Health and social care workers' **quality of working life and coping** while working during the COVID-19 pandemic 10th May - 2nd July 2021

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Findings from a UK Survey

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

Phase 3: 10th May 2021 – 5th July 2021

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FOREWORD

It's a privilege to be asked to introduce this latest report looking at the quality of working life and coping experiences during the COVID-19 pandemic for health and social care workers.

The wellbeing of the social care workforce remains our biggest and most precious asset in delivering high quality care and support. At Social Care Wales, we are working with others to develop initiatives and resources to support a range of experiences in different settings and roles. In 2020, we established a social care wellbeing network to respond to the emerging health and wellbeing needs of the workforce. We also facilitate a number of peer support groups and, with the support of Welsh Government, we launched an Employee Assistance Programme, which offers well-being support to those employed in the social care workforce in the private and voluntary sectors in Wales, including personal assistants.

An important finding from this current phase of research is the way the workforce has moved away from 'positive' ways of coping like positive reframing and use of emotional support, towards 'negative' ways such as self-blame and substance misuse. Findings like this will help us identify forms of support to address these issues before they become embedded.

We are also delighted to be involved with research that spans all four countries of the UK. The pandemic has shown that there are notable differences in the way we each approach health and social care. The setting up of a National Care Service in Scotland is a prime example; on a smaller scale, our intention to implement the Real Living Wage in social care settings across Wales is another. As our policies and approaches diverge, it becomes even more important to understand the impact of these distinct policy directions on the experiences of our workforces, and ultimately the experiences and outcomes for people who use care and support.

We also look forward to the next phase of the research, with a fourth survey due in 2022. We will work hard to promote completion of the survey to people working in health and social care in Wales and would urge our partners across the UK to do the same. Gathering the views of a wide range of people will help us all better support this invaluable workforce, so they can continue to support those who rely on their knowledge and experience.

Sue Evans

Chief Executive Social Care Wales

The research team thank all participants who contributed to this research

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1. Background

1.1 Aim

This study builds upon the findings from the Phase 1 survey (data collected between May – July 2020) and Phase 2 (data collected between November-January 2021) to further explore the impact of providing health and social care during the COVID-19 pandemic in UK. The study focuses specifically on the experiences of nurses, midwives, allied health professionals (AHPs), social care workers and social workers.

1.2 Objectives

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

2. Methodology

2.1. Primary Research Instrument

The data for the current report were collected using an online survey questionnaire, which was adapted from the questionnaires used in the Phases 1 and 2 of the 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 questionnaire was predominantly quantitative, but contained two open-ended qualitative questions. The main parts of the questionnaire covered as follows:

- ***Demographic and work-related information***: age, sex, country of work, occupational group, ethnicity, disability status, relationship status, caring responsibilities, job tenure, hours of work, working overtime, working at home, considering changing one's occupation and/or employer, the effects of the pandemic on one's place of work, impact of COVID-19 on morale, employer support/use of any employer support and whether the workforce have received vaccination(s).
- ***Mental wellbeing***: Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS; NHS Health Scotland, 2008).
- ***Quality of working life***: Work-Related Quality of Life scale (WRQOL; Easton & van Laar, 2018).
- ***Burnout***: Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen, & Christensen, 2005).
- ***Coping with COVID-19-related occupational demands***: 20 items from Brief COPE (Coping Orientation to Problems Experienced, Carver, 1997).
- ***Coping with work-related stressors***: 15 items from Clark, Michel, Early and Baltes (2014).
- ***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 management of work and non-work responsibilities.

2.1.1. Mental Wellbeing

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

Table 2.1: Cut-off points for SWEMWBS scores

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

2.1.2. Quality of Working Life

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

Table 2.2: Cut-off points for WRQOL scores

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

2.1.3. Burnout

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

- Personal burnout: *"state of prolonged physical and psychological exhaustion"*

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

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

Table 2.3: Cut-off points for Burnout scores

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

2.1.4. Coping with COVID-19 Related Occupational Demands

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

2.1.5 Coping with Work-Related Stressors

Coping with work-related stressors was also assessed using 15 items from the 81-item scale assessing work and family stressor coping strategies, developed by Clark et al. (2014). The 15 items assessed five specific coping strategies (three items per strategy), including Family-work segmentation, Work-family segmentation, Working to improve skills/efficiency, Recreation and relaxation, and Exercise. Respondents were asked to use a six-point Likert scale ranging from 1 = 'Never have done this' to 6 =

'Almost always do this' to indicate how often they have been doing what is described by the items to cope with work stressors. The scores for each item are averaged and can range from 1 to 6. Higher scores indicate that respondents use the specific coping strategy more often.

2.1.6. Open-Ended Questions

The two open-ended questions asked of respondents were:

1. Between February and June 2021, what was the impact of COVID-19 on your specific place of work, in relation to patient / service user numbers and service demand?
2. How did the experience of the pandemic change the way you now manage work and non-work responsibilities?

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 3 study period (May-July 2021). A wide variety of recruitment channels and methods were utilised in order to reach as many potential respondents as possible. These included Northern Ireland Social Care Council, Social Care Wales, the five Northern Ireland Health and Social Care Trusts, Community Care, 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), and College of Podiatry. Support was also provided by the Chief Nursing and AHP Officers from across the UK. These regulatory bodies, unions, associations and Chief professionals used a variety of methods to disseminate the study information, including newsletters, direct emails, or social media platforms. The study website was also used to raise awareness about the study among the health and social care staff.

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

2.2.1 Sample Profile

There were a total of 2,721 respondents to the survey. Most of the responses came from Northern Ireland (n = 1116), followed by Scotland (n = 745), England (n = 539) and then Wales (n = 321). Most of the sample were social care workers and social workers (see Figure 2.1).

Table 2.4 below shows that 36.4% of nurses were from Northern Ireland, 48.8% from Scotland; 12.2% were from England, and 2.7% from Wales. A total of 171 midwives responded to the survey. The majority of these respondents (45.0%) were from England, 27.5% from Wales, 17.5% from Northern Ireland and only 9.9% from Scotland. The majority of AHPs were again from Northern Ireland (52.1%), followed by England (26.2%), Scotland (16.7%) and the smallest number were from Wales (5.0%). A total of 43.1% of social care workers were from Northern Ireland, 34.4% were from Scotland, 17.4% from Wales and the remaining 5.2% were from England. The largest proportion of social workers in the sample were from Northern Ireland (41.8%), followed by England (33.2%), Scotland (12.7%) and Wales (12.2%)

Figure 2.1: Occupation of Respondents (Unweighted)

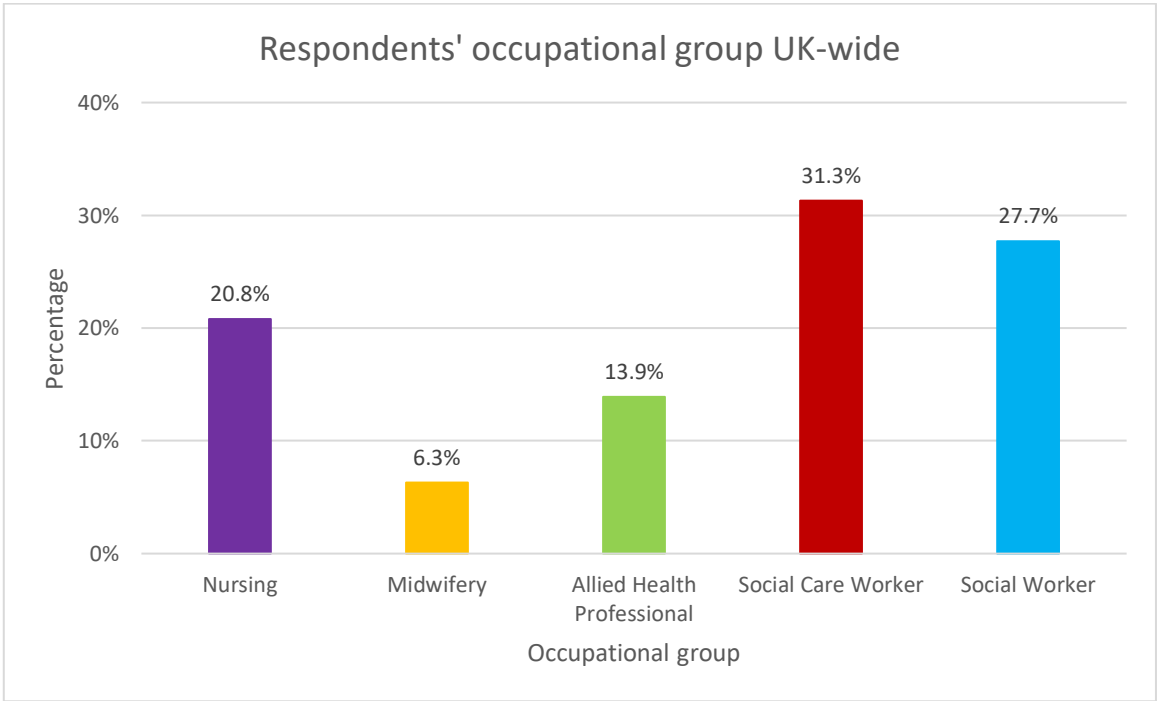


Table 2.4: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	69 (12.2)%	276 (48.8%)	15 (2.0%)	206 (36.4%)	**566 (100%)**
Midwifery	77 (45.0%)	17 (9.9%)	47 (27.5%)	30 (17.5%)	**171(100%)**
AHP	99 (26.2%)	63 (16.7%)	19 (5.0%)	197 (52.1%)	**378 (100%)**
Social Care Worker	44 (5.2%)	293 (34.3%)	148 (17.4%)	368 (43.1%)	**853 (100%)**
Social Worker	250 (33.2%)	96 (12.7%)	92 (12.2%)	315 (41.8%)	**753 (100%)**

Most respondents were female (86.8% UK-wide) with a similar sex distribution across countries. A majority of midwives in the sample were female (98.4%) and nursing had the highest proportion of males (15.8% within nursing). Respondents were primarily in the 30-59 group (83.7% UK-Wide) with only a small proportion from the 66+ age group (1.9% UK-Wide). Scotland had the highest proportion of respondents from the 50-59 age group (38.7% within Scotland). The majority of respondents were of white ethnic origin (89.5% UK-wide). England had the highest proportion of respondents who identified as other than white (12% within England) and nursing was the most diverse occupational group, with 13.1% of nurses identifying as not white. England had the highest proportion of respondents with a disability (14% within England) and social workers were the most likely occupations to report having a disability (23.10% within social work). The majority of respondents UK-wide were married (52.2%) or cohabiting (21.7%). UK-wide, 41.2% of respondents considered themselves to be a carer outside of work and 52.40% did not. Northern Ireland had the highest proportion of respondents who were carers outside of work (58.8% within Northern Ireland).

Almost half of all the respondents worked in the community (44.9% UK-wide), but 27.4% (UK-wide) worked in a hospital. Most worked in the statutory health and social care sector (66.60% UK-wide), but almost half of social care workers (56.30% of social care workers) worked in non-statutory services. For respondents working in the NHS/HSC Trust, the most frequently reported pay scale was Band 7 (24.20% UK-wide), followed by Band 6 (22.9% UK-wide) and Band 8 (19.2% UK-wide). Social care workers were more likely to be paid at the lower end of the pay scale or equivalent, with Band 5 being the most frequently reported category (26.4% of social care workers working in the NHS/HSC Trust). UK-wide, 16.5% of respondents had been redeployed due to COVID-19, but 48.1% of these felt unprepared for their new role. Only 3.1% of respondents UK-wide came out of retirement to support the workforce during the pandemic and these were mostly nurses or social care workers.

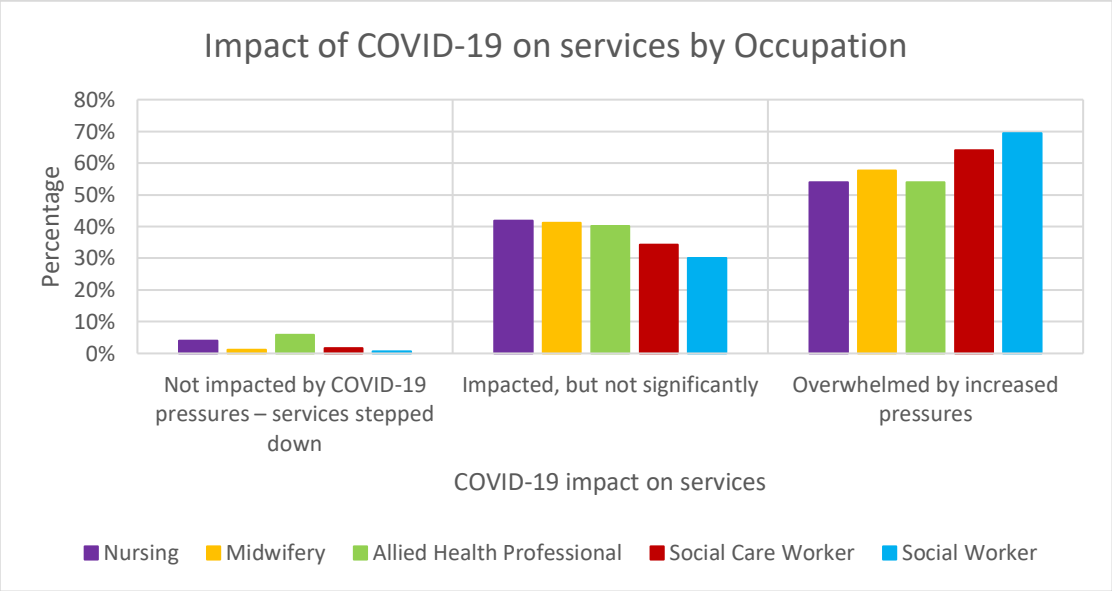
Most respondents were employed on a permanent basis (85.90% UK-wide) and the majority were employed full-time (76.0% UK-wide), typically working 37.5 hours per week (69% UK-wide). Scotland had the highest proportion of respondents employed on a part-time basis (30.6% within Scotland). A total of 33.5% of respondents UK-wide typically did not work overtime, but since the start of the pandemic, 23.5% 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. Under half of the respondents (48.0% UK-wide) have taken no sick days in the previous 12 months, 52.0% have taken one or more sick days in the previous 12 months, 47.3% (UK-wide) of these said that at least some of their sickness absence was related to COVID-19. When sick, most respondents (58.8% UK-wide) reported getting pay from their employer in addition to statutory sick pay. AHPs were the most likely to report not getting sick pay when off sick (25.7% of AHPs). Respondents were asked if they had received the COVID-19 vaccination, 85.0% had received both doses, while 5.2% did not wish to receive the vaccination for a number of reasons detailed in Appendix 2.

A large proportion of respondents UK-wide had either 11-20 years of work experience (33.0%) or more than 30 years (21.8%). England had the highest proportion of those with 11-20 years of experience (31.4% within England) and those with more than 30 years of experience were primarily nurses (33.1% of nurses) and AHPs (26.4% of AHPs). The main area of practice for most respondents were adults (37.0% UK-wide) and older people (22.9% UK-wide), but in Wales, the most commonly reported areas of practice were older people (30.5% within Wales) and children (17.3% within Wales) services. Of those who were carers, most respondents cared for their parents (47.3% UK-wide) or children (44.4% UK-wide), 48.6% lived with the person they cared for and 62.2% (UK-wide) reported that their caring responsibilities had changed during the COVID-19 pandemic. Midwives had the highest reported COVID related impact on morale at 50.0%, while AHPs had 35.6% reporting a lower COVID related impacted on morale. In this study phase, respondents were asked whether they worked from home, over half of respondents did not work from home at all during the January-July 2021 period of the pandemic (57.80% UK Wide). Social workers were most likely to work from home all of the time, 42.2%, while Midwives had the lowest percentage working from home, 1.9%. When asked about the impact of the pandemic on their morale, 30.4% (UK-wide) reported low morale, while 34.6% reported high morale.

Respondents were also asked about the impact of COVID-19 on their work. UK-wide, only 3.4% reported that their service had not been impacted (services stepped down due to COVID-19) with 62.1% reporting feeling overwhelmed by increased pressures. As shown in Figure 2.2, social care workers and social workers were the most impacted occupational groups (69.4% of social workers and 64.1% of social care workers). That said, significant percentages expressed feeling overwhelmed in all

occupational groups. Respondents were also asked whether they had considered changing their employer or occupation since the start of the pandemic. Under half of the respondents UK-wide (41.80%) had not considered changing their employer, with the highest proportion of these being from Wales (66.30% within Wales). Similarly, over a third of the respondents UK-wide (37.8%) had not considered changing their occupation and again, Wales had the highest proportion of these (60.1% within Wales).

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



2.3 Focus Groups

Two focus groups were conducted to gain deeper insights into the Health and Social Care Workforce (Social Work, Social Care, Nursing, Midwifery and AHP professionals) and the impact of COVID on their work, one with managers and one with frontline workers (June 2021). Each group began with a brief introduction of the research study before discussion commenced. These findings will contribute to our recommendations for improving quality of working life and wellbeing for health and social care professionals even beyond the pandemic. Table 2.5 below shows the country and occupational group of the ten participants.

Table 2.5: Focus Group Participants

Focus group	Country	Occupation
Managers	Northern Ireland	Social Care
	Northern Ireland	Social Work
	Northern Ireland	Social Work
	Northern Ireland	Social Work
Front Line workers	England	AHP
	Scotland	Nursing
	Wales	Social Work
	Northern Ireland	Nursing
	Northern Ireland	Social Care
	Northern Ireland	Social Work/Mental health

2.4 Data Analysis

The survey data were analysed using SPSS 26. Presented are primarily descriptive statistics, specifically frequencies, percentages, mean values of the measured constructs, and some correlations. Sub-groups were compared using analyses of variance (ANOVA), independent samples t-tests and chi-square tests. Multiple regression analyses were used to examine the association between coping strategies and mental wellbeing, quality of working life and burnout, and also to compare findings from Phase 1, Phase 2 and this Phase 3 of the study. Analyses were conducted both with raw and weighted data. The data was weighted using respondents' country of work and occupational group. The main findings (weighted) are presented in Section 3. Appendices provide more detailed results, including the unweighted findings. The analyses were conducted with all available data. Some participants had missing data and therefore the sample total for the different analyses differs throughout this report.

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

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

2.5 Ethical Considerations

Data collection took place during an 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 wellbeing, 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. 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 3.

3.1. Quantitative Findings

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

3.1.1. Mental Wellbeing

Mental wellbeing was assessed using the Warwick-Edinburgh Mental Wellbeing Scale. The overall mean wellbeing score in our sample was 20.25, which is more than three points below the population mean of 23.61 (NHS Health Survey for England, 2011) and it is also lower than the mean score of 20.95 reported in Phase 1 of the study, however it has improved from the mean score of 20.10 reported in Phase 2 of the study. Multiple regression analysis revealed that this was a **significant difference in wellbeing from Phase 1 to Phase 3**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -0.951$, $p < .001$). There was no **significant difference in wellbeing from Phase 2 to Phase 3**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 0.066$, $p = 0.528$). As shown in Tables 3.1 and 3.2 below, the decrease in wellbeing, was observed across all four countries and all five occupational groups and the slight increase was also similarly reported between Phases 1 and 3. While between Phase 2 and 3, wellbeing increased slightly across each country, but decreased in all occupations except nursing.

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

Study phase	Country				
	UK-Wide	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1	20.95	21.15	20.74	21.25	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85

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

Study phase	Country				
	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	19.7	19.31

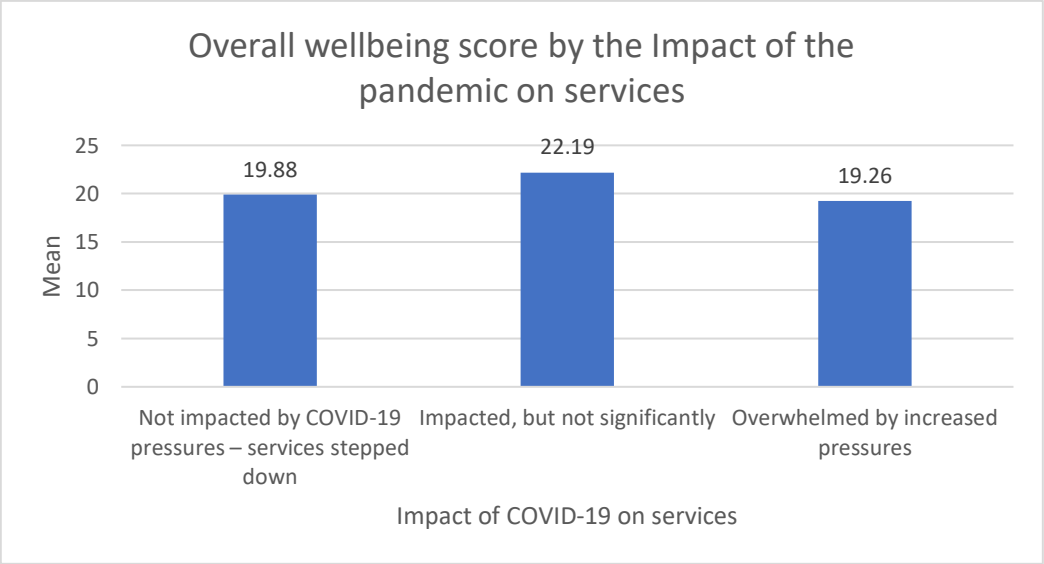
When the wellbeing scores were converted to indicate probable or possible cases of depression/anxiety, it was found that UK-wide, 20.7% were probable (likely) cases of anxiety or depression and a further 14.4% were possible cases of anxiety or depression. In Phase 2 of the study, only 17.7% of respondents were probable (likely) cases of anxiety or depression and a further 22.% were possible cases of anxiety or depression. In Phase 1 of the study, these numbers were 9.0% and 33.0% respectively, suggesting an increase in the severity of problems from Phase 1 to Phase 3.

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

- Males reported significantly lower wellbeing than females.
- Older respondents had significantly better wellbeing than younger respondents.
- Respondents from the black ethnic group scored significantly higher on wellbeing than those from the other three ethnic groups; and respondents from the Asian ethnic group scored significantly lower than those from the other ethnic groups.
- Respondents who had a disability had significantly lower wellbeing scores than those who did not have a disability.
- Respondents who worked had a more flexible working life, working from home only sometimes scored significantly higher on wellbeing than those who worked at home all the time or those who never worked at home.

- Line managers scored significantly lower on wellbeing than those who were not line managers.
- Respondents who had only received one vaccination had significantly lower mental wellbeing scores than who had both vaccinations, those not yet able to receive the vaccine and those medically exempt from the current vaccination.
- Respondents who felt that their service was impacted but not significantly scored significantly higher on wellbeing than those whose service was not impacted and those who were overwhelmed by increased pressures (see Figure 3.12).

Figure 3.12: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Weighted)



In Phase 3, we found that after controlling for the effects of respondents' age, sex, disability status, ethnicity, country of work, occupational group, number of sick days in previous 12 months, line manager status and the effects of the pandemic on services, the following coping strategies were significantly associated with wellbeing scores:

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

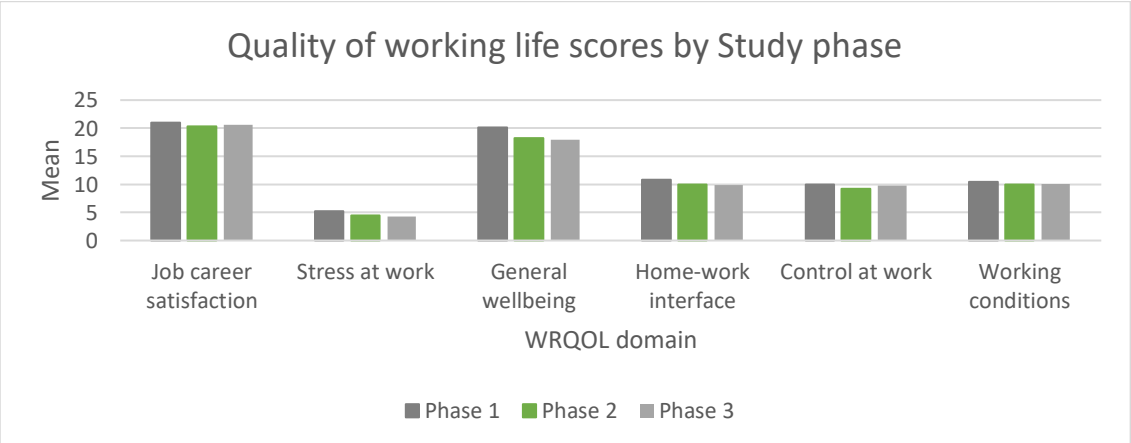
Detailed breakdown of wellbeing scores across different variables is provided in Appendix 3 and detailed results of the multiple regression analysis are provided in Appendix 8.

3.1.2. Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life (WRQOL) Scale. The overall WRQOL score across the UK was 72.45, which is lower compared to the 77.59 in Phase 1 of the study but a slight improvement compared to 72.13 in Phase 2.

A multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed that this **decrease in quality of working life from Phase 1 to Phase 3 of the study was statistically significant** ($\beta = -6.739$, $p < .001$). There was also a statistically **significant difference in quality of working life from Phase 2 to Phase 3 which included a slight increase in quality of working life from Phase 2 to Phase**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 1.406$, $p = .002$). As shown in Figure 3.13, there was also a decrease from Phase 1 to Phase 3 on all domains of the quality of working life and these decreases were again statistically significant. Also shown in Figure 3.13. there was a decrease from Phase 2 to Phase 3 in Stress at Work, general wellbeing, home-work interface and working conditions while an increase in job career satisfaction and control at work. All changes were significant except stress at work and working conditions.

Figure 3.13: UK-wide Mean Quality of Working Life Scores by Study phase (Weighted)



As shown in Table 3.3, the decrease in WRQOL scores was observed across all three countries (England, Wales and Northern Ireland), with Scotland reporting higher WRQOL scores in Phase 3.

Similarly, Table 3.4 shows an increase in WRQOL of life across the three phases, with the highest score observed in Phase 3. However, amongst the other four occupational groups (Midwifery, AHPs, Social Care Workers and Social Workers) a decrease in WRQOL of life was observed.

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

Study phase	Country				
	UK-Wide	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1	77.59	79.33	73.07	80.35	76.63
Phase 2	72.13	72.21	70.37	79.46	74.06
Phase 3	72.45	71.54	71.92	78.69	73.29

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

Study phase	Occupation				
	Nursing	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1	72.54	78.56	81.16	78.34	80.63
Phase 2	70.01	66.95	74.41	73.24	73.67
Phase 3	73.77	64.35	73.79	71.15	69.92

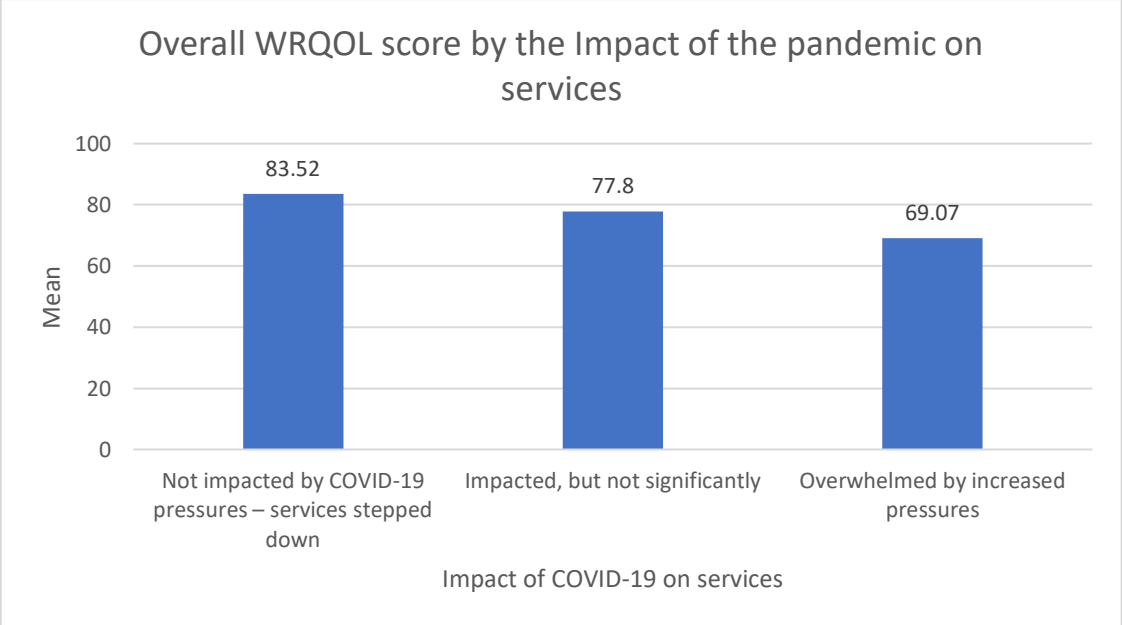
When the WRQOL scores were converted to Lower, Average, or Higher quality of working life, we found that UK-wide, 50.0% of respondents had lower quality of working life, 19.5 had average quality of working life and 30.5% had higher quality of working life in Phase 3. This compares to 46.7% of respondents having lower quality of working life, 26.0% having average quality of working life and 27.3% having higher quality of working life in Phase 2 and 30.4%, 27.1%, and 42.5% for higher, average and lower quality of working life respectively in Phase 1 of the study.

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

- Females had significantly higher quality of working life than males.
- The older age groups report significantly better quality of working life than some of the younger age groups.
- Respondents from the Asian ethnic group had significantly lower quality of working life than all the other ethnic groups.

- Respondents with a disability and those who reported no disability had a significantly higher quality of working life than those who were unsure of whether or not they had a disability.
- Those who received both vaccinations had higher work related quality of life that those who had not yet received the vaccine and those who decided not to get one.
- Line managers and those who were not line managers did not differ significantly in their quality of working life scores
- There was no significant difference in quality of working life scores in those working from home all the time, some of the time or none of the time.
- Respondents who felt that their service was overwhelmed by increased pressures scored significantly lower on quality of working life than those who felt no impact or only some impact (see Figure 3.14).

Figure 3.14: Mean Overall WRQOL Score by the Impact of the Pandemic on Services (Weighted)



We used multiple regressions to examine which coping strategies impact upon the quality of working life scores. In Phase 3, we found that after controlling for the effects of respondents' age, sex, disability status, ethnicity, country of work, occupational group, number of sick days in previous 12 months, line manager status and the effects of the pandemic on services, the following coping strategies were significantly associated with WRQOL scores:

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

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

3.1.3. Burnout

As mentioned above, in Phase 2 and Phase 3 of the study we also measured burnout, using the Copenhagen Burnout Inventory, which assesses personal, work-related and client-related burnout. The personal burnout score across the UK was 63.2, which is higher compared to the 61.4 in Phase 2 of the study. Similarly work-related burnout was higher in Phase 3 at 59.79 compared to 56.73 at Phase 2. Client-related burnout also increased from 27.97 in Phase 2 to 29.46 in Phase 3.

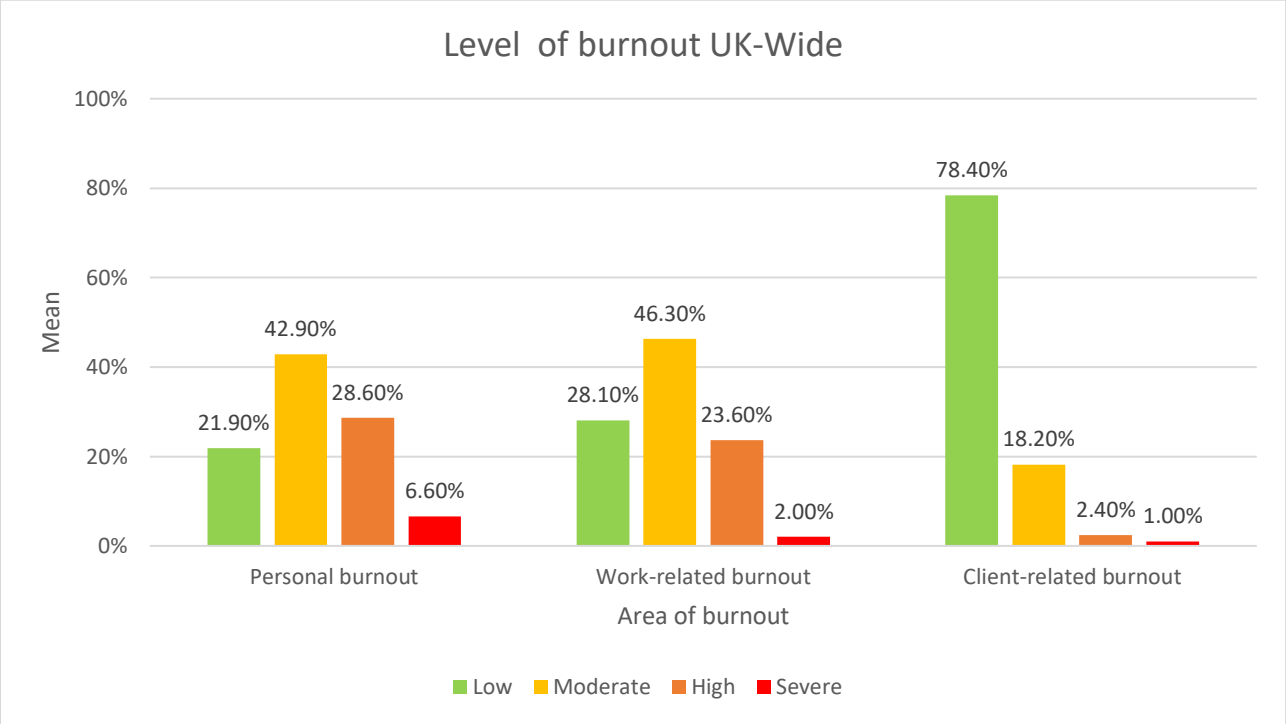
Multiple regression analysis revealed that this was a **significant difference in personal burnout from Phase 2 to Phase 3**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 1.258$, $p = .032$). There was also **significant difference in work related burnout** ($\beta = 1.325$, $p = .0.42$) and **client-related burnout** ($\beta = 1.627$, $p = .011$) **from Phase 2 to Phase 3**) even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Overall, in Phase 3 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. We also found some significant differences in the burnout scores across countries. The most consistent finding was that respondents from England scored significantly higher (i.e., experienced more burnout) than respondents from Wales, Scotland and Northern Ireland on all three areas of burnout (see Table 3.5). Comparing the occupational groups on their burnout scores, the findings were that respondents who were midwives scored significantly higher than respondents from all other occupations (see Table 3.6).

When the burnout scores for each domain (personal, work and client) were converted to low, moderate, high or severe burnout, we found that UK-wide in Phase 3 for personal burnout, 21.9% of respondents had low burnout, 42.9% moderate, 28.6% high and 6.6% faced severe burnout. This compares to 28.3% with low burnout, 46.4% with moderate, 23.7% with high and 4.6% with severe

personal burnout in Phase 2 (see Figure 3.15). In terms of work-related burnout; 28.1% of respondents had low burnout, 46.3% moderate, 23.6% high and 2.0% faced severe burnout. In relation to Phase 2 work-related burnout, 33.7% experienced low burnout, 45.0% experienced moderate burnout and a further 21.3% experienced high or severe burnout. Finally, in relation to client-related burnout in Phase 3, 78.4% 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% experienced low burnout, 17.1% experienced moderate burnout and 2.0% experienced high or severe burnout.

Figure 3.15: Level of burnout UK-wide

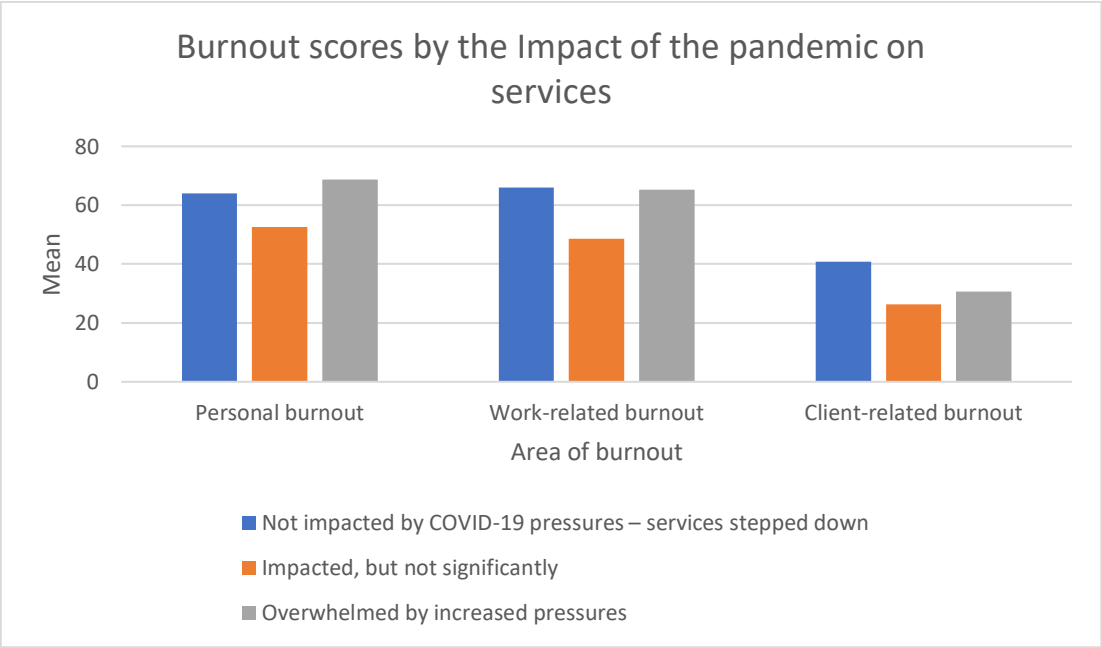


The analyses of the effects of other variables on burnout scores revealed the following:

- Females experienced significantly higher levels of personal and client-related burnout than males, but no statistically significant sex differences were found for work-related burnout.
- The older age groups generally experienced significantly lower personal, client-related and work-related burnout than the younger age groups.
- Respondents from the black ethnic group experienced significantly less personal, work-related and client-observed burnout while Asian groups experiences significantly more personal, client-related burnout, work-related burnout than other ethnic groups.

- Respondents without a disability experienced significantly less personal and client-related burnout than those who were unsure of whether they had a disability.
- Line managers experienced significantly more personal and work-related burnout and significantly less client-related burnout than respondents who were not line managers.
- Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more burnout in all three areas than those who felt impacted but not significantly (see Figure 3.16).

Figure 3.16: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)



As shown in Table 3.7, we found strong negative correlations between personal burnout and wellbeing scores and a moderate negative correlation between personal burnout and quality of working life, work-related burnout and wellbeing scores, and work-related burnout and quality of working life scores. There were also weak, but statistically significant, negative correlations between client-related burnout and wellbeing scores, and client-related burnout and quality of working life scores. This indicates that as burnout in any area increased, respondents' wellbeing and quality of working life decreased. Considering the association between burnout, wellbeing and quality of working life, another area of interest is whether respondents have considered leaving their current employer and how this impacts burnout.

Table 3.7: Correlations between Burnout Scores, Mental Wellbeing (SWEMWBS) and WRQOL Scores (Weighted)

Burnout area	Wellbeing	Quality of working life
Personal	-.700	-.596
Work-related	-.592	-.661
Client-related	-.376	-.350

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: $\chi^2 = 410.763$, df = 15, $p < .001$; Work-related burnout: $\chi^2 = 566.657$, df = 15, $p < .001$; Client-related burnout: $\chi^2 = 145.172$, df = 15, $p < .001$). Specifically, respondents who were experiencing high/severe levels of personal burnout were very likely to report having considered changing their employer since the start of the pandemic for two specific reasons; 1) the job being very stressful, and 2) the job impacting on their health and wellbeing. Those experiencing low levels of personal burnout were less likely to have considered changing their employer for these reasons. The same was found for work-related burnout and client-related burnout.

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

Personal burnout:

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

Work-related burnout:

- Positive reframing, Acceptance, Use of emotional support, Work-family segmentation, Working to improve skills/efficiency, Recreation and Relaxation, and Exercise, all predicted less burnout.

- Planning, Use of instrumental support, Venting, Behavioural disengagement, Self-blame, and Family-work segmentation, all predicted more burnout.

Client-related burnout:

- Working to improve skills/efficiency predicted less burnout.
- Planning, Venting, Substance use, Behavioural disengagement, and Self-blame predicted more burnout.

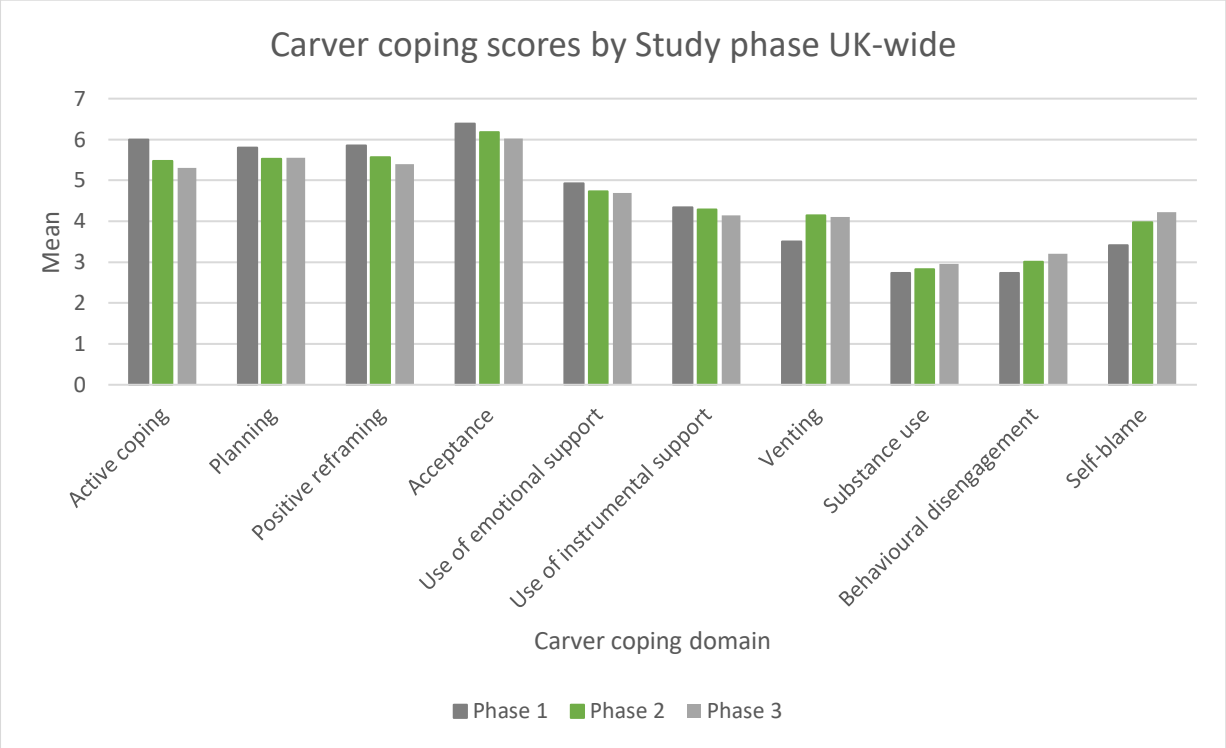
Detailed breakdown of the burnout scores across different variables is provided in Appendix 5 and detailed results of the multiple regression analysis are provided in Appendix 8.

3.1.4 Coping

UK-wide, there seemed to be **an overall decrease in the use of most of the positive coping strategies and an increase in the use of negative coping strategies from Phase 1 to Phase 3 and between Phase 2 to Phase 3 of the study**, as shown in Figure 3.17. 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 ($\beta = -0.719$, $p < .001$)., planning ($\beta = -0.384$ $p < .001$) , positive reframing ($\beta = -0.412$, $p < .001$), acceptance ($\beta = -0.412$, $p < .001$) and emotional support ($\beta = -0.247$, $p < .001$) were statistically significant from Phase 1 to Phase 3; and the increase in the use of venting ($\beta = .941$, $p < .001$), substance use ($\beta = 0.162$, $p < .001$), behavioural disengagement ($\beta = 0.398$, $p < .001$) and self-blame ($\beta = 0.840$, $p < .001$) was also statistically significant. The use of instrumental support as a coping strategy remained unchanged from Phase 1 to Phase 3 ($\beta = -0.075$, $> .05$).

Between Phase 2 to 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 that the decrease in respondents' use of active coping ($\beta = -0.169$, $p < .001$), positive reframing ($\beta = -0.080$, p .05), acceptance ($\beta = -0.127$, $p < .05$) and instrumental support, ($\beta = -0.111$, $p < .05$), were statistically significant. There was an increase in the use of self-blame between Phase 2 to Phase 3 that was statistically significant ($\beta = 0.227$ $p < .001$). However, there was no significant differences in planning ($\beta = -.080$, $p > .05$), positive reframing ($\beta = -0.138$, p , $p > .05$), emotional support ($\beta = -0.102$ $p > .05$), use of venting ($\beta = 0.039$, $p > .05$), substance use ($\beta = 0.031$, $p > .05$) and behavioural engagement ($\beta = 0.062$, $p > .05$) between Phase 2 to Phase 3.

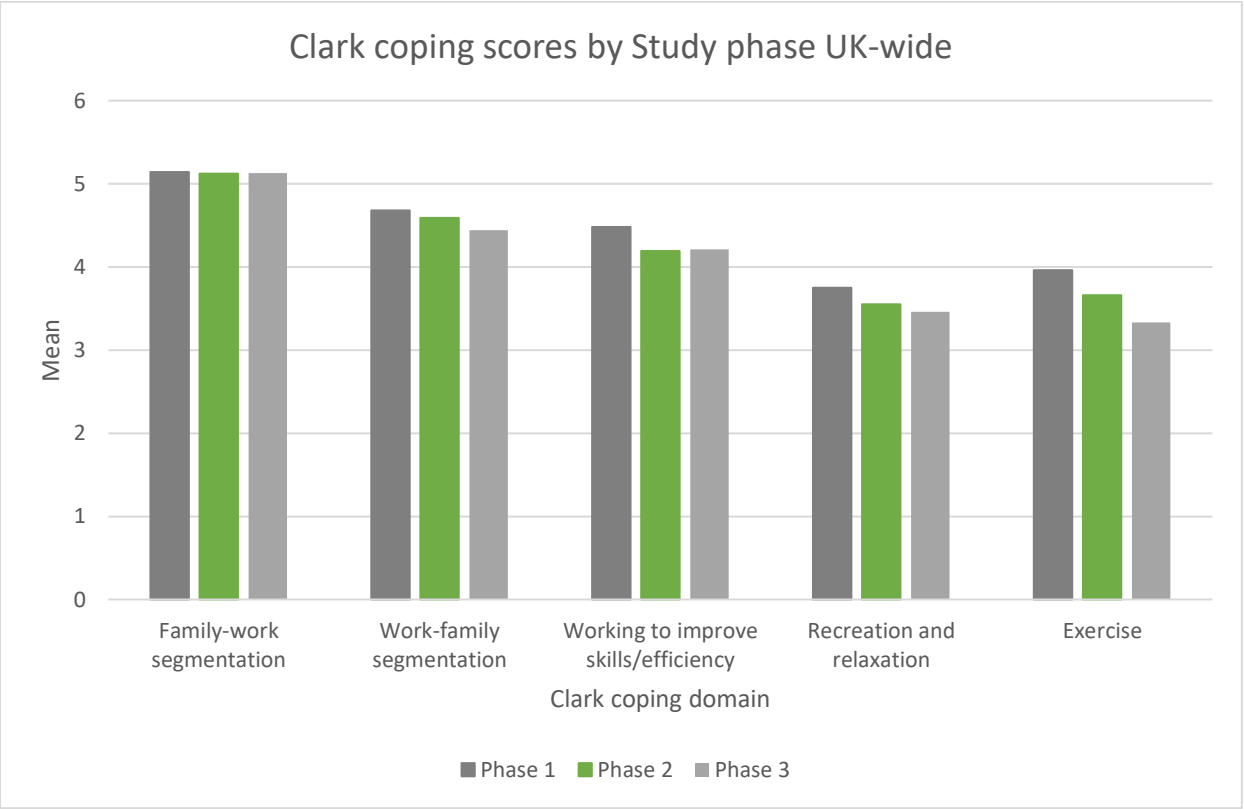
Figure 3.17: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)



Looking at Clark et al.'s coping strategies (Figure 3.18), a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed **significant difference between Phase 1 and 3 in respondents' working to improve skills/efficiency** (β = -0.246, p = .003), but **no significant difference in use of family-work segmentation** (β = 0.064, p = .924)**, in use of work-family segmentation** (β = -0.112, p > .05)**, recreation and relaxation** (β = -0.157 , p > .05)**, and exercise** (β = -0.103, p > .05 **from Phase 1 to Phase 2 of the study**.

Between Phases 2 to 3, 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 between Phase 2 and 3 in respondents' use of family-work segmentation** (β = .003, p > .05), **use of work-family segmentation** (β = -0.010, p > .05), **working to improve skills/efficiency** (β = -0.003, p > .05), **recreation and relaxation** (β = -0.026, p > .05) **and exercise** (β = -0.0018, p > .05).

Figure 3.18: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)



3.2. Findings: Changing conditions, communication and connections

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 two focus groups that were conducted with managers and frontline workers in June 2021. The overarching themes that emerged in Phase 3 (May 2021 – July 2021) have similarities to the themes identified in Phase 1 (April – July 2020) and Phase 2 (November 2020-January 2021) of the study.

Responses revealed a workforce often struggling with the continuing impact of Covid-19 due to increased demand coupled with reduced staffing due to illness, re-deployment and the stand down of some services during the earlier and current stage of the pandemic. A consistent message emerged across job roles about increased workload and changed working patterns often needing sustained communication with line managers, colleagues, as well as with service users/patients and their families. It appeared that the combination of work context, communication with colleagues and managers and connections with significant others influenced well-being as well as a continued overall

drop in morale and descriptions of heightened levels of anxiety. In the following we will discuss the **three "C's" – changing conditions, communication and connections –** as well as views on health and wellbeing in greater detail. Overall, many workers were still facing continual work disruptions throughout the pandemic in terms of changed work practices, staffing pressures and sustained demand. Depending on individual circumstances in work and at home, these changes presented opportunities and challenges for addressing work-life balance.

3.2.1. Changing conditions

Most respondents reported that their services in which they worked were (again) affected by staff shortages, leading to increased workloads. Shortages were due to sickness, staff being on Covid-19 related shielding or leave, or deployment to other units or services. In addition to covering for temporary absences, some services had lost staff who had left their current workplace or occupation during the pandemic and it was hard to replace them. These factors help explain why many respondents also mentioned increased workloads sometimes exacerbated by other external influences such as having to take on the responsibilities of other services that had closed or changed due to Covid-19. Social workers reported assisting clients in relation to housing and benefits services, while a community nurse said:

> *I was working in children's community with learning disability team, the pressures were enormous as all services to families were stopped. … working as a nurse and having to resume duty of care it resulted in my role taking on new duties and responsibilities. I was the only point of contact at times for the families (Nurse, Northern Ireland, Community).*

Figure 3.1 below presents the overtime levels reported across countries. A total of 33.5% of respondents UK-wide typically do not work overtime, but since the start of the pandemic, this has decreased to 22.5% UK-wide who did not do any overtime (Figure 3.2). Overall, respondents have been working significantly more hours of overtime since the start of the pandemic compared to before.

Figure 3.1: Typically Working Overtime by Country (Weighted)

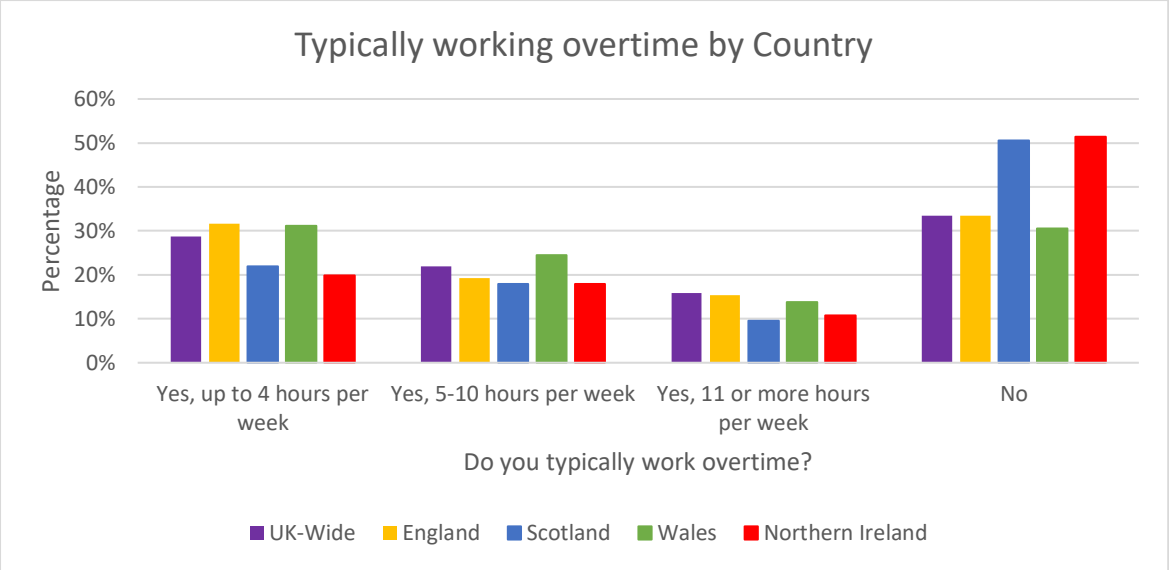
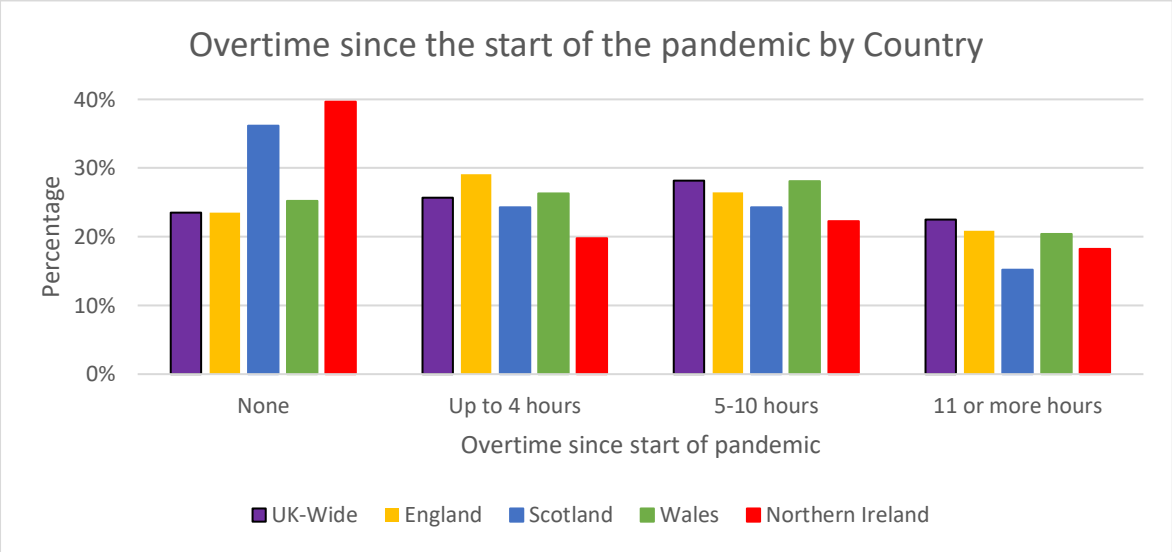


Figure 3.2: Overtime since the start of the pandemic by Country (Weighted)



Many reported having an increasing number of complex cases to deal with, aggravated by perceived lack of support within and across services as well as perceived increased risks. This is illustrated below:

> *Increase in pregnant women. GP and Health Visitor services suspended because of the increased risk to them seeing patients, so maternity services had to increase cover for the GP appointments in the antenatal period as well as doing extra home visits in the postnatal period as health visitors would not do home visits. This in turn increased our risk. (Midwife, England, Community).*

In contrast to Phase 1, some services now had substantial waiting lists as result of Covid-19 pressures, which placed an additional burden on staff. An AHP reported that this was affecting their ability to take breaks:

> *Playing catch up on studies not performed in the first lockdown period now on top of red flag and urgent referrals, squeezing patients into already full lists, starting earlier, finishing later often not able to take breaks, which is probably just as well as Its difficult to get to the loo ... (AHP, Northern IrelandI, Hospital).*

In response to increased workloads and staff shortages, some respondents felt that they were putting quality of care at risk and finding this distressing (sometimes this can be referred to as moral distress often cited in the literature; Delaney et al., 2021; Hines et al., 2021; Smallwood et al,. 2021). This included a nurse in Scotland who said that "*In the last few weeks to month we have had to supply one nurse every shift to cover a covid ward, sometimes leaving our ward short staffed and unsafe. (Nurse, Scotland, Hospital)*" as well as an AHP who felt that "*staff shortage…has impact on their care and safe working practices". (AHP, Northern Ireland, Care home).* Respondents also talked about putting themselves at risk in work:

> *Staff expected to go to other projects and not being told that positive covid cases were in these projects. Being made to feel that you didn't have a choice (Social Care Worker, Northern Ireland, Community).*

Some impacts were on physical health. A social worker working in the community (England) explained that, *'the reality is I am working much harder and take less breaks due to guilt. I have neck and wrist pain due to this and a poor home set up'.* Others commented on the tiring effects of Long Covid on work responsibilities.

The effects on mental health were numerous. Some respondents could not even address the question because the pressures and emotion made it too difficult to talk about or articulate. Others reported low mood, depression or anxiety, having little motivation, and feeling 'disconnected', 'introspective', 'withdrawn' or more 'distant from people'. For example, a hospital nurse in England explained how their ITU (intensive care) experiences affected social relationships:

> *'Being redeployed to ITU had a psychological impact that still affects me at times. As a result I feel disconnected at times from family & still don't engage with friends that much, especially those who constantly ask "how was it?".'*

Other respondents felt unable to focus at work. For example:

> *Seem to have brain fog and in ground hog day, used to be proactive and innovative now struggle to come to work and when in work can look at my computer at 9 and next time its 3 and I have done nothing (Nursing, Scotland, Care Home).*

Similar to Phase 2, burnout was measured during Phase 3. The Copenhagen Burnout Inventory was the measure used, as this separated personal burnout, work-related burnout and client-related burnout, with all areas relating to energy levels associated with each specific area. We found significant differences between occupational groups in mean burnout scores across all three domains (see Figure 3.3.). In the personal burnout area, AHPs scored lower (i.e., had lower levels of burnout) than nurses and social workers, and social care workers scored lower than social workers. Social care workers scored significantly lower than nurses, midwives and social workers and AHPs scored significantly lower than social workers. In relation to client-related burnout, midwives scored significantly higher (i.e., had higher levels of burnout) than nurses or social care workers. Compared to the other two areas of burnout (personal and work-related), client-related burnout was lower overall. When the burnout scores were converted into Low/Moderate/High/Severe burnout, using the cut-off scores from the literature, we found that moderate, high or severe levels of burnout were common across the occupational groups for both personal and work-related burnout, as shown in Figure 3.4.

Figure 3.3. Burnout scores by occupation (Weighted)

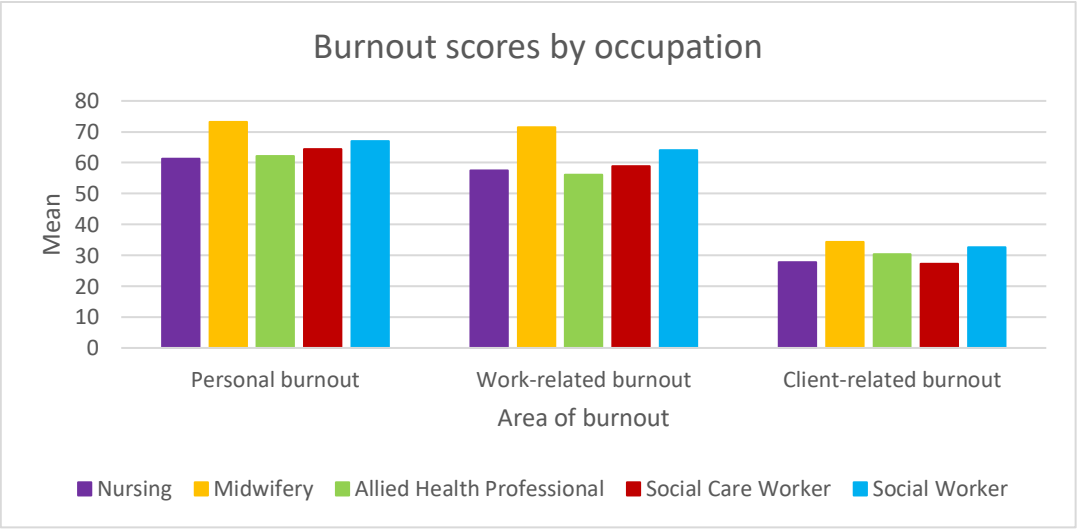
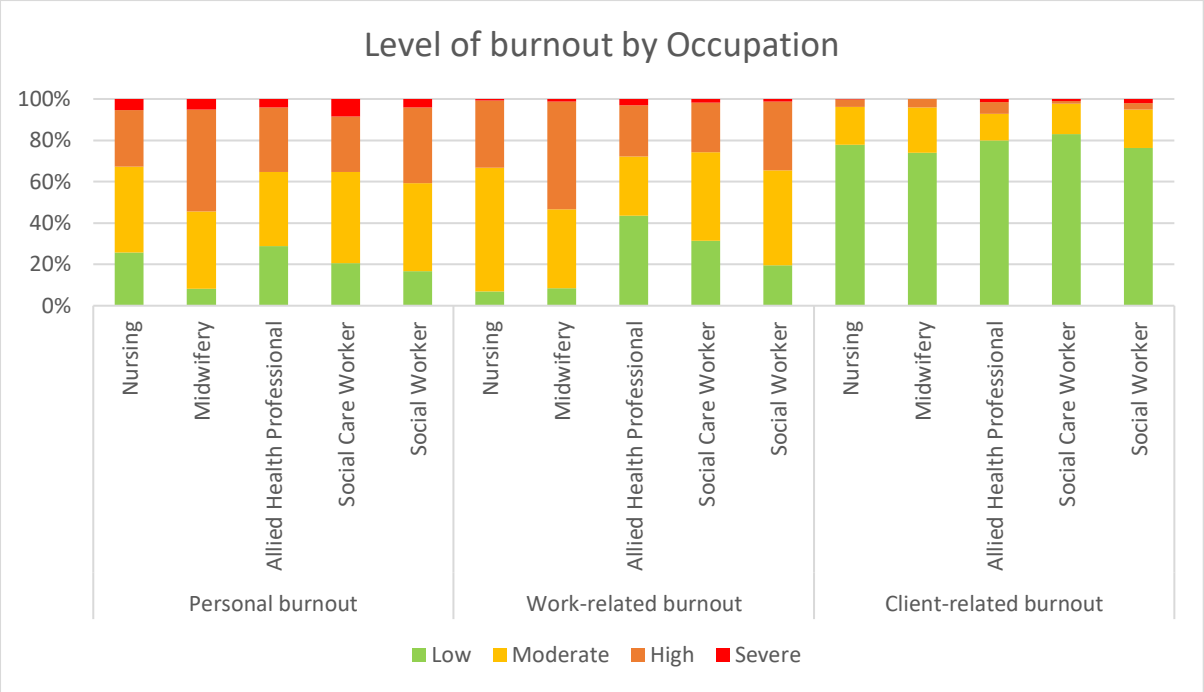


Figure 3.4. Level of burnout by Occupation (Weighted)



Managers' efforts to support their staff affected their own wellbeing. An AHP working in outpatients from Scotland reported finding *"it difficult to cope with increased workload, and deal with the emotions and concerns of my team. Constantly have to support them which is draining".*

A common thread was that some HSC workers felt drained at work and drained at home. Experiences of work were 'bleeding into' their home life, affecting wellbeing and mental health. Overall, the picture emerging from some of the responses was bleak. Many admitted struggling and, despite efforts to manage, were reconsidering their professional futures or employer to help prioritise their own health and wellbeing. This extract demonstrates how some are trying to cope:

> *I can't manage. I have tried counselling, taking time off work, considering changing jobs, occupational health reviews, meditation, breathing exercises, mental exercises, exercising... I cannot manage at all. I am steadily declining and I am worried about my future (Nursing, England, Hospital).*

Some respondents had learned that self-care helped manage pandemic pressures at work and home. If fearful of 'burning out' they could take actions to address it:

> *I have been more conscious of listening to my own body and paying attention to my emotional responses. I am scared of burning out and needing to go off sick. I rest if I need to rest. I will try to make the effort to do some physical activity/connect with*

friends if I feel like my mood is low. I have been focusing on my gardening and yoga. (Midwife, Wales. Community).

I think COVID has presented an opportunity for us all, to focus on what we need and how we need to feel ourselves and how we need to support each other to feel, in order to be effective in what we do. I think it has sharpened the focus on all of these areas. I certainly think it has been more important to me, the place I work in, how I behave towards other people and how I expect them to behave towards me, emm, I think it has defiantly all become far more important to me (Social Work, Manager, Northern Ireland, Community).

3.2.2. Work-Life Balance

Many respondents talked about their experiences of continuing to work from home. These were mainly social workers. Figure 3.5. below presents the percentage of respondents able to work from home between May-July 2021. A total of 57.8% of respondents UK-wide were not able to work from home, with 29.2% able to work at home some of the time and 13.0% all of the time. Overall, as Figure 3.6 shows, social workers were the most likely profession to be able to work from home.

Figure 3.5: Working from home by Country (Weighted)

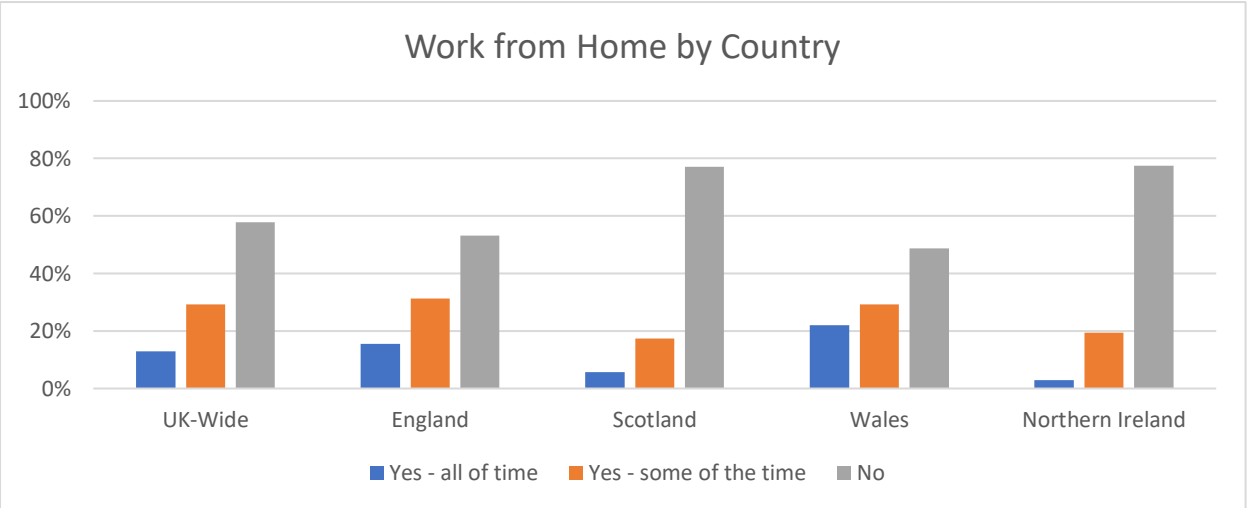
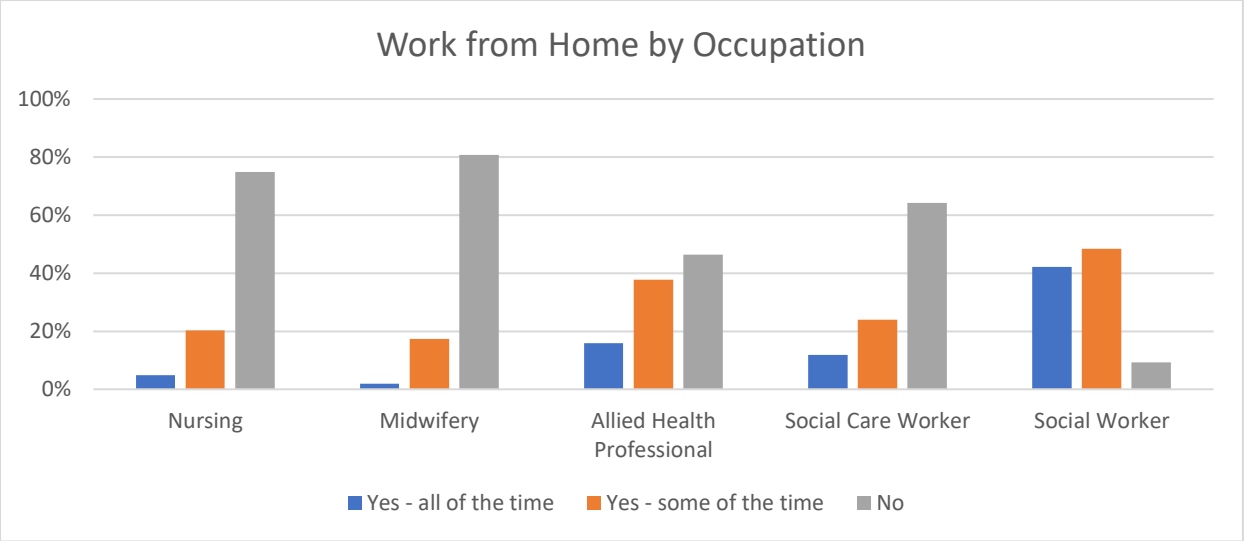


Figure 3.6: Working from home by Occupation(Weighted)



While a few mentioned that this enabled them to continue contributing to their services, which otherwise they would not have been able to do due to shielding, working from home was now being negatively perceived by several. Some felt ineffective in doing their jobs while at home because "*The task which is almost entirely 'relational' cannot be effectively done in this way. I am still expected to meet targets and keep standards within this exceptional situation"*. (Social Worker, *Northern Ireland*, Community). Other respondents, again mostly social workers, felt that working from home "*negated it being my "safe place" after a difficult day*" (Social Worker, Scotland, Other).

Several workers were maintaining work life balance by setting up a home office and taking exercise breaks. Working from home brought many advantages for some such as those who appreciated not having to commute and having extra time and energy for their family, and for other non-work commitments. The spatial and temporal flexibility was also highlighted in the focus group data:

> *I know my staff really appreciated like the stability and the support they got from myself and the assistant manager and the Trust as a whole, you know there was lot of flexibility, particularly with the schools being closed then reopening, and the kids having to self-isolate so that flexibility I felt that the staff because of that the staff had been a bit more flexible with me as well. (Manager, Social Care, Northern Ireland).*

However, others found it difficult to balance work and home commitments. One summed up the experience of both benefits and drawbacks of working from home:

Being at home in some ways helped the balance as without the commute I still had a little energy for my children after work. On other occasions it has been negative as work has been non-stop for more than 12 hours in a day so there has been no time for family and it can be hard to switch off as clearly as you do when leaving an office. (Social Worker, Scotland, Community).

One of the biggest ones for me was keeping work and home separate and transition you know you learn…I don't feel like I'm working from home, I feel my home is become my work. (Children's Social Worker, Wales, Community).

Others had learned to keep work and home time separate, which became more critical as the pandemic continued. A nurse working in a hospital from Scotland was now "*mak(ing) even more time for friends, family and exercise".* Some had adopted routines to suit their workload and protect their time. For example, a social worker working in the community from Wales explained that when *"mainly working from home, start earlier, finish later and less breaks, tend not to go back on computer at night unless something can't wait",* while others simply did less overtime if possible.

However, respondents felt guilty when work and non-work responsibilities collided and negatively affected relationships. Some felt too exhausted to give time to family members or were irritable. Several respondents reported 'little tolerance', or that they *"don't have as much patience now and (are) more easily upset"* (Midwife, Northern Ireland, Community). Many respondents found it increasingly difficult to 'switch off' after work, with some feeling 'absent' at home or with family or 'distracted'. A NI care home manager's constant worry impacted her work life balance:

I have found this time very difficult to switch of when I come home, I feel I'm constantly worrying about my staff and service users regarding Covid-19 … I am in constant fear of getting something wrong that will cause me personally to be blamed by the Trust, (regulator) etc.

Additionally, managers in the focus group discussed that while productivity increased, they had to stop some of their staff working longer hours by putting clearer boundaries on working time:

The only downside I actually had was to stop staff working beyond their hours when they had laptops and access to emails at home… at 9.30/10.30 at night, while they were emailing and updating, so I kind of had pull that back and tell them you need to take more control of what you're doing at home as well and their working hours shouldn't change just because you are sat at home (Manager, Social Care, Northern Ireland).

To manage the boundary of home and work, some respondents consciously decided not to talk about work at home. Social workers in particular mentioned missing the opportunity to share their thoughts and concerns with colleagues after a 'bad day' before going home.

Whilst some had a separate home office, others did not, and this was difficult. For those wanting to go back to the office, full or part time, many feared space would be reduced, especially if plans for return had not been communicated and discussed.

Some respondents felt that staffing levels necessary for Covid services had still not materialised, for example some ICU (intensive care unit) services still lacked qualified and trained staff:

> *ICU nurses working 1 nurse to 4 ICU pts. Training every single day of non-trained ICU nurses. eg day surgery nurses, health visitors etc. huge additional responsibility. (Nurse, Northern Ireland, Hospital).*

Survey respondents also talked about increasing levels of administration, which were mostly seen as negatively affecting their work, especially in times of both increasing service demand and staff shortages. An AHP from Scotland felt that increased paperwork left them with less time to spend with people, and a care home nurse from England mentioned that increased Covid-19 related administrative tasks had affected their and colleagues' morale:

> *Testing, testing, testing, more testing and some testing. Capacity tracker, Capacity tracker, Capacity tracker, Capacity tracker, and more Capacity tracker, Reporting to local authority, supporting staff, leading direct care, motivating staff and boosting morale, wondering what I am doing this for! Impacted on staff morale. For the first time in 32 years lost staff to NHS. (Nurse, England, Care Home).*

A domiciliary care worker noted during the focus groups that the work has become increasingly difficult in the social care sector as they are juggling increasing paperwork, staff shortages, and increased workload:

> *I think it's snowballed for a lot of social care workers you know and we are catching up again too because we never had to face to face some of this I have it all the time but I find it has snowballed and all the time because there was always worry, concern, what's going to happen here, am I going to make it you know (Domiciliary Care Worker, Northern Ireland).*

For some, what had been early (in 2020) responses to the pandemic were wearing thin. Some respondents talked about short-term changes to working time arrangements - such as the temporary

withdrawal of flexi-time arrangements to meet work demand – that seemed to be continuing and others mentioned back pay/overtime pay was owing to them.

However, several respondents contributed reflections about more personal development over the pandemic period. Some considered they had become 'more organised and more time focused'. An AHP from Wales felt more, 'solution focused' and 'autonomous', while another from England was now seeking early support with problems. Others had become more direct with colleagues but also more supportive, and now *"expect(ing) others to play their part to help themselves"* (Nurse, England, Care home). Many felt better able to adapt to change and manage uncertainty. The pandemic experience had encouraged many to reflect on how they 'valued friendships and colleagues.' A NI hospital nurse mentioned that even though non-work responsibilities increased through the pandemic, it 'brought family closer together'. There were other similar accounts about stronger relationships amongst colleagues and mutual support.

Several respondents felt more resilient, having done what a NI social worker described as 'a lot of firefighting along the way'. However, this might now be waning with a midwife working in a hospital setting in Wales explaining:

> *I feel I started off with a lot of resilience and was keen to get through this, especially as a team. This resilience has decreased over time, and seemingly across the board.*

It seemed that a continued high-pressured environment, both at work and sometimes at home, had encouraged many people to develop new skills and attributes, but some workplace behaviours that are potentially dysfunctional were also emerging as the pandemic pressures continued. There was some recognition that, 'the longer it goes on the harder it is' (Social Care Worker, Northern Ireland, Community).

3.2.3. Communication

A second theme covers the communication of our health and social care respondents with employers, managers, colleagues and service users. Overall, the qualitative data suggest that communication with employers and managers had worsened since the beginning of the pandemic. This was particularly in relation to perceived levels of support from line managers where some respondents felt that help and support were not forthcoming even when requested:

> *I am extremely tired and has asked my line manager many times for help. Our team needs a floater or bank (worker). We had no help over lockdown. Sometimes I feel*

pressured into working shifts I don't want. We need staff. (Social Care Worker, Northern Ireland, Community).

Managers unavailable to speak to of any concerns of service users. Not being informed from office staff that service users have died and staff turning up at the door during an emotive time for family members. No respect and no communication from managers. (Social Care Worker, Wales, Community).

A few respondents talked about a lack of communication or mistimed communication from their employer, mostly in relation to changes to work practices or wellbeing support:

There has been a lack of comminution from the PHA (Public Health Agency) and Trust regarding changes in practice which is unhelpful when working with families who assume I know everything. (Social Worker, Northern Ireland, Community).

What really surprised me was whenever I used to get those global emails with all these coping strategies made me so angry… I suppose it was it was kind of mistimed that was part of my frustration with it. It was the … you know we should have been offered that kind of support on a more personal basis on a more personal level at the very initiation of redeployment rather than a whole barrage of things now… (Nurse, Northern Ireland, Hospital).

Only a few respondents reported feeling bullied and possibly exploited by their managers, who were thought to use one-sided means of communication without acknowledging or responding to staff concerns:

Unrealistic hours, unrealistic rotas no help, Bullying from management, Not following covid rules sending people out on shift when they are unwell, Telling people to get back to work after having covid even though they were still not right, Making staff use our cars when we shouldn't have been. No work/hone life balance, Hounded when you're off to get back, stressed/depressed and mental breakdown but still they don't care (Social Care Worker, Scotland, Community)

While the amount and type of communication with employers and managers were often seen in a negative light, many respondents, and especially those working from home, reported missing communication with colleagues.

Respondents also commented on communication with patients/service users and their families. Many elaborated on how communication had changed from face-to-face interaction to online or phone.

They reported both positive and negative experiences around this. Some felt that it was good to be able to stay in touch remotely while others thought that phone/online communication made parts of their jobs more difficult. A social care worker from Scotland reported that it had been difficult to get mobile phones for service users that could not afford their own. As the pandemic wore on, some respondents felt that service users became increasingly unrealistic, expecting services that were not allowed under Covid-19 conditions or were affected by staff shortages. An example was a nurse who felt threatened by family members to be allowed to visit non-critically ill patients:

> *Duty of care is for all patients not just the ones who have threatening families. (Nurse, Scotland, Hospital)*

Another felt that "*Clients increasingly difficult to manage. Their fear and expectations were extremely heightened. Increase abuse to staff and unrealistic expectations of service delivery noted. Highly stressful work environment' (Midwife, Northern Ireland, Hospital).*

It was acknowledged that many respondents dealt with backlash from patients/service users who were tired of the changes in practices, not having their regular appointments or constant scheduling changes:

> *We were experienced at that time are real backlash from patients about the backlog and about you know all the problems… they were nearly kinda questioning well I suppose your dedication a certain extent, even though it wasn't our choice you know to go but emm, and so that has been very difficult (Nurse, Hospital, Northern Ireland).*

3.2.4. Connections

A third section of themes covered connections, or relationships, with colleagues, managers and patients/service users. While patients/service users and carers were mostly described as vulnerable and in need of better care and support, relationships with colleagues and managers were often seen more negatively. Some felt their relationships with colleagues had worsened as the pandemic wore on. This was either attributed to stress and anxiety or to the feeling of being treated differently from colleagues, as evidenced in the following two quotes:

> *The fear, and anxiety from everyone was high. In turn it also made people more aggressive and quick to snap. It is very hard working in conditions like that. It takes its toll (on) everyone involved. (Social Care Worker, Northern Ireland, Community).*

> *I have felt that those returning, who have been shielding are often left with the lower risk patients and we are left with the higher risk, more demanding patients, despite*

vaccination. Sometimes it feels like a punishment for being a young, healthy woman. (Midwife, England, Hospital).

Relationships with managers were sometimes seen as negative as noted above. Some complained about management's poor understanding of staff difficulties, which generated a "we" against "them" perspective in which management was presented as predominantly being interested in economic and performance outcomes:

The senior managers preach about mental health, they talk about retention, they have no clue how hard it is, they are interested in OFSTED (children's services inspectorate) (Social Worker, England, Other).

Along with this; during the pandemic, our Trust implemented a digital system and continuity of carer model of care which has applied further pressures to us and has again left us feeling undervalued and literally flogged. … I really don't believe anyone outside of health care or higher up than the 'shop floor' really understands the pressures. I believe once you reach a certain banding you are automatically devoid of humility and compassion. (Midwife, England, Hospital).

However, for some their managers had helped them rediscover a better work life balance. After a very difficult year, one hospital nurse in Scotland had learned to 'focus more on free time', 'discover a healthy work life balance' and now appreciates *'time off far more having had so little over the last year'.* It was support from her managers and sometimes colleagues that made this possible. Those who had been redeployed by managers also struggled at times to maintain their routines for work life balance because of new work schedules alongside other home commitments. On the other hand, some redeployed respondents had gained better work life balance with new colleagues:

I have more autonomy in my redeployed role and work within a small supportive team. The work is less demanding physically and mentally. This enables me to achieve a more balanced working/home life. I am anxious about returning to my substantive post (Social Care Worker, Wales, Day Care).

I know my staff really appreciated like the stability and the support they got from myself and the assistant manager and the Trust as a whole, you know there was lot of flexibility, particularly with the schools being closed then reopening, and the kids having to self-isolate so that flexibility I felt that the staff because of that the staff had been a bit more flexible with me as well. (Social Care Manager, Northern Ireland, Community).

Patients, service users and carers, on the other hand, were described as being adversely affected by the continued lack of face-to-face contact and assessment along with the pressure of increased demand due to long waiting lists emanating from earlier service closures and the lack of timely interventions which increased the morbidity, complexity and critical nature of presenting problems. Most respondents who talked about patient/service users did so with a high level of concern for their welfare and well-being and felt that they were suffering long-term:

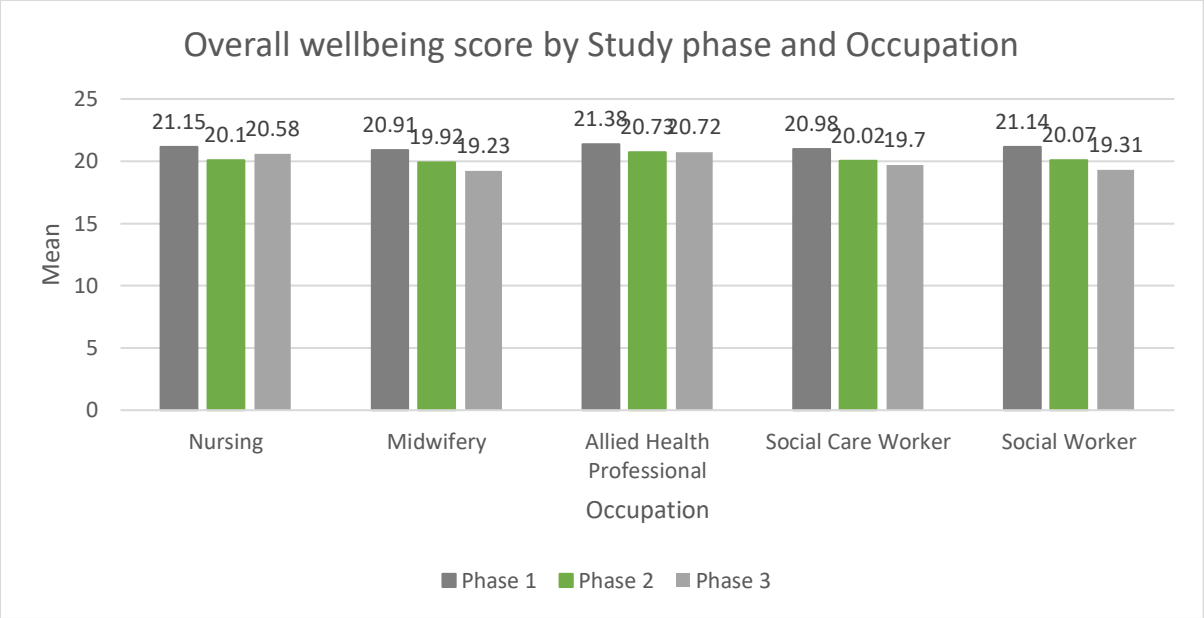
> *Majority of our service users have long term mental ill health and or addictions. The lockdown generally escalated the mental ill health of 99.9% of our service users. The impact on them is enormous (Social Care Worker, Northern Ireland).*

> *I support 2 adults with severe learning difficulties, mental health issues and physical disabilities. …Huge increase in challenging behaviour, deterioration in mental and physical abilities. Both had Covid and were not admitted to hospital so we nursed them. (Social Care Worker, Wales, Community).*

> *Connection. I think also is loneliness, really loneliness isn't being alone it's feeling not connected so like we've got all this tech that is supposed to keep us connected but it's not the same human to human and yeah emm, being able to be….I really, I really miss being in the room I didn't realise how, you got your voice and you got your questioning but you've also got your peripheral vision, you've got your body then you've got your eye contact you've got your brain scanning for what's the atmosphere in the room is this safe and your brain still tries to do that on this medium but you don't get the information (Children's social worker, Wales).*

Figure 3.7 below shows that across all occupations, average wellbeing scores (obtained from the SWEMWBS used in the survey), reduced between Phase 1 and Phase 2 and in nearly all occupations between Phases 2 and 3 except nursing which increased slightly. At all-time points, average wellbeing scores were under population norms of wellbeing of 23.6 (NHS, 2011).

Figure 3.7: Overall wellbeing score (SWEMWBS) by study phase and occupation (Weighted)



Those that talked about their own wellbeing mentioned that they were fatigued due to the changed working conditions and the increased work demand: "*now 100% virtual via telephone or "Near Me", work in isolation in one room, virtual fatigue is overwhelming" (AHP, Scotland, Hospital).* Working conditions and lack of recognition of staff problems by management were affecting staff morale as can be seen in the following account:

> *Very very low staff morale and if staff air their feelings the message received back is that the problem is an individual one. The work really is becoming quite superficial or at least that's the drive and expectation. Yet we contribute to decisions about children's lives. It is a very uncomfortable situation (Social Worker, Northern Ireland, Other).*

Figure 3.8 below shows that across that UK wide, wellbeing scores were lowest for respondents who felt a high impact of the COVID-19 pandemic on their morale. Figure 3.7 demonstrates that social care workers had the lowest wellbeing scores since COVID-19 had a high impact on their morale compared to all other occupations.

Figure 3.8: Overall wellbeing score by COVID-19 impact on morale UK Wide (Weighted)

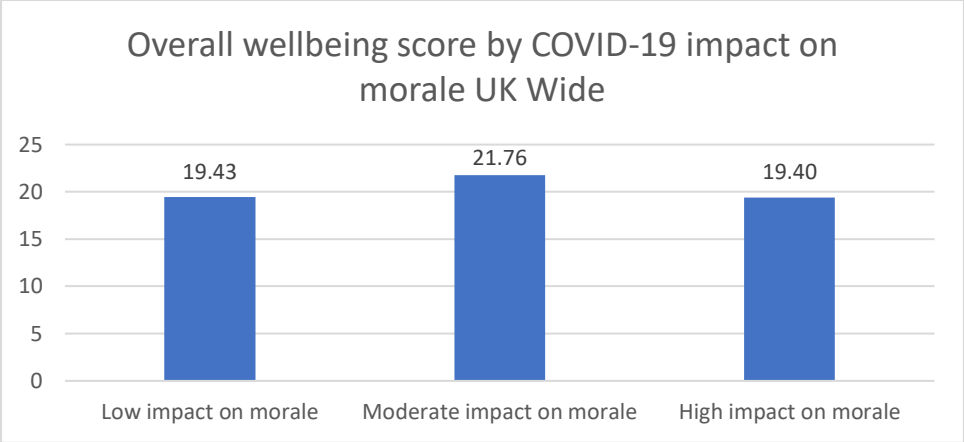
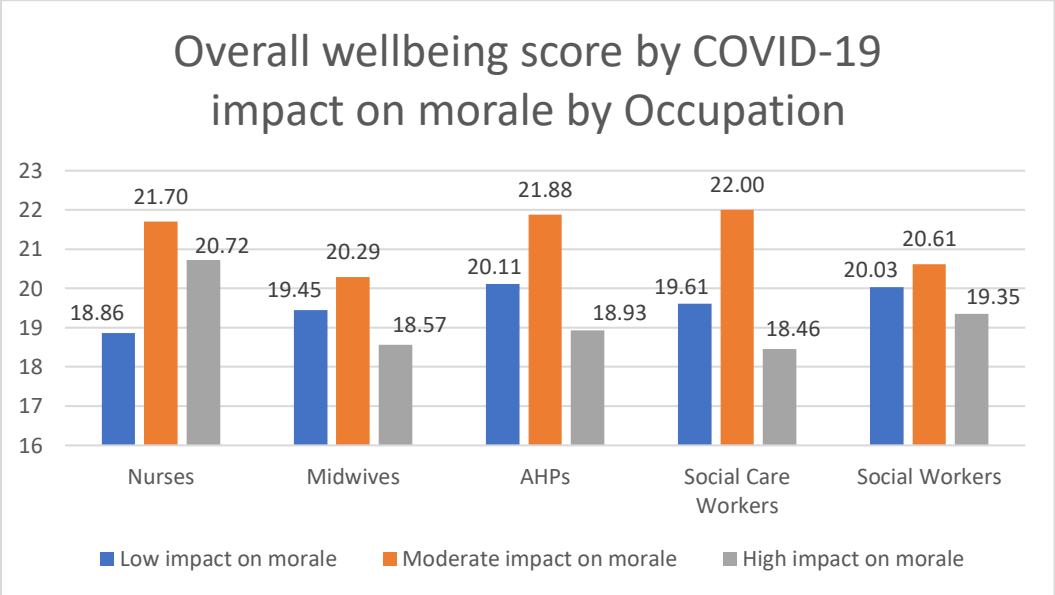


Figure 3.9: Overall wellbeing score by COVID-19 impact on morale UK Wide by Occupation (Weighted)

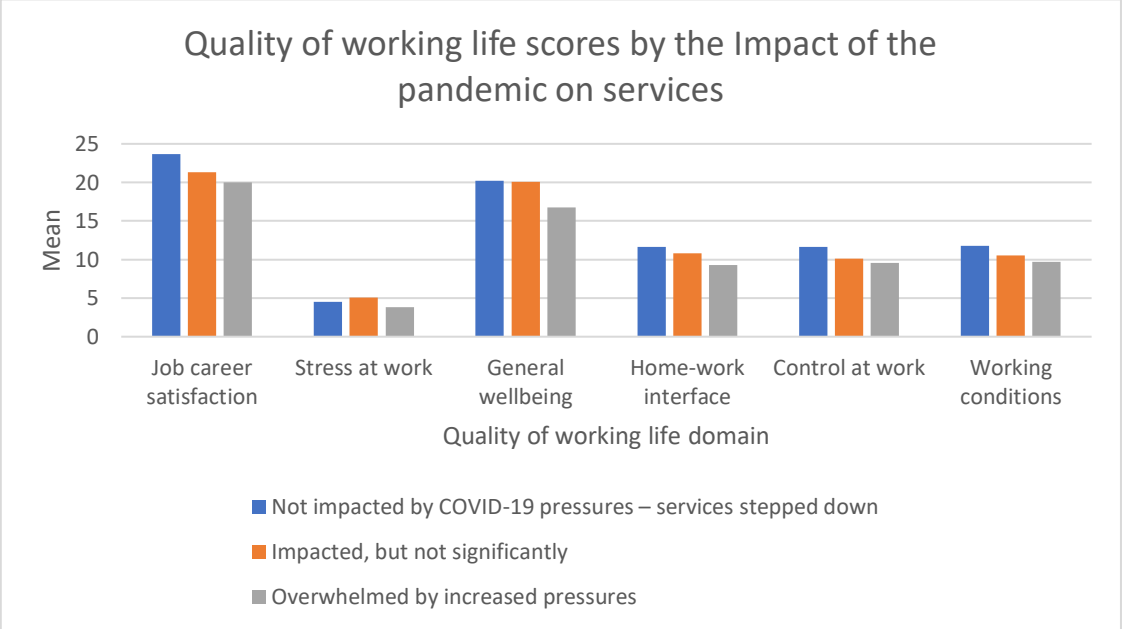


Increased service pressures, absent colleagues and changing working conditions had also caused high stress levels among some where *"the impact has been extremely physical emotional and stressful, it has made it very hard to stay positive and every day coming to work really is a struggle" (Social Care Worker, Scotland, Community).* Some respondents also felt that work had become even more emotionally demanding, especially where a range of services had been closed and patients/service users depended on the remaining services: *"We were the only people these patients saw for the best part a year, we became everything to them and their families, this was on top of reduced staffing and*

increased tasks" (Nurse, Scotland, Community). However, some respondents also reported that they felt a lack of appreciation for their work, especially if their work was not directly Covid-19 related.

Figure 3.10. below presents the levels of pressures on the workforce, impacting on Work-Related Quality of Life scores. There were significant differences in the overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 105.168$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures had a significantly lower overall WRQOL score than those who only felt some impact or those who felt no impact. Higher scores indicate better quality of life across the WRQOL domains, but stress at work is reverse scored, so lower stress scores indicate higher stress at work. Those not impacted by the pandemic have higher WRQOL scores in all areas except stress at work. Those who felt overwhelmed reported higher stress at work than those impacted and those not impacted.

Figure 3.10: Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)

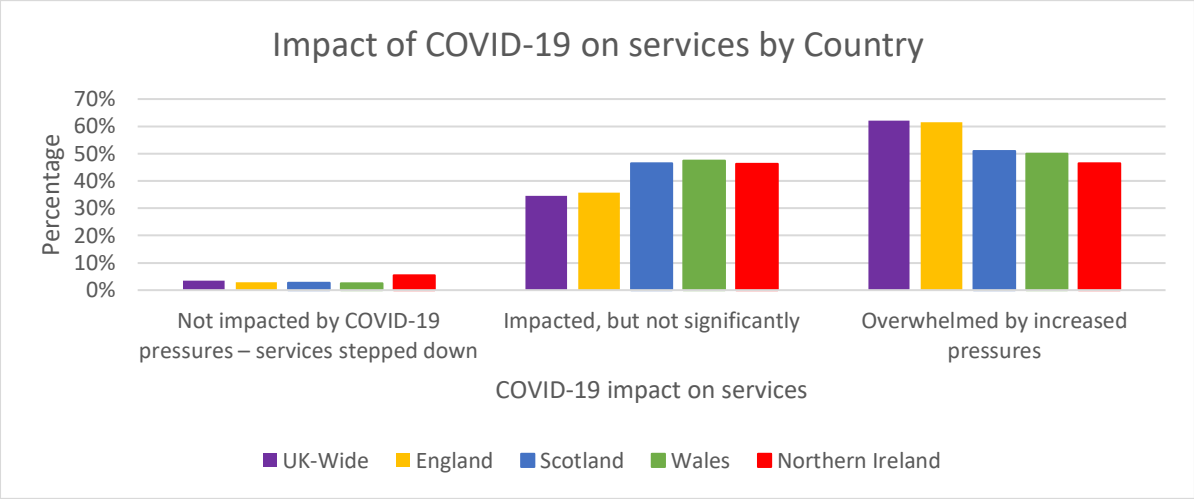


A few respondents reported increased trauma, fear and anxiety that they experienced for themselves and their families, or that they felt for their patients/service users as evidenced in the following quote:

> *In my whole 11 years career I've came across many illnesses. However we staff members that dealt with it are actually traumatised. It was horrific.' (Social Care Worker, Northern Ireland, Community).*

Figure 3.11. shows the impact respondents felt COVID-19 had on services during the pandemic.

Figure 3.11: Impact of COVID-19 on services by country (Weighted)



3.2.5. Career Reflections and outcomes

Given the continued strain reported by many respondents, unsurprisingly some were considering retiring early, reducing working hours, stepping down or changing roles. For example, a social care worker from Wales had just 'given notice' whilst another noted they 'wanted to leave, despite loving the job'. Most of those were considering such moves reluctantly but cited frustrations and grievances, lack of management support and resource shortages. A NI social worker commented: *"I felt abandoned by my employer. I felt there was no help and nothing was going to change".* Within the focus groups, one social care manager changed jobs several times during the pandemic as they felt the role was not what it initially had been and had lost all face to face interaction with clients which made the job more difficult:

> *It just became more difficult emm and eventually I have since then since left that post and I am sort of in a different post with children and disability and have since moved again and I am in a post now that I am very excited about. But at the same time, I don't think without COVID, I probably wouldn't have moved but which is kind of unique, maybe not unique but a different set of circumstances, but definitely COVID has been responsibility, partly responsible for me moving on from where I was. I just missed that interaction that was part of the job I really loved (Social Care Manager, Northern Ireland).*

Another respondent highlighted that redeployment brought many challenges to their jobs and impacted their relationships with patients:

> *I was redeployed to the ward for a second time and … so we had just got back after three to four months of redeployment the first time and we have never really got on top of suppose, with still a huge backlog so when we were then redeployed for the second time in January…probably you know you were much more you know willing to help and then second time we spent like seriously, are you even serious…it was just like it was a bad joke. It was like please don't even let this be happening because you're just aware of how far we were still behind (Nurse, Hospital, Northern Ireland).*

4. Discussion

4.1. Summary of Findings and Comparison with Other Literature

4.1.1. Main Messages

The results from the Phase 3 survey specifically focuses on the experiences of 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 3 study period (May-July 2021). The findings build upon previous survey responses collected during Phase 1 (May – July 2020) and Phase 2 studies (November-January 2021) 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 was collected and collated during the May-July 2021 period (May-July 2021)when the four countries of the UK were rolling out their mass vaccination programmes, initially commencing with priority populations including those most at risk of mortality from COVID-19 (Robertson et al., 2021) and health and social care workers (WHO, 2020). While Governments in each part of the UK took differing approaches to the lifting of restrictions, all four countries had lifted most restrictions during the Phase 3 data collection period (Institute for Government, 2021). The subsequent re-opening of Health and Social Care services was characterised by long waiting lists, treatment backlogs and increased A&E attendances leading to a sense that winter pressures were being experienced in the middle of summer (Taylor, 2021). The Phase 1 survey in May-July 2020 received 3,290 responses, the Phase 2 survey between November 2020-January 2021 received 3,499, while the Phase 3 survey received 2,721 responses. This third survey supports the previous themes identified in Phases 1 and 2 of the study as discussed in sections 3.3 and 3.4 of this report. The findings of the Phase study revealed consistent themes of changing conditions/context, communication and connections across Health and Social Care job roles and demonstrate a continuing struggle with the impact of Covid-19 in respect of workload demand and changing work patterns. Staff shortages incurring additional workload burden on staff remained a feature of the workplace context in this phase of the study.

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

Phase 3 respondents continued to highlight employment conditions affected by increased workloads as result of staff shortages and service closures or changes due to Covid-19. This was characterised by increased levels of overtime, extensive waiting lists, increased administration and complexity of cases. Respondents also perceived lack of appreciation for their work as contributing to stress and low morale. These findings add to the growing literature on moral distress (Delaney et al., 2021; Hines et al., 2021; Smallwood et al,. 2021) with several respondents voicing anxiety about increasing service demand which adversely impacted physical and mental health and a perceived reduction in quality of

care. The Phase 3 study findings demonstrate consistent messages of a struggling workforce with many respondents expressing their intent to reconsider their professional futures in order to cope and to prevent burn out. The majority of respondents indicated high levels of impact on their services and were either overwhelmed (62.1%) or their service was impacted but not significantly (34.5%) and only a small number of respondents (3.4%) said their services were not impacted at all. While over 50% of all occupations examined in this study felt overwhelmed by the increased pressures, social workers felt the largest impact on Services during this period (69.4%). Compared to Phases 1 in which 9.0% of respondents were probable (likely) cases of anxiety or depression and a further 33.0.% were possible cases of anxiety or depression, in Phase 2 these numbers were 17.7% and 22% respectively, while in Phase 3, 20.7% were probable (likely) cases of anxiety or depression and a further 14.4% were possible cases of anxiety or depression, suggesting an increase in the severity of problems from Phase 1 to Phase 3.

This was further impacted by a perceived deterioration in communication between employers and managers with respondents indicating reduced levels of support from line managers since the beginning of the pandemic. In the Phase 3 findings, Managers expressed the pressure of trying to support staff in these working circumstances. While there was some positive evidence of management support, negative views of managers consistently involved a perception of manager's limited understanding of workforce difficulties during the pandemic. Working conditions and the perceived lack of recognition of staff problems by management were reported as affecting staff morale and many respondents in Phase 3 of the study cited frustrations and grievances about lack of management support and resource shortages as their contributing to intentions to leave the workforce.

4.1.3. Burnout

Phase 3 findings demonstrated the significantly higher burnout levels among midwives and social workers across all three domains of personal, work-related and client-related burnout. Multiple regression analysis revealed a significant difference in personal burnout from Phase 2 to Phase 3, There was also significant difference in work related burnout and client-related burnout from Phase 2 to Phase 3. These findings amplify the concerns raised by the NHS Workforce (King's Fund., 2021) who identified a workforce crisis in the NHS in England exacerbated by the Covid-19 pandemic and called for urgent workforce planning.

Respondents from England consistently experienced more burnout than respondents from Wales, Scotland and Northern Ireland on all three areas of burnout and midwives scored significantly higher than respondents from all other occupations. Respondents who felt that their service was

overwhelmed by increased pressures experienced significantly more burnout and Phase 3 findings indicated that as burnout in any area increased, respondents' wellbeing and quality of working life decreased. While the Phase 3 multiple regression analyses has demonstrated several coping strategies which were significantly associated with burnout scores the findings highlighted strong links between burnout and intention to change employment specifically where respondents were experiencing severe levels of personal burnout. These findings resonate with the Workforce Recruitment and Retention Survey findings (Scottish Care, 2021) which attributed working long hours to poor quality care and to staff burnout resulting in high levels of staff permanently exiting the workforce. Likewise a report of the UK Parliament Health and Social Care Committee in June 2021 asserted that burnout in health and social care threatened the future functioning of both NHS and social care services (UK Parliament, 2021).

4.1.4. Mental Wellbeing

The Phase 3 findings demonstrated reduced average wellbeing scores between Phase 1 and Phase 3 and in nearly all occupations between Phases 2 and 3 except Nursing which increased slightly. At all-time points, average wellbeing scores were under population norms of wellbeing of 23.6 (Fat et al. 2017; NHS, 2011) suggesting the pandemic has had a major impact on the wellbeing of health and social care workers. These findings are also lower than previous UK reports pre pandemic in which Durkin et al. (2016) reported a mean score of 25.2 (3.1) amongst community nurses while during the pandemic, Smith et al. 2021 reported similar mean scores among UK-based respondents of all occupations 20.8 (5.1). Wellbeing scores were lowest for respondents who felt a high impact of the COVID-19 pandemic on their morale with social care workers exhibiting the lowest wellbeing scores and COVID-19 having a higher impact on their morale compared to all other occupations. Conversion of The Phase 3 wellbeing scores as indications of depression/anxiety suggest an increase in the severity of problems between Phase 2 and Phase 3.

4.1.5. Quality of Working Life

In Phase 3, England, Scotland and Northern Ireland respondents demonstrated lower overall WRQOL scores than Wales. 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" (45.9%) and Wales had the highest proportion with "higher quality of working life" (43.3%). Variables such as gender, age, ethnicity and disability status affected WRQOL scores with

those who received both vaccinations having higher WRQOL scores that those who had not yet received the vaccine and those who decided not to get one.

The overall WRQOL score decreased from Phase 1 of the study to Phase 3, 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 3 there was a slight increase in overall WRQOL scores UK wide but on further examination there was a decrease in overall WRQOL in Wales, England and Northern Ireland between these study phases, while Scotland exhibited a slight increase in overall WRQOL between Phases 2 and 3. Midwives exhibited the lowest overall WRQOL similar to Phase 2 findings, while nurses reported slightly higher scores in Phase 3 compared to Phase 2.

4.1.6. Coping

The Phase 3 multiple regression analysis demonstrated a statistically significant decrease in respondents' use of active coping strategies from Phase 1 to Phase 3There was also a statistically significant increase in the use of venting, substance use, behavioural disengagement and self-blame from Phase 1 to Phase 3. Similar findings were found between Phase 2 and 3 (full details of the regressions can be found in Appendix 9). The study found that factors such as Active coping, Use of emotional support, Recreation and relaxation, and Exercise, all predicted higher wellbeing scores while Planning, Venting, Substance use, Behavioural disengagement, and Self-blame, all predicted lower wellbeing scores.

4.2. Limitations and Strengths

This was a cross-sectional survey based on a convenience sample of health and social care workers and therefore the results cannot be considered representative of all health and social care workers in the UK. There was also an uneven distribution of responses across the four UK countries and across the work settings and types, so the results are not representative across countries nor occupational groups or types of employers. Another limitation associated with the convenience sample for the survey is that some participants may have been motivated to complete the survey due to personal bias or specific negative/positive experiences, which could potentially skew the results. It is also important to note that any comparisons between Phase 1, Phase 2 and Phase 3 of the study and conclusions drawn from these are tentative, as the three samples consisted of different individuals (although some may have been the same).

4.3. Implications

This study has important implications for the health and social care workforce. This study has collected 'real time' data during pre-defined periods of the COVID-19 pandemic and attempts to inform employers, regulators, policy makers, professional bodies and workplace unions about what the workforce impact has been and what is required to recover from the sustained period of pressures during this pandemic. Response levels have been consistently good in all phases of the study, and whilst the results cannot be generalised, results are a snapshot in time provided by respondents, and therefore provide valuable and worthy UK wide and cross disciplinary data, enabling statistical comparison across countries and disciplines. The analysis of the data through the lens of 'good practice recommendations' enables the voice of participants to shape key messages to employers about what might improve their working conditions, during both pandemic or disaster periods, and in non-pandemic times.

4.3. Good Practice Recommendations: May-July 2021 Survey

The 15 Good Practice Recommendations from Survey 1 and 2 were reviewed in the context of findings from Survey 3, in the third phase of this study. These Good Practice Recommendations are organised under the main themes the analysis of phase 1 and 2 data: Changing Conditions, Connections and Communication with reflections on health and wellbeing. They are then further categorised at an individual, organisational and policy level.

4.3.1. Changing Conditions

Organisational and Individual Level

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

Organisational Level

2. PUTTING INTO PRACTICE THE ADVANTAGES OF MORE FLEXIBILITY IN EMPLOYMENT: During the pandemic most employers have provided, as far as possible, increased flexibility around working hours, location of working, while recognising additional childcare or other caring responsibilities of individual members of staff to support the workforce. For some, they were not easy to provide, but our surveys have revealed that flexibility was valued when it could be offered. As the level of the pandemic subsides, staff will need to feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about long-term flexibility in working hours and location must now start to happen at pace with employers demonstrating greater trust in staff to get on with their job when working from home.
3. TRAINING FOR REDEPLOYMENT, SKILL MIX AND SKILL ACQUISITION: We found that training and development to equip staff with the ability to, where possible, perform multiple or new roles were under-developed and suggest that this becomes a strategy for employers to prioritise. This will need to involve employers, professional bodies, regulators, workplace unions, educational and training bodies, and service users and patient groups. Good evidence about what sort of training and development works well would be further helpful. Some respondents in Phase 3, felt that they had gained from redeployment in relation to team working and type of work they were undertaking.
4. EQUITY IN HOME WORKING WHEN POSSIBLE: We noted that policies about working from home (if appropriate) should be fair and seen to be fair in our first report. Home working will need to be considered as well as office or care/treatment settings' impact on outcomes and productivity. Also as home working is often role dependent, clarity and consistency around for whom and when homeworking may be facilitated is important with hybrid models of working, such as part home working/part in office made available where possible. Our survey identified a risk that the connections with managers, supervisors and colleagues were declining in amount and quality when the initial novelty of home working wore off. Employers will need to address not only choices among individual workers but also the team or work unit effect. This will apply to managers as well as professionals working in desk or face to face patient/user engagement. Our findings that there were increasing levels of anxiety and depression may impact on staff willingness to go back to offices and attend in person large meetings as well as individual face to face encounters. Human Resources (HR) staff will need to support managers in addressing a positive return of being physically present at work where necessary.

Policy and Organisational Level

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

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

7. STAFF WELLBEING AND RETENTION: Our third survey confirms that a large proportion of staff are experiencing moderate to severe levels of burnout with a need for time to recover from a prolonged period of unprecedented stress and pressure. Taking holidays, being recognised and feeling appreciated remain important. This survey indicates that the setting up of wellbeing services while appreciated by some did not meet the needs of others. The high risk remains that some staff will leave prematurely owing to stress or reduced work-based quality of life, with some evidence that this is already happening. 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 a change in place of work.

4.3.2. Connections

Organisational and Individual Level

1. ANNUAL LEAVE AND REGULAR BREAKS: Managers 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.

2. CONNECTION: There should be development of evidence-based good practice guidance on communication that meets the broad range of health and social care services by national bodies with strong input from the frontline. Our survey was electronic, and we recognise that staff with limited IT skills may need support in developing online communication skills. Also some staff have limited access to computers and work email during work time – both of these

are important contributors to staff engagement and connection and could be audited by employers.

Organisational Level

3. COMMUNICATION: There is room now to consider corporate and employer communications – our findings show that these are appreciated but timing and amount can seem onerous. It continues to be important that communication is relevant and timely.
4. MANAGEMENT VISIBILITY: Managers should be visible, either in person (if possible) or virtually, so that workers feel they are as valued and that work pressures are understood. They, the managers, should also be valued explicitly.

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

4.3.3. Communication

Organisational and Individual Level

1. ORGANISATIONAL SUPPORT: Respondents provided several accounts of employers and managers signposting staff to organisational supports, counselling, mentoring or coaching supports, or Occupational Health (if required). However, while 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; some staff are not finding that their needs are being met and need to be asked what else can be done.

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

Policy and Organisational Level

3. RESOURCING AND INFRASTRUCTURE: The unprecedented demand on the health and social care sectors has shone a light on the chronic under-resourcing of staff and infrastructure.

Concerted efforts are required to make work within the Nursing, Midwifery, AHP, social care and social work sectors an attractive option, with pay and working conditions requiring sustained attention.

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Appendix 1: Weighting Representativeness for Country, Region and Occupation

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

Estimating the true population

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

Social Work

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

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

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

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

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

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

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

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

Social Care

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

Nurses and Midwives

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

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

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

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

Table A1.1: Regional aggregation for NHS Digital

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

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

Allied Health Professionals

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

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

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

Regional Aggregation for Weighting

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

Table A1.2: Regions for Calculation of Weights

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

Table A1.3: Final Estimated Population and Distribution

	London	South	Midlands & East	North & Yorkshire	England Total	Scotland	Wales	Northern Ireland	Total
Nursing	91845.6	117972.1	147743.6	167606.8	525168.0	66084.0	34661.0	23953.0	649866.0
	5.18%	6.66%	8.34%	9.46%	29.63%	3.73%	1.96%	1.35%	36.67%
Midwifery	5760.5	7327.6	9100.5	9036.6	31225.2	3360.0	1663.0	1212.0	37460.2
	0.33%	0.41%	0.51%	0.51%	1.76%	0.19%	0.09%	0.07%	2.11%
AHP	37638.1	47468.8	60194.7	69215.4	214517.0	17624.0	11819.0	8093.0	252053.0
	2.12%	2.68%	3.40%	3.91%	12.10%	0.99%	0.67%	0.46%	14.22%
Social Care Worker	102452.3	127336.0	163202.9	190660.8	583652.0	63274.0	37220.4	37779.0	721925.4
	5.78%	7.19%	9.21%	10.76%	32.93%	3.57%	2.10%	2.13%	40.74%
Social Worker	2985.0	3710.0	4755.0	5555.0	17005.0	10647.0	6263.0	6357.0	40272.0
	0.97%	1.21%	1.55%	1.81%	5.54%	0.60%	0.35%	0.36%	6.85%
TOTAL[1]	**254130.4**	**320506.5**	**406431.0**	**467338.1**	1448406.0	**157629.0**	**89963.4**	**76182.0**	**1772180.4**

[1] The population estimates used in this report are the same as those used in the Phase 1 and Phase 2 reports, as we found no evidence of major changes in staffing levels between May and July 2021.

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

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

A2.1 Country and Occupation of Respondents

Summary (Weighted results):

Not reported.

Summary (Unweighted results):

Just under half of respondents (n = 1116, 41.0%) indicated that they currently work in Northern Ireland and almost a third (n = 745, 31.3%) work in Scotland. Another 19.8% (n = 539) work in England, with respondents working in Wales representing the smallest proportion of all survey respondents (n = 321, 11.8%).

Most of the respondents worked as social care workers (n=853, 31.3%) and social workers (n=753, 27.7%), followed by nurses (n=566, 20.8%) and AHPs (n=378, 13.9%). Midwives represented the smallest proportion of respondents (n=171, 6.3%).

Figure A2.1: Country of Respondents (Unweighted)

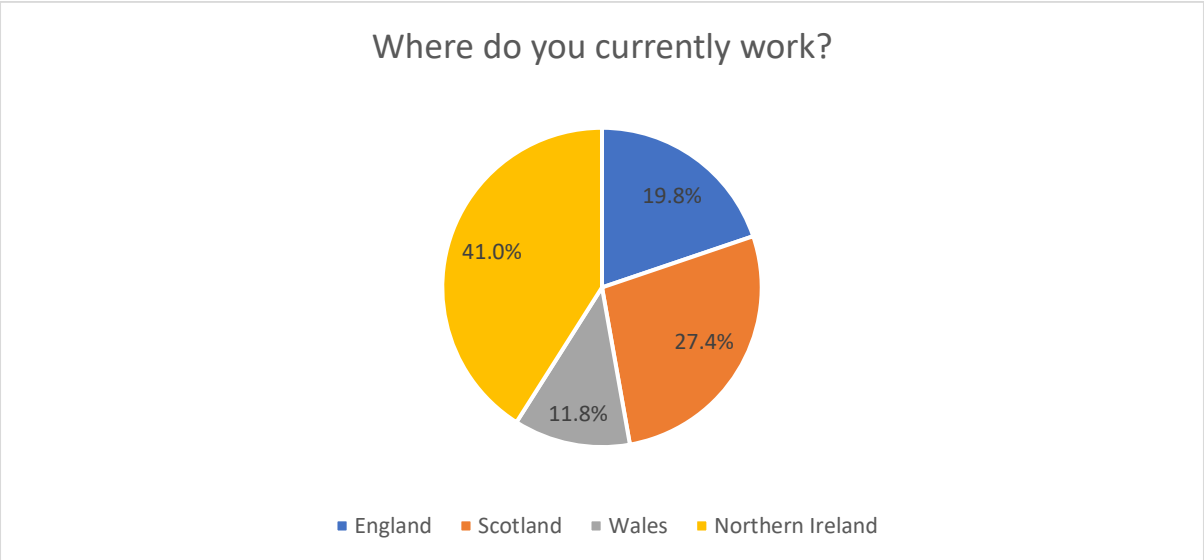


Table A2.1: Country of Respondents (Unweighted)

Country	n (%)
England	539 (19.8%)
Scotland	745 (27.4%)
Wales	321 (11.8%)
Northern Ireland	1116 (41.0%)
Total	**2721 (100%)**

Figure A2.2: Occupation of Respondents (Unweighted)

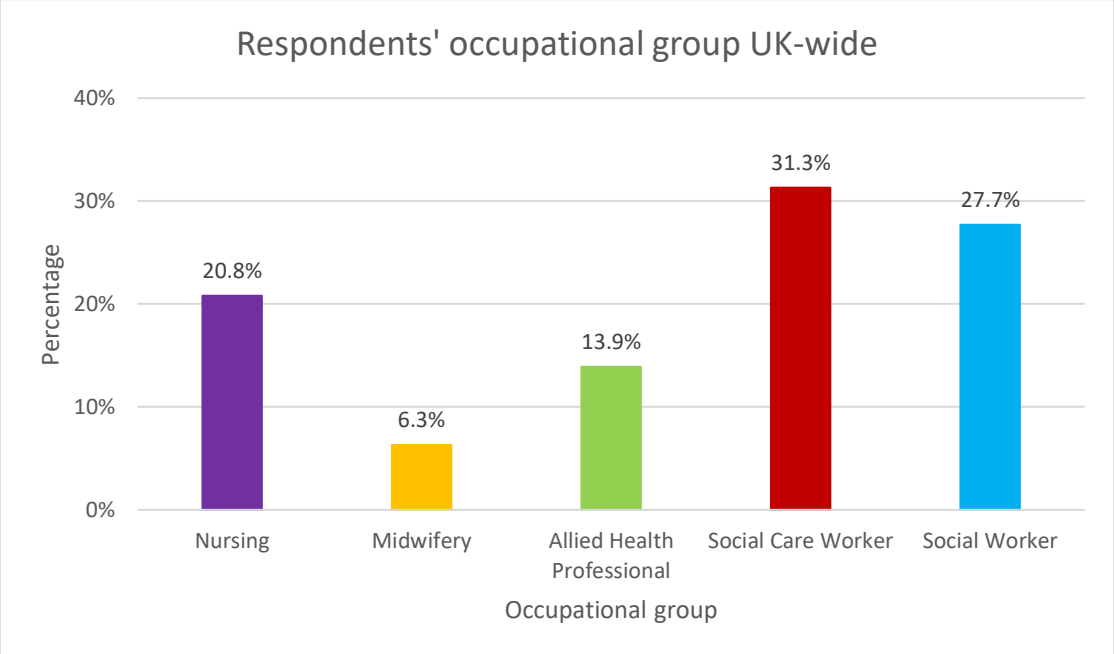


Table A2.2:Occupation of Respondents (Unweighted)

Occupation	UK-Wide n (%)
Nursing	566 (20.8%)
Midwifery	171 (6.3%)
AHP	378 (13.9%)
Social Care Worker	853 (31.3%)
Social Worker	753 (27.7%)
Total	**2721 (100%)**

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

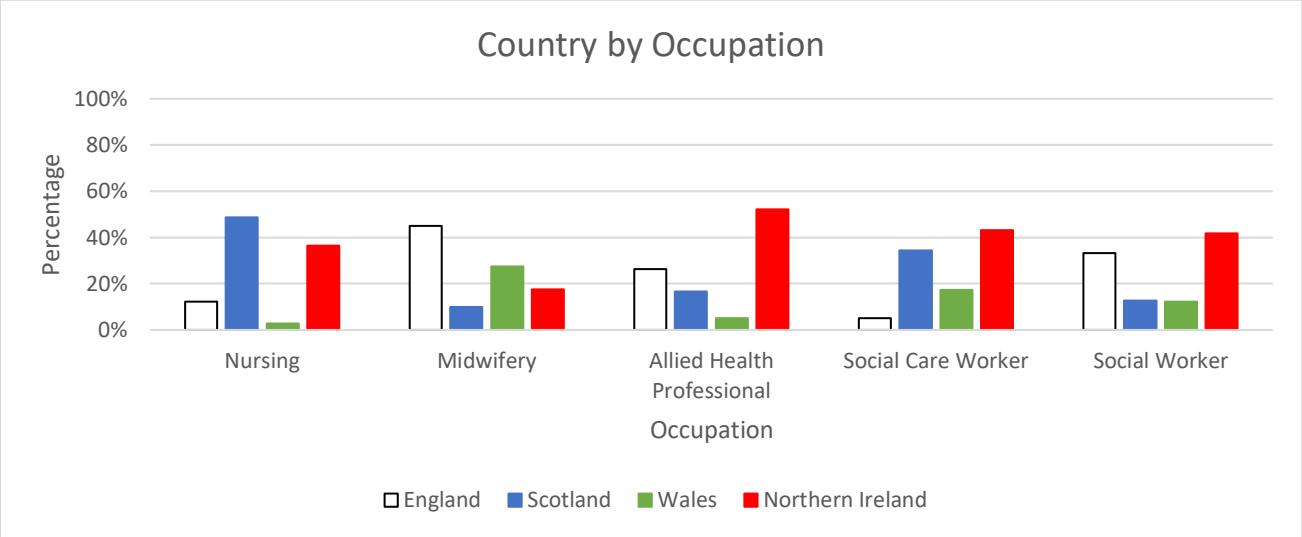


Table A2.3: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	69 (12.2%)	276 (48.8%)	15 (2.7)%	206 (36.4%)	**566 (100%)**
Midwifery	77 (45.0%)	17 (9.9%)	47 (27.5%)	30 (17.5%)	**171(100%)**
AHP	99 (26.2%)	63 (16.7%)	19 (5.0%)	197 (52.1%)	**378 (100%)**
Social Care Worker	44 (5.2%)	293 (34.3%)	148 (17.4%)	368 (43.1%)	**853 (100%)**
Social Worker	250 (33.2%)	96 (12.7%)	92 (12.2%)	315 (41.8%)	**753 (100%)**

A2.2 Sex of Respondents

Summary (Weighted results):

The vast majority of respondents were female (86.8%), with a similar sex distribution across countries. Most midwifery respondents were female. Social care workers had the highest proportion of males (14.4%).

Summary (Unweighted results):

The vast majority of respondents were female (87.6%), with a similar sex distribution across countries. A majority of midwifery respondents were female (98.3%). Social workers had the highest proportion of males (14.1%).

Figure A2.4: Sex by Country (Weighted)

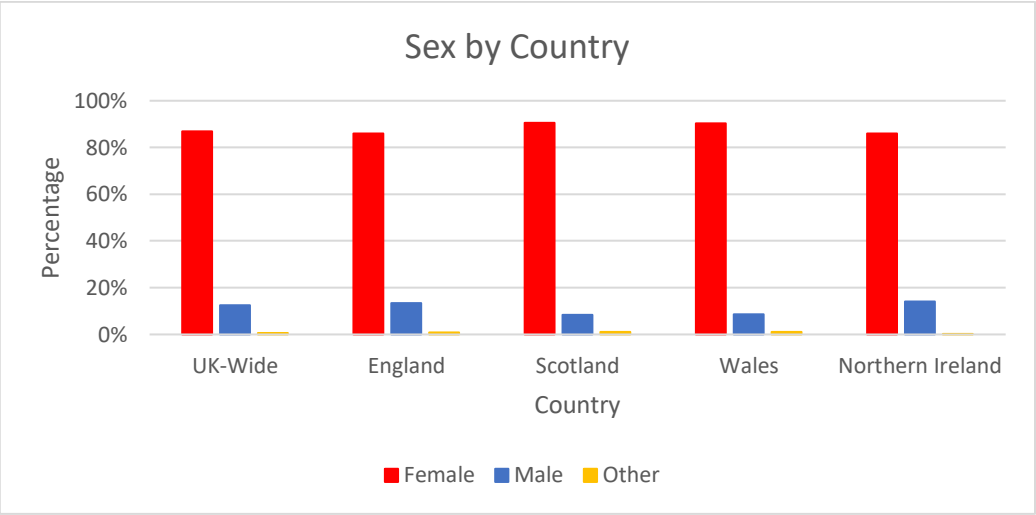


Figure A2.5: Sex by Country (Unweighted)

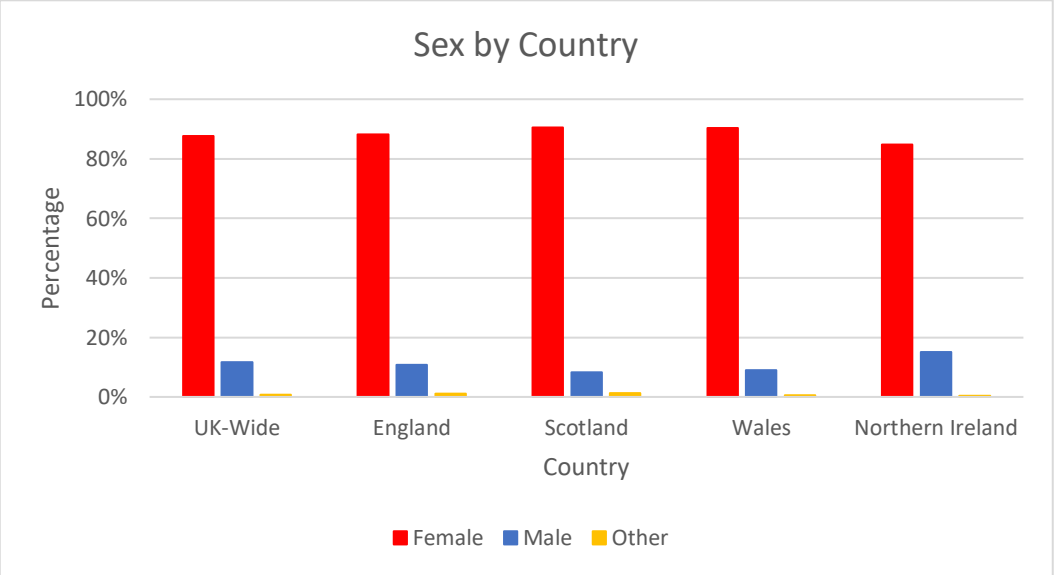


Table A2.4: Sex by Country (Weighted)

Sex	Country				
	UK-Wide	**England**	**Scotland**	**Wales**	**Northern Ireland**
Female	86.8%	85.9%	90.5%	90.3%	85.9%
Male	12.6%	13.3%	8.3%	8.7%	14.0%
Other	0.6%	0.8%	1.1%	1.1%	0.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.5: Sex by Country (Unweighted)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	2364 (87.6%)	475 (88.1%)	674 (90.5%)	290 (90.3%)	945 (84.7%)
Male	316 (11.6%)	58 (10.8%)	61 (8.2%)	29 (9.0%)	168 (15.1%)
Transgender	2 (0.1%)	0 (0%)	2 (0.3%)	0 (0%)	0 (0%)
Non-binary	7 (0.3%)	3 (0.6%)	3 (0.4%)	0 (0%)	1 (0.1%)
Intersex	2 (0.1%)	0 (0%)	1 (0.1%)	0 (0%)	1 (0.1%)
Not-listed – other	2 (0.1%)	0 (0%)	1 (0.1%)	1 (0.3%)	0 (0%)
Prefer not to say	8 (0.3%)	3 (0.6%)	3 (0.4%)	1 (0.3%)	1 (0.1%)
Total	**2721 (100%)**	**756 (100%)**	**459 (100%)**	**1094 (100%)**	**1189 (100%)**

Figure A2.6: Sex by Occupation (Weighted)

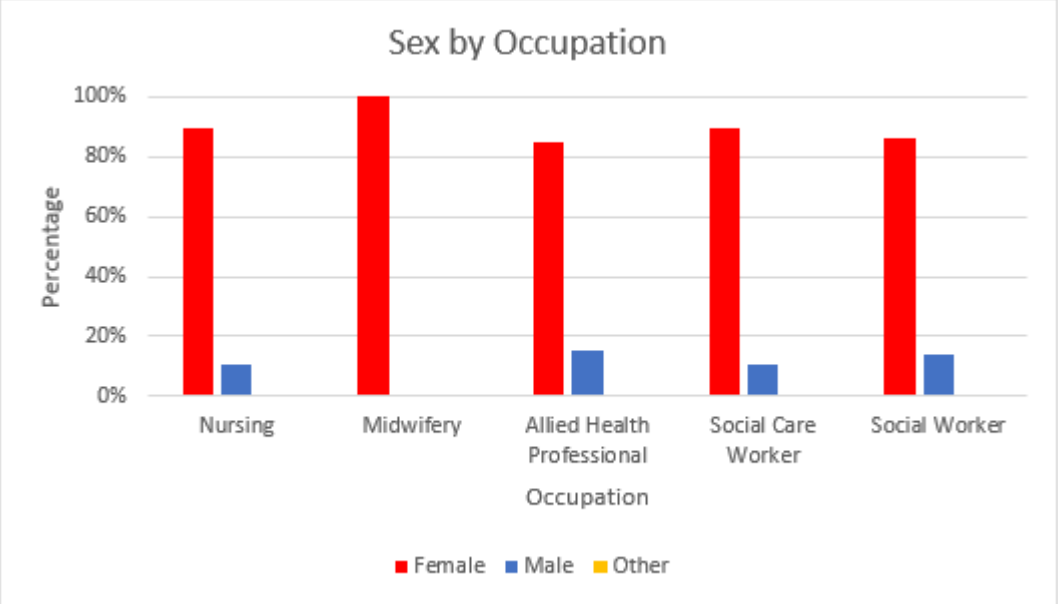


Figure A2.7: Sex by Occupation (Unweighted)

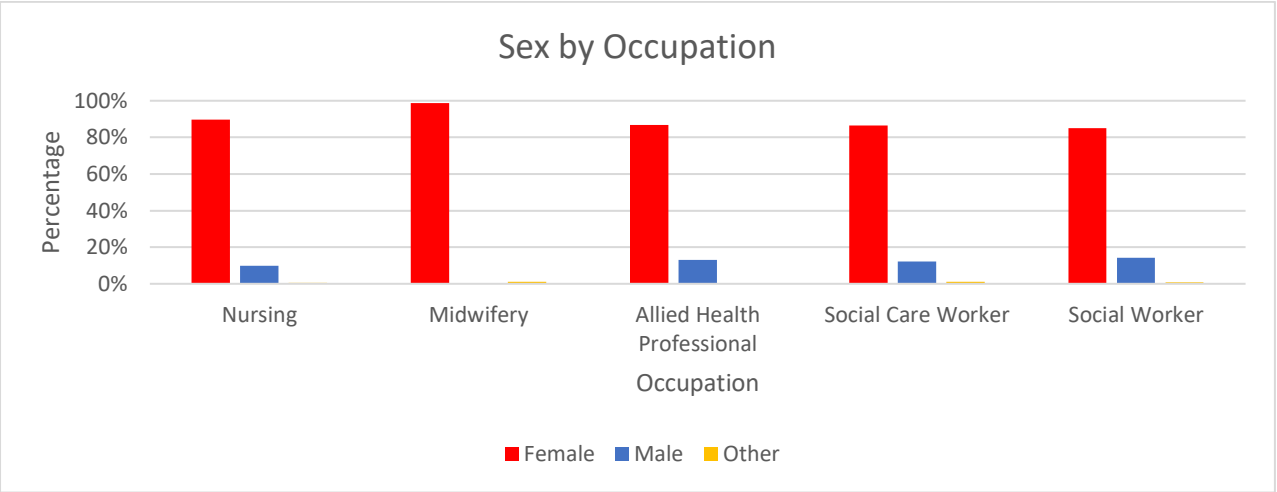


Table A2 6: Sex by Occupation (Weighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	84.20%	15.80%	0.00%	**100%**
Midwifery	98.40%	0.00%	1.60%	**100%**
AHP	91.30%	8.70%	0.00%	**100%**
Social Care Worker	83.20%	14.40%	2.40%	**100%**
Social Worker	87.80%	11.20%	1.10%	**100%**

Table A2.7: Sex by Occupation (Unweighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	508 (89.9%)	56 (9.9%)	2 (0.4%)	**566 (100%)**
Midwifery	169 (98.8%)	0 (0.0%)	2 (1.2%)	**171(100%)**
AHP	328 (86.8%)	49 (13.0%)	1 (0.3%)	**378 (100%)**
Social Care Worker	739 (86.6%)	105 (12.3%)	9 (1.1%)	**853 (100%)**
Social Worker	640 (85.0%)	106 (14.1%)	7 (0.9%)	**753 (100%)**

A2.3 Age of Respondents

Summary (Weighted results):

The majority of respondents were aged 30-59 years, with only a small proportion from the 66+ age group. The nurses in the 16-19 age group were most likely students on placements. Scotland had the highest proportion of the 50-59 year-old respondents (38.7%).

Summary (Unweighted results):

The majority of respondents were aged 40-59 years, with only a small proportion from the 66+ age group. Scotland had the highest proportion of the 50-59 year-old respondents (33.9%).

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 as only six respondents from this category answered the survey which was too small for subgroup comparisons.

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

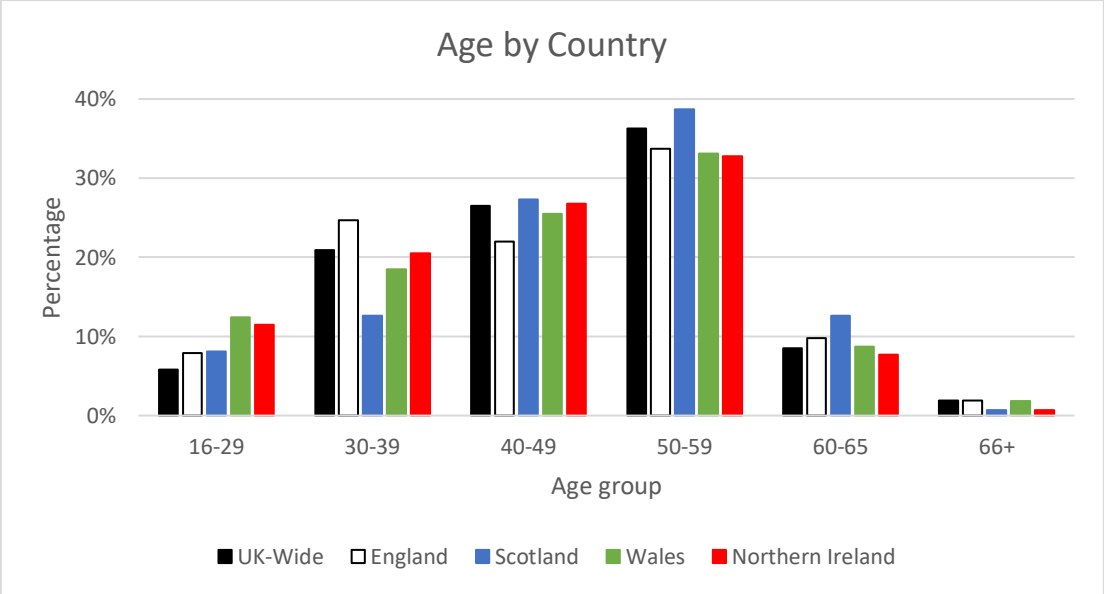


Figure A2.9: Age of Respondents by Country (Unweighted)

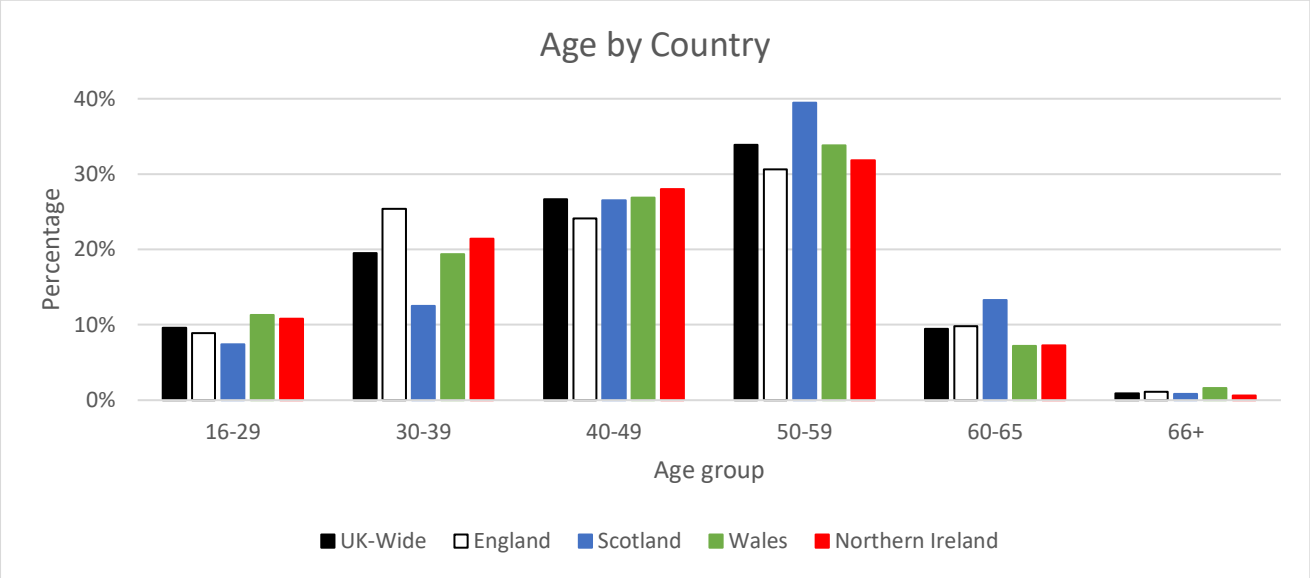


Table A2.8: Age of Respondents by Country (Weighted)

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-29	5.80%	7.90%	8.10%	12.40%	11.50%
30-39	20.90%	24.70%	12.60%	18.50%	20.50%
40-49	26.50%	22.00%	27.30%	25.50%	26.80%
50-59	36.30%	33.70%	38.70%	33.10%	32.80%
60-65	8.50%	9.80%	12.60%	8.70%	7.70%
66+	1.90%	1.90%	0.70%	1.80%	0.70%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

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

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-29	260 (9.6%)	48 (8.9%)	55 (7.4%)	36 (11.3%)	121 (10.8%)
30-39	531 (19.5%)	137 (25.4%)	93 (12.5%)	62 (19.4%)	239 (21.4%)
40-49	725 (26.7%)	130 (24.1%)	197 (26.5%)	86 (26.9%)	312 (28.0%)
50-59	922 (33.9%)	165 (30.6%)	294 (39.5%)	108 (33.8%)	355 (31.8%)
60-65	257 (9.5%)	53 (9.8%)	99 (13.3%)	23 (7.2%)	82 (7.3%)
66+	24 (0.9%)	6 (1.1%)	6 (0.8%)	5 (1.6%)	7 (0.6%)
Total	**2719 (100%)**	**539 (100%)**	**744 (100%)**	**320 (100%)**	**1116 (100%)**

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

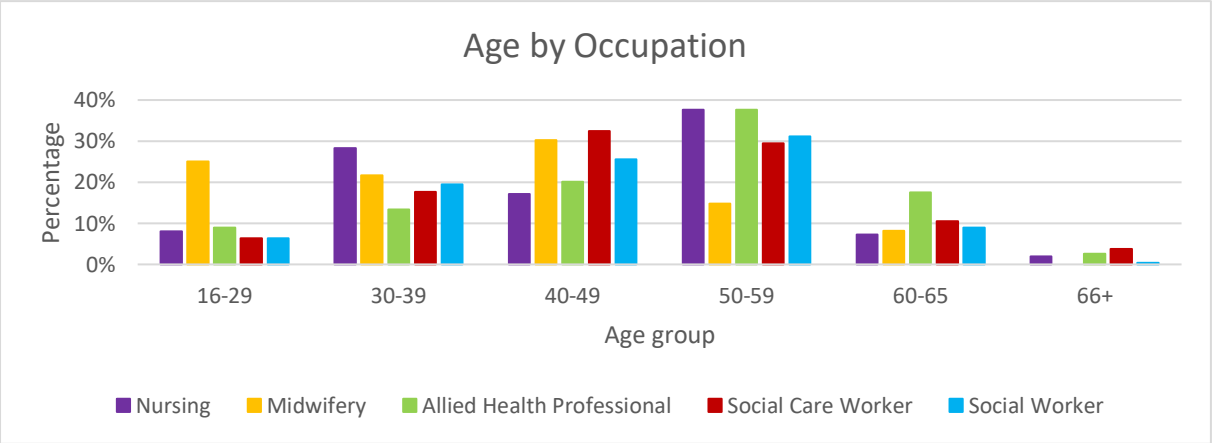


Figure A2.11: Age of Respondents by Occupation (Unweighted)

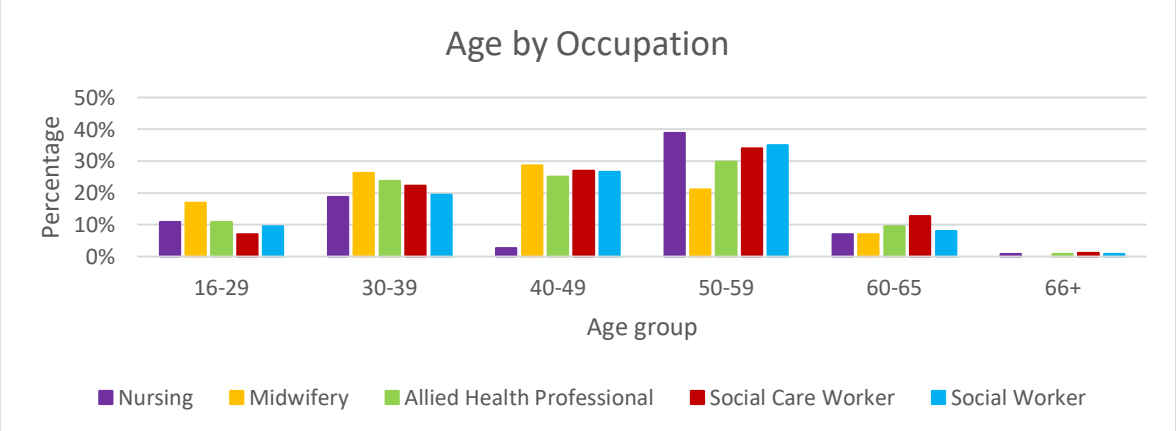


Table A2.10: Age of Respondents by Occupation (Weighted)

Occupation	Age group						Total
	16-29	30-39	40-49	50-59	60-65	66+	
Nursing	8.00%	28.30%	17.10%	37.60%	7.20%	1.90%	**100%**
Midwifery	25.00%	21.70%	30.20%	14.80%	8.20%	0.00%	**100%**
AHP	8.90%	13.40%	20.10%	37.60%	17.50%	2.60%	**100%**
Social Care Worker	6.30%	17.60%	32.50%	29.40%	10.50%	3.70%	**100%**
Social Worker	6.40%	19.50%	25.60%	31.20%	8.90%	0.40%	**100%**

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

Occupation	Age group						Total
	16-29	30-39	40-49	50-59	60-65	66+	
Nursing	61 (10.8%)	106 (18.7%)	134 (2.7%)	220 (38.9%)	40 (7.1%)	5 (0.9%)	**566 (100%)**
Midwifery	29 (17.0%)	45 (26.3%)	49 (28.7%)	36 (21.1%)	12 (7.0%)	0 (0.0%)	**171 (100%)**
AHP	41 (10.8%)	90 (23.8%)	95 (25.1%)	113 (29.9%)	36 (9.5%)	3 (0.8%)	**378 (100%)**
Social Care Worker	76 (7.0%)	123 (22.2%)	244 (27.0%)	290 (34.0%)	109 (12.8%)	10 (1.2%)	**852 (100%)**
Social Worker	53 (9.6%)	167 (19.5%)	203 (26.7%)	263 (35.0%)	60 (8.0%)	6 (0.8%)	**2719 (100%)**

A2.4 Ethnic Origin of Respondents

Summary (Weighted results):

The vast majority of respondents were of white ethnic origin (89.%). England was the most ethnically diverse country, with 12.1% of respondents identifying as not white. Nurses were the most ethnically diverse occupational group, with 13.1% identifying as not white.

Summary (Unweighted results):

The vast majority of respondents were of white ethnic origin (96.40%). England was the most ethnically diverse country, with 10.3% of respondents identifying as not white. Nurses were the most ethnically diverse occupational group, with 4.7% identifying as not white.

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

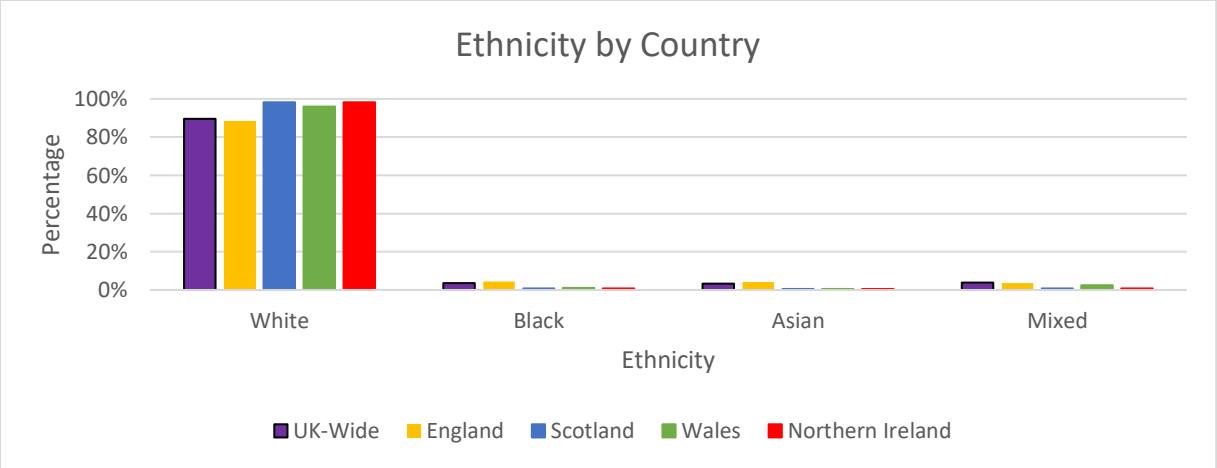


Figure A2.13: Ethnic Origin of Respondents by Country (Unweighted)

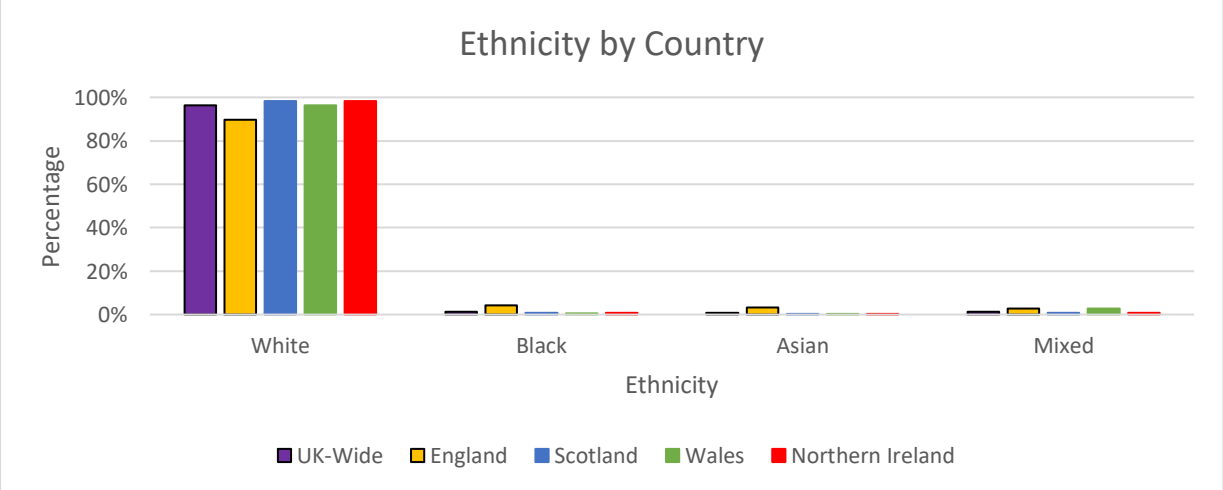


Table A2.12: Ethnic Origin of Respondents by Country (Weighted)

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	89.5%	88.0%	98.1%	96.0%	98.1%
Black	3.6%	4.4%	0.7%	1.1%	0.7%
Asian	3.2%	4.1%	0.4%	0.4%	0.5%
Mixed	3.8%	3.5%	0.7%	2.5%	0.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	2617 (96.4%)	481 (89.7%)	732 (98.4%)	309 (96.3%)	1095 (98.2%)
Black	37 (1.4%)	23 (4.3%)	5 (0.7%)	2 (0.6%)	7 (0.7%)
Asian	24 (0.9%)	17 (3.2%)	2 (0.3%)	1 (0.3%)	4 (0.4%)
Mixed	38 (1.4%)	15 (2.8%)	5 (0.7%)	9 (2.8%)	9 (0.8%)
Total	**2716 (100%)**	**536 (100%)**	**744 (100%)**	**321 (100%)**	**1115 (100%)**

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

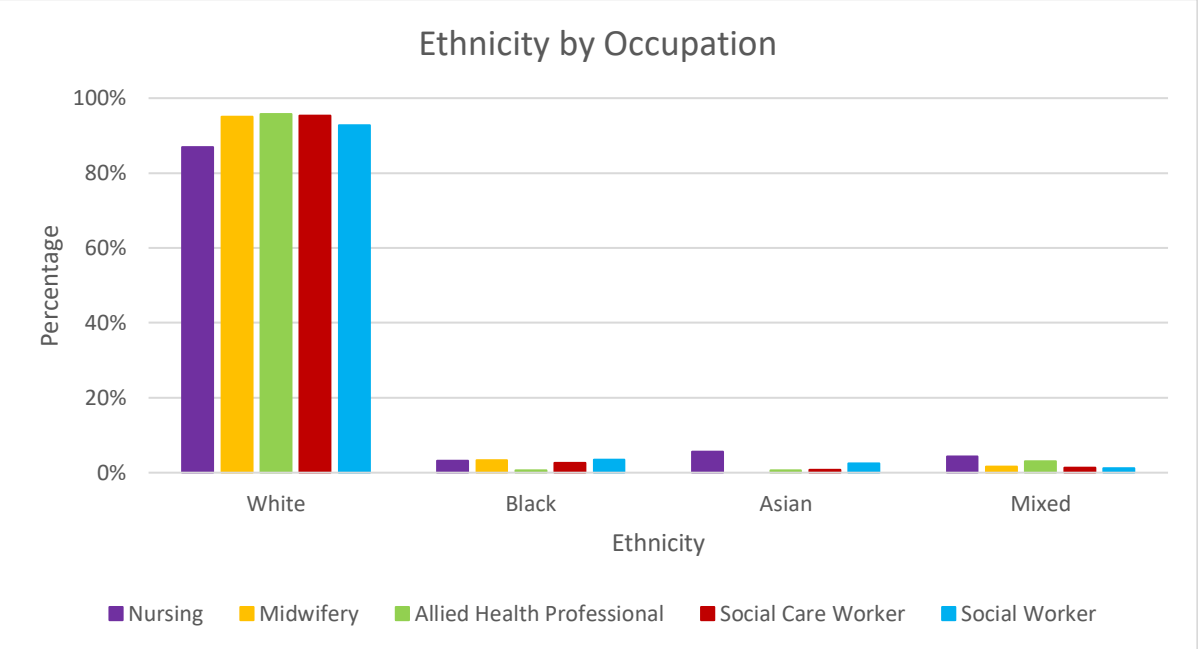


Figure A2.15: Ethnic Origin of Respondents by Occupation (Unweighted)

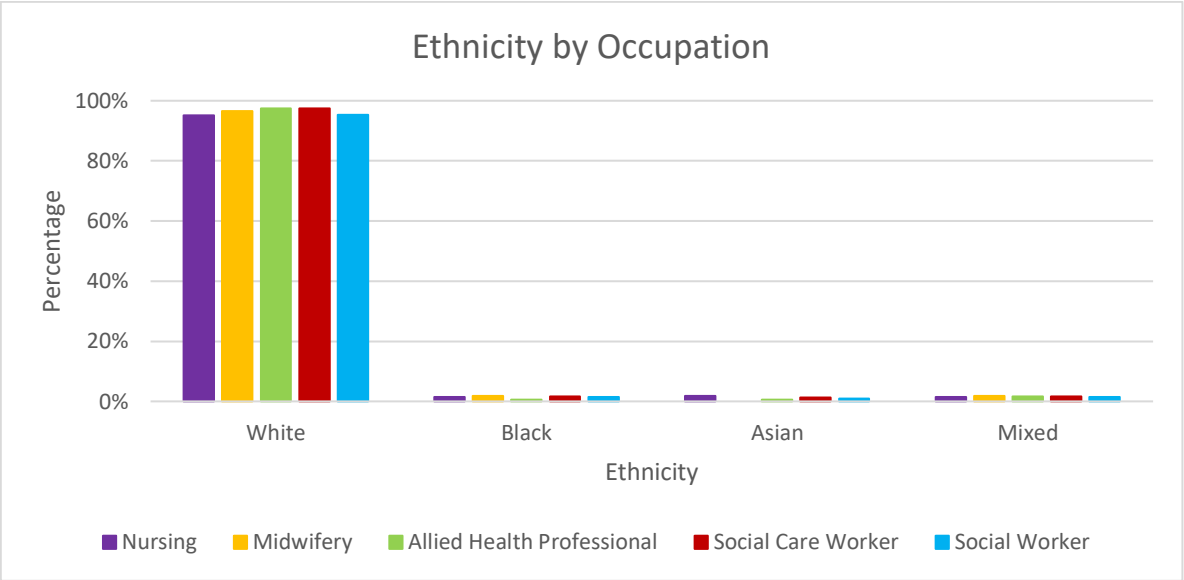


Table A2.14: Ethnic Origin of Respondents by Occupation (Weighted)

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	86.9%	3.2%	5.6%	4.3%	**100%**
Midwifery	95.1%	3.3%	0.0%	1.6%	**100%**
AHP	95.7%	0.6%	0.6%	3.0%	**100%**
Social Care Worker	95.3%	2.6%	0.8%	1.3%	**100%**
Social Worker	92.7%	3.5%	2.5%	1.2%	**100%**

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

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	539 (95.2%)	8 (1.4%)	11 (1.9%)	8 (1.4%)	**566 (100%)**
Midwifery	165 (96.5%)	3 (1.8%)	0 (0.0%)	3 (1.8%)	**171 (100%)**
AHP	368 (97.4%)	2 (0.5%)	2 (0.5%)	6 (1.6%)	**378 (100%)**
Social Care Worker	830 (97.5%)	11 (1.3%)	2 (0.5%)	8 (0.9%)	**851 (100%)**
Social Worker	715 (95.3%)	13 (1.7%)	9 (1.2%)	13 (1.7%)	**750 (100%)**

A2.5 Respondents with a Disability

Summary (Weighted results):

England had the highest proportion of respondents with a disability (14.0%). Of the different professions, social workers were the most likely ones to report having a disability (23.1%).

Summary (Unweighted results):

England had the highest proportion (16.8%) of respondents with a disability. Of the different professions, social workers (17.5%) were the most likely ones to report having a disability.

