



# Health and social care workers' **quality of working life and coping** while working during the COVID-19 pandemic 16th May 2022 – 8th July 2022



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## Phase 5: Findings from Survey and Focus Groups



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

Phase 5: 16<sup>th</sup> May 2022 – 8<sup>th</sup> July 2022

## REPORT 5

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## FOREWORD

We are proud to present the report from Phase 5 of our Health and Social Care Workforce Study. The survey and focus group data discussed here were collected between May and July 2022 when life for many in the UK had returned to normal after the ravages of the Covid-19 pandemic. Across the UK most people were no longer being affected by lockdowns; vaccinations were available to those who wanted them; social distancing and asymptomatic testing rules were significantly relaxed; and many people returned to their workplaces and picked up most leisure and social activities.

The findings from our study, however, show that our respondents – Nurses, Midwives, Allied Health Professionals, Social Workers, and Social Care Workers – were still very much caught up in health and safety restrictions while in work and in the aftermath of the pandemic and many could not see clear light at the end of the tunnel. There is compelling evidence that stress and burnout still affected many respondents at the time of the survey (Summer 2022), and this was often due to increased job demands as well as persistent staff shortages because of the pandemic and its legacy. While many respondents in previous Phases of this survey reported using positive coping strategies to deal with stress and reported being keen on supporting one another, we now see an increase in negative coping strategies, including venting (displays of anger) and substance use, in some cases an increase in incivility at work and tensions with co-workers and managers, as well as increasing unwillingness to go above and beyond. We also found that supports offered by employers were often not taken up, and we suggest that this is due to some staff not feeling the support on offer would be helpful to them, a feeling that they are rather tokenistic, and unwillingness to embark on ‘online’ support, perhaps because respondents did not have enough energy after a working day to take, say, a relaxation course.

These are worrying trends. It is worrying because of the very real risk of mental and physical health problems developing among many members of this workforce. It is also worrying because this level of job dissatisfaction might lead to even higher staff turnover, with many leaving their health and social care work for less stressful or more fulfilling (or higher paying) jobs in other sectors. Our evidence shows that the health and social care workforce is already hard to replace with insufficient applicants, and this trend will affect the quality and availability of services in health and social care for years to come.

What can be done? In previous reports, we highlighted the long overdue need to improve health and social care working conditions. We also commented on the necessity to re-evaluate and improve pay, terms and conditions, even if the readers of this report might not have the power to do so. We therefore suggest that employers, including policy makers, re-evaluate their investment into their workforce by increasing pay – thereby making these roles financially attractive and sustainable. This is even more important as the cost of living is now skyrocketing for many. Increasing pay, however, is not enough. Employers and policymakers must also increase staff retention by improving working conditions and staff recognition. Individualised approaches to staff support will improve communication between employer and employee and will therefore enable employers to offer the specific and customised supports that their health and social care workers need and value. We have set out a range of Good Practice Recommendations, based on our findings, which may help accomplish these goals.

While this is the final report of the original research project, we were able to secure an extension, for a follow-up study, we will therefore be able to investigate further how working conditions may change and affect the health and social care workforce over the winter months (2022-23). We are very grateful to our funders and especially study respondents and look forward to hearing further about their experiences.

*The HSC Workforce Research Team*

*The research team thanks all participants who contributed to this research, all those who helped with raising awareness about the study and those who are using the evidence from the study to improve the working lives and well-being of health and social care staff*



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# 1. Background

## 1.1 Aim

This study builds upon the findings from our wider study (see Figure 1.1) on health and social care worker well-being and coping during COVID-19. To date, there have been five Phases, namely Phase 1 (data collected between 7<sup>th</sup> May – 3<sup>rd</sup> July 2020), Phase 2 (data collected between 17<sup>th</sup> November 2020-1<sup>st</sup> February 2021), Phase 3 (data collected between 10<sup>th</sup> May – 2<sup>nd</sup> July 2021) and Phase 4 (24<sup>th</sup> Nov 2021- 4<sup>th</sup> February 2022) using surveys and focus groups, to further explore the impact of providing health and social care during the COVID-19 (SARS-CoV-2) pandemic in the United Kingdom (UK). The study focuses specifically on the experiences of Nurses, Midwives, Allied Health Professionals (AHPs), Social Care Workers and Social Workers. Our fifth survey (16<sup>th</sup> May-8<sup>th</sup> July 2022), followed by focus groups with human resource (HR) staff from health and social care, line managers, and frontline workers, sought to gain further understanding of how the COVID-19 pandemic has affected their work and home life as well as their health and well-being during this phase of the pandemic.

Figure 1. 1. Research Phases of Wider Study



## 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 well-being, quality of working life and levels of burnout in this workforce.
4. To find out what coping strategies are used to deal with work-related stressors and the effects of these on respondents' well-being, quality of working life and levels of burnout.

## 2. Methodology

### 2.1. Primary Research Instrument-Survey

Data for this current report were collected using an online survey questionnaire, which was adapted from the questionnaires used in Phases 1-4 of our Health and Social Care Workforce Study. Most 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 survey was predominantly quantitative but contained two open-ended qualitative questions. The main parts of the survey covered the areas below:

- **Demographic and work-related information:** age, sex, country of work, occupational group, ethnicity, disability status, relationship status, job tenure, hours of work, working overtime, working at home, considering changing one's occupation and/or employer, the effects of the pandemic on one's place of work, the impact of COVID-19 and employer support or use of any employer support.
- **Open-ended questions:** two questions related to 1) the impact of COVID-19 on respondents' place of work and 2) respondents' experience of how the pandemic changed the management of work and non-work responsibilities.
- **Mental well-being:** Short Warwick Edinburgh Mental Well-being 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 (Coping Orientation to Problems Experienced, Carver, 1997).
- ***Coping with work-related stressors***: 15 items from Clark, Michel, Early and Baltes (2014).

### 2.1.1. Mental Well-being

Mental well-being was assessed using the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008). It contains seven items that 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 well-being score, which can range from 7 to 35. Higher scores indicate better mental well-being. 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: Categories created by 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 well-being (six items), Home-work interface (three items), Control at work (three items), and Working conditions (three items). The last item measures overall well-being 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 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: Categories created by WRQOL scores

Level of quality of working life	WRQOL domain						Overall WRQOL score
	Job career satisfaction	Stress at work	General well-being	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 by Kristensen et al. (2005) 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., Creed, Sidebotham, Gamble, Pallant, & Fenwick, 2017).



Table 2.3: Cut-off points for CBI 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 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 (not handling family related things while working), Work-family segmentation (not handling work while at home), 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 – Descriptions of COVID-19 Demands and Impacts

Two open-ended questions were asked:

1. Between March 2022 and now, what is the impact of COVID-19 on your specific place of work, in relation to patient / service user numbers and service demand?
2. Did the experience of the pandemic change the way you now manage work and non-work responsibilities? If yes, please tell us how.

It was expected that these would elicit further detail about the most important aspects of respondents' work and home life during the pandemic and how they had affected their health and well-being.

## 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 5 study period (16<sup>th</sup> May- 8<sup>th</sup> July 2022). A wide variety of recruitment channels and methods were utilised to reach as many potential respondents as possible. These included The Northern Ireland Social Care Council, Social Care Wales, the five Northern Ireland Health and Social Care Trusts, Community Care magazine, Nursing and Midwifery Council, the Health and Care Professions Council, Northern Ireland Practice and Education Council, Royal College of Midwives, Royal College of Nursing, AHP Federation and AHPs Professional Associations such as the Royal College of Occupational Therapists (RCOT), British Association of Social Workers, and the College of Podiatry. Support was also provided by the Chief Nursing and AHP Officers from across the UK. These regulatory bodies, unions, associations and lead 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 which was hosted on Qualtrics™ by accessing a dedicated weblink or using a QR code. The survey was completed anonymously to encourage honest responses and was available in both English and Welsh.

### 2.2.1 Sample Profile

A total of 1,737 individuals responded to the survey. Most of the responses came from Northern Ireland (n = 1295), followed by England (n = 205), Scotland (n = 141), and then Wales (n = 96). Most of the sample were Social Care Workers (see Figure 2.1).

Figure 2.1: Occupation of Respondents (Unweighted)

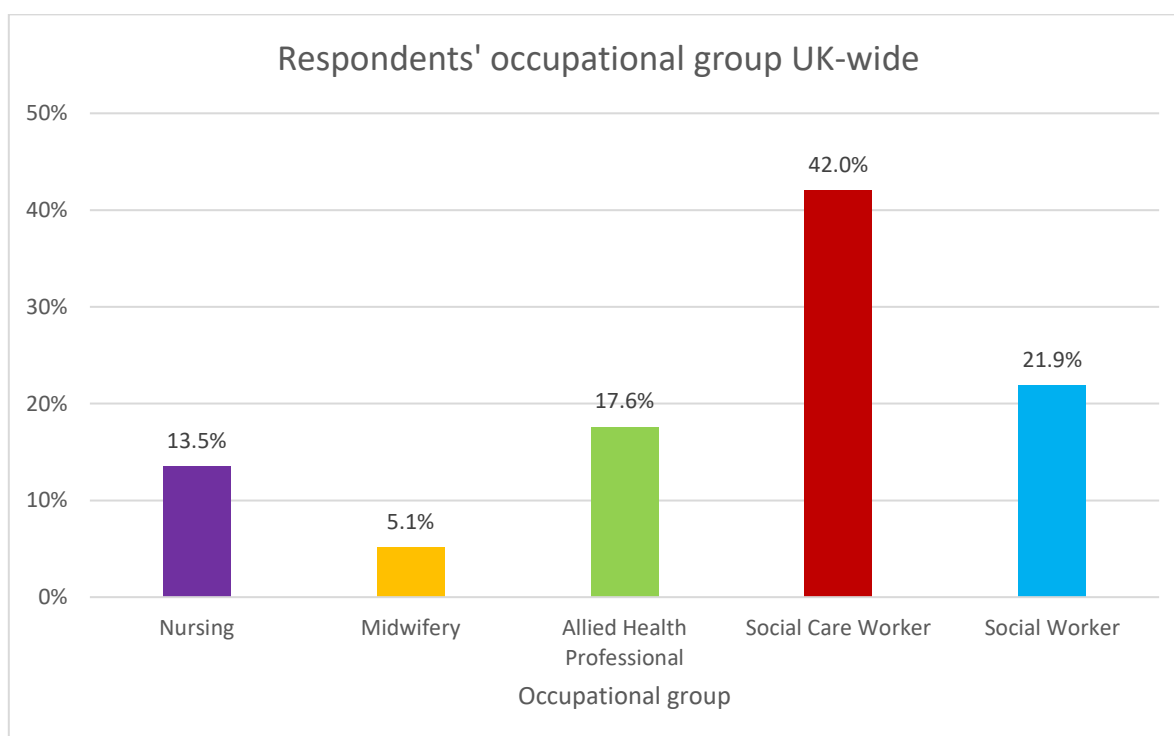


Table 2.4 below shows that of the 234 nursing respondents, 60.7% were from Northern Ireland, 31.2% from England, 5.1% from Wales and 3.0% from Scotland. A total of 88 midwives responded to the survey. Overall, most respondents (52.3%) were from England, 28.4% from Northern Ireland, 17.0% from Wales and 2.3% from Scotland. The majority of AHPs were from Northern Ireland (80.7%), followed by Wales (11.1%) and England (7.2%) with the smallest number were from Scotland (1.0%). A total of 77.8% of social care workers were from Northern Ireland, 15.8% were from Scotland, 3.3% from England and the remaining 3.2% from Wales. The largest proportion of social workers in the sample were from Northern Ireland (82.6%), followed by England (10.5%), Scotland (3.7%) and Wales (3.2%).

Table 2.4: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
<b>Nursing</b>	73 (31.2%)	7 (3.0%)	12 (5.1%)	142 (60.7%)	234 (13.5%)
<b>Midwifery</b>	46 (52.3%)	2 (2.3%)	15 (17.0%)	25 (28.4%)	88 (5.1%)
<b>AHP</b>	22 (7.2%)	3 (1.0%)	34 (11.1%)	246 (80.7%)	305 (17.0%)
<b>Social Care Worker</b>	24 (3.3%)	115 (15.8%)	23 (3.2%)	568 (77.8%)	730 (42.0%)
<b>Social Worker</b>	40 (10.5%)	14 (3.7%)	12 (3.2%)	314 (82.6%)	380 (21.3%)

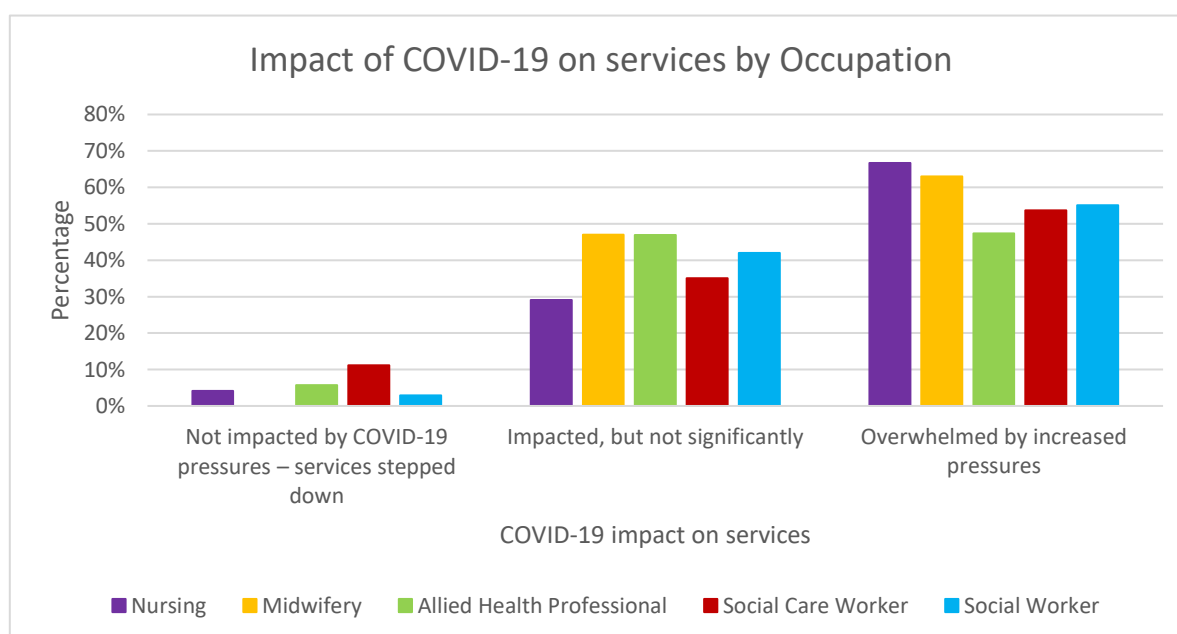
Most respondents were female (88.3% UK-wide) with a similar gender distribution across countries. Most midwives in the sample were female (96.2%) while AHPs had the highest proportion of males (20.3%). Respondents were primarily in the 30-59 years age group (81.0% UK-Wide). Scotland had the highest proportion of respondents in the 50-59 age group (39.6% within Scotland). Most respondents were of White ethnic origin (90.7% UK-wide). England had the highest proportion of respondents who identified as belonging to an ethnicity other than White (6.3% within England) and midwifery was the most diverse occupational group, with 13.0% of midwives identifying as not White. Scotland had the highest proportion of respondents with a disability (14.6% within Scotland) and midwives were the most likely occupation to report having a disability (25.7% within midwifery). Most respondents UK-wide were married (50.8%) or single (19.4%).

UK-wide, over half of all the respondents worked in the community (54.1% UK-wide), while 23.3% (UK-wide) worked in a care home. Most worked in the statutory health and social care sectors (65.2% UK-wide), but over half of social care workers (59.3% of social care workers) worked in non-statutory services (private or voluntary sector, directly employed or other). Just under half of study respondents UK-wide were line managers in their jobs (48.2%). Most respondents were employed on a permanent basis (85.7% UK-wide) with the majority employed full-time (68.3% UK-wide), typically working 37.5 hours per week (52.5% UK-wide). England had the highest proportion of respondents employed on a part-time basis (36.8% within England). A total of 29.7% of respondents UK-wide typically did not work overtime, but since the start of the pandemic, slightly less, 26.6% 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 it. Under half of the respondents (36.4% UK-wide) had taken no sick days in the previous 12 months, 63.6% had taken one or more sick days in the previous 12 months, midwives had taken the most sick days with 73.3% having one or more days sick leave. UK-wide,

52.0% of respondents said that at least some of their sickness absence was related to COVID-19 with 76.8% of midwives and 66.5% of social care workers having sickness related to COVID-19. When sick, nearly half of respondents (48.3% UK-wide) reported being paid by their employer.

A large proportion of respondents UK-wide had either 11-20 years of work experience (28.3%) or 21-30 years (25.6%). Scotland had the highest proportion of those with 11-20 years of experience (34.1% within Scotland) and those with more than 30 years of experience were primarily nurses (31.5% of nurses). The main area of practice for most respondents was work with older people (38.1% UK-wide) followed by other groups, this included working across multiple service groups, e.g. mental health, geriatrics, outpatients etc (16.2% UK-wide). UK-wide, only 7.2% reported that their service had not been impacted (services stepped down due to COVID-19) with 59.4% reporting feeling overwhelmed by increased pressures. As shown in Figure 2.2, nurses and midwives were the most impacted occupational groups (66.7% of nurses and 63.0% of midwives). That said, significant percentages of respondents expressed feeling overwhelmed in all occupational groups with over 45% of respondents in each occupation group feeling overwhelmed.

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



Respondents were asked whether they worked from home before the pandemic, more than half of respondents did not work from home at all (72.5% UK-wide). During the COVID-19 pandemic from March 2022-July 2022, 7.1% were able to work from home all the time, while 43.8% could work from

home some of the time. Social workers were most likely to work from home all the time (18.5% of social workers) or some of the time (66.1% of social workers), while most nurses (63.2% of nurses), social care workers (62.0% of social care workers) and midwives (51.4% of midwives) were not able to work from home at all.

Respondents were also asked whether they had considered changing their employer or occupation since the start of the pandemic. Over a third of the respondents UK-wide (37.4%) had considered changing their employer, with the highest proportion of these being from England (43.9% within England) and followed closely by Northern Ireland (43.5% within Northern Ireland). Within social work, 58.5% of respondents considered changing their employer. Over a third of the respondents UK-wide (38.6%) also had considered changing their occupation with the highest proportion of these being from England (40.6% within England) and followed closely by Northern Ireland (39.0%). Within midwifery, 50.3% considered changing their occupation during the pandemic. Respondents indicated that pay increases, flexible working hours and more peer support would change their minds about wanting to leave their employer or current occupation. Most of respondents were still in the same job on the same contractual working hours (70.4% UK-wide).

Most respondents did not take up employer support (72.4% UK-wide) and Wales had the highest percentage uptake of employer support (29.1% within Wales). AHPs were most likely to access employer support (26.6% within AHPs) while midwives were least likely to access employer support with only 24.1% of midwives taking up employer support. For those respondents who accessed employer support, the most common were manager support, well-being support and flexible working hours. When respondents were asked why they had not taken up employer support, 30.3% indicated that the support was not accessible or took place at an inconvenient time, 27.1% stated they had support elsewhere, 26.5% felt the support was not needed and 16.1% stated other (reasons reported in the other category can be found in Appendix A2.40 of this report).

## 2.3 Focus Groups

Three focus groups were conducted to gain deeper insights into the health and social care workforce (Social Care Workers, Social Workers, Midwives, Nurses and AHPs) and the impact of COVID-19 on their work, one with health and social care Human Resource (HR) professionals, one with line managers and one with frontline workers (note: focus groups were conducted in June and July 2022).



Participants were mainly from Northern Ireland. Three males and 14 females took part in these focus groups.. Each group began with a brief introduction of the research study before discussion commenced with discussions based around key findings from the survey. These views contributed to our good practice recommendations for improving quality of working life and well-being for health and social care professionals now and beyond the pandemic. Table 2.5 below shows the country and occupational group of the 17 participants.

Table 2.5: Focus Group Participants

Focus group	Country	Occupation	Setting
<b>Human Resources (HR)</b>	Northern Ireland	HR – Trade Unions staff	Hospital
	Wales	HR & Organisational Development Business Partner	Community
	Scotland	Head of HR	Community
	Scotland	Head of People and Organisational Development	Community
	Scotland	HR Business Partner	Community
<b>Managers</b>	Northern Ireland	Social Work	Community
	Wales	Social Work	Other
	Wales	Social Work	Other
	Wales	Health and Social	Other
	Northern Ireland	Midwife	Hospital
	Northern Ireland	AHP	Hospital
	Northern Ireland	Nursing	Hospital
	Wales	Social Care	Community
<b>Front Line workers</b>	Northern Ireland	Nurse	Community/Home-based
	England	Midwife	Hospital
	Northern Ireland	Social Worker	Community
	England	AHP	Hospital/Other

## 2.4 Data Analysis

Quantitative survey data were analysed using SPSS 28. Presented are primarily descriptive statistics, specifically frequencies, percentages, and mean values of the measured constructs, as well as 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 well-being, quality of working life and burnout, and to compare

findings with those from Phases 1-4 of the study. Analyses were conducted both with raw and weighted data. The data were weighted using respondents' country of work and occupational group to adjust for potential bias accruing from under-representation of large groups. Weighted responses are summarised in Section 3. Appendices provide more detailed results, including the unweighted response summaries. 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'. Members of the 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 Sections 3.2.1 and 3.2.2. of the main part of this report, with further insights provided in Appendix 10.

## 2.5 Ethical Considerations

Data collection took place during another 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 well-being, quality of working life and burnout rates in order to formulate recommendations for supporting the workforce during busy times such as these. 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 or afterwards. All permissions for the use of the measurement scales were obtained prior to the study commencing.

## 3. Findings

The following sections provide a summary of the quantitative and qualitative findings from Phase 5, with particular attention given to changes from the four previous phases.

### 3.1. Quantitative Findings

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

#### 3.1.1. Mental Well-being

Mental well-being was assessed using the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008). The overall UK-wide mean well-being score in our sample was 20.80, which is nearly three points below the population mean of 23.61 (NHS Health Survey for England, 2011). This is also lower than the mean score of 20.95 reported in Phase 1 of the study, and is an improvement on the mean score of 20.10 reported in Phase 2 of the study and the mean score of 20.25 in Phase 3. However, in this fifth phase of the study the well-being score has decreased slightly from the reported mean score of 20.85 in Phase 4 (Table 3.1).

Table 3.1: Mean Overall Well-being Score by Study Phase and Country (Weighted)

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	20.95	21.16	20.74	21.24	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85
Phase 4	20.85	20.98	20.28	20.8	20.69
Phase 5	20.80	20.39	20.89	20.28	20.87

Multiple regression analysis revealed that this was a **significant difference in well-being from Phase 1 to Phase 5**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -0.678$ ,  $p < .001$ ). There was a slight increase in the overall mean well-being scores between Phase 2 and Phase 5 of the study which was found **statistically significant** when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.271$ ,  $p = .032$ ). There was a slight increase in the overall mean well-being scores between Phase 3 and Phase 5 of the study which was found **not statistically significant** when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.205$ ,  $p = .116$ ). There was a slight decrease in the overall

mean well-being scores between Phase 4 and Phase 5 of the study which was found **not statistically significant** when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.271$ ,  $p = .116$ ).

Those who worked as Nurses, Midwives and Social Workers showed a decrease in their overall mean well-being scores from Phase 1 of the study to Phase 5, while AHPs and Social Care Workers showed an increase. Between Phase 2 and Phase 5, all occupations showed an increase in overall well-being scores. Between Phase 3 and Phase 5, Nurses showed a decrease in overall well-being scores while Midwives, AHPs, Social Care Workers and Social Workers showed an increase in overall well-being scores. Between Phase 4 and Phase 5, Nurses showed a decrease in overall well-being scores while Midwives, AHPs, Social Care Workers and Social Workers showed an increase in overall well-being scores (Table 3.2).

Table 3.2: Mean Overall Well-being Score by Study Phase and Occupation (Weighted)

Study phase	Occupation				
	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
Phase 3	20.58	19.23	20.72	19.70	19.31
Phase 4	20.85	20.98	20.27	20.80	20.69
Phase 5	20.32	19.93	21.60	21.15	20.19

When the well-being scores were converted to indicate probable or possible cases of depression/anxiety, it was found that UK-wide, 11.8% were probable (likely) cases of anxiety or depression and a further 18.6% were possible cases of anxiety or depression (Table 3.3). With the overall average well-being score increasing slightly from Phase 3 to Phase 5, fewer participants were now in the Likely Condition category. In comparison to Phase 4, less people fell into the probable (likely) or possible anxiety/depression brackets. Taken together, the estimated proportion of scores between 20-21 has remained similar and shows that well-being has not improved even as the population begins to move beyond the pandemic restrictions.

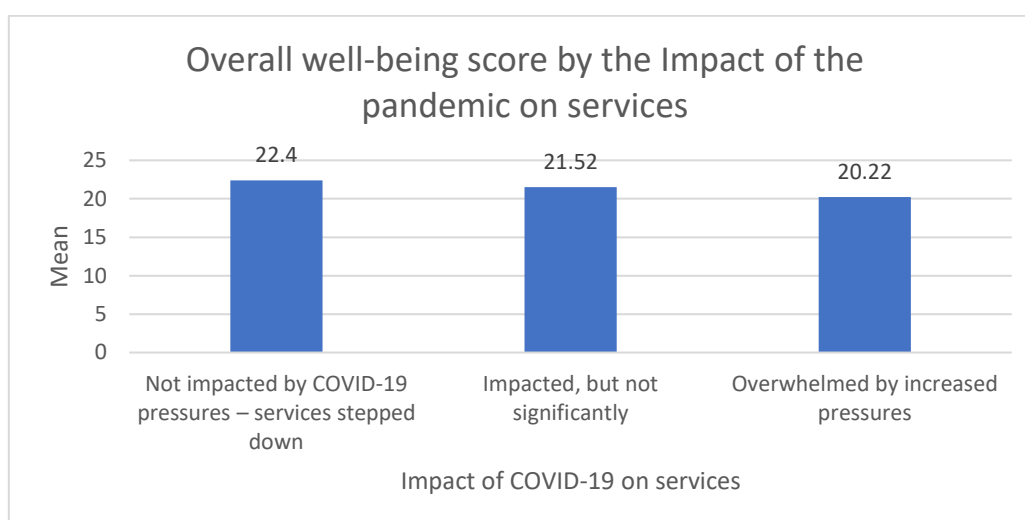
Table 3.3: Well-being scores translated to anxiety/depression scores UK-wide (Weighted)

Study phase	UK-Wide	
	Probably (Likely)	Possible
Phase 1	9.0%	33.0%
Phase 2	17.7%	22.0%
Phase 3	20.7%	14.4%
Phase 4	12.4%	20.1%
Phase 5	11.8%	18.6%

We also looked at the effects of other variables on mental well-being and found the following:

- Males had significantly higher well-being scores than females.
- Younger respondents (16-29 age group) had significantly better well-being than older respondents (specifically 40-49 and 60+ age groups).
- Respondents of Mixed ethnicity scored significantly higher in well-being scores than all other ethnic groups.
- Respondents who considered themselves to not have a disability reported significantly lower well-being scores than those with a disability and those who were unsure about their disability.
- Respondents who worked with children and young people scored significantly higher well-being scores than those in midwifery, working with adults, in learning disability services, with older people, within mental health and in the area 'other'.
- Those who were line managers scored significantly higher in overall mean well-being scores than respondents who were not line managers.
- Respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures (see Figure 3.1).

Figure 3.1: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Weighted)



Compared to Phases 2 and 3 of the study which also measured impact, overall well-being scores for those overwhelmed increased in Phase 5. Comparison with Phase 4 showed that well-being had begun to decrease again (Table 3.4).

Table 3.4: Overall well-being scores by those overwhelmed working in the pandemic (Weighted)

Study phase	Respondents overwhelmed	
	Mean well-being score	Percentage of respondents
Phase 2	19.66	49.3%
Phase 3	19.26	62.1%
Phase 4	20.35	59.8%
Phase 5	20.22	59.4%

In Phase 5, 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 the previous 12 months, line manager status and the effects of the pandemic on services, the following coping strategies were significantly associated with well-being scores:

- Positive reframing, Acceptance, Use of emotional support, Use of Instrumental support, Work-family segmentation, Working to improve skills/efficiency, Recreation and relaxation, and Exercise, **all predicted higher well-being scores**



- Family-work segmentation, Planning, Venting, Substance use, Behavioural disengagement, and Self-blame, **all predicted lower well-being scores.**

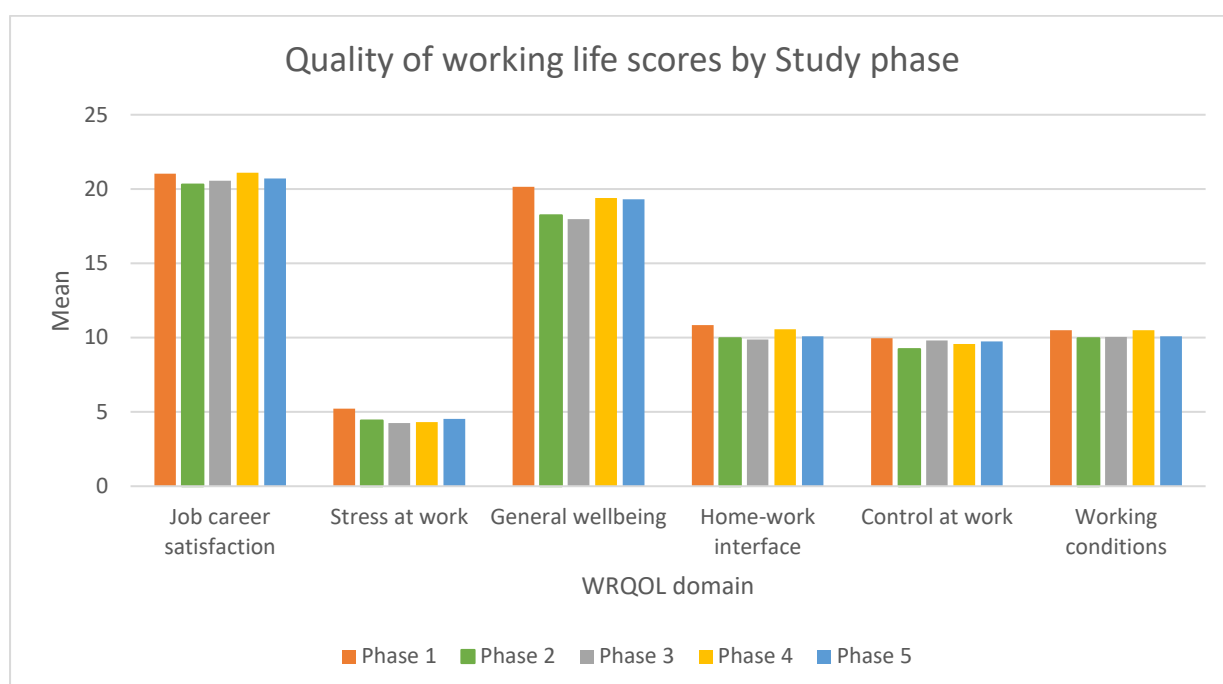
We found that there was a decreased in the use of positive coping strategies (positive reframing, acceptance, emotional support and use of instrumental support) from Phase 4 while the use of negative strategies substance use and self-blame recorded their highest scores during Phase 5 in comparison to the previous four phases. A detailed breakdown of well-being scores across different variables is provided in Appendix 3 and detailed results of the multiple regression analysis are provided in Appendix 8.

### 3.1.2. Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life (WRQOL) Scale (Easton and Van Laar, 2018). The overall WRQOL score across the UK was 74.49 which is lower compared to the 77.59 in Phase 1 and 75.42 reported in Phase 4 of this study but a slight improvement compared to 72.13 in Phase 2 and 72.45 in Phase 3. A multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed the decrease in the overall WRQOL scores between Phase 1 and Phase 5 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 ( $\beta = -4.441$ ,  $p < .001$ ). The change in the overall WRQOL scores between Phase 2 and Phase 5 of the study was **statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -1.377$   $p = .016$ ). The change in the overall WRQOL scores between Phase 3 and Phase 5 of the study was **not statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.043$ ,  $p = .941$ ). The change in the overall WRQOL scores between Phase 4 and Phase 5 of the study was **not statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = .180$ ,  $p = .787$ ).

As shown in Figure 3.2, there was a decrease from Phase 4 to Phase 5 in Job Satisfaction, general well-being, home-work interface and working conditions while an increase stress at work and control at work.

Figure 3.2: UK-wide Mean Quality of Working Life Scores by Study phase (Weighted)



As shown in Table 3.5, in Phase 5, the decrease in mean WRQOL scores was observed UK-wide and shown in two countries (England and Scotland). Similarly, Table 3.6 shows that WRQOL has declined in Nurses and Social Workers in Phase 5.

Table 3.5: 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
Phase 3	72.45	71.54	71.92	78.69	73.29
Phase 4	75.42	75.30	70.28	77.67	72.12
Phase 5	74.49	73.10	69.64	78.70	72.54

Table 3.6: 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
Phase 3	73.77	64.35	73.79	71.15	69.92
Phase 4	78.37	63.76	73.92	72.78	68.39
Phase 5	73.81	66.89	76.42	75.41	66.75

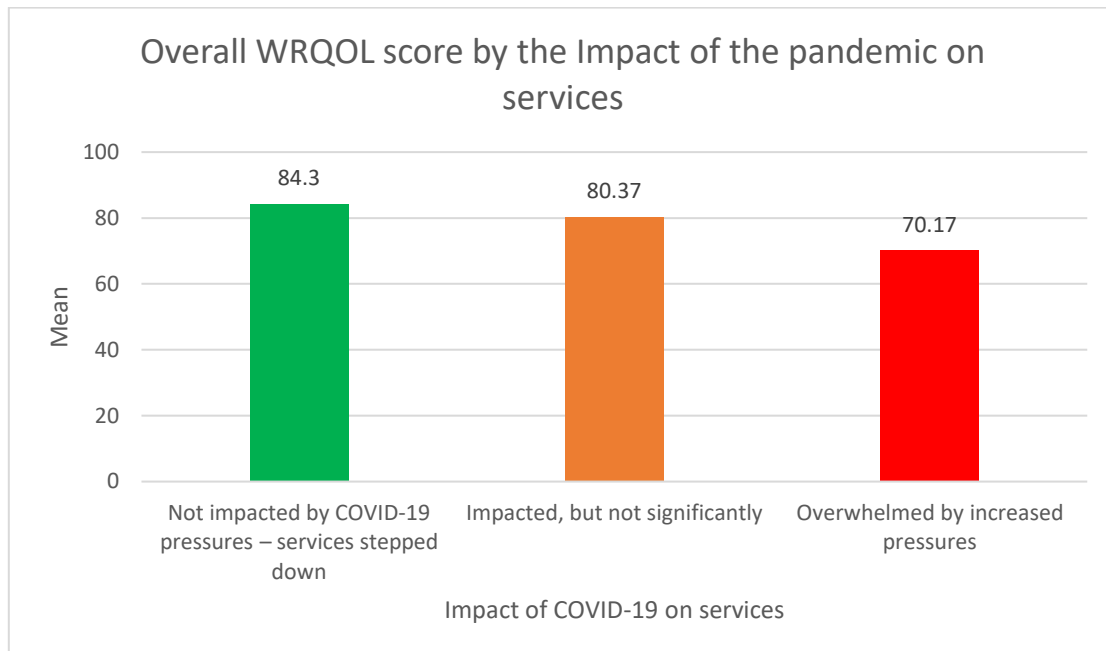
When the WRQOL scores were converted to Lower, Average, or Higher quality of working life, we found that UK-wide, 47.3% of respondents had lower quality of working life, 23.0% had average quality of working life and 29.7% had higher quality of working life in Phase 5. In Phase 4, 36.9% of respondents had lower quality of working life, 25.5% had average quality of working life and 37.5% had higher quality of working life in Phase 4. In Phase 3 in which 50.0% of respondents had lower quality of working life, 19.5% had average quality of working life and 30.5% had higher quality of working life. While in Phase 2, 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 and 30.4%, 27.1%, and 42.5% for higher, average and lower quality of working life respectively in Phase 1 of the study. Results from this study (Phase 5) indicate more respondents had a lower level of WRQOL quality life.

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

- Females had significantly lower quality of working life than males.
- The 16-29 age group reported significantly better quality of working life than all other age groups.
- Respondents from the White ethnic group reported lower scores than those of Black or Mixed ethnicity but higher scores than those of Asian Ethnicity.
- Respondents without a disability scored significantly higher than those with a disability and those who were unsure if they had a disability.
- Respondents working with children and young people scored significantly higher than those working in midwifery, with adults of working age, those in the areas of mental health or 'other'.
- Line managers scored significantly higher in the mean overall WRQOL scores those who were not.

- 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 (see Figure 3.3).

Figure 3.3: Mean Overall WRQOL Score by the Impact of the Pandemic on Services (Weighted)



We used multiple regressions to examine which coping strategies impacted upon the quality of working life scores. In Phase 5, 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 the 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, Use of emotional support, Work-family segmentation, Working to improve skills/efficiency, and Recreation and relaxation, **all uniquely predicted higher quality of working life scores.**
- Family-work segmentation, Planning, Venting, Behavioural disengagement, and Self-blame, **all uniquely predicted lower quality of working life scores.**

A 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.

### 3.1.3. Burnout

Burnout was measured from Phase 2 onwards. In Phase 5, the personal burnout score UK-wide was 61.10, which is lower than the personal burnout scores in Phase 4 (62.62), Phase 3 (63.20) and Phase 2 (61.40). The work-related burnout score across the UK was 56.51 which was lower than all previous phases. The client-related burnout score across the UK was 25.88 which was higher than Phase 4 (25.24), but lower compared to Phase 2 (27.97) and Phase 3 (29.46).

Multiple regression analysis revealed **a significant increase** in personal burnout from Phase 2 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 1.724$   $p = .017$ ). There was also **a significant increase** in work-related burnout ( $\beta = 2.326$ ,  $p = .003$ ) but **no significant difference** in client-related burnout ( $\beta = 1.252$ ,  $p = .118$ ) from Phase 2 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

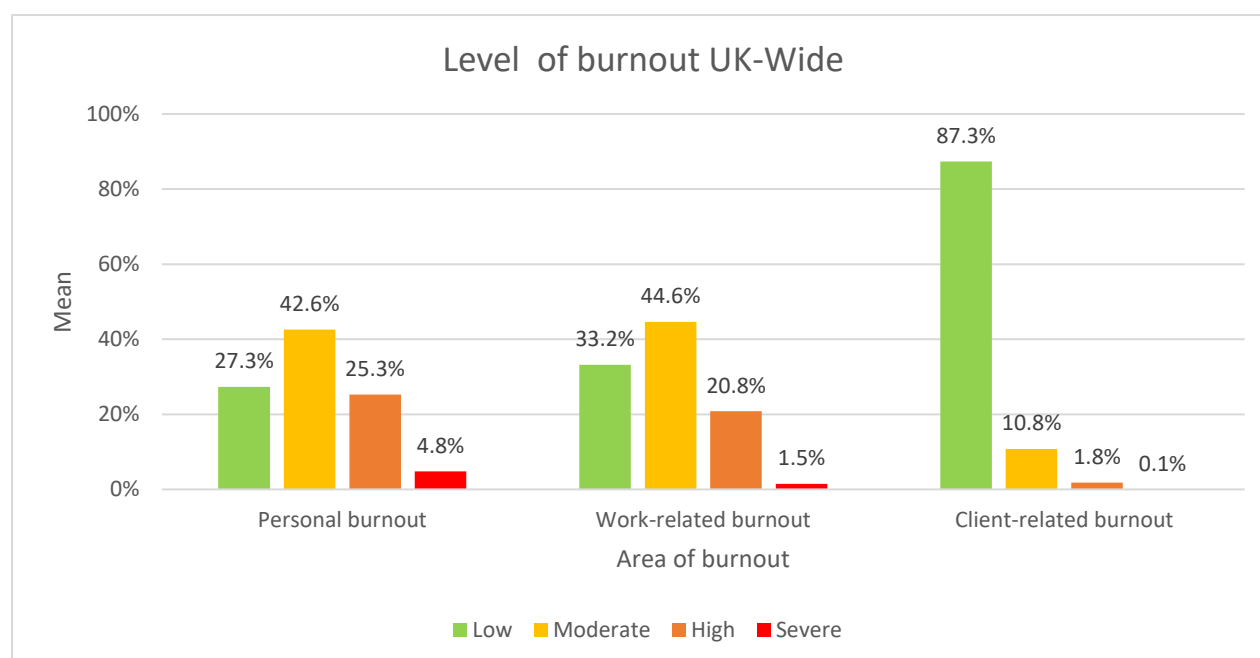
Multiple regression analysis revealed that there was **no significant difference** in personal burnout from Phase 3 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.478$ ,  $p = .515$ ). **There were no significant differences** in work-related burnout ( $\beta = 0.0483$ ,  $p = .539$ ) or client-related burnout ( $\beta = 0.062$ ,  $p = .939$ ) from Phase 3 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that **no significant difference** in personal burnout from Phase 4 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -0.070$ ,  $p = .933$ ). There was also **no significant difference** in work-related burnout ( $\beta = -0.328$ ,  $p = .713$ ) or client-related burnout ( $\beta = 0.474$ ,  $p = .612$ ) from Phase 4 to Phase 5 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Overall, in Phase 5 we found that client-related burnout was much lower than personal and work-related burnout, suggesting that clients or patients/service users are rarely the reason for staff burnout. There were no significant differences between the countries in mean personal burnout scores ( $F = 1.041$ ,  $df = 3$ ,  $p > .05$ ), or in mean work-related burnout scores ( $F = .449$ ,  $df = 3$ ,  $p > .05$ ) or

in mean client-related burnout scores ( $F = 2.268$ ,  $df = 3$ ,  $p > .05$ ). Burnout scores for each domain (personal, work and client) were converted to low, moderate, high or severe burnout (Figure 3.4).

Figure 3.4: Level of burnout UK-wide



We found that UK-wide in Phase 5, 27.3% of respondents had low personal burnout, 42.6% had moderate burnout and a further 30.1% experienced high to severe levels. This compares to Phase 4 personal burnout, 25.3% of respondents had low burnout, 42.6% moderate, 25.3% high and 4.8% faced severe burnout (see Figure 3.4). Additionally, 21.9% of respondents had low burnout, 42.9% moderate burnout, 37.2% high/severe burnout in Phase 3 and 28.3% reported low burnout, 46.4% reported moderate burnout, while 28.3% reported high/severe personal burnout in Phase 2. (Table 3.7).

Table 3.7. Level of personal burnout UK-wide across the Phases (Weighted)

Personal Burnout	Low	Moderate	High/Severe
Phase 2	25.3%	46.4%	28.3%
Phase 3	21.9%	42.9%	37.2%
Phase 4	18.1%	54.6%	27.3%
Phase 5	27.3%	42.6%	30.1%



In terms of work-related burnout in Phase 5, 33.2% had low burnout, 44.6% had moderate burnout and a further 22.3% experienced high to severe levels of work-related burnout. In Phase 4, 29.0% of respondents had low burnout, 43.4% moderate, 27.6% reported high/severe burnout. In Phase 3, 28.1% of respondents had low burnout, 46.3% moderate, 23.6% high and 2.0% faced severe burnout. In relation to work-related burnout in Phase 2, 33.7% experienced low burnout, 45.0% experienced moderate burnout and a further 21.3% experienced high or severe burnout (Table 3.8).

Table 3.8. Level of work-related burnout UK-wide across the Phases (Weighted)

<b>Work-related Burnout</b>	<b>Low</b>	<b>Moderate</b>	<b>High/Severe</b>
<b>Phase 2</b>	33.7%	45.0%	21.3%
<b>Phase 3</b>	28.1%	46.3%	25.6%
<b>Phase 4</b>	29.0%	43.4%	27.6%
<b>Phase 5</b>	33.2%	44.6%	22.3%

Finally, in relation to client-related burnout in Phase 5, 87.3% experienced low burnout, 10.8% experienced moderate burnout and 1.9% experienced high or severe burnout (Table 3.9). In Phase 4, 81.7% experienced low burnout, 16.2% experienced moderate burnout and 2.1% experienced high or severe burnout (Table 3.9). In Phase 3, 78.4% had experienced low burnout, 18.2% experienced moderate burnout and 3.4% experienced high or severe burnout. For client-related burnout in Phase 2, 80.9% had experienced low burnout, 17.1% experienced moderate burnout and 2.0% experienced high or severe burnout.

Table 3.9. Level of client-related burnout UK-wide across the Phases (Weighted)

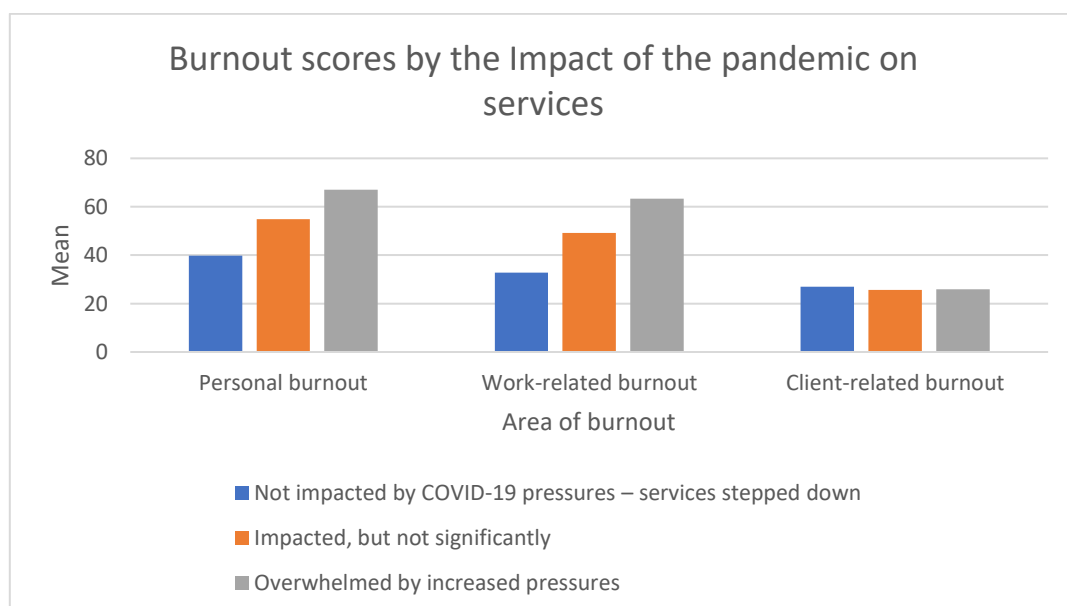
<b>Client-related Burnout</b>	<b>Low</b>	<b>Moderate</b>	<b>High/Severe</b>
<b>Phase 2</b>	80.9%	17.1%	2.0%
<b>Phase 3</b>	78.4%	18.2%	3.4%
<b>Phase 4</b>	81.7%	16.2%	2.1%
<b>Phase 5</b>	87.3%	10.8%	1.9%

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 but had lower client-related burnout than males.

- The 50-59 age group scored significantly higher in personal burnout than the 16-29 and 30-39 age groups. The 16-29 age group scored significantly higher in work-related burnout scores than the 40-49 and 50-59 age groups. The 30-39 age group scored significantly higher in client-related burnout scores than the 40-49, 50-59 and 60+ age groups but significantly lower than the 16-29 age group.
- In terms of personal burnout, the White ethnic group scored significantly higher than the Black and Mixed ethnic groups. The Asian ethnic group scored significantly higher than the Black or Mixed ethnic groups in work-related burnout. For client-related burnout, the Asian ethnic group scored significantly higher than the White or Black ethnic groups.
- Respondents without a disability experienced significantly less personal and work-related burnout than those who were unsure of whether they had a disability or those with a disability. Those who were unsure if they had a disability scored significantly higher in client-related burnout than those who did have a disability and those who did not have a disability.
- Line managers experienced significantly lower personal burnout.
- Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more personal and work-related burnout than those who felt impacted but not significantly and those not impacted (see Figure 3.5).

Figure 3.5: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)



As shown in Table 3.10, we found strong negative correlations between personal burnout and well-being scores and a moderate negative correlation between personal burnout and quality of working life, work-related burnout and well-being 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 well-being scores, and client-related burnout and quality of working life scores. This indicates that as burnout in any area increased, respondents' well-being and quality of working life decreased. Considering the association between burnout, well-being and quality of working life, another area of interest for the survey was whether respondents have considered leaving their current employer and how this impacts burnout.

Table 3.10: Pearson correlations between Burnout Scores, Mental Well-being (SWEMWBS) and WRQOL Scores (Weighted)

Burnout area	Well-being	Quality of working life
Personal	-.700	-.607
Work-related	-.689	-.740
Client-related	-.245	-.315

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:  $\chi^2 = 143.657$ ,  $df = 15$ ,  $p < .001$ ; Work-related burnout:  $\chi^2 = 171.009$ ,  $df = 15$ ,  $p < .001$ ; Client-related burnout:  $\chi^2 = 36.257$ ,  $df = 15$ ,  $p = .002$ ). 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 impacting on their health and well-being and 2) they wanted a change in work experiences. 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 and client-related burnout.

Using multiple regressions to examine which coping strategies were predictive of the burnout scores, we found that after controlling for 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, Recreation and relaxation, and Exercise, **all uniquely predicted lower burnout scores.**
- Planning, Venting, Substance use, Behavioural disengagement, Self-blame, and Family-work segmentation, **all uniquely predicted higher burnout scores.**

#### ***Work-related burnout:***

- Positive reframing, acceptance, Use of emotional support, Use of instrumental support, Work-family segmentation, Working to improve skills/efficiency, and Recreation and Relaxation **all uniquely predicted lower burnout scores.**
- Planning, Venting, Behavioural disengagement, Self-blame, and Family-work segmentation, **all uniquely predicted higher burnout scores.**

#### ***Client-related burnout:***

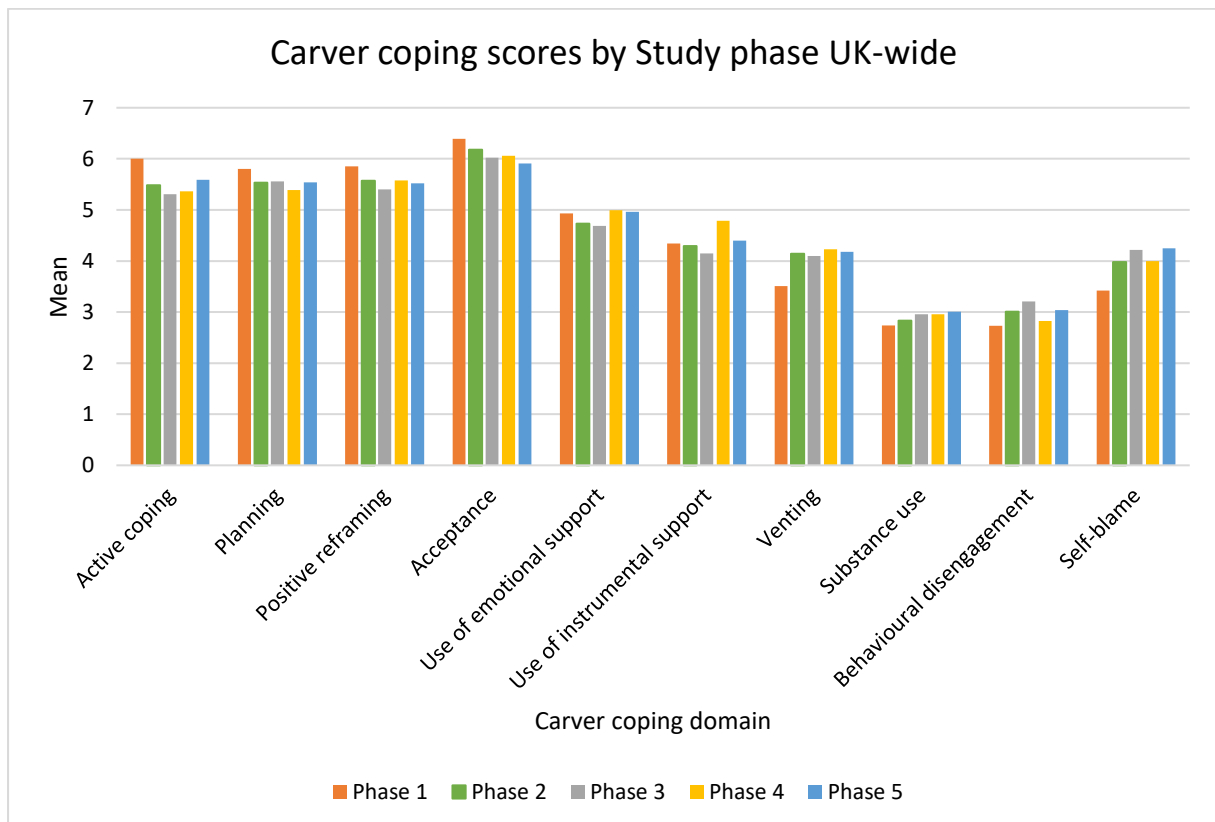
- Higher positive framing and working to improve skills/efficiency **predicted uniquely lower burnout scores.**
- Higher Exercise, Venting, Substance use, and Self-blame scores **predicted uniquely higher burnout scores.**

A 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.

### **3.1.4 Coping**

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 5. Between Phase 2 and Phase 5, there was a decrease in the use of some positive coping strategies and an increase in the use of negative coping strategies. UK-wide there was a decrease in the use of Planning and Acceptance as positive coping strategies and an increase in Venting, Substance Use and Self-blame as negative coping strategies from Phase 3 of the study to Phase 5. Between Phase 4 and Phase 5 there was a decrease in the use of Positive Reframing and Acceptance as positive coping strategies and an increase in Substance Use, Behavioural Disengagement and Self-Blame as negative coping strategies. These changes are shown in Figure 3.6.

Figure 3.6: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)



Comparing Phase 1 to Phase 5, 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 ( $\beta = -0.879$ ,  $p < .001$ ), Planning ( $\beta = -0.523$ ,  $p < .001$ ), Positive Reframing ( $\beta = -0.589$ ,  $p < .001$ ), Acceptance ( $\beta = -0.573$ ,  $p < .001$ ), the use of Emotional Support ( $\beta = -0.311$ ,  $p < .001$ ) were statistically significant and the increase in Venting ( $\beta = 0.653$ ,  $p < .001$ ), Behavioural Disengagement ( $\beta = 0.407$ ,  $p < .001$ ) and Self-Blame ( $\beta = 0.745$ ,  $p < .001$ ) was also statistically significant.

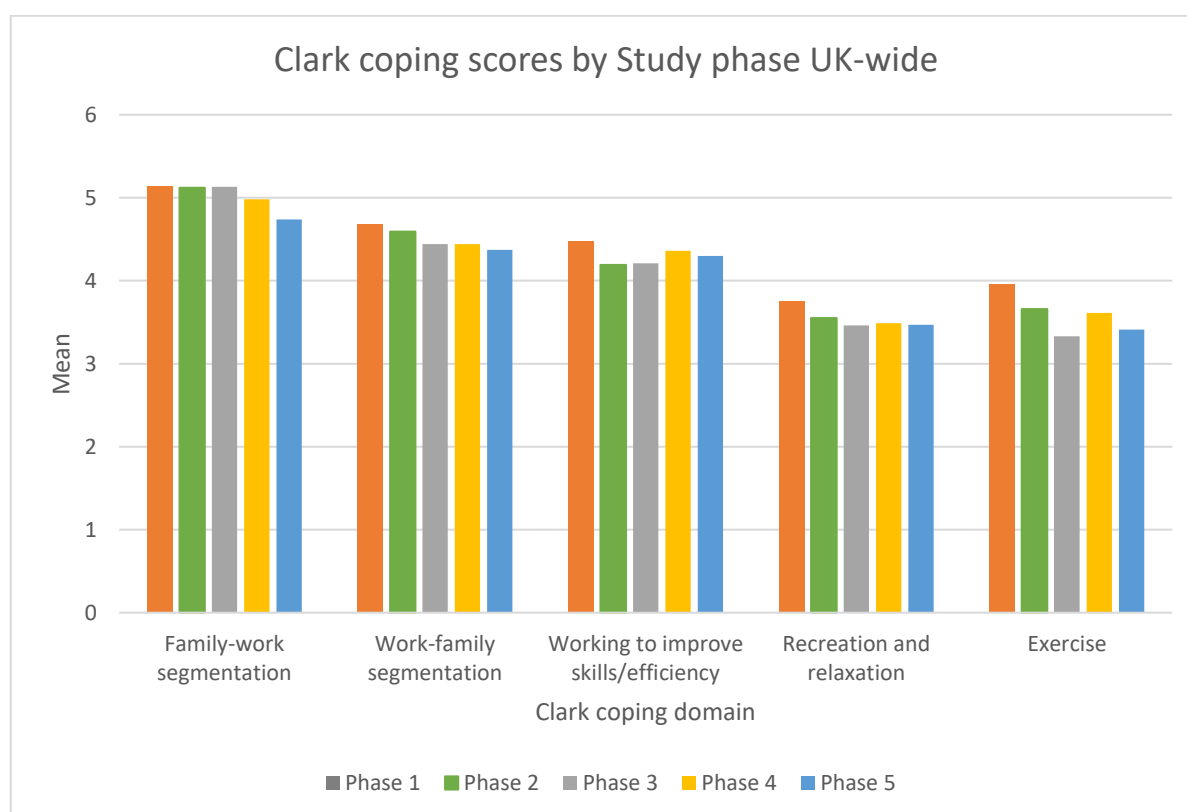
Between Phase 2 to Phase 5, a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status, showed that the decrease in respondents' use of Active Coping ( $\beta = -0.258$ ,  $p < .001$ ), Planning ( $\beta = -0.147$ ,  $p = 0.034$ ), Positive Reframing ( $\beta = -0.277$ ,  $p < .001$ ), Acceptance ( $\beta = -0.174$ ,  $p = .003$ ), the use of Emotional Support ( $\beta = -0.241$ ,  $p < .001$ ), the use of Instrumental Support ( $\beta = -0.151$ ,  $p = .002$ ) were statistically significant. While the increase in Self-Blame ( $\beta = 0.158$ ,  $p = .021$ ) was statistically significant.

Between Phase 3 to Phase 5, 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 positive reframing ( $\beta = -0.132$ ,  $p = 0.039$ ), and the use of Emotional Support ( $\beta = -0.152$ ,  $p = .021$ ) were statistically significant. While the increase in self-blame ( $\beta = 0.158$ ,  $p = .021$ ) was statistically significant. A multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status, showed no significant differences between Phase 4 and 5 for any coping strategy.

Looking at Clark et al's. (2014) coping strategies (Figure 3.7), 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 reduction between Phase 1 and 5 in** respondents' Work-Family Segmentation ( $\beta = -0.149$ ,  $p < .001$ ), Working to Improve skills/efficiency ( $\beta = -0.198$ ,  $p < .001$ ), Recreation and Relaxation ( $\beta = -0.252$ ,  $p < .001$ ) and Exercise ( $\beta = -0.229$ ,  $p < .001$ ). Between Phases 2 to 5, 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 reduction in respondents'** in the use of recreation and relaxation ( $\beta = -0.157$ ,  $p < .001$ ).

Between Phases 3 to 5, 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 reduction in respondents'** in the use of Recreation and Relaxation ( $\beta = -0.093$ ,  $p = .050$ ). Between Phases 4 to 5, a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed **no significant difference in respondents'** in the use of any of the Clark coping strategies.

Figure 3.7: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)



## 3.2. Findings: Qualitative responses

Responses to the two open-ended questions in the survey 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 the three focus groups that were held with Human Resources (HR) professionals, managers and frontline workers in June and July 2022. The overarching themes that emerged in Phase 5 (May 2022-July 2022) have similarities to the themes identified in Phase 1 (April – July 2020), Phase 2 (November 2020-January 2021), Phase 3 (May 2021 – July 2021) and Phase 4 (November 2021-February 2022) of the study such as changing conditions, connections, communication and work-life balance.

### 3.2.1. Open-ended responses – Descriptions of COVID-19 Demands and Impacts

The following questions were asked in the Phase 5 survey:

- **Q22.** Between March 2022 and now, what is the impact of COVID-19 on your specific place of work, in relation to patient / service user numbers and service demand?
- **Q42.** Did the experience of the pandemic change the way you now manage work and non-work responsibilities? If yes, please tell us how.

Generally, across the two opened ended questions, responses suggested that a vicious cycle of how staff shortages and work demand was impacting many health and social care workers, causing additional stress and pressures. Staff were still mostly feeling very overwhelmed and exhausted. The data revealed that staff were also impacted by the effects of the pandemic on patients/ service users with an increase in demand within their services. Respondents discussed a perceived lack of support particularly in regard to these staffing shortages and still felt a lack of support from management in terms of new working conditions and working procedures. A new normal was discussed by most respondents who indicated that while services were beginning to return to some normality, things were often still different from pre-pandemic times.

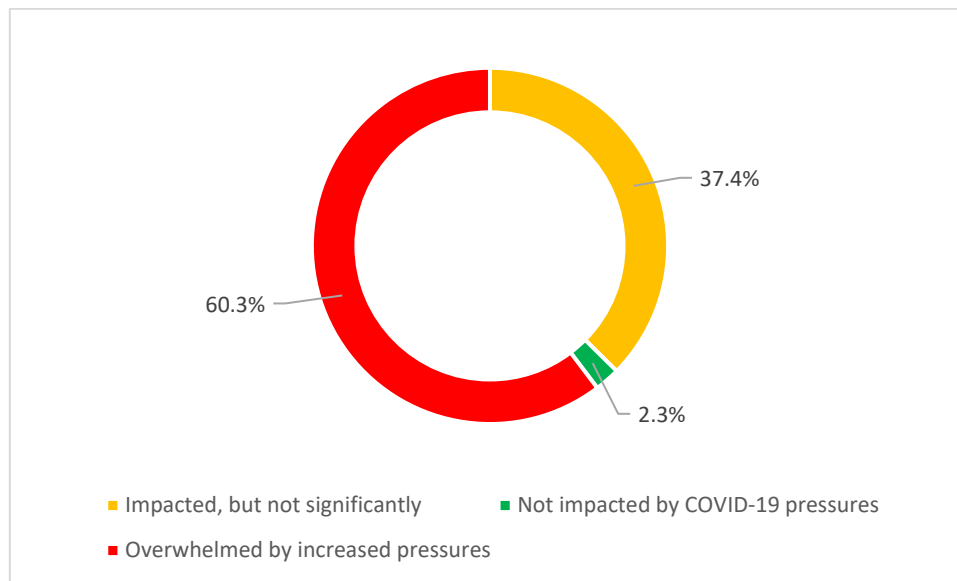
In the following section, we discuss responses to each open-ended question in greater detail to highlight the challenges that the health and social care sector staff face as the COVID-19 pandemic continues to affect their working conditions, as services rebuild, and patients and service users are seeking a return to 'business as usual' within health and social care provision. While the health and social care sector returns to a new normal, as the pandemic restrictions cease throughout the UK, with few restrictions and limited virus testing at the time of the Phase 5 survey, those working in health and social care services continue to face difficulties which are discussed in detail below.

### Responses to open-ended Q22

Out of the 1,737 survey participants, 1,370 individuals responded to the open-ended question Q22 *"Between March 2022 and now, what was the impact of COVID-19 on your specific place of work, in relation to patient / service user numbers and service demand?"* For the respondents that answered Q22, over half felt overwhelmed working during the pandemic (Figure 3.8).



Figure 3.8 Impact on working during the pandemic by Q22 respondents.



Phase 5 of our survey asked respondents to comment once more on any impacts that COVID-19 had made on their specific place of work, in relation to patient or service user numbers and in relation to service demand.

### Vicious cycle of staff shortage and work demand

Phase 4 data had indicated a negative feedback loop, or vicious cycle, in relation to staff shortages and work demand, and this vicious cycle was evident in our Phase 5 data as well. By far the subject most commented on by our respondents was staffing shortages followed by increase in workload and complexity of cases. As observed by a one Social Care Worker working in the community *“Demand has doubled, and workforce halved.”* (Social Care Worker, England, Community). This combination continued to put additional pressure on the remaining staff. It has contributed to difficulty providing the care or support required for patients/service users, causing additional stress and burnout for staff at a time when pressures on services and workload have continued to increase for a range of reasons. This was similarly experienced across occupations and countries.

*“Staffing levels were horrendous we struggled day to day and were expected to get everything done running on skeleton staffing levels”* (Social Care Worker, Northern Ireland, Community).

*“Reduced staffing-Should have at least 14 midwives per shift most days we have 8 midwives to run postnatal 20 bed ward antenatal 15 bed ward and 9 bed labour ward and 3 bed birthing unit”* (Midwife, England, Hospital).

*"Demand outstripping capacity+ but no extra staffing funding plus regular COVID absences impacting on business continuity" (AHP, Wales, Hospital).*

Many staff described feeling 'overwhelmed' by the pressure on services with demand remaining high and inadequate staff to deal with this. Other respondents also commented on the effect of this imbalance on their own and their colleagues' (mental) health:

*"Being overwhelmed and feeling helplessness; Unsafe working practices due to staffing issues; Impact on own mental health and well-being" (Social Worker, Community, Northern Ireland).*

*"Patient numbers continue to be high with fast turnover. High service demand overwhelming at times" (AHP, Northern Ireland, Hospital).*

*"Staff crisis every shift going on to 'SOS' requests for 2 members of staff that you see prior to shift and just know it's going to be overwhelming." (Midwife, Scotland, Hospital).*

While most discussions were around staff shortages and service demand, we identified that the pandemic itself and how it was managed was also still a major source of stress:

*"The pandemic has been catastrophic for people's mental health and well-being" (Social Care Worker, Northern Ireland, Community).*

*"We as a facility lost clients...was so hard to watch the healthiest service users pass away" (Social Care Worker, Northern Ireland, Community).*

*"Burnout, exhaustion, constantly changing guidelines, miscommunication from senior management" (Nurse, Northern Ireland, Hospital).*

## **Staff Shortages**

Respondents cited various reasons for staff shortages. The most important reason mentioned was sick leave, either due to workload-related stress, COVID-19 or other illnesses:

*"Since March 22, the biggest impact is on staffing levels. A significantly high percentage of staff off on sick leave (stress related). These staff are not replaced, thus their case load is distributed to the staff remaining" (Social Worker, Northern Ireland, Community).*

*"COVID sickness ongoing, staff shortages due to both COVID sickness and poor retention due to burnout. Harder to recruit staff therefore knock-on effect across service feeling very stretched and short staffed despite usual numbers of patient" (Midwifery, England, Hospital).*

*"We had an outbreak mid-February to late March 2022. 1/6th of workforce were affected and 40% of those in our care. We have had overwhelming demand for beds during this time" (Nursing, England, Care Home).*

While sickness levels had significant impact on staffing levels, there was pressure on staff to cover these absences and a perception that services had to be kept running.

*"Increased number of infections in team. Still having to provide a front-line service with reduced staffing" (Social Care Worker, Scotland, Community).*

*The pressure for doing extra shift can be extreme! You can find mentally and physically exhausted but be expected to carry on regardless like you're a robot" (Social Care Worker, Northern Ireland, Community).*

Other important reasons for staff shortage included staff leaving their professions and/or employers to move into less stressful or better paying jobs, lack of job applicants and inability to fill vacancies. This was affecting not only remaining staff but also patients'/service users' experience and access to services:

*"... staff leaving the trust for other jobs" (AHP, Northern Ireland, Community).*

*"We can't get new staff to replace staff that have left. We would of had staff stay for years but now they don't stay for long. When we had a COVID outbreak we only had 5 members of staff to run a 24/7 service for over a week with no cleaner or cook. The 5 staff that worked were put under major stress and worked crazy hours" (Social Care Worker, Northern Ireland, Community).*

*"Many staff have left and the remaining staff workload has increased dramatically. The company is finding it extremely difficult to recruit and in some cases we are having to hire agency staff. Staff morale is at an all time low . Add to this ever increasing amounts of people trying to access our services things just are not great" (Social Care Worker, Scotland, Community).*

## **Work Demand**

While staff levels were low, work demand was still high at the time of data collection. Reasons for this included increased job demands due to COVID-19. Many respondents talked about an increase in complexity in cases - such as increased mental health problems among the general population and increased medical complexities due to longer waiting times to be seen by medical services - which added to their workload:

*“The amount of difficulties families have experienced throughout COVID-19 has seen an increase in referrals in regards to domestic abuse, substance misuse, poor mental health and neglect. Families have become more dependent on social workers making the job more demanding” (Social Worker, Northern Ireland, Community).*

*“Lack of visitors for new mothers, limiting birth partners to one - this causes anxiety in our service users” (Midwife, England, Hospital).*

*“It is difficult to estimate the effect of COVID-19 in isolation from other 'system' pressures, nonetheless since March 2022 my organisation has almost consistently been in the highest 'official' level of escalation known as REAP 4. Service user numbers and service demand have been higher than in previous years. Service pressures have increased due to these higher levels of demand but also significantly through workforce absence” (Nurse, Northern Ireland, Other).*

*“Service demand has increased dramatically, and more people are presenting with mental health needs for which there are very long waiting lists. For the first time one of my services has 307 on the waiting list” (Social Care Worker, England, Community).*

*“Service user numbers have dramatically increased along with the complexity of their needs” (Nurse, Wales, Other).*

### **Effect on patients’/service users**

Consequently, staff felt that there were continued impacts on patient/service users in terms of waiting for services. Some reported that patients/service users were becoming increasingly frustrated with the lack of ‘normal’ service or length of waiting times:

*“We have had numerous members off staff off with sickness which has left us bare bones of staff and sometimes having to cancel services for the adults in our care meaning they miss [out] on their day care and the parents are having to take days off work or find [carers]” (Social Care Worker, Northern Ireland, Day Care).*

*“Seeing an increase in carer breakdowns, lack of services and funding available to support people” (Social Worker, England, Community) .*

Furthermore, service provision and resources were lacking, to a point that patients’/service users’ needs sometimes were not being met. Rapid discharge of patients from hospital was increasing demand on community services with insufficient equipment and support for patients in place.

*“As a quality monitoring officer, I have found the quality within care services has decreased during the pandemic as staffing pressures have taken priority over governance. Many providers who I*

*work with have become non-compliant and are struggling to recruit sufficient staff” (Social Care Worker, England, Community).*

*“As part of the discharge team, we had a surge in referrals from hospital. Many clients being discharged with no care packages, no equipment and unsafe discharges that required significant input from the discharge service to make safe at home” (AHP, Northern Ireland, Community).*

*“Support was significantly reduced causing detrimental effects to our service users. ...SERVICE USERS WERE LET DOWN” (Social Care Worker, Northern Ireland, Community [their emphasis]).*

*“Lack of additional community resources to provide support to families. High waiting lists for services, other professionals not yet completing face-to-face visits. Impact of increased food and energy prices, resulting in more demand for assistance” (Social Worker, Wales, Community).*

In line with this, some respondents talked about patients’/service users’ expectations that sometimes could not be met, further affecting people’s experiences and perceptions of health and social care services:

*“Service user expectations have become increasingly unrealistic with regards to the level of input they will receive and services available” (AHP, Northern Ireland, Community).*

*“I feel like patient demand is unchanged but the opinion of the public on our profession has changed significantly” (Midwife, England, Hospital).*

### **Availability of management support**

There was consensus that management support was more important than ever: *“Support needs have grown, people have needed much more emotional support as have staff” (Social Care Worker, Northern Ireland, Community).* However, a significant minority of respondents mentioned the lack of management support when managing risks associated with COVID-19. Some respondents felt that their employers and/or managers still had not done enough to protect them from COVID-19 and/or to mitigate their fears of spreading the virus to family.

*“Very Stressful times worrying about COVID and carrying COVID and to old people an my [ailing] parents for a little support from the trust, just work you to you drop then harass you if you go on the sick” (Social Care Worker, Northern Ireland, Community).*

*“Felt unsafe due to health issues and age. Little support from management other than to move me on after years of experience in the job/field” (Social Worker, Northern Ireland, Care Home).*

Furthermore, a minority of respondents thought there had been a lack of support when navigating staff shortages and work demand:

*“Stress levels have never been higher. It's as if the powers above have forgotten what we have just come through!” (AHP, Northern Ireland, Hospital).*

*“Very high demand and extra clients and no support from line manager” (Social Care Worker, Northern Ireland, Community).*

As in previous phases of our study, we found indications that respondents were not satisfied with communication from managers and the management skills of their senior management and/or employers, and that these issues affected their own work as well as their service users:

*“Very poor senior management organising skills. Very poor communication from senior management on what was happening both with staff and service users through pandemic. Delayed decision making at start of pandemic lead to high levels of stress for staff and unclear messages about what was happening” (Social Worker, Northern Ireland, Community).*

*“STRESSFUL all coming from management and not the caring of looking after our residents. Management continuing to trash our work with no support giving us a really hard time. High lack of communication. Constant bombardment of negativity around our work and no respect for our service users. It was a nightmare” (Social Care Worker, Northern Ireland, Care Home).*

### **Back to normal?**

Despite the increased emphasis on services returning to normal and tackling backlogs, many respondents reported that working practices continued to be restricted and/or had permanently changed. Many appointments were still carried out online, or using ‘garden’ visits (keeping to a distance and outdoors), and some services remained closed or reduced:

*“Our ways of working and delivering patient assessment clinics have changed. Our numbers have not returned in terms of clinic capacity and the type of appointment and the number of investigations done on the day has also decreased. This is alongside an increased service demand- our waiting lists were not in a good place prior to COVID: now they are considerably worse” (Nurse, Northern Ireland, Hospital).*

*“Big changes in terms of how we work, changes to services and increased demand for services” (Midwifery, England, Community).*

*“Our work went down as simple cases were being sorted by phone by the local authority” (Social Worker, England, Community)*

*“Change in how we manage staff; home working contracts offered; telemedicine expanded - less in clinic consultations” (Midwifery, England, Other).*

It was also reported that COVID-19 related cleaning meant that some clinics had to reduce numbers to allow extra time for this. Staff expressed concerns regarding the additional time that continued cleaning or administration related to COVID-19 was taking as well as donning/doffing of Personal Protective Equipment (PPE):

*“Same number of patients in the home. Increased workload due to isolating residents and increased hygiene measures” (Social Care Worker, Northern Ireland, Care Home).*

While some respondents felt that there was a lack of support by management, there was also some indication of increasing expectations by management, causing a mismatch between resources and demands:

*“Expectations of manager unrealistic re amount of work people could manage” (Social Worker, Northern Ireland, Community).*

*“Expectation to work through sickness or our own children’s sickness because we can work from home” (Social Worker, Northern Ireland, Other).*

*“Two weeks into the first lockdown, my employer removed sick pay if a staff member was sick for over 14 days, which was the length of time people had to isolate for if in contact. I thought this was a pretty reprehensible thing to do” (Social Care Worker, Northern Ireland, Community).*

## **Q22 summary**

In summary, a very large majority of respondents reported high stress levels due to low staff numbers, high sickness absences, lack of ability to replace missing staff yet increasing work demand, and sustained concern for patients’/service users’ as well as their own health and well-being. For some it felt, *“it’s been a total mess.” (Social Care Worker, Northern Ireland, Other).*

Nevertheless, a few respondents expressed positive thoughts due to the lifting of restrictions and due to the exceptional efforts of their colleagues that enabled them to navigate the pandemic:

*“There has been no impact only improvement as restrictions are starting to lift allowing service users a little more freedom” (Social Care Worker, Northern Ireland, Care Home).*

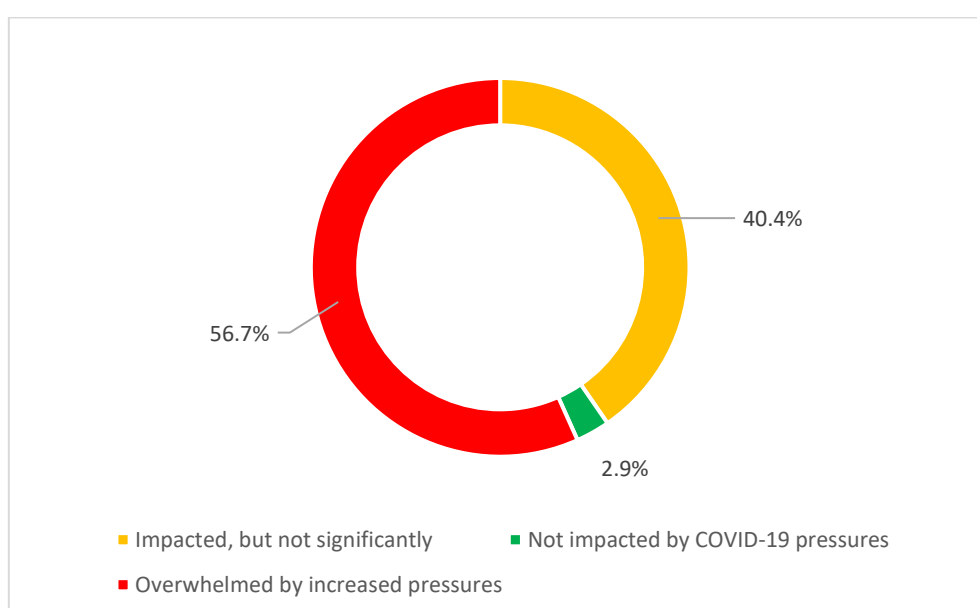
*“We are currently clear (of COVID) due to extra cleaning, limited visitors and the dedication of each staff member” (Social Care Worker, Northern Ireland, Care Home).*

*“The impact was mainly around creativity and vision in relation to ensuring safeguarding and child protection was adhered to and ensuring strong communication links were planned and established in relation to supporting the families we work with” (Social Worker, Northern Ireland, Community).*

## Responses to open-ended Q42

Out of the 1,737 survey participants, 1,078 individuals responded to the open-ended question Q42 *“How did the experience of the pandemic change the way you now manage work and non-work-related responsibilities?”* For those who answered Q42, over half of respondents reported being overwhelmed working during the pandemic (Figure 3.9).

Figure 3.9. Impact on working during the pandemic by Q42 respondents



During Phase 5 of the study, COVID-19 restrictions were reduced significantly across the UK, but as revealed in the responses to Q22, health and social care settings continued to be greatly impacted by high demand, increasing pressures, and continued infection control measures. Survey 5 included an additional qualitative question to help assess the ongoing impact of COVID-19 on the respondents' approach to managing work and non-work responsibilities. Respondents commented on number of similar themes that emerged in response to the same question in Phase 3 and 4, revealing changing attitudes to work and non-work life as the pandemic wore on. Like Phase 3 and Phase 4, the picture



emerging in Phase 5 continued to depict the difficulties in managing work-life balance, but Phase 5 also revealed that many individuals were learning how best to segment work and home life in a manner that protected their well-being, despite continued work pressures. A theme emerging more strongly in Phase 5 revealed that one of the key mechanisms that respondents adopted for managing work/ life balance was to cognitively reframe their attitudes towards work or to detach themselves from the emotional labour often associated with working in health and social care.

The following section outlines 1) how attitudes to work and non-work priorities changed, 2) the difficulties associated with attaining work life balance and the strategies adopted to manage work life boundaries in an optimal way, 3) how respondents developed other coping mechanisms to cope with increasing challenges 4) the impact of the workplace climate 5) the prevalence of career and job exit, and lastly 6) the overall impact on respondents' well-being. Several respondents also reported no change in how they managed their work and non- work responsibilities, but these responses were very much in the minority.

### **Work and non-work priorities**

Phase 3 and Phase 4 respondents discussed how they viewed their priorities of work and home and how this changed as the pandemic wore on. Similar findings emerged in Phase 5. Some respondents felt they had no choice but to reluctantly prioritise work because of the increasing service pressures with a AHP working in the community explaining: *"Can only do one at a time. My life revolves around work...unfortunately!!"* (AHP, Community, England).

However most respondents overwhelmingly depicted a psychological reorientation towards valuing home and family life more and consciously made efforts to prioritise home life. Survey responses included numerous variations of statements like *'This clarified for me that home is more important than work'* (AHP, Northern Ireland, Other) or *'I try to prioritise family life more'* (Social Worker, Northern Ireland, Hospital). Respondents reported that they felt the pandemic had changed their view of life. Some seemed to adopt a more proactive and positive stance, where they were more inclined to 'live life to the full' or 'enjoy every moment' they could (Social Care Workers, NI). There was *'no point in moaning'* and *'life was too short'* to be downhearted. On the other hand, others took a more protective stance, reporting about how they changed their attitudes to work and learned about the importance of 'switching off' and 'leaving work at work' in order to protect their well-being.

At times, respondents explained how this changing attitude impacted on their work, on the hours and emotions they invested in work, and their relationship and attitudes towards colleagues and people they worked with. Many reported now 'opting out' of overtime hours, saving their 'energy' for home life, or trying to detach themselves emotionally from work. This 'mindset' was summed up by a Social Worker from NI:

*"Since COVID has eased off and people are now re-engaging with services, the demands on our time are at an all time high. Despite this, my motivation for 'giving more of myself' and to do a good job has significantly lessened. I will work to the best of my ability until 5/6pm everyday but I will no longer go above and beyond. What's the point? Completing extra work and getting things done just leads to more work. I am not alone in this mindset." (Social Worker, Northern Ireland, Community).*

### **Learning to manage work life boundaries**

Phases 3 and 4 revealed the difficulties individuals encountered in managing the temporal, spatial, cognitive and risk boundaries between work and non-work, and described many ways in which respondents' attempted to integrate and/ or segment work and non-work responsibilities in order to achieve a better work life balance. While similar insights emerged in Phase 5, we found that for some respondents, adopting these strategies for work life balance was increasingly difficult due to increasing service pressures and demands. Many reported how work was increasingly spilling over to home life or free time. Like previous phases, this spill over was often characterised by continuing difficulties in temporal segmentation of work and home life. Many reported extended working hours, often unpaid, or increasing expectations for doing overtime. Some respondents felt compelled to work longer to help alleviate pressure on colleagues and ensure continuity of care for patients'/service users. On the other hand, some respondents reported on how they were increasingly more successful at managing temporal work life boundaries. For example, an AHP from Northern Ireland working in a GP practice reported that initially they felt compelled to work longer hours, but now the pressures had become so normalised, that they had learned to leave 'work at work' despite the continued work pressures.

Others noted the difficulties in managing cognitive boundaries and the ability to 'switch off'. This was often attributed to the overwhelming number of responsibilities at work which were difficult to forget about when at home. A hospital nurse from England described how their time off was often disturbed - '...you are always being contacted or needing to follow things up on your day off'. Whereas, on the

other hand, others reported on how they learned to 'switch off' with many citing the benefits of the commute to and from work enabling them to decompress.

Managing spatial boundaries also continued to be challenging for some, particularly those who continued to work from home, or who were now expected to work in a hybrid manner. In the context of Phases 5, many organisations including health and social care providers have experimented, tweaked or formalised their flexible working policies including policies on working from home and hybrid working. As in Phases 3 and 4, we continued to find a mixed assessment of the experiences of working from home and/ or hybrid working. Some reported feeling isolated, stressed, and emotionally exhausted working from home all the time. Difficulties in spatially separating working life from home life created problems in being able to cognitively segment work life from home life. As one social worker reported, they felt there was '*no escape*', where '*home is no longer a relaxing place and is tainted by spending so much time here doing stressful work*' (Social Worker, England, Community).

Relating to the permanency of working from home/ hybrid working policies, others bemoaned the lack of connection to colleagues, the limited opportunity to 'bounce ideas off colleagues', the poorer 'team feel', which were reported to exasperate feelings of stress and isolation. One explained how working in isolation limited opportunities to discuss matters with colleagues, and were thus less likely to gain a broader or diverse perspective on how best to handle these them. These sentiments were mostly conveyed by social workers, but some other professions also seemed to struggle with hybrid working. Nurses, midwives and AHPs also reported on their experiences of hybrid work. While it was at times beneficial to have the flexibility to do paper work or to conduct meetings at home, some reported that work often bled into home life and commented on the increasing expectations of being available, or continuing to '*work from home, even when you're sick or your child is sick*' (Nurse, Community, England).

On the other hand, many reported huge benefits to working from home/ hybrid working, and these seemed to now outweigh the negative experiences reported. However overall, responses revealed that individuals have varied preferences for the extent of hybrid working adopted. Many recognised the positive impact of the continuation of these policies had on their productivity, service quality and individual well-being. On the other hand, where respondents were expected to return fully to the office, some described their frustrations about the impact this had on newfound work-life balance,

and thus voiced intentions to find a new position where work from home was permitted. Others described frustrations with the mismatching of hybrid working policies and their individual preferences, with one reporting that they were only permitted to work in the office one day a week, which was deemed insufficient for their needs.

Lastly, an emerging theme relating to the boundaries between work and home identified in Phase 5, was the increasing frustrations many respondents had with depleted energy for home life, after expending so much of their energy in work. Thus, even if individuals managed to segment work in a temporal, spatial or cognitive manner so to focus on family life, they felt too physically and emotionally exhausted to enjoy the time they had purposively carved out with family. For example, a social worker from Northern Ireland explained:

*“Staff including myself are physically and mentally exhausted. It is challenging to do family activities as I feel exhausted after work. A good example is taking family to the cinema and 20 minutes in I was sleeping” (Social Worker, Northern Ireland, Hospital).*

A Nurse working in England also commented:

*“I give much more of myself at work and have less to give at home and to my family because I am so exhausted at the end of each day. The emotional toll has at times been overwhelming. Working from home is incredibly difficult because there is nowhere to get away from work – there is no decompression time of space/ I go straight from the desk to the kitchen to cook for the family and other family related chores. The joy of family life has all but gone at the moment” (Nurse, hospital, England).*

## **Coping**

In order to cope with the challenges of managing work and non-work responsibilities, and ensuring work life balance, respondents reported a number of coping mechanisms. As in Phase 3 and 4, some respondents commented on their continued focus on self-care routines that help to balance work and life commitments. Prioritising time for social connections, exercise, reading, walking, work breaks, family events and outings were some of the personal activities mentioned. Many recognised the importance of ‘self-care’ and why it should be prioritised especially when working in very demanding services. However it was also noted that the continued uncertainty associated with COVID-19 and

service pressures made planning and managing work life boundaries difficult. A Social Care Worker explained how such uncertainty filtered through to both home and professional lives:

*“It has changed the world we live in. I feel its difficult to plan both personally and on a professional levels as Covid still seems to scupper plans all the time, whether its staff levels, or a holiday – its never ending” (Social Care worker, Northern Ireland, Community).*

Whereas another AHP explained how they limited their personal lives for fear of catching COVID-19 and having to be absent from work:

*“I feel I am less able to manage my responsibilities than I was before. I worry more now and stress about the future and how covid might potentially impacts some of the things I do. Or plan to do. I sometimes avoid going to social events in case I catch covid, not because I worry about being sick, but because I worry about the impact my absence at work would have on my colleagues and the service I provide” (AHP, Northern Ireland, Hospital).*

Others described how they had learned to be more resilient, efficient or adaptable in work, or more realistic about what they could achieve in work. Many acknowledged and recognised their contribution to their community, their profession and patients’/service users, and were proud of the impact they made during the pandemic. One Social care worker from Northern Ireland explained they were *‘humbled to be able to provide supports, company, safety and compassions during the pandemic’* (Social Care Worker, Northern Ireland, Other settings).

However, whereas some seemed to take comfort in the contribution they had made or were making to the health or social care sector and to their patients/service users, others seemed to cope by detaching themselves from the difficulties they experienced while working in pressurised services. Many suggested they *‘try not to get emotionally involved’* (Social Care Worker, Northern Ireland, Community). A Nurse stated:

*“I do what I can and I don’t feel guilty if I can’t get things completed” (Nurse, Northern Ireland Community).*

Another suggested that the problems with health and social care services were simply outside their control, that they *‘cannot fix the health service’* and thus could only do their *‘bit each day’* (Nurse

Northern Ireland, Hospital). The emotional burden on health and social care sector staff was evident across all Phases, but in Phase 5, more respondents articulated their detachment from work, *'loss of passion for their work'* (Social Worker, Northern Ireland, Care Home). As a means to cope with burnout, this corroborates survey data outlining increasing levels of burnout across the workforce:

*"Feel like I have to be more cut throat and almost have to care less at work to get through it. If I think about the experience of patients, in pain/ delays due to covid, it's horrible. If I thought about it every days, I'd be miserable"* (AHP, England, Hospital).

## **Workplace climate**

The increasing pressures at work combined with the difficulties of achieving work life balance led to a great deal of dissatisfaction with the current workplace climate for many. Whereas in Phases 3 and 4 respondents often commented on the efforts of managers and colleagues to support each other, such descriptions of the work environment were not as prevalent in Phase 5. Instead, some respondents highlighted concerns about chaotic and unsupportive working environments, bullying, and hostility. A community AHP commented:

*"My team is great and so supportive but there is a lot more hostility in the system (less communication, compassion and understanding between services which used to work well together)"* (AHP, Northern Ireland, Community)

One community Social Worker in Northern Ireland appreciated the opportunity to continue working from home so to avoid 'chaotic environment prevalent in the office'. Respondents also raised concerns relating to the climate of psychological safety in the workplace. A Midwife from England highlighted concerns about employee voice stating:

*"I've realised that people are afraid to voice their concerns and opinions and therefore are more reluctant to ask for help or be more open and honest. We need to make efforts to cultivate a true non-judgemental space that supports everyone"* (Midwifery, Hospital, England).

Many respondents also reported how they felt undervalued, unrecognised, 'just a number' and unsupported by line managers. Others bemoaned the poor pay and the overreliance on the 'good will' of health and social care workers. Respondents often drew on these feelings to justify why they were unprepared to prioritise work over home and non-work responsibilities and why many are unwilling

to tolerate these conditions any longer, often citing an intention to leave their employer or their professional altogether.

### **Intention to leave**

Increasing pressures, coupled with feelings of being undervalued and unappreciated, precipitated many respondents' resignations, decisions to retire, reduce hours, or exit their profession. Dissatisfaction with working hours, unpaid work, being under-resourced and dissatisfaction with hybrid working policies contributed to these decisions. Many reported the significant benefits of this decision on their work life balance and overall well-being, often citing better flexibility and a reduction in workload pressure associated with their new positions. For example, a Social Care worker from Northern Ireland explained changing from a fixed hourly contract with a care home to an agency to get a 'better work life balance'. A Nurse from Northern Ireland, reflecting on their decision to move to a different position with less hours whilst topping up income with agency work as a district nurse, explained:

*"I have more time to enjoy life, be with the family and dogs, go outside, camp etc. .... I love my job, but I love my life more!" (Nurse, Northern Ireland, Community).*

An overall trend of resignations however added additional pressures to remaining staff. Not only in terms of staff shortages in the context of increasing demands, but some respondents also reported the anxiety they experience because of this continually unfolding situation, exacerbating pressures, with little sign of relief. A Social Worker explained:

*"I have been a social worker for a considerable period of time, however the lack of resources has been highlighted particularly during Covid. The situation is critical now. Staff are emotionally saturated and many are at breaking point. Several nurses on the ward are leaving their profession and to be honest, most of the social workers I know are desperate to leave their profession also" (Social Worker, England, Hospital).*

### **Well-being**

The responses to Q42 on work and non-work responsibilities emphasized qualitatively the clear relationship between the respondent's perception of work life balance and overall well-being

outcomes. Where individuals felt that their ‘work’ was encroaching on their ‘life’, they often described the impact this had on their overall well-being:

*“I am anxious about my mental well-being because the sector I work in is collapsing and not meeting the needs of people with complex mental health needs, I am anxious about people in general not having effective (mental) health services in the country any more” (Nurse, Community, England).*

*“I find the back log from the pandemic and burnout among professionals makes work more difficult. I do not have the energy to pursue leisure activities. I often feel vacant at home due to exhaustion” (Social Workers, Northern Ireland, Hospital).*

As reported in Phases 3 and 4, the picture emerging from the responses is bleak for many respondents, and despite efforts to manage, they are reconsidering their futures within their profession or with their employer so they can prioritise their own health and well-being. However an encouraging development in Phase 5 is that many individuals seem to be learning to adopt coping mechanisms that help to segment and/or integrate work and home lives optimally to protect or enhance their well-being. On the other hand, a related concern for health and social care providers is that their staff are therefore increasingly reluctant to tolerate the encroachment of work into non-work lives and have depleting levels of ‘good will’ to go above and beyond, creating additional pressures on services that are already in high demand and under resourced.

### **3.2.2. Focus group discussions**

Three focus groups were conducted with Human Resource (HR) professionals, managers and frontline workers in June and July 2022. A total of 17 participants provided deeper insights into work in the health and social care sector between March 2022 and June/July 2022 discussing the main impact that the pandemic has had on job satisfaction, working conditions, control at work and home-life balance. Participants also answered questions which focused on their own experiences working during the pandemic, on how this changed from the first wave of the COVID-19 pandemic in March 2020 to July 2022, their use of coping strategies, work-related quality of life, employer support and what they recommend needs to be changed.



## Frontline workers focus group discussion

The subjects emerging from the frontline workers focus group in Phase 5 can be summarised under the following themes: remaining pressures, changing public perceptions, connections, lack of motivation and supports.

### Remaining pressures

A recurring theme discussed within the frontline workers focus group was remaining pressures. While restrictions were easing and vaccination programmes had been rolled out, frontline workers were still finding that the pressure within their sector was on an upward trend with no end in sight. Respondents discussed seeing a lot of COVID-19 fatigue among staff due to the pressures that the pandemic had placed on their working conditions. It was highlighted that the health and social care sector had been under pressure even before the pandemic but as we enter this pandemic phase, work pressures are having a detrimental impact on staff evidenced in the quantitative data within this study. Staffing remains a major contributing factor to the increased pressures on most staff, with many frontline workers still having to work extra shifts on top of their already large caseloads/workloads.

*"I think the persistent sickness that keeps going on, that means that ... they are fully staffed except for the sickness. So the repeated cycle of people getting COVID puts those pressures on" (Midwife, England, Hospital).*

*"...the things are getting dramatically worse over the last few weeks. People are leaving their jobs, people are retiring. There is levels of sickness, of course, but I think that the senior people leaving or new people coming in and faced with such huge pressures and... no, I'm gone. Literally after two weeks, just going. And there is dramatic understaffing at the moment where I work...So it's got to that point, there's literally no staff" (Nurse, NI, Other)*

Another frontline worker highlighted that pre-pandemic issues were now exacerbated to a level that was becoming out of control and felt popular press and media did not represent the issues well, resulting in staff feeling responsibility for a 'failing NHS':

*"...the quantity of pressure has increased. We all know pressure on our health service has been increasing exponentially year on year. But we didn't have any level of release valve for most of that during Covid. So yes, we weren't able to do as much as we wanted to, pre-Covid, but we were at least doing some elective surgery, getting some appointments. But during Covid we couldn't really do any of that. So we've just had a build-up....the systems and things needing to be done better and done differently. Whereas that's not what the Daily Mail splashes across the front page. What*

*they say is, the NHS is failing. Waiting lists are out of control. Without giving... even if maybe the rest of the article does give some nuance, but it feels like an attack on the individuals in the NHS ... overall the issues here are systemic problems that were building up pre-Covid. We've got waiting lists that were getting out of control, and now they're completely out of control.....Because the pressure that was building on it, had no release valve at all, basically (AHP, England, Hospital/Other).*

One respondent indicated that the system was broken not just for services but for staff with many other respondents echoing this sentiment:

*"Even as an insider, understanding those pressures, it doesn't help me to not be angry. Can you please just manage it a bit better? Can you just pay the staff a bit more? Can you appreciate them? Can you change the system? And I know it's not easy. But still you've got those feelings of... I've got those feelings of a bit of resentment to the management and leadership of how things were done. That they let the situation deteriorate so much before Covid and now everything is literally falling apart and people dying on the streets because they can't get the ambulance. I do have quite a bit of anger towards the management about it" (Nurse, Northern Ireland, Other).*

### **Change in public perceptions**

Another theme evident was a change in public perceptions. This theme was discussed by frontline workers in terms of the public's changing perceptions of the health and social care service alongside their changing perceptions of COVID-19 guidance and seriousness of the situation. Respondents discussed feeling how the public is becoming more critical with the handling of the COVID-19 pandemic within the healthcare system and how these services are not just returning to normal quickly. Additionally, some mentioned that not everyone believes COVID-19 to be a serious issue at the moment, with fewer people wearing masks which is also making some health and social care workers feel uncomfortable:

*"...when I talk to the public and you say to them, oh you know it's increasing again, they've got no consciousness of it anymore. And I'm a vaccinator and I feel very, very uncomfortable in that environment. They are not enforcing mask wearing. And we've got some very vulnerable people coming forward for their fifth vaccine. People undertaking chemotherapy. Some people who are actually terminally ill and all sorts of things. So for me there's some slightly mixed messages going on, really" (Midwife, England, Hospital).*

*"I think part of the issue here was that, as you say, during Covid, people kind of understood, we are not going to get seen for that screening or this or that. But because people have gone, oh, Covid is*

*gone... .. that's a public perception... then they immediately jump to, well I expect my health service to be like it was pre-Covid. And it just can't" (AHP, England, Hospital/Other).*

*"I don't know if it is a lot to do with the Executive and Stormont [government] and just feeling like the health service is being totally mistreated and underfunded. I just feel like the public have forgotten everything that we sacrificed. We sacrificed our lives, our personal lives. We sacrificed a lot. We didn't see family. And I know that the nation didn't, but it just felt like we gave up so much and for people, when you see online and in the media, criticising failures in the health service and long waiting lists, it feels like a real kick in the teeth, after everything that you've done" (Social Worker, Northern Ireland, Community).*

Interesting it was not just the general public's changing perceptions of COVID-19 guidance, some of those working within the health and social care sector now want return to normal living and have removed their masks in settings:

*"I was one of those people that was religious about cleaning, mask wearing, very safe. When I could I got all the vaccinations and everything. But last few months I was like, everything completely gone. I don't wear mask anywhere" (Nurse, Northern Ireland, Other).*

## **Connection**

The recurring theme of connections was evident across the phases but was further emphasised within the frontline workers focus group in this fifth phase. Respondents discussed that while restrictions had eased across the majority of the UK some guidelines were still in place within the health care and social care sector that required a continuation of limited face-to-face contact with patients/service users and colleagues. This lack of contact was thought to be threatening the mental health of Social Care workers:

*"...it became clear that people were starting to destabilise by stepping back from face-to-face contact" (Social Worker, NI, Community).*

One frontline worker felt these connections were becoming even more important as we moved into a new part of the pandemic, feeling that there had been so much trauma as a result of the lack of face-to-face contact and that it has impacted so many parts of people's lives:

*"So for me now it's just anything to get those people human contact. And yes it's about safety, but it's also about quality of life and about relationships. And we lost so much of it. I've seen too much.*

*Too much trauma with people who are dying alone that I absolutely don't want to see return of any sort of restrictions, even in future pandemics. We need to make it safe for people to still continue to see each other" (Nurse, Northern Ireland, Other).*

Several respondents discussed connections within their workplace, noting that it was important during these last few months to talk with colleagues who have experienced the pandemic in a similar way to them. Respondents found that this helped them when stressed or improved team morale in the workplace.

*"...having people that you can talk to who hold very similar views to you that, when you are stressing out about something" (AHP, England, Hospital/Other).*

*"...in terms of the positives, the camaraderie in our team since Covid, it did bring us closer together" (Social Worker, Northern Ireland, Community).*

### **Lack of motivation**

Respondents recalled that at the beginning of the COVID-19 pandemic in March 2020, they had found themselves helping out more in work when possible and getting outside for a break or when allowed. However, those taking part in the focus group in Phase 5 acknowledged that as the pandemic went on, by June 2022 people were now struggling for motivation. At the start they were trying to help as they could within the health and social care sector, but, as time went on and workloads increased or more hours were worked, respondents indicated that it just felt like they were drowning in work and by the time they got home they found themselves wanting to be anti-social. As the restrictions were lifting across the UK, several frontline workers felt they had lost motivation once they stopped work and found they would rather spend the evening alone as they had become so attached to their work that it was beginning to impact their personal lives:

*"...even in the evening, I am constantly thinking about work. And I know that I should be utilising my own coping strategies that I give out all the time, but I am just constantly thinking about work and wanting to be in work and doing work so in the evenings I find that it's a bit of a struggle to get through the night until I'm in work the next day. I have really struggled during Covid. I've found it so hard to be motivated" (Social Work, Northern Ireland, Community).*

*"I could do more things, I'm actually doing considerably less" (AHP, England, Hospital/Other).*

## Supports

In terms of support, respondents discussed the reluctance of staff to access supports but also noted that such support has not been readily available to many people who have been affected by the trauma of the pandemic. It was evident that in some workplaces people had begun to move on, while others were still struggling to deal with what had happened over the last few months and that supports were not always in place to assist.

Interestingly, respondents observed that staff were not always keen to come forward for support and felt that certain supports would be more approachable particularly if they were offering face-to-face assistance:

*“People are very reluctant contacting those counselling services, or looking at the well-being website, because it feels impersonal ... because for people it’s difficult to take those steps because it’s into something unknown. It feels like it’s a very big deal to ask for help. But whenever it’s with the environment, with the people that you know, this is much more approachable” (Nurse, Northern Ireland, Other).*

In terms of the support needed respondents highlighted that in the past few months several workers seemed to be facing long-lasting trauma as a result of burnout, exhaustion and personal experiences during this period.

*“...three members of my family died from Covid before the vaccine rollout. So I’ve found it really difficult to see everybody move on. I find it really hard that there was the debate about vaccines, that there was the refusal to wear masks, and now people are moving on like it never happened.” (Social Work, Northern Ireland, Community).*

There were some discussions about the need for recognition of suitable supports for the thousands of workers who have been affected in different ways through the pandemic. So therefore, it is important to understand the differences and ways of working across each sector and to offer a range of assistance. At one level several staff have experienced deaths within their workplaces from COVID-19 and this, or its possibility, has highlighted possible needs for counselling and psychological support. From the experience of those taking part in the group even this was lacking in several workplaces:

*“I think that a lot of healthcare professionals will have been affected, maybe mildly, but it may have a long-term effect on them. Maybe they didn’t lose any colleagues, but maybe just that fear,*

*that every day fear and stress, all the changes, maybe that's enough" (Nurse, Northern Ireland, Other).*

*"Grief counselling for staff needs to be in there. Again something that we should have, but did not consider before that first interview was, when you ask NHS staff to tell me about your experience, or your colleagues' experience of Covid, that occasionally they say, well we had colleagues who died. And that somehow gets forgotten. Psychological support for NHS staff. It's not just the patients, it's also people they worked alongside, who got exposed in the same way they were exposed" (AHP, England, Hospital/Other).*

The different type of supports needed within the workplace were discussed, with respondents feeling that there is insufficient of understanding within health and social care organisations of what support services are most effective. Several noted that it might be too late now to supply such support, but others argued that it is important to make such supports more readily available and that peer interaction could be key:

*"There seems to be a lack of understanding of what really can make a difference, as well as actually people who do need real, more intensive support. But people are not necessarily going to ring a helpline, are they?" (Midwife, England, Hospital).*

*"I don't know if it's almost too late now but those staff, particularly who were really, really at that front line of seeing that and seeing colleagues and whatever... they needed something up and above, perhaps, what was normal. And even to the point where you could argue they maybe needed to be orientated out and get a balance in their view of care. But they definitely needed something, and I don't know if that actually happened or whether those nurses... and the other healthcare professionals of course... really got what they needed. And of course, it could come back later. That's the whole thing about post-traumatic stress disorder, isn't it, about how it can come back later on" (Midwife, England, Hospital).*

*"I think there is something about the making the available resources really obvious to everyone. And whether that is having a room... like wobble rooms they had where the whole point was, you could go and talk to peers or there were people to help. Like the airlines ran them. But people have to be aware they are there" (AHP, England, Hospital/Other).*

## **Managers' focus group discussion**

The subjects emerging from the managers focus group in Phase 5 can be summarised under the following themes: working conditions, changing connections, changing productivity, increasing staff

frustrations, need for suitable services, burnout and exhaustion, struggling to service and decreased partnerships and co-production.

### **Working conditions**

Since March 2022, the managers noted that many workplaces had adopted a hybrid style of working. They noted that while employers were encouraging staff back into the workplace if staff felt uncomfortable then in certain circumstances they could work at home with no pressure and that staff were generally adapting to working conditions under this 'new normal':

*"...giving staff the flexibility to work remotely and the office and encouraging having face-to-face supervision in the office. If staff feel uncomfortable then fine, there's no pressure on that fence so far ... and also it we just take into consideration and on personal circumstances....it's yeah it's slowly, slowly coming back to the new norm if it's such a thing, but yeah" (Social Care Manager, Wales, Community).*

*"I think we're still we're still struggling to work it out ... like what this normal now is, you know what this hybrid is, you know it's sort of you know emm yeah particularly office culture it's like it's, it's sort of back, but not back....I think, but the actual office I work in it's really weird you know you go in you're not sure who's going to be in and is anybody going to be in and most people don't want to come in and, and then there's tensions" (Social work manager, Northern Ireland, Community).*

One manager noted that working conditions had generally become more flexible with risk assessments in place allowing better practices to suit their service users.

*"it's very much a case of on a case-by-case basis, because it's one of the new opportunities that COVID presented is different ways of working so once you get to know the family, once you get to see their home, you can see the conditions. Emm, the, you can then work with the family, get to know them, you know, for example, if you can referral informality this way to go home conditions are going to look. As long as there is risk assessment and then the things that okay you carry it into the piece of work to suit the needs of the family so it's a bit more flexible" (Social Care Manager, Wales, Community).*

Indeed, some managers thought there may be a need for further increased flexibility as some staff were finding it more difficult to travel to work due to the increased cost of living across the UK:

*“...we've changed in the last week, as a result of feedback from our staff is we've reduced the office work into two days and homeworking to three if staff wish to they can still come in for 3-4-5 if they want to and that's a direct response to the financial situation so that includes the cost of living rises raises for utilities and for few well but we are expecting to see that change again in the autumn, when staff won't be able to afford to heat their houses and will be coming into the office. So, we're trying to be as flexible as we can and, and listen to what they're, they're asking for” (Health and Social Care Manager, Wales, Other)*

These constant changes to working conditions, for some, were affecting home and work-life balance while reducing staff abilities to cope:

*“Now we've got back into this this so called new way of working, we stopped doing those walks (for a break) so we're going to try and get that back, and it is that's the big thing for me was right, having a clear definition between work and home life so whether that's getting changed, having a shower and then going for a walk or whatever, getting back to that if we are going to have a blended work day” (Social Care Manager, Wales, Community).*

*“I'm thinking people are not switching off and I, I'm worried that are we not going to be able to get back to a more separate life” (Social Work Manager, Wales, Other).*

## **Changing connections**

Since the pandemic, some employees have had less face-to-face interaction with co-workers and patients/service users and this was continuing still in July 2022. Managers discussed that while online interaction is suitable at times, they too miss the face-to-face interaction with one manager noting that some conversations in the workplace have become more difficult when online, while face-to-face personal conversations help build trust and help make decisions easier:

*“You know, but like difficult conversations are impossible on this medium, you know and I've done annual reviews for foster carers on this and I hate it. You know, and you build connection with people, because those are the things that can sustain you and things get really tough, you know, and you know builds their trust in you as well, when you've got maybe when you have got difficult decisions to make” (Social work manager, NI, Community).*

Another manager working in a hospital setting noted that staff are still dealing with trauma due to this lack of contact with patients as well as with colleagues, while also worrying about the impact of the isolation on patients:



*"I would say the trauma of what we have experienced in hospital settings has been a big thing, lack of contact with families and observing the impact on them has a lasting impact on many of us and is still ongoing at present" (Clinical Lead, AHP, NI, Hospital).*

It was noted that while hybrid working is beneficial, that the ability to discuss things with colleagues and have social interaction has suffered greatly. Managers also reported needing to rebuild relationships and communication pathways with colleagues, reconnection was discussed by all managers as important for improving working conditions, relationships and social well-being.

*"...what I found the last few weeks I have been gone into the office a little bit more and what I've found is when I go into the office, the colleagues that there I spent a lot of time, so with colleagues rebuilding those relationships and you know building up the communication (Social Work Manager, Wales, Other).*

*"I think it's some building the relationships back between the teams, because there have been so many changes within teams as well, people leave in people join them, you know that I really feel that those relationships have been affected a bit. Emm yeah, so you know sort of like some of that some of the cases there's a bit of discord" (Social Work Manager, Wales, Other).*

*"...some of those meetings don't actually provide, they don't provide the social connection that you need to do the work and that you know, and I mean if you're doing, if you're doing human based work, you need you the whole approach stuff you know the kind of the organization has to narrow the work, you know, you have that has to, you can't be going out and nurturing people if you're not being nurtured" (Social work manager, Northern Ireland, Community).*

One positive point in the discussion about connections during this focus group was that online meetings allowed more people to be present in meetings and created connections with those in higher positions to influence change, when, in normal times, those in the frontline would not generally have attended such in person meetings:

*"I mean one like working with health and social care trusts here and we've got people around these kinds of meetings you would never got around these meetings and at the speed that was actually really useful" (Social work manager, Northern Ireland, Community).*

## **Changing productivity**

There were different perspectives between the managers in terms of productivity since those working in hospitals or care homes did not generally have the flexibility of working from home while those

managing most Social Work services and some Social Care workers noted that productivity varied from when they were in the office/service or at home. One respondent said that they preferred working in the office for its increased productivity but suggested that productivity is not always easy to measure:

*"...you wonder how effective you are then as when you're home when you're pounding away on the keyboard and doing all the emails but then a different way that you're working and you're trying to do something different when you're in the office" (Social Work Manager, Wales, Other).*

Another respondent discussed the importance of getting the balance in productivity right as they found they were more productive at home and also busier because they could take on more meetings, while office working enabled them to be more productive when dealing with colleagues:

*"I go in twice a week and emm, I don't find myself as productive because, from the perspective getting pieces work done and I think right I've got to take a zoom call meeting now whatever teams meeting, so I gotta go find a room to do that, I have to rework my diary to do that, that. I think for me I've just literally in the last couple weeks recognize actually if I don't spend as much time being as productive as I was and busy as it was on teams, or whatever I'm spending time with some of the staff in the office, and we have something called a laugh, remember a laugh in the office a while back and you can have a laugh and bit of office chat and right whose turn is it to make a cup of tea and it's quite nice yeah so it's, it's getting back to it but yeah I'm finding when, as I could cope with five or six meetings, a day on MS team you can't really do that in the office, trying to find a balance" (Social Care manager, Wales, Community).*

### **Increasing staff frustrations**

While staff frustrations have been noted in previous phases, these now seem to have reached near 'boiling point', particularly for some within the hospital setting. Some services have remained unchanged or did not stop during the pandemic and, while public restrictions ended, not all restrictions have ended for health and social care staff particularly those in Northern Ireland (at the time of the discussion group) but with increasing staff shortages staff were more in demand and under pressure:

*"...there have been no changes, our service hasn't stopped since the pandemic began and I think that's exacerbated by the fact that, with major stuff on shortages within the service and COVID just has made that so much harder. I do feel that there's frustration with staff that the public area is opening up again, but the health care on where they work is still very, very much restricted and, and we understand that, but there is huge frustrations and, as always, the additional PPE, they*

*understand them and, and they, they are coping with it but it just hinders their working and makes it much more difficult when they're short staffed so from a midwifery perspective it is probably worse than it has ever been" (Midwifery Manager, Northern Ireland, Hospital)*

*"...it's very frustrating for staff and then now again we're hit by another wave and staff are off again and it's just it's an impact on all the time, the only thing that really has changed is initially at the beginning was the visiting, but it was only one parent at a time, but now we're allowing two parents in together, but anything else, nothing has changed that I mean we are woefully impacted because ... we were impacted in terms of staffing, and numbers of staff or we didn't have any and then other people and everybody else, including myself doing, over and above extra hours, trying to get the service to continue to run, but our cot numbers were reduced because we didn't have enough staff and again that is happening this time round with staff going off are cot numbers are down again so that hasn't really changed" (Nurse/Service Manager, NI, Hospital).*

### **Need for suitable services and support for coping**

The managers considered that employee well-being support needed addressing with more psychological services and individual approaches. There was some impression that current approaches felt like they were just there to be a service and tick a necessary box but that staff were not availing of these services as the approaches were not suitable or they were under pressure and didn't have the time to take them up:

*"....we don't have any psychology services in neonatal unit or for staff or parents, and this has been a long standing thing, ....we don't have it and we're trying to build the case with the commissioners to say that we really need this, not just for parents, but for staff, cause staff are burnt out exhausted and then, when everybody was in initial lockdowns, .... in your own bubble not been able to go anywhere, meet with friends, you know stuff like that, like social nights out so it's been hard for everybody and it is still quite stressful, I have to say, for us, and because of were like because we're hospital based the biggest thing for us has to be that there's no psychology, I know for staff that were off with COVID, and some family members died through COVID, they got help through occupational health but it's still limited to what they could provide actually on the floor for staff working in the environment there was nothing and that's our biggest downfall" (Nurse/Service Manager, Northern Ireland, Hospital).*

*"As a manager..... personally, the thing that impacted me the most negatively was my inability to reach out to the health and well-being ... support and resources that I would normally so we, we increased the health and well-being support and catch up, confidential listening ears ... and things like that, so we increased that as an organization to try and compensate but for me personally, .... the virtual stuff was like sticking a plaster on an open wound it, it didn't, I wouldn't say didn't really help it must have taken the edge off, but I think that, for me, that was the that that was the biggest impact" (Health and Social Care Manager, Wales, Other)*

*“...individualized bespoke plans, what I mean by that is rather than policy blanket approach, consistency and all, all that we're concentrating more on the individual circumstances and how to support them and make any adjustments that they need, so far we've always had an individual, individualized approach, but now it's even more, more so than it was before” (Health and Social Care Manager, Wales, Other)*

*“...within our trust they did put up psychology help desk for all staff. But I find that staff who were struggling weren't availing of that, you know you were nearly having to say two and three and four times to actually you know go ahead and and ring the number or ring the (help) line, but you were actually nearly, nearly forcing them to sit down at the phone line that they needed the help and it's there take it. So I spent half my time begging staff to ring the help lines, you know that in itself was actually mentally drained and because I, myself was worried about the staff and the team. You know so, so on one hand, the services were there and staff weren't availing of them” (Midwife Manager, Northern Ireland, Hospital)*

Additionally, the communication pathways decreased over time and managers felt less supported as the pandemic continued which affected their own working conditions:

*“...the other thing from my perspective, as a manager is the communication so originally the communication from senior management was very frequent and it was very informative and you know and the longer we gone on the less that communication has happened” (Social Care Manager, Wales, Other)*

## **Burnout and exhaustion**

Similar to the previous phases, managers indicated that some employees and managers across the health and social care workforce seemed burnt out, or physically and mentally exhausted. While it would be assumed that with easing restrictions and return to work initiatives in place then this would get better, many staff were still described as being under severe pressure with increasingly high work demands that seem never ending, causing this exhaustion. Some managers considered that the work atmosphere is becoming more difficult:

*“It just struck in the last few weeks, but just have flat everybody is. I think we had a lot of privileges and the voluntary sector at the start and actually quality of life was not too bad at the beginning of the pandemic ....we've also gone into this point when you should be recovering and you go back to all the old worries you had before, which were, where's the money going to come from you know, are we going to be supported, you know it hasn't it, hasn't produced more partnership with*

*the statutory side and they're actually they're coping by retreating" (Social Work Manager, Northern Ireland, Community)*

*"...there is a baseline of everybody's flagged out, you know and actually kind of an all these kind of work have different levels of emotional commitment in them and, and the need to be psychologically present and, and that's, that's really tough" (Social work manager, Northern Ireland, Community).*

### **Struggling to survive**

As of March 2022, due to circumstances including Brexit and more recently COVID-19, managers noted that one recommendation they could make was to improve staff wages. Managers acknowledged how hard staff had worked during the pandemic with little or no break but now they are struggling to survive with the threats of increased taxes and increasing cost of living now becoming problematic:

*"Pay people more. You know I mean I just think, and I mean, I think you know I mean you know so very well you know we stood up and clapped people you know, but you know you've got nurses going to food banks and it's become cliché but it's true, and you know and I've got, I've got colleagues who do early years work who can't make ends meet. You know yet they're working with families who also can't make ends meet that's, that's fundamentally wrong, you know and everything else is just cosmetic" (Social Work Manager, NI, Community)*

*"...in terms of pay more, particularly when you get your staff as social care staff now who are suffering in the same challenges that some of the other families working without using a square into a circle" (Social Care Manager, Wales, Community).*

### **Decreased partnerships and co-production**

In previous years, pre-pandemic, there had been an increase in co-design and co-production approaches within the health and social care sector to improve services for the benefit of patients/service users. However, managers noted that from March 2022 they had noticed a decline in co-production due to the lack of connection with and conversations taking place with patients/service users which could prove to be detrimental to future services:

*"The other thing I've been very involved with co-production with service users over the last four years, and that has definitely taken a step back. And that's a very, very bad sign, you know, because that means we will have things that aren't patient and service user informed, led you know, and it will be that you can have any service you'd like as long as it's this one, you know" (Social Work Manager, Northern Ireland, Community).*

## HR focus group discussion

Focus groups with HR professionals have been held since Phase 4 of the study. Although the focus of this study was on the well-being and coping of Nurses, Midwives, AHPs, Social Care Workers and Social Workers, findings from the previous phases increasingly highlighted the important role that HR personnel play in supporting staff working in health and social care and dealing with many of the challenges associated with the retention and recruitment of staff. Therefore, a focus group with HR professionals was held to help the research team better understand how and why employers responded as they did during COVID-19.

Six overarching themes were identified: Recognition of different experiences of staff across health and social care, staffing levels - recruitment and retention, lack of recognition for work undertaken by HR, coping strategies of staff, changes in ways of working and supporting the health and well-being of staff. We have added three further recommendations relating to pay, hybrid working and recovery from COVID-19 experiences.

### Recognition of different experiences of staff across Health and Social Care

There was growing recognition that, depending on their role and circumstances, staff have had different experiences of work during COVID-19; ranging from those on furlough, those working at home and those working extra hours to cover patient/service user care while exposed to the risk of catching COVID-19 and bringing it home to their families:

*"So there's a huge difference between providing social support during the day to you know lifesaving care, maybe not lifesaving but you know life enabling care 24 hours a day, so there's a huge, huge disparity between those two things, I think that has may be caused a bit of backlash or resentment but there's definitely, I'm noticing a difference between the type of staff we, we have one level everyone's a support worker that are paid the same role treated the same but I'm starting to notice that they are perhaps doing very different jobs and it's becoming quite apparent that they are noticing that as well" (HR, Scotland, Community).*

Employers have worked to improve their communication to and support for staff who having seen others work more flexible work patterns, and/or home working and want that these options too:

*"...and so it's making sure that the messaging that we do, company wide that you are taking into account that people do different jobs and again that's okay you're doing their job because that's*

*the job that you either want to do or you're stuck in however if you look at it and if you'd like to do something different than we can support you and what we can't do is change the fundamentals of your job, like there is only so much we can't do like you can't have customers in your house, so you can't work from home" (HR, Scotland, Community).*

### **Staffing levels- recruitment and retention**

There was discussion around increasing staff shortages, caused by staff sickness and also staff choosing to leave, as increasing challenges in replacing and backfilling staff leading to greater pressure on remaining staff. Recruiting new staff was difficult with potential recruits taking the opportunity to move jobs or work in other sectors:

*"I think for us it's got worse over the last couple of months we've found the last couple of years were definitely easier. We are struggling more now to cover the care that needs to be covered, because of sickness absence, or because of the number of people that have left and moved on from the industry into other roles" (HR, Scotland, Community).*

*"I think we are struggling staff wise and there's a lot of people leaving and the recruitment markets really difficult, it's really buoyant, people are looking for different things and have different expectations, so I think there's quite a lot of things coming together at the same time for kind of HR to deal with on the back of coming out of COVID" (HR, Scotland, Community).*

Concerns were expressed around the challenges of recruiting staff including newly qualified staff to work for the statutory services with many choosing the flexibility of agency working. It was considered that further work was needed at regional and national level to incentivise staff, including a competitive rate of pay for staff.

*"So it a terrible job being in HR for any HR manager, but I think it needs to be looked at, you know the Department of Health need to look at what they're giving the trust and funding, more funding for social work, AHPs, and nurses more pay and you know incentives to get people out there and qualified and brought in because what we're finding too, we have qualified nurses, but rather than take the trust terms and conditions they will go agency, because less stressful and it works around their work life balance so its monetary too" (HR, Northern Ireland, Hospital).*

Those taking part in the discussion reported many HR teams are putting a lot of thought into how best they can recruit staff with values based approaches being considered as a way to attract millennials into health and social care role while recognising that people need to work to pay their bills.

*“...the millennials coming through a more interested in the values-based recruitment and said how would you put that into your strategy when sometimes their hands is forced if they can't afford the fuel or the minimum wage” (HR, Scotland, Community).*

A way to reward staff who have been working for some time in an organisation was also considered important to set up:

*“So were are trying to reward that length of service and that experience to see you'd actually I know a senior support worker, because you have done more it's still not like you know amazing wage but it's going to be more than the person who's been there 10 minutes...” (HR, Scotland, Community).*

### **Lack of recognition for work undertaken by HR**

The diversity of roles and increased volume of work undertaken by HR professionals was discussed with many administrative staff being furloughed in some services, leaving those still working to take on these roles with an increase in demand for data and often being a listening ear for frontline staff, while dealing with the challenges of their own situation at home situations:

*“I think it's quite difficult because the front line like trump's the support system so you're kind of you're sitting there thinking actually this has been really difficult for me”. (HR, Scotland, Community)*

An increase in workload has led to some HR staff exploring different ways of working to cope with demand for their own services:

*“we're having to look at different ways of working and looking for solutions that we would be hadn't thought of before then, to try and cope with the demands of the work that we've got just now” (HR, Scotland, Community).*

### **Coping Strategies**

A range of coping strategies were discussed. One member had that putting a positive spin on things was a helpful way to help herself and others to cope until feedback from colleagues helped her to understand that 'toxic positivity' was not always helpful.

*“I found myself actively trying to prove that I was okay and everything's okay, because it could be worse, it could always be worse, it could be nuclear war. And people, people told me these last few*



*months, you know that wasn't really helpful and actually make you feel worse” (HR, Scotland, Community).*

A shift in perception of staff about well-being initiatives offered by employers was discussed with a demand for more tangible support such as help with workload, more autonomy and better pay, rather than solely well-being and resilience type support.

*“...we're getting a bit of pushback on well-being initiatives from the organization, people are like you know I'm knackered and I'm stressed and I'm overworked and, and, and you're going, going to cut and stop giving me well-being seminars, I do not want to attend any more lunch learns about my own work life balance that's not what you need to do for me, what you need to do for me is manage my work load and give me more control of my day to day tasks and you need to review pay and or whatever...” (HR, Scotland, Community).*

In contrast, some members reported sickness absence levels falling, which in part they thought may be attributable to the support offered by employers.

*“...but our sickness absence has gone down so there must be some benefit there, you know knowledge and you know signposting staff to well-being and resilience” (HR, Northern Ireland, Hospital).*

### **Changes in ways of working**

Employers are being challenged by a reluctance among some staff to returning to work in the office following the increased flexibility about place of work during COVID-19. Organisations are trying to support their staff in their choices, but some staff are not responding as expected, with many showing a reluctance to return to office. In addition, the cost of living ‘crisis’ that is emerging has already been seen to affect how staff are thinking about how and where they work:

*“I think we are saying things that we want to support people to work in the way they want, but we don't really know what that looks like, and I think there's a bit of a conflict that is compounded by cost of living, people are saying to us, we can't afford to come into work, because petrol is too high, in the winter that maybe we'd like to come into work, because the heating is too high, but we are getting some of those conversations people saying the expectation to coming to work now is untenable” (HR, Scotland, Community).*

There was further discussion around the different expectations of employers and staff in relation to hybrid working with employers thinking that staff would want to come back into work for collegial and collaboration purposes but that is not being realised, leaving management conflicted with trying to support staff but also needing to decide what to do with apparently obsolete office space:

*“So we kind of left it to staff and then it's been a bit oh people aren't coming in, what does that mean we've got 14 offices do we have to shut some and then, if we shut them...that you know it so there's all those kind of questions, so I think, and I think there's a feeling from senior management of being in work and collaborating is helpful and then I think there's this feeling from a lot of staff that they are doing that, but they are doing it differently now. And, actually, why do you want me to come in, and when I do come in there's no one else there and I'm sitting on my team screen all day but I'm just doing it in the office, rather than at home, so what is the point in being in?”* (HR, Scotland, Community).

### **Supporting the health and well-being of staff**

Some health and social care staff were reported to have developed long COVID-19 which has affected their ability to return to work and their ongoing health and well-being. As a result, several employers have developed a framework of support for them:

*“I know the other trusts are looking to do, what they have brought in is Long COVID clinics. As a support as we have had a lot of staff off with Long COVID, so a support system to bring them back into the workplace and up training with managers, middle managers on stress toolkit as well and, again, it's not going to solve all the problems but it is a starting point”* (HR, Northern Ireland, Hospital).

Initially, employers had explored ways to support staff who moved out of their usual role during the pandemic and were anxious about returning to that role, providing support for the individual and risk assessments of the work environment to minimise any hazards or risks. However, as the risks associated with COVID-19 were now considered to have diminished, organisations were asking individuals to return to work as normal which sometimes leads to challenging conversations for managers with individual staff members

*“...the expectation is now that you come and resume your normal job and if you're telling us you can't then we'll be going down a redeployment capability route with you, with that's getting quite difficult after two years or do what you can do it from where you can do the work that's fine we'll support you, here's some paperwork to do at home and that's all lovely and now it's like actually we're in a different position”* (HR, Scotland, Community)

Some of the employers were using external companies to support their Employee Assistance Programme

*“Companies are quite good at coming forward and say you know your support workers are eligible for this, are entitled to this and some companies have been quite good at coming to promote the product that we have, so that both a bit of things that can be organised within the company”. (HR, Scotland, Community)*

### **Recommendations:**

When asked about recommendations related to HR that would help HR initiatives for staff, money in the form of wages or salary was specified as important for attracting and retaining staff in order to provide care; as well as understanding the type of hybrid working that suits employees; promoting health and social care as a career from an early age and allowing staff time to recover from their COVID-19 experiences.

*“So really just need money we can't keep going on and there's only going to be so many people that will do the jobs that we provide for £10.50 hour and we're going to eventually run out of people and. and that's, that's gonna be the real crisis is, what do you do when you physically can't provide care” (HR, Scotland, Community)*

*“I think as employers tss about being consistent about people don't just suddenly make a decision that everyone has to work hybrid or that everyone has to work in the office or from home consult with your employees and ask questions of and find out what actually does work best for them as an individual and because we all learned vigilance and it's about getting the most of the people that you've got so consult with people before making a decision one way or the other” (HR, Scotland, Community).*

*“I think, on the other side on the back of COVID, I don't think we're giving enough attention and space to actually the impact of the last few years on people I think we're in a bit of oh that's over now let's just crack on as normal without really understanding the cumulative impact the last few years has taken on people, I think, working at home. I think, looking after the children at home, I think people have lost people, I think the extra work, the different kind of work, working in a different kind of way, I think all of that has had a real impact on workers and I don't think we've taken the time to understand that” (HR, Scotland, Community).*

### 3.2.3. Summary of open-ended questions and focus group findings

In summary, on reviewing the data from the Phase 5 survey, the two open-ended question responses and the three focus groups, the themes arising can be categorised into three overall themes. These overarching themes from Phase 5 (May-July 2022) have similarities to the themes identified in Phase 1 (April – July 2020), Phase 2 (November 2020-January 2021), Phase 3 (May 2021-July 2021) and Phase 4 (November 2021-February 2022) of the study. Overall, the themes identified in Phase 5 can be categorised in three overarching themes, **referred to as the “3 c’s” in the previous reports– changing conditions, communication and connections** – as well as views on health and well-being, staffing challenges, work-life balance boundaries, coping and support (Table 3.11). Findings revealed that many in the health and social care workforce are continuing to struggle, and while they are returning to a new working normal as restrictions lift, many staff have been left facing relentless pressures and demands in their daily jobs. Staff are furthermore dealing with changing public perceptions that sometimes have given rise to negative attention and comments directed at the workforce that is additionally now facing struggles with coping and lack of motivation once out of the workplace. A vicious cycle of staff shortages, alongside the lack of recognition and increasing staff frustrations are leading to exhaustion and burnout for many. The changed working conditions have affected valued connections with patients/service users and have affected the workplace climate. A theme emerging more strongly in Phase 5 was that one of the key mechanisms that respondents adopted for managing work/ life balance was to cognitively reframe their attitudes towards work or to detach themselves from the emotional labour often associated with working in health and social care.

Table 3.11. Themes identified through open-ended questions and focus groups.

Overarching theme	Sub-themes
<b>Connections</b>	<ul style="list-style-type: none"> <li>• Decreased partnerships</li> <li>• Decreased co-production</li> <li>• Changing connections</li> <li>• Effects on patients/service users</li> </ul>
<b>Communications</b>	<ul style="list-style-type: none"> <li>• Changing public perceptions</li> <li>• Lack of motivation</li> <li>• Increasing staff frustrations</li> <li>• Coping strategies</li> <li>• Lack of recognition</li> <li>• Recognition of different experiences of staff</li> <li>• Availability of management support</li> </ul>
<b>Changing conditions</b>	<ul style="list-style-type: none"> <li>• Struggling to survive</li> <li>• Changing productivity</li> <li>• Remaining pressures</li> <li>• Burnout and exhaustion</li> <li>• Changes to working conditions</li> <li>• Need for suitable services and support for coping, health and well-being</li> <li>• Recommendations</li> <li>• Changes in ways of working</li> <li>• Staffing levels – shortages, recruitment and retention</li> <li>• Work demand</li> <li>• Changing attitudes to work and non-work</li> <li>• Difficulty attaining work-life balance</li> <li>• Coping mechanisms to deal with changes</li> <li>• Impact of workplace climate</li> <li>• Prevalence of career and job exit</li> <li>• Impact on well-being.</li> </ul>

## 4. Discussion

### 4.1. Summary of Findings and Comparison with Other Literature

#### 4.1.1. Main Messages

The findings from the Phase 5 survey specifically focus on the experiences of Nurses, Midwives, AHPs, Social Care Workers and Social Workers in the UK who were working in health and social care services during the Phase 5 study period (May-July 2022). The findings build upon previous survey responses collected during Phase 1 (May – July 2020), and survey and focus group responses collected during Phase 2 (November-January 2021), Phase 3 (May-July 2021) and Phase 4 (November 2021-February 2022) to further explore the impact of providing health and social care during the COVID-19 pandemic in the UK. The survey responses and focus groups data for this report were collected and collated during the May 2022-July 2022 period when the four countries of the UK were experiencing the spread of the COVID-19 Omicron variants BA.4 and BA.5. Although there were continuing reductions or removal of most public restrictions during this data collection period, the use of PPE and face masks was still being recommended across the UK in health and social care settings.

Our Phase 1 survey in May-July 2020 received 3,290 responses, the Phase 2 survey between November 2020-January 2021 received 3,499, the Phase 3 survey in May-July 2021 received 2,721 responses Phase 4 received 1,758 responses while the Phase 5 survey received 1,737 responses. A decrease in responses from previous phases may be a result of survey fatigue which may be due to the increased amount of health and social care research taking place during the COVID-19 pandemic (Gnanapragasam et al. 2021; Koning et al. 2021, Patel et al. 2020).

This fifth survey supports the previous themes identified in earlier phases of the study as discussed in sections 3.3 and 3.4 of this report. The findings of the overall study revealed consistent themes of work-life balance, changing conditions/context, communication and connections across health and social care job roles and demonstrate the continuing challenges of dealing with the impact of COVID-19 in respect of burnout, exhaustion, workload demand and changing work conditions. Staff shortages, due to sickness absences alongside recruitment and retention problems have increased work demands/responsibilities on remaining staff who are still struggling to cope with their experiences of the pandemic and would like more managerial support.

#### 4.1.2. COVID-19 Impact on working conditions and service pressures

As previous research has outlined, the COVID-19 pandemic amplified problems that have been facing UK health and social care services for many years, such as lack of funding, under-resourcing, staff recruitment and retention problems, exhaustion, public perceptions, and insufficient planning for epidemic/pandemic situations (British Medical Association, 2022). During the pandemic health and social care staff have faced trauma, changes to their working conditions, suffered fractured relationships, burnout, while feeling that there has been insufficient protection of their own health and well-being (Borek et al. 2022, French et al. 2022; Royal College of Nursing, 2022).

In Phase 5, respondents reported that their working conditions were still changing due to public guidance and organisational policies. There was sustained hybrid working for some, which many individuals found was beneficial in helping maintain a clear work life balance. However, work demand was still increasing with rises in caseloads across each sector with many staff feeling exhausted, burnout and lacking motivation. Respondents discussed the vicious cycle of staff shortages due to illness and other factors, and highlighted that recruitment and retention problems are contributing to a need to cover for vacancies which then result in existing staff becoming overworked. There is now increased frustration among the public who are facing long waiting lists for referrals, appointments, procedures and so on, and some staff feel they are being blamed for these problems even though such problems are out of their control. When reference is made {see quote on page 39} to 'REAP4' (Resource Escalation Action Plan) the clinical measurement of risk is acknowledged formally, with REAP4 indicating a risk of service failure. This REAP system provides a framework to assist managers to maintain an effective and safe operational and clinical response for patients. To operate at this level, staff are working under extreme pressure. Staff felt that the connections they had pre-pandemic were no longer the same and in some cases they were having to rebuild relationships and communication pathways with colleagues. This disconnection was prevalent particularly in Social Work, with a study by Ferguson et al. (2022) noting that disconnection and working in isolation created disorientation, and disruptions which impacted the work of social workers. All these factors have had an impact on staff's mental health and well-being with some respondents discussing a form of lasting trauma as a result of working through the pandemic, even as restrictions cease and new ways of working have begun. The findings reflect the growing evidence that also has noted the extreme exhaustion levels of staff and increasing mental health problems (De Kock et al. 2022; Nishihara et al. 2022; Nyashanu et al. 2020).

### 4.1.3. Burnout

Phase 5 findings revealed that personal and work-related burnout have improved slightly from previous phases, however client-related burnout increased from Phase 4 to Phase 5. Overall, in Phase 5, we found that client-related burnout was still much lower than personal and work-related burnout, suggesting that clients or patients/service users are rarely the reason for staff burnout. This was also indicated within the qualitative data analysis, in which respondents suggested that increased work demands/responsibilities, staff shortages, lack of resources and exhaustion were leading to burnout across the health and social care sector. Midwives scored significantly higher than Nurses, AHPs and Social Care Workers in client-related burnout. This reflects the qualitative findings as midwifery services continued throughout the pandemic but with restrictions and mask wearing still in place as of July 2022. Line managers experienced lower scores in personal burnout, work-related burnout and client-related burnout compared to those who were not line managers. Female respondents experienced significantly higher levels of personal and work-related burnout but had lower client-related burnout than male respondents. Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more personal and work-related burnout than those who felt impacted but not significantly and those not impacted.

Our survey findings are confirmed by other studies, media outlets and professional organisations.. A survey of Nurses by Maben et al. (2022) highlighted that the COVID-19 pandemic brought extra pressures to already tough working conditions. They noted that Nurses were already at high risk of burnout but the systemic challenges and altered working conditions have resulted in exhaustion and burnout. Similarly, Giebel et al. (2022) reported stress and burnout among some care home staff and how managing pressures and greater demands has increased frustrations, with burnout affecting coping and the need for staff support. These findings were also evident within the qualitative data reported in this Phase 5 report, in which respondents highlighted that while demand has increased the workforce has decreased, placing additional pressures on staff resulting in burnout and stress and that the job is now tougher. Unison Scotland (2022) also noted that the levels of stress and burnout were impacting the workforce and taking a toll on the mental and physical health of the staff. Headlines across the media have acknowledged that staff in the health and social care sector are under pressure and burnout following the pandemic. Furthermore, changes to working conditions alongside increasing demands have created a record number of staff departures across the NHS particularly (Savage, 2022).



On further examination of the quantitative data, respondents who felt that their service was overwhelmed by increased pressures experienced significantly more personal and work-related burnout than those who felt impacted but not significantly and those not impacted. The Phase 5 study also found strong negative correlations between personal burnout and well-being scores and a moderate negative correlation between personal burnout and quality of working life, work-related burnout and well-being 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 well-being scores, and client-related burnout and quality of working life scores. This indicates that, as burnout in any area increased, respondents' well-being and quality of working life decreased. The Phase 5 multiple regression analyses revealed that the use of more positive coping strategies such as acceptance or positive reframing were associated with lower burnout scores, while negative strategies such as venting and self-blame were associated with higher burnout scores. Our findings also revealed strong links between burnout and intention to change employment specifically where respondents were experiencing severe levels of personal burnout, work-related and client-related burnout.

These findings resonate with other UK studies of recruitment and retention. Deakin (2022) noted that particularly within the NHS, the staff shortages and burnout levels are taking a toll with professionals overstretched, noting that investment is needed. A report from the House of Commons (2022) on the adult social care workforce in England highlighted high vacancy rates (estimated to be 10.3%, just under a four-point increase from previous year) and high turnover, accompanied by a rising demand for services. The report noted that there were limited opportunities for career progression, something highlighted within this report and our previous Phase 4 report. Additionally, the rising demand was noted as leading to concerns around burnout which the COVID-19 pandemic had exacerbated (House of Commons, 2022). Unison Scotland (2022) recently issued a report in February 2022 called The Burnout Pandemic, noting that over 96% of social care staff felt that their employer was short staffed emphasising the staffing crisis discussed in this Phase 5 report, with burnout and stress being noted by a majority as the main reason for staff being off sick. In Phase 5, the vicious cycle of staff shortages was increasing the pressures of remaining staff as also noted within Unison's (2022) report. The findings from this study's Phase 5 that 37.4% of staff were considering leaving their employer, while 38.6% were considering leaving their occupation, would create even higher staffing shortages. With the levels of burnout increasing across the sectors, more staff are considering leaving on a daily basis as highlighted by Nursing Notes (2022) which reported that around 16% of health and social care workers are looking to leave their jobs owing to exhaustion and burnout.

#### 4.1.4. Mental Well-being

The overall UK-wide mean well-being score in our sample was 20.80, which is nearly three points below the population mean of 23.61 (NHS Health Survey for England, 2011). This is also lower than the mean score of 20.95 reported in Phase 1 of the study, however, it has improved from the mean score of 20.10 reported in Phase 2 of the study and the mean score of 20.25 reported in Phase 3, although it has decreased slightly from the reported mean score of 20.85 in Phase 4 (as shown in Table 3.1 in section 3 of this report). When well-being scores were translated to indications of anxiety/depression, 30.4% were found to have probable (likely) or possible cases of anxiety/depression. Taken together, the estimated proportion of scores between 20-21 has remained similar across the study phases and shows that well-being has not improved even as the population begins to move beyond the pandemic restrictions to new ways of working across other occupations. Respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressure while Midwives and Social Workers had the lowest overall mean well-being score. Those who worked as Nurses, Midwives and Social Workers showed a decrease in their overall mean well-being scores from Phase 1 of the study to Phase 5, while AHPs and Social Care Workers showed an increase in overall mean well-being score.

In comparison to other evidence, these changing scores could be a result of the changing times between the phases. For example, De Kock et al. (2022) reported that individuals who had no disruption had an increase in mental well-being while individuals who faced disruption during this time in the health care service experienced a decrease in mental well-being. Additionally, a report by the University of Exeter (2022) examining the impact of the COVID-19 pandemic on the well-being of UK care home practitioners found that staff were frustrated, felt undervalued, were upset and faced trauma with exhaustion a huge factor. These findings are similar to the research reported in this present study in which the qualitative data highlighted that many respondents felt frustrated by the lack of progress in their workplace and felt undervalued by their employers and the general public. Additionally, another factor impacting well-being was the increased workload and experiences that they had dealt with since the pandemic which respondents highlighted as a *‘trauma of what we have experienced’*.

#### 4.1.5. Quality of Working Life

In Phase 5, quality of working life has decreased from Phase 4, with respondents from England, Scotland and Northern Ireland demonstrating lower overall WRQOL scores than those from Wales. Scotland reported the lowest WRQOL scores in Phase 5 at 69.64, lower than the UK-wide average of 74.49 reported in this study, England and Northern Ireland also reported scores lower than the UK average. In comparison to other literature, the findings from the Phase 5 ( $74.49/23 = 3.24$ ) are lower than the mean normative score of 3.44 ( $78.09/23 = 3.40$ ) from the UK NHS workforce study (Easton and Van Laar, 2018). Howie-Esquivel et al. (2022) reported a score of 3.3. for overall WRQOL in American Advanced Practice Nurses, this finding showed a similar result to this Phase 5 study, showing the impact of the pandemic on wider health and social care workers. The findings of 74.49 in this Phase 5 UK cohort were lower than that reported in an Iranian study by Rostami et al. (2021), a score of 82.92 being found in Iranian Occupational Therapists.

The overall WRQOL score decreased from Phase 1 of the study to Phase 5, both UK-wide and across the individual countries. There was also a decrease in the majority of the WRQOL domain scores across the countries. Comparing Phase 2 and Phase 5 there was a slight increase in overall WRQOL scores UK-wide but, on further examination, there was a decrease in overall WRQOL in Wales, Scotland and Northern Ireland between these study phases, while Scotland exhibited a slight increase in overall WRQOL between Phases 2 and 5. There were increases in UK-wide WRQOL between Phases 3 and 5, however Scotland and Northern Ireland showed a decrease in WRQOL scores. Between Phase 4 and Phase 5, the mean quality of work-related quality of life decreased UK-wide and specifically decreased in England, Scotland and Northern Ireland. There was also a decrease from Phase 4 to Phase 5 in Job Satisfaction, general well-being, home-work interface and working conditions while an increase in stress at work and control at work. Social Workers exhibited the lowest overall WRQOL which is slightly different than our previous survey findings which reported Midwives with the lowest overall WRQOL score. Also in Phase 5, Nurses showed a decrease in overall WRQOL while Midwives, AHPs and Social Care workers showing an increase.

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” (52.2%) and Wales had the highest proportion with “higher quality of working life” (47.4%). Qualitative responses suggested that health and social care workers had less job satisfaction due to changing working

conditions and increased workload, which, alongside the increase in stress at work, could impact general well-being.

#### 4.1.6. Coping

The Phase 5 multiple regression analyses demonstrated a statistically significant decrease in respondents' use of active coping, planning, positive reframing, acceptance, and emotional support strategies from Phase 1 to Phase 5. There was also a statistically significant increase in the use of self-blame from Phase 1 to Phase 5 (full details of the regressions can be found in Appendix 9). Family work segmentation continued to decrease over the phases with the lowest score reported during Phase 5. Additionally, participation in activities such as exercise, recreation and relaxation decreased from Phase 4 to Phase 5 which corresponds to the qualitative data suggesting that many staff in the health and social care sector are now burnt out and exhausted so much so that by the time they finish work they lack the motivation for social and physical activities. Employers now need to look at the type of support services they are providing their employees, as the data within Phase 5 suggested that staff were not always taking up the current support on offer, with 72.4% of respondents not taking up employer support. There seem to be several reasons behind this, with respondents noting that support was sometimes not accessible, not convenient or not relevant (Appendix 2, pages 193-209). Therefore, employers may wish to provide more bespoke individual services to improve their employees' coping while encouraging exercise and recreational activities. The declining ability to cope has been highlighted within the research literature that has reported high stress, increased work demand/responsibilities, lack of resources, physical exhaustion and loss of connection (Beattie et al. 2022; Halliday et al. 2021) amongst many other factors that were also reported in this study as affecting coping.

## 4.2. Limitations and Strengths

As with the previous study phases, this phase (Phase 5) involved an anonymous online cross-sectional survey based on a convenience sample of health and social care workers and it is not possible to infer causality which limits the evaluation between the outcomes. The findings also cannot be considered fully representative of the full health and social care workforce or general population. Although the survey was anonymous it was self-reported by participants therefore it may be subject to social desirability bias or recall bias. Sample attrition has been consistent across the last two phases, with a further decrease in the number of responses in Phase 5. This could be a result of survey fatigue due to the increase in research activity within the health and social care sector throughout the pandemic.

It is also important to note that any comparisons across the five phases of the study must be viewed tentatively, as the five samples consisted of different individuals and sample sizes (although some respondents may have been the same).

Nonetheless, this research has several strengths, for example, it extends four previous phases of research examining the health and social care workforce. Therefore, while the data are cross-sectional, the surveys track different experiences at different time points during the COVID-19 pandemic. Another strength is the examination of five different occupations within the health and social care sector, as several studies only include specific occupational groups such as Nurses or Social Workers.

### 4.3. Implications

At the time of writing this report (September 2022), well over two years on from the start of the COVID-19 pandemic, restrictions and social distancing have eased, vaccinations are available and, while COVID-19 is still with us, hospitalisations have decreased. Some guidelines still exist in certain services across the UK, such as mask wearing in Northern Ireland's hospitals, and recommendations to isolate for five days if unwell with COVID-19 symptoms. However, the health and social care sector is still facing colossal pressure which is taking a detrimental toll on the mental well-being and physical health of all staff within this sector. As services begin to rebuild and resume, with new hybrid ways of working in some occupations, several issues need to be addressed in plans or strategies. Improving health and well-being support for this workforce will hopefully help improve long-term retention of staff. Strong staff support is one of the most important elements required. Staff need to feel recognised and have their experiences understood. Communication is still essential as services move forward or get reorganised. Organisations should look at what supports their staff want and need rather than just implementing a set policy. Holding regular staff meetings and conducting surveys can be helpful in identifying what will work and for whom.

