



Health and social care workers' **quality of working life and coping** while working during the COVID-19 pandemic November 2022 – January 2023



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Phase 6: Findings from Survey and Focus Groups



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

Phase 6: 25th November 2022 – 13th January 2023

REPORT 6

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FOREWORD

Dear reader.

We are proud to present to you the sixth report in our Health and Social Care Workforce research series. This phase was again made up of a nationwide survey completed by Health and Social Care workers of varying job roles and series of focus group activities, with the survey collecting data between November 2022 and January 2023, a time that many are describing as 'post pandemic', but a time when we are hearing many anecdotal and media reports of ongoing struggles across the country in the Health and Social Care sectors. Testing has ended, lockdowns have eased, social distancing is no more, and people are returning to whatever the 'new normal' is for their own work practices. This report therefore outlines the working context for these workers who were jointly described as 'Key Workers' during the highest ravages of the Covid-19 pandemic.

Interestingly, findings from this project (and in particular our qualitative survey findings) demonstrate consistent and ongoing concerns. There are few 'new' findings that emerged in Phase 6 which are different to any of the previous five Phases. High workloads due to staff shortages and ongoing impacts of pandemic delays stand out. This has meant working long hours consistently for the past two years, an overreliance on agency staff and pay which is not commensurate with the number of hours being worked. With these trends ongoing over the nearly three years and six phases of this project, it is no surprise that we are seeing ongoing recruitment and retention issues.

The findings of this research series have potential for far-reaching impacts and influence. Whether as a reader you are a Health and/or Social Care employer, a practitioner, policymaker or researcher, the findings and recommendations should provide essential food for thought. Our health and social care workforce have never been under as much strain as they are presently, and we should be working to support them, with important recommendations for support in this report.

And so, the last thing to say is 'thank you'. Thank you to those who took part in this study. Thank you to those who were key workers during the pandemic. Thank you to those key workers who continue to sacrifice so much to support their patients and service users. Just because we are 'post pandemic', does not make any of you any less 'key'.

The HSC Workforce Research Team

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

INDEX

1. Background.....	6
1.1 Aim.....	7
1.2 Objectives.....	8
2. Methodology.....	9
2.1. Primary Research Instrument-Survey.....	9
2.1.1. Mental Well-being.....	9
2.1.2. Quality of Working Life.....	10
2.1.3. Burnout.....	11
2.1.4. Coping with COVID-19 Related Occupational Demands.....	11
2.1.5. Coping with Work-Related Stressors.....	12
2.1.6. Open-Ended Questions – Descriptions of COVID-19 Demands and Impacts.....	12
2.2. Study Respondents: Sampling, Access, and Recruitment.....	12
2.2.1 Sample Profile.....	13
2.3 Focus Groups.....	17
2.4 Data Analysis.....	18
2.5 Ethical Considerations.....	19
3. Findings.....	19
3.1. Quantitative Findings.....	19
3.1.1. Mental Well-being.....	19
3.1.2. Quality of Working Life.....	24
3.1.3. Burnout.....	29
3.1.4 Coping.....	35
3.2. Findings: Qualitative responses.....	38
3.2.1. Open-ended responses – Descriptions of Demands and Impacts on Service.....	38
3.2.2. Focus group discussion.....	52
4. Discussion.....	64
4.1. Main Messages.....	64
4.1.1. COVID-19 Impact on working conditions and service pressures.....	65
4.2. Limitations and Strengths.....	66
4.3. Implications.....	66
5. References.....	74
6. Appendices.....	77

LIST OF FIGURES	77
LIST OF TABLES	85
Appendix 1: Weighting Representativeness for Country, Region and Occupation	92
Appendix 2: Descriptive Results (Weighted and Unweighted) – Tables and Charts	97
Appendix 3: Mental Well-being Results (Weighted and Unweighted) – Tables and Charts	229
Appendix 4: Quality of Working Life (Weighted and Unweighted) – Tables and Charts.....	252
Appendix 5: Copenhagen Burnout Inventory (Unweighted) – Tables and Charts.....	304
Appendix 6: Carver Coping Scale (Weighted and Unweighted) – Tables and Charts	377
Appendix 7: Clark Coping Scale (Weighted and Unweighted) – Tables and Charts.....	408
Appendix 8: Multiple Regression Results (Unweighted)	432
Appendix 9: Comparison of Phase 1 (May – July 2020), Phase 2 (Nov 2020 – Feb 2021), Phase 3 (May – July 2021), Phase 4 (Nov 2021-Feb 2022), Phase 5 (May-July 2022) and Phase 6 (Nov 2022 – January 2023).	443

1. Background

The first 20 years of the 21st century has seen newly recognised coronaviruses appear and spread quickly across the world (Bradley & Bryan, 2019). These viruses include the severe acute respiratory syndrome virus (SARS) and the Middle Eastern respiratory syndrome virus (MERS). In 2009, a novel H1N1 pandemic influenza strain caused considerable morbidity and mortality around the world and continues to occur on a seasonal basis. In December 2019, a novel coronavirus emerged in China (COVID-19), and within a matter of weeks was designated a pandemic with all countries urged to take 'urgent and aggressive action' (WHO, 2020). Globally, this pandemic has led to great social and economic disruption for governments and their citizens with a rising death toll and attempts to prepare, protect, and treat citizens. Alongside a rising death toll, attempts to prepare, protect, and treat citizens have had a significant impact across all sectors in society. While rhetoric has stressed that fighting this pandemic is everybody's business (WHO, 2020), the main burden of caring and treating in Northern Ireland and the United Kingdom (UK) has fallen to an understaffed and underfunded health and social care sector and those who work in it. Prior to the outbreak of this pandemic, it had been recognised that Brexit was adding to the many skills shortages in the health and social care sector in the UK. In addition, increasing numbers of people with complex disabilities and an ageing population with co-morbidities have put the National Health Service (NHS) under increasing strain (ONS, 2017). Even before the pandemic became apparent, thought had already been given to how health and social care sector employers could encourage all staff – both young and old to stay healthy and to reduce their health risks as well as to recover from or cope with problems once they have occurred (Manthorpe & Moriarty, 2009; Ryan et al., 2017; McFadden et al., 2020).

Despite our experience of pandemics, there is limited reporting in the literature about how health and social care workers cope with the challenges of caring for patients/service users, in both hospital and community settings, when potentially putting their own health at risk (Griffiths et al., 2023). This study sought to build on previous studies undertaken regarding the impact of the pandemic on health care and social care staff, their coping strategies and ability to manage the challenges of caring for patients or service users (Lee et al, 2005; Khalid, et al 2015; Chen, 2020; Woolham et al 2020; West et al 2020; Harrikari et al., 2023). This report builds upon the findings from Phases 1-5 of the 'Health and social care workers' quality of working life and coping while working during a COVID-19 Pandemic' study. The reports from Phases 1-5 contain a series of good practice recommendations based on learning from the COVID-19 Pandemic (McFadden et al., 2020, 2021). The most recent

publications and conference presentations are available on the Study website:

<https://www.hscworkforcestudy.co.uk/>.

1.1 Aim

This study builds upon the findings from the previous five Phases of our wider research (see Figure 1.1) on health and social care worker well-being and coping during COVID-19. Phase 1 (data collected between May – July 2020), Phase 2 (data collected between November 2020- February 2021), Phase 3 (data collected between May – July 2021), Phase 4 (data collected between Nov 2021-February 2022) and Phase 5 (data collected between May – July 2022). Each phase used surveys and focus groups, to further explore the impact of providing health and social care during the COVID-19 (SARS-CoV-2) pandemic in Northern Ireland and the United Kingdom (UK). The study focuses specifically on the experiences of Nurses, Midwives, Allied Health Professionals (AHPs), Social Care Workers and Social Workers. Our sixth survey (25th November 2022 – 13th January 2023), followed by focus groups with human resource (HR) staff from health and social care, line managers, and frontline workers, sought to gain further understanding of how the COVID-19 pandemic has affected their work and home life as well as their health and well-being during this phase of the pandemic. To explore further their working conditions and the impact of such on health and well-being in this post-pandemic phase respondents were also asked their views about safe staffing in the HSC sector post COVID -19.

Figure 1. 1. Research Phases of Wider Study



1.2 Objectives

1. To gather demographic and work-related information from a cross-sectional convenience sample of Nurses, Midwives, AHPs, Social Care Workers and Social Workers in the UK.
2. To examine the perspectives of Nurses, Midwives, AHPs, Social Care Workers and Social Workers on the challenges they are facing while providing health and social care during (and following) the COVID-19 pandemic, including their perspectives on employers' supports and potential ways to improve these.
3. To assess well-being, quality of working life and levels of burnout in this workforce.
4. To find out what coping strategies are used to deal with work-related stressors and the effects of these strategies on respondents' well-being, quality of working life and levels of burnout.
5. To elicit detail about perceived levels of safe staffing within the HSC and the effects of this on respondents' work life and their health and well-being post-pandemic.

2. Methodology

2.1. Primary Research Instrument-Survey

Data for this current report were collected using an online survey questionnaire, which was adapted from the questionnaires used in Phases 1-5 of our Health and Social Care Workforce Study. Most questions remained the same, but some were amended, others were removed, and some new ones were added to gain more insights into the effects of COVID-19 on the workforce and to reflect the rapidly changing COVID-19 situation in the UK. The survey was predominantly quantitative but contained two open-ended qualitative questions. The main parts of the survey covered the areas below:

- **Demographic and work-related information:** age, sex, country of work, occupational group, ethnicity, disability status, relationship status, job tenure, hours of work, working overtime, working at home, considering changing one's occupation and/or employer, the effects of the pandemic on one's place of work, the impact of COVID-19 and employer support or use of any employer support.
- **Open-ended questions:** two questions related to 1) the impact of COVID-19 on respondents' place of work and 2) whether respondents believed their service operated a safe staff-to-service user ratio.
- **Mental well-being:** Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008).
- **Quality of working life:** Work-Related Quality of Life scale (WRQOL; Easton & van Laar, 2018).
- **Burnout:** Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen, & Christensen, 2005).
- **Coping with COVID-19-related occupational demands:** 20 items from Brief COPE (Coping Orientation to Problems Experienced, Carver, 1997).
- **Coping with work-related stressors:** 15 items from Clark, Michel, Early and Baltes (2014).

2.1.1. Mental Well-being

Mental well-being was assessed using the Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008). The scale contains seven items asking respondents to indicate how often in the previous two weeks they had feelings or thoughts described in each of the items (e.g., I've been feeling useful). The seven items are rated using a five-point Likert scale ranging from 1 = 'None of the time' to 5 = 'All of the time'. The item scores are summed to provide an overall well-being score, which can range from 7 to 35. Higher scores indicate better mental well-being. We

used cut-off points shown in Table 2.1 to categorise respondents into those who were *probable* or *possible* cases of depression or anxiety (Warwick Medical School, 2021):

Table 2.1: Categories created by SWEMWBS Score

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

2.1.2. Quality of Working Life

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

Table 2.2: Categories created by WRQOL Score

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

2.1.3. Burnout

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

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

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

Table 2.3: Cut-off points for CBI Burnout scores

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

2.1.4. Coping with COVID-19 Related Occupational Demands

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

range from 2 to 8 and higher scores indicate that respondents use the specific coping strategy more often.

2.1.5. Coping with Work-Related Stressors

Coping with work-related stressors was assessed using 15 items from the 81-item scale assessing work and family stressor coping strategies, developed by Clark et al. (2014). The 15 items assessed five specific coping strategies (three items per strategy), including Family-work segmentation (not handling family related things while working), Work-family segmentation (not handling work while at home), Working to improve skills/efficiency, Recreation and relaxation, and Exercise. Respondents were asked to use a six-point Likert scale ranging from 1 = 'Never have done this' to 6 = 'Almost always do this' to indicate how often they have been doing what is described by the items to cope with work stressors. The scores for each item are averaged and can range from 1 to 6. Higher scores indicate that respondents use the specific coping strategy more often.

2.1.6. Open-Ended Questions – Descriptions of COVID-19 Demands and Impacts

Two open-ended questions were asked:

1. Between March 2022 and now, what is the impact of COVID-19 on your specific place of work, in relation to patient / service user numbers and service demand?
2. Do you think your service operates a safe staff-to-service user ratio? Please say more about this.

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

2.2. Study Respondents: Sampling, Access, and Recruitment

Respondents were Nurses, Midwives, AHPs, Social Care Workers and Social Workers in the UK who were working in health and social care during the Phase 6 study period (15th November 2022- 13th January 2023). A wide variety of recruitment channels and methods were utilised to reach as many potential respondents as possible. Outreach took place through the Northern Ireland Social Care Council, Social Care Wales, the five Northern Ireland Health and Social Care Trusts, Community Care magazine, Nursing and Midwifery Council, the Health and Care Professions Council, Northern Ireland Practice and Education Council, Royal College of Midwives, Royal College of Nursing, AHP Federation and AHPs Professional Associations such as the Royal College of Occupational Therapists (RCOT),

British Association of Social Workers, and the College of Podiatry. Support was also provided by the Chief Nursing and AHP Officers from across the UK. These regulatory bodies, unions, associations, and lead professionals used a variety of methods to disseminate the study information, including newsletters, direct emails, or social media platforms. A dedicated 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 through the above-mentioned bodies, associations, and individuals. Respondents completed the survey online which was hosted on Qualtrics™ by accessing a dedicated weblink or using a QR code. The survey was completed anonymously to encourage honest responses and was available in both the English and Welsh language.

2.2.1 Sample Profile

A total of 1,395 individuals responded to the survey. Most of the responses came from Northern Ireland (n = 781), followed by Scotland (n = 332), England (n = 188), and then Wales (n = 94). Social Care Workers comprised the largest proportion (37.9%) of the sample (See Figure 2.1).

Figure 2.1: Occupation of Respondents (Unweighted)

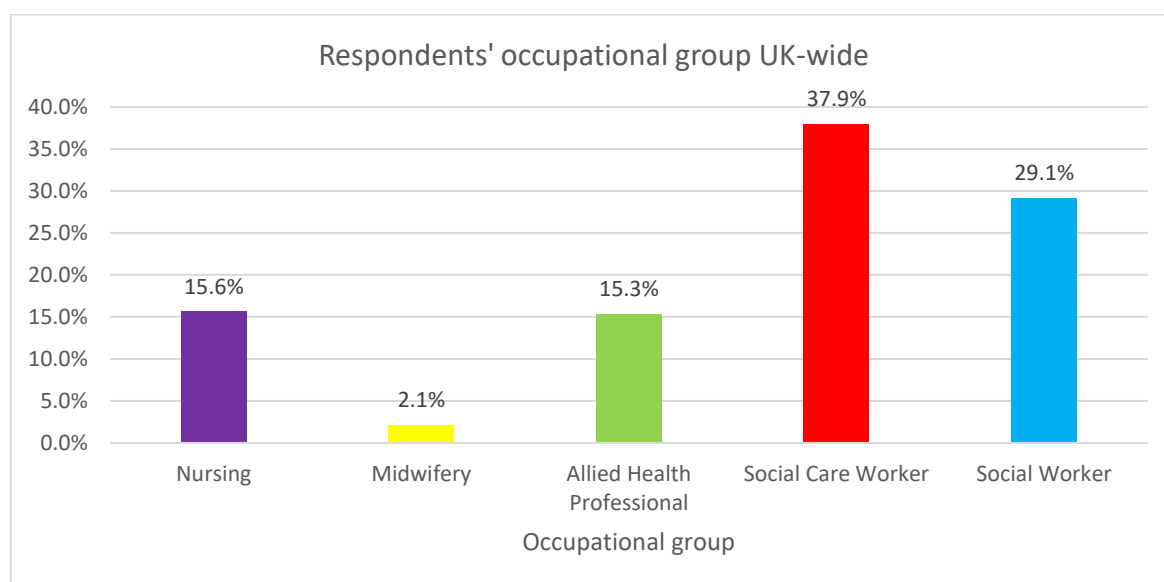


Table 2.4 below shows that of the 218 nursing respondents, 79.8% were from Northern Ireland, 11.5% from England, 7.8% from Scotland and 0.9% from Wales. A total of 29 midwives responded to the survey. Overall, most respondents (51.7%) were from Northern Ireland, 31.0% from Wales, 13.8%

from England and 3.4% from Scotland. The majority of AHPs were from Northern Ireland (66.7%), followed by England (21.1%) and Scotland (9.9%) with the smallest number were from Wales (2.3%). A total of 52.2% of social care workers were from Northern Ireland, 42.5% were from Scotland, 3.4% from Wales and the remaining 1.9% from England. The largest proportion of social workers in the sample were from Northern Ireland (42.9%), followed by England (25.6%), Scotland (16.7%) and Wales (14.8%).

Table 2.4: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	25 (11.5%)	17 (7.8%)	2 (0.9%)	174 (79.8%)	218 (15.6%)
Midwifery	4 (13.8%)	1 (3.4%)	9 (31.0%)	15 (51.7%)	29 (2.1%)
AHP	45 (21.1%)	21 (9.9%)	5 (2.3%)	142 (66.7%)	213 (15.3%)
Social Care Worker	10 (1.9%)	225 (42.5%)	18 (3.4%)	276 (52.2%)	529 (37.9%)
Social Worker	104 (25.6%)	68 (16.7%)	60 (14.8%)	174 (42.9%)	340 (29.1%)

Most respondents were female (88.3% UK-wide) with a similar gender distribution across countries. The majority of midwives in the sample were female (96.6%) while AHPs had the highest proportion of males (19.7%). Those aged 50-59 years age comprised the largest age category (33.2% UK-Wide). Scotland had the highest proportion of respondents in the 50-59 age group (41.3% within Scotland). The majority of respondents were of White ethnic origin (97.4% UK-wide). England had the highest proportion of respondents who identified as belonging to an ethnicity other than White (12.2% within England) and midwifery was the most diverse occupational group, with 6.9% of midwives identifying as not White. England had the highest proportion of respondents with a disability (17.6% within England) and social workers were the most likely occupation to report having a disability (17.2% within social work). Most respondents UK-wide were married (57.2%) or single (19.6%).

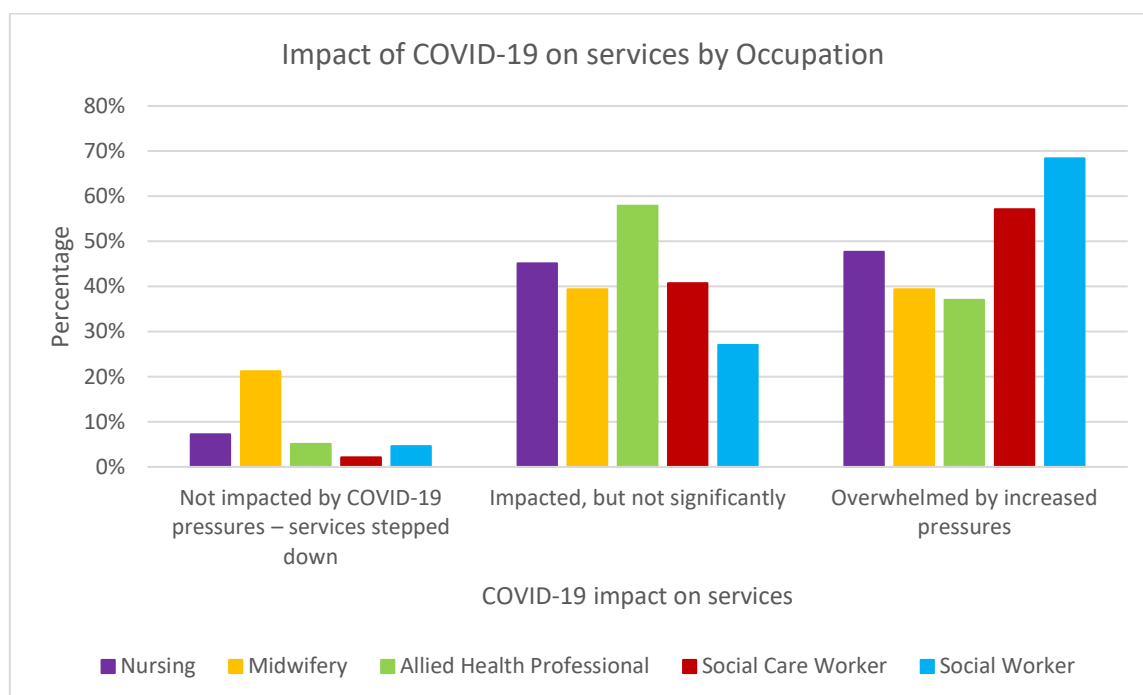
UK-wide, over half of all the respondents worked in the community (51.5% UK-wide), while 19.1% (UK-wide) worked in a hospital. Most worked in the statutory health and social care sectors (38.1% UK-wide), but over half of social care workers (59.7% of social care workers) worked in non-statutory services (private or voluntary sector, directly employed or other). Just under one-third of study respondents UK-wide were line managers in their jobs (31.1%). Most respondents were employed on

a permanent basis (89.3% UK-wide) with the majority employed full-time (75.2% UK-wide), typically working 37.5 hours per week (57.6% UK-wide). Northern Ireland had the highest proportion of respondents employed on a part-time basis (26.8% within Northern Ireland).

A total of 35.9% of respondents UK-wide typically did not work overtime but since the start of the pandemic, slightly less, 29.2% UK-wide, did not do any overtime. Overall, respondents reported working significantly more hours of overtime since the start of the pandemic compared to before it. Around a third of the respondents (32.9% UK-wide) had taken no sick days in the previous 12 months, 67.1% had taken one or more sick days in the previous 12 months, with proportionately more midwives (75.9%) reporting taking one or more sick days. UK-wide, 70.1% of respondents said that at least some of their sickness absence was related to COVID-19 with 75.6% of nursing and 74.0% of social care workers having sickness related in some way to COVID-19. When sick, nearly half of respondents (41.9% UK-wide) reported being paid by their employer.

A large proportion of respondents UK-wide had either 11-20 years of work experience (28.9%) or 21-30 years (22.9%). Scotland had the highest proportion of those with 11-20 years of experience (30.4% within Scotland) and midwives contained the highest proportion of staff with over 30 years of experience (31.0%). The main area of practice for most respondents was working with older people (27.8% UK-wide) followed by 'Other' groups, this included working across multiple service groups, e.g., mental health, older people, outpatients etc (15.8% UK-wide). UK-wide, only 2.9% reported that their service had not been impacted (services stepped down due to COVID-19) with 58.1% reporting feeling overwhelmed by increased pressures. As shown in Figure 2.2, social workers and social care workers were the most impacted occupational groups (68.4% of social workers and 57.1% of social care workers). That said, significant percentages of respondents expressed feeling overwhelmed in all occupational groups with over 37% of respondents in each occupation group feeling overwhelmed.

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



Respondents were asked whether they worked from home before the pandemic, more than three-quarters of respondents did not work from home at all (77.2% UK-wide). During the COVID-19 pandemic from November 2022-January 2023, 3.5% of respondents reported they were able to work from home all the time, while 34.3% could work from home some of the time. Social workers were most likely to work from home all the time (8.6% of social workers) or some of the time (70.9% of social workers), while most social care workers (84.8% of social care workers), nurses (77.1% of nurses) and midwives (75.9% of midwives) were not able to work from home at all.

Respondents were also asked whether they had considered changing their employer or occupation since the start of the pandemic. Nearly one-half of the respondents UK-wide (43.0%) had considered changing their employer, with the highest proportion of these being from England (51.5% within England) and closely followed by Northern Ireland (43.3% within Northern Ireland). Within social work, 48.9% of respondents considered changing their employer. Over a third of the respondents UK-wide (39.6%) also had considered changing their occupation with the highest proportion of these being from Scotland (43.4% within Scotland) and closely followed by England (42.0%). Within social care workers, 44.2% had considered changing their occupation during the pandemic. Respondents

indicated that a pay increase (61.2%), manager support (46.2%), well-being support (41.0%), and safer working conditions (38.6%), would change their minds about wanting to leave their employer or current occupation. Most respondents were still in the same job on the same contractual working hours (74.6% UK-wide) as they had been since the pandemic arrived.

Most respondents reported not taking up employer support (74.4% UK-wide). Respondents from Wales had the highest percentage uptake of employer support (39.4% within Wales). Social workers were most likely to report accessing employer support (30.8% within social workers) while AHPs were least likely to access employer support with only 23.0% of AHPs taking up employer support. For those respondents who accessed employer support, the most common forms were manager support (48.5%), well-being support (45.4%), peer support (34.7%), and counselling services (33.2%). When respondents were asked why they had not taken up employer support, 25.8% indicated that the support was not needed at all, 25.5% stated that support was not accessible or at an inconvenient time, 24.8% felt the support was not needed as they had support from elsewhere, and 23.9% stated other (reasons reported in the other category can be found in Appendix A2.40 of this report).

2.3 Focus Groups

Three focus groups were conducted to gain deeper insights into the health and social care workforce (Social Care Workers, Social Workers, Midwives, Nurses and AHPs) and the impact of the aftermath of COVID-19 on their work, one with health and social care Human Resource (HR) professionals, one with line managers and one with frontline workers (note: focus groups were conducted in both November and December 2022). Participants were from Northern Ireland, Wales, Scotland, and England. One male and seven females took part in these focus groups. Each group began with a brief introduction of the research study before discussion based on key findings from the survey. The views expressed in these focus groups and the qualitative responses to survey questions, contributed to our good practice recommendations to improve the quality of working life and well-being of health and social care professionals now and beyond the pandemic. Table 2.5 below shows the country and occupational group of the 8 participants.

Table 2.5: Focus Group Participants

Focus group	Country	Occupation	Setting
Human Resources (HR)	Northern Ireland	HR – Trust	Community
	Scotland	HR – Social Services Council	Community
Managers	Northern Ireland	Social Care	Community
	Northern Ireland	Fostering Services	Community
Front Line workers	England	AHP	Community/Hospital
	Wales	Social Worker	Community
	Wales	Social Worker	Community
	Wales	Social Worker	Community

2.4 Data Analysis

Quantitative survey data were analysed using SPSS 28. The analysis presented in this report draws primarily on descriptive statistics, specifically frequencies, percentages, and mean values of the measured constructs, as well as some correlations. Sub-groups were compared using analyses of variance (ANOVA), independent samples t-tests and chi-square tests. Multiple regression analyses were used to examine the association between coping strategies and mental well-being, quality of working life and burnout, and to compare findings with those from Phases 1-6 of the study. Analyses were conducted both with raw and weighted data. The data were weighted using respondents' country of work and occupational group to adjust for potential bias accruing from under-representation of large groups. In terms of weighting, for three of the five occupational categories, weightings were created which adjust for the skew in numbers towards NI versus GB. So, for nursing, midwifery and social care, we weight by occupation and region, but with region as a binary variable, NI versus GB. Weighted responses are summarised in Section 3. Appendices provide more detailed results, including both the weighted and unweighted response summaries. The analyses were conducted with all available data. Some participants had missing data and therefore the sample total for the different analyses differs throughout this report.

Qualitative questions from the survey were analysed using thematic analysis (Braun and Clark, 2019). Initial coding was based on respondents' identification of groups, according to those who were 'overwhelmed', 'impacted but not significantly' and 'not impacted at all'. Members of the research

team read responses to identify recurring themes and outliers across professional groups and countries. Thematic analysis was also used to analyse data from the focus groups. The results of these are presented together with the survey findings in Sections 3.2.1 and 3.2.2. of the main part of this report.

2.5 Ethical Considerations

Data collection took place during another exceptionally busy period for health and social care staff. It was also a period of increased industrial action in Northern Ireland and the UK. While the research team were aware of these challenges, the view was that it was important to conduct this research at this time to gain a better understanding of staff well-being, quality of working life and burnout rates in order to formulate recommendations for supporting the workforce. The completion of the survey was voluntary; however, respondents were provided with contact details for support organisations if they became distressed during or following survey completion. Permissions for the use of all measurement scales used were obtained prior to the study commencing.

3. Findings

The following sections provide a summary of the quantitative and qualitative findings from Phase 6, with particular attention given to what has changed from the five previous Phases.

3.1. Quantitative Findings

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

3.1.1. Mental Well-being

Mental well-being was assessed using the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS; NHS Health Scotland, 2008). The overall UK-wide mean well-being score in our sample was 20.36, which is more than three points below the population mean of 23.61 (NHS Health Survey for England, 2011). This score is also lower than the mean score of 20.95 reported in Phase 1 of the study and is higher than the mean score of 20.10 reported in Phase 2 of the study and the mean score

of 20.25 in Phase 3. However, in this sixth phase of the study the well-being score was slightly lower from the reported mean score of 20.80 in Phase 5 (Table 3.1).

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

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	20.95	21.16	20.74	21.24	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85
Phase 4	20.85	20.98	20.28	20.8	20.69
Phase 5	20.80	20.39	20.89	20.28	20.87
Phase 6	20.36	21.11	19.88	20.66	20.59

Phase differences in Mental Well-being UK-wide

Multiple regression analysis revealed a **significant decrease in well-being from Phase 1 to Phase 6**, even after accounting for respondents' demographics such as country of work, occupational group, sex, age, ethnicity, and disability status ($\beta = -.943, p < .001$). There was a slight increase in the overall mean well-being scores between Phase 2 and Phase 6 of the study which was found **not statistically significant** when controlling for demographics ($\beta = .068, p = .610$). There was also a slight increase in the overall mean well-being scores between Phase 3 and Phase 6 of the study which was found **not statistically significant** when controlling for demographics ($\beta = -.144, p = .286$). However, there was a slight decrease in the overall mean well-being scores between Phase 4 and Phase 6 of the study which was found **not statistically significant** when controlling for demographics ($\beta = .026, p = .877$). There was also a slight decrease in the overall mean well-being scores between Phase 5 and Phase 6 of the study which was found **not statistically significant** when controlling for demographics ($\beta = .033, p = .852$).

Changes in Mental Well-being within professions

Those who worked as Midwives, AHPs, Social Workers, and Social Care Workers showed a decrease in their overall mean well-being scores from Phase 1 of the study to Phase 6, while Nurses showed an increase. Between Phase 2 and Phase 6, Nurses and Social Care Workers showed an increase in overall

well-being scores. Between Phase 3 and Phase 6, AHPs showed a decrease in overall well-being scores while Nurses, Midwives, Social Care Workers, and Social Workers showed an increase in overall well-being scores. Between Phase 4 and Phase 6, Nurses, Midwives and Social Workers showed a decrease in overall well-being scores while AHPs and Social Care Workers showed an increase in overall well-being scores (Table 3.2). Between Phase 5 and Phase 6, only the Nursing occupation showed a slight increase in well-being score, whereas Midwives, AHPs, Social Care Workers, and Social Workers showed a decrease in scores.

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

Study phase	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 1	21.15	20.91	21.38	20.98	21.14
Phase 2	20.10	19.92	20.73	20.02	20.07
Phase 3	20.58	19.23	20.72	19.70	19.31
Phase 4	20.85	20.98	20.27	20.80	20.69
Phase 5	20.32	19.93	21.60	21.15	20.19
Phase 6	21.63	19.76	20.68	20.82	19.76

When the well-being scores were converted to indicate probable or possible cases of depression/anxiety, it was found that UK-wide, 12.8% were probable (likely) cases of anxiety or depression and a further 24.0% were possible cases of anxiety or depression (See table 2.1 for cut-off points). With the overall average well-being score increasing slightly from Phase 3 to Phase 6, there were fewer respondents in the most recent study falling into the Likely Condition category. However, in comparison to Phase 5, more respondents fell into the probable (likely) or possible anxiety/depression brackets. Taken together, the estimated proportion of scores between 20-21 has remained similar and shows that well-being has not improved even as the population begins to move beyond the pandemic restrictions.

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

Study phase	UK-Wide	
	Probable (Likely)	Possible
Phase 1	9.0%	33.0%
Phase 2	17.7%	22.0%
Phase 3	20.7%	14.4%
Phase 4	12.4%	20.1%
Phase 5	11.8%	18.6%
Phase 6	12.8%	24.0%

*See table 2.1 for cut off scores

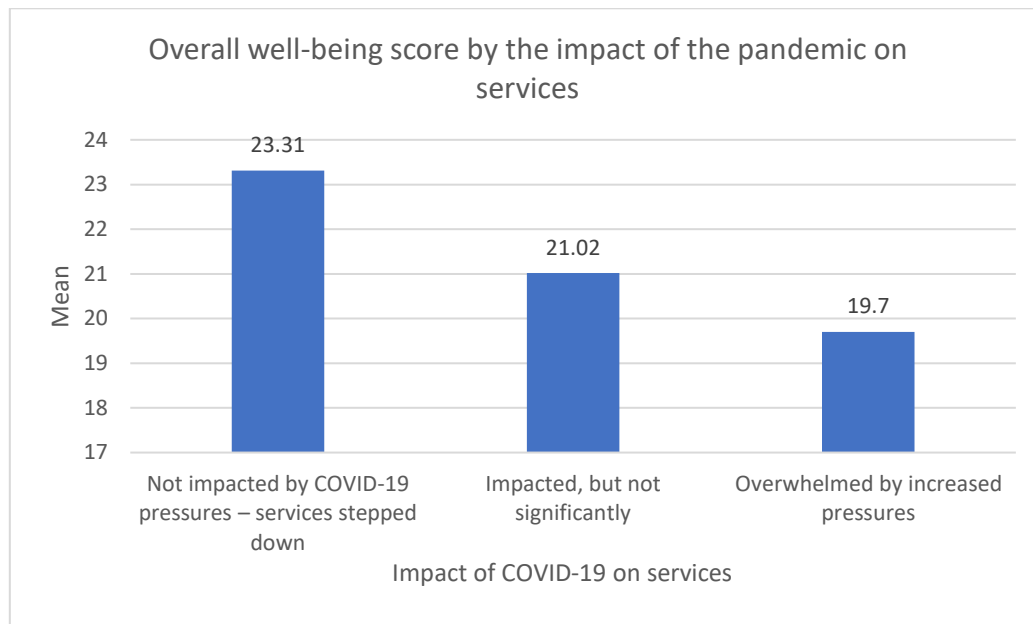
Demographic variables and Mental Well-being

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

- There were significant differences in the overall mean well-being scores across occupational groups. Specifically, the overall well-being scores were significantly higher in nursing than in social workers.
- Males and females differed significantly on their overall mean well-being scores with females having significantly higher well-being scores than their male counterparts.
- Younger respondents (16-29 age group) had significantly lower well-being than older respondents (specifically the 60+ age group).
- There were significant differences between the ethnic groups on their overall mean well-being scores. Specifically, respondents who identified as Asian scored significantly higher in well-being scores than both, White and Mixed ethnic groups.
- Respondents who worked with adults scored significantly higher than those working with children, in physical disabilities, in learning disabilities, with older people, and within mental health.
- Those who were line managers scored significantly lower in overall mean well-being scores than respondents who were not line managers.