Figure A2.16: Disability by Country (Weighted)

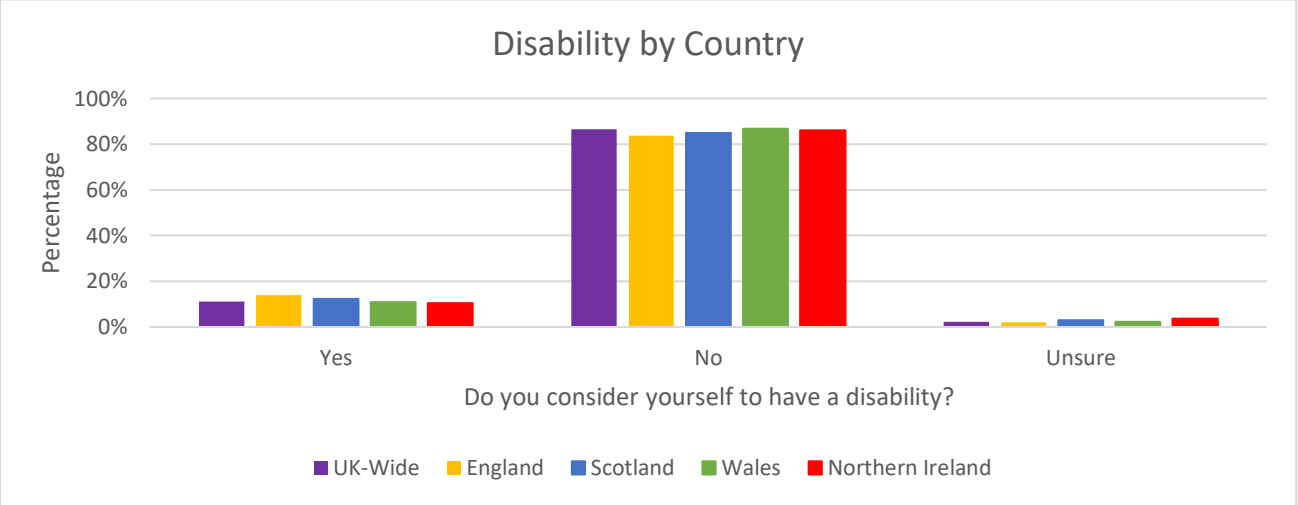


Figure A2.17: Disability by Country (Unweighted)

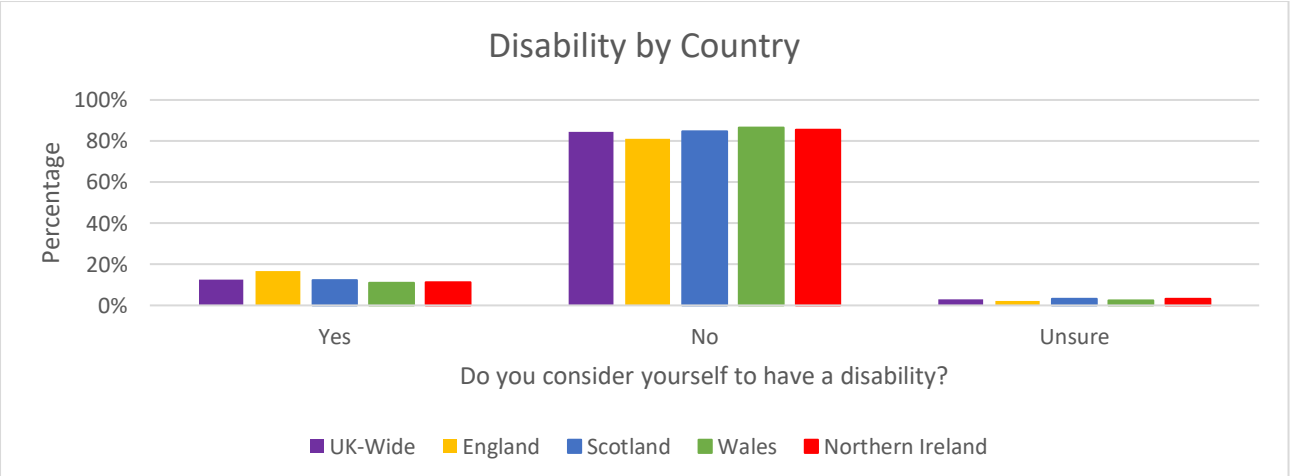


Table A2.16:Disability by Country (Weighted)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	11.10%	14.00%	12.20%	10.90%	10.40%
No	86.60%	83.80%	84.80%	86.80%	86.00%
Unsure	2.30%	2.10%	3.00%	2.30%	3.70%
Total	100%	100%	100%	100%	100%

Table A2.17: Disability by Country (Unweighted)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	311 (12.6%)	81 (16.8%)	84 (12.2%)	33 (11.1%)	113 (11.2%)
No	2090 (84.5%)	390 (81.1%)	582 (84.6%)	256 (86.5%)	862 (85.6%)
Unsure	71 (2.9%)	10 (2.1%)	22 (3.2%)	7 (2.4%)	32 (3.2%)
Total	**2472 (100%)**	**481 (100%)**	**688 (100%)**	**296 (100%)**	**1007 (100%)**

Figure A2.18: Disability by Occupation (Weighted)

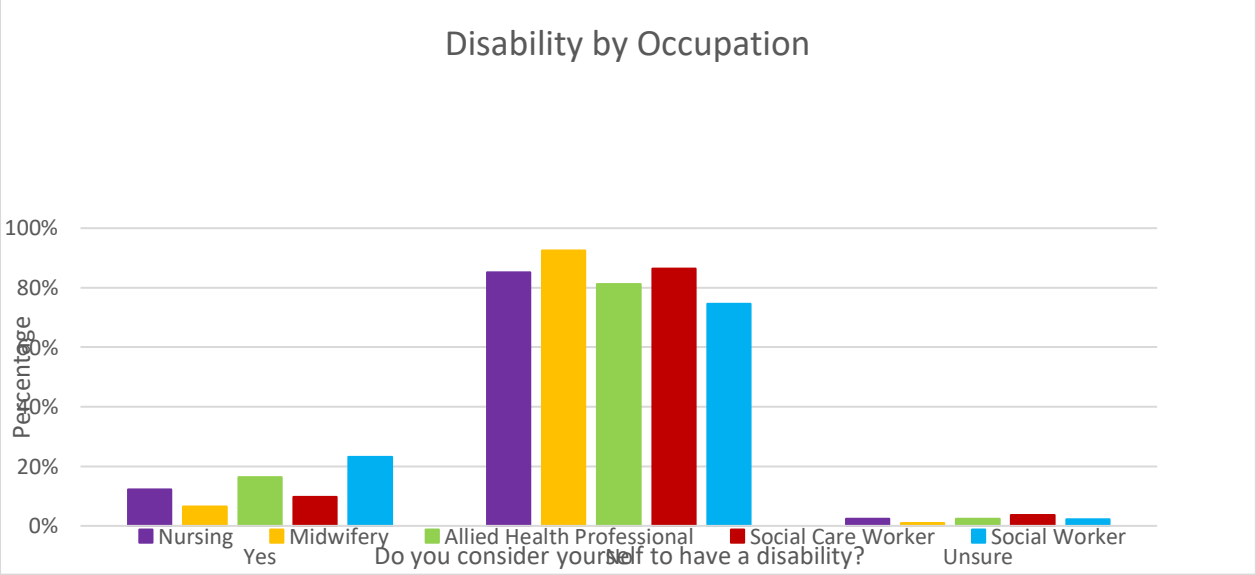


Figure A2.19: Disability by Occupation (Unweighted)

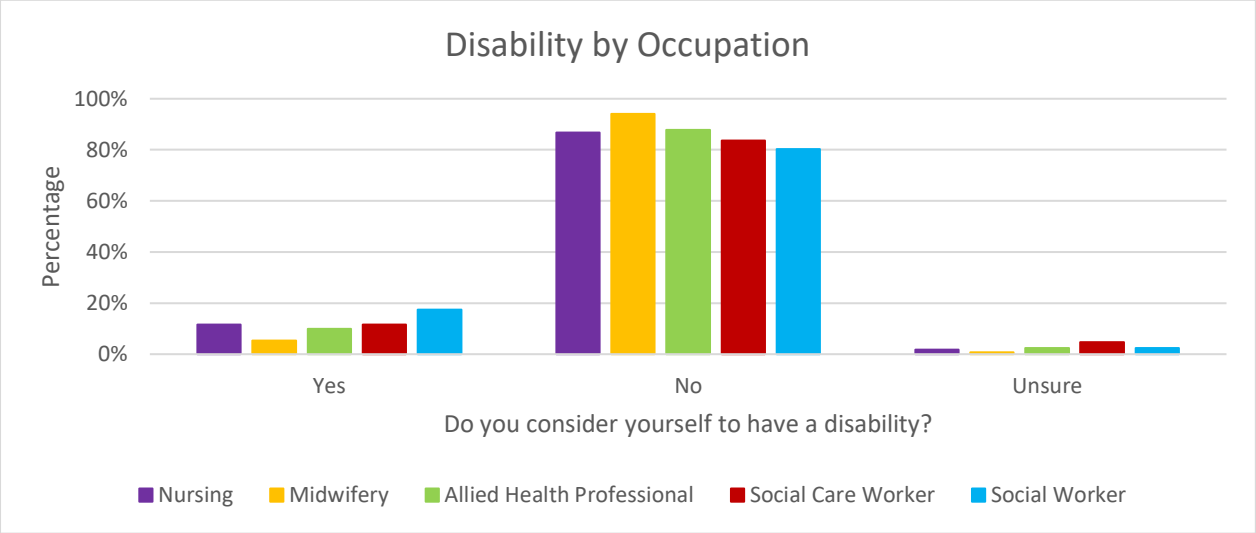


Table A2.18: Disability by Occupation (Weighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	12.3%	85.2%	2.4%	**100%**
Midwifery	6.6%	92.5%	0.9%	**100%**
AHP	16.4%	81.2%	2.4%	**100%**
Social Care Worker	9.7%	86.5%	3.7%	**100%**
Social Worker	23.1%	74.6%	2.2%	**100%**

Table A2.19: Disability by Occupation (Unweighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	59 (11.5%)	443 (86.7%)	9 (1.8%)	**511 (100%)**
Midwifery	8 (5.3%)	142 (94.0%)	1 (0.7%)	**151 (100%)**
AHP	34 (9.9%)	302 (87.8%)	8 (2.3%)	**344 (100%)**
Social Care Worker	89 (11.5%)	649 (83.7%)	37 (4.8%)	**775 (100%)**
Social Worker	121 (17.5%)	554 (80.2%)	16 (2.3%)	**691 (100%)**

A2.6 Respondents' Relationship Status

Summary (Weighted results):

Over half the respondents reported they were married (52.2%).

Summary (Unweighted results):

Over half the respondents reported they were married (53.5%).

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

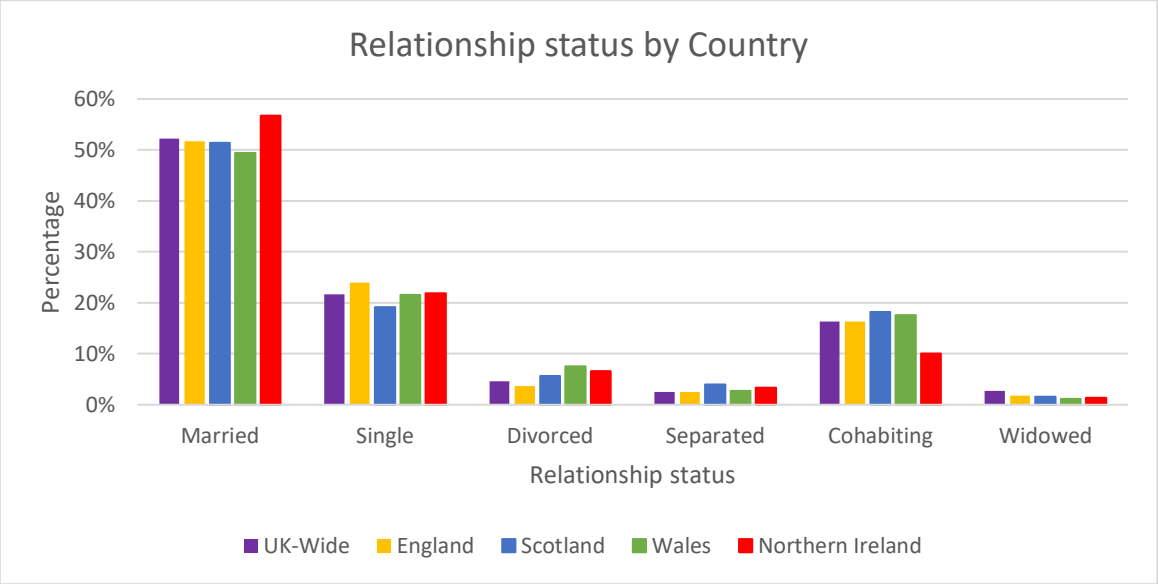


Figure A2.21: Relationship Status by Country (Unweighted)

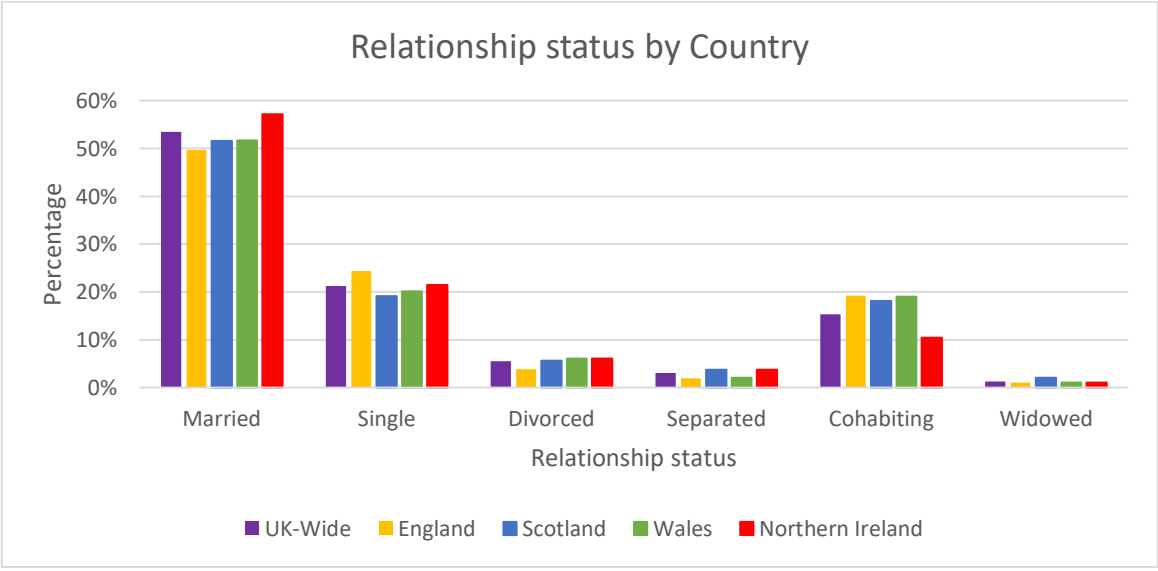


Table A2 20:: Relationship Status by Country (Weighted)

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	52.20%	51.70%	51.40%	49.40%	56.70%
Single	21.70%	24.00%	19.20%	21.60%	21.90%
Divorced	4.60%	3.70%	5.60%	7.50%	6.60%
Separated	2.50%	2.50%	4.00%	2.70%	3.30%
Cohabiting	16.30%	16.30%	18.20%	17.60%	10.10%
Widowed	2.70%	1.80%	1.60%	1.20%	1.40%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

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

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	1311 (53.5%)	238 (49.7%)	351 (51.5%)	152 (51.7%)	570 (57.1%)
Single	521 (21.2%)	117 (24.4%)	130 (19.1%)	59(20.1%)	215 (21.5%)
Divorced	135 (5.5%)	18 (3.8%)	38 (5.6%)	18 (6.1%)	61 (6.1%)
Separated	77 (3.1%)	9 (1.9%)	25 3.7%)	6 (2.0%)	37 (3.7%)
Cohabiting	375 (15.3%)	92 (19.2%)	123 (18.1%)	56 (19.0%)	104 (10.4%)
Widowed	33 (1.3%)	5 (1.0%)	14 (2.1%)	3 (1.0%)	11 (1.1%)
Total	**2452 (100%)**	**479 (100%)**	**681 (100%)**	**294 (100%)**	**998 (100%)**

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

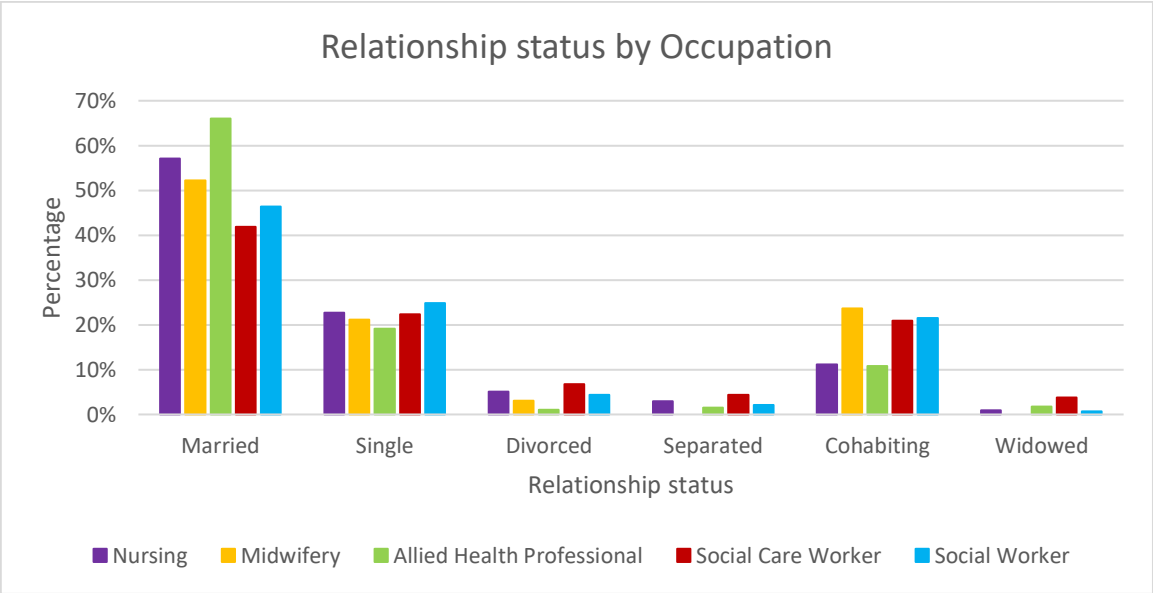


Figure A2.23: Relationship Status by Occupation (Unweighted)

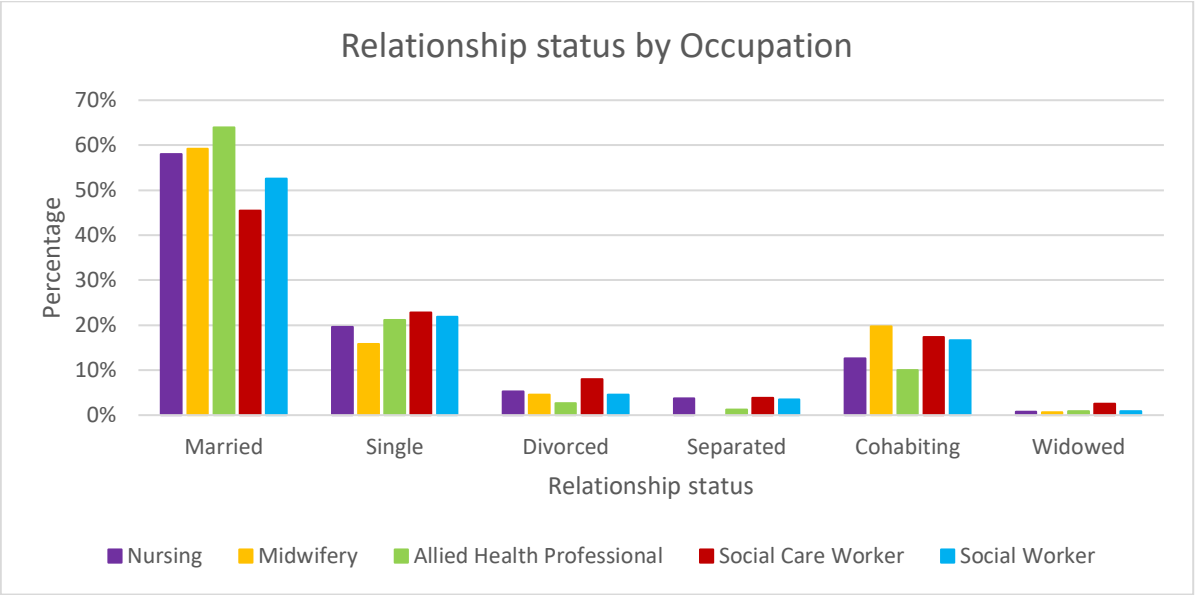


Table A2.22: Relationship Status by Occupation (Weighted)

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	57.10%	22.70%	5.10%	3.00%	11.20%	0.90%	**100%**
Midwifery	52.20%	21.10%	3.10%	0.00%	23.60%	0.00%	**100%**
AHP	66.00%	19.10%	1.00%	1.50%	10.80%	1.70%	**100%**
Social Care Worker	41.90%	22.40%	6.70%	4.40%	20.90%	3.80%	**100%**
Social Worker	46.40%	24.90%	4.40%	2.10%	21.50%	0.70%	**100%**

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

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	295 (58.0%)	100 (19.6%)	27 (5.3%)	19 (3.7%)	64 (12.6%)	4 (0.8%)	**509 (100%)**
Midwifery	90 (59.2%)	24 (1.8%)	7 (4.6%)	0 (0.0%)	30 (19.7%)	1 (0.7%)	**152 (100%)**
AHP	217 (64.0%)	72 (21.2%)	9 (2.7%)	4 (1.2%)	34 (10.0%)	3 (0.9%)	**339 (100%)**
Social Care Worker	348 (45.4%)	175 (22.8%)	61 (8.0%)	30 (3.9%)	133 (17.4%)	19 (2.5%)	**766 (100%)**
Social Worker	361 (52.6%)	150 (21.9%)	31 (4.5%)	24 (3.5%)	114 (16.6%)	6 (0.9%)	**686 (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, social workers and AHPs frequently reported working in the community.

Summary (Unweighted results):

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

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

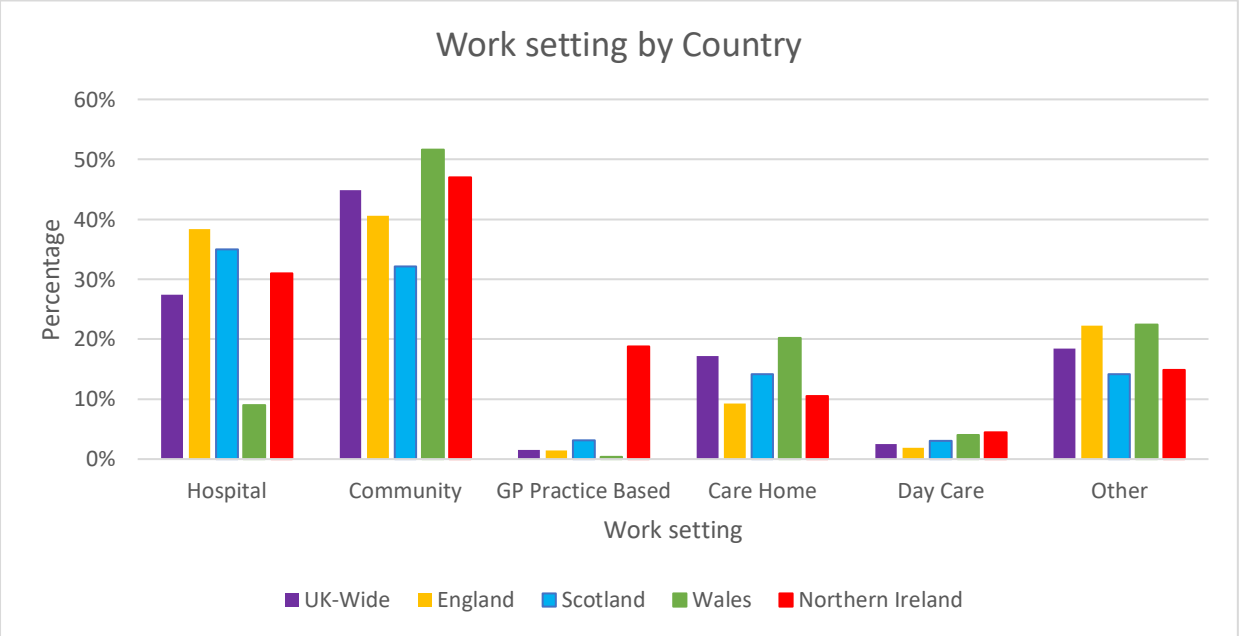


Figure A2.25: Work Setting by Country (Unweighted)

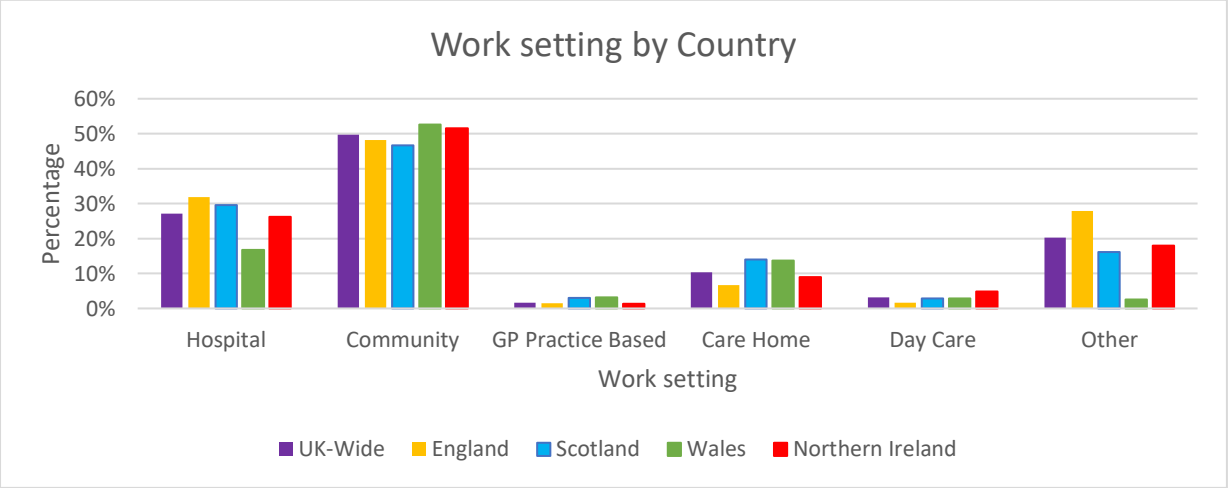


Table A2.24: Work Setting by Country (Weighted)

	Country				
Work setting	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Hospital	27.40%	38.40%	35.00%	9.00%	31.00%
Community	44.90%	40.60%	32.10%	51.60%	47.00%
GP Practice Based	1.50%	1.40%	3.10%	0.40%	18.80%
Care Home	17.20%	9.30%	14.20%	20.20%	10.50%
Day Care	2.50%	1.90%	3.00%	4.00%	4.50%
Other	18.40%	22.30%	14.20%	22.40%	14.90%

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	736 (27.1%)	170 (31.8%)	220 (29.5%)	54 (16.8%)	292 (26.2%)
Community	1350 (49.7%)	258 (48.2%)	347 (46.6%)	169 (52.6%)	576 (51.6%)
GP Practice Based	45 (1.7%)	8 (1.5%)	22 (3.0%)	1 (3.1%)	14 (1.3%)
Care Home	283 (10.4%)	36 (6.7%)	104 (14.0%)	44 (13.7%)	99 (8.9%)
Day Care	84 (3.1%)	9 (1.7%)	21 (2.8%)	9 (2.8%)	54 (4.8%)
Other	550 (20.2%)	149 (27.9%)	120 (16.1%)	80 (2.5%)	201 (18.0%)
No. of respondents who answered the question	**2717**	**539**	**745**	**321**	**1116**

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

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

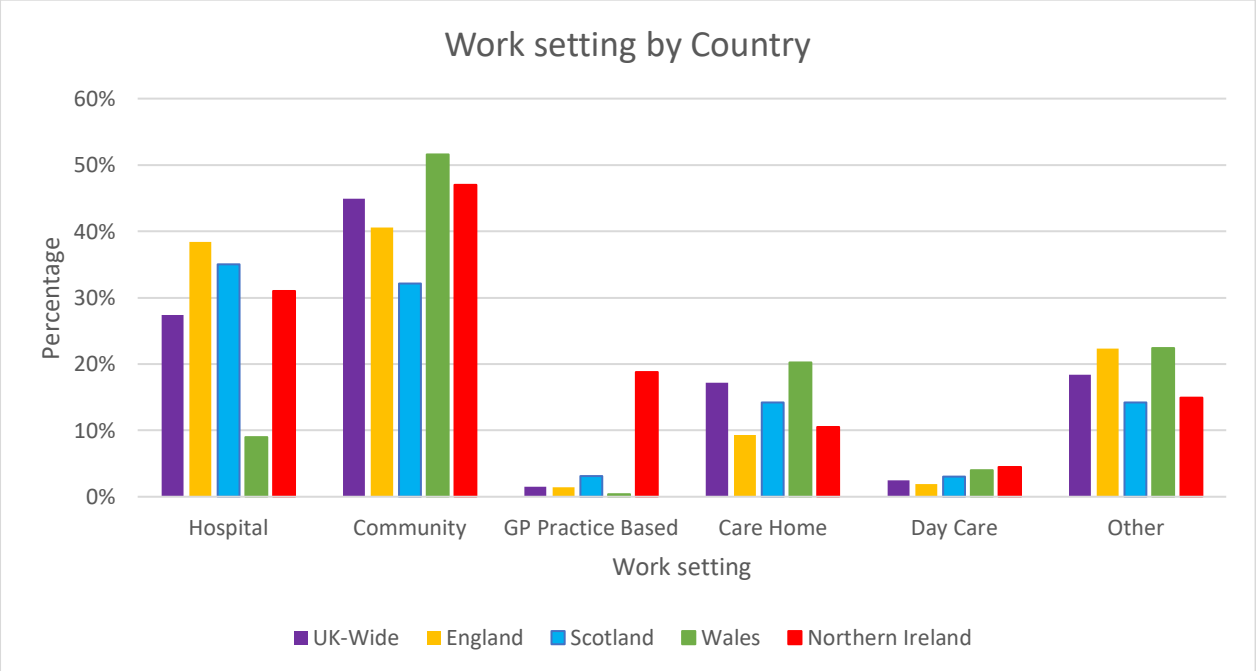


Figure A2.27: Work Setting by Occupation (Unweighted)

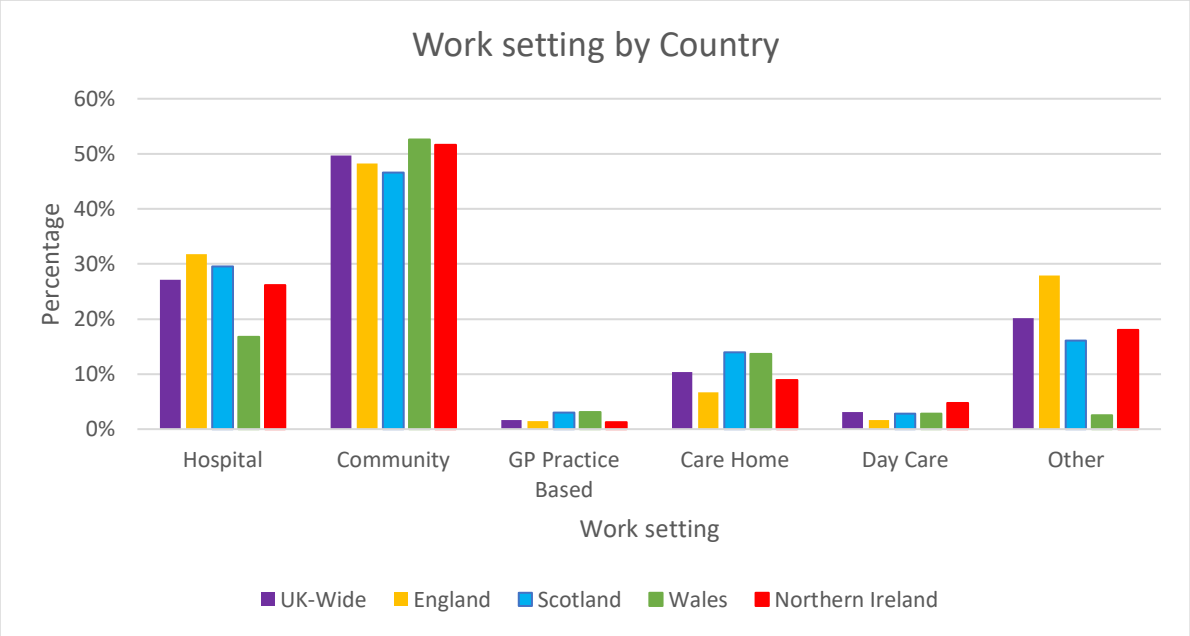


Table A2.26: Work Setting by Occupation (Weighted)

	Work setting					
Occupation	**Hospital**	**Community**	**GP Practice Based**	**Care Home**	**Day Care**	**Other**
Nursing	60.60%	65.00%	2.90%	5.40%	0.50%	11.80%
Midwifery	81.40%	32.90%	5.80%	0.00%	0.00%	5.80%
AHP	29.40%	46.20%	2.20%	7.10%	3.20%	3.90%
Social Care Worker	2.10%	54.20%	0.00%	27.70%	5.50%	19.60%
Social Worker	11.30%	61.50%	0.60%	5.30%	2.00%	38.20%

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

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

Occupation	Work setting						No. of respondents who answered the question
	Hospital	Community	GP Practice Based	Care Home	Day Care	Other	
Nursing	331 (58.4%)	162 (28.6%)	20 (3.5%)	34 (6.0%)	8 (1.4%)	70 (12.4%)	**566**
Midwifery	132 (77.2%)	54 (31.6%)	6 (3.5%)	0 (0.0%)	0 (0.0%)	12 (7.0%)	**171**
AHP	166 (43.9%)	162 (42.9%)	8 (2.1%)	28 (7.4%)	7 (1.9%)	79 (20.9%)	**378**
Social Care Worker	21 (2.5%)	504 (59.1%)	1 (0.2%)	191 (22.4%)	156 (18.3%)	136 (15.9%)	**853**
Social Worker	86 (11.5%)	468 (62.5%)	10 (1.3%)	30 (4.0%)	13 (1.7%)	253 (36.4%)	**753**

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

A2.8 Health and Social Care Sector of Respondents

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

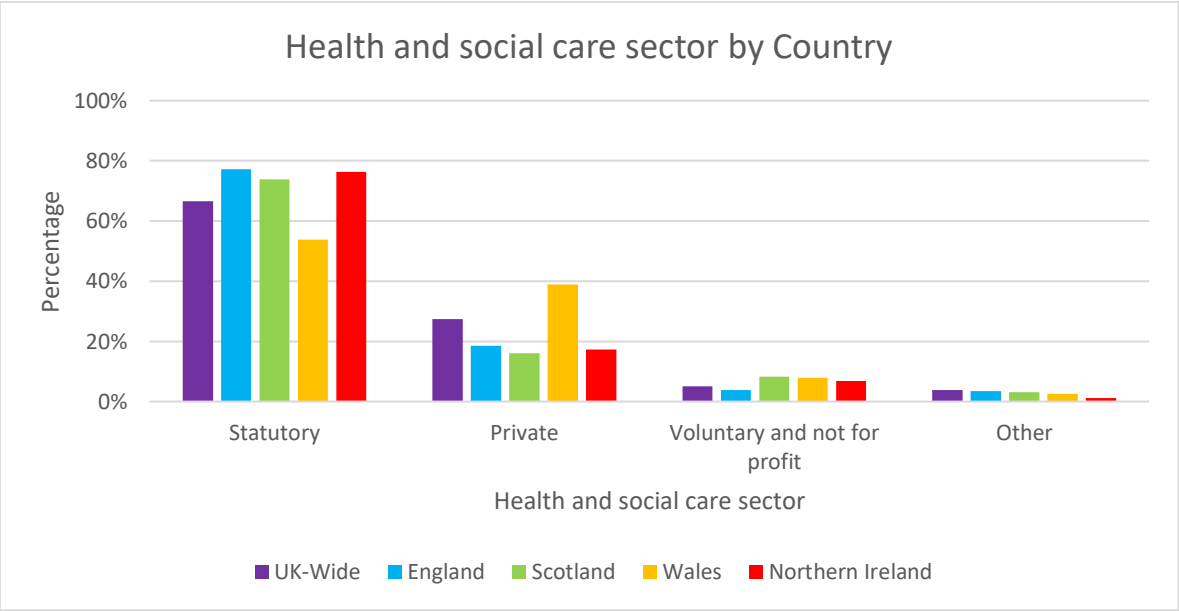


Figure A2.29: Health and Social Care Sector of Respondents by Country (Unweighted)

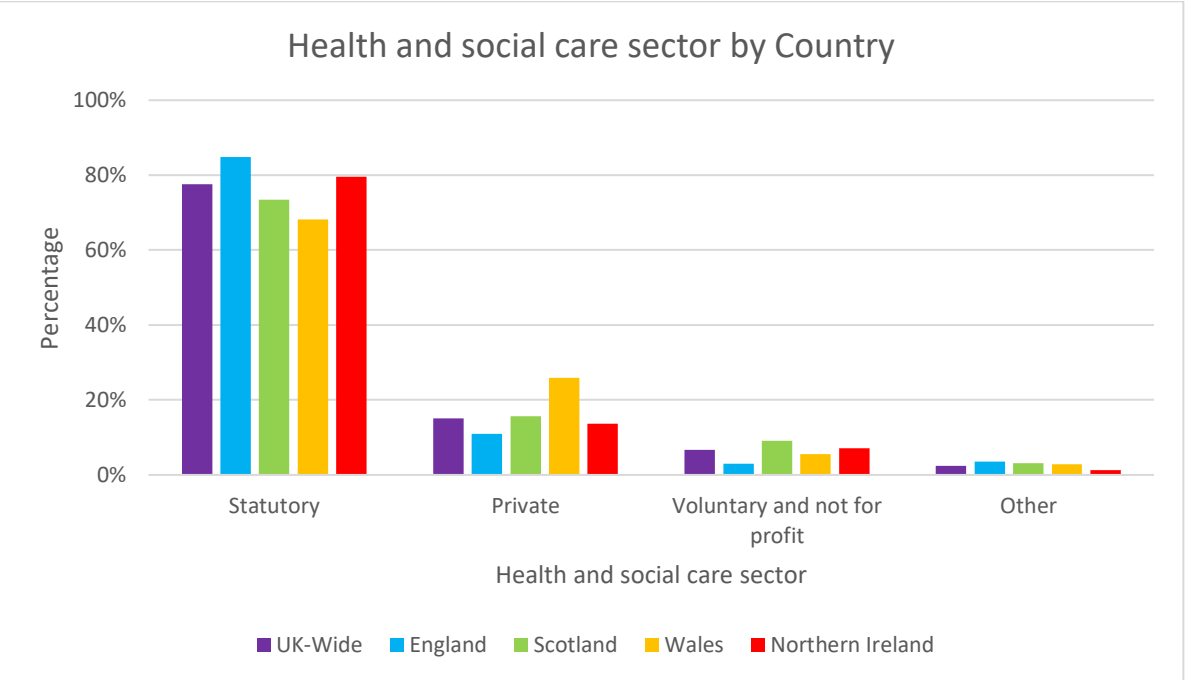


Table A2.28: Health and Social Care Sector of Respondents by Country (Weighted)

Health and social care sector	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Statutory	66.60%	77.20%	73.90%	53.80%	76.40%
Private	27.40%	18.50%	16.10%	39.00%	17.30%
Voluntary and not for profit	5.10%	3.80%	8.30%	7.90%	6.90%
Other	3.90%	3.50%	3.20%	2.50%	1.10%

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	2111 (77.6%)	457 (84.8%)	547 (73.4%)	219 (68.2%)	888 (79.6%)
Private	411 (15.1%)	59 (10.9%)	117 (15.7%)	83(25.9%)	152(13.6%)
Voluntary and not for profit	181 (6.7%)	16 (3.0%)	68 (9.1%)	18 (5.6%)	79 (7.1%)
Other	66 (2.4%)	19 (3.5%)	24 (3.2%)	9 (2.8%)	14 (1.3%)
No. of respondents who answered the question	**2721**	**539**	**745**	**321**	**1116**

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)

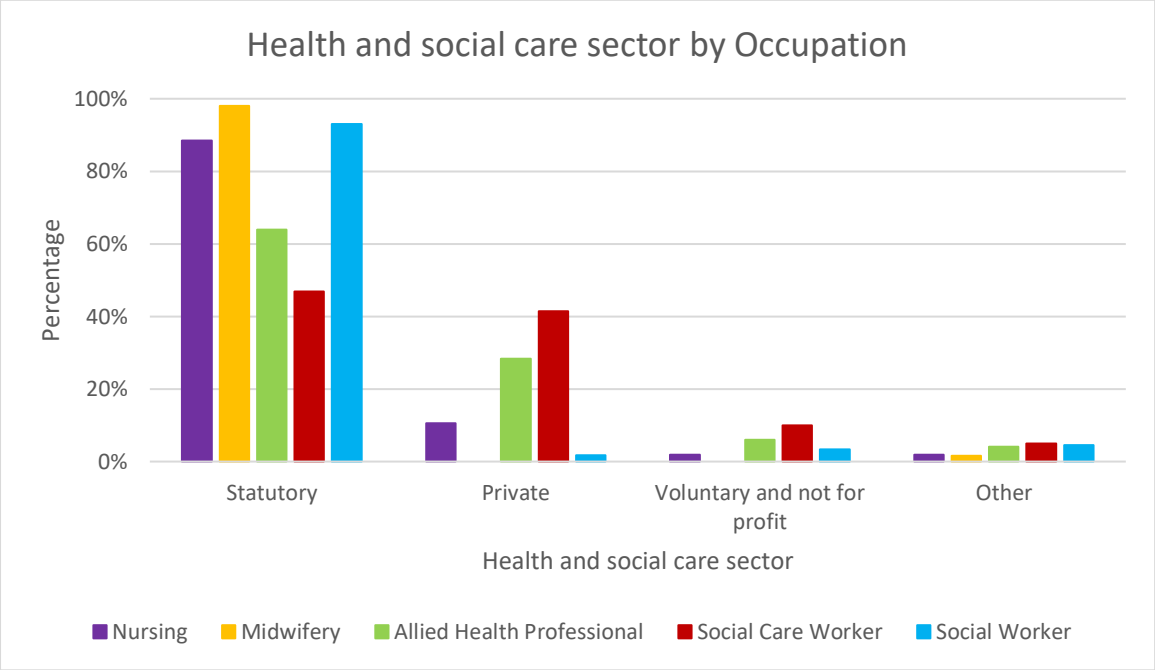


Figure A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)

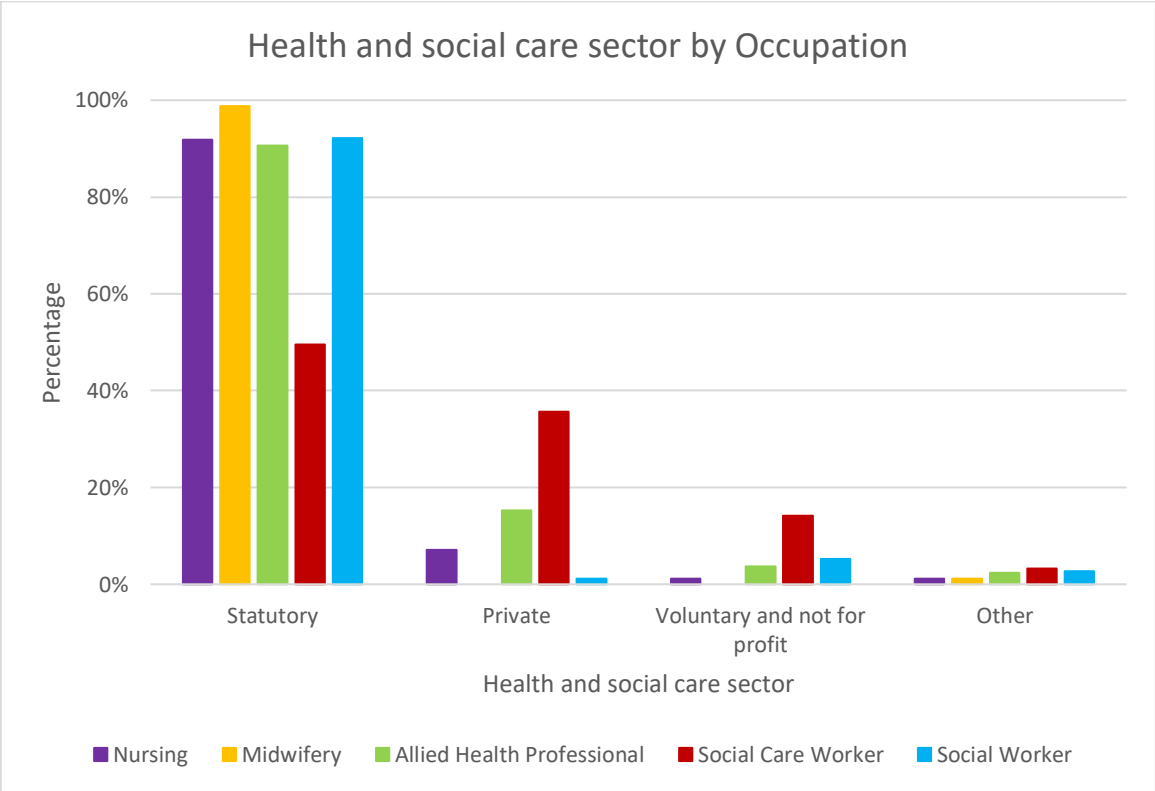


Table A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)

Occupation	Health and social care sector			
	Statutory	Private	Voluntary and not for profit	Other
Nursing	88.5%	10.5%	1.9%	1.9%
Midwifery	98.0%	0.0%	0.0%	1.6%
AHP	63.9%	28.3%	6.0%	4.0%
Social Care Worker	46.9%	41.4%	9.9%	5.0%
Social Worker	93.1%	1.7%	3.3%	4.0%

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	Private	Voluntary and not for profit	Other	
Nursing	520 (91.9%)	40 (7.1%)	7 (1.2%)	7 (1.2%)	**566**
Midwifery	169 (98.8%)	0 (0.0%)	0 (0.0%)	2 (1.2%)	**171**
AHP	306 (90.6%)	58 (15.3%)	14 (3.7%)	9 (2.4%)	**378**
Social Care Worker	422 (49.5%)	304 (35.6%)	121 (14.2%)	28 (3.3%)	**853**
Social Worker	694 (92.2%)	9(1.2%)	39 (5.2%)	20 (2.7%)	**753**

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):

Almost two thirds of respondents were not line managers.

Summary (Unweighted results):

The majority of respondents were not line managers.

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

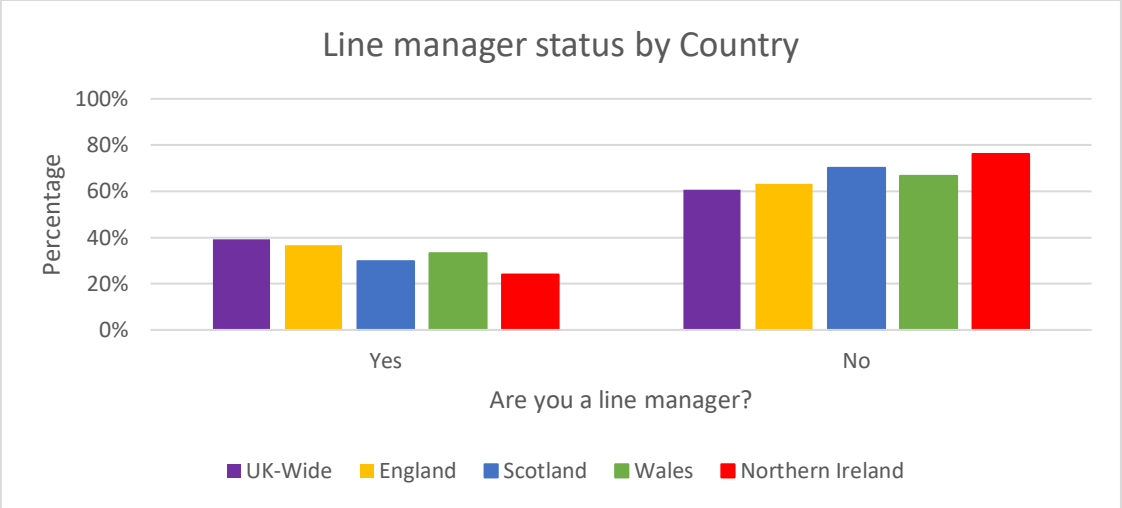


Figure A2.33: Line Manager Status of Respondents by Country (Unweighted)

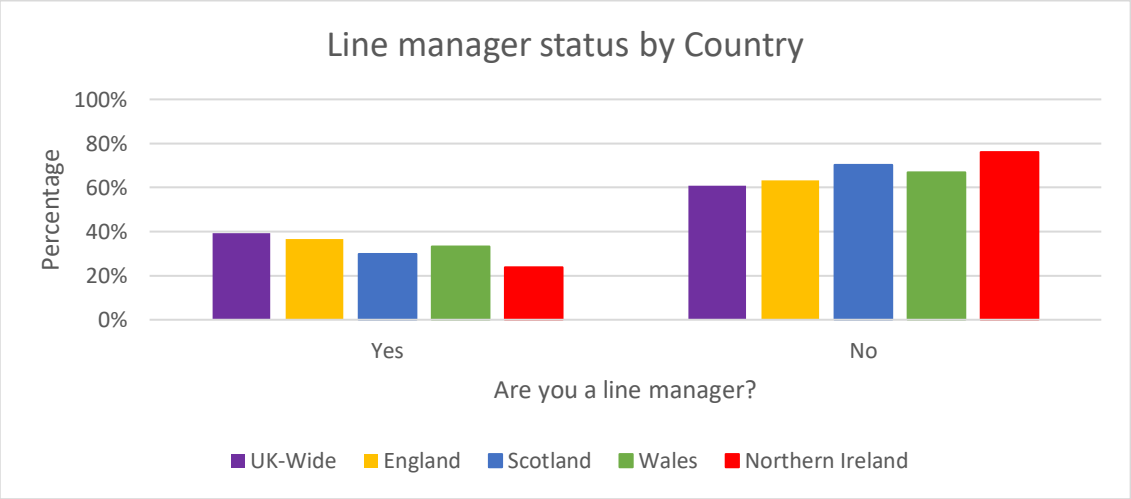


Table A2.32: Line Manager Status of Respondents by Country (Weighted)

Are you a line manager?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	39.2%	36.7%	29.8%	33.2%	23.9%
No	60.8%	63.3%	70.2%	66.8%	76.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

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

Are you a line manager?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	766 (28.2%)	166 (30.8%)	221 (29.7%)	102 (31.8%)	277 (24.8%)
No	1955 (71.8%)	373 (69.2%)	524 (70.3%)	219 (68.2%)	839 (75.2%)
Total	**2721 (100%)**	**539 (100%)**	**745 (100%)**	**321 (100%)**	**1116 (100%)**

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

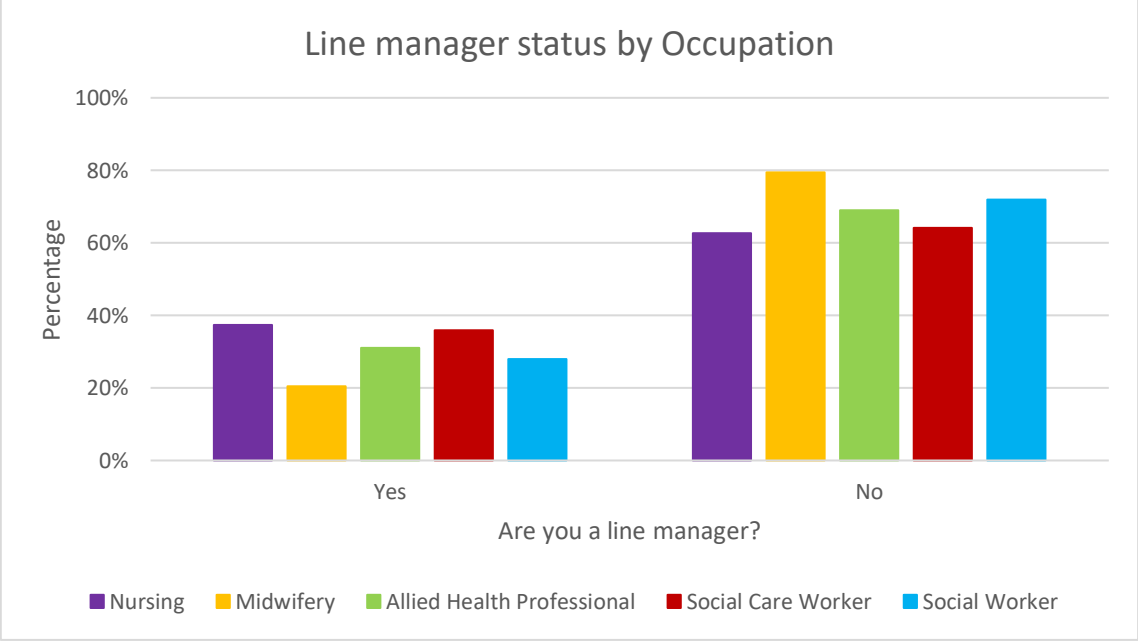


Figure A2.35: Line Manager Status of Respondents by Occupation (Unweighted)

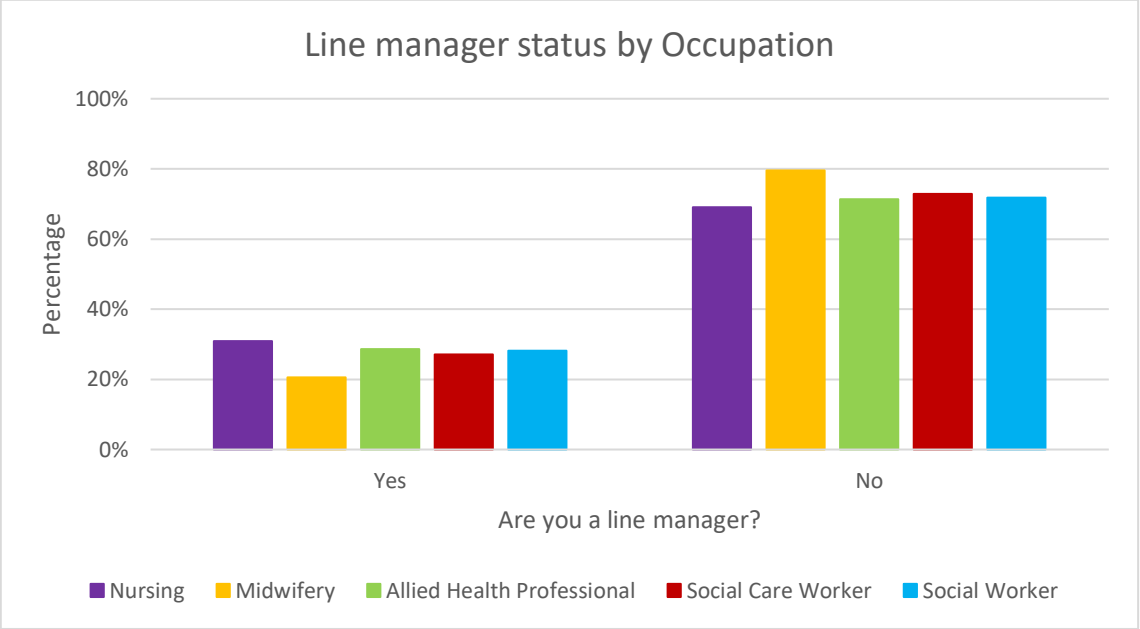


Table A2.34: Line Manager Status of Respondents by Occupation (Weighted)

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	37.3%	62.7%	**100%**
Midwifery	20.5%	79.5%	**100%**
AHP	31.0%	69.0%	**100%**
Social Care Worker	35.9%	64.1%	**100%**
Social Worker	28.0%	72.0%	**100%**

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

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	175 (30.9%)	391 (69.1%)	**566 (100%)**
Midwifery	35 (20.5%)	136 (79.5%)	**171 (100%)**
AHP	108 (28.6%)	270 (71.4%)	**378 (100%)**
Social Care Worker	231 (27.1%)	622 (72.9%)	**853 (100%)**
Social Worker	217 (28.2%)	536 (71.8%)	**753 (100%)**

A2.10 Pay Scale of Respondents

Summary (Weighted results):

Participants were divided into those who worked for the NHS or the HSC Trust (45.1%) and those who did not (54.9%) and were subsequently asked questions about their pay scale. Across the countries, the most frequently reported pay scale for NHS/HSC Trust staff was Band 7, followed by Band 6 and Band 8. For staff outside of the NHS/HSC Trust, the results were more varied. In terms of the different occupational groups, Band 6 was most frequently reported by midwives, followed by social workers, nurses and AHPs, for social care workers it was Band 5 followed by Band 3. The results were again more varied for the non-NHS/HSC Trust staff.

Summary (Unweighted results):

Participants were divided into those who worked for the NHS or the HSC Trust (n = 1540, 56.6%) and those who did not (n = 1179, 43.4%) and were subsequently asked questions about their pay scale. Across the countries, the most frequently reported pay scale for NHS/HSC Trust staff was Band 6, followed by Band 7. For staff outside of the NHS/HSC Trust, the results were more varied. In terms of the different occupational groups, Band 6 was most frequently reported by all groups except for the social care workers, the majority of whom were in Band 3. The results were again more varied for the non-NHS/HSC Trust staff.

Figure A2.36: Working in the NHS or the HSC Trust by Country (Unweighted)

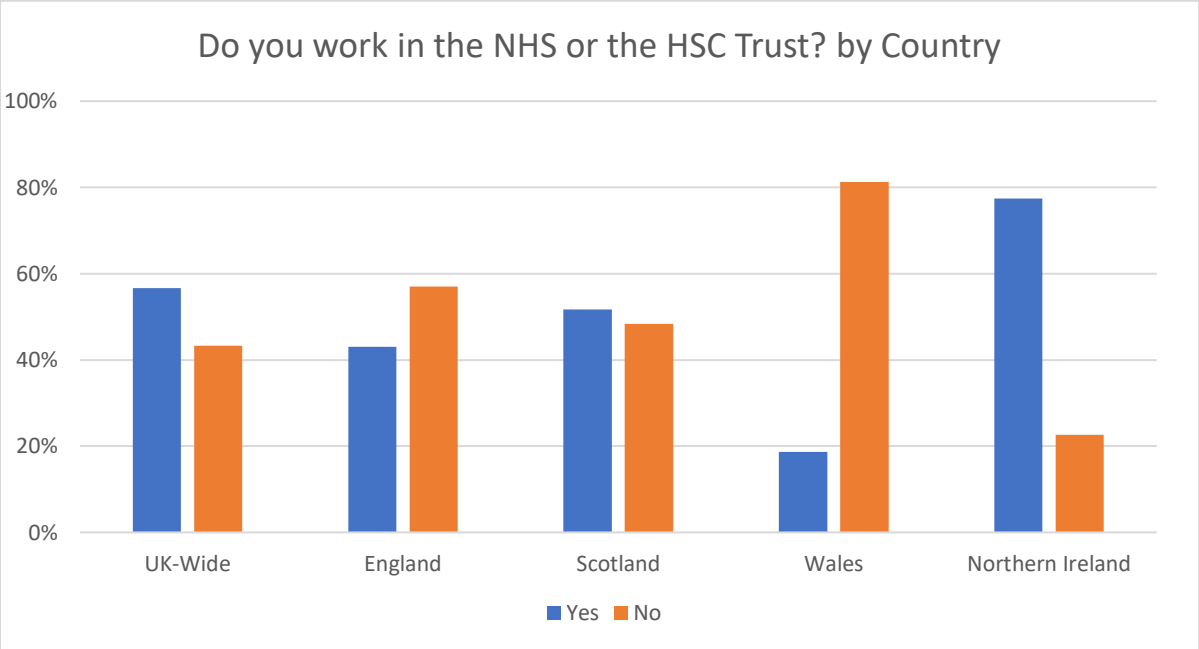


Table A2.36: Working in the NHS or the HSC Trust by Country (Unweighted)

Do you work in the NHS or the HSC Trust?	UK-Wide
Yes	45.1%
No	54.9%
Total	**100%**

Table A2.37: Working in the NHS or the HSC Trust by Country (Unweighted)

Do you work in the NHS or the HSC Trust?	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	1540 (56.6%)	232 (43.0%)	384 (51.7%)	60 (18.7%)	864 (77.4%)
No	1179 (43.4%)	307(57.0%)	359 (48.3%)	261 (81.3%)	252 (22.6%)
Total	**2719 (100%)**	**539 (100%)**	**743 (100%)**	**321 (100%)**	**1116 (100%)**

Figure A2.37: Working in the NHS or the HSC Trust by Occupation (Unweighted)

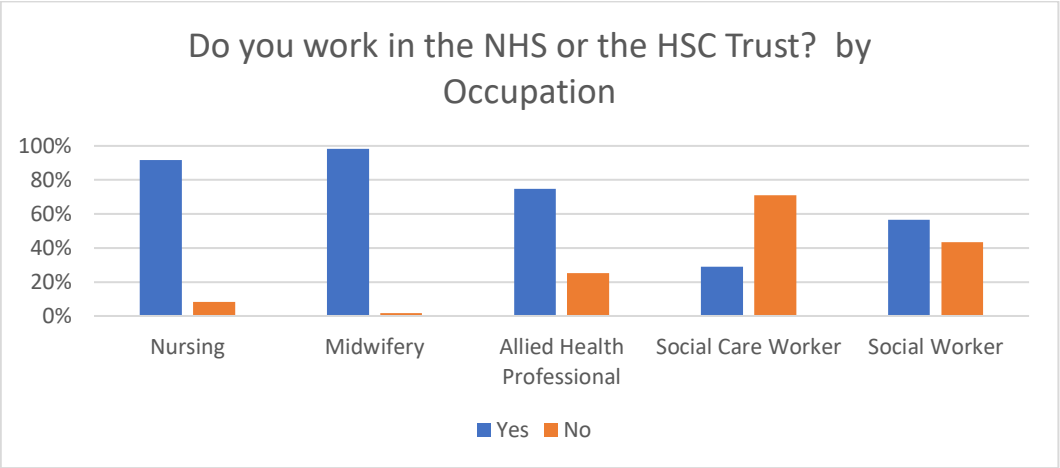


Table A2.38: Working in the NHS or the HSC Trust by Occupation (Unweighted)

Occupation	Yes	No	Total
Nursing	519 (91.7%)	47 (8.3%)	**566 (100%)**
Midwifery	169 (98.2%)	3 (1.8%)	**171(100%)**
AHP	283 (74.9%)	95 (25.1%)	**378 (100%)**
Social Care Worker	248 (29.1%)	603 (70.9%)	**851 (100%)**
Social Worker	322 (56.6%)	431 (43.4%)	**753 (100%)**
Total	**1540 (56.6%)**	**1179 (43.4%)**	**2719 (100%)**

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

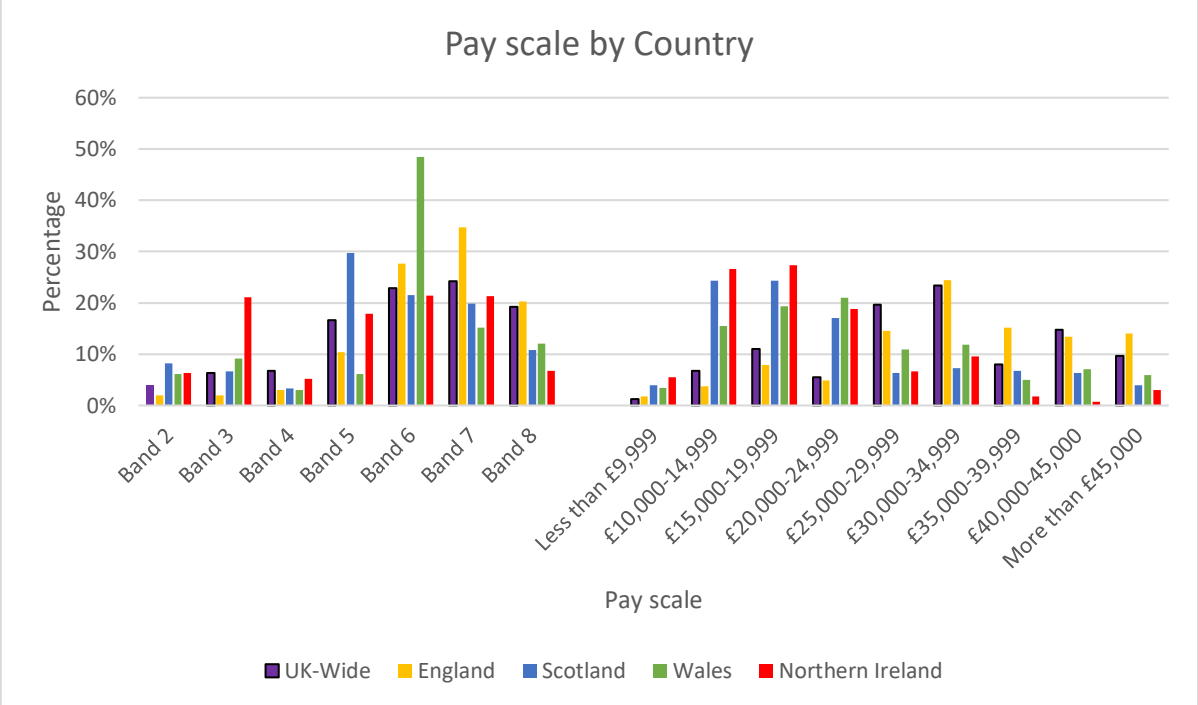


Figure A2.39: Pay Scale of Respondents by Country (Unweighted)

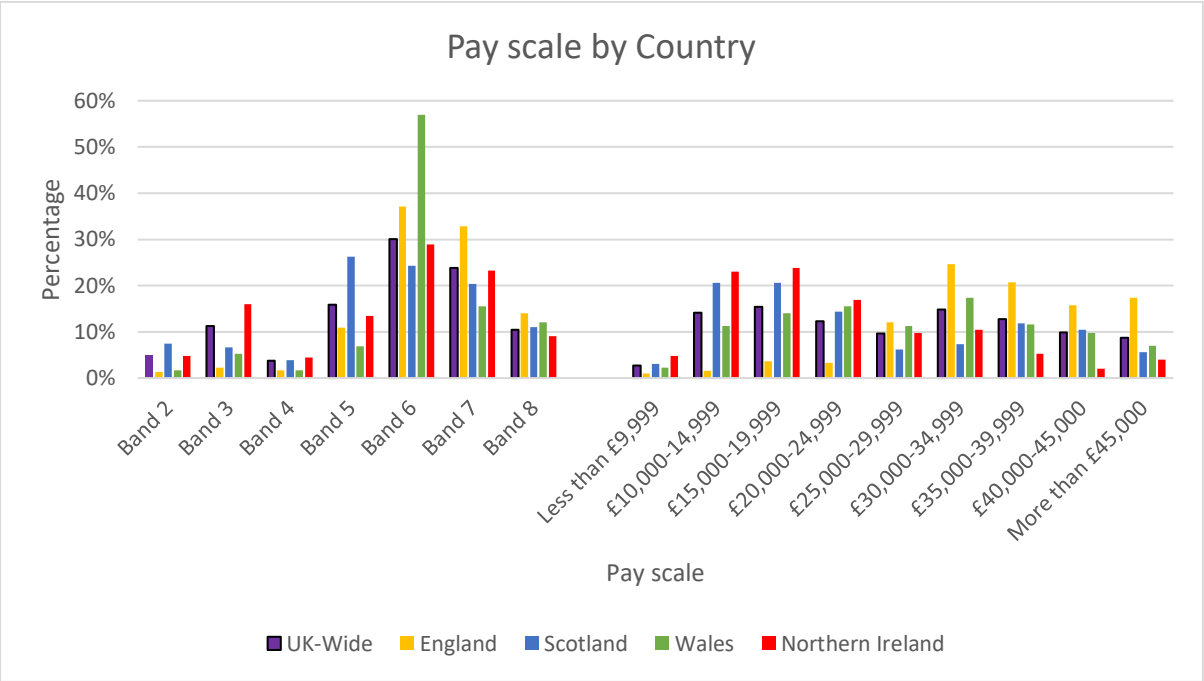


Table A2.39: Pay Scale of Respondents by Country (Weighted)

Pay scale	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
NHS or HSC Trust staff					
Band 2	4.0%	2.0%	8.2%	6.1%	6.3%
Band 3	6.3%	2.0%	6.6%	9.1%	21.1%
Band 4	6.8%	3.0%	3.3%	3.0%	5.2%
Band 5	16.6%	10.4%	29.7%	6.1%	17.9%
Band 6	22.9%	27.7%	21.5%	48.5%	21.4%
Band 7	24.2%	34.7%	19.9%	15.2%	21.3%
Band 8	19.2%	20.3%	10.8%	12.1%	6.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Other staff					
Less than £9,999	1.2%	1.8%	3.9%	3.4%	5.5%
£10,000-14,999	6.7%	3.7%	24.3%	15.5%	26.6%
£15,000-19,999	11.0%	7.9%	24.3%	19.3%	27.3%
£20,000-24,999	5.5%	4.9%	17.0%	21.0%	18.8%
£25,000-29,999	19.6%	14.6%	6.3%	10.9%	6.6%
£30,000-34,999	23.4%	24.4%	7.3%	11.8%	9.6%
£35,000-39,999	8.0%	15.2%	6.8%	5.0%	1.8%
£40,000-45,000	14.8%	13.4%	6.3%	7.1%	0.7%
More than £45,000	9.7%	14.0%	3.9%	5.9%	3.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.40: Pay Scale of Respondents by Country (Unweighted)

Pay scale	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
NHS or HSC Trust staff					
Band 2	72 (4.8%)	3 (1.3%)	27 (7.5%)	1 (1.7%)	41 (4.8%)
Band 3	169 (11.2%)	5 (2.2%0	24 (6.6%)	3 (5.2%)	137 (16.0%)
Band 4	57 (3.8%)	4 (1.7%)	14 (3.9%)	1 (1.7%)	38 (4.4%)
Band 5	239 (15.9%)	95 (10.9%)	95 (26.2%)	4 (6.9%)	115 (13.4%)
Band 6	454 (30.1%)	85 (37.1%)	88 (24.3%)	33 (56.9%)	248 (28.9%)
Band 7	368 (23.8%)	75 (32.8%)	74 (20.4%)	9 (15.5%)	200 (23.3%)
Band 8	157 (10.4%)	32 (14.0%)	40 (11.0%)	7 (12.1%)	78 (9.1%)
Total	**1506 (100%)**	**229 (100%)**	**362 (100%)**	**58 (100%)**	**857 (100%)**
Other staff					
Less than £9,999	32 (2.7%)	3 (1.0%)	(3.1%)	(2.3%)	(4.8%)
£10,000-14,999	164 (14.1%)	5 (1.6%)	(20.6%)	(11.2%)	(23.0%)
£15,000-19,999	179 (15.4%)	11 (3.6%)	(20.6%)	(14.0%)	59 (23.8%)
£20,000-24,999	143 (12.3%)	10 (3.3%)	51 (14.4%)	40 (15.5%)	42 (16.9%)
£25,000-29,999	112 (9.6%)	37 (12.1%)	22 (6.2%)	29 (11.2%)	24 (9.7%)
£30,000-34,999	172 (14.8%)	75 (24.6%)	26 (7.3%)	45 (17.4%)	26 (10.5%)
£35,000-39,999	148 (12.7%)	63 (20.7%)	42 (11.8%)	30 (11.6%)	13 (5.2%)
£40,000-45,000	115 (9.9%)	48 (15.7%)	37 (10.4%)	25 (9.7%)	5 (2.0%)
More than £45,000	101 (8.7%)	53 (17.4%)	20 (5.6%)	18 (7.0%)	10 (4.0%)
Total	**1166 (100%)**	**305 (100%)**	**355 (100%)**	**258 (100%)**	**248 (100%)**

Figure A2.40: Pay Scale of Respondents by Occupation (Weighted)

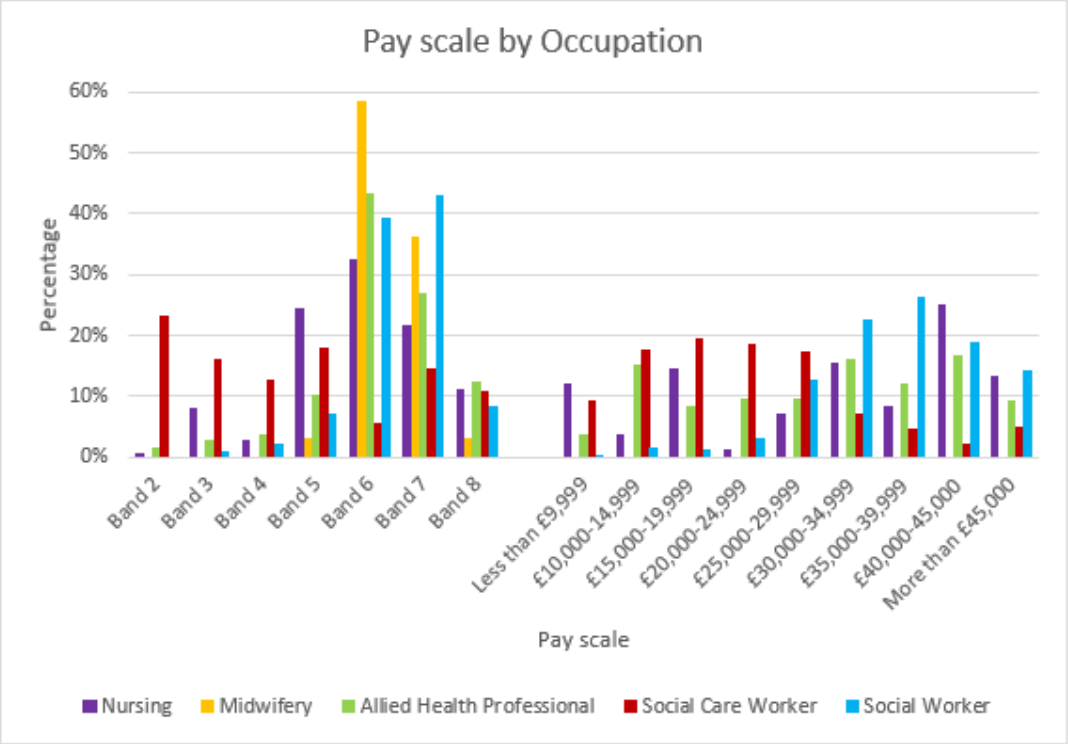


Figure A2.41: Pay Scale of Respondents by Occupation (Unweighted)

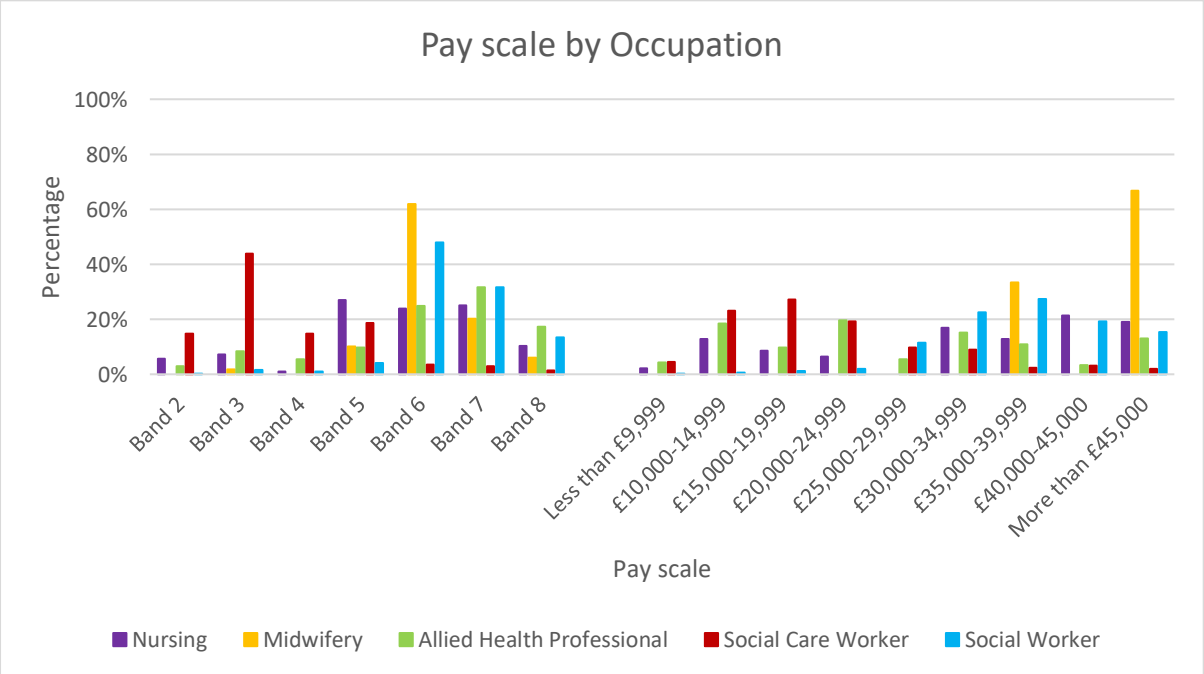


Table A2.41: Pay Scale of Respondents by Occupation (Weighted)

Pay scale	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
NHS or HSC Trust staff					
Band 2	3.3%	0.0%	1.7%	20.8%	0.0%
Band 3	5.7%	1.7%	1.3%	24.5%	3.9%
Band 4	3.0%	0.0%	2.6%	20.8%	0.0%
Band 5	15.5%	14.3%	9.8%	26.4%	4.6%
Band 6	24.5%	55.5%	31.1%	3.8%	41.8%
Band 7	29.0%	24.6%	31.5%	1.9%	40.5%
Band 8	19.1%	3.9%	22.1%	1.9%	9.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Other staff					
Less than £9,999	0.0%	0.0%	7.0%	2.2%	0.0%
£10,000-14,999	10.5%	0.0%	4.2%	14.4%	0.1%
£15,000-19,999	2.6%	0.0%	9.8%	21.6%	0.1%
£20,000-24,999	2.6%	0.0%	11.2%	13.1%	2.0%
£25,000-29,999	0.0%	0.0%	9.3%	20.3%	11.6%
£30,000-34,999	21.1%	0.0%	23.3%	14.7%	26.4%
£35,000-39,999	13.2%	85.7%	14.0%	3.8%	25.2%
£40,000-45,000	28.9%	0.0%	4.2%	5.3%	18.6%
More than £45,000	21.1%	14.3%	17.2%	4.7%	16.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.42: Pay Scale of Respondents by Occupation (Unweighted)

Pay scale	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
NHS or HSC Trust staff					
Band 2	29 (5.6%)	0 (0.0%)	8 (2.9%)	34 (14.8%)	1 (0.3%)
Band 3	37 (7.2%)	3 (1.8%)	23 (8.3%)	101 (43.9%	5 (1.6%)
Band 4	5 (1.0%)	0 (0.0%)	15 (5.4%)	34 (14.8%	3 (1.0%)
Band 5	139 (26.9%)	17 (10.1%)	27 (9.7%)	43 (18.7%)	13 (4.2%)
Band 6	123 (23.8%)	104 (61.9%)	69 (24.9%)	8 (3.5%)	150 (47.9%)
Band 7	130 (25.1%)	34 (20.2%)	88 (31.7%)	7 (3.0%)	99 (31.6%)
Band 8	54 (10.4%)	10 (6.0%)	48 (17.3%)	3 (1.3%)	42 (13.4%)
Total	**517 (100%)**	**168 (100%)**	**278 (100%)**	**230 (100%)**	**313 (100%)**
Other staff					
Less than £9,999	1 (2.1%)	0 (0.0%)	4 (4.3%)	26 (4.4%)	1 (0.2%)
£10,000-14,999	6 (12.8%)	0 (0.0%)	17 (18.5%)	138 (23.2%)	3 (0.7%)
£15,000-19,999	4 (8.5%)	0 (0.0%)	9 (9.8%)	161 (27.1%)	5 (1.2%)
£20,000-24,999	0 (6.4%)	0 (0.0%)	18 (19.6%)	114 (19.2%)	8 (1.9%)
£25,000-29,999	8 (0.0%)	0 (0.0%)	5 (5.4%)	58 (9.7%)	49 (11.4%)
£30,000-34,999	(17.0%)	0 (0.0%)	14 (15.2%)	53 (8.9%)	97 (22.6%)
£35,000-39,999	6 (12.8%)	1 (33.3%)	10 (10.9%)	14 (2.4%)	117 (27.3%)
£40,000-45,000	10 (21.3%)	0 (0.0%)	3 (3.3%)	19 (3.2%)	83 (19.3%)
More than £45,000	9 (19.1%)	2 (66.7%)	12 (13.0%)	12 (2.0%)	66 (15.4%)
Total	**47 (100%)**	**3 (100%)**	**92 (100%)**	**595 (100%)**	**429 (100%)**

A2.11 Respondents Redeployed due to COVID-19

Summary (Weighted results):

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

Summary (Unweighted results):

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

Figure A2.42: Redeployment by Country (Weighted)

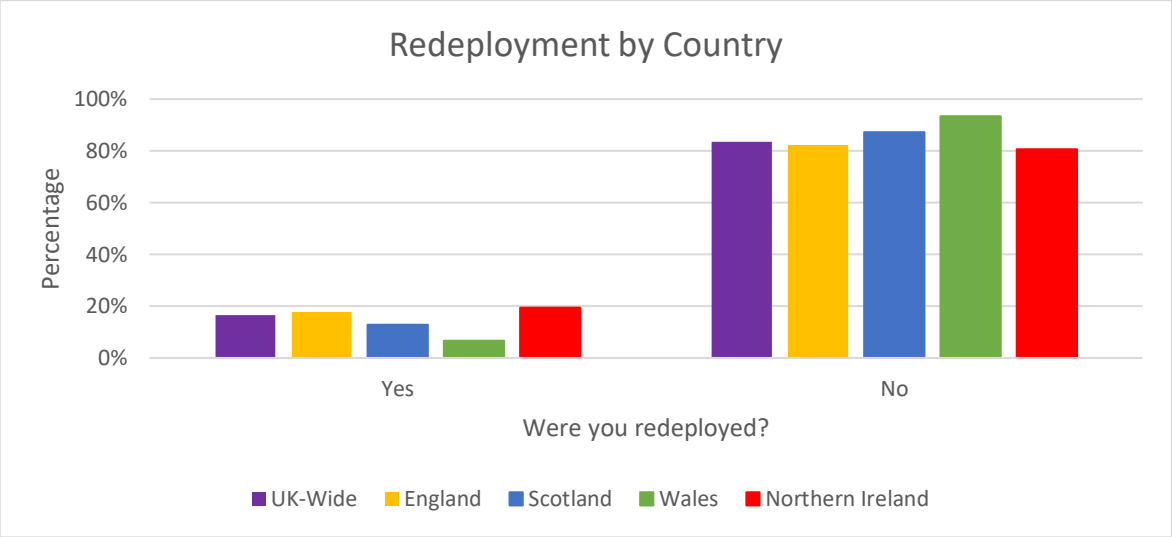


Figure A2.43: Redeployment by Country (Unweighted)

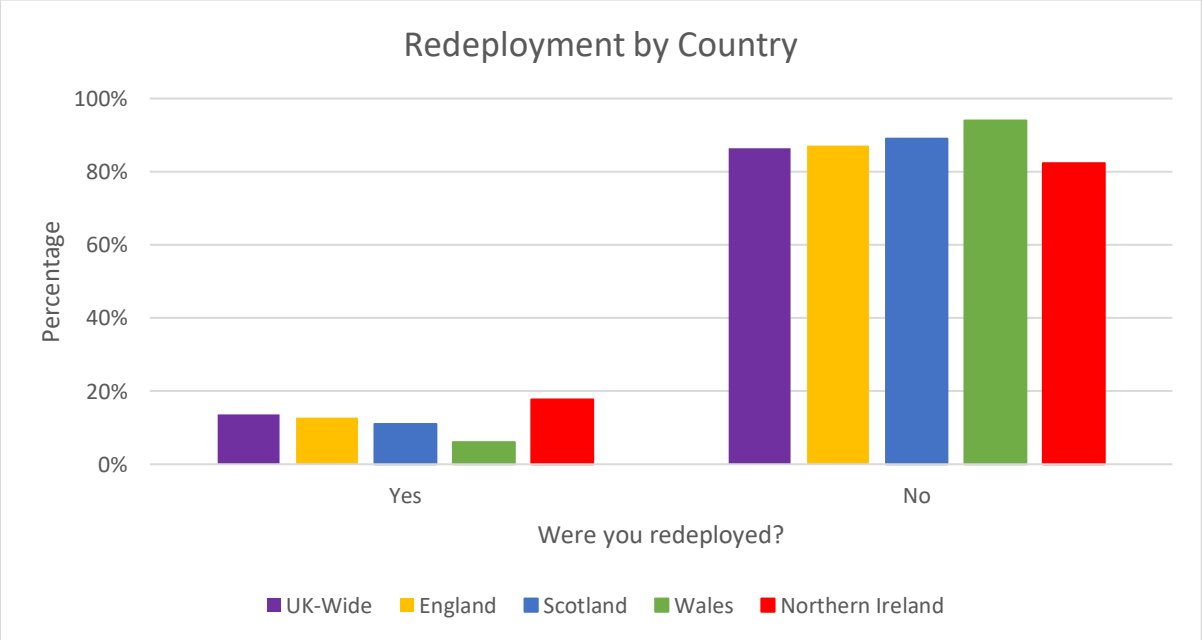


Table A2.43: Table A2.44: Redeployment by Country (Weighted)

Were you redeployed?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	16.5%	17.8%	12.9%	6.6%	19.5%
No	83.5%	82.2%	87.1%	93.4%	80.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.44: Redeployment by Country (Unweighted)

Were you redeployed?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	366 (13.6%)	69 (12.8%)	81 (11.0%)	19 (6.0%)	197 (17.7%)
No	2335 (86.4%)	468 (87.2%)	655 (89.0%)	299 (94.0%)	913 (82.3%)
Total	**2701 (100%)**	**537 (100%)**	**736 (100%)**	**318 (100%)**	**1110 (100%)**

Figure A2.44: Redeployment by Occupation (Weighted)

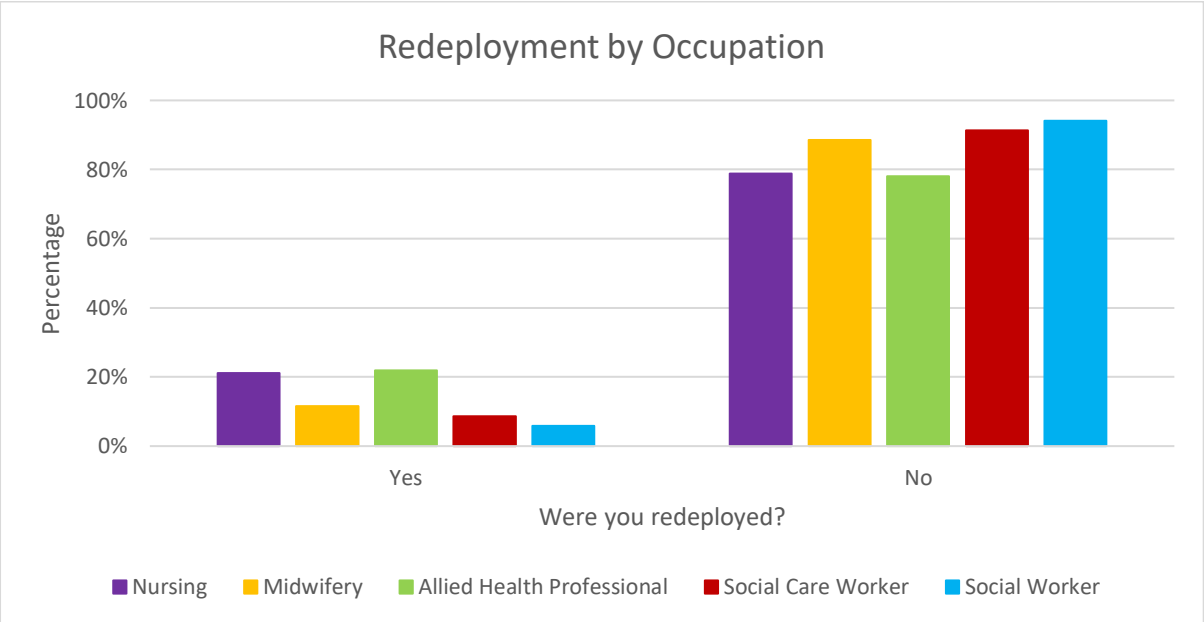


Figure A2.45: Redeployment by Occupation (Unweighted)

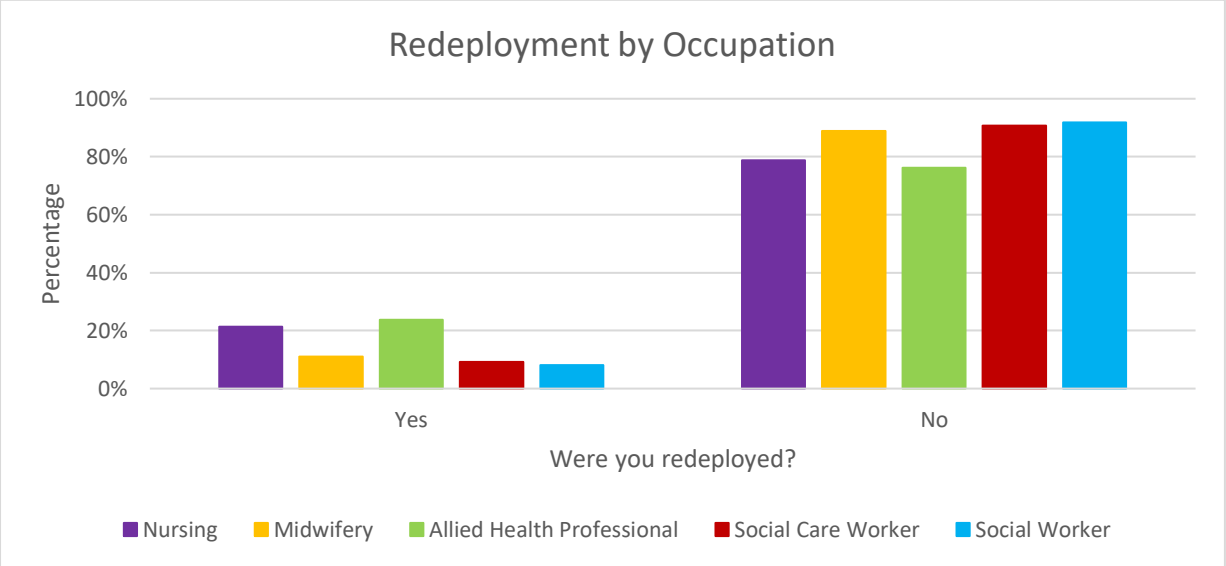


Table A2.45: Redeployment by Occupation (Weighted)

Occupation	Were you redeployed?		Total
	Yes	No	
Nursing	21.2%	78.8%	**100%**
Midwifery	11.5%	88.5%	**100%**
AHP	21.9%	78.1%	**100%**
Social Care Worker	8.7%	91.3%	**100%**
Social Worker	5.9%	94.1%	**100%**

Table A2.46: Redeployment by Occupation (Unweighted)

Occupation	Were you redeployed?		Total
	Yes	No	
Nursing	120 (21.3%)	444 (78.7%)	**564 (100%)**
Midwifery	19 (11.1%)	152 (88.9%)	**171 (100%)**
AHP	89 (23.8%)	285 (76.2%)	**374 (100%)**
Social Care Worker	77 (9.2%)	763 (90.8%)	**840 (100%)**
Social Worker	61 (8.1%)	691 (91.9%)	**752 (100%)**

A2.12 Preparedness of Redeployed Respondents

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

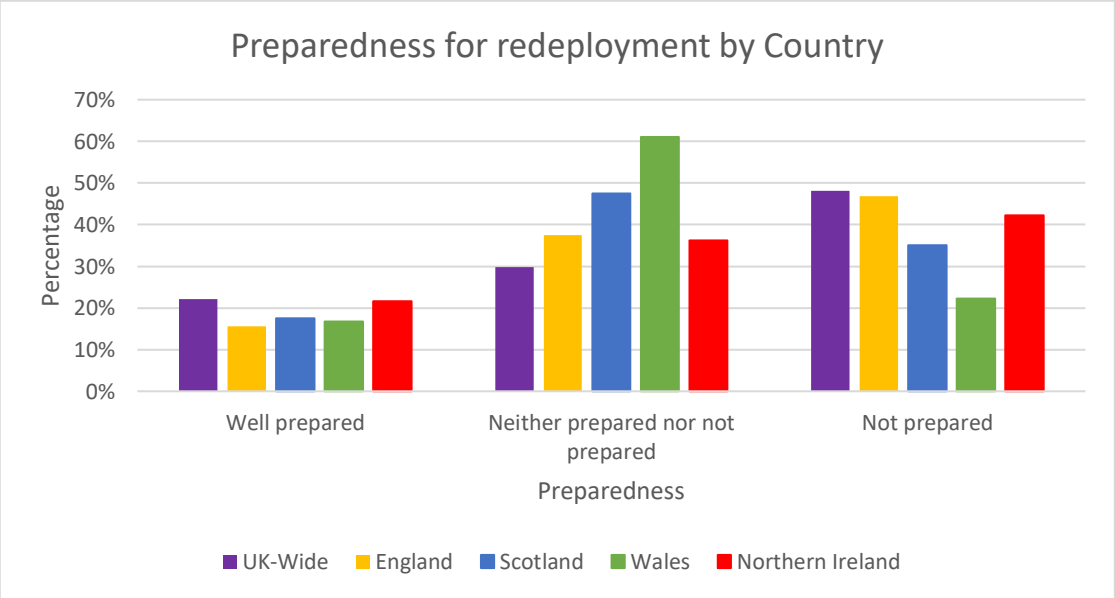


Figure A2.47: Preparedness for Redeployment by Country (Unweighted)

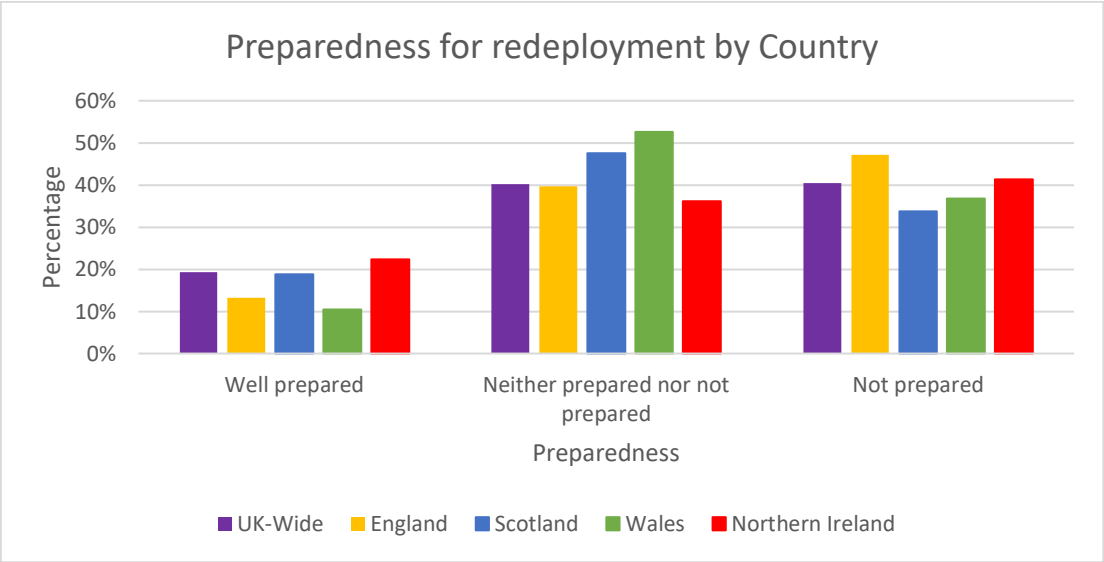


Table A2.47: Preparedness for Redeployment by Country (Weighted)

Preparedness for redeployment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	22.1%	15.6%	17.5%	16.7%	21.6%
Neither prepared nor not prepared	29.8%	37.5%	47.5%	61.1%	36.2%
Not prepared	48.1%	46.9%	35.0%	22.2%	42.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.48: Preparedness for Redeployment by Country (Unweighted)

Preparedness for redeployment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	70 (19.3%)	9 (13.2%)	15 (18.8%)	2 (10.5%)	44 (22.4%)
Neither prepared nor not prepared	146 (40.2%)	27 (39.7%)	38 (47.5%)	10 (52.6%)	71 (36.2%)
Not prepared	147 (40.5%)	32 (47.1%)	27 (33.8%)	7 (36.8%)	81 (41.3%)
Total	**363 (100%)**	**68 (100%)**	**80 (100%)**	**19 (100%)**	**196 (100%)**

Figure A2.48: Preparedness for Redeployment by Occupation (Weighted)

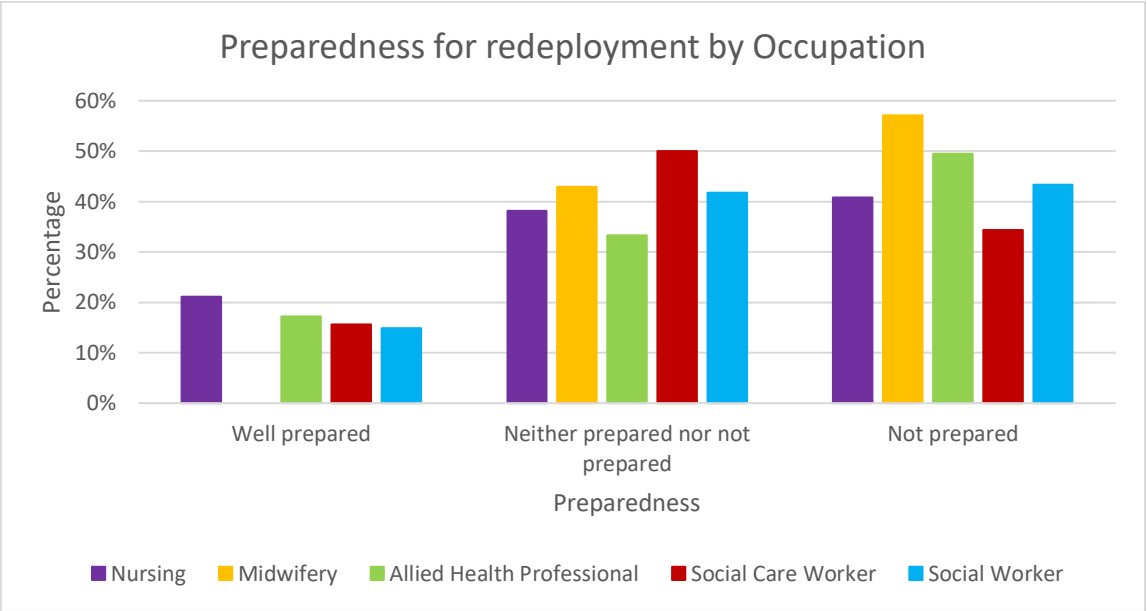


Figure A2.49: Preparedness for Redeployment by Occupation (Unweighted)

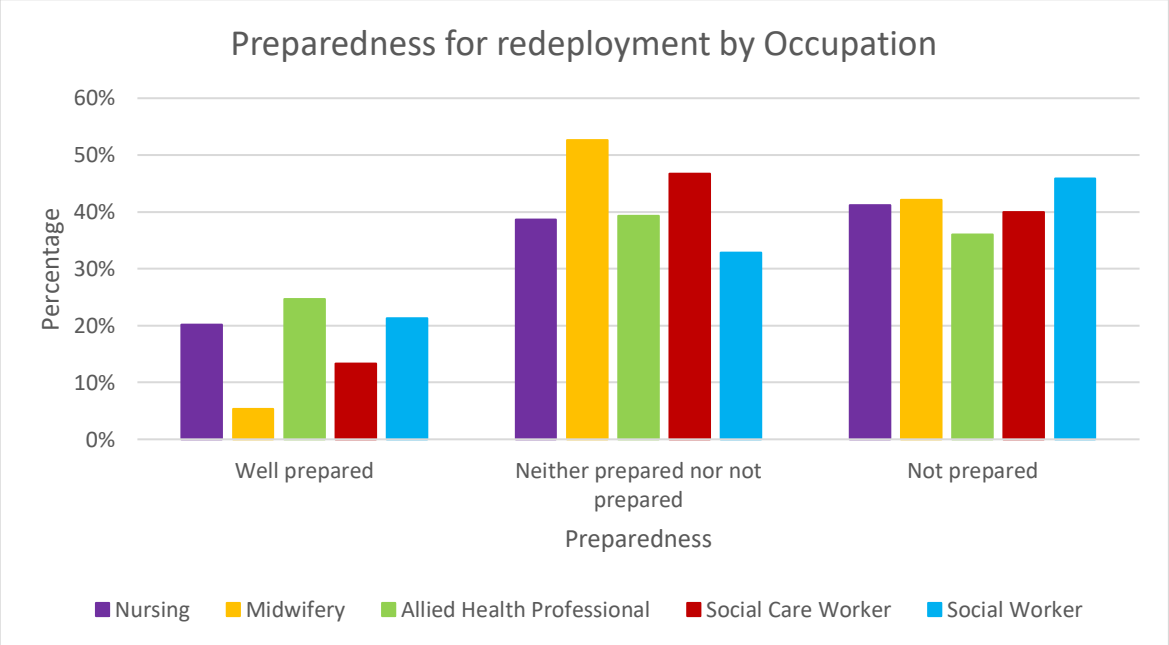


Table A2.49: Preparedness for Redeployment by Occupation (Weighted)

Occupation	Preparedness for redeployment			Total
	Well prepared	Neither prepared nor not prepared	Not prepared	
Nursing	21.1%	38.2%	40.8%	**100%**
Midwifery	0.0%	42.9%	57.1%	**100%**
AHP	17.2%	33.3%	49.5%	**100%**
Social Care Worker	15.6%	50.0%	34.4%	**100%**
Social Worker	14.9%	41.8%	43.3%	**100%**

Table A2. 50: Preparedness for Redeployment by Occupation (Unweighted)

Occupation	Preparedness for redeployment			Total
	Well prepared	Neither prepared nor not prepared	Not prepared	
Nursing	24 (20.2%)	46 (38.7%)	49 (41.2%)	**119 (100%)**
Midwifery	1 (5.3%)	10 (52.6%)	8 (42.1%)	**19 (100%)**
AHP	22 (24.7%)	35 (39.3%)	32 (36.0%)	**89 (100%)**
Social Care Worker	10 (13.3%)	35 (46.7%)	30 (40.0%)	**75 (100%)**
Social Worker	13 (21.3%)	20 (32.8%)	28 (45.9%)	**61 (100%)**

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

Summary (Weighted results):

UK-wide, only 3.1% of respondents came out of retirement to support the workforce during the COVID-19 pandemic, and these were either nurses or social workers.

Summary (Unweighted results):

UK-wide, only 1.5% of respondents came out of retirement to support the workforce during the COVID-19 pandemic.

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

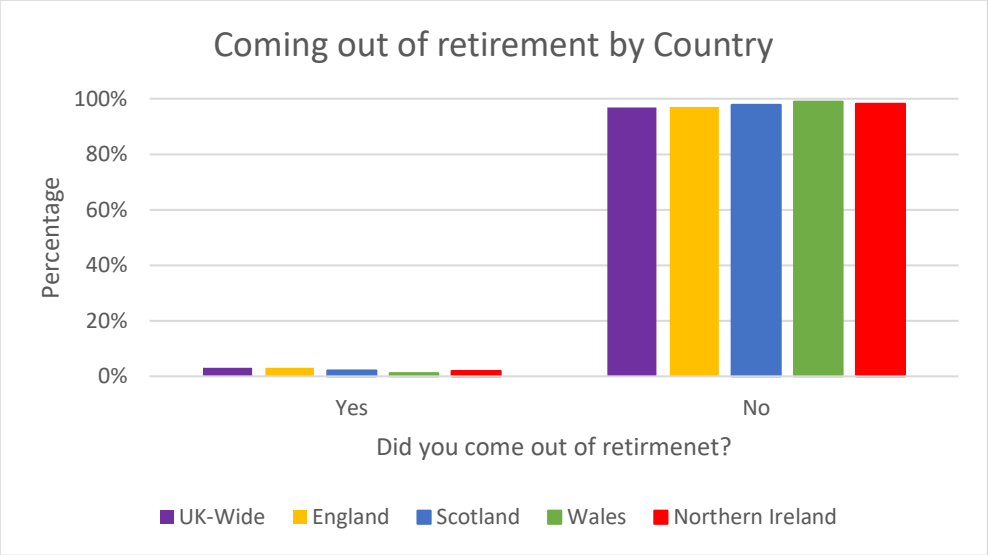


Figure A2.51: Coming out of Retirement to Support the Workforce by Country (Unweighted)

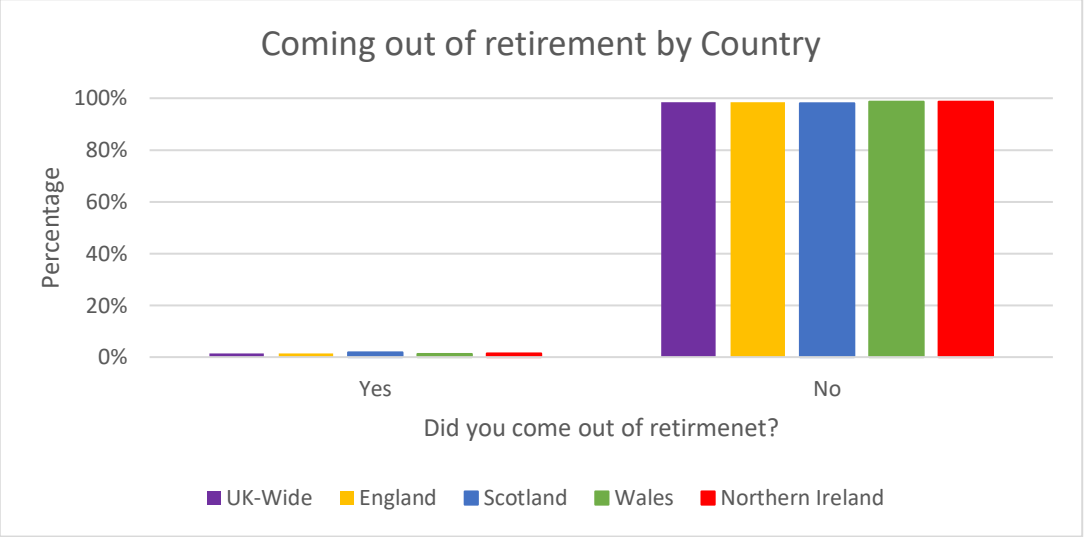


Table A2.51: Coming out of Retirement to Support the Workforce by Country (Weighted)

Did you come out of retirement?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	3.1%	3.0%	2.2%	1.1%	1.9%
No	96.9%	97.0%	97.8%	98.9%	98.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.52: Coming out of Retirement to Support the Workforce by Country (Unweighted)

Did you come out of retirement?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	41 (1.5%)	8 (1.5%)	14 (1.9%)	4 (1.3%)	15 (1.4%)
No	2655 (98.5%)	527 (98.5%)	720 (98.1%)	314 (98.7%)	1094 (98.6%)
Total	**2696 (100%)**	**535 (100%)**	**734 (100%)**	**318 (100%)**	**1109 (100%)**

Figure A2.52: Coming out of Retirement to Support the Workforce by Occupation (Weighted)

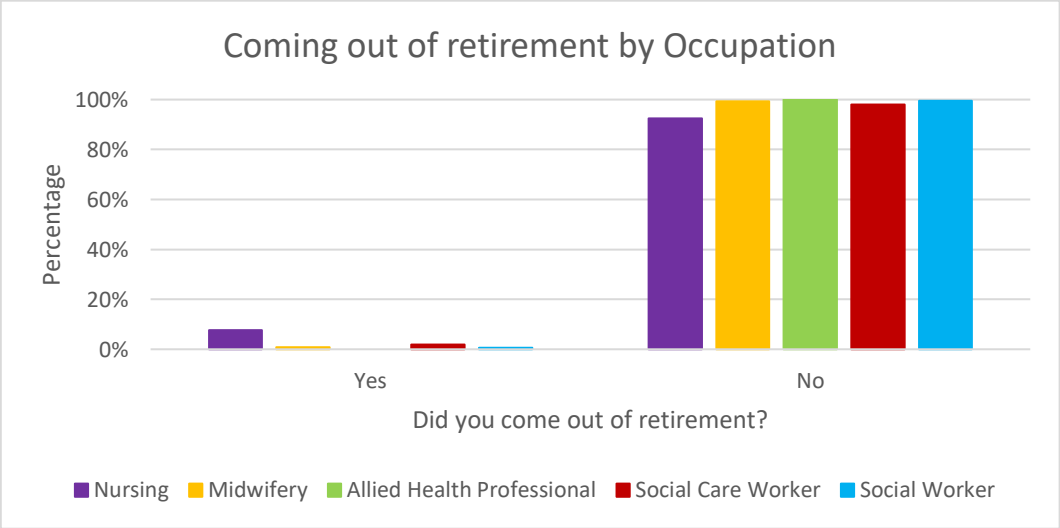


Figure A2.53: Coming out of Retirement to Support the Workforce by Occupation (Unweighted)

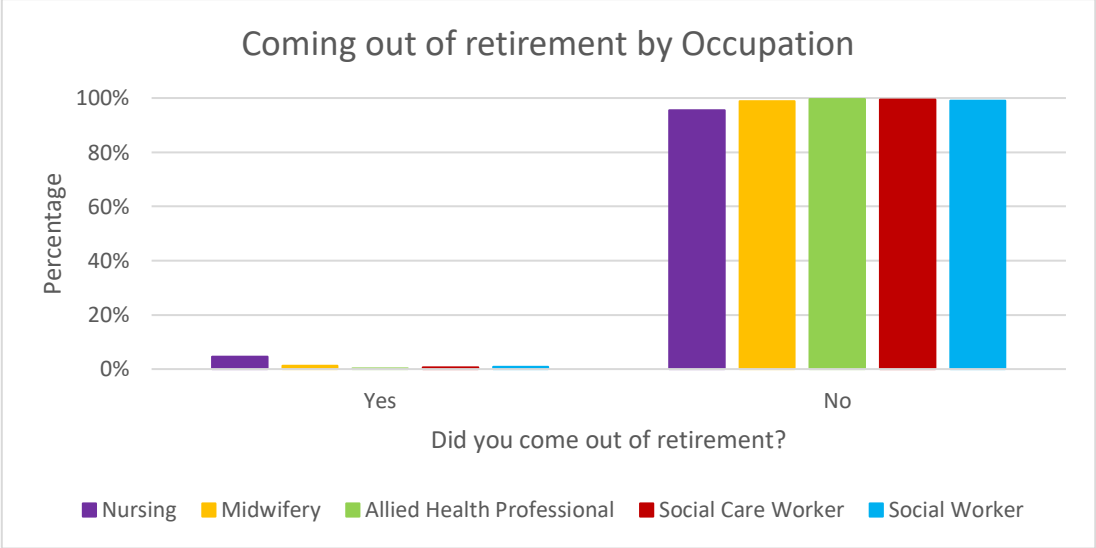


Table A2.53: Coming out of Retirement to Support the Workforce by Occupation (Weighted)

Occupation	Did you come out of retirement?		Total
	Yes	No	
Nursing	7.6%	92.4%	**100%**
Midwifery	0.8%	99.2%	**100%**
AHP	0.0%	100.0%	**100%**
Social Care Worker	1.9%	98.1%	**100%**
Social Worker	0.6%	99.4%	**100%**

Table A2.54: Coming out of Retirement to Support the Workforce by Occupation (Unweighted)

Occupation	Did you come out of retirement?		Total
	Yes	No	
Nursing	26 (4.6%)	537 (95.4%)	**563 (100%)**
Midwifery	2 (1.2%)	169 (98.8%)	**171 (100%)**
AHP	1 (0.3%)	372 (99.7%)	**373 (100%)**
Social Care Worker	5 (0.6%)	833 (99.4%)	**838 (100%)**
Social Worker	7 (0.9%)	744 (99.1%)	**751 (100%)**

A2.14 Job Tenure of Respondents

Summary (Weighted results):

The majority of respondents were employed on a permanent basis.

Summary (Unweighted results):

The majority of respondents were employed on a permanent basis.

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

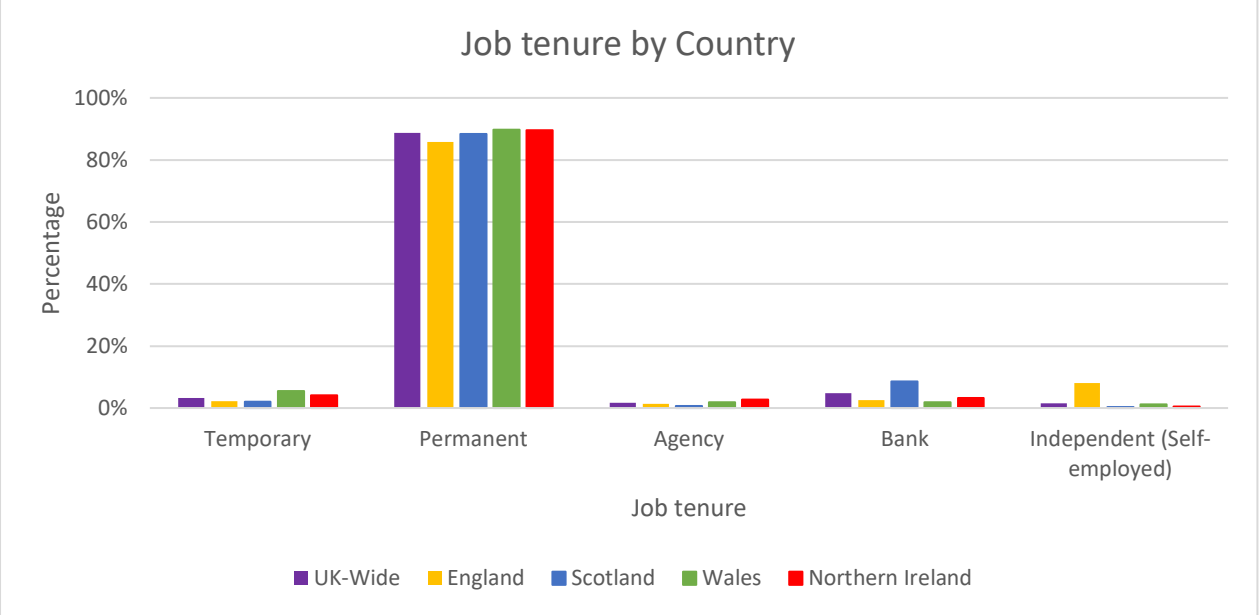


Figure A2. 55: Job Tenure by Country (Unweighted)

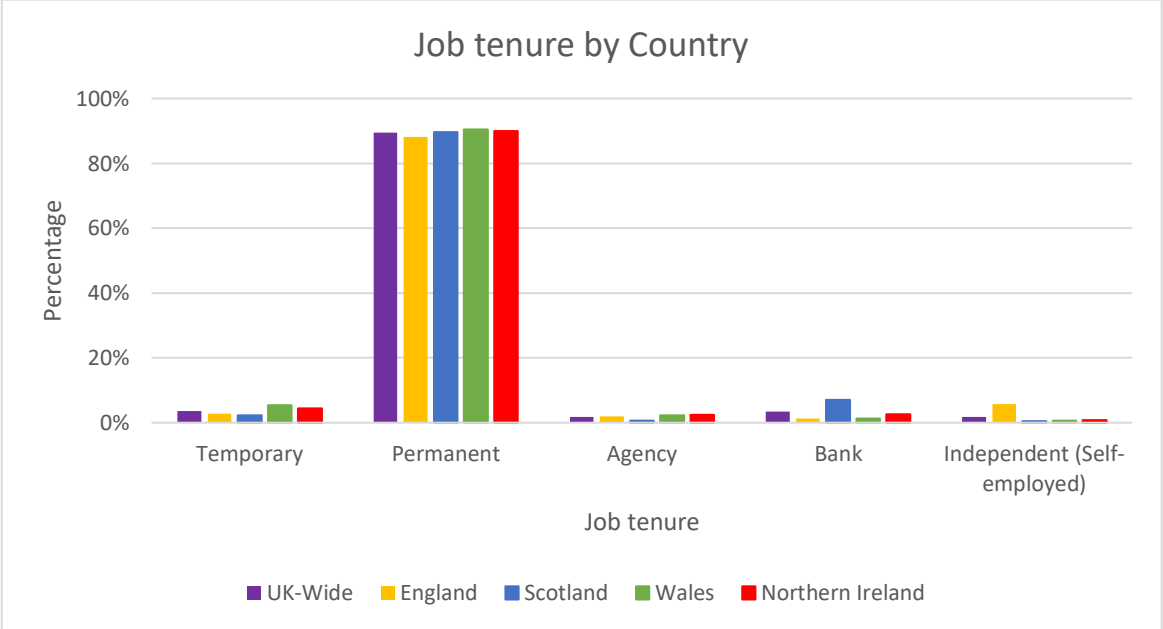


Table A2.55: Job Tenure by Country (Weighted)

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary	3.3%	2.2%	2.1%	5.5%	4.1%
Permanent	88.7%	85.8%	88.3%	89.7%	89.6%
Agency	1.7%	1.4%	0.6%	1.8%	2.7%
Bank	4.8%	2.5%	8.6%	1.8%	3.2%
Independent (Self-employed)	1.5%	8.1%	0.3%	1.1%	0.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.56: Job Tenure by Country (Unweighted)

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary	96 (3.6%)	15 (2.8%)	16 (2.2%)	17 (5.4%)	48 (4.4%)
Permanent	2395 (89.5%)	468 (88.1%)	655 (89.6%)	286 (90.5%)	986 (89.9%)
Agency	48 (1.8%)	10 (1.9%)	5 (0.7%)	7 (2.2%)	26 (2.4%)
Bank	91 (3.4%)	7 (1.3%)	52 (7.1%)	4 (1.3%)	28 (2.6%)
Independent (Self-employed)	45 (1.7%)	31 (5.8%)	3 (0.4%)	2 (0.6%)	9 (0.8%)
Total	**2675 (100%)**	**531 (100%)**	**731 (100%)**	**316 (100%)**	**1097 (100%)**

Figure A2.56: Job Tenure by Occupation (Weighted)

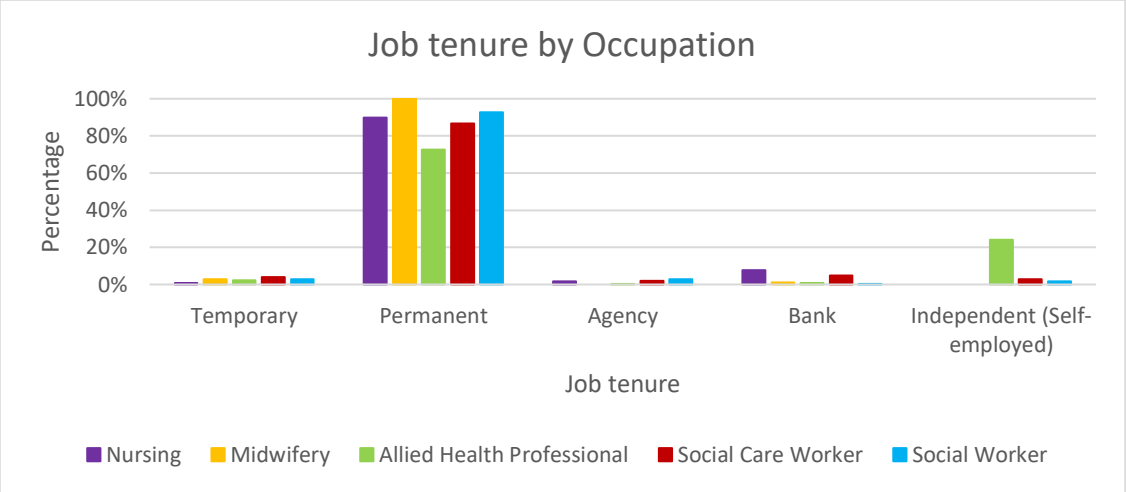


Figure A2.57: Job Tenure by Occupation (Unweighted)

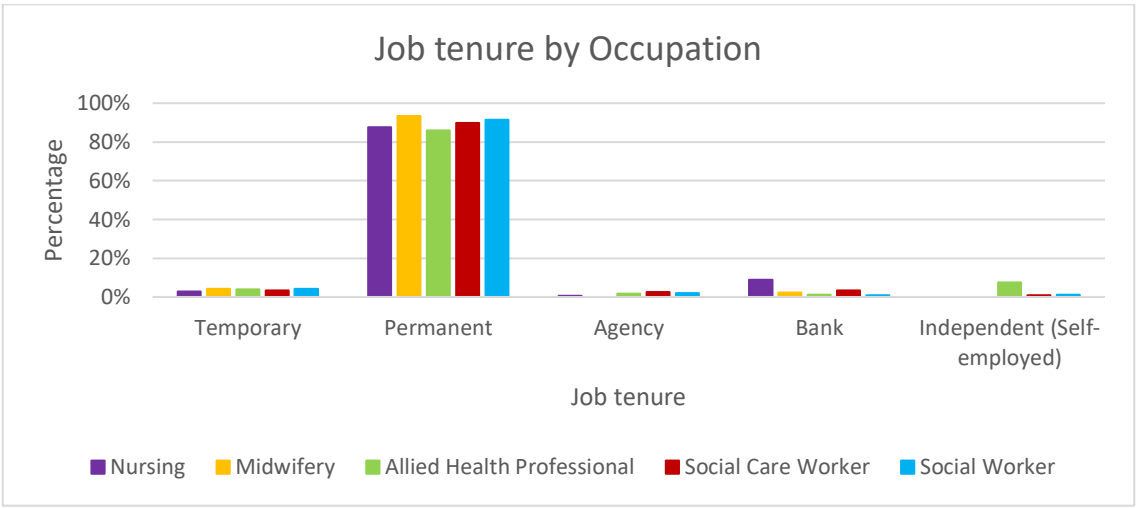


Table A2.57: Job Tenure by Occupation (Weighted)

Occupation	Job tenure					Total
	Temporary	Permanent	Agency	Bank	Independent (Self-employed)	
Nursing	0.8%	89.9%	1.6%	7.7%	0.0%	**100%**
Midwifery	2.8%	961.0%	0.0%	1.1%	0.0%	**100%**
AHP	2.2%	72.7%	0.2%	0.9%	24.0%	**100%**
Social Care Worker	4.0%	86.6%	1.9%	4.8%	2.7%	**100%**
Social Worker	2.7%	92.8%	2.7%	0.1%	1.6%	**100%**

Table A2.58: Job Tenure by Occupation (Unweighted)

Occupation	Job tenure					Total
	Temporary	Permanent	Agency	Bank	Independent (Self-employed)	
Nursing	16 (2.9%	487 (87.6%)	4 (0.7%)	49 (8.8%)	0 (0.0%)	**354 (100%)**
Midwifery	7 (4.1%)	158 (93.5%)	0 (0.0%)	4 (2.4%)	0 (0.0%)	**75 (100%)**
AHP	14 (3.8%)	317 (85.9%)	6 (1.6%)	4 (1.1%)	28 (7.6%)	**628 (100%)**
Social Care Worker	28 (3.4%)	749 (89.8%)	22 (2.6%)	28 (3.4%)	7 (0.8%)	**1239 (100%)**
Social Worker	31 (4.1%)	684 (91.6%)	16 (2.1%)	6 (0.8%)	10 (1.3%)	**1150 (100%)**

A2.15 Respondents' Years of Experience

Summary (Weighted results):

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

Summary (Unweighted results):

Almost one third of respondents UK-wide (27.0%) reported having between 11-20 years of work experience. The highest proportion of these were in England. Of those with more than 30 years of experience, the majority were nurses and midwives.

Figure A2 58: Years of Experience by Country (Weighted)

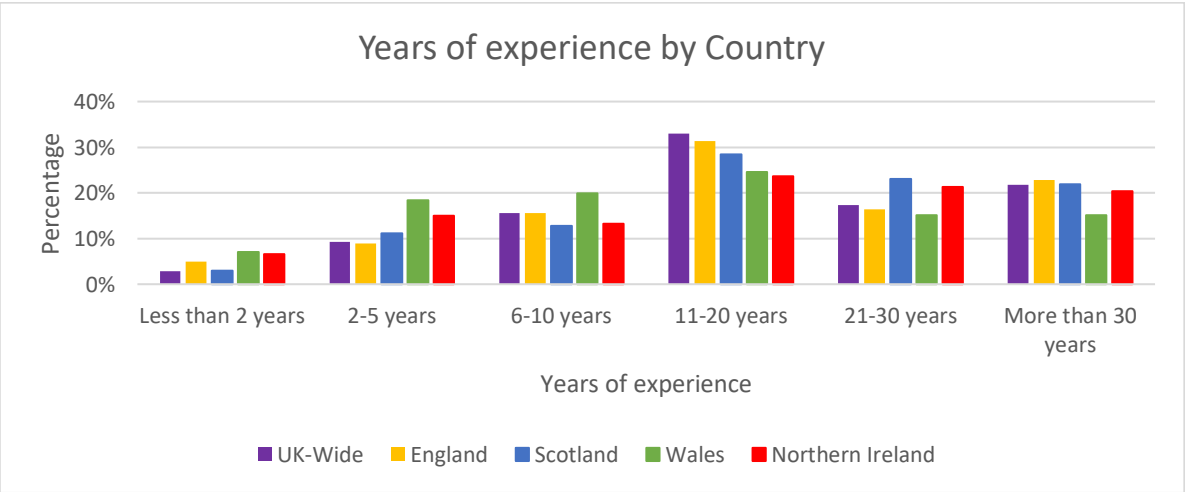


Figure A2.59: Years of Experience by Country (Unweighted)

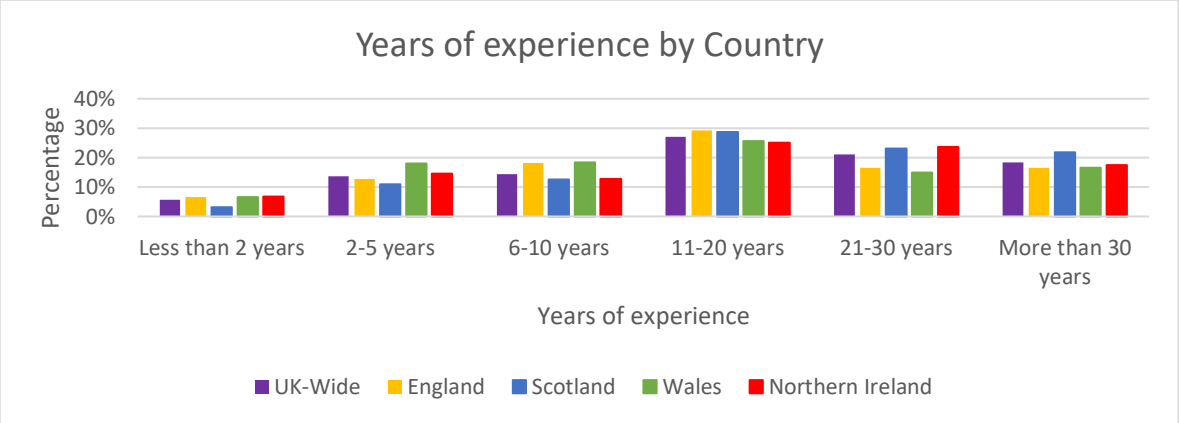


Table A2.59: Years of Experience by Country (Weighted)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	2.9%	5.0%	3.0%	7.0%	6.6%
2-5 years	9.3%	8.9%	11.1%	18.4%	15.0%
6-10 years	15.6%	15.6%	12.8%	19.9%	13.2%
11-20 years	33.0%	31.4%	28.4%	24.6%	23.6%
21-30 years	17.3%	16.4%	23.0%	15.1%	21.3%
More than 30 years	21.8%	22.8%	21.9%	15.1%	20.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.60: Years of Experience by Country (Unweighted)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	152 (5.7%)	35 (6.6%)	23 (3.2%)	21 (6.6%)	(6.7%)
2-5 years	364 (13.6%)	68 (12.8%)	80 (11.0%)	57 (18.0%)	(14.5%)
6-10 years	386 (14.4%)	97 (18.2%)	91 (12.5%)	58 (18.4%)	(12.8%)
11-20 years	721 (27.0%)	156 (29.3%)	209 (28.6%)	81 (25.6%)	(25.1%)
21-30 years	562 (21.0%)	88 (16.5%)	168 (23.0%)	47 (14.9%)	(23.6%)
More than 30 years	490 (18.3%)	88 (16.5%)	159 (21.8%)	52 (16.5%)	(17.4%)
Total	**2675 (100%)**	**532 (100%)**	**730 (100%)**	**316 (100%)**	**1097 (100%)**

Figure A2.60: Years of Experience by Occupation (Weighted)

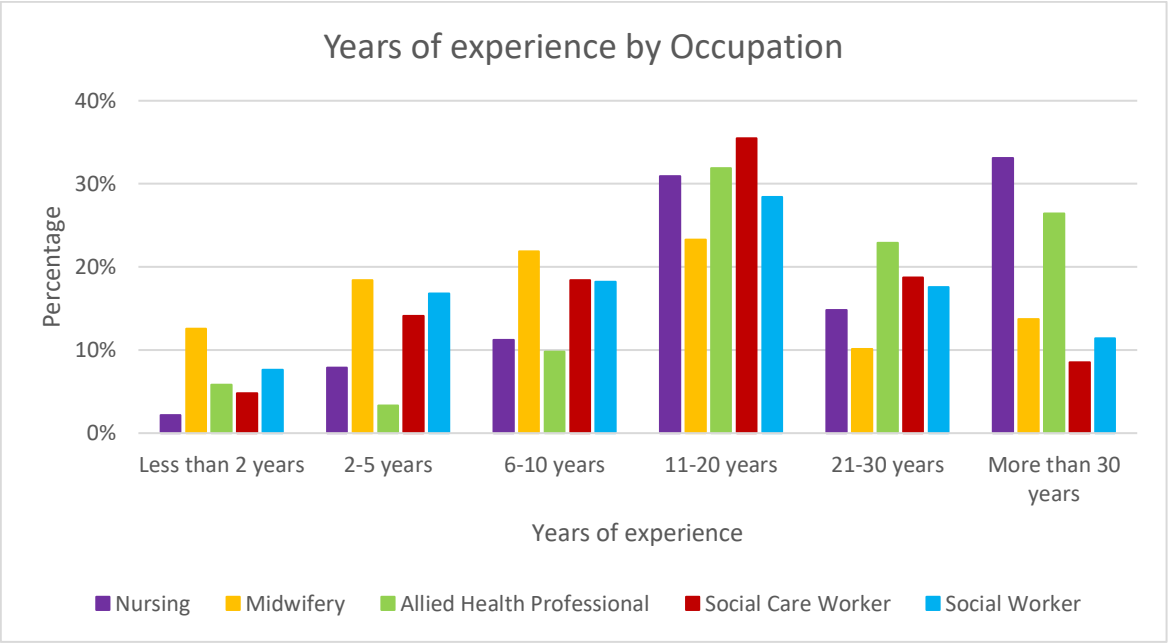


Figure A2.61: Years of Experience by Occupation (Unweighted)

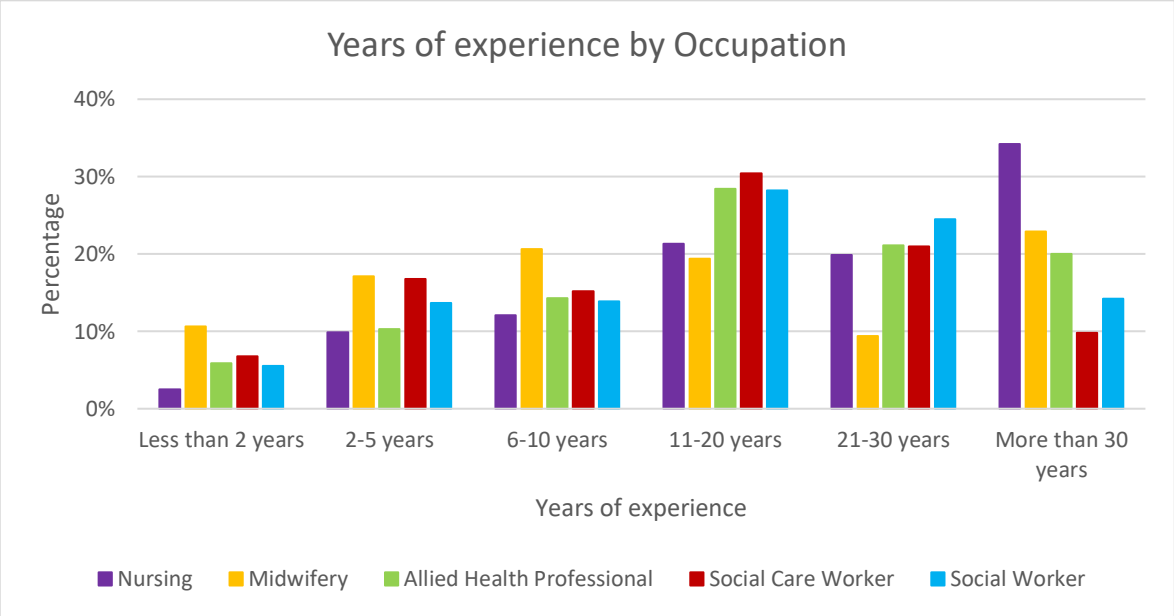


Table A2.61: Years of Experience by Occupation (Weighted)

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	2.2%	7.9%	11.2%	30.9%	14.8%	33.1%	**100%**
Midwifery	12.6%	18.4%	21.9%	23.3%	10.1%	13.7%	**100%**
AHP	5.8%	3.3%	9.8%	31.9%	22.9%	26.4%	**100%**
Social Care Worker	4.8%	14.1%	18.4%	35.5%	18.7%	8.5%	**100%**
Social Worker	7.6%	16.8%	18.2%	28.4%	17.6%	11.4%	**100%**

Table A2.62: 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	14 (2.5%)	55 (9.9%)	67 (12.1%)	118 (21.3%)	110 (19.9%)	199 (34.2%)	**553 (100%)**
Midwifery	18 (10.6%)	29 (17.1%)	35 (20.6%)	33 (19.4%)	16 (9.4%)	39 (22.9%)	**170 (100%)**
AHP	22 (5.9%)	38 (10.3%)	53 (14.3%)	105 (28.4%)	(78 21.1%)	74 (20.0%)	**370 (100%)**
Social Care Worker	57 (6.8%)	140 (16.8%)	127 (15.2%)	254 (30.4%)	175 (21.0%)	82 (9.8%)	**835 (100%)**
Social Worker	41 (5.5%)	102 (13.7%)	104 (13.9%)	211 (28.2%)	183 (24.5%)	106 (14.2%)	**747 (100%)**

A2.16 Respondents' Main Area of Practice

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

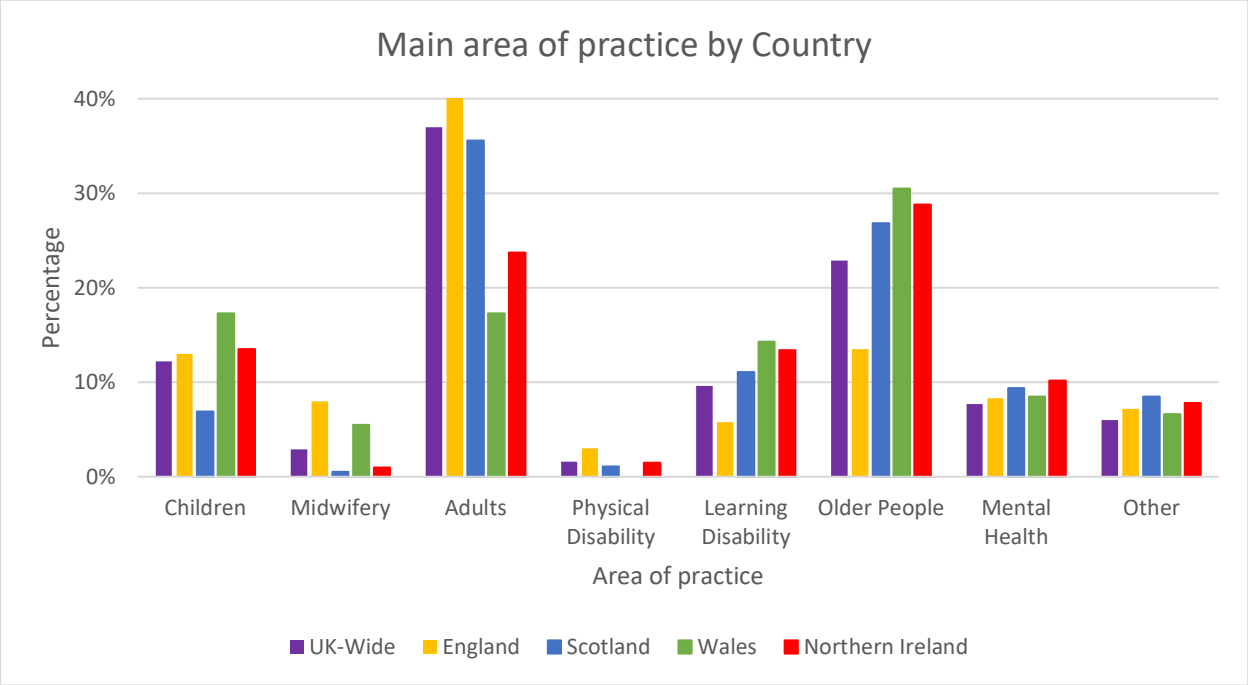


Figure A2.63: Main Area of Practice by Country (Unweighted)

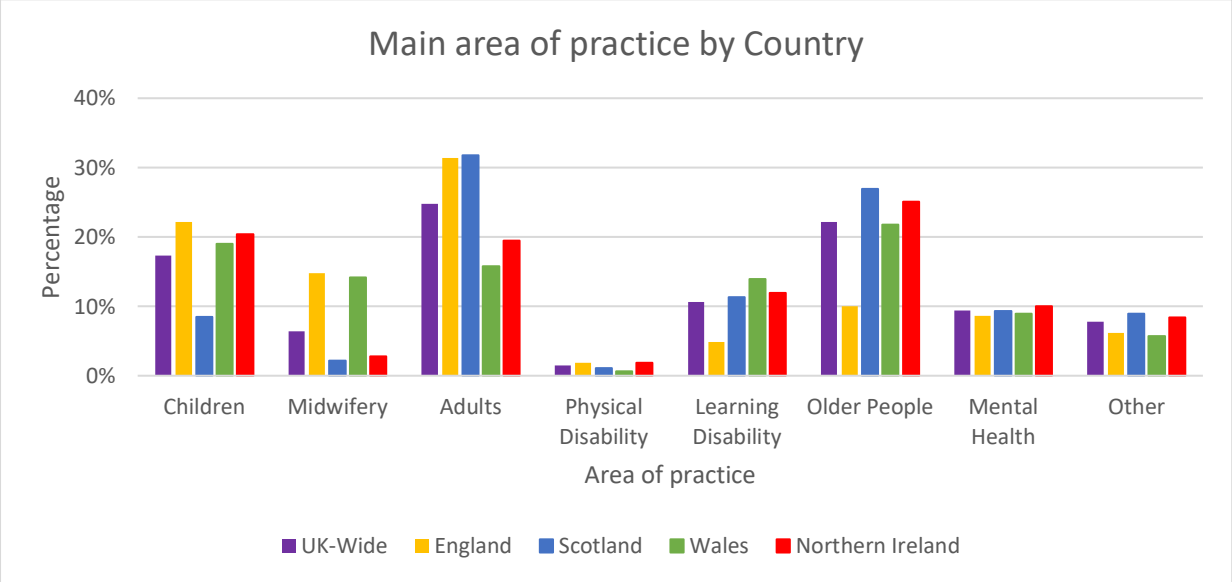


Table A2.63: Main Area of Practice by Country (Weighted)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	12.2%	13.0%	6.9%	17.3%	13.5%
Midwifery	2.9%	8.0%	0.5%	5.5%	1.0%
Adults	37.0%	41.2%	35.6%	17.3%	23.7%
Physical Disability	1.6%	3.0%	1.1%	0.0%	1.5%
Learning Disability	9.6%	5.8%	11.1%	14.3%	13.4%
Older People	22.9%	13.5%	26.8%	30.5%	28.8%
Mental Health	7.7%	8.3%	9.4%	8.5%	10.2%
Other	6.0%	7.2%	8.5%	6.6%	7.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2 64: Main Area of Practice by Country (Unweighted)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	464 (17.3%)	118 (22.2%)	62 (8.5%)	60 (19.0%)	224 (20.4%)
Midwifery	171 (6.4%)	79 (14.8%)	16 (2.2%)	45 (14.2%)	31 (2.8%)
Adults	664 (24.8%)	167 (31.4%)	233 (31.8%)	50 (15.8%)	214 (19.5%)
Physical Disability	41 (1.5%)	10 (1.9%)	8 (1.1%)	2 (0.6%)	21 (1.9%)
Learning Disability	284 (10.6%)	26 (4.9%)	83 (11.3%)	44 (13.9%)	131 (11.9%)
Older People	595 (22.2%)	53 (10.0%)	197 (26.9%)	69 (21.8%)	276 (25.1%)
Mental Health	252 (9.4%)	46 (8.6%)	68 (9.3%)	28 (8.9%)	110 (10.0%)
Other	208 (7.8%)	33 (6.2%)	65 (8.9%)	16 (5.7%)	92 (8.4%)
Total	**2679 (100%)**	**748 (100%)**	**453 (100%)**	**1076 (100%)**	**1169 (100%)**

Figure A2.64: Main Area of Practice by Occupation (Weighted)

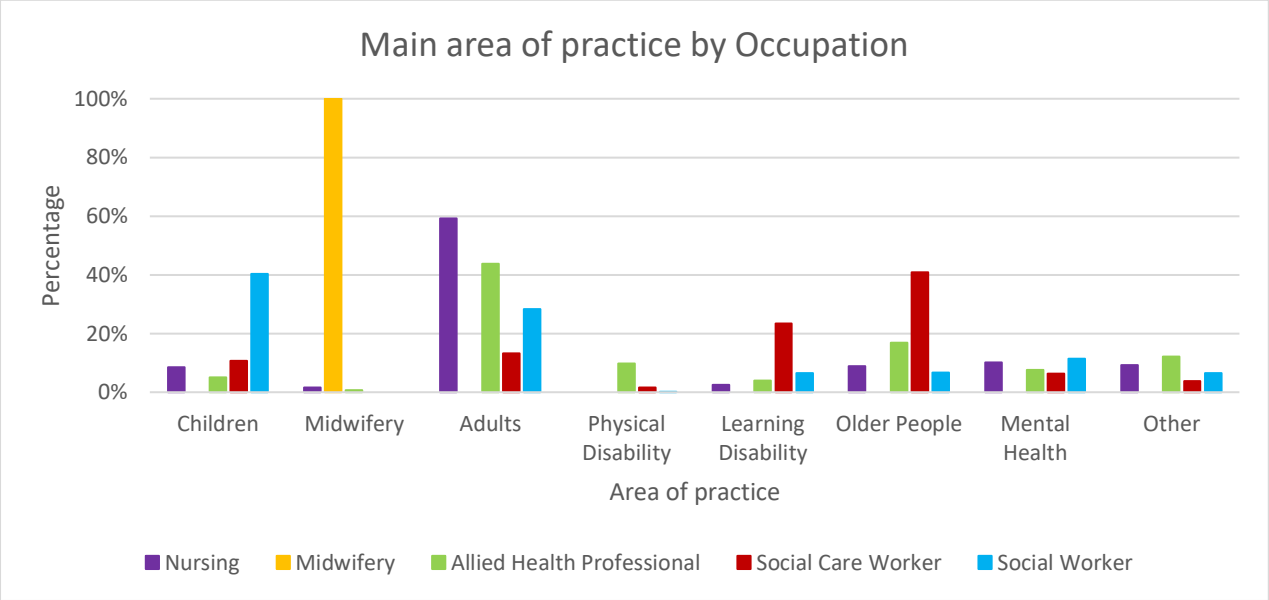


Figure A2.65: Main Area of Practice by Occupation (Unweighted)

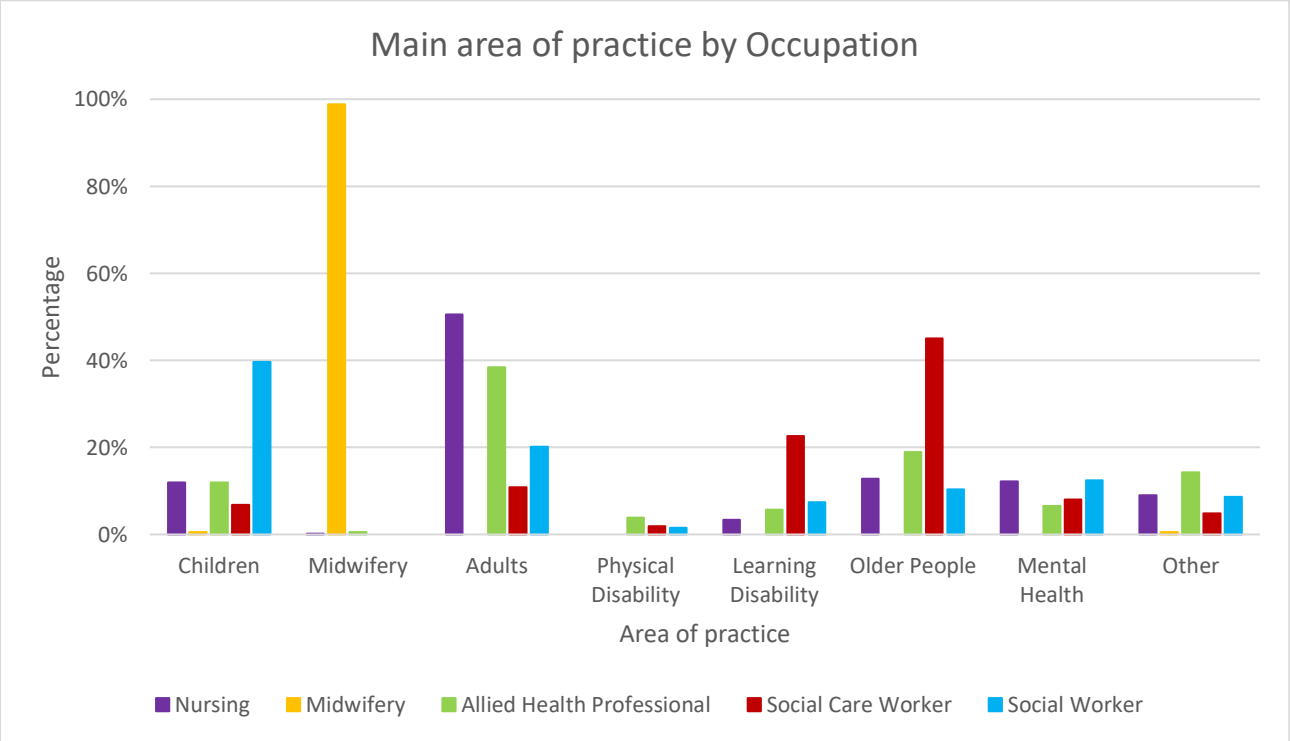


Table A2 65: Main Area of Practice by Occupation (Weighted)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	8.5%	0.0%	5.1%	10.7%	40.3%
Midwifery	1.6%	100.0%	0.7%	0.0%	0.0%
Adults	59.2%	0.0%	43.7%	13.3%	28.3%
Physical Disability	0.0%	0.0%	9.8%	1.6%	0.2%
Learning Disability	2.5%	0.0%	4.0%	23.5%	6.6%
Older People	8.8%	0.0%	16.9%	40.8%	6.7%
Mental Health	10.1%	0.0%	7.6%	6.4%	11.4%
Other	9.3%	0.0%	12.2%	3.7%	6.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.66: Main Area of Practice by Occupation (Unweighted)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	66 (11.9%)	1 (0.6%)	44 (11.9%)	57 (6.8%)	296 (39.6%)
Midwifery	1 (0.2%)	168 (98.8%)	2 (0.5%)	0 (0.0%)	0 (0.0%)
Adults	281 (50.5%)	0 (0.0%)	142 (38.4%)	90 (10.8%)	151 (20.2%)
Physical Disability	0 (0.0%)	0 (0.0%)	14 (3.8%)	16 (1.9%)	11 (1.5%)
Learning Disability	19 (3.4%)	0 (0.0%)	21 (5.7%)	189 (22.6%)	55 (7.4%)
Older People	71(12.8%)	0 (0.0%)	70 (18.9%)	376 (45.0%)	78 (10.4%)
Mental Health	68 (12.2%)	0 (0.0%)	24 (6.5%)	67 (8.0%)	93 (12.4%)
Other	50 (9.0%)	1 (0.6%)	53 (14.3%)	40 (4.8%)	64 (8.6%)
Total	**556 (100%)**	**170 (100%)**	**370 (100%)**	**835 (100%)**	**748 (100%)**

A2.17 Respondents Employed Full- or Part-Time

Summary (Weighted results):

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

Summary (Unweighted results):

The majority of respondents were employed full-time (74.9%). Scotland had the highest proportion of respondents (29.4%) employed on a part-time basis. Social workers had the highest proportion employed full-time, whereas nurses had the highest proportion employed part-time.

