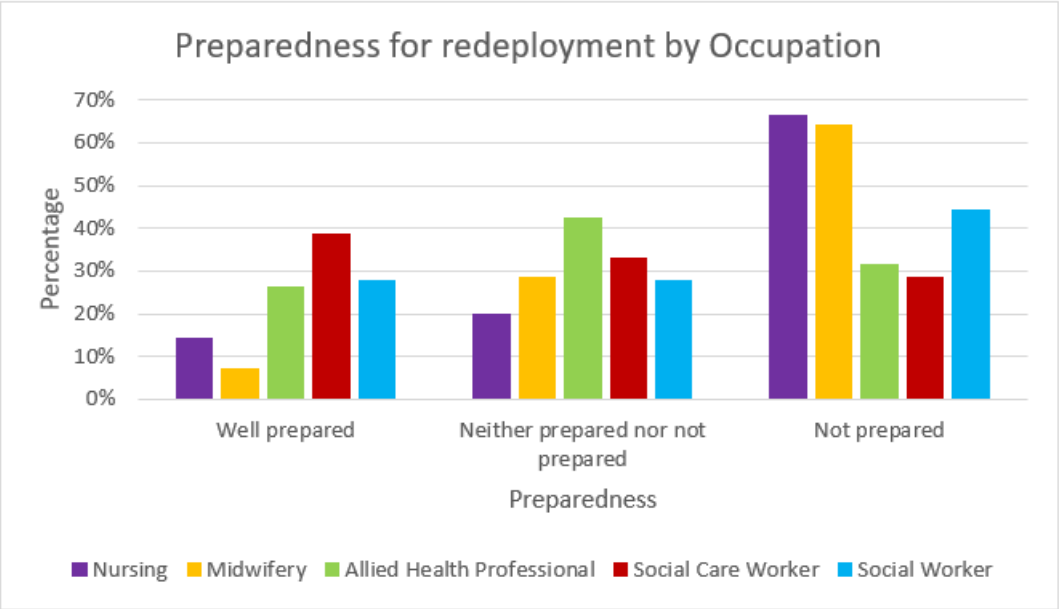

Table A2.46: Preparedness for Redeployment by Occupation (Weighted)

Occupation	Preparedness for redeployment			Total
	Well prepared	Neither prepared nor not prepared	Not prepared	
Nursing	10.8%	7.2%	81.9%	**100%**
Midwifery	0.0%	75.0%	25.0%	**100%**
AHP	19.8%	49.5%	30.7%	**100%**
Social Care Worker	27.5%	31.4%	41.2%	**100%**
Social Worker	30.4%	30.4%	39.1%	**100%**

Table A2.47: Preparedness for Redeployment by Occupation (Unweighted)

Occupation	Preparedness for redeployment			Total
	Well prepared	Neither prepared nor not prepared	Not prepared	
Nursing	10 (14.1%)	14 (19.7%)	47 (66.2%)	**71 (100%)**
Midwifery	1 (7.1%)	4 (28.6%)	9 (64.3%)	**14 (100%)**
AHP	36 (26.3%)	58 (42.3%)	43 (31.4%)	**137 (100%)**
Social Care Worker	35 (38.5%)	30 (33.0%)	26 (28.6%)	**91 (100%)**
Social Worker	20 (27.8%)	20 (27.8%)	32 (44.4%)	**72 (100%)**

A2.13 Respondents Coming out of Retirement to Support the Workforce during COVID-19

Summary (Weighted results):

UK-wide, only 0.9% of respondents came out of retirement to support the workforce during the COVID-19 pandemic, and these were either nurses or social workers.

Summary (Unweighted results):

UK-wide, only 0.4% of respondents came out of retirement to support the workforce during the COVID-19 pandemic.

Figure A2.48: Coming out of Retirement to Support the Workforce by Country (Weighted)

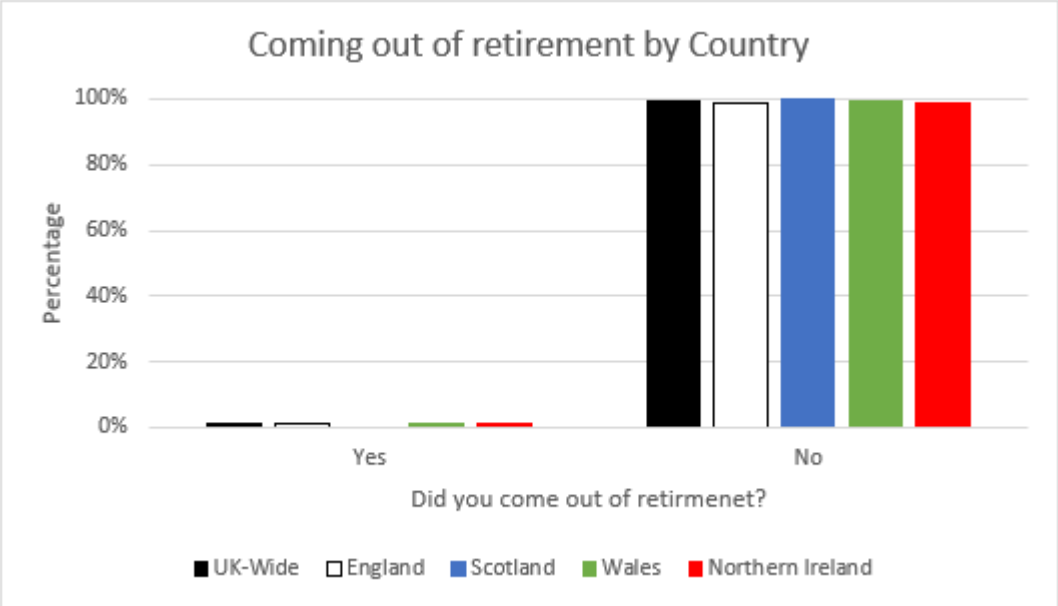

Figure A2.49: Coming out of Retirement to Support the Workforce by Country (Unweighted)

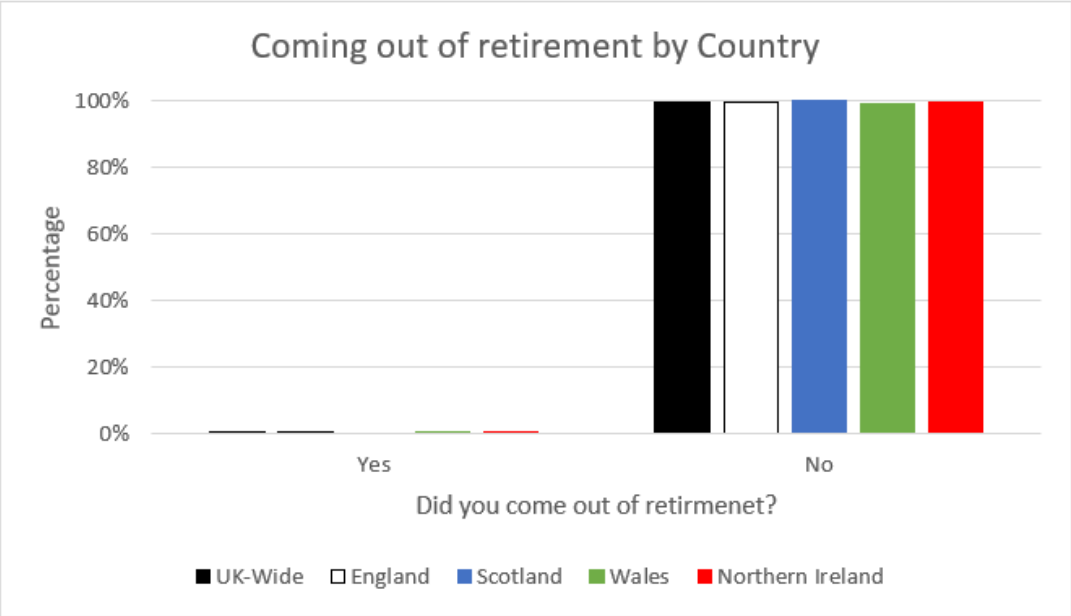

Table A2.48: Coming out of Retirement to Support the Workforce by Country (Weighted)

Did you come out of retirement?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	0.9%	1.3%	0.0%	0.9%	1.1%
No	99.1%	98.7%	100%	99.1%	98.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.49: Coming out of Retirement to Support the Workforce by Country (Unweighted)

Did you come out of retirement?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	15 (0.4%)	4 (0.5%)	0 (0.0%)	6 (0.6%)	15 (0.4%)
No	3433 (99.6%)	744 (99.5%)	453 (100%)	1070 (99.4%)	3433 (99.6%)
Total	**3448 (100%)**	**748 (100%)**	**453 (100%)**	**1076 (100%)**	**3448 (100%)**

Figure A2.50: Coming out of Retirement to Support the Workforce by Occupation (Weighted)

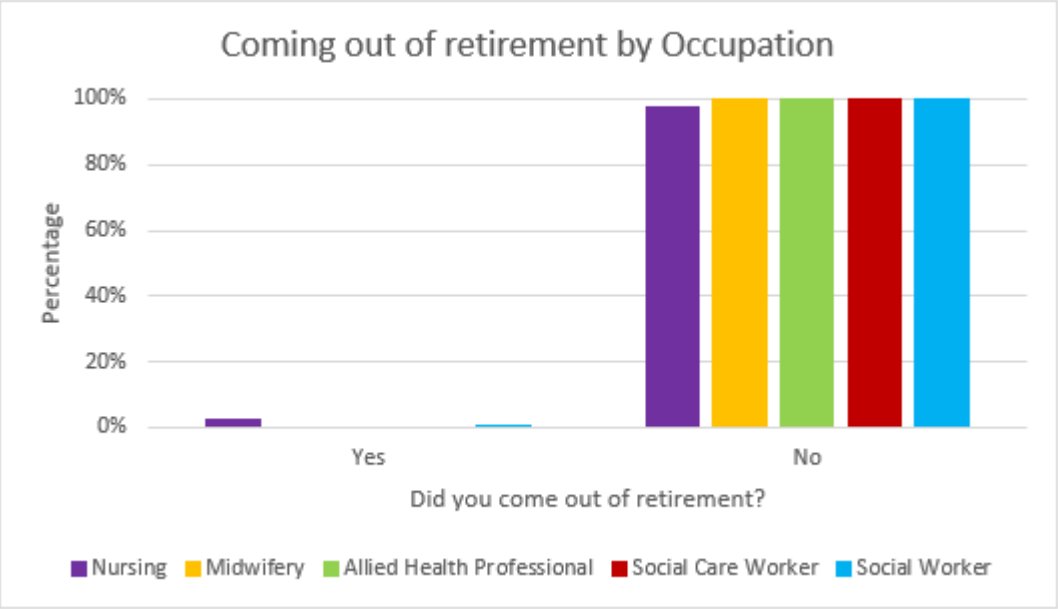

Figure A2.51: Coming out of Retirement to Support the Workforce by Occupation (Unweighted)

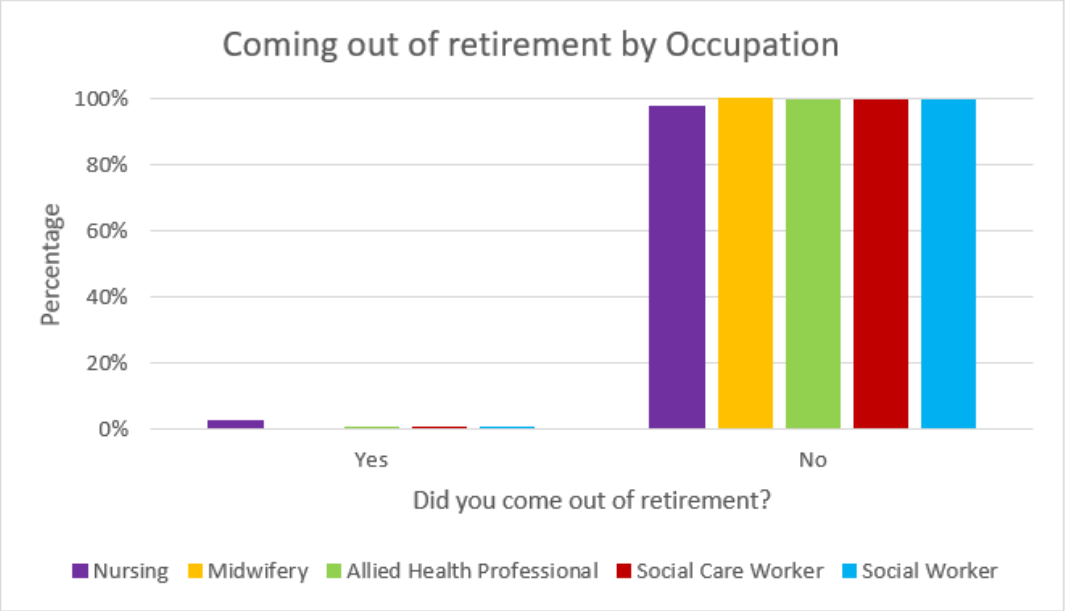

Table A2.50: Coming out of Retirement to Support the Workforce by Occupation (Weighted)

Occupation	Did you come out of retirement?		Total
	Yes	No	
Nursing	2.5%	97.5%	**100%**
Midwifery	0.0%	100%	**100%**
AHP	0.0%	100%	**100%**
Social Care Worker	0.0%	100%	**100%**
Social Worker	0.3%	99.7%	**100%**

Table A2.51: Coming out of Retirement to Support the Workforce by Occupation (Unweighted)

Occupation	Did you come out of retirement?		Total
	Yes	No	
Nursing	8 (2.3%)	346 (97.7%)	**354 (100%)**
Midwifery	0 (0.0%)	75 (100.0%)	**75 (100%)**
AHP	1 (0.2%)	628 (99.8%)	**629 (100%)**
Social Care Worker	1 (0.1%)	1238 (99.9%)	**1239 (100%)**
Social Worker	5 (0.4%)	1146 (99.6%)	**1151 (100%)**

A2.14 Job Tenure of Respondents

Summary (Weighted results):

The majority of respondents were employed on a permanent basis.

Summary (Unweighted results):

The majority of respondents were employed on a permanent basis.

Figure A2.52: Job Tenure by Country (Weighted)

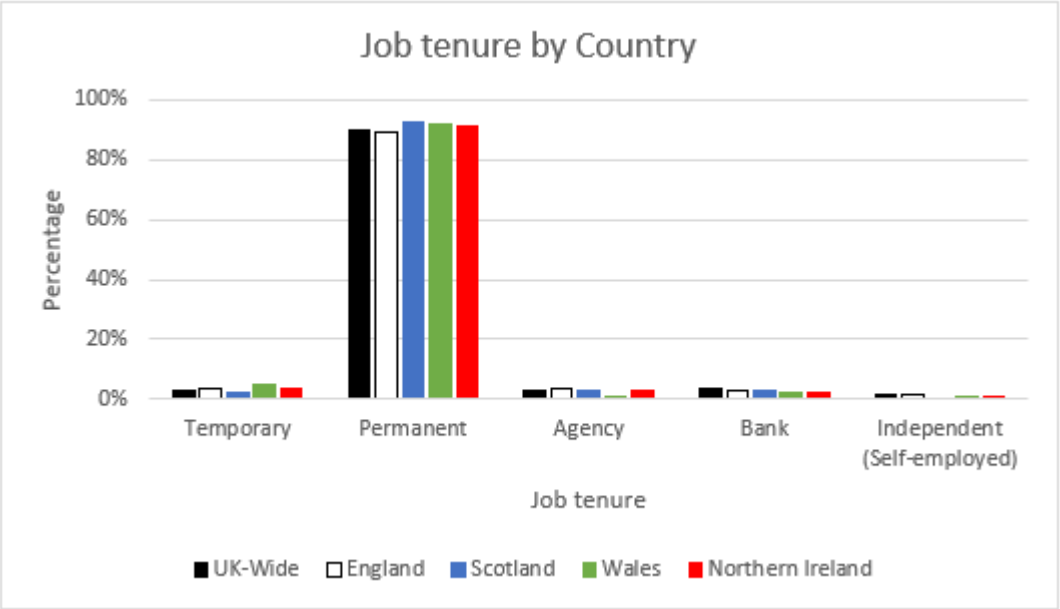

Figure A2.53: Job Tenure by Country (Unweighted)

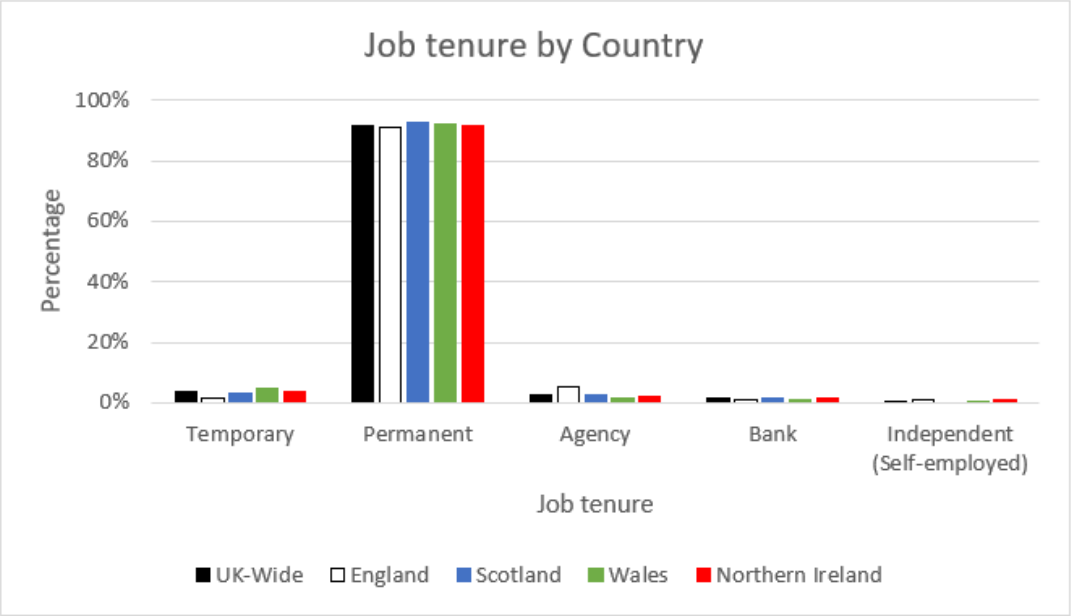

Table A2.52: Job Tenure by Country (Weighted)

	Country				
Job tenure	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Temporary	2.8%	3.4%	2.1%	4.7%	3.3%
Permanent	89.8%	89.1%	92.5%	92.2%	91.2%
Agency	2.8%	3.6%	2.5%	0.8%	2.8%
Bank	3.2%	2.6%	2.9%	2.0%	2.1%
Independent (Self-employed)	1.3%	1.3%	0.0%	0.3%	0.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.53: Job Tenure by Country (Unweighted)

	Country				
Job tenure	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Temporary	125 (3.6%)	13 (1.7%)	13 (2.9%)	54 (5.0%)	45 (3.8%)
Permanent	3165 (91.8%)	680 (90.9%)	421 (92.9%)	992 (92.3%)	1072 (91.6%)
Agency	92 (2.7%)	39 (5.2%)	11 (2.4%)	16 (1.5%)	26 (2.2%)
Bank	44 (1.3%)	9 (1.2%)	8 (1.8%)	10 (0.9%)	17 (1.5%)
Independent (Self-employed)	20 (0.6%)	7 (0.9%)	0 (0.0%)	3 (0.3%)	10 (0.9%)
Total	**3446 (100%)**	**748 (100%)**	**453 (100%)**	**1075 (100%)**	**1170 (100%)**

Figure A2.54: Job Tenure by Occupation (Weighted)

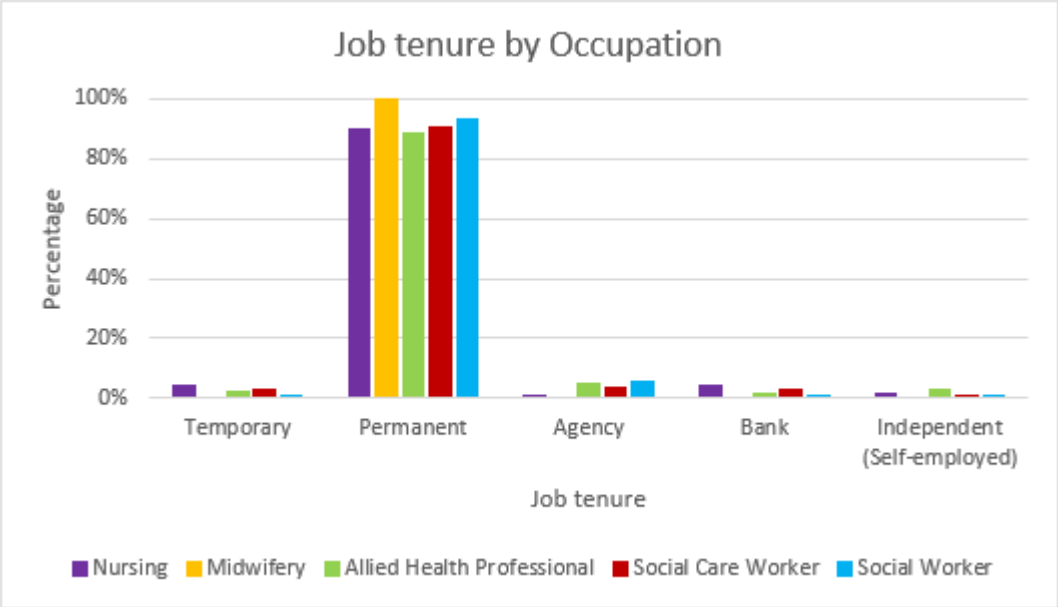

Figure A2.55: Job Tenure by Occupation (Unweighted)

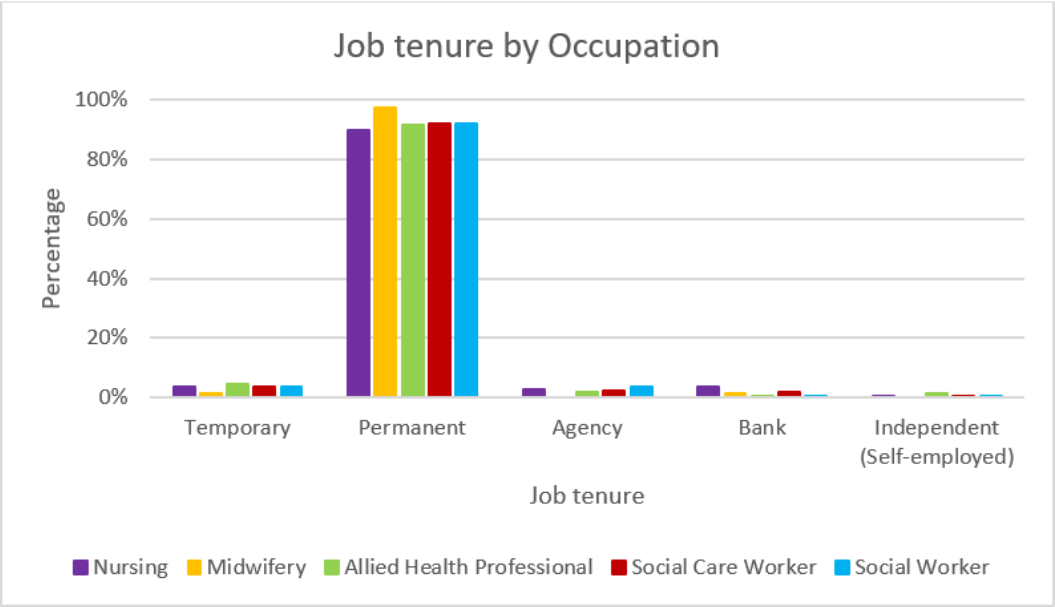

Table A2.54: Job Tenure by Occupation (Weighted)

	Job tenure					
Occupation	**Temporary**	**Permanent**	**Agency**	**Bank**	**Independent (Self-employed)**	**Total**
Nursing	3.9%	89.8%	1.1%	3.9%	1.4%	**100%**
Midwifery	0.0%	100%	0.0%	0.0%	0.0%	**100%**
AHP	1.9%	88.6%	5.0%	1.4%	3.1%	**100%**
Social Care Worker	2.6%	90.7%	3.3%	2.9%	0.6%	**100%**
Social Worker	1.1%	93.2%	5.2%	0.2%	0.4%	**100%**

Table A2.55: Job Tenure by Occupation (Unweighted)

Occupation	Job tenure					Total
	Temporary	Permanent	Agency	Bank	Independent (Self-employed)	
Nursing	12 (3.4%)	318 (89.8%)	9 (2.5%)	13 (3.7%)	2 (0.6%)	**354 (100%)**
Midwifery	1 (1.3%)	73 (97.3%)	0 (0.0%)	1 (1.3%)	0 (0.0%)	**75 (100%)**
AHP	27 (4.3%)	576 (91.7%)	12 (1.9%)	4 (0.6%)	9 (1.4%)	**628 (100%)**
Social Care Worker	44 (3.6%)	1140 (92.0%)	28 (2.3%)	23 (1.9%)	4 (0.3%)	**1239 (100%)**
Social Worker	41 (3.6%)	1058 (92.0%)	43 (3.7%)	3 (0.3%)	5 (0.4%)	**1150 (100%)**

A2.15 Respondents' Years of Experience

Summary (Weighted results):

The majority of respondents UK-wide reported having between 11-20 years of work experience. The highest proportion of these were in Scotland. Of those with more than 30 years of experience, the majority were nurses and midwives.

Summary (Unweighted results):

Almost one third of respondents UK-wide (30.4%) reported having between 11-20 years of work experience. The highest proportion of these were in Scotland. Of those with more than 30 years of experience, the majority were nurses and midwives.

Figure A2.56: Years of Experience by Country (Weighted)

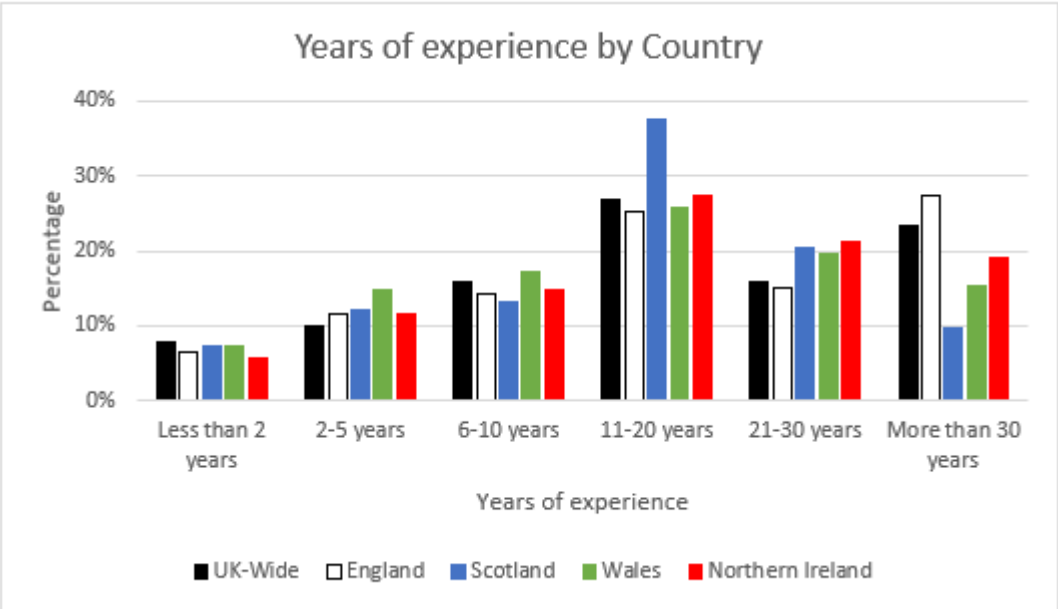

Figure A2.57: Years of Experience by Country (Unweighted)

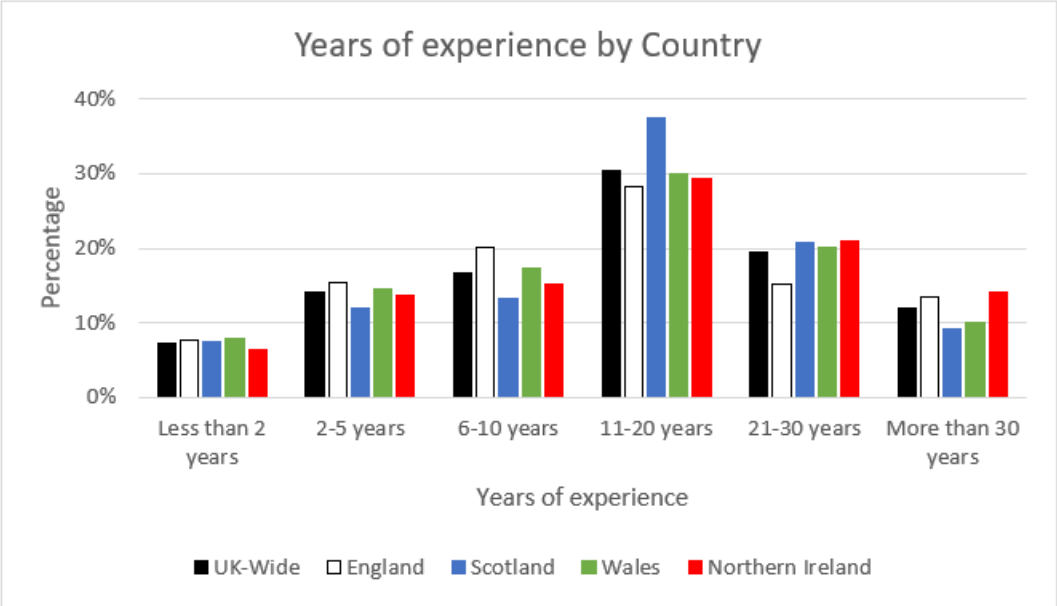

Table A2.56: Years of Experience by Country (Weighted)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	7.9%	6.5%	7.3%	7.3%	5.8%
2-5 years	10.0%	11.6%	12.1%	14.9%	11.7%
6-10 years	16.0%	14.2%	13.1%	17.2%	14.7%
11-20 years	26.8%	25.3%	37.5%	25.7%	27.4%
21-30 years	15.8%	15.0%	20.4%	19.6%	21.2%
More than 30 years	23.5%	27.4%	9.6%	15.4%	19.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.57: Years of Experience by Country (Unweighted)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	251 (7.3%)	57 (7.6%)	34 (7.5%)	85 (7.9%)	75 (6.4%)
2-5 years	488 (14.2%)	116 (15.5%)	54 (11.9%)	157 (14.6%)	151 (13.8%)
6-10 years	575 (16.7%)	150 (20.1%)	60 (13.2%)	187 (17.4%)	178 (15.2%)
11-20 years	1047 (30.4%)	211 (28.2%)	170 (37.5%)	322 (30.0%)	344 (29.4%)
21-30 years	669 (19.4%)	113 (15.1%)	94 (20.8%)	216 (20.1%)	246 (21.0%)
More than 30 years	415 (12.0%)	101 (13.5%)	41 (9.1%)	108 (10.0%)	165 (14.1%)
Total	**3445 (100%)**	**748 (100%)**	**453 (100%)**	**1075 (100%)**	**1169 (100%)**

Figure A2.58: Years of Experience by Occupation (Weighted)

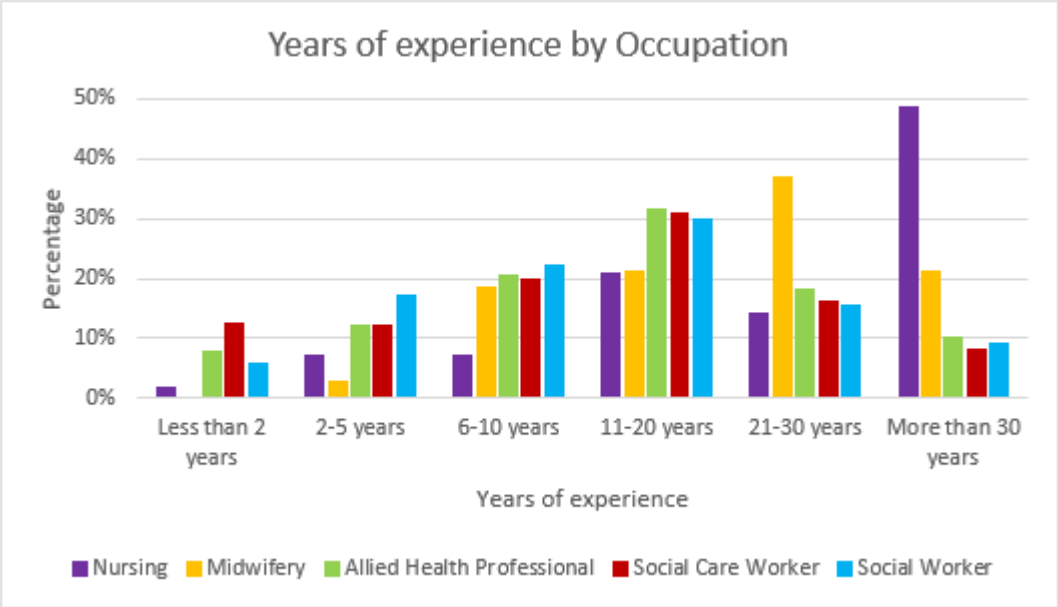

Figure A2.59: Years of Experience by Occupation (Unweighted)

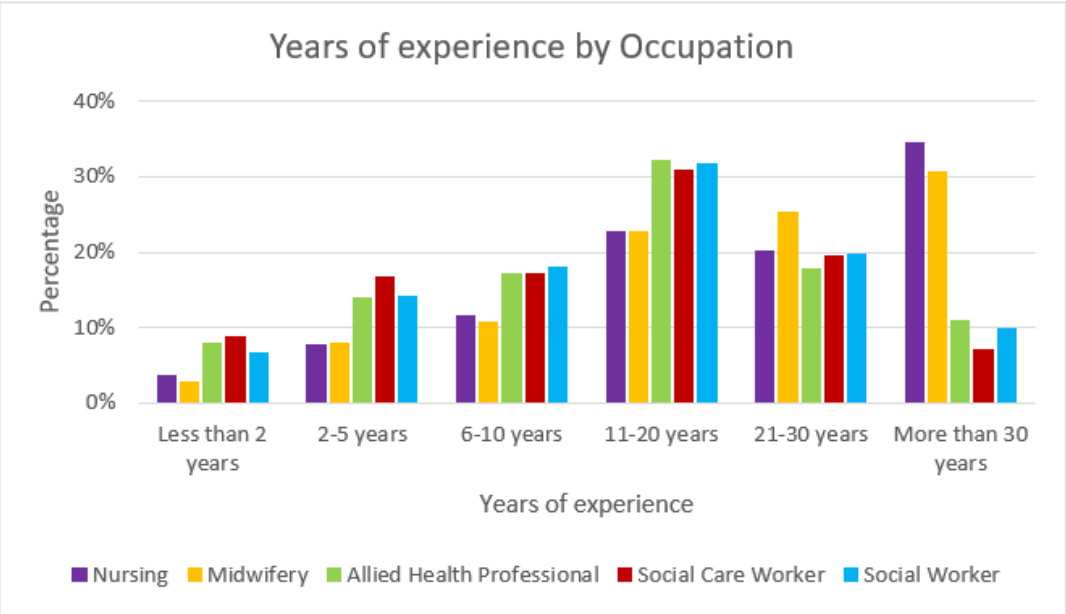

Table A2.58: Years of Experience by Occupation (Weighted)

	Years of experience						
Occupation	**Less than 2 years**	**2-5 years**	**6-10 years**	**11-20 years**	**21-30 years**	**More than 30 years**	**Total**
Nursing	1.9%	7.2%	7.2%	20.8%	14.1%	48.8%	**100%**
Midwifery	0.0%	2.6%	18.4%	21.1%	36.8%	21.1%	**100%**
AHP	7.8%	12.0%	20.4%	31.7%	18.1%	10.1%	**100%**
Social Care Worker	12.6%	12.1%	20.0%	30.8%	16.3%	8.2%	**100%**
Social Worker	5.9%	17.3%	22.1%	29.8%	15.6%	9.2%	**100%**

Table A2.59: Years of Experience by Occupation (Unweighted)

Occupation	Years of experience						Total
	Less than 2 years	2-5 years	6-10 years	11-20 years	21-30 years	More than 30 years	
Nursing	13 (3.7%)	27 (7.6%)	41 (11.6%)	80 (22.6%)	71 (20.1%)	122 (34.5%)	**354 (100%)**
Midwifery	2 (2.7%)	6 (8.0%)	8 (10.7%)	17 (22.7%)	19 (25.3%)	23 (30.7%)	**75 (100%)**
AHP	50 (8.0%)	87 (13.9%)	108 (17.2%)	202 (32.2%)	111 (17.7%)	69 (11.0%)	**627 (100%)**
Social Care Worker	109 (8.8%)	205 (16.6%)	212 (17.1%)	383 (30.9%)	241 (19.5%)	88 (7.1%)	**1238 (100%)**
Social Worker	77 (6.7%)	163 (14.2%)	206 (17.9%)	365 (31.7%)	227 (19.7%)	113 (9.8%)	**1151 (100%)**

A2.16 Respondents' Main Area of Practice

Summary (Weighted results):

Adults, older people and children were the most frequently reported areas of practice by respondents.

Summary (Unweighted results):

Children, adults and older people were the most frequently reported areas of practice by respondents.

Figure A2.60: Main Area of Practice by Country (Weighted)

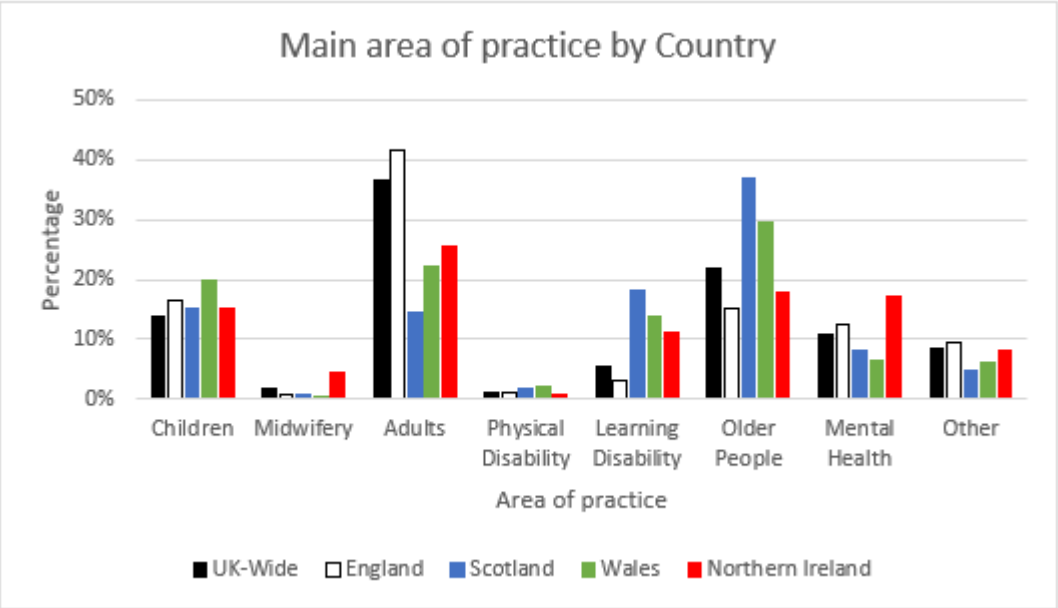

Figure A2.61: Main Area of Practice by Country (Unweighted)

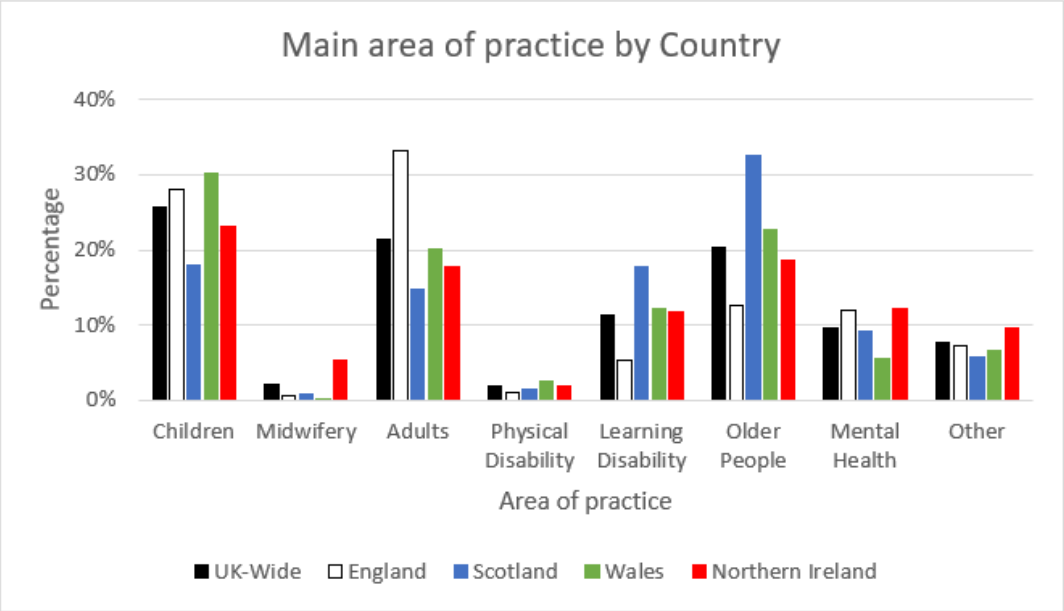

Table A2.60: Main Area of Practice by Country (Weighted)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	13.8%	16.4%	15.0%	19.7%	15.3%
Midwifery	1.9%	0.8%	0.8%	0.1%	4.3%
Adults	36.7%	41.7%	14.6%	22.1%	25.6%
Physical Disability	1.0%	1.0%	1.7%	2.0%	0.9%
Learning Disability	5.3%	3.1%	18.3%	13.8%	11.0%
Older People	21.9%	15.1%	36.9%	29.6%	17.8%
Mental Health	10.8%	12.5%	8.1%	6.6%	17.1%
Other	8.5%	9.3%	4.6%	6.0%	8.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.61: Main Area of Practice by Country (Unweighted)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	885 (25.7%)	210 (28.1%)	81 (17.9%)	324 (30.1%)	270 (23.1%)
Midwifery	72 (2.1%)	5 (0.7%)	4 (0.9%)	1 (0.1%)	62 (5.3%)
Adults	739 (21.4%)	248 (33.2%)	67 (14.8%)	217 (20.2%)	207 (17.7%)
Physical Disability	63 (1.8%)	8 (1.1%)	7 (1.5%)	27 (2.5%)	21 (1.8%)
Learning Disability	389 (11.3%)	40 (5.3%)	80 (17.7%)	132 (12.3%)	137 (11.7%)
Older People	704 (20.4%)	94 (12.6%)	147 (32.5%)	244 (22.7%)	219 (18.7%)
Mental Health	331 (9.6%)	89 (11.9%)	41 (9.1%)	60 (5.6%)	141 (12.1%)
Other	263 (7.6%)	54 (7.2%)	26 (5.7%)	71 (6.6%)	112 (9.6%)
Total	**3446 (100%)**	**748 (100%)**	**453 (100%)**	**1076 (100%)**	**1169 (100%)**

Figure A2.62: Main Area of Practice by Occupation (Weighted)

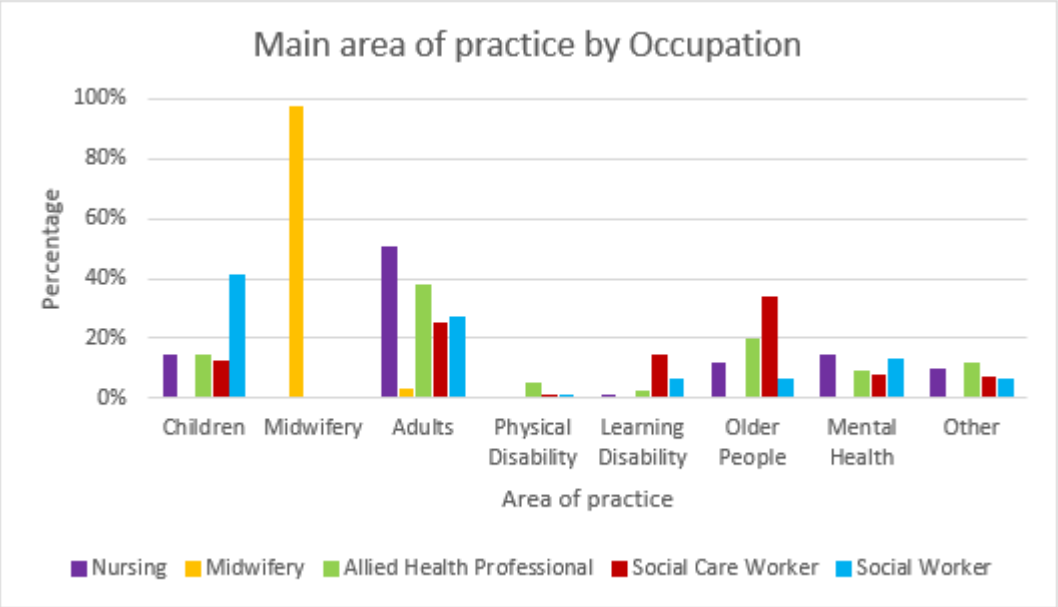

Figure A2.63: Main Area of Practice by Occupation (Unweighted)

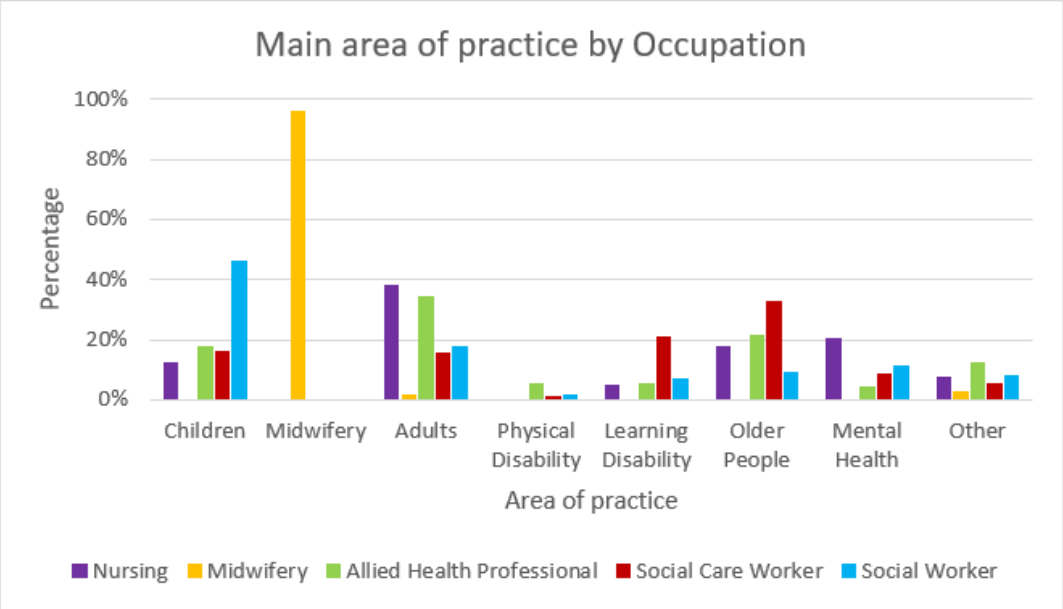

Table A2.62: Main Area of Practice by Occupation (Weighted)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	14.0%	0.0%	14.4%	12.4%	41.1%
Midwifery	0.0%	97.4%	0.0%	0.0%	0.0%
Adults	50.5%	2.6%	37.9%	24.9%	27.0%
Physical Disability	0.0%	0.0%	4.9%	0.9%	0.5%
Learning Disability	0.5%	0.0%	2.3%	13.9%	6.3%
Older People	11.3%	0.0%	19.6%	33.4%	6.1%
Mental Health	14.0%	0.0%	9.1%	7.8%	13.1%
Other	9.6%	0.0%	11.8%	6.6%	5.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.63: Main Area of Practice by Occupation (Unweighted)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	44 (12.4%)	0 (0.0%)	111 (17.7%)	200 (16.1%)	530 (46.0%)
Midwifery	0 (0.0%)	72 (96.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Adults	134 (37.9%)	1 (1.3%)	213 (34.0%)	189 (15.3%)	202 (17.5%)
Physical Disability	0 (0.0%)	0 (0.0%)	33 (5.3%)	15 (1.2%)	15 (1.3%)
Learning Disability	17 (4.8%)	0 (0.0%)	33 (5.3%)	257 (20.7%)	82 (7.1%)
Older People	62 (17.5%)	0 (0.0%)	133 (21.2%)	404 (32.6%)	105 (9.1%)
Mental Health	71 (20.1%)	0 (0.0%)	27 (4.3%)	106 (8.6%)	127 (11.0%)
Other	26 (7.3%)	2 (2.7%)	77 (12.3%)	68 (5.5%)	90 (7.8%)
Total	**354 (100%)**	**75 (100%)**	**627 (100%)**	**1239 (100%)**	**1151 (100%)**

A2.17 Respondents Employed Full- or Part-Time

Summary (Weighted results):

The majority of respondents were employed full-time. Scotland had the highest proportion of respondents employed on a part-time basis. Social workers had the highest proportion employed full-time, whereas nurses had the highest proportion employed part-time.

Summary (Unweighted results):

The majority of respondents were employed full-time. Scotland had the highest proportion of respondents (35.0%) employed on a part-time basis.

Figure A2.64: Employed Full- or Part-Time by Country (Weighted)

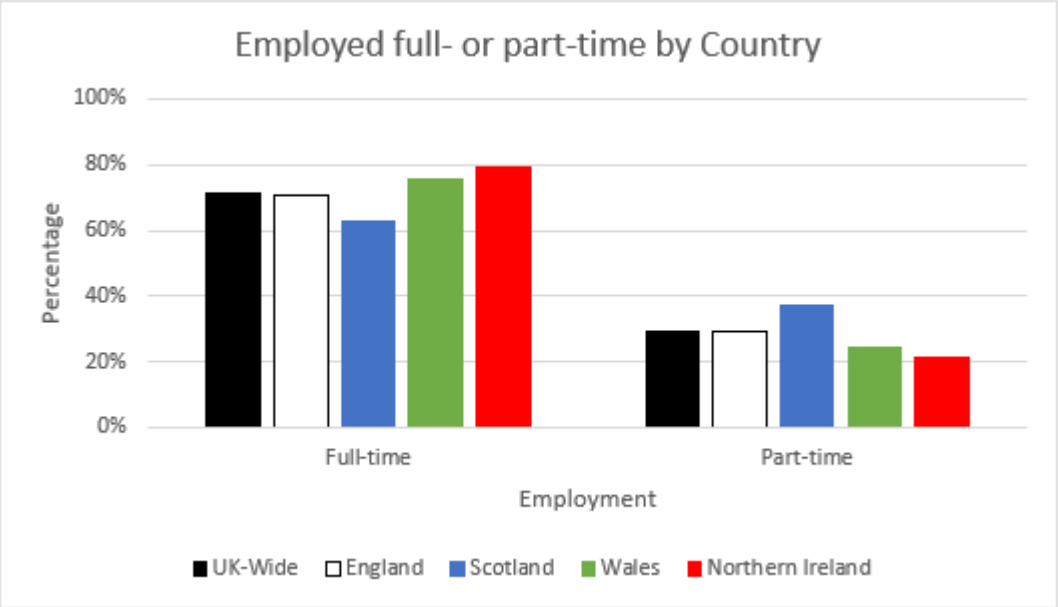

Figure A2.65: Employed Full- or Part-Time by Country (Unweighted)

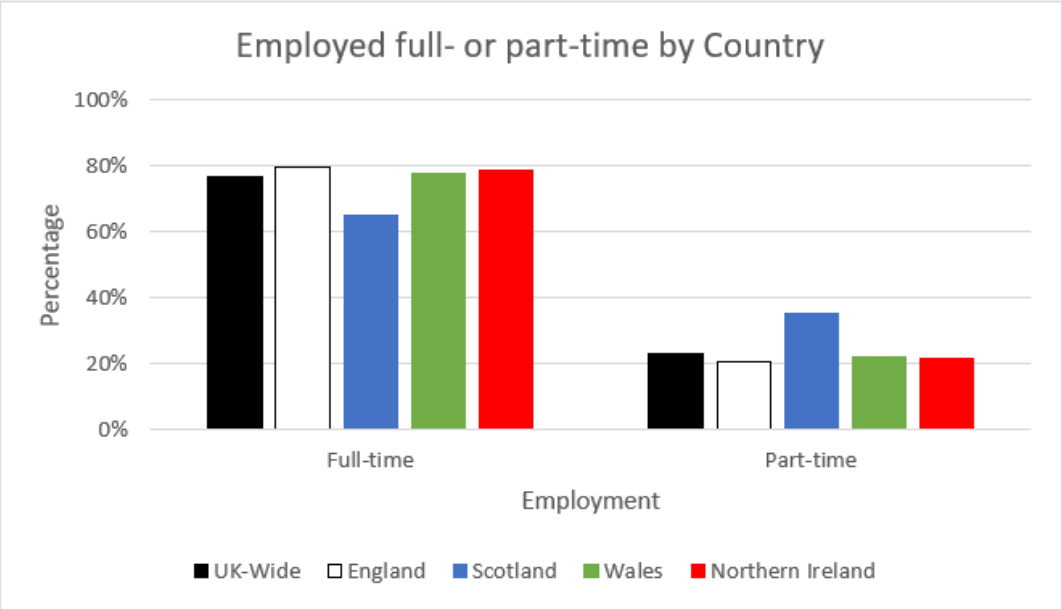

Table A2.64: Employed Full- or Part-Time by Country (Weighted)

	Country				
Employment	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Full-time	71.0%	70.6%	62.9%	75.6%	79.0%
Part-time	29.0%	29.4%	37.1%	24.4%	21.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.65: Employed Full- or Part-Time by Country (Unweighted)

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	2623 (76.8%)	592 (79.6%)	291 (65.0%)	832 (77.8%)	908 (78.5%)
Part-time	794 (23.2%)	152 (20.4%)	157 (35.0%)	237 (22.2%)	248 (21.5%)
Total	**3417 (100%)**	**744 (100%)**	**448 (100%)**	**1069 (100%)**	**1156 (100%)**

Figure A2.66: Employed Full- or Part-Time by Occupation (Weighted)

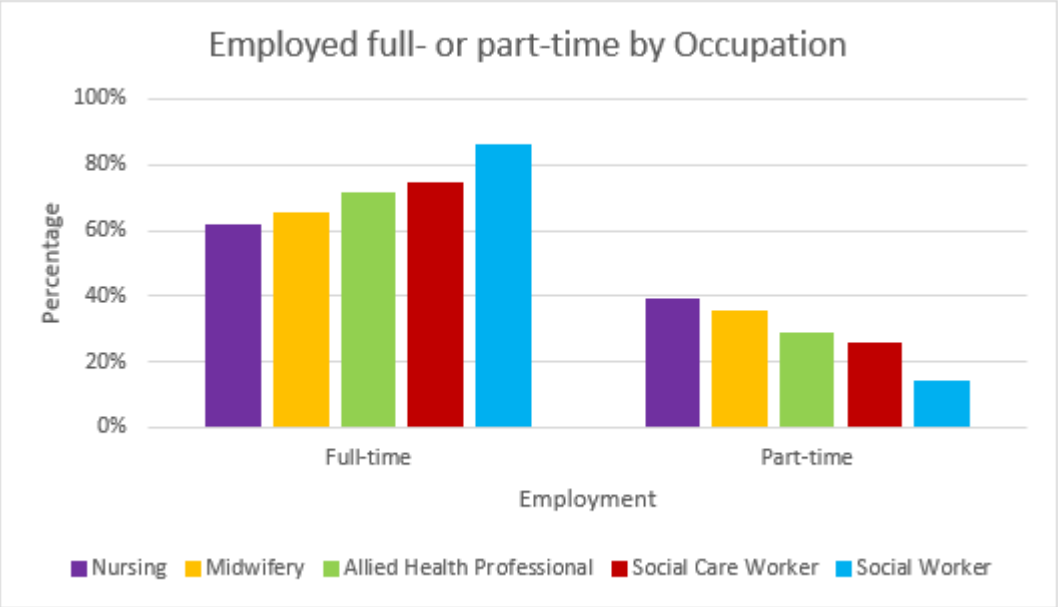

Figure A2.67: Employed Full- or Part-Time by Occupation (Unweighted)

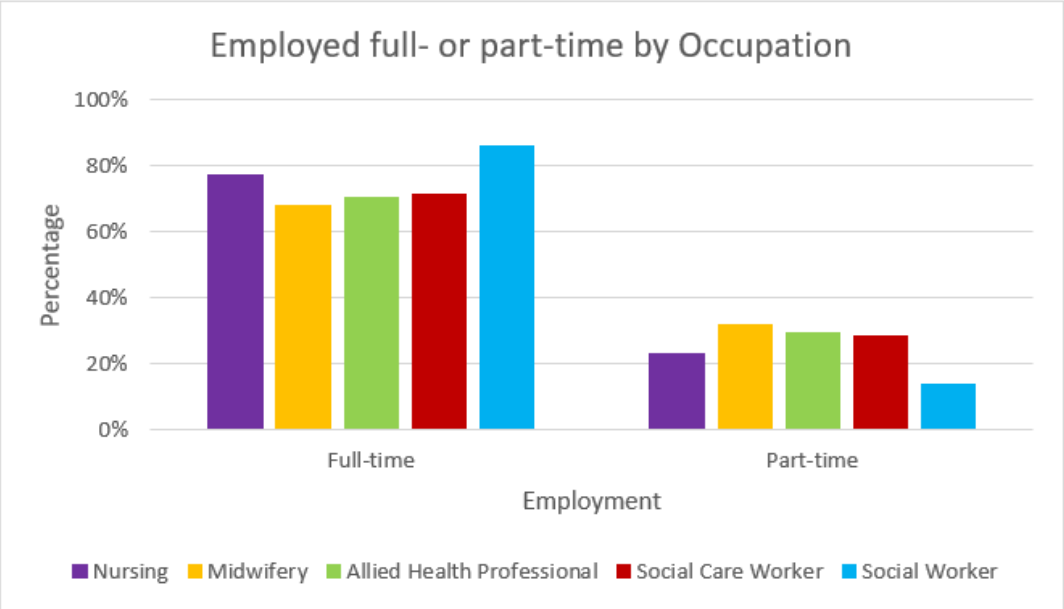

Table A2.66: Employed Full- or Part-Time by Occupation (Weighted)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	61.3%	38.7%	**100%**
Midwifery	64.9%	35.1%	**100%**
AHP	71.5%	28.5%	**100%**
Social Care Worker	74.3%	25.7%	**100%**
Social Worker	85.9%	14.1%	**100%**

Table A2.67: Employed Full- or Part-Time by Occupation (Unweighted)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	271 (77.0%)	81 (23.0%)	**352 (100%)**
Midwifery	51 (68.0%)	24 (32.0%)	**75 (100%)**
AHP	438 (70.5%)	183 (29.5%)	**621 (100%)**
Social Care Worker	877 (71.6%)	348 (28.4%)	**1225 (100%)**
Social Worker	986 (86.2%)	158 (13.8%)	**1144 (100%)**

A2.18 Respondents' Number of Hours Worked per Week

Summary (Weighted results):

Respondents were asked how many hours of work per week they typically do and for the majority, it was 37.5 hours per week.

Summary (Unweighted results):

Respondents were asked how many hours of work per week they typically do and for the majority, it was 37.5 hours per week.

Figure A2.68: Number of Hours Worked per Week by Country (Weighted)

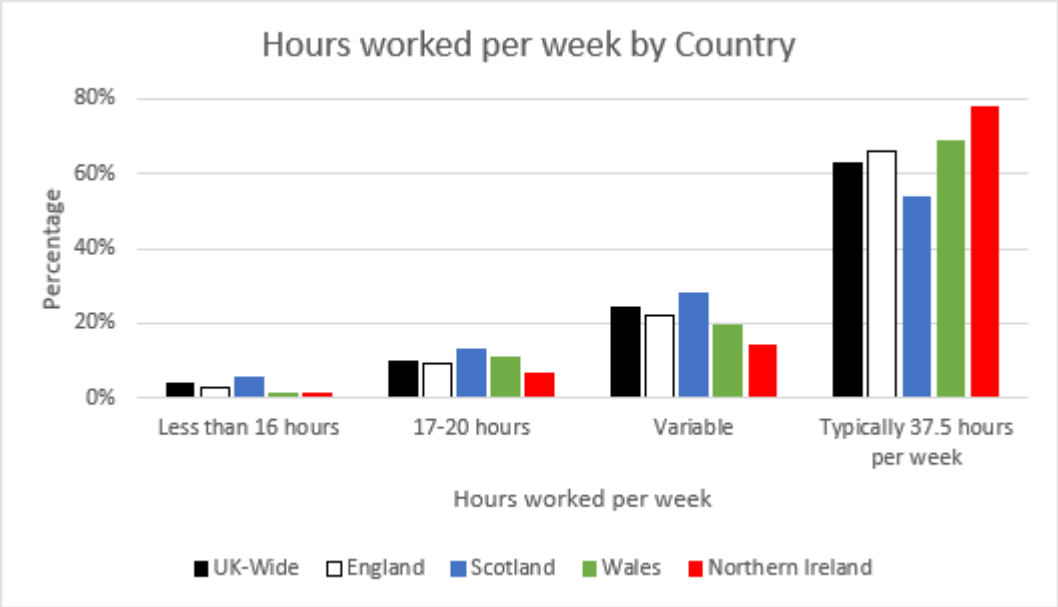

Figure A2.69: Number of Hours Worked per Week by Country (Unweighted)

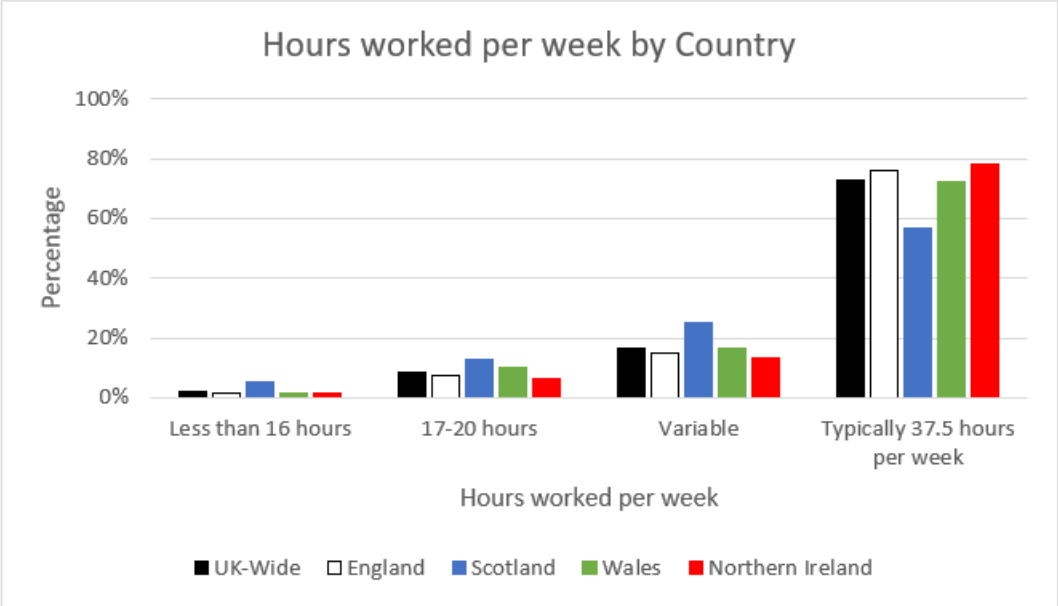

Table A2.68: Number of Hours Worked per Week by Country (Weighted)

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	3.7%	2.8%	5.3%	1.4%	1.4%
17-20 hours	9.5%	9.3%	13.0%	10.6%	6.4%
Variable	24.0%	22.1%	28.0%	19.4%	14.2%
Typically 37.5 hours per week	62.8%	65.8%	53.6%	68.6%	78.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.69: Number of Hours Worked per Week by Country (Unweighted)

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	68 (2.0%)	12 (1.6%)	23 (5.2%)	14 (1.3%)	19 (1.7%)
17-20 hours	290 (8.6%)	54 (7.3%)	57 (12.9%)	105 (9.9%)	74 (6.4%)
Variable	553 (16.3%)	110 (14.9%)	111 (25.2%)	177 (16.7%)	155 (13.5%)
Typically 37.5 hours per week	2475 (73.1%)	560 (76.1%)	250 (56.7%)	764 (72.1%)	901 (78.4%)
Total	**3386 (100%)**	**736 (100%)**	**441 (100%)**	**1060 (100%)**	**1149 (100%)**

Figure A2.70: Number of Hours Worked per Week by Occupation (Weighted)

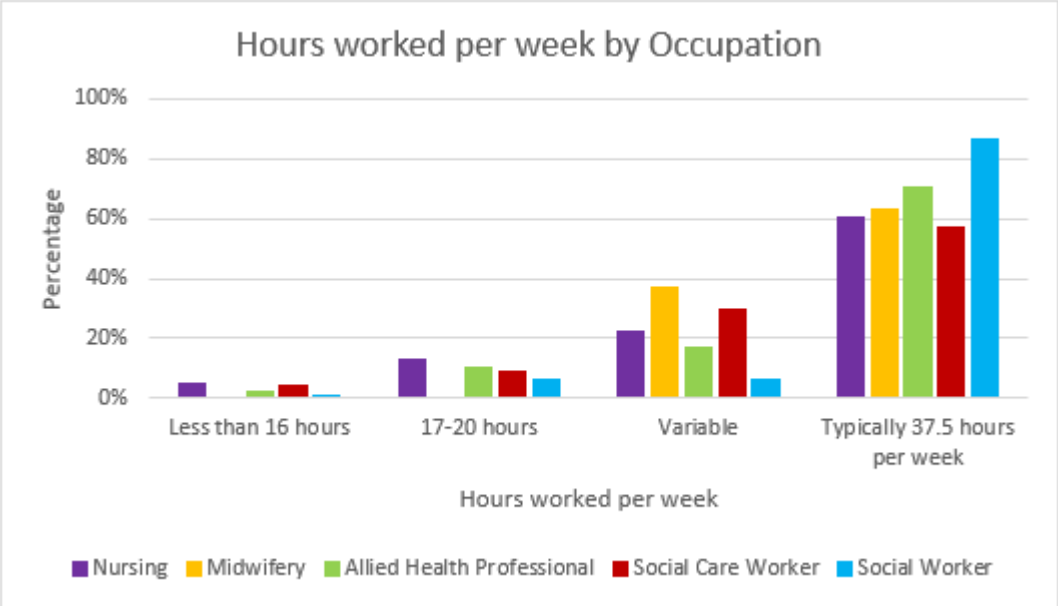

Figure A2.71: Number of Hours Worked per Week by Occupation (Unweighted)

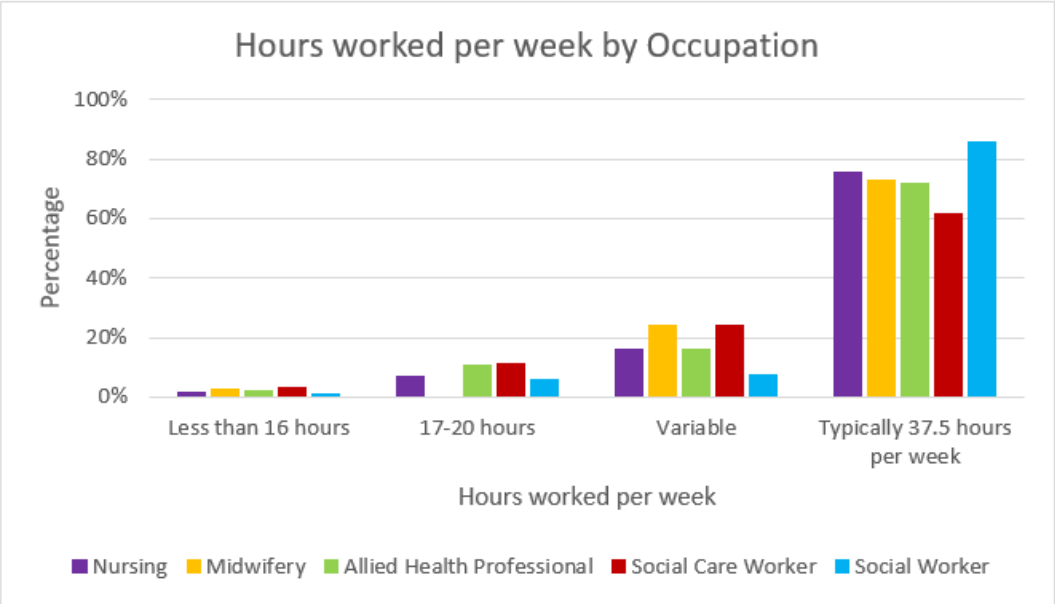

Table A2.70: Number of Hours Worked per Week by Occupation (Weighted)

Occupation	How many hours of work per week do you typically do?				Total
	Less than 16 hours	17-20 hours	Variable	Typically 37.5 hours per week	
Nursing	4.8%	12.6%	22.4%	60.2%	**100%**
Midwifery	0.0%	0.0%	36.8%	63.2%	**100%**
AHP	2.2%	10.3%	16.7%	70.8%	**100%**
Social Care Worker	4.0%	9.0%	29.7%	57.2%	**100%**
Social Worker	0.8%	6.5%	6.4%	86.3%	**100%**

Table A2.71: Number of Hours Worked per Week by Occupation (Unweighted)

Occupation	How many hours of work per week do you typically do?				Total
	Less than 16 hours	17-20 hours	Variable	Typically 37.5 hours per week	
Nursing	5 (1.4%)	25 (7.1%)	56 (15.9%)	266 (75.6%)	**352 (100%)**
Midwifery	2 (2.7%)	0 (0.0%)	18 (24.3%)	54 (73.0%)	**74 (100%)**
AHP	13 (2.1%)	64 (10.5%)	97 (15.9%)	436 (71.5%)	**610 (100%)**
Social Care Worker	38 (3.1%)	136 (11.2%)	295 (24.3%)	746 (61.4%)	**1215 (100%)**
Social Worker	10 (0.9%)	65 (5.7%)	87 (7.7%)	973 (85.7%)	**1135 (100%)**

A2.19 Respondents Typically Working Overtime

Summary (Weighted results):

Respondents were asked if they typically work overtime and the most frequent response across the countries was 'No'.

Summary (Unweighted results):

Respondents were asked if they typically work overtime and the most frequent response across the countries was 'No'. AHPs were the least likely to work overtime.

Figure A2.72: Typically Working Overtime by Country (Weighted)

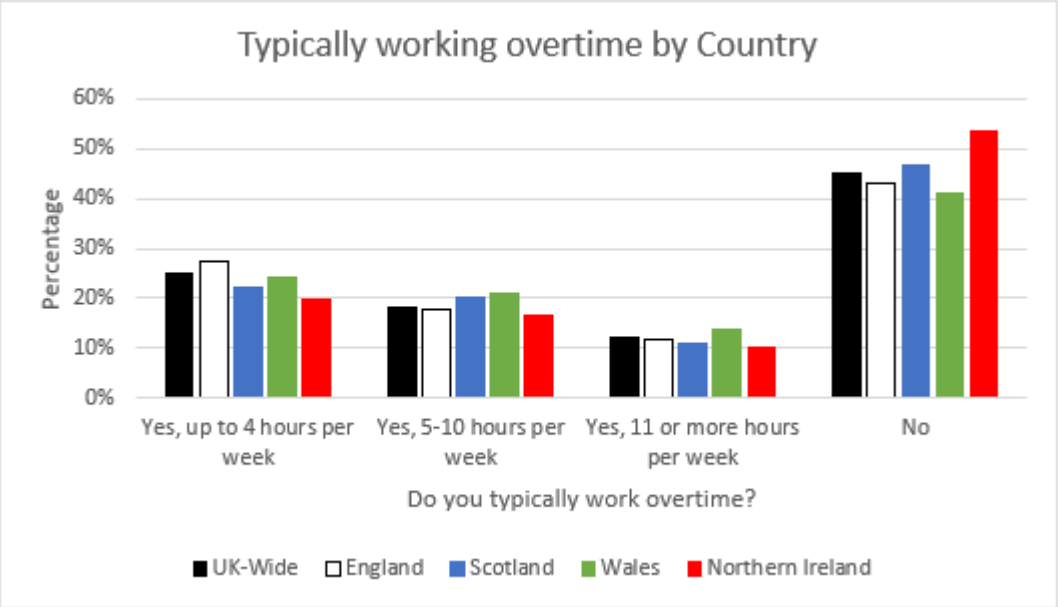

Figure A2.73: Typically Working Overtime by Country (Unweighted)

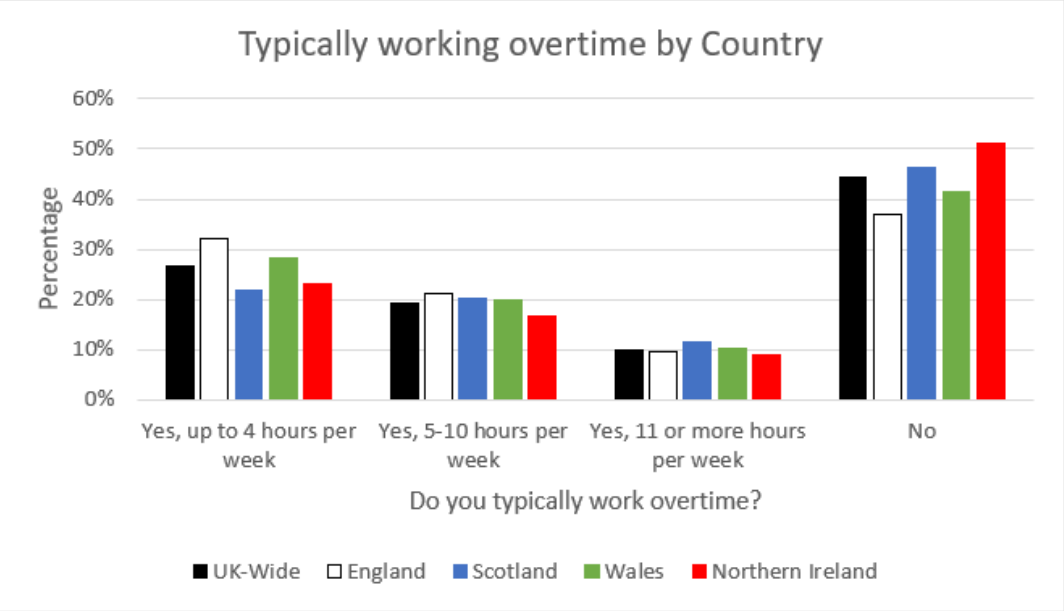

Table A2.72: Typically Working Overtime by Country (Weighted)

	Country				
Do you typically work overtime?	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Yes, up to 4 hours per week	25.0%	27.5%	22.2%	24.3%	19.8%
Yes, 5-10 hours per week	18.0%	17.8%	20.1%	20.9%	16.5%
Yes, 11 or more hours per week	12.0%	11.7%	10.8%	13.8%	10.3%
No	45.0%	43.1%	46.9%	40.9%	53.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.73: Typically Working Overtime by Country (Unweighted)

Do you typically work overtime?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, up to 4 hours per week	904 (26.5%)	239 (32.1%)	98 (21.9%)	302 (28.3%)	265 (23.0%)
Yes, 5-10 hours per week	657 (19.2%)	158 (21.2%)	91 (20.3%)	214 (20.0%)	194 (16.8%)
Yes, 11 or more hours per week	338 (9.9%)	72 (9.7%)	51 (11.4%)	111 (10.4%)	104 (9.0%)
No	1515 (44.4%)	275 (37.0%)	208 (46.4%)	441 (41.3%)	591 (51.2%)
Total	**3414 (100%)**	**744 (100%)**	**448 (100%)**	**1068 (100%)**	**1154 (100%)**

Figure A2.74: Typically Working Overtime by Occupation (Weighted)

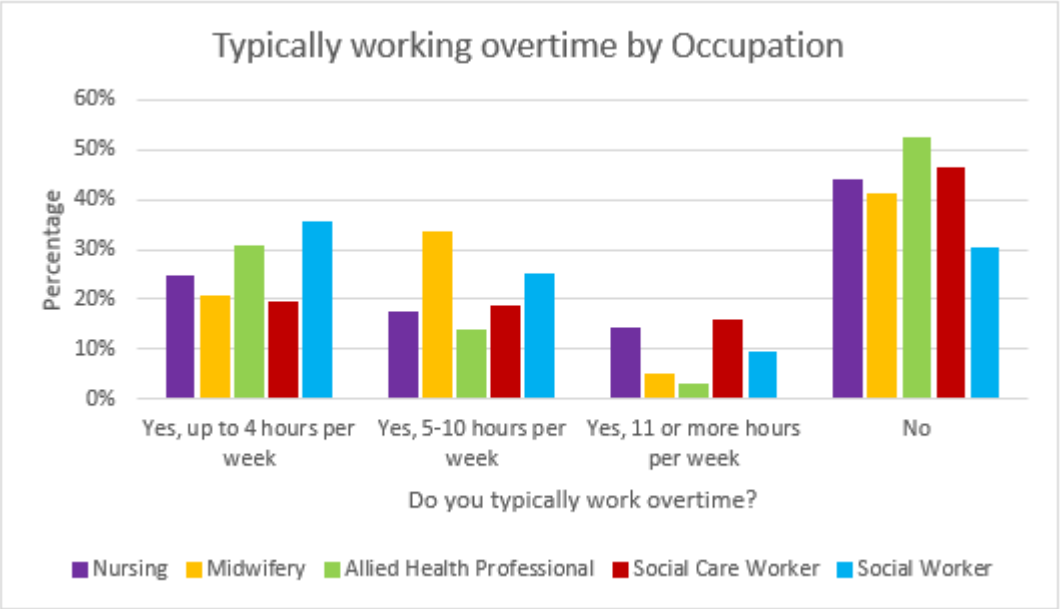

Figure A2.75: Typically Working Overtime by Occupation (Unweighted)

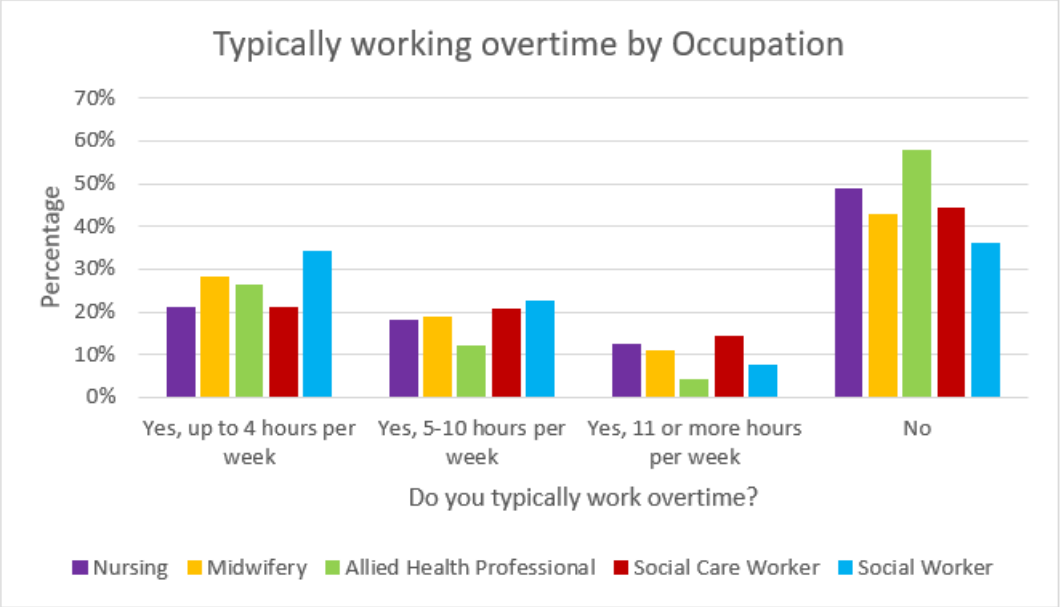

Table A2.74: Typically Working Overtime by Occupation (Weighted)

Occupation	Do you typically work overtime?				Total
	Yes, up to 4 hours per week	Yes, 5-10 hours per week	Yes, 11 or more hours per week	No	
Nursing	24.6%	17.3%	14.0%	44.1%	**100%**
Midwifery	20.5%	33.3%	5.1%	41.0%	**100%**
AHP	30.6%	13.9%	2.9%	52.5%	**100%**
Social Care Worker	19.3%	18.6%	15.8%	46.3%	**100%**
Social Worker	35.6%	24.9%	9.4%	30.1%	**100%**

Table A2.75: Typically Working Overtime by Occupation (Unweighted)

Occupation	Do you typically work overtime?				Total
	Yes, up to 4 hours per week	Yes, 5-10 hours per week	Yes, 11 or more hours per week	No	
Nursing	74 (21.0%)	63 (17.9%)	43 (12.2%)	172 (48.9%)	**352 (100%)**
Midwifery	21 (28.0%)	14 (18.7%)	8 (10.7%)	32 (42.7%)	**75 (100%)**
AHP	163 (26.2%)	74 (11.9%)	26 (4.2%)	358 (57.6%)	**621 (100%)**
Social Care Worker	256 (20.9%)	251 (20.5%)	175 (14.3%)	542 (44.3%)	**1224 (100%)**
Social Worker	390 (34.2%)	255 (22.3%)	86 (7.5%)	411 (36.0%)	**1142 (100%)**

A2.20 Respondents' Hours of Overtime per Week since the Start of the Pandemic

Respondents were also asked how many hours of overtime per week they have been doing since the start of the pandemic.

Summary (Weighted results):

Overall, across the countries, respondents have been working significantly more hours overtime since the start of the pandemic, compared to before. All occupational groups have also been working significantly more overtime hours since the start of the pandemic, compared to before.

Summary (Unweighted results):

On average, across all countries, respondents have been working significantly more hours overtime since the start of the pandemic, compared to before. All occupational groups, except for midwives, have also been working significantly more overtime hours since the start of the pandemic, compared to before.

Figure A2.76: Overtime since the Start of the Pandemic by Country (Weighted)

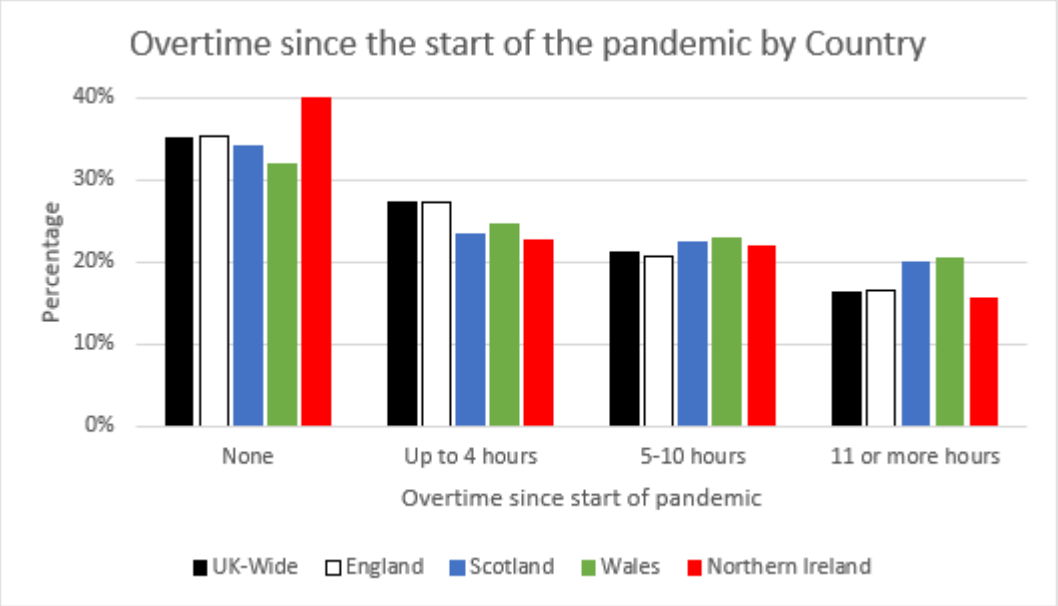

Figure A2.77: Overtime since the Start of the Pandemic by Country (Unweighted)

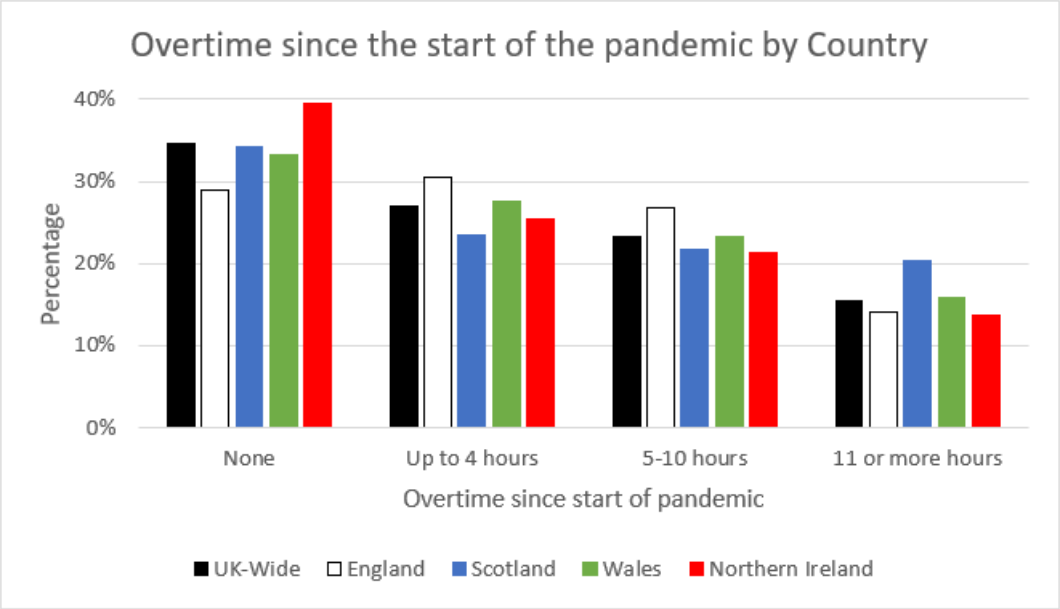

Table A2.76: Overtime since the Start of the Pandemic by Country (Weighted)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	35.0%	35.3%	34.2%	31.9%	40.0%
Up to 4 hours	27.2%	27.3%	23.5%	24.7%	22.6%
5-10 hours	21.3%	20.8%	22.4%	22.9%	21.9%
11 or more hours	16.4%	16.6%	19.9%	20.5%	15.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.77: Overtime since the Start of the Pandemic by Country (Unweighted)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	1175 (34.5%)	215 (28.9%)	153 (34.3%)	354 (33.2%)	453 (39.4%)
Up to 4 hours	919 (27.0%)	226 (30.4%)	105 (23.5%)	295 (27.6%)	293 (25.5%)
5-10 hours	789 (23.2%)	199 (26.7%)	97 (21.7%)	248 (23.2%)	245 (21.3%)
11 or more hours	524 (15.4%)	104 (14.0%)	91 (20.4%)	170 (15.9%)	159 (13.8%)
Total	**3407 (100%)**	**744 (100%)**	**446 (100%)**	**1067 (100%)**	**1150 (100%)**

Figure A2.78: Overtime since the Start of the Pandemic by Occupation (Weighted)

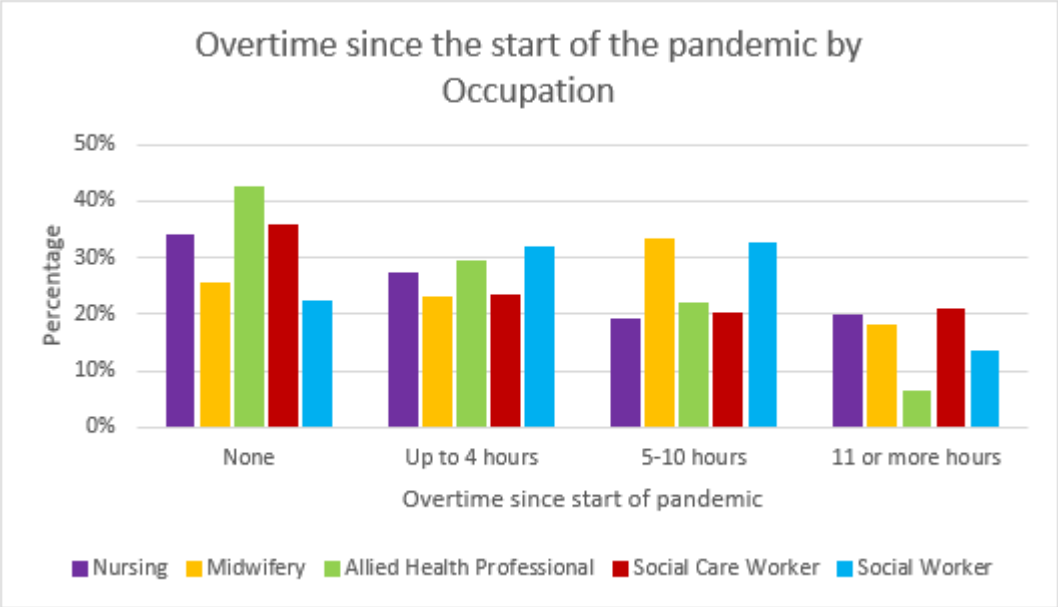

Figure A2.79: Overtime since the Start of the Pandemic by Occupation (Unweighted)

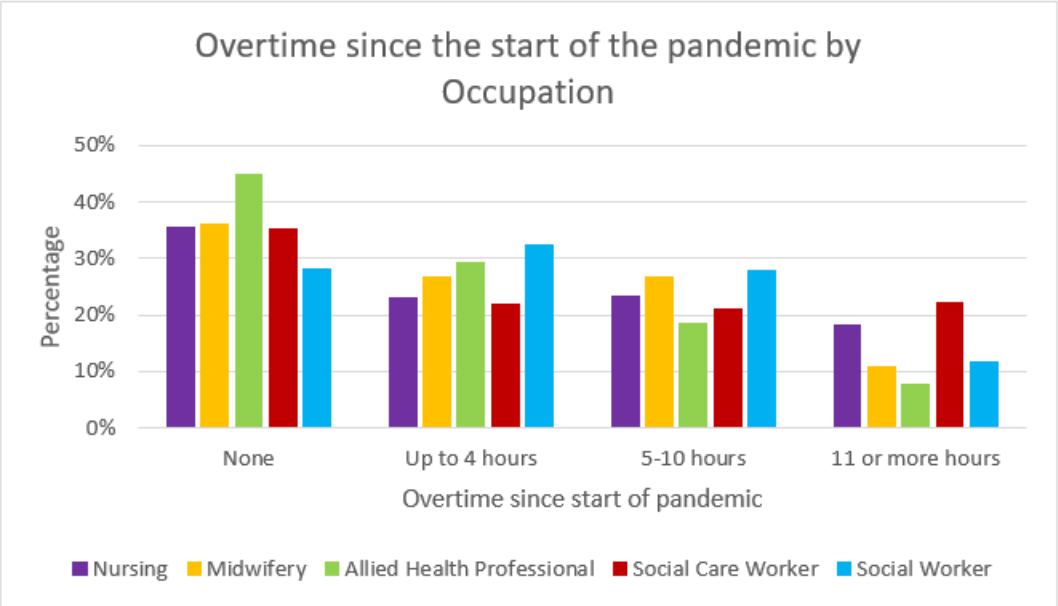

Table A2.78: Overtime since the Start of the Pandemic by Occupation (Weighted)

	Overtime per week since the start of the pandemic				
Occupation	**None**	**Up to 4 hours**	**5-10 hours**	**11 or more hours**	**Total**
Nursing	34.1%	27.1%	19.0%	19.8%	**100%**
Midwifery	25.6%	23.1%	33.3%	17.9%	**100%**
AHP	42.4%	29.3%	22.0%	6.3%	**100%**
Social Care Worker	35.8%	23.3%	20.1%	20.7%	**100%**
Social Worker	22.3%	31.8%	32.4%	13.5%	**100%**

Table A2.79: Overtime since the Start of the Pandemic by Occupation (Unweighted)

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	125 (35.5%)	81 (23.0%)	82 (23.3%)	64 (18.2%)	**352 (100%)**
Midwifery	27 (36.0%)	20 (26.7%)	20 (26.7%)	8 (10.7%)	**75 (100%)**
AHP	276 (44.7%)	181 (29.3%)	114 (18.4%)	47 (7.6%)	**618 (100%)**
Social Care Worker	428 (35.1%)	266 (21.8%)	256 (21.0%)	271 (22.2%)	**1221 (100%)**
Social Worker	319 (28.0%)	371 (32.5%)	317 (27.8%)	134 (11.7%)	**1141 (100%)**

A2.21 Respondents' Number of Sick Days in the last 12 months

Summary (Weighted results):

About half of the respondents (49.2%) had not taken any sick days in the previous 12 months.

Summary (Unweighted results):

About half of the respondents (52.3%) had not taken any sick days in the previous 12 months. Respondents in Scotland were the least likely to take sick days and those in England were the most likely.