- Respondents who felt overwhelmed by increased pressures scored significantly lower in well-being scores than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures (see Figure 3.1).

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



Compared to Phases 4 and 5 of the study which also measured impact, overall well-being scores for those overwhelmed was significantly lower in Phase 6 (Table 3.4).

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

Study phase	Respondents overwhelmed	
	Mean well-being score	Percentage of respondents
Phase 2	19.66	49.3%
Phase 3	19.26	62.1%
Phase 4	20.35	59.8%
Phase 5	20.22	59.4%
Phase 6	19.70	57.7%

Phase differences in Quality of Working Life UK-wide.

In Phase 6, after controlling for the effects of respondents' age, sex, disability status, ethnicity, country of work, occupational group, number of sick days in the previous 12 months, line manager status and the effects of the pandemic on services, we found that the following coping strategies were significantly associated with well-being scores:

- Acceptance, use of emotional support, work-family segmentation, working to improve skills/efficiency, recreation and relaxation, and exercise, **all predicted higher well-being scores.**
- Family-work segmentation, use of instrumental support, substance use, behavioural disengagement, and self-blame, **all predicted lower well-being scores.**

Additionally, we found that there was a decrease in the use of positive coping strategies (active coping, planning, positive reframing, acceptance, emotional support, and use of instrumental support) from Phase 5 while the use of negative strategies also decreased from Phase 5 (venting, substance use, behavioural disengagement, and self-blame). A detailed breakdown of coping scores across different variables is provided in Appendices 6 and 7, and detailed results of the multiple regression analysis are provided in Appendix 8.

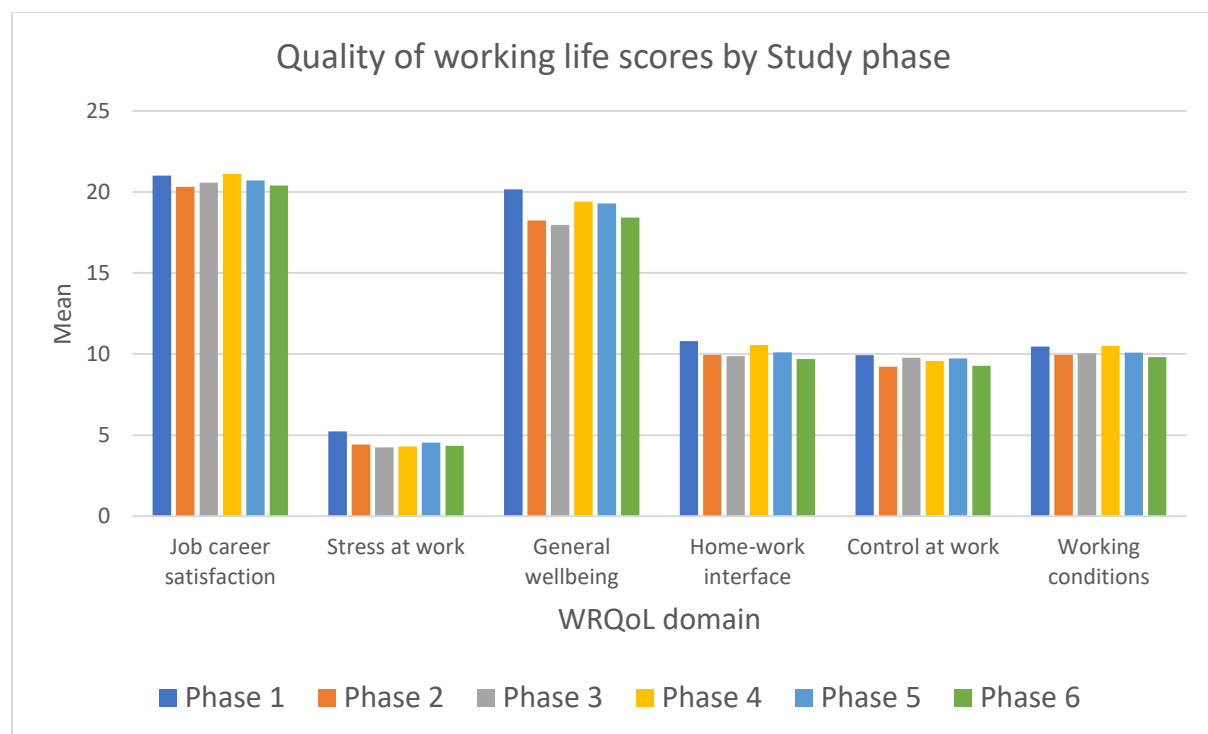
3.1.2. Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life (WRQOL) Scale (Easton and Van Laar, 2018). The overall WRQOL score in Phase 6 across the UK was 71.14 which was the lowest score of all the phases (i.e., Phase 1 – 77.59; Phase 2 – 72.13; Phase 3 – 72.45; Phase 4 – 75.46; Phase 5 – 74.49). Lower scores mean lower work-related quality of life. A multiple regression analysis, controlling for the effects of respondents' demographics such as country of work, occupational group, sex, age, ethnicity and disability status found the decrease in the overall WRQOL scores between Phase 1 and Phase 6 of the study **statistically significant** ($\beta = -5.712$, $p < .001$). The change in the overall WRQOL scores between Phase 2 and Phase 6 of the study was also **statistically significant**, when controlling for the effects of respondents' demographics ($\beta = -1.844$, $p = .002$). The change in the overall WRQOL scores between Phase 3 and Phase 6 of the study was also **statistically significant**, when controlling for the effects of respondents' demographics ($\beta = -1.368$, $p = .022$). The change in the overall WRQOL scores between Phase 4 and Phase 6 of the study was **not statistically significant**, when controlling for the effects of respondents' demographics ($\beta = .299$, $p = .703$). The change in the

overall WRQOL scores between Phase 5 and Phase 6 of the study was **statistically significant**, when controlling for the effects of respondents' demographics ($\beta = 2.397, p = .003$).

As shown in Figure 3.2, there was a decrease from Phase 5 to Phase 6 in job satisfaction, general well-being, home-work interface, control at work, and working conditions. Whereas stress at work increased (this scale was reversed scored).

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



As shown in Table 3.5., in Phase 6, the decrease in mean WRQOL scores was observed UK-wide and shown in two individual countries (Scotland and Northern Ireland). Similarly, Table 3.6 shows that WRQOL has declined from Phase 5 for AHPs and Social Care Workers in Phase 6.

Table 3.5: Mean Quality of Working Life Score by Study Phase and Country (Weighted by Occupation)

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	77.59	79.23	73.08	80.35	76.66
Phase 2	72.13	72.21	70.37	79.46	74.06
Phase 3	72.45	71.56	71.99	78.69	73.28
Phase 4	75.46	75.34	70.28	77.67	72.11
Phase 5	74.49	73.10	69.64	78.70	72.54
Phase 6	71.97	76.51	68.25	79.00	71.27

Table 3.6: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted by Region)

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	73.80	64.35	73.79	71.15	69.92
Phase 4	78.36	63.76	74.17	72.79	68.39
Phase 5	73.81	66.89	76.42	75.41	66.75
Phase 6	78.70	68.34	75.58	73.18	69.10

When the WRQOL scores were converted to Lower, Average, or Higher quality of working life, we found that UK-wide, 50.2% of respondents had lower quality of working life, 24.2% had average quality of working life and 25.5% had higher quality of working life in Phase 6. In Phase 5, 47.3% of respondents had lower quality of working life, 23.0% had average quality of working life and 29.7% had higher quality of working life. In Phase 4, 47.1% of respondents had lower quality of working life, 23.4% had average quality of working life and 29.5% had higher quality of working life in Phase 4. In Phase 3 in which 46.1% of respondents had lower quality of working life, 24.9% had average quality of working life and 29% had higher quality of working life. While in Phase 2, 37.3% of respondents had lower quality of working life, 27.5% had average quality of working life and 35.2% had higher quality of working life and 31.7%, 26.1%, and 42.2% for higher, average, and lower quality of working life

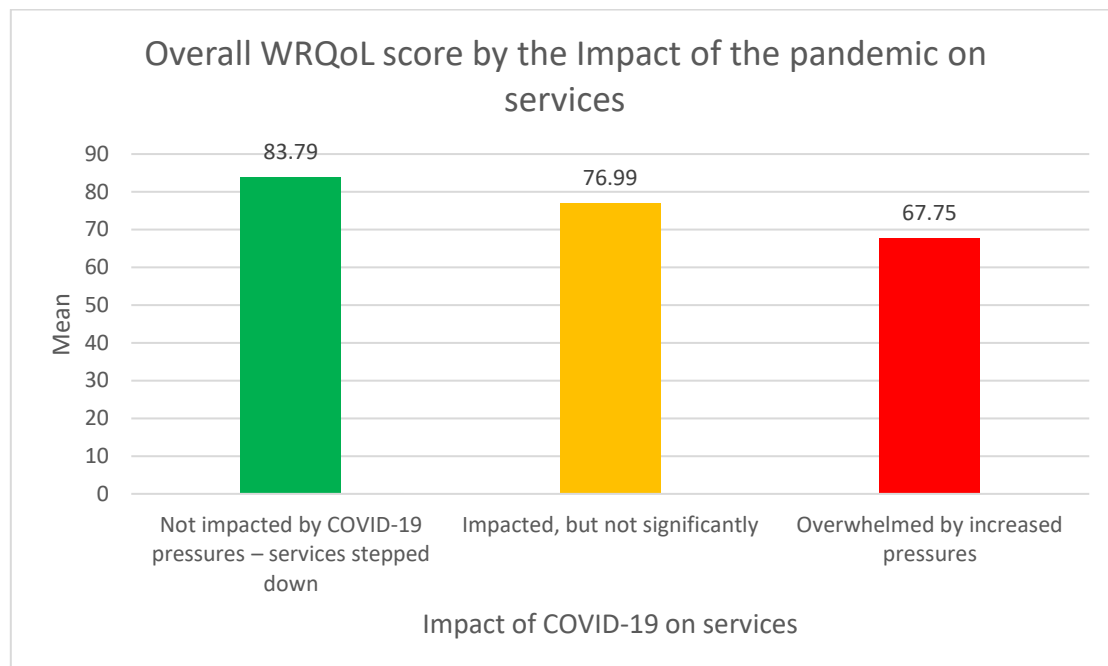
respectively in Phase 1 of the study. Results from this study (Phase 6) indicate a higher percentage of respondents had a lower level of WRQOL quality life.

Demographic variables and Quality of Working Life

Analyses of the associations of other variables with overall quality of working life revealed the following:

- The overall WRQOL score was significantly higher in Wales compared to Scotland and Northern Ireland. When respondents were categorised into those with lower, average, and higher quality of working life, Scotland had the highest proportion of respondents with “lower quality of working life” (54.9%) and England had the highest proportion with “higher quality of working life” (38.7%).
- Nurses scored significantly higher than midwives, social care workers, and social workers on quality of working life.
- Females had significantly higher quality of working life than males.
- Respondents in the 16-29 age group scored significantly lower than those in the 30-39 and the 60+ age groups.
- Those of Asian ethnicity reported higher scores than all other ethnicities.
- Respondents without a disability scored significantly higher than those with a disability.
- Respondents working with adults scored significantly higher than those working in all the other listed areas of practice.
- Respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact of COVID-19 (see Figure 3.3).

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



Coping and Quality of Working Life

We used multiple regressions to examine which coping strategies impacted upon the quality of working life scores. In Phase 6, we found that after controlling for the effects of respondents' age, sex, disability status, ethnicity, country of work, occupational group, number of sick days in the previous 12 months, line manager status, and the effects of the pandemic on services, the following coping strategies were significantly associated with WRQOL scores:

- Positive reframing, acceptance, use of emotional support, work-family segmentation, working to improve skills/efficiency, and recreation and relaxation, **all uniquely predicted higher quality of working life scores.**
- Family-work segmentation, planning, behavioural disengagement, venting, and self-blame, **all uniquely predicted lower quality of working life scores.**

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

3.1.3. Burnout

Burnout was measured from Phase 2 onwards. In Phase 6, the personal burnout score UK-wide was 62.69, which is higher than the personal burnout scores in Phase 5 (61.10), Phase 4 (62.62), and Phase 2 (61.40). However, the score in Phase 6 was lower than Phase 3 (63.20). The work-related burnout score across the UK was 58.33 which was higher than Phase 5 (56.51) and Phase 2 (56.73) but lower than Phase 4 (58.65), and Phase 3 (59.79). The client-related burnout score across the UK was 30.01 which was higher than Phase 5 (25.88), Phase 4 (25.24), Phase 3 (29.46) and Phase 2 (27.97).

Phase differences in Burnout UK-wide

Multiple regression analysis revealed a **significant increase** in personal burnout from Phase 2 to Phase 6, even after accounting for respondents' demographics such as country of work, occupational group, sex, age, ethnicity, and disability status ($\beta = 2.473, p < .001$). There was also a **significant increase** in work-related burnout ($\beta = 3.400, p < .001$) and a **significant difference** in client-related burnout ($\beta = 4.320, p < .001$) from Phase 2 to Phase 6.

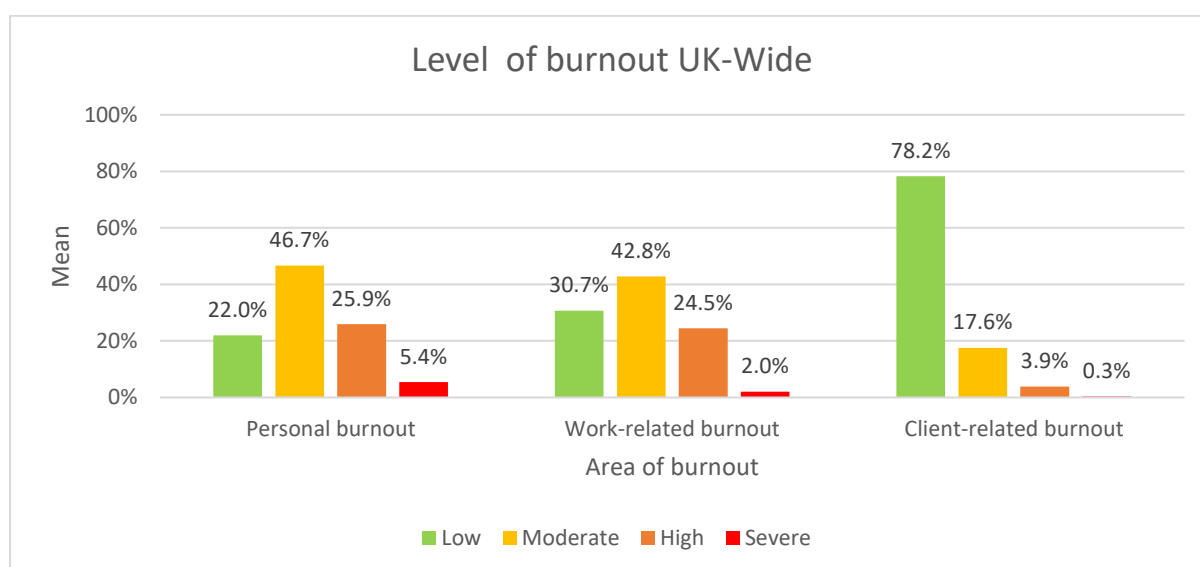
Multiple regression analysis revealed a **significant increase** in personal burnout from Phase 3 to Phase 6, even after accounting for respondents' demographics ($\beta = 2.766, p < .001$). There was also a **significant increase** in work-related burnout ($\beta = 3.186, p < .001$) from Phase 3 to Phase 6. Additionally, there was also a **significant difference** in client-related burnout ($\beta = 2.219, p < .001$) from Phase 3 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity, and disability status.

Multiple regression analysis revealed **no significant increase** in personal burnout from Phase 4 to Phase 6, even after accounting for respondents' demographics ($\beta = .713, p = .465$). There was also **no significant difference** in work-related burnout ($\beta = 1.061, p = .313$) from Phase 4 to Phase 6. In addition, there was no **significant difference** in client-related burnout ($\beta = 1.707, p = .133$).

Multiple regression analysis revealed **no significant difference** in personal burnout from Phase 5 to Phase 6, even after accounting for respondents' demographics ($\beta = 1.691, p = .055$). However, there was a **significant difference** in work-related burnout ($\beta = 2.392, p = .011$) and in client-related burnout ($\beta = 2.648, p = .008$) from Phase 5 to Phase 6 when accounting for respondents' country of work, occupational group, sex, age, ethnicity, and disability status.

There were no **significant differences** in mean personal burnout, work-related burnout, and client-related burnout scores between the countries, burnout scores for each domain (personal, work and client) were converted to low, moderate, high, or severe burnout (Figure 3.4).

Figure 3.4: Level of burnout UK-wide (Weighted)



*See table 2.3 for cut-off points

Burnout categories

Overall, there was an increase in personal burnout in Phase 6. We found that UK-wide in Phase 6, 22% of respondents had low personal burnout, 46.7% had moderate burnout, 25.9% had high burnout and a further 5.4% experienced severe levels. This compares to Phase 5 personal burnout, when 27.9% of respondents had low burnout, 41.3% moderate, 25.8% high and 5.1% faced severe burnout. Moreover, in Phase 4 personal burnout scores UK-wide were 25.8% of respondents had low, 42.7% moderate, 27.8% experienced high personal burnout with a further 3.8% experiencing severe levels. Additionally, in Phase 3, 25.5% of respondents had low burnout, 44.3% moderate burnout, 26.4% high personal burnout and 3.8% severe. In Phase 2, 27.7% reported low burnout, 45.9% reported moderate burnout, 23.5% reported high burnout, and 2.8% reported severe personal burnout (Table 3.7 for weighted results).

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

Personal Burnout	Low	Moderate	High/Severe
Phase 2	25.3%	46.4%	28.3%
Phase 3	21.9%	42.9%	37.2%
Phase 4	18.1%	54.6%	27.3%
Phase 5	27.4%	42.6%	30.1%
Phase 6	22.0%	46.7%	31.3%

*See table 2.3 for cut-off points

Phase 6 also reveals an overall increase in the level of work-related burnout: 30.7% had low burnout, 42.8% had moderate burnout, 24.5% had high work-related burnout, with a further 2% experiencing severe levels. In Phase 5, 33.1% had low burnout, 39.8% had moderate burnout and a further 27.2% experienced high to severe levels of work-related burnout. In Phase 4, 29.1% of respondents had low burnout, 43.3% moderate, 27.6% reported high/severe burnout. In Phase 3, 28.1% of respondents had low burnout, 46.3% moderate, 23.6% high and 2.0% faced severe burnout. In relation to work-related burnout in Phase 2, 33.7% experienced low burnout, 45.0% experienced moderate burnout and a further 21.3% experienced high or severe burnout (Table 3.8).

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

Work-related Burnout	Low	Moderate	High/Severe
Phase 2	33.7%	45.0%	21.3%
Phase 3	28.1%	46.3%	25.6%
Phase 4	29.0%	43.4%	27.6%
Phase 5	33.2%	44.6%	22.3%
Phase 6	30.7%	42.8%	26.5%

*See table 2.3 for cut-off points

Finally, in relation to client-related burnout, this remains low in Phase 6 with 78.2% experiencing low burnout, 17.6% experiencing moderate burnout, and 3.9% experiencing high client-related burnout, and a further 0.3% experiencing severe levels. In Phase 5, 79.8% experienced low burnout, 17.0% experienced moderate burnout and 3.2% experienced high or severe burnout (Table 3.9 for weighted results). In Phase 4, 79.4% experienced low burnout, 16.3% experienced moderate burnout and 4.3% experienced high or severe burnout. In Phase 3, 80.8% had experienced low burnout, 15.4% experienced moderate burnout and 3.8% experienced high or severe burnout. For client-related burnout in Phase 2, 83.1% had experienced low burnout, 14.4% experienced moderate burnout and 2.6% experienced high or severe burnout.

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

Client-related Burnout	Low	Moderate	High/Severe
Phase 2	80.9%	17.1%	2.0%
Phase 3	78.4%	18.2%	3.4%
Phase 4	81.7%	16.2%	2.1%
Phase 5	87.3%	10.8%	1.9%
Phase 6	78.2%	17.6%	4.2%

*See table 2.3 for cut-off points

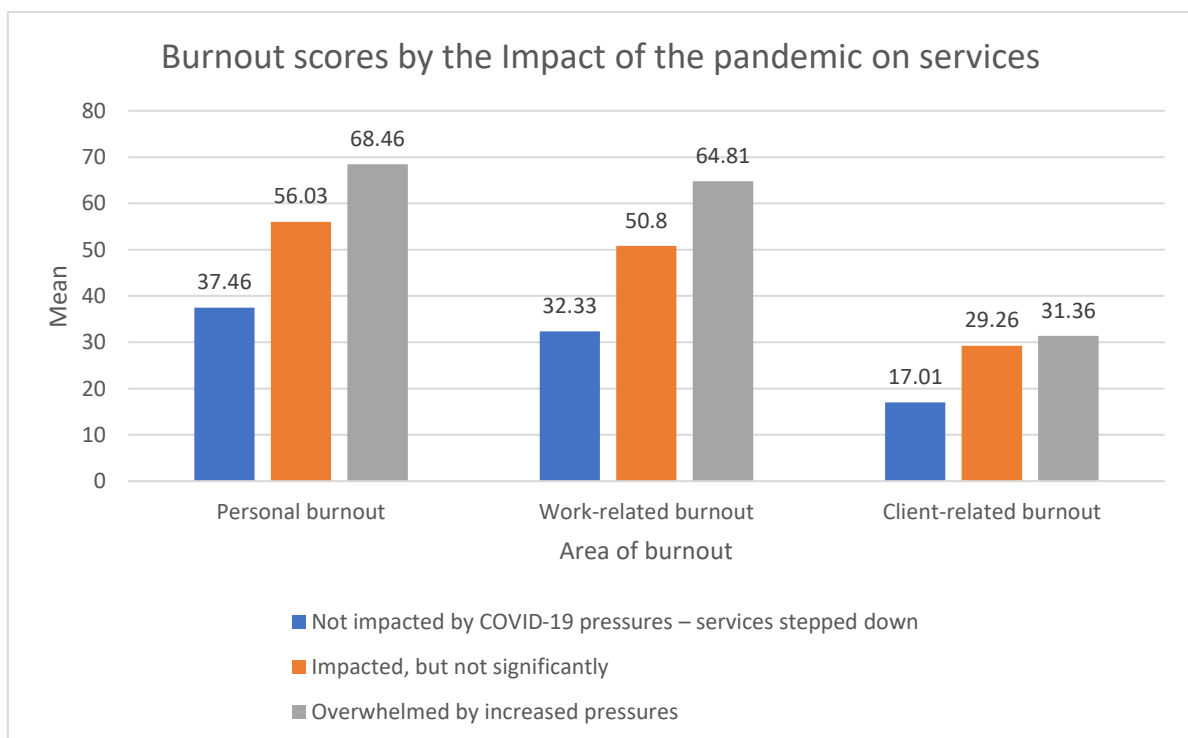
Demographic variables and Burnout

The analyses of the associations of other variables with burnout scores revealed the following:

- There were significant differences between the countries in mean personal burnout scores and in mean work-related burnout scores, but no significant difference in mean client-related burnout scores.
- In terms of personal burnout, social workers scored significantly higher than nurses, AHPs, and social care workers.
- In terms of work-related burnout, social workers also scored significantly higher than nurses, AHPs, and social care workers.
- In terms of client-related burnout, social workers again scored significantly higher than both nursing and social care workers.
- Females experienced significantly higher levels of personal related burnout but had significantly lower client-related burnout than males.
- The 60-65 age group scored significantly lower in personal burnout and work-related burnout than all other age groups. While the 16-29 age group scored significantly higher client-related burnout than all other age groups.
- The Asian ethnic group scored significantly lower in both personal and work-related burnout than all other ethnic groups. While the Black ethnic group scored significantly higher in client-related burnout than the White or Asian ethnic groups.
- Respondents without a disability experienced significantly less personal and work-related burnout than those who had a disability.

- Respondents working with adults scored significantly lower in personal burnout than those working with children and young people, in learning disability, with older people, and in mental health. Additionally, those working with adults scored significantly lower in work-related burnout than those working with children and young people, in learning disability, with older people, and in mental health.
- Respondents who were line managers scored significantly lower in client-related burnout than those who were not line managers.
- Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more personal, work-related, and client-related burnout than those not impacted (see Figure 3.5).
- Respondents who took employer support reported higher scores of personal and work-related burnout.

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



Correlations among Burnout, Quality of Working Life, and Well-being

As shown in Table 3.10, we found strong negative correlations between personal burnout and well-being scores and quality of working life. Work-related burnout had a similar strong negative

correlation with well-being and quality of life. Whereas client-related burnout had a moderate negative correlation with well-being and quality of life. This indicates that as burnout in any area increased, respondents' well-being and quality of working life decreased. Considering the association between burnout, well-being, and quality of working life, another area of interest for the study was whether respondents have considered leaving their current employer and how this impacts burnout.

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

Burnout area	Well-being	Quality of working life
Personal	-.654**	-.665**
Work-related	-.624**	-.730**
Client-related	-.414**	-.477**

** = Correlations are statistically significant at $p < .001$

In relation to respondents considering 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: $\chi^2 = 205.134$, $df = 15$, $p < .001$; Work-related burnout: $\chi^2 = 289.413$, $df = 15$, $p < .001$; Client-related burnout: $\chi^2 = 103.871$, $df = 15$, $p = .002$). Specifically, respondents who were experiencing high/severe levels of personal burnout were very likely to report considering changing their employer since the start of the pandemic for two specific reasons; 1) the job impacting on their health and well-being and 2) the job being very stressful. 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. Respondents who reported high client-related burnout were very likely to report having considered changing their employer due to the job impacting on their health and well-being in addition to just wanting a change.

Coping and Burnout

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

Personal burnout:

- Emotional support, work-family segmentation, and exercise, **all uniquely predicted lower burnout scores.**

- Planning, behavioural disengagement, self-blame, and family-work segmentation, **all uniquely predicted higher burnout scores.**

Work-related burnout:

- Acceptance, emotional support, work-family segmentation, and recreation and relaxation, **all uniquely predicted lower burnout scores.**
- Planning, venting, behavioural disengagement, self-blame, and family-work segmentation, **all uniquely predicted higher burnout scores.**

Client-related burnout:

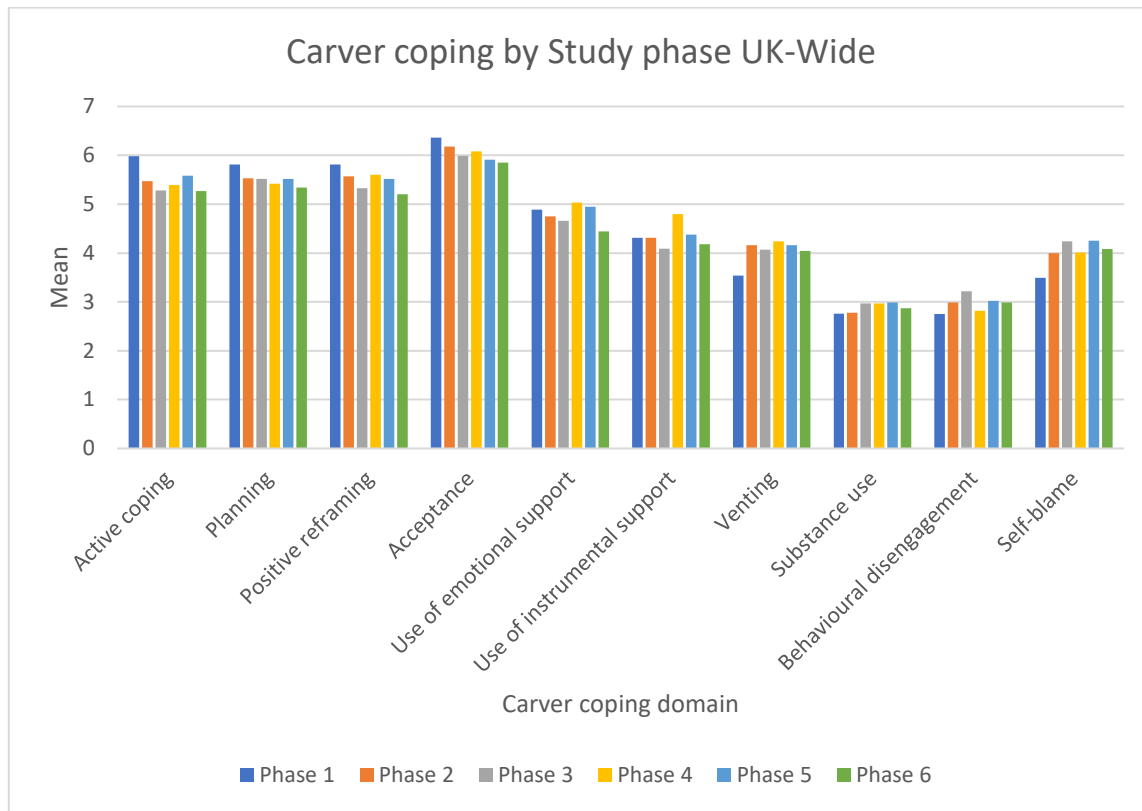
- Emotional support, work-family segmentation, and working to improve skills/efficiency **uniquely predicted lower burnout scores.**
- Venting, substance use, behavioural disengagement, and self-blame, **uniquely predicted higher burnout scores.**

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

3.1.4 Coping

UK-wide there was a significant decrease in the use of all positive coping strategies and an increase in the use of negative coping strategies such as Venting, Behavioural disengagement, and Self-blame from Phase 1 of the study to Phase 6. Similarly, between Phase 2 and Phase 6, there was a significant decrease in the use of all positive coping strategies and a significant increase in the use of negative coping strategies such as Self-blame. Between Phase 3 and Phase 6 there was a significant decrease in the use of most positive coping strategies and no significant change in the use of negative coping strategies. UK-wide there was a significant decrease in Active coping, Positive reframing, Acceptance, and Emotional support strategies from Phase 4 of the study to Phase 6. Between Phase 5 and Phase 6 Positive reframing and Acceptance coping strategies significantly decreased. These changes are shown in Figure 3.6.

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



Phase differences in Coping

Comparing Phase 1 to Phase 6, a multiple regression analysis, which controlled for the effects of demographics such as respondents' country of work, occupational group, sex, age, ethnicity and disability status, showed that the decrease in respondents' use of Active Coping ($\beta = -.957, p < .001$), Planning ($\beta = -.662, p < .001$), Positive Reframing ($\beta = -.798, p < .001$), Acceptance ($\beta = -.758, p < .001$), Emotional Support ($\beta = -.415, p < .001$), Instrumental support ($\beta = -.178, p = .006$) were **statistically significant** and an increase in Venting ($\beta = .725, p < .001$), Behavioural Disengagement ($\beta = .502, p < .001$) and Self-Blame ($\beta = .811, p < .001$) were also **statistically significant**.

Between Phase 2 to Phase 6, a multiple regression analysis, which controlled for demographics, showed that the decrease in respondents' use of Active Coping ($\beta = -.384, p < .001$), Planning ($\beta = -.288, p < .001$), Positive Reframing ($\beta = -.510, p < .001$), Acceptance ($\beta = -.452, p < .001$), the use of Emotional Support ($\beta = -.302, p < .001$) and Instrumental support ($\beta = -.193, p = .002$), were **statistically significant**. While Behavioural disengagement ($\beta = .160, p = .002$), and Self-blame ($\beta = .211, p = .001$), **significantly increased** between these two phases.

Between Phase 3 to Phase 6, a multiple regression analysis, which controlled for demographics, showed that the decrease in respondents' use of Active Coping ($\beta = -.188, p = .003$), Planning ($\beta = -.173, p = .009$), Positive reframing ($\beta = -.357, p < .001$), Acceptance ($\beta = -.302, p < .001$), and Emotional Support ($\beta = -.215, p < .001$) were **statistically significant**.