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

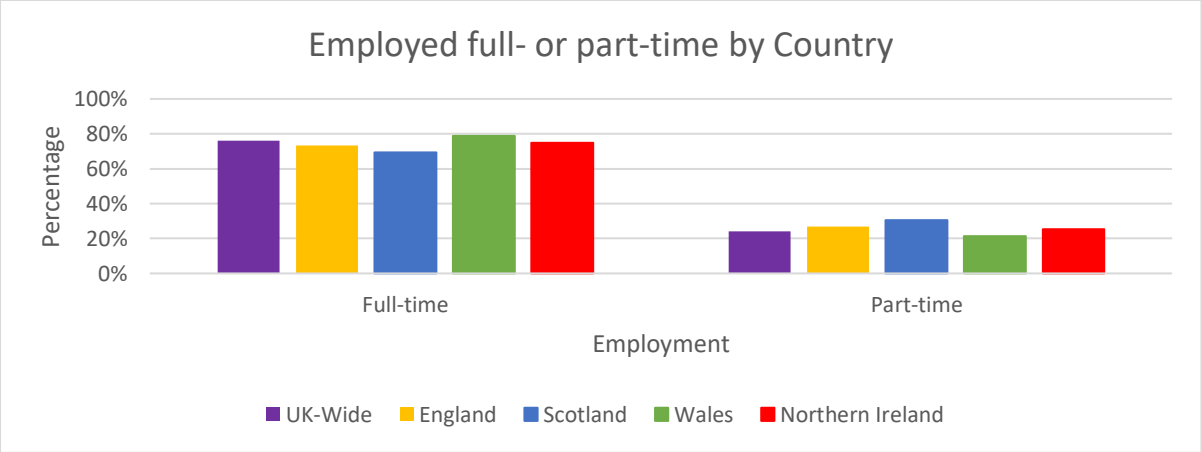


Figure A2.67: Employed Full- or Part-Time by Country (Unweighted)

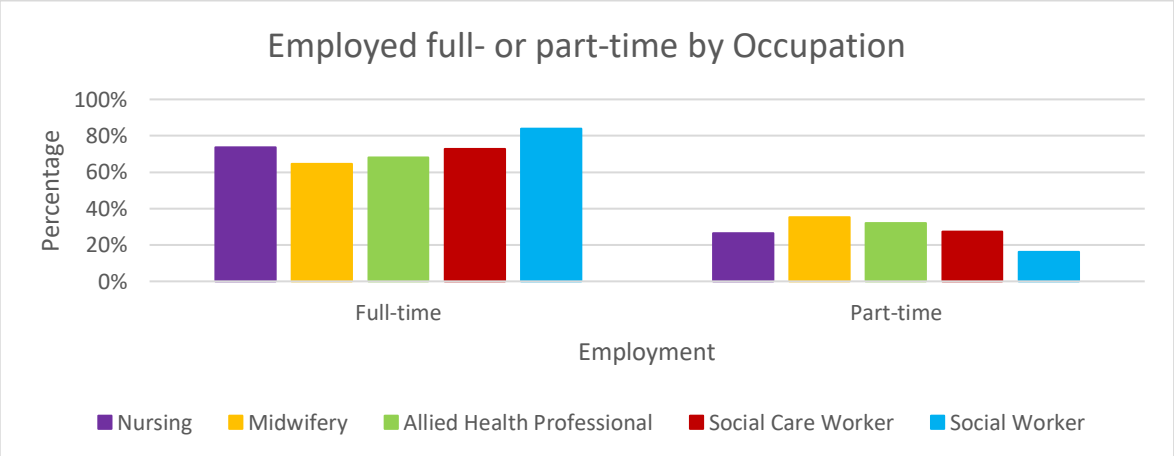


Table A2.67: Employed Full- or Part-Time by Country (Weighted)

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	76.0%	73.2%	69.4%	78.8%	74.7%
Part-time	24.0%	26.8%	30.6%	21.2%	25.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.68: Employed Full- or Part-Time by Country (Unweighted)

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	1994 (74.9%)	400 (75.8%)	514 (70.6%)	245 (78.3%)	835 (76.4%)
Part-time	668 (25.1%)	128 (24.2%)	214 (29.4%)	68 (21.7%)	258 (23.6%)
Total	**2662 (100%)**	**528 (100%)**	**728 (100%)**	**313 (100%)**	**1093 (100%)**

Figure A2.68: Employed Full- or Part-Time by Occupation (Weighted)

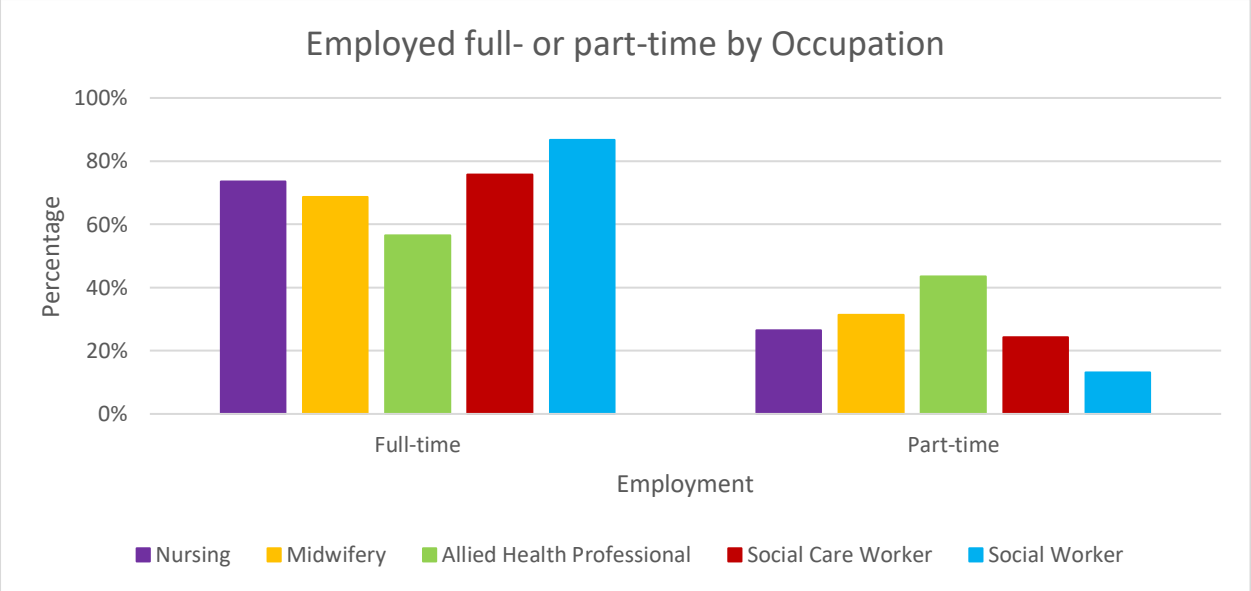


Figure A2.69: Employed Full- or Part-Time by Occupation (Unweighted)

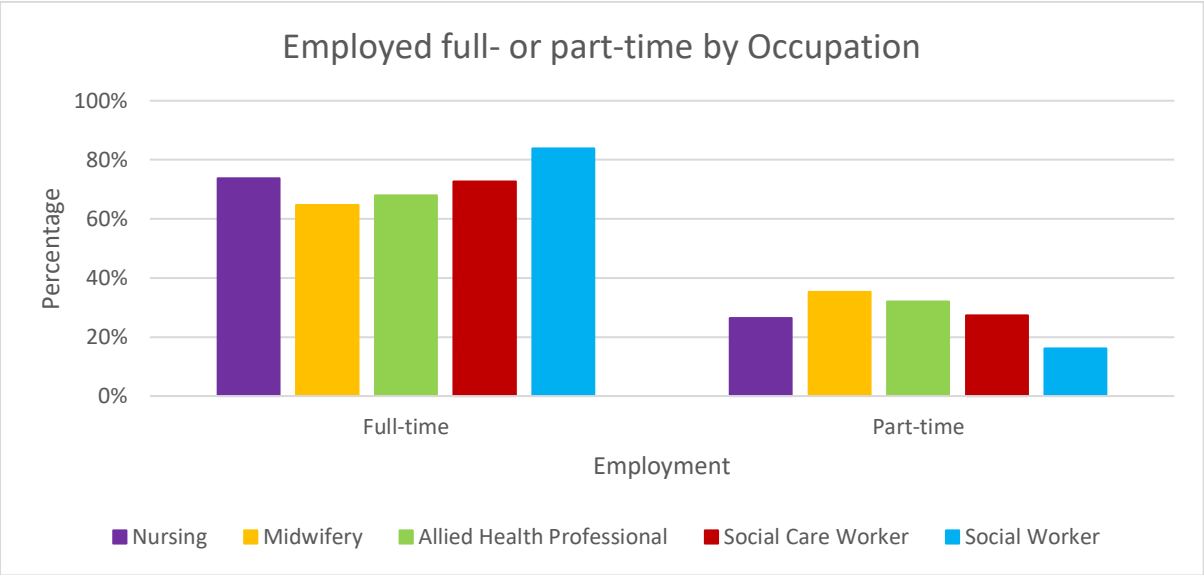


Table A2.69: Employed Full- or Part-Time by Occupation (Weighted)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	73.5%	26.5%	**100%**
Midwifery	68.7%	31.3%	**100%**
AHP	56.5%	43.5%	**100%**
Social Care Worker	75.8%	24.2%	**100%**
Social Worker	86.8%	13.2%	**100%**

Table A2.70: Employed Full- or Part-Time by Occupation (Unweighted)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	409 (73.7%)	146 (26.4%)	**555 (100%)**
Midwifery	108 (64.7%)	59 (35.3%)	**167 (100%)**
AHP	249 (68.0%)	117 (32.0%)	**366 (100%)**
Social Care Worker	602 (72.7%)	226 (27.3%)	**828 (100%)**
Social Worker	626 (83.9%)	120 (16.1%)	**746 (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 A2.70: Number of Hours Worked per Week by Country (Weighted)

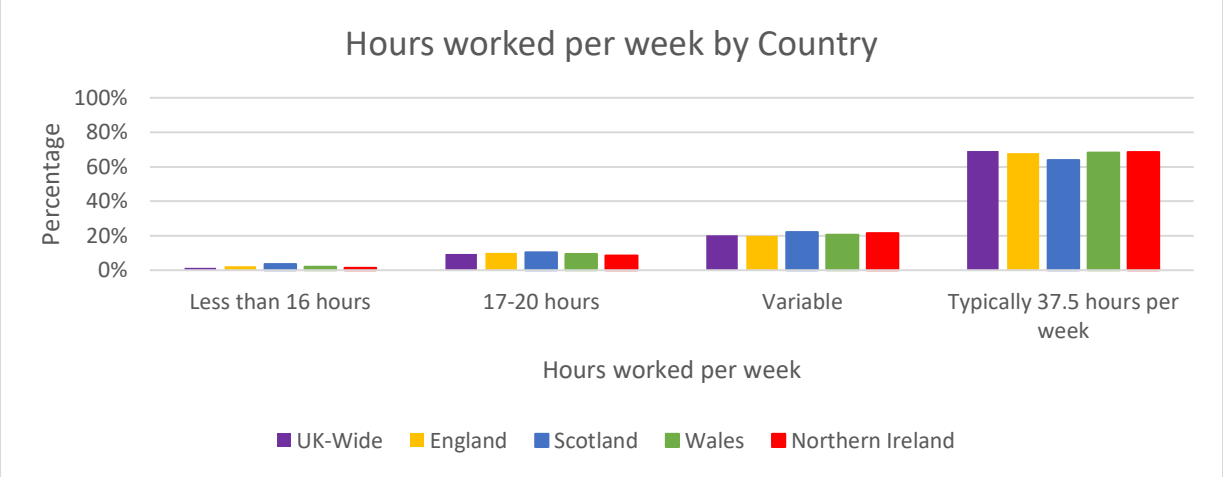


Figure A2.71: Number of Hours Worked per Week by Country (Unweighted)

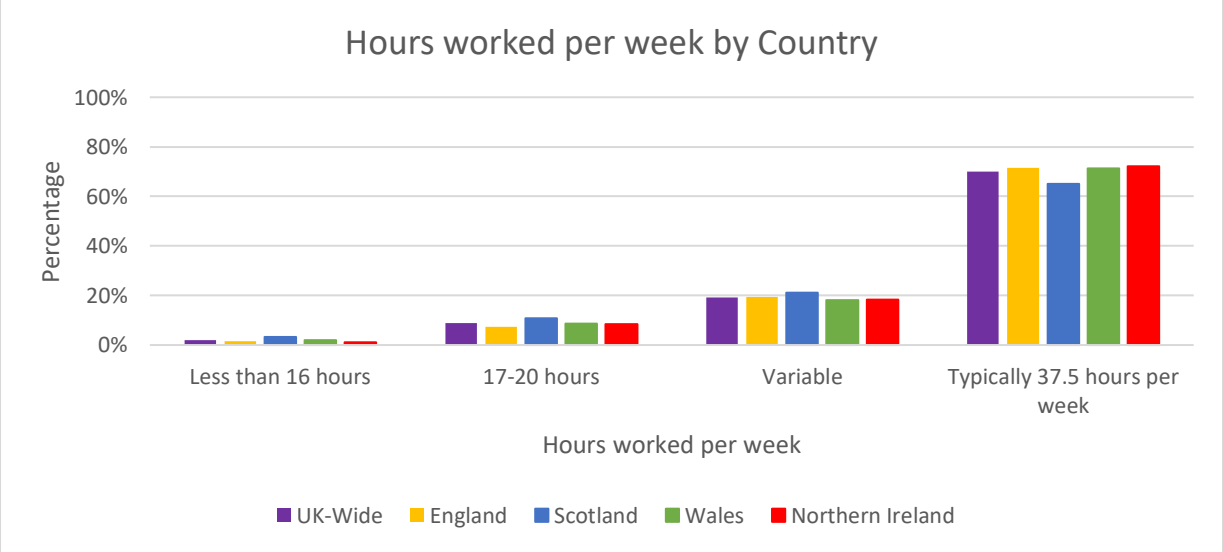


Table A2.71: Number of Hours Worked per Week by Country (Weighted)

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	1.3%	2.2%	3.6%	1.9%	1.4%
17-20 hours	9.5%	10.1%	10.3%	9.4%	8.6%
Variable	20.2%	19.8%	22.1%	20.6%	21.6%
Typically 37.5 hours per week	69.0%	67.9%	64.0%	68.2%	68.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.72: 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	49 (1.9%)	8 (1.5%)	23 (3.2%)	6 (1.9%)	12 (1.1%)
17-20 hours	234 (8.9%)	39 (7.4%)	77 (10.7%)	27 (8.7%)	91 (8.4%)
Variable	510 (19.3%)	102 (19.4%)	152 (21.1%)	56 (18.1%)	200 (18.4%)
Typically 37.5 hours per week	1850 (70.0%)	376 (71.6%)	469 (65.0%)	220 (71.2%)	785 (72.2%)
Total	**2643 (100%)**	**525 (100%)**	**721 (100%)**	**309 (100%)**	**1088 (100%)**

Figure A2.72: Number of Hours Worked per Week by Occupation (Weighted)

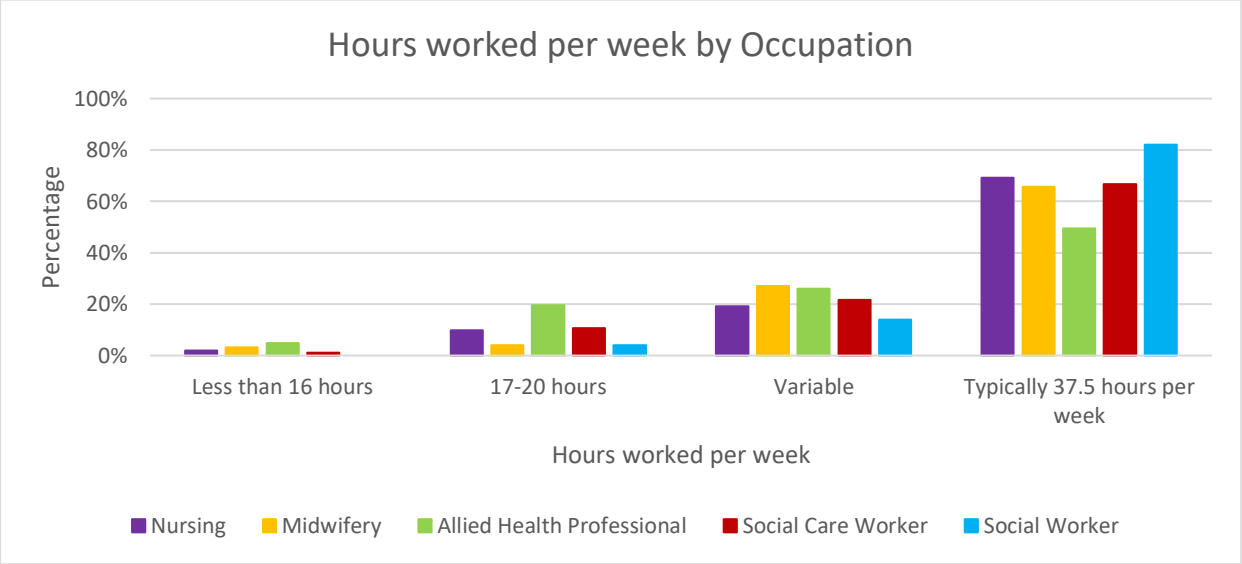


Figure A2.73: Number of Hours Worked per Week by Occupation (Unweighted)

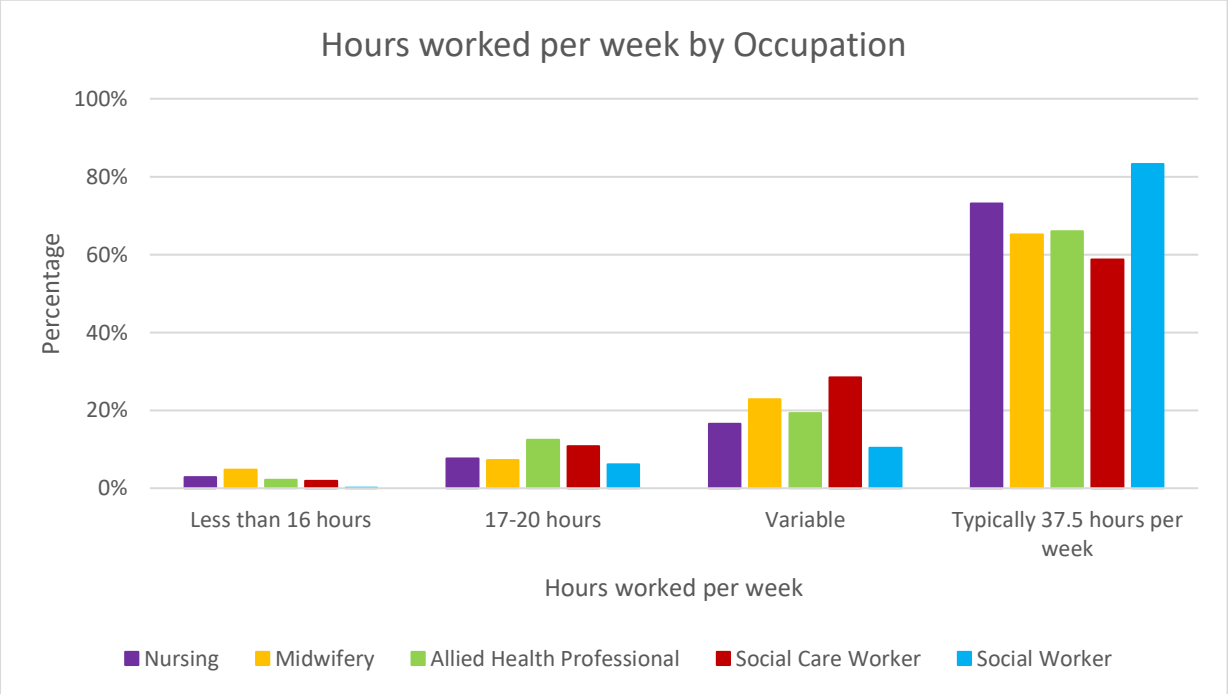


Table A2.73: Number of Hours Worked per Week by Occupation (Weighted)

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	1.9%	9.8%	19.1%	69.1%	**100%**
Midwifery	3.1%	4.0%	27.1%	65.7%	**100%**
AHP	4.8%	19.5%	26.1%	49.5%	**100%**
Social Care Worker	1.1%	10.6%	21.7%	66.7%	**100%**
Social Worker	0.0%	4.1%	13.9%	82.0%	**100%**

Table A2.74: Number of Hours Worked per Week by Occupation (Unweighted)

Occupation	How many hours of work per week do you typically do?				Total
	Less than 16 hours	17-20 hours	Variable	Typically 37.5 hours per week	
Nursing	16 (2.9%)	42 (7.6%)	91 (16.5%)	404 (73.1%)	**553 (100%)**
Midwifery	8 (4.8%)	12 (7.2%)	38 (22.9%)	108 (65.1%)	**166 (100%)**
AHP	8 (2.2%)	45 (12.4%)	70 (19.3%)	239 (66.0%)	**362 (100%)**
Social Care Worker	16 (1.9%)	89 (10.8%)	234 (28.5%)	482 (58.7%)	**821 (100%)**
Social Worker	1 (0.1%)	46 (6.2%)	77 (10.4%)	617 (83.3%)	**741 (100%)**

A2.19 Respondents Typically Working Overtime

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

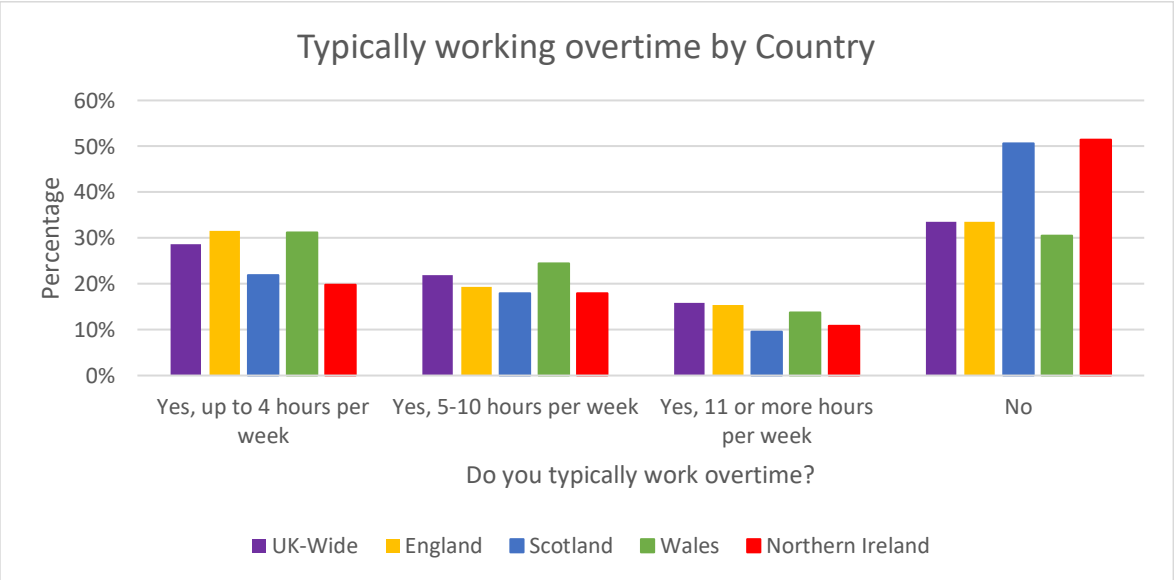


Figure A2.75: Typically Working Overtime by Country (Unweighted)

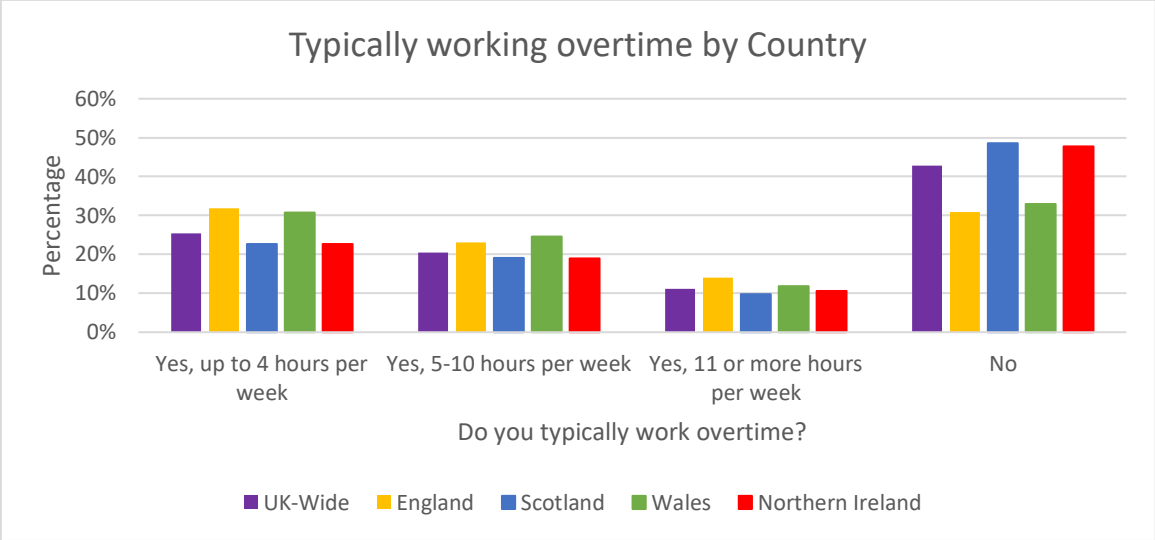


Table A2.75: Typically Working Overtime by Country (Weighted)

Do you typically work overtime?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, up to 4 hours per week	28.7%	31.6%	21.9%	31.2%	19.8%
Yes, 5-10 hours per week	21.9%	19.3%	17.9%	24.5%	17.9%
Yes, 11 or more hours per week	15.8%	15.4%	9.6%	13.8%	10.8%
No	33.5%	33.5%	50.6%	30.5%	51.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.76: 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	677 (25.4%)	168 (31.9%)	165 (22.7%)	96 (30.7%)	249 (22.7%)
Yes, 5-10 hours per week	546 (20.5%)	122 (23.1%)	139 (19.1%)	77 (24.6%)	208 (19.0%)
Yes, 11 or more hours per week	298 (11.2%)	74(14.0%)	71 (9.8%)	37 103 (11.8%)	116 (10.6%)
No	1140 (42.8%)	163 (30.9%)	353 (48.5%)	(32.9%)	521 (47.7%)
Total	**2661 (100%)**	**527 (100%)**	**728 (100%)**	**313 (100%)**	**1093 (100%)**

Figure A2.76: Typically Working Overtime by Occupation (Weighted)

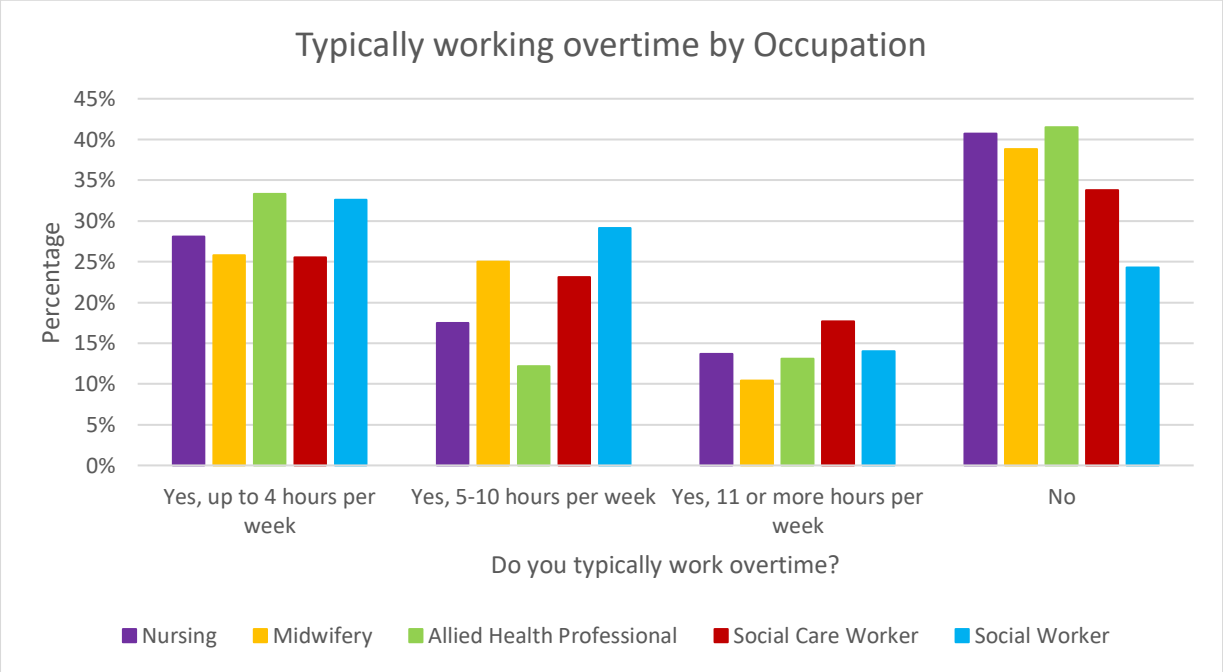


Figure A2.77: Typically Working Overtime by Occupation (Unweighted)

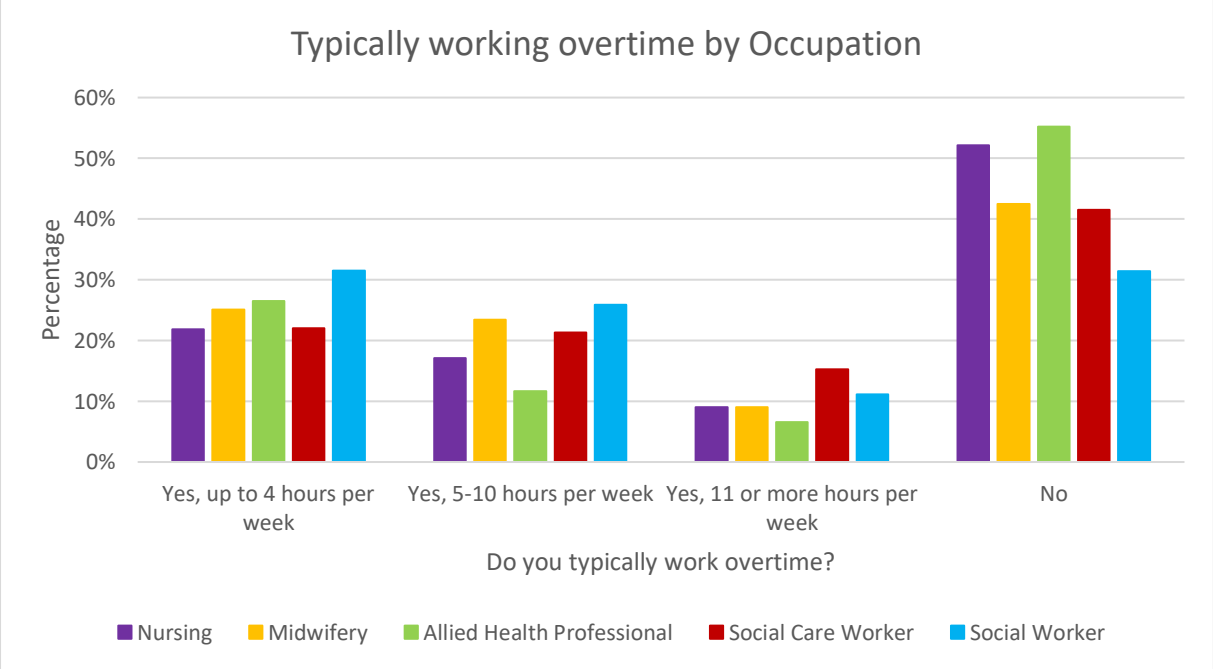


Table A2.77: Typically Working Overtime by Occupation (Weighted)

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	28.1%	17.5%	13.7%	40.7%	**100%**
Midwifery	25.8%	25.0%	10.4%	38.8%	**100%**
AHP	33.3%	12.2%	13.1%	41.5%	**100%**
Social Care Worker	25.5%	23.1%	17.7%	33.8%	**100%**
Social Worker	32.6%	29.1%	14.0%	24.3%	**100%**

Table A2.78: 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	121 (21.8%)	95 (17.1%)	50 (9.0%)	289 (52.1%)	**555 (100%)**
Midwifery	42 (25.1%)	39 (23.4%)	15 (9.0%)	71 (42.5%)	**167 (100%)**
AHP	97 (26.5%)	43 (11.7%)	24 (6.6%)	202 (55.2%)	**366 (100%)**
Social Care Worker	182 (22.0%)	176 (21.3%)	126 (15.3%)	344 (41.5%)	**828 (100%)**
Social Worker	235 (31.5%)	193 (25.9%)	83 (11.1%)	234 (31.4%)	**745 (100%)**

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

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

Summary (Weighted results):

Overall, across the countries, respondents have been working significantly 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.

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

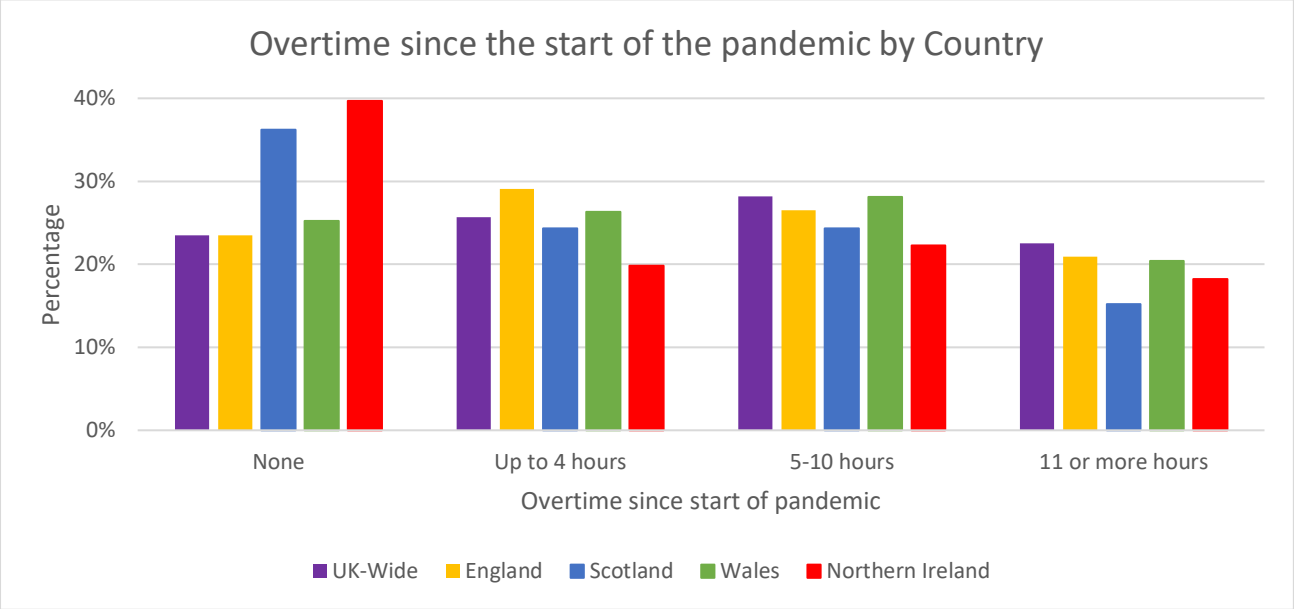


Figure A2.79: Overtime since the Start of the Pandemic by Country (Unweighted)

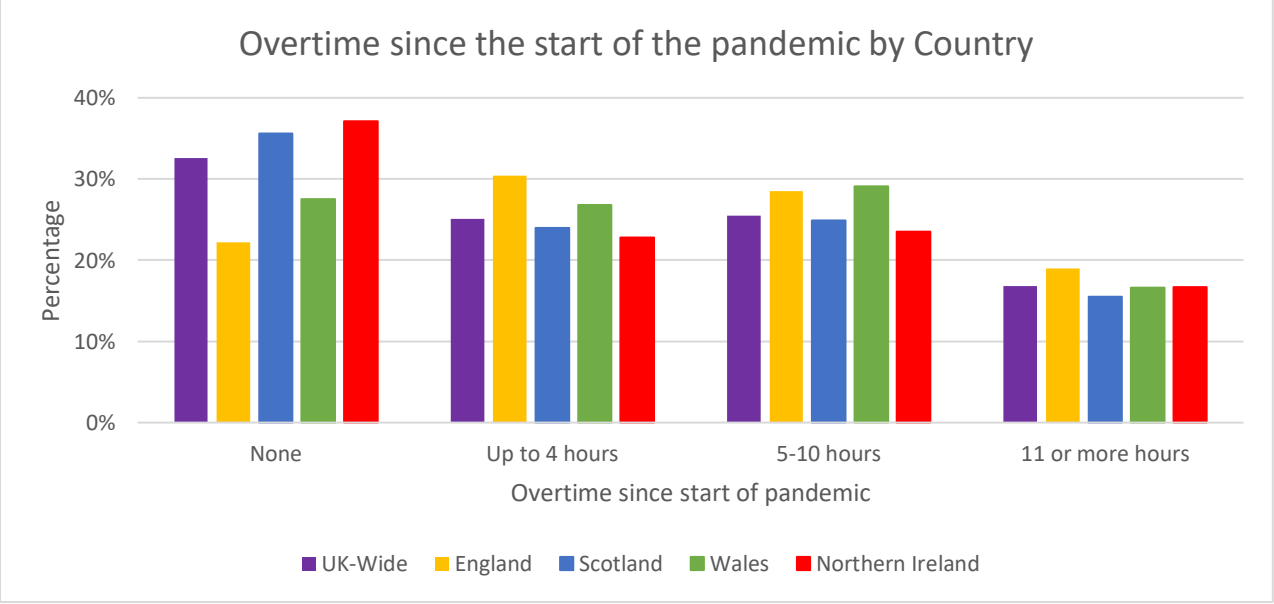


Table A2.79: Overtime since the Start of the Pandemic by Country (Weighted)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	23.5%	23.5%	36.2%	25.2%	39.7%
Up to 4 hours	25.7%	29.1%	24.3%	26.3%	19.8%
5-10 hours	28.2%	26.5%	24.3%	28.1%	22.3%
11 or more hours	22.5%	20.9%	15.2%	20.4%	18.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.80: Overtime since the Start of the Pandemic by Country (Unweighted)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	865 (32.6%)	117 (22.2%)	268 (35.6%)	86 (27.5%)	404 (37.1%)
Up to 4 hours	666 (25.1%)	160 (30.4%)	174 (24.0%)	84 (26.8%)	248 (22.8%)
5-10 hours	677 (25.5%)	150 (28.5%)	180 (24.9%)	91 (29.1%)	256 (23.5%)
11 or more hours	466 (16.8%)	100 (19.0%)	112 (15.5%)	52 (16.6%)	182 (16.7%)
Total	**2654 (100%)**	**527 (100%)**	**724 (100%)**	**313 (100%)**	**1090 (100%)**

Figure A2.80: Overtime since the Start of the Pandemic by Occupation (Weighted)

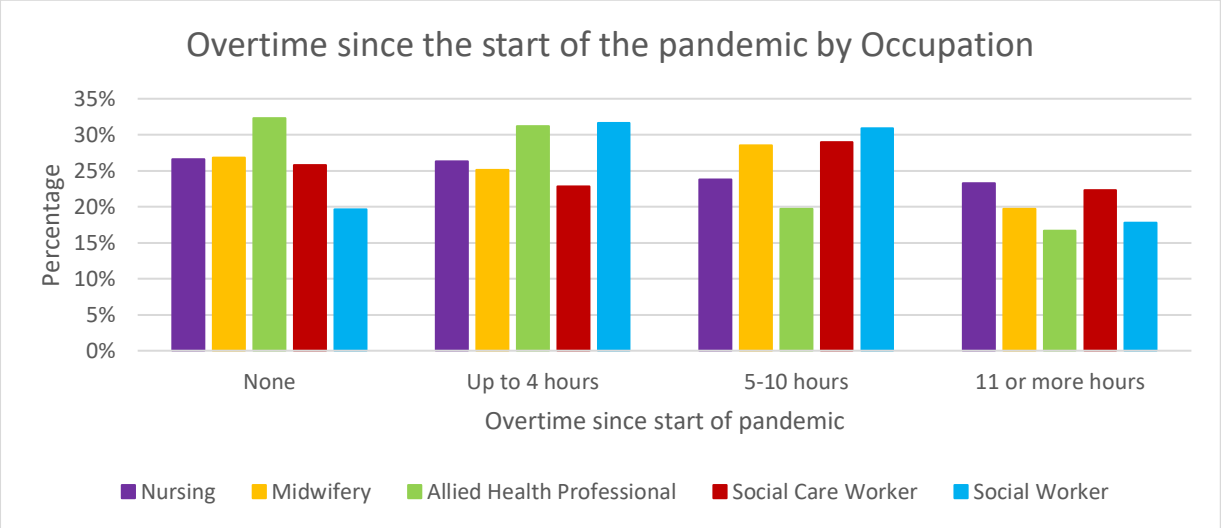


Figure A2.81: Overtime since the Start of the Pandemic by Occupation (Unweighted)

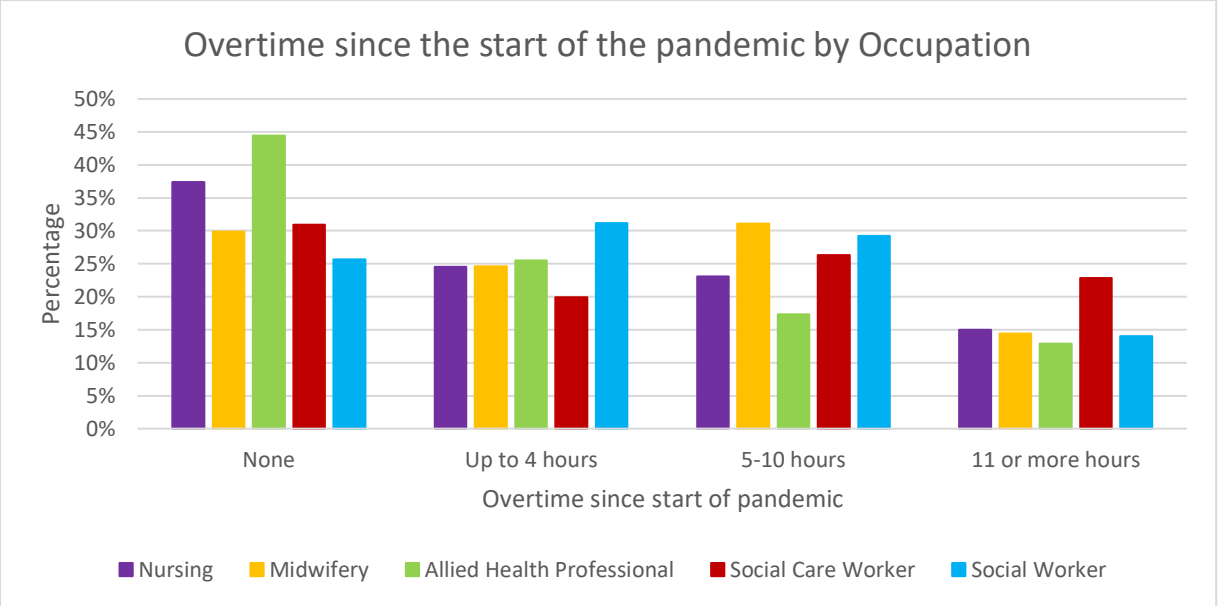


Table A2.81: Overtime since the Start of the Pandemic by Occupation (Weighted)

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	23.5%	23.5%	36.2%	25.2%	**100%**
Midwifery	25.7%	29.1%	24.3%	26.3%	**100%**
AHP	28.2%	26.5%	24.3%	28.1%	**100%**
Social Care Worker	22.5%	20.9%	15.2%	20.4%	**100%**
Social Worker	23.5%	23.5%	36.2%	25.2%	**100%**

Table A2.82: Overtime since the Start of the Pandemic by Occupation (Unweighted)

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	207 (37.4%)	136 (24.5%)	128 (23.1%)	83 (15.0%)	**554 (100%)**
Midwifery	50 (29.9%)	41 (24.6%)	52 (31.1%)	24 (14.4%)	**167 (100%)**
AHP	162 (44.4%)	93 (25.5%)	63 (17.3%)	47 (12.9%)	**365 (100%)**
Social Care Worker	255 (30.9%)	164 (19.9%)	217 (26.3%)	188 (22.8%)	**824 (100%)**
Social Worker	191 (25.7%)	232 (31.2%)	217 (29.2%)	104 (14.0%)	**744 (100%)**

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

Summary (Weighted results):

About half of the respondents (48.0%) had not taken any sick days in the previous 12 months.

Summary (Unweighted results):

About half of the respondents (53.8%) had not taken any sick days in the previous 12 months. Respondents in Wales were the least likely to take sick days and those in England were the most likely.

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

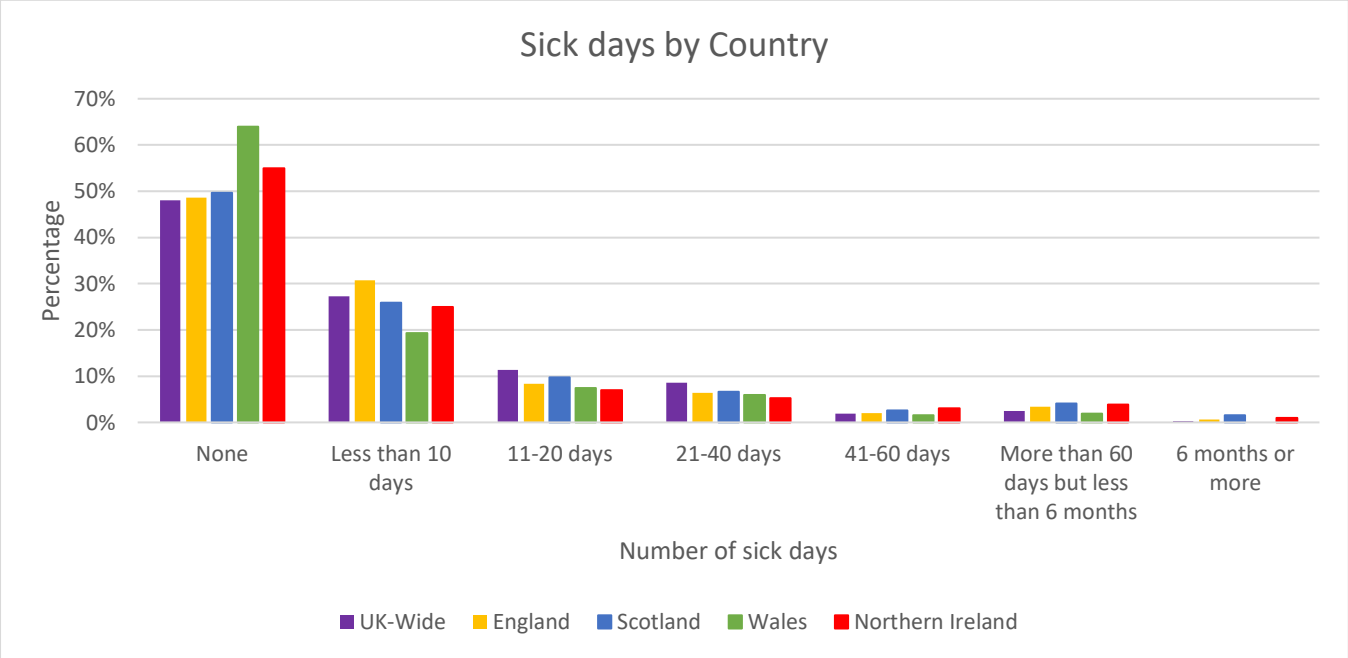


Figure A2.83: Sick Days by Country (Unweighted)

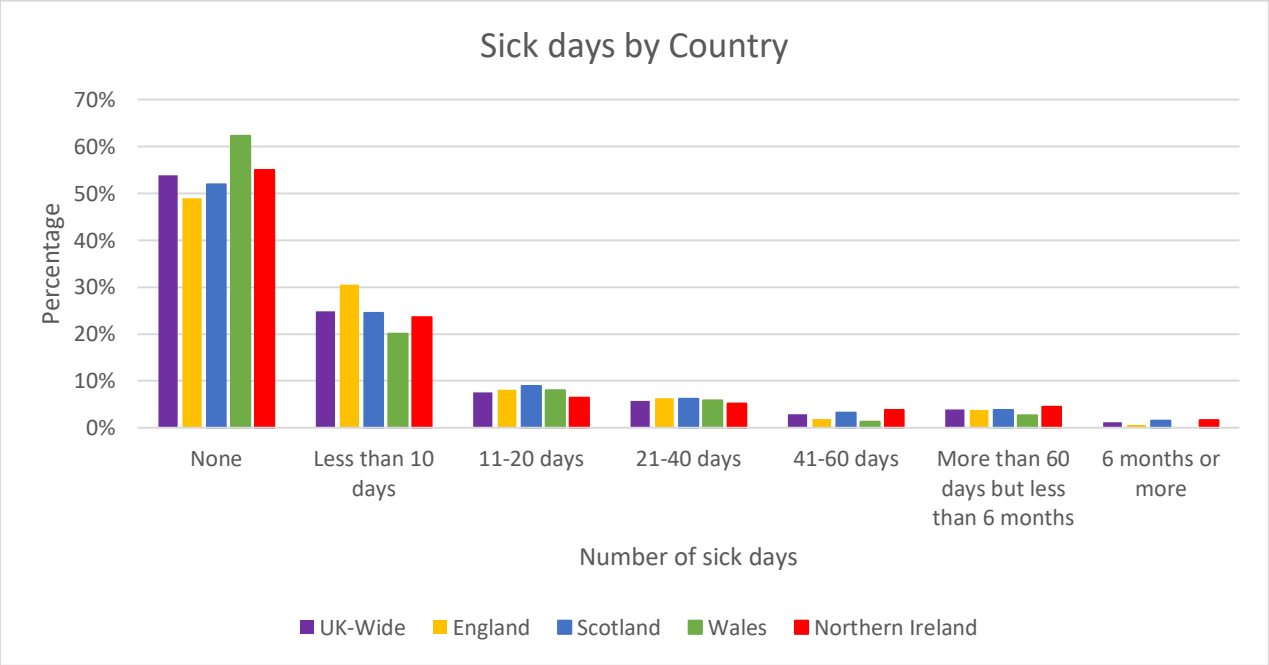


Table A2.83: Sick Days by Country (Weighted)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	48.0%	48.6%	49.7%	63.9%	54.9%
Less than 10 days	27.3%	30.7%	25.9%	19.3%	25.0%
Between 11-20 days	11.4%	8.4%	9.7%	7.4%	7.0%
Between 21-40 days	8.6%	6.4%	6.6%	5.9%	5.2%
Between 41-60 days	1.9%	2.0%	2.6%	1.5%	3.1%
More than 60 days but less than 6 months	2.5%	3.4%	4.1%	1.9%	3.8%
6 months or more	0.3%	0.6%	1.5%	0.0%	1.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.84: Sick Days by Country (Unweighted)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	1432 (53.8%)	258 (48.9%)	378 (51.9%)	195 (62.3%)	601 (55.0%)
Less than 10 days	660 (24.8%)	161 (30.5%)	178 (24.5%)	63 (20.1%)	258 (23.6%)
Between 11-20 days	203 (7.6%)	43 (8.1%)	65 (8.9%)	25 (8.0%)	70 (6.4%)
Between 21-40 days	153 (5.7%)	33 (6.3%)	45 (6.2%)	18 (5.8%)	57 (5.2%)
Between 41-60 days	78 (2.9%)	10 (1.9%)	23 (3.2%)	4 (1.3%)	41 (3.8%)
More than 60 days but less than 6 months	105 (3.9%)	20 (3.8%)	28 (3.8%)	8 (2.6%)	49 (4.5%)
6 months or more	31 (1.2%)	3 (0.6%)	11 (1.5%)	0 (0.0%)	17 (1.6%)
Total	**2662 (100%)**	**528 (100%)**	**728 (100%)**	**313 100%)**	**1093 (100%)**

Figure A2.84: Sick Days by Occupation (Weighted)

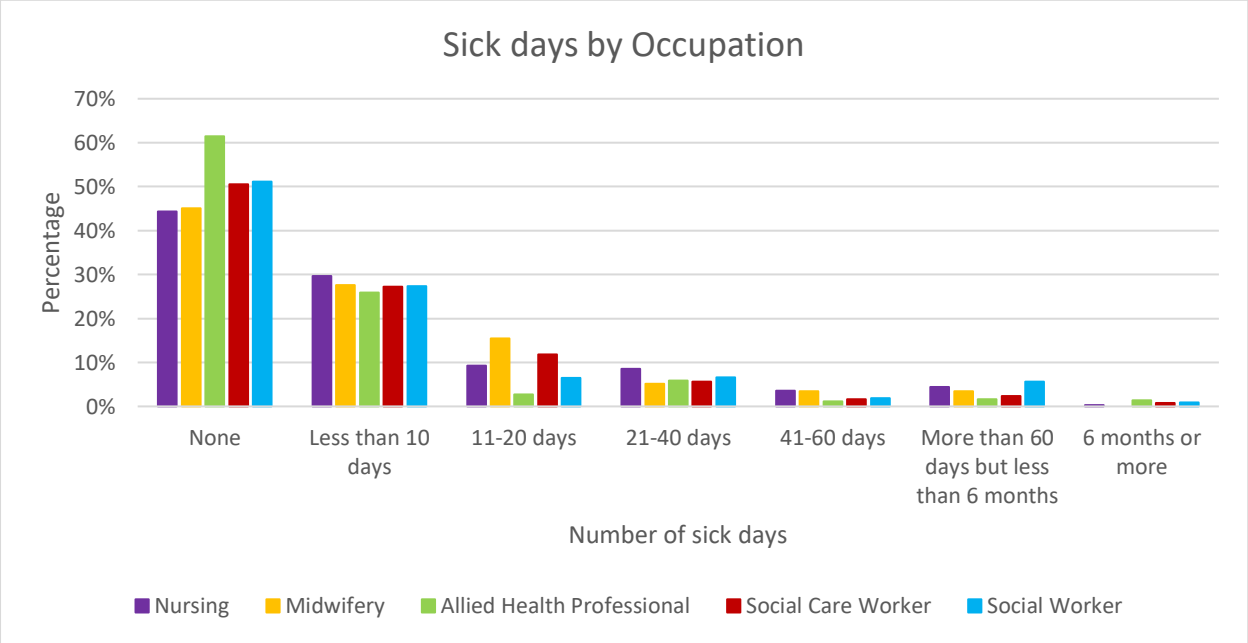


Figure A2.85: Sick Days by Occupation (Unweighted)

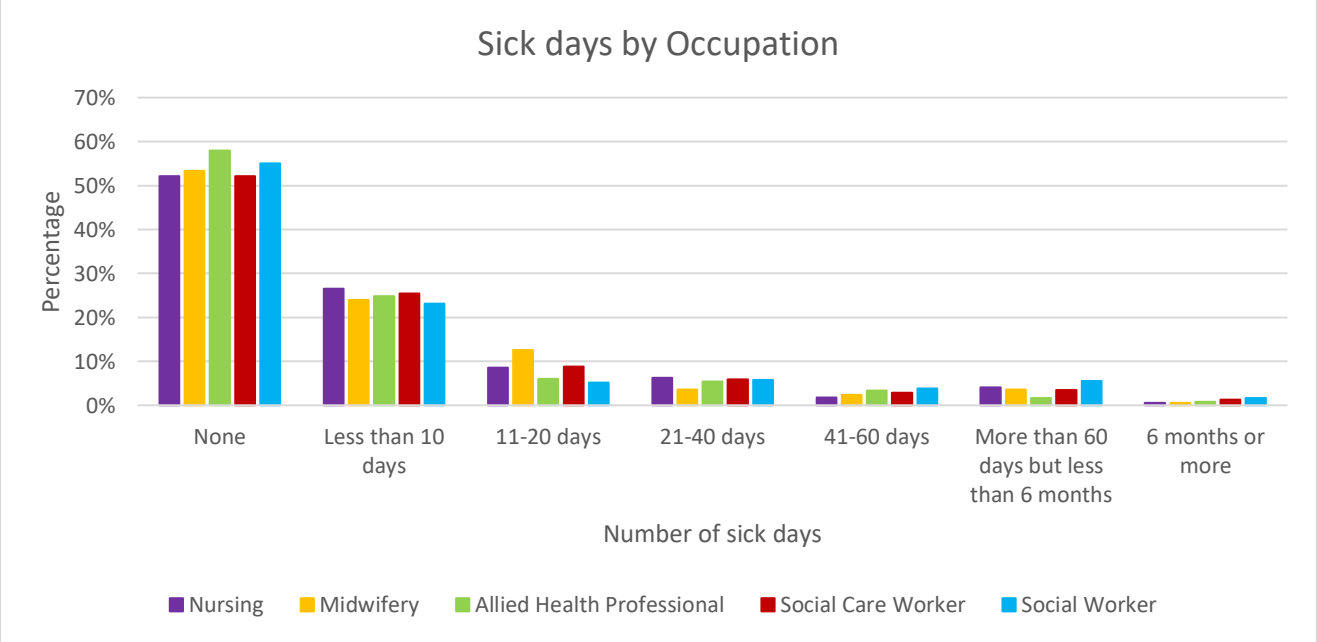


Table A2.85: Sick Days by Occupation (Weighted)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	44.4%	45.1%	61.5%	50.5%	51.2%
Less than 10 days	29.6%	27.6%	25.9%	27.2%	27.4%
Between 11-20 days	9.3%	15.5%	2.7%	11.8%	6.5%
Between 21-40 days	8.5%	5.1%	5.9%	5.6%	6.6%
Between 41-60 days	3.6%	3.4%	1.1%	1.6%	1.9%
More than 60 days but less than 6 months	4.4%	3.4%	1.6%	2.4%	5.6%
6 months or more	0.3%	0.0%	1.4%	0.8%	0.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.86: Sick Days by Occupation (Unweighted)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	289 (52.1%)	89 (53.3%)	213 (58.0%)	431 (52.1%)	410 (55.0%)
Less than 10 days	147 (26.5%)	40 (24.0%)	91 (24.8%)	210 (25.4%)	172 (23.1%)
Between 11-20 days	48 (8.6%)	21 (12.6%)	22 (6.0%)	73 (8.8%)	39 (5.2%)
Between 21-40 days	35 (6.3%)	6 (3.6%)	20 (5.4%)	49 (5.9%)	43 (5.8%)
Between 41-60 days	10 (1.8%)	4 (2.4%)	12 (3.3%)	24 (2.9%)	28 (3.8%)
More than 60 days but less than 6 months	23 (4.1%)	6 (3.6%)	6 (1.6%)	29 (3.5%)	41 (5.5%)
6 months or more	3 (0.5%)	1 (0.6%)	3 (0.8%)	11 (1.3%)	13 (1.7%)
Total	**555 (100%)**	**167 (100%)**	**367 (100%)**	**827 (100%)**	**746 (100%)**

A2.22 Sickness Absence Related to COVID-19

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

Summary (Weighted results):

Scotland had the highest proportion of respondents with COVID-19 related sickness absence. Nurses were most likely to have COVID-19 related sickness absence and midwives were the least likely.

Summary (Unweighted results):

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

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

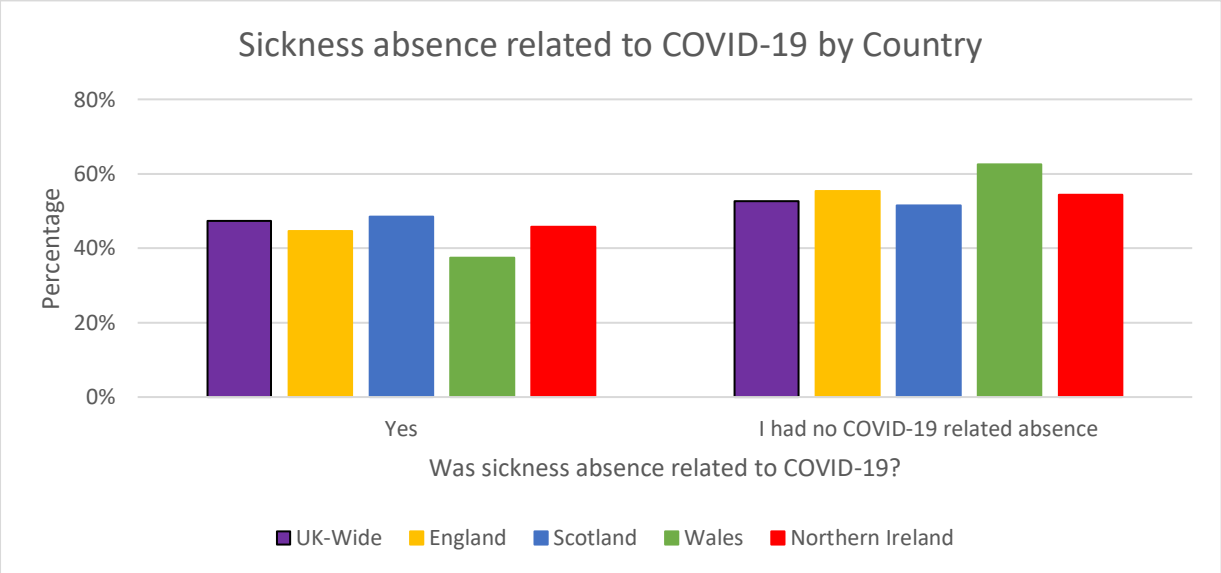


Figure A2.87: Sickness Absence Related to COVID-19 by Country (Unweighted)

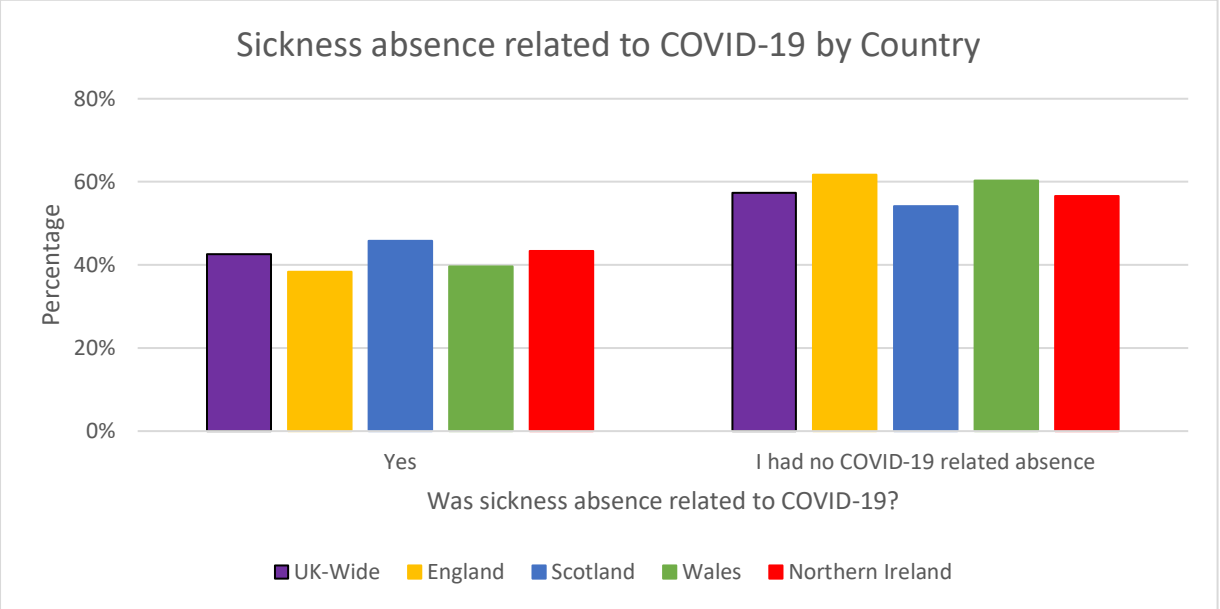


Table A2.87: Sickness Absence Related to COVID-19 by Country (Weighted)

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	47.3%	44.6%	48.5%	37.5%	45.7%
I had no COVID-19 related absence	52.7%	55.4%	51.5%	62.5%	54.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.88: 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	519 (42.6%)	103 (38.3%)	158 (45.8%)	46 (39.7%)	212 (43.4%)
I had no COVID-19 related absence	699 (57.4%)	166 (61.7%)	187 (54.2%)	70 (60.3%)	276 (56.6%)
Total	**1218 (100%)**	**269 (100%)**	**345 (100%)**	**116 (100%)**	**488 (100%)**

Figure A2.88: Sickness Absence Related to COVID-19 by Occupation (Weighted)

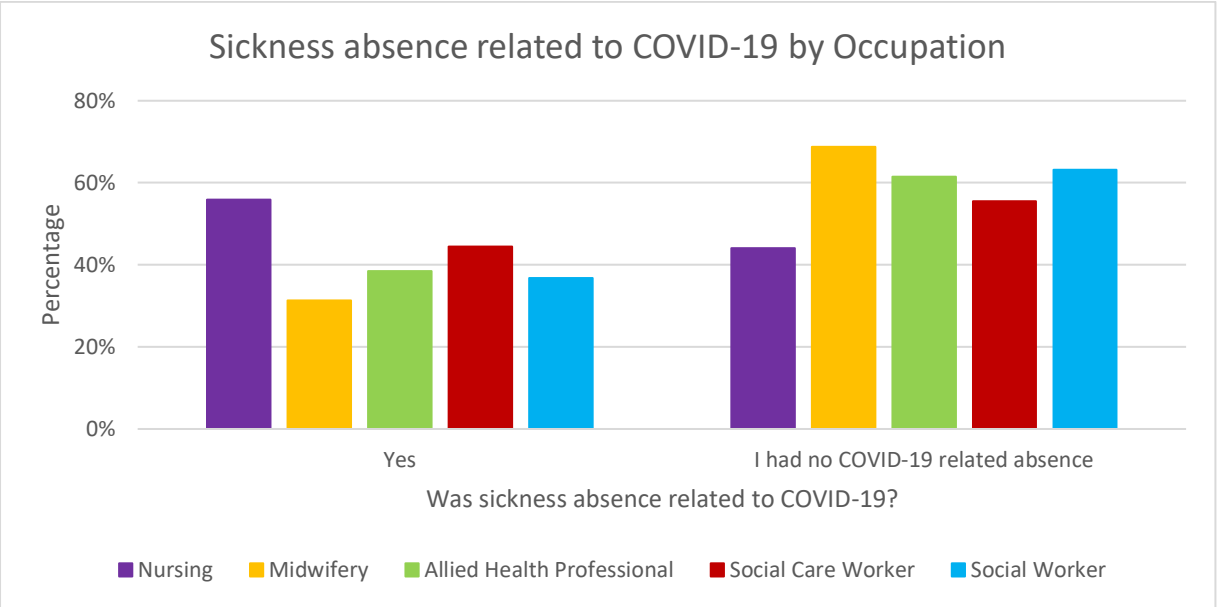


Figure A2.89: Sickness Absence Related to COVID-19 by Occupation (Unweighted)

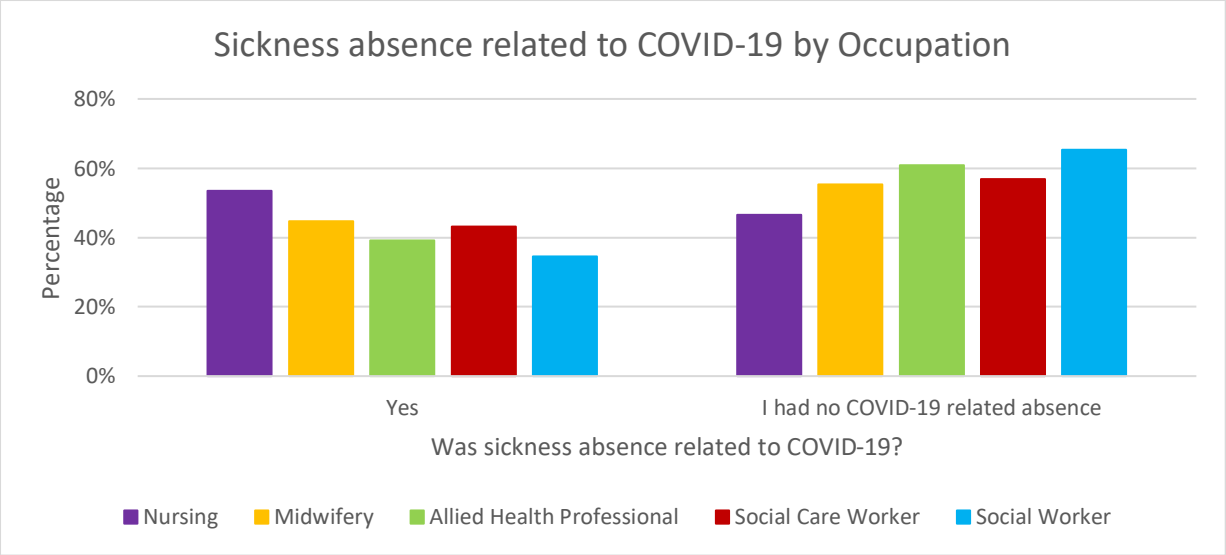


Table A2.89: Sickness Absence Related to COVID-19 by Occupation (Weighted)

Occupation	Was sickness absence related to COVID-19?		Total
	Yes	I had no COVID-19 related absence	
Nursing	55.9%	44.1%	**100%**
Midwifery	31.3%	68.8%	**100%**
AHP	38.5%	61.5%	**100%**
Social Care Worker	44.5%	55.5%	**100%**
Social Worker	36.8%	63.2%	**100%**

Table A2.90: 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	140 (53.4%)	122 (46.6%)	**262 (100%)**
Midwifery	34 (44.7%)	42 (55.3%)	**76 (100%)**
AHP	60 (39.2%)	93 (60.8%)	**153 (100%)**
Social Care Worker	169 (43.1%)	223 (56.9%)	**392 (100%)**
Social Worker	116 (34.6%)	219 (65.4%)	**335 (100%)**

A2.23 Respondents' Sick Pay

Summary (Weighted results):

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

Summary (Unweighted results):

UK-wide, most respondents (63.2%) reported getting statutory sick pay plus their employer pay. AHPs were the most likely to report not getting any sick pay when off sick.

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

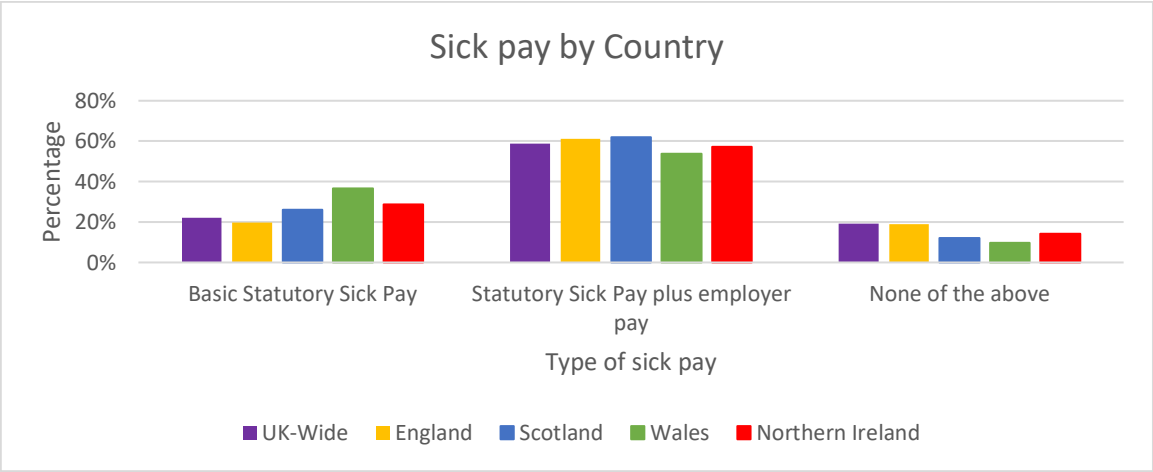


Figure A2.91: Respondents' Sick Pay by Country (Unweighted)

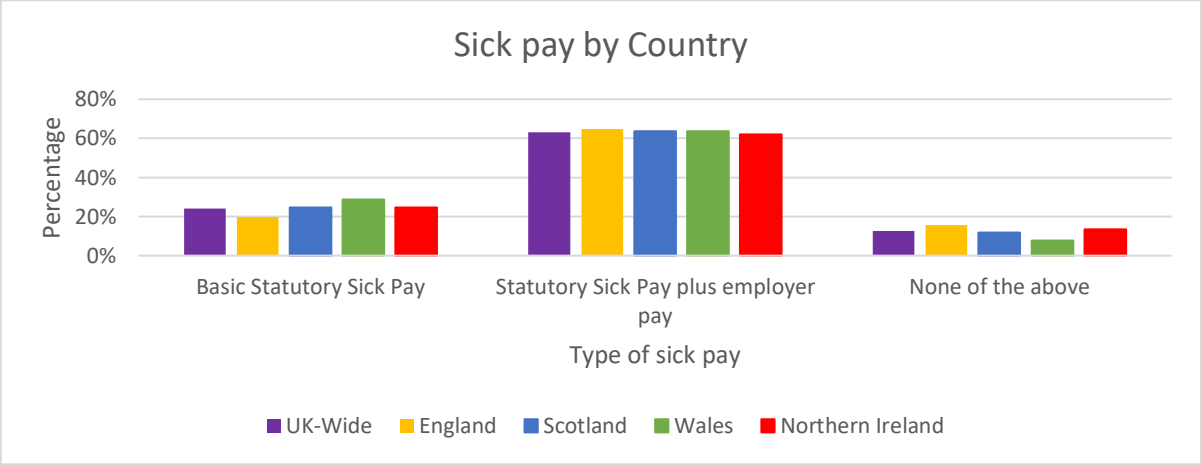


Table A2.91: Respondents' Sick Pay by Country (Weighted)

	Country				
Type of sick pay	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Basic Statutory Sick Pay (SSP)	22.1%	19.8%	26.1%	36.7%	28.8%
Statutory Sick Pay (SSP) plus employer pay	58.8%	61.2%	61.9%	53.8%	57.1%
None of the above	19.1%	18.9%	12.0%	9.6%	14.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.92: Respondents' Sick Pay by Country (Unweighted)

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Basic Statutory Sick Pay (SSP)	586 (24.1%)	98 (19.6%)	162 (24.5%)	84 (28.6%)	242 (24.7%)
Statutory Sick Pay (SSP) plus employer pay	1540 (63.2%)	324 (64.8%)	422 (63.7%)	187 (63.6%)	607 (61.9%)
None of the above	310 (12.7%)	78 (15.6%)	78 (11.8%)	23 (7.8%)	131 (13.4%)
Total	**2436 (100%)**	**500 (100%)**	**662 (100%)**	**294 (100%)**	**980 (100%)**

Figure A2.92: Respondents' Sick Pay by Occupation (Weighted)

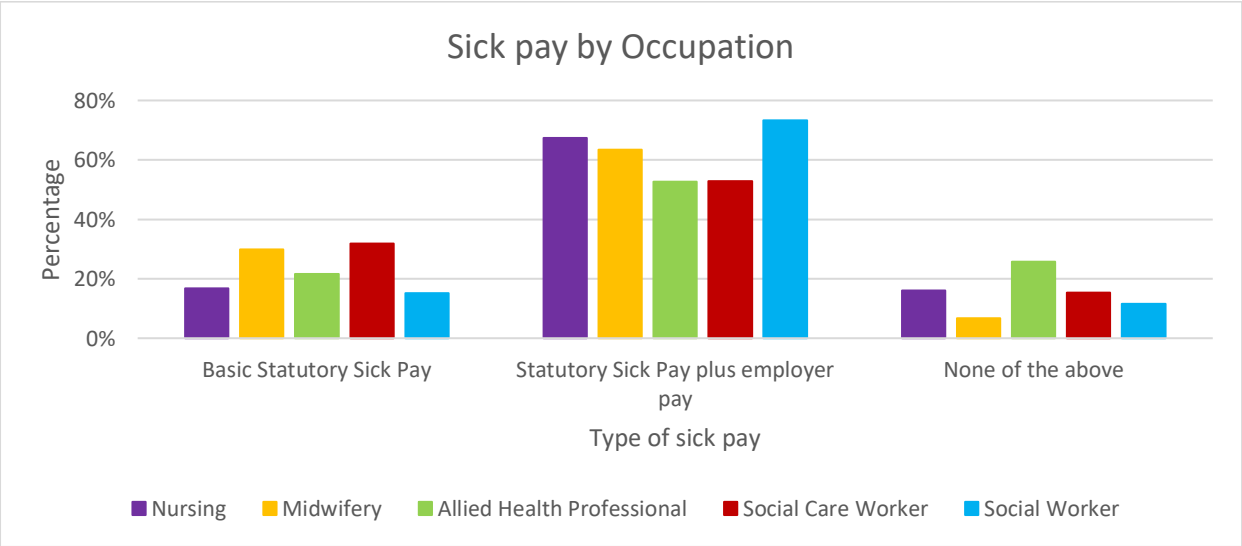


Figure A2.93: Respondents' Sick Pay by Occupation (Unweighted)

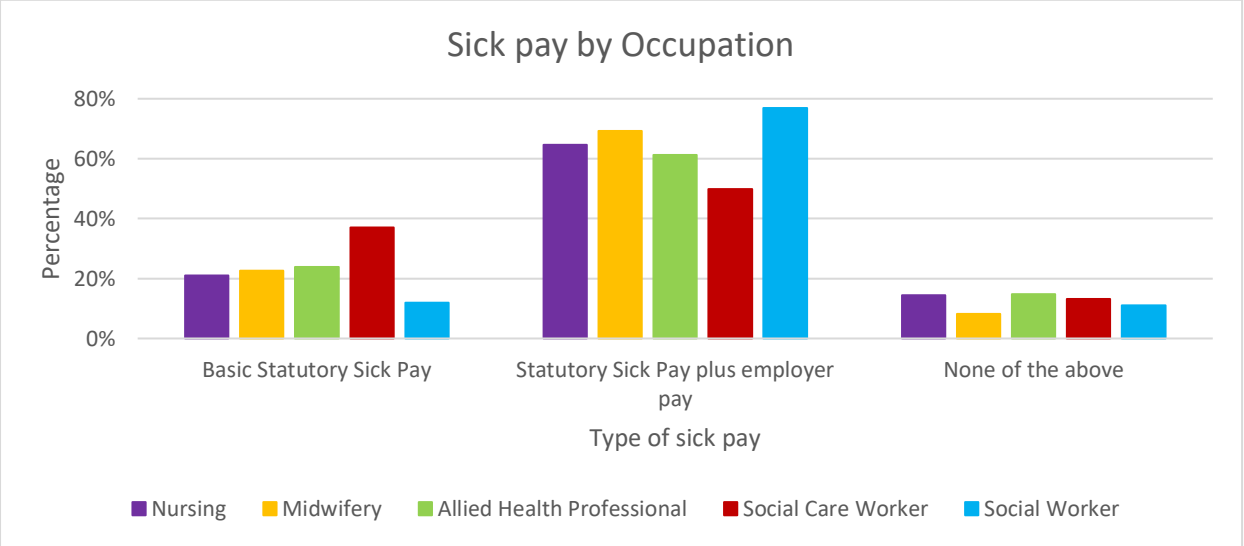


Table A2.93: Respondents' Sick Pay by Occupation (Weighted)

Occupation	Type of sick pay			Total
	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	None of the above	
Nursing	16.7%	67.3%	16.1%	**100%**
Midwifery	29.8%	63.5%	6.7%	**100%**
AHP	21.6%	52.7%	25.7%	**100%**
Social Care Worker	31.8%	52.9%	15.3%	**100%**
Social Worker	15.1%	73.3%	11.6%	**100%**

Table A2.94: Respondents' Sick Pay by Occupation (Unweighted)

Occupation	Type of sick pay			Total
	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	None of the above	
Nursing	104 (21.1%)	319 (64.6%)	71 (14.4%)	**492 (100%)**
Midwifery	36 (22.6%)	110 (69.2%)	13 (8.2%)	**159 (100%)**
AHP	79 (23.9%)	202 (61.2%)	49 (14.8%)	**330 (100%)**
Social Care Worker	285 (37.1%)	383 (49.8%)	101 (13.1%)	**769 (100%)**
Social Worker	82 (12.0%)	526 (76.9%)	76 (11.1%)	**684 (100%)**

A2.24 Impact of COVID-19 on Services

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

Summary (Weighted results):

UK-wide, only 3.4% of respondents reported that their service was not impacted and it was stepped down. More than half of the respondents (62.1%) felt overwhelmed by increased pressures. Social work and nursing were the most impacted of the examined occupational groups.

Summary (Unweighted results):

UK-wide, only 3.1% of respondents reported that their service was not impacted and it was stepped down. Almost half of the respondents (53.4%) felt overwhelmed by increased pressures, particularly those in England. Social work were the most impacted of the examined occupational groups.

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

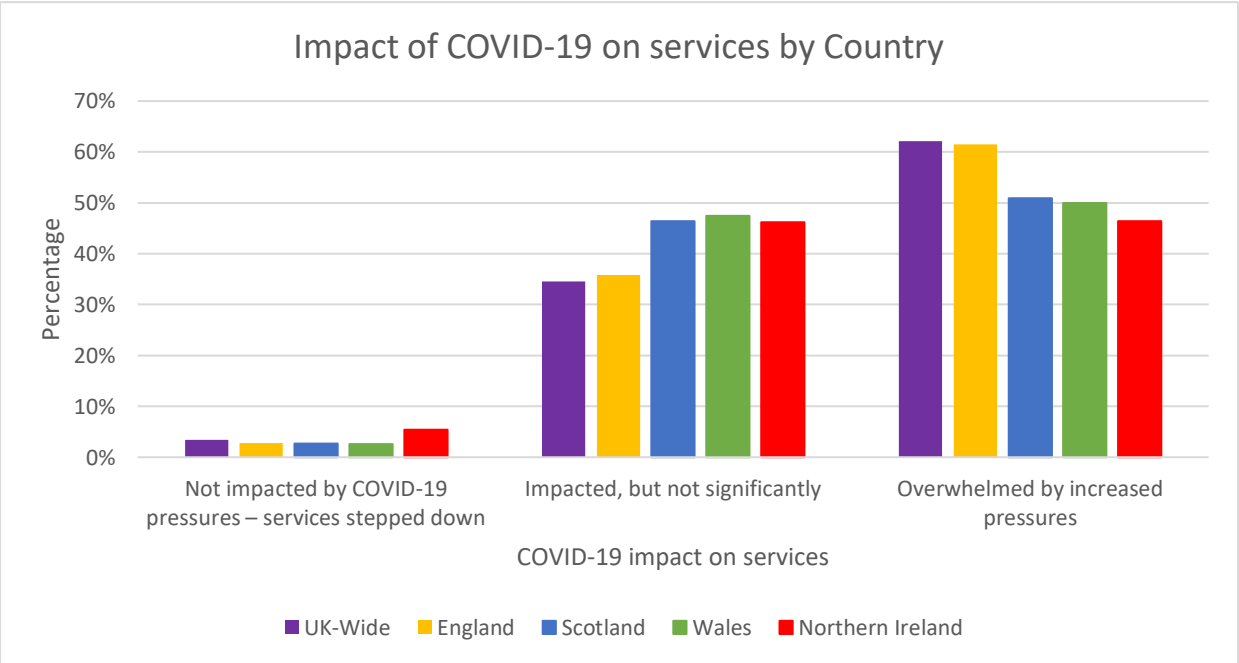


Figure A2.95: Impact of COVID-19 on Services by Country (Unweighted)

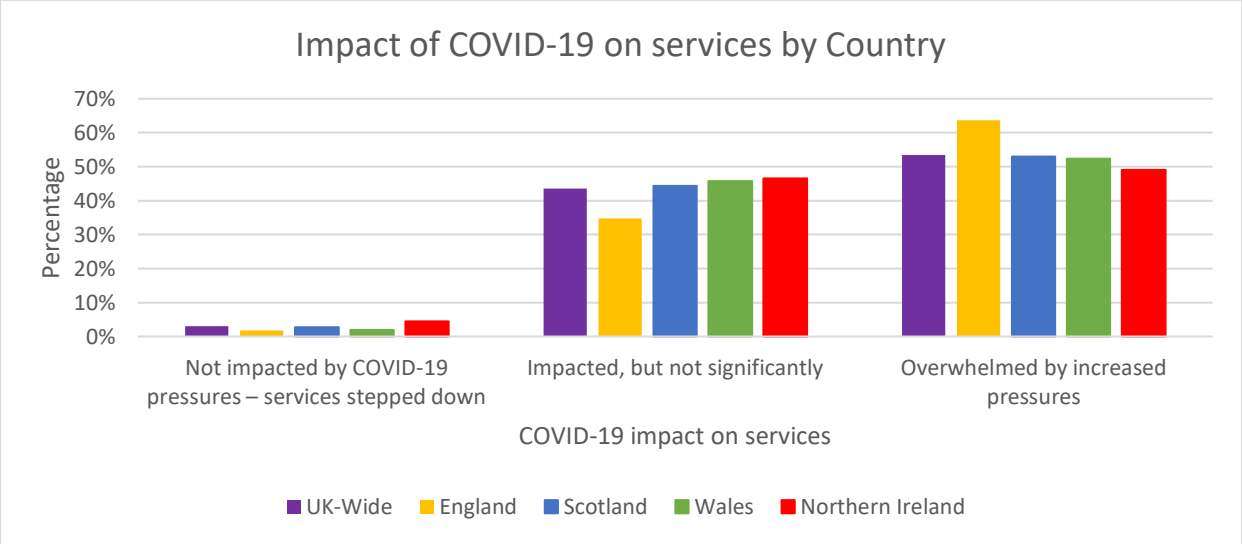


Table A2.95: Impact of COVID-19 on Services by Country (Weighted)

	Country				
Impact of COVID-19 on services	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Not impacted by COVID-19 pressures – services stepped down	3.4%	2.8%	2.7%	2.6%	5.4%
Impacted, but not significantly	34.5%	35.8%	46.4%	47.4%	46.2%
Overwhelmed by increased pressures	62.1%	61.5%	50.9%	50.0%	46.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.96: 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	82 (3.1%)	9 (1.7%)	19 (2.7%)	6 (1.9%)	48 (4.4%)
Impacted, but not significantly	1147 (43.5%)	183 (34.7%)	317 (44.3%)	142 (45.7%)	505 (46.5%)
Overwhelmed by increased pressures	1409 (53.4%)	335 (63.6%)	379 (53.0%)	163 (52.4%)	532 (49.0%)
Total	**2638 (100%)**	**527 (100%)**	**715 (100%)**	**311 (100%)**	**1085 (100%)**

Figure A2.96: Impact of COVID-19 on Services by Occupation (Weighted)

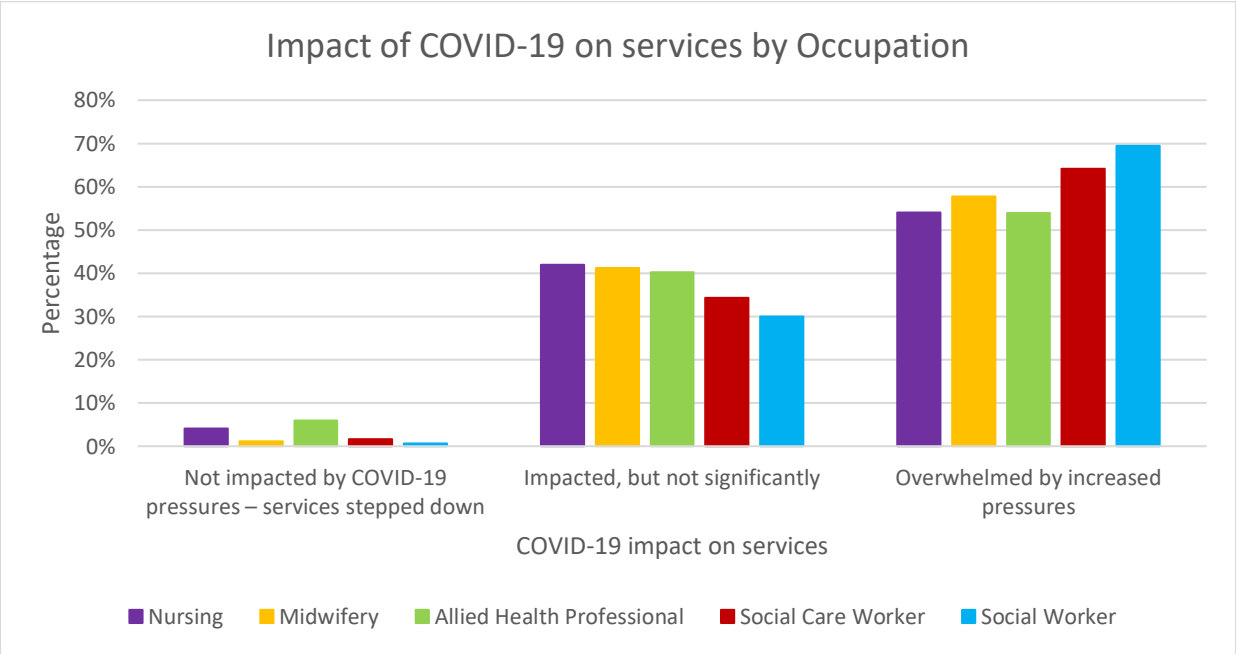


Figure A2.97: Impact of COVID-19 on Services by Occupation (Unweighted)

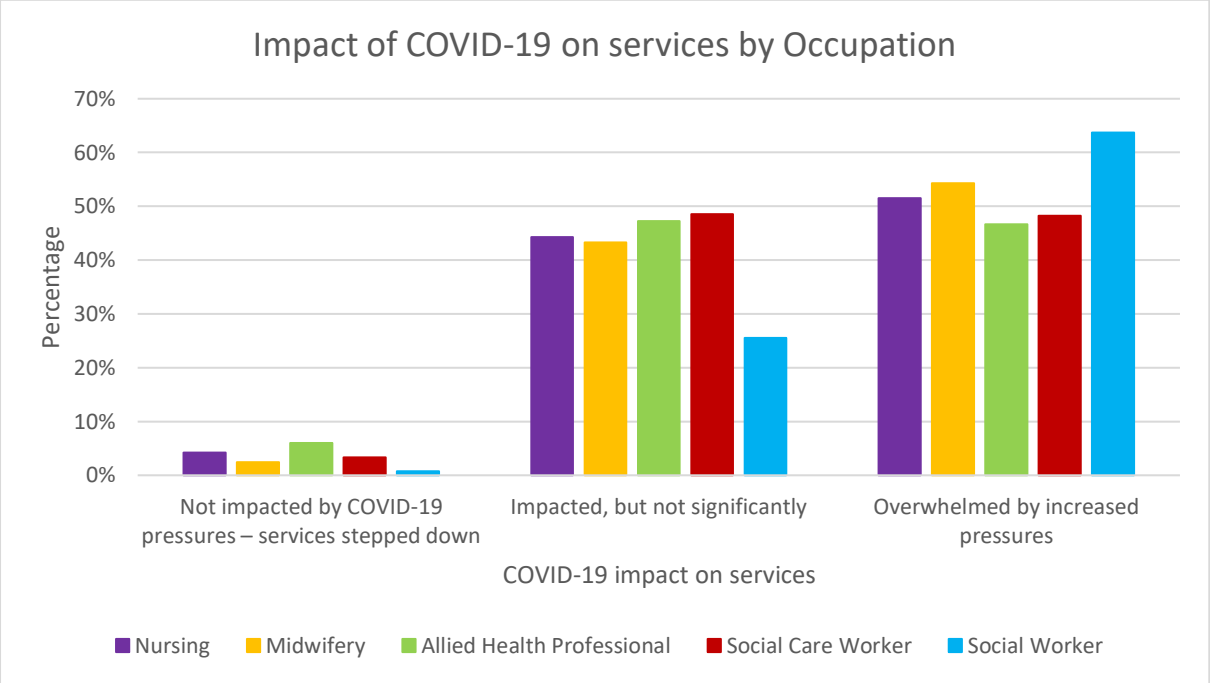


Table A2.97: Impact of COVID-19 on Services by Occupation (Weighted)

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%	41.9%	54.0%	**100%**
Midwifery	1.1%	41.2%	57.7%	**100%**
AHP	5.9%	40.2%	53.9%	**100%**
Social Care Worker	1.6%	34.3%	64.1%	**100%**
Social Worker	0.6%	30.0%	69.4%	**100%**

Table A2 98: 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	23 (4.2%)	243 (44.3%)	282 (51.5%)	**548 (100%)**
Midwifery	4 (2.4%)	71 (43.3%)	89 (54.3%)	**164 (100%)**
AHP	22 (6.0%)	172 (47.3%)	170 (46.7%)	**364 (100%)**
Social Care Worker	27 (3.3%)	397 (48.5%)	394 (48.2%)	**818 (100%)**
Social Worker	6 (0.8%)	264 (25.5%)	474 (63.7%)	**744 (100%)**

A2.24 Vaccination uptake

Respondents were asked whether they had received their COVID-19 Vaccination.

Summary (Weighted results):

UK-wide, 85.1% of respondents reported that they had received both of their vaccines. Nurses were the group with the highest uptake of both vaccinations followed by Social Workers.

Summary (Unweighted results):

UK-wide, 86.1% of respondents reported that they had received both of their vaccines. Out of all the countries, Scotland had the highest uptake of both vaccinations in this population (89.9%). Nurses were the group with the highest uptake of both vaccinations followed by Social Care Workers.

Respondents reported other (n=114) as the reason for not taking the vaccination had a range of reasons including;

- Own choice and do not want to get the vaccination
- Pregnancy and do not want to take risk
- Allergies
- Waiting until trials are completed

Figure A2.98: Vaccination uptake by Country (Weighted)

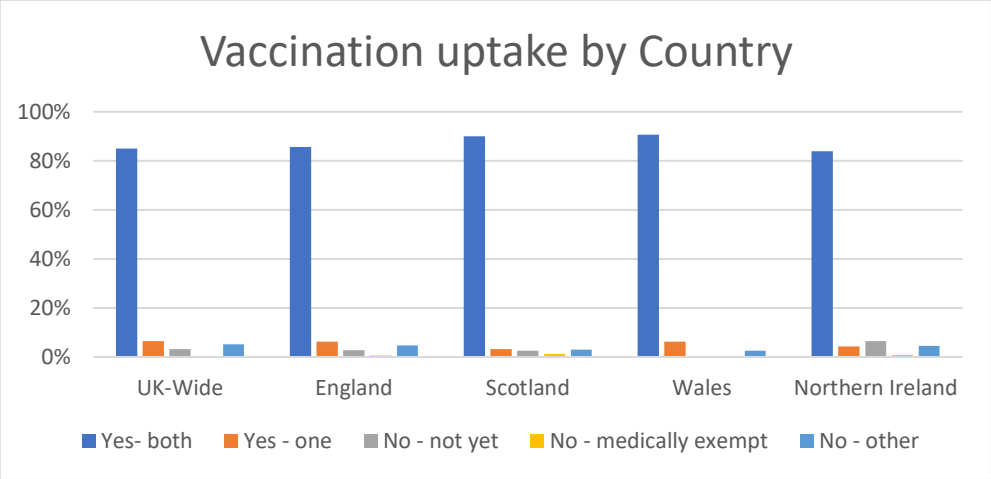


Figure A2.99: Vaccination uptake by Country (Unweighted)

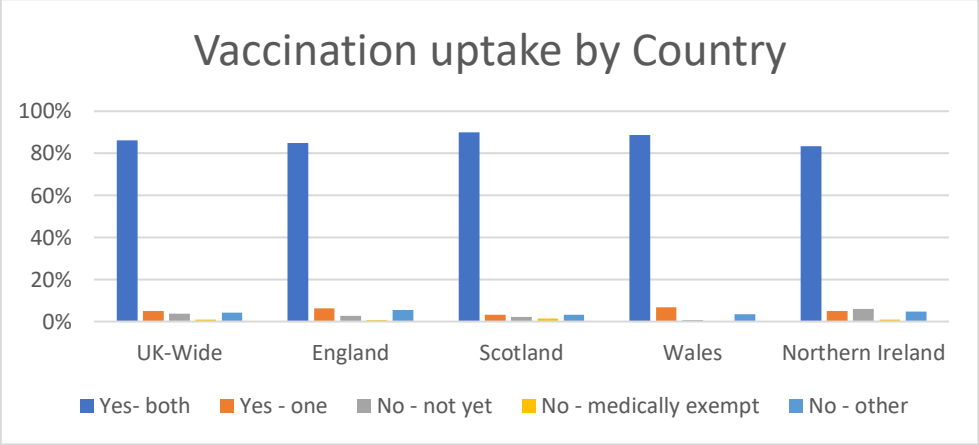


Table A2.99: Vaccination uptake by Country (Weighted)

Have you received your vaccination?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes- both	85.1%	85.7%	89.9%	90.7%	84.0%
Yes - one	6.4%	6.2%	3.3%	6.3%	4.2%
No - not yet	3.2%	2.8%	2.5%	0.4%	6.5%
No - medically exempt	0.3%	0.6%	1.2%	0.0%	0.8%
No - other	5.2%	4.8%	3.1%	2.6%	4.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.100: Vaccination uptake by Country (Unweighted)

Have you received your vaccination?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes- both	2276 (86.1%)	448 (85.0%)	647 (89.9%)	276 (88.7%)	905 (83.3%)
Yes - one	133 (5.0%)	33 (6.3%)	24 (3.3%)	21 (6.8%)	55 (5.1%)
No - not yet	97 (3.7%)	14 (2.7%)	16 (2.2%)	2 (0.6%)	65 (6.0%)
No - medically exempt	24 (0.9%)	3 (0.6%)	10 (1.4%)	1 (0.3%)	10 (0.9%)
No - other	114 (4.3%)	29 (5.5%)	23 (3.2%)	11 (3.5%)	51 (4.7%)
Total	**2644 (100%)**	**527 (100%)**	**720 (100%)**	**311 (100%)**	**1086 (100%)**

Figure A2.100: Vaccination uptake by Occupation (Weighted)

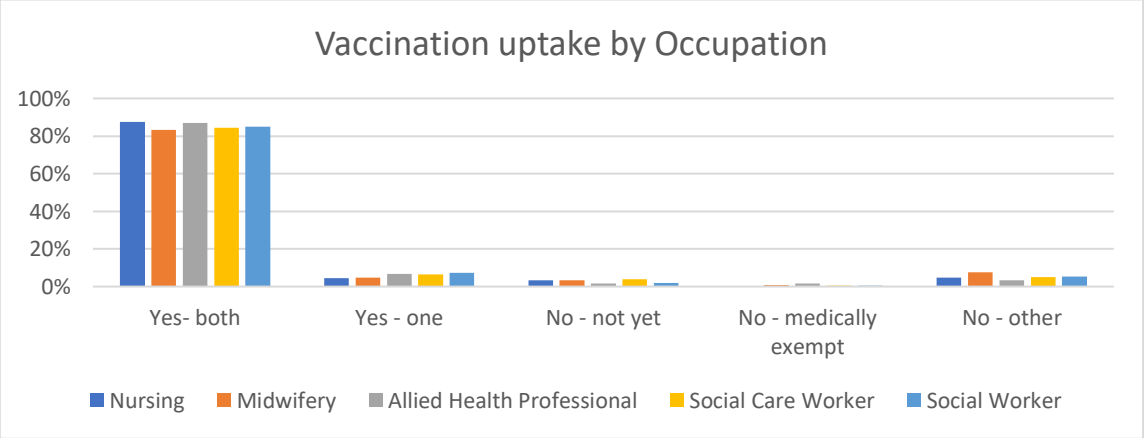


Figure A2.101: Vaccination by Occupation (Unweighted)

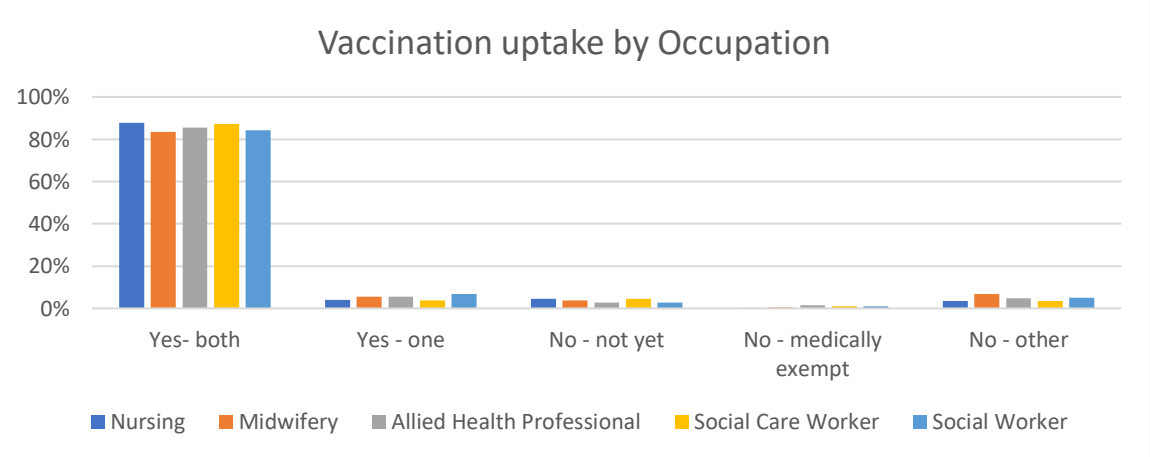


Table A2.101: Vaccination uptake by Occupation (Weighted)

Occupation	Have you received your vaccination?					Total
	Yes- both	Yes - one	No - not yet	No - medically exempt	No - other	
Nursing	87.6%	4.4%	3.3%	0.0%	4.7%	**100%**
Midwifery	83.2%	4.8%	3.4%	0.9%	7.7%	**100%**
AHP	87.0%	6.6%	1.6%	1.6%	3.2%	**100%**
Social Care Worker	84.3%	6.5%	3.8%	0.5%	4.9%	**100%**
Social Worker	85.1%	7.3%	1.9%	0.4%	5.3%	**100%**

Table A2.102: Vaccination uptake by Occupation (Unweighted)

Occupation	Have you received your vaccination?					Total
	Yes- both	Yes - one	No - not yet	No - medically exempt	No - other	
Nursing	483 (87.8%)	22 (4.0%)	24 (4.4%)	1 (0.2%)	20 (3.6%)	**550 (100%)**
Midwifery	137 (83.5%)	9 (5.5%)	6 (3.7%)	1 (0.6%)	11 (6.7%)	**164 (100%)**
AHP	311 (85.4%)	20 (5.5%)	10 (2.7%)	6 (1.6%)	17 (4.7%)	**364 (100%)**
Social Care Worker	717 (87.3%)	31 (3.8%)	36(4.4%)	9 (1.1%)	28 (3.4%)	**821 (100%)**
Social Worker	628 (84.3%)	51 (6.8%)	21 (2.8%)	7 (0.9%)	38 (5.1%)	**745 (100%)**

A2.25 Respondents working from home

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

Summary (Weighted results):

Over half of respondents were not able to work from home during the pandemic. Northern Ireland workers were least likely to work from home while Welsh workers were more likely to work at home.

Summary (Unweighted results):

Over half of respondents did not work from home during the pandemic (58.3%). Respondents from England were the most likely to work from home (61.6%) and those from Scotland were the least likely (69.5%). Social work respondents were mostly likely to work from home some or all of the time (81.2%) while Midwives were least likely to work from home (80.6%).

Figure A2.102: Respondents working from home by Country (Weighted)

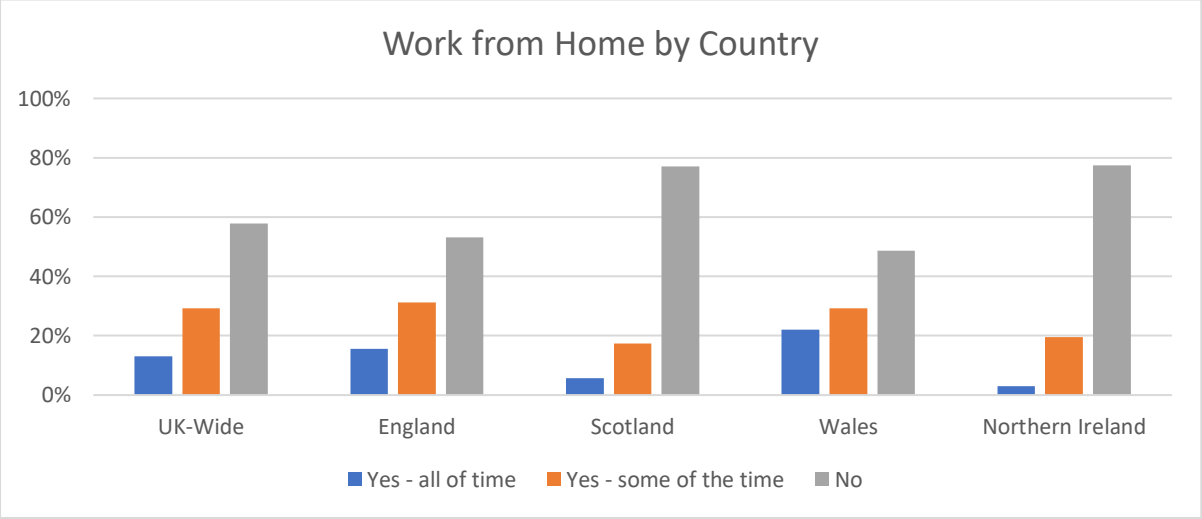


Figure A2.103: Respondents working from home by Country (Unweighted)

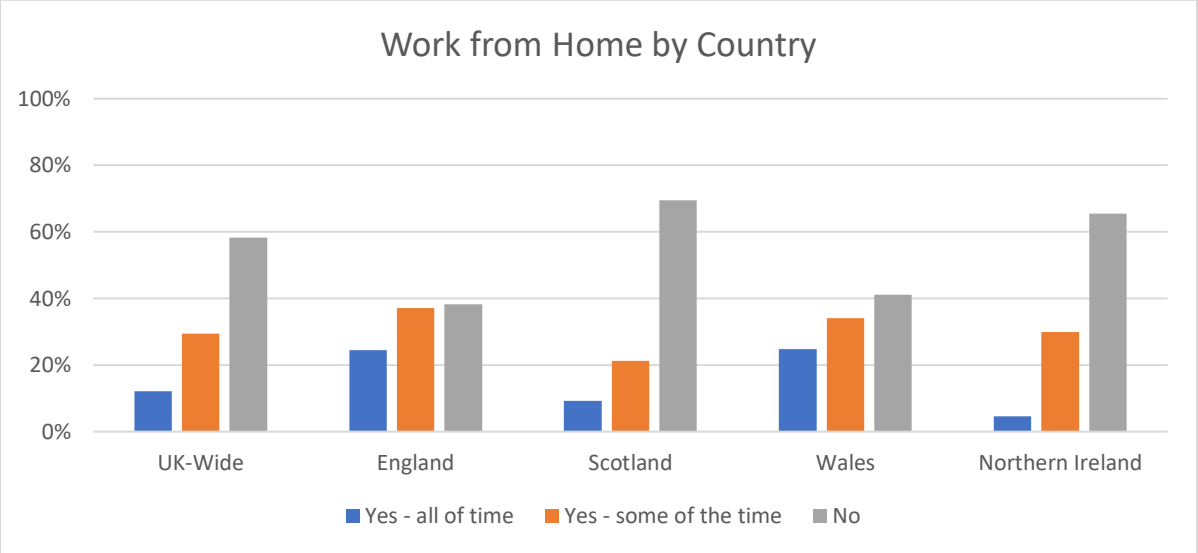


Table A2.103: Respondents working from home by Country (Weighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes - all of time	13.0%	15.5%	5.7%	22.1%	3.0%
Yes - some of the time	29.2%	31.3%	17.3%	29.2%	19.5%
No	57.8%	53.2%	77.1%	48.7%	77.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.104: Respondents working from home by Country (Unweighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes - all of time	325 (12.2%)	130 (24.4%)	67 (9.2%)	78 (24.8%)	50 (4.6%)
Yes - some of the time	788 (29.5%)	198 (37.2%)	155 (21.3%)	107 (34.1%)	328 (30.0%)
No	1556 (58.3%)	204 (38.3%)	107 (69.5%)	129 (41.1%)	717 (65.5%)
Total	**2669 (100%)**	**532 (100%)**	**728 (100%)**	**314 (100%)**	**1095 (100%)**

Figure A2.104: Respondents working from home by Occupation (Weighted)

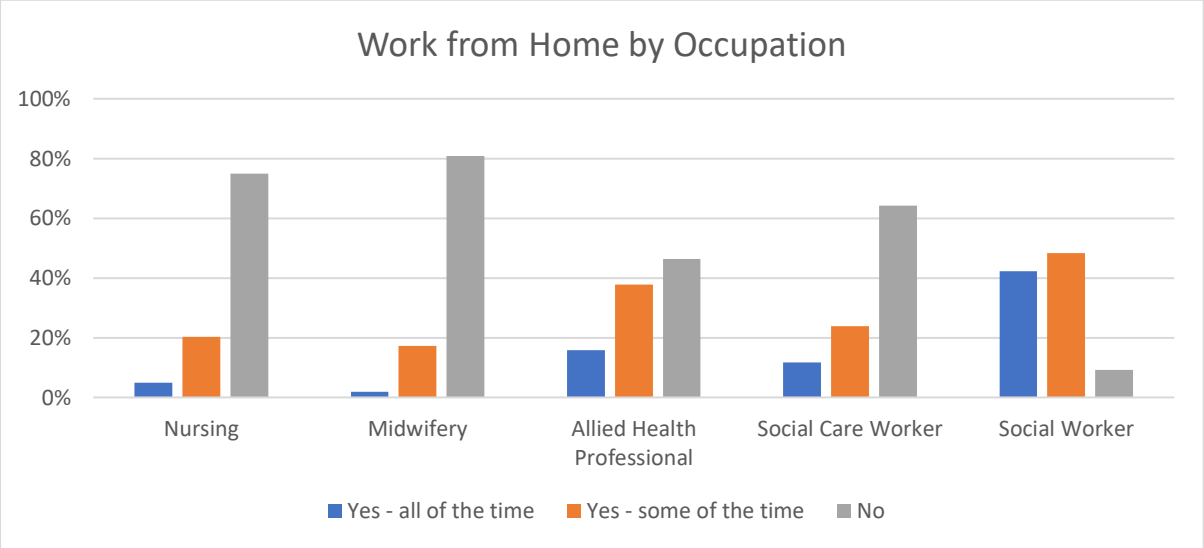


Figure A2.105: Respondents working from home by Occupation (Unweighted)

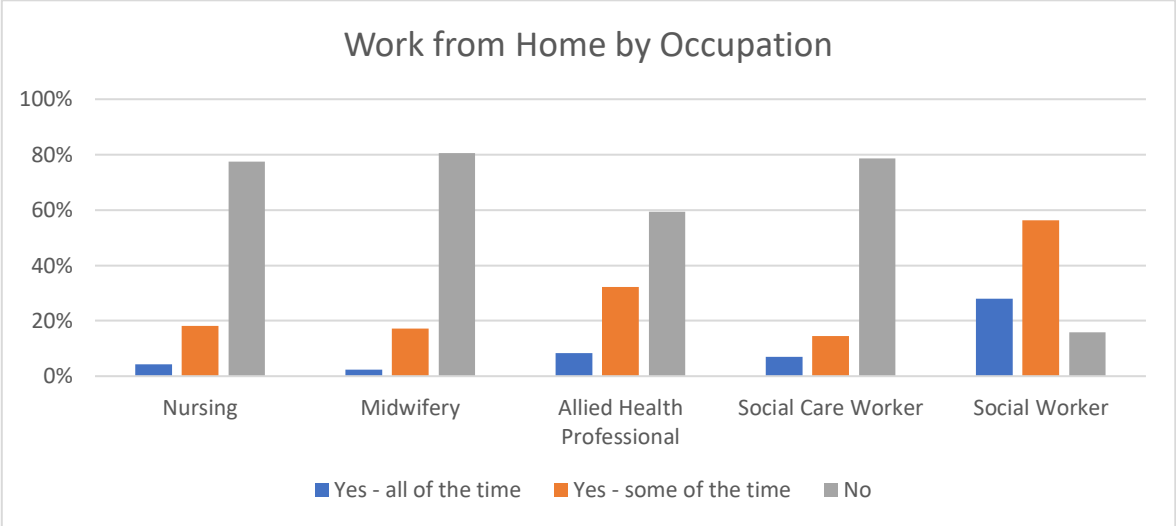


Table A2.105: Respondents working from home by Occupation (Weighted)

Occupation	Are you working from home?			
	Yes - all of time	Yes - some of the time	No	**Total**
Nursing	4.9%	20.2%	74.9%	**100%**
Midwifery	1.9%	17.3%	80.8%	**100%**
AHP	15.8%	37.8%	46.4%	**100%**
Social Care Worker	11.8%	23.9%	64.2%	**100%**
Social Worker	42.2%	48.4%	9.3%	**100%**

Table A2.106: 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	24 (4.3%)	101 (18.2%)	430 (77.5%)	**555 (100%)**
Midwifery	4 (2.4%)	29 (17.1%)	137 (80.6%)	**170 (100%)**
AHP	31 (8.4%)	119 (32.2%)	219 (59.3%)	**369 (100%)**
Social Care Worker	57 (6.9%)	120 (14.5%)	652 (78.6%)	**829 (100%)**
Social Worker	209 (28.0%)	419 (56.2%)	118 (15.8%)	**746 (100%**

A2.25 Respondents Work Morale

Respondents were asked what has been the impact of working through COVID-19, on your morale? Respondents scored their morale on a scale of 1 to 10, which was then recoded into low, moderate or high impact on morale.

Summary (Weighted results):

Respondents from England were most likely to have reported a higher impact of the COVID-19 pandemic on their morale.

Summary (Unweighted results):

Respondents from England were most likely to have reported a higher impact of the COVID-19 pandemic on their morale and Scotland were most likely to have reported the lowest impact of the COVID-19 pandemic on their morale at work.

Figure A2.106: Respondents impact on COVID on their morale by Country (Weighted)

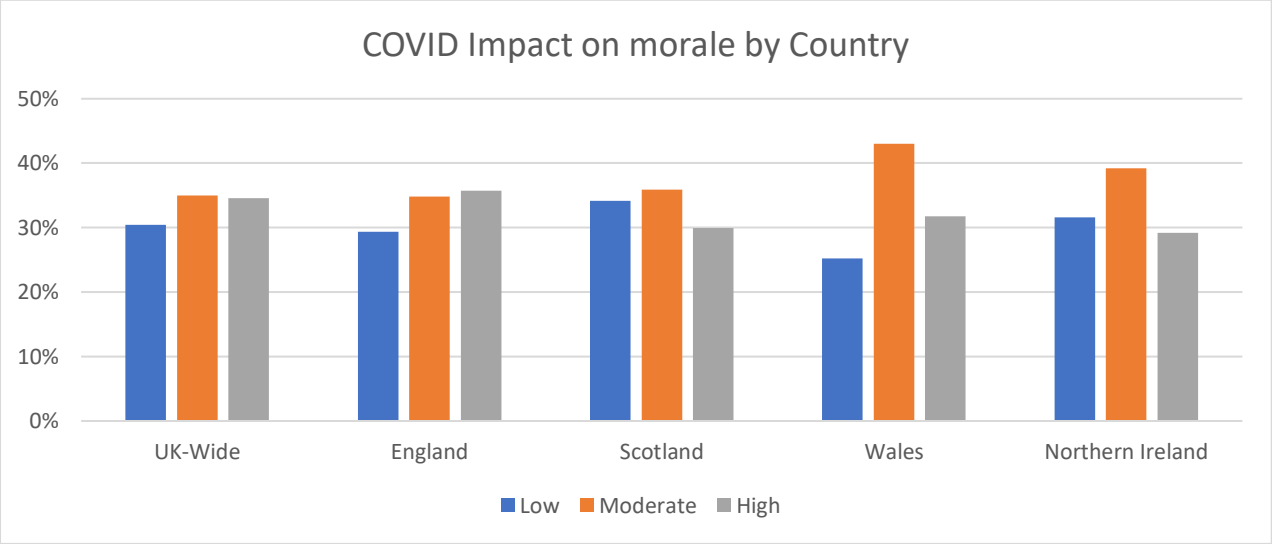


Figure A2.107: Respondents impact on COVID on their morale by Country (Unweighted)

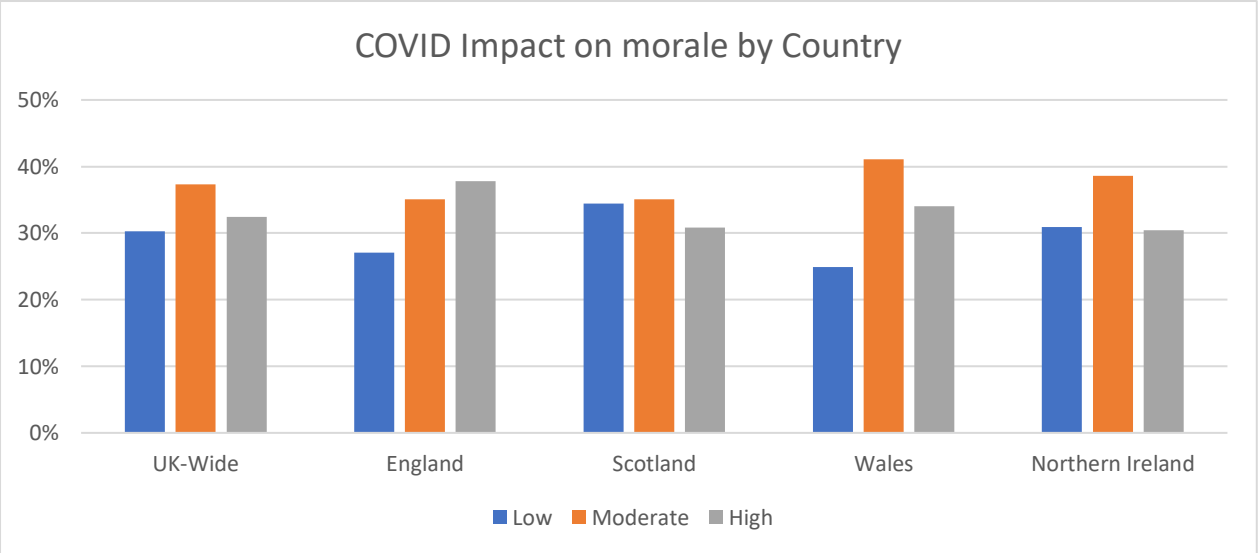


Table A2.107: Respondents impact on COVID on their morale by Country (Weighted)

What has been the impact of working through COVID-19, on your morale?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Low Impact	30.4%	29.4%	34.2%	25.2%	31.6%
Moderate Impact	35.0%	34.8%	35.9%	43.0%	39.2%
High Impact	34.6%	35.7%	29.9%	31.8%	29.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.108: Respondents impact on COVID on their morale by Country (Unweighted)

What has been the impact of working through COVID-19, on your morale?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Low Impact	755 (30.3%)	132 (27.1%)	235 (34.4%)	74 (24.9%)	314 (30.9%)
Moderate Impact	927 (37.3%)	171 (35.1%)	242 (35.1%)	122 (41.1%)	392 (38.6%)
High Impact	806 (32.4%)	184 (37.8%)	212 (30.8%)	101 (34.0%)	309 (30.4%)
Total	**2488 (100%)**	**487 (100%)**	**689 (100%)**	**297 (100%)**	**1015 (100%)**

Figure A2.108: Respondents impact on COVID on their morale by Occupation (Weighted)

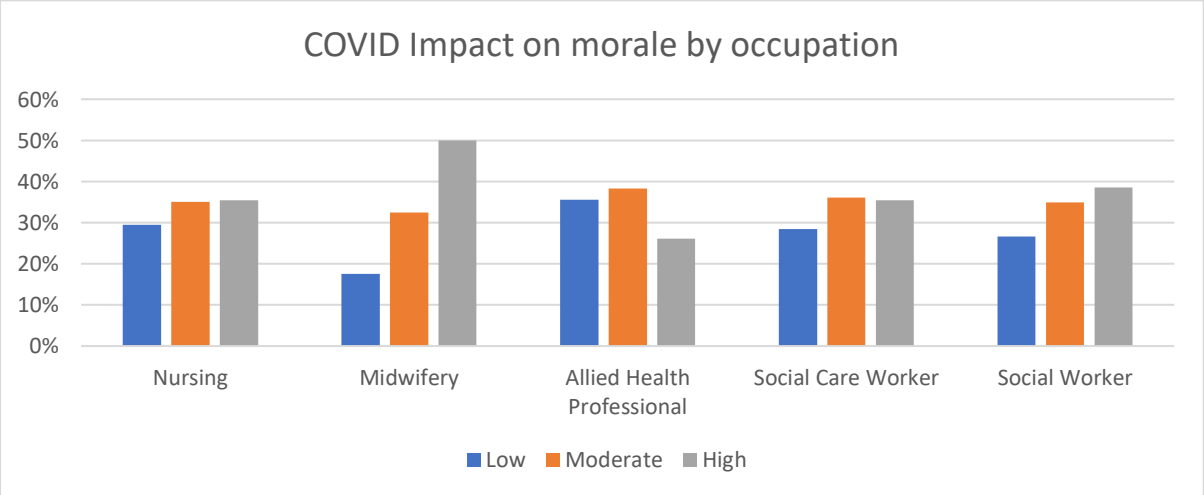


Figure A2.109: Respondents impact on COVID on their morale by Occupation (Unweighted)

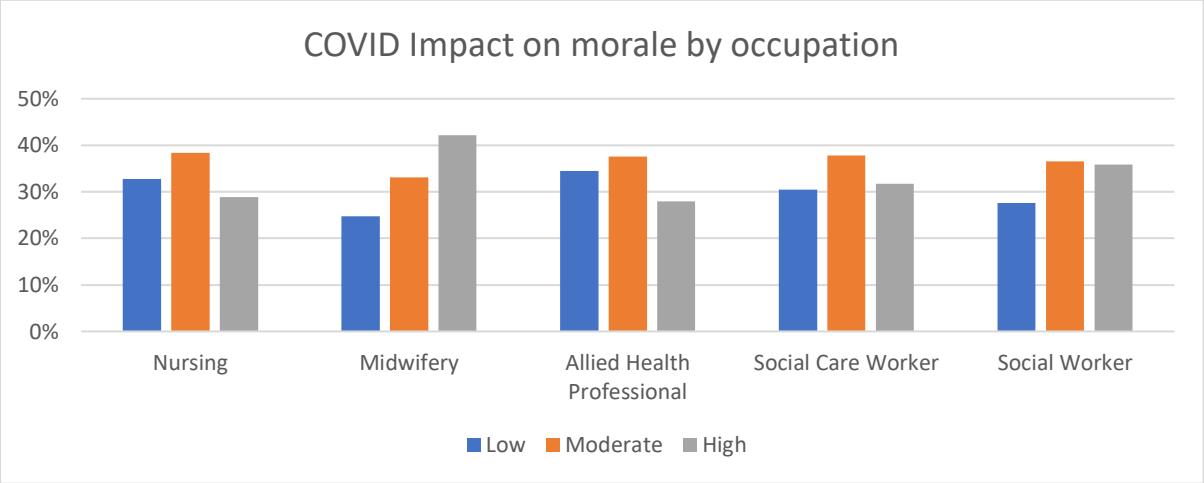


Table A2.109: Respondents impact on COVID on their morale by Occupation (Weighted)

Occupation	What has been the impact of working through COVID-19, on your morale?.			
	Low	Moderate	High	Total
Nursing	29.5%	35.1%	35.4%	**100%**
Midwifery	17.5%	32.5%	50.0%	**100%**
AHP	35.6%	38.3%	26.1%	**100%**
Social Care Worker	28.4%	36.1%	35.5%	**100%**
Social Worker	26.6%	34.9%	38.5%	**100%**

Table A2.110: Respondents impact on COVID on their morale by Occupation (Unweighted)

Occupation	What has been the impact of working through COVID-19, on your morale?.			
	Low	Moderate	High	Total
Nursing	169 (32.8%)	198 (38.4%)	149 (28.9%)	**516 (100%)**
Midwifery	38 (24.7%)	51 (33.1%)	65 (42.2%)	**154 (100%)**
AHP	120 (34.5%)	131 (37.6%)	97 (27.9%)	**348 (100%)**
Social Care Worker	237 (30.5%)	294 (37.8%)	246 (31.7%)	**777 (100%)**
Social Worker	191 (27.6%)	253 (36.5%)	249 (35.9%)	**683 (100%)**

A2.25 Respondents Considering Changing their Employer

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

- Limited options in their area
- Restructure
- High risk
- Refusal to be furloughed due to illness
- Bullying behaviour in workplace
- Need for more hours
- Unmanageable stress
- Family
- Los of autonomy and flexibility
- No job security – temporary contracts
- Not valued or supported
- Poor work-life balance
- Considering retirement
- Costs of working at home

Figure A2.110: Considering Changing Employer by Country (Weighted)

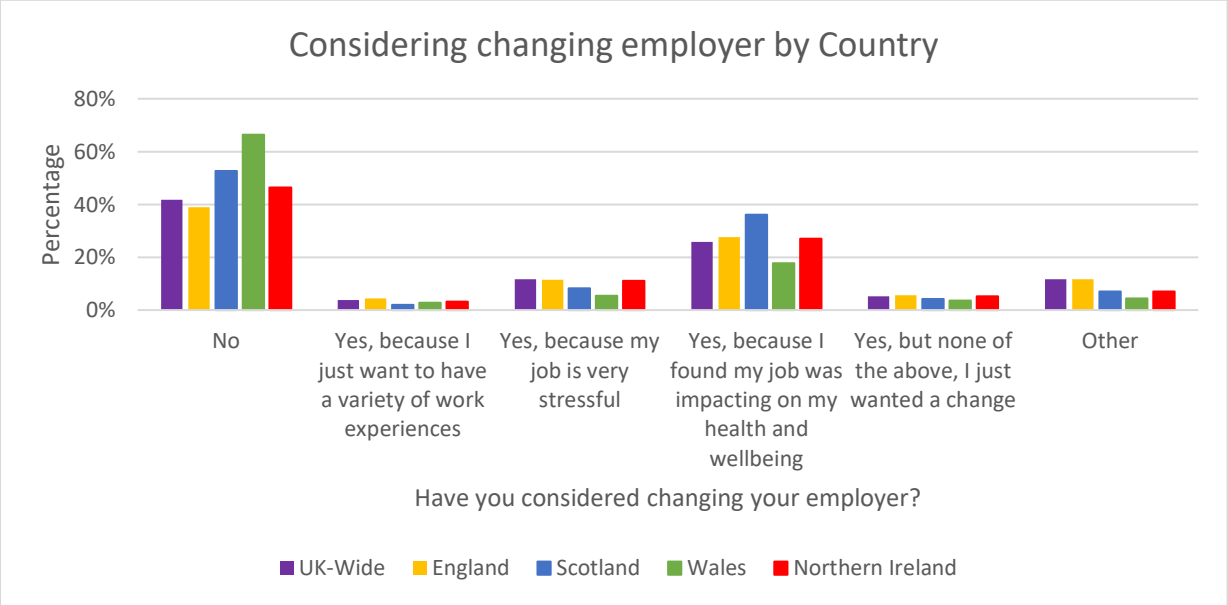


Figure A2.111: Considering Changing Employer by Country (Unweighted)

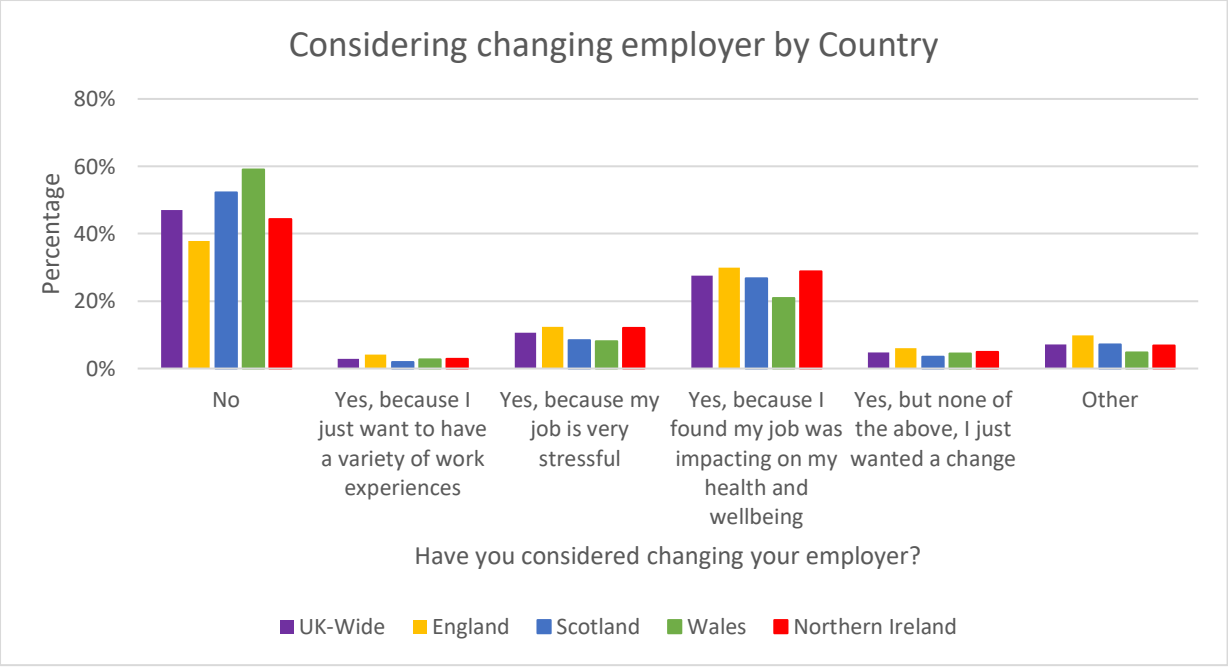


Table A2.111: Considering Changing Employer by Country (Weighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	41.8%	39.0%	52.6%	66.3%	46.4%
Yes, because I just want to have a variety of work experiences	3.8%	4.5%	1.9%	2.7%	3.2%
Yes, because my job is very stressful	11.6%	11.4%	8.3%	5.4%	11.1%
Yes, because I found my job was impacting on my health and wellbeing	25.8%	27.6%	36.1%	17.8%	27.0%
Yes, but none of the above, I just wanted a change	5.3%	5.7%	4.1%	3.5%	5.3%
Other	11.7%	11.7%	7.0%	4.3%	7.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.112: Considering Changing Employer by Country (Unweighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	1171 (47.0%)	184 (37.8%)	362 (52.3%)	175 (59.1%)	450 (44.3%)
Yes, because I just want to have a variety of work experiences	70 (2.8%)	20 (4.1%)	13 (1.9%)	8 (2.7%)	29 (2.9%)
Yes, because my job is very stressful	265 (10.6%)	60 (12.3%)	58 (8.4%)	24 (8.1%)	123 (12.1%)
Yes, because I found my job was impacting on my health and wellbeing	687 (27.6%)	146 (30.0%)	186 (26.8%)	62 (20.9%)	293 (28.9%)
Yes, but none of the above, I just wanted a change	117 (4.7%)	29 (6.0%)	24 (3.5%)	13 (4.4%)	51 (5.0%)
Other	180 (7.2%)	48 (9.9%)	49 (7.1%)	14 (4.7%)	69 (6.8%)
Total	**2490 (100%)**	**487 (100%)**	**692 (100%)**	**296 (100%)**	**1015 (100%)**

Figure A2.112: Considering Changing Employer by Occupation (Weighted)

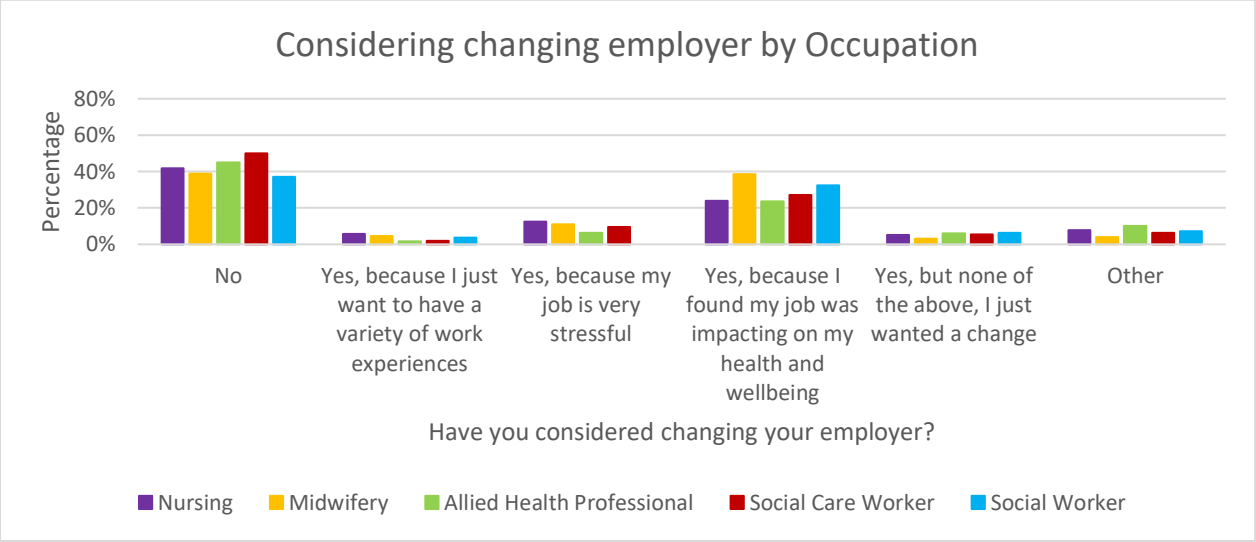


Figure A2.113: Considering Changing Employer by Occupation (Unweighted)

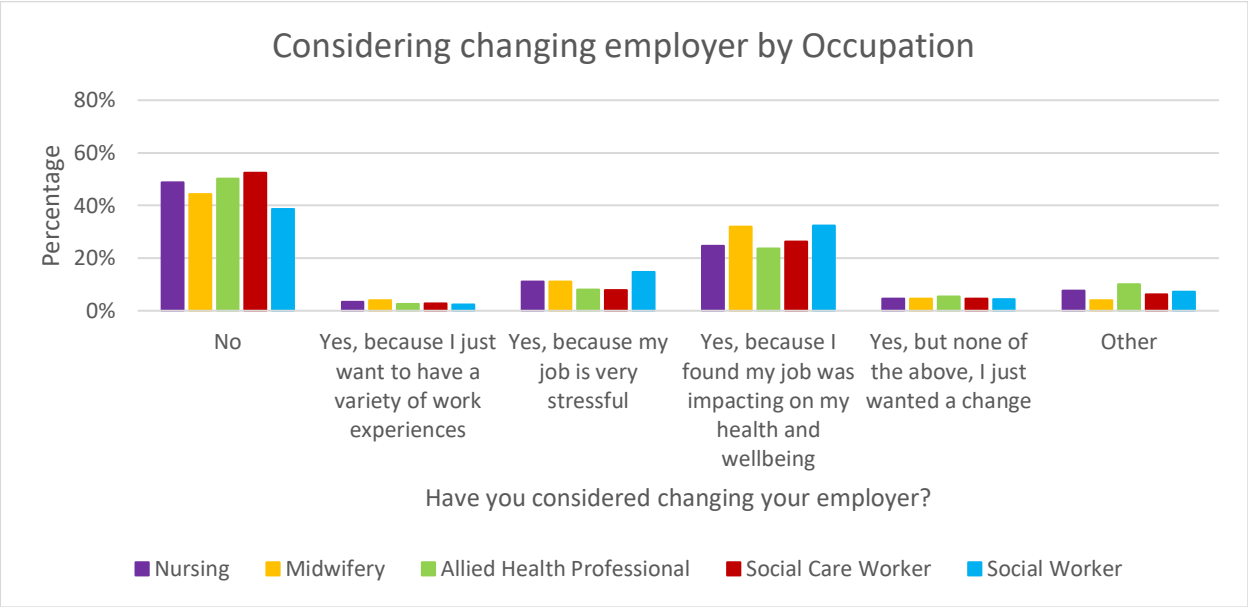


Table A2.113: Considering Changing Employer by Occupation (Weighted)

Occupation	Have you considered changing your employer?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	
Nursing	41.7%	5.8%	12.4%	24.0%	5.0%	7.7%	**100%**
Midwifery	38.9%	4.7%	10.9%	38.6%	3.1%	3.9%	**100%**
AHP	44.9%	1.7%	6.4%	23.6%	6.0%	10.1%	**100%**
Social Care Worker	50.1%	2.0%	9.4%	27.1%	5.4%	6.2%	**100%**
Social Worker	37.0%	3.6%	13..9%	32.4%	6.2%	7.3%	**100%**

Table A2.114: Considering Changing Employer by Occupation (Unweighted)

Occupation	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	252 (48.7%)	17 (3.3%)	57 (11.0%)	127 (24.6%)	24 (4.6%)	40 (7.7%)	**517 (100%)**
Midwifery	68 (44.4%)	6 (3.9%)	17 (11.1%)	49 (32.0%)	7 (4.6%)	6 (3.9%)	**153 (100%)**
AHP	175 (50.3%)	9 (2.6%)	28 (8.0%)	82 (23.6%)	19 (5.5%)	35 (10.1%)	**348 (100%)**
Social Care Worker	408 (52.4%)	21 (2.7%)	61 (7.8%)	204 (26.2%)	36 (4.6%)	48 (6.2%)	**778 (100%)**
Social Worker	268 (38.6%)	17 (2.4%)	102 (14.7%)	225 (32.4%)	31 (4.5%)	51 (7.3%0	**694 (100%)**

A2.26 Respondents Considering Changing their Occupation

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

Summary (Weighted results):

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

Summary (Unweighted results):

Respondents from Wales and Social Care Workers 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;

- Retraining required
- Considering retirement
- Job is now too demanding
- Unable to work for hours at home
- Redeployed with no sign of returning to original role
- Additional family pressures
- Constant stress for the foreseeable future
- Lack of organisation support for the occupation
- Wages are too low
- Not wanting to get COVID Vaccine
- Frightened

Figure A2.114: Considering Changing Occupation by Country (Weighted)

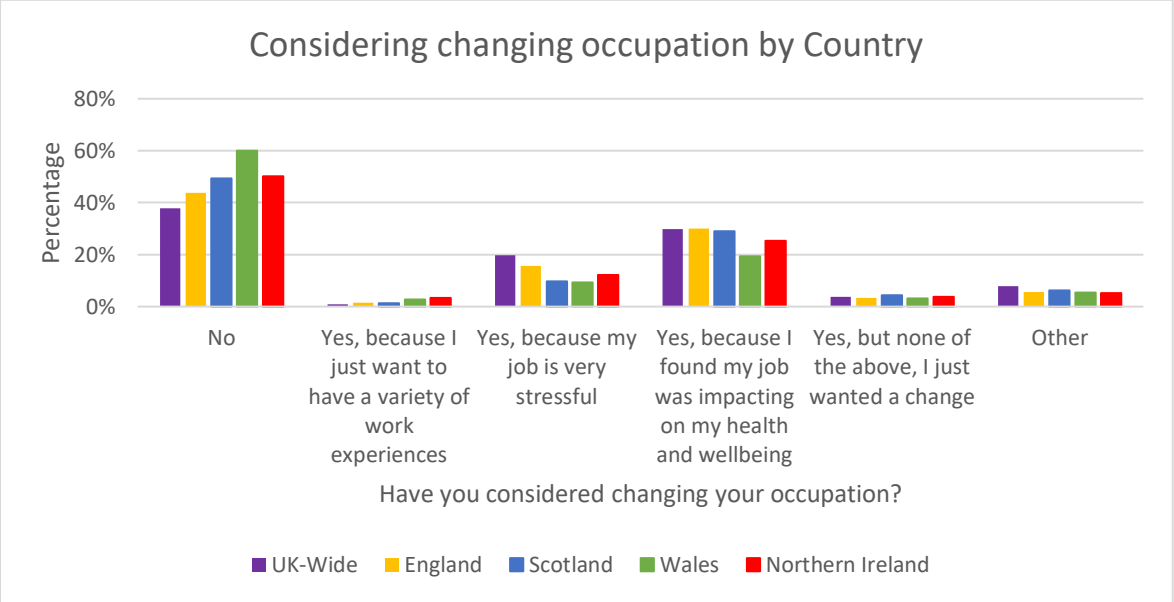


Figure A2.115: Considering Changing Occupation by Country (Unweighted)

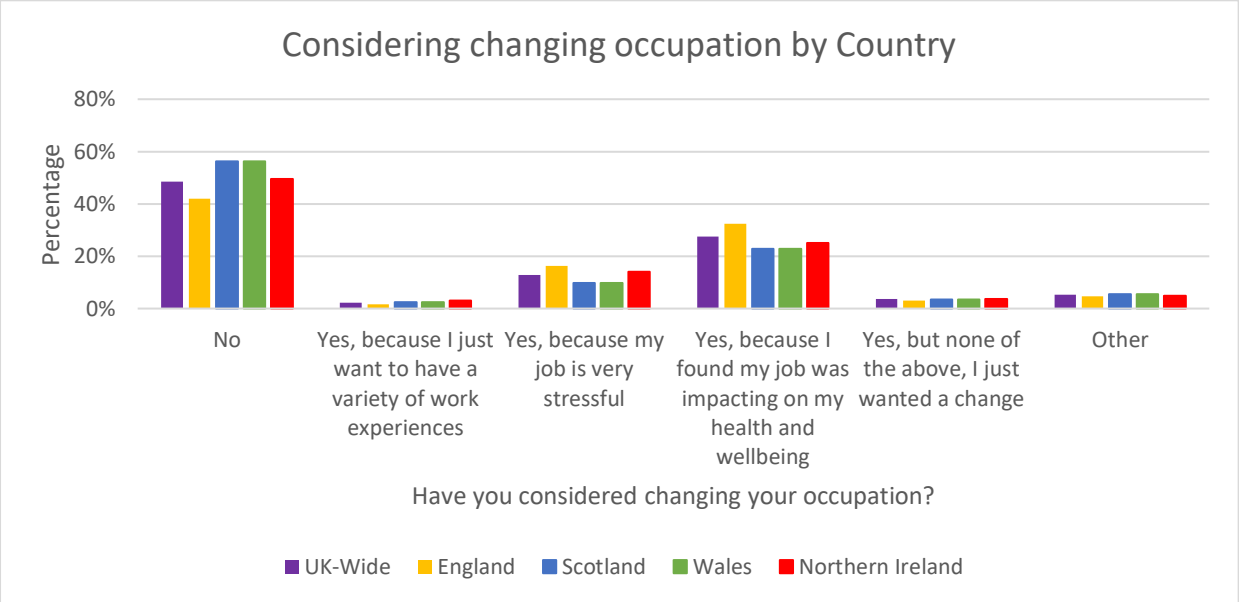


Table A2.115: Considering Changing Occupation by Country (Weighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	37.8%	43.8%	49.4%	60.1%	50.2%
Yes, because I just want to have a variety of work experiences	0.9%	1.5%	1.2%	2.7%	3.3%
Yes, because my job is very stressful	19.7%	15.6%	9.8%	9.3%	12.2%
Yes, because I found my job was impacting on my health and wellbeing	29.9%	30.0%	29.0%	19.4%	25.4%
Yes, but none of the above, I just wanted a change	3.8%	3.3%	4.4%	3.1%	3.7%
Other	7.9%	5.7%	6.3%	5.4%	5.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.116: Considering Changing Occupation by Country (Unweighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	1208 (48.6%)	204 (41.9%)	336 (48.6%)	167 (56.2%)	501 (49.5%)
Yes, because I just want to have a variety of work experiences	54 (2.2%)	8 (1.6%)	9 (1.3%)	7 (2.4%)	30 (3.0%)
Yes, because my job is very stressful	319 (12.8%)	79 (16.2%)	69 (10.0%)	29 (9.8%)	142 (14.0%)
Yes, because I found my job was impacting on my health and wellbeing	685 (17.5%)	158 (32.4%)	205 (29.7%)	68 (22.9%)	254 (25.1%)
Yes, but none of the above, I just wanted a change	90 (3.6%)	15 (3.1%)	29 (4.2%)	10 (3.4%)	36 (3.6%)
Other	132 (5.3%)	23 (4.7%)	43 (6.2%)	16 (5.4%)	50 (4.9%)
Total	**2488 (100%)**	**487 (100%)**	**691 (100%)**	**297 (100%)**	**1013 (100%)**

Figure A2.116: Considering Changing Occupation by Occupation (Weighted)

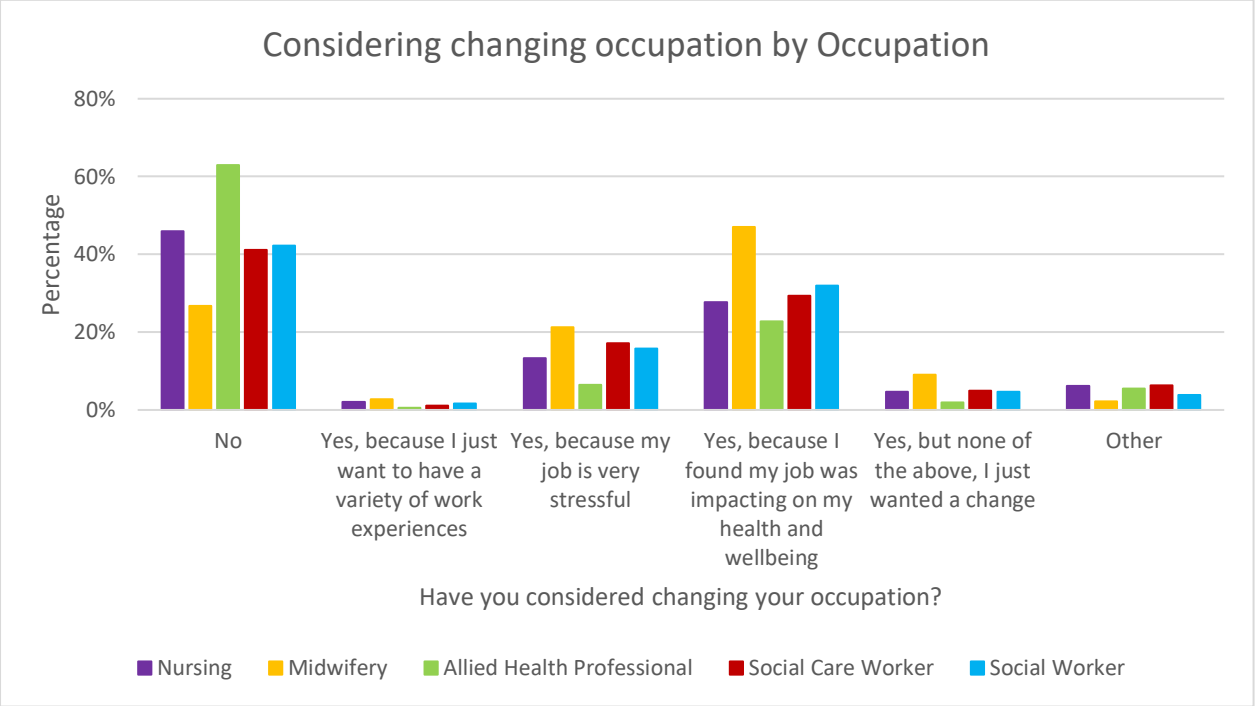


Figure A2.117: Considering Changing Occupation by Occupation (Unweighted)

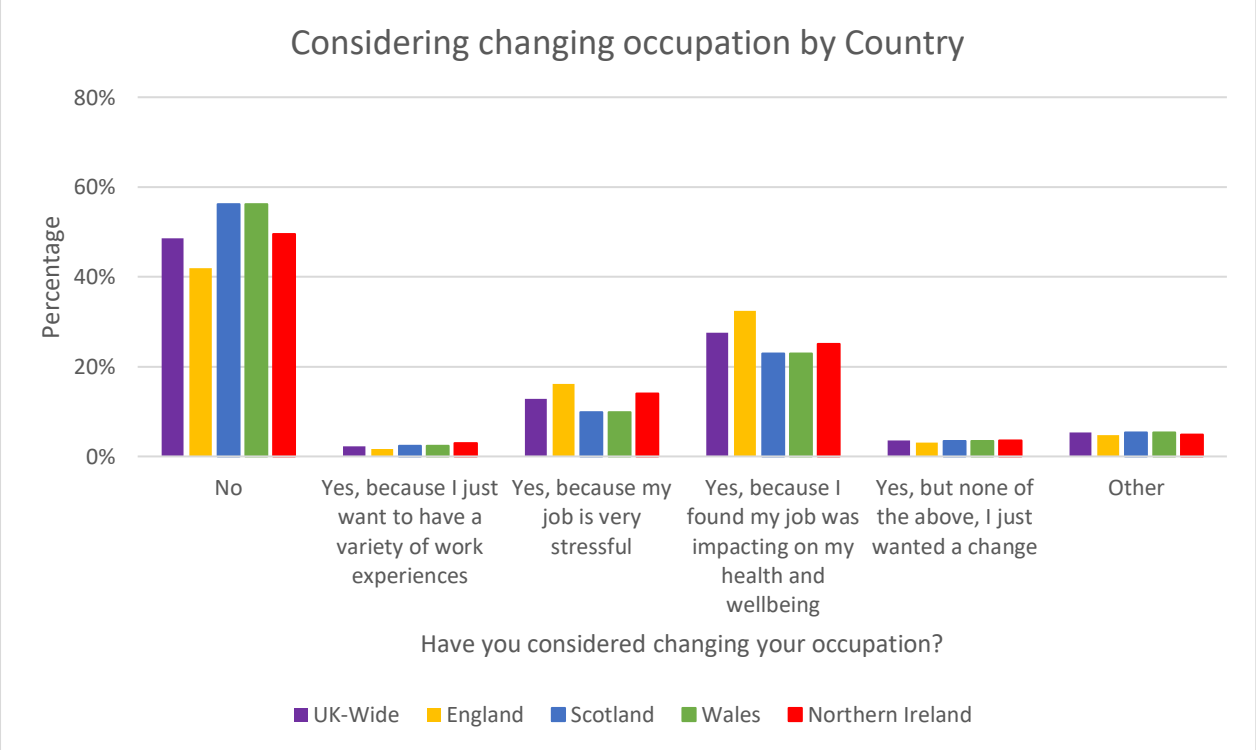


Table A2.117: Considering Changing Occupation by Occupation (Weighted)

Occupation	Have you considered changing your occupation?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	
Nursing	46.0%	2.1%	13.3%	27.7%	4.7%	6.2%	**100%**
Midwifery	26.8%	2.8%	21.2%	47.0%	9.0%	2.2%	**100%**
AHP	63.0%	0.5%	6.4%	22.7%	1.9%	5.5%	**100%**
Social Care Worker	41.1%	1.1%	17.1%	29.4%	4.9%	6.3%	**100%**
Social Worker	42.2%	1.6%	15.8%	32.0%	4.6%	3.9%	**100%**

Table A2.118: 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 wellbeing	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	257 (49.8%)	9 (1.7%)	59 (11.4%)	140 (27.1%)	19 (3.7%)	32 (6.2%)	**516 (100%)**
Midwifery	58 (37.7%)	3 (1.9%)	31 (20.1%)	58 (37.7%)	1 (0.6%)	3 (1.9%)	**154 (100%)**
AHP	204 (58.6%)	8 (2.3%)	32 (9.2%)	74 (21.3%)	13 (3.7%)	17 (4.9%)	**348 (100%)**
Social Care Worker	380 (48.9%)	22 (2.8%)	88 (11.3%)	211 (27.2%)	33 (4.2%)	43 (5.5%)	**777 (100%)**
Social Worker	309 (44.6%)	12 (1.7%)	109 (15.7%)	202 (29.1%)	24 (3.5%)	37 (5.3%)	**693 (100%)**

A2.25 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 manager support, followed by pay increase and other are what needs to happen for them to change their minds about wanting to leave.

Summary (Unweighted results):

More respondents felt that manager support, followed by pay increase and 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.