Figure A2.80: Sick Days by Country (Weighted)

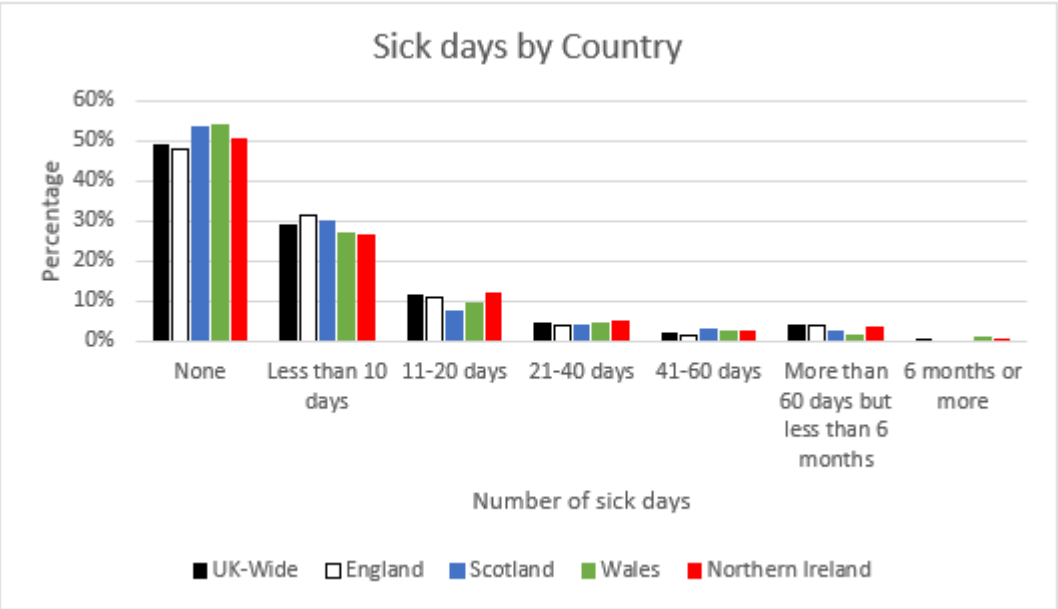

Figure A2.81: Sick Days by Country (Unweighted)

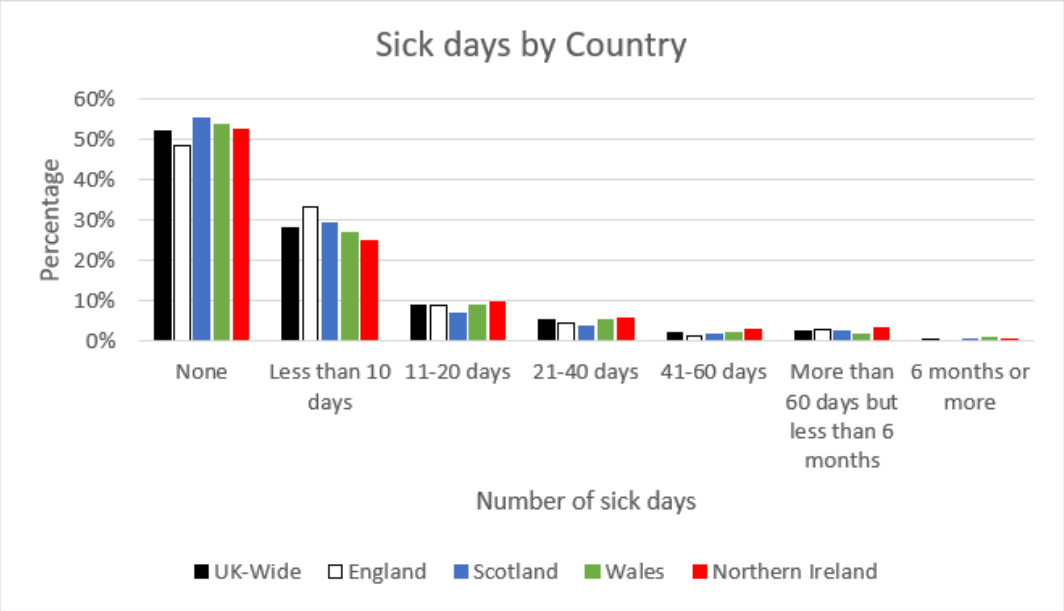

Table A2.80: Sick Days by Country (Weighted)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	49.2%	48.2%	53.3%	54.2%	50.3%
Less than 10 days	29.2%	31.3%	30.0%	27.1%	26.5%
Between 11-20 days	11.3%	11.2%	7.4%	9.7%	11.9%
Between 21-40 days	4.3%	4.1%	4.0%	4.4%	4.9%
Between 41-60 days	2.0%	1.3%	3.0%	2.4%	2.5%
More than 60 days but less than 6 months	4.0%	3.9%	2.3%	1.4%	3.7%
6 months or more	0.1%	0.0%	0.0%	0.8%	0.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.81: Sick Days by Country (Unweighted)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	1784 (52.3%)	360 (48.5%)	248 (55.4%)	572 (53.7%)	604 (52.4%)
Less than 10 days	955 (28.0%)	249 (33.5%)	131 (29.2%)	288 (27.0%)	287 (24.9%)
Between 11-20 days	309 (9.1%)	67 (9.0%)	32 (7.1%)	96 (9.0%)	114 (9.9%)
Between 21-40 days	176 (5.2%)	34 (4.6%)	16 (3.6%)	58 (5.4%)	68 (5.9%)
Between 41-60 days	80 (2.3%)	11 (1.5%)	8 (1.8%)	25 (2.3%)	36 (3.1%)
More than 60 days but less than 6 months	92 (2.7%)	22 (3.0%)	11 (2.5%)	19 (1.8%)	40 (3.5%)
6 months or more	14 (0.4%)	0 (0.0%)	2 (0.4%)	8 (0.8%)	4 (0.3%)
Total	**3410 (100%)**	**743 (100%)**	**448 (100%)**	**1066 (100%)**	**1153 (100%)**

Figure A2.82: Sick Days by Occupation (Weighted)

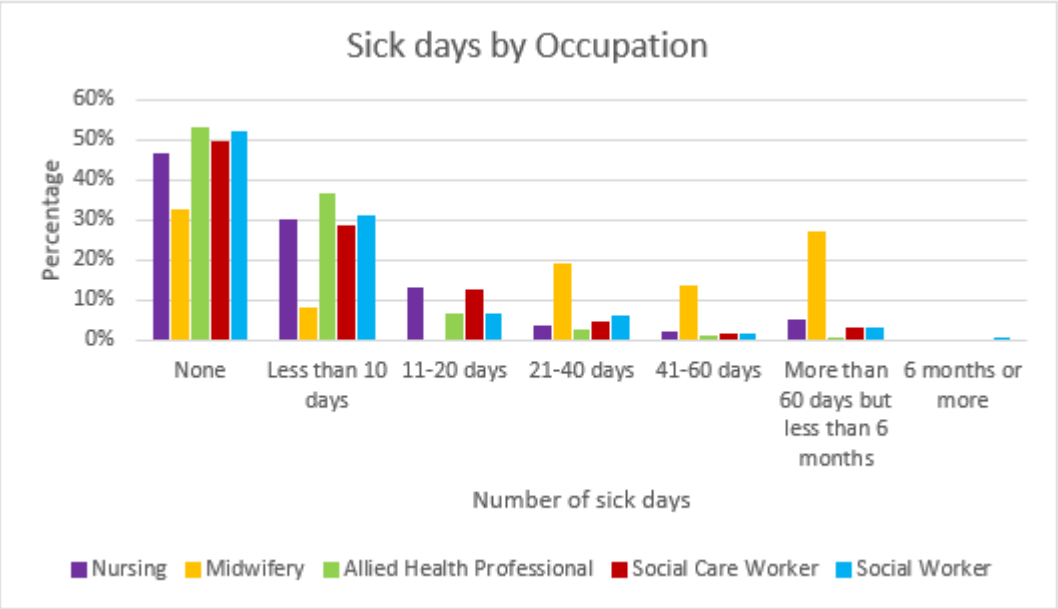

Figure A2.83: Sick Days by Occupation (Unweighted)

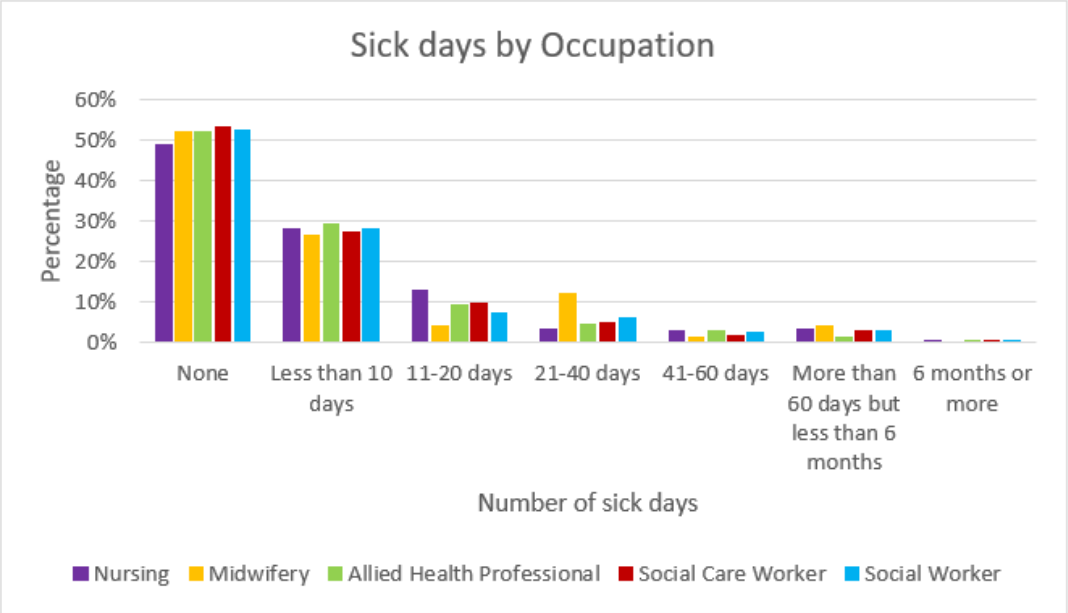

Table A2.82: Sick Days by Occupation (Weighted)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	46.4%	32.4%	53.2%	49.5%	52.0%
Less than 10 days	29.9%	8.1%	36.7%	28.7%	31.0%
Between 11-20 days	13.1%	0.0%	6.3%	12.7%	6.6%
Between 21-40 days	3.4%	18.9%	2.6%	4.6%	5.8%
Between 41-60 days	2.2%	13.5%	1.0%	1.4%	1.7%
More than 60 days but less than 6 months	5.0%	27.0%	0.2%	3.1%	2.8%
6 months or more	0.0%	0.0%	0.0%	0.0%	0.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.83: Sick Days by Occupation (Unweighted)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	172 (48.9%)	39 (52.0%)	324 (52.2%)	650 (53.2%)	599 (52.5%)
Less than 10 days	99 (28.1%)	20 (26.7%)	183 (29.5%)	334 (27.4%)	319 (28.0%)
Between 11-20 days	45 (12.8%)	3 (4.0%)	57 (9.2%)	121 (9.9%)	83 (7.3%)
Between 21-40 days	12 (3.4%)	9 (12.0%)	28 (4.5%)	59 (4.8%)	68 (6.0%)
Between 41-60 days	10 (2.8%)	1 (1.3%)	19 (3.1%)	20 (1.6%)	30 (2.6%)
More than 60 days but less than 6 months	12 (3.4%)	3 (4.0%)	8 (1.3%)	35 (2.9%)	34 (3.0%)
6 months or more	2 (0.6%)	0 (0.0%)	2 (0.3%)	2 (0.2%)	8 (0.7%)
Total	**352 (100%)**	**75 (100%)**	**621 (100%)**	**1221 (100%)**	**1141 (100%)**

A2.22 Sickness Absence Related to COVID-19

Respondents who indicated that they had taken any sick days in the previous 12 months were subsequently asked if any of their sickness absence was related to COVID-19.

Summary (Weighted results):

Northern Ireland had the highest proportion of respondents with COVID-19 related sickness absence. Midwives were most likely to have COVID-19 related sickness absence and AHPs were the least likely.

Summary (Unweighted results):

Those in Northern Ireland were the most likely to report COVID-19 related sickness absence and those in England were the least likely. Nurses and midwives were the most likely to have COVID-19 related sickness absence and social workers were the least likely.

Figure A2.84: Sickness Absence Related to COVID-19 by Country (Weighted)

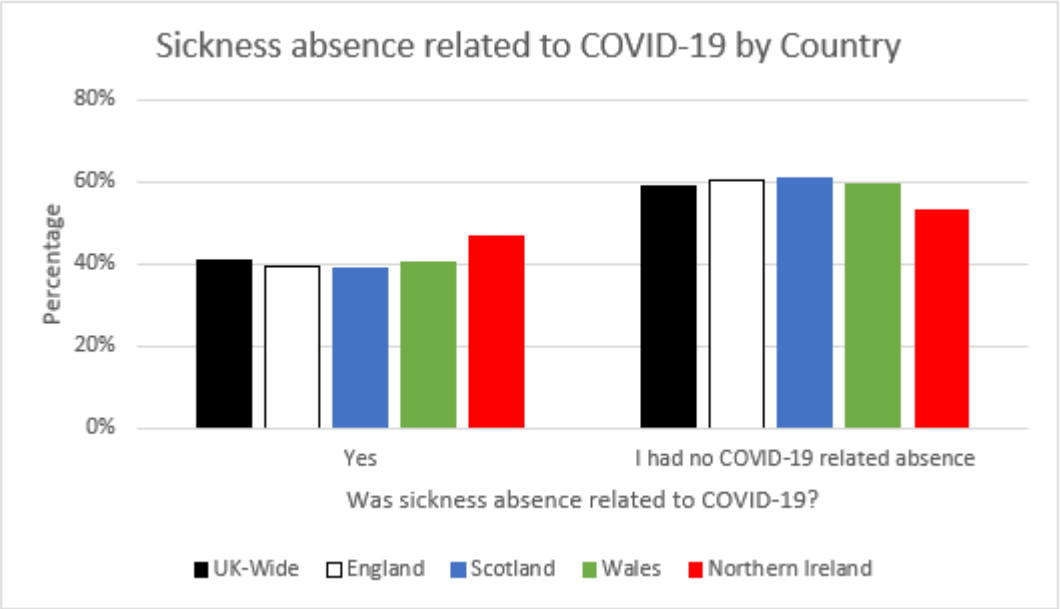

Figure A2.85: Sickness Absence Related to COVID-19 by Country (Unweighted)

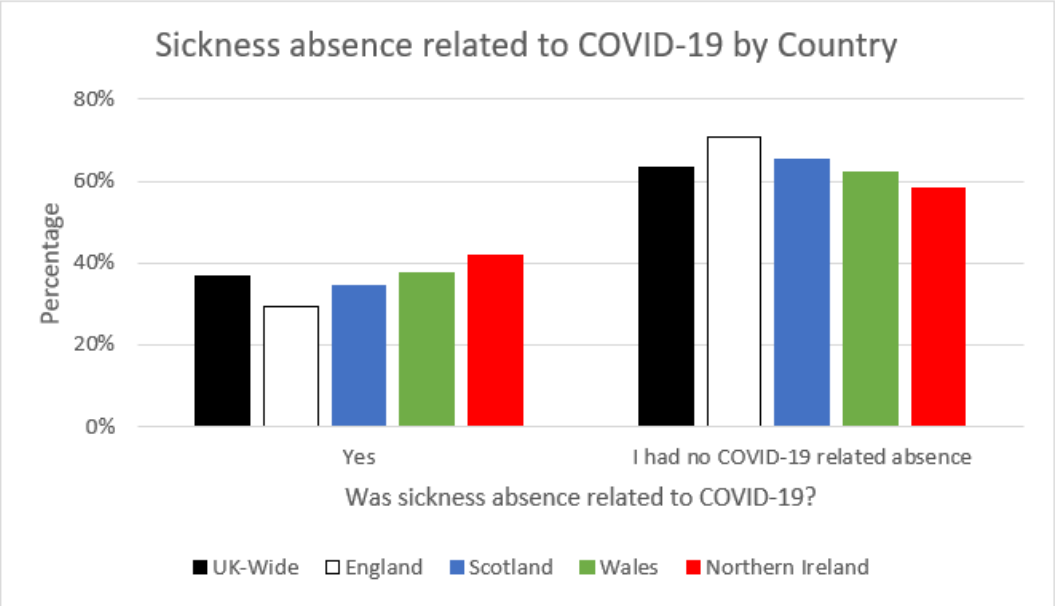

Table A2.84: Sickness Absence Related to COVID-19 by Country (Weighted)

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	41.1%	39.4%	38.9%	40.6%	46.7%
I had no COVID-19 related absence	58.9%	60.6%	61.1%	59.4%	53.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.85: Sickness Absence Related to COVID-19 by Country (Unweighted)

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	560 (36.7%)	108 (29.4%)	63 (34.6%)	174 (37.7%)	215 (41.7%)
I had no COVID-19 related absence	966 (63.3%)	259 (70.6%)	119 (65.4%)	288 (62.3%)	300 (58.3%)
Total	**1526 (100%)**	**367 (100%)**	**182 (100%)**	**462 (100%)**	**515 (100%)**

Figure A2.86: Sickness Absence Related to COVID-19 by Occupation (Weighted)

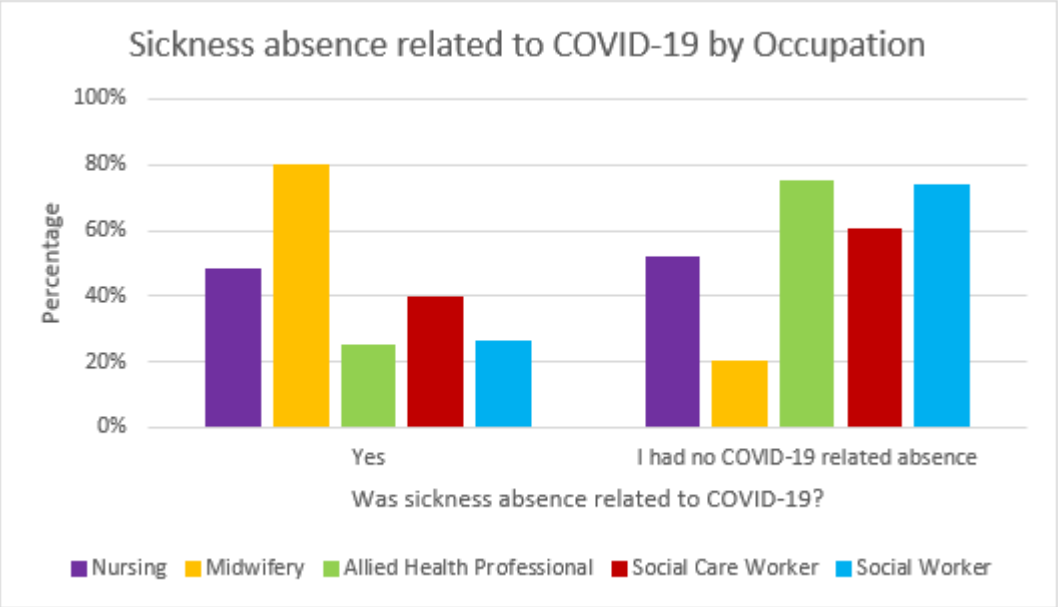

Figure A2.87: Sickness Absence Related to COVID-19 by Occupation (Unweighted)

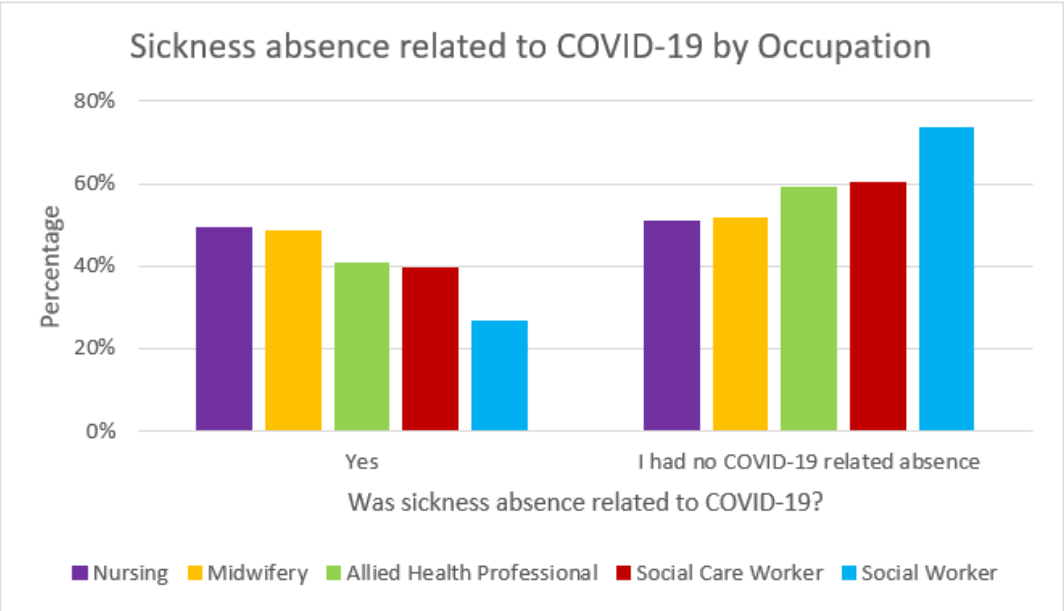

Table A2.86: Sickness Absence Related to COVID-19 by Occupation (Weighted)

	Was sickness absence related to COVID-19?		
Occupation	**Yes**	**I had no COVID-19 related absence**	**Total**
Nursing	48.4%	51.6%	**100%**
Midwifery	80.0%	20.0%	**100%**
AHP	25.1%	74.9%	**100%**
Social Care Worker	39.8%	60.2%	**100%**
Social Worker	26.2%	73.8%	**100%**

Table A2.87: Sickness Absence Related to COVID-19 by Occupation (Unweighted)

Occupation	Was sickness absence related to COVID-19?		Total
	Yes	I had no COVID-19 related absence	
Nursing	81 (49.1%)	84 (50.9%)	**165 (100%)**
Midwifery	15 (48.4%)	16 (51.6%)	**31 (100%)**
AHP	117 (40.8%)	170 (59.2%)	**287 (100%)**
Social Care Worker	213 (39.7%)	324 (60.3%)	**537 (100%)**
Social Worker	134 (26.5%)	372 (73.5%)	**506 (100%)**

A2.23 Respondents' Sick Pay

Summary (Weighted results):

UK-wide, most respondents reported getting statutory sick pay plus their employer pay. Nurses were the most likely to report not getting any sick pay when off sick.

Summary (Unweighted results):

UK-wide, most respondents (65.0%) reported getting statutory sick pay plus their employer pay. Almost one third of respondents in Scotland (31.1%) were only getting basic statutory sick pay. Social care workers were the most likely to report not getting any sick pay when off sick.

Figure A2.88: Respondents' Sick Pay by Country (Weighted)

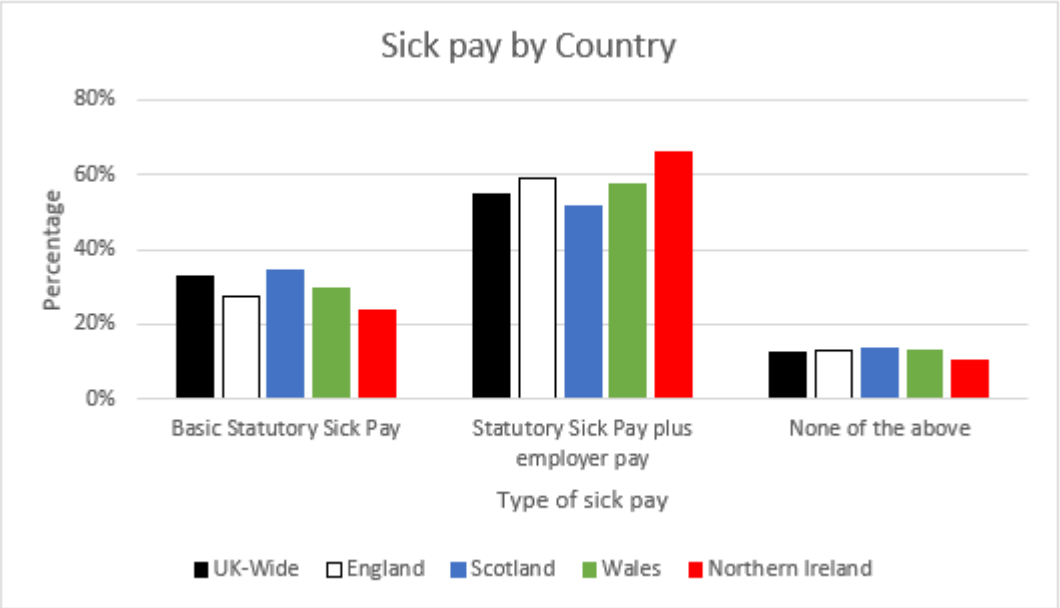

Figure A2.89: Respondents' Sick Pay by Country (Unweighted)

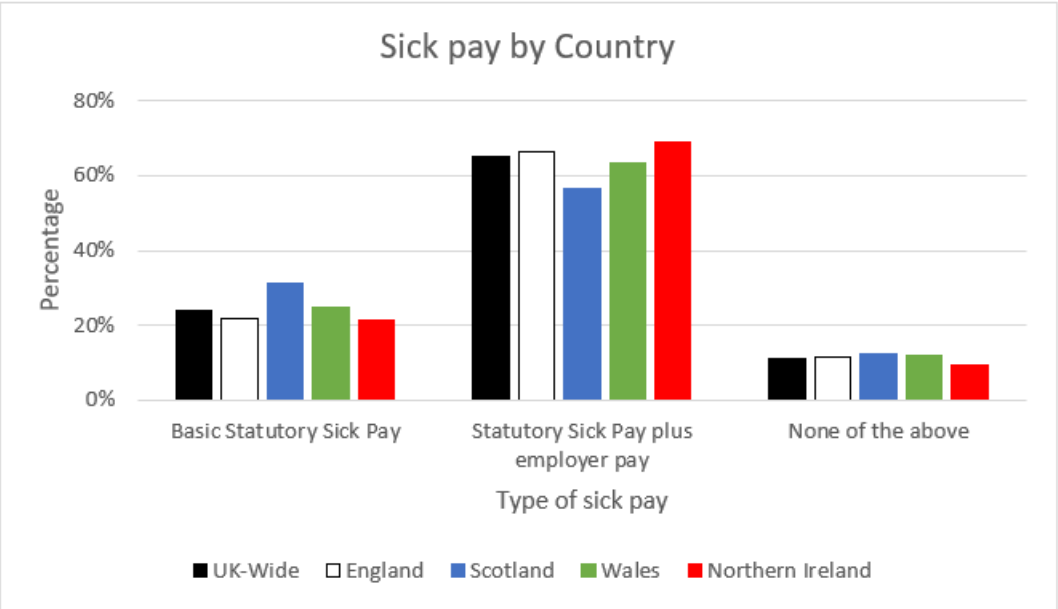

Table A2.88: Respondents' Sick Pay by Country (Weighted)

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Basic Statutory Sick Pay (SSP)	32.8%	27.7%	34.6%	29.7%	23.5%
Statutory Sick Pay (SSP) plus employer pay	54.9%	59.3%	51.8%	57.4%	66.3%
None of the above	12.3%	13.0%	13.6%	12.9%	10.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.89: Respondents' Sick Pay by Country (Unweighted)

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Basic Statutory Sick Pay (SSP)	719 (23.9%)	150 (22.0%)	118 (31.1%)	235 (24.7%)	215 (21.6%)
Statutory Sick Pay (SSP) plus employer pay	1953 (65.0%)	454 (66.6%)	214 (56.5%)	600 (63.2%)	685 (68.8%)
None of the above	335 (11.1%)	78 (11.4%)	47 (12.4%)	115 (12.1%)	95 (9.5%)
Total	**3006 (100%)**	**682 (100%)**	**379 (100%)**	**950 (100%)**	**995 (100%)**

Figure A2.90: Respondents' Sick Pay by Occupation (Weighted)

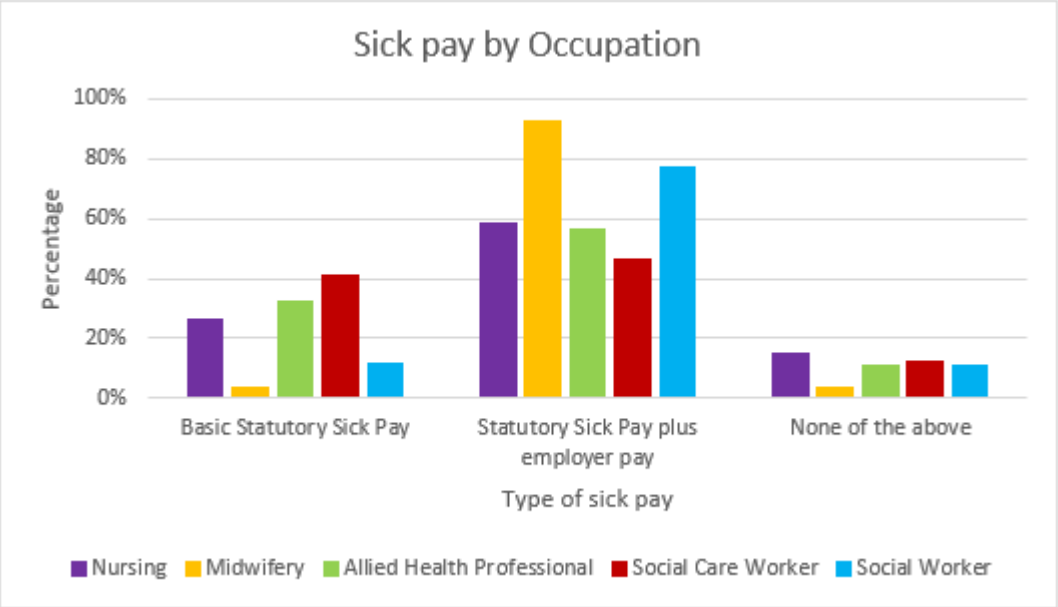

Figure A2.91: Respondents' Sick Pay by Occupation (Unweighted)

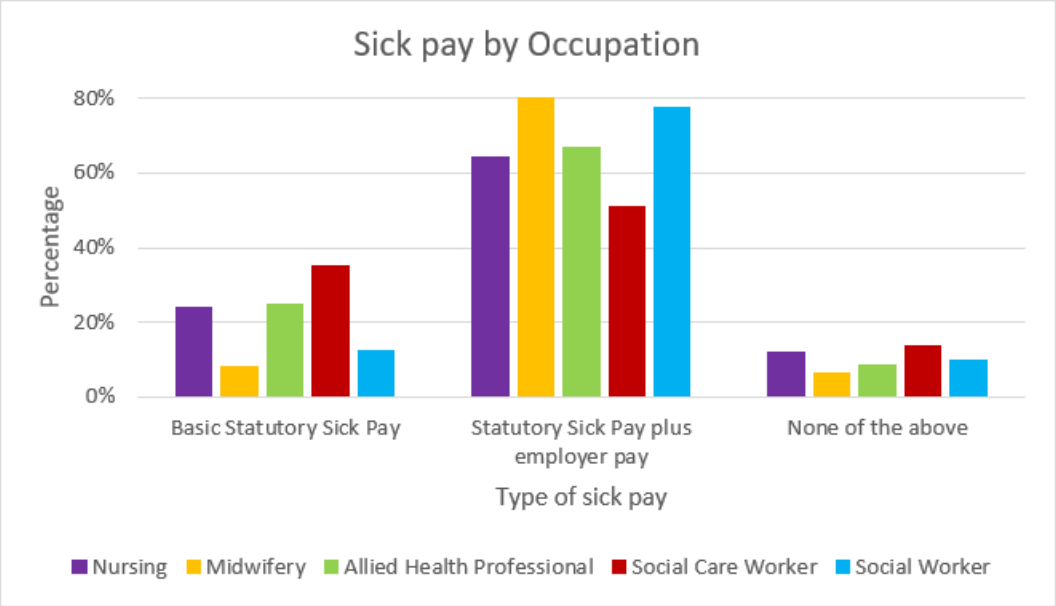

Table A2.90: Respondents' Sick Pay by Occupation (Weighted)

Occupation	Type of sick pay			Total
	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	None of the above	
Nursing	26.5%	58.3%	15.1%	**100%**
Midwifery	3.7%	92.6%	3.7%	**100%**
AHP	32.2%	56.7%	11.1%	**100%**
Social Care Worker	41.2%	46.6%	12.2%	**100%**
Social Worker	11.7%	77.5%	10.8%	**100%**

Table A2.91: Respondents' Sick Pay by Occupation (Unweighted)

Occupation	Type of sick pay			Total
	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	None of the above	
Nursing	73 (23.9%)	196 (64.1%)	37 (12.1%)	**306 (100%)**
Midwifery	5 (7.9%)	54 (85.7%)	4 (6.3%)	**63 (100%)**
AHP	138 (24.7%)	374 (66.9%)	47 (8.4%)	**559 (100%)**
Social Care Worker	377 (35.2%)	547 (51.1%)	146 (13.6%)	**1070 (100%)**
Social Worker	125 (12.4%)	782 (77.6%)	101 (10.0%)	**1008 (100%)**

A2.24 Impact of COVID-19 on Services

Respondents were asked which of the following work-related groups they considered themselves to belong to: 1) Not impacted by COVID-19 pressures, with services stepped down; 2) Impacted, but not significantly; and 3) Overwhelmed by increased pressures.

Summary (Weighted results):

UK-wide, only 4.6% of respondents reported that their service was not impacted and it was stepped down. Almost half of the respondents (49.3%) felt overwhelmed by increased pressures. Social work and nursing were the most impacted of the examined occupational groups.

Summary (Unweighted results):

UK-wide, only 3.9% of respondents reported that their service was not impacted and it was stepped down. Almost half of the respondents (47.1%) felt overwhelmed by increased pressures, particularly those in England. Social work and nursing were the most impacted of the examined occupational groups.

Figure A2.92: Impact of COVID-19 on Services by Country (Weighted)

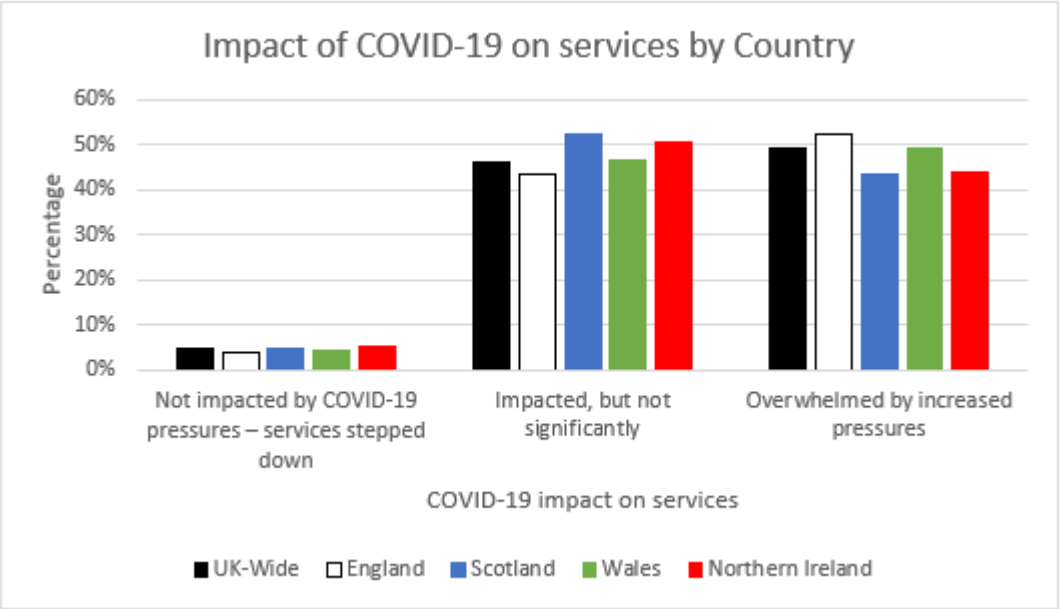

Figure A2.93: Impact of COVID-19 on Services by Country (Unweighted)

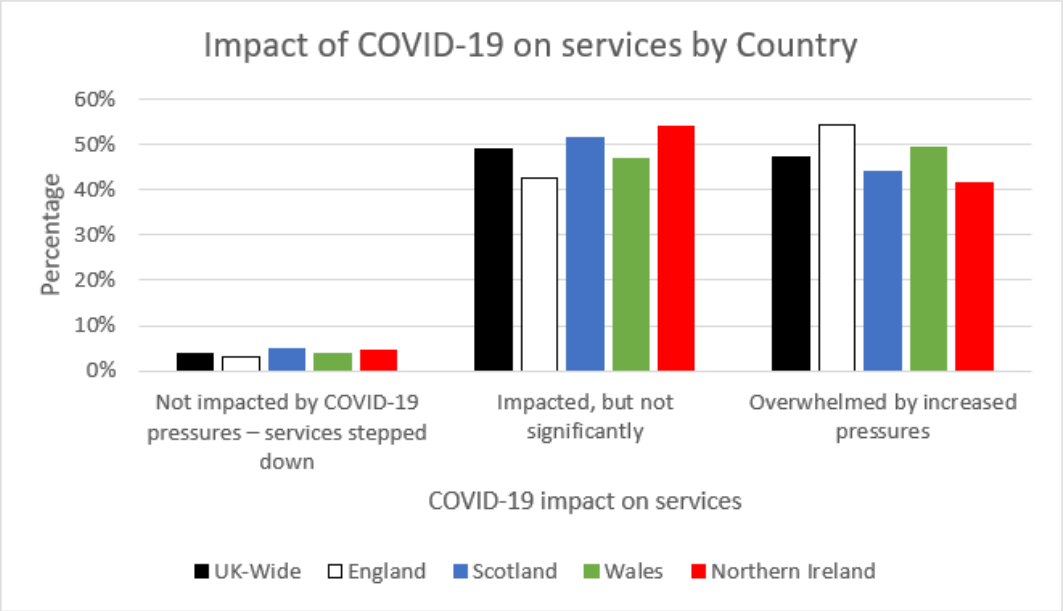

Table A2.92: Impact of COVID-19 on Services by Country (Weighted)

	Country				
Impact of COVID-19 on services	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Not impacted by COVID-19 pressures – services stepped down	4.6%	3.9%	4.5%	4.1%	5.0%
Impacted, but not significantly	46.1%	43.4%	52.2%	46.4%	50.8%
Overwhelmed by increased pressures	49.3%	52.6%	43.3%	49.5%	44.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.93: Impact of COVID-19 on Services by Country (Unweighted)

	Country				
Impact of COVID-19 on services	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Not impacted by COVID-19 pressures – services stepped down	126 (3.9%)	21 (2.9%)	19 (4.7%)	37 (3.7%)	49 (4.6%)
Impacted, but not significantly	1561 (48.9%)	304 (42.6%)	210 (51.5%)	466 (46.9%)	581 (54.0%)
Overwhelmed by increased pressures	1504 (47.1%)	388 (54.4%)	179 (43.9%)	491 (49.4%)	446 (41.4%)
Total	**3191 (100%)**	**713 (100%)**	**408 (100%)**	**994 (100%)**	**1076 (100%)**

Figure A2.94: Impact of COVID-19 on Services by Occupation (Weighted)

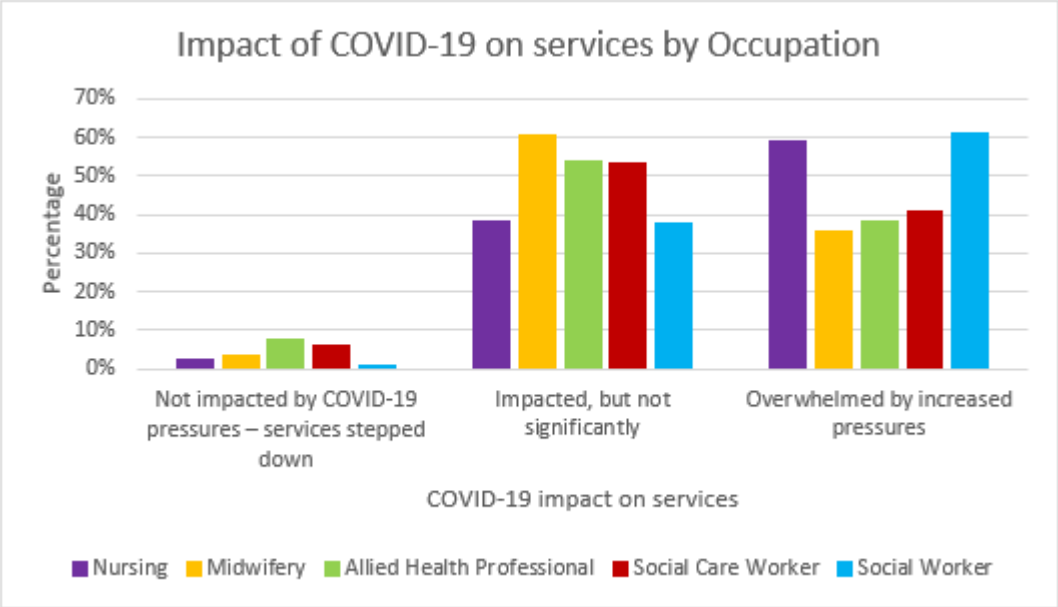

Figure A2.95: Impact of COVID-19 on Services by Occupation (Unweighted)

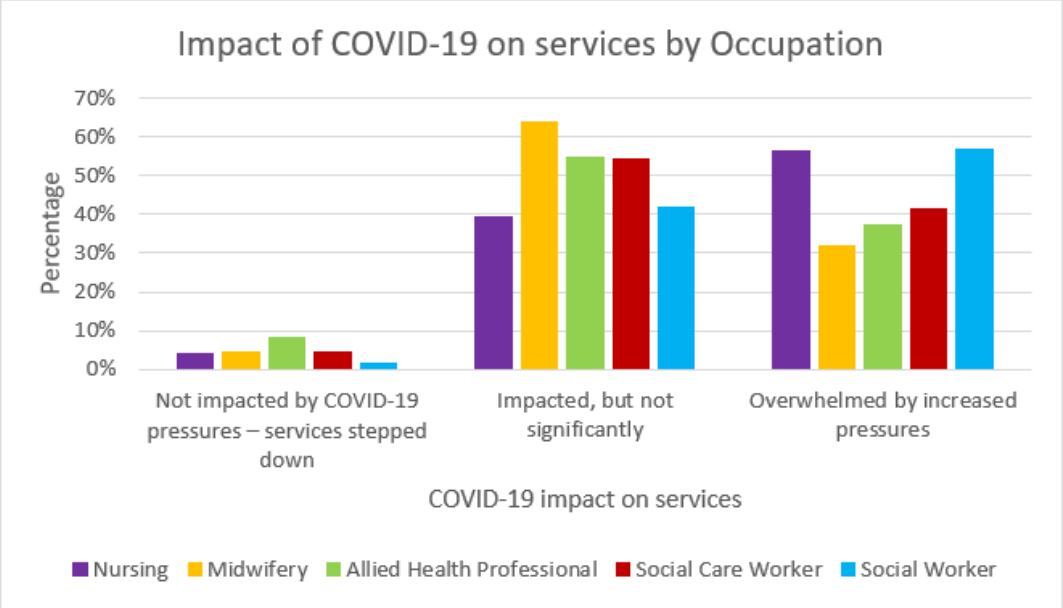

Table A2.94: Impact of COVID-19 on Services by Occupation (Weighted)

Occupation	Impact of COVID-19 on services			Total
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures	
Nursing	2.6%	38.2%	59.2%	**100%**
Midwifery	3.6%	60.7%	35.7%	**100%**
AHP	7.8%	54.0%	38.2%	**100%**
Social Care Worker	5.8%	53.2%	40.9%	**100%**
Social Worker	1.0%	37.7%	61.3%	**100%**

Table A2.95: Impact of COVID-19 on Services by Occupation (Unweighted)

Occupation	Impact of COVID-19 on services			Total
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures	
Nursing	13 (4.0%)	128 (39.5%)	183 (56.5%)	**324 (100%)**
Midwifery	3 (4.3%)	44 (63.8%)	22 (31.9%)	**69 (100%)**
AHP	48 (8.2%)	320 (54.6%)	218 (37.2%)	**586 (100%)**
Social Care Worker	48 (4.2%)	621 (54.5%)	470 (41.3%)	**1139 (100%)**
Social Worker	14 (1.3%)	448 (41.8%)	611 (56.9%)	**1073 (100%)**

A2.25 Respondents Considering Changing their Employer

Respondents were asked if, since the start of the pandemic, they had considered changing their employer while staying within their current occupation.

Summary (Weighted results):

Respondents from Wales were the least likely to consider changing their employer.

Summary (Unweighted results):

Respondents from Wales were the least likely to consider changing their employer and those from England were the most likely.

Figure A2.96: Considering Changing Employer by Country (Weighted)

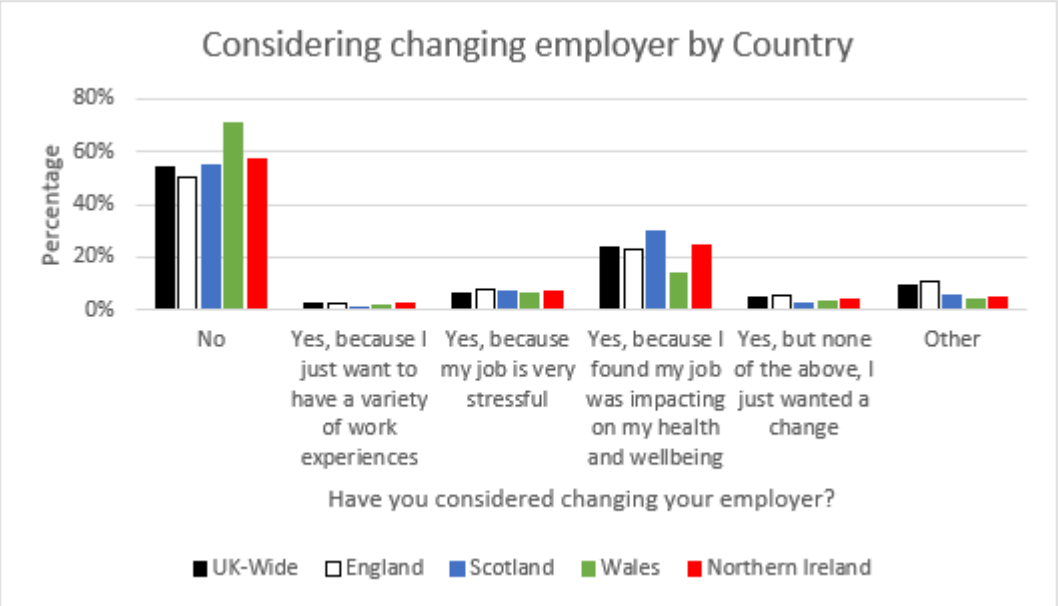

Figure A2.97: Considering Changing Employer by Country (Unweighted)

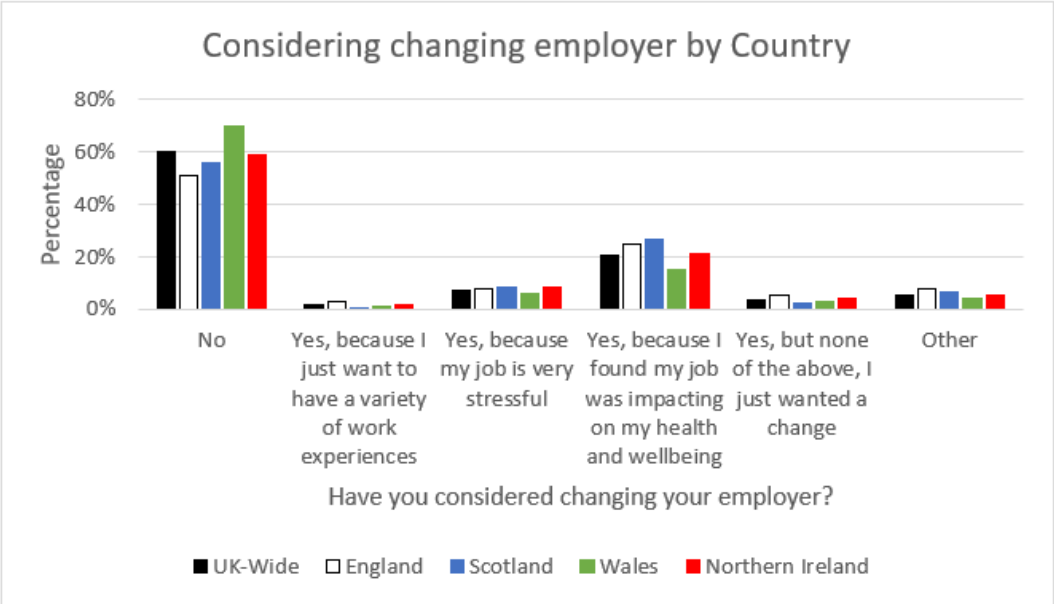

Table A2.96: Considering Changing Employer by Country (Weighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	53.8%	50.6%	55.2%	70.8%	57.3%
Yes, because I just want to have a variety of work experiences	2.5%	2.8%	0.2%	1.4%	2.3%
Yes, because my job is very stressful	6.0%	7.6%	7.2%	6.5%	7.0%
Yes, because I found my job was impacting on my health and wellbeing	23.5%	23.0%	29.5%	14.1%	24.3%
Yes, but none of the above, I just wanted a change	4.7%	5.5%	2.4%	3.2%	4.3%
Other	9.5%	10.5%	5.5%	3.9%	4.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.97: Considering Changing Employer by Country (Unweighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	1904 (60.2%)	361 (51.2%)	226 (55.8%)	690 (70.0%)	627 (58.7%)
Yes, because I just want to have a variety of work experiences	59 (1.9%)	21 (3.0%)	1 (0.2%)	15 (1.5%)	22 (2.1%)
Yes, because my job is very stressful	238 (7.5%)	56 (7.9%)	34 (8.4%)	57 (5.8%)	91 (8.5%)
Yes, because I found my job was impacting on my health and wellbeing	661 (20.9%)	175 (24.8%)	108 (26.7%)	151 (15.3%)	227 (21.2%)
Yes, but none of the above, I just wanted a change	124 (3.9%)	38 (5.4%)	10 (2.5%)	32 (3.2%)	44 (4.1%)
Other	179 (5.7%)	54 (7.7%)	26 (6.4%)	41 (4.2%)	58 (5.4%)
Total	**3165 (100%)**	**705 (100%)**	**405 (100%)**	**986 (100%)**	**1069 (100%)**

Figure A2.98: Considering Changing Employer by Occupation (Weighted)

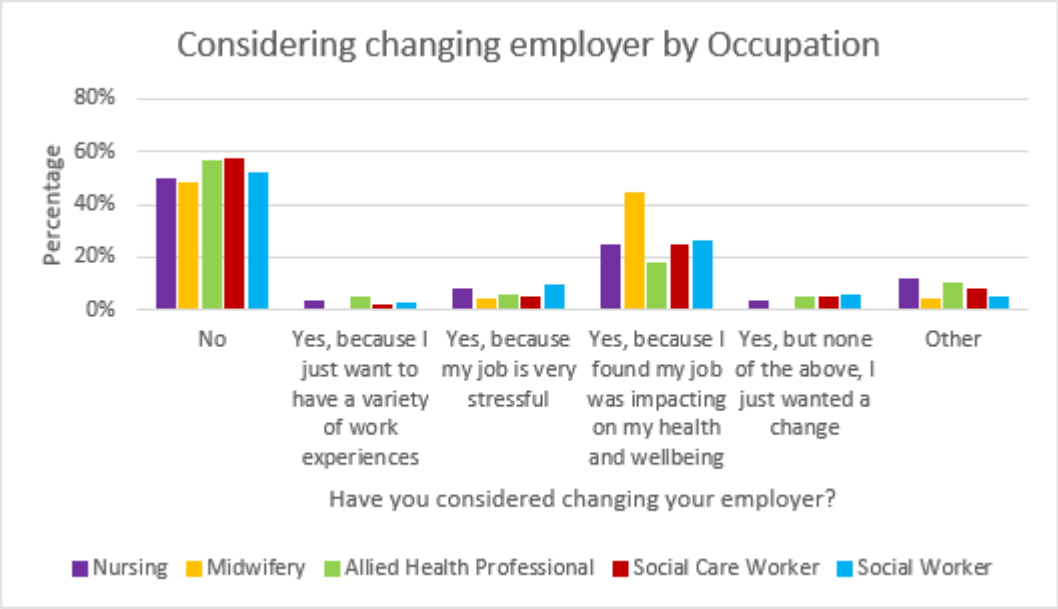

Figure A2.99: Considering Changing Employer by Occupation (Unweighted)

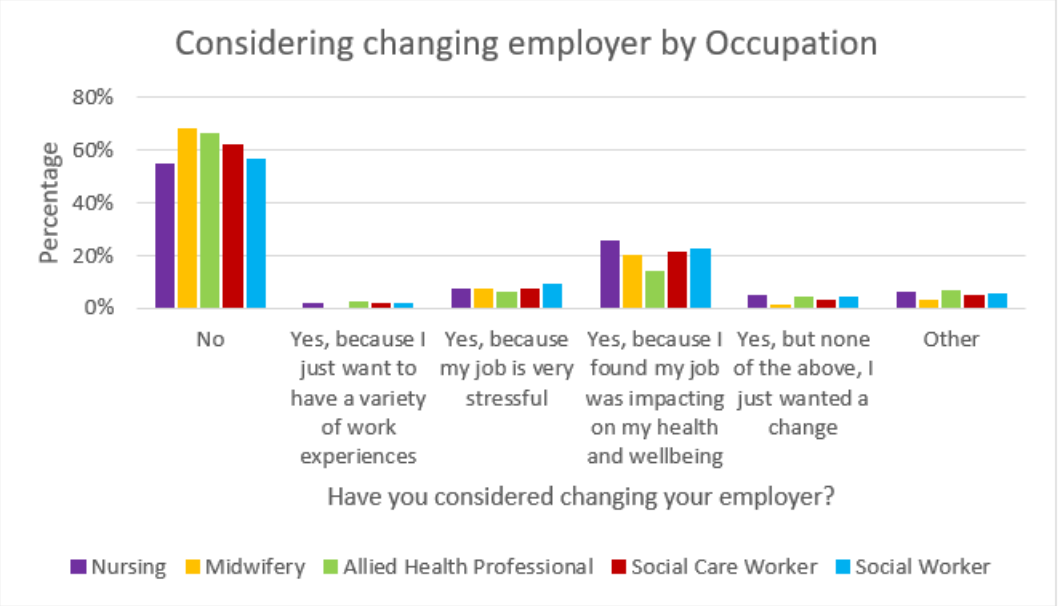

Table A2.98: Considering Changing Employer by Occupation (Weighted)

Occupation	Have you considered changing your employer?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	
Nursing	49.6%	3.3%	7.5%	24.5%	3.6%	11.6%	**100%**
Midwifery	48.1%	0.0%	3.7%	44.4%	0.0%	3.7%	**100%**
AHP	56.3%	4.8%	5.8%	18.0%	5.0%	10.1%	**100%**
Social Care Worker	56.8%	1.5%	5.1%	24.2%	4.5%	7.8%	**100%**
Social Worker	52.0%	2.2%	9.4%	26.4%	5.5%	4.5%	**100%**

Table A2.99: Considering Changing Employer by Occupation (Unweighted)

Occupation	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	172 (54.4%)	6 (1.9%)	22 (7.0%)	81 (25.6%)	15 (4.7%)	20 (6.3%)	**316 (100%)**
Midwifery	47 (68.1%)	0 (0.0%)	5 (7.2%)	14 (20.3%)	1 (1.4%)	2 (2.9%)	**69 (100%)**
AHP	384 (66.3%)	15 (2.6%)	36 (6.2%)	80 (13.8%)	24 (4.1%)	40 (6.9%)	**579 (100%)**
Social Care Worker	699 (61.7%)	18 (1.6%)	79 (7.0%)	244 (21.5%)	37 (3.3%)	56 (4.9%)	**1133 (100%)**
Social Worker	602 (56.4%)	20 (1.9%)	96 (9.0%)	242 (22.7%)	47 (4.4%)	61 (5.7%)	**1068 (100%)**

A2.26 Respondents Considering Changing their Occupation

Respondents were also asked if, since the start of the pandemic, they had considered changing their occupation.

Summary (Weighted results):

Respondents from Wales were the least likely to consider changing their occupation.

Summary (Unweighted results):

Respondents from Wales and AHPs were the least likely ones to consider changing their occupation.

Figure A2.100: Considering Changing Occupation by Country (Weighted)

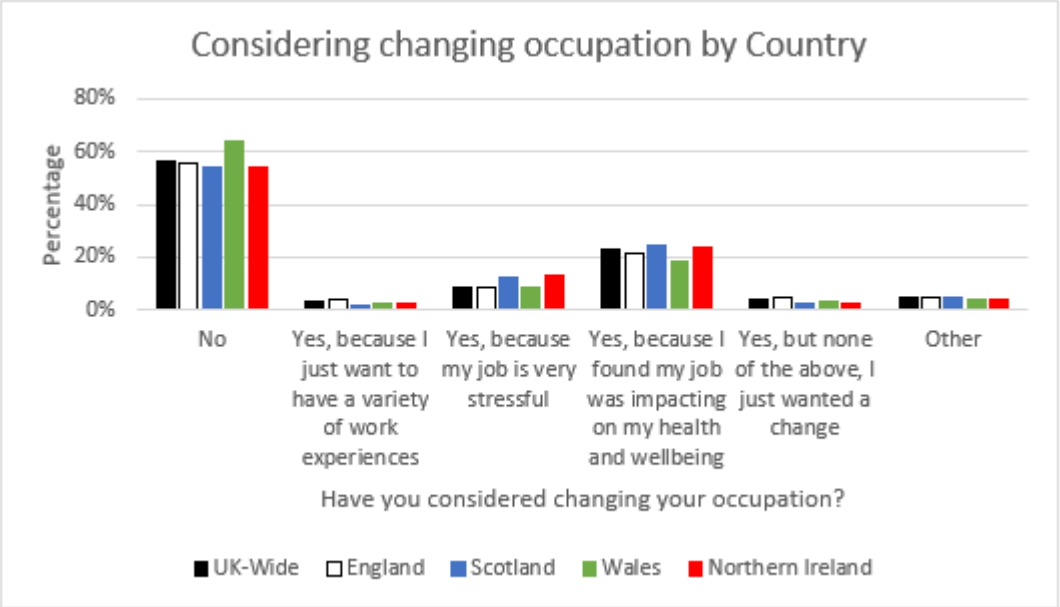

Figure A2.101: Considering Changing Occupation by Country (Unweighted)

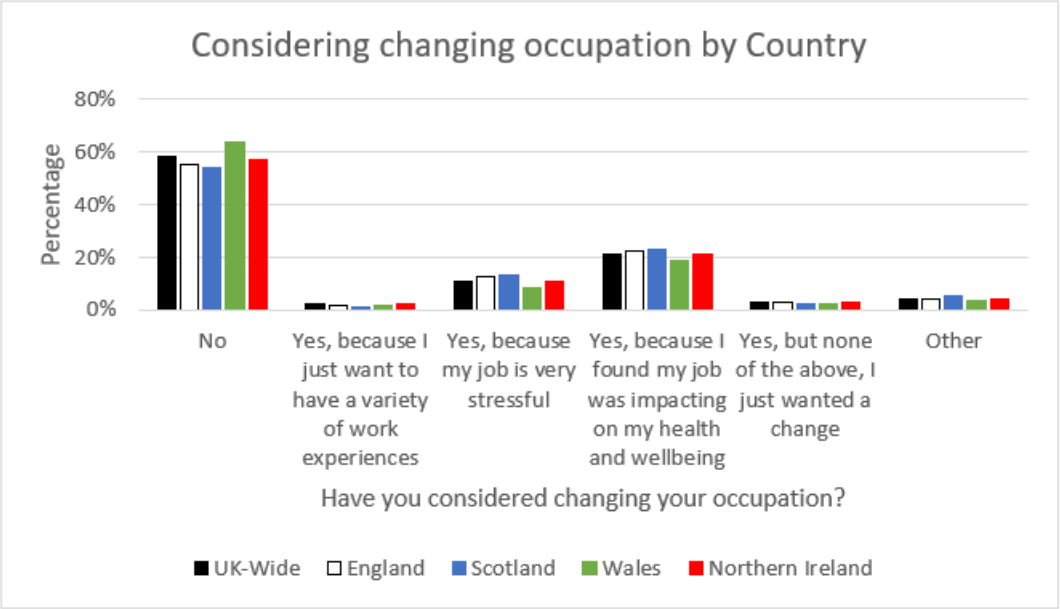

Table A2.100: Considering Changing Occupation by Country (Weighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	56.4%	56.0%	54.5%	64.1%	53.8%
Yes, because I just want to have a variety of work experiences	3.1%	4.1%	1.4%	2.2%	2.5%
Yes, because my job is very stressful	8.8%	8.8%	12.0%	8.5%	13.1%
Yes, because I found my job was impacting on my health and wellbeing	22.8%	21.6%	24.3%	18.6%	23.9%
Yes, but none of the above, I just wanted a change	3.9%	4.5%	2.7%	2.9%	2.5%
Other	4.9%	5.0%	5.1%	3.8%	4.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.101: Considering Changing Occupation by Country (Unweighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	1848 (58.4%)	388 (55.0%)	218 (54.0%)	628 (63.8%)	614 (57.4%)
Yes, because I just want to have a variety of work experiences	68 (2.2%)	15 (2.1%)	6 (1.5%)	21 (2.1%)	26 (2.4%)
Yes, because my job is very stressful	348 (11.0%)	90 (12.8%)	53 (13.1%)	86 (8.7%)	119 (11.1%)
Yes, because I found my job was impacting on my health and wellbeing	667 (21.1%)	158 (22.4%)	94 (23.3%)	185 (18.8%)	230 (21.5%)
Yes, but none of the above, I just wanted a change	93 (2.9%)	23 (3.3%)	11 (2.7%)	27 (2.7%)	32 (3.0%)
Other	138 (4.4%)	31 (4.4%)	22 (5.4%)	37 (3.8%)	48 (4.5%)
Total	**3162 (100%)**	**705 (100%)**	**404 (100%)**	**984 (100%)**	**1069 (100%)**

Figure A2.102: Considering Changing Occupation by Occupation (Weighted)

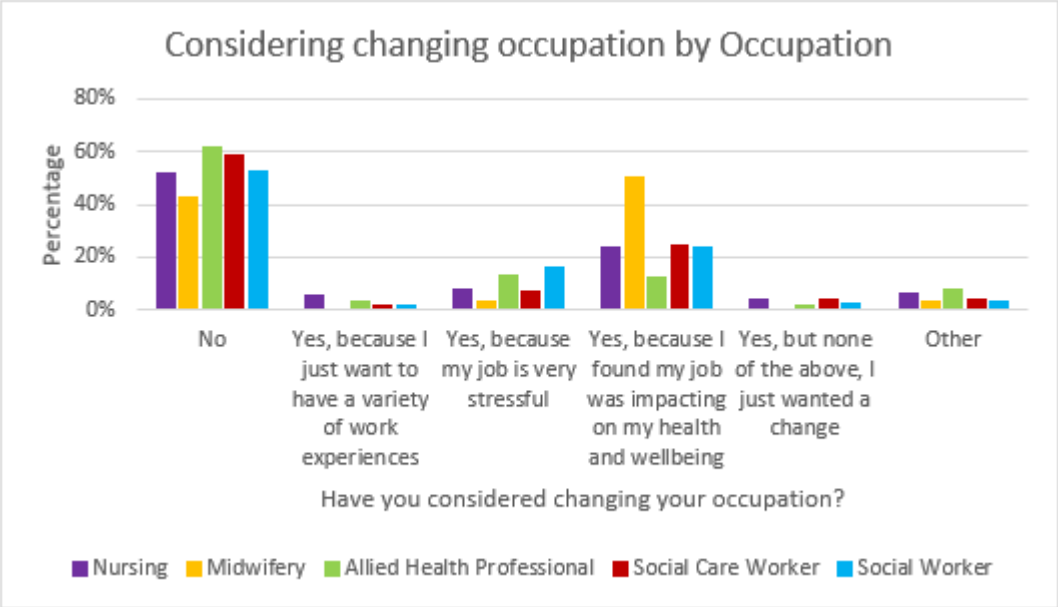

Figure A2.103: Considering Changing Occupation by Occupation (Unweighted)

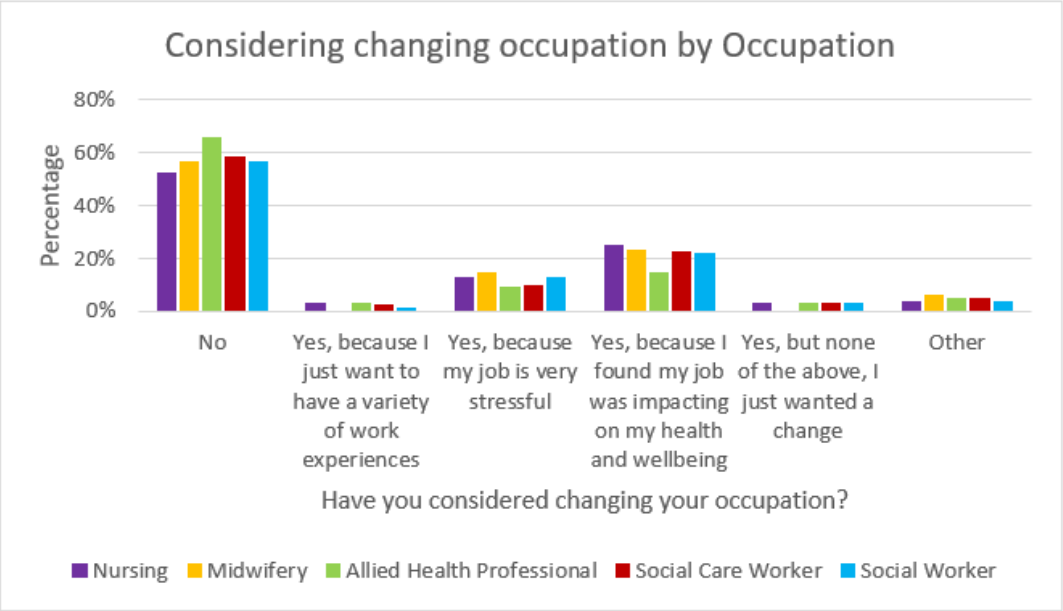

Table A2.102: Considering Changing Occupation by Occupation (Weighted)

Occupation	Have you considered changing your occupation?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	
Nursing	51.9%	5.9%	8.0%	23.7%	4.2%	6.2%	**100%**
Midwifery	42.9%	0.0%	3.6%	50.0%	0.0%	3.6%	**100%**
AHP	61.8%	3.1%	13.3%	12.7%	1.7%	7.5%	**100%**
Social Care Worker	58.9%	1.5%	7.4%	24.2%	3.9%	4.2%	**100%**
Social Worker	52.8%	1.4%	16.2%	23.9%	2.3%	3.4%	**100%**

Table A2.103: Considering Changing Occupation by Occupation (Unweighted)

Occupation	Have you considered changing your occupation?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	
Nursing	166 (52.5%)	10 (3.2%)	40 (12.7%)	78 (24.7%)	10 (3.2%)	12 (3.8%)	**316 (100%)**
Midwifery	39 (56.5%)	0 (0.0%)	10 (14.5%)	16 (23.2%)	0 (0.0%)	4 (5.8%)	**69 (100%)**
AHP	378 (65.4%)	18 (3.1%)	52 (9.0%)	84 (14.5%)	19 (3.3%)	27 (4.7%)	**578 (100%)**
Social Care Worker	660 (58.4%)	25 (2.2%)	107 (9.5%)	253 (22.4%)	33 (2.9%)	53 (4.7%)	**1131 (100%)**
Social Worker	605 (56.6%)	15 (1.4%)	139 (13.0%)	236 (22.1%)	31 (2.9%)	42 (3.9%)	**1068 (100%)**

A2.27 Respondents' Caring Responsibilities

Respondents were asked if, outside of work, they consider themselves to be a carer, defined as someone who "usually provides support to another person that depends on that support for aspects of daily living such as food, shelter, warmth and social and emotional needs".

Summary (Weighted results):

Northern Ireland had the highest proportion of respondents who definitely considered themselves to be a carer.

Summary (Unweighted results):

Northern Ireland had the highest proportion of respondents who definitely considered themselves to be a carer and England had the highest proportion of those who definitely did not consider themselves to be a carer. Social workers were the least the likely ones to be a carer (reporting 'definitely not') and midwives were the most likely ones (reporting 'definitely yes').

Figure A2.104: Caring Responsibilities by Country (Weighted)

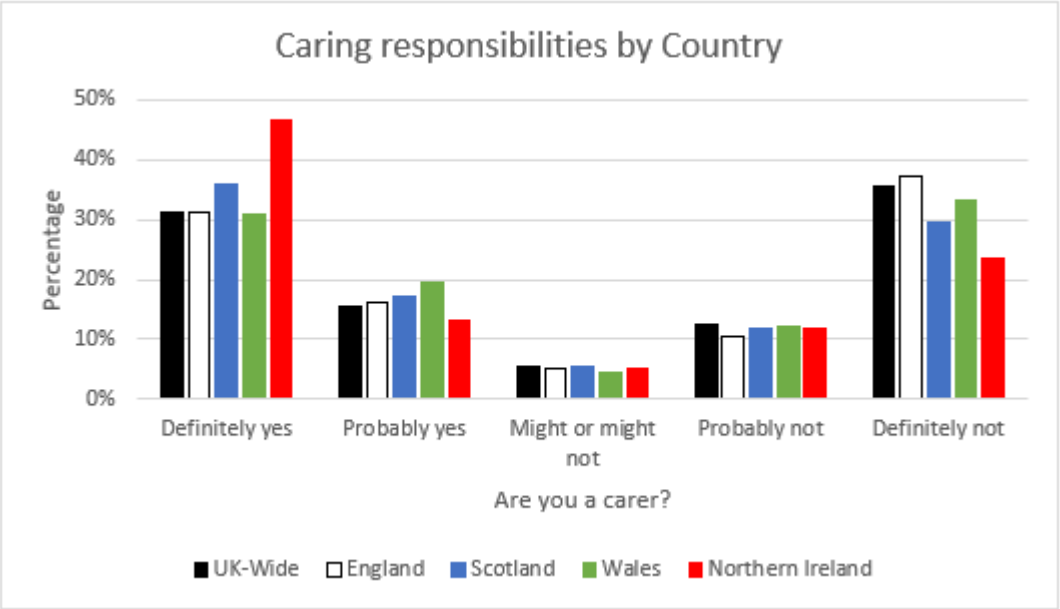

Figure A2.105: Caring Responsibilities by Country (Unweighted)

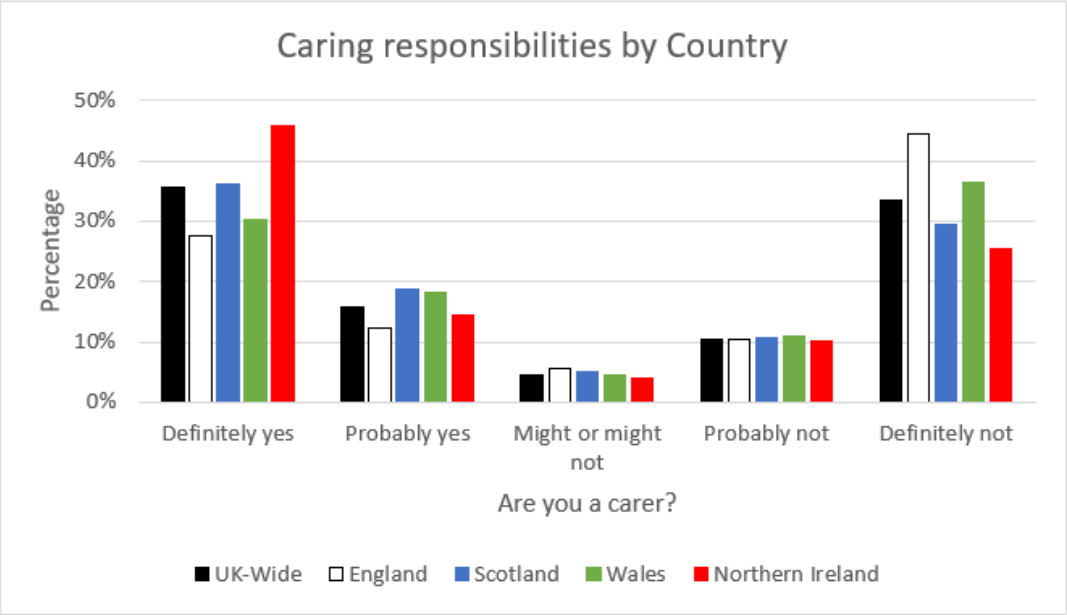

Table A2.104: Caring Responsibilities by Country (Weighted)

Do you consider yourself to be a carer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	31.3%	31.3%	35.9%	30.8%	46.5%
Probably yes	15.5%	16.1%	17.3%	19.5%	13.2%
Might or might not	5.5%	5.0%	5.3%	4.5%	5.1%
Probably not	12.3%	10.5%	11.8%	12.1%	11.9%
Definitely not	35.5%	37.1%	29.6%	33.1%	23.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.105: Caring Responsibilities by Country (Unweighted)

Do you consider yourself to be a carer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	1124 (35.6%)	193 (27.5%)	146 (36.1%)	296 (30.2%)	489 (45.8%)
Probably yes	494 (15.7%)	86 (12.2%)	76 (18.8%)	177 (18.1%)	155 (14.5%)
Might or might not	145 (4.6%)	39 (5.5%)	20 (5.0%)	43 (4.4%)	43 (4.0%)
Probably not	331 (10.5%)	73 (10.4%)	43 (10.6%)	107 (10.9%)	108 (10.1%)
Definitely not	1060 (33.6%)	312 (44.4%)	119 (29.5%)	357 (36.4%)	272 (25.5%)
Total	**3154 (100%)**	**703 (100%)**	**404 (100%)**	**980 (100%)**	**1067 (100%)**

Figure A2.106: Caring Responsibilities by Occupation (Weighted)

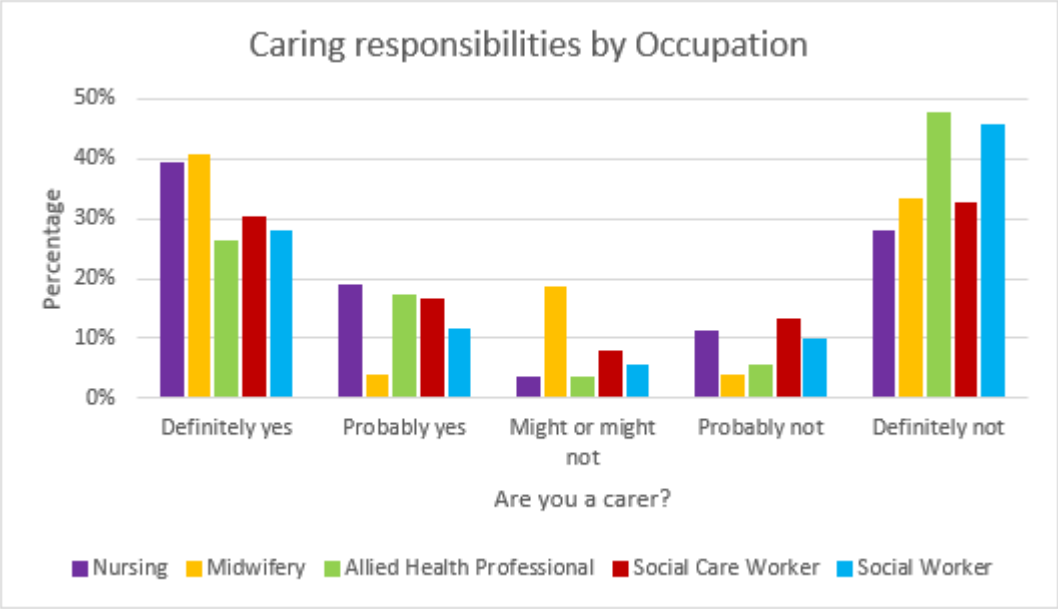

Figure A2.107: Caring Responsibilities by Occupation (Unweighted)

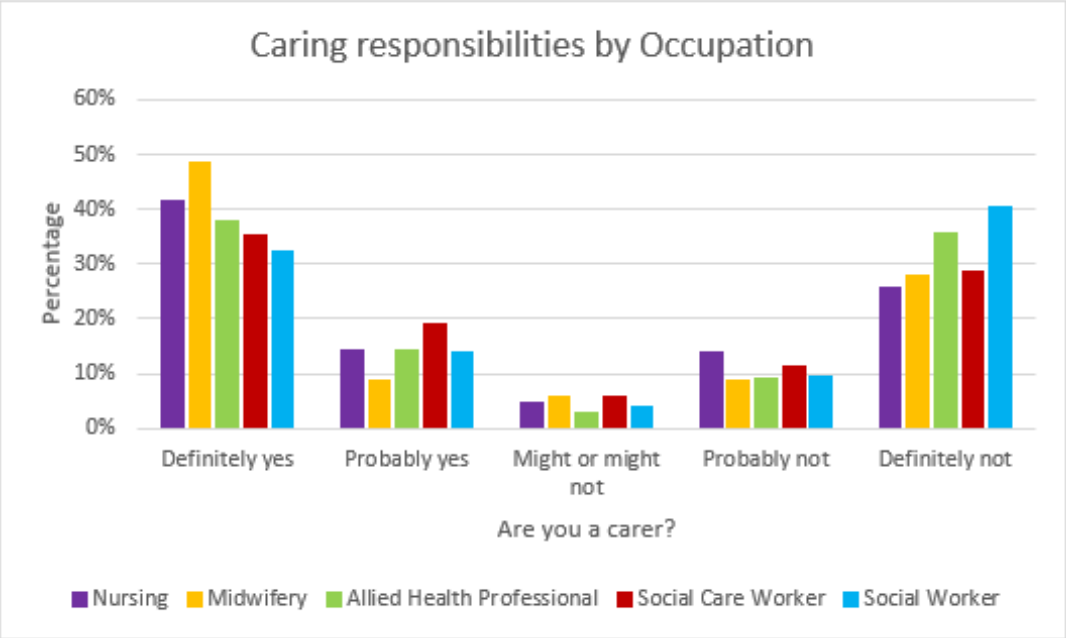

Table A2.106: Caring Responsibilities by Occupation (Weighted)

Occupation	Do you consider yourself to be a carer?					Total
	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	
Nursing	39.1%	18.8%	3.3%	11.0%	27.8%	**100%**
Midwifery	40.7%	3.7%	18.5%	3.7%	33.3%	**100%**
AHP	26.3%	17.2%	3.3%	5.4%	47.8%	**100%**
Social Care Worker	30.1%	16.4%	7.9%	13.1%	32.6%	**100%**
Social Worker	27.8%	11.5%	5.3%	9.8%	45.6%	**100%**

Table A2.107: Caring Responsibilities by Occupation (Unweighted)

Occupation	Do you consider yourself to be a carer?					Total
	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	
Nursing	131 (41.5%)	45 (14.2%)	15 (4.7%)	44 (13.9%)	81 (25.6%)	**316 (100%)**
Midwifery	33 (48.5%)	6 (8.8%)	4 (5.9%)	6 (8.8%)	19 (27.9%)	**68 (100%)**
AHP	220 (38.0%)	83 (14.3%)	17 (2.9%)	52 (9.0%)	207 (35.8%)	**579 (100%)**
Social Care Worker	396 (35.2%)	214 (19.0%)	66 (5.9%)	127 (11.3%)	322 (28.6%)	**1125 (100%)**
Social Worker	344 (32.3%)	146 (13.7%)	43 (4.0%)	102 (9.6%)	431 (40.4%)	**1066 (100%)**

A2.28 Who Respondents Care for

Respondents who indicated that they were a carer were subsequently asked who they care for. Multiple responses were allowed, which means that the percentages do not add up to 100%.

Summary (Weighted results):

Most respondents UK-wide, who were carers, were caring for their children and parents.

Summary (Unweighted results):

Most respondents, UK-wide and across the occupational groups, were caring for their children and parents.

Figure A2.108: Who Respondents Care for by Country (Weighted)

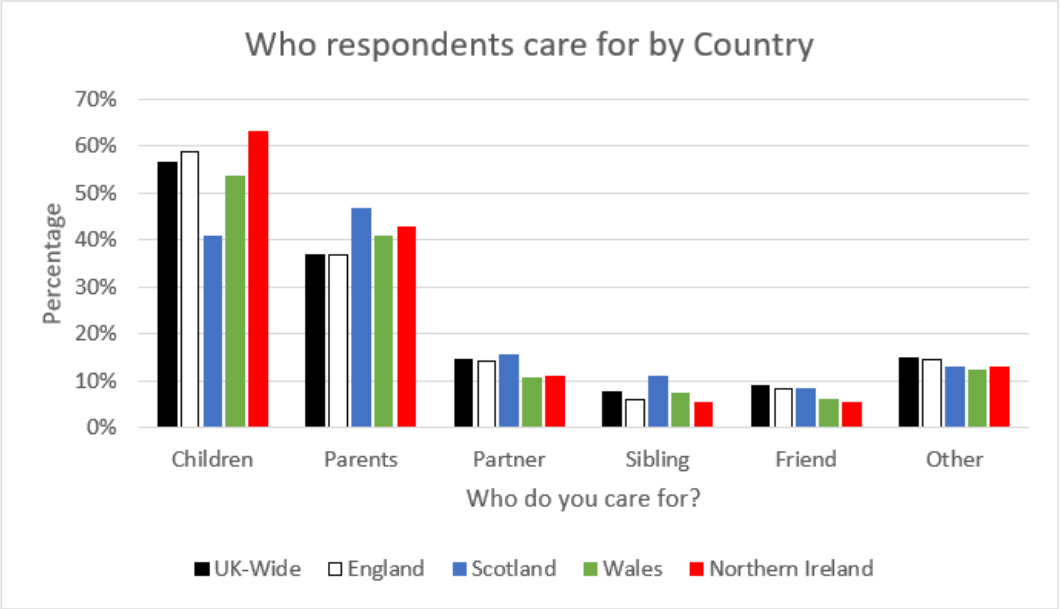

Figure A2.109: Who Respondents Care for by Country (Unweighted)

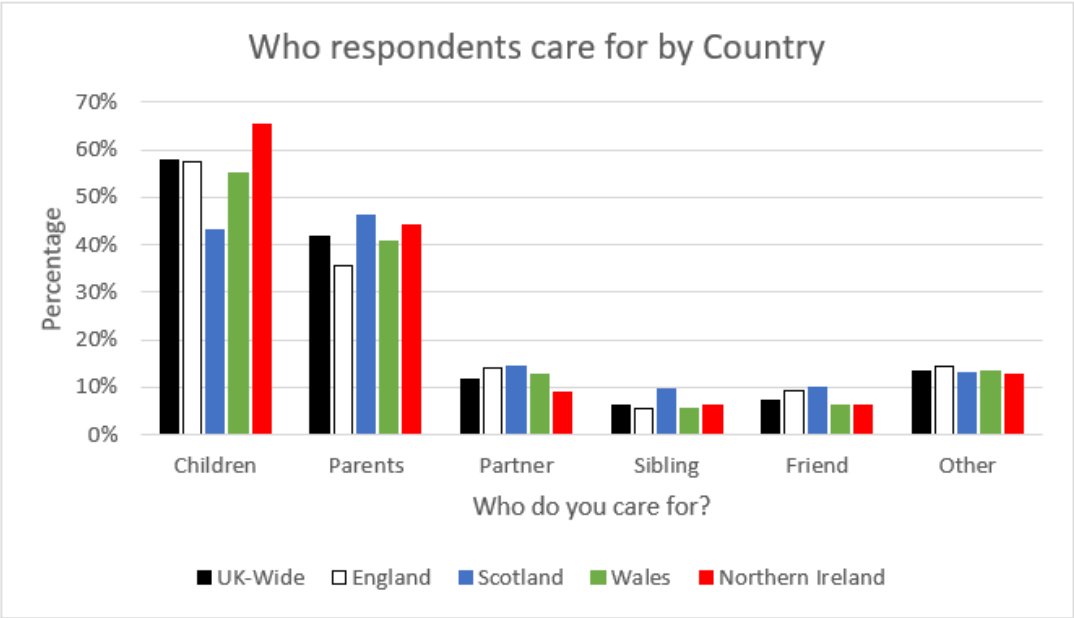

Table A2.108: Who Respondents Care for by Country (Weighted)

Who do you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	56.5%	58.7%	40.9%	53.7%	63.1%
Parents	36.8%	37.0%	46.8%	40.9%	42.9%
Partner	14.7%	14.1%	15.6%	10.7%	10.9%
Sibling	7.5%	5.9%	10.8%	7.2%	5.4%
Friend	8.8%	8.2%	8.2%	6.1%	5.5%
Other	14.9%	14.7%	13.0%	12.4%	13.0%

Table A2.109: Who Respondents Care for by Country (Unweighted)

Who do you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	1131 (57.9%)	206 (57.4%)	113 (43.1%)	322 (55.1%)	490 (65.3%)
Parents	819 (41.9%)	128 (35.7%)	121 (46.2%)	238 (40.8%)	332 (44.3%)
Partner	231 (11.8%)	51 (14.2%)	38 (14.5%)	75 (12.8%)	67 (8.9%)
Sibling	124 (6.3%)	20 (5.6%)	25 (9.5%)	32 (5.5%)	47 (6.3%)
Friend	141 (7.2%)	33 (9.2%)	26 (9.9%)	36 (6.2%)	46 (6.1%)
Other	260 (13.3%)	52 (14.5%)	34 (13.0%)	78 (13.4%)	96 (12.8%)
No. of respondents who answered the question	**1955**	**359**	**262**	**584**	**750**

Figure A2.110: Who Respondents Care for by Occupation (Weighted)

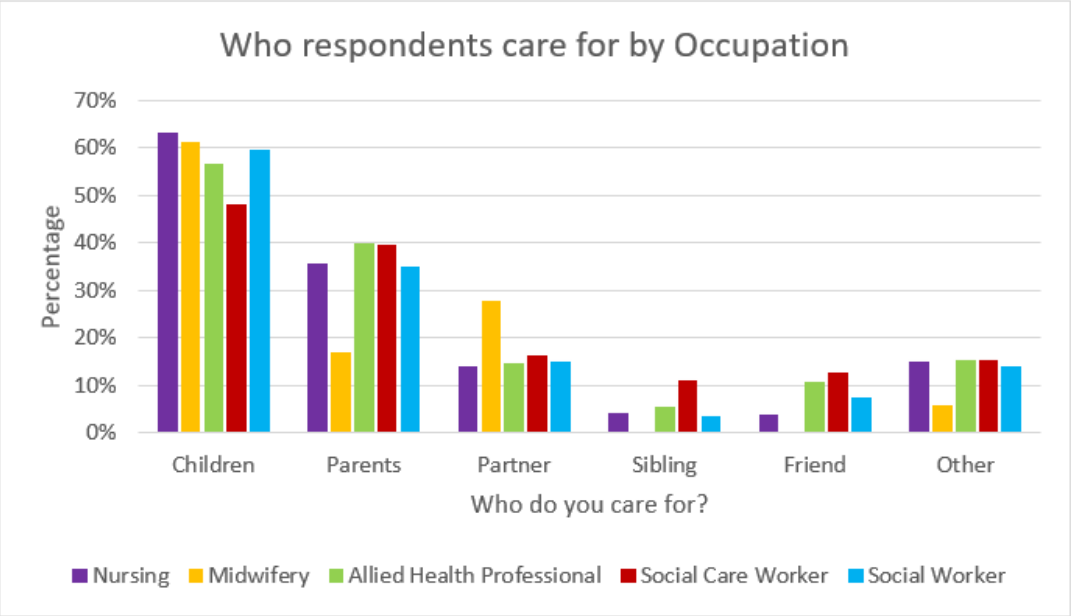

Figure A2.111: Who Respondents Care for by Occupation (Unweighted)

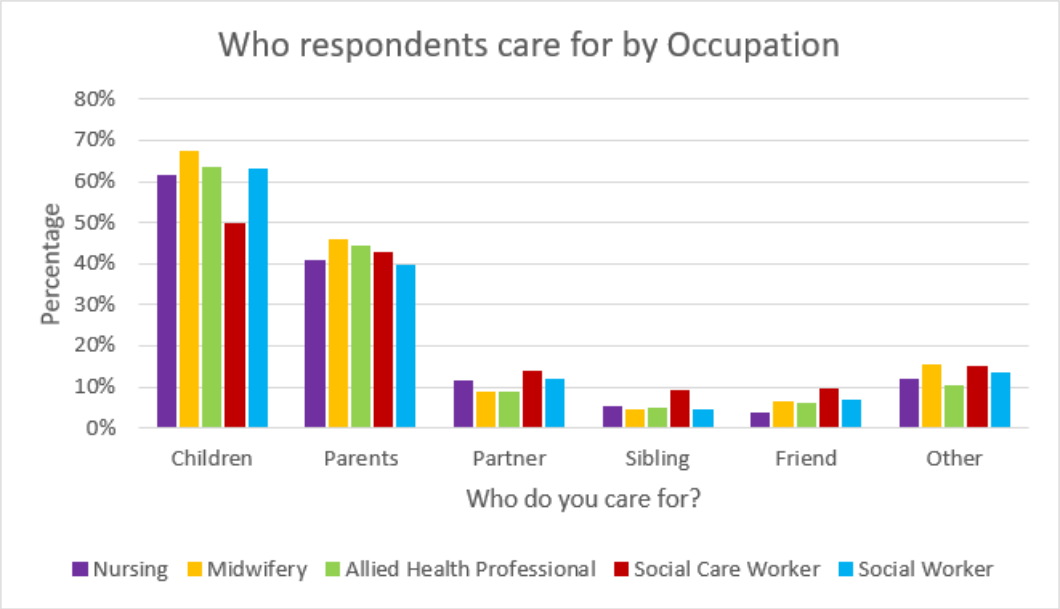

Table A2.110: Who Respondents Care for by Occupation (Weighted)

Occupation	Who do you care for?					
	Children	Parents	Partner	Sibling	Friend	Other
Nursing	63.1%	35.6%	14.0%	4.2%	3.8%	14.8%
Midwifery	61.1%	16.7%	27.8%	0.0%	0.0%	5.6%
AHP	56.4%	39.9%	14.4%	5.3%	10.7%	15.2%
Social Care Worker	48.0%	39.5%	16.1%	10.8%	12.7%	15.2%
Social Worker	59.4%	34.9%	14.9%	3.4%	7.3%	13.8%

Table A2.111: Who Respondents Care for by Occupation (Unweighted)

Occupation	Who do you care for?						No. of respondents who answered the question
	Children	Parents	Partner	Sibling	Friend	Other	
Nursing	139 (61.2%)	92 (40.5%)	26 (11.5%)	12 (5.3%)	8 (3.5%)	27 (11.9%)	**227**
Midwifery	31 (67.4%)	21 (45.7%)	4 (8.7%)	2 (4.3%)	3 (6.5%)	7 (15.2%)	**46**
AHP	220 (63.2%)	154 (44.3%)	30 (8.6%)	16 (4.6%)	21 (6.0%)	36 (10.3%)	**348**
Social Care Worker	366 (49.7%)	315 (42.7%)	102 (13.8%)	67 (9.1%)	69 (9.4%)	110 (14.9%)	**737**
Social Worker	375 (62.8%)	237 (39.7%)	69 (11.6%)	27 (4.5%)	40 (6.7%)	80 (13.4%)	**597**

A2.29 Respondents Living with the Person They Care for

Respondents were also asked whether they live with the person they care for.

Summary (Weighted results):

Northern Ireland had the highest proportion of respondents who were living with the person they were caring for.

Summary (Unweighted results):

Northern Ireland had the highest and Scotland the lowest proportion of respondents who were living with the person they were caring for.

Figure A2.112: Respondents Living with the Person They Care for by Country (Weighted)

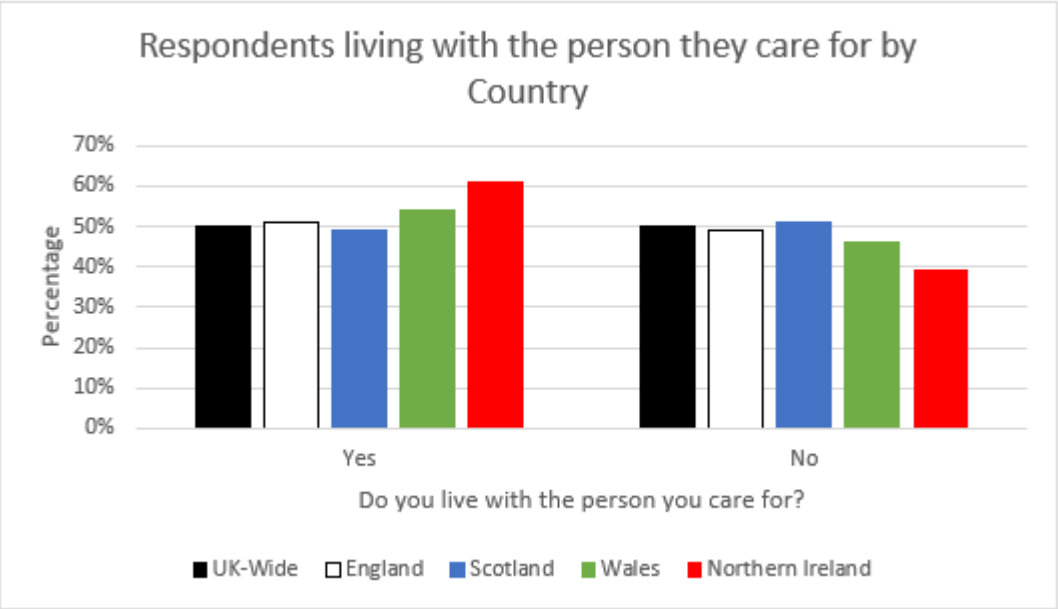

Figure A2.113: Respondents Living with the Person They Care for by Country (Unweighted)

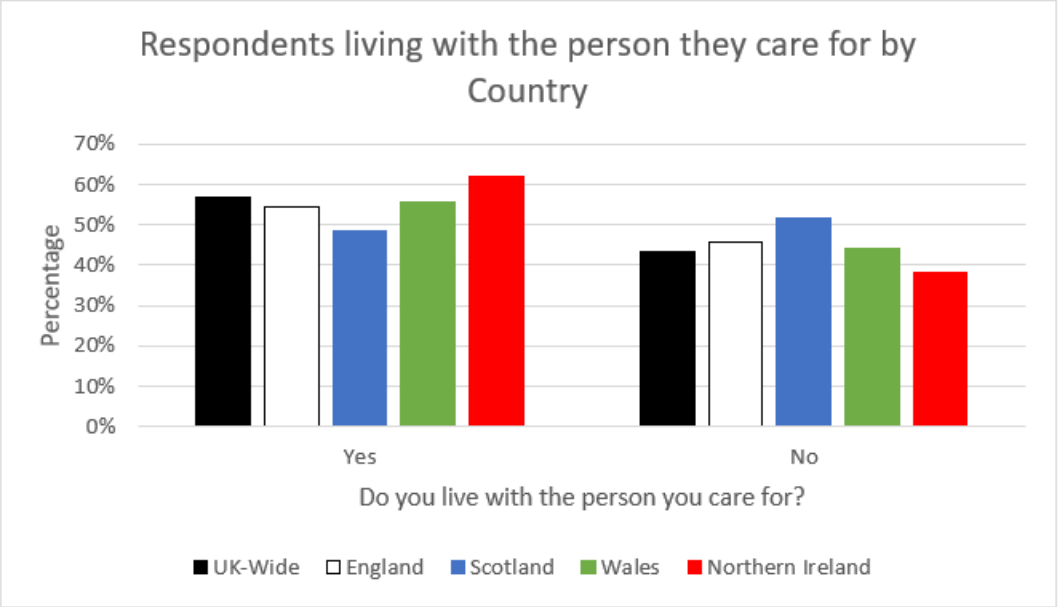

Table A2.112: Respondents Living with the Person They Care for by Country (Weighted)

Do you live with the person you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	50.2%	51.1%	48.9%	54.0%	60.9%
No	49.8%	48.9%	51.1%	46.0%	39.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.113: Respondents Living with the Person They Care for by Country (Unweighted)

Do you live with the person you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	1139 (56.8%)	203 (54.4%)	131 (48.3%)	334 (55.8%)	471 (61.8%)
No	866 (43.2%)	170 (45.6%)	140 (51.7%)	265 (44.2%)	291 (38.2%)
Total	**2005 (100%)**	**373 (100%)**	**271 (100%)**	**599 (100%)**	**762 (100%)**

Figure A2.114: Respondents Living with the Person They Care for by Occupation (Weighted)

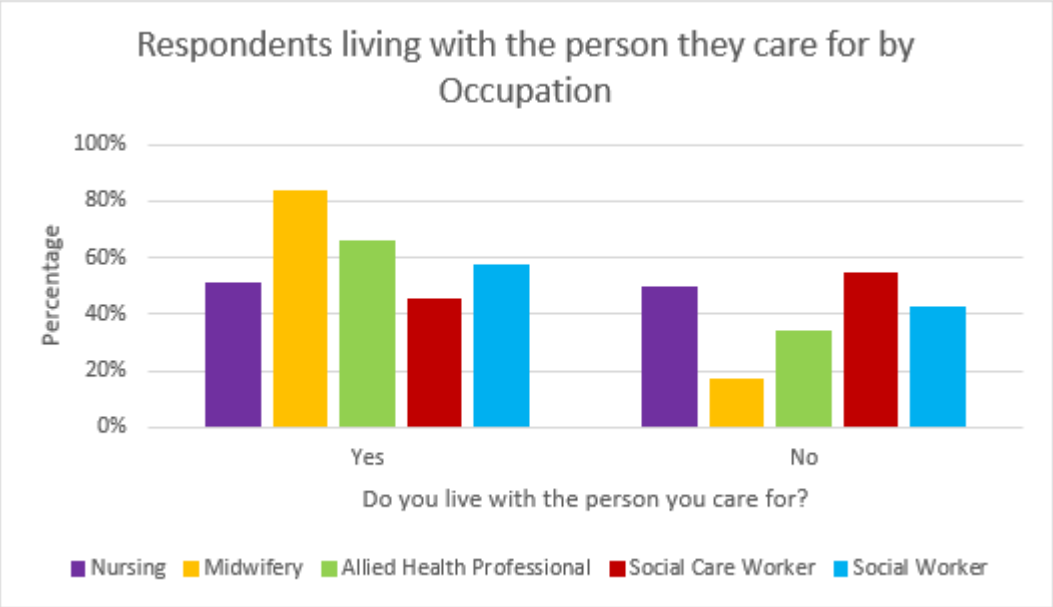

Figure A2.115: Respondents Living with the Person They Care for by Occupation (Unweighted)

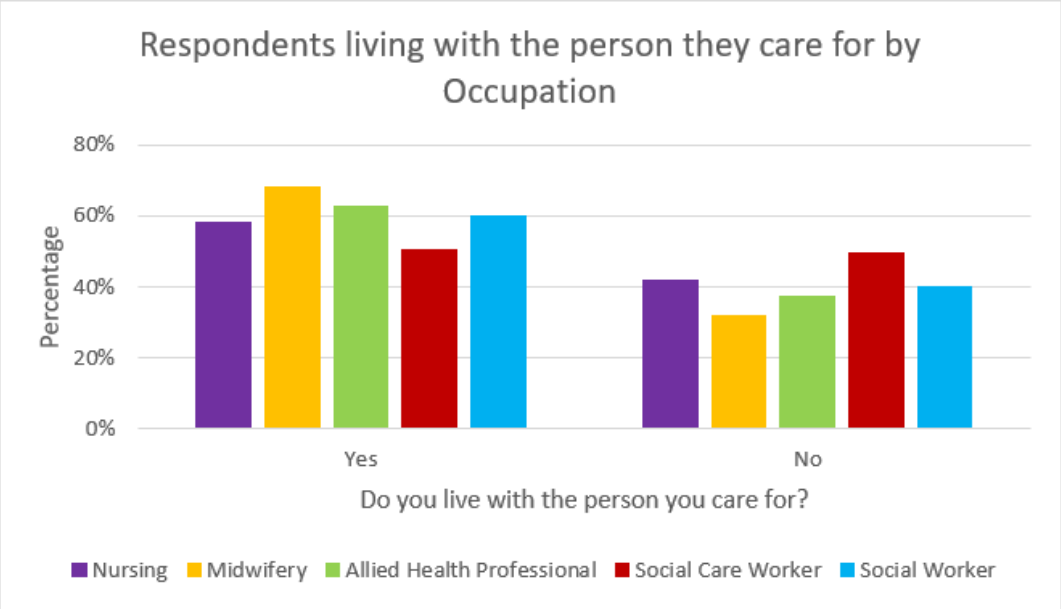

Table A2.114: Respondents Living with the Person They Care for by Occupation (Weighted)

	Do you live with the person you care for?		
Occupation	**Yes**	**No**	**Total**
Nursing	50.6%	49.4%	**100%**
Midwifery	83.3%	16.7%	**100%**
AHP	65.9%	34.1%	**100%**
Social Care Worker	45.5%	54.5%	**100%**
Social Worker	57.4%	42.6%	**100%**

Table A2.115: Respondents Living with the Person They Care for by Occupation (Unweighted)

Occupation	Do you live with the person you care for?		Total
	Yes	No	
Nursing	134 (58.3%)	96 (41.7%)	**230 (100%)**
Midwifery	32 (68.1%)	15 (31.9%)	**47 (100%)**
AHP	223 (62.6%)	133 (37.4%)	**356 (100%)**
Social Care Worker	384 (50.3%)	379 (49.7%)	**763 (100%)**
Social Worker	366 (60.1%)	243 (39.9%)	**609 (100%)**

A2.30 Respondents' Change in Caring Responsibilities During COVID-19

Summary (Weighted results):

The majority of respondents UK-wide and across the occupational groups reported that their caring responsibilities had changed during the COVID-19 pandemic.