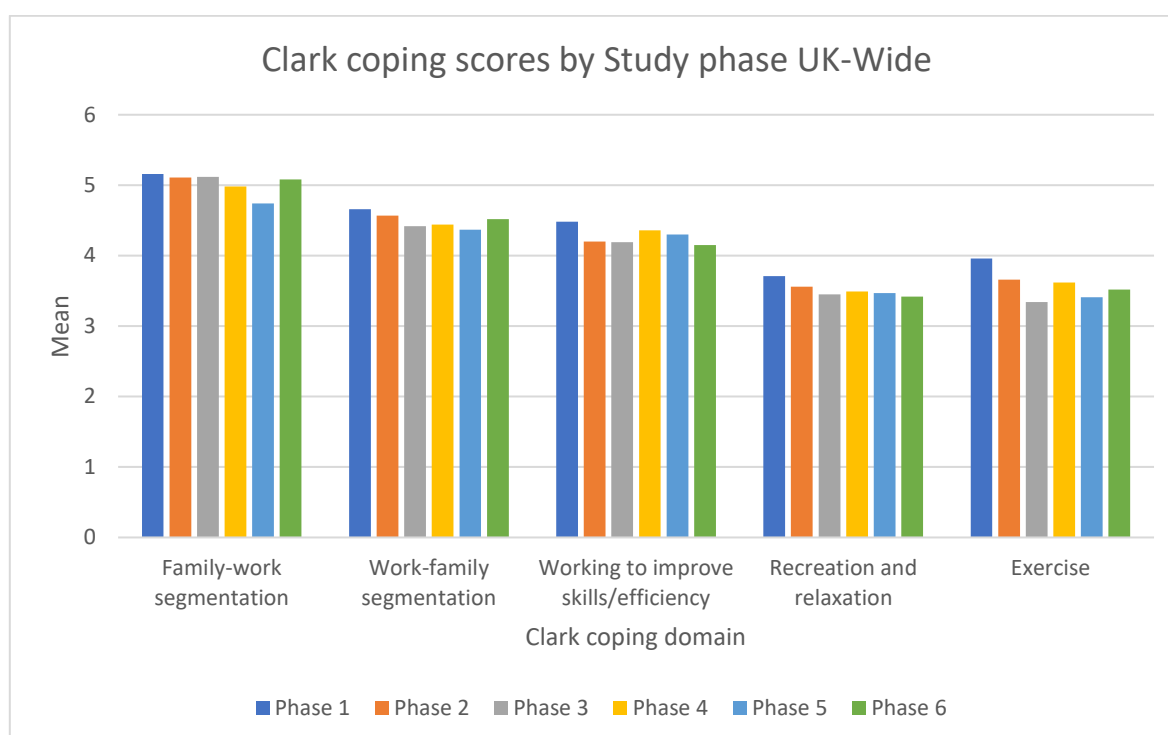
Between Phase 4 to Phase 6, a multiple regression analysis, which controlled for demographics, showed that the decrease in respondents' use of Active Coping ($\beta = -.1153, p = .029$), Positive reframing ($\beta = -.183, p = .009$), Acceptance ($\beta = -.221, p < .001$), and Emotional Support ($\beta = -.155, p = .031$) were **statistically significant**.

Between Phase 5 to Phase 6, a multiple regression analysis, which controlled for demographics, showed that the decrease in respondents' use of Positive reframing ($\beta = -.208, p = .003$), and Acceptance ($\beta = -.253, p < .001$) were **statistically significant**.

Looking at Clark et al's. (2014) coping strategies (Figure 3.7), a multiple regression analysis, which controlled for demographics showed **a significant reduction** between Phase 1 and 6 in respondents' Work-Family Segmentation ($\beta = -.176, p < .001$), Working to Improve skills/efficiency ($\beta = -.279, p < .001$), Recreation and Relaxation ($\beta = -.308, p < .001$) and Exercise ($\beta = -.426, p < .001$). Between Phases 2 to 6, a multiple regression analysis, which controlled for demographics showed **a significant reduction** in respondents' Work-family segmentation ($\beta = -.088, p = .028$), Working to improve skills/efficiency ($\beta = -.114, p = .004$), Recreation and Relaxation ($\beta = -.157, p < .001$), and Exercise ($\beta = -.224, p < .001$).

Between Phases 3 to 6, a multiple regression analysis, which controlled for demographics showed **a significant reduction** in respondents' Recreation and relaxation ($\beta = -.107, p = .017$), and of Exercise ($\beta = -.272, p < .001$). Between Phases 4 to 6, a multiple regression analysis, which controlled for demographics showed **a significant decrease** in the use of Exercise ($\beta = -.162, p = .005$). Between Phases 5 to 6, a multiple regression analysis, which controlled for demographics showed **a significant decrease** in the use of Exercise ($\beta = -.184, p = .002$).

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



3.2. Findings: Qualitative responses

Responses to the two open-ended questions in the survey were examined using thematic analysis (Braun and Clarke, 2019). Members of the research team familiarised themselves with the data, individually generated initial codes, met, and agreed codes, reviewed common themes, and then collated and presented the data as outlined below. Also included in this analysis were data from the three focus groups that were held with Human Resources (HR) professionals, managers and frontline workers in November and December of 2022. The overarching themes that emerged in Phase 6 (Nov 2022-Jan 2023) have similarities to the themes identified in other Phases of the study such as staff shortages, increased demands, and increased workload.

3.2.1. Open-ended responses – Descriptions of Demands and Impacts on Service

The following questions were asked in the Phase 6 survey:

- **Q22.** Between March 2022 and now, what is the impact of COVID-19 on your specific place of work, in relation to patient / service user numbers and service demand?
- **Q42.** Do you think your service operates a safe staff-to-service user ratio? Please say more about this.

Due to the large overlap in answers to these questions the analysis presented combines responses to both.

In Phase 6 of the survey, Question 22 *“Between July 2022 and now, what was the impact of COVID-19 on your specific place of work, in relation to patient/service user numbers and service demands?”* received a total of 1230 responses (see Figure 3.8). The responses were analyzed by five members of the research project team. A further qualitative question – Question 42 - asked for comments in answer to the following: *“Do you believe your service operates a safe staff-to-service user ratio?”* There were a total of 1202 responses: 43.6% responded ‘Yes’, while 56.4% responded ‘No’. The comments on Question 42 were analyzed by three members of the research project team (see Figure 3.9). Although both questions were answered separately, the emerging codes fused into similar responses. We have therefore presented the themes together in this section.

Overall, many themes identified in previous phases remain relevant to Phase 6. Respondents placed a renewed focus on work demand and staff shortages. In response to both questions, many answers elaborated on the vicious cycle of increasing work demand following the pandemic and increasing staff shortages resulting from staff sickness absence, skill shortages, staff retention and inability to fill open and advertised job positions. One nurse who works in a hospital in Northern Ireland summed it up as:

*“Increased demand. Increased staff sickness. Increased workload. Increased stress.
Increase in staff leaving the trust so overall Decreased permanent staff” (813).*

This vicious cycle was discussed across all four countries and five professions and was also attributed to increasing concerns about poor staff-to-service user ratios.

In the following section, we discuss responses to both open-ended questions in greater detail to highlight the challenges that the health and social care sector staff face as the outworking of the COVID-19 pandemic continues to affect their working conditions, as services rebuild, and patients and service users are seeking a return to ‘business as usual’ within health and social care provision. While the health and social care sector returns to a new normal, those working in health and social care services continue to face difficulties which are discussed in detail below.

Long term effects of the Pandemic

While the pandemic had mostly subsided at the time of data collection, in identifying reasons for increased work demand respondents elaborated on the long-term effect of COVID 19 on their services, for example, long waitlists and an increase in acuity and complexity of cases presented following the pandemic. An Allied Health Professional from England stated that:

“Waiting lists increased as patients developed new problems, or their current problems deteriorated during COVID-19 lockdowns” (619)

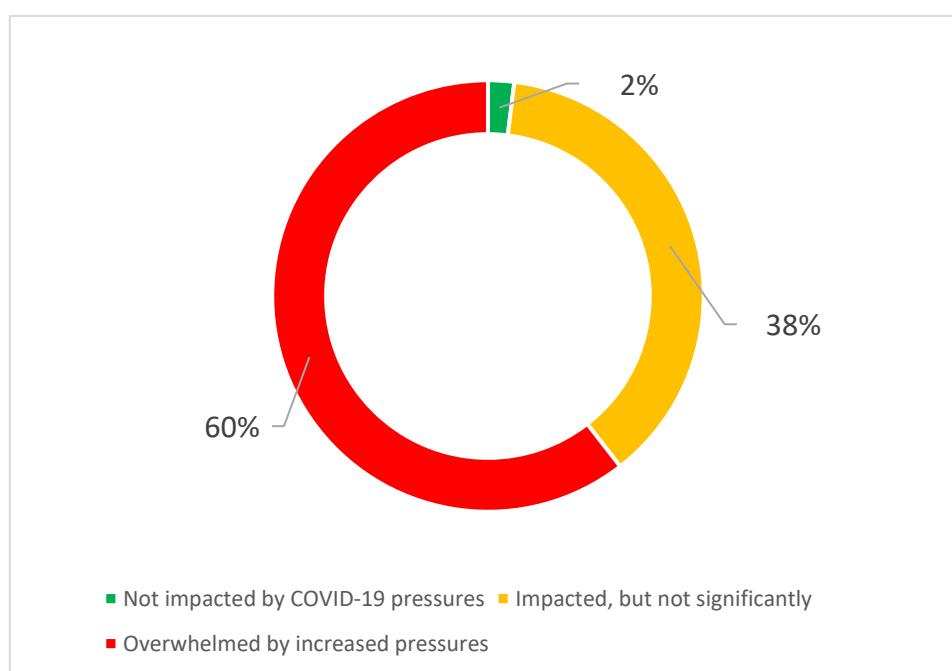
and a Social Worker from England confirmed that:

“Service demand has increased, in addition cases tend to be more complex and require longer interventions” (26).

Demand has also increased in response to the cost-of-living crisis, which affects health and social services alongside the long-term effects of the pandemic. As discussed by a Social Worker based in the Community in Northern Ireland:

“Demand, driven by poverty and social isolation continued to grow” . (694)

Figure 3.8 Impact on working during the pandemic by Q22 respondents (Unweighted)



Staff Shortages

Respondents continued to comment on staff shortages, often due to illness - including Covid19 - but also due to unrelated physical and mental health-related sickness absences. Respondents therefore elaborated on short-term staffing shortages, as expressed, for example, by a Social Care Worker in the Community in Northern Ireland:

“Staff shortages, COVID sickness, long COVID and staff left working really stretched due to low staffing levels” (627).

However, many respondents also talked about more permanent staff shortages that were caused by staff leaving the profession or an inability to fill advertised posts. A Northern Irish nurse stated that there was:

“Increased demand. Staff lost due to other opportunities. Increased recruitment of newly qualified / less experience staff” (766)

A Social Care Worker in Northern Ireland specified that the terms and conditions in Social Care were not attractive financially, which affected staff retention and, in turn, increased workloads for those social care workers who stayed:

“Just not enough pay and no fuel or travel allowance paid so staff leaving the industry to work in Asda or McDonalds as better paid which means pressure on to pick up extra calls and in turn means more fuel” (796).

Increased pressures on recruitment were also raised by a social worker in Scotland:

“A large number of staff left the team and we’ve not been able to recruit. I believe this was related to mismanagement during the pandemic and after. Workloads have increased, the work is more complex than ever before yet we’ve less staff and sickness rates are still high.” (535)

Working time and pay

The effect of this continuously high work demand was an increase in working hours. A Social Care Worker based in Scotland commented:

“Staff shortages, along with greater pressure to be a care assistant, hairdressers, beautician, the only company the elderly residents have most days. Plus, some weeks are 48 to 60 hours a week.” (979).

Many respondents reported working overtime to meet demand and a few respondents mentioned that overtime was sometimes unpaid or not paid adequately. A Social Worker based in England stated that:

“Due to work from home there has been no stopping time, work goes on endlessly. Earlier we still worked unpaid overtime because you can only meet children after educational

hours anyway, now all professionals email, teams, chat, phone and text at all hours expecting our availability” (916).

Furthermore, respondents suggested that their jobs were insufficiently rewarded “*Not enough pay*” (Social Care Worker, Northern Ireland, 596) or they compared work with “*slave labour*” (Social Worker, Northern Ireland, 628) due to the long hours and lack of overtime pay. The post-pandemic era therefore left some respondents in financial difficulties, including a Social Care Worker in Northern Ireland:

“Working with learning disabilities ... everyone residents and staff got covid. This then left us out of work with no pay only SSP which affected me as a single mother trying to provide for my son.” (678).

A Social Worker based in Northern Ireland reiterated this point:

“Case load increase but no increase pay or over time to allow job to be done Saltley [safely]. Therefore, having to work for free to meet demand and practice safely. Having to work overtime elsewhere to pay bills and then added pressure from additional work” (947).

While the workload had increased, in these cases, staff were apparently not compensated, and respondents had to seek additional employment to pay the bills.

Impact on Health and Well-being

While there was continued concern for service users, a significant number of respondents commented on the effect of the workload and working conditions on their own and colleagues’ health and well-being. A Social Worker based in Northern Ireland felt that the increase in case load and work demand had a significant impact on workers’ health:

“Hugh unmanageable caseloads and work demands that are impossible to meet within working times. Often don’t have time to take breaks... it’s an intense environment that has a significant impact on workers physical and mental health” (559).

A midwife based in a Northern Irish hospital further elaborated on this point and described working conditions that disregarded worker health and safety:

“PPE for 12hr shift, horrendous at times, not able to drink on ward, nightmare.....if you felt weak unwell you had to leave ward and go to what management called 'A Panic Room', have a drink and return ASAP to word [work]!!” (826)

A social worker from Northern Ireland described her own health and well-being as being de-prioritized until she felt that the need to change:

“Initially I was on automatic pilot, we were so busy; I did not give any thought to my or my assistants well-being/self-care but then one day I noticed how exhausted my assistant looked so that made me reflect and incorporate self-care into our working week” (972).

Experiences of new staff

The increase in work demand has also affected new job entrants’ ability to transition into their roles and to learn on the job. A nurse in Northern Ireland felt that senior staff had not had enough time to provide her with adequate training and guidance:

“Being a student the learning opportunities were limited due to nursing staff shortage, the staff being under pressure and students being used to make up numbers on wards to do one to one supervision to ensure safety of patients.” (798).

Another newly qualified nurse [country removed to retain anonymity] spoke about how she had to take responsibility early on. She felt that patients were left with nurses who were not sufficiently supported or trained:

“I started as a newly qualified nurse during the pandemic, working in the busiest ED level 1 Trauma Centre in xxxx [country removed to retain anonymity] As soon as I was off supernumery I was expected to take on over 22 patients myself at a time and across 6 months I became one of the most qualified nurses in resus areas on shifts, being expected to know, lead and teach other newer staff. More and more staff left due to the pressures, having to take on more patients, the doors never closed, and patients kept going with less and less staff, staff and nurses that were not adequately supported or taught.” (830)

Dependence on agency staff

While many respondents mentioned that agency or bank staff were in place to alleviate staff shortages, these staff (while appreciated by respondents) were sometimes not sufficiently trained for their roles and services. A Social Care Worker based in Scotland reported that:

“Not enough staff for increased pressure due to covid. Staff off with covid meaning agency workers unfamiliar with the unit was brought in.” (923)

Similarly, a nurse in Northern Ireland specified that her unit had been:

“dependent on agency which we appreciate but we feel undervalued and overwhelmed because we have the end responsibility of those nurses despite us only being band 5’s ourselves. If things are missed or done incorrectly, permanent staff are answerable. Agency staff aren’t given access to certain things-again-putting more jobs/tasks onto permanent staff despite everyone being stretched thinly enough.” (813).

Another nurse from Northern Ireland confirmed that:

“Additional staff came to help but had no ICU experience which added the workload to the current ICU staff. breaks, patient safety and staff health were greatly affected.” (818)

Therefore, while agency and bank workers appear to have covered some staff shortages in a quantitative way, several respondents felt that this did not alleviate increased work demand completely and might, in some cases, have caused additional work demand due to training and coordination needs.

Perceptions of Safe Staffing

In response to the increasing work demand and the unsatisfactory staffing situation, some respondents to Q.22 felt that their services had become unsafe for patients. This was either because there were not enough staff available or because those present did not have the required skills or qualifications. A social worker based in Scotland, for example, stated that a lack of social workers affected service users:

“Staff shortages in the main children and family’s teams means accommodated children are not being visited” (544).

A nurse from England likewise suggested that a lack of resources affected patient safety:

“Horrendously under resourced. No support from the trust for the staff during or after Covid, just left to get on with it. Feels like a very risky and dangerous place to work and that patient’s lives are being put at risk.” (944).

An Allied Health Professional from Scotland mentioned that they had been asked to do tasks that were outside of their skill sets, including:

“Dealing with things that were out of our job description i.e., surgical dressing”. (538)

Many respondents reiterated their concerns about safe staffing when responding to Q. 42, but 43.6% agreed that their service does operate a safe staff to service-user ratio. A nurse from Northern Ireland suggested that additional funding was improving the situation:

“Additional funding recently made recurrent to employ more staff” (158).

One commented that:

“Service is well resourced with a supportive management structure” (AHP, Northern Ireland, 120)

A number of respondents suggested positively that that standards are consistently met with one highlighting that:

“Everything is done by the regulations” (Social Care Worker, NI, 527).

Other evaluations of safe staffing ratios seemed contingent on a number of other factors, such as the nature of the service. Theatre nurses commented on the requirement to work with a minimal number of staff (640 and 553), while a nurse from Scotland explained that:

“Its unlikely patients will come to serious physical harm in my service even if the staffing ratio is very poor” (244).

For those who responded ‘Yes’ to Q.42, a majority suggested that the use of agency staff and overtime enabled safe staffing ratios to be maintained. A social care worker from Scotland commented:

“Using agency staff and lots of staff doing overtime to ensure support is continued on a daily basis” (441).

However, further commentary from those who responded ‘Yes’ revealed more nuanced evaluation of safe staffing, with many suggesting that it is “just about” safe and safe staffing is contingent on staff sickness, demand, and complexity of service user needs. A social Worker from Scotland stated that safe staffing is:

“...difficult to judge because circumstances can change quickly” (329).

Likewise, a community midwife from Wales explained:

“...in theory the numbers add up and the WTE are just about adequate, but sickness, vacancies play a huge role in constantly depleting the teams. each team has four midwives, so you only have to have one off and it skews the on calls” (720).

Responses also revealed differing conceptualisations of what ‘safe’ means. A social care worker from Scotland (364) stated that: *“Just because it's safe doesn't mean its optimal”*, with many referring to

time limitations with service users potentially compromising the quality-of-service delivery. A social worker from Wales (837) commented that:

“Physically impossible within the time of a working day and more time to spend with each person would always be beneficial and make practice safer”.

On the other hand, others focused more on how staff perceived their own safety especially when engaging in lone working. A social worker from Scotland explained that:

“Although [their] ratio may be safe, lone working is not monitored safely and there are no clear steps to follow” (354)

When analysing responses that stated ‘No’ to Q.42 (indicating concerns on safe staffing), a range of explanations were presented for concerns about safe staff-to-service-user ratios. Staff shortages relating to recruitment challenges and unfilled positions, and staff absences were cited as some of the main reasons, leading to conditions that were described as ‘*dangerous*’ (Nurse, Northern Ireland, 343), ‘*compromised*’ (Social Worker, Scotland, 156) and ‘*illegal*’ (AHP, Scotland, 431). Some stated clearly that the advised ratios and staffing levels are rarely adhered to with respondents from all professions noting their concerns. A midwife from Wales stated:

“No safe staffing levels in maternity and the ones advised are often not adhered to”.

An AHP from Scotland stated:

“Chronically short staffed. Can't find staff. Often the shortage forces us to work under illegal conditions, e.g., no nurse on shift even though we are a nursing home” (431).

A nurse from England suggested that:

“...restructure and difficulties recruiting mean that we have waiting lists and insufficient staff. Our safeguarding capacity is too low, and we are not providing a safe service”.

A social care worker from Northern Ireland acknowledged that:

“There is ratio of service users we are meant to work with which varies depending on the issues. However, we have been a member of staff short for over 6 months, so people are working over capacity”. (762)

Many midwives also noted how understaffing created difficulties in managing the care needs of women in labour:

“We are now constantly running understaffed due to sickness, but induction rates continue just the same. Sometimes inducing more women than we have midwives to look

after them, never mind those that also come in spontaneous labour". (Midwife, Northern Ireland).

Many social workers noted challenges with 'unmanageable' and 'risky' caseloads (Social worker, NI, 624) compounded by increasingly complex needs of their service users.

"No, I feel that there is increasing caseloads and complexities in older people's services. currently we are managing around 70-80 cases, many with complex needs, requiring capacity assessments, ongoing assessment, and review, safeguarding investigations and other duties. Alongside this it is extremely challenging to get the services to meet assessed needs due to lack of resources". (Social Worker, NI, 619)

Due to ongoing recruitment challenges and staff sickness, others described challenges relying on agency staff and more inexperienced or 'unskilled' staff to cover, leading to what were deemed as less safe conditions for service-users, and more stressful conditions for staff. Many respondents expressed their frustrations at the over-reliance on agency staff. A Social care worker from Northern Ireland bemoaned:

"No staff. Then agency is used who are useless" (455).

Many nurses also indicated their frustrations. A nurse from NI (653) explained:

"Constantly short staffed or bringing in agency staff who don't know the area or patients. No continuity in care and being paid twice as much and quite often expect us to support".

Another nurse from NI (368) explained that:

"...coping with a poor skill mix and very junior staff and a lot of sick leave put us outside safe staffing ratios".

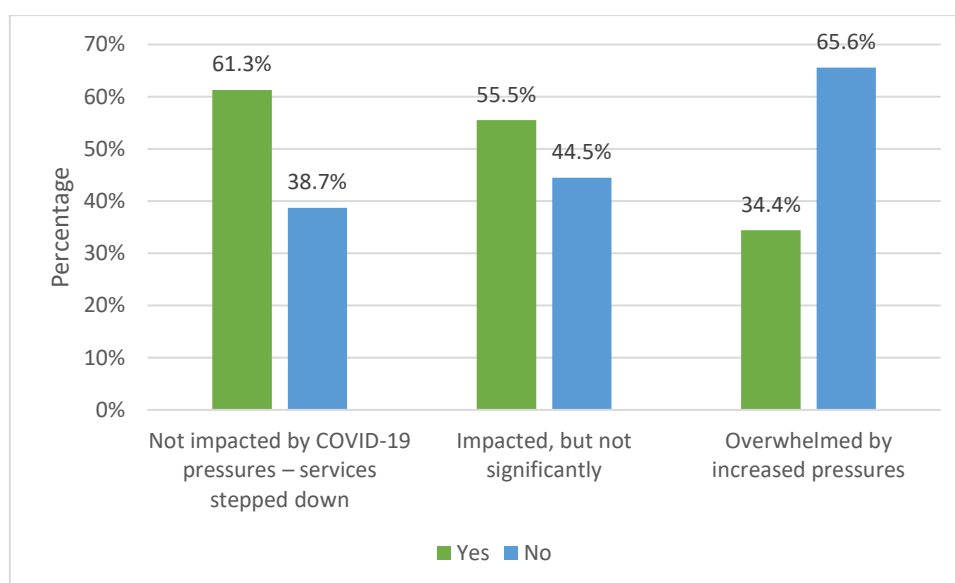
In many cases, there seemed to be acknowledgement that staff – service user ratios were deemed adequate, but that the level of experience and skills available for dealing with service needs was inadequate and was again compounded by increasingly complex needs of service users:

"Critical care is a specialised area, although physically we have the correct ratio, the skill mix is very poor. This is due a large number of senior nurses having left, these nurses have been replaced by newly qualified nurses or international nurses who communication skills are not adequate" (Nurse, NI, 644).

“Only enough staff to cover basic care. No activities or quality one to one time with key residents and to support residents with complex emotional needs and mental health issues”. (Social Care worker, Scotland. 165)

“There are much higher numbers of children on my caseload than is possible to see in my contracted hours. Whilst this is not physically unsafe there is a lot of unmet identified need” (Social Worker, NI).

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



Management Intervention

The discussion of the vicious cycle of work demand and staff shortage took center stage in our Phase 6 responses. In response to Q.22, only a few respondents elaborated on the role of management or on (the lack of) support received by their organisations. Those that commented spoke about a lack of support rather than an increase in support received. A hospital-based social care worker from Northern Ireland, for example, mentioned that:

“...staffing, and lack of support from upper management, more piled onto us without having the proper support” (915).

Additional commentary regarding employer and management support emerged more strongly in relation to Q.42. Several respondents voiced their view that those in leadership and management positions were failing to act even though they were aware of safe staffing problems. Often respondents felt that no one cared. A social worker from NI (453) explained there were:

“Too many vacancies, staff carry too high of a caseload. I have addressed this so many times with my employer”.

Compared to findings from previous Phases, there seemed to be increasing frustration that managers and employers were not listening to concerns, and that expectations were too high considering the context that individuals were working in. For example, a nurse from Scotland explained:

“Constantly short of staff and covering for vacancies and absences, but management expect the same level of service provision, documentation etc. It's all put on to the practitioners and we are constantly working over our contracted hours, which impacts our health and coping. Online self-help is no substitute for being able to finish work on time” (214).

Whereas a social worker from NI described the impact that this lack of support has had on their well-being:

“Additional pressures due to Covid, increased demands, response to operational staff/AYE/student needs means that I constantly have to work additional hours. Increased pressures by stealth, where the manager agrees to us taking on additional work without consulting or discussing. “You’ll do what you are told” is the response. Emails requesting meeting/clarification were being ignored until challenged, making me feel that I was the issue. For the first time in my long career, I feel emotionally exhausted and unsupported” (814).

Having no control over the outcomes of the situations faced exasperated concerns about safety and the ability to meet service user needs. An APH from NI explained:

“I have no control over numbers entering my caseload, no ability to say no or to change working conditions to manage the needs and that seems like an unsafe staff to service user ratio” (614).

Strategies to Improve Safe Staffing

On the other hand, our findings also revealed a number of management interventions and strategies to address concerns about safe staffing. Respondents noted efforts to improve caseload and service burden through various measures such as using waiting lists, Red, Amber Green (RAG) and risk assessment systems, as well as targeted supervision meetings. A social care worker from Northern Ireland explained:

"We currently have a waiting list for clients to use our services due to short staffing" (790).

But a significant number of respondents also explained how the increase in waiting lists added additional pressure and moral distress when they felt unable to address the needs of service-users in a timely manner. A social worker from Wales acknowledged:

"The fact that we have to operate a waiting list suggests that we do not have a sufficient staff to service user ratio. Risk on the waiting list needs to be managed on an ad hoc basis as crisis points arise" (821).

Another social care worker from Scotland explained:

"...we are able to control our scheduling therefore we reduce where possible when times get harder, however I feel that gives a degree of guilt for people who are awaiting support" (541).

Many blamed the increasing waiting lists on staff shortages, and noted their concerns about the effect this has on service users. An AHP from NI stated:

"Always staff shortages so pressure always on remaining staff to make up the difference. Always a waiting list which is detrimental to clients' (100), while many others echoed the sentiment that they worried about the 'risk [of] not getting to someone because on the waiting list" (Social Worker, Scotland, 306)

Adding to the moral distress reported by some respondents was the fact many people in need were being turned away so that existing service users could be treated safely. A social care worker from Northern Ireland explained that:

"...service is monitored and although it can be difficult to say no to requests for additional services it is taken into account the need to provide a safe service to existing service users" (742).

It seems that attempts to hold timely and appropriate supervision meetings to discuss these issues alongside the challenges to caseloads were appreciated by some workers. For example, a nurse from NI acknowledged the:

"...regular discussion at MDT meetings and with team lead who advise and support staff re: case load". (841).

There was an assumption that staff shortages and high work demand would be the “New Normal”. A nurse from Northern Ireland recounted a conversation with senior management that suggested that staff will have to get used to this situation:

“Less staff expected to do more. When concerns were brought to attention of senior management told “this the way it’s going to be”. Patients are very sick and just not possible to give the best care. Very stressful” (814)

Lastly, a Social Care Worker from Scotland felt that the situation for service users had deteriorated since the end of the pandemic, as family members of service users were often no longer working from home and therefore no longer available to care for them just as Social Care Workers’ workloads were spiraling:

“Within Homecare families are unable to help support their relatives, this was much easier for us during lock down and furlough as families were around and had the time to help with their loved ones. (602)

Only a few respondents saw light at the end of the tunnel or positive developments emerging from the pandemic. One social care worker from Northern Ireland, for example, saw that life was returning to normal for her service users:

“The relaxing of isolation restrictions has meant the re-opening of day centers, hairdressers, churches etc. meaning that not every client takes every call which is great and also the clients mental health is greatly improving.” (663)

While a Nurse from England mentioned that additional funding had become available due to the increase in number and acuity of referrals to her service:

“I work in eating disorders and our service has seen a big increase in number of referrals and acuity... We are really lucky on the community side (where I work now) that we’ve had a big increase in funding to improve the service and implement the early intervention pathway.” (853)

A Social Worker from Northern Ireland elaborated on how the pandemic had enabled the building of relationships:

“On a positive note, I built a lot of relationships with community and also patients because we had to be innovative on how we kept connected to people during this time” (972).

However, the overall situation in the health and social care services was seen as negative. This was summarized by a Social Care Worker working in a care home in Scotland:

“As the world and our politicians chose to state the pandemic was over, we were left in a no man’s land of navigating the expectations of competing views. Service users have needed extra support to transition from lock Down to reopening. They are more frail, less resilient. Outbreaks have been smaller and less physically damaging- however the emotional impact increases every time.” (338)

A Social Worker from Wales discussed how working during and after the pandemic, as well as during the cost-of-living crisis, had affected colleagues’ long-term outlook on their lives and their careers:

“Staff morale, people feeling unable to keep up with the pace... [A] colleague has said she would like a 2nd child, but cannot as she and her partner say they need to buy a house, these are young professional women with degrees. They have queried what is the point of working in the public sector work when the standard of living is becoming so low and the work complex, stressful and anxiety provoking. People in the community have no idea how hard it is to get services and trust doesn't seem to be there.” (778)

3.2.2. Focus group discussion.

Three focus groups were conducted with Human Resource (HR) professionals, managers and frontline workers in November and December of 2022. A total of eight participants provided deeper insights into work in the health and social care sector between May 2022 and November 2022. The participants discussed their experience during this post COVID-19 period, and their thoughts on safe staff-to-service user ratios, the main impact that the pandemic has had on well-being, working conditions, control at work, stress at work, as well as job satisfaction. Participants also answered questions which focused on their own experiences working during the pandemic, on how this changed from the first wave of the COVID-19 pandemic in March 2020 to November 2022, their use of coping strategies, work-related quality of life, employer support and what they recommend needs to be changed.

Frontline workers focus group discussion.

The subjects emerging from the frontline workers focus group in Phase 6 can be summarised under the following themes:

- staffing issues
- working from home
- moving from one crisis to another
- overworked and overstretched workforce
- low rate of pay and well-being
- impaired work-life balance and well-being
- getting back to the office is good for people
- flexible working patterns
- staff retention
- negative impact of agency workers on safe staffing ratios
- the importance of connection
- incivility in the workplace
- no capacity to develop wider skill-mix in the workforce.

Staffing issues:

Frontline workers identified staffing issues as one of the problems exacerbated by COVID-19. This was due to the large number of vacancies and recruitment problems, but also due to the problems with staff retention. One participant mentioned retention bonuses, which had a positive impact in their line of work. Another participant acknowledged that staffing issues are also dependent on the specific work area. They felt that as therapists, they were not routinely understaffed, but if more staff were available, patients would have been getting better quality care.

“In some of our frontline teams there are only forty percent of the posts are filled, so sixty percent of empty, and then we've got a rolling advert out all the time, and no applicants um, and in my twenty years, when a senior post goes out Um, you'd get lots of internal candidates, lots of external candidates. So, we've had senior posts, and there hasn't been one application.” [Social Worker (1), Wales]

“What I don't see very much is people returning to the field the way that they used to perhaps maybe have some time out to go and do something different, and then come back. People don't seem to be doing that as much so once people have left, they stay gone.” [Social Worker (2) Wales]

“I think that there is significant pressure on staff, and this does sometimes translate into staff having to work in a situation in which they feel the ratio of staff to service users is

unsafe, but this is not solely because of COVID19. This situation has existed, and has been worsening, for some time, COVID just exacerbated it somewhat as retention & recruitment are being negatively influenced in the aftermath of the more acute phase of the pandemic.” [AHP, England]

Working from home:

Two participants identified working from home as an issue adversely impacting upon their well-being. They missed the camaraderie within the office where difficult work calls could be followed by a de-stressing chat with a colleague over a cup of tea. They were also missing the divide between the work and home life and mentioned the drive home after work or between visits to have a decompressing effect and to provide time for reflection. Since this had gone it had affected their mental health.

“I’ve really struggled to work from home. It’s had a massive impact on me, I don’t like it. It’s not good for my family. It’s not good for me. It’s not good for my work.” [Social Worker (3) Wales]

“What coping strategy have I developed over twenty years, well, transitions to and from the office, decompressing in the car, seeing other people being able to talk about it, being in the same building, having a common purpose. All of those are really necessary for my resilience. Um! And they went.” [Social Worker (3) Wales]

“So yeah, it’s about connection. Isn’t it? It’s about feeling like you belong. I think that’s common, that common purpose you have when you have a difficult day, and you see somebody else having success with their work. That’s a positive thing for you. You think I’ll have a better day tomorrow.” [Social Worker (3) Wales]

“When everyone was in the office if somebody had a very difficult phone call or came back from a visit that’d been particularly traumatic, you would pick up on that, you would see that person, you’d make them a drink, you’d have a chat with them, you’d take the time out.” [Social Worker (2) Wales]

“Social work is always going to be tough, but we’ve lost some of the safety measures to protect people by having, you know, support around you, by having that reflection time and a bit of space, I found very difficult.” [Social Worker (2) Wales]

Managers Focus Group Discussion

Moving from one crisis to another:

Participants mentioned the negative impacts of the cost-of-living crisis directly following the end of the COVID-19 pandemic and how the workforce did not get any breathing space.