Figure A2.118: What has to happen for you to change your mind about wanting to leave by Country (Weighted)

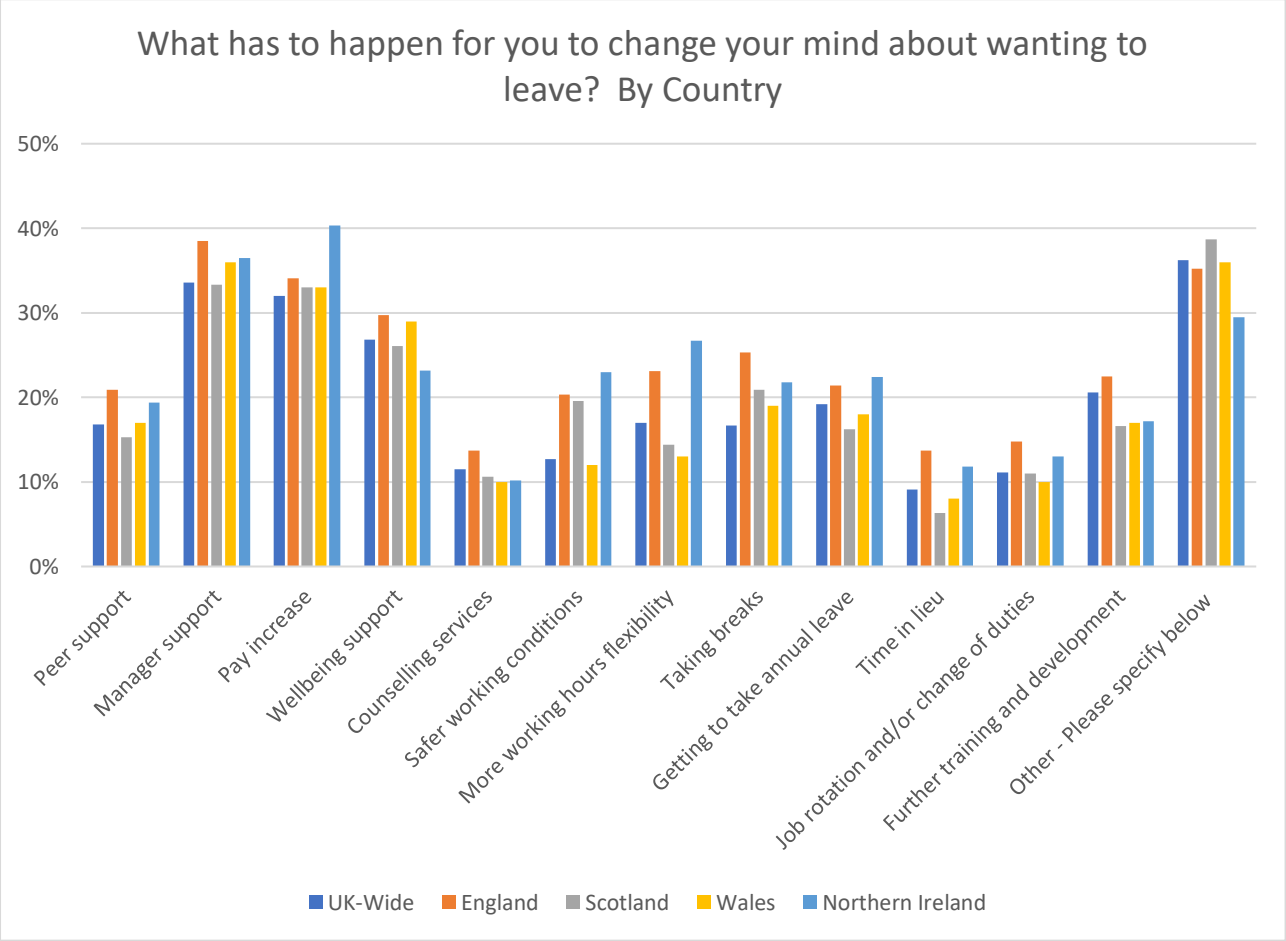


Figure A2.119: What has to happen for you to change your mind about wanting to leave by Country (Unweighted)

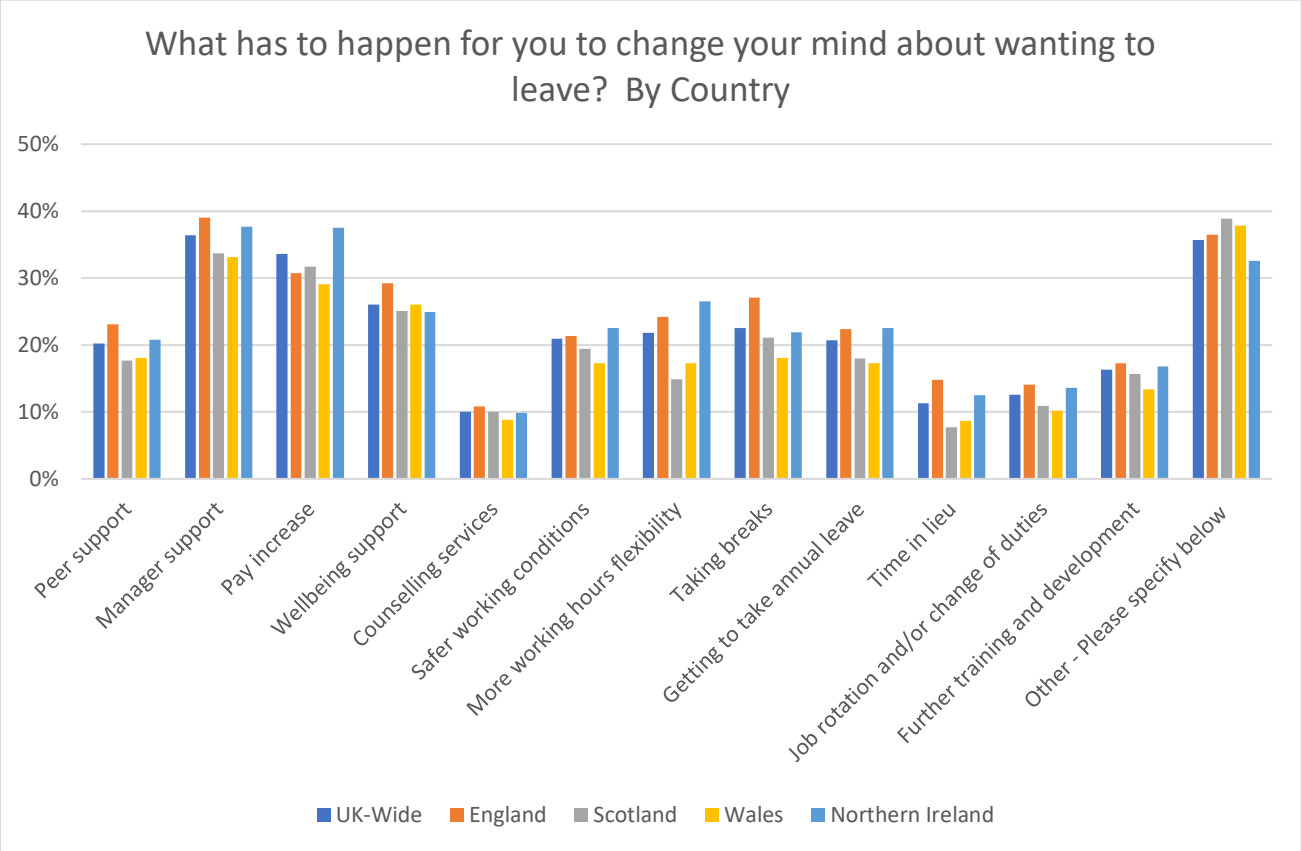


Table A2.119: What has to happen for you to change your mind about wanting to leave by Country (Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	16.8%	20.9%	15.3%	17.0%	19.4%
Manager support	33.6%	38.5%	33.3%	36.0%	36.5%
Pay increase	32.0%	34.1%	33.0%	33.0%	40.3%
Wellbeing support	26.8%	29.7%	26.1%	29.0%	23.2%
Counselling services	11.5%	13.7%	10.6%	10.0%	10.2%
Safer working conditions	12.7%	20.3%	19.6%	12.0%	23.0%
More working hours flexibility	17.0%	23.1%	14.4%	13.0%	26.7%
Taking breaks	16.7%	25.3%	20.9%	19.0%	21.8%
Getting to take annual leave	19.2%	21.4%	16.2%	18.0%	22.4%
Time in lieu	9.1%	13.7%	6.3%	8.0%	11.8%
Job rotation and/or change of duties	11.1%	14.8%	11.0%	10.0%	13.0%
Further training and development	20.6%	22.5%	16.6%	17.0%	17.2%
Other - Please specify below	36.2%	35.2%	38.7%	36.0%	29.5%

Table A2.120: 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	254 (20.2%)	64 (23.1%)	62 (17.7%)	23 (18.1%)	105 (20.8%)
Manager support	459 (36.4%)	108 (39.0%)	118 (33.7%)	42 (33.1%)	191 (37.7%)
Pay increase	423 (33.6%)	85 (30.7%)	111 (31.7%)	37 (29.1%)	190 (37.5%)
Wellbeing support	328 (26.0%)	81 (29.2%)	88 (25.1%)	33 (26.0%)	126 (24.9%)
Counselling services	126 (10.0%)	30 (10.8%)	35 (10.0%)	11 (8.8%)	50 (9.9%)
Safer working conditions	263 (20.9%)	59 (21.3%)	68 (19.4%)	22 (17.3%)	114 (22.5%)
More working hours flexibility	275 (21.8%)	67 (24.2%)	52 (14.9%)	22 (17.3%)	134 (26.5%)
Taking breaks	283 (22.5%)	75 (27.1%)	74 (21.1%)	23 (18.1%)	111 (21.9%)
Getting to take annual leave	261 (20.7%)	62 (22.4%)	63 (18.0%)	22 (17.3%)	114 (22.5%)
Time in lieu	142 (11.3%)	41 (14.8%)	27 (7.7%)	11 (8.7%)	63 (12.5%)
Job rotation and/or change of duties	159 (12.6%)	39 (14.1%)	38 (10.9%)	13 (10.2%)	69 (13.6%)
Further training and development	205 (16.3%0	48 (17.3%)	55 (15.7%)	17 (13.4%)	85 (16.8%)
Other - Please specify below	450 (35.7%)	101 (36.5%)	136 (38.9%)	48 (37.8%)	165 (32.6%)
Total	**1260**	**277**	**350**	**127**	**506**

Figure A2.120: What has to happen for you to change your mind about wanting to leave by Occupation (Weighted)

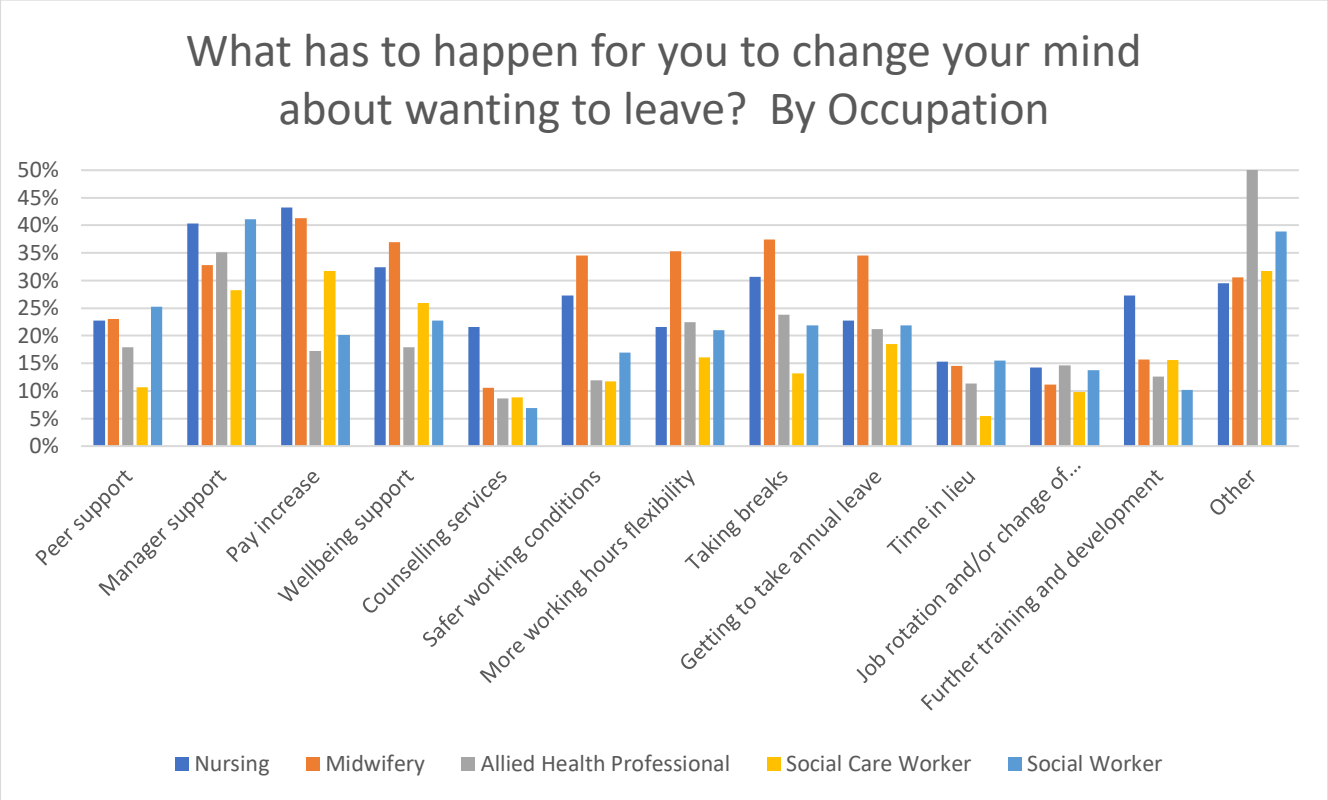


Figure A2.121: What has to happen for you to change your mind about wanting to leave by Occupation (Unweighted)

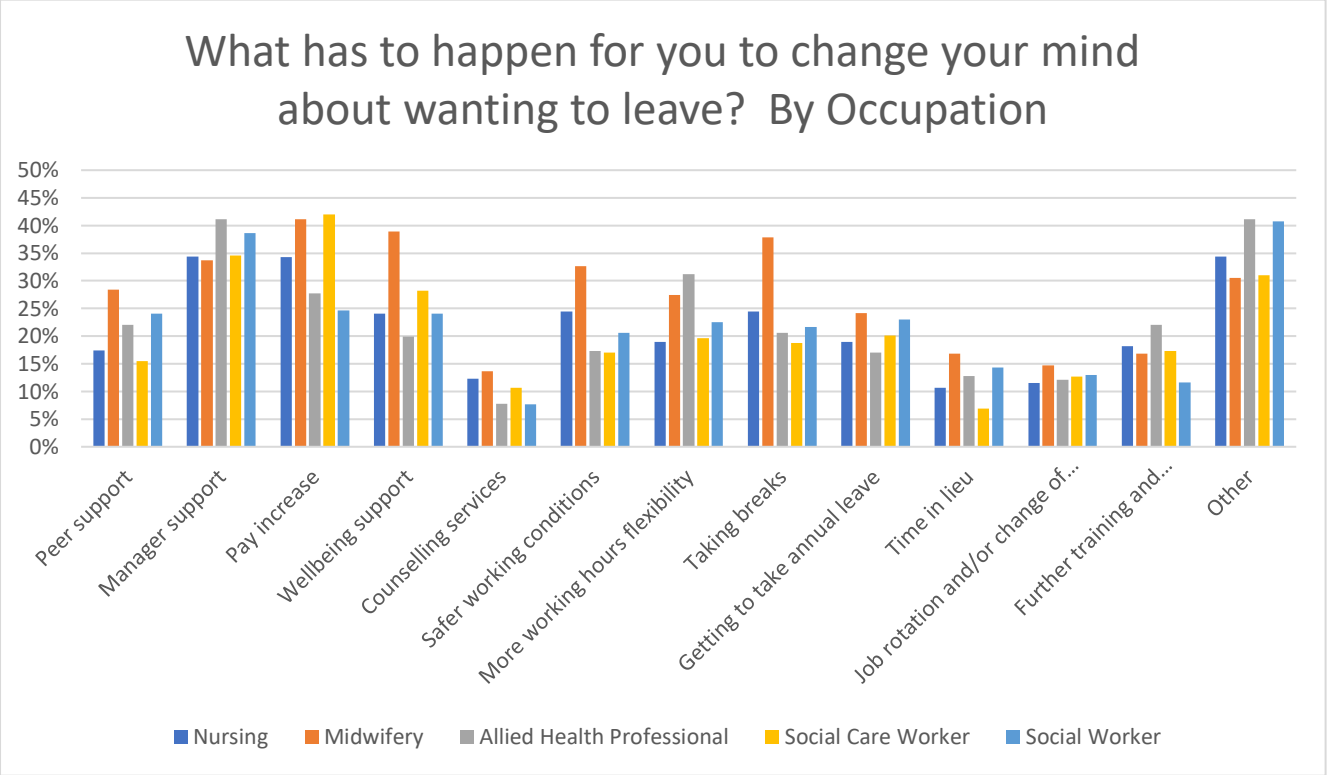


Table A2.121: What has to happen for you to change your mind about wanting to leave by Occupation(Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	22.7%	23.0%	17.9%	10.7%	25.3%
Manager support	40.3%	32.8%	41.3%	37.0%	10.6%
Pay increase	43.2%	41.3%	17.2%	31.7%	20.1%
Wellbeing support	32.4%	37.%	17.9%	25.9%	22.7%
Counselling services	21.6%	10.6%	8.6%	8.8%	6.9%
Safer working conditions	27.3%	34.5%	11.9%	11.7%	16.9%
More working hours flexibility	21.6%	35.3%	22.5%	16.1%	21.0%
Taking breaks	30.7%	37.4%	23.8%	13.2%	21.9%
Getting to take annual leave	22.7%	34.5%	21.2%	18.5%	21.9%
Time in lieu	15.3%	14.5%	11.3%	5.4%	15.5%
Job rotation and/or change of duties	14.2%	11.1%	14.6%	9.8%	13.8%
Further training and development	27.3%	15.7%	12.6%	15.6%	10.2%
Other - Please specify below	29.5%	30.6%	52.3%	31.7%	38.9%

Table A2.122: 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	44 (17.4%)	27 (28.4%)	31 (22.0%)	61 (15.5%)	91 (24.1%)
Manager support	87 (34.4%)	32 (33.7%)	58 (41.1%)	136 (34.6%)	146 (38.6%)
Pay increase	87 (34.3%)	39 (41.1%)	39 (27.7%)	165 (42.0%)	93 (24.6%)
Wellbeing support	61 (24.1%)	37 (38.9%)	28 (19.9%)	111 (28.2%)	91 (24.1%)
Counselling services	31 (12.3%)	13 (13.7%)	11 (7.8%)	42 (10.7%)	29 (7.7%)
Safer working conditions	62 (24.5%)	31 (32.6%)	25 (17.3%)	67 (17.0%)	78 (20.6%)
More working hours flexibility	43 (19.0%)	26 (27.4%)	44 (31.2%)	77 (19.6%)	85 (22.5%)
Taking breaks	62 (24.5%)	36 (37.9%)	29 (20.6%)	74 (18.8%)	82 (21.7%)
Getting to take annual leave	48 (19.0%)	23 (24.2%)	24 (17.0%)	79 (20.1%)	87 (23.0%)
Time in lieu	27 (10.7%)	16 (16.8%)	18 (12.8%)	27 (6.9%)	54 (14.3%)
Job rotation and/or change of duties	29 (11.5%)	14 (14.7%)	17 (12.1%)	50 (12.7%)	49 (13.0%)
Further training and development	46 (18.2%)	16 (16.8%)	31 (22.0%)	68 (17.3%)	44 (11.6%)
Other - Please specify below	87 (34.4%)	29 (30.5%)	58 (41.1%)	122 (31.0%)	154 (40.7%)
Total of respondents answering question	**253**	**95**	**141**	**393**	**378**

A2.25 Respondents taking up employer support

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

Summary (Weighted results):

Most respondents did not take up employer support. Out of all occupations social workers were most likely to take up employer wellbeing support while midwives were least likely to take up support.

Summary (Unweighted results):

Most respondents did not take up employer support (74.2%). Out of all occupations social workers were most likely to take up employer wellbeing support while midwives were least likely to take up support. Those respondents in Northern Ireland were less likely to take up employer support.

Figure A2.122: Taken up Employer support by Country (Weighted)

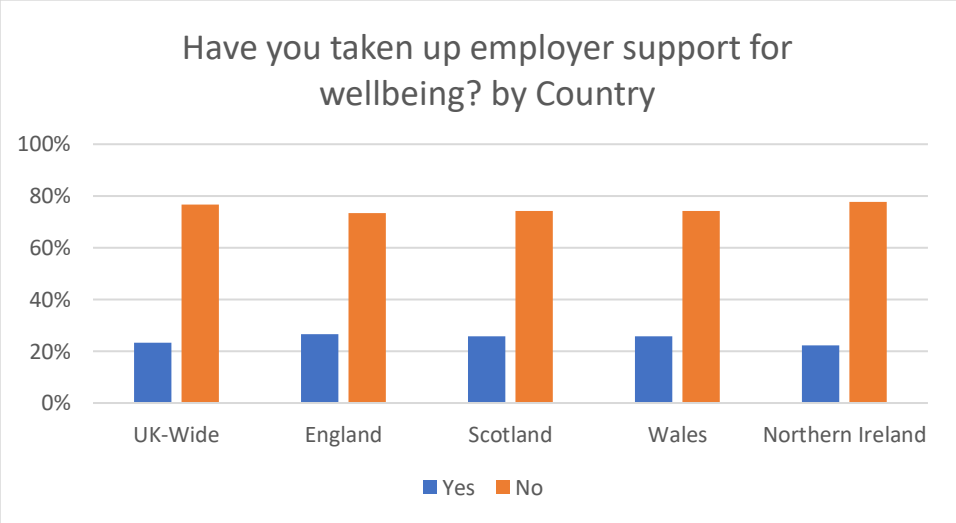


Figure A2.123: Taken up Employer support by Country (Unweighted)

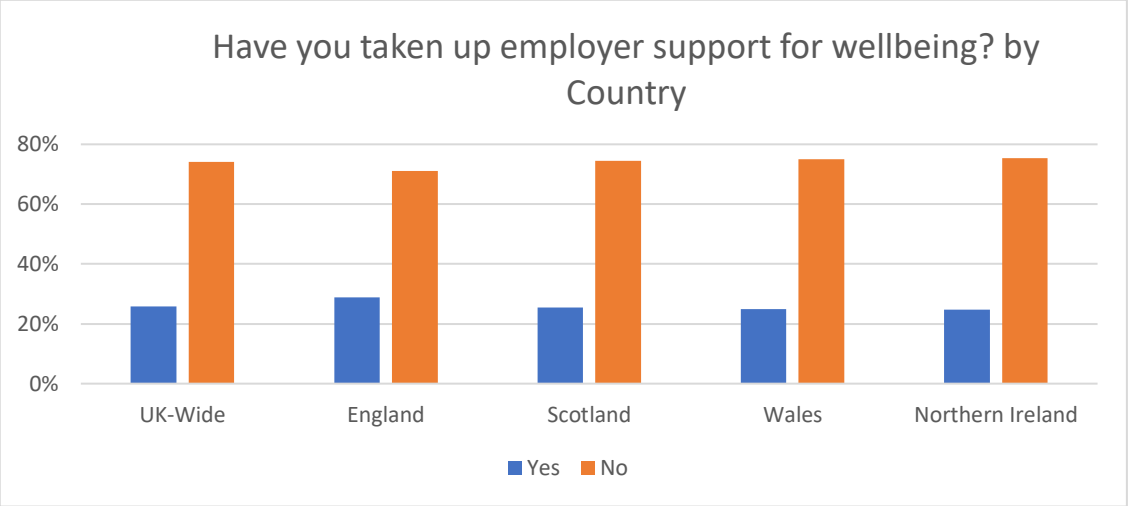


Table A2.123: Taken up employer support by Country (Weighted)

Have you taken up employer support for wellbeing?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	23.4%	26.7%	25.8%	25.7%	22.3%
No	76.6%	73.3%	74.2%	74.3%	77.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.124: Taken up employer support by Country (Unweighted)

Have you taken up employer support for wellbeing?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	638 (25.8%)	140 (28.9%)	175 (25.5%)	74 (25.0%)	249 (24.7%)
No	1836 (74.2%)	344 (71.1%)	512 (74.5%)	222 (75.0%)	758 (75.3%)
Total	**2474 (100%)**	**484 (100%)**	**687 (100%)**	**296 (100%)**	**1007 (100%)**

Figure A2.124: Taken up Employer support by Occupation (Weighted)

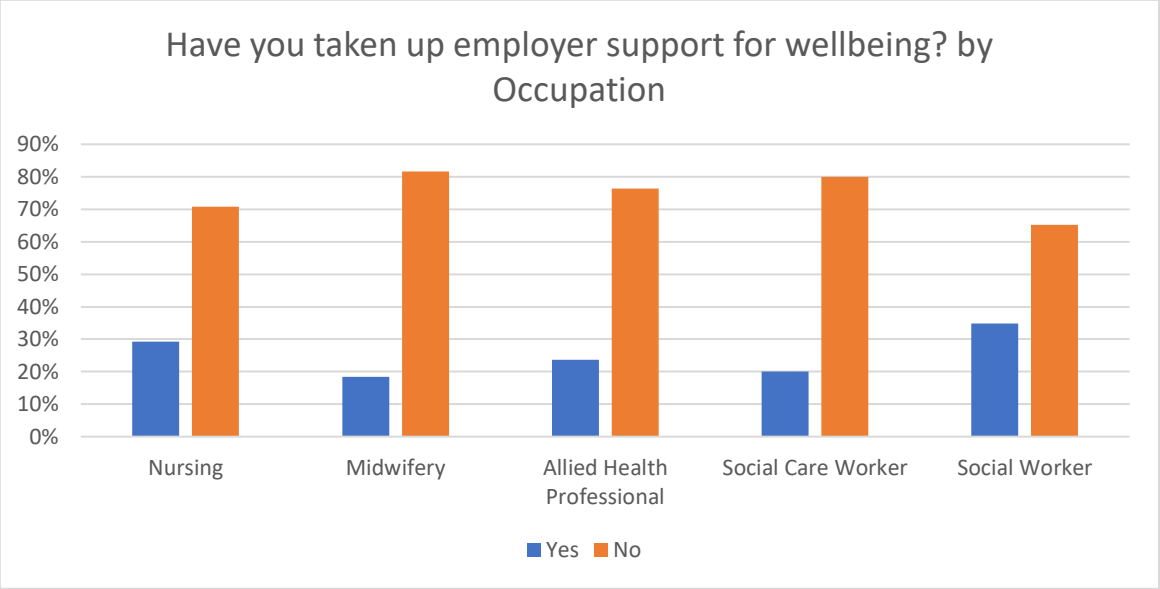


Figure A2.125: Taken up Employer support by Occupation (Unweighted)

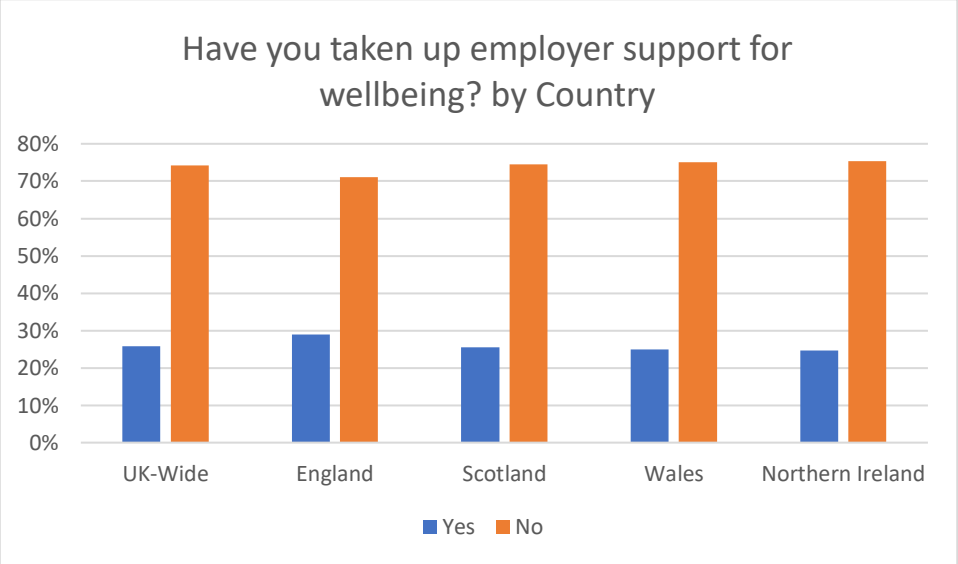


Table A2.125: Taken up employer support by Occupation (Weighted)

Have you taken up employer support for wellbeing?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	29.2%	18.4%	23.6%	20.0%	34.8%
No	70.8%	81.6%	76.4%	80.0%	65.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.126: Taken up employer support by Occupation (Unweighted)

Have you taken up employer support for wellbeing?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	140 (27.5%)	30 (19.6%)	86 (24.9%)	159 (20.5%)	223 (32.2%)
No	370 (72.5%)	123 (80.4%)	259 (75.1%)	615 (79.5%)	469 (67.8%)
Total	**510 (100%)**	**153 (100%)**	**345 (100%)**	**774 (100%)**	**692 (100%)**

A2.25 Respondents on what employer support they have taken up

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

Summary (Weighted results):

Most respondents reported that they had taken up wellbeing support from their employers.

Summary (Unweighted results):

Most respondents reported that they had taken up wellbeing support and manager support from their employers for their wellbeing.

Figure A2.126: What have you taken up from your employer to support your wellbeing by Country (Weighted)

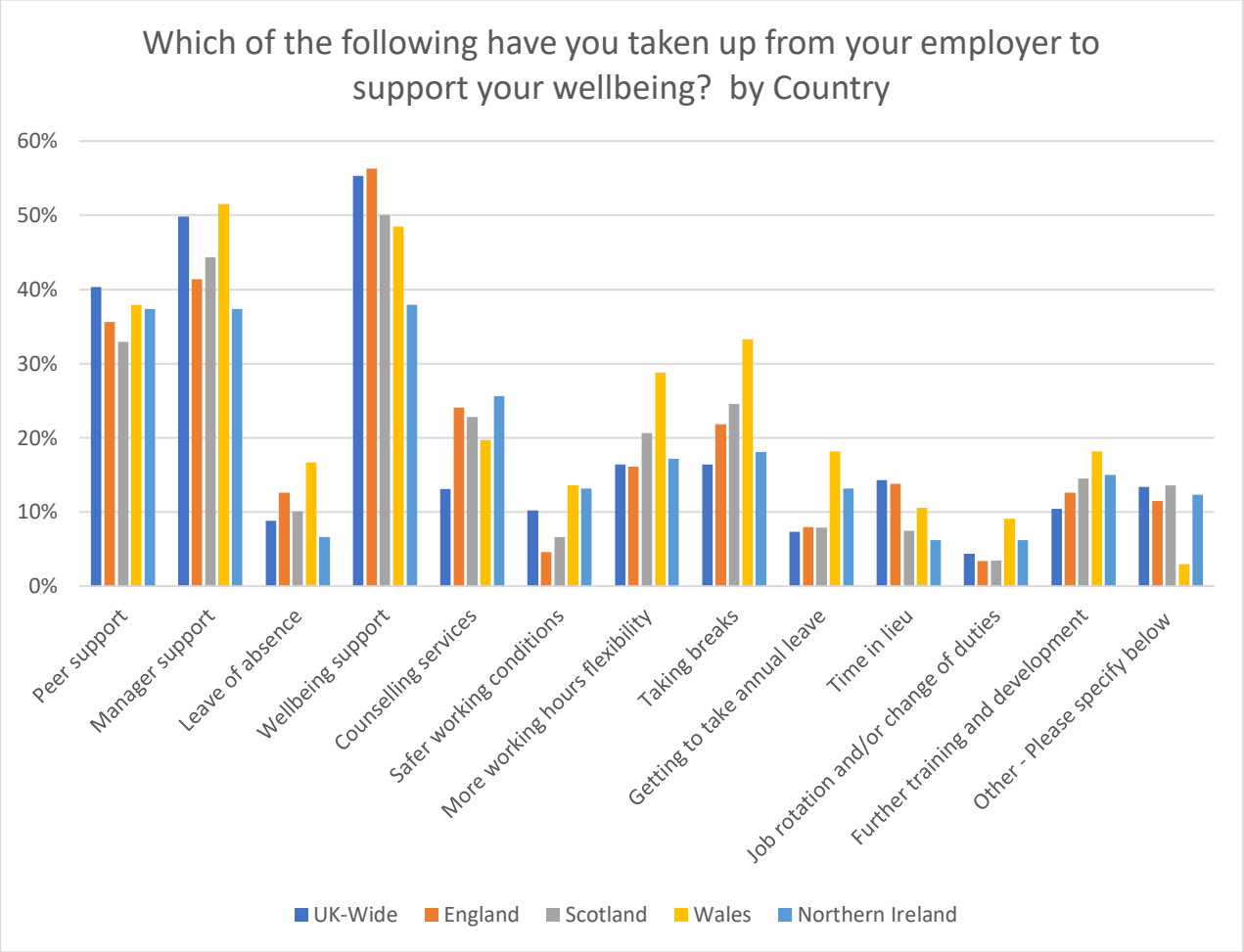


Figure A2.127: What have you taken up from your employer to support your wellbeing by Country (Unweighted)

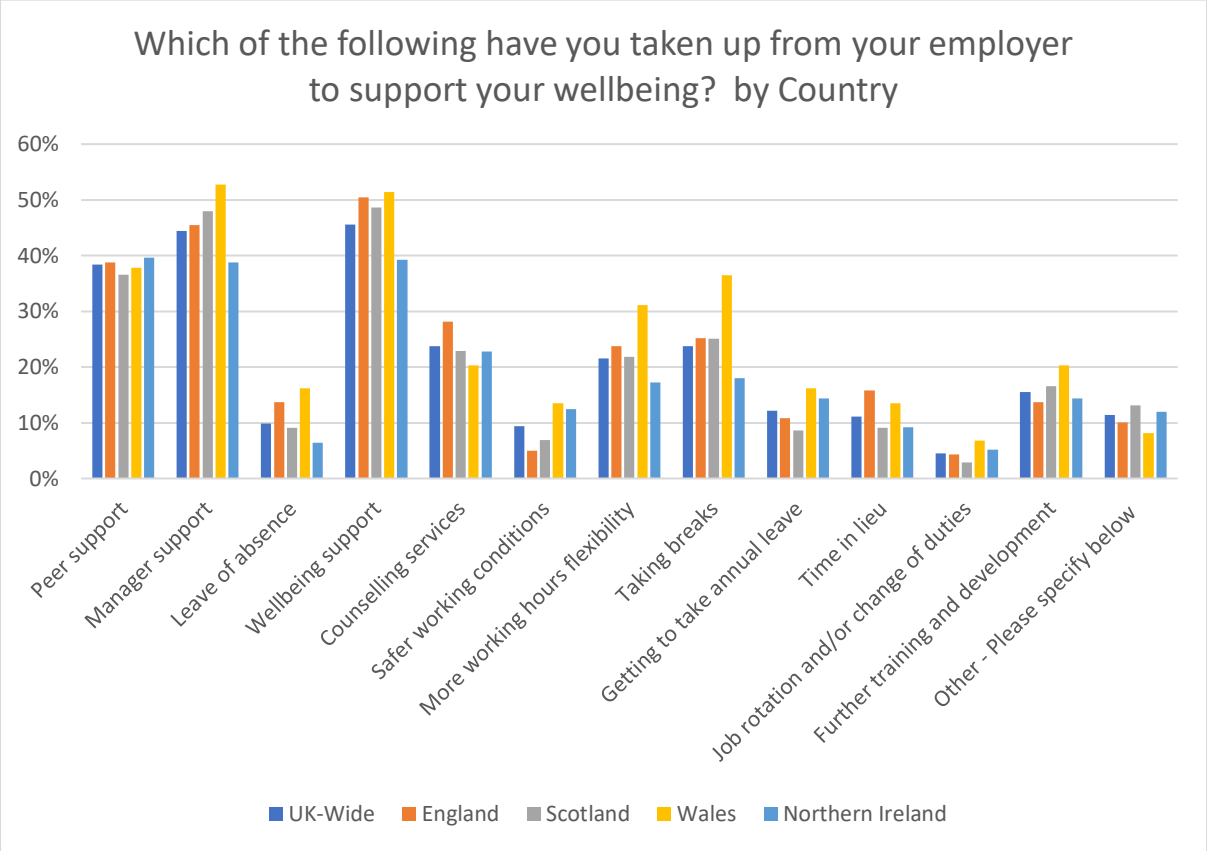


Table A2.127: What have you taken up from your employer to support your wellbeing by Country (Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	40.3%	35.6%	32.9%	37.9%	37.4%
Manager support	49.8%	41.4%	44.3%	51.5%	37.4%
Leave of absence	8.8%	12.6%	10.1%	16.7%	6.6%
Wellbeing support	55.3%	56.3%	50.0%	48.5%	37.9%
Counselling services	13.1%	24.1%	22.8%	19.7%	25.6%
Safer working conditions	10.2%	4.6%	6.6%	13.6%	13.2%
More working hours flexibility	16.4%	16.1%	20.6%	28.8%	17.2%
Taking breaks	16.4%	21.8%	24.6%	33.3%	18.1%
Getting to take annual leave	7.3%	8.0%	7.9%	18.2%	13.2%
Time in lieu	14.3%	13.8%	7.5%	10.6%	6.2%
Job rotation and/or change of duties	4.4%	3.4%	3.5%	9.1%	6.2%
Further training and development	10.4%	12.6%	14.5%	18.2%	15.0%
Other - Please specify below	13.4%	11.5%	13.6%	3.0%	12.3%

Table A2.128: What have you taken up from your employer to support your wellbeing 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	245 (38.4%)	54 (38.8%)	64 (36.6%)	28 (37.8%)	99 (39.6%)
Manager support	283 (44.4%)	63 (45.5%)	84 (48.0%)	39 (52.7%)	97 (38.8%)
Leave of absence	63 (9.9%)	19 (13.7%)	16 (9.1%)	12 (16.2%)	16 (6.4%)
Wellbeing support	291 (45.6%)	70 (50.4%)	85 (48.6%)	38 (51.4%)	98 (39.2%)
Counselling services	151 (23.7%)	39 (28.1%)	40 (22.9%)	15 (20.3%)	57 (22.8%)
Safer working conditions	60 (9.4%)	7 (5.0%)	12 (6.9%)	10 (13.5%)	31 (12.4%)
More working hours flexibility	137 (21.5%)	33 (23.7%)	38 (21.8%)	23 (31.1%)	43 (17.2%)
Taking breaks	151 (23.7%)	35 (25.2%)	44 (25.1%)	27 (36.5%)	45 (18.0%)
Getting to take annual leave	78 (12.2%)	15 (10.8%)	15 (8.6%)	12 (16.2%)	36 (14.4%)
Time in lieu	71 (11.1%)	22 (15.8%)	16 (9.1%)	10 (13.5%)	23 (9.2%)
Job rotation and/or change of duties	29 (4.5%)	6 (4.3%)	5 (2.9%)	5 (6.8%)	13 (5.2%)
Further training and development	99 (15.5%)	19 (13.7%)	29 (16.6%)	15 (20.3%)	36 (14.4%)
Other - Please specify below	73 (11.4%)	14 (10.1%)	23 (13.1%)	6 (8.1%)	30 (12.0%)
No. of respondents who answered the question	**638**	**139**	**175**	**74**	**250**

Figure A2.128: What have you taken up from your employer to support your wellbeing by Occupation (Weighted)

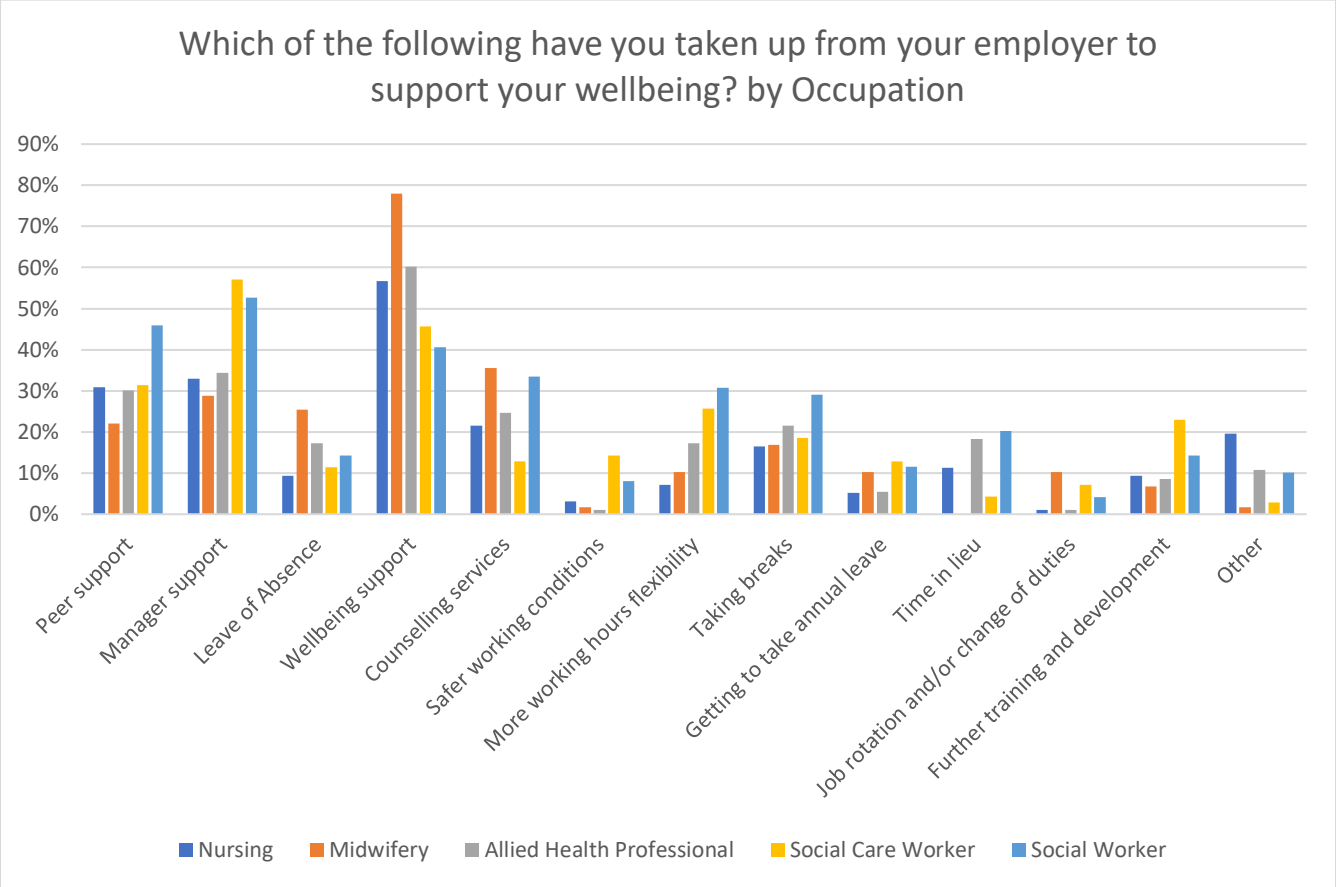


Figure A2.129: What have you taken up from your employer to support your wellbeing by Occupation (Unweighted)

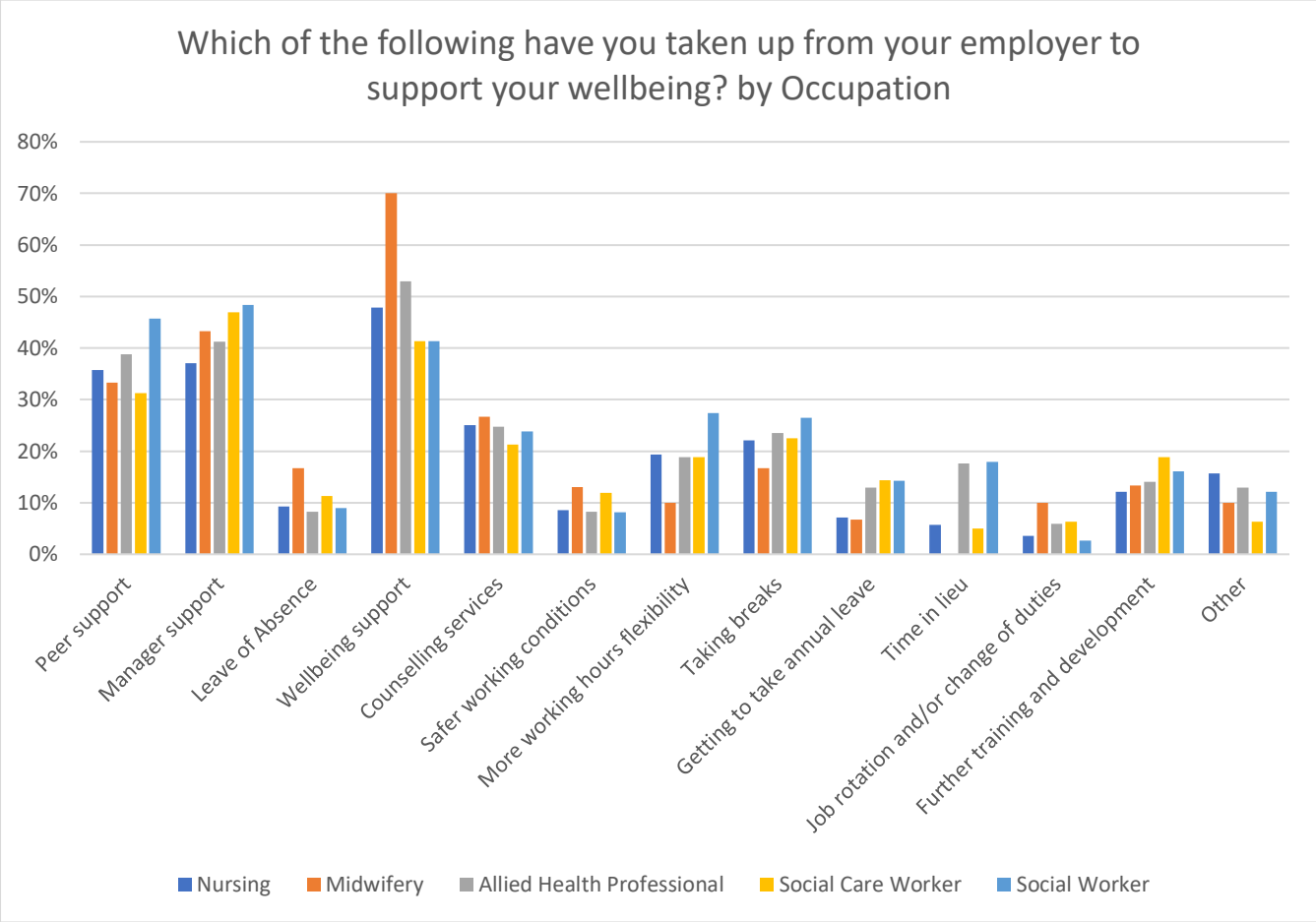


Table A2.129: What have you taken up from your employer to support your wellbeing by Occupation(Weighted)

What has to happen for you to change your mind about wanting to leave?	Occupation				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	30.9%	22.0%	30.1%	31.4%	45.9%
Manager support	33.0%	28.8%	34.4%	57.1%	52.7%
Leave of absence	9.3%	25.4	17.2%	11.4%	14.3%
Wellbeing support	56.7%	78.0%	60.2%	45.7%	40.6%
Counselling services	21.6%	35.6%	24.7%	12.9%	33.5%
Safer working conditions	3.1%	1.7%	1.1%	14.3%	8.1%
More working hours flexibility	7.2%	10.2%	17.2%	25.7%	30.8%
Taking breaks	16.5%	16.9%	21.5%	18.6%	29.1%
Getting to take annual leave	5.2%	10.2%	5.4%	12.9%	11.5%
Time in lieu	11.3%	0.0%	18.3%	4.3%	20.2%
Job rotation and/or change of duties	1.00%	10.2%	1.1%	7.1%	4.2%
Further training and development	9.3%	6.8%	8.6%	22.9%	14.3%
Other - Please specify below	19.6%	1.7%	10.8%	2.9%	10.1%

Table A2.130: What have you taken up from your employer to support your wellbeing 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	50 (35.7%)	10 (33.3%)	33 (38.8%)	50 (31.3%)	102 (45.7%)
Manager support	52 (37.1%)	13 (43.3%)	35 (41.2%)	75 (46.9%)	108 (48.4%)
Leave of absence	13 (9.3%)	5 (16.7%)	7 (8.2%)	18 (11.3%)	20 (9.0%)
Wellbeing support	67 (47.9%)	21 (70.0%)	45 (52.9%)	66 (41.3%)	92 (41.3%)
Counselling services	35 (25.0%)	8 (26.7%)	21 (24.7%)	34 (21.3%)	53 (23.8%)
Safer working conditions	12 (8.6%)	4 (13.0%)	7 (8.2%)	19 (11.9%)	18 (8.1%)
More working hours flexibility	27 (19.3%)	3 (10.0%)	16 (18.8%)	30 (18.8%)	61 (27.4%)
Taking breaks	31 (22.1%)	5 (16.7%)	20 (23.5%)	36 (22.5%)	59 (26.5%)
Getting to take annual leave	10 (7.1%)	2 (6.7%)	11 (12.9%)	23 (14.4%)	32 (14.3%)
Time in lieu	8 (5.7%)	0 (0.0%)	15 (17.6%)	8 (5.0%)	40 (17.9%)
Job rotation and/or change of duties	5 (3.6%)	3 (10.0%)	5 (5.9%)	10 (6.3%)	6 (2.7%)
Further training and development	17 (12.1%)	4 (13.3%)	12 (14.1%)	30 (18.8%)	36 (16.1%)
Other - Please specify below	22 (15.7%)	3 (10.0%)	11 (12.9%)	10 (6.3%)	27 (12.1%)
No. of respondents who answered the question	**140**	**30**	**85**	**160**	**223**

2.27 Respondents' Caring Responsibilities

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

Figure A2.130: Caring Responsibilities by Country (Weighted)

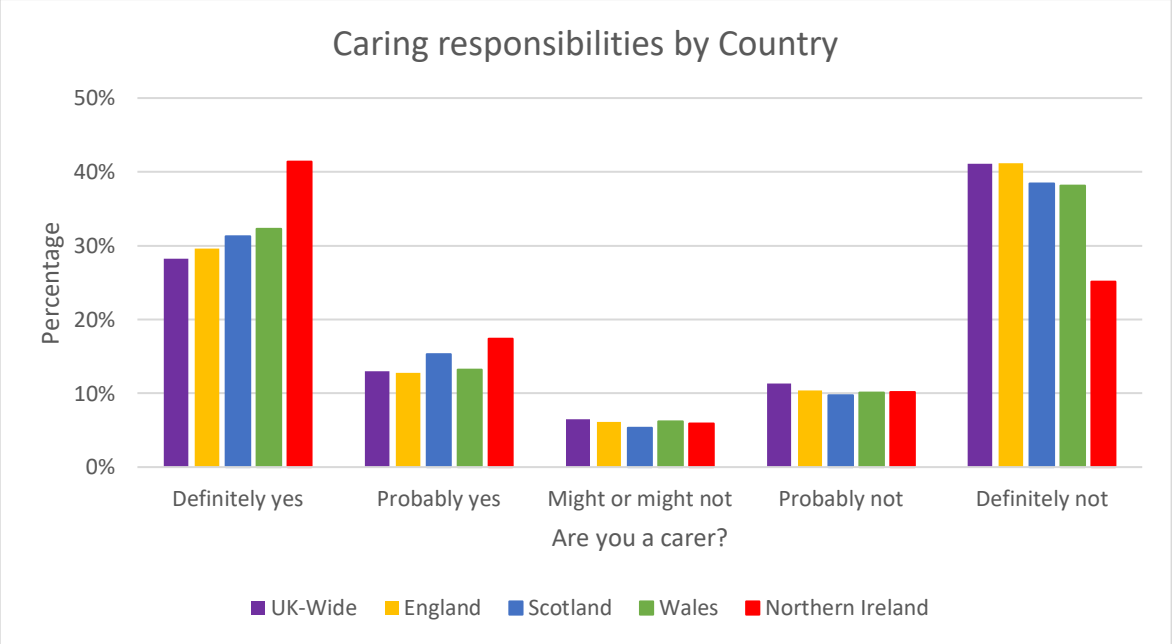


Figure A2.131: Caring Responsibilities by Country (Unweighted)

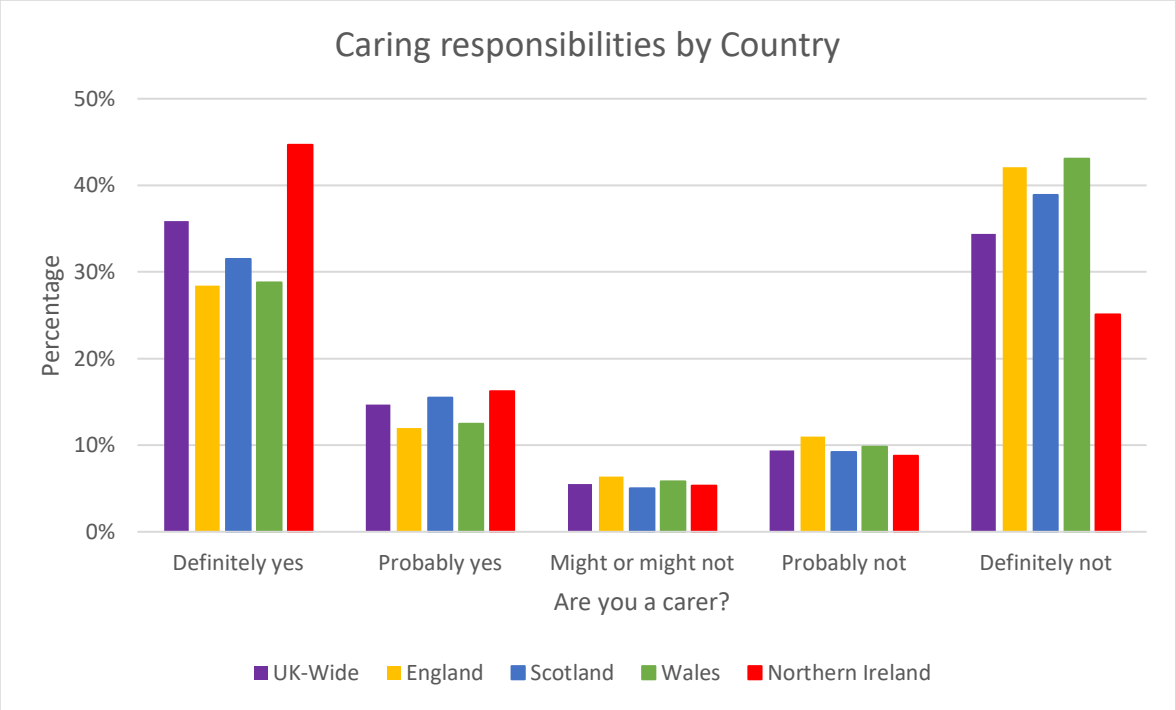


Table A2.131: Caring Responsibilities by Country (Weighted)

Do you consider yourself to be a carer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	28.2%	29.6%	31.3%	32.3%	41.4%
Probably yes	13.0%	12.8%	15.3%	13.2%	17.4%
Might or might not	6.5%	6.1%	5.3%	6.2%	5.9%
Probably not	11.3%	10.4%	9.7%	10.1%	10.2%
Definitely not	41.1%	41.2%	38.4%	38.1%	25.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.132: Caring Responsibilities by Country (Unweighted)

Do you consider yourself to be a carer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	886 (35.9%)	137 (28.4%)	216 (31.5%)	85 (28.8%)	448 (44.7%)
Probably yes	363 (14.7%)	58 (12.0%)	106 (15.5%)	37 (12.5%)	162 (16.2%)
Might or might not	135 (5.5%)	31 (6.4%)	34 (5.0%)	17(5.8%)	53 (5.3%)
Probably not	233 (9.4%)	53 (11.0%)	63 (9.2%)	29 (9.8%)	88 (8.8%)
Definitely not	849 (34.4%)	203 (42.1%)	267 (38.9%)	127 (43.1%)	252 (25.1%)
Total	**2466 (100%)**	**482 (100%)**	**686 (100%)**	**295 (100%)**	**1003 (100%)**

Figure A2.132: Caring Responsibilities by Occupation (Weighted)

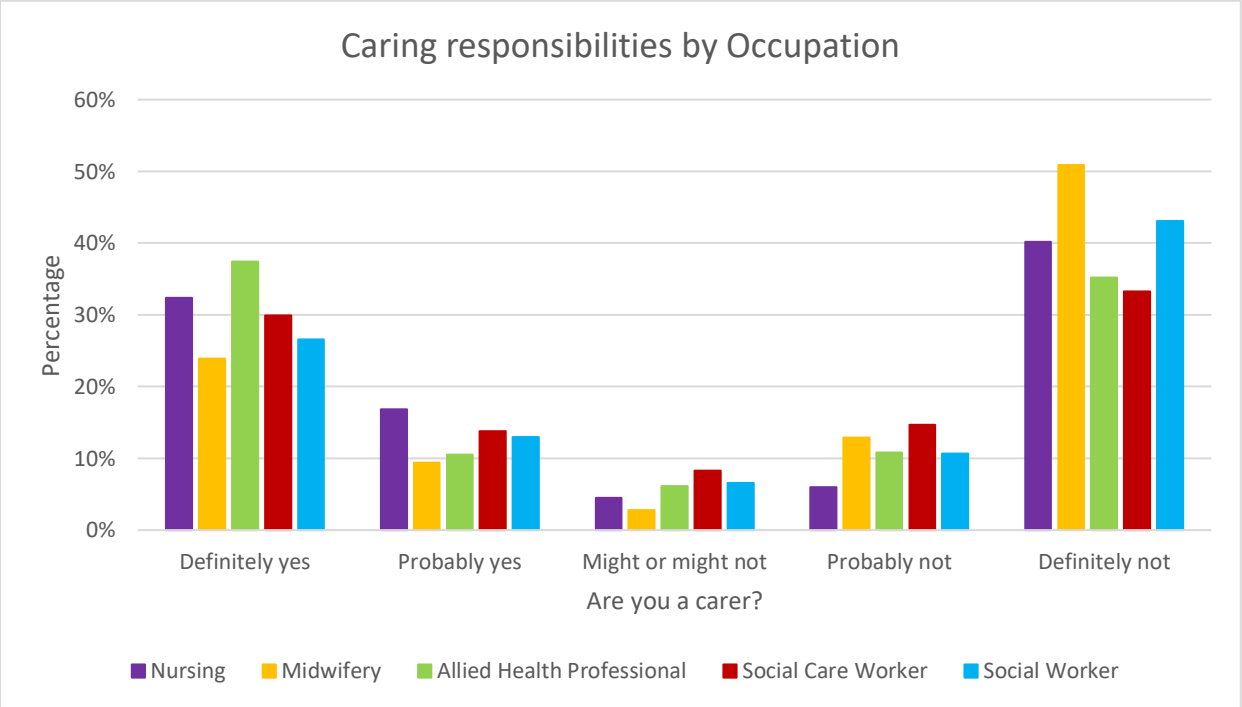


Figure A2.133: Caring Responsibilities by Occupation (Unweighted)

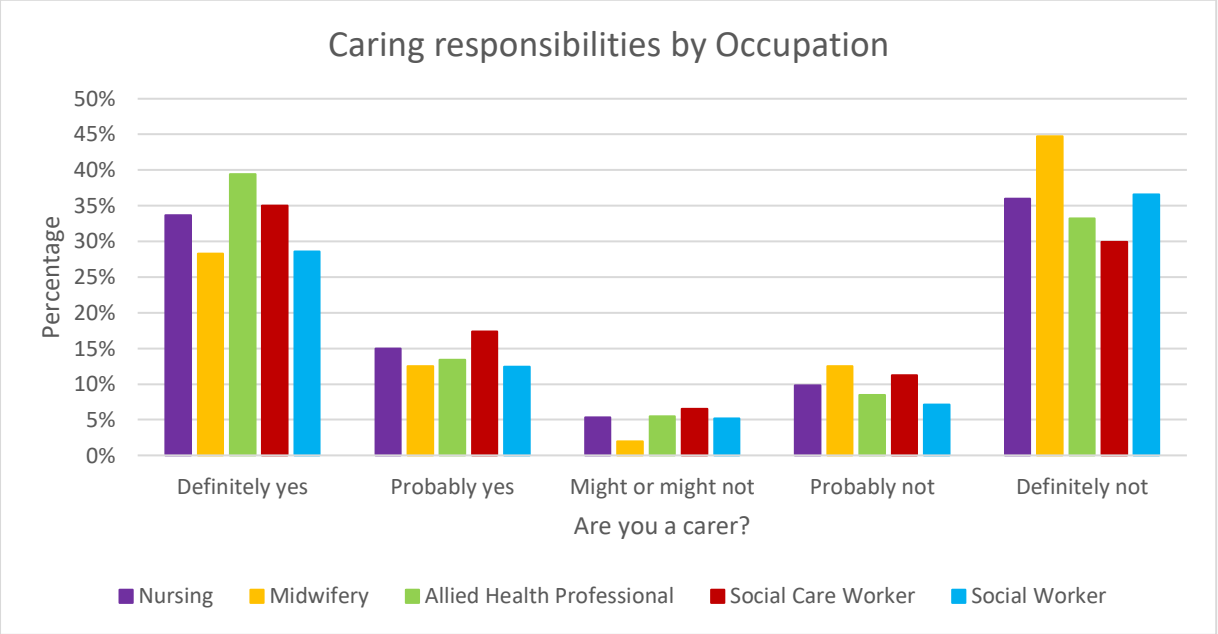


Table A2.133: Caring Responsibilities by Occupation (Weighted)

Occupation	Do you consider yourself to be a carer?					Total
	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	
Nursing	32.4%	16.8%	4.5%	6.0%	40.2%	**100%**
Midwifery	23.9%	9.4%	2.8%	12.9%	50.9%	**100%**
AHP	37.4%	10.5%	6.1%	10.8%	35.2%	**100%**
Social Care Worker	29.9%	13.8%	8.3%	14.7%	33.3%	**100%**
Social Worker	26.6%	13.0%	6.6%	10.7%	43.1%	**100%**

Table A2.134: Caring Responsibilities by Occupation (Unweighted)

Occupation	Do you consider yourself to be a carer?					Total
	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	
Nursing	172 (33.7%)	78 (15.0%)	27 (5.3%)	50 (9.8%)	164 (36.0%)	**511 (100%)**
Midwifery	43 (28.3%)	19 (12.5%)	3 (2.0%)	19 (12.5%)	68 (44.7%)	**152 (100%)**
AHP	135 (39.4%)	46 (13.4%)	19 (5.5%)	29 (8.5%)	114 (33.2%)	**343 (100%)**
Social Care Worker	269 (35.0%)	134 (17.4%)	50 (6.5%)	86 (11.2%)	230 (29.9%)	**769 (100%)**
Social Worker	267 (28.6%)	86 (12.4%)	36 (5.2%)	49 (7.1%)	253 (36.6%)	**691 (100%)**

A2.28 Who Respondents Care for

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

Figure A2.134: Who Respondents Care for by Country (Weighted)

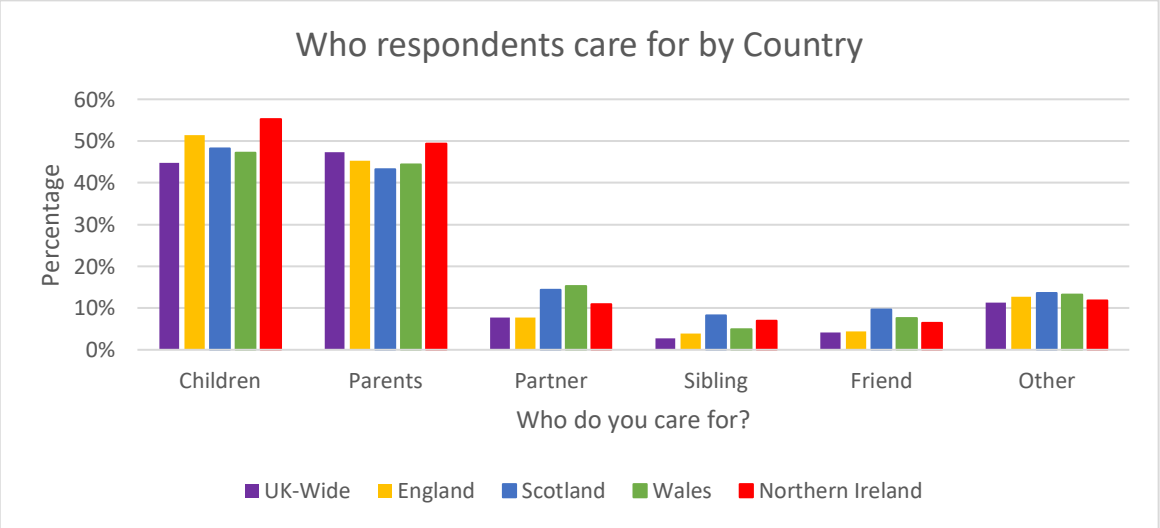


Figure A2.135: Who Respondents Care for by Country (Unweighted)

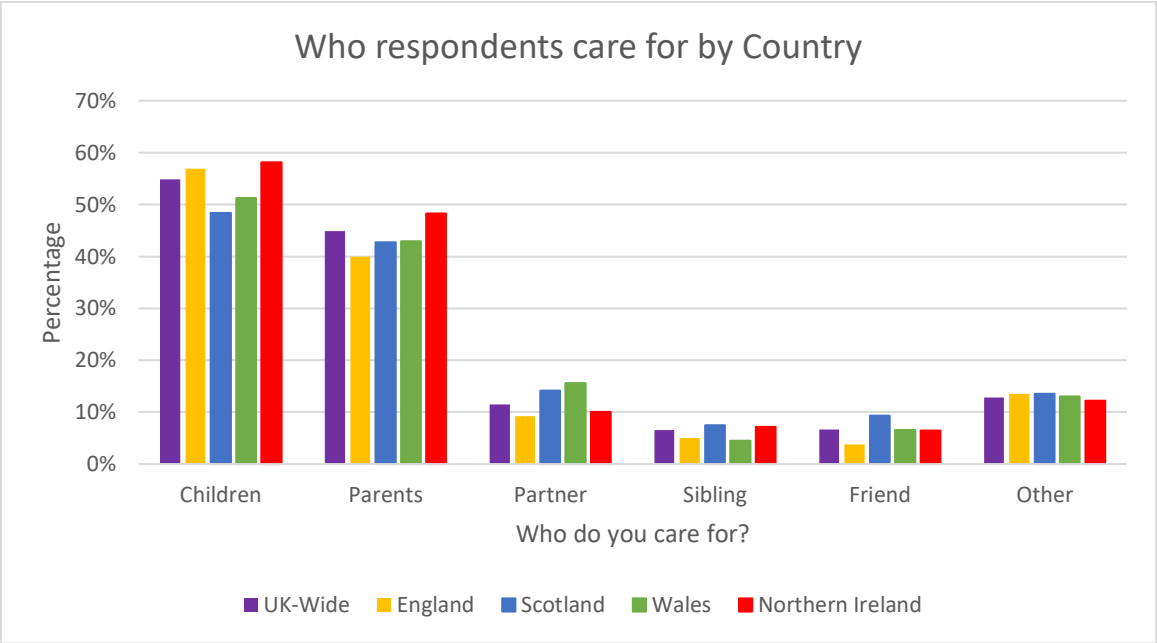


Table A2.135: Who Respondents Care for by Country (Weighted)

Who do you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	44.8%	51.4%	48.2%	47.2%	55.3%
Parents	47.3%	45.3%	43.2%	44.4%	49.4%
Partner	7.7%	7.7%	14.4%	15.3%	10.9%
Sibling	2.8%	3.9%	8.2%	4.9%	6.9%
Friend	4.2%	4.4%	9.6%	7.6%	6.4%
Other	11.3%	12.7%	13.6%	13.2%	11.8%

Table A2.136: Who Respondents Care for by Country (Unweighted)

Who do you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	832 (54.8%)	148 (56.9%)	187 (48.4%)	79 (51.3%)	418 (58.1%)
Parents	682 (44.9%)	104 (40.0%)	165 (42.7%)	66 (42.9%)	347 (48.3%)
Partner	175 (11.5%)	24 (9.2%)	55 (14.2%)	24 (15.6%)	72 (10.0%)
Sibling	101 (6.6%)	13 (5.0%)	29 (7.5%)	7 (4.5%)	52 (7.2%)
Friend	102 (6.7%)	10 (3.8%)	36 (9.3%)	10 (6.5%)	46 (6.4%)
Other	195 (12.8%)	35 (13.5%)	52 (13.5%)	20 (13.0%)	88 (12.2%)
No. of respondents who answered the question	**1519**	**260**	**386**	**154**	**719**

Figure A2.136: Who Respondents Care for by Occupation (Weighted)

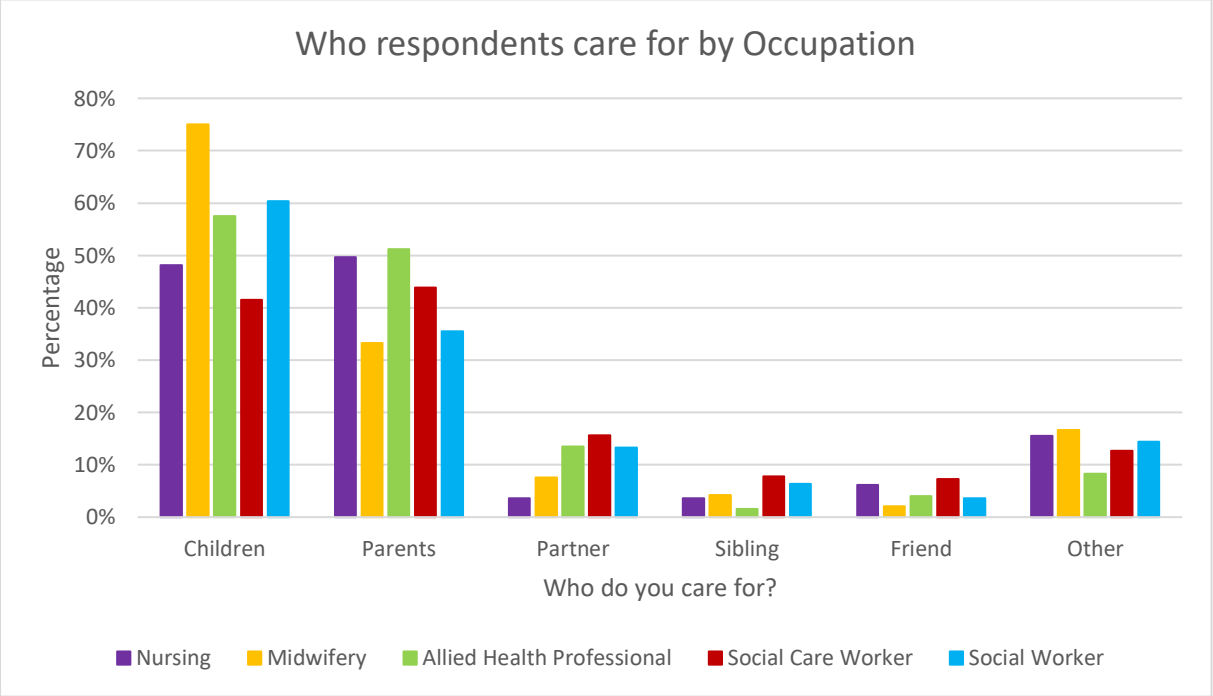


Figure A2.137: Who Respondents Care for by Occupation (Unweighted)

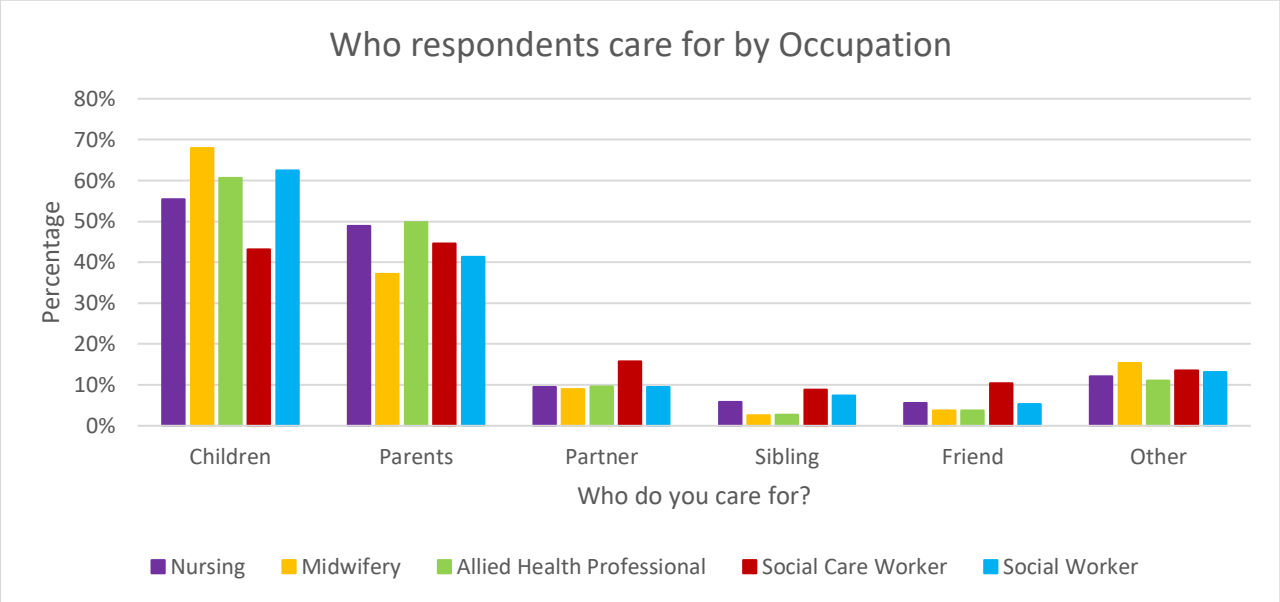


Table A2.137: Who Respondents Care for by Occupation (Weighted)

Occupation	Who do you care for?					
	Children	Parents	Partner	Sibling	Friend	Other
Nursing	48.1%	49.7%	3.6%	3.6%	6.2%	15.5%
Midwifery	75.0%	33.3%	7.6%	4.2%	2.1%	16.7%
AHP	57.5%	51.2%	13.5%	1.6%	4.0%	8.3%
Social Care Worker	41.5%	43.9%	15.6%	7.8%	7.3%	12.7%
Social Worker	60.4%	35.5%	13.3%	6.4%	3.6%	14.4%

Table A2.138: Who Respondents Care for by Occupation (Unweighted)

Occupation	Who do you care for?						No. of respondents who answered the question
	Children	Parents	Partner	Sibling	Friend	Other	
Nursing	169 (55.4%)	149 (48.9%)	29 (9.5%)	18 (5.9%)	17 (5.6%)	37 (12.1%)	**305**
Midwifery	53 (67.9%)	29 (37.2%)	7 (9.0%)	2 (2.6%)	3 (3.8%)	12 (15.4%)	**78**
AHP	133 (60.7%)	109 (49.8%)	21 (9.6%)	6 (2.7%)	8 (3.7%)	24 (11.0%)	**219**
Social Care Worker	215 (43.2%)	222 (44.6%)	78 (15.7%)	44 (8.8%)	52 (10.4%)	67 (13.5%)	**498**
Social Worker	262 (62.5%)	173 (41.3%)	40 (9.5%)	31 (7.4%)	52 (5.3%)	55 (13.1%)	**419**

A2.29 Respondents Living with the Person They Care for

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

Summary (Weighted results):

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

Summary (Unweighted results):

Northern Ireland had the highest (59.6%) and Scotland the lowest proportion of respondents (54.9%) who were living with the person they were caring for.

Figure A2.138: Respondents Living with the Person They Care for by Country (Weighted)

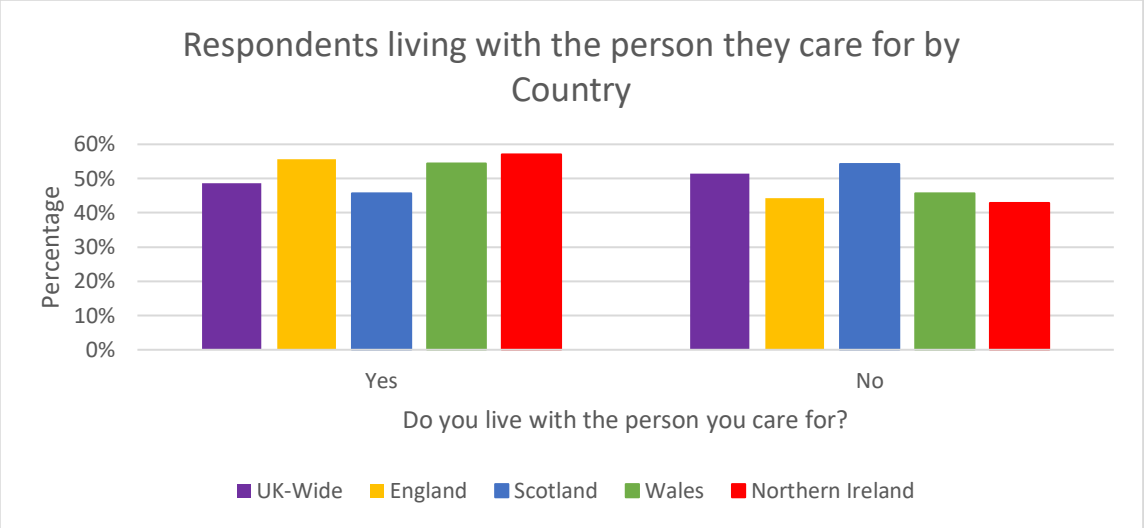


Figure A2.139: Respondents Living with the Person They Care for by Country (Unweighted)

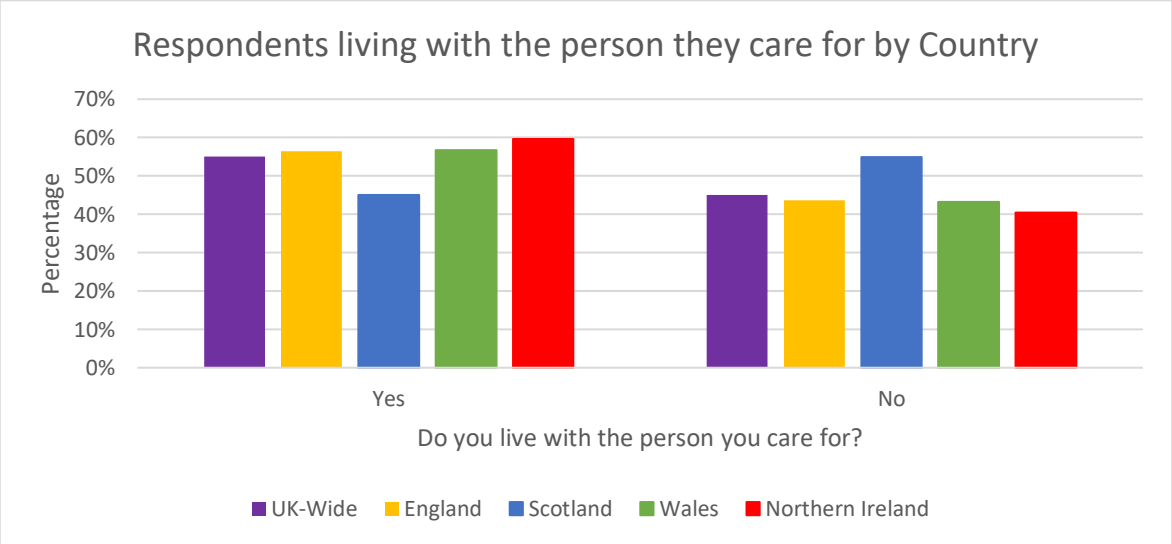


Table A2.139: Respondents Living with the Person They Care for by Country (Weighted)

Do you live with the person you care for?	**Country**				
	UK-Wide	**England**	**Scotland**	**Wales**	**Northern Ireland**
Yes	48.6%	55.7%	45.7%	54.4%	57.1%
No	51.4%	44.3%	54.3%	45.6%	42.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.140: Respondents Living with the Person They Care for by Country (Unweighted)

Do you live with the person you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	851 (55.0%)	150 (56.4%)	180 (45.1%)	89 (56.7%)	432 (59.6%)
No	696 (45.0%)	116 (43.6%)	219 (54.9%)	68 (43.3%)	293 (40.4%)
Total	**1547 (100%)**	**266 (100%)**	**399 (100%)**	**157 (100%)**	**725 (100%)**

Figure A2.140: Respondents Living with the Person They Care for by Occupation (Weighted)

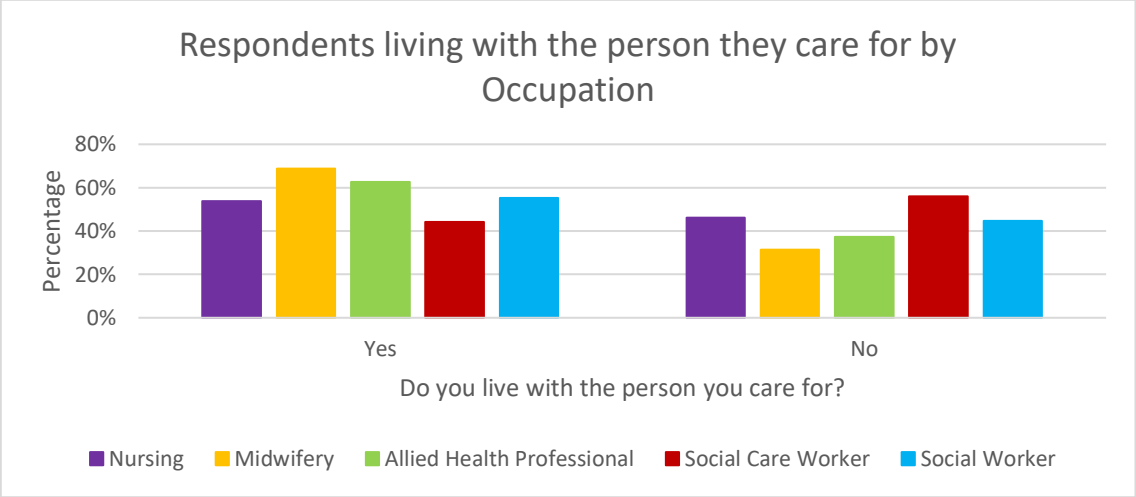


Figure A2.141: Respondents Living with the Person They Care for by Occupation (Unweighted)

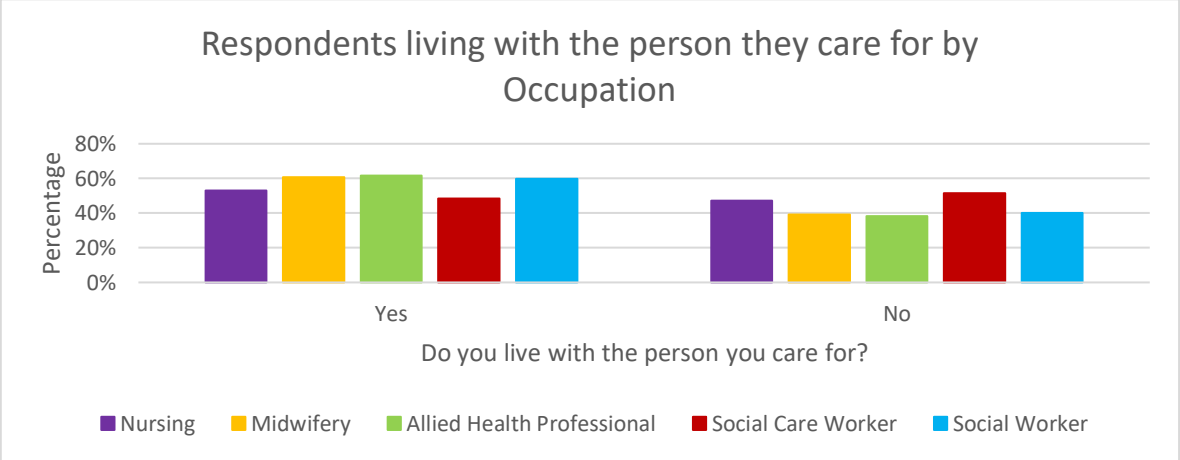


Table A2.141: Respondents Living with the Person They Care for by Occupation (Weighted)

Occupation	Do you live with the person you care for?		Total
	Yes	No	
Nursing	53.8%	46.2%	**100%**
Midwifery	68.8%	31.3%	**100%**
AHP	62.7%	37.3%	**100%**
Social Care Worker	44.1%	55.9%	**100%**
Social Worker	55.3%	44.7%	**100%**

Table A2.142: Respondents Living with the Person They Care for by Occupation (Unweighted)

Occupation	Do you live with the person you care for?		Total
	Yes	No	
Nursing	165 (52.9%)	147 (47.1%)	**312 (100%)**
Midwifery	48 (60.8%)	31 (39.2%)	**79 (100%)**
AHP	136 (61.8%)	84 (38.2%)	**220 (100%)**
Social Care Worker	247 (48.4%)	263 (51.6%)	**510 (100%)**
Social Worker	255 (59.9%)	171 (40.1%)	**426 (100%)**

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

Figure A2.142: Change in Caring Responsibilities During the Pandemic by Country (Weighted)

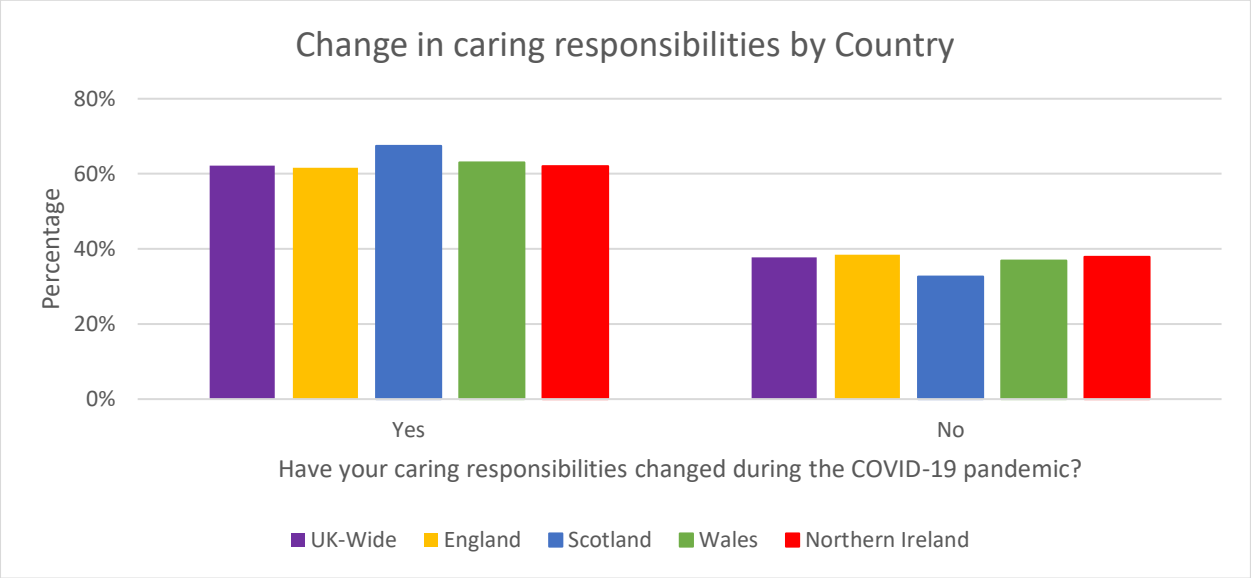


Figure A2.143: Change in Caring Responsibilities During the Pandemic by Country (Unweighted)

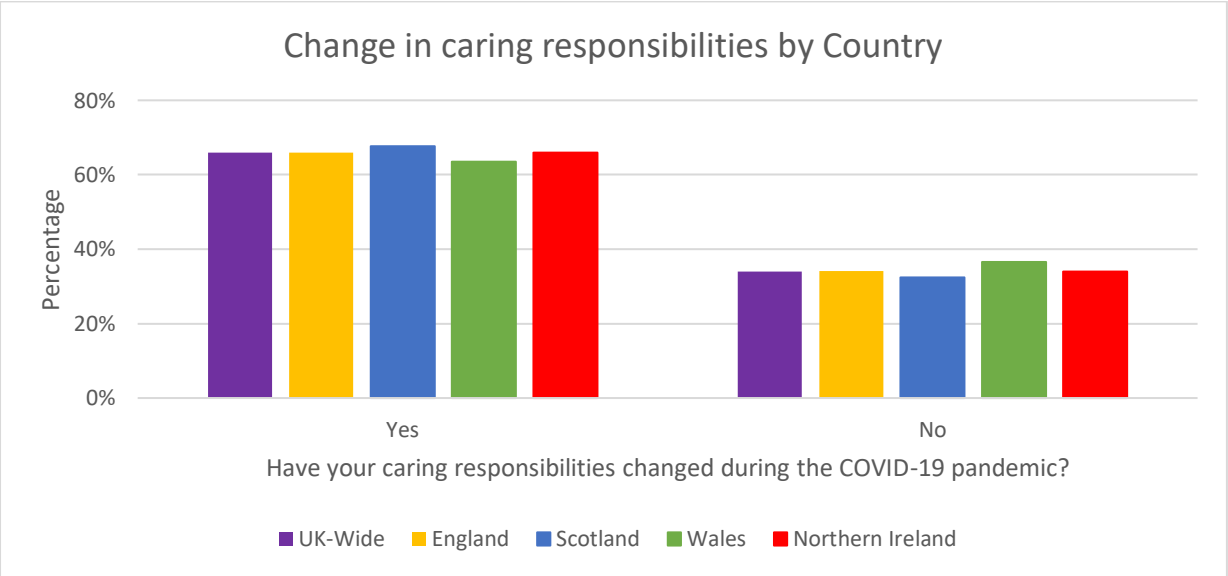


Table A2.143: Change in Caring Responsibilities During the Pandemic by Country (Weighted)

Have your caring responsibilities changed during the COVID-19 pandemic?	**Country**				
	UK-Wide	**England**	**Scotland**	**Wales**	**Northern Ireland**
Yes	62.2%	61.6%	67.4%	63.1%	62.1%
No	37.8%	38.4%	32.6%	36.9%	37.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A2.144: Change in Caring Responsibilities During the Pandemic by Country (Unweighted)

Have your caring responsibilities changed during the COVID-19 pandemic?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	1035 (66.0%)	178 (65.9%)	271 (67.6%)	101 (63.5%)	485 (66.0%)
No	533 (34.0%)	92 (34.1%)	130 (32.4%)	58 (36.5%)	253 (34.0%)
Total	**1568 (100%)**	**270 (100%)**	**401 (100%)**	**159 (100%)**	**738 (100%)**

Figure A2.144: Change in Caring Responsibilities During the Pandemic by Occupation (Weighted)

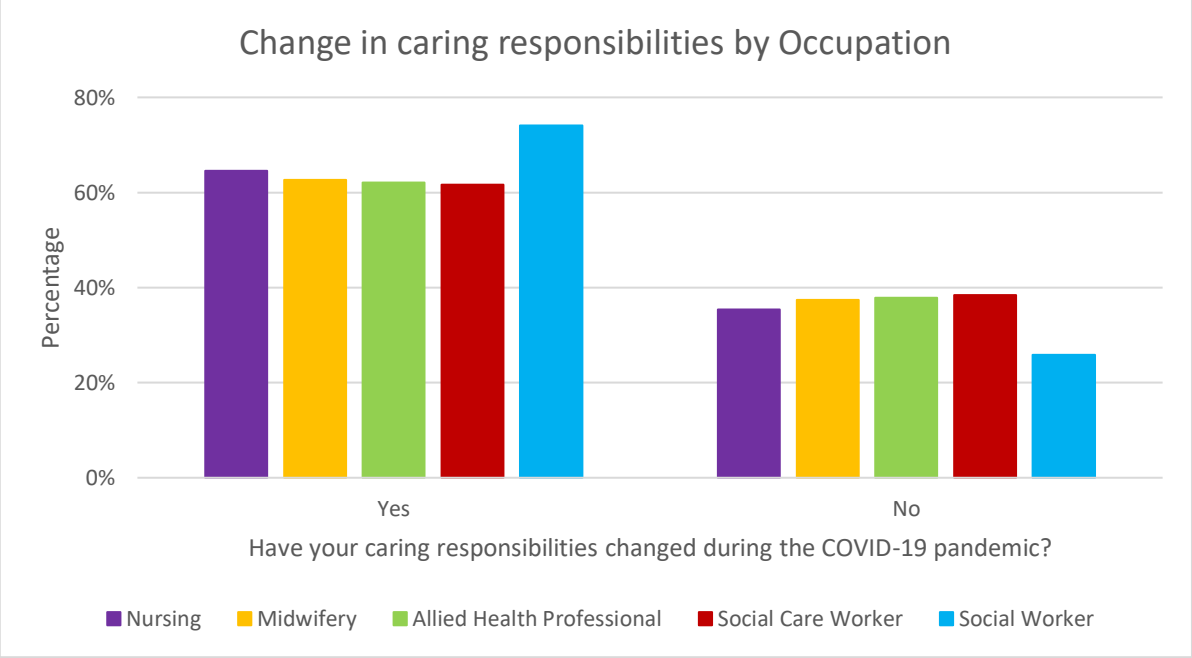


Figure A2.145: Change in Caring Responsibilities During the Pandemic by Occupation (Unweighted)

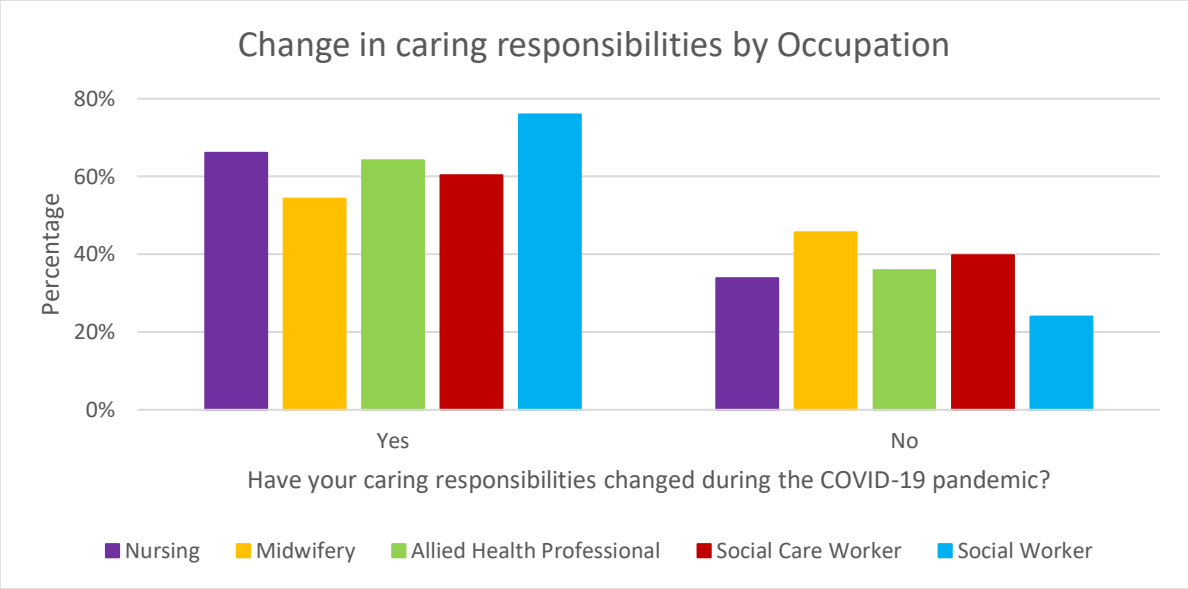


Table A2.145: Change in Caring Responsibilities During the Pandemic by Occupation (Weighted)

Occupation	Have your caring responsibilities changed during the COVID-19 pandemic?		Total
	Yes	No	
Nursing	64.6%	35.4%	**100%**
Midwifery	62.6%	37.4%	**100%**
AHP	62.1%	37.9%	**100%**
Social Care Worker	61.6%	38.4%	**100%**
Social Worker	74.1%	25.9%	**100%**

Table A2.146: Change in Caring Responsibilities During the Pandemic by Occupation (Unweighted)

Occupation	Have your caring responsibilities changed during the COVID-19 pandemic?		Total
	Yes	No	
Nursing	207 (66.1%)	106 (33.9%)	**313 (100%)**
Midwifery	44 (54.3%)	37 (45.7%)	**81 (100%)**
AHP	143 (64.1%)	80 (35.9%)	**223 (100%)**
Social Care Worker	315 (60.3%)	207 (39.7%)	**522 (100%)**
Social Worker	326 (76.0%)	103 (24.0%)	**429 (100%)**

A2.31 Respondents' Region of Work

Summary (Weighted results):

Not reported.

Summary (Unweighted results):

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

Table A2.147: Responses by Region (Unweighted)

Region	n (%)
England: London	140 (5.1%)
England: North West	55 (2.0%)
England: South East	92 (3.4%)
England: West Midlands	32 (1.2%)
England: East of England	55 (2.0%)
England: Yorkshire and the Humber	47 (1.7%)
England: North East	21 (0.8%)
England: East Midlands	18 (0.7%)
England: South West	79 (2.9%)
Scotland	745 (27.4%)
Wales	321 (11.8%)
Northern Ireland	1116 (41.0%)
Total	**2721 (100%)**

Figure A2.146: Responses by Region (Unweighted)

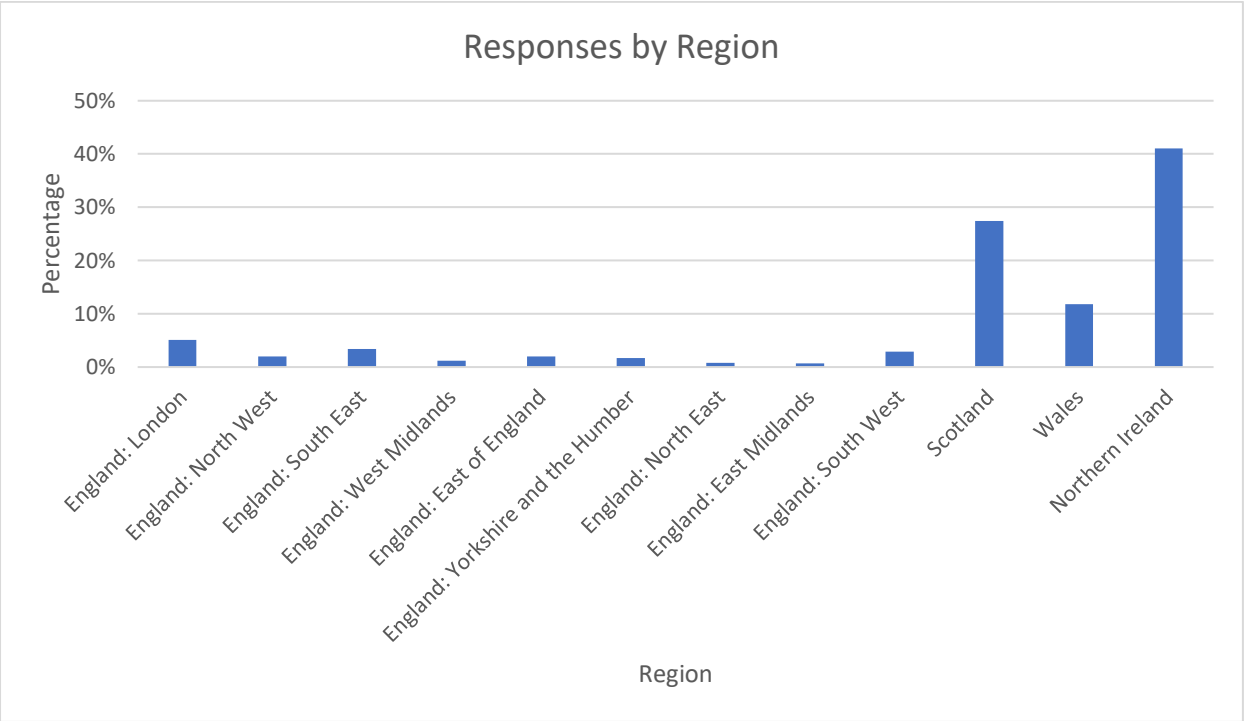


Figure A2.147: Region by Occupation (Unweighted)

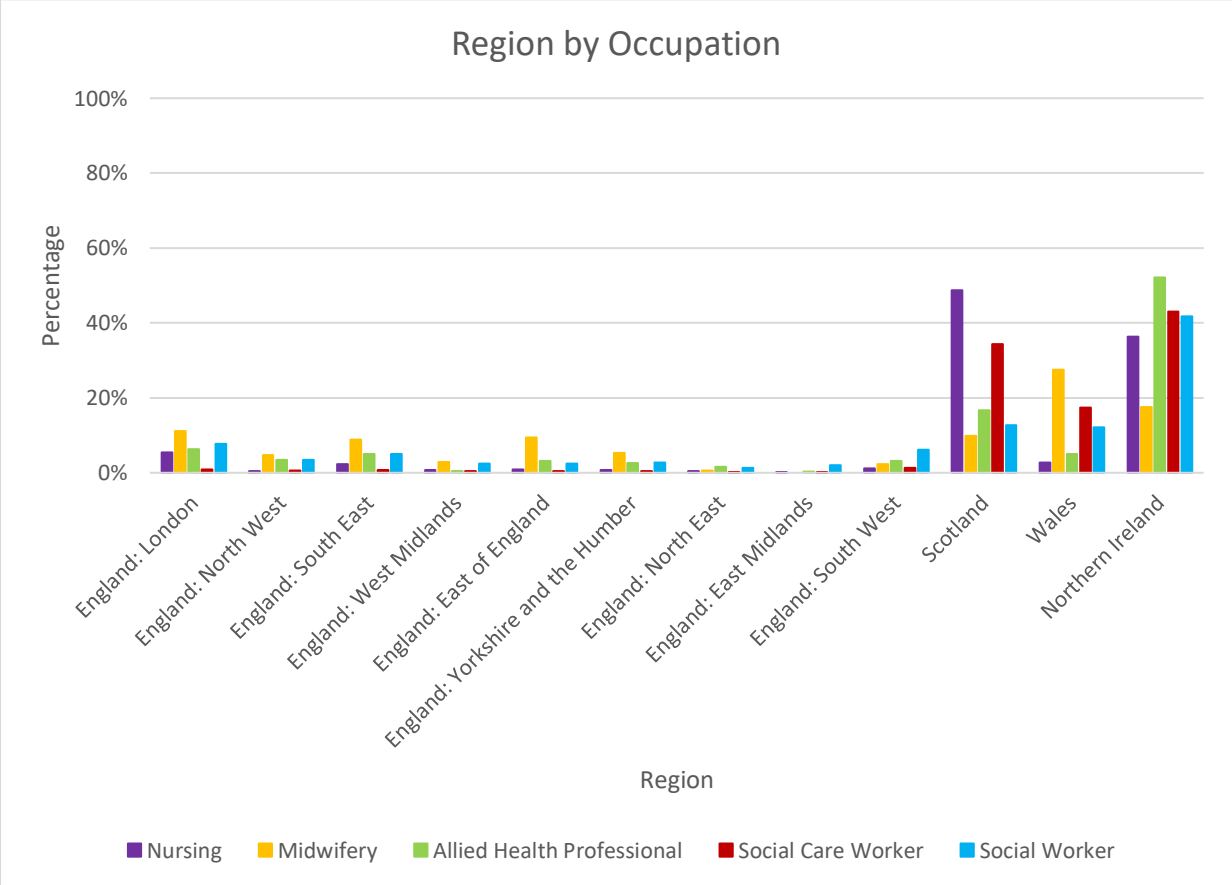


Table A2.148: Region by Occupation (Unweighted)

Region	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
England: London	31 (5.5%)	19 (11.1%)	24 (6.3%)	8 (0.9%)	58 (7.7%)
England: North West	3 (0.5%)	8 (4.7%)	13 (3.4%)	5 (0.6%)	26 (3.5%)
England: South East	13 (2.3%)	15 (8.8%)	19 (5.0%)	7 (0.8%)	38 (5.0%)
England: West Midlands	4 (0.7%)	5 (2.9%)	2 (0.5%)	3 (0.4%)	18 (2.4%)
England: East of England	5 (0.9%)	16 (9.4%)	12 (3.2%)	4 (0.5%)	18 (2.4%)
England: Yorkshire and the Humber	4 (0.7%)	9 (5.3%)	10 (2.6%)	3 (0.4%)	21 (2.8%)
England: North East	2 (0.4%)	1(0.6%)	6 (1.6%)	2 (0.2%)	10 (1.3%)
England: East Midlands	1 (0.2%)	0 (0.0%)	1 (0.3%)	1 (0.1%)	15 (2.0%)
England: South West	6 (1.1%)	4 (2.3%)	12 (3.2%)	11 (1.3%)	46 (6.1%)
Scotland	276 (48.8%)	17 (9.9%)	63 (16.7%)	293 (34.3%)	96 (12.7%)
Wales	15 (2.7%)	47 (27.5%)	19 (5.0%)	148 (17.4%)	92 (12.2%)
Northern Ireland	206 (36.4%	30 (17.5%)	197 (52.1%)	368 (43.1%)	315 (41.8%)
Total	**566 (100%)**	**171 (100%)**	**378 (100%)**	**853 (100%)**	**753 (100%)**

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

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

A3.1 Wellbeing Scores by Country

Summary (Weighted results):

There was a significant difference in the overall mean wellbeing scores across countries ($F = 3.808$, $df = 3$, $p < .01$). Specifically, the overall wellbeing score was significantly higher in Northern Ireland compared to England. When the scores were converted to possible or probable cases of anxiety/depression, a total of 14.4% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 20.7% were possible cases.

Summary (Unweighted results):

There was a significant difference in the overall mean wellbeing scores across countries ($F = 6.029$, $df = 3$, $p < .001$). Specifically, the overall wellbeing score was significantly higher in Northern Ireland and Wales compared to England. When the scores were converted to possible or probable cases of anxiety/depression, a total of 14.6% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 21.1% were possible cases.

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

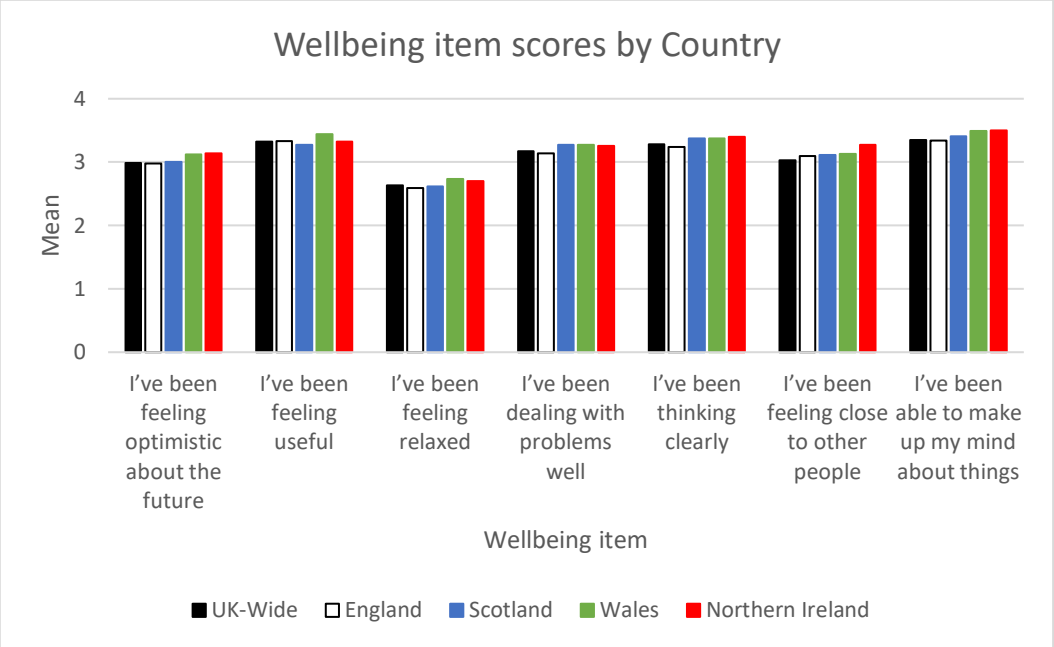


Figure A3.2: Mean Wellbeing Item Scores by Country (Unweighted)

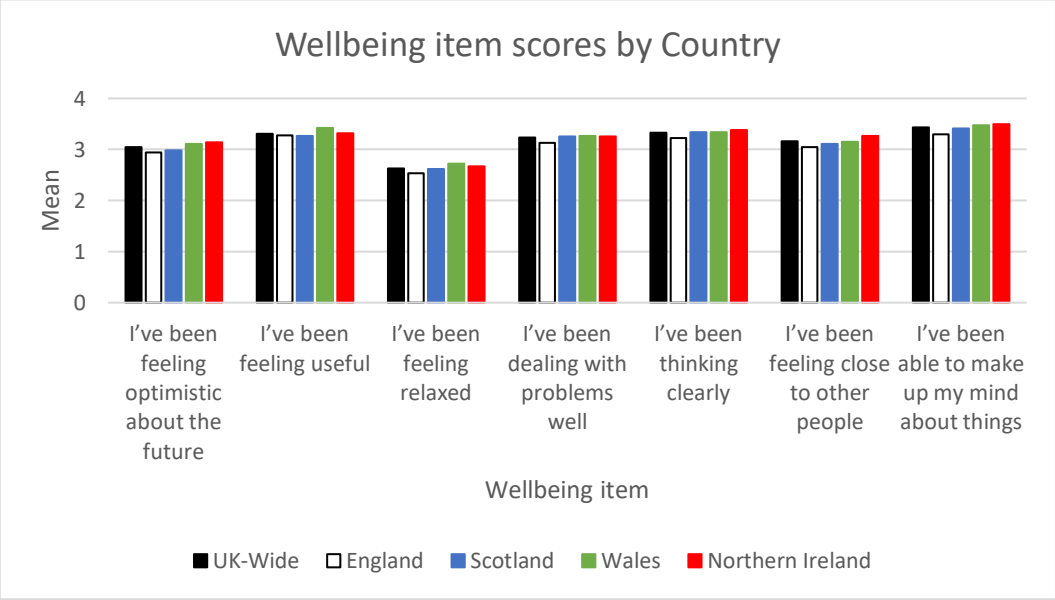


Figure A3.3: Mean Overall Wellbeing Score by Country (Weighted)

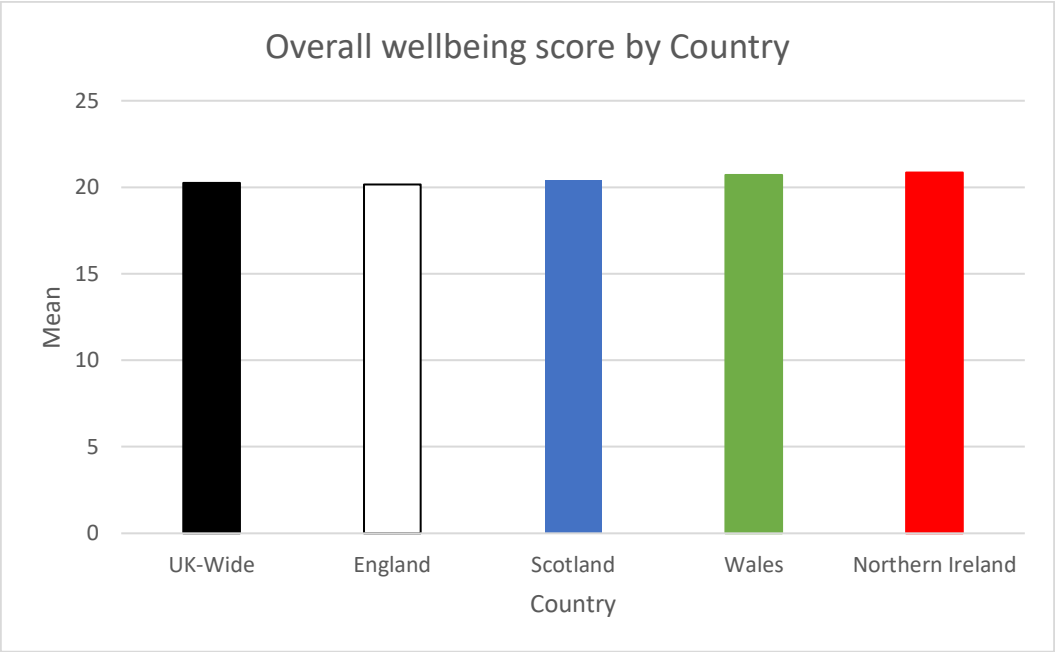


Figure A3.4: Mean Overall Wellbeing Score by Country (Unweighted)

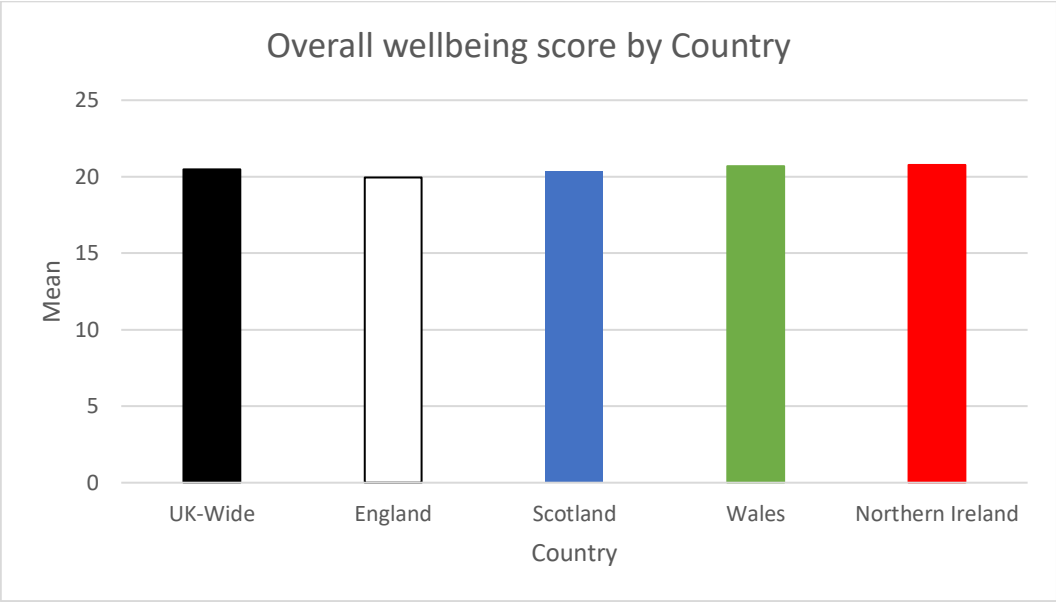


Table A3.1: Mean Overall and Item Wellbeing Scores by Country (Weighted)

Wellbeing item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	2.99	2.98	3	3.12	3.14
I've been feeling useful	3.32	3.33	3.27	3.44	3.32
I've been feeling relaxed	2.63	2.59	2.62	2.73	2.7
I've been dealing with problems well	3.17	3.14	3.27	3.27	3.26
I've been thinking clearly	3.28	3.24	3.37	3.37	3.4
I've been feeling close to other people	3.03	3.1	3.11	3.13	3.27
I've been able to make up my mind about things	3.35	3.34	3.41	3.49	3.5
Mean overall wellbeing score	**20.25**	**20.16**	**20.4**	**20.71**	**20.85**

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

Wellbeing item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	3.05	2.94	2.98	3.11	3.14
I've been feeling useful	3.31	3.28	3.26	3.42	3.32
I've been feeling relaxed	2.63	2.53	2.62	2.72	2.67
I've been dealing with problems well	3.23	3.13	3.25	3.27	3.25
I've been thinking clearly	3.33	3.22	3.34	3.34	3.38
I've been feeling close to other people	3.16	3.05	3.11	3.15	3.26
I've been able to make up my mind about things	3.43	3.3	3.41	3.47	3.49
Mean overall wellbeing score	**20.48**	**19.95**	**20.33**	**20.69**	**20.77**

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

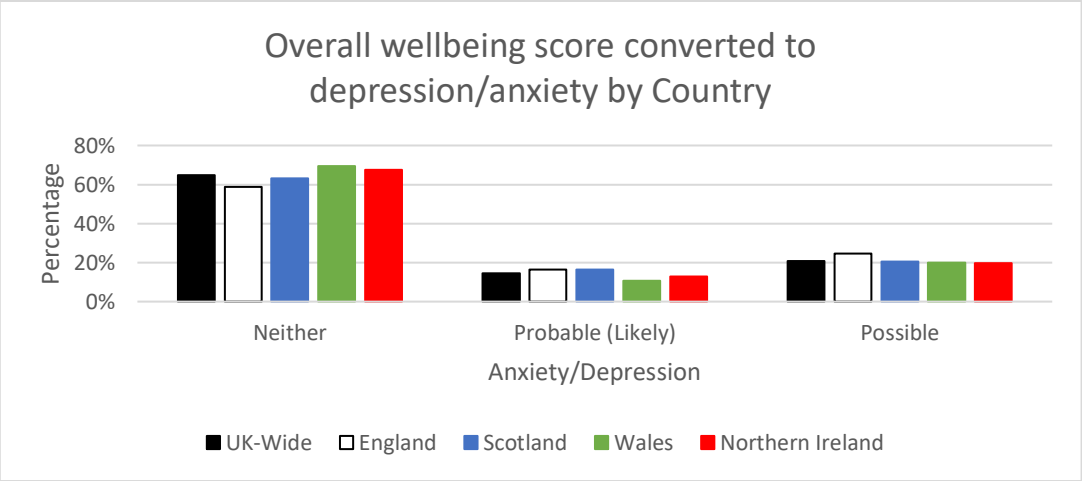


Figure A3.6: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Unweighted)

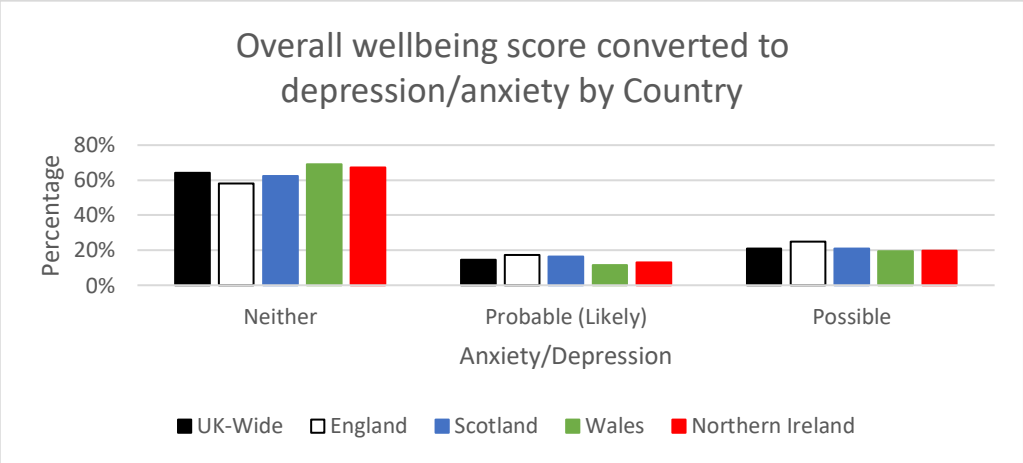


Table A3.3: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Weighted)

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	64.9%	58.8%	63.1%	69.5%	67.4%
Probable (Likely)	14.4%	16.5%	16.3%	10.6%	12.9%
Possible	20.7%	24.7%	20.6%	19.9%	19.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

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

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	1528 (64.3%)	204 (58.1%)	408 (62.4%)	197 (69.1%)	649 (67.3%)
Probable (Likely)	346 (14.6%)	81 (17.2%)	108 (16.5%)	33 (11.6%)	124 (12.9%)
Possible	501 (21.1%)	117 (24.8%)	138 (21.1%)	55 (19.3%)	191 (19.8%)
Total	**2375 (100%)**	**472 (100%)**	**654 (100%)**	**285 (100%)**	**964 (100%)**

A3.2 Wellbeing Scores by Occupation

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores across occupational groups (F = 11.793, df = 4, p = .001). Specifically, the overall wellbeing score was significantly higher in AHPs compared to midwives, social care workers and social workers.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores across occupational groups (F = 3.818, df = 4, p = .004). Specifically, the overall wellbeing scores were significantly lower in midwives compared to Nurses and AHPs.

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

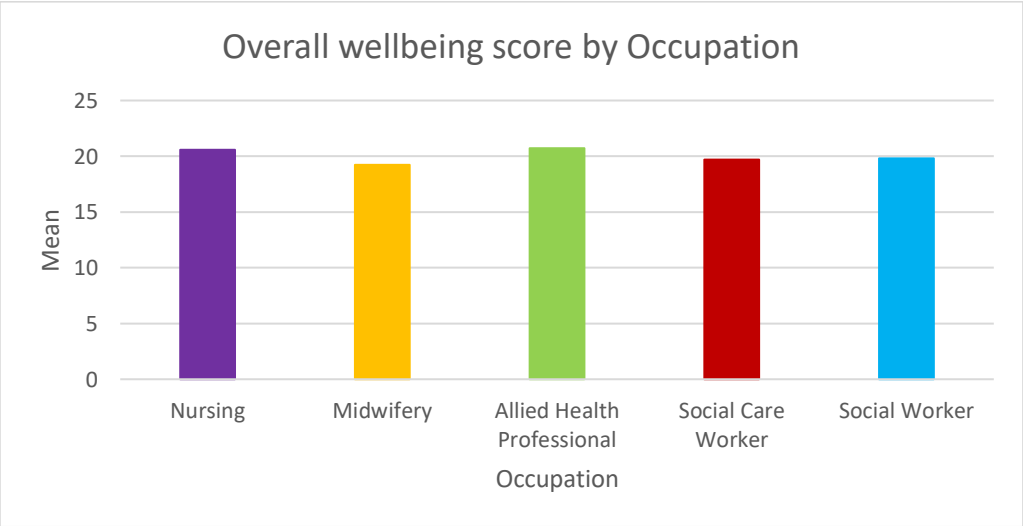


Figure A3.8: Mean Overall Wellbeing Score by Occupation (Unweighted)

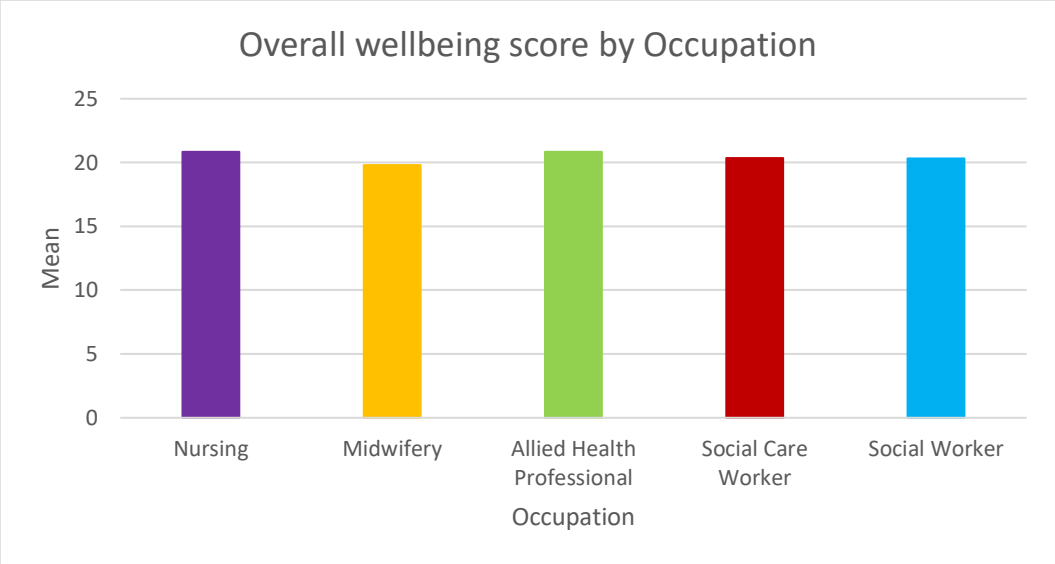


Table A3.5: Mean Overall Wellbeing Score by Occupation (Weighted)

Occupation	Mean overall wellbeing score
Nursing	20.58
Midwifery	19.23
AHP	20.72
Social Care Worker	19.70
Social Worker	19.81

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

Occupation	Mean overall wellbeing score
Nursing	20.84
Midwifery	19.8
AHP	20.84
Social Care Worker	20.35
Social Worker	20.32

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

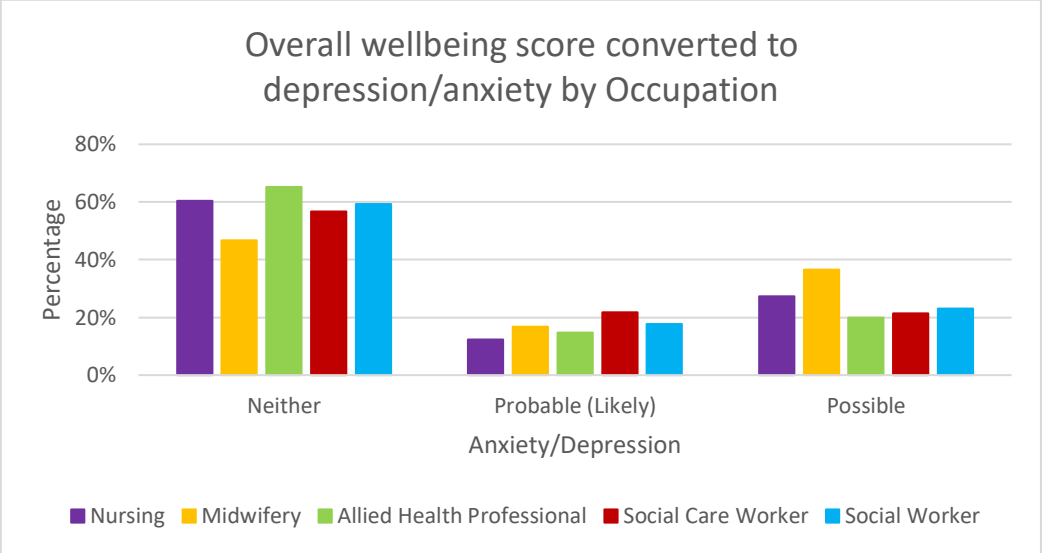


Figure A3.10: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Unweighted)

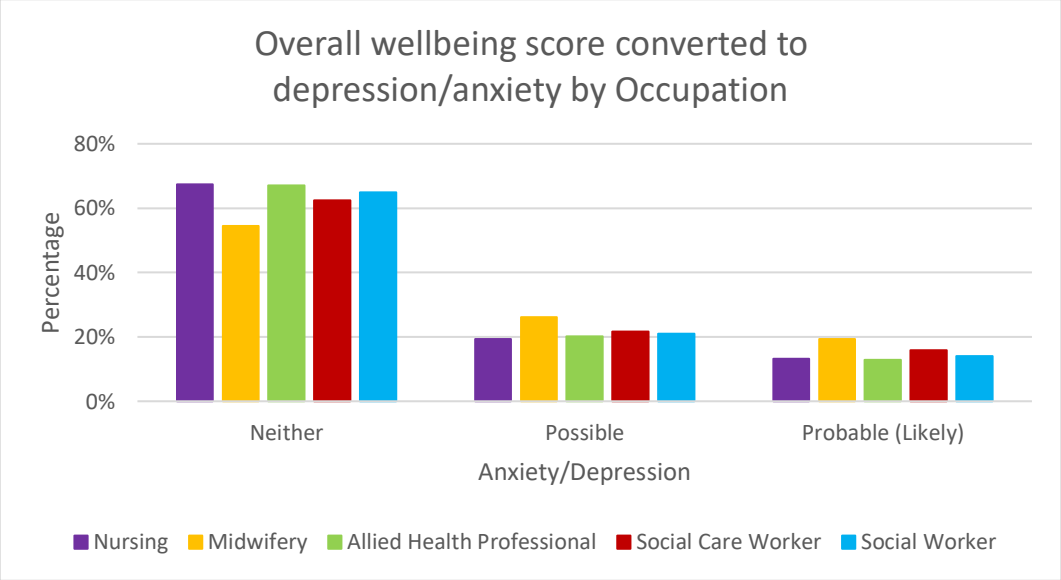


Table A3.7: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Weighted)

Case of anxiety/depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	60.4%	46.8%	65.3%	56.8%	59.3%
Probable (Likely)	12.3%	16.7%	14.8%	21.8%	17.7%
Possible	27.3%	36.5%	19.9%	21.4%	23.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

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

Case of anxiety/ depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	327 (67.4%)	79)54.5%)	224 (67.1%)	460 (62.5%)	438 (64.9%
Probable (Likely)	64 (19.4%)	28 (19.3%)	67 (12.9%)	116 (15.8%)	95 (14.1%)
Possible	94 (13.2%)	38 (26.2%)	67 (20.1%)	160 (21.7%)	142 (21.0%)
Total	**485 (100%)**	**145 (100%)**	**334 (100%)**	**736 (100%)**	**675 (100%)**

A3.3 Wellbeing Scores by Sex

Only 21 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):

Comparing males and females, there was a significant difference in their overall mean wellbeing score ($t = 3.511$, $df = 2747$, $p < .001$), with males scoring significantly lower than females.

Summary (Unweighted results):

Males and females did not differ significantly from each other on their overall mean wellbeing scores ($t=1.950$, $df=2357$, $p>0.05$).

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

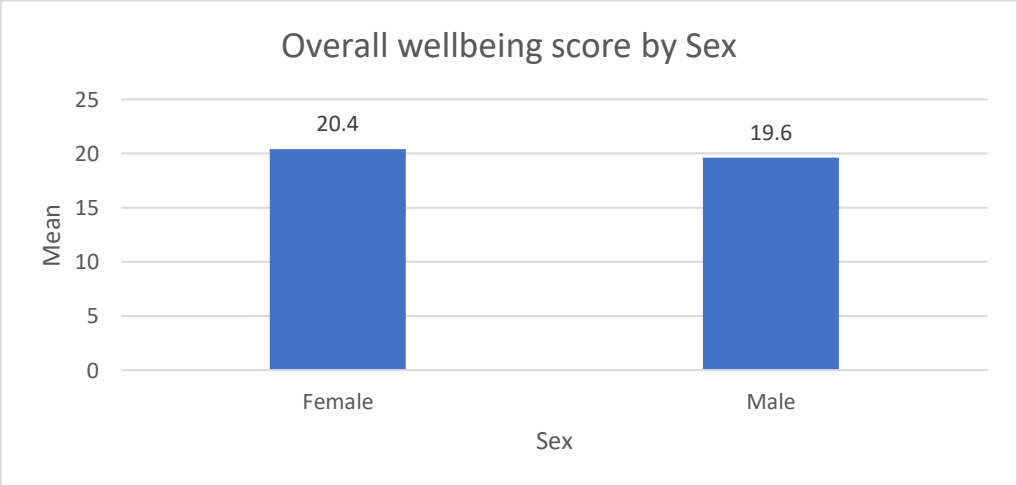


Figure A3.12: Mean Overall Wellbeing Score by Sex (Unweighted)

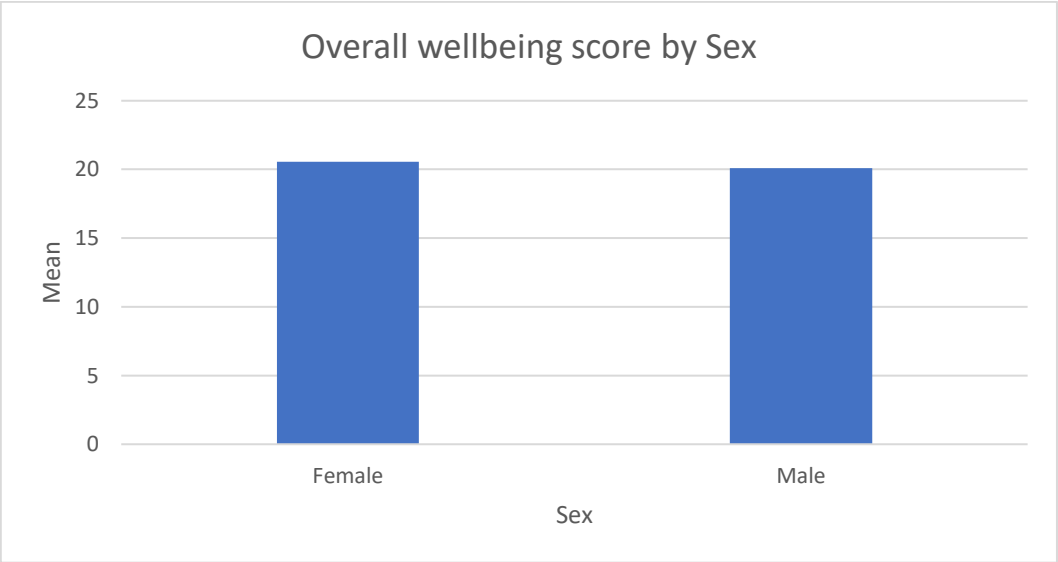


Table A3.9: Mean Overall Wellbeing Score by Sex (Weighted)

Sex	Mean overall wellbeing score
Female	20.4
Male	19.6

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

Sex	Mean overall wellbeing score
Female	20.54
Male	20.08

A3.4 Wellbeing Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in their overall mean wellbeing scores ($F = 19.114$, $df = 5$, $p < .001$). Most of the older age groups had higher wellbeing scores compared to the younger age groups. Specifically, the wellbeing score was significantly higher in the 50-59 group compared to the 16-29, 30-39, 40-49 and 60-65 age groups.

Summary (Unweighted results):

There were significant differences across the age groups in their overall mean wellbeing scores (F = 4.377, df = 5, p < .001). The overall wellbeing scores were higher in the older age groups compared to the younger age groups. Specifically, the wellbeing score was significantly higher in the 50-59 and 60-65 age groups compared to the 16-29 and 30-39 age groups.

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

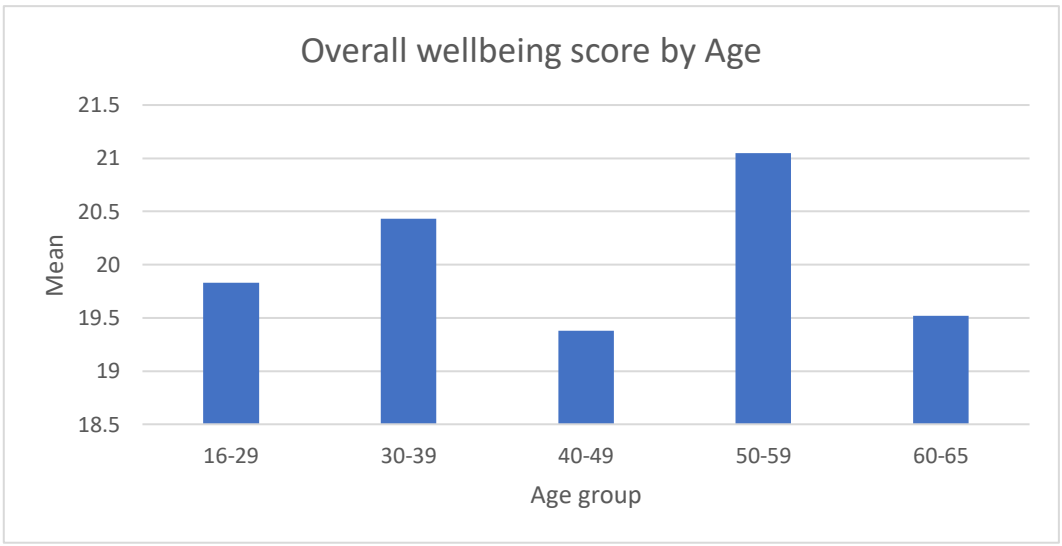


Figure A3.14: Mean Overall Wellbeing Score by Age (Unweighted)

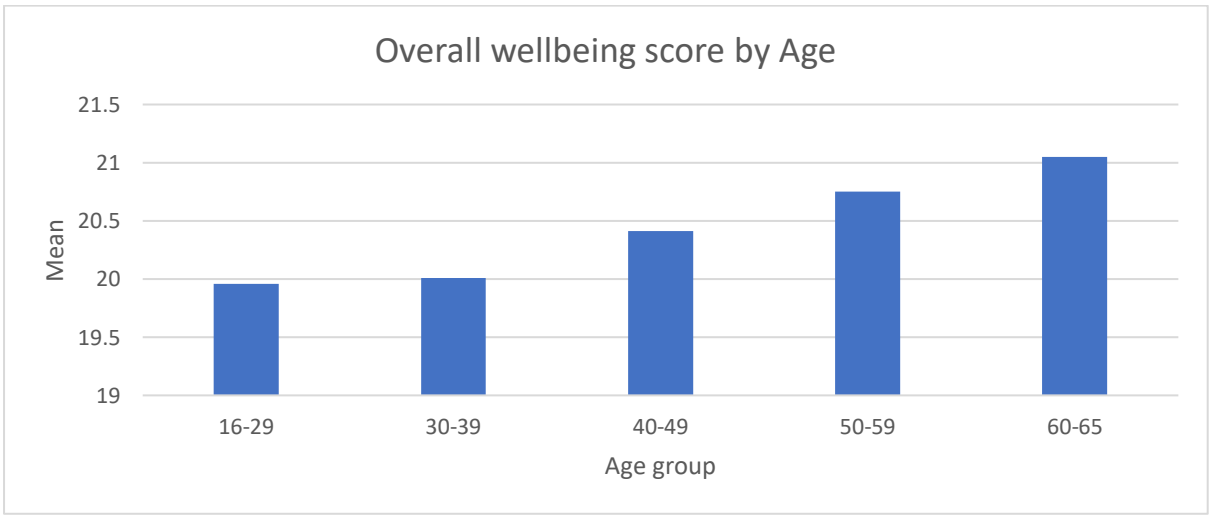


Table A3.11: Mean Overall Wellbeing Score by Age (Weighted)

Age	Mean overall wellbeing score
16-29 years	19.83
30-39 years	20.43
40-49 years	19.38
50-59 years	21.05
60-65 years	19.52
66+ years	20.19

Note. Only six respondents were in the 16-19 years age group, therefore this was merged with the 20-29 for analysis.

Table A3.12: Mean Overall Wellbeing Score by Age (Unweighted)

Age	Mean overall wellbeing score
16-29 years	19.96
30-39 years	20.01
40-49 years	20.41
50-59 years	20.75
60-65 years	21.05
66+ years	20.67

Note. Only six respondents were in the 16-19 years age group, therefore this was merged with the 20-29 for analysis.

A3.5 Wellbeing Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups on their overall mean wellbeing scores ($F = 136.964$, $df = 3$, $p < .001$). Specifically, respondents who identified as black had significantly higher wellbeing scores than all the other ethnic groups, and those who identified as Asian had significantly lower wellbeing scores than all the other groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups on their overall mean wellbeing scores ($F = 4.090$, $df = 3$, $p < .01$). Specifically, respondents who identified as black had significantly higher wellbeing scores than those who identified as white.

Figure A3.15: Mean Overall Wellbeing Score by Ethnicity (Weighted)

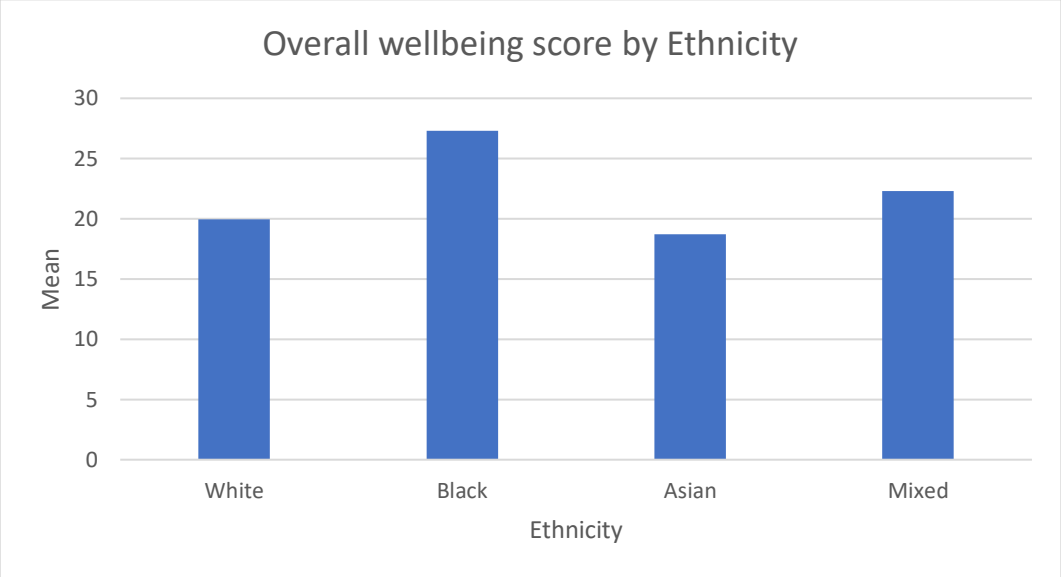


Figure A3.16: Mean Overall Wellbeing Score by Ethnicity (Unweighted)

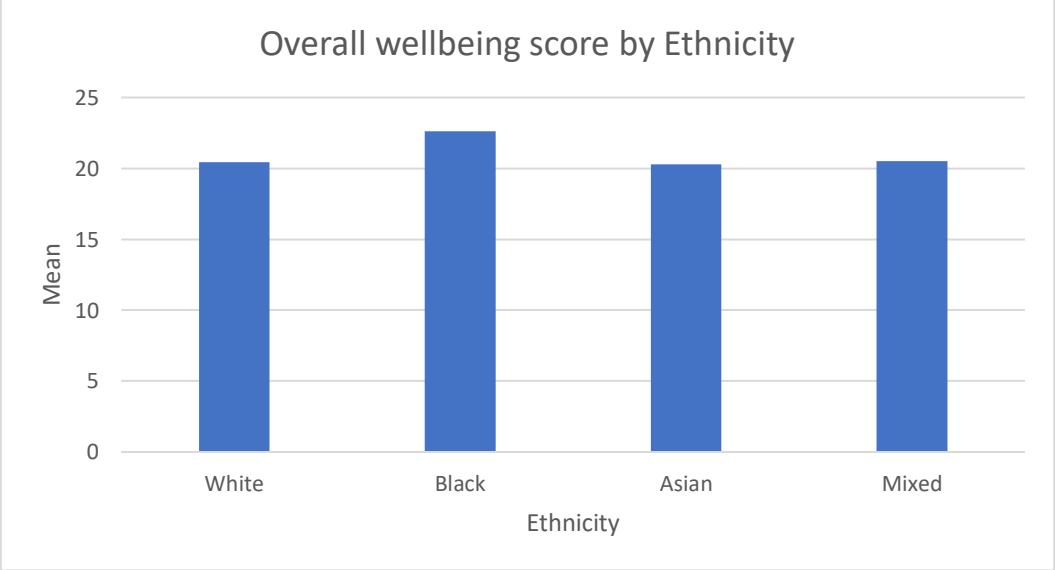


Table A3.13: Mean Overall Wellbeing Score by Ethnicity (Weighted)

Ethnicity	Mean overall wellbeing score
White	19.95
Black	27.29
Asian	18.72
Mixed	22.29

Table A3.14: Mean Overall Wellbeing Score by Ethnicity (Unweighted)

Ethnicity	Mean overall wellbeing score
White	20.44
Black	22.62
Asian	20.29
Mixed	20.53

A3.6 Wellbeing Scores by Disability

Summary (Weighted results):

There were significant differences between respondents on their overall mean wellbeing scores based on their disability status ($F = 4.790$, $df = 2$, $p < .01$). Specifically, respondents who considered themselves to have a disability had significantly lower wellbeing scores than those without a disability.

Summary (Unweighted results):

There were significant differences between respondents on their overall mean wellbeing scores based on their disability status ($F = 16.034$, $df = 2$, $p < .001$). Specifically, respondents who considered themselves to have a disability had significantly lower wellbeing scores than those without a disability.

Figure A3.17: Mean Overall Wellbeing Score by Disability (Weighted)

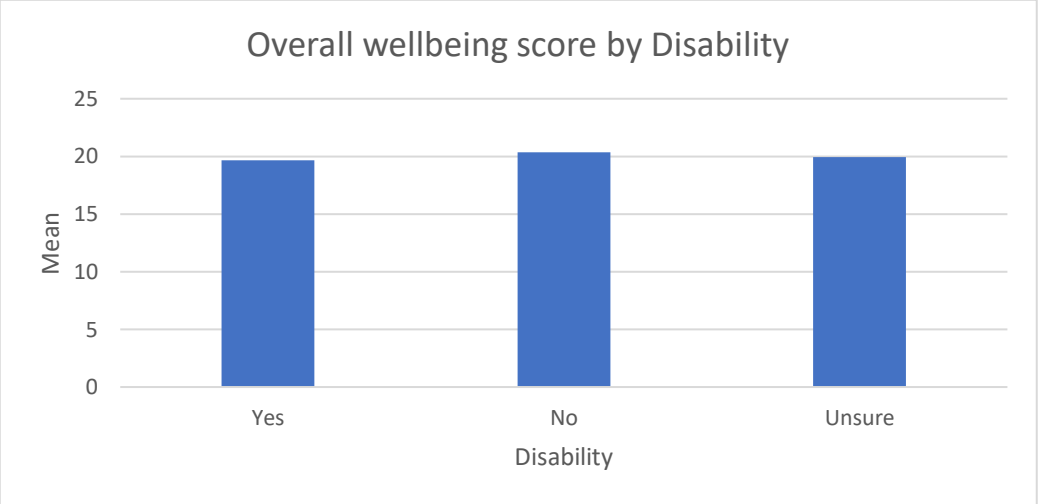


Figure A3.18: Mean Overall Wellbeing Score by Disability (Unweighted)

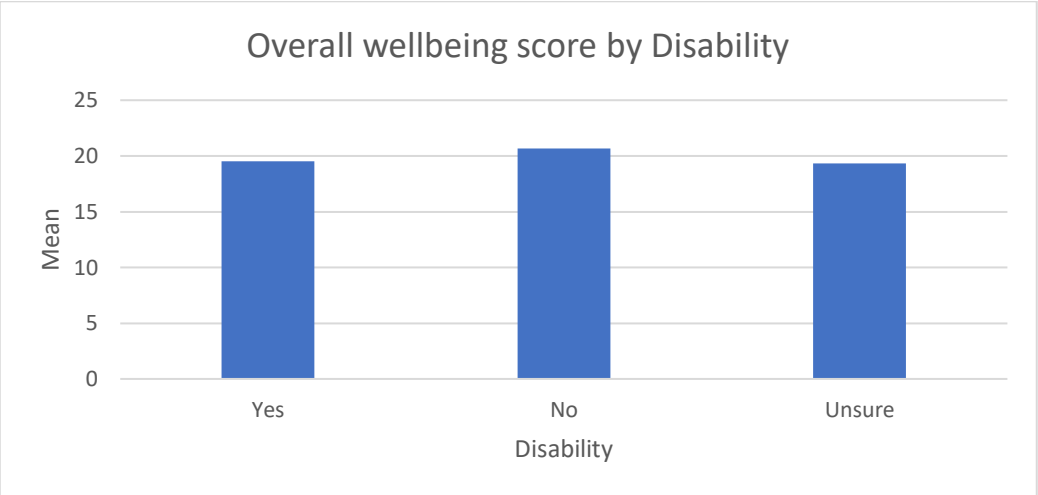


Table A3.15: Mean Overall Wellbeing Score by Disability (Weighted)

Do you consider yourself to have a disability?	Mean overall wellbeing score
Yes	19.64
No	20.34
Unsure	19.94

Table A3.16: Mean Overall Wellbeing Score by Disability (Unweighted)

Do you consider yourself to have a disability?	Mean overall wellbeing score
Yes	19.53
No	20.66
Unsure	19.35

A3.7 Wellbeing Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who worked in different areas of practice (F = 13.393, df = 7, p = .001). Specifically, respondents who worked with their main area of practice being children scored significantly higher than those who worked in learning disability or with older people. Those whose main area of practice was midwifery had significantly lower scores than those who worked with children. Those who worked with adults had significantly lower scores than those working with children, in mental health or learning disability.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores between respondents who worked in different areas of practice (F = 3.188, df =7, p = .002). Multiple comparison tests revealed no statistically significant differences, although there was a trend towards higher scores in those who worked with children, in mental health or other as their area of practice.

Figure A3.19: Mean Overall Wellbeing Score by Area of Practice (Weighted)

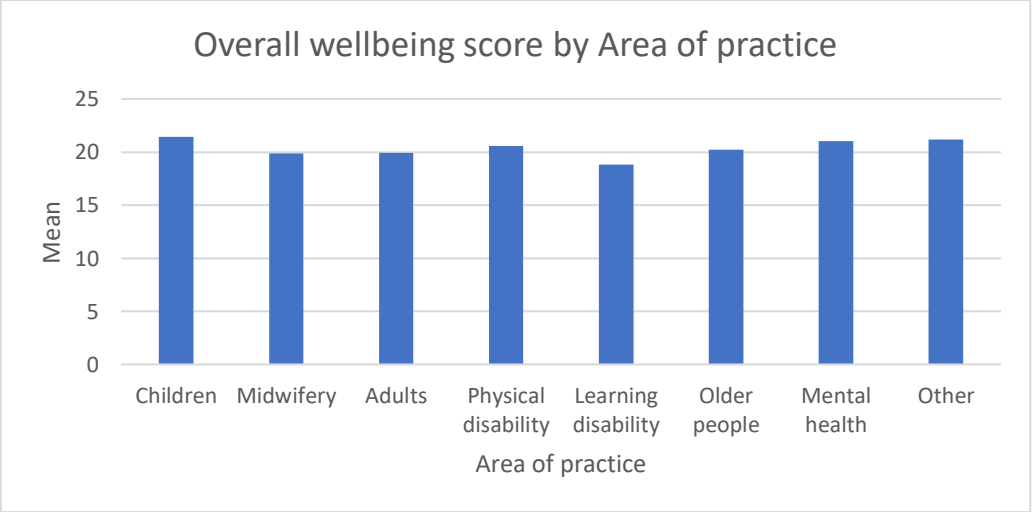


Figure A3.20: Mean Overall Wellbeing Score by Area of Practice (Unweighted)

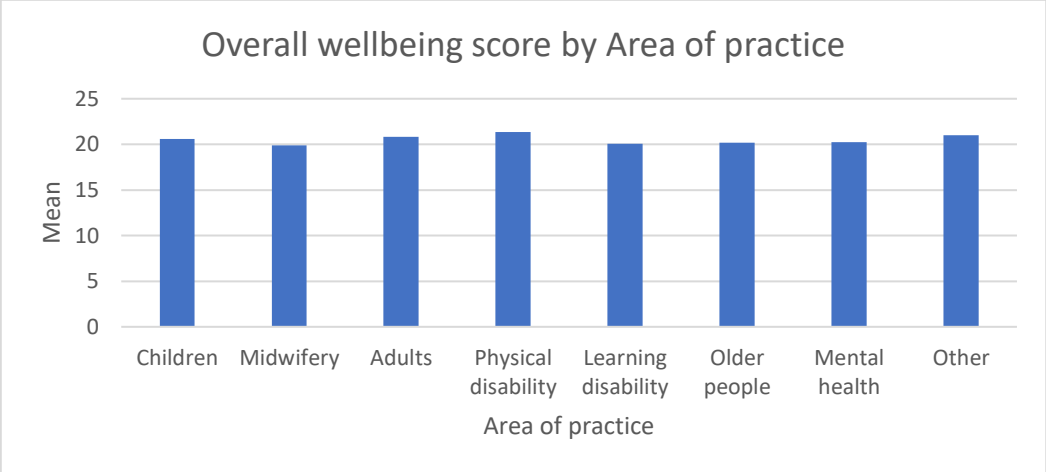


Table A3.17: Mean Overall Wellbeing Score by Area of Practice (Weighted)

Main area of practice	Mean overall wellbeing score
Children	21.41
Midwifery	19.86
Adults	19.92
Physical disability	20.6
Learning disability	18.82
Older people	20.25
Mental health	21.04
Other	21.16

Table A3.18: Mean Overall Wellbeing Score by Area of Practice (Unweighted)

Main area of practice	Mean overall wellbeing score
Children	20.58
Midwifery	19.88
Adults	20.82
Physical disability	21.33
Learning disability	20.09
Older people	20.19
Mental health	20.26
Other	21.01

A3.8 Wellbeing Scores by Line Manager Status

Summary (Weighted results):

There was a significant difference in the overall mean wellbeing scores between respondents who were line managers and those who were not (t = -6.828, df = 2462, p = .001); line managers scored significantly higher than those who were not line managers.

Summary (Unweighted results):

There was no significant difference in the overall mean wellbeing scores between respondents who were line managers and those who were not (t = 1.150, df = 2373, p = .250).

Figure A3.21: Mean Overall Wellbeing Score by Line Manager Status (Weighted)

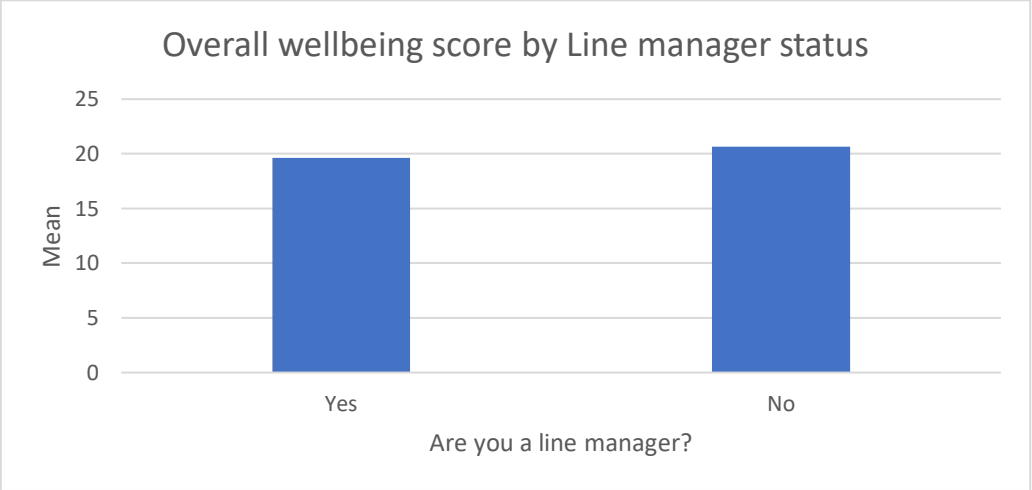


Figure A3.22: Mean Overall Wellbeing Score by Line Manager Status (Unweighted)

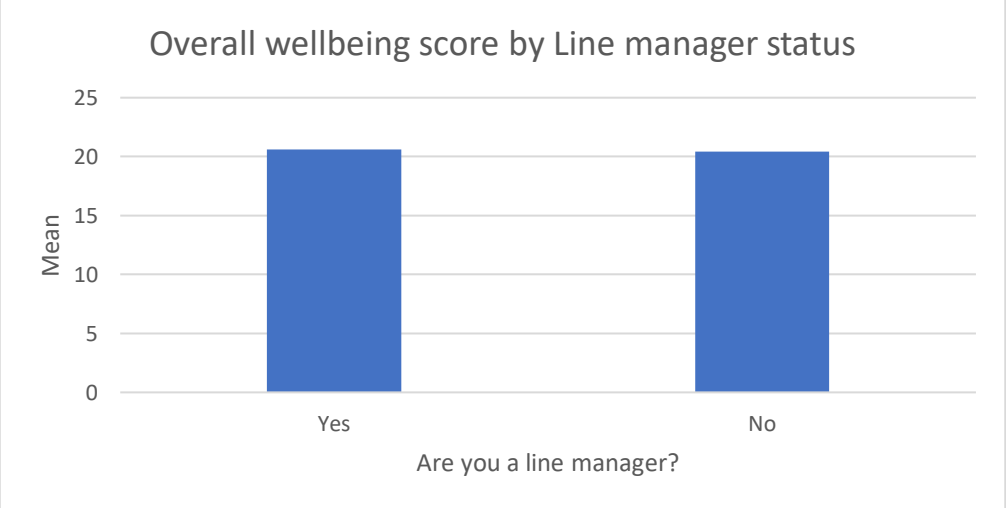


Table A3.19: Mean Overall Wellbeing Score by Line Manager Status (Weighted)

Are you a line manager?	Mean overall wellbeing score
Yes	19.64
No	20.66

Table A3.20: Mean Overall Wellbeing Score by Line Manager Status (Unweighted)

Are you a line manager?	Mean overall wellbeing score
Yes	20.61
No	20.42

A3.9 Wellbeing Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ($F = 194.315$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19. Those who were not impacted by COVID-19 pressures but had services stepped down to due to COVID-19 scored significantly lower than those who felt some impact.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ($F = 54.306$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19.

Figure A3.23: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Weighted)

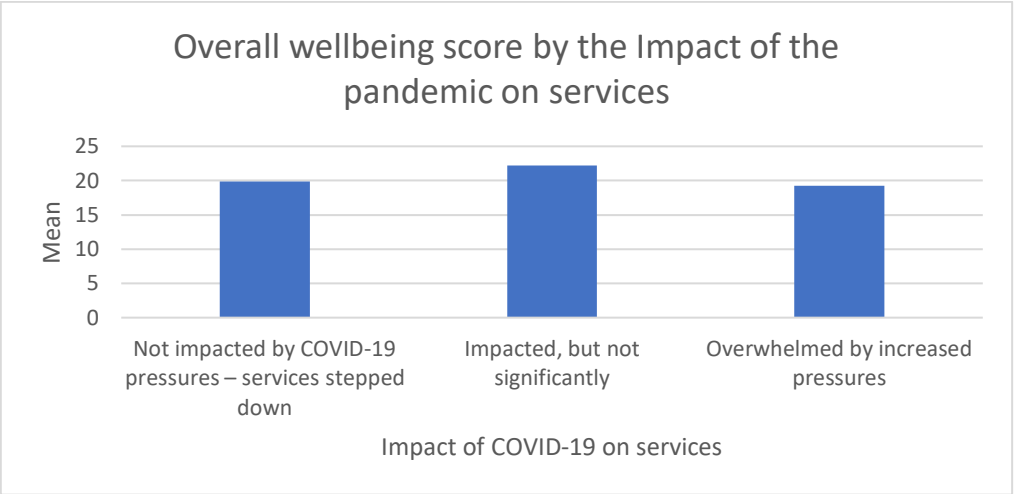


Figure A3.24: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Unweighted)

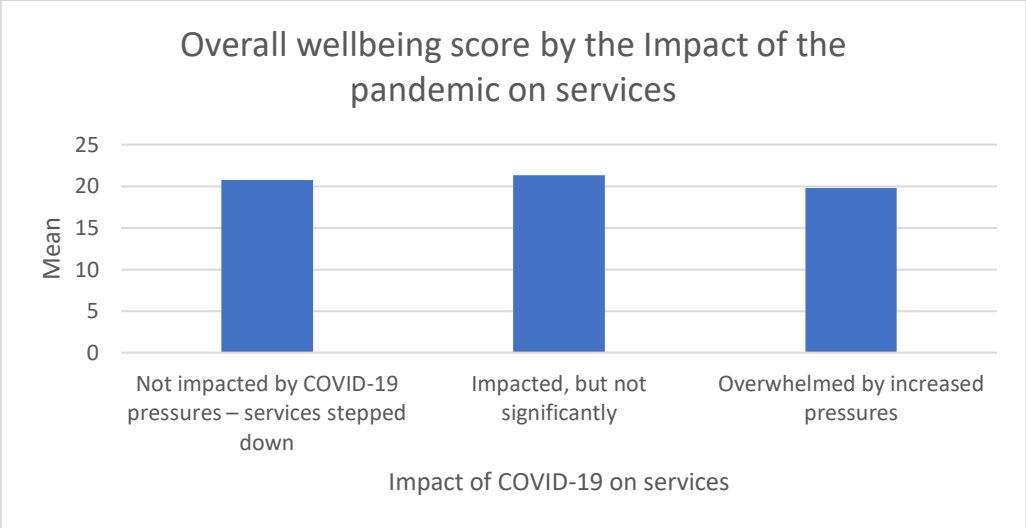


Table A3.21: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Weighted)

Impact of the pandemic on services	Mean overall wellbeing score
Not impacted by COVID-19 pressures – services stepped down	19.88
Impacted, but not significantly	22.19
Overwhelmed by increased pressures	19.26

Table A3.22: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Unweighted)

Impact of the pandemic on services	Mean overall wellbeing score
Not impacted by COVID-19 pressures – services stepped down	20.75
Impacted, but not significantly	21.32
Overwhelmed by increased pressures	19.76

A3.10 Wellbeing Scores by Working at home status

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who worked at home all the time, some of the time or never during COVID-19 ($F = 22.629$, $df = 2$, $p < .001$). Specifically, respondents who worked at home some of the time reported significantly higher scores wellbeing scores that those who did not work at home during the pandemic or those who worked at home all of the time.

Summary (Unweighted results):

There were no significant differences in the overall mean wellbeing scores between respondents who worked at home all the time, some of the time or never during COVID-19 ($F = 1.096$, $df = 2$, $p > .05$).