Within this report, 72.4% of respondents indicated that they did not take up employer support, highlighting a need for further examination. Some respondents had support elsewhere, but others found support at work was not accessible, offered at an inconvenient time and/or not suited to their needs. Within the qualitative data, many felt it was a tokenistic approach rather than being thought-out fully for staff, with one reporting the support offer was only 'like sticking a plaster on a broken

leg’. These findings have implications for the development of robust and reliable support systems/services within the workplace to help employees deal with what they have experienced throughout the pandemic and beyond, such as facing criticism and anger from the public.

### 4.3. Good Practice Recommendations: May 2022-July 2022

The Good Practice Recommendations from the previous four phases were reviewed in the context of findings from Phase 5. These Good Practice Recommendations are organised under the main themes of analysis from previous Phases: **Changing Conditions, Connections and Communication**, with the addition of a work-life balance section in the recommendations of this fifth phase.

#### Changing Conditions

##### *Organisational and Individual Level*

1. **HEALTH AND SAFETY:** In Phase 1, we 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. This Recommendation still stands and requires ‘Safe Systems at Work’ level of risk management and strategic investment in emergency supplies of PPE in non-pandemic times, to ensure preparedness for future pandemics, fire, flood, or other disasters. In Phase 5, Infection, Prevention and Control (IPC) continues to be a major challenge for some staff. Employers are responsible for alleviating workforce concerns about spreading infection within workplaces, while increasing access to care and treatment for members of the public, patients, service users, and their families. These are the responsibilities of employers and authorities, but the experience and views of frontline staff need to inform and guide specific interventions and policies, based on accurate research and knowledge from the workforce. Employers also need to feel confident that the advice they are giving is as accurate as possible and to share this openly.
2. **TRAINING FOR REDEPLOYMENT, SKILL MIX AND SKILL ACQUISITION:** While redeployment of staff is now infrequent, all training and development will need to equip staff with the expectation and ability to, where possible, perform multiple or new roles. Therefore, strategies to accomplish this are needed. The training and development needed must involve employers, professional bodies, regulators, workplace unions, educational and training bodies, and service user and patient groups. Evidence is needed about what sort of training and system change should inform these developments and guide commissioning decisions.

### *Policy and Organisational Level*

3. **TERMS AND CONDITIONS GENERAL:** We noted in our first report that employers in the health and social care sector should address the adequacy and coverage of Statutory Sick Pay for their staff. This Recommendation stands. We now add to this some evidence that sickness rates remain high and, with the temporary arrangements for COVID-19 absence generally having been withdrawn by health and social care employers, we believe it is important to address the reasons for absence, including the impact of Long Covid on the health and care workforce.
4. **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 as operating by necessity during the height of the pandemic 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 using the experience of the pandemic to inform these deliberations. We are hopeful that the national inquiry into the management of the pandemic will consider these questions and will forward our reports to the inquiry.
5. **STAFF WELL-BEING AND RETENTION:** Our fourth and now our fifth survey confirmed that a large proportion of health and care staff are experiencing moderate to severe levels of burnout, and reduced well-being (evidenced by reported levels of anxiety and depression). Affected employees will need time to recover from a prolonged period of unprecedented stress and pressure or may feel that moving jobs and/or reducing hours will assist. Absence levels due to stress were evident in our study and the pressures these are placing on remaining staff could potentially cause irreparable strain on systems, services and patient or user outcomes. Staff need to be supported to take breaks, including holidays, be recognised and feel appreciated. It is important that they feel a sense of purpose in moving back to the office and benefitting from peer support.

The setting up of well-being services and other forms of employer help, while appreciated by many, did not meet the needs of others. Accessibility, in relation to the timing of available support as well as this having an 'in person' option, is important. Many did not feel online options were helpful and think these can be tokenistic. If well-being is not managed strategically, the risk remains that some staff will leave prematurely owing to stress or reduced work-based quality of life. Employers need to be proactive in understanding why staff are leaving and what If anything can be done to change their decision, such as offering more flexible working hours or days, or a

change in place of work. This applies to older workers since the loss of their experience can affect new colleagues and students. In addition, sharing of staff support initiatives that have been proven to be helpful for staff needs to be encouraged, such as 'in-reach services' and 'well-being appraisals' as highlighted by the HR Focus Group. While frontline staff may be the target for such initiatives, we note the risks of burnout among managers and these need to be addressed.

6. **CHANGE OF CULTURE:** Workplace bullying and what might be called a toxic work culture were highlighted by some respondents as reasons for staff leaving their employers or professions. There is increasing evidence of the presence of negative workplace behaviour including perceptions of bullying in many health and social care workplaces. This may in part be due to both internal responses to pressures manifesting as incivility from co-workers, managers and external pressures from a frustrated, stressed and distressed public. Concerted efforts that are resourced and sustained are required to address these behaviours and system failings, some of which need to start with education and training for staff and awareness raising for patients/service users as well as fairness and mutual regard.

## **Work-Life Balance**

### *Organisational Level*

1. **PUTTING INTO PRACTICE THE ADVANTAGES OF MORE FLEXIBILITY IN EMPLOYMENT:** During the pandemic most employers provided, as far as possible, increased flexibility around working hours and location, often recognising additional childcare or other caring responsibilities of staff. Flexibility continues to be highly valued by staff. As the present level of the pandemic subsides, and employers seek to encourage home-based staff to return to their offices for at least part of their working week, staff need to feel that their individual well-being and circumstances are being considered. Firming up policy and procedures with staff and their representatives about long-term flexibility in working hours and location, must be embedded within organizational Human Resource policies, , including, for example, more part-time working options. For students or trainees, there is a need to prepare this workforce of the future for different ways of working within agencies and organisations.
2. **EQUITY IN HOME WORKING WHEN POSSIBLE:** We recommended that policies about working from home (if appropriate) should be fair and seen to be fair in our first report. Home working is mainly role dependent, with hybrid models of working for some, such as part home working/part in office, increasingly adopted. Employers need to offer choices to individual



workers where the job can be done at home but must also consider the team or work unit effect. Our findings of increasing levels of anxiety and depression suggest the value of Human Resources (HR) staff support for managers in addressing mental health risks, and noting them at early stages (through online communications) if people are working at home or relatively independently. The high levels of depression and anxiety we found in this phase may make working from home seem attractive but there are risks of losing social contacts and stimulation.

## Connections

### *Organisational and Individual Level*

1. ANNUAL LEAVE AND REGULAR BREAKS: As previously noted, 'Staff Well-being and Retention' managers still need to ensure, where possible, that staff are supported, enabled and encouraged to take leave and breaks, and where possible, arrange for their work and responsibilities to be covered. Managers, of course, need to practice what they preach as manager pressures and burnout is clearly evident in this study, and such stress can impact on how managers can support others. In our fifth survey the issues of not taking breaks did not appear so problematic, but one point of caution is that increases in the cost of living may prompt more staff to do further overtime or shifts and so not benefit from breaks or time away from work.
2. CONNECTION: Evidence-based good practice guidance on communication to meet the broad range of health and social care staff could be assembled by national bodies with strong input from the frontline. Our surveys were electronic, and we recognise that staff with limited IT skills may need support in developing online communication skills. Some staff have limited access and/or permission to use computers and work email during work time – both of these are important contributors to staff engagement and connection and could be addressed by employers.

### *Organisational Level*

3. MANAGEMENT VISIBILITY: Managers should be visible, either in person (if possible) or virtually, so that staff feel they are valued and that work pressures are understood. They, the managers, should also be valued explicitly and have opportunities for peer support and professional development.

4. **SUPPORTIVE SUPERVISION:** Staff concerns need to be addressed whether they are personal concerns or those that can be discussed in peer or group supervision. This point also applies to managers and those who supervise managers. This Recommendation stands. The presence of depression and anxiety among many staff noted in this present survey should be addressed in supervision with offers of help extended and these important opportunities to discuss individual well-being should not be missed. Therefore, while there is a move towards group supervision for some staff groups, individual supervision sessions should also be available.

## Communication

### *Organisational and Individual Level*

1. **ORGANISATIONAL SUPPORT:** Respondents provided several accounts of employers and managers signposting staff to organisational supports, counselling, mentoring or coaching, or Occupational Health advice and help (if required). However, these resources need sustaining if they are to enable staff to manage the aftermath and emotional impact of working during the pandemic and its legacy. Furthermore, supports must be accessible – for example, not just online. As noted previously, many staff feel that their needs are not being met and it is critical that this matter is addressed strategically for workforce sustainability. Discussion with primary care colleagues about local supports that may be more accessible to health and social care workers than those that are employment-based would seem timely and may be more acceptable to some than employer provision for a variety of reasons.
2. **COMMUNICATION:** It continues to be important that communication is relevant and timely, particularly because hybrid working looks set to continue for some staff and because possible new variants of the virus may develop.
3. **TEAM SUPPORT:** Team or peer support is critical to coping, well-being and morale. Ideas about how to sustain a positive team culture and climate should be nurtured so that support is available to all team members including managers whose needs appear often overlooked but who, our research shows, are often under considerable pressure themselves. Meaningful interaction with colleagues may be helpful in fostering good working relationships and promote kind, civil and anti-bullying cultures. Students and newly qualified or newly appointed staff may need specific assistance to feel part of teams and contribute to them. It is not a good foundation for their careers if they are working with colleagues who are feeling burned out, depressed or anxious. Employers need to understand that time and energy invested in helping new team members to integrate into

their teams will ultimately reduce their workload and stress level; without this, new members may just leave.

#### *Policy and Organisational Level*

4. RESOURCING AND INFRASTRUCTURE: The unprecedented demands on the health and social care sectors over the past two years and more have exposed the chronic under-resourcing of staff and infrastructure. Staff shortages and vacancies are of rising concern. Concerted efforts are required to make work within the health and social care sectors an attractive option, with pay and working conditions requiring sustained attention. Indications that the pandemic has increased people's desires to do work that is meaningful should not be thwarted by negative experiences of health and social care work.

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## 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://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](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

<b>Social Services Reporting</b>	<b>NHS Reporting</b>
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:

**Note:** As we go through the pandemic sample attrition occurs in a random way. This has consequences for the data, for example in this Phase (Phase 5), the number and representation of within certain occupations was lower than all previous phases, therefore participation numbers needed to be viewed tentatively.

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
<b>Nursing</b>	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%
<b>Midwifery</b>	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%
<b>AHP</b>	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%
<b>Social Care Worker</b>	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%
<b>Social Worker</b>	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%
<b>TOTAL<sup>1</sup></b>	<b>254130.4</b>	<b>320506.5</b>	<b>406431.0</b>	<b>467338.1</b>	<b>1448406.0</b>	<b>157629.0</b>	<b>89963.4</b>	<b>76182.0</b>	<b>1772180.4</b>

<sup>1</sup> The population estimates used in this report are the same as those used in the Phase 1, Phase 2 and Phase 3 reports, as we found no evidence of major changes in staffing levels between Nov 2021 and Feb 2022.

## 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):

A majority of the respondents (n = 1295, 74.6%) indicated that they currently work in Northern Ireland, 11.8% (n=205) worked in England, while less than 10% worked in Scotland (n=141, 8.1%) or Wales (n=96, 5.5%). Most of the respondents worked as Social Care Workers (n= 730, 42.0%), followed by Social Workers (n=380, 21.9%), AHPs (n=305, 17.6%) and nurses (n=243, 13.5%). Midwives represented the smallest proportion of respondents (n=88, 5.1%).

Figure A2. 1: Country of Respondents (Unweighted)

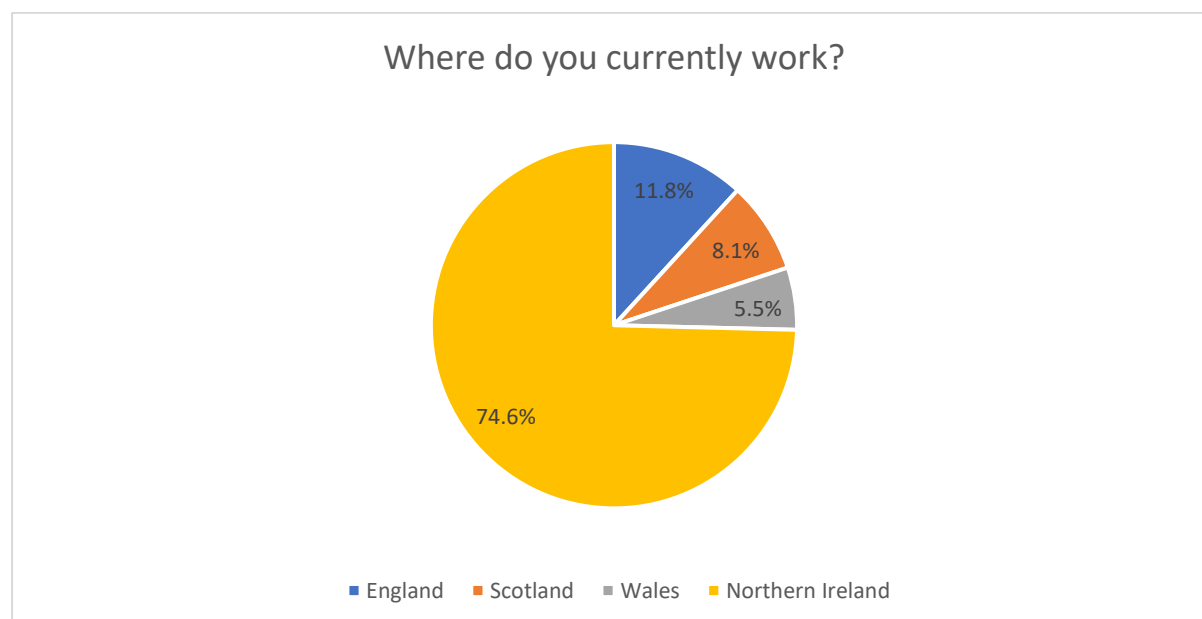


Table A2. 1: Country of Respondents (Unweighted)

Country	n (%)
England	205 (11.8%)
Scotland	141 (8.1%)
Wales	96 (5.5%)
Northern Ireland	1295 (74.6%)
<b>Total</b>	<b>1737 (100%)</b>

Figure A2.2: Occupation of Respondents (Unweighted)

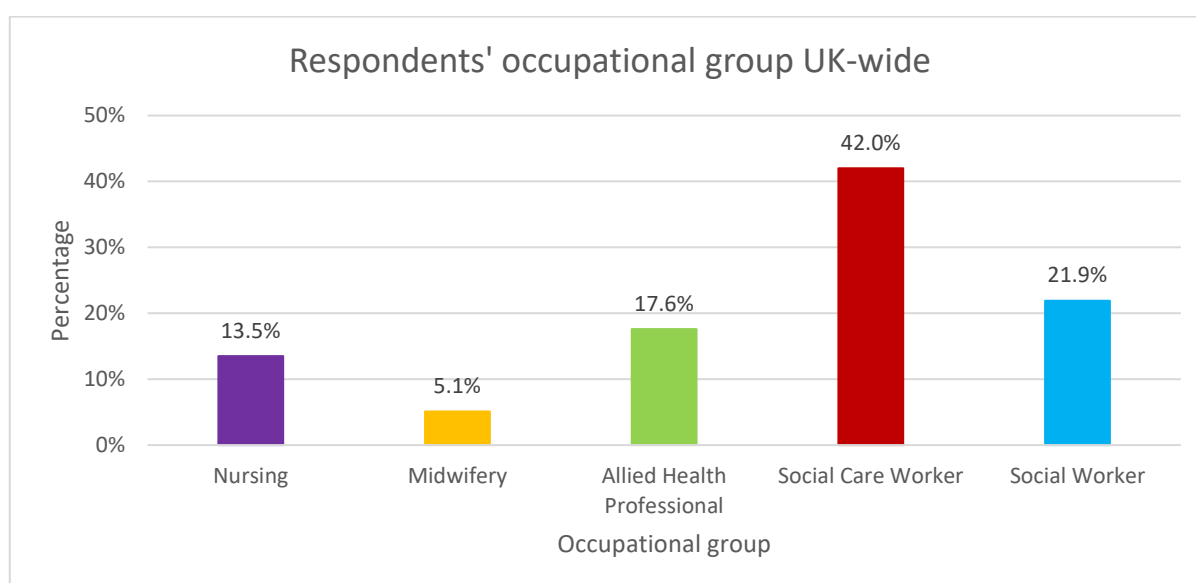


Table A2. 2: Occupation of Respondents (Unweighted)

Occupation	UK-Wide n (%)
Nursing	234 (13.5%)
Midwifery	88 (5.1%)
AHP	305 (17.%)
Social Care Worker	730 (42.0%)
Social Worker	380 (21.3%)
<b>Total</b>	<b>1737 (100%)</b>

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

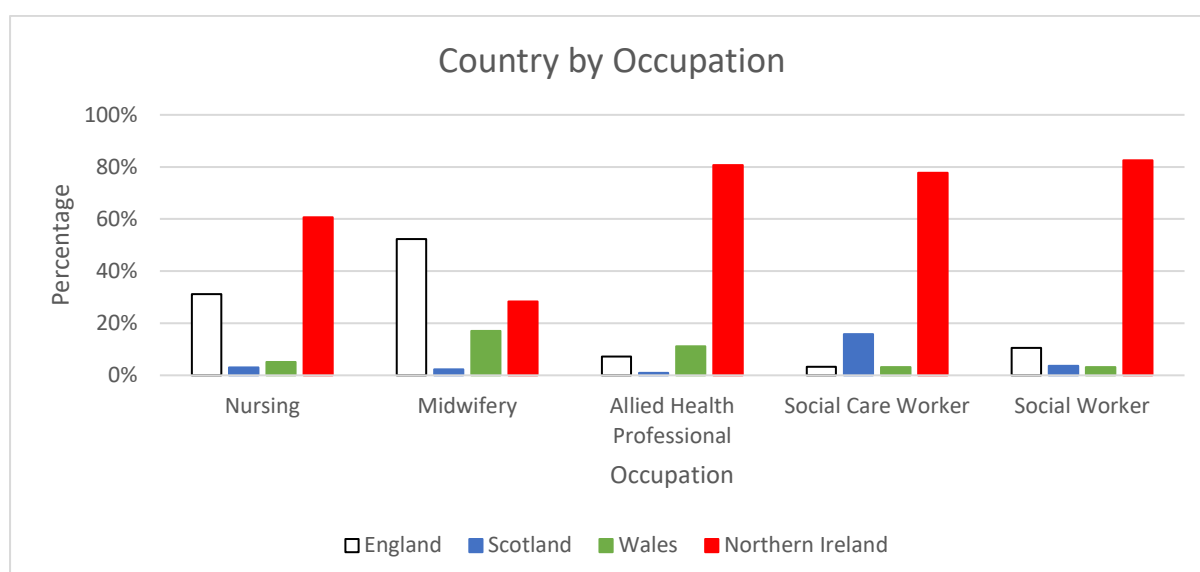


Table A2. 3: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	73 (31.2%)	7 (3.0%)	12 (5.1%)	142 (60.7%)	234 (13.5%)
Midwifery	46 (52.3%)	2 (2.3%)	15 (17.0%)	25 (28.4%)	88 (5.1%)
AHP	22 (7.2%)	3 (1.0%)	34 (11.1%)	246 (80.7%)	305 (17.%)
Social Care Worker	24 (3.3%)	115 (15.8%)	23 (3.2%)	568 (77.8%)	730 (42.0%)
Social Worker	40 (10.5%)	14 (3.7%)	12 (3.2%)	314 (82.6%)	380 (21.3%)

## A2.2 Sex of Respondents

### Summary (Weighted results):

The vast majority of respondents were female (88.3%), with a similar sex distribution across countries. Most midwifery respondents were female (96.2%). AHPs had the highest proportion of males (20.3%).

### Summary (Unweighted results):

The vast majority of respondents were female (84.4%), with a similar sex distribution across countries. A majority of midwifery respondents were female (97.7%). AHPs had the highest proportion of males (23.9%).

Figure A2. 4: Sex by Country (Weighted)

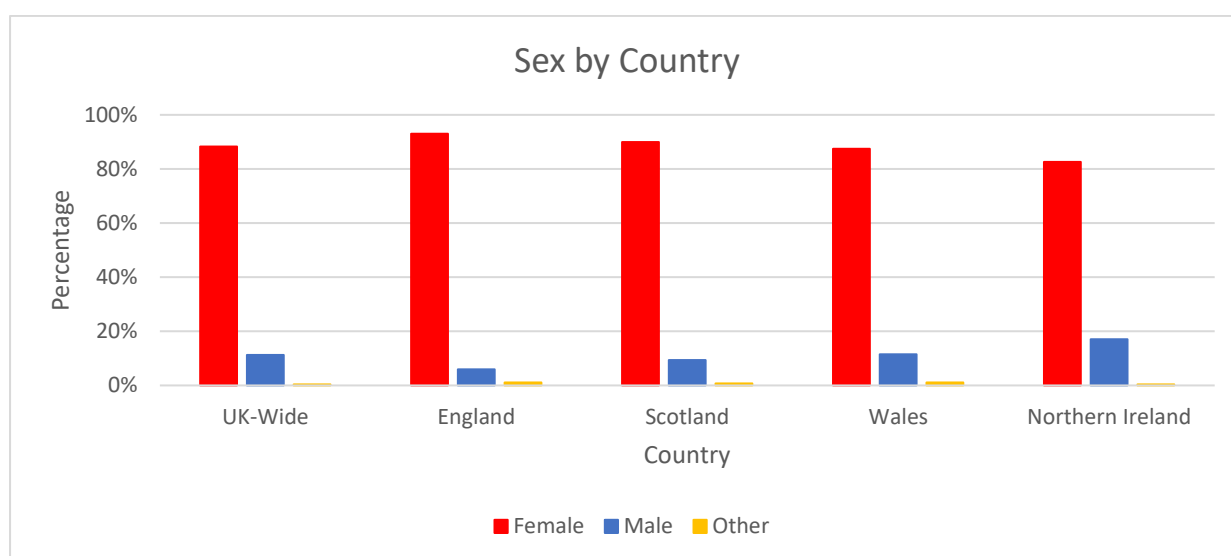


Figure A2.5: Sex by Country (Unweighted)

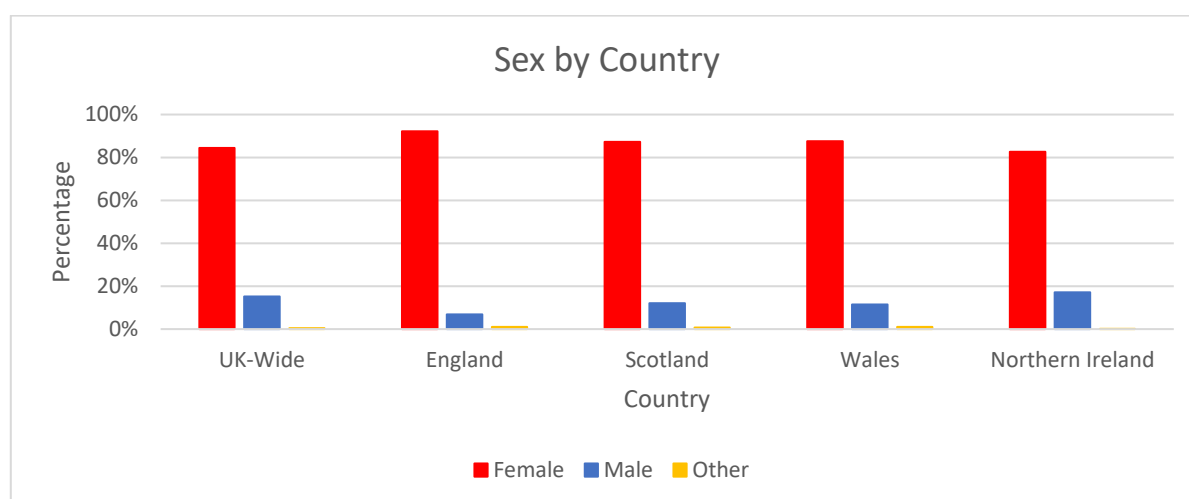


Table A2. 4: Sex by Country (Weighted)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	88.3%	93.0%	89.9%	87.5%	82.6%
Male	11.3%	5.9%	9.4%	11.5%	17.1%
Other	0.4%	1.1%	0.7%	1.1%	0.4%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2.5: Sex by Country (Unweighted)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	1466 (84.4%)	189 (92.2%)	123 (87.2%)	84 (87.5%)	1070 (82.6%)
Male	264 (15.2%)	14 (6.8%)	17 (12.1%)	11 (11.5%)	222 (17.1%)
Others	7 (0.4%)	2 (1.0%)	1 (0.7%)	1 (1.0%)	3 (0.2%)
<b>Total</b>	<b>1737 (100%)</b>	<b>205 (100%)</b>	<b>141 (100%)</b>	<b>96 (100%)</b>	<b>1295 (100%)</b>

Figure A2.6: Sex by Occupation (Weighted)

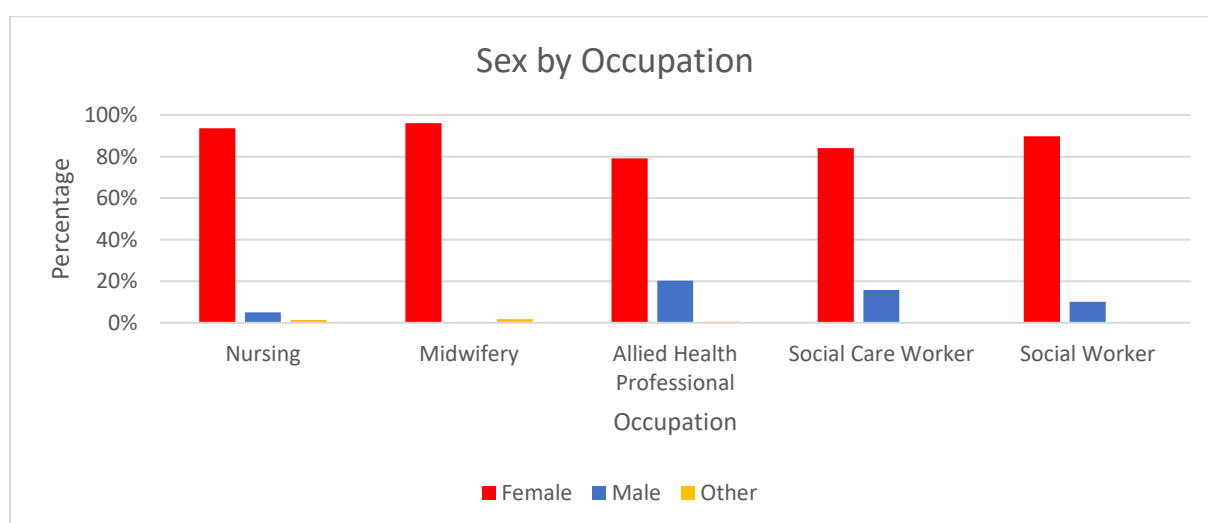


Figure A2.7: Sex by Occupation (Unweighted)

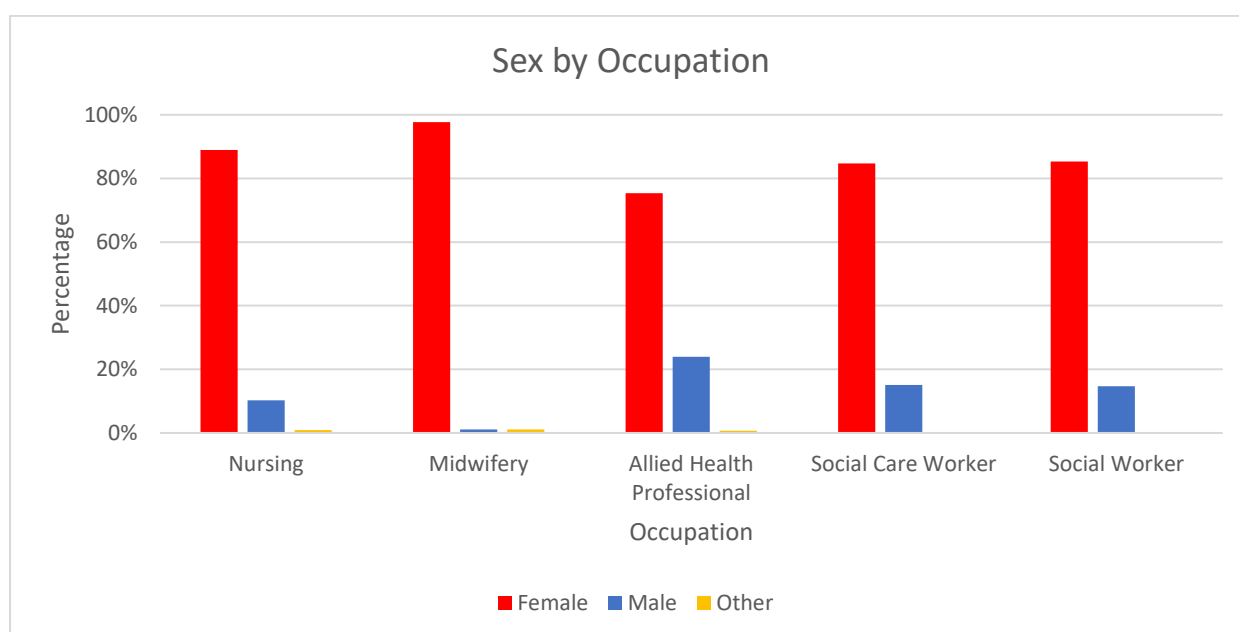


Table A2 6: Sex by Occupation (Weighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	93.7%	5.0%	1.3%	100%
Midwifery	96.2%	0.0%	1.8%	100%
AHP	79.2%	20.3%	0.5%	100%
Social Care Worker	84.1%	15.8%	0.3%	100%
Social Worker	89.8%	10.2%	0.0%	100%

Table A2.7: Sex by Occupation (Unweighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	208 (88.9%)	24 (10.3%)	2 (0.9%)	205 (20.5%)
Midwifery	86 (97.7%)	1 (1.1%)	1 (1.1%)	88 (8.1%)
AHP	230 (75.4%)	73 (23.9%)	2 (0.7%)	305 (32.6%)
Social Care Worker	618 (84.7%)	110 (15.1%)	2 (0.3%)	730 (18.9%)
Social Worker	324 (85.3%)	56 (14.7%)	0 (0.0%)	380 (19.9%)

### A2.3 Age of Respondents

#### Summary (Weighted results):

The majority of respondents were aged 40-59 years, with only a small proportion from the 60+ age group. Scotland had the highest proportion of the 40-59 year-old respondents (69.9%).

#### Summary (Unweighted results):

The majority of respondents were aged 50-59 years, with only a small proportion from the 60+ age group. Scotland had the highest proportion of the 50-59 year-old respondents (37.0%).

*Note: In both the weighted and unweighted results from regression and comparison analysis, the 16-19 age group was merged with the 20-29 age group and the 66+ age group was merged with the 60-65 age group as both groups had a small number of respondents which was too small for subgroup comparisons.*

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

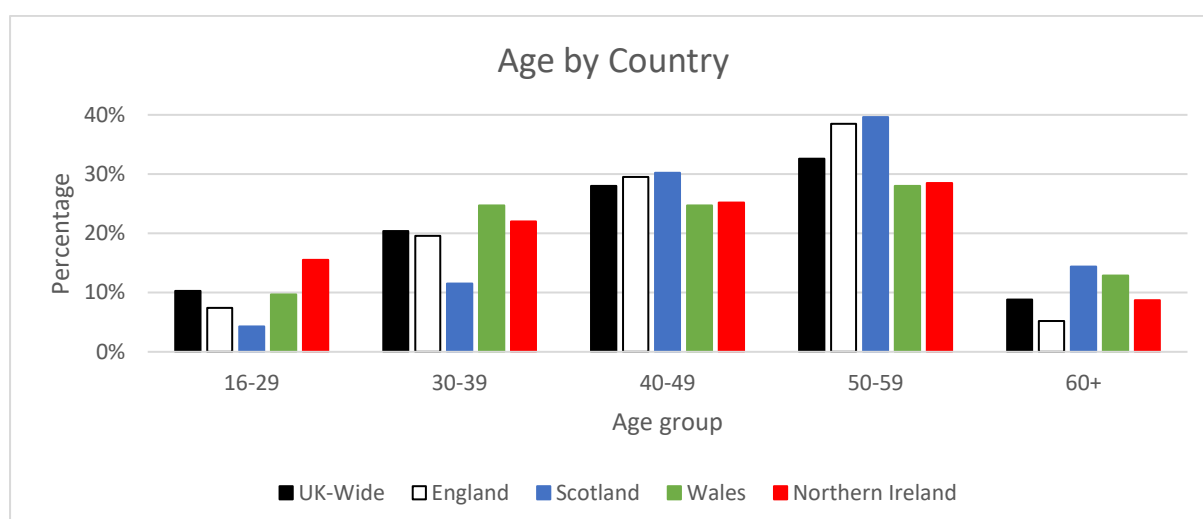


Figure A2.9: Age of Respondents by Country (Unweighted)

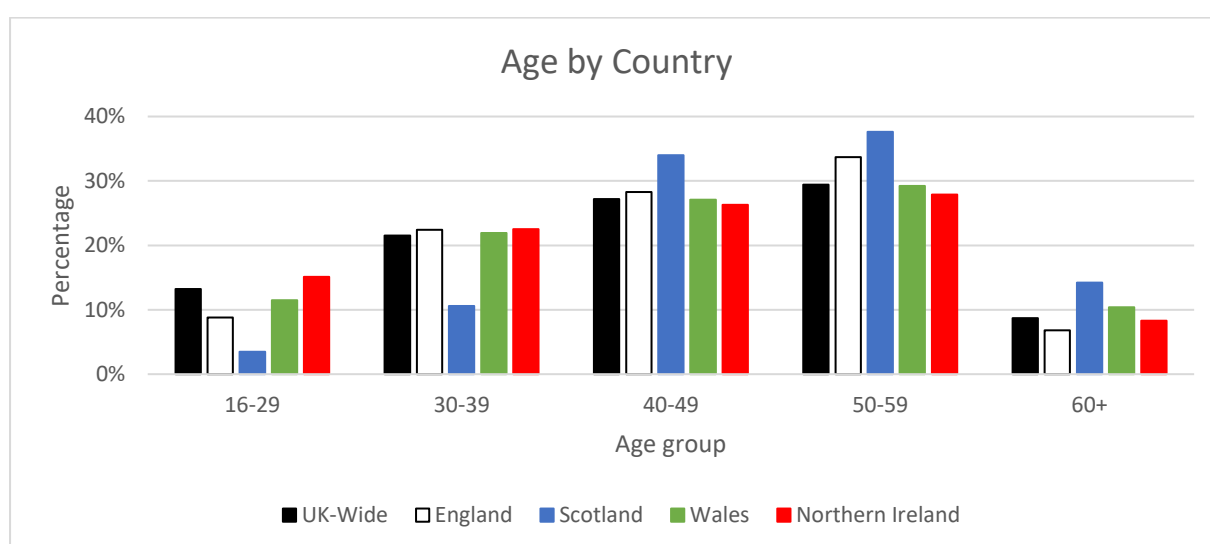


Table A2.8: Age of Respondents by Country (Weighted)

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-29	10.3%	7.4%	4.3%	9.7%	15.5%
30-39	20.4%	19.6%	11.5%	24.7%	22.0%
40-49	28.0%	29.5%	30.2%	24.7%	25.2%
50-59	32.6%	38.5%	39.6%	28.0%	28.5%
60+	8.8%	5.2%	14.4%	12.9%	8.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>



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

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-29	230 (13.2%)	18 (8.8%)	5 (3.5%)	11 (11.5%)	196 (15.1%)
30-39	373 (21.5%)	46 (22.4%)	15 (10.6%)	21 (21.9%)	291 (22.5%)
40-49	472 (27.2%)	58 (28.3%)	48 (34.0%)	26 (27.1%)	340 (26.3%)
50-59	511 (29.4%)	69 (33.7%)	53 (37.6%)	28 (29.2%)	361 (27.9%)
60+	151 (8.7%)	14 (6.8%)	20 (14.2%)	10 (10.4%)	107 (8.3%)
<b>Total</b>	<b>1737 (100%)</b>	<b>205 (100%)</b>	<b>141 (100%)</b>	<b>96 (100%)</b>	<b>1295 (100%)</b>

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

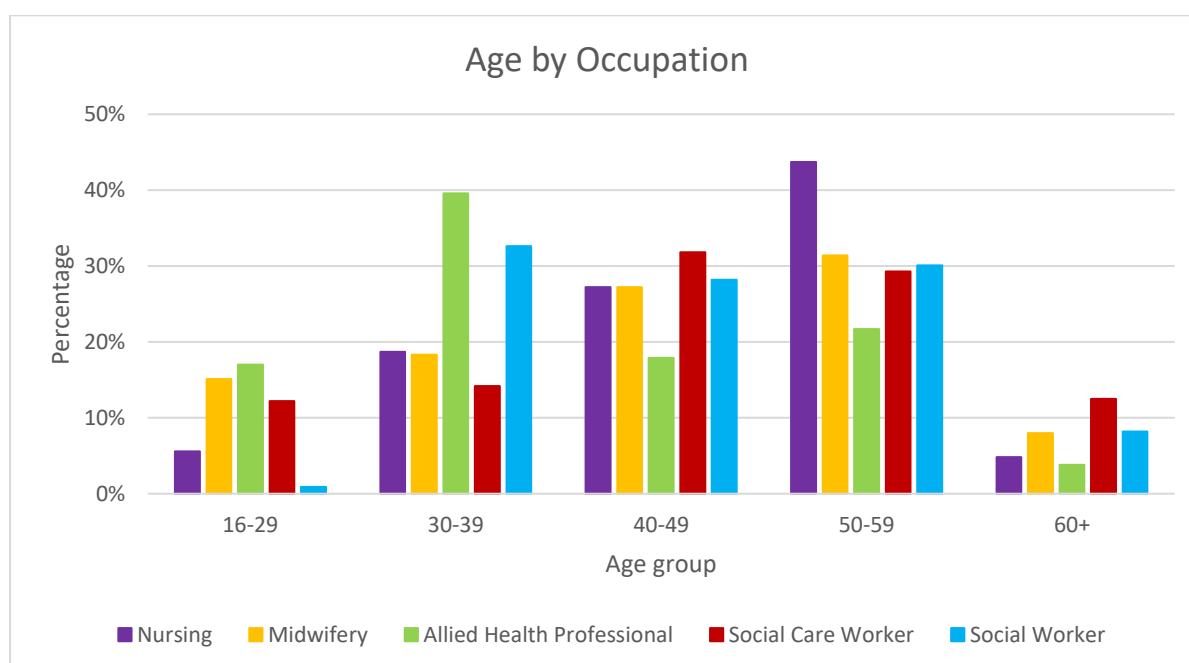


Figure A2.11: Age of Respondents by Occupation (Unweighted)

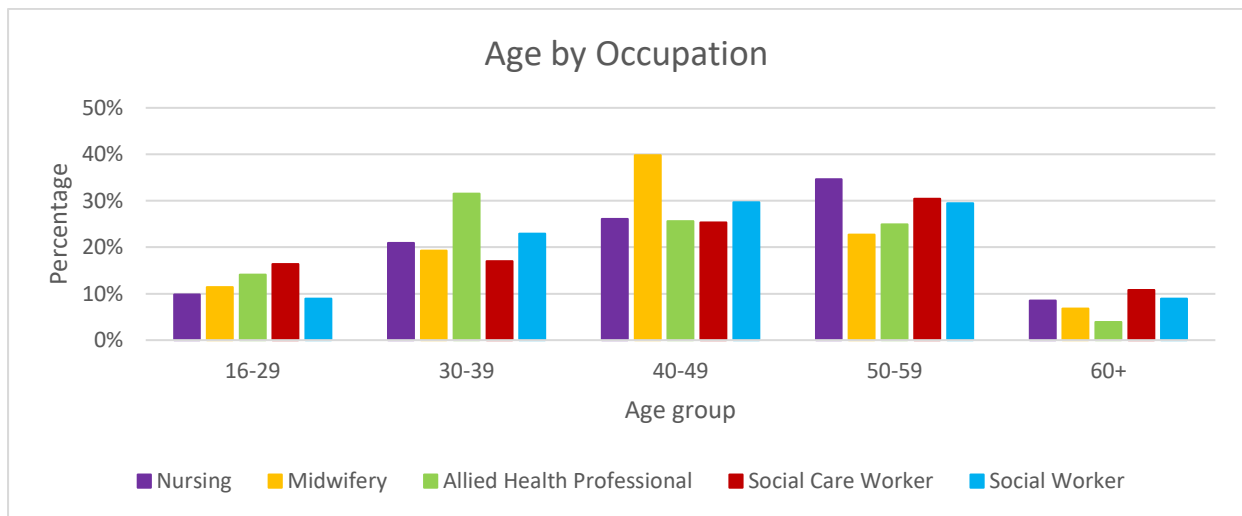


Table A2.10: Age of Respondents by Occupation (Weighted)

Occupation	Age group					Total
	16-29	30-39	40-49	50-59	60+	
Nursing	5.6%	18.7%	27.2%	43.7%	4.8%	100%
Midwifery	15.1%	18.3%	27.2%	31.4%	8.0%	100%
AHP	17.0%	39.6%	17.9%	21.7%	3.8%	100%
Social Care Worker	12.2%	14.2%	31.8%	29.3%	12.5%	100%
Social Worker	0.9%	32.6%	28.2%	30.1%	8.2%	100%

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

Occupation	Age group					Total
	16-29	30-39	40-49	50-59	60+	
Nursing	23 (9.8%)	49 (20.9%)	61 (26.1%)	81 (34.6%)	20 (8.5%)	234 (100%)
Midwifery	10 (11.4%)	17 (19.3%)	35 (39.8%)	20 (22.7%)	6 (6.8%)	88 (100%)
AHP	43 (14.1%)	96 (31.5%)	78 (25.6%)	76 (24.9%)	12 (3.9%)	305 (100%)
Social Care Worker	120 (16.4%)	124 (17.0%)	185 (25.3%)	222 (30.4%)	79 (10.8%)	730 (100%)
Social Worker	34 (8.9%)	87 (22.9%)	113 (29.7%)	112 (29.5%)	34 (8.9%)	380 (100%)

## A2.4 Ethnic Origin of Respondents

### Summary (Weighted results):

The vast majority of respondents were of white ethnic origin (90.7%). England was the most ethnically diverse country, with 6.3% of respondents identifying as not white. Midwives were the most ethnically diverse occupational group, with 12.9% identifying as not white.

### Summary (Unweighted results):

The vast majority of respondents were of white ethnic origin (97.2%). England was the most ethnically diverse country, with 8.3% of respondents identifying as not white. Midwives were the most ethnically diverse occupational group, with 6.8% identifying as not white.

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

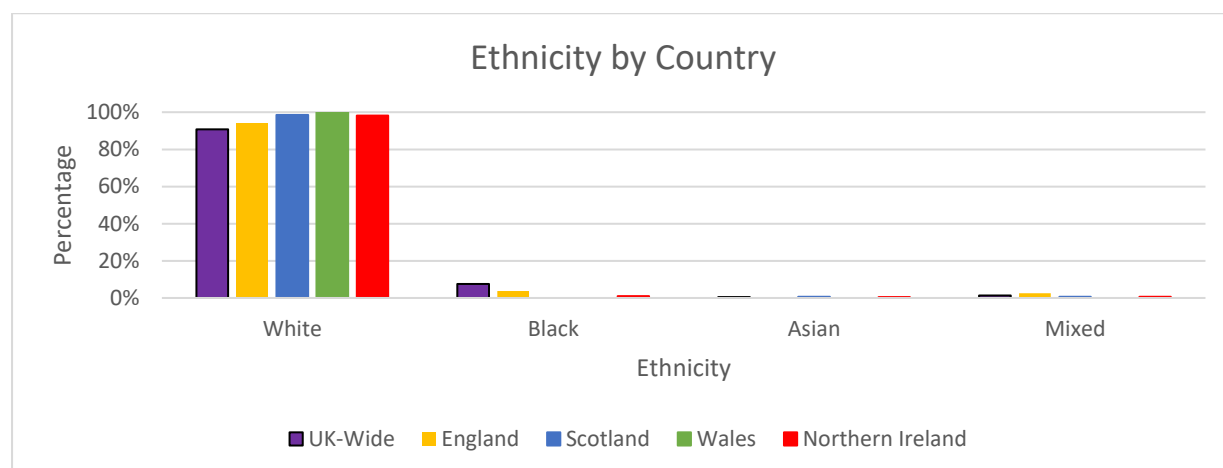


Figure A2.13: Ethnic Origin of Respondents by Country (Unweighted)

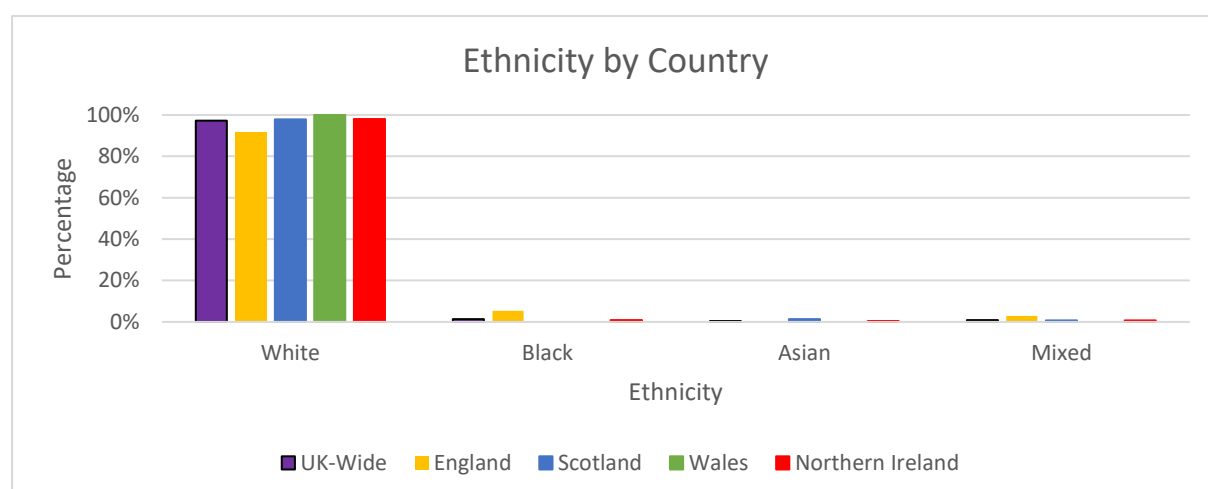


Table A2.12: Ethnic Origin of Respondents by Country (Weighted)

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	90.7%	93.7%	98.6%	100.0%	98.1%
Black	7.6%	3.7%	0.0%	0.0%	0.9%
Asian	0.4%	0.0%	0.7%	0.0%	0.4%
Mixed	1.3%	2.6%	0.7%	0.0%	0.6%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	1689 (97.3%)	188 (91.7%)	137 (97.8%)	96 (100.0%)	1268 (98.0%)
Black	23 (1.3%)	11 (5.4%)	0 (0.0%)	0 (0.0%)	12 (0.9%)
Asian	7 (0.4%)	0 (0.0%)	2 (1.4%)	0 (0.0%)	5 (0.4%)
Mixed	9 (0.9%)	6 (2.9%)	1 (0.7%)	0 (0.0%)	9 (0.7%)
<b>Total</b>	<b>1735 (100%)</b>	<b>205 (100%)</b>	<b>140 (100%)</b>	<b>96 (100%)</b>	<b>1294 (100%)</b>

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

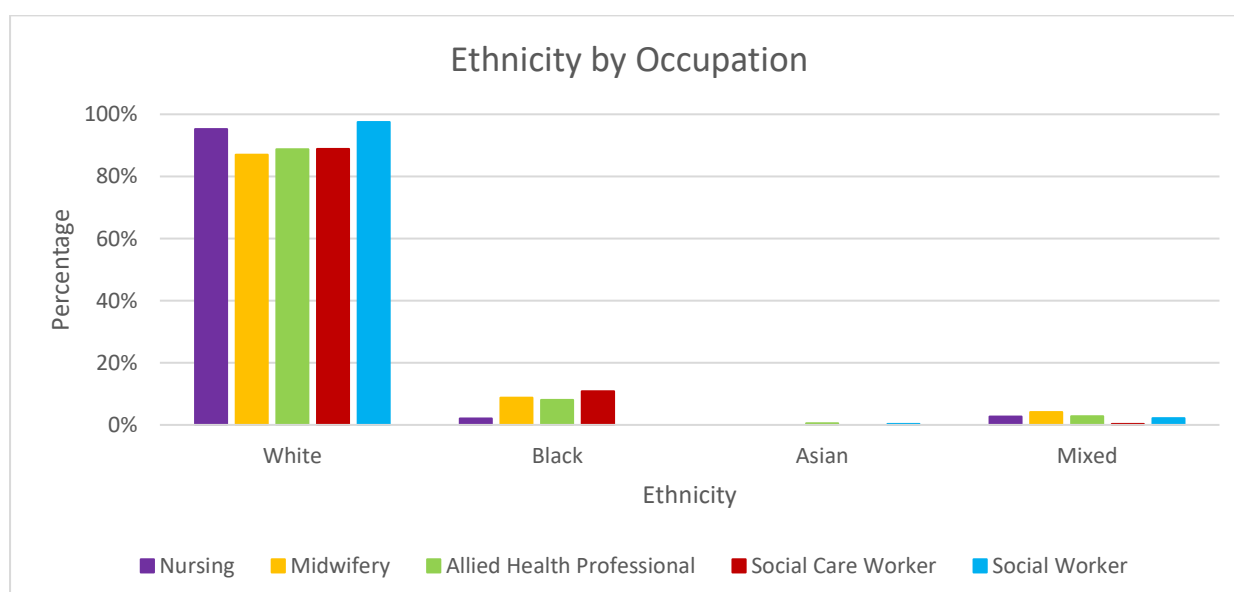


Figure A2.15: Ethnic Origin of Respondents by Occupation (Unweighted)

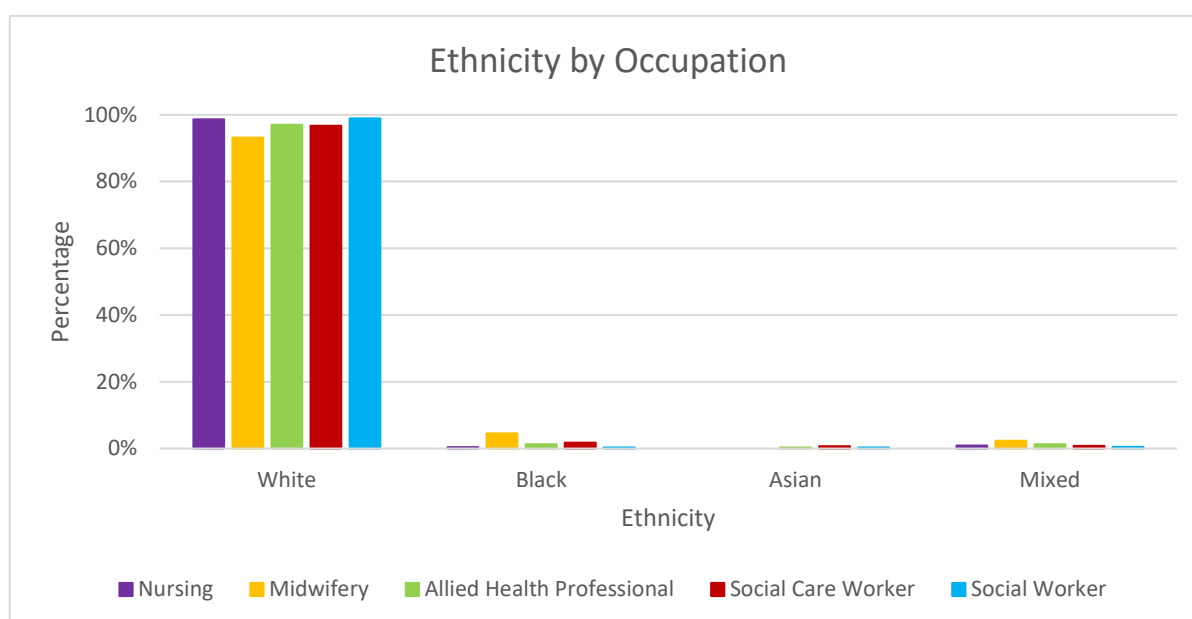


Table A2.14: Ethnic Origin of Respondents by Occupation (Weighted)

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	95.2%	2.1%	0.0%	2.7%	100%
Midwifery	87.0%	8.8%	0.0%	4.1%	100%
AHP	88.7%	8.0%	0.5%	2.8%	100%
Social Care Worker	88.9%	10.8%	0.0%	0.3%	100%
Social Worker	97.5%	0.0%	0.3%	2.2%	100%

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

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	231 (98.7%)	1 (0.4%)	0 (0.0%)	2 (0.9%)	234 (100%)
Midwifery	82 (93.2%)	4 (4.5%)	0 (0.0%)	2 (2.3%)	88 (100%)
AHP	295 (97.0%)	4 (1.3%)	1 (0.3%)	4 (1.3%)	304 (100%)
Social Care Worker	706 (96.7%)	13 (1.8%)	5 (0.7%)	6 (0.8%)	730 (100%)
Social Worker	375 (98.9%)	1 (0.3%)	1 (0.3%)	2 (0.5%)	379 (100%)

## A2.5 Respondents with a Disability

### Summary (Weighted results):

Scotland had the highest proportion of respondents with a disability (14.6%). Of the different professions, social workers were the most likely ones to report having a disability (29.3%).

### Summary (Unweighted results):

England had the highest proportion (18.7%) of respondents with a disability. Of the different professions, midwives (20.3%) were the most likely ones to report having a disability.

Figure A2.16: Disability by Country (Weighted)

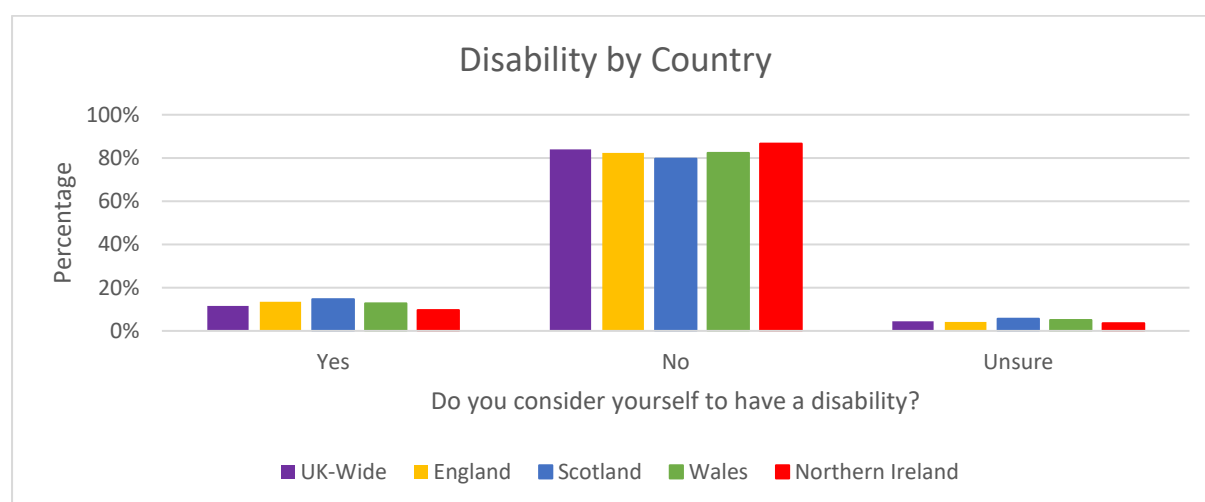


Figure A2.17: Disability by Country (Unweighted)

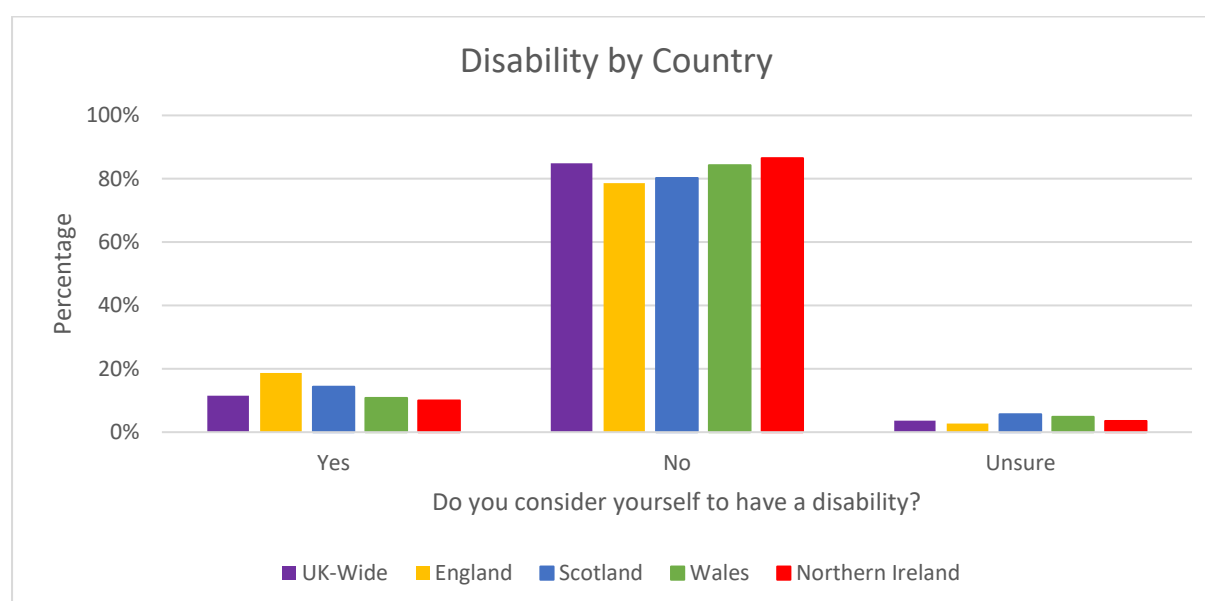


Table A2.16: Disability by Country (Weighted)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	11.6%	13.5%	14.6%	12.7%	9.7%
No	84.0%	82.3%	79.7%	82.3%	86.7%
Unsure	4.4%	4.2%	5.7%	5.1%	3.6%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2.17: Disability by Country (Unweighted)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	176 (11.5%)	34 (18.7%)	18 (14.3%)	9 (10.8%)	115 (10.0%)
No	1305 (84.9%)	143 (78.6%)	101 (80.2%)	70 (84.3%)	991 (86.5%)
Unsure	56 (3.6%)	5 (2.7%)	7 (5.6%)	4 (4.8%)	40 (3.5%)
<b>Total</b>	<b>1537 (100%)</b>	<b>182 (100%)</b>	<b>126 (100%)</b>	<b>83 (100%)</b>	<b>1146 (100%)</b>

Figure A2.18: Disability by Occupation (Weighted)

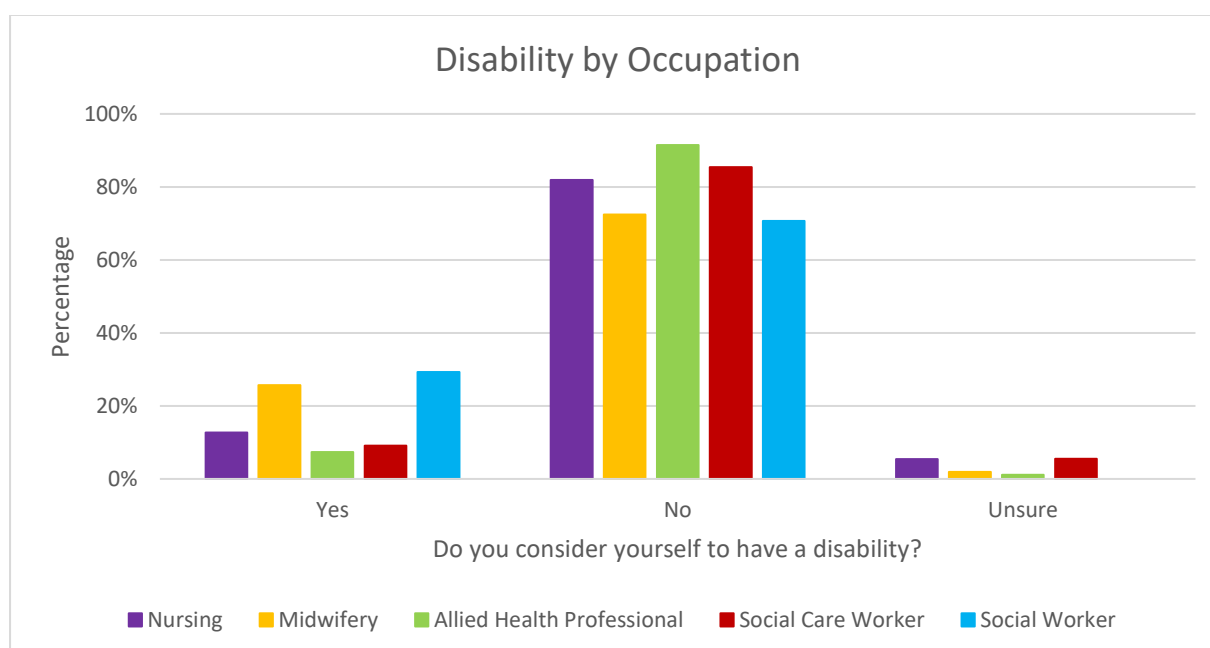


Figure A2.19: Disability by Occupation (Unweighted)

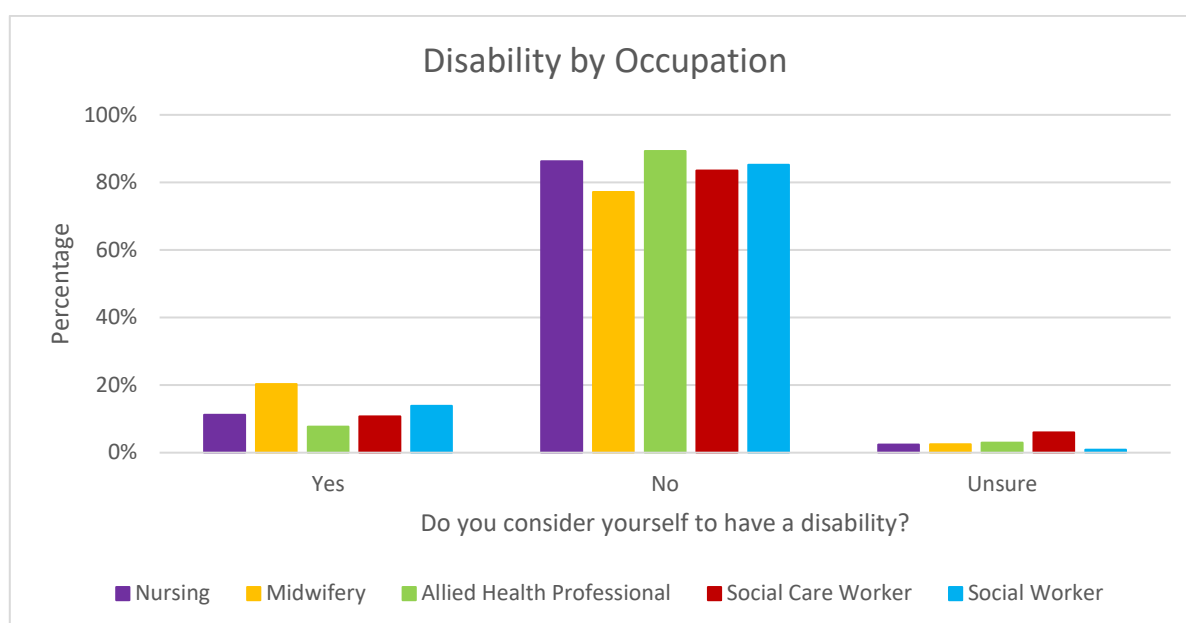


Table A2.18: Disability by Occupation (Weighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	12.7%	81.9%	5.4%	100%
Midwifery	25.7%	72.4%	1.9%	100%
AHP	7.4%	91.5%	1.1%	100%
Social Care Worker	9.1%	85.4%	5.5%	100%
Social Worker	29.3%	70.7%	0.0%	100%

Table A2.19: Disability by Occupation (Unweighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	23 (11.2%)	177 (86.3%)	5 (2.4%)	205 (100%)
Midwifery	16 (20.3%)	61 (77.2%)	2 (2.5%)	79 (100%)
AHP	21 (7.7%)	242 (89.3%)	8 (3.0%)	271 (100%)
Social Care Worker	68 (10.7%)	531 (83.5%)	38 (6.0%)	637 (100%)
Social Worker	48 (13.9%)	294 (85.2%)	3 (0.9%)	345 (100%)



## A2.6 Respondents' Relationship Status

### Summary (Weighted results):

Over half the respondents reported they were married (50.8%).

### Summary (Unweighted results):

Over half the respondents reported they were married (52.4%).

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

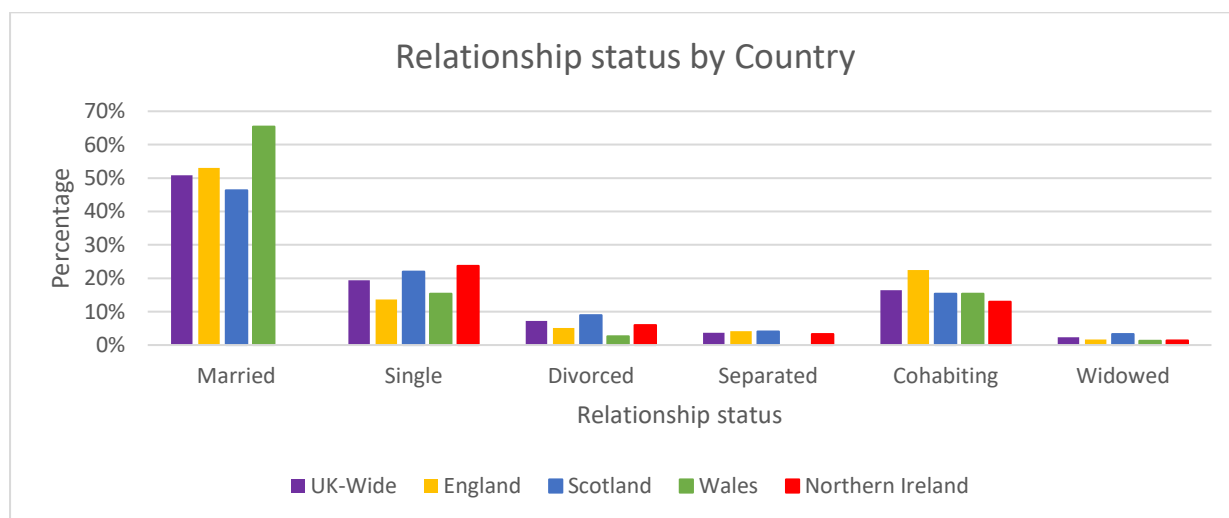


Figure A2.21: Relationship Status by Country (Unweighted)

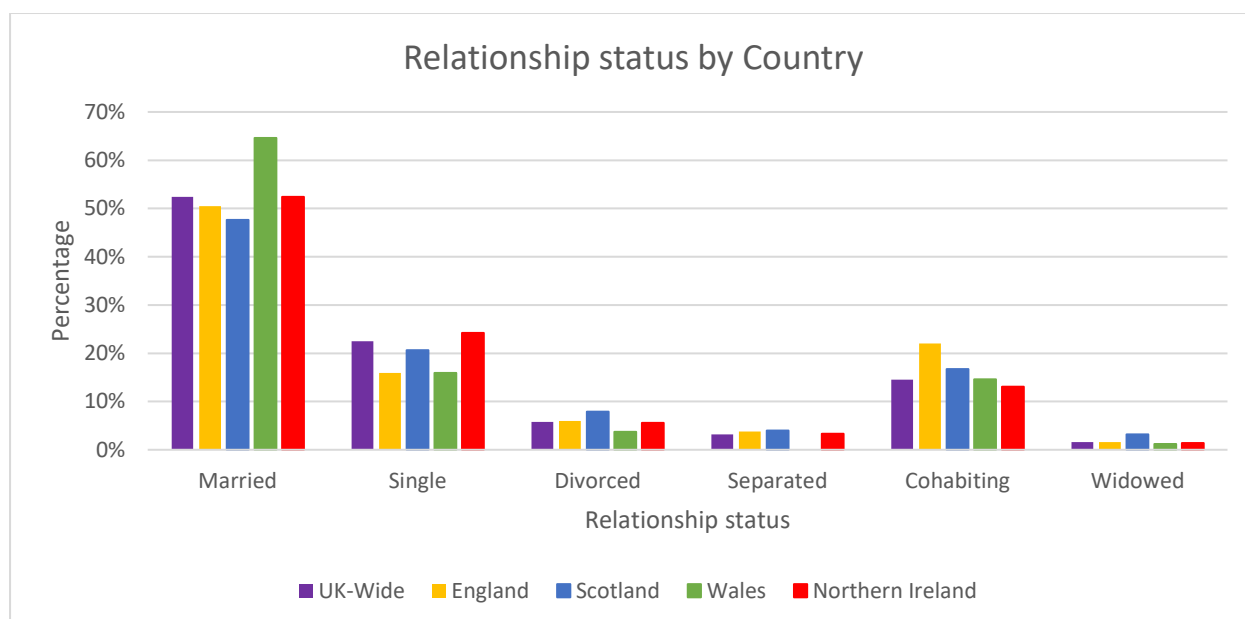


Table A2 20:: Relationship Status by Country (Weighted)

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	50.8%	53.0%	46.3%	65.4%	52.8%
Single	19.4%	13.6%	22.0%	15.4%	23.7%
Divorced	7.2%	5.1%	8.9%	2.6%	6.0%
Separated	3.7%	4.2%	4.1%	0.0%	3.3%
Cohabiting	16.4%	22.5%	15.4%	15.4%	13.0%
Widowed	2.3%	1.7%	3.3%	1.3%	1.4%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	800 (52.4%)	92 (50.5%)	60 (47.6%)	53 (64.6%)	595 (52.4%)
Single	343 (22.5%)	29 (15.9%)	26 (20.6%)	13 (15.9%)	275 (24.2%)
Divorced	88 (5.8%)	11 (6.0%)	10 (7.9%)	3 (3.7%)	64 (5.6%)
Separated	49 (3.2%)	7 (3.8%)	5 (4.0%)	0 (0.0%)	37 (3.3%)
Cohabiting	222 (14.5%)	40 (22.0%)	21 (16.7%)	12 (14.6%)	149 (13.1%)
Widowed	24 (1.6%)	3 (1.6%)	4 (3.2%)	1 (1.2%)	16 (1.4%)
<b>Total</b>	<b>1526 (100%)</b>	<b>182 (100%)</b>	<b>126 (100%)</b>	<b>82 (100%)</b>	<b>1136 (100%)</b>

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

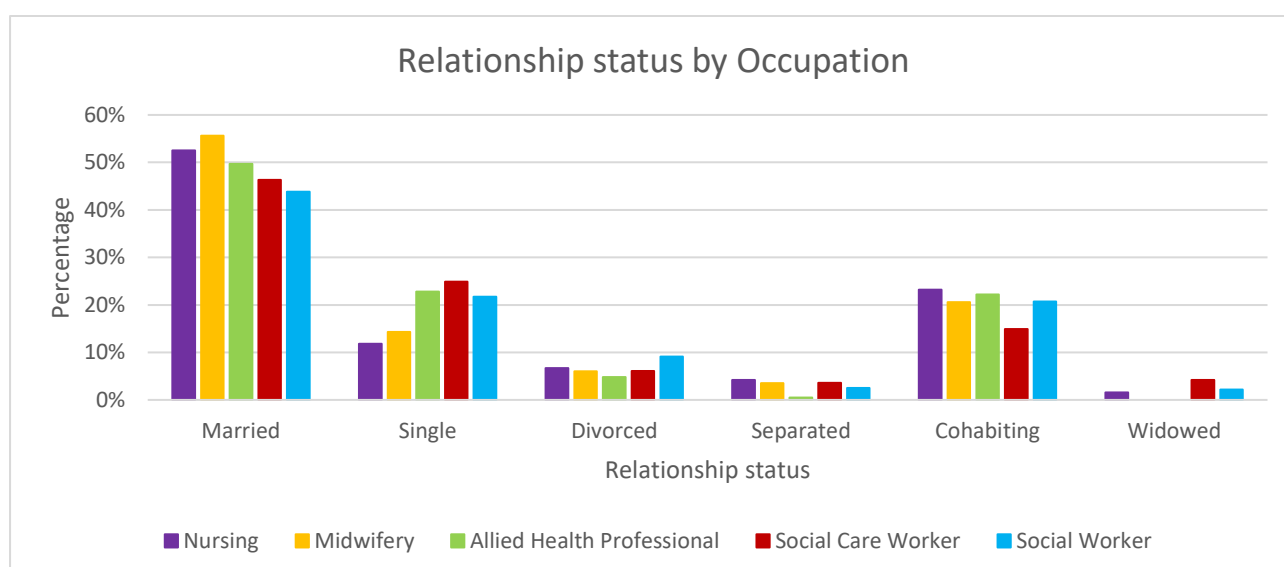


Figure A2.23: Relationship Status by Occupation (Unweighted)

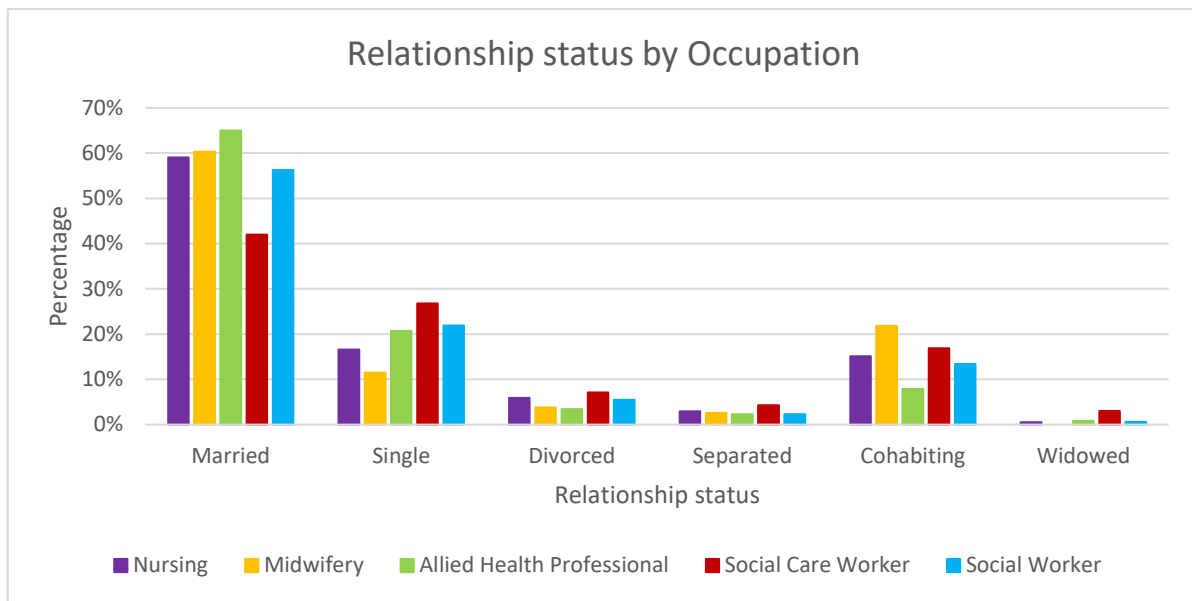


Table A2.22: Relationship Status by Occupation (Weighted)

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	52.5%	11.8%	6.7%	4.2%	23.2%	1.6%	100%
Midwifery	55.6%	14.3%	6.0%	3.5%	20.6%	0.0%	100%
AHP	49.7%	22.8%	4.8%	0.5%	22.2%	0.0%	100%
Social Care Worker	46.3%	24.9%	6.1%	3.6%	14.9%	4.2%	100%
Social Worker	43.8%	21.7%	9.1%	2.5%	20.7%	2.2%	100%

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

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	121 (59.0%)	34 (16.6%)	12 (5.9%)	6 (2.9%)	31 (15.1%)	1 (0.5%)	205 (100%)
Midwifery	47 (60.3%)	9 (11.5%)	3 (3.8%)	2 (2.6%)	17 (21.8%)	0 (0.0%)	78 (100%)
AHP	173 (65.0%)	55 (20.7%)	9 (3.4%)	6 (2.3%)	21 (7.9%)	2 (0.8%)	266 (100%)
Social Care Worker	266 (42.0%)	170 (26.8%)	45 (7.1%)	27 (4.3%)	107 (16.9%)	19 (3.0%)	634 (100%)
Social Worker	193 (56.3%)	75 (21.9%)	19 (5.5%)	8 (2.3%)	46 (13.4%)	2 (0.6%)	343 (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 while social care workers and social workers 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.

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

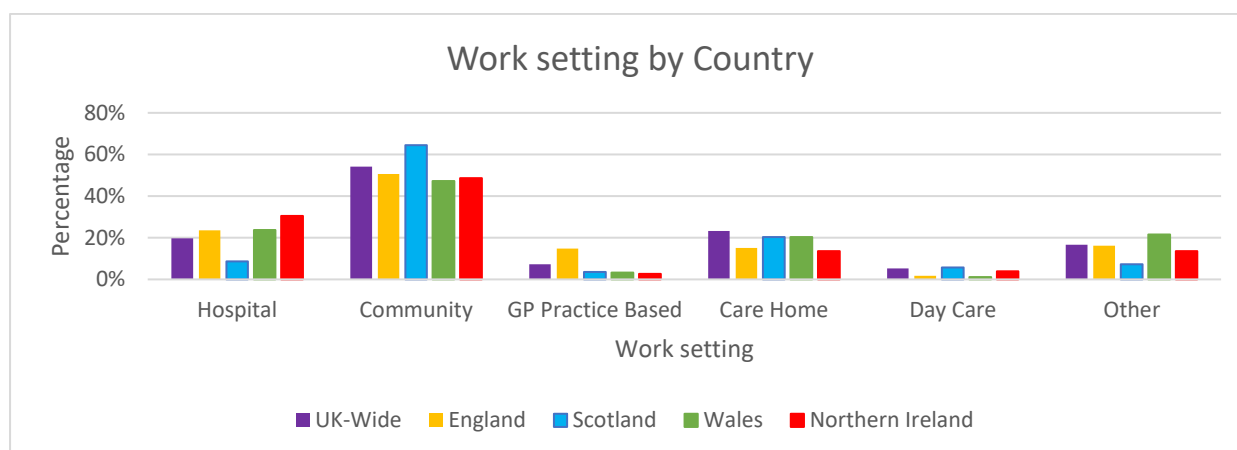


Figure A2.25: Work Setting by Country (Unweighted)

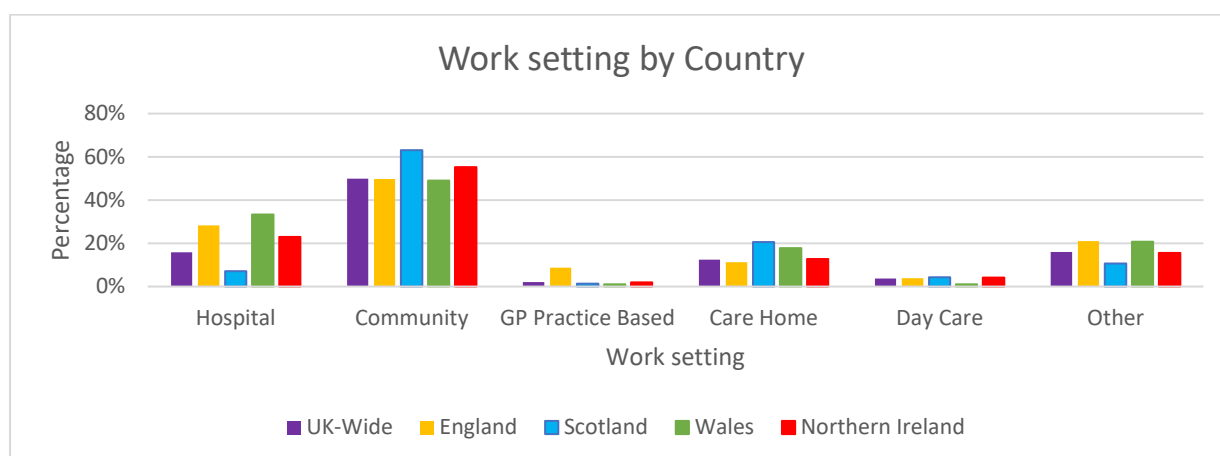


Table A2.24: Work Setting by Country (Weighted)

Work setting	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	19.7%	23.6%	8.7%	23.7%	30.5%
Community	54.1%	50.6%	64.5%	47.3%	48.6%
GP Practice	7.3%	14.8%	3.6%	3.3%	2.6%
Care Home	23.3%	15.1%	20.3%	20.4%	13.5%
Day Care	5.3%	1.8%	5.8%	1.1%	3.9%
Other	16.7%	16.2%	7.2%	21.5%	13.6%

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	275 (15.8%)	58 (28.3%)	10 (7.1%)	32 (33.3%)	297 (23.0%)
Community	867 (49.9%)	102 (49.8%)	89 (63.1%)	47 (49.0%)	716 (55.3%)
GP Practice	37 (2.1%)	18 (8.7%)	2 (1.4%)	1 (1.0%)	24 (1.9%)
Care Home	215 (12.4%)	23 (11.2%)	29 (20.6%)	17 (17.7%)	164 (12.7%)
Day Care	64 (3.7%)	8 (3.9%)	6 (4.3%)	1 (1.0%)	53 (4.1%)
Other	278 (16.0%)	43 (21.0%)	15 (10.6%)	20 (20.8%)	200 (15.5%)
<b>No. of respondents who answered the question</b>	<b>1736</b>	<b>205</b>	<b>141</b>	<b>96</b>	<b>1294</b>

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)

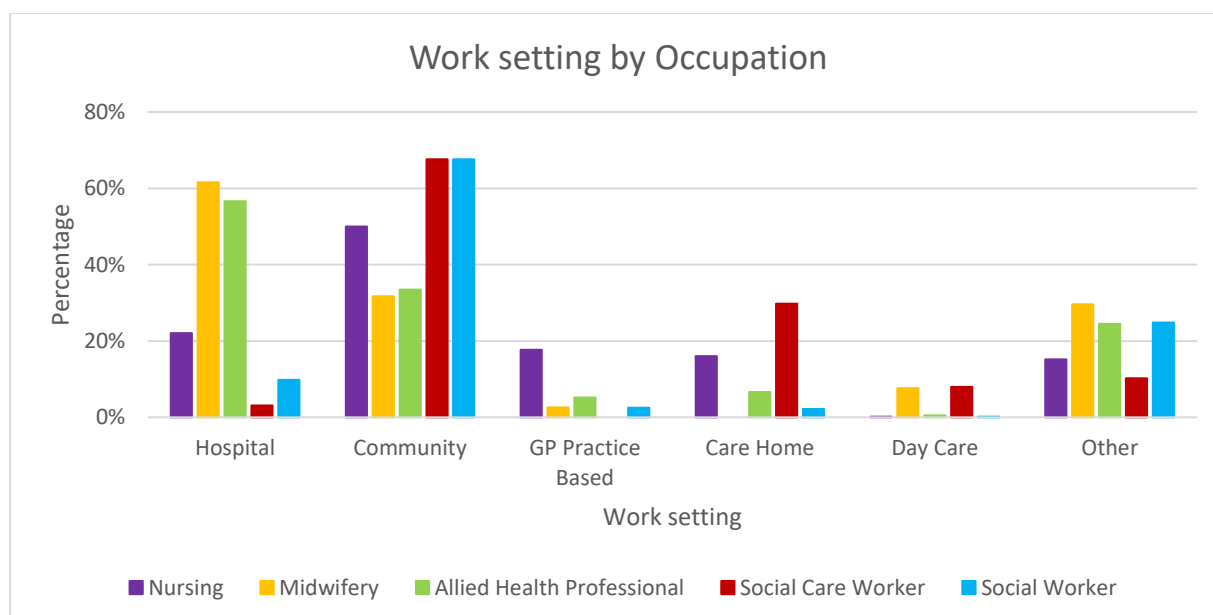


Figure A2.27: Work Setting by Occupation (Unweighted)

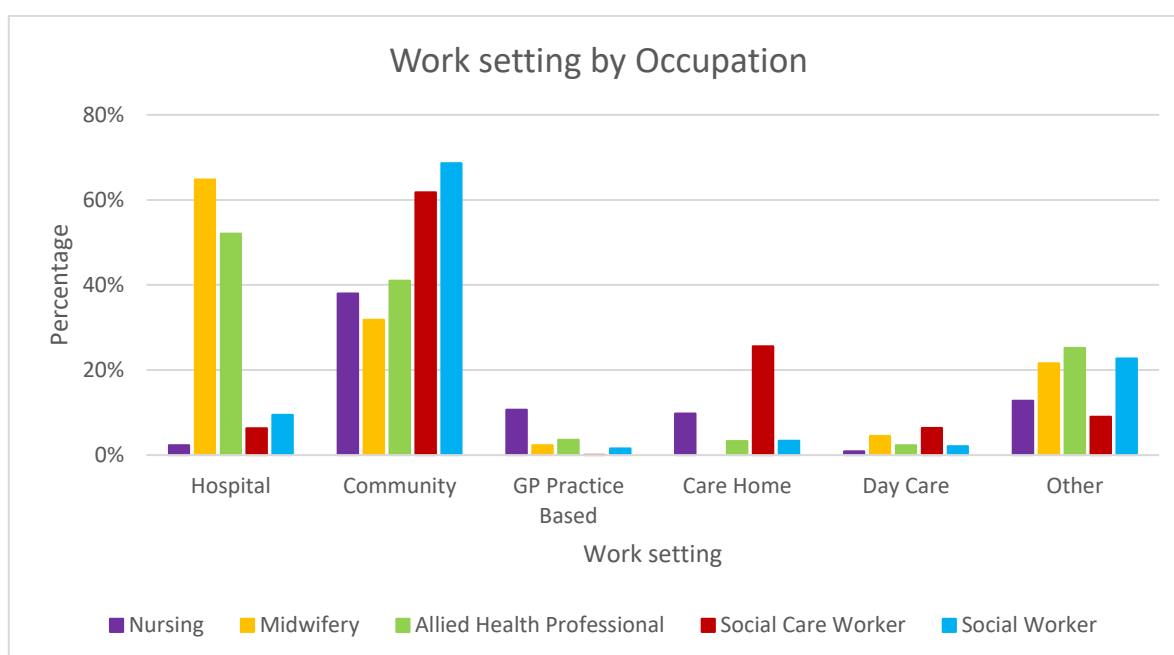


Table A2.26: Work Setting by Occupation (Weighted)

Occupation	Work setting					
	Hospital	Community	GP Practice	Care Home	Day Care	Other
Nursing	22.1%	50.0%	17.7%	16.0%	0.2%	15.2%
Midwifery	61.6%	31.7%	2.6%	0.0%	7.6%	29.6%
AHP	56.6%	33.5%	5.2%	6.6%	0.5%	24.5%
Social Care Worker	3.1%	67.6%	0.0%	29.8%	8.0%	10.2%
Social Worker	9.8%	67.6%	2.5%	2.2%	0.2%	24.8%

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	Care Home	Day Care	Other	
Nursing	99 (2.3%)	89 (38.0%)	25 (10.7%)	23 (9.8%)	2 (0.9%)	23 (12.8%)	234
Midwifery	57 (64.8%)	28 (31.8%)	2 (2.3%)	0 (0.0%)	4 (4.5%)	19 (21.6%)	88
AHP	159 (52.1%)	125 (41.0%)	11 (3.6%)	10 (3.3%)	7 (2.3%)	77 (25.2%)	305
Social Care Worker	46 (6.3%)	452 (61.8%)	1 (0.1%)	187 (25.6%)	47 (6.4%)	66 (9.0%)	731
Social Worker	36 (9.5%)	260 (68.6%)	6 (1.6%)	13 (3.4%)	8 (2.1%)	86 (22.7%)	379

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, 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.

### 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)

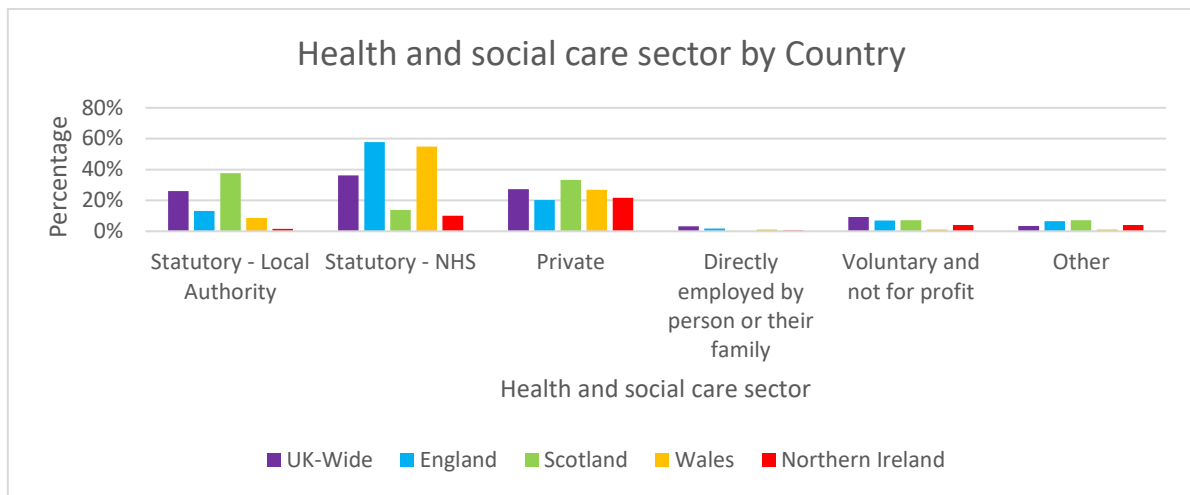


Figure A2.29: Health and Social Care Sector of Respondents by Country (Unweighted)

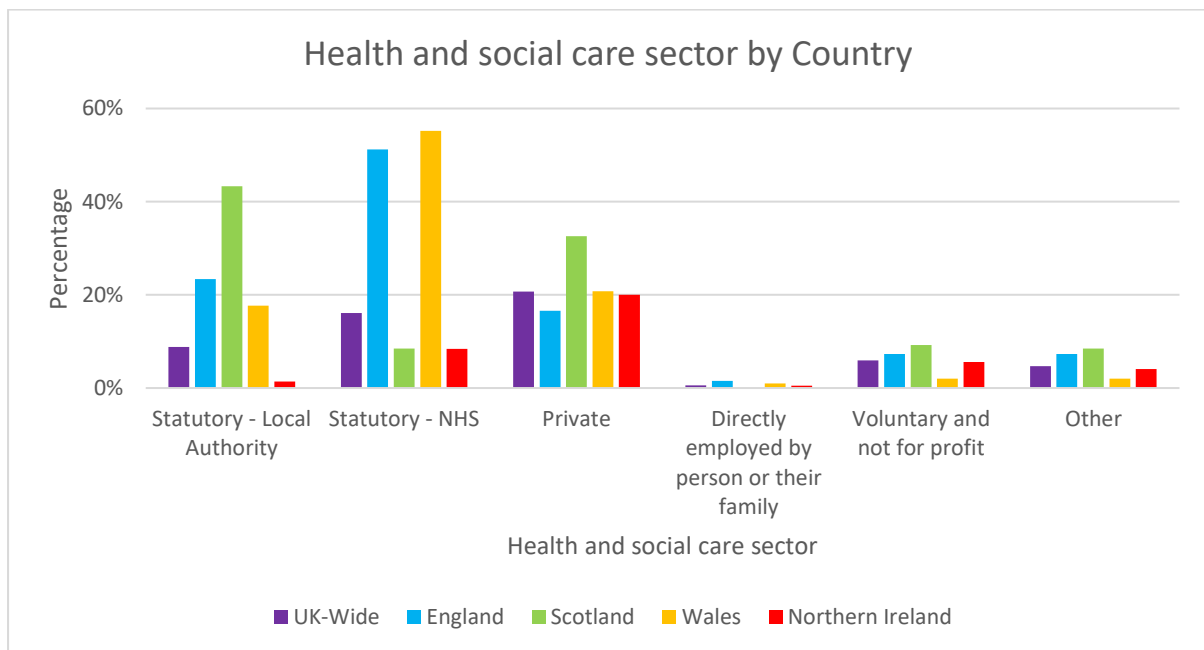


Table A2.28: Health and Social Care Sector of Respondents by Country (Weighted)

Health and social care sector	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Statutory – HSC Trust	2.8%	0.4%	2.8%	1.1%	63.3%
Statutory – Local Authority	26.1%	13.3%	37.7%	8.6%	1.5%
Statutory – NHS	36.3%	57.9%	13.8%	54.8%	10.0%
Private	27.4%	20.3%	33.3%	26.9%	21.7%
Directly employed by person or their family	3.2%	1.8%	0.0%	1.1%	0.5%
Voluntary and not for profit	9.3%	7.0%	7.2%	1.1%	4.0%
Other	3.5%	6.6%	7.2%	1.1%	4.0%

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 – HSC Trust	43 (48.6%)	2 (1.0%)	4 (2.8%)	2 (2.0%)	835 (64.6%)
Statutory – Local Authority	153 (8.8%)	48 (23.4%)	61 (43.3%)	17 (17.7%)	17 (1.4%)
Statutory – NHS	279 (16.1%)	105 (51.2%)	12 (8.5%)	53 (55.2%)	109 (8.4%)
Private	359 (20.7%)	34 (16.6%)	46 (32.6%)	20 (20.8%)	259 (20.0%)
Directly employed by person or their family	10 (0.6%)	3 (1.5%)	0 (0.0%)	1 (1.0%)	6 (0.5%)
Voluntary and not for profit	103 (5.9%)	15 (7.3%)	13 (9.2%)	2 (2.0%)	73 (5.6%)
Other	82 (4.7%)	15 (7.3%)	12 (8.5%)	2 (2.0%)	53 (4.1%)
No. of respondents who answered the question	1734	205	141	96	1292

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)

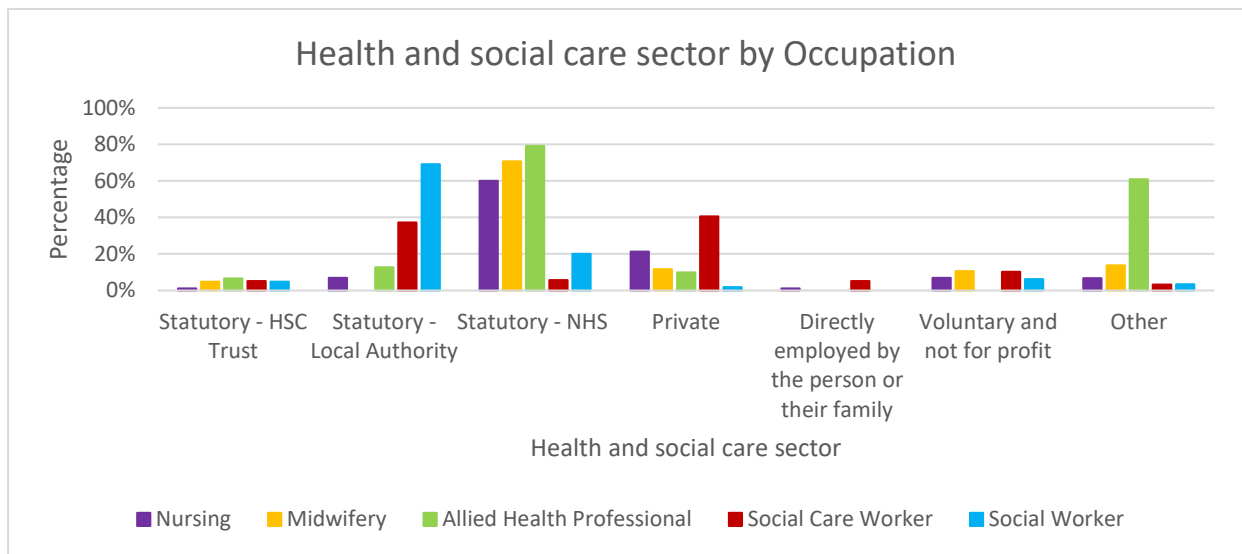


Figure A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)

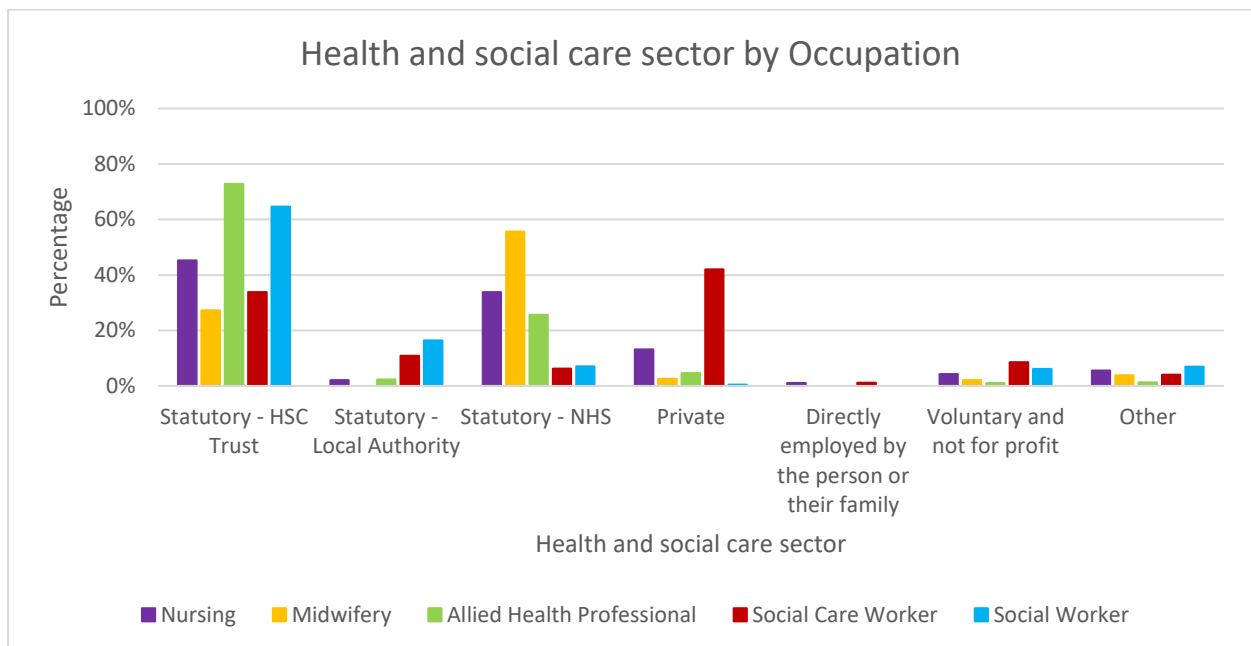


Table A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)

Occupation	Health and social care sector						
	Statutory – HSC Trust	Statutory – Local Authority	Statutory – NHS	Private	Directly employed by the person or their family	Voluntary and not for profit	Other
Nursing	1.2%	6.9%	60.0%	21.3%	1.2%	6.9%	6.7%
Midwifery	4.9%	0.0%	70.7%	11.6%	0.0%	10.6%	13.7%
AHP	6.6%	12.7%	79.2%	9.9%	0.0%	0.0%	61.0%
Social Care Worker	5.2%	37.3%	5.8%	40.6%	5.2%	10.2%	3.3%
Social Worker	4.8%	69.2%	20.0%	1.9%	0.0%	6.3%	3.5%

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)

Occupation	Health and social care sector							No. of respondents who answered the question
	Statutory – HSC Trust	Statutory – Local Authority	Statutory – NHS	Private	Directly employed by the person or their family	Voluntary and not for profit	Other	
Nursing	106 (45.3%)	5 (2.1%)	79 (33.8%)	31 (13.2%)	1 (1.0%)	10 (4.3%)	13 (5.6%)	234
Midwifery	24 (27.3%)	0 (0.0%)	49 (55.7%)	6 (2.6%)	0 (0.0%)	5 (2.1%)	9 (3.8%)	88
AHP	222 (72.8%)	7 (2.3%)	78 (25.6%)	14 (4.6%)	0 (0.0%)	3 (1.0%)	4 (1.3%)	305
Social Care Worker	246 (33.8%)	79 (10.9%)	46 (6.3%)	306 (42.0%)	9 (1.2%)	62 (8.5%)	30 (4.1%)	728
Social Worker	245 (64.6%)	62 (16.4%)	27 (7.1%)	2 (0.5%)	0 (0.0%)	23 (6.1%)	26 (6.9%)	379

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):

Half of respondents were not line managers.

### Summary (Unweighted results):

Over two thirds of respondents were not line managers.

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

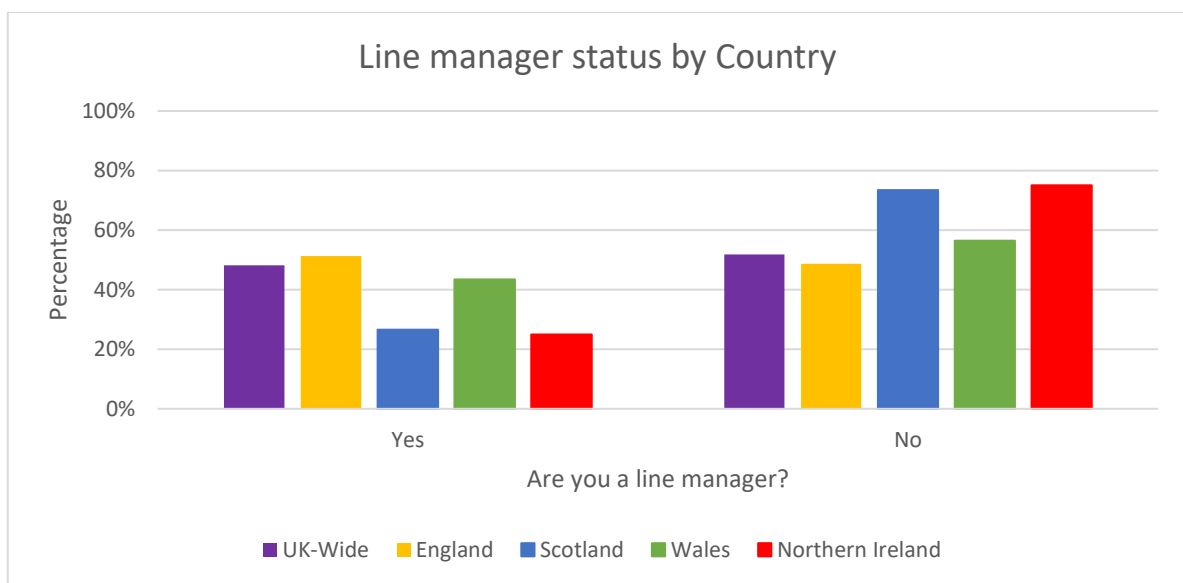


Figure A2.33: Line Manager Status of Respondents by Country (Unweighted)

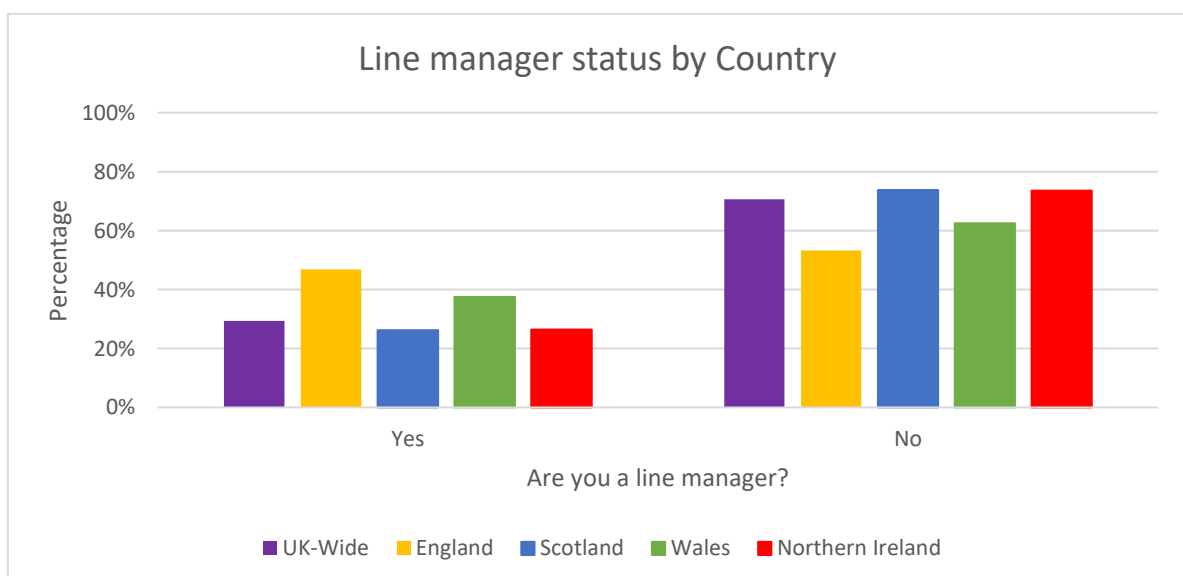


Table A2.32: Line Manager Status of Respondents by Country (Weighted)

Are you a line manager?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	48.2%	51.3%	26.6%	43.5%	25.0%
No	51.8%	48.7%	73.4%	56.5%	75.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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	511 (29.4%)	96 (46.8%)	37 (26.2%)	36 (37.5%)	342 (26.4%)
No	1226 (70.6%)	109 (53.2%)	104 (73.8%)	60 (62.5%)	953 (73.6%)
<b>Total</b>	<b>1737 (100%)</b>	<b>205 (100%)</b>	<b>141 (100%)</b>	<b>96 (100%)</b>	<b>1295 (100%)</b>

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

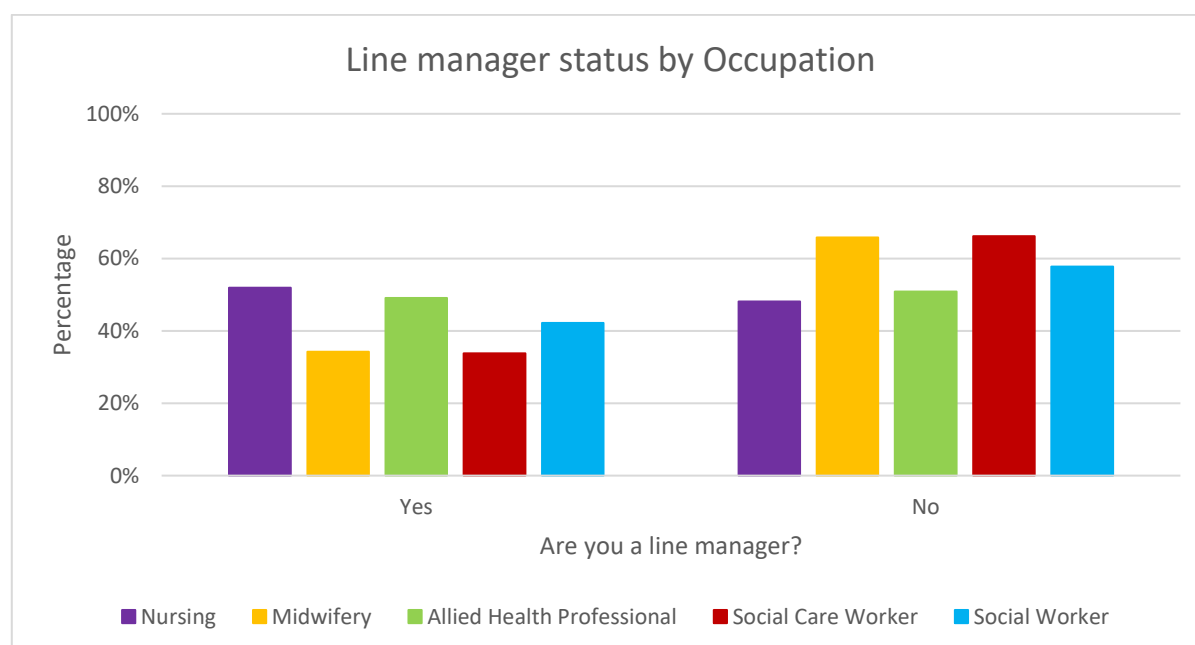


Figure A2.35: Line Manager Status of Respondents by Occupation (Unweighted)

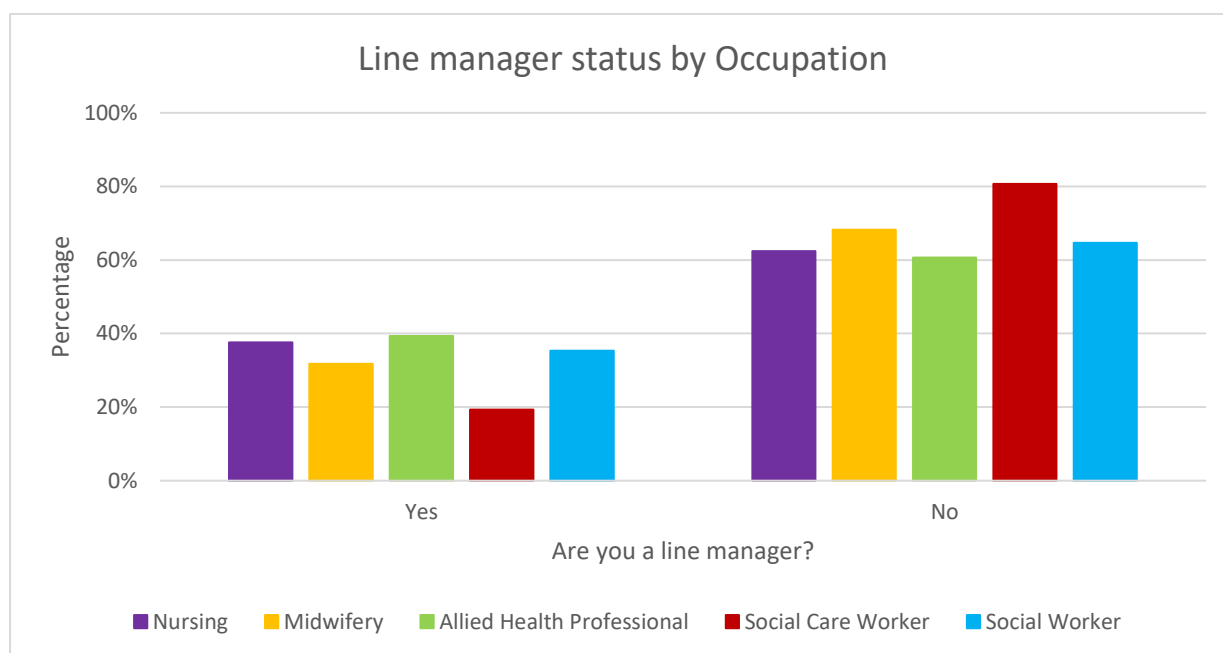


Table A2.34: Line Manager Status of Respondents by Occupation (Weighted)

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	51.9%	48.1%	100%
Midwifery	34.2%	65.8%	100%
AHP	49.1%	50.9%	100%
Social Care Worker	33.8%	66.2%	100%
Social Worker	42.2%	57.8%	100%

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

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	88 (37.6%)	146 (62.4%)	234 (100%)
Midwifery	28 (31.8%)	60 (68.2%)	88 (100%)
AHP	120 (39.3%)	185 (60.7%)	305 (100%)
Social Care Worker	141 (19.3%)	589 (80.7%)	730 (100%)
Social Worker	134 (35.3%)	246 (64.7%)	380 (100%)



## A2.10 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. 36: Job Tenure by Country (Weighted)

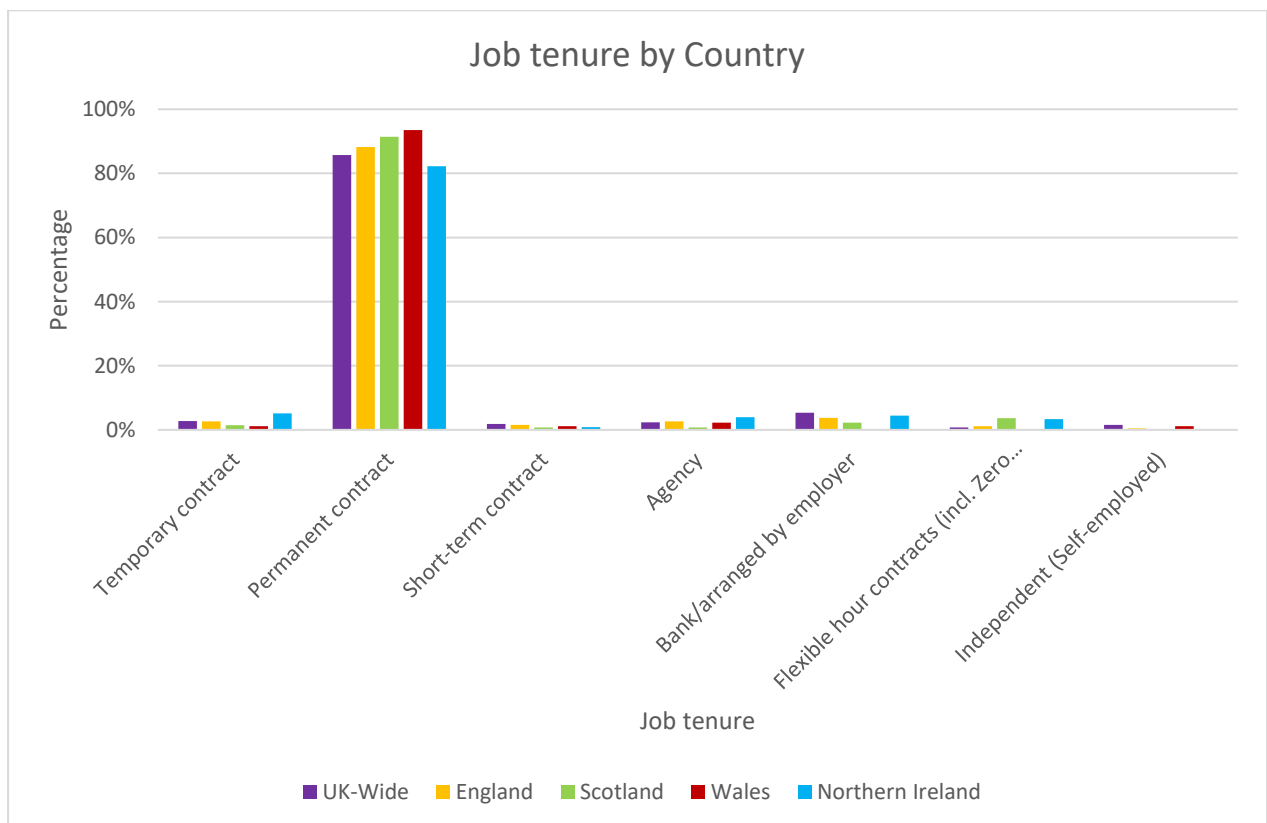


Figure A2. 37: Job Tenure by Country (Unweighted)

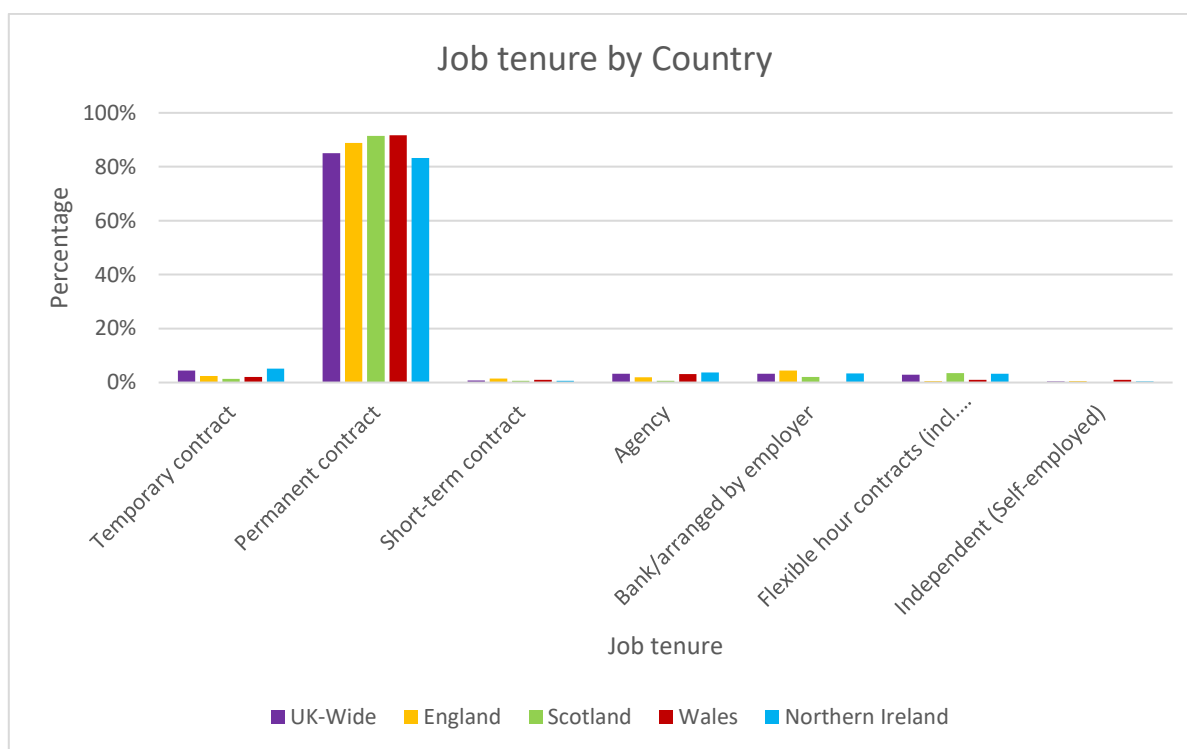


Table A2. 36: Job Tenure by Country (Weighted)

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary	2.7%	2.6%	1.4%	1.1%	5.1%
Permanent	85.7%	88.2%	91.4%	93.5%	82.2%
Agency	1.8%	1.5%	0.7%	1.1%	0.8%
Bank	2.3%	2.6%	0.7%	2.2%	3.9%
Independent (Self-employed)	5.3%	3.7%	2.2%	0.0%	4.4%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 37: Job Tenure by Country (Unweighted)

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary contract	76 (4.4%)	5 (2.4%)	2 (1.4%)	2 (2.1%)	67 (5.2%)
Permanent contract	1477 (85.1%)	182 (88.8%)	129 (91.5%)	88 (91.7%)	1078 (83.3%)
Short-term contract	14 (0.8%)	3 (1.5%)	1 (0.7%)	1 (1.0%)	9 (0.7%)
Agency	56 (3.2%)	4 (2.0%)	1 (0.7%)	3 (3.1%)	48 (3.7%)
Bank/arranged by employer	56 (3.2%)	9 (4.4%)	3 (2.1%)	0 (0.0%)	44 (3.4%)
Flexible hour contracts (incl. Zero hour contracts)	50 (2.9%)	1 (0.5%)	5 (3.5%)	1 (1.0%)	43 (3.3%)
Independent (Self-employed)	7 (0.4%)	1 (0.5%)	0 (0.0%)	1 (1.0%)	5 (0.4%)
<b>Total</b>	<b>1736 (100%)</b>	<b>373 (100%)</b>	<b>491 (100%)</b>	<b>95 (100%)</b>	<b>791 (100%)</b>

Figure A2. 38: Job Tenure by Occupation (Weighted)

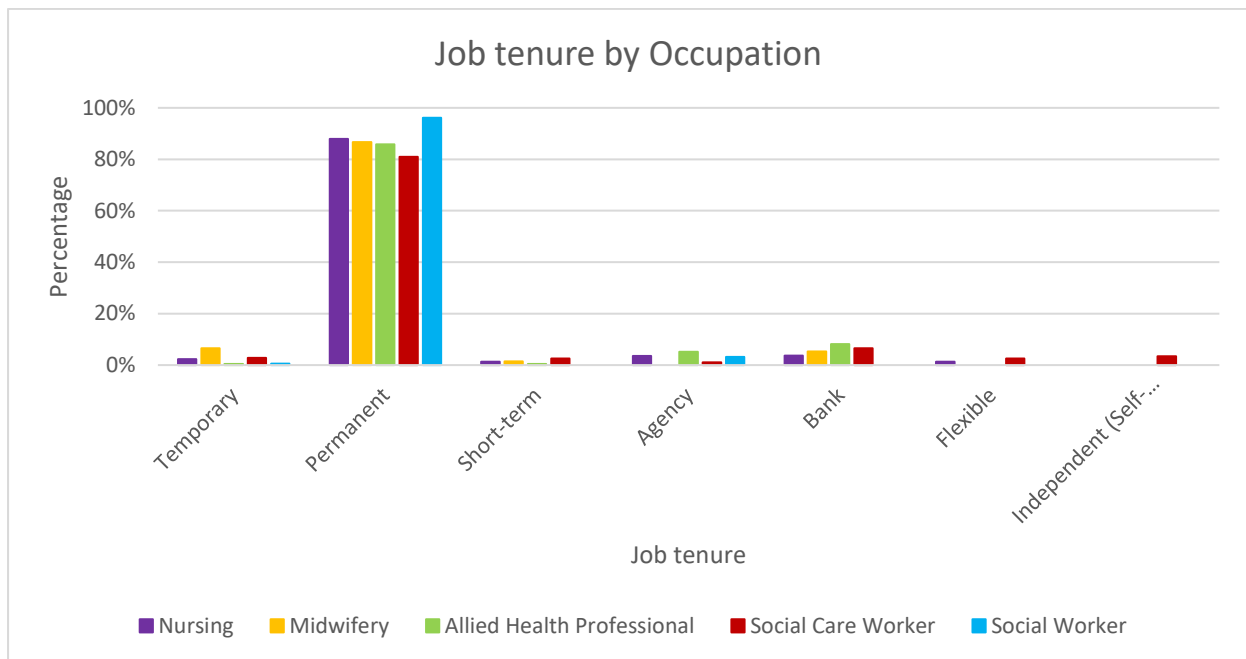


Figure A2. 39: Job Tenure by Occupation (Unweighted)

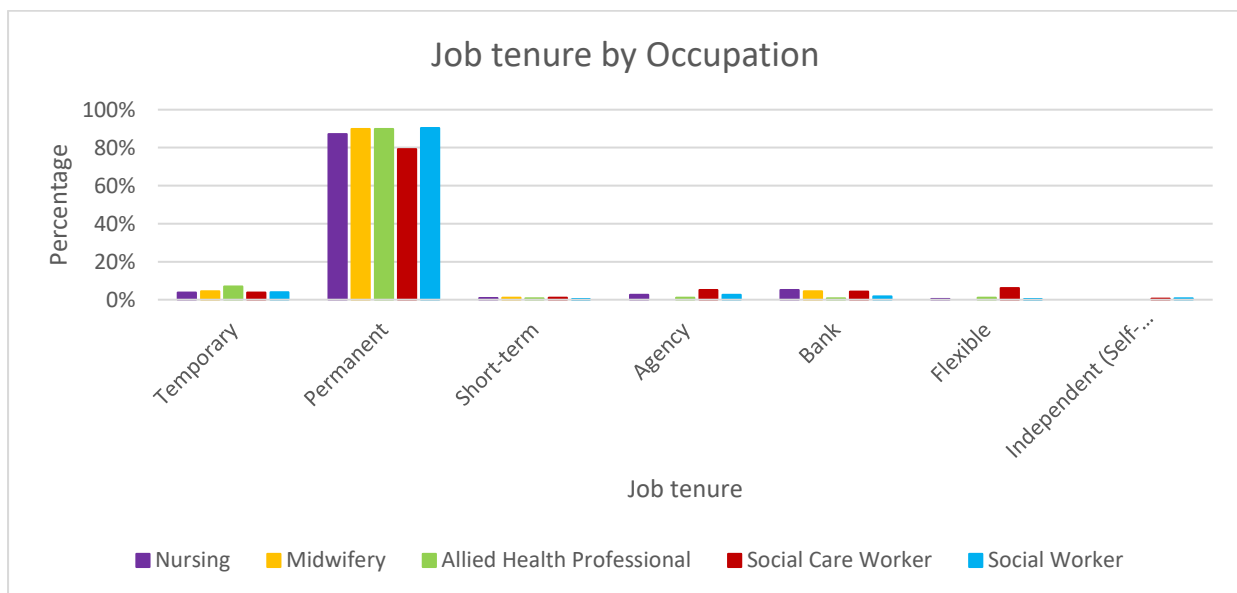


Table A2. 38: Job Tenure by Occupation (Weighted)

Occupation	Job tenure							Total
	Temporary contract	Permanent contract	Short-term contract	Agency	Bank/arranged by employer	Flexible hour contracts (incl. Zero hour contracts)	Independent (Self-employed)	
Nursing	2.3%	87.9%	1.3%	3.5%	3.7%	1.3%	0.0%	100%
Midwifery	6.5%	86.7%	1.5%	0.0%	5.3%	0.0%	0.0%	100%
AHP	0.5%	85.8%	0.5%	5.2%	8.1%	0.0%	0.0%	100%
Social Care Worker	2.8%	81.0%	2.6%	1.1%	6.5%	2.6%	3.4%	100%
Social Worker	0.6%	96.2%	0.0%	3.2%	0.0%	0.0%	0.0%	100%

Table A2. 39: Job Tenure by Occupation (Unweighted)

Occupation	Job tenure							Total
	Temporary contract	Permanent contract	Short-term contract	Agency	Bank/arranged by employer	Flexible hour contracts (incl. Zero hour contracts)	Independent (Self-employed)	
Nursing	9 (3.8%)	204 (87.2%)	2 (0.9%)	6 (2.6%)	12 (5.1%)	1 (0.4%)	0 (0.0%)	234 (100%)
Midwifery	4 (4.5%)	79 (89.8%)	1 (1.1%)	0 (0.0%)	4 (4.5%)	0 (0.0%)	0 (0.0%)	88 (100%)
AHP	21 (6.9%)	273 (89.8%)	2 (0.7%)	3 (1.0%)	2 (0.7%)	3 (1.0%)	0 (0.0%)	304 (100%)
Social Care Worker	27 (3.7%)	578 (79.2%)	8 (1.1%)	37 (5.1%)	31 (4.2%)	45 (6.2%)	4 (0.5%)	730 (100%)
Social Worker	15 (3.9%)	343 (90.3%)	1 (0.3%)	10 (2.6%)	7 (1.8%)	1 (0.3%)	3 (0.8%)	380 (100%)

## A2.17 Respondents Employed Full- or Part-Time

### Summary (Weighted results):

The majority of respondents were employed full-time. England 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 (73.4%). Scotland had the highest proportion of respondents (31.9%) employed on a part-time basis. Social workers had the highest proportion employed full-time, whereas midwives had the highest proportion employed part-time.

Figure A2. 40: Employed Full- or Part-Time by Country (Weighted)

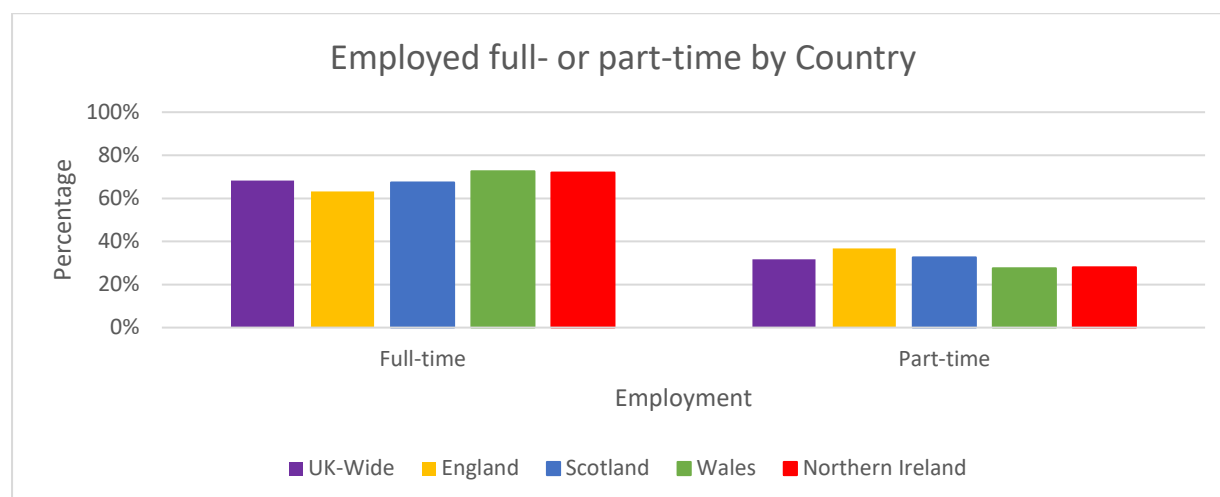


Figure A2. 41: Employed Full- or Part-Time by Country (Unweighted)

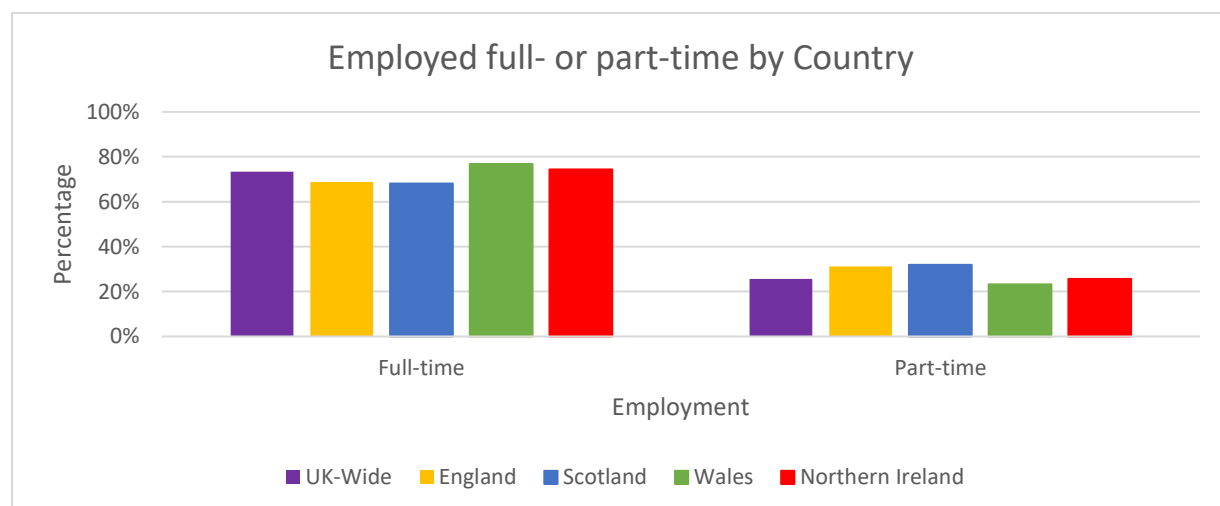


Table A2. 40: Employed Full- or Part-Time by Country (Weighted)

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	68.3%	63.2%	67.4%	72.5%	72.0%
Part-time	31.7%	36.8%	32.6%	27.5%	28.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 41: Employed Full- or Part-Time by Country (Unweighted)

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	964 (73.4%)	141 (68.8%)	96 (68.1%)	73 (76.8%)	964 (74.4%)
Part-time	231 (25.6%)	64 (31.2%)	45 (31.9%)	22 (23.2%)	331 (25.6%)
<b>Total</b>	<b>1736 (100%)</b>	<b>205 (100%)</b>	<b>141 (100%)</b>	<b>95 (100%)</b>	<b>1295 (100%)</b>

Figure A2. 42: Employed Full- or Part-Time by Occupation (Weighted)

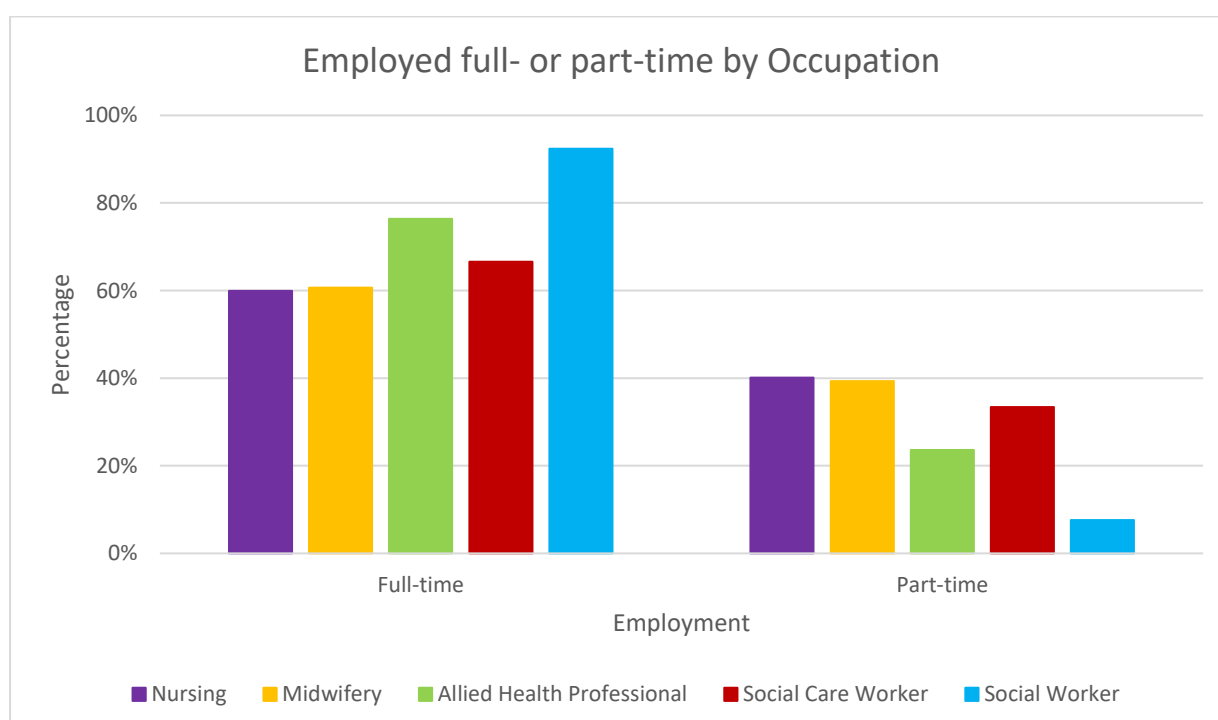


Figure A2. 43: Employed Full- or Part-Time by Occupation (Unweighted)

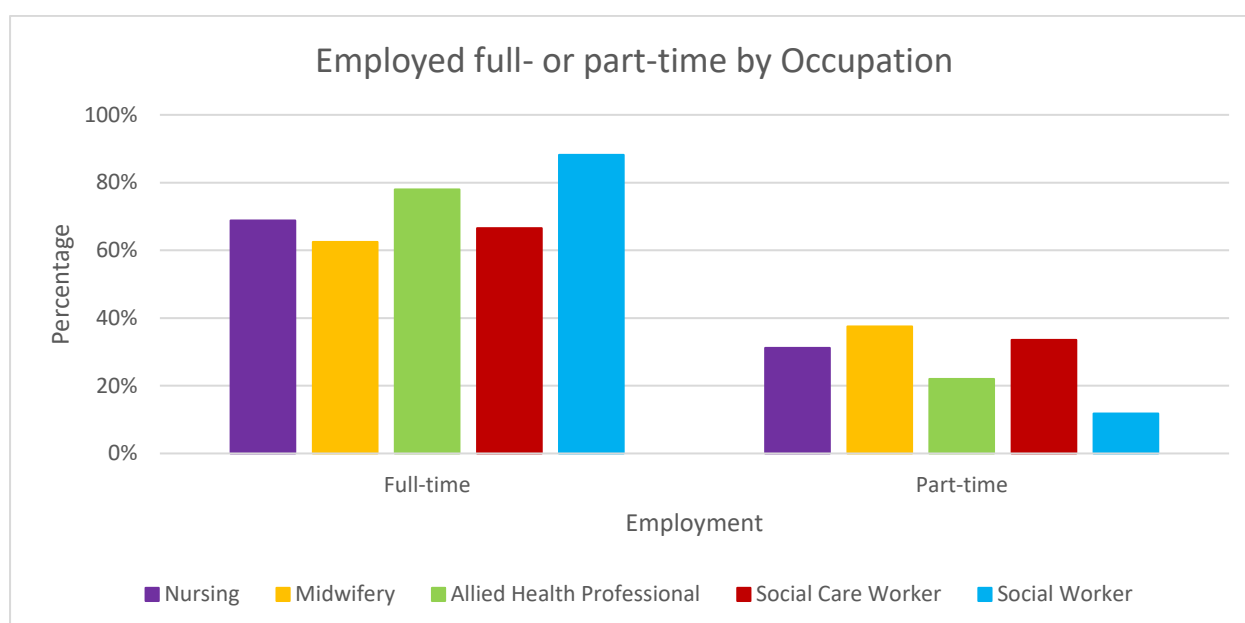


Table A2. 42: Employed Full- or Part-Time by Occupation (Weighted)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	59.9%	40.1%	100%
Midwifery	60.7%	39.3%	100%
AHP	76.4%	23.6%	100%
Social Care Worker	66.6%	33.4%	100%
Social Worker	92.4%	7.6%	100%

Table A2.43: Employed Full- or Part-Time by Occupation (Unweighted)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	161 (68.8%)	73 (31.2%)	234 (100%)
Midwifery	55 (62.5%)	33 (37.5%)	88 (100%)
AHP	238 (78.0%)	67 (22.0%)	305 (100%)
Social Care Worker	485 (66.5%)	244 (33.5%)	729 (100%)
Social Worker	335 (88.2%)	45 (11.8%)	380 (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. 44: Number of Hours Worked per Week by Country (Weighted)

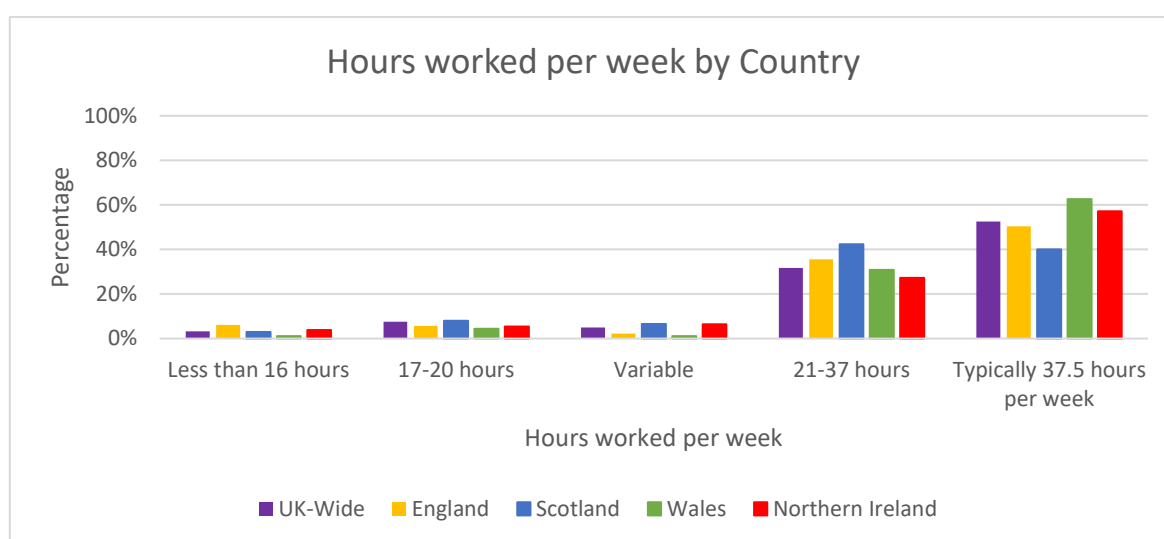


Figure A2. 45: Number of Hours Worked per Week by Country (Unweighted)

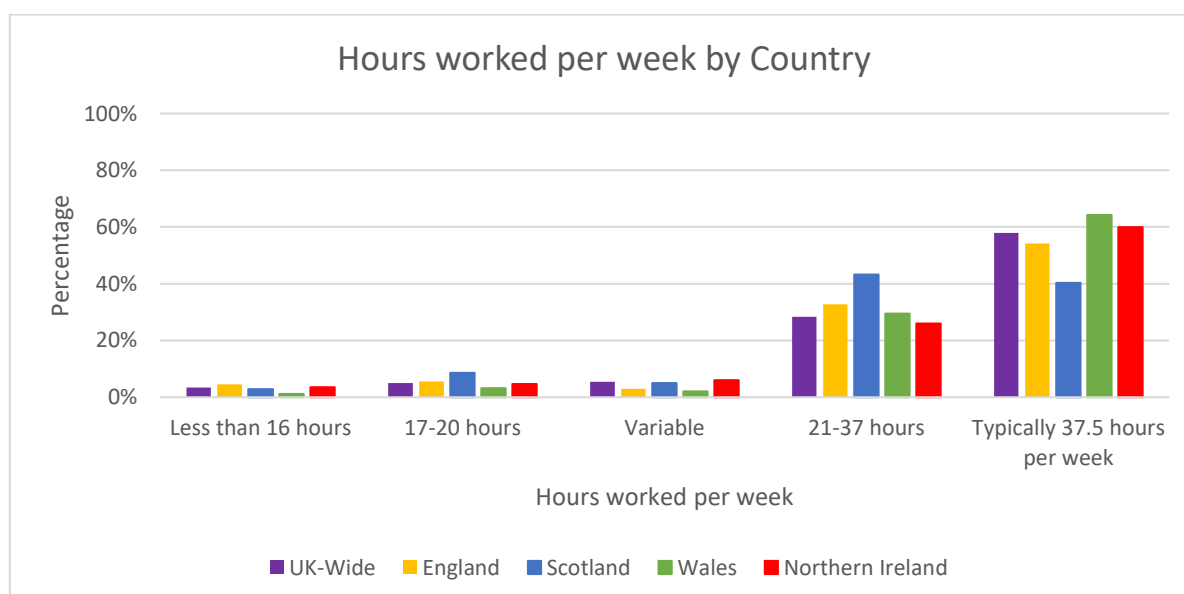


Table A2. 44: Number of Hours Worked per Week by Country (Weighted)

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	3.2%	6.1%	2.9%	1.1%	3.8%
17-20 hours	7.6%	5.7%	8.0%	4.4%	5.4%
Variable	5.0%	2.3%	6.6%	1.1%	6.4%
21-37 hours	31.7%	35.6%	42.3%	30.8%	27.2%
Typically 37.5 hours per week	52.5%	50.4%	40.1%	62.6%	57.1%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2.45: 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	58 (3.4%)	9 (4.5%)	4 (2.9%)	1 (1.1%)	44 (3.5%)
17-20 hours	85 (5.0%)	11 (5.5%)	12 (8.6%)	3 (3.2%)	59 (4.6%)
Variable	92 (5.4%)	6 (3.0%)	7 (5.0%)	2 (2.1%)	77 (6.0%)
21-37 hours	485 (28.4%)	66 (32.8%)	60 (43.2%)	28 (29.5%)	331 (26.0%)
Typically 37.5 hours per week	989 (57.9%)	109 (54.2%)	56 (40.3%)	61 (64.2%)	763 (59.9%)
<b>Total</b>	<b>1709 (100%)</b>	<b>201 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1274 (100%)</b>

Figure A2. 46: Number of Hours Worked per Week by Occupation (Weighted)

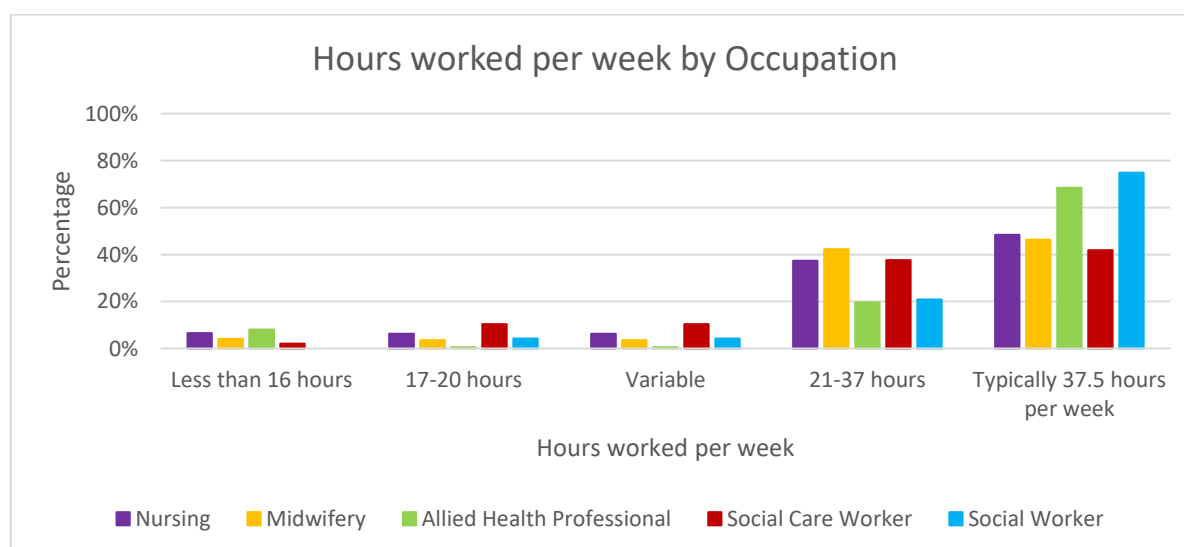


Figure A2. 47: Number of Hours Worked per Week by Occupation (Unweighted)

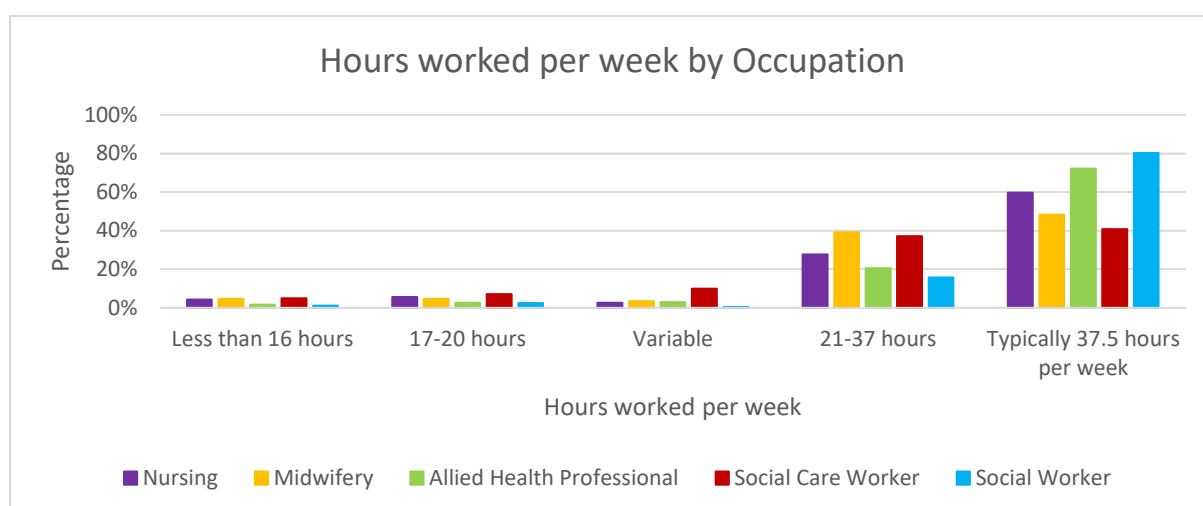


Table A2. 46: Number of Hours Worked per Week by Occupation (Weighted)

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	6.5%	6.3%	6.3%	37.4%	100%
Midwifery	4.1%	3.5%	3.5%	42.2%	100%
AHP	8.1%	0.5%	0.5%	19.6%	100%
Social Care Worker	2.0%	10.4%	10.4%	37.6%	100%
Social Worker	0.0%	4.2%	4.2%	20.8%	100%

Table A2. 47: 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	21-37 hours	Typically 37.5 hours per week	
Nursing	10 (4.3%)	13 (5.6%)	6 (2.6%)	64 (27.7%)	138 (59.7%)	231 (100%)
Midwifery	4 (4.6%)	4 (4.6%)	3 (3.4%)	34 (39.1%)	42 (48.3%)	87 (100%)
AHP	5 (1.7%)	8 (2.7%)	9 (3.0%)	61 (20.5%)	215 (72.1%)	298 (100%)
Social Care Worker	35 (4.9%)	51 (7.1%)	72 (10.0%)	267 (37.2%)	293 (40.8%)	718 (100%)
Social Worker	4 (1.1%)	9 (2.4%)	2 (0.5%)	59 (15.7%)	301 (80.3%)	375 (100%)

## A2.19 Respondents Typically Working Overtime

### Summary (Weighted results):

Respondents were asked if they typically work overtime and the most frequent response UK-wide was 'Yes, 5-10 hours a week'.