"We've gone from a Covid mode to a different type of crisis that's impacting on people which is obviously the cost of living" [Care Home, Northern Ireland]

"It feels like we've come out of one process where people felt that there was going to be, I suppose, normality, if you can describe that, I don't know what normal is anymore, and into something else that feels uncertain for them. So, there's a degree of uncertainty that's carrying through which is impacting on people." [Care Home, Northern Ireland]

"When we started off at the beginning of the pandemic, and we kinda knew it was going to go on for a long time, and we knew the kind of effort we were putting in at the beginning we were already having, we already thinking ahead and trying to think, well, what's it going to be like when we come out of this thing? Little did we know that it's going to be like 2 and a half years. Then, it hasn't really, didn't really reach a point where you said right, that's it, it's over". [Fostering Services, Northern Ireland]

Overworked and overstretched workforce:

Participants mentioned the adverse impacts of the crisis on the overworked workforce, which is now impacting on people's resilience. There are not enough resources, which means people are overstretched.

"It's getting harder and harder to take breaks. And partly that's about trying to do the same things with less resources. Also, I mean like so I'm my worst enemy, I wanted to do this, and wanted to contribute to this, because I think it's important. But you know your level of availability now is ridiculous, you know, and you've got to be very strong to be able to say no." [Fostering Services, Northern Ireland]

"But people's resilience is broken. and that that's the big thing for me that I really notice is, resilience is not as common as it was, and not everyone can demonstrate it anymore, because they probably utilized all the resilience that they've had in the last 3 years to keep themselves strong and keep the mind strong, keep themselves focused, and you know they've reached Burnout without a break. So, the resilience has disappeared, and

I think that's one of the key strengths of people in in this neck of the woods, and when we lose that we lose so much.” [Care Home, Northern Ireland]

Low rate of pay impacts people’s well-being:

Participants agreed that one of the main factors affecting the well-being of the workforce is the low rate of pay.

“I would say rate of pay is, you know, across the industry is definitely one of the key, the key things that impacts people's well-being. Probably the biggest factor, I would say.” [Care Home, Northern Ireland]

Impaired work-life balance impacts people’s well-being:

Another factor affecting the well-being of the workforce was work-life balance. One participant mentioned that an impaired work-life balance was to some extent, driven by workers’ loyalty:

“So, they feel bought in and loyal. Particularly, I find, some of our older clients, who, you know, through Covid it might have been the only person that they saw, and they built up really strong relationships with them. So, they're bought into that as well. There's an emotional, I suppose, tie in with a lot of this that they feel under pressure to maintain, and it's impacting at times with their balance of work and life.” [Care Home, Northern Ireland]

Another participant commented on what seemed to be the now culturally accepted phenomenon of working day and night:

“They're sending emails at, you know, at 12 min past 11 at night and beyond midnight. You know, and that's just really, I mean I, I'm still at the point, I'd be sort of having words with somebody who was doing that. What you're playing it, you know. But I mean, I think there's a cultural acceptance now in the Trust that people work like that.” [Fostering Services, Northern Ireland]

The participant also commented that the blurring of the boundaries between work and home life can lead to unsafe work practices:

“So, you're a constantly in the tyranny of the urgent, and you never get on top of things, and then your chances of missing something that's really really important or has a nuanced detail that should red flag you.” [Fostering Services, Northern Ireland]

Getting back to the office is good for people:

Participants also commented on the workforce coming back to the office.

"I think once people got to the taste of it again, they're realizing it's really nice to actually be in space with people again." [Fostering Services, Northern Ireland]

"we've had people tell us in large volumes that they need to get back out, they need to interact, they need to be mingling with the teams." [Care Home, Northern Ireland]

The need for better pay and flexible working patterns:

Participants from the managers focus group agreed that there had been a shift in the workforce, whereby people move jobs based on specific requirements such as more flexibility.

"We found, for certainly for our office teams, that we've had to approach recruitment in a different way, because, you know, at the minute it's hard to get people who want to do full time work. And if you are too regimented and restricted in the role that you're offering, and how they go about delivering that role. We find that we're not getting any applications around it." ... "There is an expectation out there that people can choose their working patterns a little bit more, and have a little bit more influence in that, and where they work, and how they approach their jobs. And if, if people are now becoming quite adamant, that if the job doesn't, meet my requirements, whether it's financial need or not, they're not going to move." [Care Home, Northern Ireland]

"You know you've created jobs that people don't want to do." [Fostering Services, Northern Ireland]

Participants also agreed that the workforce were being "grossly underpaid", and they may choose to do other jobs instead, for example, in retail, where the pay is better and the responsibility much lower. The low pay was linked to lack of resources, which could, again, impact safe staffing levels.

"And I'm not carrying all that responsibility of young people who are self-harming or going missing, or you know, or going on to a shift, and not knowing to the last minute, is there going to be somebody else on with me? But again, all you see, all the contracts are configured to be absolutely cut to the bone. So, there is no, there's no spare capacity in them for that, you know. So, you know, you've only got to have one person or 2 people off, and you're in diffs, you know, which then starts to, you know, people working additional hours is part of the model, not the exception." [Fostering Services, Northern Ireland]

HR Focus Group Discussion

Staff retention is problematic.

One of the biggest changes in what participants talked about in Phase 6/the last six months was problems with staff retention. One participant mentioned that while COVID still had an impact they are starting to plan for the future and getting back to 2019 staffing numbers.

"We are seeing increasing attrition rates. Um. We're seeing a lot of staff leave um staff, who have perhaps held on a bit longer just because they wanted to help out throughout Covid. Others who have re-evaluated their lives and decided enough is enough, and they're going to leave perhaps earlier than they had intended, and others who are just exiting from health care. Um! And for us, then that has increased, If anything, the pressures on um trying to recruit and retain staff um, in that context." [Trust, Northern Ireland]

"Our biggest challenge and the biggest focus across the workforce. Both health and social care is recruitment retention, burnout, you know, well-being. And so, in terms of a shift to focus over the last six months, it's definitely been around that focusing on how we support the well-being of staff, and in particular, for my area in leadership, leadership and improvement, it's about that connection between leadership and well-being. So, we don't talk about one without talking about the other these days, those two go hand in hand and very much starting with the self-leadership element of that. But actually, things are really critical, particularly in the social services sector, particularly in the social care sector, because of the pay, because of the conditions, the pay, people are leaving in droves those who stayed and stuck with it during the pandemic, because, you know, we have a workforce of people who care right. Um are now at a point where they just can't take any more." [Social Services Council, Scotland]

Key areas of concern for the workforce:

When asked about the main areas of concern for the workforce, one participant said that this was dependent on the area of the work, although she identified low pay as one of the key areas. The participant felt that this has been an issue for a while, but the cost-of-living crisis had compounded it even more.

"I'm working with the workforce of people who don't have that privilege. You know. A lot of them are on minimum wage. A lot of them, you know, there's been a recent survey

done in some particular geographical areas in Scotland for care at home workers in particular. They can't afford to put petrol in their cars there are managers paying, giving them extra money, for you know. So, I think it depends on what area of the workforce you're talking about Denise because I think there's a lot of, there is quite a disparity isn't there." [Social Services Council, Scotland]

Another participant felt that the key issue has been chronic understaffing and an overworked workforce.

"The key issue for us, I think, has been just a relentless um chronic under staffing and overwork." [Trust, Northern Ireland]

"That has an impact across all of those areas, so you don't feel that you're competent to do your job if you don't actually have safe staffing on the ward. Um, and then that leads to moral distress, um, moral injury, um, and that leads to burnout, um, and that leads to people wanting to leave the organization so it has um, impacts right across the ABCs [Autonomy, belonging, confidence]." [Trust, Northern Ireland]

"If you're asking me the kind of main area it's the chronic, chronic lack of staff and a chronic overwork is probably the key issue, followed then by pay and that sense that people are being undervalued by society. Um, not by all of society, but by the default of the fact that they're not being paid what they feel is a kind of fair wage for the work that they undertake." [Trust, Northern Ireland]

Agency workers have a negative impact on safe staffing ratios:

When asked about whether their service operates safe patient to staff ratios, one participant mentioned that this is very difficult to quantify due to a number of issues, such as the ratios being measured differently in different areas. He said:

"We've never got to a point where you know, the Trusts were in a position where they can assess effectively and or, give guarantees that we are in a safe staffing environment." [Trust, Northern Ireland]

Both participants said that safe staffing ratios are not simply about the number of bodies on shift, but also the quality of care provided. Both talked about how agency workers are not the same as permanent staff members.

"Are we operating under safe staffing. Um! I could say Yes, in some areas we are, and definitely in other areas we're not. But what comes into that then as well is the agency

ratio because there was a talk of right, well, you shouldn't have any more than I think it was fifty percent of your staff, it might be, maybe not as low as that. Um! Fifty percent of your staff should not be made up of agency. And again, because of the vacancy rates, we are heavily reliant on agency, and there's a big push to reduce agency. Um! But what comes with that is a requirement then to increase the bank rate and you know, all of this other stuff. So, it's a system-wide issue.” [Trust, Northern Ireland]

“Agency staff, and what's happening is, you know, obviously because they pay more. But what's happening is there, you know, um services whereby there are people are turning up, they don't know the staff, they don't know the residents, you know. You can imagine the impact that has an elderly people that you know those relationships are not there. It's just It's just not the level of care that you would like to see...” [Social Services Council, Scotland]

The importance of connection:

In terms of the well-being of the workforce, participants talked about the importance of personal connection. They mentioned how, especially during COVID, the workforce was sent a lot of health and well-being resources, but they were not effective in promoting well-being. What was more effective was the support staff were getting from within their own teams.

“Actually, we find that supporting each other is the most important support.” [Trust, Northern Ireland]

“And so we promote, and we try to um, develop as much interest and put out stuff as much as we can, but yet um staff have told us they like to know that it's there, and it's reassuring that it's there, but actually where they get their greatest support is actually from the team, and yet we are not finding that we have the time to actually spend with the teams to help them support each other,” [Trust, Northern Ireland]

“What happened in response to, you know, the initial, you know, Covid and Lockdowns was we all got very busy creating well-being resources and sending everything out, and with the best intentions, but very, very quickly it became horrifically difficult to navigate the resources.” [Social Services Council, Scotland]

“and the things that have landed best, and that people have asked for more of, are a couple of things we did around collaborative well-being where we created spaces for people to come together to support each other, to connect with each other, to give them

opportunities to step outside their own organizations just to understand actually, it's not just me here. You over there are having a very similar experience to me. So that was really powerful, people talked about feeling less alone, less isolated, so those are sort of national offerings that we did to bring people together from across the system. We also did some more local stuff around that, for people within their own teams which was extremely, you know, people found that was really useful.” [Social Services Council, Scotland]

Incivility in the workplace:

When asked about the incivility in the workplace, participants agreed that there was a lot of conflict amongst the workforce. One participant mentioned that one factor causing the issues is the working from home, as people are too busy and don't have time for each other. This goes back to first working from home during COVID, when not being busy was seen as equivalent to not working, thus creating distrust across the teams.

“There has definitely been a lot more clashes at a team level amongst people who used to get on and used to work effectively. Um losing their temper. Um losing patience and creating um breakdowns and relationships which are quite difficult to repair.” [Trust, Northern Ireland]

“Anecdotally, at every level in the organization we're seeing people uh whose relationships used to be strong, break down because of the pressures and stress across the system. And I know of a couple of kind of live examples, for that has happened, and it's been really hard to repair relationships as a result of that.” [Trust, Northern Ireland]

“The impact of having um, you know, people who worked right across Scotland but we're now working from home, and busyness became the new norm, and what that busyness meant was that they couldn't be available for each other, really for anything, because they had to make out they were busy all the time, because there was a lack of trust in relation to the fact that we were all working from home now, so, if you weren't busy it meant you were not doing your job properly. And the conflict that was creating within the team was horrific because it had created this massive amount of distrust across the team, and these people in particular had no support whatsoever when working in this new way.” [Social Services Council, Scotland]

“The other thing that worries me about that, though, is um is to what extent people have just given up, and they're actually feeling, you know, I'm not even going to address this, and they don't even bother um, so, they're living with a situation where conflict is just a day-to-day norm. But that's not sustainable longer term, and that worries me that the culture has changed where it's now just, you know, its incivility is the norm.” [Trust, Northern Ireland]

No capacity to develop wider skill-mix in the workforce:

Participants agreed that there is no capacity to develop a wider skill-mix in the workforce in case of redeployments or simply to be more flexible in the workplace.

“I have not heard in the last six months anywhere where there is, has been time or space for sufficient training or support or building skills to be able to be responsive.” [Social Services Council, Scotland]

“It's not happening... there is not the capacity.” [Trust, Northern Ireland]

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

Overarching theme	Sub-themes
Connections	<ul style="list-style-type: none"> • Long-term effects of the pandemic on relationships • Working from home/getting back to the office • Incivility • Experiences of new staff • Management interventions
Communications	<ul style="list-style-type: none"> • Increasing staff frustrations around pay • Availability of management support • Dependency on agency staff • Perceptions of safe staffing • Strategies to improve safe staffing. • Staff retention problematic
Changing conditions	<ul style="list-style-type: none"> • Staffing levels – shortages, recruitment, and retention • Impact on staff health and well-being. • The ‘new normal’ culture shift • Moving from crisis to crisis • Overworked workforce • Impaired work-life balance • Agency workers negative impact on safe staffing • No capacity to develop skill mix

4. Discussion

4.1. Main Messages

The findings from the Phase 6 survey specifically focus on the experiences of Nurses, Midwives, AHPs, Social Care Workers and Social Workers who were working in UK health and social care services during the Phase 6 study period (November 2022 – January 2023). The findings build upon previous survey responses, Phases 1-5. The survey responses and focus groups data for this report were collected and collated during a time when Northern Ireland and the UK were largely returning to pre-Covid activities. There were by then few public restrictions, the use of face masks had generally ceased, although still being recommended in health and social care encounters and settings. Health and social care services were therefore adapting themselves to a post-pandemic time but also being the service sectors where COVID-19 still presented problems, some of which were outside the public view. The health and care impacts of COVID-19 were also by then placing new pressures on health and social care since needs that had been suppressed re-emerged. Other impacts of the pandemic were also placing new pressures on health and care services, such as mental health problems and new conditions such as Long-COVID (ONS, 2023).

This Phase 6 of our survey received 1,395 responses continuing the steady decline in responses since Phase 1. This may be a result of survey fatigue (see, for example, other surveys such as Gnanapragasam et al. 2021; Koning et al. 2021, Patel et al. 2020), some of the data collection taking place over the holiday period, industrial action, overwhelming pressures, and/or a wish to move on from thinking about the pandemic.

This sixth Phase survey supports the previous themes identified in earlier phases. The findings of the overall study revealed consistent themes of disruptions in work-life balance, changing workplace conditions/context, altered communication and connections across health and social care job roles and demonstrated the continuing challenges of dealing with the impact of COVID-19 and its legacy in respect of burnout, exhaustion, workload demand and changing work conditions. Staff shortages, due to turnover, vacancies and recruitment difficulties have increased the work demands/responsibilities on remaining staff. Newly qualified staff and agency workers are of help, of course, but many lack experience or are unfamiliar with the service. We heard little of preparations for new crises, despite the pandemic revealing the need to keep alert to other risks.

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

As other research has outlined, the COVID-19 pandemic amplified problems that had been facing Northern Ireland and the UK health and social care services for many years, such as under-resourcing, staff recruitment and retention pressures, low morale, declining public satisfaction, and insufficient planning for epidemic/pandemic situations (British Medical Association, 2022). Both sectors had little resilience, in terms of human resources, equipment, service capacity, and emergency preparedness. During the height of the pandemic health and social care staff have faced trauma, changes to their working conditions, suffered fractured relationships, burnout, while feeling that there has been insufficient protection of their own health and well-being (Borek et al. 2022, French et al. 2022; Royal College of Nursing, 2022). This phase survey's findings highlight that such problems remain and are compounding the problems of the 'new normal' working world.

In Phase 6, respondents reported that their working conditions were facing new or resurfacing demands. There was sustained hybrid (home working and office based) working for some Social Workers in the main, which many found beneficial in helping maintain a clear work life balance although this may risk not taking time for team communications. and reflection. However, overall work demand was still increasing across both sectors with many staff feeling exhausted, burned out and lacking motivation. Respondents indicated the presence of the vicious cycle of staff shortages due to illness and other factors, compounded by recruitment and retention problems and the cost-of-living pressures, all contributing to a need to cover for vacancies or support new or agency staff which mean existing staff risk becoming overworked and stressed and join the ranks of people taking sick leave or considering leaving work. There is now increased frustration among the public who are facing long waiting lists for referrals, assessments, appointments, procedures and so on, and some staff seemed to feel they are being blamed for these problems. Many feel moral distress and guilt that service users are having to wait for important services. This needs handling by senior managers and politicians.

All these factors impact on staff's mental health and well-being with some respondents indicating a form of lasting trauma or depression and anxiety as a result of working through the pandemic, even though restrictions have largely ceased. Feelings about lack of reward were evident in this survey's responses and reports of seeking new employment suggested a rising rate of resignations or possibly retirements which are likely to be linked to perceptions that the usual rewards of public and user/patient appreciation do not pay the bills. Survey findings reflect the other evidence of exhaustion among some staff and increasing mental health problems such as depression and anxiety (De Kock et al. 2022; Nishihara et al. 2022; Nyashanu et al. 2020). Unsurprisingly, respondents reporting high

client-related burnout, suggesting that they were no longer feeling that their work with patients or service users was personally rewarding, were very likely to have considered changing their job.

4.2. Limitations and Strengths

As with the previous study phases, this phase (Phase 6) involved an anonymous online cross-sectional survey based on a convenience sample of health and social care workers and it is not possible to infer causality which limits the evaluation between the outcomes. The findings also cannot be considered fully representative of the full health and social care workforce or general population. Although the survey was anonymous findings were self-reported by participants therefore it may be subject to social desirability bias or recall bias. Sample attrition has been consistent across the last three phases, with a further decrease in the number of responses in Phase 6. This could be a result of survey fatigue due to the increase in research activity within the health and social care sector throughout the pandemic or a wish to move on from the subject. It is also important to note that any comparisons across the six phases of the study must be viewed tentatively, as the six samples consisted of different individuals and sample sizes (although some respondents may have been the same).

Nonetheless, this research has several strengths, for example, it extends the previous phases of research examining the health and social care workforce in a way that few other studies have been able to do. Therefore, while the data are cross-sectional, the surveys track different experiences at different time points during the COVID-19 pandemic. Another strength is the examination of five different occupations within the health and social care sector, as several studies only include specific occupational groups such as Nurses or Social Workers or are not UK wide.

4.3. Implications

At the time of writing this report (March 2023), it is nearly three years on from the initial pandemic's national restrictions and rising infection and death rates. Clapping for carers may have become a distant memory, social distancing posters and other reminders are tattered or removed, vaccination services are largely stood down, treatments are available for at-risk groups, and, while COVID-19 is still with us, hospitalisations and deaths have largely decreased. However, the health and social care sector is still facing substantial pressure, which is further affecting the mental well-being and physical health of its staff. Reward in the form of pay has become a major concern with the cost-of-living crisis and the NHS has faced unparalleled industrial action.

Improving the health and well-being support for this workforce is necessary to improve long-term retention of staff and thereby patient and service user well-being. Strong staff support is an important element of this. Staff need to feel recognised and have their experiences understood and perhaps reframed so that people can move on from the distress and stresses of the pandemic in the confidence that services will be not just 'back to normal' but that lessons have been learned from the shock of the pandemic. Communication is still essential as services move forward or get reorganised. Managers could examine what supports their staff want and need rather than just implementing a set menu. Holding regular staff meetings and conducting surveys can be helpful in identifying what will work and for whom but will not address problems of resources or investment.

Within this report, about three-quarters (74.4%) of respondents declared that they did not take up employer support. Some respondents found support elsewhere, but others found support at work was not accessible, or at an inconvenient time and/or not suited to their needs. This was not a simple health and social care divide, since Social Workers were most likely to access employer support (30.8% within Social Workers) while AHPs were least likely to access employer support. However, employer support ranges from manager support, well-being support, peer support, and counselling services. The 'offer' of employer support is therefore a mixed menu potentially. Some common understandings of employers' offer of support may be worth developing, in line with Occupational Health guidance. Our survey findings suggest robust and reliable support systems/services are needed among all health and social care employers to help their staff reflect on what they have experienced throughout the pandemic and beyond, such as team or work unit tensions. The reliance on managers to provide such support begs the question of the adequacy of support for managers particularly those working in small and medium size organisations. Our focus group analysis has confirmed that the main support people benefit from are each other. Building teams and support for teams is critically important.

4.4. Good Practice Recommendations: Nov 2022 – Jan 2023

The Good Practice Recommendations from the previous five phases were reviewed in the context of findings from Phase 6. These Good Practice Recommendations are organised under the main themes of analysis from previous Phases: Changing Conditions, Connections and Communication, enabling comparison. Whilst some recommendations have changed in terms of priority, reflecting our research findings and the changing conditions, most of them remain similar to earlier phases.

Changing Conditions

Organisational and Individual Level

1. RETENTION & RECRUITMENT ISSUES NEED ACTION:

It is noted that recruitment and retention are impacted by a range of issues evident in the findings across the six phases including but not limited to terms and conditions, flexibility in working, management and team support, supportive supervision, and workplace culture. However, retention and recruitment have become more significant issues over the period, with huge knock-on effects in terms of staff workload and welfare as well as service safety and quality. Indeed, there seems to be a “vicious cycle” developing whereby the effects of staff attrition on colleagues lead to further staff departures. At the same time, it is also noted that changing economic conditions are currently impacting retention and recruitment, especially the cost-of-living increases which can precipitate staff departures. These are the “push” factors. At the same time, there are “pull factors”. As the economy opens, post-pandemic, there is greater availability of alternative employment, some offering greater flexibility and higher remuneration. Furthermore, and not unrelated to economic change, the education sector reports significant decreases in students taking up places in many areas of health and social care which will impact recruitment soon. Therefore, the need for action on retention and recruitment has developed greater urgency.

2. STAFF WELL-BEING SUPPORT REQUIRES RETHINKING:

Related to retention issues, Phase 6 confirms previous phase findings that a large proportion of health and care staff are experiencing moderate to severe levels of burnout, and reduced well-being, with evidence that some absence was a result of stress, placing an additional burden on remaining staff. The setting up of well-being services and other forms of employer help, while appreciated by many, does not meet the needs of others. Specific strategies need to be developed by employers to ensure support is both accessible, appropriate, and effective. Respondents provided several accounts of employers and managers signposting staff to organisational supports, counselling, mentoring, or coaching, or Occupational Health advice and help (if required). However, these resources need sustaining if they are to enable staff to manage the aftermath and emotional impact of working during the pandemic and its legacy. Furthermore, supports must be accessible – for example, not just online. Support from colleagues, co-workers and teams have been noted as effective, and this knowledge should be applied to team level supports and interventions. Many staff feel that their needs are not being met and it is critical that

this matter is addressed strategically for workforce sustainability. Discussion with primary care colleagues about local supports that may be more accessible to health and social care workers than those that are employment-based would seem timely and may be more acceptable to some than employer provision for a variety of reasons.

3. PLANNING NEEDED FOR HEALTH AND SAFETY PREPAREDNESS:

Safe Systems at Work' level of risk management and strategic investment in emergency supplies of PPE in non-pandemic times, to ensure preparedness for future pandemics, fire, flood, or other disasters are required. This is the responsibility of employers and authorities, but the experience and views of frontline staff need to inform and guide specific interventions and policies, based on accurate research and knowledge from the workforce. Employers also need to feel confident that the advice they are giving is as accurate as possible and to share this openly.

4. NEW STRATEGY NECESSARY FOR TRAINING FOR SKILL MIX AND SKILL ACQUISITION:

While redeployment of staff is now infrequent, all training and development will need to equip staff with the expectation and ability to, where possible, perform multiple or new roles. Therefore, strategies to accomplish this are needed. The training and development needed must involve employers, professional bodies, regulators, workplace unions, educational and training bodies, and service user and patient groups. Evidence is needed about what sort of training and system change should inform these developments and guide commissioning decisions.

Policy and Organisational Level

5. TERMS AND CONDITIONS REGARDING ILLNESS REQUIRE UPDATING:

We noted in our first report that employers in the health and social care sector should address the adequacy and coverage of Statutory Sick Pay for their staff. This Recommendation stands. We now add to this some evidence that sickness rates remain high and, with the temporary arrangements for COVID-19 absence generally having been withdrawn by health and social care employers, we believe it is important to address the reasons for absence, including the impact of Long Covid on the health and care workforce. Phase 6 findings indicate that large numbers of staff are considering changing employer or even changing their profession. Employers need to be proactive in understanding why staff are leaving and what, if anything, can be done to change their decision, such as offering more flexible working hours or days, or a change in place of work. This also applies to older workers since the loss of their experience can affect new colleagues and students. In addition, sharing of staff support initiatives that have been proven to be helpful for staff needs to

be encouraged, such as 'in-reach services', 'team level social supports' and 'well-being appraisals' as highlighted by the HR Focus Group in Phases 5 and 6. While frontline staff may be the target for such initiatives, we note the reports of stress in the findings and risks of burnout among managers and these need to be addressed. Without the critical human infrastructure provided by positive manager support, managers will be unable to support front line teams and retain staff.

6. RESEARCH NEEDED ON CHANGE IN ORGANISATIONAL STRUCTURES:

In our first survey report we called for research on patient and service user outcomes to see whether organisational structure changes involving reductions in hierarchy permitting greater autonomy, which operated by necessity during the height of the pandemic, can make a positive difference to service quality on an ongoing basis. We also suggest that local forums and national planning consider the right balance between clinical or professional judgment and guidelines using the experience of the pandemic to inform these deliberations. We are hopeful that the national inquiry into the management of the pandemic will consider these questions and will forward our reports to the inquiry.

7. TOXIC WORKPLACE CULTURES MUST BE ADDRESSED:

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

Organisational Level

8. PUT INTO PRACTICE THE ADVANTAGES OF MORE FLEXIBILITY IN EMPLOYMENT:

During the pandemic most employers provided, as far as possible, increased flexibility around working hours and location, often recognising additional childcare or other caring responsibilities of staff. Flexibility continues to be highly valued by staff. As the present level of the pandemic

subsidies, and employers seek to encourage home-based staff to return to their offices for at least part of their working week, staff need to feel that their individual well-being and circumstances are being considered. Firming up policy and procedures with staff and their representatives about long-term flexibility in working hours and location, must be embedded within organizational Human Resource policies, including, for example, more part-time working options. For students or trainees, there is a need to prepare this workforce of the future for different ways of working within agencies and organisations.

We recommended that policies about working from home (if appropriate) should be fair and be seen to be fair. Home working is mainly role dependent, with hybrid models of working for some, such as part home working/part in office, increasingly adopted. Employers need to offer choices to individual workers where the job can be done at home but must also consider the team or work unit effect. Our findings of increasing levels of anxiety and depression suggest the value of Human Resources (HR) staff support for managers in addressing mental health risks and noting them at early stages (through online communications) if people are working at home or relatively independently. The high levels of depression and anxiety we found in this phase may make working from home seem attractive but there are risks of losing social contacts and stimulation.

Connections

Organisational Level

9. ANNUAL LEAVE AND REGULAR BREAKS NEED ATTENTION:

Managers still need to ensure that staff are supported, enabled, and encouraged to take leave and breaks, and where possible, arrange for their work and responsibilities to be covered. Managers, of course, need to practice what they preach as manager stress and burnout is clearly evident in this study, and such stress can impact on how managers can support others and receive support themselves. In our sixth survey, the issues of not taking breaks were less evident, however many reported working increased hours of overtime due to short staffing, and it is noted that increases in the cost of living may prompt more staff to do further overtime or shifts and so not benefit from breaks or time away from work.

Organisational Level

10. SUPPORTIVE INDIVIDUAL SUPERVISION NEEDS TO BE IMPLEMENTED FOR ALL:

Staff concerns need to be addressed whether they are personal concerns or those that can be discussed in peer or group supervision. This point also applies to managers and those who supervise managers. This recommendation stands. The presence of depression and anxiety among

many staff noted in this present survey should be addressed in supervision with offers of help extended. These important opportunities to discuss individual well-being should not be missed. Therefore, while there is a move towards group supervision for some staff groups, individual supervision sessions should also be available.

Communication

Organisational and Individual Level

11. IMPROVED ORGANISATIONAL SUPPORT REQUIRED:

Phase 6 findings indicate the large numbers of staff considering changing employer or even changing profession. Employers need to be proactive in understanding why staff are leaving and what, if anything, can be done to change their decision, such as offering more flexible working hours or days, or a change in place of work. This notably applies to older workers since the loss of their experience can affect new colleagues and students. In addition, sharing of staff support initiatives that have been proven to be helpful for staff needs to be encouraged, such as 'in-reach services' and 'team level social support', and 'well-being appraisals' as highlighted by the HR Focus Group in Phases 5 and 6. While frontline staff may be the target for such initiatives, we note the reports of stress in the findings and risks of burnout among managers and these also need to be addressed.

12. TEAM SUPPORT NEEDS STRENGTHENING:

Team or peer support is critical to coping, well-being, and morale. Ideas about how to sustain a positive team culture and climate should be nurtured so that support is available to all team members including managers whose needs often appear overlooked but who, as our research shows, are often under considerable pressure themselves. Meaningful interaction with colleagues may be helpful in fostering good working relationships and promote compassionate, civil, and anti-bullying cultures. Students and newly qualified or newly appointed staff may need specific assistance to feel part of teams and contribute to them. It is not a good foundation for their careers if they are working with colleagues who are feeling burned out, depressed or anxious. Employers need to understand that time and energy invested in helping new team members to integrate into their teams will ultimately reduce their workload and stress level; without this, new members may just leave.

13. CONCERTED EFFORTS NEEDED TO UPGRADE RESOURCING AND INFRASTRUCTURE:

The unprecedented demands on the health and social care sectors over the past three years have exposed the chronic under-resourcing of staff and infrastructure. Staff shortages and vacancies are of rising concern. Concerted efforts are required to make work within the health and social care sectors an attractive option, with pay and working conditions requiring swift and sustained attention. This has implications for the well-being of both the health and social care workforce and well-being and safety of the people that use health and social care services.