Figure A3.25: Mean Overall Wellbeing Score by working at home status (Weighted)

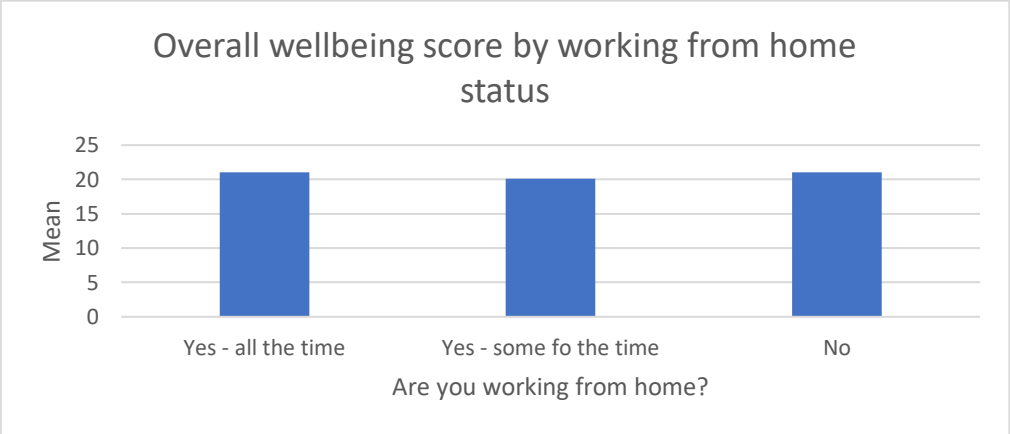


Figure A3.26: Mean Overall Wellbeing Score by working at home status (Unweighted)

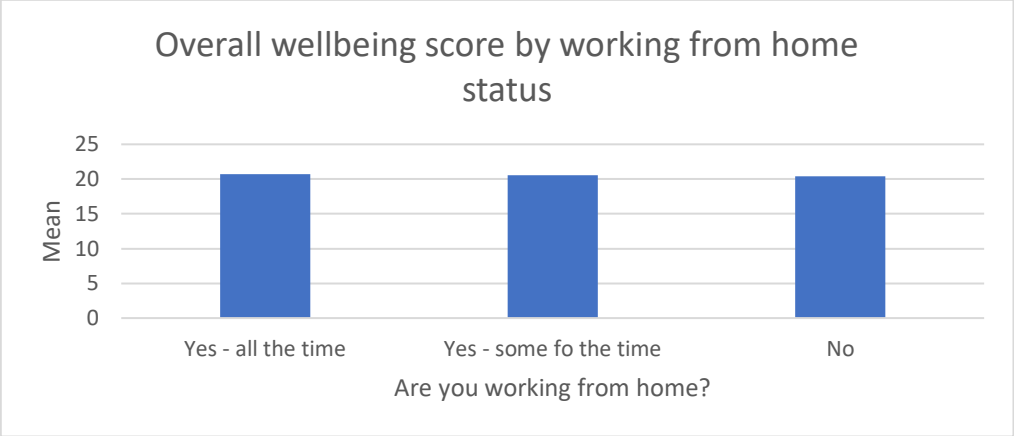


Table A3.23: Mean Overall Wellbeing Score by Working at home (Weighted)

Working at home	Mean overall wellbeing score
Yes - all the time	21.01
Yes - some of the time	20.12
No	21.04

Table A3.24: Mean Overall Wellbeing Score by Working at home (Unweighted)

Working at home	Mean overall wellbeing score
Yes - all the time	20.67
Yes - some of the time	20.57
No	20.38

A3.11 Wellbeing Scores by Vaccination uptake

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) ($F = 15.749$, $df = 4$, $p < .001$). Specifically, respondents who had both doses had reported higher wellbeing that those who had only had received one vaccine and those who reported no – other regarding receiving the vaccine. Those who had not yet received the vaccination reported a significantly higher average score than who had received one or both doses of the vaccination.

Summary (Unweighted results):

There were no significant differences in the overall mean wellbeing scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) (F = .203, df = 4, p = .937).

Figure A3.27: Mean Overall Wellbeing Score by vaccination uptake (Weighted)

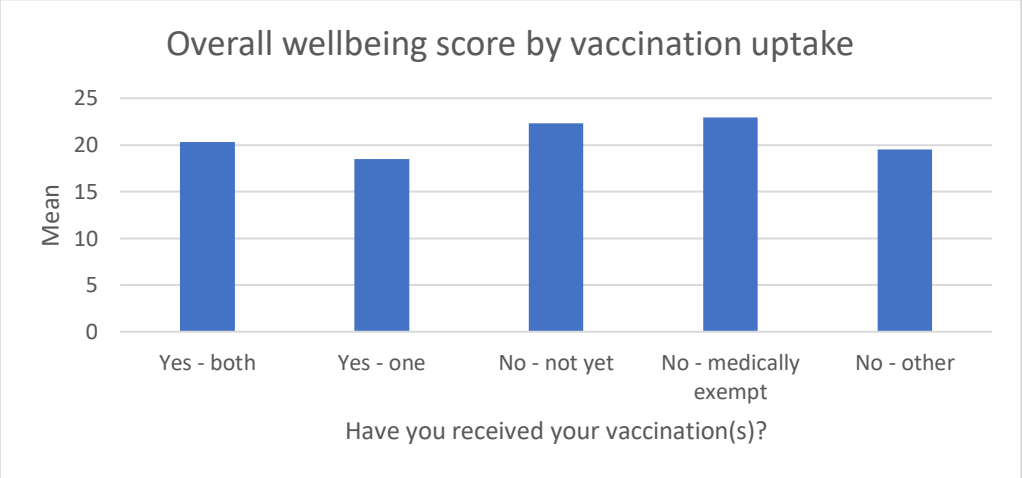


Figure A3.28: Mean Overall Wellbeing Score by vaccination uptake (Unweighted)

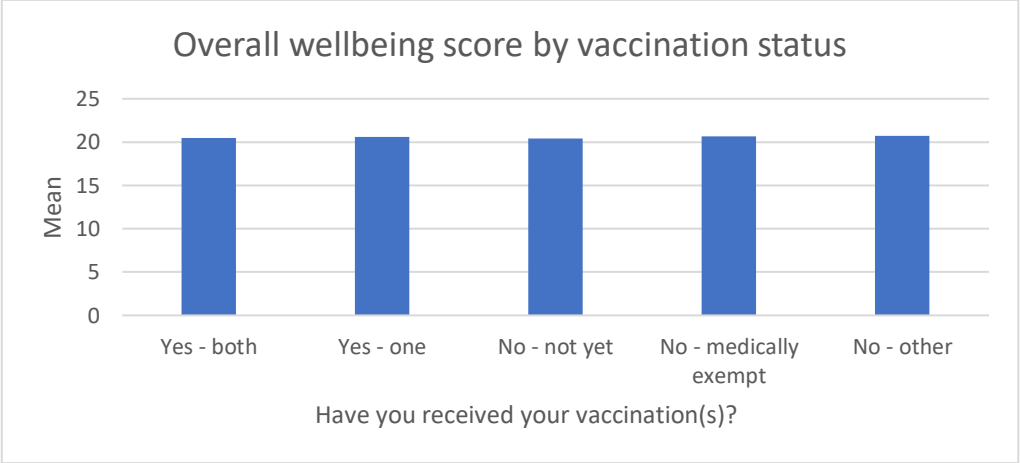


Table A3.25: Mean Overall Wellbeing Score by Vaccination uptake (Weighted)

Vaccination uptake	Mean overall wellbeing score
Yes - both	20.30
Yes - one	18.47
No - not yet	22.32
No - medically exempt	22.94
No - other	19.54

Table A3.26: Mean Overall Wellbeing Score by Vaccination uptake (Unweighted)

Vaccination uptake	Mean overall wellbeing score
Yes - both	20.46
Yes - one	20.59
No - not yet	20.4
No - medically exempt	20.68
No - other	20.75

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 and Phase 3 surveys), please see Appendix 9.

A4.1 Quality of Working Life Scores by Country

Summary (Weighted results):

There were significant differences in the overall mean WRQOL scores across countries ($F = 12.781$, $df = 3$, $p < .001$). Specifically, the overall WRQOL score was significantly higher in Wales compared to all the other countries. 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" (45.9%) and Wales had the highest proportion with "higher quality of working life" (43.3%).

Summary (Unweighted results):

There were significant differences in the overall mean WRQOL scores across countries ($F = 12.983$, $df = 3$, $p < .001$). Specifically, the overall WRQOL score was significantly higher in Wales compared to all the other countries; and additionally, the score was significantly higher in Northern Ireland compared to England. When respondents were categorised into those with lower, average and higher quality of working life, England had the highest proportion of respondents with "lower quality of working life" (54.9%) and Wales had the highest proportion with "higher quality of working life" (38.7%).

Figure A4.1: Mean Quality of Working Life Scores by Country (Weighted)

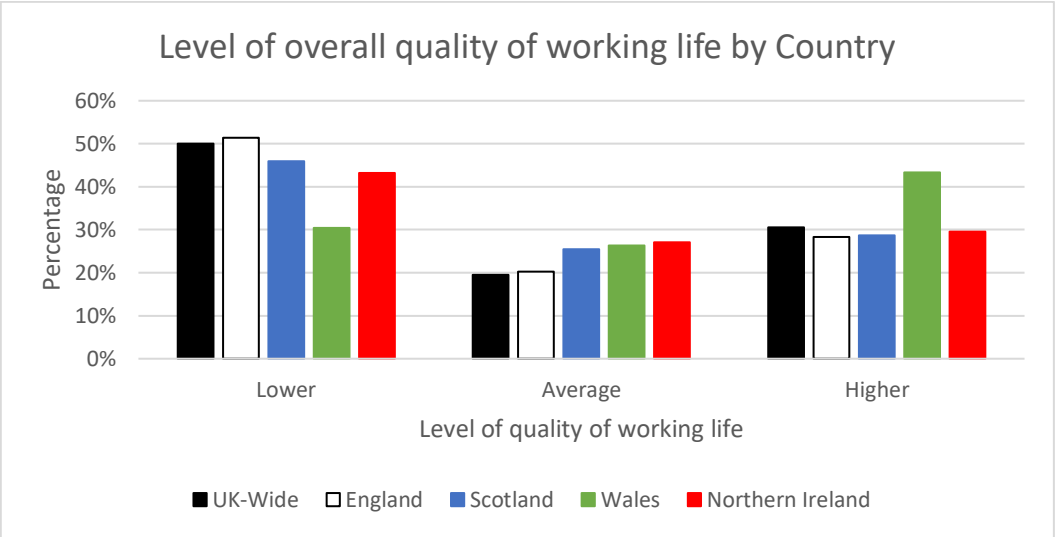


Figure A4.2: Mean Quality of Working Life Scores by Country (Unweighted)

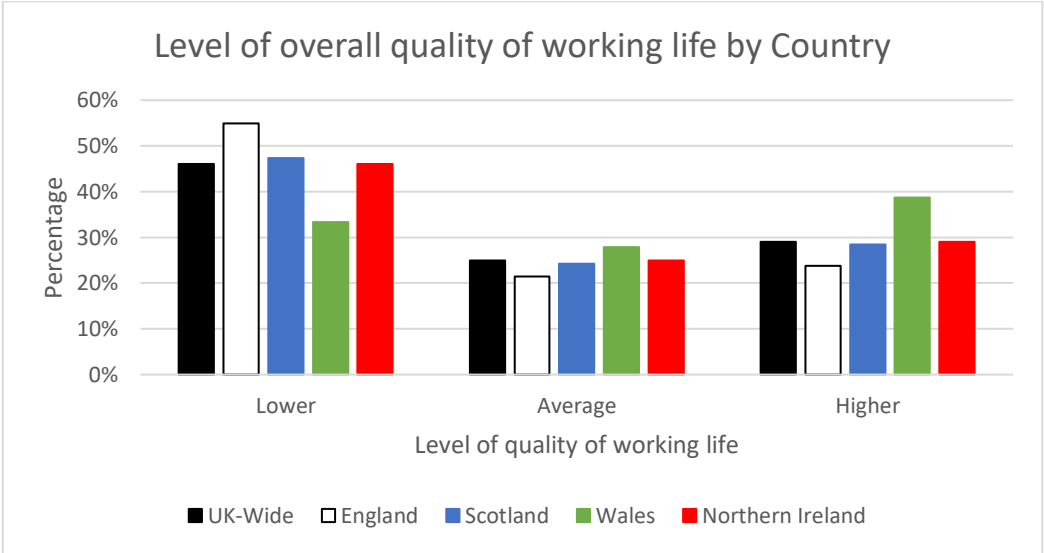


Figure A4.3: Mean Overall Quality of Working Life Score by Country (Weighted)

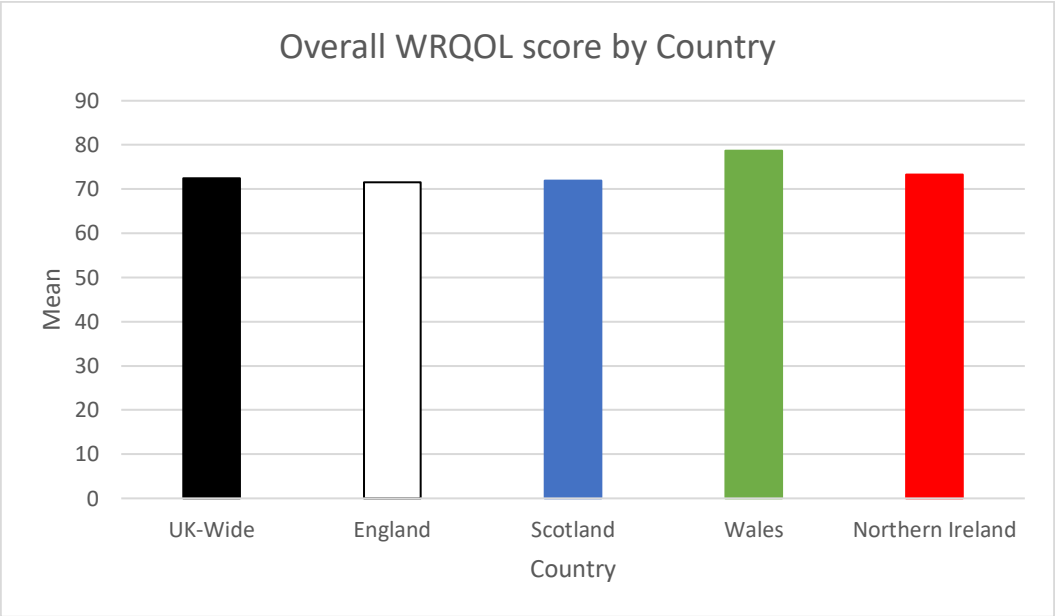


Figure A4.4: Mean Overall Quality of Working Life Score by Country (Unweighted)

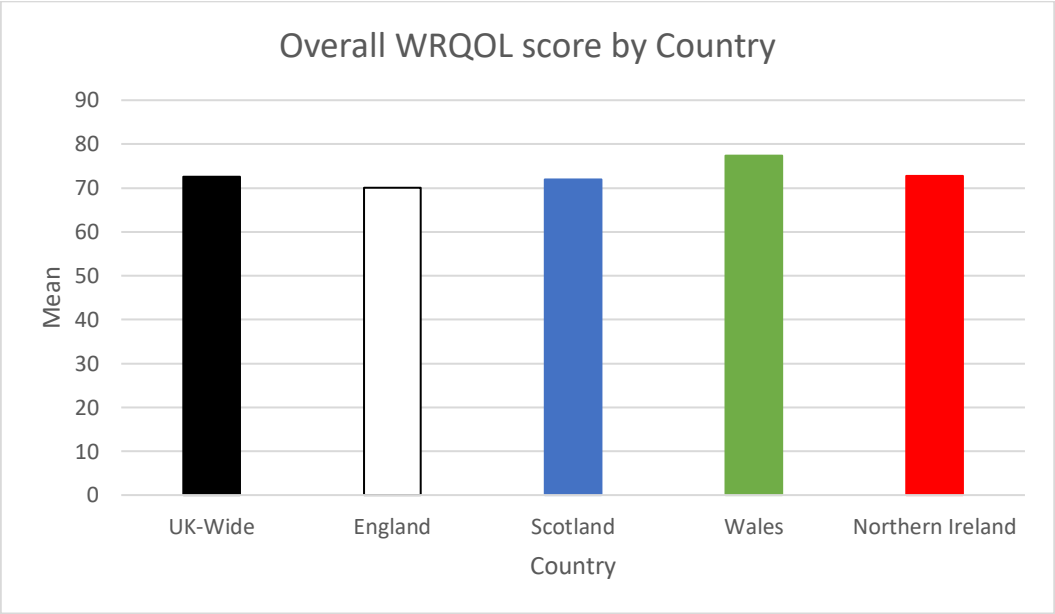


Table A4.1: Mean Quality of Working Life Scores by Country (Weighted)

WRQOL domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Job career satisfaction	20.57	20.34	19.95	21.96	20.28
Stress at work	4.26	4.24	4.72	4.73	4.75
General wellbeing	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
Overall WRQOL Score	**72.45**	**71.54**	**71.92**	**78.69**	**73.29**

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	20.36	20.13	20.02	21.77	21.08
Stress at work	4.50	4.07	4.67	4.53	20.27
General wellbeing	18.73	17.55	18.6	19.56	4.58
Home-work interface	9.77	9.63	9.65	10.59	19.16
Control at work	9.27	9.32	9.00	10.09	9.68
Working conditions	9.92	9.39	9.97	10.85	9.17
Overall WRQOL score	**72.56**	**70.05**	**71.94**	**77.37**	**72.75**

Figure A4.5: Level of Quality of Working Life Scores – UK-Wide (Weighted)

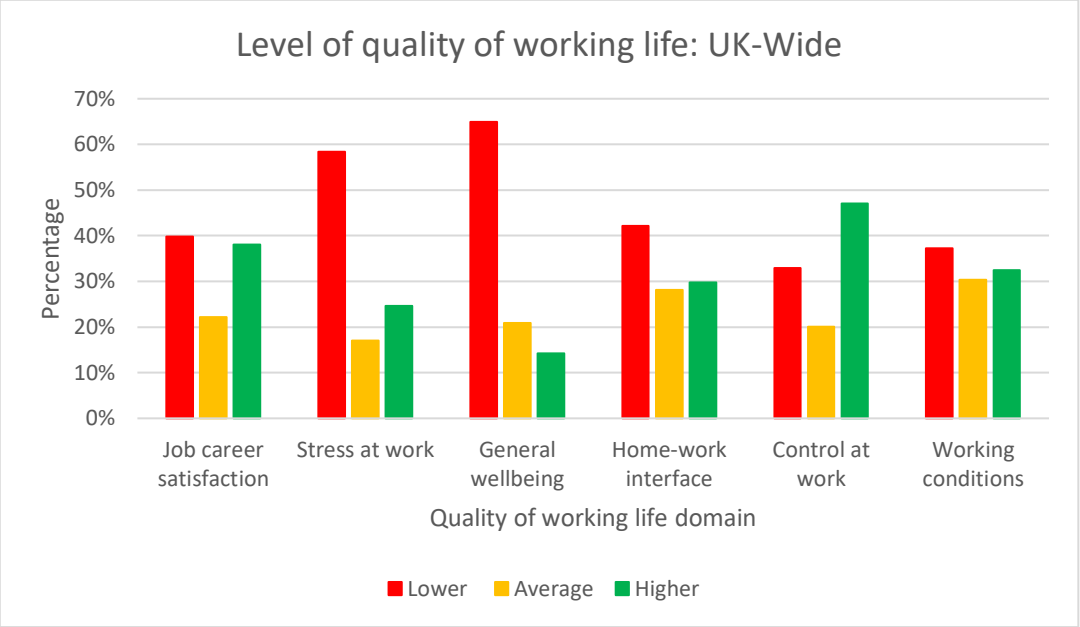


Figure A4.6: Level of Quality of Working Life Scores – UK-Wide (Unweighted)

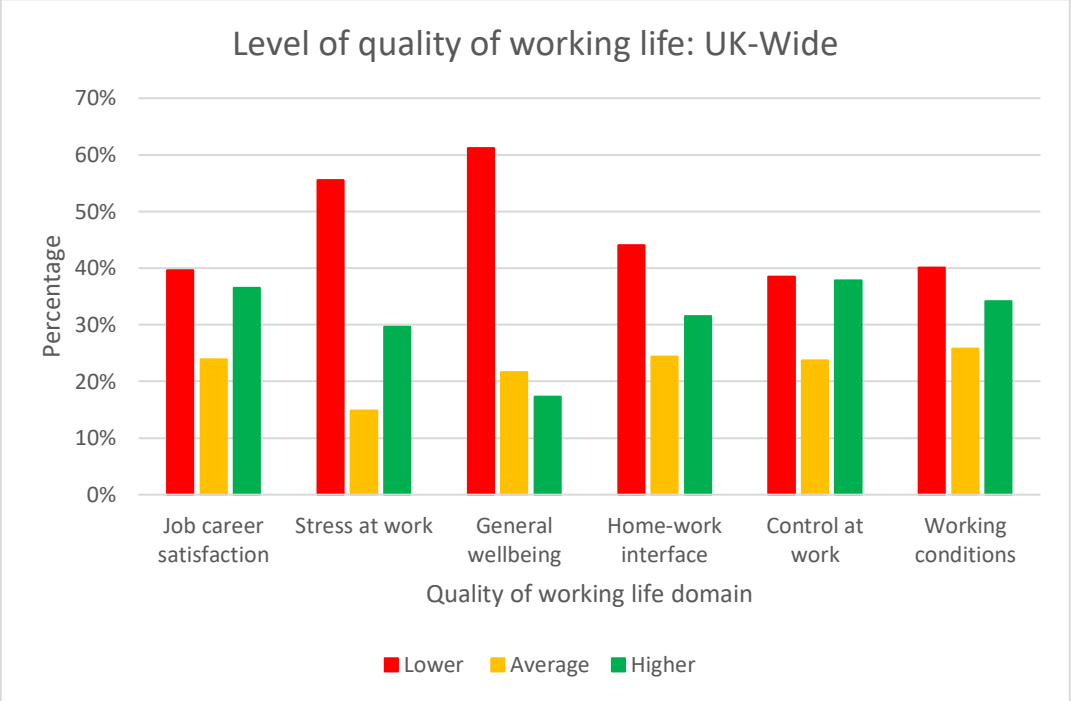


Table A4.3: Level of Quality of Working Life Scores – UK-Wide (Weighted)

WRQOL domain	Level of WRQOL			Total
	Lower	Average	Higher	
Job career satisfaction	39.8%	22.2%	38.1%	**100%**
Stress at work	58.4%	17.0%	24.6%	**100%**
General wellbeing	64.9%	20.9%	14.2%	**100%**
Home-work interface	42.1%	28.1%	29.8%	**100%**
Control at work	32.9%	20.1%	47.0%	**100%**
Working conditions	37.2%	30.4%	32.4%	**100%**
Overall WRQOL	**50.0%**	**19.5%**	**30.5%**	**100%**

Table A4 4: Level of Quality of Working Life Scores – UK-Wide (Unweighted)

WRQOL domain	Level of WRQOL			Total
	Lower	Average	Higher	
Job career satisfaction	942 (39.6%)	570 (23.9%)	869 (36.5%)	**2381 (100%)**
Stress at work	1331 (55.5%)	358 (14.9%)	710 (29.6%)	**2399 (100%)**
General wellbeing	1461 (61.2%)	515 (21.6%)	413 (17.3%)	**2389 (100%)**
Home-work interface	1061 (44.1%)	588 (24.4%)	758 (31.5%)	**2407 (100%)**
Control at work	921 (38.5%)	567 (23.7%)	906 (37.8%)	**2394 (100%)**
Working conditions	959 (40.1%)	616 (25.8%)	817 (34.2%)	**2392 (100%)**
Overall WRQOL	**1090 (46.1%)**	**589 (24.9%)**	**686 (29.0%)**	2365 (100%)

Figure A4.7: Level of Overall Quality of Working Life by Country (Weighted)

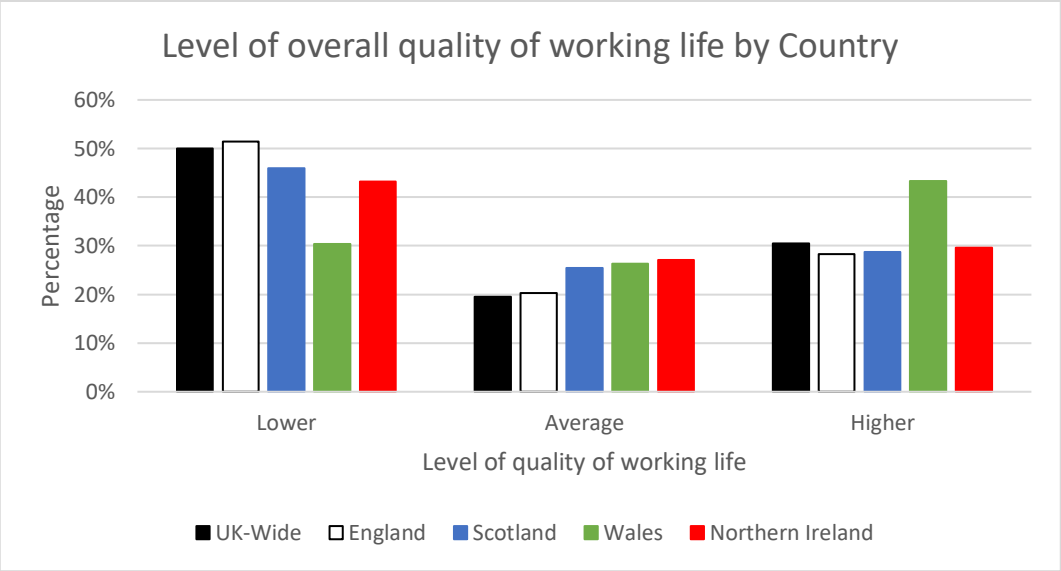


Figure A4.8: Level of Overall Quality of Working Life by Country (Unweighted)

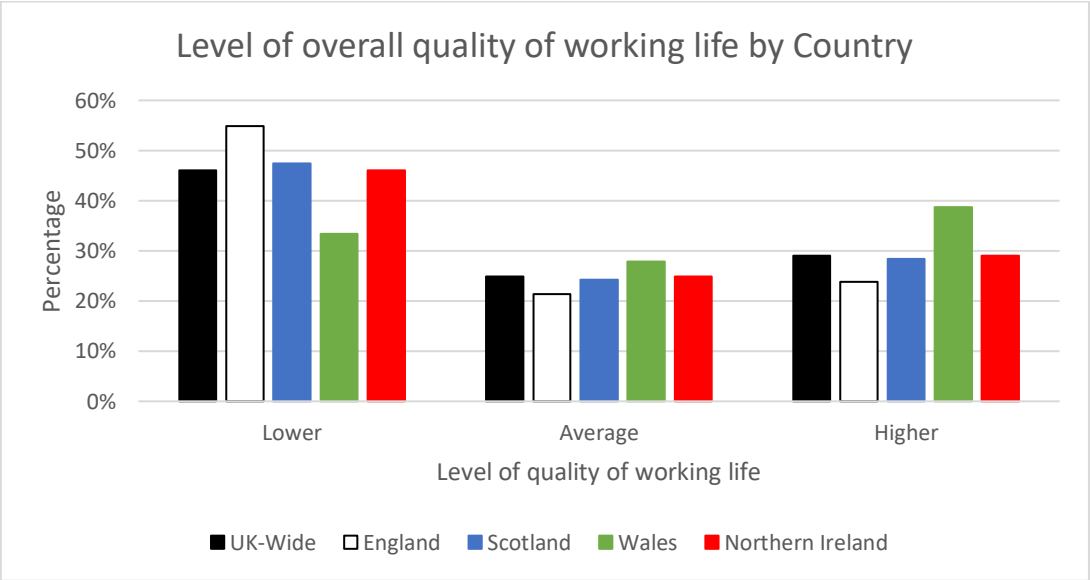


Table A4.5: Level of Overall Quality of Working Life by Country (Weighted)

Level of WRQOL	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower	50.00%	51.40%	45.90%	30.40%	43.20%
Average	19.50%	20.30%	25.40%	26.30%	27.10%
Higher	30.50%	28.30%	28.70%	43.30%	29.60%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A4.6: Level of Overall Quality of Working Life by Country (Unweighted)

Level of WRQOL	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower	46.10%	54.90%	47.40%	33.40%	46.10%
Average	24.90%	21.40%	24.20%	27.90%	24.90%
Higher	29.00%	23.80%	28.40%	38.70%	29.00%
Total	**2365 (100%)**	**463 (100%)**	**656 (100%)**	**923 (100%)**	**2365 (100%)**

A4.2 Quality of Working Life Scores by Occupation

Summary (Weighted results):

There were significant differences in the overall mean WRQOL score between the occupational groups ($F = 19.417$, $df = 4$, $p < .001$). Specifically, midwives scored significantly lower than nurses, AHPs, social care workers and social workers.

Summary (Unweighted results):

There were significant differences in the overall mean WRQOL score between the occupational groups ($F = 6.089$, $df = 4$, $p = .001$). Specifically, midwives scored significantly lower than nurses, AHPs, social care workers and social workers.

Figure A4.9: Mean Quality of Working Life Scores by Occupation (Weighted)

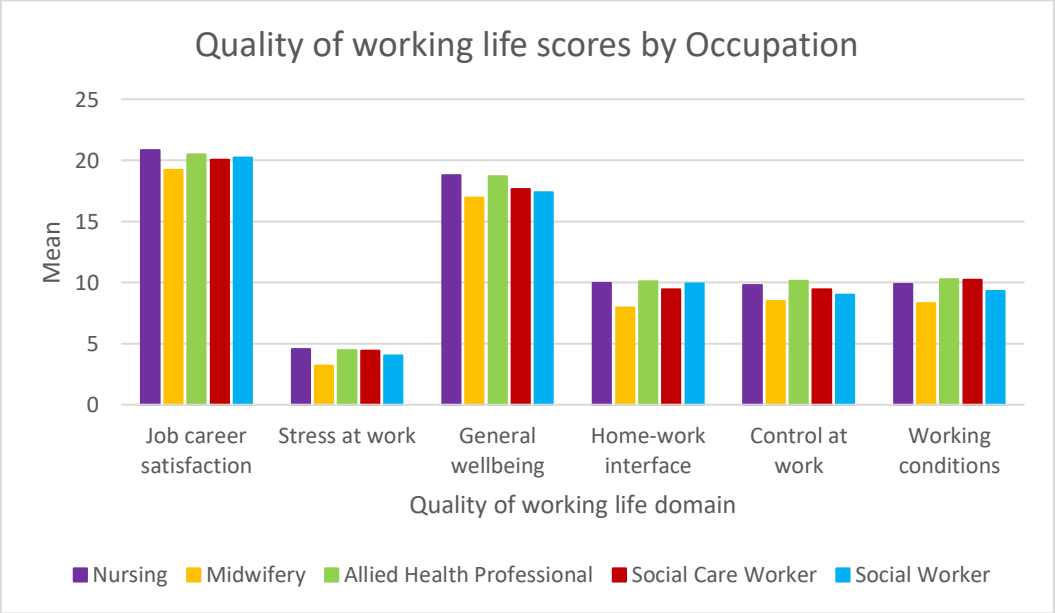


Figure A4.10: Mean Quality of Working Life Scores by Occupation (Unweighted)

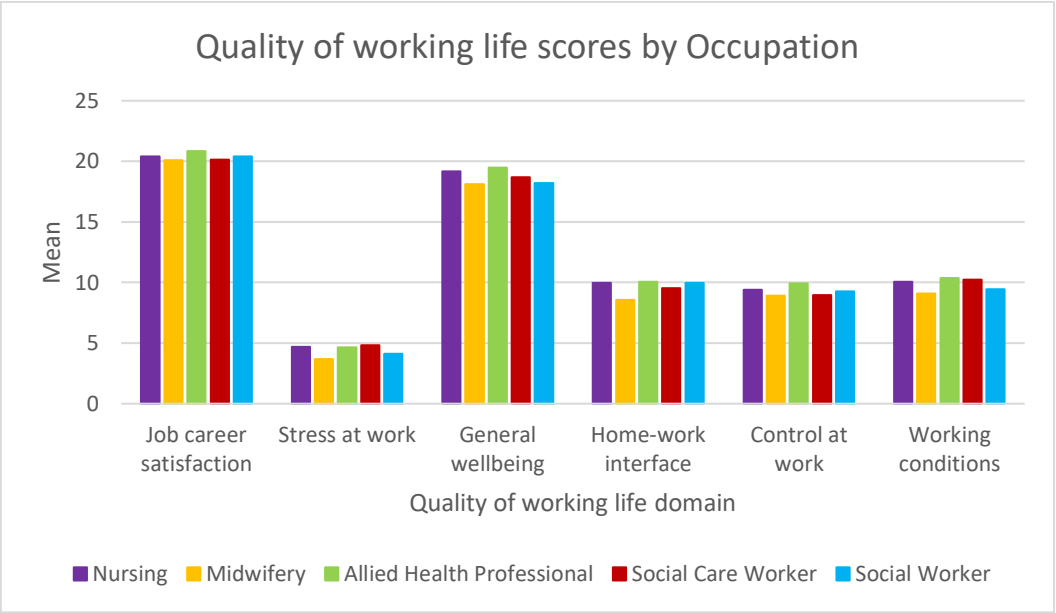


Figure A4.11: Mean Overall Quality of Working Life Score by Occupation (Weighted)

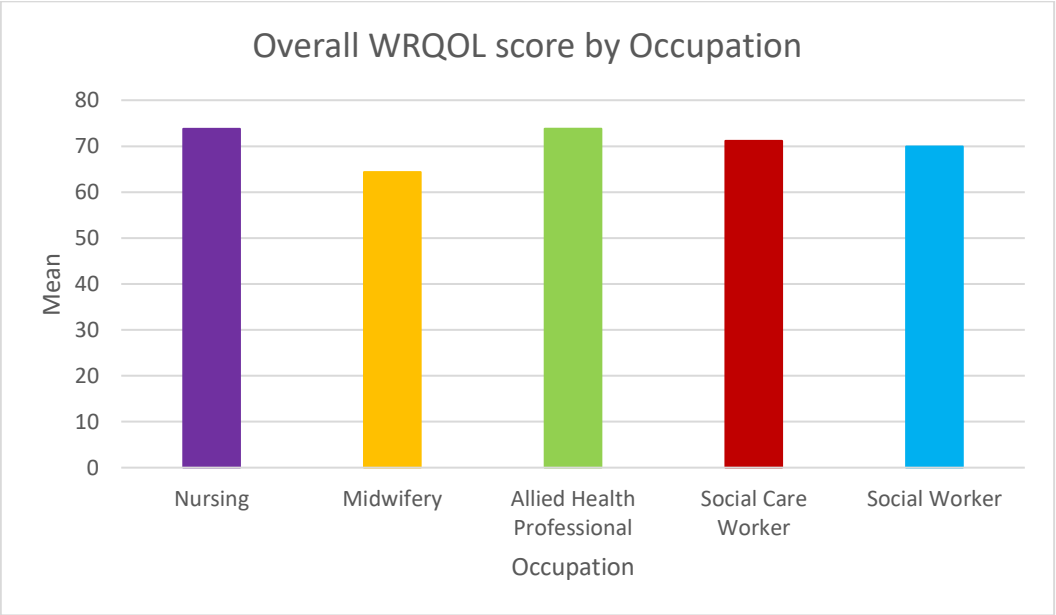


Figure A4.12: Mean Overall Quality of Working Life Score by Occupation (Unweighted)

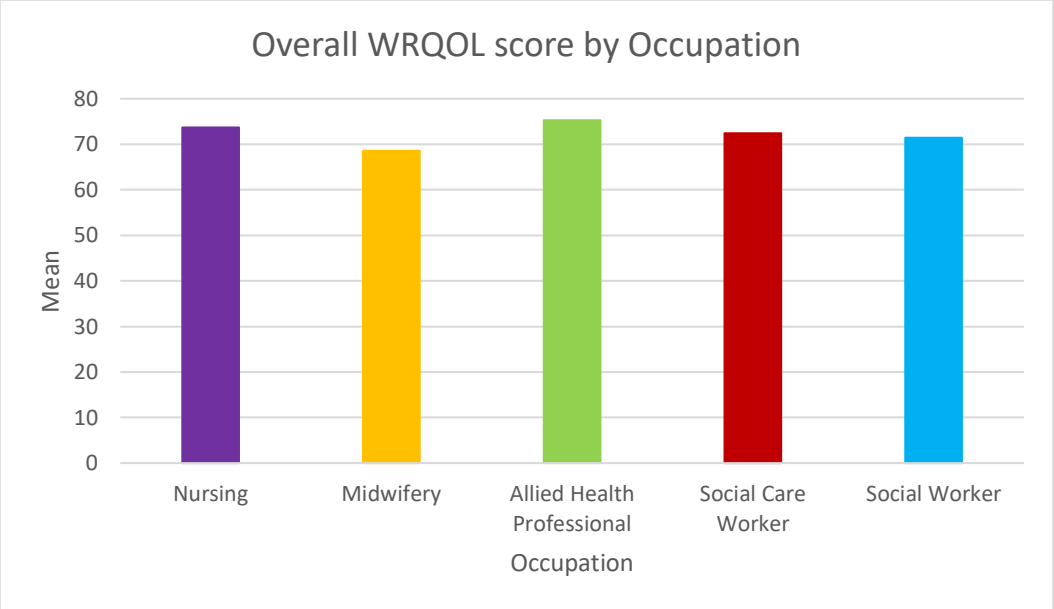


Table A4.7: Mean Quality of Working Life Scores by Occupation (Weighted)

WRQOL domain	Occupation				
	Nursing	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Job career satisfaction	20.83	19.20	20.50	20.07	20.23
Stress at work	4.55	3.20	4.47	4.43	4.03
General wellbeing	18.80	16.97	18.70	17.67	17.4
Home-work interface	9.96	7.96	10.10	9.43	9.92
Control at work	9.78	8.47	10.15	9.44	9.00
Working conditions	9.88	8.29	10.26	10.24	9.30
Overall WRQOL score	**73.77**	**64.35**	**73.79**	**71.15**	**69.92**

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	20.41	20.10	20.86	20.12	20.39
Stress at work	4.67	3.68	4.66	4.83	4.11
General wellbeing	19.18	18.12	19.47	18.70	18.22
Home-work interface	9.98	8.58	10.08	9.53	9.98
Control at work	9.40	8.90	9.93	8.96	9.25
Working conditions	10.06	9.08	10.38	10.23	9.46
Overall WRQOL score	**73.69**	**68.57**	**75.28**	**72.42**	**71.44**

Figure A4.13: Level of Overall Quality of Working Life by Occupation (Weighted)

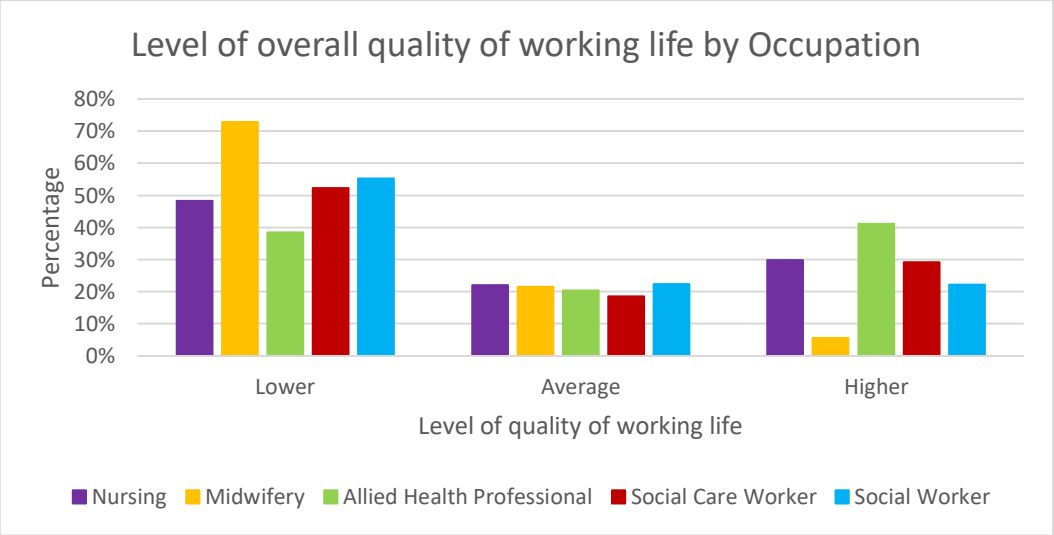


Figure A4.14: Level of Overall Quality of Working Life by Occupation (Unweighted)

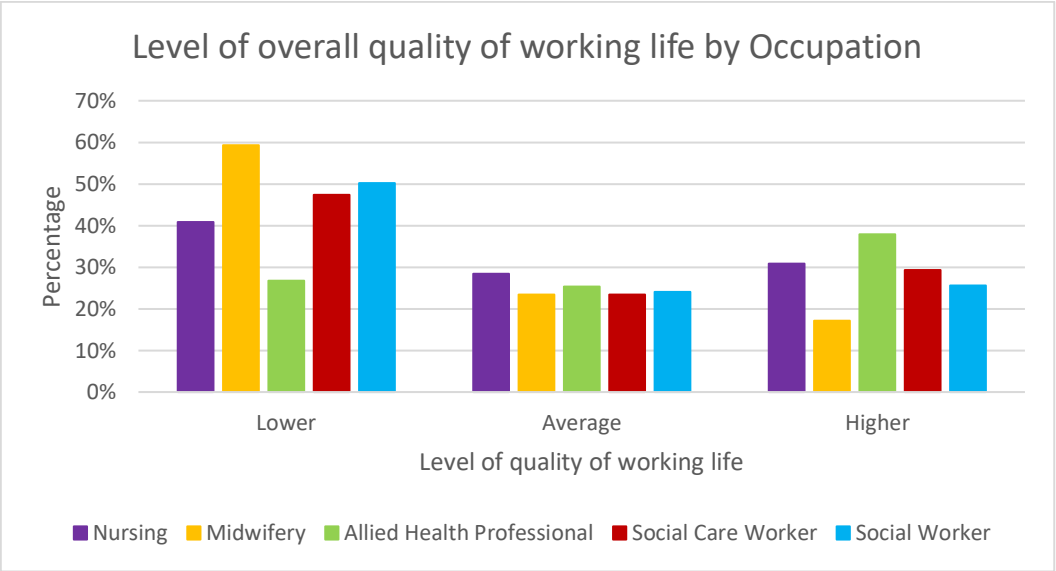


Table A4.9: Level of Overall Quality of Working Life by Occupation (Weighted)

Level of WRQOL	Occupation				
	Nursing	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Lower	48.20%	72.90%	38.50%	52.20%	55.30%
Average	22.10%	21.50%	20.40%	18.60%	22.40%
Higher	29.80%	5.60%	41.10%	29.20%	22.20%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A4.10: Level of Overall Quality of Working Life by Occupation (Unweighted)

Level of WRQOL	Occupation				
	Nursing	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Lower	40.80%	59.30%	26.70%	47.40%	50.20%
Average	28.40%	23.40%	25.40%	23.40%	24.10%
Higher	30.80%	17.20%	37.90%	29.30%	25.60%
Total	**490 (100%)**	**145 (100%)**	**327 (100%)**	**728 (100%)**	**675 (100%)**

A4.3 Quality of Working Life Scores by Sex

Only 21 respondents in the full sample stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

Males and females differed significantly in their mean overall WRQOL score (t = 5.072, df = 2686, p = .002). Specifically, females had significantly higher WRQOL scores than males.

Summary (Unweighted results):

Males and females differed significantly in their mean overall WRQOL score (t = 2.282 df = 332.714, p = .023). Specifically, females had significantly higher WRQOL scores than males.

Figure A4.15: Mean Quality of Working Life Scores by Sex (Weighted)

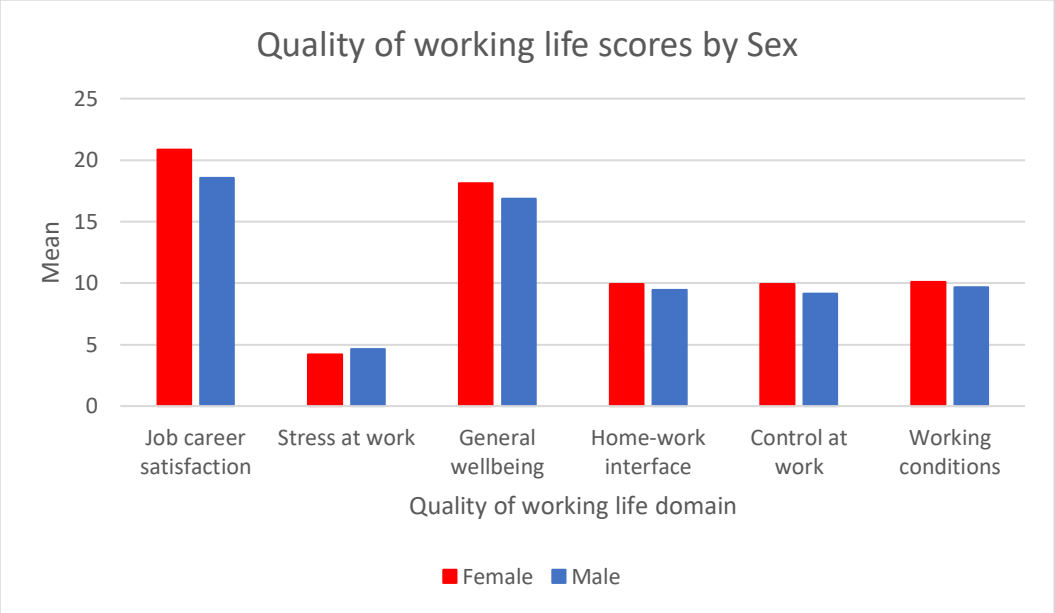


Figure A4.16: Mean Quality of Working Life Scores by Sex (Unweighted)

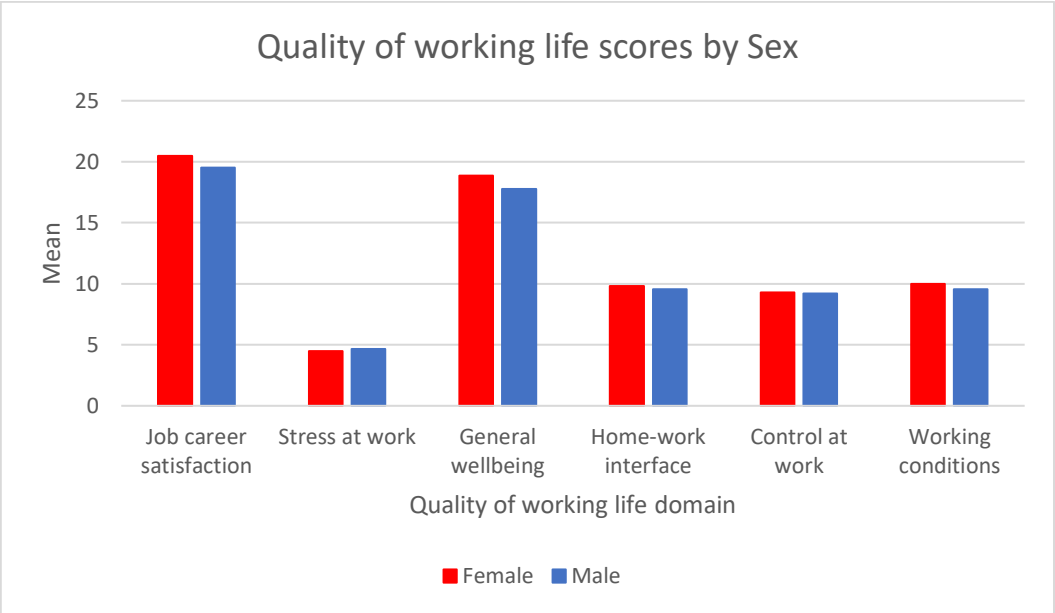


Figure A4.17: Mean Overall Quality of Working Life Score by Sex (Weighted)

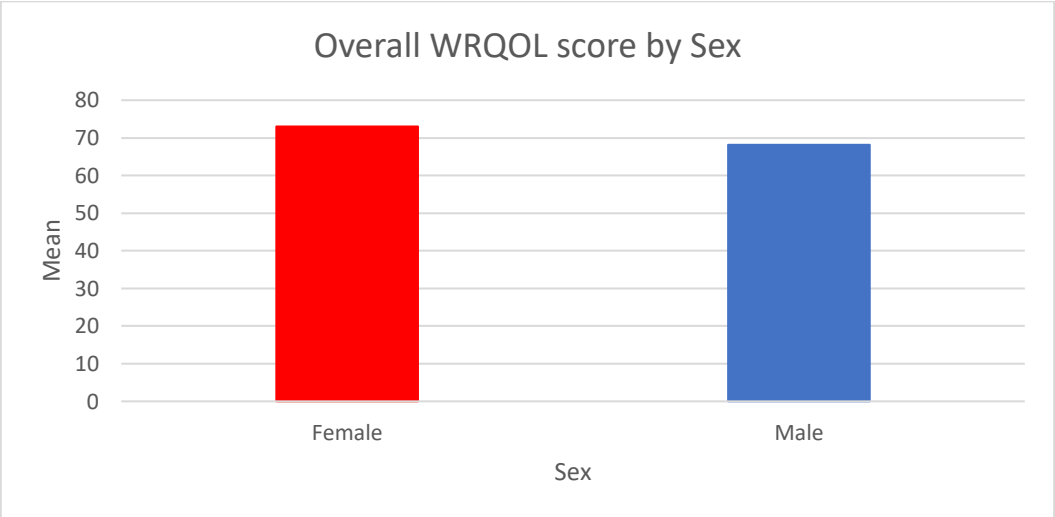


Figure A4.18: Mean Overall Quality of Working Life Score by Sex (Unweighted)

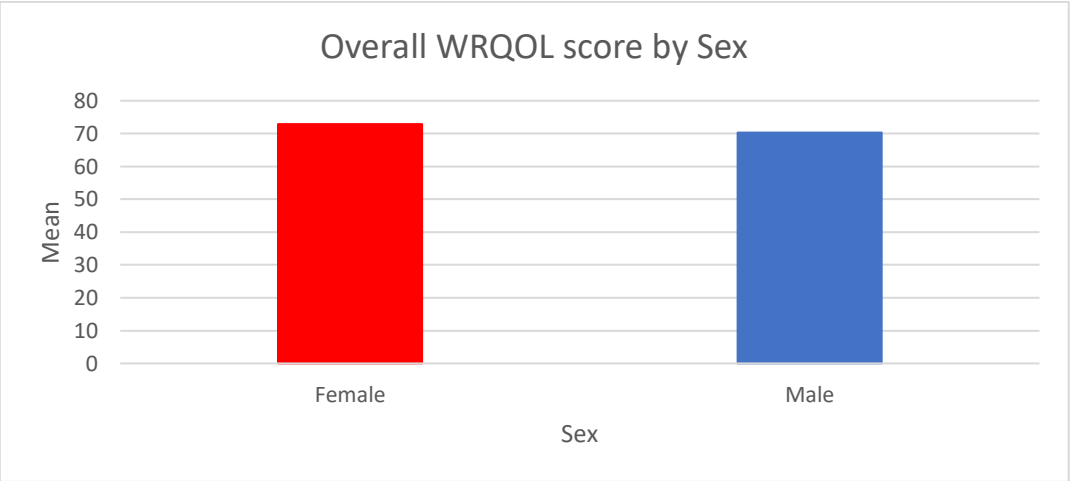


Table A4.11: Mean Quality of Working Life Scores by Sex (Weighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.84	18.56
Stress at work	4.22	4.62
General wellbeing	18.12	16.85
Home-work interface	9.92	9.43
Control at work	9.91	9.13
Working conditions	10.1	9.68
Overall WRQOL score	**73.02**	**68.16**

Table A4.12: Mean Quality of Working Life Scores by Sex (Unweighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.48	19.54
Stress at work	4.48	4.64
General wellbeing	18.87	17.77
Home-work interface	9.81	9.55
Control at work	9.28	9.22
Working conditions	9.98	9.57
Overall WRQOL score	**72.88**	**70.30**

Figure A4.19: Level of Overall Quality of Working Life by Sex (Weighted)

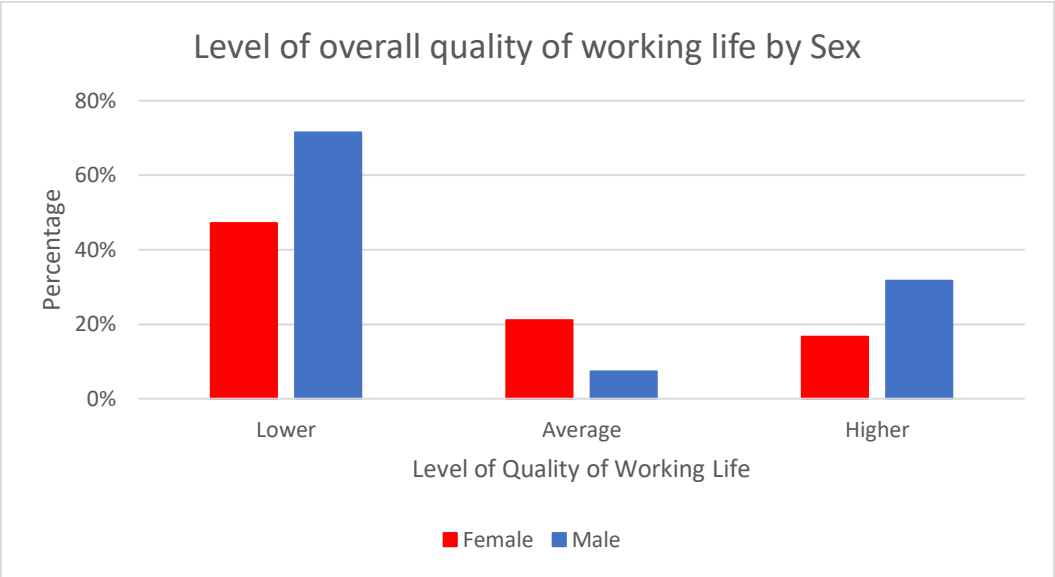


Figure A4.20: Level of Overall Quality of Working Life by Sex (Unweighted)

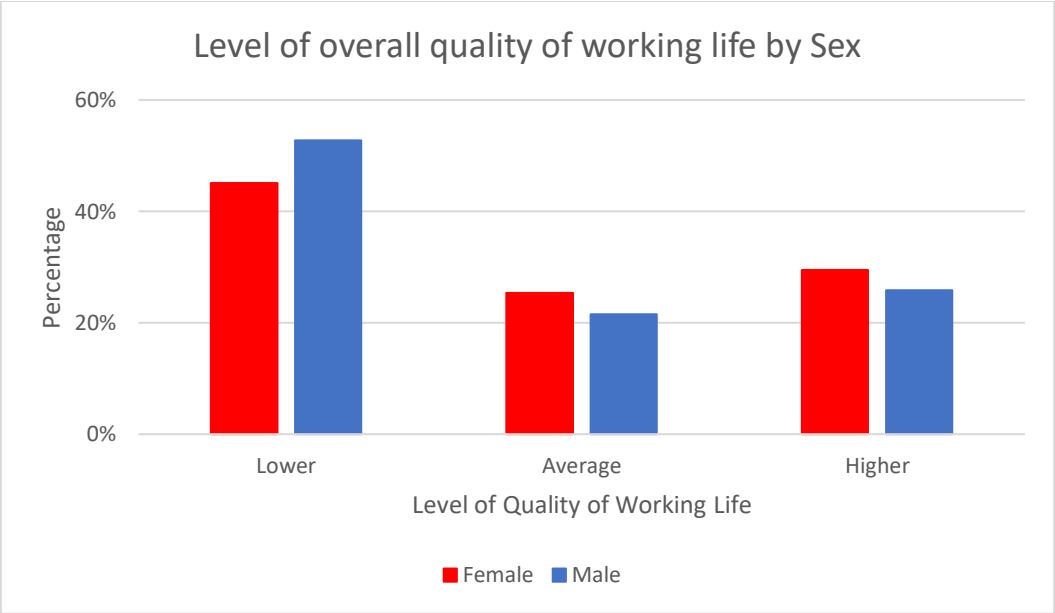


Table A4.13: Level of Overall Quality of Working Life by Sex (Weighted)

Level of WRQOL	Sex	
	Female	Male
Lower	47.20%	71.50%
Average	21.10%	7.40%
Higher	16.70%	31.70%
Total	**100%**	**100%**

Table A4.14: Level of Overall Quality of Working Life by Sex (Unweighted)

Level of WRQOL	Sex	
	Female	Male
Lower	45.10%	52.70%
Average	25.40%	21.50%
Higher	29.50%	25.80%
Total	**2076 (100%)**	**275 (100%)**

A4.4 Quality of Working Life Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in the mean overall WRQOL scores (F = 51.871, df = 5, p < .001). Specifically, 16-29 age group scored significantly lower than the 30-39, 50-59, 60-65 and 66+ age groups; 66+ scored significantly higher than the 16-29; 30-39, 40-49 and the 50-59, 60-65 age groups.

Summary (Unweighted results):

There appeared to be significant differences in the mean overall WRQOL score across age groups (F = 6.788, df = 5, p = .004). Specifically, 16-29 age group scored significantly lower than the 60-65; the 30-39 scored significantly lower than the 50-59 and 60-65 age groups.

Figure A4.21: Mean Quality of Working Life Scores by Age (Weighted)

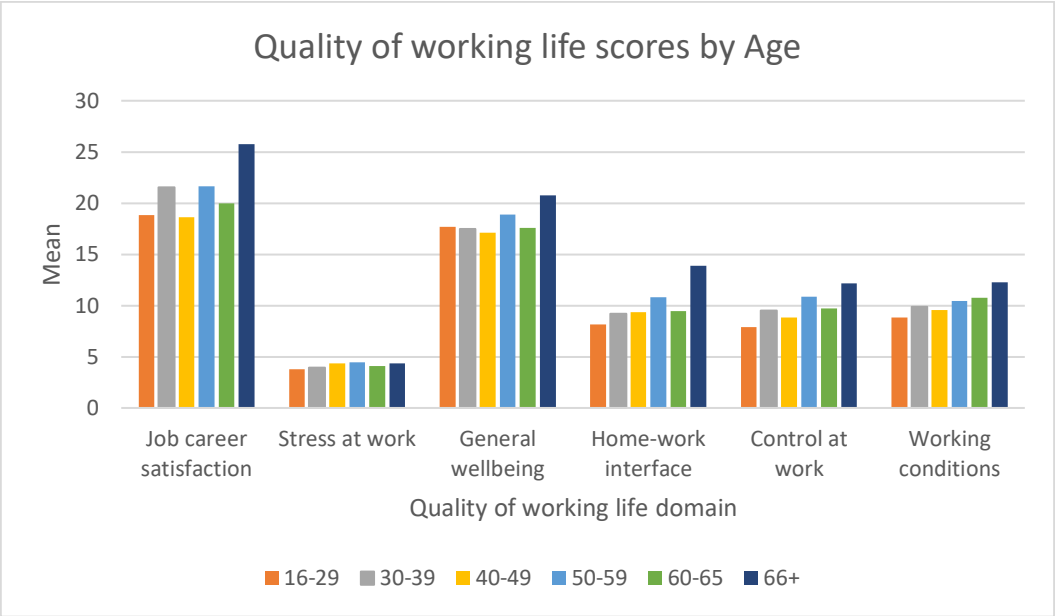


Figure A4.22: Mean Quality of Working Life Scores by Age (Unweighted)

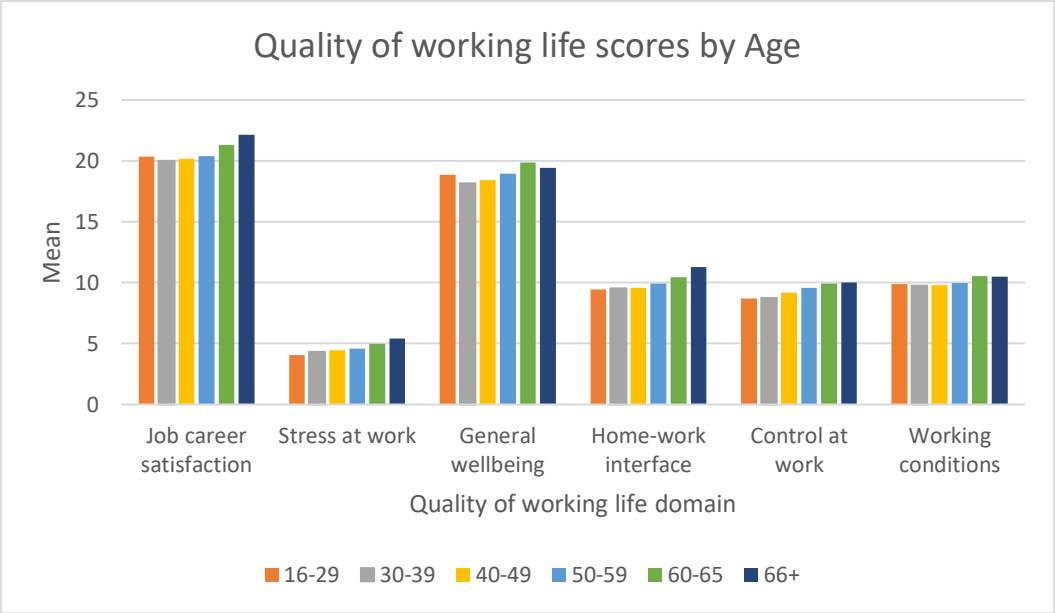


Figure A4.23: Mean Overall Quality of Working Life Score by Age (Weighted)

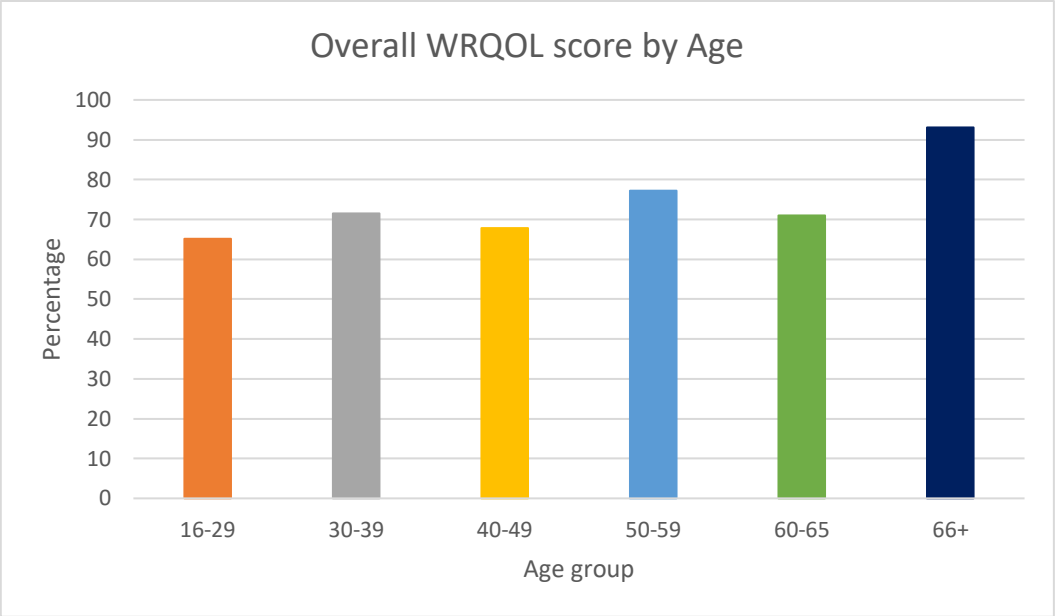


Figure A4.24: Mean Overall Quality of Working Life Score by Age (Unweighted)

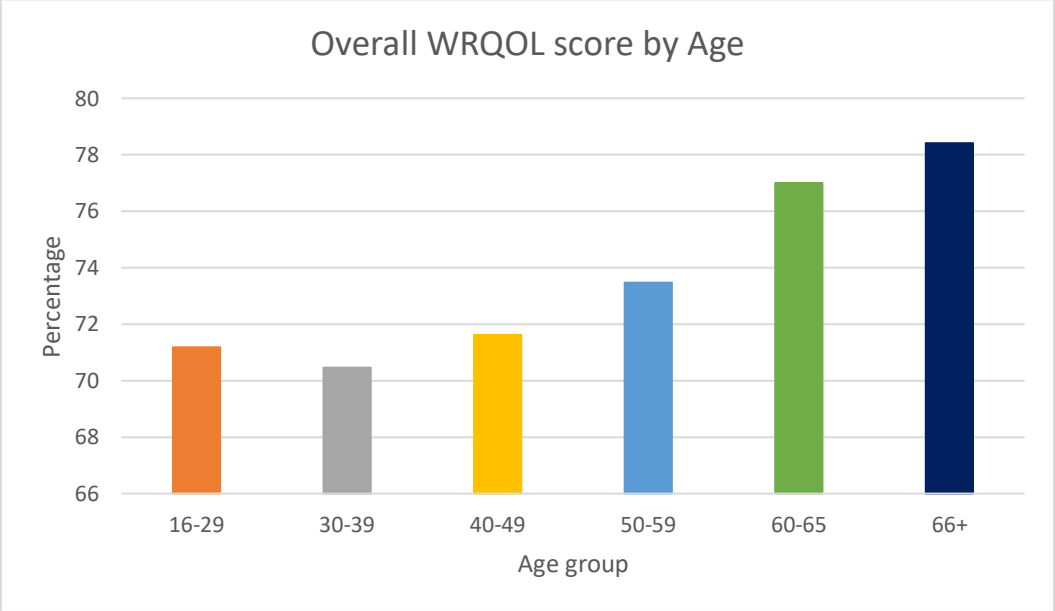


Table A4.15: Mean Quality of Working Life Scores by Age (Weighted)

WRQOL domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Job career satisfaction	18.82	21.53	18.61	21.66	19.99	25.76
Stress at work	3.77	3.94	4.35	4.48	4.08	4.33
General wellbeing	17.68	17.48	17.12	18.9	17.6	20.74
Home-work interface	8.18	9.19	9.36	10.81	9.45	13.89
Control at work	7.88	9.52	8.85	10.88	9.71	12.19
Working conditions	8.84	9.86	9.54	10.47	10.74	12.28
Overall WRQOL score	**65.15**	**71.51**	**67.83**	**77.22**	**71.0**	**93.09**

Table A4.16: Mean Quality of Working Life Scores by Age (Unweighted)

WRQOL domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Job career satisfaction	20.34	20	20.16	20.41	21.31	22.16
Stress at work	4.05	4.33	4.46	4.58	4.97	5.42
General wellbeing	18.86	18.14	18.41	18.95	19.88	19.42
Home-work interface	9.46	9.51	9.57	9.93	10.44	11.28
Control at work	8.71	8.73	9.19	9.56	9.92	10.0
Working conditions	9.86	9.76	9.8	9.97	10.53	10.5
Overall WRQOL score	**71.18**	**70.46**	**71.62**	**73.47**	**77.0**	**78.41**

Figure A4.25: Level of Overall Quality of Working Life by Age (Weighted)

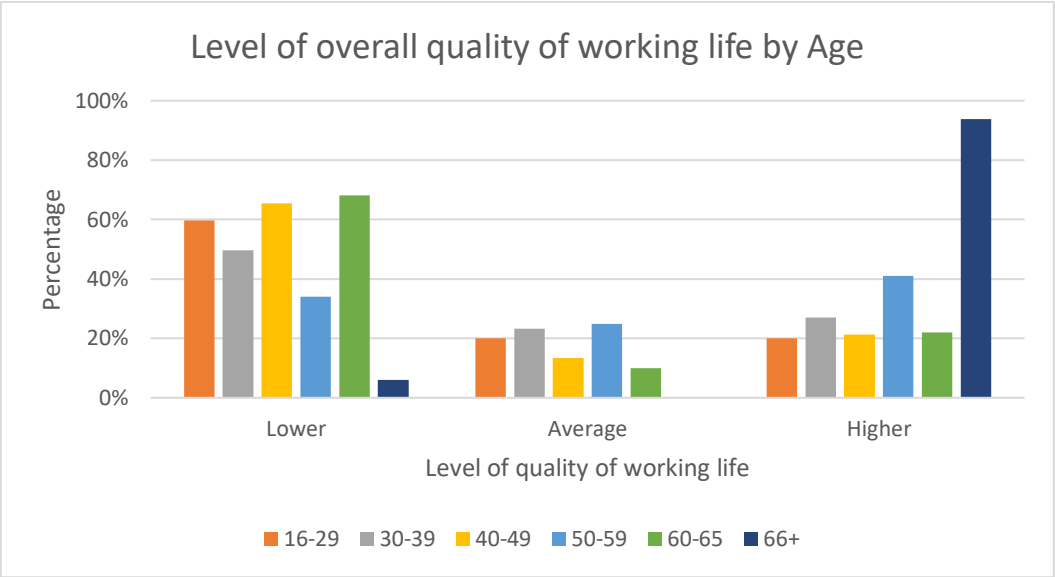


Figure A4.26: Level of Overall Quality of Working Life by Age (Unweighted)

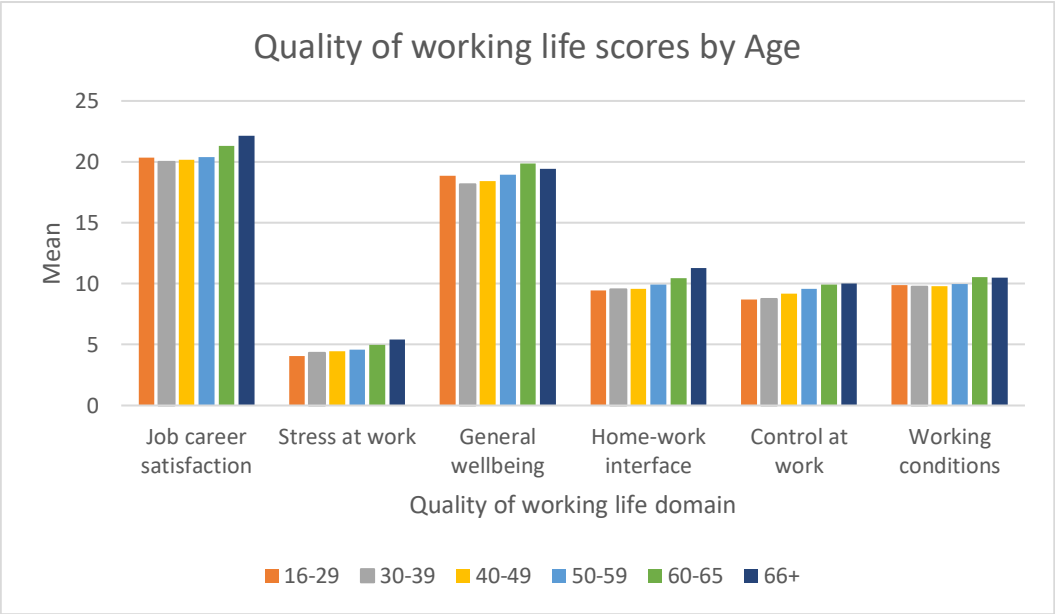


Table A4.17: Level of Overall Quality of Working Life by Age (Weighted)

Level of WRQOL	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Lower	59.70%	49.70%	65.50%	34.00%	68.10%	6.10%
Average	20.10%	23.30%	13.40%	24.90%	9.90%	0.00%
Higher	20.10%	27.00%	21.20%	41.10%	22.00%	93.90%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

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	60-65	66+
Lower	50.50%	50.30%	49.30%	42.90%	36.40%	35.30%
Average	22.90%	25.60%	24.30%	26.50%	22.20%	11.80%
Higher	26.70%	24.10%	26.40%	30.50%	41.30%	52.90%
Total	**210 (100%)**	**449 (100%)**	**637 (100%)**	**825 (100%)**	**225 (100%)**	**17 (100%)**

A4.5 Quality of Working Life Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in the mean overall WRQOL score ($F = 31.525$, $df = 3$, $p < .001$). Specifically, respondents who identified as Asian scored significantly lower than all the other ethnic groups; and those identifying as black scored significantly higher than those identifying as white.

Summary (Unweighted results):

There were no significant differences between the ethnic groups in their mean overall WRQOL scores.

Figure A4.27: Mean Quality of Working Life Scores by Ethnicity (Weighted)

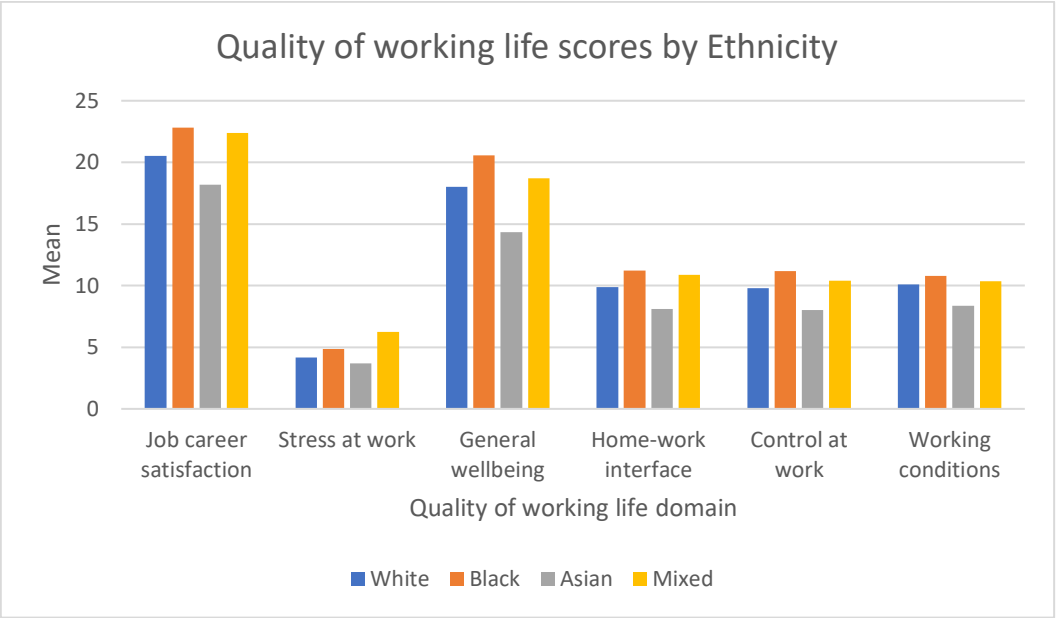


Figure A4.28: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

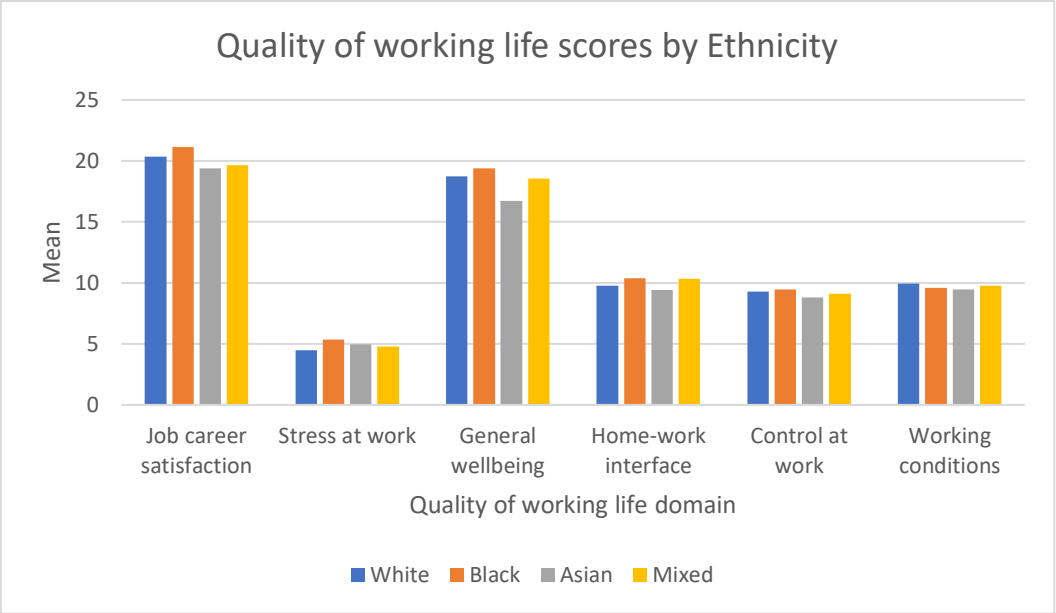


Figure A4.29: Mean Overall Quality of Working Life Score by Ethnicity (Weighted)

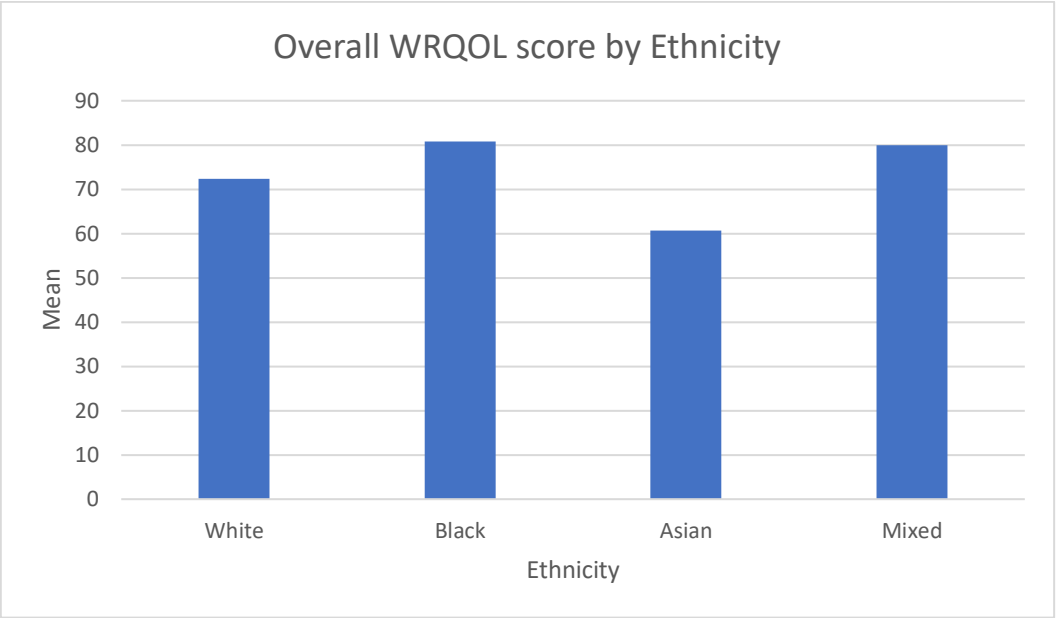


Figure A4.30: Mean Overall Quality of Working Life Score by Ethnicity (Unweighted)

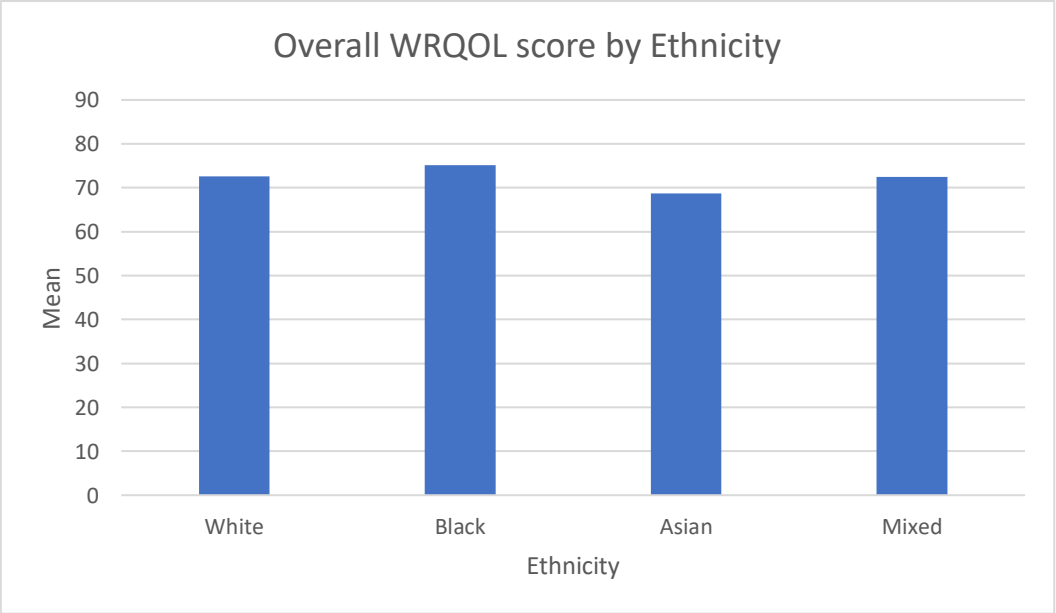


Table A4.19: Mean Quality of Working Life Scores by Ethnicity (Weighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	20.52	22.82	18.19	22.38
Stress at work	4.17	4.86	3.68	6.25
General wellbeing	18	20.55	14.32	18.72
Home-work interface	9.86	11.21	8.09	10.89
Control at work	9.81	11.16	8.04	10.39
Working conditions	10.08	10.77	8.38	10.34
Overall WRQOL score	**72.32**	**80.79**	**60.70**	**79.94**

Table A4.20: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	20.37	21.13	19.37	19.65
Stress at work	4.48	5.35	4.95	4.80
General wellbeing	18.74	19.38	16.74	18.56
Home-work interface	9.76	10.38	9.42	10.32
Control at work	9.27	9.48	8.79	9.11
Working conditions	9.94	9.59	9.47	9.79
Overall WRQOL score	**72.55**	**75.16**	**68.74**	**72.45**

Figure A4.31: Level of Overall Quality of Working Life by Ethnicity (Weighted)

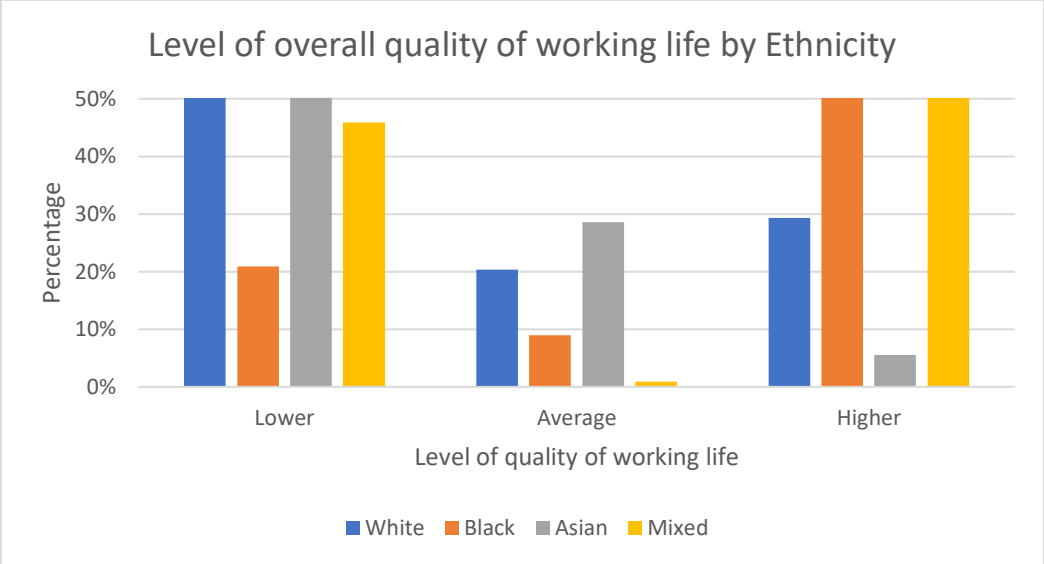


Figure A4.32: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

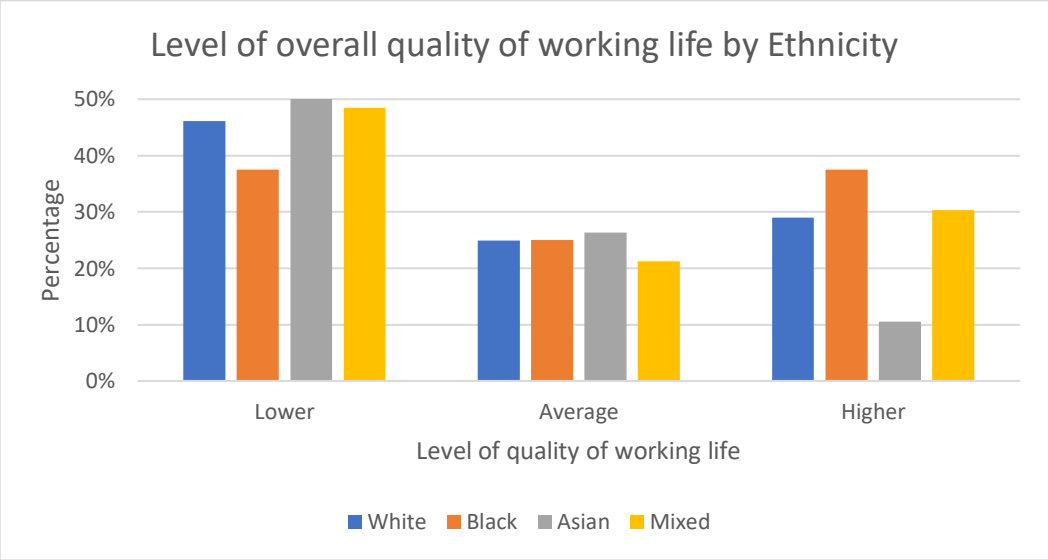


Table A4.21: Level of Overall Quality of Working Life by Ethnicity (Weighted)

	Ethnicity			
Level of WRQOL	**White**	**Black**	**Asian**	**Mixed**
Lower	50.40%	20.90%	65.90%	45.90%
Average	20.30%	9.00%	28.60%	0.90%
Higher	29.30%	70.10%	5.50%	53.20%
Total	**100%**	**100%**	**100%**	**100%**

Table A4.22: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

Level of WRQOL	Ethnicity			
	White	Black	Asian	Mixed
Lower	46.10%	37.50%	63.20%	48.50%
Average	24.90%	25.00%	26.30%	21.20%
Higher	29.00%	37.50%	10.50%	30.30%
Total	**2277 (100%)**	**32 (100%)**	**19 (100%)**	**33 (100%)**

A4.6 Quality of Working Life Scores by Disability

Summary (Weighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their disability status (F = 4.790, df = 2, p < .01). Specifically, respondents without a disability scored significantly higher than those with a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in the mean overall WRQOL scores (F = 16.034, df = 2, p < .001). Specifically, respondents without a disability scored significantly higher than those with a disability or those who were unsure of whether or not they had a disability.

Figure A4.33: Mean Quality of Working Life Scores by Disability (Weighted)

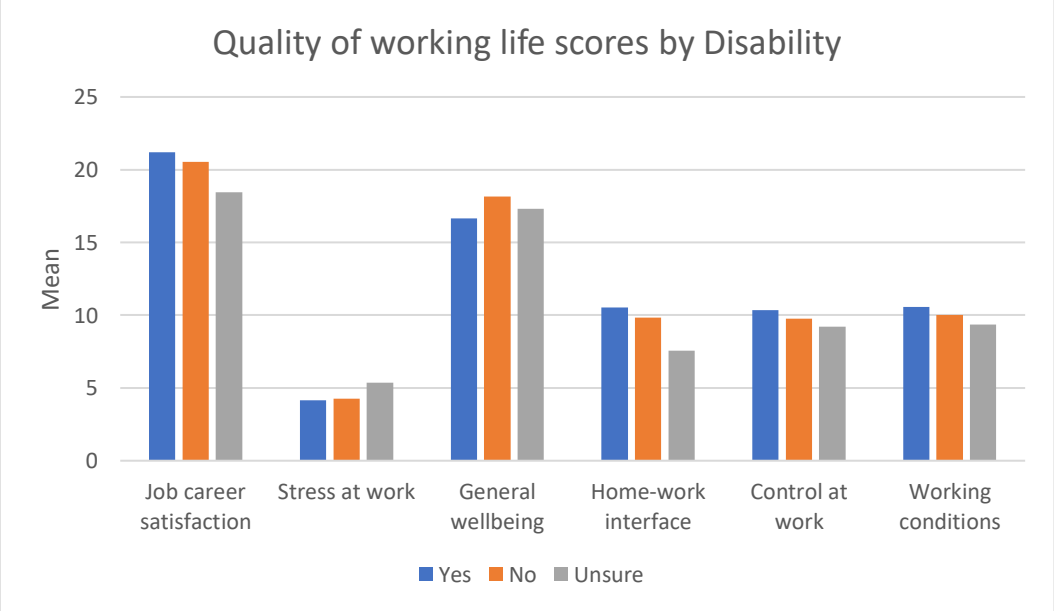


Figure A4.34: Mean Quality of Working Life Scores by Disability (Unweighted)

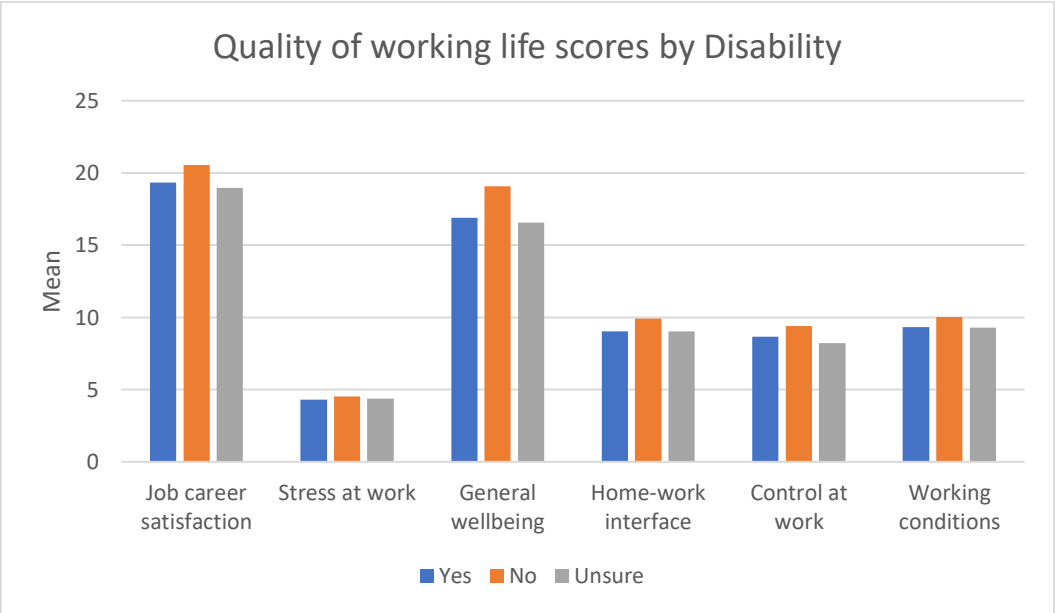


Figure A4.35: Mean Overall Quality of Working Life Score by Disability (Weighted)

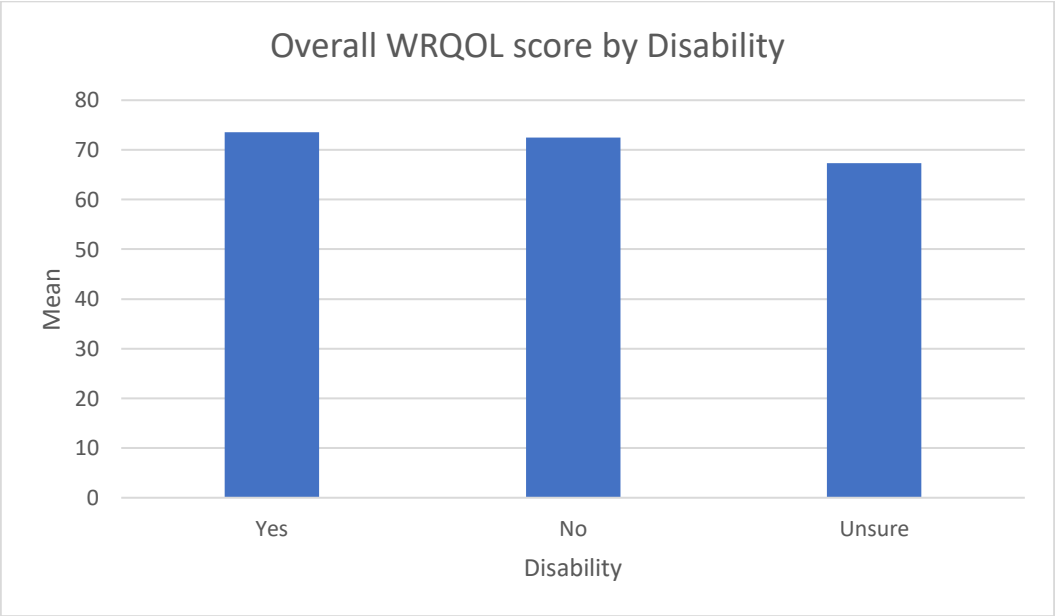


Figure A4.36: Mean Overall Quality of Working Life Score by Disability (Unweighted)

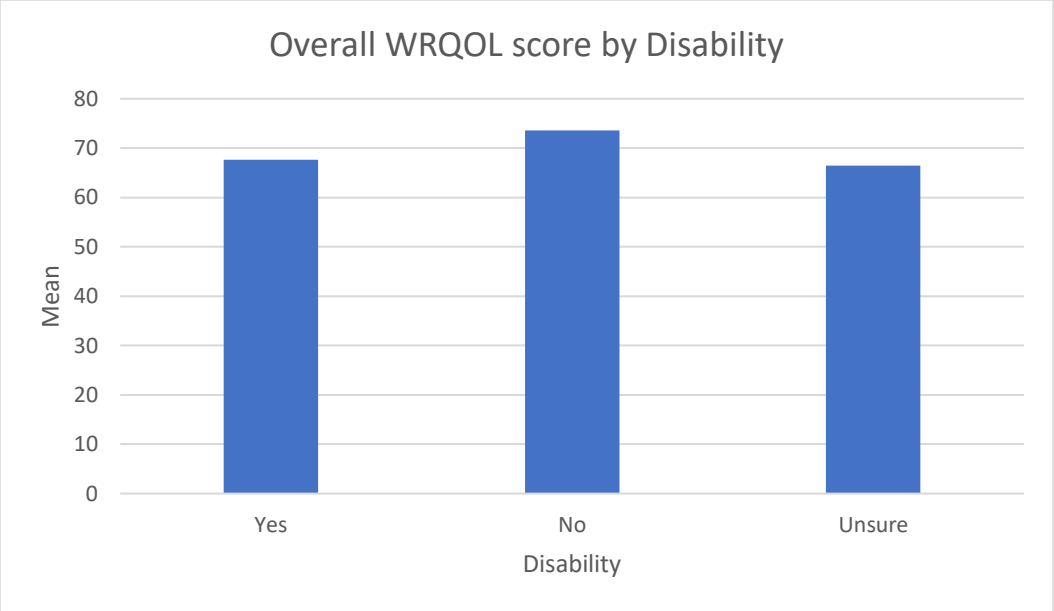


Table A4.23: Mean Quality of Working Life Scores by Disability (Weighted)

WRQOL domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Job career satisfaction	21.19	20.54	18.45
Stress at work	4.16	4.25	5.38
General wellbeing	16.65	18.16	17.33
Home-work interface	10.52	9.85	7.57
Control at work	10.35	9.77	9.2
Working conditions	10.55	10.01	9.37
Overall WRQOL score	**73.53**	**72.45**	**67.29**

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	19.34	20.56	18.95
Stress at work	4.32	4.53	4.39
General wellbeing	16.89	19.09	16.58
Home-work interface	9.05	9.91	9.03
Control at work	8.65	9.4	8.21
Working conditions	9.34	10.04	9.3
Overall WRQOL score	**67.67**	**73.53**	**66.44**

Figure A4.37: Level of Overall Quality of Working Life by Disability (Weighted)

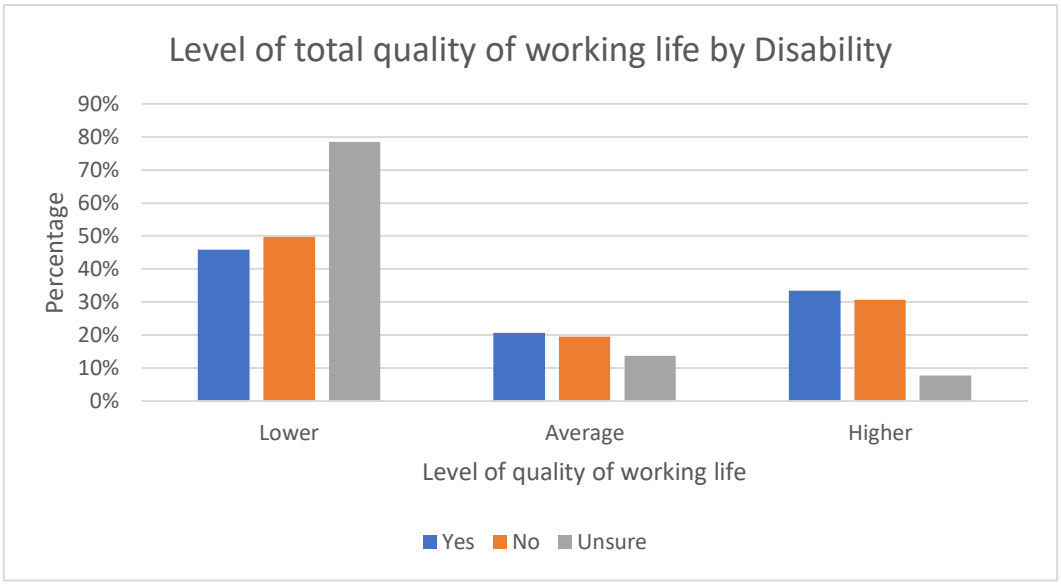


Figure A4.38: Level of Overall Quality of Working Life by Disability (Unweighted)

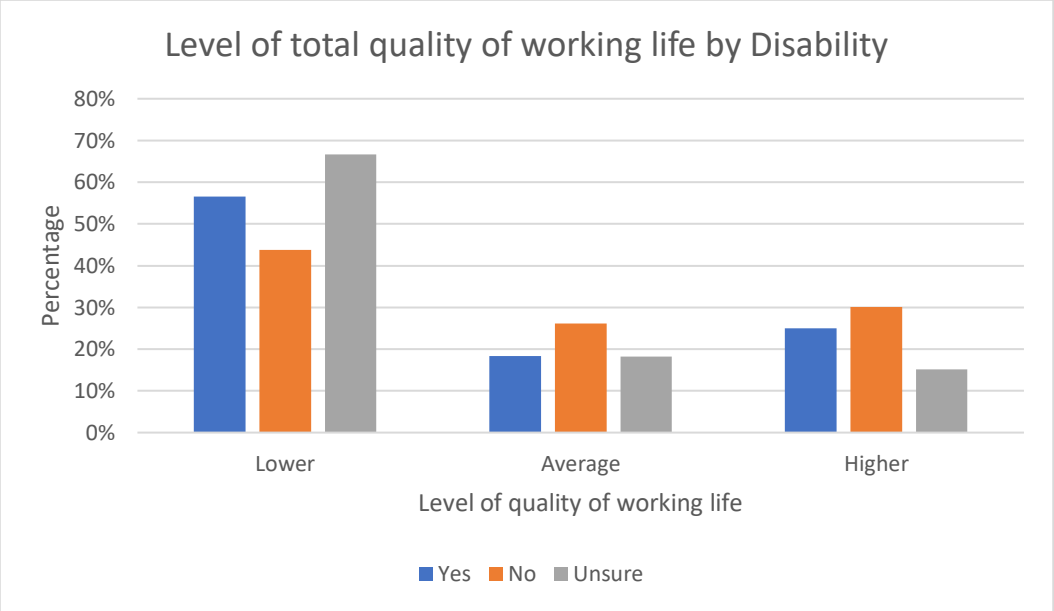


Table A4.25: Level of Overall Quality of Working Life by Disability (Weighted)

Level of WRQOL	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Lower	45.90%	49.70%	78.50%
Average	20.70%	19.50%	13.80%
Higher	33.40%	30.70%	7.70%
Total	**100%**	**100%**	**100%**

Table A4.26: Level of Overall Quality of Working Life by Disability (Unweighted)

Level of WRQOL	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Lower	56.60%	43.80%	66.70%
Average	18.40%	26.10%	18.20%
Higher	25.00%	30.10%	15.20%
Total	**304 (100%)**	**1994 (100%)**	**66 (100%)**

A4.7 Quality of Working Life Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their main area of practice (F = 13.670, df = 7, p < .001). Specifically, respondents working in 'Children' area scored significantly lower than those working in the area of mental health, older people 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 = 3.188, df = 7, p < .01). Specifically, respondents working with older people scored significantly lower than those working with in the area of older people, in the area of learning disability, mental health or 'other'.

Figure A4.39: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

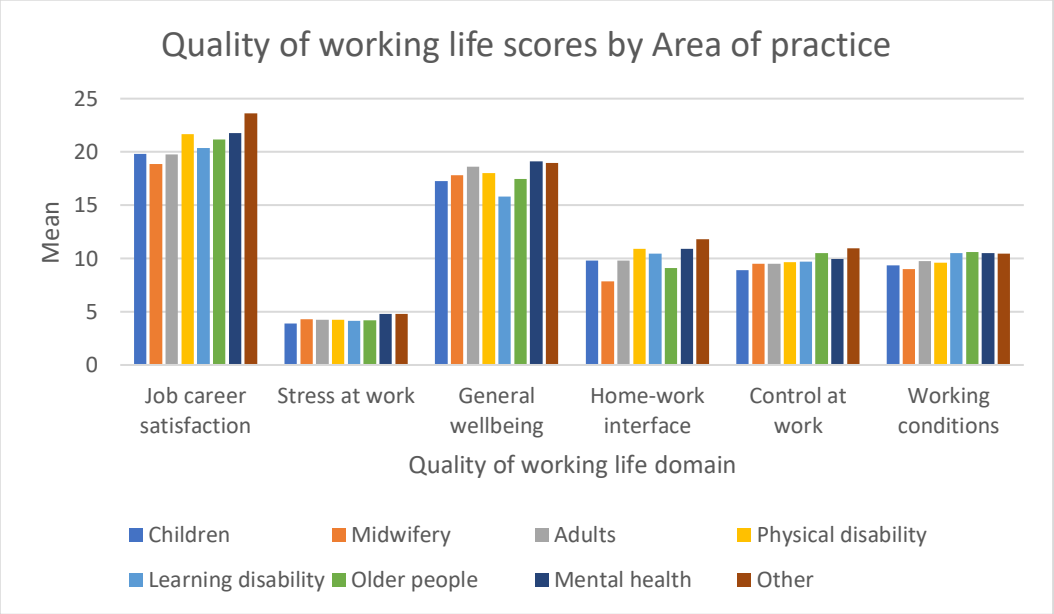


Figure A4.40: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

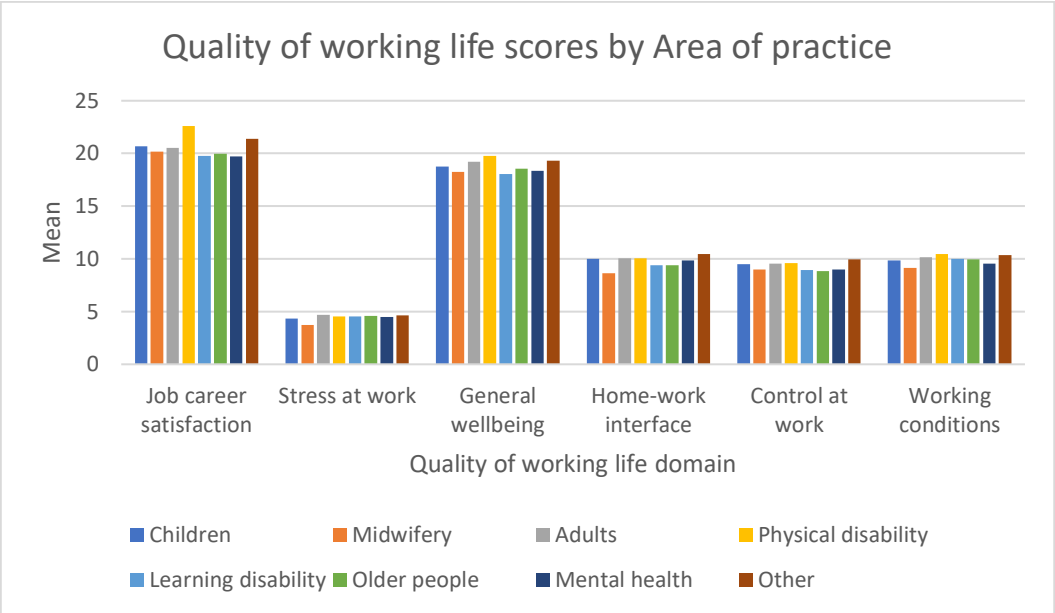


Figure A4.41: Mean Overall Quality of Working Life Score by Main Area of Practice (Weighted)

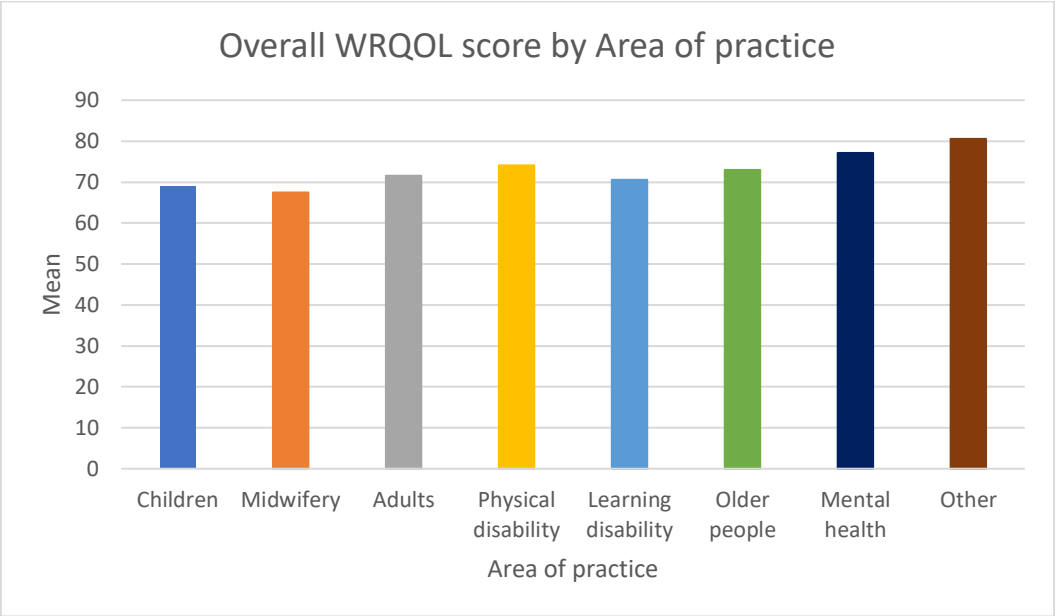


Figure A4.42: Mean Overall Quality of Working Life Score by Main Area of Practice (Unweighted)

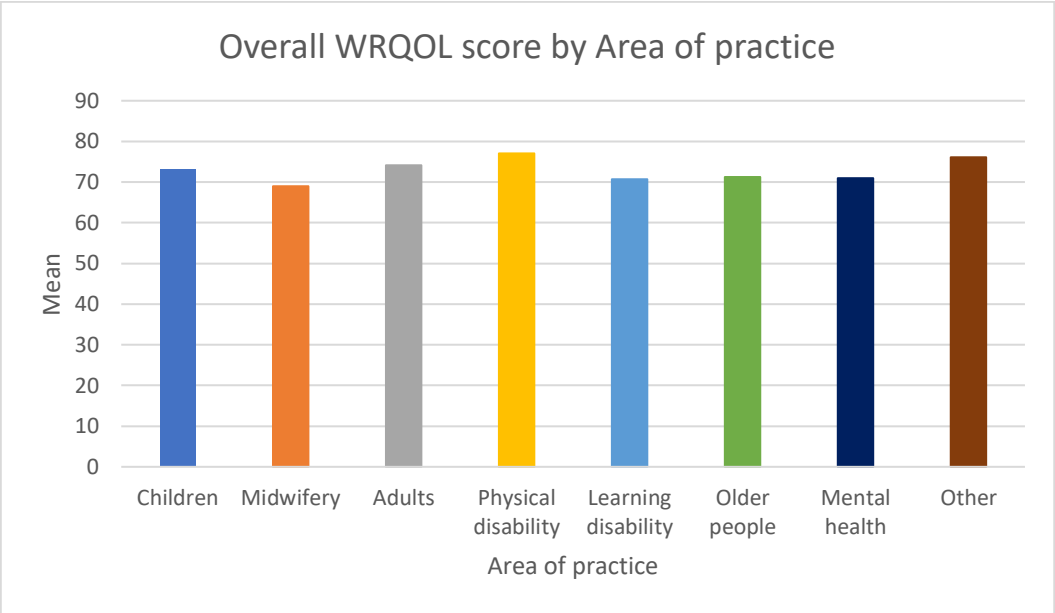


Table A4.27: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

WRQOL domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	19.83	18.85	19.76	21.66	20.35	21.15	21.77	23.61
Stress at work	3.87	4.28	4.25	4.25	4.14	4.19	4.78	4.81
General wellbeing	17.27	17.82	18.6	17.99	15.81	17.48	19.12	18.95
Home-work interface	9.79	7.83	9.80	10.91	10.44	9.12	10.9	11.79
Control at work	8.91	9.52	9.49	9.67	9.68	10.52	9.95	10.94
Working conditions	9.35	9.00	9.76	9.62	10.49	10.59	10.52	10.47
Overall WRQOL score	**69.04**	**67.47**	**71.56**	**74.09**	**70.56**	**72.97**	**77.12**	**80.56**

Table A4.28: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

WRQOL domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	20.69	20.16	20.53	22.58	19.76	19.98	19.73	21.4
Stress at work	4.35	3.74	4.67	4.56	4.54	4.57	4.47	4.66
General wellbeing	18.78	18.23	19.23	19.76	18.07	18.53	18.35	19.32
Home-work interface	10.00	8.63	10.06	10.07	9.41	9.40	9.85	10.45
Control at work	9.52	8.97	9.53	9.61	8.94	8.84	9.00	9.97
Working conditions	9.85	9.14	10.13	10.44	9.98	9.94	9.53	10.37
Overall WRQOL score	**73.19**	**68.98**	**74.13**	**77.05**	**70.7**	**71.25**	**70.96**	**76.10**

Figure A4.43: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

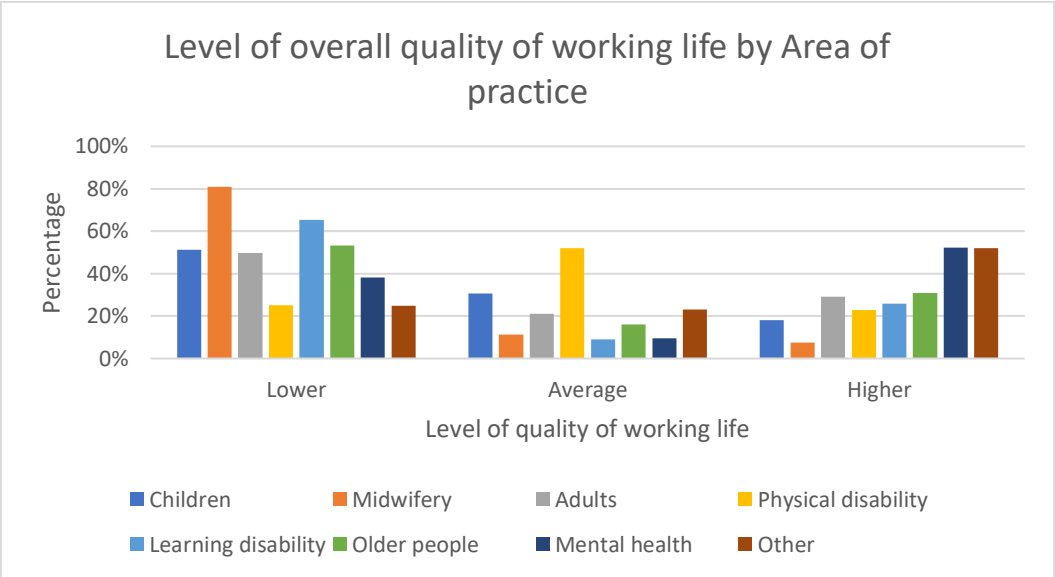


Figure A4.44: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

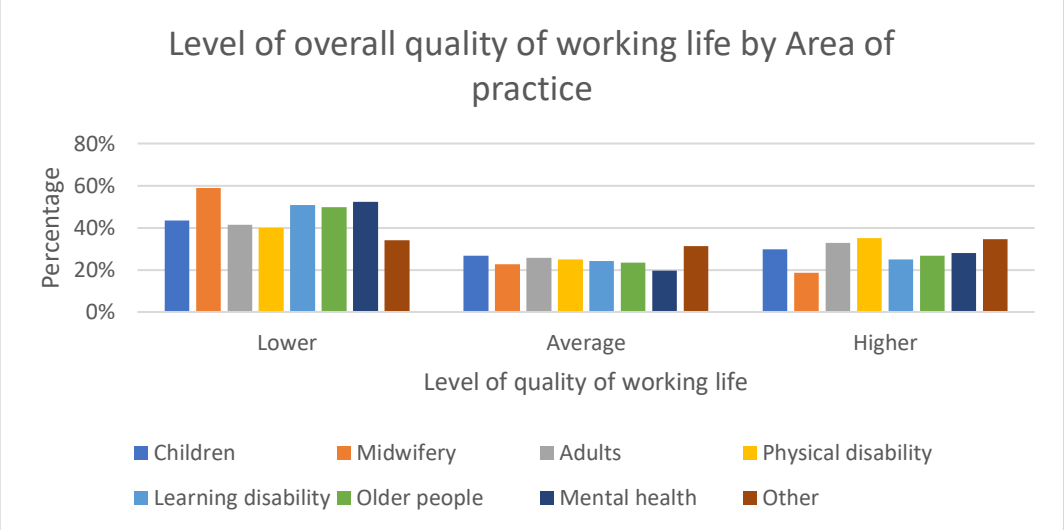


Table A4.29: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

Level of WRQOL	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Lower	51.2%	81.0%	49.7%	25.0%	65.2%	53.2%	38.2%	24.9%
Average	30.7%	11.4%	21.2%	52.1%	9.0%	16.0%	9.5%	23.1%
Higher	18.1%	7.6%	29.1%	22.9%	25.8%	30.9%	52.3%	52.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table A4.30: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

Level of WRQOL	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Lower	182 (43.5%)	86 (58.9%)	243 (41.3%)	16 (40.0)%	130 (50.8%)	247 (49.8%)	123 (52.3%)	63 (34.1%)
Average	112 (26.8%)	33 (22.6%)	152 (25.8%)	10 (25.0%)	62 (24.2%)	116 (23.4%)	46 (19.6%)	58 (31.4%)
Higher	124 (29.7%)	27 (18.5%)	194 (32.9%)	14 (35.0%)	64 (25.0%)	133 (26.8%)	66 (28.1%)	64 (34.6%)
Total	**418 (100%)**	**146 (100%)**	**589 (100%)**	**40 (100%)**	**256 (100%)**	**496 (100%)**	**235 (100%)**	**185 (100%)**

A4.8 Quality of Working Life Scores by Line Manager Status

Summary (Weighted results):

There was no significant difference in the mean overall WRQOL score between line managers and those who were not line managers ($t = 1.222$, $df = 2691$, $p > 0.05$).

Summary (Unweighted results):

There was a significant difference in the mean overall WRQOL scores between respondents who were line managers and those who were not ($t = 3.655$, $df = 2363$, $p < .001$); line managers scored significantly higher.

Figure A4.45: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

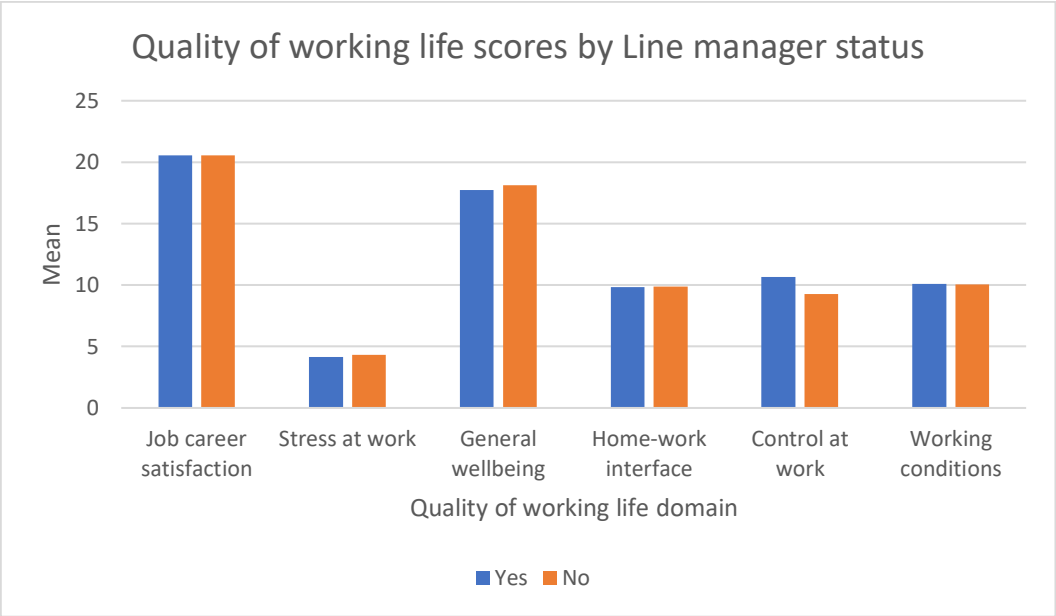


Figure A4.46: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

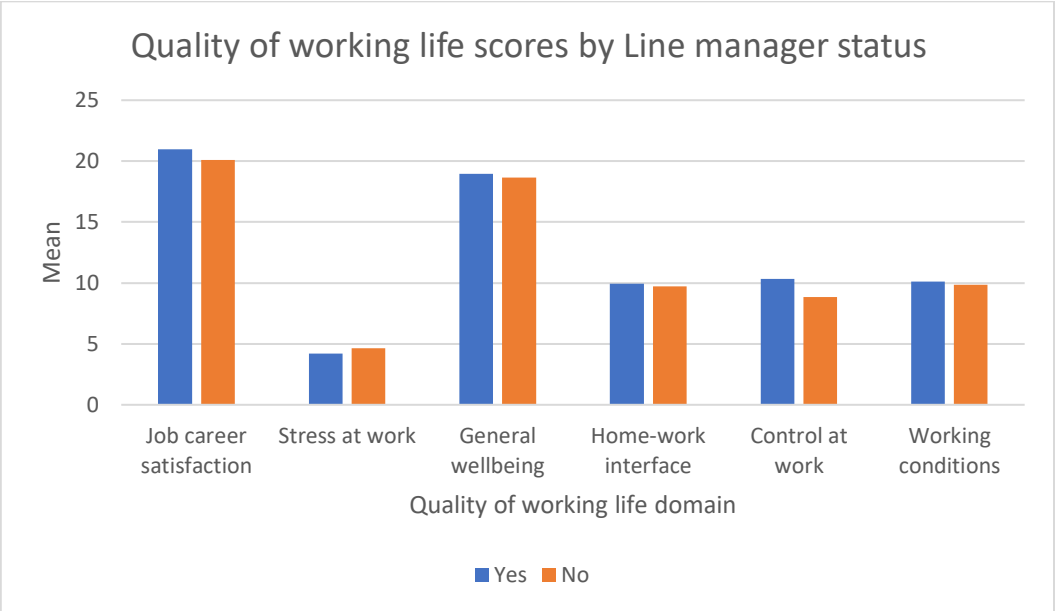


Figure A4.47: Mean Overall Quality of Working Life Score by Line Manager Status (Weighted)

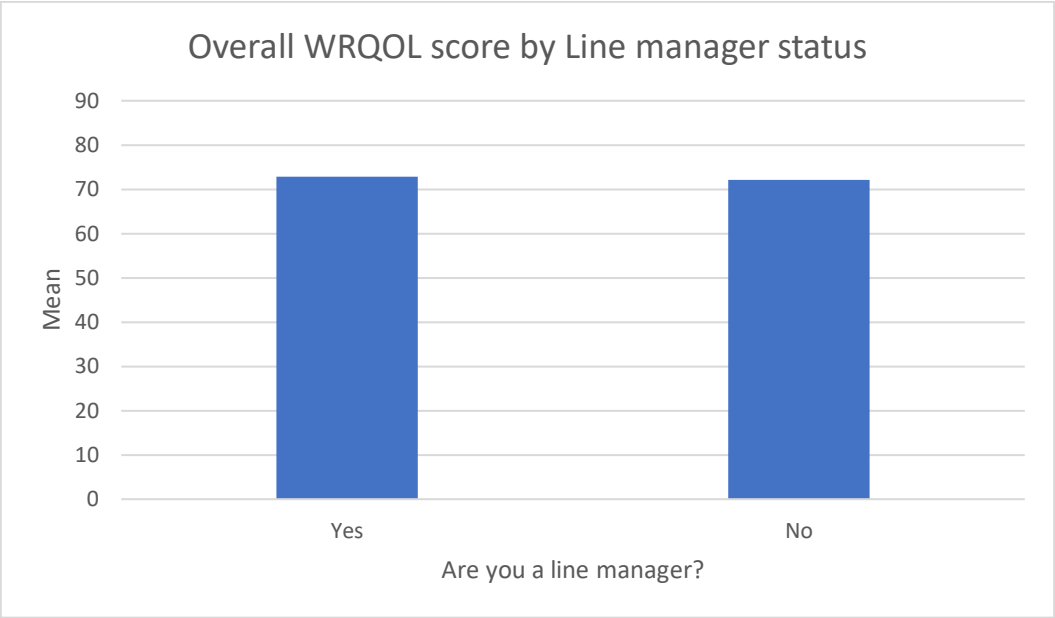


Figure A4.48: Mean Overall Quality of Working Life Score by Line Manager Status (Unweighted)

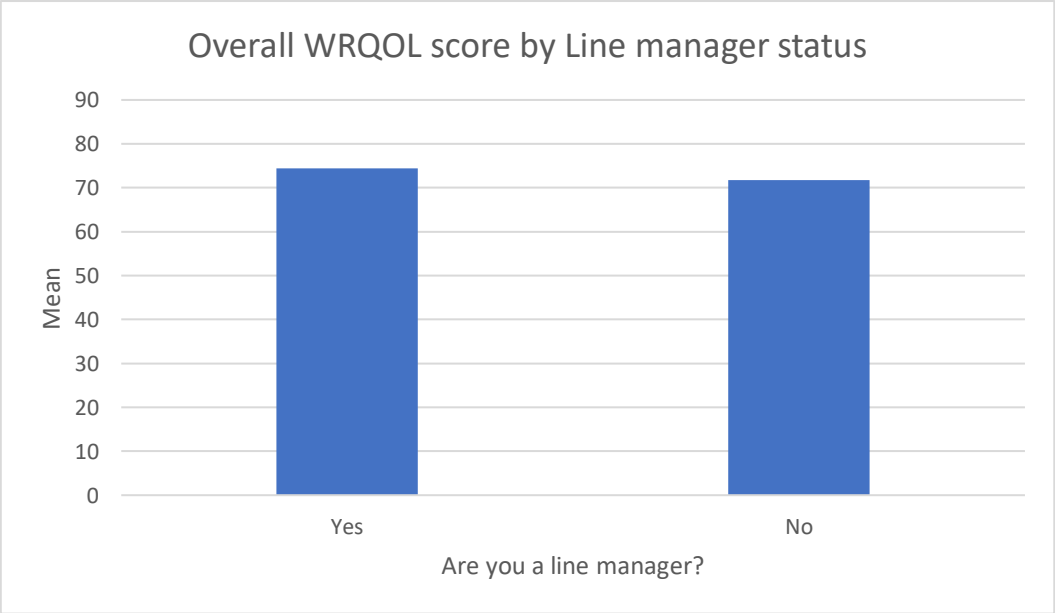


Table A4.31: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

WRQOL Domain	Are you a line manager?	
	Yes	No
Job career satisfaction	20.56	20.57
Stress at work	4.14	4.34
General wellbeing	17.73	18.13
Home-work interface	9.85	9.88
Control at work	10.66	9.26
Working conditions	10.09	10.03
Overall WRQOL score	**72.90**	**72.14**

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	20.98	20.11
Stress at work	4.21	4.62
General wellbeing	18.96	18.64
Home-work interface	9.94	9.70
Control at work	10.32	8.84
Working conditions	10.10	9.86
Overall WRQOL score	**74.44**	**71.80**

Figure A4.49: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

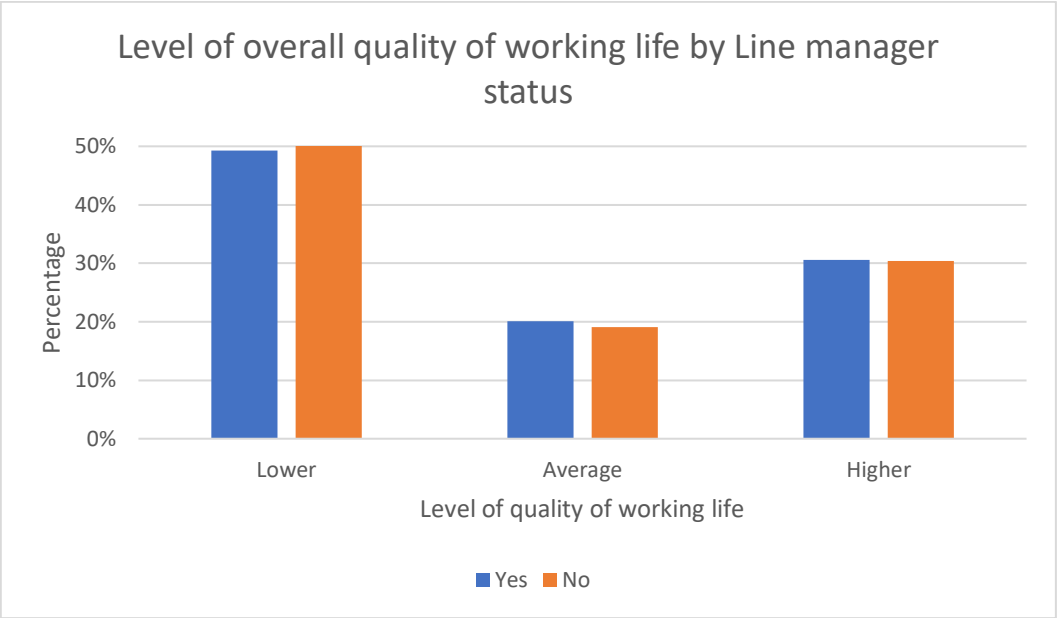


Figure A4.50: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

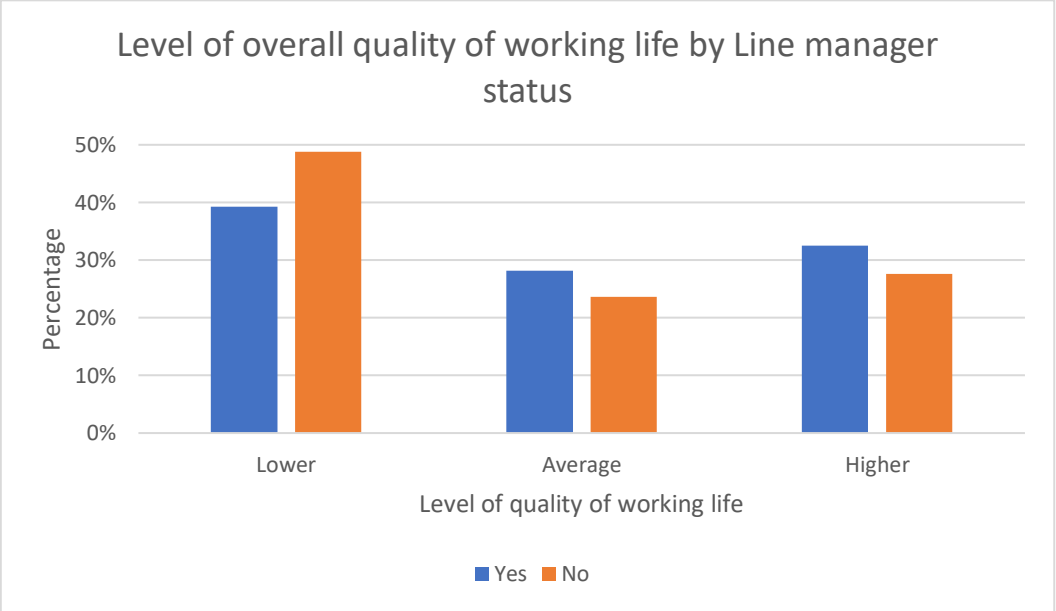


Table A4.33: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

Level of WRQOL	Are you a line manager?	
	Yes	No
Lower	49.30%	50.50%
Average	20.10%	19.10%
Higher	30.60%	30.40%
Total	**100%**	**100%**

Table A4.34: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

Level of WRQOL	Are you a line manager?	
	Yes	No
Lower	269 (39.3%)	821 (48.8%)
Average	193 (28.2%)	396 (23.6%)
Higher	222 (32.5%)	464 (27.6%)
Total	**684 (100%)**	**1681 (100%)**

A4.9 Quality of Working Life Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in the mean overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 121.688$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact or those who felt no impact.

Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 105.168$, $df = 2$, $p < .001$). 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)

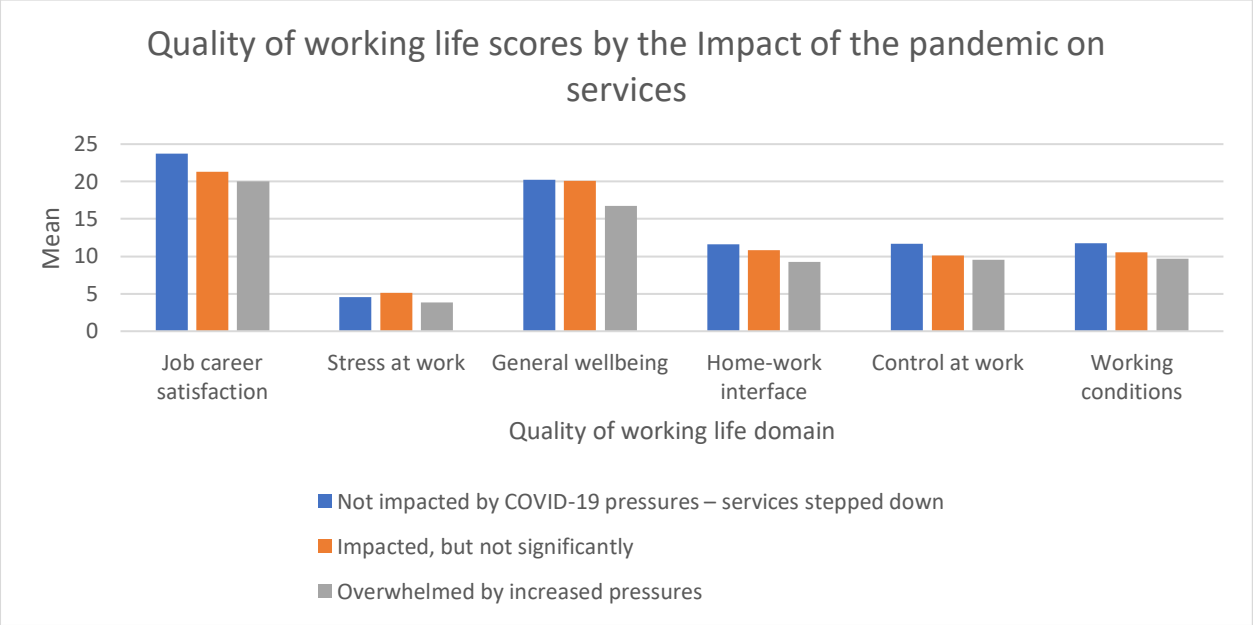


Figure A4.52: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)

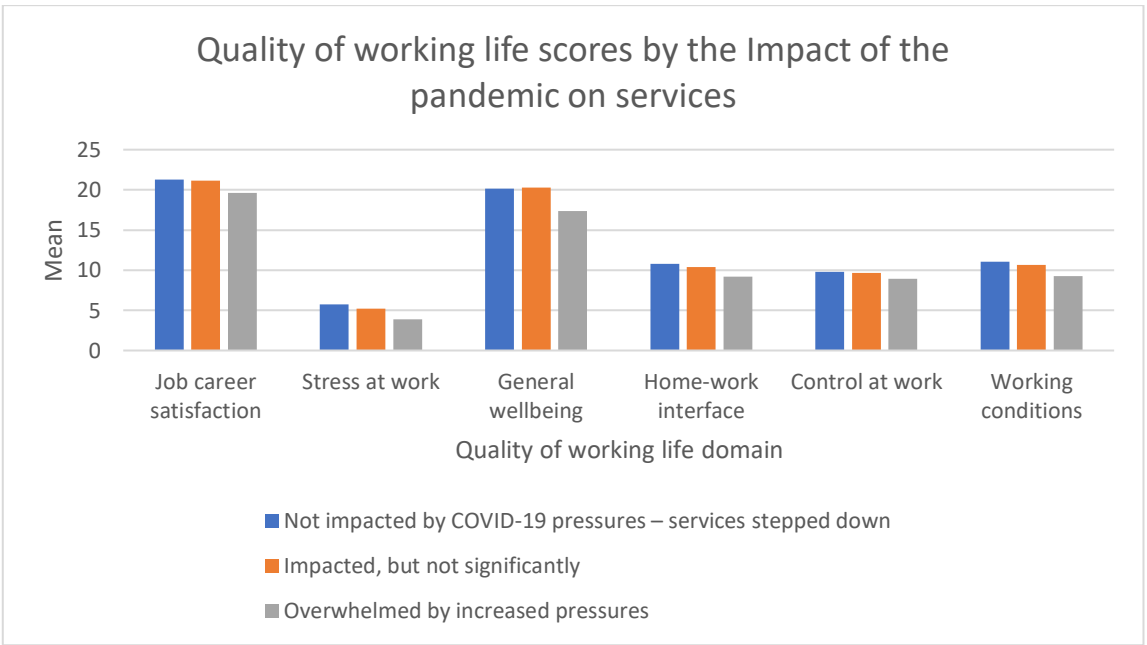


Figure A4. 53: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Weighted)

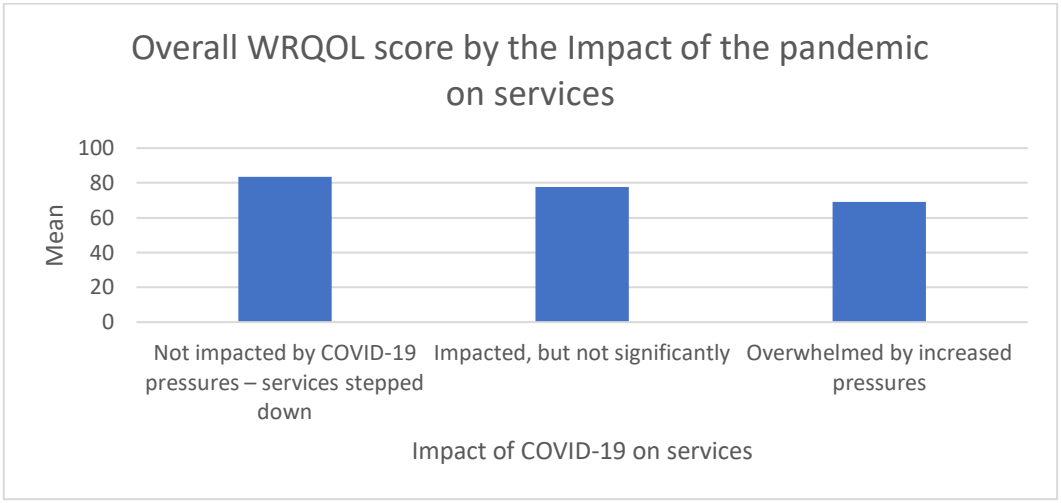


Figure A4.54: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Unweighted)

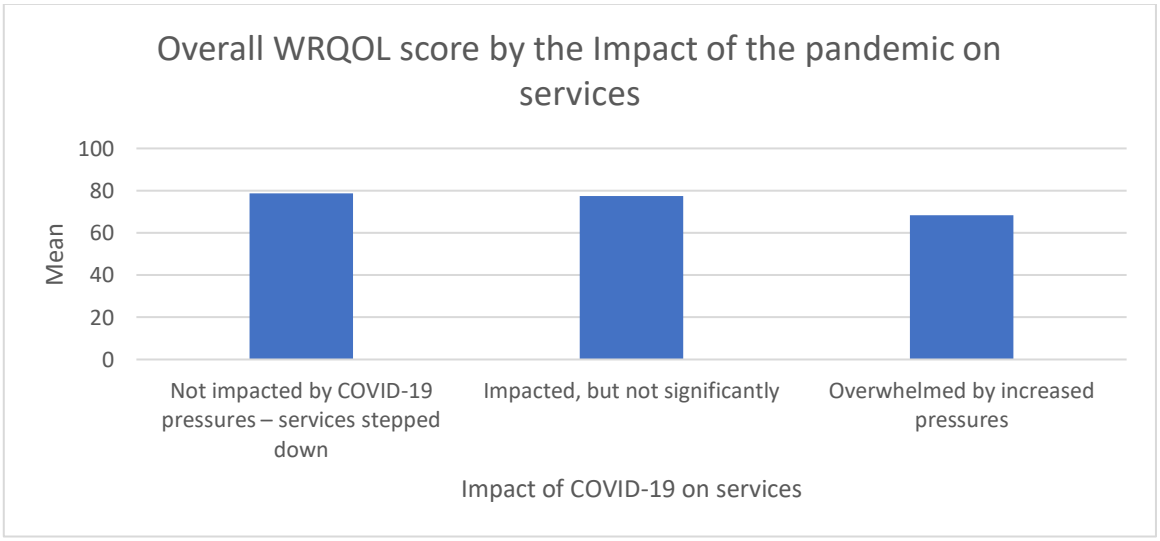


Table A4.35: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)

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	23.70	21.29	20.02
Stress at work	4.54	5.10	3.81
General wellbeing	20.21	20.11	16.75
Home-work interface	11.61	10.83	9.28
Control at work	11.66	10.11	9.56
Working conditions	11.79	10.56	9.70
Overall WRQOL score	**83.52**	**77.80**	**69.07**

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	21.26	21.17	19.64
Stress at work	5.73	5.19	3.86
General wellbeing	20.14	20.3	17.37
Home-work interface	10.79	10.37	9.21
Control at work	9.78	9.66	8.91
Working conditions	11.05	10.66	9.27
Overall WRQOL score	**78.81**	**77.35**	**68.26**

Figure A4.55: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

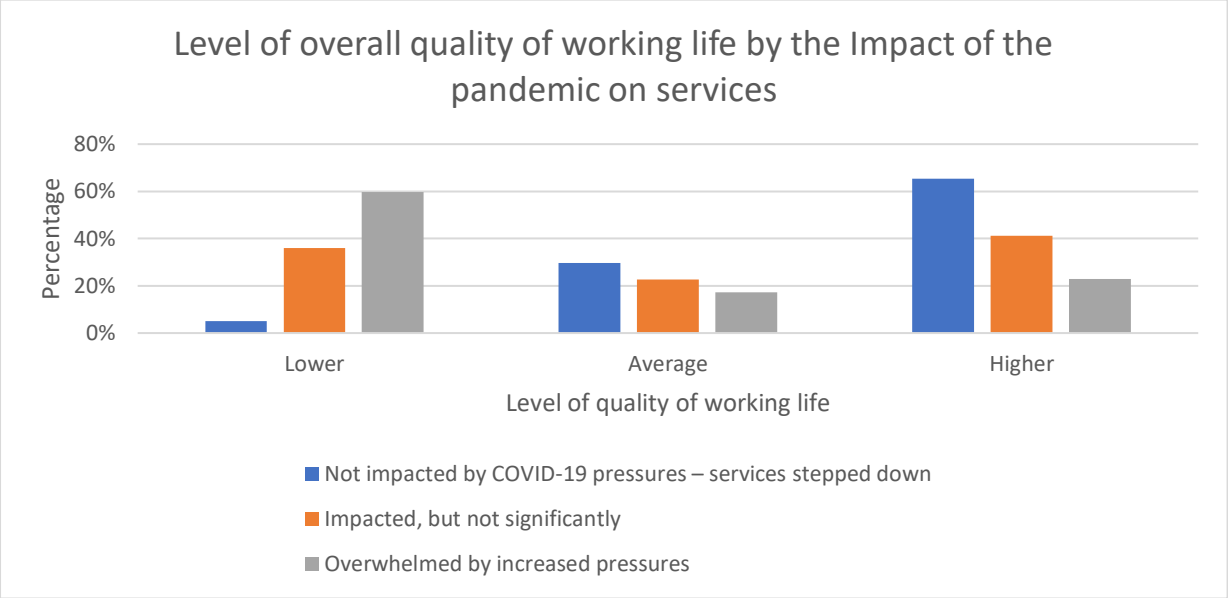


Figure A4.56: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

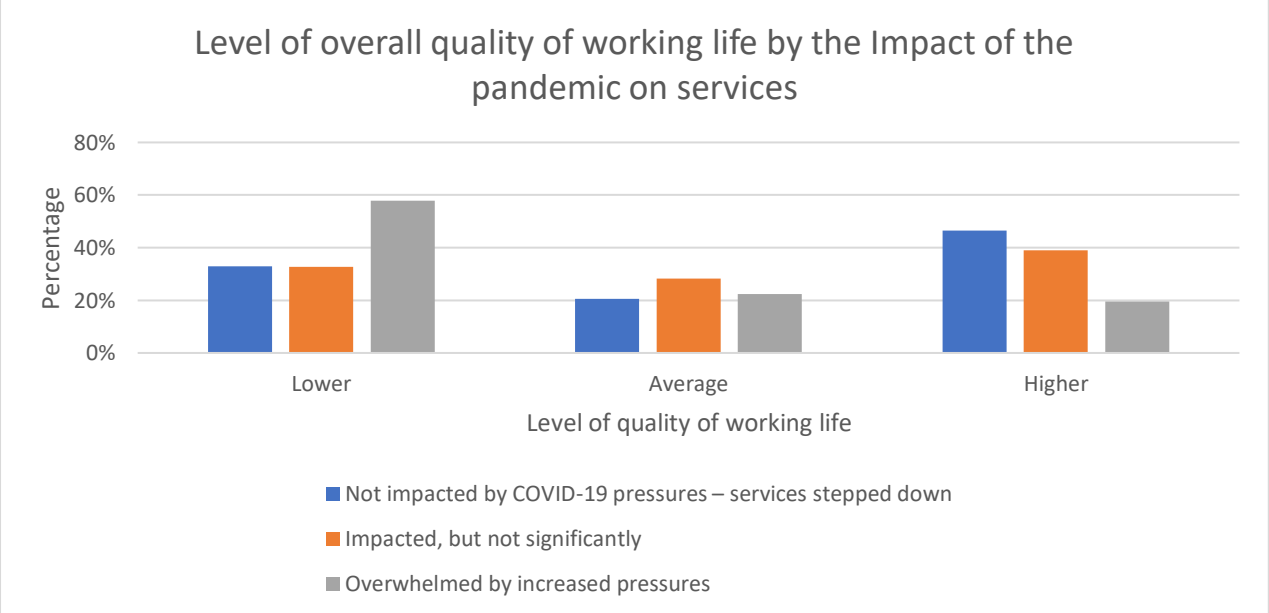


Table A4.37: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

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	5.00%	36.10%	59.70%
Average	29.70%	22.70%	17.30%
Higher	65.30%	41.10%	23.00%
Total	**100%**	**100%**	**100%**

Table A4.38: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

Level of WRQOL	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Lower	24 (32.9%)	336 (32.7%)	728 (57.9%)
Average	15 (20.5%)	291 (28.3%)	282 (22.4%)
Higher	34 (46.6%)	402 (39.1%)	247 (19.6%)
Total	**73 (100%)**	**1029 (100%)**	**1257 (100%)**

A4.10 Quality of Working Life Scores by Working at home status

Summary (Weighted results):

There were significant differences in the overall mean quality of working life scores between respondents who worked at home all the time, some of the time or never during COVID-19 ($F = 58.496$, $df = 2$, $p < .001$). Specifically, respondents who did not work at home reported significantly lower scores of quality of working life than those who worked from home some of the time or all of the time.

Summary (Unweighted results):

There were significant differences in the overall mean quality of working life scores between respondents who worked at home all the time, some of the time or never during COVID-19 ($F = 10.860$,

df = 2, p < 0.001). Specifically, respondents who did not work at home reported significantly lower scores of quality of working life than those who worked from home some of the time or all of the time.

Figure A4.57: Mean Overall Quality of Working Life Score by working at home status (Weighted)

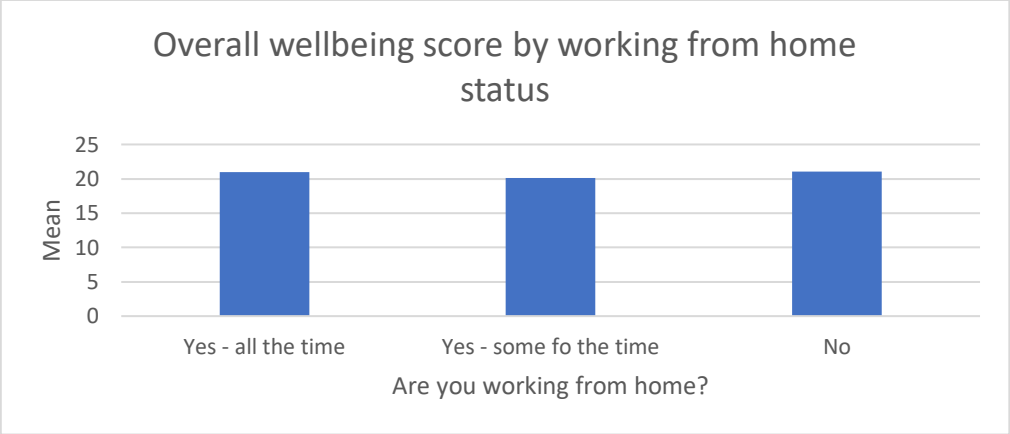


Figure A4.58: Mean Overall Quality of Working Life Score by working at home status (Unweighted)

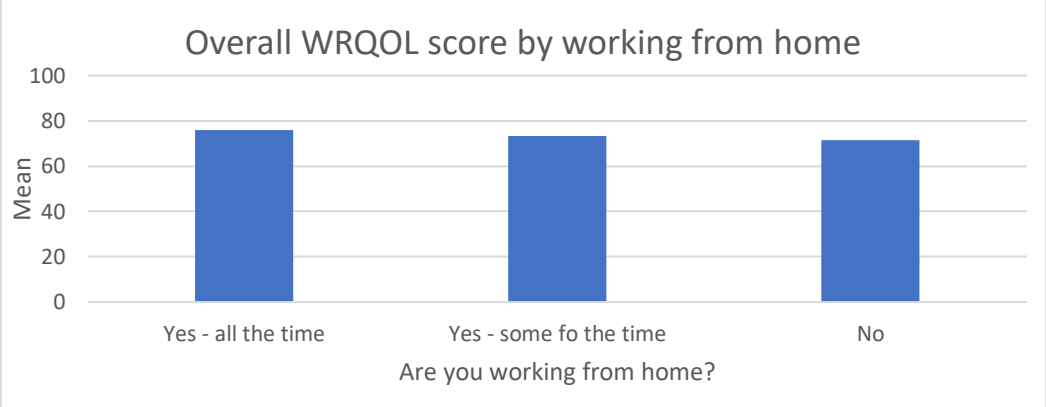


Table A4.39: Mean Overall Wellbeing Score by Working at home (Weighted)

Working at home	Level of Quality of Working Life
Yes - all the time	76.85
Yes - some of the time	76.05
No	69.71

Table A4.40: Mean Overall Wellbeing Score by Working at home (Unweighted)

Working at home	Level of Quality of Working Life
Yes - all the time	75.94
Yes - some of the time	73.27
No	71.41

Figure A4.59: Level of Quality of Working Life by working at home status (Weighted)

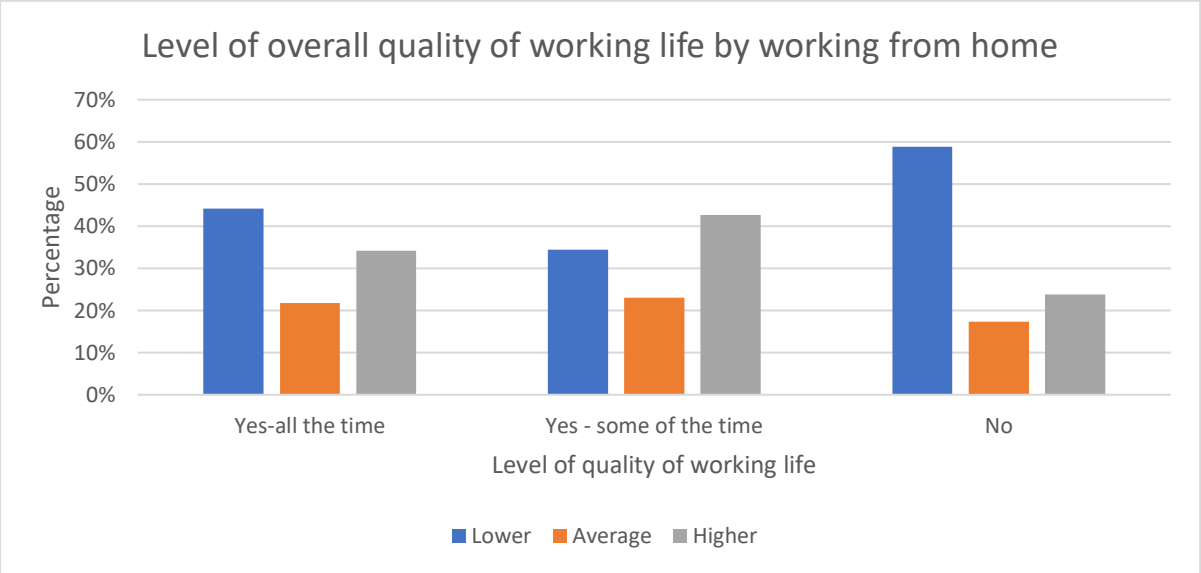


Figure A4.60: Level of Quality of Working Life by working at home status (Unweighted)

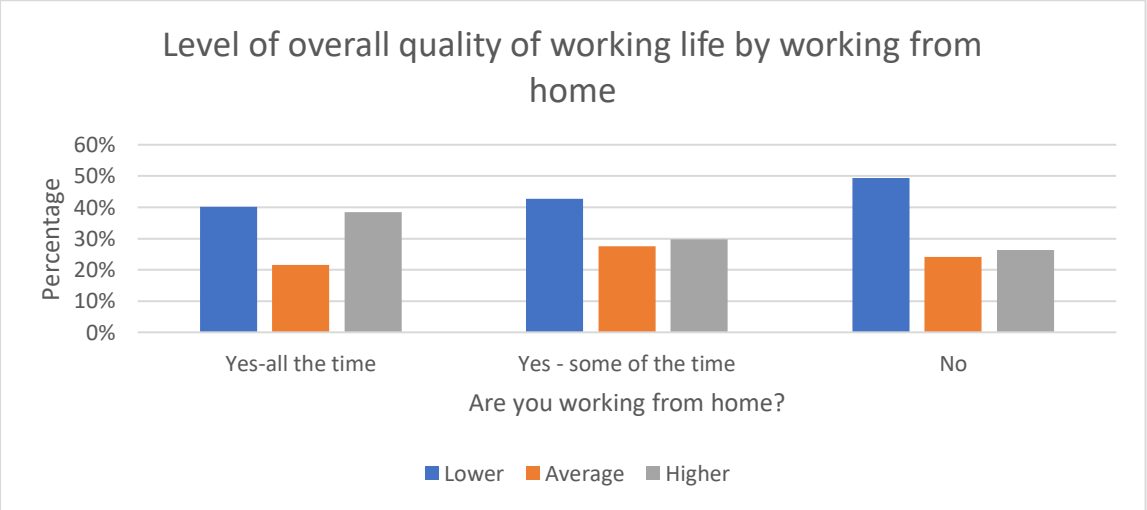


Table A4.41: Level of WRQOL by Working at home (Weighted)

Working from home	Yes-all the time	Yes - some of the time	No
Lower	44.20%	34.40%	58.90%
Average	21.70%	23.00%	17.30%
Higher	34.10%	42.70%	23.80%

Table A4.42: Level of WRQOL by Working at home (Unweighted)

Working from home	Yes-all the time	Yes - some of the time	No
Lower	119 (40.1%)	303 (42.7%)	666 (49.3%)
Average	64 (21.5%)	196 (27.6%)	327 (24.2%)
Higher	114 (38.4%)	211 (29.7%)	357 (26.4%)
Total	**297 (100%)**	**710 (100%)**	**1350 (100%)**

A4.11 Quality of Working Life Scores by Vaccination uptake

Summary (Weighted results):

There were significant differences in the overall quality of working life scores between received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = 15.196$, $df = 4$, $p < .001$). Specifically, respondents who had both doses had reported higher WRQOL that those who had only had one vaccine, those who had not yet received the vaccine and those who reported no – other.

Summary (Unweighted results):

There were no significant differences in the overall quality of working life scores between received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = 2.122$, $df = 4$, $p > 0.05$).