### Summary (Unweighted results):

Respondents were asked if they typically work overtime and the most frequent response across the countries was 'No'. The highest proportion of respondents answering 'No' were from Scotland. AHPs were the least likely to work overtime.

Figure A2. 48: Typically Working Overtime by Country (Weighted)

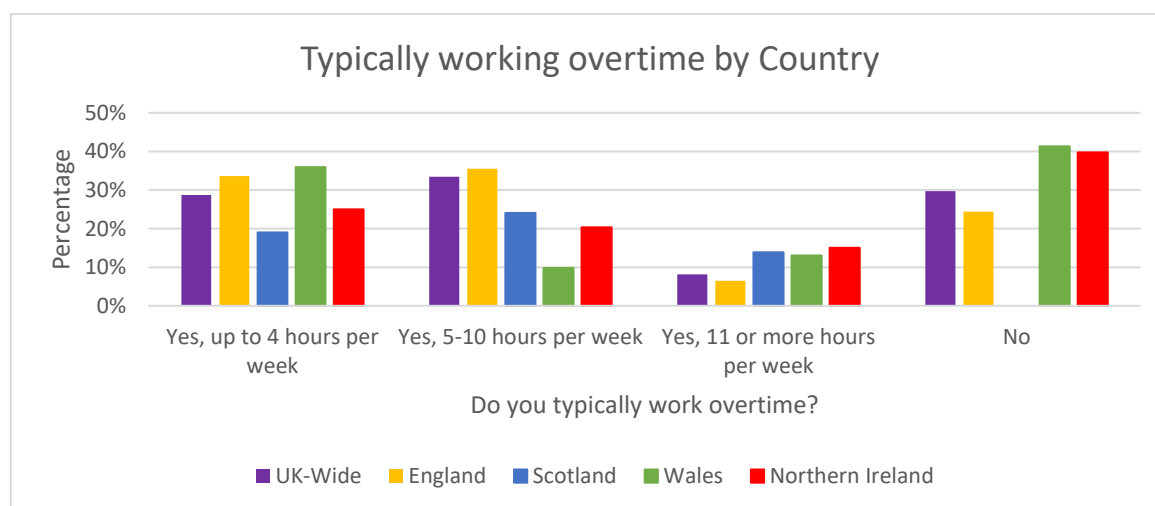


Figure A2. 49: Typically Working Overtime by Country (Unweighted)

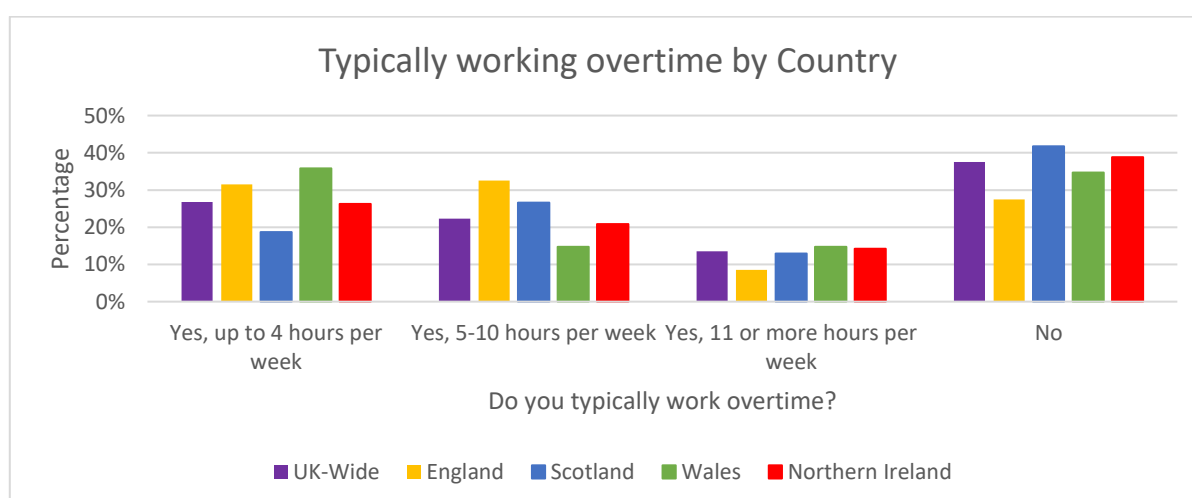


Table A2. 48: Typically Working Overtime by Country (Weighted)

Do you typically work overtime?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, up to 4 hours per week	28.7%	33.6%	19.0%	35.9%	25.0%
Yes, 5-10 hours per week	33.4%	35.5%	24.1%	9.8%	20.3%
Yes, 11 or more hours per week	8.1%	6.5%	13.9%	13.0%	15.0%
No	29.7%	24.4%	43.1%	41.3%	39.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 49: 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	335 (26.8%)	63 (31.5%)	26 (18.7%)	34 (35.8%)	335 (26.3%)
Yes, 5-10 hours per week	265 (22.3%)	65 (32.5%)	37 (26.6%)	14 (14.7%)	265 (20.8%)
Yes, 11 or more hours per week	181 (13.5%)	17 (8.5%)	18 (12.9%)	14 (14.7%)	181 (14.2%)
No	495 (37.5%)	55 (27.5%)	58 (41.7%)	33 (34.7%)	495 (38.8%)
<b>Total</b>	<b>1710 (100%)</b>	<b>200 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1276 (100%)</b>

Figure A2. 50: Typically Working Overtime by Occupation (Weighted)

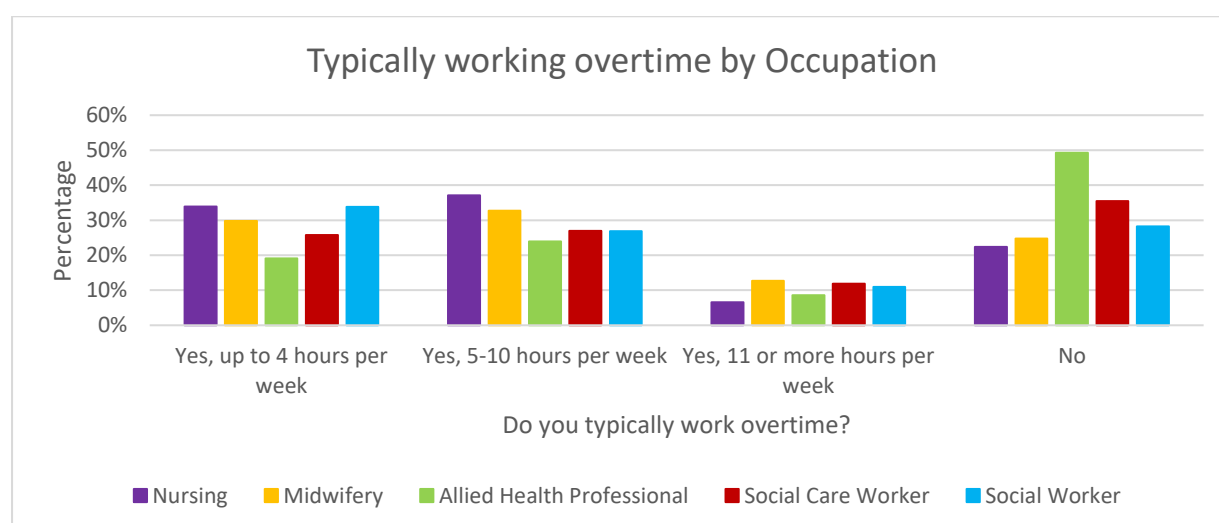


Figure A2. 51: Typically Working Overtime by Occupation (Unweighted)

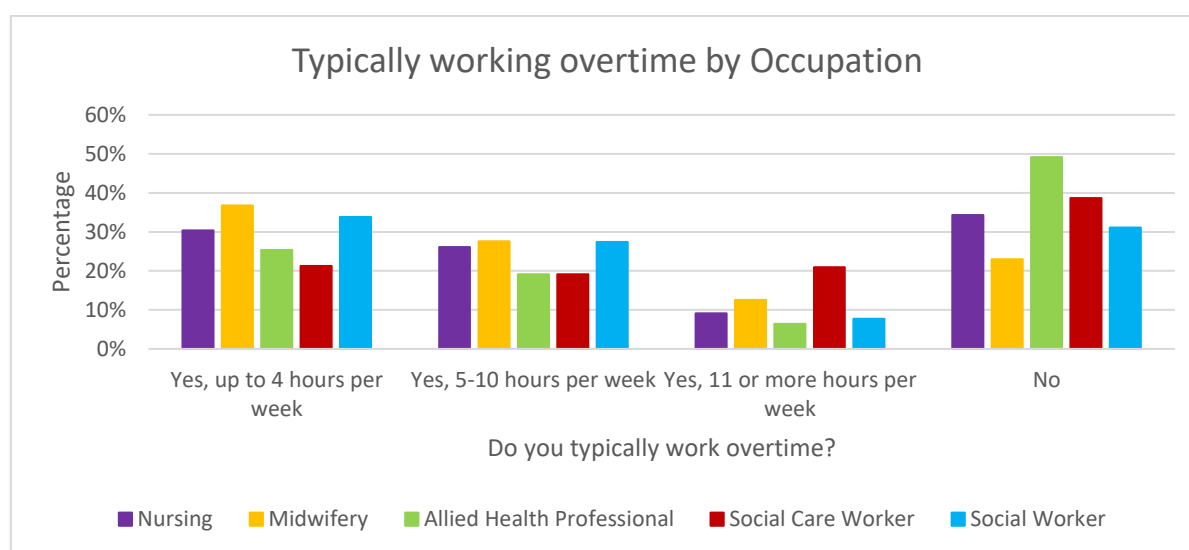


Table A2. 50: Typically Working Overtime by Occupation (Weighted)

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	33.9%	37.1%	6.6%	22.4%	100%
Midwifery	29.8%	32.7%	12.7%	24.8%	100%
AHP	19.1%	23.9%	8.6%	49.3%	100%
Social Care Worker	25.8%	27.0%	11.9%	35.5%	100%
Social Worker	33.8%	26.9%	11.0%	28.2%	100%

Table A2. 51: 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	70 (30.4%)	60 (26.1%)	21 (9.1%)	79 (34.3%)	230 (100%)
Midwifery	32 (36.8%)	24 (27.6%)	11 (12.6%)	20 (23.0%)	87 (100%)
AHP	76 (25.4%)	57 (19.1%)	19 (6.4%)	147 (49.2%)	299 (100%)
Social Care Worker	153 (21.3%)	137 (19.1%)	150 (20.9%)	278 (38.7%)	718 (100%)
Social Worker	127 (33.8%)	103 (27.4%)	29 (7.7%)	117 (31.1%)	376 (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):

UK-wide, respondents have been working significantly less hours overtime since the start of the pandemic, compared to before. Those working in England showed no significant difference but those respondents working in Scotland, Wales and Northern Ireland have been working significantly less hours overtime since the start of the pandemic, compared to before have been working significantly less hours overtime since the start of the pandemic, compared to before. Within the examined occupations, nurses, and social care workers have also been working significantly less overtime hours since the start of the pandemic, compared to before.

### Summary (Unweighted results):

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

Figure A2. 52: Overtime since March 2022-present by Country (Weighted)

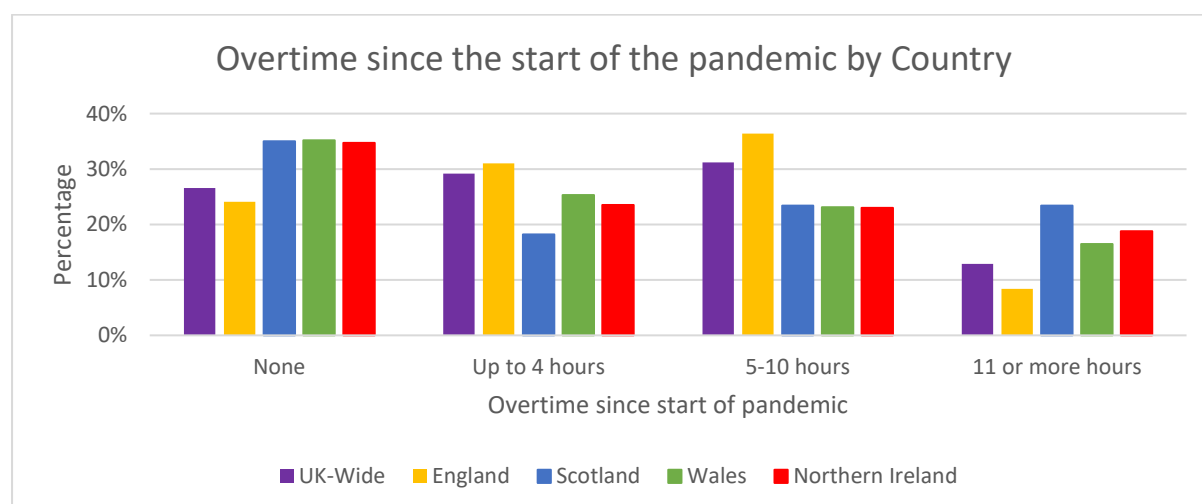


Figure A2. 53: Overtime since March 2022-present by Country (Unweighted)

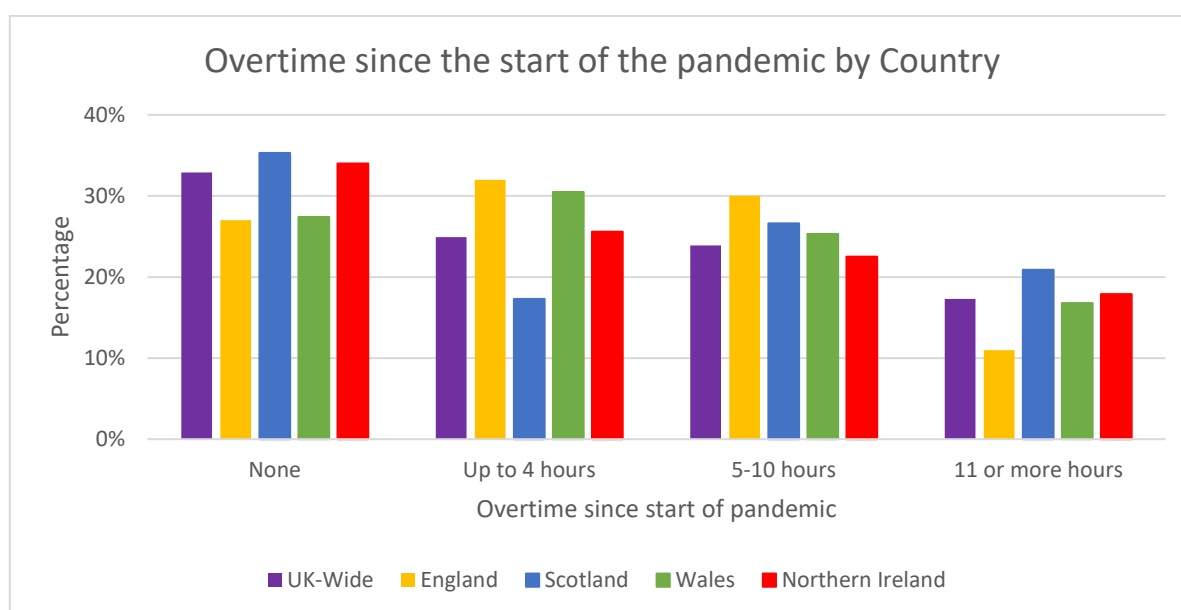


Table A2. 52: Overtime since March 2022-present by Country (Weighted)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	26.6%	24.1%	35.0%	35.2%	34.7%
Up to 4 hours	29.2%	31.0%	18.2%	25.3%	23.5%
5-10 hours	31.2%	36.4%	23.4%	23.1%	23.0%
11 or more hours	12.9%	8.4%	23.4%	16.5%	18.8%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 53: Overtime since March 2022-present by Country (Unweighted)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	562 (32.9%)	54 (27.0%)	49 (35.3%)	26 (27.4%)	433 (34.0%)
Up to 4 hours	443 (24.9%)	64 (32.0%)	24 (17.3%)	29 (30.5%)	326 (25.6%)
5-10 hours	408 (23.9%)	60 (30.0%)	37 (26.6%)	24 (25.3%)	287 (22.5%)
11 or more hours	295 (17.3%)	22 (11.0%)	29 (20.9%)	16 (16.8%)	228 (17.9%)
<b>Total</b>	<b>1708 (100%)</b>	<b>200 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1274 (100%)</b>



Figure A2. 54: Overtime since March 2022-present by Occupation (Weighted)

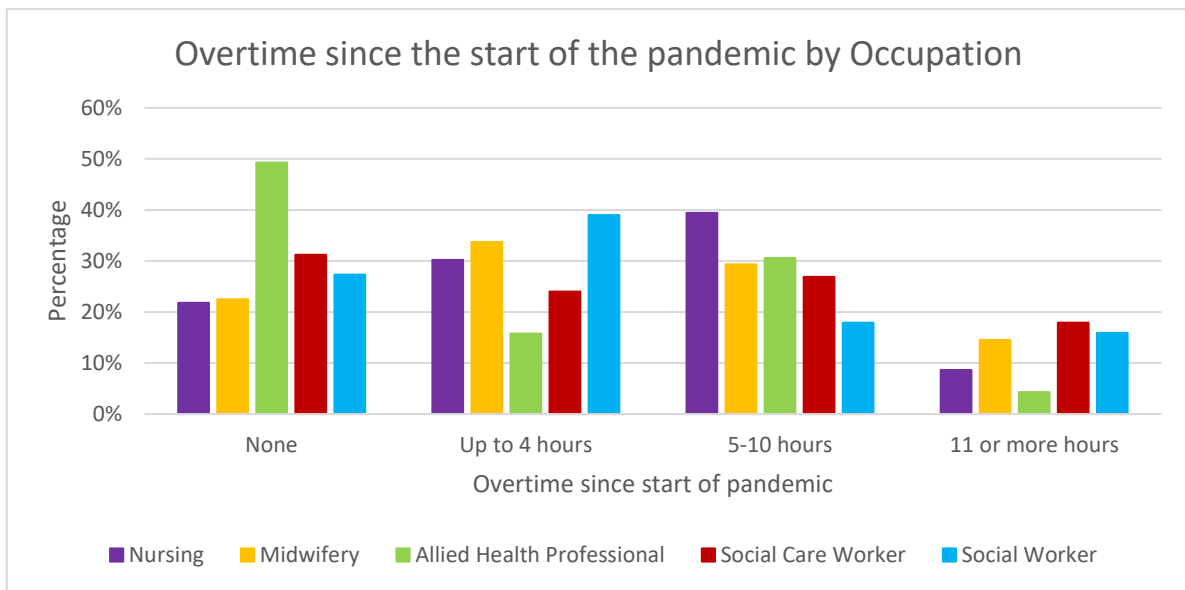


Figure A2. 55: Overtime since March 2022-present by Occupation (Unweighted)

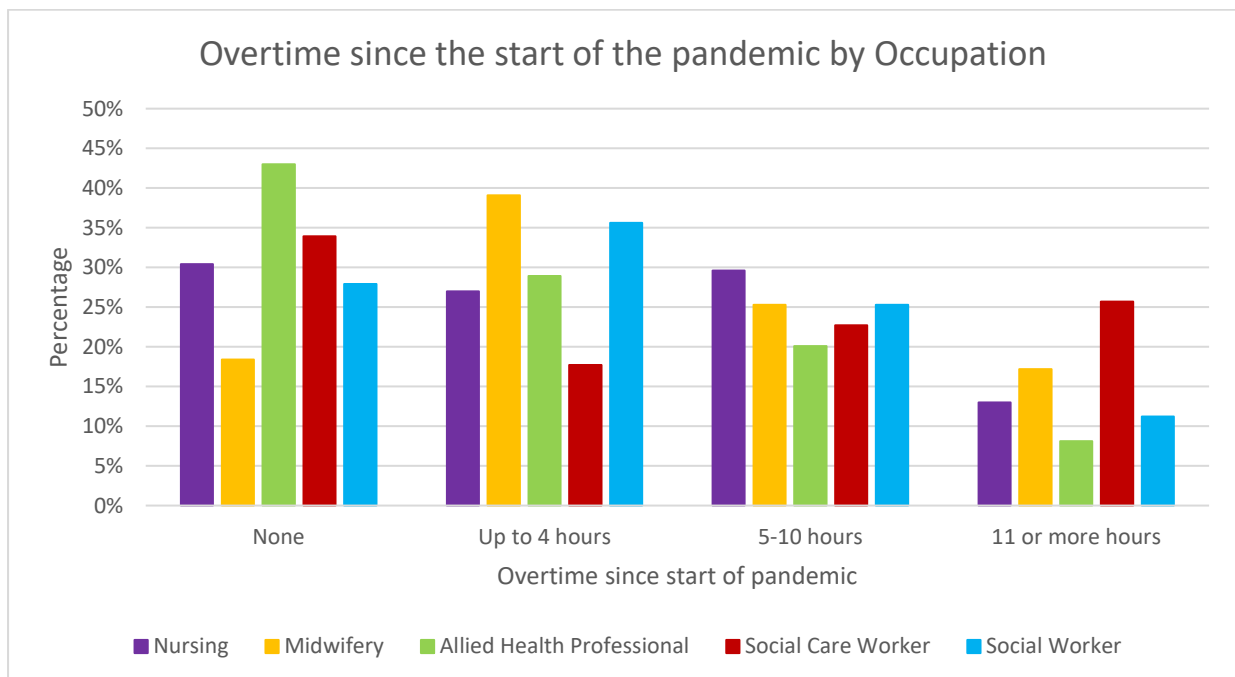


Table A2. 54: Overtime since March 2022-present by Occupation (Weighted)

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	21.8%	30.2%	39.4%	8.6%	100%
Midwifery	22.5%	33.7%	29.3%	14.5%	100%
AHP	49.3%	15.8%	30.6%	4.3%	100%
Social Care Worker	31.2%	24.0%	26.9%	17.9%	100%
Social Worker	27.3%	39.0%	17.9%	15.9%	100%

Table A2. 55: Overtime since March 2022-present 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	70 (30.4%)	62 (27.0%)	68 (29.6%)	30 (13.0%)	230 (100%)
Midwifery	16 (18.4%)	34 (39.1%)	22 (25.3%)	15 (17.2%)	87 (100%)
AHP	128 (43.0%)	86 (28.9%)	60 (20.1%)	24 (8.1%)	298 (100%)
Social Care Worker	243 (33.9%)	127 (17.7%)	163 (22.7%)	184 (25.7%)	717 (100%)
Social Worker	105 (27.9%)	134 (35.6%)	95 (25.3%)	42 (11.2%)	376 (100%)

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

#### Summary (Weighted results):

Over a third of respondents (36.4%) had not taken any sick days in the previous 12 months.

#### Summary (Unweighted results):

Just over a third of respondents (39.2%) had not taken any sick days in the previous 12 months. Respondents in Northern Ireland were the least likely to take sick days and those in Scotland were the most likely.

Figure A2. 56: Sick Days by Country (Weighted)

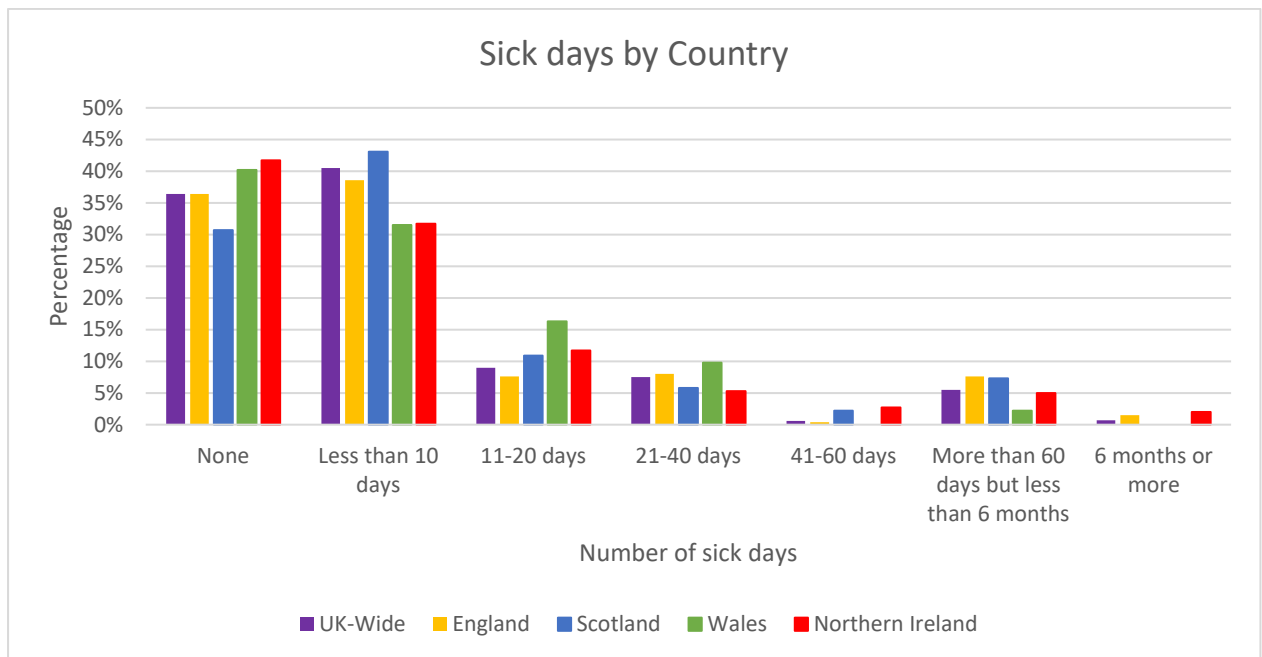


Figure A2. 57: Sick Days by Country (Unweighted)

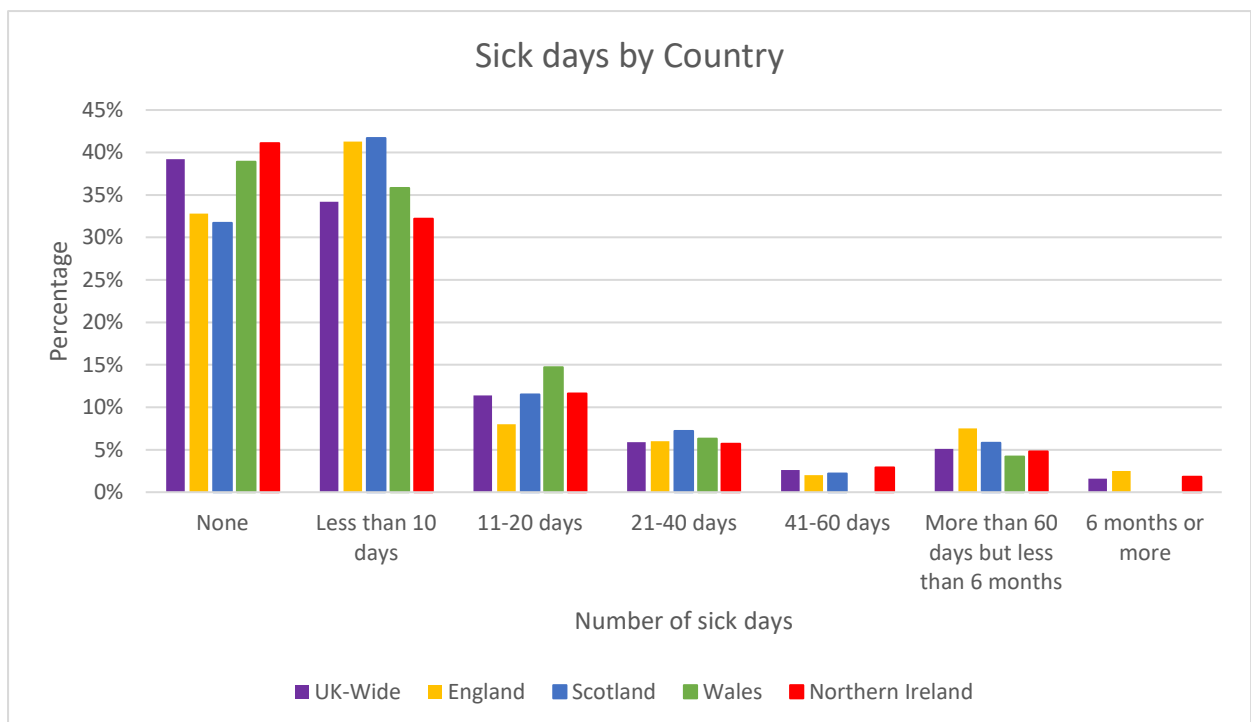


Table A2. 56: Sick Days by Country (Weighted)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	36.4%	36.4%	30.7%	40.2%	41.7%
Less than 10 days	40.5%	38.6%	43.1%	31.5%	31.7%
Between 11-20 days	9.0%	7.6%	10.9%	16.3%	11.7%
Between 21-40 days	7.5%	8.0%	5.8%	9.8%	5.3%
Between 41-60 days	0.6%	0.4%	2.2%	0.0%	2.7%
More than 60 days but less than 6 months	5.5%	7.6%	7.3%	2.2%	5.0%
6 months or more	0.7%	1.5%	0.0%	0.0%	2.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 57: Sick Days by Country (Unweighted)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	670 (39.2%)	66 (32.8%)	44 (31.7%)	37 (38.9%)	523 (41.1%)
Less than 10 days	585 (34.2%)	83 (41.3%)	58 (41.7%)	34 (35.8%)	410 (32.2%)
Between 11-20 days	194 (11.4%)	16 (8.0%)	16 (11.5%)	14(14.7%)	148 (11.6%)
Between 21-40 days	100 (5.9%)	12 (6.0%)	10 (7.2%)	6 (6.3%)	72 (5.7%)
Between 41-60 days	44 (2.6%)	4 (2.0%)	3 (2.2%)	0 (0.0%)	37 (2.9%)
More than 60 days but less than 6 months	88 (5.1%)	15 (7.5%)	8 (5.8%)	4 (4.2%)	61(4.8%)
6 months or more	28 (1.6%)	5 (2.5%)	0 (0.0%)	0 (0.0%)	23 (1.8%)
<b>Total</b>	<b>1709 (100%)</b>	<b>201 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1274 (100%)</b>

Figure A2. 58: Sick Days by Occupation (Weighted)

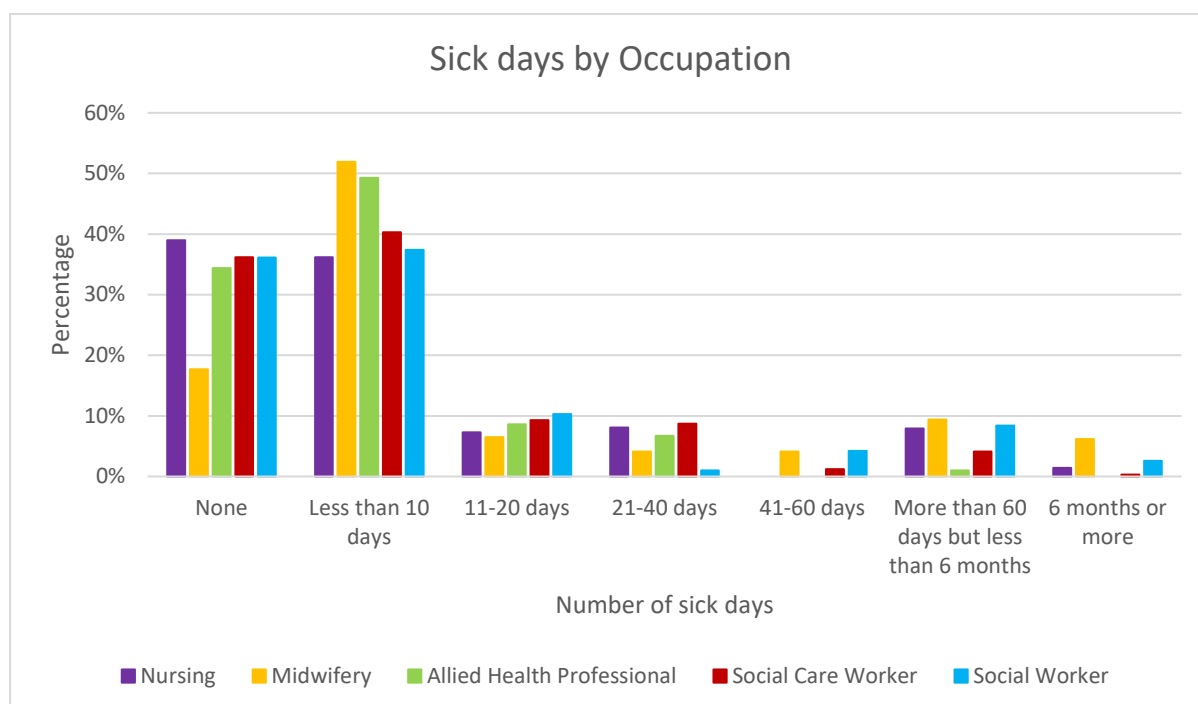


Figure A2. 59: Sick Days by Occupation (Unweighted)

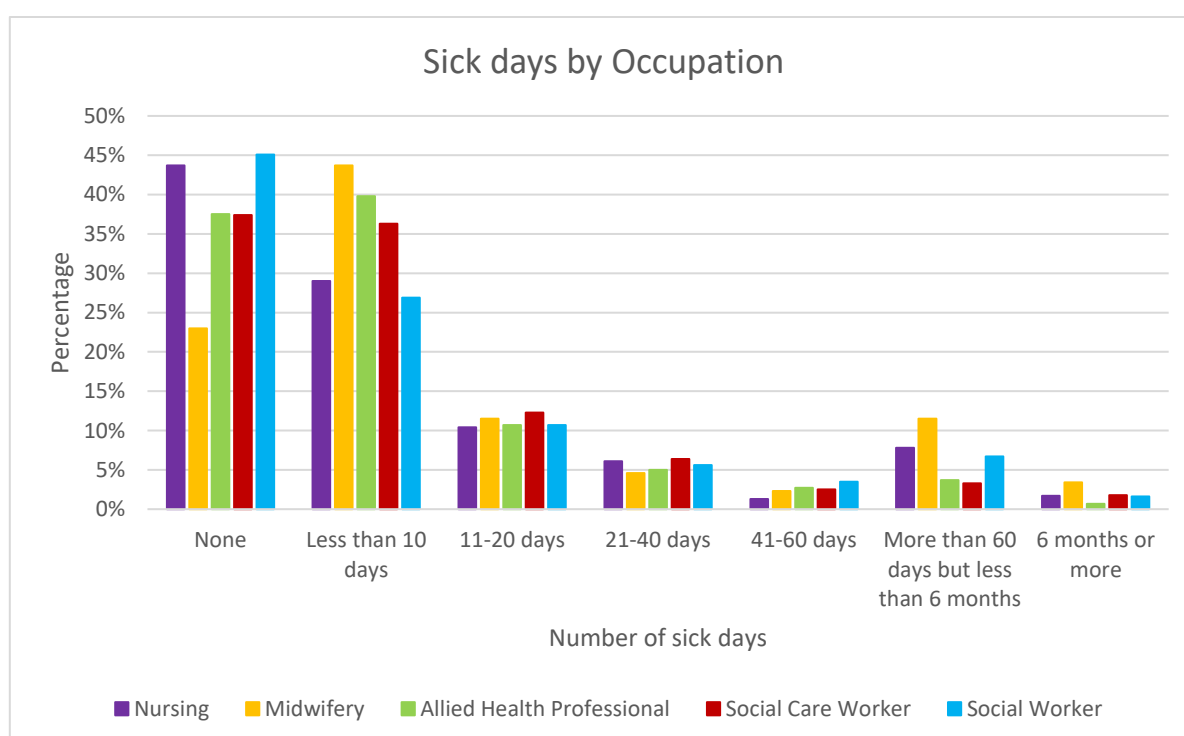


Table A2. 58: Sick Days by Occupation (Weighted)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	39.0%	17.7%	34.4%	36.2%	36.1%
Less than 10 days	36.2%	51.9%	49.3%	40.3%	37.4%
Between 11-20 days	7.3%	6.5%	8.6%	9.3%	10.3%
Between 21-40 days	8.1%	4.1%	6.7%	8.7%	1.0%
Between 41-60 days	0.0%	4.1%	0.0%	1.2%	4.2%
More than 60 days but less than 6 months	7.9%	9.4%	1.0%	4.1%	8.4%
6 months or more	1.4%	6.2%	0.0%	0.3%	2.6%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 59: Sick Days by Occupation (Unweighted)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	101 (43.7%)	20 (23.0%)	112 (37.5%)	268 (37.4%)	169 (45.1%)
Less than 10 days	67 (29.0%)	38 (43.7%)	119 (39.8%)	260 (36.3%)	101 (26.9%)
Between 11-20 days	24 (10.4%)	10 (11.5%)	32 (10.7%)	88 (12.3%)	40 (10.7%)
Between 21-40 days	14 (6.1%)	4 (4.6%)	15 (5.0%)	46 (6.4%)	21v(5.6%)
Between 41-60 days	3 (1.3%)	2 (2.3%)	8 (2.7%)	18 (2.5%)	13v(3.5%)
More than 60 days but less than 6 months	18 (7.8%)	10 (11.5%)	11 (3.7%)	24 (3.3%)	25v(6.7%)
6 months or more	4 (1.7%)	3 (3.4%)	2 (0.7%)	13 (1.8%)	6 (1.6%)
<b>Total</b>	<b>231 (100%)</b>	<b>87 (100%)</b>	<b>299 (100%)</b>	<b>717 (100%)</b>	<b>375 (100%)</b>

## 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):

Wales had the highest proportion of respondents with COVID-19 related sickness absence. Midwives were most likely to have COVID-19 related sickness absence and social workers were the least likely.

### Summary (Unweighted results):

Those in Wales were the most likely to report COVID-19 related sickness absence and those in England were the least likely. Midwives were the most likely to have COVID-19 related sickness absence and social workers were the least likely.

Figure A2. 60: Sickness Absence Related to COVID-19 by Country (Weighted)

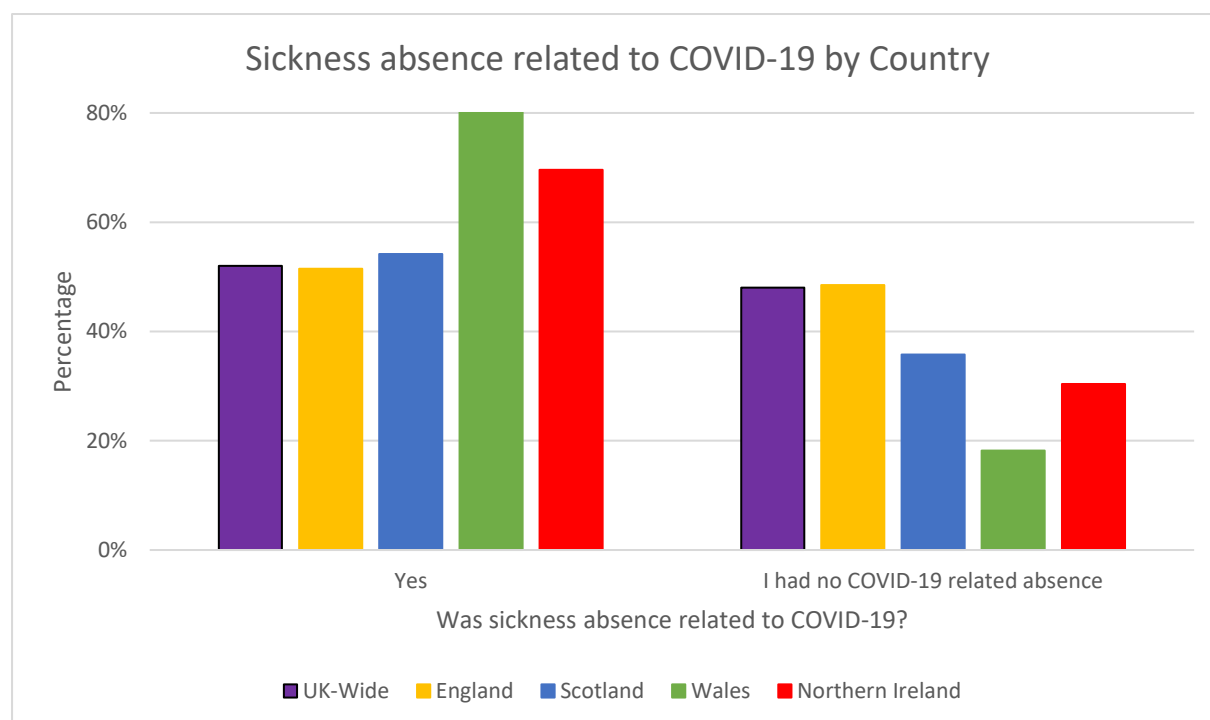


Figure A2. 61: Sickness Absence Related to COVID-19 by Country (Unweighted)

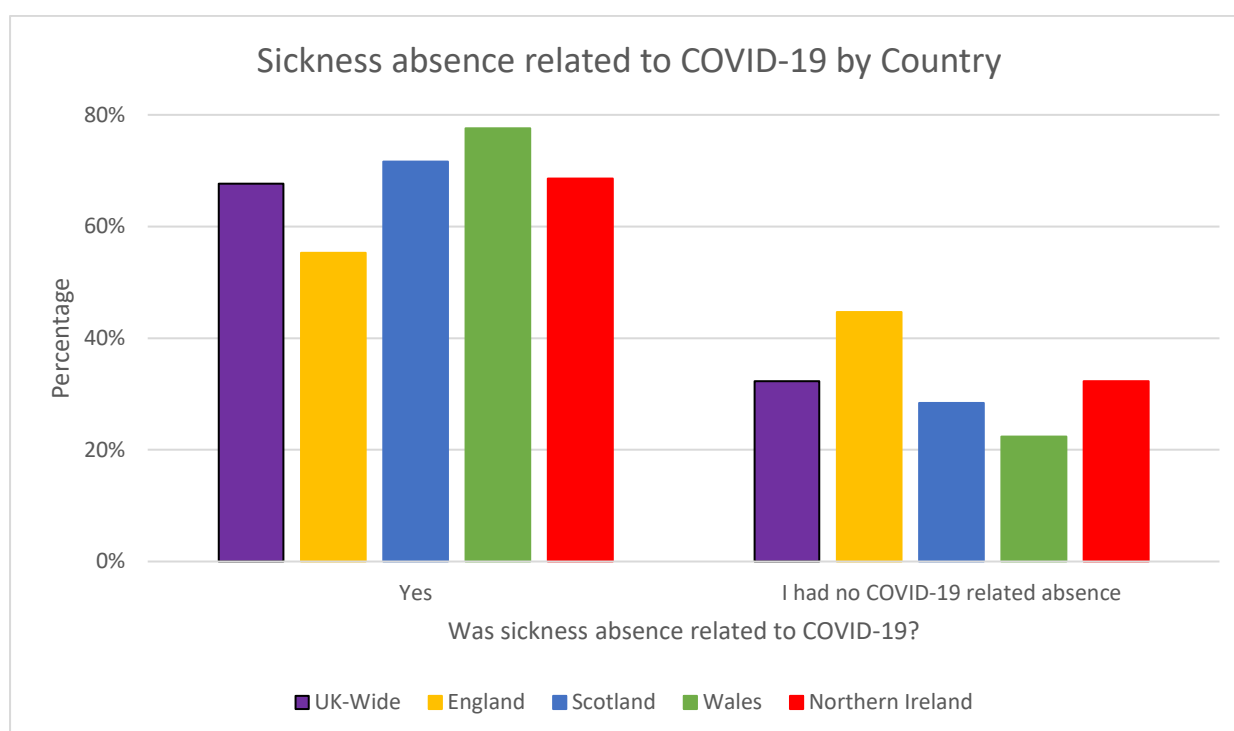


Table A2. 60: Sickness Absence Related to COVID-19 by Country (Weighted)

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	52.0%	51.5%	54.2%	81.8%	69.6%
I had no COVID-19 related absence	48.0%	48.5%	35.8%	18.2%	30.4%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 61: 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	596 (67.7%)	73 (55.3%)	68 (71.6%)	45 (77.6%)	510 (68.6%)
I had no COVID-19 related absence	332 (32.3%)	59 (44.7%)	27 (28.4%)	13 (22.4%)	233 (32.3%)
<b>Total</b>	<b>1028 (100%)</b>	<b>132 (100%)</b>	<b>95 (100%)</b>	<b>58 (100%)</b>	<b>743 (100%)</b>



Figure A2. 62: Sickness Absence Related to COVID-19 by Occupation (Weighted)

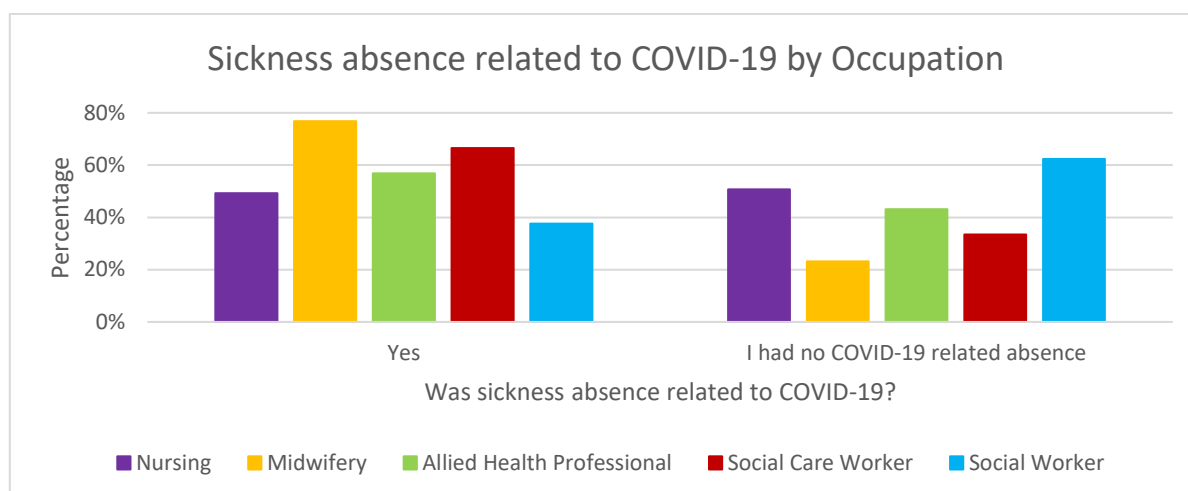


Figure A2. 63: Sickness Absence Related to COVID-19 by Occupation (Unweighted)

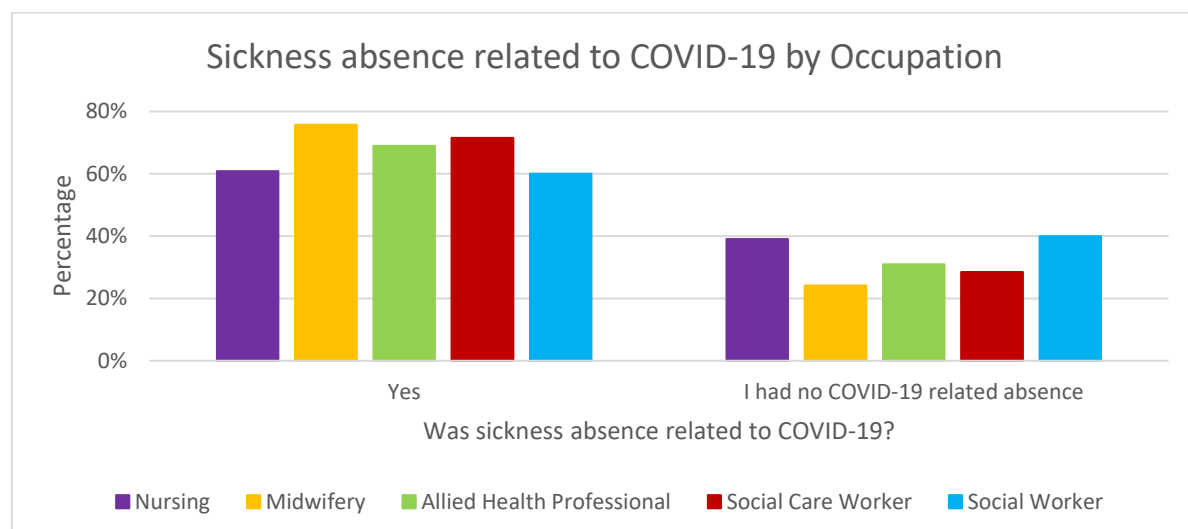


Table A2. 62: Sickness Absence Related to COVID-19 by Occupation (Weighted)

Occupation	Was sickness absence related to COVID-19?		Total
	Yes	I had no COVID-19 related absence	
Nursing	49.3%	50.7%	100%
Midwifery	76.8%	23.2%	100%
AHP	56.9%	43.1%	100%
Social Care Worker	66.5%	33.5%	100%
Social Worker	37.6%	62.4%	100%

Table A2. 63: 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	78 (60.9%)	50 (39.1%)	128 (100%)
Midwifery	50 (75.8%)	16 (24.2%)	66 (100%)
AHP	127 (69.0%)	57 (31.0%)	184 (100%)
Social Care Worker	318 (71.5%)	127 (28.5%)	445 (100%)
Social Worker	123 (60.0%)	82 (40.0%)	205 (100%)

### A2.23 Respondents' Sick Pay

#### Summary (Weighted results):

UK-wide, most respondents reported getting employer pay.

#### Summary (Unweighted results):

UK-wide, most respondents (40.0%) reported getting employer pay.

Figure A2. 64: Respondents' Sick Pay by Country (Weighted)

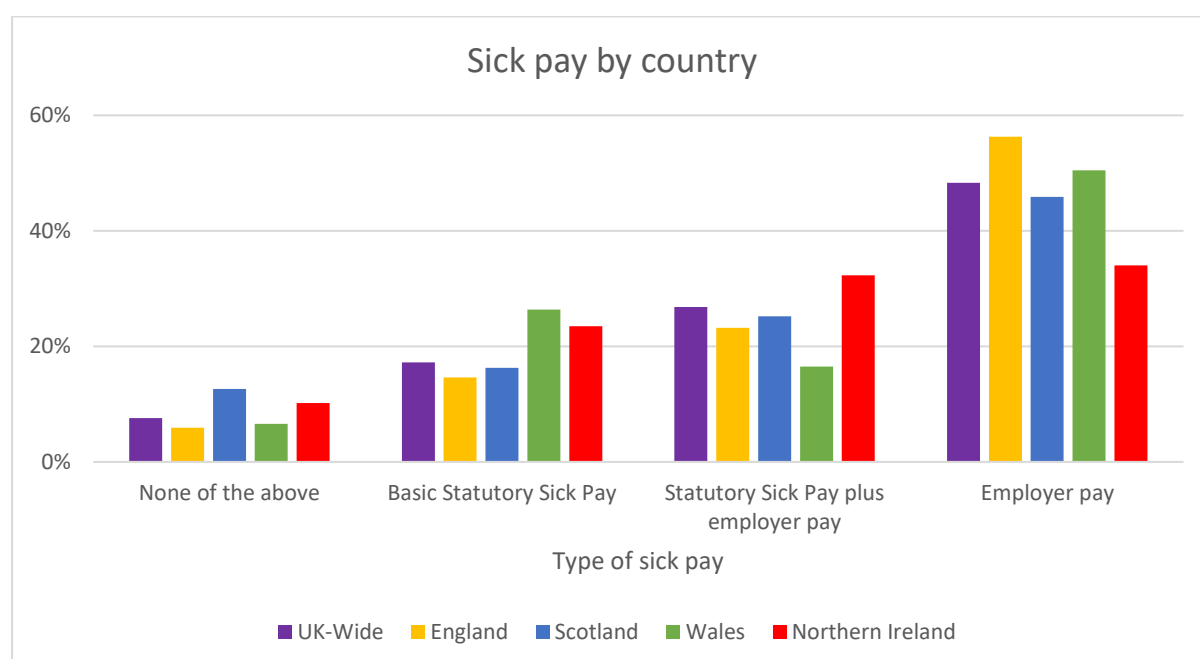


Figure A2. 65: Respondents' Sick Pay by Country (Unweighted)

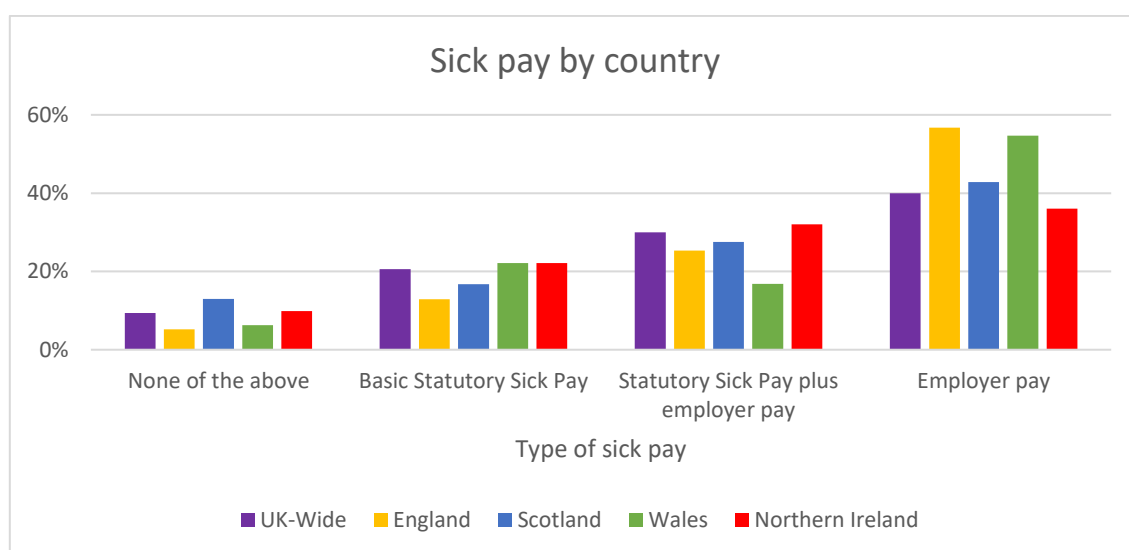


Table A2. 64: Respondents' Sick Pay by Country (Weighted)

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None of the above	7.6%	5.9%	12.6%	6.6%	10.2%
Basic Statutory Sick Pay	17.2%	14.6%	16.3%	26.4%	23.5%
Statutory Sick Pay plus employer pay	26.8%	23.2%	25.2%	16.5%	32.3%
Employer pay	48.3%	56.3%	45.9%	50.5%	34.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 65: Respondents' Sick Pay by Country (Unweighted)

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None of those mentioned	157 (9.4%)	10 (5.2%)	18 (13.0%)	6 (6.3%)	123 2(9.9%)
Basic Statutory Sick Pay (SSP)	343 (20.6%)	25 (12.9%)	23 (16.7%)	21 (22.1%)	274 (22.1%)
Statutory Sick Pay (SSP) plus employer pay	499 (30.0%)	49 (25.3%)	38 (27.5%)	16 (16.8%)	396 (32.0%)
None of the above	667 (40.0%)	100 (56.7%)	52 (42.8%)	52 (54.7%)	446 (36.0%)
<b>Total</b>	<b>1666 (100%)</b>	<b>194 (100%)</b>	<b>138 (100%)</b>	<b>95 (100%)</b>	<b>1239 (100%)</b>

Figure A2. 66: Respondents' Sick Pay by Occupation (Weighted)

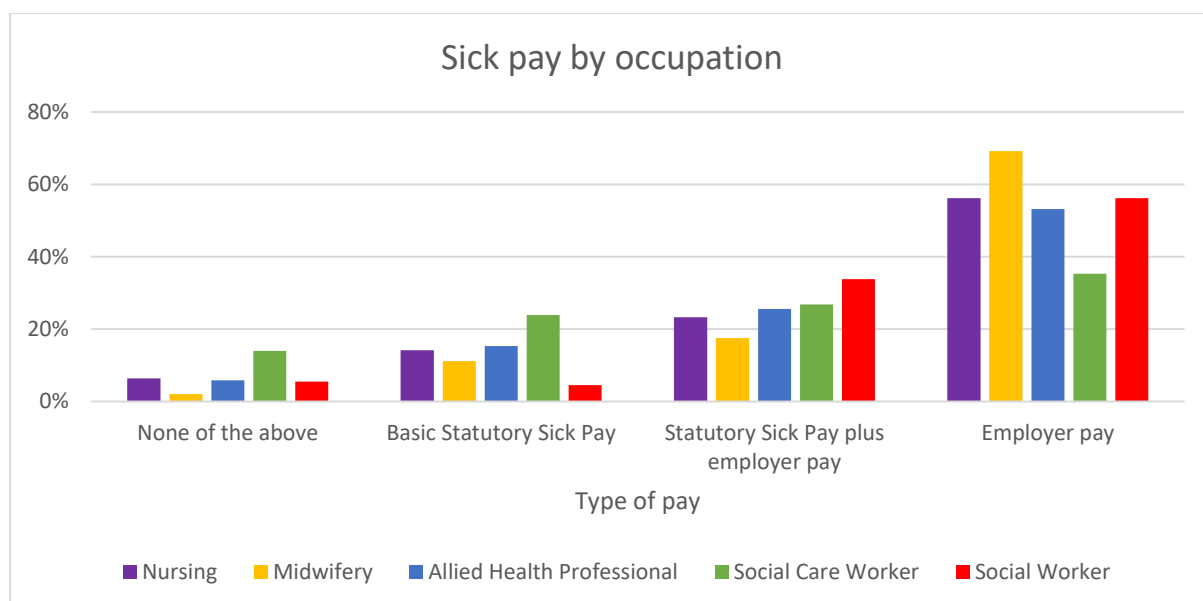


Figure A2. 67: Respondents' Sick Pay by Occupation (Unweighted)

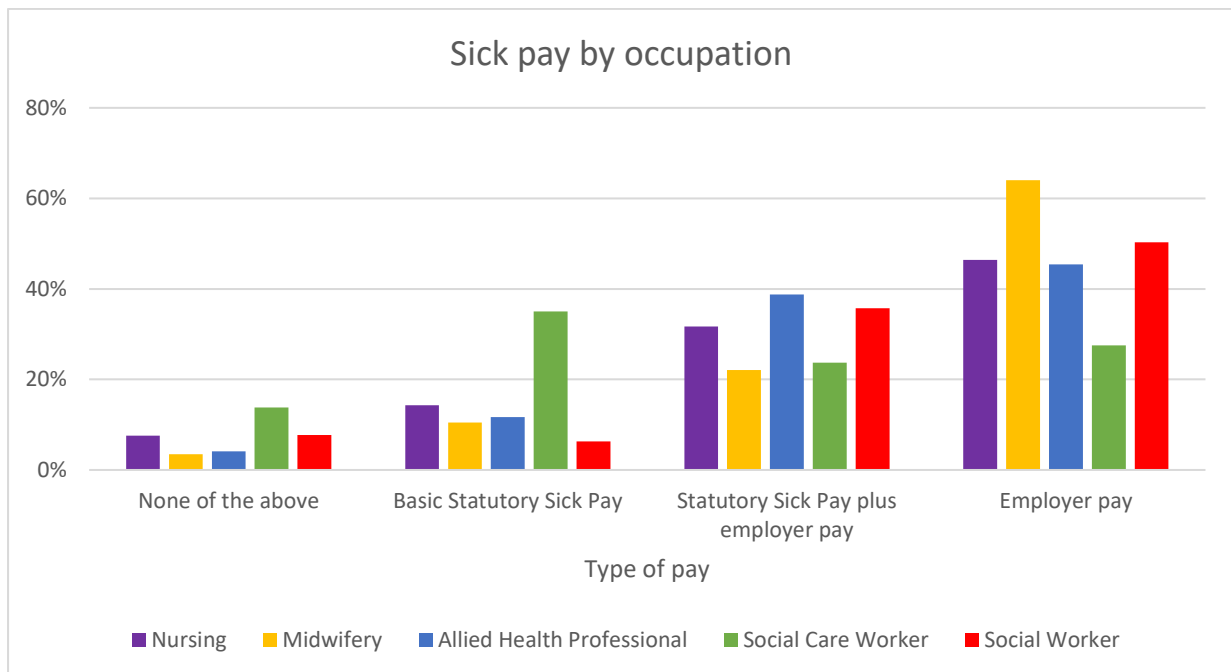


Table A2. 66: Respondents' Sick Pay by Occupation (Weighted)

Occupation	Type of sick pay				Total
	None of the others	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	Employer Pay	
Nursing	6.4%	14.2%	23.3%	56.2%	100%
Midwifery	2.1%	11.2%	17.5%	69.2%	100%
AHP	5.9%	15.3%	25.6%	53.2%	100%
Social Care Worker	14.0%	23.9%	26.8%	35.3%	100%
Social Worker	5.5%	4.5%	33.8%	56.2%	100%

Table A2. 67: Respondents' Sick Pay by Occupation (Unweighted)

Occupation	Type of sick pay				Total
	None of the others	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	Employer Pay	
Nursing	17 (7.6%)	32 (14.3%)	71 (31.7%)	104 (46.4%)	<b>224 (100%)</b>
Midwifery	3 (3.5%)	9 (10.5%)	19 (22.1%)	55 (64.0%)	<b>86 (100%)</b>
AHP	12 (4.1%)	34 (11.7%)	113 (38.8%)	132 (45.4%)	<b>291 (100%)</b>
Social Care Worker	97 (13.8%)	245 (35.0%)	166 (23.7%)	193 (27.5%)	<b>701 (100%)</b>
Social Worker	28 (7.7%)	23 (6.3%)	130 (35.7%)	183 (50.3%)	<b>364 (100%)</b>

### A2.15 Respondents' Years of Experience

#### Summary (Weighted results):

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

#### Summary (Unweighted results):

Almost one third of respondents UK-wide (27.0%) 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 social workers.

Figure A2. 68: Years of Experience by Country (Weighted)

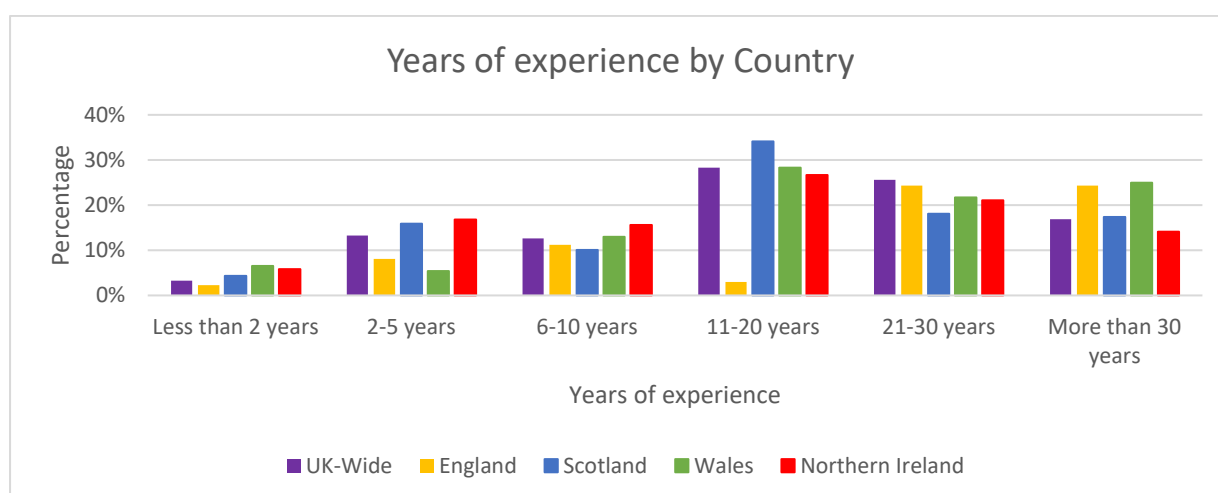


Figure A2. 69: Years of Experience by Country (Unweighted)

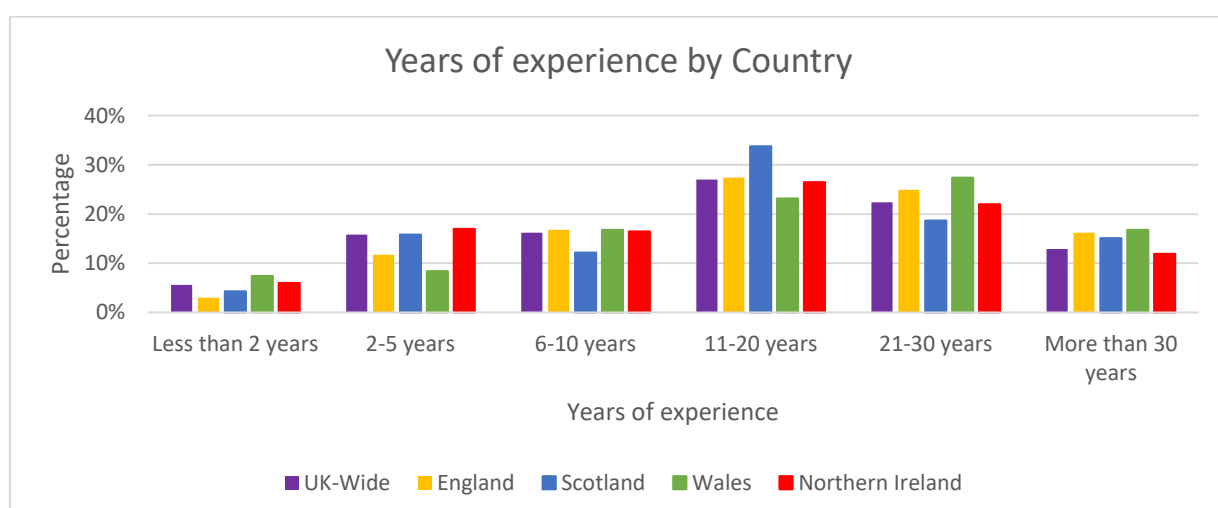


Table A2. 68: Years of Experience by Country (Weighted)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	3.3%	2.3%	4.3%	6.5%	5.8%
2-5 years	13.3%	8.1%	15.9%	5.4%	16.8%
6-10 years	12.6%	11.2%	10.1%	13.0%	15.6%
11-20 years	28.3%	3.0%	34.1%	28.3%	26.7%
21-30 years	25.6%	24.3%	18.1%	21.7%	21.1%
More than 30 years	16.9%	24.3%	17.4%	25.0%	14.1%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 69: Years of Experience by Country (Unweighted)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	95 (5.6%)	6 (3.0%)	6 (4.3%)	7 (7.4%)	76 (6.0%)
2-5 years	268 (15.8%)	23 (11.7%)	22 (15.8%)	8 (8.4%)	215 (17.0%)
6-10 years	274 (16.2%)	33 (16.8%)	17 (12.2%)	16 (16.8%)	208 (16.5%)
11-20 years	475 (27.0%)	54 (27.4%)	47 (33.8%)	22 (23.2%)	334 (26.5%)
21-30 years	379 (22.4%)	49 (24.9%)	26 (18.7%)	26 (27.4%)	278 (22.0%)
More than 30 years	219 (12.9%)	32 (16.2%)	21 (15.1%)	16 (16.8%)	150 (11.9%)
<b>Total</b>	<b>1692 (100%)</b>	<b>197 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1261 (100%)</b>

Figure A2. 70: Years of Experience by Occupation (Weighted)

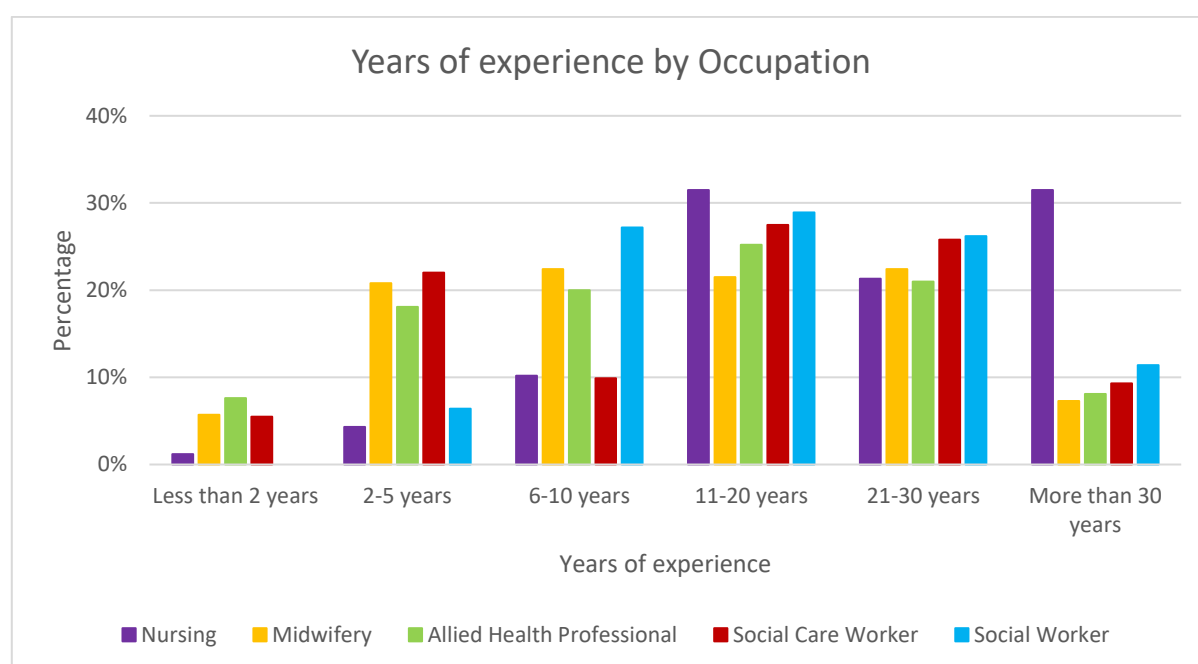




Figure A2. 71: Years of Experience by Occupation (Unweighted)

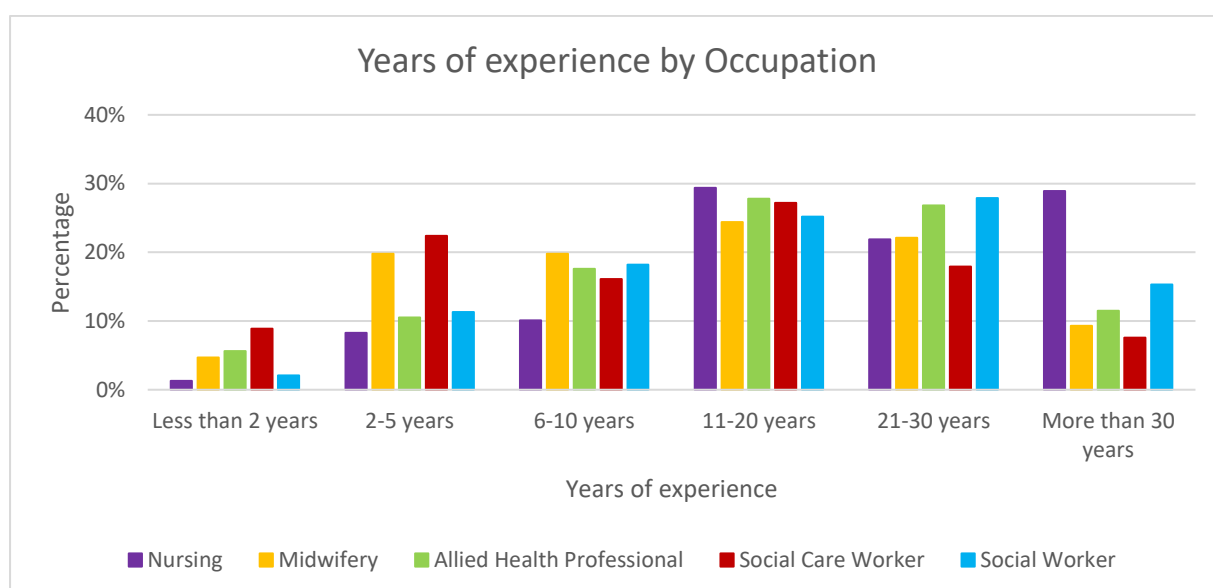


Table A2. 70: Years of Experience by Occupation (Weighted)

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	1.2%	4.3%	10.2%	31.5%	21.3%	31.5%	100%
Midwifery	5.7%	20.8%	22.4%	21.5%	22.4%	7.3%	100%
AHP	7.6%	18.1%	20.0%	25.2%	21.0%	8.1%	100%
Social Care Worker	5.5%	22.0%	9.9%	27.5%	25.8%	9.3%	100%
Social Worker	0.0%	6.4%	27.2%	28.9%	26.2%	11.4%	100%

Table A2. 71: 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	3 (1.3%)	19 (8.3%)	23 (10.1%)	67 (29.4%)	50 (21.9%)	66 (28.9%)	228 (100%)
Midwifery	4 (4.7%)	17 (19.8%)	17 (19.8%)	21 (24.4%)	19 (22.1%)	8 (9.3%)	86 (100%)
AHP	17 (5.6%)	31 (10.5%)	52 (17.6%)	82 (27.8%)	79 (26.8%)	34 (11.5%)	295 (100%)
Social Care Worker	63 (8.9%)	159 (22.4%)	114 (16.1%)	193 (27.2%)	127 (17.9%)	54 (7.6%)	710 (100%)
Social Worker	8 (2.1%)	42 (11.3%)	68 (18.2%)	94 (25.2%)	104 (27.9%)	57 (15.3%)	373 (100%)

## A2.16 Respondents' Main Area of Practice

### Summary (Weighted results):

Working with older people was the most frequently reported area of practice by respondents.

### Summary (Unweighted results):

Working with older people were the most frequently reported areas of practice by respondents.

Figure A2. 72: Main Area of Practice by Country (Weighted)

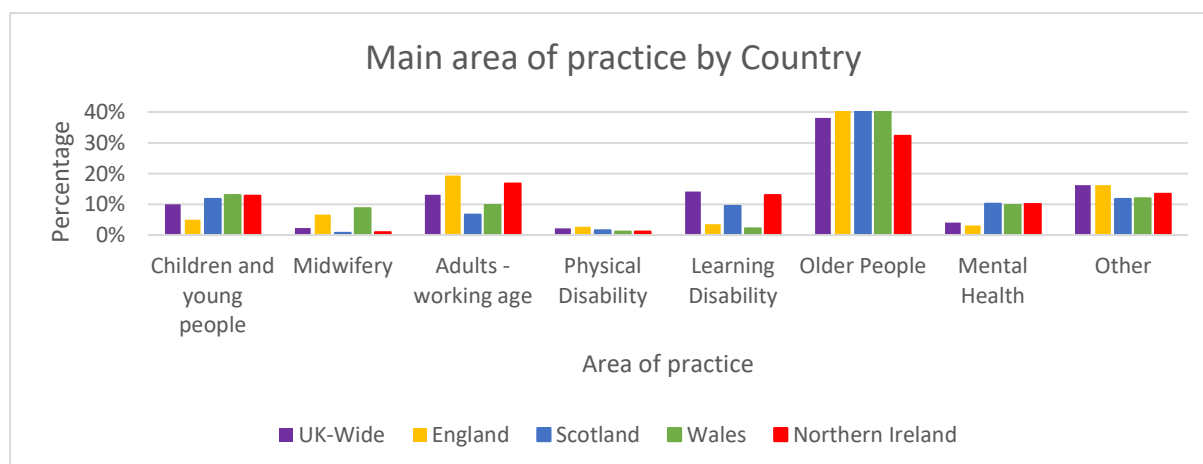


Figure A2. 73: Main Area of Practice by Country (Unweighted)

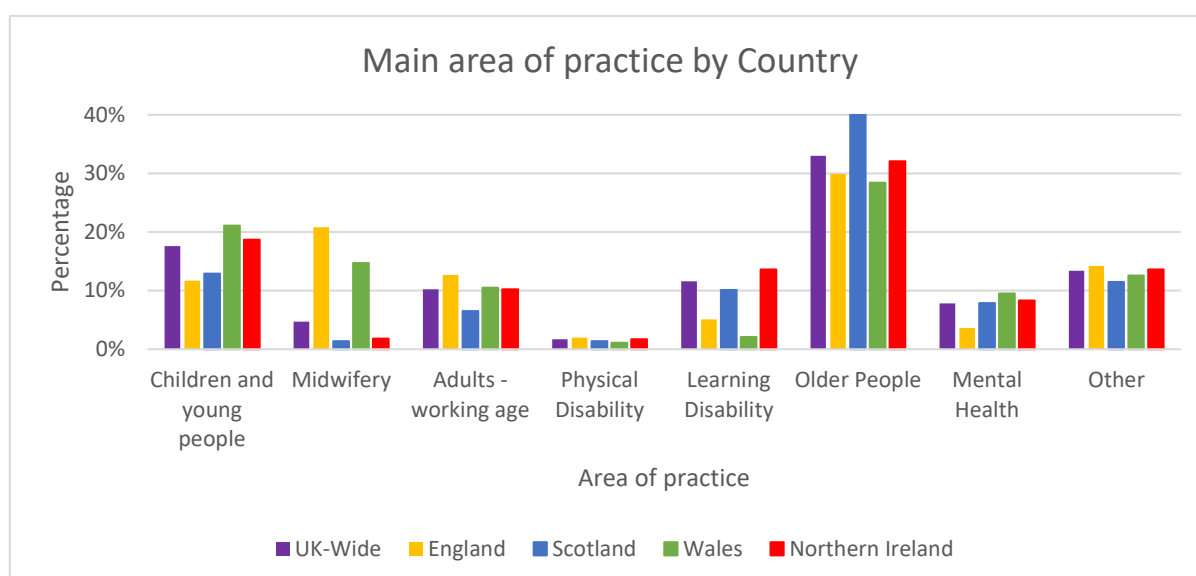


Table A2. 72: Main Area of Practice by Country (Weighted)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	10.0%	5.0%	11.7%	13.0%	12.8%
Midwifery	2.3%	6.6%	0.7%	8.7%	0.9%
Adults	13.1%	19.3%	6.6%	9.8%	16.7%
Physical Disability	2.2%	2.7%	1.5%	1.1%	1.1%
Learning Disability	14.1%	3.5%	9.5%	2.2%	13.0%
Older People	38.1%	43.6%	48.2%	43.5%	32.2%
Mental Health	4.0%	3.1%	10.2%	9.8%	10.1%
Other	16.2%	16.2%	11.7%	12.0%	13.4%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 73: Main Area of Practice by Country (Unweighted)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	297 (17.6%)	23 (11.7%)	18 (12.9%)	20 (21.1%)	236 (18.7%)
Midwifery	80 (4.7%)	41 (20.8%)	2 (1.4%)	14 (14.7%)	23 (1.8%)
Adults	172 (10.2%)	25 (12.7%)	9 (6.5%)	10 (10.5%)	128 (10.2%)
Physical Disability	28 (1.7%)	4 (2.0%)	2 (1.4%)	1 (1.1%)	21 (1.7%)
Learning Disability	197 (11.6%)	10 (5.1%)	14 (10.1%)	2 (2.1%)	171 (13.6%)
Older People	558 (33.0%)	59 (29.9%)	67 (48.2%)	27 (28.4%)	405 (32.1%)
Mental Health	132 (7.8%)	7 (3.6%)	11 (7.9%)	9 (9.5%)	105 (8.3%)
Other	227 (13.4%)	28 (14.2%)	16 (11.5%)	12 (12.6%)	171 (13.6%)
<b>Total</b>	<b>1691 (100%)</b>	<b>197 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1260 (100%)</b>

Figure A2. 74: Main Area of Practice by Occupation (Weighted)

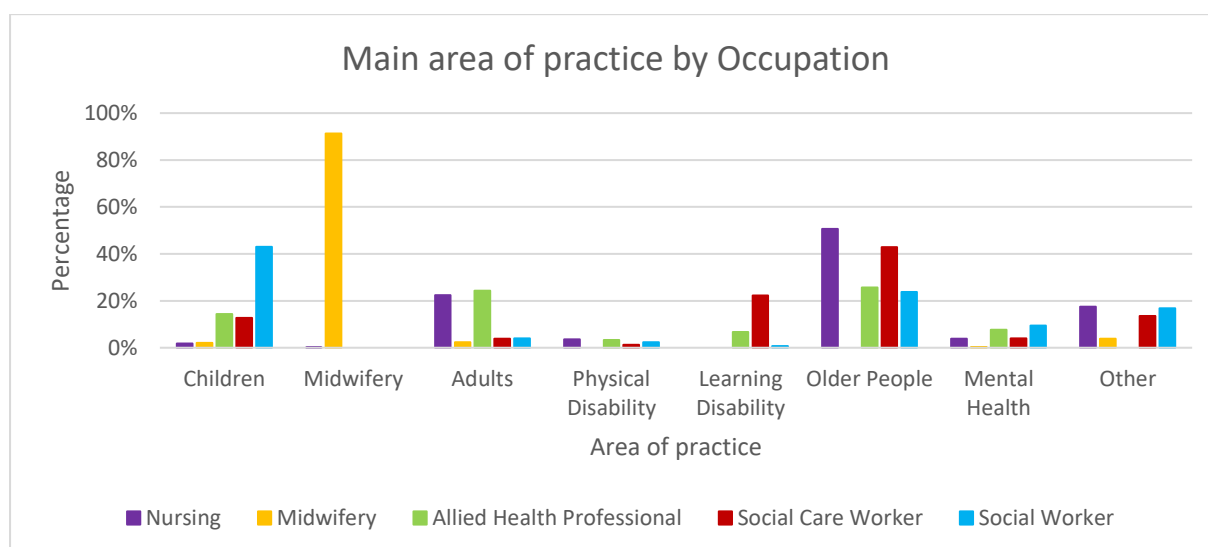


Figure A2. 75: Main Area of Practice by Occupation (Unweighted)

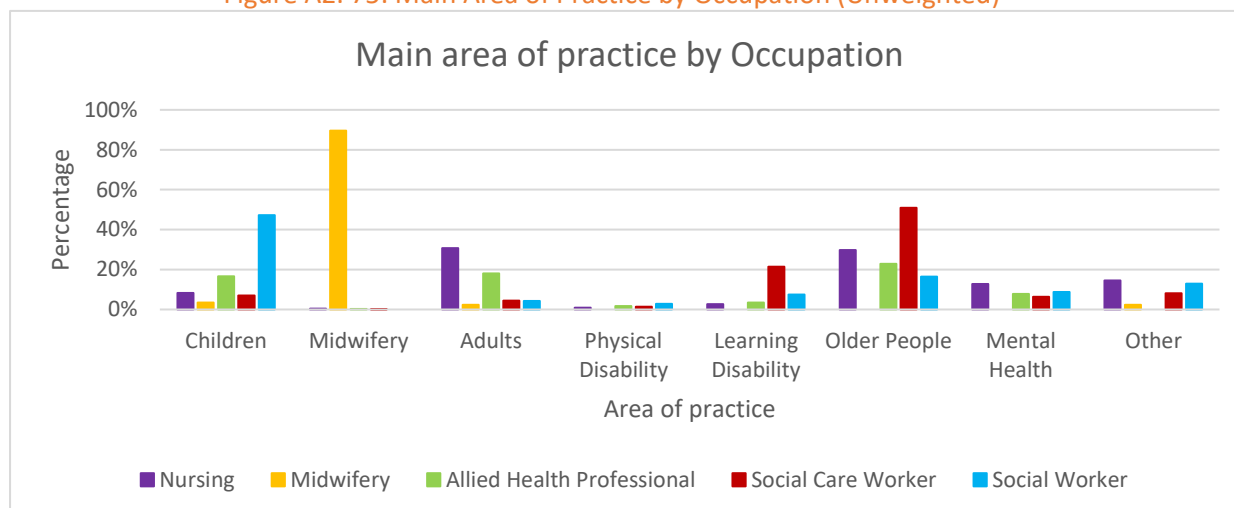


Table A2. 74: Main Area of Practice by Occupation (Weighted)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	1.8%	2.1%	14.3%	12.7%	43.0%
Midwifery	0.2%	91.3%	0.0%	0.0%	0.0%
Adults	22.4%	2.4%	24.3%	3.8%	4.0%
Physical Disability	3.5%	0.0%	3.3%	1.2%	2.3%
Learning Disability	0.0%	0.0%	6.7%	22.3%	0.7%
Older People	50.7%	0.0%	25.7%	42.9%	23.8%
Mental Health	3.9%	0.3%	7.6%	4.0%	9.4%
Other	17.5%	3.9%	18.1%	13.5%	16.8%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 75: Main Area of Practice by Occupation (Unweighted)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	19 (8.3%)	3 (3.5%)	49 (16.7%)	50 (7.0%)	176 (47.2%)
Midwifery	1 (0.4%)	77 (89.5%)	1 (0.3%)	1 (0.1%)	0 (0.0%)
Adults	70 (30.7%)	2 (2.3%)	53 (18.0%)	31 (4.4%)	16 (4.3%)
Physical Disability	2 (0.9%)	0 (0.0%)	5 (1.7%)	10 (1.4%)	11 (2.9%)
Learning Disability	6 (2.6%)	0 (0.0%)	10 (3.4%)	153 (21.5%)	28 (7.5%)
Older People	68 (29.8%)	0 (0.0%)	67 (22.8%)	362 (51.0%)	61 (16.4%)
Mental Health	29 (12.7%)	0 (0.0%)	23 (7.8%)	81 (6.3%)	33 (8.8%)
Other	33 (14.5%)	2 (2.3%)	86 (29.3%)	58 (8.2%)	48 (12.9%)
<b>Total</b>	<b>228 (100%)</b>	<b>86 (100%)</b>	<b>294 (100%)</b>	<b>710 (100%)</b>	<b>397 (100%)</b>

#### 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 7.2% of respondents reported that their service was not impacted and it was stepped down. More than half of the respondents (59.4%) felt overwhelmed by increased pressures. Nurses and midwives were the most impacted of the examined occupational groups.

##### Summary (Unweighted results):

UK-wide, 3.2% of respondents reported that their service was not impacted and it was stepped down. Over half of the respondents (58.1%) felt overwhelmed by increased pressures, particularly those in Wales. Nurses were the most impacted of the examined occupational groups.

Figure A2. 76: Impact of COVID-19 on Services by Country (Weighted)

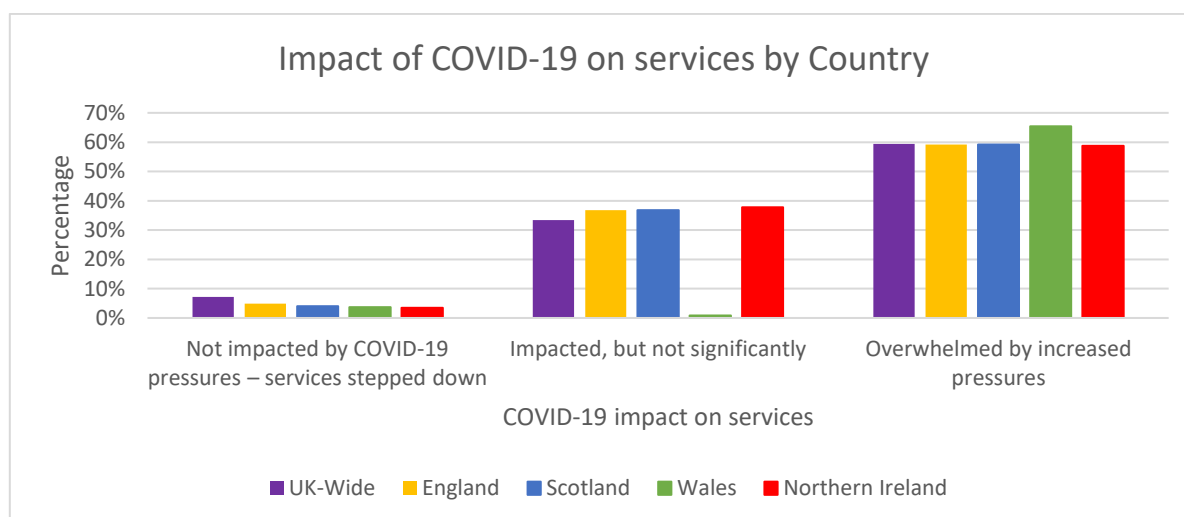


Figure A2. 77: Impact of COVID-19 on Services by Country (Unweighted)

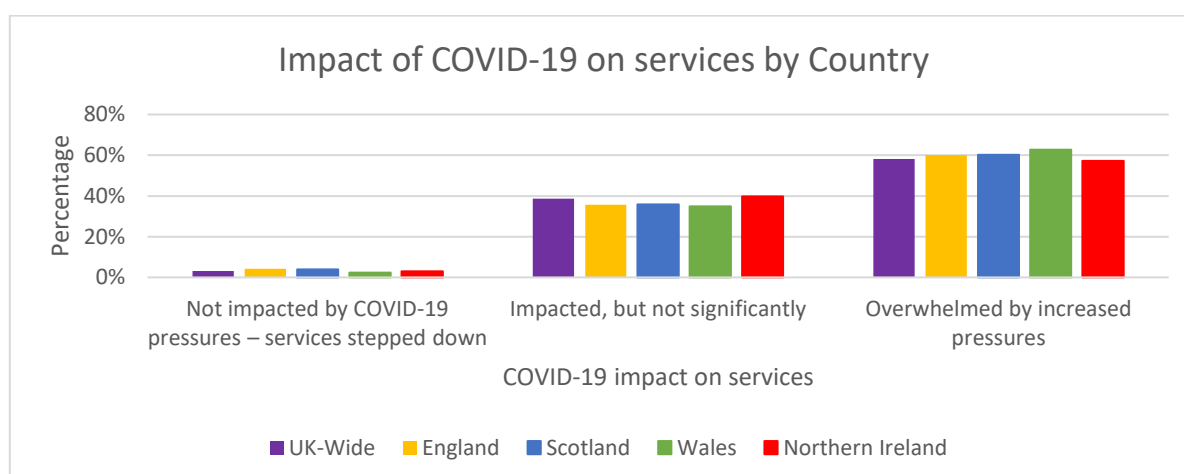


Table A2. 76: Impact of COVID-19 on Services by Country (Weighted)

Impact of COVID-19 on services	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Not impacted by COVID-19 pressures – services stepped down	7.2%	4.9%	4.0%	3.7%	3.5%
Impacted, but not significantly	33.4%	36.8%	36.8%	0.9%	37.8%
Overwhelmed by increased pressures	59.4%	59.2%	59.2%	65.4%	58.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 77: Impact of COVID-19 on Services by Country (Unweighted)

Impact of COVID-19 on services	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Not impacted by COVID-19 pressures – services stepped down	50 (3.2%)	8 (4.3%)	5 (3.9%)	2 (2.3%)	35 (3.0%)
Impacted, but not significantly	606 (38.7%)	66 (35.7%)	46 (35.9%)	30 (34.9%)	464 (39.8%)
Overwhelmed by increased pressures	910 (58.1%)	111 (60.0%)	77 (60.2%)	54 (62.8%)	668 (57.2%)
<b>Total</b>	<b>1566 (100%)</b>	<b>185 (100%)</b>	<b>128 (100%)</b>	<b>86 (100%)</b>	<b>1167 (100%)</b>

Figure A2. 78: Impact of COVID-19 on Services by Occupation (Weighted)

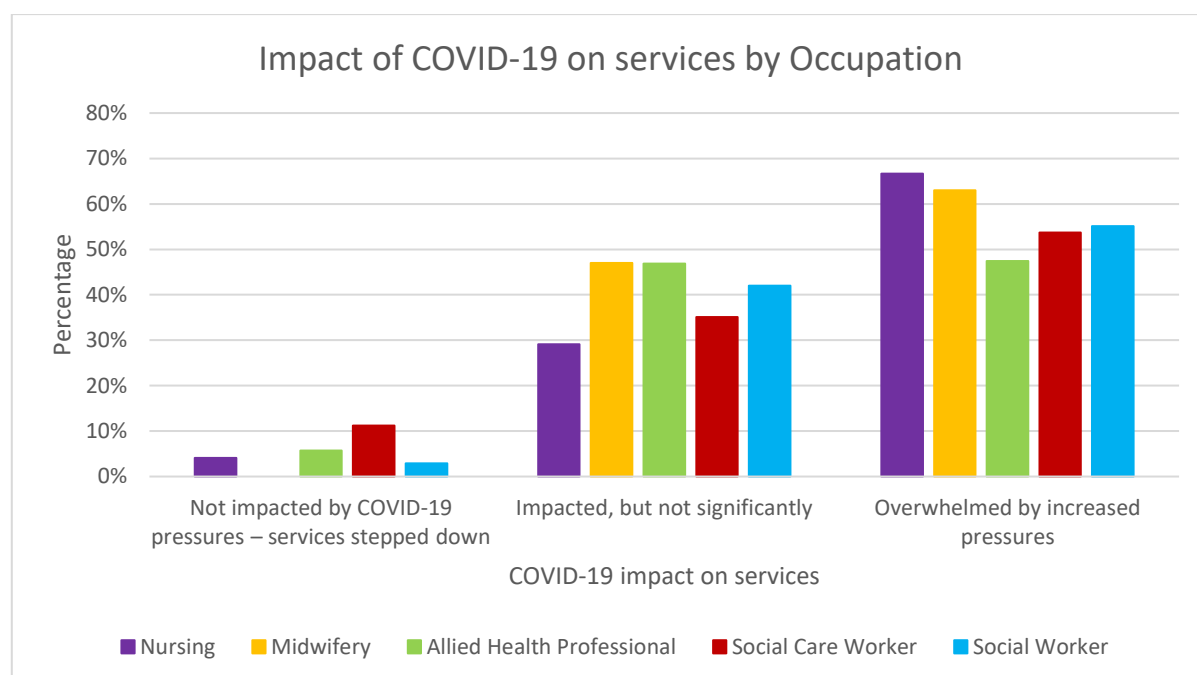




Figure A2. 79: Impact of COVID-19 on Services by Occupation (Unweighted)

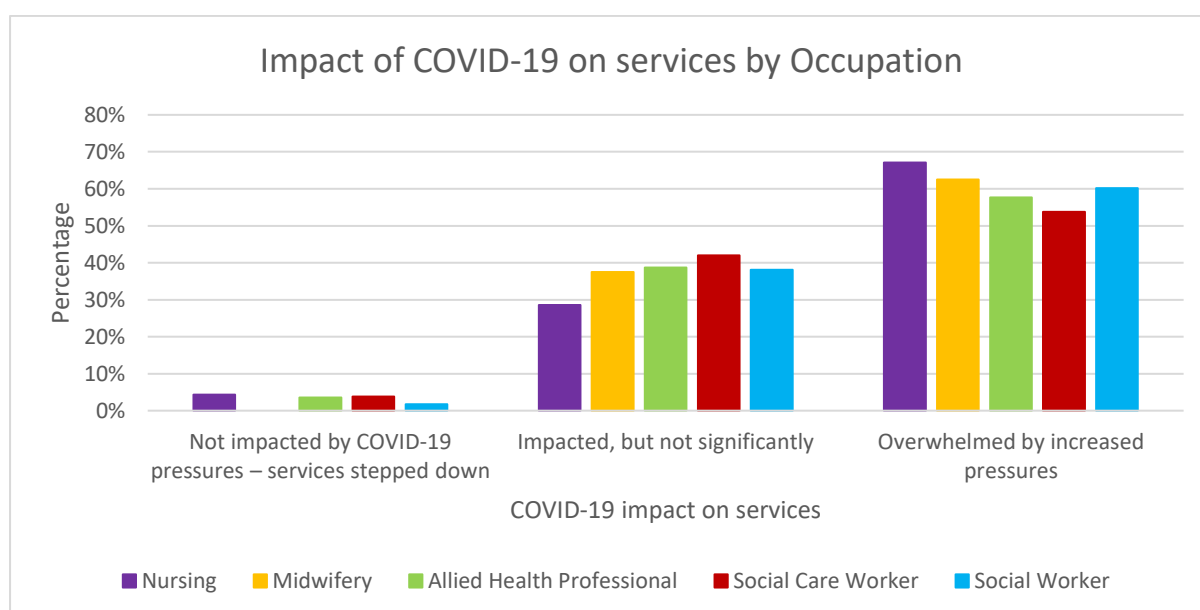


Table A2. 78: Impact of COVID-19 on Services by Occupation (Weighted)

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	4.1%	29.1%	66.7%	100%
Midwifery	0.0%	47.0%	63.0%	100%
AHP	5.7%	46.9%	47.4%	100%
Social Care Worker	11.2%	35.1%	53.7%	100%
Social Worker	2.9%	42.0%	55.1%	100%

Table A2. 79: 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	9 (4.3%)	60 (28.6%)	141 (67.1%)	210 (100%)
Midwifery	0 (0.0%)	30 (37.5%)	50 (62.5%)	80 (100%)
AHP	10 (3.6%)	105 (38.7%)	158 (57.7%)	274 (100%)
Social Care Worker	25 (3.8%)	277 (42.0%)	351 (53.8%)	653 (100%)
Social Worker	6 (1.7%)	133 (38.1%)	210 (60.2%)	349 (100%)

### A2.17 Respondents working from home – pre-pandemic

Respondents were asked if, had they been able to work from home pre-pandemic.

#### Summary (Weighted results):

A majority of respondents were not able to work from home before the pandemic. Scottish workers were least likely to work from home while Welsh workers were more likely to work at home.

#### Summary (Unweighted results):

A majority of the respondents did not work from home during the pandemic (82.9%). Respondents from England were the most likely to work from home (25.4%) before the pandemic and those from Scotland were the least likely (11.5%). Social work respondents were mostly likely to work from home (40.9%) while Social Care workers were least likely to work from home (5.6%).

Figure A2. 80: Respondents working from home by Country (Weighted)

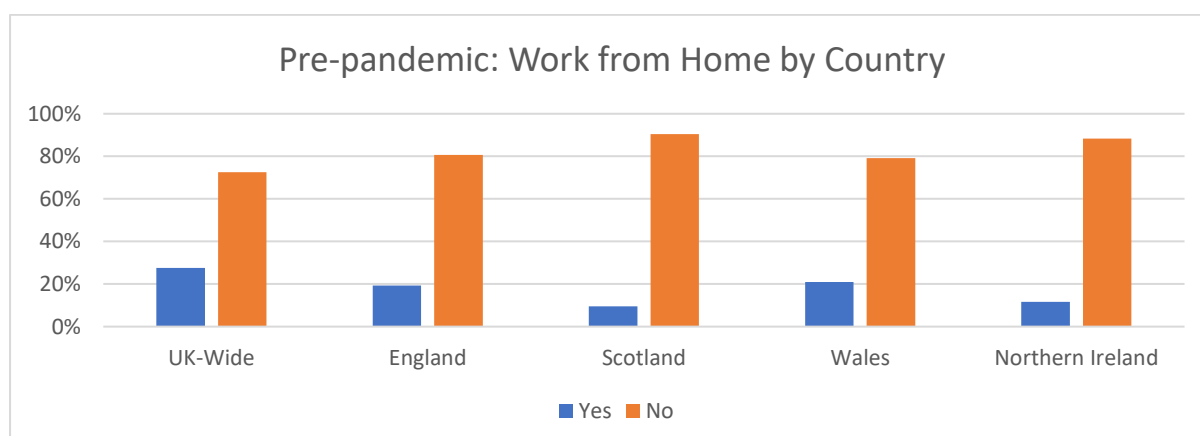


Figure A2. 81: Respondents working from home by Country (Unweighted)

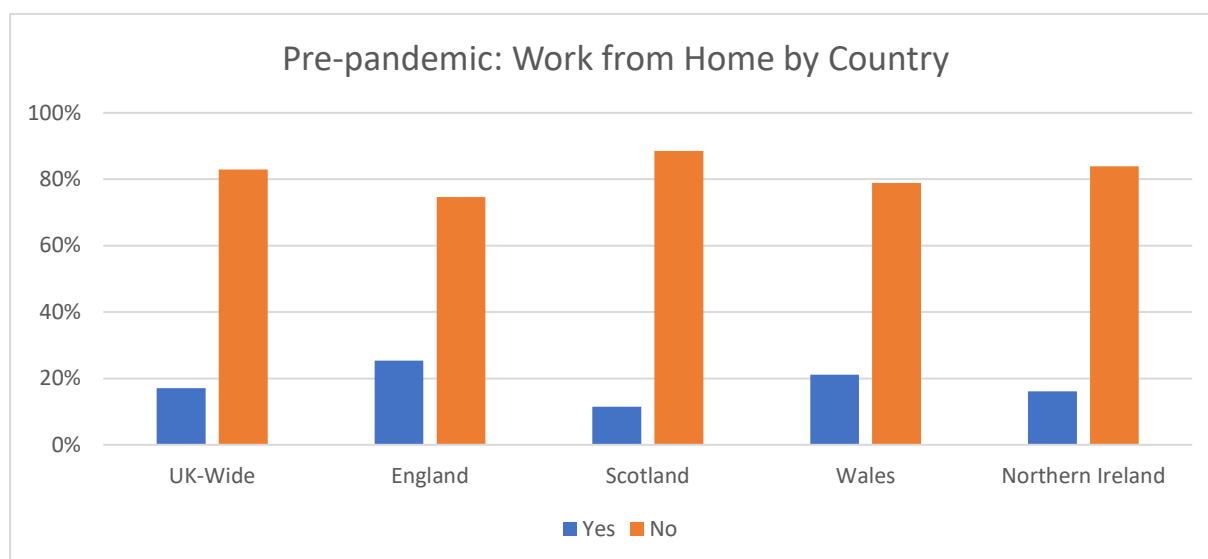


Table A2. 80: Respondents working from home by Country (Weighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	27.5%	19.3%	9.5%	20.9%	11.7%
No	72.5%	80.7%	90.5%	79.1%	88.3%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 81: Respondents working from home by Country (Unweighted)

Had you been able to work from home pre-pandemic?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	288 (17.1%)	50 (25.4%)	16 (11.5%)	20 (21.1%)	202 (16.1%)
No	1400 (82.9%)	147 (74.6%)	123 (88.5%)	75 (78.9%)	1055 (83.9%)
<b>Total</b>	<b>1688 (100%)</b>	<b>197 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1257 (100%)</b>

Figure A2. 82: Respondents working from home by Occupation (Weighted)

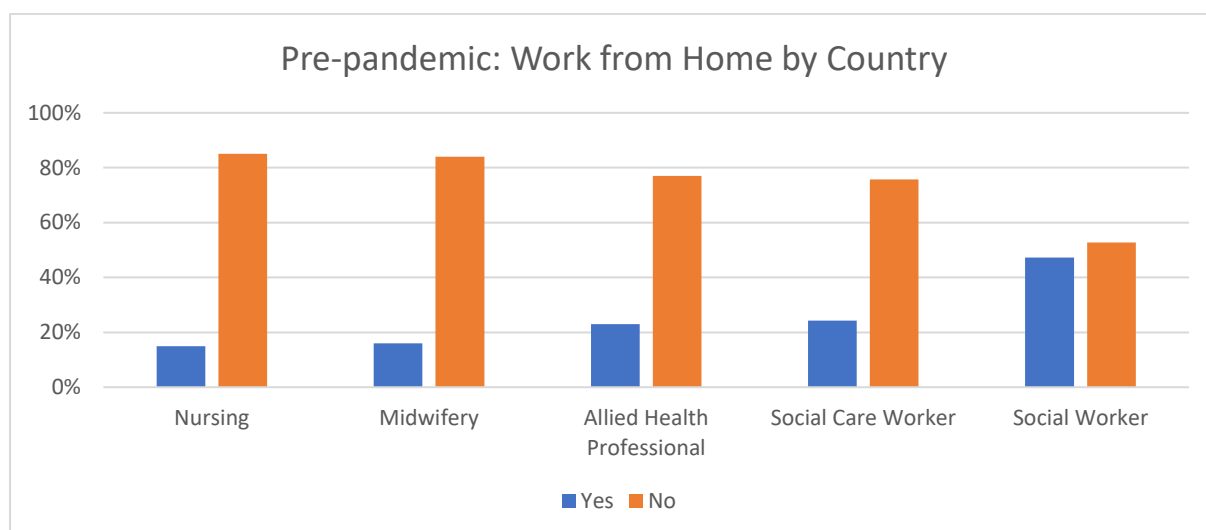


Figure A2. 83: Respondents working from home by Occupation (Unweighted)

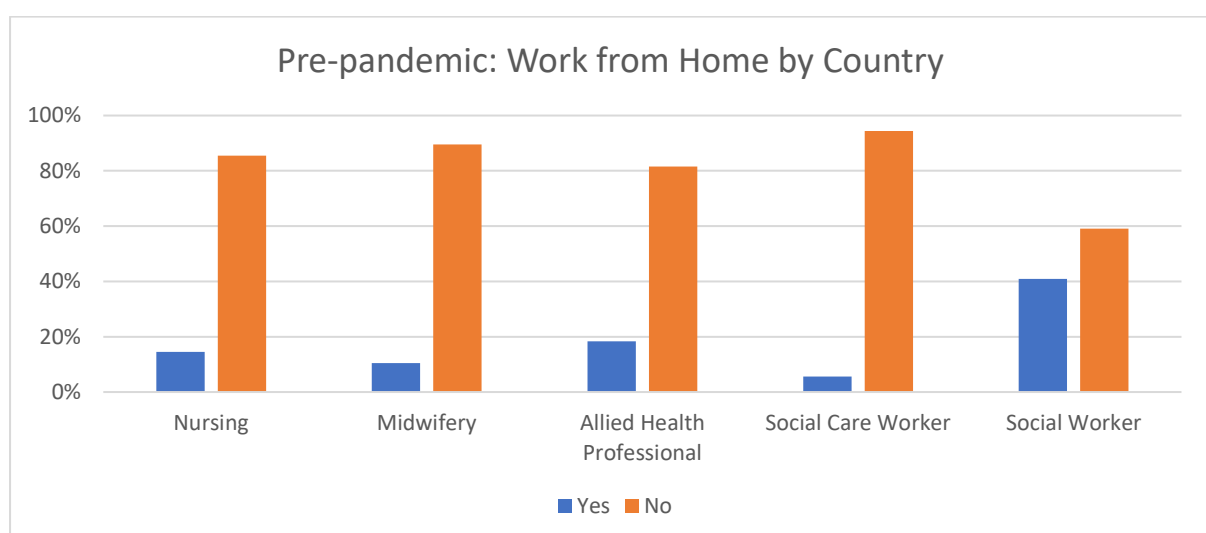


Table A2. 82: Respondents working from home by Occupation (Weighted)

Occupation	Did you work from home pre-pandemic?		Total
	Yes	No	
Nursing	14.9%	85.1%	100%
Midwifery	16.0%	84.0%	100%
AHP	23.0%	77.0%	100%
Social Care Worker	24.3%	75.7%	100%
Social Worker	47.3%	52.7%	100%

Table A2. 83: Respondents working from home by Occupation (Unweighted)

Occupation	Did you work from home pre-pandemic?		Total
	Yes	No	
Nursing	33 (14.5%)	195 (85.5%)	228 (100%)
Midwifery	9 (10.5%)	77 (89.5%)	86 (100%)
AHP	54 (18.4%)	240 (81.6%)	294 (100%)
Social Care Worker	40 (5.6%)	668 (94.4%)	708 (100%)
Social Worker	152 (40.9%)	220 (59.1%)	372 (100%)

## A2.18 Respondents working from home during the pandemic

Respondents were asked if, since the start of the pandemic, if they were able to work from home?

### Summary (Weighted results):

Just under half of respondents were not able to work from home during the pandemic. Scottish respondents were least likely to work from home while English respondents were more likely to work at home.

### Summary (Unweighted results):

Over two thirds of the respondents were not able to work from home at this point of the COVID-19 pandemic, May-July 2022 (67.6%). Scottish workers were least likely to work from home, while English workers were more likely to work at home. Social workers were the mostly likely group to work from home all or some of the time.

Figure A2. 84: Respondents working from home by Country (Weighted)

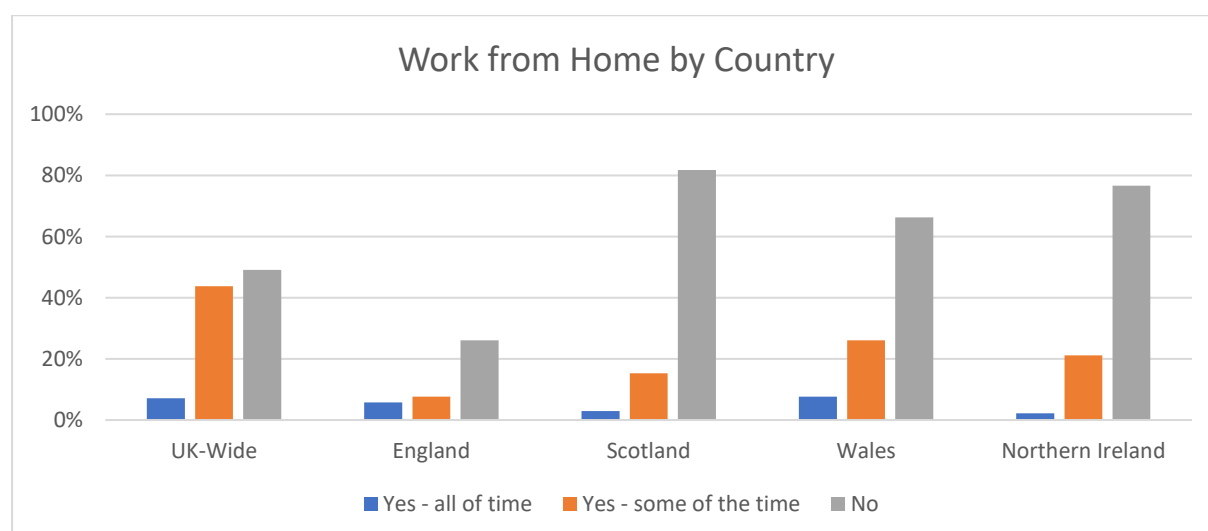


Figure A2. 85: Respondents working from home by Country (Unweighted)

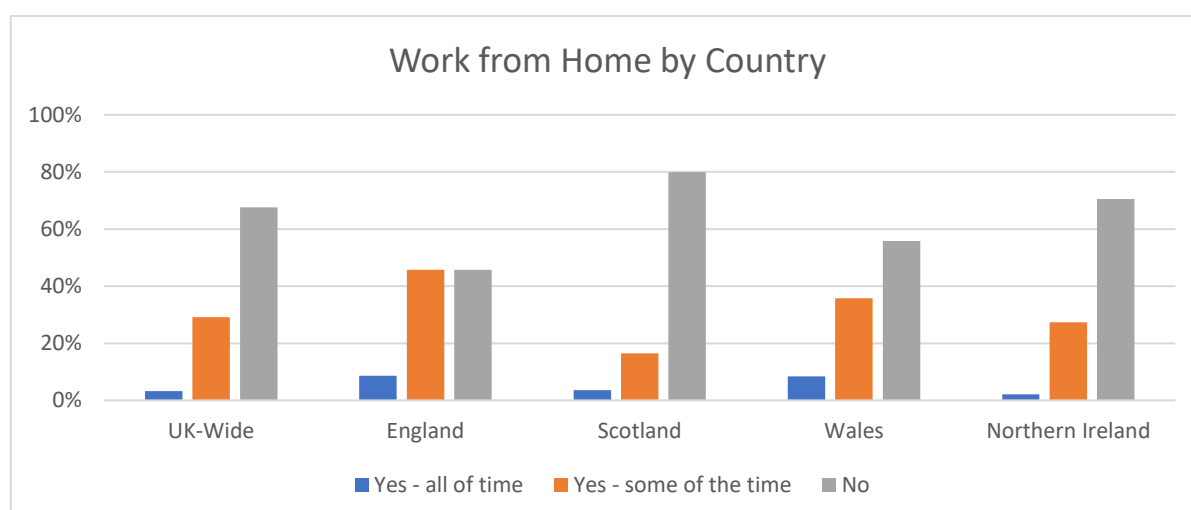


Table A2. 84: Respondents working from home by Country (Weighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes – all of time	7.1%	5.8%	2.9%	7.6%	2.2%
Yes – some of the time	43.8%	7.6%	15.3%	26.1%	21.1%
No	49.1%	26.1%	81.8%	66.3%	76.6%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 85: Respondents working from home by Country (Unweighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes – all of time	56 (3.3%)	5 (8.6%)	5 (3.6%)	8 (8.4%)	26 (2.1%)
Yes – some of the time	492 (29.1%)	90 (45.7%)	23 (16.5%)	34 (35.8%)	345 (27.4%)
No	1142 (67.6%)	90 (45.7%)	111 (79.9%)	53 (55.8%)	888 (70.5%)
<b>Total</b>	<b>1690 (100%)</b>	<b>197 (100%)</b>	<b>139 (100%)</b>	<b>95 (100%)</b>	<b>1259 (100%)</b>

Figure A2. 86: Respondents working from home by Occupation (Weighted)

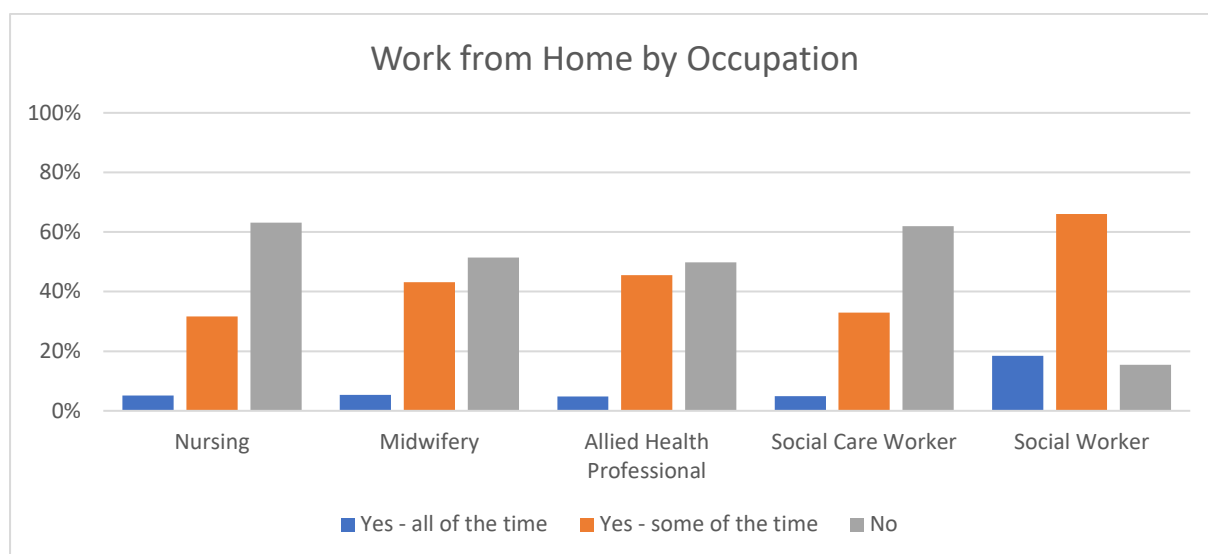


Figure A2. 87: Respondents working from home by Occupation (Unweighted)

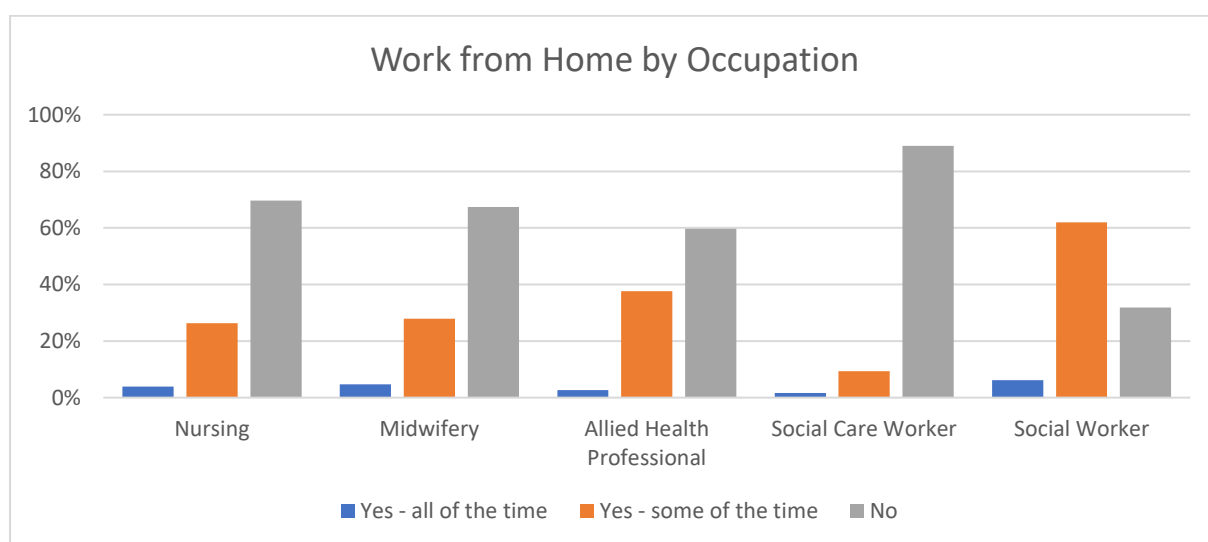


Table A2. 86: Respondents working from home by Occupation (Weighted)

Occupation	Are you working from home?			
	Yes – all of the time	Yes – some of the time	No	Total
Nursing	5.1%	31.7%	63.2%	100%
Midwifery	5.4%	43.2%	51.4%	100%
AHP	4.8%	45.5%	49.8%	100%
Social Care Worker	4.9%	33.0%	62.0%	100%
Social Worker	18.5%	66.1%	15.4%	100%

Table A2. 87: Respondents working from home by Occupation (Unweighted)

Occupation	Are you working from home?			
	Yes – all of time	Yes – some of the time	No	Total
Nursing	9 (3.9%)	60 (26.3%)	159 (69.7%)	<b>228 (100%)</b>
Midwifery	4 (4.7%)	24 (27.9%)	58 (67.4%)	<b>86 (100%)</b>
AHP	8 (2.7%)	111 (37.6%)	176 (59.7%)	<b>295 (100%)</b>
Social Care Worker	12 (1.7%)	66 (9.3%)	630 (89.0%)	<b>708 (100%)</b>
Social Worker	23 (6.2%)	231 (61.9%)	119 (31.9%)	<b>373 (100%)</b>

### A2.19 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.

Respondents reported other as the reason for considering changing their employer had a range of reasons including;

- Early retirement
- Pay is currently too low for the work done
- Considering more specialist roles
- Difficulty balancing work-home life
- To be closer to home
- Considering private sector due to better pay
- Not appreciated or respected by current employer
- To get a permanent post
- To further career development
- Personal reasons
- Being constantly overlooked for promotion



- Pressures within the healthcare system are impacting ability to be effective and impacting safety
- Hostility from public and fellow workers
- Frustration at current systems and support
- Unsupportive management
- Lack of clear communication from management
- Stress related issues impacting physical and mental health
- Poor working conditions
- Gaslighting by colleagues and constant bullying

Figure A2. 88: Considering Changing Employer by Country (Weighted)

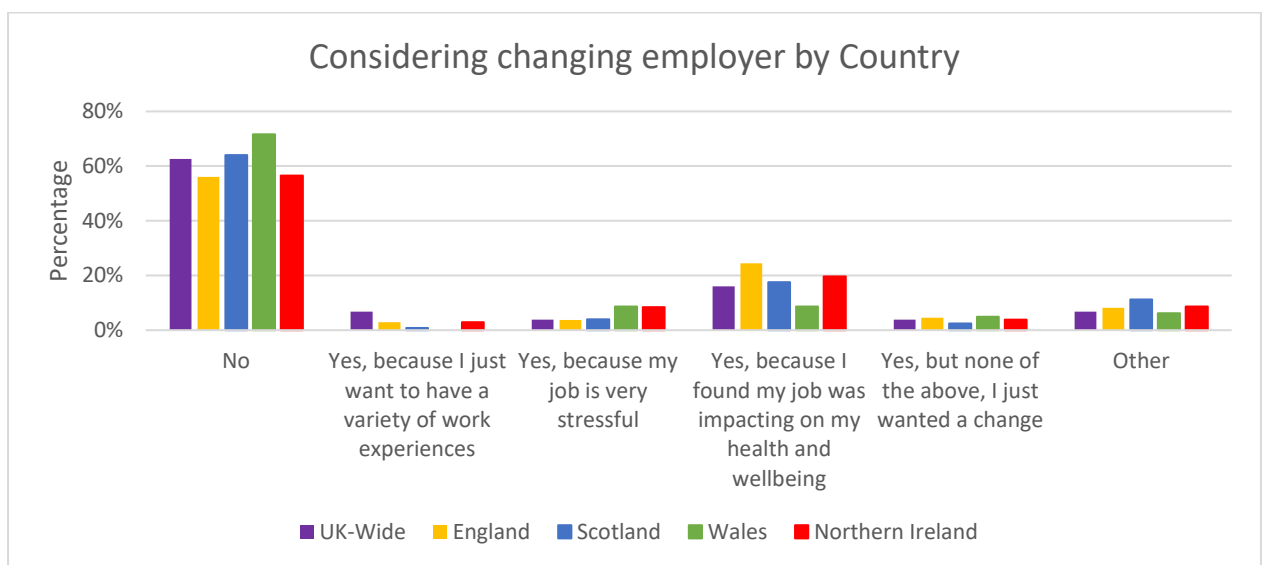


Figure A2. 89: Considering Changing Employer by Country (Unweighted)

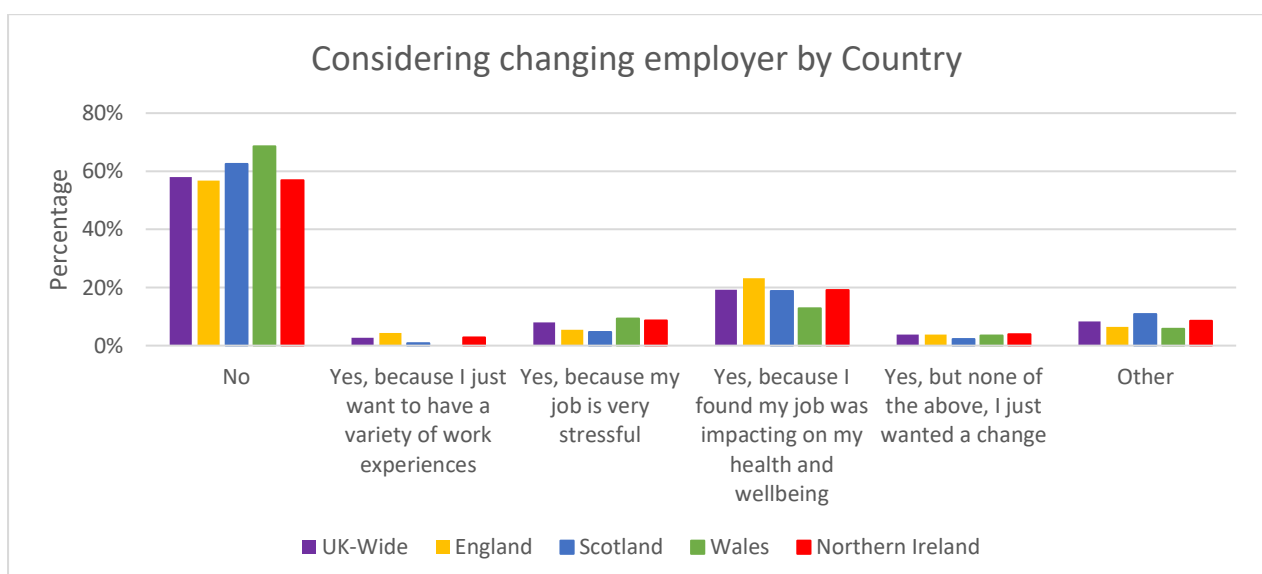


Table A2. 88: Considering Changing Employer by Country (Weighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	62.6%	56.1%	64.0%	71.6%	56.5%
Yes, because I just want to have a variety of work experiences	6.8%	2.9%	0.8%	0.0%	2.9%
Yes, because my job is very stressful	3.9%	3.7%	4.0%	8.6%	8.4%
Yes, because I found my job was impacting on my health and well-being	16.0%	24.5%	17.6%	8.6%	19.6%
Yes, but none of the above, I just wanted a change	3.9%	4.5%	2.4%	4.9%	3.9%
Other	6.8%	8.2%	11.2%	6.2%	8.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 89: Considering Changing Employer by Country (Unweighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	908 (58.0%)	105 (56.8%)	80 (62.5%)	59 (68.6%)	664 (56.9%)
Yes, because I just want to have a variety of work experiences	42 (2.7%)	8 (4.3%)	1 (0.8%)	0 (0.0%)	33 (2.8%)
Yes, because my job is very stressful	126 (8.0%)	10 (5.4%)	6 (4.7%)	8 (9.3%)	102 (8.7%)
Yes, because I found my job was impacting on my health and well-being	301 (19.2%)	43 (23.2%)	24 (18.8%)	11 (12.8%)	223 (19.1%)
Yes, but none of the above, I just wanted a change	59 (3.8%)	7 (3.8%)	3 (2.3%)	3 (3.5%)	46 (3.9%)
Other	130 (8.3%)	12 (6.5%)	14 (10.9%)	5 (5.8%)	99 (8.5%)
<b>Total</b>	<b>1566 (100%)</b>	<b>185 (100%)</b>	<b>128 (100%)</b>	<b>86 (100%)</b>	<b>1167 (100%)</b>

Figure A2. 90: Considering Changing Employer by Occupation (Weighted)

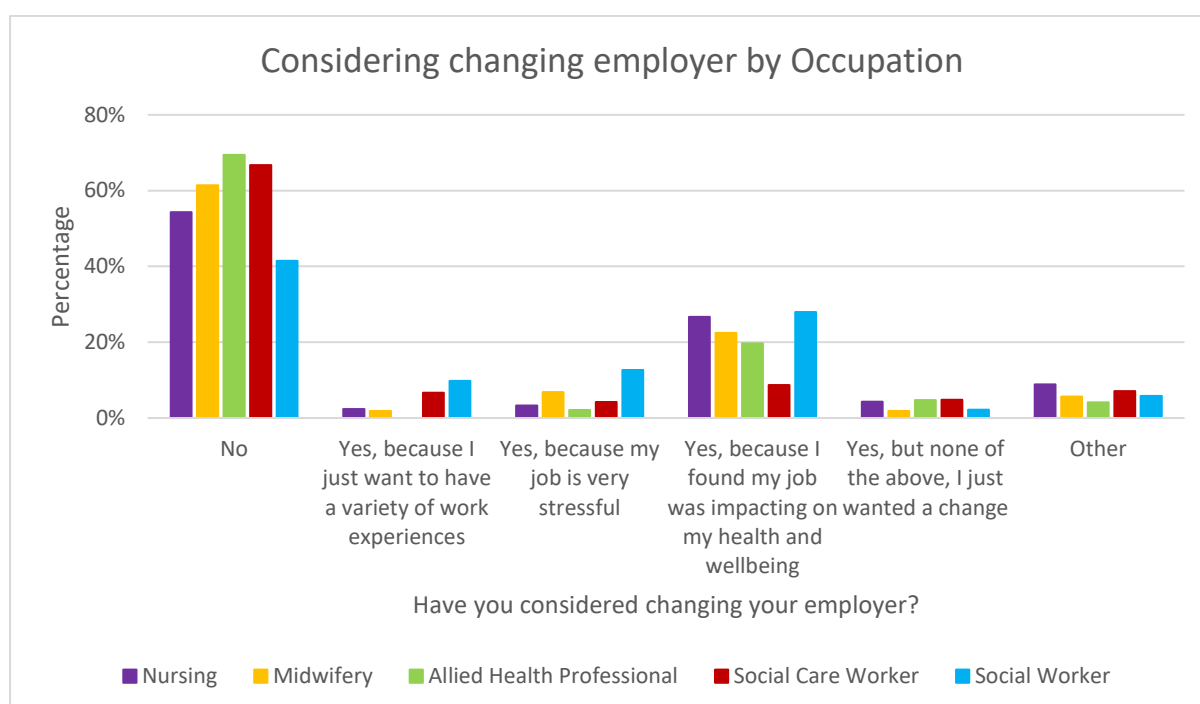


Figure A2. 91: Considering Changing Employer by Occupation (Unweighted)

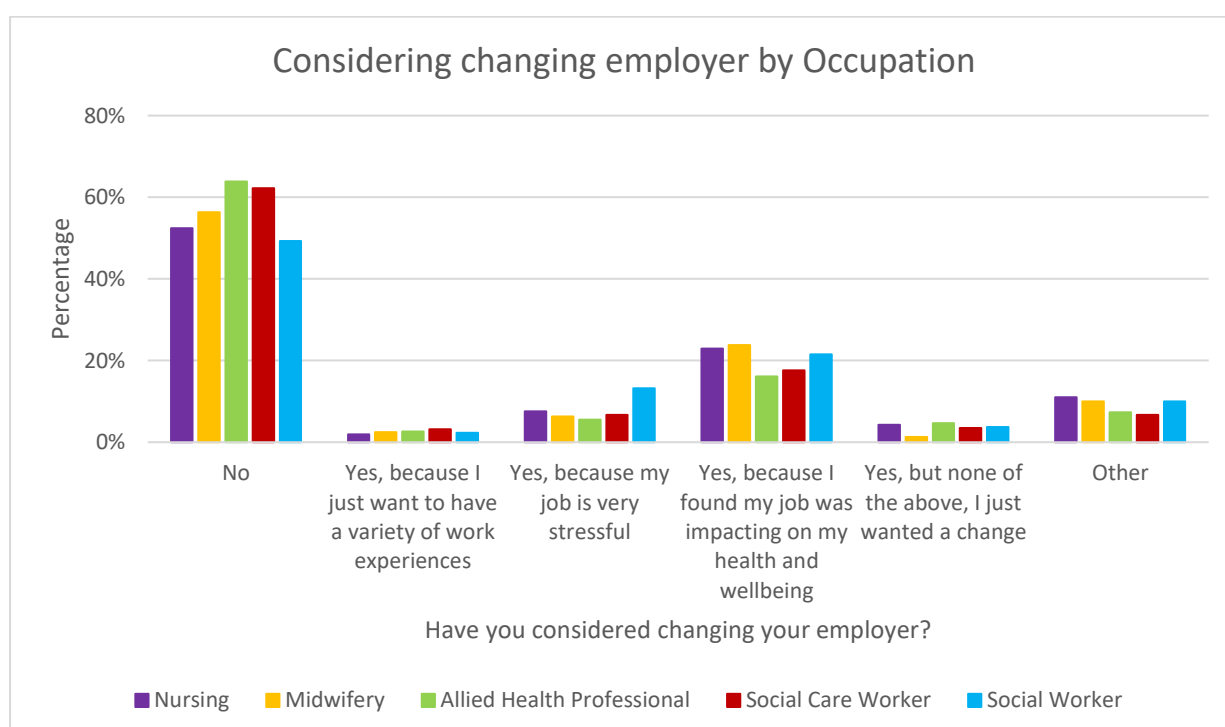


Table A2. 90: Considering Changing Employer by Occupation (Weighted)

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 well-being	Yes, but none of the above, I just wanted a change	Other	
Nursing	54.3%	2.4%	3.3%	26.7%	4.3%	8.9%	100%
Midwifery	61.4%	1.9%	6.8%	22.5%	1.9%	5.7%	100%
AHP	69.4%	0.0%	2.1%	19.7%	4.7%	4.1%	100%
Social Care Worker	66.7%	6.7%	4.2%	8.7%	4.8%	7.1%	100%
Social Worker	41.5%	9.8%	12.7%	28.0%	2.2%	5.8%	100%

Table A2. 91: 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 well-being	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	110 (52.4%)	4 (1.9%)	16 (7.6%)	48 (22.9%)	9 (4.3%)	23 (11.0%)	<b>210 (100%)</b>
Midwifery	45 (56.3%)	2 (2.5%)	5 (6.3%)	19 (23.8%)	1 (1.3%)	8 (10.0%)	<b>80 (100%)</b>
AHP	175 (63.9%)	7 (2.6%)	15 (5.5%)	44 (16.1%)	13 (4.7%)	20 (7.3%)	<b>274 (100%)</b>
Social Care Worker	406 (62.2%)	21 (3.2%)	44 (6.7%)	115 (17.6%)	23 (3.5%)	44 (6.7%)	<b>653 (100%)</b>
Social Worker	172 (49.3%)	8 (2.3%)	46 (13.2%)	75 (21.5%)	13 (3.7%)	35 (10.0%)	<b>349 (100%)</b>

## **A2.20 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.

Respondents reported other as the reason for considering changing their occupation had a range of reasons including;

- Dangers of COVID
- Changed job
- Lack of new opportunities/promotion
- Getting pulled in all different directions
- Lack of support
- Not paid enough
- Carer status changed
- Job requirements changed
- Early retirement
- Lack of staff support and unity
- Poor outlook
- Personal circumstances
- No enjoyment for job
- Undervalued
- Stressful, long hours
- Further education

Figure A2. 92: Considering Changing Occupation by Country (Weighted)

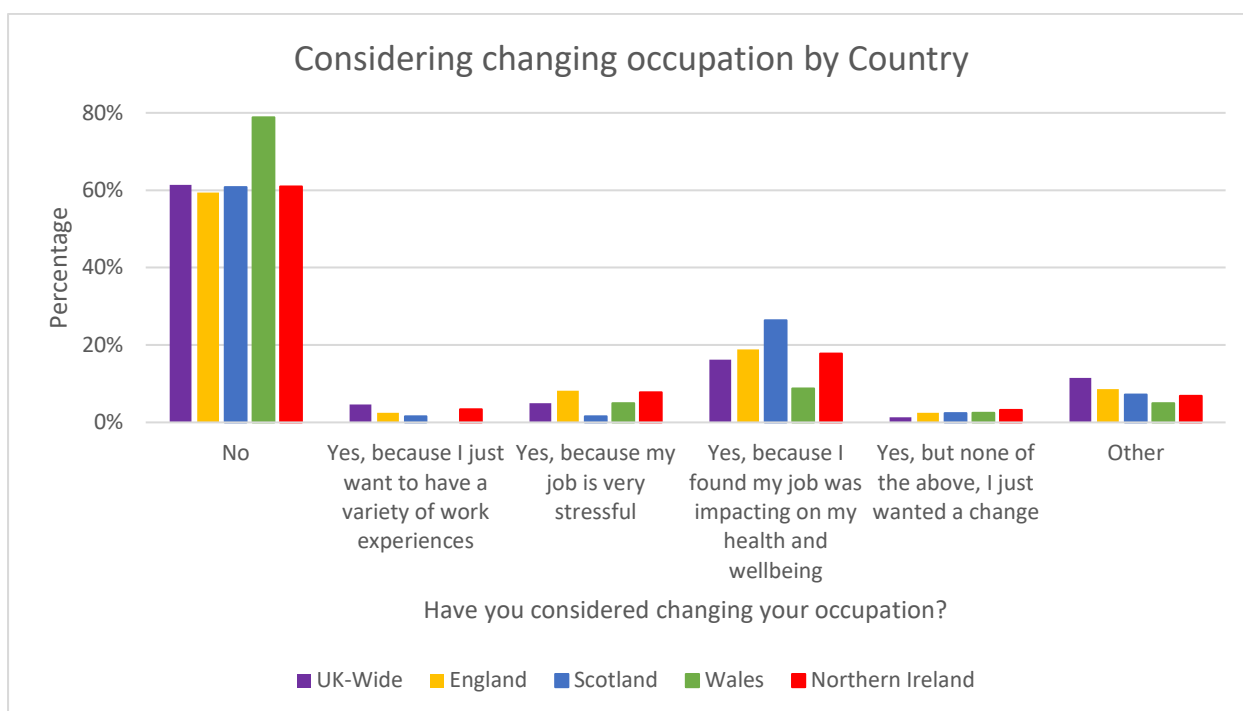


Figure A2. 93: Considering Changing Occupation by Country (Unweighted)

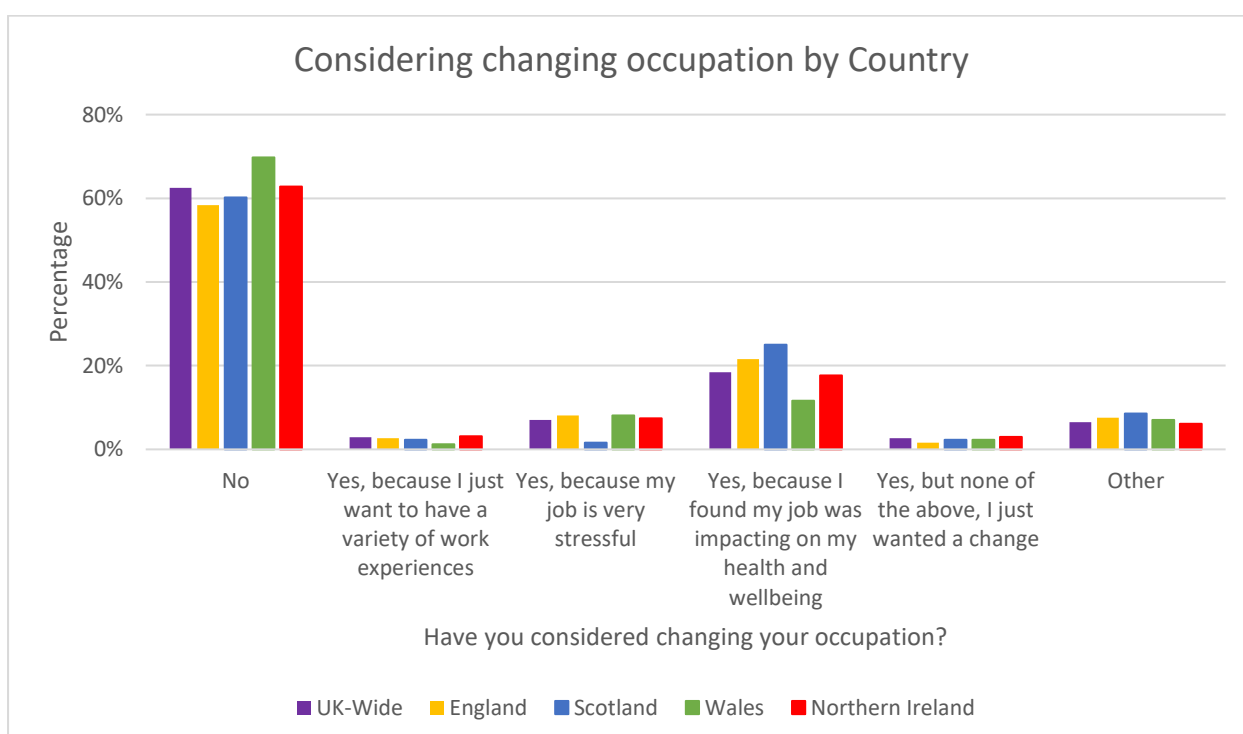




Table A2. 92: Considering Changing Occupation by Country (Weighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	61.4%	59.4%	60.8%	78.8%	61.0%
Yes, because I just want to have a variety of work experiences	4.6%	2.5%	1.6%	0.0%	3.4%
Yes, because my job is very stressful	5.0%	8.2%	1.6%	5.0%	7.8%
Yes, because I found my job was impacting on my health and well-being	16.2%	18.9%	26.4%	8.8%	17.8%
Yes, but none of the above, I just wanted a change	1.3%	2.5%	2.4%	2.5%	3.2%
Other	11.5%	8.6%	7.2%	5.0%	6.9%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 93: Considering Changing Occupation by Country (Unweighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	978 (62.5%)	108 (58.4%)	77 (60.2%)	60 (69.8%)	733 (62.8%)
Yes, because I just want to have a variety of work experiences	45 (2.9%)	5 (2.7%)	3 (2.3%)	1 (1.2%)	36 (3.1%)
Yes, because my job is very stressful	110 (7.0%)	15 (8.1%)	2 (1.6%)	7 (8.1%)	86 (7.4%)
Yes, because I found my job was impacting on my health and well-being	288 (18.4%)	40 (21.6%)	32 (25.0%)	10 (11.6%)	206 (17.7%)
Yes, but none of the above, I just wanted a change	43 (2.7%)	3 (1.6%)	3 (2.3%)	2 (2.3%)	35 (3.0%)
Other	102 (6.5%)	14(7.6%)	11 (8.6%)	6 (7.0%)	71 (6.1%)
<b>Total</b>	<b>1566 (100%)</b>	<b>185 (100%)</b>	<b>128 (100%)</b>	<b>86 (100%)</b>	<b>1167 (100%)</b>

Figure A2. 94: Considering Changing Occupation by Occupation (Weighted)

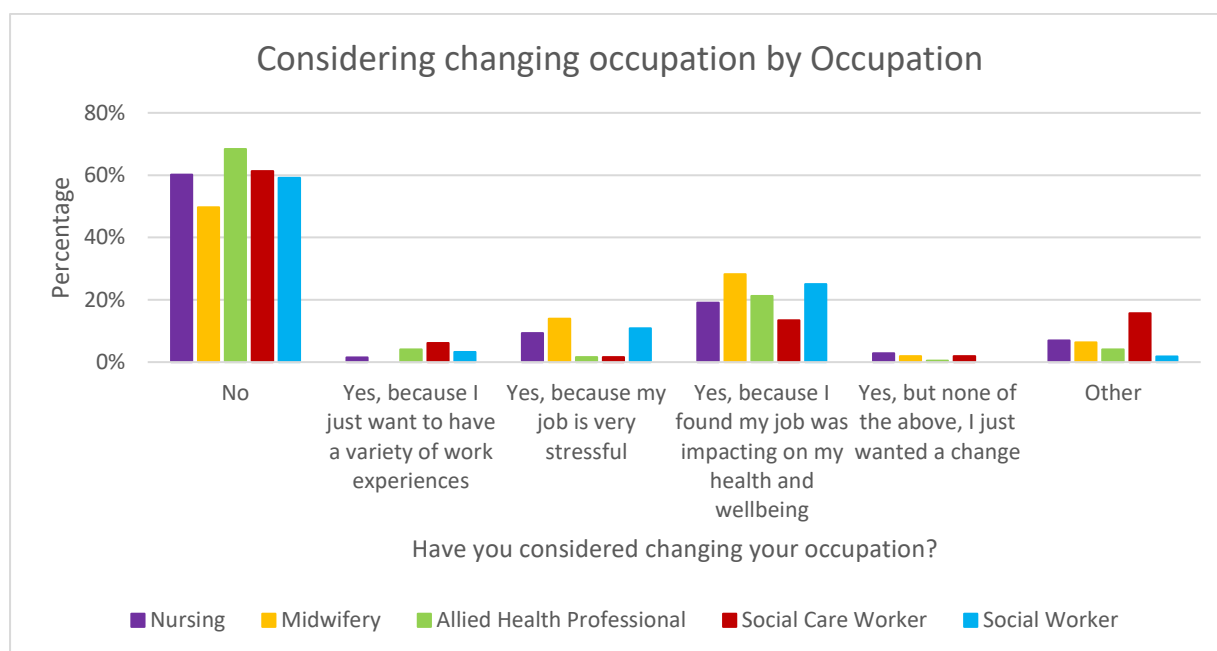


Figure A2. 95: Considering Changing Occupation by Occupation (Unweighted)

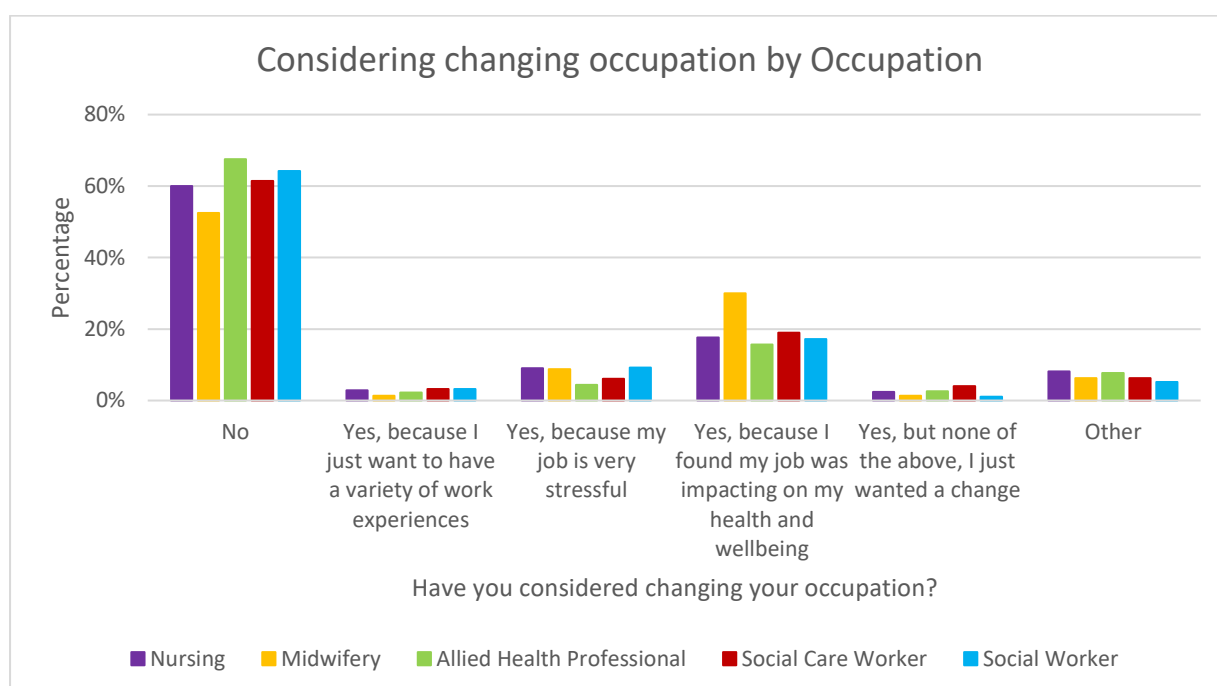


Table A2. 94: Considering Changing Occupation by Occupation (Weighted)

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 well-being	Yes, but none of the above, I just wanted a change	Other	
Nursing	60.2%	1.5%	9.3%	19.1%	2.8%	7.0%	100%
Midwifery	49.7%	0.0%	13.9%	28.2%	1.9%	6.3%	100%
AHP	68.4%	4.1%	1.6%	21.2%	0.5%	4.1%	100%
Social Care Worker	61.3%	6.1%	1.6%	13.4%	1.9%	15.7%	100%
Social Worker	59.1%	3.3%	10.9%	25.0%	0.0%	1.8%	100%

Table A2. 95: Considering Changing Occupation by Occupation (Unweighted)

Occupation	Have you considered changing your 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 well-being	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	126 (60.0%)	6 (2.9%)	19 (9.0%)	37 (17.6%)	5 (2.4%)	17 (8.1%)	<b>210 (100%)</b>
Midwifery	42 (52.5%)	1 (1.3%)	7 (8.8%)	24 (30.0%)	1 (1.3%)	5 (6.3%)	<b>80 (100%)</b>
AHP	185 (67.5%)	6 (2.2%)	12 (4.4%)	43 (15.7%)	7 (2.6%)	21 (7.7%)	<b>274 (100%)</b>
Social Care Worker	401 (61.4%)	21 (3.2%)	40 (6.1%)	124 (19.0%)	26 (4.0%)	41 (6.3%)	<b>653 (100%)</b>
Social Worker	224 (64.2%)	11 (3.2%)	32 (9.2%)	60 (17.2%)	4 (1.1%)	18 (5.2%)	<b>349 (100%)</b>

#### **A2.21 Respondents reasons for why they might change their mind about wanting to leave.**

Respondents were asked what has to happen for them to change their mind about wanting to leave. Multiple responses were allowed, which means that the percentages do not add up to 100%.