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6. Appendices

LIST OF FIGURES

Figure 1. 1. Research Phases of Wider Study.....	8
Figure A2. 1: Country of Respondents (Unweighted)	97
Figure A2.2: Occupation of Respondents (Unweighted)	98
Figure A2. 3: Country of Respondents by Occupation (Unweighted).....	99
Figure A2. 4: Sex by Country (Weighted).....	100
Figure A2.5: Sex by Country (Unweighted).....	100
Figure A2.6: Sex by Occupation (Weighted)	101
Figure A2.7: Sex by Occupation (Unweighted)	102
Figure A2.8: Age of Respondents by Country (Weighted)	103
Figure A2.9: Age of Respondents by Country (Unweighted)	104
Figure A2.10: Age of Respondents by Occupation (Weighted)	105
Figure A2.11: Age of Respondents by Occupation (Unweighted)	105
Figure A2.12: Ethnic Origin of Respondents by Country (Weighted)	107
Figure A2.13: Ethnic Origin of Respondents by Country (Unweighted)	108
Figure A2.14: Ethnic Origin of Respondents by Occupation (Weighted).....	109
Figure A2.15: Ethnic Origin of Respondents by Occupation (Unweighted).....	109
Figure A2.16: Disability by Country (Weighted).....	111
Figure A2.17: Disability by Country (Unweighted).....	111
Figure A2.18: Disability by Occupation (Weighted).....	112
Figure A2.19: Disability by Occupation (Unweighted)	113
Figure A2.20: Relationship Status by Country (Weighted)	114
Figure A2.21: Relationship Status by Country (Unweighted)	114
Figure A2.22: Relationship Status by Occupation (Weighted).....	116
Figure A2.23: Relationship Status by Occupation (Unweighted).....	116
Figure A2.24: Work Setting by Country (Weighted)	118
Figure A2.25: Work Setting by Country (Unweighted)	119
Figure A2.26: Work Setting by Occupation (Weighted).....	120
Figure A2.27: Work Setting by Occupation (Unweighted).....	121
Figure A2.28: Health and Social Care Sector of Respondents by Country (Weighted).....	123
Figure A2.29: Health and Social Care Sector of Respondents by Country (Unweighted).....	123
Figure A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)	125
Figure A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)	125
Figure A2.32: Line Manager Status of Respondents by Country (Weighted)	128
Figure A2.33: Line Manager Status of Respondents by Country (Unweighted)	129
Figure A2.34: Line Manager Status of Respondents by Occupation (Weighted)	130
Figure A2.35: Line Manager Status of Respondents by Occupation (Unweighted)	130
Figure A2. 36: Job Tenure by Country (Weighted).....	132
Figure A2. 37: Job Tenure by Country (Unweighted).....	133
Figure A2. 38: Job Tenure by Occupation (Weighted)	135
Figure A2. 39: Job Tenure by Occupation (Unweighted)	135
Figure A2. 40: Employed Full- or Part-Time by Country (Weighted)	137
Figure A2. 41: Employed Full- or Part-Time by Country (Unweighted)	138

Figure A2. 42: Employed Full- or Part-Time by Occupation (Weighted).....	139
Figure A2. 43: Employed Full- or Part-Time by Occupation (Unweighted).....	139
Figure A2. 44: Number of Hours Worked per Week by Country (Weighted)	141
Figure A2. 45: Number of Hours Worked per Week by Country (Unweighted)	141
Figure A2. 46: Number of Hours Worked per Week by Occupation (Weighted)	142
Figure A2. 47: Number of Hours Worked per Week by Occupation (Unweighted)	143
Figure A2. 48: Typically Working Overtime by Country (Weighted).....	145
Figure A2. 49: Typically Working Overtime by Country (Unweighted).....	145
Figure A2. 50: Typically Working Overtime by Occupation (Weighted)	146
Figure A2. 51: Typically Working Overtime by Occupation (Unweighted)	147
Figure A2. 52: Overtime since March 2022-present by Country (Weighted)	148
Figure A2. 53: Overtime since March 2022-present by Country (Unweighted)	148
Figure A2. 54: Overtime since March 2022-present by Occupation (Weighted)	149
Figure A2. 55: Overtime since March 2022-present by Occupation (Unweighted)	150
Figure A2. 56: Sick Days by Country (Weighted).....	151
Figure A2. 57: Sick Days by Country (Unweighted).....	152
Figure A2. 58: Sick Days by Occupation (Weighted)	154
Figure A2. 59: Sick Days by Occupation (Unweighted)	154
Figure A2. 60: Sickness Absence Related to COVID-19 by Country (Weighted)	156
Figure A2. 61: Sickness Absence Related to COVID-19 by Country (Unweighted)	157
Figure A2. 62: Sickness Absence Related to COVID-19 by Occupation (Weighted).....	158
Figure A2. 63: Sickness Absence Related to COVID-19 by Occupation (Unweighted).....	158
Figure A2. 64: Respondents' Sick Pay by Country (Weighted).....	160
Figure A2. 65: Respondents' Sick Pay by Country (Unweighted).....	160
Figure A2. 66: Respondents' Sick Pay by Occupation (Weighted)	162
Figure A2. 67: Respondents' Sick Pay by Occupation (Unweighted)	162
Figure A2. 68: Years of Experience by Country (Weighted).....	164
Figure A2. 69: Years of Experience by Country (Unweighted).....	165
Figure A2. 70: Years of Experience by Occupation (Weighted)	166
Figure A2. 71: Years of Experience by Occupation (Unweighted)	167
Figure A2. 72: Main Area of Practice by Country (Weighted).....	169
Figure A2. 73: Main Area of Practice by Country (Unweighted).....	169
Figure A2. 74: Main Area of Practice by Occupation (Weighted)	171
Figure A2. 75: Main Area of Practice by Occupation (Unweighted)	171
Figure A2. 76: Impact of COVID-19 on Services by Country (Weighted)	173
Figure A2. 77: Impact of COVID-19 on Services by Country (Unweighted)	174
Figure A2. 78: Impact of COVID-19 on Services by Occupation (Weighted).....	175
Figure A2. 79: Impact of COVID-19 on Services by Occupation (Unweighted).....	176
Figure A2. 80: Respondents working from home by Country (Weighted)	178
Figure A2. 81: Respondents working from home by Country (Unweighted)	179
Figure A2. 82: Respondents working from home by Occupation (Weighted).....	180
Figure A2. 83: Respondents working from home by Occupation (Unweighted).....	180
Figure A2. 84: Respondents working from home by Country (Weighted)	182
Figure A2. 85: Respondents working from home by Country (Unweighted)	183
Figure A2. 86: Respondents working from home by Occupation (Weighted).....	184
Figure A2. 87: Respondents working from home by Occupation (Unweighted).....	184
Figure A2. 88: Considering Changing Employer by Country (Weighted)	186
Figure A2. 89: Considering Changing Employer by Country (Unweighted)	187

Figure A2. 90: Considering Changing Employer by Occupation (Weighted)	190
Figure A2. 91: Considering Changing Employer by Occupation (Unweighted).....	190
Figure A2. 92: Considering Changing Occupation by Country (Weighted)	194
Figure A2. 93: Considering Changing Occupation by Country (Unweighted)	194
Figure A2. 94: Considering Changing Occupation by Occupation (Weighted)	197
Figure A2. 95: Considering Changing Occupation by Occupation (Unweighted)	197
Figure A2. 96: What has to happen for you to change your mind about wanting to leave by Country (Weighted)	200
Figure A2. 97: What has to happen for you to change your mind about wanting to leave by Country (Unweighted)	201
Figure A2. 98: What has to happen for you to change your mind about wanting to leave by Occupation (Weighted).....	203
Figure A2. 99: What has to happen for you to change your mind about wanting to leave by Occupation (Unweighted).....	203
Figure A2. 100: Chosen to change job or contractual working hours by Country (Weighted).....	206
Figure A2. 101: Chosen to change job or contractual working hours by Country (Unweighted).....	207
Figure A2. 102: Chosen to change job or contractual working hours by Occupation (Weighted)	208
Figure A2. 103: Chosen to change job or contractual working hours by Occupation (Unweighted) .	209
Figure A2. 104: Taken up Employer support by Country (Weighted).....	211
Figure A2. 105: Taken up Employer support by Country (Unweighted)	211
Figure A2. 106: Taken up Employer support by Occupation (Weighted)	212
Figure A2. 107: Taken up Employer support by Occupation (Unweighted)	213
Figure A2. 108: What have you taken up from your employer to support your well-being by Country (Weighted)	215
Figure A2. 109: What have you taken up from your employer to support your well-being by Country (Unweighted)	215
Figure A2. 110: What have you taken up from your employer to support your well-being by Occupation (Weighted).....	218
Figure A2. 111: What have you taken up from your employer to support your well-being by Occupation (Unweighted).....	218
Figure A2. 112: Reasons for not taking up employer support by Country (Weighted)	222
Figure A2. 113: Reasons for not taking up employer support by Country (Unweighted)	222
Figure A2. 114: Reasons for not taking up employer support by Occupation (Weighted).....	224
Figure A2. 115: Reasons for not taking up employer support by Occupation (Unweighted).....	224
Figure A2. 116: Responses by Region (Unweighted)	226
Figure A2. 117: Region by Occupation (Unweighted).....	227
Figure A3. 1: Mean Well-being Item Scores by Country (Weighted).....	229
Figure A3. 2: Mean Well-being Item Scores by Country (Unweighted).....	230
Figure A3.3: Mean Overall Well-being Score by Country (Weighted)	230
Figure A3.4: Mean Overall Well-being Score by Country (Unweighted)	231
Figure A3.5: Overall Well-being Score Converted to Depression/Anxiety by Country (Weighted)....	232
Figure A3.6: Overall Well-being Score Converted to Depression/Anxiety by Country (Unweighted)	233
Figure A3.7: Mean Overall Well-being Score by Occupation (Weighted).....	234
Figure A3.8: Mean Overall Well-being Score by Occupation (Unweighted).....	235
Figure A3.9: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Weighted)	236

Figure A3.10: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Unweighted)	236
Figure A3.11: Mean Overall Well-being Score by Sex (Weighted).....	238
Figure A3.12: Mean Overall Well-being Score by Sex (Unweighted).....	238
Figure A3.13: Mean Overall Well-being Score by Age (Weighted)	239
Figure A3.14: Mean Overall Well-being Score by Age (Unweighted)	240
Figure A3.15: Mean Overall Well-being Score by Ethnicity (Weighted)	241
Figure A3.16: Mean Overall Well-being Score by Ethnicity (Unweighted)	241
Figure A3.17: Mean Overall Well-being Score by Disability (Weighted)	243
Figure A3.18: Mean Overall Well-being Score by Disability (Unweighted)	244
Figure A3.19: Mean Overall Well-being Score by Area of Practice (Weighted)	245
Figure A3.20: Mean Overall Well-being Score by Area of Practice (Unweighted)	245
Figure A3.21: Mean Overall Well-being Score by Line Manager Status (Weighted)	247
Figure A3.22: Mean Overall Well-being Score by Line Manager Status (Unweighted)	247
Figure A3.23: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Weighted)	249
Figure A3.24: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Unweighted)	249
Figure A3. 25: Mean Overall Well-being Score by the Uptake of Employer Support (Weighted).....	250
Figure A3. 26: Mean Overall Well-being Score by the Uptake of Employer Support (Unweighted) ..	251
Figure A4. 1: Mean Quality of Working Life Scores by Country (Weighted).....	253
Figure A4. 2: Mean Quality of Working Life Scores by Country (Unweighted).....	253
Figure A4.3: Mean Overall Quality of Working Life Score by Country (Weighted)	254
Figure A4.4: Mean Overall Quality of Working Life Score by Country (Unweighted).....	254
Figure A4.5: Level of Quality of Working Life Scores – UK-Wide (Weighted).....	255
Figure A4.6: Level of Quality of Working Life Scores – UK-Wide (Unweighted).....	256
Figure A4.7: Level of Overall Quality of Working Life by Country (Weighted)	257
Figure A4.8: Level of Overall Quality of Working Life by Country (Unweighted)	257
Figure A4.9: Mean Quality of Working Life Scores by Occupation (Weighted).....	259
Figure A4.10: Mean Quality of Working Life Scores by Occupation (Unweighted).....	259
Figure A4.11: Mean Overall Quality of Working Life Score by Occupation (Weighted).....	260
Figure A4.12: Mean Overall Quality of Working Life Score by Occupation (Unweighted)	260
Figure A4.13: Level of Overall Quality of Working Life by Occupation (Weighted).....	261
Figure A4.14: Level of Overall Quality of Working Life by Occupation (Unweighted).....	262
Figure A4.15: Mean Quality of Working Life Scores by Sex (Weighted).....	263
Figure A4.16: Mean Quality of Working Life Scores by Sex (Unweighted).....	264
Figure A4.17: Mean Overall Quality of Working Life Score by Sex (Weighted)	264
Figure A4.18: Mean Overall Quality of Working Life Score by Sex (Unweighted)	265
Figure A4.19: Level of Overall Quality of Working Life by Sex (Weighted).....	266
Figure A4.20: Level of Overall Quality of Working Life by Sex (Unweighted).....	267
Figure A4.21: Mean Quality of Working Life Scores by Age (Weighted)	268
Figure A4.22: Mean Quality of Working Life Scores by Age (Unweighted)	269
Figure A4.23: Mean Overall Quality of Working Life Score by Age (Weighted)	269
Figure A4.24: Mean Overall Quality of Working Life Score by Age (Unweighted)	269
Figure A4.25: Level of Overall Quality of Working Life by Age (Weighted)	270
Figure A4.26: Level of Overall Quality of Working Life by Age (Unweighted)	271

Figure A4.27: Mean Quality of Working Life Scores by Ethnicity (Weighted)	272
Figure A4.28: Mean Quality of Working Life Scores by Ethnicity (Unweighted)	273
Figure A4.29: Mean Overall Quality of Working Life Score by Ethnicity (Weighted)	273
Figure A4.30: Mean Overall Quality of Working Life Score by Ethnicity (Unweighted)	274
Figure A4.31: Level of Overall Quality of Working Life by Ethnicity (Weighted)	275
Figure A4.32: Level of Overall Quality of Working Life by Ethnicity (Unweighted)	275
Figure A4.33: Mean Quality of Working Life Scores by Disability (Weighted).....	277
Figure A4.34: Mean Quality of Working Life Scores by Disability (Unweighted).....	277
Figure A4.35: Mean Overall Quality of Working Life Score by Disability (Weighted).....	278
Figure A4. 36: Mean Overall Quality of Working Life Score by Disability (Unweighted).....	278
Figure A4.37: Level of Overall Quality of Working Life by Disability (Weighted)	280
Figure A4.38: Level of Overall Quality of Working Life by Disability (Unweighted)	280
Figure A4.39: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)	282
Figure A4.40: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)	282
Figure A4.41: Mean Overall Quality of Working Life Score by Main Area of Practice (Weighted).....	283
Figure A4.42: Mean Overall Quality of Working Life Score by Main Area of Practice (Unweighted). 283	
Figure A4.43: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)	286
Figure A4.44: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)	286
Figure A4.45: Mean Quality of Working Life Scores by Line Manager Status (Weighted)	288
Figure A4.46: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)	289
Figure A4.47: Mean Overall Quality of Working Life Score by Line Manager Status (Weighted)	289
Figure A4.48: Mean Overall Quality of Working Life Score by Line Manager Status (Unweighted) ..	290
Figure A4.49: Level of Overall Quality of Working Life by Line Manager Status (Weighted)	292
Figure A4.50: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)	292
Figure A4.51: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)	294
Figure A4.52: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)	294
Figure A4. 53: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Weighted)	295
Figure A4. 54: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Unweighted)	295
Figure A4. 55: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)	297
Figure A4. 56: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)	297
Figure A4. 57: Mean Quality of Working Life Scores by Uptake of Employer Support (Weighted) ...	299
Figure A4. 58: Mean Quality of Working Life Scores by Uptake of Employer Support (Unweighted) 299	
Figure A4. 59: Mean Overall Quality of Working Life Score by the Uptake of Employer Support (Weighted)	300
Figure A4. 60: Mean Overall Quality of Working Life Score by the Uptake of Employer Support (Unweighted)	300
Figure A4. 61: Level of Overall Quality of Working Life by Employer Uptake (Weighted)	302
Figure A4. 62: Level of Overall Quality of Working Life by Employer Uptake (Unweighted)	302
 Figure A5. 1: Mean Burnout Scores by Country (Weighted)	 304
Figure A5.2: Mean Burnout Scores by Country (Unweighted)	305

Figure A5.3: Level of Personal Burnout by Country (Weighted).....	306
Figure A5.4: Level of Personal Burnout by Country (Unweighted).....	306
Figure A5.5: Level of Work-Related Burnout by Country (Weighted)	307
Figure A5.6: Level of Work-Related Burnout by Country (Unweighted)	307
Figure A5.7: Level of Client-Related Burnout by Country (Weighted).....	308
Figure A5.8: Level of Client-Related Burnout by Country (Unweighted).....	308
Figure A5.9: Mean Burnout Scores by Occupation (Weighted).....	311
Figure A5.10: Mean Burnout Scores by Occupation (Unweighted).....	312
Figure A5.11: Level of Personal Burnout by Occupation (Weighted)	313
Figure A5.12: Level of Personal Burnout by Occupation (Unweighted)	313
Figure A5.13: Level of Work-Related Burnout by Occupation (Weighted).....	314
Figure A5.14: Level of Work-Related Burnout by Occupation (Unweighted).....	314
Figure A5.15: Level of Client-Related Burnout by Occupation (Weighted)	315
Figure A5.16: Level of Client-Related Burnout by Occupation (Unweighted)	315
Figure A5.17: Mean Burnout Scores by Sex (Weighted).....	318
Figure A5.18: Mean Burnout Scores by Sex (Unweighted).....	319
Figure A5.19: Level of Personal Burnout by Sex (Weighted)	320
Figure A5.20: Level of Personal Burnout by Sex (Unweighted)	320
Figure A5.21: Level of Work-Related Burnout by Sex (Weighted).....	321
Figure A5.22: Level of Work-Related Burnout by Sex (Unweighted).....	321
Figure A5.23: Level of Client-Related Burnout by Sex (Weighted)	322
Figure A5.24: Level of Client-Related Burnout by Sex (Unweighted)	322
Figure A5.25: Mean Burnout Scores by Age (Weighted)	325
Figure A5.26: Mean Burnout Scores by Age (Unweighted)	325
Figure A5.27: Level of Personal Burnout by Age (Weighted)	327
Figure A5.28: Level of Personal Burnout by Age (Unweighted)	327
Figure A5.29: Level of Work-Related Burnout by Age (Weighted)	327
Figure A5.30: Level of Work-Related Burnout by Age (Unweighted)	328
Figure A5.31: Level of Client-Related Burnout by Age (Weighted)	328
Figure A5.32: Level of Client-Related Burnout by Age (Unweighted).....	329
Figure A5.33: Mean Burnout Scores by Ethnicity (Weighted)	332
Figure A5.34: Mean Burnout Scores by Ethnicity (Unweighted)	333
Figure A5.35: Level of Personal Burnout by Ethnicity (Weighted)	334
Figure A5.36: Level of Personal Burnout by Ethnicity (Unweighted).....	334
Figure A5.37: Level of Work-Related Burnout by Ethnicity (Weighted)	335
Figure A5.38: Level of Work-Related Burnout by Ethnicity (Unweighted)	335
Figure A5.39: Level of Client-Related Burnout by Ethnicity (Weighted).....	336
Figure A5.40: Level of Client-Related Burnout by Ethnicity (Unweighted).....	336
Figure A5.41: Mean Burnout Scores by Disability (Weighted)	340
Figure A5.42: Mean Burnout Scores by Disability (Unweighted)	340
Figure A5.43: Level of Personal Burnout by Disability (Weighted).....	341
Figure A5.44: Level of Personal Burnout by Disability (Unweighted).....	342
Figure A5.45: Level of Work-Related Burnout by Disability (Weighted)	342
Figure A5.46: Level of Work-Related Burnout by Disability (Unweighted)	343
Figure A5.47: Level of Client-Related Burnout by Disability (Weighted).....	343
Figure A5.48: Level of Client-Related Burnout by Disability (Unweighted)	343
Figure A5.49: Mean Burnout Scores by Main Area of Practice (Weighted)	347
Figure A5.50: Mean Burnout Scores by Main Area of Practice (Unweighted)	347

Figure A5.51: Level of Personal Burnout by Main Area of Practice (Weighted).....	349
Figure A5.52: Level of Personal Burnout by Main Area of Practice (Unweighted).....	349
Figure A5.53: Level of Work-Related Burnout by Main Area of Practice (Weighted)	350
Figure A5.54: Level of Work-Related Burnout by Main Area of Practice (Unweighted)	350
Figure A5.55: Level of Client-Related Burnout by Main Area of Practice (Weighted).....	351
Figure A5.56: Level of Client-Related Burnout by Main Area of Practice (Unweighted).....	351
Figure A5.57: Mean Burnout Scores by Line Manager Status (Weighted)	354
Figure A5.58: Mean Burnout Scores by Line Manager Status (Unweighted)	355
Figure A5.59: Level of Personal Burnout by Line Manager Status (Weighted).....	356
Figure A5.60: Level of Personal Burnout by Line Manager Status (Unweighted).....	356
Figure A5.61: Level of Work-Related Burnout by Line Manager Status (Weighted)	357
Figure A5.62: Level of Work-Related Burnout by Line Manager Status (Unweighted)	357
Figure A5.63: Level of Client-Related Burnout by Line Manager Status (Weighted).....	358
Figure A5.64: Level of Client-Related Burnout by Line Manager Status (Unweighted).....	358
Figure A5.65: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)	362
Figure A5.66: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)	362
Figure A5.67: Level of Personal Burnout by the Impact of the Pandemic on Services (Weighted)....	363
Figure A5.68: Level of Personal Burnout by the Impact of the Pandemic on Services (Unweighted)	364
Figure A5.69: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Weighted)	364
Figure A5.70: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Unweighted)	365
Figure A5.71: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Weighted)	365
Figure A5.72: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Unweighted)	366
Figure A5. 73: Mean Burnout Scores by Uptake of Employer Support (Weighted)	370
Figure A5. 74: Mean Burnout Scores by Uptake of Employer Support (Unweighted)	370
Figure A5. 75: Level of Personal Burnout by Uptake of Employer Support (Weighted).....	371
Figure A5.76: Level of Personal Burnout by Uptake of Employer Support Unweighted)	372
Figure A5. 77: Level of Work-Related Burnout by Uptake of Employer Support (Weighted)	372
Figure A5. 78: Level of Work-Related Burnout by Uptake of Employer Support (Unweighted)	373
Figure A5. 79: Level of Client-Related Burnout by Uptake of Employer Support (Weighted).....	373
Figure A5.80: Level of Client-Related Burnout by Uptake of Employer Support (Unweighted).....	374
Figure A6. 1Mean Carver Coping Scores by Country (Weighted)	377
Figure A6. 2: Mean Carver Coping Scores by Country (Unweighted)	378
Figure A6.3: Mean Carver Coping Scores by Occupation (Weighted)	380
Figure A6.4: Mean Carver Coping Scores by Occupation (Unweighted)	381
Figure A6.5: Mean Carver Coping Scores by Sex (Weighted)	383
Figure A6.6: Mean Carver Coping Scores by Sex (Unweighted)	383
Figure A6.7: Mean Carver Coping Scores by Age (Weighted).....	386
Figure A6.8: Mean Carver Coping Scores by Age (Unweighted).....	386
Figure A6.9: Mean Carver Coping Scores by Ethnicity (Weighted).....	389
Figure A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted).....	389
Figure A6.11: Mean Carver Coping Scores by Disability (Weighted).....	392
Figure A6.12: Mean Carver Coping Scores by Disability (Unweighted)	392

Figure A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)	395
Figure A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)	395
Figure A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)	398
Figure A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)	399
Figure A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)	402
Figure A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)	403
Figure A6. 19: Mean Carver Coping Scores by Uptake of Employer Support (Weighted)	405
Figure A6. 20: Mean Carver Coping Scores by Uptake of Employer Support (Unweighted)	406
Figure A7. 1: Mean Clark Coping Scores by Country (Weighted)	409
Figure A7. 2: Mean Clark Coping Scores by Country (Unweighted)	409
Figure A7.3: Mean Clark Coping Scores by Occupation (Weighted)	411
Figure A7.4: Mean Clark Coping Scores by Occupation (Unweighted)	412
Figure A7.5: Mean Clark Coping Scores by Sex (Weighted)	414
Figure A7.6: Mean Clark Coping Scores by Sex (Unweighted)	414
Figure A7.7: Mean Clark Coping Scores by Age (Weighted)	416
Figure A7.8: Mean Clark Coping Scores by Age (Unweighted)	416
Figure A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)	418
Figure A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)	418
Figure A7.11: Mean Clark Coping Scores by Disability (Weighted)	420
Figure A7.12: Mean Clark Coping Scores by Disability (Unweighted)	420
Figure A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)	422
Figure A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)	423
Figure A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)	425
Figure A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)	425
Figure A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)	428
Figure A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)	428
Figure A7.19: Mean Clark Coping Scores by Uptake of Employer Support (Weighted)	430
Figure A7.20: Mean Clark Coping Scores by Uptake of Employer Support (Unweighted)	430
Figure A9. 1: Mean Overall Well-being Score by Study Phase and Country (Weighted)	444
Figure A9. 2: Mean Overall Well-being Score by Study Phase and Occupation (Weighted)	445
Figure A9. 3: Mean Overall Quality of Working Life Score by Study Phase and Country (Weighted)	448
Figure A9. 4: Mean Overall Quality of Working Life Score by Study Phase and Occupation (Weighted)	450
Figure A9. 5: Personal Burnout Score by Study phase and Country (Weighted)	454
Figure A9. 6: Work-related Burnout Score by Study phase and Country (Weighted)	454
Figure A9. 7: Client-related Burnout Score by Study phase and Country (Weighted)	455
Figure A9. 8: Personal Burnout Score by Study phase and Occupation (Weighted)	457
Figure A9. 9: Work-related Burnout Score by Study phase and Occupation (Weighted)	457
Figure A9. 10: Client-related Burnout Score by Study phase and Occupation (Weighted)	458
Figure A9. 11: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)	462
Figure A9. 12: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)	469

Figure A10. 1: Word cloud of key words from qualitative analysis. **Error! Bookmark not defined.**

LIST OF TABLES

Table A1. 1: Regional aggregation for NHS Digital.....	93
Table A1. 2: Regions for Calculation of Weights.....	95
Table A1. 3: Final Estimated Population and Distribution	96
Table A2. 1: Country of Respondents (Unweighted)	98
Table A2. 2: Occupation of Respondents (Unweighted).....	98
Table A2. 3: Country of Respondents by Occupation (Unweighted)	99
Table A2. 4: Sex by Country (Weighted)	100
Table A2.5: Sex by Country (Unweighted)	101
Table A2.6: Sex by Occupation (Weighted).....	102
Table A2.7: Sex by Occupation (Unweighted)	103
Table A2.8: Age of Respondents by Country (Weighted)	104
Table A2.9: Age of Respondents by Country (Unweighted)	104
Table A2.10: Age of Respondents by Occupation (Weighted).....	106
Table A2.11: Age of Respondents by Occupation (Unweighted).....	106
Table A2.12: Ethnic Origin of Respondents by Country (Weighted).....	108
Table A2.13: Ethnic Origin of Respondents by Country (Unweighted).....	108
Table A2.14: Ethnic Origin of Respondents by Occupation (Weighted)	110
Table A2.15: Ethnic Origin of Respondents by Occupation (Unweighted)	110
Table A2.16: Disability by Country (Weighted).....	112
Table A2.17: Disability by Country (Unweighted).....	112
Table A2.18: Disability by Occupation (Weighted)	113
Table A2.19: Disability by Occupation (Unweighted)	113
Table A2.20: Relationship Status by Country (Weighted).....	115
Table A2.21: Relationship Status by Country (Unweighted).....	115
Table A2.22: Relationship Status by Occupation (Weighted)	117
Table A2.23: Relationship Status by Occupation (Unweighted)	117
Table A2.24: Work Setting by Country (Weighted)	119
Table A2.25: Work Setting by Country (Unweighted).....	120
Table A2.26: Work Setting by Occupation (Weighted)	121
Table A2.27: Work Setting by Occupation (Unweighted)	122
Table A2.28: Health and Social Care Sector of Respondents by Country (Weighted)	124
Table A2.29: Health and Social Care Sector of Respondents by Country (Unweighted)	124
Table A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)	126
Table A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)	127
Table A2.32: Line Manager Status of Respondents by Country (Weighted)	129
Table A2.33: Line Manager Status of Respondents by Country (Unweighted)	129
Table A2.34: Line Manager Status of Respondents by Occupation (Weighted).....	131
Table A2.35: Line Manager Status of Respondents by Occupation (Unweighted).....	131
Table A2.36: Job Tenure by Country (Weighted).....	133

Table A2. 37: Job Tenure by Country (Unweighted)	134
Table A2. 38: Job Tenure by Occupation (Weighted)	136
Table A2. 39: Job Tenure by Occupation (Unweighted)	136
Table A2. 40: Employed Full- or Part-Time by Country (Weighted)	138
Table A2. 41: Employed Full- or Part-Time by Country (Unweighted)	138
Table A2. 42: Employed Full- or Part-Time by Occupation (Weighted)	140
Table A2.43: Employed Full- or Part-Time by Occupation (Unweighted)	140
Table A2. 44: Number of Hours Worked per Week by Country (Weighted)	142
Table A2.45: Number of Hours Worked per Week by Country (Unweighted)	142
Table A2. 46: Number of Hours Worked per Week by Occupation (Weighted)	144
Table A2. 47: Number of Hours Worked per Week by Occupation (Unweighted)	144
Table A2. 48: Typically Working Overtime by Country (Weighted)	146
Table A2. 49: Typically Working Overtime by Country (Unweighted)	146
Table A2. 50: Typically Working Overtime by Occupation (Weighted)	147
Table A2. 51: Typically Working Overtime by Occupation (Unweighted)	147
Table A2. 52: Overtime since March 2022-present by Country (Weighted)	149
Table A2. 53: Overtime since March 2022-present by Country (Unweighted)	149
Table A2. 54: Overtime since March 2022-present by Occupation (Weighted)	150
Table A2. 55: Overtime since March 2022-present by Occupation (Unweighted)	150
Table A2. 56: Sick Days by Country (Weighted)	153
Table A2. 57: Sick Days by Country (Unweighted)	153
Table A2. 58: Sick Days by Occupation (Weighted)	155
Table A2. 59: Sick Days by Occupation (Unweighted)	155
Table A2. 60: Sickness Absence Related to COVID-19 by Country (Weighted)	157
Table A2. 61: Sickness Absence Related to COVID-19 by Country (Unweighted)	157
Table A2. 62: Sickness Absence Related to COVID-19 by Occupation (Weighted)	159
Table A2. 63: Sickness Absence Related to COVID-19 by Occupation (Unweighted)	159
Table A2. 64: Respondents' Sick Pay by Country (Weighted)	161
Table A2. 65: Respondents' Sick Pay by Country (Unweighted)	161
Table A2. 66: Respondents' Sick Pay by Occupation (Weighted)	163
Table A2. 67: Respondents' Sick Pay by Occupation (Unweighted)	163
Table A2. 68: Years of Experience by Country (Weighted)	165
Table A2. 69: Years of Experience by Country (Unweighted)	166
Table A2. 70: Years of Experience by Occupation (Weighted)	167
Table A2. 71: Years of Experience by Occupation (Unweighted)	168
Table A2. 72: Main Area of Practice by Country (Weighted)	170
Table A2. 73: Main Area of Practice by Country (Unweighted)	170
Table A2. 74: Main Area of Practice by Occupation (Weighted)	172
Table A2. 75: Main Area of Practice by Occupation (Unweighted)	172
Table A2. 76: Impact of COVID-19 on Services by Country (Weighted)	174
Table A2. 77: Impact of COVID-19 on Services by Country (Unweighted)	175
Table A2. 78: Impact of COVID-19 on Services by Occupation (Weighted)	176
Table A2. 79: Impact of COVID-19 on Services by Occupation (Unweighted)	177
Table A2. 80: Respondents working from home by Country (Weighted)	179
Table A2. 81: Respondents working from home by Country (Unweighted)	179
Table A2. 82: Respondents working from home by Occupation (Weighted)	180
Table A2. 83: Respondents working from home by Occupation (Unweighted)	181
Table A2. 84: Respondents working from home by Country (Weighted)	183

Table A2. 85: Respondents working from home by Country (Unweighted).....	183
Table A2. 86: Respondents working from home by Occupation (Weighted)	185
Table A2. 87: Respondents working from home by Occupation (Unweighted)	185
Table A2. 88: Considering Changing Employer by Country (Weighted)	188
Table A2. 89: Considering Changing Employer by Country (Unweighted)	189
Table A2. 90: Considering Changing Employer by Occupation (Weighted).....	191
Table A2. 91: Considering Changing Employer by Occupation (Unweighted).....	192
Table A2. 92: Considering Changing Occupation by Country (Weighted)	195
Table A2. 93: Considering Changing Occupation by Country (Unweighted)	196
Table A2. 94: Considering Changing Occupation by Occupation (Weighted).....	198
Table A2. 95: Considering Changing Occupation by Occupation (Unweighted).....	199
Table A2. 96: What has to happen for you to change your mind about wanting to leave by Country (Weighted)	201
Table A2. 97: What has to happen for you to change your mind about wanting to leave by Country (Unweighted)	202
Table A2. 98: What has to happen for you to change your mind about wanting to leave by Occupation(Weighted).....	204
Table A2. 99: What has to happen for you to change your mind about wanting to leave by Occupation (Unweighted).....	205
Table A2. 100: Chosen to change job or contractual working hours by Country (Weighted)	207
Table A2. 101: Chosen to change job or contractual working hours by Country (Unweighted)	208
Table A2. 102: Chosen to change job or contractual working hours by Occupation (Weighted)	209
Table A2. 103: Chosen to change job or contractual working hours by Occupation (Unweighted) ..	210
Table A2. 104: Taken up employer support by Country (Weighted).....	212
Table A2. 105: Taken up employer support by Country (Unweighted)	212
Table A2. 106: Taken up employer support by Occupation (Weighted)	213
Table A2. 107: Taken up employer support by Occupation (Unweighted)	213
Table A2. 108: What have you taken up from your employer to support your well-being by Country (Weighted)	216
Table A2. 109: What have you taken up from your employer to support your well-being by Country (Unweighted)	217
Table A2. 110: What have you taken up from your employer to support your well-being by Occupation(Weighted).....	219
Table A2. 111: What have you taken up from your employer to support your well-being by Occupation (Unweighted).....	220
Table A2. 112: Reasons for not taking up employer support by Country (Weighted)	223
Table A2. 113: Reasons for not taking up employer support by Country (Unweighted)	223
Table A2. 114: Reasons for not taking up employer support by Occupation (Weighted).....	225
Table A2. 115: Reasons for not taking up employer support by Occupation (Unweighted)	225
Table A2. 116: Responses by Region (Unweighted)	226
Table A2. 117: Region by Occupation (Unweighted).....	228
 Table A3. 1: Mean Overall and Item Well-being Scores by Country (Weighted).....	 231
Table A3.2: Mean Overall and Item Well-being Scores by Country (Unweighted)	232
Table A3.3: Overall Well-being Score Converted to Depression/Anxiety by Country (Weighted)	233
Table A3.4: Overall Well-being Score Converted to Depression/Anxiety by Country (Unweighted) ..	234
Table A3.5: Mean Overall Well-being Score by Occupation (Weighted).....	235

Table A3.6: Mean Overall Well-being Score by Occupation (Unweighted)	235
Table A3.7: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Weighted).....	237
Table A3.8: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Unweighted)	237
Table A3.9: Mean Overall Well-being Score by Sex (Weighted)	239
Table A3.10: Mean Overall Well-being Score by Sex (Unweighted)	239
Table A3.11: Mean Overall Well-being Score by Age (Weighted)	240
Table A3.12: Mean Overall Well-being Score by Age (Unweighted)	240
Table A3.13: Mean Overall Well-being Score by Ethnicity (Weighted)	242
Table A3.14: Mean Overall Well-being Score by Ethnicity (Unweighted)	242
Table A3.15: Mean Overall Well-being Score by Disability (Weighted)	244
Table A3.16: Mean Overall Well-being Score by Disability (Unweighted).....	244
Table A3.17: Mean Overall Well-being Score by Area of Practice (Weighted).....	246
Table A3.18: Mean Overall Well-being Score by Area of Practice (Unweighted).....	246
Table A3.19: Mean Overall Well-being Score by Line Manager Status (Weighted)	248
Table A3.20: Mean Overall Well-being Score by Line Manager Status (Unweighted)	248
Table A3.21: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Weighted)	249
Table A3.22: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Unweighted)	250
Table A3. 23: Mean Overall Well-being Score by the Uptake of Employer Support (Weighted)	251
Table A3. 24: Mean Overall Well-being Score by the Uptake of Employer Support (Unweighted) ...	251
Table A4. 1: Mean Quality of Working Life Scores by Country (Weighted).....	255
Table A4.2: Mean Quality of Working Life Scores by Country (Unweighted).....	255
Table A4.3: Level of Quality of Working Life Scores – UK-Wide (Weighted)	256
Table A4 4: Level of Quality of Working Life Scores – UK-Wide (Unweighted)	256
Table A4.5: Level of Overall Quality of Working Life by Country (Weighted)	258
Table A4.6: Level of Overall Quality of Working Life by Country (Unweighted).....	258
Table A4.7: Mean Quality of Working Life Scores by Occupation (Weighted)	261
Table A4.8: Mean Quality of Working Life Scores by Occupation (Unweighted)	261
Table A4.9: Level of Overall Quality of Working Life by Occupation (Weighted)	262
Table A4.10: Level of Overall Quality of Working Life by Occupation (Unweighted)	262
Table A4.11: Mean Quality of Working Life Scores by Sex (Weighted)	265
Table A4.12: Mean Quality of Working Life Scores by Sex (Unweighted)	266
Table A4.13: Level of Overall Quality of Working Life by Sex (Weighted)	267
Table A4.14: Level of Overall Quality of Working Life by Sex (Unweighted)	267
Table A4.15: Mean Quality of Working Life Scores by Age (Weighted)	270
Table A4.16: Mean Quality of Working Life Scores by Age (Unweighted)	270
Table A4.17: Level of Overall Quality of Working Life by Age (Weighted)	271
Table A4.18: Level of Overall Quality of Working Life by Age (Unweighted)	271
Table A4.19: Mean Quality of Working Life Scores by Ethnicity (Weighted)	274
Table A4.20: Mean Quality of Working Life Scores by Ethnicity (Unweighted)	274
Table A4.21: Level of Overall Quality of Working Life by Ethnicity (Weighted)	276
Table A4.22: Level of Overall Quality of Working Life by Ethnicity (Unweighted)	276
Table A4.23: Mean Quality of Working Life Scores by Disability (Weighted).....	279
Table A4.24: Mean Quality of Working Life Scores by Disability (Unweighted).....	279