Summary (Unweighted results):

The majority of respondents UK-wide and across the occupational groups reported that their caring responsibilities had changed during the COVID-19 pandemic.

Figure A2.116: Change in Caring Responsibilities During the Pandemic by Country (Weighted)

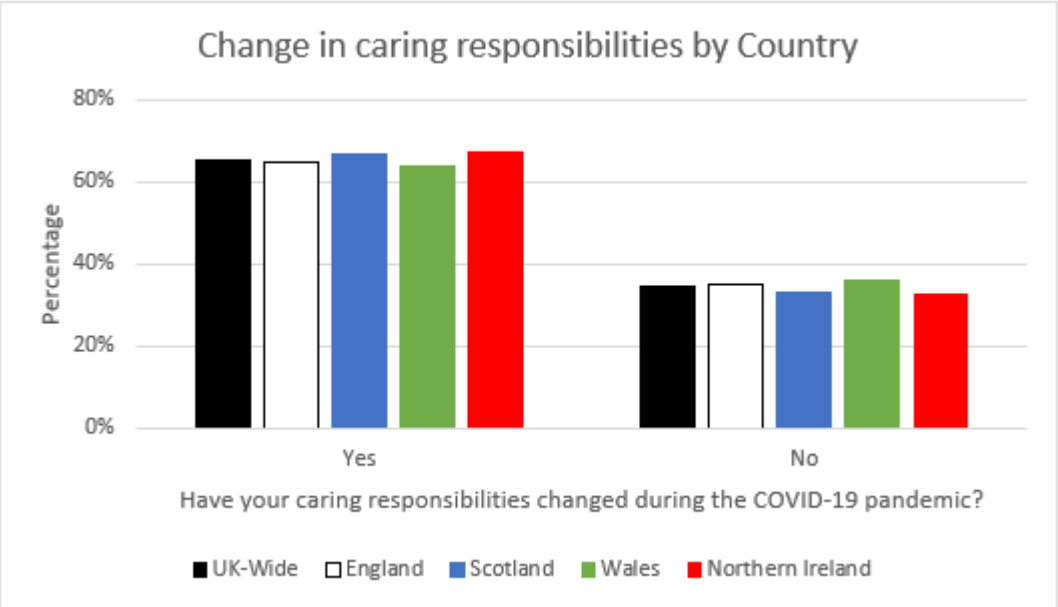

Figure A2.117: Change in Caring Responsibilities During the Pandemic by Country (Unweighted)

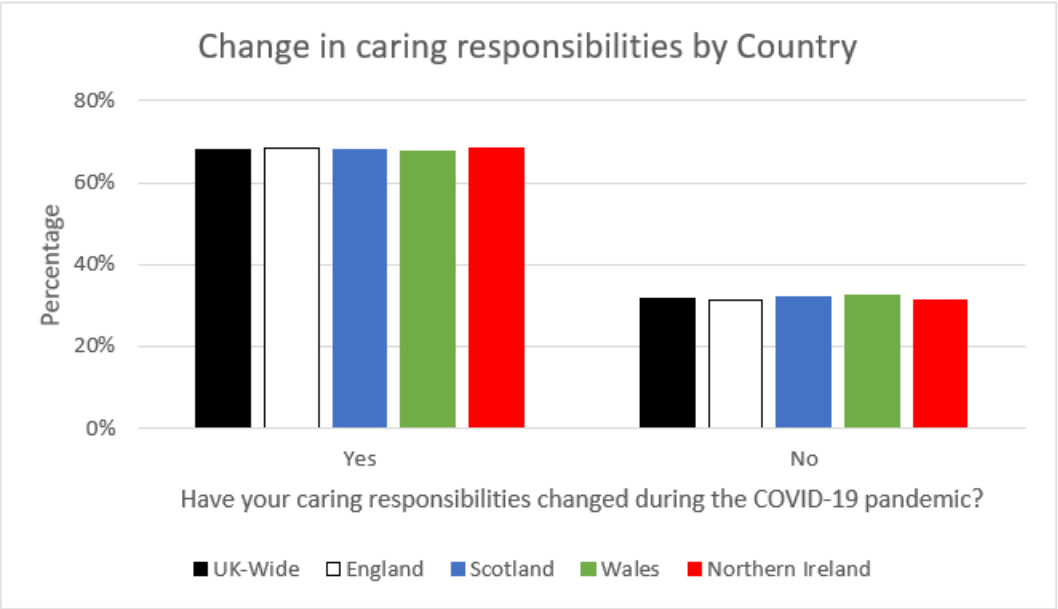

Table A2.116: Change in Caring Responsibilities During the Pandemic by Country (Weighted)

Have your caring responsibilities changed during the COVID-19 pandemic?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	65.2%	64.7%	67.0%	64.1%	67.3%
No	34.8%	35.3%	33.0%	35.9%	32.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.117: Change in Caring Responsibilities During the Pandemic by Country (Unweighted)

Have your caring responsibilities changed during the COVID-19 pandemic?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	1379 (68.2%)	257 (68.5%)	185 (68.0%)	409 (67.6%)	528 (68.5%)
No	644 (31.8%)	118 (31.5%)	87 (32.0%)	196 (32.4%)	243 (31.5%)
Total	**2023 (100%)**	**375 (100%)**	**272 (100%)**	**605 (100%)**	**771 (100%)**

Figure A2.118: Change in Caring Responsibilities During the Pandemic by Occupation (Weighted)

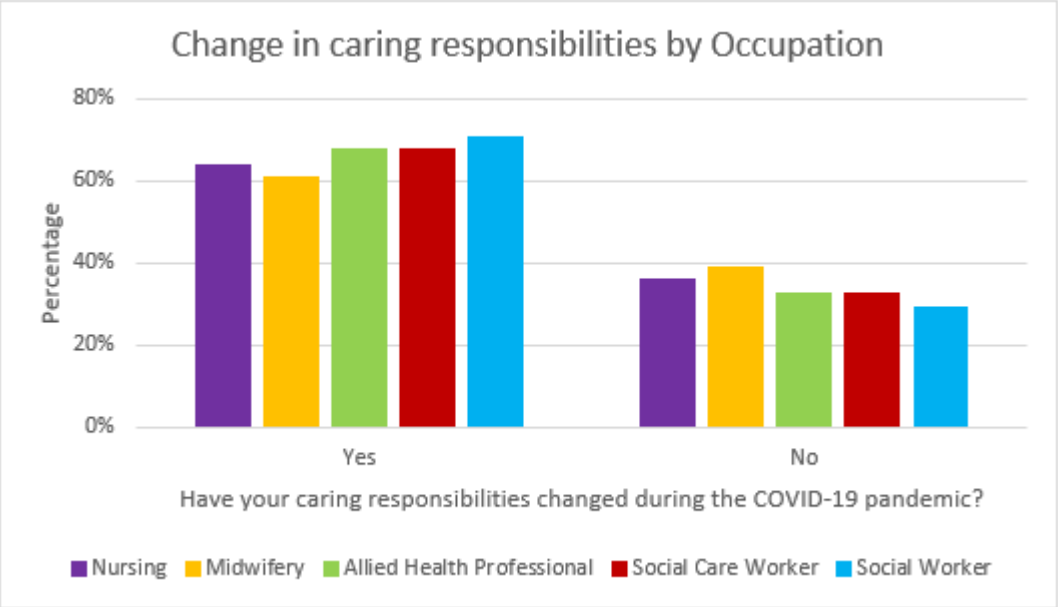

Figure A2.119: Change in Caring Responsibilities During the Pandemic by Occupation (Unweighted)

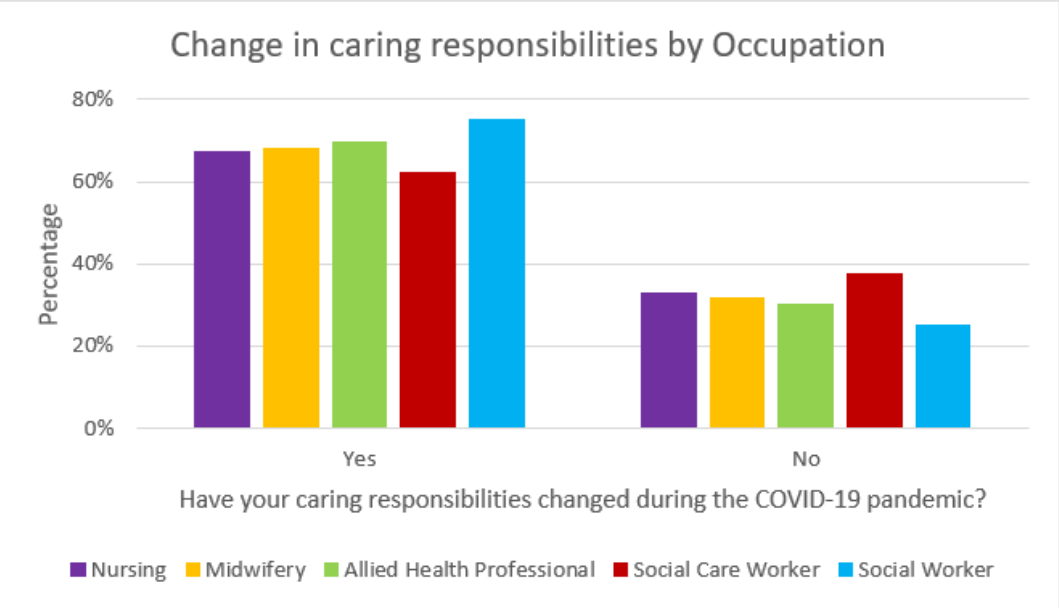

Table A2.118: Change in Caring Responsibilities During the Pandemic by Occupation (Weighted)

	Have your caring responsibilities changed during the COVID-19 pandemic?		
Occupation	**Yes**	**No**	**Total**
Nursing	64.0%	36.0%	**100%**
Midwifery	61.1%	38.9%	**100%**
AHP	67.6%	32.4%	**100%**
Social Care Worker	67.6%	32.4%	**100%**
Social Worker	70.6%	29.4%	**100%**

Table A2.119: Change in Caring Responsibilities During the Pandemic by Occupation (Unweighted)

Occupation	Have your caring responsibilities changed during the COVID-19 pandemic?		Total
	Yes	No	
Nursing	156 (67.2%)	76 (32.8%)	**232 (100%)**
Midwifery	32 (68.1%)	15 (31.9%)	**47 (100%)**
AHP	251 (69.7%)	109 (30.3%)	**360 (100%)**
Social Care Worker	479 (62.3%)	290 (37.7%)	**769 (100%)**
Social Worker	461 (75.0%)	154 (25.0%)	**615 (100%)**

A2.31 Respondents' Region of Work

Summary (Weighted results):

Not reported

Summary (Unweighted results):

The majority of respondents from England were from the London region, followed by the South East and the South West.

Figure A2.120: Responses by Region (Unweighted)

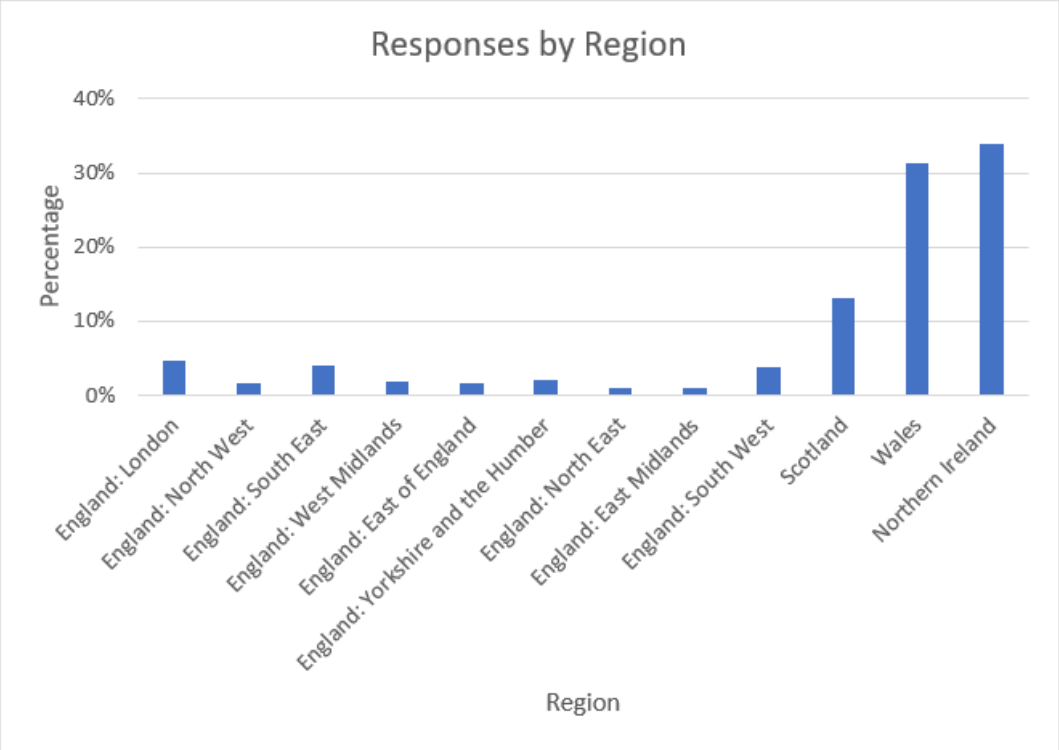

Table A2.120: Responses by Region (Unweighted)

Region	n (%)
England: London	163 (4.7%)
England: North West	59 (1.7%)
England: South East	140 (4.0%)
England: West Midlands	67 (1.9%)
England: East of England	60 (1.7%)
England: Yorkshire and the Humber	70 (2.0%)
England: North East	32 (0.9%)
England: East Midlands	32 (0.9%)
England: South West	133 (3.8%)
Scotland	459 (13.1%)
Wales	1095 (31.3%)
Northern Ireland	1189 (34.0%)
Total	**3499 (100%)**

Figure A2.121: Region by Occupation (Unweighted)

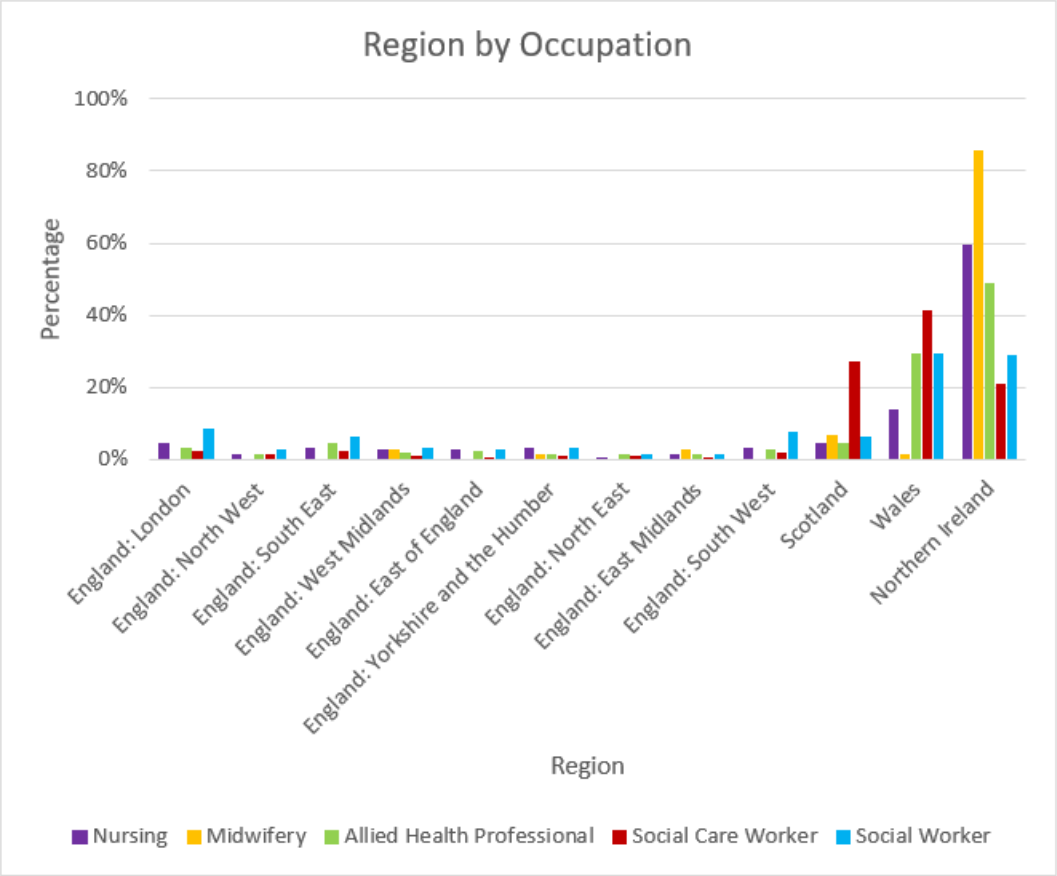

Table A2.121: Region by Occupation (Unweighted)

Region	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
England: London	16 (4.4%)	0 (0.0%)	19 (3.0%)	30 (2.4%)	98 (8.4%)
England: North West	5 (1.4%)	0 (0.0%)	7 (1.1%)	15 (1.2%)	32 (2.7%)
England: South East	12 (3.3%)	0 (0.0%)	27 (4.2%)	27 (2.2%)	74 (6.3%)
England: West Midlands	10 (2.8%)	2 (2.7%)	10 (1.6%)	11 (0.9%)	34 (2.9%)
England: East of England	9 (2.5%)	0 (0.0%)	13 (2.0%)	6 (0.5%)	32 (2.7%)
England: Yorkshire and the Humber	12 (3.3%)	1 (1.3%)	8 (1.3%)	11 (0.9%)	38 (3.2%)
England: North East	1 (0.3%)	0 (0.0%)	7 (1.1%)	10 (0.8%)	14 (1.2%)
England: East Midlands	4 (1.1%)	2 (2.7%)	7 (1.1%)	3 (0.2%)	16 (1.4%)
England: South West	12 (3.3%)	0 (0.0%)	16 (2.5%)	20 (1.6%)	85 (7.3%)
Scotland	16 (4.4%)	5 (6.7%)	27 (4.2%)	340 (27.1%)	71 (6.1%)
Wales	50 (13.9%)	1 (1.3%)	186 (29.2%)	517 (41.3%)	341 (29.1%)
Northern Ireland	214 (59.3%)	64 (85.3%)	311 (48.7%)	263 (21.0%)	337 (28.8%)
Total	**361 (100%)**	**75 (100%)**	**638 (100%)**	**1253 (100%)**	**1172 (100%)**

Appendix 3: Mental Wellbeing Results (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of respondents' mental wellbeing, which was measured using the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A3.1 Wellbeing Scores by Country

Summary (Weighted results):

There was a significant difference in the overall mean wellbeing scores across countries (F = 5.792, df = 3, p = .001). Specifically, the overall wellbeing score was significantly higher in Northern Ireland compared to England and Scotland.

When the scores were converted to possible or probable cases of anxiety/depression, a total of 17.7% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 22.0% were possible cases.

Summary (Unweighted results):

There was a significant difference in the overall mean wellbeing scores across countries (F = 6.554, df = 3, p < .001). Specifically, the overall wellbeing score was significantly higher in Northern Ireland compared to England and Scotland.

When the scores were converted to possible or probable cases of anxiety/depression, a total of 14.0% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 22.2% were possible cases.

Figure A3.1: Mean Wellbeing Item Scores by Country (Weighted)

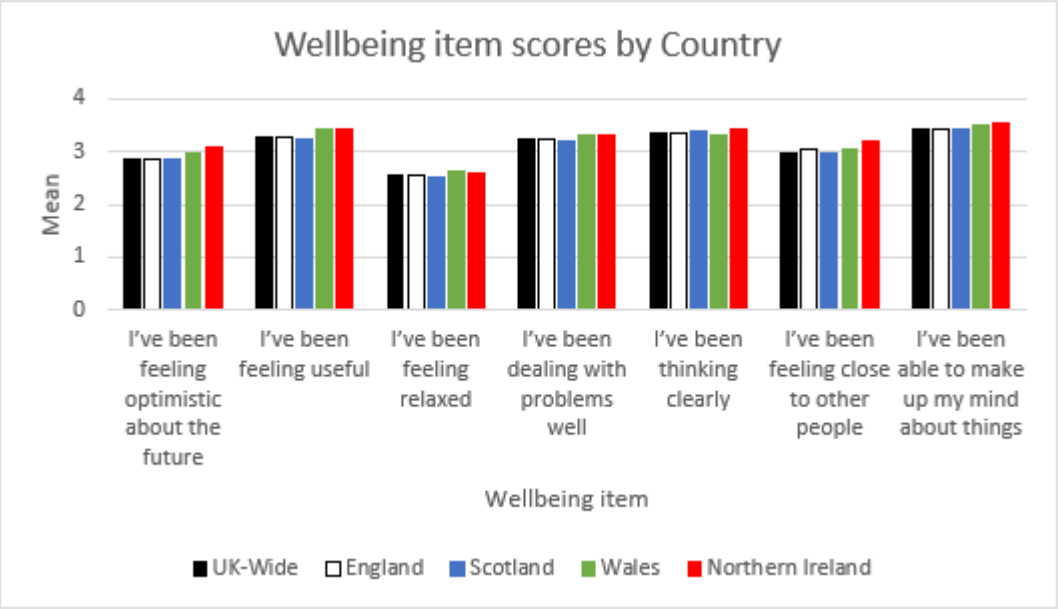

Figure A3.2: Mean Wellbeing Item Scores by Country (Unweighted)

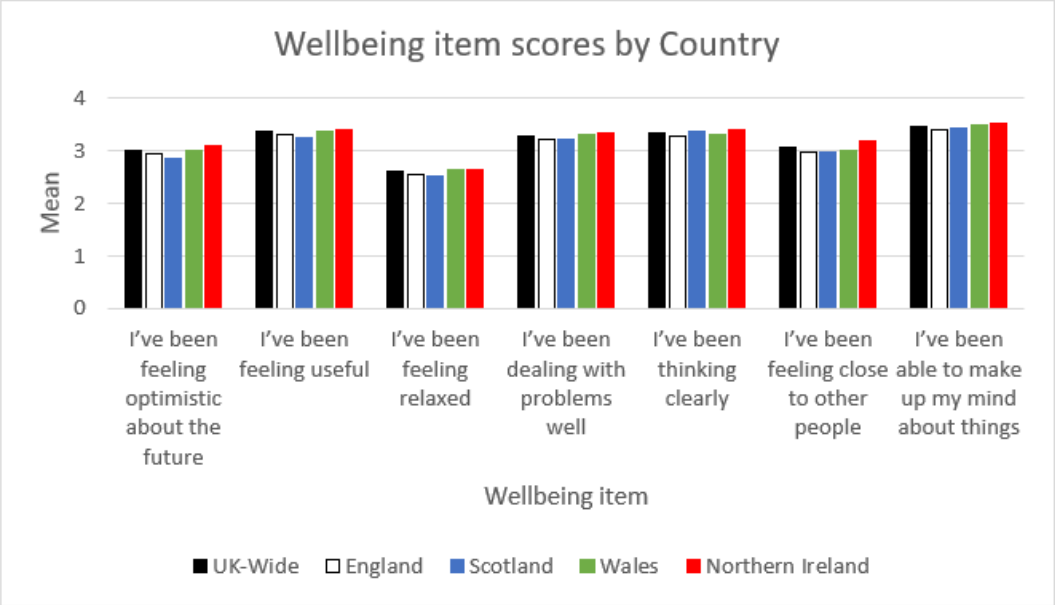

Figure A3.3: Mean Overall Wellbeing Score by Country (Weighted)

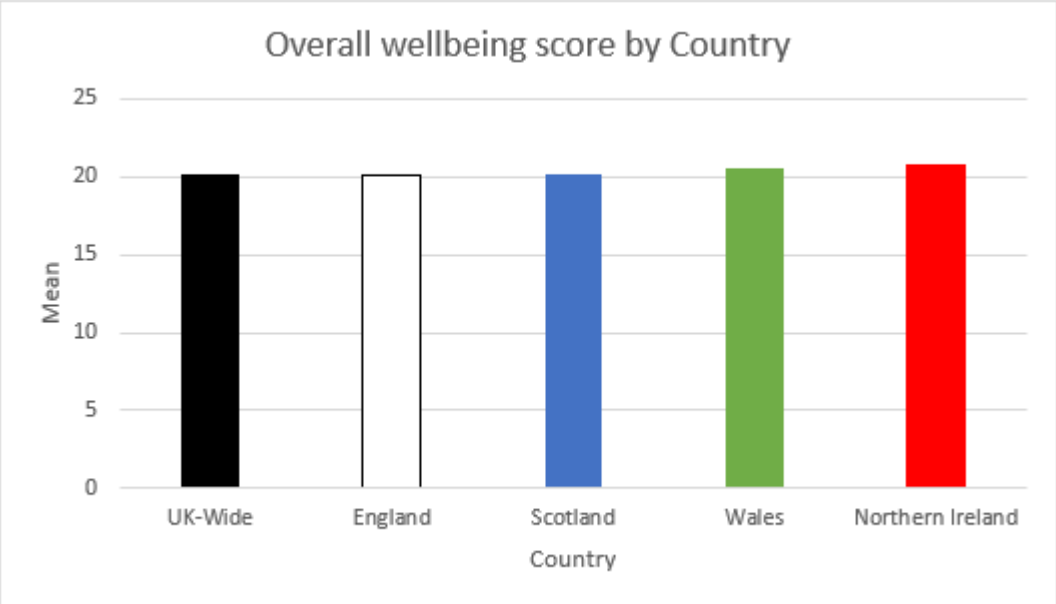

Figure A3.4: Mean Overall Wellbeing Score by Country (Unweighted)

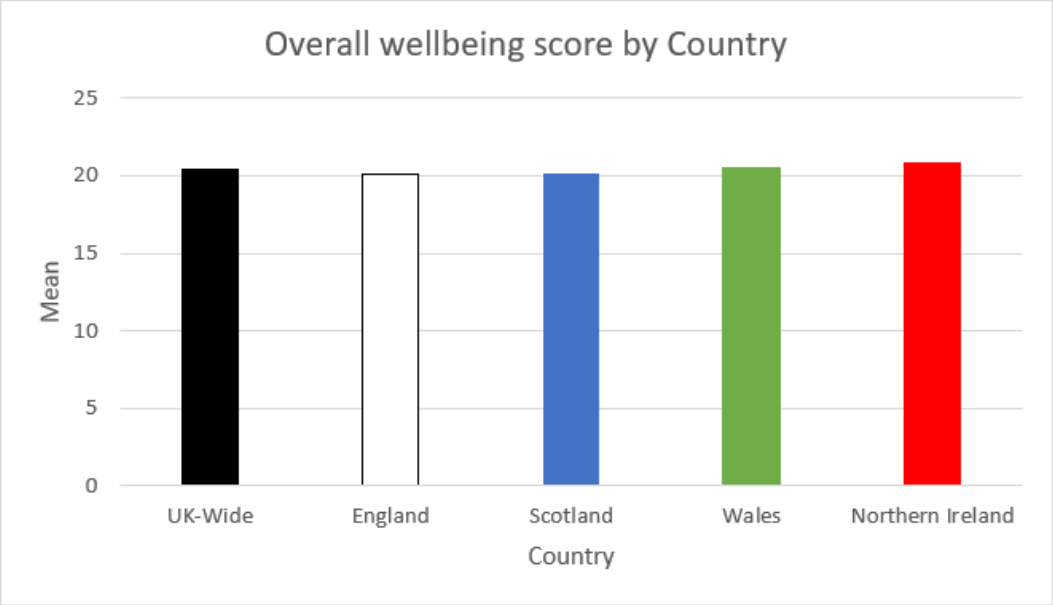

Table A3.1: Mean Overall and Item Wellbeing Scores by Country (Weighted)

	Country				
Wellbeing item	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
I've been feeling optimistic about the future	2.85	2.85	2.84	2.98	3.08
I've been feeling useful	3.27	3.27	3.23	3.41	3.41
I've been feeling relaxed	2.55	2.57	2.52	2.62	2.59
I've been dealing with problems well	3.25	3.24	3.21	3.32	3.32
I've been thinking clearly	3.35	3.35	3.40	3.33	3.42
I've been feeling close to other people	2.98	3.03	2.99	3.04	3.20
I've been able to make up my mind about things	3.42	3.42	3.43	3.49	3.53
Mean overall wellbeing score	**20.10**	**20.14**	**20.13**	**20.50**	**20.76**

Table A3.2: Mean Overall and Item Wellbeing Scores by Country (Unweighted)

	Country				
Wellbeing item	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
I've been feeling optimistic about the future	3.01	2.96	2.87	3.01	3.10
I've been feeling useful	3.36	3.32	3.25	3.37	3.41
I've been feeling relaxed	2.60	2.54	2.53	2.63	2.64
I've been dealing with problems well	3.29	3.21	3.23	3.32	3.33
I've been thinking clearly	3.35	3.28	3.38	3.32	3.41
I've been feeling close to other people	3.06	2.98	2.99	3.00	3.20
I've been able to make up my mind about things	3.47	3.39	3.43	3.49	3.51
Mean overall wellbeing score	**20.44**	**20.09**	**20.15**	**20.46**	**20.78**

Figure A3.5: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Weighted)

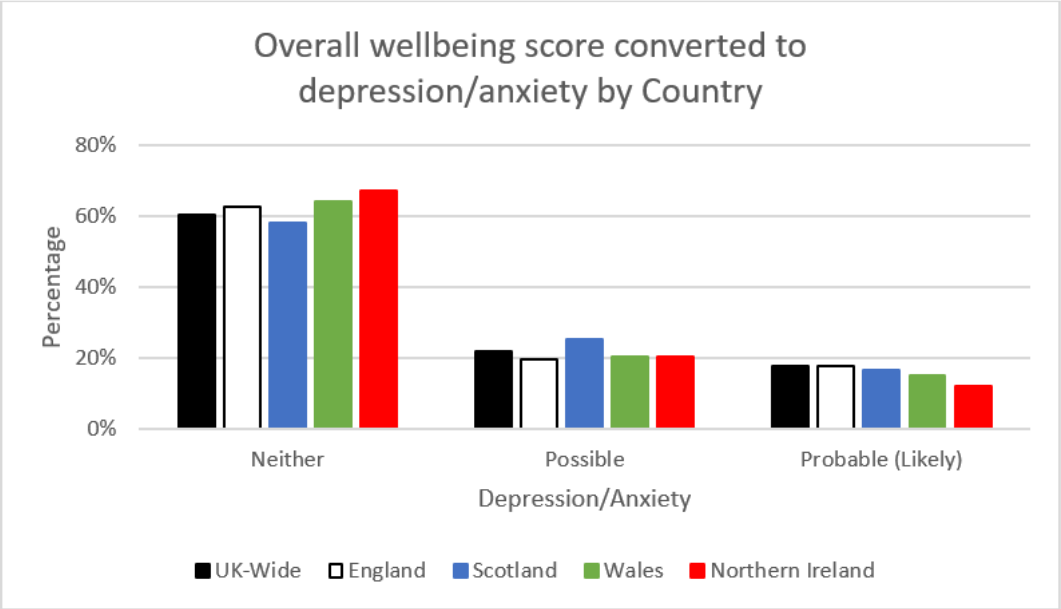

Figure A3.6: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Unweighted)

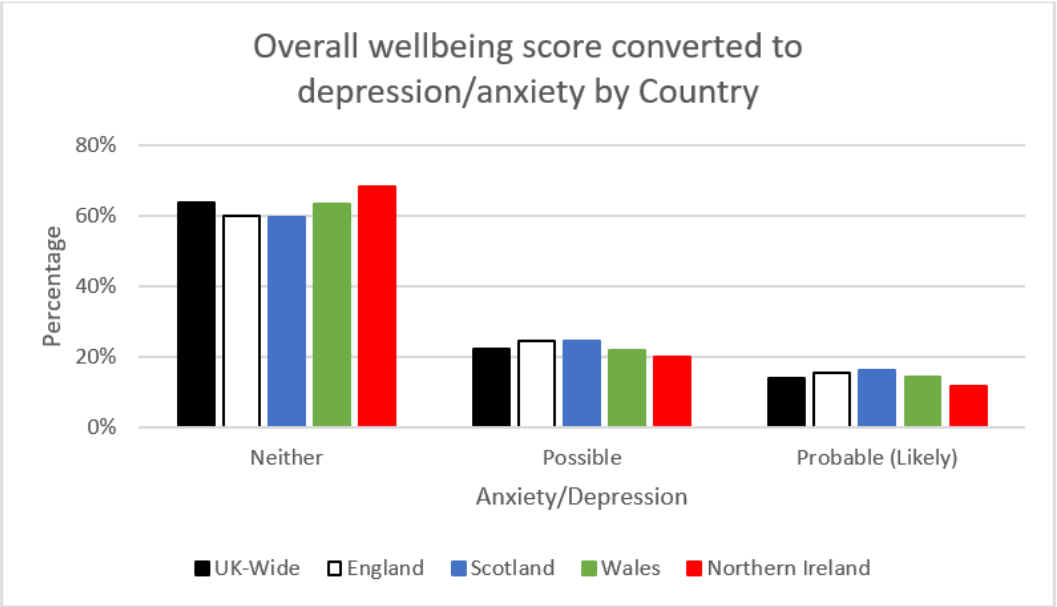

Table A3.3: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Weighted)

	Country				
Case of anxiety/depression	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Neither	60.3%	62.7%	58.1%	64.4%	67.3%
Possible	22.0%	19.5%	25.3%	20.6%	20.5%
Probable (Likely)	17.7%	17.8%	16.5%	15.0%	12.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.4: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Unweighted)

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	1898 (63.8%)	406 (60.0%)	230 (59.6%)	585 (63.5%)	677 (68.5%)
Possible	659 (22.2%)	165 (24.4%)	94 (24.4%)	203 (22.0%)	197 (19.9%)
Probable (Likely)	416 (14.0%)	106 (15.7%)	62 (16.1%)	133 (14.4%)	115 (11.6%)
Total	**2973 (100%)**	**677 (100%)**	**386 (100%)**	**921 (100%)**	**989 (100%)**

A3.2 Wellbeing Scores by Occupation

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores across occupational groups (F = 4.100, df = 4, p = .003). Specifically, the overall wellbeing score was significantly higher in AHPs compared to social care workers and social workers.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores across occupational groups (F = 4.001, df = 4, p = .003). Specifically, the overall wellbeing score was significantly higher in AHPs compared to social care workers and social workers.

Figure A3.7: Mean Overall Wellbeing Score by Occupation (Weighted)

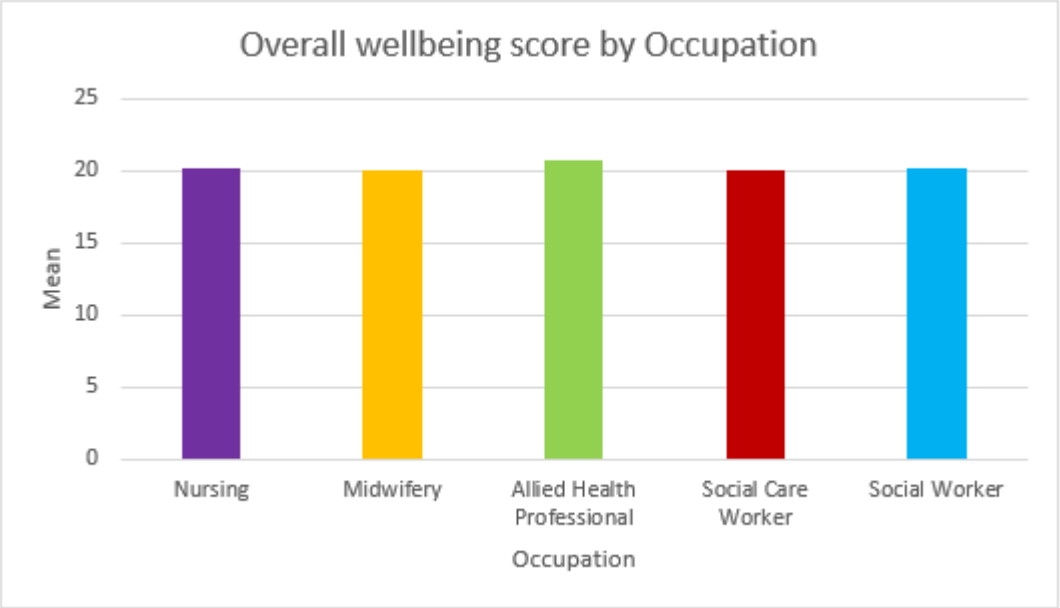

Figure A3.8: Mean Overall Wellbeing Score by Occupation (Unweighted)

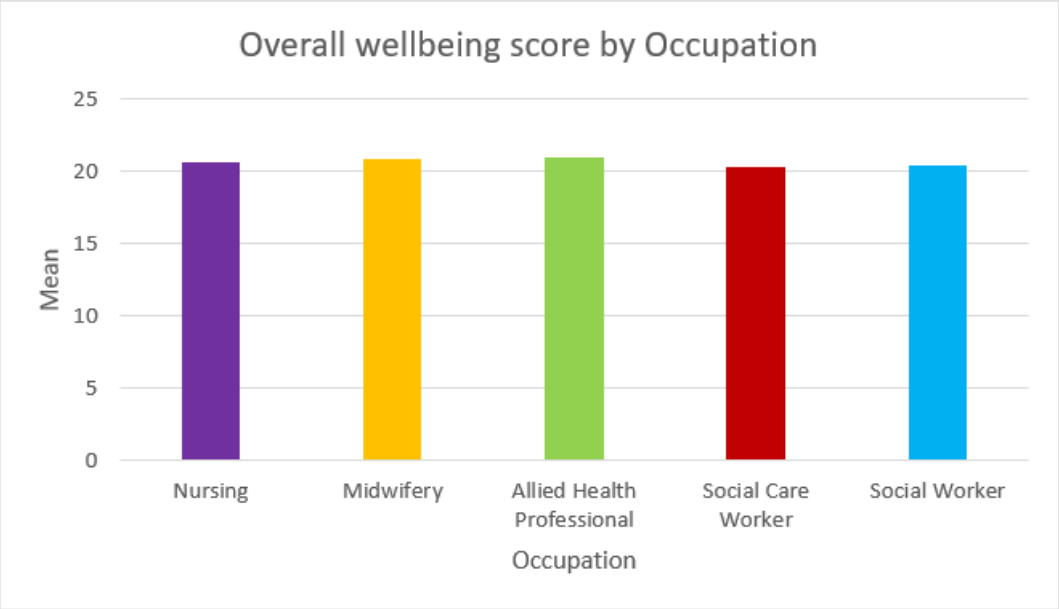

Table A3.5: Mean Overall Wellbeing Score by Occupation (Weighted)

Occupation	Mean overall wellbeing score
Nursing	20.10
Midwifery	19.92
AHP	20.73
Social Care Worker	20.02
Social Worker	20.07

Table A3.6: Mean Overall Wellbeing Score by Occupation (Unweighted)

Occupation	Mean overall wellbeing score
Nursing	20.64
Midwifery	20.77
AHP	20.89
Social Care Worker	20.22
Social Worker	20.36

Figure A3.9: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Weighted)

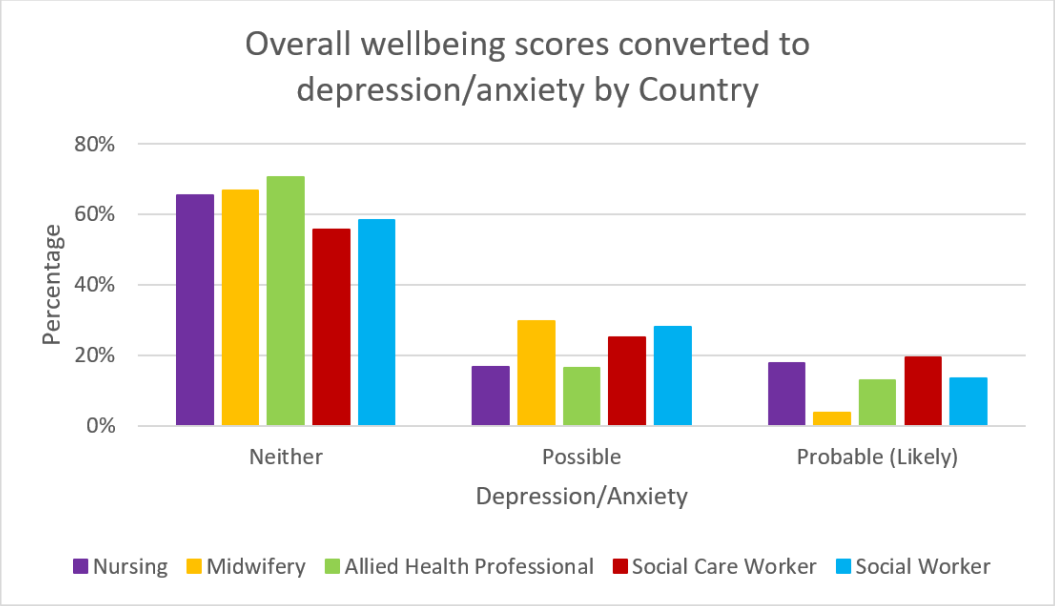

Figure A3.10: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Unweighted)

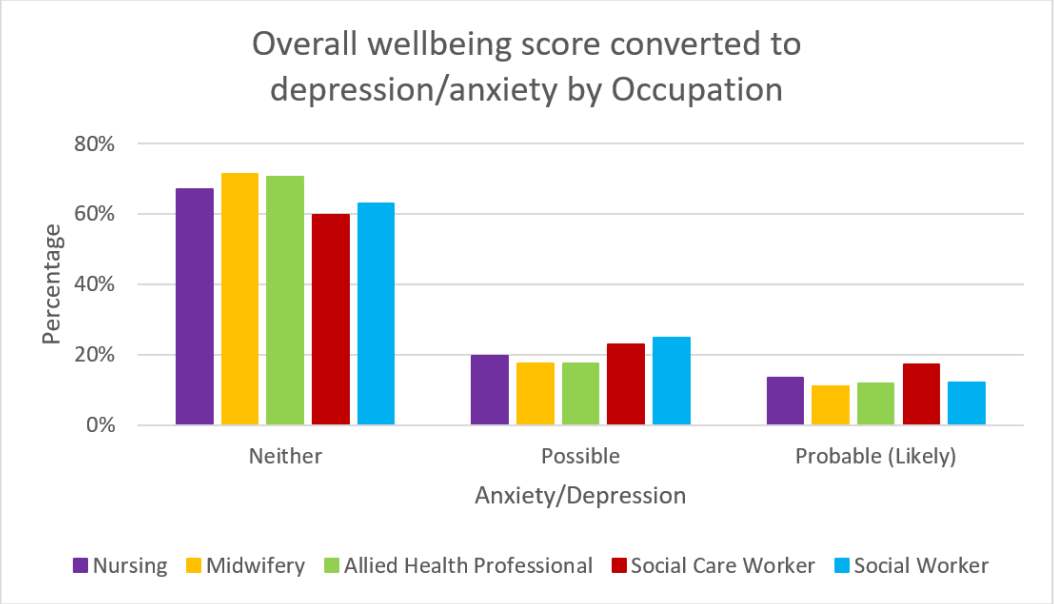

Table A3.7: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Weighted)

	Occupation				
Case of anxiety/depression	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Neither	65.5%	66.7%	70.7%	55.6%	58.4%
Possible	16.8%	29.6%	16.5%	25.1%	28.0%
Probable (Likely)	17.7%	3.7%	12.8%	19.3%	13.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.8: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Unweighted)

Case of anxiety/ depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	205 (67.0%)	45 (71.4%)	377 (70.6%)	628 (59.8%)	643 (63.0%)
Possible	60 (19.6%)	11 (17.5%)	94 (17.6%)	241 (23.0%)	253 (24.8%)
Probable (Likely)	41 (13.4%)	7 (11.1%)	63 (11.8%)	181 (17.2%)	124 (12.2%)
Total	**306 (100%)**	**63 (100%)**	**534 (100%)**	**1050 (100%)**	**1020 (100%)**

A3.3 Wellbeing Scores by Sex

Only three respondents in the full sample stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

Comparing males and females, there was a significant difference in their overall mean wellbeing score ($t = -6.953$, $df = 3091$, $p < .001$), with males scoring significantly higher than females.

Summary (Unweighted results):

Males and females did not differ significantly from each other on their overall mean wellbeing scores.

Figure A3.11: Mean Overall Wellbeing Score by Sex (Weighted)

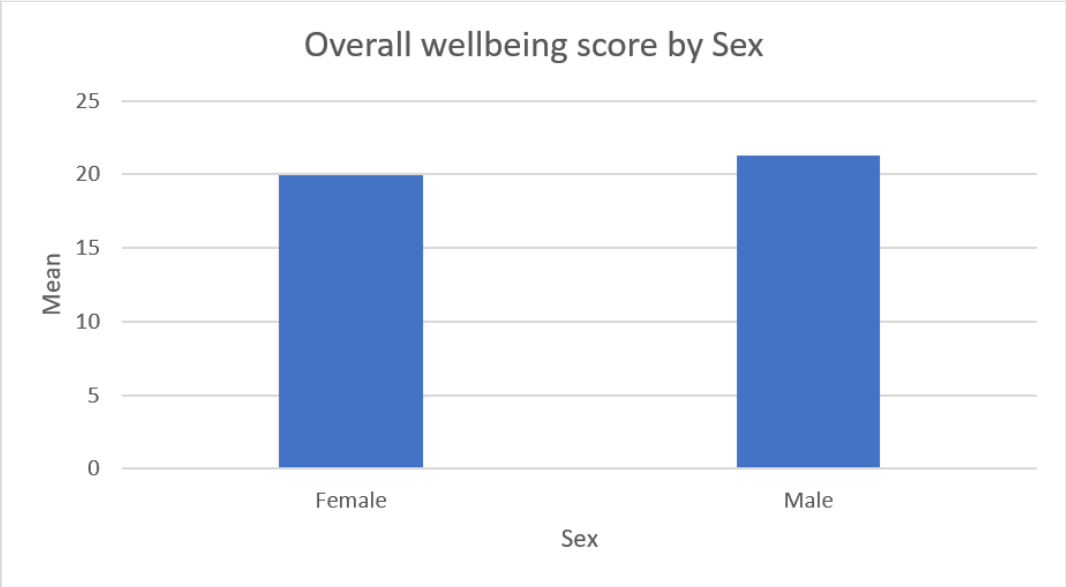

Figure A3.12: Mean Overall Wellbeing Score by Sex (Unweighted)

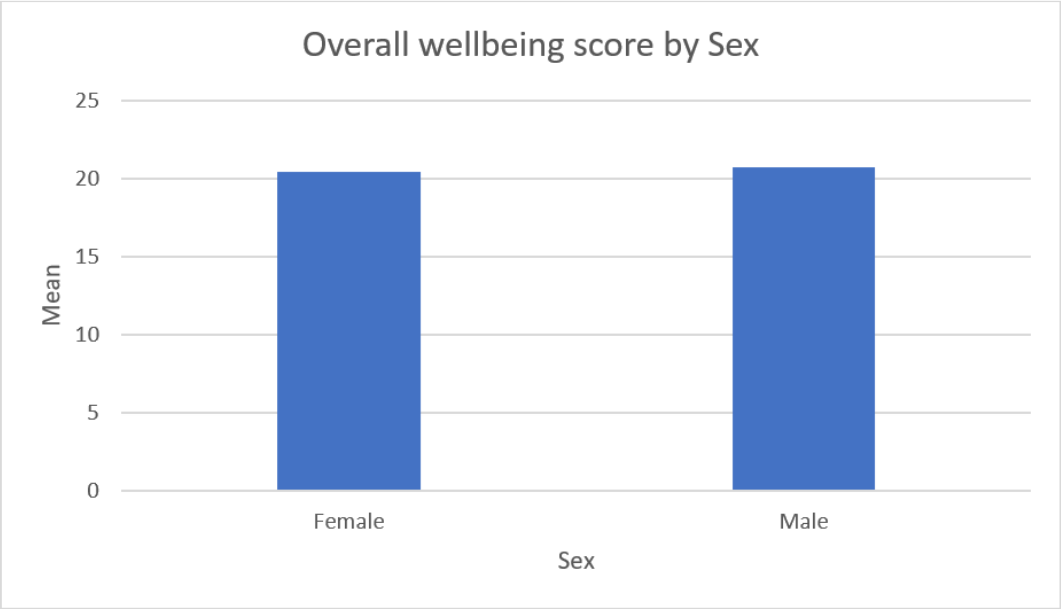

Table A3.9: Mean Overall Wellbeing Score by Sex (Weighted)

Sex	Mean overall wellbeing score
Female	19.95
Male	21.30

Table A3.10: Mean Overall Wellbeing Score by Sex (Unweighted)

Sex	Mean overall wellbeing score
Female	20.40
Male	20.72

A3.4 Wellbeing Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in their overall mean wellbeing scores ($F = 35.460$, $df = 6$, $p < .001$). The older age groups had higher wellbeing scores compared to the younger age groups. Specifically, the wellbeing score was significantly higher in the 50-59, 60-65 and 66+ age groups compared to the 30-39 and 40-49 age groups, the 66+ age group had significantly higher scores than the 20-29, 50-59 and the 60-65 age groups, the 60-65 age group had significantly higher scores than the 20-29 and the 50-59 age groups, but the 20-29 age group had significantly higher scores than the 30-39 age group.

Summary (Unweighted results):

There were significant differences across the age groups in their overall mean wellbeing scores ($F = 9.662$, $df = 6$, $p < .001$). The overall wellbeing scores were higher in the older age groups compared to

the younger age groups. Specifically, the wellbeing score was significantly higher in the 50-59, 60-65 and 66+ age groups compared to the 16-19, 20-29 and 30-39 age groups.

Figure A3.13: Mean Overall Wellbeing Score by Age (Weighted)

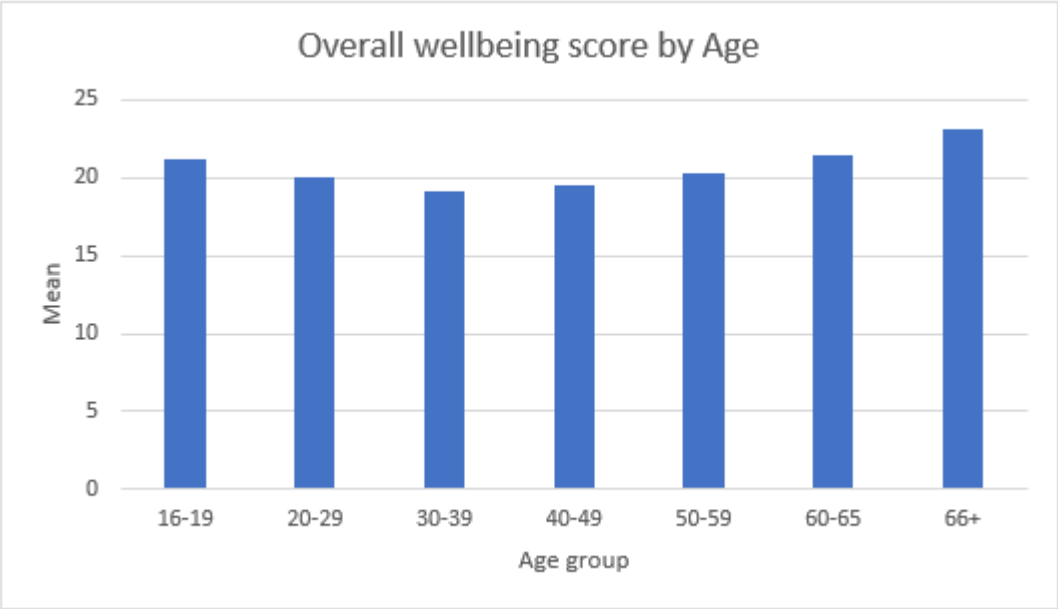

Figure A3.14: Mean Overall Wellbeing Score by Age (Unweighted)

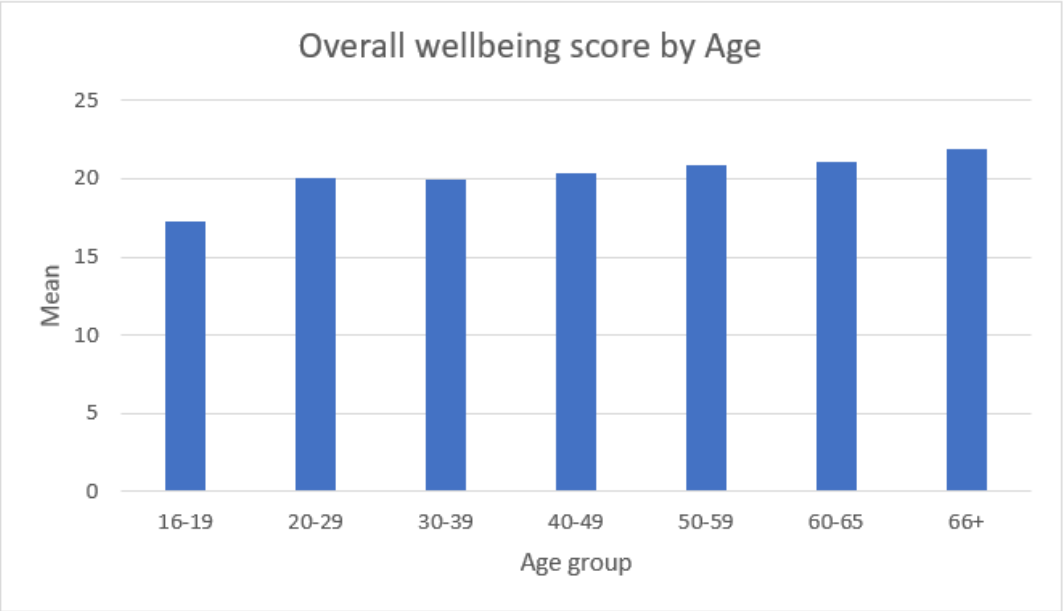

Table A3.11: Mean Overall Wellbeing Score by Age (Weighted)

Age	Mean overall wellbeing score
16-19 years	21.14
20-29 years	19.99
30-39 years	19.19
40-49 years	19.47
50-59 years	20.31
60-65 years	21.52
66+ years	23.18

Note. Only six respondents were in the 16-19 years age group.

Table A3.12: Mean Overall Wellbeing Score by Age (Unweighted)

Age	Mean overall wellbeing score
16-19 years	17.24
20-29 years	20.07
30-39 years	19.89
40-49 years	20.40
50-59 years	20.84
60-65 years	21.12
66+ years	21.86

Note. Only eight respondents were in the 16-19 years age group.

A3.5 Wellbeing Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups on their overall mean wellbeing scores ($F = 38.125$, $df = 3$, $p < .001$). Specifically, respondents who identified as black had significantly higher wellbeing scores than all the other ethnic groups, and those who identified as Asian had significantly lower wellbeing scores than all the other groups.

Summary (Unweighted results):

There were no significant differences between the ethnic groups on their overall mean wellbeing scores.

Figure A3.15: Mean Overall Wellbeing Score by Ethnicity (Weighted)

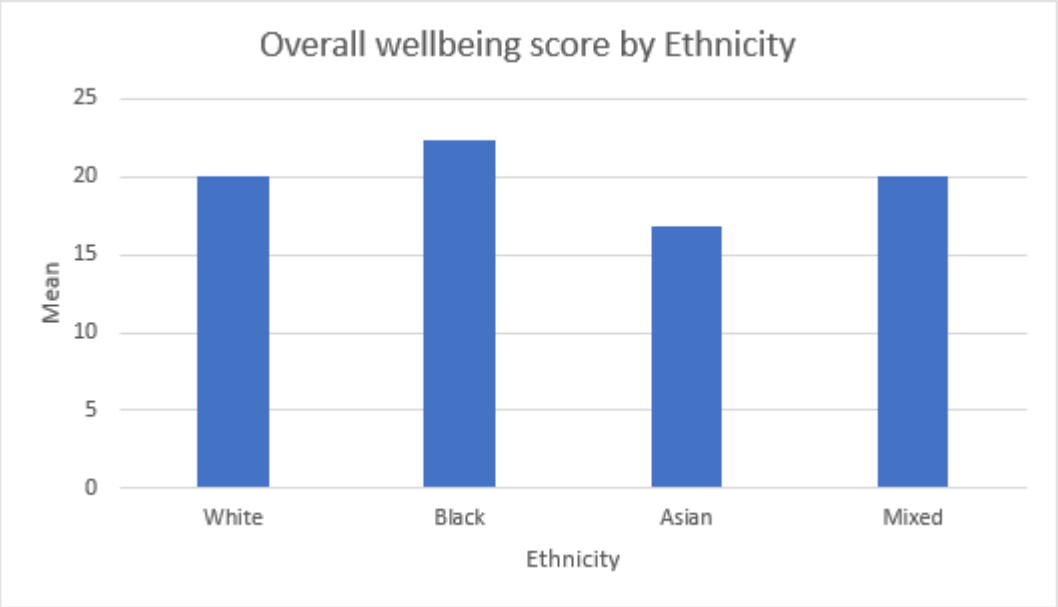

Figure A3.16: Mean Overall Wellbeing Score by Ethnicity (Unweighted)

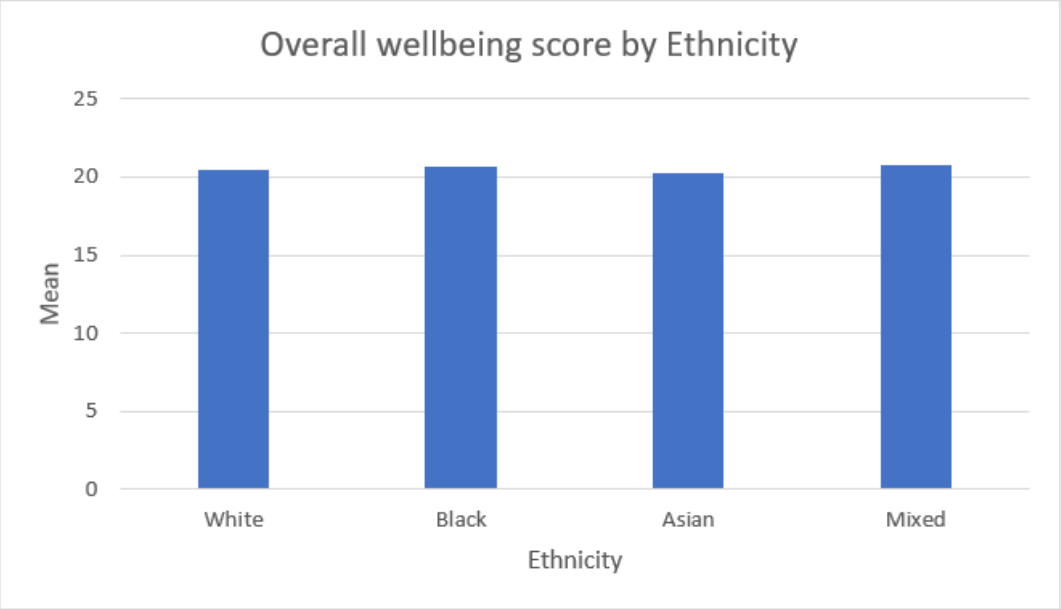

Table A3.13: Mean Overall Wellbeing Score by Ethnicity (Weighted)

Ethnicity	Mean overall wellbeing score
White	20.10
Black	22.39
Asian	16.78
Mixed	20.04

Table A3.14: Mean Overall Wellbeing Score by Ethnicity (Unweighted)

Ethnicity	Mean overall wellbeing score
White	20.43
Black	20.65
Asian	20.26
Mixed	20.76

A3.6 Wellbeing Scores by Disability

Summary (Weighted results):

There were significant differences between respondents on their overall mean wellbeing scores based on their disability status (F = 15.685, df = 2, p < .001). Specifically, respondents who were unsure of whether or not they had a disability had significantly lower wellbeing scores than those with or without a disability.

Summary (Unweighted results):

There were significant differences between respondents on their overall mean wellbeing scores based on their disability status (F = 13.307, df = 2, p < .001). Specifically, respondents without a disability had significantly higher wellbeing scores than those with a disability and those who were unsure of whether or not they had a disability.

Figure A3.17: Mean Overall Wellbeing Score by Disability (Weighted)

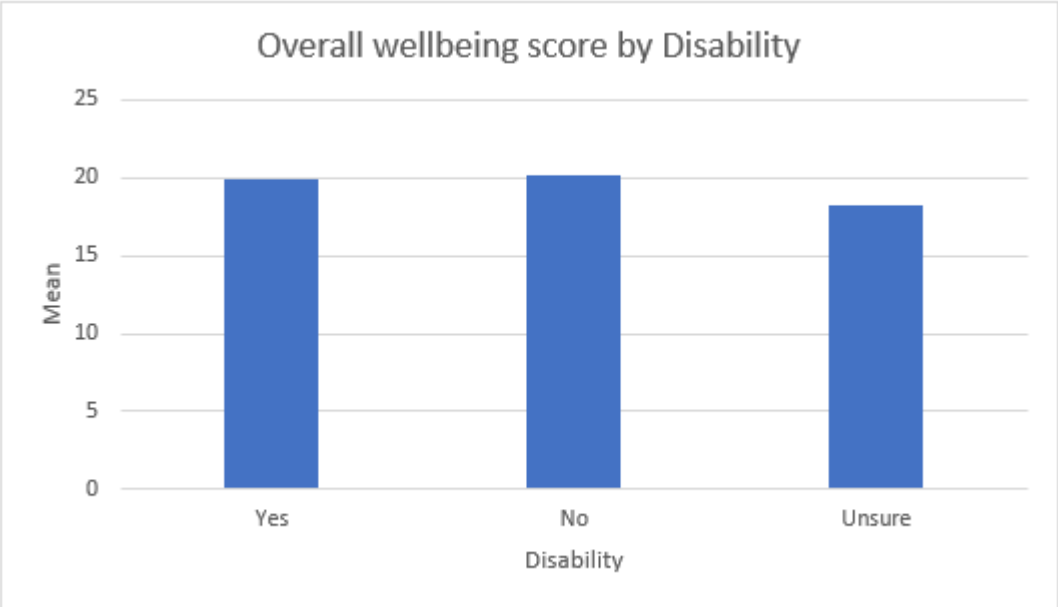

Figure A3.18: Mean Overall Wellbeing Score by Disability (Unweighted)

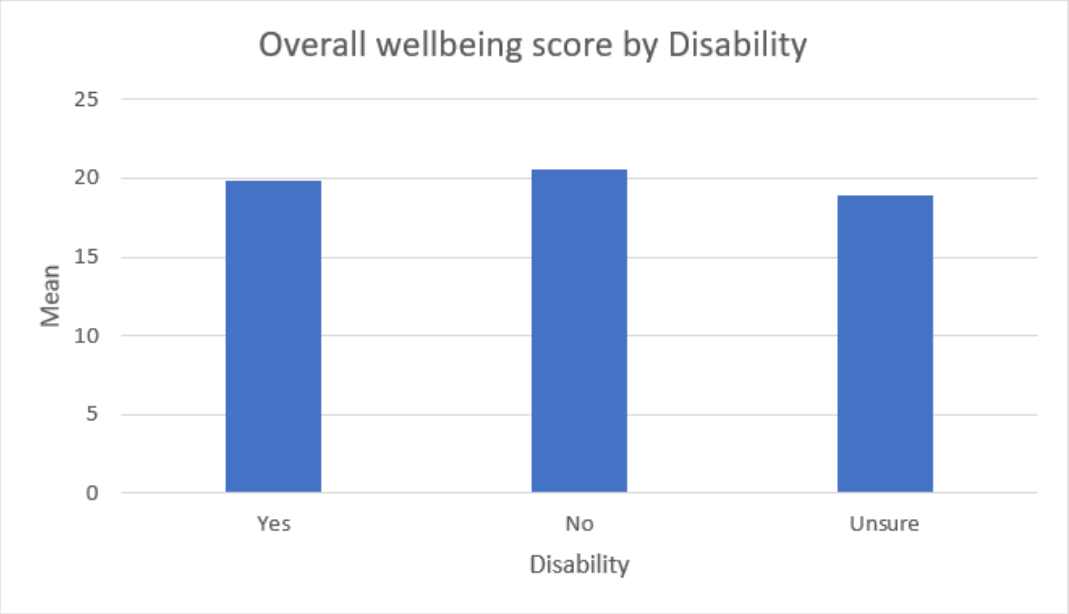

Table A3.15: Mean Overall Wellbeing Score by Disability (Weighted)

Do you consider yourself to have a disability?	Mean overall wellbeing score
Yes	19.88
No	20.20
Unsure	18.19

Table A3.16: Mean Overall Wellbeing Score by Disability (Unweighted)

Do you consider yourself to have a disability?	Mean overall wellbeing score
Yes	19.86
No	20.55
Unsure	18.88

A3.7 Wellbeing Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who worked in different areas of practice ($F = 3.251$, $df = 7$, $p = .002$). Specifically, respondents who worked in the area of physical disability scored significantly higher than those working in midwifery or with older people, and respondents who worked in the area of mental health scored significantly higher than those who worked with older people.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores between respondents who worked in different areas of practice (F = 2.503, df = 7, p = .015). Specifically, respondents who worked in the area of mental health scored significantly higher than those working with older people.

Figure A3.19: Mean Overall Wellbeing Score by Area of Practice (Weighted)

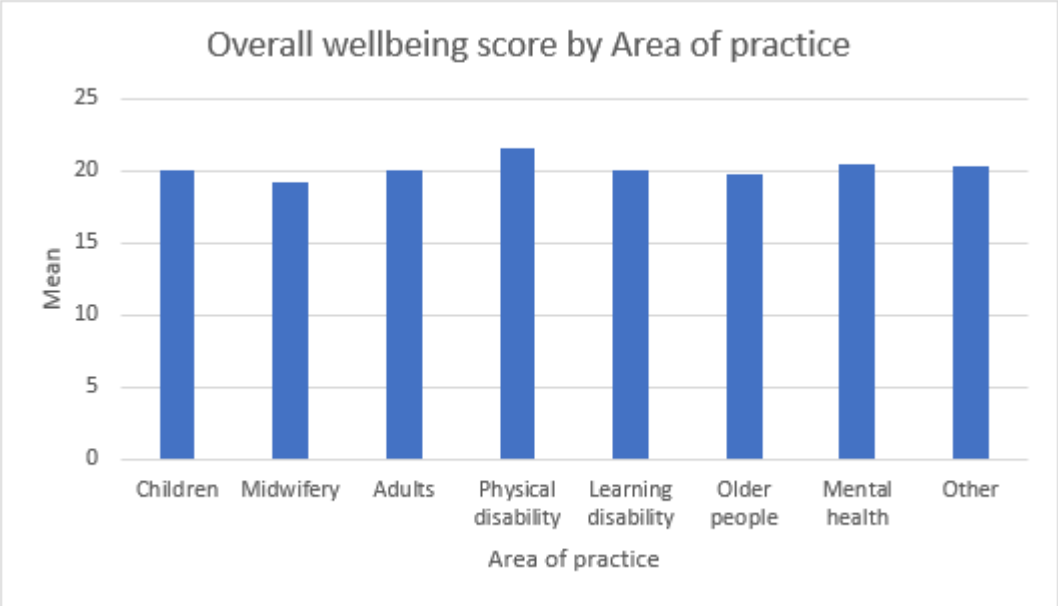

Figure A3.20: Mean Overall Wellbeing Score by Area of Practice (Unweighted)

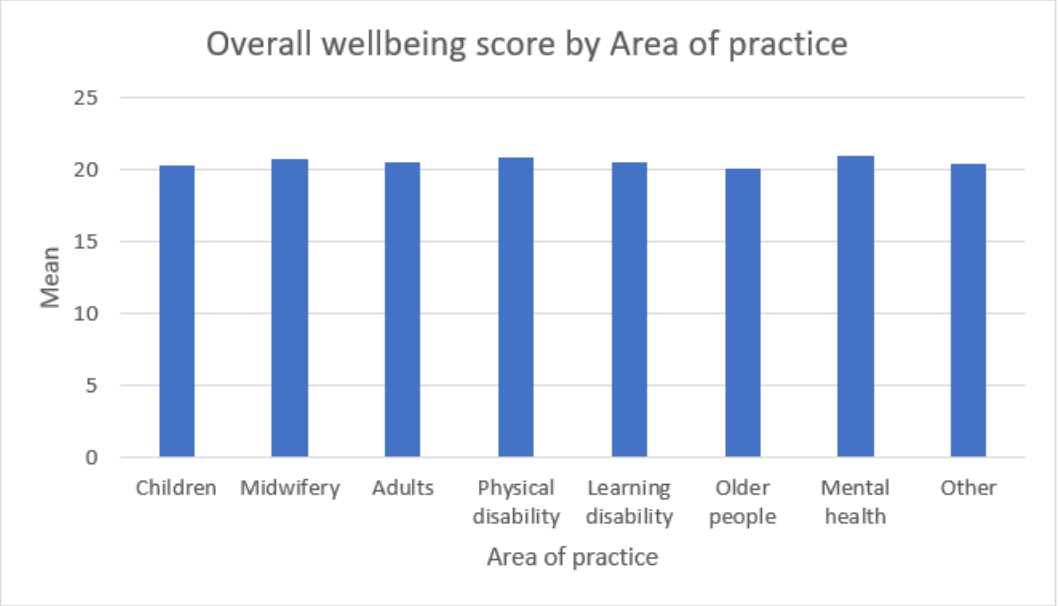

Table A3.17: Mean Overall Wellbeing Score by Area of Practice (Weighted)

Main area of practice	Mean overall wellbeing score
Children	20.07
Midwifery	19.21
Adults	20.10
Physical disability	21.61
Learning disability	20.06
Older people	19.77
Mental health	20.50
Other	20.37

Table A3.18: Mean Overall Wellbeing Score by Area of Practice (Unweighted)

Main area of practice	Mean overall wellbeing score
Children	20.35
Midwifery	20.77
Adults	20.51
Physical disability	20.89
Learning disability	20.54
Older people	20.09
Mental health	21.02
Other	20.39

A3.8 Wellbeing Scores by Line Manager Status

Summary (Weighted results):

There was a significant difference in the overall mean wellbeing scores between respondents who were line managers and those who were not ($t = 3.164$, $df = 30.92$, $p = .002$); line managers scored significantly higher than those who were not line managers.

Summary (Unweighted results):

There was a significant difference in the overall mean wellbeing scores between respondents who were line managers and those who were not ($t = 2.008$, $df = 2971$, $p = .045$); line managers scored significantly higher than those who were not line managers.

Figure A3.21: Mean Overall Wellbeing Score by Line Manager Status (Weighted)

Figure A3.22: Mean Overall Wellbeing Score by Line Manager Status (Unweighted)

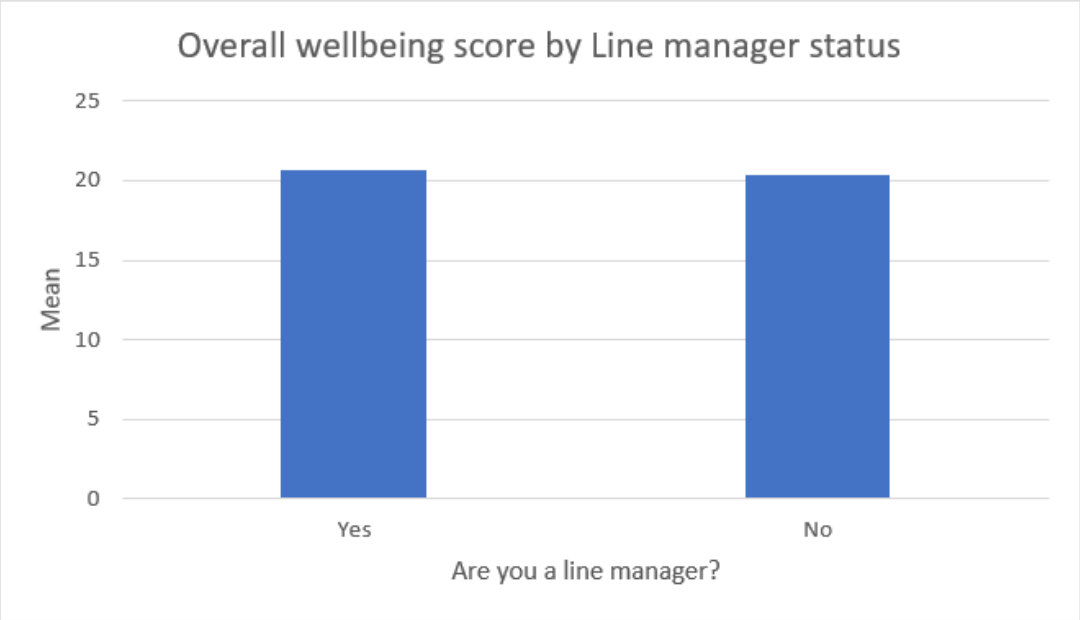

Table A3.19: Mean Overall Wellbeing Score by Line Manager Status (Weighted)

Are you a line manager?	Mean overall wellbeing score
Yes	20.43
No	19.99

Table A3.20: Mean Overall Wellbeing Score by Line Manager Status (Unweighted)

Are you a line manager?	Mean overall wellbeing score
Yes	20.64
No	20.36

A3.9 Wellbeing Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ($F = 26.223$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact of COVID-19.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 50.171$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact of COVID-19.

Figure A3.23: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Weighted)

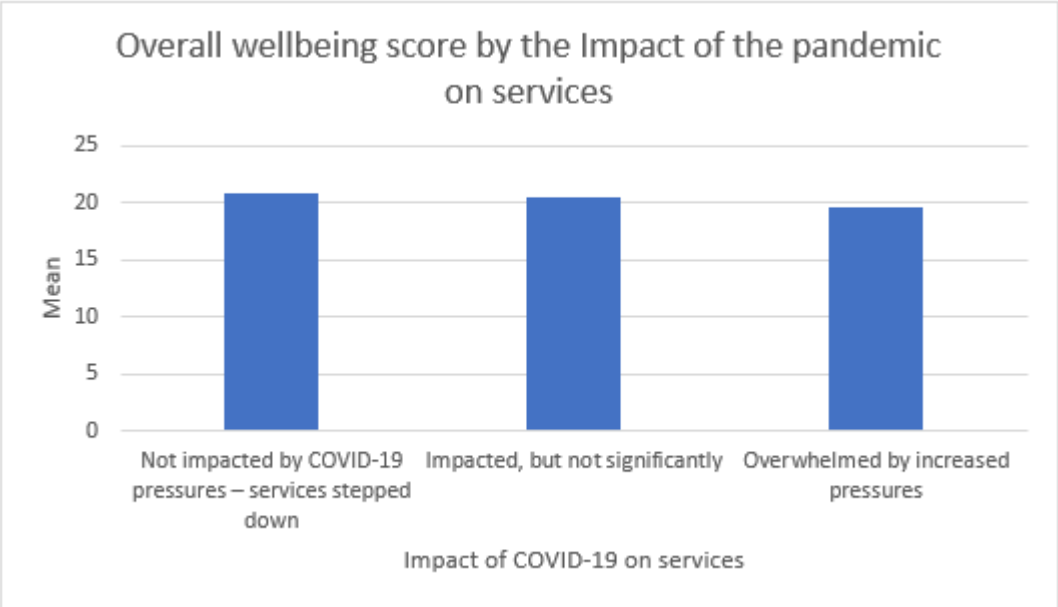

Figure A3.24: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Unweighted)

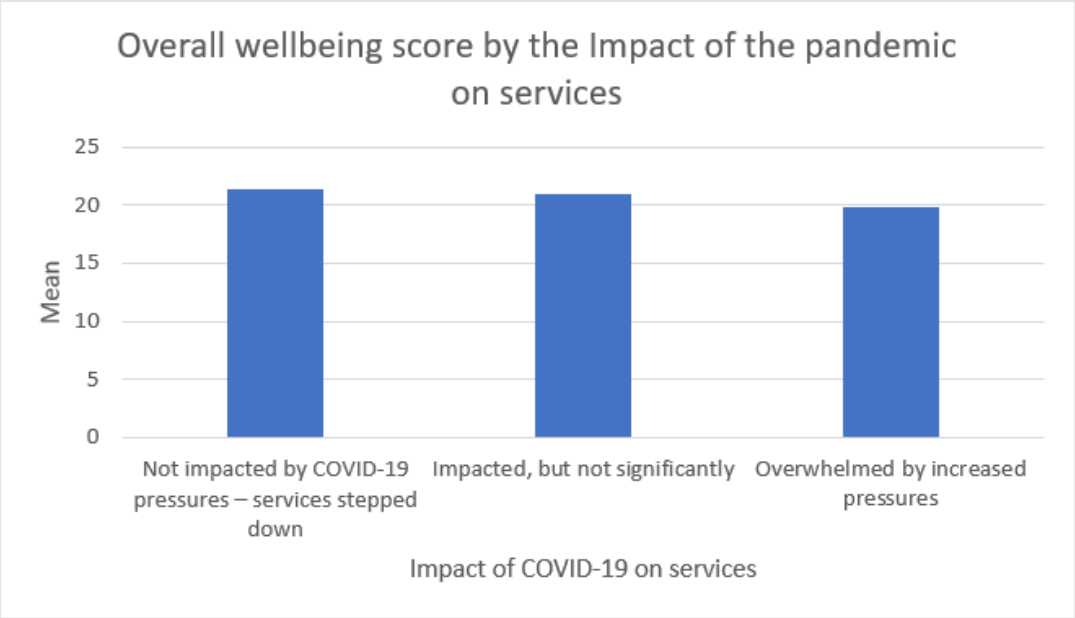

Table A3.21: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Weighted)

Impact of the pandemic on services	Mean overall wellbeing score
Not impacted by COVID-19 pressures – services stepped down	20.81
Impacted, but not significantly	20.51
Overwhelmed by increased pressures	19.66

Table A3.22: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Unweighted)

Impact of the pandemic on services	Mean overall wellbeing score
Not impacted by COVID-19 pressures – services stepped down	21.43
Impacted, but not significantly	20.99
Overwhelmed by increased pressures	19.79

Appendix 4: Quality of Working Life (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of respondents' quality of working life, which was measured using the Work-Related Quality of Life (WRQOL) scale. Higher scores on all domains indicate better quality of working life (e.g., higher score on the Stress at Work domain means less stress experienced by respondents and hence better quality of working life). Scores are comparable within domains, but not across them, due to different numbers of items contributing to each domain. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

The overall scores were calculated differently in the Phase 1 report. For direct comparisons across reports (i.e., across Phase 1 and Phase 2 surveys), please see Appendix 9.

A4.1 Quality of Working Life Scores by Country

Summary (Weighted results):

There were significant differences in the overall mean WRQOL scores across countries ($F = 42.362$, $df = 3$, $p < .001$). Specifically, the overall WRQOL score was significantly higher in Wales compared to all the other countries. Additionally, the score was significantly higher in Northern Ireland compared to Scotland.

When respondents were categorised into those with lower, average and higher quality of working life, Scotland had the highest proportion of respondents with "lower quality of working life" and Wales had the highest proportion with "higher quality of working life".

Summary (Unweighted results):

There were significant differences in the overall mean WRQOL scores across countries ($F = 35.430$, $df = 3$, $p < .001$). Specifically, the overall WRQOL score was significantly higher in Wales compared to all the other countries; and additionally, the score was significantly higher in Northern Ireland compared to Scotland.

When respondents were categorised into those with lower, average and higher quality of working life, Scotland had the highest proportion of respondents with "lower quality of working life" and Wales had the highest proportion with "higher quality of working life".

Figure A4.1: Mean Quality of Working Life Scores by Country (Weighted)

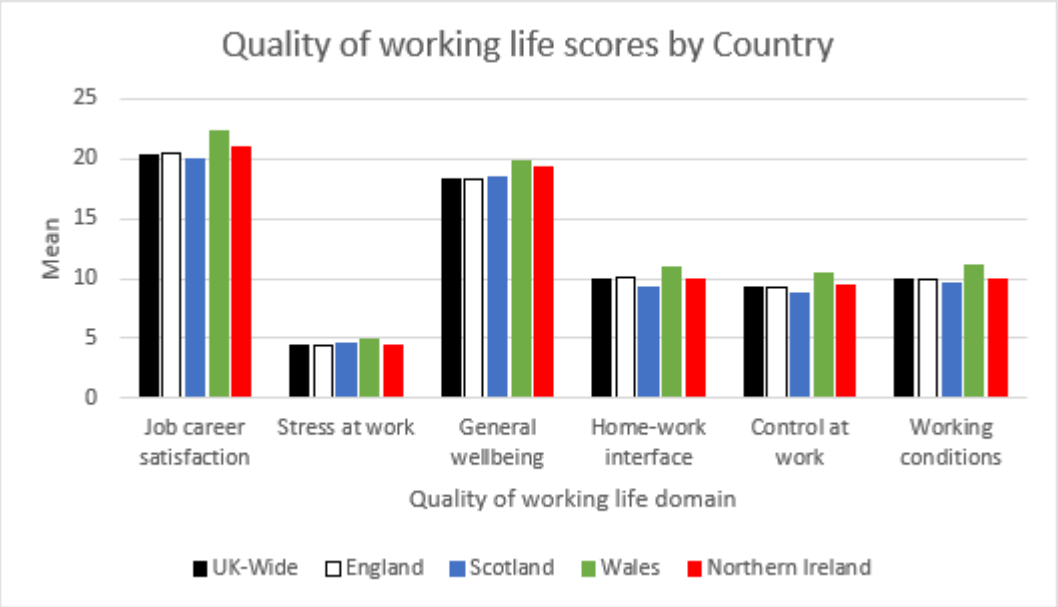

Figure A4.2: Mean Quality of Working Life Scores by Country (Unweighted)

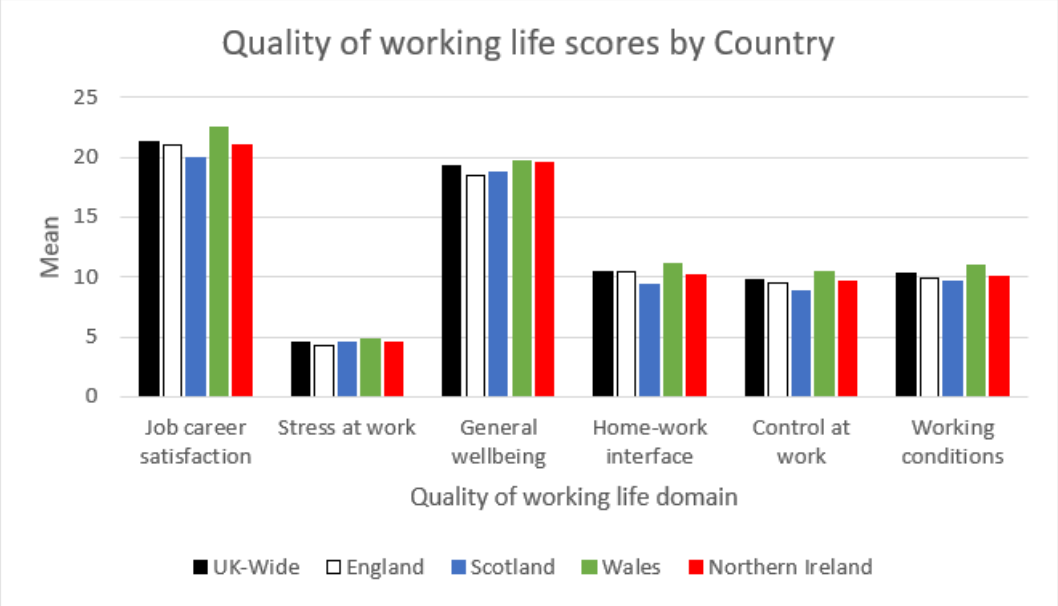

Figure A4.3: Mean Overall Quality of Working Life Score by Country (Weighted)

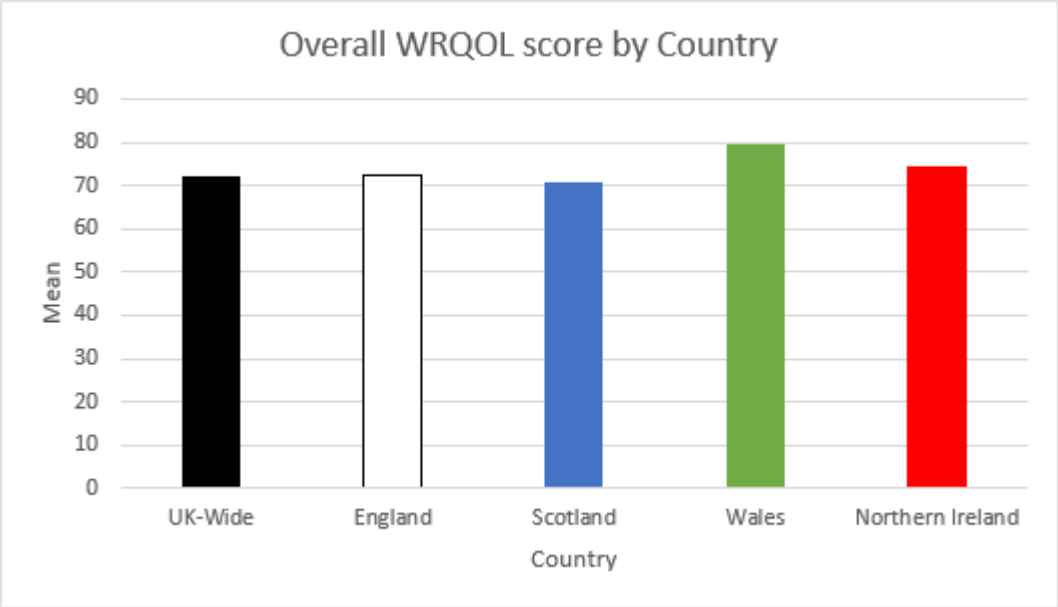

Figure A4.4: Mean Overall Quality of Working Life Score by Country (Unweighted)

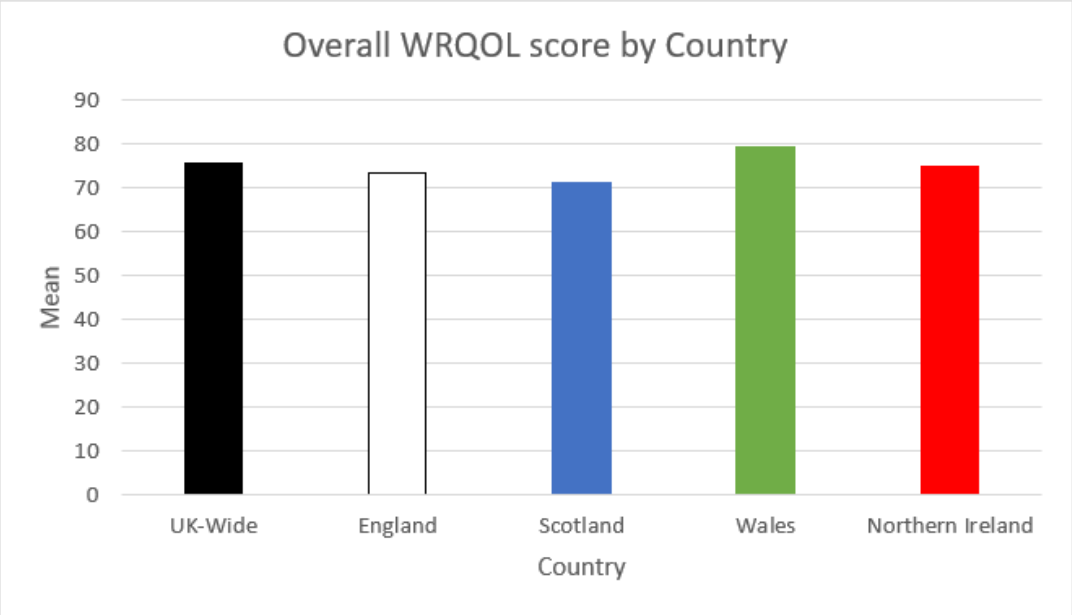

Table A4.1: Mean Quality of Working Life Scores by Country (Weighted)

WRQOL domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Job career satisfaction	20.31	20.39	19.89	22.32	20.91
Stress at work	4.43	4.36	4.56	4.87	4.37
General wellbeing	18.23	18.21	18.44	19.73	19.37
Home-work interface	9.95	10.03	9.19	10.97	9.99
Control at work	9.22	9.28	8.75	10.44	9.37
Working conditions	9.96	9.90	9.54	11.12	9.95
Overall WRQOL score	**72.13**	**72.21**	**70.37**	**79.46**	**74.06**

Table A4.2: Mean Quality of Working Life Scores by Country (Unweighted)

WRQOL domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Job career satisfaction	21.34	21.01	19.99	22.43	21.08
Stress at work	4.56	4.24	4.58	4.86	4.49
General wellbeing	19.23	18.41	18.73	19.71	19.54
Home-work interface	10.44	10.46	9.34	11.15	10.18
Control at work	9.74	9.52	8.89	10.43	9.57
Working conditions	10.27	9.93	9.62	11.02	10.06
Overall WRQOL score	**75.59**	**73.60**	**71.18**	**79.53**	**75.00**

Figure A4.5: Level of Quality of Working Life Scores – UK-Wide (Weighted)

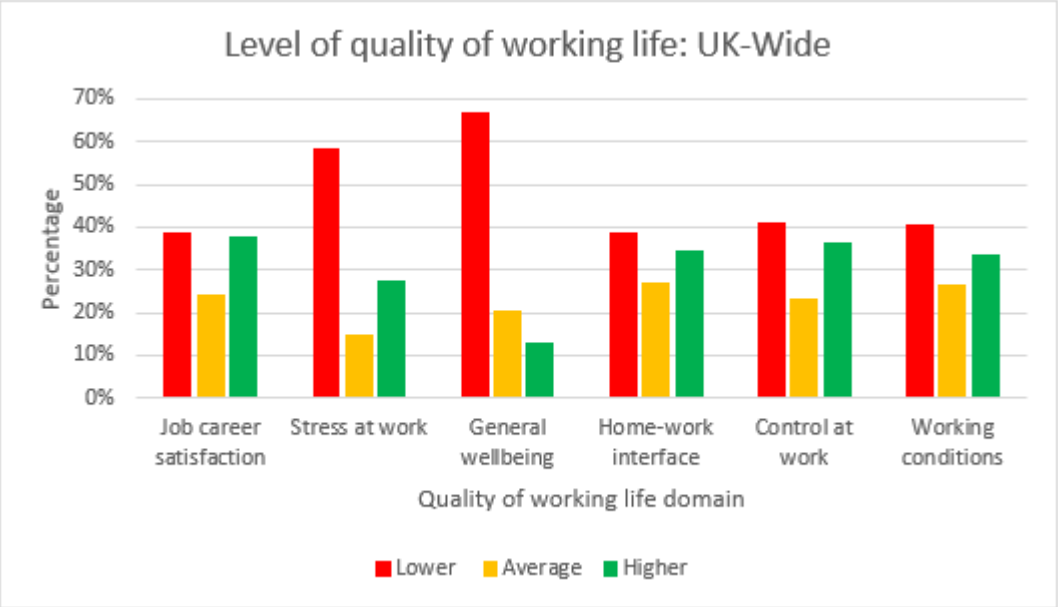

Figure A4.6: Level of Quality of Working Life Scores – UK-Wide (Unweighted)

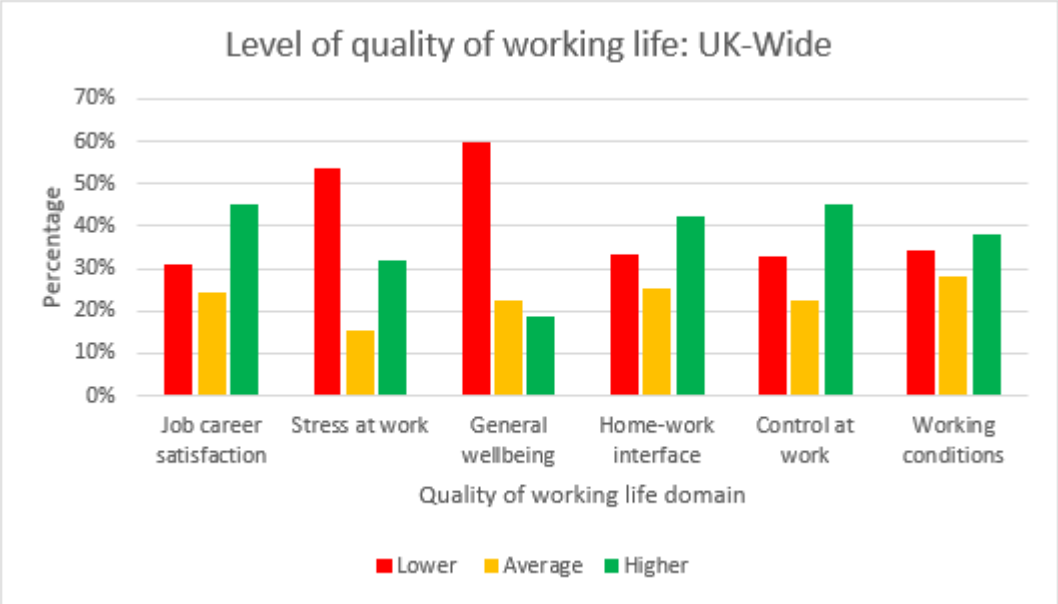

Table A4.3: Level of Quality of Working Life Scores – UK-Wide (Weighted)

WRQOL domain	Level of WRQOL			Total
	Lower	Average	Higher	
Job career satisfaction	38.5%	23.9%	37.5%	**100%**
Stress at work	58.3%	14.6%	27.1%	**100%**
General wellbeing	66.6%	20.5%	12.9%	**100%**
Home-work interface	38.6%	26.9%	34.5%	**100%**
Control at work	40.8%	23.2%	36.0%	**100%**
Working conditions	40.6%	26.2%	33.2%	**100%**
Overall WRQOL	**46.7%**	**26.0%**	**27.3%**	**100%**

Table A4.4: Level of Quality of Working Life Scores – UK-Wide (Unweighted)

WRQOL domain	Level of WRQOL			Total
	Lower	Average	Higher	
Job career satisfaction	928 (30.8%)	724 (24.1%)	1358 (45.1%)	**3010 (100%)**
Stress at work	1611 (53.4%)	452 (15.0%)	953 (31.6%)	**3016 (100%)**
General wellbeing	1792 (59.5%)	664 (22.1%)	554 (18.4%)	**3010 (100%)**
Home-work interface	1016 (33.3%)	759 (24.9%)	1278 (41.9%)	**3053 (100%)**
Control at work	977 (32.4%)	675 (22.4%)	1359 (45.1%)	**3011 (100%)**
Working conditions	1033 (34.2%)	846 (28.0%)	1139 (37.7%)	**3018 (100%)**
Overall WRQOL	**1114 (37.3%)**	**822 (27.5%)**	**1051 (35.2%)**	**2987 (100%)**

Figure A4.7: Level of Overall Quality of Working Life by Country (Weighted)

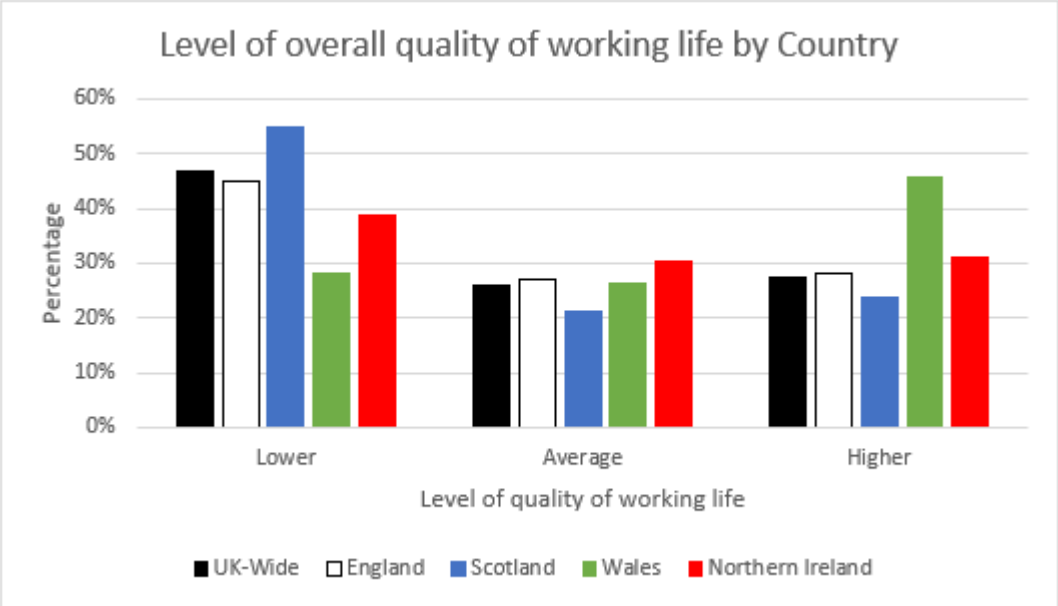

Figure A4.8: Level of Overall Quality of Working Life by Country (Unweighted)

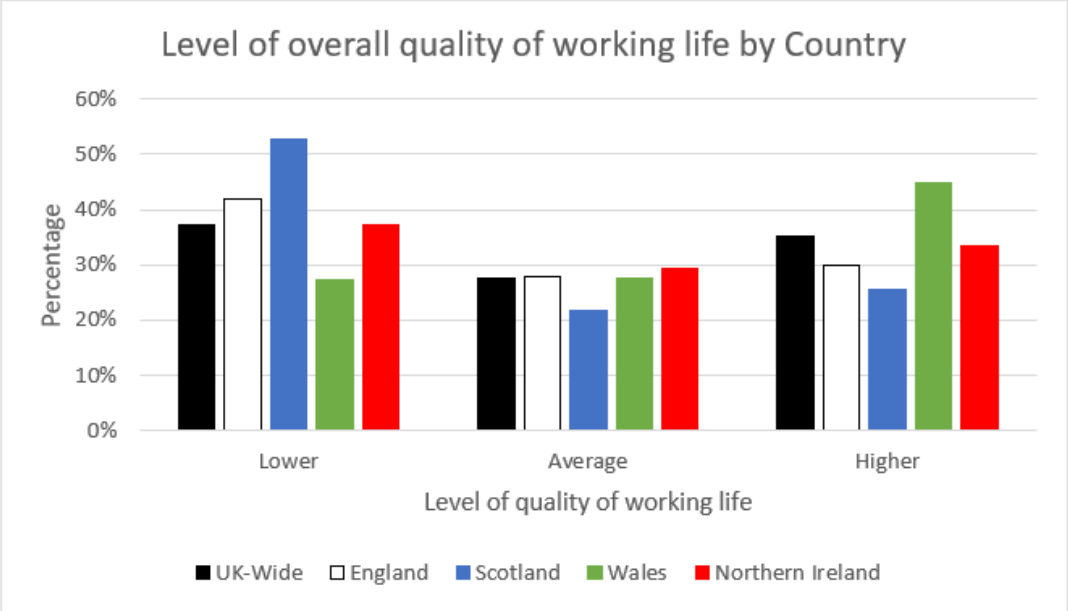

Table A4.5: Level of Overall Quality of Working Life by Country (Weighted)

	Country				
Level of WRQOL	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Lower	46.7%	45.0%	54.9%	28.0%	38.7%
Average	26.0%	26.9%	21.3%	26.2%	30.3%
Higher	27.3%	28.1%	23.8%	45.8%	31.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A4.6: Level of Overall Quality of Working Life by Country (Unweighted)

Level of WRQOL	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower	1114 (37.3%)	285 (42.0%)	204 (52.8%)	253 (27.4%)	372 (37.2%)
Average	822 (27.5%)	190 (28.0%)	84 (21.8%)	255 (27.6%)	293 (29.3%)
Higher	1051 (35.2%)	204 (30.0%)	98 (25.4%)	415 (45.0%)	334 (33.4%)
Total	**2987 (100%)**	**679 (100%)**	**386 (100%)**	**923 (100%)**	**999 (100%)**

A4.2 Quality of Working Life Scores by Occupation

Summary (Weighted results):

There were significant differences in the overall mean WRQOL score between the occupational groups ($F = 5.481$, $df = 4$, $p < .001$). Specifically, nurses scored significantly lower than AHPs, social care workers and social workers.