Figure A4.61: Mean Overall WRQOL Score by vaccination uptake (Weighted)

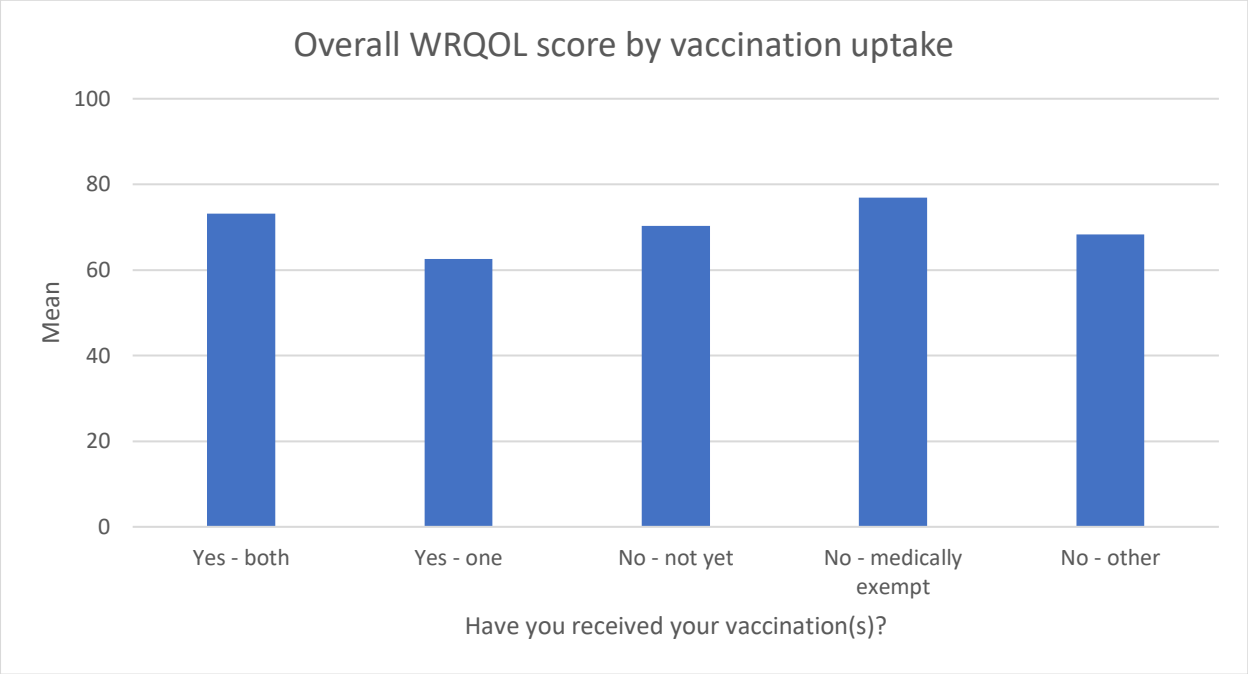


Figure A4.62: Mean WRQOL Score by vaccination uptake (Unweighted)

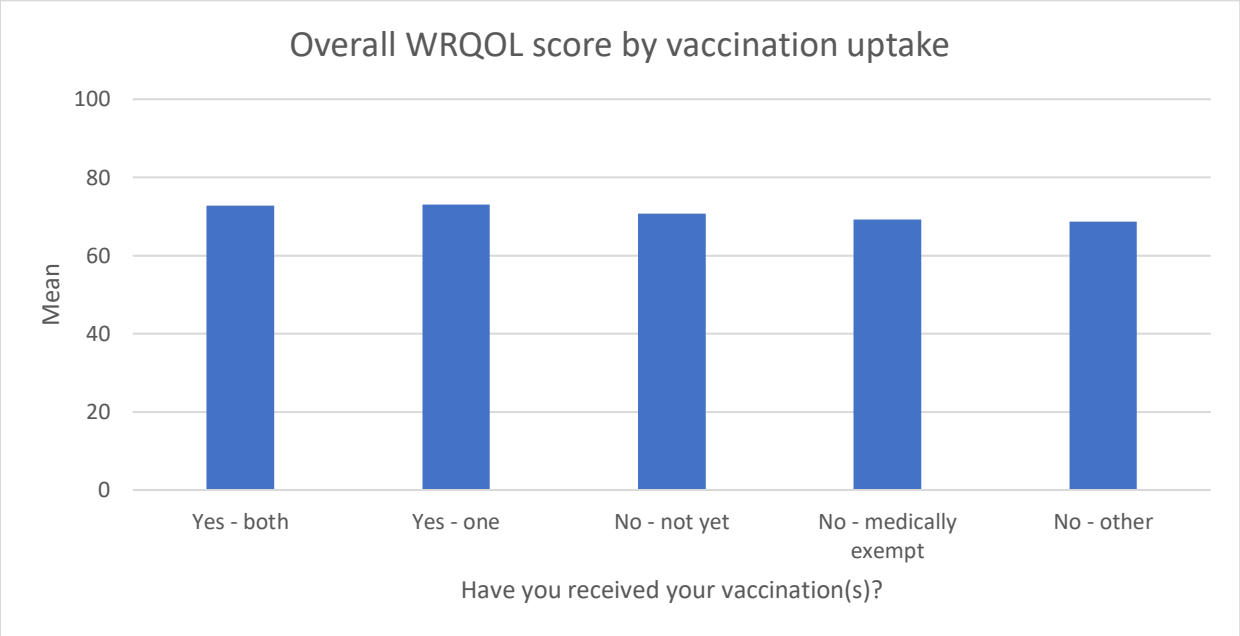


Table A4.43: Mean Overall Wellbeing Score by vaccination uptake (Weighted)

Vaccination uptake	Mean overall WRQOL score
Yes - both	73.20
Yes - one	62.63
No - not yet	70.27
No - medically exempt	76.96
No - other	68.32

Table A4.44: Mean Overall WRQOL score by vaccination uptake (Unweighted)

Vaccination uptake	Mean overall WRQOL score
Yes - both	72.83
Yes - one	73.01
No - not yet	70.66
No - medically exempt	69.25
No - other	68.69

Figure A4.63: Level of overall quality of working life by vaccination uptake (Weighted)

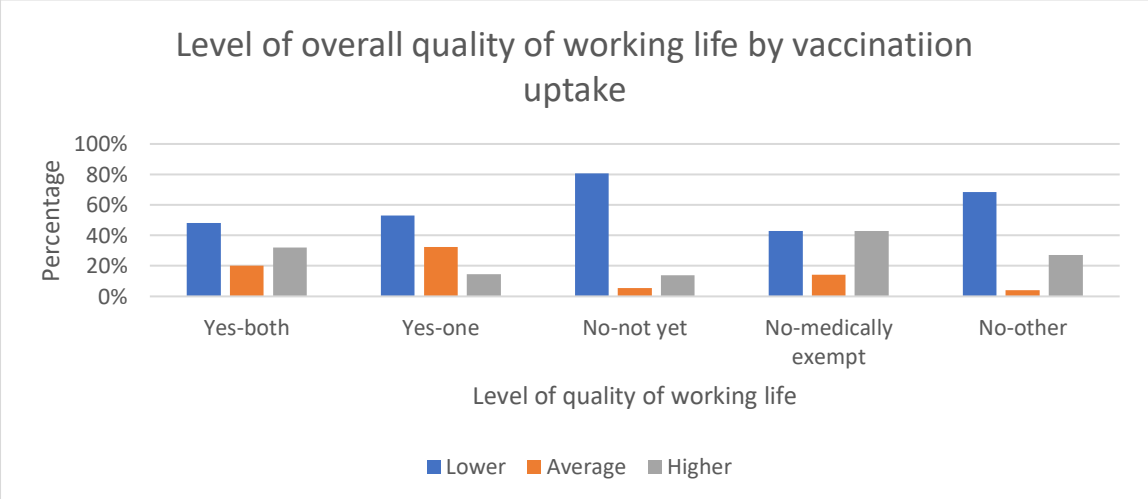


Figure A4.64: Level of overall quality of working life by vaccination uptake (Unweighted)

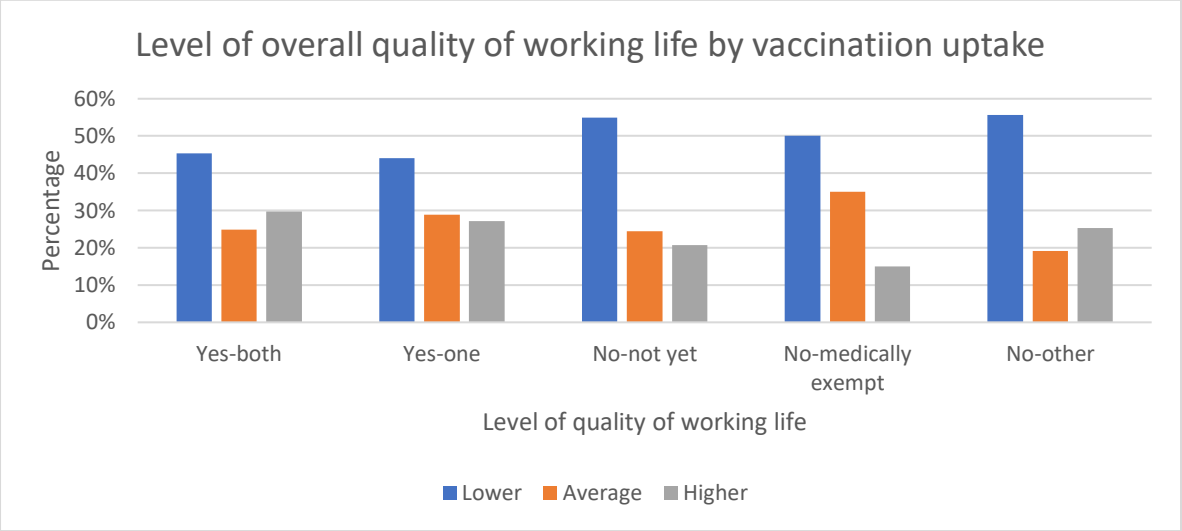


Table A4.45: Level of overall quality of working life by vaccination uptake (Weighted)

Vaccination uptake	Yes-both	Yes-one	No-not yet	No-medically exempt	No-other
Lower	48.00%	53.00%	80.80%	42.90%	68.60%
Average	20.10%	32.50%	5.50%	14.30%	4.10%
Higher	31.90%	14.50%	13.70%	42.90%	27.30%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A4.46: Level of overall quality of working life by vaccination uptake (Unweighted)

Vaccination uptake	Yes-both	Yes-one	No-not yet	No-medically exempt	No-other
Lower	927 (45.3%)	52 (44.1%)	45 (54.9%)	10 (50.0%)	55 (55.6%)
Average	509 (24.9%)	34 (28.9%)	20 (24.4%)	7 (35.0%)	19 (19.2%)
Higher	609 (29.8%)	32 (27.1%)	17 (20.7%)	3 (15.0%)	25 (25.3%)
Total	**2045 (100%)**	**118 (100%)**	**82 (100%)**	**20 (100%)**	**99 (100%)**

Appendix 5: Copenhagen Burnout Inventory (Unweighted) – Tables and Charts

This section provides detailed results of respondents' burnout, which was measured using the Copenhagen Burnout Inventory. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A5.1 Burnout Scores by Country

Summary (Weighted results):

There were significant differences between the countries in mean personal burnout scores ($F = 5.518$, $df = 3$, $p < .001$). Specifically, respondents from England scored significantly higher than those from all other countries.

There were also significant differences between the countries in mean work-related burnout scores ($F = 5.932$, $df = 3$, $p < .001$). Respondents from England and Northern Ireland scored significantly higher than those from Wales.

Significant differences between countries were also found in mean client-related burnout scores ($F = 6.175$, $df = 3$, $p < .001$). Respondents from England scored significantly higher than those from Wales.

Summary (Unweighted results):

There were significant differences between the countries in mean personal burnout scores ($F = 11.057$, $df = 3$, $p < .001$). Specifically, respondents from England scored significantly higher than those from Wales.

There were also significant differences between the countries in mean work-related burnout scores ($F = 11.462$, $df = 3$, $p < .001$). Respondents from England scored significantly higher than those from all other countries.

Significant differences between countries were also found in mean client-related burnout scores ($F = 8.119$, $df = 3$, $p < .001$). Respondents from England scored significantly higher than those from all other countries.

Figure A5.1: Mean Burnout Scores by Country (Weighted)

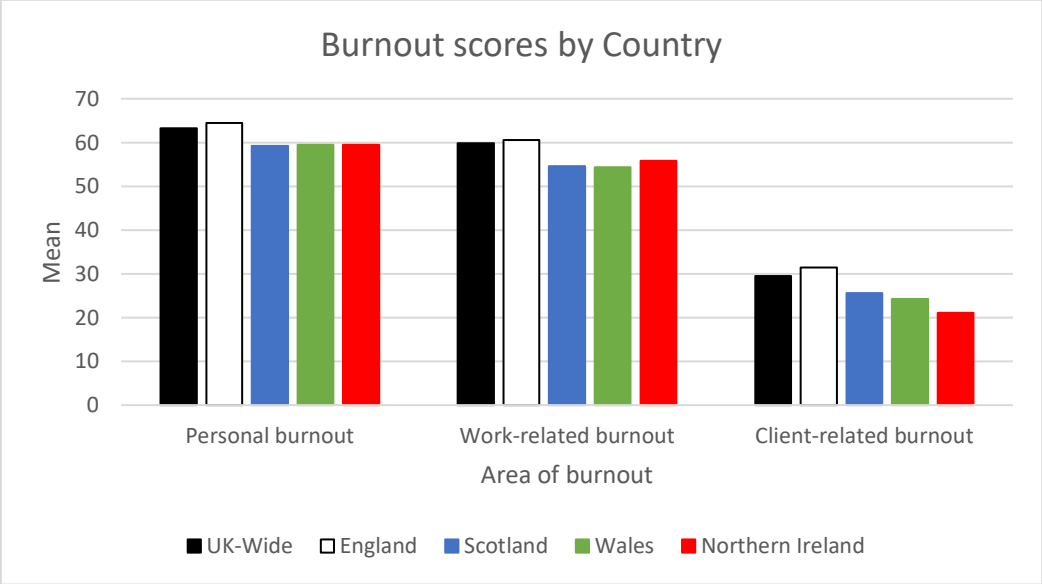


Figure A5.2: Mean Burnout Scores by Country (Unweighted)

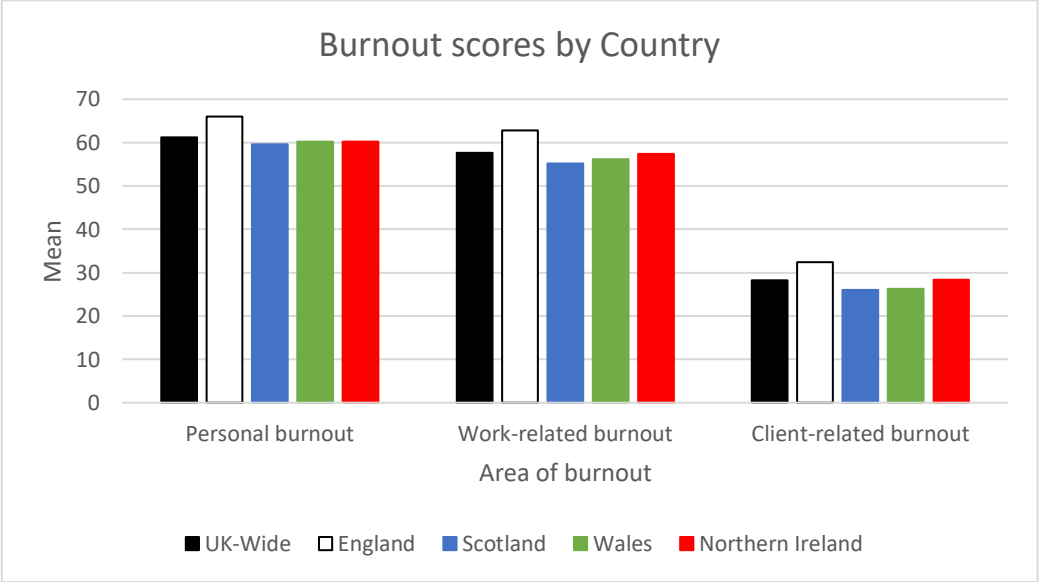


Table A5.1: Mean Burnout Scores by Country (Weighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
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

Table A5.2: Mean Burnout Scores by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	61.17	66.03	59.58	60.21	60.18
Work-related burnout	57.68	62.75	55.15	56.13	57.4
Client-related burnout	28.22	32.38	26.02	26.24	28.3

Figure A5.3: Level of Personal Burnout by Country (Weighted)

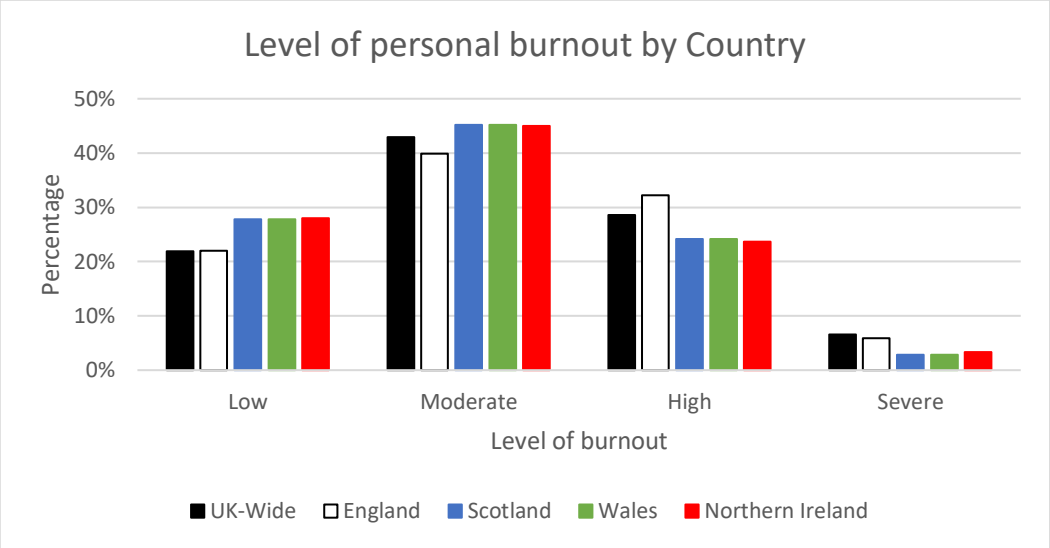


Figure A5.4: Level of Personal Burnout by Country (Unweighted)

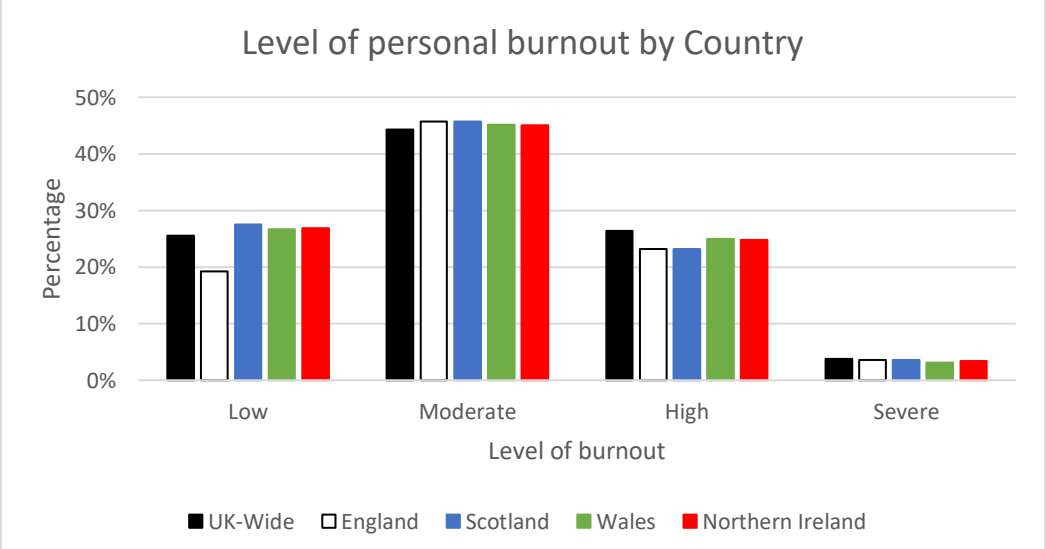


Figure A5.5: Level of Work-Related Burnout by Country (Weighted)

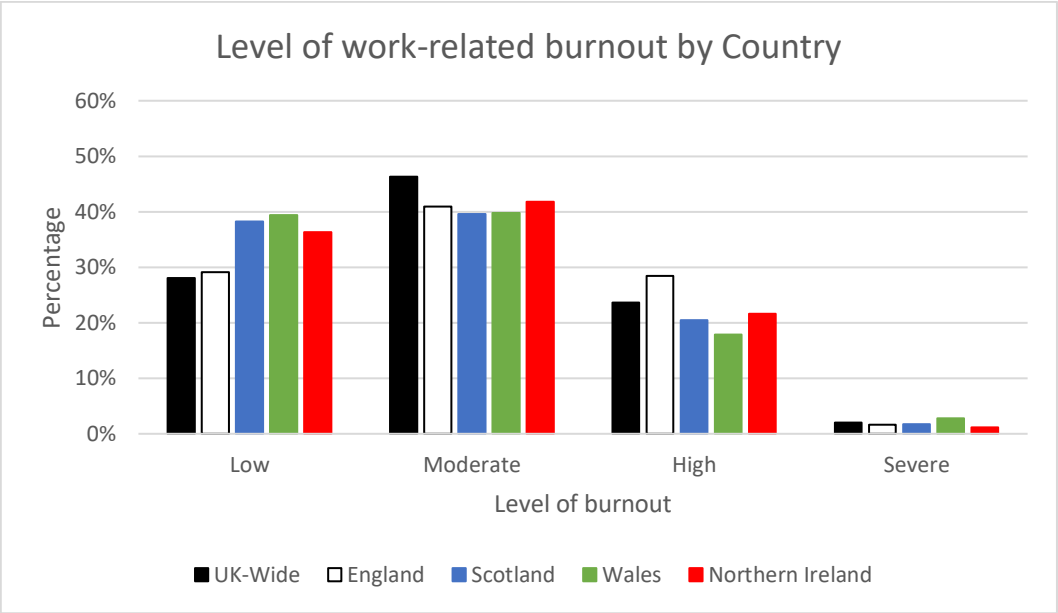


Figure A5.6: Level of Work-Related Burnout by Country (Unweighted)

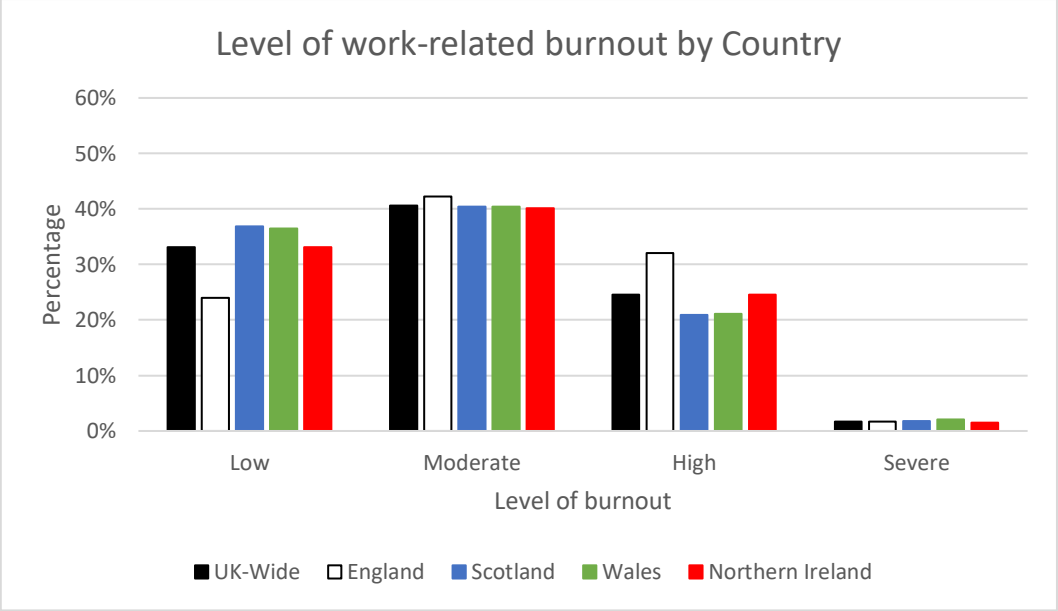


Figure A5.7: Level of Client-Related Burnout by Country (Weighted)

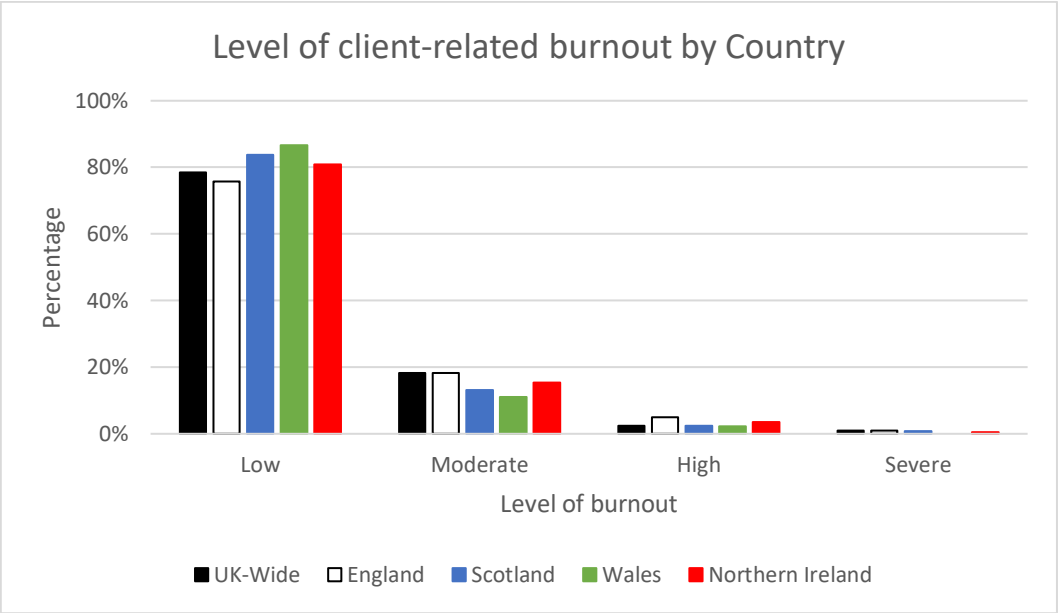


Figure A5.8: Level of Client-Related Burnout by Country (Unweighted)

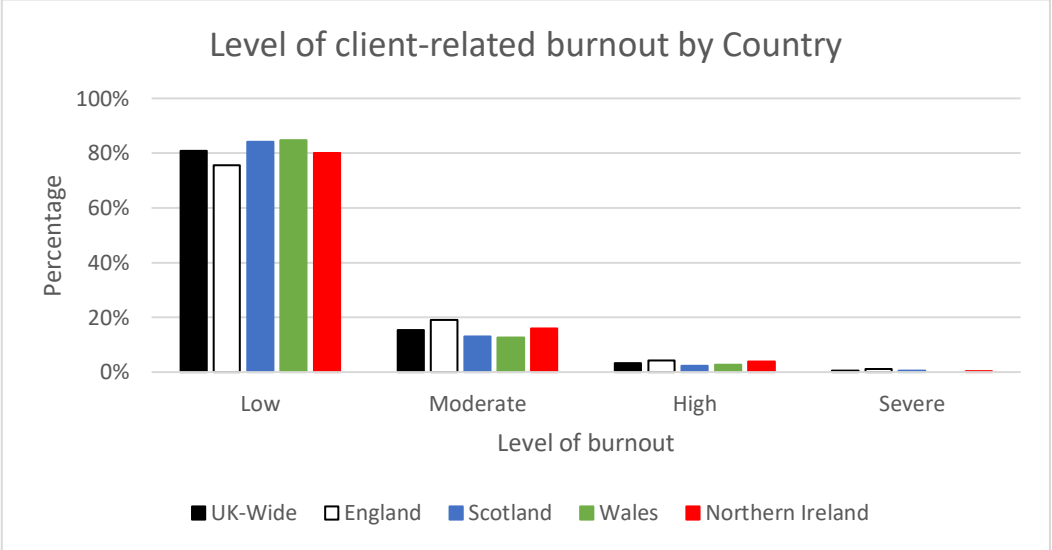


Table A5.3: Level of Burnout by Country (Weighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout:					
Low	21.9%	22.0%	27.8%	27.8%	28.0%
Moderate	42.9%	39.9%	45.2%	45.2%	45.0%
High	28.6%	32.2%	24.2%	24.2%	23.7%
Severe	6.6%	5.9%	2.8%	2.8%	3.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:					
Low	28.1%	29.1%	38.2%	39.4%	36.3%
Moderate	46.3%	40.9%	39.6%	39.8%	41.8%
High	23.6%	28.4%	20.5%	17.9%	21.6%
Severe	2.0%	1.6%	1.7%	2.8%	1.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:					
Low	78.4%	75.7%	83.7%	86.6%	80.8%
Moderate	18.2%	18.3%	13.2%	11.1%	15.3%
High	2.4%	5.0%	2.4%	2.2%	3.5%
Severe	1.0%	1.0%	0.8%	0.0%	0.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.4: Level of Burnout by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout:					
Low	612 (25.5%)	91 (19.2%)	183 (27.5%)	77 (26.7%)	261 (26.9%)
Moderate	1062 (44.3%)	191 (45.7%)	304 (45.7%)	130 (45.1%)	437 (45.0%)
High	634 (26.4%)	167 (23.2%)	154 (23.2%)	72 (25.0%)	241 (24.8%)
Severe	91 (3.8%)	25 (3.6%)	24 (3.6%)	9 (3.1%)	33 (3.4%)
Total	**2399 (100%)**	**474 (100%)**	**665 (100%)**	**288 (100%)**	**972 (100%)**
Work-related burnout:					
Low	784 (33.1%)	112 (24.0%)	241 (36.9%)	104 (36.5%)	327 (33.9%)
Moderate	963 (40.6%)	197 (42.2%)	264 (40.4%)	115 (40.4%)	387 (40.1%)
High	584 (24.6%)	150 (32.1%)	137 (20.9%)	60 (21.1%)	237 (24.6%)
Severe	40 (1.7%)	8 (1.7%)	12 (1.8%)	6 (2.1%)	14 (1.5%)
Total	**2371 (100%)**	**467 (100%)**	**654 (100%)**	**285 (100%)**	**965 (!00%)**
Client-related burnout:					
Low	1803 (80.8%)	332 (75.5%)	522 (84.1%)	227 (84.7%)	722 (80.0%)
Moderate	343 (15.4%)	84 (19.1%)	81 (13.0%)	34 (12.7%)	144 (15.9%)
High	74 (3.3%)	19 (4.3%)	14 (2.3%)	7 (2.6%)	34 (3.8%)
Severe	12 (0.5%)	5 (1.1%)	4 (0.6%)	0 (0.0%)	3 (0.3%)
Total	**2232 (100%)**	**440 (100%)**	**621 (100%)**	**268 (100%)**	**903 (100%)**

A5.2 Burnout Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean personal burnout scores ($F = 19.058$, $df = 4$, $p < .001$). Specifically, Midwives scored significantly higher than all other occupations.

There were also significant differences between the occupational groups in mean work-related burnout scores ($F = 32.066$, $df = 4$, $p < .001$). Social care workers scored significantly lower than midwives and social workers; and AHPs scored significantly lower than midwives.

Significant differences between occupational groups were also found in mean client-related burnout scores (F = 6.489, df = 4, p < .001). Midwives scored significantly higher than nurses and social care workers.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean personal burnout scores (F = 8.316, df = 4, p = .001). Specifically, Midwives scored significantly higher than all other occupations.

There were also significant differences between the occupational groups in mean work-related burnout scores (F = 17.416, df = 4, p < .001). Midwives scored significantly higher than nurses, AHPs and social care workers.

Significant differences between occupational groups were also found in mean client-related burnout scores (F = 6.716, df = 4, p < .001). Social workers scored significantly higher than nurses and social care workers.

Figure A5.9: Mean Burnout Scores by Occupation (Weighted)

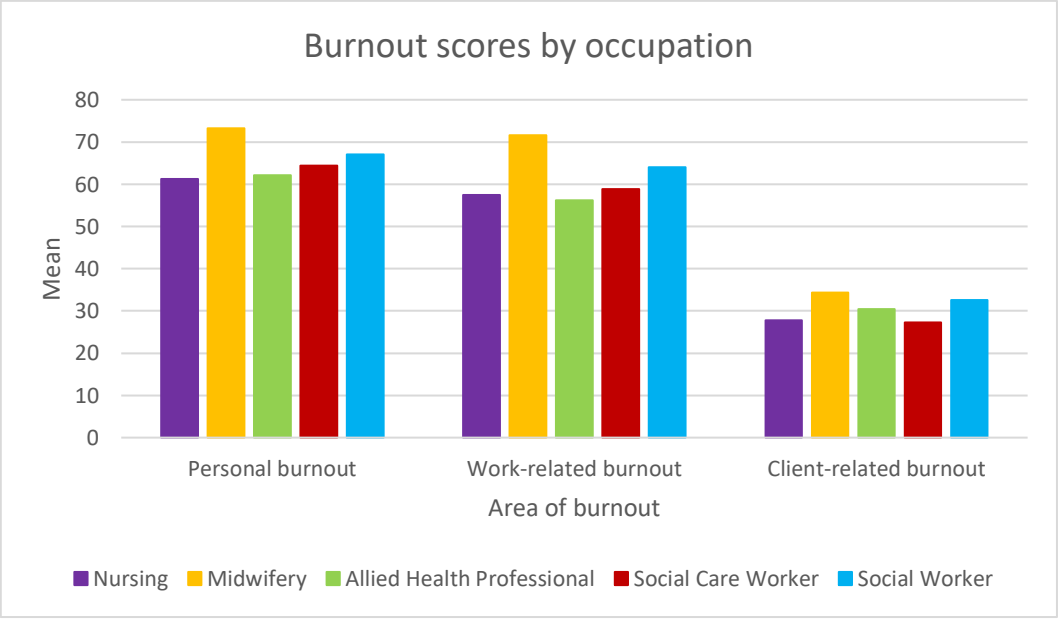


Figure A5.10: Mean Burnout Scores by Occupation (Unweighted)

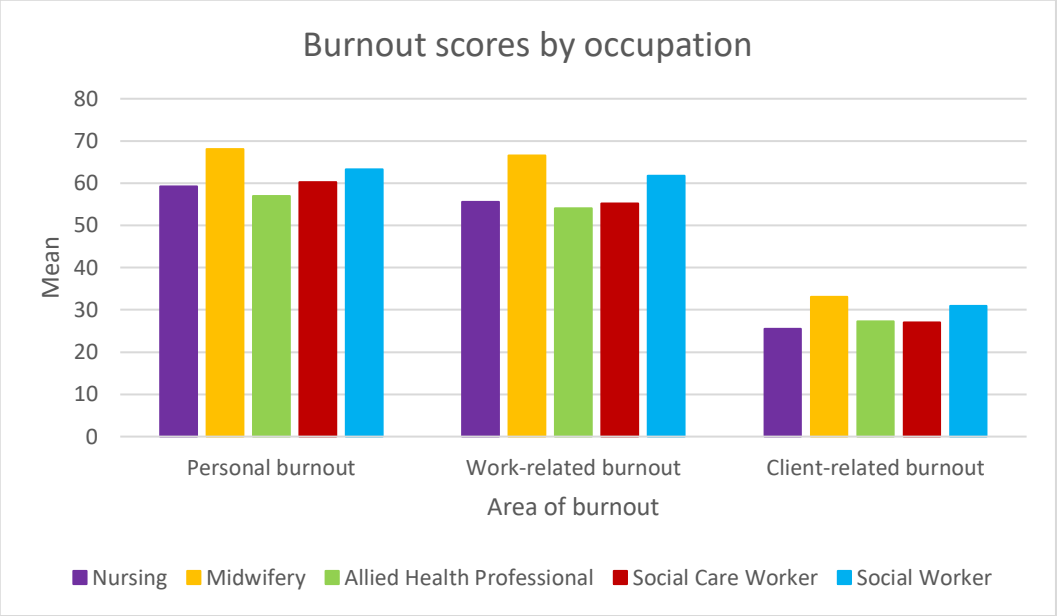


Table A5.5: Mean Burnout Scores by Occupation (Weighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	61.29	73.21	62.12	64.37	67.00
Work-related burnout	57.47	71.54	56.16	58.80	64.06
Client-related burnout	27.75	34.36	30.37	27.33	32.56

Table A5.6: Mean Burnout Scores by Occupation (Unweighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	59.26	68.12	56.92	60.21	63.24
Work-related burnout	55.62	66.59	54.11	55.14	61.80
Client-related burnout	25.47	33.03	27.22	27.00	30.98

Figure A5.11: Level of Personal Burnout by Occupation (Weighted)

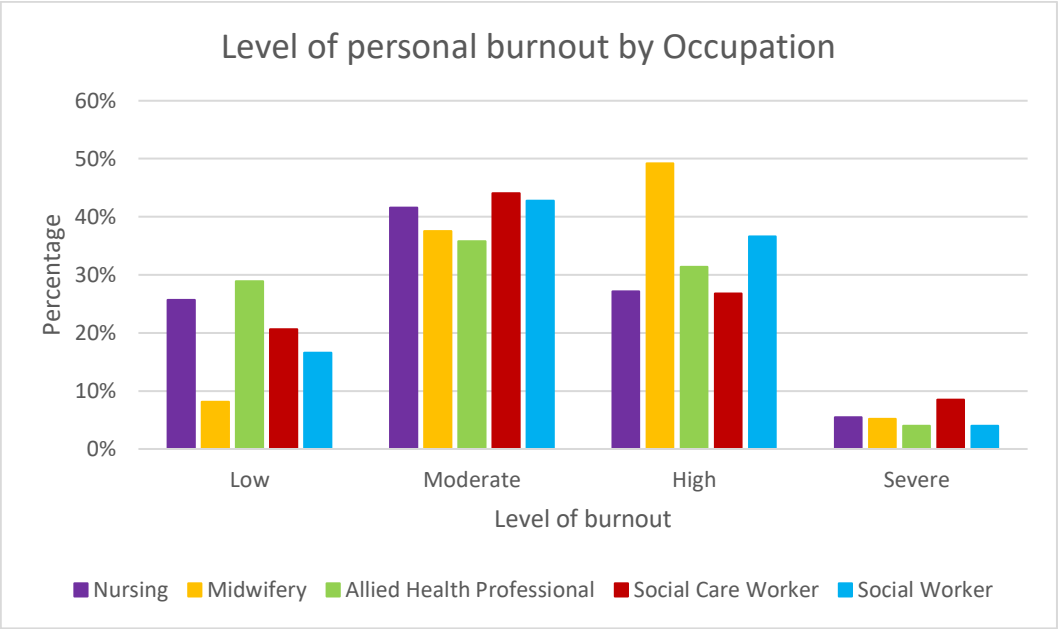


Figure A5.12: Level of Personal Burnout by Occupation (Unweighted)

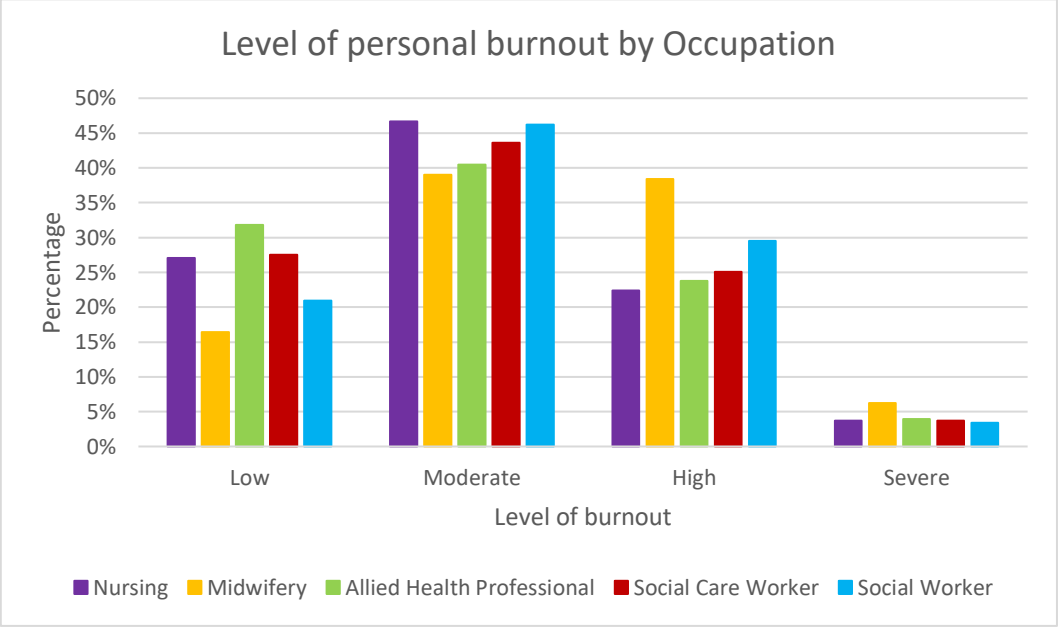


Figure A5.13: Level of Work-Related Burnout by Occupation (Weighted)

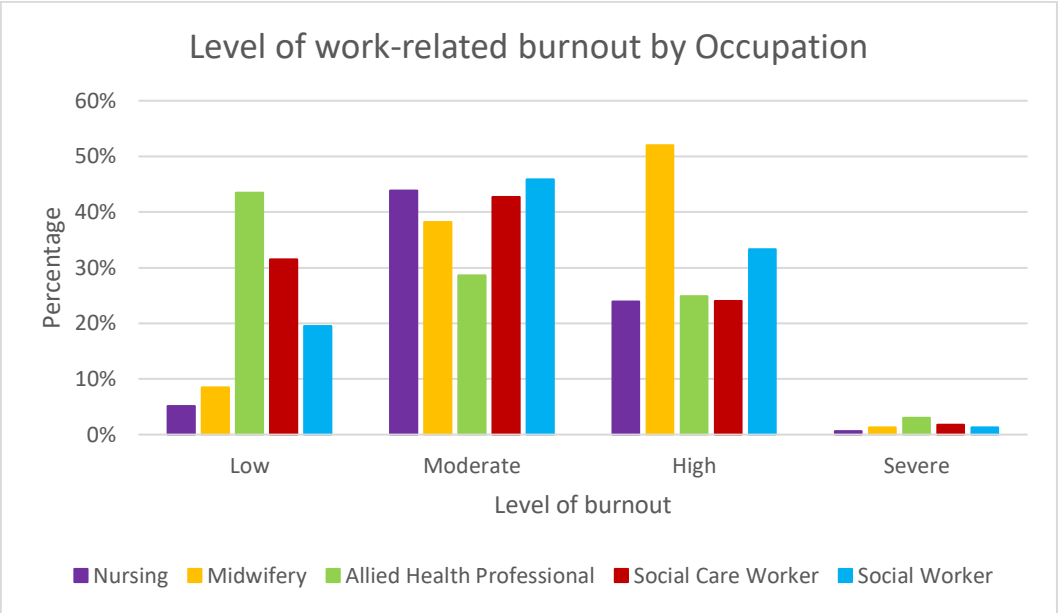


Figure A5.14: Level of Work-Related Burnout by Occupation (Unweighted)

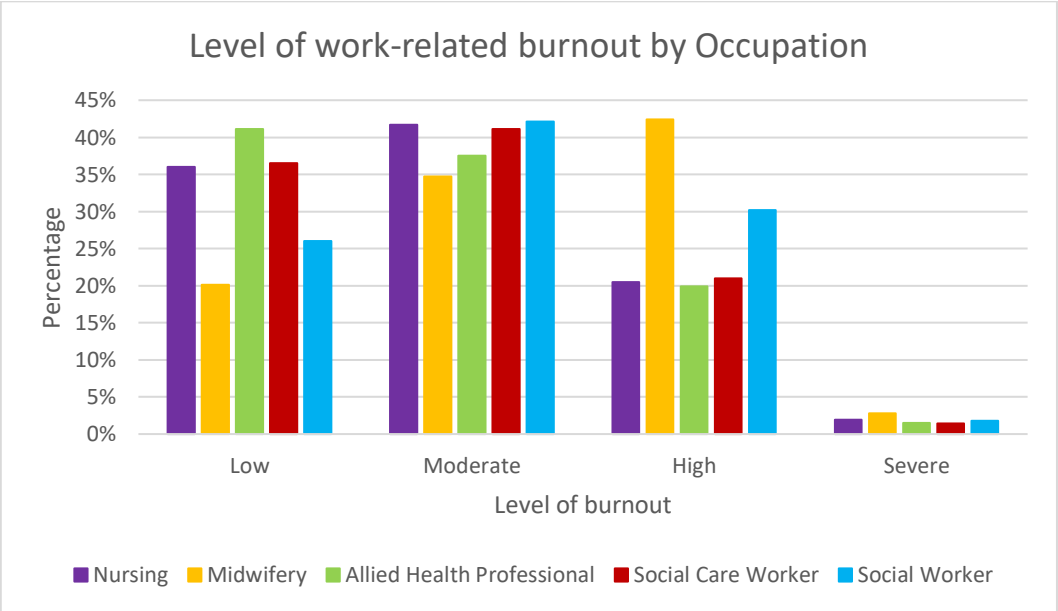


Figure A5.15: Level of Client-Related Burnout by Occupation (Weighted)

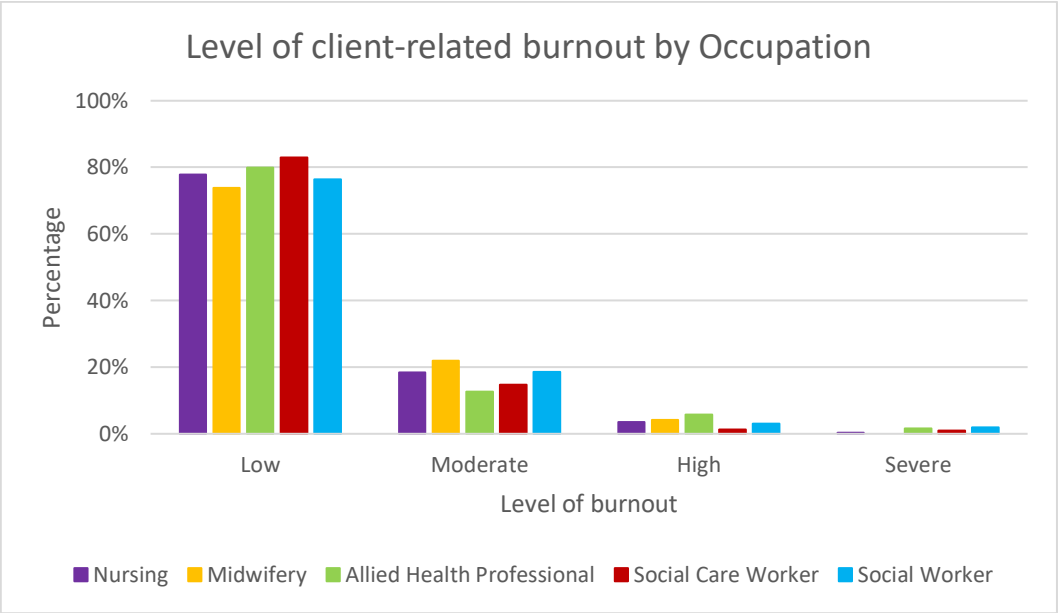


Figure A5.16: Level of Client-Related Burnout by Occupation (Unweighted)

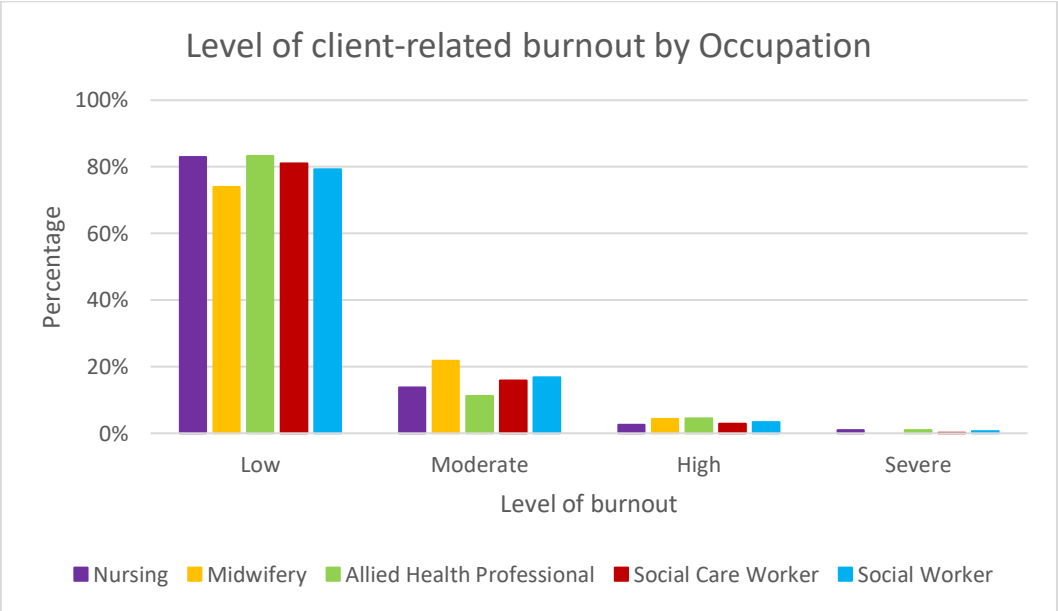


Table A5.7: Level of Burnout by Occupation (Weighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout:					
Low	25.7%	8.1%	28.9%	20.6%	16.6%
Moderate	41.6%	37.5%	35.8%	44.1%	42.8%
High	27.2%	49.2%	31.4%	26.8%	36.6%
Severe	5.5%	5.2%	4.0%	8.5%	4.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:					
Low	5.2%	8.5%	43.5%	31.5%	19.5%
Moderate	43.9%	38.2%	28.6%	42.7%	45.9%
High	23.9%	52.0%	24.9%	24.0%	33.3%
Severe	0.6%	1.3%	3.0%	1.8%	1.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:					
Low	77.8%	73.9%	79.9%	83.0%	76.4%
Moderate	18.4%	21.9%	12.7%	14.8%	18.6%
High	3.5%	4.2%	5.7%	1.3%	3.1%
Severe	0.3%	0.0%	1.6%	1.0%	1.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.8: Level of Burnout by Occupation (Unweighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout:					
Low	133 (27.1%)	24 (16.4%)	107 (31.8%)	206 (27.5%)	142 (20.9%)
Moderate	229 (46.7%)	57 (39.0%)	136 (40.5%)	326 (43.6%)	314 (46.2%)
High	110 (22.4%)	56 (38.4%)	80 (23.8%)	188 (25.1%)	200 (29.5%)
Severe	18 (3.7%)	9 (6.2%)	13 (3.9%)	28 (3.7%)	23 (3.4%)
Total	**490 (100%)**	**146 (100%)**	**336 (1005)**	**748 (100%)**	**679 (100%)**
Work-related burnout:					
Low	174 (36.0%)	29 (20.1%)	136 (41.1%)	270 (36.5%)	175 (26.0%)
Moderate	202 (41.7%)	50 (34.7%)	124 (37.5%)	304 (41.1%)	283 (42.1%)
High	99 (20.5%)	61 (42.4%)	66 (19.9%)	155 (21.0%)	203 (30.2%)
Severe	9 (1.9%)	4 (2.8%)	5 (1.5%)	10 (1.4%)	12 (1.8%)
Total	**484 (100%)**	**144(100%)**	**331 (100%)**	**739 (100%)**	**673 (100%)**
Client-related burnout:					
Low	382 (82.9%)	102 (73.9%)	250 (83.3%)	554 (81.1%)	505 (79.2%)
Moderate	63 (13.7%)	30 (21.7%)	35 (11.2%)	108 (15.8%)	107 (16.8%)
High	12 (2.6%)	6 (4.3%)	14 (4.5%)	20 (2.9%)	22 (3.4%)
Severe	4 (0.9%)	0 (0.0%)	3(1.0%)	1 (0.1%)	4 (0.6%)
Total	**461 (100%)**	**138 (100%)**	**312 (100%)**	**683 (100%)**	**638 (100%)**

A5.3 Burnout Scores by Sex

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

Summary (Weighted results):

There were significant differences between males and females in mean personal burnout scores ($t = 3.923$, $df = 2756$, $p < .001$). Specifically, females scored significantly higher than males.

There were no significant differences between males and females in mean work-related burnout scores ($t = 1.869$, $df = 2733$, $p > .05$).

There were significant differences between males and females in mean work-related burnout scores (t = -8.999, df = 2576, p < .001). Males scored significantly higher than females.

Summary (Unweighted results):

There were no significant differences between males and females in mean personal burnout scores (t = 1.719, df = 2381, p > .05).

There were no significant differences between males and females in mean work-related burnout scores (t = 4.19, df = 2353, p > .05).

There were significant differences between males and females in mean work-related burnout scores (t = -5.086, df = 2215, p < .001). Males scored significantly higher than females.

Figure A5.17: Mean Burnout Scores by Sex (Weighted)

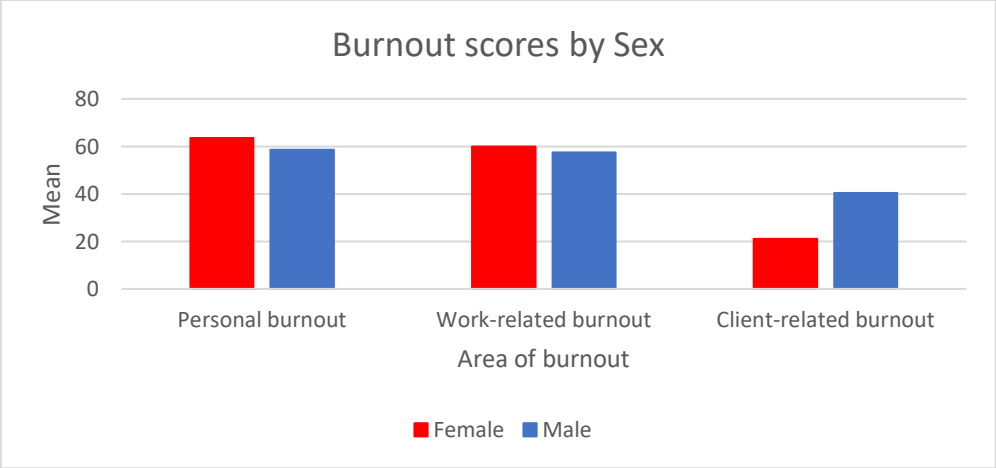


Figure A5.18: Mean Burnout Scores by Sex (Unweighted)

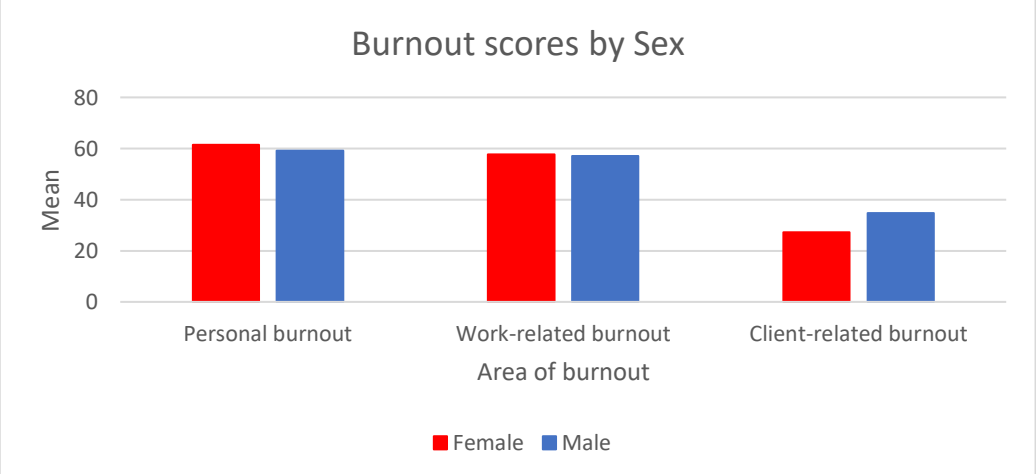


Table A5.9: Mean Burnout Scores by Sex (Weighted)

Burnout	Sex	
	Female	Male
Personal burnout	63.62	58.65
Work-related burnout	59.97	57.55
Client-related burnout	21.14	40.31

Table A5.10: Mean Burnout Scores by Sex (Unweighted)

Burnout	Sex	
	Female	Male
Personal burnout	61.41	59.10
Work-related burnout	57.74	57.15
Client-related burnout	27.33	34.65

Figure A5.19: Level of Personal Burnout by Sex (Weighted)

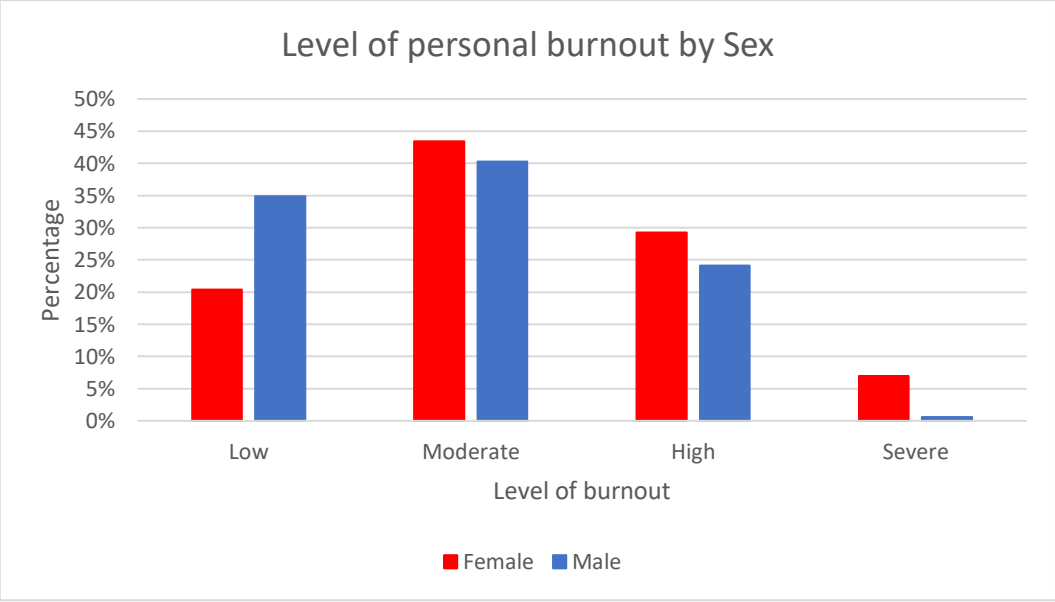


Figure A5.20: Level of Personal Burnout by Sex (Unweighted)

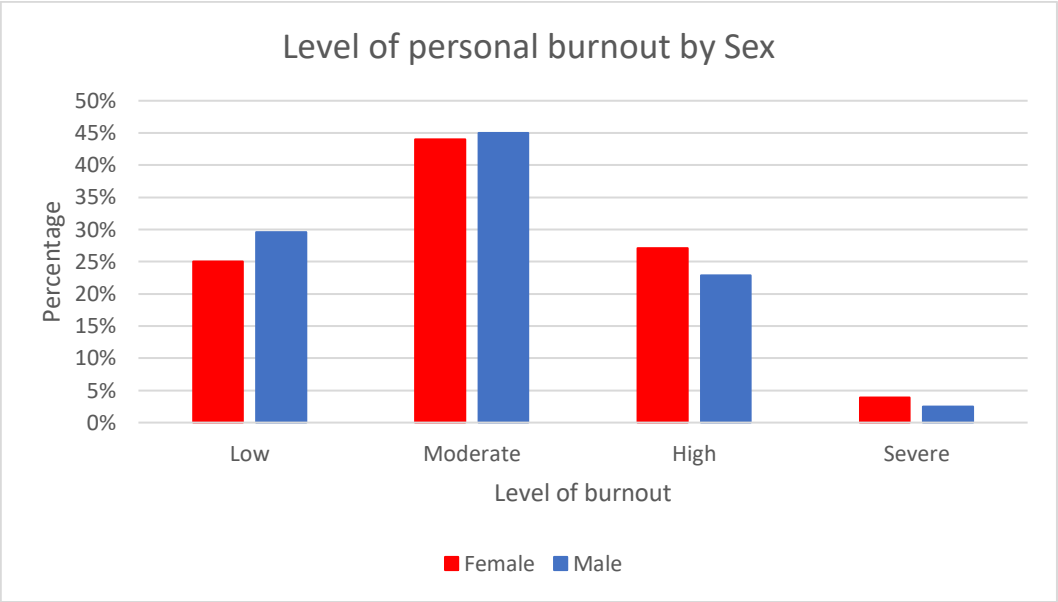


Figure A5.21: Level of Work-Related Burnout by Sex (Weighted)

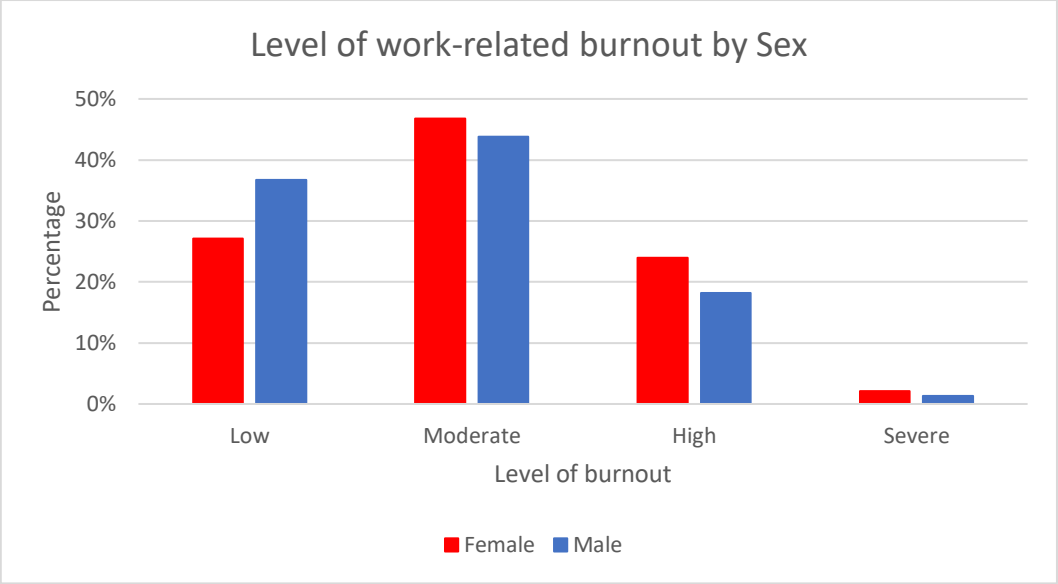


Figure A5.22: Level of Work-Related Burnout by Sex (Unweighted)

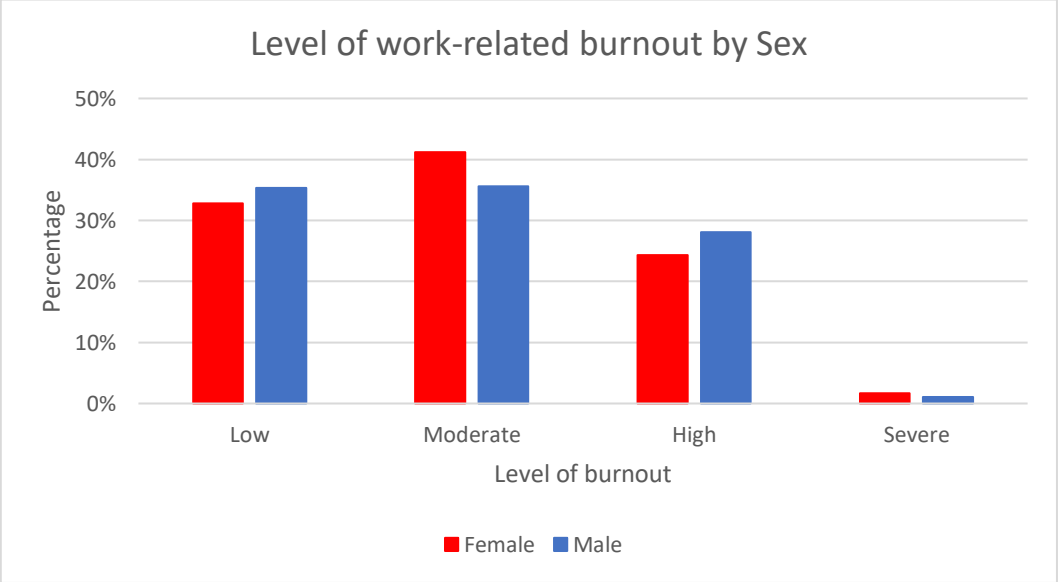


Figure A5.23: Level of Client-Related Burnout by Sex (Weighted)

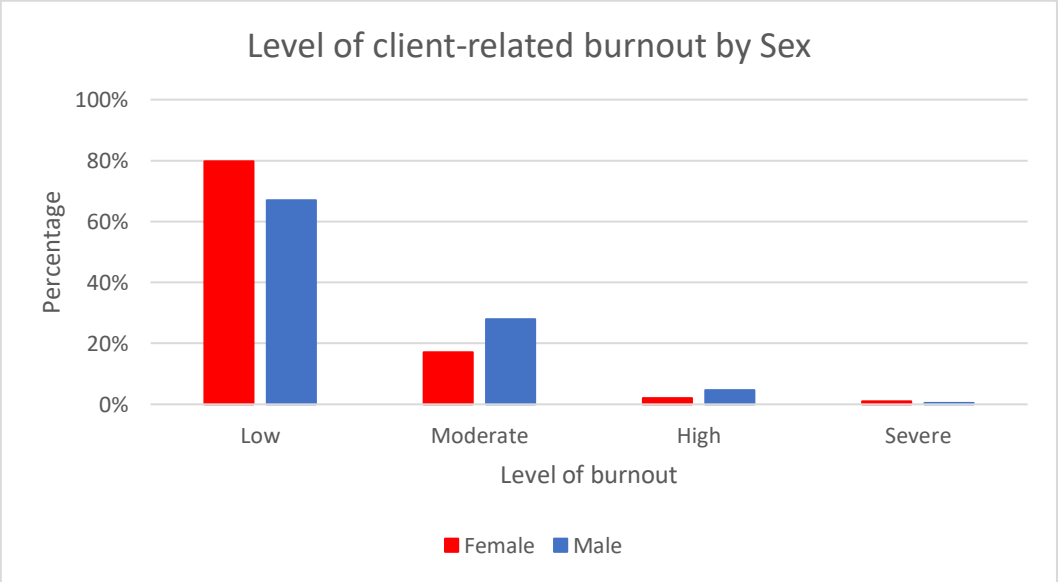


Figure A5.24: Level of Client-Related Burnout by Sex (Unweighted)

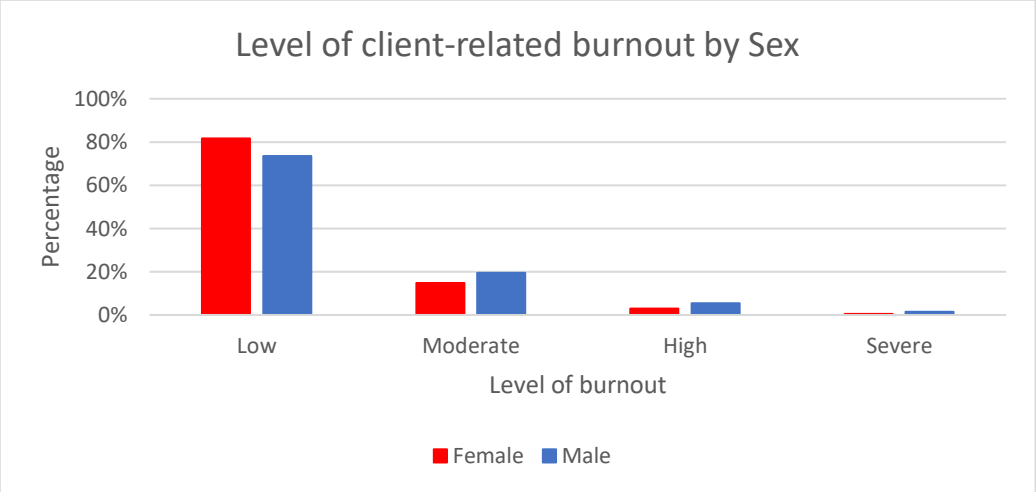


Table A5.11: Level of Burnout by Sex (Weighted)

Burnout	Sex	
	Female	**Male**
Personal burnout:		
Low	20.4%	34.9%
Moderate	43.4%	40.3%
High	29.3%	24.1%
Severe	7.0%	0.6%
Total	**100%**	**100%**
Work-related burnout:		
Low	27.1%	36.7%
Moderate	46.8%	43.8%
High	24.0%	18.2%
Severe	2.1%	1.3%
Total	**100%**	**100%**
Client-related burnout:		
Low	79.8%	67.0%
Moderate	17.1%	28.0%
High	2.1%	4.7%
Severe	1.0%	0.4%
Total	**100%**	**100%**

Table A5.12: Level of Burnout by Sex (Unweighted)

Burnout	Sex	
	Female	Male
Personal burnout:		
Low	526 (25.0%)	83 (29.6%)
Moderate	926 (44.0%)	126 (45.0%)
High	569 (27.1%)	64 (22.9%)
Severe	82 (3.9%)	7 (2.5%)
Total	**2103 (100%)**	**280 (100%)**
Work-related burnout:		
Low	682(32.8%)	98 (35.3%)
Moderate	855 (41.2%)	99 (35.6%)
High	504 (24.3%)	78 (28.1%)
Severe	36 (1.7%)	3 (1.1%)
Total	**2077 (100%)**	**278 (100%)**
Client-related burnout:		
Low	1599 (81.7%)	192 (73.6%)
Moderate	29 (14.9%)	51 (19.5%)
High	58 (3.0%)	14 (5.4%)
Severe	8 (0.4%)	4 (1.5%)
Total	**1956 (100%)**	**261 (100%)**

A5.4 Burnout Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean personal burnout scores (F = 29.522, df = 5, p < .001). The 16-29 age group scored significantly higher than all other age groups.

There were significant differences between the age groups in mean work-related burnout scores (F = 18.528, df = 5, p < .001). Specifically, the 16-29 age group scored significantly higher than the 40-49, 50-59, 60-65 and 66+ age groups.

There were also significant differences between the age groups in mean client related burnout scores (F = 12.630, df = 5, p < .001). Specifically, the 16-29 age group scored significantly higher than the 40-49, 50-59 and 60-65 age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean personal burnout scores (F = 13.648, df = 5, p < .001). The 16-29 age group scored significantly higher than the 50-59, 60-65 and 66+ age groups.

There were significant differences between the age groups in mean work-related burnout scores (F = 17.944, df = 5, p < .001). Specifically, the 16-29 age group scored significantly higher than the 50-59, 60-65 and 66+ age groups.

There were also significant differences between the age groups in mean client related burnout scores (F = 8.448, df = 5, p < .001). Specifically, the 30-39 age group scored significantly higher than the 40-49, 50-59, 60-65 and 66+ age groups.

Figure A5.25: Mean Burnout Scores by Age (Weighted)

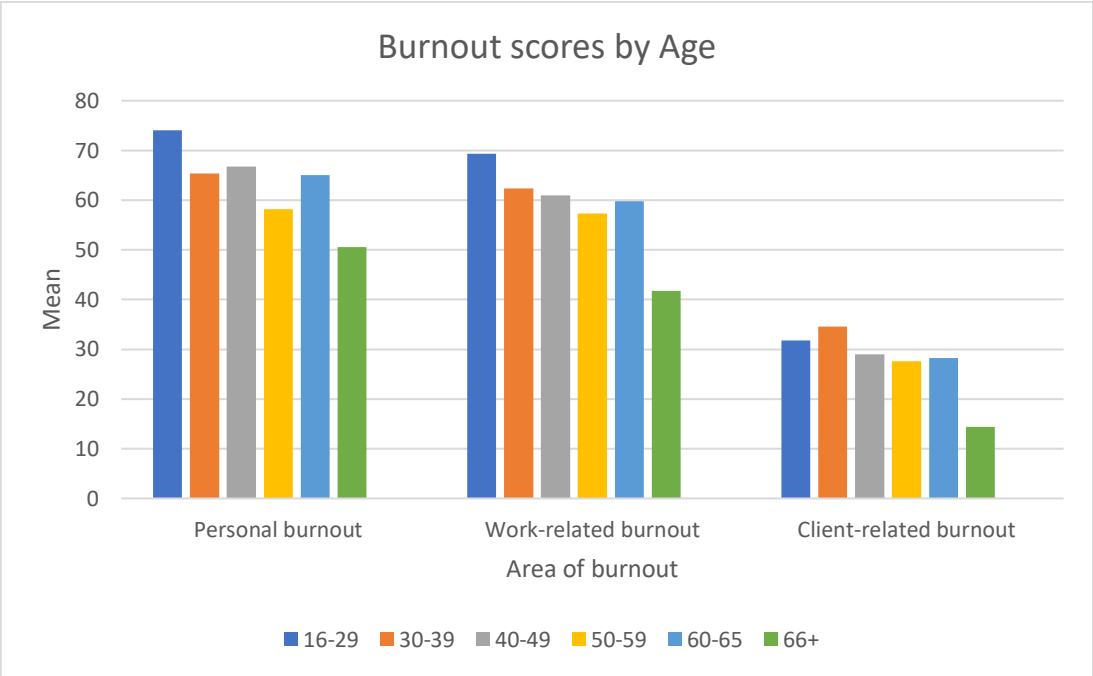


Figure A5.26: Mean Burnout Scores by Age (Unweighted)

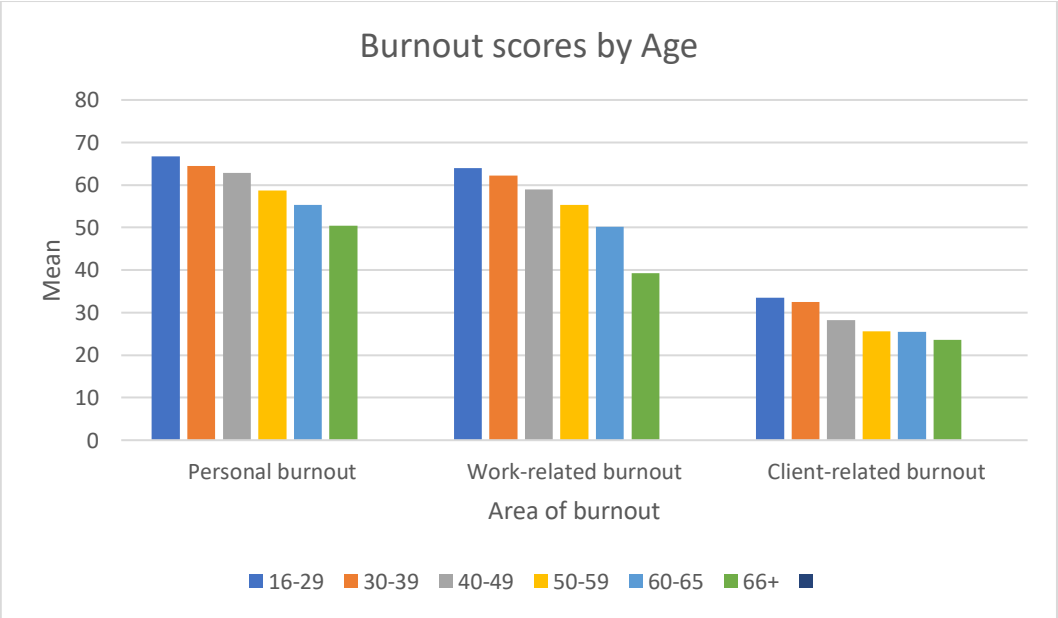


Table A5.13: Mean Burnout Scores by Age (Weighted)

Burnout	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Personal burnout	74.02	65.38	66.77	58.18	65.04	50.55
Work-related burnout	69.34	62.31	60.99	57.28	59.76	41.73
Client-related burnout	31.80	34.60	28.98	27.62	28.22	14.35

Table A5.14: Mean Burnout Scores by Age (Unweighted)

Burnout	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Personal burnout	66.69	64.53	62.82	58.66	55.36	50.42
Work-related burnout	63.99	62.27	58.92	55.28	50.12	39.29
Client-related burnout	33.44	32.47	28.25	25.59	25.47	23.61

Figure A5.27: Level of Personal Burnout by Age (Weighted)

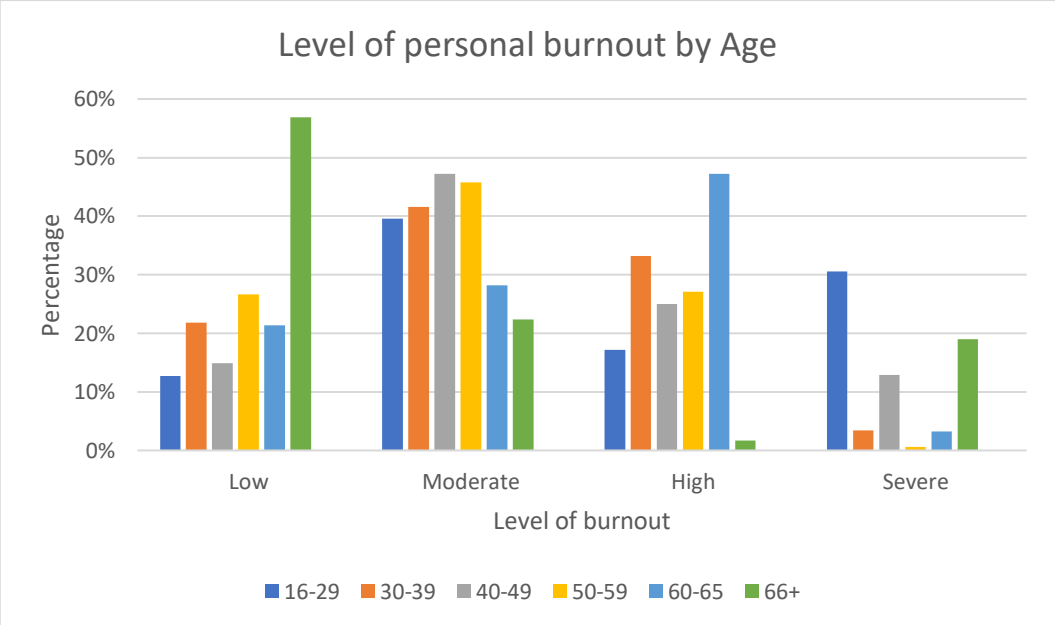


Figure A5.28: Level of Personal Burnout by Age (Unweighted)

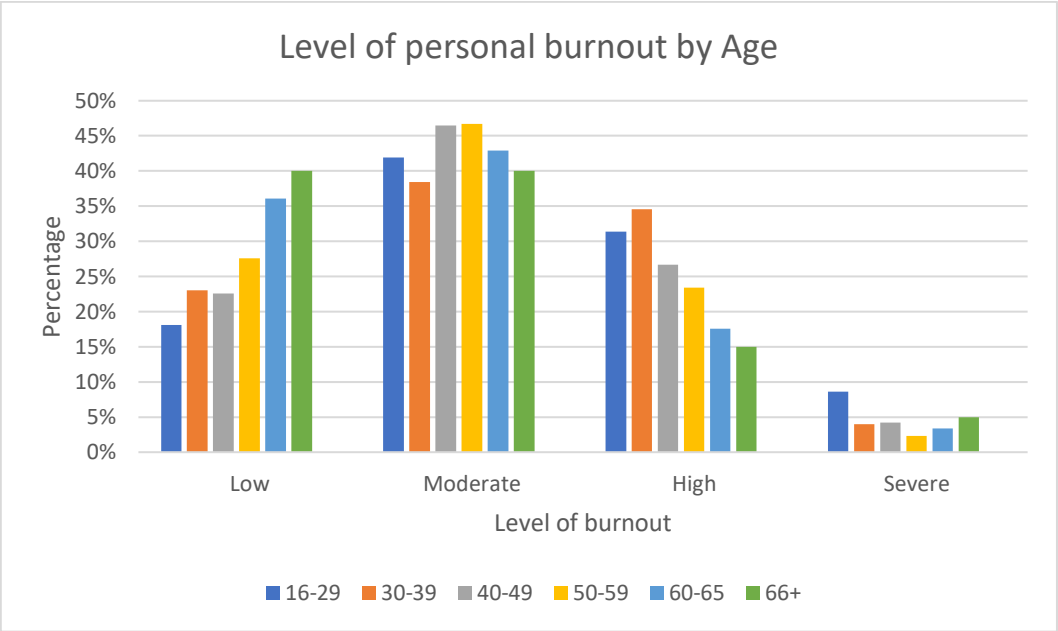


Figure A5.29: Level of Work-Related Burnout by Age (Weighted)

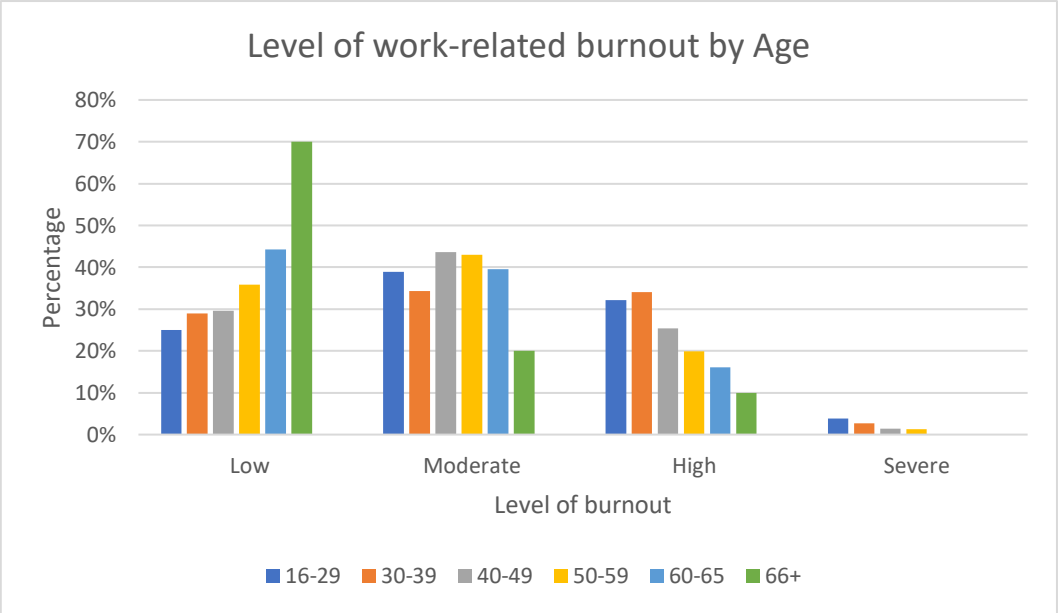


Figure A5.30: Level of Work-Related Burnout by Age (Unweighted)

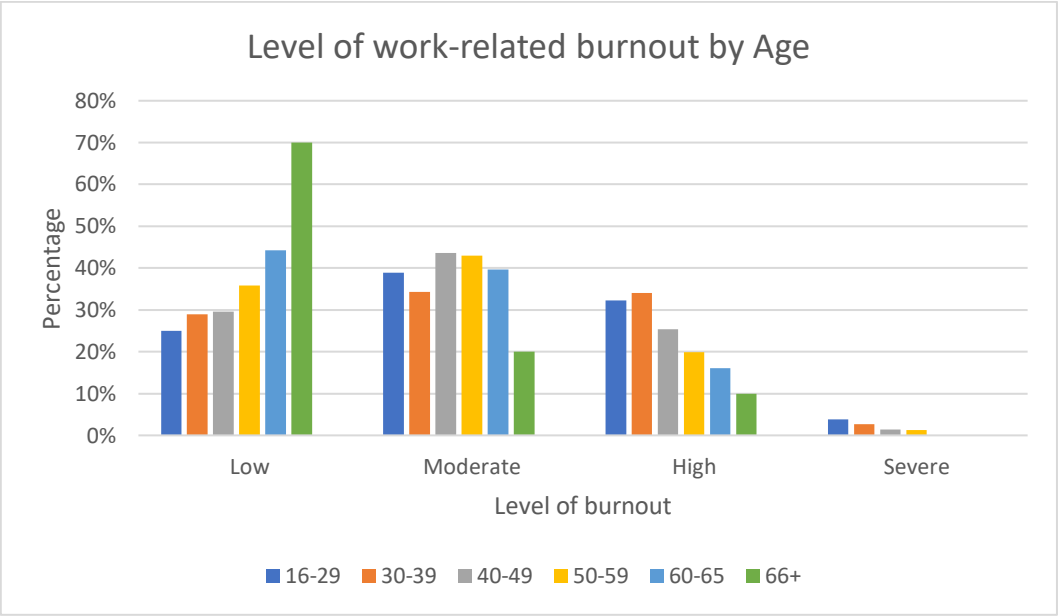


Figure A5.31: Level of Client-Related Burnout by Age (Weighted)

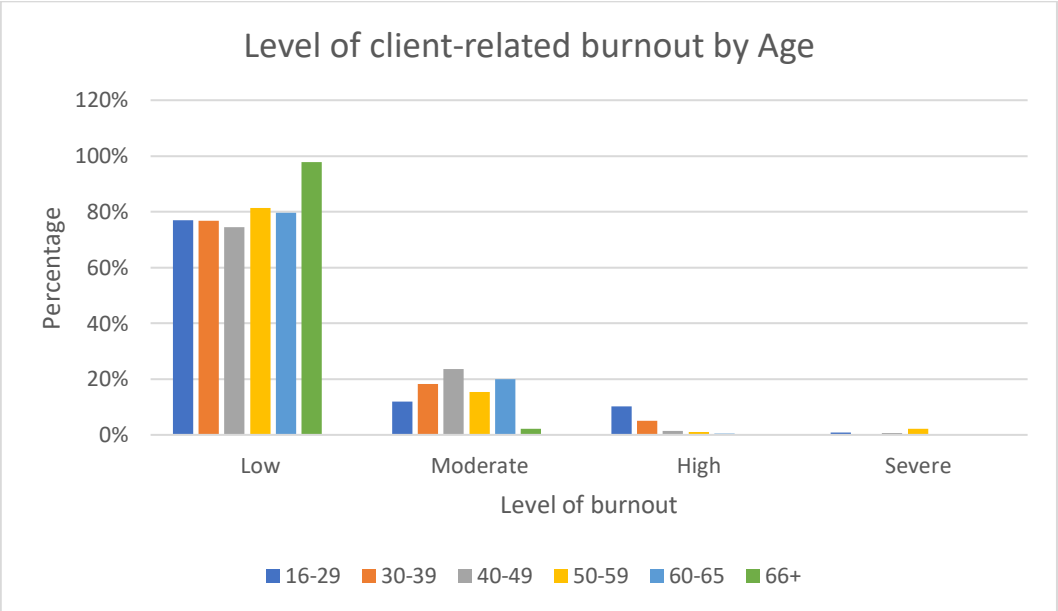


Figure A5.32: Level of Client-Related Burnout by Age (Unweighted)

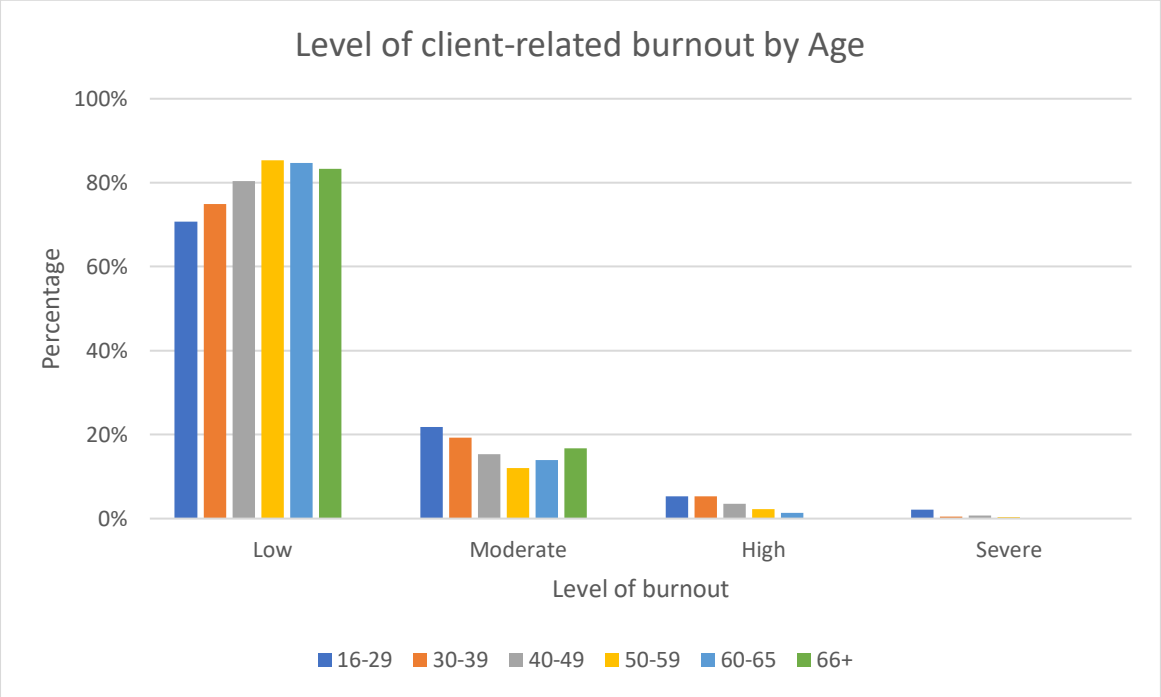


Table A5.15: Level of Burnout by Age (Weighted)

Burnout	Age					
	16-29	**30-39**	**40-49**	**50-59**	**60-65**	**66+**
Personal burnout:						
Low	12.7%	21.8%	14.9%	26.6%	21.4%	56.9%
Moderate	39.6%	41.6%	47.2%	45.8%	28.2%	22.4%
High	17.2%	33.2%	25.0%	27.1%	47.2%	1.70%
Severe	30.6%	3.4%	12.9%	0.6%	3.2%	19.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:						
Low	21.1%	30.2%	25.0%	29.5%	23.5%	60.3%
Moderate	34.6%	39.3%	43.6%	55.8%	44.5%	20.7%
High	42.1%	28.2%	27.1%	14.2%	32.0%	19.0%
Severe	2.3%	2.3%	4.4%	0.5%	0.0%	0.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:						
Low	77.0%	76.8%	74.4%	81.4%	79.7%	97.8%
Moderate	11.9%	18.2%	23.6%	15.3%	19.9%	2.2%
High	10.3%	5.1%	1.4%	1.1%	0.4%	0.0%
Severe	0.8%	0.0%	0.6%	2.2%	0.0%	0.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.16: Level of Burnout by Age (Unweighted)

Burnout	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Personal burnout:						
Low	38 (18.1%)	103 (23.0%)	145 (22.6%)	233 (27.6%)	84 (36.1%)	8 (40.0%)
Moderate	88 (41.9%)	172 (38.4%)	299 (46.5%)	394 (46.7%)	100 (42.9%)	8 (40.0%)
High	66 (31.4%)	155 (34.6%)	172 (26.7%)	197 (23.4%)	41 (17.6%)	3 (15.0%)
Severe	18 (8.6%)	18 (4.0%)	27 (4.2%)	19 (2.3%)	8 (3.4%)	1 (5.0%)
Total	**210 (100%)**	**448 (100%)**	**643 (100%)**	**843 (100%)**	**233 (100%)**	**20 (100%)**
Work-related burnout:						
Low	52 (25.0%)	128 (28.9%)	188 (29.6%)	298 (35.8%)	102 (44.3%)	14 (70.0%)
Moderate	81 (38.9%)	152 (34.3%)	277 (43.6%)	358 (43.0%)	91 (39.6%)	4 (20.0%)
High	67 (32.2%)	151 (34.1%)	161 (25.4%)	166 (19.9%)	37 (16.1%)	2 (10.0%)
Severe	8 (3.8%)	12 (2.7%)	9 (1.4%)	11 (1.3%)	0 (0.0%)	0 (0.0%)
Total	**208 (100%)**	**443 (100%)**	**635 (100%)**	**833 (100%)**	**230 (100%)**	**20 (100%)**
Client-related burnout:						
Low	133 (70.7%)	311 (74.9%)	484 (80.4%)	676 (85.4%)	182 (84.7%)	15 (83.3%)
Moderate	41 (21.8%)	80 (19.3%)	93 (15.4%)	96 (12.1%)	30 (14.0%)	3 (16.7%)
High	10 (5.3%)	22 (5.3%)	21 (3.5%)	18 (2.3%)	3 (1.4%)	0 (0.0%)
Severe	4 (2.1%)	2 (0.5%)	4 (0.7%)	2 (0.3%)	0 (0.0%)	0 (0.0%)
Total	**188 (100%)**	**415 (100%)**	**602 (100%)**	**792 (100%)**	**215 (100%)**	**18 (100%)**

A5.5 Burnout Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean personal burnout scores (F = 226.080, df = 3, p < .001). Specifically, the black ethnic group scored significantly lower than all other groups; and the white ethnic group scored significantly lower than the Asian group.

There were also significant differences between the ethnic groups in mean work-related burnout scores (F = 13.166, df = 3, p < .001). Specifically, the Asian ethnic group scored significantly higher than all the other ethnic groups.

There were significant differences between the ethnic groups in mean client burnout scores (F = 7.118, df = 3, p < .001). Specifically, the black ethnic group scored significantly lower than all other groups; and the white ethnic group scored significantly lower than the Asian group.

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)

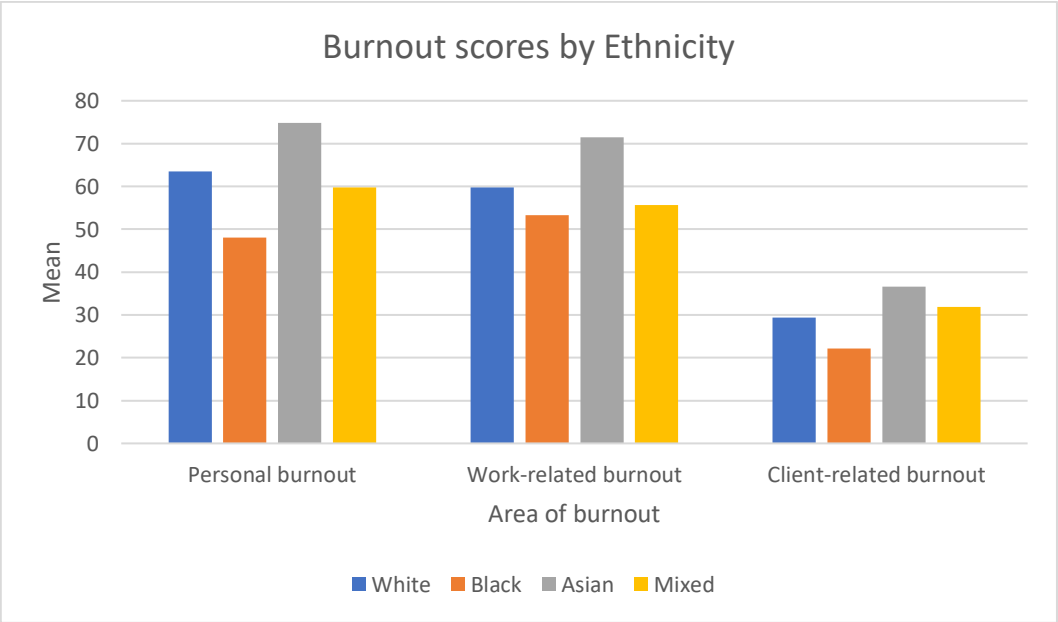


Figure A5.34: Mean Burnout Scores by Ethnicity (Unweighted)

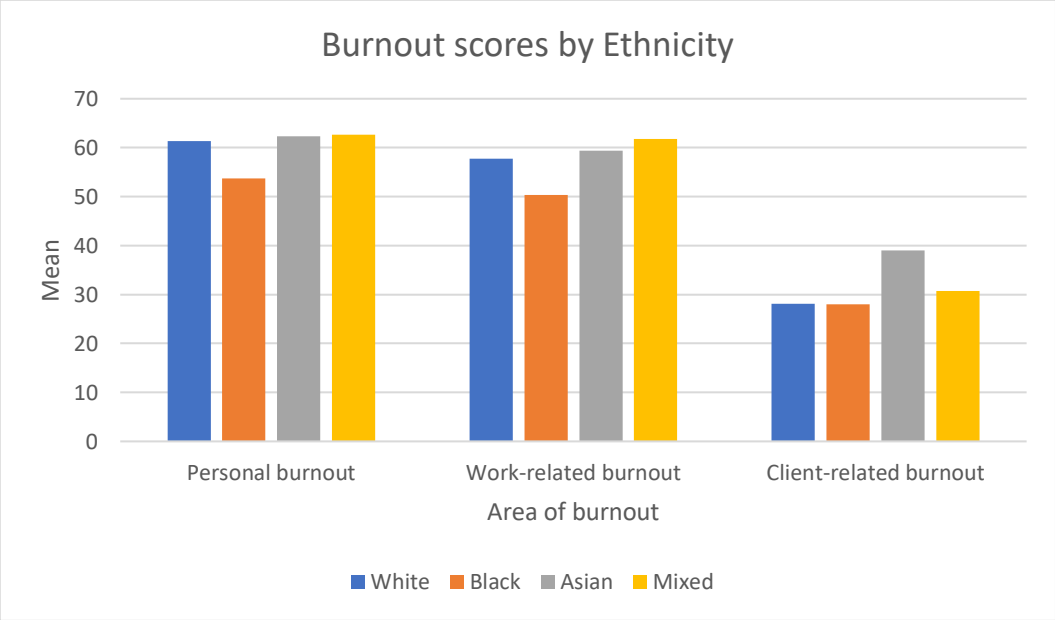


Table A5.17: Mean Burnout Scores by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	63.51	48.10	74.8	59.77
Work-related burnout	59.80	53.25	71.46	55.69
Client-related burnout	29.37	22.2	36.62	31.86

Table A5.18: Mean Burnout Scores by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	61.31	53.69	62.28	62.62
Work-related burnout	57.75	50.31	59.40	61.76
Client-related burnout	28.12	28.03	39.04	30.73

Figure A5.35: Level of Personal Burnout by Ethnicity (Weighted)

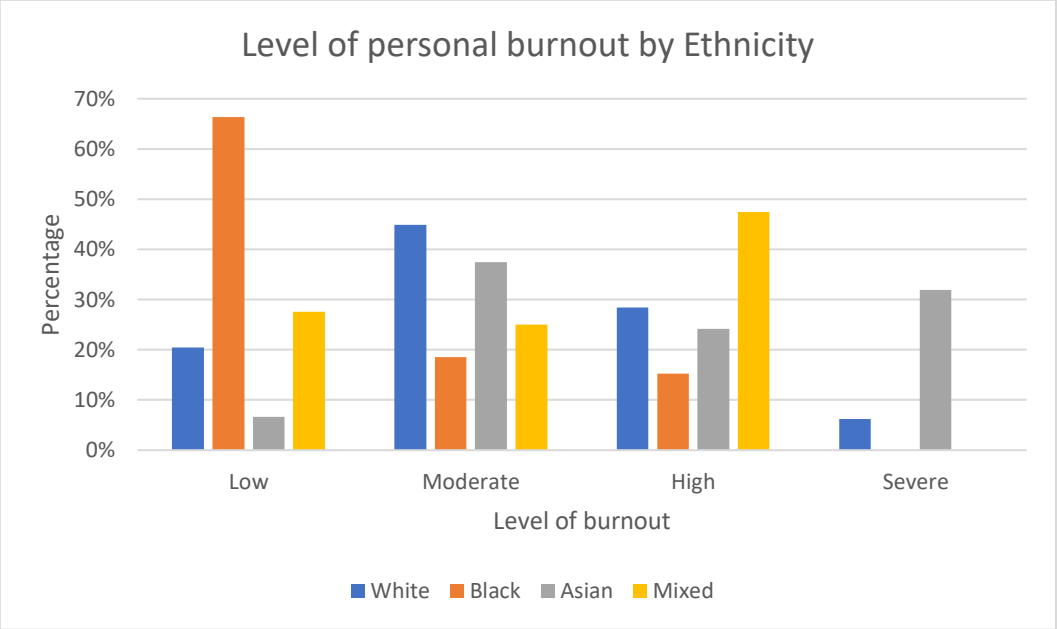


Figure A5.36: Level of Personal Burnout by Ethnicity (Unweighted)

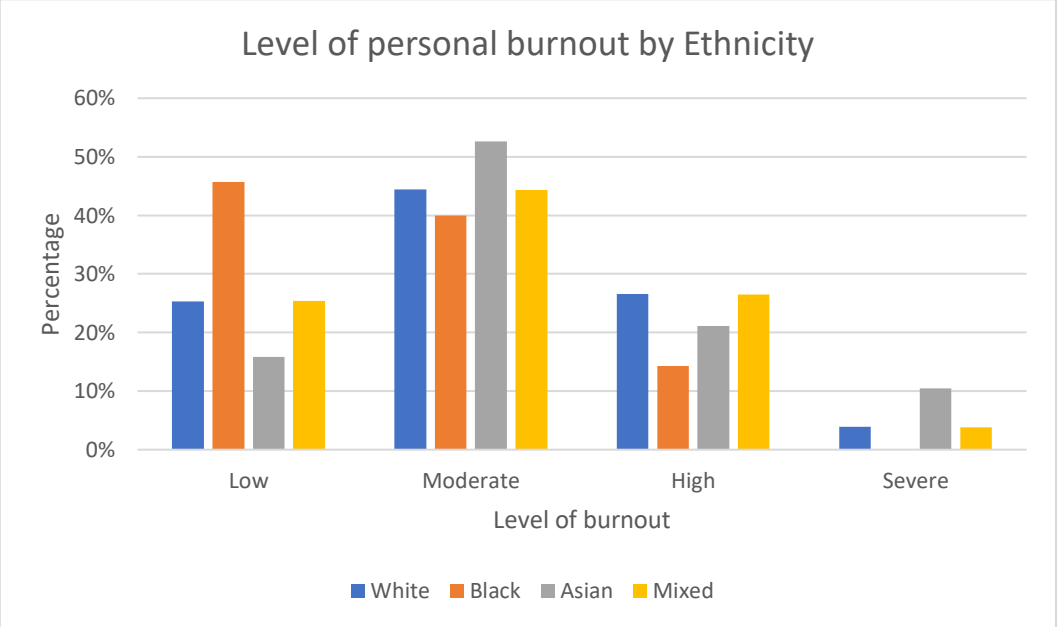


Figure A5.37: Level of Work-Related Burnout by Ethnicity (Weighted)

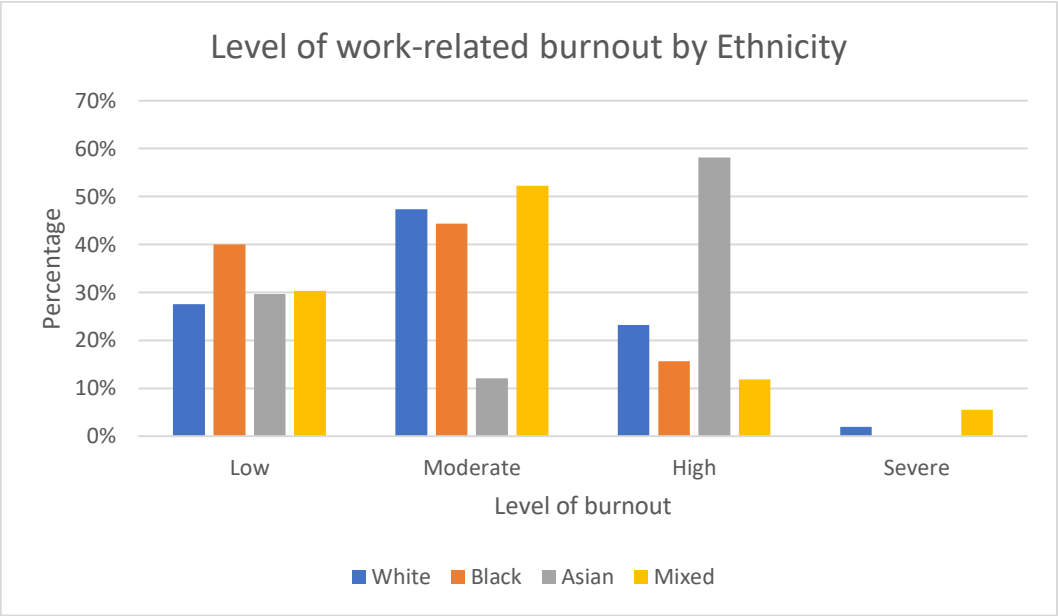


Figure A5.38: Level of Work-Related Burnout by Ethnicity (Unweighted)

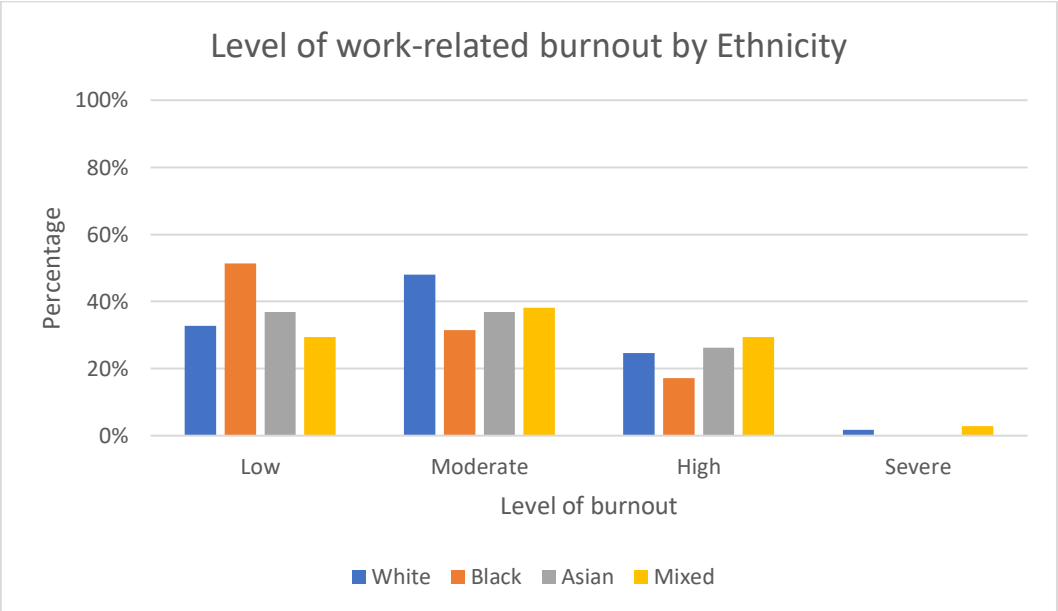


Figure A5.39: Level of Client-Related Burnout by Ethnicity (Weighted)

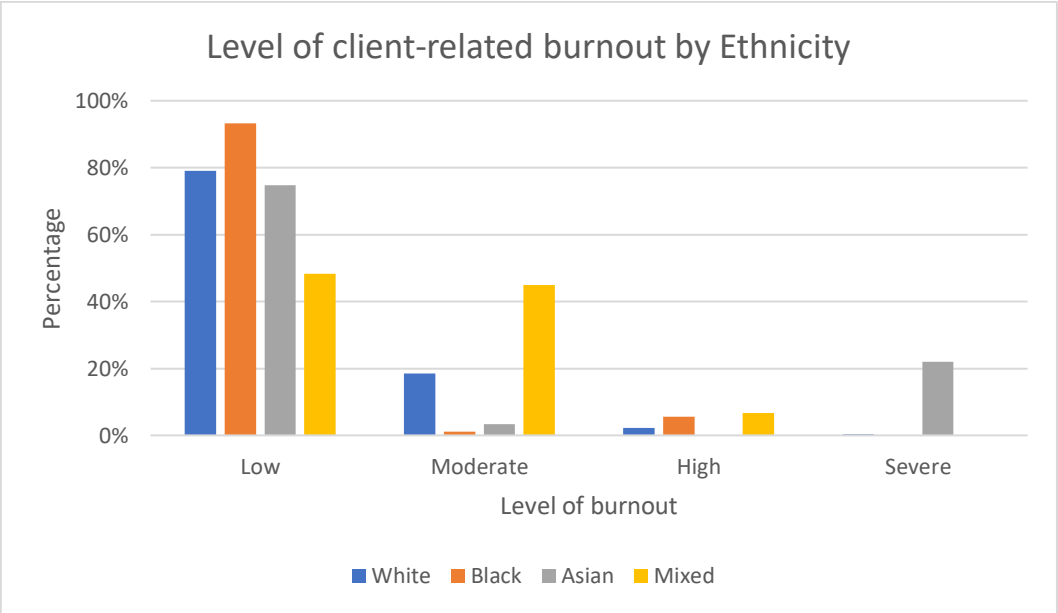


Figure A5.40: Level of Client-Related Burnout by Ethnicity (Unweighted)

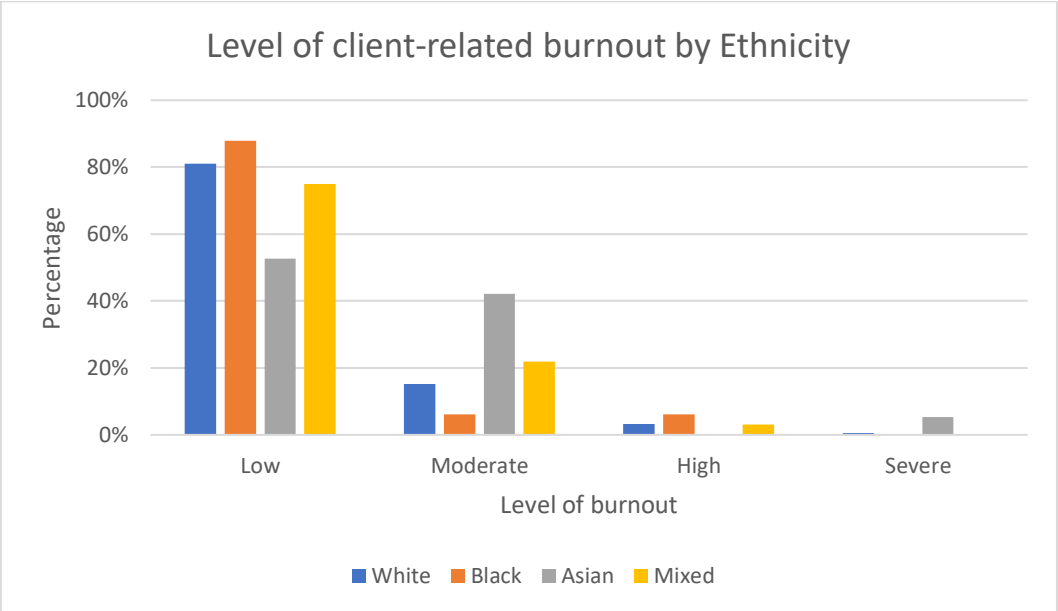


Table A5.19: Level of Burnout by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	**Black**	**Asian**	**Mixed**
Personal burnout:				
Low	20.5%	66.3%	6.6%	27.6%
Moderate	44.9%	18.5%	37.4%	25.0%
High	28.4%	15.2%	24.2%	47.4%
Severe	6.2%	0.0%	31.9%	0.0%
Total	**100%**	**100%**	**100%**	**100%**
Work-related burnout:				
Low	27.5%	40.0%	29.7%	30.3%
Moderate	47.4%	44.4%	12.1%	52.3%
High	23.2%	15.6%	58.2%	11.9%
Severe	2.0%	0.0%	0.0%	5.5%
Total	**100%**	**100%**	**100%**	**100%**
Client-related burnout:				
Low	79.1%	93.3%	74.7%	48.3%
Moderate	18.5%	1.1%	3.3%	44.9%
High	2.2%	5.6%	0.0%	6.7%
Severe	0.3%	0.0%	22.0%	0.0%
Total	**100%**	**100%**	**100%**	**100%**

Table A5.20: Level of Burnout by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout:				
Low	580 (25.2%)	16 (45.7%)	3 (15.8%)	9 (25.7%)
Moderate	1024 (44.4%)	14 (40.0%)	10 (52.6%)	13 (37.1%)
High	612 (26.6%)	5 (14.3%)	4 (21.1%)	13 (37.1%)
Severe	89 (3.9%)	0 (0.0%)	2 (10.5%)	0 (0.0%)
Total	**2305 (100%)**	**35 (100%)**	**19 (100%)**	**35 (100%)**
Work-related burnout:				
Low	746 (32.7%)	18 (51.4%)	7 (36.8%)	10 (29.4%)
Moderate	930 (40.8%)	11 (31.4%)	7 (36.8%)	13 (38.2%)
High	563 (24.7%)	6 (17.1%)	5 (26.3%)	10 (29.4%)
Severe	39 (1.7%)	0 (0.0%)	0 (0.0%)	1 (2.9%)
Totak	**2278 (100%)**	**35 (100%)**	**19 (100%)**	**34 (100%)**
Client-related burnout:				
Low	1737 (81.0%)	29 (87.9%)	10 (52.6%)	24 (75.0%)
Moderate	326 (15.2%)	2 (6.1%)	8 (42.1%)	7 21.9%)
High	71 (3.3%)	2 (6.1%)	0 (0.0%)	1 (3.1%)
Severe	11 (0.5%)	0 (0.5)	1 (5.3%)	0 (0.0%)
Total	**2145 (100%)**	**33 (100%)**	**19 (100%)**	**32 (100%)**

A5.6 Burnout Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in mean personal burnout scores (F = 4.093, df = 2, p = .017). Specifically, those who did not have a disability scored significantly higher than those who were not sure of whether or not they had a disability.

There were no significant differences between respondents based on their disability status in mean work-related burnout scores (F = 2.030, df = 2, p = .131).

There were significant differences between respondents based on their disability status in mean client burnout scores (F = 21.181, df = 2, p < .001). Specifically, those who did not have a disability scored significantly higher than those who were not sure of whether or not they had a disability and those who did have a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean personal burnout scores (F = 30.270, 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 = 14.164, df = 2, p < .001). Those who did not have a disability scored significantly lower than those who did have a disability.

Significant differences between respondents based on their disability status were also found in mean client-related burnout scores (F = 11.404, df = 2, p < .001). Those who did not have a disability scored significantly lower than those who did have a disability.

Figure A5.41: Mean Burnout Scores by Disability (Weighted)

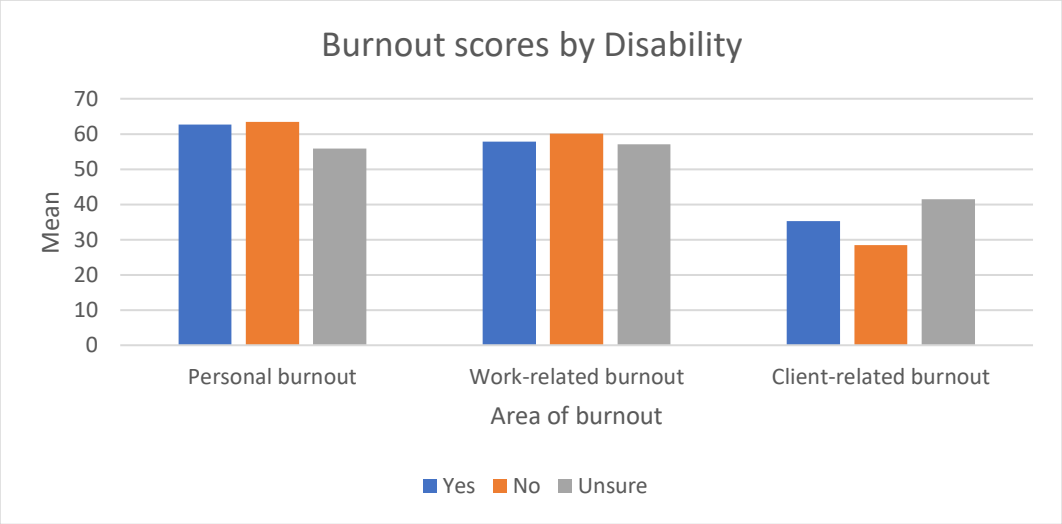


Figure A5.42: Mean Burnout Scores by Disability (Unweighted)

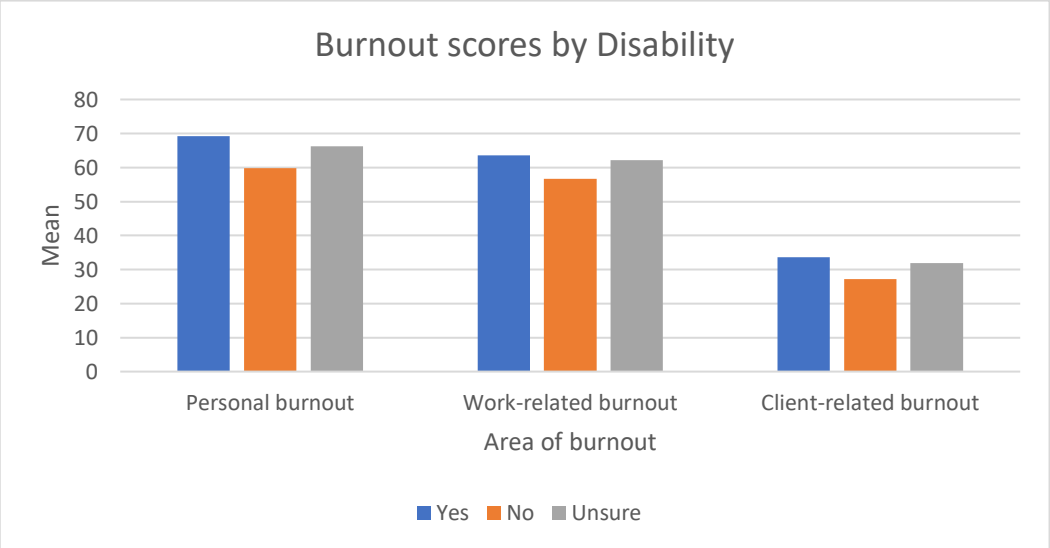


Table A5.21: Mean Burnout Scores by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	62.67	63.47	55.9
Work-related burnout	57.87	60.12	57.09
Client-related burnout	35.19	28.48	41.41

Table A5.22: Mean Burnout Scores by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	69.18	59.78	66.29
Work-related burnout	63.52	56.62	62.17
Client-related burnout	33.59	27.26	31.85

Figure A5.43: Level of Personal Burnout by Disability (Weighted)

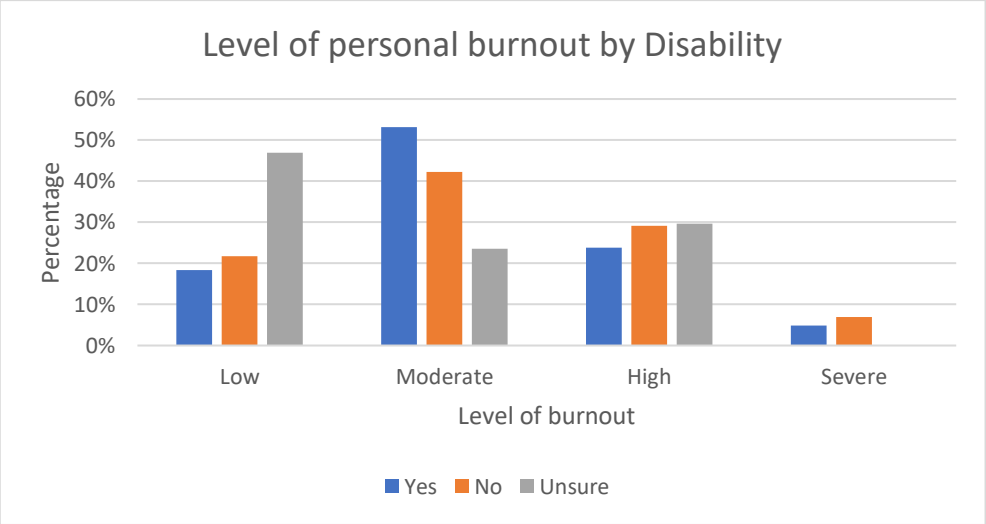


Figure A5.44: Level of Personal Burnout by Disability (Unweighted)

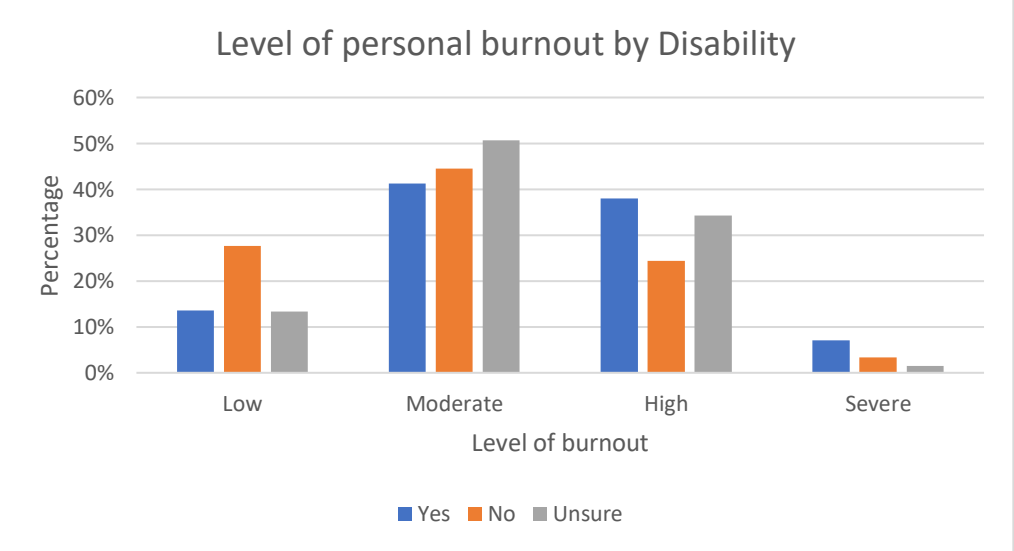


Figure A5.45: Level of Work-Related Burnout by Disability (Weighted)

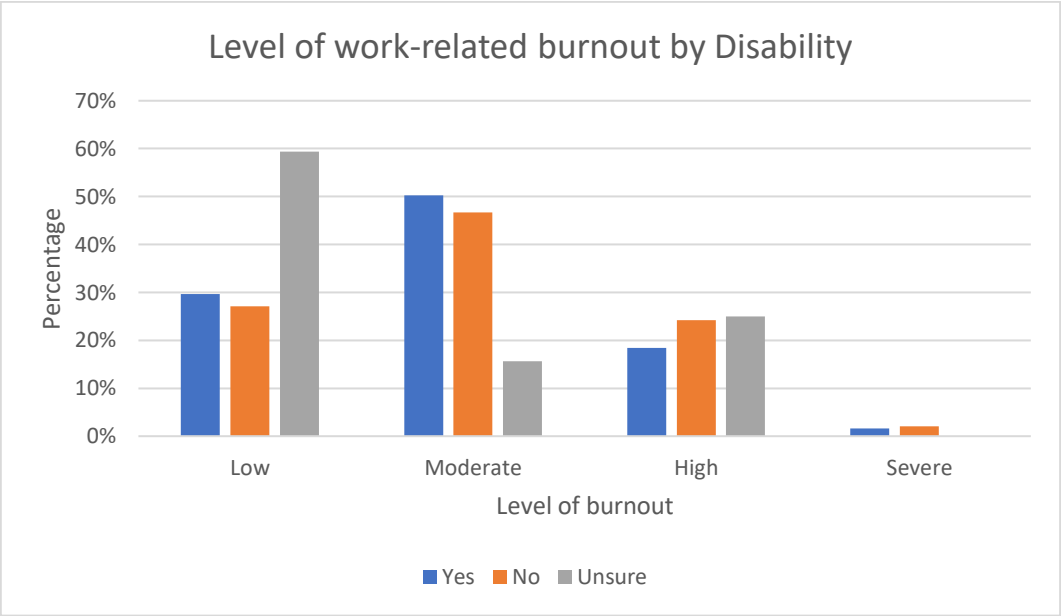


Figure A5.46: Level of Work-Related Burnout by Disability (Unweighted)

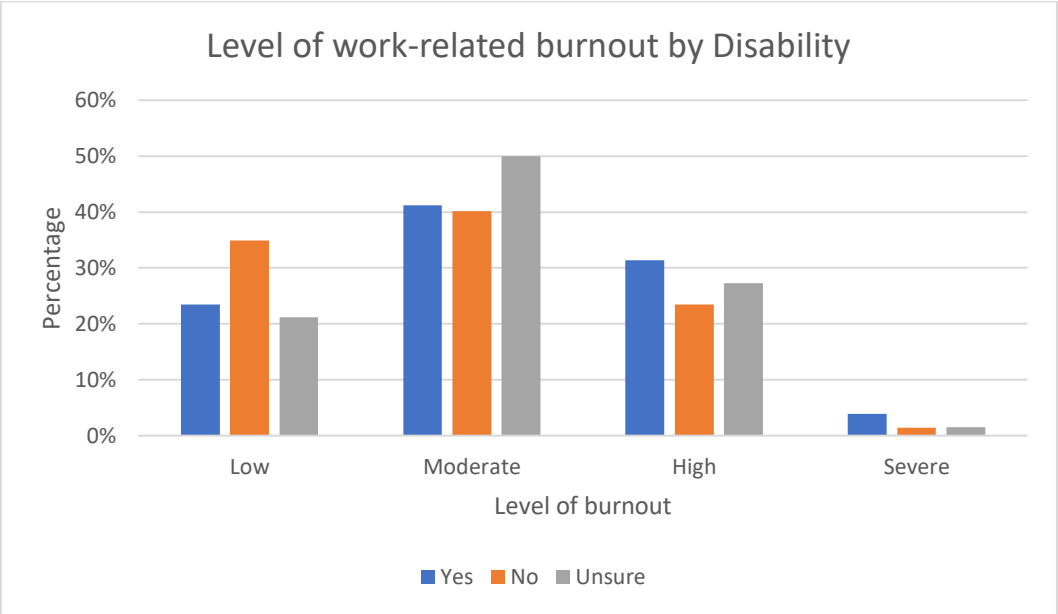


Figure A5.47: Level of Client-Related Burnout by Disability (Weighted)

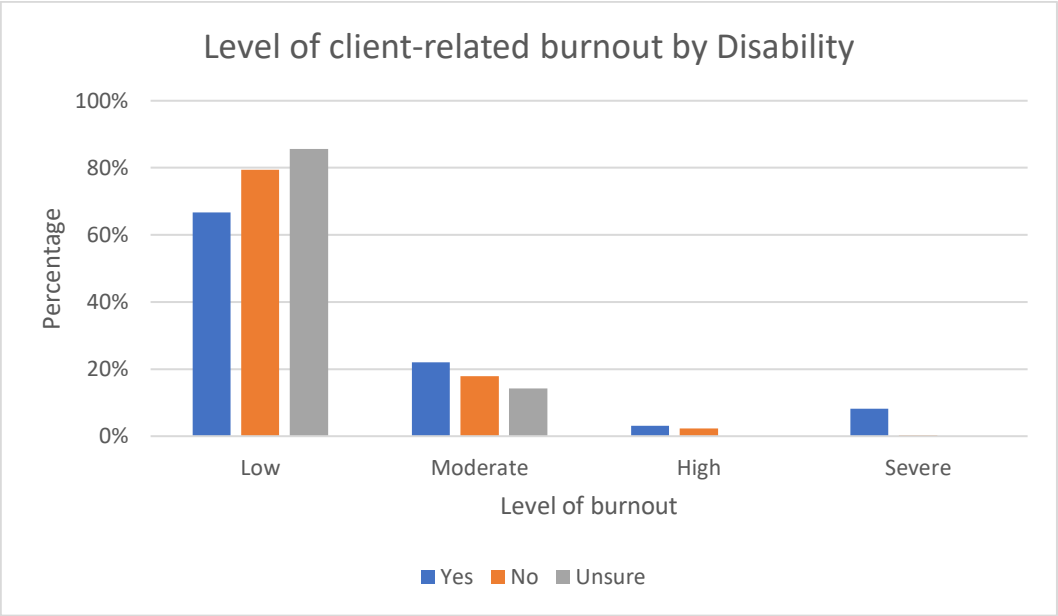


Figure A5.48: Level of Client-Related Burnout by Disability (Unweighted)

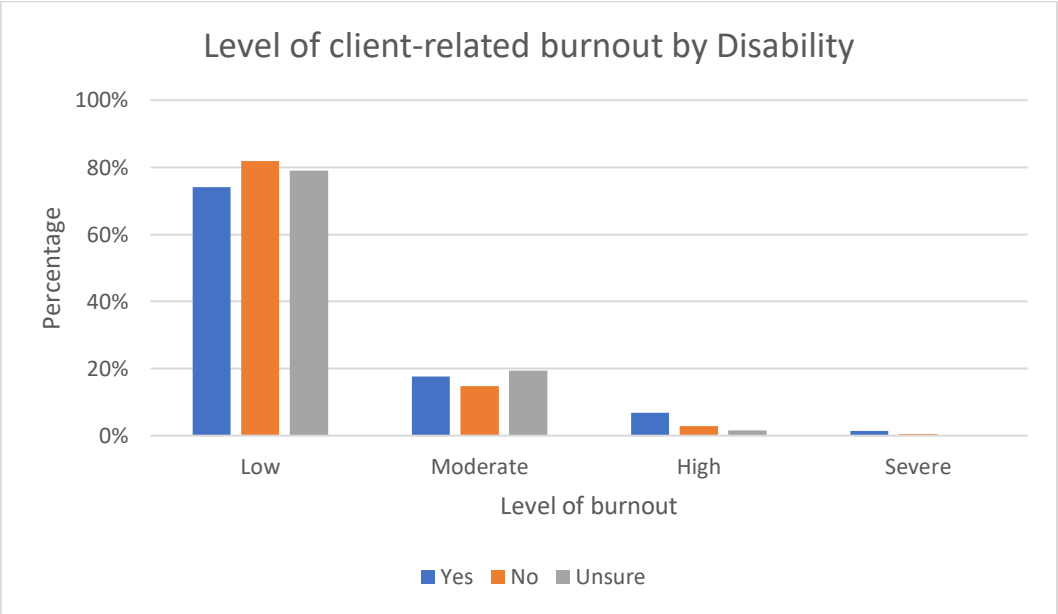


Table A5.23: Level of Burnout by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	**No**	**Unsure**
Personal burnout:			
Low	18.3%	21.7%	46.9%
Moderate	53.1%	42.2%	23.5%
High	23.8%	29.2%	29.7%
Severe	4.8%	7.0%	0.0%
Total	**100%**	**100%**	**100%**
Work-related burnout:			
Low	29.7%	27.1%	59.4%
Moderate	50.3%	46.7%	15.6%
High	18.4%	24.2%	25.0%
Severe	1.6%	2.1%	0.0%
Total	**100%**	**100%**	**100%**
Client-related burnout:			
Low	66.7%	79.5%	85.7%
Moderate	22.0%	17.9%	14.3%
High	3.1%	2.3%	0.0%
Severe	8.2%	0.2%	0.0%
Total	**100%**	**100%**	**100%**

Table A5.24: Level of Burnout by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout:			
Low	42 (13.6%)	561 (27.7%)	9 (13.4%)
Moderate	127 (41.2%)	901(44.5%)	34 (50.7%)
High	117 (38.0%)	493 (24.4%)	23 (34.3%)
Severe	22 (7.1%)	68 (3.4%)	1 (1.5%)
Total	**308 (100%)**	**2023 (100%)**	**67 (100%)**
Work-related burnout:			
Low	72 (23.5%)	698 (34.9%)	14 (21.2%)
Moderate	126 (41.2%)	804 (40.2%)	33 (50.0%)
High	96 (31.4%)	469 (23.5%)	18 (27.3%)
Severe	12 (3.9%)	27 (1.4%)	1 (1.5%)
Total	**306 (100%)**	**1998 (100%)**	**66 (100%)**
Client-related burnout:			
Low	215 (74.1%)	1539 (81.9%)	49 (79.0%)
Moderate	51 (17.6%)	279 (14.8%)	12 (19.4%)
High	20 (6.9%)	53 (2.8%)	1 (1.6%)
Severe	4 (1.4%)	8 (0.4%)	0 (0.0%)
Total	**290 (100%)**	**1879 (100%)**	**62 (100%)**

A5.7 Burnout Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences between respondents based on their main area of practice in mean personal burnout scores ($F = 11.149$, $df = 7$, $p < .001$). Specifically, respondents working in mental health scored significantly lower than those working with adults and older people; and respondents working with older people scored significantly higher than those working with children, adults, learning disability, mental health and 'other'.

There were also significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 14.753$, $df = 7$, $p < .001$). Respondents working with children scored significantly higher than those working in 'other' and those in mental health; and respondents working with older people scored significantly higher than those working in 'other' area, with adults, with those with learning disability and in the area of mental health.

Significant differences were also found in the mean client-related burnout scores ($F = 11.826$, $df = 7$, $p < .001$). Respondents working with older people scored significantly lower than those working in midwifery, with adults, learning disability and 'other'.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean personal burnout scores ($F = 3.676$, $df = 7$, $p < .001$). Specifically, respondents working in midwifery scored significantly higher than those working with adults, with those with a learning disability or those in 'other' areas.

There were significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 5.956$, $df = 7$, $p < .001$). Specifically, respondents working in midwifery scored significantly higher than those working with adults, with those with a learning disability, with older people or those in 'other' areas.

There were significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 3.483$, $df = 7$, $p = .001$). Specifically, respondents working with adults or with older people scored significantly lower than those working in mental health.

Figure A5.49: Mean Burnout Scores by Main Area of Practice (Weighted)

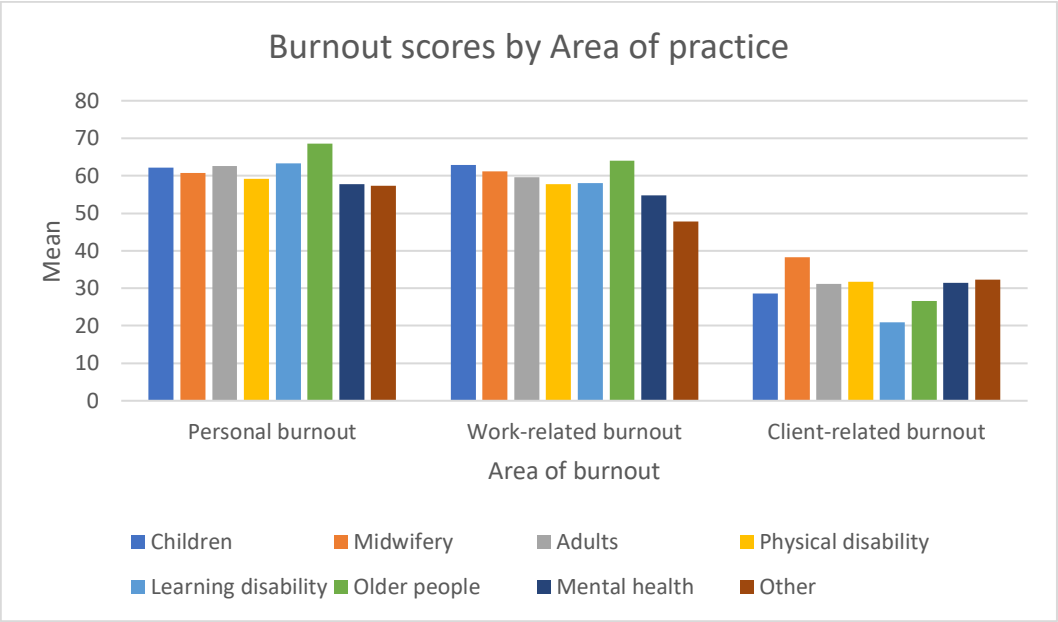


Figure A5.50: Mean Burnout Scores by Main Area of Practice (Unweighted)

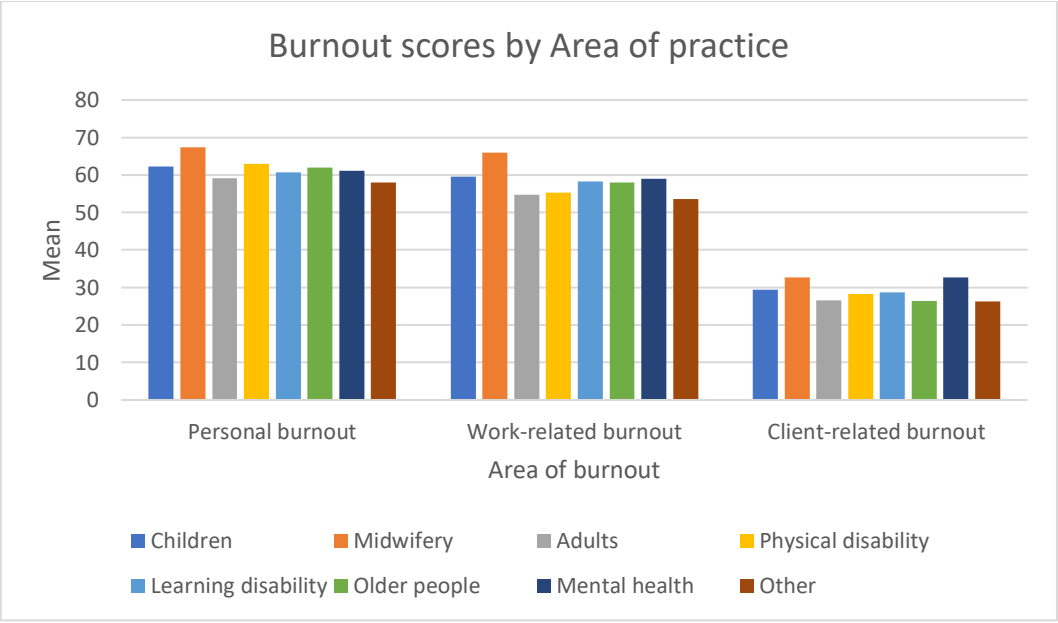


Table A5.25: Mean Burnout Scores by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout	62.22	60.75	62.58	59.14	63.33	68.61	57.70	57.33
Work-related burnout	62.92	61.18	59.54	57.77	58.04	64.05	54.78	47.79
Client-related burnout	28.65	38.21	31.15	31.69	20.94	26.55	31.4	32.34

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	62.29	67.40	59.17	62.91	60.76	62.04	61.06	58.04
Work-related burnout	59.55	65.99	54.73	55.23	58.28	57.96	59.04	53.55
Client-related burnout	29.36	32.70	26.53	28.21	28.69	26.38	32.71	26.23

Figure A5.51: Level of Personal Burnout by Main Area of Practice (Weighted)

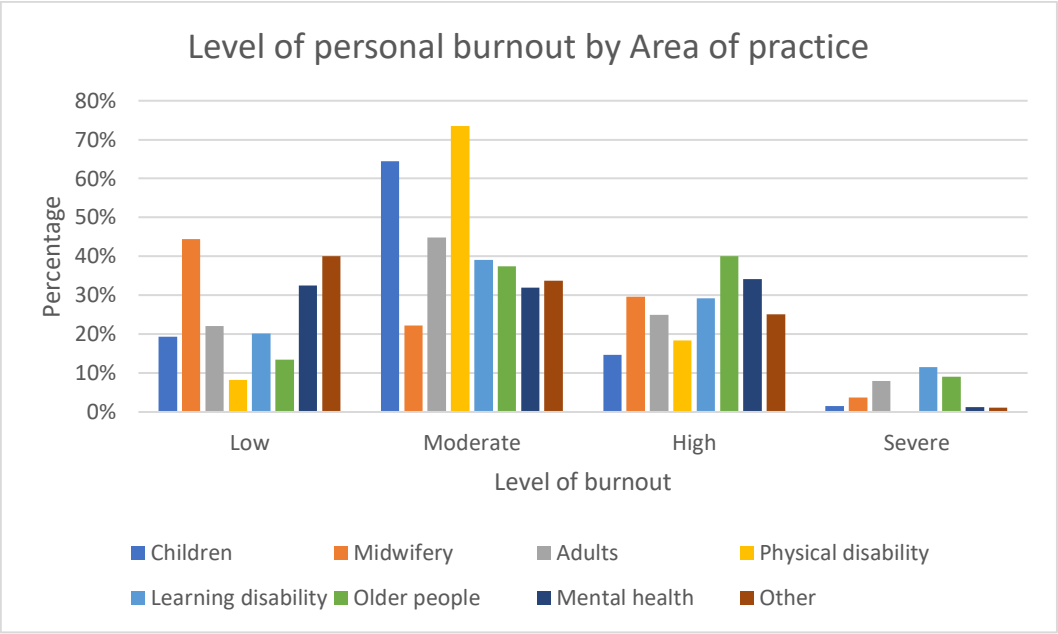


Figure A5.52: Level of Personal Burnout by Main Area of Practice (Unweighted)

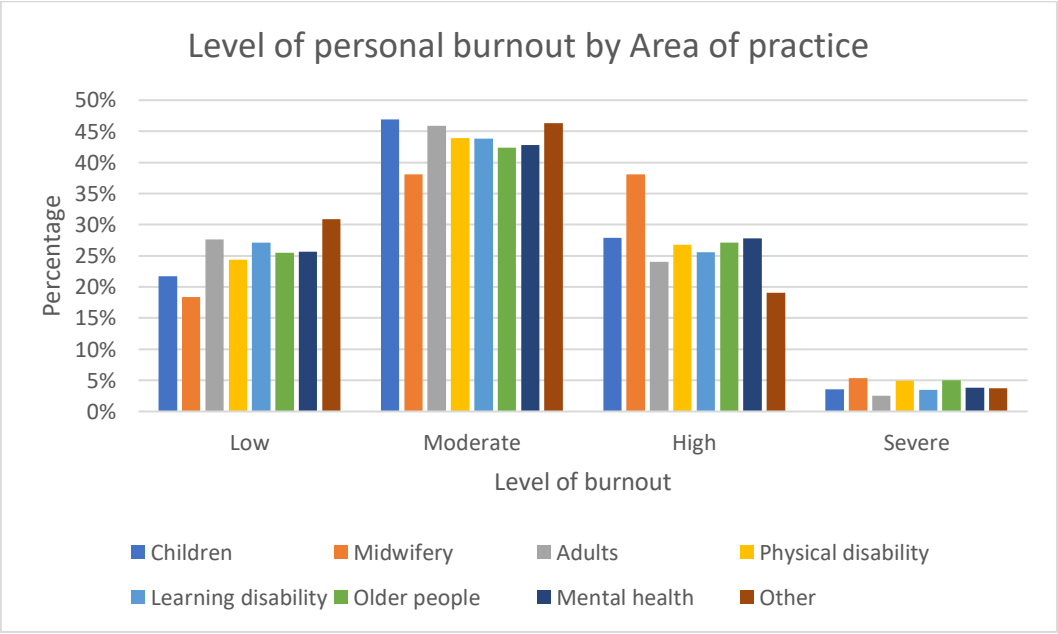


Figure A5.53: Level of Work-Related Burnout by Main Area of Practice (Weighted)

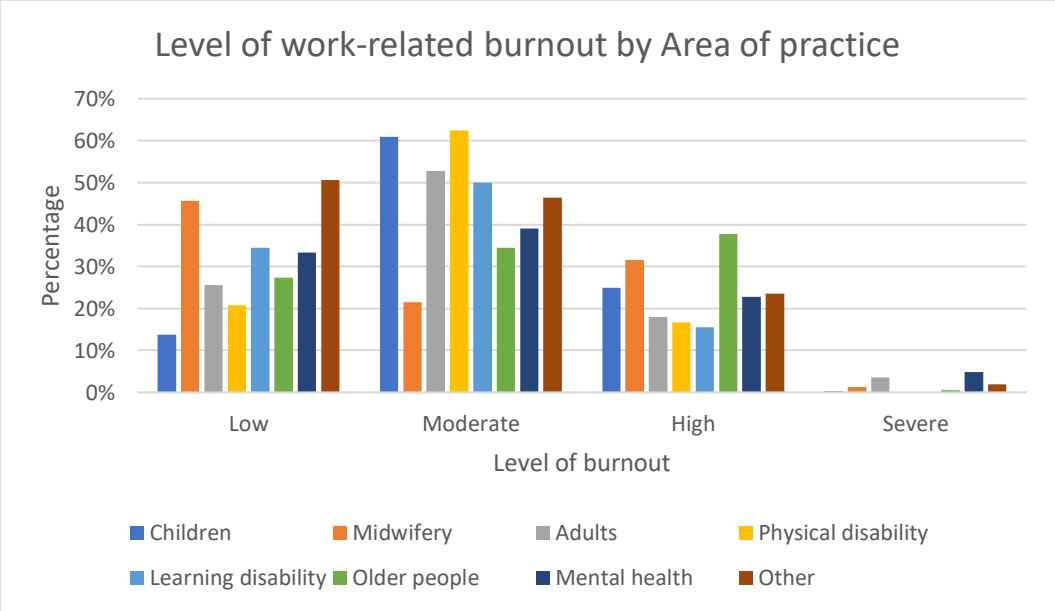


Figure A5.54: Level of Work-Related Burnout by Main Area of Practice (Unweighted)

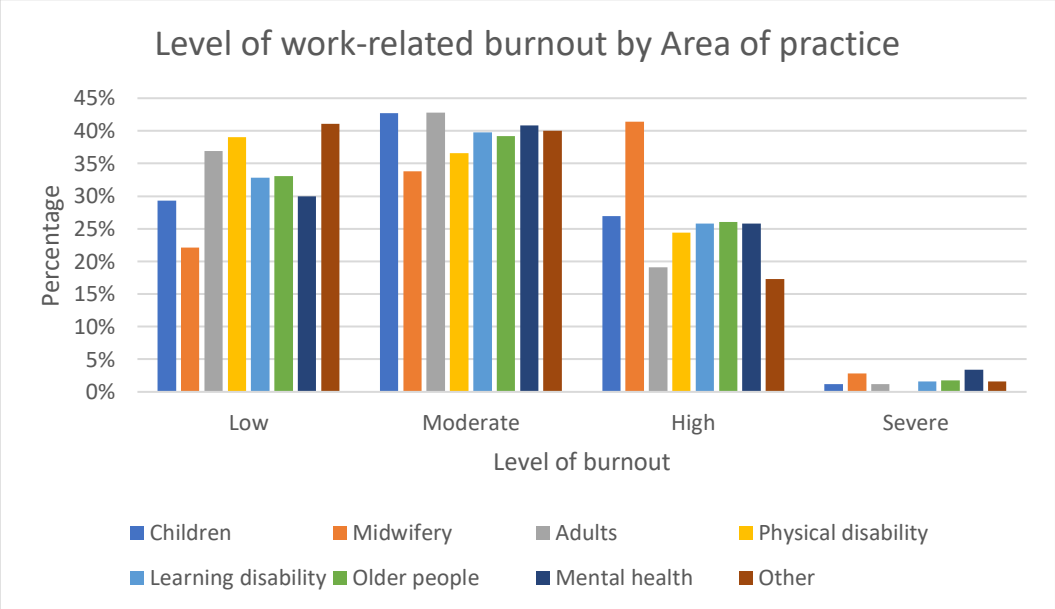


Figure A5.55: Level of Client-Related Burnout by Main Area of Practice (Weighted)

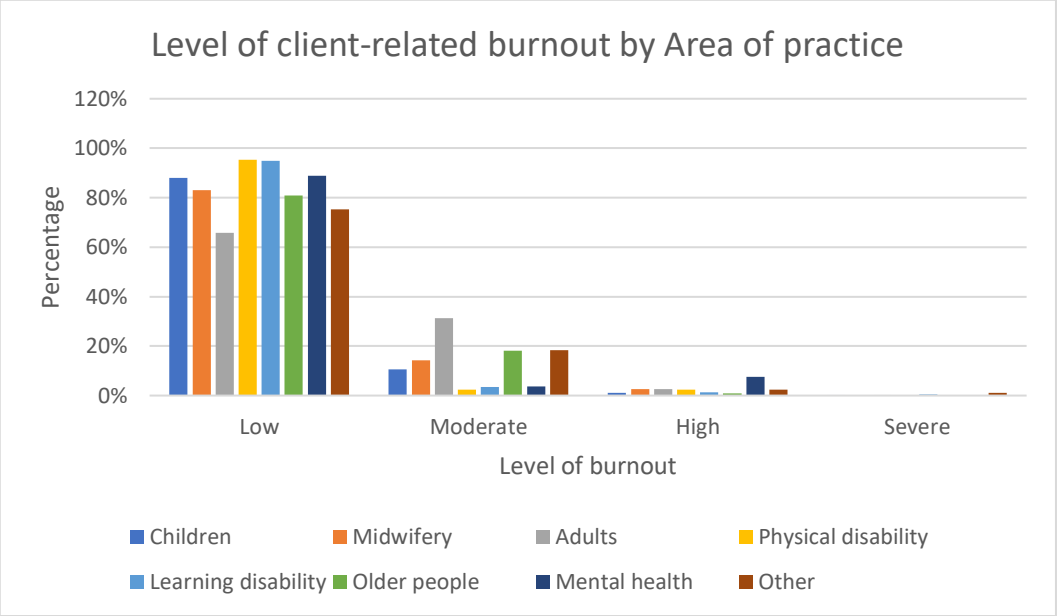


Figure A5.56: Level of Client-Related Burnout by Main Area of Practice (Unweighted)

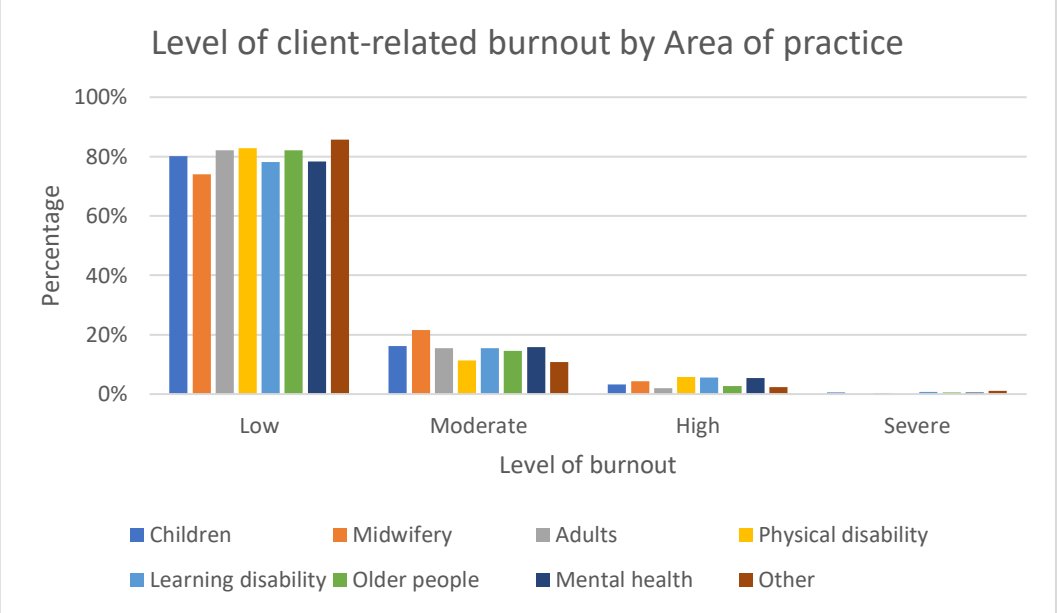


Table A5.27: Level of Burnout by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout:								
Low	19.3%	44.4%	22.1%	8.2%	20.2%	13.5%	32.5%	40.0%
Moderate	64.4%	22.2%	44.9%	73.5%	39.1%	37.4%	32.0%	33.7%
High	14.7%	29.6%	25.0%	18.4%	29.2%	40.1%	34.2%	25.1%
Severe	1.5%	3.7%	8.0%	0.0%	11.5%	9.0%	1.3%	1.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:								
Low	13.8%	45.6%	25.6%	20.8%	34.5%	27.3%	33.3%	50.6%
Moderate	60.9%	21.5%	52.8%	62.5%	50.0%	34.5%	39.0%	46.4%
High	24.9%	31.6%	17.9%	16.7%	15.5%	37.8%	22.8%	23.6%
Severe	0.3%	1.3%	3.6%	0.0%	0.0%	0.5%	4.8%	1.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:								
Low	88.1%	83.1%	65.8%	95.3%	95.0%	80.8%	88.9%	75.3%
Moderate	10.5%	14.3%	31.2%	2.3%	3.4%	18.2%	3.6%	18.3%
High	1.0%	2.6%	2.6%	2.3%	1.3%	0.8%	7.6%	2.4%
Severe	0.3%	0.0%	0.3%	0.0%	0.4%	0.2%	0.0%	1.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.28: Level of Burnout by Main Area of Practice (Unweighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout:								
Low	91 (21.7%)	27 (18.4%)	163 (27.6%)	10 (24.4%)	70 (27.1%)	132 (25.5%)	61 (25.7%)	58 (30.9%)
Moderate	197 (46.9%)	56 (38.1%)	271 (45.9%)	18 (43.9%)	113 (43.8%)	219 (42.4%)	101 (42.8%)	87 (46.3%)
High	117 (27.9%)	56 (38.1%)	142 (24.0%)	11 26.8%)	66 (25.6%)	140 (27.1%)	66 (27.8%)	36 (19.1%)
Severe	15 (3.6%)	8 (5.4%)	15 (2.5%)	2 (4.9%)	9 (3.5%)	26 (5.0%)	9 (3.8%)	7 (3.7%)
Total	**420 (100%)**	**147 (100%)**	**591 (100%)**	**41 (100%)**	**258 (100%)**	**517 (100%)**	**237 (100%)**	**188 (100%)**
Work-related burnout:								
Low	122 (29.3%)	32 (22.1%)	216 (36.9%)	16 (39.0%)	84 (32.8%)	168 (33.1%)	70 (30.0%)	76 (41.1%)
Moderate	178 (42.7%)	49 (33.8%)	251 (42.8%)	15 (36.6%)	102 (39.8%)	199 (39.2%)	95 (40.8%)	74 (40.0%)
High	112 (26.9%)	60 (41.4%)	112 (19.1%)	10 (24.4%)	66 (25.8%)	132 (26.0%)	60 (25.8%)	32 (17.3%)
Severe	5 (1.2%)	4 (2.8%)	7 (1.2%)	0 (0.0%)	4 (1.6%)	9 (1.8%)	8 (3.4%)	3 (1.6%)
Total	**417 (100%)**	**145 (100%)**	**586 (100%)**	**41 (100%)**	**256 (100%)**	**508 (100%)**	**233 (100%)**	**185 (100%)**
Client-related burnout:								
Low	313 (80.1%)	103 (74.1%)	458 (82.2%)	29 (82.9%)	186 (78.2%)	390 (82.1%)	173 (78.3%)	151 (85.8%)
Moderate	63 (16.1%)	30 (21.6%)	86 (15.4%)	4 (11.4%)	37 (15.5%)	69 (14.5%)	35 (15.8%)	19 (10.8%)
High	13 (3.3%)	(6 4.3%)	11 (2.0%)	2 (5.7%)	13 (5.5%)	13 (2.7%)	12 (5.4%)	4 (2.3%)
Severe	2 (0.5%)	0 (0.0%)	2 (0.4%)	0 (0.0%)	2 (0.8%)	3 (0.6%)	1 (0.5%)	2 (1.1%)
Total	**391 (100%)**	**139 (100%)**	**557 (100%)**	**35 (100%)**	**238 (100%)**	**475 (100%)**	**221 (100%)**	**176 (100%)**

A5.8 Burnout Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between respondents based on their line manager status in mean person burnout scores (t = 5.029, df = 2773, p < .001); line managers scored significantly higher than respondents who were not line managers.