##### **Summary (Weighted results):**

More respondents felt that they had other reasons to change their mind about wanting to leave for example; a return to office based working, a commitment from managers on adequate protection, new job roles, decent sick pay, effective supervision, more services available, adequate staffing, an end to the COVID-19 pandemic, ability to work from home when needed, clear leadership etc.

##### **Summary (Unweighted results):**

More respondents felt that manager support, followed by other (e.g. lack of other jobs available during pandemic, home-work balance, getting back to office, to feel valued, improve morale, reduced caseloads needed) are what needs to happen for them to change their minds about wanting to leave.

Those who selected other reasons noted the following:

- Making simple changes to make workload more manageable
- Equal spread of workload
- Ability to work from home with continued support
- Additional baking staff to help out when staff shortage issues arose
- Adequate staffing levels
- Being valued by senior management
- Change in work culture
- Client group/risk management
- Consistent professional supervision and safety netting of role
- Working conditions addresses
- Job satisfaction

Several respondents actually reported issues that would cause them to leave their current employer. Some felt that they had to stay because they couldn't find another job with the same pay while others noted that while they might change their mind was because of bullying. Increased bullying was noted as a problem in the workplace and respondents felt this must be dealt with for them to operate more effectively. If this issue was dealt with then respondents would not want to leave their current

employer. Other respondents continued to highlight that poor pay and staffing issues were leaving teams on their knees with also a need to end the current blame culture that exists within the workplace. Several highlighted that the increased load of paper work, lack of practical support and lack of other suitable jobs were issues leading them to consider leaving,

Figure A2. 96: What has to happen for you to change your mind about wanting to leave by Country (Weighted)

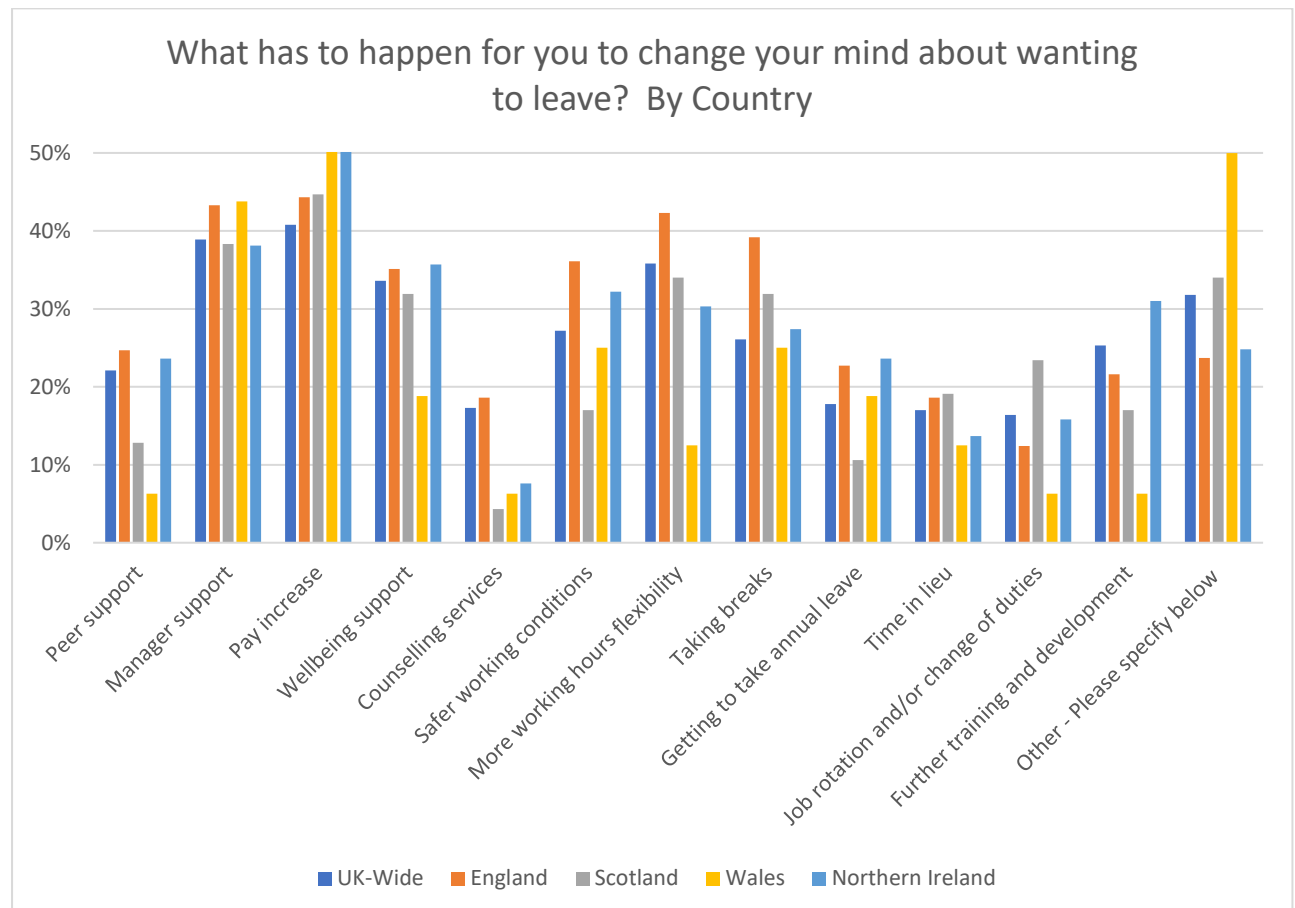


Figure A2. 97: What has to happen for you to change your mind about wanting to leave by Country (Unweighted)

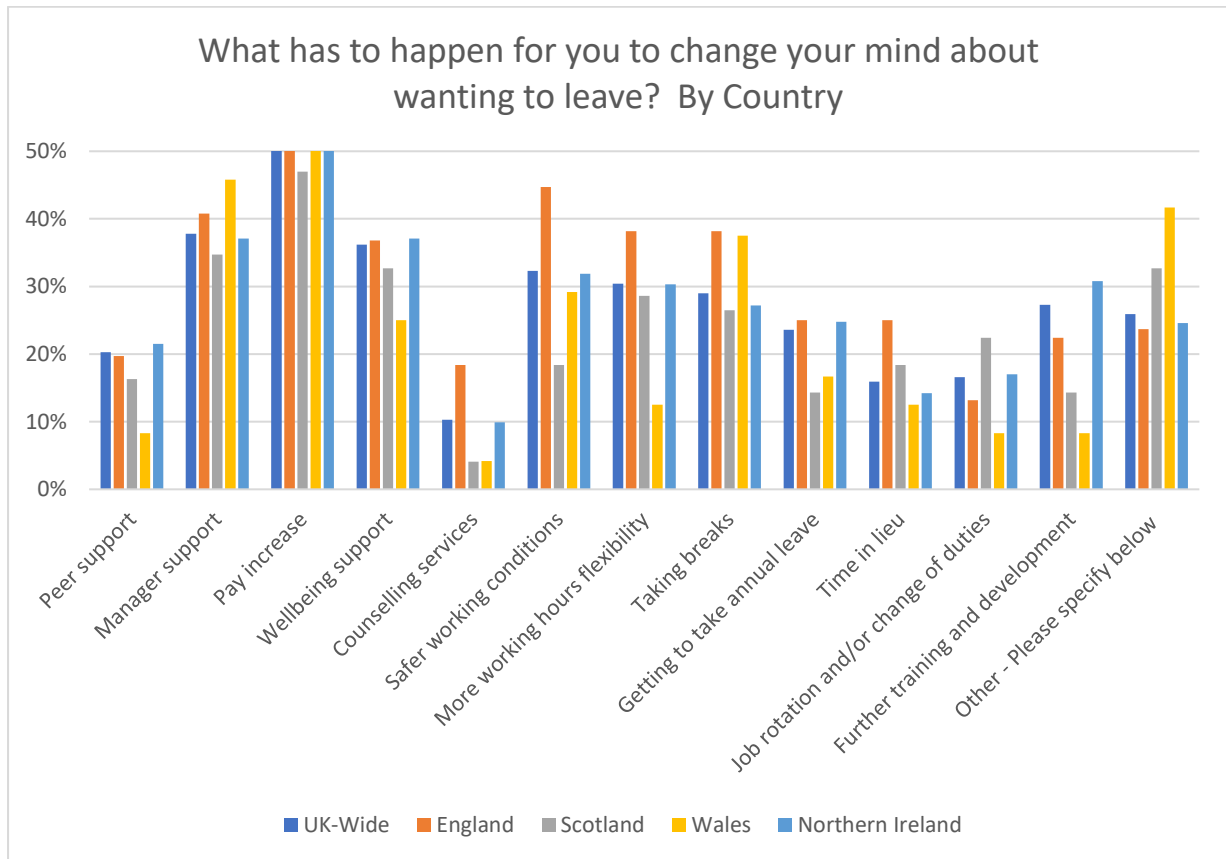




Table A2. 96: What has to happen for you to change your mind about wanting to leave by Country (Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	22.1%	24.7%	12.8%	6.3%	23.6%
Manager support	38.9%	43.3%	38.3%	43.8%	38.1%
Pay increase	40.8%	44.3%	44.7%	56.3%	61.3%
Well-being support	33.6%	35.1%	31.9%	18.8%	35.7%
Counselling services	17.3%	18.6%	4.3%	6.3%	7.6%
Safer working conditions	27.2%	36.1%	17.0%	25.0%	32.2%
More working hours flexibility	35.8%	42.3%	34.0%	12.5%	30.3%
Taking breaks	26.1%	39.2%	31.9%	25.0%	27.4%
Getting to take annual leave	17.8%	22.7%	10.6%	18.8%	23.6%
Time in lieu	17.0%	18.6%	19.1%	12.5%	13.7%
Job rotation and/or change of duties	16.4%	12.4%	23.4%	6.3%	15.8%
Further training and development	25.3%	21.6%	17.0%	6.3%	31.0%
Other – Please specify below	31.8%	23.7%	34.0%	50.0%	24.8%

Table A2. 97: What has to happen for you to change your mind about wanting to leave by Country (Unweighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	116 (20.3%)	15 (19.7%)	8 (16.3%)	2 (8.3%)	91 (21.5%)
Manager support	216 (37.8%)	31 (40.8%)	17 (34.7%)	11 (45.8%)	157 (37.1%)
Pay increase	335 (58.6%)	40 (52.6%)	23 (47.0%)	15 (62.5%)	257 (60.8%)
Well-being support	207 (36.2%)	28 (36.8%)	16 (32.7%)	6 (25.0%)	137 (37.1%)
Counselling services	59 (10.3%)	14 (18.4%)	2 (4.1%)	1 (4.2%)	42 (9.9%)
Safer working conditions	185 (32.3%)	34 (44.7%)	9 (18.4%)	7 (29.2%)	135 (31.9%)
More working hours flexibility	174 (30.4%)	29 (38.2%)	14 (28.6%)	3 (12.5%)	128 (30.3%)
Taking breaks	166 (29.0%)	29 (38.2%)	13 (26.5%)	9 (37.5%)	115 (27.2%)
Getting to take annual leave	135 (23.6%)	19 (25.0%)	7 (14.3%)	4 (16.7%)	105 (24.8%)
Time in lieu	91 (15.9%)	19 (25.0%)	9 (18.4%)	3 (12.5%)	60 (14.2%)
Job rotation and/or change of duties	95 (16.6%)	10 (13.2%)	11 (22.4%)	2 (8.3%)	72 (17.0%)
Further training and development	156 (27.3%)	17 (22.4%)	7 (14.3%)	2 (8.3%)	130 (30.8%)
Other – Please specify below	148 (25.9%)	18 (23.7%)	16 (32.7%)	10 (41.7%)	104 (24.6%)
<b>Total no of respondents answering question</b>	<b>572</b>	<b>76</b>	<b>49</b>	<b>24</b>	<b>423</b>

Figure A2. 98: What has to happen for you to change your mind about wanting to leave by Occupation (Weighted)

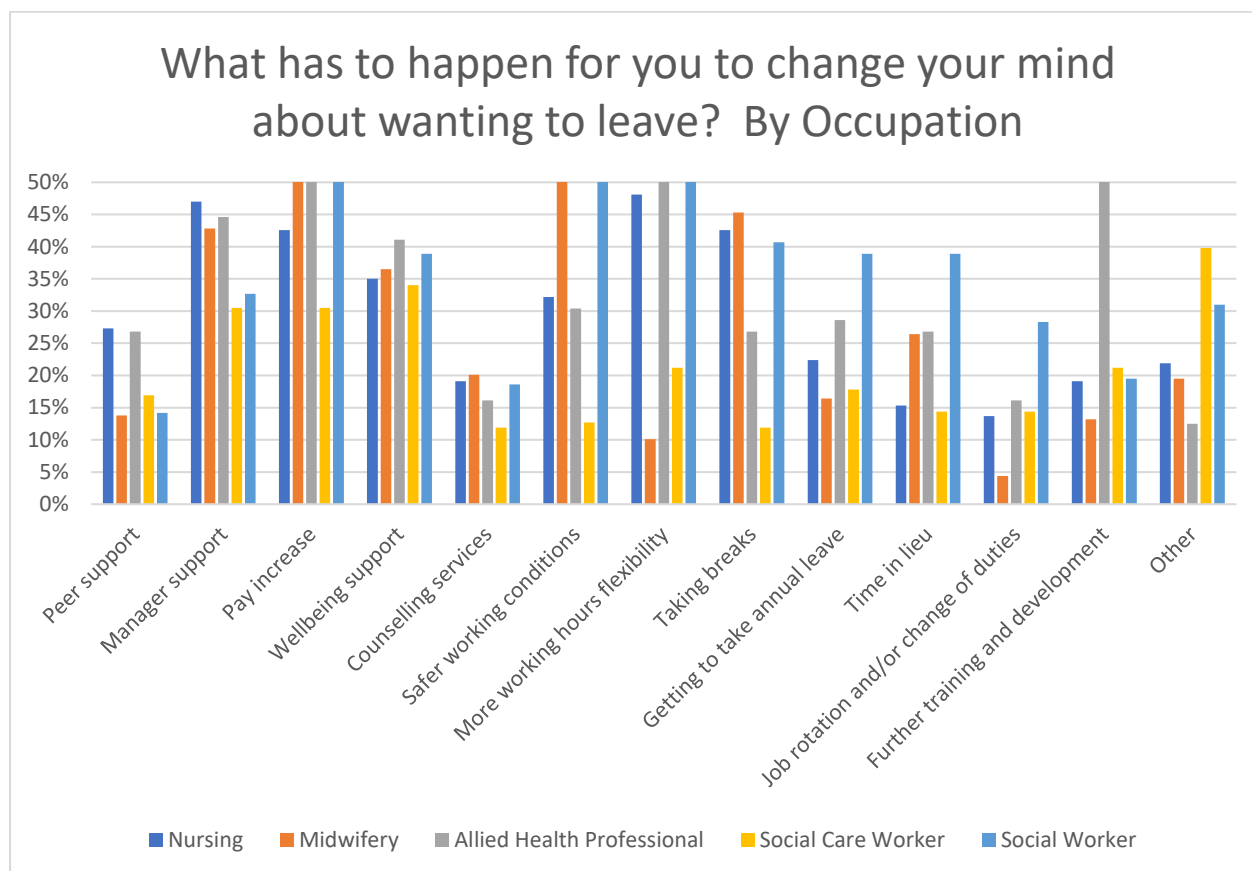


Figure A2. 99: What has to happen for you to change your mind about wanting to leave by Occupation (Unweighted)

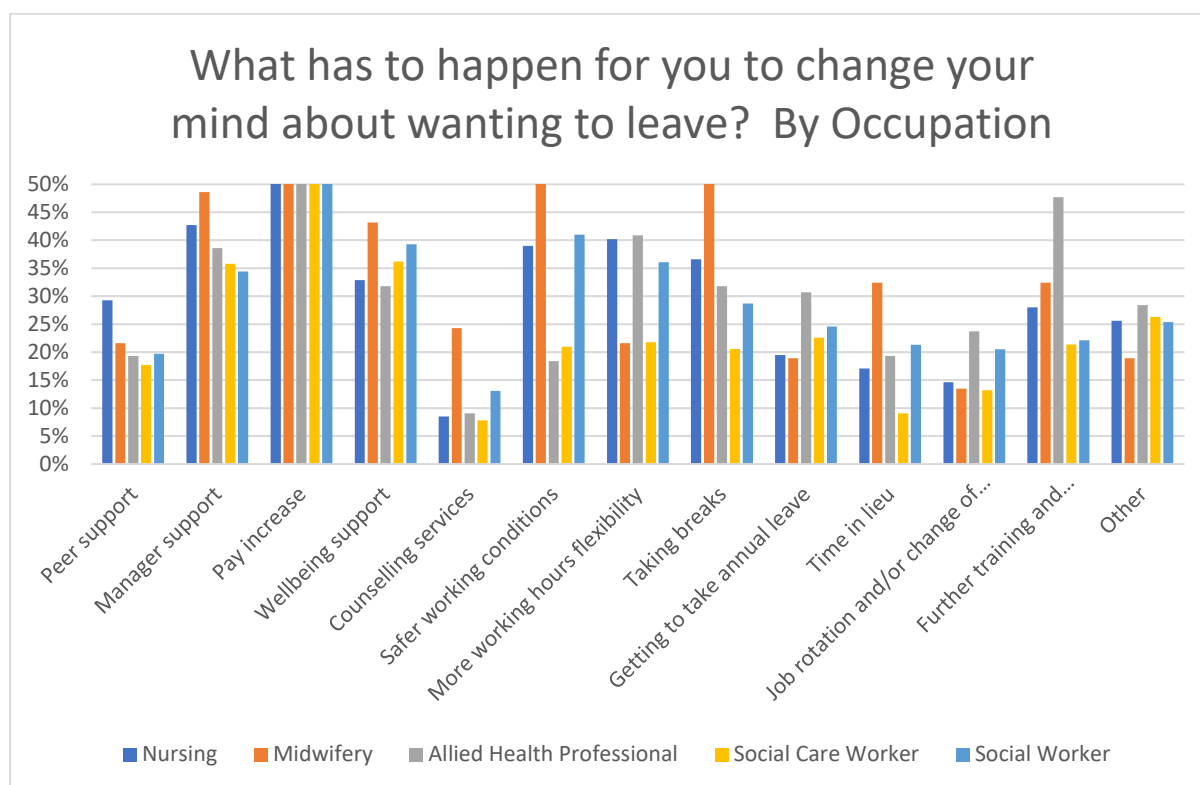


Table A2. 98: What has to happen for you to change your mind about wanting to leave by Occupation(Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	27.3%	13.8%	26.8%	16.9%	14.2%
Manager support	47.0%	42.8%	44.6%	30.5%	32.7%
Pay increase	42.6%	63.5%	58.9%	30.5%	67.3%
Well-being support	35.0%	36.5%	41.1%	34.0%	38.9%
Counselling services	19.1%	20.1%	16.1%	11.9%	18.6%
Safer working conditions	32.2%	64.2%	30.4%	12.7%	52.2%
More working hours flexibility	48.1%	10.1%	73.2%	21.2%	54.9%
Taking breaks	42.6%	45.3%	26.8%	11.9%	40.7%
Getting to take annual leave	22.4%	16.4%	28.6%	17.8%	38.9%
Time in lieu	15.3%	26.4%	26.8%	14.4%	38.9%
Job rotation and/or change of duties	13.7%	4.4%	16.1%	14.4%	28.3%
Further training and development	19.1%	13.2%	60.7%	21.2%	19.5%
Other – Please specify below	21.9%	19.5%	12.5%	39.8%	31.0%

Table A2. 99: What has to happen for you to change your mind about wanting to leave by Occupation (Unweighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	24 (29.3%)	8 (21.6%)	17 (19.3%)	43 (17.7%)	24 (19.7%)
Manager support	35 (42.7%)	18 (48.6%)	34 (38.6%)	87 (35.8%)	42 (34.4%)
Pay increase	45 (54.9%)	26 (70.3%)	54 (61.4%)	136 (56.0%)	74 (60.7%)
Well-being support	27 (32.9%)	16 (43.2%)	54 (61.4%)	88 (36.2%)	48 (39.3%)
Counselling services	7 (8.5%)	9 (24.3%)	28 (31.8%)	19 (7.8%)	16 (13.1%)
Safer working conditions	32 (39.0%)	27 (7.3%)	8 (9.1%)	51 (21.0%)	50 (41.0%)
More working hours flexibility	33 (40.2%)	8 (21.6%)	25 (28.4%)	53 (21.8%)	44 (36.1%)
Taking breaks	30 (36.6%)	23 (62.7%)	36 (40.9%)	50 (20.6%)	35 (28.7%)
Getting to take annual leave	16 (19.5%)	7 (18.9%)	28 (31.8%)	55 (22.6%)	30 (24.6%)
Time in lieu	14 (17.1%)	12 (32.4%)	27 (30.7%)	22 (9.1%)	26 (21.3%)
Job rotation and/or change of duties	12 (14.6%)	5 (13.5%)	17 (19.3%)	32 (13.2%)	25 (20.5%)
Further training and development	23 (28.0%)	12 (32.4%)	21 (23.7%)	52 (21.5%)	27 (22.1%)
Other – Please specify below	21 (25.6%)	7 (18.9%)	42 (47.7%)	64 (26.3%)	31 (25.4%)
<b>Total of respondents answering question</b>	<b>82</b>	<b>37</b>	<b>88</b>	<b>243</b>	<b>122</b>

## A2.22 Change in job or contractual working hours since the start of pandemic? (Not including redeployment)

Respondents were asked if had they had actually chosen to change their job or contractual working hours since the start of the pandemic.

### Summary (Weighted results):

A majority of the respondents reported to still being in the same job, with the same contractual working hours.

### Summary (Unweighted results):

A majority of respondents stated no that they were still in the same job with the same contractual working hours (80.9%).

Figure A2. 100: Chosen to change job or contractual working hours by Country (Weighted)

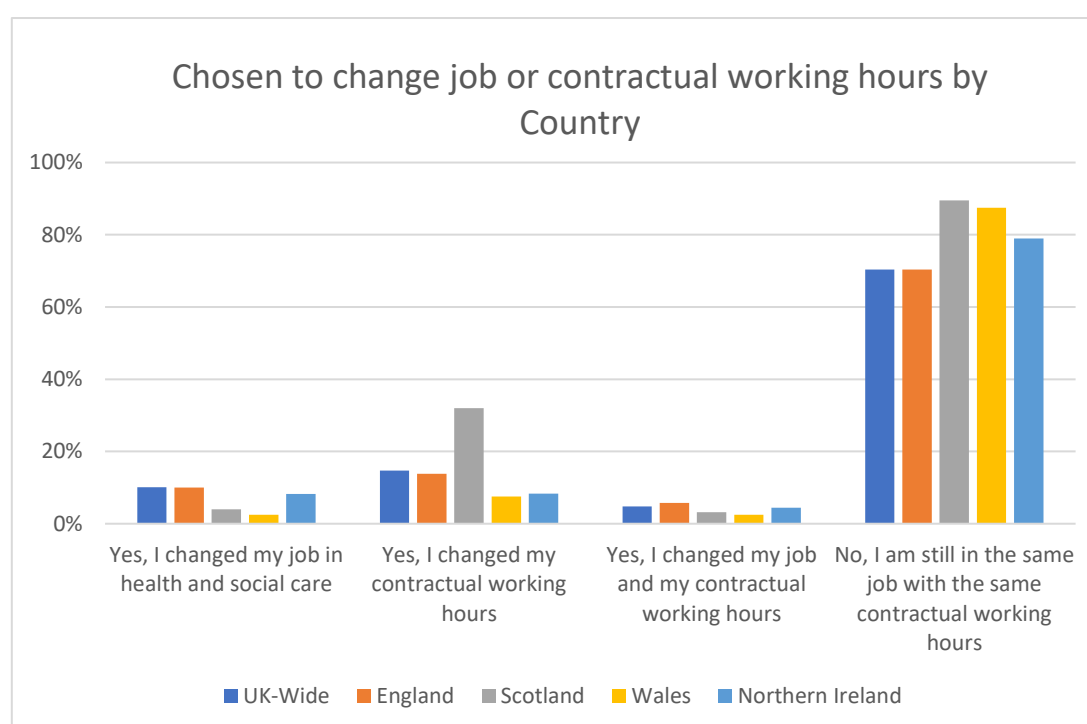


Figure A2. 101: Chosen to change job or contractual working hours by Country (Unweighted)

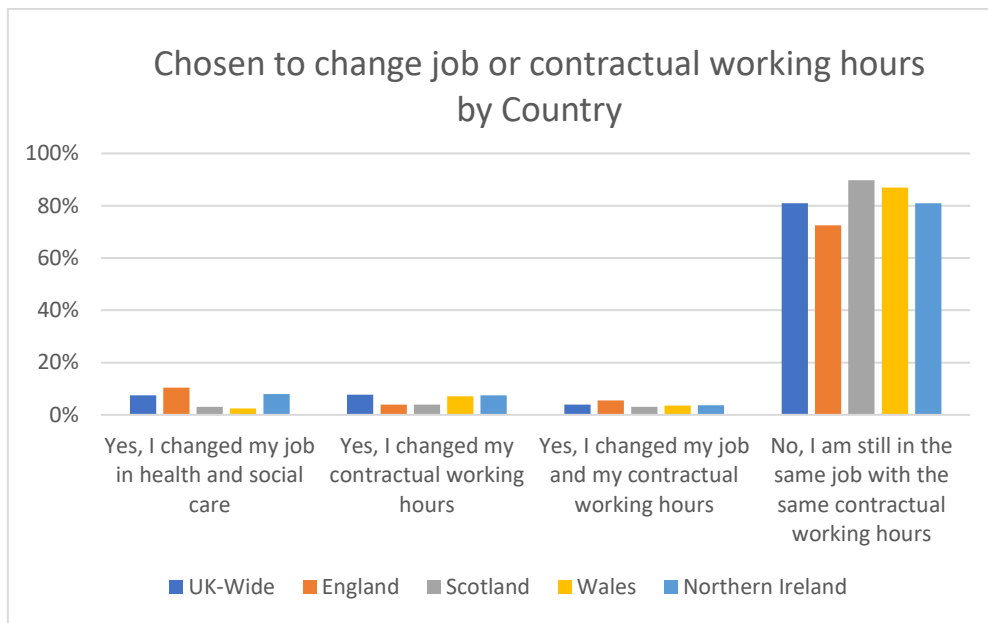


Table A2. 100: Chosen to change job or contractual working hours by Country (Weighted)

	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, I changed my job in health and social care	10.1%	10.0%	4.0%	2.5%	8.2%
Yes, I changed my contractual working hours	14.7%	13.8%	32.0%	7.5%	8.3%
Yes, I changed my job and my contractual working hours	4.8%	5.8%	3.2%	2.5%	4.4%
No, I am still in the same job with the same contractual working hours	70.4%	70.4%	89.5%	87.5%	79.0%
Total	100%	100%	100%	100%	100%



Table A2. 101: Chosen to change job or contractual working hours by Country (Unweighted)

	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, I changed my job in health and social care	116 (7.5%)	19 (10.4%)	4 (3.1%)	2 (2.4%)	91 (7.9%)
Yes, I changed my contractual working hours	119 (7.7%)	21 (3.9%)	5 (3.9%)	6 (7.1%)	87 (7.5%)
Yes, I changed my job and my contractual working hours	60 (3.9%)	10 (5.5%)	4 (3.1%)	3 (3.6%)	43 (3.7%)
No, I am still in the same job with the same contractual working hours	1253 (80.9%)	132 (72.5%)	114 (89.8%)	73 (86.9%)	934 (80.9%)
<b>Total</b>	<b>1548 (100%)</b>	<b>184 (100%)</b>	<b>127 (100%)</b>	<b>84 (100%)</b>	<b>1155 (100%)</b>

Figure A2. 102: Chosen to change job or contractual working hours by Occupation (Weighted)

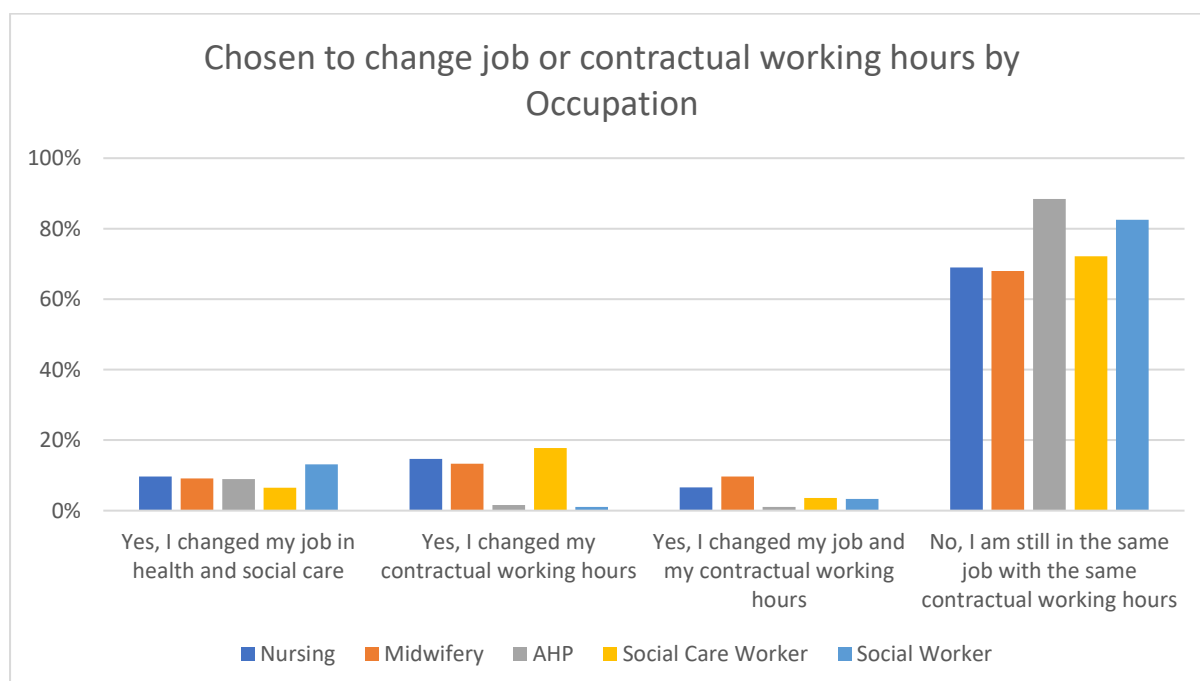


Figure A2. 103: Chosen to change job or contractual working hours by Occupation (Unweighted)

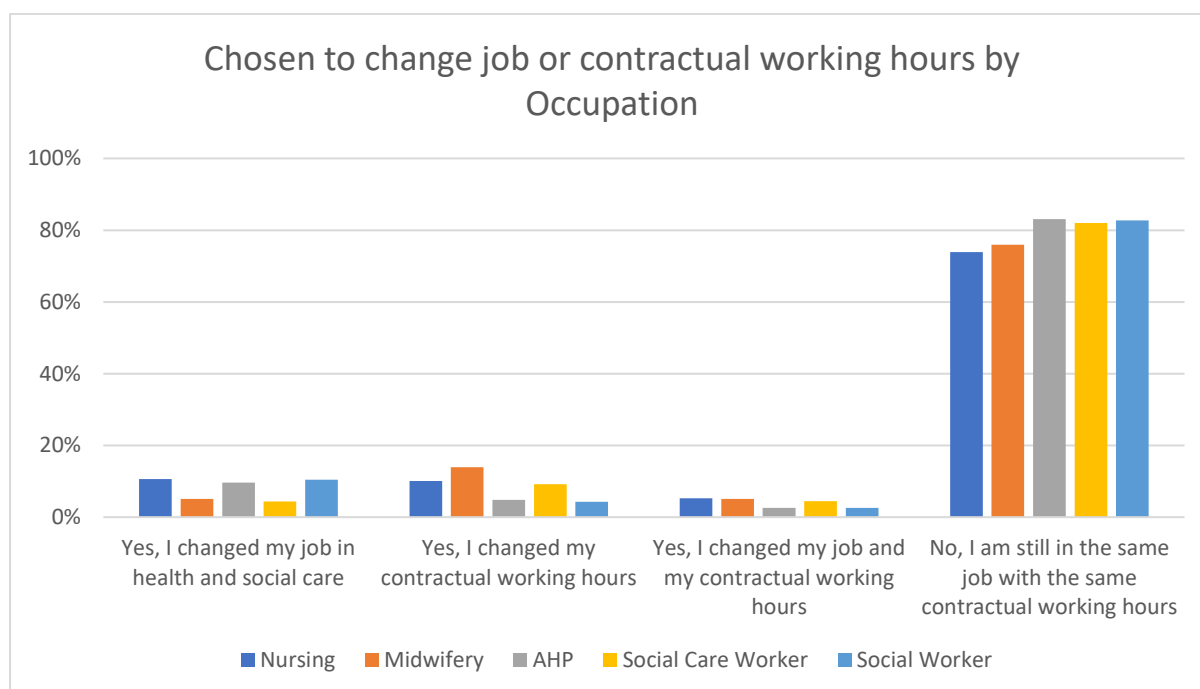


Table A2. 102: Chosen to change job or contractual working hours by Occupation (Weighted)

Occupation	Yes, I changed my job in health and social care	Yes, I changed my contractual working hours	Yes, I changed my job and my contractual working hours	No, I am still in the same job with the same contractual working hours	Total
Nursing	9.7%	14.7%	6.6%	69.0%	100%
Midwifery	9.1%	13.3%	9.7%	68.0%	100%
AHP	9.0%	1.6%	1.1%	88.4%	100%
Social Care	6.5%	17.8%	3.6%	72.2%	100%
Social Work	13.1%	1.1%	3.3%	82.5%	100%

Table A2. 103: Chosen to change job or contractual working hours by Occupation (Unweighted)

Occupation	Yes, I changed my job in health and social care	Yes, I changed my contractual working hours	Yes, I changed my job and my contractual working hours	No, I am still in the same job with the same contractual working hours	Total
Nursing	22 (10.6%)	22 (10.1%)	11 (5.3%)	153 (73.9%)	207 (100%)
Midwifery	4 (5.1%)	4 (13.9%)	4 (5.1%)	60 (75.9%)	79 (100%)
AHP	26 (9.6%)	26 (4.8%)	7 (2.6%)	226 (83.1%)	272 (100%)
Social Care	36 (4.4%)	28 (9.2%)	29 (4.5%)	527 (82.0%)	643 (100%)
Social Work	116 (10.4%)	36 (4.3%)	9 (2.6%)	287 (82.7%)	347 (100%)

## A2.23 Respondents taking up employer support

Respondents were asked had they taken up employer support for well-being.

### Summary (Weighted results):

Most respondents did not take up employer support. Those in England were more likely to take up employer support, while those in Scotland were least likely to take up employer support. Out of all occupations AHPs were most likely to take up employer well-being support while midwives were least likely to take up support.

### Summary (Unweighted results):

A majority of respondents did not take up employer support (80.3%). Those in Wales were more likely to take up employer support (31.3%) while those in Scotland were least likely to take up employer support (16.7%). Out of all occupations, social workers were most likely to take up employer well-being support while social care workers were least likely to take up support.

Figure A2. 104: Taken up Employer support by Country (Weighted)

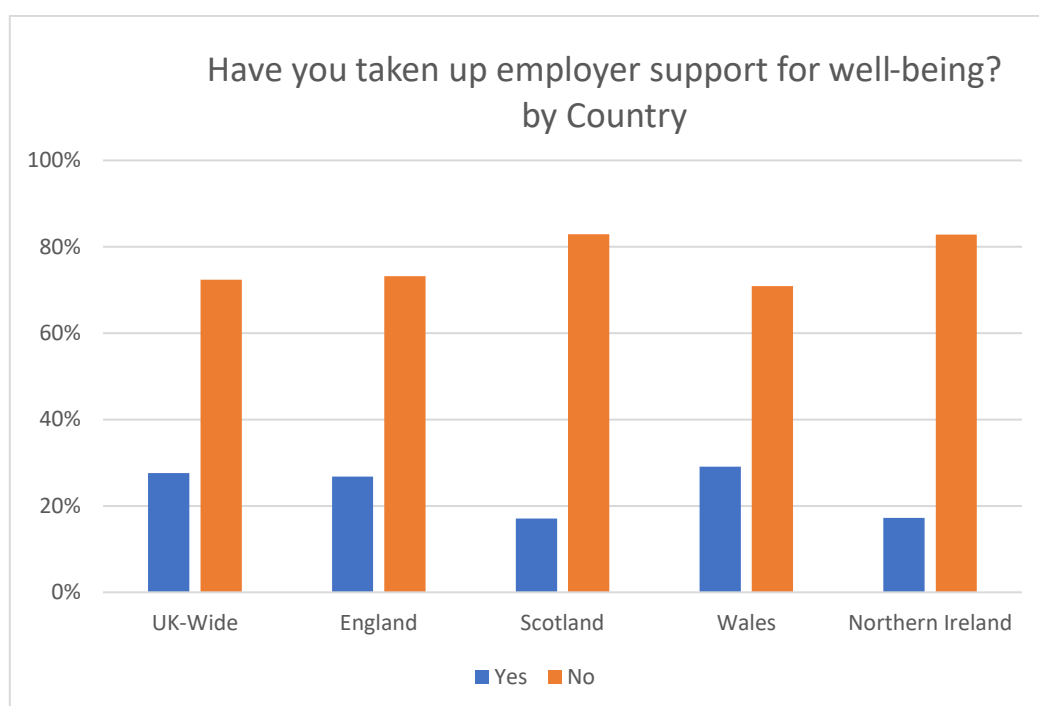


Figure A2. 105: Taken up Employer support by Country (Unweighted)

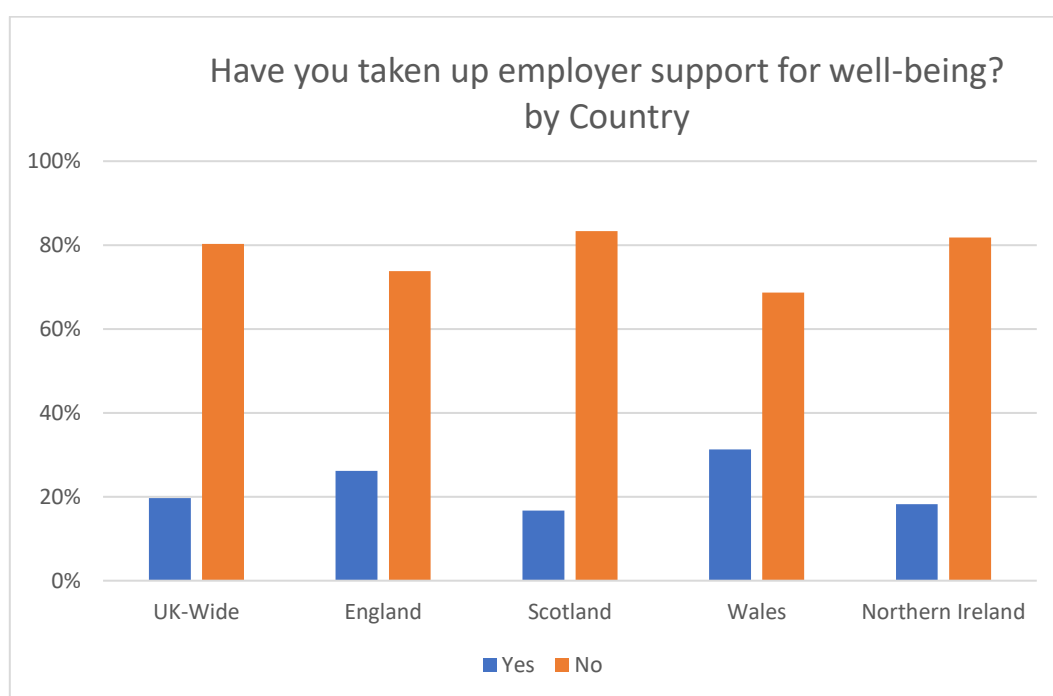


Table A2. 104: Taken up employer support by Country (Weighted)

Have you taken up employer support for well-being?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	27.6%	26.8%	17.1%	29.1%	17.2%
No	72.4%	73.2%	82.9%	70.9%	82.8%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 105: Taken up employer support by Country (Unweighted)

Have you taken up employer support for well-being?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	305 (19.7%)	48 (26.2%)	21 (16.7%)	26 (31.3%)	210 (18.2%)
No	1242 (80.3%)	135 (73.8%)	105 (83.3%)	57 (68.7%)	945 (81.8%)
<b>Total</b>	<b>1547 (100%)</b>	<b>183 (10%)</b>	<b>126 (100%)</b>	<b>83 (100%)</b>	<b>1155 (100%)</b>

Figure A2. 106: Taken up Employer support by Occupation (Weighted)



Figure A2. 107: Taken up Employer support by Occupation (Unweighted)



Table A2. 106: Taken up employer support by Occupation (Weighted)

Have you taken up employer support for well-being?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	26.4%	24.1%	26.6%	25.0%	25.1%
No	73.6%	75.9%	73.4%	75.0%	74.9%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A2. 107: Taken up employer support by Occupation (Unweighted)

Have you taken up employer support for well-being?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	44 (21.3%)	16 (20.3%)	52 (19.1%)	104 (16.2%)	89 (25.6%)
No	163 (78.7%)	63 (79.7%)	220 (80.9%)	538 (83.8%)	258 (74.4%)
<b>Total</b>	<b>207 (100%)</b>	<b>79 (100%)</b>	<b>272 (100%)</b>	<b>642 (100%)</b>	<b>347 (100%)</b>

## **A2.24 Respondents on what employer support they have taken up**

Respondents were asked which employer support they had taken up for their well-being. Multiple responses were allowed, which means that the percentages do not add up to 100%.

### **Summary (Weighted results):**

Respondents indicated they took up peer support or manager support.

### **Summary (Unweighted results):**

Half of the respondents indicated to that the support they had taken up from their employer was manager support and well-being support.

Those who reported other (n=32), specified that the following was the support they had taken up from their employer to support their well-being:

- Attending occupational health
- Changing working hours
- Flexible/Hybrid working
- Phased return to work
- Reduced caseload
- Exercise classes or part funded access to local leisure facilities
- Staff supporting meetings and briefs
- Stress control course
- Support of Union
- Reflective practice sessions through therapeutic support services.

However several noted that the well-being services were not suitable for everyone and that even with referrals to occupational health they had not been able to see anyone or that they felt these appointments achieved nothing, so therefore they had no help or support .

Figure A2. 108: What have you taken up from your employer to support your well-being by Country (Weighted)

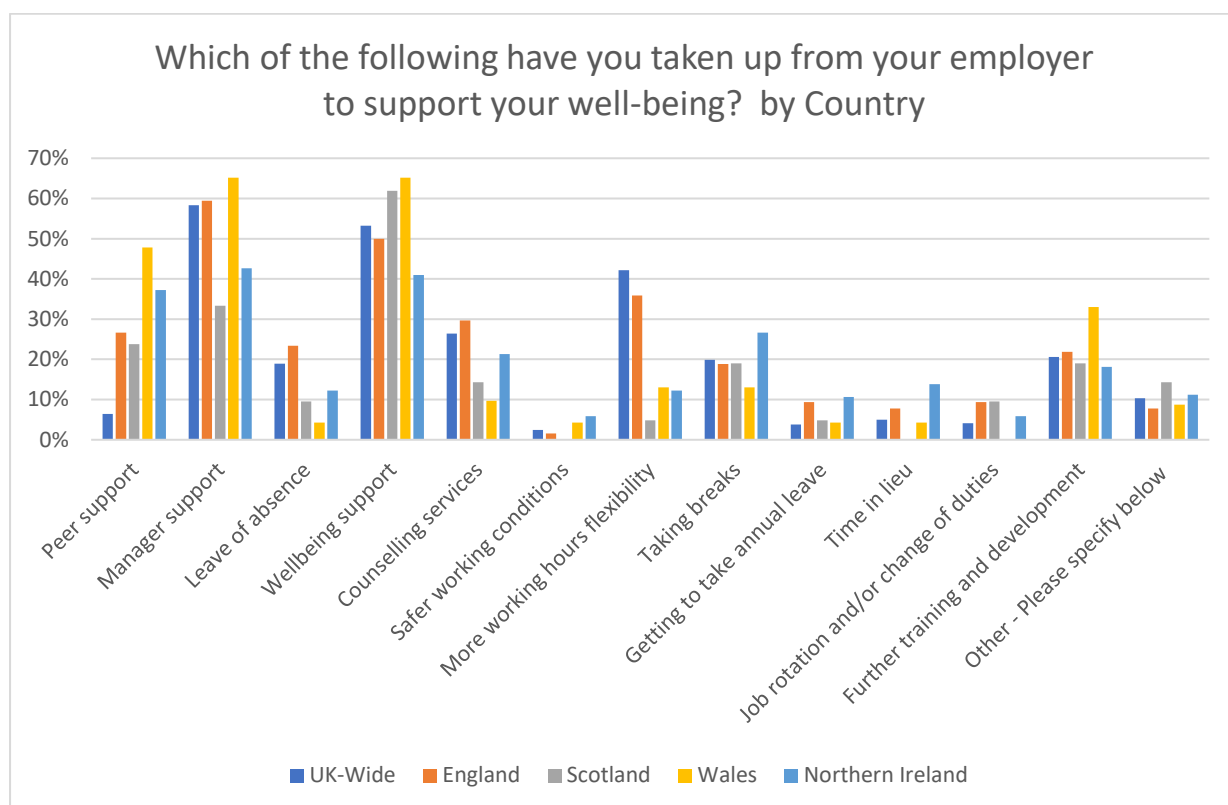


Figure A2. 109: What have you taken up from your employer to support your well-being by Country (Unweighted)

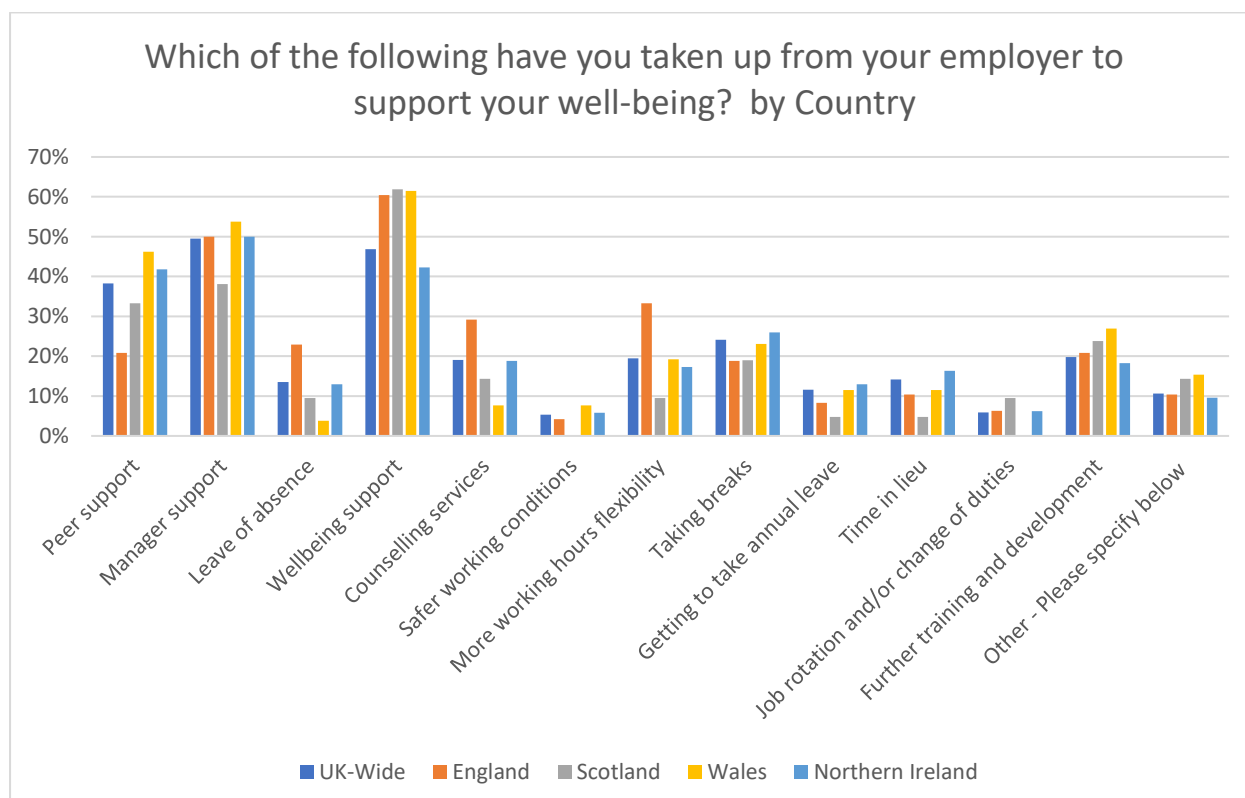




Table A2. 108: What have you taken up from your employer to support your well-being by Country (Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	6.4%	26.6%	23.8%	47.8%	37.2%
Manager support	58.3%	59.4%	33.3%	65.2%	42.6%
Leave of absence	18.9%	23.4%	9.5%	4.3%	12.2%
Well-being support	53.2%	50.0%	61.9%	65.2%	41.0%
Counselling services	26.4%	29.7%	14.3%	9.7%	21.3%
Safer working conditions	2.4%	1.6%	0.0%	4.3%	5.9%
More working hours flexibility	42.2%	35.9%	4.8%	13.0%	12.2%
Taking breaks	19.9%	18.8%	19.0%	13.0%	26.6%
Getting to take annual leave	3.8%	9.4%	4.8%	4.3%	10.6%
Time in lieu	5.0%	7.8%	0.0%	4.3%	13.8%
Job rotation and/or change of duties	4.1%	9.4%	9.5%	0.0%	5.9%
Further training and development	20.6%	21.9%	19.0%	33.0%	18.1%
Other – Please specify below	10.3%	7.8%	14.3%	8.7%	11.2%

Table A2. 109: What have you taken up from your employer to support your well-being by Country (Unweighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	116 (38.3%)	10 (20.8%)	7 (33.3%)	12 (46.2%)	87 (41.8%)
Manager support	150 (49.5%)	24 (50.0%)	8 (38.1%)	14 (53.8%)	104 (50.0%)
Leave of absence	41 (13.5%)	11 (22.9%)	2 (9.5%)	1 (3.8%)	27 (13.0%)
Well-being support	142 (46.9%)	29 (60.4%)	13 (61.9%)	16 (61.5%)	88 (42.3%)
Counselling services	58 (19.1%)	14 (29.2%)	3 (14.3%)	2 (7.7%)	39 (18.8%)
Safer working conditions	16 (5.3%)	2 (4.2%)	0 (0.0%)	2 (7.7%)	12 (5.8%)
More working hours flexibility	59 (19.5%)	16 (33.3%)	2 (9.5%)	5 (19.2%)	36 (17.3%)
Taking breaks	73 (24.1%)	9 (18.8%)	4 (19.0%)	6 (23.1%)	54 (26.0%)
Getting to take annual leave	35 (11.6%)	4 (8.3%)	1 (4.8%)	3 (11.5%)	27 (13.0%)
Time in lieu	43 (14.2%)	5 (10.4%)	1 (4.8%)	3 (11.5%)	34 (16.3%)
Job rotation and/or change of duties	18 (5.9%)	3 (6.3%)	2 (9.5%)	0 (0.0%)	13 (6.2%)
Further training and development	60 (19.8%)	10 (20.8%)	5 (23.8%)	7 (26.9%)	38 (18.3%)
Other – Please specify below	32 (10.6%)	5 (10.4%)	3 (14.3%)	4 (15.4%)	20 (9.6%)
<b>No. of respondents who answered the question</b>	<b>303</b>	<b>48</b>	<b>21</b>	<b>26</b>	<b>208</b>

Figure A2. 110: What have you taken up from your employer to support your well-being by Occupation (Weighted)

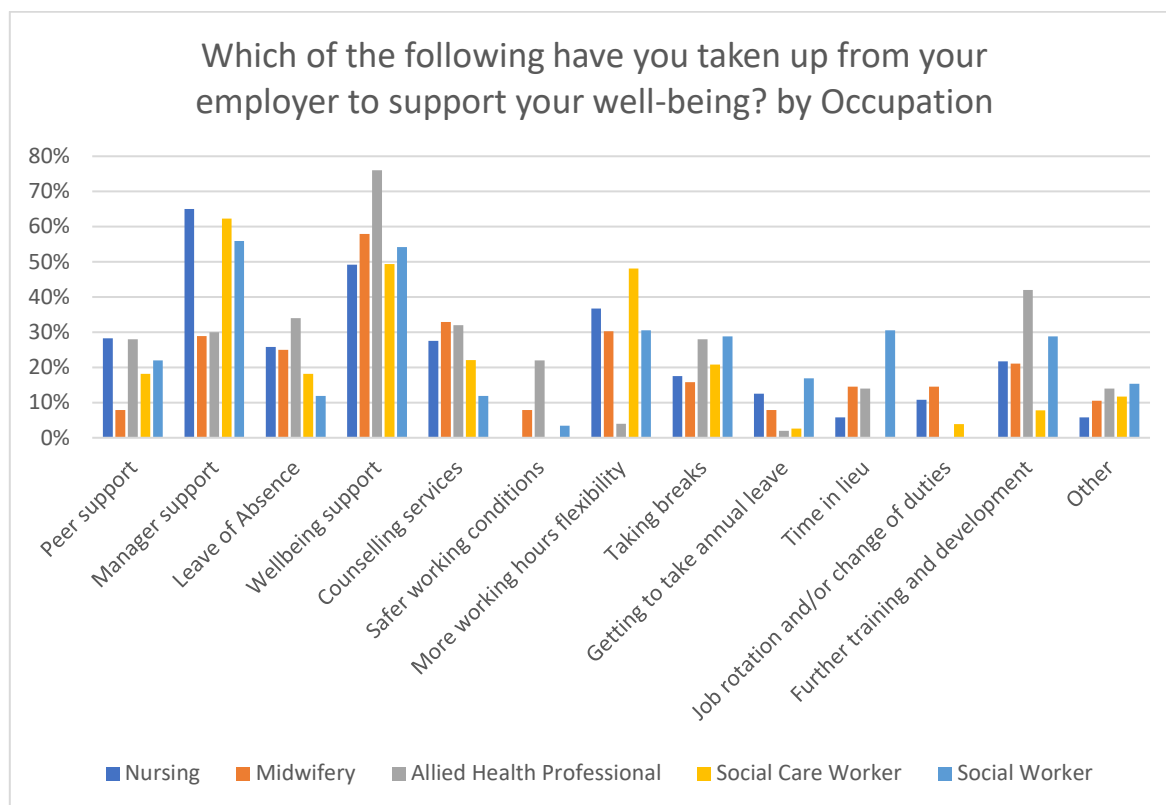


Figure A2. 111: What have you taken up from your employer to support your well-being by Occupation (Unweighted)

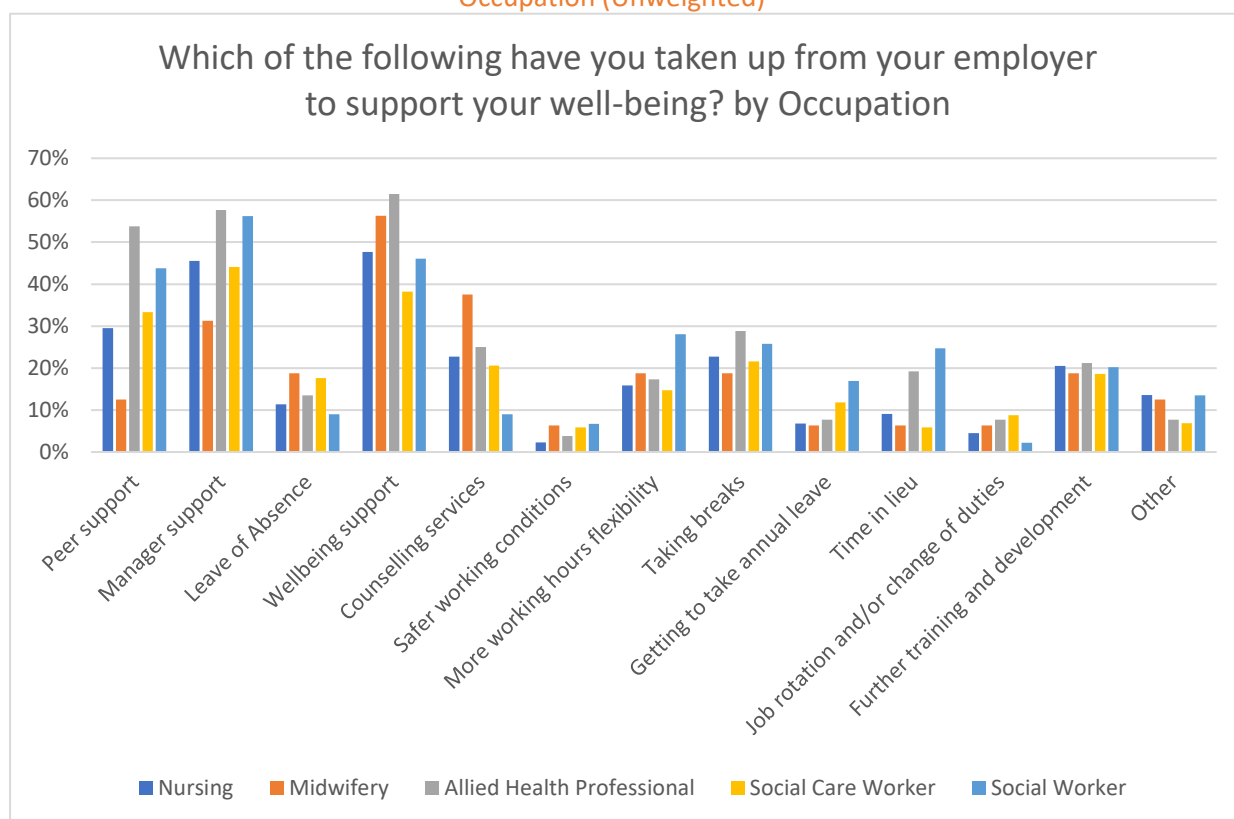


Table A2. 110: What have you taken up from your employer to support your well-being by Occupation(Weighted)

What has to happen for you to change your mind about wanting to leave?	Occupation				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	28.3%	7.9%	28.0%	18.2%	22.0%
Manager support	65.0%	28.9%	30.0%	62.3%	55.9%
Leave of absence	25.8%	25.0%	34.0%	18.2%	11.9%
Well-being support	49.2%	57.9%	76.0%	49.4%	54.2%
Counselling services	27.5%	32.9%	32.0%	22.1%	11.9%
Safer working conditions	0.0%	7.9%	22.0%	0.0%	3.4%
More working hours flexibility	36.7%	30.3%	4.0%	48.1%	30.5%
Taking breaks	17.7%	15.8%	28.0%	20.8%	28.8%
Getting to take annual leave	12.5%	7.9%	2.0%	2.6%	16.9%
Time in lieu	5.8%	14.5%	14.0%	0.0%	30.5%
Job rotation and/or change of duties	10.8%	14.5%	0.0%	3.9%	0.0%
Further training and development	21.7%	21.1%	42.0%	7.8%	28.8%
Other – Please specify below	5.8%	10.5%	14.0%	11.7%	15.3%

Table A2. 111: What have you taken up from your employer to support your well-being by Occupation (Unweighted)

What has to happen for you to change your mind about wanting to leave?	Occupation				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	13 (29.5%)	2 (12.5%)	28 (53.8%)	102 (33.3%)	39 (43.8%)
Manager support	20 (45.5%)	5 (31.%)	30 (57.7%)	45 (44.1%)	50 (56.2%)
Leave of absence	5 (11.4%)	3 (18.8%)	7 (13.5%)	18 (17.6%)	8 (9.0%)
Well-being support	21 (47.7%)	9 (56.3%)	32 (61.5%)	39 (38.2%)	41 (46.1%)
Counselling services	10 (22.7%)	6 (37.5%)	13 (25.0%)	21 (20.6%)	8 (9.0%)
Safer working conditions	1 (2.3%)	1 (6.3%)	2 (3.8%)	6 (5.9%)	6 (6.7%)
More working hours flexibility	7 (15.9%)	3 (18.8%)	9 (17.3%)	15 (14.7%)	25 (28.1%)
Taking breaks	10 (22.7%)	3 (18.8%)	15 (28.8%)	22 (21.6%)	23 (25.8%)
Getting to take annual leave	3 (6.8%)	1 (6.3%)	4 (7.7%)	12 (11.8%)	15 (16.9%)
Time in lieu	4 (9.1%)	1 (6.3%)	10 (19.2%)	6 (5.9%)	22 (24.7%)
Job rotation and/or change of duties	2 (4.5%)	1 (6.3%)	4 (7.7%)	9 (8.8%)	2 (2.2%)
Further training and development	9 (20.5%)	3 (18.8%)	11 (21.2%)	19 (18.6%)	18 (20.2%)
Other – Please specify below	6 (13.6%)	2 (12.5%)	4 (7.7%)	7 (6.9%)	12 (13.5%)
<b>No. of respondents who answered the question</b>	<b>44</b>	<b>16</b>	<b>52</b>	<b>102</b>	<b>89</b>

## **A2.25 Reasons for not taking employer support**

### **Summary (Weighted results):**

In Wales, 48.2% felt employer support was not needed, while 41.7% of AHPs felt it was not needed.

### **Summary (Unweighted results):**

In Wales, 43.0% felt employer support was not needed. A total of n= 267 (21.6%) selected other as their reason for not taking employer support.

The reasons behind this were reported as the following:

- Support given was absolute nonsense and not appropriate for a majority of staff.
- Agency workers had no access.
- Lack of managerial input
- Self-employment means no access to agency supports
- The system is broken and the support does little to help stress levels
- Not being allowed to look after own needs
- Awaiting support meeting
- Working overtime so no time
- Did not get the offer of support or no information provided by employer
- The courses offered are generic and 'like sticking a plaster on a broken leg'
- Uncertainty on how to apply for support
- Do not want to receive support from the source of the stressors.
- Online support not beneficial
- Not matching personal need
- Not sufficient and tokenistic

Figure A2. 112: Reasons for not taking up employer support by Country (Weighted)

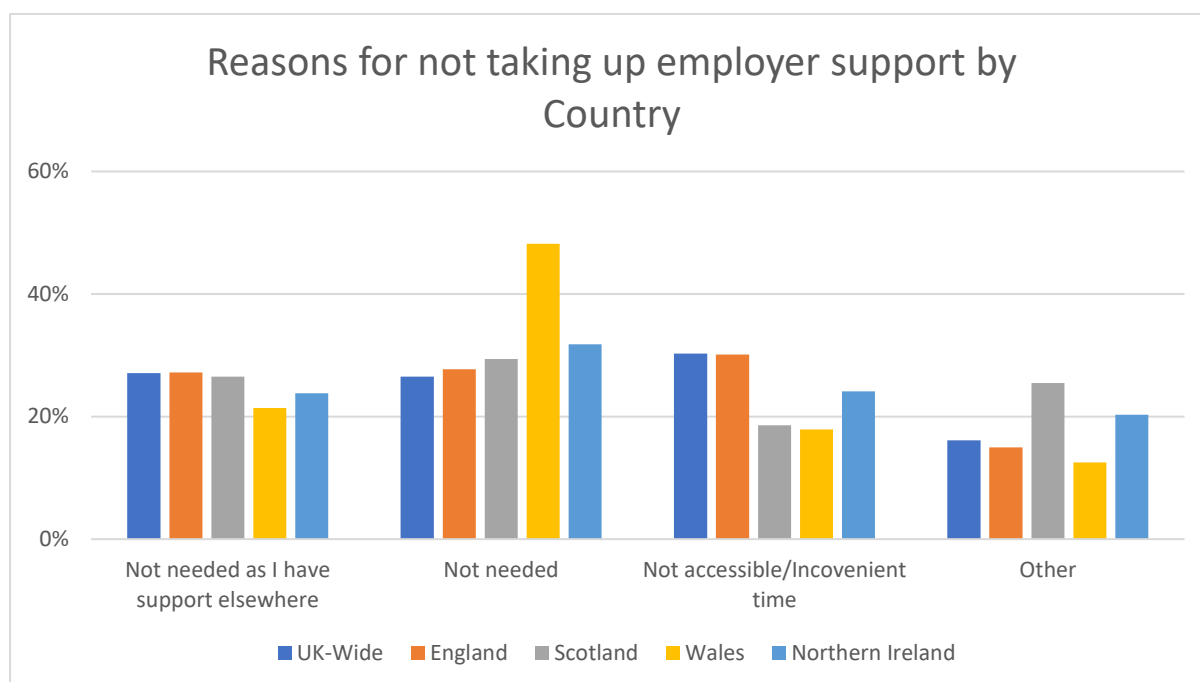


Figure A2. 113: Reasons for not taking up employer support by Country (Unweighted)

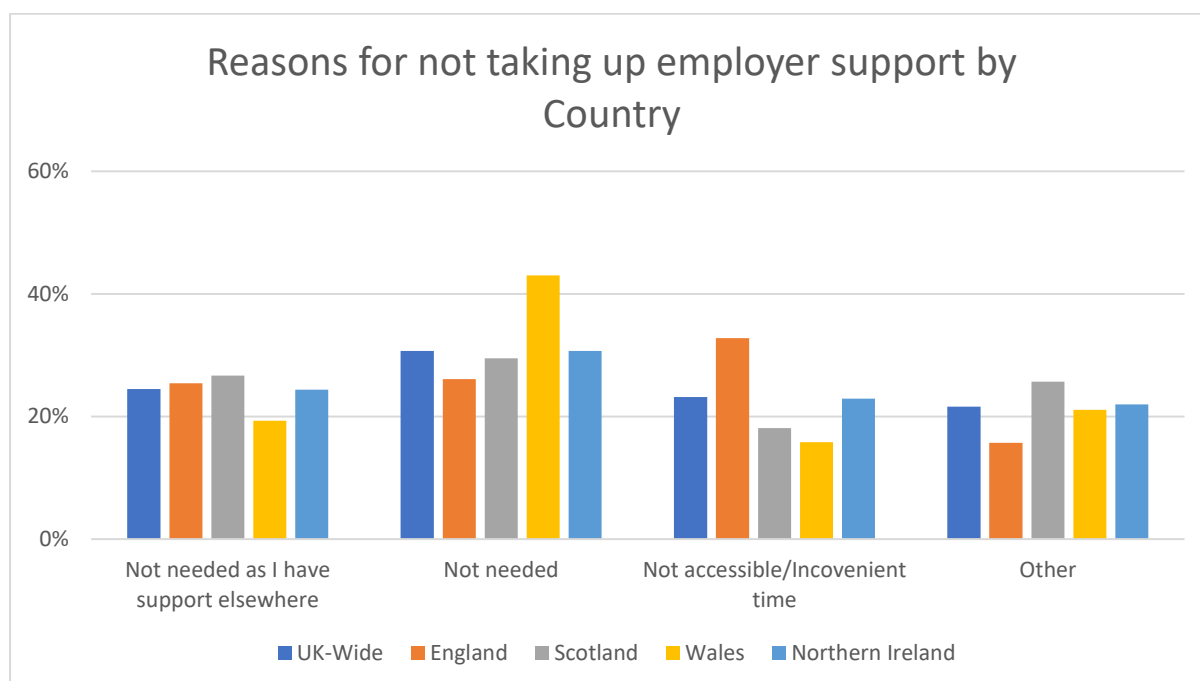




Table A2. 112: Reasons for not taking up employer support by Country (Weighted)

Country	UK-Wide	England	Scotland	Wales	Northern Ireland
Not needed as I have support elsewhere	27.1%	27.2%	26.5%	21.4%	23.8%
Not needed	26.5%	27.7%	29.4%	48.2%	31.8%
Not accessible or Inconvenient time	30.3%	30.1%	18.6%	17.9%	24.1%
Other	16.1%	15.0%	25.5%	12.5%	20.3%
Total	100%	100%	100%	100%	100%

Table A2. 113: Reasons for not taking up employer support by Country (Unweighted)

Country	UK-Wide	England	Scotland	Wales	Northern Ireland
Not needed as I have support elsewhere	302 (24.5%)	34 (25.4%)	28 (26.7%)	11 (19.3%)	229 (24.4%)
Not needed	379 (30.7%)	35 (26.1%)	31 (29.5%)	25 (43.0%)	288 (30.7%)
Not accessible or Inconvenient time	287 (23.2%)	44 (32.8%)	19 (18.1%)	9 (15.8%)	215 (22.9%)
Other	267 (21.6%)	21 (15.7%)	27 (25.7%)	12 (21.1%)	207 (22.0%)
Total	1235 (100%)	134 (100%)	105 (100%)	57 (100%)	939 (100%)

Figure A2. 114: Reasons for not taking up employer support by Occupation (Weighted)

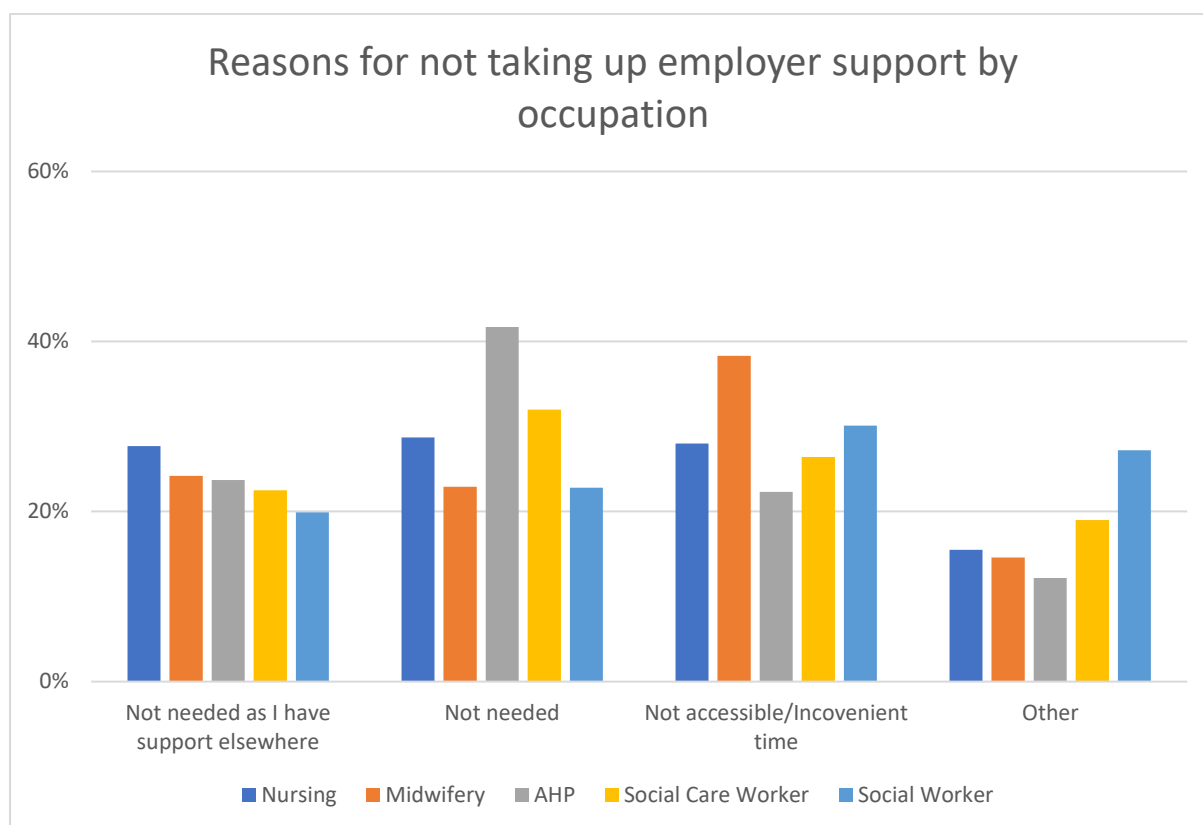


Figure A2. 115: Reasons for not taking up employer support by Occupation (Unweighted)

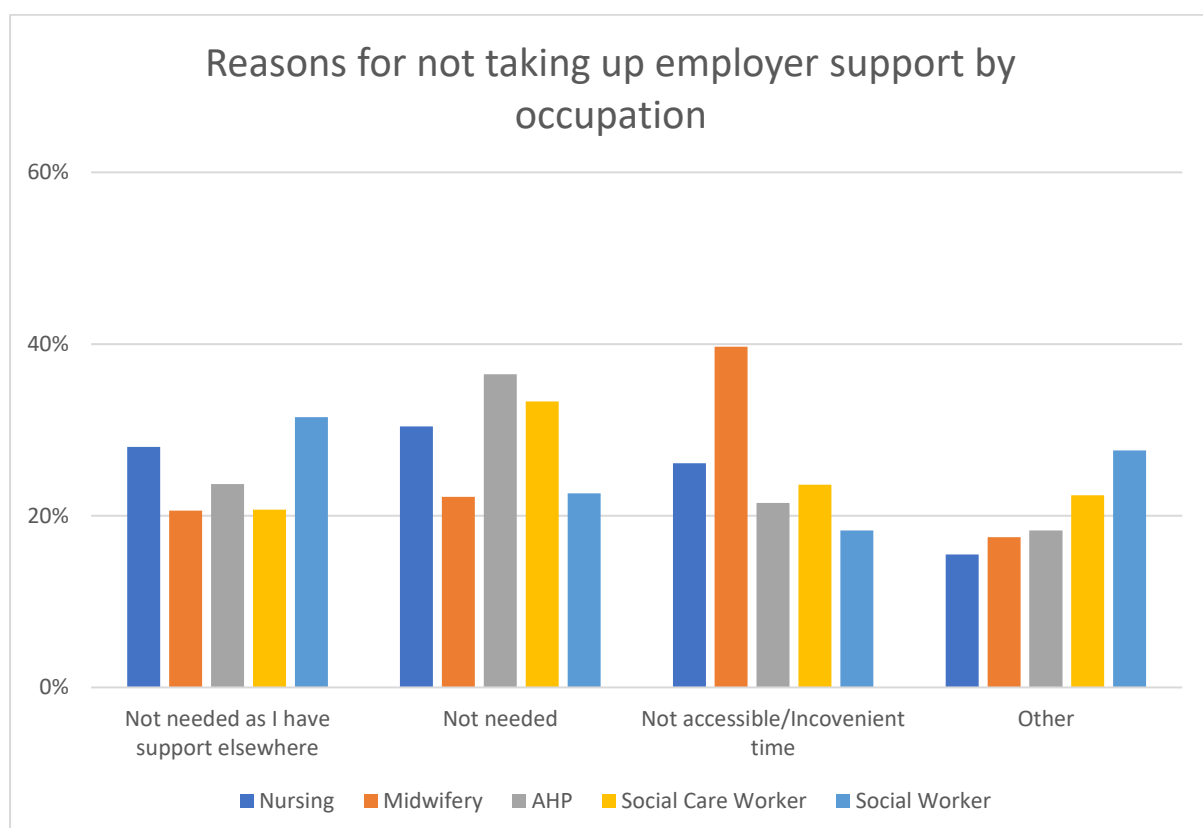


Table A2. 114: Reasons for not taking up employer support by Occupation (Weighted)

Occupation	Not needed as I have support elsewhere	Not needed	Not accessible or Inconvenient time	Other	Total
Nursing	27.7%	28.7%	28.0%	15.5%	100%
Midwifery	24.2%	22.9%	38.3%	14.6%	100%
AHP	23.7%	41.7%	22.3%	12.2%	100%
Social Care Worker	22.5%	32.0%	26.4%	19.0%	100%
Social Worker	19.9%	22.8%	30.1%	27.2%	100%

Table A2. 115: Reasons for not taking up employer support by Occupation (Unweighted)

Occupation	Not needed as I have support elsewhere	Not needed	Not accessible or Inconvenient time	Other	Total
Nursing	45 (28.0%)	49 (30.4%)	42 (26.1%)	25 (15.5%)	161 (100%)
Midwifery	13 (20.6%)	14 (22.2%)	25 (39.7%)	11 (17.5%)	63 (100%)
AHP	52 (23.7%)	80 (36.5%)	47 (21.5%)	40 (18.3%)	219 (100%)
Social Care Worker	111 (20.7%)	178 (33.3%)	126 (23.6%)	120 (22.4%)	535 (100%)
Social Worker	81 (31.5%)	58 (22.6%)	47 (18.3%)	71 (27.6%)	257 (100%)

## A2.26 Respondents' Region of Work

### Summary (Weighted results):

Not reported.

### Summary (Unweighted results):

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

Table A2. 116: Responses by Region (Unweighted)

Region	n (%)
England: London	47 (2.7%)
England: North West	50 (2.8%)
England: South East	58 (3.3%)
England: West Midlands	41 (2.3%)
England: East of England	33 (1.9%)
England: Yorkshire and the Humber	40 (2.3%)
England: North East	6 (0.3%)
England: East Midlands	29 (1.6%)
England: South West	72 (4.1%)
Scotland	492 (28.0%)
Wales	95 (5.4%)
Northern Ireland	795 (45.2%)
<b>Total</b>	<b>1758</b>

Figure A2. 116: Responses by Region (Unweighted)

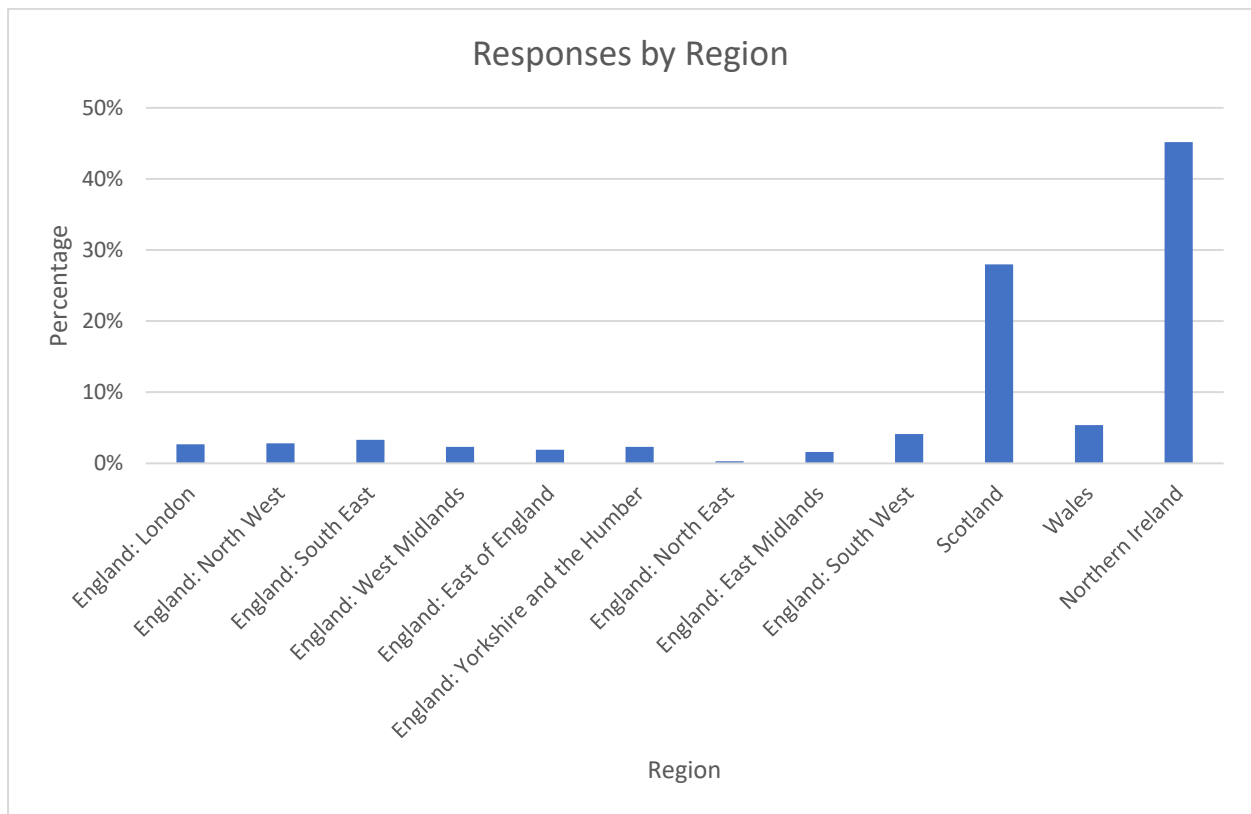


Figure A2. 117: Region by Occupation (Unweighted)

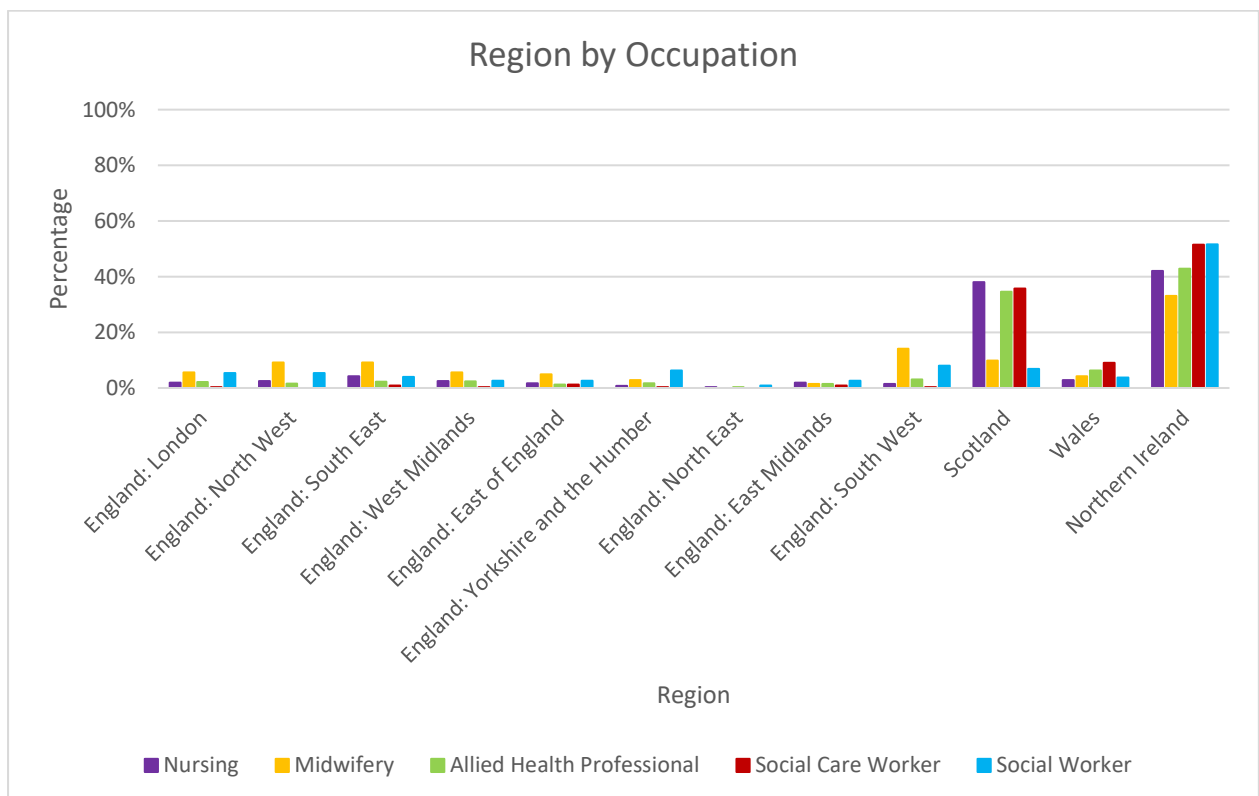


Table A2. 117: Region by Occupation (Unweighted)

Region	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
England: London	7 (1.9%)	8 (5.6%)	12 (2.1%)	1 (0.3%)	19 (5.4%)
England: North West	8 (2.5%)	13 (9.2%)	9 (1.6%)	0 (0.0%)	19 (5.4%)
England: South East	15 (4.2%)	13 (9.2%)	13 (2.3%)	3 (0.9%)	14 (4.0%)
England: West Midlands	9 (2.5%)	8 (5.6%)	14 (2.4%)	1 (0.3%)	9 (2.6%)
England: East of England	6 (1.7%)	7 (4.9%)	7 (1.2%)	4 (1.2%)	9 (2.6%)
England: Yorkshire and the Humber	3 (0.8%)	4 (2.8%)	10 (1.7%)	1 (0.3%)	22 (6.3%)
England: North East	1 (0.3%)	0 (0.0%)	2 (0.3%)	0 (0.0%)	3 (0.9%)
England: East Midlands	7 (1.9%)	2 (1.4%)	8 (1.4%)	3 (0.9%)	9 (2.6%)
England: South West	5 (1.4%)	20 (14.1%)	18 (3.1%)	1 (0.3%)	28 (8.0%)
Scotland	137 (38.0%)	14 (9.9%)	198 (34.6%)	119 (35.7%)	24 (6.9%)
Wales	10 (2.8%)	6 (4.2%)	36 (6.3%)	30 (9.0%)	13 (3.7%)
Northern Ireland	152 (42.1%)	47 (33.1%)	246 (42.9%)	170 (51.5%)	180 (51.6%)
<b>Total</b>	<b>361 (100%)</b>	<b>142 (100%)</b>	<b>573 (100%)</b>	<b>333 (100%)</b>	<b>349 (100%)</b>

## Appendix 3: Mental Well-being Results (Weighted and Unweighted) – Tables and Charts

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

### A3.1 Well-being Scores by Country

#### Summary (Weighted results):

#### Summary (Unweighted results):

There was no significant difference in the overall mean well-being scores across countries ( $F = 1.696$ ,  $df = 3$ ,  $p = .166$ ). When the scores were converted to possible or probable cases of anxiety/depression, a total of 13.2% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 18.8% were possible cases.

Figure A3. 1: Mean Well-being Item Scores by Country (Weighted)

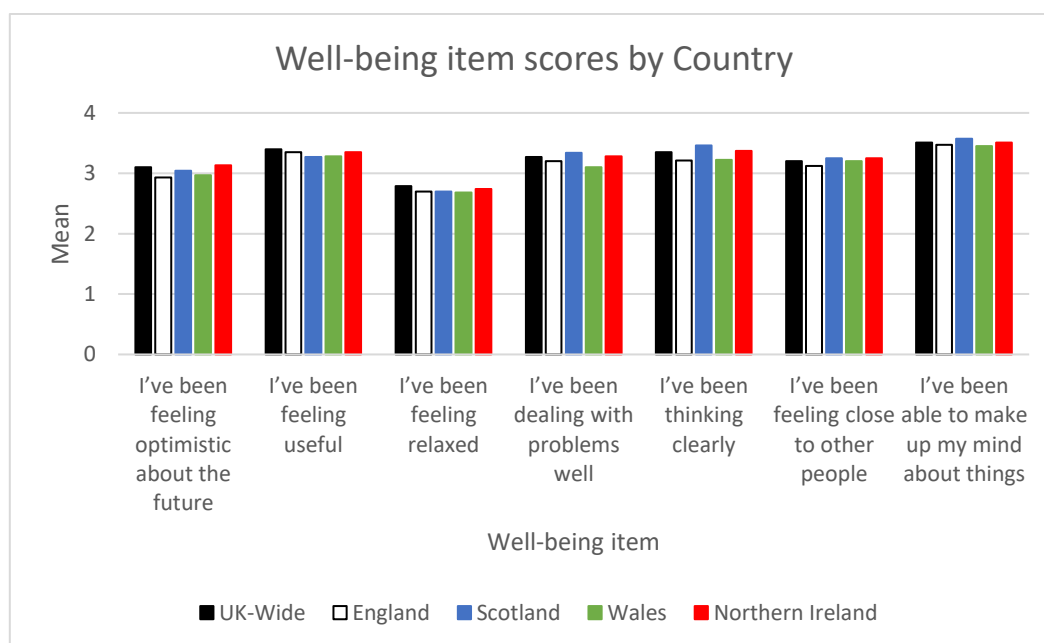


Figure A3. 2: Mean Well-being Item Scores by Country (Unweighted)

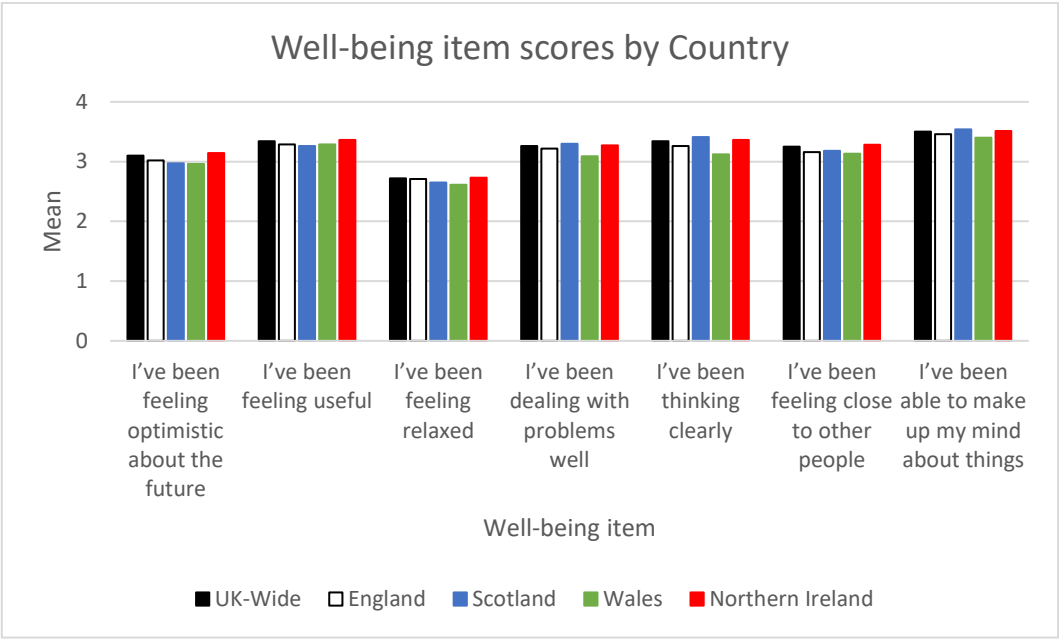


Figure A3.3: Mean Overall Well-being Score by Country (Weighted)

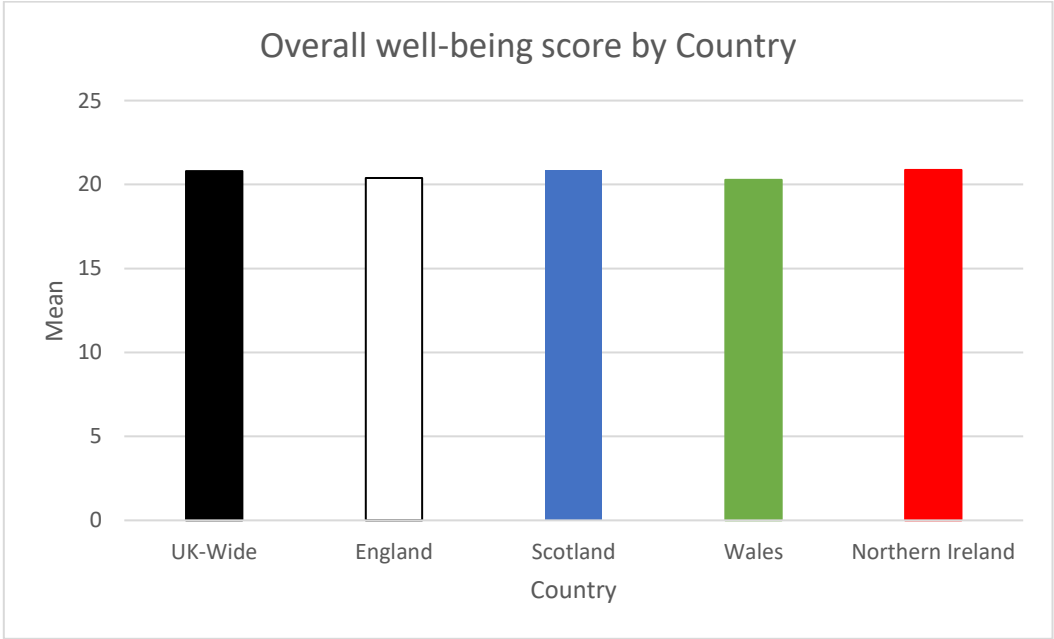




Figure A3.4: Mean Overall Well-being Score by Country (Unweighted)

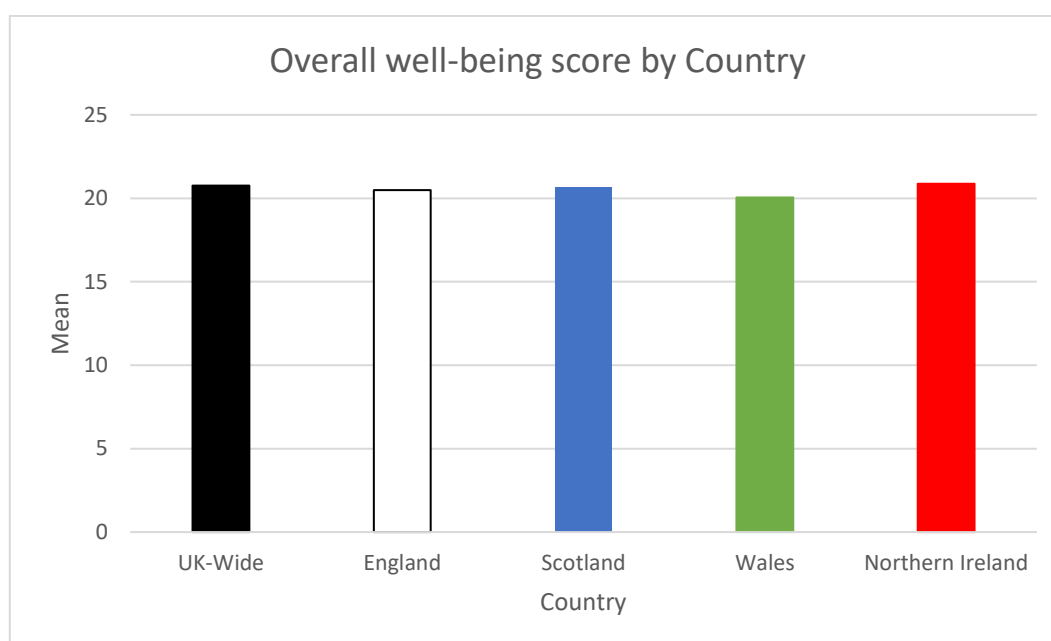


Table A3. 1: Mean Overall and Item Well-being Scores by Country (Weighted)

Well-being item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	3.10	2.93	3.04	2.97	3.13
I've been feeling useful	3.40	3.35	3.27	3.28	3.35
I've been feeling relaxed	2.79	2.70	2.70	2.68	2.74
I've been dealing with problems well	3.27	3.20	3.34	3.10	3.28
I've been thinking clearly	3.35	3.21	3.46	3.22	3.37
I've been feeling close to other people	3.20	3.12	3.25	3.20	3.25
I've been able to make up my mind about things	3.51	3.47	3.57	3.45	3.51
<b>Mean overall well-being score</b>	<b>20.80</b>	<b>20.39</b>	<b>20.89</b>	<b>20.28</b>	<b>20.87</b>

Table A3.2: Mean Overall and Item Well-being Scores by Country (Unweighted)

Well-being item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	3.10	3.02	2.97	2.96	3.14
I've been feeling useful	3.34	3.29	3.26	3.29	3.36
I've been feeling relaxed	2.72	2.71	2.65	2.61	2.73
I've been dealing with problems well	3.26	3.22	3.30	3.09	3.27
I've been thinking clearly	3.34	3.26	3.41	3.12	3.36
I've been feeling close to other people	3.25	3.16	3.18	3.13	3.28
I've been able to make up my mind about things	3.50	3.46	3.54	3.40	3.51
<b>Mean overall well-being score</b>	<b>20.76</b>	<b>20.49</b>	<b>20.64</b>	<b>20.05</b>	<b>20.87</b>

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

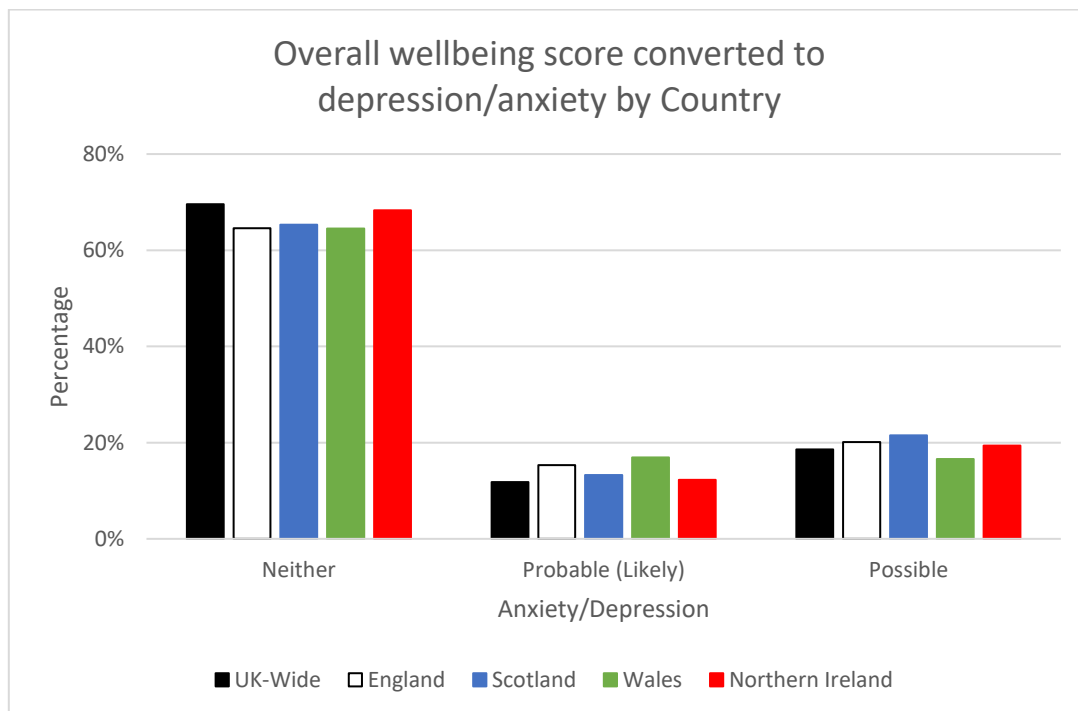


Figure A3.6: Overall Well-being Score Converted to Depression/Anxiety by Country (Unweighted)

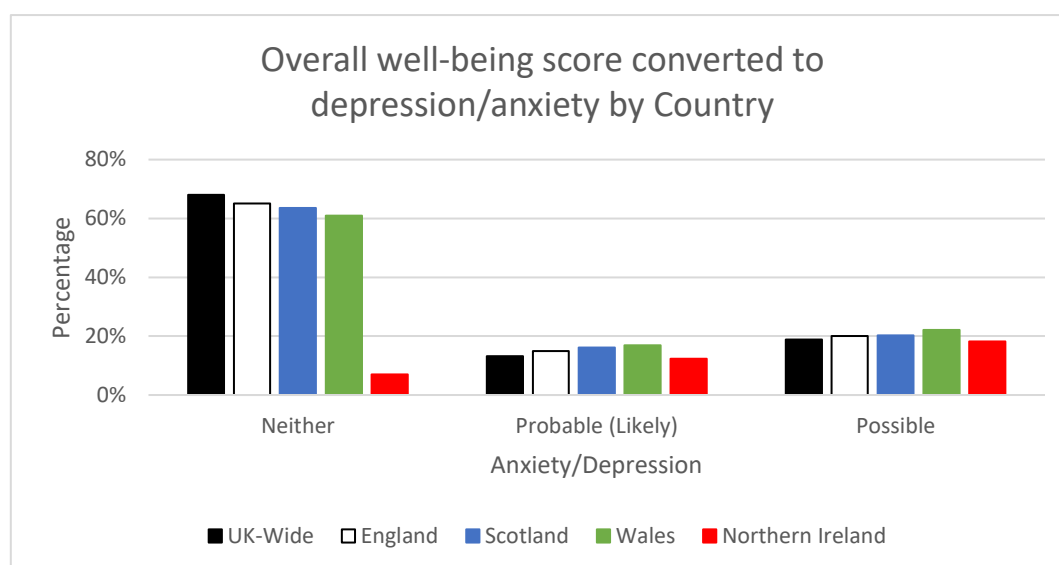


Table A3.3: Overall Well-being Score Converted to Depression/Anxiety by Country (Weighted)

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	69.6%	64.6%	65.3%	64.5%	68.3%
Probable (Likely)	11.8%	15.3%	13.3%	16.9%	12.3%
Possible	18.6%	20.1%	21.5%	16.6%	19.4%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	996 (68.0%)	114 (65.1%)	75 (63.6%)	47 (61.0%)	760 (7.0%)
Probable (Likely)	193 (13.2%)	26 (14.9%)	19 (16.1%)	13 (16.9%)	135 (12.3%)
Possible	275 (18.8%)	35 (20.0%)	24 (20.3%)	17 (22.1%)	199 (18.2%)
<b>Total</b>	<b>1464 (100%)</b>	<b>175 (100%)</b>	<b>118 (100%)</b>	<b>77 (100%)</b>	<b>1094 (100%)</b>

### A3.2 Well-being Scores by Occupation

#### Summary (Weighted results):

There were significant differences in the overall mean well-being scores across occupational groups ( $F = 8.194$ ,  $df = 4$ ,  $p < .001$ ). Specifically, the overall well-being scores were significantly higher in AHPs than in nurses, midwives and social care workers.

#### Summary (Unweighted results):

There were significant differences in the overall mean well-being scores across occupational groups ( $F = 3.932$ ,  $df = 4$ ,  $p = .004$ ). Specifically, the overall well-being scores were significantly higher in AHPs than in midwives and social care workers.

Figure A3.7: Mean Overall Well-being Score by Occupation (Weighted)

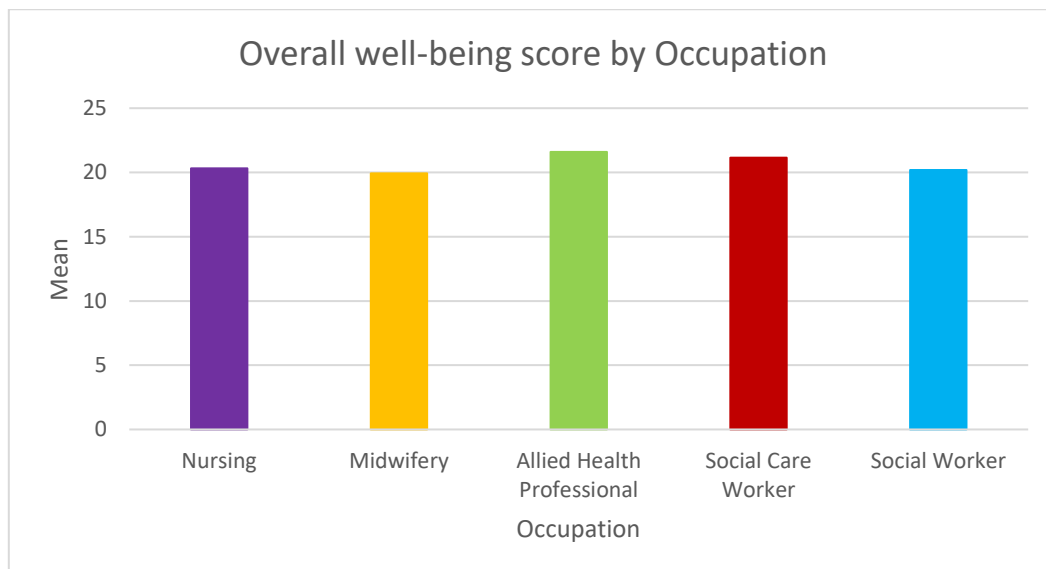


Figure A3.8: Mean Overall Well-being Score by Occupation (Unweighted)

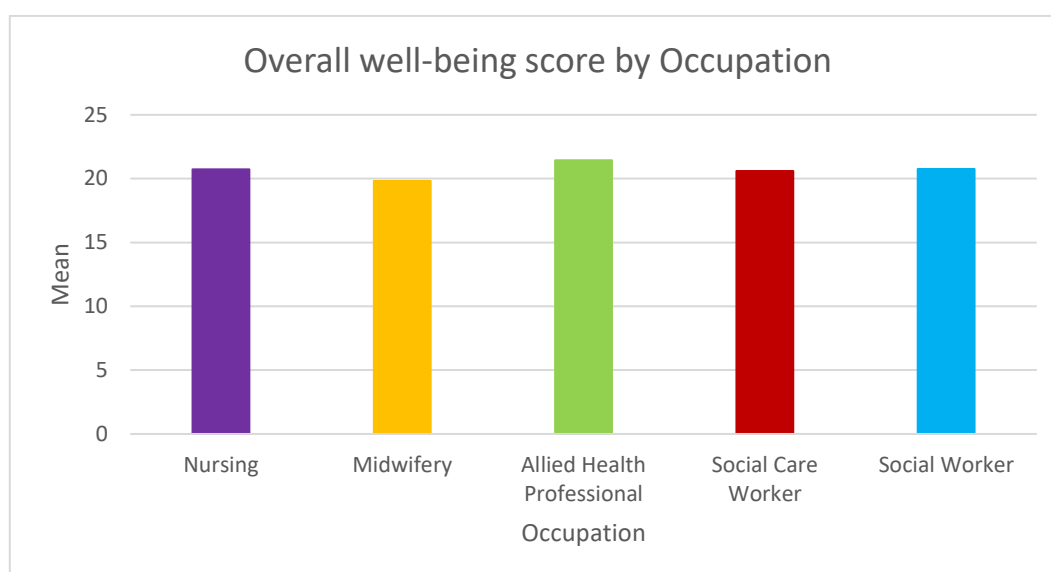


Table A3.5: Mean Overall Well-being Score by Occupation (Weighted)

Occupation	Mean overall well-being score
Nursing	20.32
Midwifery	19.93
AHP	21.60
Social Care Worker	21.15
Social Worker	20.19

Table A3.6: Mean Overall Well-being Score by Occupation (Unweighted)

Occupation	Mean overall well-being score
Nursing	20.73
Midwifery	19.82
AHP	21.44
Social Care Worker	20.60
Social Worker	20.76

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

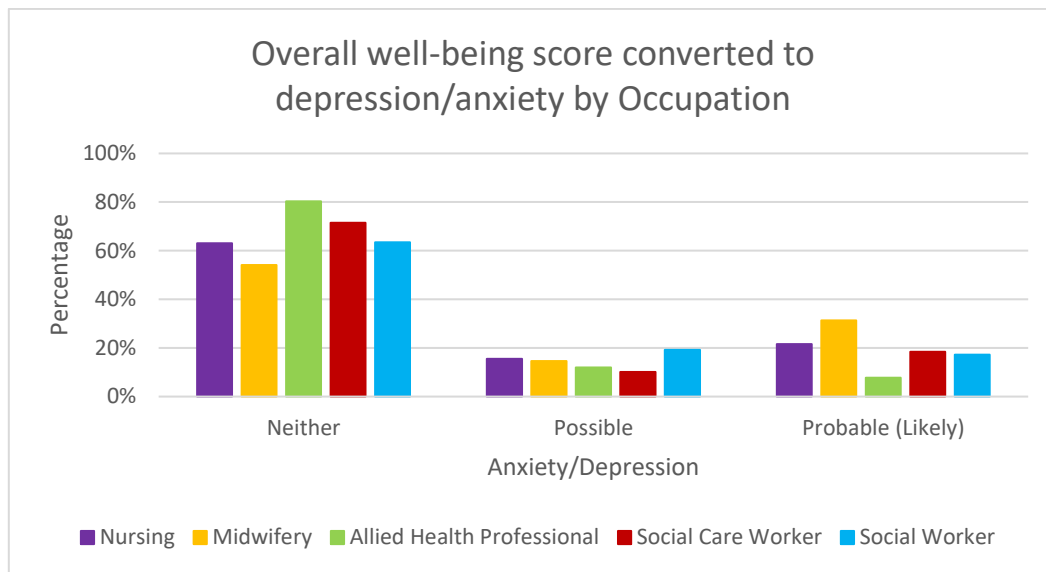


Figure A3.10: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Unweighted)

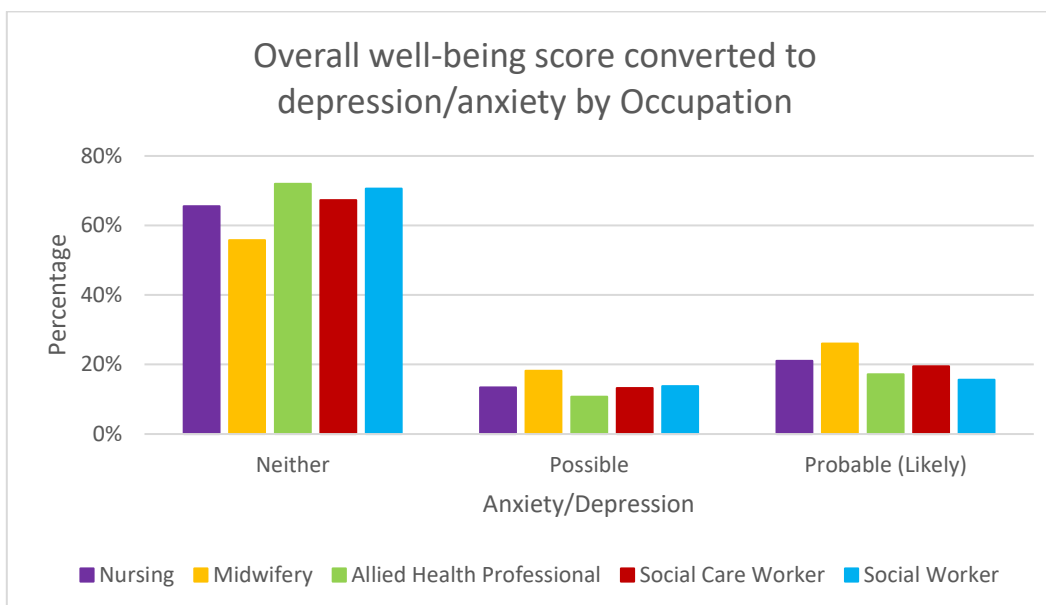


Table A3.7: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Weighted)

Case of anxiety/depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	63.0%	54.1%	80.3%	71.5%	63.5%
Probable (Likely)	15.5%	14.6%	12.0%	10.1%	19.2%
Possible	21.6%	31.3%	7.7%	18.4%	17.3%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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

Case of anxiety/ depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	127 (65.5%)	43 (55.8%)	188 (72.0%)	403 (67.3%)	235 (70.6%)
Probable (Likely)	26 (13.4%)	14 (18.2%)	28 (10.7%)	79 (13.2%)	46 (13.8%)
Possible	41(21.1%)	20 (26.0%)	45 (17.2%)	117 (19.5%)	52 (15.6%)
<b>Total</b>	<b>194 (100%)</b>	<b>77 (100%)</b>	<b>261 (100%)</b>	<b>599 (100%)</b>	<b>333 (100%)</b>

### A3.3 Well-being Scores by Sex

Only 5 respondents in the full sample stated their sex to be transgender, non-binary, intersex, other or preferred not to state which category of gender they identified with. 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 on their overall mean well-being scores ( $t = .543$ ,  $df=1427$ ,  $p<.001$ ).

#### Summary (Unweighted results):

Males and females did not differ significantly on their overall mean well-being scores ( $t = .667$ ,  $df=1457$ ,  $p>0.05$ ).

Figure A3.11: Mean Overall Well-being Score by Sex (Weighted)

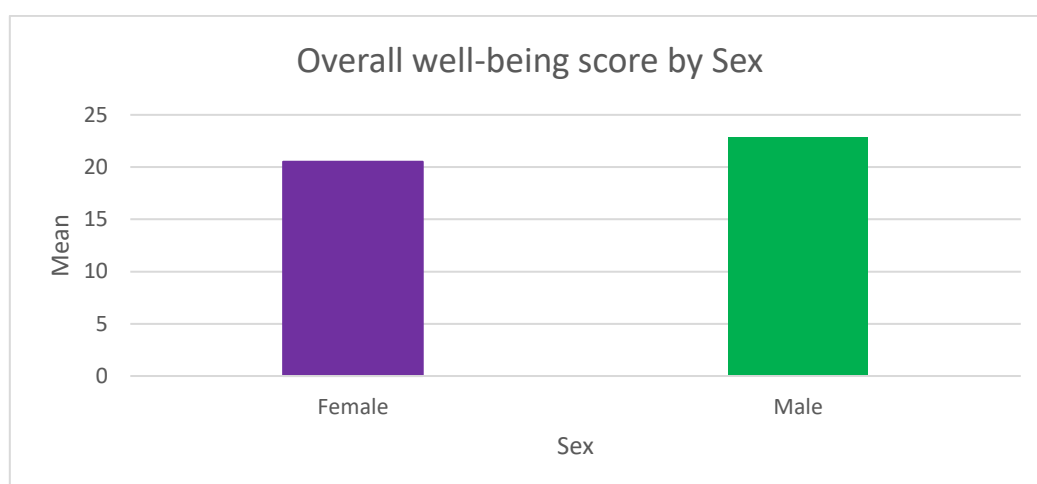


Figure A3.12: Mean Overall Well-being Score by Sex (Unweighted)

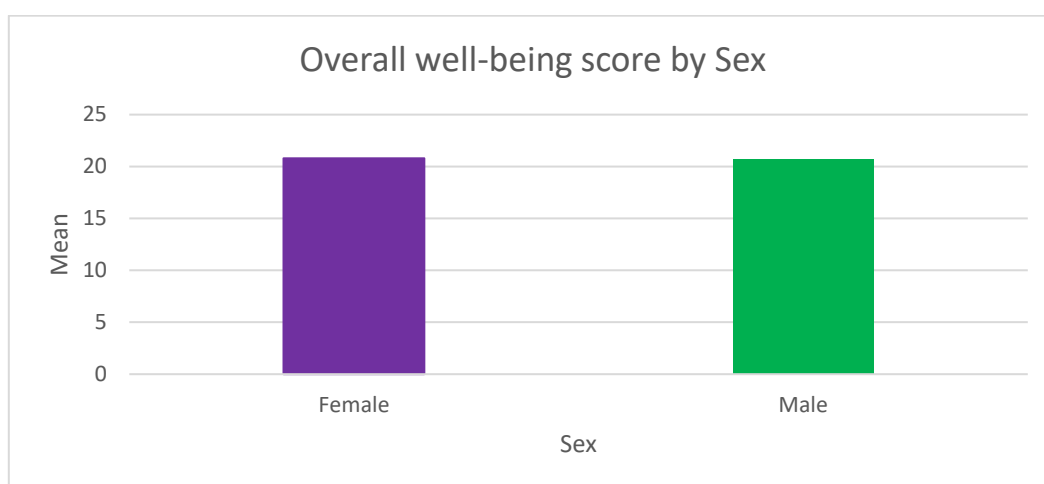


Table A3.9: Mean Overall Well-being Score by Sex (Weighted)

Sex	Mean overall well-being score
Female	20.51
Male	22.84

Table A3.10: Mean Overall Well-being Score by Sex (Unweighted)

Sex	Mean overall well-being score
Female	20.79
Male	20.68



### A3.4 Well-being Scores by Age

#### Summary (Weighted results):

There were significant differences across the age groups in their overall mean well-being scores ( $F = 3.401$ ,  $df = 4$ ,  $p = .009$ ). Specifically, those aged 16-29 scored significantly higher than the 40-49 and 60+ age groups.

#### Summary (Unweighted results):

There were no significant differences across the age groups in their overall mean well-being scores ( $F = 1.144$ ,  $df = 4$ ,  $p = .334$ ).

Figure A3.13: Mean Overall Well-being Score by Age (Weighted)

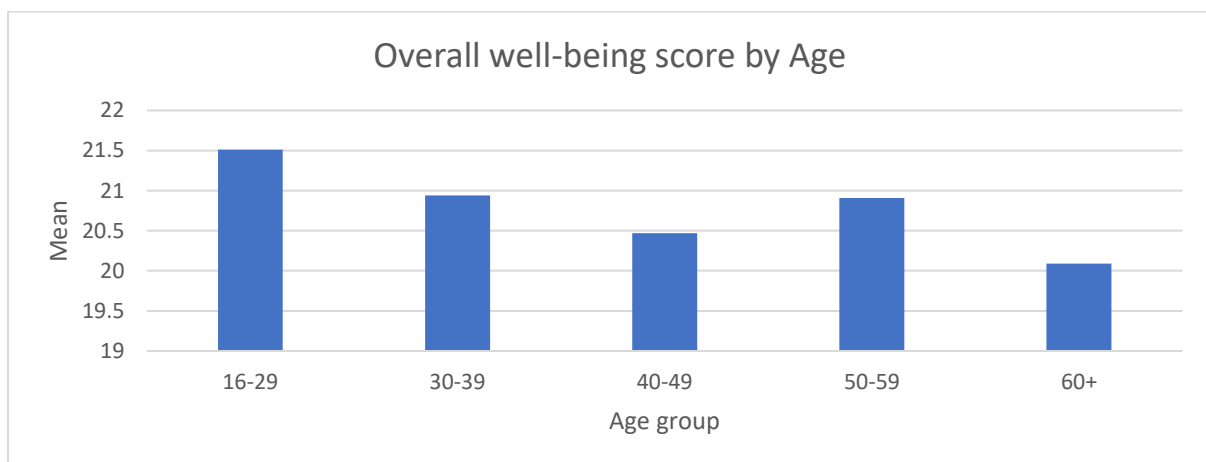


Figure A3.14: Mean Overall Well-being Score by Age (Unweighted)

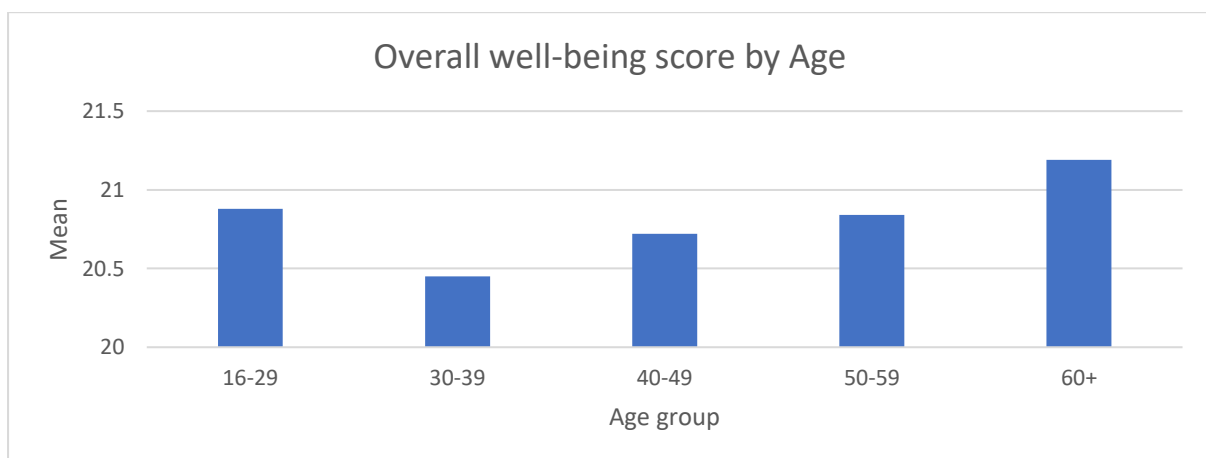


Table A3.11: Mean Overall Well-being Score by Age (Weighted)

Age	Mean overall well-being score
16-29 years	21.51
30-39 years	20.94
40-49 years	20.47
50-59 years	20.91
60+ years	20.09

Table A3.12: Mean Overall Well-being Score by Age (Unweighted)

Age	Mean overall well-being score
16-29 years	20.88
30-39 years	20.45
40-49 years	20.72
50-59 years	20.84
60+ years	21.19

### A3.5 Well-being Scores by Ethnicity

#### Summary (Weighted results):

There were significant differences between the ethnic groups on their overall mean well-being scores ( $F = 35.972$ ,  $df = 3$ ,  $p < .001$ ). Specifically, respondents who identified as Mixed ethnicity scored significantly higher in well-being scores than all other ethnic groups.

#### Summary (Unweighted results):

There were significant differences between the ethnic groups on their overall mean well-being scores ( $F = 3.761$ ,  $df = 3$ ,  $p = .01$ ). Specifically, respondents who identified as Black had significantly higher well-being scores than those who identified as White.

Figure A3.15: Mean Overall Well-being Score by Ethnicity (Weighted)

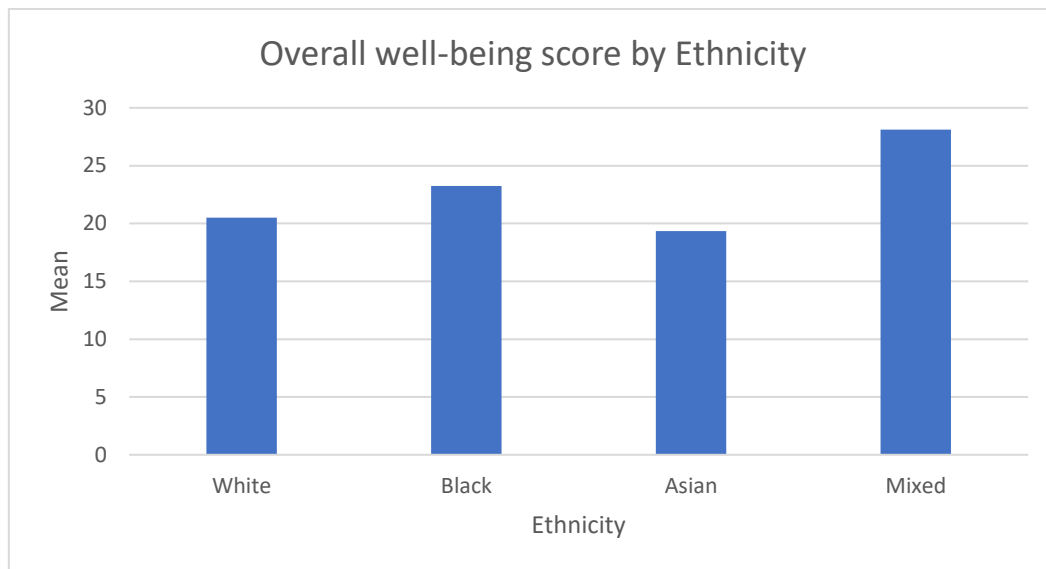


Figure A3.16: Mean Overall Well-being Score by Ethnicity (Unweighted)

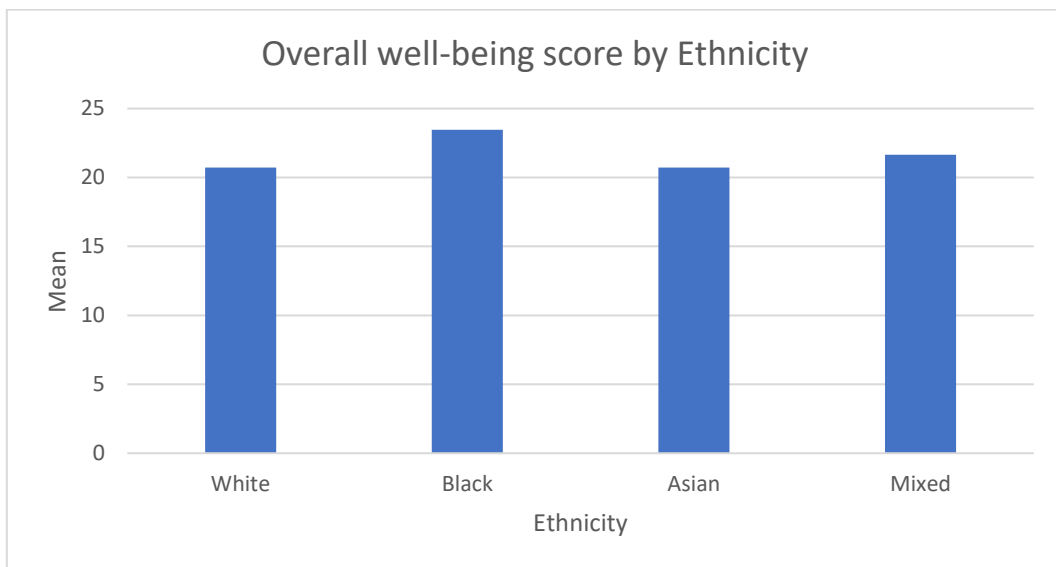


Table A3.13: Mean Overall Well-being Score by Ethnicity (Weighted)

Ethnicity	Mean overall well-being score
White	20.50
Black	23.24
Asian	19.34
Mixed	28.11

Table A3.14: Mean Overall Well-being Score by Ethnicity (Unweighted)

Ethnicity	Mean overall well-being score
White	20.72
Black	23.47
Asian	20.71
Mixed	21.65

### A3.6 Well-being Scores by Disability

#### Summary (Weighted results):

There were significant differences between respondents on their overall mean well-being scores based on their disability status ( $F = 33.955$ ,  $df = 2$ ,  $p < .001$ ). Specifically, respondents who considered themselves to not have a disability reported significantly lower well-being scores than those with a disability and those who were unsure about their disability.

#### Summary (Unweighted results):

There were significant differences between respondents on their overall mean well-being scores based on their disability status ( $F = 10.864$ ,  $df = 2$ ,  $p < .001$ ). Specifically, respondents who considered themselves to not have a disability reported significantly lower well-being scores than those with a disability and those who were unsure about their disability.

Figure A3.17: Mean Overall Well-being Score by Disability (Weighted)

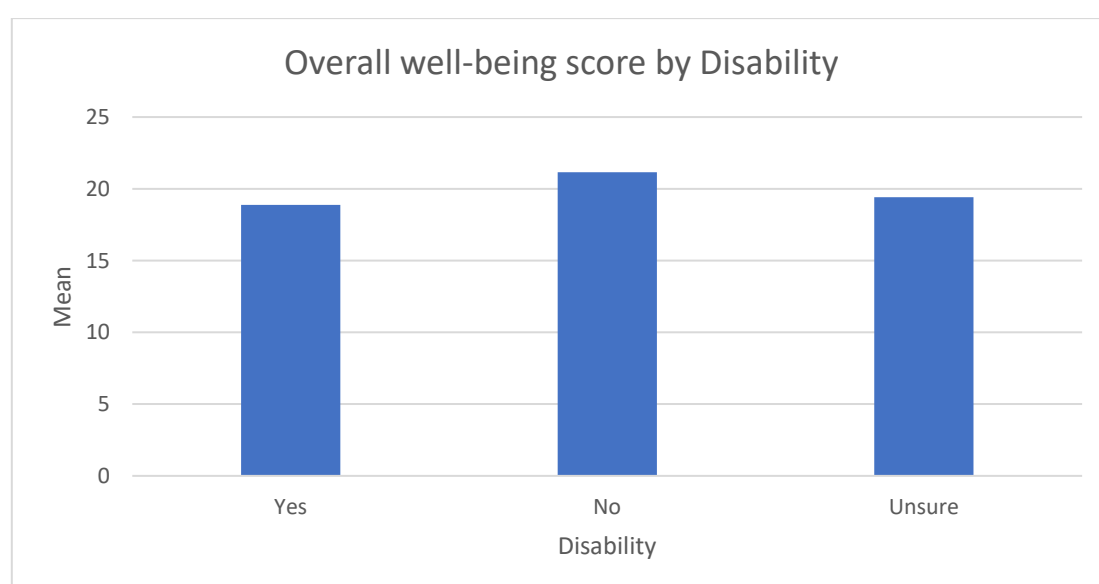


Figure A3.18: Mean Overall Well-being Score by Disability (Unweighted)

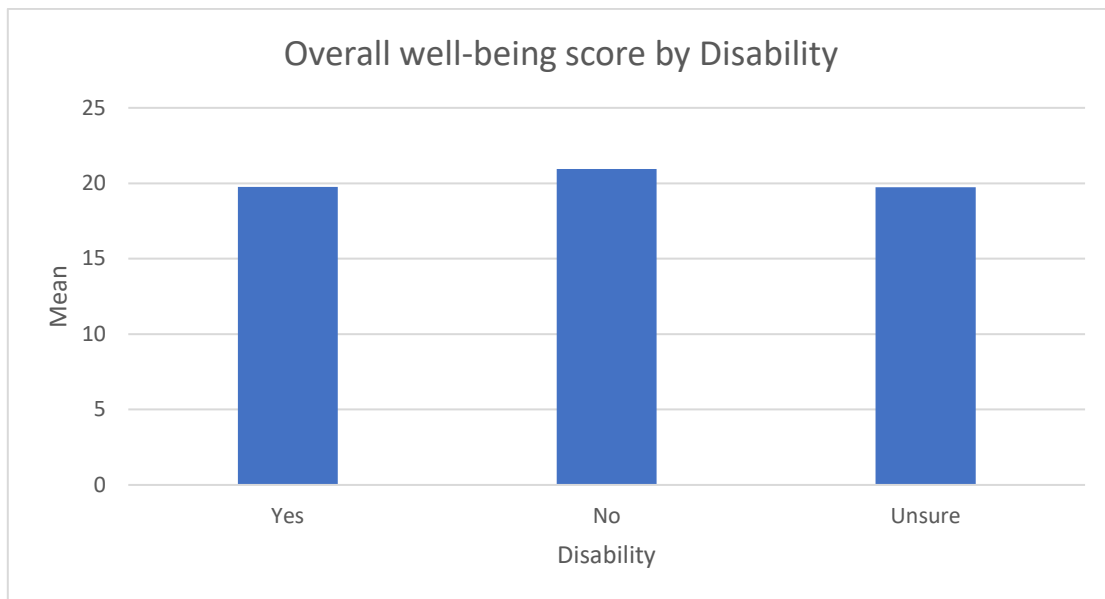


Table A3.15: Mean Overall Well-being Score by Disability (Weighted)

Do you consider yourself to have a disability?	Mean overall well-being score
Yes	18.87
No	21.16
Unsure	19.42

Table A3.16: Mean Overall Well-being Score by Disability (Unweighted)

Do you consider yourself to have a disability?	Mean overall well-being score
Yes	19.75
No	20.95
Unsure	19.74

### A3.7 Well-being Scores by Main Area of Practice

#### Summary (Weighted results):

There were significant differences in the overall mean well-being scores between respondents who worked in different areas of practice ( $F = 28.540$ ,  $df = 7$ ,  $p < .001$ ). Specifically, respondents who

worked with children and young people scored significantly higher than those in midwifery, working with adults, in learning disability, with older people, within mental health and in the area 'other'.

#### Summary (Unweighted results):

There were significant differences in the overall mean well-being scores between respondents who worked in different areas of practice ( $F = 3.136$ ,  $df = 7$ ,  $p = .003$ ). Specifically, respondents who worked with adults of working age scored significantly higher than those who worked in midwifery, and those who worked with older people.

Figure A3.19: Mean Overall Well-being Score by Area of Practice (Weighted)

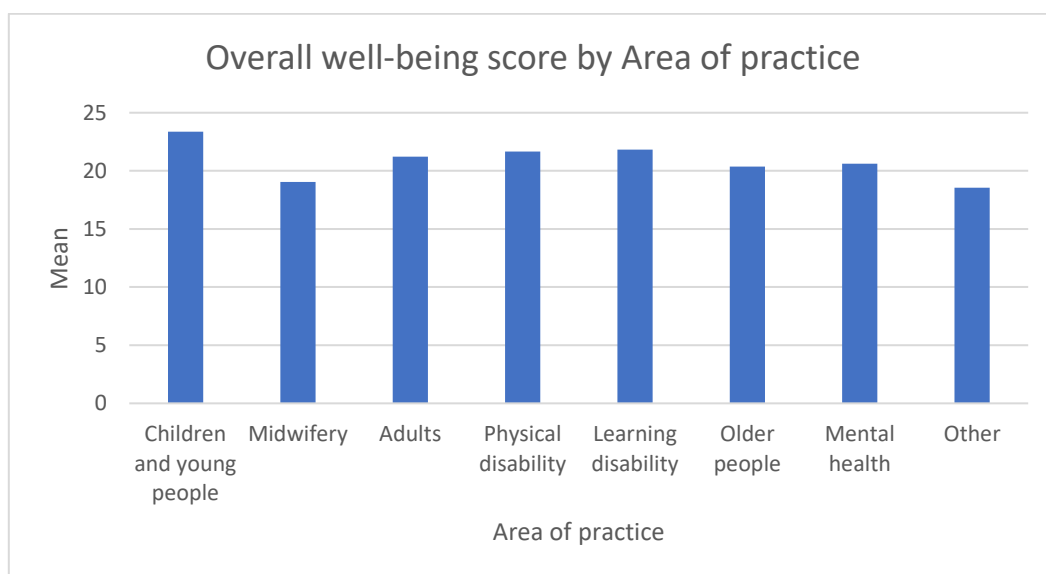


Figure A3.20: Mean Overall Well-being Score by Area of Practice (Unweighted)

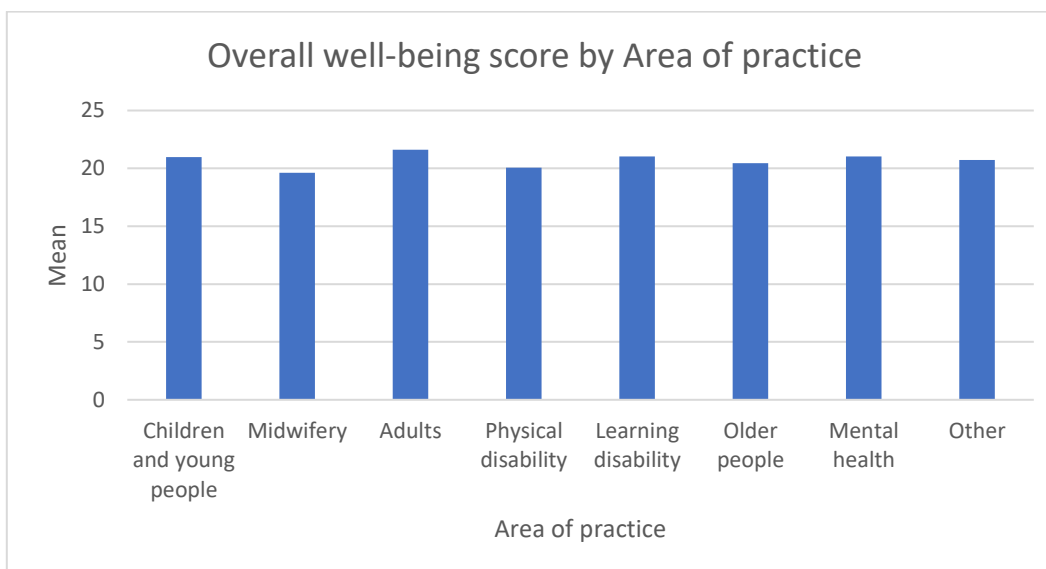


Table A3.17: Mean Overall Well-being Score by Area of Practice (Weighted)

Main area of practice	Mean overall well-being score
Children	23.38
Midwifery	19.05
Adults	21.22
Physical disability	21.66
Learning disability	21.83
Older people	20.38
Mental health	20.61
Other	18.56

Table A3.18: Mean Overall Well-being Score by Area of Practice (Unweighted)

Main area of practice	Mean overall well-being score
Children	20.98
Midwifery	19.63
Adults	21.60
Physical disability	20.07
Learning disability	21.04
Older people	20.46
Mental health	21.02
Other	20.72

### A3.8 Well-being Scores by Line Manager Status

#### Summary (Weighted results):

There was a significant difference in the overall mean well-being scores between respondents who were line managers and those who were not ( $t = 2.554$ ,  $df = 1429$ ,  $p = .011$ ).

#### Summary (Unweighted results):

There was no significant difference in the overall mean well-being scores between respondents who were line managers and those who were not ( $t = 1.142$ ,  $df = 1492$ ,  $p = .254$ ).

Figure A3.21: Mean Overall Well-being Score by Line Manager Status (Weighted)

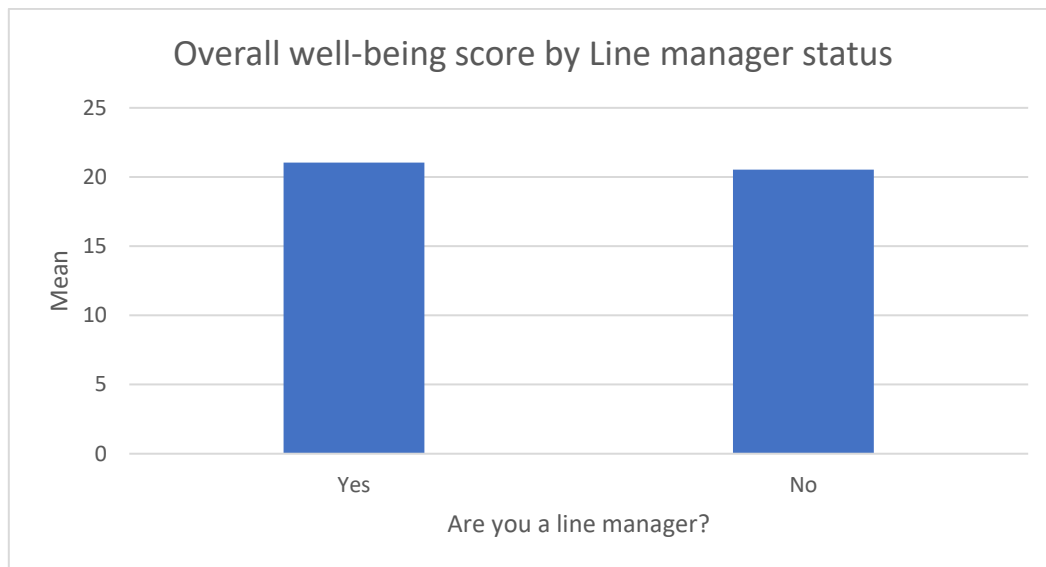


Figure A3.22: Mean Overall Well-being Score by Line Manager Status (Unweighted)

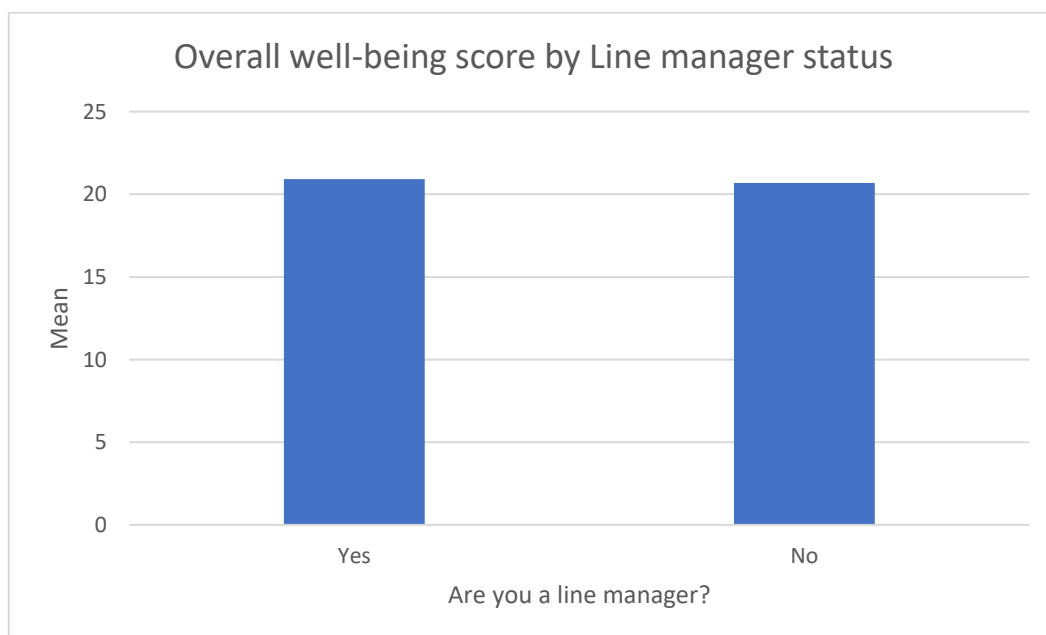


Table A3.19: Mean Overall Well-being Score by Line Manager Status (Weighted)

Are you a line manager?	Mean overall well-being score
Yes	21.05
No	20.54



Table A3.20: Mean Overall Well-being Score by Line Manager Status (Unweighted)

Are you a line manager?	Mean overall well-being score
Yes	20.92
No	20.69

### A3.9 Well-being Scores by the Impact of the Pandemic on Services

#### Summary (Weighted results):

There were significant differences in the overall mean well-being scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ( $F = 29.887$ ,  $df = 2$ ,  $p < .001$ ). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures.

#### Summary (Unweighted results):

There were significant differences in the overall mean well-being scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ( $F = 31.671$ ,  $df = 2$ ,  $p < .001$ ). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures.