Summary (Unweighted results):

There were significant differences in the overall mean WRQOL score between the occupational groups ($F = 4.756$, $df = 4$, $p = .001$). Specifically, nurses scored significantly lower than AHPs and social workers.

Figure A4.9: Mean Quality of Working Life Scores by Occupation (Weighted)

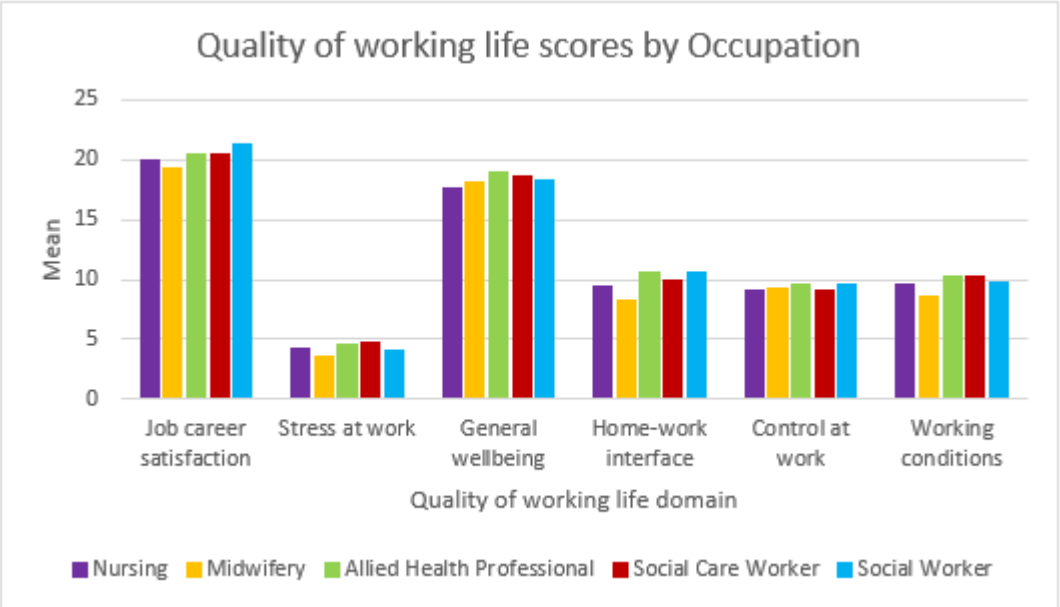

Figure A4.10: Mean Quality of Working Life Scores by Occupation (Unweighted)

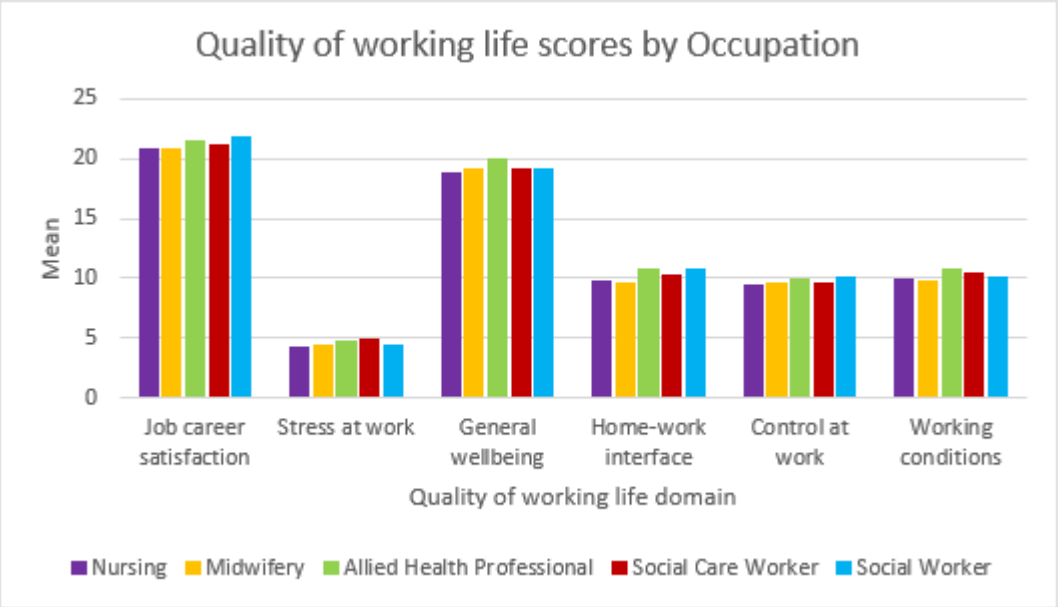

Figure A4.11: Mean Overall Quality of Working Life Score by Occupation (Weighted)

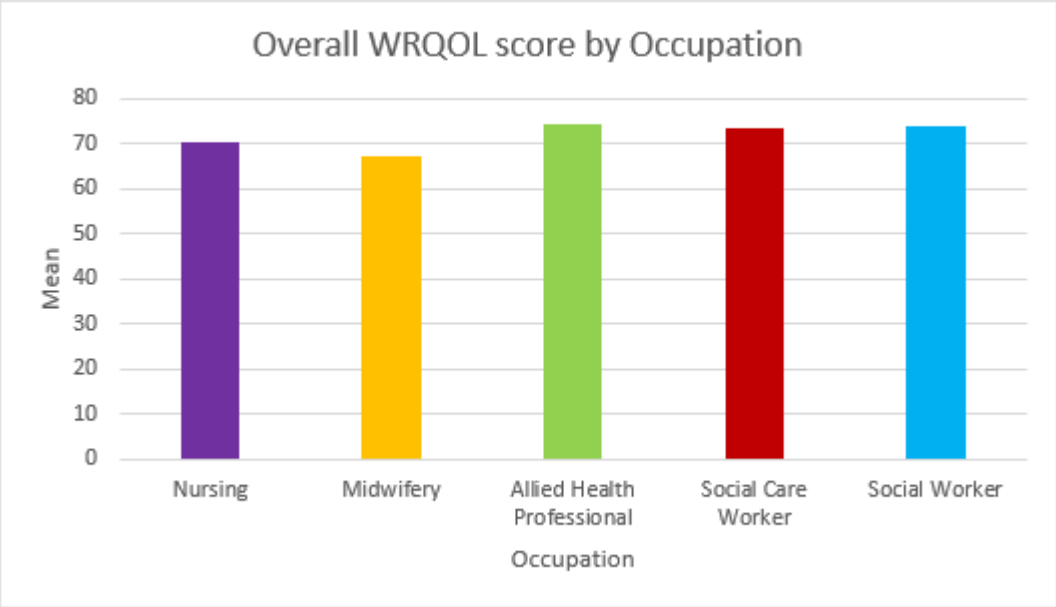

Figure A4.12: Mean Overall Quality of Working Life Score by Occupation (Unweighted)

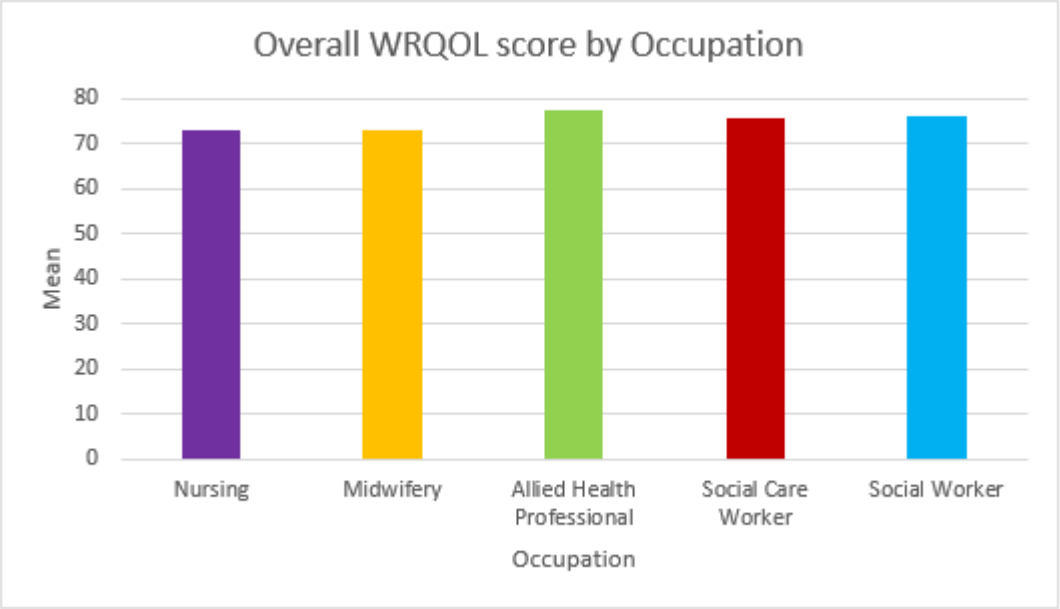

Table A4.7: Mean Quality of Working Life Scores by Occupation (Weighted)

	Occupation				
WRQOL domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Job career satisfaction	19.96	19.27	20.42	20.50	21.32
Stress at work	4.24	3.63	4.53	4.70	4.06
General wellbeing	17.65	18.07	19.04	18.64	18.34
Home-work interface	9.47	8.23	10.62	9.91	10.56
Control at work	9.08	9.17	9.61	9.13	9.63
Working conditions	9.61	8.61	10.26	10.31	9.73
Overall WRQOL score	**70.01**	**66.95**	**74.41**	**73.24**	**73.67**

Table A4.8: Mean Quality of Working Life Scores by Occupation (Unweighted)

	Occupation				
WRQOL domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Job career satisfaction	20.78	20.79	21.41	21.09	21.77
Stress at work	4.13	4.29	4.72	4.88	4.29
General wellbeing	18.78	19.06	19.91	19.19	19.06
Home-work interface	9.78	9.55	10.72	10.24	10.76
Control at work	9.42	9.54	9.95	9.48	9.99
Working conditions	9.84	9.75	10.66	10.42	10.07
Overall WRQOL score	**72.83**	**72.94**	**77.32**	**75.32**	**75.92**

Figure A4.13: Level of Overall Quality of Working Life by Occupation (Weighted)

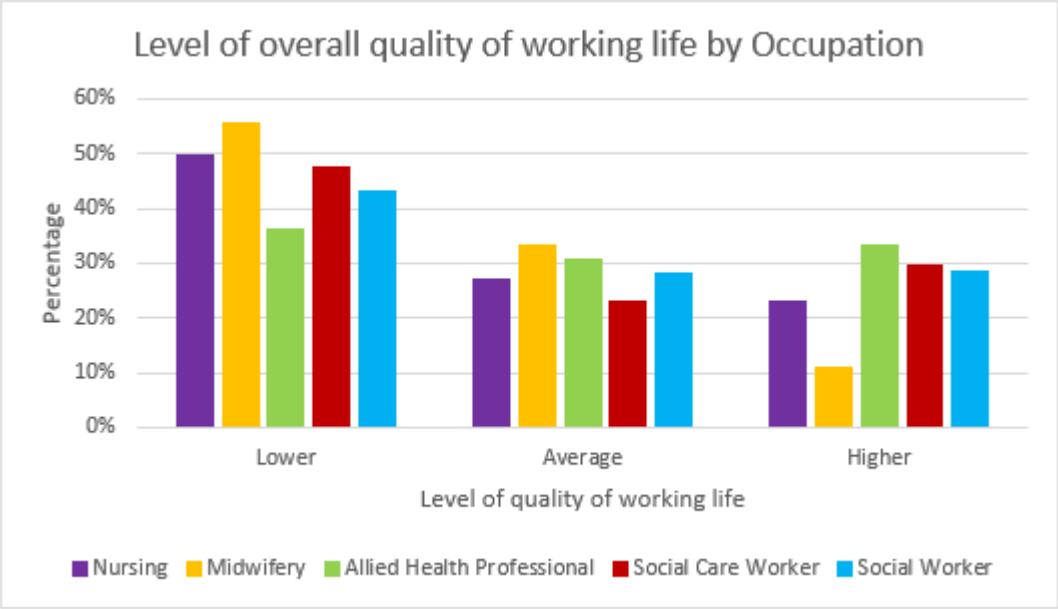

Figure A4.14: Level of Overall Quality of Working Life by Occupation (Unweighted)

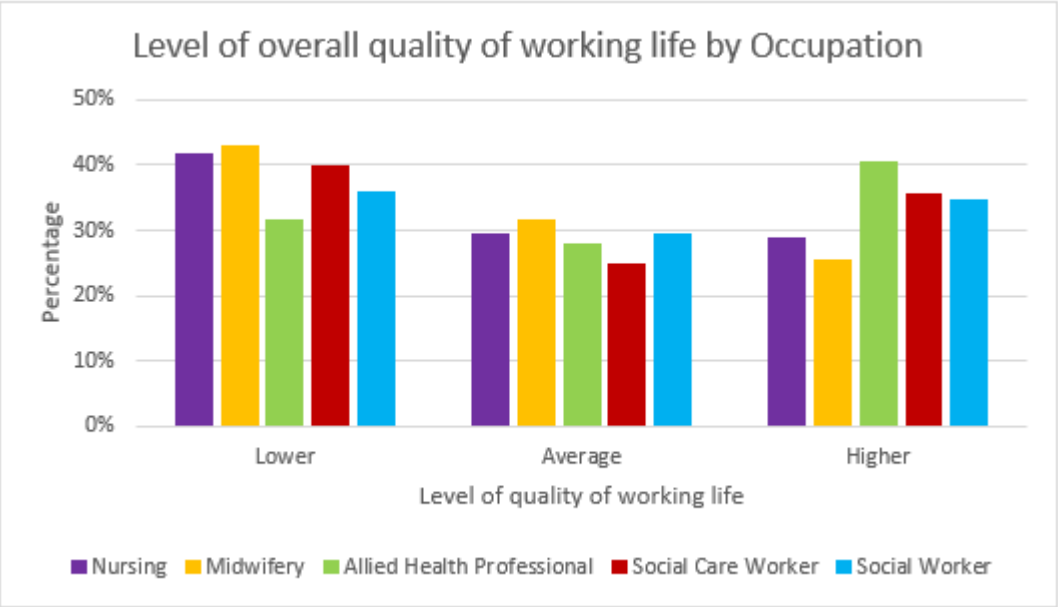

Table A4.9: Level of Overall Quality of Working Life by Occupation (Weighted)

	Occupation				
Level of WRQOL	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Lower	49.8%	55.6%	36.2%	47.5%	43.2%
Average	27.2%	33.3%	30.6%	23.0%	28.2%
Higher	22.9%	11.1%	33.2%	29.5%	28.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A4.10: Level of Overall Quality of Working Life by Occupation (Unweighted)

Level of WRQOL	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Lower	127 (41.8%)	27 (42.9%)	171 (31.5%)	420 (39.8%)	369 (36.0%)
Average	89 (29.3%)	20 (31.7%)	152 (28.0%)	260 (24.7%)	301 (29.4%)
Higher	88 (28.9%)	16 (25.4%)	219 (40.4%)	374 (35.5%)	354 (34.6%)
Total	**304 (100%)**	**63 (100%)**	**542 (100%)**	**1054 (100%)**	**1024 (100%)**

A4.3 Quality of Working Life Scores by Sex

Only three respondents in the full sample stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

Males and females differed significantly in their mean overall WRQOL score (t = -3.111, df = 3061, p = .002). Specifically, males had significantly higher WRQOL scores than females.

Summary (Unweighted results):

Males and females did not differ significantly in their mean overall WRQOL score.

Figure A4.15: Mean Quality of Working Life Scores by Sex (Weighted)

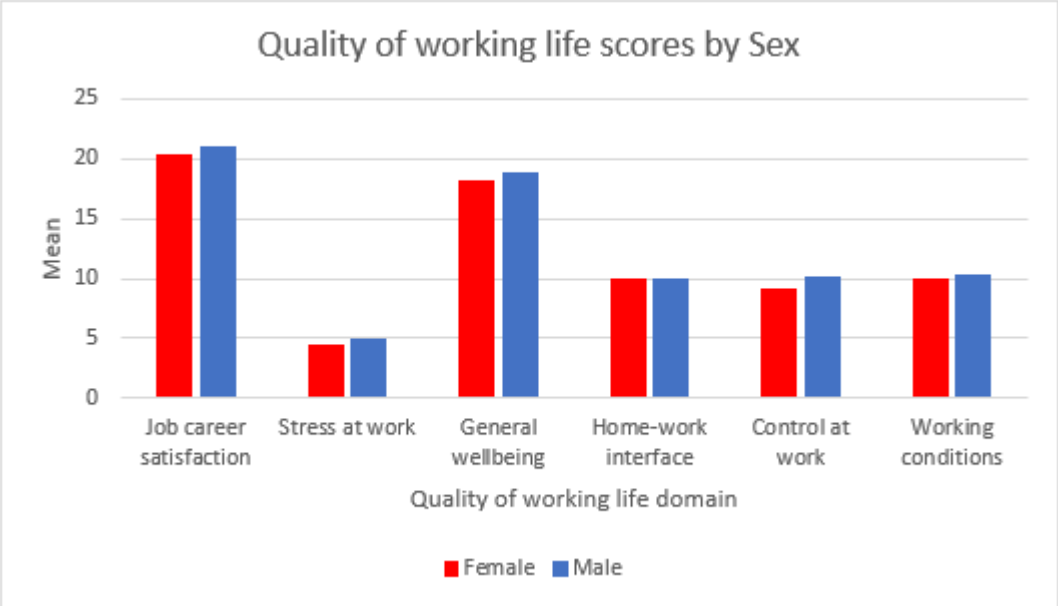

Figure A4.16: Mean Quality of Working Life Scores by Sex (Unweighted)

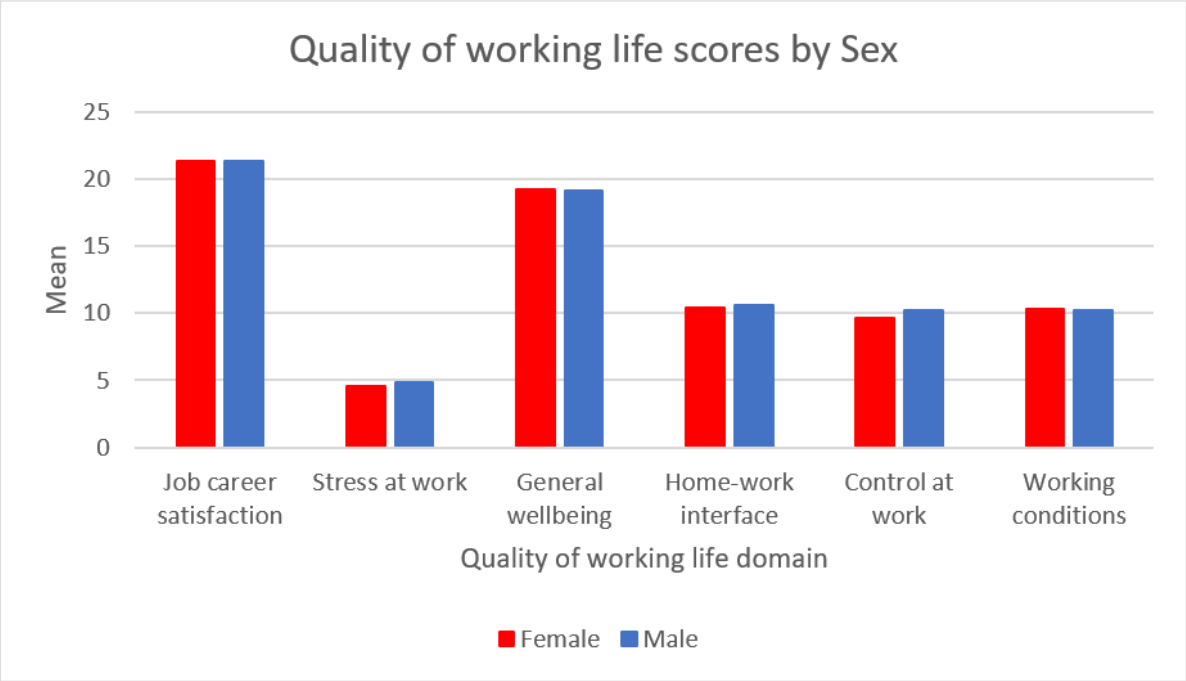

Figure A4.17: Mean Overall Quality of Working Life Score by Sex (Weighted)

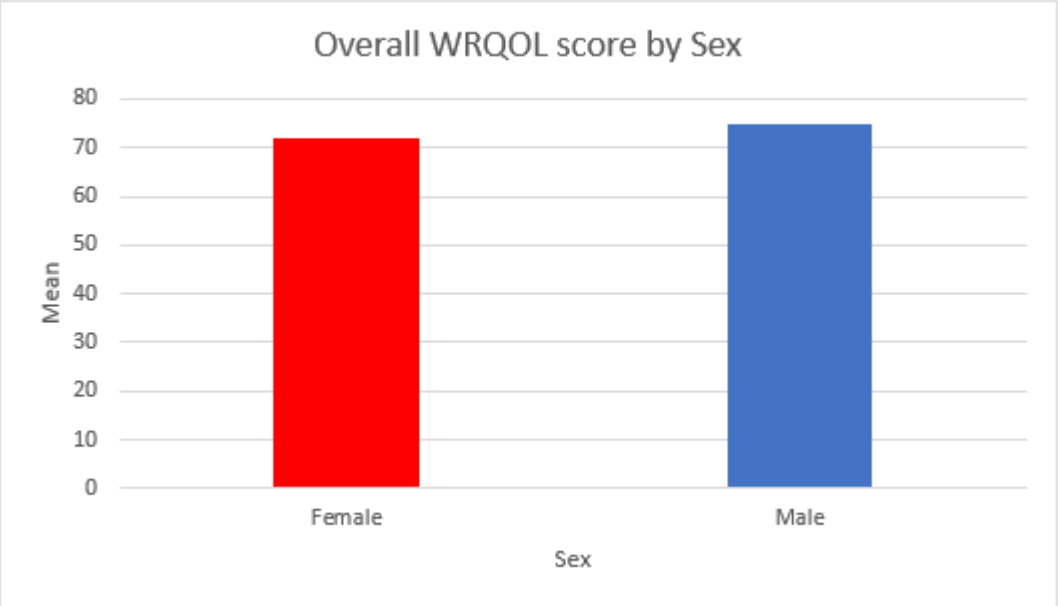

Figure A4.18: Mean Overall Quality of Working Life Score by Sex (Unweighted)

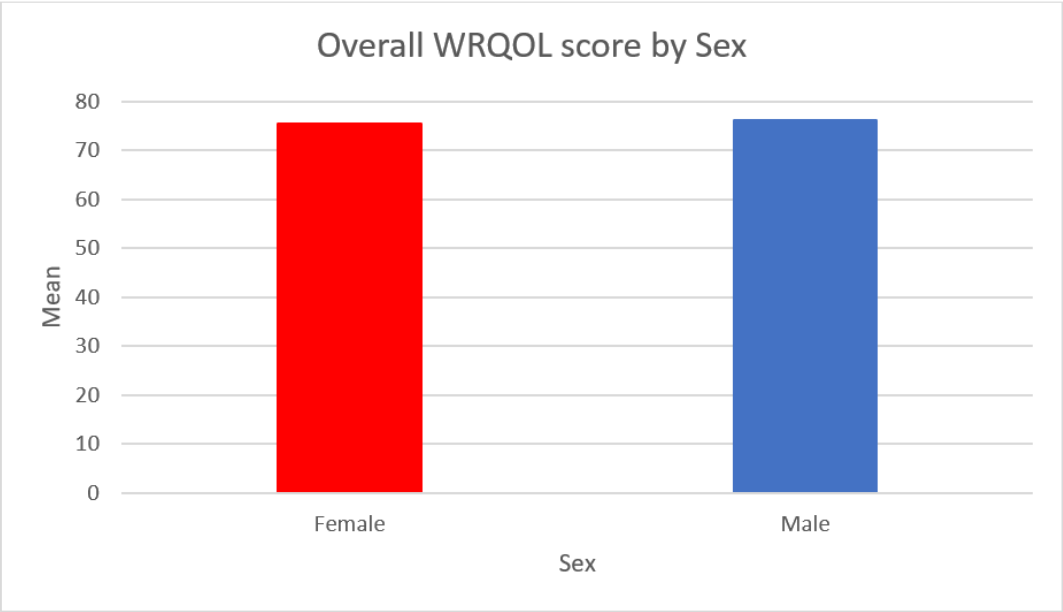

Table A4.11: Mean Quality of Working Life Scores by Sex (Weighted)

	Sex	
WRQOL domain	**Female**	**Male**
Job career satisfaction	20.24	20.91
Stress at work	4.37	4.93
General wellbeing	18.16	18.74
Home-work interface	9.95	9.95
Control at work	9.13	10.02
Working conditions	9.93	10.17
Overall WRQOL score	**71.82**	**74.69**

Table A4.12: Mean Quality of Working Life Scores by Sex (Unweighted)

	Sex	
WRQOL domain	**Female**	**Male**
Job career satisfaction	21.35	21.30
Stress at work	4.53	4.81
General wellbeing	19.25	19.11
Home-work interface	10.43	10.57
Control at work	9.68	10.18
Working conditions	10.28	10.21
Overall WRQOL score	**75.53**	**76.16**

Figure A4.19: Level of Overall Quality of Working Life by Sex (Weighted)

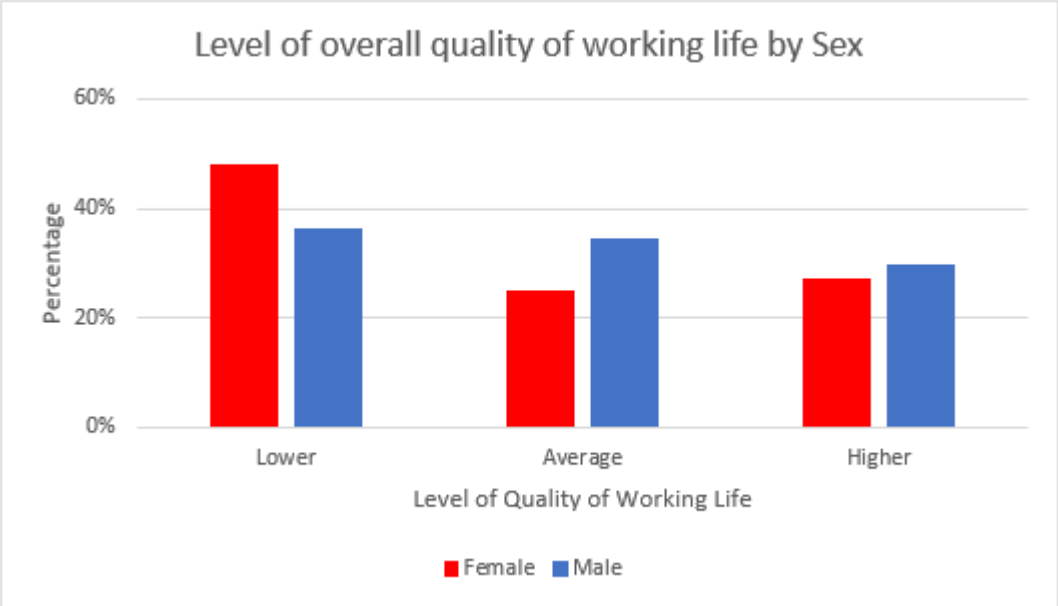

Figure A4.20: Level of Overall Quality of Working Life by Sex (Unweighted)

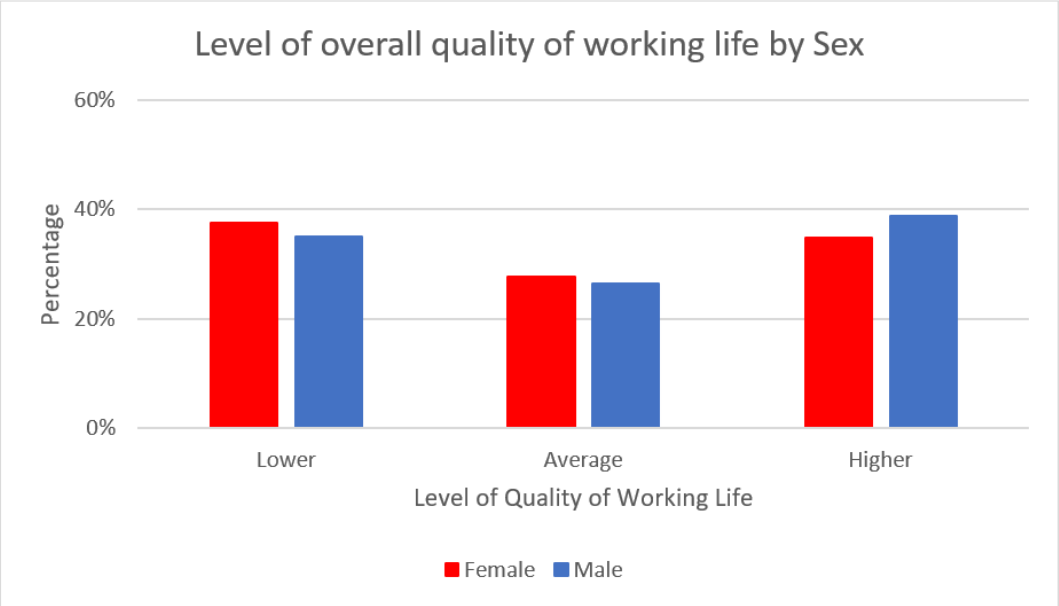

Table A4.13: Level of Overall Quality of Working Life by Sex (Weighted)

	Sex	
Level of WRQOL	**Female**	**Male**
Lower	48.0%	36.3%
Average	25.0%	34.2%
Higher	27.0%	29.5%
Total	**100%**	**100%**

Table A4.14: Level of Overall Quality of Working Life by Sex (Unweighted)

Level of WRQOL	Sex	
	Female	Male
Lower	991 (37.6%)	122 (35.0%)
Average	728 (27.6%)	92 (26.4%)
Higher	916 (34.8%)	135 (38.7%)
Total	**2635 (100%)**	**349 (100%)**

A4.4 Quality of Working Life Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in the mean overall WRQOL scores ($F = 15.009$, $df = 6$, $p < .001$). Specifically, the 66+ age group scored significantly higher than the 20-29, 30-39, 40-49, 50-59 and the 60-65 age groups; the 60-65 age group scored significantly higher than the 30-39, 40-49 and the 50-59 age groups; the 50-59 age group scored significantly higher than the 30-39 and the 40-49 age groups and the 40-49 age group scored significantly higher than the 20-29 age group.

Summary (Unweighted results):

There appeared to be significant differences in the mean overall WRQOL score across age groups ($F = 3.166$, $df = 6$, $p = .004$), but multiple comparison tests revealed no statistically significant differences, although there was a trend towards higher scores in the higher age groups.

Figure A4.21: Mean Quality of Working Life Scores by Age (Weighted)

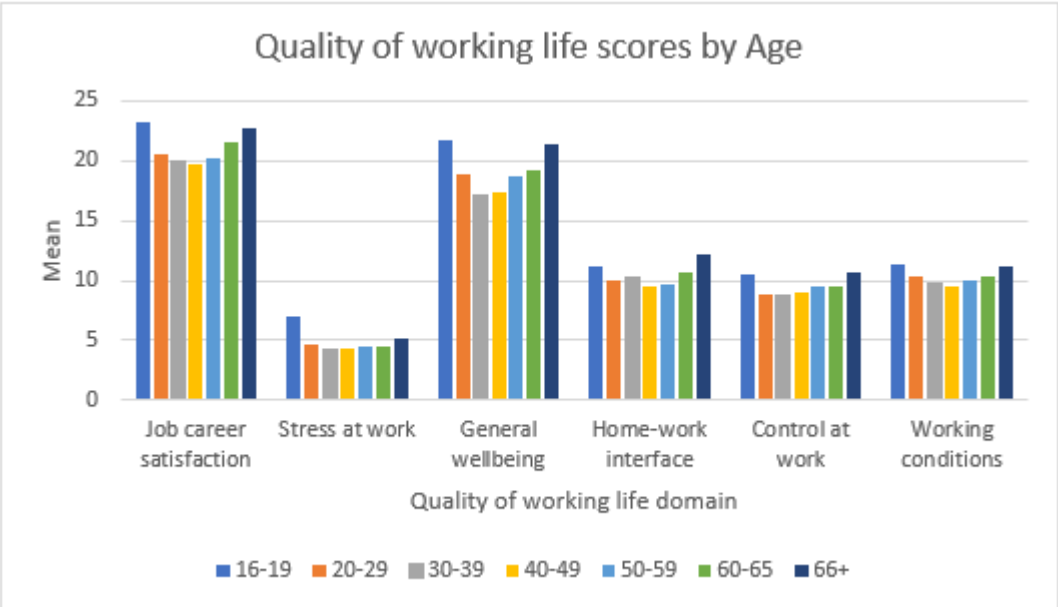

Figure A4.22: Mean Quality of Working Life Scores by Age (Unweighted)

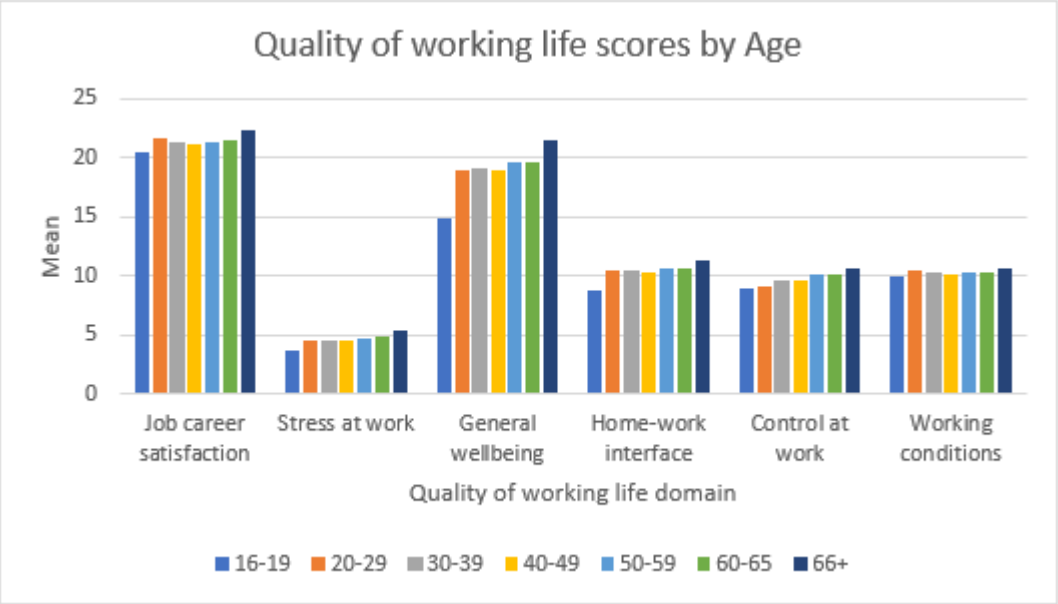

Figure A4.23: Mean Overall Quality of Working Life Score by Age (Weighted)

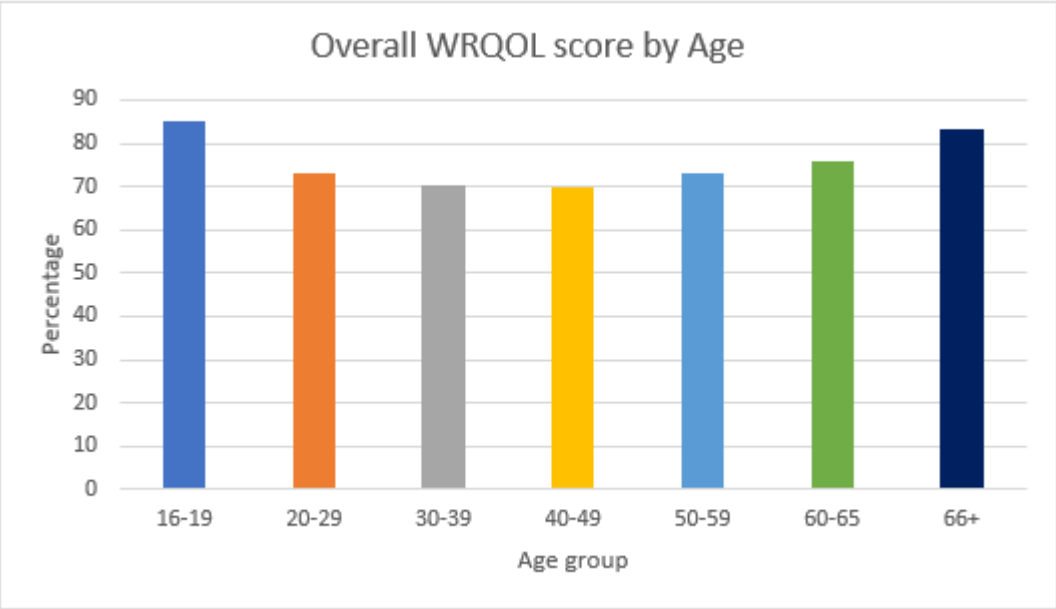

Figure A4.24: Mean Overall Quality of Working Life Score by Age (Unweighted)

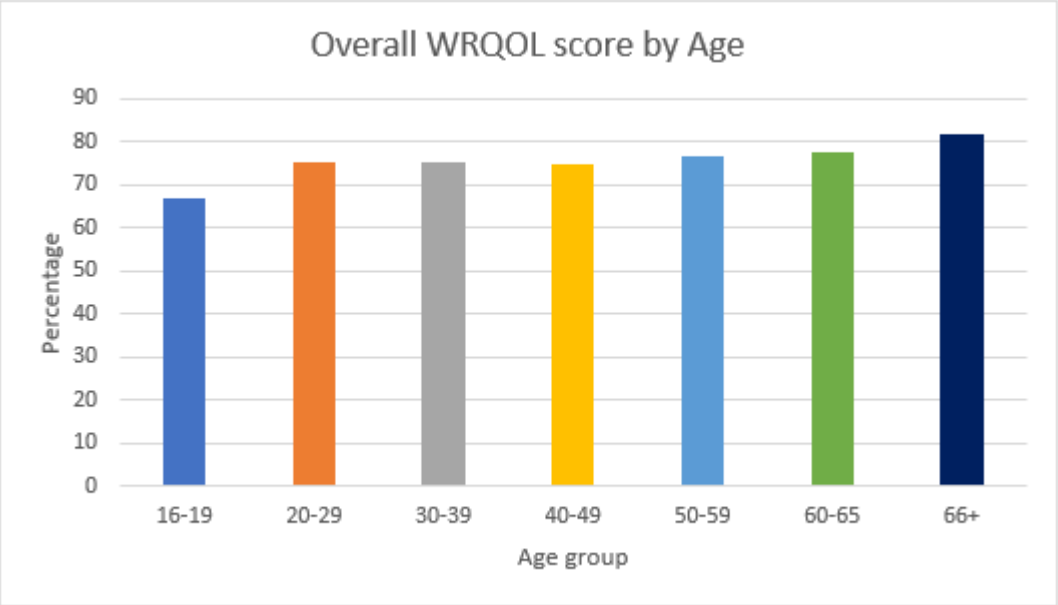

Table A4.15: Mean Quality of Working Life Scores by Age (Weighted)

	Age						
WRQOL domain	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Job career satisfaction	23.17	20.51	19.92	19.79	20.20	21.48	22.76
Stress at work	7.03	4.64	4.16	4.35	4.53	4.43	5.18
General wellbeing	21.76	18.83	17.14	17.37	18.68	19.17	21.33
Home-work interface	11.13	9.98	10.24	9.58	9.63	10.60	12.14
Control at work	10.54	8.77	8.79	9.01	9.53	9.57	10.71
Working conditions	11.37	10.32	9.74	9.50	10.06	10.34	11.12
Overall WRQOL score	**85.00**	**73.04**	**69.98**	**69.60**	**72.67**	**75.72**	**83.25**

Table A4.16: Mean Quality of Working Life Scores by Age (Unweighted)

	Age						
WRQOL domain	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Job career satisfaction	20.50	21.63	21.30	21.16	21.34	21.51	22.42
Stress at work	3.63	4.53	4.38	4.49	4.69	4.80	5.32
General wellbeing	14.88	18.99	19.03	18.89	19.60	19.70	21.50
Home-work interface	8.75	10.39	10.45	10.27	10.55	10.59	11.29
Control at work	9.00	9.13	9.52	9.69	10.05	10.10	10.58
Working conditions	10.00	10.41	10.24	10.10	10.36	10.35	10.63
Overall WRQOL score	**66.75**	**75.03**	**74.92**	**74.65**	**76.53**	**77.24**	**81.74**

Figure A4.25: Level of Overall Quality of Working Life by Age (Weighted)

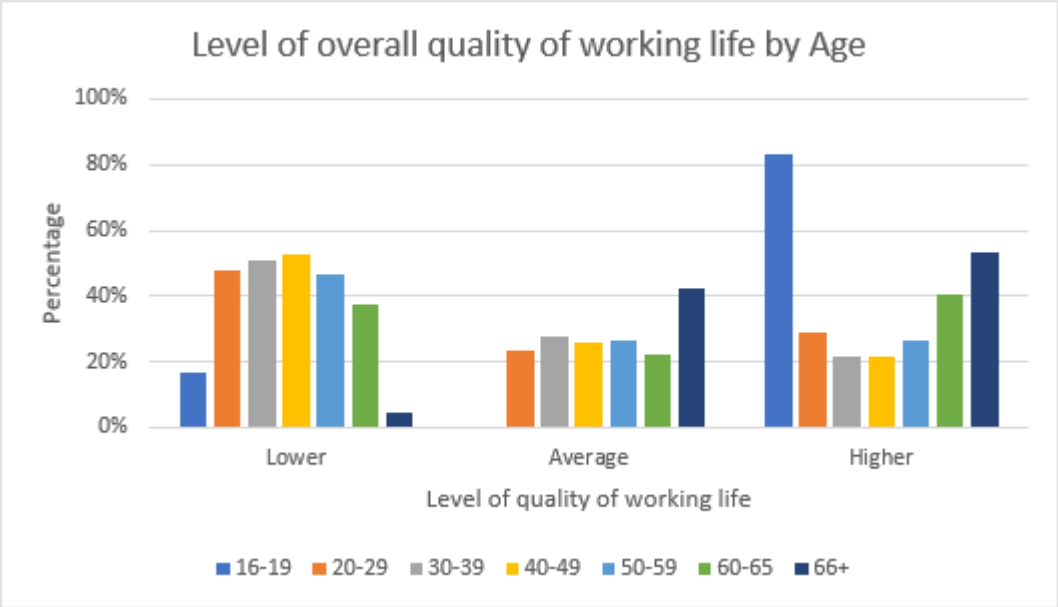

Figure A4.26: Level of Overall Quality of Working Life by Age (Unweighted)

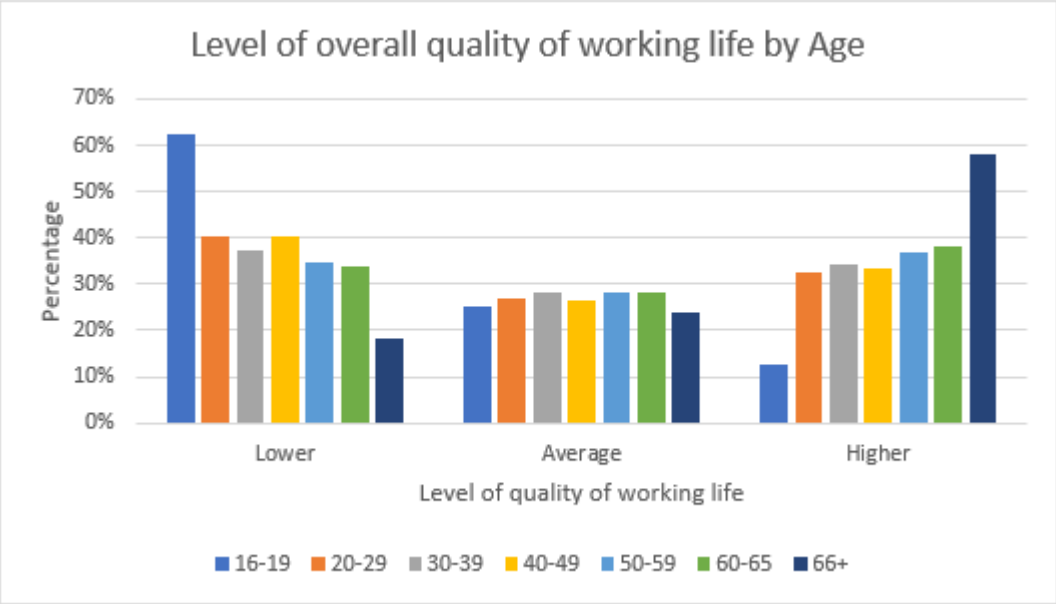

Table A4.17: Level of Overall Quality of Working Life by Age (Weighted)

	Age						
Level of WRQOL	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Lower	16.7%	47.8%	50.9%	52.4%	46.8%	37.3%	4.5%
Average	0.0%	23.1%	27.7%	25.9%	26.7%	21.9%	42.4%
Higher	83.3%	29.2%	21.5%	21.7%	26.4%	40.7%	53.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Note. There were only six respondents in the 16-19 age category.

Table A4.18: Level of Overall Quality of Working Life by Age (Unweighted)

Level of WRQOL	Age						
	16-19	20-29	30-39	40-49	50-59	60-65	66+
Lower	5 (62.5%)	135 (40.4%)	266 (37.5%)	313 (40.2%)	308 (34.9%)	80 (33.9%)	7 (18.4%)
Average	2 (25.0%)	90 (26.9%)	200 (28.2%)	205 (26.3%)	250 (28.3%)	66 (28.0%)	9 (23.7%)
Higher	1 (12.5%)	109 (32.6%)	243 (34.3%)	261 (33.5%)	325 (36.8%)	90 (38.1%)	22 (57.9%)
Total	**8 (100%)**	**334 (100%)**	**709 (100%)**	**779 (100%)**	**883 (100%)**	**236 (100%)**	**38 (100%)**

Note. There were only eight respondents in the 16-19 age category.

A4.5 Quality of Working Life Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in the mean overall WRQOL score ($F = 14.508$, $df = 3$, $p < .001$). Specifically, respondents who identified as Asian scored significantly lower than all the other ethnic groups; and those identifying as black scored significantly higher than those identifying as white.

Summary (Unweighted results):

There were no significant differences between the ethnic groups in their mean overall WRQOL scores.

Figure A4.27: Mean Quality of Working Life Scores by Ethnicity (Weighted)

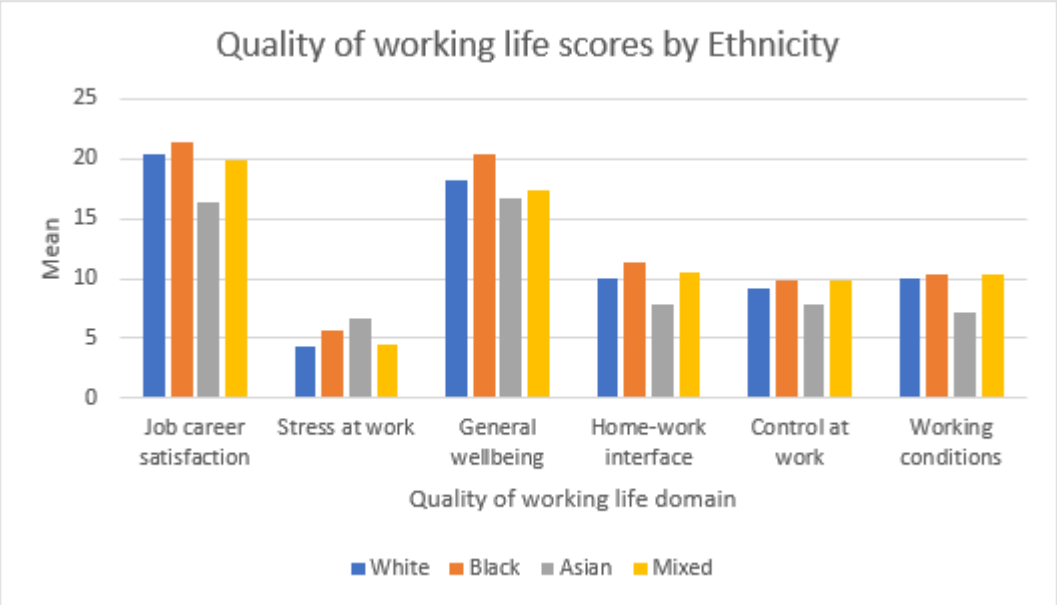

Figure A4.28: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

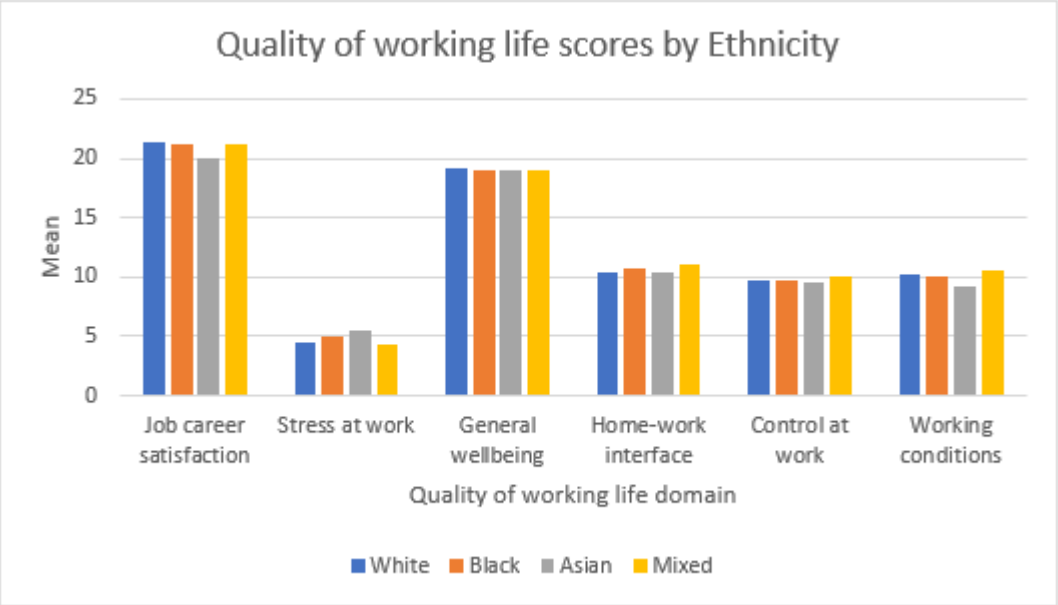

Figure A4.29: Mean Overall Quality of Working Life Score by Ethnicity (Weighted)

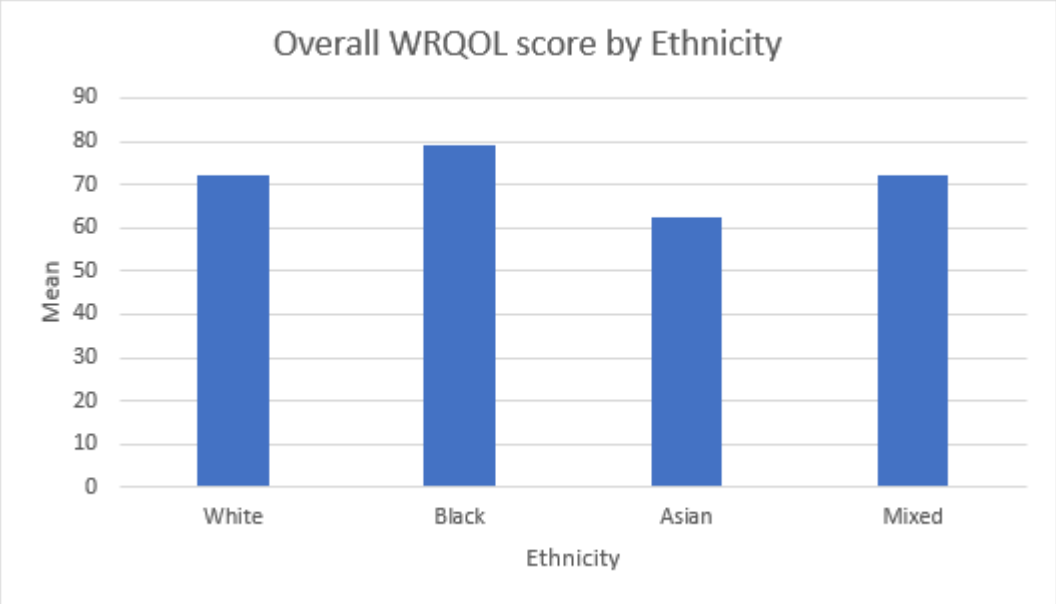

Figure A4.30: Mean Overall Quality of Working Life Score by Ethnicity (Unweighted)

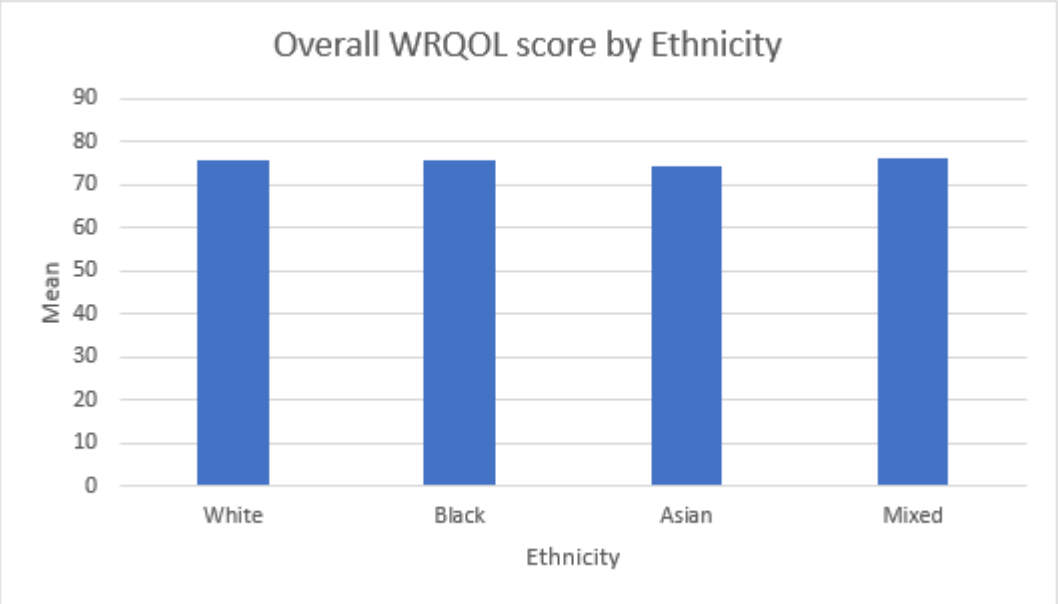

Table A4.19: Mean Quality of Working Life Scores by Ethnicity (Weighted)

	Ethnicity			
WRQOL domain	**White**	**Black**	**Asian**	**Mixed**
Job career satisfaction	20.37	21.36	16.34	19.96
Stress at work	4.34	5.72	6.58	4.48
General wellbeing	18.20	20.37	16.77	17.30
Home-work interface	9.94	11.33	7.75	10.54
Control at work	9.22	9.78	7.82	9.81
Working conditions	10.00	10.42	7.15	10.26
Overall WRQOL score	**72.08**	**78.99**	**62.45**	**72.36**

Table A4.20: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

	Ethnicity			
WRQOL domain	**White**	**Black**	**Asian**	**Mixed**
Job career satisfaction	21.36	21.22	20.06	21.20
Stress at work	4.55	4.94	5.42	4.38
General wellbeing	19.23	19.04	19.03	18.98
Home-work interface	10.43	10.65	10.43	11.11
Control at work	9.73	9.63	9.53	10.13
Working conditions	10.28	10.10	9.16	10.53
Overall WRQOL score	**75.57**	**75.66**	**74.31**	**76.33**

Figure A4.31: Level of Overall Quality of Working Life by Ethnicity (Weighted)

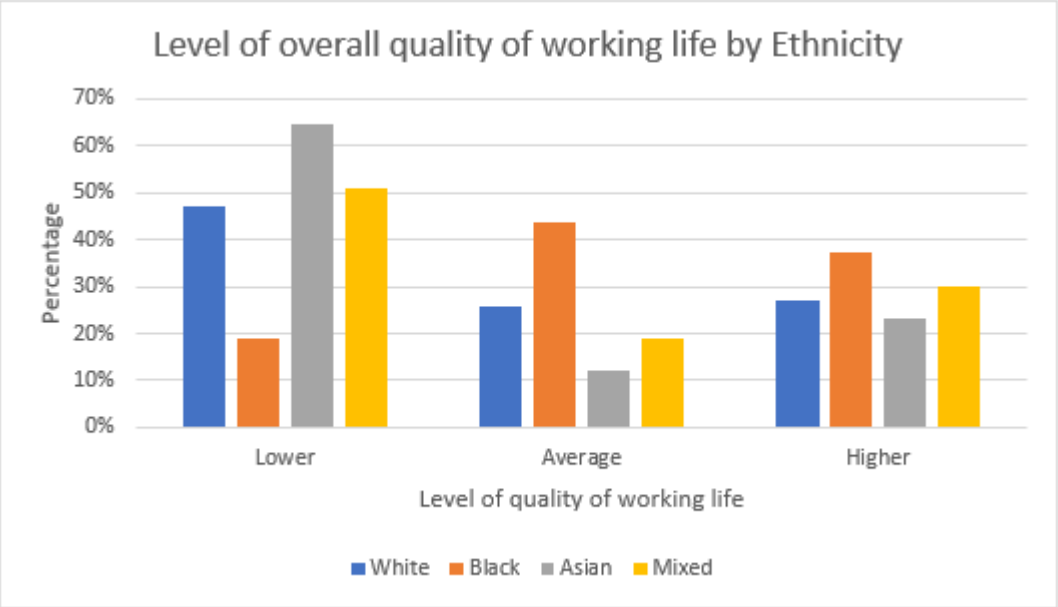

Figure A4.32: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

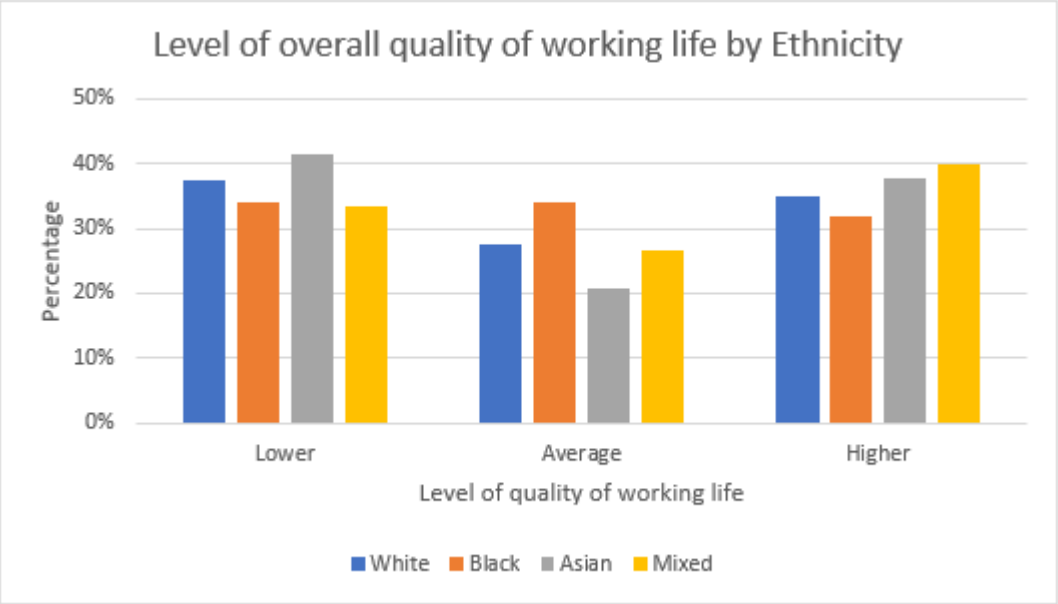

Table A4.21: Level of Overall Quality of Working Life by Ethnicity (Weighted)

	Ethnicity			
Level of WRQOL	**White**	**Black**	**Asian**	**Mixed**
Lower	47.3%	19.0%	64.6%	50.9%
Average	25.7%	43.8%	12.3%	18.9%
Higher	27.0%	37.1%	23.1%	30.2%
Total	**100%**	**100%**	**100%**	**100%**

Table A4.22: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

Level of WRQOL	Ethnicity			
	White	Black	Asian	Mixed
Lower	1068 (37.4%)	16 (34.0%)	12 (41.4%)	15 (33.3%)
Average	787 (27.5%)	16 (34.0%)	6 (20.7%)	12 (26.7%)
Higher	1004 (35.1%)	15 (31.9%)	11 (37.9%)	18 (40.0%)
Total	**2859 (100%)**	**47 (100%)**	**29 (100%)**	**45 (100%)**

A4.6 Quality of Working Life Scores by Disability

Summary (Weighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their disability status ($F = 7.652$, $df = 2$, $p < .001$). Specifically, respondents without a disability scored significantly higher than those with a disability or those who were unsure of whether or not they had a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in the mean overall WRQOL scores ($F = 18.091$, $df = 2$, $p < .001$). Specifically, respondents without a disability scored significantly higher than those with a disability or those who were unsure of whether or not they had a disability.

Figure A4.33: Mean Quality of Working Life Scores by Disability (Weighted)

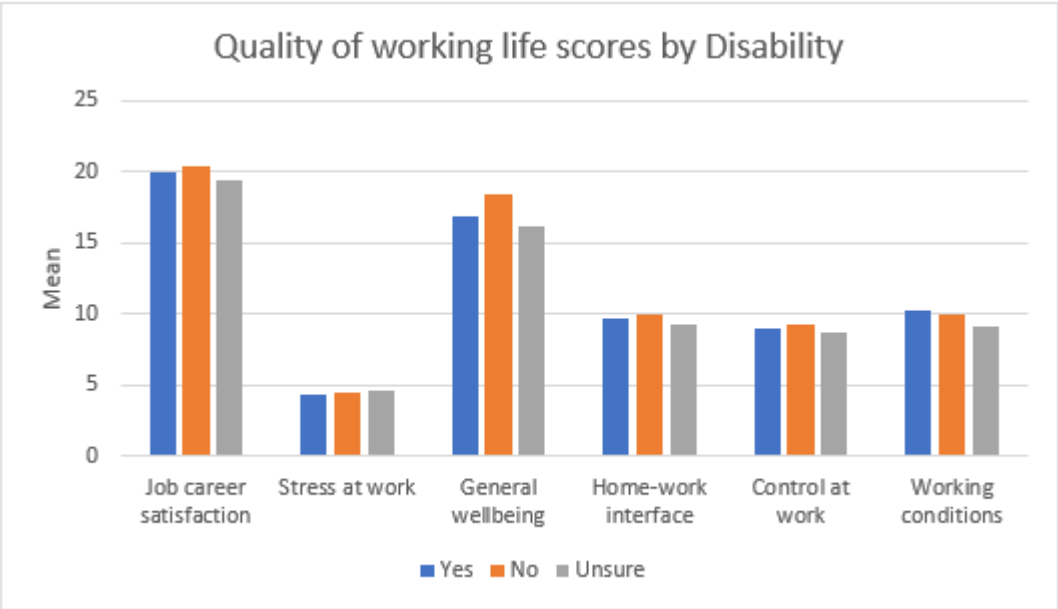

Figure A4.34: Mean Quality of Working Life Scores by Disability (Unweighted)

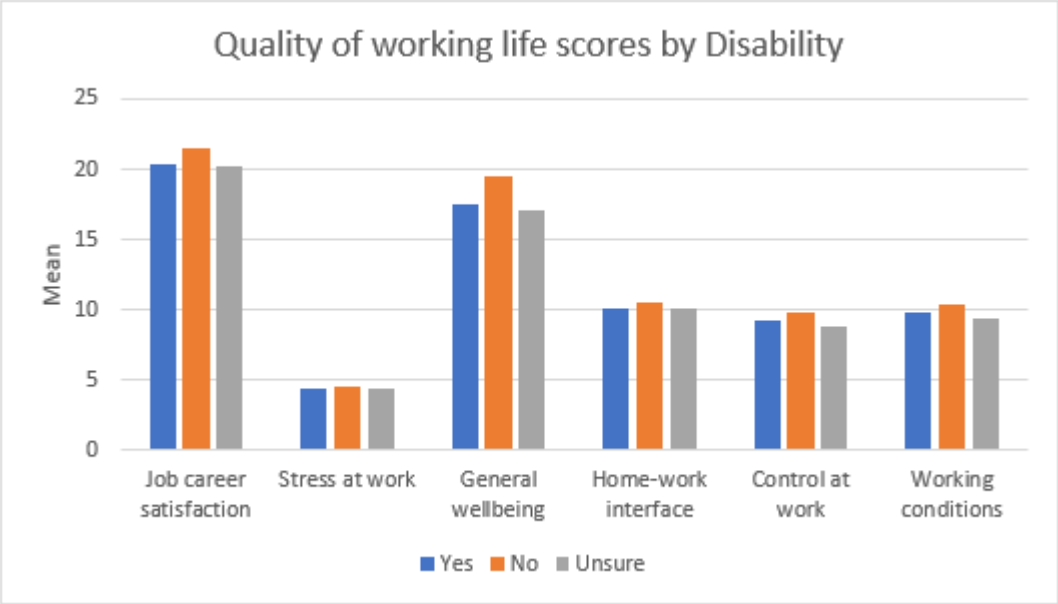

Figure A4.35: Mean Overall Quality of Working Life Score by Disability (Weighted)

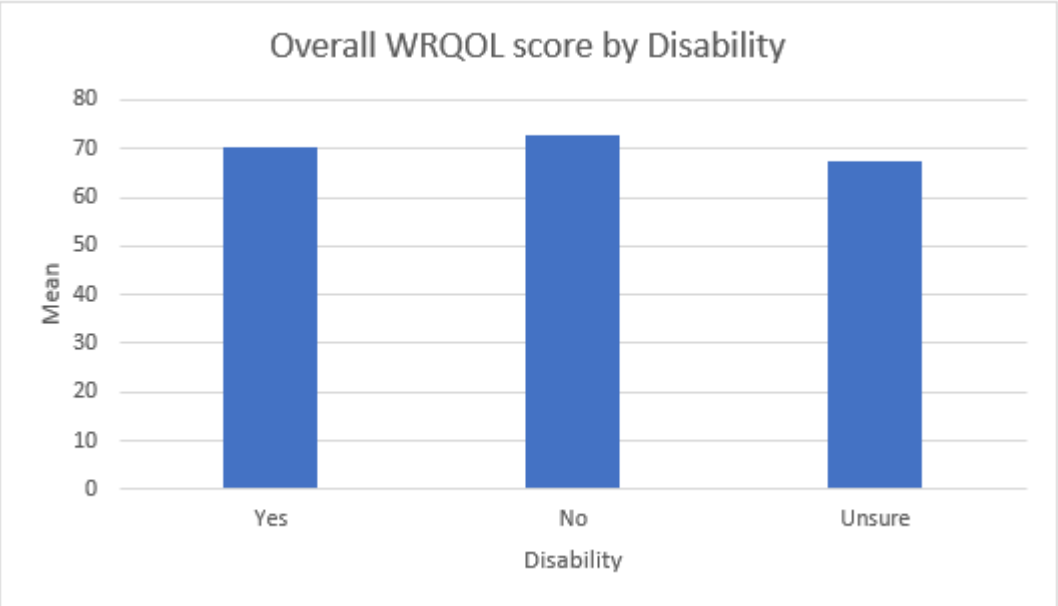

Figure A4.36: Mean Overall Quality of Working Life Score by Disability (Unweighted)

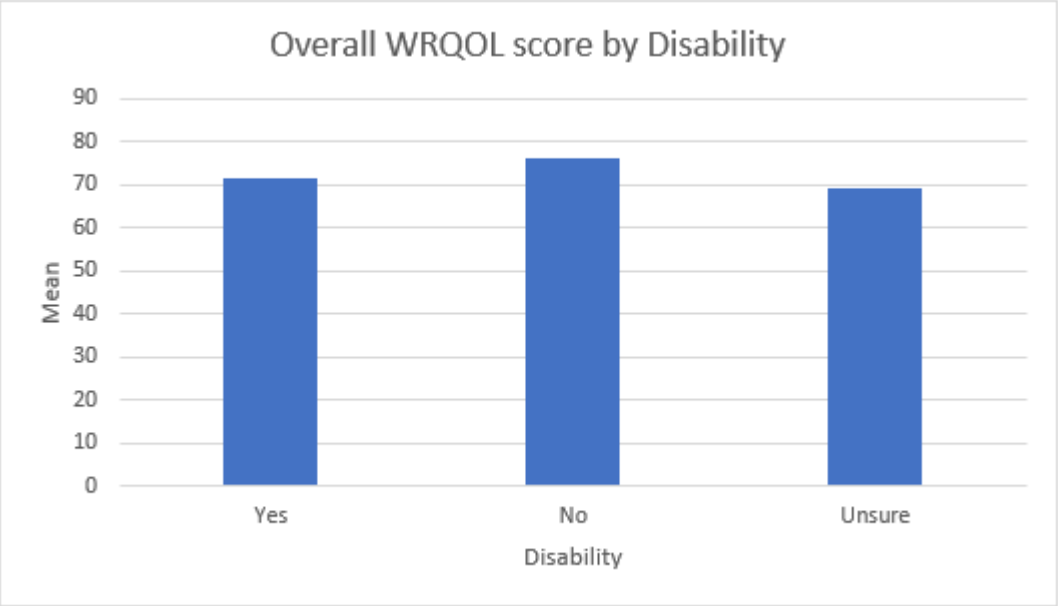

Table A4.23: Mean Quality of Working Life Scores by Disability (Weighted)

	Do you consider yourself to have a disability?		
WRQOL domain	**Yes**	**No**	**Unsure**
Job career satisfaction	19.99	20.40	19.48
Stress at work	4.32	4.45	4.58
General wellbeing	16.96	18.50	16.13
Home-work interface	9.73	10.01	9.33
Control at work	9.07	9.26	8.78
Working conditions	10.24	9.94	9.09
Overall WRQOL score	**70.33**	**72.59**	**67.30**

Table A4.24: Mean Quality of Working Life Scores by Disability (Unweighted)

	Do you consider yourself to have a disability?		
WRQOL domain	**Yes**	**No**	**Unsure**
Job career satisfaction	20.43	21.49	20.16
Stress at work	4.36	4.59	4.32
General wellbeing	17.57	19.48	17.11
Home-work interface	10.13	10.49	10.12
Control at work	9.17	9.83	8.81
Working conditions	9.85	10.35	9.32
Overall WRQOL score	**71.56**	**76.22**	**69.30**

Figure A4.37: Level of Overall Quality of Working Life by Disability (Weighted)

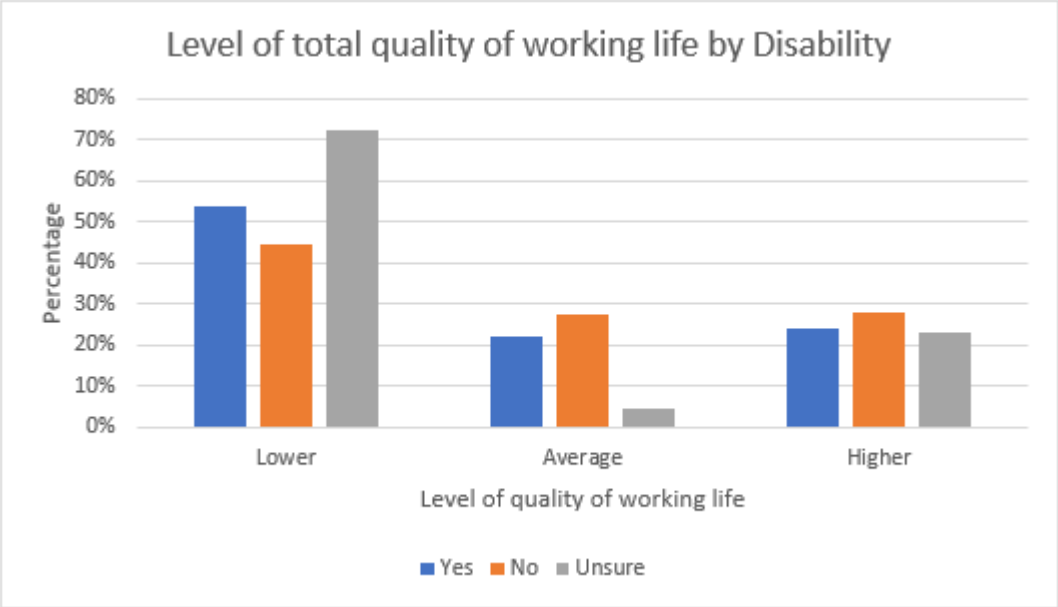

Figure A4.38: Level of Overall Quality of Working Life by Disability (Unweighted)

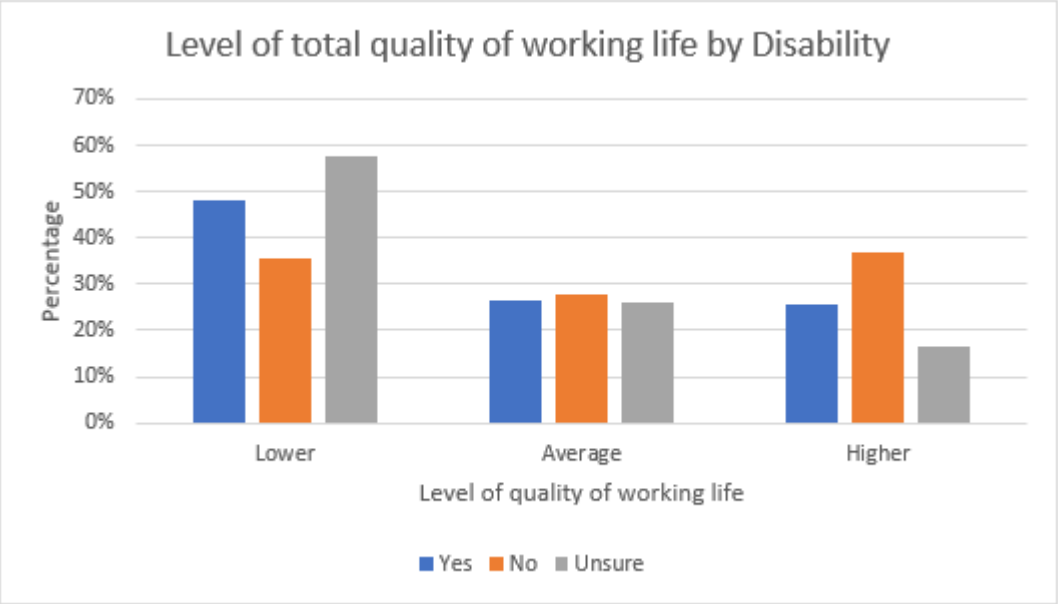

Table A4.25: Level of Overall Quality of Working Life by Disability (Weighted)

	Do you consider yourself to have a disability?		
Level of WRQOL	**Yes**	**No**	**Unsure**
Lower	53.7%	44.7%	72.4%
Average	22.0%	27.4%	4.6%
Higher	24.3%	27.9%	23.0%
Total	**100%**	**100%**	**100%**

Table A4.26: Level of Overall Quality of Working Life by Disability (Unweighted)

Level of WRQOL	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Lower	140 (48.1%)	930 (35.5%)	42 (57.5%)
Average	77 (26.5%)	725 (27.7%)	19 (26.0%)
Higher	74 (25.4%)	965 (36.8%)	12 (16.4%)
Total	**291 (100%)**	**2620 (100%)**	**73 (100%)**

A4.7 Quality of Working Life Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their main area of practice ($F = 4.904$, $df = 7$, $p < .001$). Specifically, respondents working in 'Other' area scored significantly higher than those working in midwifery, with adults or older people.

Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their main area of practice ($F = 4.650$, $df = 7$, $p < .001$). Specifically, respondents working with older people scored significantly lower than those working with children, adults, in the area of learning disability, mental health or 'other'.

Figure A4.39: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

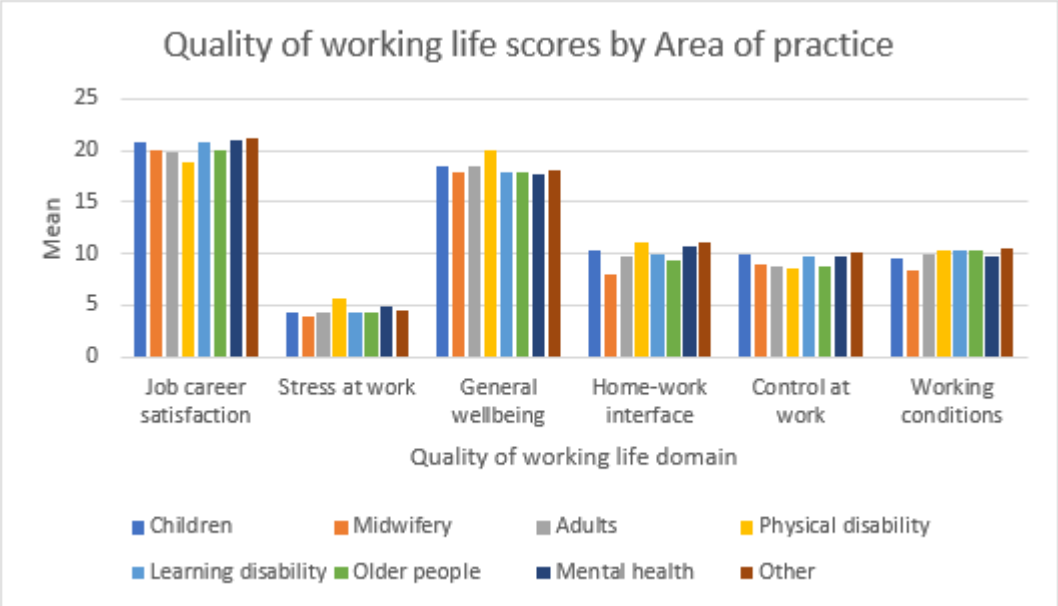

Figure A4.40: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

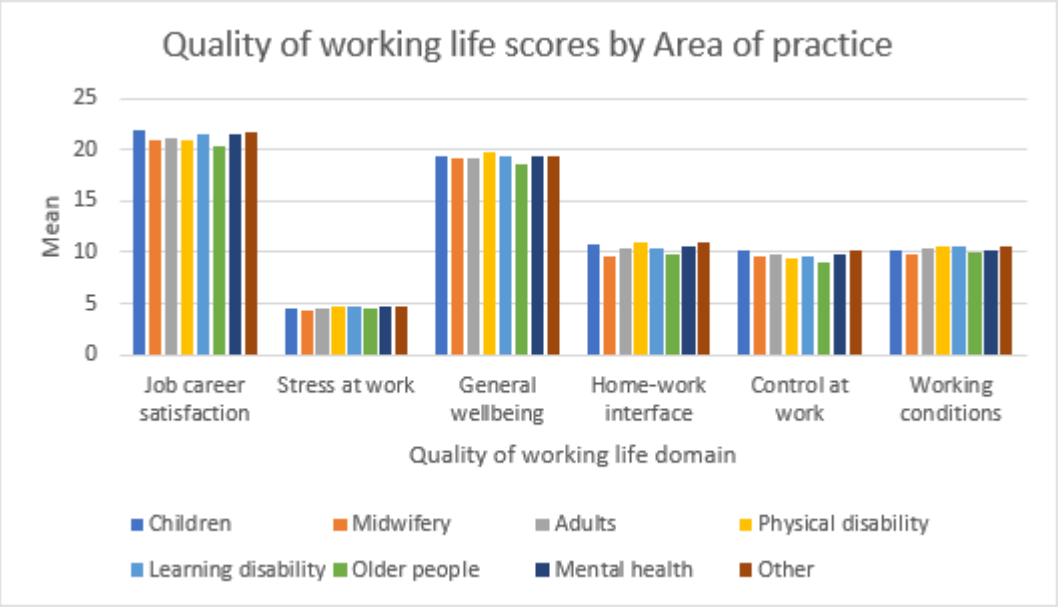

Figure A4.41: Mean Overall Quality of Working Life Score by Main Area of Practice (Weighted)

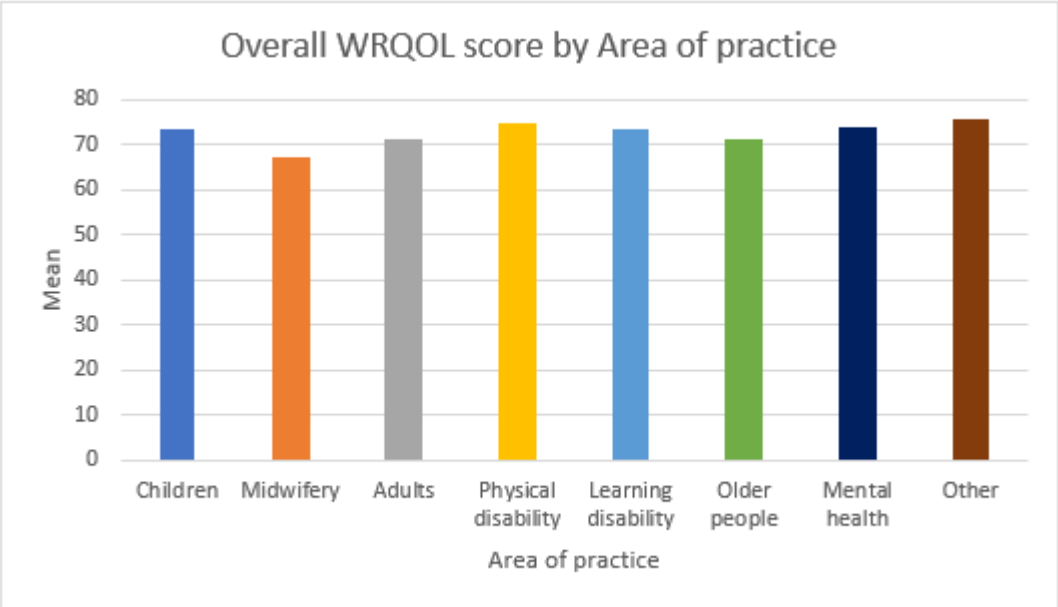

Figure A4.42: Mean Overall Quality of Working Life Score by Main Area of Practice (Unweighted)

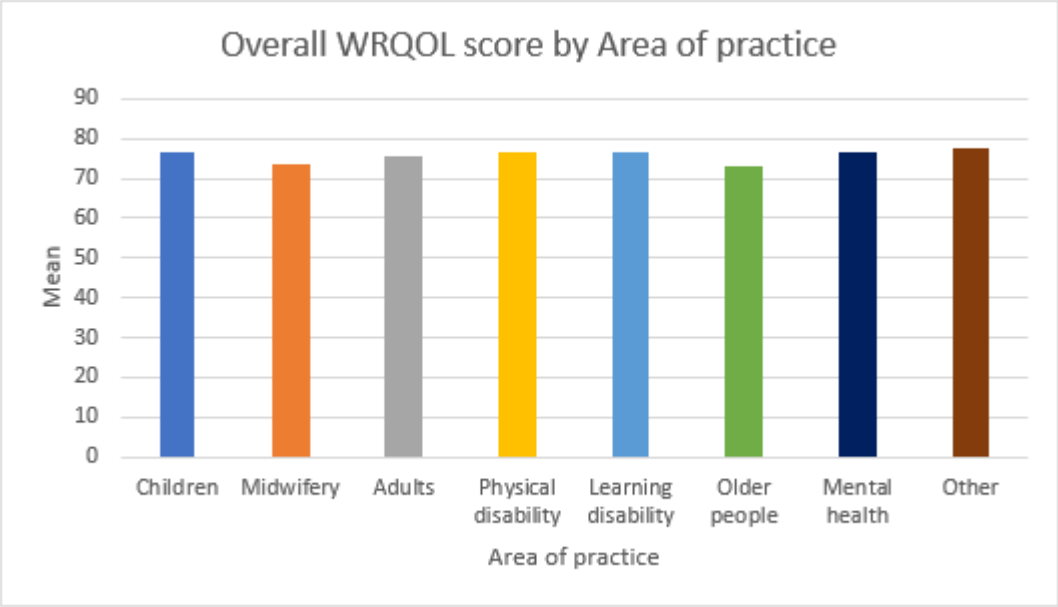

Table A4.27: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

WRQOL domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	20.80	20.04	19.83	18.84	20.81	20.09	20.96	21.23
Stress at work	4.37	4.01	4.37	5.69	4.40	4.34	4.83	4.44
General wellbeing	18.46	17.93	18.42	19.96	17.99	17.98	17.76	18.13
Home-work interface	10.39	8.07	9.68	11.13	9.99	9.40	10.64	11.04
Control at work	9.94	8.91	8.84	8.62	9.68	8.75	9.66	10.06
Working conditions	9.62	8.31	9.86	10.28	10.36	10.29	9.71	10.53
Overall WRQOL score	**73.55**	**67.26**	**71.02**	**74.51**	**73.24**	**70.89**	**73.61**	**75.58**

Table A4.28: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

WRQOL domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	21.96	20.93	21.22	20.90	21.51	20.43	21.56	21.69
Stress at work	4.46	4.25	4.51	4.66	4.63	4.58	4.79	4.66
General wellbeing	19.31	19.13	19.28	19.86	19.46	18.70	19.44	19.46
Home-work interface	10.71	9.62	10.47	11.03	10.41	9.84	10.58	10.95
Control at work	10.16	9.60	9.76	9.38	9.66	9.03	9.84	10.16
Working conditions	10.23	9.80	10.32	10.62	10.57	10.09	10.11	10.58
Overall WRQOL score	**76.83**	**73.30**	**75.50**	**76.44**	**76.27**	**72.65**	**76.40**	**77.52**

Figure A4.43: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

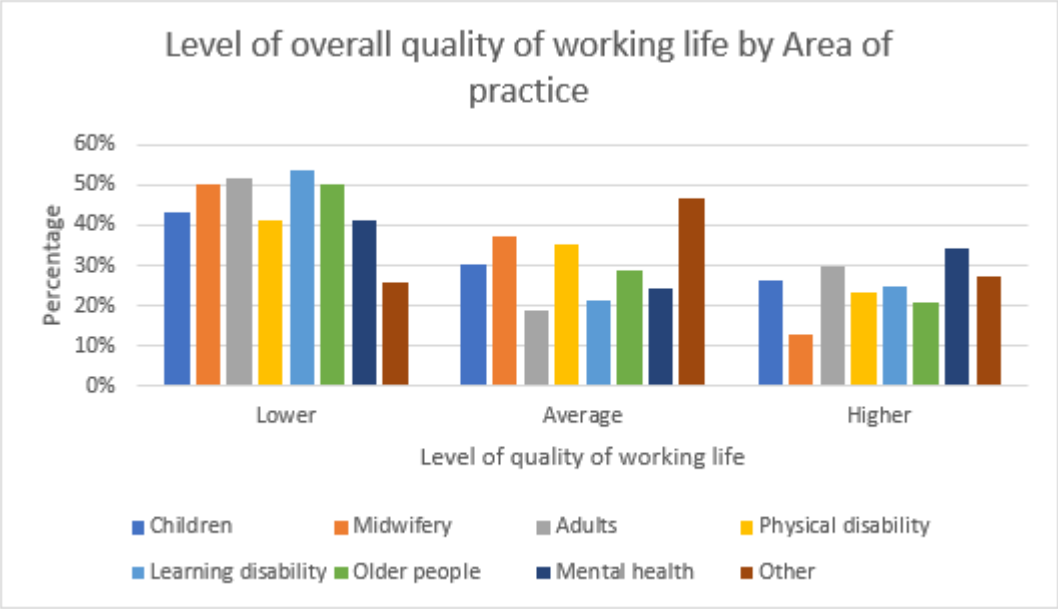

Figure A4.44: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

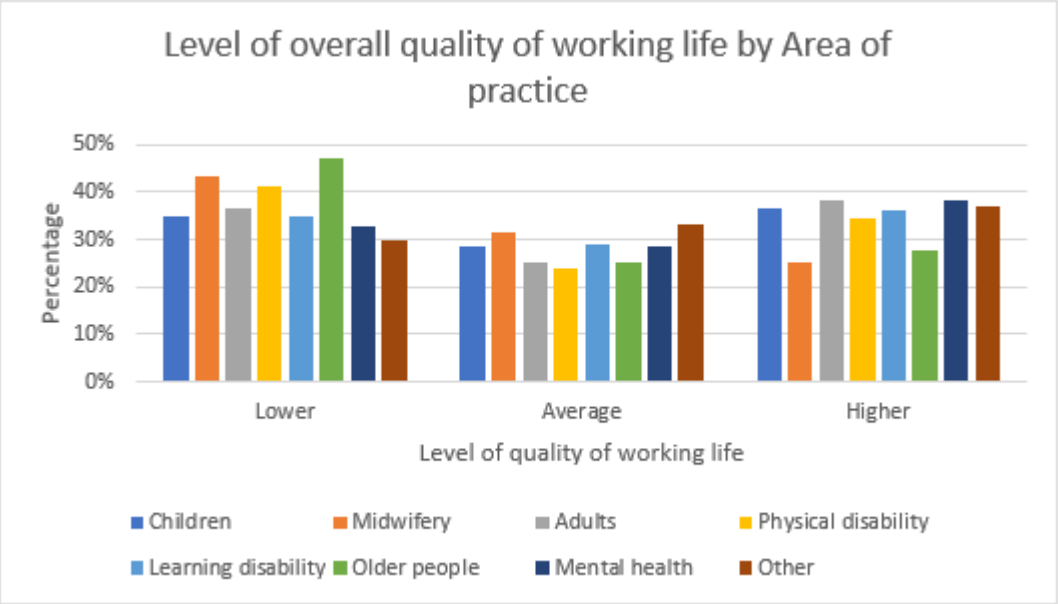

Table A4.29: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

Level of WRQOL	Main area of practice							
	Children	**Midwifery**	**Adults**	**Physical disability**	**Learning disability**	**Older people**	**Mental health**	**Other**
Lower	43.1%	50.0%	51.6%	41.2%	53.9%	50.3%	41.0%	25.9%
Average	30.4%	37.0%	18.7%	35.3%	21.2%	28.7%	24.5%	46.7%
Higher	26.5%	13.0%	29.7%	23.5%	24.8%	21.0%	34.5%	27.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table A4.30: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

Level of WRQOL	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Lower	269 (34.7%)	26 (43.3%)	239 (36.7%)	24 (41.4%)	113 (34.7%)	277 (47.0%)	98 (33.0%)	68 (29.7%)
Average	222 (28.6%)	19 (31.7%)	163 (25.0%)	14 (24.1%)	95 (29.1%)	148 (25.1%)	85 (28.6%)	76 (33.2%)
Higher	285 (36.7%)	15 (25.0%)	250 (38.3%)	20 (34.5%)	118 (36.2%)	164 (27.8%)	114 (38.4%)	85 (37.1%)
Total	**776 (100%)**	**60 (100%)**	**652 (100%)**	**58 (100%)**	**326 (100%)**	**589 (100%)**	**297 (100%)**	**229 (100%)**

A4.8 Quality of Working Life Scores by Line Manager Status

Summary (Weighted results):

There was no significant difference in the mean overall WRQOL score between line managers and those who were not line managers.

Summary (Unweighted results):

There was a significant difference in the mean overall WRQOL scores between respondents who were line managers and those who were not ($t = 3.938$, $df = 2985$, $p < .001$); line managers scored significantly higher.