There were significant differences between respondents based on their line manager status in mean work-related burnout scores (t = 9.281, df = 2750, p < .001); line managers scored significantly higher than respondents who were not line managers.

There were also significant differences between respondents based on their line manager status in mean client-related burnout scores (t = -5.877, df = 2581, p < .001); respondents who were line managers scored significantly lower than those who were not line managers.

Summary (Unweighted results):

There were significant differences between respondents based on their line manager status in mean personal burnout scores (t = -.200, df = 2397, p < .001); line managers scored significantly lower than respondents who were not line managers.

There were significant differences between respondents based on their line manager status in mean work-related burnout scores (t = 2.924, df = 2750, p = .003); line managers scored significantly higher than respondents who were not line managers.

There were also significant differences between respondents based on their line manager status in mean client-related burnout scores (t = -3.509, df = 2230, p < .001); respondents who were line managers scored significantly lower than those who were not line managers.

Figure A5.57: Mean Burnout Scores by Line Manager Status (Weighted)

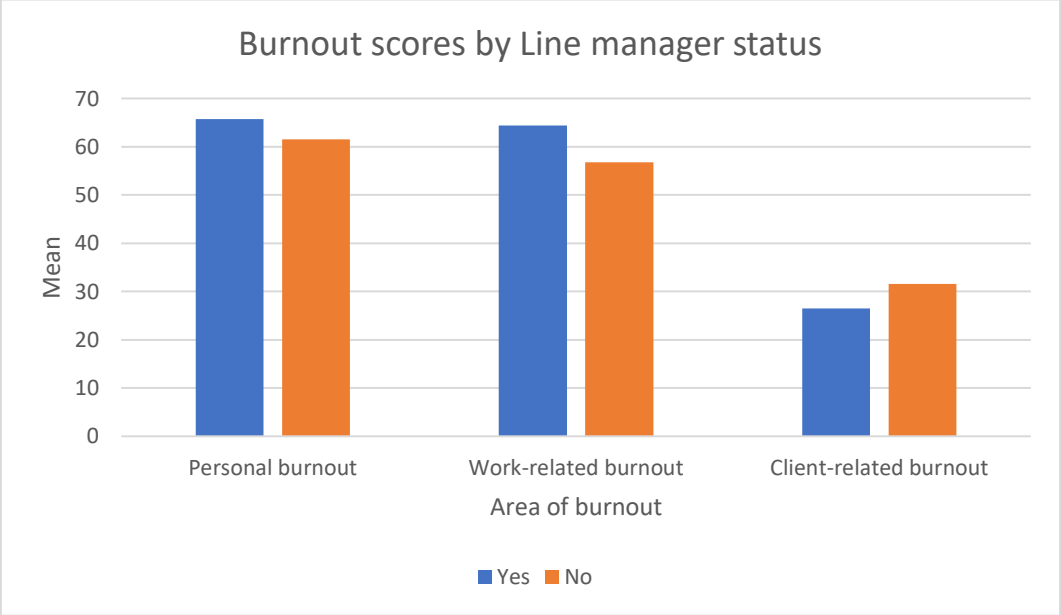


Figure A5.58: Mean Burnout Scores by Line Manager Status (Unweighted)

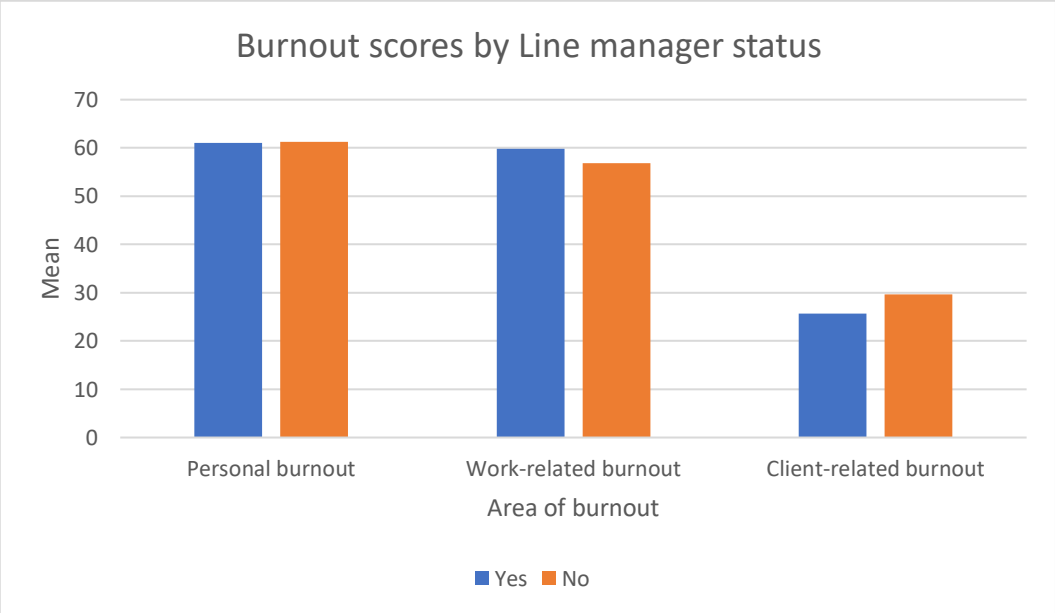


Table A5.29: Mean Burnout Scores by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	65.71	61.57
Work-related burnout	64.42	56.75
Client-related burnout	26.46	31.52

Table A5.30: Mean Burnout Scores by Line Manager Status (Unweighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	61.04	61.23
Work-related burnout	59.80	56.83
Client-related burnout	25.66	29.62

Figure A5.59: Level of Personal Burnout by Line Manager Status (Weighted)

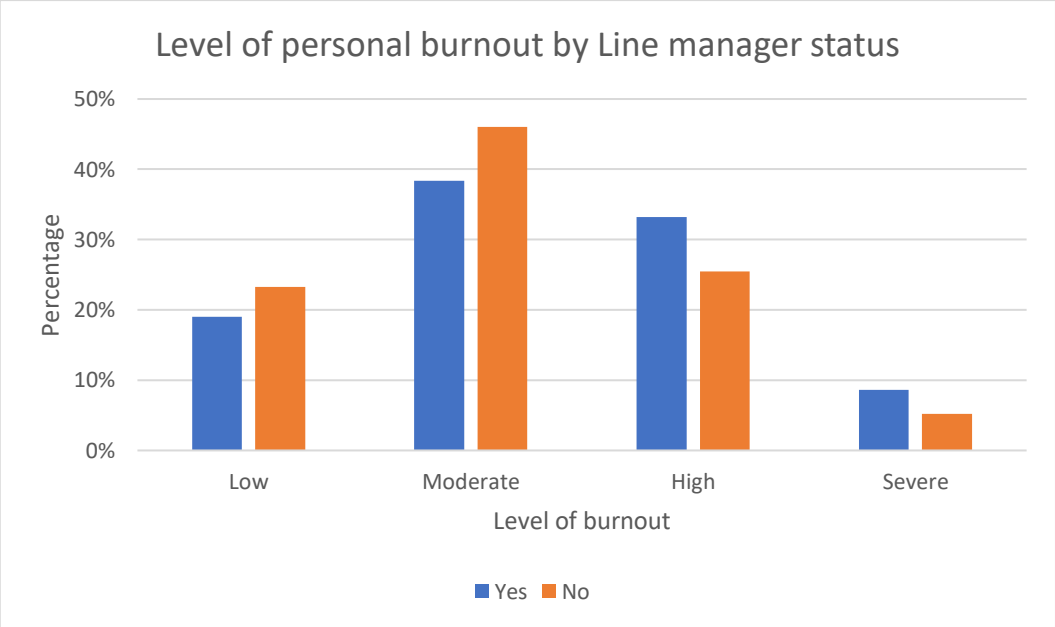


Figure A5.60: Level of Personal Burnout by Line Manager Status (Unweighted)

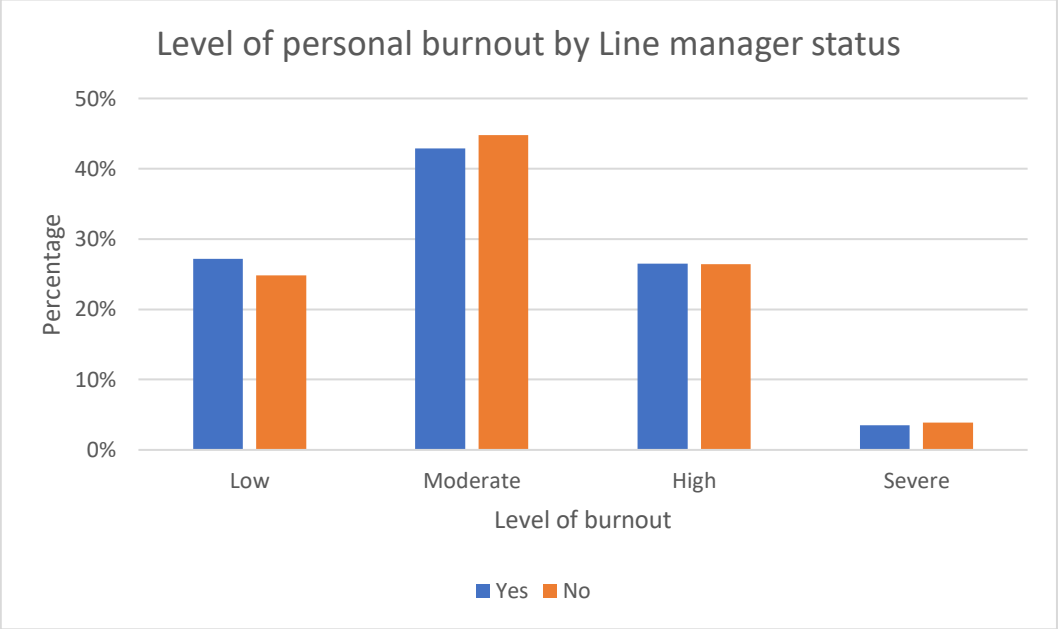


Figure A5.61: Level of Work-Related Burnout by Line Manager Status (Weighted)

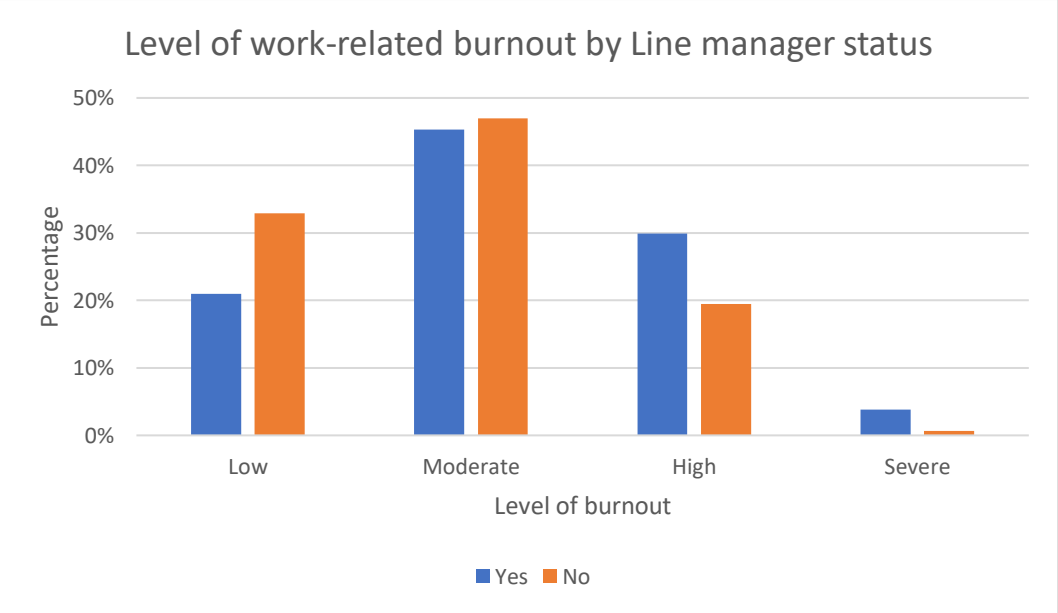


Figure A5.62: Level of Work-Related Burnout by Line Manager Status (Unweighted)

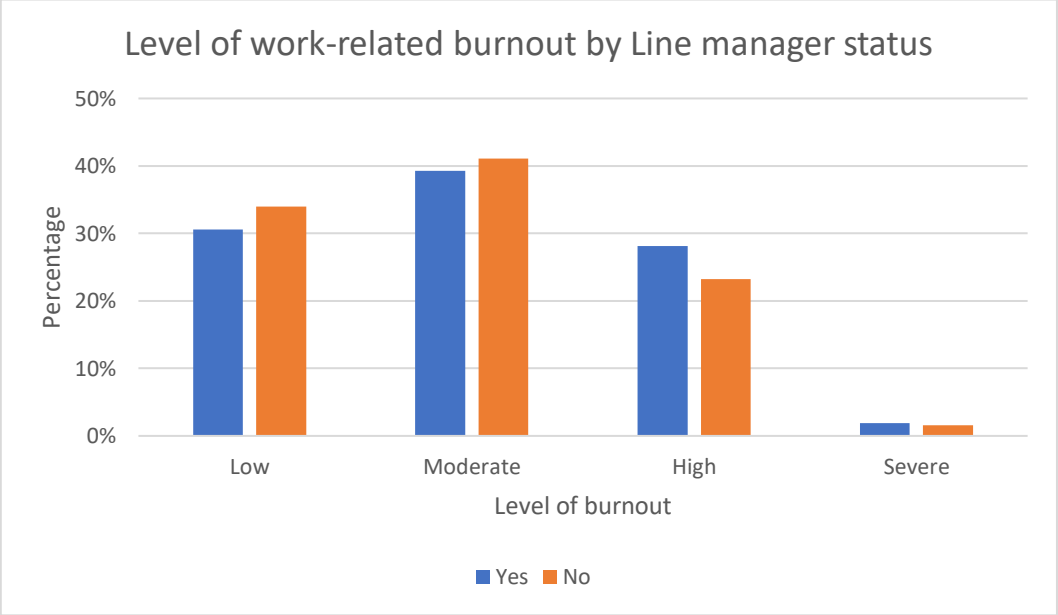


Figure A5.63: Level of Client-Related Burnout by Line Manager Status (Weighted)

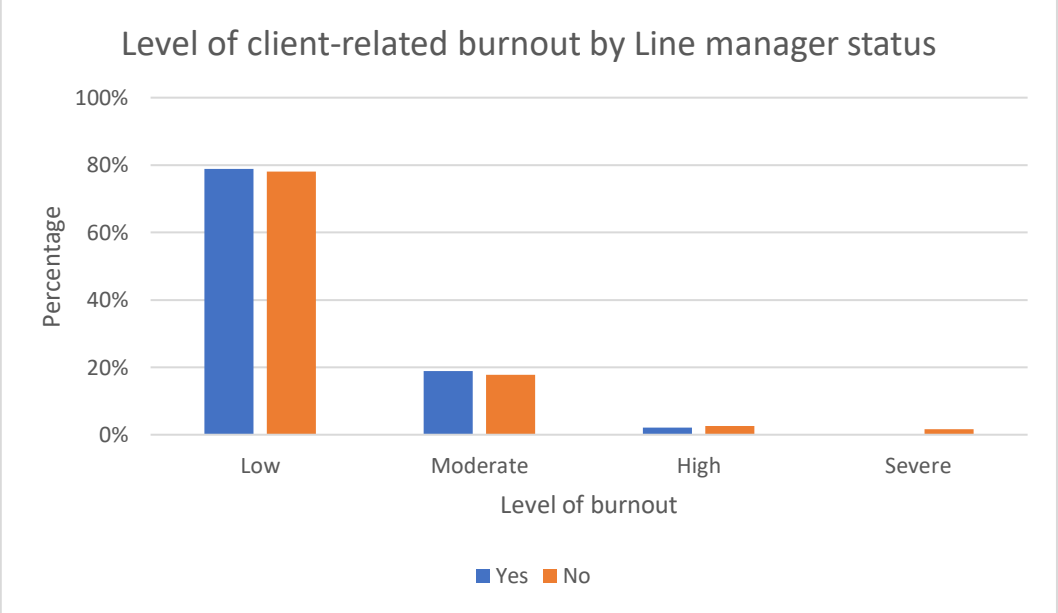


Figure A5.64: Level of Client-Related Burnout by Line Manager Status (Unweighted)

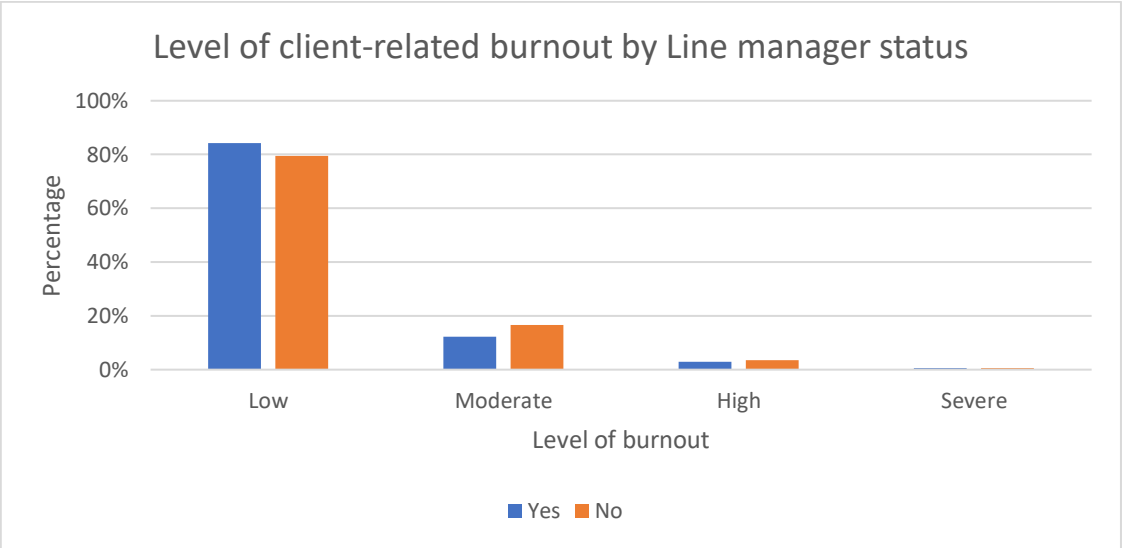


Table A5.31: Level of Burnout by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout:		
Low	19.0%	23.3%
Moderate	38.4%	46.0%
High	33.2%	25.5%
Severe	8.6%	5.2%
TOTAL	**100%**	**100%**
Work-related burnout:		
Low	21.0%	32.9%
Moderate	45.3%	47.0%
High	29.9%	19.5%
Severe	3.8%	0.7%
TOTAL	**100%**	**100%**
Client-related burnout:		
Low	78.9%	78.1%
Moderate	18.9%	17.8%
High	2.1%	2.6%
Severe	0.1%	1.6%
TOTAL	**100%**	**100%**

Table A5.32: Level of Burnout by Line Manager Status (Unweighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout:		
Low	187 (27.2%)	425 (24.8%)
Moderate	295 (42.9%)	767 (44.8%)
High	182 (26.5%)	452 (26.4%)
Severe	24 (3.5%)	67 (3.9%)
TOTAL	**688 (100%)**	**1711 (100%)**
Work-related burnout:		
Low	209 (30.6%)	576 (34.0%)
Moderate	267 (39.3%)	696 (41.1%)
High	13 (28.1%)	393 (23.2%)
Severe	679 (1.9%)	27 (1.6%)
TOTAL	**679 (100%)**	**1692 (100%)**
Client-related burnout:		
Low	542 (84.3%)	1261 (79.4%)
Moderate	79 (12.3%)	264 (16.6%)
High	19 (3.0%)	55 (3.5%)
Severe	3 (0.5%)	9 (0.6%)
TOTAL	**643 (100%)**	**1589 (100%)**

A5.9 Burnout Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean personal burnout scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 193.422$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact.

There were also significant differences in mean work-related burnout scores between respondents who experienced different levels of pressure on their service due to the COVID-19 pandemic ($F = 209.382$, $df = 2$, $p < .001$). Those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact.

Significant differences in mean client-related burnout scores between respondents were also found ($F = 22.510$, $df = 2$, $p < .001$). Those who felt overwhelmed by increased pressures scored significantly higher than the other two groups.

Summary (Unweighted results):

There were significant differences in personal burnout scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 169.186$, $df = 2$, $p < .001$). 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 ($F = 223.856$, $df = 2$, $p < .001$). 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 in client-related burnout scores between respondents who experienced different levels of pressure on their service were also found ($F = 31.380$, $df = 2$, $p < .001$). 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)

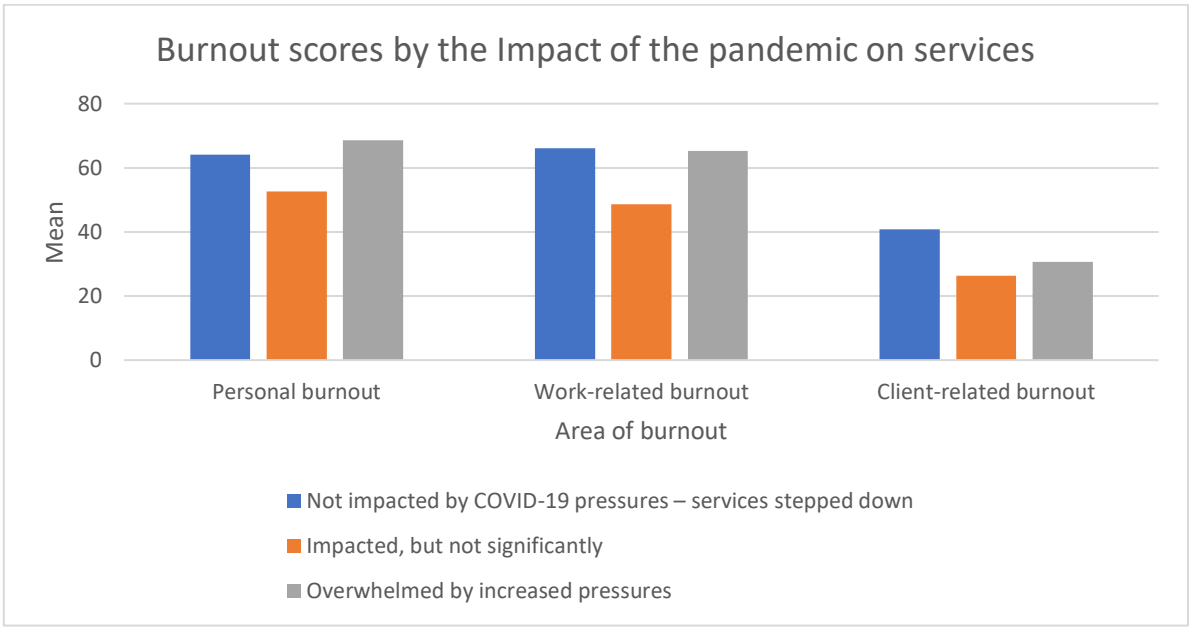


Figure A5.66: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

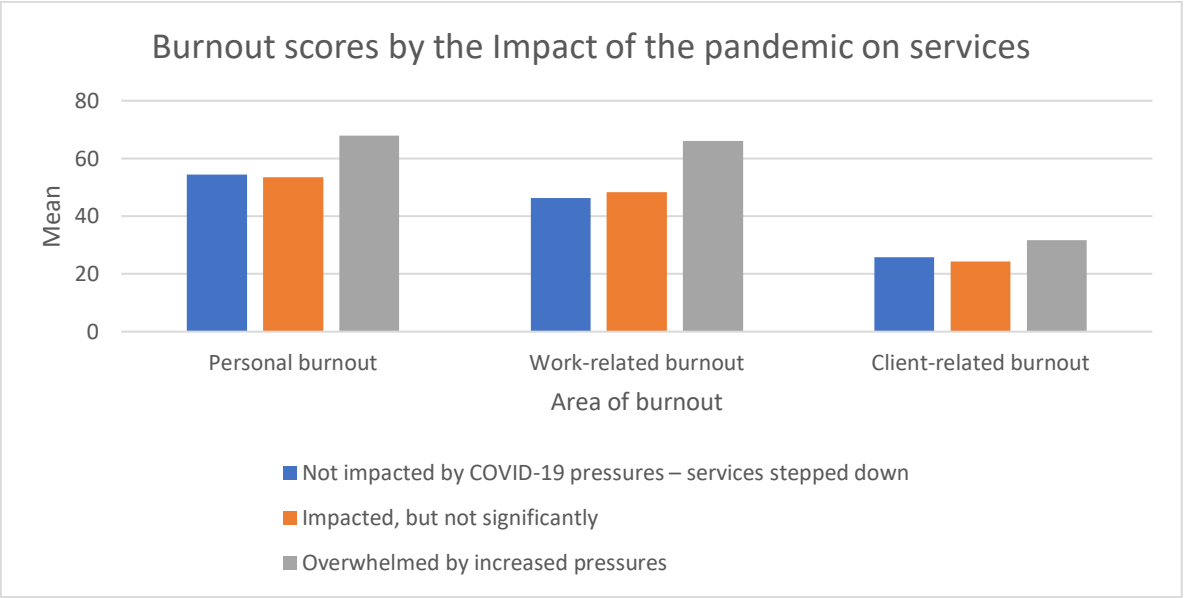


Table A5.33: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

	Impact of the pandemic on services		
Burnout	**Not impacted by COVID-19 pressures – services stepped down**	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Personal burnout	64.05	52.68	68.66
Work-related burnout	66.02	48.64	65.26
Client-related burnout	40.83	26.28	30.61

Table A5.34: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

	Impact of the pandemic on services		
Burnout	**Not impacted by COVID-19 pressures – services stepped down**	**Impacted, but not significantly**	**Overwhelmed by increased pressures**
Personal burnout	54.51	53.52	67.87
Work-related burnout	46.23	48.33	66.05
Client-related burnout	25.83	24.24	31.62

Figure A5.67: Level of Personal Burnout by the Impact of the Pandemic on Services (Weighted)

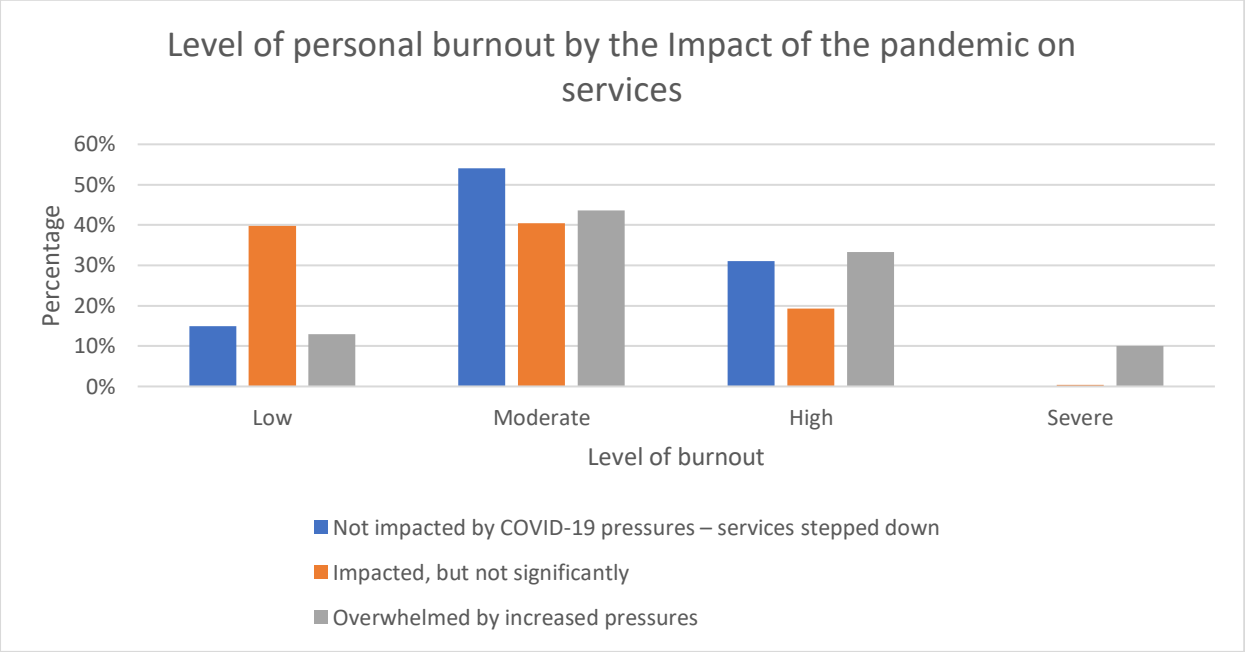


Figure A5.68: Level of Personal Burnout by the Impact of the Pandemic on Services (Unweighted)

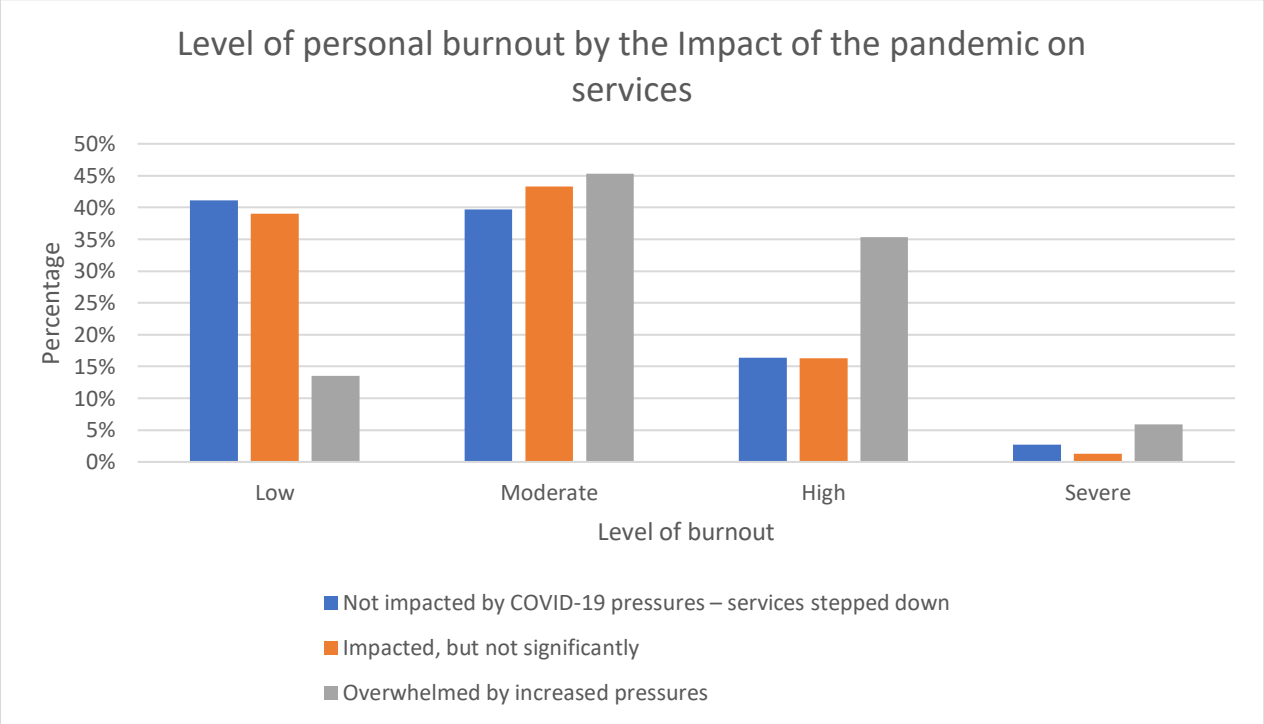


Figure A5.69: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Weighted)

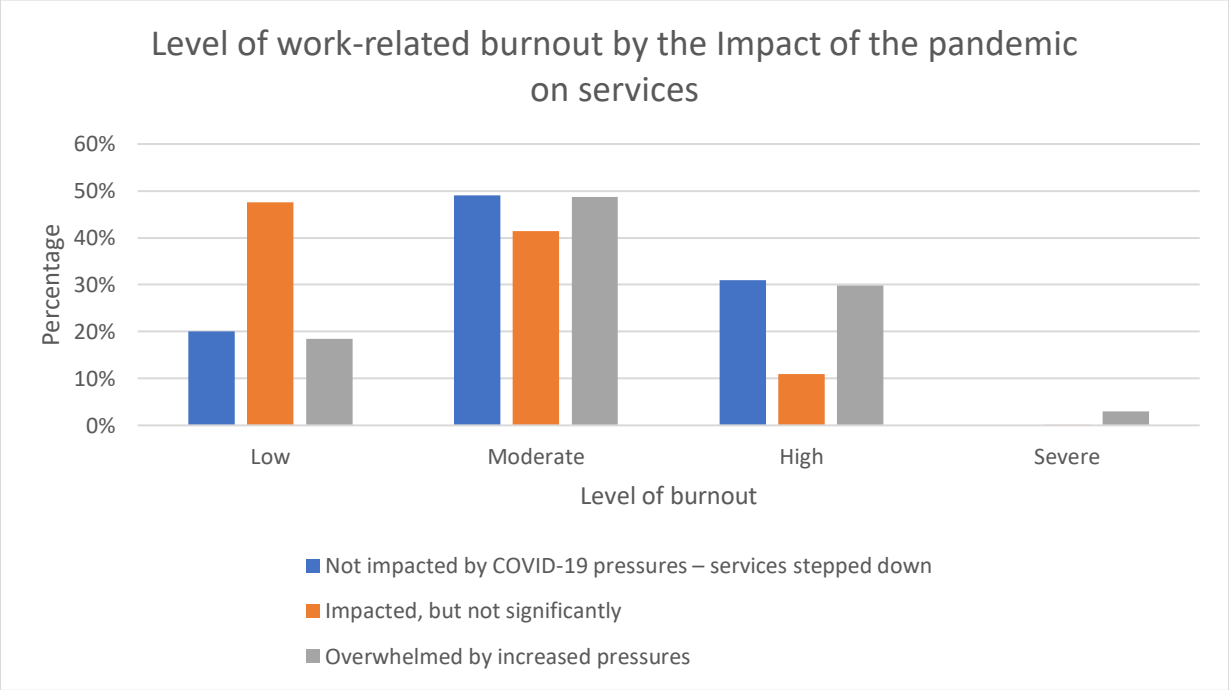


Figure A5.70: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

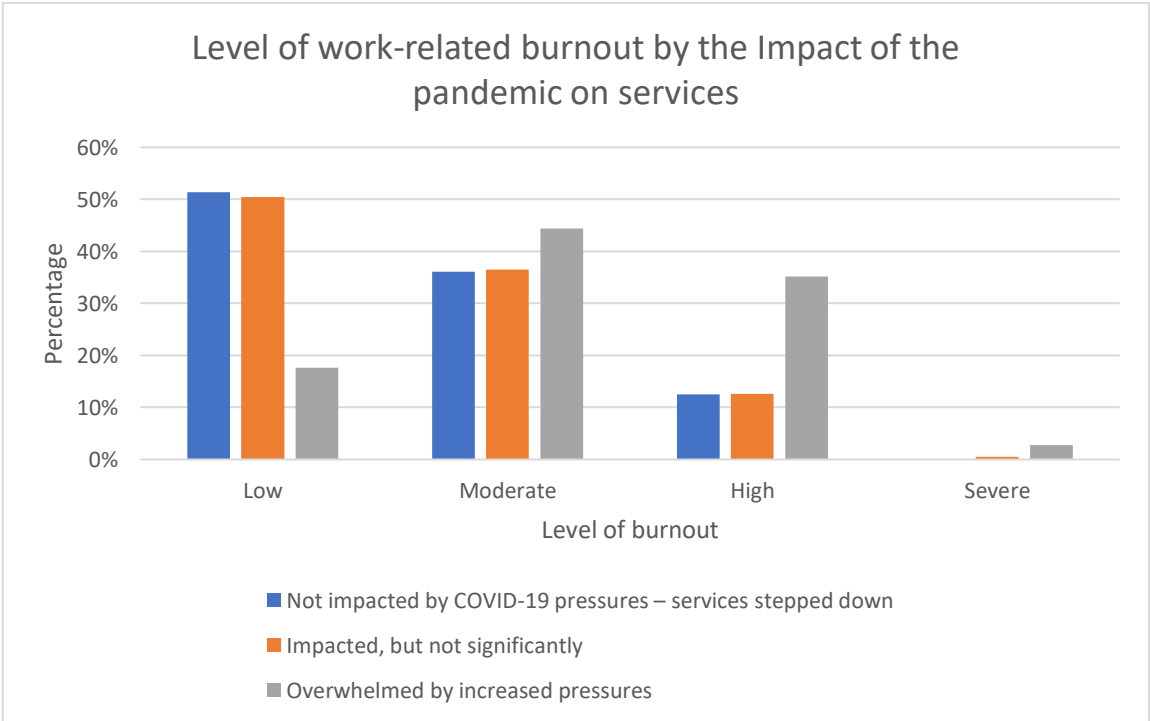


Figure A5.71: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Weighted)

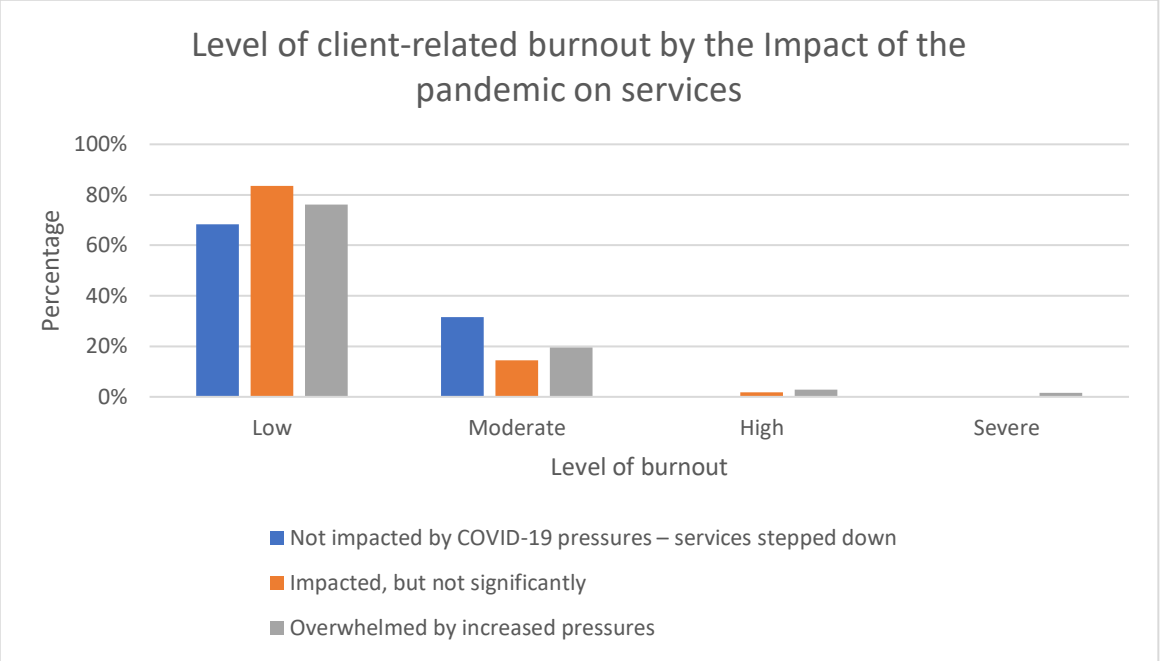


Figure A5.72: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

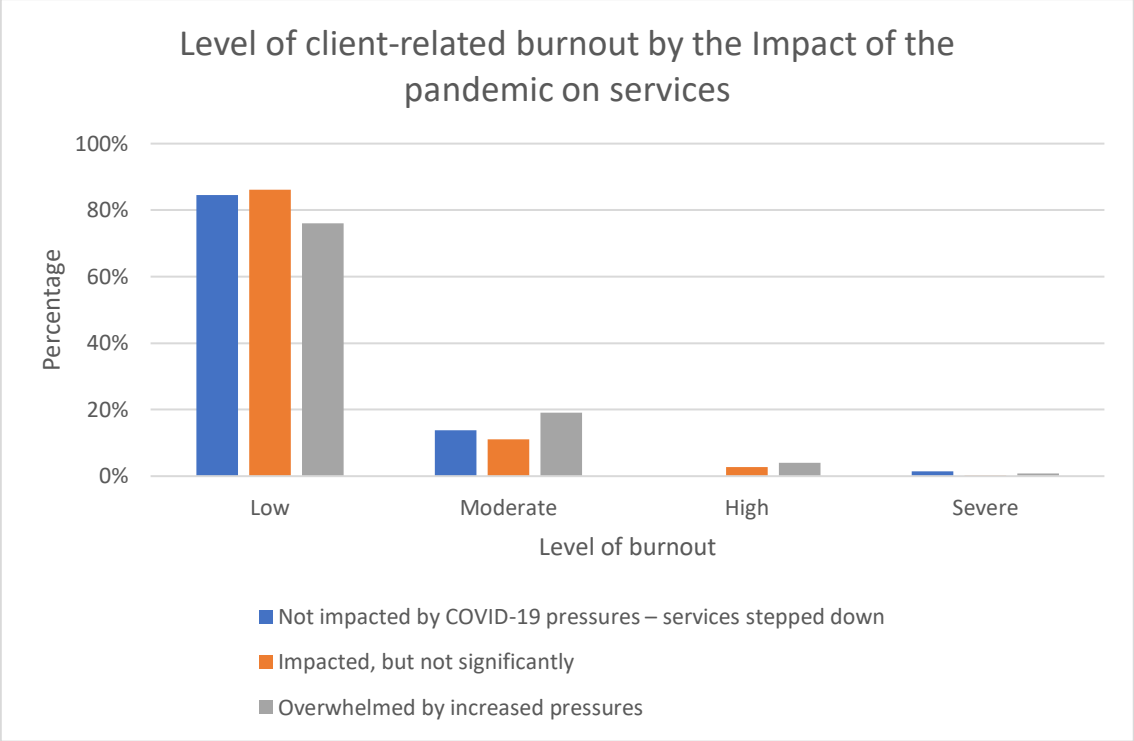


Table A5.35: Level of Burnout by the Impact of the Pandemic on Services (Weighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout:			
Low	15.0%	39.8%	13.0%
Moderate	54.0%	40.4%	43.6%
High	31.0%	19.3%	33.3%
Severe	0.0%	0.4%	10.1%
TOTAL	**100%**	**100%**	**100%**
Work-related burnout:			
Low	20.0%	47.6%	18.4%
Moderate	49.0%	41.4%	48.7%
High	31.0%	10.9%	29.8%
Severe	0.0%	0.1%	3.0%
TOTAL	**100%**	**100%**	**100%**
Client-related burnout:			
Low	68.4%	83.6%	76.2%
Moderate	31.6%	14.5%	19.6%
High	0.0%	1.8%	2.8%
Severe	0.0%	0.1%	1.5%
TOTAL	**100%**	**100%**	**100%**

Table A5.36: Level of Burnout by the Impact of the Pandemic on Services (Unweighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout:			
Low	30 (41.1%)	406 (39.0%)	173 (13.5%)
Moderate	29 (39.7%)	451 (43.3%)	579 (45.3%)
High	12 (16.4%)	170 (16.3%)	452 (35.3%)
Severe	2 (2.7%)	14 (1.3%)	75 (5.9%)
TOTAL	**73 (100%)**	**1041 (100%)**	**1279 (100%)**
Work-related burnout:			
Low	37 (51.4%)	519 (50.4%)	223 (17.6%)
Moderate	26 (36.1%)	376 (36.5%)	561 (44.4%)
High	9 (12.5%)	130 (12.6%)	445 (35.2%)
Severe	0 (0.0%)	5 (0.5%)	35 (2.8%)
TOTAL	**72 (100%)**	**1030 (100%)**	**1264 (100%)**
Client-related burnout:			
Low	55 (84.5%)	840 (86.1%)	903 (76.1%)
Moderate	9 (13.8%)	108 (11.1%)	226 (19.1%)
High	0 (0.0%)	26 (2.7%)	48 (4.0%)
Severe	1 (1.5%)	2 (0.2%)	9 (0.8%)
TOTAL	**65 (100%)**	**976 (100%)**	**1186 (100%)**

A5.10 Burnout Scores by Working from home.

Summary (Weighted results):

There were significant differences in mean personal burnout scores between respondents working from home or not during the COVID-19 pandemic ($F = 27.564$, $df = 2$, $p < .001$). Specifically, those who worked at home all of the time had significantly lower personal burnout scores than those who worked from home some of the time or not at all.

There were also significant differences in mean work-related burnout scores between respondents working from home or not during the COVID-19 pandemic ($F = 19.254$, $df = 2$, $p < .001$). Specifically,

those who worked at home all of the time had significantly lower personal burnout scores than those who worked from home some of the time or not at all.

Significant differences in mean client-related burnout scores between respondents working from home or not during the COVID-19 pandemic were also found ($F = 9.666$, $df = 2$, $p < .001$). Those who worked at home all of the time had significantly lower personal burnout scores than those who worked from home some of the time or not at all.

Summary (Unweighted results):

There were no significant differences in personal burnout scores respondents working from home or not during the COVID-19 pandemic (($F = 2.372$, $df = 2$, $p > .05$).

There were also no significant differences in work-related burnout scores respondents working from home or not during the COVID-19 pandemic (($F = 2.696$, $df = 2$, $p > .05$) or in client burnout scores respondents working from home or not during the COVID-19 pandemic ($F = .482$, $df = 2$, $p > .05$).

Figure A5.73: Mean Burnout Scores by Working from Home (Weighted)

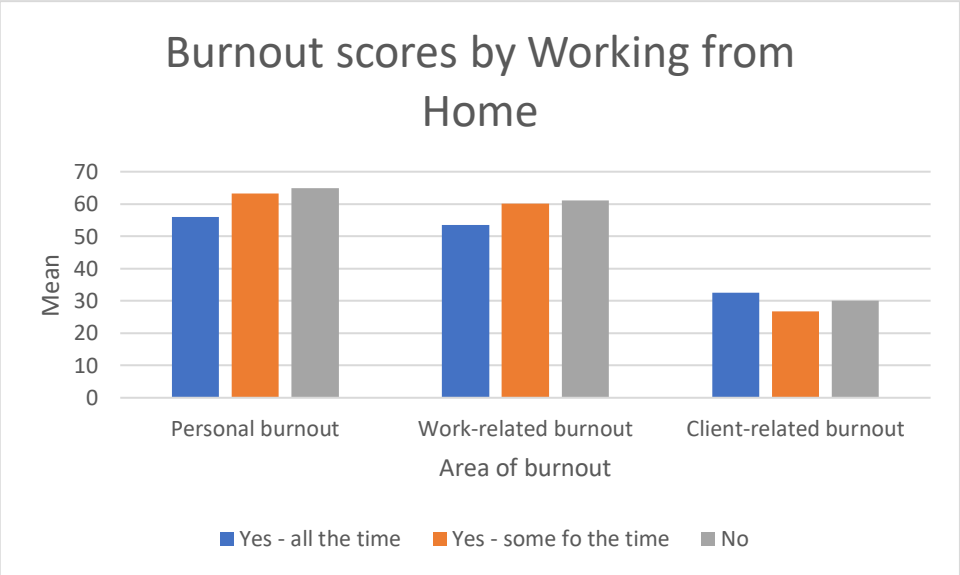


Figure A5.74: Mean Burnout Scores by Working from Home (Unweighted)

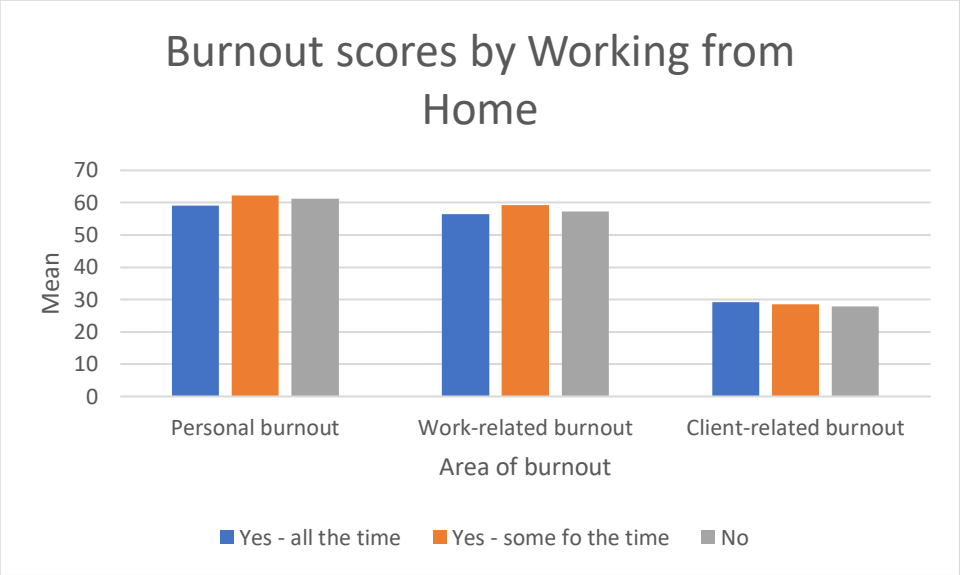


Table A5.37: Mean Burnout Scores by Working from Home (Weighted)

	Are you working from home?		
Burnout	**Yes – all of the time**	**Yes – some of the time**	**No**
Personal burnout	55.90	63.21	64.88
Work-related burnout	53.46	60.18	61.08
Client-related burnout	32.52	26.73	30.01

Table A5.38: Mean Burnout Scores by Working from Home (Unweighted)

	Are you working from home?		
Burnout	**Yes – all of the time**	**Yes – all of the time**	**Yes – all of the time**
Personal burnout	59.11	62.21	61.17
Work-related burnout	56.38	59.30	57.20
Client-related burnout	29.12	28.57	27.87

Figure A5.75: Level of Personal Burnout by Working from Home (Weighted)

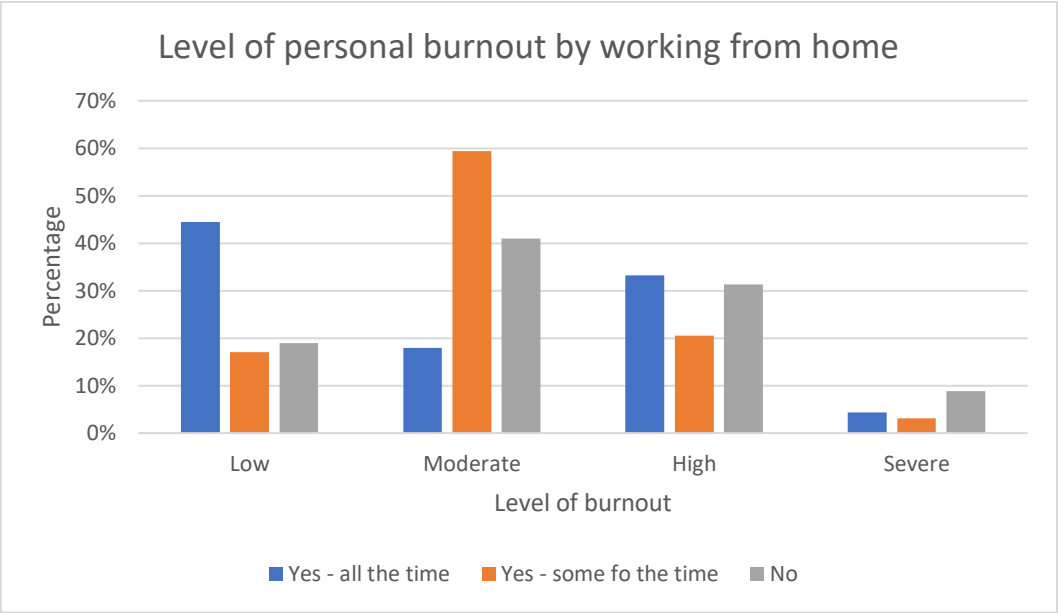


Figure A5.76: Level of Personal Burnout by Working from Home (Unweighted)

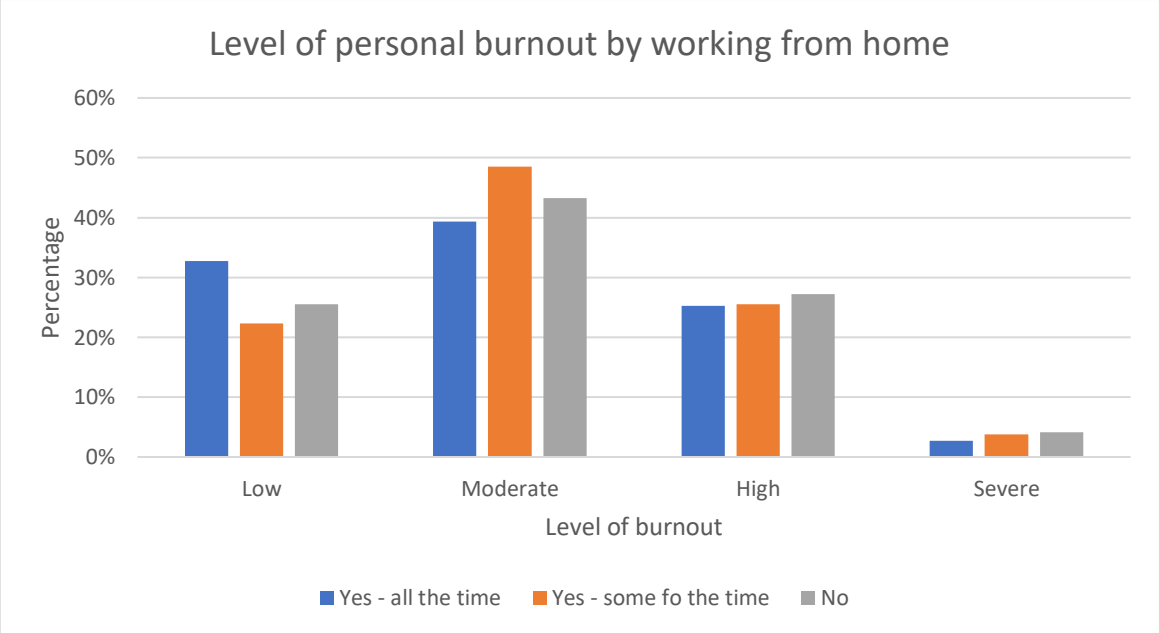


Figure A5.77: Level of Work-Related Burnout by Working from Home (Weighted)

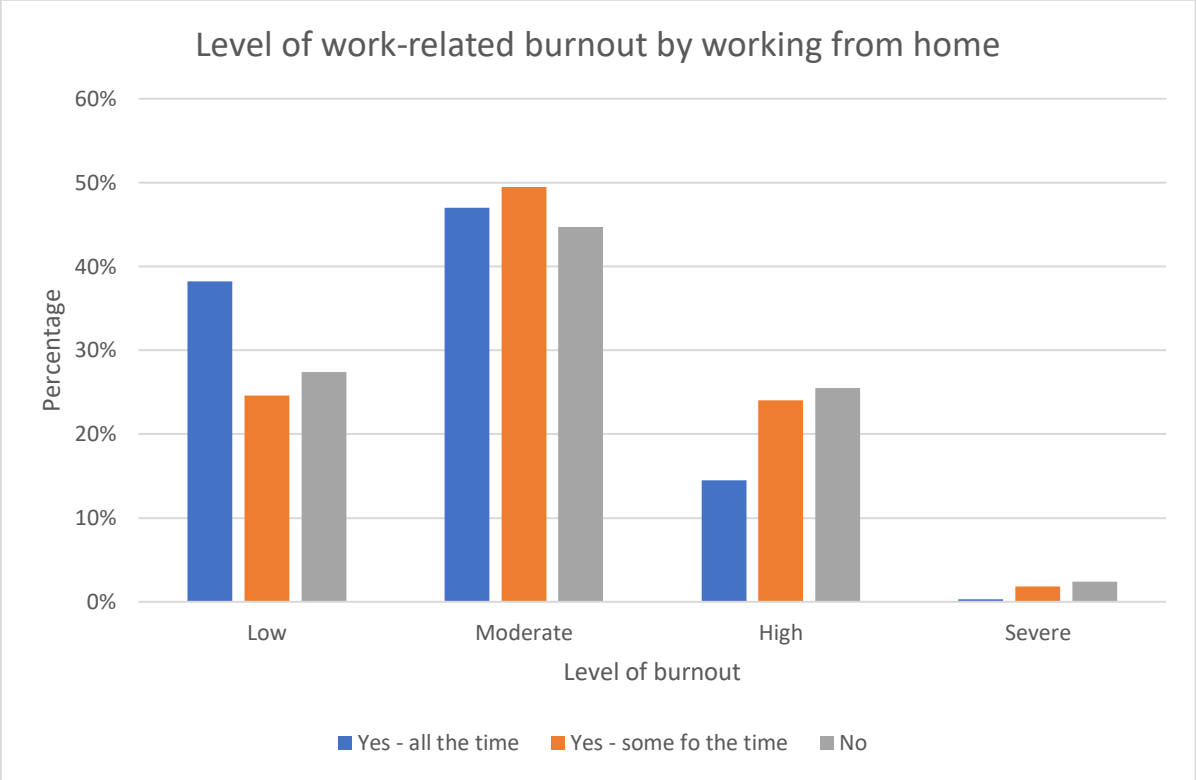


Figure A5.78: Level of Work-Related Burnout by Working from Home (Unweighted)

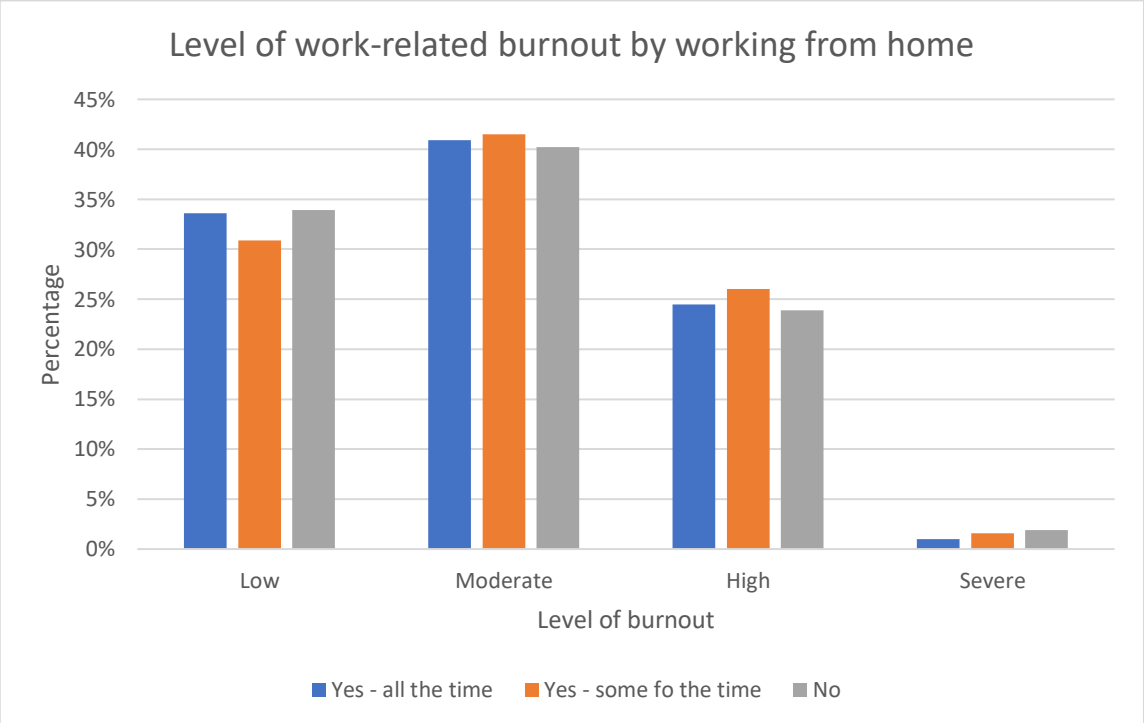


Figure A5.79: Level of Client-Related Burnout by Working from Home (Weighted)

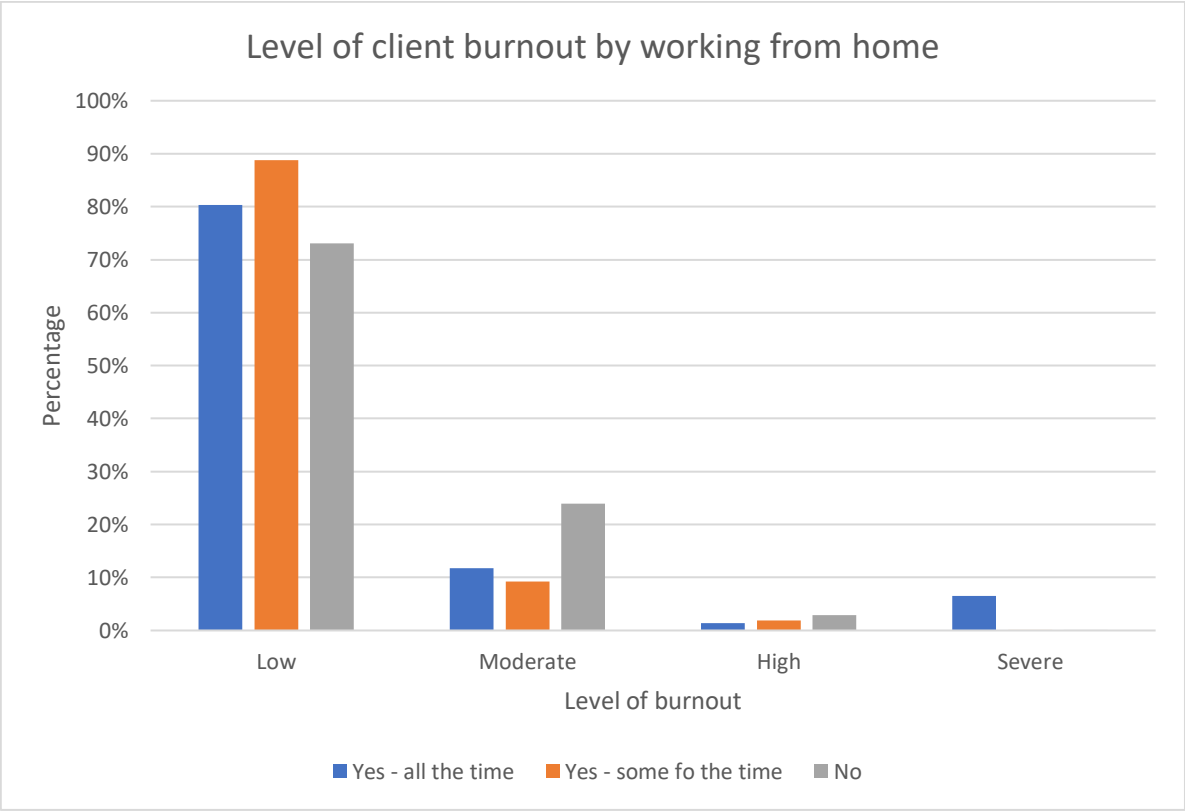


Figure A5.80: Level of Client-Related Burnout by Working from Home (Unweighted)

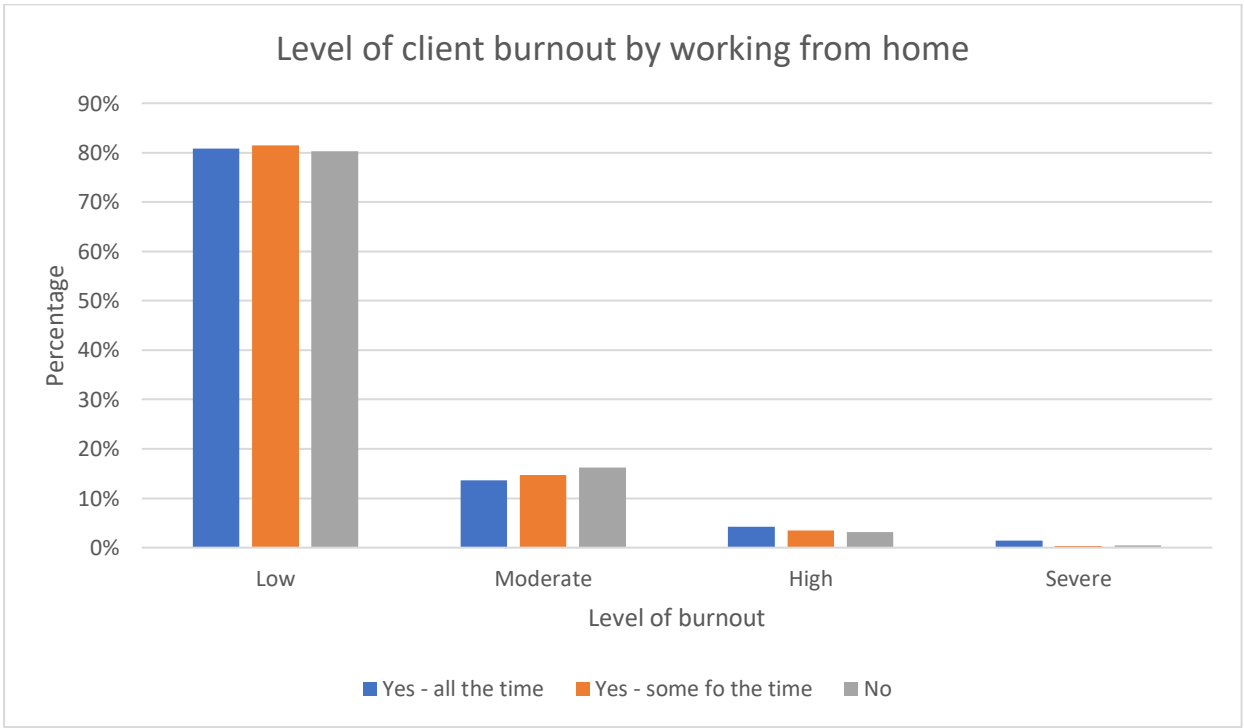


Table A5.39: Level of Burnout by Working from Home (Weighted)

Burnout	Are you working from home?		
	Yes – all of the time	Yes – some of the time	No
Personal burnout:			
Low	44.5%	17.0%	19.0%
Moderate	18.0%	59.4%	41.0%
High	33.2%	20.5%	31.3%
Severe	4.3%	3.1%	8.8%
TOTAL	**100%**	**100%**	**100%**
Work-related burnout:			
Low	38.2%	24.6%	27.4%
Moderate	47.0%	49.5%	44.7%
High	14.5%	24.0%	25.5%
Severe	0.3%	1.8%	2.4%
TOTAL	**100%**	**100%**	**100%**
Client-related burnout:			
Low	80.3%	88.8%	73.1%
Moderate	11.8%	9.2%	23.9%
High	1.4%	1.9%	2.9%
Severe	6.5%	0.1%	0.1%
TOTAL	**100%**	**100%**	**100%**

Table A5.40: Level of Burnout by the Impact of the Pandemic on Services (Unweighted)

Burnout	Are you working from home?		
	Yes – all of the time	Yes – some of the time	No
Personal burnout:			
Low	98 (32.7%)	159 (22.3%)	351 (25.5%)
Moderate	118 (39.3%)	346 (48.5%)	596 (43.3%)
High	76 (25.3%)	182 (25.5%)	374 (27.2%)
Severe	8 (2.7%)	27 (3.8%)	56 (4.1%)
TOTAL	**300 (100%)**	**714 (100%)**	**1377 (100%)**
Work-related burnout:			
Low	100 (33.6%)	219 (30.9%)	460 (33.9%)
Moderate	122(40.9%)	294 (41.5)	546 (40.2%)
High	73 (24.5%)	184 (26.0%)	325 (23.9%)
Severe	3 (1.0%)	11 (1.6%)	26 (1.9%)
TOTAL	**298 (100%)**	**708 (100%)**	**1357 (100%)**
Client-related burnout:			
Low	231 (80.8%)	543 (81.5%)	1023 (80.3%)
Moderate	39 (13.6%)	98 (14.7%)	206 (16.2%)
High	12 (4.2%)	23 (3.5%)	39 (3.1%)
Severe	4 (1.4%)	2 (0.3%)	6 (0.5%)
TOTAL	**286 (100%)**	**666 (100%)**	**1186 (100%)**

A3.11 Burnout Scores by Vaccination uptake

Summary (Weighted results):

There were significant differences in personal burnout scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = 20.669$, $df = 4$, $p < .001$). Specifically, respondents who had both doses had reported higher personal burnout that those who had not yet received the vaccine and those who reported no – other. Those who had received one vaccination had significantly higher personal burnout than those who had both doses and those who had yet to receive a dose.

There were significant differences in work-related burnout scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = 4.982$, $df = 4$, $p = .001$). Specifically, respondents who had both doses had reported higher work-related burnout that those who had not yet received the vaccine and those who reported no – other.

There were significant differences in client burnout scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = 4.982$, $df = 4$, $p = .001$). Specifically, respondents who had both doses had reported higher client related burnout than those who had not yet received the vaccine and those who reported no – other.

Summary (Unweighted results):

There were no significant differences in personal burnout scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = .892$, $df = 4$, $p > .05$).

There were no significant differences in work-related burnout scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = 1.104$, $df = 4$, $p > .05$).

There were also no significant differences in client burnout scores between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other) during COVID-19 ($F = 1.131$, $df = 4$, $p > .05$).

Figure A3.27: Mean Burnout Scores by vaccination uptake (Weighted)

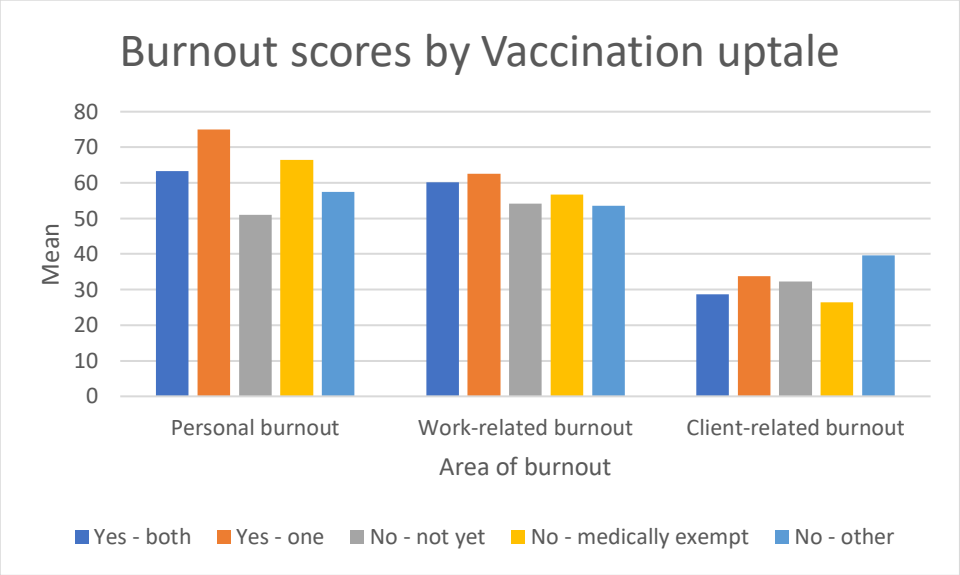


Figure A3.28: Mean Burnout Scores by vaccination uptake (Unweighted)

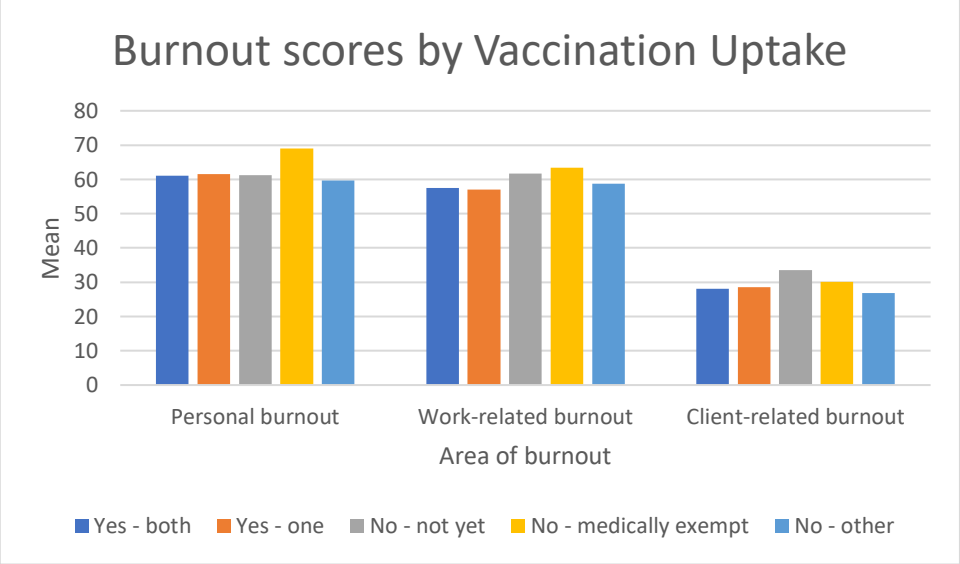


Table A5.41: Mean Burnout Scores by vaccination uptake (Weighted)

Burnout	Have you received your vaccination(s)?				
	Yes - both	Yes - one	No - not yet	No - medically exempt	No - other
Personal burnout	63.30	75.00	51.01	66.44	57.46
Work-related burnout	60.19	62.55	54.15	56.74	53.50
Client-related burnout	28.72	33.76	32.27	26.45	39.66

Table A5.42: Mean Burnout Scores by vaccination uptake (Unweighted)

Burnout	Have you received your vaccination(s)?				
	Yes - both	Yes - one	No - not yet	No - medically exempt	No - other
Personal burnout	61.14	61.58	61.19	69.05	59.71
Work-related burnout	57.46	56.99	61.61	63.44	58.79
Client-related burnout	28.07	28.53	33.46	30.16	26.83

Figure A5.81: Level of personal burnout by vaccination uptake (Weighted)

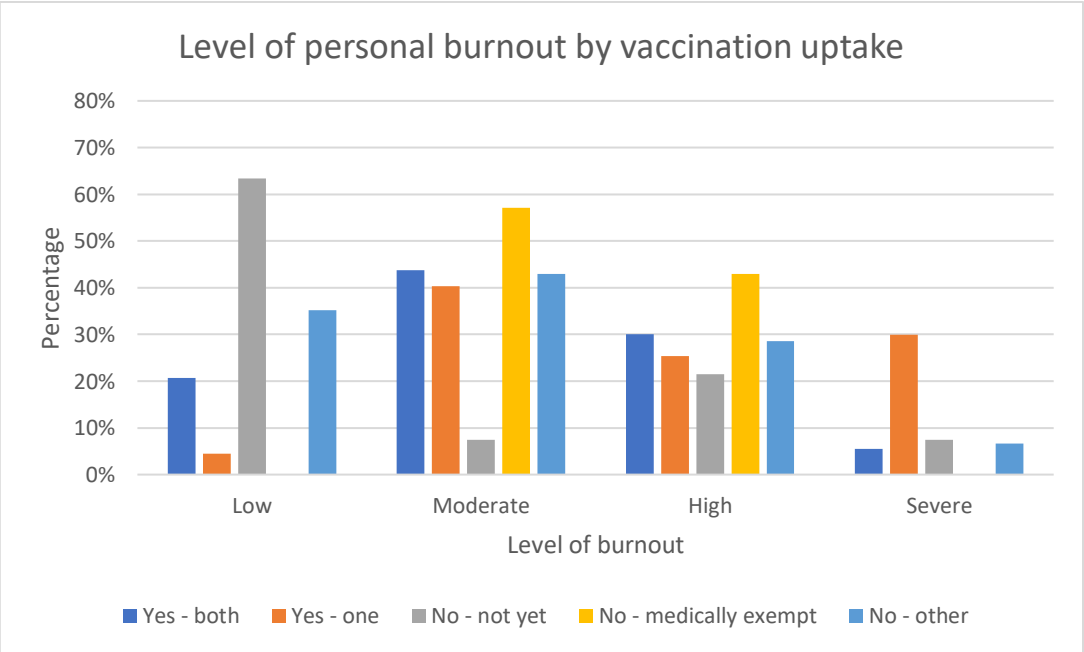


Figure A5.82: Level of personal burnout by vaccination uptake (Unweighted)

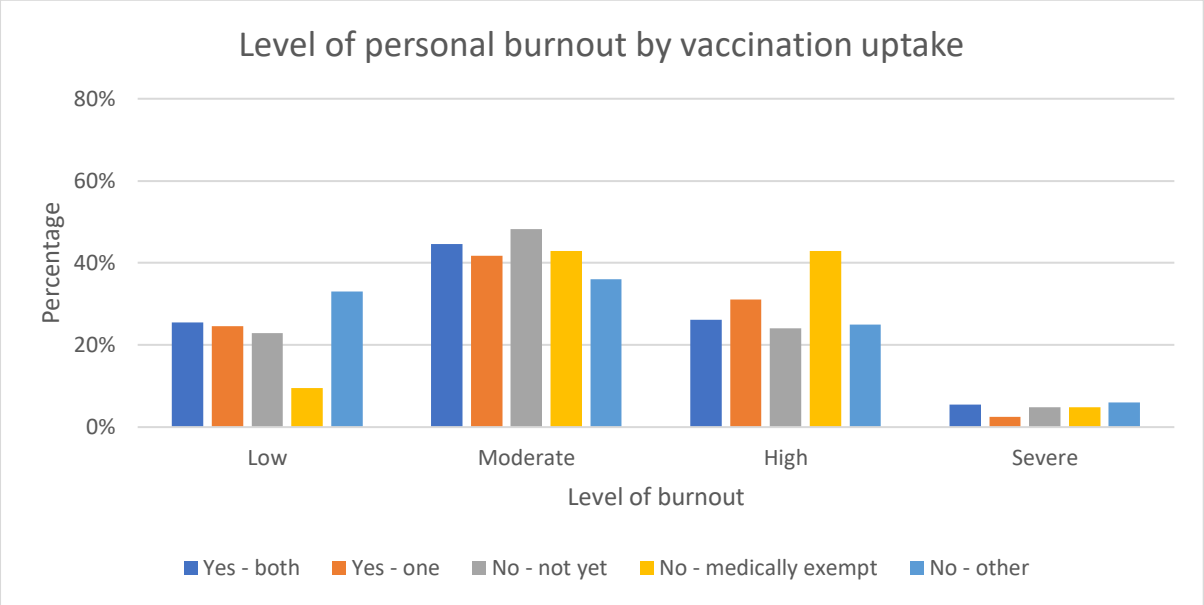


Figure A5.83: Level of work-related burnout by vaccination uptake (Weighted)

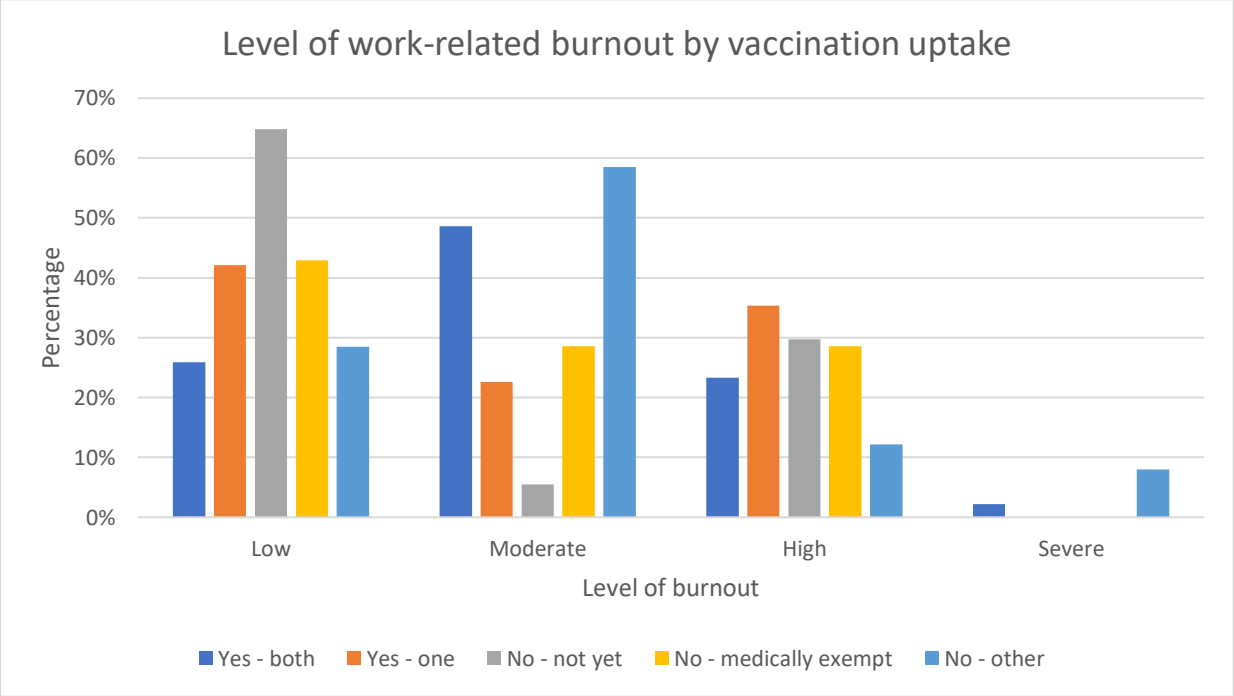


Figure A5.84: Level of work-related burnout by vaccination uptake (Unweighted)

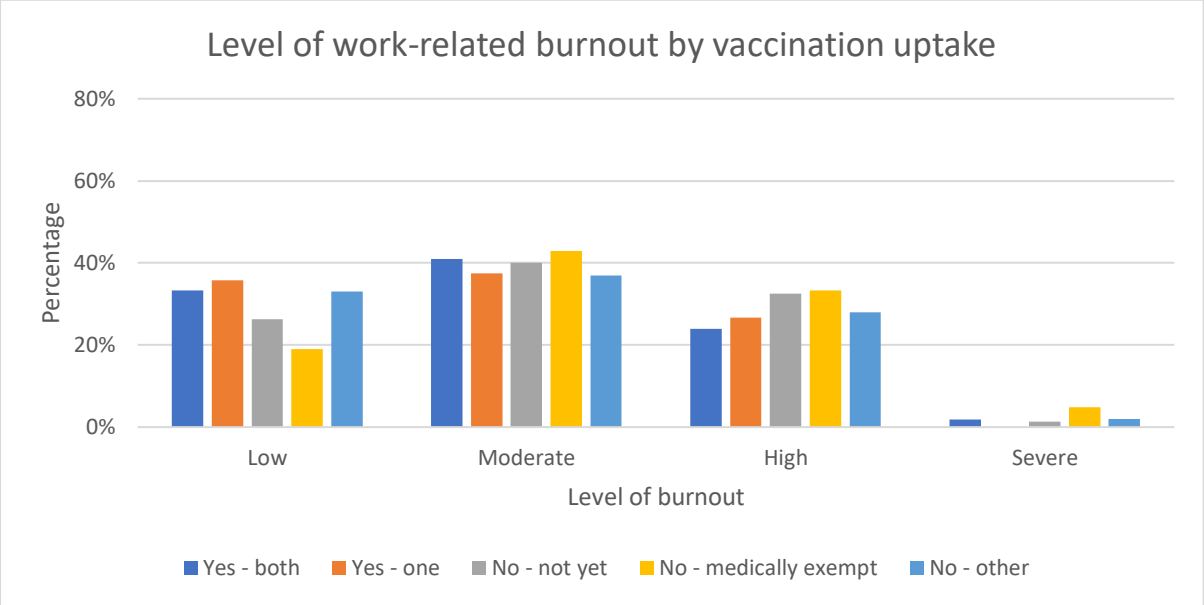


Figure A5.85: Level of client burnout by vaccination uptake (Weighted)

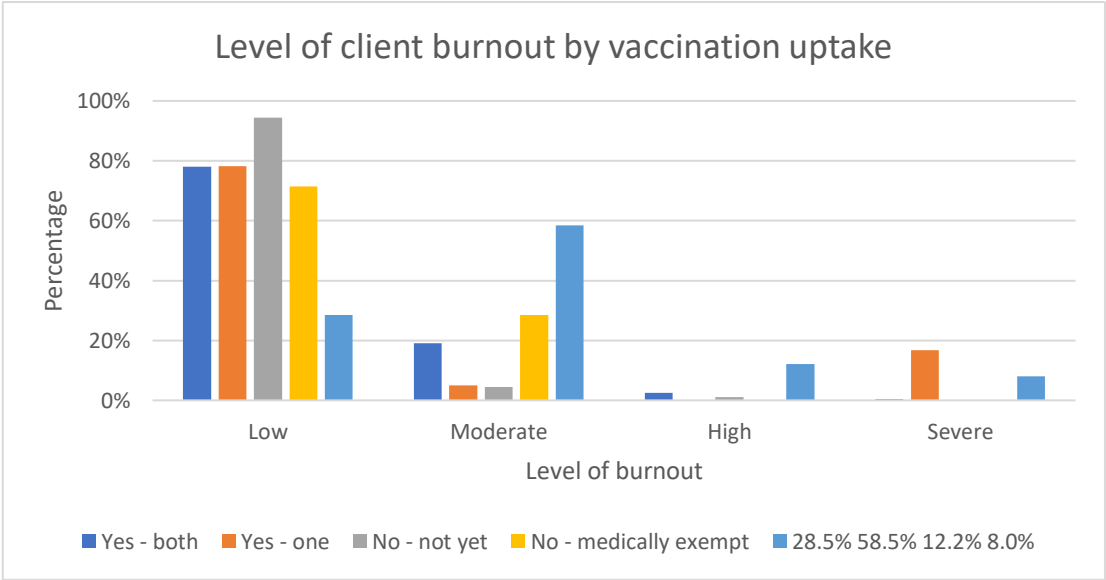


Figure A5. 86: Level of client burnout quality of working life by vaccination uptake (Unweighted)

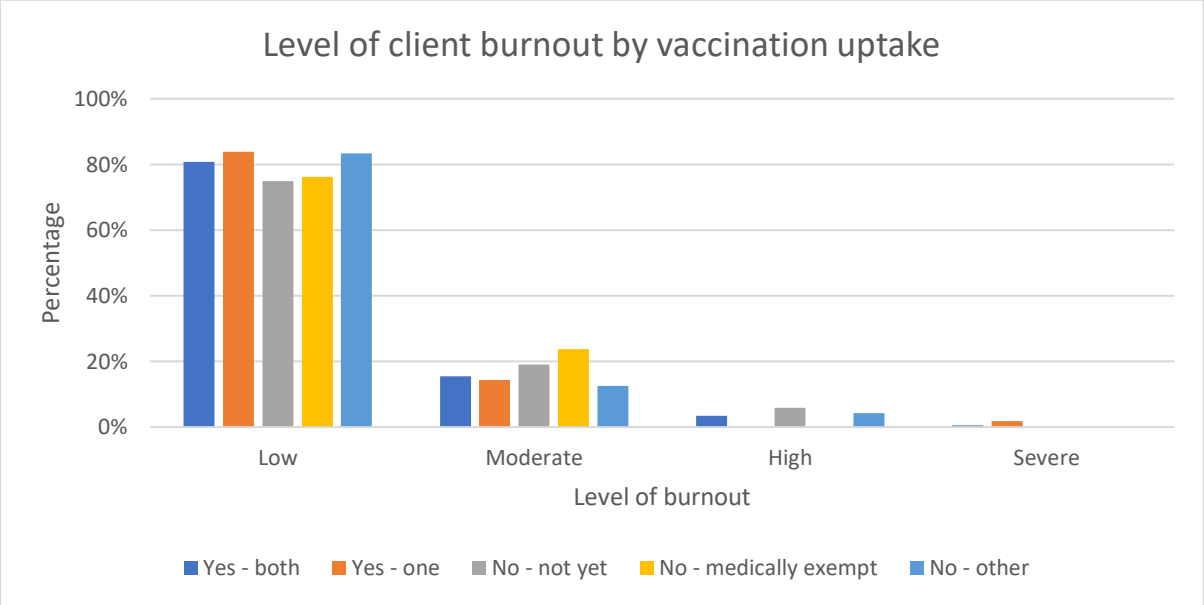


Table A5.43: Level of burnout by vaccination uptake (Weighted)

Burnout	Have you received your vaccination(s)?				
	Yes-both	Yes-one	No-not yet	No-medically exempt	No-other
Personal burnout :					
Low	20.7%	4.5%	63.4%	0.0%	35.2%
Moderate	43.8%	40.3%	7.5%	57.1%	42.9%
High	30.0%	25.4%	21.5%	42.9%	28.6%
Severe	5.5%	29.9%	7.5%	0.0%	6.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Work-related burnout:					
Low	25.9%	42.1%	64.8%	42.9%	28.5%
Moderate	48.6%	22.6%	5.5%	28.6%	58.5%
High	23.3%	35.3%	29.7%	28.6%	12.2%
Severe	2.2%	0.0%	0.0%	0.0%	8.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**
Client-related burnout:					
Low	78.0%	78.3%	94.5%	71.4%	71.7%
Moderate	19.1%	5.0%	4.4%	28.6%	27.2%
High	2.6%	0.0%	1.1%	0.0%	1.1%
Severe	0.3%	16.7%	0.0%	0.0%	1.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A5.44: Level of burnout by vaccination uptake (Unweighted)

Burnout	Have you received your vaccination(s)?				
	Yes-both	Yes-one	No-not yet	No-medically exempt	No-other
Personal burnout :					
Low	528 (25.5%)	30 (24.6%)	19 (22.9%)	2 (9.5%)	33 (33.0%)
Moderate	925 (44.6%)	51 (41.8%)	40 (48.2%)	9 (42.9%)	36 (36.0%)
High	542 (26.2%)	38 (31.1%)	20 (24.1%)	9 (42.9%)	25 (25.0%)
Severe	77 (5.5%)	3 (2.5%)	4 (4.8%)	1 (4.8%)	6 (6.0%)
Total	**2072 (100%)**	**122 (100%)**	**83 (100%)**	**21 (100%)**	**100 (100%)**
Work-related burnout:					
Low	682 (33.3%)	43 (35.8%)	21 (26.3%)	4 (19.0%)	33 (33.0%)
Moderate	840 (41.0%)	45 (37.5%)	32 (40.0%)	9 (42.9%)	37 (37.0%)
High	491 (24.0%)	32 (26.7%)	26 (32.5%)	7 (33.3%)	28 (28.0%)
Severe	36 (1.8%)	(0.0%)	1 (1.3%)	1 (4.8%)	2 (2.0%)
Total	**2049 (100%)**	**129 (100%)**	**80 (100%)**	**21 (100%)**	**100 (100%)**
Client-related burnout:					
Low	1561 (80.7%)	94 (83.9%)	51 (75.0%)	16 (76.2%)	80 (83.3%)
Moderate	297 (15.4%)	16 (14.3%)	13 (19.1%)	5 (23.8%)	12 (12.5%)
High	66 (3.4%)	0 (0.0%)	4 (5.9%)	0 (0.0%)	4 (4.2%)
Severe	10 (0.5%)	2 (1.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	**1934 (100%)**	**112 (100%)**	**68 (100%)**	**21 (100%)**	**96 (100%)**

Appendix 6: Carver Coping Scale (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of how respondents coped with COVID-19 related occupational demands, which was measured using 20 items from the Brief COPE scale. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A6.1 Carver Coping Scores by Country

Summary (Weighted results):

There were significant differences across countries in mean scores on two out of the ten examined Carver coping domains. These differences were in:

- Acceptance (F = 4.171, df = 3, p = .006), where Northern Ireland scored significantly lower than Scotland and Wales.
- Self-blame (F = 4.166 df = 3, p = .006), where Scotland scored significantly higher than Northern Ireland.

There also appeared to be a significant difference between the countries in the use of behavioural disengagement as a coping strategy ((F = 2.638, df = 3, p = .048); but multiple comparison tests revealed no statistically significant differences between the countries, although there was a trend towards higher scores in using behavioural engagement as a coping strategy by those in England.

Summary (Unweighted results):

There were significant differences across countries in mean scores on two out of the ten examined Carver coping domains. These differences were in:

- Acceptance (F = 3.606, df = 3, p = .013), where Scotland scored significantly higher than Northern Ireland.
- Self-blame (F = 6.112, df = 3, p < .001), where England and Scotland scored significantly higher than Northern Ireland.

There also appeared to be a significant difference between the countries in the use of instrumental support (F = 2.652, df = 3, p = .047), as a coping strategy, but multiple comparison tests revealed no statistically significant differences between the countries, although there was a trend towards higher scores in use of instrumental support as a coping strategy by those in Wales. Similarly, Behavioural disengagement (F = 3.470, df = 3, p = .016); but post hoc tests revealed no statistically significant

differences between the countries, although there was a trend towards higher scores in using behavioural engagement as a coping strategy by those in England.

Figure A6.1: Mean Carver Coping Scores by Country (Weighted)

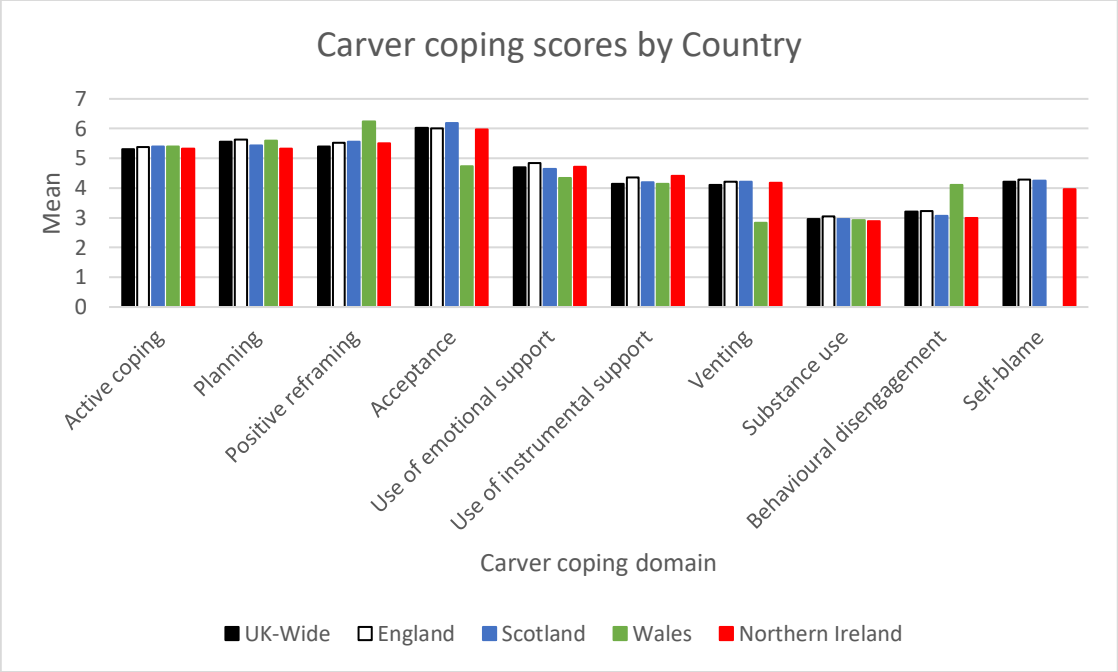


Figure A6.2: Mean Carver Coping Scores by Country (Unweighted)

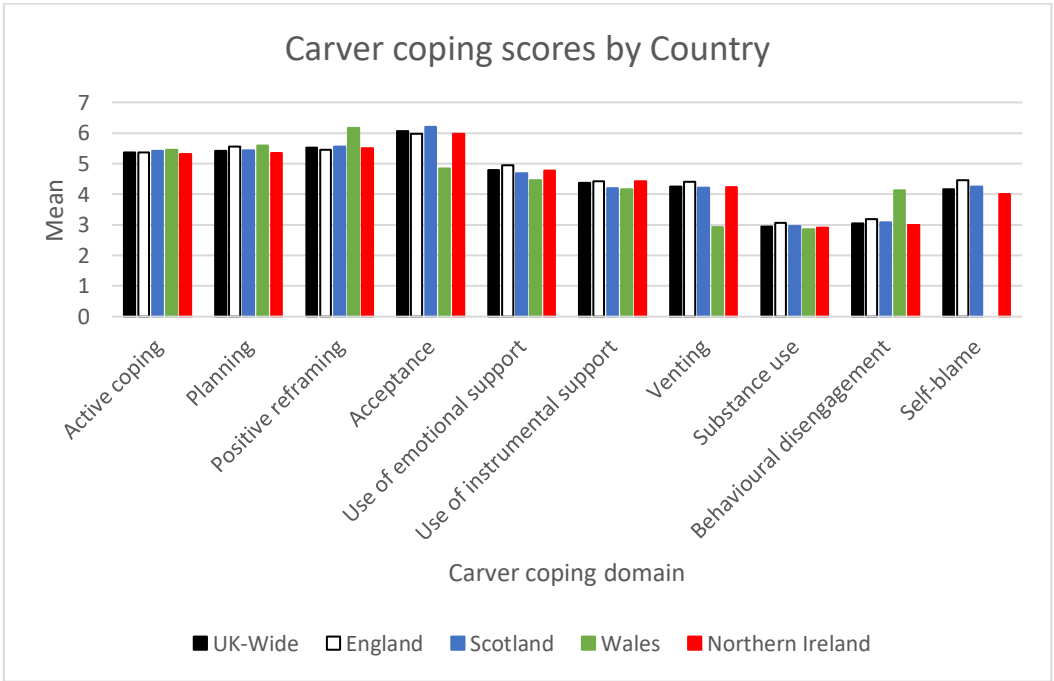


Table A6.1: Mean Carver Coping Scores by Country (Weighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.31	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

Table A6.2: Mean Carver Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.37	5.37	5.41	5.44	5.32
Planning	5.42	5.56	5.44	5.45	5.34
Positive reframing	5.52	5.45	5.55	5.59	5.51
Acceptance	6.06	5.97	6.20	6.17	5.97
Use of emotional support	4.79	4.94	4.68	4.85	4.78
Use of instrumental support	4.37	4.42	4.20	4.46	4.43
Venting	4.25	4.41	4.21	4.17	4.24
Substance use	2.95	3.06	2.96	2.92	2.9
Behavioural disengagement	3.04	3.18	3.08	2.86	2.99
Self-blame	4.17	4.45	4.25	4.13	4.00

A6.2 Carver Coping Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on all ten examined Carver coping domains. These differences were in:

- Active coping (F = 11.067, df = 4, p < .001), where AHPs scored significantly higher than nurses or midwives.
- Planning (F = 7.940, df = 4, p < .001) where AHPs scored significantly higher than all other professions.
- Positive reframing (F = 6.395, df = 4, < .001), where AHPs scored significantly higher than all other professions.
- Acceptance (F = 18.786, df = 4, < .001), where nurses scored significantly lower than AHPs and social care workers.
- Use of emotional support (F = 13.313, df = 4, p < .001), where social care workers scored significantly lower than all professions.
- Use of instrumental support (F = 7.138, df = 4, p < .001), where social workers scored significantly higher than AHPs and social care workers.
- Venting (F = 14.050, df = 4, p < .001), where social workers scored significantly higher than all other professions.
- Substance use (F = 4.879, df = 4, p = .001), where midwives scored significantly higher than nurses, AHPs and social care workers; and social workers scored significantly higher than AHPs.
- Behavioural disengagement (F = 3.216, df = 4, p = .012), where nurses scored significantly higher than AHPs.
- Self-blame (F = 11.618, df = 4, p < .001), where AHPs scored significantly lower than all other professions.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on four out of the ten examined Carver coping domains. These differences were found in:

- Use of emotional support (F = 11.185, df = 4, p < .001), where social care workers scored significantly lower than nurses, AHPs and social care workers.
- Use of instrumental support (F = 4.043, df = 4, p = .003), where social care workers scored significantly lower than social workers.
- Venting (F = 2.955, df = 4, p = .019), where social workers scored significantly higher than social care workers.
- Self-blame (F = 3.689, df = 4, p = .005), where midwives scored significantly higher than AHPS and Social Care Workers.

Figure A6.3: Mean Carver Coping Scores by Occupation (Weighted)

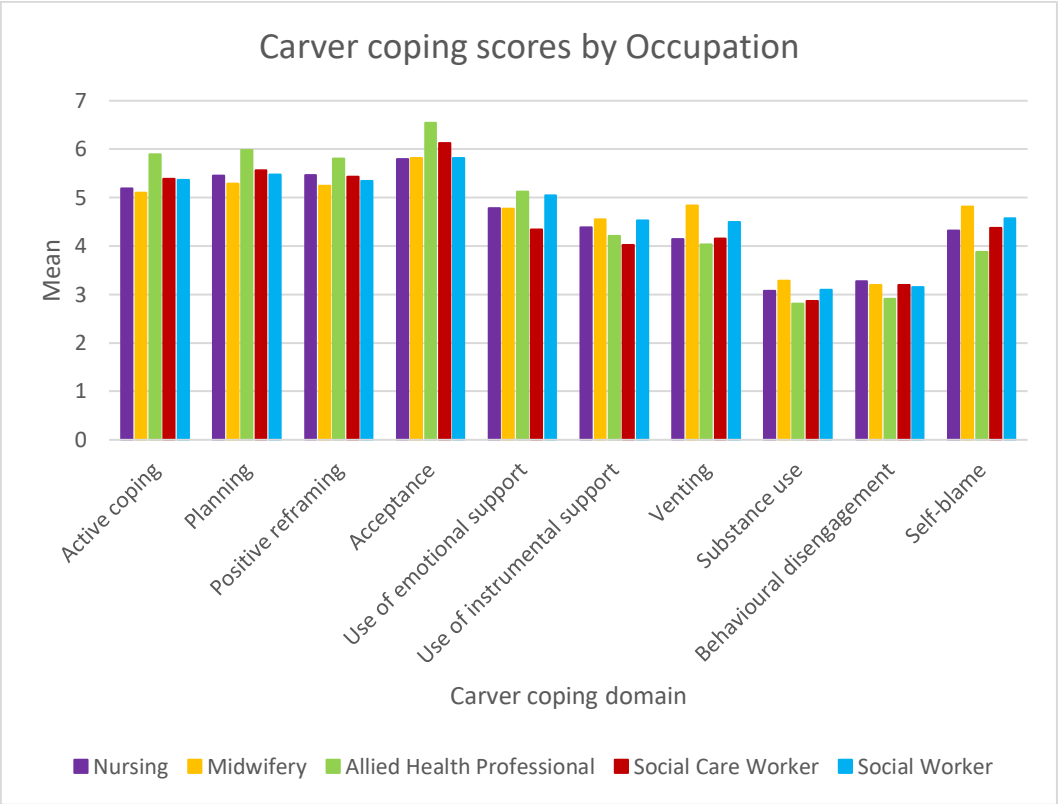


Figure A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

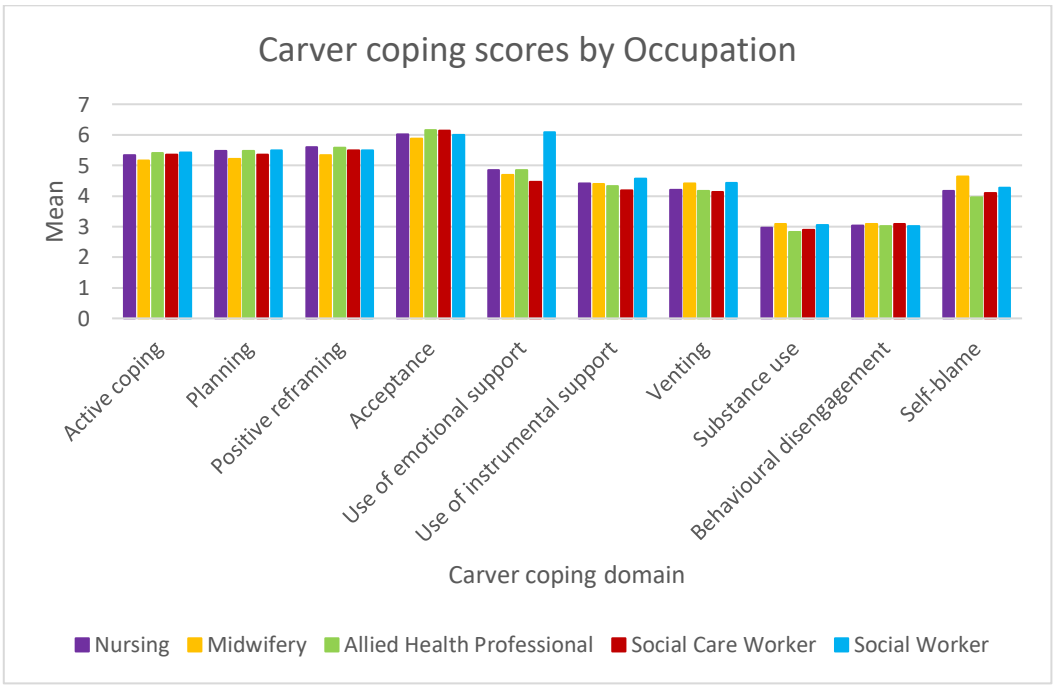


Table A6.3: Mean Carver Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.19	5.1	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	4.5
Substance use	3.08	3.29	2.81	2.87	3.1
Behavioural disengagement	3.27	3.2	2.91	3.2	3.15
Self-blame	4.32	4.82	3.88	4.37	4.57

Table A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.33	5.16	5.41	5.36	5.42
Planning	5.47	5.21	5.47	5.35	5.49
Positive reframing	5.60	5.34	5.58	5.49	5.50
Acceptance	6.02	5.87	6.15	6.13	6.00
Use of emotional support	4.85	4.69	4.84	4.46	6.09
Use of instrumental support	4.41	4.40	4.32	4.18	4.56
Venting	4.20	4.41	4.16	4.14	4.43
Substance use	2.96	3.09	2.83	2.89	3.05
Behavioural disengagement	3.03	3.09	3.01	3.08	3.01
Self-blame	4.16	4.63	3.95	4.10	4.27

A6.3 Carver Coping Scores by Sex

There were 16 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:

- Acceptance (t = 3.394, df = 2622, p = .001), where females scored significantly higher than males.
- Use of instrumental support (t = -4.789, df = 2621, p =< .001 4), where males scored significantly higher than females.
- Venting (t = -2.789, df = 2620, p < .001), where males scored significantly higher than females.
- Substance use (t = -5.339, df = 2621, p < .001), where males scored significantly higher than females.
- Behavioural disengagement (t = -2.319, df = 2617, p = .020), where males scored significantly higher than females.

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:

- Positive reframing (t = 3.063, df = 2273, p = .002), where females scored significantly higher than males.
- Acceptance (t = 2.934, df = 2274, p = .003), where females scored significantly higher than males.
- Use of emotional support (t = 2.999, df = 2269, p = .003), where females scored significantly higher than males
- Substance use (t = -5.321, df = 2273, p < .001), where males scored significantly higher than females.
- Behavioural engagement (t = -2.382, df = 2264, p = .017), where males scored significantly higher than females.

Figure A6.5: Mean Carver Coping Scores by Sex (Weighted)

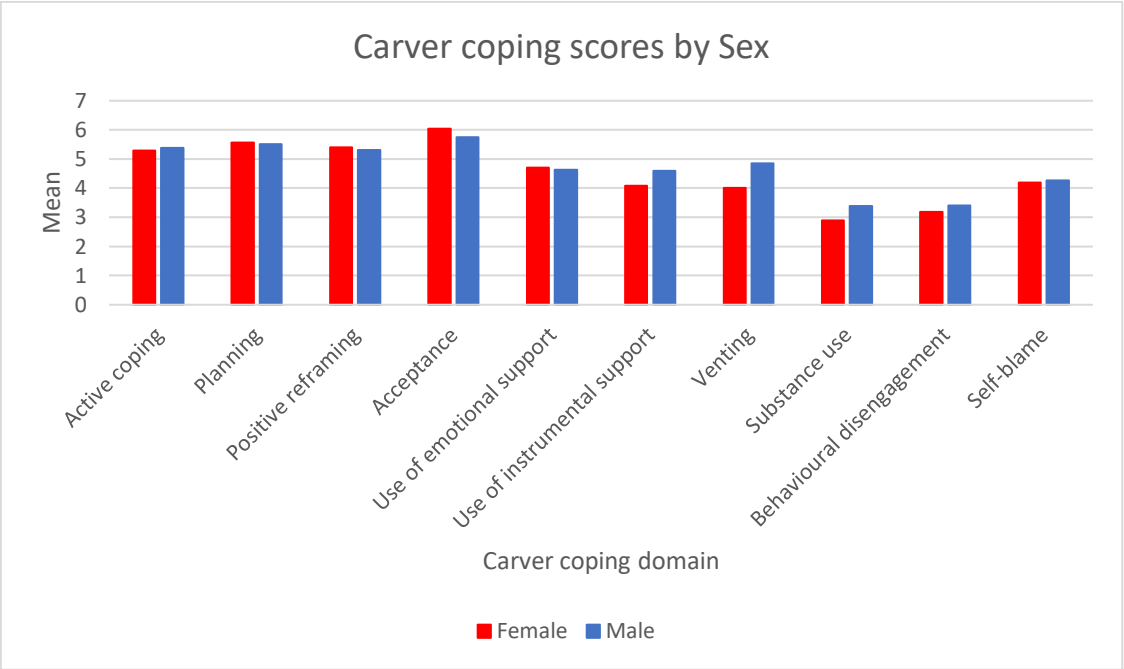


Figure A6.6: Mean Carver Coping Scores by Sex (Unweighted)

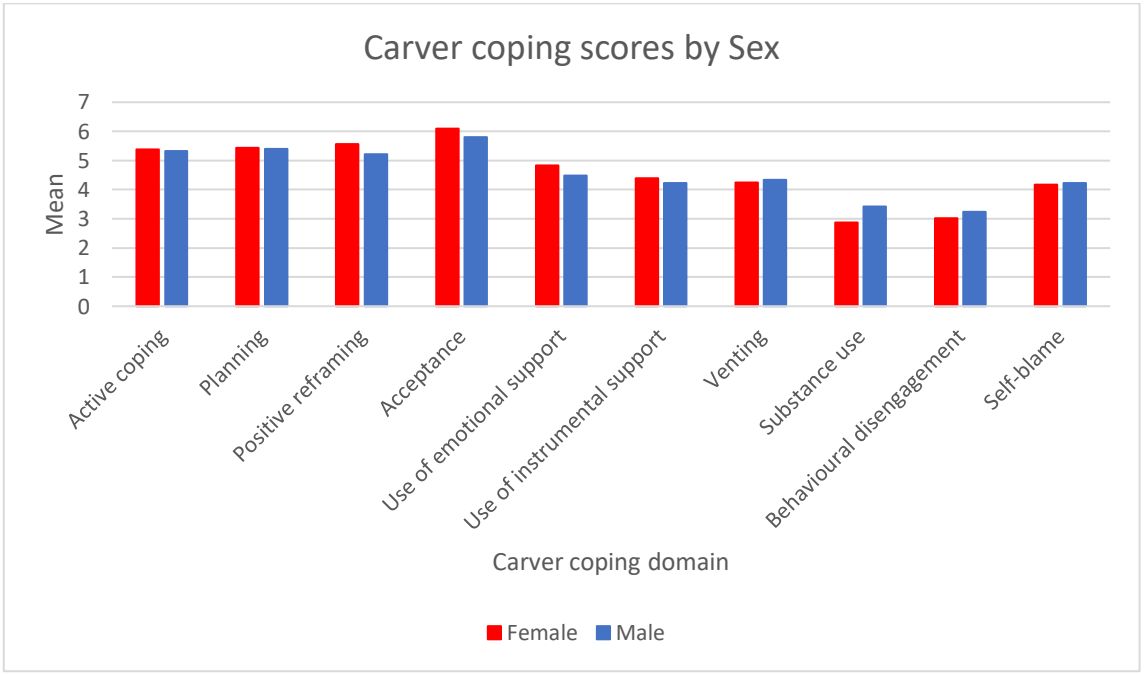


Table A6.5: Mean Carver Coping Scores by Sex (Weighted)

Coping domain	Sex	
	Female	Male
Active coping	5.29	5.39
Planning	5.56	5.51
Positive reframing	5.40	5.30
Acceptance	6.04	5.74
Use of emotional support	4.71	4.63
Use of instrumental support	4.08	4.59
Venting	4.00	4.86
Substance use	2.89	3.38
Behavioural disengagement	3.19	3.40
Self-blame	4.20	4.27

Table A6.6: Mean Carver Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Active coping	5.38	5.33
Planning	5.43	5.40
Positive reframing	5.56	5.22
Acceptance	6.09	5.8
Use of emotional support	4.83	4.49
Use of instrumental support	4.39	4.23
Venting	4.24	4.33
Substance use	2.88	3.42
Behavioural disengagement	3.01	3.24
Self-blame	4.17	4.23

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 = 30.079, df = 5, p < .001), where the 16-29 age group scored significantly lower than 60-65 and66+ age groups; and the 66+ age group scored significantly higher than all other age groups.
- Planning (F = 30.092, df = 5 p < .001), where the 66+ age group scored significantly higher than all other groups; 50-59 age group scored significantly lower than all other age groups.
- Positive reframing (F = 28.949, df = 5, p < .001), 66+ age group sored significantly higher than all other age groups, 60-65 age groups scored significantly lower than all other age groups; 50-59 age groups scored significantly lower than the 30-39, 40-49 and 66+ age groups.
- Acceptance (F = 7.838, df = 5, p < .001), where the 66+ age group sored significantly higher than all other age groups.
- Use of emotional support (F = 6.477, df = 5, p < .001), where the 66+ age group scored significantly higher than all except for the 60-65 age group.
- Use of instrumental support (F = 26.280, df = 5, p < .001), where the 16-29 age group scored significantly higher than the 50-59, 60-65 and 66+ age groups, 30-39 scored significantly higher than all groups except for the 16-29 age group.
- Venting (F = 79.106, df = 5, p < .001), where the 66+ age group sored significantly lower than all other age groups.; 60-65 age group scored significantly lower than the 16-29, 30-39, 40-49 age groups and significantly higher than the 50-59 and 66+ age groups. The 50-59 age group scored significantly lower than all groups except 66+.
- Substance use (F = 4.348, df = 5, p = .001), where the 50-59 age group scored significantly lower than the 40-49 age group; and the 40-49 age group scored significantly higher than the 30-39 and 50-59 age groups.
- Behavioural disengagement (F = 6.652, df = 5, p < .001), where the 66+ age group sored significantly higher than all other age groups.
- Self-blame (F = 35.005, df = 5, p < .001), where the 66+ age group scored significantly lower than the 16-29, 30-39 and 40-49 age groups, the 50-59 and 60-69 age groups scored significantly lower than the 16-29, 30-39 and 40-49 age groups. The 16-29 age group scored significantly higher than the 50-59, 60-65 and 66+ age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on five out of the ten examined Carver coping domains. These differences were in:

- Use of emotional support (F = 2.387 df = 5, p = .036), where the 16-29 age group scored significantly higher than the 66+ age group.
- Use of instrumental support (F = 5.841, df = 5, p < .001), where the 60-65 age group is scored significantly lower than the 16-29 and 30-39 age groups, the 40-49 age group scored significantly lower than the 16-29 age group. The 16-29 age group scored significantly higher than the 40-49, 50-59, 60-65 and 66+ age groups.
- Venting (F = 23.748, df = 5, p < .001), where the 66+ age group scored significantly lower than all groups except the 60-65 age group; the 60-65 age group scored significantly lower than the 16-29 and 30-39 age groups; the 16-29 age group scored significantly higher than all age groups except for 30-29 age group.
- Substance use (F = 2.284, df = 5, p = .044), where 40-49 age group scored significantly higher than the 60-65 age group.
- Self-blame (F=9.726, df = 5, p = .044), where the 16-29 age group scored significantly higher than the 40-49, 50-59, 60-65 and 66+ age groups.

Figure A6.7: Mean Carver Coping Scores by Age (Weighted)

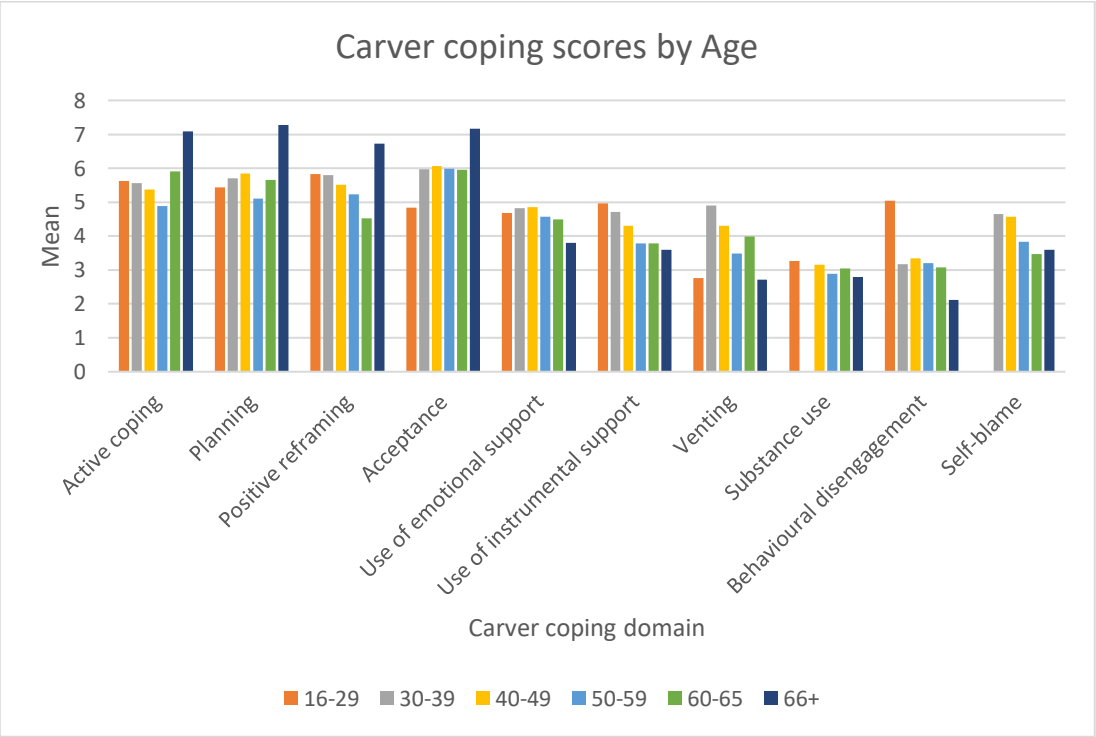


Figure A6.8: Mean Carver Coping Scores by Age (Unweighted)

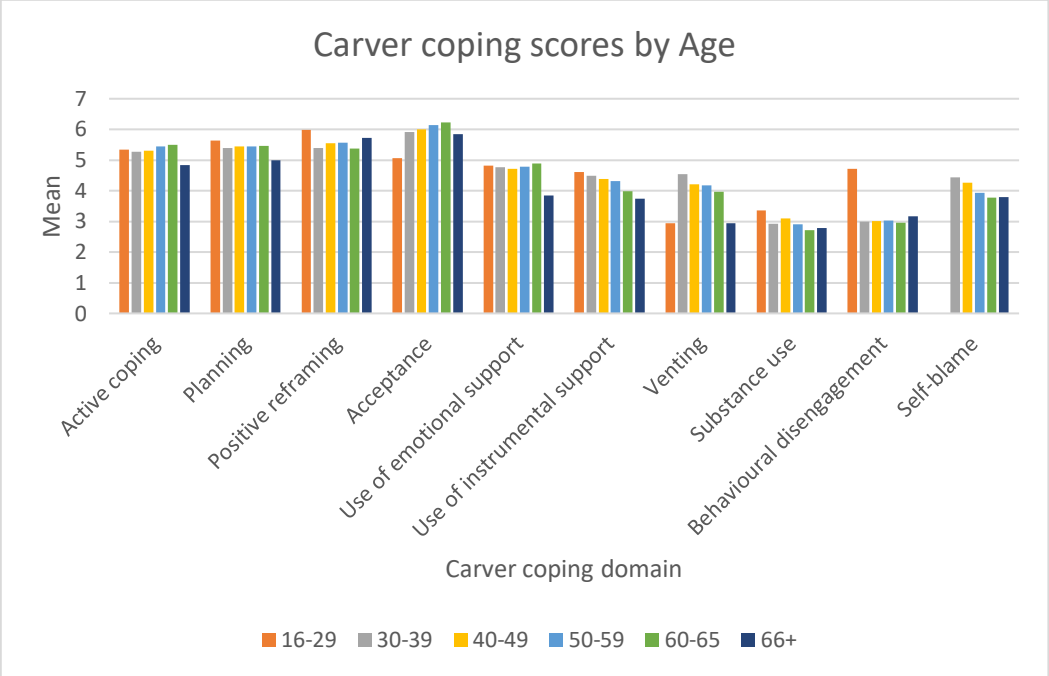


Table A6.7: Mean Carver Coping Scores by Age (Weighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Active coping	5.19	5.56	5.38	4.89	5.91	7.08
Planning	5.63	5.71	5.85	5.11	5.65	7.28
Positive reframing	5.44	5.79	5.52	5.23	4.53	6.72
Acceptance	5.83	5.97	6.06	5.98	5.95	7.16
Use of emotional support	4.84	4.83	4.86	4.57	4.49	3.8
Use of instrumental support	4.68	4.71	4.31	3.79	3.79	3.59
Venting	4.97	4.90	4.30	3.48	3.99	2.72
Substance use	2.76	2,82	3.16	2.89	3.05	2.80
Behavioural disengagement	3.26	3.17	3.35	3.20	3.08	2.11
Self-blame	5.04	4.65	4.57	3.83	3.47	3.59

Table A6.8: Mean Carver Coping Scores by Age (Unweighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Active coping	5.34	5.27	5.3	5.45	5.5	4.84
Planning	5.34	5.40	5.44	5.44	5.46	5.00
Positive reframing	5.63	5.40	5.55	5.57	5.37	5.72
Acceptance	5.99	5.91	6.01	6.14	6.23	5.84
Use of emotional support	5.07	4.76	4.72	4.79	4.88	3.84
Use of instrumental support	4.82	4.49	4.38	4.31	3.99	3.74
Venting	4.61	4.54	4.21	4.17	3.96	2.94
Substance use	2.94	2.93	3.10	2.91	2.72	2.79
Behavioural disengagement	3.35	3.00	3.01	3.02	2.96	3.17
Self-blame	4.72	4.44	4.26	3.94	3.78	3.79

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 23., df = 3, p < .001), where respondents identifying as black scored significantly higher than all the other ethnic groups.
- Planning (F = 19.990, df = 3, p < .001), where respondents identifying as black scored significantly higher than all the other ethnic groups; and respondents identifying as white scored significantly higher than the Mixed ethnic group.
- Positive reframing (F = 37.916, df = 3, p < .001), where respondents identifying as Mixed scored significantly lower than all the other ethnic groups; and the black ethnic group scored significantly higher than all other ethnic groups.
- Acceptance (F = 5.563, df = 3, p = .001), where the black ethnic group scored significantly higher than the White and Asian ethnic groups.
- Use of emotional support (F = 31.709, df = 3, p < .001), where the black ethnic group scored significantly higher than all other ethnic groups; the Asian Ethnic group scored significantly lower than the White or Black ethnic groups.
- Use of instrumental support (F = 51.080, df = 3, p < .001), where the black ethnic group scored significantly higher than all other ethnic groups.

- Venting (F = 34.815, df = 3, p < .001), where the black ethnic group scored significantly higher than all other ethnic groups.
- Substance use (F = 34.685, df = 3, p < .001), where the Mixed ethnic groups scored significantly higher than all other ethnic groups.
- Behavioural disengagement (F = 12.341, df = 3, p < .001),), where the Mixed ethnic groups scored significantly higher than all other ethnic groups.
- Self-blame (F = 25.046, df = 3, p < .001), where the Black ethnic group scored significantly lower than all other ethnic groups; and the white ethnic group scored significantly lower than the Mixed or Asian ethnic groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups in mean scores on two out of the ten examined Carver coping domains. These differences were in:

- Substance use (F = 4.350, df = 3, p = .005), where respondents from the black ethnic group scored significantly lower than White or Mixed ethnic groups.
- Self-blame (F = 4.255, df = 3, p = .005), where respondents from the black ethnic group scored significantly lower than White or Mixed ethnic groups.

Figure A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

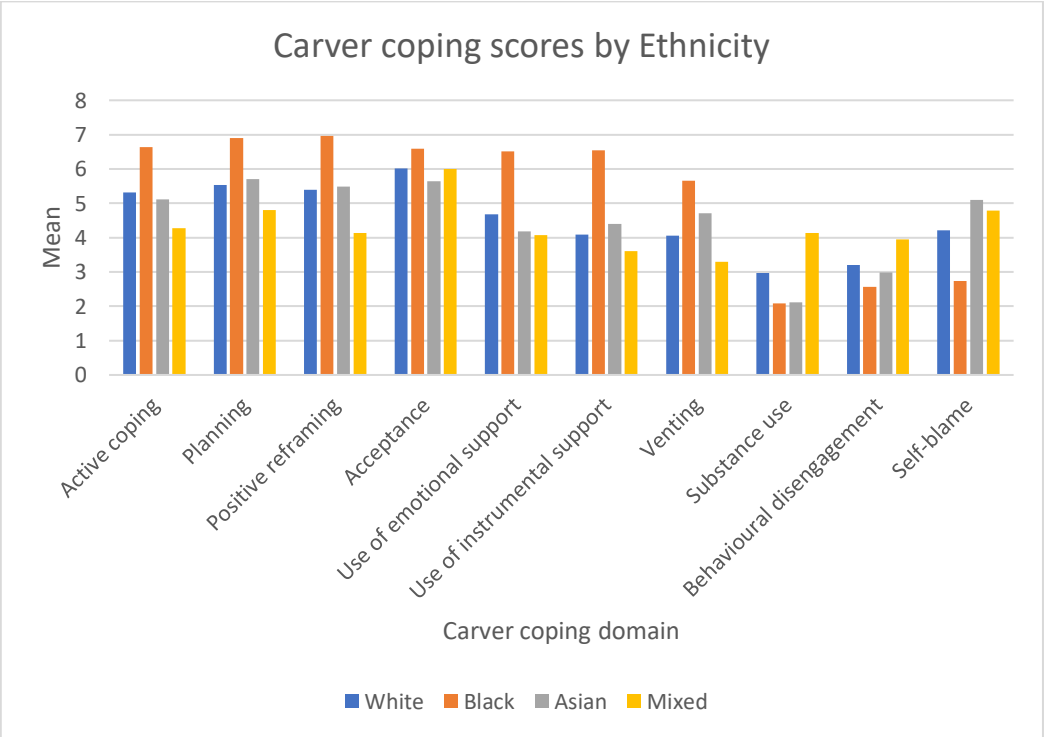


Figure A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

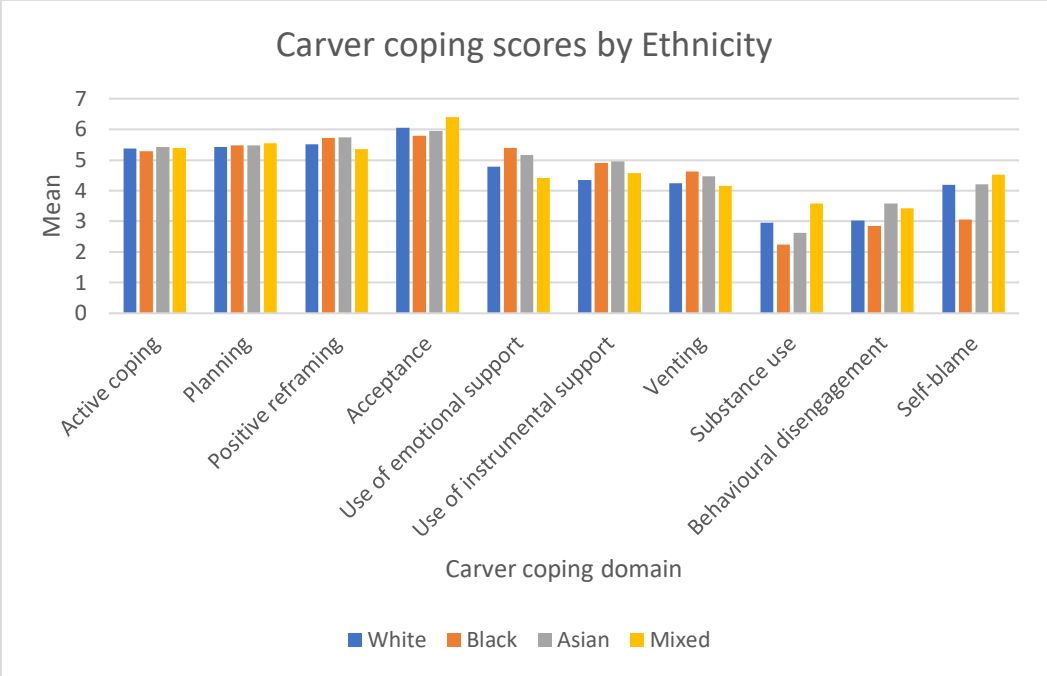


Table A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.32	6.64	5.11	4.28
Planning	5.54	6.90	5.71	4.81
Positive reframing	5.40	6.96	5.48	4.14
Acceptance	6.01	6.59	5.64	6.00
Use of emotional support	4.68	6.51	4.18	4.07
Use of instrumental support	4.09	6.55	4.40	3.60
Venting	4.06	5.65	4.71	3.29
Substance use	2.97	2.09	2.12	4.14
Behavioural disengagement	3.21	2.56	2.99	3.95
Self-blame	4.21	2.73	5.09	4.78

Table A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.37	5.29	5.42	5.40
Planning	5.42	5.48	5.47	5.55
Positive reframing	5.52	5.73	5.74	5.36
Acceptance	6.06	5.79	5.95	6.40
Use of emotional support	4.78	5.4	5.16	4.42
Use of instrumental support	4.35	4.91	4.95	4.58
Venting	4.25	4.62	4.47	4.15
Substance use	2.96	2.24	2.63	3.58
Behavioural disengagement	3.03	2.85	3.58	3.42
Self-blame	4.19	3.06	4.21	4.53

A6.6 Carver Coping Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in mean scores on eight out of the ten examined Carver coping domains. These differences were found in:

- Active coping ($F = 20.538$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability and those who were unsure whether or not they had a disability.
- Planning ($F = 37.210$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability and those who were unsure whether or not they had a disability.
- Positive reframing ($F = 12.473$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability and those who were unsure whether or not they had a disability.
- Acceptance ($F = 11.701$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability and those who were unsure whether or not they had a disability.

- Use of instrumental support (F = 4.690, df = 2, p = .009), where respondents who were unsure of whether or not they had a disability scored significantly higher than the other two groups.
- Venting (F = 31.181, df = 2, p = .009), where respondents who were unsure of whether or not they had a disability scored significantly higher than the other two groups.
- Substance use (F = 9.521, df = 2, p < .001), where respondents with a disability scored significantly lower than the other two groups.
- Behavioural disengagement (F = 20.578, df = 2, p < .001), where respondents who were unsure of whether or not they had a disability scored significantly higher than the other two groups.
- Self-blame (F = 9.259, df = 2, p < .001), where respondents who were unsure of whether or not they had a disability scored significantly higher than the other two groups.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on one out of the ten examined Carver coping domains. These differences were in:

- Behavioural disengagement (F = 10.547, df = 2, p < .001), where respondents with a disability scored significantly higher than those without a disability; respondents with no disability scored significantly lower than those who were unsure of whether or not they had a disability.
- Self-blame (F = 11.248, df = 2, p < .001), where respondents without a disability scored significantly lower than those with a disability and those who were unsure of whether or not they had a disability.

Figure A6.11: Mean Carver Coping Scores by Disability (Weighted)

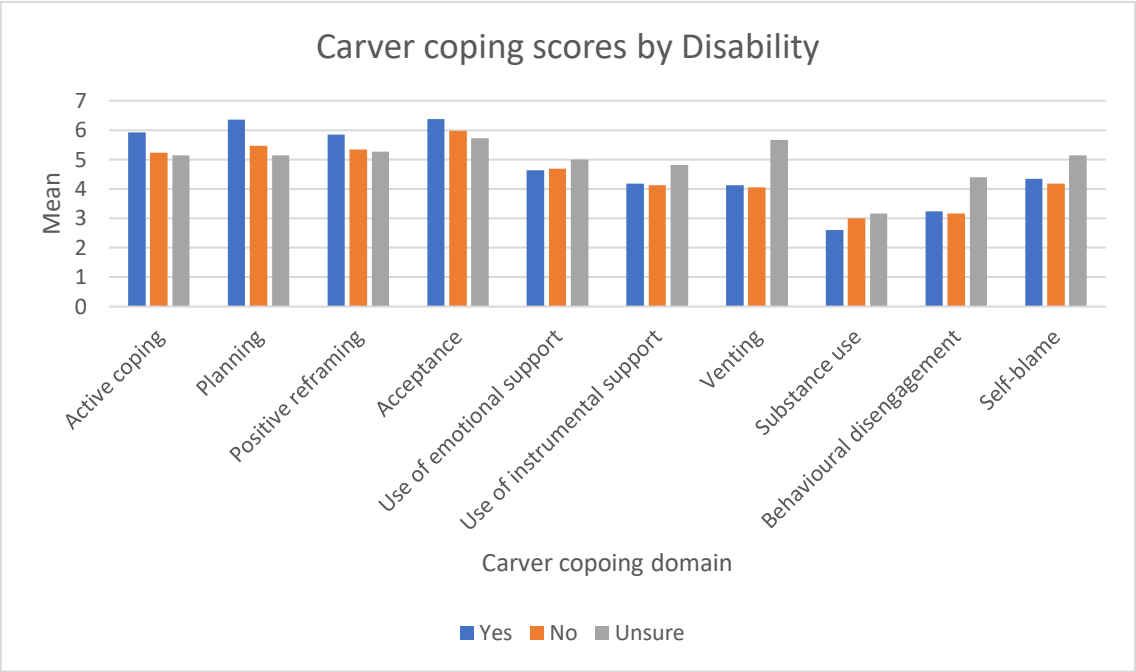


Figure A6.12: Mean Carver Coping Scores by Disability (Unweighted)

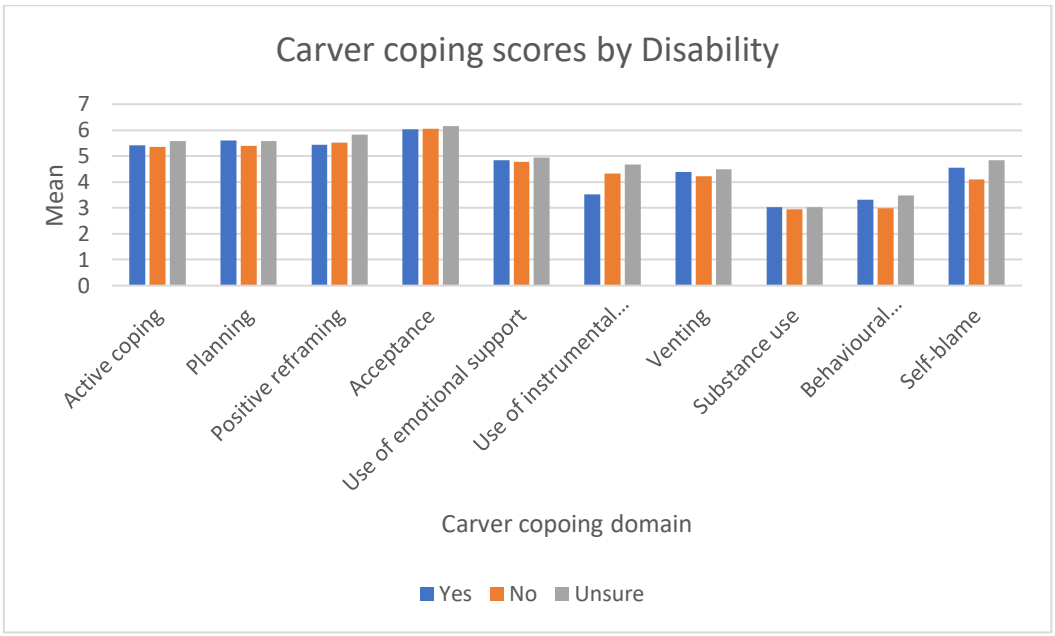


Table A6.11: Mean Carver Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Active coping	5.93	5.24	5.15
Planning	6.35	5.46	5.15
Positive reframing	5.85	5.34	5.27
Acceptance	6.38	5.98	5.73
Use of emotional support	4.64	4.69	5.00
Use of instrumental support	4.19	4.13	4.81
Venting	4.13	4.05	5.66
Substance use	2.60	3.00	3.17
Behavioural disengagement	3.24	3.17	4.39
Self-blame	4.35	4.18	5.15

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	5.41	5.35	5.57
Planning	5.60	5.39	5.57
Positive reframing	5.43	5.52	5.82
Acceptance	6.03	6.06	6.15
Use of emotional support	4.84	4.78	4.94
Use of instrumental support	3.52	4.33	4.68
Venting	4.38	4.23	4.48
Substance use	3.03	2.94	3.02
Behavioural disengagement	3.32	2.98	3.49
Self-blame	4.44	3.85	4.13

A6.7 Carver Coping Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences between respondents based on their main area of practice in mean scores on ten out of the ten examined Carver coping domains. These differences were in:

- Active coping (F = 12.300, df = 7, p < .001), where those working in the Mental Health area scored significantly lower than those working with adults, those with a learning disability, older people and 'other'.
- Planning (F = 14.868, df = 7, p < .001), where those working in the Mental Health area scored significantly lower than those working with children, with adults, physical disability, learning disability, older people and 'other'.
- Positive reframing (F = 12.464, df = 7, < .001), where respondents working with the 'Other' area scored significantly higher than those in midwifery, with learning disability, older people or in mental health.
- Acceptance (F = 19.530, df = 7, < .001), where respondents working in the area of physical disability scored significantly higher than those working with children, in midwifery, with adults, learning disability, older people and in mental health.
- Use of emotional support (F = 22.393, df = 7, p < .001), where respondents working in the area of learning disability scored significantly lower than all other areas of practice.
- Use of instrumental support (F = 17.724, df = 7, p < .001), where respondents working in the area of Physical disability scored significantly higher than those working with adults, learning disability, older people, mental health and 'other'; while those working with those with learning disability scored significantly lower than those working with children, in midwifery, with adults, physical disability, older people and mental health.
- Venting (F = 18.951, df = 7, p < .001), where respondents working with children scored significantly higher than those working with adults, learning disability, older people, in the area of mental health or 'other' services; respondents working in learning disability scored significantly lower than those working with children and adults, in the area of midwifery, and older people.
- Substance use (F = 29.030, df = 7, p < .001), where respondents working in midwifery scored significantly higher than those working with children, physical disability, older people and 'other'; and those working with adults scored significantly higher than those working with children, physical disability, learning disability, older people and 'other'.
- Behavioural disengagement (F = 14.372, df = 7, p < .001), where respondents working in the area of midwifery scored significantly higher than those working with children, adults, physical disability, older people, mental health and 'other' services; respondents working with children scored significantly lower than those working in midwifery, with adults, and in learning disability; and those working with adults or in learning disability scored significantly higher than those working with children, physical disability, older people and mental health.

- Self-blame (F = 8.872, df = 7, p < .001), where respondents working in midwifery scored significantly higher than those working with adults, physical disability, and mental health; and those working in physical disability services scored significantly lower than those working in learning disability or midwifery services.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean scores on two out of the ten examined Carver coping domains. These differences were in:

- Use of emotional support (F = 5.169, df = 7, p = .006), where respondents working with children scored significantly higher than those working in the area of learning disability and with older people.
- Behavioural disengagement (F = 2.114, df = 7, p = .039), where respondents working with older people scored significantly higher than those working with children.

There were significant differences in the Acceptance as a coping strategy between respondents who worked in different areas of practice (F = 2.017, df = 7, p = .050). Multiple comparison tests revealed no statistically significant differences, although there was a trend towards higher scores in those who worked other as their area of practice.

Figure A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

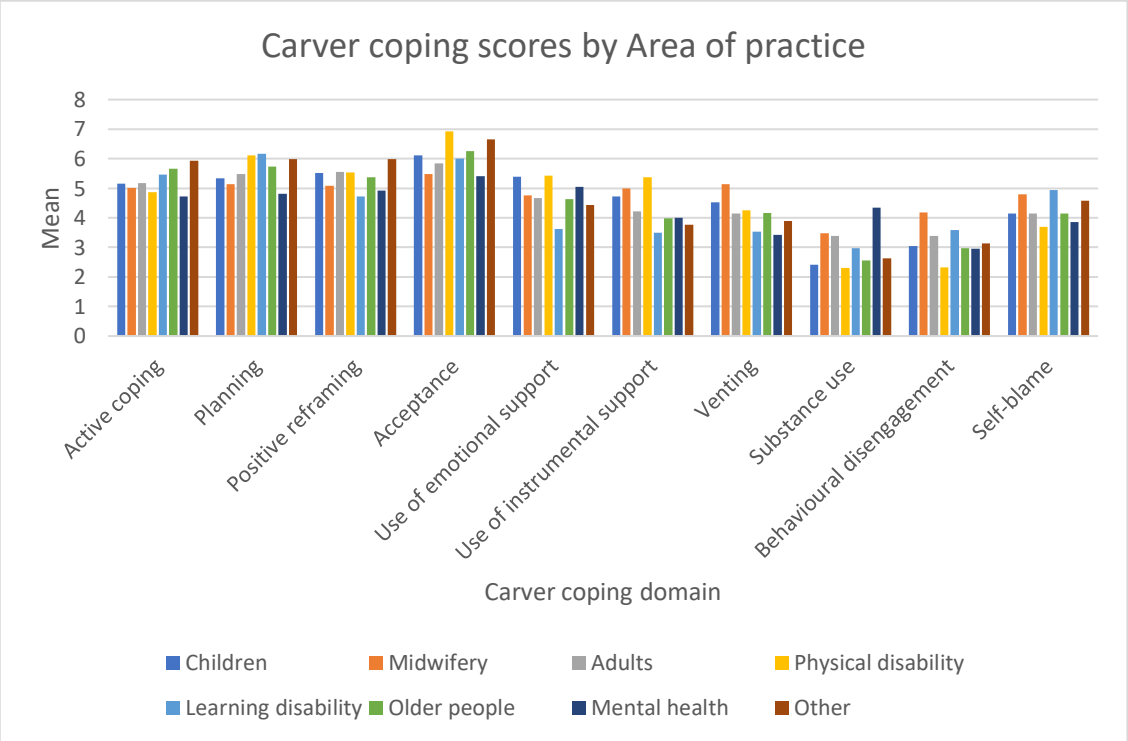


Figure A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)

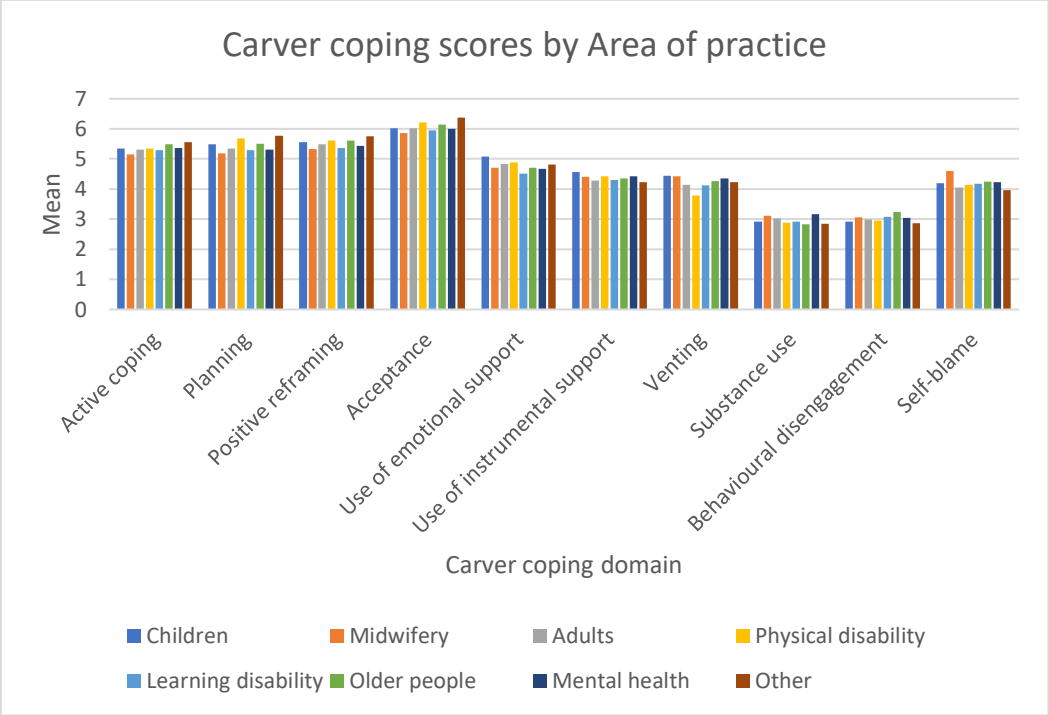


Table A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Active coping	5.15	5.02	5.17	4.87	5.47	5.66	4.72	5.94
Planning	5.33	5.13	5.48	6.12	6.16	5.74	4.81	5.99
Positive reframing	5.52	5.08	5.56	5.54	4.72	5.37	4.93	5.98
Acceptance	6.12	5.48	5.85	6.93	6.00	6.26	5.40	6.66
Use of emotional support	5.39	4.76	4.67	5.42	3.62	4.63	5.05	4.43
Use of instrumental support	4.72	4.99	4.21	5.37	3.49	3.99	4.00	3.77
Venting	4.53	5.13	4.15	4.26	3.53	4.16	3.42	3.90
Substance use	2.41	3.47	3.38	2.30	2.97	2.56	4.35	2.63
Behavioural disengagement	3.04	4.18	3.38	2.32	3.58	2.98	2.95	3.13
Self-blame	4.15	4.80	4.14	3.70	4.94	4.14	3.86	4.57

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	5.34	5.15	5.31	5.34	5.29	5.49	5.36	5.56
Planning	5.48	5.18	5.35	5.68	5.30	5.50	5.31	5.77
Positive reframing	5.55	5.33	5.48	5.61	5.37	5.61	5.44	5.75
Acceptance	6.01	5.86	6.01	6.21	5.95	6.15	6.00	6.37
Use of emotional support	5.08	4.70	4.83	4.89	4.51	4.70	4.67	4.82
Use of instrumental support	4.56	4.40	4.29	4.42	4.30	4.35	4.43	4.22
Venting	4.45	4.42	4.14	3.79	4.12	4.26	4.36	4.22
Substance use	2.92	3.12	3.02	2.89	2.91	2.82	3.16	2.85
Behavioural disengagement	2.92	3.06	2.99	2.95	3.07	3.23	3.05	2.86
Self-blame	4.20	4.6	4.05	4.14	4.17	4.24	4.23	3.96

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 eight out of the ten Carver coping domains. These differences were in:

- Active coping (t = 2.994, df = 2671, p = .003), where line managers scored significantly higher than those who were not line managers.
- Planning (t = 6.207, df = 2670, p < .001), where line managers scored significantly higher than those who were not line managers
- Acceptance (t = -8.452, df = 2638, p < .001), where line managers scored significantly lower than those who were not line managers.
- Use of emotional support (t = -10.891, df = 2636, p < .001), where line managers scored significantly lower than those who were not line managers.
- Use of instrumental support (t = -5.516, df = 2637, p < .001), where line managers scored significantly lower than those who were not line managers.
- Venting (t = -8.107, df = 2626, p < .001), where line managers scored significantly lower than those who were not line managers.
- Behavioural disengagement (t = 9.626, df = 2623, p < .001), where line managers scored significantly higher than those who were not line managers.
- Self-blame (t = 8.811, df = 2636, 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 five out of the ten examined Carver coping domains. These differences were in:

- Active coping (t = 3.238, df = 2299, p = .001), where line managers scored significantly higher than those who were not line managers.
- Planning (t = 4.533, df = 2295, p < .001), where line managers scored significantly higher than those who were not line managers.
- Positive reframing (t = 3.708, df = 2289, p < .001), where line managers scored significantly higher than those who were not line managers
- Acceptance (t = 2.231, df = 2290, p = .026), where line managers scored significantly higher than those who were not line managers.

- Venting (t = -3.177, df = 2283, p = .002), where line managers scored significantly lower than those who were not line managers.

Figure A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)

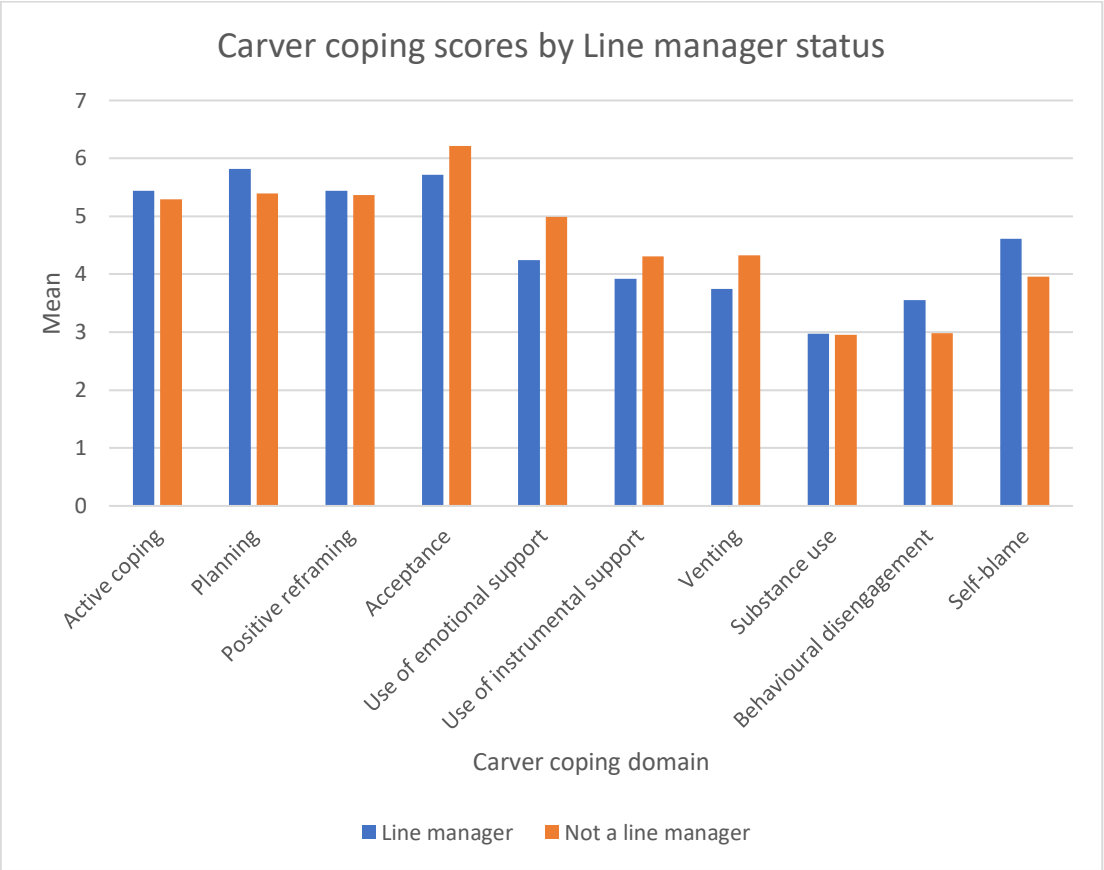


Figure A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

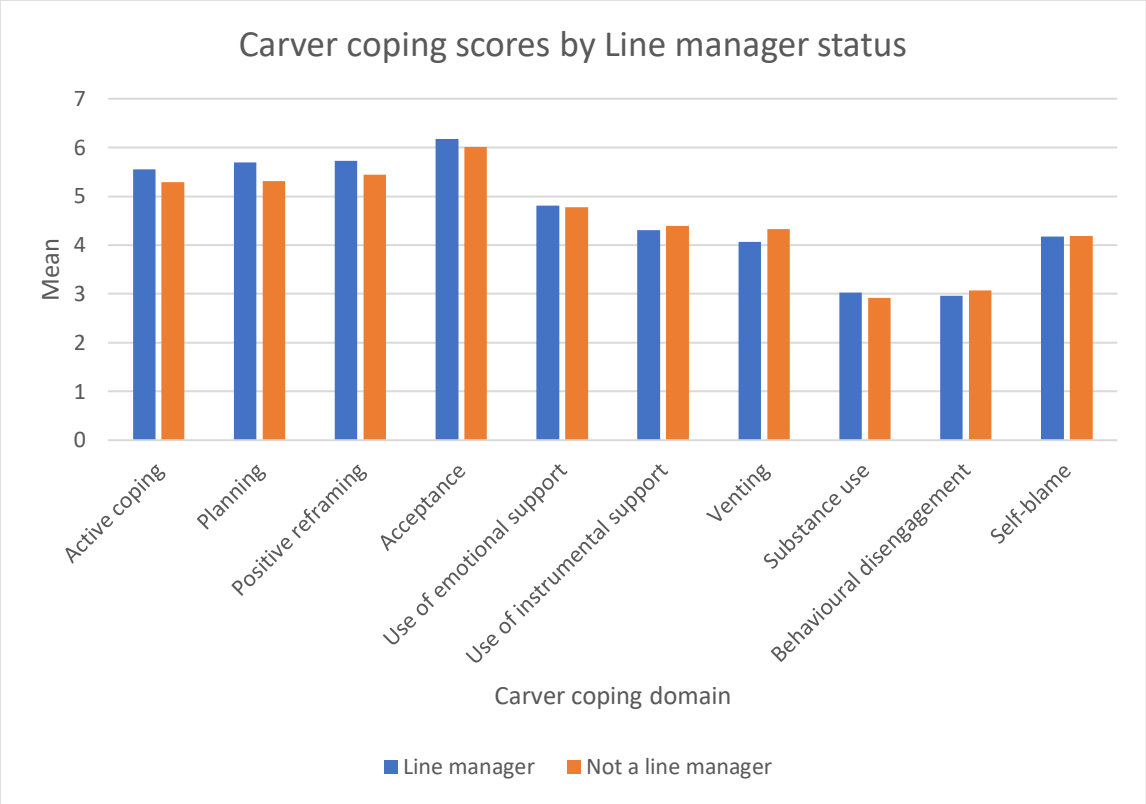


Table A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.44	5.29
Planning	5.82	5.39
Positive reframing	5.44	5.37
Acceptance	5.72	6.21
Use of emotional support	4.24	4.99
Use of instrumental support	3.92	4.31
Venting	3.75	4.33
Substance use	2.97	2.95
Behavioural disengagement	3.55	2.98
Self-blame	4.61	3.96

Table A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.55	5.29
Planning	5.69	5.31
Positive reframing	5.73	5.44
Acceptance	6.17	6.01
Use of emotional support	4.81	4.78
Use of instrumental support	4.31	4.39
Venting	4.07	4.33
Substance use	3.03	2.92
Behavioural disengagement	2.96	3.07
Self-blame	4.17	4.18

A6.9 Carver Coping Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean scores on nine out of the ten examined Carver coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Active coping ($F = 9.770$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those felt some impact but not significantly. Those who were impacted but not significantly scored significantly higher than those who were not impacted and those who were overwhelmed by the pressures.
- Positive reframing ($F = 23.201$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups. Those overwhelmed by increased pressures scored significantly lower than the other two groups.
- Acceptance ($F = 26.623$, $df = 2$, $p < .001$), where respondents who had some impacted scored significantly higher than those who felt no impact of those who were overwhelmed by increased pressures.
- Use of emotional support ($F = 99.888$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than the other two groups.