Figure A3.23: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Weighted)

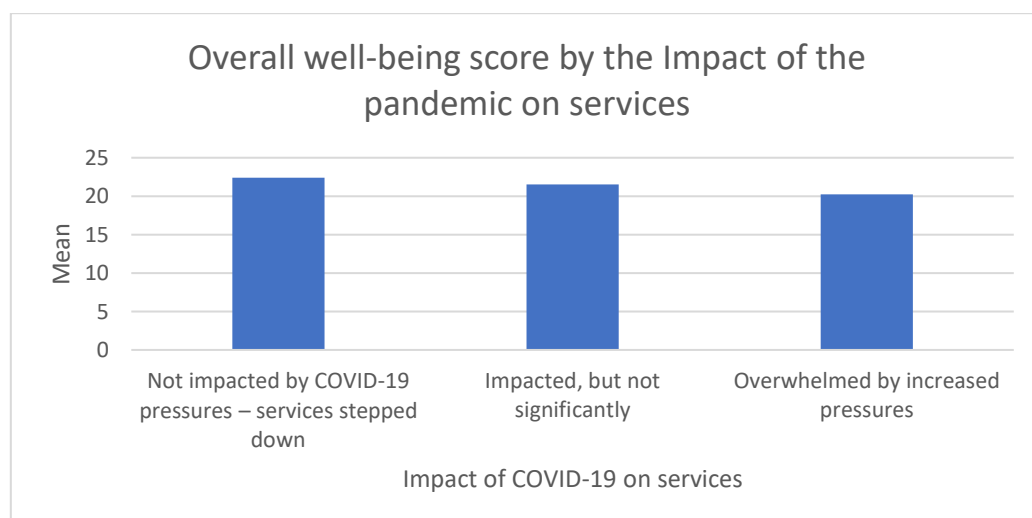


Figure A3.24: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Unweighted)

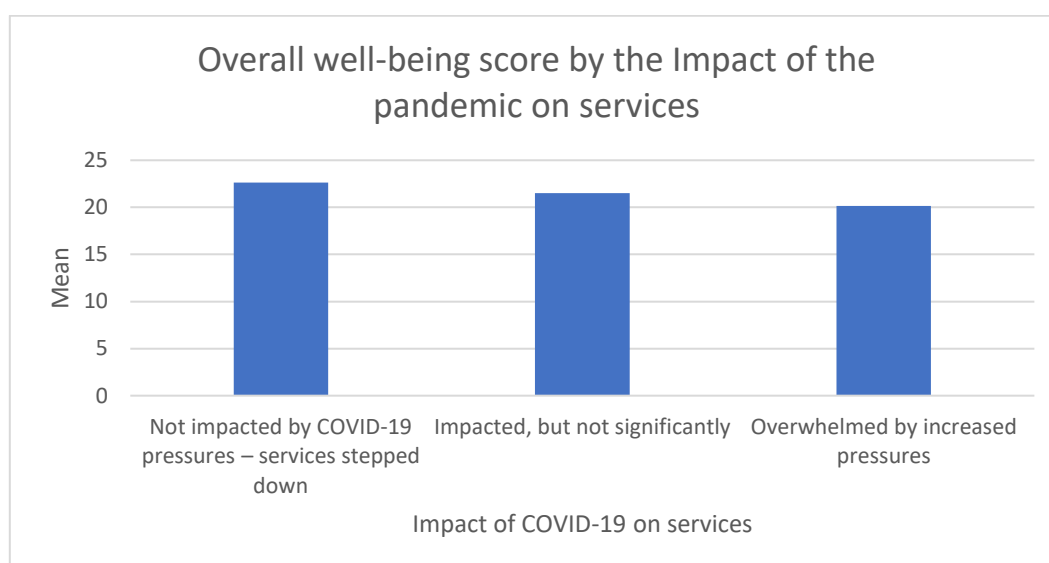


Table A3.21: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Weighted)

Impact of the pandemic on services	Mean overall well-being score
Not impacted by COVID-19 pressures – services stepped down	22.40
Impacted, but not significantly	21.52
Overwhelmed by increased pressures	20.22

Table A3.22: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Unweighted)

Impact of the pandemic on services	Mean overall well-being score
Not impacted by COVID-19 pressures – services stepped down	22.64
Impacted, but not significantly	21.51
Overwhelmed by increased pressures	20.16

### A3.10 Well-being Scores by the Uptake of Employer Support

#### Summary (Weighted results):

There were no significant differences on overall well-being scores between those who took employer support and those who did not ( $t = .56$ -,  $df=1429$ ,  $p>0.05$ ).

#### Summary (Unweighted results):

There were no significant differences on overall well-being scores between those who took employer support and those who did not ( $t = -1.251$ ,  $df=1461$ ,  $p>0.05$ ).

Figure A3. 25: Mean Overall Well-being Score by the Uptake of Employer Support (Weighted)

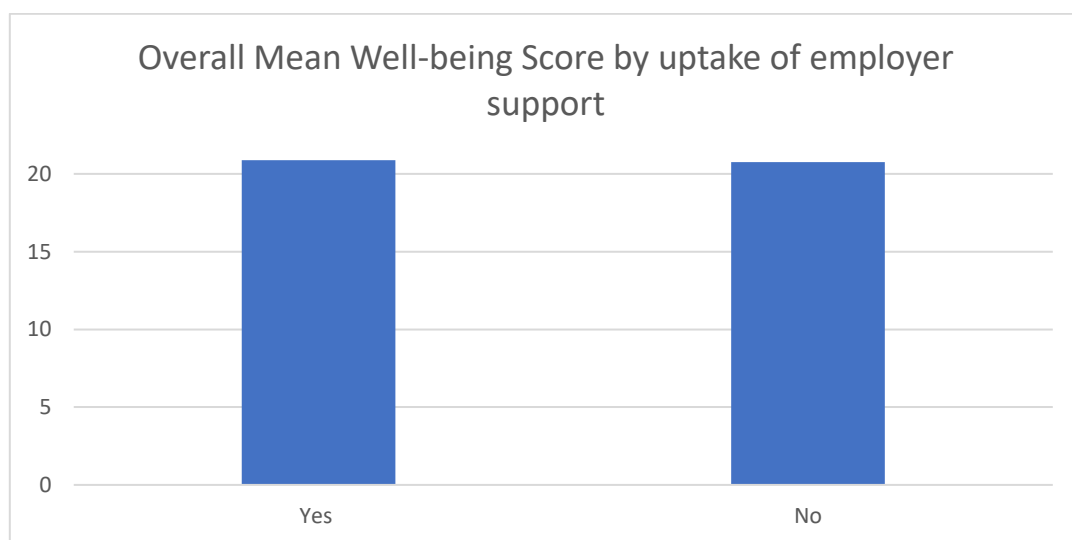


Figure A3. 26: Mean Overall Well-being Score by the Uptake of Employer Support (Unweighted)

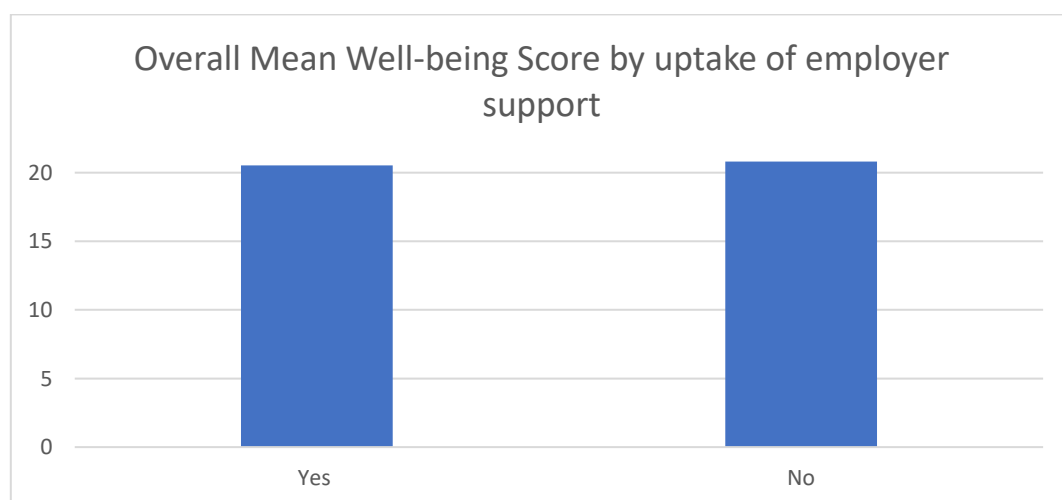


Table A3. 23: Mean Overall Well-being Score by the Uptake of Employer Support (Weighted)

Uptake of employer support	Mean overall well-being score
Yes	20.89
No	20.76

Table A3. 24: Mean Overall Well-being Score by the Uptake of Employer Support (Unweighted)

Uptake of employer support	Mean overall well-being score
Yes	20.52
No	20.82

## 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**.

For direct comparisons across reports (i.e., across Phase 1, Phase 2, Phase 3 and Phase 4), 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 ( $F = 4.660$ ,  $df = 3$ ,  $p = .003$ ). Specifically, the overall WRQOL score was significantly higher in Wales compared to Scotland and Northern Ireland. 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” (52.2%) and Wales had the highest proportion with “higher quality of working life” (47.4%).

#### Summary (Unweighted results):

There were significant differences in the overall mean WRQOL scores across countries ( $F = 2.702$ ,  $df = 3$ ,  $p = .044$ ). Specifically, the overall WRQOL score was significantly higher in Wales 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” (52.5%) and Wales had the highest proportion with “higher quality of working life” (44.3%).

Figure A4. 1: Mean Quality of Working Life Scores by Country (Weighted)

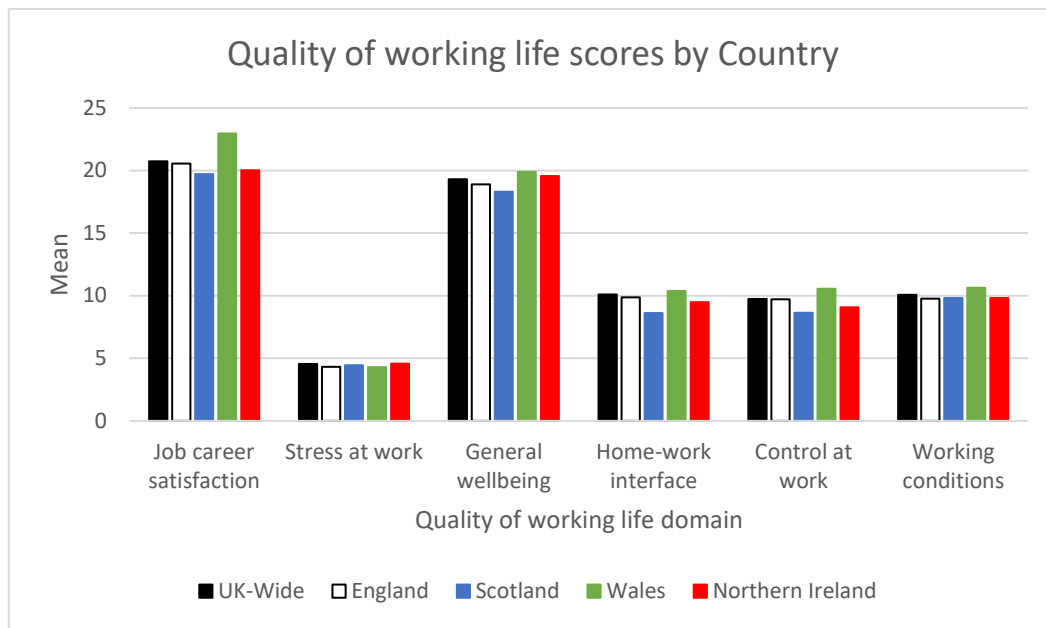


Figure A4. 2: Mean Quality of Working Life Scores by Country (Unweighted)

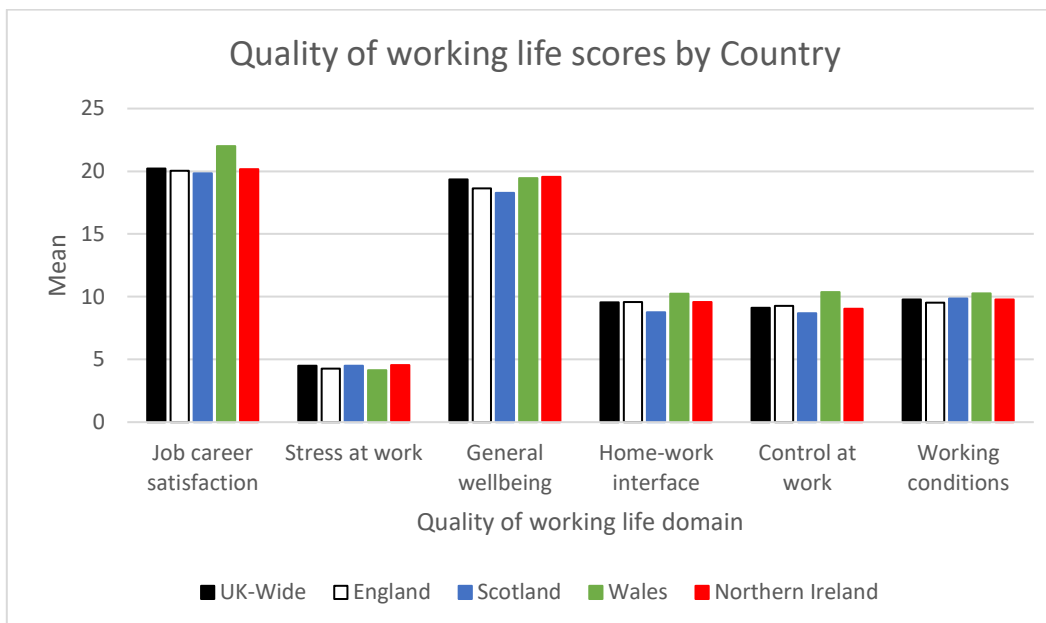


Figure A4.3: Mean Overall Quality of Working Life Score by Country (Weighted)

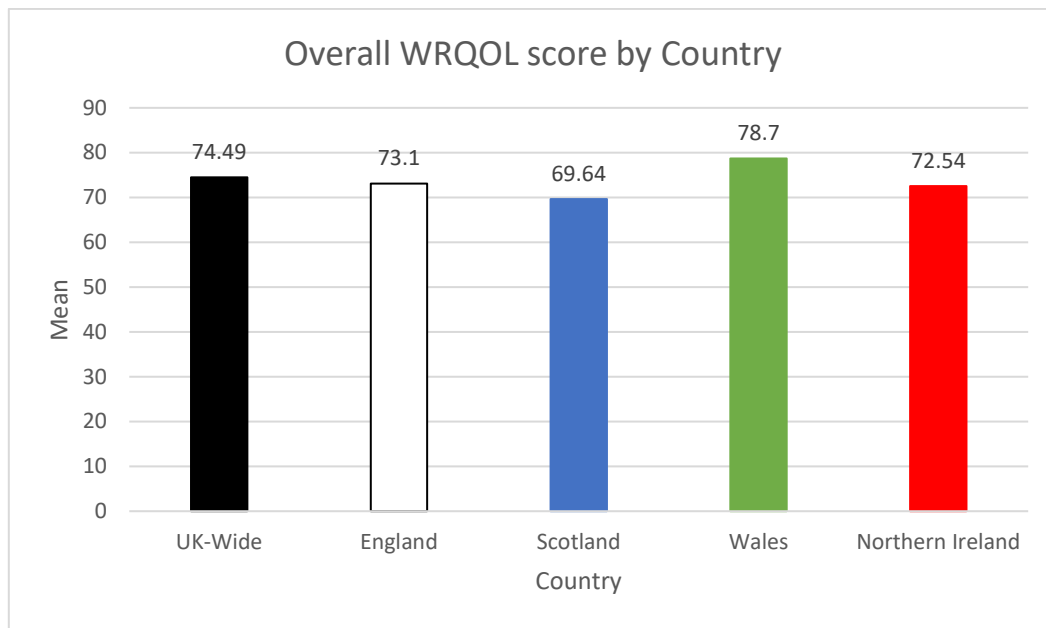


Figure A4.4: Mean Overall Quality of Working Life Score by Country (Unweighted)

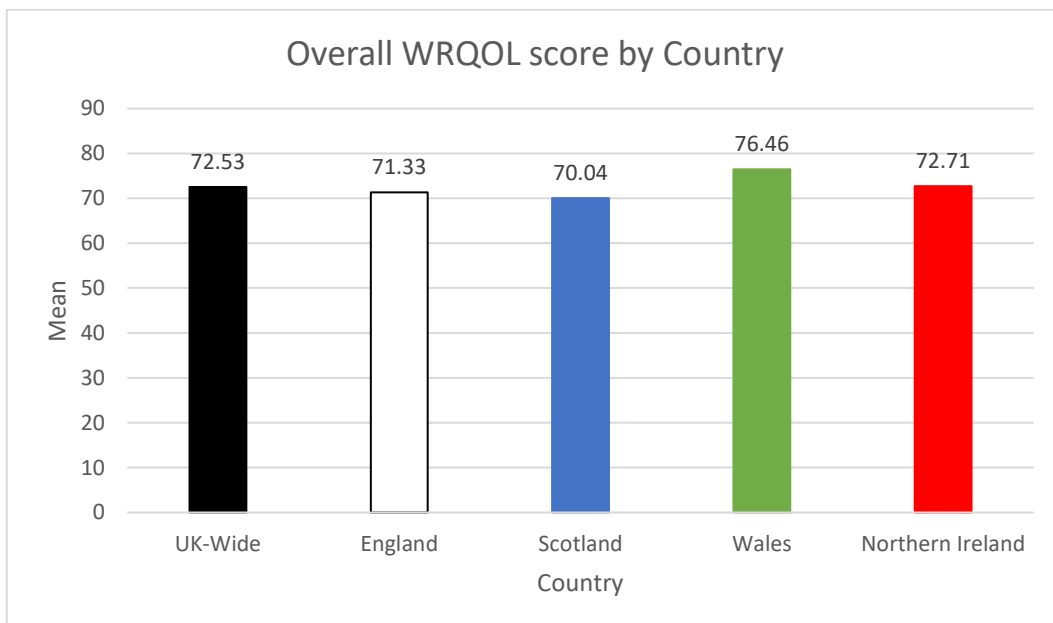


Table A4. 1: Mean Quality of Working Life Scores by Country (Weighted)

WRQOL domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Job career satisfaction	20.72	20.55	19.71	22.95	20.02
Stress at work	4.54	4.31	4.45	4.28	4.58
General well-being	19.30	18.90	18.30	19.88	19.55
Home-work interface	10.10	9.86	8.62	10.38	9.48
Control at work	9.74	9.70	8.65	10.56	9.07
Working conditions	10.08	9.76	9.82	10.64	9.81
<b>Overall WRQOL Score</b>	<b>74.49</b>	<b>73.1</b>	<b>69.64</b>	<b>78.7</b>	<b>72.54</b>

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	20.23	20.04	19.83	22	20.18
Stress at work	4.49	4.26	4.51	4.15	4.55
General well-being	19.34	18.63	18.29	19.46	19.55
Home-work interface	9.55	9.57	8.77	10.23	9.58
Control at work	9.12	9.28	8.68	10.37	9.05
Working conditions	9.78	9.52	9.86	10.27	9.77
<b>Overall WRQOL score</b>	<b>72.53</b>	<b>71.33</b>	<b>70.04</b>	<b>76.46</b>	<b>72.71</b>

Figure A4.5: Level of Quality of Working Life Scores – UK-Wide (Weighted)

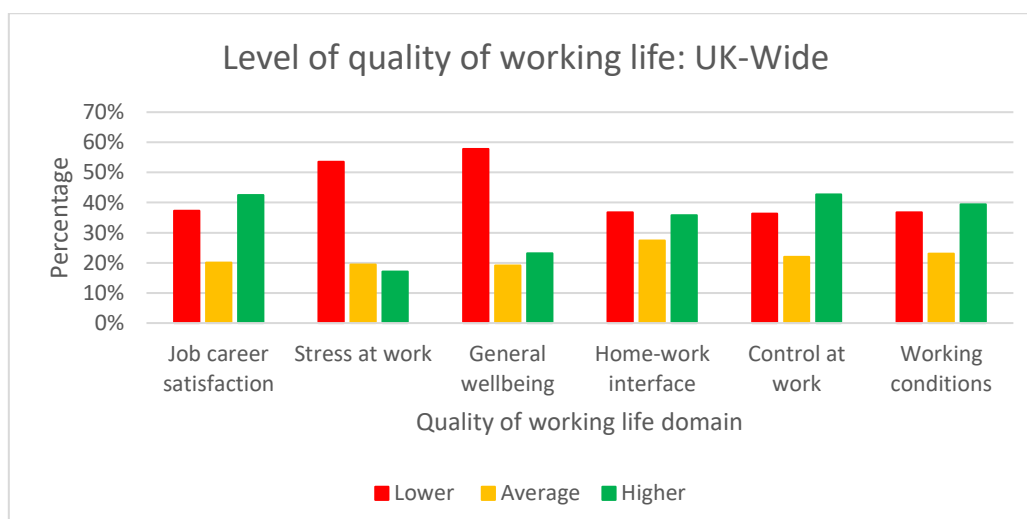




Figure A4.6: Level of Quality of Working Life Scores – UK-Wide (Unweighted)

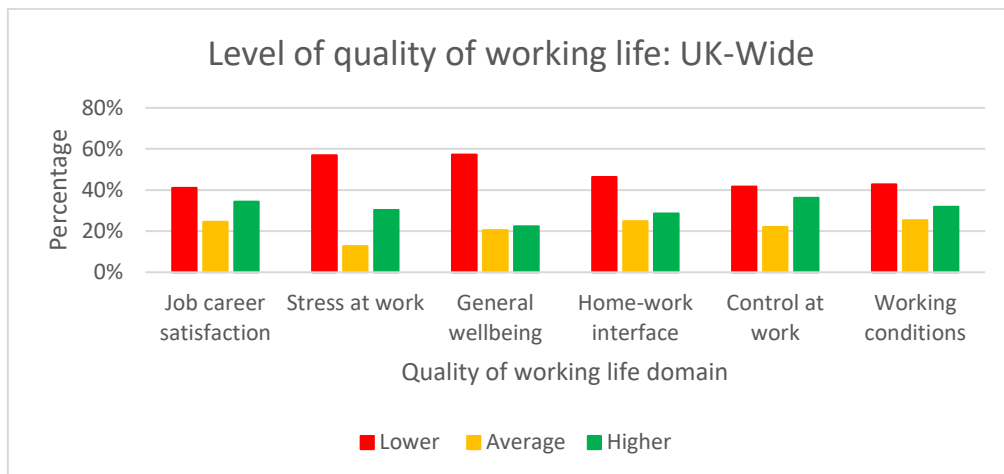


Table A4.3: Level of Quality of Working Life Scores – UK-Wide (Weighted)

WRQOL domain	Level of WRQOL			Total
	Lower	Average	Higher	
Job career satisfaction	37.3%	20.1%	42.5%	100%
Stress at work	53.5%	19.4%	17.1%	100%
General well-being	57.8%	19.1%	23.1%	100%
Home-work interface	36.8%	27.4%	35.8%	100%
Control at work	36.3%	22.0%	42.7%	100%
Working conditions	36.7%	23.0%	39.4%	100%
<b>Overall WRQOL</b>	<b>38.2%</b>	<b>27.8%</b>	<b>34.0%</b>	<b>100%</b>

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	41.0%	24.6%	34.4%	1481 (100%)
Stress at work	57.0%	12.7%	30.3%	1486 (100%)
General well-being	57.2%	20.5%	22.4%	1480 (100%)
Home-work interface	46.4%	24.9%	28.6%	1505 (100%)
Control at work	41.7%	22.1%	36.2%	1482 (100%)
Working conditions	42.8%	25.3%	31.9%	1487 (100%)
<b>Overall WRQOL</b>	<b>47.3%</b>	<b>23.0%</b>	<b>29.7%</b>	<b>1476 (100%)</b>

Figure A4.7: Level of Overall Quality of Working Life by Country (Weighted)

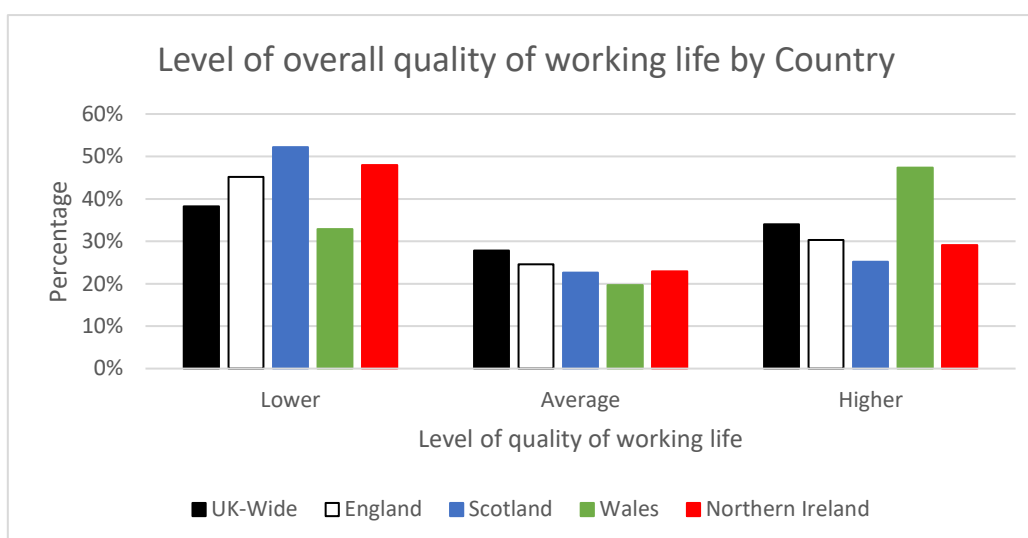


Figure A4.8: Level of Overall Quality of Working Life by Country (Unweighted)

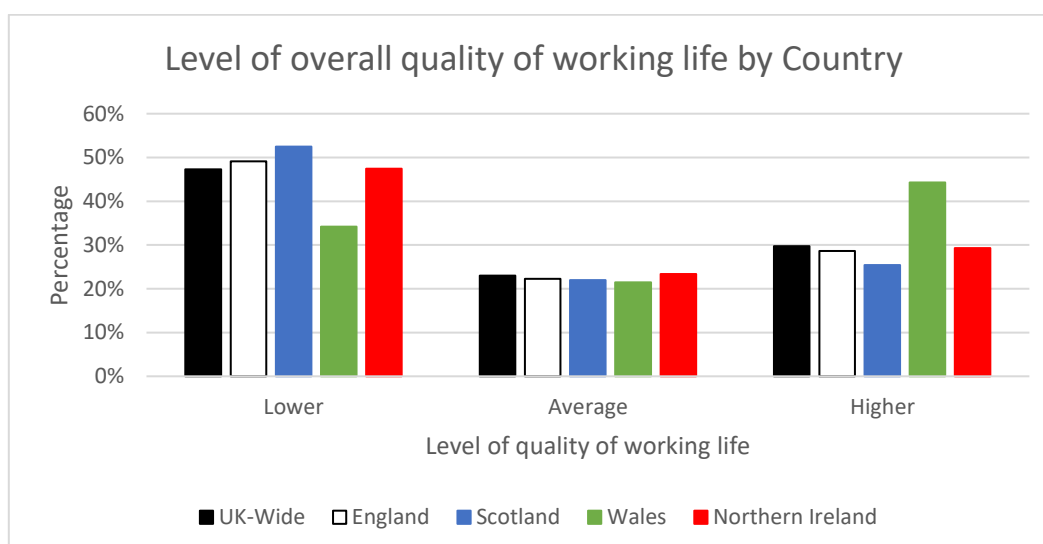


Table A4.5: Level of Overall Quality of Working Life by Country (Weighted)

Level of WRQOL	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower	38.2%	45.2%	52.2%	32.9%	48.0%
Average	27.8%	24.6%	22.6%	19.7%	22.9%
Higher	34.0%	30.3%	25.2%	47.4%	29.1%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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	47.3%	49.1%	52.5%	34.2%	47.4%
Average	23.0%	22.3%	22.0%	21.5%	23.4%
Higher	29.7%	28.6%	25.4%	44.3%	29.3%
<b>Total</b>	<b>1476 (100%)</b>	<b>175 (100%)</b>	<b>118 (100%)</b>	<b>79 (100%)</b>	<b>1104 (100%)</b>

## 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 ( $F = 18.372$ ,  $df = 4$ ,  $p < .001$ ). Specifically, midwives scored significantly lower than all other occupations.

### Summary (Unweighted results):

There were significant differences in the overall mean WRQOL score between the occupational groups ( $F = 5.277$ ,  $df = 4$ ,  $p < .001$ ). Specifically, midwives scored significantly lower than social care workers and AHPs. AHPs scored significantly higher than Social Workers.

Figure A4.9: Mean Quality of Working Life Scores by Occupation (Weighted)

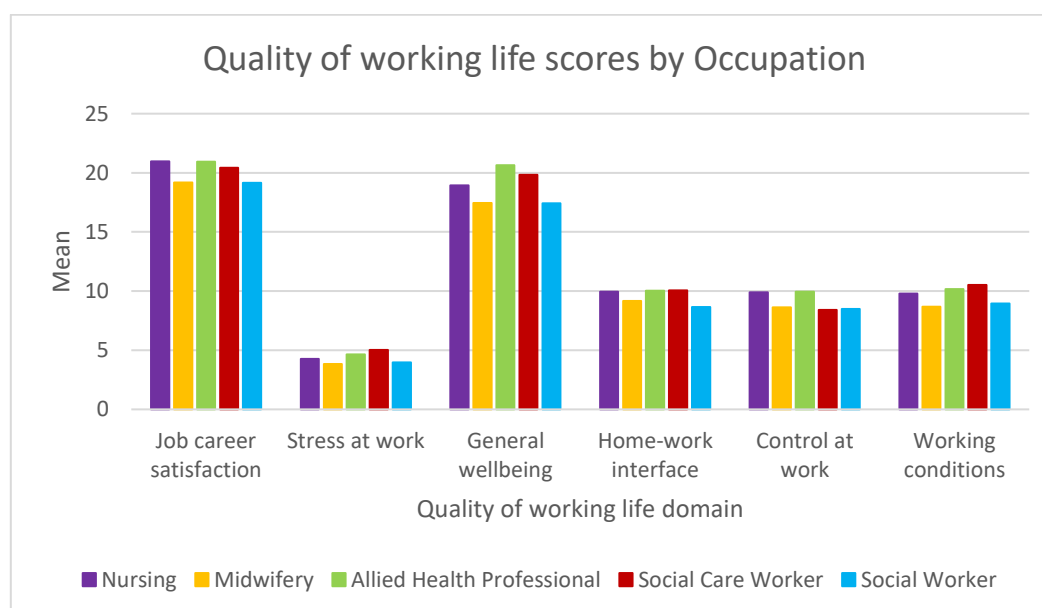


Figure A4.10: Mean Quality of Working Life Scores by Occupation (Unweighted)

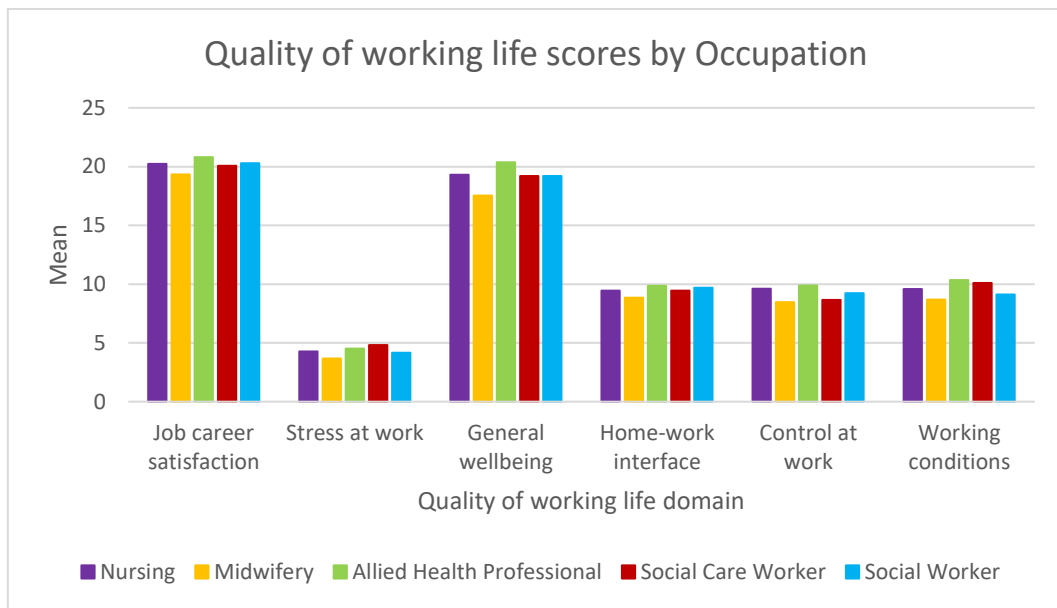


Figure A4.11: Mean Overall Quality of Working Life Score by Occupation (Weighted)

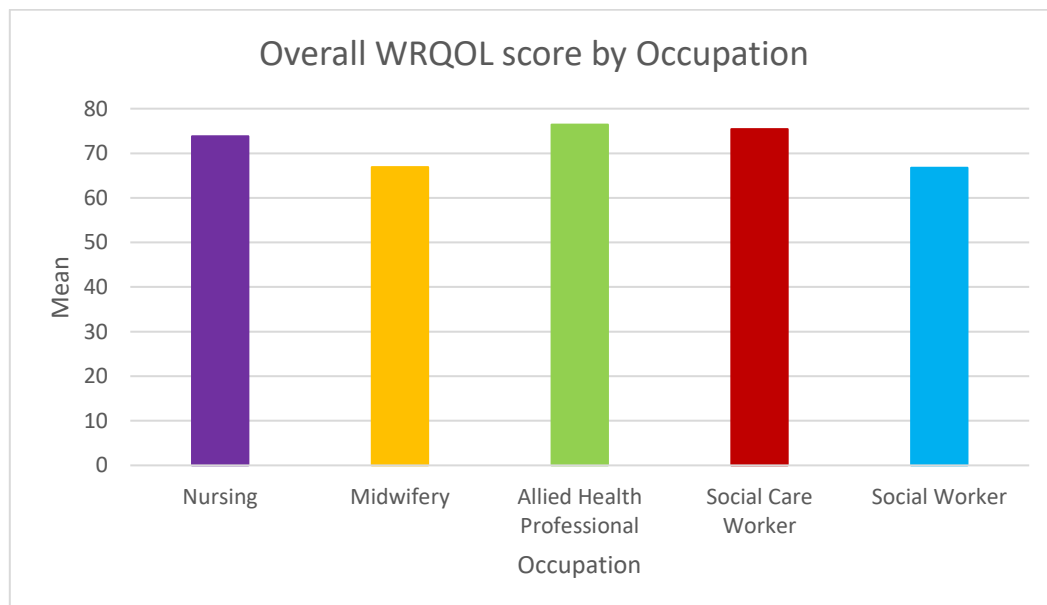


Figure A4.12: Mean Overall Quality of Working Life Score by Occupation (Unweighted)

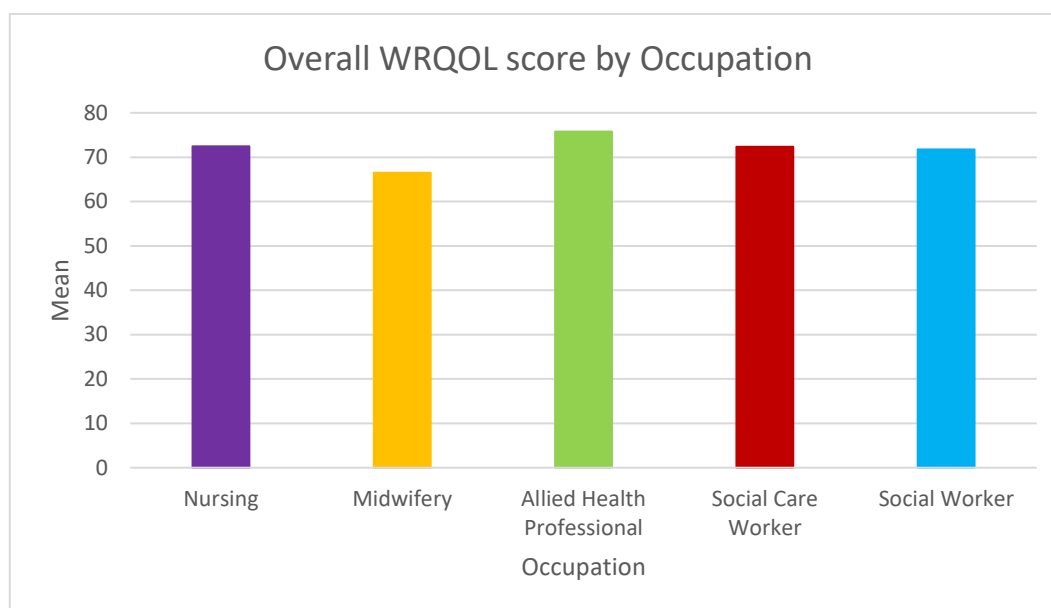


Table A4.7: Mean Quality of Working Life Scores by Occupation (Weighted)

WRQOL domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Job career satisfaction	20.97	19.17	20.95	20.43	19.14
Stress at work	4.27	3.83	4.65	5.03	3.98
General well-being	18.93	17.45	20.63	19.84	17.41
Home-work interface	9.96	9.17	10.03	10.06	8.66
Control at work	9.91	8.63	9.96	8.42	8.48
Working conditions	9.78	8.69	10.16	10.53	8.94
<b>Overall WRQOL score</b>	<b>73.81</b>	<b>66.89</b>	<b>76.42</b>	<b>75.41</b>	<b>66.75</b>

Table A4.8: Mean Quality of Working Life Scores by Occupation (Unweighted)

WRQOL domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Job career satisfaction	20.22	19.34	20.81	20.07	20.28
Stress at work	4.28	3.66	4.51	4.83	4.17
General well-being	19.30	17.53	20.36	19.20	19.20
Home-work interface	9.46	8.86	9.86	9.45	9.70
Control at work	9.61	8.47	9.88	8.65	9.24
Working conditions	9.59	8.69	10.35	10.09	9.12
<b>Overall WRQOL score</b>	<b>72.45</b>	<b>66.49</b>	<b>75.78</b>	<b>72.35</b>	<b>71.75</b>

Figure A4.13: Level of Overall Quality of Working Life by Occupation (Weighted)

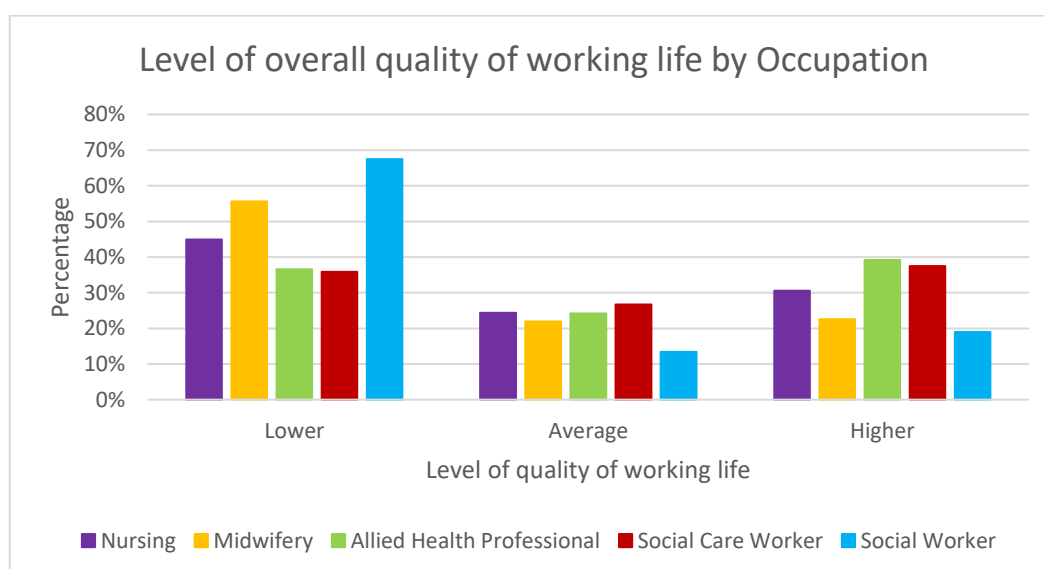


Figure A4.14: Level of Overall Quality of Working Life by Occupation (Unweighted)

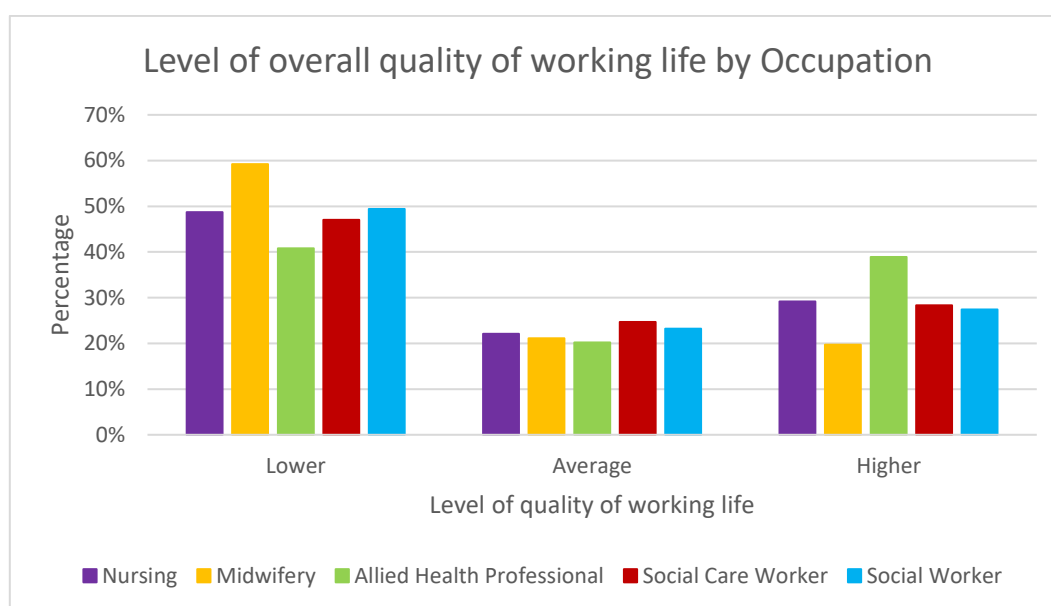


Table A4.9: Level of Overall Quality of Working Life by Occupation (Weighted)

Level of WRQOL	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Lower	44.9%	55.6%	36.6%	35.9%	67.5%
Average	24.4%	21.9%	24.2%	26.7%	13.4%
Higher	30.6%	22.6%	39.2%	37.5%	19.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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	48.7%	59.2%	40.8%	47.0%	49.4%
Average	22.1%	21.1%	20.2%	24.7%	23.2%
Higher	29.2%	19.7%	38.9%	28.3%	27.4%
<b>Total</b>	<b>195 (100%)</b>	<b>76 (100%)</b>	<b>262 (100%)</b>	<b>607 (100%)</b>	<b>336 (100%)</b>

### A4.3 Quality of Working Life Scores by Sex

Only 5 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 was a significant difference in mean overall WRQOL scores between males and females ( $t = -10.837$ ,  $df = 1430$ ,  $p < .001$ ).

#### Summary (Unweighted results):

Males and females did not differ significantly in their mean overall WRQOL score ( $t = -.659$ ,  $df = 1469$ ,  $p = .510$ ).

Figure A4.15: Mean Quality of Working Life Scores by Sex (Weighted)

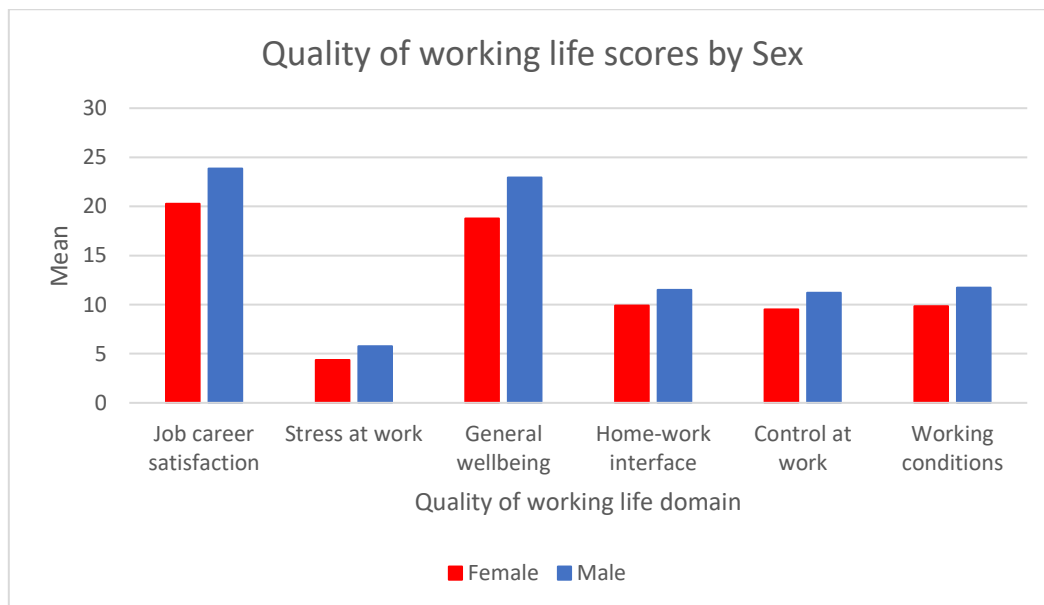




Figure A4.16: Mean Quality of Working Life Scores by Sex (Unweighted)

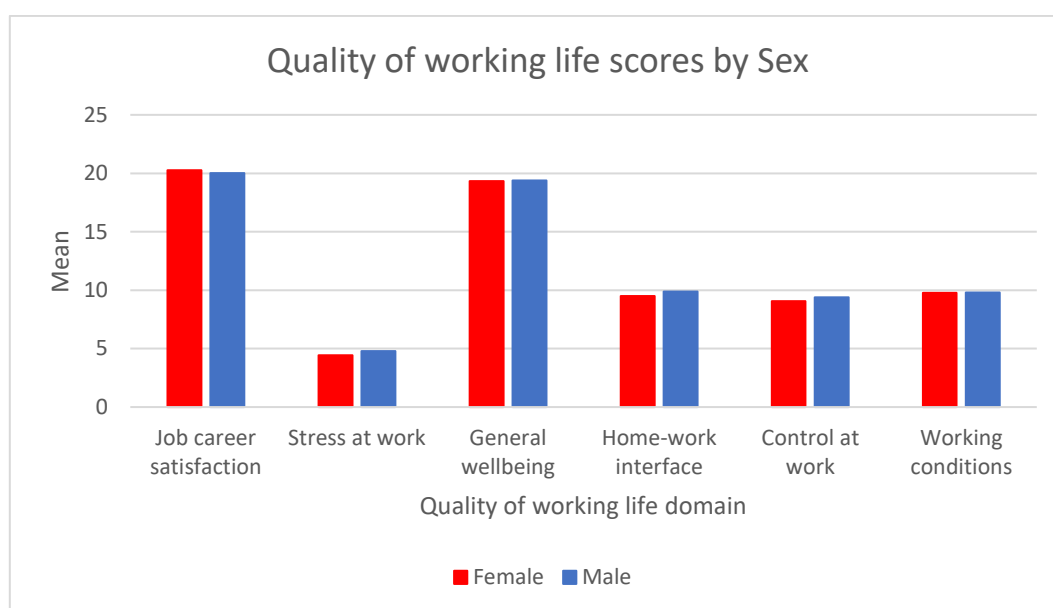


Figure A4.17: Mean Overall Quality of Working Life Score by Sex (Weighted)

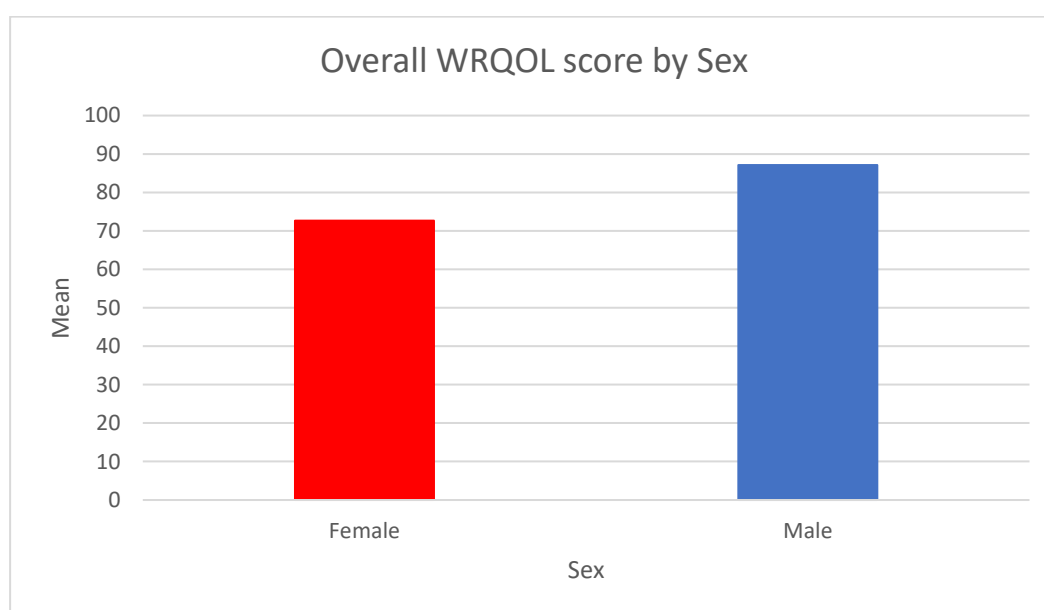


Figure A4.18: Mean Overall Quality of Working Life Score by Sex (Unweighted)

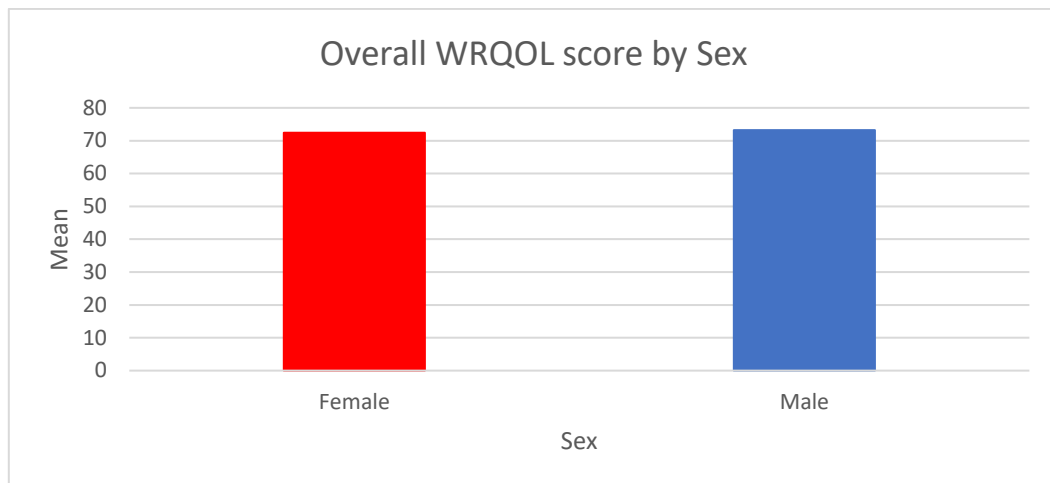


Table A4.11: Mean Quality of Working Life Scores by Sex (Weighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.26	23.87
Stress at work	4.36	5.77
General well-being	18.78	22.94
Home-work interface	9.89	11.51
Control at work	9.52	11.20
Working conditions	9.84	11.73
<b>Overall WRQOL score</b>	<b>72.67</b>	<b>87.13</b>

Table A4.12: Mean Quality of Working Life Scores by Sex (Unweighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.27	20.01
Stress at work	4.44	4.78
General well-being	19.33	19.38
Home-work interface	9.49	9.89
Control at work	9.07	9.38
Working conditions	9.77	9.80
<b>Overall WRQOL score</b>	<b>72.42</b>	<b>73.21</b>

Figure A4.19: Level of Overall Quality of Working Life by Sex (Weighted)

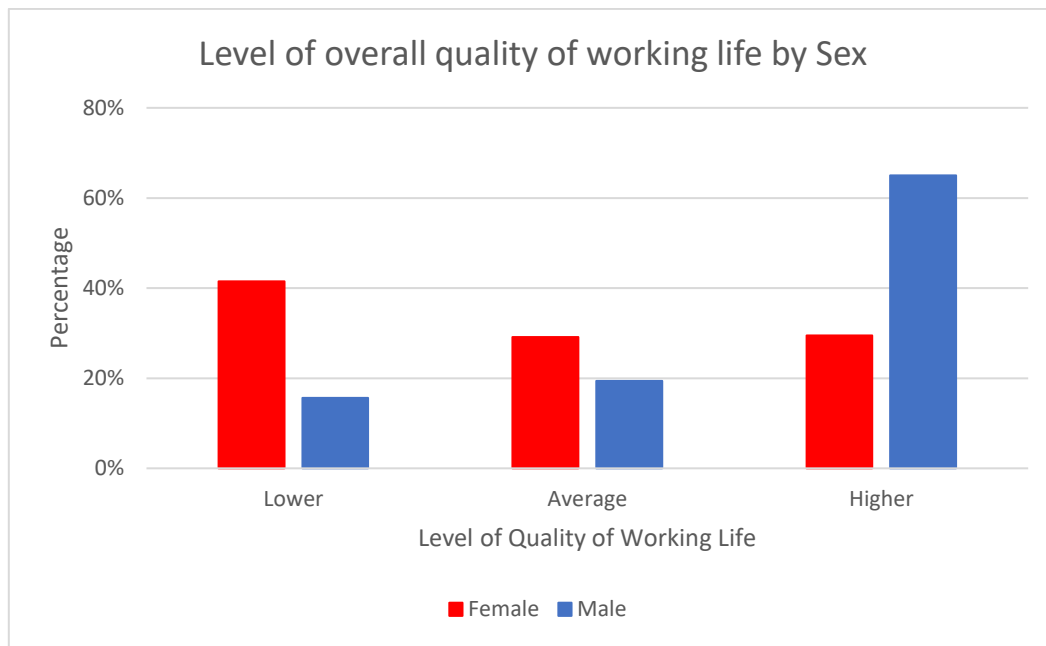


Figure A4.20: Level of Overall Quality of Working Life by Sex (Unweighted)

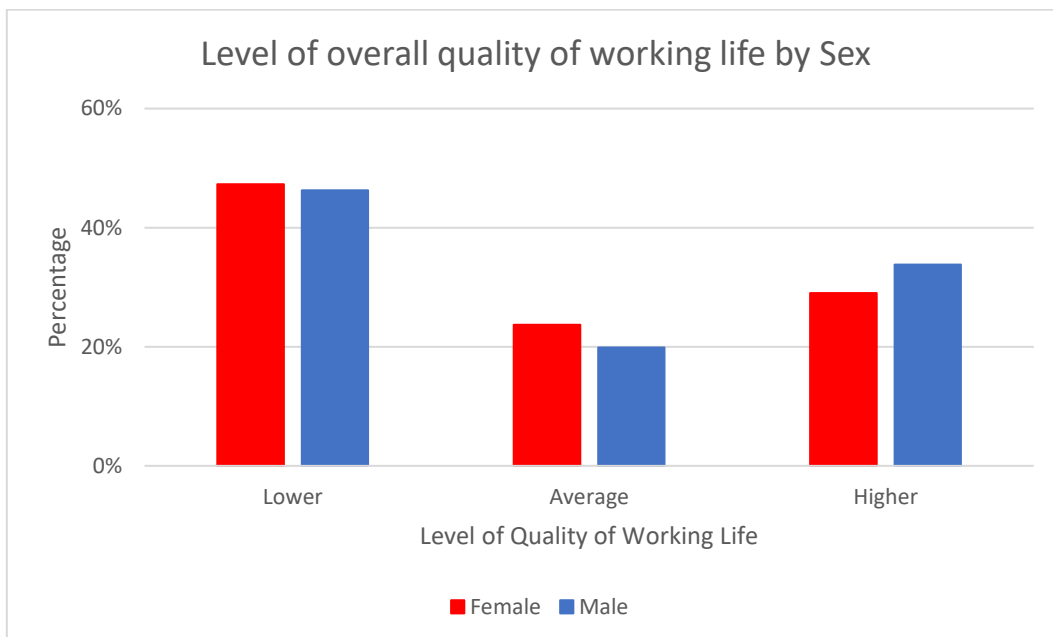


Table A4.13: Level of Overall Quality of Working Life by Sex (Weighted)

Level of WRQOL	Sex	
	Female	Male
Lower	41.5%	15.6%
Average	29.1%	19.4%
Higher	29.5%	65.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>

Table A4.14: Level of Overall Quality of Working Life by Sex (Unweighted)

Level of WRQOL	Sex	
	Female	Male
Lower	47.3%	46.3%
Average	23.7%	19.9%
Higher	29.0%	33.8%
<b>Total</b>	<b>1240 (100%)</b>	<b>231 (100%)</b>

#### A4.4 Quality of Working Life Scores by Age

##### Summary (Weighted results):

There appeared to be significant differences in the mean overall WRQOL score across age groups ( $F = 6.713$ ,  $df = 4$ ,  $p < .001$ ). Specially those respondents in the 16-29 age group scored significantly higher than those in all other age groups.

##### Summary (Unweighted results):

There appeared to be significant differences in the mean overall WRQOL score across age groups ( $F = 2.686$ ,  $df = 4$ ,  $p = .030$ ).

Figure A4.21: Mean Quality of Working Life Scores by Age (Weighted)

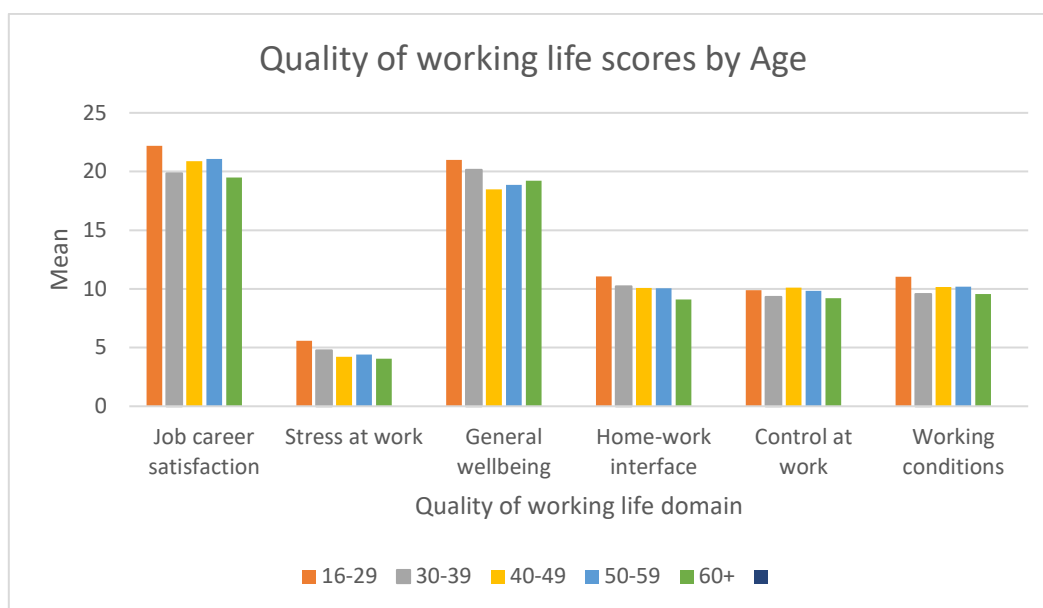


Figure A4.22: Mean Quality of Working Life Scores by Age (Unweighted)

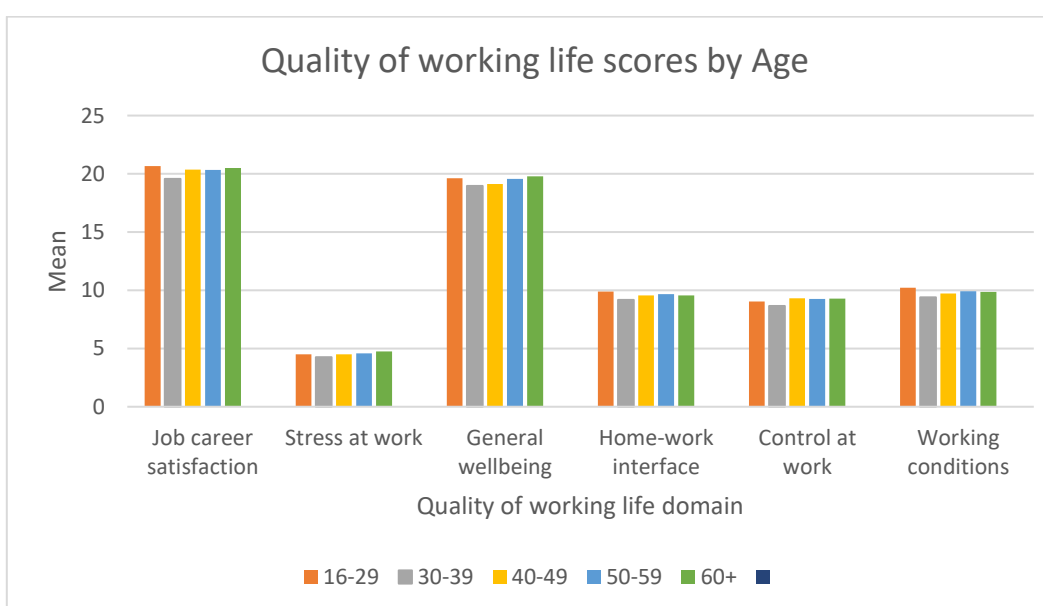


Figure A4.23: Mean Overall Quality of Working Life Score by Age (Weighted)

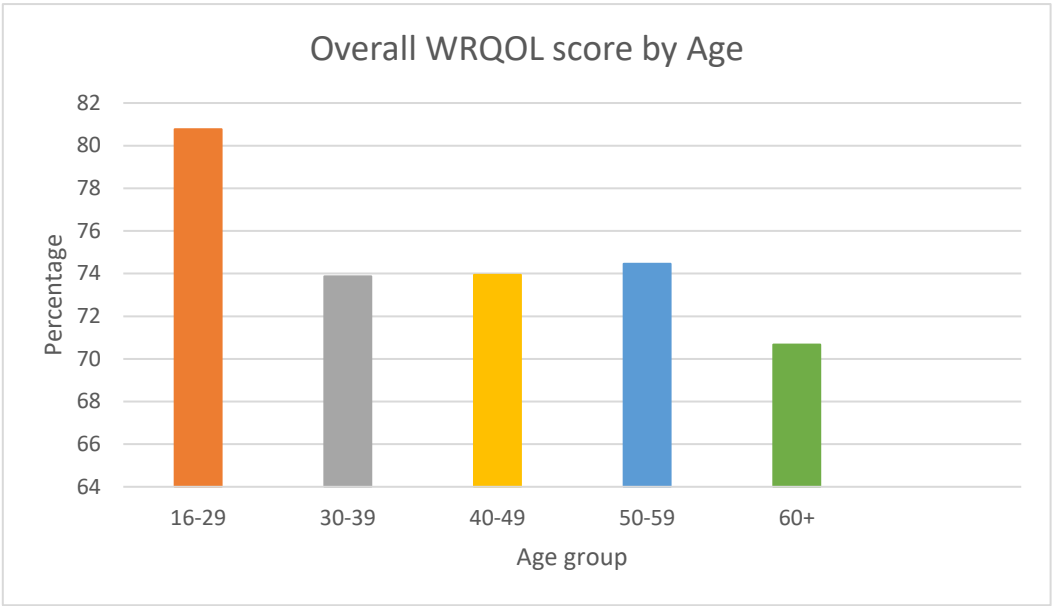


Figure A4.24: Mean Overall Quality of Working Life Score by Age (Unweighted)

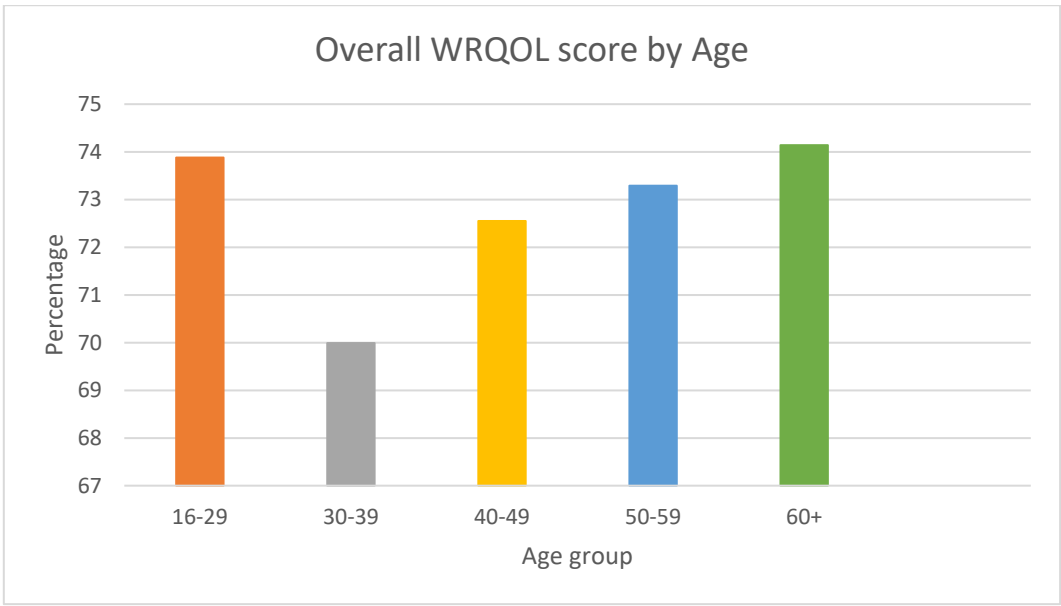


Table A4.15: Mean Quality of Working Life Scores by Age (Weighted)

WRQOL domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Job career satisfaction	22.20	19.84	20.87	21.08	19.49	22.2
Stress at work	5.58	4.77	4.22	4.42	4.06	5.58
General well-being	20.98	20.15	18.47	18.85	19.21	20.98
Home-work interface	11.06	10.22	10.07	10.04	9.09	11.06
Control at work	9.90	9.31	10.12	9.84	9.20	9.90
Working conditions	11.04	9.57	10.17	10.19	9.56	11.04
<b>Overall WRQOL score</b>	<b>80.77</b>	<b>73.87</b>	<b>73.94</b>	<b>74.46</b>	<b>70.67</b>	<b>80.77</b>

Table A4.16: Mean Quality of Working Life Scores by Age (Unweighted)

WRQOL domain	Age				
	16-29	30-39	40-49	50-59	60+
Job career satisfaction	20.67	19.56	20.35	20.34	20.49
Stress at work	4.49	4.26	4.49	4.58	4.76
General well-being	19.62	18.96	19.11	19.56	19.79
Home-work interface	9.88	9.16	9.57	9.67	9.57
Control at work	9.03	8.66	9.31	9.25	9.29
Working conditions	10.21	9.38	9.71	9.91	9.87
<b>Overall WRQOL score</b>	<b>73.88</b>	<b>69.99</b>	<b>72.55</b>	<b>73.29</b>	<b>74.14</b>

Figure A4.25: Level of Overall Quality of Working Life by Age (Weighted)

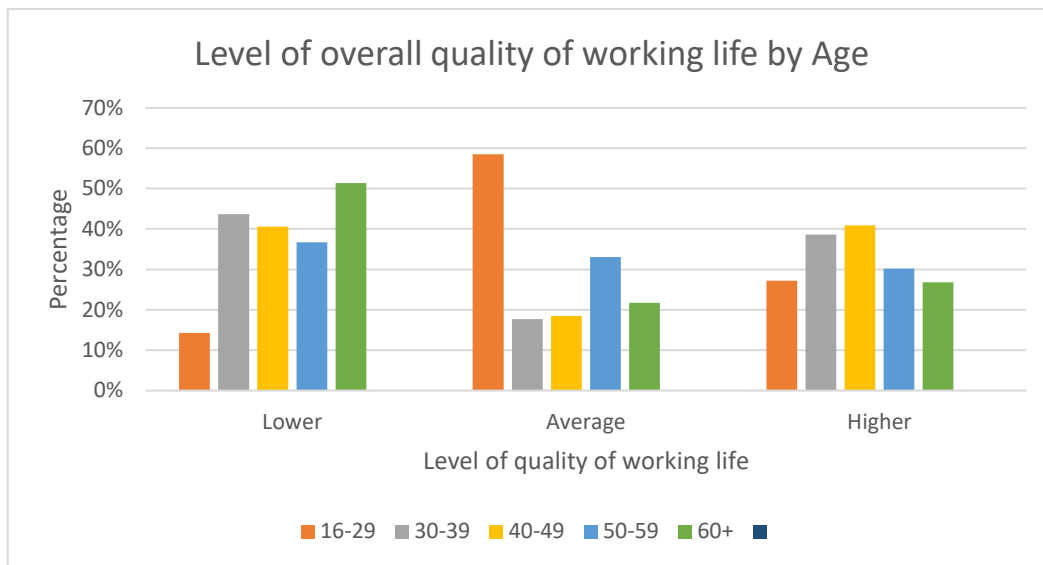


Figure A4.26: Level of Overall Quality of Working Life by Age (Unweighted)

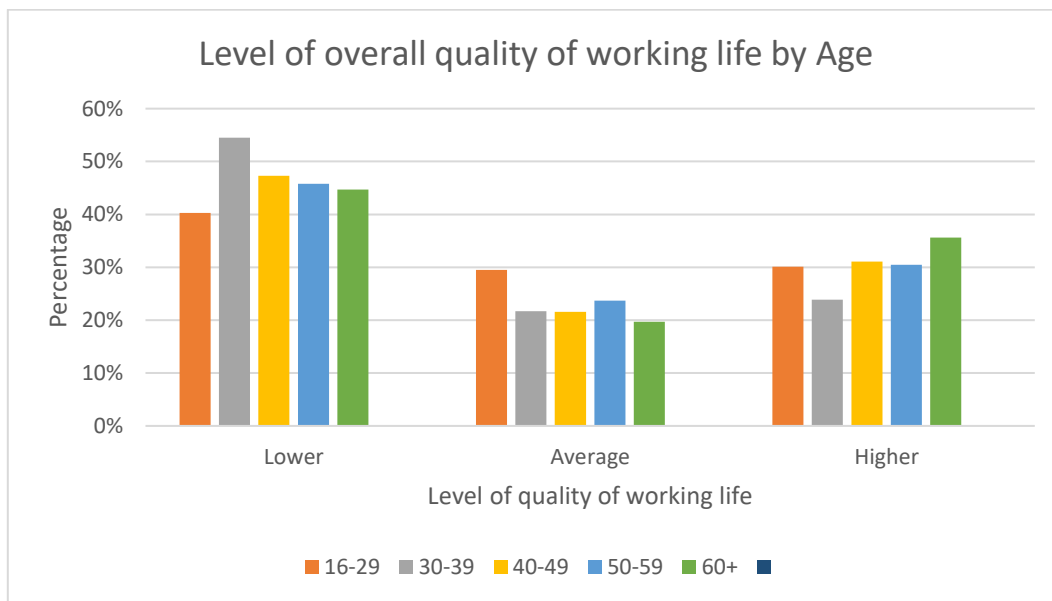


Table A4.17: Level of Overall Quality of Working Life by Age (Weighted)

Level of WRQOL	Age				
	16-29	30-39	40-49	50-59	60+
Lower	14.3%	43.7%	40.6%	36.7%	51.4%
Average	58.5%	17.7%	18.5%	33.1%	21.7%
Higher	27.2%	38.6%	40.9%	30.2%	26.8%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>



Table A4.18: Level of Overall Quality of Working Life by Age (Unweighted)

Level of WRQOL	Age				
	16-29	30-39	40-49	50-59	60+
Lower	40.3%	54.5%	47.3%	45.8%	44.7%
Average	29.5%	21.7%	21.6%	23.7%	19.7%
Higher	30.1%	23.9%	31.1%	30.5%	35.6%
<b>Total</b>	<b>176 (100%)</b>	<b>314 (100%)</b>	<b>402 (100%)</b>	<b>452 (100%)</b>	<b>132 (100%)</b>

#### A4.5 Quality of Working Life Scores by Ethnicity

##### Summary (Weighted results):

There were significant differences between the ethnic groups in their mean overall WRQOL scores ( $F = 17.185$ ,  $df = 3$ ,  $p < .001$ ). Those of White Ethnicity reported lower scores than those of Black or Mixed ethnicity but higher scores than those of Asian Ethnicity.

##### Summary (Unweighted results):

There were no significant differences between the ethnic groups in their mean overall WRQOL scores ( $F = 1.319$ ,  $df = 3$ ,  $p = .266$ ).

Figure A4.27: Mean Quality of Working Life Scores by Ethnicity (Weighted)

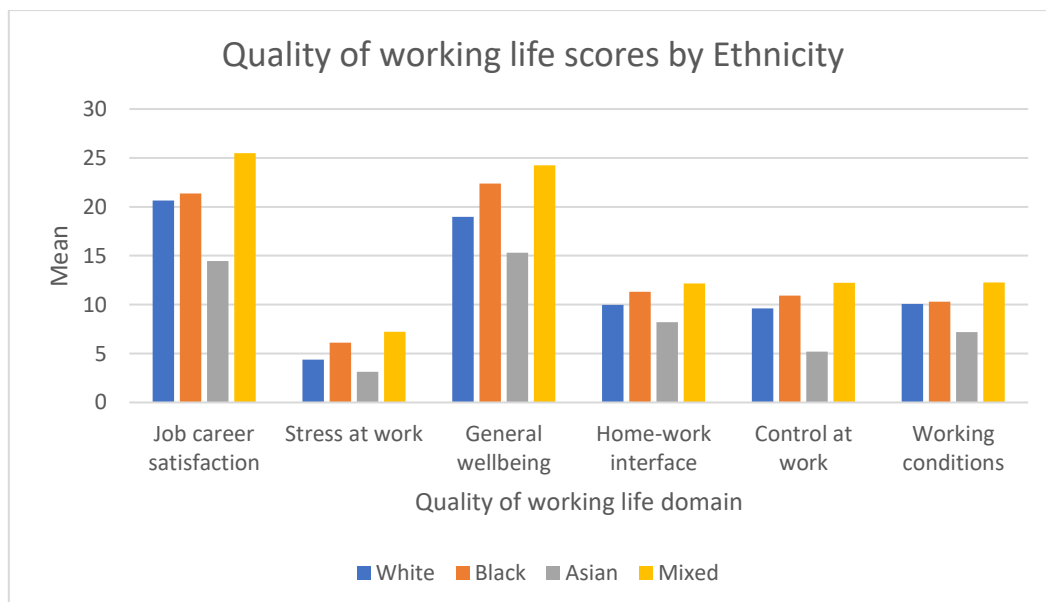


Figure A4.28: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

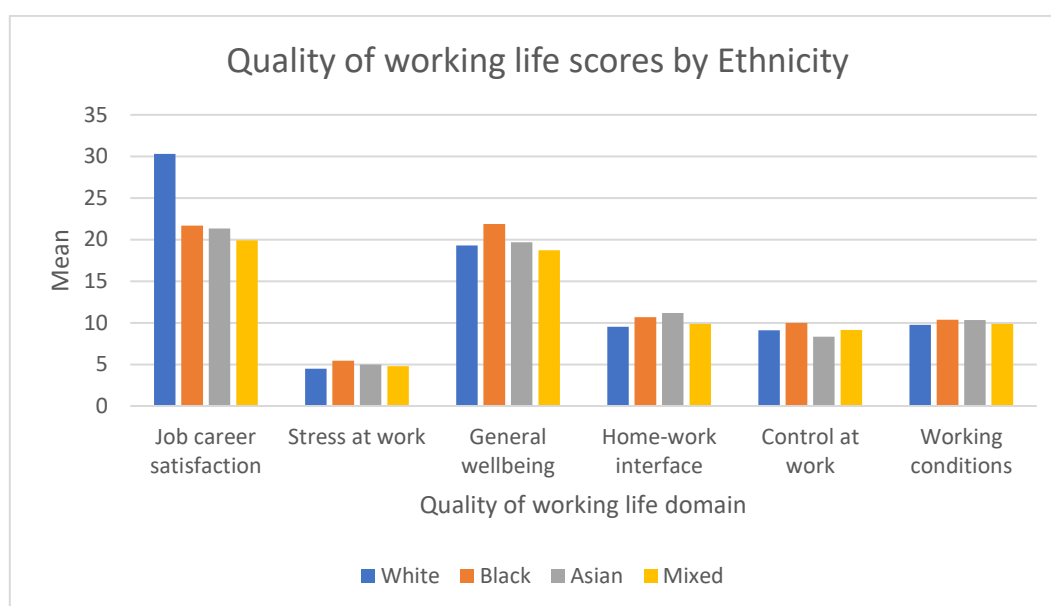


Figure A4.29: Mean Overall Quality of Working Life Score by Ethnicity (Weighted)

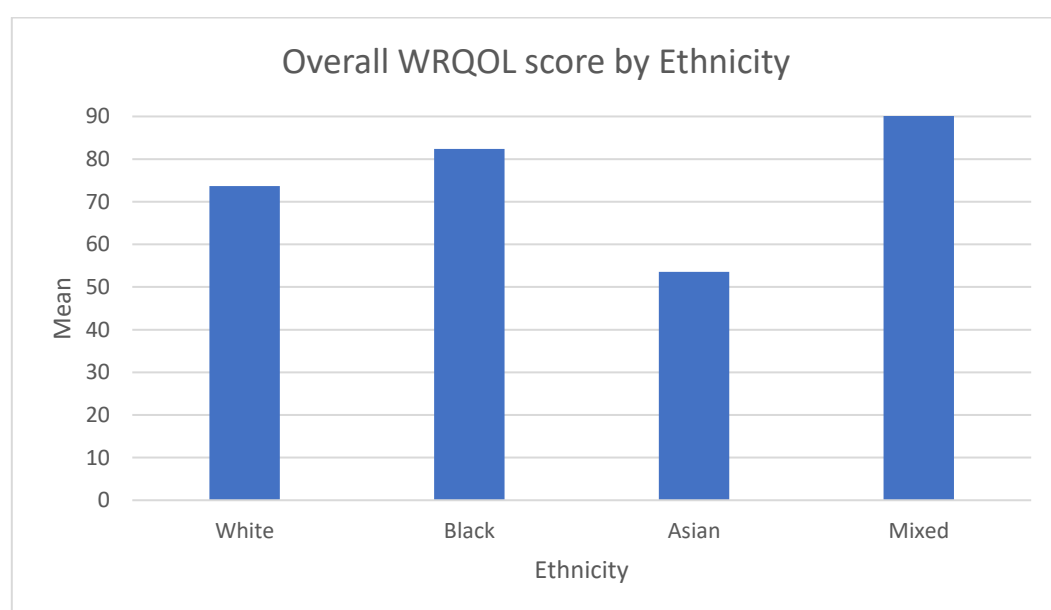


Figure A4.30: Mean Overall Quality of Working Life Score by Ethnicity (Unweighted)

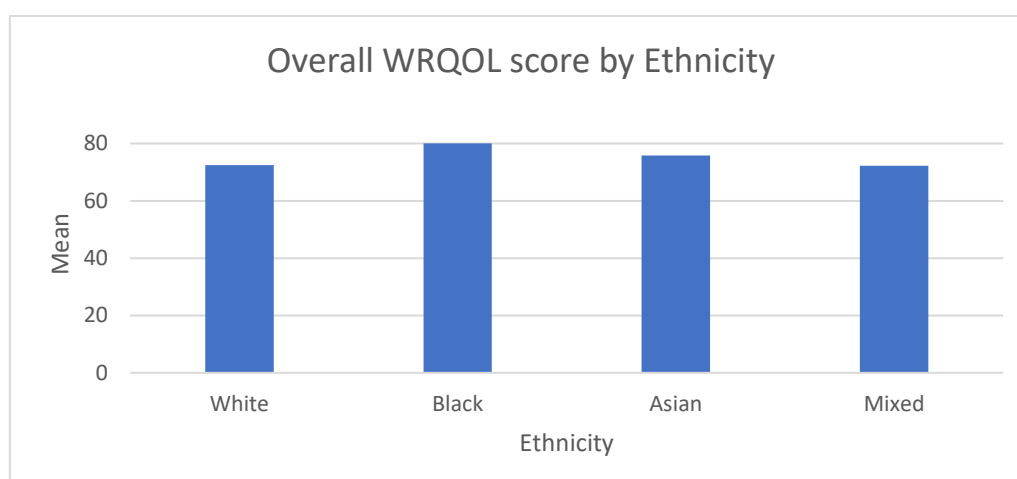


Table A4.19: Mean Quality of Working Life Scores by Ethnicity (Weighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	20.64	21.37	14.47	25.5
Stress at work	4.37	6.11	3.13	7.23
General well-being	18.98	22.37	15.30	24.24
Home-work interface	9.98	11.31	8.20	12.17
Control at work	9.62	10.91	5.21	12.25
Working conditions	10.06	10.29	7.21	12.26
<b>Overall WRQOL score</b>	<b>73.67</b>	<b>82.36</b>	<b>53.53</b>	<b>93.65</b>

Table A4.20: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	30.32	21.67	21.33	19.93
Stress at work	4.48	5.44	5.00	4.79
General well-being	19.31	21.89	19.67	18.71
Home-work interface	9.53	10.67	11.17	9.86
Control at work	9.11	10.00	8.33	9.14
Working conditions	9.77	10.39	10.33	9.86
<b>Overall WRQOL score</b>	<b>72.45</b>	<b>80.06</b>	<b>75.83</b>	<b>72.29</b>

Figure A4.31: Level of Overall Quality of Working Life by Ethnicity (Weighted)

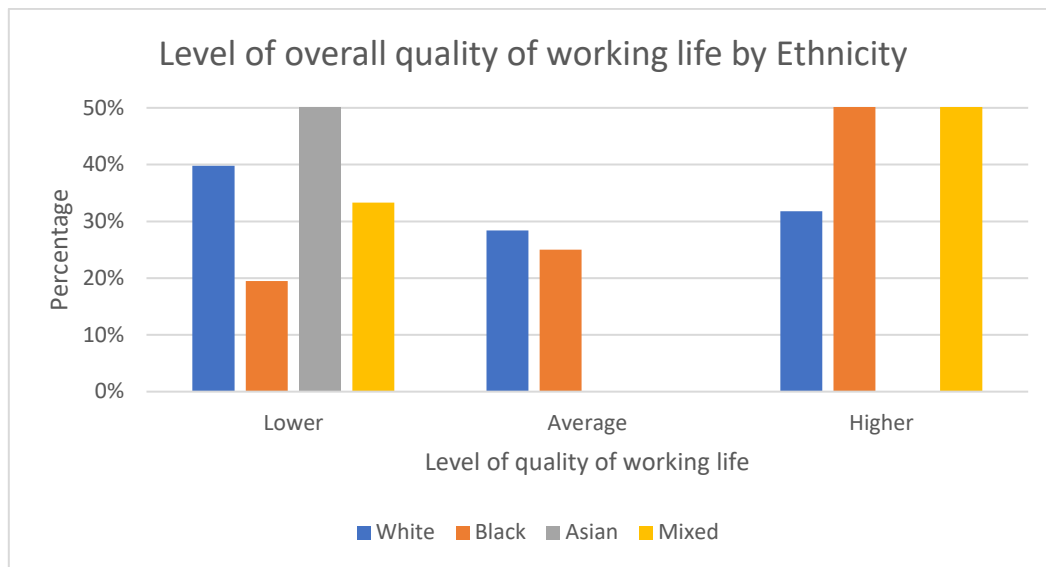


Figure A4.32: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

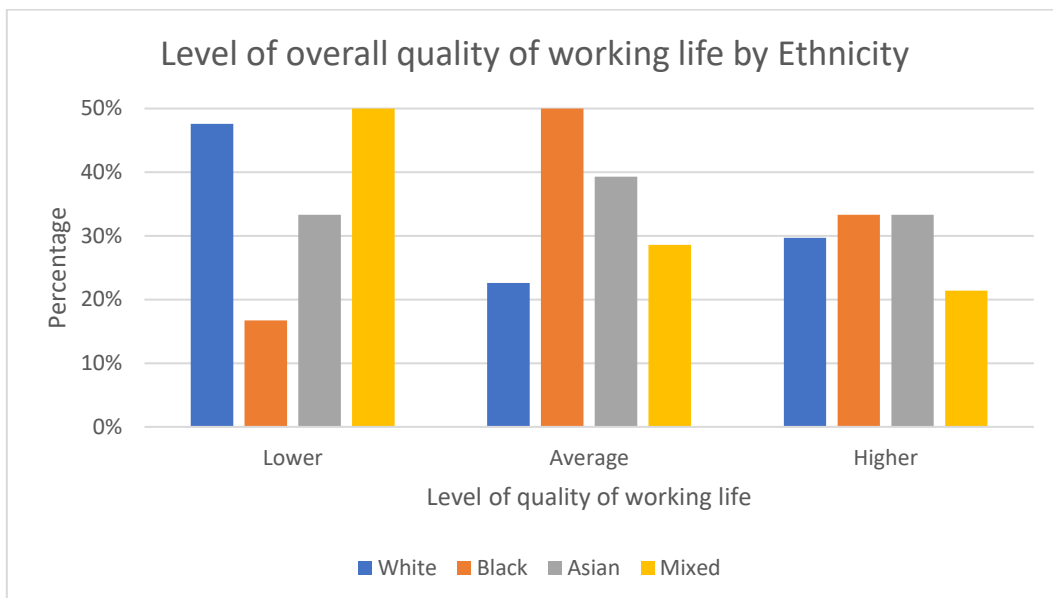


Table A4.21: Level of Overall Quality of Working Life by Ethnicity (Weighted)

Level of WRQOL	Ethnicity			
	White	Black	Asian	Mixed
Lower	39.8%	19.5%	100.0%	33.3%
Average	28.4%	25.0%	0.0%	0.0%
Higher	31.8%	55.5%	0.0%	66.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A4.22: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

Level of WRQOL	Ethnicity			
	White	Black	Asian	Mixed
Lower	47.6%	16.7%	33.3%	50.0%
Average	22.6%	50.0%	39.3%	28.6%
Higher	29.7%	33.3%	33.3%	21.4%
<b>Total</b>	<b>1436 (100%)</b>	<b>18 (100%)</b>	<b>6 (100%)</b>	<b>14 (100%)</b>

#### A4.6 Quality of Working Life Scores by Disability

##### Summary (Weighted results):

There were significant differences between respondents based on their disability status in the mean overall WRQOL scores ( $F = 24.087$ ,  $df = 2$ ,  $p < .001$ ). Specifically, respondents without a disability scored significantly higher than those with a disability and those who were unsure if they had a disability.

##### Summary (Unweighted results):

There were significant differences between respondents based on their disability status in the mean overall WRQOL scores ( $F = 17.175$ ,  $df = 2$ ,  $p < .001$ ). Specifically, respondents without a disability scored significantly higher than those with a disability.

Figure A4.33: Mean Quality of Working Life Scores by Disability (Weighted)

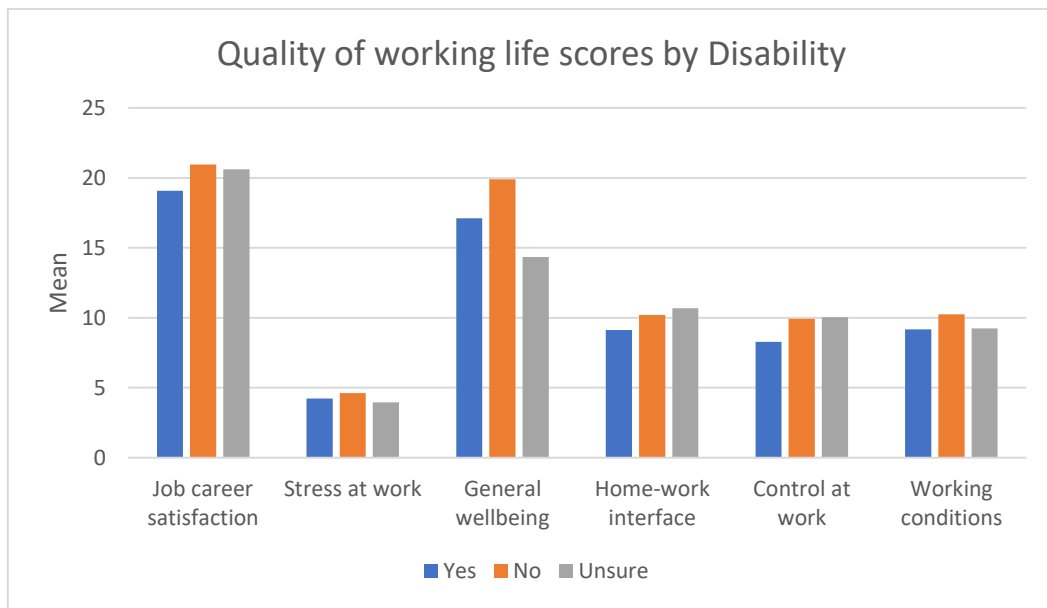


Figure A4.34: Mean Quality of Working Life Scores by Disability (Unweighted)

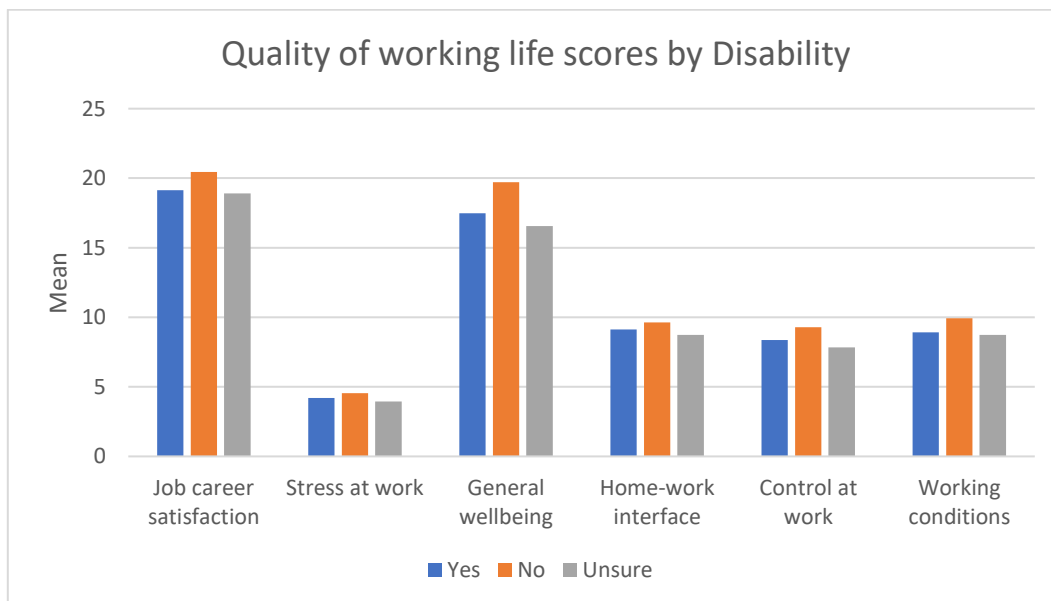


Figure A4.35: Mean Overall Quality of Working Life Score by Disability (Weighted)

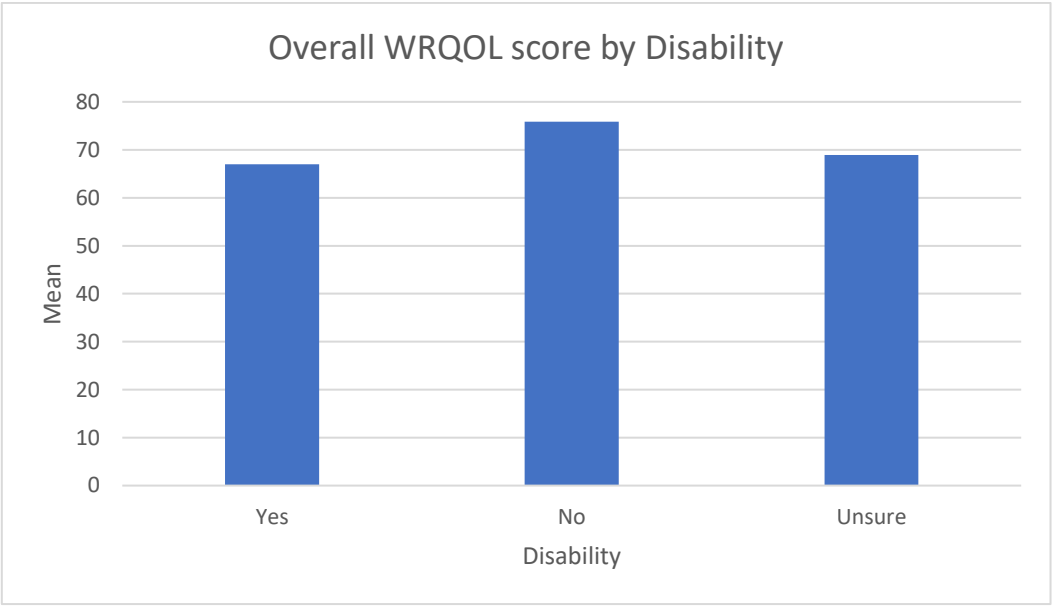


Figure A4. 36: Mean Overall Quality of Working Life Score by Disability (Unweighted)

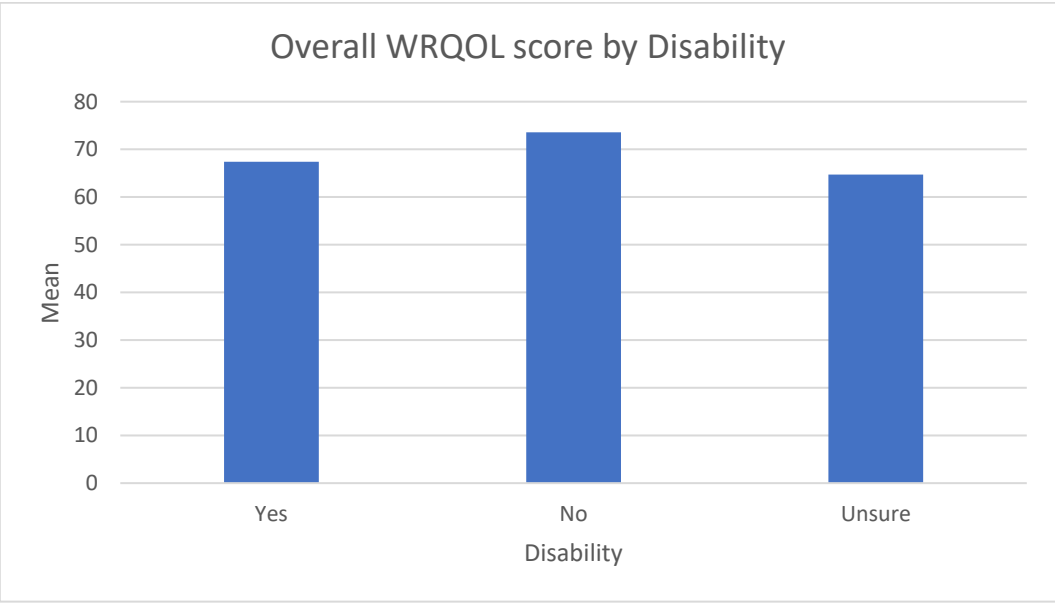


Table A4.23: Mean Quality of Working Life Scores by Disability (Weighted)

WRQOL domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Job career satisfaction	19.08	20.96	20.61
Stress at work	4.22	4.62	3.96
General well-being	17.11	19.89	14.35
Home-work interface	9.13	10.21	10.69
Control at work	8.28	9.93	10.03
Working conditions	9.17	10.25	9.25
<b>Overall WRQOL score</b>	<b>67.00</b>	<b>75.89</b>	<b>68.89</b>

Table A4.24: Mean Quality of Working Life Scores by Disability (Unweighted)

WRQOL domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Job career satisfaction	19.14	20.44	18.91
Stress at work	4.21	4.55	3.95
General well-being	17.49	19.71	16.56
Home-work interface	9.13	9.64	8.73
Control at work	8.36	9.28	7.84
Working conditions	8.91	9.94	8.73
<b>Overall WRQOL score</b>	<b>67.41</b>	<b>73.59</b>	<b>64.71</b>



Figure A4.37: Level of Overall Quality of Working Life by Disability (Weighted)

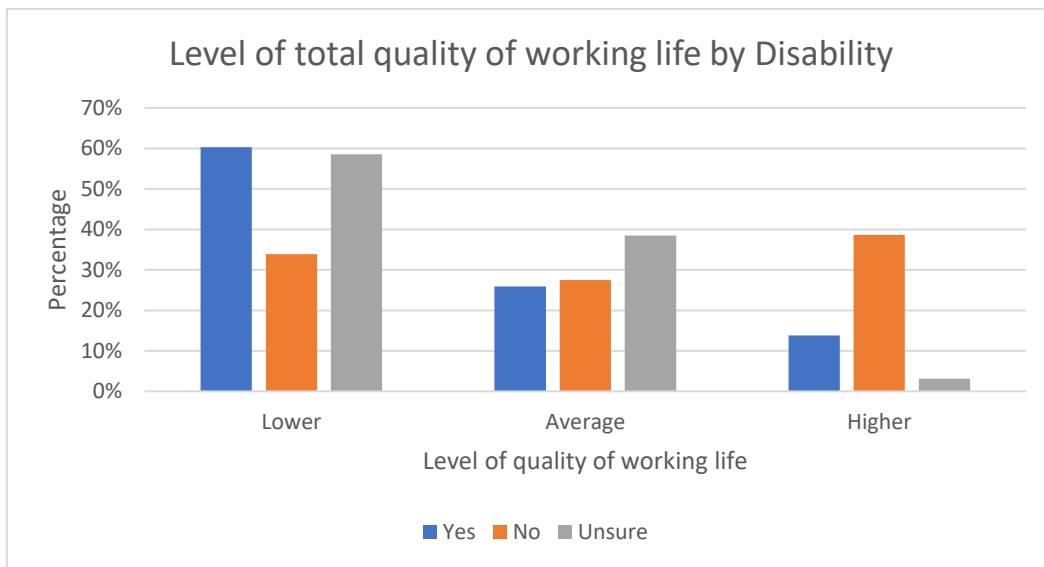


Figure A4.38: Level of Overall Quality of Working Life by Disability (Unweighted)

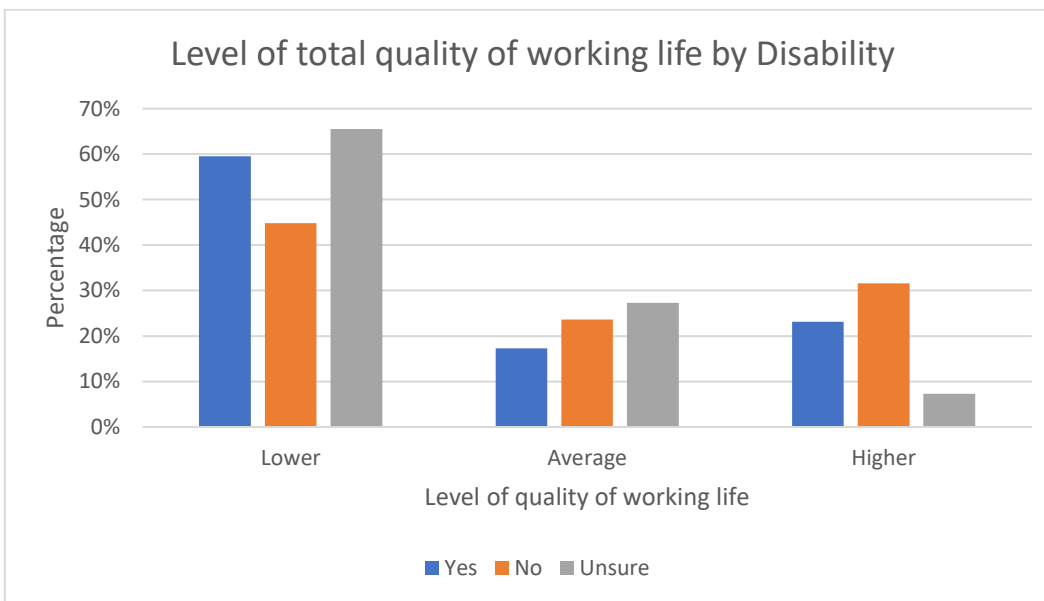


Table A4.25: Level of Overall Quality of Working Life by Disability (Weighted)

Level of WRQOL	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Lower	60.3%	33.9%	58.5%
Average	25.9%	27.5%	38.5%
Higher	13.8%	38.6%	3.1%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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	59.5%	44.8%	65.5%
Average	17.3%	23.6%	27.3%
Higher	23.1%	31.6%	7.3%
<b>Total</b>	<b>173 (100%)</b>	<b>1248 (100%)</b>	<b>55 (100%)</b>

#### 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 ( $F = 9.558$ ,  $df = 7$ ,  $p < .001$ ). Specifically, respondents working with children and young people scored significantly higher than those working in midwifery, with adults of working age, those in the areas of mental health or 'other'.

##### Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their main area of practice ( $F = 2.237$ ,  $df = 7$ ,  $p = .029$ ). Specifically, respondents working in midwifery scored significantly lower than those working with children and young people, adults of working age, those working in the area of learning disability.

Figure A4.39: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

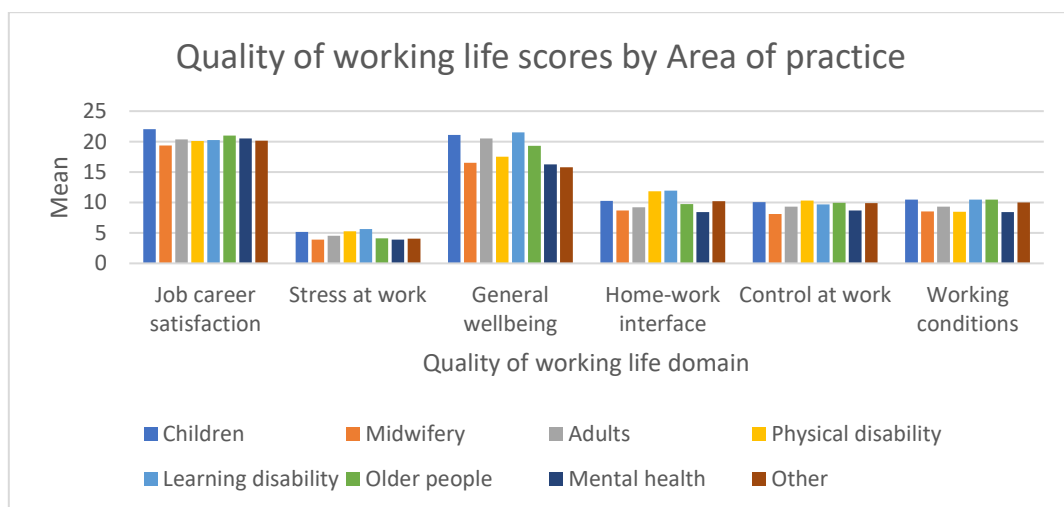


Figure A4.40: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

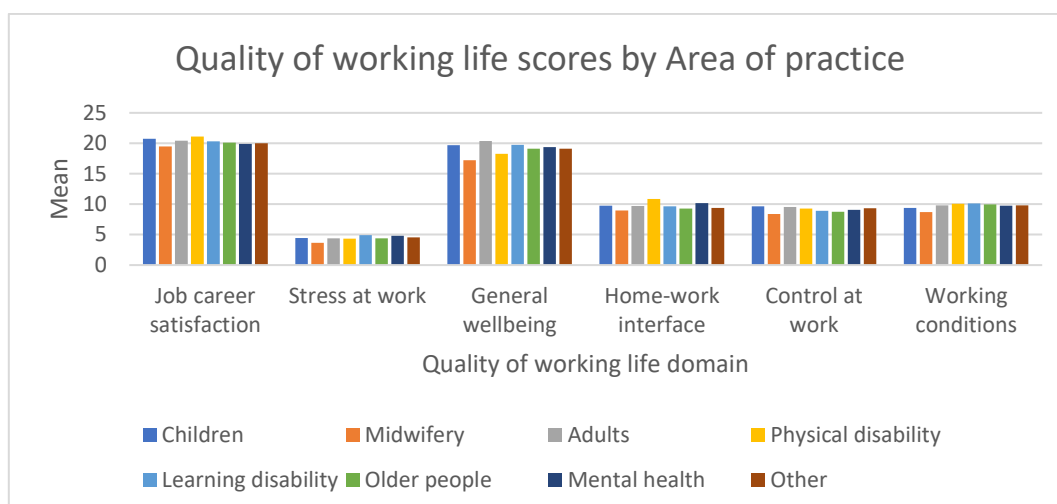


Figure A4.41: Mean Overall Quality of Working Life Score by Main Area of Practice (Weighted)

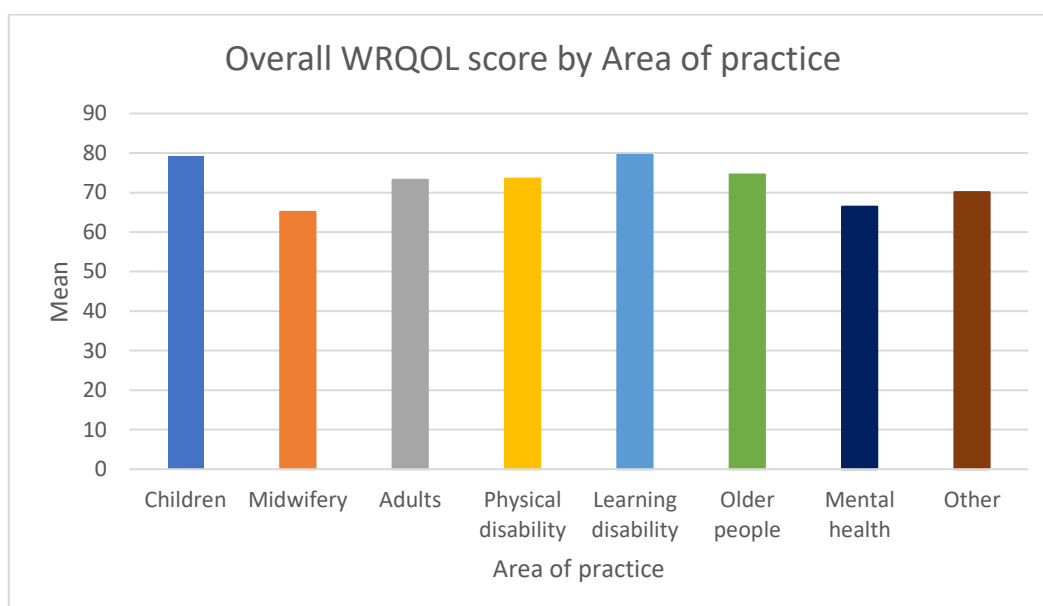


Figure A4.42: Mean Overall Quality of Working Life Score by Main Area of Practice (Unweighted)

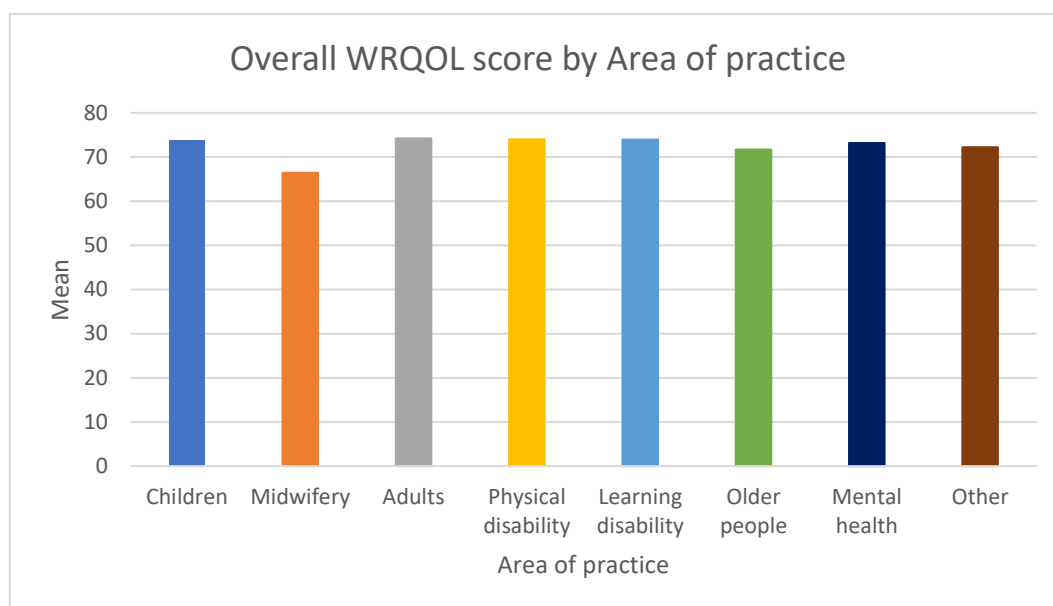


Table A4.27: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

WRQOL domain	Main area of practice							
	Children and young people	Midwifery	Adults - working age	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	22.06	19.35	20.37	20.11	20.24	21.01	20.52	20.13
Stress at work	5.17	3.91	4.51	5.29	5.64	4.13	3.92	4.08
General well-being	21.10	16.51	20.53	17.51	21.52	19.3	16.23	15.77
Home-work interface	10.26	8.71	9.21	11.84	11.95	9.74	8.43	10.23
Control at work	10.03	8.11	9.32	10.31	9.71	9.93	8.67	9.89
Working conditions	10.50	8.52	9.30	8.47	10.47	10.47	8.43	10.00
<b>Overall WRQOL score</b>	<b>79.15</b>	<b>65.11</b>	<b>73.23</b>	<b>73.53</b>	<b>79.55</b>	<b>74.57</b>	<b>66.43</b>	<b>70.11</b>

Table A4.28: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

WRQOL domain	Main area of practice							
	Children and young people	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	20.74	19.50	20.41	21.13	20.34	20.12	19.91	20.02
Stress at work	4.43	3.67	4.40	4.35	4.94	4.40	4.82	4.56
General well-being	19.71	17.24	20.35	18.26	19.72	19.13	19.37	19.09
Home-work interface	9.77	8.97	9.72	10.87	9.65	9.29	10.15	9.39
Control at work	9.67	8.38	9.53	9.30	8.94	8.78	9.07	9.33
Working conditions	9.41	8.71	9.82	10.09	10.13	9.98	9.73	9.80
<b>Overall WRQOL score</b>	<b>73.78</b>	<b>66.43</b>	<b>74.21</b>	<b>74.00</b>	<b>73.94</b>	<b>71.68</b>	<b>73.17</b>	<b>72.21</b>

Figure A4.43: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

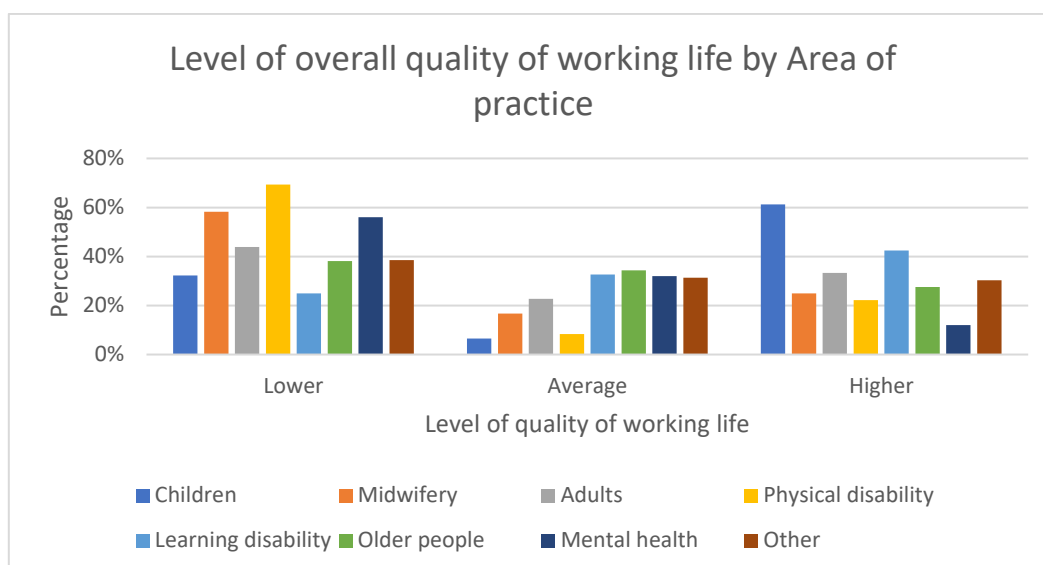


Figure A4.44: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

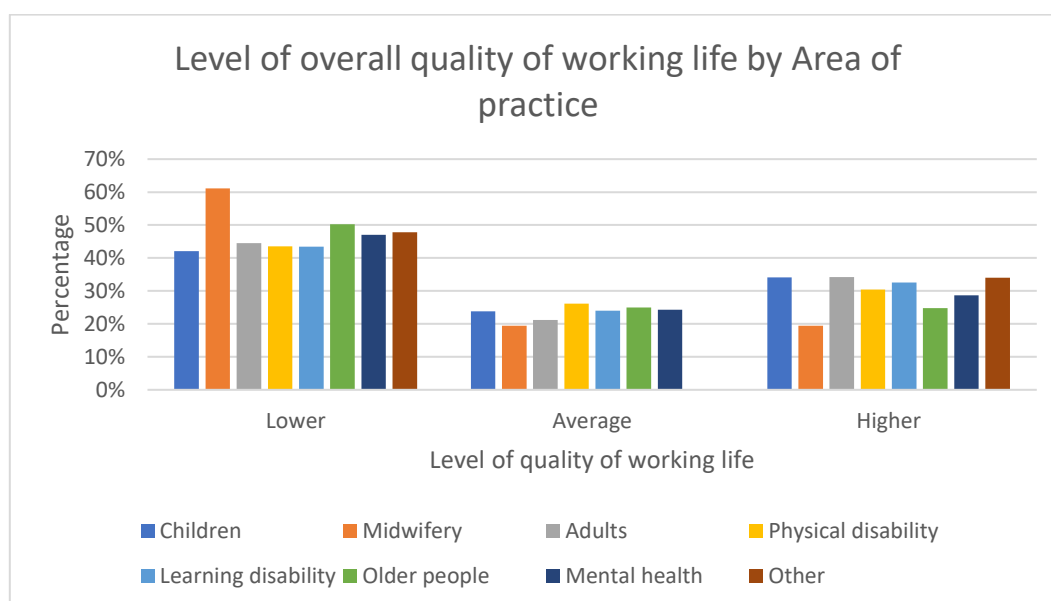


Table A4.29: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

Level of WRQOL	Main area of practice							
	Children and young people	Midwifery	Adults-working age	Physical disability	Learning disability	Older people	Mental health	Other
Lower	32.3%	58.3%	43.9%	69.4%	24.9%	38.1%	56.0%	38.5%
Average	6.5%	16.7%	22.7%	8.3%	32.6%	34.3%	32.0%	31.3%
Higher	61.3%	25.0%	33.3%	22.2%	42.5%	27.6%	12.0%	30.3%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A4.30: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

Level of WRQOL	Main area of practice							
	Children and young people	Midwifery	Adults-working age	Physical disability	Learning disability	Older people	Mental health	Other
Lower	42.1%	61.1%	44.5%	43.5%	43.4%	50.2%	47.0%	47.8%
Average	23.8%	19.4%	21.2%	26.1%	24.0%	25.0%	24.3%	18,2%
Higher	34.1%	19.4%	34.2%	30.4%	32.6%	24.8%	28.7%	34.0%
<b>Total</b>	<b>261 (100%)</b>	<b>72 (100%)</b>	<b>146 (100%)</b>	<b>23 (100%)</b>	<b>175 (100%)</b>	<b>480 (100%)</b>	<b>115 (100%)</b>	<b>203 (100%)</b>



#### A4.8 Quality of Working Life Scores by Line Manager Status

##### Summary (Weighted results):

There was a significant difference in the mean overall WRQOL scores between respondents who were line managers and those who were not ( $t = 3.369$ ,  $df = 1432$ ,  $p < .001$ ); line managers scored significantly higher.

##### 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 ( $t = 4.776$ ,  $df = 1474$ ,  $p < .001$ ); line managers scored significantly higher.

Figure A4.45: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

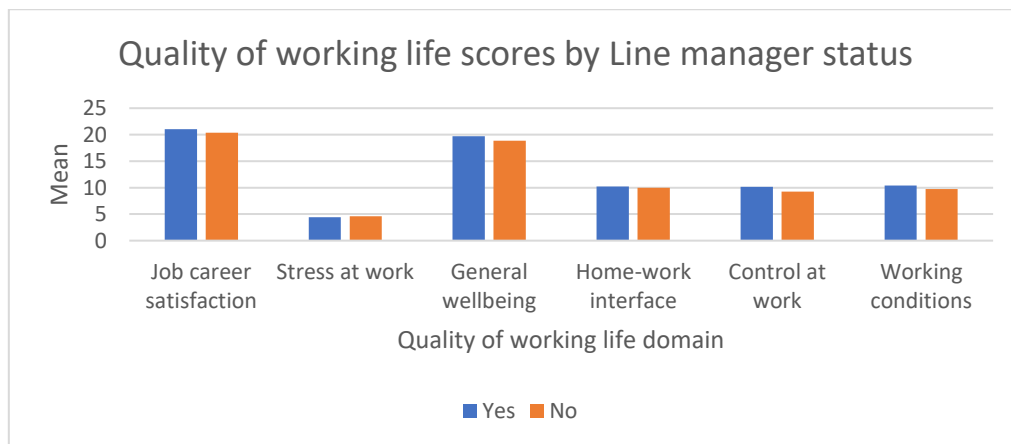


Figure A4.46: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

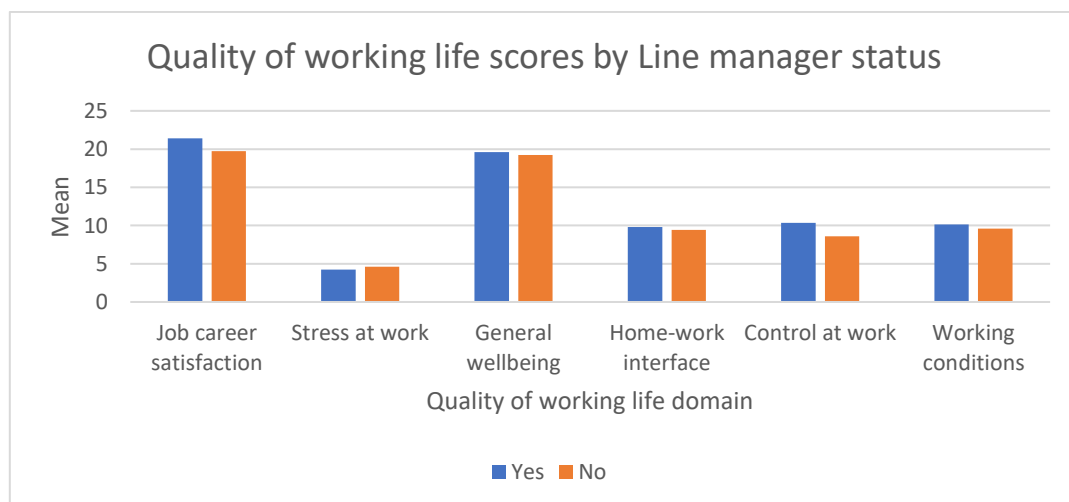


Figure A4.47: Mean Overall Quality of Working Life Score by Line Manager Status (Weighted)

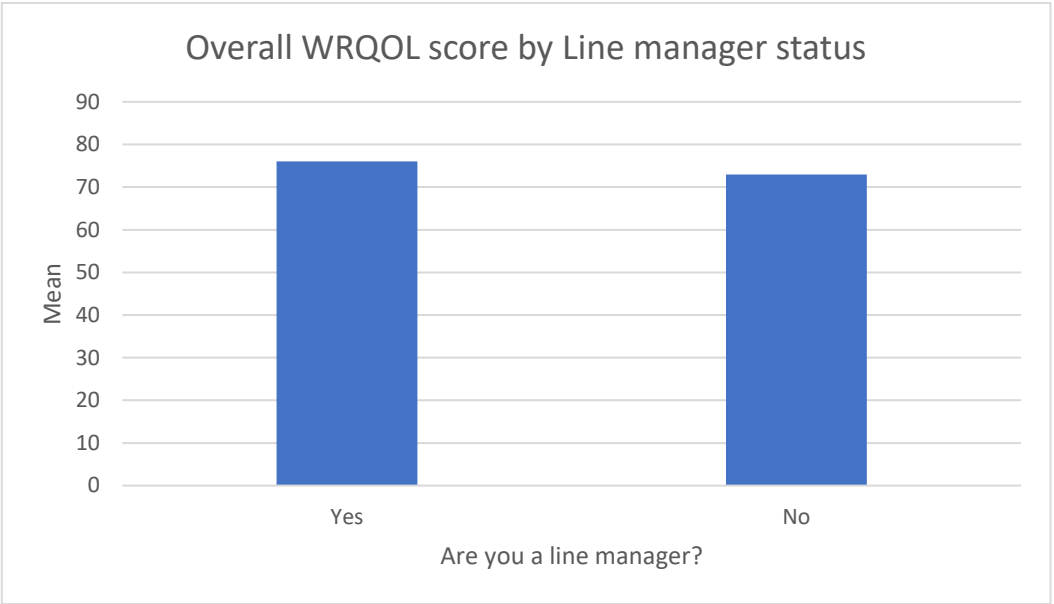


Figure A4.48: Mean Overall Quality of Working Life Score by Line Manager Status (Unweighted)

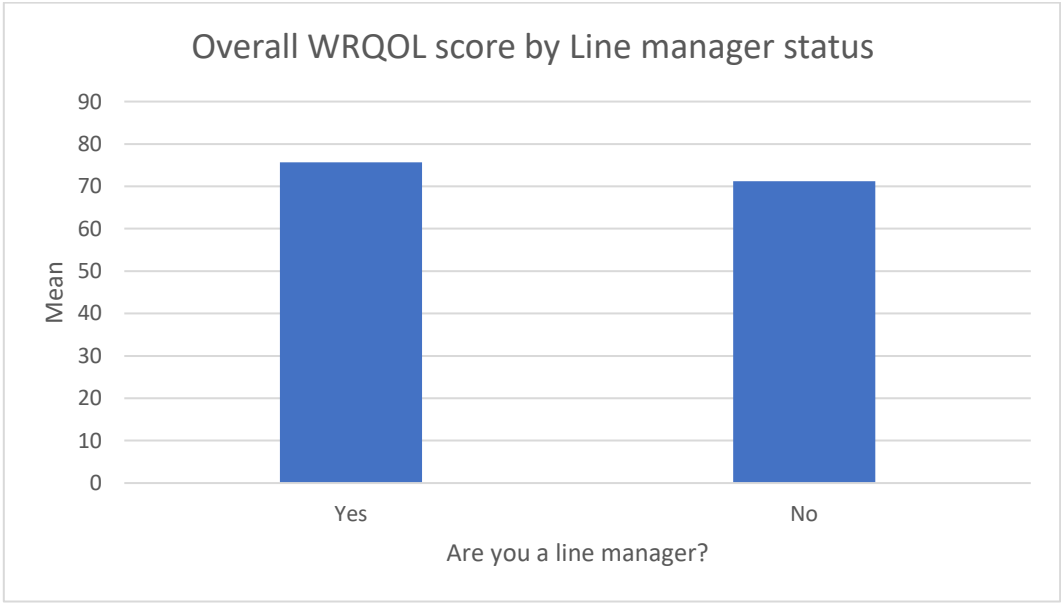


Table A4.31: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

WRQOL Domain	Are you a line manager?	
	Yes	No
Job career satisfaction	21.03	20.4
Stress at work	4.45	4.63
General well-being	19.72	18.88
Home-work interface	10.22	9.98
Control at work	10.18	9.28
Working conditions	10.42	9.73
<b>Overall WRQOL score</b>	<b>76.03</b>	<b>72.93</b>

Table A4.32: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

WRQOL Domain	Are you a line manager?	
	Yes	No
Job career satisfaction	21.42	19.71
Stress at work	4.25	4.60
General well-being	19.61	19.22
Home-work interface	9.80	9.44
Control at work	10.37	8.58
Working conditions	10.16	9.61
<b>Overall WRQOL score</b>	<b>75.65</b>	<b>71.18</b>

Figure A4.49: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

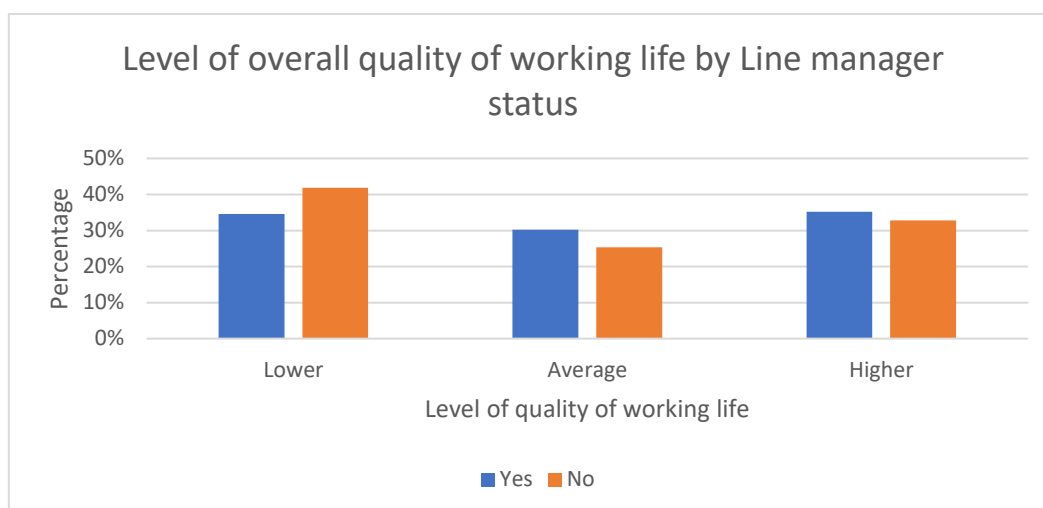


Figure A4.50: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

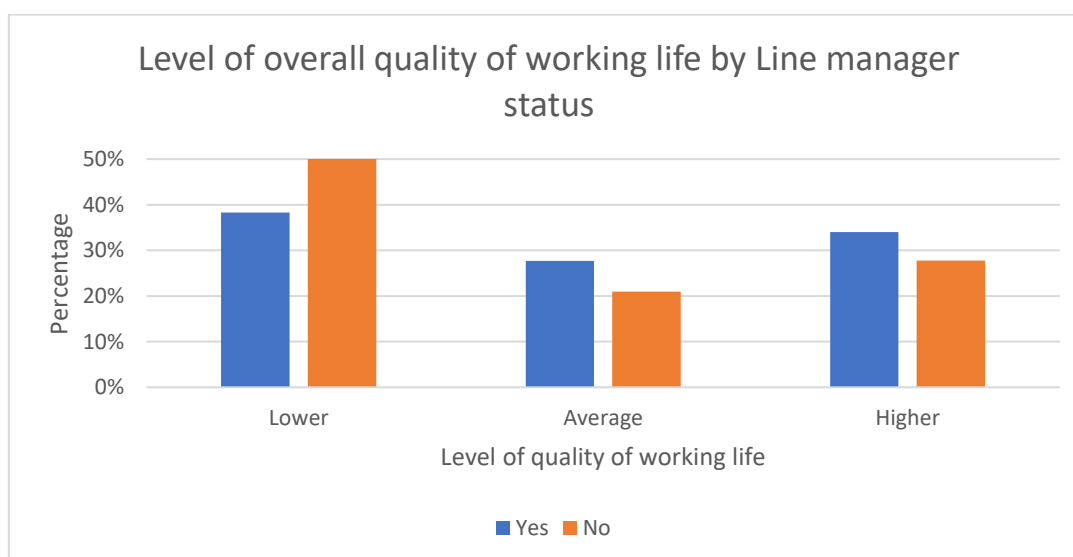


Table A4.33: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

Level of WRQOL	Are you a line manager?	
	Yes	No
Lower	34.6%	41.9%
Average	30.2%	25.3%
Higher	35.2%	32.8%
<b>Total</b>	<b>100%</b>	<b>100%</b>

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	38.3%	51.2%
Average	27.7%	21.0%
Higher	34.0%	27.8%
<b>Total</b>	<b>447 (100%)</b>	<b>1029 (100%)</b>

#### 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 ( $F = 77.3390$ ,  $df = 2$ ,  $p < .001$ ). 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 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 ( $F = 66.990$ ,  $df = 2$ ,  $p < .001$ ). 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)

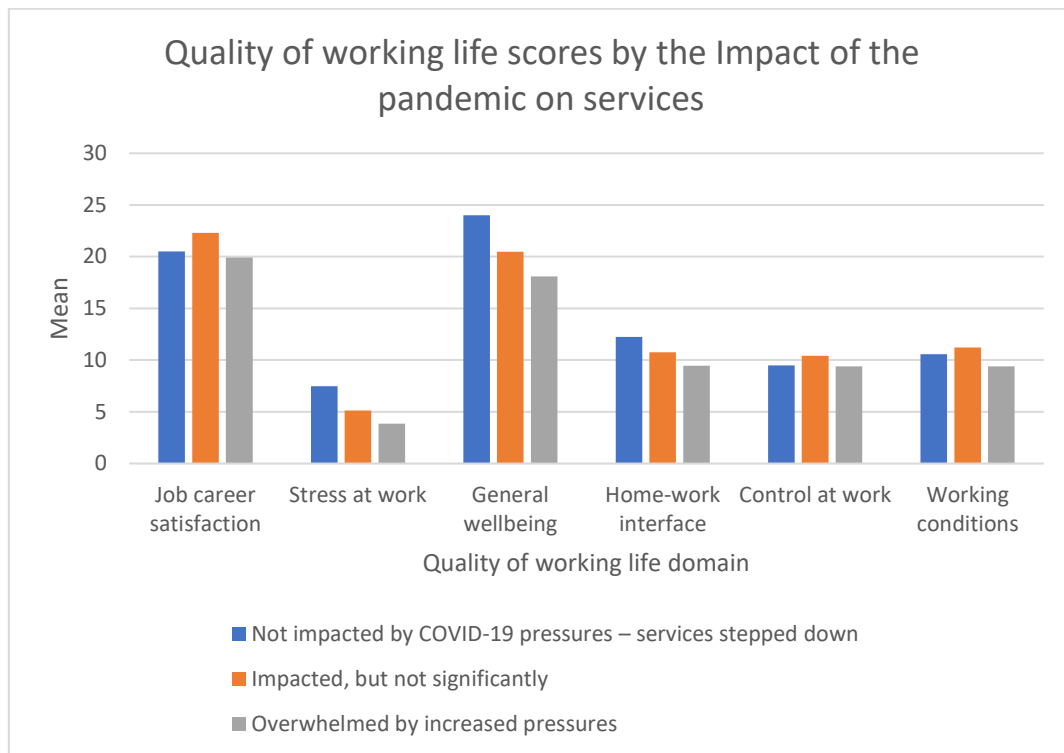


Figure A4.52: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)

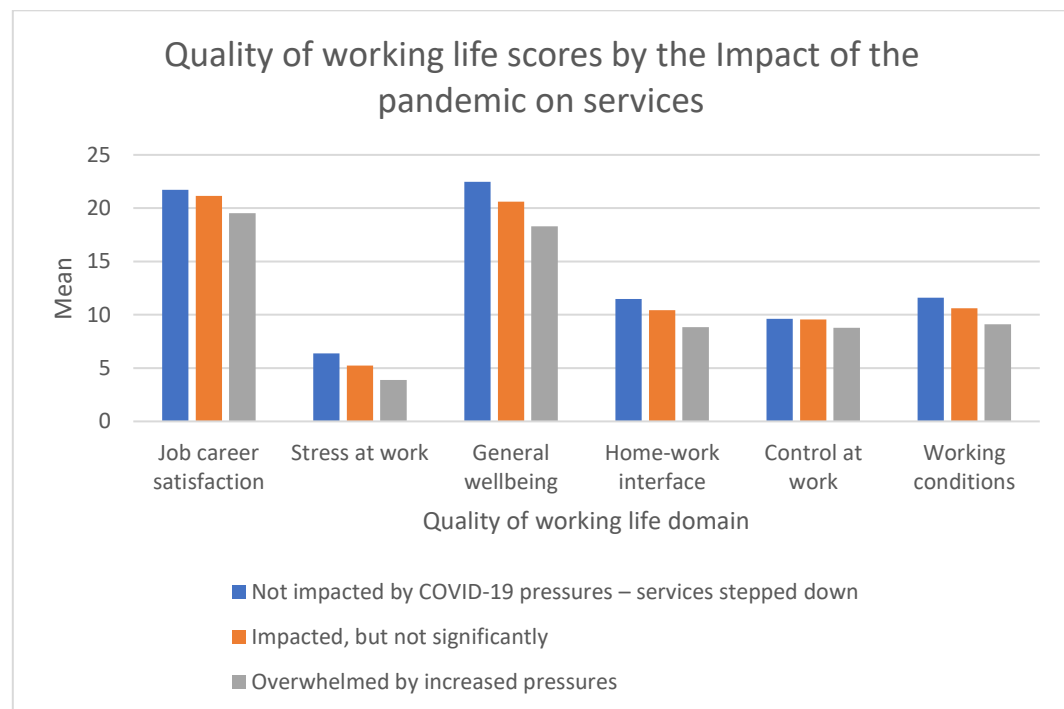


Figure A4. 53: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Weighted)

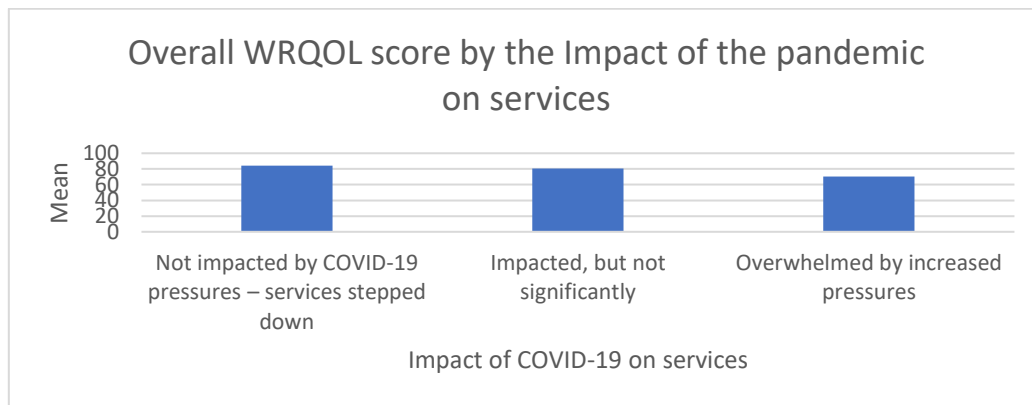


Figure A4. 54: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Unweighted)

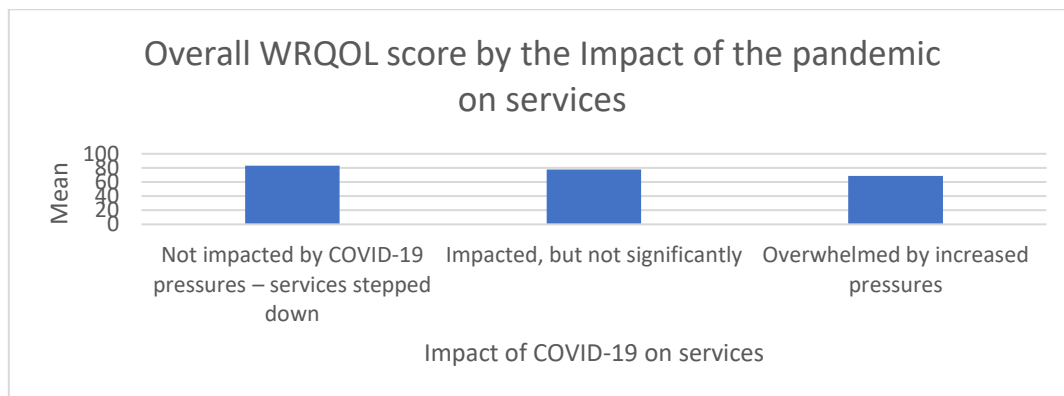


Table A4.35: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)

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	20.52	22.29	19.91
Stress at work	7.49	5.13	3.85
General well-being	23.99	20.48	18.09
Home-work interface	12.23	10.77	9.47
Control at work	9.50	10.42	9.41
Working conditions	10.57	11.23	9.41
<b>Overall WRQOL score</b>	<b>84.30</b>	<b>80.37</b>	<b>70.17</b>

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	21.71	21.15	19.53
Stress at work	6.39	5.24	3.88
General well-being	22.48	20.61	18.3
Home-work interface	11.49	10.43	8.85
Control at work	9.63	9.57	8.78
Working conditions	11.61	10.62	9.11
<b>Overall WRQOL score</b>	<b>83.13</b>	<b>77.65</b>	<b>68.51</b>

Figure A4. 55: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

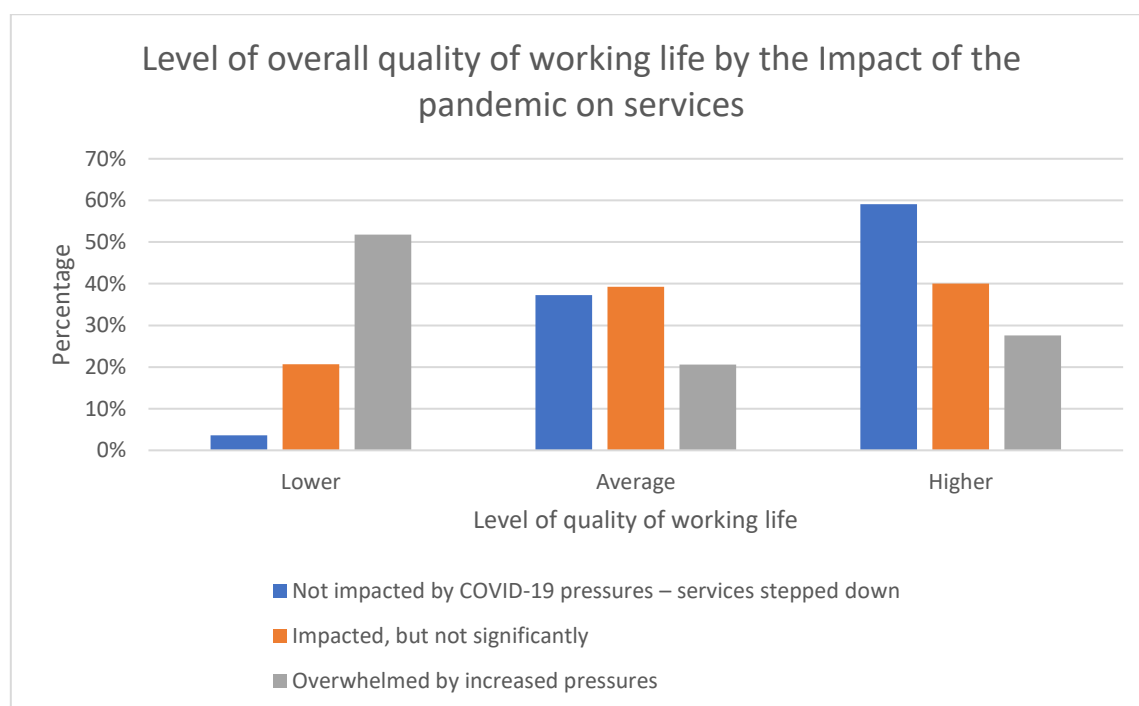




Figure A4. 56: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

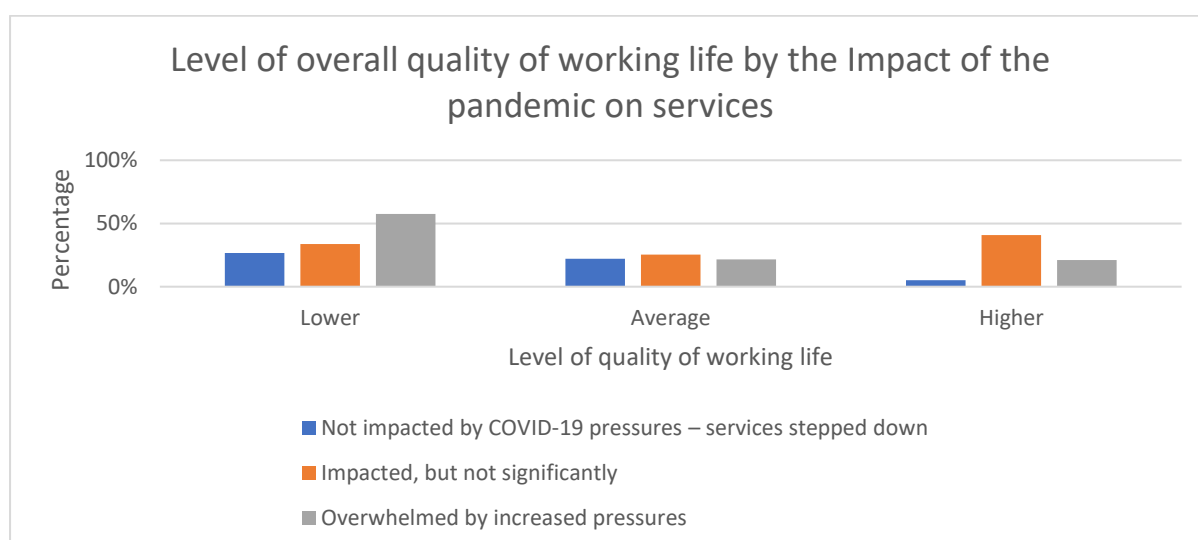


Table A4.37: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

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	3.6%	20.7%	51.8%
Average	37.3%	39.3%	20.6%
Higher	59.1%	40.0%	27.6%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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	12 (26.7%)	195 (33.7%)	491 (57.6%)
Average	10 (22.2%)	147 (25.4%)	183 (21.5%)
Higher	23 (51.1%)	236 (40.8%)	179 (21.0%)
<b>Total</b>	<b>45 (100%)</b>	<b>578 (100%)</b>	<b>853 (100%)</b>

#### A4.10. WRQOL Scores by the Uptake of Employer Support

##### Summary (Weighted results):

There were no significant differences on overall well-being scores between those who took employer support and those who did not ( $t = -.305$ ,  $df=1432$ ,  $p>0.05$ ). Those respondents who took employer support only had a slightly higher WRQOL score than those who did not.

##### Summary (Unweighted results):

There were no significant differences on overall well-being scores between those who took employer support and those who did not ( $t = -.837$ ,  $df=1473$ ,  $p>0.05$ ).