Figure A4.45: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

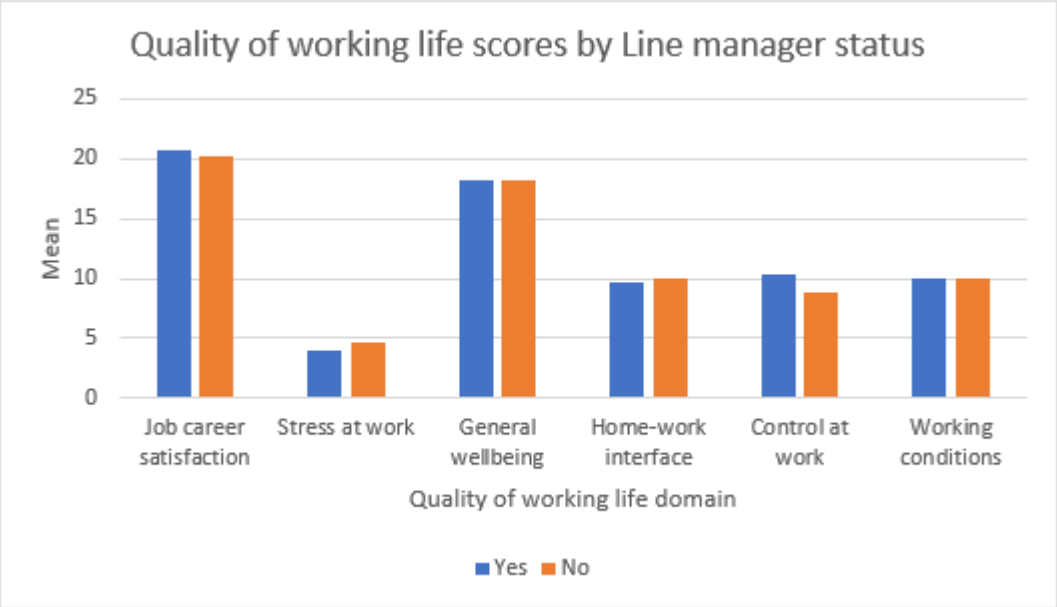

Figure A4.46: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

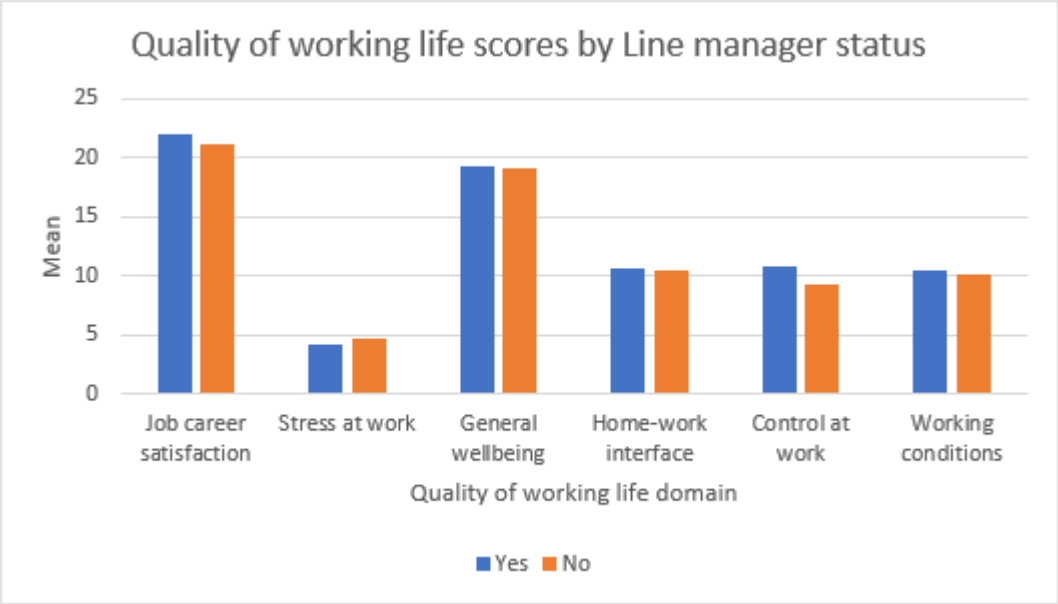

Figure A4.47: Mean Overall Quality of Working Life Score by Line Manager Status (Weighted)

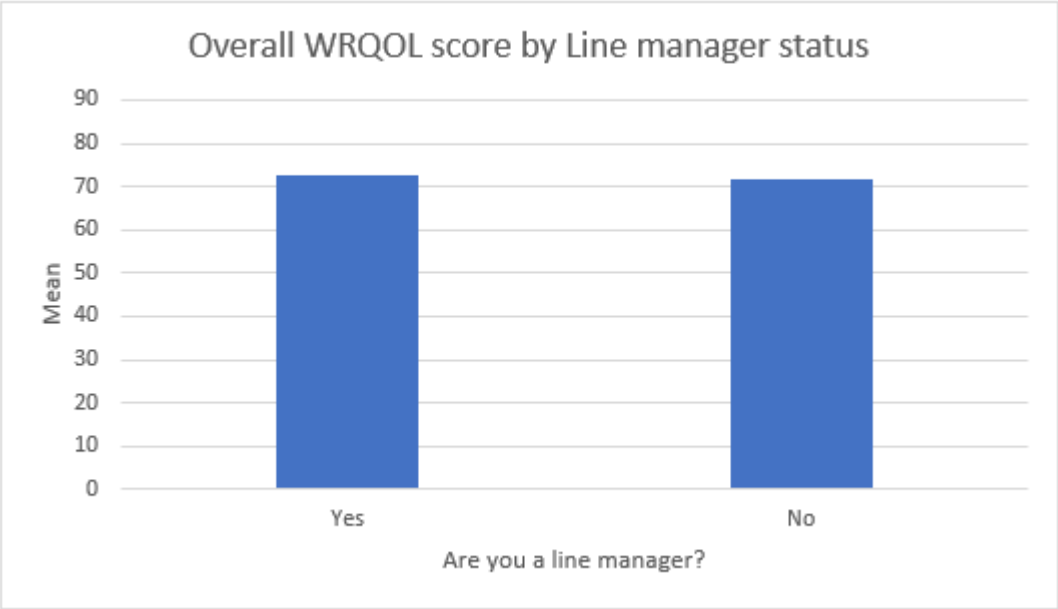

Figure A4.48: Mean Overall Quality of Working Life Score by Line Manager Status (Unweighted)

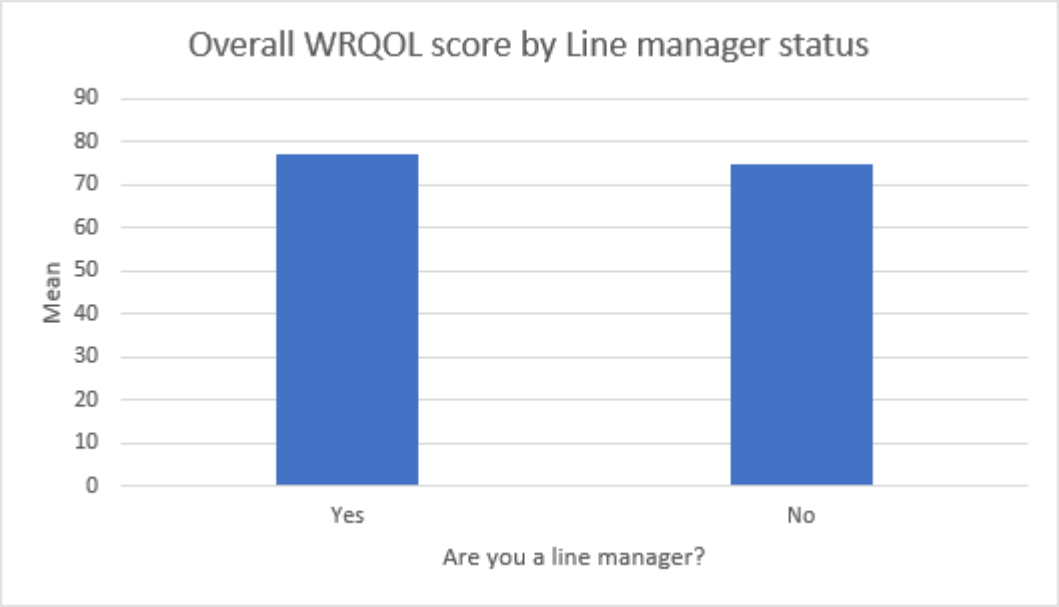

Table A4.31: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

	Are you a line manager?	
WRQOL Domain	**Yes**	**No**
Job career satisfaction	20.71	20.18
Stress at work	3.95	4.60
General wellbeing	18.27	18.21
Home-work interface	9.73	10.03
Control at work	10.31	8.85
Working conditions	9.92	9.97
Overall WRQOL score	**72.84**	**71.88**

Table A4.32: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

	Are you a line manager?	
WRQOL Domain	**Yes**	**No**
Job career satisfaction	21.95	21.11
Stress at work	4.11	4.73
General wellbeing	19.36	19.18
Home-work interface	10.56	10.40
Control at work	10.88	9.29
Working conditions	10.51	10.18
Overall WRQOL score	**77.38**	**74.89**

Figure A4.49: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

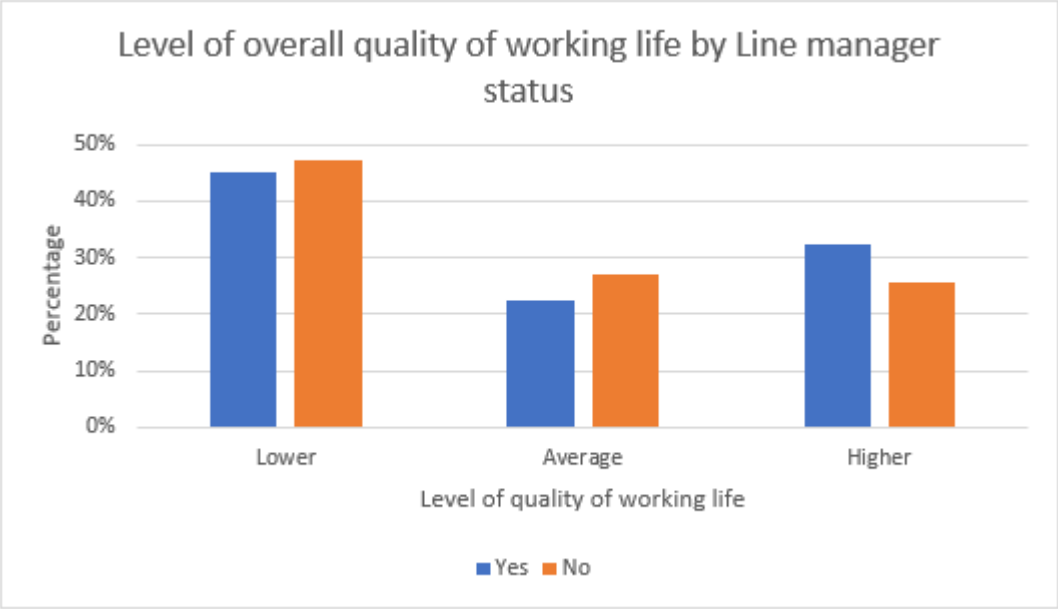

Figure A4.50: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

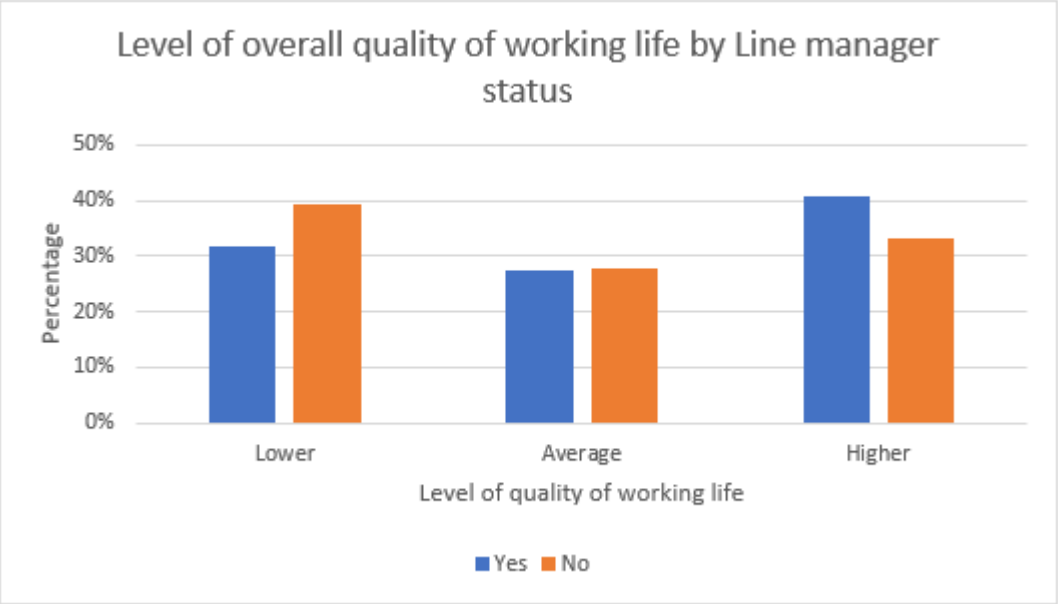

Table A4.33: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

	Are you a line manager?	
Level of WRQOL	**Yes**	**No**
Lower	45.1%	47.3%
Average	22.6%	27.2%
Higher	32.3%	25.5%
Total	**100%**	**100%**

Table A4.34: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

Level of WRQOL	Are you a line manager?	
	Yes	No
Lower	267 (31.9%)	847 (39.4%)
Average	229 (27.3%)	593 (27.6%)
Higher	342 (40.8%)	709 (33.0%)
Total	**838 (100%)**	**2149 (100%)**

A4.9 Quality of Working Life Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in the mean overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 83.608$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact or those who felt no impact.

Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 97.366$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact of COVID-19.

Figure A4.51: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)

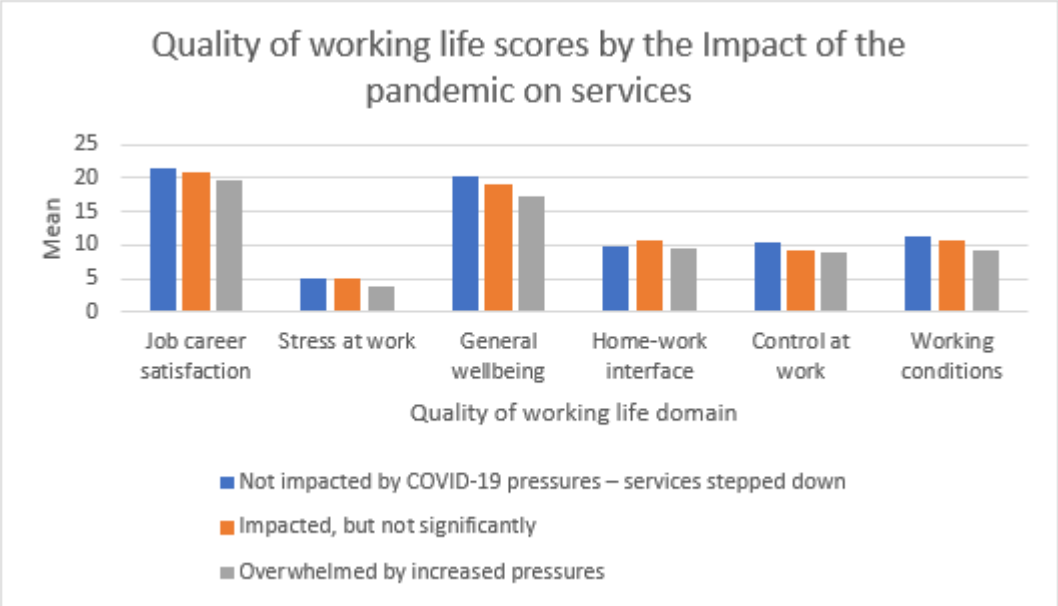

Figure A4.52: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)

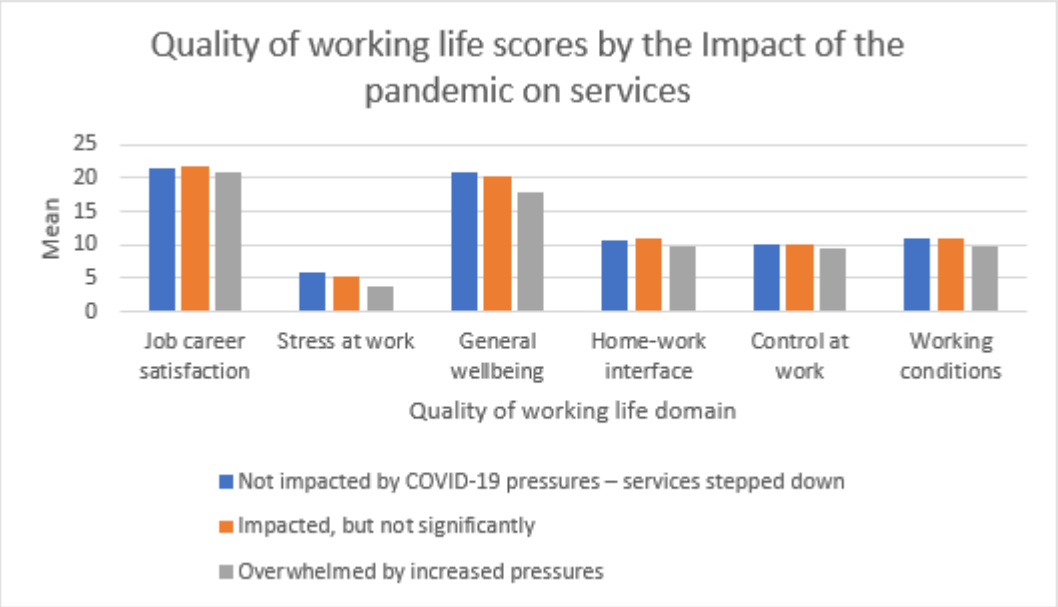

Figure A4.53: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Weighted)

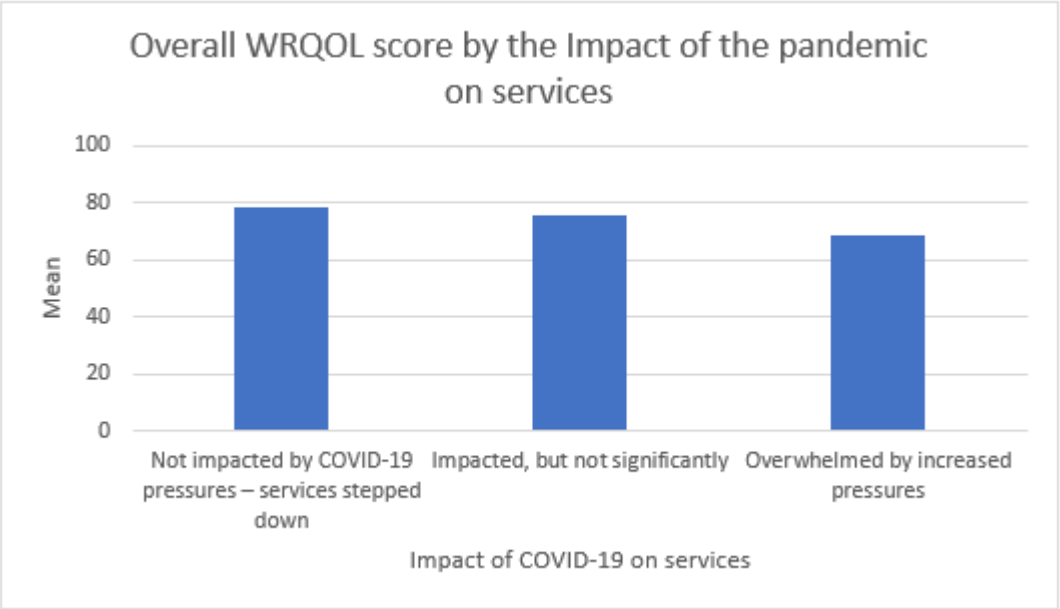

Figure A4.54: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Unweighted)

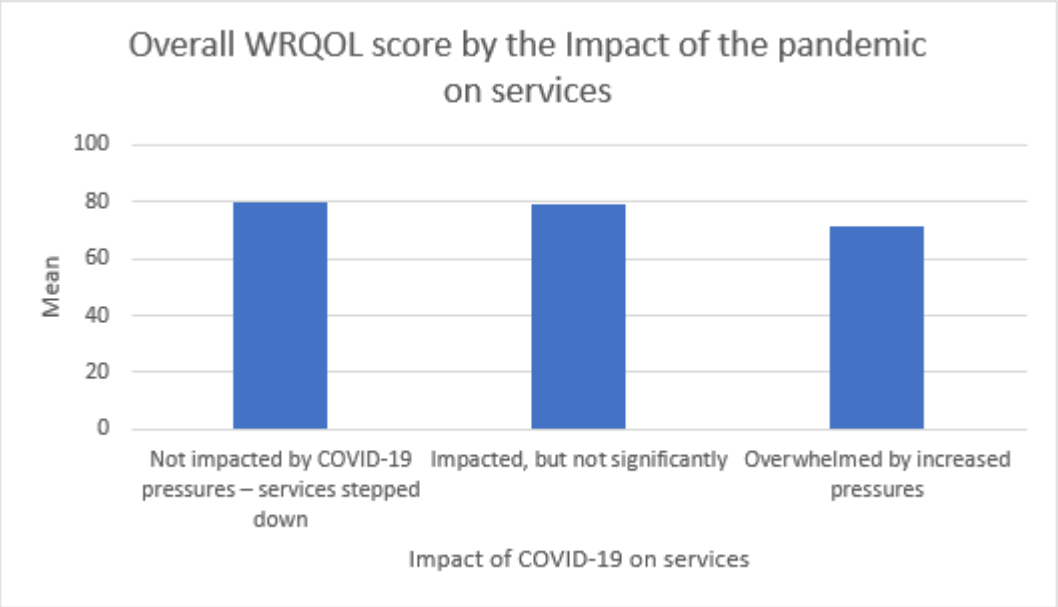

Table A4.35: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)

WRQOL domain	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Job career satisfaction	21.57	20.80	19.78
Stress at work	4.94	5.02	3.85
General wellbeing	20.42	19.13	17.21
Home-work interface	9.76	10.60	9.38
Control at work	10.29	9.33	9.04
Working conditions	11.37	10.55	9.29
Overall WRQOL score	**78.26**	**75.55**	**68.54**

Table A4.36: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)

WRQOL domain	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Job career satisfaction	21.61	21.90	20.75
Stress at work	5.90	5.18	3.82
General wellbeing	20.73	20.33	17.98
Home-work interface	10.75	10.96	9.89
Control at work	9.97	9.98	9.47
Working conditions	11.00	10.83	9.64
Overall WRQOL score	**79.82**	**79.22**	**71.54**

Figure A4.55: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

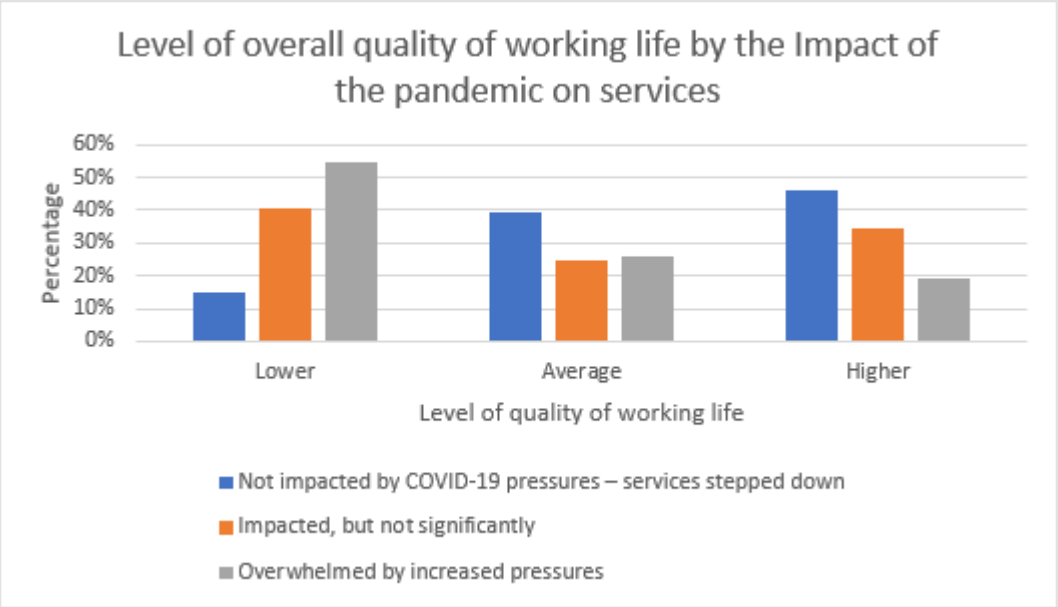

Figure A4.56: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

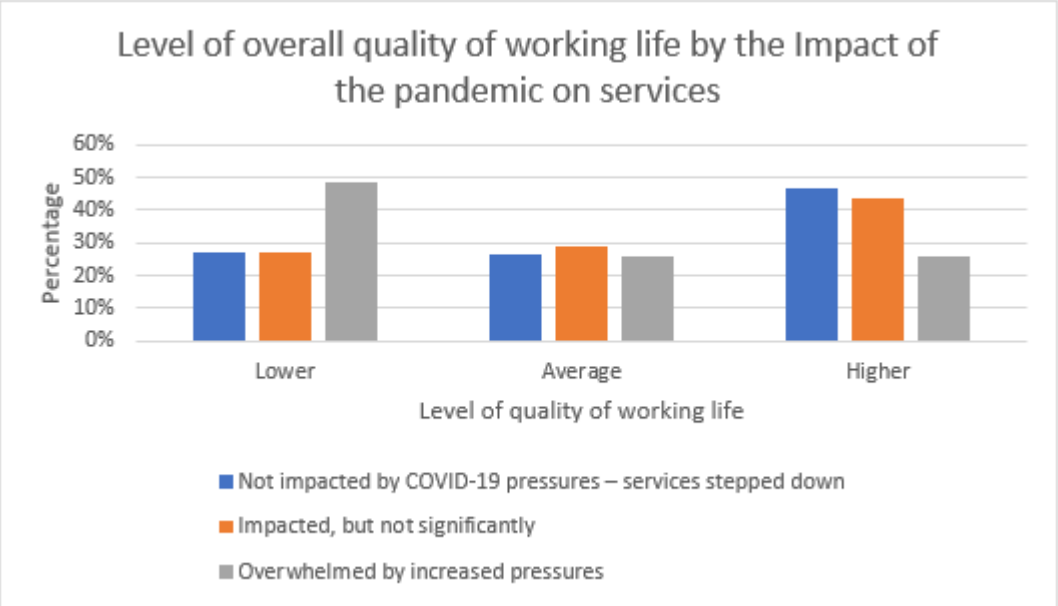

Table A4.37: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

Level of WRQOL	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Lower	15.0%	40.4%	54.9%
Average	39.2%	24.9%	26.0%
Higher	45.8%	34.7%	19.1%
Total	**100%**	**100%**	**100%**

Table A4.38: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

Level of WRQOL	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Lower	31 (27.2%)	395 (27.3%)	687 (48.4%)
Average	30 (26.3%)	421 (29.1%)	368 (25.9%)
Higher	53 (46.5%)	632 (43.6%)	364 (25.7%)
Total	**114 (100%)**	**1448 (100%)**	**1419 (100%)**

Appendix 5: Copenhagen Burnout Inventory (Unweighted) – Tables and Charts

This section provides detailed results of respondents' burnout, which was measured using the Copenhagen Burnout Inventory. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A5.1 Burnout Scores by Country

Summary (Weighted results):

There were significant differences between the countries in mean personal burnout scores ($F = 3.470$, $df = 3$, $p = .015$). Specifically, respondents from England scored significantly higher than those from Wales.

There were also significant differences between the countries in mean work-related burnout scores ($F = 9.322$, $df = 3$, $p < .001$). Respondents from England and Northern Ireland scored significantly higher than those from Wales.

Significant differences between countries were also found in mean client-related burnout scores ($F = 6.175$, $df = 3$, $p < .001$). Respondents from England scored significantly higher than those from Wales.

Summary (Unweighted results):

There were significant differences between the countries in mean personal burnout scores ($F = 3.989$, $df = 3$, $p = .008$). Specifically, respondents from England scored significantly higher than those from Wales.

There were also significant differences between the countries in mean work-related burnout scores ($F = 8.740$, $df = 3$, $p < .001$). Respondents from England scored significantly higher than those from Wales and Northern Ireland; and respondents from Northern Ireland scored significantly higher than those from Wales.

Significant differences between countries were also found in mean client-related burnout scores ($F = 5.613$, $df = 3$, $p = .001$). Respondents from England scored significantly higher than those from all other countries.

Figure A5.1: Mean Burnout Scores by Country (Weighted)

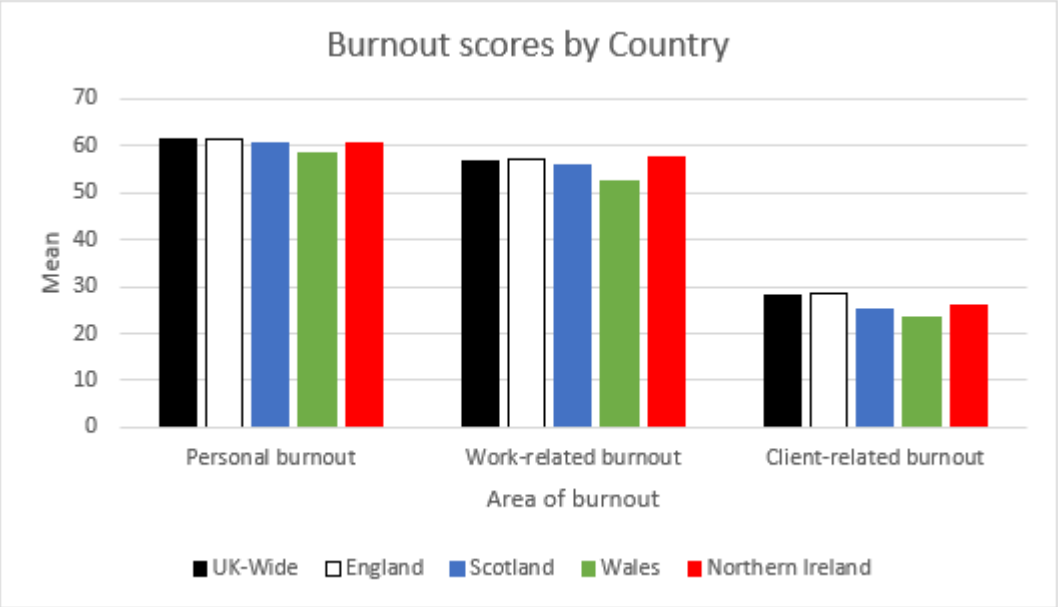

Figure A5.2: Mean Burnout Scores by Country (Unweighted)

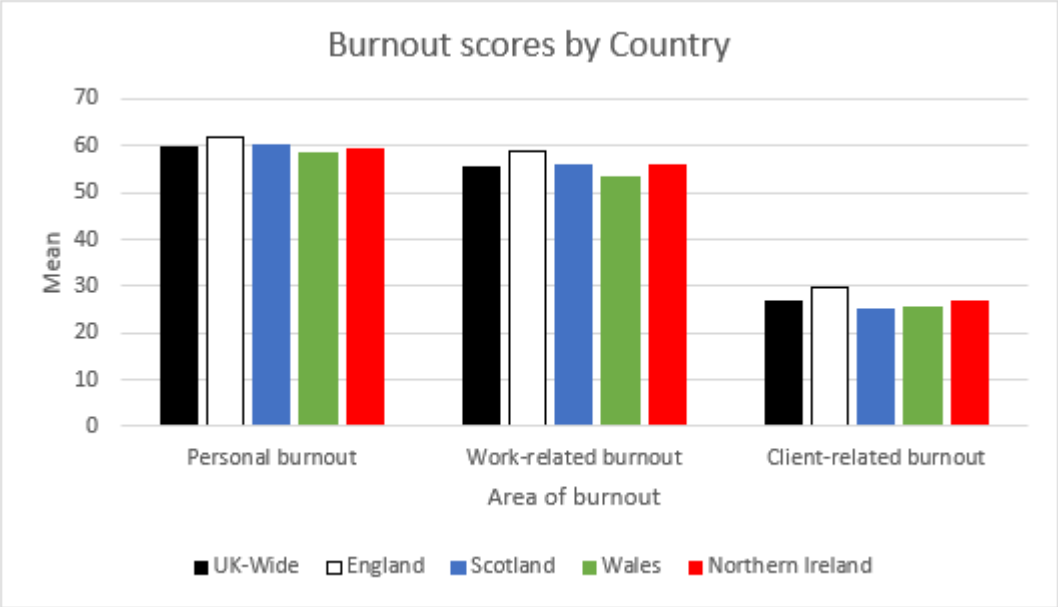

Table A5.1: Mean Burnout Scores by Country (Weighted)

	Country				
Burnout	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Personal burnout	61.40	61.53	60.68	58.26	60.39
Work-related burnout	56.73	57.36	55.78	52.53	57.43
Client-related burnout	27.97	28.58	25.12	23.61	25.93

Table A5.2: Mean Burnout Scores by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	59.63	61.72	60.06	58.32	59.28
Work-related burnout	55.63	58.66	55.86	53.11	55.81
Client-related burnout	26.88	29.61	25.24	25.54	26.85

Figure A5.3: Level of Personal Burnout by Country (Weighted)

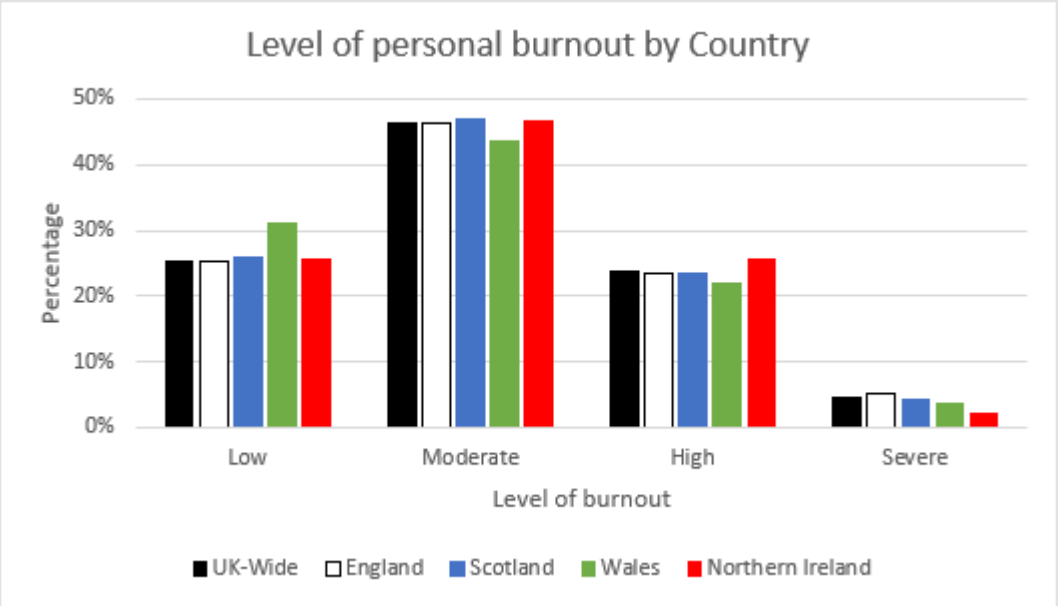

Figure A5.4: Level of Personal Burnout by Country (Unweighted)

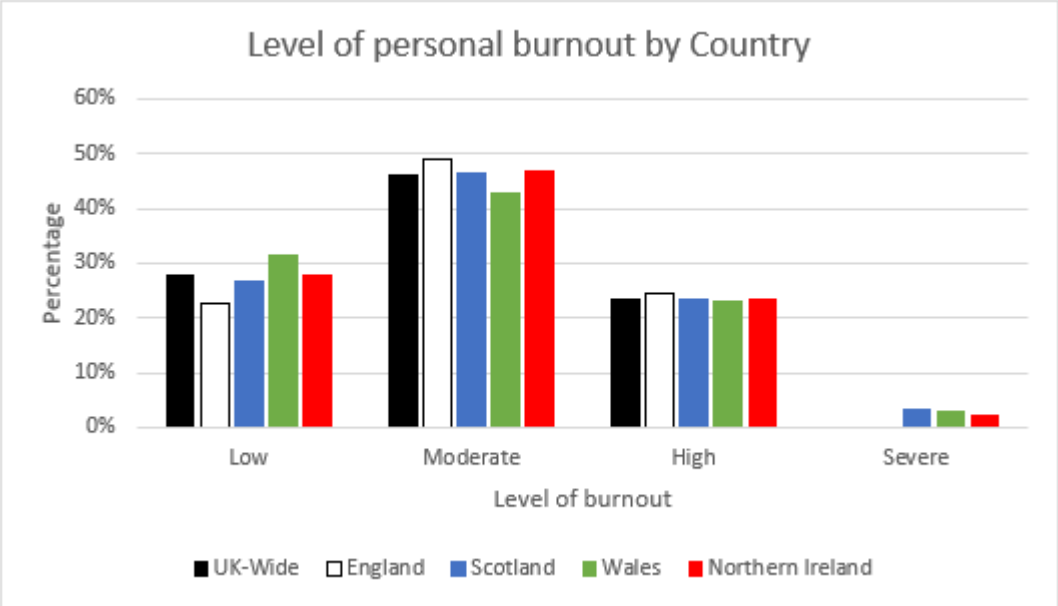

Figure A5.5: Level of Work-Related Burnout by Country (Weighted)

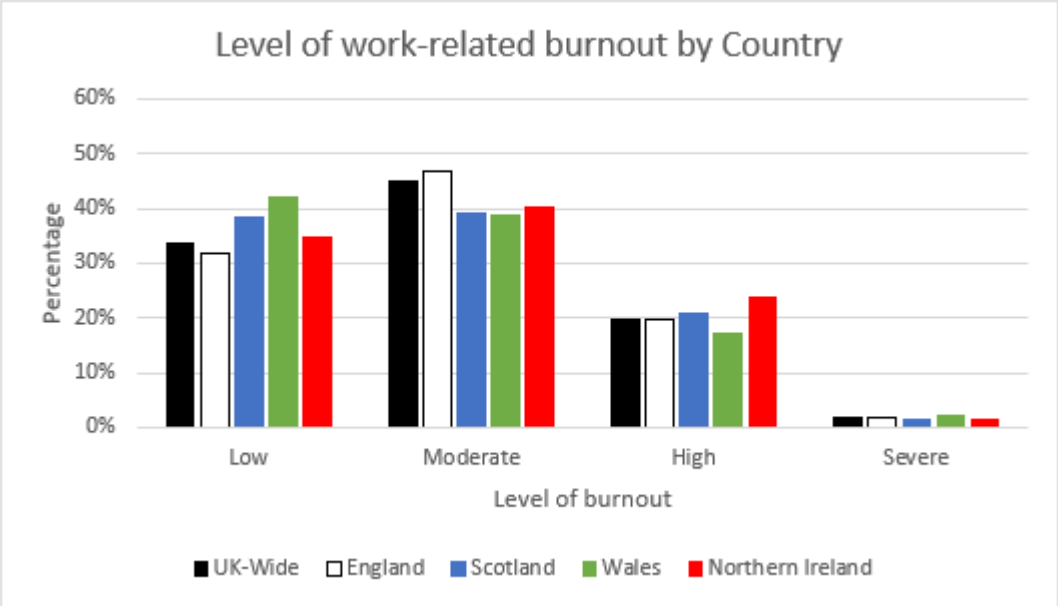

Figure A5.6: Level of Work-Related Burnout by Country (Unweighted)

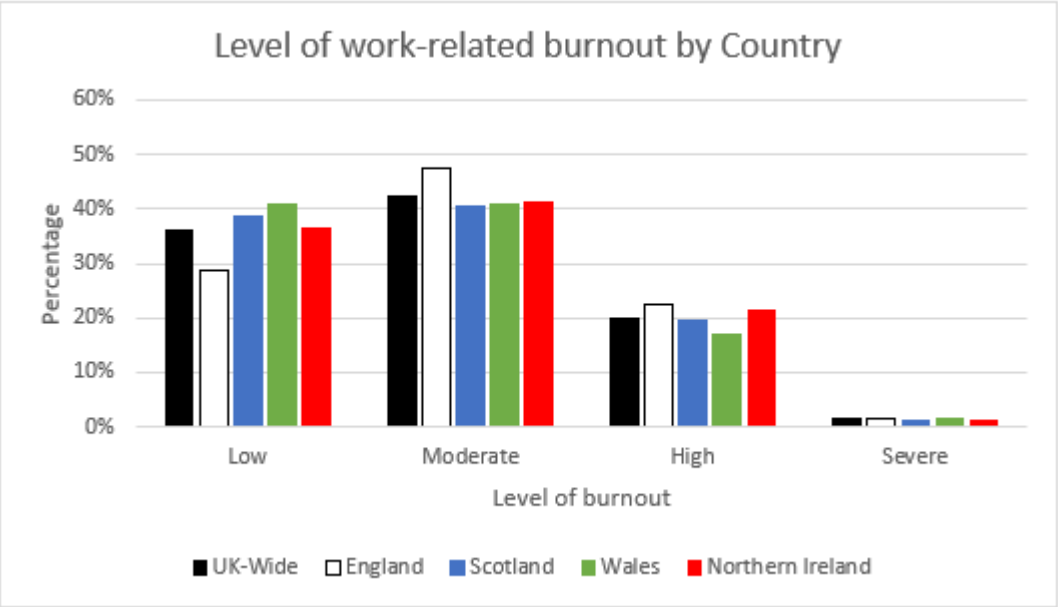

Figure A5.7: Level of Client-Related Burnout by Country (Weighted)

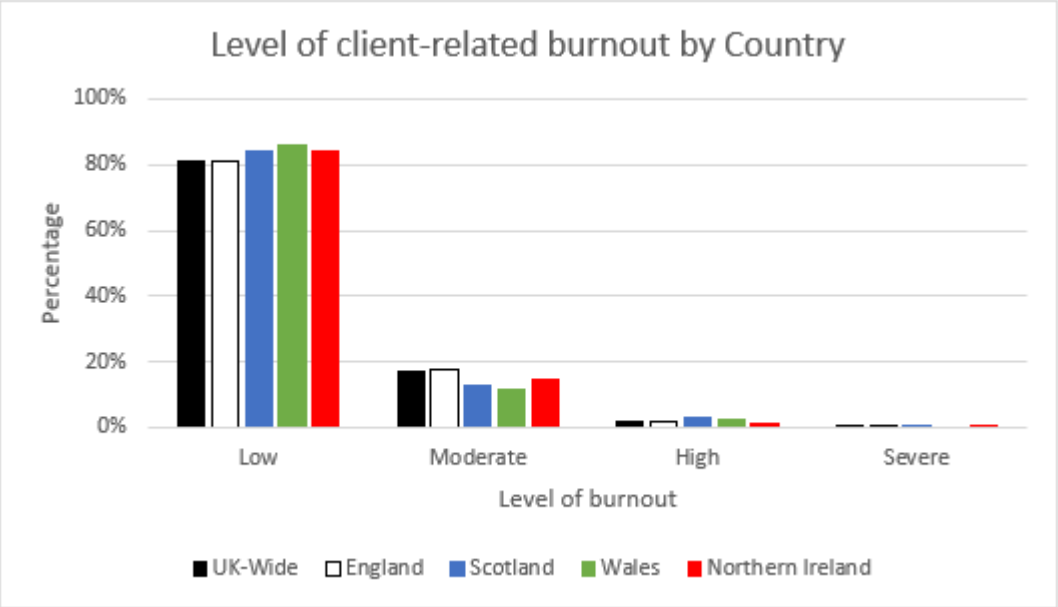

Figure A5.8: Level of Client-Related Burnout by Country (Unweighted)

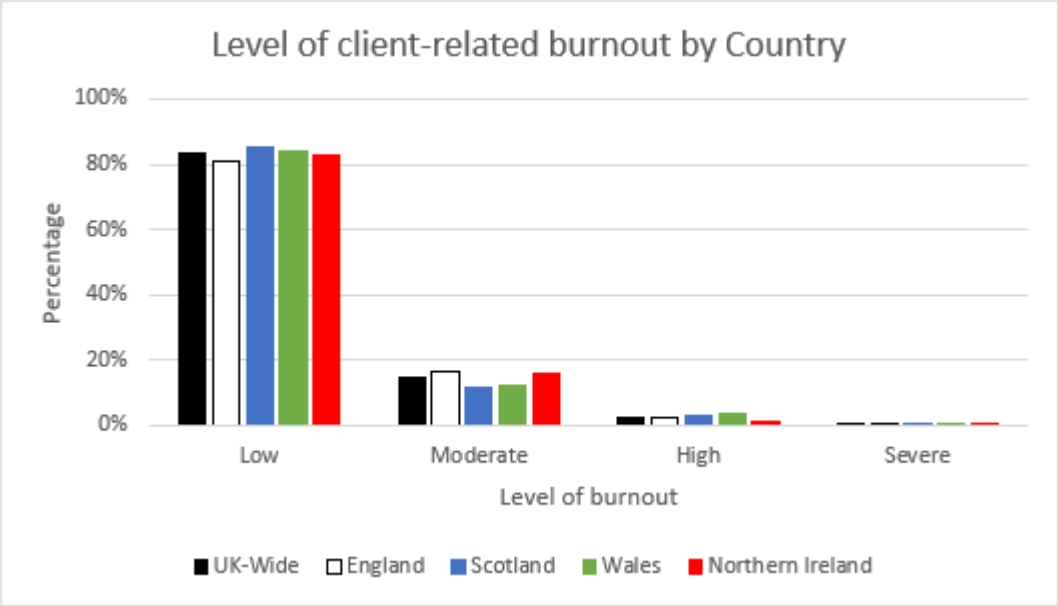

Table A5.3: Level of Burnout by Country (Weighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout:					
Low	25.3%	25.2%	25.8%	31.0%	25.5%
Moderate	46.4%	46.3%	46.8%	43.5%	46.5%
High	23.7%	23.4%	23.3%	21.8%	25.7%
Severe	4.6%	5.1%	4.3%	3.7%	2.2%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:					
Low	33.7%	31.8%	38.3%	42.1%	34.8%
Moderate	45.0%	46.9%	39.3%	38.6%	40.1%
High	19.7%	19.7%	20.9%	17.2%	23.7%
Severe	1.6%	1.6%	1.5%	2.1%	1.5%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:					
Low	80.9%	80.8%	84.0%	85.8%	84.4%
Moderate	17.1%	17.5%	13.0%	11.7%	14.3%
High	1.8%	1.5%	2.8%	2.6%	0.9%
Severe	0.2%	0.2%	0.3%	0.0%	0.4%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.4: Level of Burnout by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout:					
Low	835 (27.7%)	155 (22.7%)	104 (26.8%)	297 (31.6%)	279 (27.8%)
Moderate	1384 (45.9%)	334 (49.0%)	181 (46.6%)	400 (42.6%)	469 (46.8%)
High	708 (23.5%)	167 (24.5%)	91 (23.5%)	216 (23.0%)	234 (23.4%)
Severe	85 (2.8%)	26 (3.8%)	12 (3.1%)	27 (2.9%)	20 (2.0%)
TOTAL	**3012 (100%)**	**682 (100%)**	**388 (100%)**	**940 (100%)**	**1002 (100%)**
Work-related burnout:					
Low	1071 (36.2%)	193 (28.6%)	146 (38.5%)	373 (40.8%)	359 (36.4%)
Moderate	1255 (42.5%)	322 (47.6%)	154 (40.6%)	372 (40.7%)	407 (41.3%)
High	590 (20.0%)	151 (22.3%)	74 (19.5%)	156 (17.0%)	209 (21.2%)
Severe	40 (1.4%)	10 (1.5%)	5 (1.3%)	14 (1.5%)	11 (1.1%)
TOTAL	**2956 (100%)**	**676 (100%)**	**379 (100%)**	**915 (100%)**	**986 (100%)**
Client-related burnout:					
Low	2259 (83.1%)	512 (80.8%)	299 (85.2%)	709 (84.2%)	739 (82.8%)
Moderate	391 (14.4%)	105 (16.6%)	41 (11.7%)	104 (12.4%)	141 (15.8%)
High	62 (2.3%)	14 (2.2%)	10 (2.8%)	28 (3.3%)	10 (1.1%)
Severe	7 (0.3%)	3 (0.5%)	1 (0.3%)	1 (0.1%)	2 (0.2%)
TOTAL	**2719 (100%)**	**634 (100%)**	**351 (100%)**	**842 (100%)**	**892 (100%)**

A5.2 Burnout Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean personal burnout scores ($F = 9.344$, $df = 4$, $p < .001$). Specifically, AHPs scored significantly lower than nurses and social workers; and social care workers scored significantly lower than social workers.

There were also significant differences between the occupational groups in mean work-related burnout scores ($F = 15.497$, $df = 4$, $p < .001$). Social care workers scored significantly lower than nurses, midwives and social workers; and AHPs scored significantly lower than social workers.

Significant differences between occupational groups were also found in mean client-related burnout scores ($F = 7.631$, $df = 4$, $p < .001$). Social workers scored significantly higher than social care workers.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean personal burnout scores ($F = 4.603$, $df = 4$, $p = .001$). Specifically, AHPs scored significantly lower than nurses and social workers.

There were also significant differences between the occupational groups in mean work-related burnout scores ($F = 12.868$, $df = 4$, $p < .001$). Both nurses and social workers scored significantly higher than AHPs and social care workers.

Significant differences between occupational groups were also found in mean client-related burnout scores ($F = 9.559$, $df = 4$, $p < .001$). Social workers scored significantly higher than nurses, AHPs and social care workers.

Figure A5.9: Mean Burnout Scores by Occupation (Weighted)

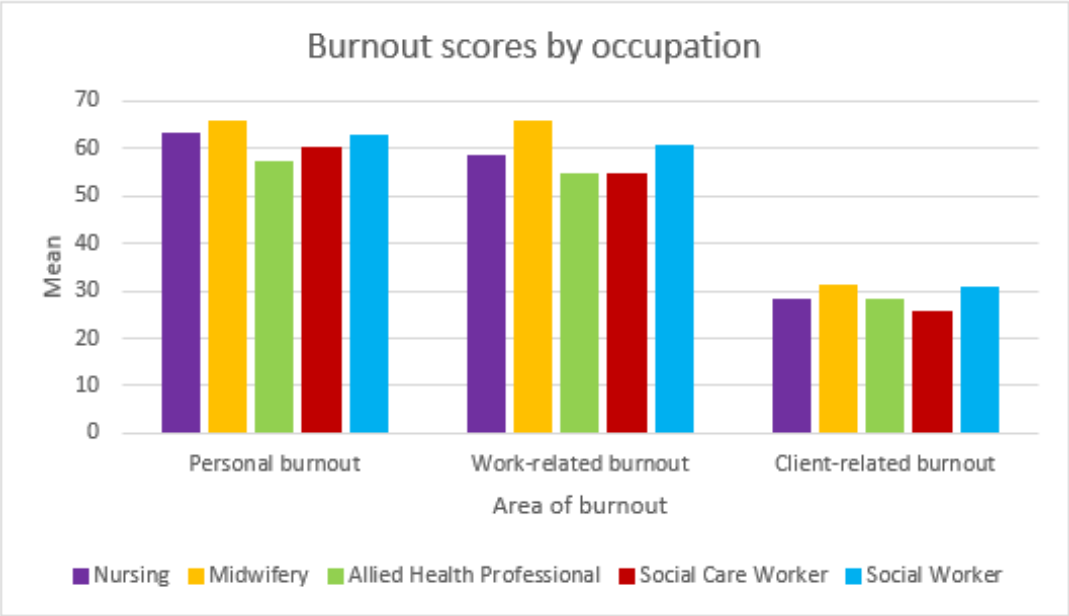

Figure A5.10: Mean Burnout Scores by Occupation (Unweighted)

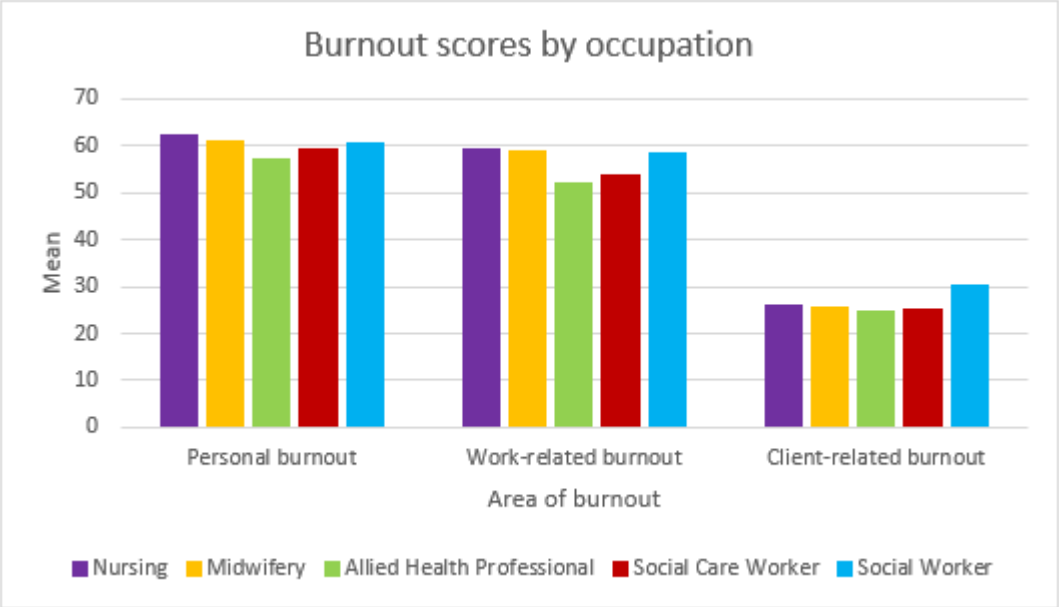

Table A5.5: Mean Burnout Scores by Occupation (Weighted)

	Occupation				
Burnout	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Personal burnout	63.32	65.73	57.32	59.98	62.87
Work-related burnout	58.61	65.78	54.77	54.49	60.63
Client-related burnout	28.19	31.02	28.01	25.58	30.68

Table A5.6: Mean Burnout Scores by Occupation (Unweighted)

	Occupation				
Burnout	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Personal burnout	62.11	60.98	57.02	59.09	60.76
Work-related burnout	59.18	58.93	52.06	53.55	58.38
Client-related burnout	25.85	25.73	24.51	25.19	30.19

Figure A5.11: Level of Personal Burnout by Occupation (Weighted)

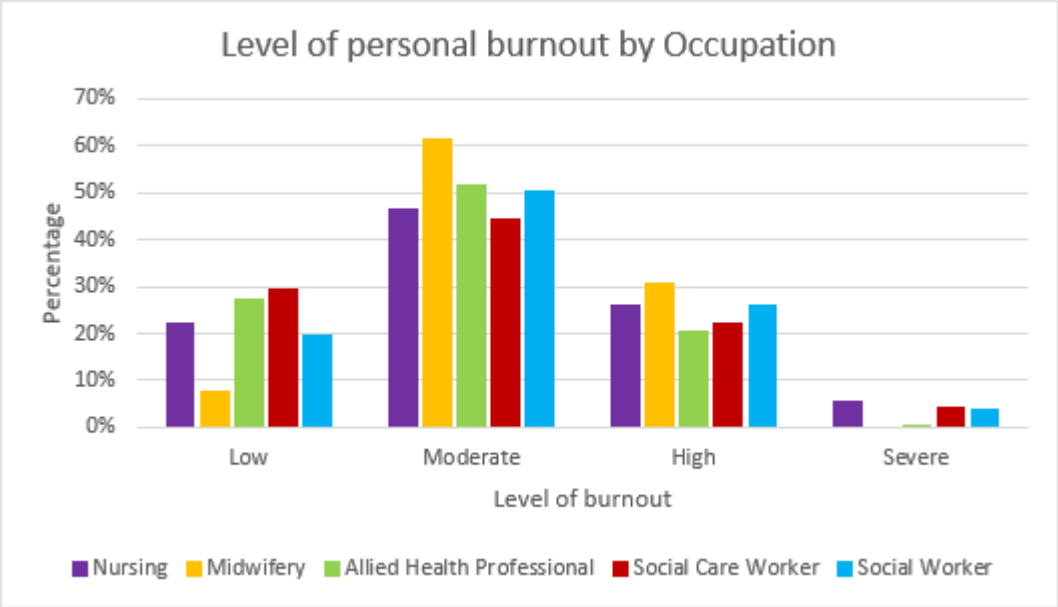

Figure A5.12: Level of Personal Burnout by Occupation (Unweighted)

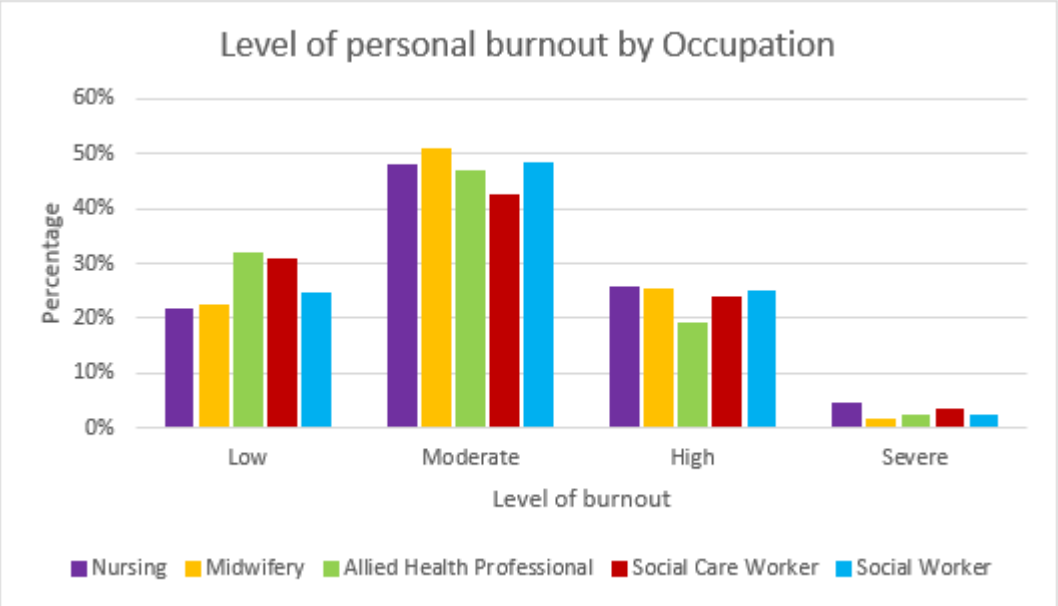

Figure A5.13: Level of Work-Related Burnout by Occupation (Weighted)

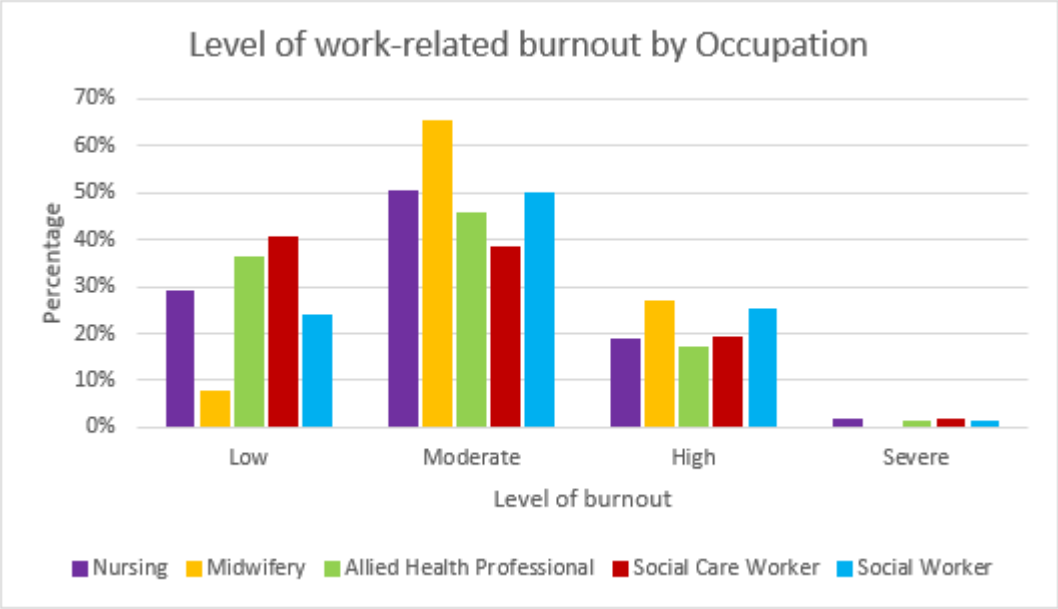

Figure A5.14: Level of Work-Related Burnout by Occupation (Unweighted)

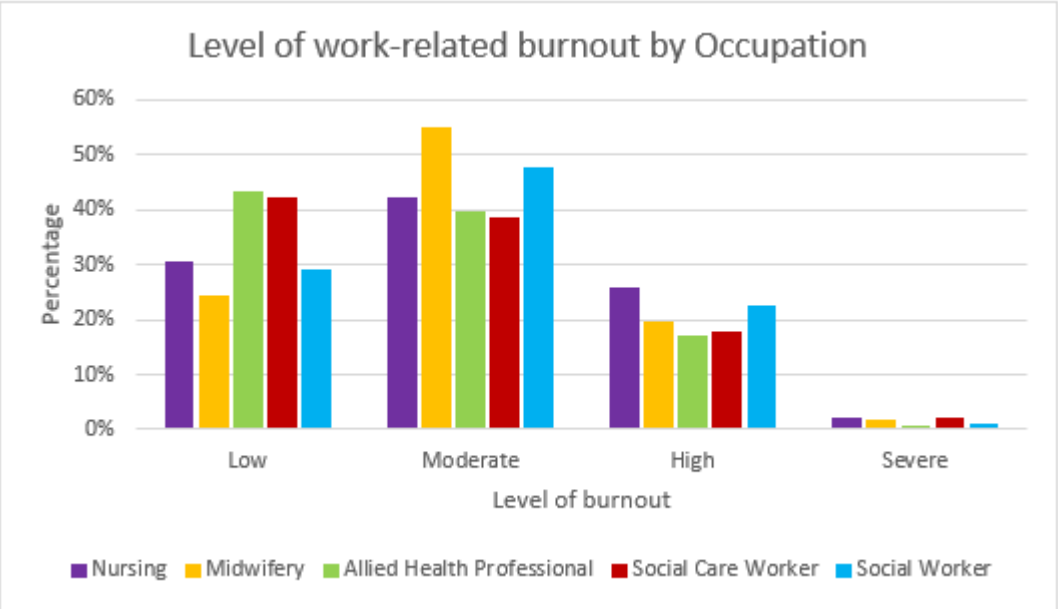

Figure A5.15: Level of Client-Related Burnout by Occupation (Weighted)

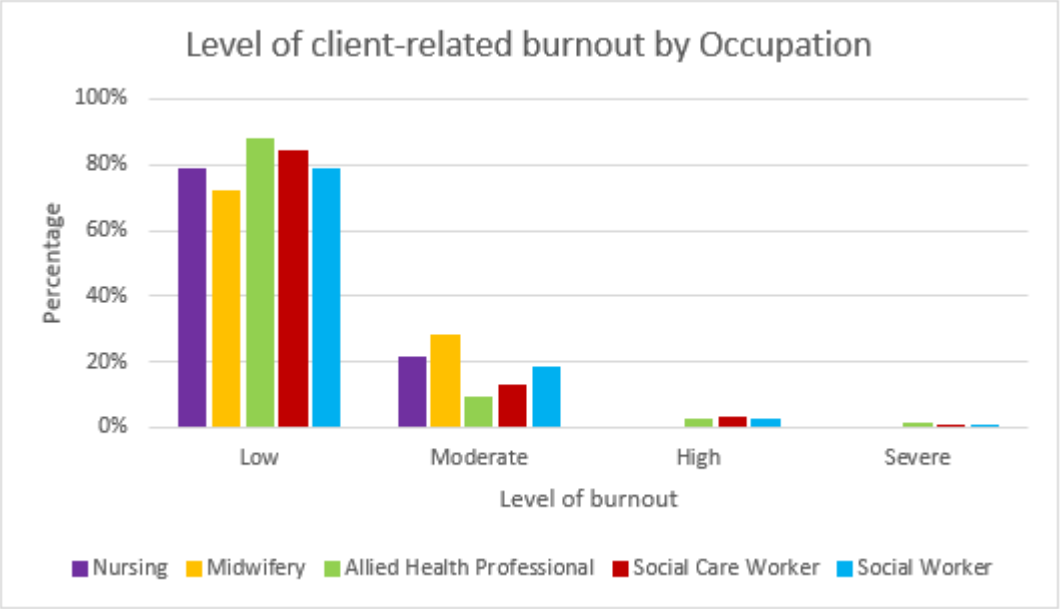

Figure A5.16: Level of Client-Related Burnout by Occupation (Unweighted)

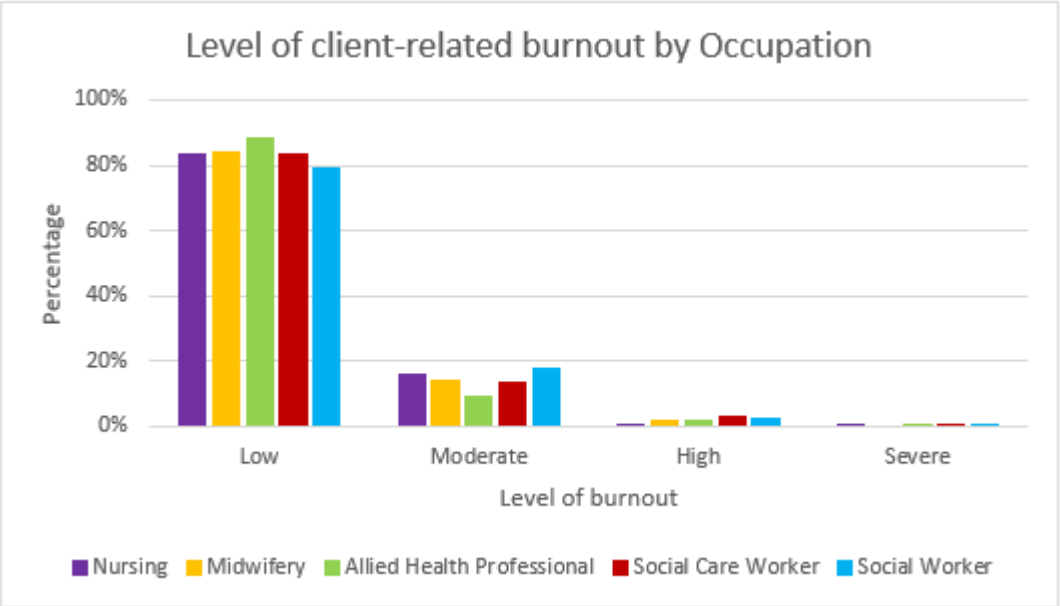

Table A5.7: Level of Burnout by Occupation (Weighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout:					
Low	22.1%	7.7%	27.4%	29.4%	19.6%
Moderate	46.7%	61.5%	51.7%	44.2%	50.5%
High	25.8%	30.8%	20.5%	22.0%	26.1%
Severe	5.5%	0.0%	0.4%	4.4%	3.7%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:					
Low	29.1%	7.7%	36.3%	40.5%	23.7%
Moderate	50.5%	65.4%	45.7%	38.5%	49.9%
High	18.7%	26.9%	17.0%	19.3%	25.1%
Severe	1.8%	0.0%	1.1%	1.7%	1.3%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:					
Low	78.7%	72.0%	87.8%	84.3%	78.8%
Moderate	21.3%	28.0%	8.8%	12.8%	18.5%
High	0.0%	0.0%	2.3%	2.8%	2.2%
Severe	0.0%	0.0%	1.1%	0.1%	0.6%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.8: Level of Burnout by Occupation (Unweighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout:					
Low	67 (21.8%)	14 (22.2%)	173 (31.7%)	327 (30.7%)	254 (24.7%)
Moderate	148 (48.1%)	32 (50.8%)	256 (46.9%)	451 (42.3%)	497 (48.3%)
High	79 (25.6%)	16 (25.4%)	104 (19.0%)	253 (23.8%)	256 (24.9%)
Severe	14 (4.5%)	1 (1.6%)	13 (2.4%)	34 (3.2%)	23 (2.2%)
TOTAL	**308 (100%)**	**63 (100%)**	**546 (100%)**	**1065 (100%)**	**1030 (100%)**
Work-related burnout:					
Low	93 (30.5%)	15 (24.2%)	229 (43.2%)	439 (42.0%)	295 (29.1%)
Moderate	128 (42.0%)	34 (54.8%)	209 (39.4%)	402 (38.5%)	482 (47.5%)
High	78 (25.6%)	12 (19.4%)	89 (16.8%)	184 (17.6%)	227 (22.4%)
Severe	6 (2.0%)	1 (1.6%)	3 (0.6%)	20 (1.9%)	10 (1.0%)
TOTAL	**305 (100%)**	**62 (100%)**	**530 (100%)**	**1045 (100%)**	**1014 (100%)**
Client-related burnout:					
Low	236 (83.4%)	48 (84.2%)	435 (88.6%)	790 (83.7%)	750 (79.4%)
Moderate	45 (15.9%)	8 (14.0%)	46 (9.4%)	126 (13.3%)	166 (17.6%)
High	1 (0.4%)	1 (1.8%)	9 (1.8%)	27 (2.9%)	24 (2.5%)
Severe	1 (0.4%)	0 (0.0%)	1 (0.2%)	1 (0.1%)	4 (0.4%)
TOTAL	**283 (100%)**	**57 (100%)**	**491 (100%)**	**944 (100%)**	**944 (100%)**

A5.3 Burnout Scores by Sex

Only three respondents in the full sample stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

There were significant differences between males and females in mean personal burnout scores ($t = 12.862$, $df = 3099$, $p < .001$). Specifically, females scored significantly higher than males.

There were also significant differences between males and females in mean work-related burnout scores ($t = 8.549$, $df = 3070$, $p < .001$). Females scored significantly higher than males.

Summary (Unweighted results):

There were significant differences between males and females in mean personal burnout scores ($t = 6.517$, $df = 3007$, $p < .001$). Specifically, females scored significantly higher than males.

There were also significant differences between males and females in mean work-related burnout scores ($t = 3.615$, $df = 2951$, $p < .001$). Females scored significantly higher than males.

Significant differences between males and females were also found in mean client-related burnout scores ($t = -3.767$, $df = 2715$, $p < .001$). Females scored significantly lower than males.

Figure A5.17: Mean Burnout Scores by Sex (Weighted)

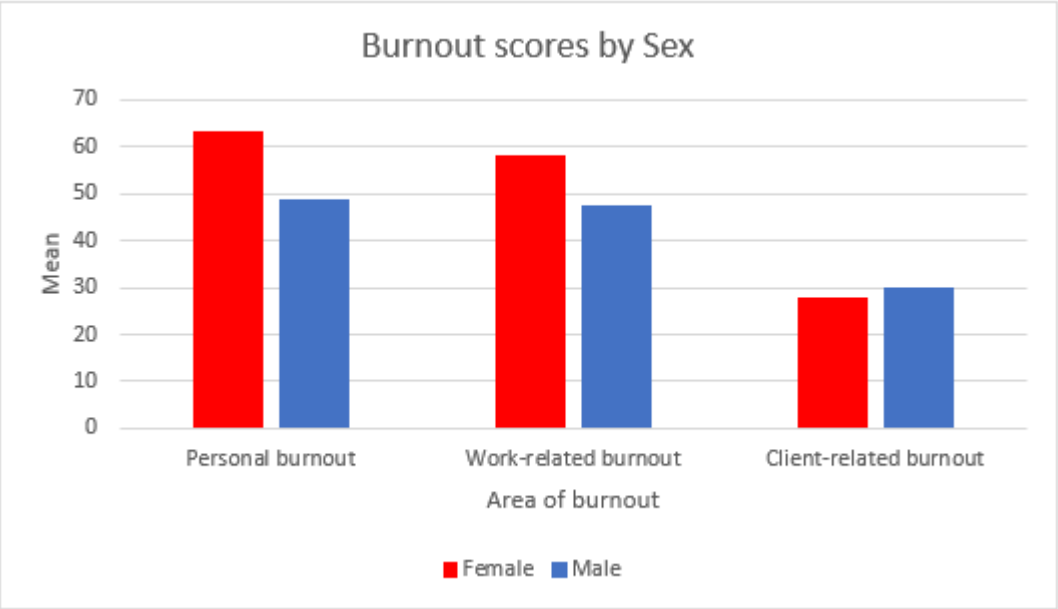

Figure A5.18: Mean Burnout Scores by Sex (Unweighted)

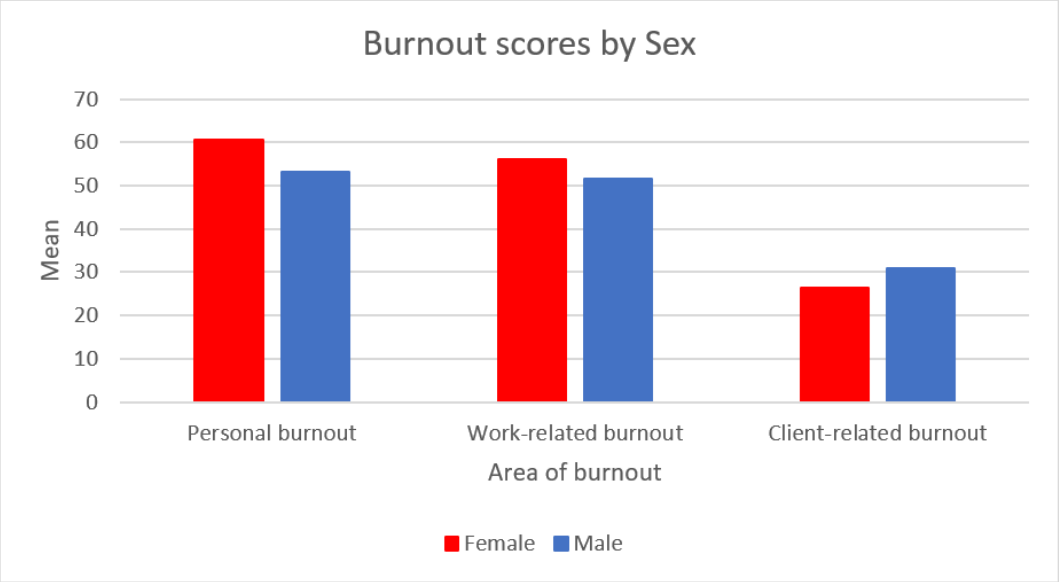

Table A5.9: Mean Burnout Scores by Sex (Weighted)

	Sex	
Burnout	**Female**	**Male**
Personal burnout	62.97	48.73
Work-related burnout	57.84	47.55
Client-related burnout	27.76	29.73

Table A5.10: Mean Burnout Scores by Sex (Unweighted)

	Sex	
Burnout	**Female**	**Male**
Personal burnout	60.48	53.14
Work-related burnout	56.13	51.69
Client-related burnout	26.34	30.97

Figure A5.19: Level of Personal Burnout by Sex (Weighted)

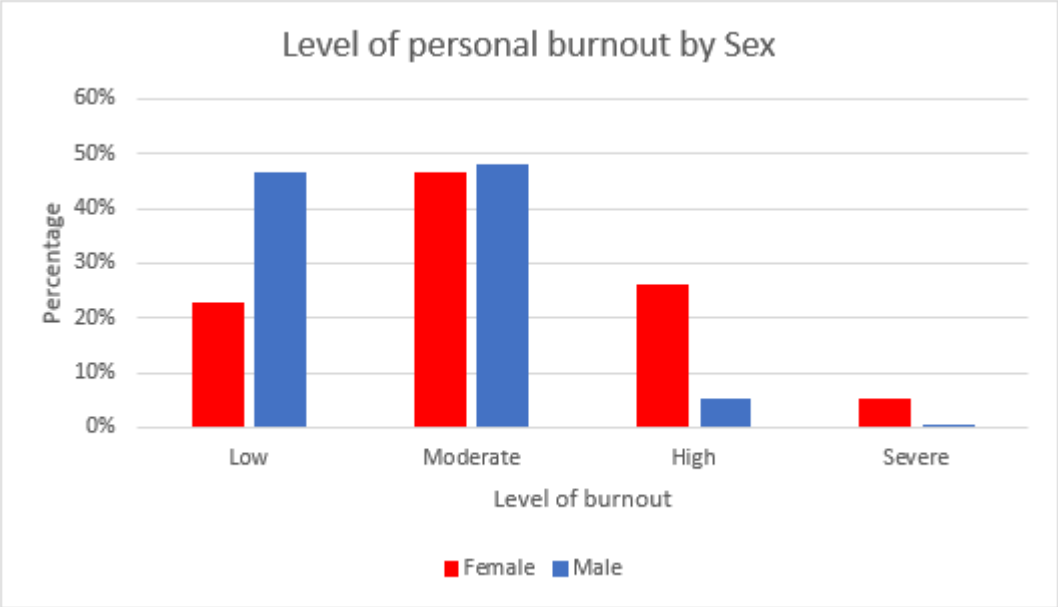

Figure A5.20: Level of Personal Burnout by Sex (Unweighted)

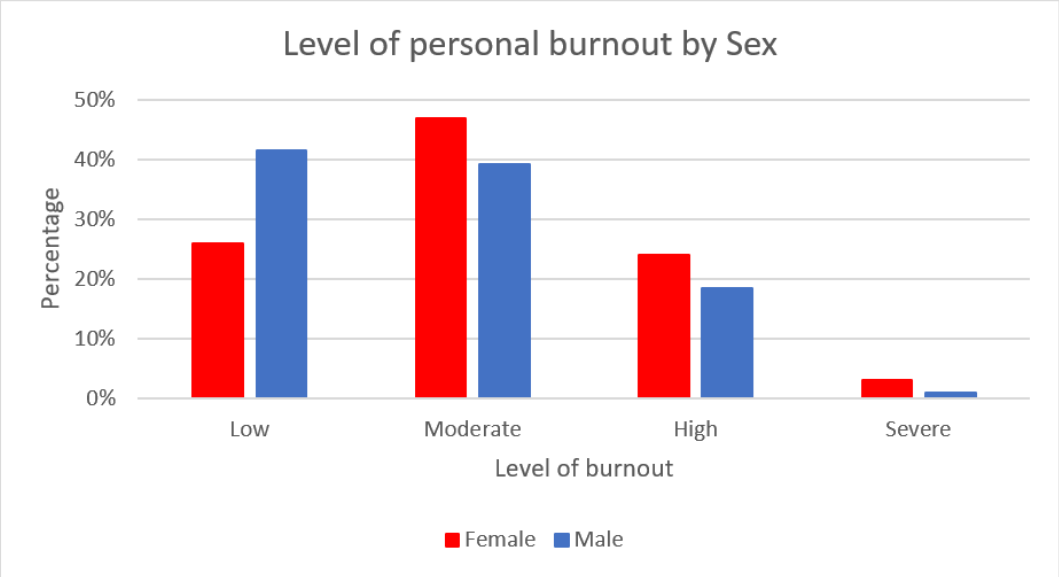

Figure A5.21: Level of Work-Related Burnout by Sex (Weighted)

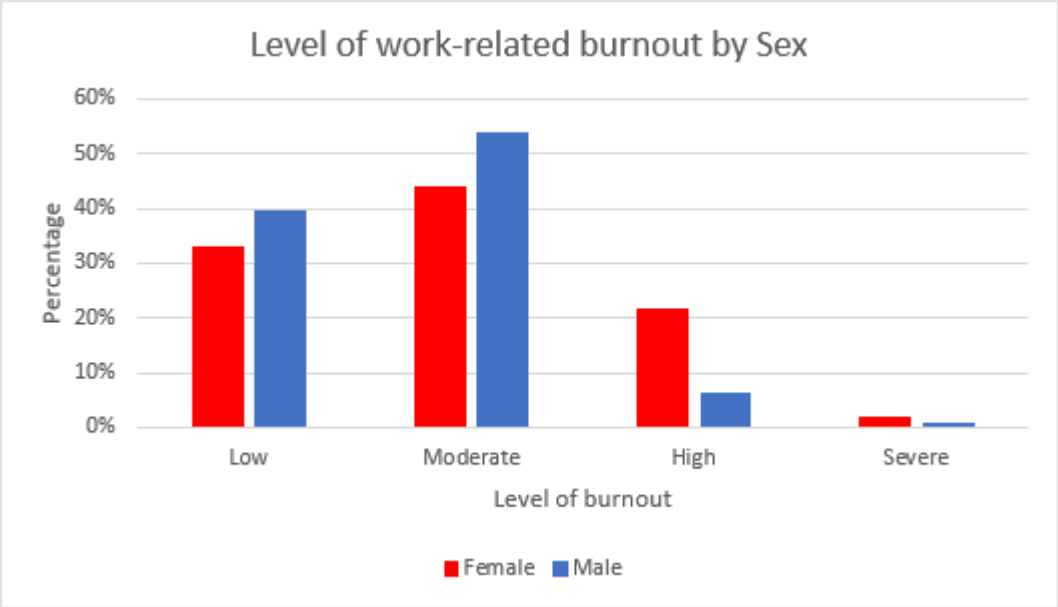

Figure A5.22: Level of Work-Related Burnout by Sex (Unweighted)

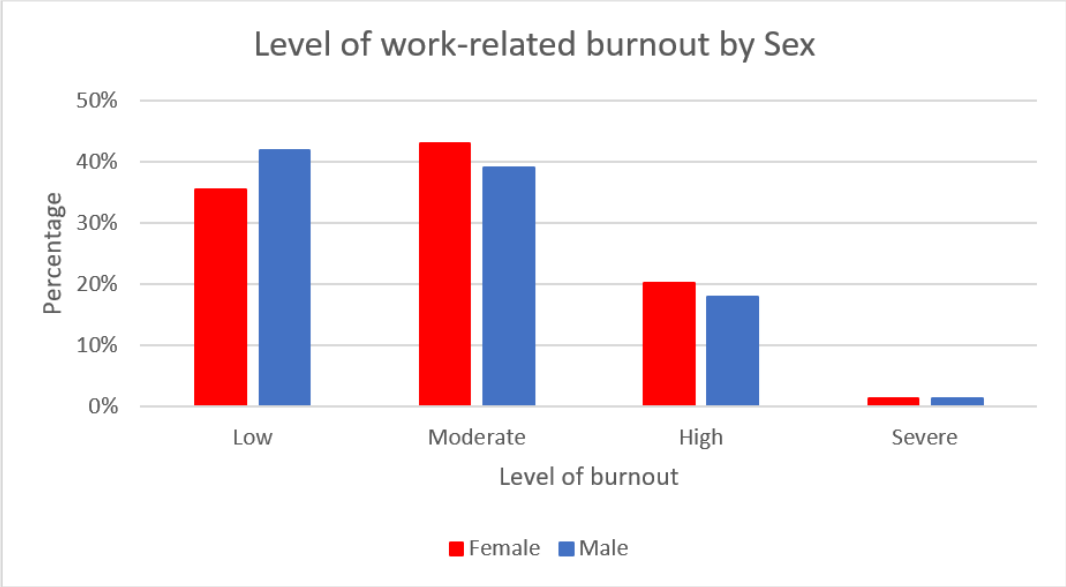

Figure A5.23: Level of Client-Related Burnout by Sex (Weighted)

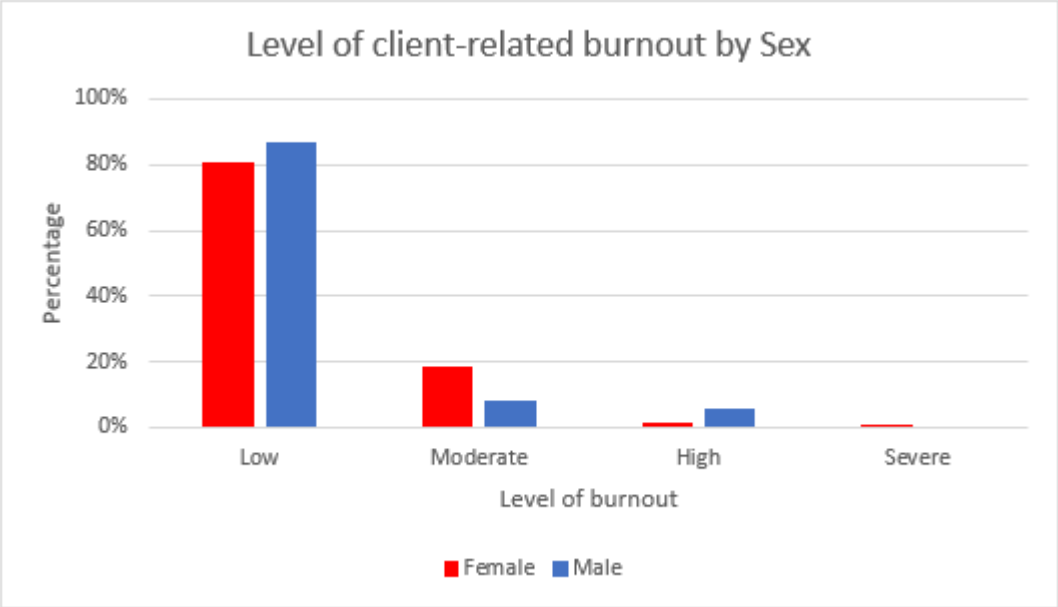

Figure A5.24: Level of Client-Related Burnout by Sex (Unweighted)

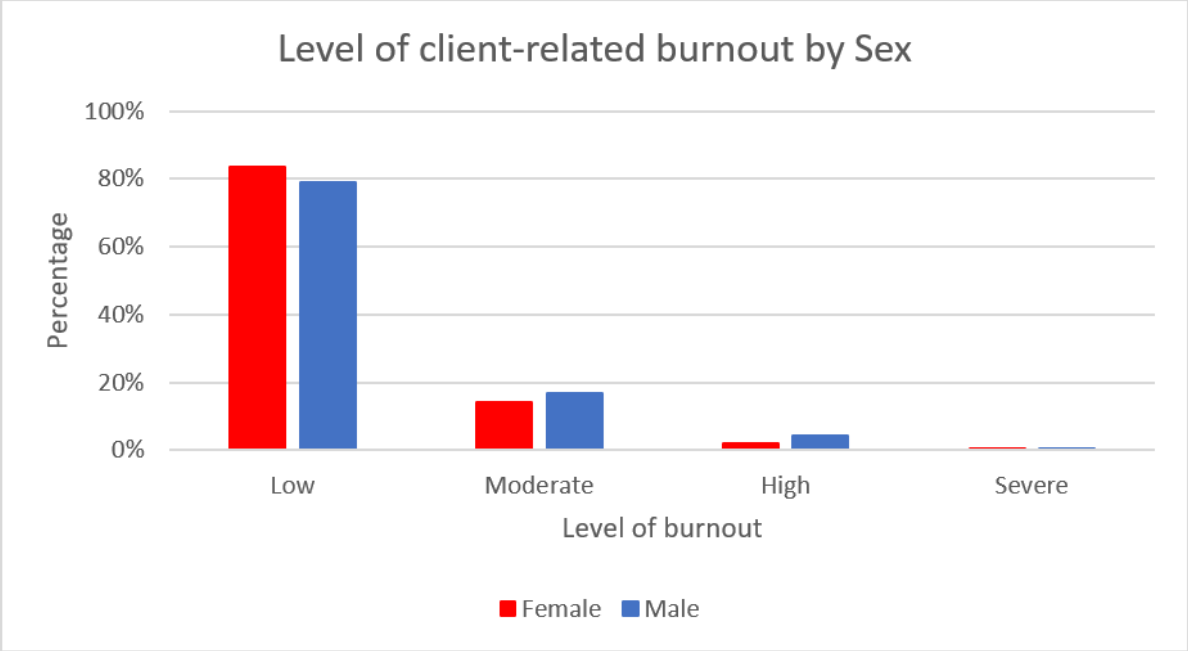

Table A5.11: Level of Burnout by Sex (Weighted)

Burnout	Sex	
	Female	Male
Personal burnout:		
Low	22.6%	46.6%
Moderate	46.3%	47.8%
High	26.0%	5.2%
Severe	5.1%	0.3%
TOTAL	**100%**	**100%**
Work-related burnout:		
Low	33.0%	39.6%
Moderate	43.9%	53.8%
High	21.4%	6.0%
Severe	1.8%	0.6%
TOTAL	**100%**	**100%**
Client-related burnout:		
Low	80.2%	86.8%
Moderate	18.2%	8.1%
High	1.4%	5.2%
Severe	0.2%	0.0%
TOTAL	**100%**	**100%**

Table A5.12: Level of Burnout by Sex (Unweighted)

Burnout	Sex	
	Male	Female
Personal burnout:		
Low	146 (41.5%)	689 (25.9%)
Moderate	138 (39.2%)	1245 (46.9%)
High	65 (18.5%)	641 (24.1%)
Severe	3 (0.9%)	82 (3.1%)
TOTAL	**352 (100%)**	**2657 (100%)**
Work-related burnout:		
Low	145 (41.8%)	926 (35.5%)
Moderate	135 (38.9%)	1119 (42.9%)
High	62 (17.9%)	526 (20.2%)
Severe	5 (1.4%)	35 (1.3%)
TOTAL	**347 (100%)**	**2606 (100%)**
Client-related burnout:		
Low	252 (78.8%)	2006 (83.7%)
Moderate	53 (16.6%)	337 (14.1%)
High	13 (4.1%)	49 (2.0%)
Severe	2 (0.6%)	5 (0.2%)
TOTAL	**320 (100%)**	**2397 (100%)**

A5.4 Burnout Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean personal burnout scores ($F = 36.018$, $df = 6$, $p < .001$). Specifically, the 66+ age group scored significantly lower than all the other age groups except for the 16-19 age group; the 60-65 age group scored significantly lower than the 20-29, 30-39, 40-49 and the 50-59 age group; the 50-59 age group scored significantly lower than the 16-19, 30-39 and the 40-49 age groups; the 16-19 age group scored significantly lower than the 20-29, 30-39 and the 40-49 age groups; and the 20-29 age group scored significantly lower than the 30-39 age group.

There were also significant differences between the age groups in mean work-related burnout scores ($F = 35.445$, $df = 6$, $p < .001$). Specifically, the 66+ age group scored significantly lower than the all the other age groups except for the 16-19 age group; the 60-65 age group scored significantly lower than the 20-29, 30-39, 40-49 and the 50-59 age group; the 50-59 age group scored significantly lower than the 30-39 and the 40-49 age groups; the 40-49 age group scored significantly lower than the 30-39 age group; and the 20-29 age group also scored significantly lower than the 30-39 age group.

Summary (Unweighted results):

There were significant differences between the age groups in mean personal burnout scores ($F = 16.068$, $df = 6$, $p < .001$). Specifically, the 50-59, 60-65 and the 66+ age groups all scored significantly lower than the younger age categories (16-49); and the 66+ age group also scored significantly lower than the 50-59 and the 60-65 age categories.

There were also significant differences between the age groups in mean work-related burnout scores ($F = 13.136$, $df = 6$, $p < .001$). The 50-59, 60-65 and the 66+ age groups scored significantly lower than the 20-29, 30-39 and the 40-49 age groups; and the 66+ age group also scored significantly lower than the 16-19 and the 50-59 age groups.

Significant differences between the age groups were also found in mean client-related burnout scores ($F = 5.115$, $df = 6$, $p < .001$). Specifically, the 50-59 age group scored significantly lower than the 20-29 and the 30-39 age groups; and the 60-65 age group scored significantly lower than the 20-29 age group.

Figure A5.25: Mean Burnout Scores by Age (Weighted)

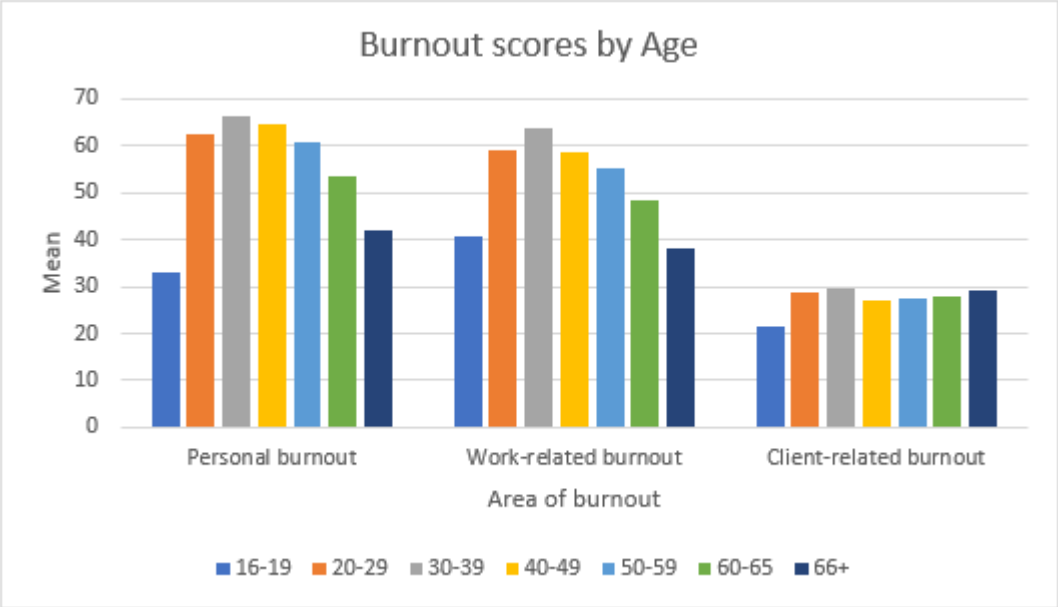

Figure A5.26: Mean Burnout Scores by Age (Unweighted)

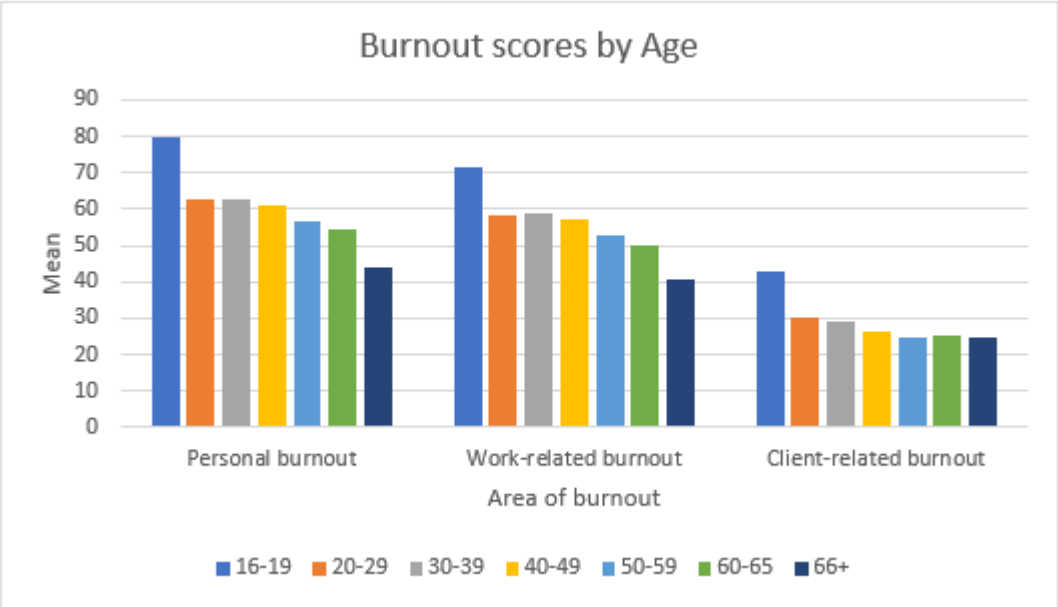

Table A5.13: Mean Burnout Scores by Age (Weighted)

	Age						
Burnout	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Personal burnout	33.10	62.33	66.41	64.62	60.64	53.55	42.05
Work-related burnout	40.81	58.89	63.60	58.86	55.41	48.51	38.14
Client-related burnout	21.68	28.85	29.76	26.94	27.32	28.10	29.38

Note. There were only six respondents in the 16-19 age group.

Table A5.14: Mean Burnout Scores by Age (Unweighted)

Burnout	Age						
	16-19	20-29	30-39	40-49	50-59	60-65	66+
Personal burnout	79.69	62.51	62.68	61.17	56.60	54.63	44.26
Work-related burnout	71.43	58.19	58.84	57.14	52.80	50.18	40.44
Client-related burnout	42.71	30.50	28.99	26.30	24.89	25.05	24.83

Note. There were only eight respondents in the 16-19 age group.