- Use of instrumental support (F = 18.550, df = 2, p < .001), where respondents who had some impacted scored significantly higher than those who felt no impact of those who were overwhelmed by increased pressures; respondents who felt overwhelmed by increased pressures scored significantly lower than the other two groups.
- Behavioural disengagement (F = 32.622, df = 2, p < .001), where respondents who had some impacted scored significantly lower than the other two groups.
- Self-blame (F = 97.005, df = 2, p < .001), where respondents who had some impacted scored significantly lower than the other two groups.

Summary (Unweighted results):

There were significant differences in mean scores on six out of the ten examined Carver coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Planning (F = 8.502, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Use of instrumental support (F = 6.849, df = 2, p = .001), where respondents who felt overwhelmed by increased pressures scored significantly higher than those felt some impact.
- Venting (F = 19.065, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Substance use (F = 8.476, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Behavioural disengagement (F = 26.603, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Self-blame (F = 61.728, 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)

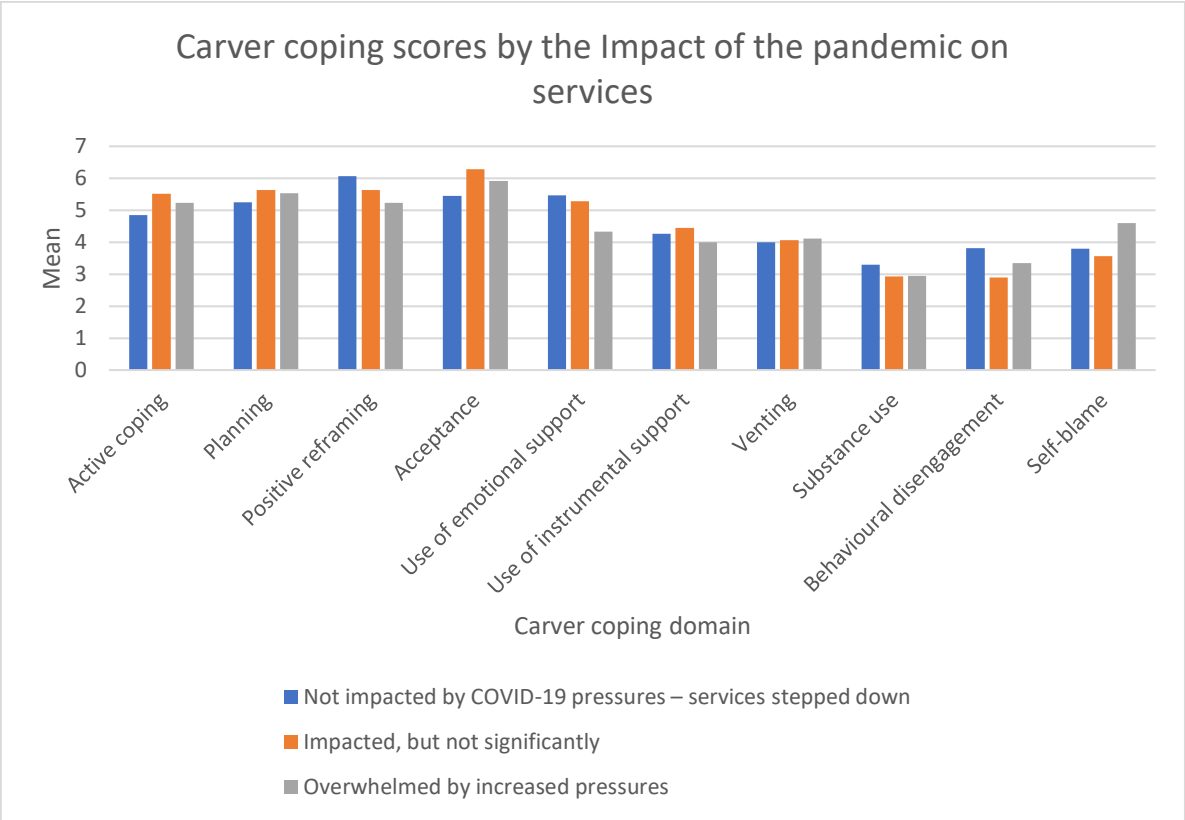


Figure A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)

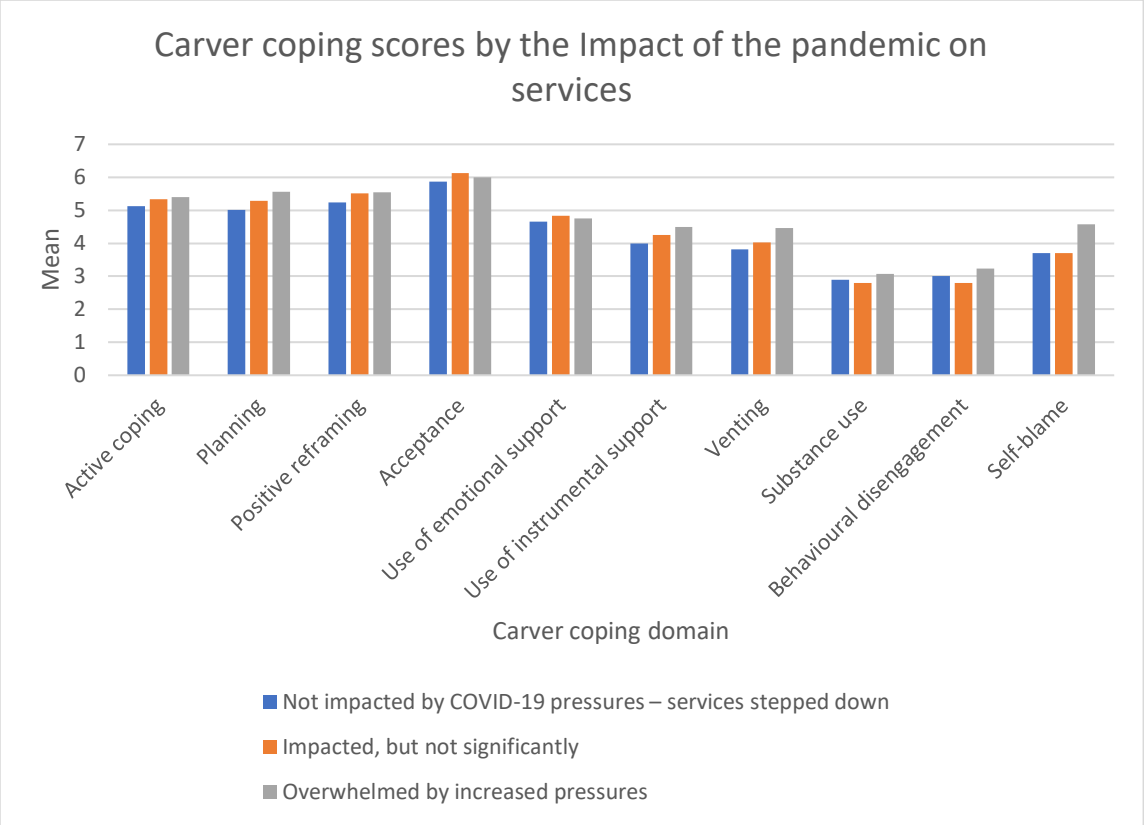


Table A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

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	4.85	5.51	5.24
Planning	5.25	5.64	5.54
Positive reframing	6.06	5.63	5.24
Acceptance	5.45	6.28	5.91
Use of emotional support	5.47	5.29	4.33
Use of instrumental support	4.27	4.44	4.00
Venting	4.00	4.07	4.12
Substance use	3.30	2.93	2.95
Behavioural disengagement	3.82	2.90	3.34
Self-blame	3.80	3.56	4.59

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	5.13	5.34	5.40
Planning	5.01	5.28	5.56
Positive reframing	5.24	5.51	5.55
Acceptance	5.87	6.13	6.00
Use of emotional support	4.65	4.83	4.76
Use of instrumental support	4.00	4.25	4.49
Venting	3.81	4.03	4.46
Substance use	2.9	2.80	3.08
Behavioural disengagement	3.01	2.79	3.24
Self-blame	3.70	3.71	4.58

A6.10 Carver Coping Scores by Working from Home

Summary (Weighted results):

There were significant differences in mean scores on ten out of the ten examined Carver coping domains between respondents working from home status(i.e., yes all the time, yes some of time, no) due to the COVID-19 pandemic. These differences were in:

- Active coping ($F = 4.812$, $df = 2$, $p = .008$), where respondents who did not work from home scored significantly higher than the other two groups.
- Planning ($F = 11.652$, $df = 2$, $p < .001$), where respondents who did not work from home scored significantly higher than the other two groups.
- Positive reframing ($F = 6.970$, $df = 2$, $p < .001$), where respondents who worked at home all the time scored significantly lower than the other two groups.
- Acceptance ($F = 20.070$, $df = 2$, $p = .001$), where respondents who did not work from home scored significantly lower than the other two groups.
- Use of emotional support ($F = 139.286$, $df = 2$, $p < .001$), where respondents who did not work from home scored significantly lower than the other two groups.
- Use of instrumental support ($F = 26.724$, $df = 2$, $p = .001$), where respondents worked from home some of the time scored significantly higher than the other two groups.

- Venting (F = 12.103, df = 2, p < .001), where respondents worked from home all of the time scored significantly lower than the other two groups.
- Substance use (F = 6.936, df = 2, p = .001), where respondents worked from home some of the time scored significantly lower than the other two groups.
- Behavioural disengagement (F = 10.194, df = 2, p < .001), where respondents who did not work from home scored significantly higher than the other two groups.
- Self-blame (F = 12.467, df = 2, p < .001), where respondents who did not work from home scored significantly higher than the other two groups.

Summary (Unweighted results):

There were significant differences in mean scores on five out of the ten examined Carver coping domains between respondents working from home status(i.e., yes all the time, yes some of time, no) due to the COVID-19 pandemic. These differences were in:

- Active coping (F = 3.847, df = 2, p = .021), where respondents who did not work from home scored significantly lower than the other two groups.
- Planning (F = 4.491, df = 2, p = .011), where respondents who did not work from home scored significantly lower than those who worked from home all of the time.
- Acceptance (F = 3.158, df = 2, p = .043), where respondents who worked from home all of the time, scored significantly higher than the other two groups.
- Use of emotional support (F = 26.523, df = 2, p = .006), where respondents who did not work from home scored significantly lower than the other two groups.
- Use of instrumental support (F = 9.661, df = 2, p < .001), where respondents worked from home some of the time scored significantly higher than those who did not work from home.
- Venting (F = 3.436, df = 2, p = .032), where respondents worked from home all of the time scored significantly lower than those who worked at home only some of the time.

Figure A6.19: Mean Carver Coping Scores by Working at home (Weighted)

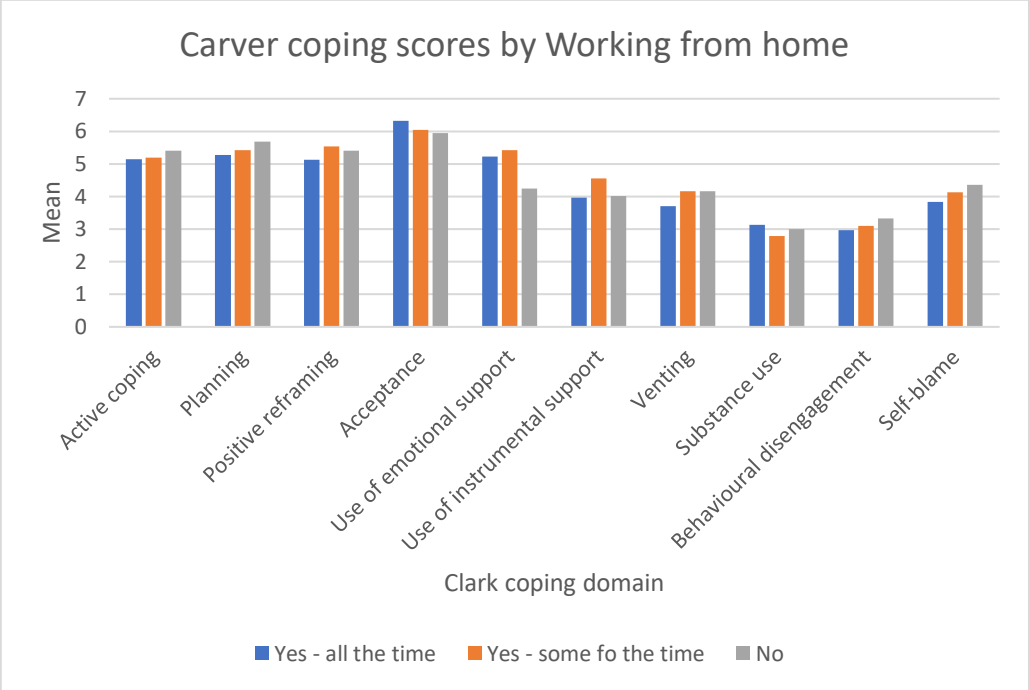


Figure A6.20: Mean Carver Coping Scores by Working at home (Unweighted)

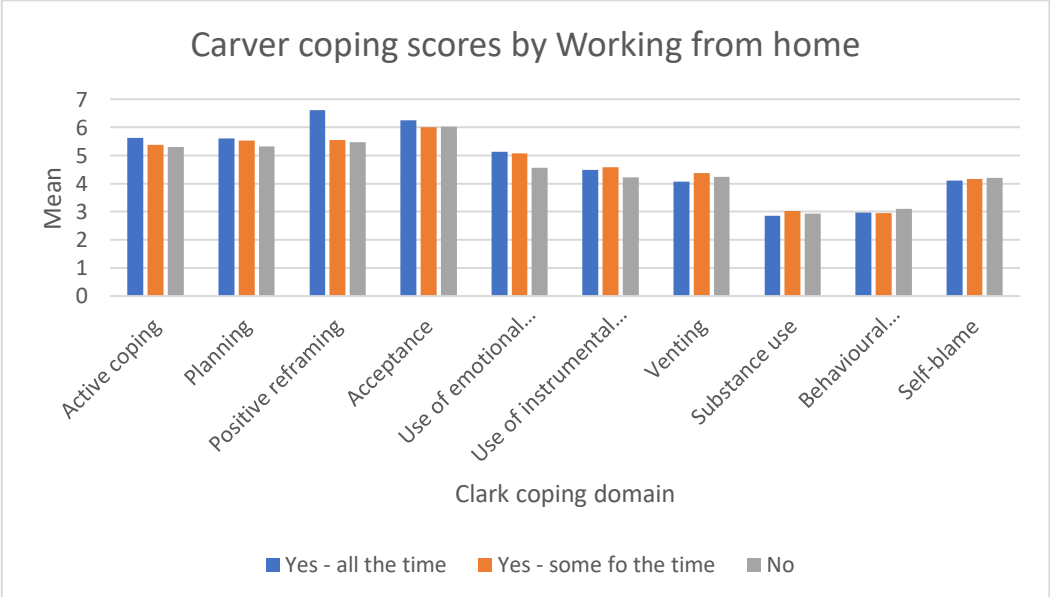


Table A6.19: Mean Carver Coping Scores by Working at home (Weighted)

Coping domain	Are you working from home?		
	Yes - all the time	Yes - some of the time	No
Active coping	5.15	5.20	5.40
Planning	5.27	5.42	5.69
Positive reframing	5.13	5.53	5.40
Acceptance	6.32	6.04	5.94
Use of emotional support	5.22	5.42	4.24
Use of instrumental support	3.96	4.56	4.01
Venting	3.71	4.16	4.16
Substance use	3.13	2.79	3.00
Behavioural disengagement	2.97	3.10	3.32
Self-blame	3.84	4.13	4.35

Table A6.20: Mean Carver Coping Scores by Working at home (Unweighted)

Coping domain	Are you working from home?		
	Yes - all the time	Yes - all the time	Yes - all the time
Active coping	5.62	5.38	5.31
Planning	5.61	5.53	5.33
Positive reframing	6.62	5.55	5.48
Acceptance	6.26	6.01	6.03
Use of emotional support	5.13	5.08	4.56
Use of instrumental support	4.48	4.58	4.23
Venting	4.07	4.38	4.24
Substance use	2.85	3.03	2.94
Behavioural disengagement	2.97	2.95	3.10
Self-blame	4.11	4.16	4.20

A3.11 Carver Coping Scores by Vaccination uptake

Summary (Weighted results):

There were significant differences in mean scores on ten out of the ten examined Carver coping domains between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other). These differences were in:

- Active coping (F = 3.606, df = 2, p = .006), where respondents who had one vaccination scored significantly higher than those who had both.
- Planning (F = 4.144 df = 2, p = .002), where respondents who had one vaccination scored significantly higher than those who had both or those who stated no – other.
- Positive reframing (F = 3.908 df = 2, p = .004), where respondents who had one vaccination scored significantly higher than those who had both, those who had not yet received the vaccination or those who stated no – other.
- Acceptance (F = 5.485 df = 2, p < .001), where respondents who stated no other were scored significantly lower that those who had both or one doses of their vaccination.
- Use of emotional support (F = 5.020 df = 2, p < .001), where respondents who had both doses of their vaccination scored significantly higher than those who only had one dose.
- Use of instrumental support (F = 12.695 df = 2, p < .001), where respondents who had one dose of their vaccination scored significantly higher than those with two doses or those who stated no 'other'.
- Venting (F = 16.718 df = 2, p < .001), where respondents who had both doses of their vaccination scored significantly lower than those with one dose or those who had not yet been vaccinated.
- Substance use (F = 11.524 df = 2, p < .001), where respondents who had one dose of their vaccination scored significantly higher than those with two doses or those who stated no 'other'.
- Behavioural disengagement (F = 19.862 df = 2, p < .001), where respondents who had one doses of their vaccination scored significantly lower than those with two doses or those who stated they had not yet been vaccinated. Those respondents who had both doses, had a significantly lower score than those who where not yet vaccinated and higher than those who had one dose or stated no 'other'.
- Self-blame (F = 9.148 df = 2, p < .001), where respondents who had one doses of their vaccination scored significantly lower than those with two doses or those who stated they had not yet been vaccinated. Those respondents who had both doses, had a significantly lower

score than those who were not yet vaccinated and higher than those who had one dose or stated no 'other'.

Summary (Unweighted results):

There were no significant differences in mean scores on all ten examined Carver coping domains between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other).

Figure A6.21: Mean Carver Coping Scores by vaccination uptake (Weighted)

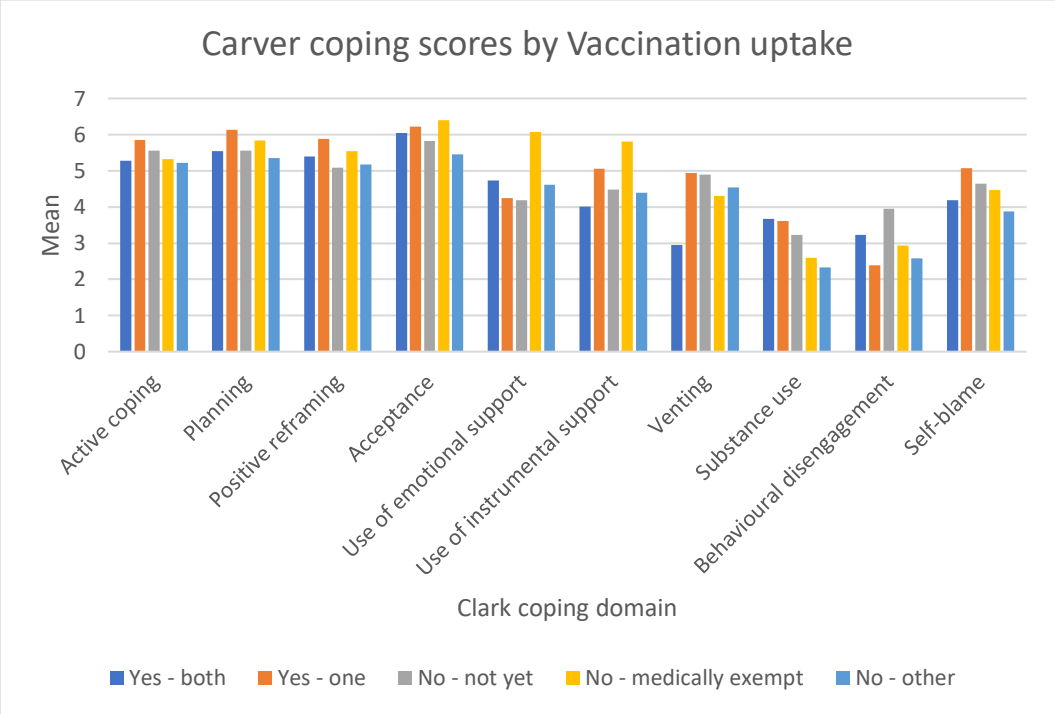


Figure A6.22: Mean Carver Coping Scores by vaccination uptake (Unweighted)

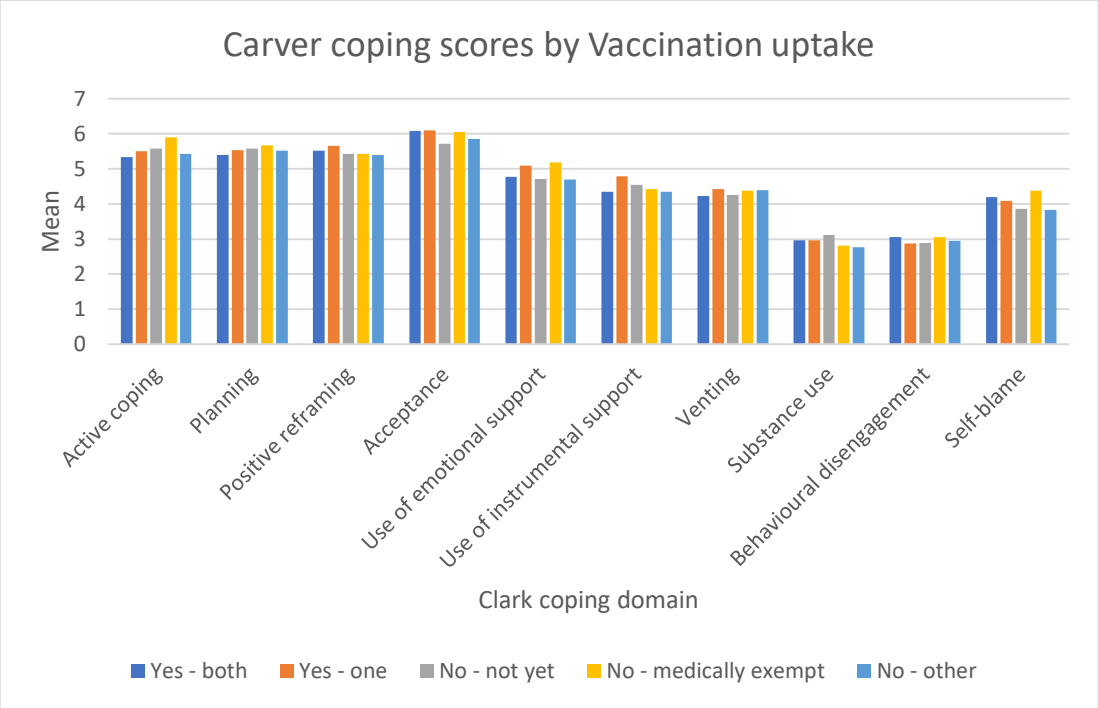


Table A6.21: Mean Carver Coping Scores by vaccination uptake (Weighted)

Coping strategy	Have you received your vaccination(s) yet?				
	Yes - both	Yes - one	No - not yet	No - medically exempt	No - other
Active coping	5.28	5.86	5.56	5.32	5.22
Planning	5.54	6.13	5.56	5.84	5.35
Positive reframing	5.39	5.89	5.08	5.54	5.17
Acceptance	6.04	6.22	5.83	6.4	5.46
Use of emotional support	4.74	4.24	4.18	6.07	4.61
Use of instrumental support	4.01	5.06	4.48	5.81	4.39
Venting	2.95	4.94	4.89	4.3	4.54
Substance use	3.67	3.61	3.23	2.59	2.33
Behavioural disengagement	3.23	2.39	3.95	2.93	2.58
Self-blame	4.18	5.07	4.65	4.46	3.88

Table A6.22: Mean Carver Coping Scores by vaccination uptake (Unweighted)

Coping strategy	Have you received your vaccination(s) yet?				
	Yes - both	Yes - one	No - not yet	No - medically exempt	No - other
Active coping	5.34	5.51	5.58	5.90	5.42
Planning	5.39	5.54	5.58	5.67	5.52
Positive reframing	5.52	5.66	5.43	5.43	5.40
Acceptance	6.08	6.09	5.72	6.05	5.85
Use of emotional support	4.78	5.09	4.71	5.19	4.70
Use of instrumental support	4.34	4.79	4.54	4.43	4.34
Venting	4.23	4.43	4.26	4.38	4.40
Substance use	2.96	2.97	3.11	2.81	2.76
Behavioural disengagement	3.06	2.87	2.88	3.05	2.95
Self-blame	4.20	4.09	3.86	4.38	3.83

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 = 2.687, df = 3, p = .045), but multiple comparison tests revealed no statistically significant differences.
- Work-family (F = 5.346, df = 3, p = .001), where respondents from England scored significantly lower than those from the other three countries.
- Exercise (F = 7.137, df = 3, p < .001), where respondents from Northern Ireland scored significantly higher than those in England or Wales.

Summary (Unweighted results):

There were significant differences between the countries in mean scores on three out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation (F = 3.786, df = 3, p = .010), where respondents from England scored significantly lower than those from the other three countries.
- Work-family segmentation (F = 8.029, df = 3, p < .001), where respondents from England scored significantly lower than those from the other three countries.
- Exercise (F = 5.336, df = 3, p = .001), where respondents from Wales scored significantly lower than those from Northern Ireland.

Figure A7.1: Mean Clark Coping Scores by Country (Weighted)

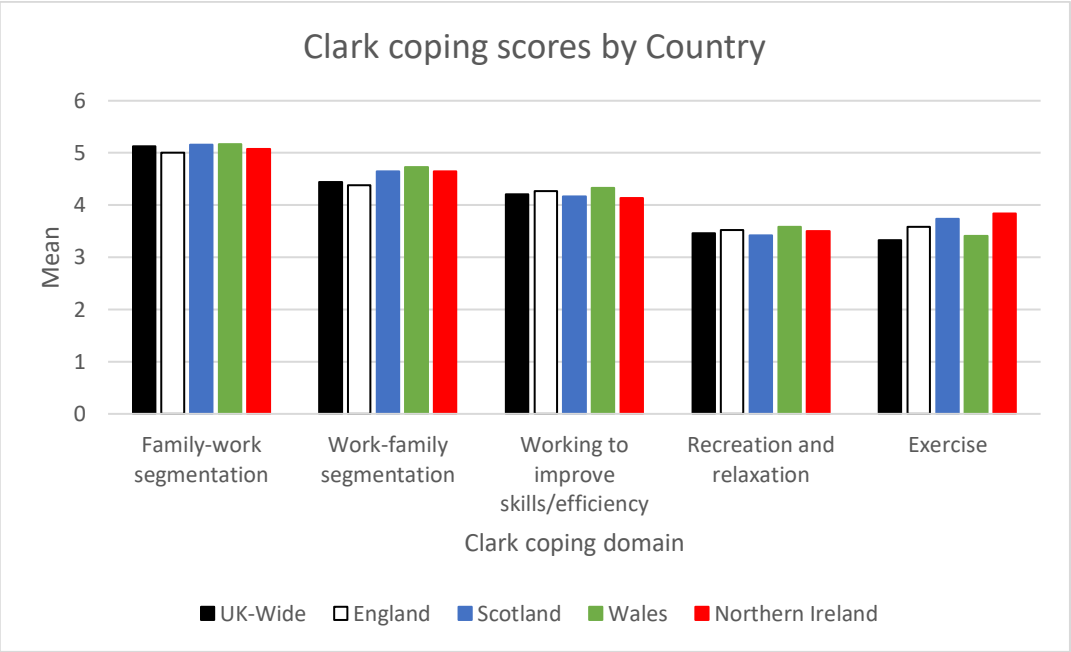


Figure A7.2: Mean Clark Coping Scores by Country (Unweighted)

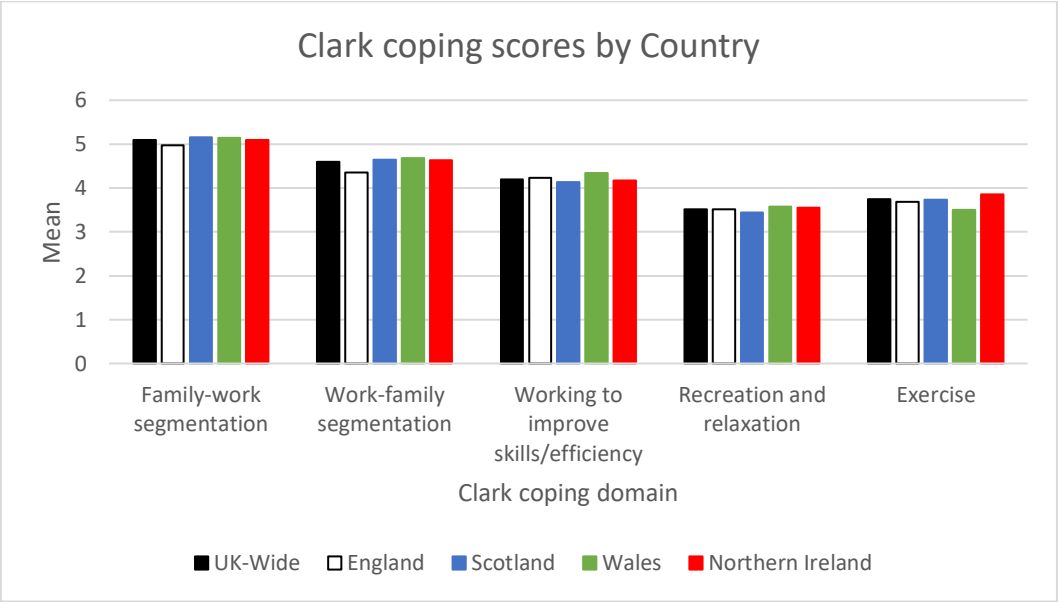


Table A7.1: Mean Clark Coping Scores by Country (Weighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
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

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	4.97	5.15	5.14	5.10
Work-family segmentation	4.59	4.35	4.64	4.68	4.63
Working to improve skills/efficiency	4.19	4.23	4.14	4.34	4.17
Recreation and relaxation	3.52	3.52	3.44	3.57	3.55
Exercise	3.74	3.68	3.73	3.50	3.86

A7.2 Clark Coping Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on all five Clark coping domains:

- Family-work segmentation ($F = 10.383$, $df = 4$, $p < .001$), where social care workers scored significantly higher than the other four occupations.
- Work-family segmentation ($F = 12.465$, $df = 4$, $p < .001$), where midwives scored significantly lower than the other four occupations.
- Working to improve skills/efficiency ($F = 15.657$, $df = 4$, $p < .001$), where AHPs scored significantly higher than the other four occupations.
- Recreation and relaxation ($F = 27.184$, $df = 4$, $p < .001$), where midwives scored significantly lower than the other occupational groups.

- Exercise (F = 14.932, df = 4, p < .001), where social care workers scored significantly lower than the other occupational groups.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on all five Clark Coping domains:

- Family-work segmentation (F = 5.803, df = 4, p < .001), where social care workers scored significantly higher than nurses, AHPs and social workers.
- Work-family segmentation (F = 7.013, df = 4, p < .001), where midwives scored significantly lower than all other occupations.
- Working to improve skills/efficiency (F = 6.606, df = 4, p < .001), where social care workers scored significantly lower than nurses, AHPs and social workers.
- Recreation and relaxation (F = 16.190, df = 4, p < .001), midwives scored significantly lower than all other occupations.
- Exercise (F = 9.305, df = 4, p < .001), where social care workers scored significantly lower than nurses, AHP's and social workers.

Figure A7.3: Mean Clark Coping Scores by Occupation (Weighted)

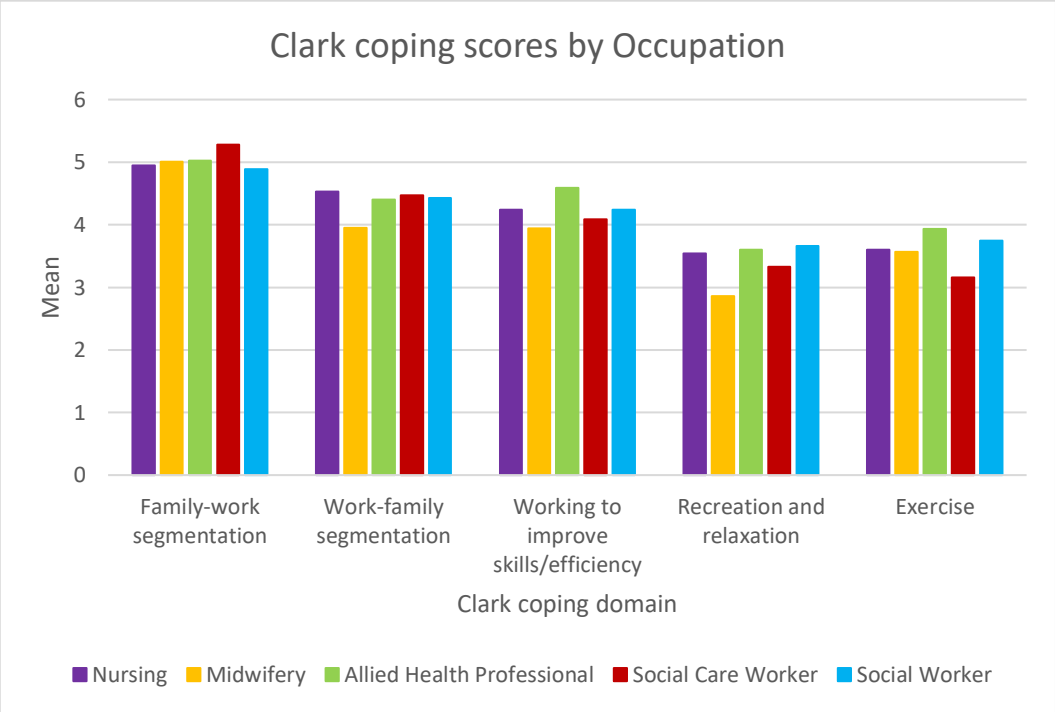


Figure A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

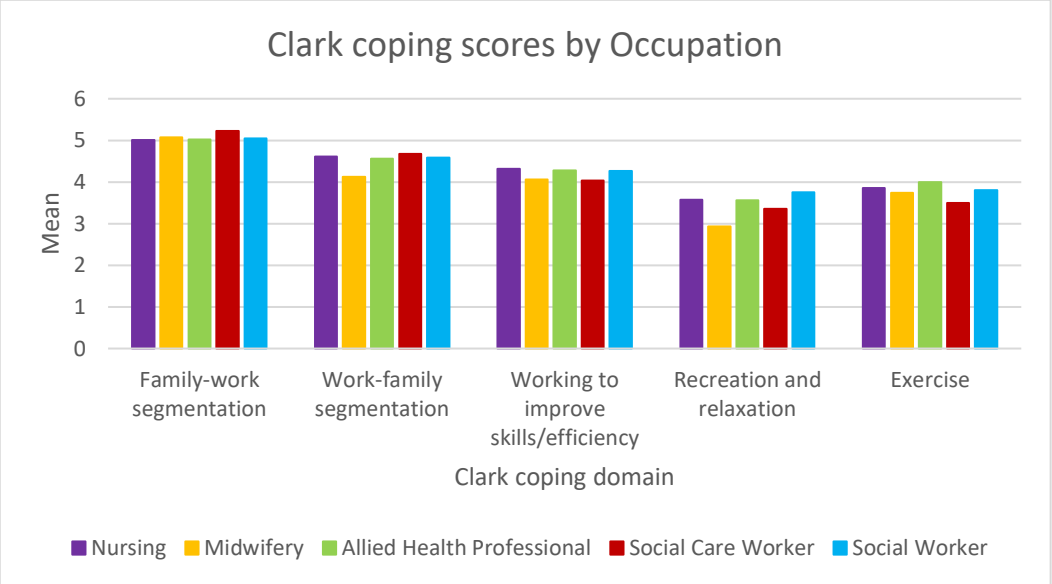


Table A7.3: Mean Clark Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	4.95	5.01	5.02	5.28	4.89
Work-family segmentation	4.53	3.95	4.4	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	3.6	3.33	3.66
Exercise	4.95	5.01	5.02	5.28	4.89

Table A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	5.01	5.07	5.02	5.23	5.05
Work-family segmentation	4.61	4.12	4.56	4.68	4.58
Working to improve skills/efficiency	4.31	4.06	4.28	4.03	4.27
Recreation and relaxation	3.57	2.93	3.56	3.36	3.75
Exercise	3.85	3.74	3.99	3.49	3.81

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 two out of the five examined Clark coping domains. These differences were in:

- Recreation and relaxation (t = -3.044, df = 2570, p = .002), where males scored significantly higher than females.
- Exercise (t = -6.067, df = 2565, p < .001), where males scored significantly higher than females.

Summary (Unweighted results):

There were significant differences between males and females in mean scores on three out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation (t = -2.450, df = 2229, p = .014), where males scored significantly higher than females.
- Working to improve skills/efficiency (t = 3.772, df = 2226, p < .001), where females scored significantly higher than males.
- Recreation and relaxation (t = -2.448, df = 2213, p = .014), where males scored significantly higher than females.

Figure A7.5: Mean Clark Coping Scores by Sex (Weighted)

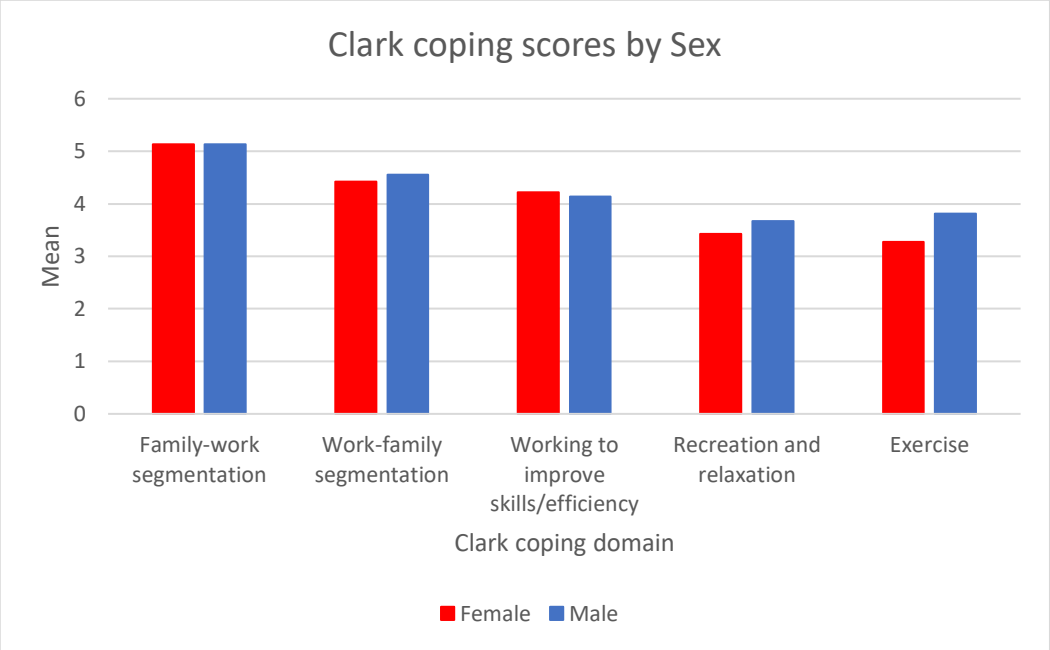


Figure A7.6: Mean Clark Coping Scores by Sex (Unweighted)

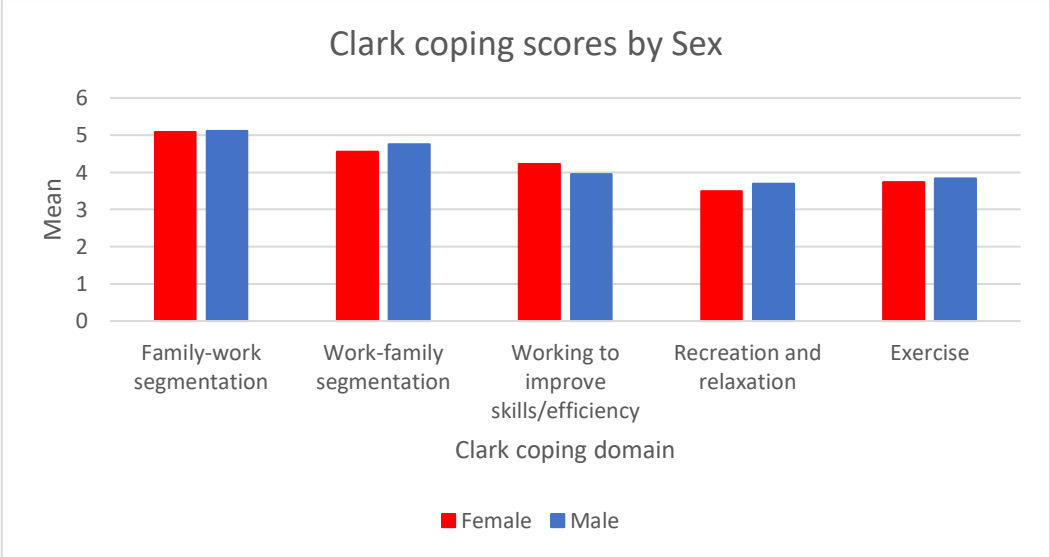


Table A7.5: Mean Clark Coping Scores by Sex (Weighted)

Coping Domain	Sex	
	Female	Male
Family-work segmentation	5.13	5.13
Work-family segmentation	4.42	4.55
Working to improve skills/efficiency	4.22	4.14
Recreation and relaxation	3.43	3.67
Exercise	3.27	3.81

Table A7.6: Mean Clark Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Family-work segmentation	5.09	5.11
Work-family segmentation	4.56	4.75
Working to improve skills/efficiency	4.23	3.95
Recreation and relaxation	3.49	3.7
Exercise	3.73	3.84

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 ($F = 39.982$, $df = 5$, $p < .001$), where the 60-65 age group scored significantly higher than all age groups except 66+, 60-65 age group scored significantly lower than the 66+ age group. The 16-29 age group scored significantly lower than all age groups except 30-39.
- Work-family segmentation ($F = 85.951$, $df = 5$, $p < .001$), where the 66+ age group scored significantly higher than all of the other age groups; the 60-65 age group scored significantly lower than all age groups except the 30-39 age group.
- Working to improve skills/efficiency ($F = 20.483$, $df = 5$, $p < .001$), where the 66+ age group scored significantly higher than all of the other age groups; the 60-65 age group scored

significantly lower than 30-39 and 66+ age groups; the 30-39 age groups scored significantly higher than all age groups except 66+ age group.

- Recreation and relaxation (F = 37.114, df = 5, p < .001), where the 66+ age group scored significantly higher than all other age groups; the 60-65 age group scored significantly lower than all age groups except the 40-49 age group; the 40-49 age group scored significantly lower than all age groups except the 60-65 age group.
- Exercise (F = 16.497, df = 5, p < .001), where the 66+ age group scored significantly higher than all other age groups; the 60-65 age groups scored significantly lower than the 30-39, 50-59 and 66+ age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on three out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation (F= 4.726, df = 5, p < .001), where the 60-65 age group scored significantly higher than the 16-29, 30-39 and 40-49 age groups.
- Work-family segmentation (F= 10.395, df = 5, p < .001), where the 60-65 age group scored significantly higher than the 16-29, 30-39 and 40-49 age groups; the 50-59 age group scored significantly higher than the 16-29 and 30-39 age groups.
- Recreation and relaxation (F= 3.646, df = 5, p = .003); where the 60-65 age group scored significantly higher than the 16-29, 30-39 and 40-49 age groups.

Figure A7.7: Mean Clark Coping Scores by Age (Weighted)

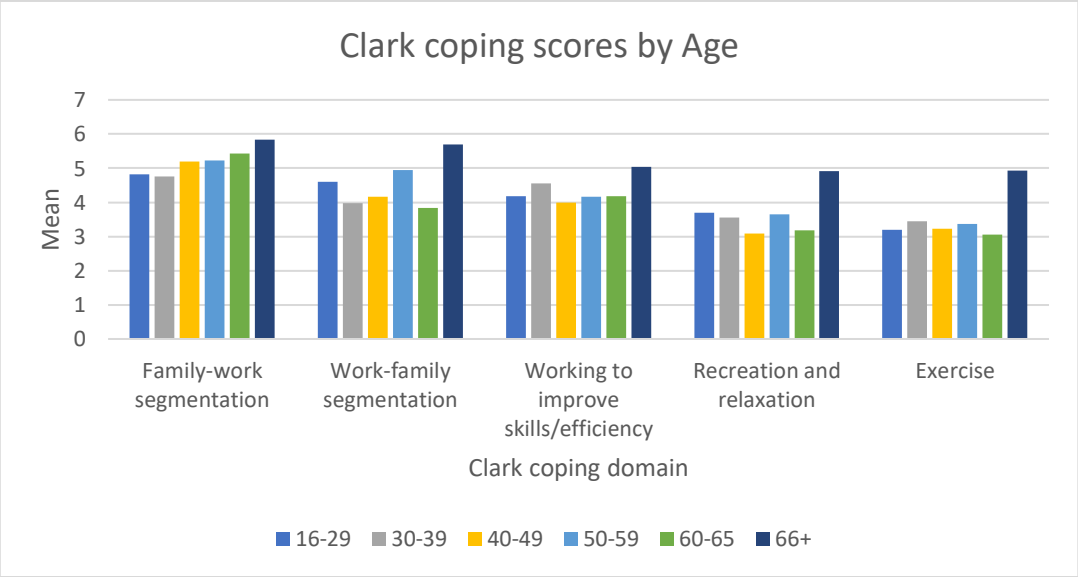


Figure A7.8: Mean Clark Coping Scores by Age (Unweighted)

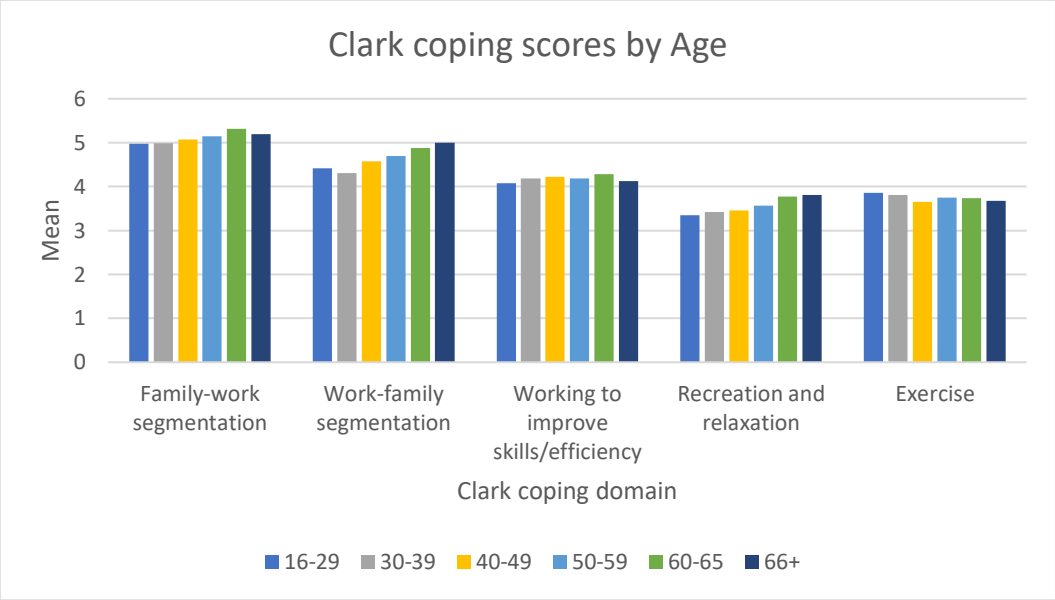


Table A7.7: Mean Clark Coping Scores by Age (Weighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Family-work segmentation	4.82	4.75	5.20	5.23	5.43	5.84
Work-family segmentation	4.60	3.98	4.17	4.95	3.84	5.70
Working to improve skills/efficiency	4.18	4.56	3.99	4.17	4.18	5.04
Recreation and relaxation	3.70	3.55	3.09	3.65	3.18	4.91
Exercise	3.19	3.45	3.22	3.37	3.05	4.93

Table A7.8: Mean Clark Coping Scores by Age (Unweighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Family-work segmentation	4.97	4.99	5.07	5.14	5.32	5.19
Work-family segmentation	4.42	4.31	4.57	4.69	4.88	5.00
Working to improve skills/efficiency	4.08	4.19	4.22	4.18	4.28	4.13
Recreation and relaxation	3.35	3.42	3.46	3.57	3.77	3.81
Exercise	3.86	3.81	3.65	3.75	3.74	3.67

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 ($F = 7.945$, $df = 3$, $p < .001$), where respondents from the black ethnic group scored significantly higher than all other ethnic groups.
- Work-family segmentation ($F = 6.955$, $df = 3$, $p < .001$), where respondents from the black ethnic group scored significantly higher those in White and Asian ethnic groups.
- Working to improve skills/efficiency ($F = 38.055$, $df = 3$, $p = .006$), where respondents from the black ethnic group scored significantly higher than all other ethnic groups; those from the White ethnic group scored significantly lower than the Mixed ethnic group.
- Recreation and relaxation ($F = 48.446$, $df = 3$, $p < .001$), where respondents from the black ethnic group scored significantly higher than all other ethnic groups; those from the White ethnic group scored significantly lower than the Mixed ethnic group, those in the Mixed ethnic group scored significantly lower than the Asian ethnic group.
- Exercise ($F = 41.496$, $df = 3$, $p = .001$), where respondents from the black ethnic group scored significantly higher than all other ethnic groups; those from the White and Mixed ethnic groups scored significantly lower than the Asian ethnic group. The Asian ethnic group scored significantly lower than all other ethnic groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups in mean scores in one out of the five examined Clark coping domains. These differences were in:

- Working to improve skills/efficiency ($F = 3.067$, $df = 3$, $p = .027$), where respondents from the black ethnic group scored significantly higher than those in the White ethnic group.

There also appeared to be significant differences between the age groups on Recreation and relaxation ($F = 3.630$, $df = 3$, $p = .012$), but multiple comparison tests revealed no statistically significant differences.

Figure A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

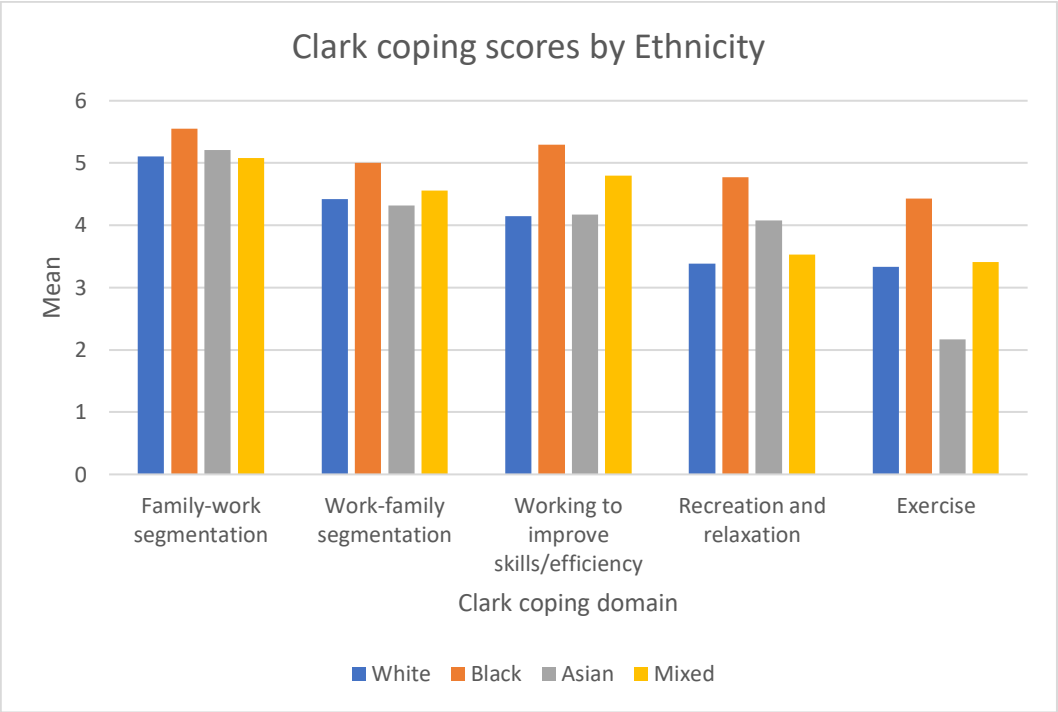


Figure A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

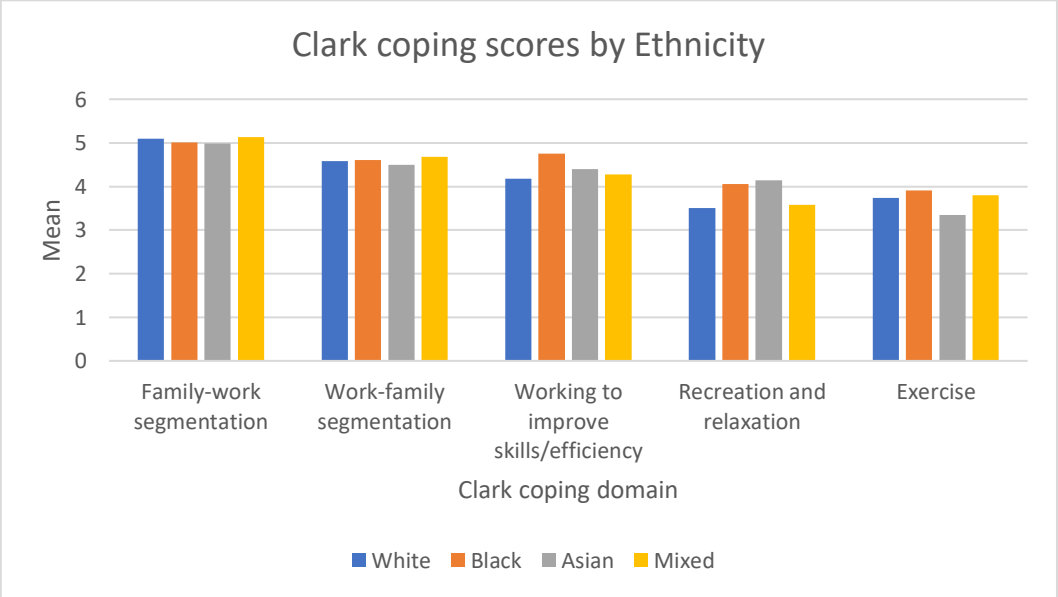


Table A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	5.11	5.55	5.21	5.08
Work-family segmentation	4.42	5.00	4.32	4.56
Working to improve skills/efficiency	4.15	5.29	4.17	4.80
Recreation and relaxation	3.38	4.77	4.08	3.53
Exercise	3.33	4.43	2.17	3.41

Table A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	5.10	5.01	4.98	5.13
Work-family segmentation	4.58	4.61	4.49	4.68
Working to improve skills/efficiency	4.18	4.75	4.40	4.27
Recreation and relaxation	3.50	4.05	4.14	3.58
Exercise	3.74	3.91	3.35	3.80

A7.6 Clark Coping Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 21.376$, $df = 2$, $p < .001$), where respondents who were unsure of whether or not they had a disability scored significantly higher than the other two groups.
- Work-family segmentation ($F = 21.113$, $df = 2$, $p < .001$), where respondents who were unsure of whether or not they had a disability scored significantly lower than the other two groups; those who had a disability scored significantly higher than those with no disability.
- Recreation and relaxation ($F = 21.072$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those with no disability.
- Exercise ($F = 16.996$, $df = 2$, $p < .001$), where respondents who had a disability scored significantly higher than those who were unsure of whether or not they had a disability and those with no disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on two out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation (F = 8.755, df = 2, p < .001), where respondents who had a disability scored significantly lower than those without a disability.
- Exercise (F = 10.338, df = 2, p < .001), where respondents without a disability scored significantly higher than those with a disability.

Figure A7.11: Mean Clark Coping Scores by Disability (Weighted)

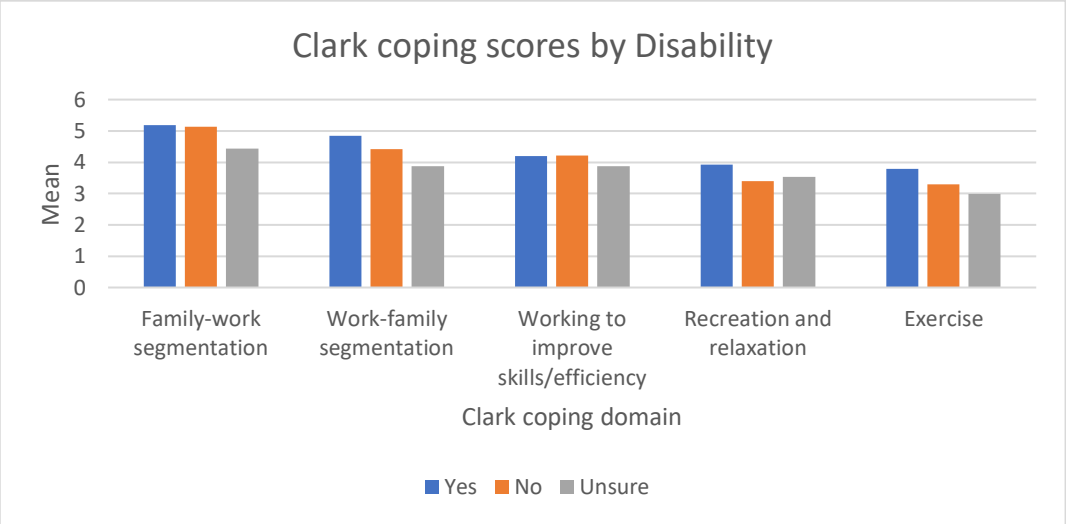


Figure A7.12: Mean Clark Coping Scores by Disability (Unweighted)

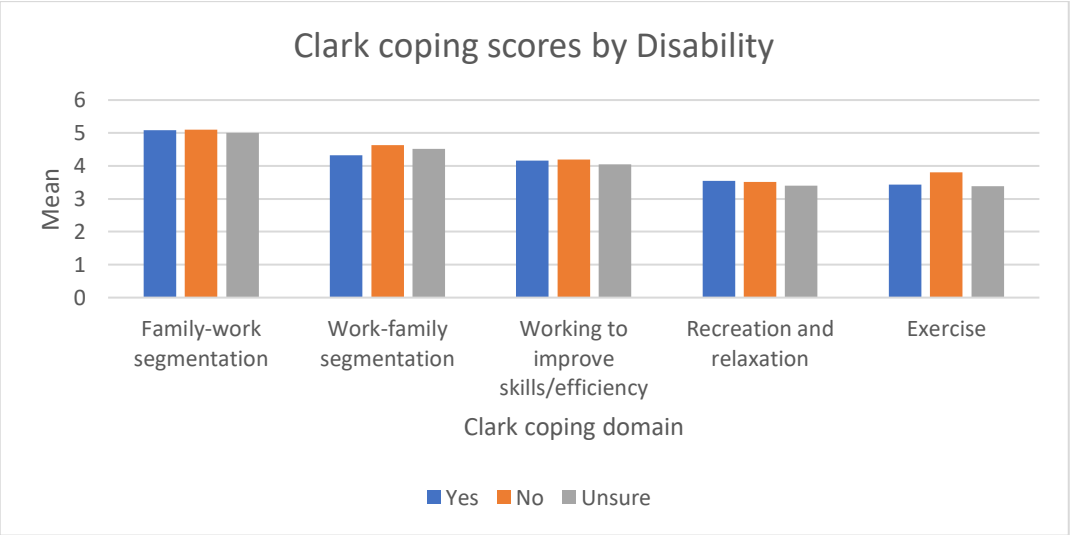


Table A7.11: Mean Clark Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Family-work segmentation	5.19	5.14	4.44
Work-family segmentation	4.85	4.41	3.88
Working to improve skills/efficiency	4.20	4.22	3.87
Recreation and relaxation	3.92	3.40	3.53
Exercise	3.79	3.29	2.98

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	5.10	5.01
Work-family segmentation	4.33	4.63	4.51
Working to improve skills/efficiency	4.16	4.20	4.05
Recreation and relaxation	3.54	3.52	3.40
Exercise	3.44	3.80	3.39

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 ($F = 15.723$, $df = 7$, $p < .001$), where respondents working in the 'Other' area scored significantly higher than with those working with children, in midwifery, with adults, older people and in mental health; and those working in midwifery scored significantly lower than those working with children, adults, physical disability, learning disability, older people or in 'other' services.
- Work-family segmentation ($F = 29.724$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly lower than those working with children, adults, learning disability, older people, mental health and in 'other' services; respondents working in the 'other' areas scored significantly higher than those working with children, in midwifery, with adults, physical disability, learning disability, older people and in mental health services; and

respondents working in the area of learning disability scored significantly higher than those working in midwifery, physical disability, older people and 'other' services.

- Working to improve skills/efficiency (F = 13.283, df = 7, p < .001), where respondents working with children scored significantly higher than those working in midwifery, with adults, and mental health services; respondents working in the 'Other' areas scored significantly higher than those working in midwifery, with adults, learning disability, older people or in mental health services.
- Recreation and relaxation (F = 5.914, df = 7, p < .001), where respondents working in learning disability scored significantly lower than those working with children, adults, in physical disability and 'other' services; those working in 'other' services scored significantly higher than those in midwifery, working with adults, older people, and in learning disability services.
- Exercise (F = 27.527, df = 7, p < .001), where respondents working with children scored significantly higher than those working with adults, older people and in learning disability services; those working with adults scored significantly higher than those working with learning disability and older people but scored significantly lower than those working with children or in 'other' services; those working with older people scored significantly lower than those working with children, adults, mental health and 'other' services; those working in 'other' services scored significantly higher than those working in midwifery, in learning disability and older people services.

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 = 2.580, df = 7, p = .012), where respondents working with older people scored significantly higher than those working with adults.
- Work-family segmentation (F = 5.021, df = 7, p < .001), where respondents working in midwifery scored significantly lower than those working with children, adults, older people in learning disability, in mental health or 'other' services.
- Working to improve skills/efficiency (F = 4.138, df = 7, p < .001), where respondents working with children scored significantly higher than those working in learning disability and with older people. Those working with adults scored significantly higher than those working with older people.
- Recreation and relaxation (F = 7.386, df = 7, p < .001), where respondents working in the area of children scored significantly higher than those working in midwifery, in learning disability,

or older people; respondents working in midwifery scored significantly lower than those working with children, adults, older people, in physical disability, mental health or 'other' services.

- Exercise (F = 3.156, df = 7, p = .003), where respondents working with older people scored significantly lower than those working with adults.

Figure A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

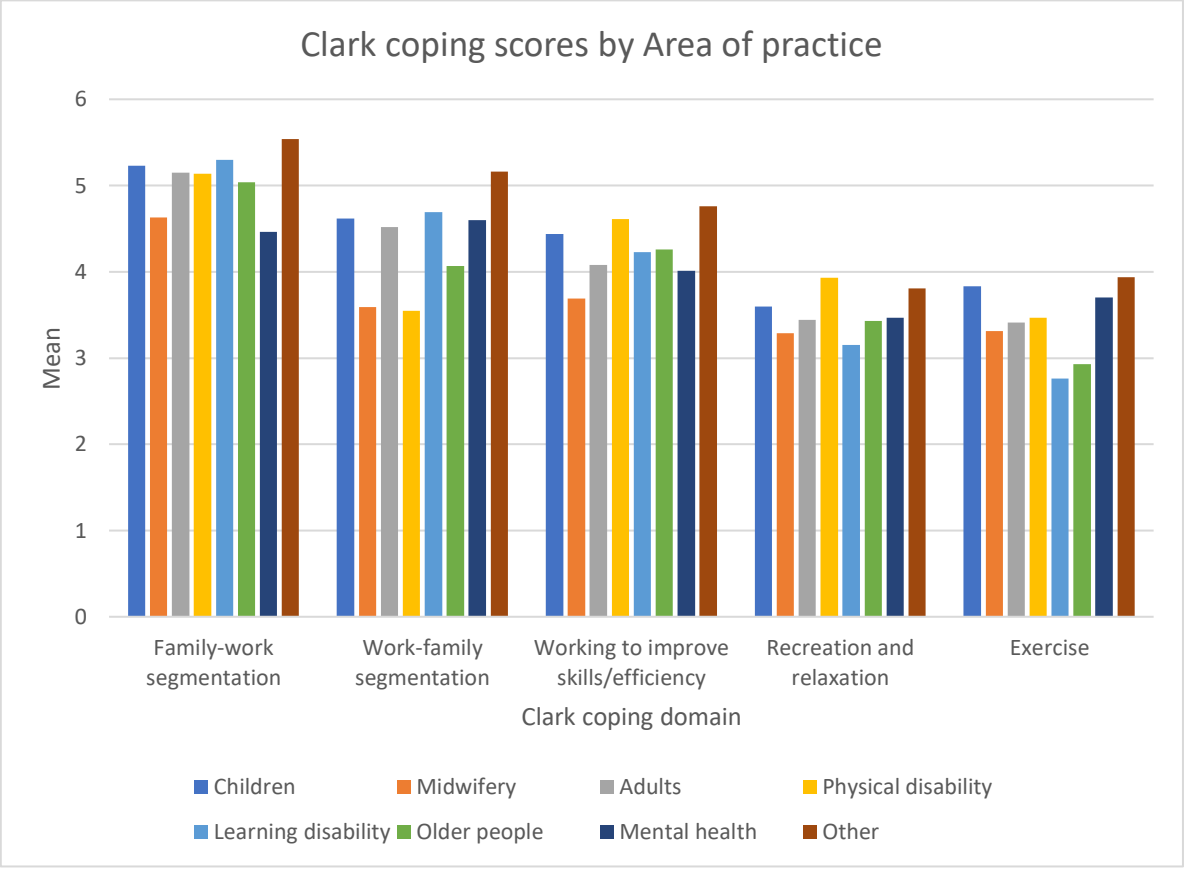


Figure A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)

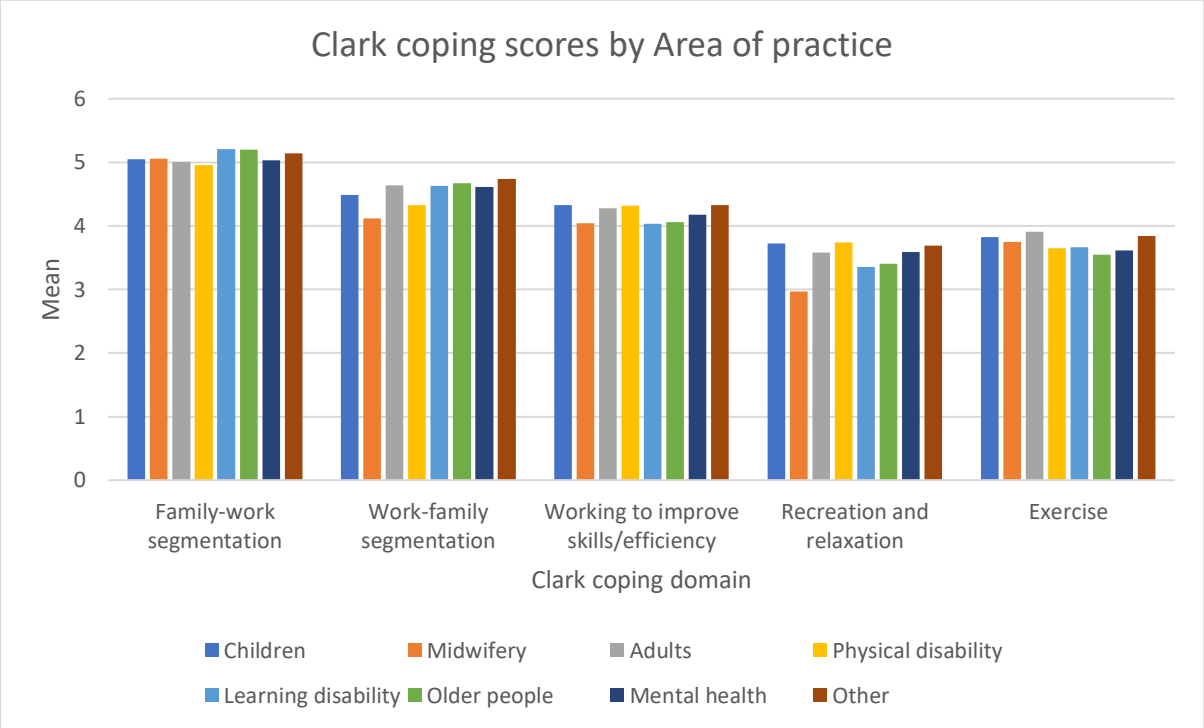


Table A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Family-work segmentation	5.23	4.63	5.15	5.14	5.30	5.04	4.46	5.54
Work-family segmentation	4.62	3.59	4.52	3.55	4.69	4.07	4.60	5.16
Working to improve skills/efficiency	4.44	3.69	4.08	4.61	4.23	4.26	4.01	4.76
Recreation and relaxation	3.60	3.29	3.44	3.93	3.15	3.43	3.47	3.81
Exercise	3.83	3.31	3.41	3.47	2.76	2.93	3.70	3.94

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	5.05	5.06	5.01	4.96	5.21	5.20	5.03	5.14
Work-family segmentation	4.49	4.12	4.64	4.33	4.63	4.67	4.61	4.74
Working to improve skills/efficiency	4.33	4.04	4.28	4.32	4.03	4.06	4.18	4.33
Recreation and relaxation	3.72	2.97	3.58	3.74	3.35	3.40	3.59	3.69
Exercise	3.82	3.75	3.91	3.65	3.66	3.55	3.61	3.84

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 all five examined Clark coping domains. These differences were in:

- Family-work segmentation (t = 3.595, df = 2562, p < .001), where line managers scored significantly higher than those who were not line managers.
- Work-family segmentation (t = -6.490, df = 2580, p < .001), where line managers scored significantly lower than those who were not line managers.
- Working to improve skills/efficiency (t = -4.509, df = 2579, p < .001), where line managers scored significantly lower than those who were not line managers.
- Recreation and relaxation (t = -3.329, df = 2576, p = .001), where line managers scored significantly lower than those who were not line managers.
- Exercise (t = -7.647, df = 2571, p < .001), where line managers scored significantly lower than those who were not line managers.

Summary (Unweighted results):

There were significant differences between respondents who were line managers and those who were not in mean scores on one out of the five examined Clark coping domains. The differences were in:

- Working to improve skills/efficiency (t = 2.033, df = 2241 p = .042), 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)

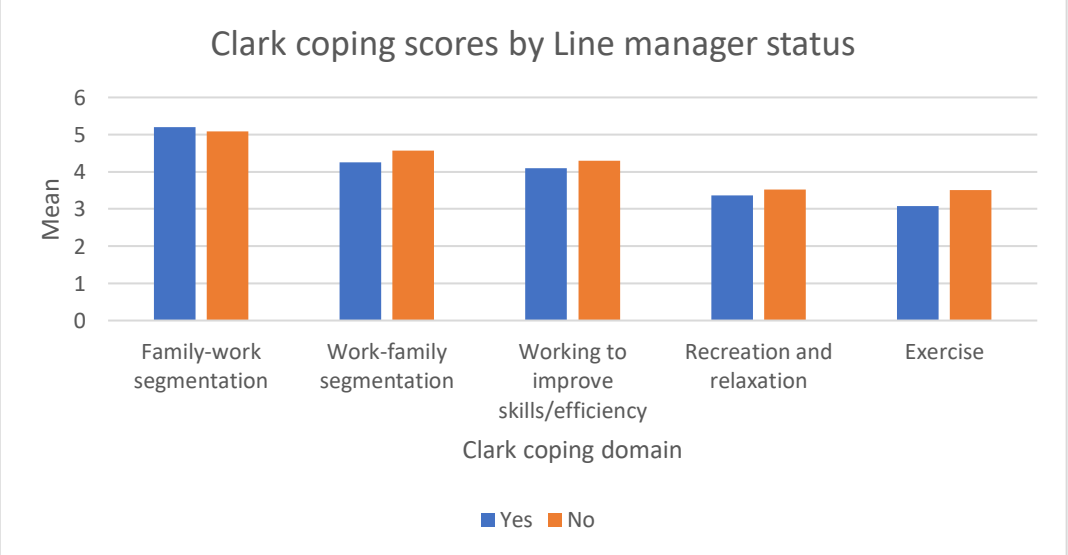


Figure A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

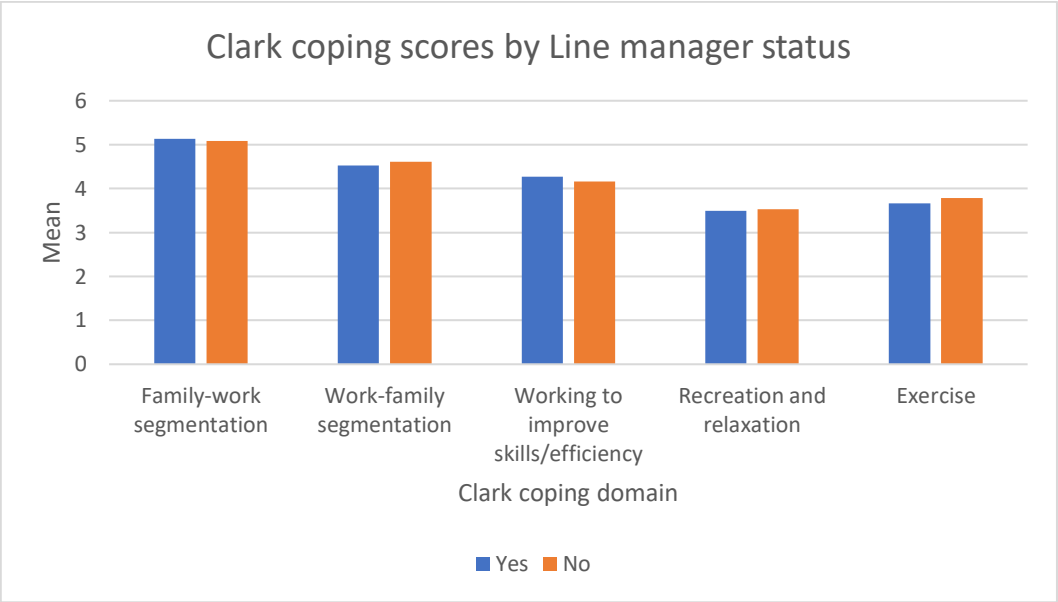


Table A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	5.20	5.08
Work-family segmentation	4.25	4.57
Working to improve skills/efficiency	4.09	4.30
Recreation and relaxation	3.36	3.52
Exercise	3.08	3.51

Table A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	5.13	5.08
Work-family segmentation	4.53	4.61
Working to improve skills/efficiency	4.27	4.16
Recreation and relaxation	3.49	3.53
Exercise	3.66	3.78

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 ($F = 32.707$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly lower than the other two groups.
- Work-family segmentation ($F = 42.038$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those not impacted and those impacted some.
- Working to improve skills/efficiency ($F = 6.347$, $df = 2$, $p = .002$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those impacted some.
- Recreation and relaxation ($F = 12.831$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who were impacted some; those who were not impacted scored significantly lower than those were impacted some.
- Exercise ($F = 62.346$, $df = 2$, $p < .001$), where respondents who felt impacted some scored significantly higher than those who were not impacted and those who felt overwhelmed by increased pressures.

Summary (Unweighted results):

There were significant differences in mean scores on four out of the five examined Clark coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Work-family segmentation ($F = 8.982$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact.
- Working to improve skills/efficiency ($F = 5.524$, $df = 2$, $p = .004$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact.
- Recreation and relaxation ($F = 6.010$, $df = 2$, $p = .002$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact.

- Exercise (F = 10.925, df = 2, p < .001), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact.

Figure A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

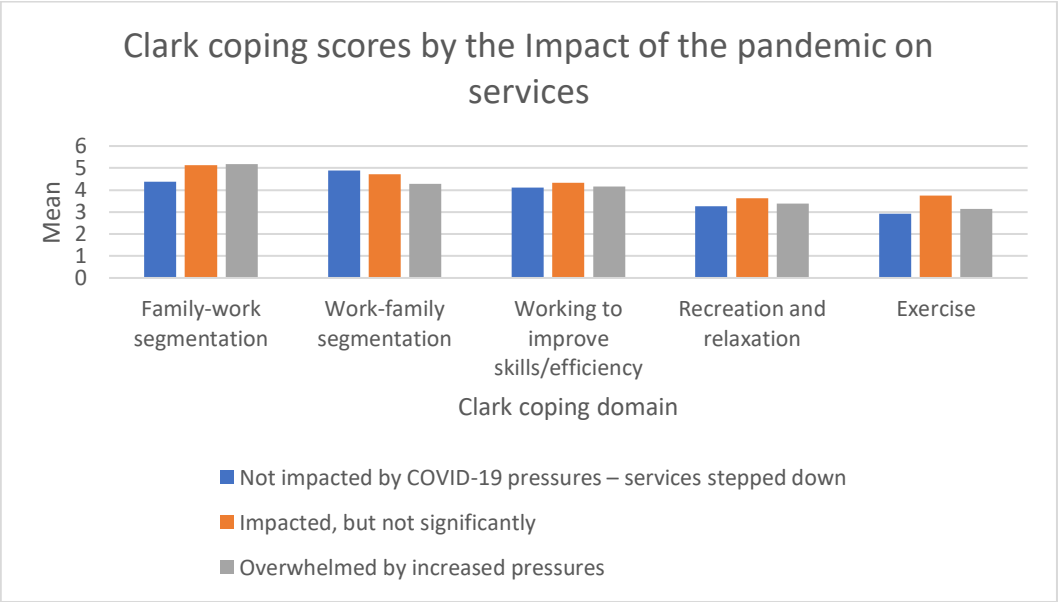


Figure A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)

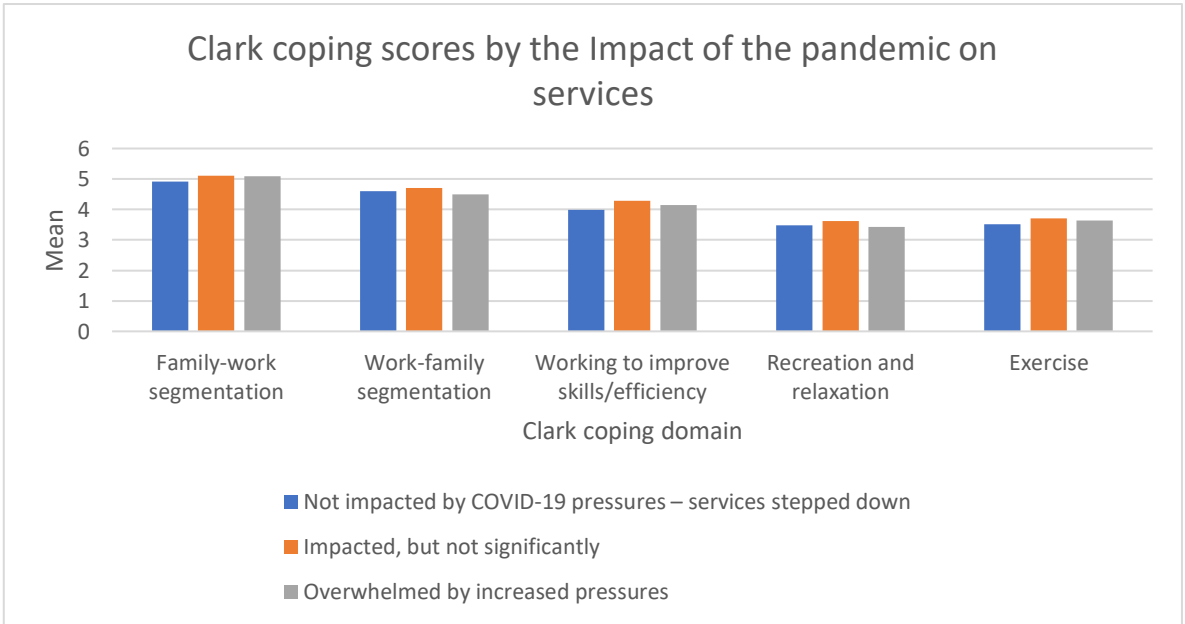


Table A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

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	4.37	5.12	5.17
Work-family segmentation	4.89	4.71	4.27
Working to improve skills/efficiency	4.12	4.32	4.16
Recreation and relaxation	3.27	3.62	3.38
Exercise	2.91	3.75	3.13

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	4.91	5.11	5.09
Work-family segmentation	4.60	4.70	4.49
Working to improve skills/efficiency	3.98	4.28	4.14
Recreation and relaxation	3.48	3.62	3.43
Exercise	3.51	3.70	3.63

A6.10 Carver Coping Scores by Working from Home

Summary (Weighted results):

There were significant differences in mean scores on all five examined Clark coping domains between respondents between respondents working from home status(i.e., yes all the time, yes some of time, no) due to the COVID-19 pandemic. These differences were in:

- Family-work segmentation (F = 6.917, df = 2, p = .001), where respondents who did not work from home scored significantly higher than those who worked from home some of the time.
- Work-family segmentation (F = 5.067, df = 2, p = .006), where respondents who did not work from home scored significantly lower than those who worked from home some of the time.

- Working to improve skills/efficiency (F = 31.218, df = 2, p < .001), where respondents who did not work from home scored significantly lower than those who worked from home some of the time or all of the time.
- Recreation and relaxation (F = 52.985, df = 2, p < .001), where respondents who did not work from home scored significantly lower than those who worked from home all of the time.
- Exercise (F = 13.027, df = 2, p < .001), where respondents who worked from home all the time scored significantly higher than those who worked at home some of the time and those who did not work from home.

Summary (Unweighted results):

There were significant differences in mean scores on two out of the five examined Clark coping domains between respondents between respondents working from home status(i.e., yes all the time, yes some of time, no) due to the COVID-19 pandemic. These differences were in:

- Working to improve skills/efficiency (F = 19.138, df = 2, p < .001), where respondents who did not work from home scored significantly lower than the other two groups.
- Recreation and relaxation (F = 24.310, df = 2, p < .001), where respondents who did not work from home scored significantly lower than the other two groups.

There also appeared to be significant differences between working from home status on Family-work segmentation (F = 3.917, df = 2, p = .020), but multiple comparison tests revealed no statistically significant differences.

Figure A7.19: Mean Clark Coping Scores by Working at home (Weighted)

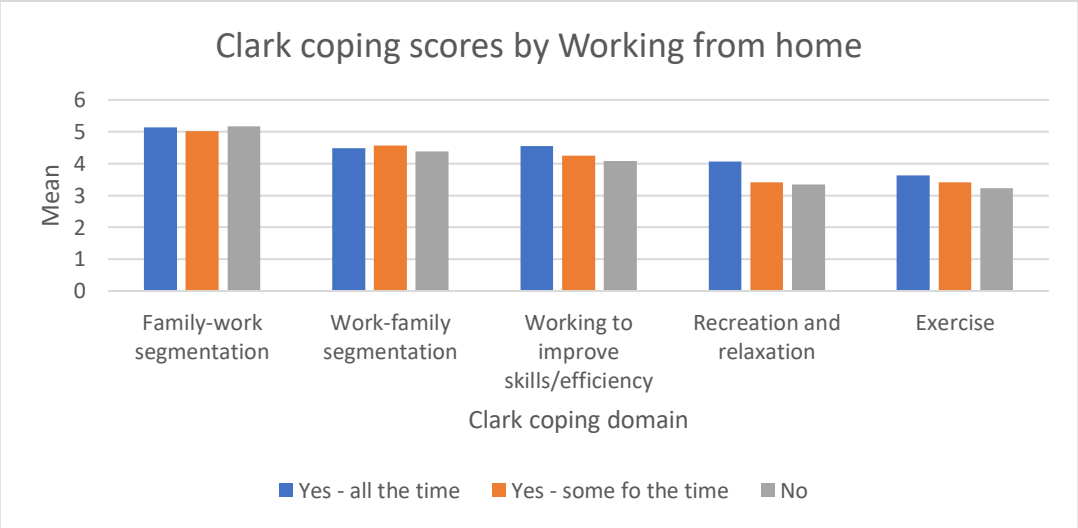


Figure A7.20: Mean Clark Coping Scores by Working at home (Unweighted)

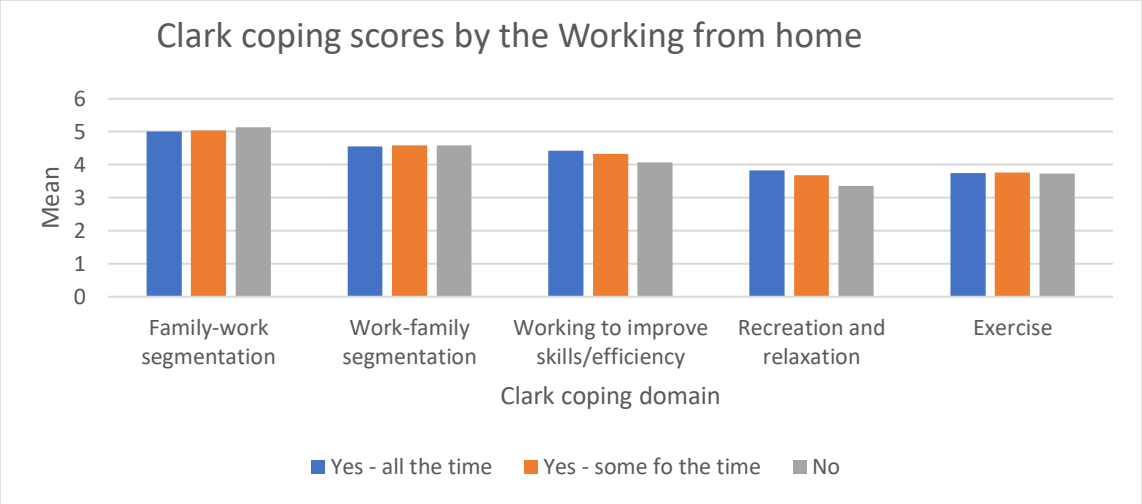


Table A7.19: Mean Clark Coping Scores by Working at home (Weighted)

Coping domain	**Are you working from home?**		
	Yes - all the time	Yes - some of the time	No
Family-work segmentation	5.14	5.02	5.17
Work-family segmentation	4.48	4.56	4.38
Working to improve skills/efficiency	4.55	4.25	4.08
Relaxation and recreation	4.06	3.41	3.34
Exercise	3.63	3.41	3.23

Table A7.20: Mean Clark Coping Scores by Working at home (Unweighted)

Coping domain	**Are you working from home?**		
	Yes - all the time	Yes - some of the time	No
Family-work segmentation	5.00	5.04	5.14
Work-family segmentation	4.56	4.58	4.59
Working to improve skills/efficiency	4.43	4.33	4.07
Relaxation and recreation	3.83	3.68	3.36
Exercise	3.75	3.76	3.73

A3.11 Clark Coping Scores by Vaccination uptake

Summary (Weighted results):

There were significant differences in mean scores in four out of the five examined Clark coping domains between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other). These differences were in:

- Family-work segmentation ($F = 8.548$, $df = 4$, $p < .001$), those respondents who said no – other scored significantly lower than those with both doses or one dose of the vaccination.
- Work-family segmentation ($F = 9.551$, $df = 4$, $p < .001$), those respondents who said no – other scored significantly lower than those with both doses or one dose of the vaccination.
- Recreation and relaxation ($F = 4.150$, $df = 4$, $p < .001$), those respondents who said no – other scored significantly lower than those with both doses of the vaccination.
- Exercise ($F = 14.836$, $df = 4$, $p < .001$), those respondents who said no – other scored significantly lower than those with both doses, one dose of the vaccination and those who stated they had not yet gotten the vaccinated.

Summary (Unweighted results):

There were significant differences in mean scores in two out of the five examined Clark coping domains between respondents who received their vaccination (both doses, one dose) and those who did not (not yet able, medically exempt, other). These differences were in:

- Working to improve skills/efficiency ($F = 3.289$, $df = 4$, $p = .011$), those respondents who said no – other scored significantly lower than those with both doses of the vaccination.
- Recreation and relaxation ($F = 2.651$, $df = 4$, $p = .032$), those respondents who said no – other scored significantly lower than those with both doses of the vaccination.

Figure A7.21: Mean Clark Coping Scores by vaccination uptake (Weighted)

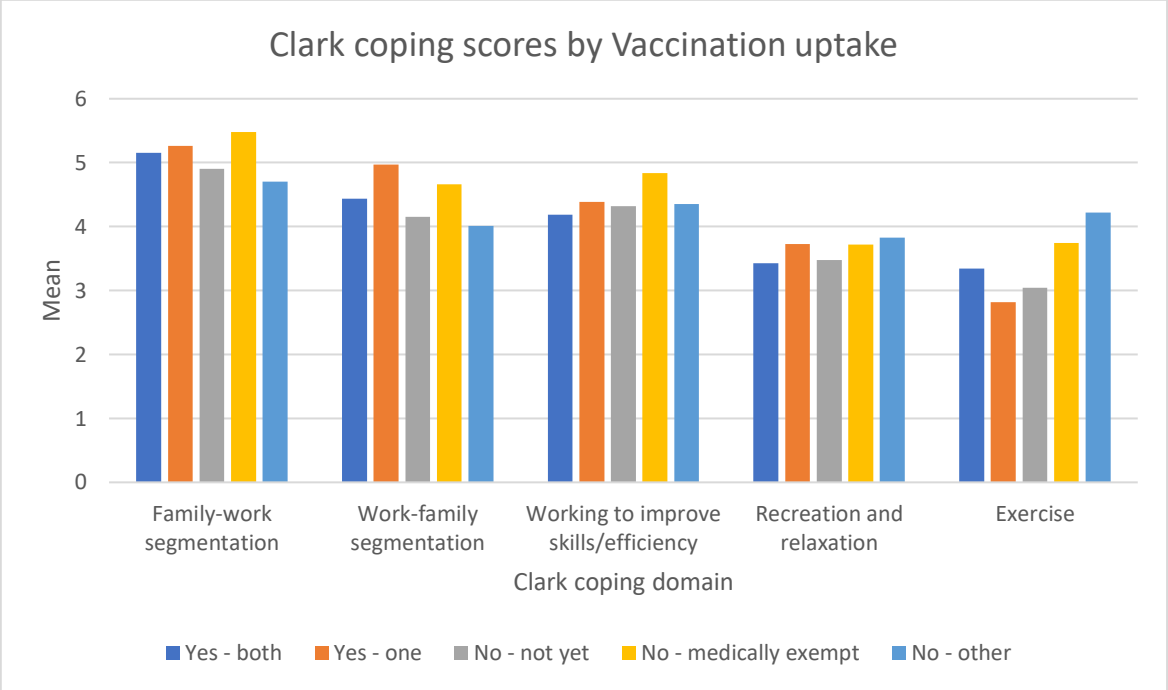


Figure A7.22: Mean Carver Coping Scores by vaccination uptake (Unweighted)

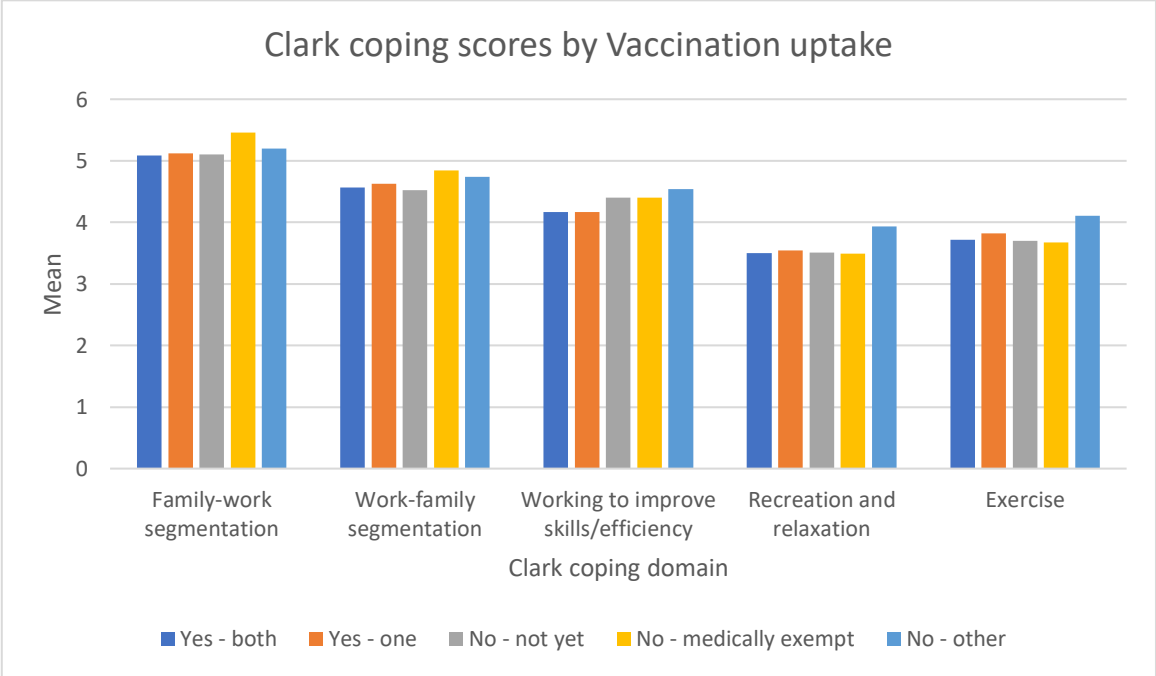


Table A7.21: Mean Carver Coping Scores by vaccination uptake (Weighted)

Coping strategy	Have you received your vaccination(s) yet?				
	Yes - both	Yes - one	No - not yet	No - medically exempt	No - other
Family-work segmentation	5.15	5.26	4.90	5.48	4.70
Work-family segmentation	4.44	4.97	4.15	4.66	4.01
Working to improve skills/efficiency	4.19	4.39	4.32	4.84	4.35
Recreation and relaxation	3.43	3.73	3.48	3.72	3.83
Exercise	3.34	2.82	3.04	3.74	4.22

Table A7.22: Mean Clark Coping Scores by vaccination uptake (Unweighted)

Coping strategy	Have you received your vaccination(s) yet?				
	Yes - both	Yes - one	No - not yet	No - medically exempt	No - other
Family-work segmentation	5.09	5.12	5.10	5.46	5.20
Work-family segmentation	4.57	4.63	4.52	4.84	4.74
Working to improve skills/efficiency	4.17	4.17	4.40	4.40	4.54
Recreation and relaxation	3.50	3.54	3.51	3.49	3.93
Exercise	3.72	3.82	3.70	3.67	4.11

Appendix 8: Multiple Regression Results (Unweighted)

A8.1 Multiple Regression Model Predicting Wellbeing Scores

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

Method: A multiple linear regression model was constructed with the Wellbeing scores (SWEMWBS) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)

Results: The model explained 46.1% of the variance (adjusted R^2 = .450, $F(41, 2130) = 44.399$, $p < .001$). The following coping strategies predicted overall wellbeing score (SWEMWBS):

1. **Carver's Active coping**; respondents with higher Active coping scores had higher Wellbeing scores ($\beta = .113$, $p < .001$).
2. **Carver's Planning**; respondents with higher Planning scores had lower Wellbeing scores ($\beta = -.126$, $p < .001$).
3. **Carver's Positive reframing**; respondents with higher Positive reframing scores had higher Wellbeing scores ($\beta = .058$, $p = .012$)

4. **Carver's Acceptance**; respondents with higher Acceptance scores had higher Wellbeing scores (β = .080, p < .001).
5. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher Wellbeing scores (β = .212, p < .001).
6. **Carver's Use of instrumental support**; respondents with higher use of instrumental scores had lower Wellbeing scores (β = -.053, p = .020).
7. **Carver's Venting**; respondents with higher venting scores had lower Wellbeing scores (β = -.-78, p < .001).
8. **Carver's Substance use**; respondents with higher Substance use scores had lower Wellbeing scores (β = -.040, p = .019).
9. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower Wellbeing scores (β = -.171, p < .001).
10. **Carver's Self-blame**; respondents with higher Self-blame scores had lower Wellbeing scores (β = -.286, p < .001).
11. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower Wellbeing scores (β = -.047, p = .010).
12. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher Wellbeing scores (β = .057, p = .003).
13. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher Wellbeing scores (β = .088, p < .001).
14. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher Wellbeing scores (β = .082, p < .001).
15. **Clark et al.'s Exercise**; respondents with higher Exercise scores had higher Wellbeing scores (β = .035, p = .048).

Other variables predicting the overall wellbeing score:

16. **Disability**; respondents who had a disability had lower wellbeing scores than those who did not have a disability (β = -.035, p = .032).
17. **Ethnicity**; respondents who were Black had higher wellbeing scores than those of White ethnicity (β = .040, p = .015).
18. **Occupational group**; Social workers (β = -.052, p = .019) all had lower wellbeing scores than nurses.
19. **Number of sick days in previous 12 months**; respondents who took 11-20 sick days in previous 12 months (β = -.034, p = .042) had lower wellbeing scores than those who took no sick days; respondents who took 21-40 sick days (β = -.035, p = .034) had lower wellbeing scores than

those who took no sick days; respondents who took more than 60 sick days (β = -.063, p < .001) had lower wellbeing scores than those who took no sick days.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, the results showed those who felt unprepared (β = -.234, p < .001) for redeployment had lower wellbeing scores than those who felt well prepared.

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

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

Method: A multiple linear regression model was constructed with the Work-related quality of life scores (WRQOL) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)

Results: The model explained 44.7% of the variance (adjusted R^2 = .437, $F(41, 2109) = 41.636$, $p < .001$). 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 ($\beta = -.179$, $p < .001$).
2. **Carver's Positive reframing**; respondents with higher Positive reframing scores had higher WRQOL scores ($\beta = .106$, $p < .001$).
3. **Carver's Acceptance**; respondents with higher Acceptance scores had higher WRQOL scores ($\beta = ..039$, $p = .048$).
4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher WRQOL scores ($\beta = .154$, $p < .001$).

5. **Carver's Venting**; respondents with higher Venting scores had lower WRQOL scores (β = -.139, p < .001).
6. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower WRQOL scores (β = -.172, p < .001).
7. **Carver's Self-blame**; respondents with higher Self-blame scores had lower WRQOL scores (β = -.151, p < .001).
8. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower WRQOL scores (β = -.127, p < .001).
9. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher WRQOL scores (β = .107, p < .001).
10. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher WRQOL scores (β = .122, p < .001).
11. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher WRQOL scores (β = .129, p < .001).

Other variables predicting the overall WRQOL score:

12. **Disability**; respondents with a disability (β = -.051, p = .003) and those who were unsure of whether or not they had a disability (β = -.039, p = .019) had lower WRQOL scores than those who did not have a disability.
13. **Country of work**; respondents working in Wales (β = .079, p < .001) had higher WRQOL scores than those working in England.
14. **Number of sick days in previous 12 months**; respondents who took 21-40 sick days (β = -.054, p = .001); those who took 41-60 (β = -3.991, p = .013) and those who took more than 60 sick days (β = -.063 p < .001) 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 (β = .079, p < .001).
16. **Effects of the pandemic on services**; respondents who felt overwhelmed by increased pressures (β = -.229, p < .001) had lower WRQOL scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, the results showed that respondents who felt unprepared (β = -.274, p < .001) for redeployment had lower WRQOL scores than those who felt well prepared.

A8.3 Multiple Regression Model Predicting Personal Burnout Scores

Research question : Do coping mechanisms predict Personal Burnout Scores when controlling for demographic, occupational and country of work variables?

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

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- 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 $R^2 = .439$, $F(41, 2133) = 42.505$, $p < .001$). The following coping strategies predicted personal burnout scores:

1. **Carver's Active coping**; respondents with higher Active coping scores had lower Personal burnout scores ($\beta = -.053$, $p = .047$).
2. **Carver's Planning**; respondents with higher Planning scores had higher Personal burnout scores ($\beta = .186$, $p < .001$).
3. **Carver's Acceptance**; respondents with higher Acceptance scores had lower Personal burnout scores ($\beta = -.041$, $p = .037$).

4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Personal burnout scores (β = -.137, p < .001).
5. **Carver's Use of instrumental support**; respondents with higher Use of instrumental support scores had higher Personal burnout scores (β = .077, p = .001).
6. **Carver's Venting**; respondents with higher Venting scores had higher Personal burnout scores (β = .097, p < .001)
7. **Carver's Substance use**; respondents with higher Substance use scores had higher Personal burnout scores (β = .052, p = .003).
8. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Personal burnout scores (β = .127, p < .001)
9. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Personal burnout scores (β = .097, p < .001).
10. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Personal burnout scores (β = .078, p < .001).
11. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had lower Personal burnout scores (β = -.076, p < .001).
12. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Personal burnout scores (β = -.040, p = .035).
13. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had lower Personal burnout scores (β = -.055, p = .005).
14. **Clark et al.'s Exercise**; respondents with higher Exercise scores had lower Personal burnout scores (β = -.076, p < .001).

Other variables predicting the personal burnout score:

15. **Age**; respondents aged 50-59 (β = -.082, p = .007), those aged 60-65 (β = -.068, p = .004) and those aged 66+ (β = - .038, p = .025) all had lower personal burnout scores than those aged 16-29.
16. **Sex**; males had lower personal burnout scores than females (β = -0.064, p < .001).
17. **Disability**; respondents with a disability (β =.084, p < .001) had higher personal burnout scores than those who did not have a disability.
18. **Ethnicity;** respondents who were Black had lower personal burnout scores than those of White ethnicity (β = .038 p = .020).
19. **Country;** respondents who were from Scotland had lower personal burnout scores than those from England (β = -.069, p = .004).

20. **Occupation;** respondents who were midwives had lower personal burnout scores than those who were nurses (β = .039, p = .041).
21. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days (β = .065, p < .001), those who took 11-20 sick days (β = .057, p = .001), those who took 21-40 sick days (β = .072, p < .001), those who took 41-60 sick days (β = .041, p = .014) and those who took more than 60 sick days (β = .053, p = .002) all had higher personal burnout scores than those who took no sick days.
20. **Effects of the pandemic on services**; respondents who felt their services had felt overwhelmed by increased pressures (β = -.044, p = .002) had higher personal burnout scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict personal burnout scores.

Respondents were asked if they wanted to leave their employer during COVID-19. Those who indicated that they had wanted to leave. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave (β = .119, p < .001) for redeployment had higher personal burnout scores than those who did not intent on leaving their employer

Respondents were asked if they wanted to leave their occupation during COVID-19. Those who indicated that they had wanted to leave. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave (β = .146, p < .001) for redeployment had higher personal burnout scores than those who did not intent 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

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 47.0% of the variance (adjusted $R^2 = .459$, $F(41, 2133) = 46.051$, $p < .001$). The following coping strategies predicted personal burnout scores:

1. **Carver's Active coping**; respondents with higher Active coping scores had lower Work-related burnout scores ($\beta = -.017$, $p < .001$).
2. **Carver's Planning**; respondents with higher Planning scores had higher Work-related burnout scores ($\beta = -.079$, $p < .001$).
3. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Work-related burnout scores ($\beta = -.117$, $p < .001$).

4. **Carver's Use of instrumental support**; respondents with higher Use of instrumental support scores had higher Work-related burnout scores (β = .061, p = .008).
5. **Carver's Venting**; respondents with higher Venting scores had higher Work-related burnout scores (β = 0.071, p < .001)
6. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Work-related burnout scores (β = .158, p < .001).
7. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Work-related burnout scores (β = .185, p < .001).
8. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Work-related burnout scores (β = .120, p < .001).
9. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had lower Work-related burnout scores (β = -.115, p < .001).
10. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Work-related burnout scores (β = -.080, p < .001).
11. **Clark et al.'s Exercise**; respondents with higher Exercise scores had lower Work-related burnout scores (β = -.038, p = .033).

Other variables predicting the work-related burnout score:

12. **Age**; respondents aged 40-49 (β = -.013, p = .028), those aged 50-59 (β = -.107, p < .001), those aged 60-65 (β = -.092, p < .001) and those aged 66+ (β = -.092, p < .001) all had lower work-related burnout scores than those aged 16-29.
13. **Sex**; males had lower work-related burnout scores than females (β = -.032, p = .050).
14. **Disability**; respondents with a disability (β = .042, p = .011) had higher work-related burnout scores than those who did not have a disability.
15. **Country of work**; respondents working in Scotland had lower work-related burnout scores than those working in England (β = -.052, p = .024).
16. **Occupational group**; midwives had lower work-related burnout scores than nurses (β = -.052, p = .005); social workers had higher work-related burnout scores than nurses (β = .064, p = .004).
17. **Number of sick days in previous 12 months**; respondents who took 21-40 sick days (β = .047, p = .004) and those who took more than 60 sick days (β = .035, p = .035) 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 (β = .289, p < .001) had higher work-related burnout scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict work-related burnout scores.

Respondents were asked if they wanted to leave their employer during COVID-19. Those who indicated that they had wanted to leave. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ($\beta = .201$, $p < .001$) for redeployment had higher work-related burnout scores than those who did not intent on leaving their employer

Respondents were asked if they wanted to leave their occupation during COVID-19. Those who indicated that they had wanted to leave. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ($\beta = .017$, $p < .001$) for redeployment had higher work-related burnout scores than those who did not intent 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

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 22.8% of the variance (adjusted $R^2 = .213$, $F(41, 2114) = 15.209$, $p < .001$). The following coping strategies predicted client-related burnout scores:

1. **Carver's Planning** respondents with higher Venting scores had higher Client-related burnout scores ($\beta = .080$, $p = .015$).
2. **Carvers Venting**; respondents with higher Venting scores had higher Client-related burnout scores ($\beta = .116$, $p < .001$).
3. **Carver's Substance use**; respondents with higher Substance use scores had higher Client-related burnout scores ($\beta = .081$, $p < .001$).

4. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Client-related burnout scores (β = .142, p < .001).
5. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Client-related burnout scores (β = .116, p < .001).
6. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Client-related burnout scores (β = -.150, p < .001).

Other variables predicting the client-related burnout score:

7. **Age**; respondents aged 50-59 (β = -.081, p = .027), had lower client-related burnout scores than those aged 16-29.
8. **Sex**; males had higher client-related burnout scores than females (β = .066, p = .001).
9. **Occupational group**; social workers had higher client-related burnout scores than nurses (β = .070, p = .009).
10. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days (β = .040, p = .050) had higher client-related burnout scores than those who took no sick days.
11. **Line manager status**; respondents who were line managers had lower client-related burnout scores than those who were not line managers (β = -.059, p = .004).

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict client-related burnout scores.

Respondents were asked if they wanted to leave their employer during COVID-19. Those who indicated that they had wanted to leave. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave (β = .137, p < .001) for redeployment had higher client-related burnout scores than those who did not intent on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. Those who indicated that they had wanted to leave. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave (β = .180, p < .001) for redeployment had higher client-related burnout scores than those who did not intent on leaving their employer.

Appendix 9: Comparison of Phase 1 (May – July 2020), Phase 2 (May – January 2021) and Phase 3 (May – July 2021).

This section presents descriptive comparisons of data from Phase 1 (May – July 2020) and Phase 2 (December 2020 – January 2021) with Phase 3 (May – July 2021) of the study. Presented are weighted results, with weights calculated separately for each phase of the study to account for the different distribution of respondents across country and occupational group in the two phases of the study, thus enabling a more direct comparison. Some results from Phase 1 presented here may be slightly different from those presented in the first report. This is because some calculations were changed in order to make the three phases of the survey directly comparable.

A9.1 Wellbeing Scores by Study Phase and Country

The overall mean wellbeing scores decreased from Phase 1 of the study to Phase 3, both UK-wide and across the individual countries. Between Phase 2 to Phase 3 of the study, the overall mean wellbeing scores increased slightly.

UK-wide analysis: Using regression analysis, the decrease in the overall mean wellbeing scores between Phase 1 and Phase 3 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 ($\beta = -0.951$, $p < .001$). There was a slight increase in the overall mean wellbeing scores between Phase 2 and Phase 3 of the study which was found to not be statistically significant when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 0.066$, $p = 0.528$).

Figure A9.1: Mean Overall Wellbeing Score by Study Phase and Country (Weighted)

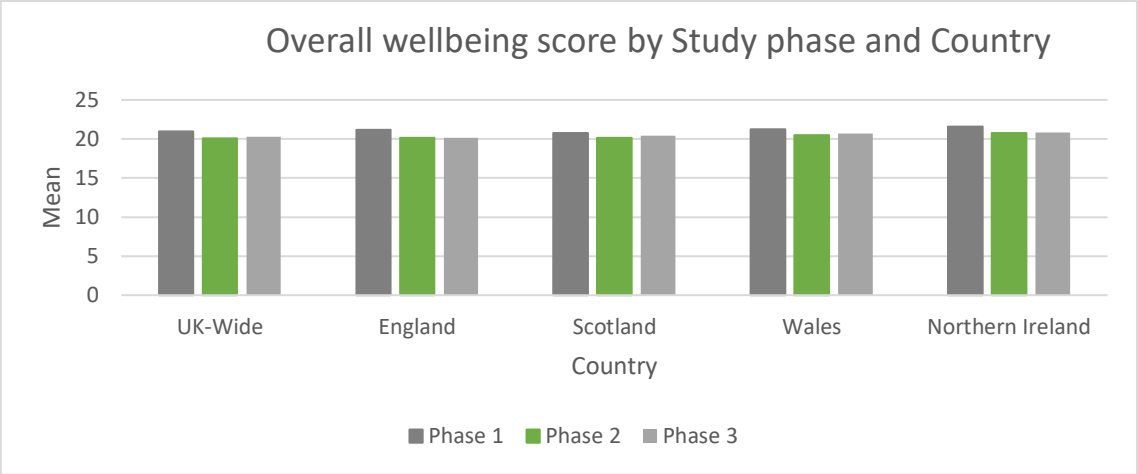


Table A9.1: Mean Overall Wellbeing Score by Study Phase and Country (Weighted)

	Country				
Study phase	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1	20.95	21.15	20.74	21.25	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85

A9.2 Wellbeing Scores by Study Phase and Occupation

All occupational groups showed a decrease in their overall mean wellbeing scores from Phase 1 of the study to Phase 3. Between Phase 2 and Phase 3 nurses and social care workers showed an increase in overall wellbeing scores while all other groups continued to show a decrease in wellbeing.

Figure A9.2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)

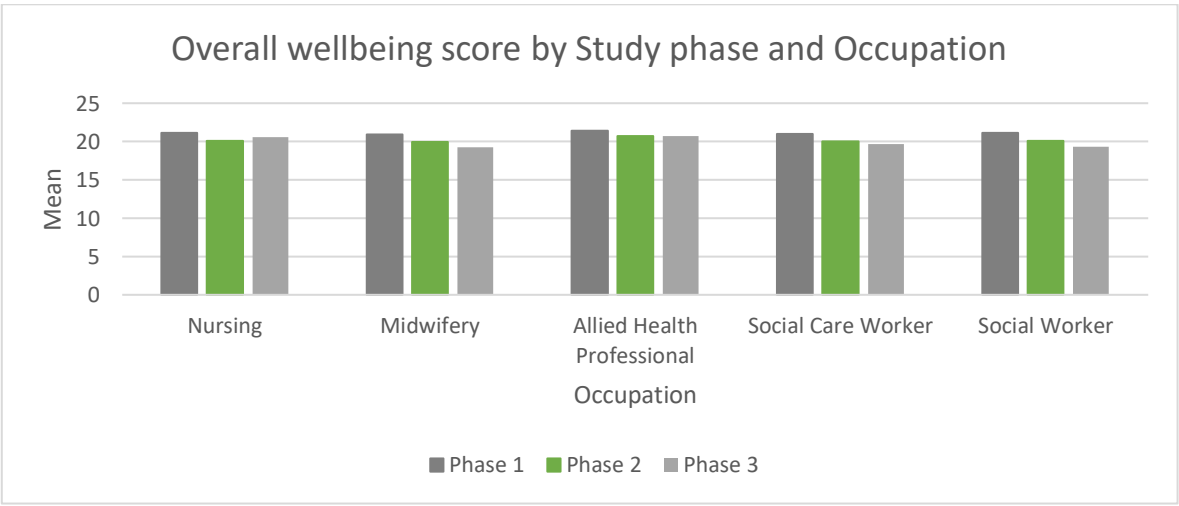


Table A9.2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)

	Occupation				
Study phase	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1	21.15	20.91	21.38	20.98	21.14
Phase 2	20.10	19.92	20.73	20.02	20.07
Phase 3	20.58	19.23	20.72	19.70	19.31

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 3, 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 3 there was a slight increase in WRQOL UK wide but a decrease in Wales, England and Northern Ireland between these study phases.

UK-wide analysis: Using regression analysis, the decrease in the overall WRQOL scores between Phase 1 and Phase 3 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 ($\beta = -6.739$, $p < .001$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: Significant decrease in scores from Phase 1 to Phase 3 ($\beta = -1.346$, $p < .001$).
- Stress at work: Slight decrease in scores from Phase 1 to Phase 3 but not significant ($\beta = -.458$, $p = 0.074$).
- Working conditions: Significant decrease in scores from Phase 1 to Phase 3 ($\beta = -.857$, $p < .001$).
- Control at work: Significant decrease in scores from Phase 1 to Phase 3 ($\beta = -.947$, $p < .001$).
- General wellbeing: Significant decrease in scores from Phase 1 to Phase 3 ($\beta = -2.189$ $p < .001$).
- Home-work interface: Significant decrease in scores from Phase 1 to Phase 3 ($\beta = -.919$, $p < .001$).

Using regression analysis, the change in the overall WRQOL scores between Phase 2 and Phase 3 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 ($\beta = 1.406$, $p = .002$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: Significant decrease in scores from Phase 2 to Phase 3 (β = -0.488, p < .001).
- Stress at work: No significant change in scores from Phase 2 to Phase 3 (β = -0.004, p =.949).
- Working conditions: No significant change in scores from Phase 2 to Phase 3 (β = -0.083, p =.270).
- Control at work: Significant decrease in scores from Phase 2 to Phase 3 (β = -0.198 p = .020).
- General wellbeing: Significant decrease in scores from Phase 2 to Phase 3 (β = -0.284, p = .042).
- Home-work interface: Significant decrease in scores from Phase 2 to Phase 3 (β = -0.368, p < .001).

Figure A9.3: Mean Overall Quality of Working Life Score by Study Phase and Country (Weighted)

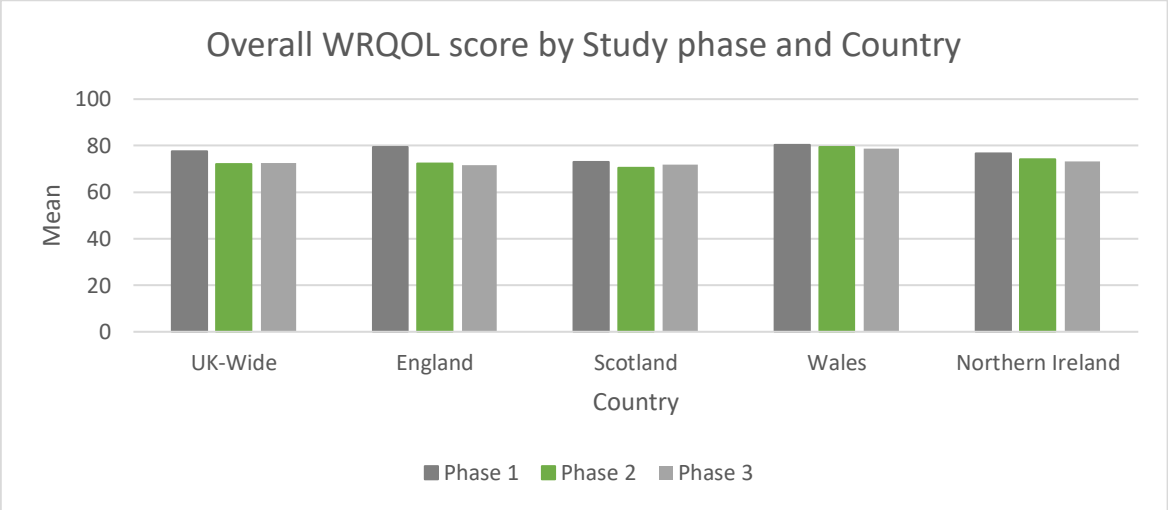


Table A9.3: Mean Quality of Working Life Score by Study Phase and Country (Weighted)

Study phase	Country				
WRQOL domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1					
Job career satisfaction	21.03	21.48	20.23	21.93	21.06
Stress at work	5.23	5.22	4.57	4.98	5.06
General wellbeing	20.16	20.65	19.32	20.85	20.55
Home-work interface	10.84	11.11	9.71	11.26	10.18
Control at work	9.97	10.27	9.22	10.26	9.57
Working conditions	10.49	10.71	9.87	11.13	10.23
Overall WRQOL score	**77.59**	**79.33**	**73.07**	**80.35**	**76.63**
Phase 2					
Job career satisfaction	20.31	20.39	19.89	22.32	20.91
Stress at work	4.43	4.36	4.56	4.87	4.37
General wellbeing	18.23	18.21	18.44	19.73	19.37
Home-work interface	9.95	10.03	9.19	10.97	9.99
Control at work	9.22	9.28	8.75	10.44	9.37
Working conditions	9.96	9.90	9.54	11.12	9.95
Overall WRQOL score	**72.13**	**72.21**	**70.37**	**79.46**	**74.06**
Phase 3					
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 wellbeing	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
Overall WRQOL score	**72.45**	**71.54**	**71.92**	**78.69**	**73.29**

A9.4 Quality of Working Life Scores by Study Phase and Occupation

The overall WRQOL scores decreased from Phase 1 of the study to Phase 3 for all occupational groups. The majority of WRQOL domain scores also decreased for all groups. The overall WRQOL scores increased from Phase 2 of the study to Phase 3 for nurses but decreased for all other occupation groups.

Figure A9.4: Mean Overall Quality of Working Life Score by Study Phase and Occupation (Weighted)

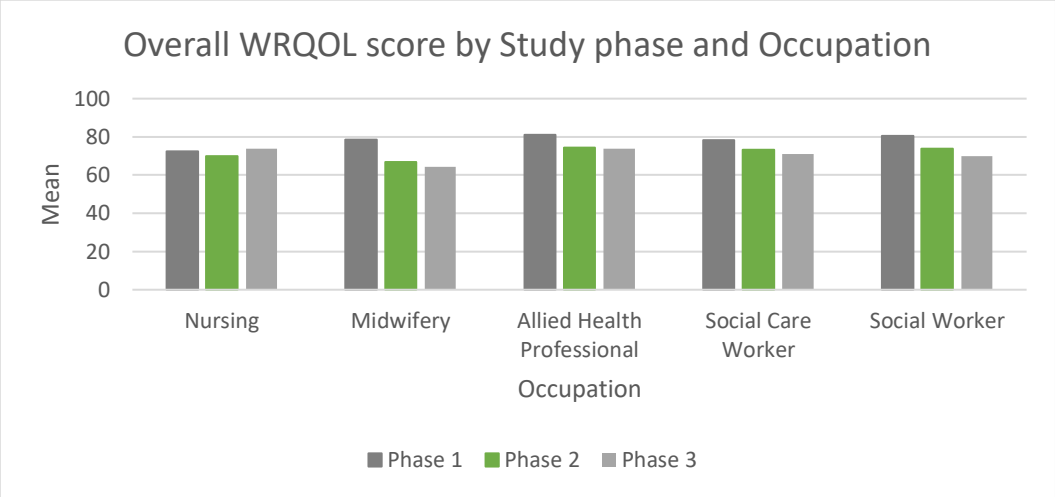


Table A9.4: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted)

Study phase	**Occupation**				
WRQOL domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1					
Job career satisfaction	19.15	21.67	22.22	21.27	22.28
Stress at work	5.25	4.55	5.02	5.25	4.81
General wellbeing	19.77	20.91	21.19	20.02	20.75
Home-work interface	10.11	10.68	11.29	10.82	11.32
Control at work	8.79	9.96	10.47	10.31	10.58
Working conditions	9.82	10.79	10.99	10.62	10.80
Overall WRQOL score	**72.54**	**78.56**	**81.16**	**78.34**	**80.63**
Phase 2					
Job career satisfaction	19.96	19.27	20.42	20.50	21.32
Stress at work	4.24	3.63	4.53	4.70	4.06
General wellbeing	17.65	18.07	19.04	18.64	18.34
Home-work interface	9.47	8.23	10.62	9.91	10.56
Control at work	9.08	9.17	9.61	9.13	9.63
Working conditions	9.61	8.61	10.26	10.31	9.73
Overall WRQOL score	**70.01**	**66.95**	**74.41**	**73.24**	**73.67**
Phase 3					
Job career satisfaction	20.83	19.2	20.5	20.07	20.23
Stress at work	4.55	3.2	4.47	4.43	4.03
General wellbeing	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	9.0
Working conditions	9.88	8.29	10.26	10.24	9.3

Overall WRQOL score	**73.77**	**64.35**	**73.79**	**71.15**	**69.92**

A9.4 Burnout Scores by Study Phase and Country

The overall personal, work-related and client related burnout scores increased from Phase 2 of the study to Phase 3 UK Wide. Scotland had a decreased in work-related burnout between Phases 2 and 3 but all other domains increased across the individual countries.

Multiple regression analysis revealed that this was a **significant difference in personal burnout from Phase 2 to Phase 3**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status (β = 1.258, p = .032). There was also **significant difference in work related burnout** (β = 1.325, p = .0.42) and **client-related burnout** (β = 1.627, p = .011) **from Phase 2 to Phase 3**) 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**
Phase 2					
Personal burnout	61.4	61.53	60.68	58.26	60.39
Work-related burnout	56.73	57.36	55.78	52.53	57.43
Client burnout	27.97	28.58	25.12	23.61	25.93
Phase 3					
Personal burnout	63.2	64.42	59.27	59.47	59.45
Work-related burnout	59.79	60.53	54.54	54.31	55.87
Client burnout	29.46	31.45	25.57	24.28	21.10

Figure A9. 4: Personal Burnout Score by Study phase and Country (Weighted)

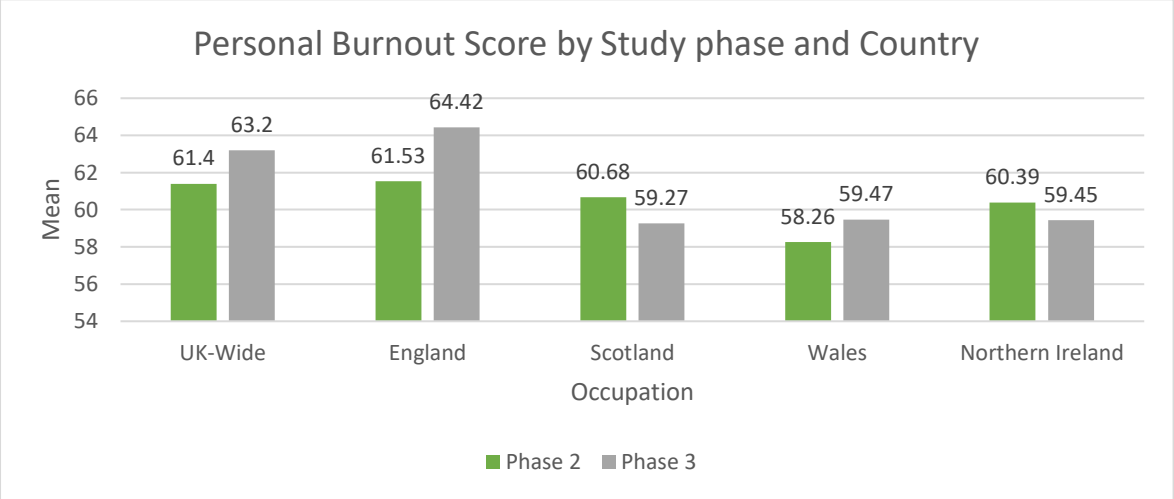


Figure A9. 5: Work-related Burnout Score by Study phase and Country (Weighted)

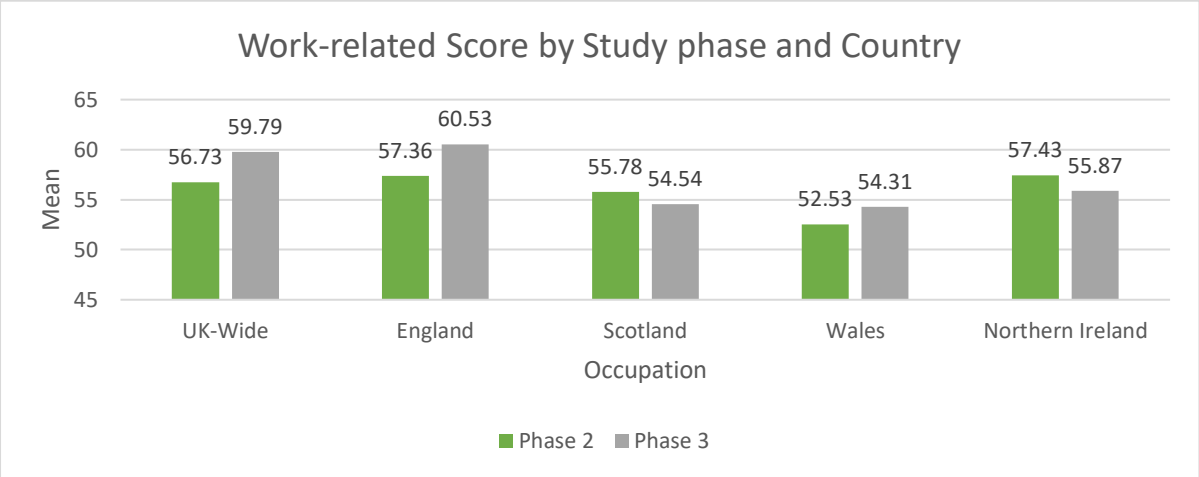
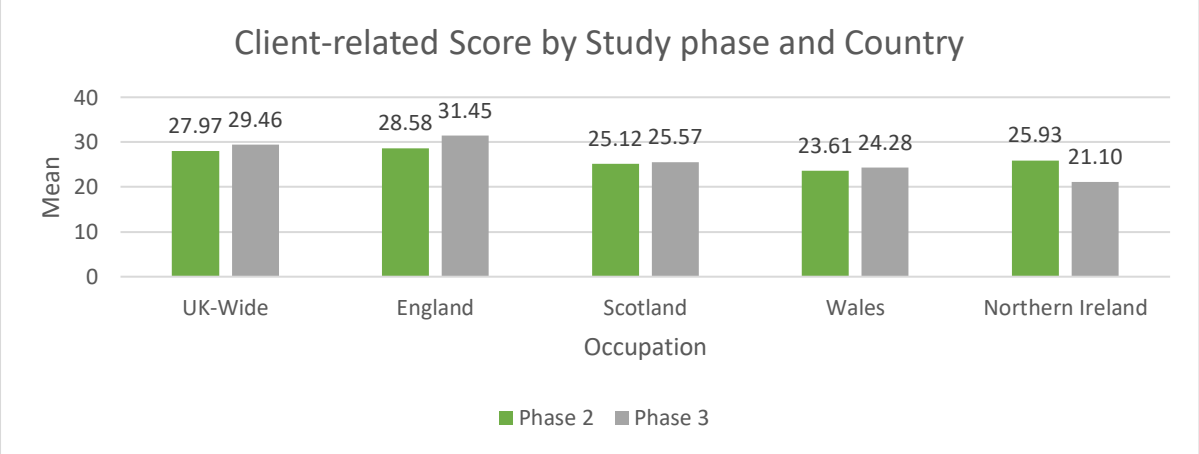


Figure A9. 6: Client-related Burnout Score by Study phase and Country (Weighted)



A9.4 Burnout Scores by Study Phase and Occupation

All domains of burnout increased from Phase 2 of the study to Phase 3 for Midwives, AHPs, Social Care Workers and Social Workers, Nurses saw slight decreases across all domains between the phases.

Table A9. 6: Burnout Scores by Study Phase and Occupation

Study phase	Occupation				
WRQOL domain	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 2					
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 burnout	28.19	31.02	28.01	25.58	30.68
Personal burnout	61.29	73.21	62.12	64.37	67
Work-related burnout	57.47	71.54	56.16	58.8	64.06
Client burnout	27.75	34.36	30.37	27.33	32.56

Figure A9. 7: Personal Burnout Score by Study phase and Occupation (Weighted)

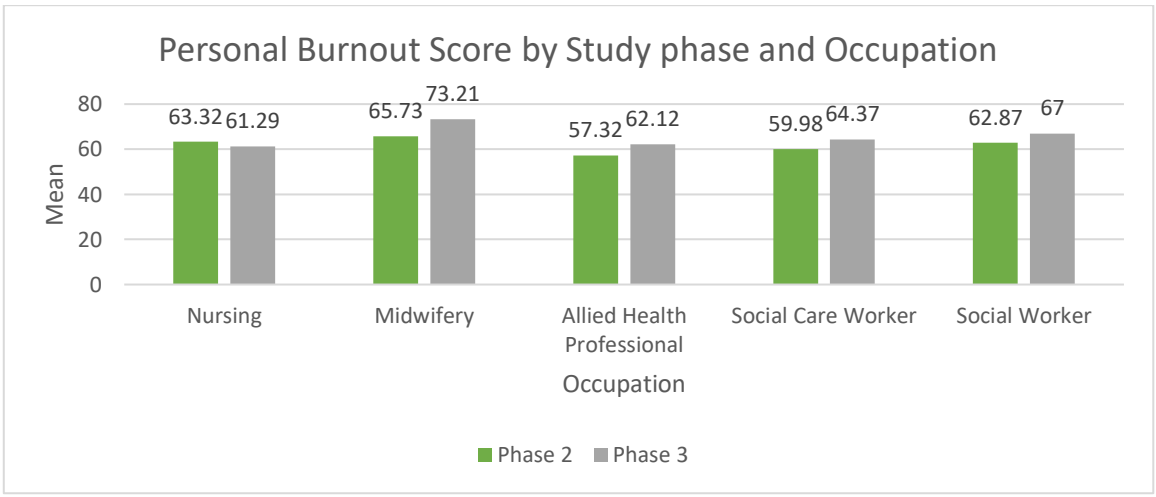


Figure A9. 8: Work-related Burnout Score by Study phase and Occupation (Weighted)

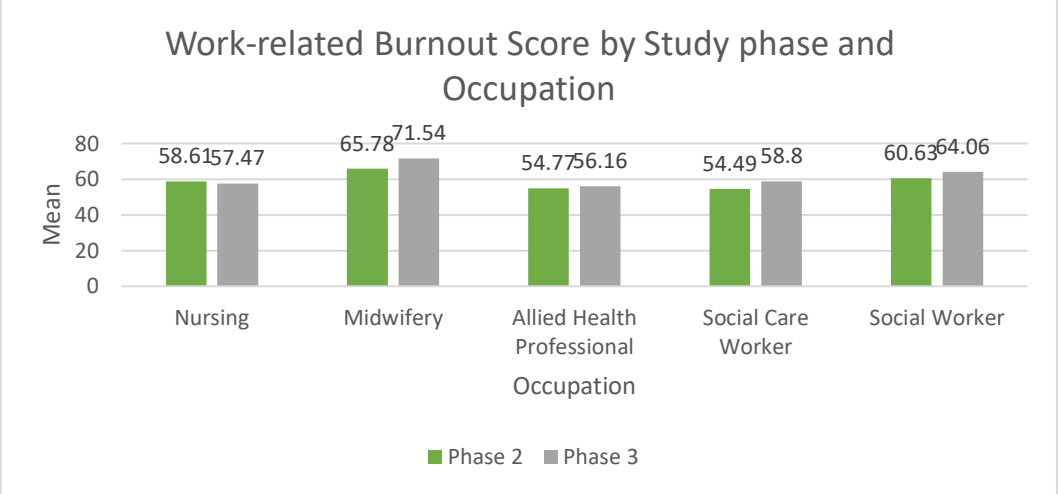
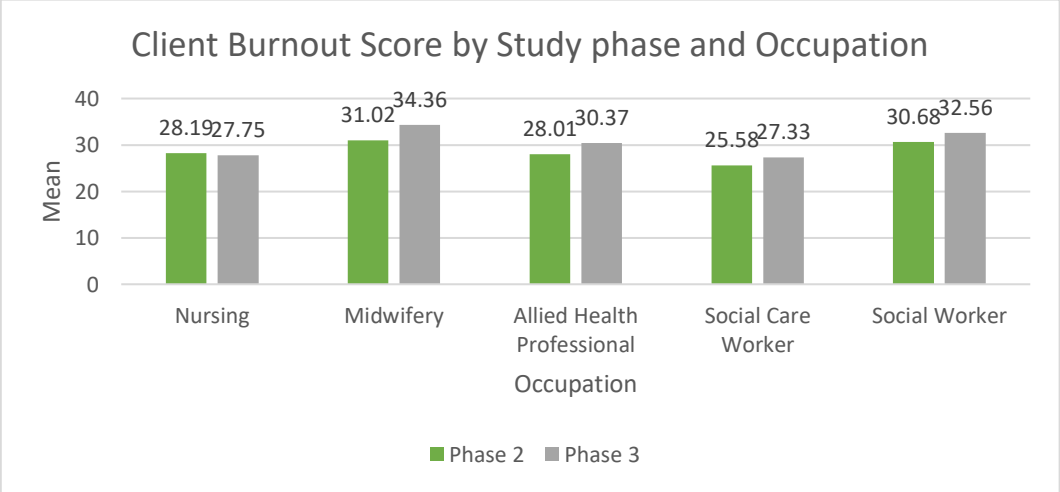


Figure A9. 9: Client-related Burnout Score by Study phase and Occupation (Weighted)



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 3. Similar pattern was observed across the countries for the majority of coping domains.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 3 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 3 ($\beta = -0.719$, $p < .001$).
- Planning: Significant decrease in scores from Phase 1 to Phase 3 ($\beta = -0.384$, $p = .004$).

- Positive reframing: Significant decrease in scores from Phase 1 to Phase 3 (β = -0.268, p = .031).
- Acceptance: Significant decrease in scores from Phase 1 to Phase 3 (β = -0.412, p < .001).
- Use of emotional support: Significant decrease in scores from Phase 1 to Phase 3 (β = -0.247, p = .060).
- Use of instrumental support: No significant decrease in scores from Phase 1 to Phase 3 (β = -0.075, p = .562).
- Venting: Significant increase in scores from Phase 1 to Phase 3 (β = 0.941, p < .001).
- Substance use: Significant increase in scores from Phase 1 to Phase 3 (β = 0.162, p = .044).
- Behavioural disengagement: Significant increase in scores from Phase 1 to Phase 3 (β = 0.398, p < .001).
- Self-blame: Significant increase in scores from Phase 1 to Phase 3 (β = 0.840, p < .001).

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 2 of the study to Phase 3. 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 3 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 3 (β = -0.169, p = .001).
- Planning: Decrease in scores from Phase 2 to Phase 3 but not significant (β = -0.080, p = .155).
- Positive reframing: Decrease in scores from Phase 2 to Phase 3 but not significant (β = -0.138, p = .080).
- Acceptance: Significant decrease in scores from Phase 2 to Phase 3 (β = -0.127, p = .007).
- Use of emotional support: Decrease in scores from Phase 2 to Phase 3 but not significant (β = -0.102, p = .060).
- Use of instrumental support: Significant decrease in scores from Phase 2 to Phase 3 (β = -0.111 p = .039).
- Venting: Increase in scores from Phase 2 to Phase 3 but not significant (β = 0.039, p = .738).
- Substance use: Increase in scores from Phase 2 to Phase 3 but not significant (β = 0.031, p = .512).
- Behavioural disengagement: Increase in scores from Phase 2 to Phase 3 but not significant (β = 0.062, p = .153).
- Self-blame: Significant increase in scores from Phase 2 to Phase 3 (β = 0.227 p < .001).

Figure A9. 10: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)

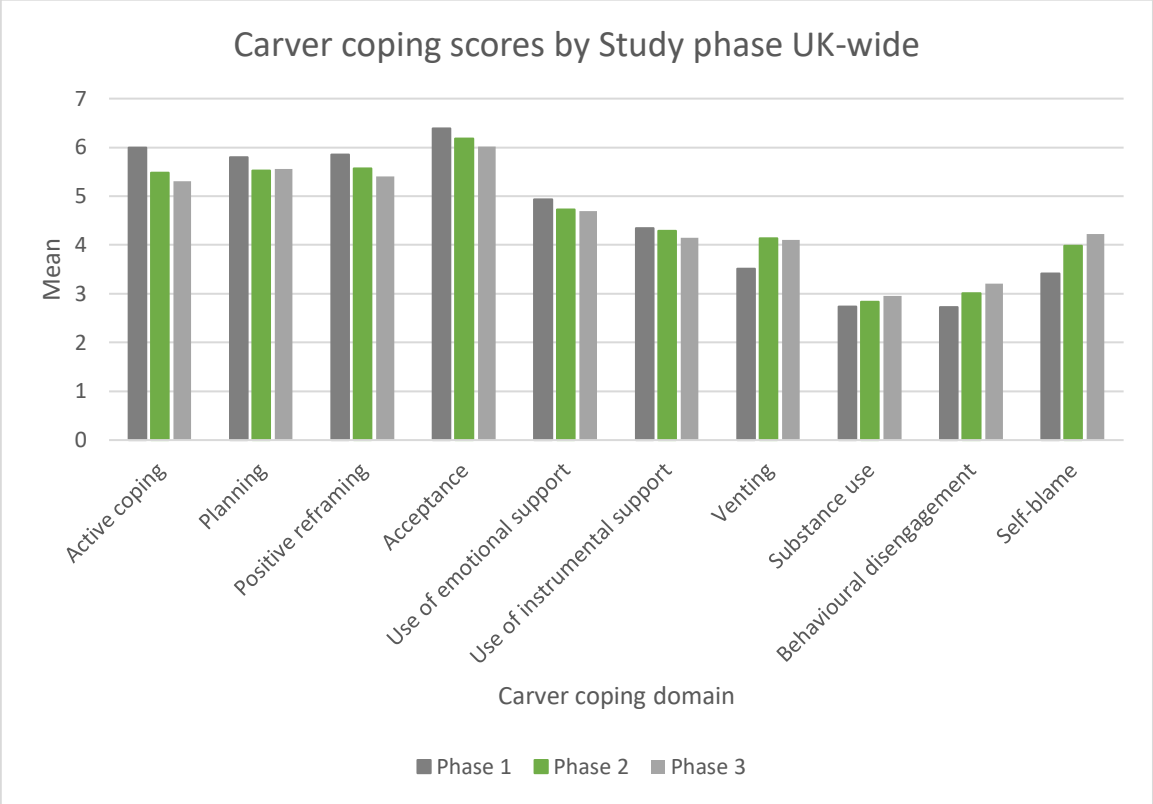


Table A9. 7: Mean Carver Coping Scores by Study Phase and Country (Weighted)

Study phase	Country				
Coping domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1					
Active coping	6.00	5.97	6.57	6.08	6.10
Planning	5.80	5.81	6.10	6.13	5.82
Positive reframing	5.85	5.92	5.66	6.07	5.90
Acceptance	6.39	6.45	6.57	6.62	6.43
Use of emotional support	4.93	5.11	4.83	4.91	4.85
Use of instrumental support	4.34	4.38	4.79	4.63	4.40
Venting	3.51	3.47	3.81	3.52	3.45
Substance use	2.74	2.74	2.87	2.95	2.73

Behavioural disengagement	2.73	2.68	2.54	3.10	2.68
Self-blame	3.42	3.28	4.00	3.48	3.23
Phase 2					
Active coping	5.48	5.50	5.80	5.46	5.56
Planning	5.53	5.56	5.77	5.42	5.42
Positive reframing	5.57	5.60	5.61	5.59	5.61
Acceptance	6.18	6.19	6.24	6.11	6.06
Use of emotional support	4.73	4.95	4.54	4.73	4.84
Use of instrumental support	4.29	4.43	4.24	4.37	4.51
Venting	4.14	4.19	4.08	4.05	4.19
Substance use	2.83	2.86	2.91	2.90	2.82
Behavioural disengagement	3.01	2.99	3.07	3.08	2.99
Self-blame	3.98	4.00	4.19	3.94	3.80
Phase 3					
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

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 3 across the occupational groups. From Phase 2 to Phase 3 there was a lot more variation in the use of strategies; within nursing, active coping, planning, positive reframing, acceptance and emotional support decreased, while instrumental support, venting, substance use, behavioural disengagement and self-blame all increased; within midwifery, acceptance, positive reframing, venting and self-blame increased, while active coping, planning, emotional support and instrumental support, substance use and behavioural disengagement all decreased. For AHPs there was an increase in self-blame, behavioural support, active coping, planning, positive reframing, acceptance and emotional support, a decrease in instrumental support and venting and no change in substance use; social care workers exhibited increases in all coping strategies positive and negative; social workers had an increase in venting, substance use, self-blame, behavioural disengagement, active coping and planning, while there was a decrease in positive reframing, acceptance, use of emotional support and use of instrumental support.

Table A9. 8: Mean Carver Coping Scores by Study Phase and Occupation (Weighted)

Study phase	**Occupation**				
Coping domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1					
Active coping	6.37	5.95	5.81	5.96	5.92
Planning	5.96	5.74	5.71	5.79	5.75
Positive reframing	5.89	6.02	5.84	5.87	5.82
Acceptance	6.59	6.20	6.52	6.33	6.35
Use of emotional support	5.12	5.34	5.44	4.87	5.28
Use of instrumental support	4.48	4.20	4.66	4.44	4.61
Venting	3.97	3.44	3.53	3.30	3.57
Substance use	2.77	2.90	2.79	2.68	2.85
Behavioural disengagement	2.84	2.57	2.55	2.62	2.67
Self-blame	3.52	3.76	3.22	3.36	3.30
Phase 2					
Active coping	5.47	4.98	5.53	5.52	5.30
Planning	5.57	4.58	5.53	5.57	5.39
Positive reframing	5.43	5.32	5.88	5.67	5.53
Acceptance	5.96	6.15	6.28	6.33	6.18
Use of emotional support	4.88	4.68	4.99	4.51	5.30
Use of instrumental support	4.38	4.22	4.56	4.18	4.76
Venting	4.12	4.68	4.43	4.03	4.44
Substance use	2.86	3.78	2.81	2.75	3.10
Behavioural disengagement	2.93	3.82	2.83	3.09	2.93
Self-blame	4.07	4.57	3.69	3.96	4.12
Phase 3					
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

A9.5 Clark Coping Scores by Study Phase and Country

There was a slight decrease in the use of some Clark et al.'s coping strategies from Phase 1 of the study to Phase 2 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 2 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: Slight decrease in scores from Phase 1 to Phase 3 but not significant (β = 0.064, p = .924).
- Work-family segmentation Slight decrease in scores from Phase 1 to Phase 3 but not significant (β = -0.112, p = .177).
- Working to improve skills/efficiency: Significant decrease in scores from Phase 1 to Phase 3 (β = -0.246, p = .003).
- Recreation and relaxation: Slight decrease in scores from Phase 1 to Phase 3 but not significant (β = -0.157, p = .089).
- Exercise: Slight decrease in scores from Phase 1 to Phase 3 but not significant (-0.103, p = 0.314).

There was a slight decrease in the use of some Clark et al.'s coping strategies from Phase 2 of the study to Phase 3 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 2 and Phase 3 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: Increase in scores from Phase 2 to Phase 3 but not significant (β = 0.003, p = .924).
- Work-family segmentation: Decrease in scores from Phase 2 to Phase 3 but not significant (β = -0.010, p = .774).
- Working to improve skills/efficiency: Decrease in scores from Phase 2 to Phase 3 but not significant (β = -0.003, p = .936).
- Recreation and relaxation: Increase in scores from Phase 2 to Phase 3 but not significant (β = -0.026, p= .500).
- Exercise: Decrease in scores from Phase 2 to Phase 3 but not significant (β = -0.018, p = .676).

Figure A9. 11: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)

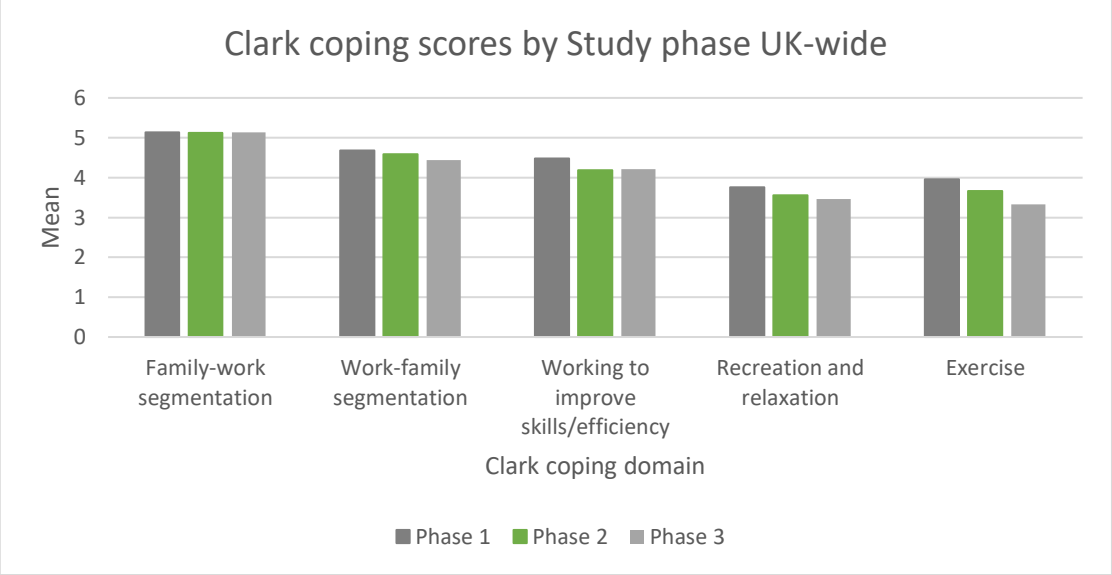


Table A9. 9: Mean Clark Coping Scores by Study Phase and Country (Weighted)

Study phase	**Country**				
Coping domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
Phase 1					
Family-work segmentation	5.14	5.08	5.09	5.07	5.11
Work-family segmentation	4.68	4.65	4.58	4.78	4.71
Working to improve skills/efficiency	4.48	4.46	4.53	4.56	4.31
Recreation and relaxation	3.75	3.87	3.47	3.70	3.57
Exercise	3.96	4.07	3.51	4.07	3.89
Phase 2					
Family-work segmentation	5.12	5.11	5.24	5.02	5.18
Work-family segmentation	4.59	4.59	4.71	4.62	4.69
Working to improve skills/efficiency	4.19	4.29	4.13	4.18	4.25
Recreation and relaxation	3.55	3.56	3.29	3.51	3.64
Exercise	3.66	3.68	3.50	3.53	3.75
Phase 3					
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

A9.6 Clark Coping Scores by Study Phase and Occupation

Across the occupational groups, there was a decrease in the use of some Clark et al.'s coping strategies, but also increase in the use of others for some groups.

Table A9. 10: Mean Clark Coping Scores by Study Phase and Occupation (Weighted)

Study phase	**Occupation**				
Coping domain	**Nursing**	**Midwifery**	**AHP**	**Social Care Worker**	**Social Worker**
Phase 1					
Family-work segmentation	5.36	4.75	4.96	5.06	4.99
Work-family segmentation	4.72	4.39	4.58	4.75	4.79
Working to improve skills/efficiency	4.75	4.16	4.44	4.36	4.37
Recreation and relaxation	3.82	3.34	3.94	3.68	4.04
Exercise	4.18	3.72	4.41	3.64	4.05
Phase 2					
Family-work segmentation	5.12	5.46	5.04	5.16	4.98
Work-family segmentation	4.67	3.98	4.48	4.66	4.49
Working to improve skills/efficiency	4.42	3.82	4.23	3.99	4.25
Recreation and relaxation	3.50	2.56	3.64	3.54	3.70
Exercise	3.49	3.15	4.07	3.60	3.63
Phase 3					
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	3.6	3.33	3.66
Exercise	3.60	3.57	3.93	3.16	3.75

Appendix 10: Individual Circumstances and Wellbeing of Frontline Workers

Focus groups were held with both managers and frontline workers in June 2021. 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. Below are vignettes that present an insight into the individual experiences of some workers as they worked on the frontline, accounting for how their professional and personal experiences intersected and how this impacted their overall health and wellbeing. Some of the details of the 'stories' presented below have been changed to protect the identity of the participants.

Sam

Sam has been a children's social worker for over a decade and found that the pandemic was *'really starting to take it toll as how can we start new work with children face to face'.* Sam highlighted that new ways of working have impacted how their jobs can be done on the front-line, while suggested that some of the changes while beneficial at times, have issue. While *'technology was gotten to replace our face to face but I think what I've learned is it's great to have this for communication but it doesn't work so well for connection and for building new relationships and maintaining and building therapeutic relationships. I really, I really miss being in the room I didn't realise how, you got your voice and you got your questioning but you've also got your peripheral vision, you've got your body then you've got your eye contact you've got your brain scanning for what's the atmosphere in the room is this safe and your brain still tries to do that on this medium but you don't get the information.'* However they also explained how working from home increased the stress and anxiety, they experienced with having to try and home-school children and work with an increased caseload which placed them under instrumental pressure and that this doesn't appear to be changing anytime soon, "*it's like OK things getting better but I'm tired but I know a lot more work is coming not more work is coming in over and I'm thinking how do I keep going so yes breathing little easier but the same time I'm worried, I'm really worried.* Sam did explain that she had started walking and had taken up crafts to try and cope with the additional stressors and constantly changing situation but highlighted that this still doesn't reduce the pressure greatly, *"no matter how many walks you have or nice bubbly baths, that's not going to change your caseload, it's still not going to change your work so yeah I'm with you there."*

Amanda

Amanda was a social care worker who acknowledged that the impact on carers and service users impacted on the workforce and changed their roles, "they were they were very, very scared and you had to reassure them. So there was a lot of pressure as a care worker, before that you just went in and did your tasks and you knew what you were doing but this was over and above of really, nearly playing as a social worker, counsellor effort, you know so we find it, a lot of stress….your work pressure was doubled". She highlighted that she used a variety of their own coping mechanisms to destress with employer support not really present, *'My coping strategies were I walked every day, came back here for lunch, switched on the TV and watched a couple of episodes of friends made me laugh and laugh and then some mornings I did Zumba online."* Amanda noted that often the staff felt they were often under-valued and expected to do more than their traditional roles and responsibilities during the pandemic, *"I think managers, senior managers, have got to realise the difficulty and distress and strain that emm the people have come though… all of them need to be very aware that it was a very, very difficult and stressful time for all of the healthcare workers, nurses, social workers, you know domiciliary care workers and what we had to do to try and make people's life a little bit different for them through the pandemic you know".* Amanda noted that while the pressures were tough at times with increased workloads and staffing issues in the beginning, it finally felt like things were beginning to calm down between February - May 2021, *"I'm just breathing now the stage I'm just so glad that we've come to the stage with the vaccines and it's almost like you're breathing now, you can sort of take a wee step back and you can be sort of be a bit normal with your clients again and reassuring them that there is light at the end of the tunnel."*

Stacey

Stacey is a nurse who was redeployed several times over the pandemic to different wards and the constant redeployment has not helped them get on top of their workload, with the backlog of patients increased after the second redeployment and explained this has impacted staff morale. *"With still a huge backlog when we were then redeployed for the second time in January 1st time probably you know you were much more you know willing to help and then second time we spent like seriously because you're just aware of how far we were still behind and now we're going to be away again and we experienced real backlash from patients about the backlog."* Stacey noted that while in normal times you have interaction with colleagues, during these last few months of the pandemic this has changed. *'Gere is a real bottleneck and you know I suppose we usually do get a lot of support from colleagues because you're totally separated from them you're very much working on your own, you have nobody to you know debrief with'.* Additionally, Stacey felt that support from

management in their organisation came at the wrong point of time when staff were already burnout and over-worked *"I used to get those global emails with all these coping strategies made me so angry…it was the you know we should have been offered that kind of support on a more personal basis on a more personal level at the very initiation of redeployment rather than a whole barrage of things now you know and so I probably just felt that it was poorly timed."*

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 3 focus groups were: **Changes in working conditions, connections, communication and coping,** these findings are interlinked with the survey responses in the main report.

The mains themes uncovered are outlined in Table *X and a* word cloud was created to highlight the key words discussed by the participants and provide data visualisation (Figure 1).

Table A10.1: Themes uncovered from focus group transcripts

Overarching themes	Description	Sub themes
Changing in working conditions	This theme encompasses disruption to services and changes to normal work routine.	• Work-life balance/home-work interface • Peer support • Workload • Working safety • Redeployment and intention to leave
Coping	The theme encompasses respondents ways to cope during the COVID-19 pandemic and highlights the stressors in place that have resulted in changes to their coping strategies. Support in the workplace is discussed in terms of wellbeing and emotional elements.	• Workplace pressures and burnout • Ways to cope • Setting priorities • Appreciation of life • Declining activism • Self-reflection/Self-care • Wellbeing support in the workplace • Emotional support in the workplace
Connections	This theme encompasses how face to face interaction has impacted how respondents worked and how these	• Connections with service users • Workplace connections • Building and appreciating relationships

	impacted their connections in the workplace and with the service users.	• Face to face interaction
Communication	This theme presents how communication changed amongst the health and social care workforce and how this communication pathway can be improved to benefit the workforce.	• Recognition and feeling valued • Communication in the workplace • Communication with service users • Day to day communication.

Figure A10.1: Word cloud of key words from qualitative analysis.