Table A4.25: Level of Overall Quality of Working Life by Disability (Weighted).....	281
Table A4.26: Level of Overall Quality of Working Life by Disability (Unweighted).....	281
Table A4.27: Mean Quality of Working Life Scores by Main Area of Practice (Weighted).....	284
Table A4.28: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted).....	285
Table A4.29: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)	287
Table A4.30: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted).....	287
Table A4.31: Mean Quality of Working Life Scores by Line Manager Status (Weighted)	290
Table A4.32: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)	291
Table A4.33: Level of Overall Quality of Working Life by Line Manager Status (Weighted)	293
Table A4.34: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)	293
Table A4.35: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)	296
Table A4.36: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)	296
Table A4.37: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)	298
Table A4.38: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)	298
Table A4.39: Mean Overall Quality of Working Life Score by the Uptake of Employer Support.....	301
Table A4.40: Mean Overall Quality of Working Life Score by the Uptake of Employer Support (Unweighted)	301
Table A4.41: Level of Overall Quality of Working Life by Uptake of Employer Support (Weighted) .	303
Table A4.42: Level of Overall Quality of Working Life by Uptake of Employer Support (Unweighted)	303
Table A5.1: Mean Burnout Scores by Country (Weighted).....	305
Table A5.2: Mean Burnout Scores by Country (Unweighted).....	305
Table A5.3: Level of Burnout by Country (Weighted).....	309
Table A5.4: Level of Burnout by Country (Unweighted).....	310
Table A5.5: Mean Burnout Scores by Occupation (Weighted)	312
Table A5.6: Mean Burnout Scores by Occupation (Unweighted)	312
Table A5.7: Level of Burnout by Occupation (Weighted)	316
Table A5.8: Level of Burnout by Occupation (Unweighted)	317
Table A5.9: Mean Burnout Scores by Sex (Weighted)	319
Table A5.10: Mean Burnout Scores by Sex (Unweighted)	319
Table A5.11: Level of Burnout by Sex (Weighted)	323
Table A5.12: Level of Burnout by Sex (Unweighted)	324
Table A5.13: Mean Burnout Scores by Age (Weighted)	326
Table A5.14: Mean Burnout Scores by Age (Unweighted)	326
Table A5.15: Level of Burnout by Age (Weighted).....	330
Table A5.16: Level of Burnout by Age (Unweighted).....	331
Table A5.17: Mean Burnout Scores by Ethnicity (Weighted)	333
Table A5.18: Mean Burnout Scores by Ethnicity (Unweighted)	333
Table A5.19: Level of Burnout by Ethnicity (Weighted).....	337
Table A5.20: Level of Burnout by Ethnicity (Unweighted).....	338
Table A5.21: Mean Burnout Scores by Disability (Weighted).....	341
Table A5.22: Mean Burnout Scores by Disability (Unweighted).....	341

Table A5.23: Level of Burnout by Disability (Weighted)	344
Table A5.24: Level of Burnout by Disability (Unweighted)	345
Table A5.25: Mean Burnout Scores by Main Area of Practice (Weighted).....	348
Table A5.26: Mean Burnout Scores by Main Area of Practice (Unweighted).....	348
Table A5.27: Level of Burnout by Main Area of Practice (Weighted)	352
Table A5.28: Level of Burnout by Main Area of Practice (Unweighted)	353
Table A5.29: Mean Burnout Scores by Line Manager Status (Weighted)	355
Table A5.30: Mean Burnout Scores by Line Manager Status (Unweighted)	355
Table A5.31: Level of Burnout by Line Manager Status (Weighted).....	359
Table A5.32: Level of Burnout by Line Manager Status (Unweighted).....	360
Table A5.33: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)	363
Table A5.34: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)	363
Table A5.35: Level of Burnout by the Impact of the Pandemic on Services (Weighted).....	367
Table A5.36: Level of Burnout by the Impact of the Pandemic on Services (Unweighted).....	368
Table A5. 37: Mean Burnout Scores by Uptake of Employer Support (Weighted).....	370
Table A5. 38: Mean Burnout Scores by Uptake of Employer Support (Unweighted).....	371
Table A5. 39: Level of Burnout Uptake of Employer Support (Weighted).....	375
Table A5. 40: Level of Burnout by Uptake of Employer Support (Unweighted).....	376
Table A6. 1: Mean Carver Coping Scores by Country (Weighted)	378
Table A6. 2: Mean Carver Coping Scores by Country (Unweighted)	379
Table A6.3: Mean Carver Coping Scores by Occupation (Weighted).....	381
Table A6.4: Mean Carver Coping Scores by Occupation (Unweighted).....	382
Table A6.5: Mean Carver Coping Scores by Sex (Weighted).....	384
Table A6.6: Mean Carver Coping Scores by Sex (Unweighted).....	384
Table A6.7: Mean Carver Coping Scores by Age (Weighted)	387
Table A6.8: Mean Carver Coping Scores by Age (Unweighted)	387
Table A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)	390
Table A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)	390
Table A6.11: Mean Carver Coping Scores by Disability (Weighted)	393
Table A6.12: Mean Carver Coping Scores by Disability (Unweighted)	393
Table A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)	396
Table A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)	397
Table A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)	399
Table A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)	400
Table A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted) ..	403
Table A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)	404
Table A6. 19: Mean Carver Coping Scores by Uptake of Employer Support (Weighted)	406
Table A6. 20: Mean Carver Coping Scores by Uptake of Employer Support (Unweighted)	407
Table A7. 1: Mean Clark Coping Scores by Country (Weighted).....	410
Table A7. 2: Mean Clark Coping Scores by Country (Unweighted).....	410
Table A7.3: Mean Clark Coping Scores by Occupation (Weighted)	412
Table A7.4: Mean Clark Coping Scores by Occupation (Unweighted)	412
Table A7.5: Mean Clark Coping Scores by Sex (Weighted)	415

Table A7.6: Mean Clark Coping Scores by Sex (Unweighted)	415
Table A7.7: Mean Clark Coping Scores by Age (Weighted)	417
Table A7.8: Mean Clark Coping Scores by Age (Unweighted)	417
Table A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)	419
Table A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)	419
Table A7.11: Mean Clark Coping Scores by Disability (Weighted).....	421
Table A7.12: Mean Clark Coping Scores by Disability (Unweighted).....	421
Table A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted).....	424
Table A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted).....	424
Table A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)	426
Table A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)	426
Table A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)	429
Table A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)	429
Table A7. 19: Mean Clark Coping Scores by Uptake of Employer Support (Weighted)	431
Table A7. 20: Mean Clark Coping Scores by Uptake of Employer Support (Unweighted).....	431
Table A9. 1: Mean Overall Well-being Score by Study Phase and Country (Weighted)	444
Table A9. 2: Mean Overall Well-being Score by Study Phase and Occupation (Weighted)	445
Table A9. 3: Mean Quality of Working Life Score by Study Phase and Country (Weighted).....	449
Table A9. 4: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted)	451
Table A9. 5: Mean Burnout scores by Study Phase and Country (Weighted)	453
Table A9. 6: Burnout Scores by Study Phase and Occupation	456
Table A9. 7: Mean Carver Coping Scores by Study Phase and Country (Weighted).....	463
Table A9. 8: Mean Carver Coping Scores by Study Phase and Occupation (Weighted)	465
Table A9. 9: Mean Clark Coping Scores by Study Phase and Country (Weighted)	470
Table A9. 10: Mean Clark Coping Scores by Study Phase and Occupation (Weighted)	472

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 these numbers regionally using the combined average of the other professions (social work, nursing and midwifery).

Regional Aggregation for Weighting

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

Note: *As we go through the post-pandemic, sample attrition occurs in a random way. This has consequences for the data, for example in this Phase (Phase 6), the number and representation of within certain occupations was lower than all previous phases, therefore participation numbers needed to be viewed tentatively.*

Table A1. 2: Regions for Calculation of Weights

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

Table A1. 3: Final Estimated Population and Distribution

	London	South	Midlands & East	North & Yorkshire	England Total	Scotland	Wales	Northern Ireland	Total
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%
TOTAL¹	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, Phase 2, Phase 3, Phase 4, and Phase 5 reports, as we found no evidence of major changes in staffing levels between Nov 2021 and Jan 2023.

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

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

A2.1 Country and Occupation of Respondents

Summary (Weighted results):

Not reported.

Summary (Unweighted results):

A majority of the respondents (n = 781, 56.0%) indicated that they currently work in Northern Ireland, 13.5% (n=188) worked in England, 23.8% (n=332) worked in Scotland and 6.7% (n=94) worked in Wales. Most of the respondents worked as Social Care Workers (n= 529, 37.9%), followed by Social Workers (n=406, 29.1%), nurses (n=218, 15.6%). AHPs (n=213, 15.3%) and Midwives represented the smallest proportion of respondents (n=29, 2.1%).

Figure A2. 1: Country of Respondents (Unweighted)

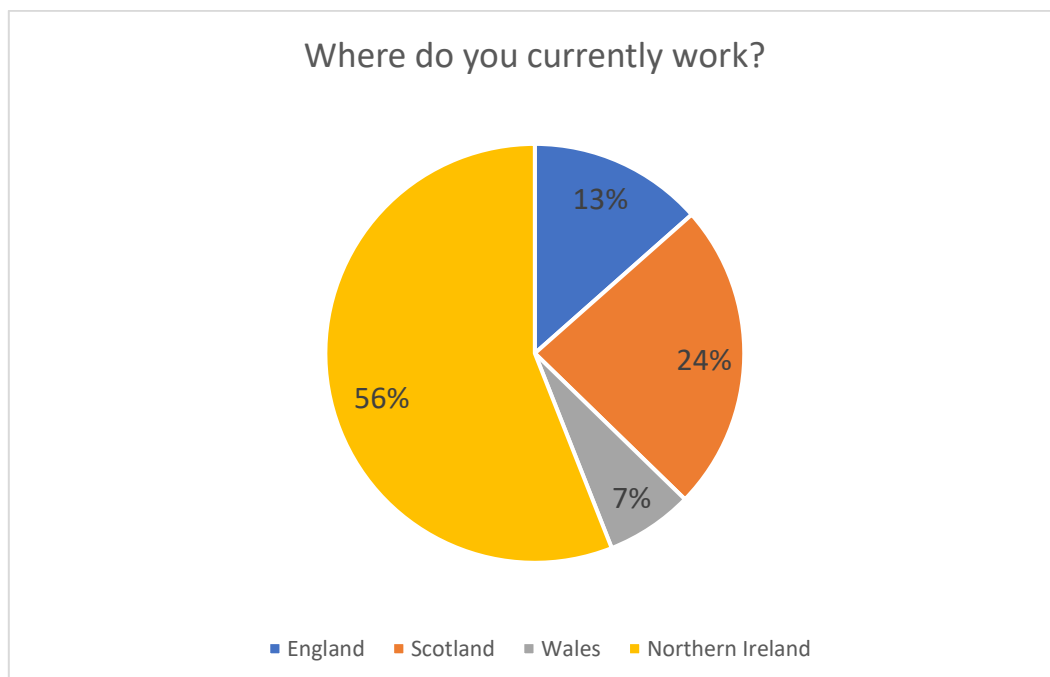


Table A2. 1: Country of Respondents (Unweighted)

Country	n (%)
England	188 (13.5%)
Scotland	332 (23.8%)
Wales	94 (6.7%)
Northern Ireland	781 (56.0%)
Total	1395 (100%)

Figure A2.2: Occupation of Respondents (Unweighted)

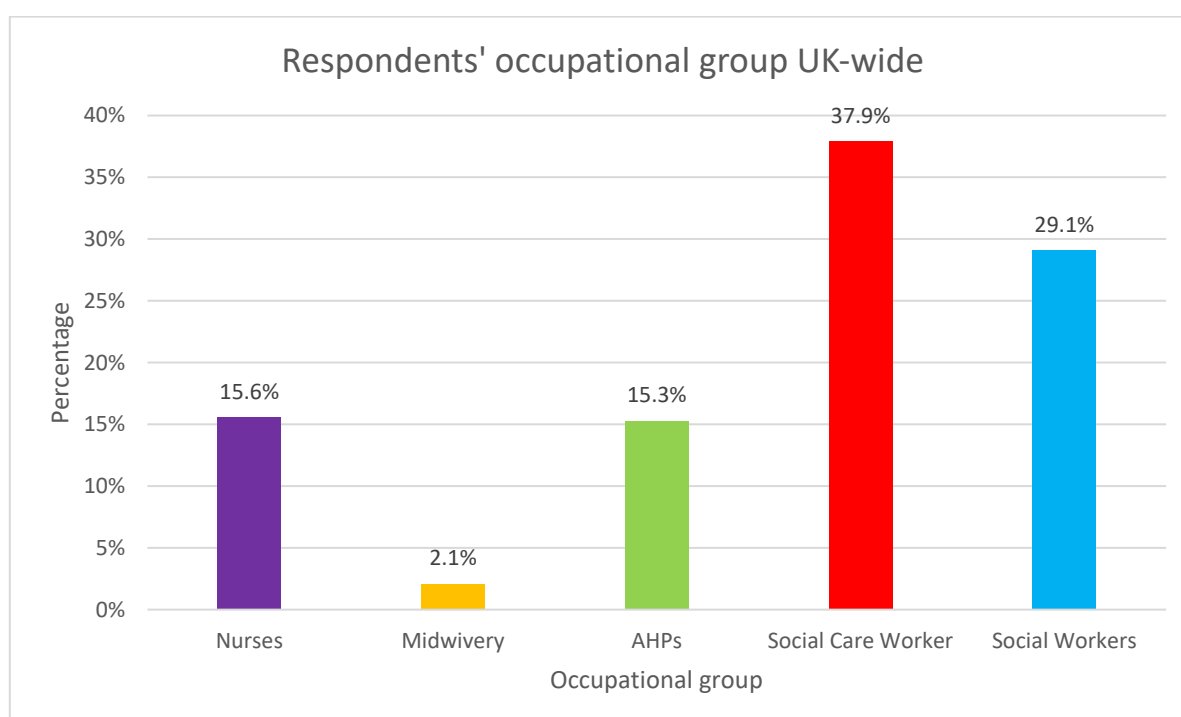


Table A2. 2: Occupation of Respondents (Unweighted)

Occupation	UK-Wide n (%)
Nursing	234 (13.5%)
Midwifery	88 (5.1%)
AHP	305 (17.0%)
Social Care Worker	730 (42.0%)
Social Worker	380 (21.3%)
Total	1737 (100%)

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

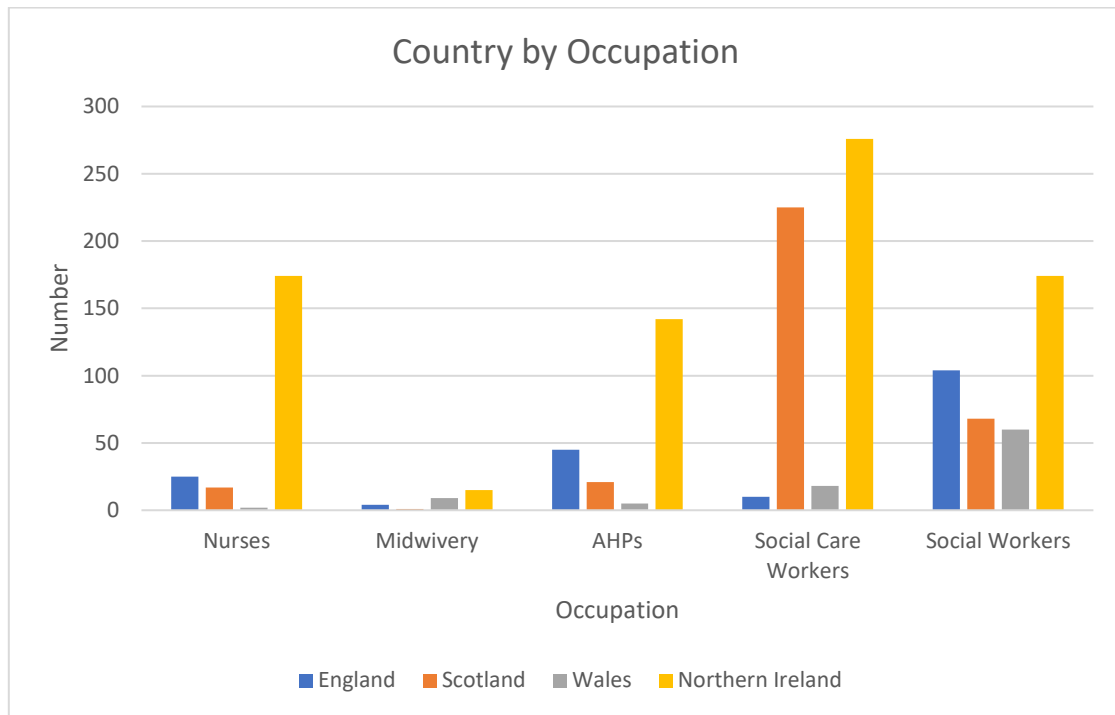


Table A2. 3:Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	25 (13.3%)	17 (5.1%)	2 (2.1%)	174(22.3%)	218 (15.6%)
Midwifery	4 (2.1%)	1 (0.3%)	9 (9.6%)	15 (1.9%)	29 (2.1%)
AHP	45 (23.9%)	21 (6.3%)	5 (5.3%)	142 (18.2%)	213 (15.3%)
Social Care Worker	10 (5.3%)	225 (67.8%)	18 (19.1%)	276 (35.3%)	529 (37.9%)
Social Worker	104 (55.3%)	68 (20.5%)	60 (63.8%)	174 (22.3%)	406 (29.1%)

A2.2 Sex of Respondents

Summary (Weighted results):

The vast majority of respondents were female (84.9%), with a similar sex distribution across countries. Most nursing respondents were female (88.8%). AHPs had the highest proportion of males (33.3%).

Summary (Unweighted results):

The vast majority of respondents were female (83.3%), with a similar sex distribution across countries. A majority of midwifery respondents were female (96.6%). AHPS had the highest proportion of males (19.7%).

Figure A2. 4: Sex by Country (Weighted by Occupation)

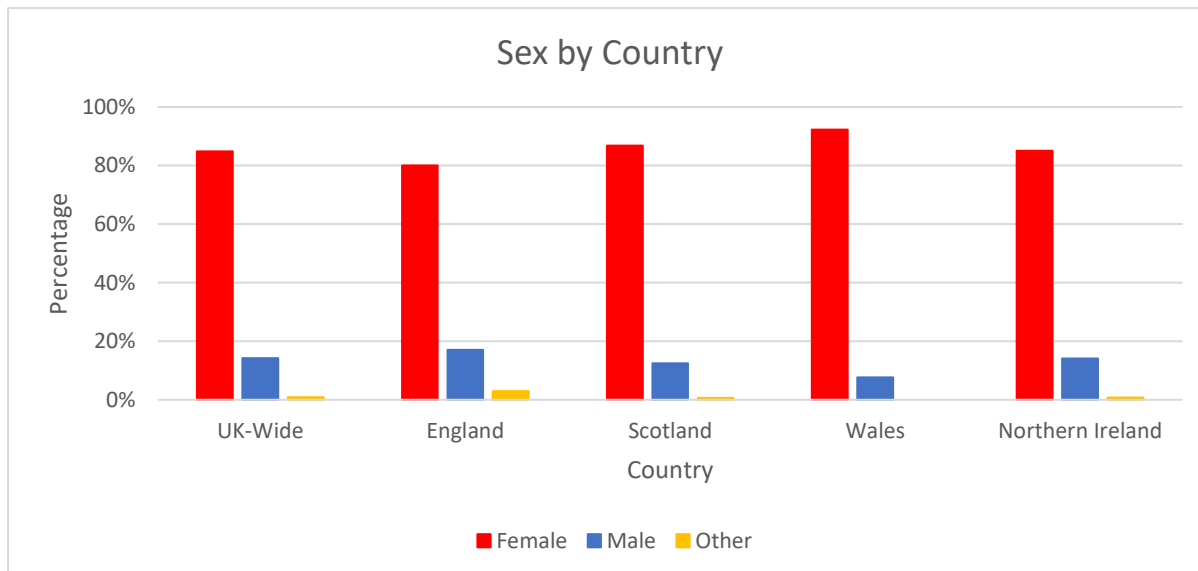


Figure A2.5: Sex by Country (Unweighted)

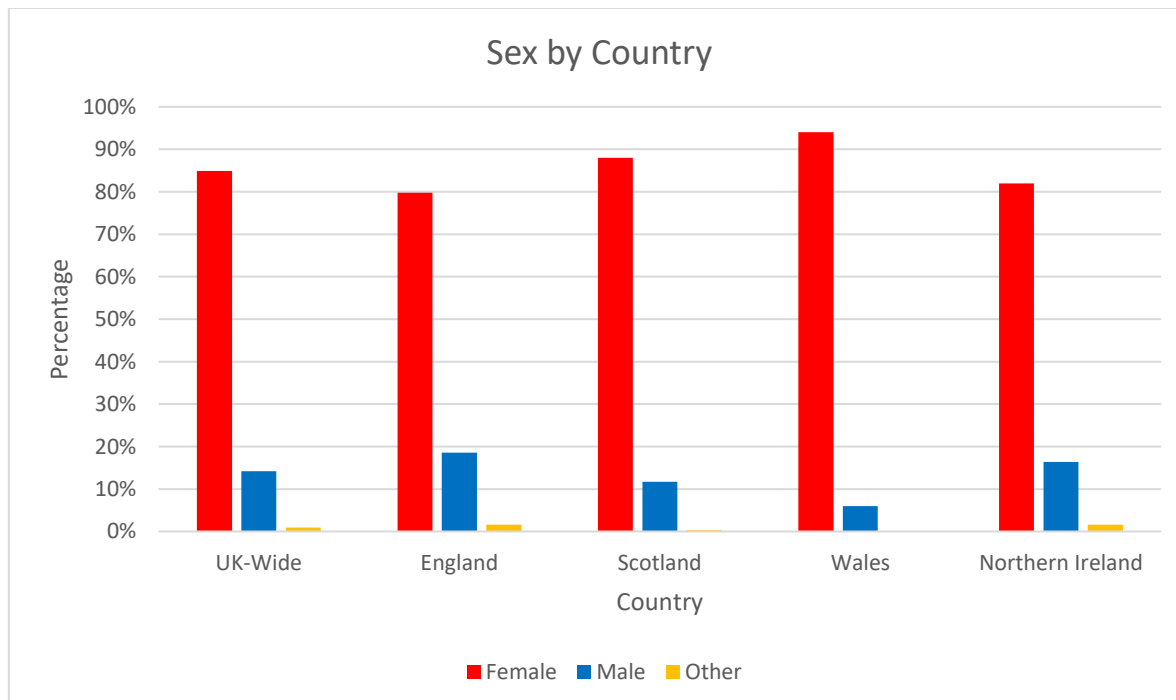


Table A2. 4: Sex by Country (Weighted by Occupation)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	84.9%	80.0%	86.8%	92.3%	85.1%
Male	14.2%	17.1%	12.5%	7.7%	14.1%
Other	0.9%	2.9%	0.6%	0.0%	0.8%
Total	100%	100%	100%	100%	100%

Table A2.5: Sex by Country (Unweighted)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	1162 (83.3%)	151 (80.3%)	284 (85.5%)	85 (90.4%)	642 (82.2%)
Male	218 (15.6%)	31 (16.5%)	45 (13.6%)	9 (9.6%)	133 (17.0%)
Others	15 (1.1%)	6 (3.2%)	3 (0.9%)	0 (0.0%)	6 (0.8%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

Figure A2.6: Sex by Occupation (Weighted by Region)

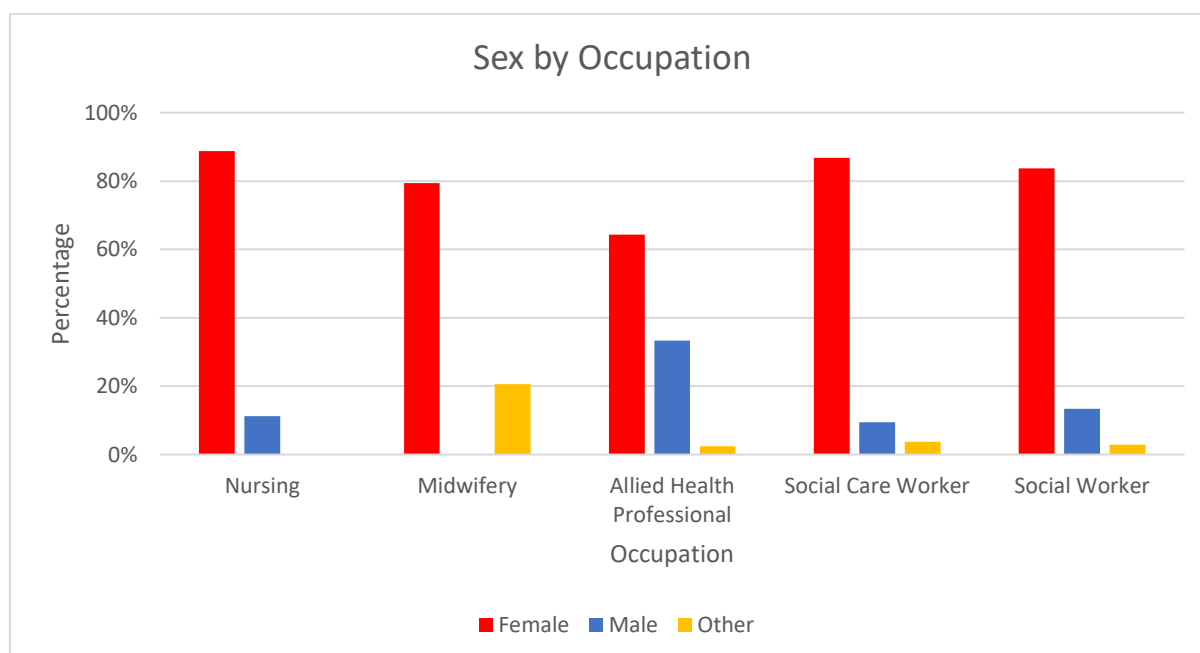


Figure A2.7: Sex by Occupation (Unweighted)

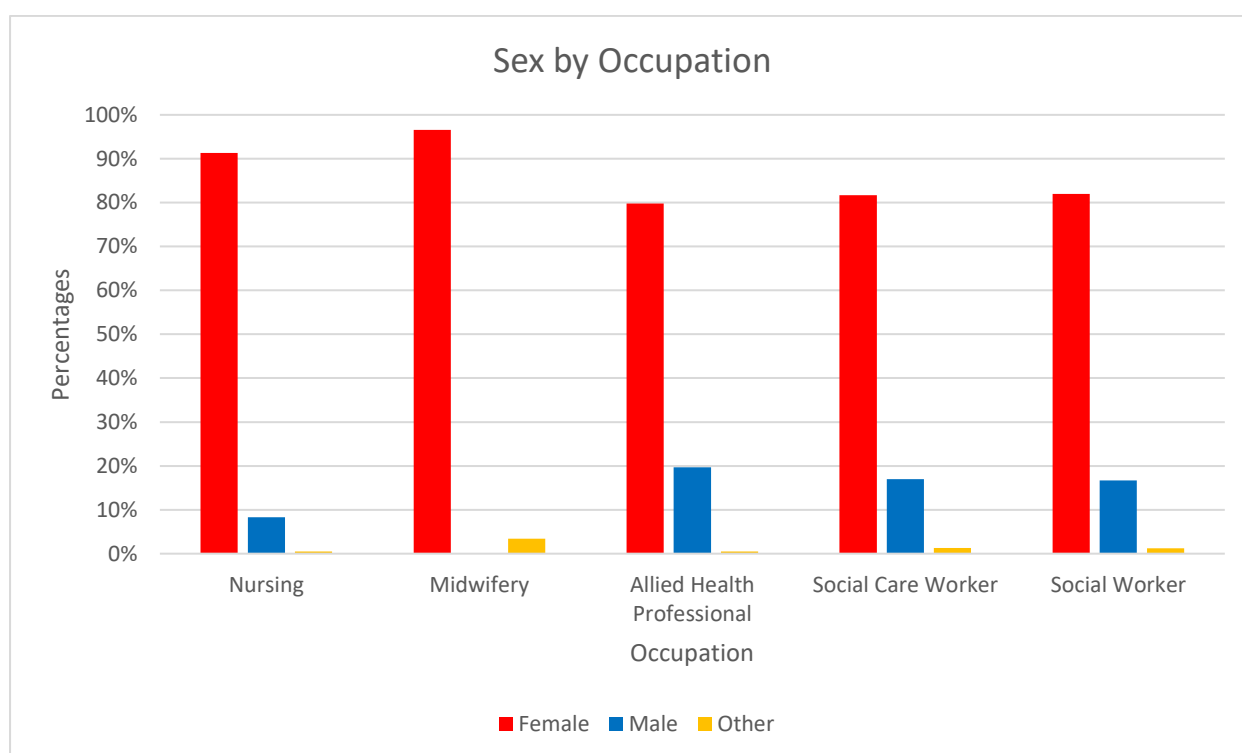


Table A2 6: Sex by Occupation (Weighted by Region)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	88.8%	11.2%	0.0%	100%
Midwifery	79.4%	0.0%	20.6%	100%
AHP	64.3%	33.3%	2.4%	100%
Social Care Worker	86.8%	9.5%	3.7%	100%
Social Worker	83.7%	13.4%	2.9%	100%

Table A2.7: Sex by Occupation (Unweighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	199 (91.3%)	18 (8.3%)	1 (0.5%)	218 (15.6%)
Midwifery	28(96.6%)	0 (0.0%)	1 (3.4%)	29 (2.1%)
AHP	170 (79.8%)	42 (19.7%)	1 (0.5%)	213 (15.3%)
Social Care Worker	432 (81.7%)	90 (17.0%)	7 (1.3%)	529 (37.9%)
Social Worker	333 (82.0%)	68(16.7%)	5 (1.2%)	406 (29.1%)

A2.3 Age of Respondents

Summary (Weighted results):

The majority of respondents were aged 50-59 years, with the smallest proportion from the 16-29 age group. Scotland had the highest proportion of the 50–59-year-old respondents (42.5%).

Summary (Unweighted results):

The majority of respondents were aged 50-59 years, with the smallest proportion from the 16-29 age group. Scotland had the highest proportion of the 50–59-year-old respondents (41.3%).