Figure A5.27: Level of Personal Burnout by Age (Weighted)

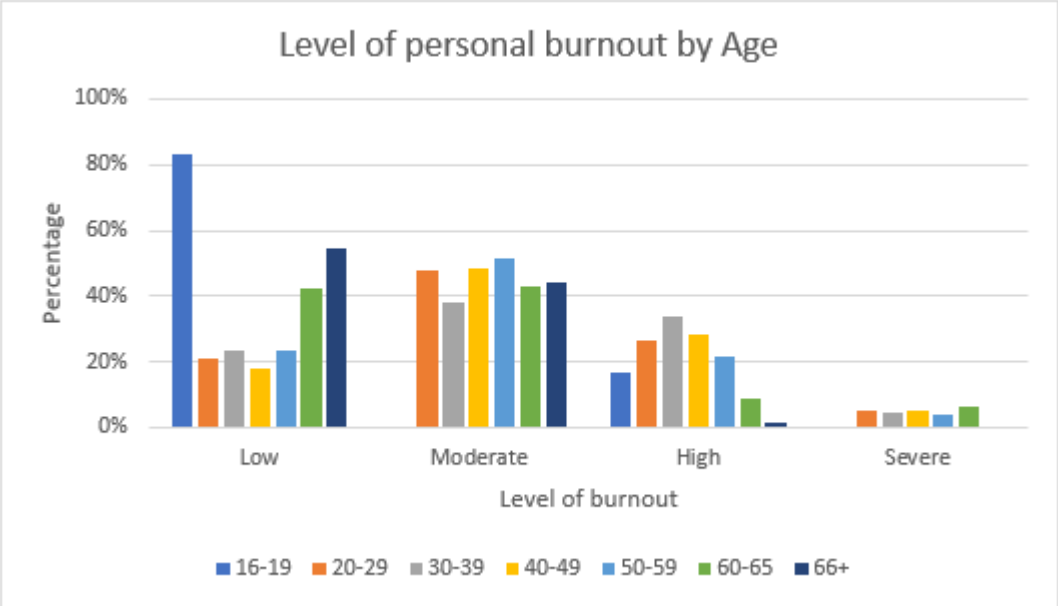

Figure A5.28: Level of Personal Burnout by Age (Unweighted)

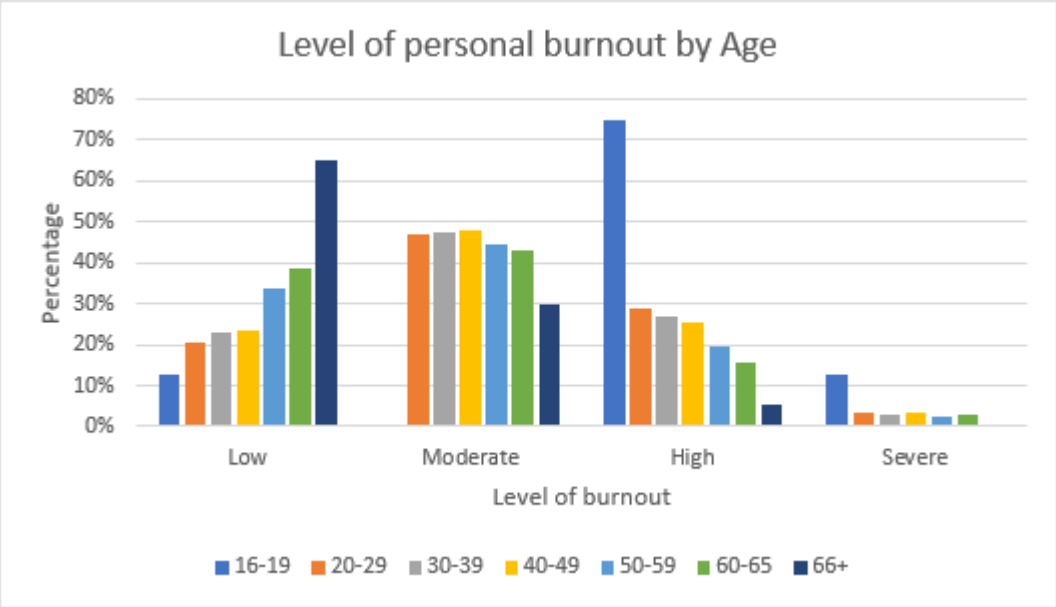

Figure A5.29: Level of Work-Related Burnout by Age (Weighted)

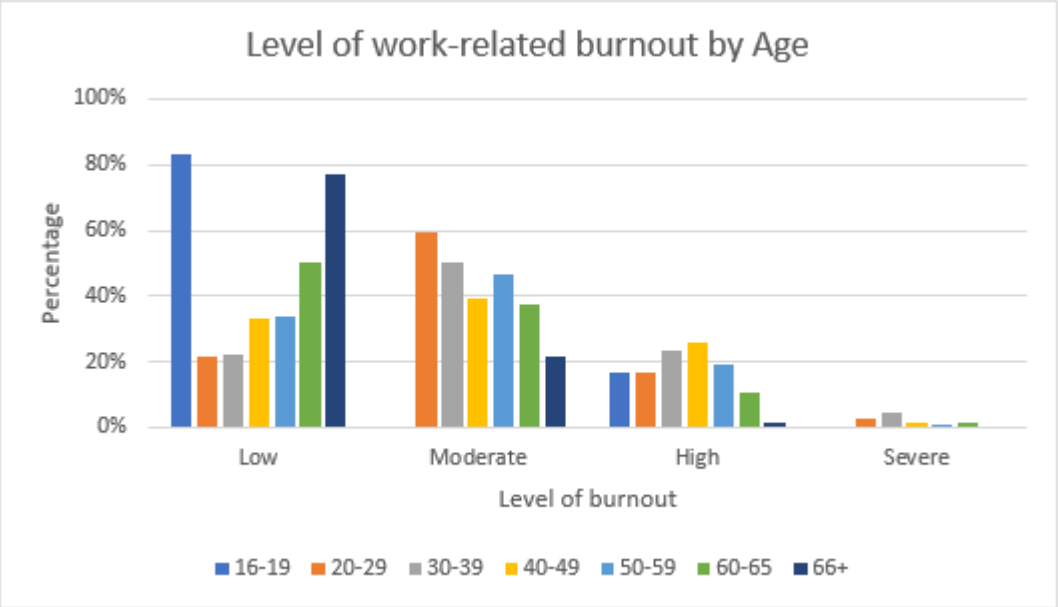

Figure A5.30: Level of Work-Related Burnout by Age (Unweighted)

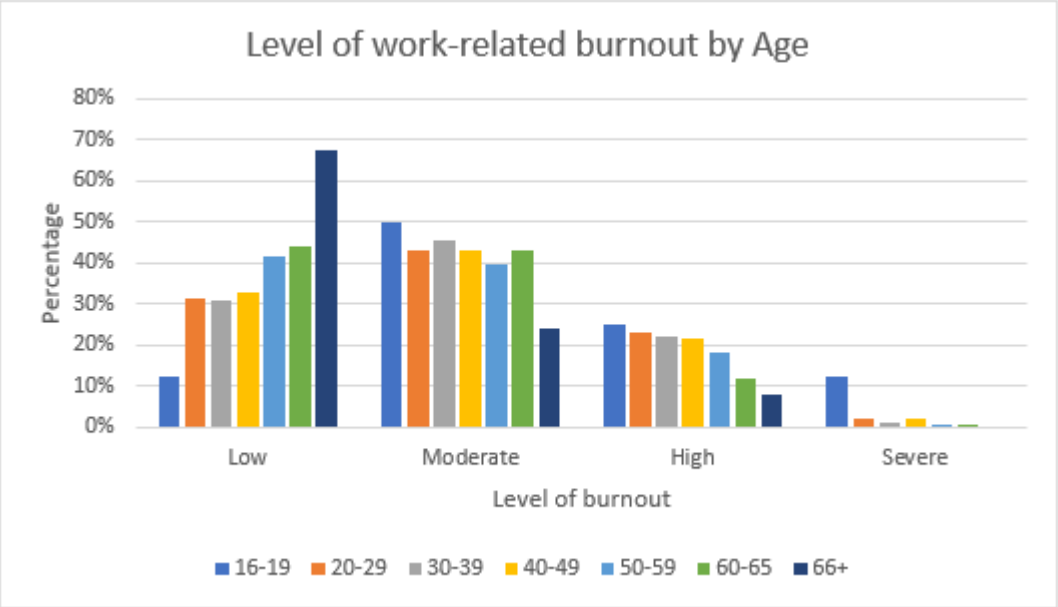

Figure A5.31: Level of Client-Related Burnout by Age (Weighted)

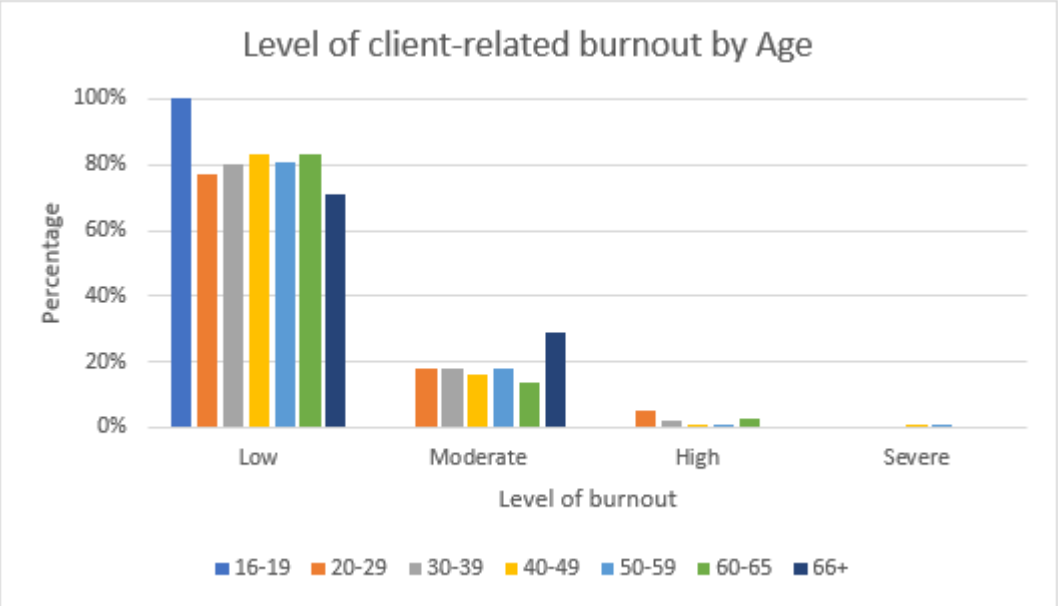

Figure A5.32: Level of Client-Related Burnout by Age (Unweighted)

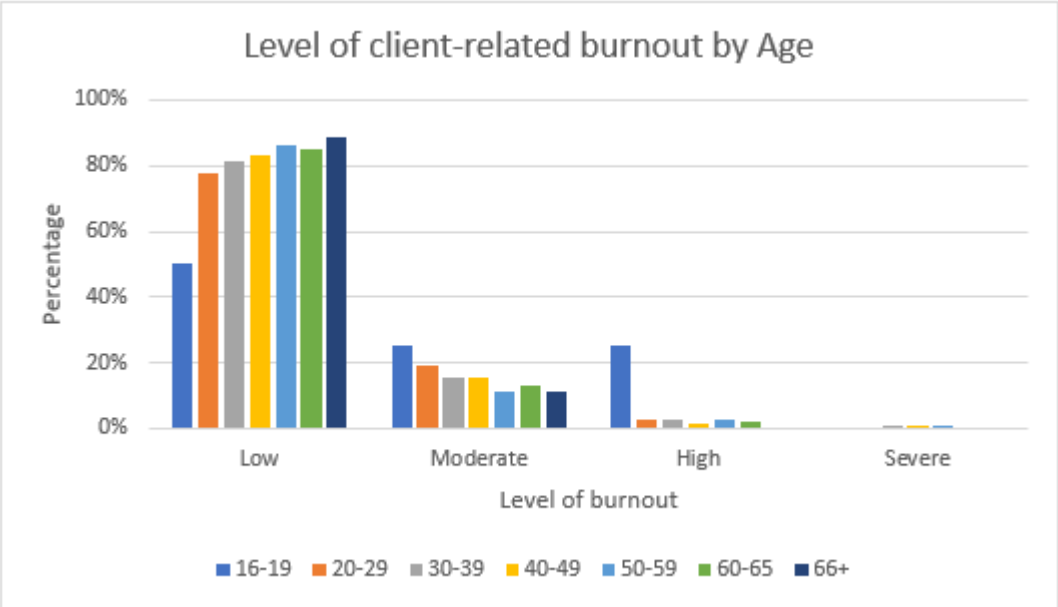

Table A5.15: Level of Burnout by Age (Weighted)

Burnout	Age						
	16-19	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Personal burnout:							
Low	83.3%	20.8%	23.5%	18.1%	23.1%	42.3%	54.5%
Moderate	0.0%	47.8%	37.9%	48.7%	51.7%	42.8%	43.9%
High	16.7%	26.6%	33.9%	28.4%	21.4%	8.5%	1.5%
Severe	0.0%	4.8%	4.7%	4.8%	3.9%	6.4%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:							
Low	83.3%	21.4%	22.4%	33.3%	33.8%	50.2%	76.9%
Moderate	0.0%	59.2%	50.2%	39.4%	46.7%	37.6%	21.5%
High	16.7%	16.8%	23.3%	25.7%	19.4%	10.8%	1.5%
Severe	0.0%	2.6%	4.2%	1.6%	0.1%	1.4%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:							
Low	100%	77.1%	80.1%	82.9%	80.9%	83.3%	70.8%
Moderate	0.0%	18.2%	17.9%	15.9%	17.9%	13.9%	29.2%
High	0.0%	4.8%	2.0%	0.6%	1.1%	2.9%	0.0%
Severe	0.0%	0.0%	0.0%	0.6%	0.1%	0.0%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Note. There were only six respondents in the 16-19 age group.

Table A5.16: Level of Burnout by Age (Unweighted)

Burnout	Age						
	16-19	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Personal burnout:							
Low	1 (12.5%)	69 (20.7%)	163 (23.0%)	184 (23.4%)	301 (33.7%)	93 (38.4%)	24 (64.9%)
Moderate	0 (0.0%)	157 (47.0%)	337 (47.5%)	377 (47.9%)	398 (44.5%)	104 (43.0%)	11 (29.7%)
High	6 (75.0%)	96 (28.7%)	191 (26.9%)	200 (25.4%)	175 (19.6%)	38 (15.7%)	2 (5.4%)
Severe	1 (12.5%)	12 (3.6%)	19 (2.7%)	26 (3.3%)	20 (2.2%)	7 (2.9%)	0 (0.0%)
TOTAL	**8 (100%)**	**334 (100%)**	**710 (100%)**	**787 (100%)**	**894 (100%)**	**242 (100%)**	**37 (100%)**
Work-related burnout:							
Low	1 (12.5%)	103 (31.5%)	214 (30.8%)	256 (33.1%)	366 (41.7%)	106 (44.2%)	25 (67.6%)
Moderate	4 (50.0%)	141 (43.1%)	318 (45.8%)	334 (43.2%)	346 (39.5%)	103 (42.9%)	9 (24.3%)
High	2 (25.0%)	76 (23.2%)	153 (22.0%)	166 (21.5%)	161 (18.4%)	29 (12.1%)	3 (8.1%)
Severe	1 (12.5%)	7 (2.1%)	9 (1.3%)	17 (2.2%)	4 (0.5%)	2 (0.8%)	0 (0.0%)
TOTAL	**8 (100%)**	**327 (100%)**	**694 (100%)**	**773 (100%)**	**877 (100%)**	**240 (100%)**	**37 (100%)**
Client-related burnout:							
Low	4 (50.0%)	231 (78.0%)	510 (81.2%)	592 (82.9%)	699 (86.0%)	192 (85.3%)	31 (88.6%)
Moderate	2 (25.0%)	57 (19.3%)	98 (15.6%)	110 (15.4%)	91 (11.2%)	29 (12.9%)	4 (11.4%)
High	2 (25.0%)	8 (2.7%)	18 (2.9%)	10 (1.4%)	20 (2.5%)	4 (1.8%)	0 (0.0%)
Severe	0 (0.0%)	0 (0.0%)	2 (0.3%)	2 (0.3%)	3 (0.4%)	0 (0.0%)	0 (0.0%)
TOTAL	**8 (100%)**	**296 (100%)**	**628 (100%)**	**714 (100%)**	**813 (100%)**	**225 (100%)**	**35 (100%)**

A5.5 Burnout Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean personal burnout scores ($F = 16.196$, $df = 3$, $p < .001$). Specifically, the black ethnic group scored significantly lower than all other groups; and the white ethnic group scored significantly lower than the Asian group.

There were also significant differences between the ethnic groups in mean work-related burnout scores ($F = 7.078$, $df = 3$, $p < .001$). Specifically, the Asian ethnic group scored significantly higher than all the other ethnic groups.

Summary (Unweighted results):

There were no significant differences between the ethnic groups in any areas of burnout.

Figure A5.33: Mean Burnout Scores by Ethnicity (Weighted)

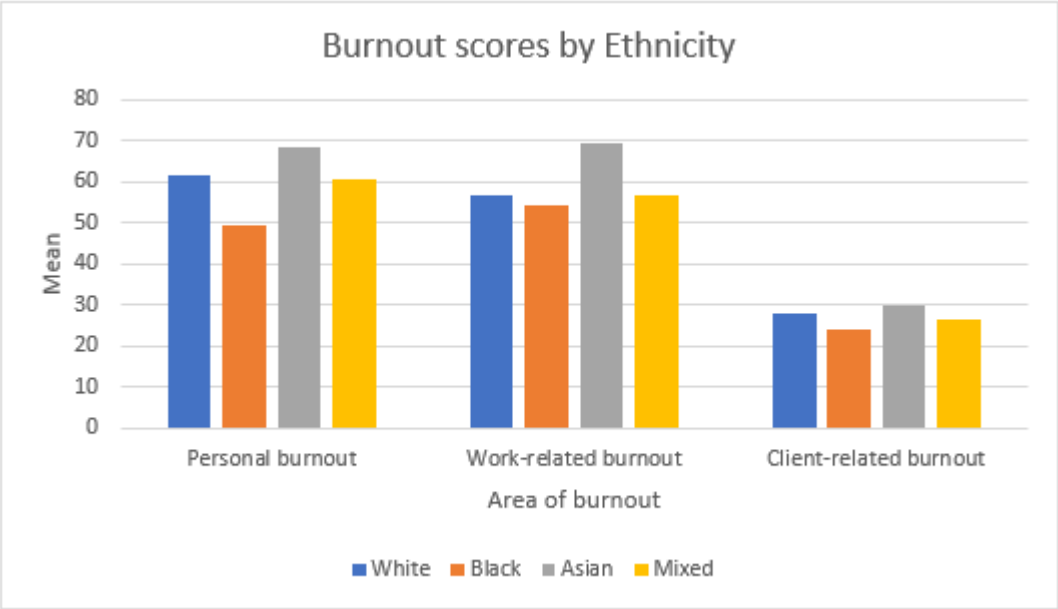

Figure A5.34: Mean Burnout Scores by Ethnicity (Unweighted)

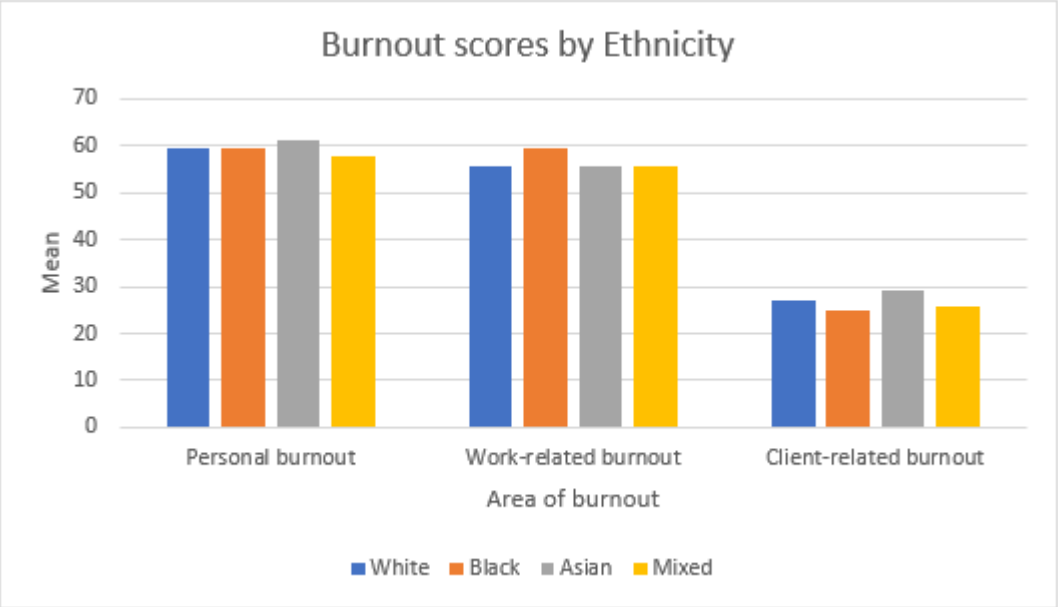

Table A5.17: Mean Burnout Scores by Ethnicity (Weighted)

	Ethnicity			
Burnout	**White**	**Black**	**Asian**	**Mixed**
Personal burnout	61.69	49.37	68.50	60.71
Work-related burnout	56.58	54.48	69.24	56.71
Client-related burnout	28.12	24.09	29.78	26.47

Table A5.18: Mean Burnout Scores by Ethnicity (Unweighted)

	Ethnicity			
Burnout	**White**	**Black**	**Asian**	**Mixed**
Personal burnout	59.69	59.40	61.25	57.96
Work-related burnout	55.60	59.44	55.57	55.63
Client-related burnout	26.89	25.06	29.32	25.79

Figure A5.35: Level of Personal Burnout by Ethnicity (Weighted)

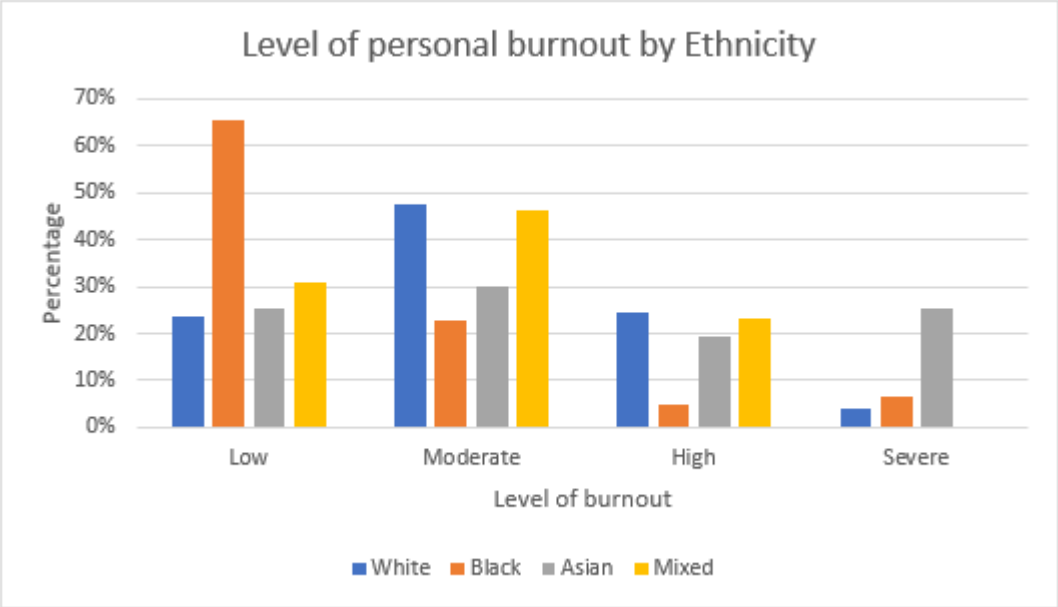

Figure A5.36: Level of Personal Burnout by Ethnicity (Unweighted)

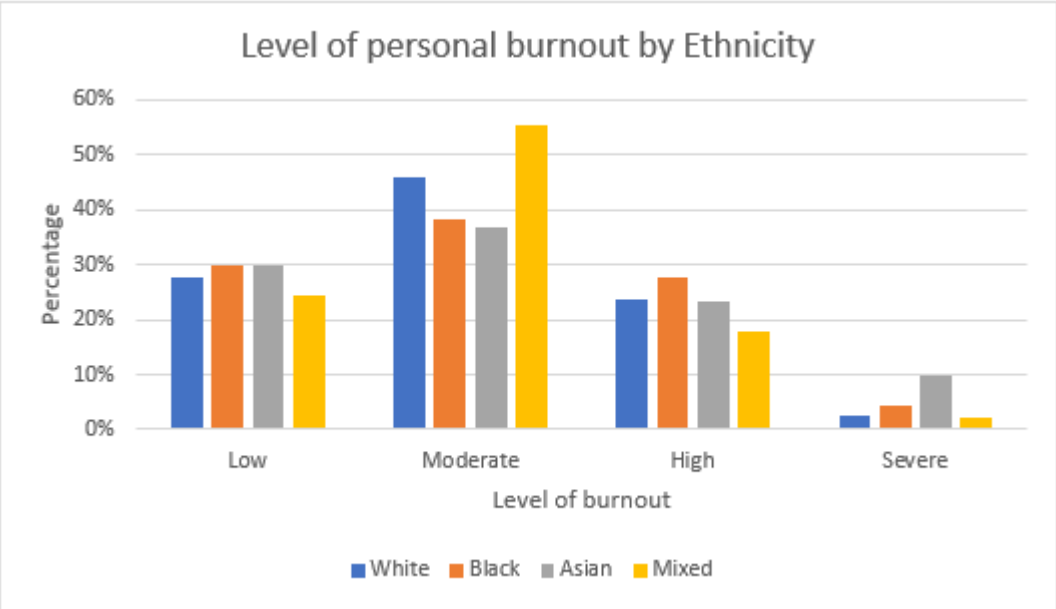

Figure A5.37: Level of Work-Related Burnout by Ethnicity (Weighted)

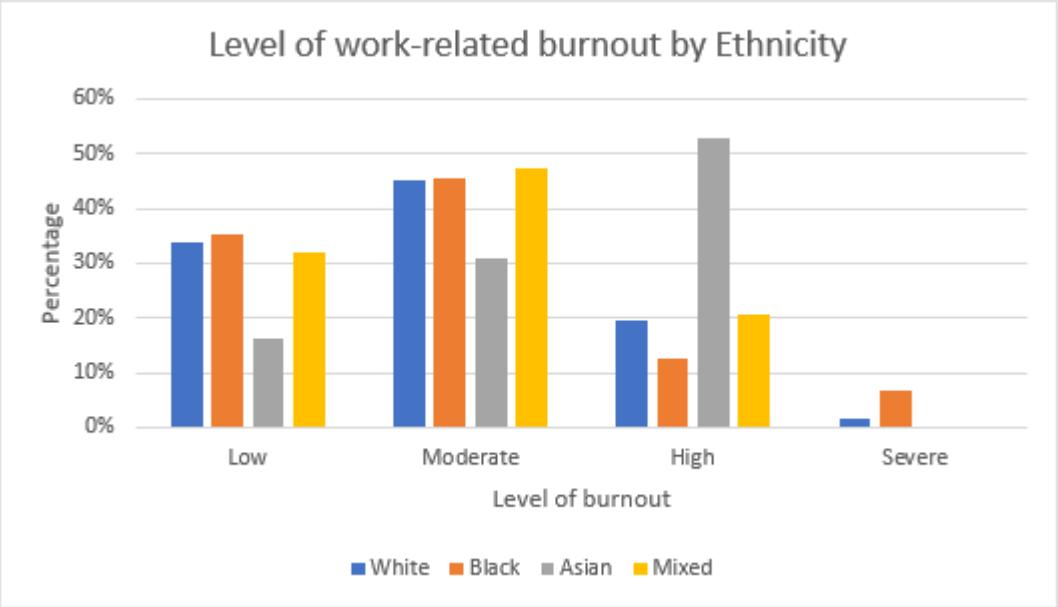

Figure A5.38: Level of Work-Related Burnout by Ethnicity (Unweighted)

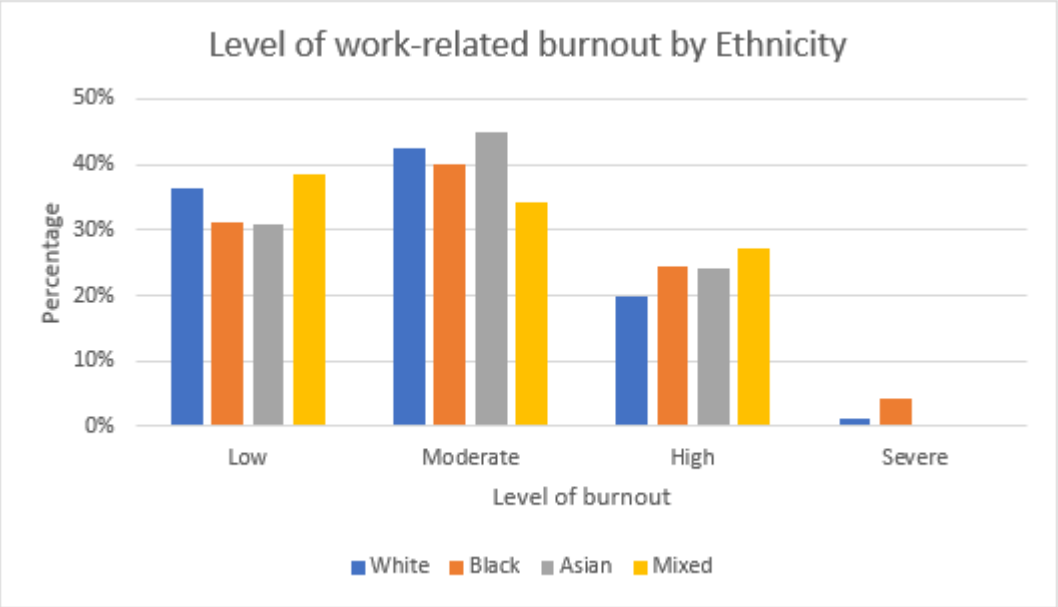

Figure A5.39: Level of Client-Related Burnout by Ethnicity (Weighted)

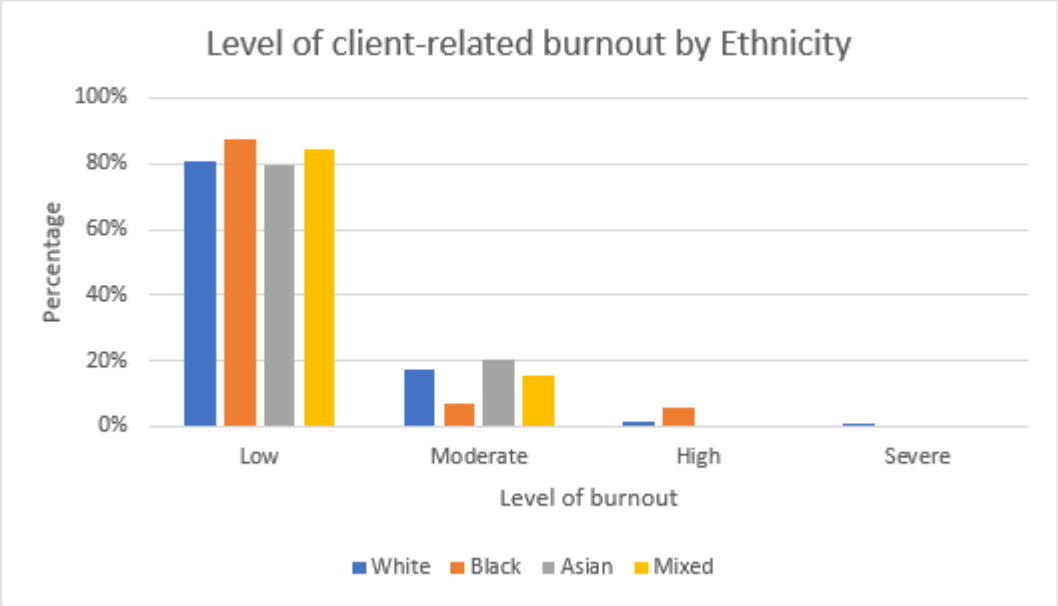

Figure A5.40: Level of Client-Related Burnout by Ethnicity (Unweighted)

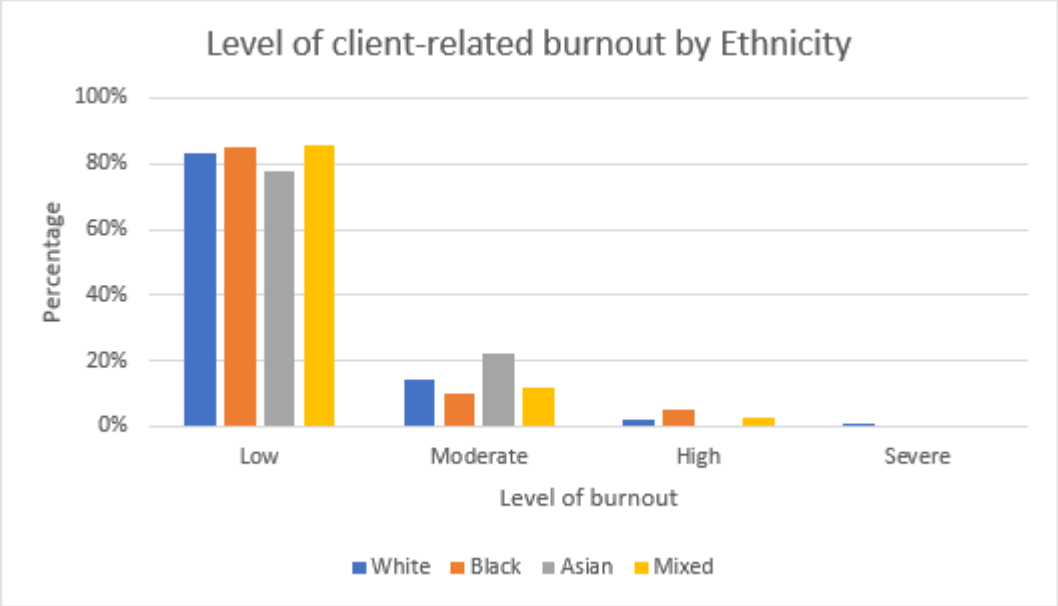

Table A5.19: Level of Burnout by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout:				
Low	23.7%	65.7%	25.4%	30.8%
Moderate	47.7%	22.9%	29.9%	46.2%
High	24.5%	4.8%	19.4%	23.1%
Severe	4.1%	6.7%	25.4%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**
Work-related burnout:				
Low	33.9%	35.2%	16.4%	32.1%
Moderate	45.2%	45.7%	30.9%	47.2%
High	19.4%	12.4%	52.7%	20.8%
Severe	1.5%	6.7%	0.0%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**
Client-related burnout:				
Low	80.6%	87.5%	79.5%	84.6%
Moderate	17.5%	6.7%	20.5%	15.4%
High	1.7%	5.8%	0.0%	0.0%
Severe	0.2%	0.0%	0.0%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**

Table A5.20: Level of Burnout by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout:				
Low	796 (27.6%)	14 (29.8%)	9 (30.0%)	11 (24.4%)
Moderate	1329 (46.1%)	18 (38.3%)	11 (36.7%)	25 (55.6%)
High	680 (23.6%)	13 (27.7%)	7 (23.3%)	8 (17.8%)
Severe	79 (2.7%)	2 (4.3%)	3 (10.0%)	1 (2.2%)
TOTAL	**2884 (100%)**	**47 (100%)**	**30 (100%)**	**45 (100%)**
Work-related burnout:				
Low	1027 (36.3%)	14 (31.1%)	9 (31.0%)	17 (38.6%)
Moderate	1207 (42.6%)	18 (40.0%)	13 (44.8%)	15 (34.1%)
High	560 (19.8%)	11 (24.4%)	7 (24.1%)	12 (27.3%)
Severe	38 (1.3%)	2 (4.4%)	0 (0.0%)	0 (0.0%)
TOTAL	**2832 (100%)**	**45 (100%)**	**29 (100%)**	**44 (100%)**
Client-related burnout:				
Low	2164 (83.1%)	34 (85.0%)	21 (77.8%)	36 (85.7%)
Moderate	375 (14.4%)	4 (10.0%)	6 (22.2%)	5 (11.9%)
High	59 (2.3%)	2 (5.0%)	0 (0.0%)	1 (2.4%)
Severe	7 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
TOTAL	**2605 (100%)**	**40 (100%)**	**27 (100%)**	**42 (100%)**

A5.6 Burnout Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in mean personal burnout scores ($F = 35.033$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who had a disability and those who were not sure of whether or not they had a disability.

There were also significant differences between respondents based on their disability status in mean work-related burnout scores ($F = 20.534$, $df = 2$, $p < .001$). Those who did not have a disability scored significantly lower than the other two groups; and those who had a disability scored significantly lower than those who were not sure whether or not they had a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean personal burnout scores ($F = 45.160$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who did have a disability and those who were unsure of whether or not they had a disability.

There were also significant differences between respondents based on their disability status in mean work-related burnout scores ($F = 20.636$, $df = 2$, $p < .001$). Those who did not have a disability scored significantly lower than the other two groups.

Significant differences between respondents based on their disability status were also found in mean client-related burnout scores ($F = 7.384$, $df = 2$, $p = .001$). Those who did not have a disability scored significantly lower than the other two groups.

Figure A5.41: Mean Burnout Scores by Disability (Weighted)

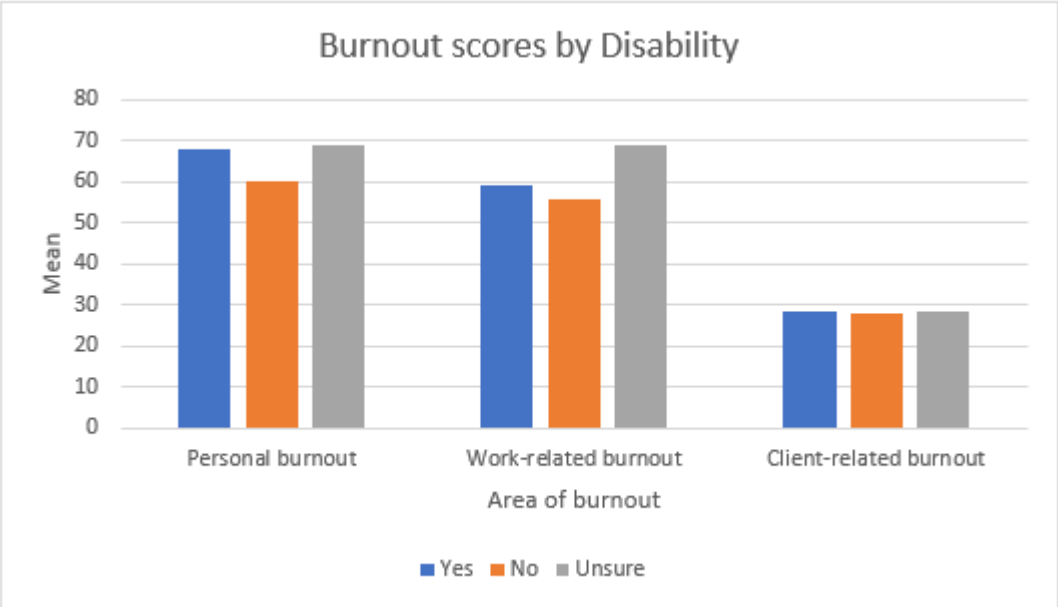

Figure A5.42: Mean Burnout Scores by Disability (Unweighted)

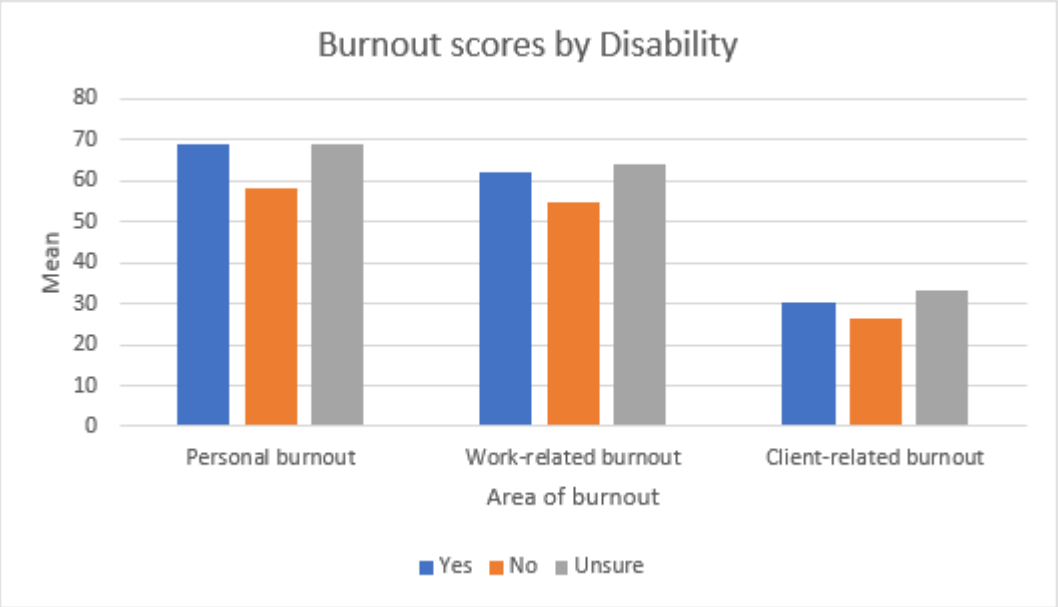

Table A5.21: Mean Burnout Scores by Disability (Weighted)

	Do you consider yourself to have a disability?		
Burnout	**Yes**	**No**	**Unsure**
Personal burnout	67.85	60.10	69.09
Work-related burnout	59.21	55.91	69.19
Client-related burnout	28.62	27.85	28.48

Table A5.22: Mean Burnout Scores by Disability (Unweighted)

	Do you consider yourself to have a disability?		
Burnout	**Yes**	**No**	**Unsure**
Personal burnout	68.74	58.36	68.83
Work-related burnout	61.90	54.70	64.16
Client-related burnout	30.15	26.33	33.47

Figure A5.43: Level of Personal Burnout by Disability (Weighted)

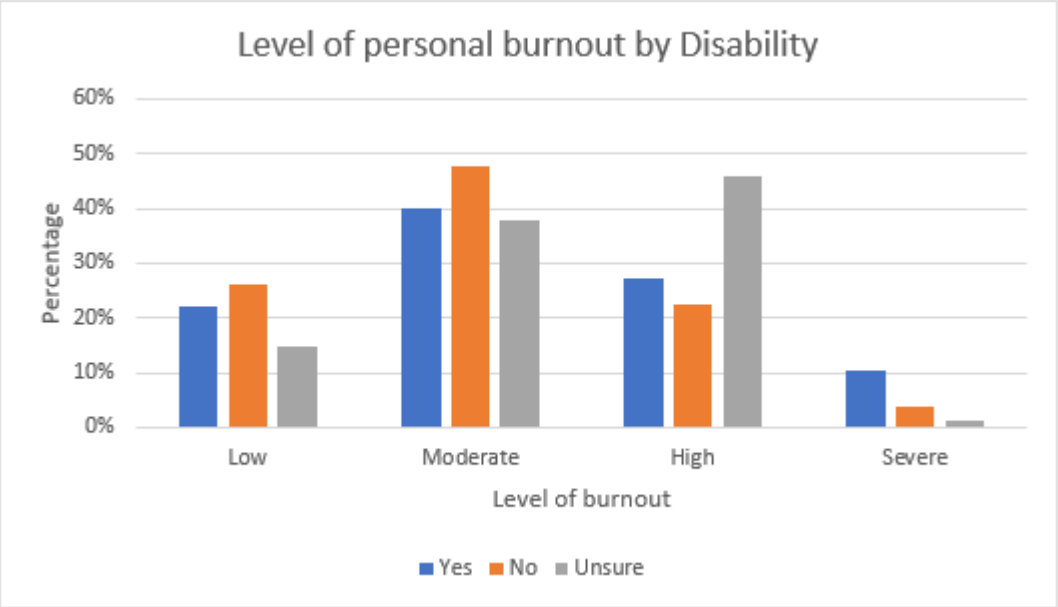

Figure A5.44: Level of Personal Burnout by Disability (Unweighted)

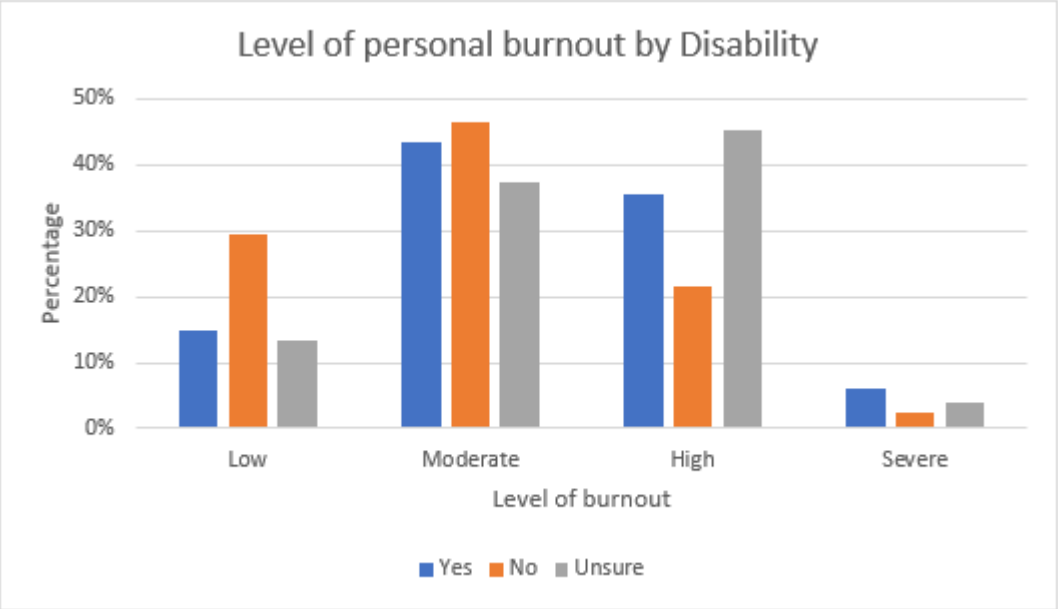

Figure A5.45: Level of Work-Related Burnout by Disability (Weighted)

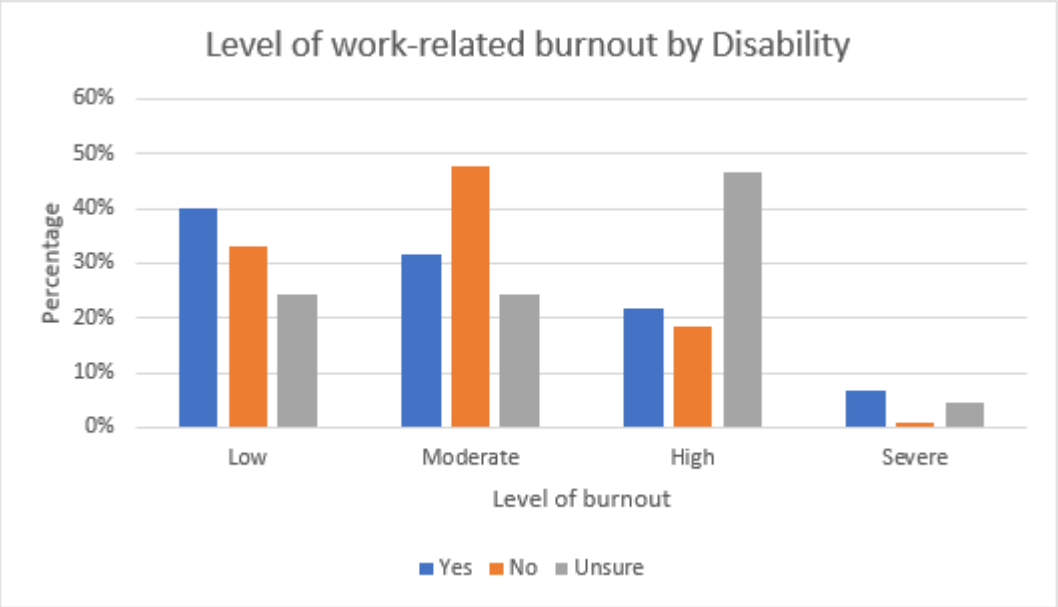

Figure A5.46: Level of Work-Related Burnout by Disability (Unweighted)

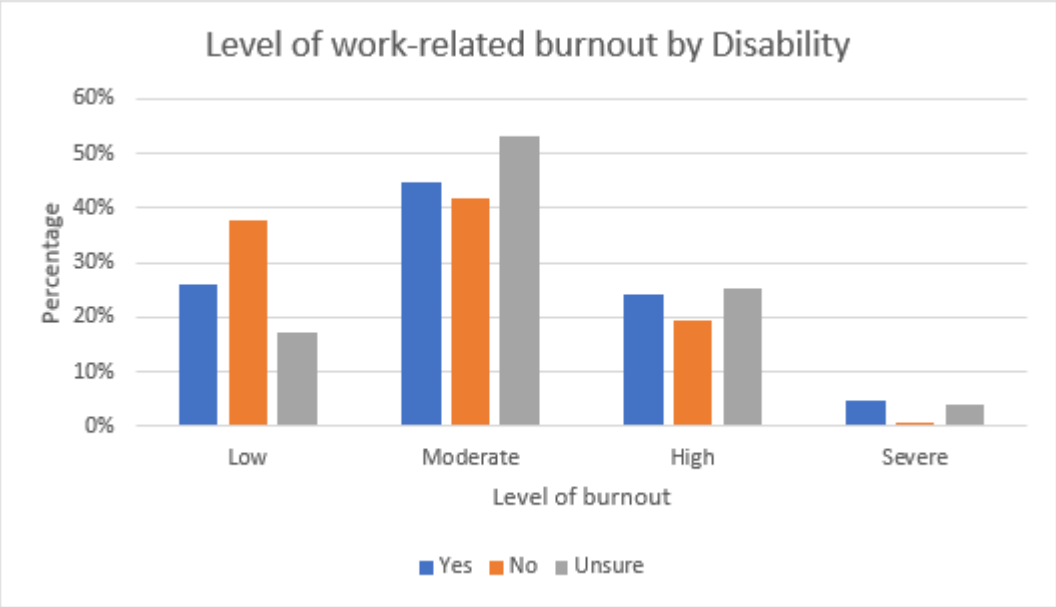

Figure A5.47: Level of Client-Related Burnout by Disability (Weighted)

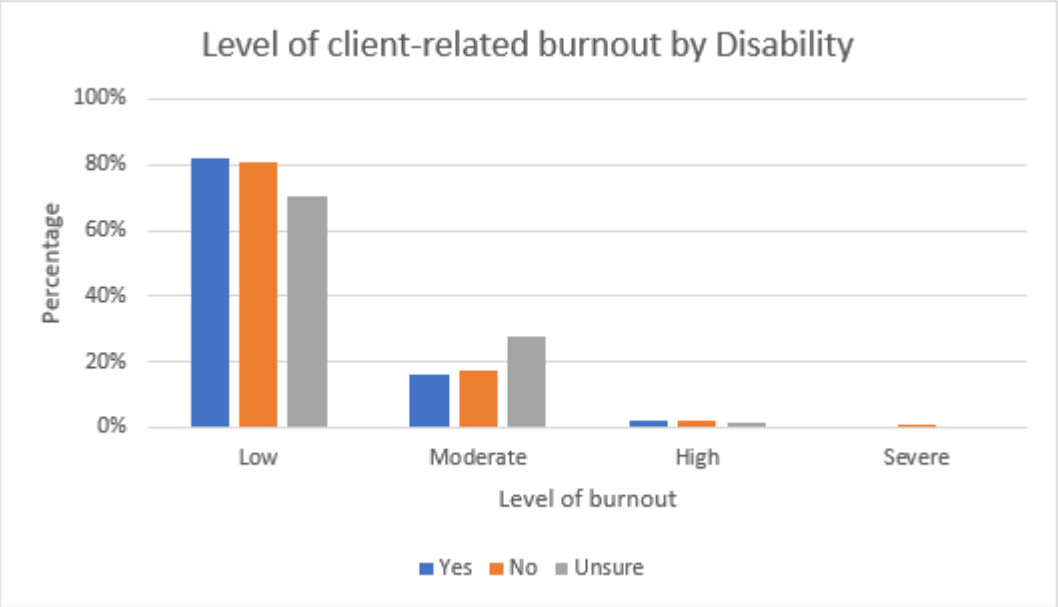

Figure A5.48: Level of Client-Related Burnout by Disability (Unweighted)

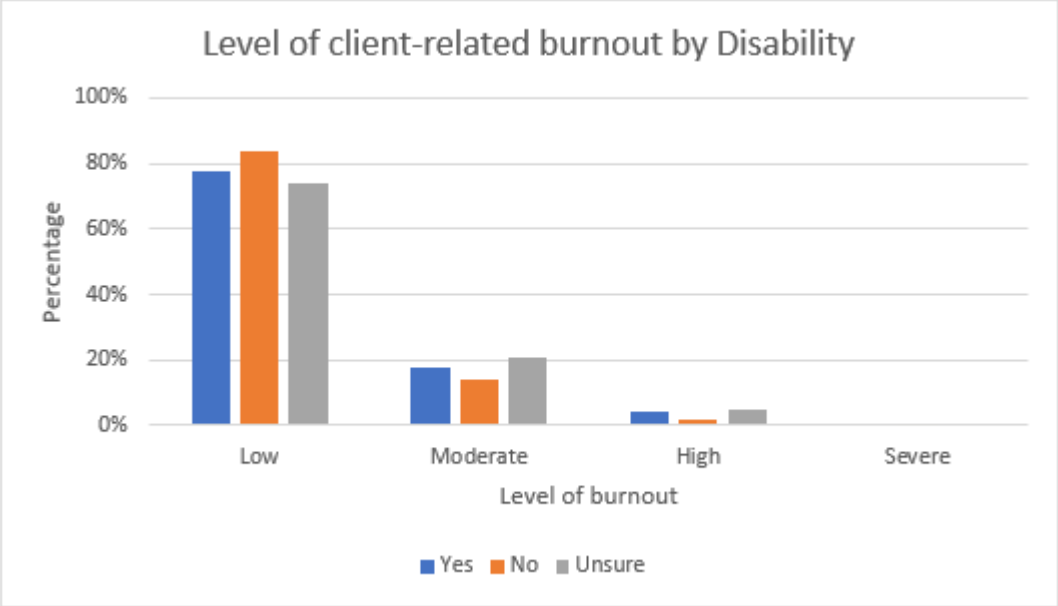

Table A5.23: Level of Burnout by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout:			
Low	22.1%	26.1%	14.9%
Moderate	40.2%	47.7%	37.9%
High	27.1%	22.4%	46.0%
Severe	10.5%	3.8%	1.1%
TOTAL	**100%**	**100%**	**100%**
Work-related burnout:			
Low	40.0%	32.9%	24.4%
Moderate	31.6%	47.9%	24.4%
High	21.8%	18.5%	46.5%
Severe	6.7%	0.7%	4.7%
TOTAL	**100%**	**100%**	**100%**
Client-related burnout:			
Low	81.9%	81.0%	70.6%
Moderate	16.1%	17.0%	27.9%
High	2.0%	1.8%	1.5%
Severe	0.0%	0.3%	0.0%
TOTAL	**100%**	**100%**	**100%**

Table A5.24: Level of Burnout by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout:			
Low	44 (14.9%)	780 (29.6%)	10 (13.3%)
Moderate	128 (43.4%)	1227 (46.5%)	28 (37.3%)
High	105 (35.6%)	568 (21.5%)	34 (45.3%)
Severe	18 (6.1%)	64 (2.4%)	3 (4.0%)
TOTAL	**295 (100%)**	**2639 (100%)**	**75 (100%)**
Work-related burnout:			
Low	74 (26.0%)	983 (37.9%)	13 (17.3%)
Moderate	128 (44.9%)	1086 (41.9%)	40 (53.3%)
High	69 (24.2%)	501 (19.3%)	19 (25.3%)
Severe	14 (4.9%)	23 (0.9%)	3 (4.0%)
TOTAL	**285 (100%)**	**2593 (100%)**	**75 (100%)**
Client-related burnout:			
Low	211 (77.9%)	2001 (83.9%)	46 (74.2%)
Moderate	48 (17.7%)	330 (13.8%)	13 (21.0%)
High	12 (4.4%)	47 (2.0%)	3 (4.8%)
Severe	0 (0.0%)	7 (0.3%)	0 (0.0%)
TOTAL	**271 (100%)**	**2385 (100%)**	**62 (100%)**

A5.7 Burnout Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences between respondents based on their main area of practice in mean personal burnout scores ($F = 7.836$, $df = 7$, $p < .001$). Specifically, respondents working in midwifery scored significantly higher than those working in all other areas except for older people; and respondents working with older people scored significantly higher than those working with children, adults, learning disability and 'other'.

There were also significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 6.661$, $df = 7$, $p < .001$). Respondents working in midwifery scored significantly higher than those working in all other areas; and respondents working with older people scored significantly higher than those working in 'other' area.

Significant differences were also found in the mean client-related burnout scores ($F = 10.795$, $df = 7$, $p < .001$). Respondents working with older people scored significantly lower than those working with children, in midwifery, mental health and 'other'; those working in learning disability scored significantly lower than those working with children, in midwifery, mental health and 'other'; and those working with adults scored significantly lower than those working with children.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean client-related burnout scores ($F = 4.349$, $df = 7$, $p < .001$). Specifically, respondents working with children scored significantly higher than those working with adults, older people or in the area of learning disability.

Figure A5.49: Mean Burnout Scores by Main Area of Practice (Weighted)

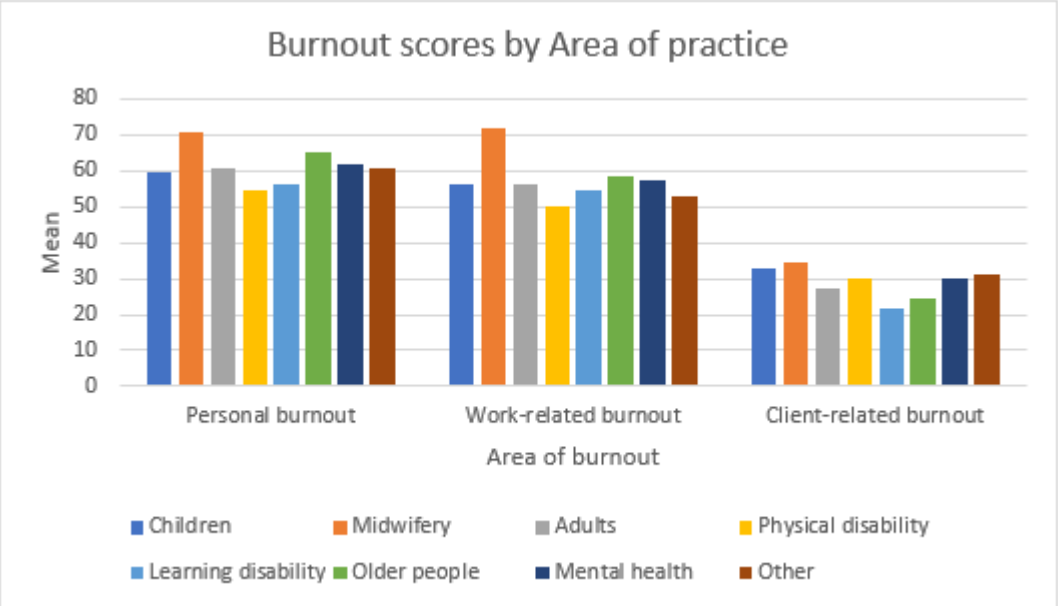

Figure A5.50: Mean Burnout Scores by Main Area of Practice (Unweighted)

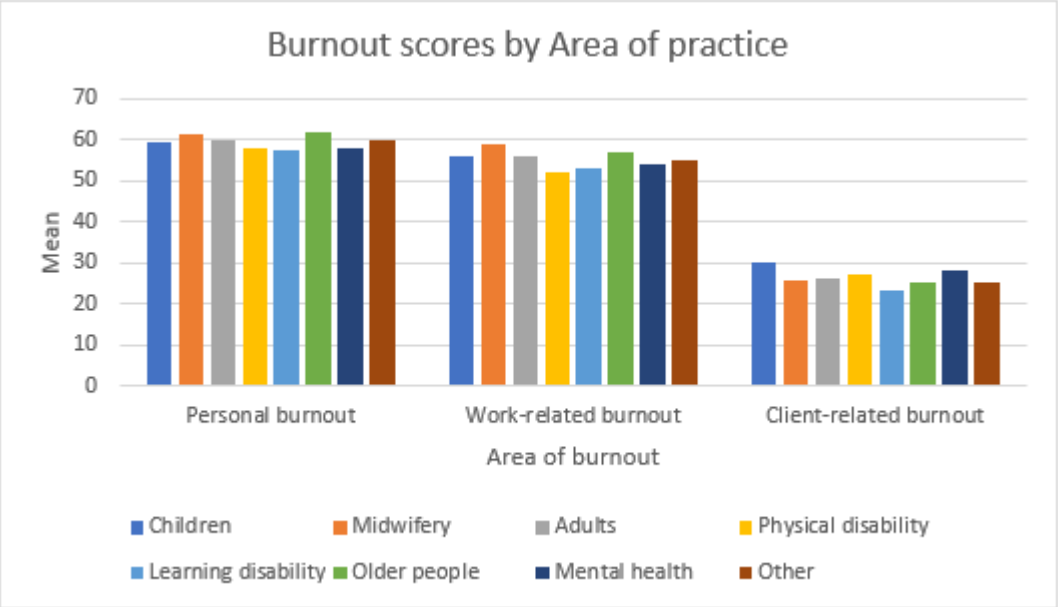

Table A5.25: Mean Burnout Scores by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout	59.47	70.94	60.70	54.71	56.41	65.08	61.73	60.70
Work-related burnout	56.16	71.76	56.54	50.31	54.32	58.35	57.51	53.06
Client-related burnout	33.11	34.55	27.13	30.02	21.94	24.19	29.80	31.31

Table A5.26: Mean Burnout Scores by Main Area of Practice (Unweighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout	59.29	61.32	59.76	58.11	57.48	61.78	57.91	60.06
Work-related burnout	56.06	58.87	56.09	51.98	53.33	56.81	54.31	54.89
Client-related burnout	29.96	25.83	26.33	27.29	23.23	25.49	28.05	25.17

Figure A5.51: Level of Personal Burnout by Main Area of Practice (Weighted)

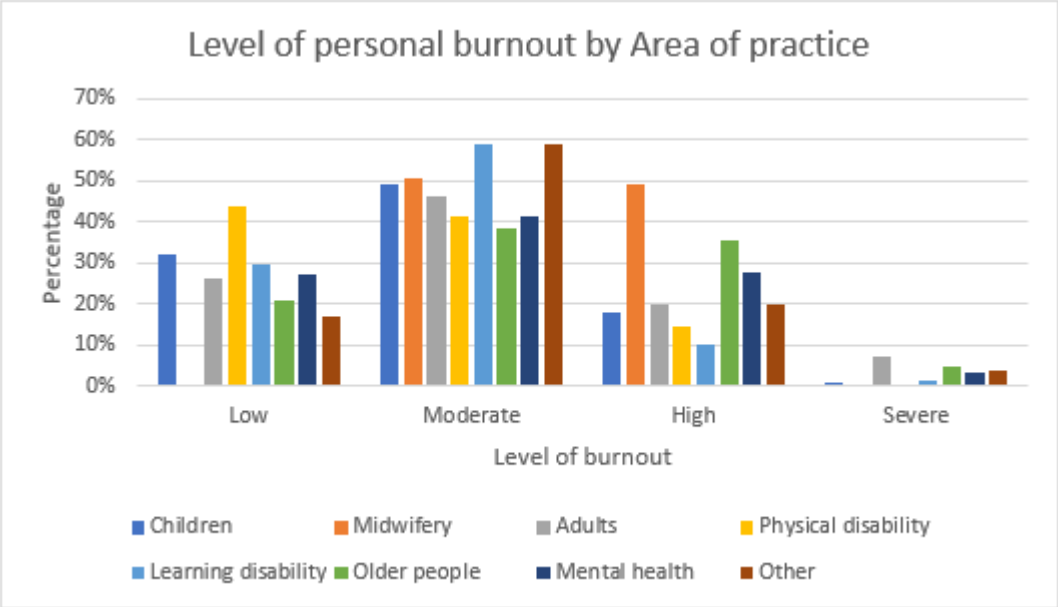

Figure A5.52: Level of Personal Burnout by Main Area of Practice (Unweighted)

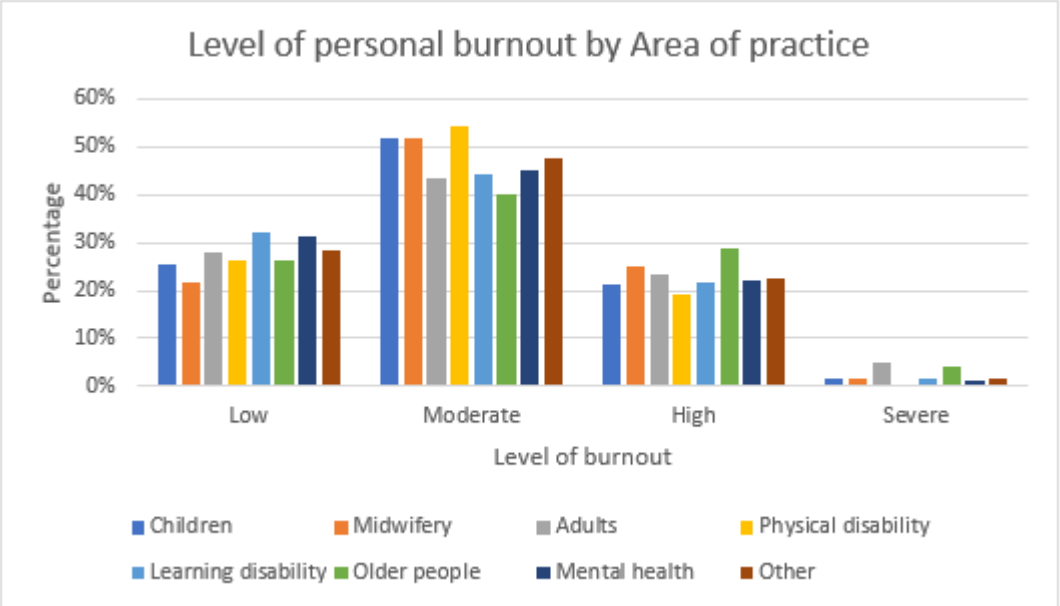

Figure A5.53: Level of Work-Related Burnout by Main Area of Practice (Weighted)

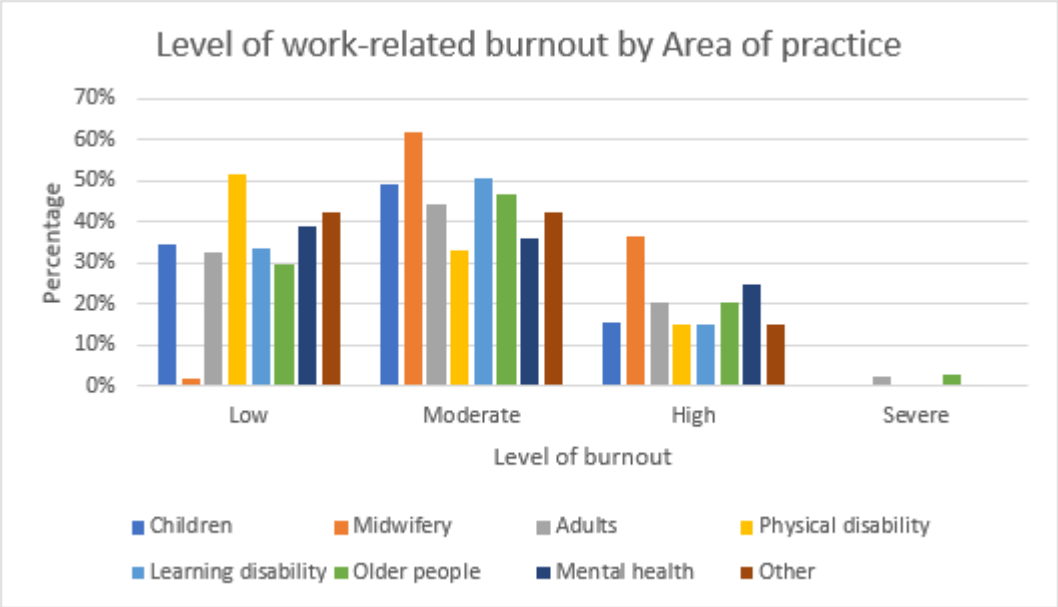

Figure A5.54: Level of Work-Related Burnout by Main Area of Practice (Unweighted)

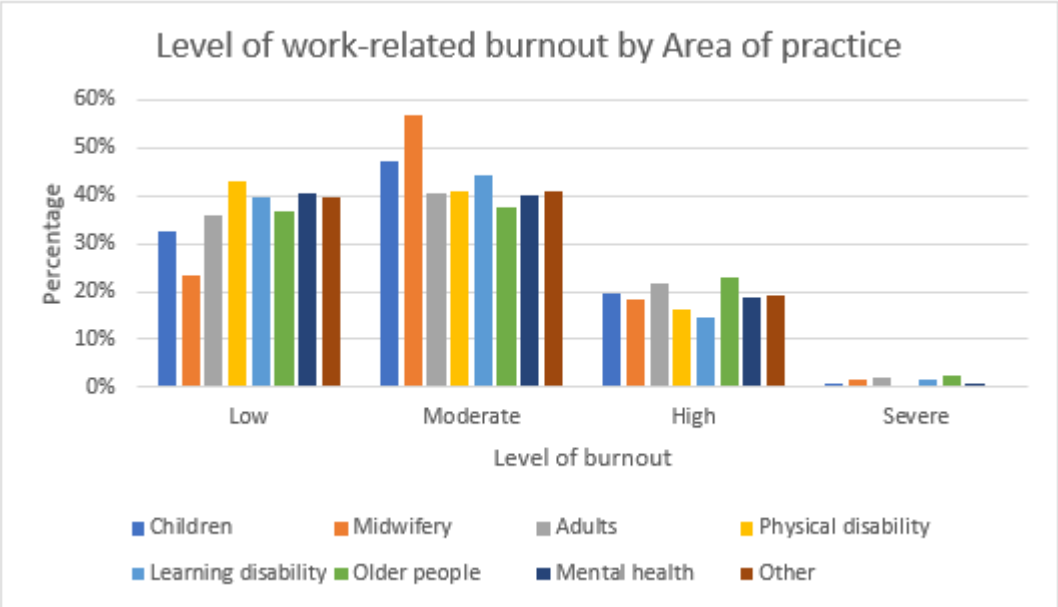

Figure A5.55: Level of Client-Related Burnout by Main Area of Practice (Weighted)

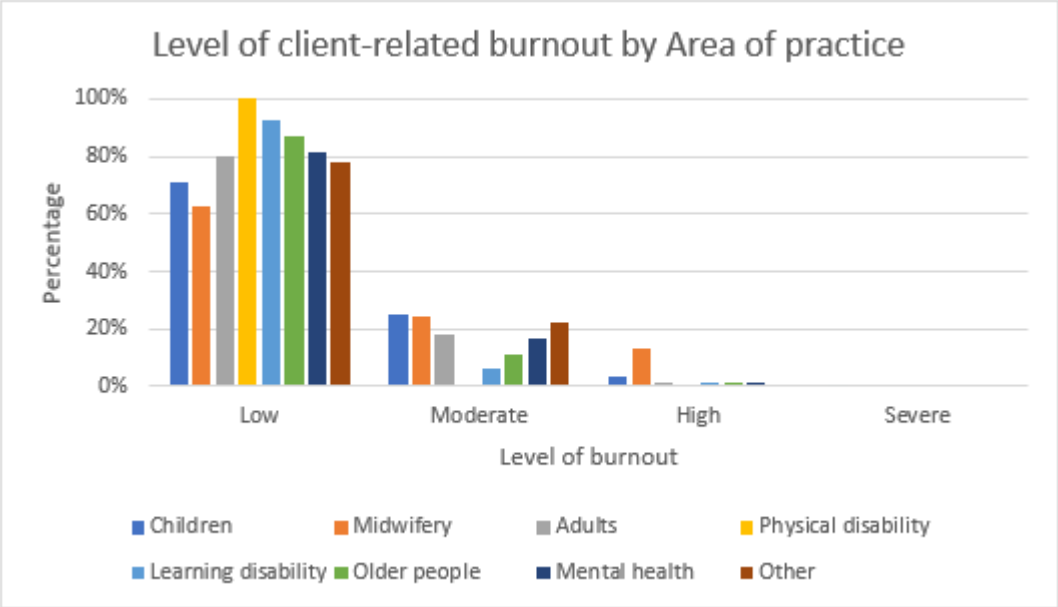

Figure A5.56: Level of Client-Related Burnout by Main Area of Practice (Unweighted)

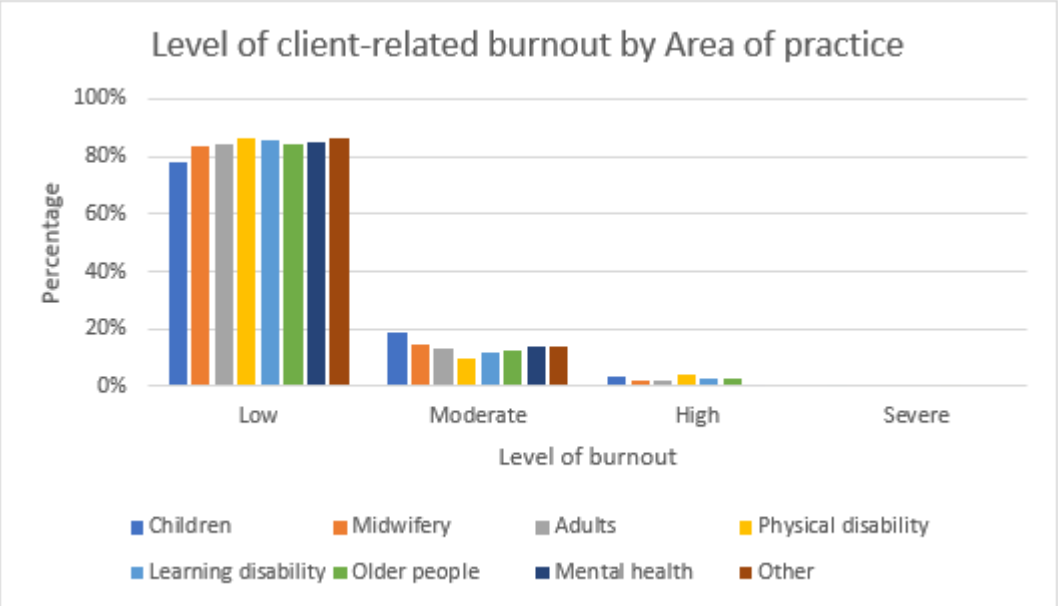

Table A5.27: Level of Burnout by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout:								
Low	32.1%	0.0%	26.2%	44.1%	29.5%	20.9%	27.3%	17.2%
Moderate	49.1%	50.9%	46.5%	41.2%	59.0%	38.3%	41.5%	59.0%
High	17.9%	49.1%	20.1%	14.7%	10.2%	35.7%	27.8%	20.1%
Severe	0.9%	0.0%	7.2%	0.0%	1.2%	5.0%	3.4%	3.7%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:								
Low	34.5%	1.8%	32.8%	51.5%	33.5%	29.7%	38.9%	42.5%
Moderate	49.4%	61.8%	44.2%	33.3%	50.6%	47.0%	36.1%	42.5%
High	15.6%	36.4%	20.5%	15.2%	15.2%	20.6%	24.7%	15.0%
Severe	0.5%	0.0%	2.5%	0.0%	0.6%	2.8%	0.3%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:								
Low	71.1%	63.0%	80.4%	100%	92.3%	87.4%	81.8%	78.0%
Moderate	25.3%	24.1%	17.9%	0.0%	6.3%	11.0%	16.7%	22.0%
High	3.3%	13.0%	1.4%	0.0%	1.4%	1.6%	1.5%	0.0%
Severe	0.3%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.28: Level of Burnout by Main Area of Practice (Unweighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout:								
Low	199 (25.5%)	13 (21.7%)	185 (28.1%)	15 (26.3%)	106 (32.2%)	160 (26.5%)	93 (31.2%)	64 (28.2%)
Moderate	403 (51.7%)	31 (51.7%)	287 (43.6%)	31 (54.4%)	146 (44.4%)	243 (40.3%)	135 (45.3%)	108 (47.6%)
High	165 (21.2%)	15 (25.0%)	154 (23.4%)	11 (19.3%)	71 (21.6%)	175 (29.0%)	66 (22.1%)	51 (22.5%)
Severe	13 (1.7%)	1 (1.7%)	32 (4.9%)	0 (0.0%)	6 (1.8%)	25 (4.1%)	4 (1.3%)	4 (1.8%)
TOTAL	**780 (100%)**	**60 (100%)**	**658 (100%)**	**57 (100%)**	**329 (100%)**	**603 (100%)**	**298 (100%)**	**227 (100%)**
Work-related burnout:								
Low	249 (32.4%)	14 (23.3%)	232 (36.0%)	24 (42.9%)	128 (39.6%)	216 (36.9%)	119 (40.5%)	89 (39.7%)
Moderate	363 (47.2%)	34 (56.7%)	261 (40.5%)	23 (41.1%)	143 (44.3%)	221 (37.8%)	118 (40.1%)	92 (41.1%)
High	152 (19.8%)	11 (18.3%)	139 (21.6%)	9 (16.1%)	47 (14.6%)	134 (22.9%)	55 (18.7%)	43 (19.2%)
Severe	5 (0.7%)	1 (1.7%)	13 (2.0%)	0 (0.0%)	5 (1.5%)	14 (2.4%)	2 (0.7%)	0 (0.0%)
TOTAL	**769 (100%)**	**60 (100%)**	**645 (100%)**	**56 (100%)**	**323 (100%)**	**585 (100%)**	**294 (100%)**	**224 (100%)**
Client-related burnout:								
Low	558 (77.9%)	46 (83.6%)	503 (84.5%)	44 (86.3%)	251 (85.4%)	451 (84.5%)	233 (85.3%)	173 (86.1%)
Moderate	133 (18.6%)	8 (14.5%)	77 (12.9%)	5 (9.8%)	35 (11.9%)	67 (12.5%)	38 (13.9%)	28 (13.9%)
High	23 (3.2%)	1 (1.8%)	12 (2.0%)	2 (3.9%)	8 (2.7%)	14 (2.6%)	2 (0.7%)	0 (0.0%)
Severe	2 (0.3%)	0 (0.0%)	3 (0.5%)	0 (0.0%)	0 (0.0%)	2 (0.4%)	0 (0.0%)	0 (0.0%)
TOTAL	**716 (100%)**	**55 (100%)**	**595 (100%)**	**51 (100%)**	**294 (100%)**	**534 (100%)**	**273 (100%)**	**201 (100%)**

A5.8 Burnout Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between respondents based on their line manager status in mean work-related burnout scores ($t = 4.343$, $df = 3070$, $p < .001$); line managers scored significantly higher than respondents who were not line managers.

There were also significant differences between respondents based on their line manager status in mean client-related burnout scores ($t = -7.026$, $df = 2845$, $p < .001$); respondents who were line managers scored significantly lower than those who were not line managers.

Summary (Unweighted results):

There were significant differences between respondents based on their line manager status in mean work-related burnout scores ($t = 3.758$, $df = 2954$, $p < .001$); line managers scored significantly higher than respondents who were not line managers.

There were also significant differences between respondents based on their line manager status in mean client-related burnout scores ($t = -6.504$, $df = 2717$, $p < .001$); respondents who were line managers scored significantly lower than those who were not line managers.

Figure A5.57: Mean Burnout Scores by Line Manager Status (Weighted)

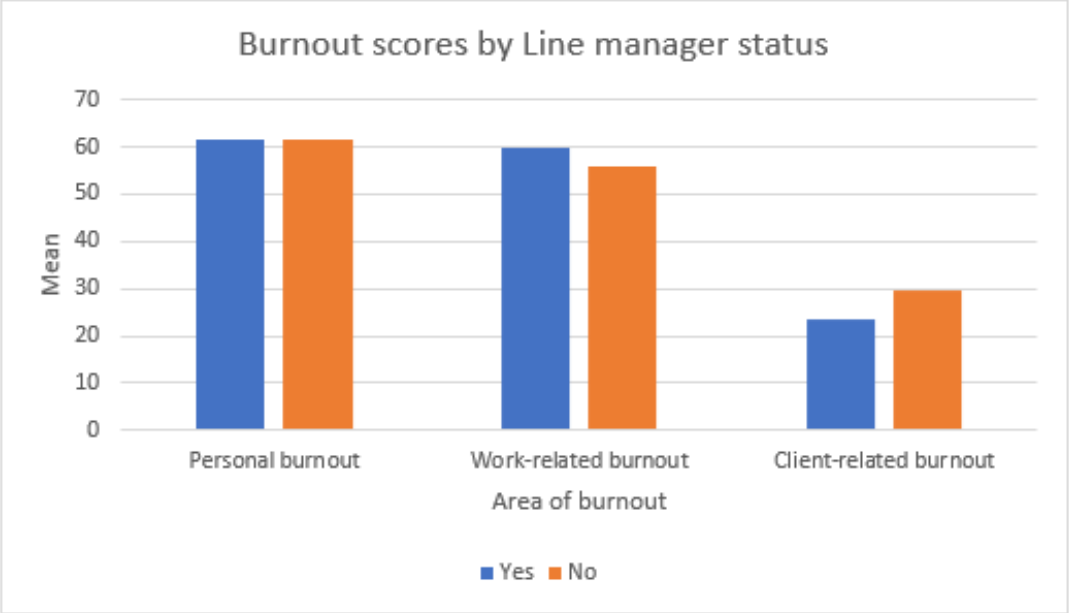

Figure A5.58: Mean Burnout Scores by Line Manager Status (Unweighted)

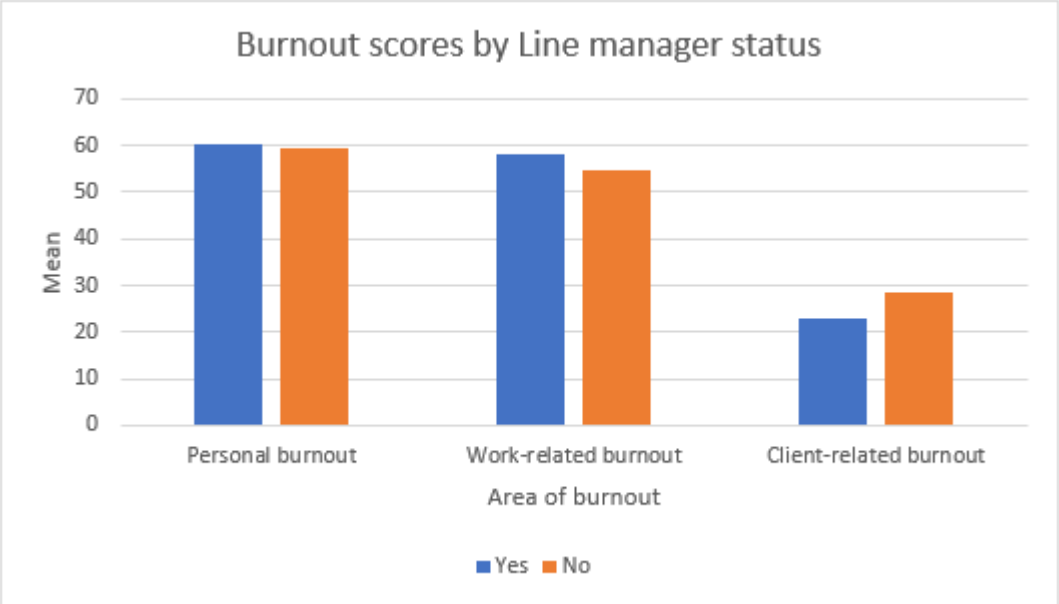

Table A5.29: Mean Burnout Scores by Line Manager Status (Weighted)

	Are you a line manager?	
Burnout	**Yes**	**No**
Personal burnout	61.48	61.37
Work-related burnout	59.55	55.78
Client-related burnout	23.40	29.52

Table A5.30: Mean Burnout Scores by Line Manager Status (Unweighted)

	Are you a line manager?	
Burnout	**Yes**	**No**
Personal burnout	60.50	59.30
Work-related burnout	58.04	54.72
Client-related burnout	22.72	28.46

Figure A5.59: Level of Personal Burnout by Line Manager Status (Weighted)

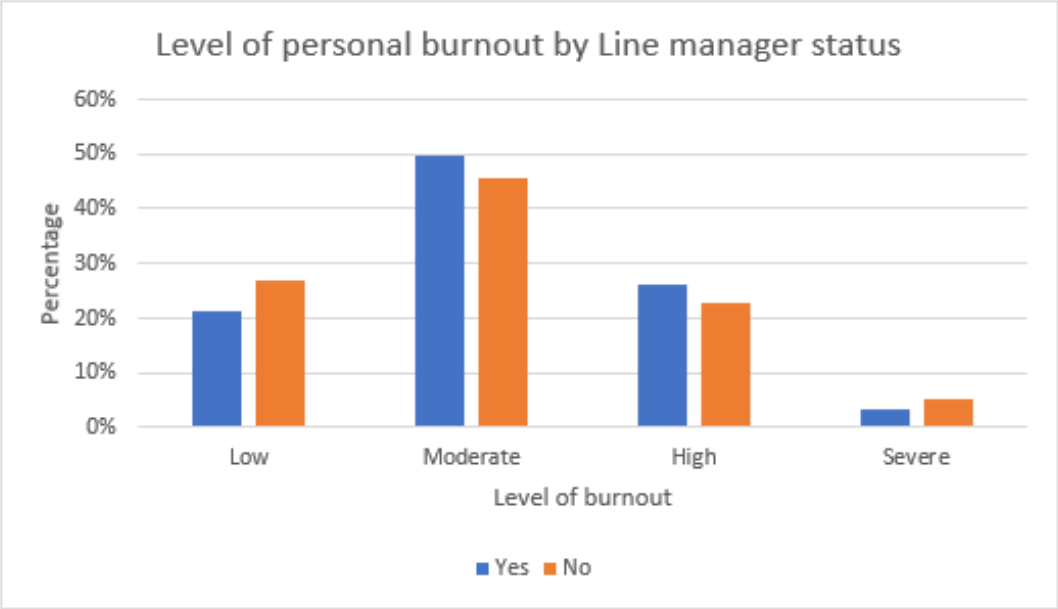

Figure A5.60: Level of Personal Burnout by Line Manager Status (Unweighted)

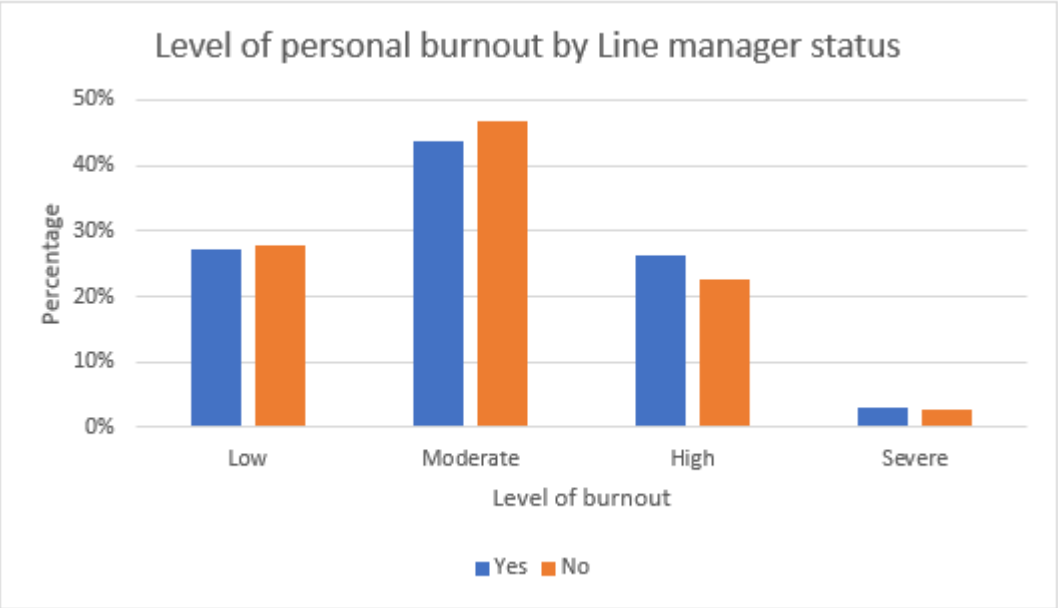

Figure A5.61: Level of Work-Related Burnout by Line Manager Status (Weighted)

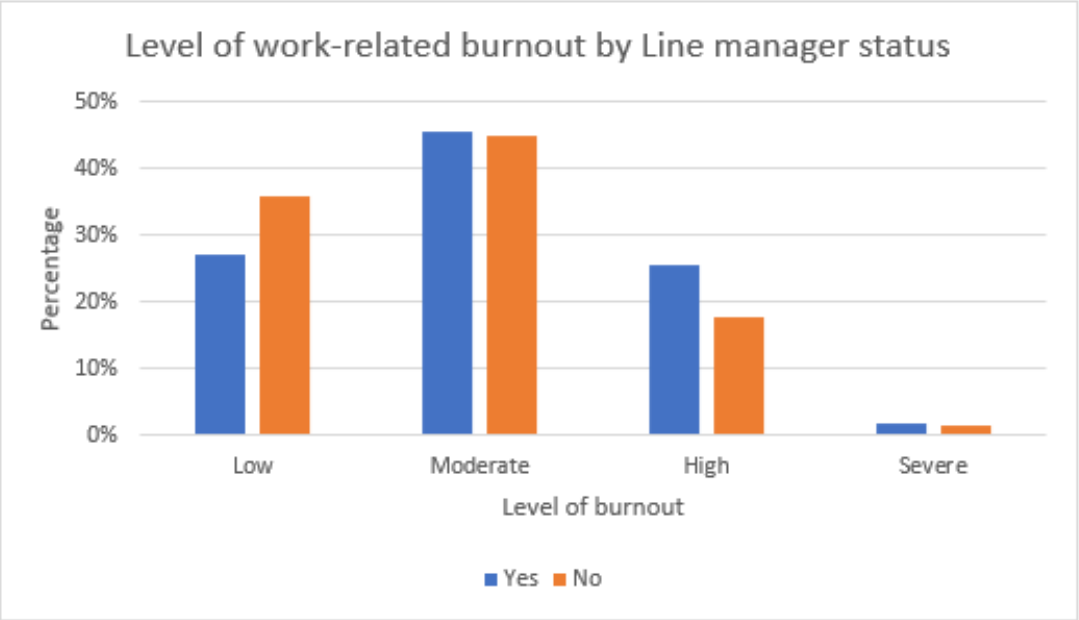

Figure A5.62: Level of Work-Related Burnout by Line Manager Status (Unweighted)

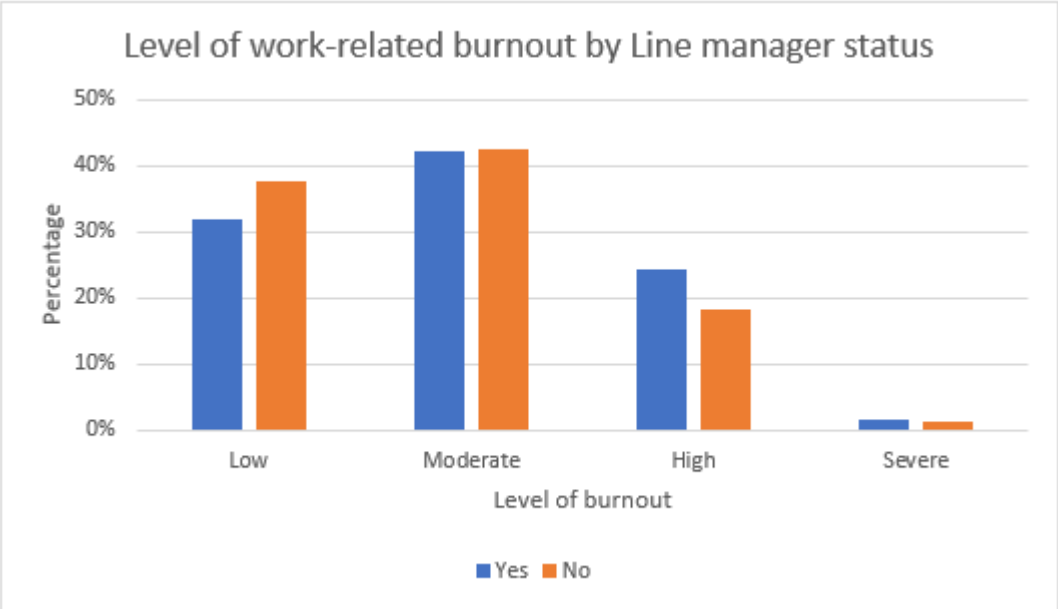

Figure A5.63: Level of Client-Related Burnout by Line Manager Status (Weighted)

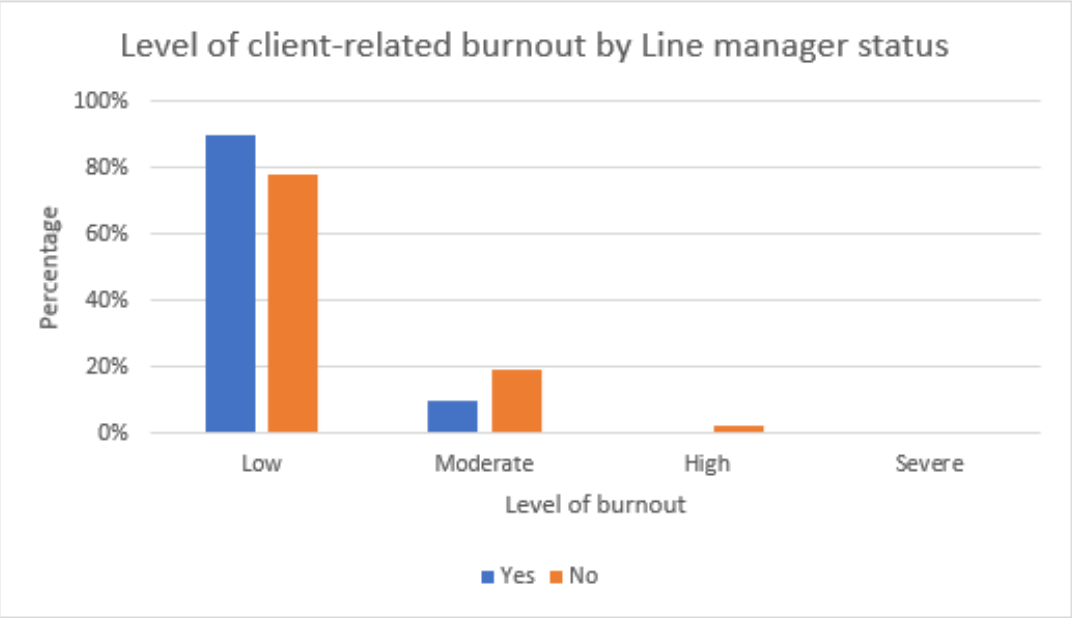

Figure A5.64: Level of Client-Related Burnout by Line Manager Status (Unweighted)

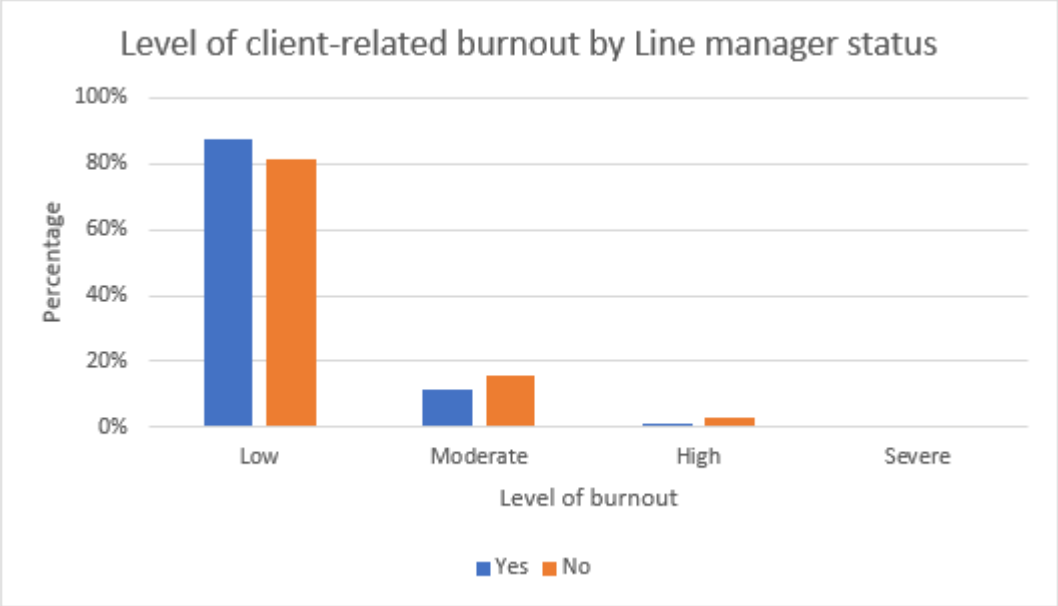

Table A5.31: Level of Burnout by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout:		
Low	21.2%	26.7%
Moderate	49.6%	45.4%
High	26.1%	22.9%
Severe	3.2%	5.1%
TOTAL	**100%**	**100%**
Work-related burnout:		
Low	27.1%	35.9%
Moderate	45.3%	44.9%
High	25.6%	17.7%
Severe	1.9%	1.5%
TOTAL	**100%**	**100%**
Client-related burnout:		
Low	89.6%	77.9%
Moderate	10.0%	19.5%
High	0.4%	2.3%
Severe	0.0%	0.3%
TOTAL	**100%**	**100%**

Table A5.32: Level of Burnout by Line Manager Status (Unweighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout:		
Low	229 (27.3%)	606 (27.9%)
Moderate	366 (43.6%)	1018 (46.8%)
High	220 (26.2%)	488 (22.5%)
Severe	24 (2.9%)	61 (2.8%)
TOTAL	**839 (100%)**	**2173 (100%)**
Work-related burnout:		
Low	261 (32.0%)	810 (37.8%)
Moderate	344 (42.2%)	911 (42.6%)
High	198 (24.3%)	392 (18.3%)
Severe	12 (1.5%)	28 (1.3%)
TOTAL	**815 (100%)**	**2141 (100%)**
Client-related burnout:		
Low	654 (87.3%)	1605 (81.5%)
Moderate	87 (11.6%)	304 (15.4%)
High	8 (1.1%)	54 (2.7%)
Severe	0 (0.0%)	7 (0.4%)
TOTAL	**749 (100%)**	**1970 (100%)**

A5.9 Burnout Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean personal burnout scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 132.487$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact and those who felt no impact; and those who only felt some impact scored significantly higher than those who felt no impact.