Figure A4. 57: Mean Quality of Working Life Scores by Uptake of Employer Support (Weighted)

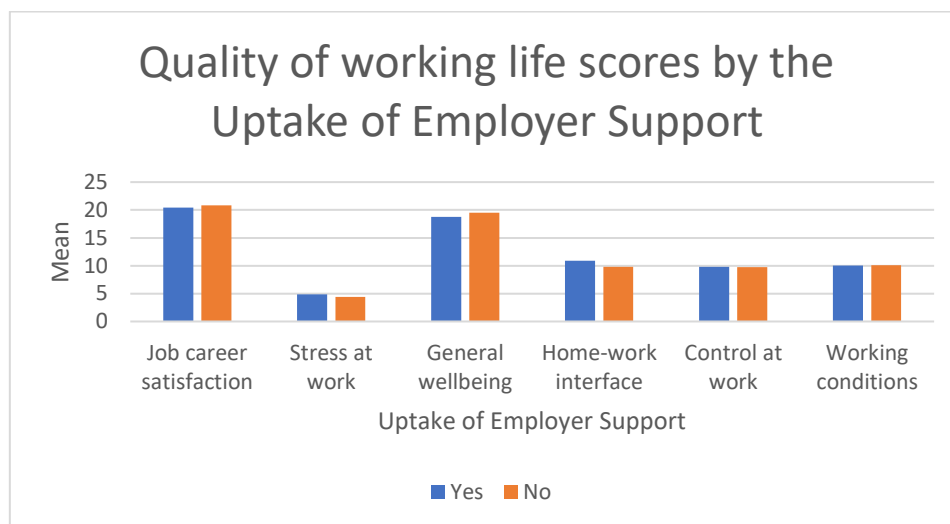


Figure A4. 58: Mean Quality of Working Life Scores by Uptake of Employer Support (Unweighted)

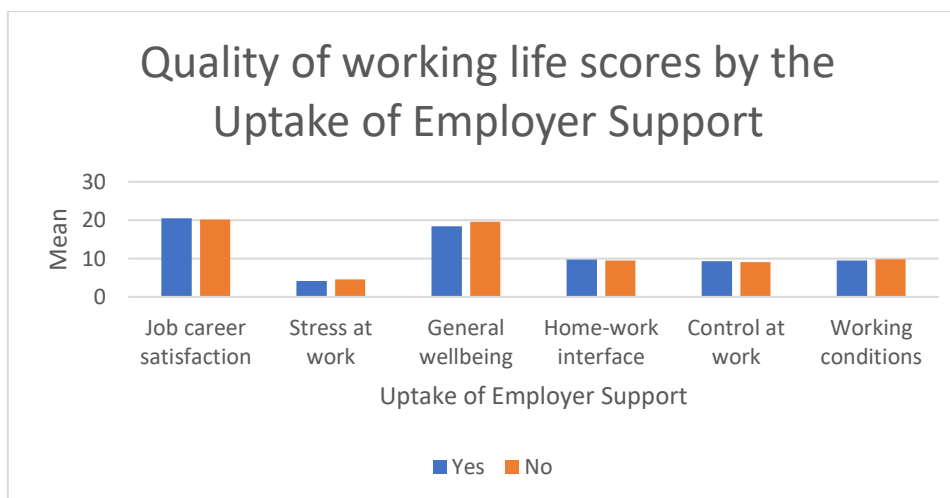


Figure A4. 59: Mean Overall Quality of Working Life Score by the Uptake of Employer Support (Weighted)

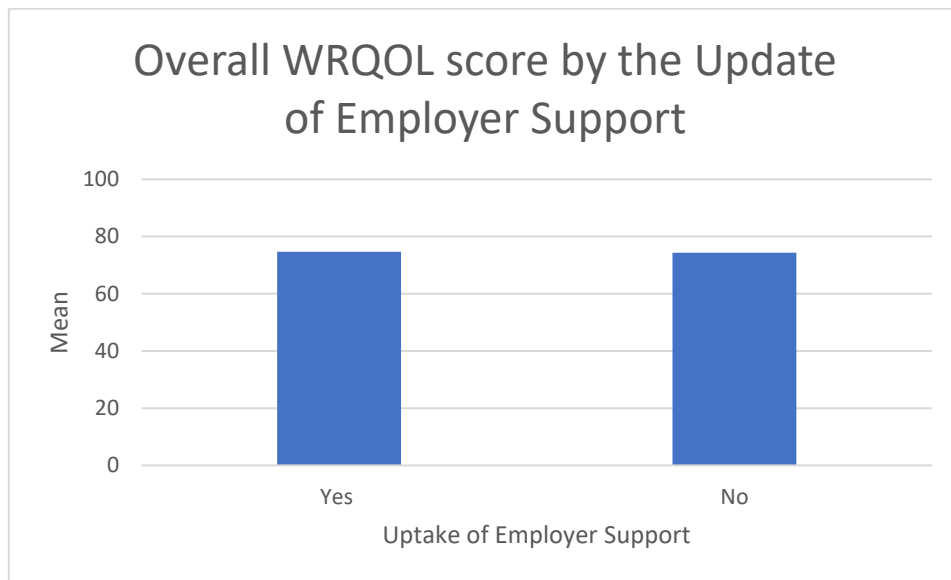


Figure A4. 60: Mean Overall Quality of Working Life Score by the Uptake of Employer Support (Unweighted)

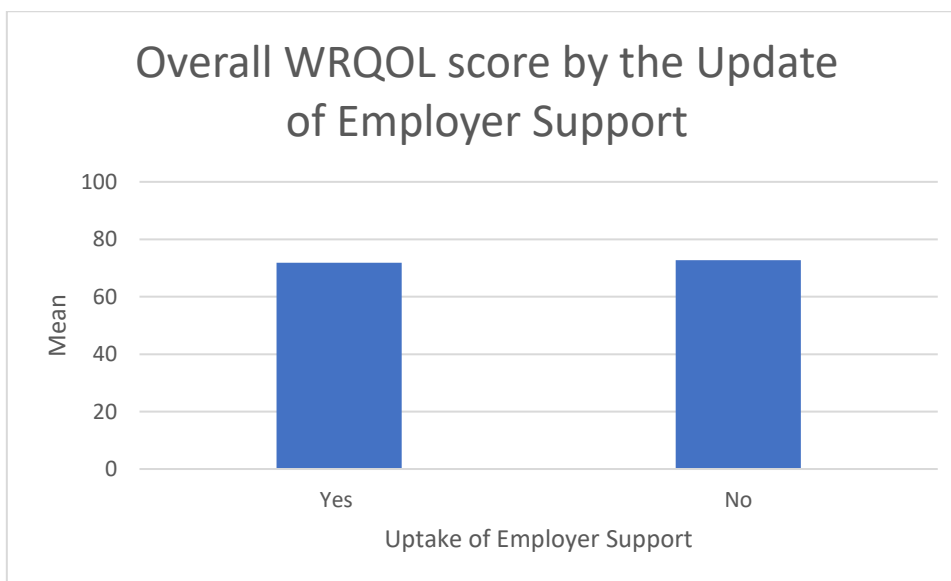


Table A4. 39: Mean Overall Quality of Working Life Score by the Uptake of Employer Support

WRQOL Domain	Uptake of employer support	
	Yes	No
Job career satisfaction	20.43	20.83
Stress at work	4.84	4.42
General well-being	18.76	19.52
Home-work interface	10.87	9.80
Control at work	9.78	9.72
Working conditions	10.03	10.10
<b>Overall WRQOL score</b>	<b>74.71</b>	<b>74.40</b>

Table A4. 40: Mean Overall Quality of Working Life Score by the Uptake of Employer Support  
(Unweighted)

WRQOL Domain	Uptake of employer support	
	Yes	No
Job career satisfaction	20.51	20.16
Stress at work	4.16	4.57
General well-being	18.44	19.56
Home-work interface	9.69	9.52
Control at work	9.35	9.06
Working conditions	9.51	9.84
<b>Overall WRQOL score</b>	<b>71.81</b>	<b>72.72</b>

Figure A4. 61: Level of Overall Quality of Working Life by Employer Uptake (Weighted)

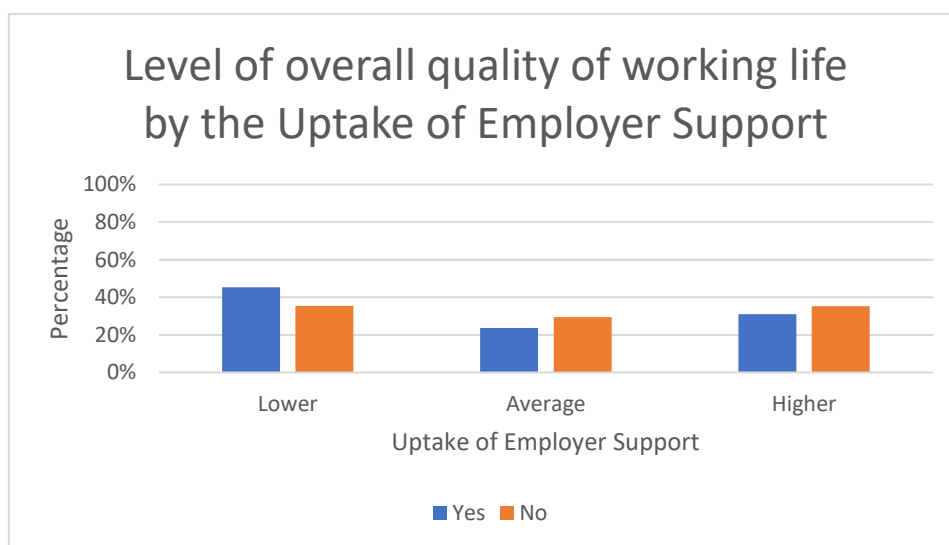


Figure A4. 62: Level of Overall Quality of Working Life by Employer Uptake (Unweighted)

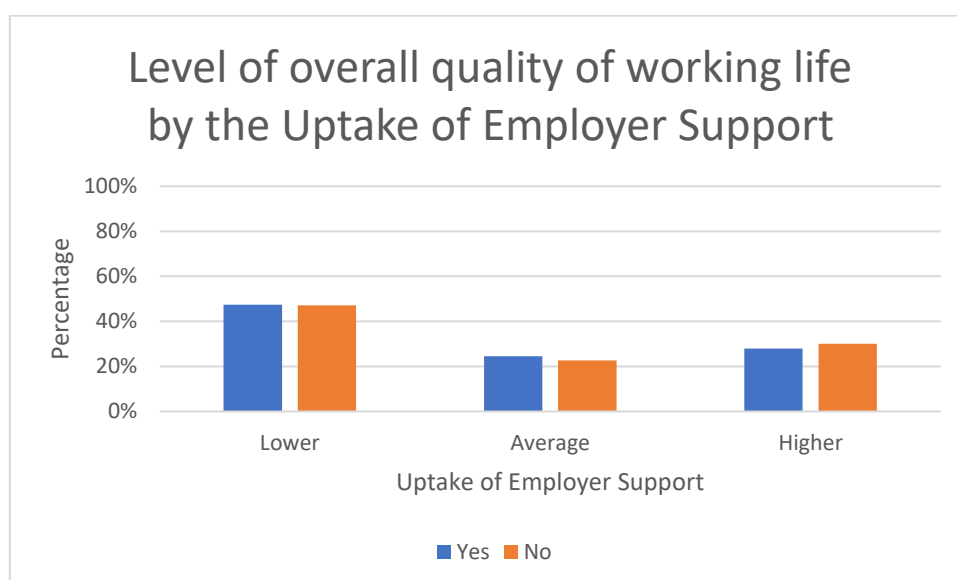


Table A4.41: Level of Overall Quality of Working Life by Uptake of Employer Support (Weighted)

Level of WRQOL	Impact of the pandemic on services	
	Yes	No
Lower	45.3%	35.4%
Average	23.7%	29.5%
Higher	31.0%	35.2%
<b>Total</b>	<b>100%</b>	<b>100%</b>

Table A4.42: Level of Overall Quality of Working Life by Uptake of Employer Support (Unweighted)

Level of WRQOL	Impact of the pandemic on services	
	Yes	No
Lower	139 (47.4%)	558 (47.2%)
Average	72 (24.6%)	268 (22.7%)
Higher	82 (28.0%)	356 (30.1%)
<b>Total</b>	<b>293 (100%)</b>	<b>1182 (100%)</b>

## 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 no significant differences between the countries in mean personal burnout scores ( $F = 1.041$ ,  $df = 3$ ,  $p > .05$ ), or in mean work-related burnout scores ( $F = .449$ ,  $df = 3$ ,  $p > .05$ ) or in mean client-related burnout scores ( $F = 2.268$ ,  $df = 3$ ,  $p > .05$ ).

#### Summary (Unweighted results):

There were no significant differences between the countries in mean personal burnout scores ( $F = 1.716$ ,  $df = 3$ ,  $p = .162$ ) or in mean work-related burnout scores ( $F = 1.108$ ,  $df = 3$ ,  $p = .345$ ). There was a significant difference in mean client-related burnout scores ( $F = 3.125$ ,  $df = 3$ ,  $p = .025$ ), however multiple comparison tests revealed no statistically significant differences between the countries, although there was a trend towards higher scores of client burnout in England.

Figure A5. 1: Mean Burnout Scores by Country (Weighted)

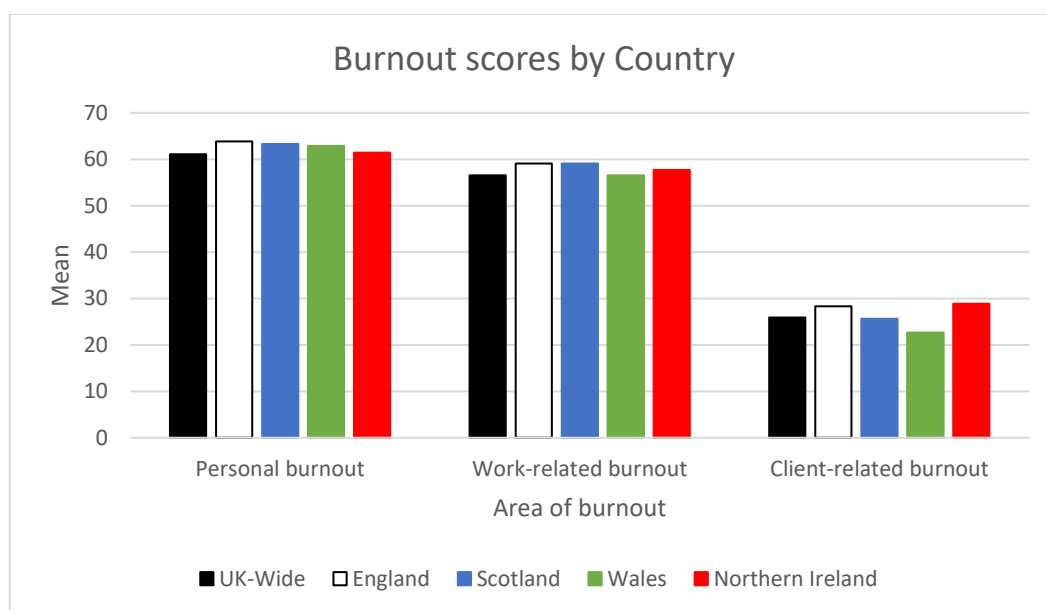


Figure A5.2: Mean Burnout Scores by Country (Unweighted)

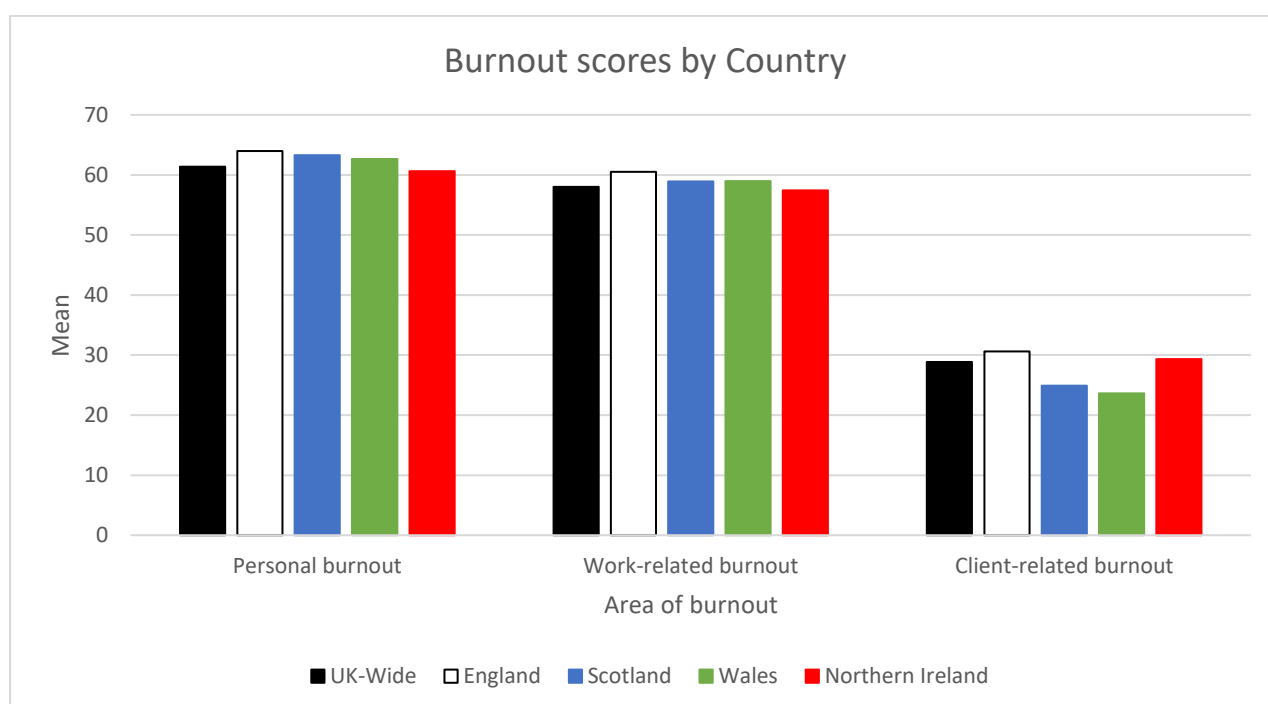


Table A5. 1: Mean Burnout Scores by Country (Weighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	61.10	63.83	63.32	62.88	61.43
Work-related burnout	56.51	59.11	59.08	56.56	57.70
Client-related burnout	25.88	28.31	25.66	22.69	28.88

Table A5.2: Mean Burnout Scores by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	61.36	63.95	63.30	62.66	60.64
Work-related burnout	57.98	60.53	58.90	58.95	57.41
Client-related burnout	28.83	30.58	24.90	23.61	29.35



Figure A5.3: Level of Personal Burnout by Country (Weighted)

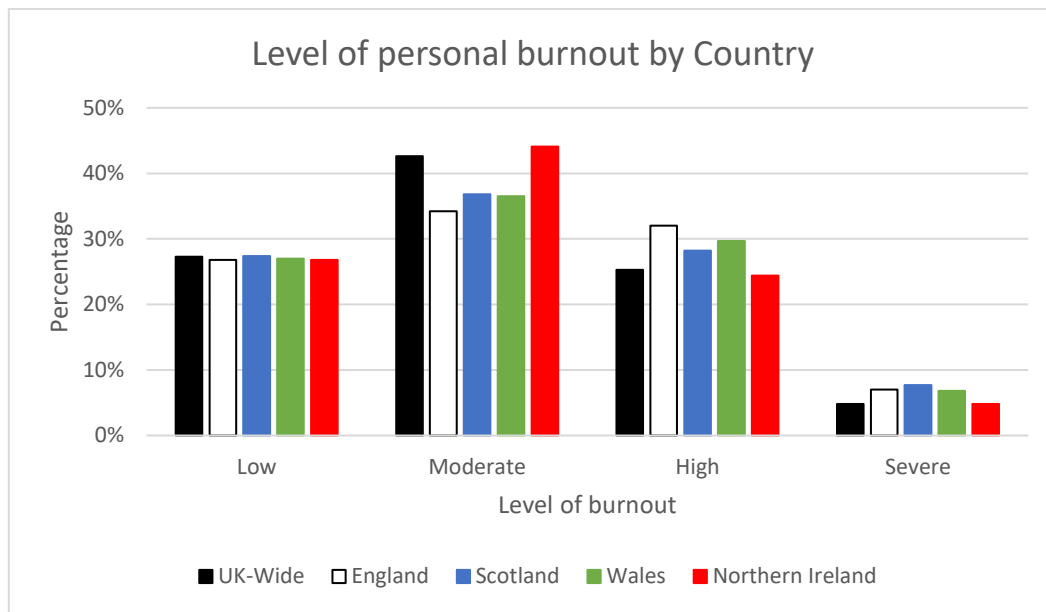


Figure A5.4: Level of Personal Burnout by Country (Unweighted)

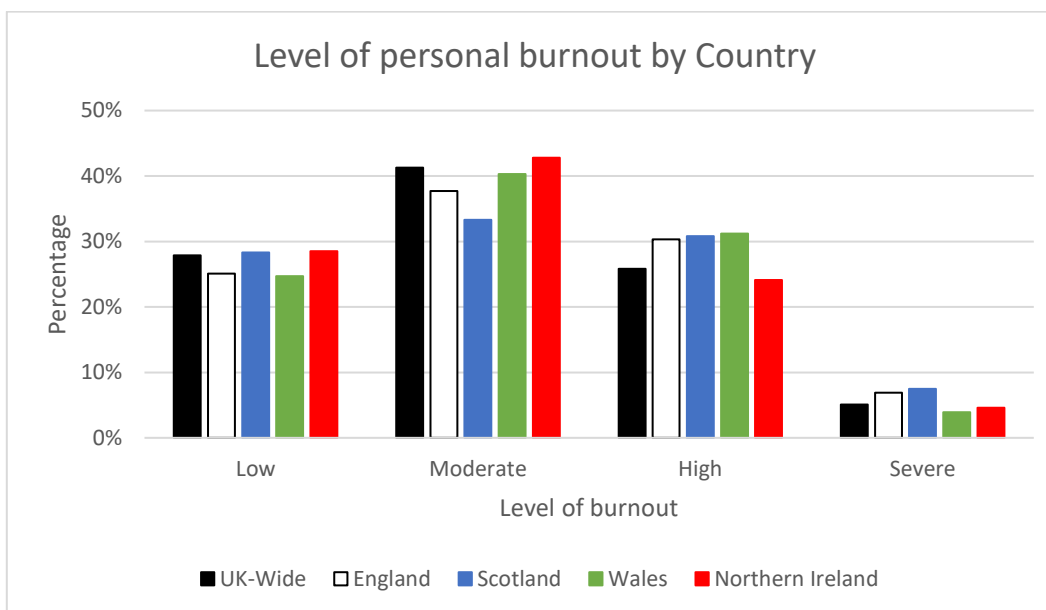


Figure A5.5: Level of Work-Related Burnout by Country (Weighted)

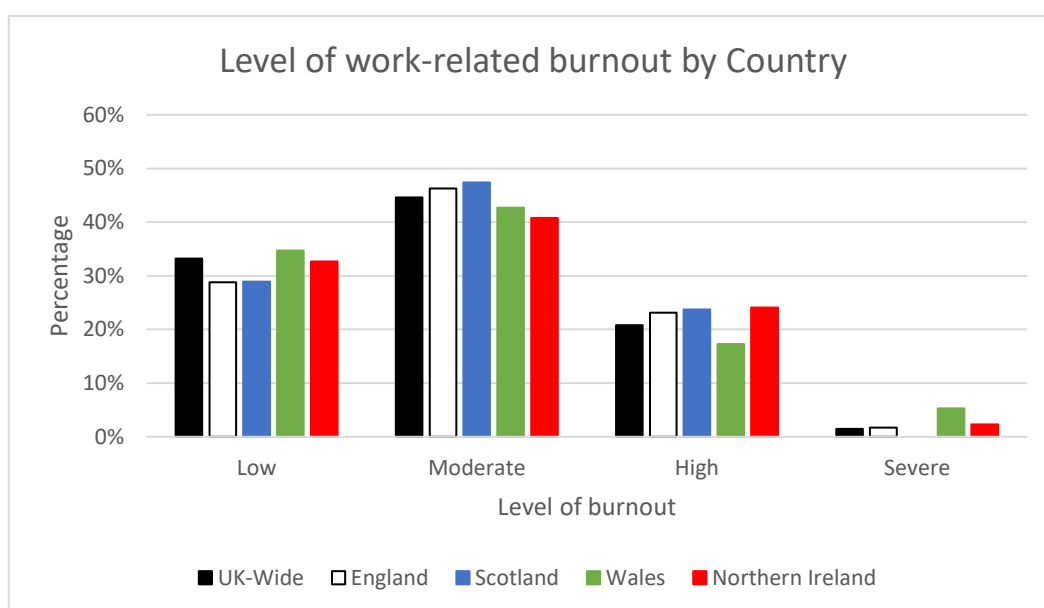


Figure A5.6: Level of Work-Related Burnout by Country (Unweighted)

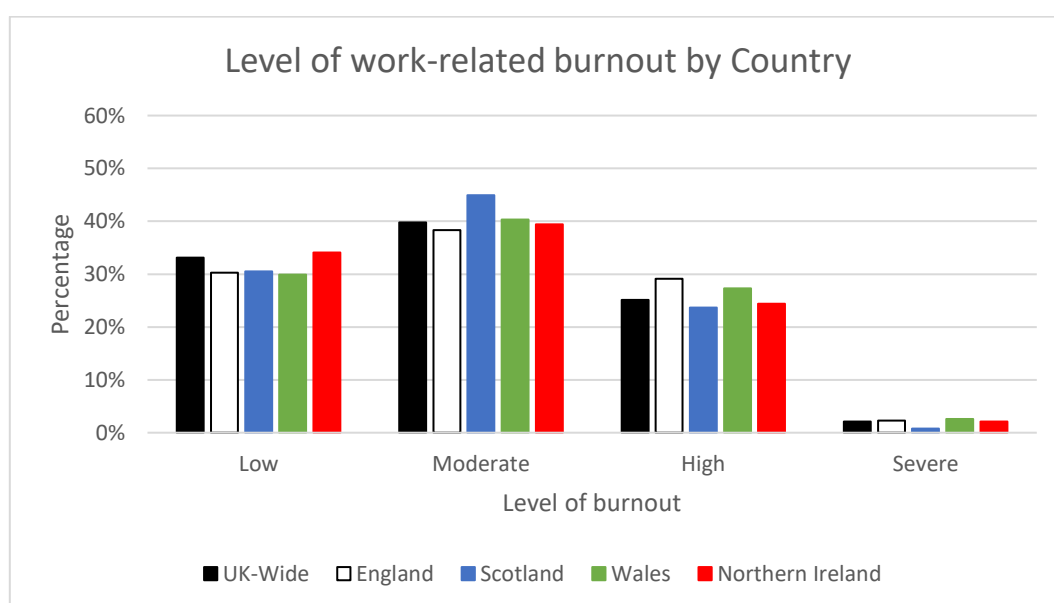


Figure A5.7: Level of Client-Related Burnout by Country (Weighted)

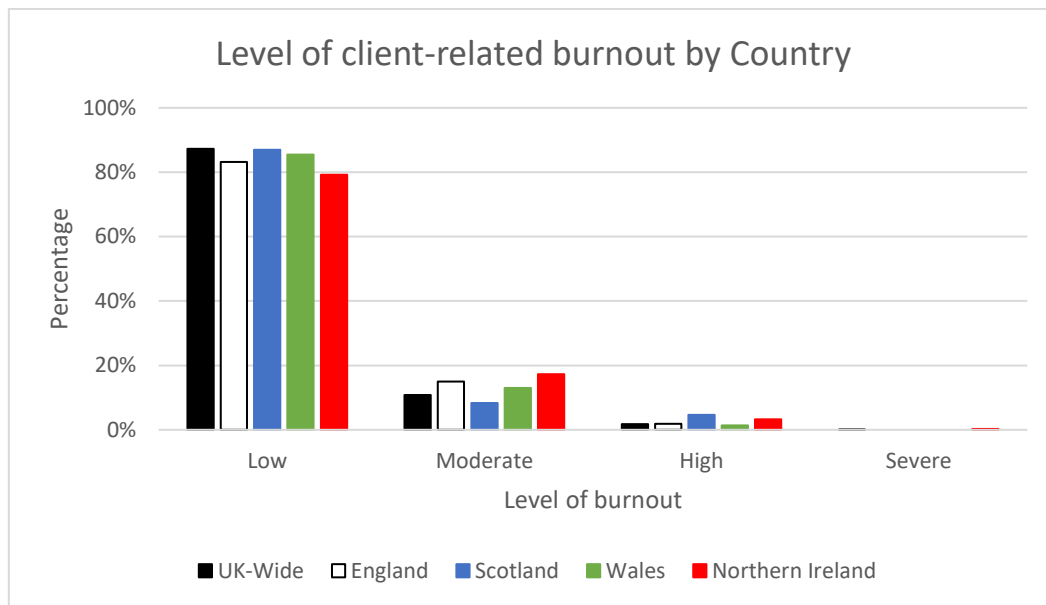


Figure A5.8: Level of Client-Related Burnout by Country (Unweighted)

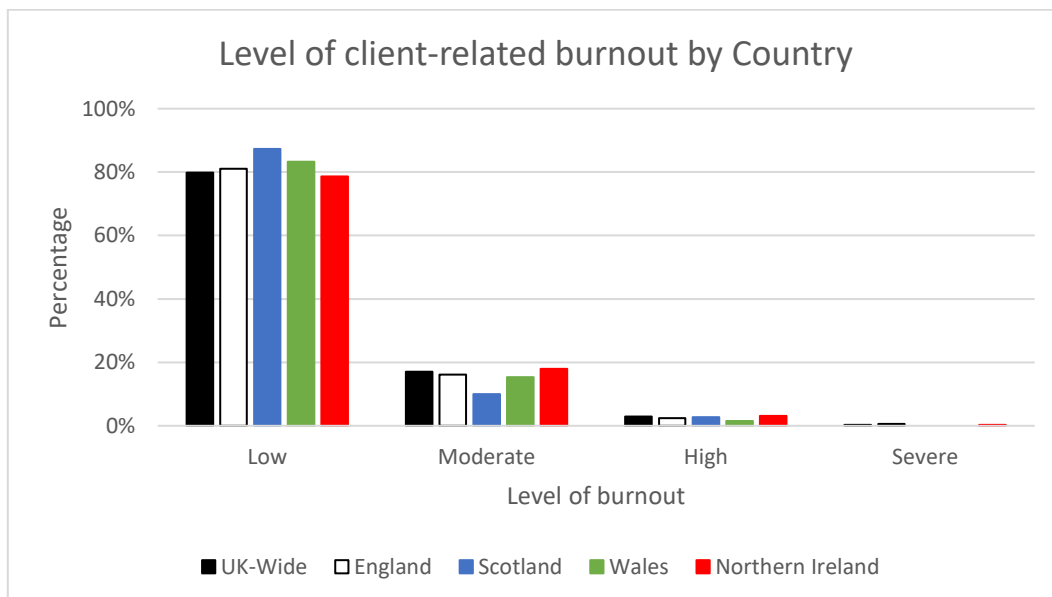


Table A5.3: Level of Burnout by Country (Weighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Personal burnout:</b>					
Low	27.3%	26.8%	27.4%	27.0%	26.8%
Moderate	42.6%	34.2%	36.8%	36.5%	44.1%
High	25.3%	32.0%	28.2%	29.7%	24.4%
Severe	4.8%	7.0%	7.7%	6.8%	4.8%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>					
Low	33.2%	28.8%	28.9%	34.7%	32.7%
Moderate	44.6%	46.3%	47.4%	42.7%	40.8%
High	20.8%	23.1%	23.7%	17.3%	24.1%
Severe	1.5%	1.7%	0.0%	5.3%	2.3%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>					
Low	87.3%	83.2%	87.0%	85.5%	79.2%
Moderate	10.8%	15.0%	8.3%	13.0%	17.3%
High	1.8%	1.9%	4.6%	1.4%	3.2%
Severe	0.1%	0.0%	0.0%	0.0%	0.3%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A5.4: Level of Burnout by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Personal burnout:</b>					
Low	412 (27.9%)	44 (25.1%)	34 (28.3%)	19 (24.7%)	315 (28.5%)
Moderate	610 (41.3%)	66 (37.7%)	40 (33.3%)	31 (40.3%)	473 (42.8%)
High	381 (25.8%)	53 (30.3%)	37 (30.8%)	24 (31.2%)	267 (24.1%)
Severe	75 (5.1%)	12 (6.9%)	9 (7.5%)	3 (3.9%)	51 (4.6%)
<b>Total</b>	<b>1478 (100%)</b>	<b>175 (100%)</b>	<b>120 (100%)</b>	<b>77 (100%)</b>	<b>1106 (100%)</b>
<b>Work-related burnout:</b>					
Low	494 (33.1%)	53 (30.3%)	36 (30.5%)	23 (29.9%)	372 (34.1%)
Moderate	581 (39.8%)	67 (38.3%)	53 (44.9%)	31 (40.3%)	430 (39.4%)
High	366 (25.1%)	51 (29.1%)	28 (23.7%)	21 (27.3%)	266 (24.4%)
Severe	30 (2.1%)	4 (2.3%)	1 (0.8%)	2 (2.6%)	23 (2.1%)
<b>Total</b>	<b>1461 (100%)</b>	<b>175 (100%)</b>	<b>118 (100%)</b>	<b>77 (100%)</b>	<b>1091 (100%)</b>
<b>Client-related burnout:</b>					
Low	1076 (79.8%)	136 (81.0%)	96 (87.3%)	60 (83.3%)	784 (78.6%)
Moderate	229 (17.0%)	27 (16.1%)	11 (10.0%)	11 (15.3%)	180 (18.0%)
High	39 (2.9%)	4 (2.4%)	3 (2.7%)	1 (1.4%)	31 (3.1%)
Severe	4 (0.3%)	1 (0.6%)	0 (0.0%)	0 (0.0%)	3 (0.3%)
<b>Total</b>	<b>1348 (100%)</b>	<b>68 (100%)</b>	<b>120 (100%)</b>	<b>77 (100%)</b>	<b>1106 (100%)</b>

## A5.2 Burnout Scores by Occupation

### Summary (Weighted results):

There were significant differences between the occupational groups in mean personal burnout scores ( $F = 20.515$ ,  $df = 4$ ,  $p < .001$ ). Specifically, social care workers scored significantly lower than nurses, midwives and social workers.

There were also significant differences between the occupational groups in mean work-related burnout scores ( $F = 27.674$ ,  $df = 4$ ,  $p < .001$ ). Specifically, nurses scored significantly lower than midwives and social workers but significantly higher than AHPs and social care workers.

Significant differences between occupational groups were also found in mean client-related burnout scores ( $F = 17.391$ ,  $df = 4$ ,  $p < .001$ ). Midwives scored significantly higher than nurses, AHPs and social care workers.

#### Summary (Unweighted results):

There were significant differences between the occupational groups in mean personal burnout scores ( $F = 8.494$ ,  $df = 4$ ,  $p < .001$ ). Specifically, midwives scored significantly higher than AHPs, social workers or midwives. Nurses scored significantly higher than AHPs or social care workers.

There were also significant differences between the occupational groups in mean work-related burnout scores ( $F = 11.551$ ,  $df = 4$ ,  $p < .001$ ). Midwives scored significantly lower than all other occupations examined.

There were no significant differences between occupational groups were also found in mean client-related burnout scores ( $F = 1.678$ ,  $df = 4$ ,  $p = .153$ ).

Figure A5.9: Mean Burnout Scores by Occupation (Weighted)

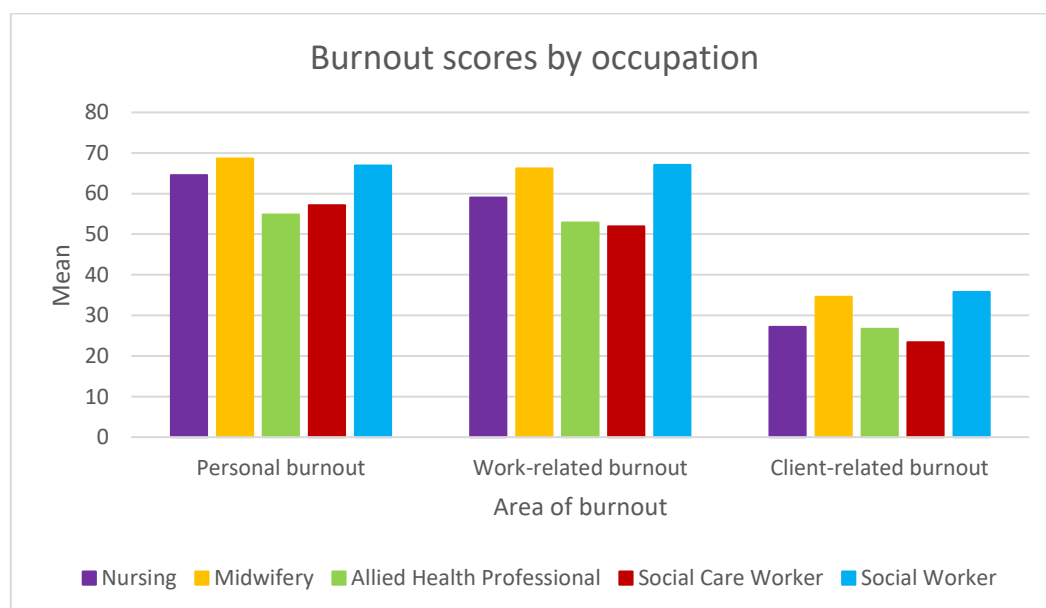


Figure A5.10: Mean Burnout Scores by Occupation (Unweighted)

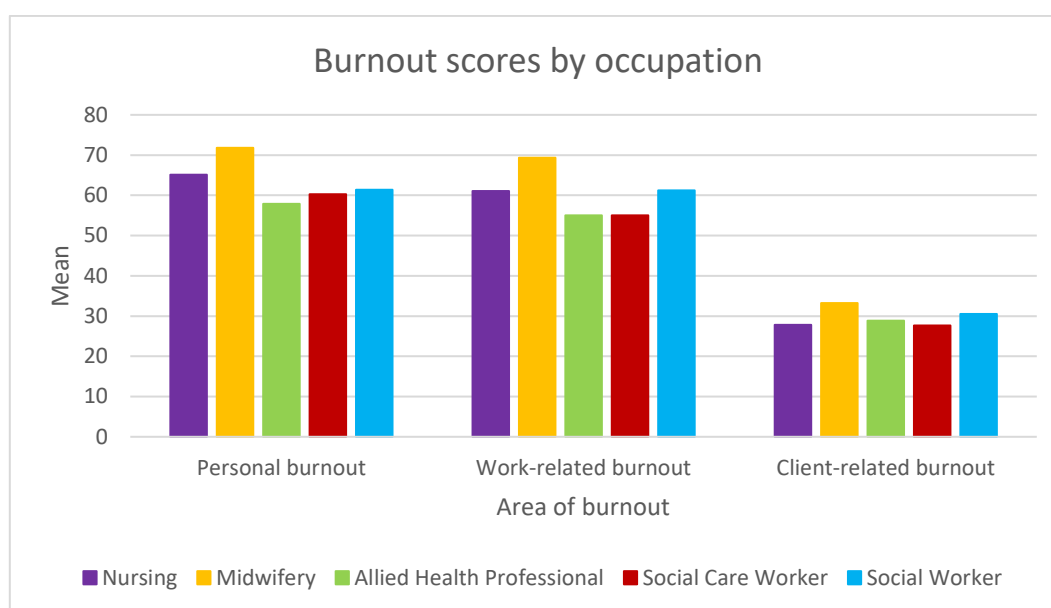


Table A5.5: Mean Burnout Scores by Occupation (Weighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	64.54	68.66	54.84	57.15	66.94
Work-related burnout	59.03	66.23	52.90	51.89	67.03
Client-related burnout	27.20	34.55	26.72	23.35	35.76

Table A5.6: Mean Burnout Scores by Occupation (Unweighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	65.15	71.81	57.89	60.28	61.41
Work-related burnout	61.05	69.30	55.02	55.04	61.19
Client-related burnout	27.79	33.21	28.87	27.64	30.51

Figure A5.11: Level of Personal Burnout by Occupation (Weighted)

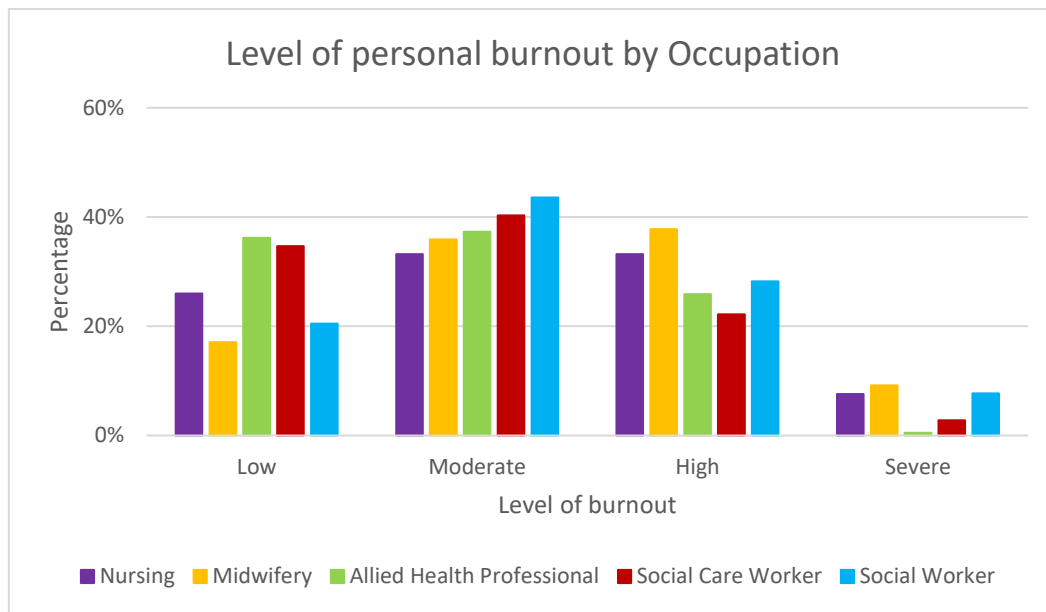


Figure A5.12: Level of Personal Burnout by Occupation (Unweighted)

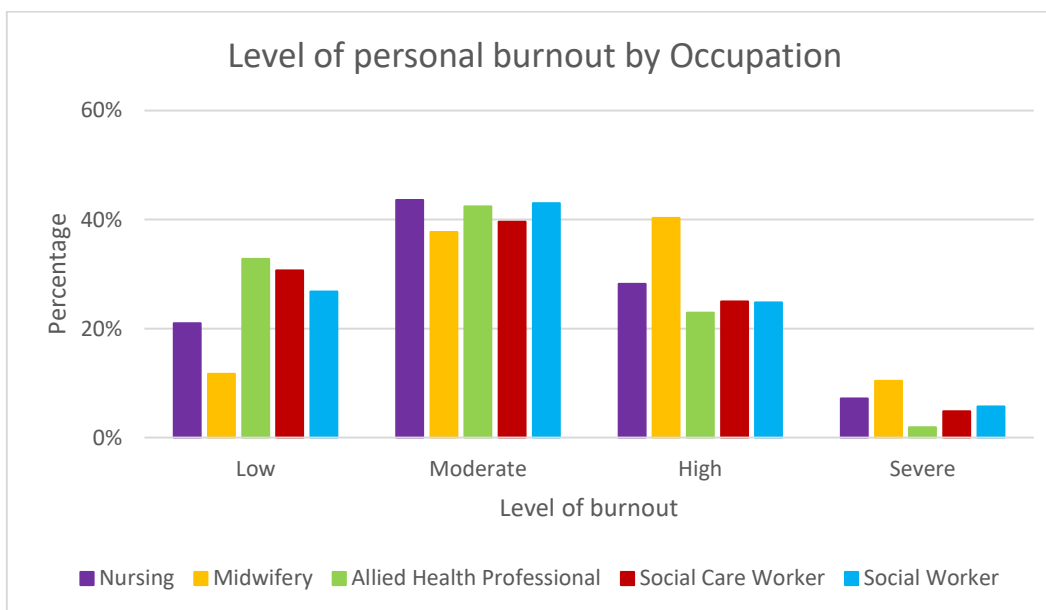




Figure A5.13: Level of Work-Related Burnout by Occupation (Weighted)

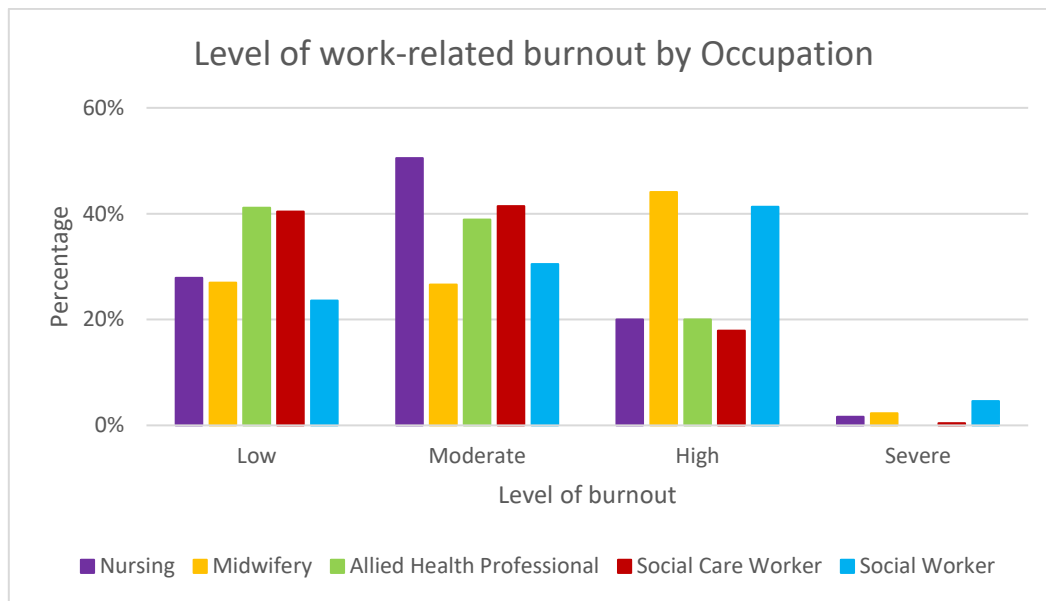


Figure A5.14: Level of Work-Related Burnout by Occupation (Unweighted)

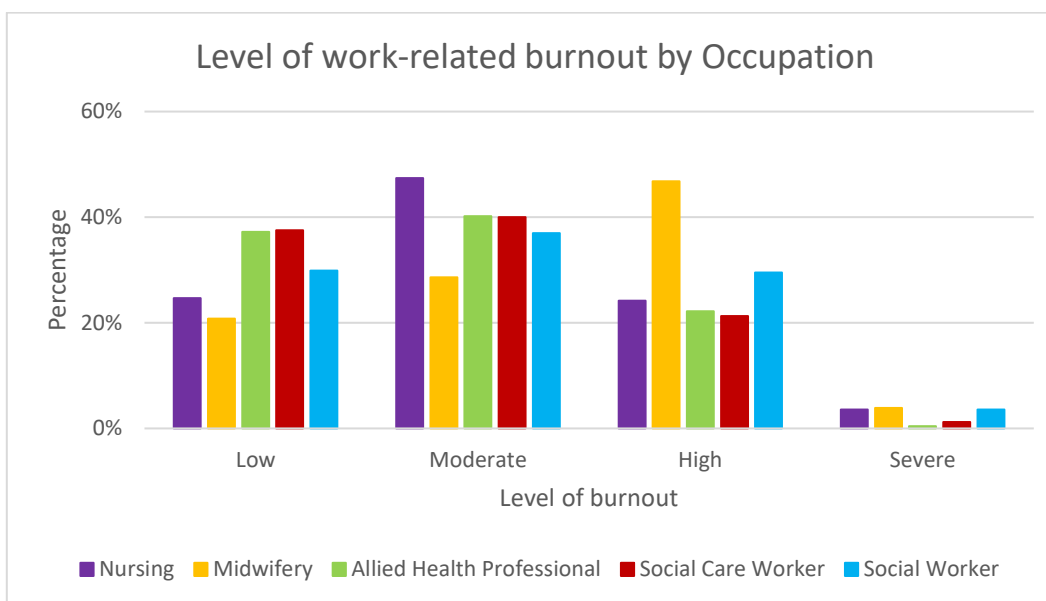


Figure A5.15: Level of Client-Related Burnout by Occupation (Weighted)

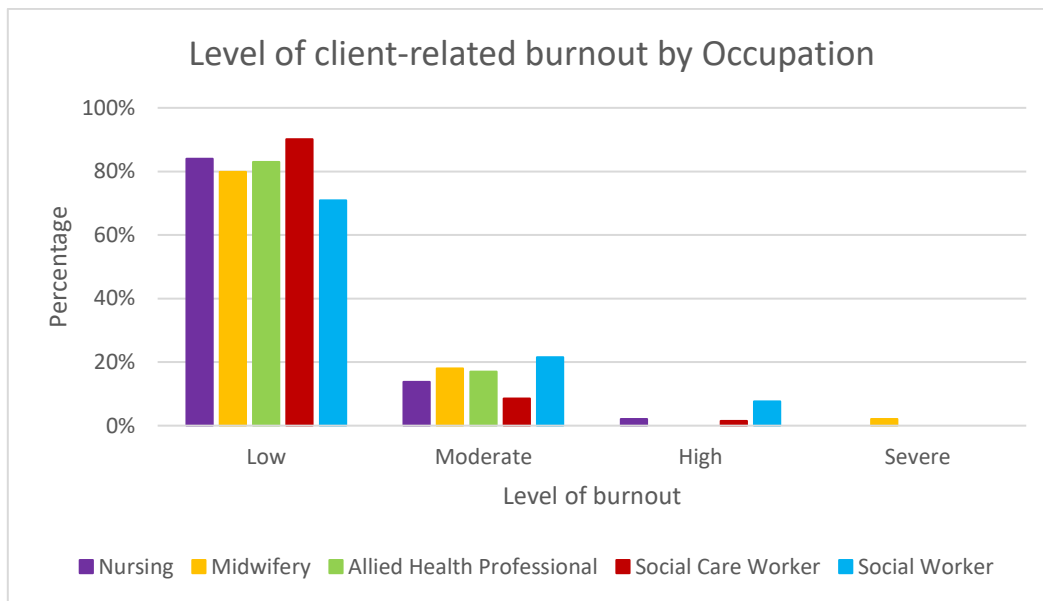


Figure A5.16: Level of Client-Related Burnout by Occupation (Unweighted)

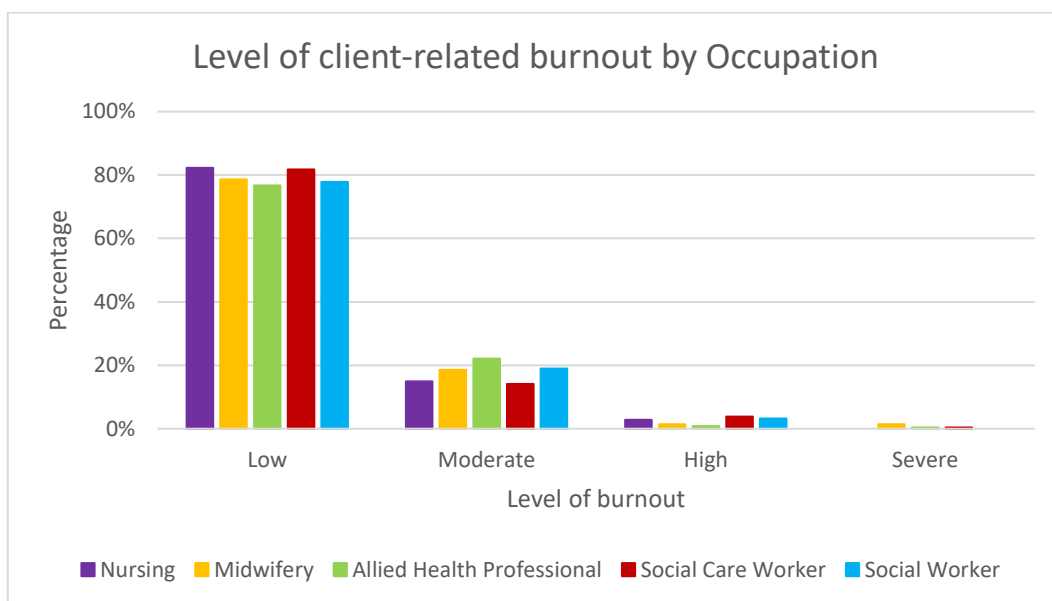


Table A5.7: Level of Burnout by Occupation (Weighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
<b>Personal burnout:</b>					
Low	26.0%	17.1%	36.2%	34.7%	20.5%
Moderate	33.2%	35.9%	37.3%	40.3%	43.6%
High	33.2%	37.8%	25.9%	22.2%	28.2%
Severe	7.6%	9.2%	0.5%	2.8%	7.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>					
Low	27.9%	27.0%	41.1%	40.4%	23.6%
Moderate	50.5%	26.6%	38.9%	41.4%	30.5%
High	20.0%	44.1%	20.0%	17.9%	41.3%
Severe	1.6%	2.3%	0.0%	0.4%	4.6%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>					
Low	84.0%	79.9%	83.0%	90.1%	70.9%
Moderate	13.8%	18.0%	17.0%	8.5%	21.5%
High	2.1%	0.0%	0.0%	1.5%	7.6%
Severe	0.0%	2.1%	0.0%	0.0%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A5.8: Level of Burnout by Occupation (Unweighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
<b>Personal burnout:</b>					
Low	41 (21.0%)	9 (11.7%)	86 (32.8%)	187 (30.7%)	89 (26.8%)
Moderate	85 (43.6%)	29 (37.7%)	111 (42.4%)	241 (39.6%)	144 (43.0%)
High	55 (28.2%)	31 (40.3%)	60 (22.9%)	152 (25.0%)	83 (24.8%)
Severe	14 (7.2%)	8 (10.4%)	5 (1.9%)	29 (4.8%)	19 (5.7%)
<b>Total</b>	<b>195 (100%)</b>	<b>77 (100%)</b>	<b>262 (100%)</b>	<b>609 (100%)</b>	<b>335 (100%)</b>
<b>Work-related burnout:</b>					
Low	48 (24.7%)	16 (20.8%)	97 (37.2%)	97 (37.5%)	99 (29.8%)
Moderate	92 (47.4%)	22 (28.6%)	105 (40.2%)	105 (40.0%)	123 (37.0%)
High	47 (24.2%)	36 (46.8%)	58 (22.2%)	58 (21.3%)	98 (29.5%)
Severe	7 (3.6%)	3 (3.9%)	1 (0.4%)	1 (1.2%)	12 (3.6%)
<b>Total</b>	<b>194 (100%)</b>	<b>77 (100%)</b>	<b>261 (100%)</b>	<b>597 (100%)</b>	<b>332 (100%)</b>
<b>Client-related burnout:</b>					
Low	140 (82.3%)	55 (78.6%)	184 (76.7%)	446 (81.7%)	242 (77.8%)
Moderate	27 (14.9%)	13 (18.6%)	53 (22.1%)	77 (14.1%)	59 (19.0%)
High	5 (2.8%)	1 (1.4%)	2 (0.8%)	21 (3.8%)	10 (3.2%)
Severe	0 (0.0%)	1 (1.4%)	1 (0.4%)	1 (0.4%)	0 (0.0%)
<b>Total</b>	<b>181 (100%)</b>	<b>70 (100%)</b>	<b>240 (100%)</b>	<b>546 (100%)</b>	<b>311 (100%)</b>

### A5.3 Burnout Scores by Sex

Only 5 respondents in the full sample for burnout 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 ( $t = 13.737$ ,  $df = 247.223$ ,  $p < .001$ ). Specifically, females scored significantly higher than males.

There were significant differences between males and females in mean work-related burnout scores ( $t = 11.649$ ,  $df = 265.239$ ,  $p < .001$ ). Specifically, females scored significantly higher than males.

There were significant differences between males and females in mean client-related burnout scores ( $t = -2.231$ ,  $df = 1380$ ,  $p = .026$ ). Males scored significantly higher than females.

#### Summary (Unweighted results):

There were significant differences between males and females in mean personal burnout scores ( $t = 4.029$ ,  $df = 1471$ ,  $p < .001$ ). Specifically, females scored significantly higher than males.

There were no significant differences between males and females in mean work-related burnout scores ( $t = 1.565$ ,  $df = 1454$ ,  $p = .118$ ).

There were significant differences between males and females in mean client-related burnout scores ( $t = -4.624$ ,  $df = 1341$ ,  $p < .001$ ). Males scored significantly higher than females.

Figure A5.17: Mean Burnout Scores by Sex (Weighted)

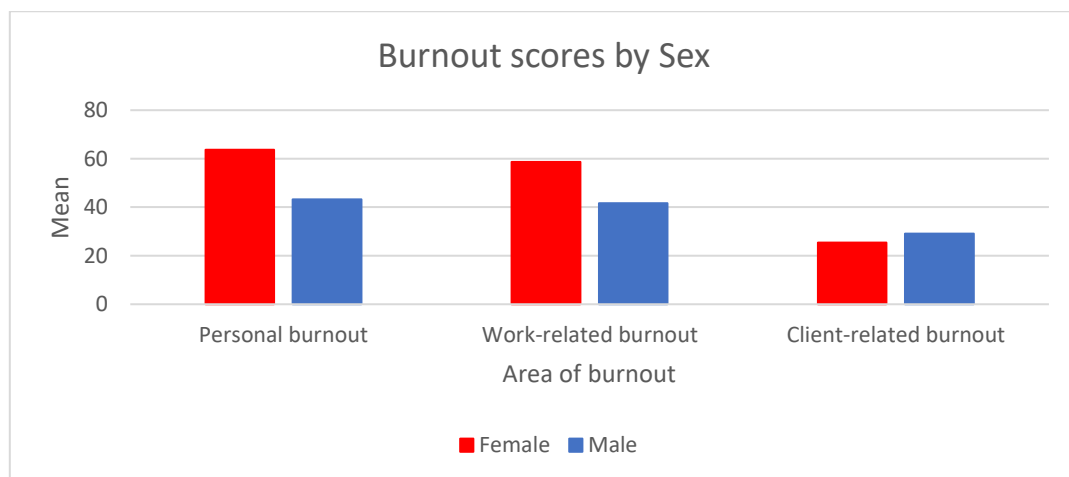


Figure A5.18: Mean Burnout Scores by Sex (Unweighted)

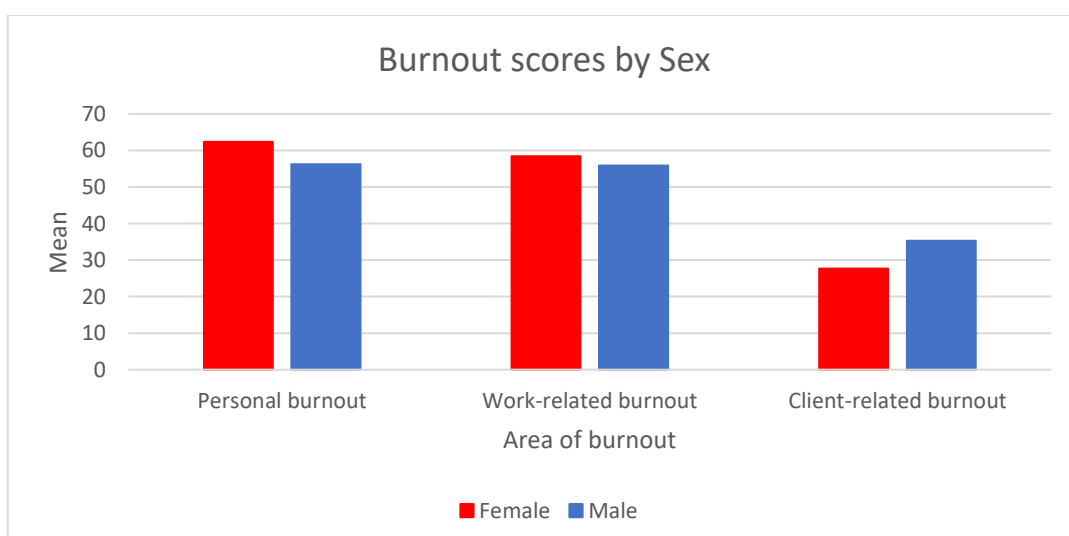


Table A5.9: Mean Burnout Scores by Sex (Weighted)

Burnout	Sex	
	Female	Male
Personal burnout	63.68	43.25
Work-related burnout	58.64	41.68
Client-related burnout	25.41	29.07

Table A5.10: Mean Burnout Scores by Sex (Unweighted)

Burnout	Sex	
	Female	Male
Personal burnout	62.32	56.20
Work-related burnout	58.39	55.85
Client-related burnout	27.66	35.27

Figure A5.19: Level of Personal Burnout by Sex (Weighted)

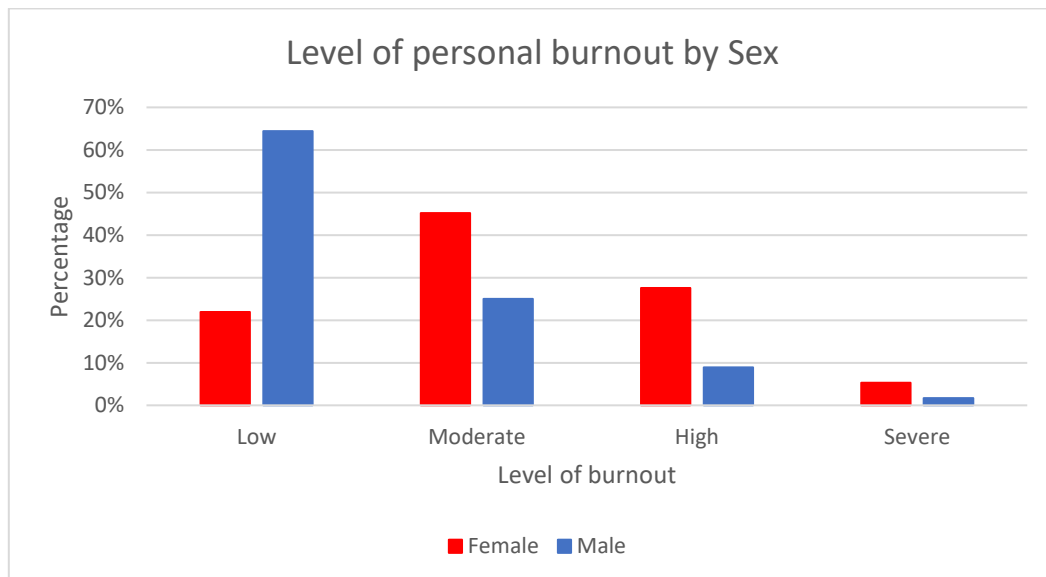


Figure A5.20: Level of Personal Burnout by Sex (Unweighted)

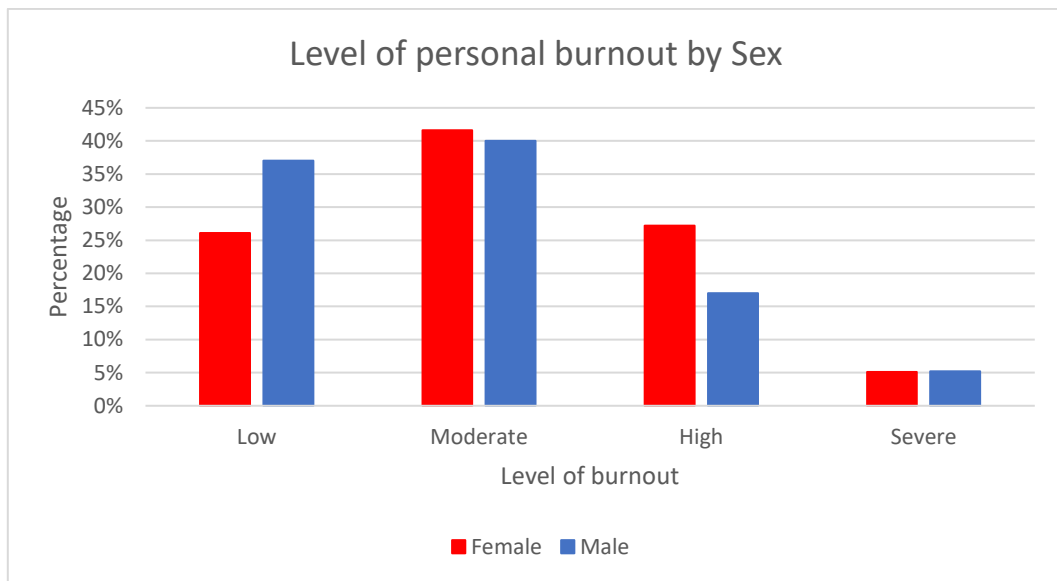


Figure A5.21: Level of Work-Related Burnout by Sex (Weighted)

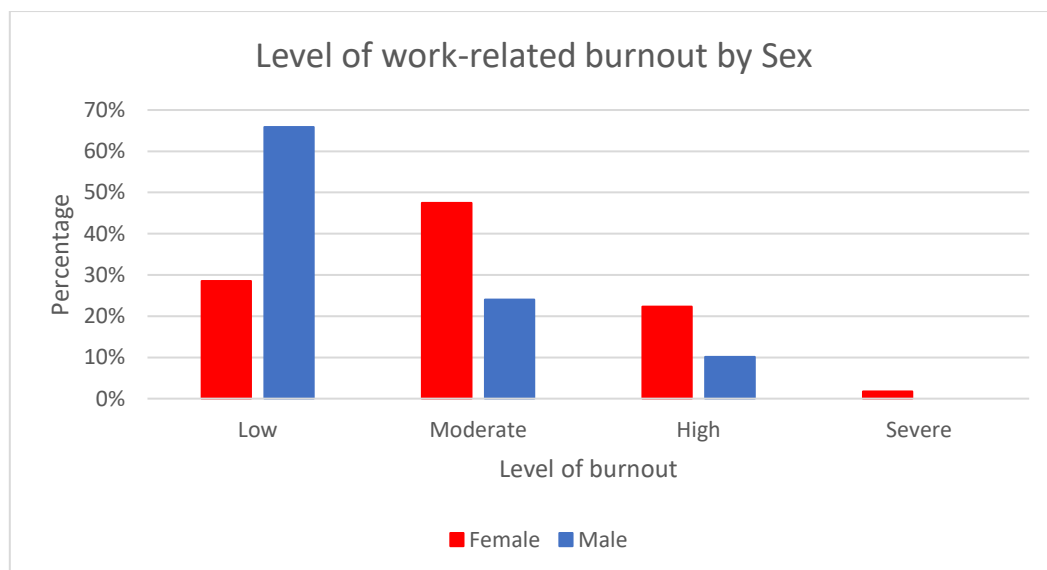


Figure A5.22: Level of Work-Related Burnout by Sex (Unweighted)

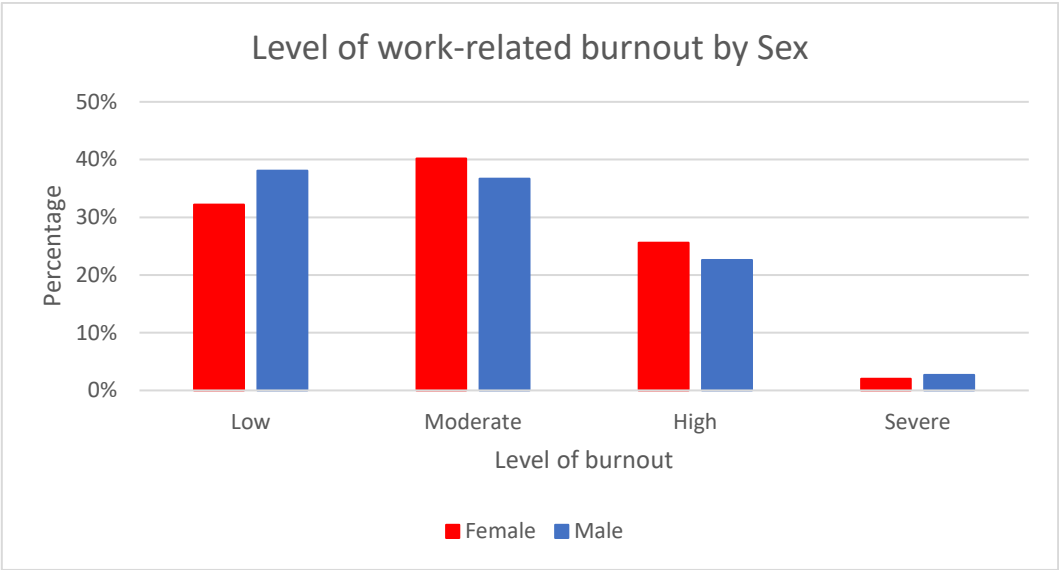


Figure A5.23: Level of Client-Related Burnout by Sex (Weighted)

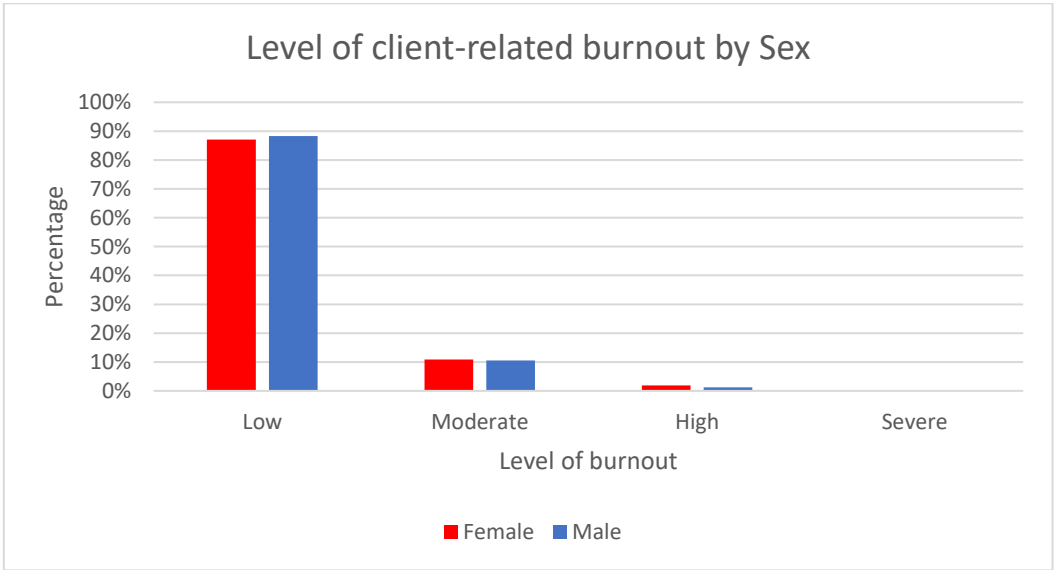




Figure A5.24: Level of Client-Related Burnout by Sex (Unweighted)

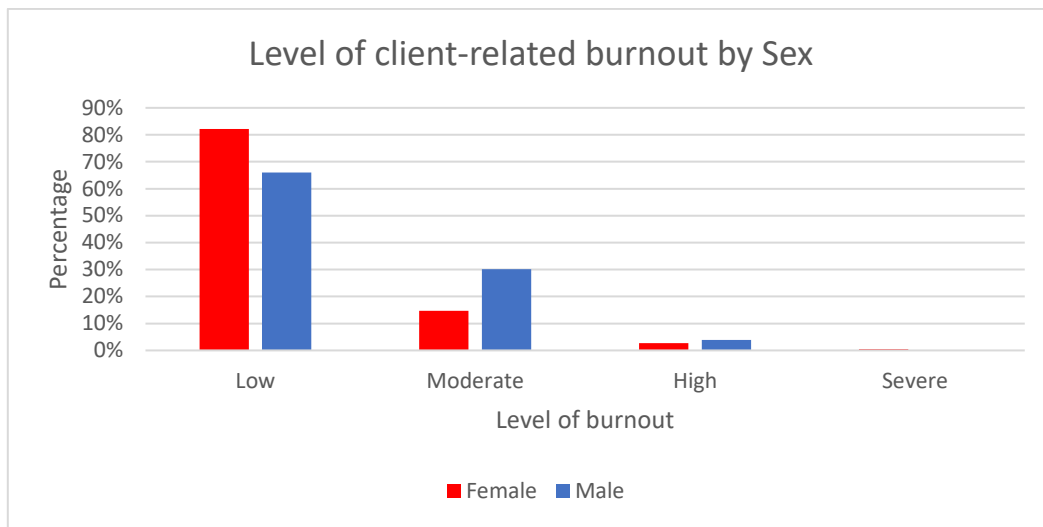


Table A5.11: Level of Burnout by Sex (Weighted)

Burnout	Sex	
	Female	Male
<b>Personal burnout:</b>		
Low	21.9%	64.4%
Moderate	45.2%	25.0%
High	27.6%	8.9%
Severe	5.3%	1.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>		
Low	28.5%	65.9%
Moderate	47.5%	24.0%
High	22.3%	10.1%
Severe	1.7%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>		
Low	87.1%	88.3%
Moderate	10.9%	10.5%
High	1.9%	1.2%
Severe	0.1%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>

Table A5.12: Level of Burnout by Sex (Unweighted)

Burnout	Sex	
	Female	Male
<b>Personal burnout:</b>		
Low	325 (26.1%)	85(37.0%)
Moderate	517 (41.6%)	92(40.0%)
High	338 (27.2%)	41 (17.0%)
Severe	63 (5.1%)	12 (5.2%)
<b>Total</b>	<b>1243 (100%)</b>	<b>230 (100%)</b>
<b>Work-related burnout:</b>		
Low	396 (32.2%)	86 (38.1%)
Moderate	495 (40.2%)	83 (36.7%)
High	315 (25.6%)	51 (22.6%)
Severe	24 (2.0%)	6 (2.7%)
<b>Total</b>	<b>1230 (100%)</b>	<b>226 (100%)</b>
<b>Client-related burnout:</b>		
Low	935 (82.2%)	136 (66.0%)
Moderate	167 (14.7%)	62 (30.1%)
High	31 (2.7%)	8 (3.9%)
Severe	4 (0.1%)	0 (0.0%)
<b>Total</b>	<b>1137 (100%)</b>	<b>149 (100%)</b>

#### A5.4 Burnout Scores by Age

##### Summary (Weighted results):

There were significant differences between the age groups in mean personal burnout scores ( $F = 4.271$ ,  $df = 4$ ,  $p = .002$ ). The 50-59 scored significantly higher than the 16-29 and 30-39 age groups.

There were significant differences between the age groups in mean work-related burnout scores ( $F = 3.568$ ,  $df = 4$ ,  $p = .007$ ). Specifically, the 16-29 scored significantly higher than the 40-49 and 50-59 age groups.

There were also significant differences between the age groups in mean client-related burnout scores ( $F = 27.302$ ,  $df = 4$ ,  $p < .001$ ). Specifically, the 30-39 age group scored significantly higher than the 40-49, 50-59 and 60+ age groups but significantly lower than the 16-29 age group.

### Summary (Unweighted results):

There were significant differences between the age groups in mean personal burnout scores ( $F = 5.332$ ,  $df = 4$ ,  $p < .001$ ). The 60+ age group scored significantly lower than the 16-29, 30-39 and 40-49 age groups.

There were significant differences between the age groups in mean work-related burnout scores ( $F = 7.434$ ,  $df = 4$ ,  $p < .001$ ). Specifically, the 60+ age group scored significantly lower than the 16-29, 30-39 and 40-49 age groups.

There were also significant differences between the age groups in mean client-related burnout scores ( $F = 3.398$ ,  $df = 4$ ,  $p = .009$ ). Specifically, the 30-39 age group scored significantly higher than the 50-59 age group.

Figure A5.25: Mean Burnout Scores by Age (Weighted)

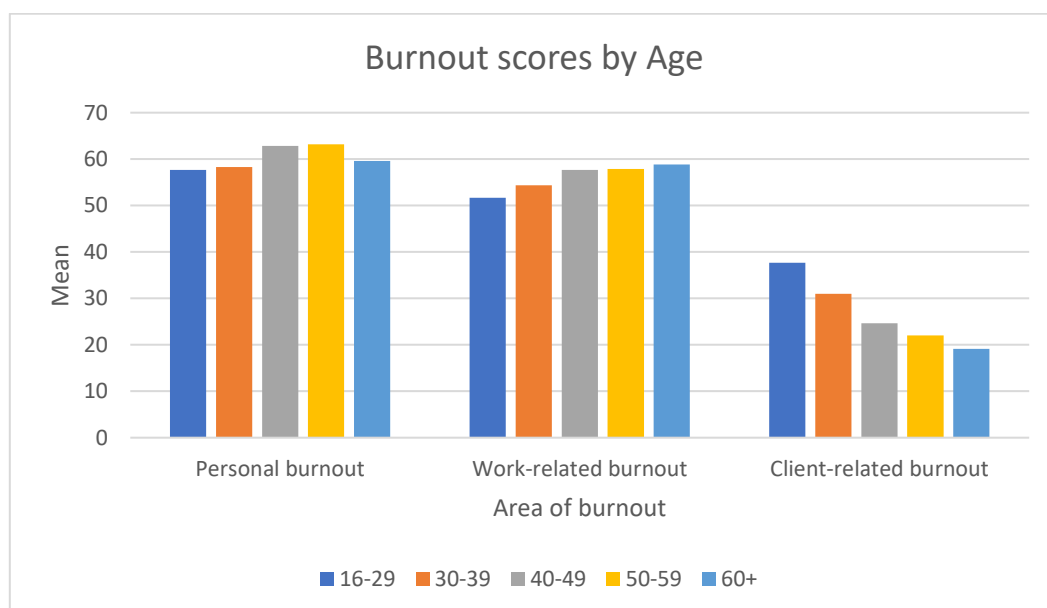


Figure A5.26: Mean Burnout Scores by Age (Unweighted)

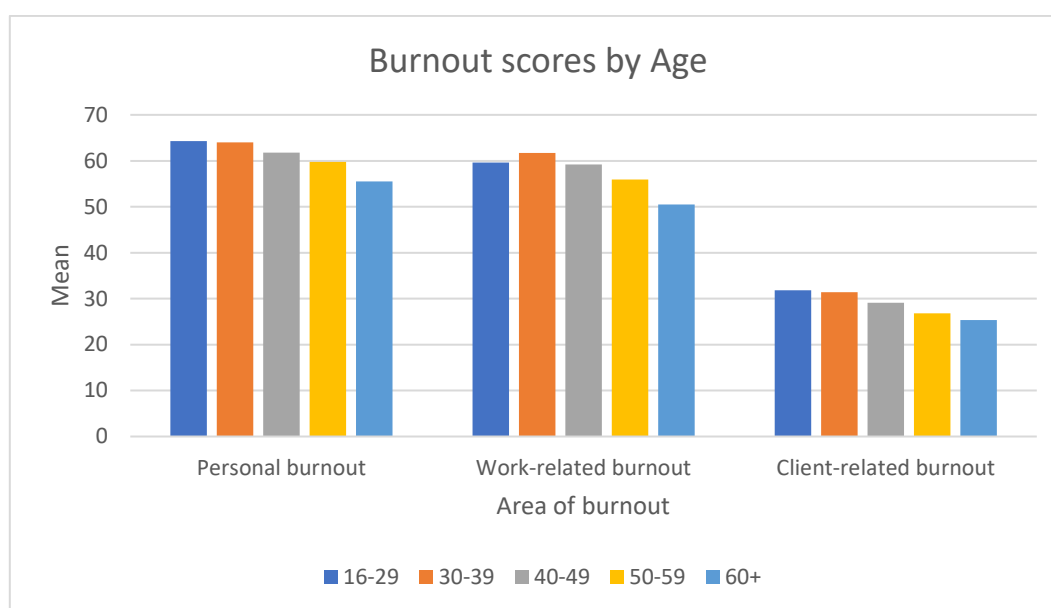


Table A5.13: Mean Burnout Scores by Age (Weighted)

Burnout	Age				
	16-29	30-39	40-49	50-59	60+
Personal burnout	57.67	58.29	62.83	63.16	59.6
Work-related burnout	51.70	54.37	57.66	57.87	58.83
Client-related burnout	37.70	30.99	24.61	22.02	19.14

Table A5.14: Mean Burnout Scores by Age (Unweighted)

Burnout	Age				
	16-29	30-39	40-49	50-59	60+
Personal burnout	64.31	64.00	61.78	59.73	55.53
Work-related burnout	59.64	61.74	59.17	55.94	50.51
Client-related burnout	31.85	31.41	29.09	26.81	25.37

Figure A5.27: Level of Personal Burnout by Age (Weighted)

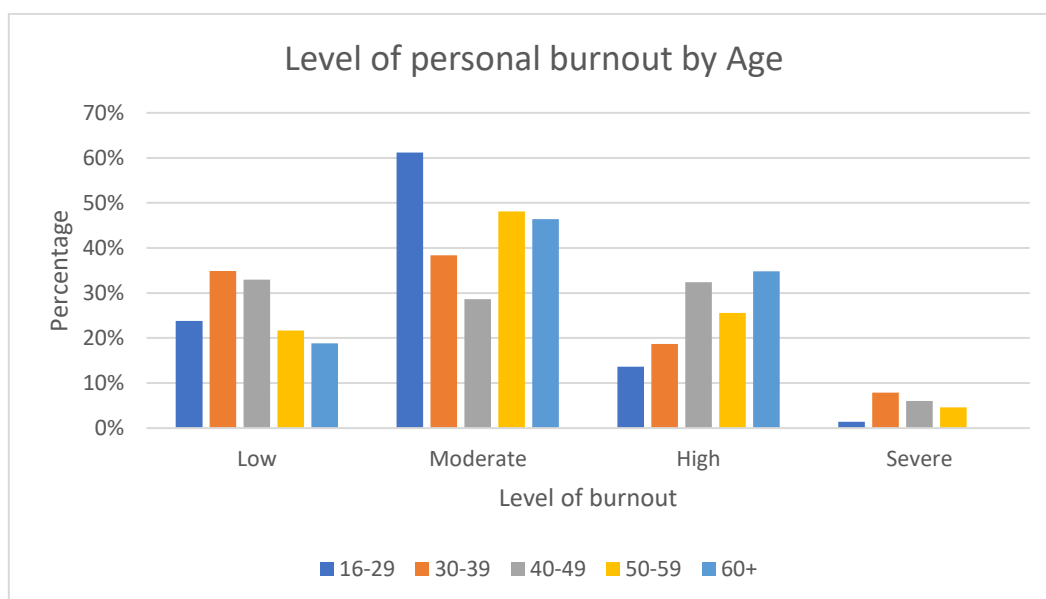


Figure A5.28: Level of Personal Burnout by Age (Unweighted)

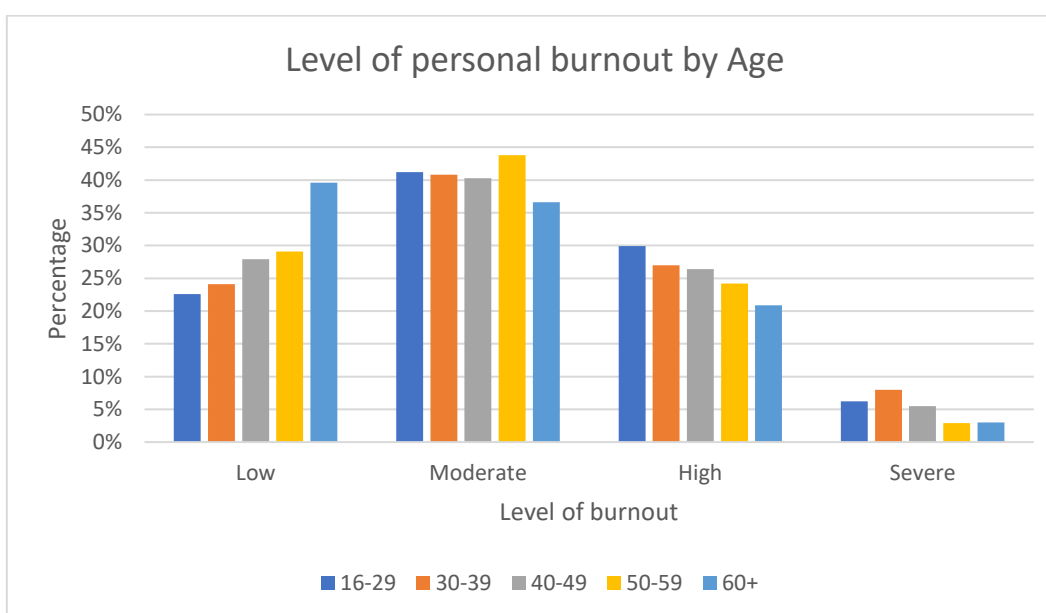


Figure A5.29: Level of Work-Related Burnout by Age (Weighted)

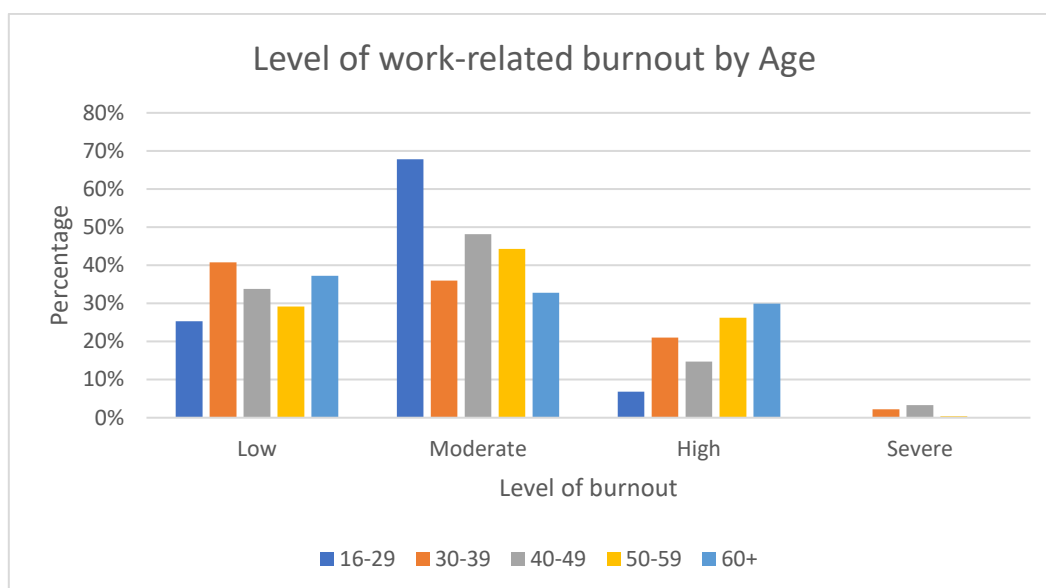


Figure A5.30: Level of Work-Related Burnout by Age (Unweighted)

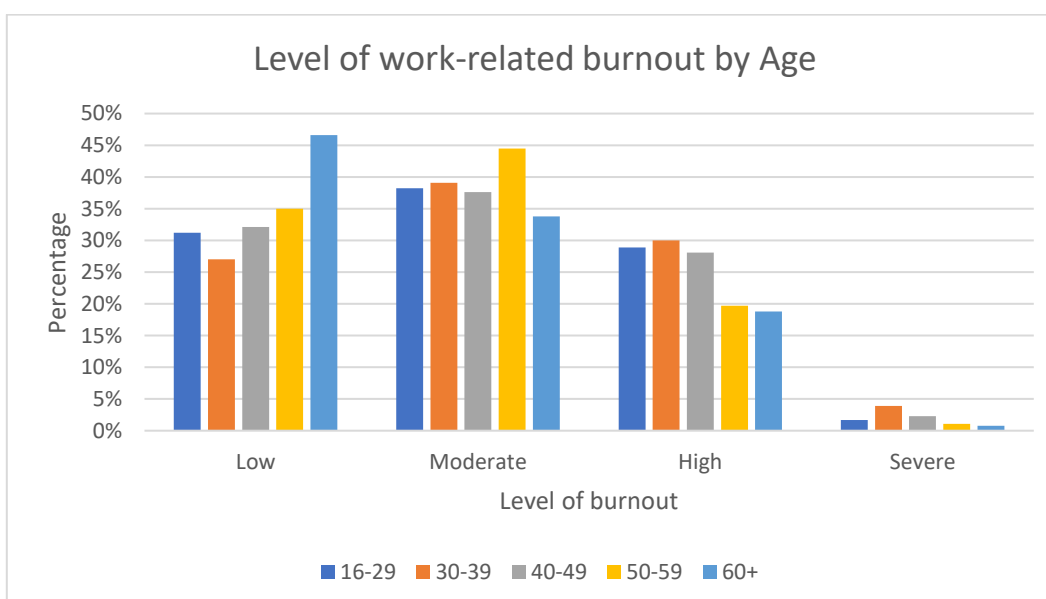


Figure A5.31: Level of Client-Related Burnout by Age (Weighted)

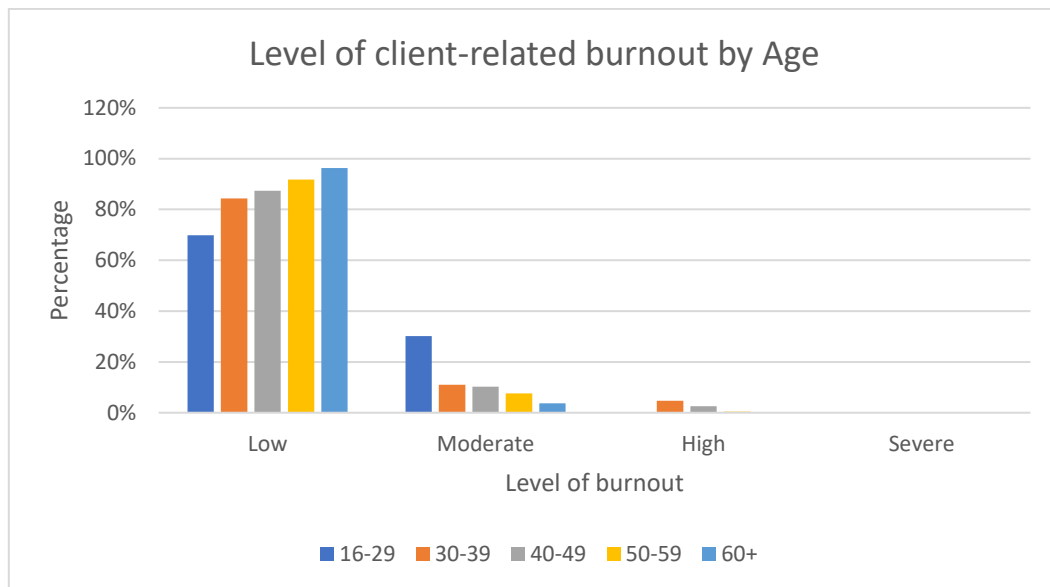


Figure A5.32: Level of Client-Related Burnout by Age (Unweighted)

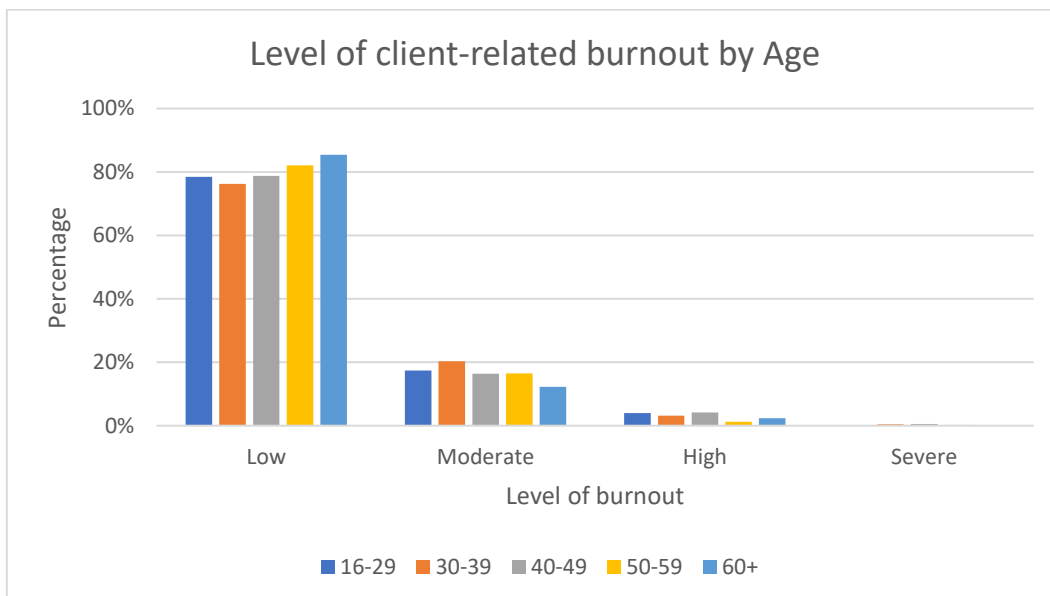


Table A5.15: Level of Burnout by Age (Weighted)

Burnout	Age				
	16-29	30-39	40-49	50-59	60+
<b>Personal burnout:</b>					
Low	23.8%	34.9%	33.0%	21.7%	18.8%
Moderate	61.2%	38.4%	28.6%	48.1%	46.4%
High	13.6%	18.7%	32.4%	25.6%	34.8%
Severe	1.4%	7.9%	6.0%	4.6%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>					
Low	25.3%	40.8%	33.8%	29.2%	37.2%
Moderate	67.8%	36.0%	48.2%	44.3%	32.8%
High	6.8%	21.0%	14.7%	26.2%	29.9%
Severe	0.0%	2.2%	3.3%	0.4%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>					
Low	69.8%	84.3%	87.4%	91.8%	96.3%
Moderate	30.2%	11.0%	10.2%	7.6%	3.7%
High	0.0%	4.7%	2.5%	0.4%	0.0%
Severe	0.0%	0.0%	0.0%	0.2%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>



Table A5.16: Level of Burnout by Age (Unweighted)

Burnout	Age				
	16-29	30-39	40-49	50-59	60+
<b>Personal burnout:</b>					
Low	40 (22.6%)	75 (24.1%)	112 (27.9%)	132 (29.1%)	53 (39.6%)
Moderate	73 (41.2%)	127 (40.8%)	162 (40.3%)	199 (43.8%)	49 (36.6%)
High	53 (29.9%)	84 (27.0%)	106 (26.4%)	110 (24.2%)	28 (20.9%)
Severe	7 (6.2%)	25 (8.0%)	22 (5.5%)	13 (2.9%)	4 (3.0%)
<b>Total</b>	<b>177 (100%)</b>	<b>311 (100%)</b>	<b>402 (100%)</b>	<b>454 (100%)</b>	<b>134 (100%)</b>
<b>Work-related burnout:</b>					
Low	54 (31.2%)	83 (27.0%)	128 (32.1%)	157 (35.0%)	62 (46.6%)
Moderate	66 (38.2%)	120 (39.1%)	150 (37.6%)	200 (44.5%)	45 (33.8%)
High	50 (28.9%)	92 (30.0%)	112(28.1%)	87 (19.7%)	25 (18.8%)
Severe	3 (1.7%)	12 (3.9%)	9 (2.3%)	5 (1.1%)	1 (0.8%)
<b>Total</b>	<b>173 (100%)</b>	<b>307 (100%)</b>	<b>399 (100%)</b>	<b>449 (100%)</b>	<b>133 (100%)</b>
<b>Client-related burnout:</b>					
Low	117 (78.5%)	214 (76.2%)	297 (78.8%)	343 (82.1%)	105 (85.4%)
Moderate	26 (17.4%)	57 (20.3%)	62 (16.4%)	69 (16.5%)	15 (12.2%)
High	6 (4.0%)	9 (3.2%)	16 (4.2%)	5 (1.2%)	3 (2.4%)
Severe	0 (0.0%)	1 (0.4%)	2 (0.5%)	1 (0.2%)	0 (0.0%)
<b>Total</b>	<b>149 (100%)</b>	<b>281 (100%)</b>	<b>377 (100%)</b>	<b>418 (100%)</b>	<b>123 (100%)</b>

## A5.5 Burnout Scores by Ethnicity

### Summary (Weighted results):

There were significant differences between the ethnic groups in mean personal burnout scores ( $F = 1.72$ ,  $df = 3$ ,  $p > .05$ ) or work-related burnout scores ( $F = 23.030$ ,  $df = 3$ ,  $p < .001$ ).

There were significant differences between the ethnic groups in mean work-related burnout scores ( $F = 28.509$ ,  $df = 3$ ,  $p < .001$ ). Specifically, the Asian ethnic group scored significantly higher than the Black or Mixed ethnic groups.

There were significant differences between the ethnic groups in mean client-related burnout scores ( $F = 4.439$ ,  $df = 3$ ,  $p = .004$ ). Specifically, the Asian ethnic group scored significantly higher than the White or Black 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)

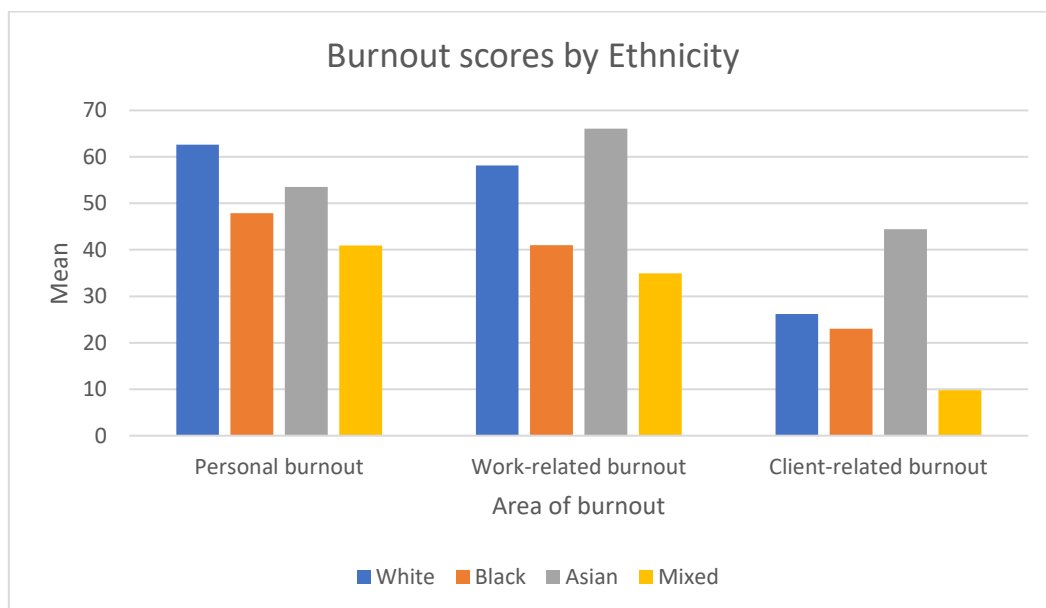


Figure A5.34: Mean Burnout Scores by Ethnicity (Unweighted)

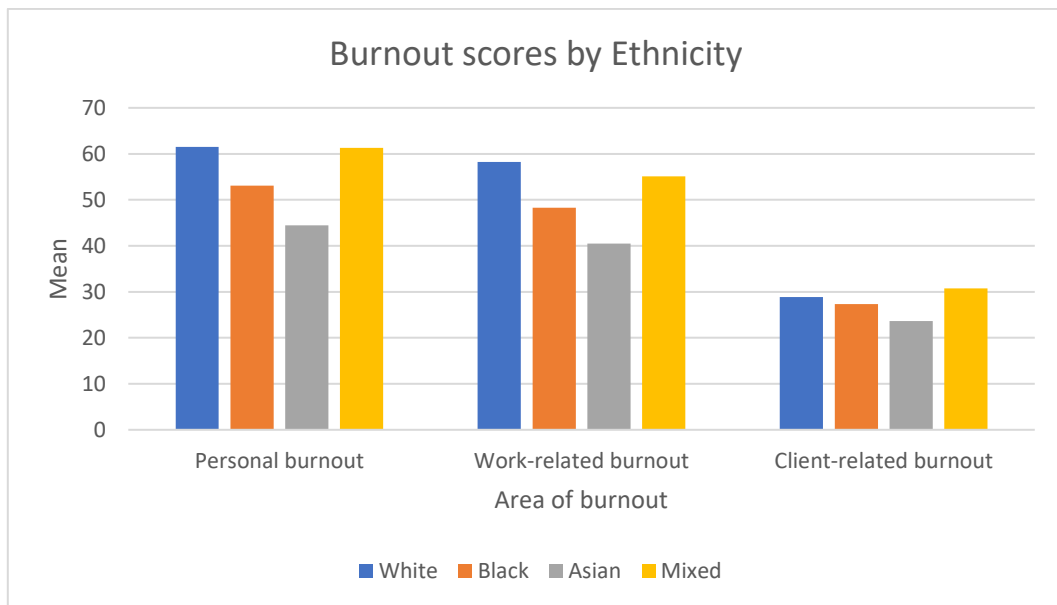


Table A5.17: Mean Burnout Scores by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	62.60	47.87	53.54	40.91
Work-related burnout	58.18	40.98	66.10	34.92
Client-related burnout	26.20	23.04	44.41	9.80

Table A5.18: Mean Burnout Scores by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	61.52	53.07	44.44	61.31
Work-related burnout	58.22	48.31	40.48	55.10
Client-related burnout	28.89	27.31	23.61	30.77

Figure A5.35: Level of Personal Burnout by Ethnicity (Weighted)

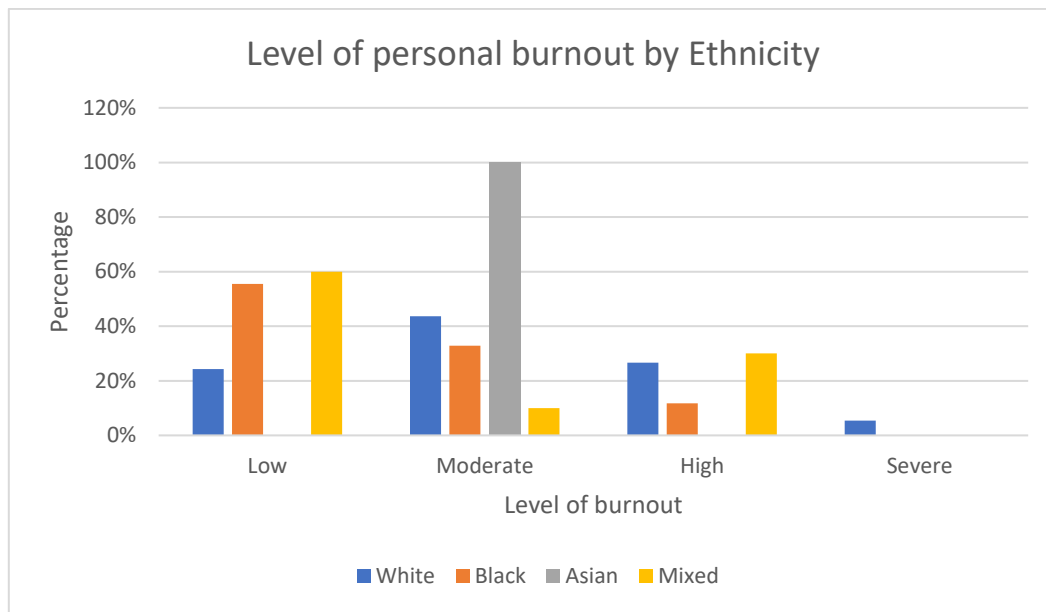


Figure A5.36: Level of Personal Burnout by Ethnicity (Unweighted)

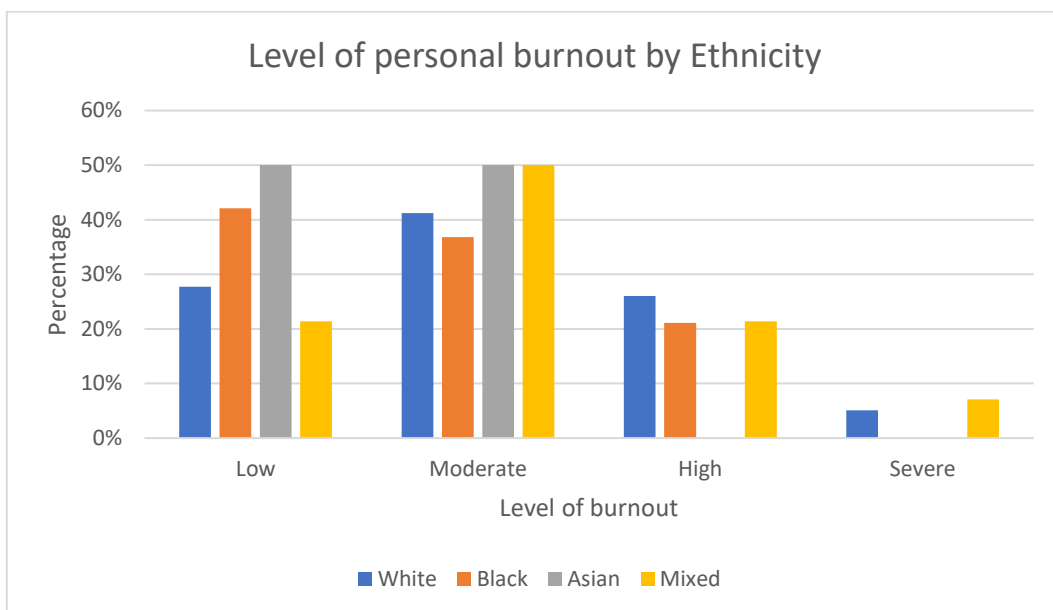


Figure A5.37: Level of Work-Related Burnout by Ethnicity (Weighted)

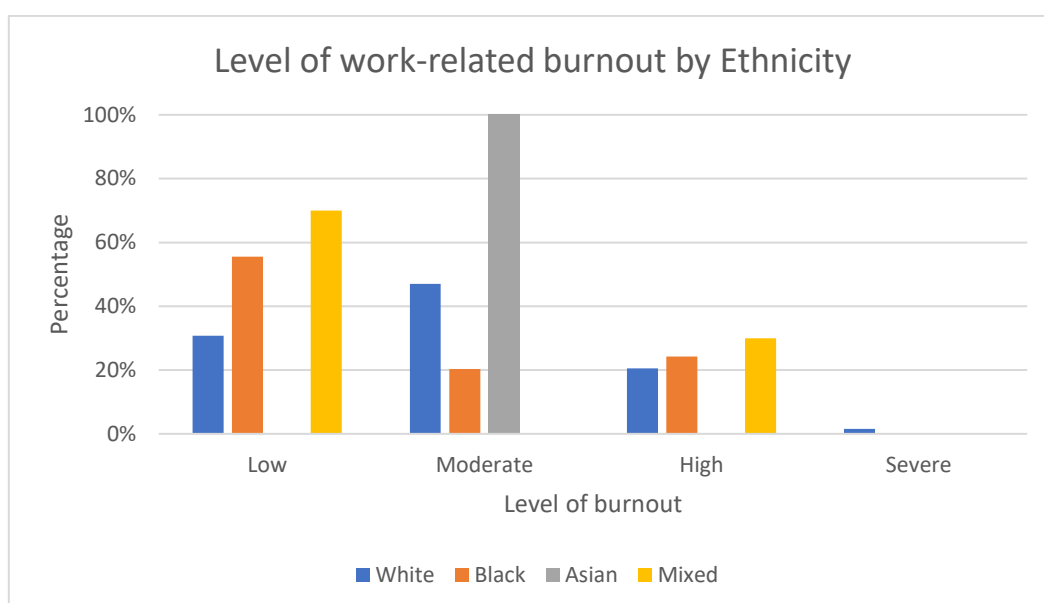


Figure A5.38: Level of Work-Related Burnout by Ethnicity (Unweighted)

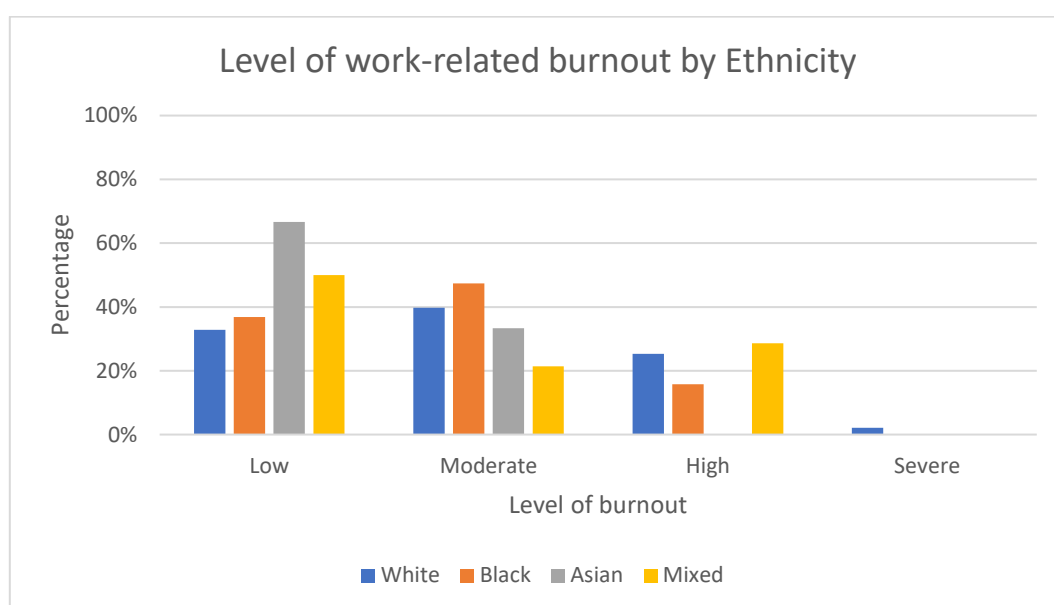


Figure A5.39: Level of Client-Related Burnout by Ethnicity (Weighted)

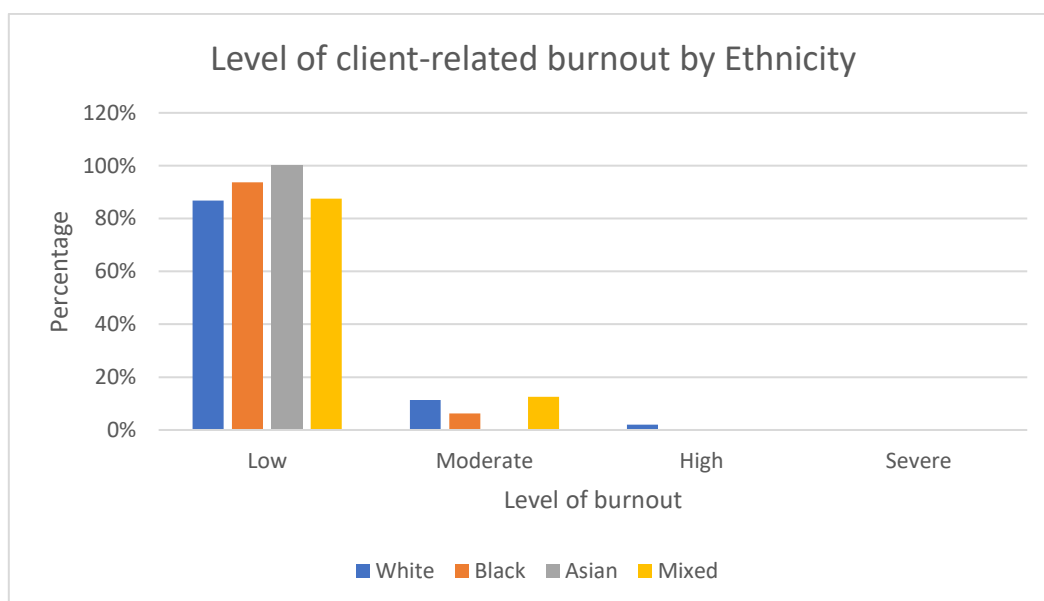


Figure A5.40: Level of Client-Related Burnout by Ethnicity (Unweighted)

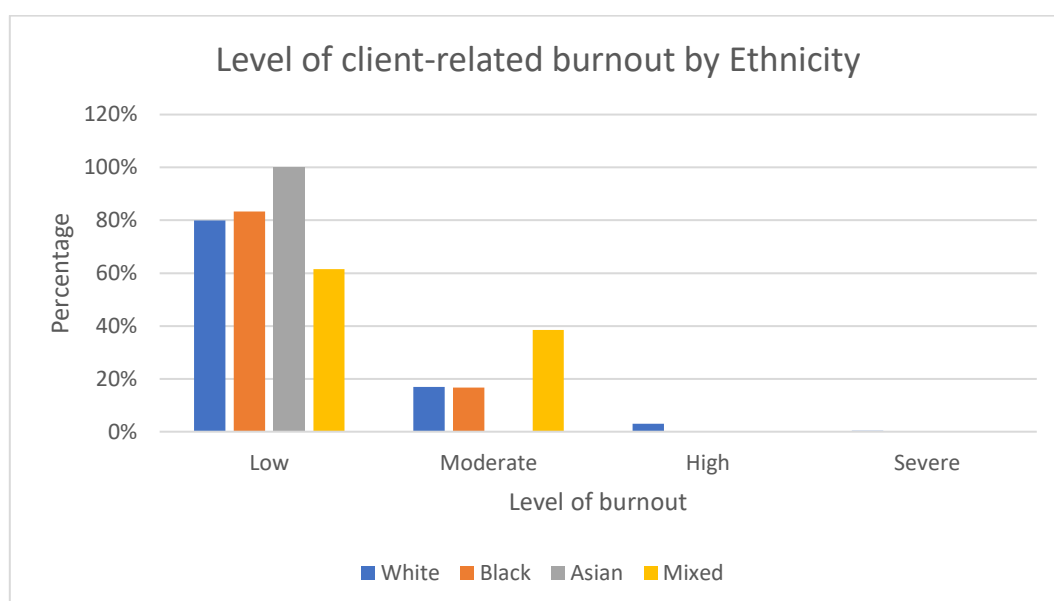


Table A5.19: Level of Burnout by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
<b>Personal burnout:</b>				
Low	24.3%	55.5%	0.0%	60.0%
Moderate	43.6%	32.8%	100.0%	10.0%
High	26.7%	11.7%	0.0%	30.0%
Severe	5.4%	0.0%	0.0%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>				
Low	30.8%	55.5%	0.0%	70.0%
Moderate	47.0%	20.3%	100.0%	0.0%
High	20.5%	24.2%	0.0%	30.0%
Severe	1.6%	0.0%	0.0%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>				
Low	86.9%	93.7%	100.0%	87.5%
Moderate	11.4%	6.3%	0.0%	12.5%
High	2.0%	0.0%	0.0%	0.0%
Severe	0.1%	0.0%	0.0%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A5.20: Level of Burnout by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
<b>Personal burnout:</b>				
Low	388 (27.7%)	8 (42.1%)	3 (50.0%)	3 (21.4%)
Moderate	592 (41.2%)	7 (36.8%)	3 (50.0%)	7 (50.0%)
High	373 (26.0%)	4 (21.1%)	0 (0.0%)	3 (21.4%)
Severe	74 (5.1%)	0 (0.0%)	0 (0.0%)	1 (7.1%)
<b>Total</b>	<b>1437 (100%)</b>	<b>19 (100%)</b>	<b>6 (100%)</b>	<b>14 (100%)</b>
<b>Work-related burnout:</b>				
Low	466 (32.8%)	7 (36.8%)	4 (66.7%)	7 (50.0%)
Moderate	565 (39.8%)	9 (47.4%)	2 (33.3%)	3 (21.4%)
High	359 (25.3%)	3 (15.8%)	0 (0.0%)	4 (28.6%)
Severe	30 (2.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
<b>Total</b>	<b>1420 (100%)</b>	<b>0 (0.0%)</b>	<b>0 (0.0%)</b>	<b>0 (0.0%)</b>
<b>Client-related burnout:</b>				
Low	1045 (79.9%)	15 (83.3%)	6 (100.0%)	8 (61.5%)
Moderate	221 (16.9%)	3 (16.7%)	0 (0.0%)	5 (38.5%)
High	39 (3.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Severe	4 (0.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
<b>Total</b>	<b>1309 (100%)</b>	<b>18 (100%)</b>	<b>6 (100%)</b>	<b>5 (100%)</b>



## **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 ( $F = 48.390$ ,  $df = 2$ ,  $p < .001$ ). Specifically, those who did not have a disability scored significantly lower than those who were not sure of whether or not they had a disability and those who had a disability.

There were significant differences between respondents based on their disability status in mean work-related burnout scores ( $F = 30.980$ ,  $df = 2$ ,  $p < .001$ ). Specifically, those who did not have a disability scored significantly lower than those who were not sure of whether or not they had a disability and those who had a disability.

There were significant differences between respondents based on their disability status in mean client burnout scores ( $F = 18.160$ ,  $df = 2$ ,  $p < .001$ ). Specifically, those who were unsure if they had a disability scored significantly higher than those who did have a disability and those who did not have a disability.

### **Summary (Unweighted results):**

There were significant differences between respondents based on their disability status in mean personal burnout scores ( $F = 22.866$ ,  $df = 2$ ,  $p < .001$ ). 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 ( $F = 11.911$ ,  $df = 2$ ,  $p < .001$ ). 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 no significant differences between respondents based on their disability status were also found in mean client-related burnout scores ( $F = 2.590$   $df = 2$ ,  $p = .075$ ).

Figure A5.41: Mean Burnout Scores by Disability (Weighted)

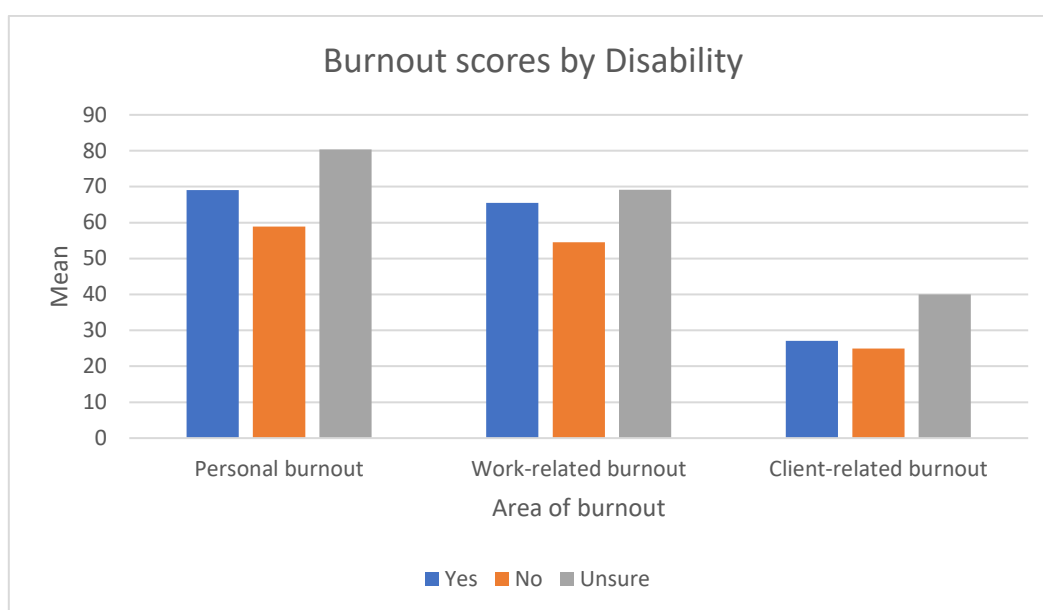


Figure A5.42: Mean Burnout Scores by Disability (Unweighted)

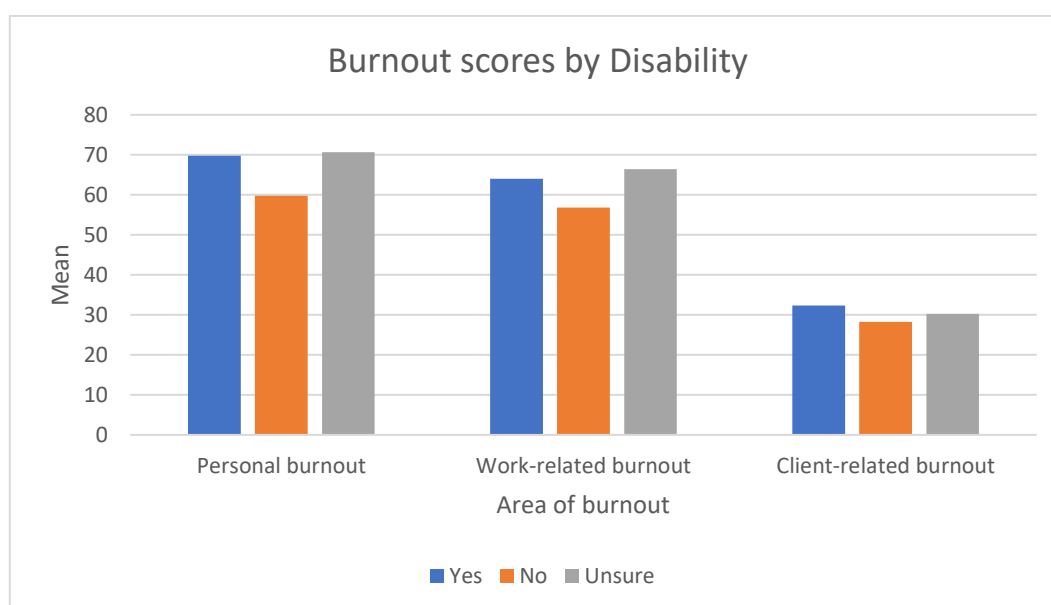


Table A5.21: Mean Burnout Scores by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	69.01	58.89	80.35
Work-related burnout	65.49	54.5	69.13
Client-related burnout	27.06	24.9	40.01

Table A5.22: Mean Burnout Scores by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	69.74	59.78	70.68
Work-related burnout	63.99	56.78	66.41
Client-related burnout	32.34	28.27	30.25

Figure A5.43: Level of Personal Burnout by Disability (Weighted)

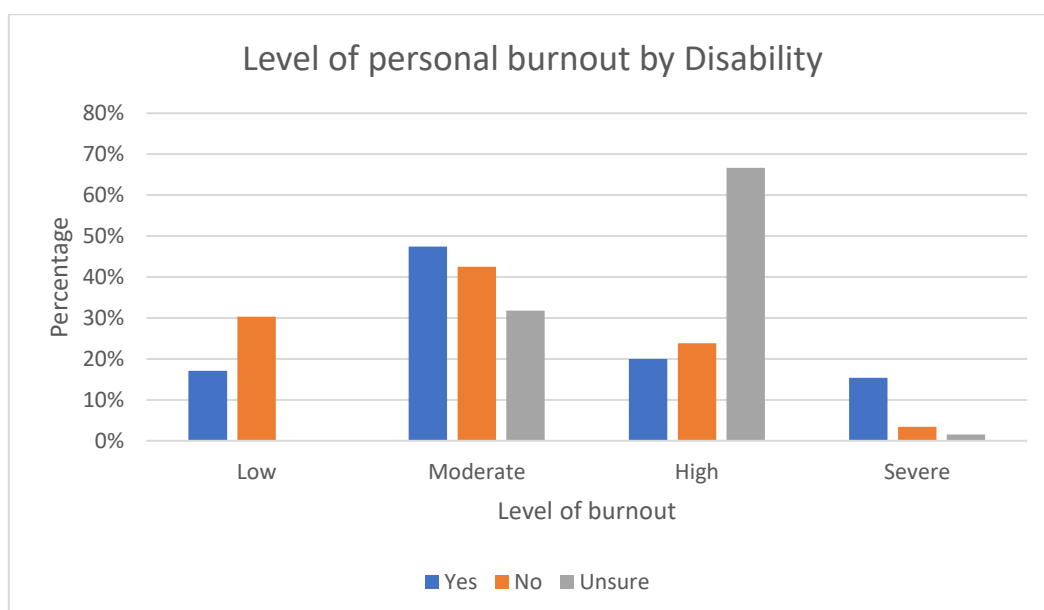


Figure A5.44: Level of Personal Burnout by Disability (Unweighted)

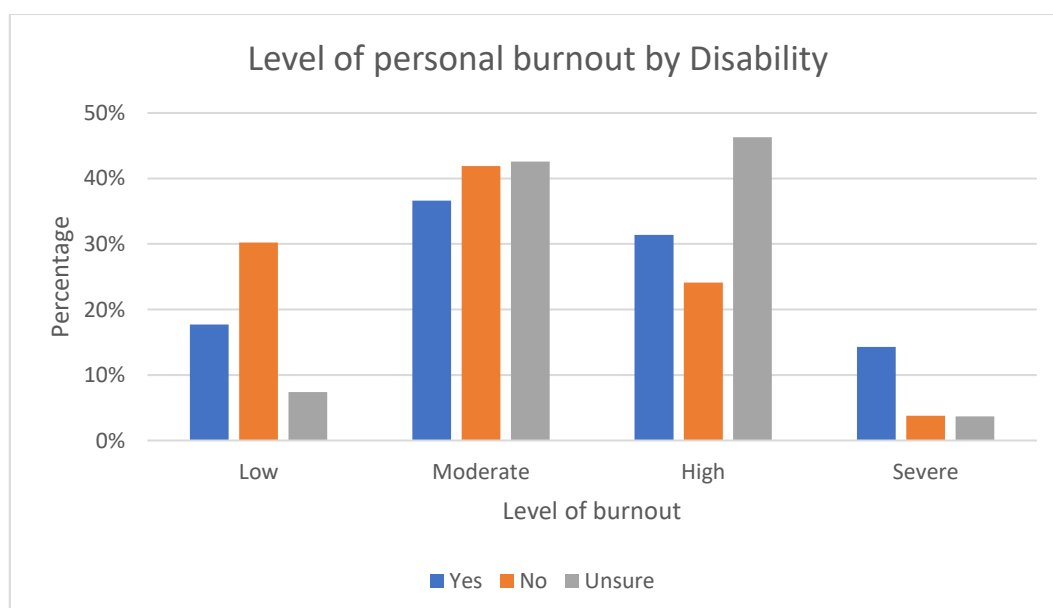


Figure A5.45: Level of Work-Related Burnout by Disability (Weighted)

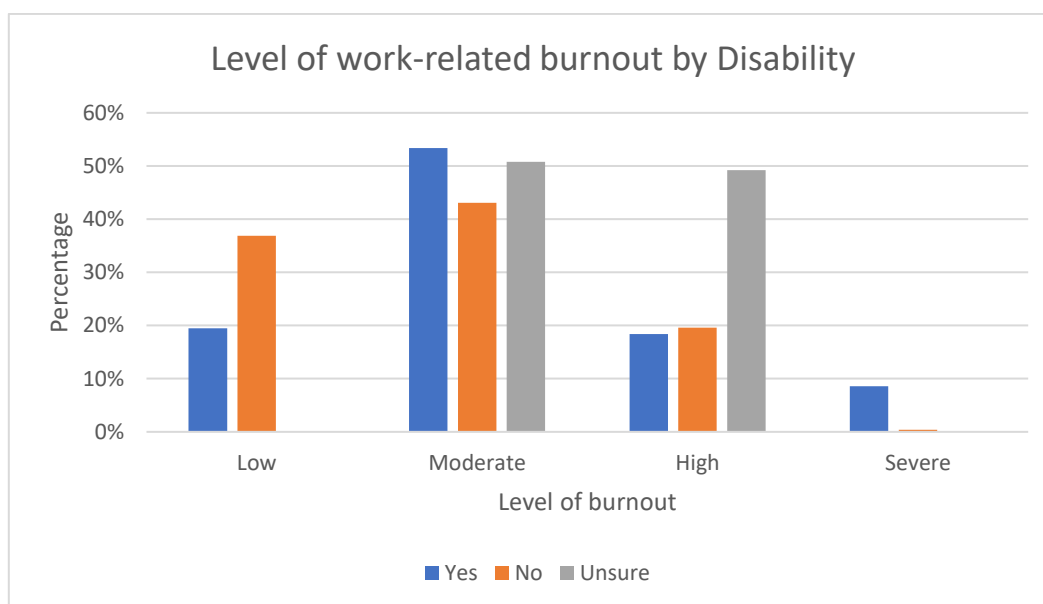


Figure A5.46: Level of Work-Related Burnout by Disability (Unweighted)

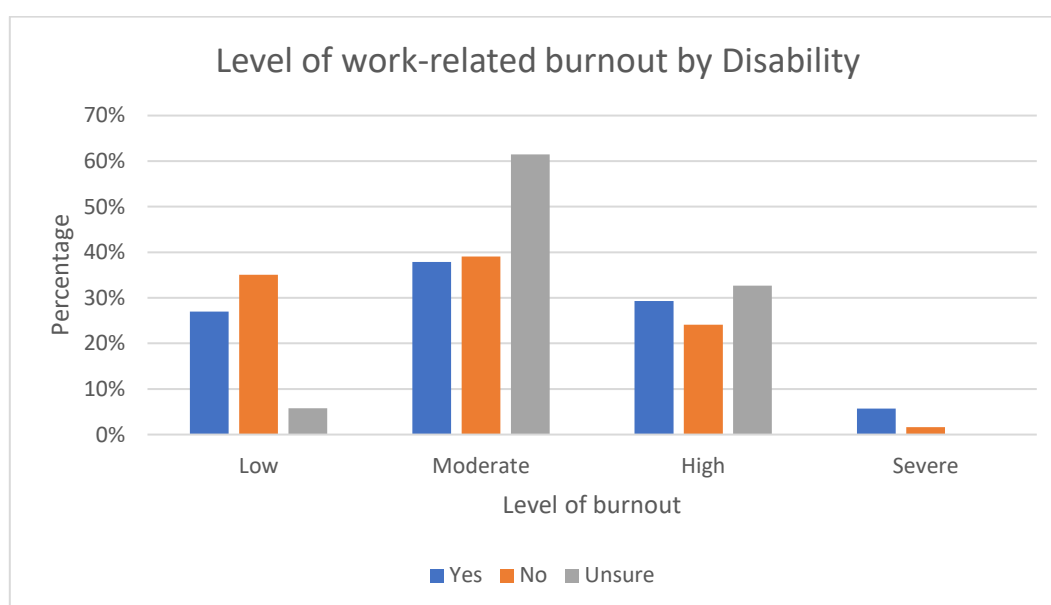


Figure A5.47: Level of Client-Related Burnout by Disability (Weighted)

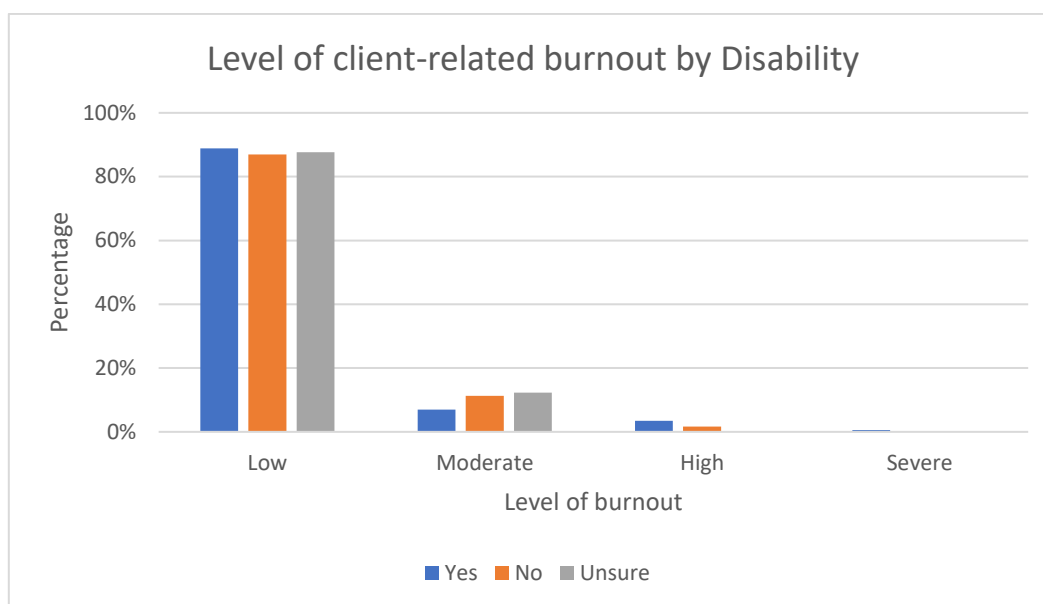


Figure A5.48: Level of Client-Related Burnout by Disability (Unweighted)

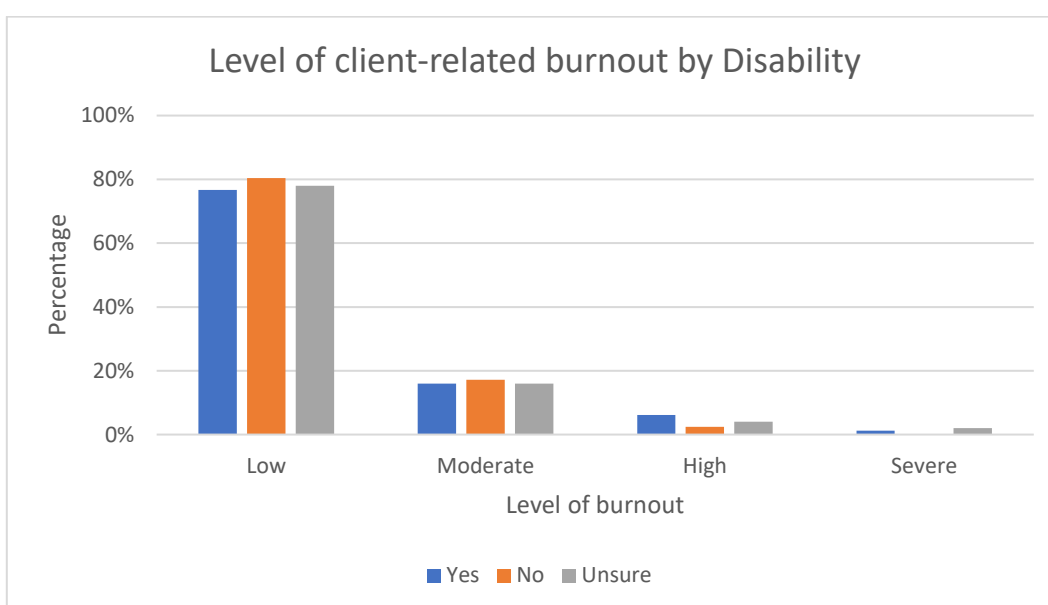


Table A5.23: Level of Burnout by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
<b>Personal burnout:</b>			
Low	17.1%	30.3%	0.0%
Moderate	47.4%	42.5%	31.8%
High	20.0%	23.8%	66.7%
Severe	15.4%	3.4%	1.5%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>			
Low	19.5%	36.9%	0.0%
Moderate	53.4%	43.1%	50.8%
High	18.4%	19.6%	49.2%
Severe	8.6%	0.4%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>			
Low	88.9%	87.0%	87.7%
Moderate	7.0%	11.3%	12.3%
High	3.5%	1.7%	0.0%
Severe	0.6%	0.0%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Table A5.24: Level of Burnout by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
<b>Personal burnout:</b>			
Low	31 (17.7%)	377 (30.2%)	4 (7.4%)
Moderate	64 (36.6%)	523 (41.9%)	23 (42.6%)
High	55 (31.4%)	301 (24.1%)	25 (46.3%)
Severe	25 (14.3%)	48 (3.8%)	2 (3.7%)
<b>Total</b>	<b>175 (100%)</b>	<b>1249 (100%)</b>	<b>54 (100%)</b>
<b>Work-related burnout:</b>			
Low	47 (27.0%)	434 (35.1%)	3 (5.8%)
Moderate	66 (37.9%)	483 (39.1%)	32 (61.5%)
High	51 (29.3%)	298 (24.1%)	17 (32.7%)
Severe	10 (5.7%)	20 (1.6%)	0 (0.0%)
<b>Total</b>	<b>174 (100%)</b>	<b>1235 (100%)</b>	<b>52 (100%)</b>
<b>Client-related burnout:</b>			
Low	125 (76.7%)	912 (80.4%)	39 (78.0%)
Moderate	26 (16.0%)	195 (17.2%)	8 (16.0%)
High	10 (6.1%)	27 (2.4%)	2 (4.0%)
Severe	2 (1.2%)	1 (0.1%)	1 (2.0%)
<b>Total</b>	<b>163 (100%)</b>	<b>1135 (100%)</b>	<b>50 (100%)</b>

## 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 ( $F = 41.269$ ,  $df = 7$ ,  $p < .001$ ). Specifically, respondents working with children and young people scored significantly lower in personal burnout than those working in midwifery, with adults of working age, with older people, in mental health or in the area of 'other'.

There were also significant differences between respondents based on their main area of practice in mean work-related burnout scores ( $F = 27.855$ ,  $df = 7$ ,  $p < .001$ ). Specifically, respondents working with children and young people scored significantly lower in personal burnout than those working in midwifery, with adults of working age, with older people, in mental health or in the area of 'other'.

Significant differences were also found in the mean client-related burnout scores ( $F = 21.087$ ,  $df = 7$ ,  $p < .001$ ). Respondents working with adults of working age scored higher than those working with children and young people, in learning disability, with older people and in the area of practice 'other'.

### Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean personal burnout scores ( $F = 4.121$ ,  $df = 7$ ,  $p < .001$ ). Specifically, respondents working in midwifery scored significantly higher than those working with children and young people, adults of working age, those working in the area learning disability, with older people, in the area of mental health or those in 'other' areas.

There were significant differences between respondents based on their main area of practice in mean work-related burnout scores ( $F = 3.464$ ,  $df = 7$ ,  $p < .001$ ). Specifically, respondents working in midwifery scored significantly higher than those working with children and young people, adults of working age, those working in the area learning disability, with older people, in the area of mental health or those in 'other' areas.

There were significant differences between respondents based on their main area of practice in mean work-related burnout scores ( $F = 2.811$ ,  $df = 7$ ,  $p = .007$ ), however multiple comparisons revealed no significant difference between the areas of practice.



Figure A5.49: Mean Burnout Scores by Main Area of Practice (Weighted)

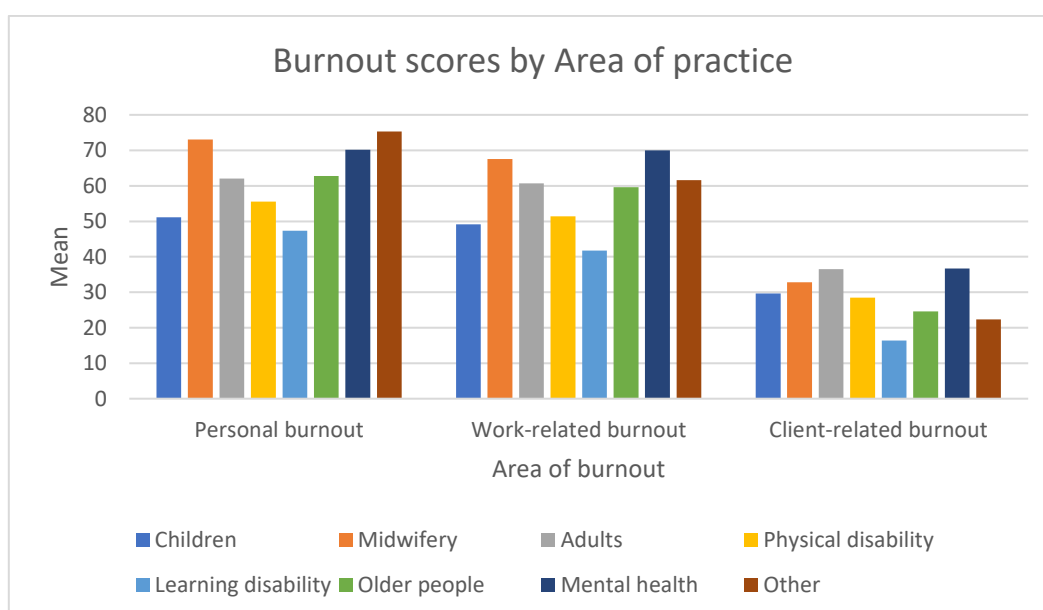


Figure A5.50: Mean Burnout Scores by Main Area of Practice (Unweighted)

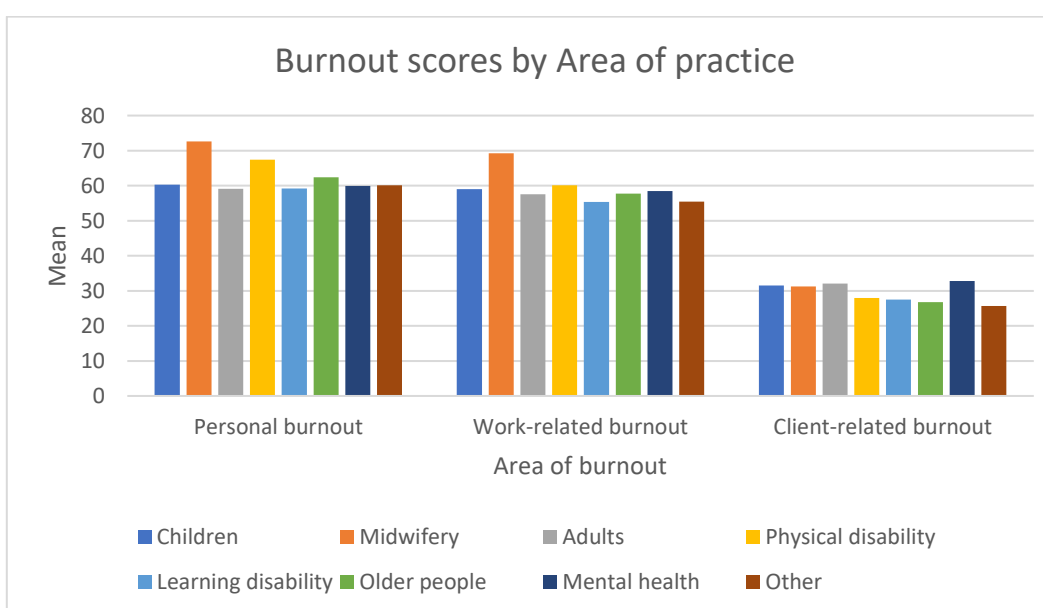


Table A5.25: Mean Burnout Scores by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout	51.17	73.01	62.05	55.59	47.30	62.81	70.19	75.30
Work-related burnout	49.17	67.54	60.71	51.43	41.72	59.58	69.96	61.63
Client-related burnout	29.66	32.81	36.51	28.48	16.40	24.62	36.70	22.34

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	60.30	72.63	59.13	67.39	59.19	62.35	59.89	60.07
Work-related burnout	59.01	69.20	57.51	60.09	55.32	57.70	58.44	55.45
Client-related burnout	31.55	31.25	32.06	27.98	27.50	26.79	32.81	25.67

Figure A5.51: Level of Personal Burnout by Main Area of Practice (Weighted)

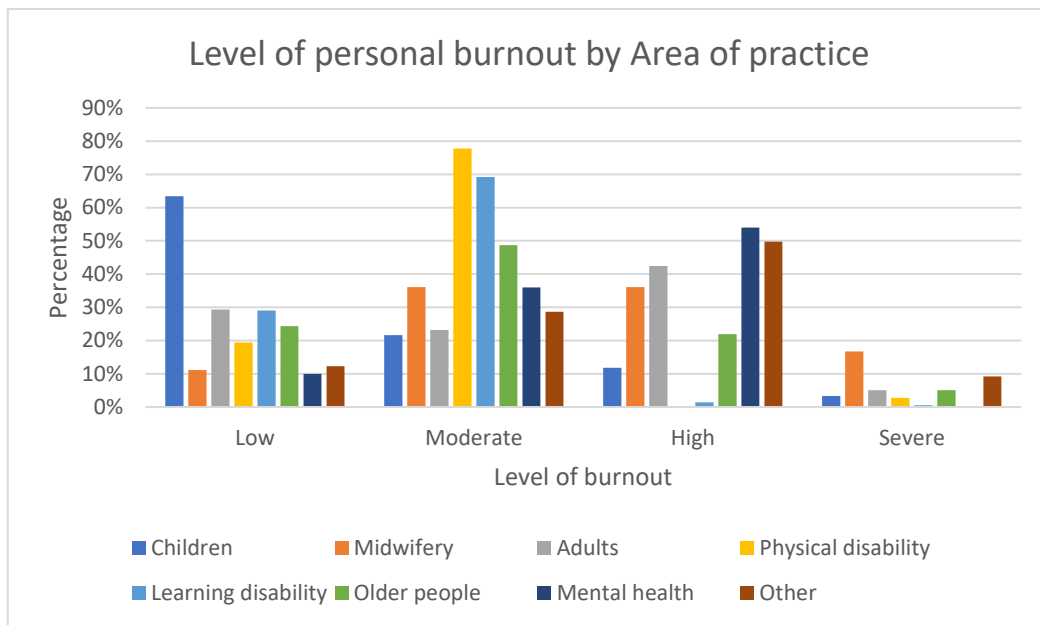


Figure A5.52: Level of Personal Burnout by Main Area of Practice (Unweighted)

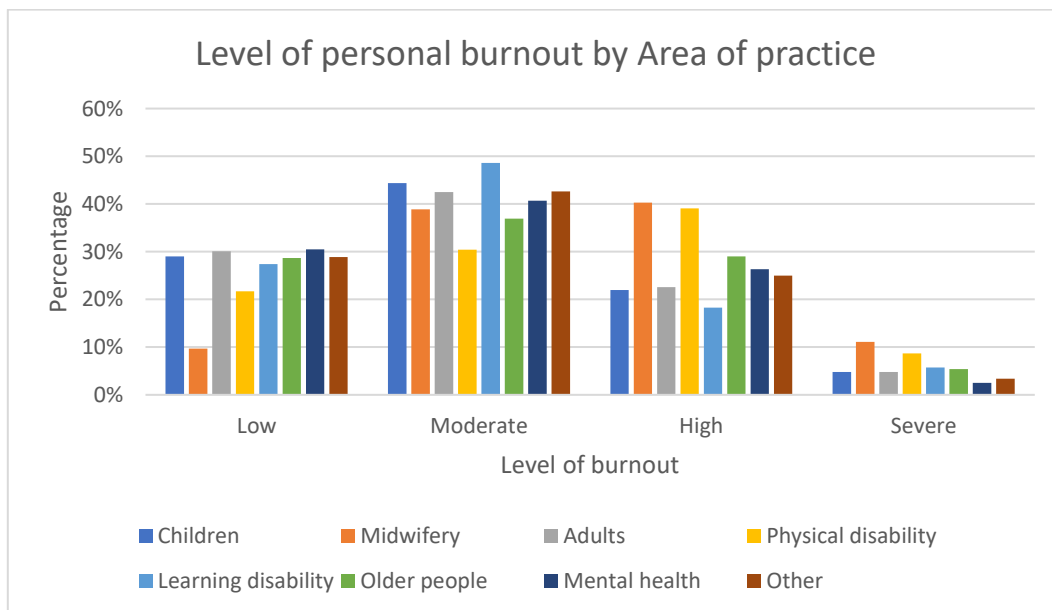


Figure A5.53: Level of Work-Related Burnout by Main Area of Practice (Weighted)

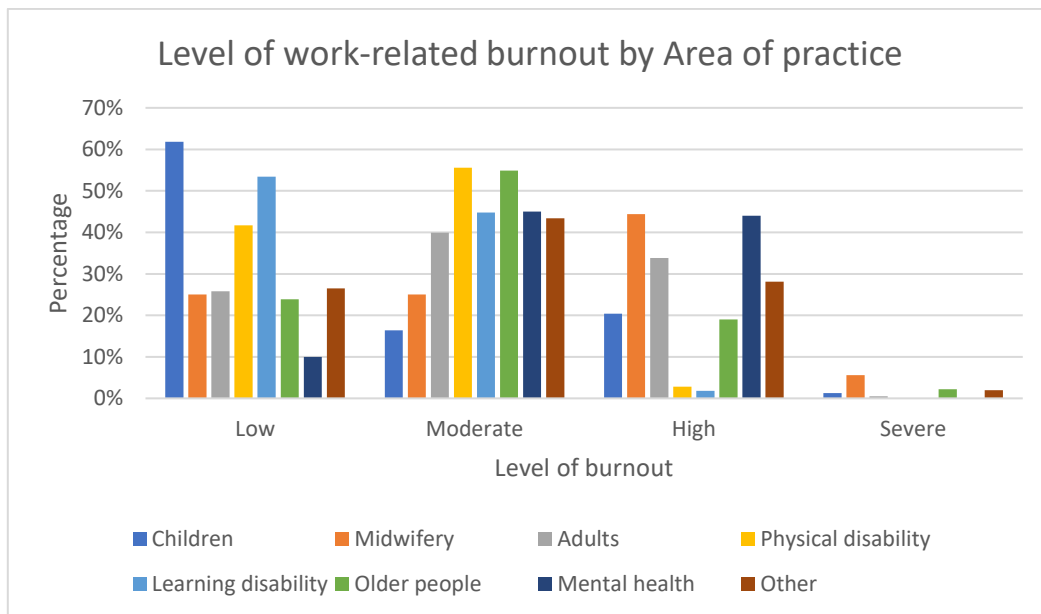


Figure A5.54: Level of Work-Related Burnout by Main Area of Practice (Unweighted)

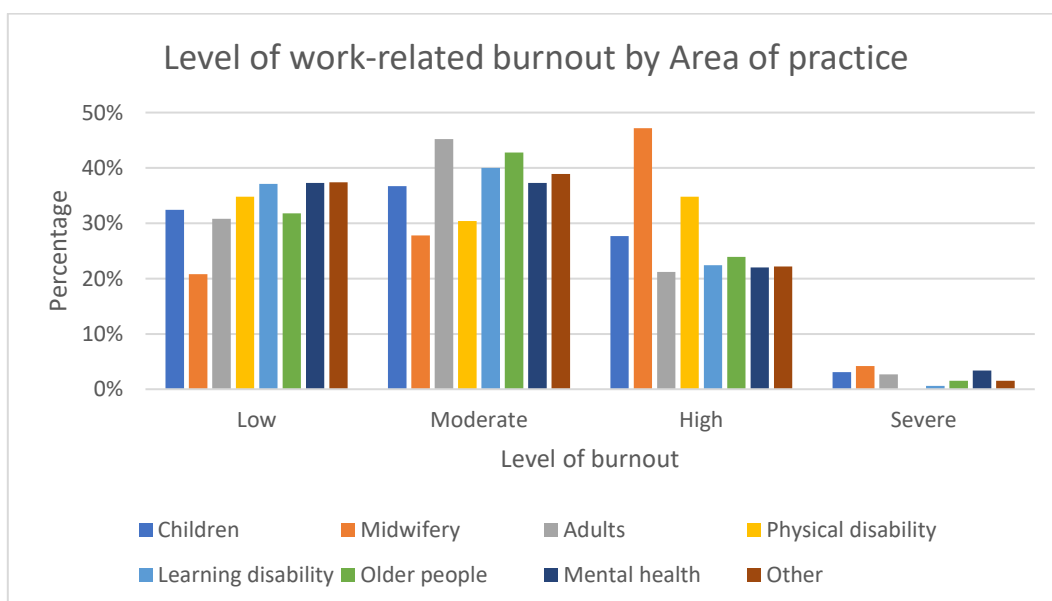


Figure A5.55: Level of Client-Related Burnout by Main Area of Practice (Weighted)

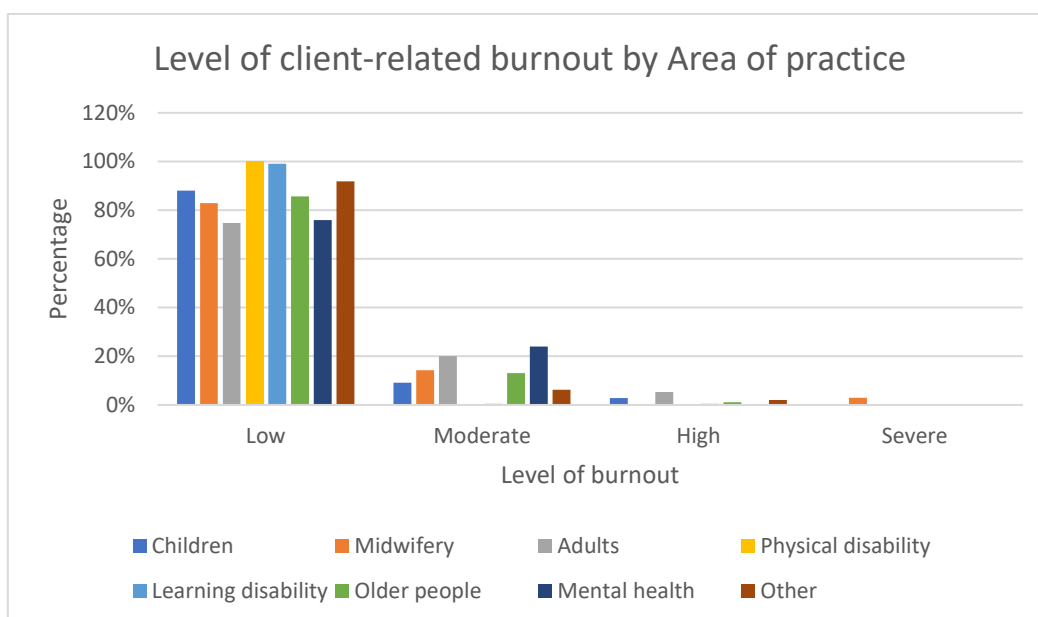


Figure A5.56: Level of Client-Related Burnout by Main Area of Practice (Unweighted)

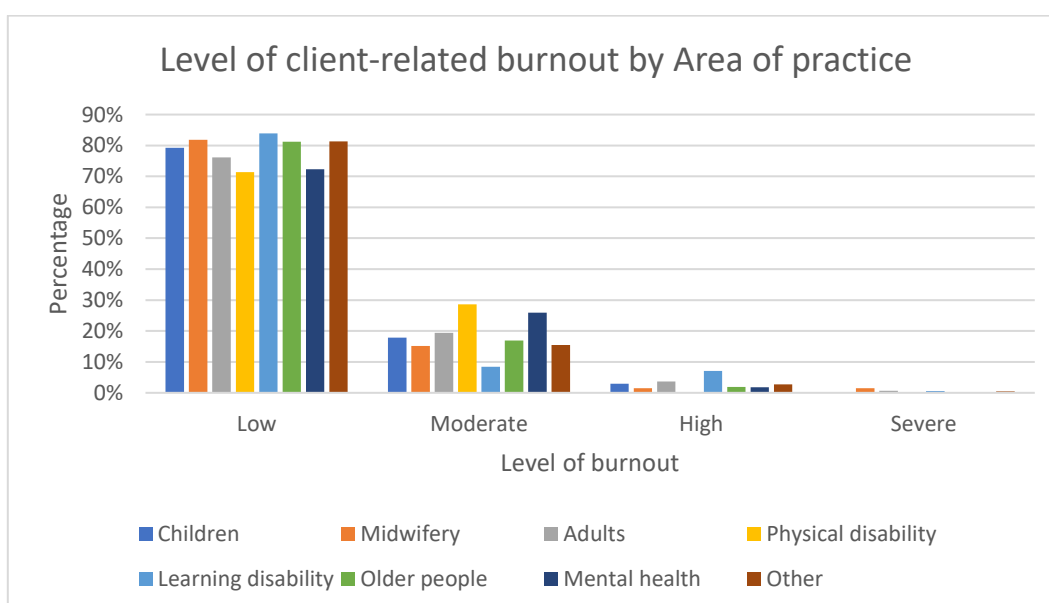


Table A5.27: Level of Burnout by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
<b>Personal burnout:</b>								
Low	63.4%	11.1%	29.3%	19.4%	29.0%	24.3%	10.0%	12.3%
Moderate	21.6%	36.1%	23.2%	77.8%	69.2%	48.7%	36.0%	28.7%
High	11.8%	36.1%	42.4%	0.0%	1.4%	21.9%	54.0%	49.7%
Severe	3.3%	16.7%	5.1%	2.8%	0.5%	5.1%	0.0%	9.2%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>								
Low	61.8%	25.0%	25.8%	41.7%	53.4%	23.9%	10.0%	26.5%
Moderate	16.4%	25.0%	39.9%	55.6%	44.8%	54.9%	45.0%	43.4%
High	20.4%	44.4%	33.8%	2.8%	1.8%	19.0%	44.0%	28.1%
Severe	1.3%	5.6%	0.5%	0.0%	0.0%	2.2%	0.0%	2.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>								
Low	88.1%	82.9%	74.7%	100.0%	99.1%	85.7%	76.0%	91.8%
Moderate	9.1%	14.3%	20.0%	0.0%	0.5%	13.1%	24.0%	6.2%
High	2.8%	0.0%	5.3%	0.0%	0.5%	1.1%	0.0%	2.1%
Severe	0.0%	2.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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
<b>Personal burnout:</b>								
Low	75 (29.0%)	7 (9.7%)	44 (30.1%)	5 (21.7%)	48 (27.4%)	138 (28.7%)	36 (30.5%)	59 (28.9%)
Moderate	115 (44.4%)	28 (38.9%)	62 (42.5%)	7 (30.4%)	85 (48.6%)	177 (36.9%)	48 (40.7%)	87 (42.6%)
High	57 (22.0%)	29 (40.3%)	33 (22.6%)	9 (39.1%)	32 (18.3%)	139 (29.0%)	31 (26.3%)	51 (25.0%)
Severe	12 (4.8%)	8 (11.1%)	7 (4.8%)	2 (8.7%)	10 (5.7%)	26 (5.4%)	3 (2.5%)	7 (3.4%)
<b>Total</b>	<b>259 (100%)</b>	<b>72 (100%)</b>	<b>146 (100%)</b>	<b>23 (100%)</b>	<b>175 (100%)</b>	<b>480 (100%)</b>	<b>118 (100%)</b>	<b>204 (100%)</b>
<b>Work-related burnout:</b>								
Low	(32.4%)	(20.8%)	(30.8%)	(34.8%)	(37.1%)	(31.8%)	(37.3%)	(37.4%)
Moderate	(36.7%)	(27.8%)	(45.2%)	(30.4%)	(40.0%)	(42.8%)	(37.3%)	(38.9%)
High	(27.7%)	(47.2%)	(21.2%)	(34.8%)	(22.4%)	(23.9%)	(22.0%)	(22.2%)
Severe	(3.1%)	(4.2%)	(2.7%)	(0.0%)	(0.6%)	(1.5%)	(3.4%)	(1.5%)
<b>Total</b>	<b>259 (100%)</b>	<b>72 (100%)</b>	<b>146 (100%)</b>	<b>23 (100%)</b>	<b>170 (100%)</b>	<b>472 (100%)</b>	<b>118 (100%)</b>	<b>203 (100%)</b>
<b>Client-related burnout:</b>								
Low	192 (79.3%)	54 (81.8%)	102 (76.1%)	15 (71.4%)	130(83.9%)	350 (81.2%)	81 (72.3%)	152 (81.3%)
Moderate	43 (17.8%)	10 (15.2%)	26 (19.4%)	6 (28.6%)	13 (8.4%)	73 (16.9%)	29 (25.9%)	29 (15.5%)
High	7 (2.9%)	1 (1.5%)	5 (3.7%)	0 (0.0%)	11 (7.1%)	8 (1.9%)	2 (1.8%)	5 (2.7%)
Severe	0 (0.0%)	1 (1.5%)	1 (0.7%)	0 (0.0%)	1 (0.6%)	0 (0.0%)	0 (0.0%)	1 (0.5%)
<b>Total</b>	<b>242 (100%)</b>	<b>66 (100%)</b>	<b>134 (100%)</b>	<b>21 (100%)</b>	<b>155 (100%)</b>	<b>431 (100%)</b>	<b>112 (100%)</b>	<b>187 (100%)</b>

## 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 person burnout scores ( $t = -5.532$ ,  $df = 1424.359$ ,  $p < .001$ ); line managers scored significantly lower than respondents who were not line managers.