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

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

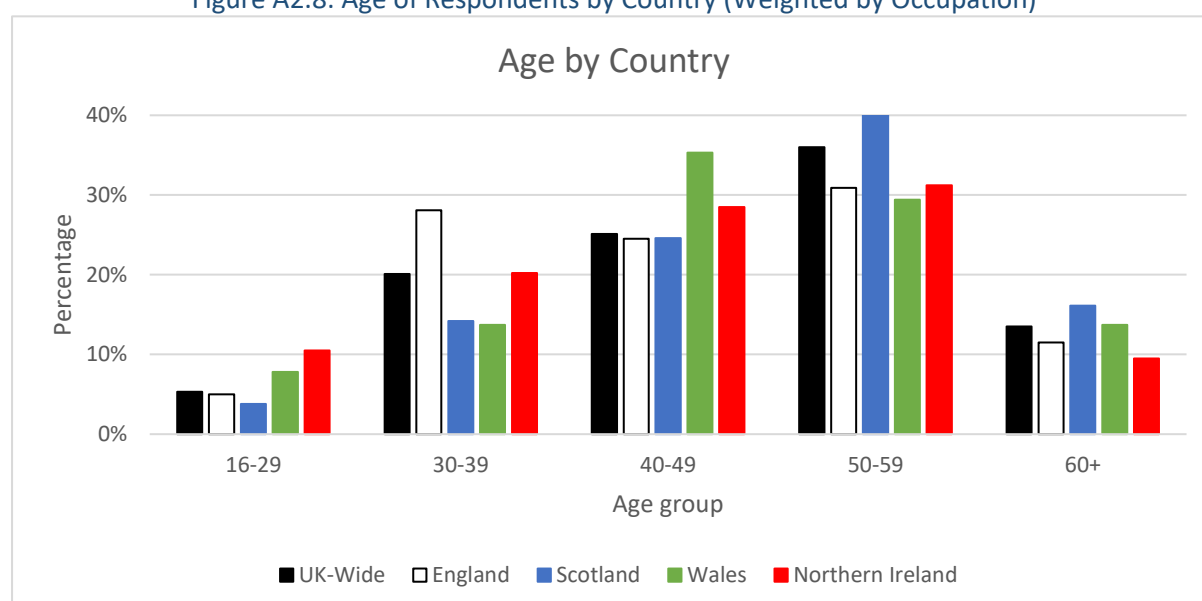


Figure A2.9: Age of Respondents by Country (Unweighted)

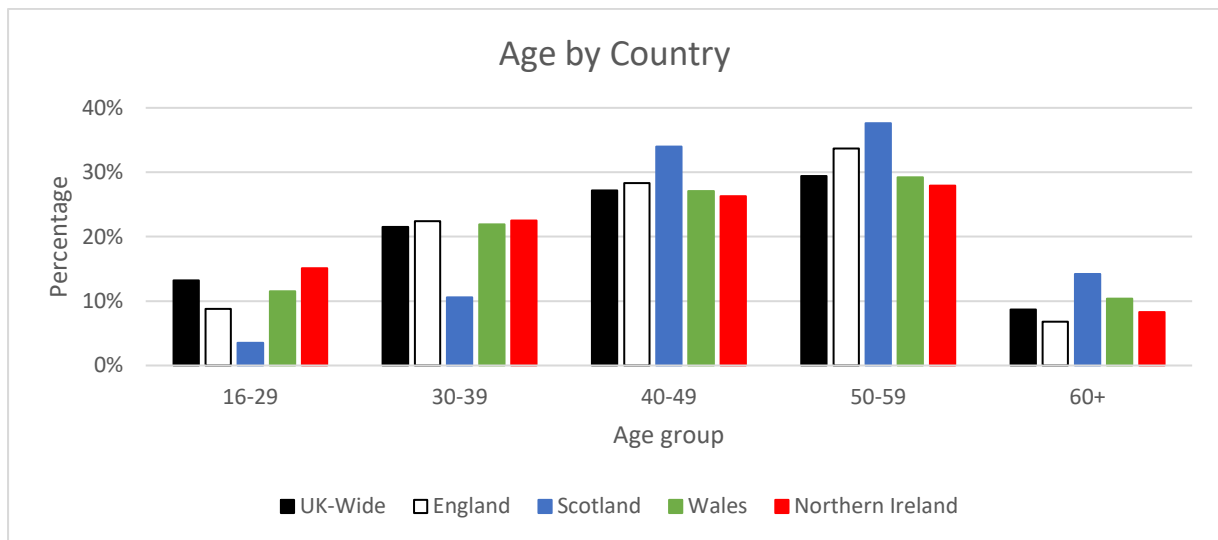


Table A2.8: Age of Respondents by Country (Weighted by Occupation)

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-29	5.3%	5.0%	3.8%	7.8%	10.5%
30-39	20.1%	28.1%	14.2%	13.7%	20.2%
40-49	25.1%	24.5%	24.6%	35.3%	28.5%
50-59	36.0%	30.9%	42.5%	29.4%	31.2%
60+	13.5%	11.5%	16.1%	13.7%	9.5%
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	99 (7.1%)	7 (3.7%)	12(3.6%)	6 (6.4%)	74 (9.5%)
30-39	267 (19.1%)	46 (24.5%)	47 (14.2%)	16 (17.0%)	158 (20.2%)
40-49	394 (28.2%)	55 (29.8%)	78 (23.5%)	34 (36.2%)	226 (28.9%)
50-59	463 (33.2%)	57 (30.3%)	137 (41.3%)	27 (28.7%)	242 (31.0%)
60+	172 (12.3%)	22 (11.7%)	58(17.5%)	11 (11.7%)	81 (10.4%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

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

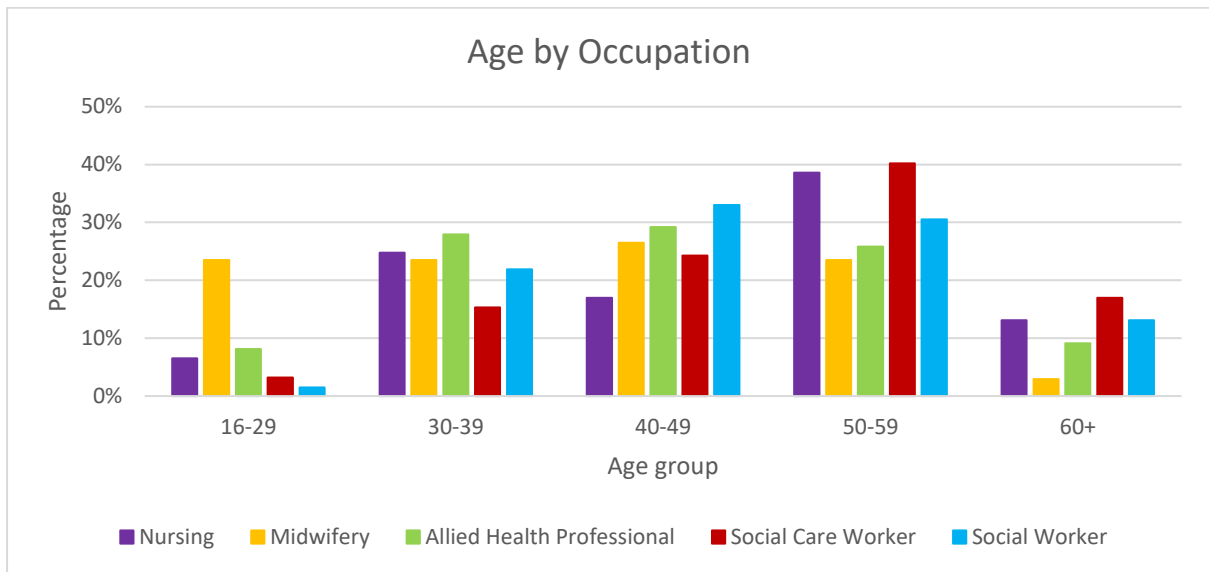


Figure A2.11: Age of Respondents by Occupation (Unweighted)

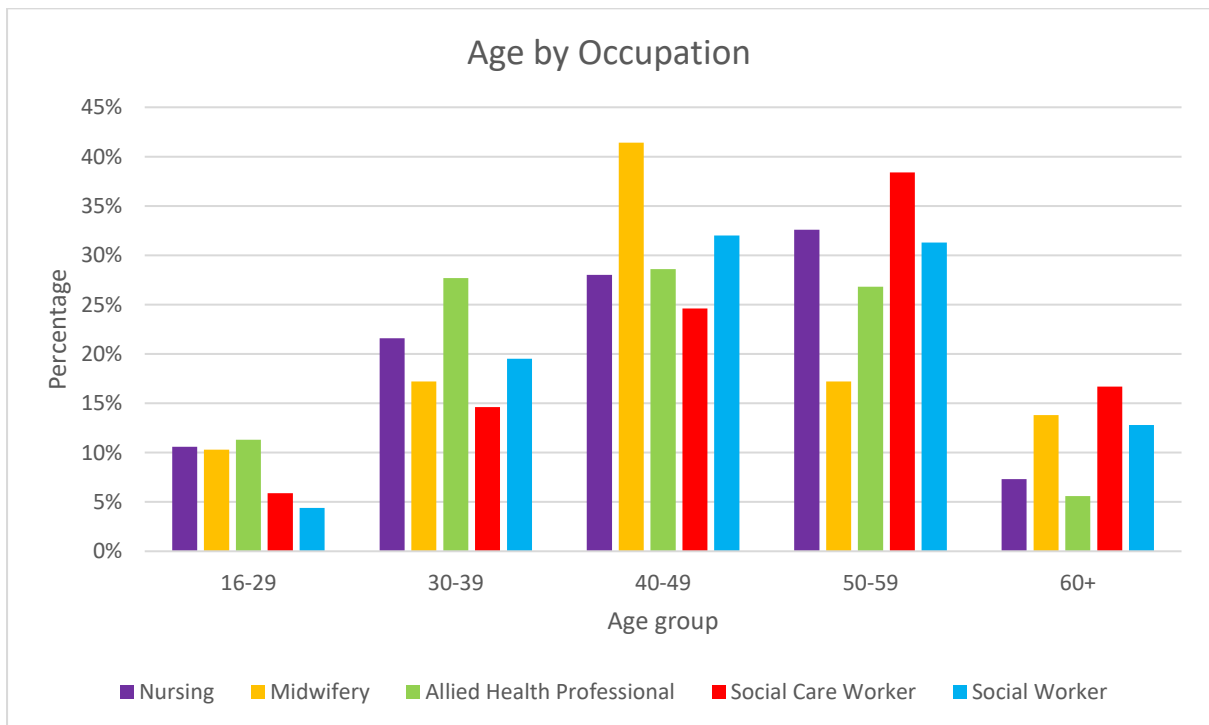


Table A2.10: Age of Respondents by Occupation (Weighted by Region)

Occupation	Age group					Total
	16-29	30-39	40-49	50-59	60+	
Nursing	6.5%	24.8%	17.0%	38.6%	13.1%	100%
Midwifery	23.5%	23.5%	26.5%	23.5%	2.9%	100%
AHP	8.1%	27.9%	29.2%	25.8%	9.1%	100%
Social Care Worker	3.2%	15.3%	24.3%	40.2%	17.0%	100%
Social Worker	1.5%	21.9%	33.0%	30.5%	13.1%	100%

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

Occupation	Age group					Total
	16-29	30-39	40-49	50-59	60+	
Nursing	23 (10.6%)	47 (21.6%)	61 (28.0%)	71 (32.6%)	16 (7.3%)	218 (100%)
Midwifery	3 (10.3%)	5 (17.2%)	12 (41.4%)	5 (17.2%)	4 (13.8%)	29 (100%)
AHP	24 (11.3%)	59 (27.7%)	61 (28.6%)	57 (26.8%)	12 (5.6%)	213 (100%)
Social Care Worker	31 (5.9%)	77 (14.6%)	130 (24.6%)	203 (38.4%)	88 (16.7%)	529 (100%)
Social Worker	18 (4.4%)	79 (19.5%)	130 (32.0%)	127 (31.3%)	52 (12.8%)	406 (100%)

A2.4 Ethnic Origin of Respondents

Summary (Weighted results):

The vast majority of respondents were of white ethnic origin (94.4%). England was the most ethnically diverse country, with 14.3% of respondents identifying as not white. Midwives were the most ethnically diverse occupational group, with 42.4% identifying as not white.

Summary (Unweighted results):

The vast majority of respondents were of white ethnic origin (97.4%). England was the most ethnically diverse country, with 12.2% of respondents identifying as not white. Midwives were the most ethnically diverse occupational group, with 6.9% identifying as not white.

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

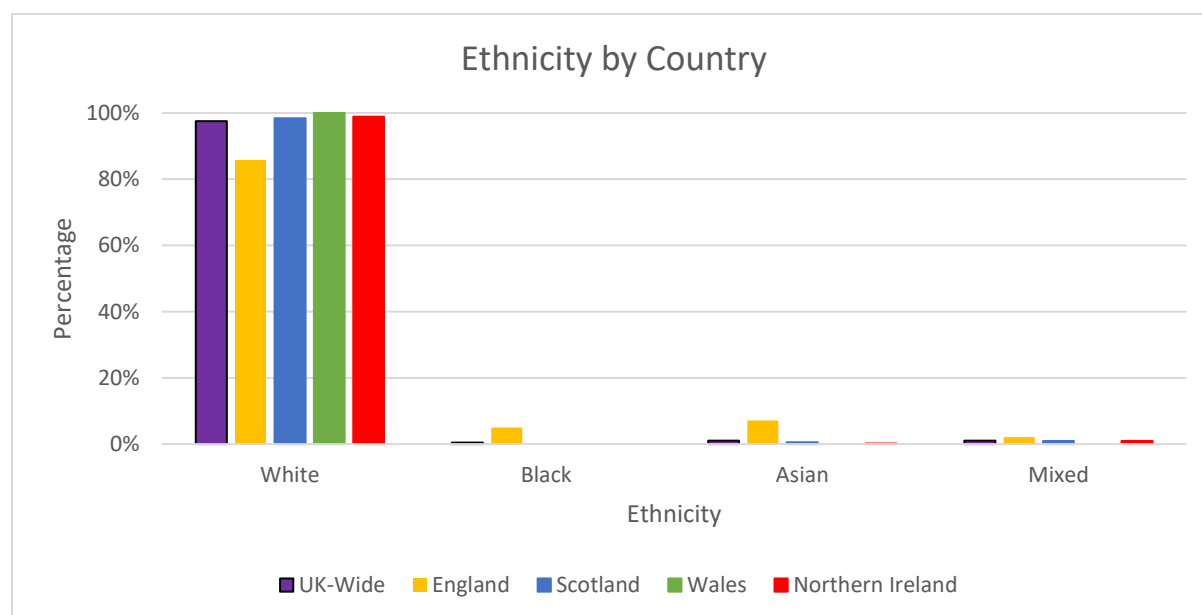


Figure A2.13: Ethnic Origin of Respondents by Country (Unweighted)

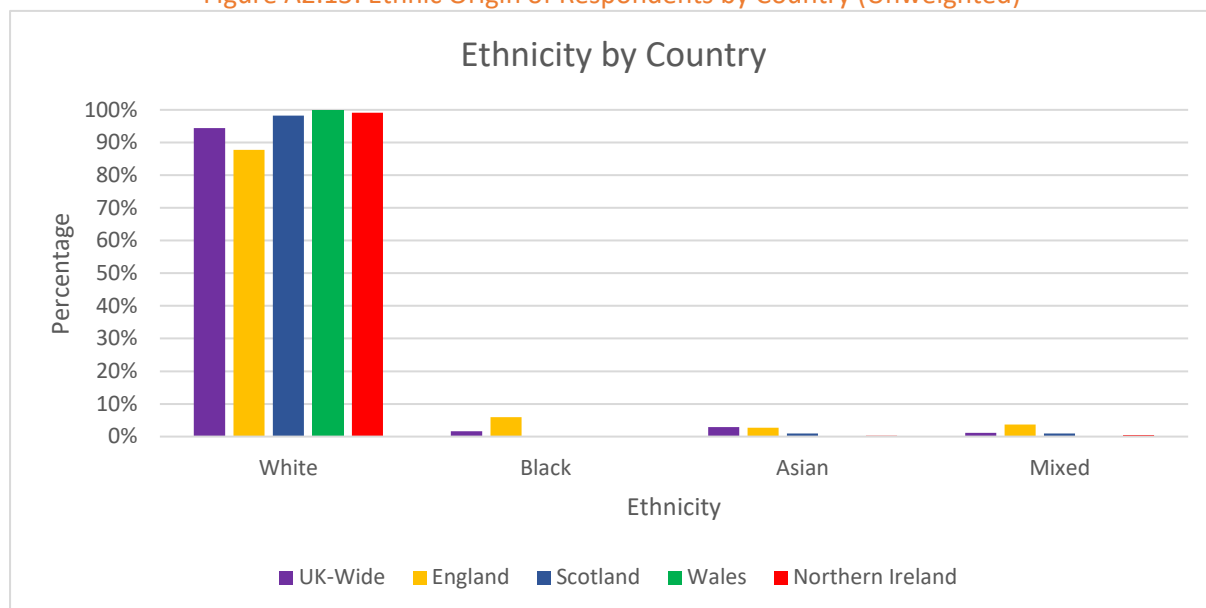


Table A2.12: Ethnic Origin of Respondents by Country (Weighted by Occupation)

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	94.4%	85.7%	98.4%	100.0%	98.9%
Black	1.6%	5.0%	0.0%	0.0%	0.0%
Asian	2.9%	7.1%	0.6%	0.0%	0.2%
Mixed	1.1%	2.1%	0.9%	0.0%	0.9%
Total	100%	100%	100%	100%	100%

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

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	1357 (97.4%)	165 (87.8%)	326 (98.2%)	94 (100.0%)	772 (99.1%)
Black	12 (0.9%)	11 (5.9%)	0 (0.0%)	0 (0.0%)	1 (0.1%)
Asian	10 (0.7%)	5 (2.7%)	3 (0.9%)	0 (0.0%)	2 (0.3%)
Mixed	14 (1.0%)	7 (3.7%)	3 (0.9%)	0 (0.0%)	4 (0.5%)
Total	1393 (100%)	188 (100%)	332 (100%)	94 (100%)	779 (100%)

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

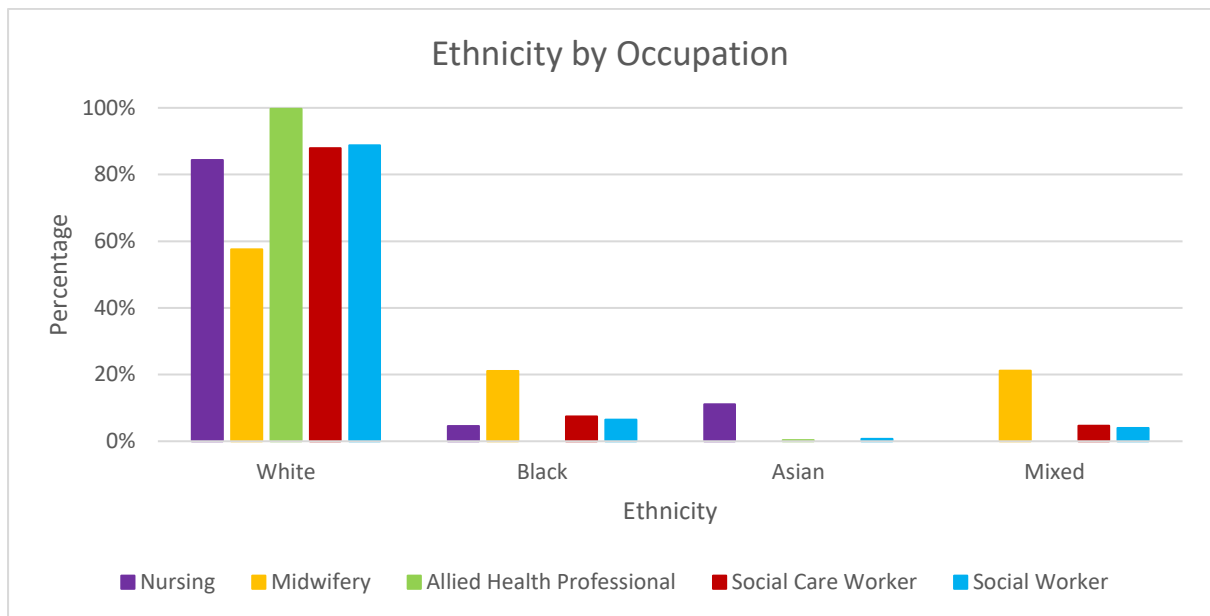


Figure A2.15: Ethnic Origin of Respondents by Occupation (Unweighted)

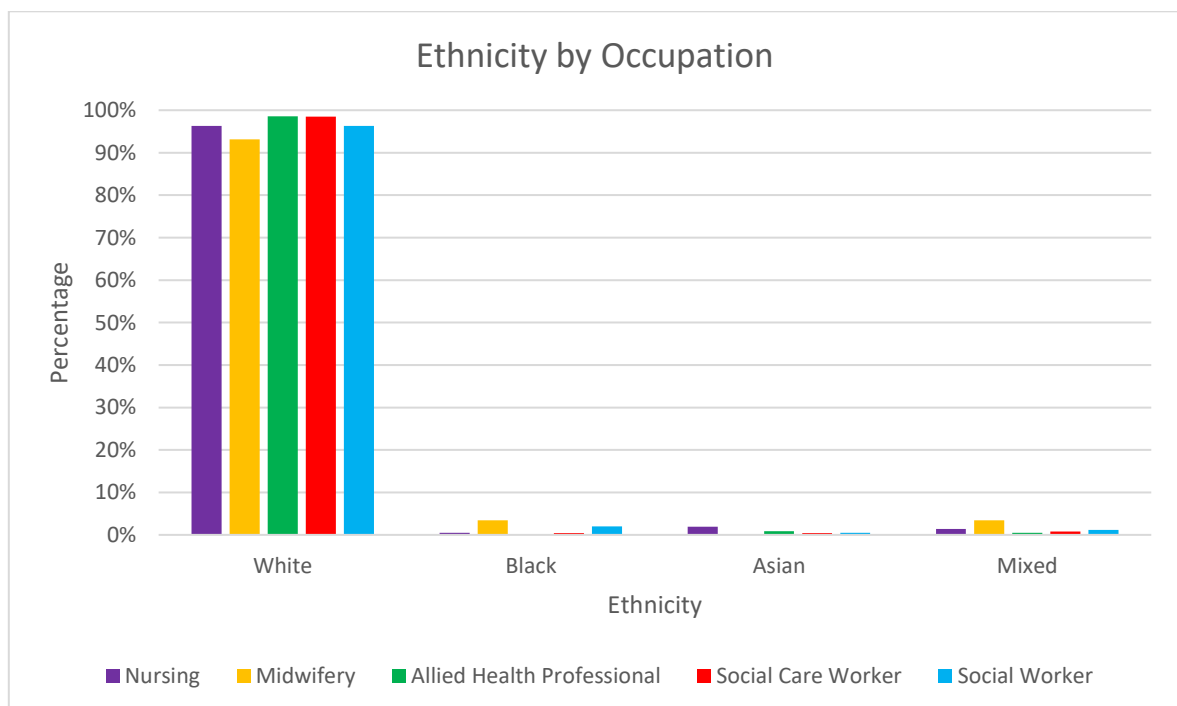


Table A2.14: Ethnic Origin of Respondents by Occupation (Weighted by Region)

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	84.3%	4.6%	11.1%	0.0%	100%
Midwifery	57.6%	21.2%	0.0%	21.2%	100%
AHP	99.7%	0.0%	0.3%	0.0%	100%
Social Care Worker	87.9%	7.4%	0.0%	4.7%	100%
Social Worker	88.8%	6.5%	0.7%	4.0%	100%

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

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	208 (96.3%)	1 (0.5%)	4 (1.9%)	3 (1.4%)	216 (100%)
Midwifery	27 (93.1%)	1 (3.4%)	0 (0.0%)	1 (3.4%)	29 (100%)
AHP	210 (98.6%)	0 (0.0%)	2 (0.9%)	1 (0.5%)	213 (100%)
Social Care Worker	521 (98.5%)	2 (0.4%)	2 (0.4%)	4 (0.8%)	529 (100%)
Social Worker	391 (96.3%)	8 (2.0%)	2 (0.5%)	5 (1.2%)	406 (100%)

A2.5 Respondents with a Disability

Summary (Weighted results):

Scotland had the highest proportion of respondents with a disability (17.9%). Of the different professions, social care workers were the most likely ones to report having a disability (25.9%).

Summary (Unweighted results):

England had the highest proportion (17.6%) of respondents with a disability. Of the different professions, social workers (17.2%) were the most likely ones to report having a disability.

Figure A2.16: Disability by Country (Weighted by Occupation)

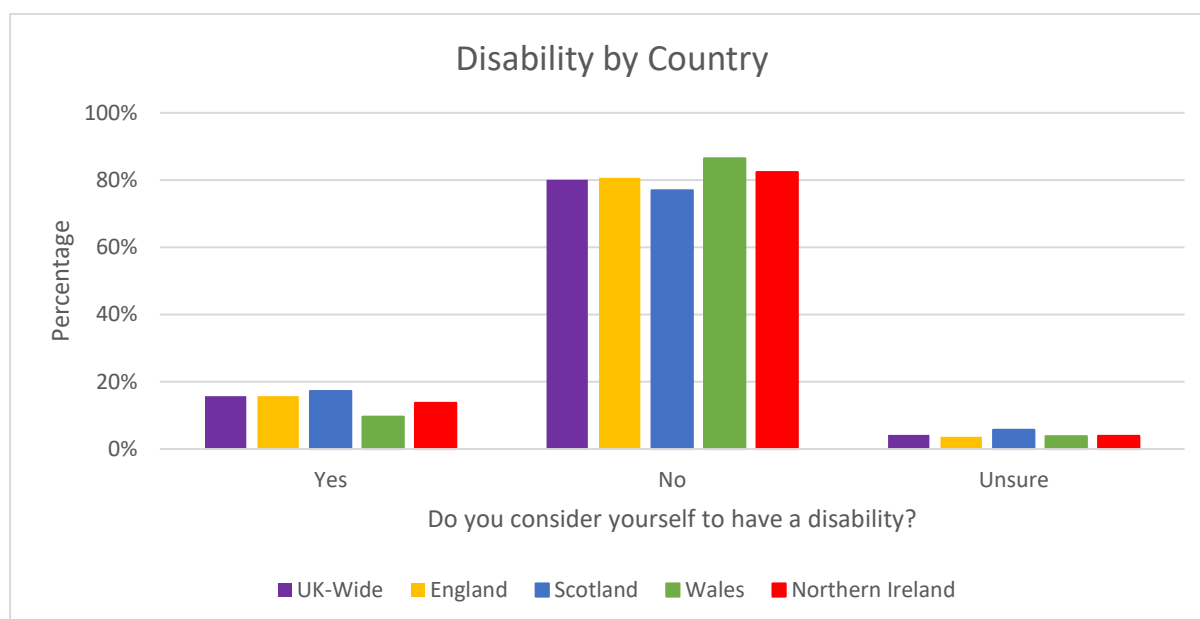


Figure A2.17: Disability by Country (Unweighted)

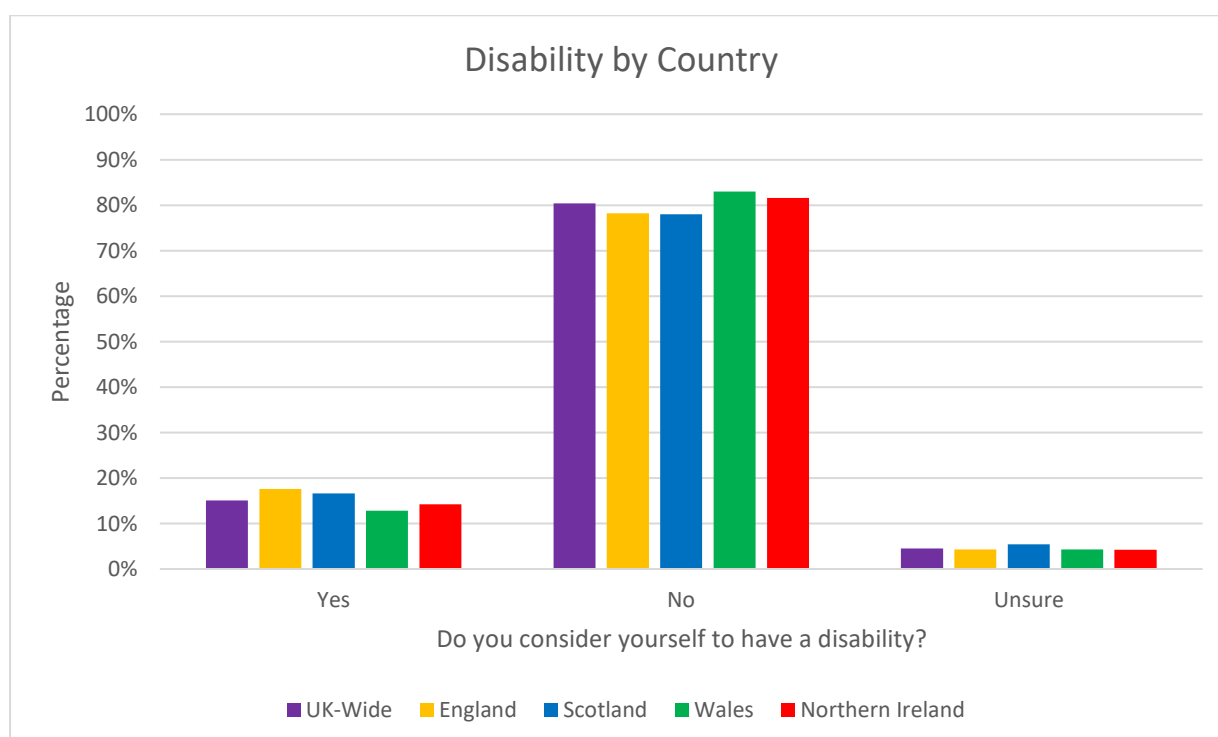


Table A2.16: Disability by Country (Weighted by Occupation)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	15.7%	15.7%	17.3%	9.6%	13.7%
No	80.1%	80.7%	77.0%	86.5%	82.4%
Unsure	4.2%	3.6%	5.7%	3.8%	3.9%
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	211 (15.1%)	33 (17.6%)	55 (16.6%)	12 (12.8%)	111 (14.2%)
No	1121 (80.4%)	147 (78.2%)	259 (78.0%)	78 (83.0%)	637 (81.6%)
Unsure	63 (4.5%)	8 (4.3%)	18 (5.4%)	4 (4.3%)	33 (4.2%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

Figure A2.18: Disability by Occupation (Weighted by Region)

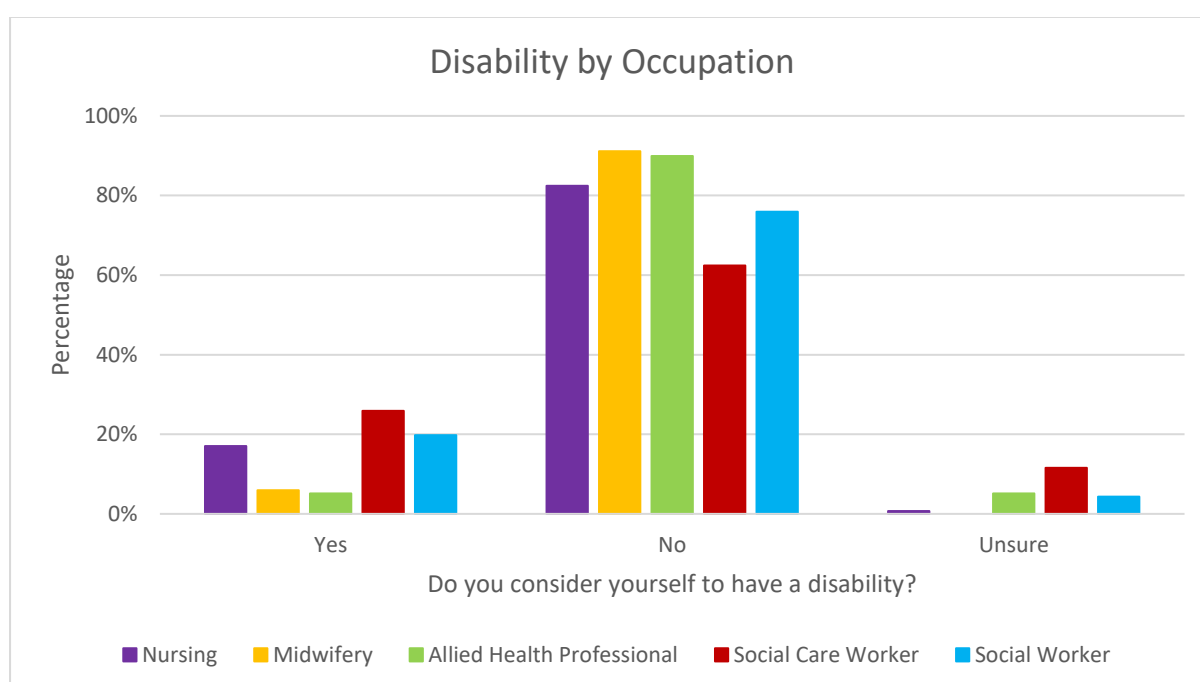


Figure A2.19: Disability by Occupation (Unweighted)

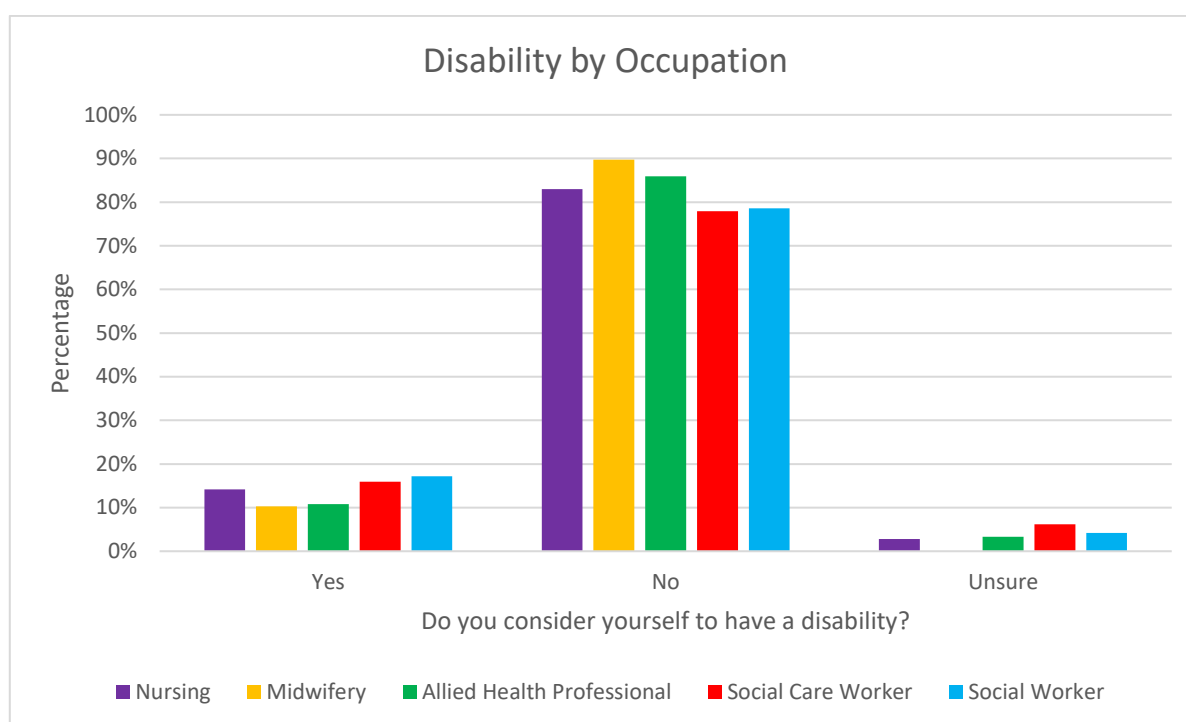


Table A2.18: Disability by Occupation (Weighted by Region)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	17.0%	82.4%	0.7%	100%
Midwifery	5.9%	91.1%	0.0%	100%
AHP	5.1%	89.9%	5.1%	100%
Social Care Worker	25.9%	62.4%	11.6%	100%
Social Worker	19.8%	75.9%	4.3%	100%

Table A2.19: Disability by Occupation (Unweighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	31 (14.2%)	181 (83.0%)	6 (2.8%)	218(100%)
Midwifery	3 (10.3%)	26 (89.7%)	0 (0.0%)	29 (100%)
AHP	23 (10.8%)	183 (85.9%)	7 (3.3%)	213 (100%)
Social Care Worker	84 (15.9%)	412 (77.9%)	33 (6.2%)	529 (100%)
Social Worker	70 (17.2%)	319 (78.6%)	17 (4.2%)	406 (100%)

A2.6 Respondents' Relationship Status

Summary (Weighted results):

Over half the respondents reported they were married (56.6%).