There were also significant differences in mean work-related burnout scores between respondents who experienced different levels of pressure on their service due to the COVID-19 pandemic ($F = 216.589$, $df = 2$, $p < .001$). Those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact and those who felt no impact; and those who only felt some impact scored significantly higher than those who felt no impact.

Significant differences in mean client-related burnout scores between respondents were also found ($F = 56.630$, $df = 2$, $p < .001$). Those who felt overwhelmed by increased pressures scored significantly higher than the other two groups.

Summary (Unweighted results):

There were significant differences in personal burnout scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 189.168$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact and those who felt no impact of COVID-19; and those who only felt some impact scored significantly higher than those who felt no impact.

There were also significant differences in work-related burnout scores between respondents who experienced different levels of pressure on their service ($F = 285.223$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact and those who felt no impact; and those who only felt some impact scored significantly higher than those who felt no impact.

Significant differences in client-related burnout scores between respondents who experienced different levels of pressure on their service were also found ($F = 28.772$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than the other two groups.

Figure A5.65: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

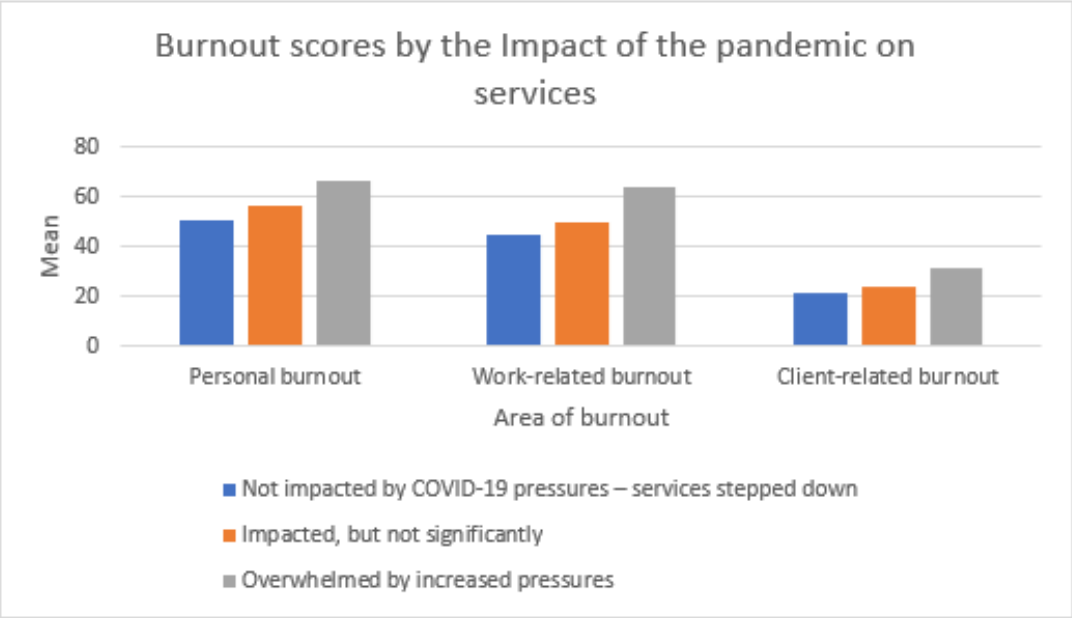

Figure A5.66: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

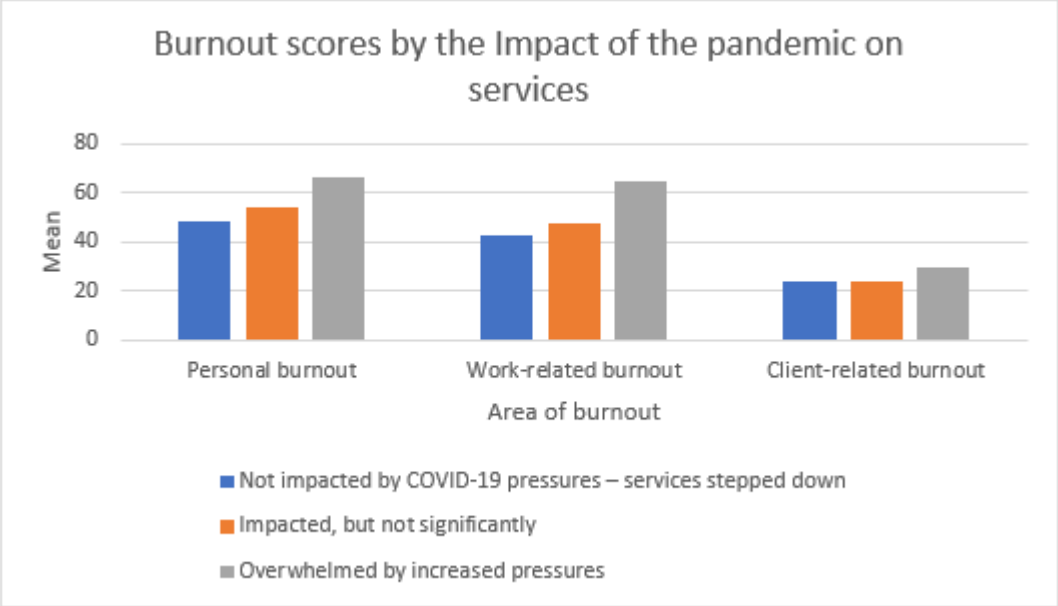

Table A5.33: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout	50.61	56.42	66.86
Work-related burnout	45.01	49.83	64.06
Client-related burnout	21.52	24.19	31.86

Table A5.34: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout	48.51	53.73	66.61
Work-related burnout	42.64	47.82	64.72
Client-related burnout	23.98	24.03	30.01

Figure A5.67: Level of Personal Burnout by the Impact of the Pandemic on Services (Weighted)

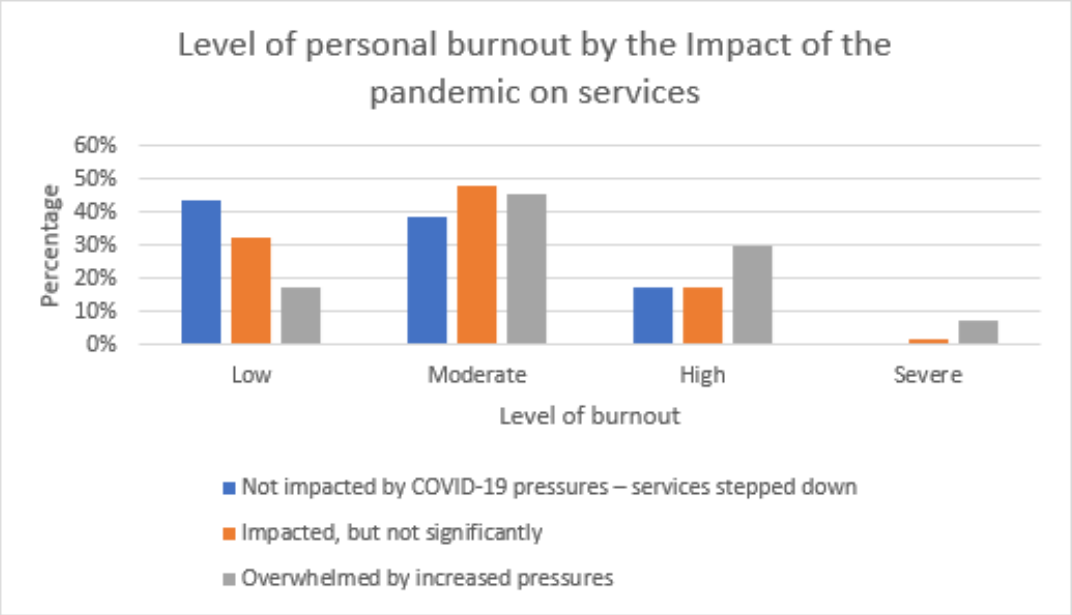

Figure A5.68: Level of Personal Burnout by the Impact of the Pandemic on Services (Unweighted)

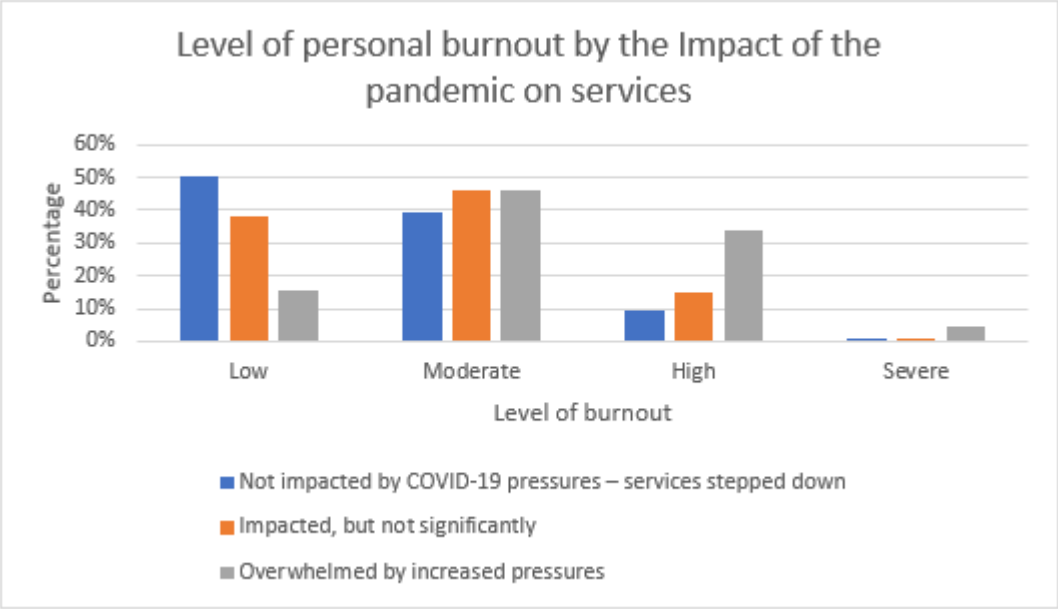

Figure A5.69: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Weighted)

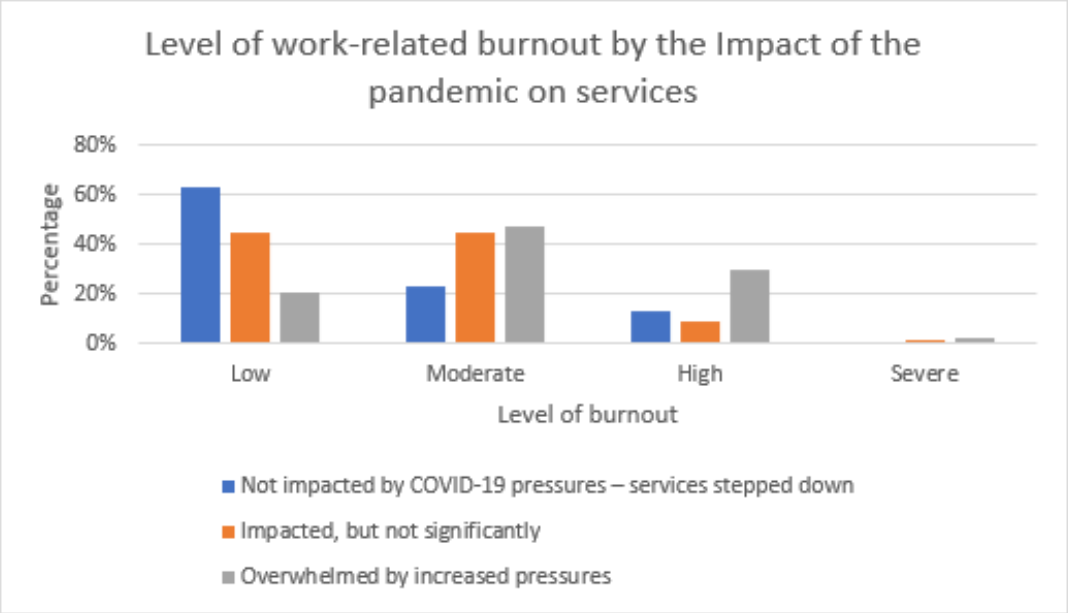

Figure A5.70: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

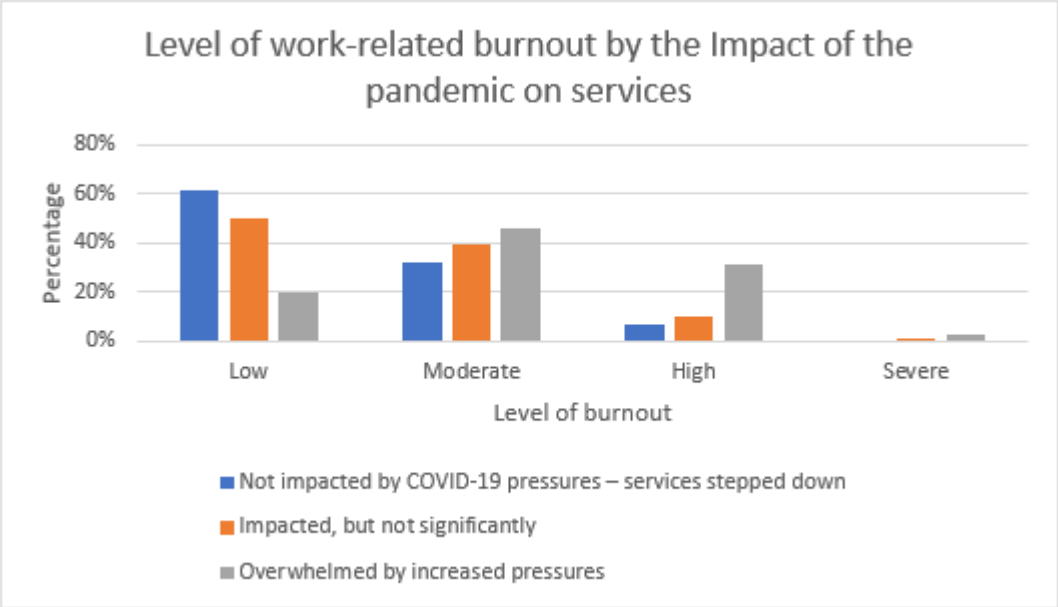

Figure A5.71: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Weighted)

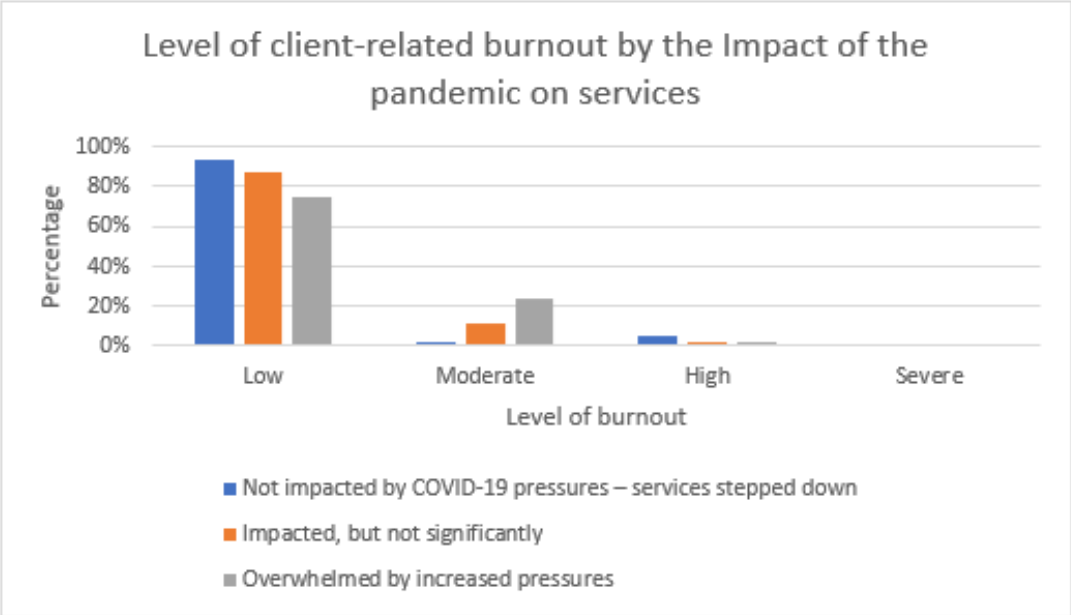

Figure A5.72: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

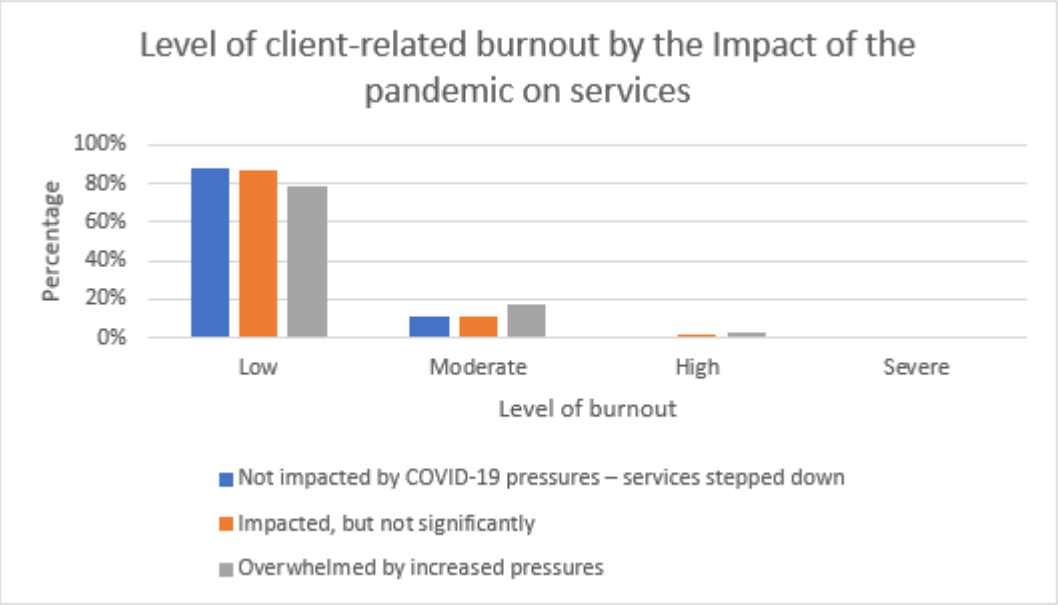

Table A5.35: Level of Burnout by the Impact of the Pandemic on Services (Weighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Personal burnout:			
Low	43.7%	32.5%	17.1%
Moderate	38.9%	48.1%	45.5%
High	17.5%	17.3%	30.0%
Severe	0.0%	2.0%	7.4%
TOTAL	**100%**	**100%**	**100%**
Work-related burnout:			
Low	63.0%	45.0%	20.9%
Moderate	23.5%	44.5%	47.0%
High	13.4%	9.1%	30.1%
Severe	0.0%	1.4%	2.0%
TOTAL	**100%**	**100%**	**100%**
Client-related burnout:			
Low	93.2%	86.9%	74.5%
Moderate	1.7%	10.8%	24.0%
High	5.1%	1.9%	1.4%
Severe	0.0%	0.3%	0.1%
TOTAL	**100%**	**100%**	**100%**

Table A5.36: Level of Burnout by the Impact of the Pandemic on Services (Unweighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Personal burnout:			
Low	58 (50.4%)	556 (38.1%)	219 (15.3%)
Moderate	45 (39.1%)	672 (46.0%)	661 (46.3%)
High	11 (9.6%)	217 (14.9%)	480 (33.6%)
Severe	1 (0.9%)	16 (1.1%)	68 (4.8%)
TOTAL	**115 (100%)**	**1461 (100%)**	**1428 (100%)**
Work-related burnout:			
Low	69 (61.1%)	721 (50.2%)	278 (19.9%)
Moderate	36 (31.9%)	570 (39.7%)	646 (46.2%)
High	8 (7.1%)	139 (9.7%)	442 (31.6%)
Severe	0 (0.0%)	7 (0.5%)	33 (2.4%)
TOTAL	**113 (100%)**	**1437 (100%)**	**1399 (100%)**
Client-related burnout:			
Low	90 (88.2%)	1139 (86.6%)	1025 (79.0%)
Moderate	11 (10.8%)	151 (11.5%)	229 (17.7%)
High	1 (1.0%)	24 (1.8%)	37 (2.9%)
Severe	0 (0.0%)	1 (0.1%)	6 (0.5%)
TOTAL	**102 (100%)**	**1315 (100%)**	**1297 (100%)**

Appendix 6: Carver Coping Scale (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of how respondents coped with COVID-19 related occupational demands, which was measured using 20 items from the Brief COPE scale. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A6.1 Carver Coping Scores by Country

Summary (Weighted results):

There were significant differences across countries in mean scores on four out of the ten examined Carver coping domains. These differences were in:

- Active coping (F = 3.728, df = 3, p = .011), where Scotland scored significantly higher than England and Wales
- Planning (F = 4.124, df = 3, p = .006), where Scotland scored significantly higher than Wales and Northern Ireland
- Use of emotional support (F = 4.311, df = 3, p = .005), where Scotland scored significantly lower than England and Northern Ireland
- Self-blame (F = 4.679, df = 3, p = .003), where Scotland scored significantly higher than Northern Ireland

Summary (Unweighted results):

There were significant differences across countries in mean scores on four out of the ten examined Carver coping domains. These differences were in:

- Active coping (F = 4.744, df = 3, p = .003), where Scotland scored significantly higher than England and Wales
- Use of emotional support (F = 5.488, df = 3, p = .001), where Scotland scored significantly lower than England and Northern Ireland
- Use of instrumental support (F = 3.184, df = 3, p = .023), where Scotland scored significantly lower than England
- Self-blame (F = 3.558, df = 3, p = .014), where Scotland scored significantly higher than Northern Ireland

There also appeared to be a significant difference between the countries in the use of Venting as a coping strategy (F = 2.755, df = 3, p = .041), but multiple comparison tests revealed no statistically significant differences.

Figure A6.1: Mean Carver Coping Scores by Country (Weighted)

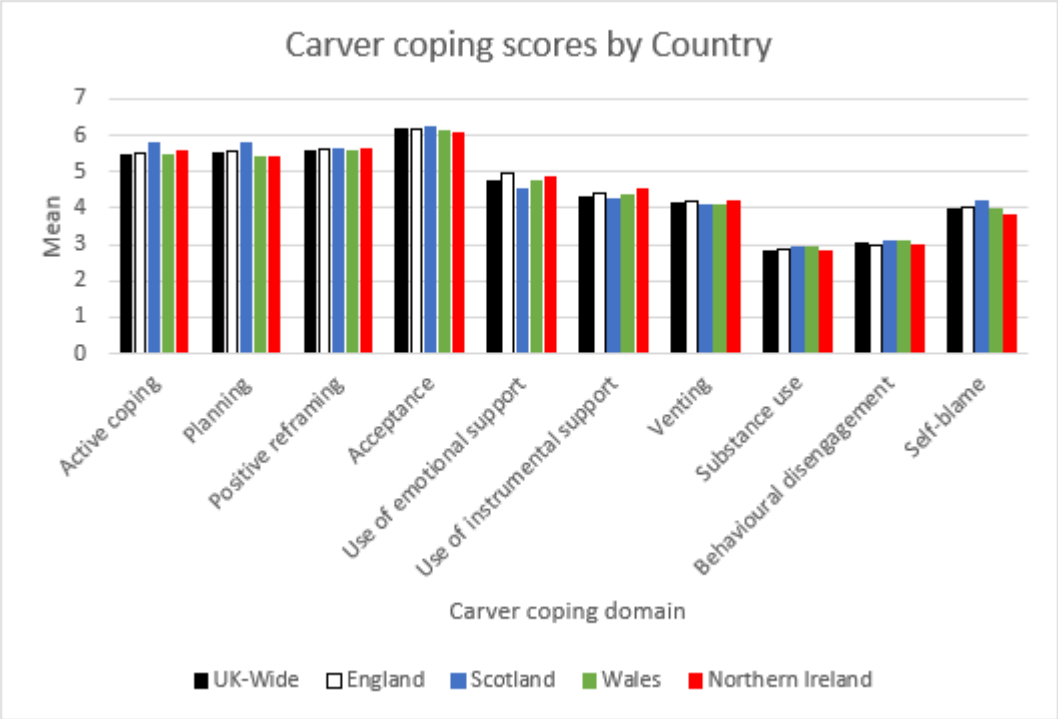

Figure A6.2: Mean Carver Coping Scores by Country (Unweighted)

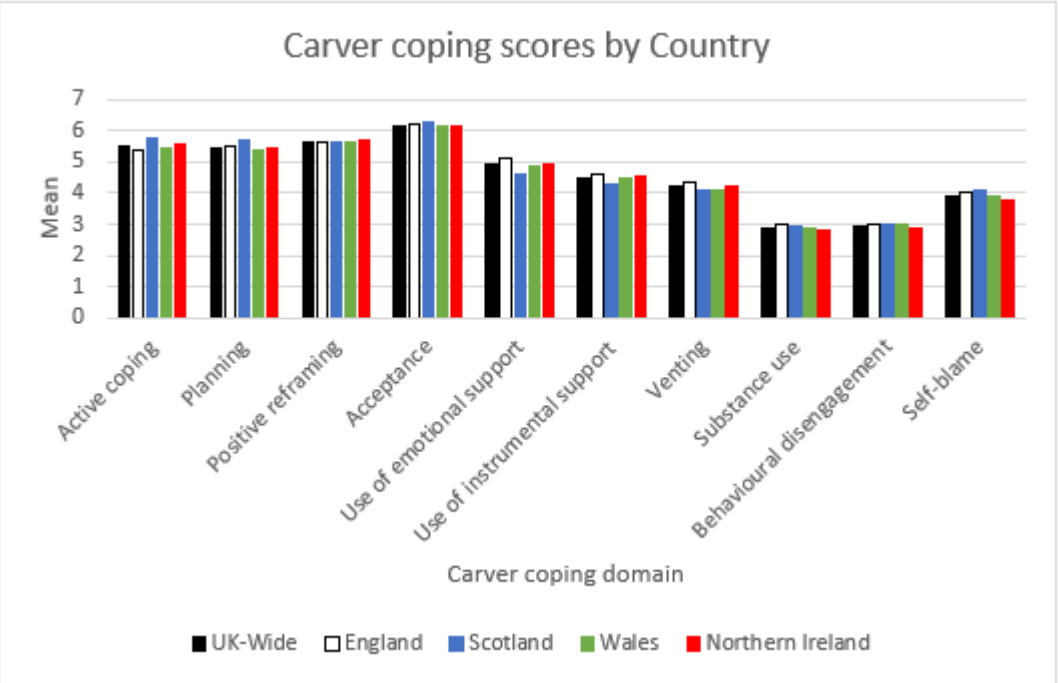

Table A6.1: Mean Carver Coping Scores by Country (Weighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.48	5.50	5.80	5.46	5.56
Planning	5.53	5.56	5.77	5.42	5.42
Positive reframing	5.57	5.60	5.61	5.59	5.61
Acceptance	6.18	6.19	6.24	6.11	6.06
Use of emotional support	4.73	4.95	4.54	4.73	4.84
Use of instrumental support	4.29	4.43	4.24	4.37	4.51
Venting	4.14	4.19	4.08	4.05	4.19
Substance use	2.83	2.86	2.91	2.90	2.82
Behavioural disengagement	3.01	2.99	3.07	3.08	2.99
Self-blame	3.98	4.00	4.19	3.94	3.80

Table A6.2: Mean Carver Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.50	5.40	5.75	5.42	5.56
Planning	5.48	5.50	5.70	5.39	5.47
Positive reframing	5.65	5.62	5.64	5.64	5.69
Acceptance	6.18	6.23	6.29	6.13	6.14
Use of emotional support	4.92	5.10	4.63	4.89	4.93
Use of instrumental support	4.51	4.62	4.28	4.47	4.55
Venting	4.21	4.34	4.11	4.12	4.25
Substance use	2.89	2.97	2.93	2.90	2.79
Behavioural disengagement	2.96	2.98	3.01	3.01	2.88
Self-blame	3.92	4.01	4.10	3.93	3.78

A6.2 Carver Coping Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on nine out of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 3.478$, $df = 4$, $p = .008$), where social care workers scored significantly higher than social workers
- Positive reframing ($F = 4.953$, $df = 4$, $p = .001$), where AHPs scored significantly higher than nurses and social workers
- Acceptance ($F = 3.731$, $df = 4$, $p = .005$), where nurses scored significantly lower than AHPs and social care workers
- Use of emotional support ($F = 24.905$, $df = 4$, $p < .001$), where social workers scored significantly higher than nurses, AHPs and social care workers; and social care workers scored significantly lower than nurses and AHPs

- Use of instrumental support ($F = 14.234$, $df = 4$, $p < .001$), where social workers scored significantly higher than nurses and social care workers; and AHPs scored significantly higher than social care workers
- Venting ($F = 9.610$, $df = 4$, $p < .001$), where social workers scored significantly higher than nurses and social care workers; and AHPs scored significantly higher than social care workers
- Substance use ($F = 9.949$, $df = 4$, $p < .001$), where midwives scored significantly higher than nurses, AHPs and social care workers; and social workers scored significantly higher than AHPs and social care workers
- Behavioural disengagement ($F = 5.591$, $df = 4$, $p < .001$), where midwives scored significantly higher than nurses, AHPs and social workers; and social care workers scored significantly higher than AHPs
- Self-blame ($F = 5.548$, $df = 4$, $p < .001$), where AHPs scored significantly lower than nurses and social workers

There also appeared to be significant differences between the occupational groups on the use of Planning as a coping strategy ($F = 3.003$, $df = 4$, $p = .017$), but multiple comparisons showed that there were no statistically significant differences.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on six out of the ten examined Carver coping domains. These differences were found in:

- Use of emotional support ($F = 16.043$, $df = 4$, $p < .001$), where social workers scored significantly higher than nurses and social care workers; and AHPs scored significantly higher than social care workers
- Use of instrumental support ($F = 8.249$, $df = 4$, $p < .001$), where social care workers scored significantly lower than AHPs and social workers
- Venting ($F = 5.826$, $df = 4$, $p < .001$), where social workers scored significantly higher than social care workers
- Substance use ($F = 3.164$, $df = 4$, $p = .013$), where social workers scored significantly higher than AHPs
- Behavioural disengagement ($F = 9.408$, $df = 4$, $p < .001$), where social care workers scored significantly higher than AHPs and social workers; and nurses scored significantly higher than AHPs
- Self-blame ($F = 8.193$, $df = 4$, $p < .001$), where AHPs scored significantly lower than all the other occupational groups

Figure A6.3: Mean Carver Coping Scores by Occupation (Weighted)

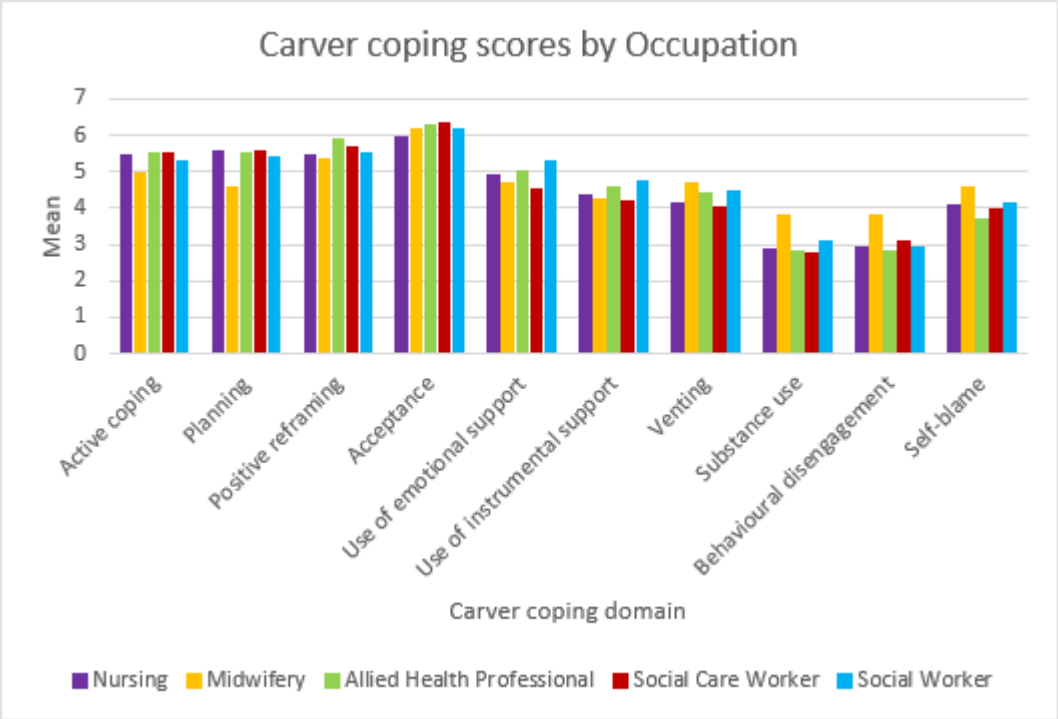

Figure A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

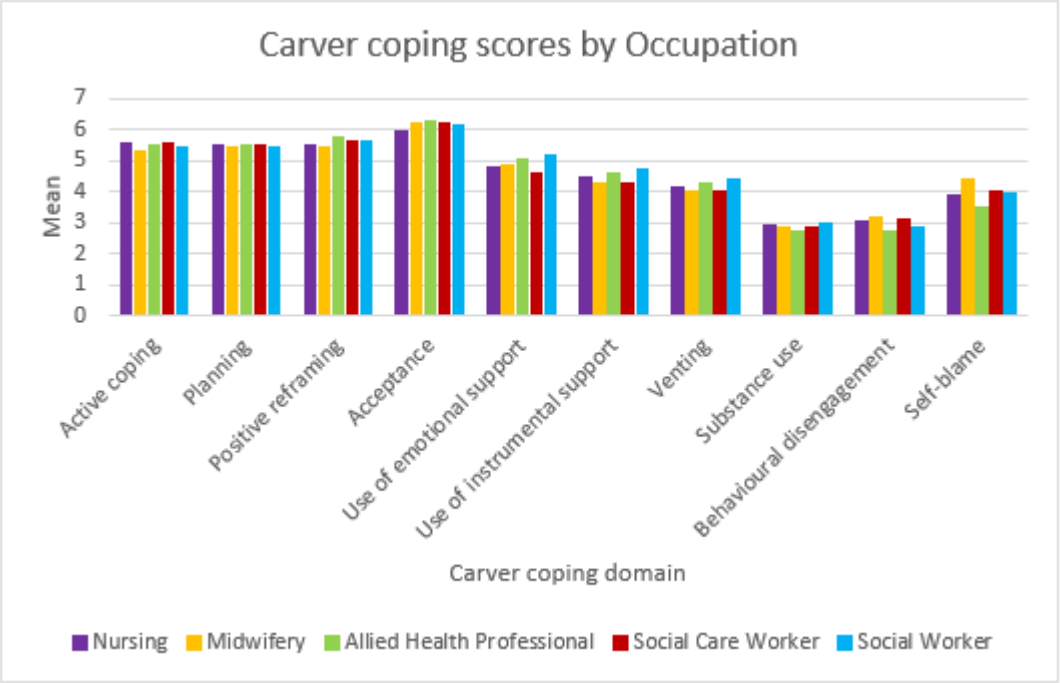

Table A6.3: Mean Carver Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.47	4.98	5.53	5.52	5.30
Planning	5.57	4.58	5.53	5.57	5.39
Positive reframing	5.43	5.32	5.88	5.67	5.53
Acceptance	5.96	6.15	6.28	6.33	6.18
Use of emotional support	4.88	4.68	4.99	4.51	5.30
Use of instrumental support	4.38	4.22	4.56	4.18	4.76
Venting	4.12	4.68	4.43	4.03	4.44
Substance use	2.86	3.78	2.81	2.75	3.10
Behavioural disengagement	2.93	3.82	2.83	3.09	2.93
Self-blame	4.07	4.57	3.69	3.96	4.12

Table A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.59	5.34	5.49	5.57	5.43
Planning	5.50	5.43	5.48	5.51	5.46
Positive reframing	5.50	5.44	5.74	5.65	5.67
Acceptance	5.98	6.20	6.26	6.19	6.17
Use of emotional support	4.82	4.87	5.06	4.59	5.21
Use of instrumental support	4.45	4.26	4.60	4.28	4.72
Venting	4.14	4.05	4.28	4.04	4.38
Substance use	2.89	2.85	2.72	2.86	3.00
Behavioural disengagement	3.04	3.16	2.73	3.14	2.86
Self-blame	3.91	4.40	3.53	4.05	3.95

A6.3 Carver Coping Scores by Sex

There were only two respondents in the full sample who answered questions on the Carver coping scale and stated their sex to be 'other'. These respondents were excluded from analyses based on sex, as the estimates would be unreliable due to the small sample size.

Summary (Weighted results):

There were significant differences between males and females in mean scores on six out of the ten examined Carver coping domains. These differences were in:

- Positive reframing ($t = -4.735$, $df = 2974$, $p < .001$), where males scored significantly higher than females
- Acceptance ($t = -4.243$, $df = 2973$, $p < .001$), where males scored significantly higher than females
- Use of emotional support ($t = -2.125$, $df = 2962$, $p = .034$), where males scored significantly higher than females

- Venting (t = -2.789, df = 2969, p = .005), where males scored significantly higher than females
- Behavioural disengagement (t = 4.861, df = 2964, p < .001), where females scored significantly higher than males
- Self-blame (t = 6.422, df = 2971, p < .001), where females scored significantly higher than males

Summary (Unweighted results):

There were significant differences between males and females in mean scores on two out of the ten examined Carver coping domains. These differences were found in:

- Use of emotional support (t = 2.720, df = 2833, p = .007), where females scored significantly higher than males
- Substance use (t = -4.343, df = 2829, p < .001), where males scored significantly higher than females

Figure A6.5: Mean Carver Coping Scores by Sex (Weighted)

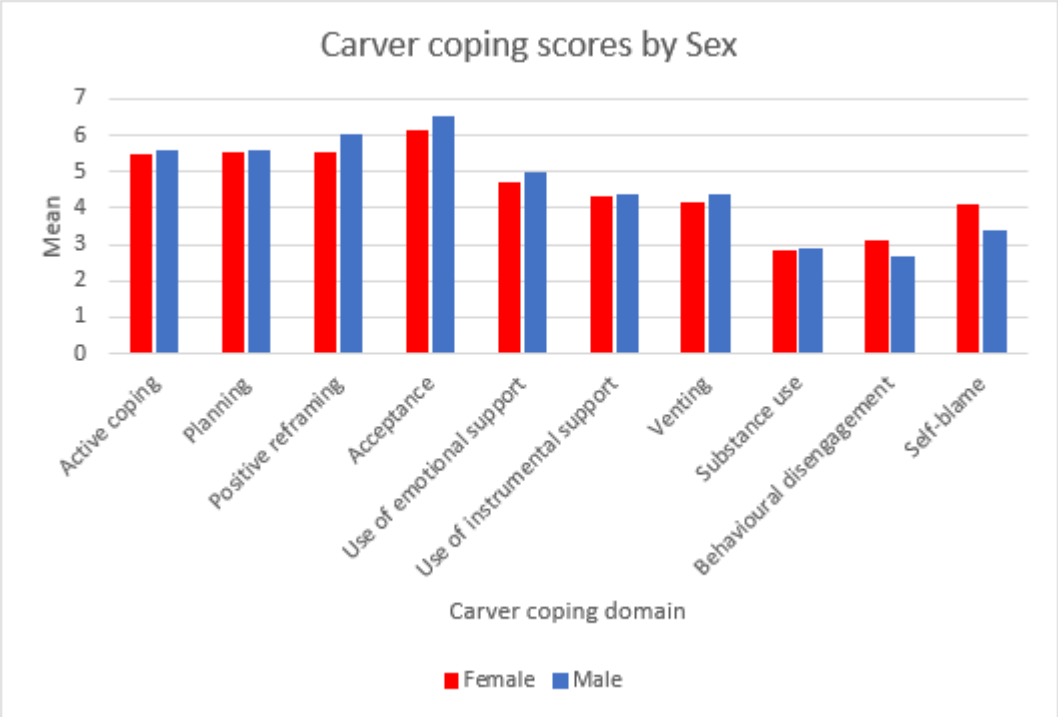

Figure A6.6: Mean Carver Coping Scores by Sex (Unweighted)

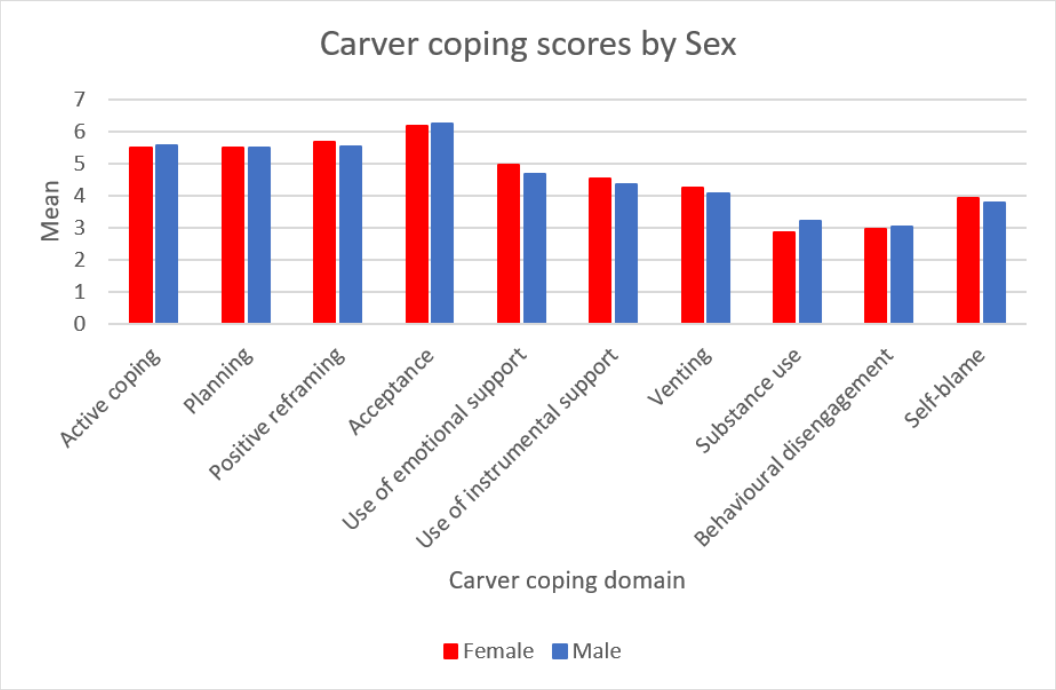

Table A6.5: Mean Carver Coping Scores by Sex (Weighted)

	Sex	
Coping domain	**Female**	**Male**
Active coping	5.47	5.55
Planning	5.53	5.55
Positive reframing	5.52	6.00
Acceptance	6.14	6.52
Use of emotional support	4.70	4.94
Use of instrumental support	4.28	4.38
Venting	4.11	4.38
Substance use	2.82	2.85
Behavioural disengagement	3.06	2.65
Self-blame	4.06	3.34

Table A6.6: Mean Carver Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Active coping	5.50	5.55
Planning	5.48	5.50
Positive reframing	5.67	5.51
Acceptance	6.17	6.22
Use of emotional support	4.95	4.66
Use of instrumental support	4.52	4.35
Venting	4.23	4.07
Substance use	2.84	3.22
Behavioural disengagement	2.95	3.02
Self-blame	3.94	3.79

A6.4 Carver Coping Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean scores on all ten Carver coping domains. These differences were in:

- Active coping ($F = 12.649$, $df = 6$, $p < .001$), where the 20-29 age group scored significantly lower than all of the older age groups; and the 66+ age group scored significantly higher than all of the younger groups except for the 16-19 age group (there were only six respondents in the 16-19 age group)
- Planning ($F = 17.490$, $df = 6$ $p < .001$), where the 66+ age group scored significantly higher than all of the younger groups except for the 16-19 age group; the 60-65 age group scored significantly higher than all of the younger age groups except for the 16-19 age group; and the 20-29 age group scored significantly lower than the 30-39, 40-49 and the 50-59 age groups.
- Positive reframing ($F = 5.301$, $df = 6$, $p < .001$), where the 30-39 age group scored significantly lower than the 50-59, 60-65 and the 66+ age groups
- Acceptance ($F = 15.695$, $df = 6$, $p < .001$), where the 60-65 and the 66+ age groups scored significantly higher than the 20-29, 30-39, 40-49 and the 50-59 age groups; and the 50-59 age group scored significantly lower than the 30-39 and the 40-49 age group
- Use of emotional support ($F = 7.069$, $df = 6$, $p < .001$), where the 66+ age group scored significantly higher than all of the younger age groups except for the 16-19 age group; and the 30-39 age group scored significantly higher than the 40-49 and the 50-59 age groups
- Use of instrumental support ($F = 19.827$, $df = 6$, $p < .001$), where the 66+ age group scored significantly higher than all of the younger age groups except for the 16-19 age group; and the 30-39 age group scored significantly higher than the 20-29, 40-49, 50-59 and the 60-65 age groups
- Venting ($F = 10.198$, $df = 6$, $p < .001$), where the 66+ age group scored significantly lower than the 16-19, 30-39, 40-49, 50-59 and the 60-65 age groups; and the 30-39 age group scored significantly higher than the 20-29, 40-49, 50-59 and the 60-65 age groups
- Substance use ($F = 14.343$, $df = 6$, $p < .001$), where the 16-19 age group scored significantly higher than all of the older age groups; the 60-65 and the 66+ age groups scored significantly lower than the 30-39, 40-49 and the 50-59 age groups; the 20-29 age group scored

significantly lower than the 30-39 and the 40-49 age groups; and the 50-59 age group scored significantly lower than the 30-39 age group

- Behavioural disengagement (F = 12.081, df = 6, p < .001), where the 16-19 age group scored significantly higher than all of the older age groups; and the 60-65 and the 66+ age groups scored significantly lower than all of the younger age groups
- Self-blame (F = 27.695, df = 6, p < .001), where the 60-65 age group scored significantly lower than all of the younger age groups; the 50-59 age group scored significantly lower than the 16-19, 20-29, 30-39 and the 40-49 age groups; and the 30-39 age group scored significantly higher than the 20-29, 40-49 and the 66+ age group

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on one out of the ten examined Carver coping domains. These differences were in:

- Use of instrumental support (F = 5.073, df = 6, p < .001), where the 50-59 age group scored significantly lower than the 20-29 and the 30-39 age groups; and the 60-65 age group scored significantly lower than the 30-39 age group

There also appeared to be significant differences between the age groups in the use of Acceptance as a coping strategy (F = 2.569, df = 6, p = .017), but multiple comparison tests revealed no statistically significant differences.

Figure A6.7: Mean Carver Coping Scores by Age (Weighted)

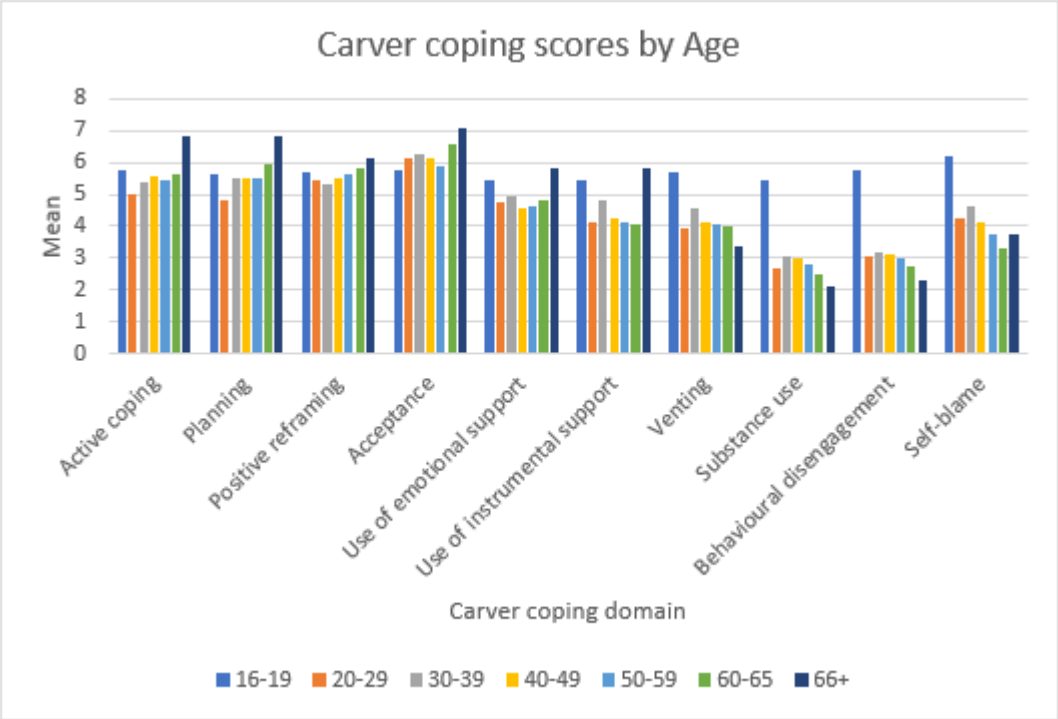

Figure A6.8: Mean Carver Coping Scores by Age (Unweighted)

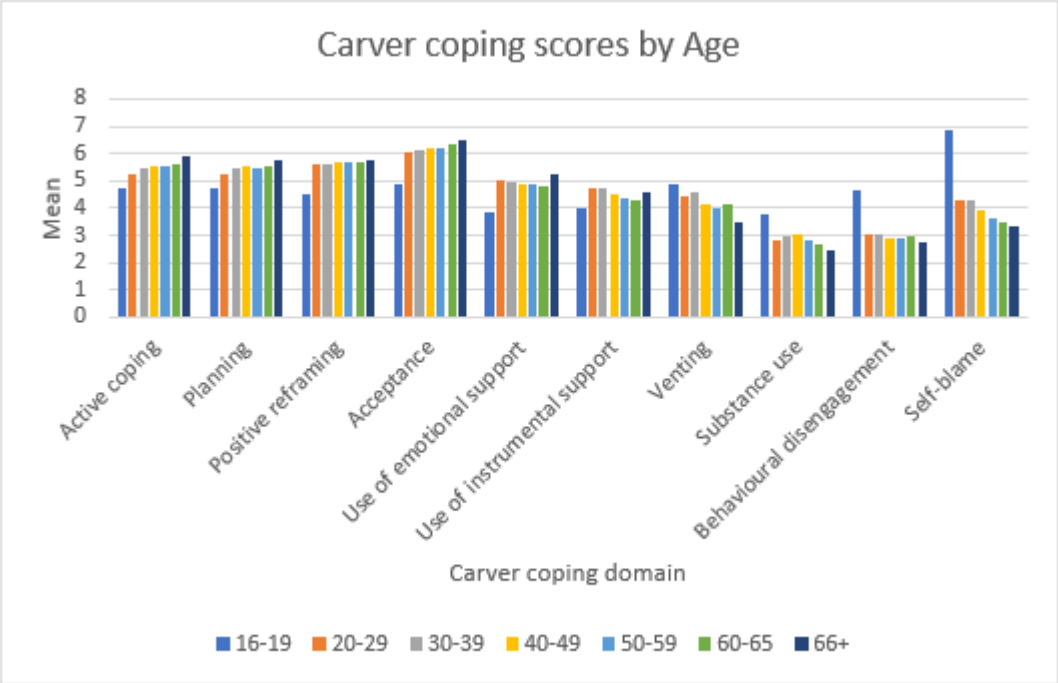

Table A6.7: Mean Carver Coping Scores by Age (Weighted)

	Age						
Coping domain	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Active coping	5.74	4.99	5.40	5.58	5.44	5.65	6.81
Planning	5.64	4.82	5.48	5.48	5.53	5.95	6.86
Positive reframing	5.67	5.46	5.32	5.51	5.65	5.81	6.15
Acceptance	5.78	6.13	6.26	6.17	5.90	6.60	7.11
Use of emotional support	5.47	4.73	4.96	4.55	4.62	4.79	5.81
Use of instrumental support	5.46	4.10	4.80	4.23	4.11	4.06	5.81
Venting	5.68	3.95	4.54	4.13	4.06	4.02	3.36
Substance use	5.47	2.66	3.07	2.99	2.80	2.51	2.09
Behavioural disengagement	5.75	3.08	3.19	3.12	2.98	2.73	2.33
Self-blame	6.21	4.22	4.65	4.11	3.74	3.31	3.73

Note. There were only six respondents in the 16-19 age group.

Table A6.8: Mean Carver Coping Scores by Age (Unweighted)

Coping domain	Age						
	16-19	20-29	30-39	40-49	50-59	60-65	66+
Active coping	4.75	5.28	5.45	5.55	5.56	5.59	5.91
Planning	4.75	5.26	5.49	5.54	5.48	5.54	5.77
Positive reframing	4.50	5.60	5.61	5.70	5.66	5.68	5.74
Acceptance	4.88	6.03	6.11	6.21	6.21	6.35	6.51
Use of emotional support	3.88	5.05	4.98	4.91	4.86	4.77	5.24
Use of instrumental support	4.00	4.72	4.74	4.49	4.33	4.27	4.60
Venting	4.88	4.43	4.59	4.12	3.97	4.11	3.49
Substance use	3.75	2.80	2.95	3.02	2.82	2.67	2.49
Behavioural disengagement	4.63	3.06	3.04	2.87	2.92	3.00	2.77
Self-blame	6.88	4.32	4.29	3.91	3.61	3.47	3.37

Note. There were only eight respondents in the 16-19 age group.

A6.5 Carver Coping Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on nine out of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 4.894$, $df = 3$, $p = .002$), where respondents identifying as black scored significantly higher than all the other ethnic groups
- Planning ($F = 11.953$, $df = 3$, $p < .001$), where respondents identifying as black scored significantly higher than all the other ethnic groups; and respondents identifying as white scored significantly higher than the Asian ethnic group
- Positive reframing ($F = 21.049$, $df = 3$, $p < .001$), where respondents identifying as Asian scored significantly lower than all the other ethnic groups; and the black ethnic group scored significantly higher than the white ethnic group
- Acceptance ($F = 4.938$, $df = 4$, $p = .002$), where the black ethnic group scored significantly higher than the white ethnic group
- Use of emotional support ($F = 5.575$, $df = 3$, $p = .001$), where the black ethnic group scored significantly higher than the white and Asian ethnic groups; and the mixed ethnic group scored significantly higher than the Asian ethnic group
- Use of instrumental support ($F = 3.443$, $df = 3$, $p = .016$), where the black ethnic group scored significantly higher than the white ethnic group
- Substance use ($F = 16.530$, $df = 3$, $p < .001$), where the Asian ethnic group scored significantly higher than all other ethnic groups; and the white ethnic group scored significantly higher than the black and mixed ethnic groups
- Behavioural disengagement ($F = 25.926$, $df = 3$, $p < .001$), where the Asian ethnic group scored significantly higher than all other ethnic groups; and the white ethnic group scored significantly higher than the black and mixed ethnic groups
- Self-blame ($F = 9.078$, $df = 3$, $p < .001$), where the Asian ethnic group scored significantly higher than all other ethnic groups; and the white ethnic group scored significantly higher than the black ethnic group

There also appeared to be significant differences in the use of Venting as a coping strategy (F = 3.301, df = 3, p = .020), but multiple comparisons revealed no statistically significant differences.

Summary (Unweighted results):

There were significant differences between the ethnic groups in mean scores on one out of the ten examined Carver coping domains. These differences were in:

- Positive reframing (F = 2.739, df = 3, p = .042), where respondents from the black ethnic group scored significantly higher than those from the Asian ethnic group

There also appeared to be significant differences between the ethnic groups in the Use of emotional support as a coping strategy (F = 3.175, df = 3, p = .023), but multiple comparison tests revealed no statistically significant differences.

Figure A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

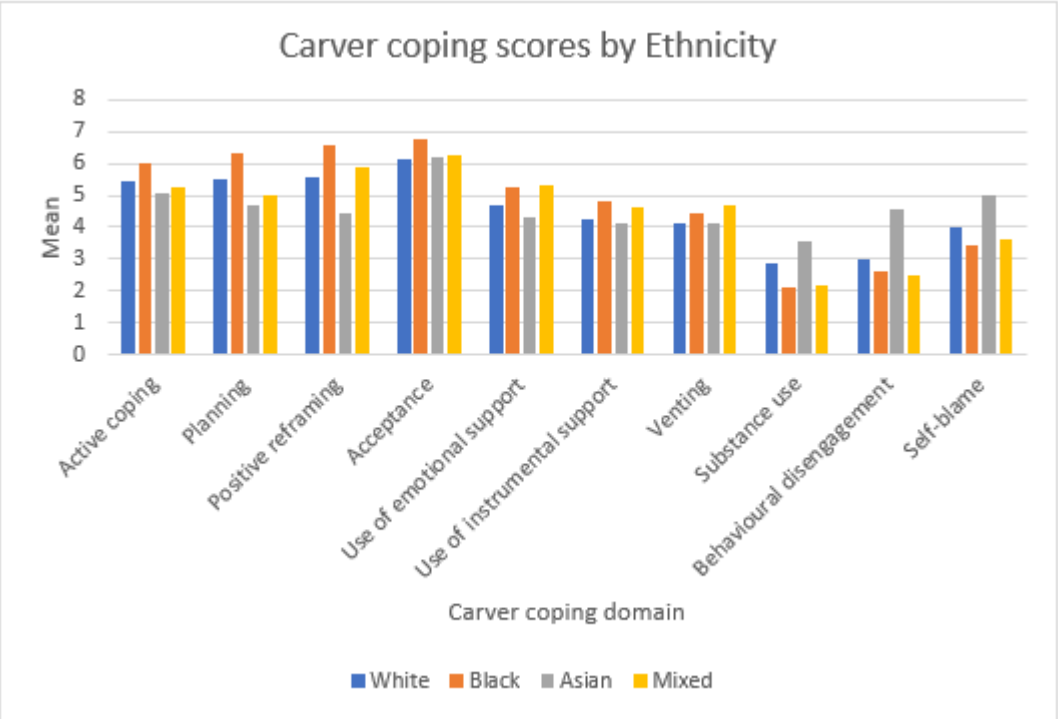

Figure A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

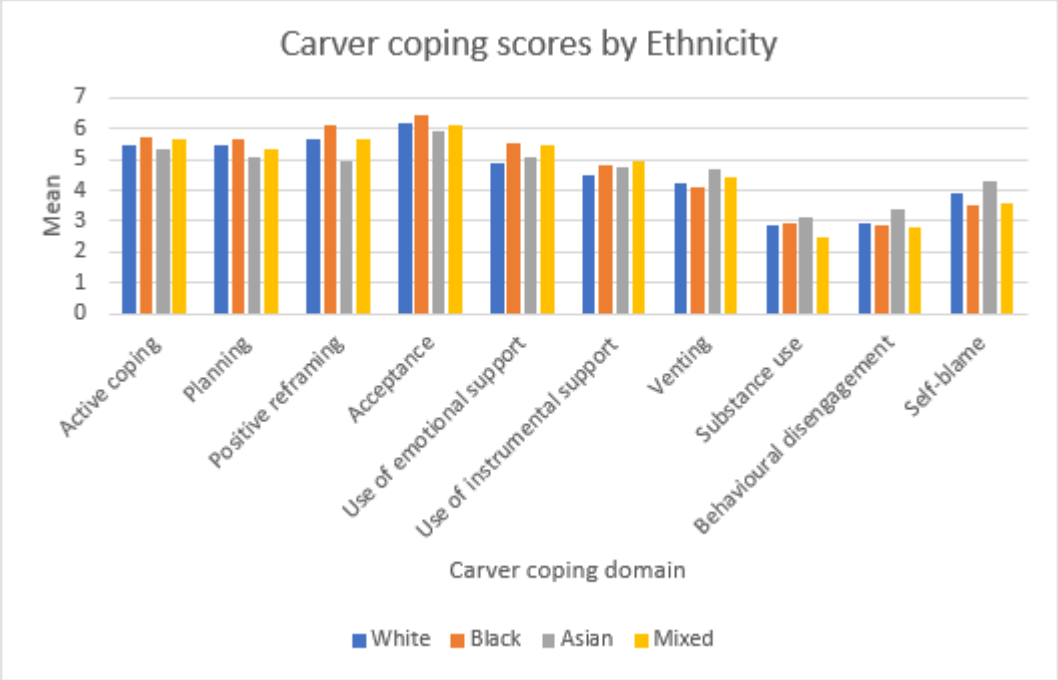

Table A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

	Ethnicity			
Coping domain	**White**	**Black**	**Asian**	**Mixed**
Active coping	5.47	6.03	5.08	5.28
Planning	5.52	6.34	4.67	5.01
Positive reframing	5.55	6.57	4.42	5.89
Acceptance	6.16	6.74	6.23	6.26
Use of emotional support	4.71	5.27	4.33	5.29
Use of instrumental support	4.27	4.79	4.13	4.61
Venting	4.11	4.45	4.14	4.68
Substance use	2.85	2.10	3.58	2.20
Behavioural disengagement	3.01	2.61	4.55	2.46
Self-blame	3.99	3.44	5.03	3.61

Table A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.50	5.74	5.32	5.67
Planning	5.49	5.65	5.07	5.33
Positive reframing	5.66	6.10	4.93	5.64
Acceptance	6.18	6.45	5.93	6.14
Use of emotional support	4.90	5.55	5.07	5.45
Use of instrumental support	4.49	4.84	4.75	4.95
Venting	4.21	4.07	4.68	4.44
Substance use	2.89	2.90	3.14	2.46
Behavioural disengagement	2.96	2.88	3.41	2.81
Self-blame	3.93	3.52	4.32	3.55

A6.6 Carver Coping Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in mean scores on eight out of the ten examined Carver coping domains. These differences were found in:

- Planning ($F = 19.344$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability and those who were unsure whether or not they had a disability
- Positive reframing ($F = 12.984$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability and those who were unsure whether or not they had a disability
- Use of emotional support ($F = 7.446$, $df = 2$, $p = .001$), where respondents who were unsure of whether or not they had a disability scored significantly lower than the other two groups
- Use of instrumental support ($F = 4.122$, $df = 2$, $p = .016$), where respondents who were unsure of whether or not they had a disability scored significantly lower than the other two groups
- Venting ($F = 4.720$, $df = 2$, $p = .009$), where respondents with a disability scored significantly lower than those without a disability
- Substance use ($F = 11.732$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than the other two groups; and respondents without a disability scored significantly higher than those who were unsure of whether or not they had a disability
- Behavioural disengagement ($F = 12.514$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than the other two groups
- Self-blame ($F = 23.739$, $df = 2$, $p < .001$), where respondents without a disability scored significantly lower than the other two groups

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on one out of the ten examined Carver coping domains. These differences were in:

- Behavioural disengagement ($F = 6.545$, $df = 2$, $p = .001$), where respondents with a disability scored significantly higher than those without a disability

Figure A6.11: Mean Carver Coping Scores by Disability (Weighted)

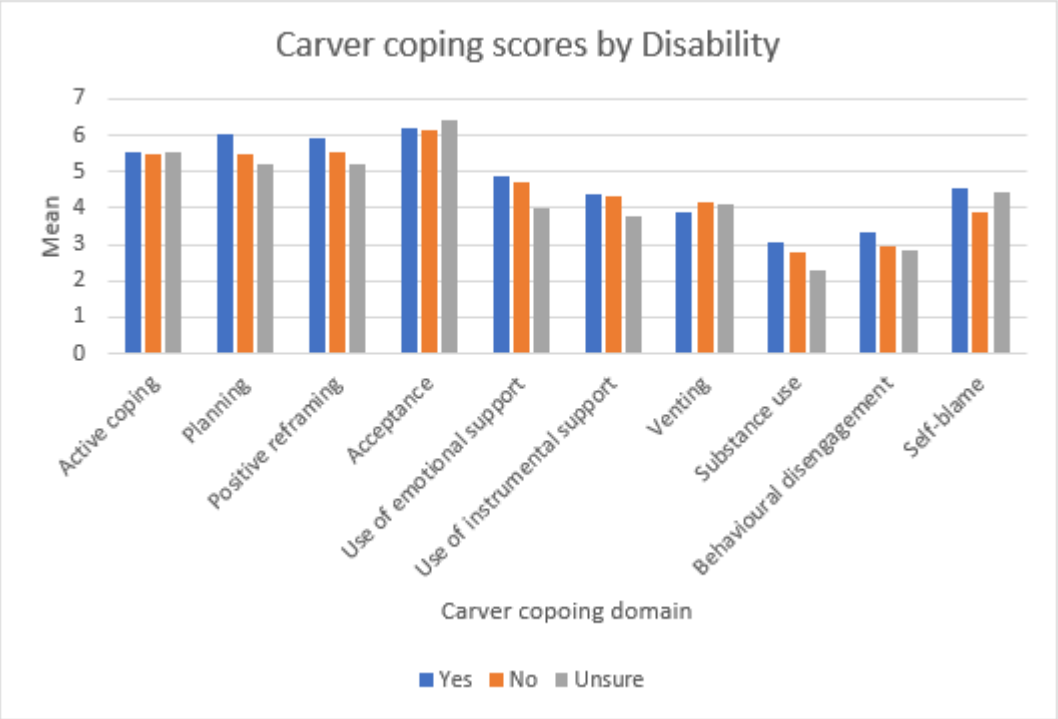

Figure A6.12: Mean Carver Coping Scores by Disability (Unweighted)

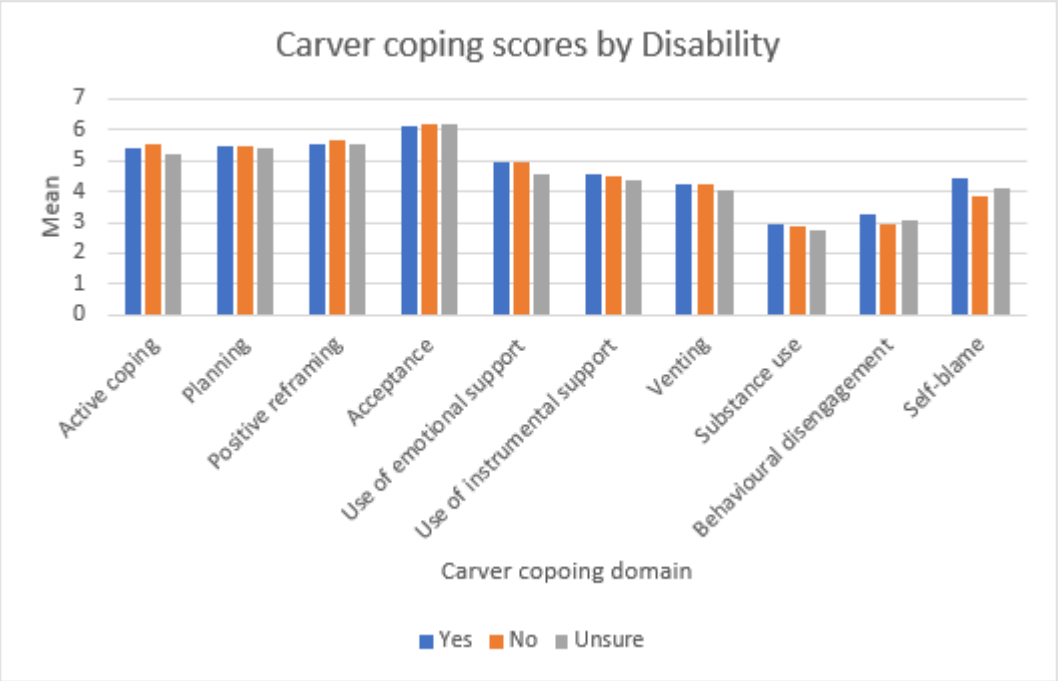

Table A6.11: Mean Carver Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Active coping	5.55	5.47	5.53
Planning	6.03	5.46	5.18
Positive reframing	5.94	5.52	5.18
Acceptance	6.22	6.17	6.43
Use of emotional support	4.86	4.73	4.02
Use of instrumental support	4.38	4.30	3.77
Venting	3.91	4.18	4.13
Substance use	3.07	2.80	2.28
Behavioural disengagement	3.33	2.97	2.86
Self-blame	4.52	3.88	4.41

Table A6.12: Mean Carver Coping Scores by Disability (Unweighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Active coping	5.40	5.53	5.18
Planning	5.44	5.49	5.43
Positive reframing	5.56	5.67	5.51
Acceptance	6.14	6.18	6.16
Use of emotional support	4.92	4.93	4.55
Use of instrumental support	4.57	4.51	4.34
Venting	4.26	4.21	4.03
Substance use	2.95	2.88	2.75
Behavioural disengagement	3.24	2.93	3.07
Self-blame	4.44	3.85	4.13

A6.7 Carver Coping Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences between respondents based on their main area of practice in mean scores on nine out of the ten examined Carver coping domains. These differences were in:

- Planning ($F = 4.422$, $df = 7$, $p < .001$), where those working in the 'Other' area scored significantly higher than those working in midwifery, with adults, physical disability and mental health services
- Positive reframing ($F = 3.333$, $df = 7$, $p = .002$), where respondents working with older people scored significantly higher than those working with adults or in mental health services
- Acceptance ($F = 3.134$, $df = 7$, $p = .003$), where respondents working in the area of midwifery scored significantly higher than those working with children, adults, physical disability, older people and mental health services
- Use of emotional support ($F = 4.471$, $df = 7$, $p < .001$), where respondents working in the area of mental health scored significantly higher than those working with adults, older people or 'other' services

- Use of instrumental support ($F = 3.953$, $df = 7$, $p < .001$), where respondents working with children or in the area of mental health scored significantly higher than those working with adults or older people
- Venting ($F = 13.441$, $df = 7$, $p < .001$), where respondents working with children scored significantly higher than those working with adults, older people, in the area of mental health or 'other' services; respondents working in midwifery scored significantly higher than those working with adults, in the area of learning disability, older people, mental health or 'other' services; and those working with adults and learning disability scored significantly higher than those working with older people
- Substance use ($F = 11.390$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly higher than those working in all other areas; and those working with adults, learning disability or mental health scored significantly higher than those working with physical disability or older people
- Behavioural disengagement ($F = 11.115$, $df = 7$, $p < .001$), where respondents working in the area of midwifery scored significantly higher than those working with children, adults, physical disability, older people, mental health and 'other' services; respondents working with children scored significantly lower than those working with adults, in learning disability or mental health services; and those working with adults, in learning disability or mental health services scored significantly higher than those working with older people or in 'other' services
- Self-blame ($F = 5.339$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly higher than those working in all other areas except for learning disability; and those working in physical disability services scored significantly lower than those working in learning disability or 'other' services

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean scores on five out of the ten examined Carver coping domains. These differences were in:

- Acceptance ($F = 2.941$, $df = 7$, $p = .005$), where respondents working in the area of learning disability scored significantly higher than those working with older people
- Use of emotional support ($F = 5.169$, $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those working with children, adults or in 'other' services; and respondents working in the area of learning disability scored significantly lower than those working with children
- Use of instrumental support ($F = 4.203$, $df = 7$, $p < .001$), where respondents working with children scored significantly higher than those working with older people or in the area of learning disability
- Venting ($F = 5.400$, $df = 7$, $p < .001$), where respondents working with children scored significantly higher than those working with older people or in the areas of learning disability or mental health services
- Behavioural disengagement ($F = 3.219$, $df = 7$, $p = .002$), where respondents working with older people scored significantly higher than those working with children

Figure A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

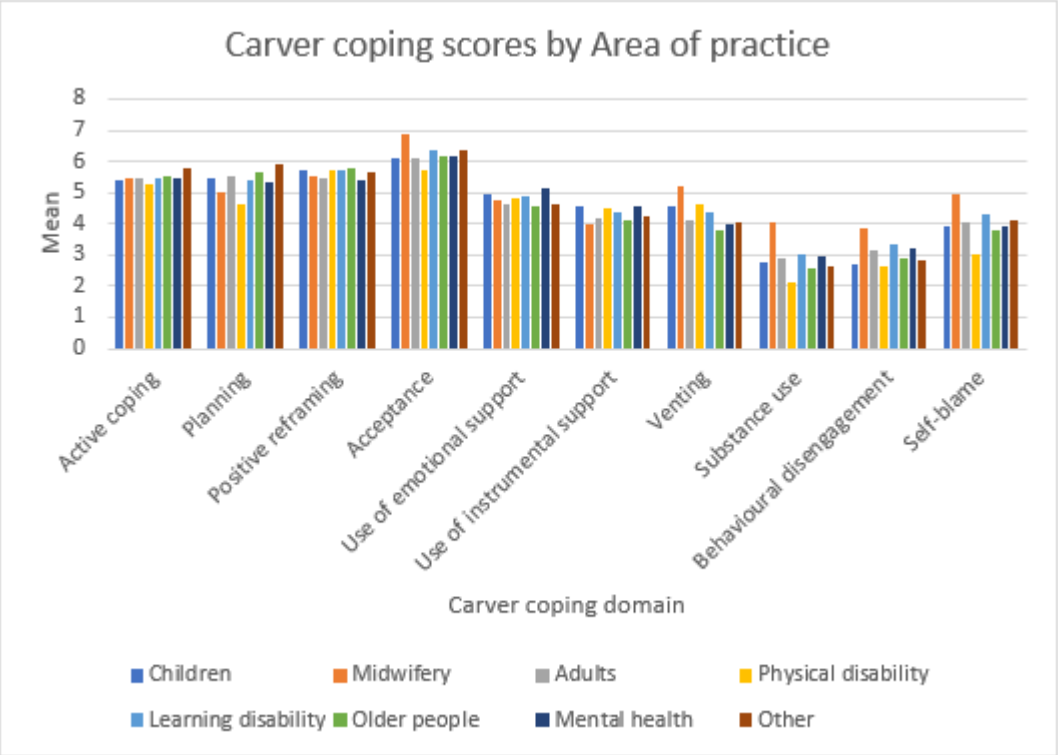

Figure A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)

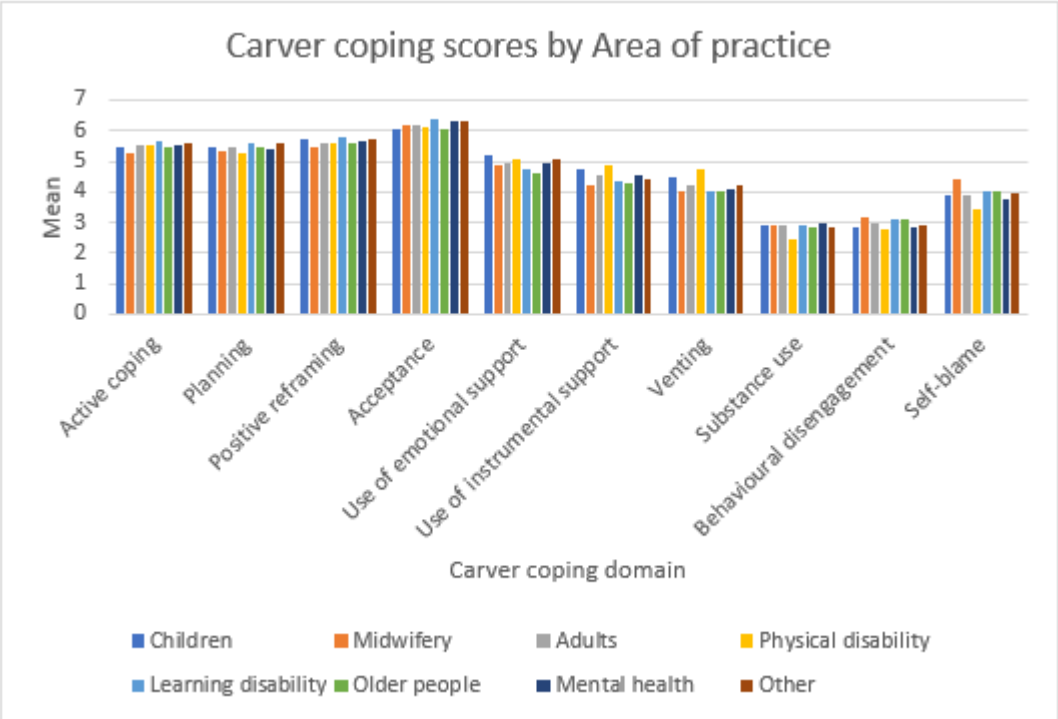

Table A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Active coping	5.39	5.49	5.44	5.28	5.49	5.51	5.45	5.80
Planning	5.49	5.01	5.53	4.63	5.41	5.63	5.32	5.92
Positive reframing	5.69	5.50	5.43	5.73	5.73	5.79	5.42	5.63
Acceptance	6.13	6.85	6.13	5.70	6.37	6.16	6.17	6.36
Use of emotional support	4.92	4.75	4.61	4.82	4.90	4.59	5.13	4.61
Use of instrumental support	4.57	4.01	4.20	4.49	4.35	4.13	4.56	4.25
Venting	4.58	5.20	4.13	4.65	4.36	3.76	4.01	4.02
Substance use	2.77	4.07	2.92	2.11	3.02	2.56	2.94	2.65
Behavioural disengagement	2.70	3.85	3.13	2.64	3.36	2.86	3.19	2.80
Self-blame	3.91	4.97	4.02	3.05	4.29	3.78	3.95	4.12

Table A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Active coping	5.46	5.27	5.51	5.51	5.66	5.45	5.51	5.62
Planning	5.46	5.36	5.47	5.28	5.60	5.47	5.42	5.60
Positive reframing	5.73	5.46	5.56	5.57	5.79	5.57	5.66	5.74
Acceptance	6.08	6.20	6.20	6.09	6.39	6.02	6.33	6.34
Use of emotional support	5.17	4.87	4.92	5.04	4.77	4.60	4.93	5.05
Use of instrumental support	4.75	4.20	4.53	4.85	4.35	4.30	4.51	4.38
Venting	4.46	4.05	4.23	4.72	4.00	4.01	4.09	4.24
Substance use	2.92	2.88	2.92	2.47	2.89	2.82	2.95	2.83
Behavioural disengagement	2.82	3.18	2.99	2.75	3.07	3.13	2.86	2.89
Self-blame	3.89	4.38	3.87	3.40	3.99	4.01	3.78	3.97

A6.8 Carver Coping Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between those who were line managers and those who were not in mean scores on six out of the ten Carver coping domains. These differences were in:

- Active coping ($t = 2.917$, $df = 2973$, $p = .004$), where line managers scored significantly higher than those who were not line managers
- Planning ($t = 5.448$, $df = 2974$, $p < .001$), where line managers scored significantly higher than those who were not line managers
- Positive reframing ($t = 12.784$, $df = 2975$, $p < .001$), where line managers scored significantly higher than those who were not line managers
- Acceptance ($t = 4.320$, $df = 2973$, $p < .001$), where line managers scored significantly higher than those who were not line managers
- Substance use ($t = 3.438$, $df = 2971$, $p = .001$), where line managers scored significantly higher than those who were not line managers
- Self-blame ($t = 4.319$, $df = 2972$, $p < .001$), where line managers scored significantly higher than those who were not line managers

Summary (Unweighted results):

There were significant differences between respondents who were line managers and those who were not in mean scores on four out of the ten examined Carver coping domains. These differences were in:

- Active coping ($t = 4.703$, $df = 2838$, $p < .001$), where line managers scored significantly higher than those who were not line managers
- Planning ($t = 6.621$, $df = 2839$, $p < .001$), where line managers scored significantly higher than those who were not line managers
- Positive reframing ($t = 6.099$, $df = 2842$, $p < .001$), where line managers scored significantly higher than those who were not line managers
- Acceptance ($t = 4.523$, $df = 2839$, $p < .001$), where line managers scored significantly higher than those who were not line managers

Figure A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)

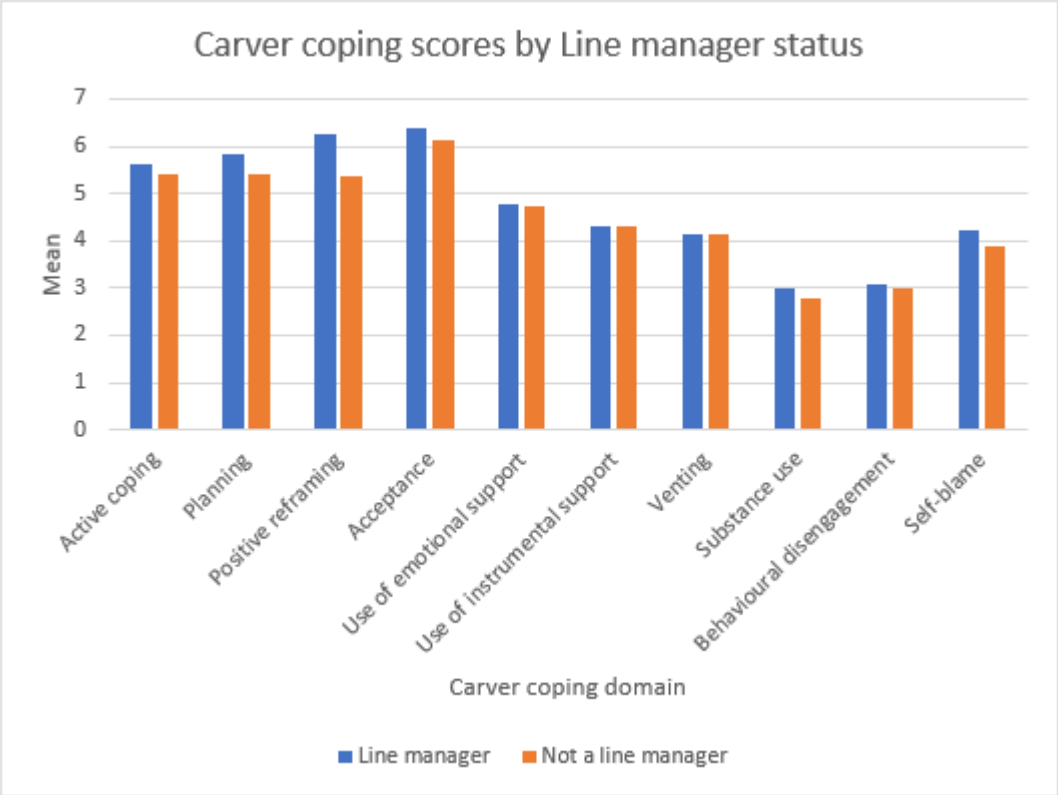

Figure A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

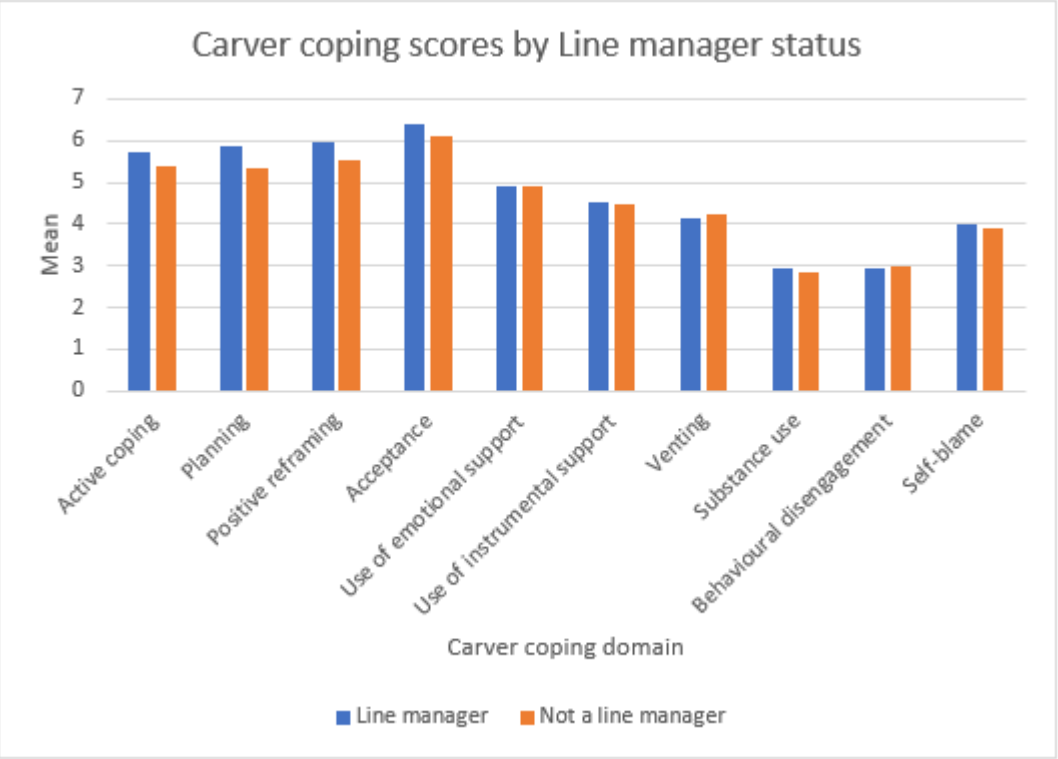

Table A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.64	5.43
Planning	5.85	5.42
Positive reframing	6.24	5.35
Acceptance	6.39	6.11
Use of emotional support	4.76	4.72
Use of instrumental support	4.32	4.29
Venting	4.12	4.14
Substance use	2.99	2.77
Behavioural disengagement	3.07	3.00
Self-blame	4.23	3.90

Table A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.74	5.41
Planning	5.85	5.34
Positive reframing	5.96	5.54
Acceptance	6.39	6.10
Use of emotional support	4.90	4.92
Use of instrumental support	4.54	4.49
Venting	4.14	4.24
Substance use	2.96	2.86
Behavioural disengagement	2.93	2.97
Self-blame	4.00	3.89

A6.9 Carver Coping Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean scores on nine out of the ten examined Carver coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Active coping ($F = 12.760$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups; and those who felt some impact scored significantly higher than those who were not impacted
- Planning ($F = 20.828$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups; and those who felt some impact scored significantly higher than those who were not impacted
- Positive reframing ($F = 14.297$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups
- Acceptance ($F = 3.075$, $df = 2$, $p = .046$), where respondents who were not impacted scored significantly higher than those who felt some impact

- Use of instrumental support ($F = 5.760$, $df = 2$, $p = .003$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who felt some impact
- Use of instrumental support ($F = 10.196$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who felt some impact
- Venting ($F = 20.183$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups
- Behavioural disengagement ($F = 20.382$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who felt some impact
- Self-blame ($F = 57.598$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups

Summary (Unweighted results):

There were significant differences in mean scores on six out of the ten examined Carver coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Planning ($F = 9.634$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact
- Use of instrumental support ($F = 6.566$, $df = 2$, $p = .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who felt no impact
- Venting ($F = 9.316$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact
- Substance use ($F = 9.172$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact
- Behavioural disengagement ($F = 27.893$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups
- Self-blame ($F = 48.182$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups

There also appeared to be significant differences between the groups in the Use of emotional support ($F = 3.586$, $df = 2$, $p = .028$), but multiple comparison tests revealed that there were no statistically significant differences.