There were no significant differences between respondents based on their line manager status in mean work-related burnout scores ( $t = -1.366$ ,  $df = 1429$ ,  $p = .172$ ). There were also no significant differences between respondents based on their line manager status in mean client-related burnout scores ( $t = -1.666$ ,  $df = 1382$ ,  $p = .096$ ).

### Summary (Unweighted results):

There were no significant differences between respondents based on their line manager status in mean personal burnout scores ( $t = .123$ ,  $df = 1476$ ,  $p = .902$ ). There were no significant differences between respondents based on their line manager status in mean work-related burnout scores ( $t = 1.048$ ,  $df = 1459$ ,  $p = .295$ ).

There were significant differences between respondents based on their line manager status in mean client-related burnout scores ( $t = -2.545$ ,  $df = 1346$ ,  $p = .006$ ); 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)

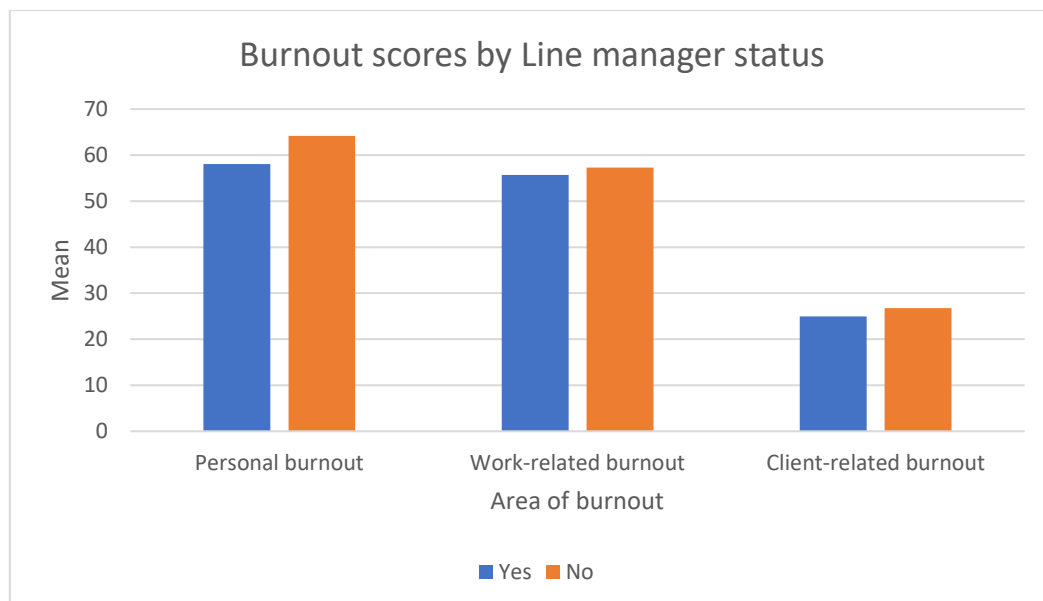




Figure A5.58: Mean Burnout Scores by Line Manager Status (Unweighted)

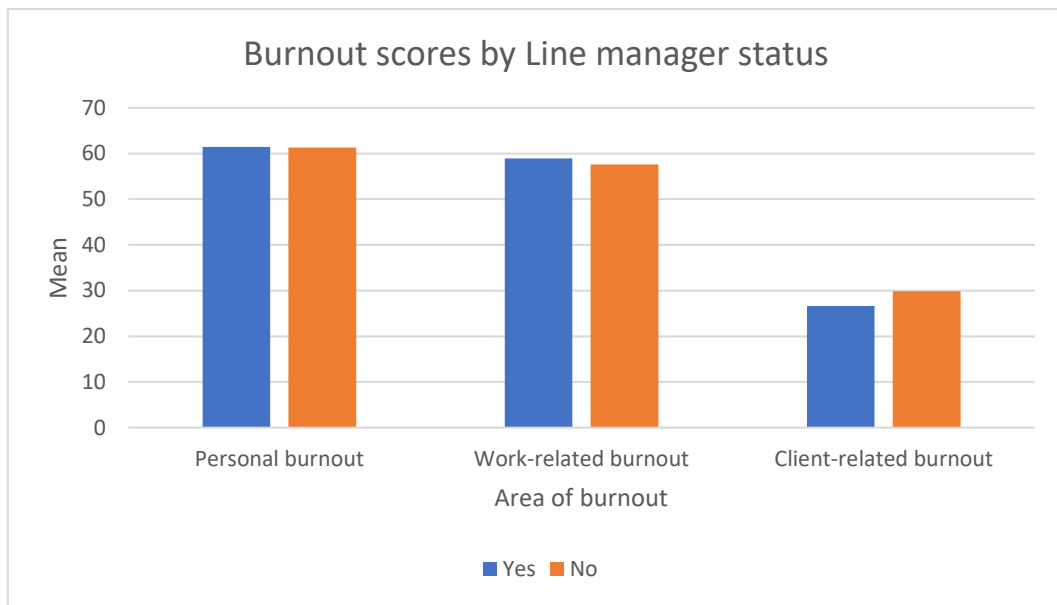


Table A5.29: Mean Burnout Scores by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	58.05	64.20
Work-related burnout	55.71	57.32
Client-related burnout	24.98	26.78

Table A5.30: Mean Burnout Scores by Line Manager Status (Unweighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	61.46	61.31
Work-related burnout	58.91	57.58
Client-related burnout	26.60	29.85

Figure A5.59: Level of Personal Burnout by Line Manager Status (Weighted)

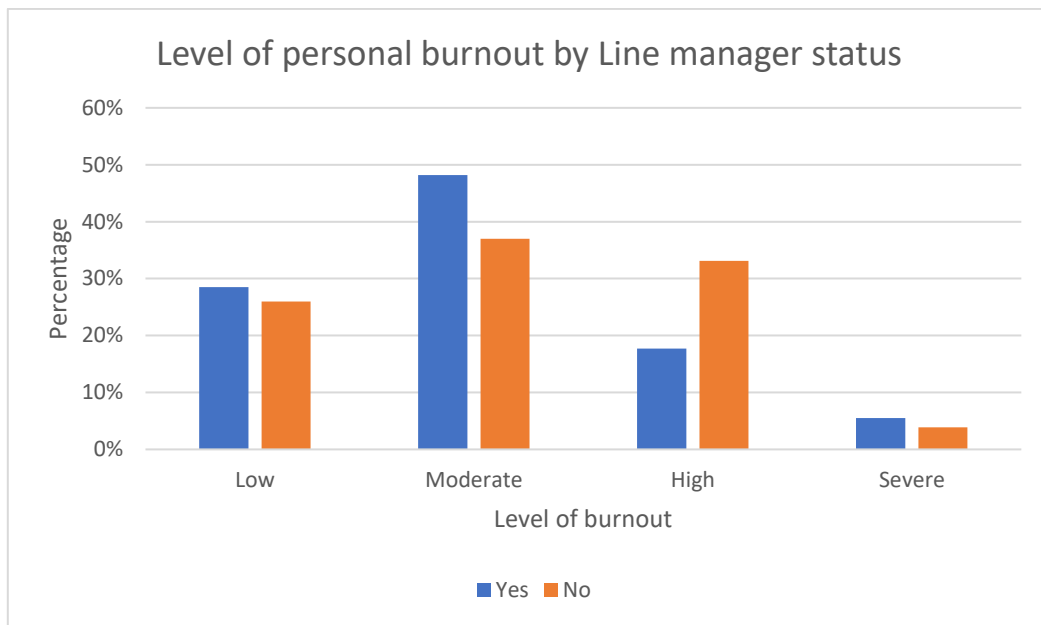


Figure A5.60: Level of Personal Burnout by Line Manager Status (Unweighted)

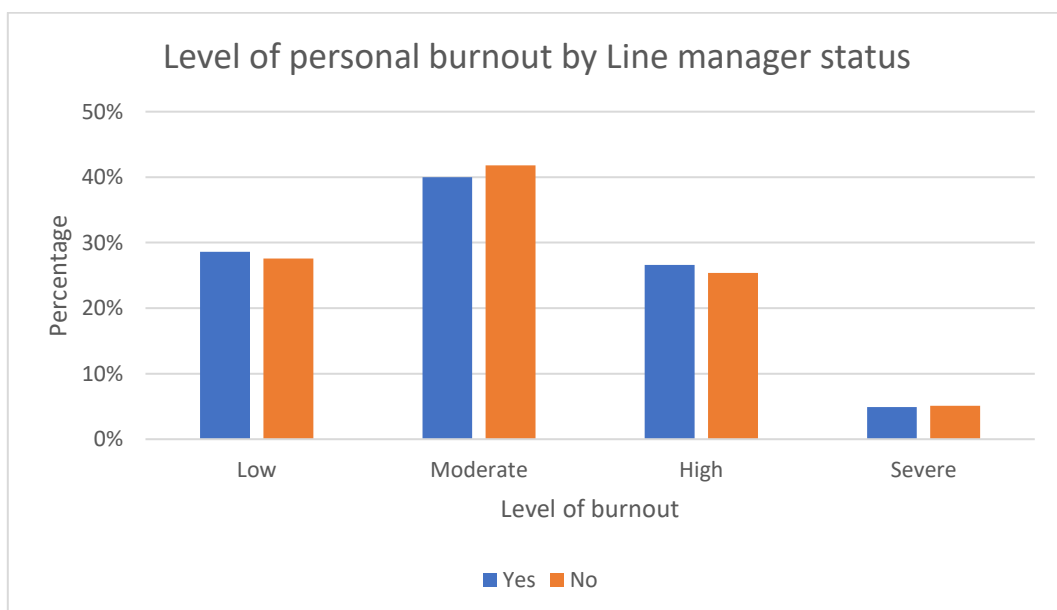


Figure A5.61: Level of Work-Related Burnout by Line Manager Status (Weighted)

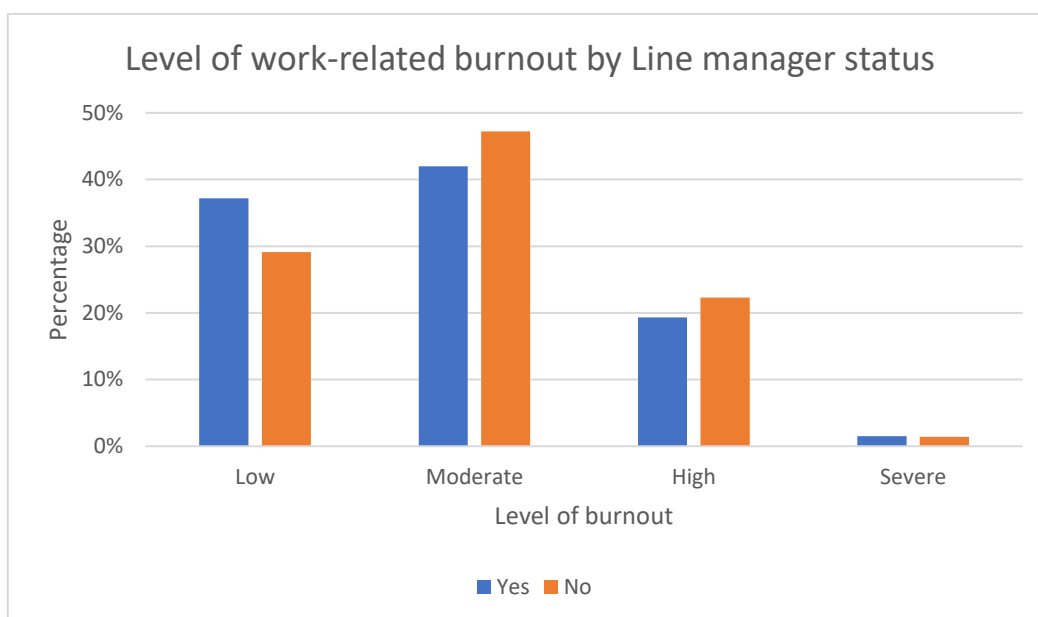


Figure A5.62: Level of Work-Related Burnout by Line Manager Status (Unweighted)

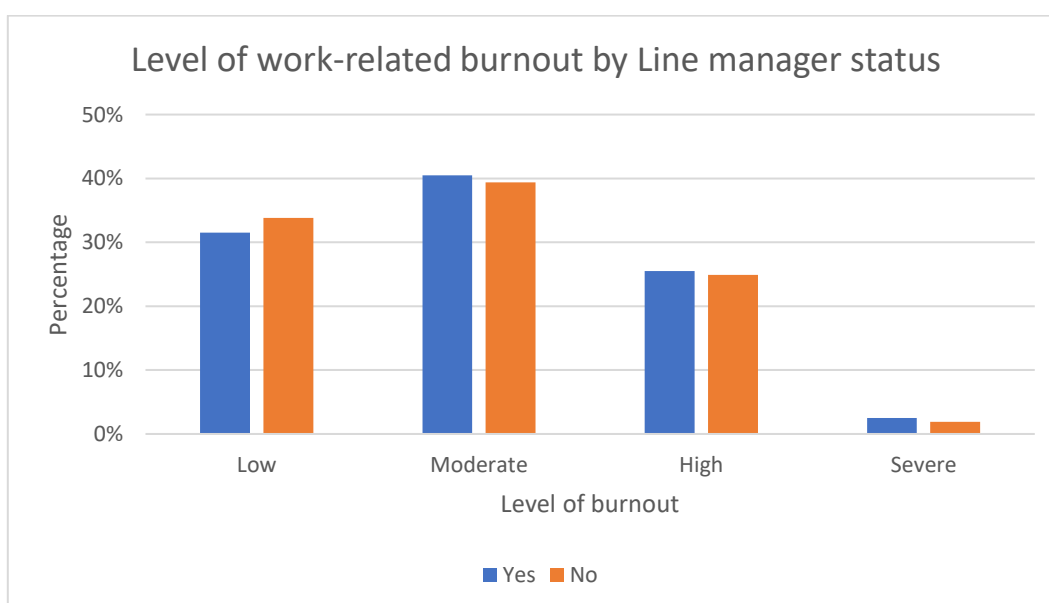


Figure A5.63: Level of Client-Related Burnout by Line Manager Status (Weighted)

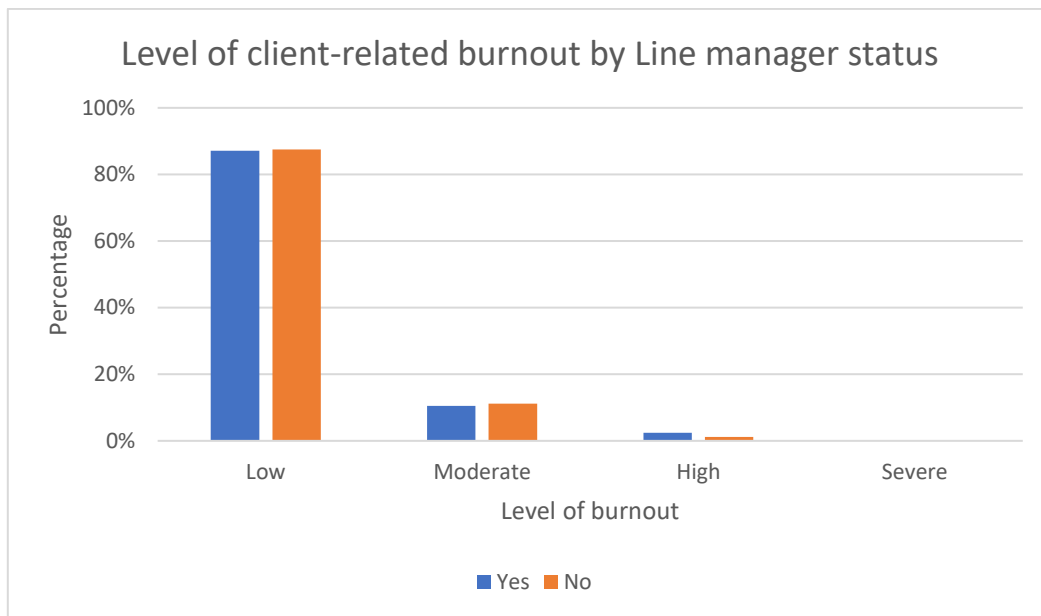


Figure A5.64: Level of Client-Related Burnout by Line Manager Status (Unweighted)

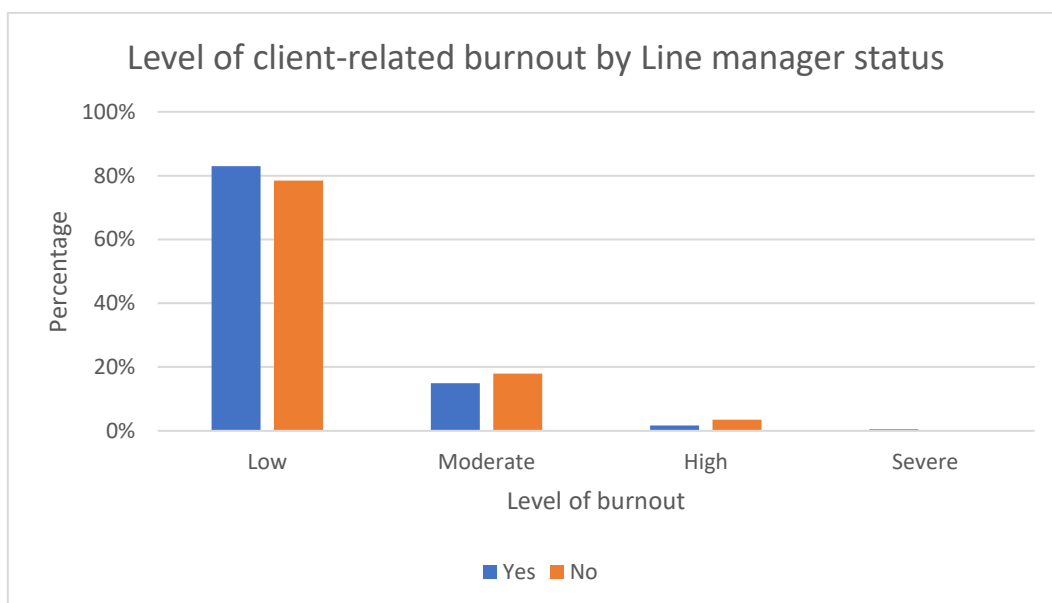


Table A5.31: Level of Burnout by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
<b>Personal burnout:</b>		
Low	28.5%	26.0%
Moderate	48.2%	37.0%
High	17.7%	33.1%
Severe	5.5%	3.9%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>		
Low	37.2%	29.1%
Moderate	42.0%	47.2%
High	19.3%	22.3%
Severe	1.5%	1.4%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>		
Low	87.1%	87.5%
Moderate	10.5%	11.2%
High	2.4%	1.2%
Severe	0.0%	0.1%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>

Table A5.32: Level of Burnout by Line Manager Status (Unweighted)

Burnout	Are you a line manager?	
	Yes	No
<b>Personal burnout:</b>		
Low	128 (28.6%)	284 (27.6%)
Moderate	179 (40.0%)	431 (41.8%)
High	119 (26.6%)	262 (25.4%)
Severe	22 (4.9%)	53 (5.1%)
<b>TOTAL</b>	<b>448 (100%)</b>	<b>1030 (100%)</b>
<b>Work-related burnout:</b>		
Low	141 (31.5%)	343 (33.8%)
Moderate	181 (40.5%)	400 (39.4%)
High	114 (25.5%)	252 (24.9%)
Severe	11 (2.5%)	19 (1.9%)
<b>TOTAL</b>	<b>447 (100%)</b>	<b>1014 (100%)</b>
<b>Client-related burnout:</b>		
Low	351 (83.0%)	725 (78.4%)
Moderate	63 (14.9%)	166 (17.9%)
High	7 (1.7%)	32 (3.5%)
Severe	2 (0.5%)	2 (0.2%)
<b>TOTAL</b>	<b>423 (100%)</b>	<b>925 (100%)</b>

### 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 ( $F = 129.00$ ,  $df = 2$ ,  $p < .001$ ). Specifically, those who overwhelmed scored significantly higher than those not impacted and those only impacted but not significantly.

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 ( $F =$

158.359 df = 2,  $p < .001$ ). Specifically, those who overwhelmed scored significantly higher than those not impacted and those only impacted but not significantly.

There were no significant differences in mean client-related burnout scores between respondents were also found ( $F = .196$ , df = 2,  $p = .822$ ).

### 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 ( $F = 88.613$ , 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.

There were also significant differences in work-related burnout scores between respondents who experienced different levels of pressure on their service ( $F = 111.772$ , 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.

Significant differences existed in client-related burnout scores between respondents who experienced different levels of pressure on their service were also found ( $F = 7.957$ , df = 2,  $p < .001$ ). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than those who were impacted but not significantly.

Figure A5.65: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

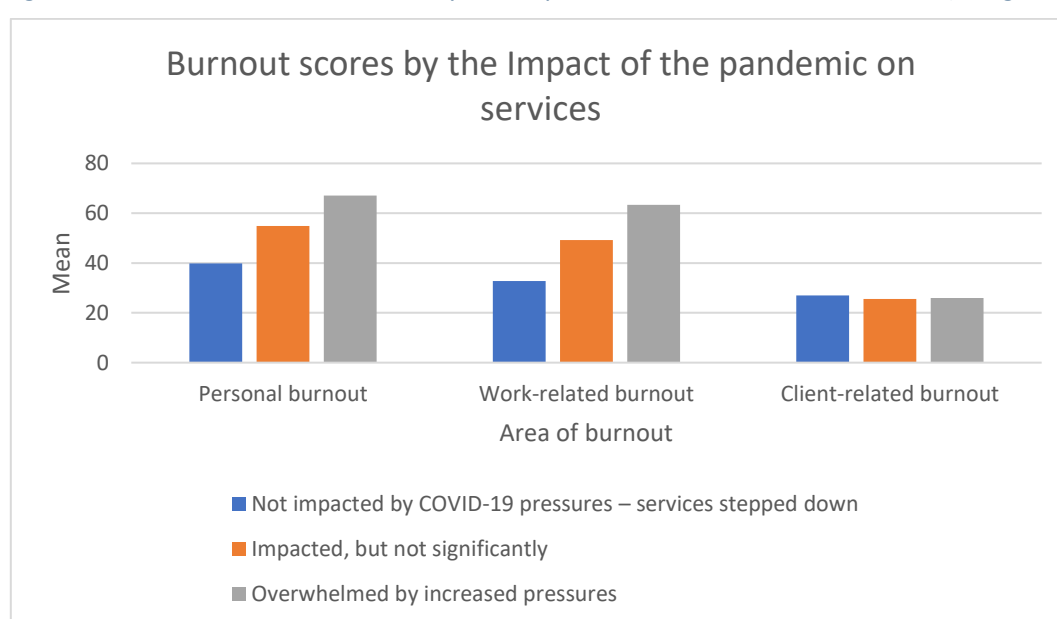


Figure A5.66: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

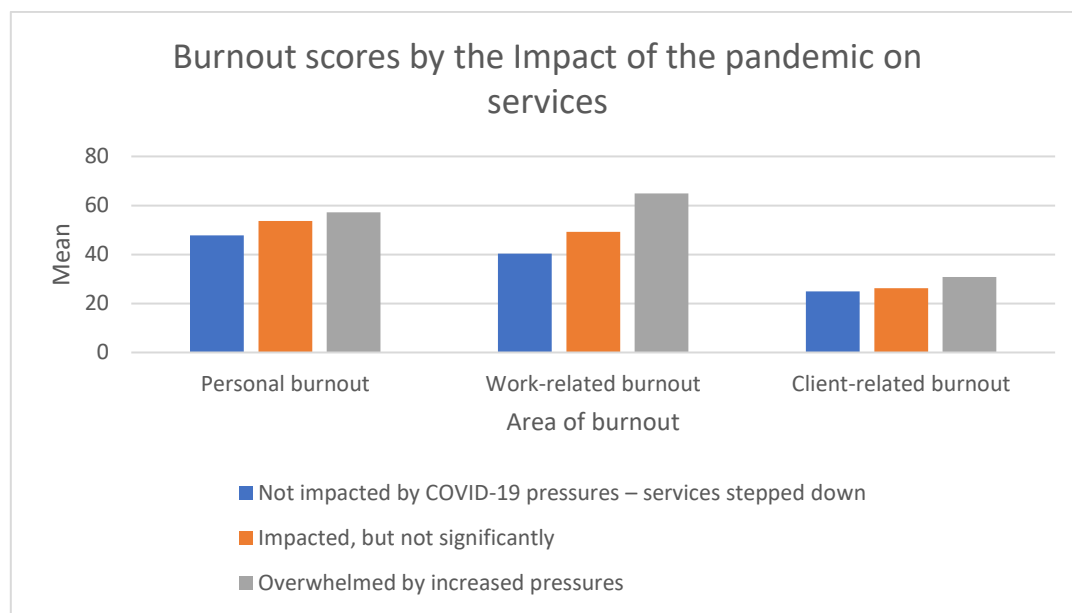


Table A5.33: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

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	39.77	54.86	67.08
Work-related burnout	32.73	49.16	63.37
Client-related burnout	27.00	25.58	25.91

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	47.74	53.73	57.24
Work-related burnout	40.30	49.27	64.84
Client-related burnout	24.90	26.18	30.85



Figure A5.67: Level of Personal Burnout by the Impact of the Pandemic on Services (Weighted)

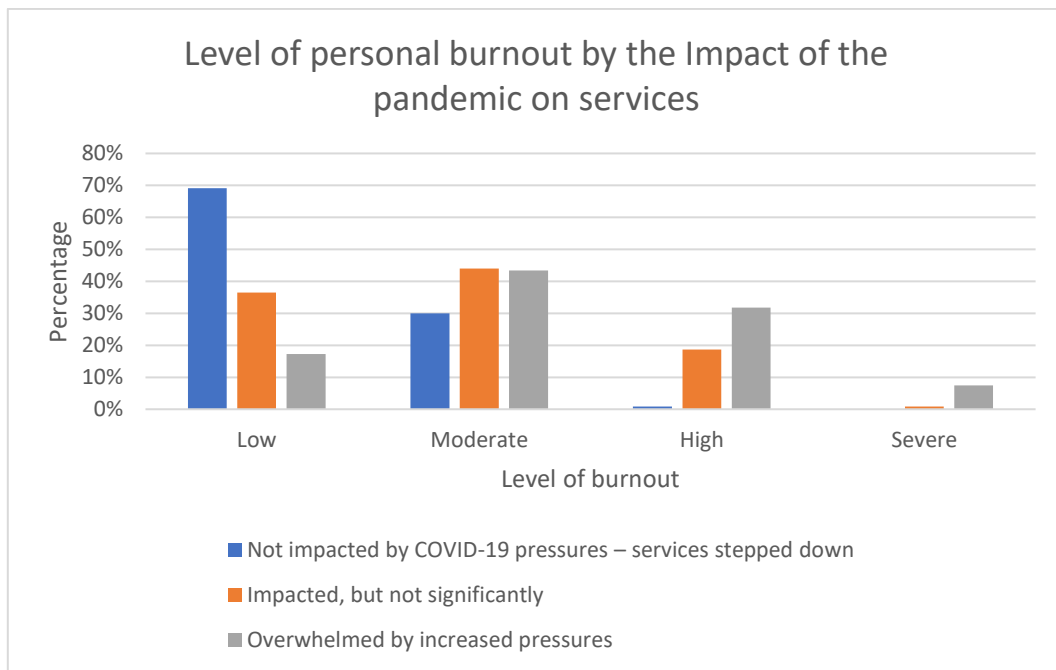


Figure A5.68: Level of Personal Burnout by the Impact of the Pandemic on Services (Unweighted)

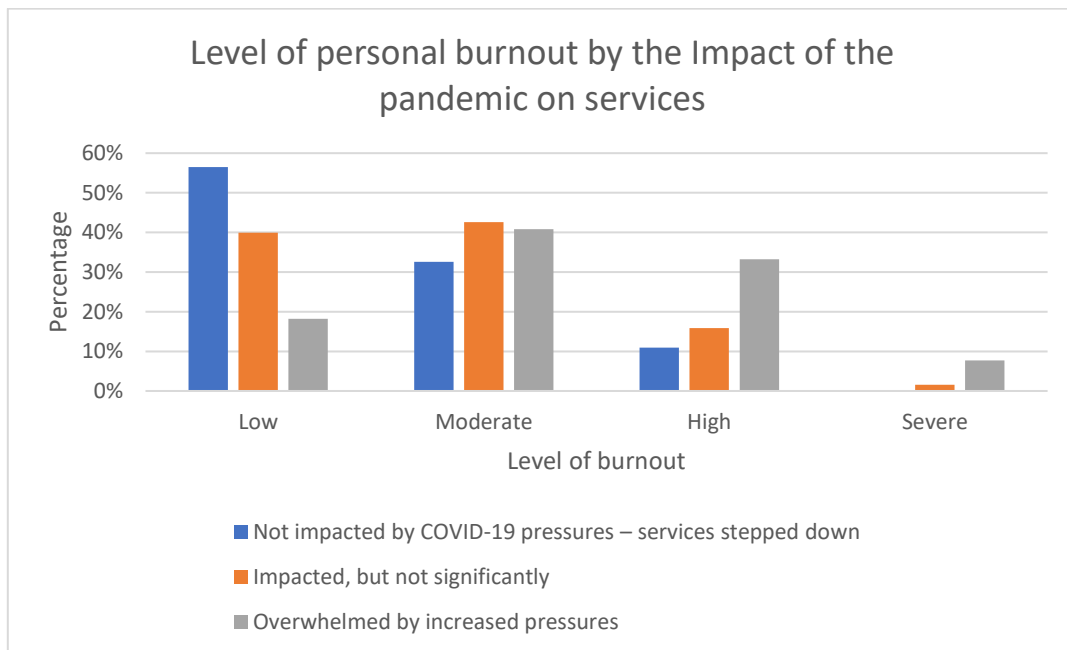


Figure A5.69: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Weighted)

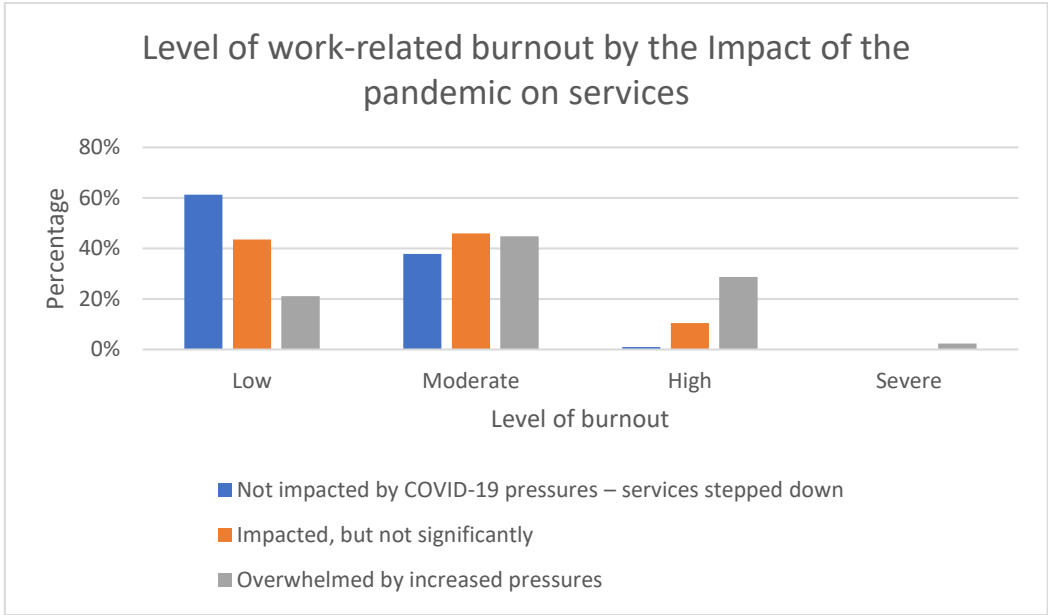


Figure A5.70: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

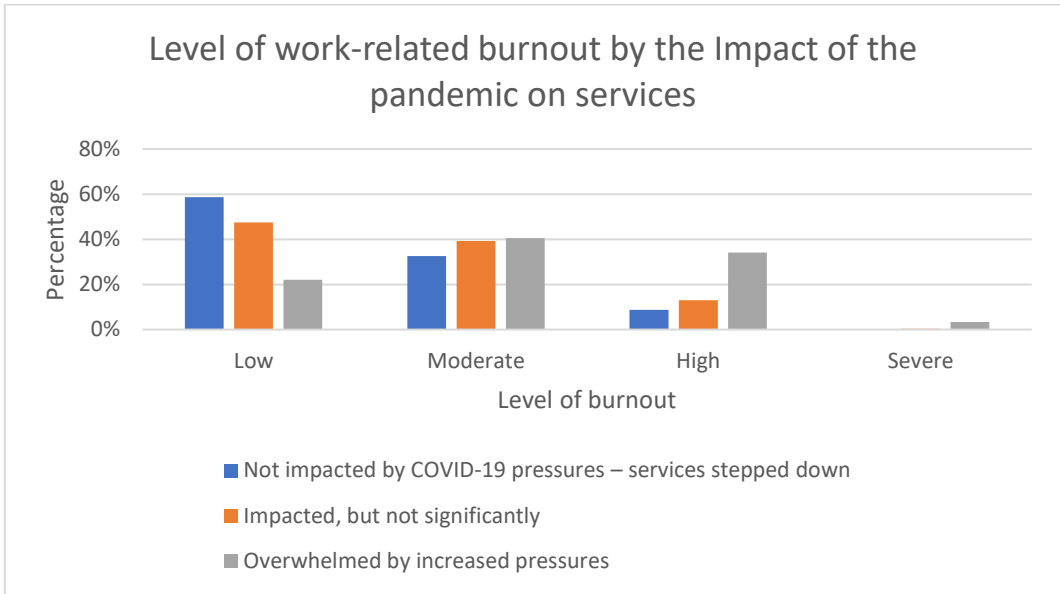


Figure A5.71: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Weighted)

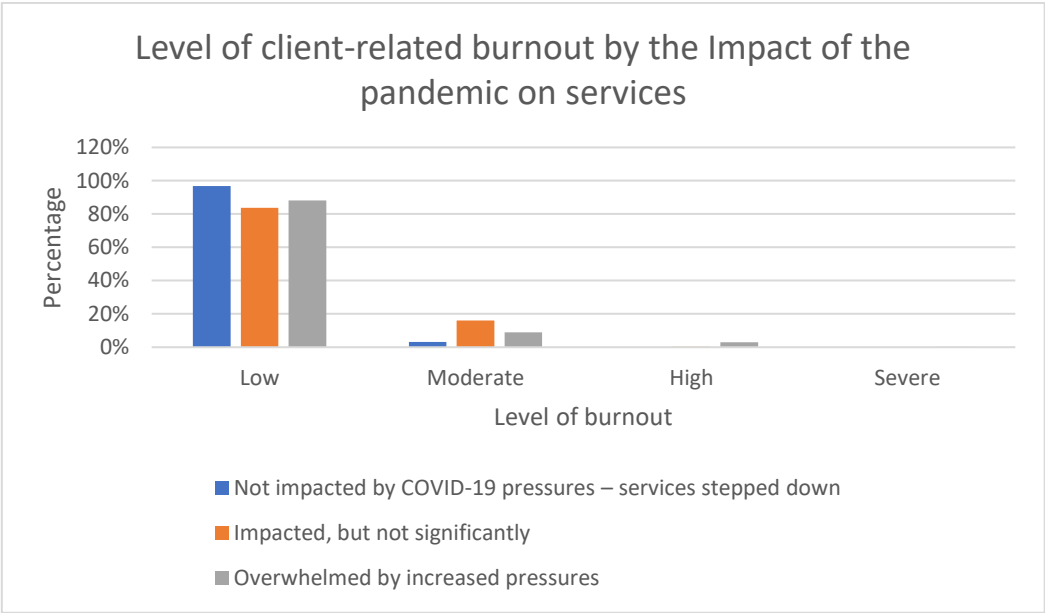


Figure A5.72: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

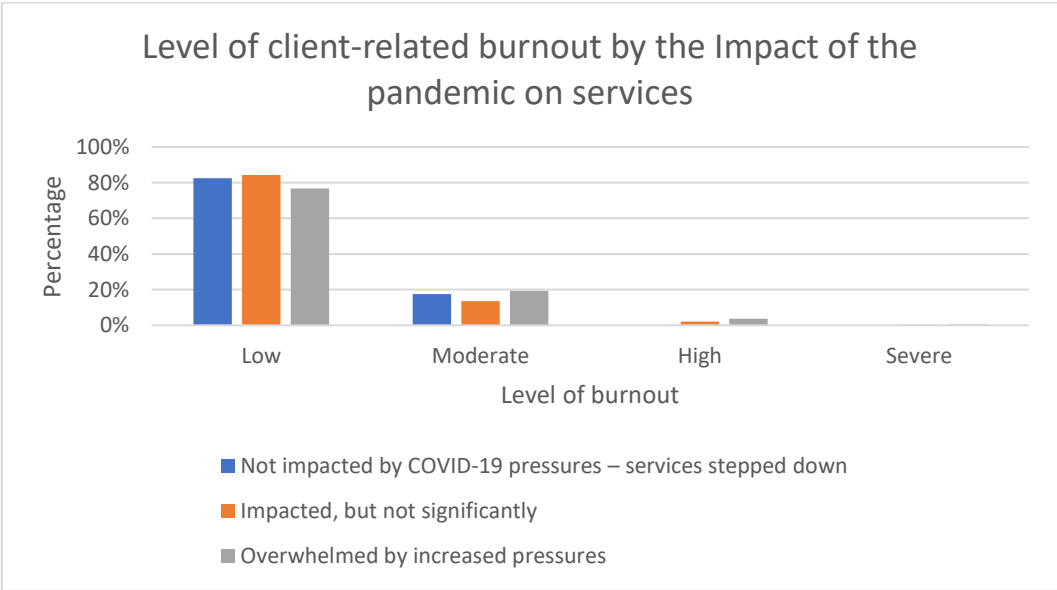


Table A5.35: Level of Burnout by the Impact of the Pandemic on Services (Weighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
<b>Personal burnout:</b>			
Low	69.1%	36.5%	17.3%
Moderate	30.0%	44.0%	43.4%
High	0.9%	18.7%	31.8%
Severe	0.0%	0.9%	7.5%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>			
Low	61.3%	43.5%	21.1%
Moderate	37.8%	45.9%	44.8%
High	0.9%	10.5%	28.7%
Severe	0.0%	0.0%	2.4%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>			
Low	96.8%	83.8%	88.1%
Moderate	3.2%	16.0%	8.9%
High	0.0%	0.2%	2.9%
Severe	0.0%	0.0%	0.1%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

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
<b>Personal burnout:</b>			
Low	26 (56.5%)	230 (39.9%)	156 (18.2%)
Moderate	15 (32.6%)	246 (42.6%)	349 (40.8%)
High	5 (10.9%)	92 (15.9%)	284 (33.2%)
Severe	0 (0.0%)	9 (1.6%)	66 (7.7%)
<b>TOTAL</b>	<b>46 (100%)</b>	<b>577 (100%)</b>	<b>855 (100%)</b>
<b>Work-related burnout:</b>			
Low	27 (58.7%)	271 (47.5%)	186 (22.0%)
Moderate	15 (32.6%)	224 (39.2%)	342 (40.5%)
High	4 (8.7%)	74 (13.0%)	288 (34.1%)
Severe	0 (0.0%)	2 (0.4%)	28 (3.3%)
<b>TOTAL</b>	<b>46 (100%)</b>	<b>571 (100%)</b>	<b>844 (100%)</b>
<b>Client-related burnout:</b>			
Low	33 (82.5%)	447 (84.2%)	596 (76.7%)
Moderate	7 (17.5%)	72 (13.6%)	150 (19.3%)
High	0 (0.0%)	11 (2.1%)	28 (3.6%)
Severe	0 (0.0%)	1 (0.2%)	3 (0.4%)
<b>TOTAL</b>	<b>40 (100%)</b>	<b>531 (100%)</b>	<b>777 (100%)</b>

### A5.10 Burnout Scores by Uptake of Employer Support

#### Summary (Weighted results):

There were no significant differences between respondents based on their line manager status in mean person burnout scores ( $t = -1.517$ ,  $df = 711.237$ ,  $p = .130$ ).

There were no significant differences between respondents based on their line manager status in mean work-related burnout scores ( $t = -1.235$ ,  $df = 881.330$ ,  $p = .217$ ).

There were also no significant differences between respondents based on their line manager status in mean client-related burnout scores ( $t = 1.863$ ,  $df = 1382$ ,  $p = .063$ ).

### Summary (Unweighted results):

There were significant differences in personal burnout scores between respondents based on whether they took on employer support or not ( $t = .3.087$ ,  $df = 1475$ ,  $p = .002$ ). Respondents who took employer support reported higher scores of personal burnout.

There were significant differences in work-related burnout scores between respondents based on whether they took on employer support or not ( $t = 2.664$ ,  $df = 1458$ ,  $p = .008$ ). Respondents who took employer support reported higher scores of work-related burnout.

There were no significant differences in client-related burnout scores between respondents based on whether they took on employer support or not ( $t = .684$ ,  $df = 1346$ ,  $p = .494$ ).

Figure A5. 73: Mean Burnout Scores by Uptake of Employer Support (Weighted)

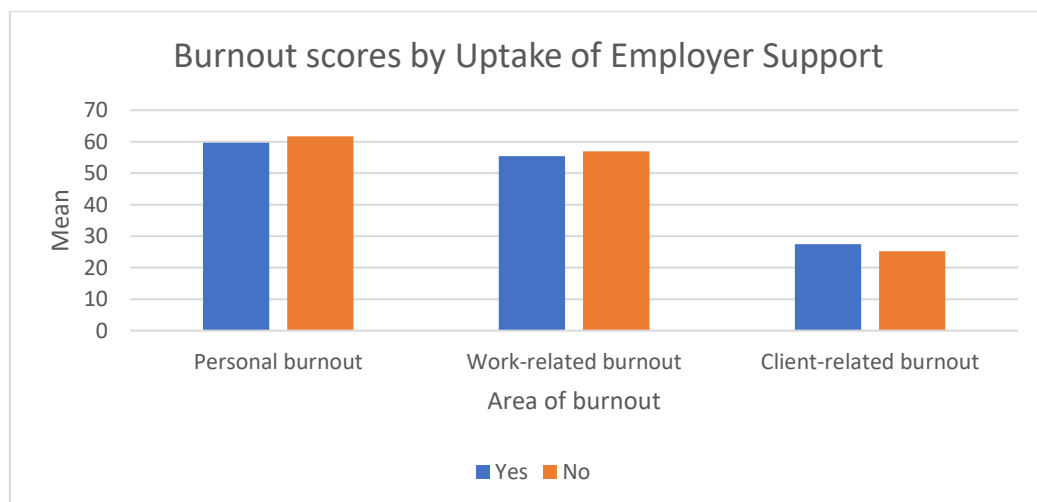


Figure A5. 74: Mean Burnout Scores by Uptake of Employer Support (Unweighted)

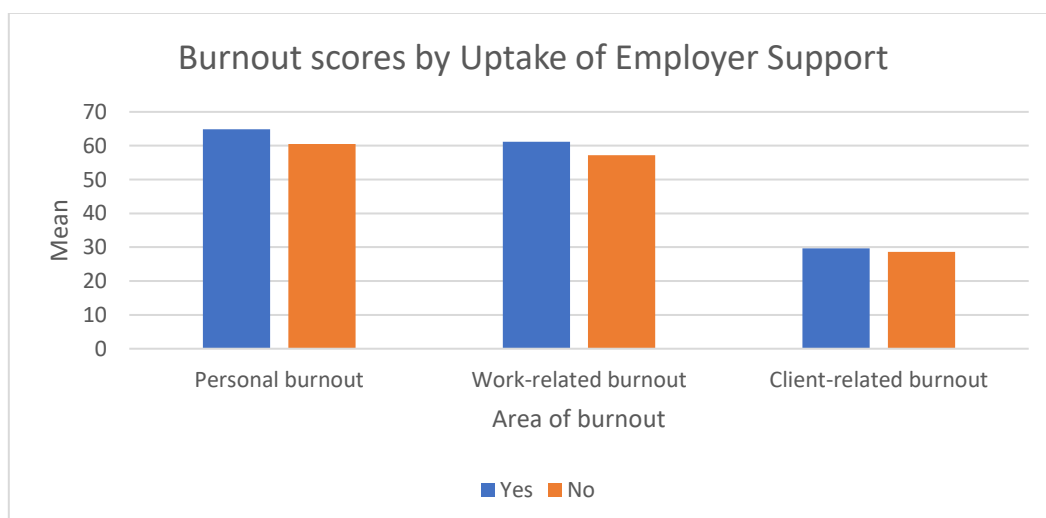


Table A5. 37: Mean Burnout Scores by Uptake of Employer Support (Weighted)

Burnout	Uptake of Employer Support	
	Yes	No
Personal burnout	59.72	61.66
Work-related burnout	55.44	56.94
Client-related burnout	27.45	25.23

Table A5. 38: Mean Burnout Scores by Uptake of Employer Support (Unweighted)

Burnout	Uptake of Employer Support	
	Yes	No
Personal burnout	64.82	60.54
Work-related burnout	61.13	57.22
Client-related burnout	29.64	28.63

Figure A5. 75: Level of Personal Burnout by Uptake of Employer Support (Weighted)

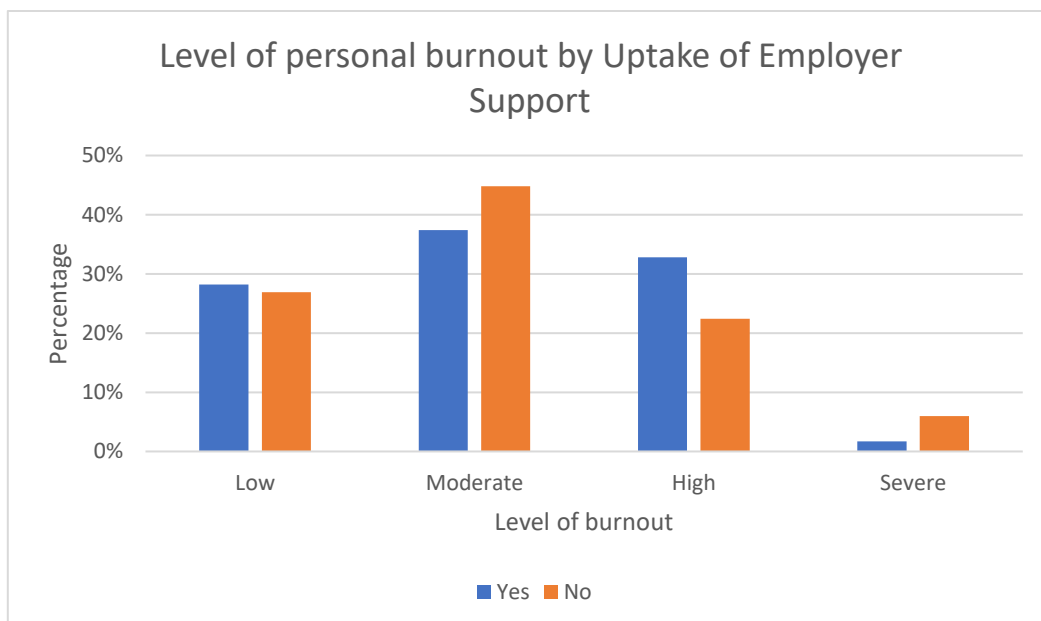


Figure A5.76: Level of Personal Burnout by Uptake of Employer Support Unweighted)

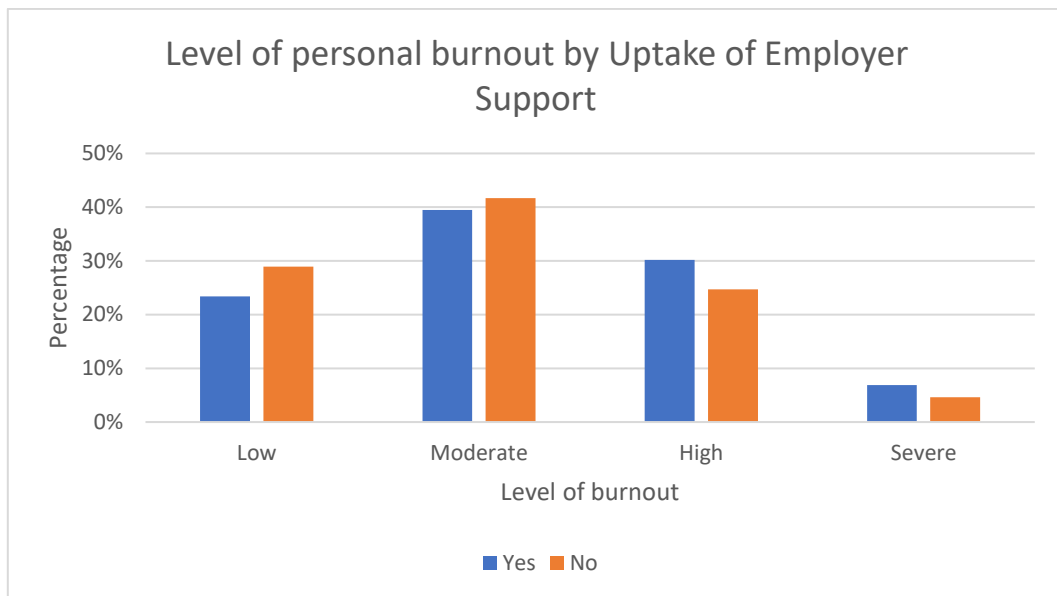


Figure A5. 77: Level of Work-Related Burnout by Uptake of Employer Support (Weighted)

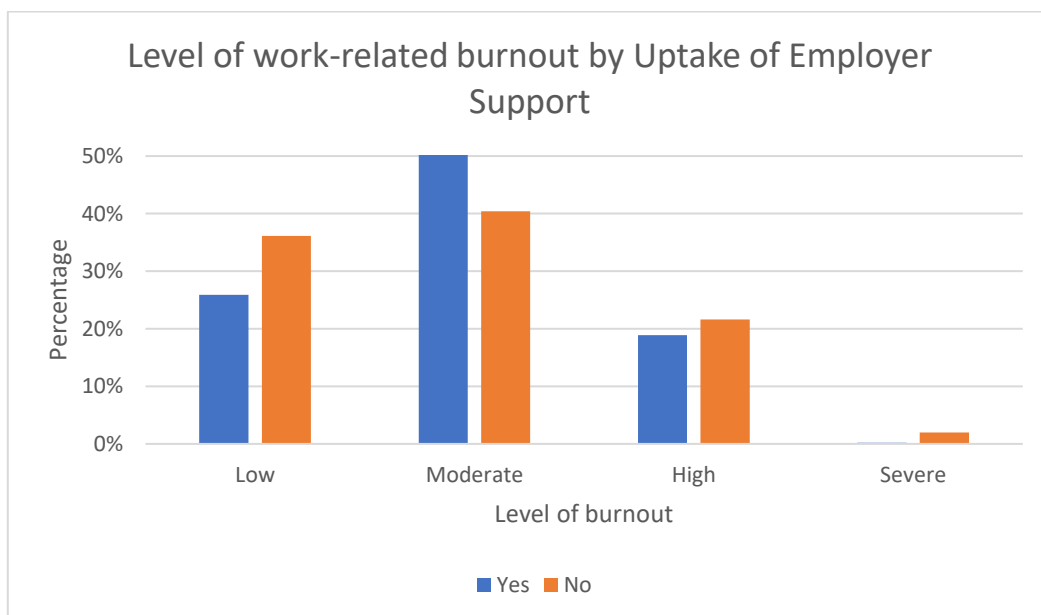




Figure A5. 78: Level of Work-Related Burnout by Uptake of Employer Support (Unweighted)

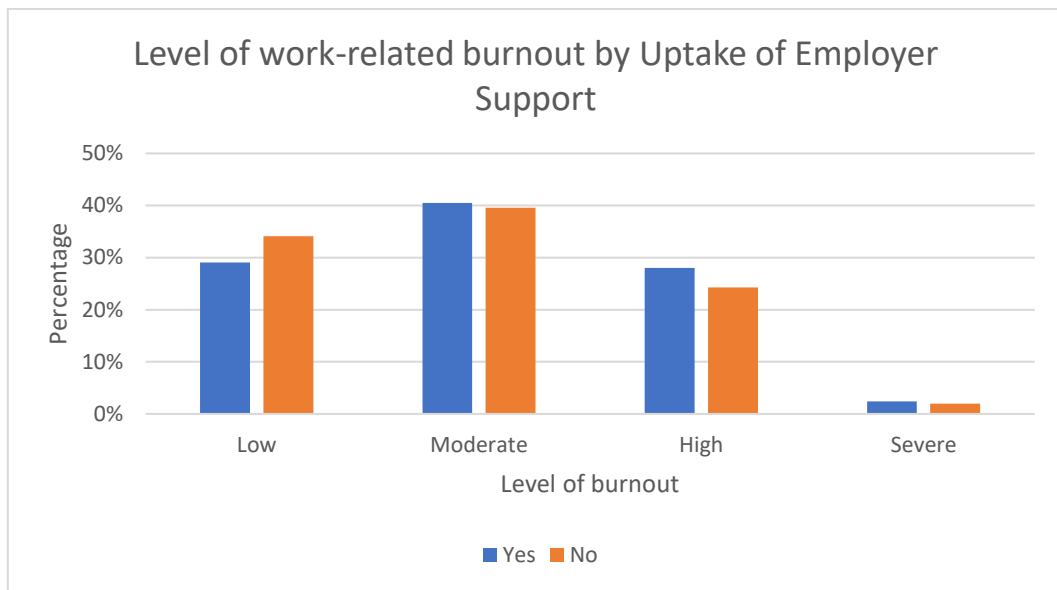


Figure A5. 79: Level of Client-Related Burnout by Uptake of Employer Support (Weighted)

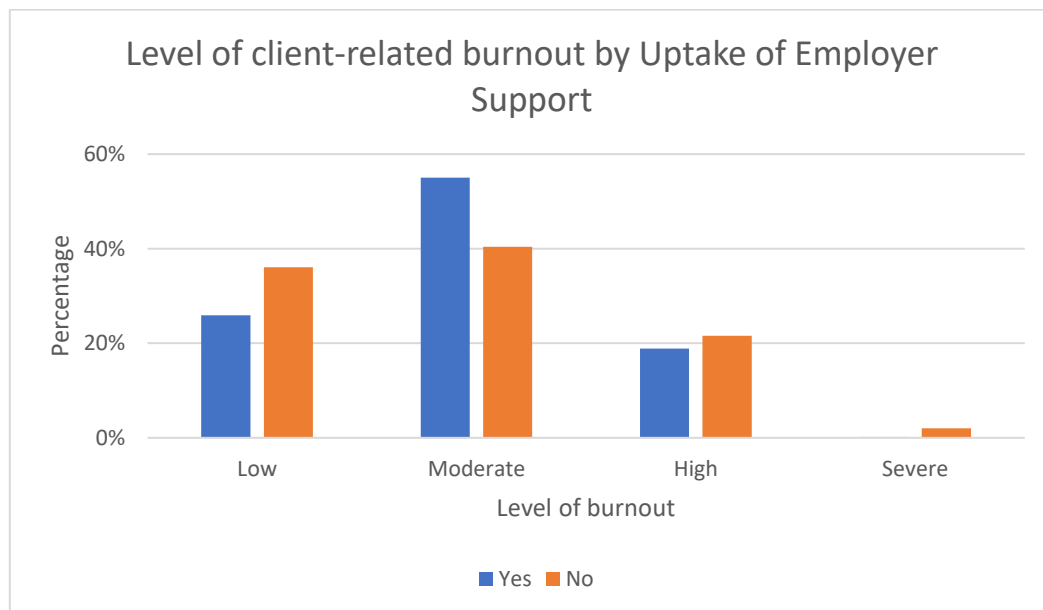


Figure A5.80: Level of Client-Related Burnout by Uptake of Employer Support (Unweighted)

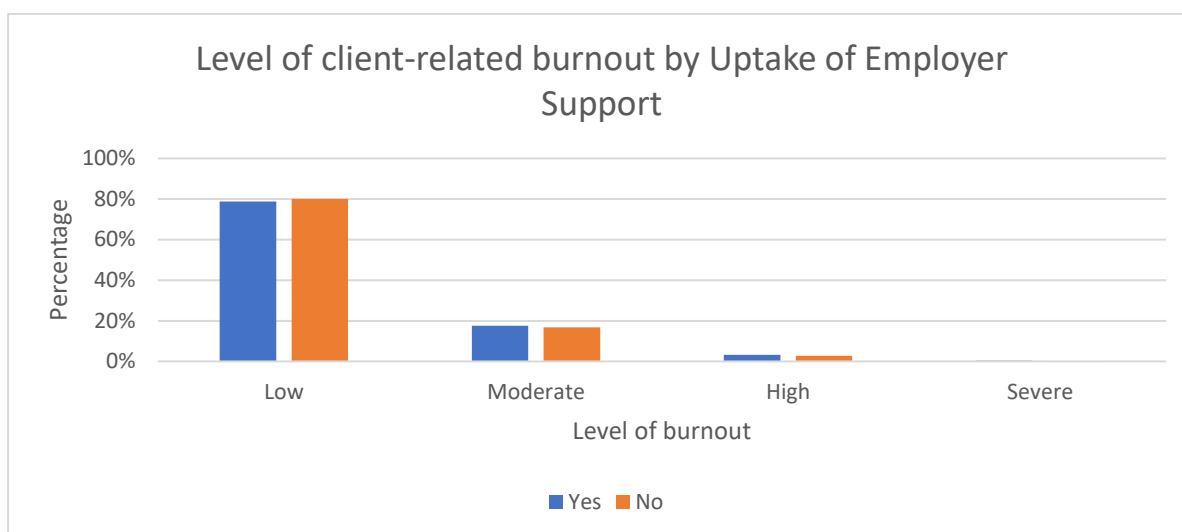


Table A5. 39: Level of Burnout Uptake of Employer Support (Weighted)

Burnout	Uptake of Employer Support	
	Yes	No
<b>Personal burnout:</b>		
Low	28.2%	26.9%
Moderate	37.4%	44.8%
High	32.8%	22.4%
Severe	1.7%	6.0%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>
<b>Work-related burnout:</b>		
Low	25.9%	36.1%
Moderate	55.0%	40.4%
High	18.9%	21.6%
Severe	0.2%	2.0%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>
<b>Client-related burnout:</b>		
Low	25.9%	36.1%
Moderate	55.0%	40.4%
High	18.9%	21.6%
Severe	0.2%	2.0%
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>

Table A5. 40: Level of Burnout by Uptake of Employer Support (Unweighted)

Burnout	Uptake of Employer Support	
	Yes	No
<b>Personal burnout:</b>		
Low	68 (23.4%)	343 (28.9%)
Moderate	115 (39.5%)	395 (41.7%)
High	88 (30.2%)	293 (24.7%)
Severe	20 (6.9%)	55 (4.6%)
<b>TOTAL</b>	<b>291 (100%)</b>	<b>1186 (100%)</b>
<b>Work-related burnout:</b>		
Low	84 (29.1%)	399 (34.1%)
Moderate	117 (40.5%)	464 (39.6%)
High	81 (28.0%)	285 (24.3%)
Severe	7 (2.4%)	23 (2.0%)
<b>TOTAL</b>	<b>289 (100%)</b>	<b>1171 (100%)</b>
<b>Client-related burnout:</b>		
Low	214 (78.7%)	862 (80.1%)
Moderate	48 (17.6%)	181 (16.8%)
High	9 (3.3%)	30 (2.8%)
Severe	1 (0.4%)	3 (0.3%)
<b>TOTAL</b>	<b>272 (100%)</b>	<b>1076 (100%)</b>

## 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 two out of the ten examined Carver coping domains. These differences were in:

- Substance use ( $F = 4.272$   $df = 3$ ,  $p = .005$ ), where England scored significantly higher than Scotland and Northern Ireland.
- Self-blame ( $F = 3.453$ ,  $df = 3$ ,  $p = .016$ ), where England scored significantly higher than Northern Ireland.

There also appeared to be a significant difference between countries in the use of emotional support ( $F = 2.898$ ,  $df = 3$ ,  $p = .034$ ), but multiple comparison tests revealed no statistically significant differences between the countries, although there was a trend towards higher scores in using emotional support as a coping strategy by those in Wales.

#### Summary (Unweighted results):

There were significant differences across countries in mean scores on only one out of the ten examined Carver coping domains. These differences were in:

- Self-blame ( $F = 3.16$ ,  $df = 3$ ,  $p = .024$ ), where Wales scored significantly higher than Northern Ireland.

Figure A6. 1: Mean Carver Coping Scores by Country (Weighted)

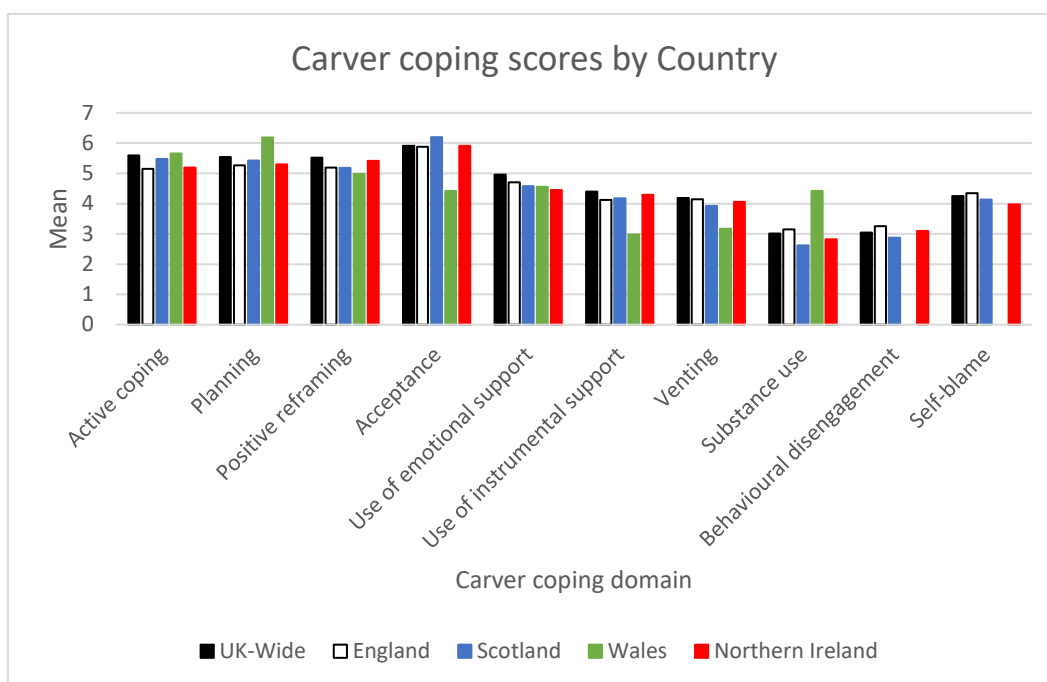


Figure A6. 2: Mean Carver Coping Scores by Country (Unweighted)

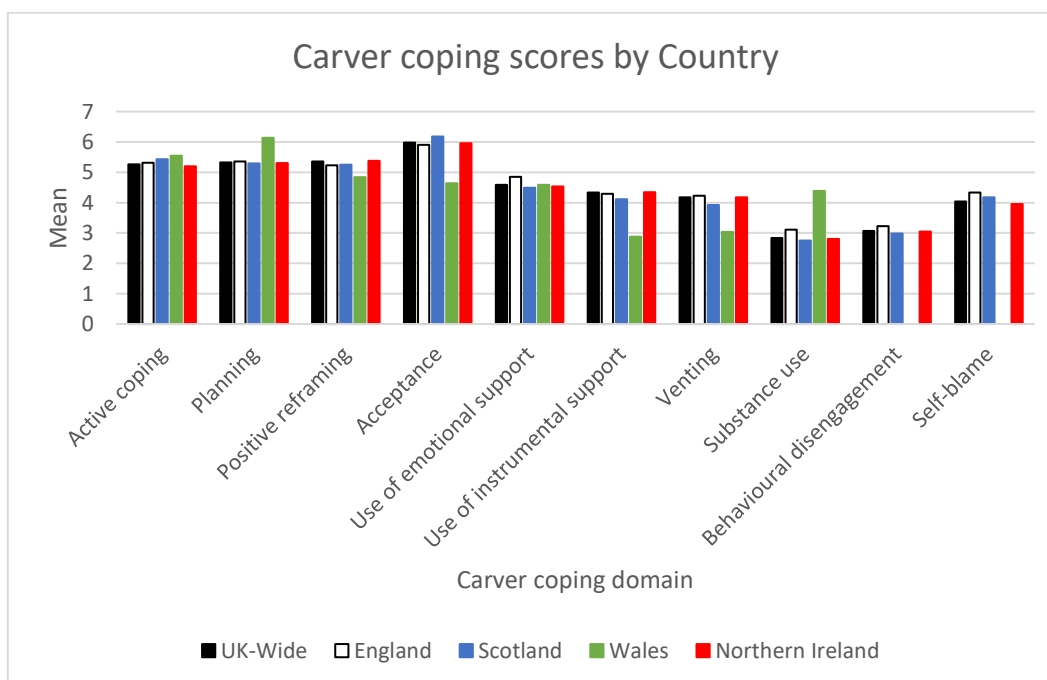


Table A6. 1: Mean Carver Coping Scores by Country (Weighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.59	5.15	5.48	5.61	5.19
Planning	5.54	5.26	5.42	5.58	5.30
Positive reframing	5.52	5.19	5.18	5.66	5.41
Acceptance	5.91	5.88	6.20	6.18	5.91
Use of emotional support	4.96	4.70	4.58	4.98	4.45
Use of instrumental support	4.40	4.12	4.17	4.42	4.29
Venting	4.18	4.14	3.92	4.56	4.06
Substance use	3.01	3.15	2.62	2.98	2.82
Behavioural disengagement	3.04	3.25	2.87	3.17	3.10
Self-blame	4.25	4.34	4.13	4.42	3.97

Table A6. 2: Mean Carver Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.26	5.31	5.43	5.59	5.20
Planning	5.32	5.36	5.29	5.61	5.30
Positive reframing	5.36	5.23	5.25	5.55	5.38
Acceptance	5.98	5.91	6.18	6.14	5.96
Use of emotional support	4.59	4.85	4.49	4.84	4.53
Use of instrumental support	4.33	4.29	4.11	4.64	4.34
Venting	4.18	4.23	3.92	4.59	4.18
Substance use	2.84	3.11	2.75	2.88	2.80
Behavioural disengagement	3.07	3.23	2.98	3.04	3.05
Self-blame	4.04	4.33	4.18	4.39	3.95

## A6.2 Carver Coping Scores by Occupation

### Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on ten of the ten examined Carver coping domains. These differences were in:

- Active coping ( $F = 18.528$ ,  $df = 4$ ,  $p < .001$ ), where nurses scored significantly lower than AHPS, social care workers and social workers.
- Planning ( $F = 5.293$ ,  $df = 4$ ,  $p < .001$ ), where nurses scored significantly lower than AHPS, social care workers and social workers.
- Positive reframing ( $F = 11.959$ ,  $df = 4$ ,  $p < .001$ ), where nurses scored significantly lower than AHPS, social care workers and social workers.
- Acceptance ( $F = 2.395$ ,  $df = 4$ ,  $p = .049$ ), where nurses scored significantly higher social care workers.
- Emotional support ( $F = 3.170$ ,  $df = 4$ ,  $p = .013$ ), where nurses scored significantly higher nurses and midwifery.
- Instrumental support ( $F = 5.417$ ,  $df = 4$ ,  $p = .013$ ), where nurses scored significantly higher than all other occupations.
- Venting ( $F = 4.470$ ,  $df = 4$ ,  $p = .001$ ), where midwives scored significantly higher than nurses and social care workers.
- Substance use ( $F = 9.237$ ,  $df = 4$ ,  $p < .001$ ), where midwives scored significantly higher than AHPs, social care workers and social workers.
- Behavioural disengagement ( $F = 7.777$ ,  $df = 4$ ,  $p < .001$ ), where midwives scored significantly higher than all other occupations.
- Self-blame ( $F = 3.618$ ,  $df = 4$ ,  $p = .006$ ), where midwives scored significantly higher than all other occupation groups.

### Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on five out of the ten examined Carver coping domains. These differences were found in:

- Use of emotional support ( $F = 4.142$ ,  $df = 4$ ,  $p = .002$ ), where social care workers scored significantly lower than social workers.
- Venting ( $F = 4.888$ ,  $df = 4$ ,  $p < .001$ ), where social workers had higher scores than nurses or social care workers. Social Care workers had lower scores than midwives and social workers.
- Substance use ( $F = 4.047$ ,  $df = 4$ ,  $p = .003$ ), where midwifery respondents scored significantly higher than AHPs and social care workers.
- Behavioural disengagement ( $F = 4.876$ ,  $df = 4$ ,  $p < .001$ ), where midwives scored significantly higher than AHPS and Social Workers.
- Self-blame ( $F = 4.975$ ,  $df = 4$ ,  $p < .001$ ), where midwives scored significantly higher all other occupations examined within this study.

Figure A6.3: Mean Carver Coping Scores by Occupation (Weighted)

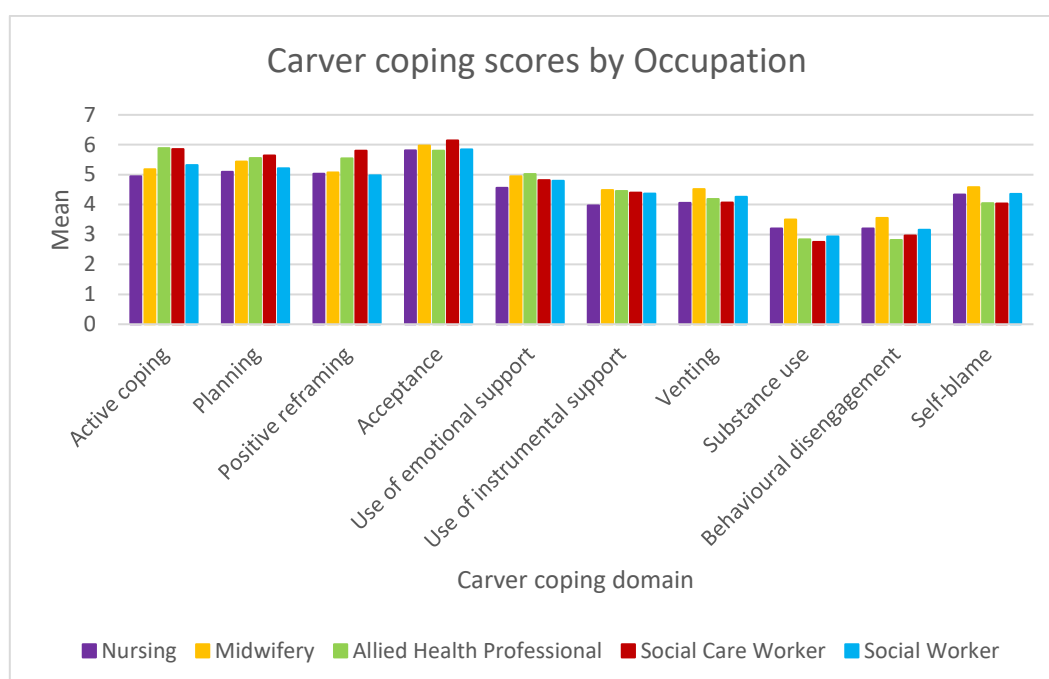


Figure A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

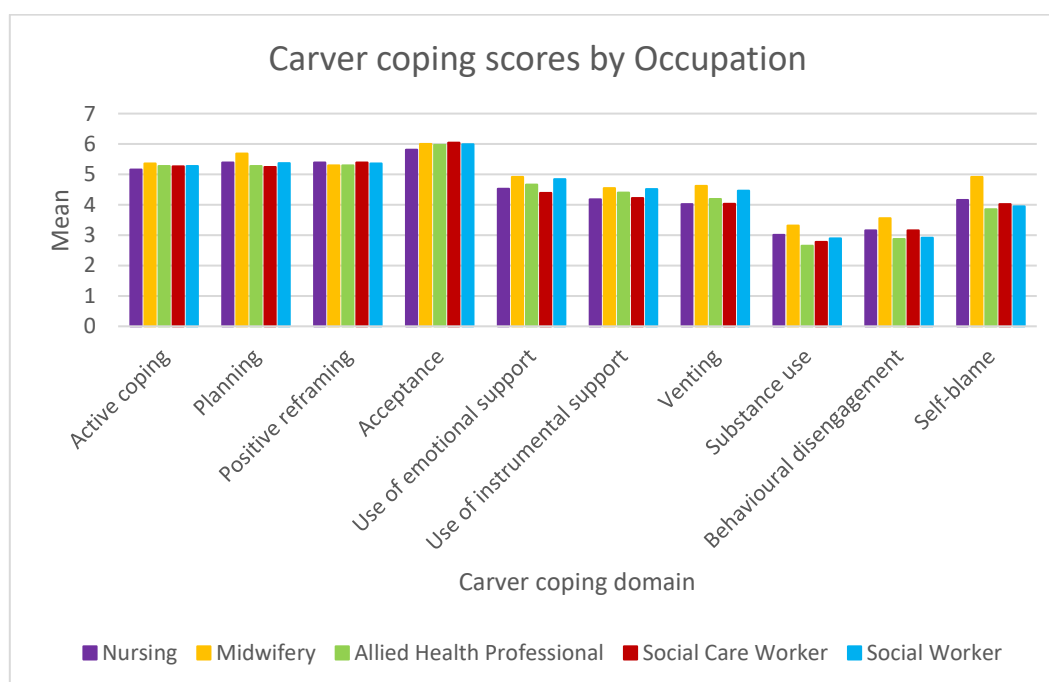




Table A6.3: Mean Carver Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	4.95	5.18	5.89	5.86	5.32
Planning	5.10	5.44	5.55	5.64	5.21
Positive reframing	5.03	5.07	5.54	5.8	4.98
Acceptance	5.81	5.97	5.8	6.14	5.84
Use of emotional support	4.56	4.95	5.02	4.82	4.80
Use of instrumental support	3.97	4.49	4.45	4.40	4.37
Venting	4.06	4.52	4.19	4.07	4.26
Substance use	3.20	3.50	2.84	2.75	2.93
Behavioural disengagement	3.20	3.55	2.81	2.97	3.16
Self-blame	4.34	4.58	4.05	4.04	4.36

Table A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.16	5.36	5.27	5.26	5.27
Planning	5.39	5.68	5.27	5.24	5.37
Positive reframing	5.39	5.29	5.3	5.39	5.36
Acceptance	5.81	6.00	5.97	6.04	5.99
Use of emotional support	4.53	4.92	4.66	4.39	4.84
Use of instrumental support	4.18	4.55	4.40	4.22	4.52
Venting	4.02	4.62	4.19	4.03	4.46
Substance use	3.01	3.32	2.65	2.78	2.89
Behavioural disengagement	3.16	3.56	2.87	3.16	2.91
Self-blame	4.16	4.92	3.85	4.02	3.95

### A6.3 Carver Coping Scores by Sex

There were 5 respondents in the full sample who answered questions on the Carver coping scale and stated their sex to be Transgender, Non-binary, Intersex, Other, Prefer not to say. 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 five out of the ten examined Carver coping domains. These differences were in:

- Active coping ( $t = -8.410$ ,  $df = 247.918$ ,  $p < .001$ ), where females scored significantly lower than males.
- Planning ( $t = -4.422$ ,  $df = 251.373$ ,  $p < .001$ ), where females scored significantly lower than males.
- Use of emotional support ( $t = -2.892$ ,  $df = 206.892$ ,  $p = .004$ ), where females scored significantly lower than males.
- Use of instrumental support ( $t = -2.503$ ,  $df = 1405$ ,  $p = .021$ ), where females scored significantly lower than males.
- Venting ( $t = 2.856$ ,  $df = 1404$ ,  $p = .002$ ), 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:

- Substance use ( $t = -3.948$ ,  $df = 260.591$ ,  $p < .001$ ), where females scored significantly lower than males.
- Behavioural engagement ( $t = -2.472$ ,  $df = 272.283$ ,  $p = .014$ ), where males scored significantly higher than females.

Figure A6.5: Mean Carver Coping Scores by Sex (Weighted)

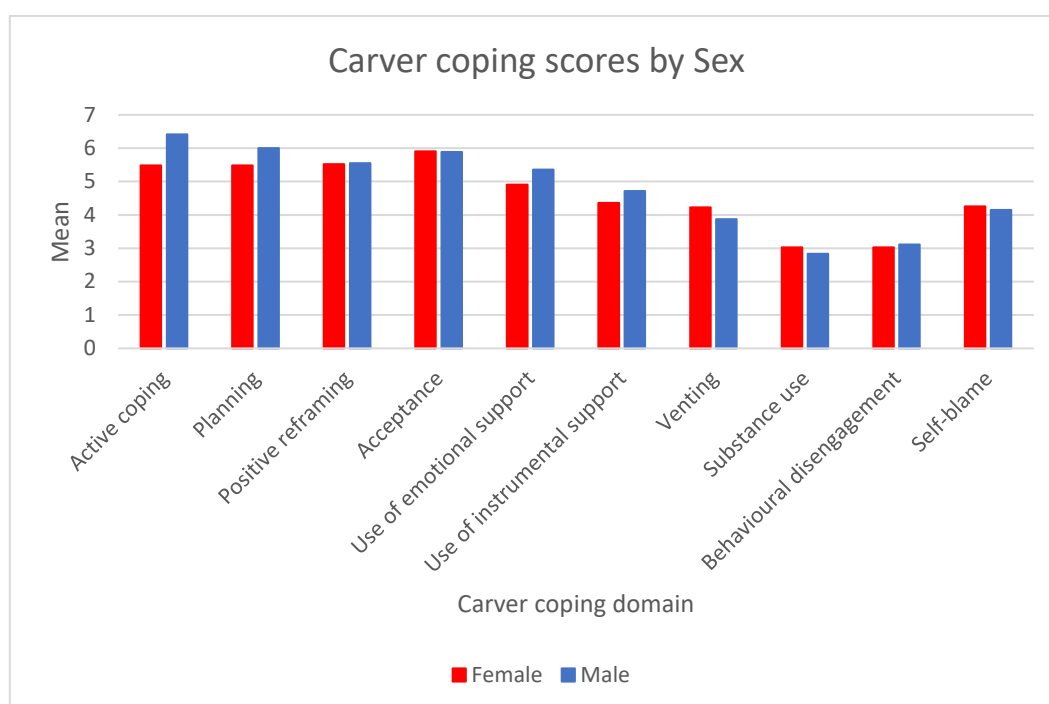


Figure A6.6: Mean Carver Coping Scores by Sex (Unweighted)

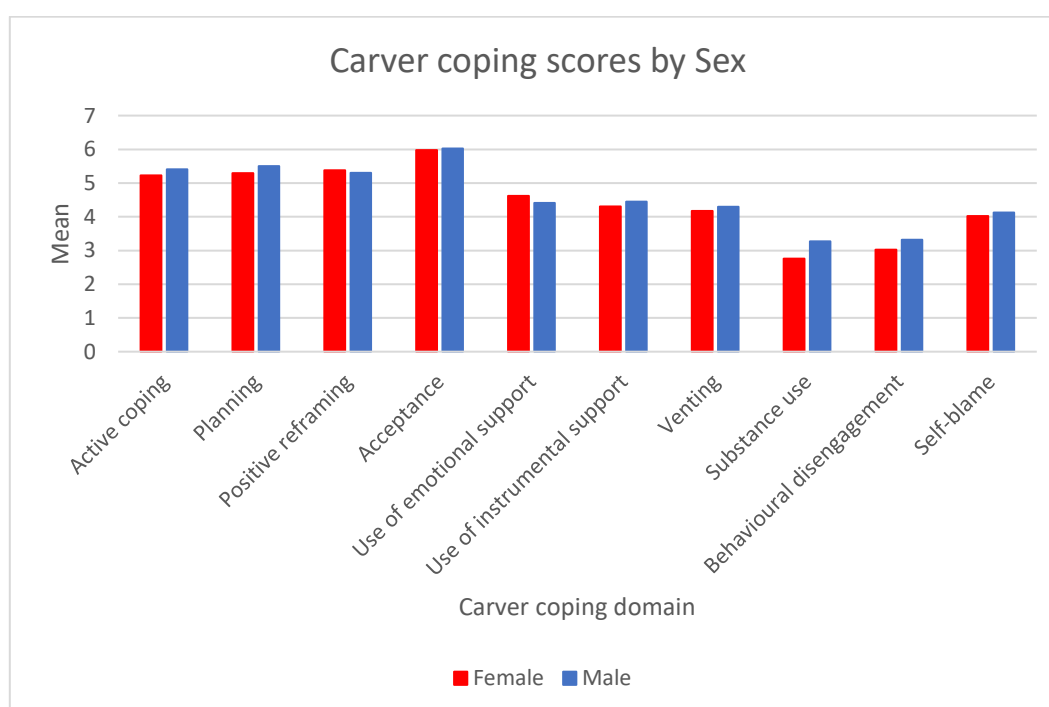


Table A6.5: Mean Carver Coping Scores by Sex (Weighted)

Coping domain	Sex	
	Female	Male
Active coping	5.48	6.41
Planning	5.48	6.00
Positive reframing	5.52	5.55
Acceptance	5.91	5.89
Use of emotional support	4.91	5.36
Use of instrumental support	4.36	4.72
Venting	4.23	3.87
Substance use	3.03	2.84
Behavioural disengagement	3.03	3.11
Self-blame	4.26	4.15

Table A6.6: Mean Carver Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Active coping	5.23	5.41
Planning	5.29	5.50
Positive reframing	5.38	5.30
Acceptance	5.98	6.02
Use of emotional support	4.62	4.41
Use of instrumental support	4.31	4.45
Venting	4.17	4.30
Substance use	2.76	3.27
Behavioural disengagement	3.02	3.32
Self-blame	4.02	4.13

## 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 ( $F = 4.507$ ,  $df = 4$ ,  $p = .001$ ), where the 30-39 age group scored significantly higher all other age groups.
- Planning ( $F = 5.683$ ,  $df = 4$ ,  $p < .001$ ), where the 16-29 group had significantly higher scores than the 30-39, 40-49 and 50-59 age groups.
- Positive reframing ( $F = 5.889$ ,  $df = 4$ ,  $p < .001$ ), where the 30-39 group had significantly higher scores than the 40-49, 50-59 and 60+ age groups.
- Acceptance ( $F = 6.846$ ,  $df = 4$ ,  $p < .001$ ), where the 60+ age group scored significantly lower than the 30-39 and 50-59 age groups.
- Use of emotional support ( $F = 9.660$ ,  $df = 4$ ,  $p < .001$ ), where the 60+ age group scored significantly lower than all other age groups.
- Use of instrumental support ( $F = 10.453$ ,  $df = 4$ ,  $p < .001$ ), where 40-49 groups had significantly lower scores than the 16-29, 30-39 and 50-59 age groups.
- Venting ( $F = 19.254$ ,  $df = 4$ ,  $p < .001$ ), where the 60+ age group scored significantly lower than the 16-29, 30-39 and 50-59 age groups.
- Substance use ( $F = 5.597$ ,  $df = 4$ ,  $p = .001$ ), where the 30-39 age group scored significantly lower than the 16-29, 30-39 and 40-49 age groups.
- Behavioural disengagement ( $F = 10.906$ ,  $df = 4$ ,  $p < .001$ ), where the 50-59 age group scored significantly lower than the 16-29, 30-39, 50-59 age groups.
- Self-blame ( $F = 4.310$ ,  $df = 4$ ,  $p = .002$ ), where the 16-29 age group scored significantly higher than the 30-39 and 50-59 age groups.

### Summary (Unweighted results):

There were significant differences between the age groups in mean scores on three out of the ten examined Carver coping domains. These differences were in:

- Instrumental support ( $F = 4.008$ ,  $df = 4$ ,  $p = .003$ ), the 16-29 age group scored significantly higher than the 40-49 and 50-59 age groups.
- Venting ( $F = 3.067$ ,  $df = 4$ ,  $p = .016$ ), where the 50-59 age group scored significantly lower than the 16-29 age group.

- Self-blame ( $F=5.57$ ,  $df = 5$ ,  $p < .001$ ), where the 16-29 age group scored significantly higher than the 50-59 and 60+ age groups.

Figure A6.7: Mean Carver Coping Scores by Age (Weighted)

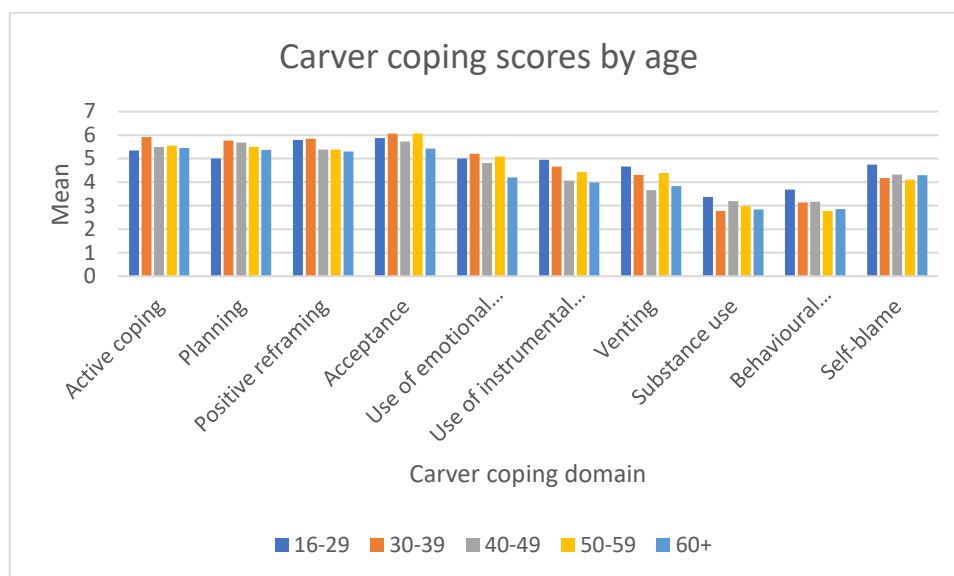


Figure A6.8: Mean Carver Coping Scores by Age (Unweighted)

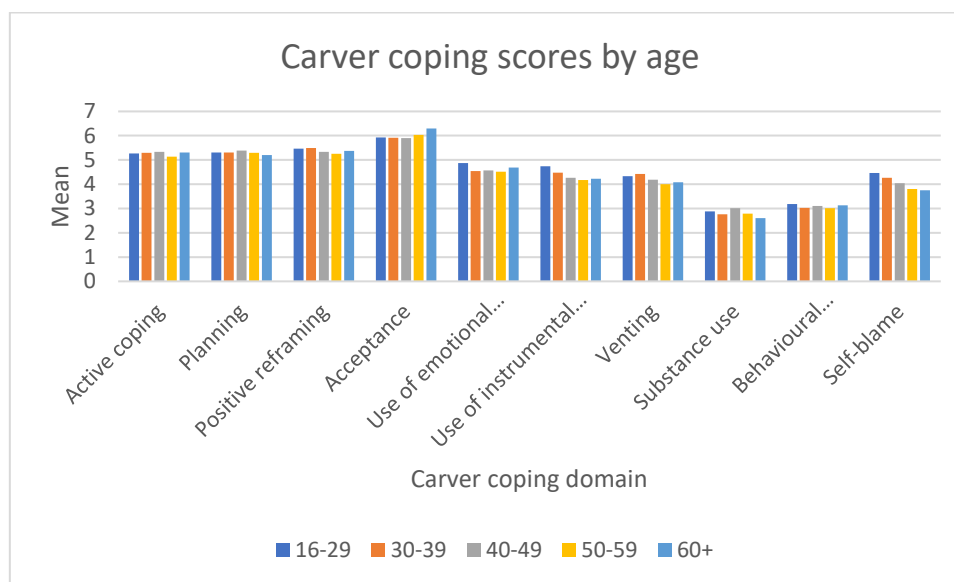


Table A6.7: Mean Carver Coping Scores by Age (Weighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60-65
Active coping	5.35	5.91	5.50	5.55	5.45
Planning	5.01	5.76	5.68	5.50	5.37
Positive reframing	5.80	5.85	5.38	5.39	5.31
Acceptance	5.87	6.07	5.73	6.07	5.43
Use of emotional support	5.01	5.21	4.81	5.09	4.20
Use of instrumental support	4.95	4.66	4.06	4.43	3.99
Venting	4.67	4.31	3.66	4.39	3.83
Substance use	3.37	2.77	3.19	2.98	2.84
Behavioural disengagement	3.69	3.14	3.17	2.77	2.85
Self-blame	4.75	4.18	4.32	4.10	4.29

Table A6.8: Mean Carver Coping Scores by Age (Unweighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60+
Active coping	5.27	5.3	5.33	5.14	5.31
Planning	5.31	5.31	5.39	5.3	5.2
Positive reframing	5.47	5.49	5.34	5.25	5.38
Acceptance	5.93	5.91	5.9	6.03	6.3
Use of emotional support	4.87	4.54	4.57	4.51	4.69
Use of instrumental support	4.74	4.48	4.26	4.17	4.23
Venting	4.33	4.42	4.19	4	4.08
Substance use	2.88	2.76	3.01	2.79	2.61
Behavioural disengagement	3.19	3.02	3.1	3.01	3.13
Self-blame	4.46	4.27	4.04	3.81	3.75

## A6.5 Carver Coping Scores by Ethnicity

### Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on ten out of the ten examined Carver coping domains. These differences were in:

- Active coping ( $F = 15.236$ ,  $df = 3$ ,  $p < .001$ ), where respondents identifying as White scored significantly lower than the Black ethnic groups.
- Planning ( $F = 5.302$ ,  $df = 3$ ,  $p = .001$ ), where respondents identifying as Mixed ethnicity scored significantly lower than Black and White ethnic groups.
- Positive reframing ( $F = 11.646$ ,  $df = 3$ ,  $p < .001$ ), where respondents identifying as White scored significantly lower than the Black ethnic groups.
- Acceptance ( $F = 7.188$ ,  $df = 3$ ,  $p = .001$ ), where respondents identifying as Black ethnicity scored significantly lower than those identifying as Asian or Mixed ethnicity.
- Use of emotional support ( $F = 15.862$ ,  $df = 3$ ,  $p < .001$ ), where respondents identifying as Black scored significantly higher than White and Mixed ethnic groups.
- Use of instrumental support ( $F = 39.601$ ,  $df = 3$ ,  $p < .001$ ), where the black ethnic group scored significantly higher than White and Mixed ethnic groups
- Venting ( $F = 4.851$ ,  $df = 3$ ,  $p = .002$ ), where the black ethnic group scored significantly higher than the White Ethnic group.
- Substance use ( $F = 3.769$ ,  $df = 3$ ,  $p = .010$ ), where the White scored significantly higher than the Black ethnic group.
- Self-blame ( $F = 3.969$ ,  $df = 3$ ,  $p = .008$ ), where respondents identifying as White scored significantly lower than Black ethnic group.

#### 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:

- Planning ( $F=2.843$ ,  $df=3$ ,  $p = .037$ ), however a post hoc between the individual countries revealed no significant difference.



Figure A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

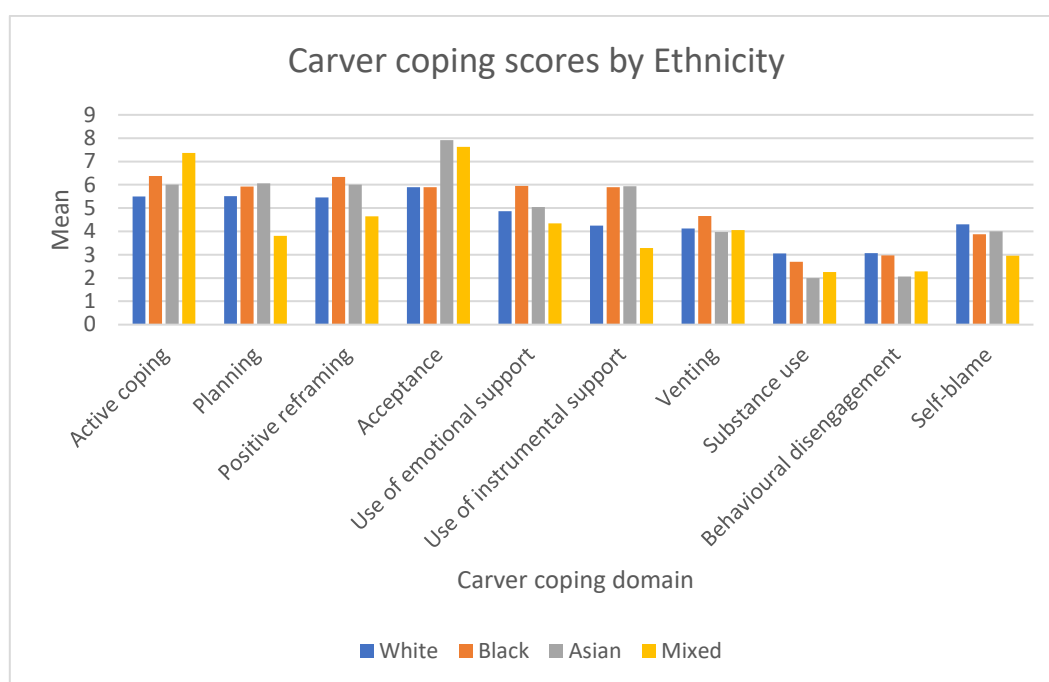


Figure A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

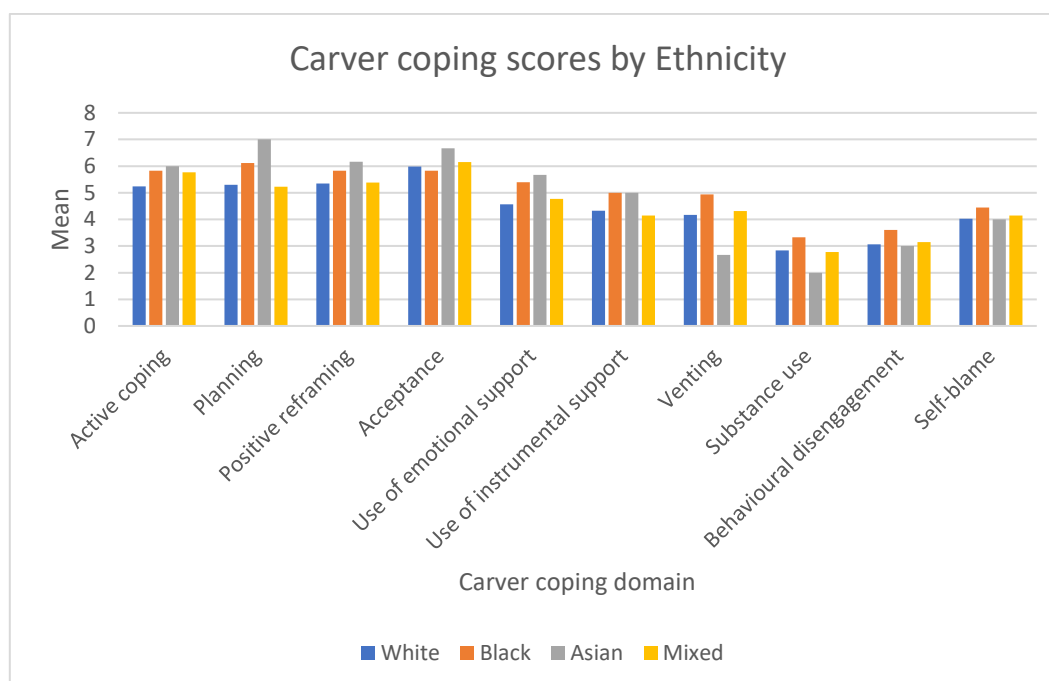


Table A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.50	6.37	6.00	7.37
Planning	5.51	5.93	6.06	3.81
Positive reframing	5.45	6.33	6.01	4.64
Acceptance	5.89	5.90	7.91	7.62
Use of emotional support	4.87	5.95	5.04	4.35
Use of instrumental support	4.25	5.90	5.94	3.29
Venting	4.13	4.66	3.98	4.05
Substance use	3.05	2.69	2.00	2.26
Behavioural disengagement	3.06	2.97	2.06	2.29
Self-blame	4.30	3.88	4.00	2.95

Table A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.24	5.83	6.00	5.77
Planning	5.30	6.11	7.00	5.23
Positive reframing	5.35	5.83	6.17	5.38
Acceptance	5.98	5.83	6.67	6.15
Use of emotional support	4.57	5.39	5.67	4.77
Use of instrumental support	4.32	5.00	5.00	4.15
Venting	4.17	4.94	2.67	4.31
Substance use	2.84	3.33	2.00	2.77
Behavioural disengagement	3.06	3.61	3.00	3.15
Self-blame	4.03	4.44	4.00	4.15

## 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 three out of the ten examined Carver coping domains. These differences were found in:

- Active coping ( $F = 6.257$ ,  $df = 2$ ,  $p = .002$ ), where respondents with a disability scored significantly lower than those without a disability.
- Use of instrumental support ( $F = 17.566$ ,  $df = 2$ ,  $p = .023$ ), where respondents who were unsure of disability scored significantly higher than those with a disability and those without a disability.
- Substance use ( $F = 5.388$ ,  $df = 2$ ,  $p = .005$ ), where respondents with a disability scored significantly higher than those without a disability.

### Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on four out of the ten examined Carver coping domains. These differences were in:

- Use of instrumental support ( $F = 3.034$ ,  $df = 2$ ,  $p = .048$ ), however a post hoc between the individual groups revealed no significant difference.
- Venting ( $F = 7.861$ ,  $df = 2$ ,  $p < .001$ ), where respondents who had a disability scored significantly higher than those with no disability.
- Behavioural disengagement ( $F = 8.11$ ,  $df = 2$ ,  $p < .001$ ), where respondents who had a disability scored significantly higher than those with no disability.
- Self-blame ( $F = 10.86$ ,  $df = 2$ ,  $p < .001$ ), where respondents who had a disability scored significantly higher than those with no disability.

Figure A6.11: Mean Carver Coping Scores by Disability (Weighted)

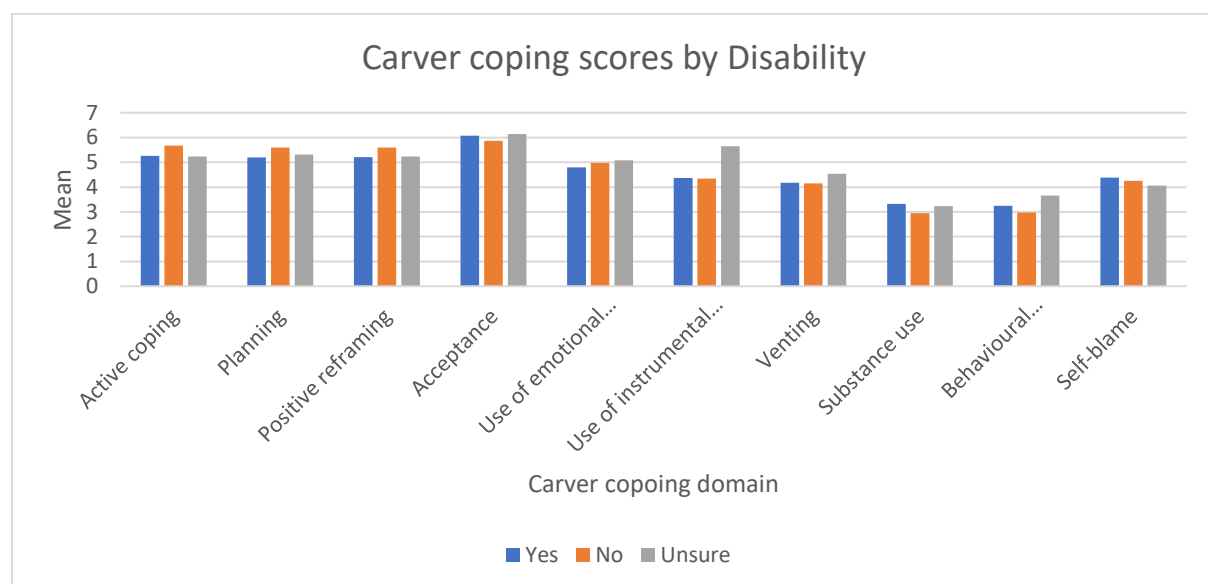


Figure A6.12: Mean Carver Coping Scores by Disability (Unweighted)

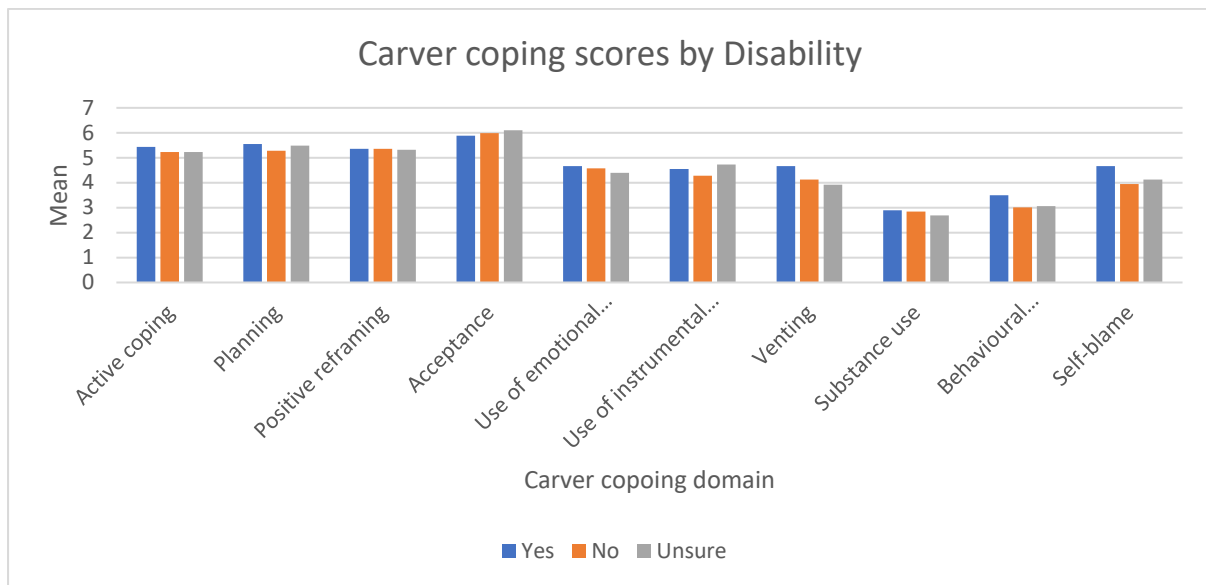


Table A6.11: Mean Carver Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Active coping	5.26	5.67	5.24
Planning	5.20	5.60	5.31
Positive reframing	5.21	5.59	5.23
Acceptance	6.07	5.87	6.14
Use of emotional support	4.79	4.98	5.08
Use of instrumental support	4.37	4.34	5.65
Venting	4.18	4.15	4.54
Substance use	3.32	2.95	3.23
Behavioural disengagement	3.24	2.98	3.66
Self-blame	4.38	4.25	4.06

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	5.44	5.23	5.23
Planning	5.55	5.28	5.49
Positive reframing	5.36	5.36	5.32
Acceptance	5.88	5.99	6.10
Use of emotional support	4.66	4.57	4.40
Use of instrumental support	4.55	4.28	4.73
Venting	4.66	4.13	3.92
Substance use	2.89	2.84	2.69
Behavioural disengagement	3.49	3.01	3.06
Self-blame	4.67	3.95	4.12

## 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 ten out of the ten examined Carver coping domains. These differences were in:

- Active coping ( $F = 15.660$ ,  $df = 7$ ,  $p < .001$ ), where those working with children and young people scored significantly higher than those working in midwifery, with adults of working age, in physical disability, in learning disability, with older people, in mental health and in the area of 'other'.
- Planning ( $F = 9.976$ ,  $df = 7$ ,  $p < .001$ ), where those working with children and young people scored significantly higher than those working with adults of working age, in physical disability, with older people, in mental health and in the area of 'other'.
- Positive reframing ( $F = 27.322$ ,  $df = 7$ ,  $p < .001$ ), where those working with children and young people scored significantly higher than those working with adults of working age, in physical disability, with older people, in mental health and in the area of 'other'.
- Acceptance ( $F = 15.410$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with adults of working age scored significantly lower than those working with children and young people, in physical disability, in learning disability, with older people, in mental health and in the area of 'other'.
- Use of emotional support ( $F = 19.922$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with children and young people scored significantly higher than all other areas of practice.

- Use of instrumental support ( $F = 18.601$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with children and young people scored significantly higher than those working with adults of working age, in learning disability, with older people, in mental health and in the area of 'other'.
- Venting ( $F = 8.800$ ,  $df = 7$ ,  $p < .001$ ), where respondents working in mental health scored significantly higher than those working with children and young people, with adults of working age, in physical disability, in learning disability, with older people and in the area of 'other'.
- Substance use ( $F = 4.036$ ,  $df = 7$ ,  $p < .001$ ), where respondents working in the area of physical disability scored significantly higher than those working in learning disability, with older people, in mental health and in the area of 'other'.
- Behavioural disengagement ( $F = 2.860$ ,  $df = 7$ ,  $p = .006$ ), where respondents working with children scored significantly lower than those working in midwifery.
- Self-blame ( $F = 8.480$ ,  $df = 7$ ,  $p < .001$ ), where respondents working in midwifery scored significantly higher than those working with children and young people, with adults of working age, in physical disability, in learning disability, and in the area of 'other'.

#### 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:

- Use of emotional support ( $F = 3.360$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with children and young people scored significantly higher than those working in Physical Disability or with older people. Respondents working in midwifery also scored significantly higher than those working in the area of Physical Disability.
- Use of instrumental support ( $F = 2.715$ ,  $df = 7$ ,  $p = .008$ ), however a post hoc between the individual groups revealed no significant difference.
- Venting ( $F = 3.182$ ,  $df = 7$ ,  $p = .002$ ), where respondents working with children and young people scored significantly higher than those working with older people.
- Behavioural disengagement ( $F = 2.860$ ,  $df = 7$ ,  $p = .006$ ), where respondents working in midwifery scored significantly higher than those working with children and young people.
- Self-blame ( $F = 2.494$ ,  $df = 7$ ,  $p = .015$ ), where respondents working in midwifery scored significantly higher than those working with children and young people, with adults, in learning disability, with older people, within mental health or in the area of practice 'other'.

Figure A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

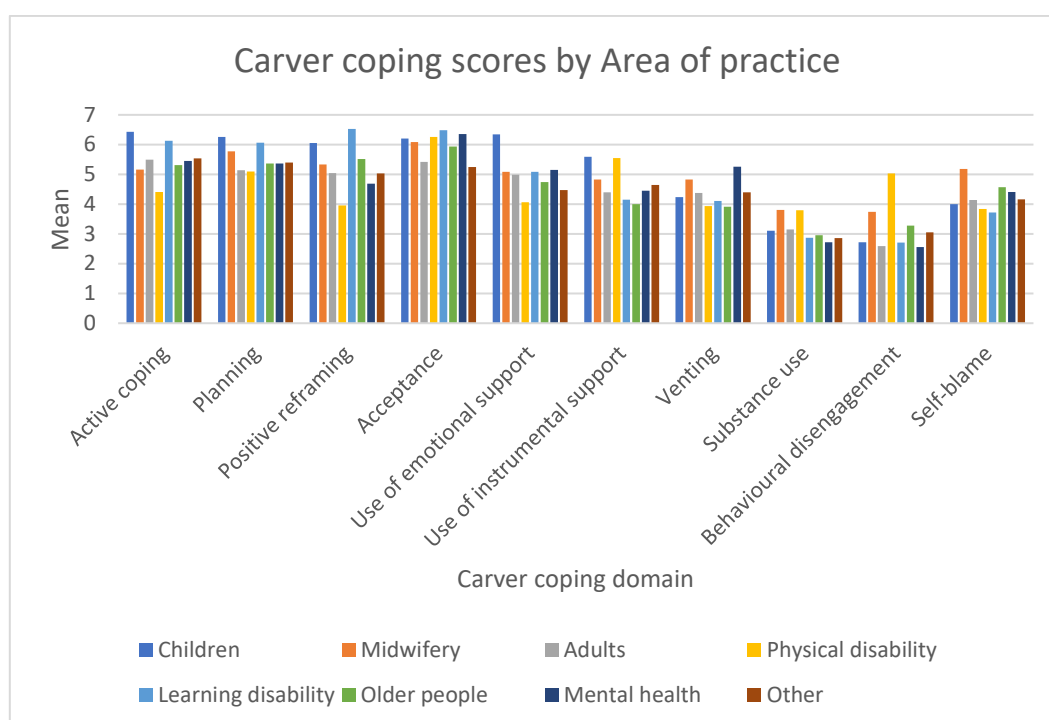


Figure A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)

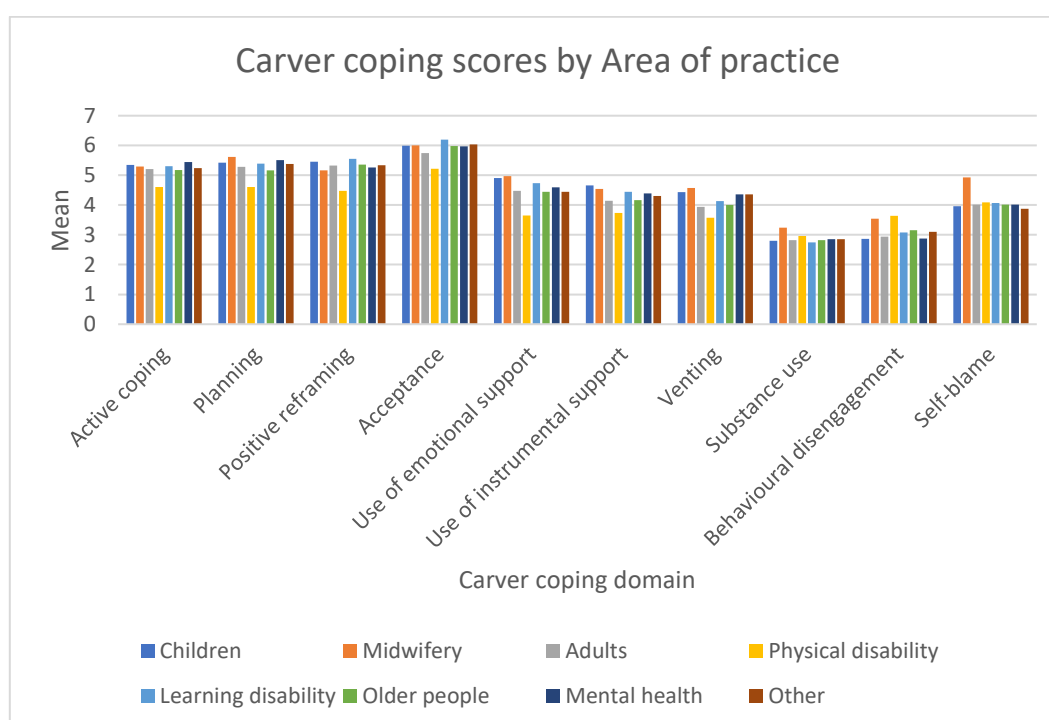


Table A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Active coping	6.43	5.16	5.49	4.41	6.13	5.31	5.45	5.54
Planning	6.26	5.77	5.14	5.10	6.06	5.36	5.36	5.40
Positive reframing	6.05	5.33	5.04	3.96	6.53	5.52	4.69	5.03
Acceptance	6.20	6.09	5.42	6.26	6.48	5.94	6.35	5.25
Use of emotional support	6.34	5.09	4.99	4.06	5.09	4.74	5.15	4.47
Use of instrumental support	5.59	4.83	4.40	5.55	4.15	4.00	4.45	4.65
Venting	4.24	4.83	4.38	3.93	4.11	3.91	5.26	4.40
Substance use	3.11	3.81	3.15	3.80	2.87	2.96	2.72	2.86
Behavioural disengagement	2.72	3.74	2.59	5.03	2.71	3.28	2.56	3.05
Self-blame	4.00	5.18	4.14	3.84	3.72	4.57	4.41	4.16



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	5.35	5.29	5.21	4.61	5.3	5.18	5.44	5.24
Planning	5.42	5.62	5.28	4.61	5.39	5.16	5.51	5.38
Positive reframing	5.46	5.17	5.33	4.48	5.55	5.36	5.26	5.34
Acceptance	5.99	6.00	5.75	5.22	6.20	5.98	5.97	6.04
Use of emotional support	4.91	4.97	4.48	3.65	4.74	4.44	4.60	4.45
Use of instrumental support	4.66	4.54	4.14	3.74	4.45	4.16	4.39	4.31
Venting	4.43	4.57	3.94	3.57	4.13	4.00	4.36	4.36
Substance use	2.80	3.24	2.82	2.96	2.75	2.82	2.85	2.85
Behavioural disengagement	2.86	3.54	2.94	3.64	3.08	3.16	2.88	3.10
Self-blame	3.96	4.93	4.01	4.09	4.07	4.02	4.01	3.87

## 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 seven out of the ten Carver coping domains. These differences were in:

- Active coping ( $t = 2.227$ ,  $df = 1558.169$ ,  $p = .026$ ), where line managers scored significantly higher than those who were not line managers.
- Planning ( $t = 5.726$ ,  $df = 1387.471$ ,  $p < .001$ ), where line managers scored significantly higher than those who were not line managers
- Use of emotional support ( $t = -3.060$ ,  $df = 1406$ ,  $p = .002$ ), where line managers scored significantly lower than those who were not line managers.
- Use of instrumental support ( $t = -3.382$ ,  $df = 1406$ ,  $p < .001$ ), where line managers scored significantly lower than those who were not line managers.
- Venting ( $t = -6.099$ ,  $df = 1397.160$ ,  $p < .001$ ), where line managers scored significantly lower than those who were not line managers.
- Substance use ( $t = 4.234$ ,  $df = 1389.260$ ,  $p < .001$ ), where line managers scored significantly higher than those who were not line managers.
- Behavioural disengagement ( $t = 3.792$ ,  $df = 1406.224$ ,  $p < .001$ ), 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 two out of the ten examined Carver coping domains. These differences were in:

- Active coping ( $t = 2.024$ ,  $df = 1406$ ,  $p = .043$ ), where line managers scored significantly higher than those who were not line managers.
- Planning ( $t = 3.647$ ,  $df = 1406$ ,  $p < .001$ ), 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)

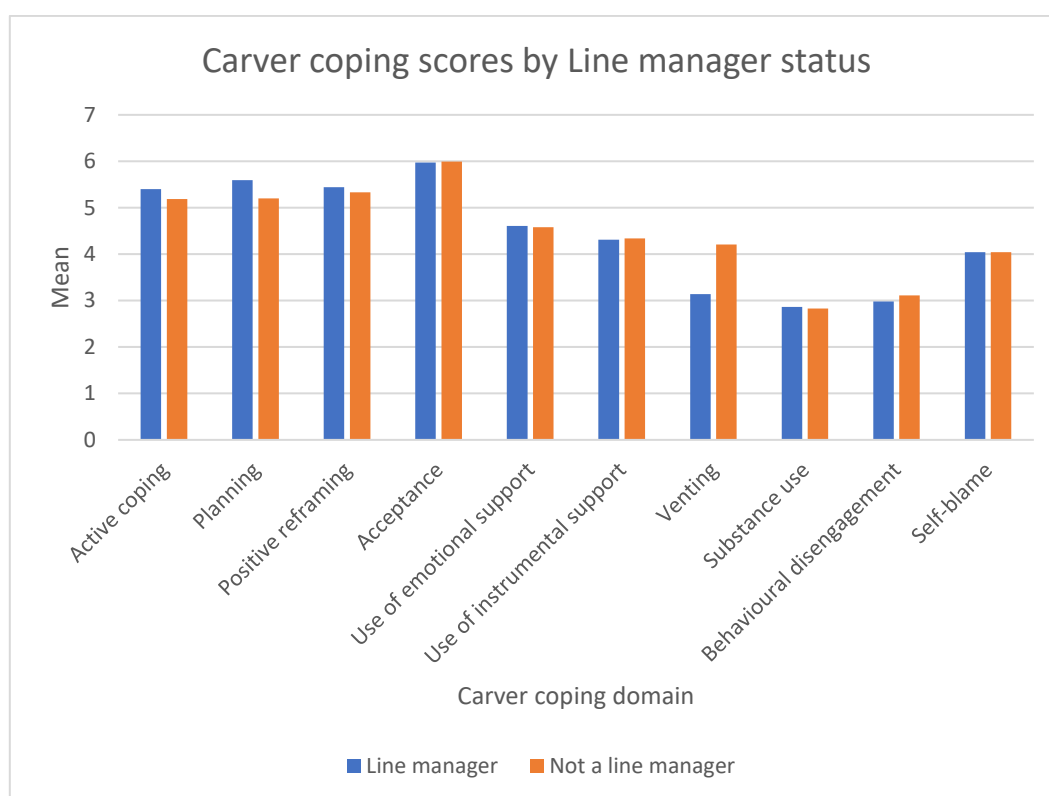


Figure A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

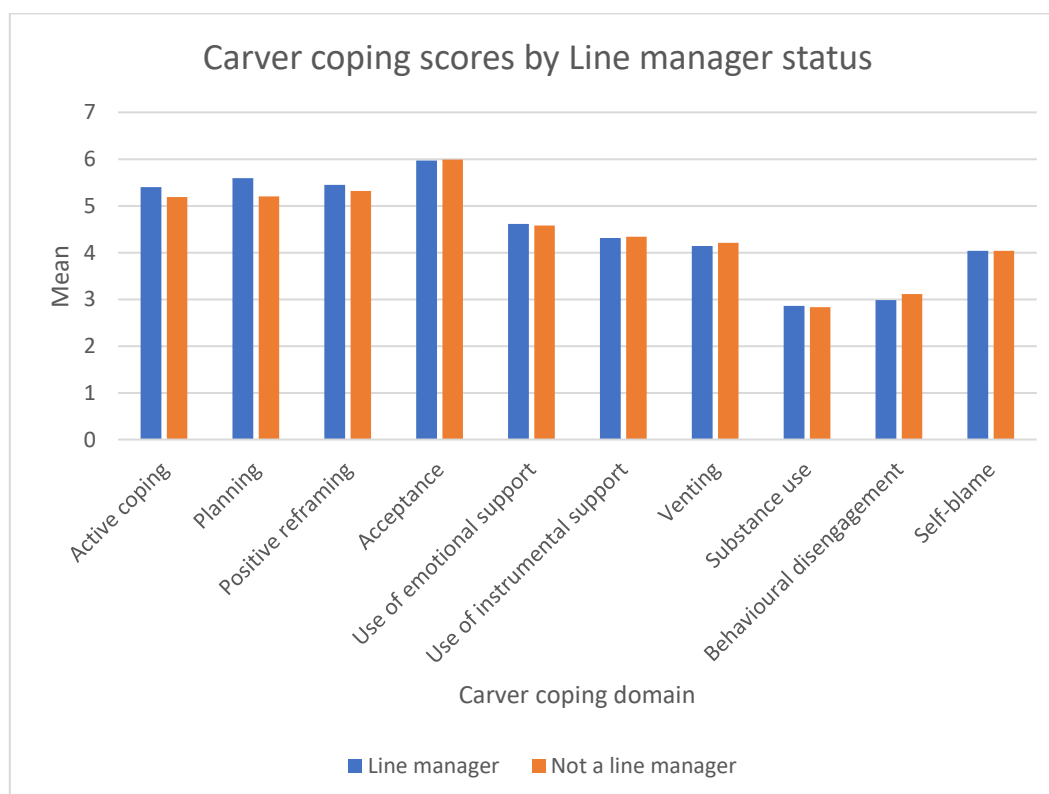


Table A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.40	5.19
Planning	5.59	5.20
Positive reframing	5.44	5.33
Acceptance	5.97	5.99
Use of emotional support	4.61	4.58
Use of instrumental support	4.31	4.34
Venting	3.14	4.21
Substance use	2.86	2.83
Behavioural disengagement	2.98	3.11
Self-blame	4.04	4.04

Table A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.40	5.19
Planning	5.59	5.20
Positive reframing	5.45	5.32
Acceptance	5.97	5.99
Use of emotional support	4.61	4.58
Use of instrumental support	4.31	4.34
Venting	4.14	4.21
Substance use	2.86	2.83
Behavioural disengagement	2.98	3.11
Self-blame	4.04	4.04

## A6.9 Carver Coping Scores by the Impact of the Pandemic on Services

### Summary (Weighted results):

There were significant differences in mean scores in all 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 ( $F = 18.532$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were impacted but not significantly scored significantly higher than those who were not impacted and those who were overwhelmed by the pressures.
- Planning ( $F = 27.049$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were overwhelmed by increased pressures significantly scored significantly higher than those who were not impacted and those who were impacted but not significantly.
- Positive reframing ( $F = 18.707$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were impacted but not significantly scored significantly higher than those who were not impacted and those who were overwhelmed by the pressures.
- Use of instrumental support ( $F = 15.926$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were overwhelmed by increased pressures scored significantly higher than those impacted but not significantly.
- Venting ( $F = 19.003$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were impacted but not significantly scored significantly higher than those who were not impacted and those who were overwhelmed by the pressures.
- Substance use ( $F = 9.419$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were overwhelmed by increased pressures significantly scored significantly higher than those who were not impacted and those who were impacted but not significantly.
- Behavioural disengagement ( $F = 10.944$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were impacted but not significantly scored significantly higher than those who were not impacted and those who were overwhelmed by the pressures.
- Self-blame ( $F = 6.164$ ,  $df = 2$ ,  $p = .002$ ), where respondents who were overwhelmed by increased pressures significantly scored significantly higher than those who were not impacted.

### 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 ( $F = 6.887$ ,  $df = 2$ ,  $p < .001$ ), where respondents who were impacted but not significantly scored significantly lower than those overwhelmed by the pressures.
- Venting ( $F = 5.915$ ,  $df = 2$ ,  $p = .003$ ), where respondents who were impacted but not significantly scored significantly lower than those overwhelmed by the pressures.
- Behavioural disengagement ( $F = 23.936$ ,  $df = 2$ ,  $p < .001$ ), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Self-blame ( $F = 14.528$ ,  $df = 2$ ,  $p < .001$ ), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- 

Figure A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

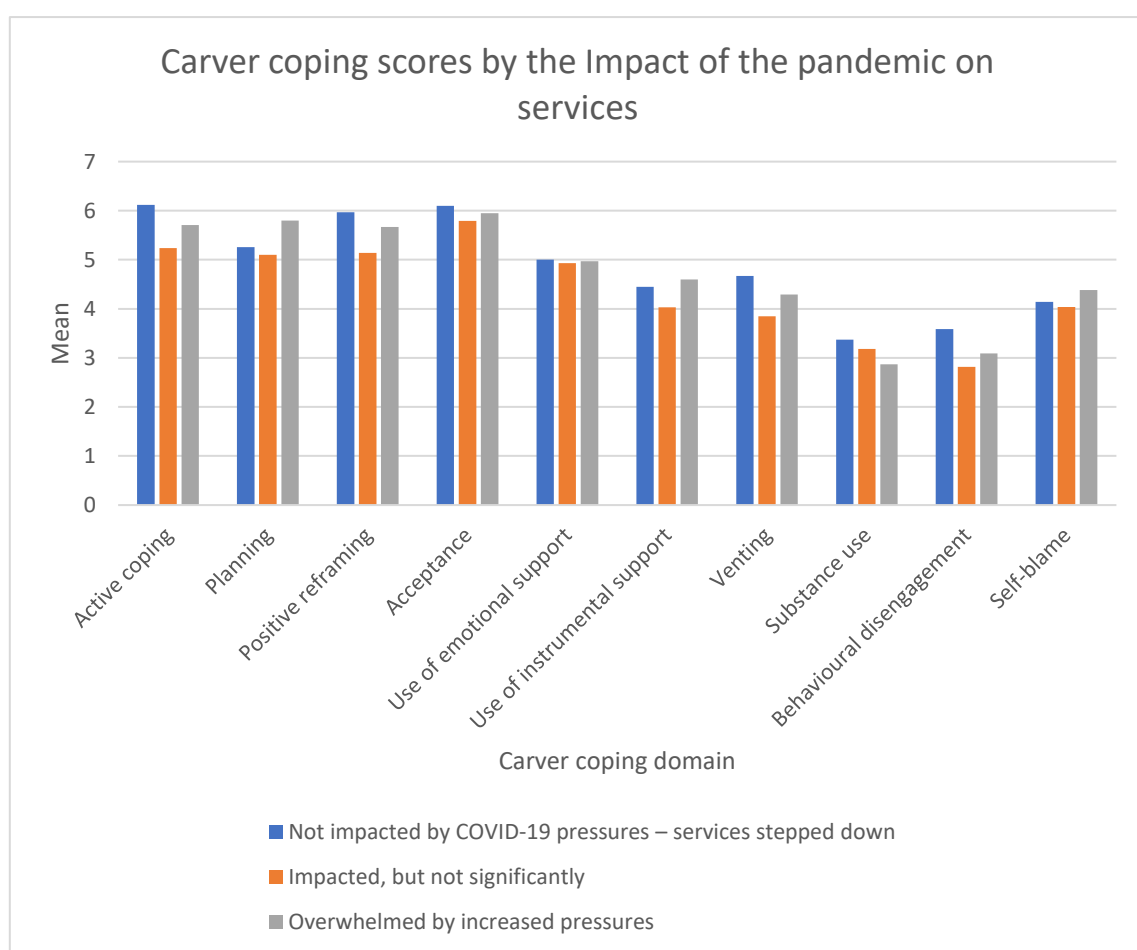


Figure A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)

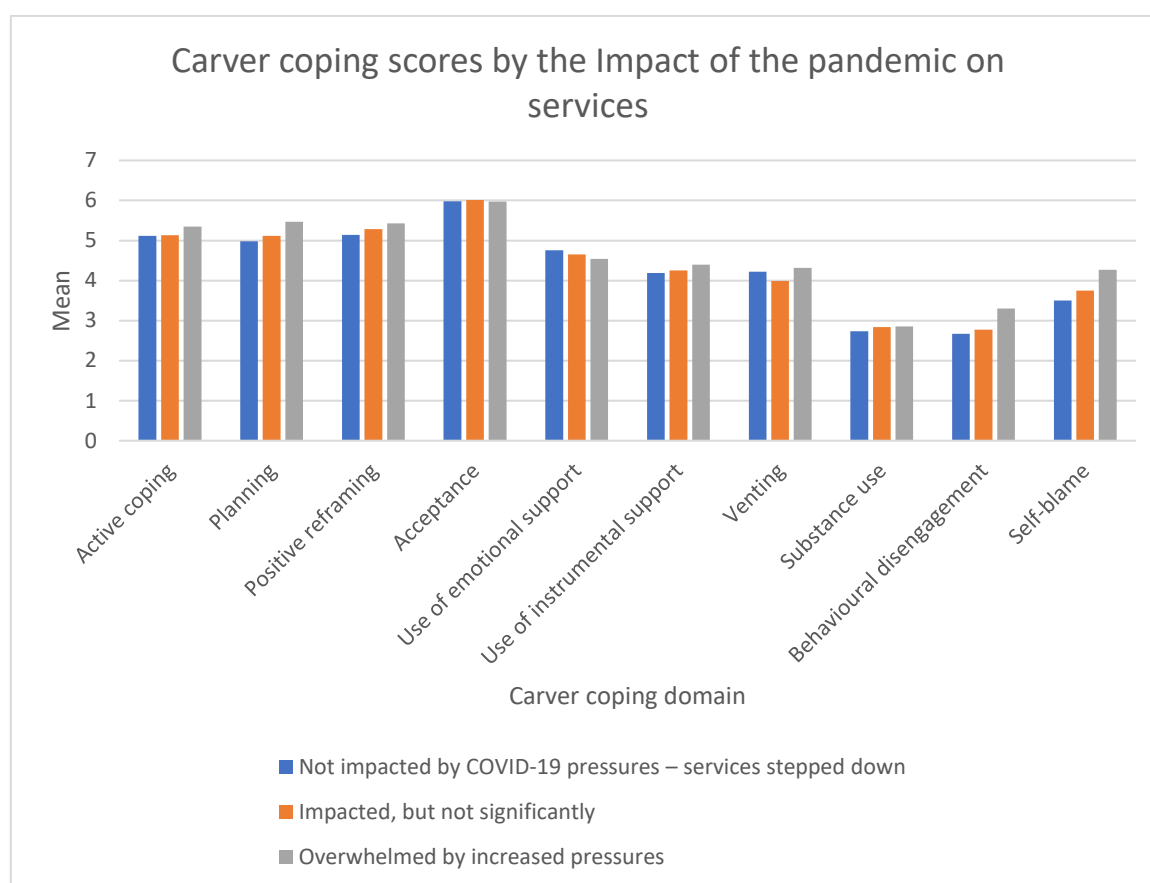


Table A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

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	6.12	5.24	5.71
Planning	5.26	5.10	5.80
Positive reframing	5.97	5.14	5.67
Acceptance	6.10	5.79	5.95
Use of emotional support	5.00	4.93	4.97
Use of instrumental support	4.45	4.03	4.60
Venting	4.67	3.85	4.29
Substance use	3.37	3.18	2.87
Behavioural disengagement	3.59	2.82	3.09
Self-blame	4.14	4.04	4.38

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	5.12	5.13	5.35
Planning	4.98	5.12	5.47
Positive reframing	5.14	5.28	5.43
Acceptance	5.98	6.01	5.97
Use of emotional support	4.76	4.65	4.54
Use of instrumental support	4.19	4.25	4.40
Venting	4.22	3.99	4.32
Substance use	2.73	2.84	2.85
Behavioural disengagement	2.67	2.77	3.30
Self-blame	3.50	3.75	4.27

#### A6.10 Carver Coping Scores by Line Manager Status

##### Summary (Weighted results):

There were significant differences between those who used employer support and those that did not use employer support in mean scores on seven out of the ten Carver coping domains. These differences were in:

- Active coping ( $t = 8.298$ ,  $df = 917.922$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not access employer support.
- Planning ( $t = 8.401$ ,  $df = 834.851$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not access employer support.
- Positive reframing ( $t = 5.186$ ,  $df = 862.272$ ,  $p < .001$ ), where those where those who took employer support scored significantly higher than those who did not access employer support.
- Acceptance ( $t = 2.961$ ,  $df = 1101.187$ ,  $p = .003$ ), where those who took employer support scored significantly higher than those who did not access employer support.
- Use of emotional support ( $t = 2.966$ ,  $df = 783.405$ ,  $p = .003$ ), where those who took employer support scored significantly higher than those who did not access employer support.



- Use of instrumental support ( $t = 13.880$ ,  $df = 705.713$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not access employer support.
- Venting ( $t = 3.079$ ,  $df = 683.694$ ,  $p = .002$ ), where those who took employer support scored significantly higher than those who did not access employer support.

#### Summary (Unweighted results):

There were significant differences those who used employer support and those that did not use employer support in mean scores on six out of the ten examined Carver coping domains. These differences were in:

- Active coping ( $t = 3.460$ ,  $df = 1406$ ,  $p < .001$ ), where those who took support for their employer had significantly higher scores than those who did not take support.
- Planning ( $t = 4.170$ ,  $df = 1406$ ,  $p < .001$ ), where those who took support for their employer had significantly higher scores than those who did not take support.
- Positive reframing ( $t = 2.588$ ,  $df = 1405$ ,  $p = .010$ ), where those who took support for their employer had significantly higher scores than those who did not take support.
- Use of emotional support ( $t = 5.664$ ,  $df = 1403$ ,  $p < .001$ ), where those who took support for their employer had significantly higher scores than those who did not take support.
- Use of instrumental support ( $t = 7.841$ ,  $df = 1403$ ,  $p < .001$ ), where those who took support for their employer had significantly higher scores than those who did not take support.
- Venting ( $t = 4.531$ ,  $df = 1404$ ,  $p < .001$ ), where those who took support for their employer had significantly higher scores than those who did not take support.

Figure A6. 19: Mean Carver Coping Scores by Uptake of Employer Support (Weighted)

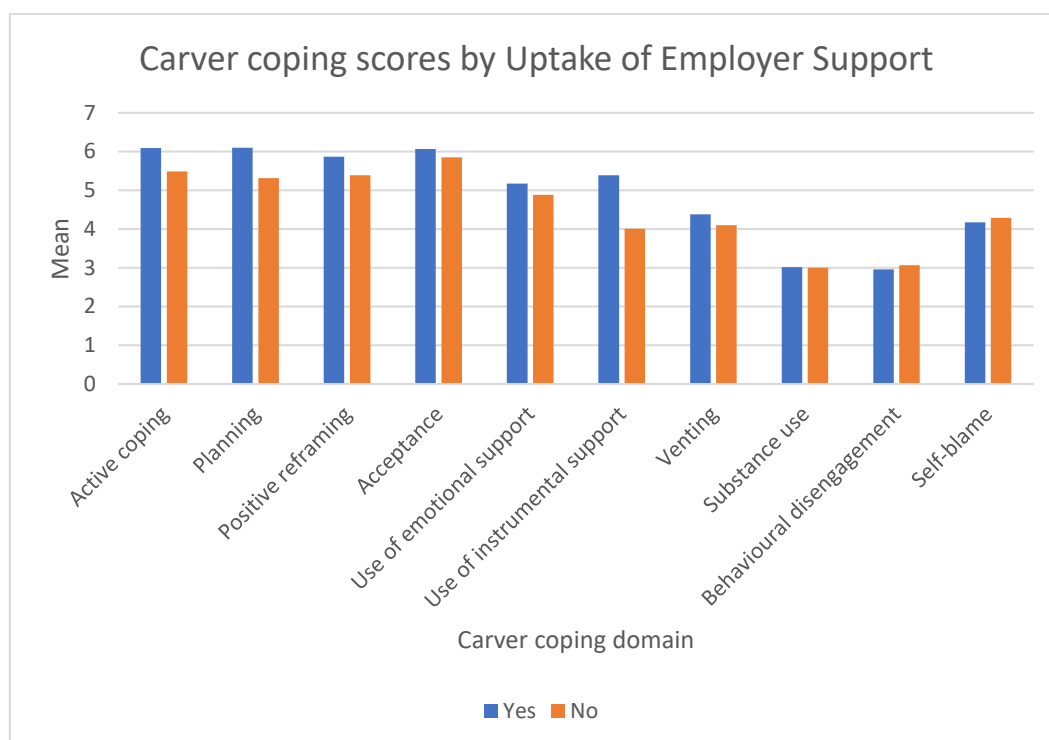


Figure A6. 20: Mean Carver Coping Scores by Uptake of Employer Support (Unweighted)

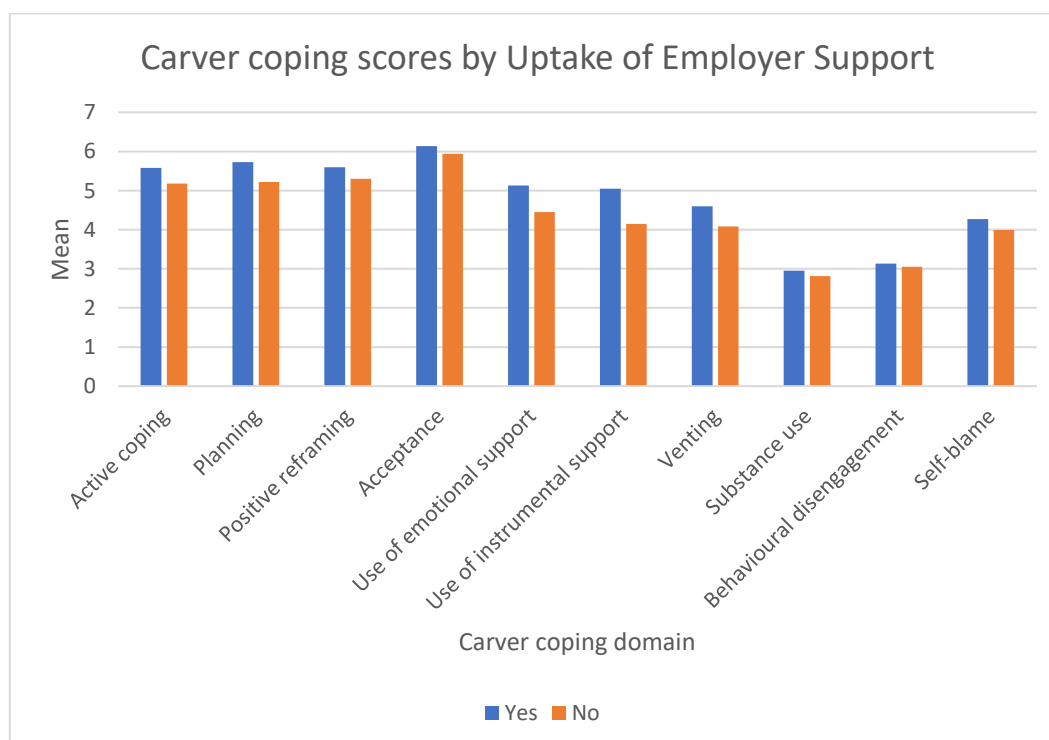


Table A6. 19: Mean Carver Coping Scores by Uptake of Employer Support (Weighted)

Coping domain	Update of employer support	
	Yes	No
Active coping	6.09	5.49
Planning	6.10	5.31
Positive reframing	5.87	5.39
Acceptance	6.07	5.85
Use of emotional support	5.17	4.88
Use of instrumental support	5.39	4.01
Venting	4.38	4.10
Substance use	3.02	3.00
Behavioural disengagement	2.96	3.07
Self-blame	4.17	4.29

Table A6. 20: Mean Carver Coping Scores by Uptake of Employer Support (Unweighted)

Coping domain	Uptake of employer support?	
	Yes	No
Active coping	5.58	5.18
Planning	5.73	5.22
Positive reframing	5.60	5.30
Acceptance	6.14	5.94
Use of emotional support	5.13	4.45
Use of instrumental support	5.05	4.15
Venting	4.60	4.08
Substance use	2.95	2.81
Behavioural disengagement	3.13	3.05
Self-blame	4.27	3.99

## 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 ( $F = 17.401$ ,  $df = 3$ ,  $p < .001$ ), those in England scored significantly lower than those in Scotland or Northern Ireland.
- Work-family segmentation ( $F = 10.285$ ,  $df = 3$ ,  $p < .001$ ), those in England scored significantly lower than those in Scotland, Wales and Northern Ireland.
- Exercise ( $F = 4.699$ ,  $df = 3$ ,  $p = .003$ ), those in Scotland scored significantly lower than those in Northern Ireland.