Figure A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

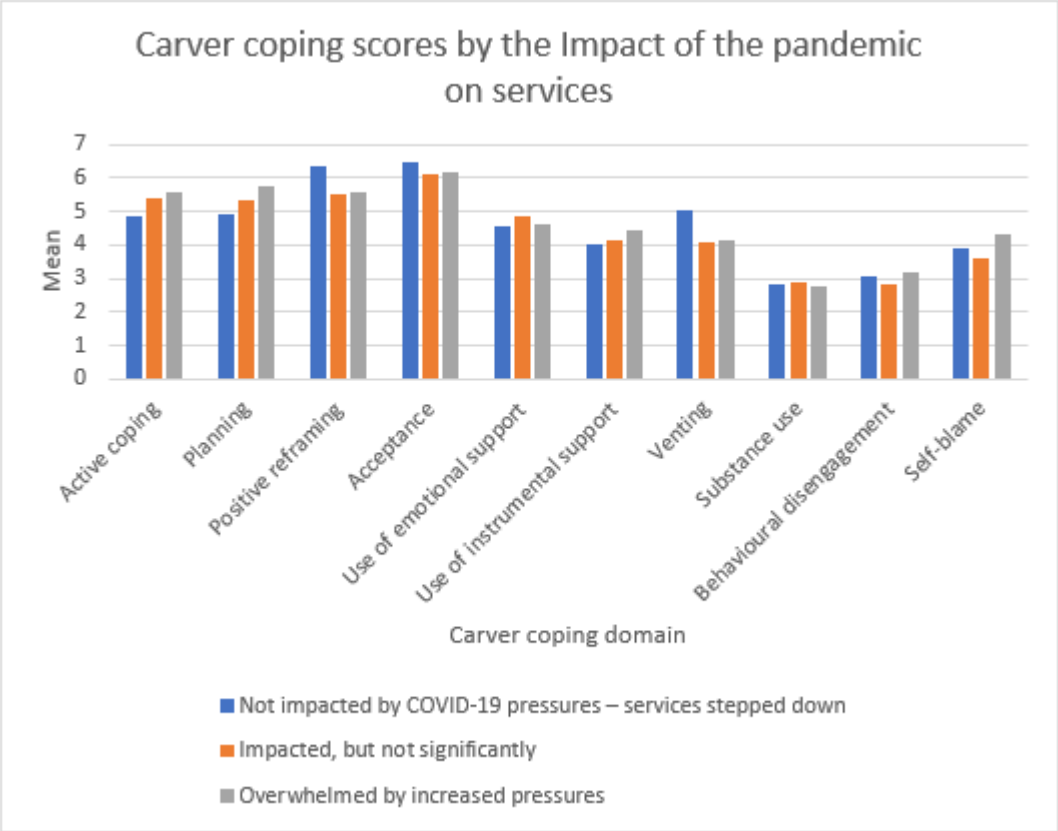

Figure A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)

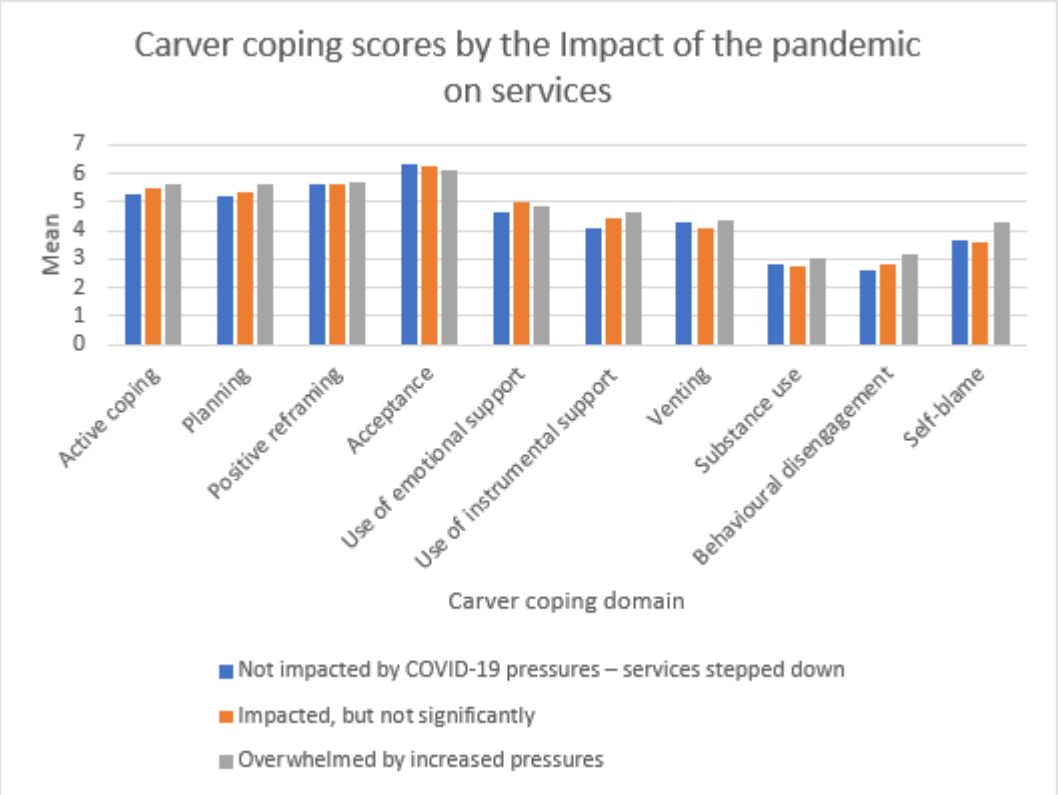

Table A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

Coping domain	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Active coping	4.89	5.40	5.60
Planning	4.92	5.36	5.73
Positive reframing	6.36	5.49	5.58
Acceptance	6.50	6.14	6.19
Use of emotional support	4.57	4.85	4.63
Use of instrumental support	4.05	4.16	4.44
Venting	5.06	4.07	4.12
Substance use	2.81	2.88	2.78
Behavioural disengagement	3.09	2.84	3.17
Self-blame	3.92	3.60	4.33

Table A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)

Coping domain	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Active coping	5.28	5.46	5.58
Planning	5.22	5.35	5.64
Positive reframing	5.64	5.61	5.70
Acceptance	6.30	6.22	6.13
Use of emotional support	4.60	4.99	4.86
Use of instrumental support	4.07	4.44	4.61
Venting	4.26	4.08	4.35
Substance use	2.81	2.77	3.01
Behavioural disengagement	2.62	2.79	3.16
Self-blame	3.63	3.60	4.27

Appendix 7: Clark Coping Scale (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of how respondents coped with work-related stressors. This was measured using 15 items (five domains) from Clark et al.'s scale. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A7.1 Clark Coping Scores by Country

Summary (Weighted results):

There were significant differences between the countries in mean scores on three out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 6.299$, $df = 3$, $p < .001$), where respondents from Wales scored significantly lower than those from Scotland and Northern Ireland
- Recreation and relaxation ($F = 6.898$, $df = 3$, $p < .001$), where respondents from Scotland scored significantly lower than those from the other three countries
- Exercise ($F = 5.358$, $df = 3$, $p = .001$), where respondents from Northern Ireland scored significantly higher than those from Scotland and Wales

Summary (Unweighted results):

There were significant differences between the countries in mean scores on three out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 6.763$, $df = 3$, $p < .001$), where respondents from Scotland scored significantly higher than those from the other three countries
- Recreation and relaxation ($F = 7.987$, $df = 3$, $p < .001$), where respondents from Scotland scored significantly lower than those from the other three countries
- Exercise ($F = 4.006$, $df = 3$, $p = .007$), where respondents from Scotland scored significantly lower than those from Northern Ireland

Figure A7.1: Mean Clark Coping Scores by Country (Weighted)

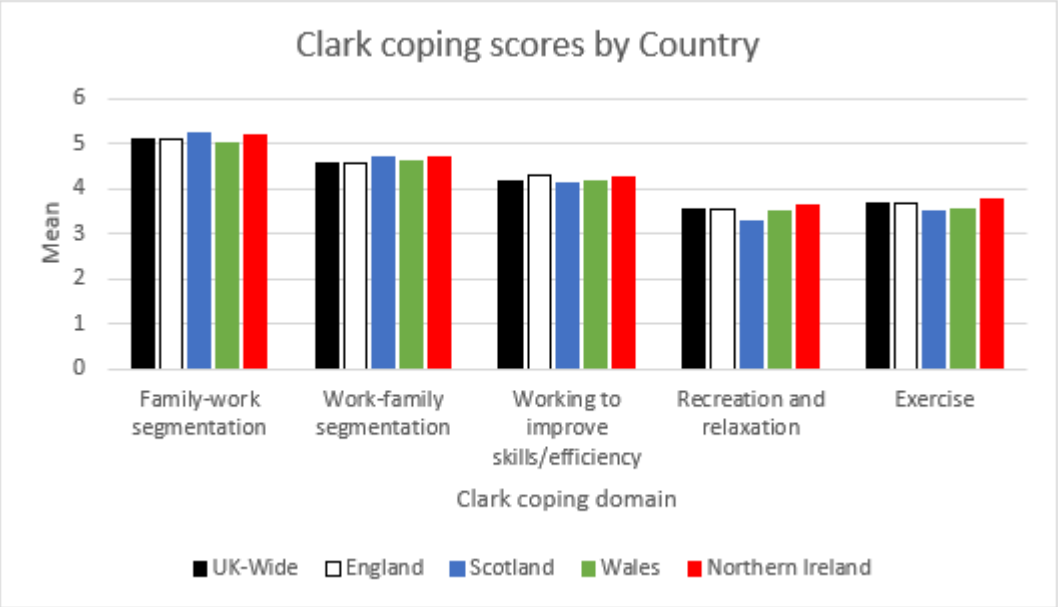

Figure A7.2: Mean Clark Coping Scores by Country (Unweighted)

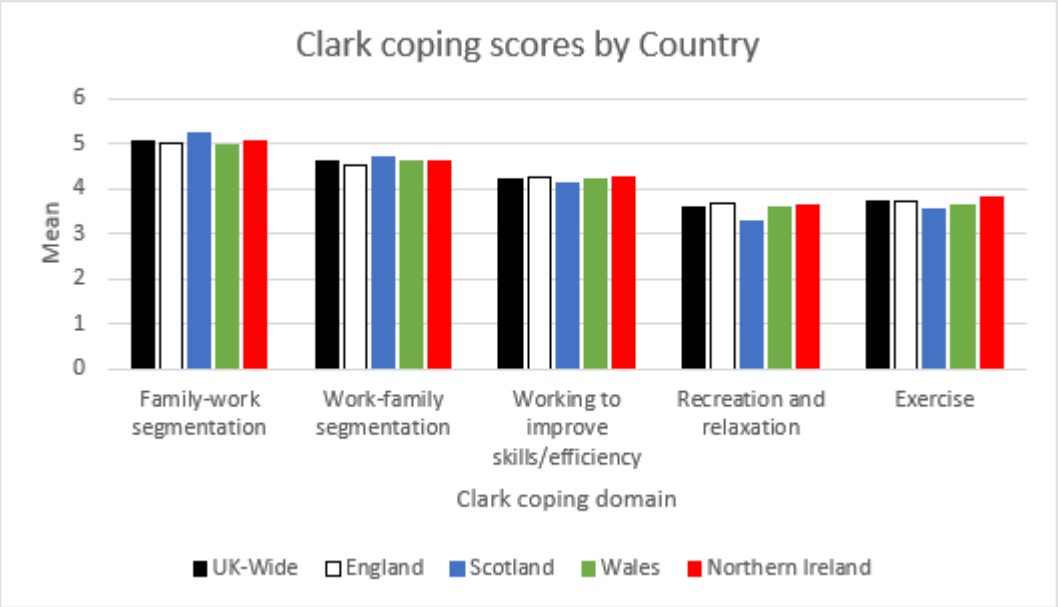

Table A7.1: Mean Clark Coping Scores by Country (Weighted)

	Country				
Coping domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Family-work segmentation	5.12	5.11	5.24	5.02	5.18
Work-family segmentation	4.59	4.59	4.71	4.62	4.69
Working to improve skills/efficiency	4.19	4.29	4.13	4.18	4.25
Recreation and relaxation	3.55	3.56	3.29	3.51	3.64
Exercise	3.66	3.68	3.50	3.53	3.75

Table A7.2: Mean Clark Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family-work segmentation	5.06	5.03	5.24	4.99	5.08
Work-family segmentation	4.60	4.52	4.71	4.61	4.60
Working to improve skills/efficiency	4.22	4.24	4.13	4.23	4.24
Recreation and relaxation	3.60	3.68	3.30	3.60	3.65
Exercise	3.71	3.72	3.55	3.65	3.82

A7.2 Clark Coping Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on all five Clark coping domains:

- Family-work segmentation ($F = 6.861$, $df = 4$, $p < .001$), where social care workers scored significantly higher than social workers
- Work-family segmentation ($F = 5.881$, $df = 4$, $p < .001$), where midwives scored significantly lower than nurses and social care workers; and social care workers scored significantly higher than social workers
- Working to improve skills/efficiency ($F = 10.219$, $df = 4$, $p < .001$), where social care workers scored significantly lower than nurses, AHPs and social workers
- Recreation and relaxation ($F = 7.286$, $df = 4$, $p < .001$), where midwives scored significantly lower than the other occupational groups
- Exercise ($F = 11.768$, $df = 4$, $p < .001$), where AHPs scored significantly higher than the other occupational groups

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on all five Clark Coping domains:

- Family-work segmentation ($F = 7.324$, $df = 4$, $p < .001$), where nurses scored significantly higher than AHPs and social workers; and social care workers scored significantly higher than AHPs and social workers
- Work-family segmentation ($F = 3.941$, $df = 4$, $p = .003$), where social care workers scored significantly higher than AHPs
- Working to improve skills/efficiency ($F = 7.348$, $df = 4$, $p < .001$), where social care workers scored significantly lower than nurses, AHPs and social workers
- Recreation and relaxation ($F = 9.674$, $df = 4$, $p < .001$), where social workers scored significantly higher than midwives and social care workers; and AHPs scored significantly higher than social care workers
- Exercise ($F = 12.696$, $df = 4$, $p < .001$), where AHPs scored significantly higher than nurses, social care workers and social workers; and social workers scored significantly higher than social care workers

Figure A7.3: Mean Clark Coping Scores by Occupation (Weighted)

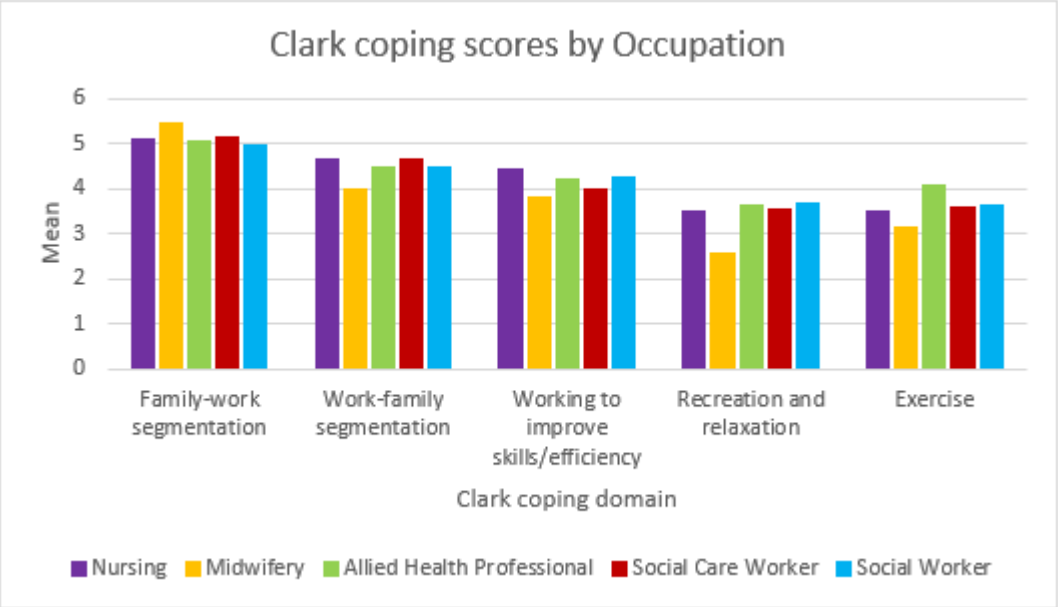

Figure A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

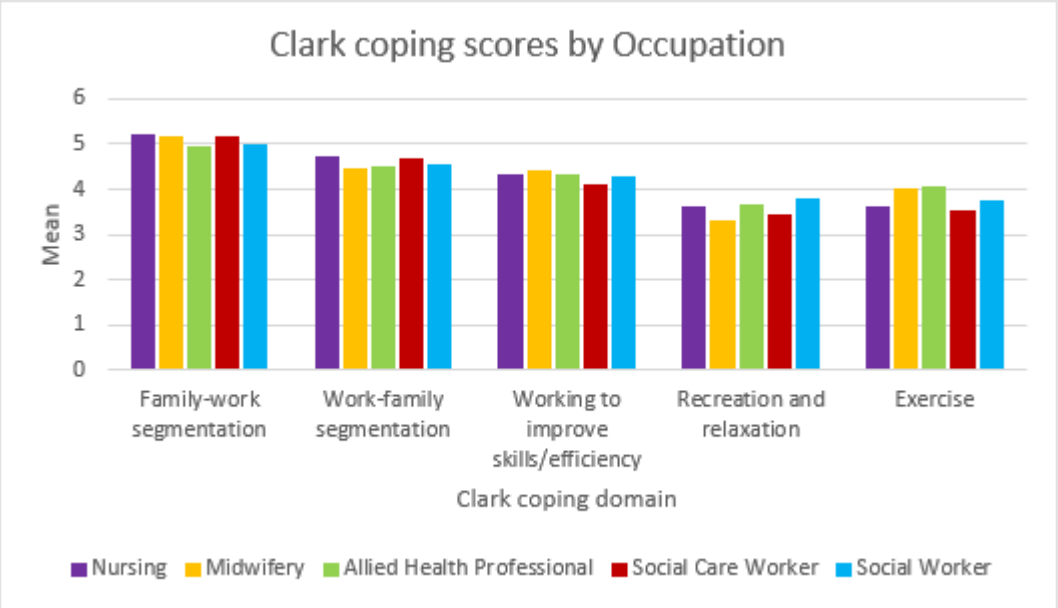

Table A7.3: Mean Clark Coping Scores by Occupation (Weighted)

	Occupation				
Coping domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Family-work segmentation	5.12	5.46	5.04	5.16	4.98
Work-family segmentation	4.67	3.98	4.48	4.66	4.49
Working to improve skills/efficiency	4.42	3.82	4.23	3.99	4.25
Recreation and relaxation	3.50	2.56	3.64	3.54	3.70
Exercise	3.49	3.15	4.07	3.60	3.63

Table A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	5.21	5.17	4.95	5.14	4.99
Work-family segmentation	4.72	4.43	4.51	4.68	4.54
Working to improve skills/efficiency	4.31	4.40	4.33	4.07	4.28
Recreation and relaxation	3.60	3.30	3.64	3.43	3.76
Exercise	3.58	4.02	4.05	3.53	3.74

A7.3 Clark Coping Scores by Sex

Only two respondents who answered questions on the Clark coping scale stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

There were significant differences between males and females in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($t = 4.224$, $df = 2865$, $p < .001$), where females scored significantly higher than males
- Work-family segmentation ($t = -4.357$, $df = 2864$, $p < .001$), where males scored significantly higher than females
- Recreation and relaxation ($t = -8.581$, $df = 2850$, $p < .001$), where males scored significantly higher than females
- Exercise ($t = -2.884$, $df = 2853$, $p = .004$), where males scored significantly higher than females

Summary (Unweighted results):

There were significant differences between males and females in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ($t = -3.176$, $df = 2753$, $p = .002$), where males scored significantly higher than females
- Working to improve skills/efficiency ($t = 2.164$, $df = 2749$, $p = .031$), where females scored significantly higher than males
- Recreation and relaxation ($t = -2.885$, $df = 2733$, $p = .004$), where males scored significantly higher than females
- Exercise ($t = -2.493$, $df = 2749$, $p = .013$), where males scored significantly higher than females

Figure A7.5: Mean Clark Coping Scores by Sex (Weighted)

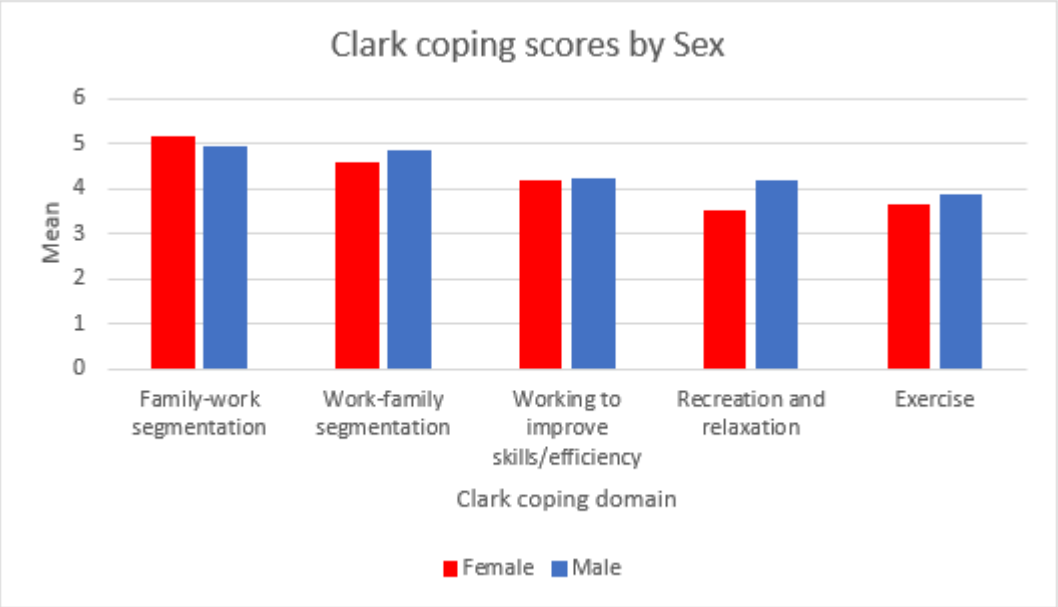

Figure A7.6: Mean Clark Coping Scores by Sex (Unweighted)

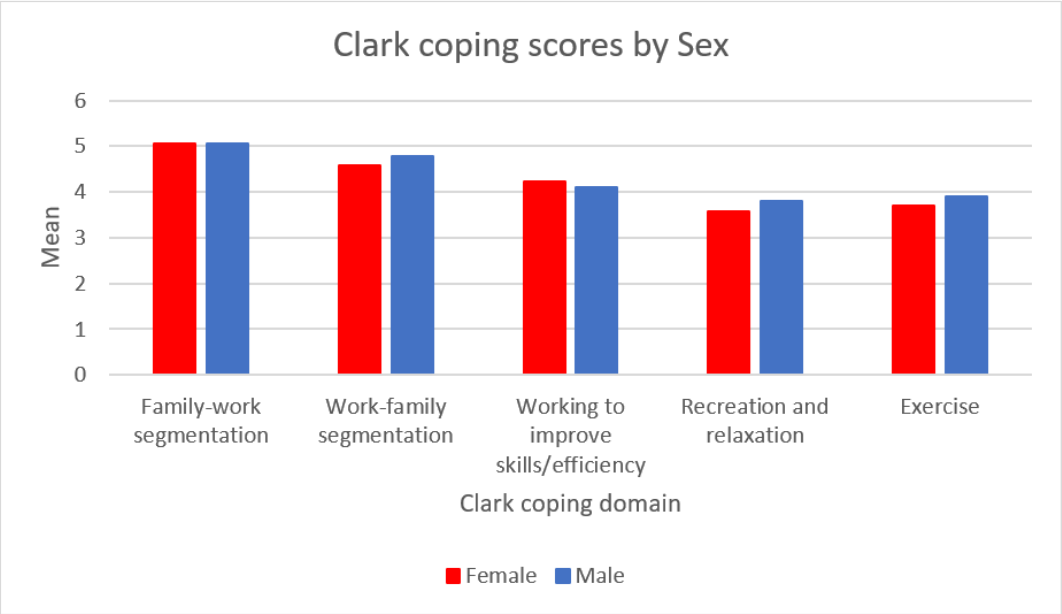

Table A7.5: Mean Clark Coping Scores by Sex (Weighted)

	Sex	
Coping Domain	**Female**	**Male**
Family-work segmentation	5.15	4.93
Work-family segmentation	4.56	4.83
Working to improve skills/efficiency	4.18	4.23
Recreation and relaxation	3.48	4.15
Exercise	3.63	3.87

Table A7.6: Mean Clark Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Family-work segmentation	5.06	5.06
Work-family segmentation	4.57	4.78
Working to improve skills/efficiency	4.24	4.10
Recreation and relaxation	3.57	3.79
Exercise	3.69	3.90

A7.4 Clark Coping Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean scores on all five Clark coping domains. These differences were in:

- Family-work segmentation ($F = 10.599$, $df = 6$, $p < .001$), where the 66+ age group scored significantly higher than all of the younger age groups except for the 16-19 age group; the 20-29 age group scored significantly higher than the 30-39 and the 60-65 age group; the 30-39 age group scored significantly lower than the 40-49 and the 50-59 age groups; and the 50-59 age group scored significantly higher than the 60-65 age group
- Work-family segmentation ($F = 13.003$, $df = 6$, $p < .001$), where the 66+ age group scored significantly higher than all of the other age groups except for the 16-19 age group; and the 30-39 age group scored significantly lower than the 16-19, 40-49, 50-59 and the 60-65 age groups
- Working to improve skills/efficiency ($F = 10.537$, $df = 6$, $p < .001$), where the 66+ age group scored significantly higher than all of the other age groups except for the 16-19 age group; the 30-39 and the 40-49 age groups scored significantly lower than the 50-59 and the 60-65 age groups; and the 16-19 age group scored significantly higher than the 20-29, 30-39 and the 40-49 age groups
- Recreation and relaxation ($F = 7.501$, $df = 6$, $p < .001$), where the 16-19 age group scored significantly higher than all of the other age groups; the 30-39 age group scored significantly lower than the 20-29, 50-59 and the 60-65 age groups; and the 20-29 age group scored significantly higher than the 40-49 age group
- Exercise ($F = 13.854$, $df = 6$, $p < .001$), where the 16-19 age group scored significantly higher than all of the other groups except for the 66+ age group; the 66+ age group scored significantly higher than the 30-39, 40-49, 50-59 and the 60-65 age groups; the 60-65 age group scored significantly lower than the 20-29, 30-39 and the 50-59 age groups; the 40-49 age group scored significantly lower than the 20-29 and the 50-59 age groups; and the 20-29 age group scored significantly higher than the 30-39 age group

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on one out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ($F= 7.915$, $df = 6$, $p < .001$), where the 20-29 age group scored significantly lower than the 40-49, 50-59, 60-65 and 66+ age groups; and the 30-39 age group scored significantly lower than the 50-59 and 60-65 age groups

There also appeared to be significant differences between the age groups on Recreation and relaxation (F = 2.537, df = 6, p = .019), but multiple comparison tests revealed no statistically significant differences.

Figure A7.7: Mean Clark Coping Scores by Age (Weighted)

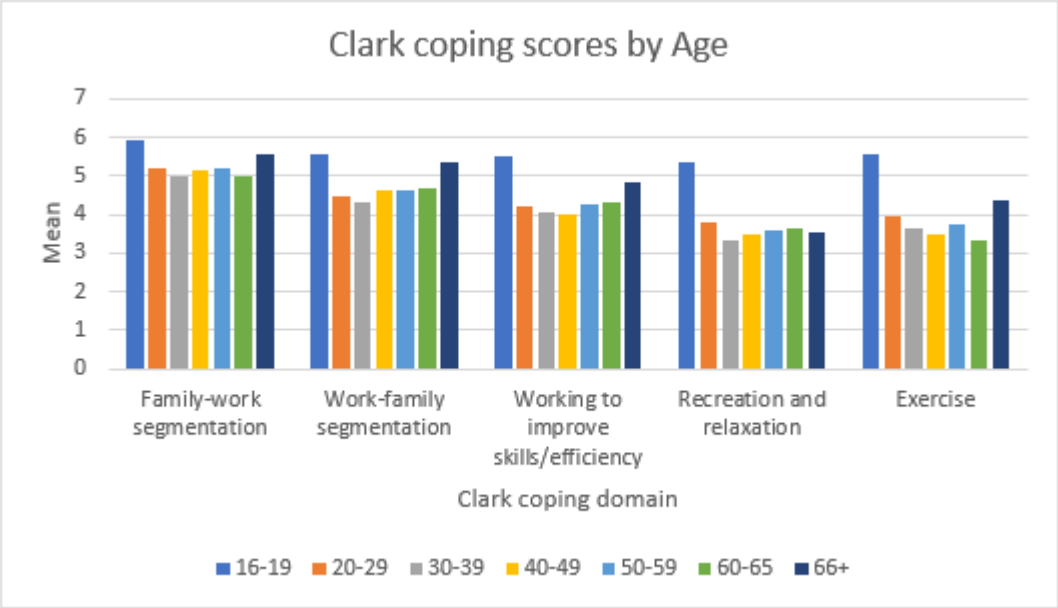

Figure A7.8: Mean Clark Coping Scores by Age (Unweighted)

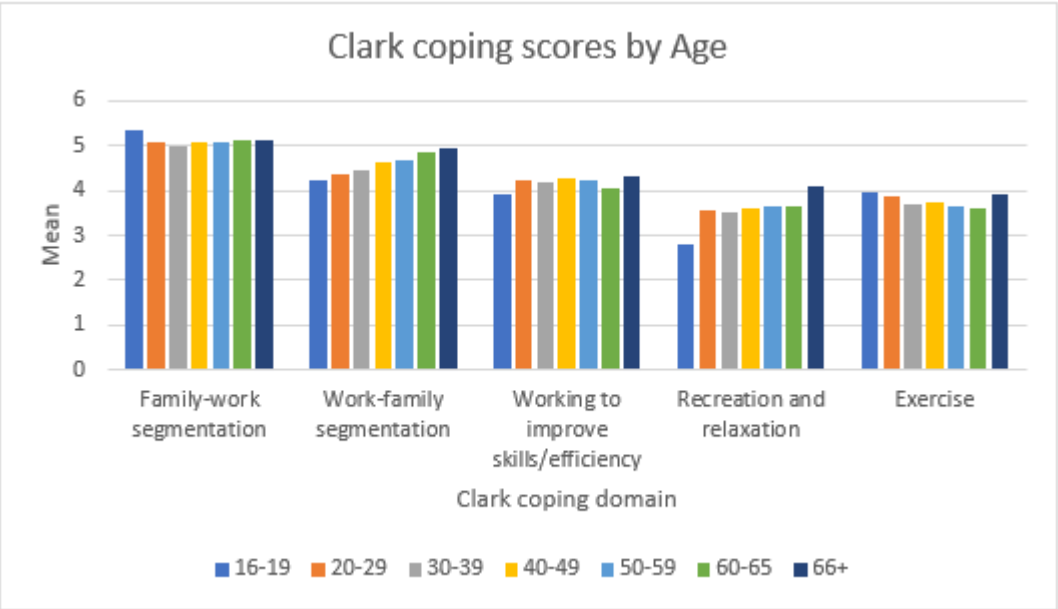

Table A7.7: Mean Clark Coping Scores by Age (Weighted)

Coping domain	Age						
	16-19	20-29	30-39	40-49	50-59	60-65	66+
Family-work segmentation	5.91	5.21	4.97	5.13	5.20	5.00	5.58
Work-family segmentation	5.59	4.47	4.34	4.65	4.62	4.67	5.34
Working to improve skills/efficiency	5.53	4.19	4.07	4.01	4.26	4.33	4.86
Recreation and relaxation	5.35	3.81	3.32	3.49	3.61	3.64	3.54
Exercise	5.59	3.95	3.64	3.49	3.77	3.34	4.39

Table A7.8: Mean Clark Coping Scores by Age (Unweighted)

Coping domain	Age						
	16-19	20-29	30-39	40-49	50-59	60-65	66+
Family-work segmentation	5.33	5.07	4.99	5.07	5.09	5.11	5.11
Work-family segmentation	4.21	4.36	4.46	4.62	4.69	4.86	4.94
Working to improve skills/efficiency	3.92	4.21	4.19	4.28	4.25	4.07	4.32
Recreation and relaxation	2.79	3.54	3.51	3.59	3.66	3.65	4.09
Exercise	3.96	3.89	3.68	3.74	3.66	3.61	3.91

A7.5 Clark Coping Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ($F = 12.061$, $df = 3$, $p < .001$), where respondents from the white ethnic group scored significantly higher than those from the black and Asian ethnic groups; and respondents from the mixed ethnic group scored significantly higher than those from the black ethnic group
- Working to improve skills/efficiency ($F = 4.106$, $df = 3$, $p = .006$), where respondents from the black ethnic group scored significantly higher than those from the white and Asian ethnic groups
- Recreation and relaxation ($F = 11.499$, $df = 3$, $p < .001$), where respondents from the Asian ethnic group scored significantly lower than those from all the other ethnic groups; and respondents from the black ethnic group scored significantly higher than those from the white ethnic group
- Exercise ($F = 5.382$, $df = 3$, $p = .001$), where respondents from the Asian ethnic group scored significantly lower than those from all other ethnic groups

Summary (Unweighted results):

There were no significant differences between the ethnic groups in mean scores on any of the five examined Clark coping domains.

Figure A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

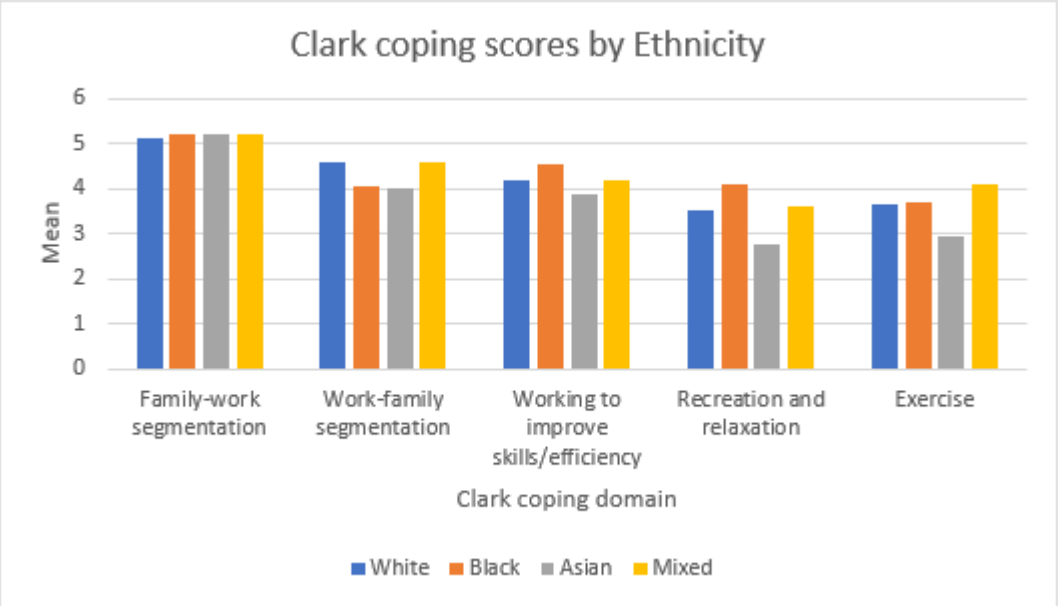

Figure A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

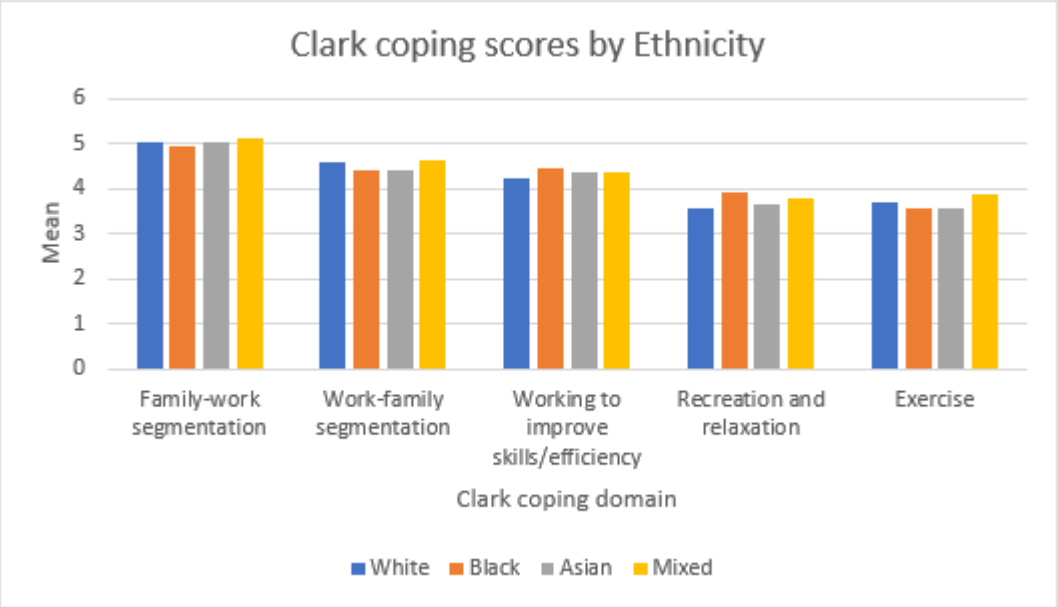

Table A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

	Ethnicity			
Coping domain	**White**	**Black**	**Asian**	**Mixed**
Family-work segmentation	5.12	5.21	5.21	5.23
Work-family segmentation	4.61	4.08	4.03	4.60
Working to improve skills/efficiency	4.18	4.54	3.90	4.20
Recreation and relaxation	3.54	4.12	2.76	3.63
Exercise	3.66	3.69	2.96	4.12

Table A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	5.06	4.97	5.03	5.11
Work-family segmentation	4.60	4.42	4.42	4.62
Working to improve skills/efficiency	4.22	4.48	4.37	4.37
Recreation and relaxation	3.59	3.92	3.68	3.81
Exercise	3.71	3.58	3.55	3.88

A7.6 Clark Coping Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 7.724$, $df = 2$, $p < .001$), where respondents who were unsure of whether or not they had a disability scored significantly higher than the other two groups
- Working to improve skills/efficiency ($F = 17.068$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than the other two groups; and those with no disability scored significantly higher than those who were unsure of whether or not they had a disability
- Recreation and relaxation ($F = 22.822$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than the other two groups; and those with no disability scored significantly higher than those who were unsure of whether or not they had a disability
- Exercise ($F = 13.981$, $df = 2$, $p < .001$), where respondents who were unsure of whether or not they had a disability scored significantly lower than the other two groups

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on one out of the five examined Clark coping domains. These differences were in:

- Exercise ($F = 14.602$, $df = 2$, $p < .001$), where respondents without a disability scored significantly higher than those with a disability and those who were unsure of whether or not they had a disability

Figure A7.11: Mean Clark Coping Scores by Disability (Weighted)

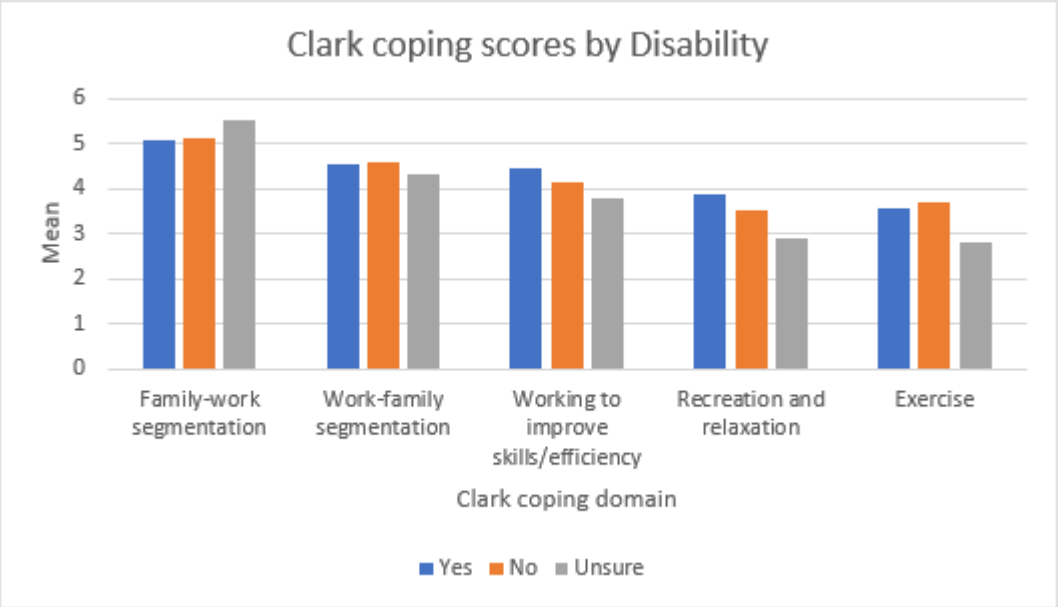

Figure A7.12: Mean Clark Coping Scores by Disability (Unweighted)

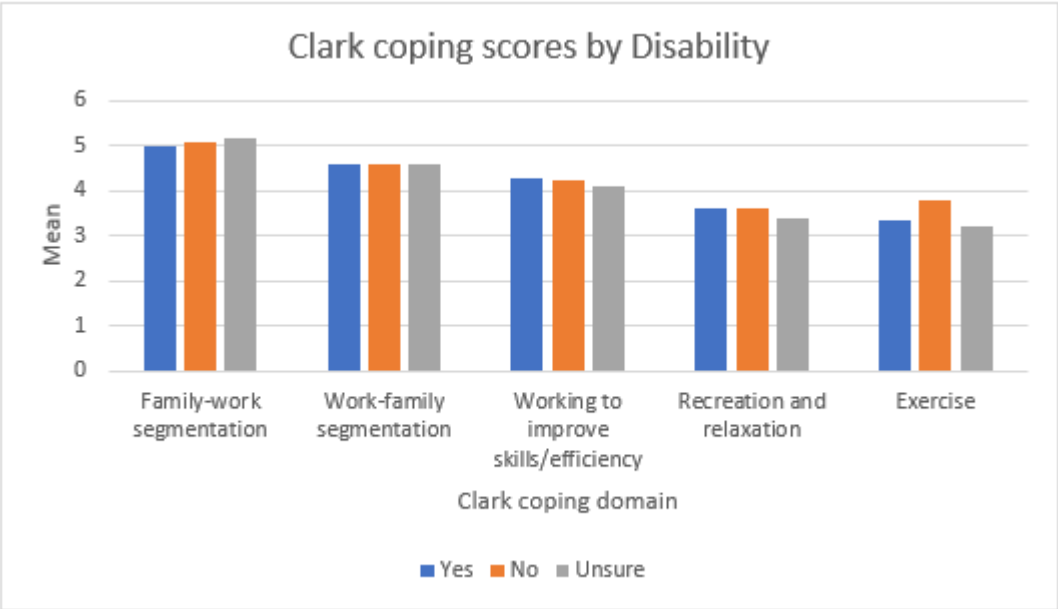

Table A7.11: Mean Clark Coping Scores by Disability (Weighted)

	Do you consider yourself to have a disability?		
Coping domain	**Yes**	**No**	**Unsure**
Family-work segmentation	5.08	5.12	5.51
Work-family segmentation	4.53	4.60	4.33
Working to improve skills/efficiency	4.47	4.15	3.80
Recreation and relaxation	3.89	3.52	2.89
Exercise	3.58	3.69	2.82

Table A7.12: Mean Clark Coping Scores by Disability (Unweighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Family-work segmentation	5.00	5.07	5.16
Work-family segmentation	4.58	4.60	4.59
Working to improve skills/efficiency	4.27	4.22	4.09
Recreation and relaxation	3.60	3.60	3.41
Exercise	3.35	3.77	3.21

A7.7 Clark Coping Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences between respondents based on their main area of practice in mean scores on all five Clark coping domains. These differences were in:

- Family-work segmentation ($F = 11.471$, $df = 7$, $p < .001$), where respondents working in the area of learning disability scored significantly lower than those from all other areas of practice; and those working in midwifery scored significantly higher than those working with children, adults, older people or in mental health services
- Work-family segmentation ($F = 7.879$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly lower than those working with children, adults, physical disability and in 'other' services; respondents working in the area of mental health scored significantly lower than those working with adults, physical disability and in 'other' services; and respondents working in the area of learning disability scored significantly lower than those working with adults, physical disability or in 'other' services
- Working to improve skills/efficiency ($F = 16.625$, $df = 7$, $p < .001$), where respondents working with children scored significantly higher than those working with adults, learning disability, older people or in 'other' services; respondents working in the area of mental health scored significantly higher than those working in learning disability, older people or in 'other' services; and respondents working with adults scored significantly higher than those working in learning disability and older people
- Recreation and relaxation ($F = 19.892$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly lower than those working with children, adults, in physical disability, learning disability and mental health services; respondents working in 'other' services scored significantly lower than those working with children, adults, in physical disability, learning disability and mental health services; respondents working with older people scored significantly lower than those working with children, adults, in physical disability, learning disability and mental health services; and those working in mental health services scored significantly higher than those working with adults
- Exercise ($F = 21.654$, $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those working with children, adults, in learning disability, mental health and 'other' services

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation (F = 3.026, df = 7, p = .004), where respondents working with children scored significantly lower than those working with older people and in mental health services
- Working to improve skills/efficiency (F = 6.421, df = 7, p < .001), where respondents working with older people scored significantly lower than those working with children, adults, in mental health and 'other' services
- Recreation and relaxation (F = 7.855, df = 7, p < .001), where respondents working in the area of mental health scored significantly higher than those working in midwifery, in learning disability, or with adults or older people; and respondents working with older people scored significantly lower than those working with children or adults
- Exercise (F = 6.899, df = 7, p < .001), where respondents working with older people scored significantly lower than those working with children, adults, or in the areas of midwifery or mental health

Figure A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

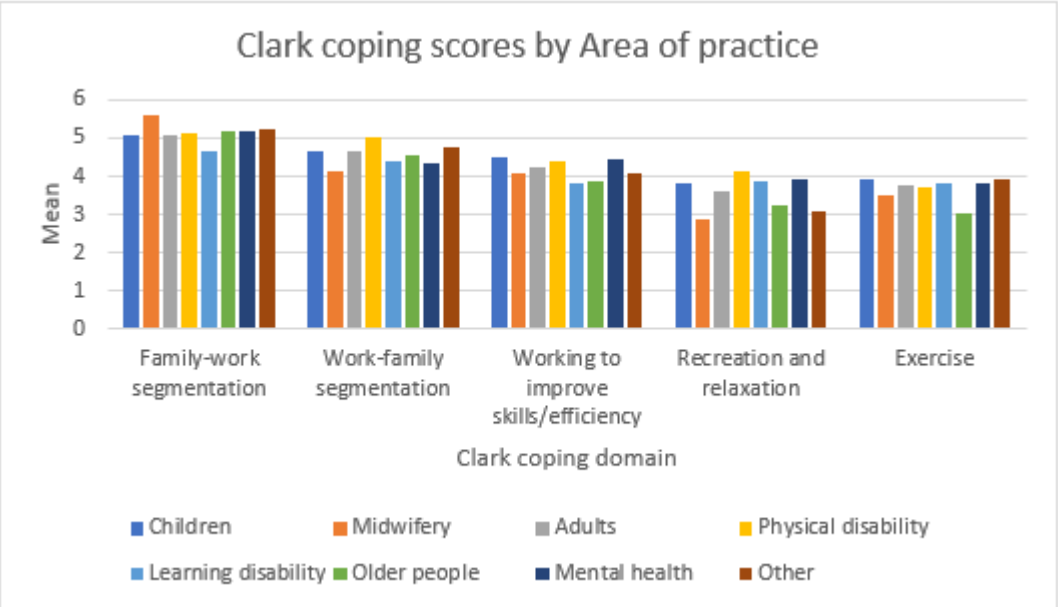

Figure A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)

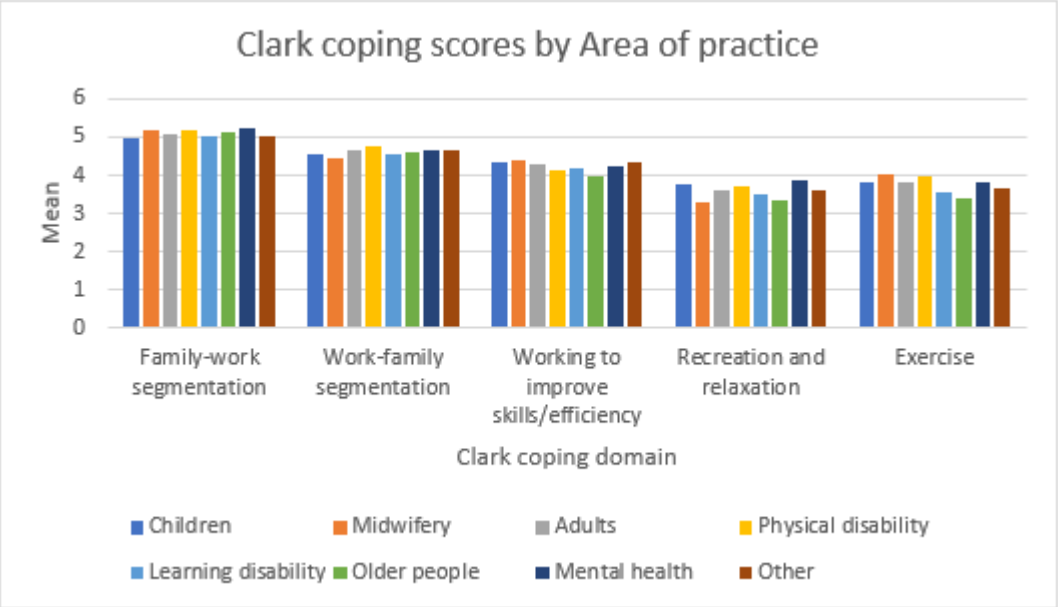

Table A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Family-work segmentation	5.06	5.61	5.10	5.15	4.65	5.19	5.20	5.24
Work-family segmentation	4.66	4.14	4.66	5.05	4.37	4.53	4.34	4.75
Working to improve skills/efficiency	4.48	4.10	4.25	4.40	3.82	3.85	4.43	4.06
Recreation and relaxation	3.79	2.89	3.62	4.12	3.85	3.25	3.90	3.06
Exercise	3.90	3.52	3.76	3.70	3.79	3.03	3.81	3.91

Table A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Family-work segmentation	4.97	5.16	5.06	5.16	5.00	5.14	5.21	5.03
Work-family segmentation	4.53	4.44	4.66	4.78	4.56	4.59	4.68	4.65
Working to improve skills/efficiency	4.33	4.39	4.29	4.12	4.16	3.97	4.25	4.34
Recreation and relaxation	3.75	3.31	3.59	3.71	3.52	3.32	3.87	3.62
Exercise	3.84	4.00	3.84	3.96	3.57	3.39	3.80	3.68

A7.8 Clark Coping Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between respondents who were line managers and those who were not in mean scores on three out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation (t = -3.305, df = 2865, p = .001), where line managers scored significantly lower than those who were not line managers
- Recreation and relaxation (t = -5.591, df = 2852, p < .001), where line managers scored significantly lower than those who were not line managers
- Exercise (t = -6.022, df = 2854, p < .001), where line managers scored significantly lower than those who were not line managers

Summary (Unweighted results):

There were significant differences between respondents who were line managers and those who were not in mean scores on two out of the five examined Clark coping domains. The differences were in:

- Recreation and relaxation (t = -2.247, df = 2735, p = .025), where line managers scored significantly lower than those who were not line managers
- Exercise (t = -2.998, df = 2751, p = .003), where line managers scored significantly lower than those who were not line managers

Figure A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

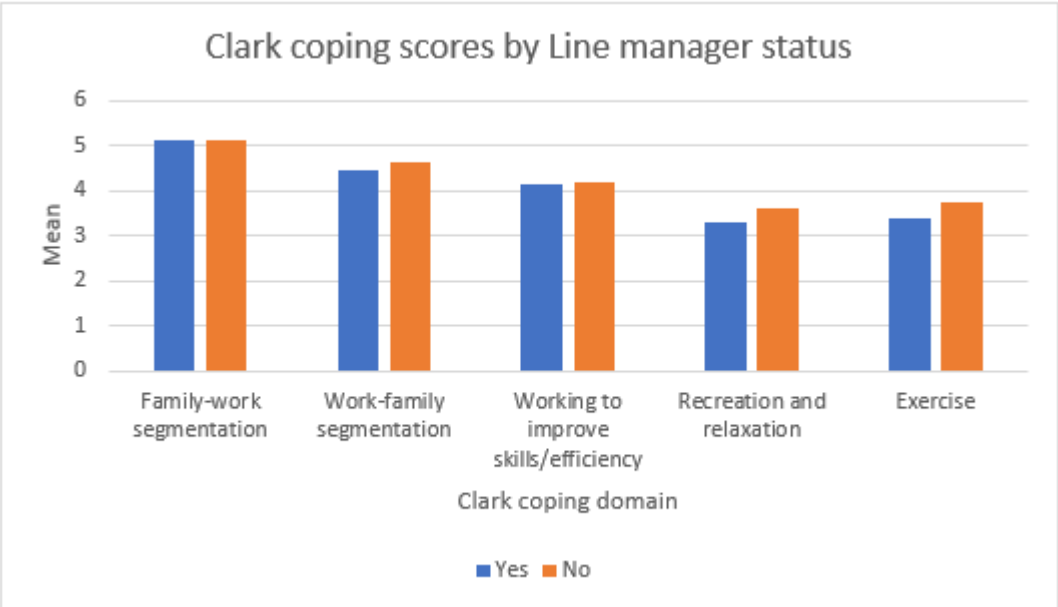

Figure A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

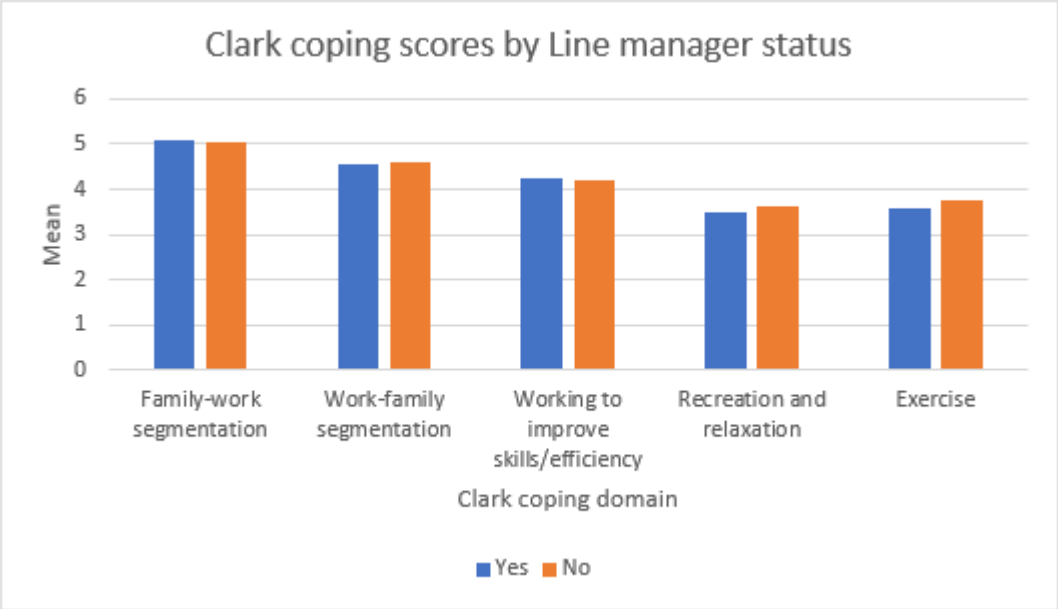

Table A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

	Are you a line manager?	
Coping domain	**Yes**	**No**
Family-work segmentation	5.12	5.12
Work-family segmentation	4.48	4.63
Working to improve skills/efficiency	4.14	4.20
Recreation and relaxation	3.32	3.63
Exercise	3.39	3.75

Table A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

	Are you a line manager?	
Coping domain	**Yes**	**No**
Family-work segmentation	5.10	5.05
Work-family segmentation	4.54	4.62
Working to improve skills/efficiency	4.23	4.22
Recreation and relaxation	3.51	3.63
Exercise	3.58	3.76

A7.9 Clark Coping Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean scores on three out of the five examined Clark coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Work-family segmentation (F = 8.996, df = 2, p < .001), where respondents who were not impacted scored significantly higher than the other two groups; and those who felt some impact scored significantly higher than those who felt overwhelmed by increased pressures
- Recreation and relaxation (F = 7.815, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly lower than the other two groups
- Exercise (F = 27.867, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who felt some impact

There also appeared to be significant differences between the groups on the Family-work segmentation (F = 3.894, df = 2, p = .020), but multiple comparisons showed no statistically significant differences.

Summary (Unweighted results):

There were significant differences in mean scores on three out of the five examined Clark coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Work-family segmentation (F = 6.712, df = 2, p = .001), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact
- Recreation and relaxation (F = 13.087, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact
- Exercise (F = 6.230, df = 2, p = .002), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact

There also appeared to be significant differences between the groups on the Working to improve skills/efficiency (F = 3.235, df = 2, p = .040), but multiple comparison tests revealed no statistically significant differences.

Figure A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

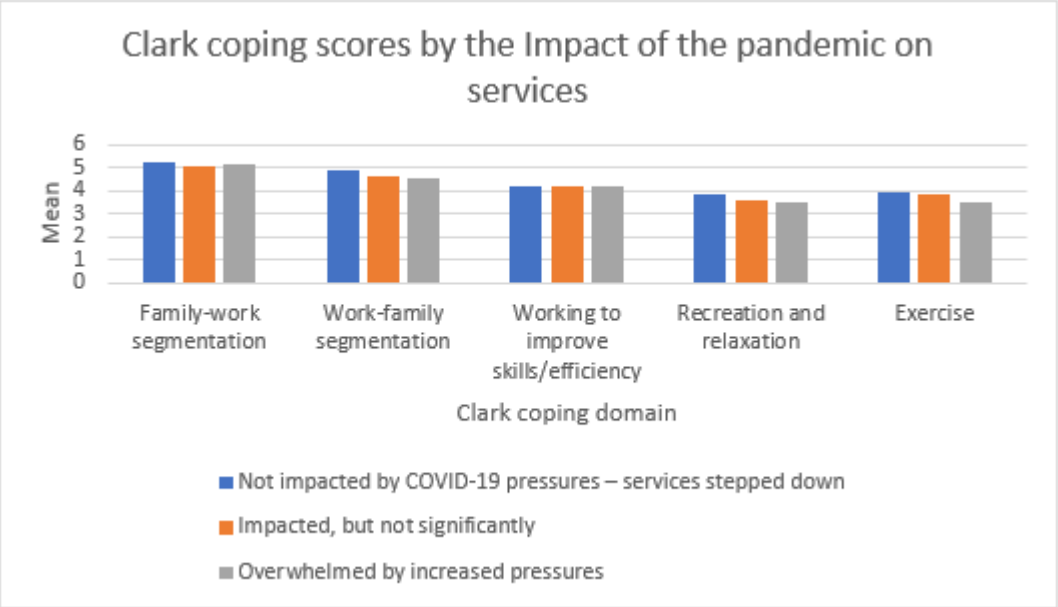

Figure A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)

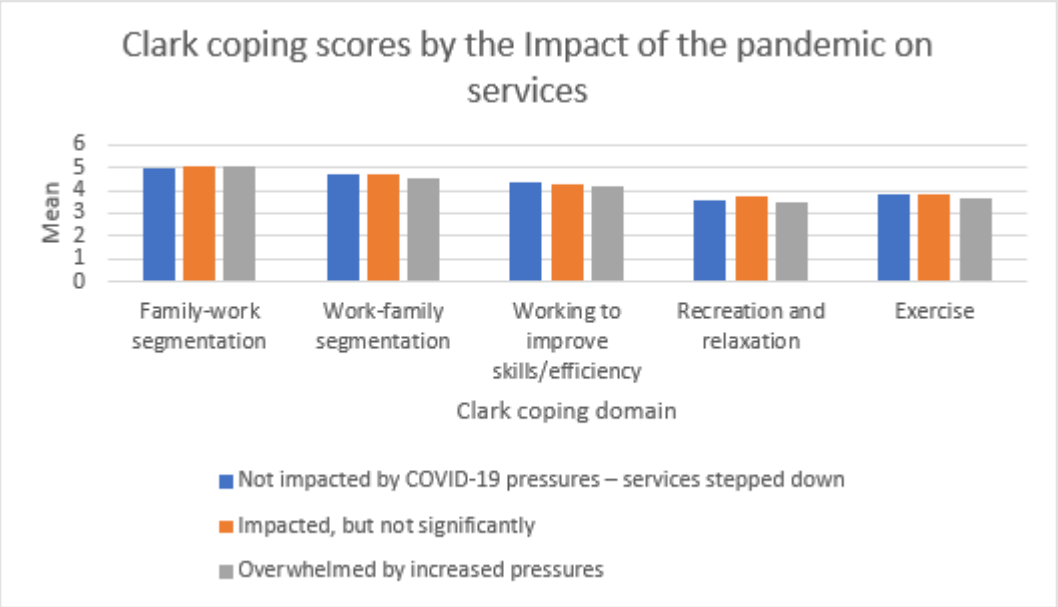

Table A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

	Impact of the pandemic on services		
Coping domain	**Not impacted by COVID-19 pressures – services stepped down**	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Family-work segmentation	5.25	5.08	5.15
Work-family segmentation	4.88	4.64	4.52
Working to improve skills/efficiency	4.18	4.20	4.17
Recreation and relaxation	3.85	3.62	3.47
Exercise	3.95	3.84	3.47

Table A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)

	Impact of the pandemic on services		
Coping domain	**Not impacted by COVID-19 pressures – services stepped down**	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Family-work segmentation	4.99	5.03	5.10
Work-family segmentation	4.70	4.67	4.52
Working to improve skills/efficiency	4.36	4.27	4.17
Recreation and relaxation	3.56	3.72	3.47
Exercise	3.84	3.80	3.61

Appendix 8: Multiple Regression Results (Unweighted)

A8.1 Multiple Regression Model Predicting Wellbeing Scores

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

Please note that the results of this regression are NOT directly comparable to the regression results from Phase 1 of the survey.

Method: A multiple linear regression model was constructed with the Wellbeing scores (SWEMWBS) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)

Results: The model explained 42.2% of the variance (adjusted $R^2 = .413$, $F(41, 2624) = 46.781$, $p < .001$). The following coping strategies predicted overall wellbeing score (SWEMWBS):

1. **Carver's Active coping**; respondents with higher Active coping scores had higher Wellbeing scores ($\beta = 0.061$, $p = .011$)
2. **Carver's Planning**; respondents with higher Planning scores had lower Wellbeing scores ($\beta = -0.056$, $p = .024$)
3. **Carver's Positive reframing**; respondents with higher Positive reframing scores had higher Wellbeing scores ($\beta = 0.082$, $p < .001$)
4. **Carver's Acceptance**; respondents with higher Acceptance scores had higher Wellbeing scores ($\beta = 0.113$, $p < .001$)
5. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher Wellbeing scores ($\beta = 0.202$, $p < .001$)
6. **Carver's Venting**; respondents with higher venting scores had lower Wellbeing scores ($\beta = -0.079$, $p < .001$)
7. **Carver's Substance use**; respondents with higher Substance use scores had lower Wellbeing scores (-0.042, $p = .009$)
8. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower Wellbeing scores ($\beta = -0.104$, $p < .001$)
9. **Carver's Self-blame**; respondents with higher Self-blame scores had lower Wellbeing scores ($\beta = -0.276$, $p < .001$)

10. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower Wellbeing scores ($\beta = -0.078$, $p < .001$)
11. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher Wellbeing scores ($\beta = 0.043$, $p = .016$)
12. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher Wellbeing scores ($\beta = 0.115$, $p < .001$)
13. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher Wellbeing scores ($\beta = 0.068$, $p < .001$)
14. **Clark et al.'s Exercise**; respondents with higher Exercise scores had higher Wellbeing scores ($\beta = 0.039$, $p = .019$)

Other variables predicting the overall wellbeing score:

15. **Disability**; respondents who were unsure of whether or not they had a disability had lower wellbeing scores than those who did not have a disability ($\beta = -0.048$, $p = .001$)
16. **Country of work**; respondents from Northern Ireland had higher scores than those from England ($\beta = 0.056$, $p = .006$)
17. **Occupational group**; AHPs ($\beta = -0.064$, $p = .005$), social care workers ($\beta = -0.059$, $p = .027$) and social workers ($\beta = -0.083$, $p = .001$) all had lower wellbeing scores than nurses
18. **Number of sick days in previous 12 months**; respondents who took 11-20 sick days in previous 12 months ($\beta = -0.040$, $p = .010$) had lower wellbeing scores than those who took no sick days
19. **Line manager status**; respondents who were line managers had higher wellbeing scores than those who were not line managers ($\beta = 0.037$, $p = .019$)
20. **Effects of the pandemic on services**; respondents who felt their services had been impacted a little ($\beta = -0.086$, $p = .030$) and those who felt overwhelmed ($\beta = -0.161$, $p < .001$) had lower wellbeing scores than those who felt no impact

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, the results showed that respondents who felt neither prepared nor unprepared ($\beta = -0.137$, $p = .015$) and those who felt unprepared ($\beta = -0.142$, $p = .017$) for redeployment had lower wellbeing scores than those who felt well prepared.

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

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

Please note that the results of this regression are NOT directly comparable to the regression results from Phase 1 of the survey.

Method: A multiple linear regression model was constructed with the Work-related quality of life scores (WRQOL) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)

Results: The model explained 39.5% of the variance (adjusted $R^2 = .385$, $F(41, 2604) = 41.453$, $p < .001$). The following coping strategies predicted overall work-related quality of life score (WRQOL):

1. **Carver's Planning**; respondents with higher Planning scores had lower WRQOL scores ($\beta = -0.101$, $p < .001$)
2. **Carver's Positive reframing**; respondents with higher Positive reframing scores had higher WRQOL scores ($\beta = 0.071$, $p = .001$)
3. **Carver's Acceptance**; respondents with higher Acceptance scores had higher WRQOL scores ($\beta = 0.055$, $p = .003$)
4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher WRQOL scores ($\beta = 0.204$, $p < .001$)
5. **Carver's Venting**; respondents with higher Venting scores had lower WRQOL scores ($\beta = -0.077$, $p < .001$)
6. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower WRQOL scores ($\beta = -0.125$, $p < .001$)
7. **Carver's Self-blame**; respondents with higher Self-blame scores had lower WRQOL scores ($\beta = -0.161$, $p < .001$)
8. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower WRQOL scores ($\beta = -0.122$, $p < .001$)
9. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher WRQOL scores ($\beta = 0.115$, $p < .001$)
10. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher WRQOL scores ($\beta = 0.138$, $p < .001$)

11. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher WRQOL scores ($\beta = 0.086$, $p < .001$)

Other variables predicting the overall WRQOL score:

12. **Age**; respondents aged 40-49 had lower WRQOL scores than those aged 16-29 ($\beta = -0.066$, $p = .007$)
13. **Disability**; respondents with a disability ($\beta = -0.039$, $p = .013$) and those who were unsure of whether or not they had a disability ($\beta = -0.045$, $p = .003$) had lower WRQOL scores than those who did not have a disability
14. **Country of work**; respondents working in Scotland ($\beta = -0.049$, $p = .012$) had lower WRQOL scores than those working in England, and respondents working in Wales ($\beta = 0.148$, $p < .001$) had higher WRQOL scores than those working in England
15. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days ($\beta = -0.040$, $p = .014$), those who took 11-20 sick days ($\beta = -0.055$, $p = .001$), those who took 21-40 sick days ($\beta = -0.056$, $p < .001$) and those who took more than 60 sick days ($\beta = -0.049$, $p = .002$) all had lower WRQOL scores than those who took no sick days
16. **Line manager status**; respondents who were line managers had higher WRQOL scores than those who were not line managers ($\beta = 0.082$, $p < .001$)
17. **Effects of the pandemic on services**; respondents who felt overwhelmed by increased pressures ($\beta = -0.221$, $p < .001$) had lower WRQOL scores than those who felt no impact

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, the results showed that respondents who felt neither prepared nor unprepared ($\beta = -0.122$, $p = .037$) and those who felt unprepared ($\beta = -0.247$, $p < .001$) for redeployment had lower WRQOL scores than those who felt well prepared.

A8.3 Multiple Regression Model Predicting Personal Burnout Scores

Research question : Do coping mechanisms predict Personal Burnout Scores when controlling for demographic, occupational and country of work variables?

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

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)

Results: The model explained 43.3% of the variance (adjusted $R^2 = .424$, $F(41, 2625) = 48.801$, $p < .001$). The following coping strategies predicted personal burnout scores:

1. **Carver's Active coping**; respondents with higher Active coping scores had lower Personal burnout scores ($\beta = -0.050$, $p = .035$)
2. **Carver's Planning**; respondents with higher Planning scores had higher Personal burnout scores ($\beta = 0.085$, $p = .001$)
3. **Carver's Acceptance**; respondents with higher Acceptance scores had lower Personal burnout scores ($\beta = -0.058$, $p = .001$)
4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Personal burnout scores ($\beta = -0.133$, $p < .001$)
5. **Carver's Use of instrumental support**; respondents with higher Use of instrumental support scores had higher Personal burnout scores ($\beta = 0.048$, $p = .020$)
6. **Carver's Venting**; respondents with higher Venting scores had higher Personal burnout scores ($\beta = 0.066$, $p < .001$)
7. **Carver's Substance use**; respondents with higher Substance use scores had higher Personal burnout scores ($\beta = 0.040$, $p = .012$)
8. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Personal burnout scores ($\beta = 0.122$, $p < .001$)
9. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Personal burnout scores ($\beta = 0.220$, $p < .001$)
10. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Personal burnout scores ($\beta = 0.072$, $p < .001$)
11. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Personal burnout scores ($\beta = -0.065$, $p < .001$)
12. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had lower Personal burnout scores ($\beta = -0.047$, $p = .007$)

13. **Clark et al.'s Exercise**; respondents with higher Exercise scores had lower Personal burnout scores ($\beta = -0.137$, $p < .001$)

Other variables predicting the personal burnout score:

14. **Age**; respondents aged 50-59 ($\beta = -0.083$, $p = .001$), those aged 60-65 ($\beta = -0.066$, $p = .001$) and those aged 66+ ($\beta = -0.074$, $p < .001$) all had lower personal burnout scores than those aged 16-29
15. **Sex**; males had lower personal burnout scores than females ($\beta = -0.090$, $p < .001$).
16. **Disability**; respondents with a disability ($\beta = 0.095$, $p < .001$) and those who were unsure of whether or not they had a disability ($\beta = 0.057$, $p < .001$) had higher personal burnout scores than those who did not have a disability
17. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days ($\beta = 0.035$, $p = .025$), those who took 11-20 sick days ($\beta = 0.057$, $p < .001$), those who took 21-40 sick days ($\beta = 0.039$, $p = .010$), those who took 41-60 sick days ($\beta = 0.056$, $p < .001$) and those who took more than 60 sick days ($\beta = 0.059$, $p < .001$) all had higher personal burnout scores than those who took no sick days
21. **Effects of the pandemic on services**; respondents who felt their services had been impacted a little ($\beta = 0.136$, $p = .001$) and those who felt overwhelmed by increased pressures ($\beta = 0.354$, $p < .001$) had higher personal burnout scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict personal burnout scores.

A8.4 Multiple Regression Model Predicting Work-Related Burnout Scores

Research question : Do coping mechanisms predict Work-Related Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Work-related burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)

Results: The model explained 43.7% of the variance (adjusted $R^2 = .428$, $F(41, 2625) = 49.718$, $p < .001$). The following coping strategies predicted personal burnout scores:

1. **Carver's Active coping**; respondents with higher Active coping scores had lower Work-related burnout scores ($\beta = -0.085$, $p < .001$)
2. **Carver's Planning**; respondents with higher Planning scores had higher Work-related burnout scores ($\beta = 0.097$, $p < .001$)
3. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Work-related burnout scores ($\beta = -0.138$, $p < .001$)
4. **Carver's Use of instrumental support**; respondents with higher Use of instrumental support scores had higher Work-related burnout scores ($\beta = 0.056$, $p = .006$)
5. **Carver's Venting**; respondents with higher Venting scores had higher Work-related burnout scores ($\beta = 0.071$, $p < .001$)
6. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Work-related burnout scores ($\beta = 0.137$, $p < .001$)
7. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Work-related burnout scores ($\beta = 0.188$, $p < .001$)
8. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Work-related burnout scores ($\beta = 0.113$, $p < .001$)
9. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had lower Work-related burnout scores ($\beta = -0.082$, $p < .001$)
10. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Work-related burnout scores ($\beta = -0.114$, $p < .001$)
11. **Clark et al.'s Exercise**; respondents with higher Exercise scores had lower Work-related burnout scores ($\beta = -0.074$, $p < .001$)

Other variables predicting the work-related burnout score:

12. **Age**; respondents aged 50-59 (β = -0.069, p = .005), those aged 60-65 (β = -0.063, p = .001) and those aged 66+ (β = -0.067, p < .001) all had lower work-related burnout scores than those aged 16-29
13. **Sex**; males had lower work-related burnout scores than females (β = -0.037, p = .013)
14. **Disability**; respondents with a disability (β = 0.048, p = .002) and those who were unsure of whether or not they had a disability (β = 0.059, p < .001) had higher work-related burnout scores than those who did not have a disability
15. **Country of work**; respondents working in Wales had lower work-related burnout scores than those working in England (β = -0.055, p = .005)
16. **Occupational group**; social care workers had lower work-related burnout scores than nurses (β = -0.084, p = .001)
17. **Number of sick days in previous 12 months**; respondents who took 11-20 sick days (β = 0.041, p = .008) and those who took more than 60 sick days (β = 0.037, p = .014) had higher work-related burnout scores than those who took no sick days
18. **Line manager status**; respondents who were line managers had higher work-related burnout scores than those who were not line managers (β = 0.039, p = .013)
19. **Effects of the pandemic on services**; respondents who felt their services had been impacted a little (β = 0.110, p = .005) and those who felt overwhelmed by increased pressures (β = 0.393, p < .001) had higher work-related burnout scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict work-related burnout scores.

A8.5 Multiple Regression Model Predicting Client-Related Burnout Scores

Research question : Do coping mechanisms predict Client-Related Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Client-related burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)

Results: The model explained 20.3% of the variance (adjusted $R^2 = .190$, $F(41, 2581) = 16.032$, $p < .001$). The following coping strategies predicted client-related burnout scores:

1. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Client-related burnout scores ($\beta = -0.108$, $p < .001$)
2. **Carver's Venting**; respondents with higher Venting scores had higher Client-related burnout scores ($\beta = 0.059$, $p = .004$)
3. **Carver's Substance use**; respondents with higher Substance use scores had higher Client-related burnout scores ($\beta = 0.077$, $p < .001$)
4. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Client-related burnout scores ($\beta = 0.103$, $p < .001$)
5. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Client-related burnout scores ($\beta = 0.132$, $p < .001$)
6. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Client-related burnout scores ($\beta = -0.153$, $p < .001$)

Other variables predicting the client-related burnout score:

7. **Sex**; males had higher client-related burnout scores than females ($\beta = 0.075$, $p < .001$)
8. **Occupational group**; social workers had higher client-related burnout scores than nurses ($\beta = 0.096$, $p = .002$)
9. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days ($\beta = 0.039$, $p = .040$) and those who took 41-60 sick days ($\beta = 0.037$, $p = .037$) had higher client-related burnout scores than those who took no sick days
10. **Line manager status**; respondents who were line managers had lower client-related burnout scores than those who were not line managers ($\beta = -0.134$, $p < .001$)

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well prepared/neither

prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict client-related burnout scores.

Appendix 9: Comparison of Phase 1 (May – July 2020) and Phase 2 (December 2020 – January 2021)

This section presents descriptive comparisons of data from Phase 1 (May – July 2020) and Phase 2 (December 2020 – January 2021) of the study. Presented are weighted results, with weights calculated separately for each phase of the study to account for the different distribution of respondents across country and occupational group in the two phases of the study, thus enabling a more direct comparison.

Some results from Phase 1 presented here may be slightly different from those presented in the first report. This is because some calculations were changed in order to make the two phases of the survey directly comparable.

A9.1 Wellbeing Scores by Study Phase and Country

The overall mean wellbeing scores decreased from Phase 1 of the study to Phase 2, both UK-wide and across the individual countries.

UK-wide analysis: Using regression analysis, the decrease in the overall mean wellbeing scores between Phase 1 and Phase 2 of the study was found to be statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -0.872$, $p < .001$).

Figure A9.1: Mean Overall Wellbeing Score by Study Phase and Country (Weighted)

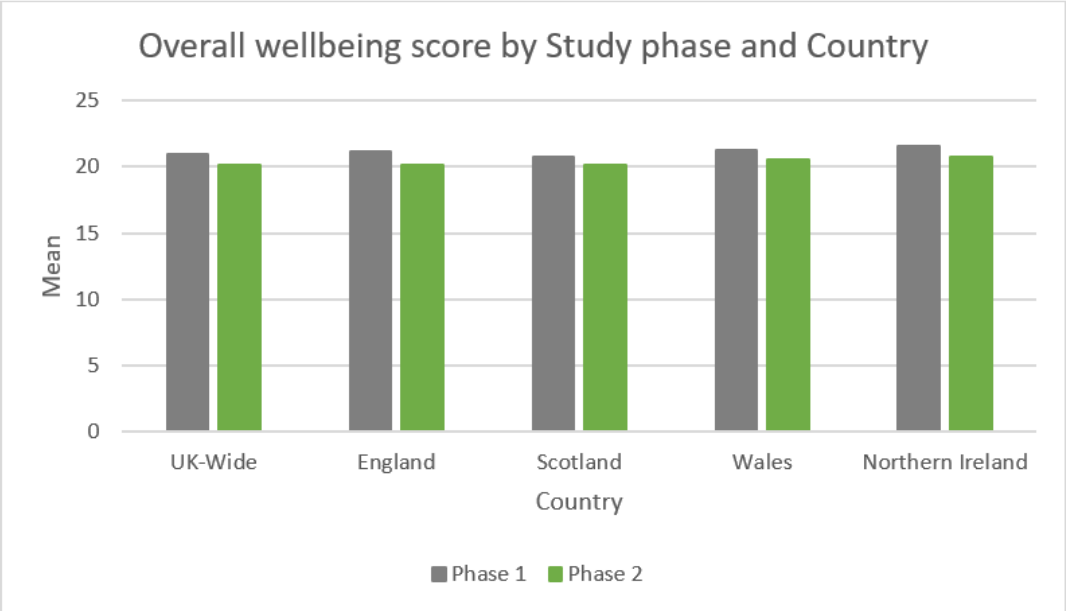

Table A9.1: Mean Overall Wellbeing Score by Study Phase and Country (Weighted)

	Country				
Study phase	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1	20.95	21.15	20.74	21.25	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76

A9.2 Wellbeing Scores by Study Phase and Occupation

All occupational groups showed a decrease in their overall mean wellbeing scores from Phase 1 of the study to Phase 2.

Figure A9.2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)

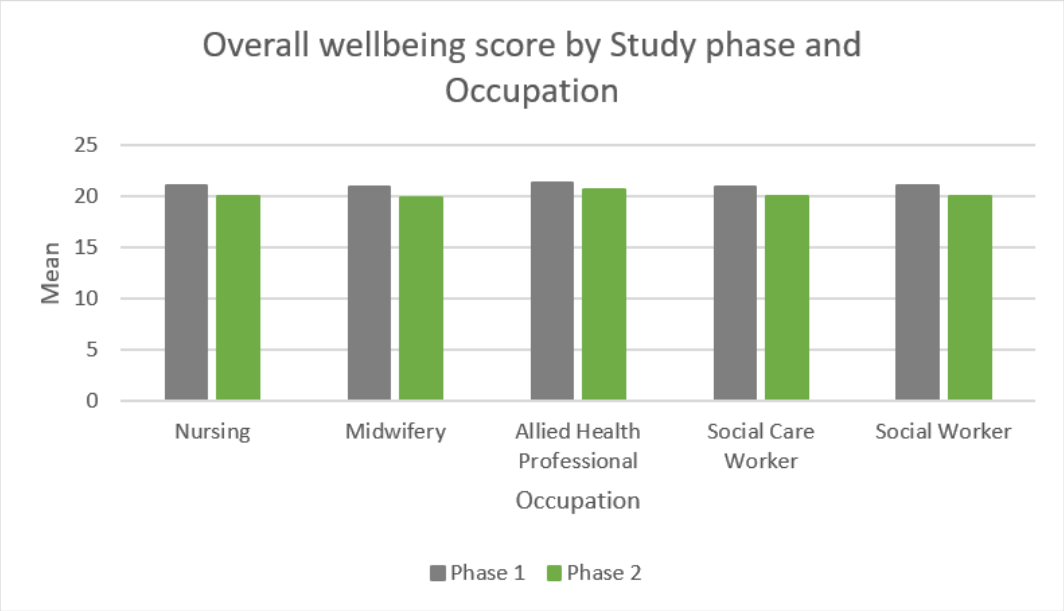

Table A9.2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)

	Occupation				
Study phase	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1	21.15	20.91	21.38	20.98	21.14
Phase 2	20.10	19.92	20.73	20.02	20.07

A9.3 Quality of Working Life Scores by Study Phase and Country

The overall WRQOL score decreased from Phase 1 of the study to Phase 2, both UK-wide and across the individual countries. There was also a decrease in the majority of the WRQOL domain scores across the countries.

UK-wide analysis: Using regression analysis, the decrease in the overall WRQOL scores between Phase 1 and Phase 2 of the study was found to be statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -3.489$, $p < .001$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.436$, $p = .001$)
- Stress at work: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.494$, $p < .001$)
- Working conditions: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.340$, $p < .001$)

- Control at work: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.375$, $p < .001$)
- General wellbeing: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -1.470$, $p < .001$)
- Home-work interface: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.403$, $p < .001$)

Figure A9.3: Mean Overall Quality of Working Life Score by Study Phase and Country (Weighted)

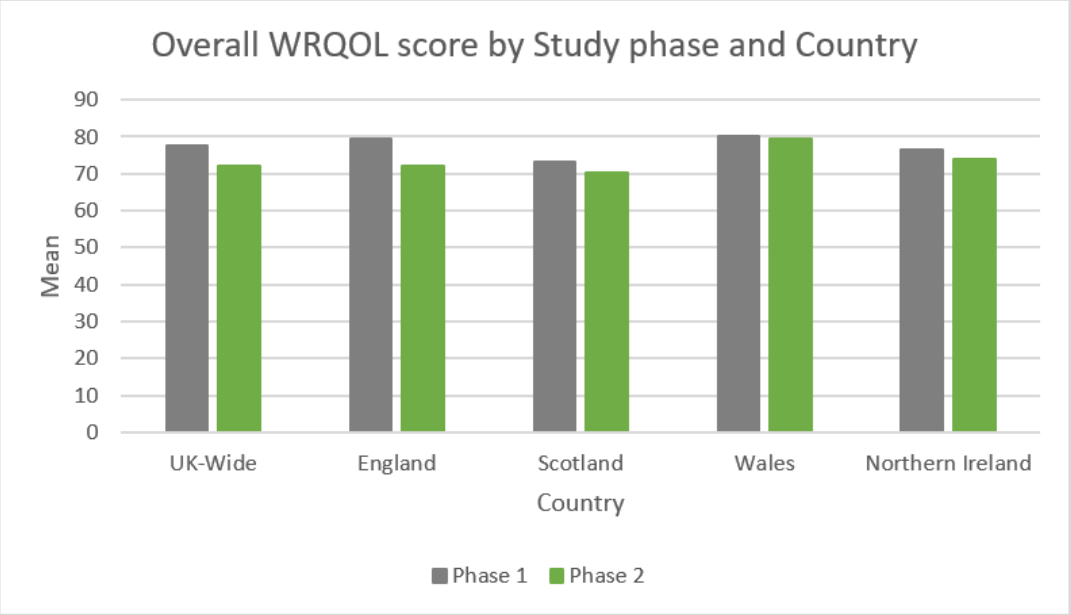

Table A9.3: Mean Quality of Working Life Score by Study Phase and Country (Weighted)

Study phase	**Country**				
WRQOL domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1					
Job career satisfaction	21.03	21.48	20.23	21.93	21.06
Stress at work	5.23	5.22	4.57	4.98	5.06
General wellbeing	20.16	20.65	19.32	20.85	20.55
Home-work interface	10.84	11.11	9.71	11.26	10.18
Control at work	9.97	10.27	9.22	10.26	9.57
Working conditions	10.49	10.71	9.87	11.13	10.23
Overall WRQOL score	**77.59**	**79.33**	**73.07**	**80.35**	**76.63**
Phase 2					
Job career satisfaction	20.31	20.39	19.89	22.32	20.91
Stress at work	4.43	4.36	4.56	4.87	4.37
General wellbeing	18.23	18.21	18.44	19.73	19.37
Home-work interface	9.95	10.03	9.19	10.97	9.99
Control at work	9.22	9.28	8.75	10.44	9.37
Working conditions	9.96	9.90	9.54	11.12	9.95
Overall WRQOL score	**72.13**	**72.21**	**70.37**	**79.46**	**74.06**

A9.4 Quality of Working Life Scores by Study Phase and Occupation

The overall WRQOL scores decreased from Phase 1 of the study to Phase 2 for all occupational groups. The majority of WRQOL domain scores also decreased for all groups.

Figure A9.4: Mean Overall Quality of Working Life Score by Study Phase and Occupation (Weighted)

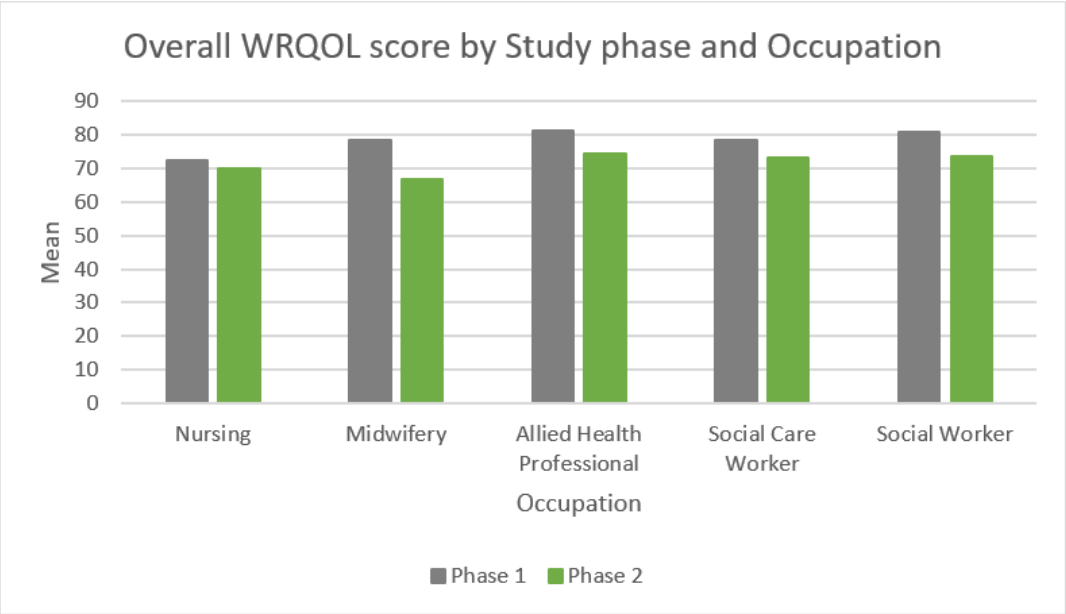

Table A9.4: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted)

Study phase	**Occupation**				
WRQOL domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1					
Job career satisfaction	19.15	21.67	22.22	21.27	22.28
Stress at work	5.25	4.55	5.02	5.25	4.81
General wellbeing	19.77	20.91	21.19	20.02	20.75
Home-work interface	10.11	10.68	11.29	10.82	11.32
Control at work	8.79	9.96	10.47	10.31	10.58
Working conditions	9.82	10.79	10.99	10.62	10.80
Overall WRQOL score	**72.54**	**78.56**	**81.16**	**78.34**	**80.63**
Phase 2					
Job career satisfaction	19.96	19.27	20.42	20.50	21.32
Stress at work	4.24	3.63	4.53	4.70	4.06
General wellbeing	17.65	18.07	19.04	18.64	18.34
Home-work interface	9.47	8.23	10.62	9.91	10.56
Control at work	9.08	9.17	9.61	9.13	9.63
Working conditions	9.61	8.61	10.26	10.31	9.73
Overall WRQOL score	**70.01**	**66.95**	**74.41**	**73.24**	**73.67**

A9.4 Carver Coping Scores by Study Phase and Country

UK-wide there was a decrease in the use of positive coping strategies and an increase in the use of negative coping strategies from Phase 1 of the study to Phase 2. Similar pattern was observed across the countries for the majority of coping domains.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 2 of the study on the different Carver coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Active coping: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.570$, $p = .001$)
- Planning: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.362$, $p < .001$)
- Positive reframing: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.280$, $p < .001$)
- Acceptance: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.284$, $p < .001$)
- Use of emotional support: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.108$, $p = .040$)
- Use of instrumental support: No change in scores from Phase 1 to Phase 2 ($\beta = 0.025$, $p = .628$)
- Venting: Significant increase in scores from Phase 1 to Phase 2 ($\beta = 0.713$, $p < .001$)
- Substance use: Significant increase in scores from Phase 1 to Phase 2 ($\beta = 0.115$, $p = .008$)
- Behavioural disengagement: Significant increase in scores from Phase 1 to Phase 2 ($\beta = 0.314$, $p < .001$)
- Self-blame: Significant increase in scores from Phase 1 to Phase 2 ($\beta = 0.601$, $p < .001$)

Figure A9.5: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)

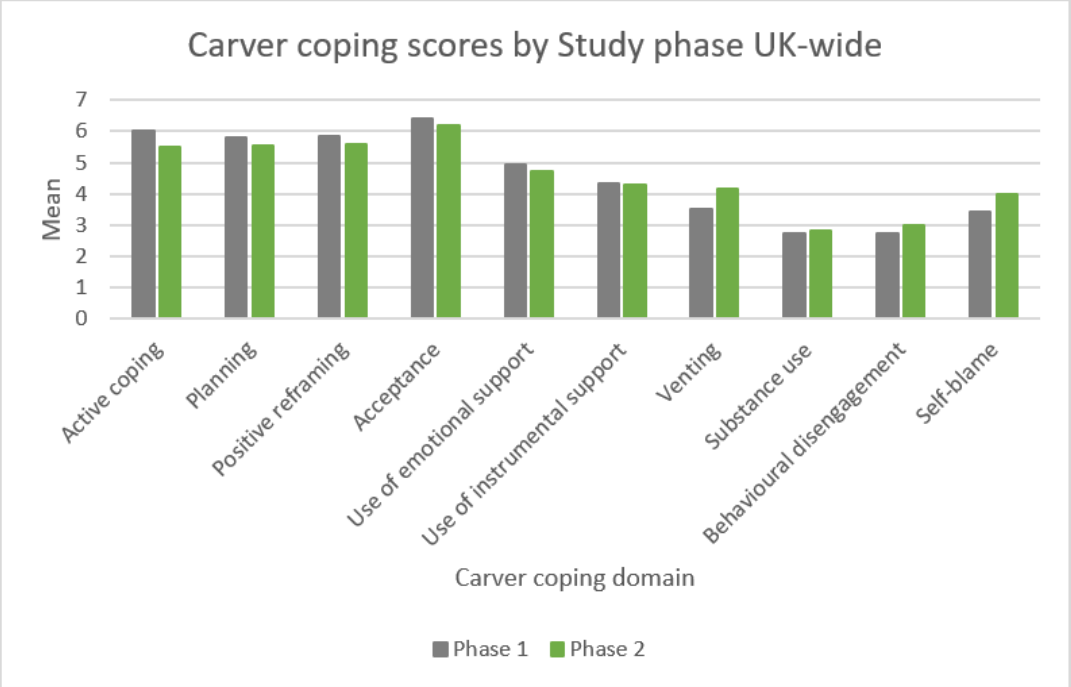

Table A9.5: Mean Carver Coping Scores by Study Phase and Country (Weighted)

Study phase	Country				
Coping domain	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1					
Active coping	6.00	5.97	6.57	6.08	6.10
Planning	5.80	5.81	6.10	6.13	5.82
Positive reframing	5.85	5.92	5.66	6.07	5.90
Acceptance	6.39	6.45	6.57	6.62	6.43
Use of emotional support	4.93	5.11	4.83	4.91	4.85
Use of instrumental support	4.34	4.38	4.79	4.63	4.40
Venting	3.51	3.47	3.81	3.52	3.45
Substance use	2.74	2.74	2.87	2.95	2.73
Behavioural disengagement	2.73	2.68	2.54	3.10	2.68
Self-blame	3.42	3.28	4.00	3.48	3.23
Phase 2					
Active coping	5.48	5.50	5.80	5.46	5.56
Planning	5.53	5.56	5.77	5.42	5.42
Positive reframing	5.57	5.60	5.61	5.59	5.61
Acceptance	6.18	6.19	6.24	6.11	6.06
Use of emotional support	4.73	4.95	4.54	4.73	4.84
Use of instrumental support	4.29	4.43	4.24	4.37	4.51
Venting	4.14	4.19	4.08	4.05	4.19
Substance use	2.83	2.86	2.91	2.90	2.82
Behavioural disengagement	3.01	2.99	3.07	3.08	2.99
Self-blame	3.98	4.00	4.19	3.94	3.80

A9.4 Carver Coping Scores by Study Phase and Occupation

There was also a slight decrease in the use of positive coping strategies and a slight increase in the use of negative coping strategies from Phase 1 of the study to Phase 2 across the occupational groups.

Table A9.6: Mean Carver Coping Scores by Study Phase and Occupation (Weighted)

Study phase	Occupation				
Coping domain	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 1					
Active coping	6.37	5.95	5.81	5.96	5.92
Planning	5.96	5.74	5.71	5.79	5.75
Positive reframing	5.89	6.02	5.84	5.87	5.82
Acceptance	6.59	6.20	6.52	6.33	6.35
Use of emotional support	5.12	5.34	5.44	4.87	5.28
Use of instrumental support	4.48	4.20	4.66	4.44	4.61
Venting	3.97	3.44	3.53	3.30	3.57
Substance use	2.77	2.90	2.79	2.68	2.85
Behavioural disengagement	2.84	2.57	2.55	2.62	2.67
Self-blame	3.52	3.76	3.22	3.36	3.30
Phase 2					
Active coping	5.47	4.98	5.53	5.52	5.30
Planning	5.57	4.58	5.53	5.57	5.39
Positive reframing	5.43	5.32	5.88	5.67	5.53
Acceptance	5.96	6.15	6.28	6.33	6.18
Use of emotional support	4.88	4.68	4.99	4.51	5.30
Use of instrumental support	4.38	4.22	4.56	4.18	4.76
Venting	4.12	4.68	4.43	4.03	4.44
Substance use	2.86	3.78	2.81	2.75	3.10
Behavioural disengagement	2.93	3.82	2.83	3.09	2.93
Self-blame	4.07	4.57	3.69	3.96	4.12

A9.5 Clark Coping Scores by Study Phase and Country

There was a slight decrease in the use of some Clark et al.'s coping strategies from Phase 1 of the study to Phase 2 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 2 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No change in scores from Phase 1 to Phase 2 ($\beta = 0.027$, $p = .332$)
- Work-family segmentation: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.117$, $p < .001$)
- Working to improve skills/efficiency: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.141$, $p < .001$)
- Recreation and relaxation: Significant decrease in scores from Phase 1 to Phase 2 ($\beta = -0.154$, $p < .001$)
- Exercise: Significant decrease in scores from Phase 1 to Phase 2 (-0.199, $p < .001$)

Figure A9.6: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)

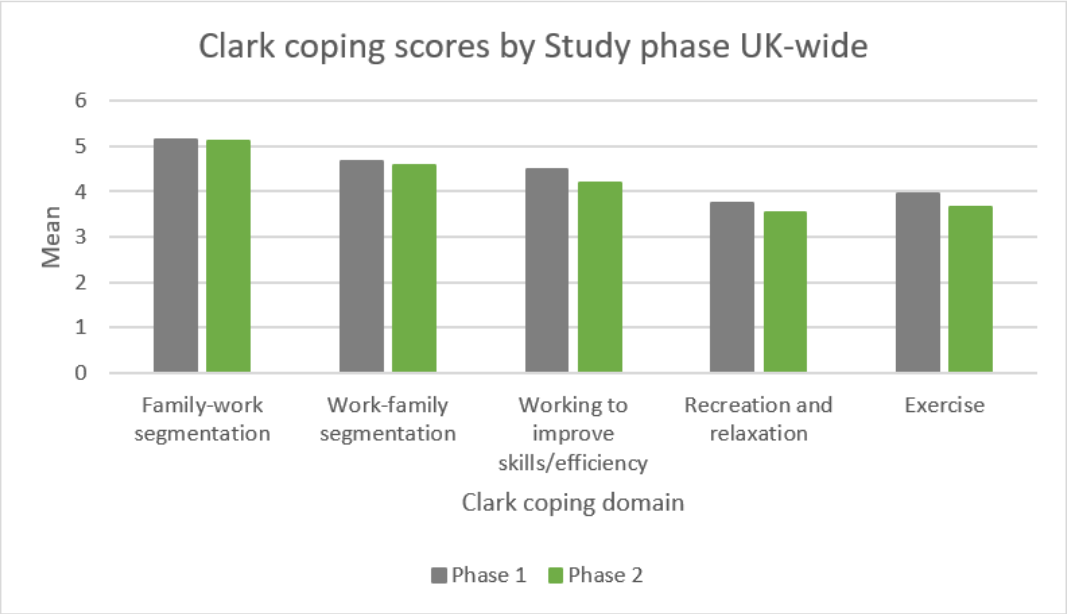

Table A9.7: Mean Clark Coping Scores by Study Phase and Country (Weighted)

Study phase	**Country**				
Coping domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1					
Family-work segmentation	5.14	5.08	5.09	5.07	5.11
Work-family segmentation	4.68	4.65	4.58	4.78	4.71
Working to improve skills/efficiency	4.48	4.46	4.53	4.56	4.31
Recreation and relaxation	3.75	3.87	3.47	3.70	3.57
Exercise	3.96	4.07	3.51	4.07	3.89
Phase 2					
Family-work segmentation	5.12	5.11	5.24	5.02	5.18
Work-family segmentation	4.59	4.59	4.71	4.62	4.69
Working to improve skills/efficiency	4.19	4.29	4.13	4.18	4.25
Recreation and relaxation	3.55	3.56	3.29	3.51	3.64
Exercise	3.66	3.68	3.50	3.53	3.75

A9.6 Clark Coping Scores by Study Phase and Occupation

Across the occupational groups, there was a decrease in the use of some Clark et al.'s coping strategies, but also increase in the use of others for some groups.

Table A9.8: Mean Clark Coping Scores by Study Phase and Occupation (Weighted)

Study phase	**Occupation**				
Coping domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1					
Family-work segmentation	5.36	4.75	4.96	5.06	4.99
Work-family segmentation	4.72	4.39	4.58	4.75	4.79
Working to improve skills/efficiency	4.75	4.16	4.44	4.36	4.37
Recreation and relaxation	3.82	3.34	3.94	3.68	4.04
Exercise	4.18	3.72	4.41	3.64	4.05
Phase 2					
Family-work segmentation	5.12	5.46	5.04	5.16	4.98
Work-family segmentation	4.67	3.98	4.48	4.66	4.49
Working to improve skills/efficiency	4.42	3.82	4.23	3.99	4.25
Recreation and relaxation	3.50	2.56	3.64	3.54	3.70
Exercise	3.49	3.15	4.07	3.60	3.63

Appendix 10: Individual Circumstances and Wellbeing of Frontline Workers

Focus groups were held with both managers and frontline workers in December 2020 and January 2021 respectively. The challenges of dealing with individual circumstances alongside changes to working conditions during the pandemic emerged as a strong theme throughout the frontline workers' focus group. Below are vignettes that present an insight into the individual experiences of some workers as they worked on the frontline, accounting for how their professional and personal experiences intersected and how this impacted their overall health and wellbeing. Some of the details of the 'stories' presented below have been changed to protect the identity of the participants.

Alex:

Alex is a physiotherapist who was redeployed to a Nightingale Hospital when the first wave emerged. Explaining the impact of working on the frontline they said, *"in an hour I saw someone get intubated, I saw somebody arrest and I saw somebody be wheeled out in a body bag within an hour of me arriving on the ward. People don't see that in a regular day. And that's traumatic… just the sheer, sheer horridness that we see"*. However, they also explained how their individual circumstances intensified the stress and anxiety they experienced. At the peak of the first wave of the pandemic, they were made homeless because their flatmate forced them out. Their visa also expired during this time and it was described as a stressful experience to get it renewed. They described their gratitude for being able to avail of free hotel rooms that were offered to NHS staff, and to cope with the situation, they decided to throw themselves into working long hours. They explained how isolated they felt at times, with no family and very little peer support. They also felt an added pressure to "remain vigilant", to abide by all the rules so not to put at risk their patients and team members. For relieving stress, they explained that they tried to use various resources such as headspace, and free online yoga sessions, but in relation to the overall support offered they said that, *"if you asked me during the pandemic, when I was working in ICU, I would have [said] that my colleagues… we were supporting each other. But in reflection, I actually think that it was a much tougher time and now I have become resentful by the lack of support"*.

Charlotte:

Charlotte was an AHP who returned from maternity leave during the pandemic. She experienced very little support or acknowledgement that she was entering a very different workplace to what she left – there were new people and new practices, and she was also expected to work different hours. Alongside this, she was also experiencing huge domestic upheaval in trying to settle a new baby into an unfamiliar childcare setting, home schooling her other children, juggling other childcare arrangements and she also suffered a family bereavement. Unlike her previous experiences of returning from maternity, she felt there was no support from managers or any understanding from colleagues about the additional pressures she was under when returning to work. She explains that *"nobody kind of cared anymore, everybody was just dealing with the mess that was going on"* and there was *"zero appreciation"* for the challenges of going back to work. She gave the example of being unable to express *"because you can't have... milk at work because of COVID, but you're meant to be technically allowed to do all these things."* Charlotte managed to move to a different role to suit her circumstances, but overall she felt her individual circumstances were not acknowledged as she returned from maternity. She highlighted the importance of acknowledging these individual circumstances because people handle challenges in different ways. She explains her frustrations when people said that *"we can't make any… differences when we've all been anxious"* and goes on to explain that *"actually, that's not recognising, …. some people have*

clinical anxiety, and we need to actually support them, not just say, actually, it's the same for everybody. What we have learned through this pandemic is everybody's felt that differently and everybody's had a tough time in different ways".

Jackie

Jackie is a social worker who moved positions during the pandemic and was also redeployed to a frontline team to work directly with families and children. They explain that *"after like a really brief …. period, where everyone was just kind of in a bit of shock, the workload load really increased".* They explain how *"the change of work, the expectations were different, and people expected a reply immediately, and everyone was very worried, and... it was tricky".* As time went on, the job stress they experienced did not relent. They explain *"that it's really really hard to safeguard children when you're doing things via Teams and Zoom and the level of stress really increases"*. Compounding this were their own personal struggles with mental health. They explain that when working with children who experienced early childhood trauma how difficult it is *"to talk about those kind of really emotionally challenging things when you're not feeling emotionally fantastic either"*. They described being at *"home all the time in lockdown, on my own, it was very isolating and I felt very isolated from colleagues and from my own social circle".* They further add, *"I've only realized how difficult I found it. And I think at the time I was trying to cope, and I was trying to get on with life, but actually, in hindsight, it was, it was really detrimental to my mental health"*. They felt their employer did all they could to support them. They commented positively about the communication from managers and how information was shared. They felt they had helpful and supportive managers and colleagues. They also welcomed the option for flexible working as well as the wellbeing supports offered, but yet their mental health suffered. They were fed up with lock down and they explained how *"the walks didn't cut it anymore"*. They had to start anti-depressants, and admitted to increasing alcohol consumption to relieve anxiety and stress.

The impact of how the personal and professional challenges intersected was also evident in some of the survey responses. For example, one respondent stated that:

> *"Pre-covid I LOVED my job. Now its affecting my mental health, physical wellbeing and I truly wish I had been able to work from home. I'm exhausted and it's bleeding over every aspect of my life- even through trying to keep work and personal lives separate". (Social Worker, Scotland)*

This was echoed by others who described how their identity was being lost to an increasingly stressful and pressurised profession:

> *"As a team we lost around half of our staff in this period - resulting in half the staff completing double the workload. This certainly impacted on my physical health and I witnessed first hand those struggling around me. The days have grown longer and time for lunch, exercise and personal connection has depleted almost to a point I have forgotten who I am alongside a Social Worker - we have become part of the dehumanised workforce". (Social Worker, England)*

Another respondent explained the upheaval they experienced when wishing to protect loved ones from their risk of infection, how it impacted their family life, their finances and ultimately their health and wellbeing:

"A family member who lives with me is at high risk of death if they contract COVID. I asked my manager if I could access any temporary accommodation to help me to fulfil my job role (which involved close contact with 39 different households, personal care and no PPE except during personal care). I was told I was not entitled to this. I asked if we could undertake a risk assessment and was told this did not apply to me and "if you do not come into work well, then I don't know what will happen to you". I never suggested I wouldn't attend my workplace, I was looking for support to do so as safely as possible. I have been told it is safe for me to work but really they are asking me to gamble with a loved ones life whilst I am in my currently living arrangements. If they catch it, it is likely to be fatal. That is a big ask and not one I am willing to risk or live with while cases are extremely high and COVID is still very much unknown. Since I could not access any support I have paid £1000 so far to move into temporary accommodation, living away from my family so I can go to work. This has massively impacted my health and well-being and my feelings toward my manager". (Social Care Worker, Scotland)

On the other hand, the survey also revealed how changes to working conditions created both positive and negative consequences for personal lives. One social worker from England explained how working from home enabled a more balanced family life, but that not having access to the support network of her colleagues meant there was an additional burden on their informal support network:

"Working from home all the time can make dealing with the emotional fall out from work more tricky - my husband is very supportive but I usually would get that support from work colleagues in the office. However, I have been very lucky - I have a great manager, work flexibly and do work that I enjoy. I've been able to build up better relationships with clients as have had more time due to not travelling - although it is much harder for those not able to use phones or video conferencing - for those clients I have still done home visits. Personally my life has improved as my husband used to commute to central London but now working from home and his work has not been busy so he has picked up a lot of the childcare and domestic work. If this had not happened then it would have been extremely difficult to cope with. Not being in an office puts additional pressure on your informal support network". (Social Worker, England)