#### 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 ( $F = 10.428$ ,  $df = 3$ ,  $p < .001$ ), those in England scored significantly lower than those in Scotland or Northern Ireland.
- Work-family segmentation ( $F = 7.169$ ,  $df = 3$ ,  $p < .001$ ), those in England scored significantly lower than those in Scotland or Northern Ireland.
- Exercise ( $F = 3.762$ ,  $df = 3$ ,  $p = .010$ ), those in Scotland scored significantly lower than those in Northern Ireland.

Figure A7. 1: Mean Clark Coping Scores by Country (Weighted)

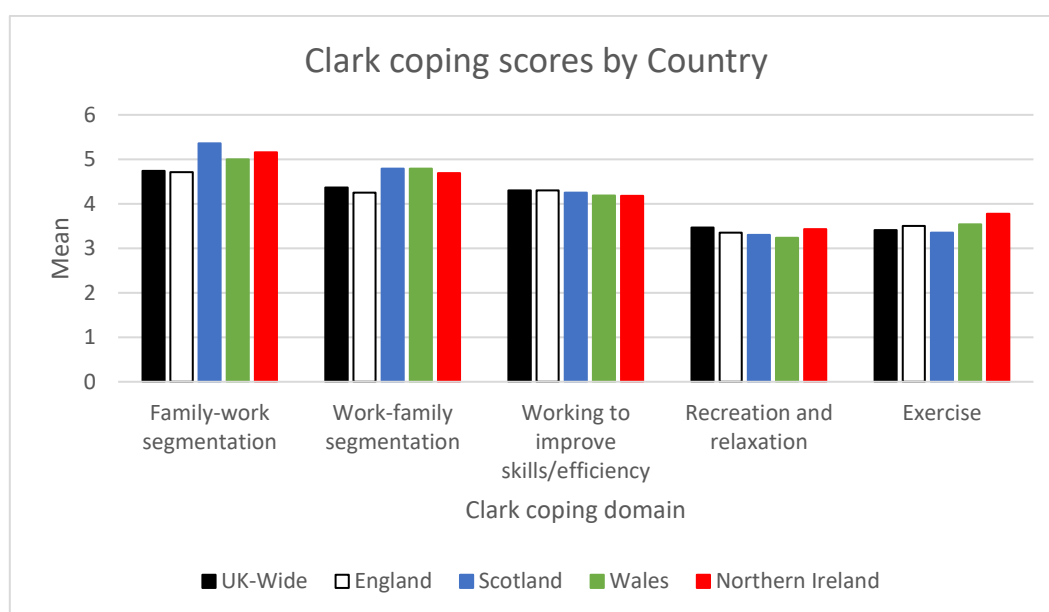


Figure A7. 2: Mean Clark Coping Scores by Country (Unweighted)

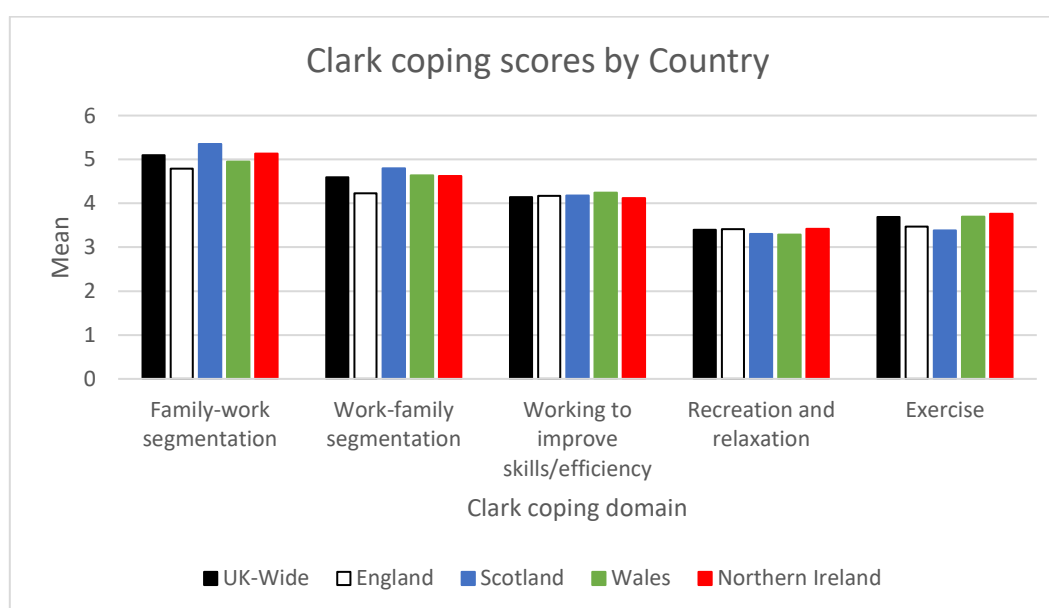


Table A7. 1: Mean Clark Coping Scores by Country (Weighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family-work segmentation	4.74	4.71	5.36	5.00	5.16
Work-family segmentation	4.37	4.25	4.79	4.79	4.69
Working to improve skills/efficiency	4.30	4.30	4.25	4.19	4.18
Recreation and relaxation	3.47	3.35	3.30	3.24	3.43
Exercise	3.41	3.50	3.35	3.54	3.78

Table A7. 2: Mean Clark Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family-work segmentation	5.10	4.79	5.35	4.95	5.13
Work-family segmentation	4.59	4.23	4.80	4.64	4.62
Working to improve skills/efficiency	4.14	4.17	4.18	4.24	4.12
Recreation and relaxation	3.40	3.41	3.30	3.29	3.42
Exercise	3.69	3.47	3.38	3.70	3.76

## A7.2 Clark Coping Scores by Occupation

### Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on three Clark coping domains:

- Family-work segmentation ( $F = 15.823$ ,  $df = 4$ ,  $p < .001$ ), where nurses scored significantly lower than midwives, social care workers and social workers but higher than AHPs.
- Work-family segmentation ( $F = 9.576$ ,  $df = 4$ ,  $p < .001$ ), where social care workers scored significantly higher than all other occupations.
- Working to improve skills/efficiency ( $F = 8.827$ ,  $df = 4$ ,  $p < .001$ ), where midwives scored significantly lower than nurses, AHPs and Social care workers.
- Recreation and relaxation ( $F = 5.959$ ,  $df = 4$ ,  $p < .001$ ), where midwives scored significantly lower than social care workers and social workers.
- Exercise ( $F = 3.523$ ,  $df = 4$ ,  $p = .007$ ), where AHPs scored significantly higher than midwives and social care workers.

### Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on all three Clark Coping domains:

- Family-work segmentation ( $F = 5.044$ ,  $df = 4$ ,  $p < .001$ ), where social care workers scored significantly higher than AHPs.
- Work-family segmentation ( $F = 3.536$ ,  $df = 4$ ,  $p = .007$ ), where social care workers scored significantly higher than midwives.
- Working to improve skills/efficiency ( $F = 3.481$ ,  $df = 4$ ,  $p = .008$ ), where nurses scored significantly higher than social care workers and social workers.
- Recreation and relaxation ( $F = 2.653$ ,  $df = 4$ ,  $p = .032$ ), however multiple comparison tests revealed no significant differences.
- Exercise ( $F = 5.061$ ,  $df = 4$ ,  $p < .001$ ), where AHPs were significantly higher than midwives and social care workers.

Figure A7.3: Mean Clark Coping Scores by Occupation (Weighted)

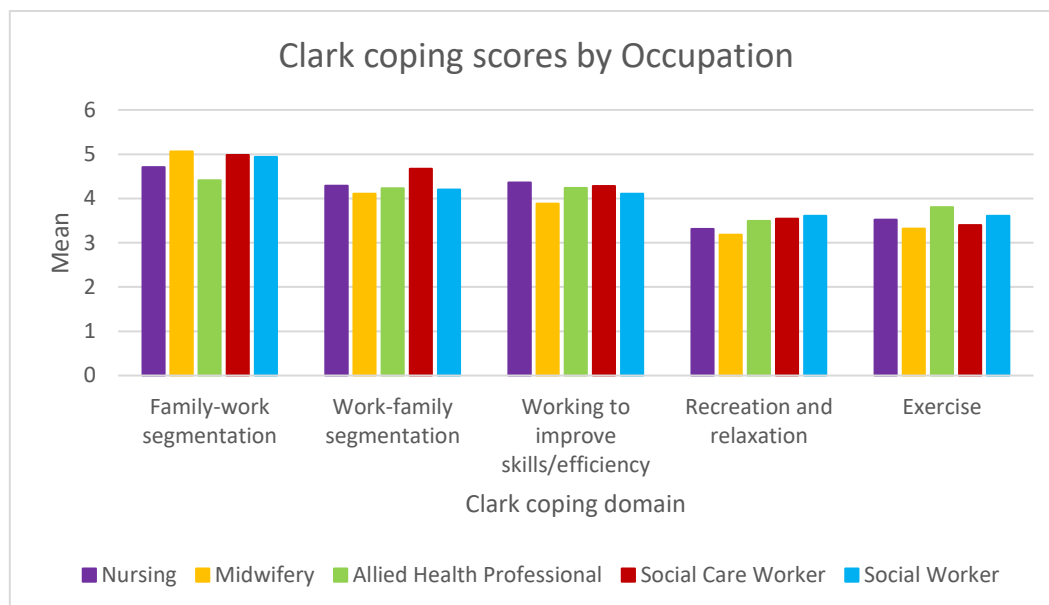


Figure A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

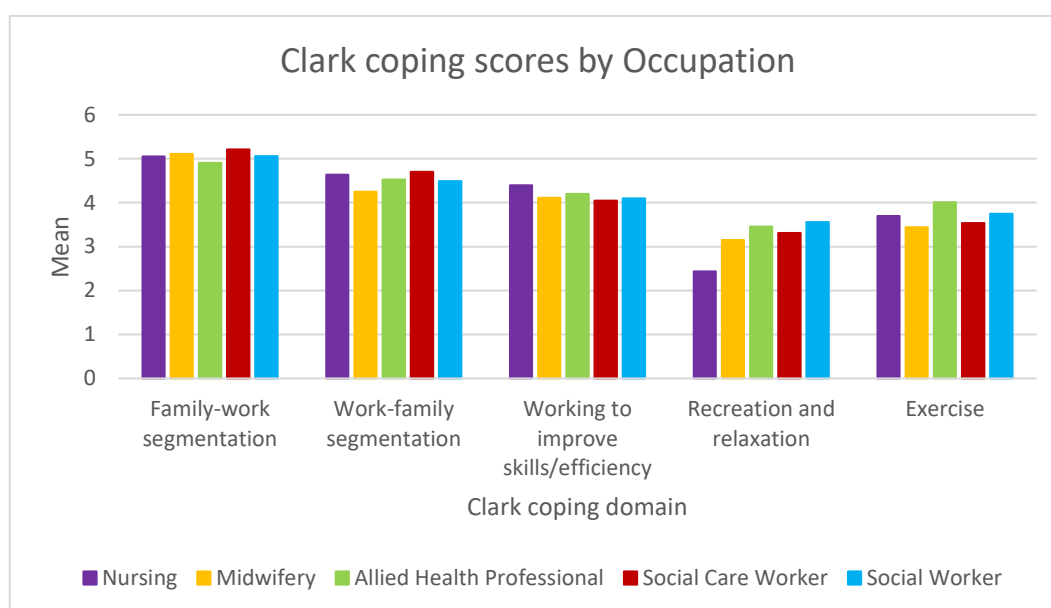


Table A7.3: Mean Clark Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	4.71	5.06	4.41	4.98	4.94
Work-family segmentation	4.29	4.11	4.23	4.67	4.20
Working to improve skills/efficiency	4.36	3.88	4.24	4.28	4.11
Recreation and relaxation	3.31	3.18	3.49	3.54	3.61
Exercise	3.52	3.32	3.80	3.40	3.61

Table A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	5.05	5.11	4.91	5.21	5.06
Work-family segmentation	4.64	4.25	4.53	4.70	4.49
Working to improve skills/efficiency	4.40	4.11	4.20	4.05	4.10
Recreation and relaxation	2.44	3.15	3.46	3.31	3.56
Exercise	3.70	3.44	4.01	3.54	3.75



### 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 ( $t = -5.804$ ,  $df = 1389$   $p < .001$ ), where females scored significantly higher than males.
- Working to improve skills/efficiency ( $t = 4.734$ ,  $df = 202.108$   $p < .001$ ), where females scored significantly higher than males.
- Recreation and relaxation ( $t = -3.566$ ,  $df = 288.268$ ,  $p < .001$ ), where females scored significantly lower than males.
- Exercise ( $t = -8.887$ ,  $df = 245.633$ ,  $p < .001$ ), where females scored significantly lower than males.

#### Summary (Unweighted results):

There were significant differences between males and females in mean scores on two out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ( $t = 2.109$ ,  $df = 1353$ ,  $p = .035$ ), where females scored significantly higher than males.
- Working to improve skills/efficiency ( $t = 2.947$ ,  $df = 1354$ ,  $p = .003$ ), where females scored significantly higher than males.

Figure A7.5: Mean Clark Coping Scores by Sex (Weighted)

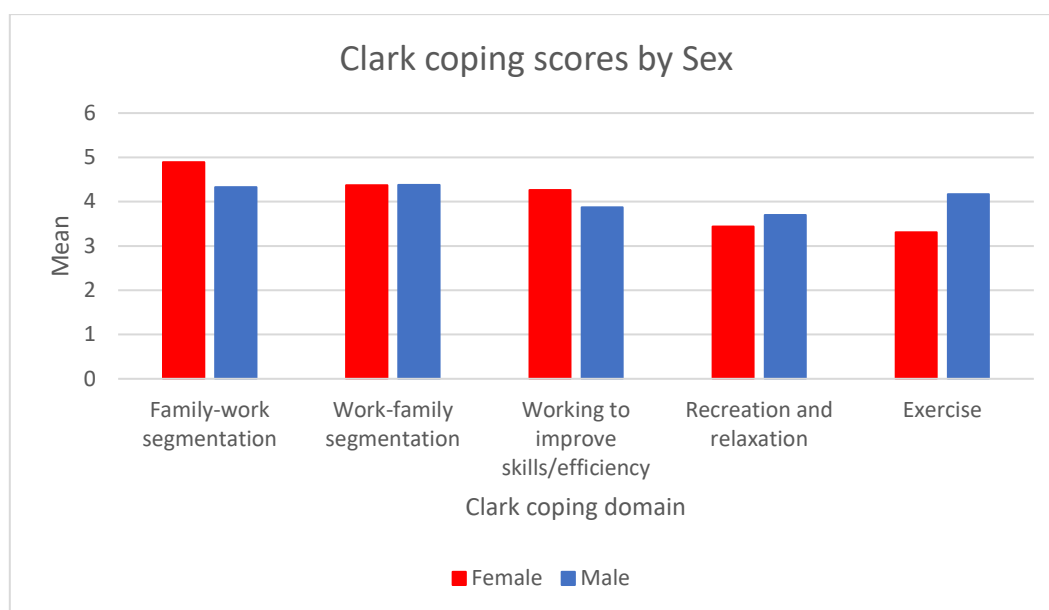


Figure A7.6: Mean Clark Coping Scores by Sex (Unweighted)

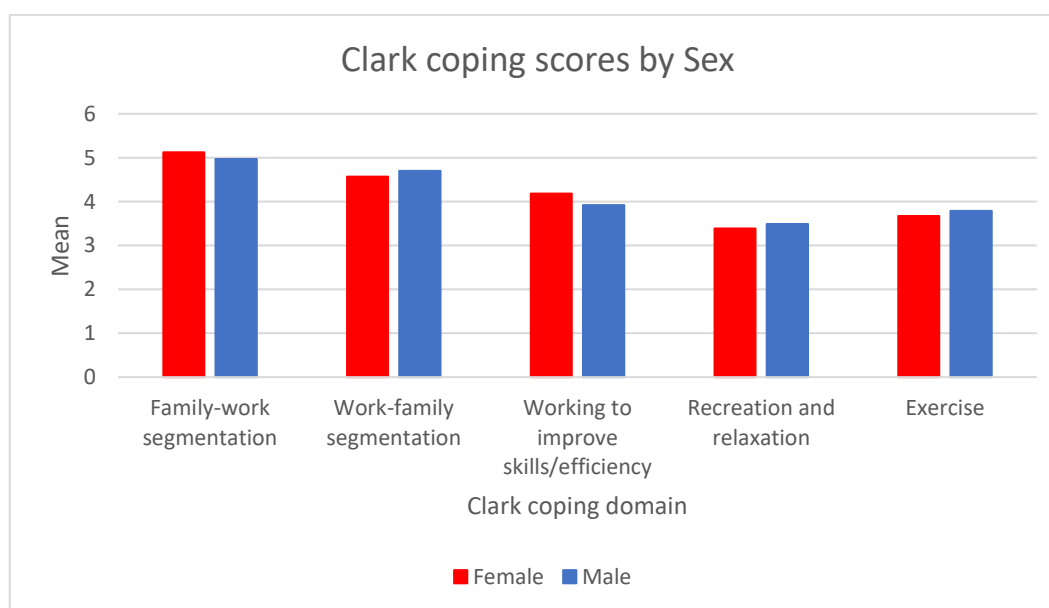


Table A7.5: Mean Clark Coping Scores by Sex (Weighted)

Coping Domain	Sex	
	Female	Male
Family-work segmentation	4.89	4.33
Work-family segmentation	4.37	4.38
Working to improve skills/efficiency	4.26	3.87
Recreation and relaxation	3.44	3.70
Exercise	3.31	4.17

Table A7.6: Mean Clark Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Family-work segmentation	5.12	4.97
Work-family segmentation	4.57	4.70
Working to improve skills/efficiency	4.18	3.92
Recreation and relaxation	3.39	3.49
Exercise	3.67	3.79

#### 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 ( $F = 29.637$ ,  $df = 4$ ,  $p < .001$ ), where the 50-59 age group scored significantly higher than the 16-29, 30-39 and 60+ age groups.
- Work-family segmentation ( $F = 9.310$ ,  $df = 4$ ,  $p < .001$ ), where the 16-29 age group scored significantly lower than the 30-39, 40-49, 50-59 and 60+ age groups.
- Working to improve skills/efficiency ( $F = 4.023$ ,  $df = 4$ ,  $p = .003$ ), where the 60+ age group scored significantly lower than the 30-39, 40-49 and 50-59 age groups.
- Recreation and relaxation ( $F = 5.889$ ,  $df = 4$ ,  $p < .001$ ), where the 50-59 age group were significantly higher than the 40-49 and 60+ age groups.

- Exercise ( $F = 22.740$ ,  $df = 4$ ,  $p < .001$ ), where the 30-39 age group scored significantly lower than all other age groups.

### Summary (Unweighted results):

There were significant differences between the age groups in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ( $F = 4.213$ ,  $df = 5$ ,  $p = .002$ ), where the 30-39 age group is significantly lower than the 40-49, 50-59 and 60+ age groups.
- Exercise ( $F = 4.613$ ,  $df = 5$ ,  $p < .001$ ); where the 16-29 age group scored significantly higher than the 40-49 and 50-59 age groups.

Figure A7.7: Mean Clark Coping Scores by Age (Weighted)

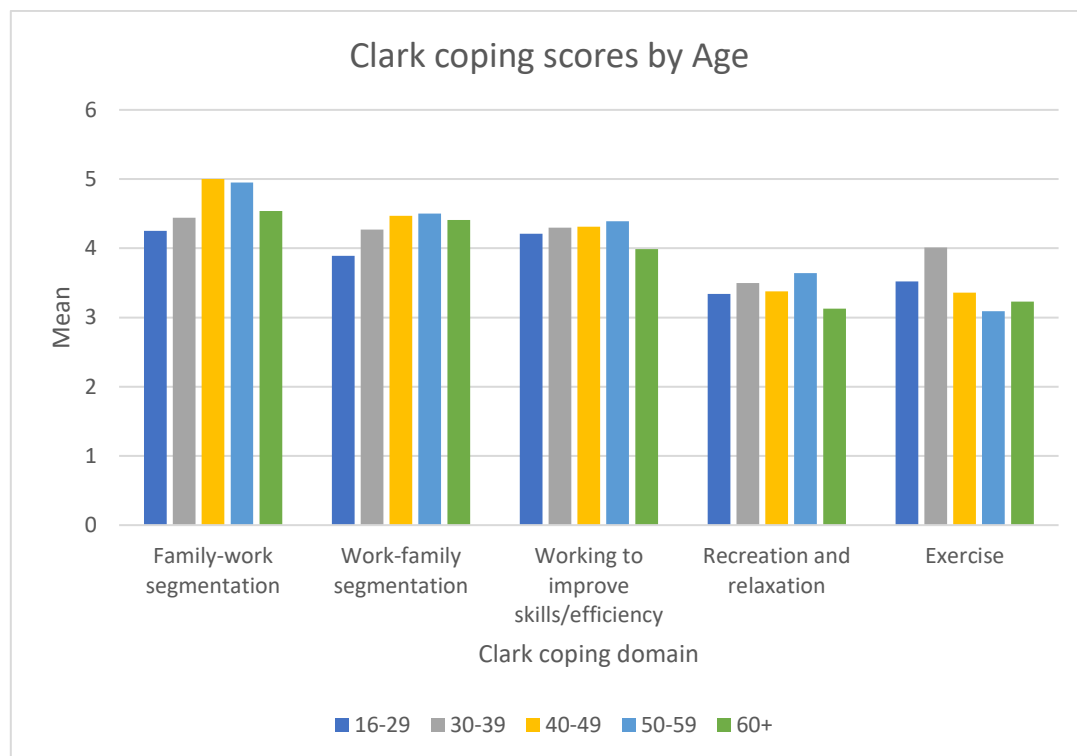


Figure A7.8: Mean Clark Coping Scores by Age (Unweighted)

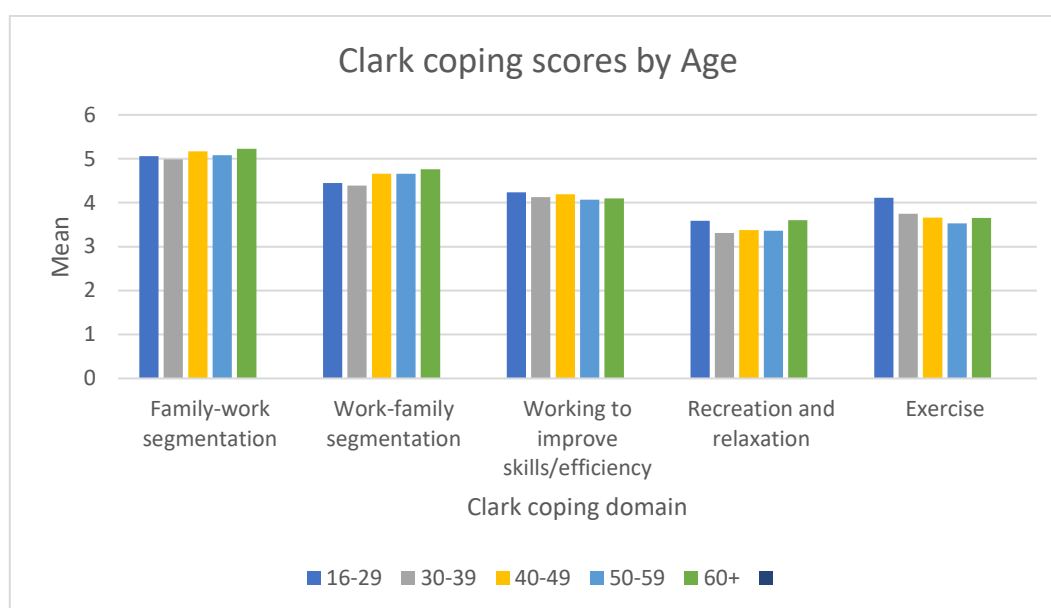


Table A7.7: Mean Clark Coping Scores by Age (Weighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60+
Family-work segmentation	4.25	4.44	5.00	4.95	4.54
Work-family segmentation	3.89	4.27	4.47	4.50	4.41
Working to improve skills/efficiency	4.21	4.30	4.31	4.39	3.99
Recreation and relaxation	3.34	3.50	3.38	3.64	3.13
Exercise	3.52	4.01	3.36	3.09	3.23

Table A7.8: Mean Clark Coping Scores by Age (Unweighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60+
Family-work segmentation	5.06	4.99	5.17	5.08	5.23
Work-family segmentation	4.45	4.39	4.66	4.66	4.76
Working to improve skills/efficiency	4.24	4.13	4.19	4.07	4.10
Recreation and relaxation	3.59	3.31	3.38	3.36	3.60
Exercise	4.11	3.75	3.66	3.53	3.65

## A7.5 Clark Coping Scores by Ethnicity

### Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on all five examined Clark coping domains. These differences were in:

- Family-work segmentation ( $F = 27.302$ ,  $df = 3$ ,  $p < .001$ ), where respondents from the Mixed ethnicity group scored significantly lower than all other ethnic groups.
- Work-family segmentation ( $F = 17.612$ ,  $df = 3$ ,  $p < .001$ ), where respondents from the Mixed ethnicity group scored significantly lower than all other ethnic groups.
- Working to improve skills/efficiency ( $F = 13.649$ ,  $df = 3$ ,  $p < .001$ ), where respondents from the White ethnic group scored significantly lower than the Black and Mixed ethnic groups.
- Recreation and relaxation ( $F = 8.614$ ,  $df = 3$ ,  $p < .001$ ), where respondents from the black ethnic group scored significantly higher than those in the White or Asian Ethnic groups.
- Exercise ( $F = 56.891$ ,  $df = 3$ ,  $p = .021$ ), where respondents from the Mixed ethnicity group scored significantly lower than all other ethnic groups.

### Summary (Unweighted results):

There were no significant differences between the ethnic groups in mean scores in any of the five examined Clark coping domains.

Figure A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

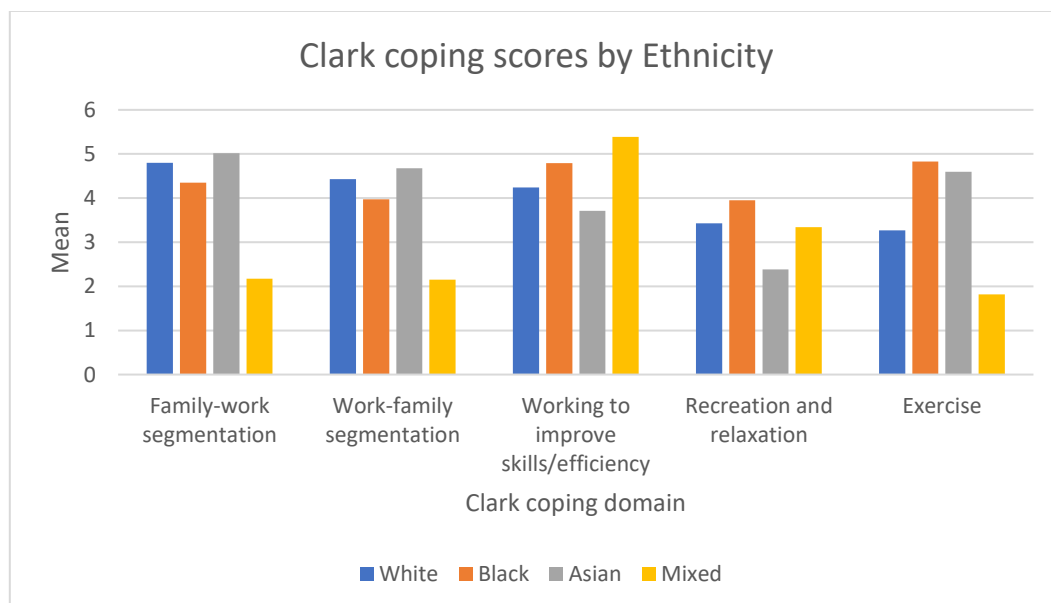


Figure A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

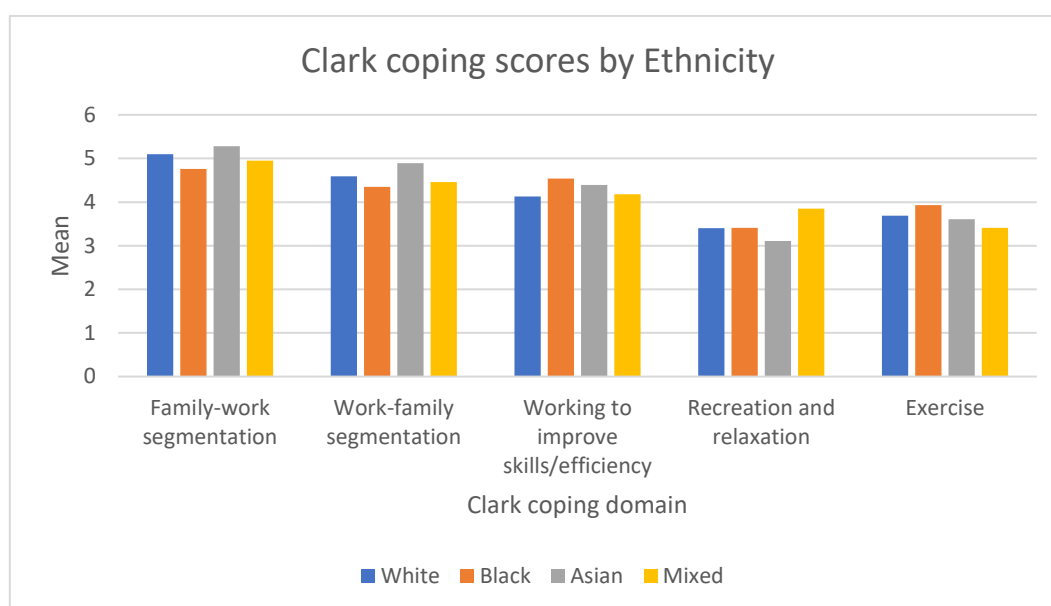


Table A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	4.80	4.35	5.02	2.17
Work-family segmentation	4.43	3.97	4.68	2.15
Working to improve skills/efficiency	4.24	4.79	3.71	5.39
Recreation and relaxation	3.43	3.95	2.38	3.34
Exercise	3.27	4.83	4.60	1.82

Table A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	5.10	4.76	5.28	4.95
Work-family segmentation	4.59	4.35	4.89	4.46
Working to improve skills/efficiency	4.13	4.54	4.39	4.18
Recreation and relaxation	3.40	3.41	3.11	3.85
Exercise	3.69	3.93	3.61	3.41

## 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 three out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ( $F = 35.783$ ,  $df = 2$ ,  $p < .001$ ), where respondents who had a disability scored significantly higher than those with no disability and those who were unsure if they had a disability.
- Work-family segmentation ( $F = 6.362$ ,  $df = 2$ ,  $p = .002$ ), where respondents who had a disability scored significantly higher than those with no disability and those who were unsure if they had a disability.
- Working to improve skills/efficiency ( $F = 4.060$ ,  $df = 2$ ,  $p = .017$ ), where respondents who were unsure if they had a disability scored significantly lower than those with a disability and those with no disability.
- Exercise ( $F = 3.074$ ,  $df = 2$ ,  $p = .047$ ), where respondents who had no disability scored significantly lower than those with a disability.

### 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:

- Work-family segmentation ( $F = 3.403$ ,  $df = 2$ ,  $p = .034$ ), where respondents without a disability scored significantly higher than those with a disability.
- Exercise ( $F = 3.983$ ,  $df = 2$ ,  $p = .019$ ), where respondents without a disability scored significantly higher than those who were unsure if they had disability.



Figure A7.11: Mean Clark Coping Scores by Disability (Weighted)

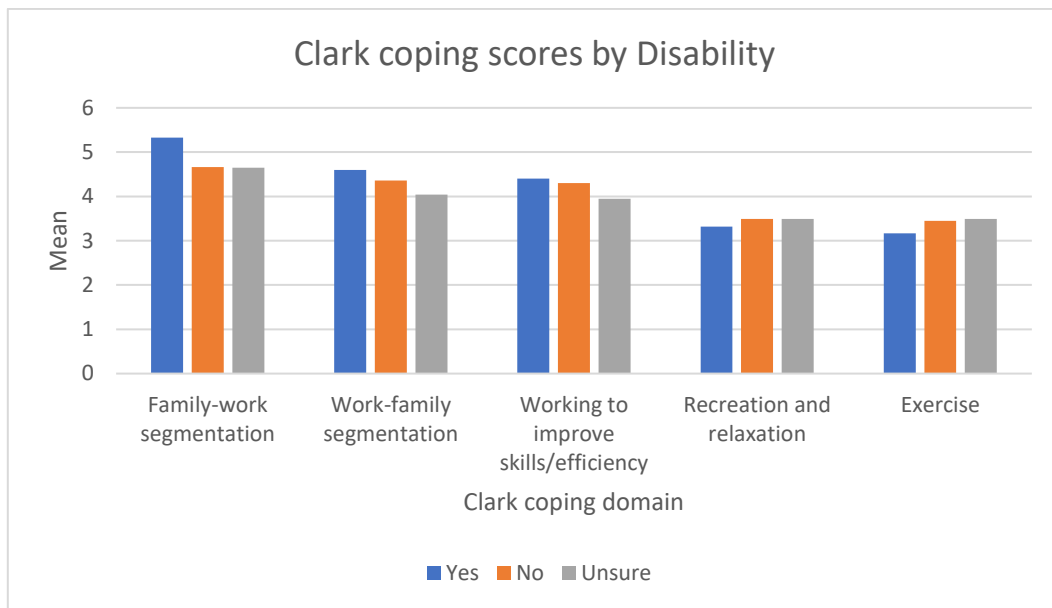


Figure A7.12: Mean Clark Coping Scores by Disability (Unweighted)

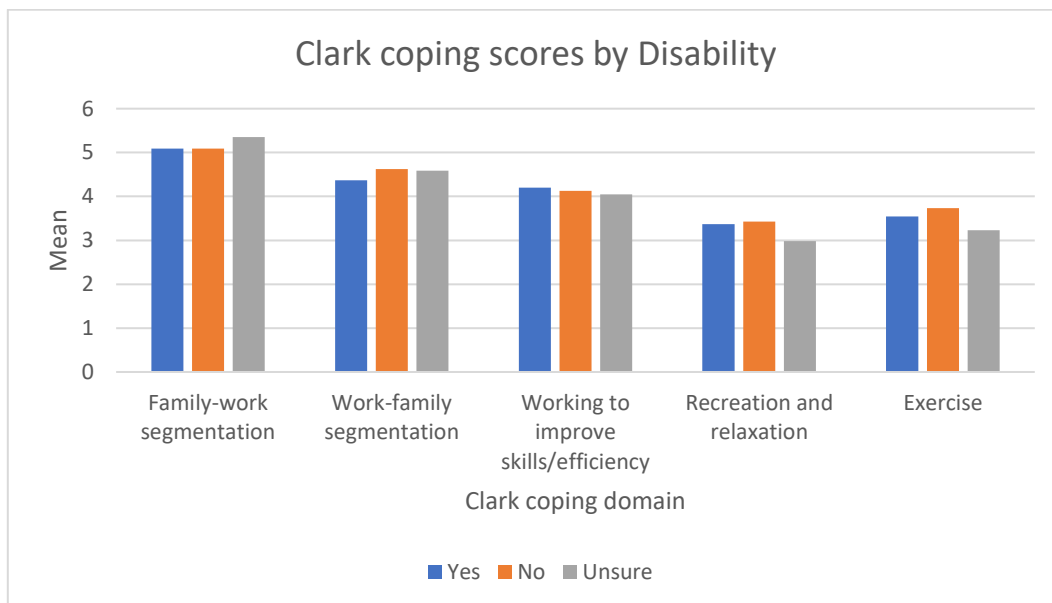


Table A7.11: Mean Clark Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Family-work segmentation	5.33	4.66	4.65
Work-family segmentation	4.60	4.36	4.04
Working to improve skills/efficiency	4.40	4.30	3.95
Recreation and relaxation	3.32	3.49	3.49
Exercise	3.17	3.45	3.49

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	5.09	5.09	5.35
Work-family segmentation	4.37	4.62	4.59
Working to improve skills/efficiency	4.20	4.13	4.05
Recreation and relaxation	3.37	3.43	2.98
Exercise	3.54	3.73	3.23

## 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 ( $F = 10.327$ ,  $df = 7$ ,  $p < .001$ ), where respondents working within the area of physical disability scored significantly lower than all those working in all other areas of practice examined.
- Work-family segmentation ( $F = 23.832$ ,  $df = 7$ ,  $p < .001$ ), where respondents working within mental health scored significantly higher than those working in midwifery, with adults of working age, within the area of physical disability, with older people and those in the area of practice 'other'. Those working with older people scored significantly lower than those working with children and young people, with adults of working age, within the area of learning disability, within mental health and those in the area of practice 'other'.

- Working to improve skills/efficiency ( $F = 8.492$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with children and young people scored significantly higher than those working in midwifery, with those working in the area of physical disability, with older people and those in the area of practice 'other'.
- Recreation and relaxation ( $F = 26.377$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with children and young people scored significantly higher than those working in midwifery, with adults of working age, in the area of physical disability, with older people and those in the area of practice 'other'.
- Exercise ( $F = 16.802$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with children and young people scored significantly higher than those working in midwifery, in the area of learning disability, with older people, within mental health and those in the area of practice 'other'.

### Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean scores in all five examined Clark coping domains. These differences were in:

- Family-work segmentation ( $F = 2.431$   $df = 7$ ,  $p = .018$ ), however multiple comparison tests revealed no significant differences.
- Work-family segmentation ( $F = 2.121$   $df = 7$ ,  $p = .039$ ), however multiple comparison tests revealed no significant differences.
- Recreation and relaxation ( $F = 5.07$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with children and young people scored significantly higher than those working in midwifery or with older people.
- Exercise ( $F = 4.199$ ,  $df = 7$ ,  $p < .001$ ), where respondents working with older people scored significantly lower than those working with children and young people, with adults of working age and within 'other' services.

Figure A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

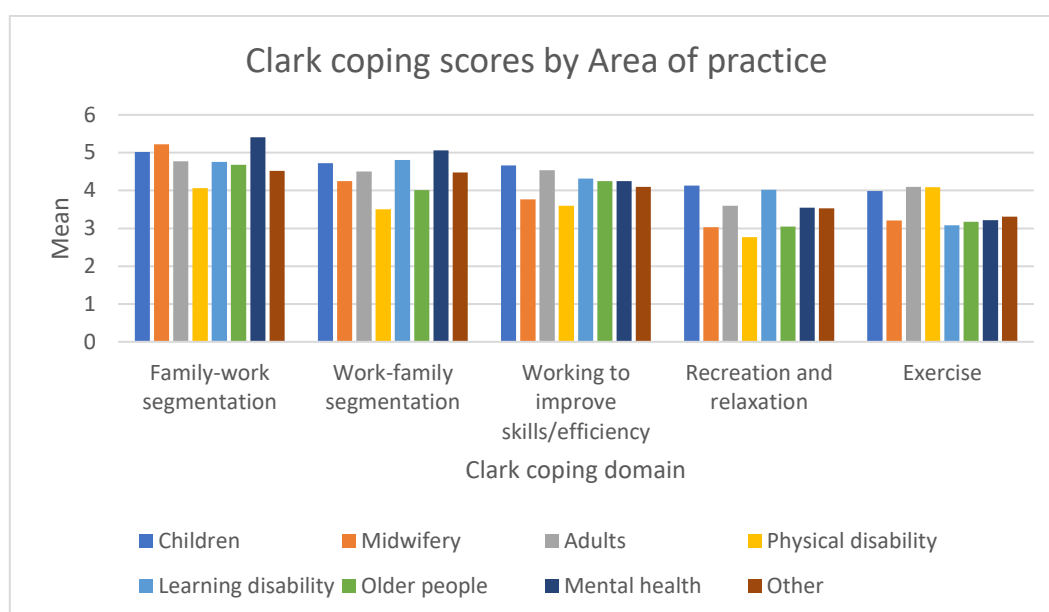


Figure A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)

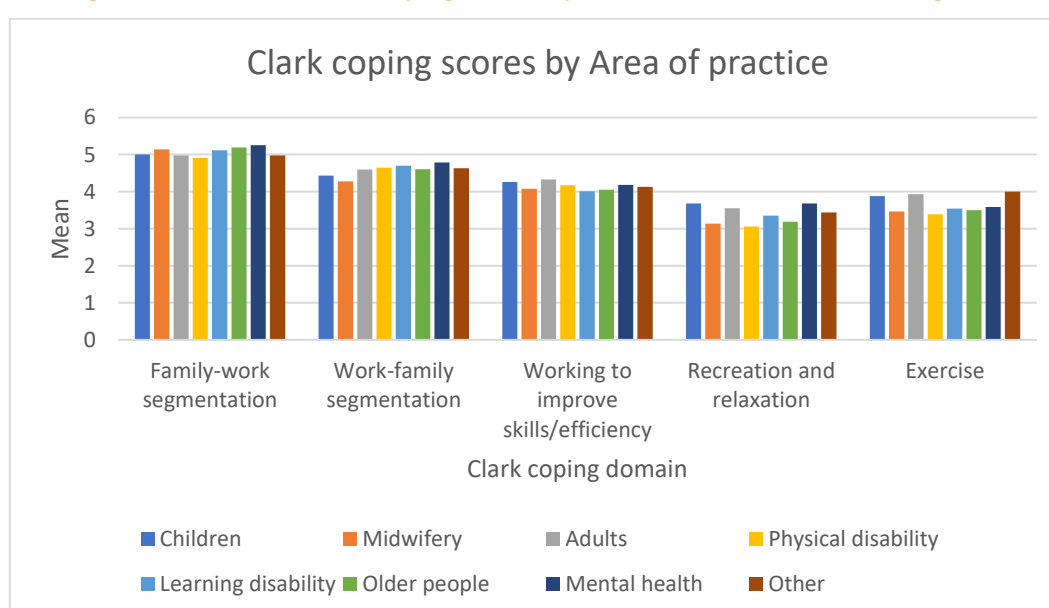


Table A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Family-work segmentation	5.02	5.22	4.77	4.06	4.76	4.68	5.41	4.52
Work-family segmentation	4.72	4.25	4.50	3.50	4.81	4.01	5.06	4.48
Working to improve skills/efficiency	4.66	3.77	4.54	3.60	4.32	4.25	4.25	4.10
Recreation and relaxation	4.13	3.03	3.60	2.77	4.02	3.05	3.55	3.53
Exercise	3.99	3.21	4.10	4.09	3.08	3.17	3.22	3.31

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	5.00	5.14	4.98	4.91	5.12	5.19	5.25	4.98
Work-family segmentation	4.43	4.28	4.60	4.65	4.70	4.61	4.79	4.63
Working to improve skills/efficiency	4.26	4.08	4.33	4.17	4.01	4.05	4.18	4.13
Recreation and relaxation	3.68	3.14	3.55	3.06	3.35	3.19	3.68	3.44
Exercise	3.88	3.47	3.93	3.39	3.54	3.50	3.59	4.00

## 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 four of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ( $t = -3.273$ ,  $df = 1390$ ,  $p = .001$ ), where line managers scored significantly lower than those who were not line managers.
- Work-family segmentation ( $t = -5.365$ ,  $df = 1387.045$ ,  $p < .001$ ), where line managers scored significantly lower than those who were not line managers.
- Working to improve skills/efficiency ( $t = -4.577$ ,  $df = 1385$ ,  $p < .001$ ), where line managers scored significantly lower than those who were not line managers.
- Recreation and relaxation ( $t = -5.928$ ,  $df = 1384$ ,  $p < .001$ ), where line managers scored significantly lower than those who were not line managers.
- Exercise ( $t = -3.022$ ,  $df = 1378.258$ ,  $p = .003$ ), 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 three out of the five examined Clark coping domains. The differences were in:

- Family-work segmentation ( $t = -2.121$ ,  $df = 1358$ ,  $p = .034$ ), where line managers scored significantly lower than those who were not line managers.
- Work-family segmentation ( $t = -2.114$ ,  $df = 1359$ ,  $p = .035$ ), where line managers scored significantly lower than those who were not line managers.
- Working to improve skills/efficiency ( $t = 2.589$ ,  $df = 896.482$ ,  $p = .010$ ), where line managers scored significantly higher than those who were not line managers.

Figure A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

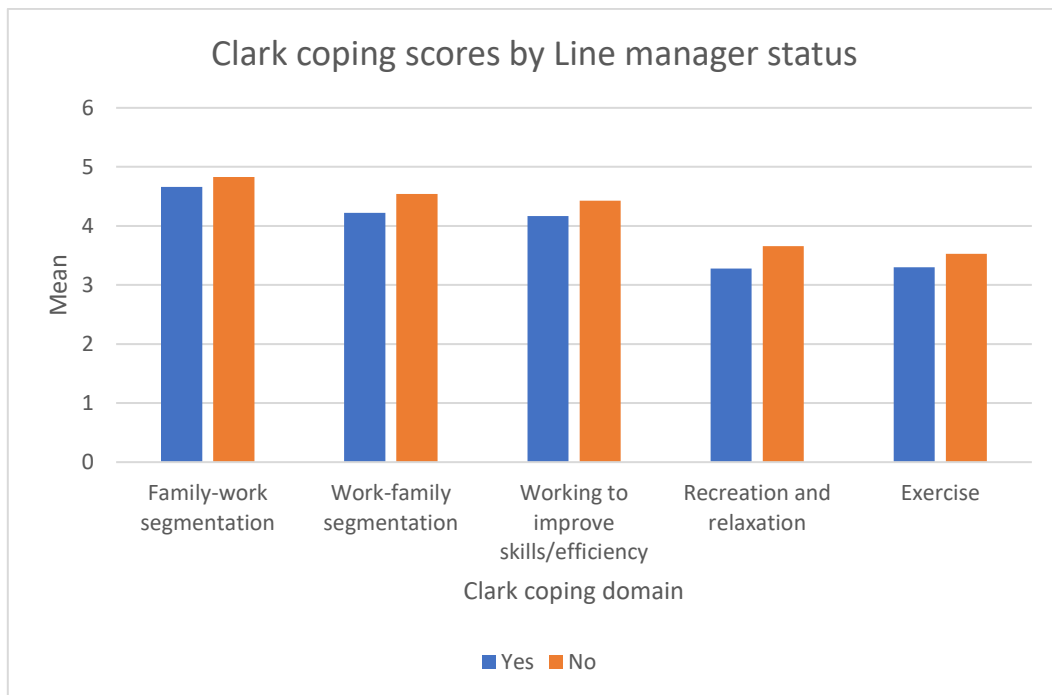


Figure A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

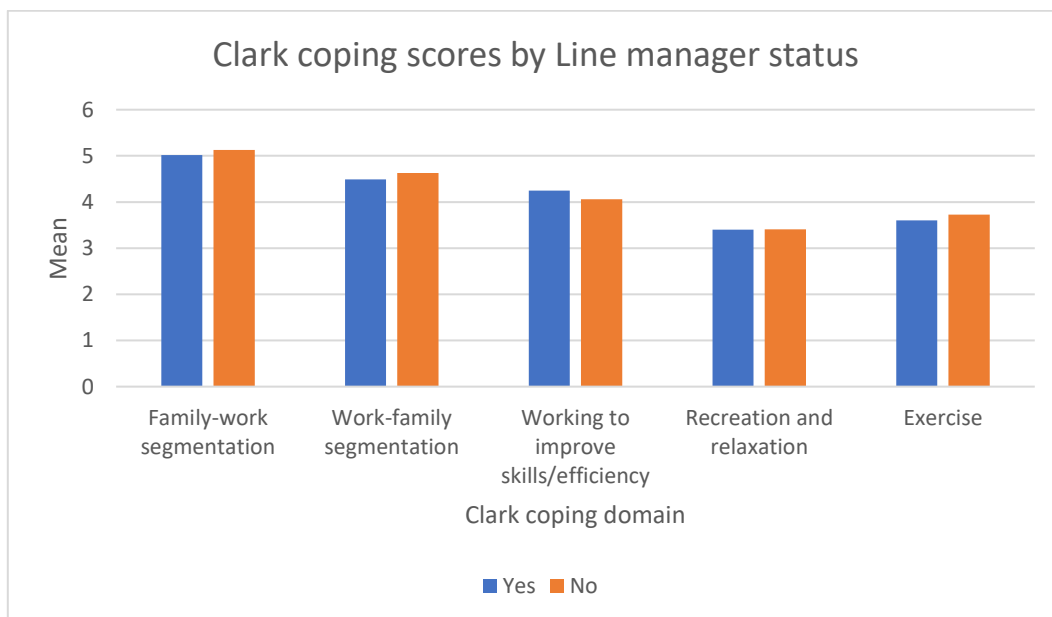


Table A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	4.66	4.83
Work-family segmentation	4.22	4.54
Working to improve skills/efficiency	4.17	4.43
Recreation and relaxation	3.28	3.66
Exercise	3.30	3.53

Table A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	5.02	5.13
Work-family segmentation	4.49	4.63
Working to improve skills/efficiency	4.25	4.06
Recreation and relaxation	3.40	3.41
Exercise	3.60	3.73

## A7.9 Clark Coping Scores by the Impact of the Pandemic on Services

### Summary (Weighted results):

There were significant differences in mean scores on all 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:

- Family-work segmentation ( $F = 77.319$   $df = 2$ ,  $p < .001$ ), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who were felt some impact and those not impacted.
- Work-family segmentation ( $F = 7.056$ ,  $df = 2$ ,  $p < .001$ ), where respondents not impacted by COVID-19 scored significantly higher than those overwhelmed by increased pressures and those impacted but not significantly.



- Working to improve skills/efficiency ( $F = 13.701$ ,  $df = 2$ ,  $p = .010$ ), where respondents who were overwhelmed by the increased pressures scored significantly higher than those who were impacted but not significantly.
- Recreation and relaxation ( $F = 24.432$ ,  $df = 2$ ,  $p < .001$ ), where respondents who felt impacted but not significantly scored significantly lower than those not impacted by COVID-19 pressures and those overwhelmed by increased pressures.
- Exercise ( $F = 47.877$ ,  $df = 2$ ,  $p < .001$ ), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who were impacted some and those who were not impacted.

### 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:

- Family-work segmentation ( $F = 3.690$ ,  $df = 2$ ,  $p = .025$ ), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who only felt impacted but not significantly.
- Work-family segmentation ( $F = 6.665$ ,  $df = 2$ ,  $p = .001$ ), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact.
- Recreation and relaxation ( $F = 3.082$ ,  $df = 2$ ,  $p = .046$ ), multiple comparison tests revealed no significant differences between the groups.

Figure A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

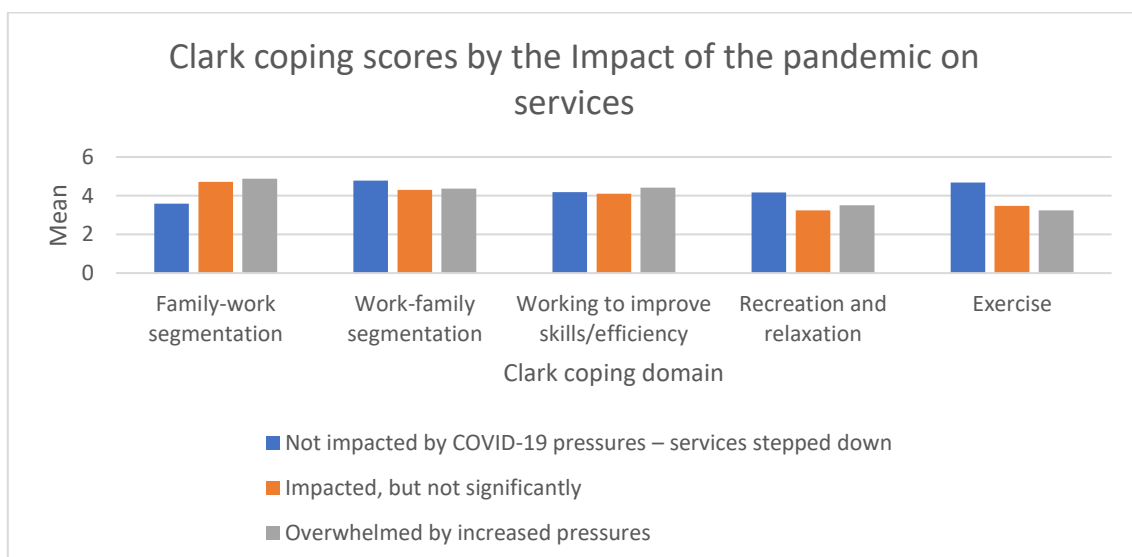


Figure A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)

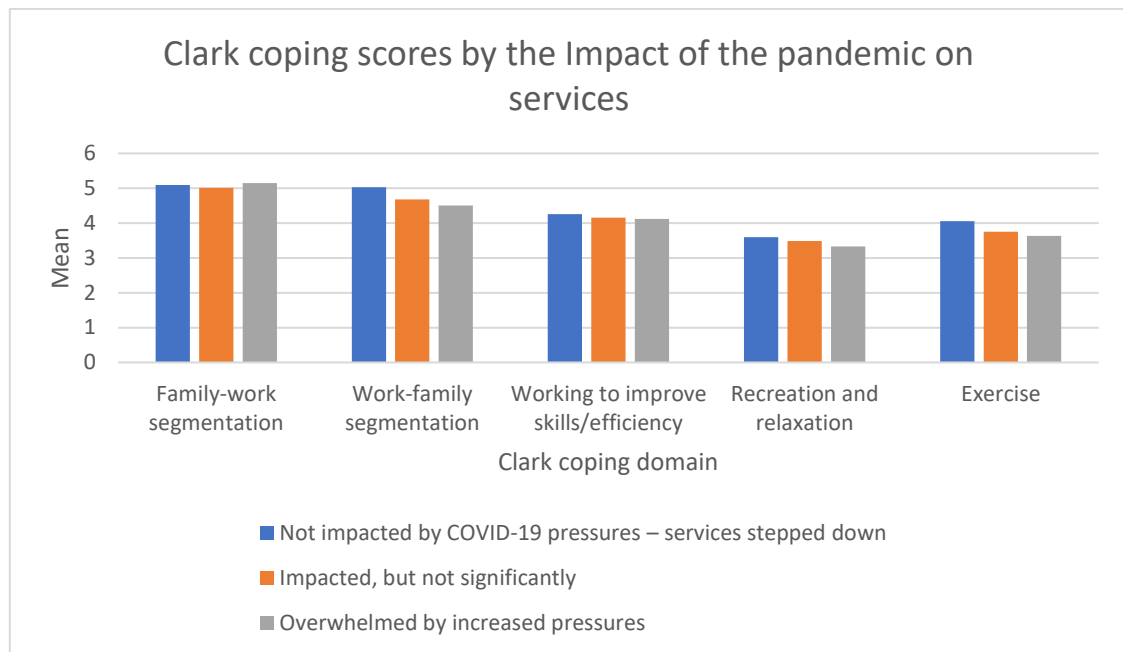


Table A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

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
Family-work segmentation	3.59	4.72	4.88
Work-family segmentation	4.78	4.30	4.37
Working to improve skills/efficiency	4.19	4.10	4.41
Recreation and relaxation	4.17	3.24	3.51
Exercise	4.68	3.47	3.24

Table A7.18: Mean Clark Coping Scores by Effects 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
Family-work segmentation	5.09	5.01	5.15
Work-family segmentation	5.03	4.68	4.51
Working to improve skills/efficiency	4.26	4.16	4.12
Recreation and relaxation	3.6	3.49	3.33
Exercise	4.06	3.75	3.63

### A7.9 Clark Coping Scores by Uptake of Employer Support

#### Summary (Weighted results):

There were significant differences in mean scores on four out of the five examined Clark coping domains between respondents who took employer support and those who did not. These differences were in:

- Family-work segmentation ( $t = -2.090$ ,  $df = 1390$ ,  $p = .037$ ), where those who took employer support scored significantly lower than those who did not.
- Working to improve skills and efficiency ( $t = 5.592$ ,  $df = 708.464$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not.
- Recreation and relaxation ( $t = 7.113$ ,  $df = 791.601$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not.
- Exercise ( $t = 5.518$ ,  $df = 743.370$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not.

#### Summary (Unweighted results):

There were significant differences in mean scores on three out of the five examined Clark coping domains between respondents who took employer support and those who did not. These differences were in:

- Family-work segmentation ( $t = -2.473$ ,  $df = 1358$ ,  $p = .014$ ), where those who took employer support scored significantly lower than those who did not.
- Working to improve skills and efficiency ( $t = 4.708$ ,  $df = 1359$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not.

- Recreation and relaxation ( $t = 4.210$ ,  $df = 1355$ ,  $p < .001$ ), where those who took employer support scored significantly higher than those who did not.

Figure A7.19: Mean Clark Coping Scores by Uptake of Employer Support (Weighted)

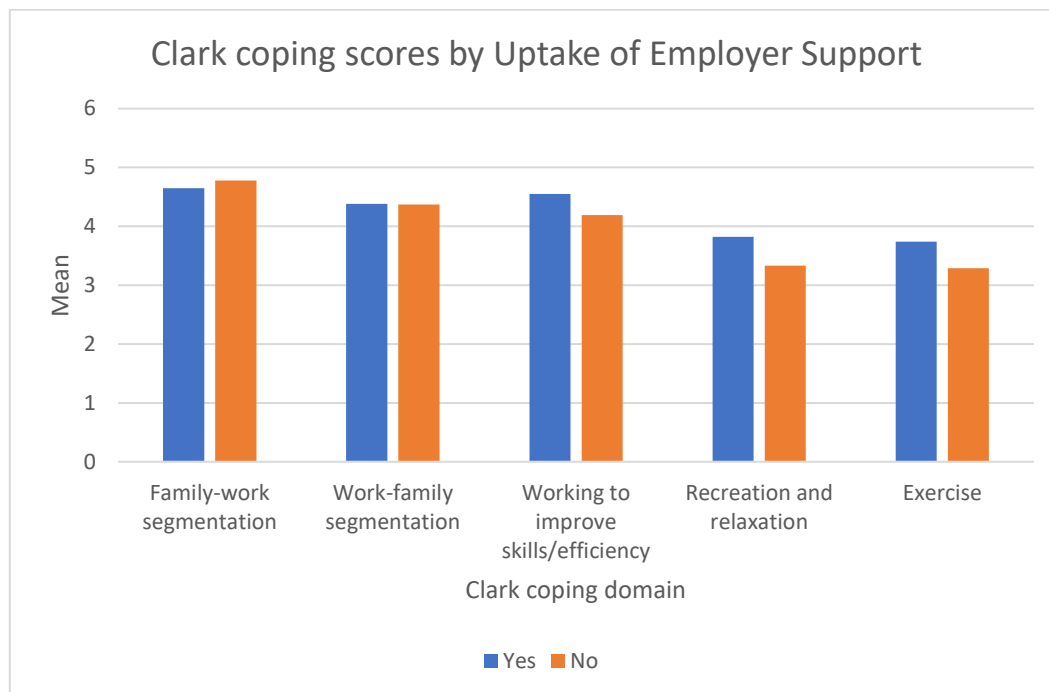


Figure A7.20: Mean Clark Coping Scores by Uptake of Employer Support (Unweighted)

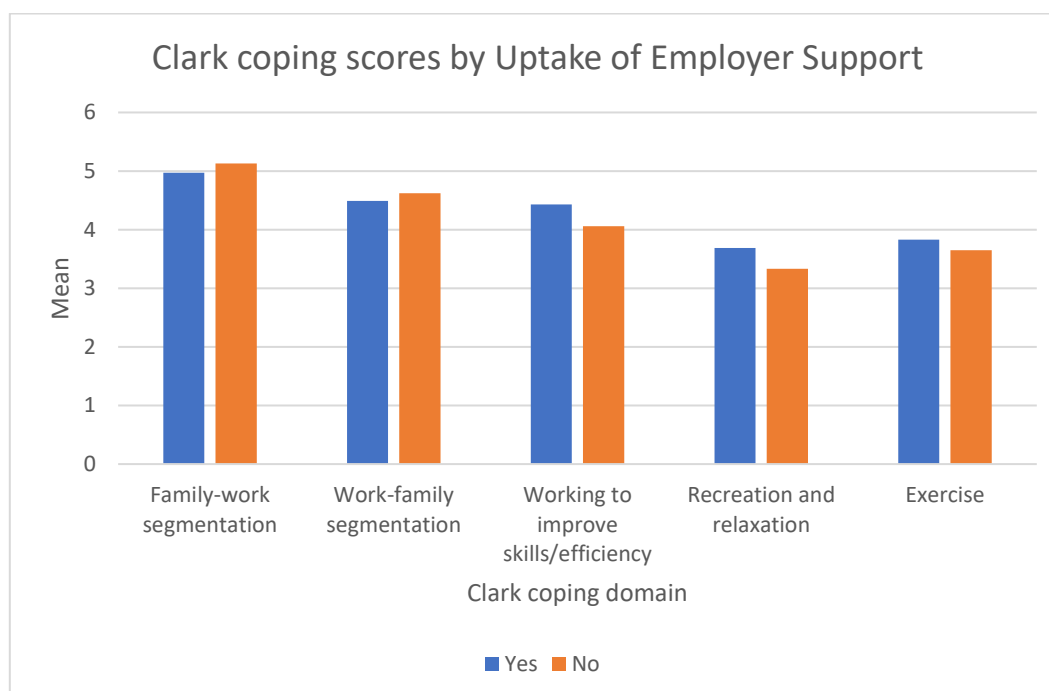


Table A7. 19: Mean Clark Coping Scores by Uptake of Employer Support (Weighted)

Coping domain	Uptake of Employer Support	
	Yes	No
Family-work segmentation	4.65	4.78
Work-family segmentation	4.38	4.37
Working to improve skills/efficiency	4.55	4.19
Recreation and relaxation	3.82	3.33
Exercise	3.74	3.29

Table A7. 20: Mean Clark Coping Scores by Uptake of Employer Support (Unweighted)

Coping domain	Uptake of Employer Support	
	Yes	No
Family-work segmentation	4.97	5.13
Work-family segmentation	4.49	4.62
Working to improve skills/efficiency	4.43	4.06
Recreation and relaxation	3.69	3.33
Exercise	3.83	3.65

## Appendix 8: Multiple Regression Results (Unweighted)

### A8.1 Multiple Regression Model Predicting Well-being Scores

Research question: Do coping mechanisms predict Well-being scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Well-being 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

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 47.6% of the variance (adjusted  $R^2 = .460$ ,  $F(40, 1289) = 29.25$   $p < .001$ ).

The following coping strategies predicted overall well-being score (SWEMWBS):

1. **Carver's Positive Reframing**; respondents with higher positive reframing scores had higher well-being scores ( $\beta = .074$ ,  $p = .009$ ).
2. **Carver's Acceptance**; respondents with higher Acceptance scores had higher Well-being scores ( $\beta = .124$ ,  $p < .001$ ).
3. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher Well-being scores ( $\beta = .228$ ,  $p < .001$ ).

4. **Carver's Use of instrumental support**; respondents with higher use of instrumental scores had lower Well-being scores ( $\beta = -.060$ ,  $p = .039$ ).
5. **Carver's Venting**; respondents with higher venting scores had lower Well-being scores ( $\beta = -.131$ ,  $p = .028$ ).
6. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower Well-being scores ( $\beta = -.088$ ,  $p < .001$ ).
7. **Carver's Self-blame**; respondents with higher Self-blame scores had lower Well-being scores ( $\beta = -.332$ ,  $p < .001$ ).
8. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower Well-being scores ( $\beta = -.089$ ,  $p = .010$ ).
9. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher Well-being scores ( $\beta = .128$ ,  $p < .001$ ).
10. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher Well-being scores ( $\beta = .078$ ,  $p = .001$ ).
11. **Clark et al.'s Exercise**; respondents with higher Exercise scores had higher Well-being scores ( $\beta = .062$ ,  $p < .001$ ).

Other variables predicting the overall well-being score:

12. **Ethnicity**; respondents who identified as black had higher well-being scores than those who were white ( $\beta = -.071$ ,  $p < .001$ ).
13. **Effects of the pandemic**; respondents who were overwhelmed by the pandemic ( $\beta = -.173$ ,  $p = .005$ ) all had lower well-being scores than those whose services were not impacted at all.
14. **Country of work**; respondents worked in Northern Ireland had higher well-being scores than those who worked in England ( $\beta = 0.063$ ,  $p = .042$ ).
15. **Number of sick days in previous 12 months**; respondents who took 41-60 ( $\beta = -0.045$ ,  $p = .032$ ) and those who took more than 60 sick days ( $\beta = -0.083$ ,  $p < .001$ ) all had lower WRQOL scores than those who took no sick days.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ( $\beta = -.084$ ,  $p < .001$ ) had lower well-being scores than those who did not intend on leaving their employer. Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that

respondents who answered yes for wanting to leave ( $\beta = -.131, p < .001$ ) had lower well-being scores than those who did not intent on leaving their occupation.



## 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?

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

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 42.4% of the variance (adjusted  $R^2 = .406$ ,  $F(40, 1281) = 23.53$ ,  $p < .001$ ).

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 ( $\beta = -0.153$ ,  $p < .001$ ).
2. **Carver's Positive reframing**; respondents with higher Positive reframing scores had higher WRQOL scores ( $\beta = 0.091$ ,  $p = .002$ ).
3. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher WRQOL scores ( $\beta = 0.213$ ,  $p < .001$ ).
4. **Carver's Venting**; respondents with higher Venting scores had lower WRQOL scores ( $\beta = -0.164$ ,  $p < .001$ ).

5. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower WRQOL scores ( $\beta = -0.088$ ,  $p < .001$ ).
6. **Carver's Self-blame**; respondents with higher Self-blame scores had lower WRQOL scores ( $\beta = -0.162$ ,  $p < .001$ ).
7. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower WRQOL scores ( $\beta = -0.133$ ,  $p < .001$ ).
8. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher WRQOL scores ( $\beta = 0.083$ ,  $p < .001$ ).
9. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher WRQOL scores ( $\beta = 0.161$ ,  $p < .001$ ).
10. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher WRQOL scores ( $\beta = 0.107$ ,  $p < .001$ ).

Other variables predicting the overall WRQOL score:

11. **Disability**; respondents who were unsure if they had a disability ( $\beta = -0.050$ ,  $p = .022$ ) had lower WRQOL scores than those who did not have a disability.
12. **Ethnicity**; respondents who reported Black ethnicity ( $\beta = 0.045$ ,  $p = .039$ ) had higher WRQOL scores than those of White Ethnicity.
13. **Country of work**; respondents working in Wales ( $\beta = -0.083$ ,  $p = .043$ ) had lower WRQOL scores than those working in England.
14. **Number of sick days in previous 12 months**; respondents who took 11-20 sick days ( $\beta = -0.053$ ,  $p = .021$ ); those who took 21-40 sick days ( $\beta = -0.086$ ,  $p < .001$ ); those who took 41-60 ( $\beta = -0.045$ ,  $p = .045$ ) and those who took more than 60 sick days ( $\beta = -0.108$ ,  $p = .014$ ) all had lower WRQOL scores than those who took no sick days.
15. **Line manager status**; respondents who were line managers had higher WRQOL scores than those who were not line managers ( $\beta = 0.132$ ,  $p < .001$ ).
16. **Effects of the pandemic on services**; respondents who felt impacted but not significantly ( $\beta = -0.159$ ,  $p = .014$ ) and respondents who felt overwhelmed by increased pressures ( $\beta = -0.335$ ,  $p < .001$ ) had lower WRQOL scores than those who felt no impact.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes

to wanting to leave ( $\beta = -0.344$ ,  $p < .001$ ) had WRQOL scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ( $\beta = -0.217$ ,  $p < .001$ ) had lower WRQOL scores than those who did not intend on leaving their occupation.

### 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

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 44.3% of the variance (adjusted  $R^2 = .426$ ,  $F(40, 1356) = 25.64$ ,  $p < .001$ ).

The following coping strategies predicted personal burnout scores:

1. **Carver's Active coping**; respondents with higher Active coping scores had lower Personal burnout scores ( $\beta = -0.079$ ,  $p = .021$ ).
2. **Carver's Planning**; respondents with higher Planning scores had higher Personal burnout scores ( $\beta = 0.132$ ,  $p < .001$ ).
3. **Carver's Acceptance**; respondents with higher Acceptance scores had lower Personal burnout scores ( $\beta = -0.071$ ,  $p = .005$ ).
4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Personal burnout scores ( $\beta = -0.146$ ,  $p < .001$ ).

5. **Carver's Venting**; respondents with higher Venting scores had higher Personal burnout scores ( $\beta = 0.138$ ,  $p < .001$ )
6. **Carver's Substance use**; respondents with higher Substance use scores had higher Personal burnout scores ( $\beta = 0.062$ ,  $p = .004$ ).
7. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Personal burnout scores ( $\beta = 0.127$ ,  $p < .001$ ).
8. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Personal burnout scores ( $\beta = 0.257$ ,  $p < .001$ ).
9. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Personal burnout scores ( $\beta = 0.120$ ,  $p < .001$ ).
10. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had lower Personal burnout scores ( $\beta = -0.083$ ,  $p < .001$ ).
11. **Clark et al.'s Exercise**; respondents with higher Exercise scores had lower Personal burnout scores ( $\beta = -0.0871$ ,  $p < .001$ ).

Other variables predicting the personal burnout score:

12. **Age**; respondents aged 50-59 ( $\beta = -0.088$ ,  $p = .017$ ), those aged 50-59 ( $\beta = -0.085$ ,  $p = .017$ ) and those aged 60+ ( $\beta = -0.081$ ,  $p = .003$ ) all had lower personal burnout scores than those aged 16-29.
13. **Sex**; males had lower personal burnout scores than females ( $\beta = -0.095$ ,  $p < .001$ ).
14. **Disability**; respondents with a disability ( $\beta = 0.064$ ,  $p = .003$ ) and those who were unsure of disability ( $\beta = 0.055$ ,  $p = .010$ ) had higher personal burnout scores than those who did not have a disability.
15. **Ethnicity**; respondents who were of Black ethnicity had lower personal burnout scores than those of White ethnicity ( $\beta = -0.053$ ,  $p = .014$ ).
16. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days ( $\beta = 0.082$ ,  $p < .001$ ), those who took 11-20 sick days ( $\beta = 0.110$ ,  $p < .001$ ), those who took 21-40 sick days ( $\beta = 0.067$ ,  $p = .003$ ), those who took 41-60 sick days ( $\beta = 0.046$ ,  $p = .036$ ), and those who took more than 60 sick days ( $\beta = 0.283$ ,  $p < .001$ ), all had higher personal burnout scores than those who took no sick days.
17. **Effects of the pandemic on services**; respondents who felt their services had felt overwhelmed by increased pressures ( $\beta = 0.283$ ,  $p < .001$ ) had higher personal burnout scores than those who felt no impact.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ( $\beta = 0.095$ ,  $p < .001$ ) had higher personal burnout scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ( $\beta = 0.115$ ,  $p < .001$ ) had higher personal burnout scores than those who did not intend on leaving their employer.

#### 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

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 45.0% of the variance (adjusted  $R^2 = .433$ ,  $F(40, 1290) = 26.42$ ,  $p < .001$ ).

The following coping strategies predicted personal burnout scores:

1. **Carver's Planning**; respondents with higher Planning scores had higher Work-related burnout scores ( $\beta = 0.126$ ,  $p < .001$ ).
2. **Carver's Positive reframing**; respondents with higher positive reframing scores had lower Work-related burnout scores ( $\beta = -0.126$ ,  $p = .011$ ).
3. **Carver's Acceptance**; respondents with higher acceptance scores had lower Work-related burnout scores ( $\beta = -0.052$ ,  $p = .036$ ).
4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Work-related burnout scores ( $\beta = -0.173$ ,  $p < .001$ ).

5. **Carver's Use of instrumental support**; respondents with higher Use of instrumental support scores had higher Work-related burnout scores ( $\beta = 0.062$ ,  $p = .006$ ).
6. **Carver's Venting**; respondents with higher Venting scores had higher Work-related burnout scores ( $\beta = 0.163$ ,  $p < .001$ ).
7. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Work-related burnout scores ( $\beta = 0.105$ ,  $p < .001$ ).
8. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Work-related burnout scores ( $\beta = 0.198$ ,  $p < .001$ ).
9. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Work-related burnout scores ( $\beta = 0.141$ ,  $p < .001$ ).
10. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had lower Work-related burnout scores ( $\beta = -0.099$ ,  $p < .001$ ).
11. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Work-related burnout scores ( $\beta = -0.081$ ,  $p < .001$ ).
12. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had lower Work-related burnout scores ( $\beta = -0.103$ ,  $p < .001$ ).

Other variables predicting the work-related burnout score:

13. **Age**; respondents aged 30-39 ( $\beta = -0.066$ ,  $p = .042$ ), those aged 50-59 ( $\beta = -0.072$ ,  $p = 0.40$ ), and those aged 60+ ( $\beta = -0.091$ ,  $p < .001$ ) all had lower work-related burnout scores than those aged 16-29.
14. **Ethnicity**; respondents of Black ethnicity ( $\beta = -0.054$ ,  $p = .011$ ) had lower work-related burnout scores than those of White ethnicity.
15. **Disability**; respondents who were unsure if they had a disability ( $\beta = 0.053$ ,  $p = .012$ ) and those who were unsure of disability ( $\beta = 0.055$ ,  $p = .010$ ) had higher work-related burnout scores than those who did not have a disability.
16. **Occupation**; respondents who worked as social care workers ( $\beta = 0.113$ ,  $p = .001$ ) had higher work-related burnout scores than those who worked in nursing.
17. **Number of sick days in previous 12 months**; respondents who took less than 10 days ( $\beta = 0.063$ ,  $p = .008$ ), those who took 11-20 sick days ( $\beta = 0.069$ ,  $p = .002$ ), those who took 21-40 sick days ( $\beta = 0.085$ ,  $p < .001$ ) and those who had more than 60 days sick leave ( $\beta = 0.101$ ,  $p < .001$ ) had higher work-related burnout scores than those who took no sick days.



**18. Effects of the pandemic on services;** respondents who felt overwhelmed by increased pressures ( $\beta = 0.381$ ,  $p < .001$ ) or impacted but not significantly ( $\beta = 0.171$ ,  $p = .006$ ) had higher work-related burnout scores than those who felt no impact.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ( $\beta = 0.213$ ,  $p < .001$ ) had higher work-related burnout scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ( $\beta = 0.203$ ,  $p < .001$ ) had higher work-related burnout scores than those who did not intend on leaving their employer.

## 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

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 20.2% of the variance (adjusted  $R^2 = .177$ ,  $F(40, 1274) = 8.06$ ,  $p < .001$ ).

The following coping strategies predicted client-related burnout scores:

1. **Carver's Positive reframing**, respondents with lower positive reframing scores had higher Client-related burnout scores ( $\beta = -0.106$ ,  $p = .003$ ).
2. **Carvers Venting**; respondents with higher Venting scores had higher Client-related burnout scores ( $\beta = 0.114$ ,  $p < .001$ ).
3. **Carver's Substance use**; respondents with higher substance use scores had higher Client-related burnout scores ( $\beta = 0.033$ ,  $p < .001$ ).
4. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Client-related burnout scores ( $\beta = 0.154$ ,  $p < .001$ ).

5. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Client-related burnout scores ( $\beta = -0.177$ ,  $p < .001$ ).
6. **Clark et al.'s Exercise**; respondents with higher Exercise scores had higher Client-related burnout scores ( $\beta = 0.066$ ,  $p = .020$ ).

Other variables predicting the client-related burnout score:

7. **Sex**; males had higher client-related burnout scores than females ( $\beta = 0.104$ ,  $p < .001$ ).
8. **Country of work**; respondents who worked in Wales ( $\beta = -0.069$ ,  $p = .022$ ) had lower client-related burnout scores than those who worked in England.
9. **Number of sick days in previous 12 months**; respondents who had more than 60 sick days ( $\beta = 0.115$ ,  $p < .001$ ) 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 ( $\beta = -0.064$ ,  $p = .018$ ).

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ( $\beta = .117$ ,  $p < .001$ ) had higher client-related burnout scores than those who did not intend on leaving their employer. Additionally, respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ( $\beta = 0.147$ ,  $p < .001$ ) had higher client-related burnout scores than those who did not intend on leaving their employer.

## Appendix 9: Comparison of Phase 1 (May – July 2020), Phase 2 (Nov 2020 – Feb 2021), Phase 3 (May – July 2021), Phase 4 (Nov 2021-Feb 2022) and Phase 5 (May-July 2022).

This section presents descriptive comparisons of data from Phase 1 (May – July 2020) and Phase 2 (November 2020 – February 2021) Phase 3 (May – July 2021, Phase 4 (November 2021-February 2022)) with Phase 5 (May – July 2022) 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.

*Note: regression coefficients used in this report are unstandardised.*

### A9.1 Well-being Scores by Study Phase and Country

The overall mean well-being scores decreased from Phase 1 of the study to Phase 5, both UK-wide and within the individual countries. Between Phase 2 to Phase 5 of the study, the overall mean well-being scores increased slightly across all countries except Wales, which showed a slight decrease. However, between Phases 3 and 5, while the UK-wide average increased, respondents in Wales, reported a decrease in well-being scores. Between Phase 4 and Phase 5, the overall mean well-being decreased UK-wide and in England and Wales, but respondents in Scotland and Northern Ireland, reported an increase in well-being scores.

*UK-wide analysis:* Using regression analysis, the decrease in the overall mean well-being scores between Phase 1 and Phase 5 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 ( $\beta = -0.678$ ,  $p < .001$ ). There was a slight increase in the overall mean well-being scores between Phase 2 and Phase 5 of the study which was found to be **statistically significant** when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.271$ ,  $p = .032$ ). The difference in the overall mean wellbeing scores between Phase 3 and Phase 5 of the study was **not statistically significant** when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = .205$ ,  $p = .116$ ). Similarly, the slight decrease in the overall mean wellbeing scores between Phase 4 and Phase 5 was **not statistically significant** when adjusting for the same covariates

Figure A9. 1: Mean Overall Well-being Score by Study Phase and Country (Weighted)

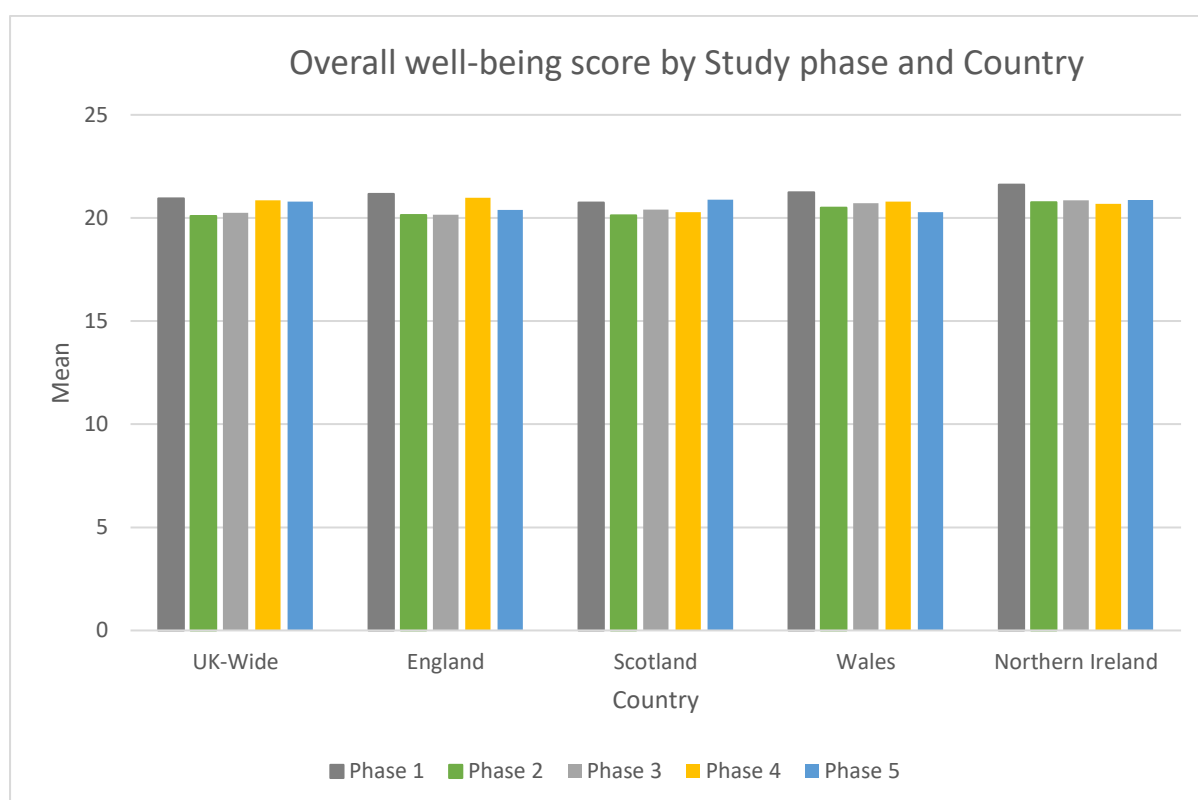


Table A9. 1: Mean Overall Well-being Score by Study Phase and Country (Weighted)

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	20.95	21.16	20.74	21.24	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85
Phase 4	20.85	20.98	20.28	20.80	20.69
Phase 5	20.80	20.39	20.89	20.28	20.87

## A9.2 Well-being Scores by Study Phase and Occupation

Those who worked as Nurses, Midwives and Social workers showed a decrease in their overall mean well-being scores from Phase 1 of the study to Phase 5, while AHPs and Social Care workers showed an increase. Between Phase 2 and Phase 5, all occupations showed an increase in overall well-being scores. Between Phase 3 and Phase 5, nurses, showed a decrease in overall well-being scores while Midwives, AHPs, social care workers and social workers showed an increase in overall well-being scores. Between Phase 4 and Phase 5, nurses, showed a decrease in overall well-being scores while Midwives, AHPs, social care workers and social workers showed an increase in overall well-being scores.

Figure A9. 2: Mean Overall Well-being Score by Study Phase and Occupation (Weighted)

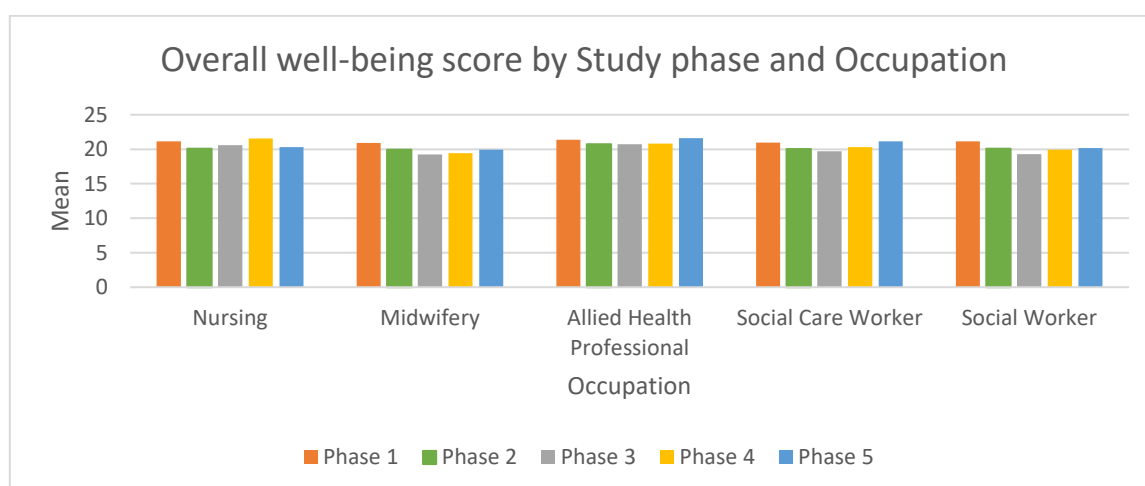


Table A9. 2: Mean Overall Well-being Score by Study Phase and Occupation (Weighted)

Study phase	Occupation				
	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
Phase 3	20.58	19.23	20.72	19.70	19.31
Phase 4	21.56	19.42	20.83	20.31	19.95
Phase 5	20.32	19.93	21.60	21.15	20.19

### 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 5, both UK-wide and across the individual countries. Between Phase 2 and 5, there was an increase UK-wide, but respondents in Scotland and Northern Ireland had overall WRQOL scores which decreased. Comparing Phase 3 and Phase 5 there was an increase in overall WRQOL scores UK-wide but a decrease in Scotland and Northern Ireland between these study phases. Between Phase 4 and Phase 5, there was a decrease UK-wide in overall WRQOL scores, respondents in England and Scotland showed decreases in overall WRQOL scores, while respondents in Wales and Northern Ireland showed slight increases.

*UK-wide analysis:* Using regression analysis, the decrease in the overall WRQOL scores between Phase 1 and Phase 5 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 ( $\beta = -4.442$ ,  $p < .001$ ). The results for WRQOL domain scores (controlling 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 5 ( $\beta = -0.992$ ,  $p < .001$ ).
- Stress at work: Significant decrease in scores from Phase 1 to Phase 5 ( $\beta = -0.516$ ,  $p < .001$ ).
- Working conditions: Significant decrease in scores from Phase 1 to Phase 5 ( $\beta = -.483$ ,  $p < .001$ ).
- Control at work: Significant decrease in scores from Phase 1 to Phase 5 that were not significant ( $\beta = -0.525$ ,  $p < .001$ ).
- General well-being: Significant decrease in scores from Phase 1 to Phase 5 ( $\beta = -1.171$ ,  $p < .001$ ).
- Home-work interface: Significant decrease in scores from Phase 1 to Phase 5 ( $\beta = -0.786$ ,  $p < .001$ ).

Using regression analysis, the change in the overall WRQOL scores between Phase 2 and Phase 5 of the study was **statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -1.138$ ,  $p = .032$ ). The results for WRQOL domain scores (controlling 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 2 to Phase 5 ( $\beta = -.559$ ,  $p < .001$ ).
- Stress at work: The variation in scores from Phase 2 to Phase 5 was not significant ( $\beta = 0.077$ ,  $p = .256$ ).
- Working conditions: Significant reduction in scores from Phase 2 to Phase 5 ( $\beta = -0.215$ ,  $p = .028$ ).
- Control at work: No significant change in scores from Phase 2 to Phase 5 ( $\beta = 0.203$ ,  $p = .057$ ).
- General wellbeing: No significant change in scores from Phase 2 to Phase 5 ( $\beta = .230$ ,  $p = .177$ ).
- Home-work interface: Significant reduction in scores from Phase 2 to Phase 5 ( $\beta = -0.562$ ,  $p < .001$ ).

Using regression analysis, the change in the overall WRQOL scores between Phase 3 and Phase 5 of the study was **not statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.043$ ,  $p = .941$ ). 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: No significant change in scores from Phase 3 to Phase 5 ( $\beta = -0.068$ ,  $p = .693$ ).

- Stress at work: No significant change in scores from Phase 3 to Phase 5 ( $\beta = -0.055$ ,  $p = .422$ ).
- Working conditions: No significant change in in scores from Phase 3 to Phase 5 ( $\beta = -0.146$ ,  $p = .131$ ).
- Control at work: No significant change in scores from Phase 3 to Phase 5 ( $\beta = -0.039$   $p = .708$ ).
- General well-being: **Significant reduction** in scores from Phase 3 to Phase 5 ( $\beta = -0.436$ ,  $p = .013$ ).
- Home-work interface: No significant change in scores from Phase 3 to Phase 5 ( $\beta = -0.130$ ,  $p = .223$ ).

Using regression analysis, the change in the overall WRQOL scores between Phase 4 and Phase 5 of the study was **not statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.173$ ,  $p = .235$ ). 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: No significant change in scores from Phase 4 to Phase 5 ( $\beta = -0.078$ ,  $p = .694$ ).
- Stress at work: No significant change in scores from Phase 4 to Phase 5 ( $\beta = -0.082$ ,  $p = .281$ ).
- Working conditions: No significant change in scores from Phase 4 to Phase 5 ( $\beta = -0.037$ ,  $p = .744$ ).
- Control at work: No significant change in scores from Phase 4 to Phase 5 ( $\beta = -0.048$   $p = .696$ ).
- General well-being: No significant change in scores from Phase 4 to Phase 5 ( $\beta = 0.362$ ,  $p = 0.068$ ).
- Home-work interface: **Significant decrease** in scores from Phase 4 to Phase 5 ( $\beta = -0.132$ ,  $p = .280$ ).

Figure A9. 3: Mean Overall Quality of Working Life Score by Study Phase and Country (Weighted)

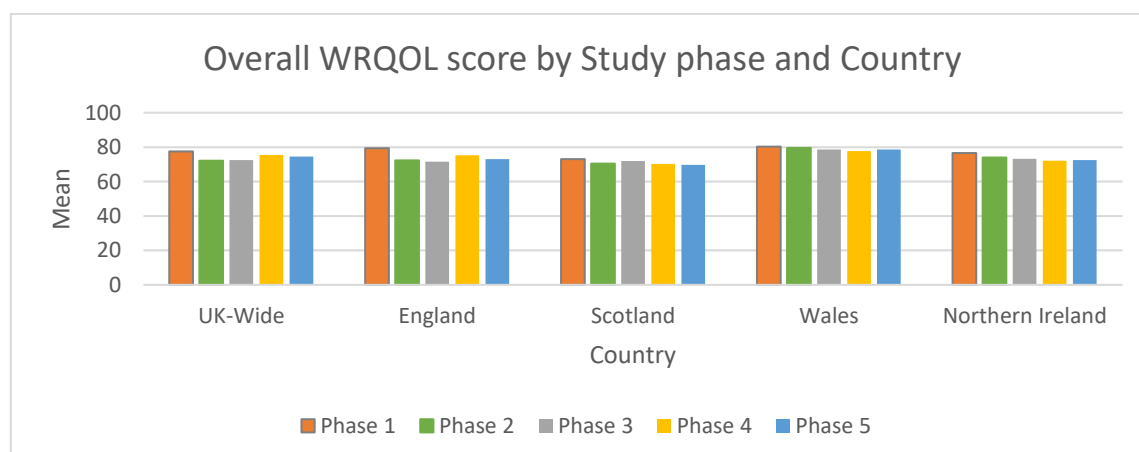




Table A9. 3: Mean Quality of Working Life Score by Study Phase and Country (Weighted)

Study phase	Country				
WRQOL domain	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Phase 1</b>					
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 well-being	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
<b>Overall WRQOL score</b>	<b>77.59</b>	<b>79.33</b>	<b>73.07</b>	<b>80.35</b>	<b>76.63</b>
<b>Phase 2</b>					
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 well-being	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
<b>Overall WRQOL score</b>	<b>72.13</b>	<b>72.21</b>	<b>70.37</b>	<b>79.46</b>	<b>74.06</b>
<b>Phase 3</b>					
Job career satisfaction	20.57	20.34	19.95	21.96	20.28
Stress at work	4.26	4.24	4.72	4.73	4.75
General well-being	17.97	17.89	18.62	19.75	19.36
Home-work interface	9.87	9.72	9.63	10.89	9.66
Control at work	9.82	9.73	8.97	10.27	9.14
Working conditions	10.05	9.73	10.03	11.15	10.05
<b>Overall WRQOL score</b>	<b>72.45</b>	<b>71.54</b>	<b>71.92</b>	<b>78.69</b>	<b>73.29</b>
<b>Phase 4</b>					
Job career satisfaction	21.09	21.08	19.75	21.77	20.13
Stress at work	4.31	4.34	4.18	4.87	4.45
General well-being	19.39	19.4	18.55	19.3	19.1
Home-work interface	10.56	10.59	9.32	10.41	9.48
Control at work	9.57	9.72	8.79	10.24	9.13
Working conditions	10.49	10.18	9.7	10.81	9.82
<b>Overall WRQOL score</b>	<b>75.42</b>	<b>75.3</b>	<b>70.28</b>	<b>77.67</b>	<b>72.12</b>
<b>Phase 5</b>					
Job career satisfaction	20.72	20.55	19.71	22.95	20.02
Stress at work	4.54	4.31	4.45	4.28	4.58
General well-being	19.3	18.9	18.30	19.88	19.55
Home-work interface	10.1	9.86	8.62	10.38	9.48
Control at work	9.74	9.70	8.65	10.56	9.07
Working conditions	10.08	9.76	9.82	10.64	9.81
<b>Overall WRQOL score</b>	<b>74.49</b>	<b>73.10</b>	<b>69.64</b>	<b>78.70</b>	<b>72.54</b>

#### A9.4 Quality of Working Life Scores by Study Phase and Occupation

The overall WRQOL scores increased from Phase 1 of the study to Phase 5 for Nurses, but decreased for other all occupational groups. The overall WRQOL scores increased from Phase 2 of the study to Phase 5 for nurses, AHPs, Social Care workers but decreased in midwifery and social work groups. The overall WRQOL scores increased from Phase 3 of the study to Phase 5 for nurses, midwives, AHPs and Social care workers but decreased in social workers. The overall WRQOL scores increased from Phase 4 of the study to Phase 5 for midwives, AHPs and Social care workers but decreased in nurses and social workers.

Figure A9. 4: Mean Overall Quality of Working Life Score by Study Phase and Occupation (Weighted)

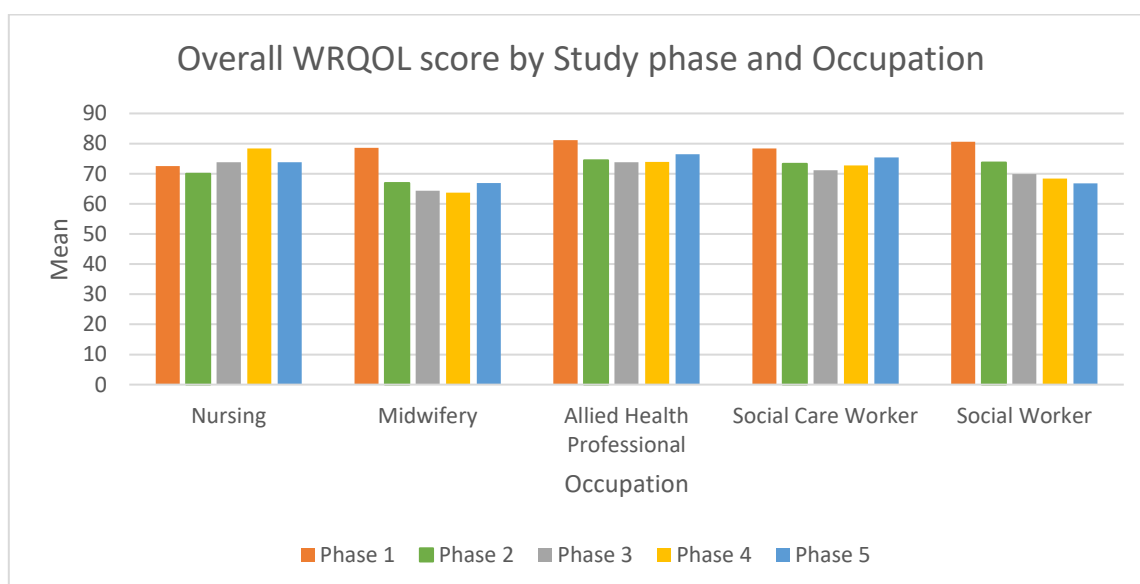


Table A9. 4: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted)

Study phase	Occupation				
WRQOL domain	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
<b>Phase 1</b>					
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 well-being	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
<b>Overall WRQOL score</b>	<b>72.54</b>	<b>78.56</b>	<b>81.16</b>	<b>78.34</b>	<b>80.63</b>
<b>Phase 2</b>					
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 well-being	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
<b>Overall WRQOL score</b>	<b>70.01</b>	<b>66.95</b>	<b>74.41</b>	<b>73.24</b>	<b>73.67</b>
<b>Phase 3</b>					
Job career satisfaction	20.83	19.2	20.5	20.07	20.23
Stress at work	4.55	3.20	4.47	4.43	4.03
General well-being	18.8	16.97	18.7	17.67	17.4
Home-work interface	9.96	7.96	10.1	9.43	9.92
Control at work	9.78	8.47	10.15	9.44	9
Working conditions	9.88	8.29	10.26	10.24	9.3
<b>Overall WRQOL score</b>	<b>73.77</b>	<b>64.35</b>	<b>73.79</b>	<b>71.15</b>	<b>69.92</b>
<b>Phase 4</b>					
Job career satisfaction	21.62	18.8	20.51	20.44	20.15
Stress at work	4.58	3.52	4.36	4.31	3.82
General well-being	20.31	16.81	18.85	18.87	17.64
Home-work interface	10.92	8.39	10.33	9.85	9.60
Control at work	10.17	8.41	9.85	9.95	8.67
Working conditions	10.74	7.89	9.99	10.37	8.80
<b>Overall WRQOL score</b>	<b>78.37</b>	<b>63.76</b>	<b>73.92</b>	<b>72.78</b>	<b>68.39</b>
<b>Phase 5</b>					
Job career satisfaction	20.97	19.17	20.95	20.43	19.14
Stress at work	4.27	3.83	4.65	5.03	3.98
General well-being	18.93	17.45	20.63	19.84	17.41
Home-work interface	9.96	9.17	10.03	10.06	8.66
Control at work	9.91	8.63	9.96	8.42	8.48
Working conditions	9.78	8.69	10.16	10.53	8.94
<b>Overall WRQOL score</b>	<b>73.81</b>	<b>66.89</b>	<b>76.42</b>	<b>75.41</b>	<b>66.75</b>

#### A9.4 Burnout Scores by Study Phase and Country

The overall personal burnout, work-related burnout and client-related scores decreased from Phase 2 of the study to Phase 5 UK-wide. In England and Wales, personal and work-related burnout scores increased, while client-related burnout scores decreased, while in Scotland all three domains of burnout increased between Phase 2 and 5, in Northern Ireland personal and client-related burnout increased while work-related burnout decreased.

Between Phase 3 and Phase 5, overall personal, work-related and client-related burnout scores decreased UK-wide, however on a country level, Scotland, and Northern Ireland showed increases in all domains of burnout and respondents in Wales showed increases in personal and work-related burnout scores.

Between Phase 4 and Phase 5, UK-wide personal and work-related burnout decreased while client-related burnout scores increased. In England, personal and work-related burnout scores increased while client-related burnout decreased, Scotland and Northern Ireland showed increases in personal and client-related burnout scores, but a decrease in work-related burnout, Wales showed increases in personal and work-related burnout but decreases in client-related burnout.

Multiple regression analysis revealed that there was a **significant difference in personal burnout** from Phase 2 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 1.724$   $p = .017$ ). There was also a **significant difference** in work-related burnout ( $\beta = 2.326$ ,  $p = .003$ ) but **no significant difference** in client-related burnout ( $\beta = 1.252$ ,  $p = .118$ ) from Phase 2 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was **no significant difference** in personal burnout from Phase 3 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = 0.478$ ,  $p = .515$ ). There were **no significant differences** in work-related burnout ( $\beta = 0.0483$ ,  $p = .539$ ) or client-related burnout ( $\beta = 0.062$ ,  $p = .939$ ) from Phase 3 to Phase 5 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was **no significant difference** in personal burnout from Phase 4 to Phase 5, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ( $\beta = -0.070$ ,  $p = .933$ ). There was also **no significant difference** in work-related burnout ( $\beta = -0.328$ ,  $p = .713$ ) or client-related burnout ( $\beta = 0.474$ ,  $p = .612$ ) from Phase 4 to Phase 5 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Table A9. 5: Mean Burnout scores by Study Phase and Country (Weighted)

Study phase	Country				
Burnout	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Phase 2</b>					
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
<b>Phase 3</b>					
Personal burnout	63.20	64.42	59.27	59.47	59.45
Work-related burnout	59.79	60.53	54.54	54.31	55.87
Client-related burnout	29.46	31.45	25.57	24.28	21.10
<b>Phase 4</b>					
Personal burnout	62.62	61.77	62.65	62.41	60.75
Work-related burnout	58.65	57.22	60.33	54.92	59.22
Client-related burnout	25.24	25.83	28.21	26.17	27.76
<b>Phase 5</b>					
Personal burnout	61.10	63.83	63.32	62.88	61.43
Work-related burnout	56.51	59.11	59.08	56.56	57.70
Client-related burnout	25.88	28.31	25.66	22.69	28.88

Figure A9. 5: Personal Burnout Score by Study phase and Country (Weighted)

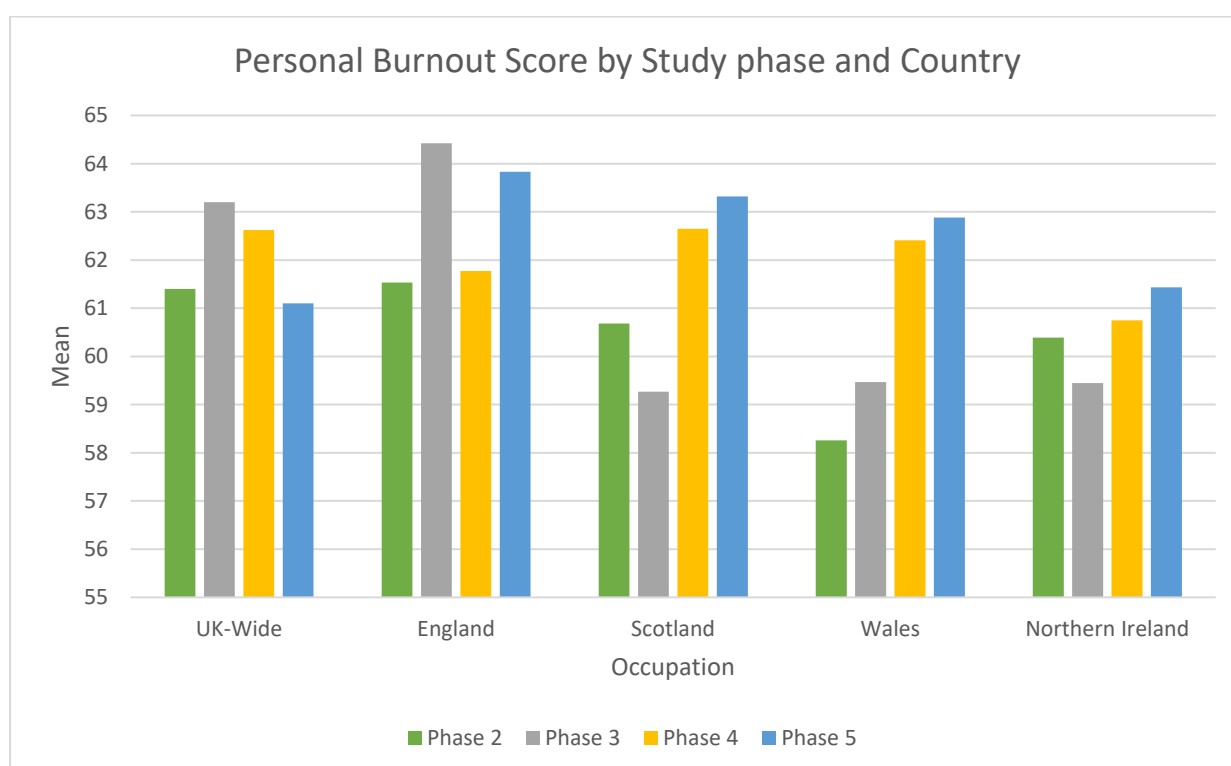


Figure A9. 6: Work-related Burnout Score by Study phase and Country (Weighted)

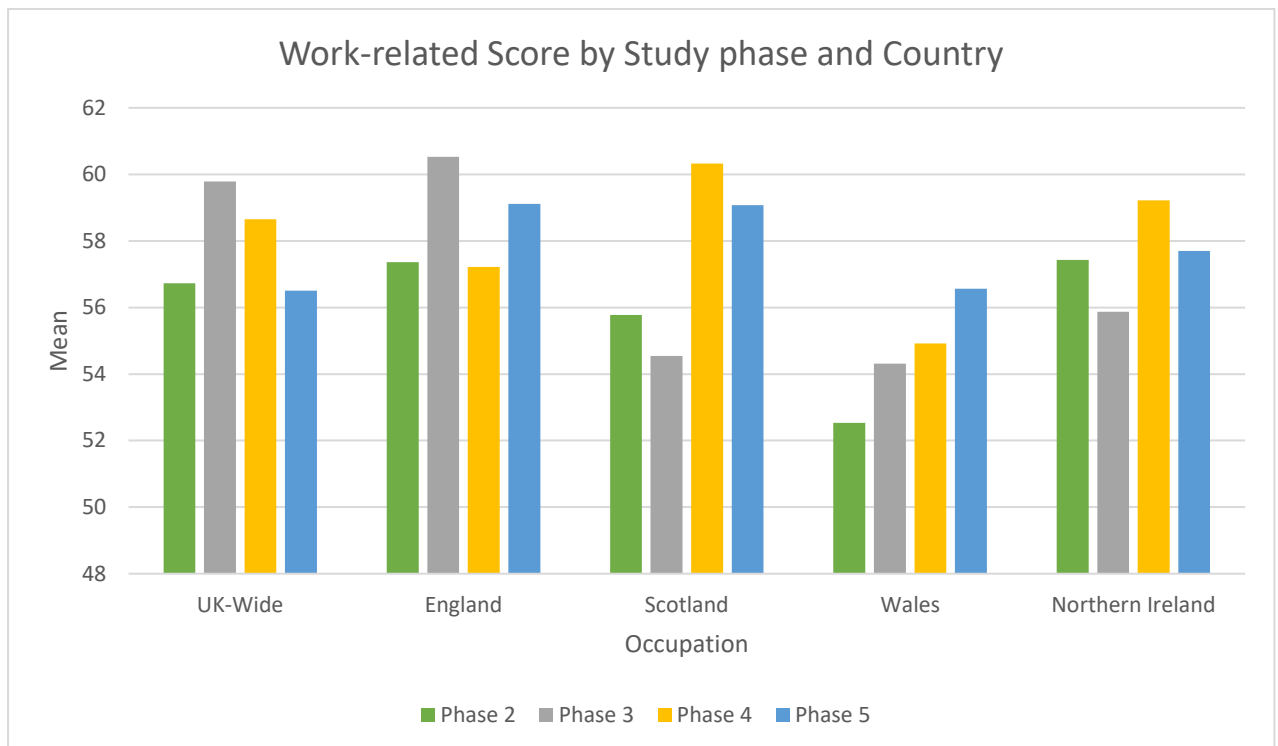


Figure A9. 7: Client-related Burnout Score by Study phase and Country (Weighted)



#### A9.4 Burnout Scores by Study Phase and Occupation

Between Phase 2 and 5, personal burnout increased for nurses, midwives, and social workers but decreased for AHPs and social care workers. Work-related burnout increased in nursing, midwifery and social work occupations, but decreased in AHP and social care occupations. Client-related burnout increased for midwifery and social work occupations.

Comparing Phase 3 and Phase 5, personal burnout decreased for all occupations except nursing. Work-related burnout decreased for midwives, AHPs and social care workers but increased for nurses and social workers. Client-related burnout increased for midwifery and social work occupations.

Between Phase 4 and 5, personal burnout increased for nurses and social workers but decreased for midwives, AHPs and social care workers. Work-related burnout increased in nursing, and social work occupations, but decreased in midwifery, AHP and social care occupations. Client-related burnout increased for nurses and social work occupations.

Table A9. 6: Burnout Scores by Study Phase and Occupation

Study phase	Occupation				
Domain	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
<b>Phase 2</b>					
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
<b>Phase 3</b>					
Personal burnout	61.29	73.21	62.12	64.37	67.00
Work-related burnout	57.47	71.54	56.16	58.8	64.06
Client-related burnout	27.75	34.36	30.37	27.33	32.56
<b>Phase 4</b>					
Personal burnout	59.97	71.69	59.66	63.80	65.08
Work-related burnout	54.06	68.69	55.10	61.28	63.45
Client-related burnout	24.08	35.36	28.33	23.84	32.90
<b>Phase 5</b>					
Personal burnout	64.54	68.66	54.84	57.15	66.94
Work-related burnout	59.03	66.23	52.90	51.89	67.03
Client-related burnout	27.20	34.55	26.72	23.35	35.76

Figure A9. 8: Personal Burnout Score by Study phase and Occupation (Weighted)

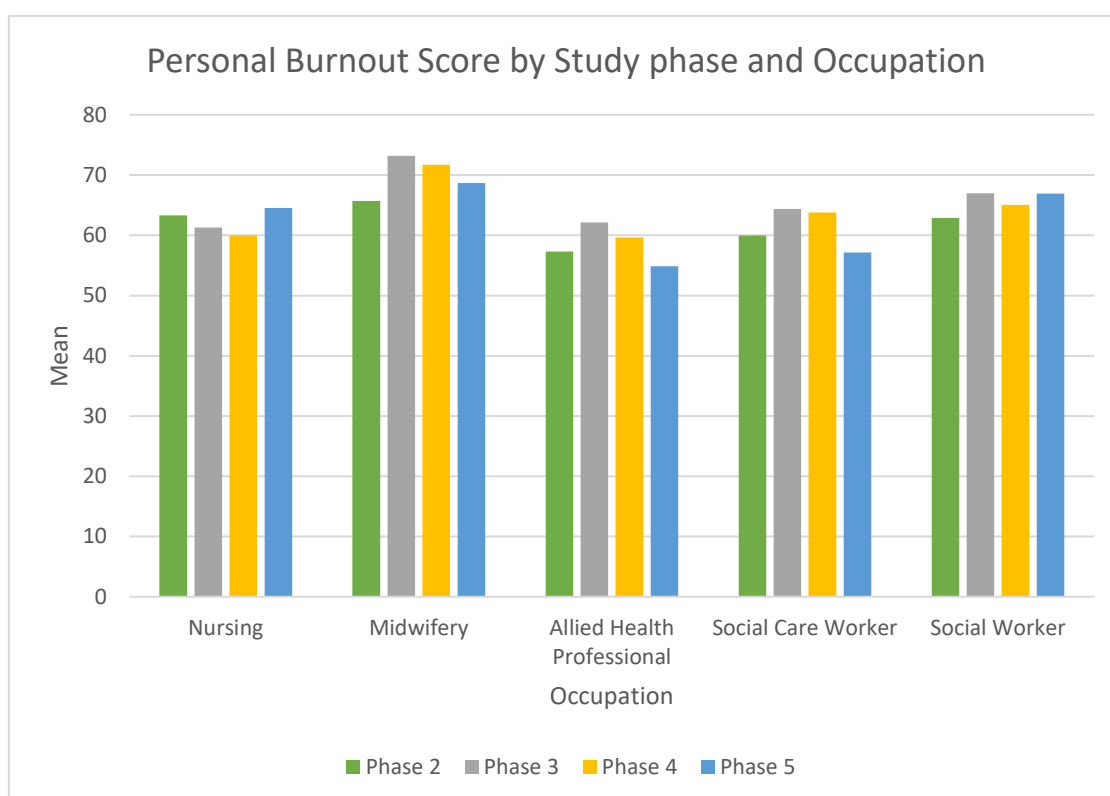


Figure A9. 9: Work-related Burnout Score by Study phase and Occupation (Weighted)

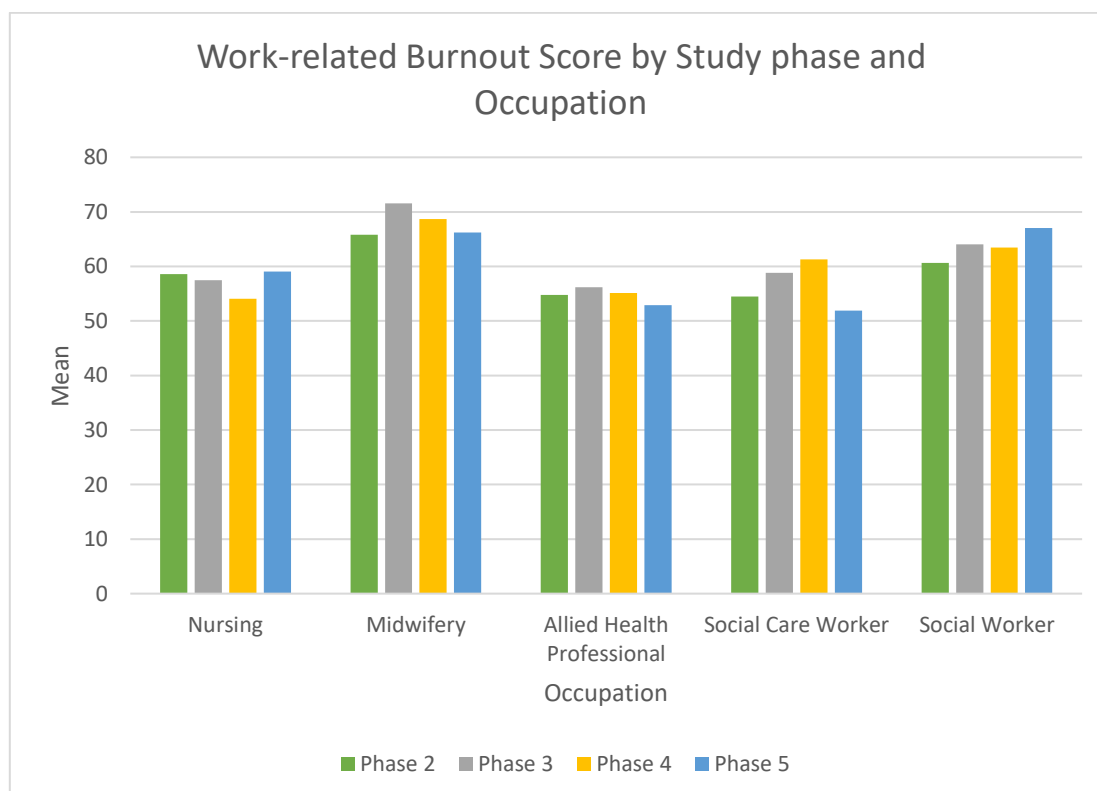
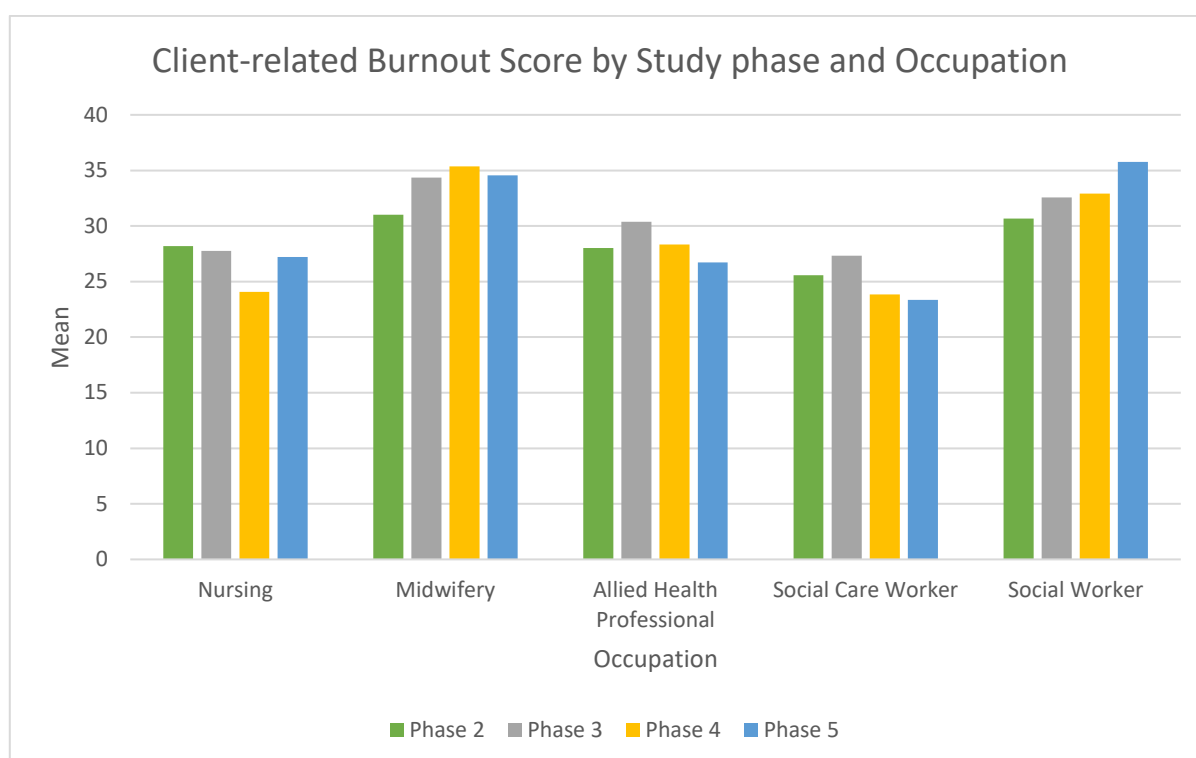




Figure A9. 10: Client-related Burnout Score by Study phase and Occupation (Weighted)



#### A9.6 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 5.

*UK-wide analysis:* Using regression analysis, the differences between Phase 1 and Phase 5 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 5 ( $\beta = -0.879$ ,  $p < .001$ ).
- Planning: **Significant decrease** in scores from Phase 1 to Phase 5 ( $\beta = -0.524$ ,  $p < .001$ ).
- Positive reframing: **Significant decrease** in scores from Phase 1 to Phase 5 ( $\beta = -0.400$ ,  $p < .001$ ).
- Acceptance: **Significant decrease** in scores from Phase 1 to Phase 5 ( $\beta = -0.573$ ,  $p < .001$ ).
- Use of emotional support: **Significant increase** in scores from Phase 1 to Phase 5 ( $\beta = 0.311$ ,  $p < .001$ ).
- Use of instrumental support: No significant change in scores from Phase 1 to Phase 5 ( $\beta = -0.067$ ,  $p = 0.307$ ).
- Venting: **Significant increase** in scores from Phase 1 to Phase 5 ( $\beta = 0.653$ ,  $p < .001$ ).
- Substance use: No significant change in scores from Phase 1 to Phase 5 ( $\beta = 0.071$ ,  $p = .185$ ).

- Behavioural disengagement: **Significant increase** in scores from Phase 1 to Phase 5 ( $\beta = 0.407$ ,  $p < .001$ ).
- Self-blame: **Significant increase** in scores from Phase 1 to Phase 5 ( $\beta = 0.745$ ,  $p < .001$ ).

UK-wide there was a decrease in the use of some positive coping strategies and an increase in the use of negative coping strategies from Phase 2 of the study to Phase 5. A similar pattern was observed across the countries for the majority of coping domains.

*UK-wide analysis:* Using regression analysis, the differences between Phase 2 and Phase 5 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 2 to Phase 5 ( $\beta = -0.258$ ,  $p < .001$ ).
- Planning: **Significant decrease** in scores from Phase 2 to Phase 5 ( $\beta = -0.147$ ,  $p = .034$ ).
- Positive reframing: **Significant decrease** in scores from Phase 2 to Phase 5 ( $\beta = -0.277$ ,  $p < .001$ ).
- Acceptance: **Significant decrease** in scores from Phase 2 to Phase 5 ( $\beta = -0.174$ ,  $p = .003$ ).
- Use of emotional support: **Significant decrease** in scores from Phase 2 to Phase 5 ( $\beta = -0.241$ ,  $p < .001$ ).
- Use of instrumental support: **Significant decrease** in scores from Phase 2 to Phase 5 ( $\beta = -0.151$ ,  $p = .022$ ).
- Venting: No significant change in scores from Phase 2 to Phase 5 ( $\beta = -0.020$ ,  $p = .751$ ).
- Substance use: No significant change in scores from Phase 2 to Phase 5 ( $\beta = -0.023$ ,  $p = .678$ ).
- Behavioural disengagement: No significant change in scores from Phase 2 to Phase 5 ( $\beta = 0.083$ ,  $p = .117$ ).
- Self-blame: **Significant increase** in scores from Phase 2 to Phase 5 ( $\beta = 0.158$ ,  $p = .021$ ).

UK-wide there was a decrease in the use of planning and acceptance as positive coping strategies and an increase in venting, substance use and self-blame as negative coping strategies from Phase 3 of the study to Phase 5.

*UK-wide analysis:* Using regression analysis, the differences between Phase 3 and Phase 5 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: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.047$ ,  $p = .468$ ).
- Planning: No significant change in scores between Phase 3 and Phase 5 ( $\beta = 0.043$ ,  $p = .527$ ).

- Positive reframing: **Significant decrease** in scores from Phase 3 to Phase 5 ( $\beta = -0.122$ ,  $p = .039$ ).
- Acceptance: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.005$ ,  $p = .933$ ).
- Use of emotional support: **Significant decrease** in scores from Phase 3 to Phase 5 ( $\beta = -0.152$ ,  $p = .021$ ).
- Use of instrumental support: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.085$ ,  $p = .191$ ).
- Venting: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.087$ ,  $p = .175$ ).
- Substance use: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.087$ ,  $p = .125$ ).
- Behavioural disengagement: No significant change in scores between Phase 3 and Phase 5 ( $\beta = 0.017$ ,  $p = .751$ ).
- Self-blame: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.057$ ,  $p = .416$ ).

UK-wide there was a decrease in the use of positive reframing and acceptance as a positive coping strategies and an increase in substance use, behavioural disengagement and self-blame as a negative coping strategies from Phase 4 of the study to Phase 5.

*UK-wide analysis:* Using regression analysis, the differences between Phase 4 and Phase 5 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: No significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.039$ ,  $p = .593$ ).
- Planning: No significant change in scores between Phase 4 and Phase 5 ( $\beta = 0.012$ ,  $p = .878$ ).
- Positive reframing: No significant change in scores from Phase 4 to Phase 5 ( $\beta = 0.008$ ,  $p = .917$ ).
- Acceptance: No significant change in scores between Phase 4 and Phase 5 ( $\beta = 0.008$ ,  $p = .909$ ).
- Use of emotional support: No significant change in scores from Phase 4 to Phase 5 ( $\beta = -0.095$ ,  $p = .199$ ).
- Use of instrumental support: No significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.095$ ,  $p = .198$ ).
- Venting: No significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.055$ ,  $p = .440$ ).
- Substance use: No significant change in scores between Phase 4 and Phase 5 ( $\beta = 0.076$ ,  $p = .207$ ).

- Behavioural disengagement: No significant change in scores between Phase 4 and Phase 5 ( $\beta = 0.015$ ,  $p = .808$ ).
- Self-blame: No significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.006$   $p = .937$ ).

Figure A9. 11: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)

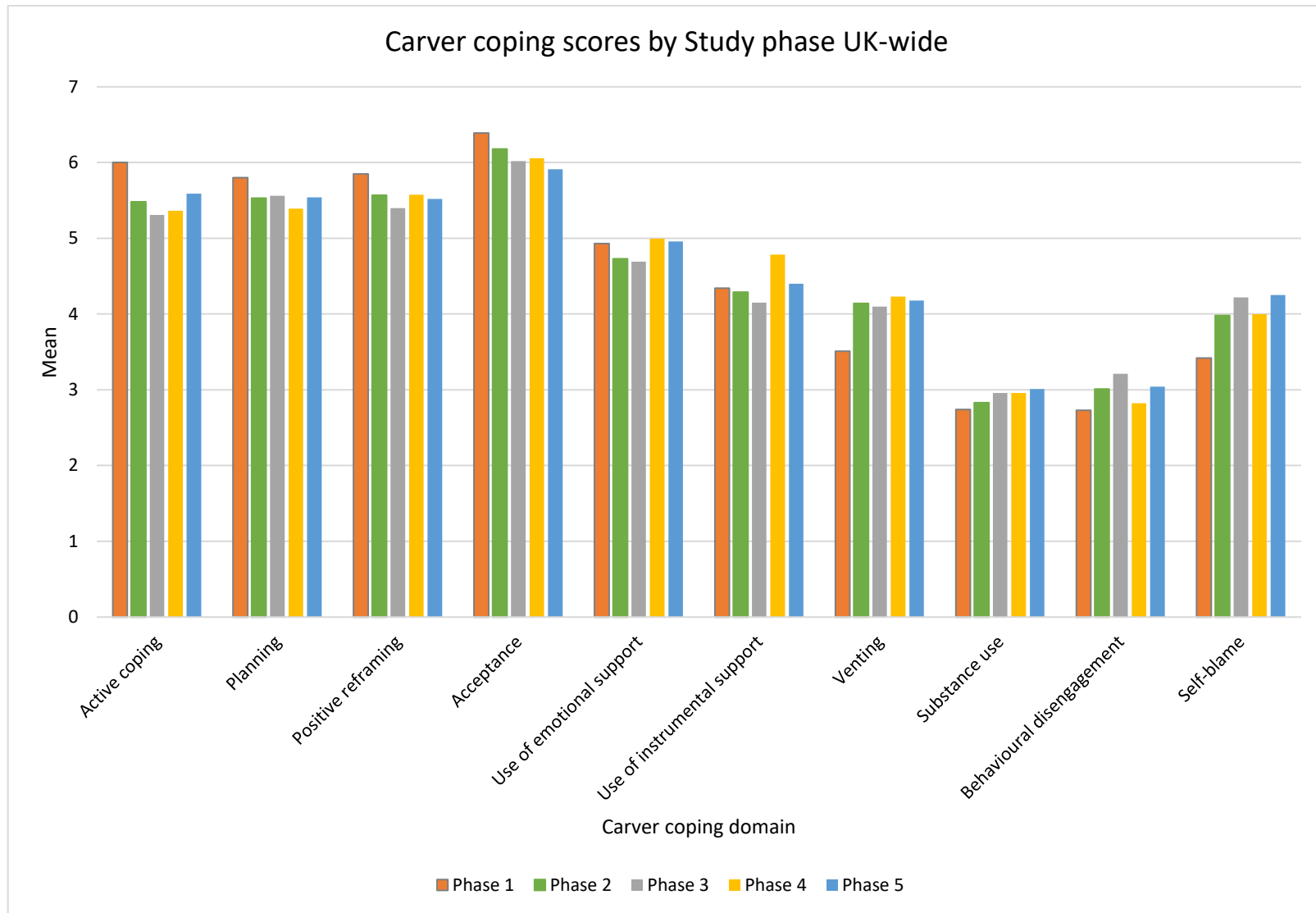


Table A9. 7: Mean Carver Coping Scores by Study Phase and Country (Weighted)

Study phase	Country				
Coping domain	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Phase 1</b>					
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
<b>Phase 2</b>					
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
<b>Phase 3</b>					
Active coping	5.31	5.38	5.39	5.36	5.32
Planning	5.56	5.64	5.44	5.39	5.33
Positive reframing	5.40	5.53	5.56	5.60	5.51
Acceptance	6.02	6.00	6.18	6.25	5.97
Use of emotional support	4.69	4.85	4.64	4.73	4.71
Use of instrumental support	4.15	4.35	4.19	4.34	4.41
Venting	4.10	4.21	4.21	4.15	4.18
Substance use	2.96	3.04	2.95	2.84	2.88
Behavioural disengagement	3.21	3.23	3.07	2.92	2.99
Self-blame	4.22	4.29	4.25	4.10	3.96
<b>Phase 4</b>					
Active coping	5.36	5.27	5.38	5.56	5.32
Planning	5.39	5.33	5.40	5.61	5.36
Positive reframing	5.58	5.42	5.42	5.51	5.41
Acceptance	6.06	6.06	5.96	6.46	5.97
Use of emotional support	5.00	4.99	4.69	4.60	4.64
Use of instrumental support	4.79	4.63	4.33	4.67	4.32
Venting	4.23	4.19	4.25	3.85	4.30
Substance use	2.96	2.95	2.88	2.95	2.66
Behavioural disengagement	2.82	2.82	3.06	3.27	3.10
Self-blame	4.00	4.07	3.97	4.30	3.97

Phase 5					
Active coping	5.59	5.15	5.48	5.61	5.19
Planning	5.54	5.26	5.42	5.58	5.3
Positive reframing	5.52	5.19	5.18	5.66	5.41
Acceptance	5.91	5.88	6.2	6.18	5.91
Use of emotional support	4.96	4.7	4.58	4.98	4.45
Use of instrumental support	4.4	4.12	4.17	4.42	4.29
Venting	4.18	4.14	3.92	4.56	4.06
Substance use	3.01	3.15	2.62	2.98	2.82
Behavioural disengagement	3.04	3.25	2.87	3.17	3.1
Self-blame	4.25	4.34	4.13	4.42	3.97

#### 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 5 across nursing, midwifery, social care and social worker occupations, within AHPS there was an increase in active coping, but decrease in other positive strategies and increase in other negative strategies (venting, substance use, behavioural disengagement and self-blame).

From Phase 2 to Phase 5, there was a lot more variation in the use of strategies; within nursing there was decrease in the use of positive coping strategies and increase in the use of negative coping strategies. Midwives say a increase in active coping, planning, instrumental support, self-blame, venting and behavioural disengagement. AHPs reported increases in active coping, planning, emotional support and self-blame, while Social Care workers had increased active coping, planning, positive reframing, emotional support and a decrease in all negative strategies. In Social Work, there was an increase in active coping, self-blame and behavioural disengagement.

Comparing Phase 3 to Phase 5, nurses had an increase in positive coping strategies such as acceptance, but had further increases in negative strategies, venting, substance use and self-blame. In midwives, planning and emotional support increased however all other positive strategies continued to decline, additionally negative strategies, substance use, behavioural disengagement and self-blame increased. Across AHPs all positive coping strategies declined, except active coping which remained unchanged, across this occupation venting, behavioural disengagement and self-blame also increased. For social care workers, all positive strategies increased and a decrease in usage of negative coping strategies. Social workers showed an increase in acceptance but a decrease in both the use of positive strategies and negative strategies.

Comparing Phase 4 to Phase 5, nurses had a decrease in all positive coping strategies but had further increases in negative strategies, substance use, behavioural disengagement and self-blame. In

midwives, acceptance and emotional support increased however all other positive strategies continued to decline, additionally negative strategies, venting, substance use and behavioural disengagement increased. Across AHPs there were increases in active coping, planning and positive reframing, across this occupation substance use also increased. For social care workers, positive strategies active coping, planning, positive reframing, acceptance and emotional support increased and an increase in usage of negative coping strategies, substance use and self-blame. Social workers showed an increase in active coping, acceptance, emotional support, substance use, behavioural disengagement and self-blame.

Table A9. 8: Mean Carver Coping Scores by Study Phase and Occupation (Weighted)

Study phase	Occupation				
Coping domain	Nursing	Midwifery	AHPs	Social Care Worker	Social Worker
<b>Phase 1</b>					
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
<b>Phase 2</b>					
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
<b>Phase 3</b>					
Active coping	5.19	5.10	5.89	5.39	5.37
Planning	5.45	5.29	5.98	5.56	5.48
Positive reframing	5.46	5.25	5.81	5.43	5.34
Acceptance	5.79	5.82	6.54	6.13	5.82
Use of emotional support	4.78	4.77	5.12	4.34	5.05
Use of instrumental support	4.39	4.55	4.21	4.02	4.53
Venting	4.14	4.84	4.03	4.15	4.50
Substance use	3.08	3.29	2.81	2.87	3.10



Behavioural disengagement	3.27	3.20	2.91	3.20	3.15
Self-blame	4.32	4.82	3.88	4.37	4.57
<b>Phase 4</b>					
Active coping	5.22	5.02	5.46	5.53	5.13
Planning	5.37	5.17	5.43	5.41	5.38
Positive reframing	5.46	5.19	5.46	5.65	5.22
Acceptance	6.30	5.64	6.02	6.01	5.78
Use of emotional support	5.09	4.89	4.93	4.70	4.78
Use of instrumental support	4.69	4.51	4.57	4.75	4.44
Venting	4.20	4.50	4.28	4.08	4.41
Substance use	3.13	3.27	2.76	2.72	2.66
Behavioural disengagement	2.77	3.28	2.84	3.02	3.09
Self-blame	4.06	4.94	4.24	3.82	4.27
<b>Phase 5</b>					
Active coping	4.95	5.18	5.89	5.86	5.32
Planning	5.10	5.44	5.55	5.64	5.21
Positive reframing	5.03	5.07	5.54	5.80	4.98
Acceptance	5.81	5.97	5.80	6.14	5.84
Use of emotional support	4.56	4.95	5.02	4.82	4.80
Use of instrumental support	3.97	4.49	4.45	4.40	4.37
Venting	4.06	4.52	4.19	4.07	4.26
Substance use	3.2	3.5	2.84	2.75	2.93
Behavioural disengagement	3.2	3.55	2.81	2.97	3.16
Self-blame	4.34	4.58	4.05	4.04	4.36

### A9.5 Clark Coping Scores by Study Phase and Country

There was a decrease in the use of some Clark et al.'s coping strategies from Phase 1 of the study to Phase 5 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 1 and Phase 5 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 significant change in scores from Phase 1 to Phase 5 ( $\beta = -.0008$ ,  $p = .823$ ).
- Work-family segmentation: Significant change in scores from Phase 1 to Phase 5 ( $\beta = 0.149$ ,  $p < .001$ ).
- Working to improve skills/efficiency: Significant change in scores from Phase 1 to Phase 5 ( $\beta = 0.198$ ,  $p < .001$ ).
- Recreation and relaxation: Significant change in scores from Phase 1 to Phase 5 ( $\beta = 0.252$ ,  $p < .001$ ).
- Exercise: Significant change in scores from Phase 1 to Phase 5 ( $\beta = 0.229$ ,  $p < .001$ ).

There was a slight decrease in the use of some Clark et al.'s coping strategies from Phase 2 of the study to Phase 5 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 2 and Phase 5 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 significant change in scores from Phase 2 to Phase 5 ( $\beta = -.020$ ,  $p = .577$ ).
- Work-family segmentation: No significant change in scores from Phase 2 to Phase 5 ( $\beta = -0.020$ ,  $p = .644$ ).
- Working to improve skills/efficiency: No significant change in scores from Phase 2 to Phase 5 ( $\beta = -0.018$ ,  $p = .671$ ).
- Recreation and relaxation: Significant change in scores from Phase 2 to Phase 5 ( $\beta = .157$ ,  $p < .001$ ).
- Exercise: No significant change in scores from Phase 2 to Phase 5 ( $\beta = -0.026$ ,  $p = .634$ ).

There was a slight decrease in the use of family-work segmentation and work-family segmentation whereas working to improve skills/efficient, recreation and relaxation and exercise all showed slight increases from Phase 3 of the study to Phase 5 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 3 and Phase 5 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 significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.010$ ,  $p = .779$ ).
- Work-family segmentation: No significant change in scores between Phase 3 and Phase 5 ( $\beta = 0.009$ ,  $p = .838$ ).
- Working to improve skills/efficiency: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.007$ ,  $p = .863$ ).
- Recreation and relaxation: Significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.093$ ,  $p = .050$ ).
- Exercise: No significant change in scores between Phase 3 and Phase 5 ( $\beta = -0.078$ ,  $p = .139$ ).

There was slight decreases in the use of family-work segmentation, work-family segmentation, working to improve skills/efficient, recreation and relaxation and exercise from Phase 4 of the study to Phase 5 UK-wide.

*UK-wide analysis:* Using regression analysis, the differences between Phase 4 and Phase 5 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 significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.052$ ,  $p = .189$ ).
- Work-family segmentation: No significant change in scores between Phase 4 and Phase 5 ( $\beta = 0.027$ ,  $p = .569$ ).
- Working to improve skills/efficiency: No significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.013$ ,  $p = .775$ ).
- Recreation and relaxation: No significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.040$ ,  $p = .462$ ).
- Exercise: No significant change in scores between Phase 4 and Phase 5 ( $\beta = -0.006$ ,  $p = .926$ ).

Figure A9. 12: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)

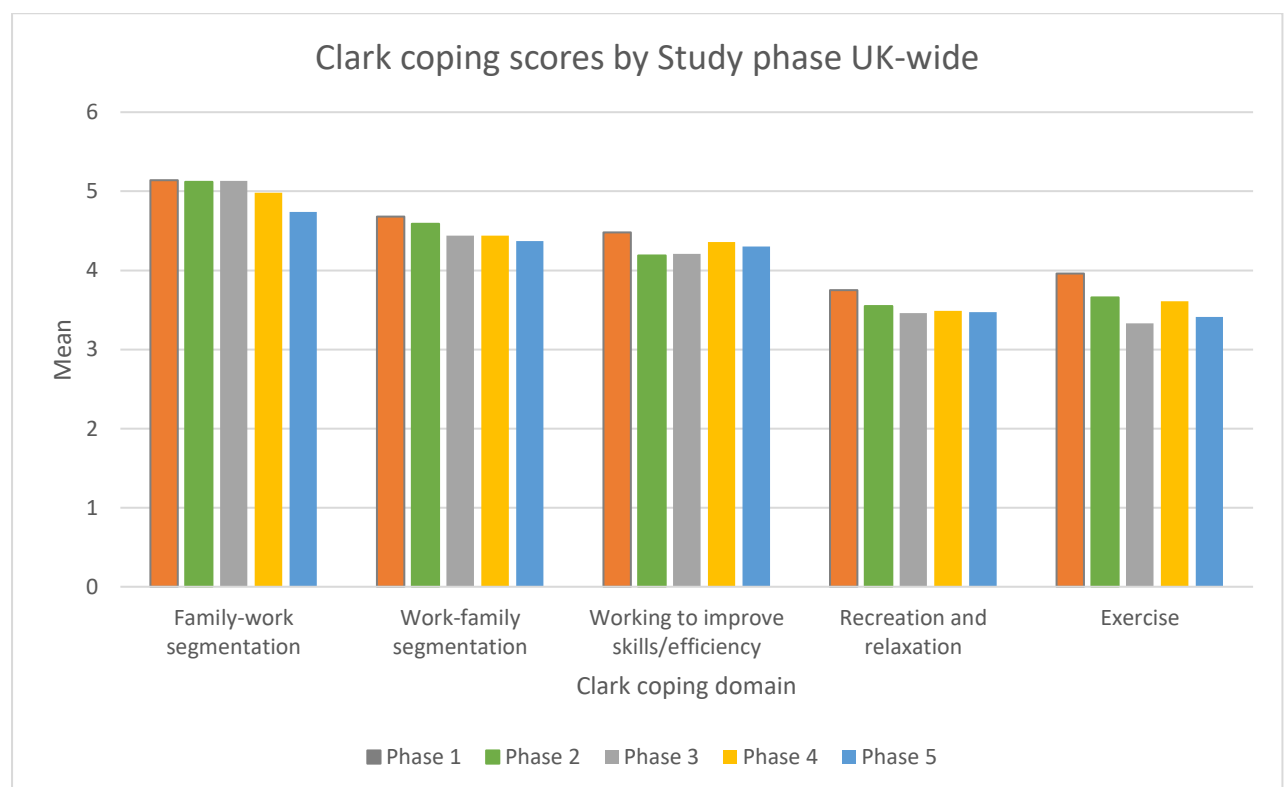


Table A9. 9: Mean Clark Coping Scores by Study Phase and Country (Weighted)

Study phase	Country				
Coping domain	UK-Wide	England	Scotland	Wales	Northern Ireland
<b>Phase 1</b>					
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
<b>Phase 2</b>					
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
<b>Phase 3</b>					
Family-work segmentation	5.13	5.00	5.16	5.17	5.08
Work-family segmentation	4.44	4.38	4.65	4.73	4.65
Working to improve skills/efficiency	4.21	4.27	4.17	4.33	4.14
Recreation and relaxation	3.46	3.52	3.42	3.58	3.50
Exercise	3.33	3.58	3.74	3.41	3.84
<b>Phase 4</b>					
Family-work segmentation	4.98	4.92	5.1	5.14	5.09
Work-family segmentation	4.44	4.49	4.74	4.63	4.53
Working to improve skills/efficiency	4.36	4.35	4.16	4.41	4.10
Recreation and relaxation	3.49	3.6	3.34	3.5	3.34
Exercise	3.61	3.77	3.72	3.48	3.62
<b>Phase 5</b>					
Family-work segmentation	4.74	4.71	5.36	5	5.16
Work-family segmentation	4.37	4.25	4.79	4.79	4.69
Working to improve skills/efficiency	4.3	4.3	4.25	4.19	4.18
Recreation and relaxation	3.47	3.35	3.3	3.24	3.43
Exercise	3.41	3.5	3.35	3.54	3.78

#### A9.6 Clark Coping Scores by Study Phase and Occupation

Between Phase 1 and 5, nurses, AHPs, social care workers and social workers showed a decrease in the use of Clark et al.'s coping strategies, while those in midwifery showed an increase in family-work segmentation but also increase in the use of others for some groups. Comparing Phase 2 and Phase 5, all occupation groups examined showed a decrease in the use of Clark et al.'s coping strategies. Between Phase 3 and 5, nurses showed an increase in work to improve skills/efficiency, midwives showed an increase in family-work segmentation, work-family segmentation and recreation relaxation, Social Care workers showed an increase in recreation and relaxation and exercise, however

AHPs and social workers showed decreases in all Clark et al. coping strategies. Comparing Phase 4 and Phase 5, nurses reported increases in exercise as a coping strategy, midwives showed increases in family-work segmentation, AHPs showed increases in recreation and relaxation, social workers had increases in family-work segmentation and exercise, while social care workers increased in all strategies except family-work segmentation.

Table A9. 10: Mean Clark Coping Scores by Study Phase and Occupation (Weighted)

Study phase	Occupation				
Coping domain	Nursing	Midwifery	AHPs	Social Care Worker	Social Worker
<b>Phase 1</b>					
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
<b>Phase 2</b>					
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
<b>Phase 3</b>					
Family-work segmentation	4.95	5.01	5.02	5.28	4.89
Work-family segmentation	4.53	3.95	4.40	4.47	4.43
Working to improve skills/efficiency	4.24	3.94	4.59	4.09	4.24
Recreation and relaxation	3.54	2.86	3.60	3.33	3.66
Exercise	3.60	3.57	3.93	3.16	3.75
<b>Phase 4</b>					
Family-work segmentation	4.94	4.97	4.98	5.13	4.88
Work-family segmentation	4.58	4.34	4.55	4.48	4.55
Working to improve skills/efficiency	4.46	3.93	4.28	4.20	4.23
Recreation and relaxation	3.64	3.07	3.68	3.22	3.63
Exercise	3.89	3.50	4.22	3.30	3.35
<b>Phase 5</b>					
Family-work segmentation	4.71	5.06	4.41	4.98	4.94
Work-family segmentation	4.29	4.11	4.23	4.67	4.20
Working to improve skills/efficiency	4.36	3.88	4.24	4.28	4.11
Recreation and relaxation	3.31	3.18	3.49	3.54	3.61
Exercise	3.52	3.32	3.80	3.40	3.61

## Appendix 10: Summary of focus group findings

Focus groups were held with both HR, managers and frontline workers in June and July 2022. The challenges of dealing with individual circumstances alongside changes to working conditions during the COVID-19 pandemic emerged as a strong theme throughout the frontline workers' focus group. The issues of recruitment and backlash were strong themes which emerged from the HR and manager focus groups. Responses to focus group questions that were conducted with managers and frontline workers were examined using a thematic analysis approach. The overarching themes that emerged from the Phase 5 focus groups were: **Changes in working conditions, connections, communication and coping**, these findings are interlinked with the survey responses in the main report. The main themes uncovered are outlined in Table A10.1. and a word cloud was created to highlight the key words discussed by the participants and provide data visualisation (Figure A10.1).

Table A10. 1: Themes uncovered from focus group transcripts

Overarching themes
Working conditions
Changing connections
Changing productivity
Increasing staff frustrations
Need for suitable services and support for coping
Burnout and exhaustion
Struggling to survive
Decreased partnerships and co-production
Remaining pressures
Change in public perceptions
Lack of motivation