Summary (Unweighted results):

Over half the respondents reported they were married (57.2%).

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

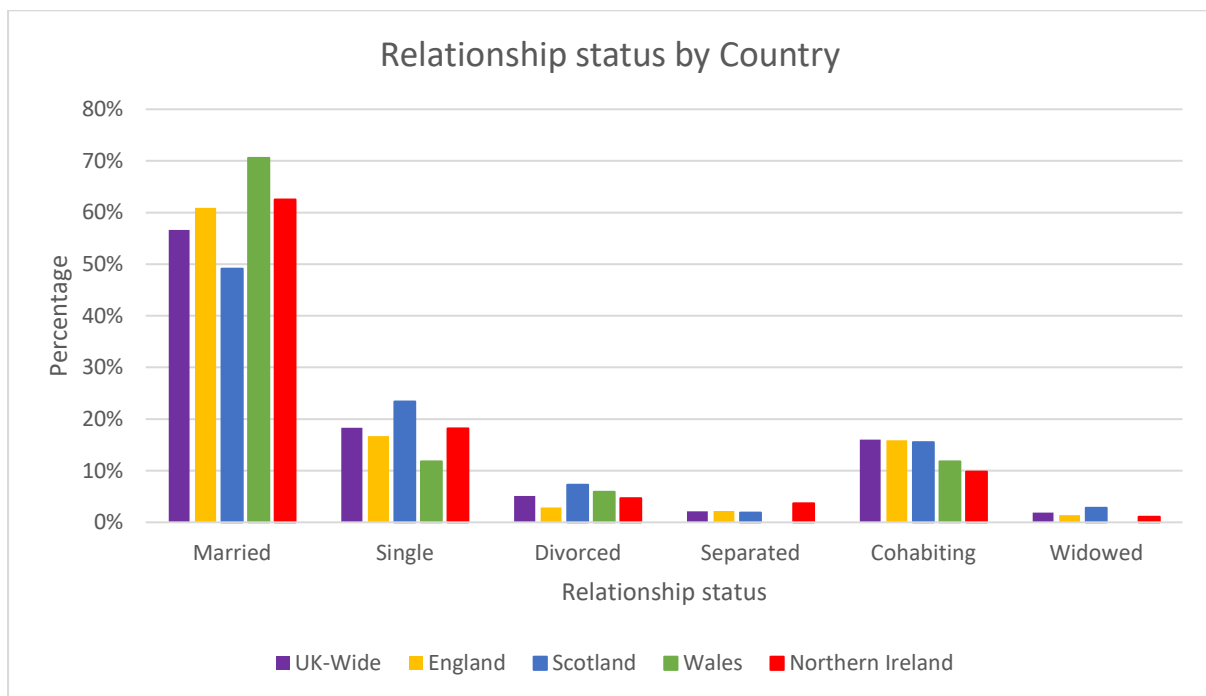


Figure A2.21: Relationship Status by Country (Unweighted)

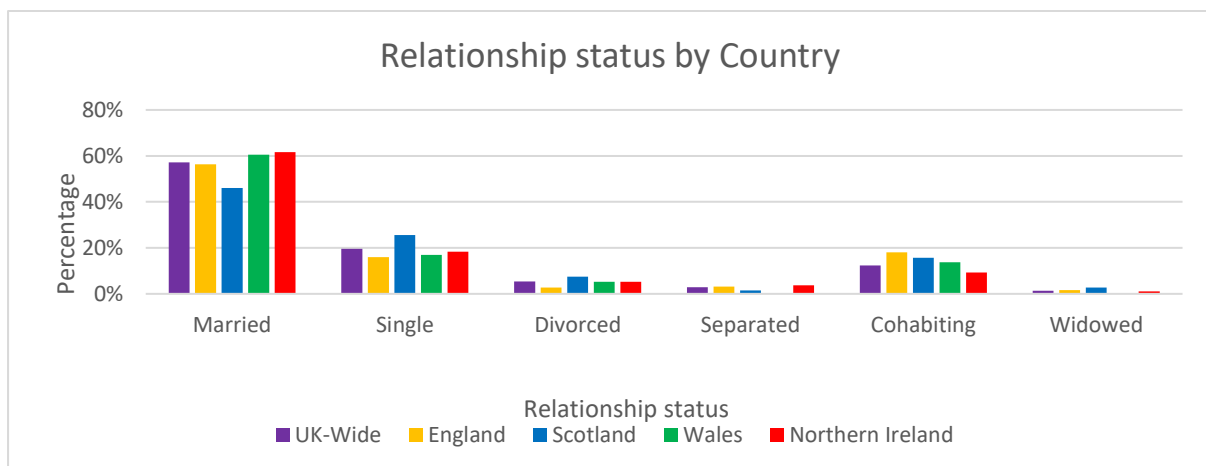


Table A2 20:: Relationship Status by Country (Weighted by Occupation)

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	56.%	60.9%	49.1%	70.6%	62.5%
Single	18.3%	16.7%	23.4%	11.8%	18.2%
Divorced	5.1%	2.9%	7.3%	5.9%	4.7%
Separated	2.1%	2.2%	1.9%	0.0%	3.7%
Cohabiting	16.0%	15.9%	15.5%	11.8%	9.8%
Widowed	1.9%	1.4%	2.8%	0.0%	1.1%
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	798 (57.2%)	106 (56.4%)	153 (46.1%)	57 (60.6%)	482 (61.7%)
Single	274 (19.6%)	30 (16.0%)	85 (25.6%)	16 (17.0%)	143 (18.3%)
Divorced	76 (5.4%)	5 (2.7%)	25 (7.5%)	5 (5.3%)	41 (5.2%)
Separated	40 (2.9%)	6 (3.2%)	5 (1.5%)	0 (0.0%)	29 (3.7%)
Cohabiting	172 (12.3%)	34 (18.1%)	52 (15.7%)	13 (13.8%)	73 (9.3%)
Widowed	20 (1.4%)	3 (1.6%)	9 (2.7%)	0 (0.0%)	8 (1.0%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

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

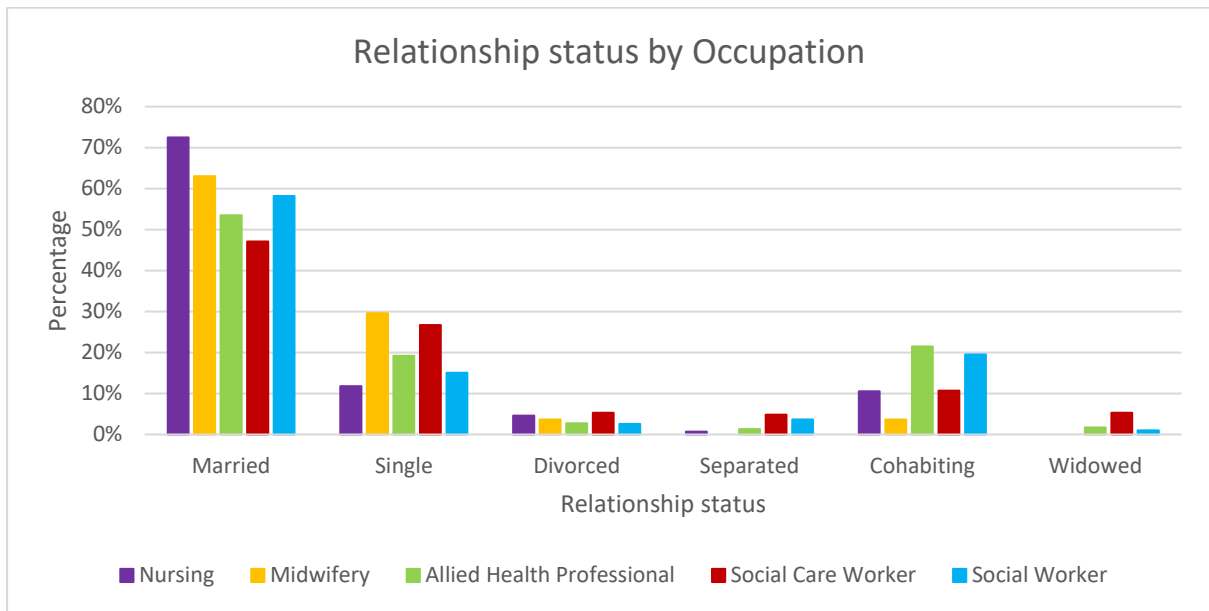


Figure A2.23: Relationship Status by Occupation (Unweighted)

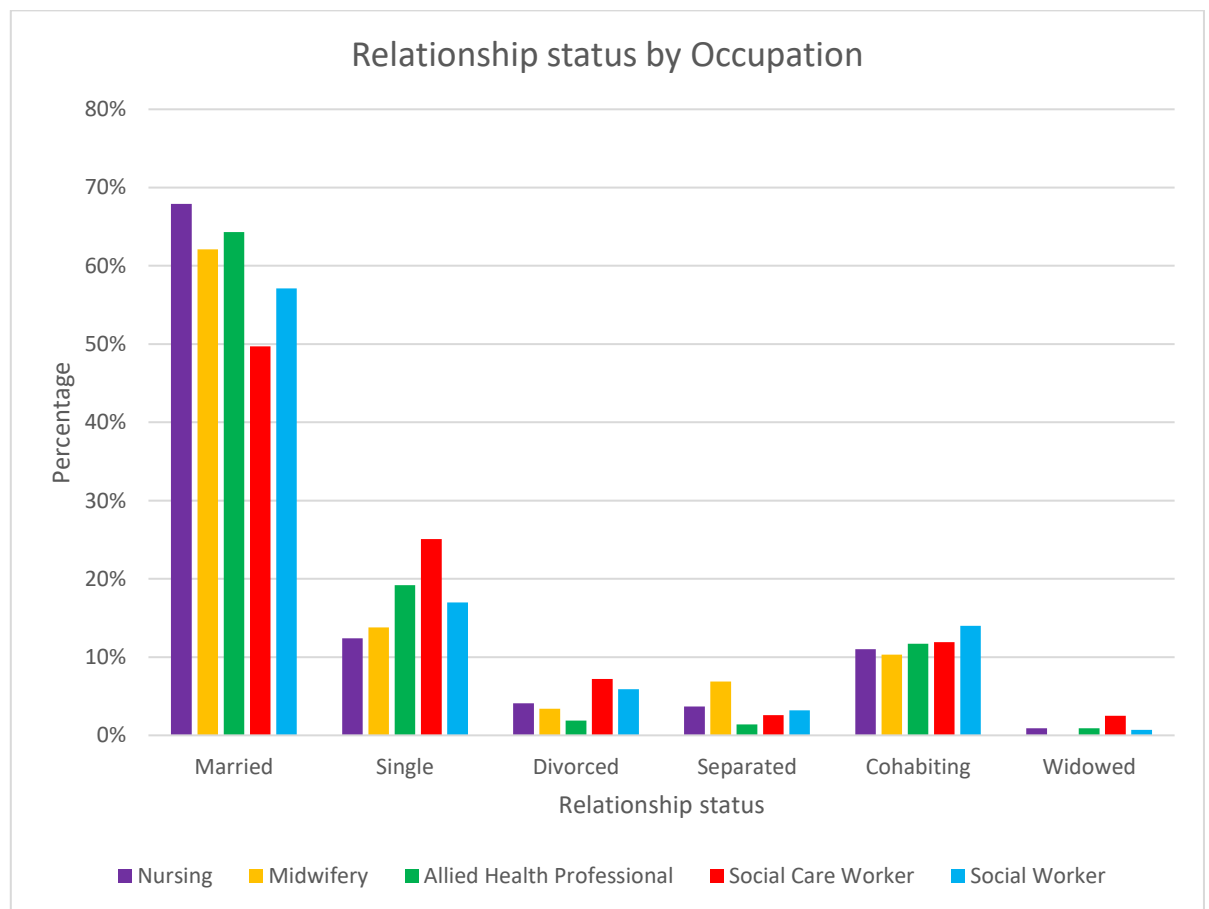


Table A2.22: Relationship Status by Occupation (Weighted by Region)

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	72.5%	11.8%	4.6%	0.7%	10.5%	0.0%	100%
Midwifery	63.0%	29.6%	3.7%	0.0%	3.7%	0.0%	100%
AHP	53.5%	19.2%	2.7%	1.3%	21.5%	1.7%	100%
Social Care Worker	47.1%	26.7%	5.3%	4.8%	10.7%	5.3%	100%
Social Worker	58.2%	15.1%	2.6%	3.7%	19.5%	1.0%	100%

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

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	148 (67.9%)	27 (12.4%)	9 (4.1%)	8 (3.7%)	24 (11.0%)	2 (0.9%)	218 (100%)
Midwifery	18 (62.1%)	4 (13.8%)	1 (3.4%)	2 (6.9%)	3 (10.3%)	0 (0.0%)	29 (100%)
AHP	137 (64.3%)	41 (19.2%)	4 (1.9%)	3 (1.4%)	25 (11.7%)	2 (0.0%)	213 (100%)
Social Care Worker	263 (49.7%)	133 (25.1%)	38 (7.2%)	14 (2.6%)	63 (11.9%)	13 (2.5%)	529 (100%)
Social Worker	232 (57.1%)	69 (17.0%)	24 (5.9%)	13 (3.2%)	57 (14.0%)	3 (0.7%)	406 (100%)

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

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

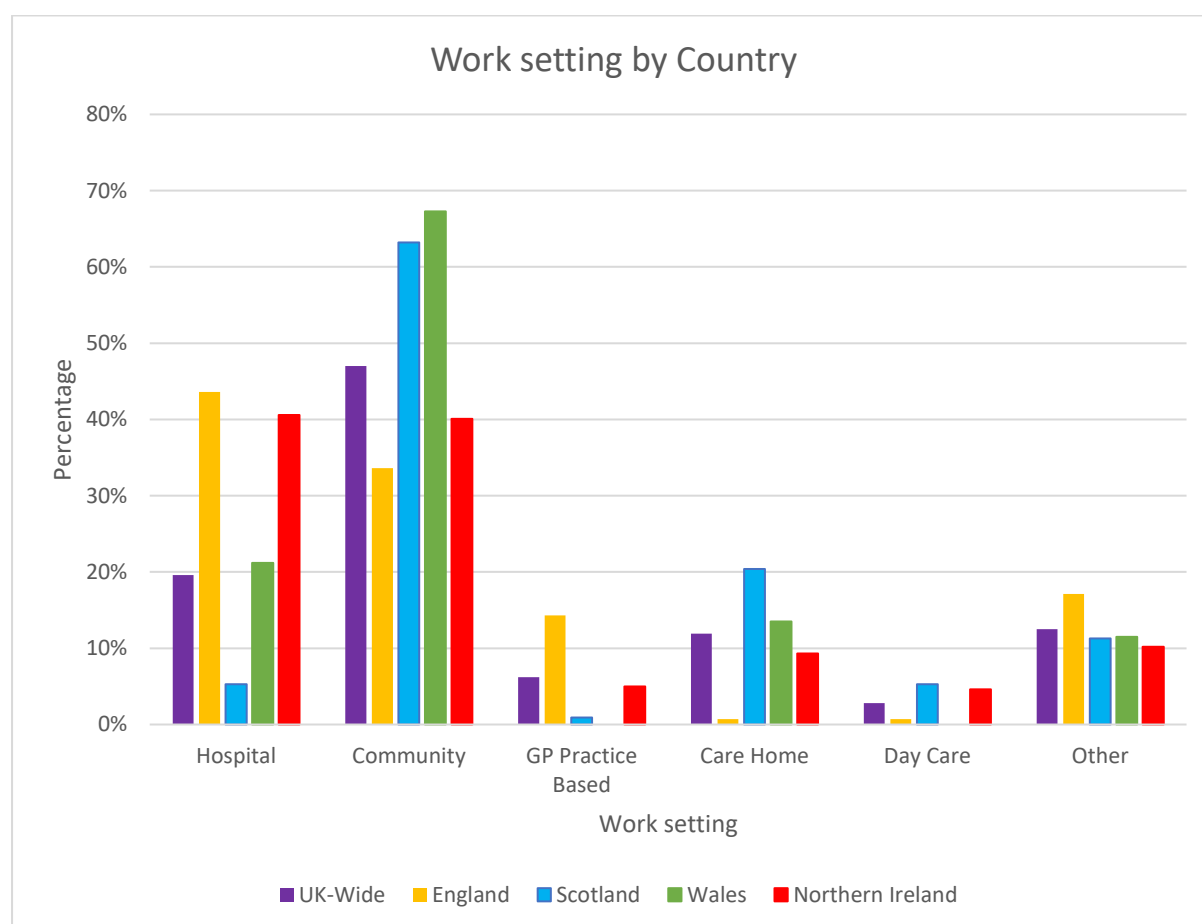


Figure A2.25: Work Setting by Country (Unweighted)

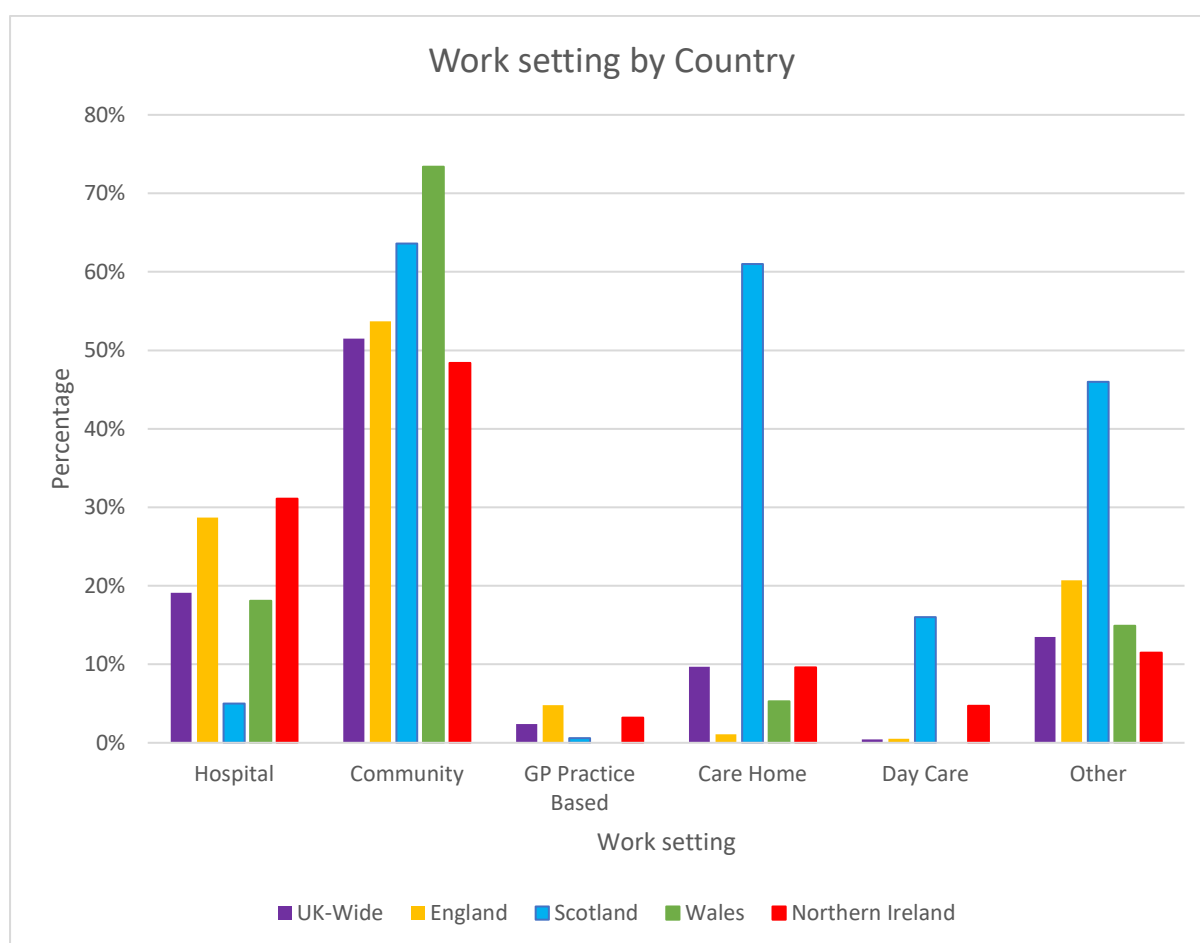


Table A2.24: Work Setting by Country (Weighted by Region)

Work setting	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	19.6%	43.6%	5.3%	21.2%	40.6%
Community	47.0%	33.6%	63.2%	67.3%	40.1%
GP Practice	6.2%	14.3%	0.9%	0.0%	5.0%
Care Home	11.9%	0.7%	20.4%	13.5%	9.3%
Day Care	2.8%	0.7%	5.3%	0.0%	4.6%
Other	12.5%	17.1%	11.3%	11.5%	10.2%

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	266 (19.1%)	54 (28.7%)	16 (5.0%)	17 (18.1%)	243 (31.1%)
Community	719 (51.5%)	101 (53.7%)	211 (63.6%)	69 (73.4%)	378 (48.4%)
GP Practice	33 (2.4%)	9 (4.8%)	2 (0.6%)	0 (0.0%)	25 (3.2%)
Care Home	136 (9.7%)	2 (1.1%)	61 (18.4%)	5 (5.3%)	75 (9.6%)
Day Care	52 (3.7%)	1 (0.5%)	16 (4.8%)	0 (0.0%)	37 (4.7%)
Other	189 (13.5%)	39 (20.7%)	46 (13.9%)	14 (14.9%)	90 (11.5%)
No. of respondents who answered the question	1395	188	332	94	781

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 by Region)

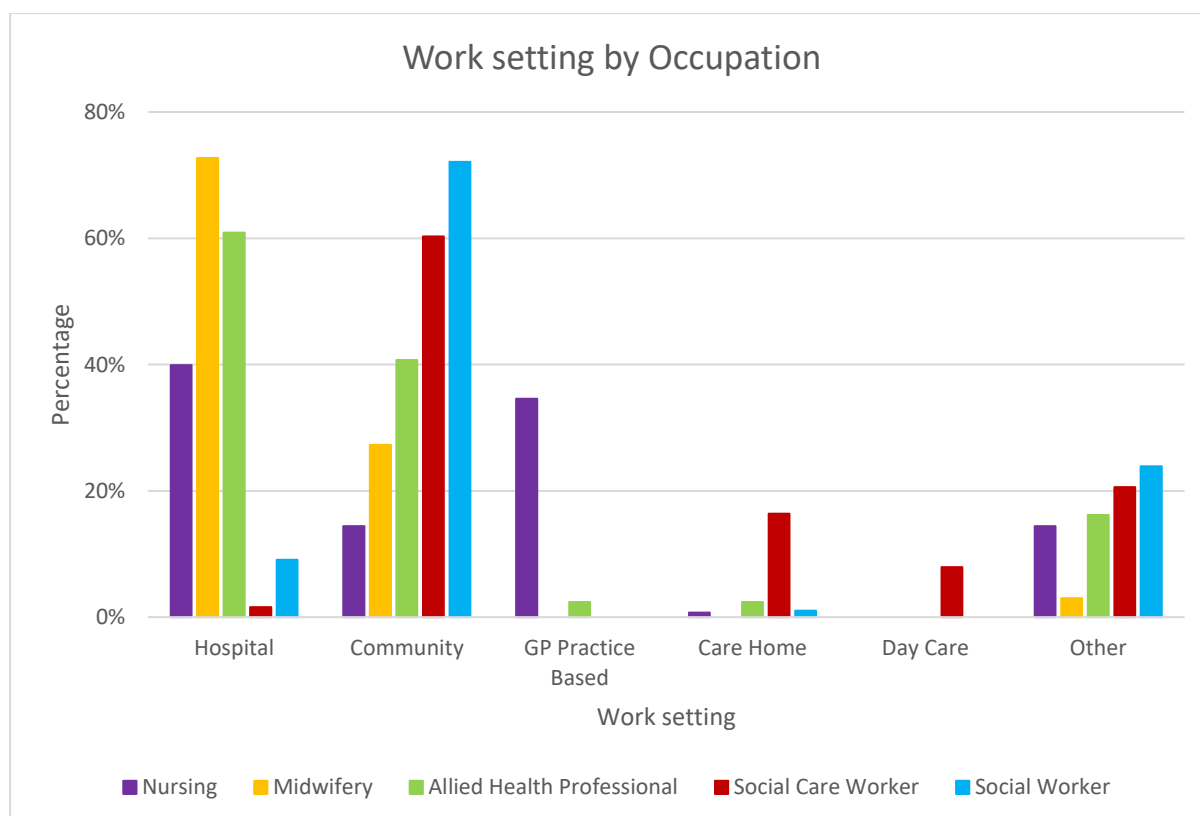


Figure A2.27: Work Setting by Occupation (Unweighted)

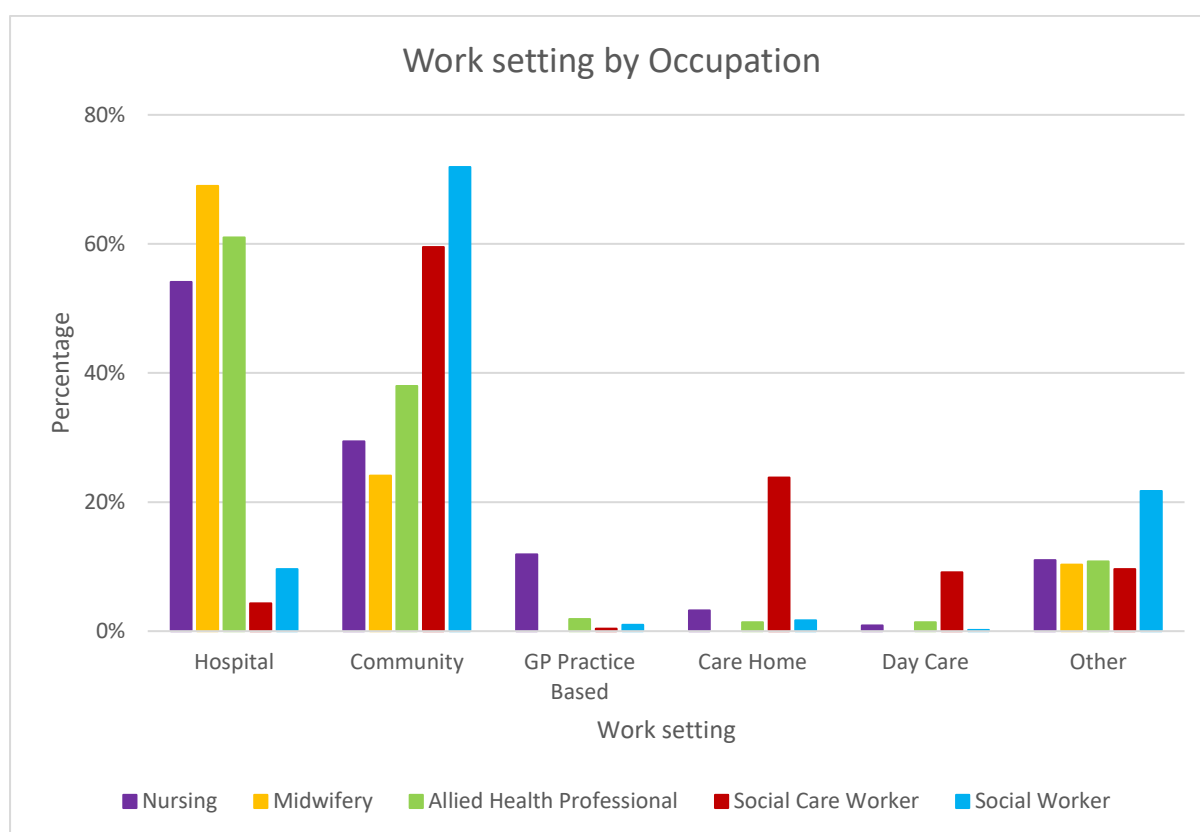


Table A2.26: Work Setting by Occupation (Weighted by Region)

Occupation	Work setting					
	Hospital	Community	GP Practice	Care Home	Day Care	Other
Nursing	39.9%	14.4%	34.6%	0.7%	0.0%	14.4%
Midwifery	72.7%	27.3%	0.0%	0.0%	0.0%	3.0%
AHP	60.9%	40.7%	2.4%	2.4%	0.0%	16.2%
Social Care Worker	1.6%	60.3%	0.0%	16.4%	7.9%	20.6%
Social Worker	9.1%	72.1%	0.0%	1.0%	0.0%	23.9%

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

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

Occupation	Work setting						No. of respondents who answered the question
	Hospital	Community	GP Practice	Care Home	Day Care	Other	
Nursing	118 (54.1%)	64 (29.4%)	26 (11.9%)	7 (3.2%)	2 (0.9%)	24 (11.0%)	218
Midwifery	20 (69.0%)	7 (24.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (10.3%)	29
AHP	130 (61.0%)	81 (38.0%)	4 (1.9%)	3 (1.4%)	3 (1.4%)	23 (10.8%)	213
Social Care Worker	23 (4.3%)	315 (59.5%)	2 (0.4%)	126 (23.8%)	48 (9.1%)	51 (9.6%)	529
Social Worker	39 (9.6%)	292 (71.9%)	4 (1.0%)	7 (1.7%)	1 (0.2%)	88 (21.7%)	406

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

A2.8 Health and Social Care Sector of Respondents

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

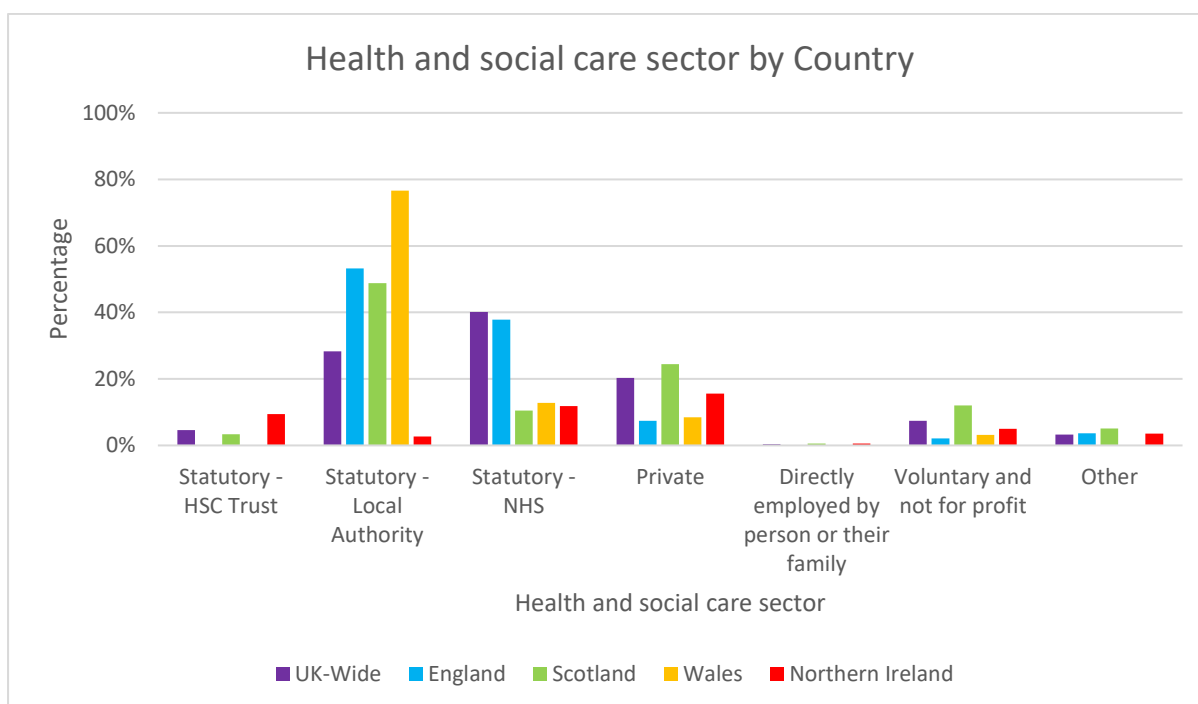


Figure A2.29: Health and Social Care Sector of Respondents by Country (Unweighted)

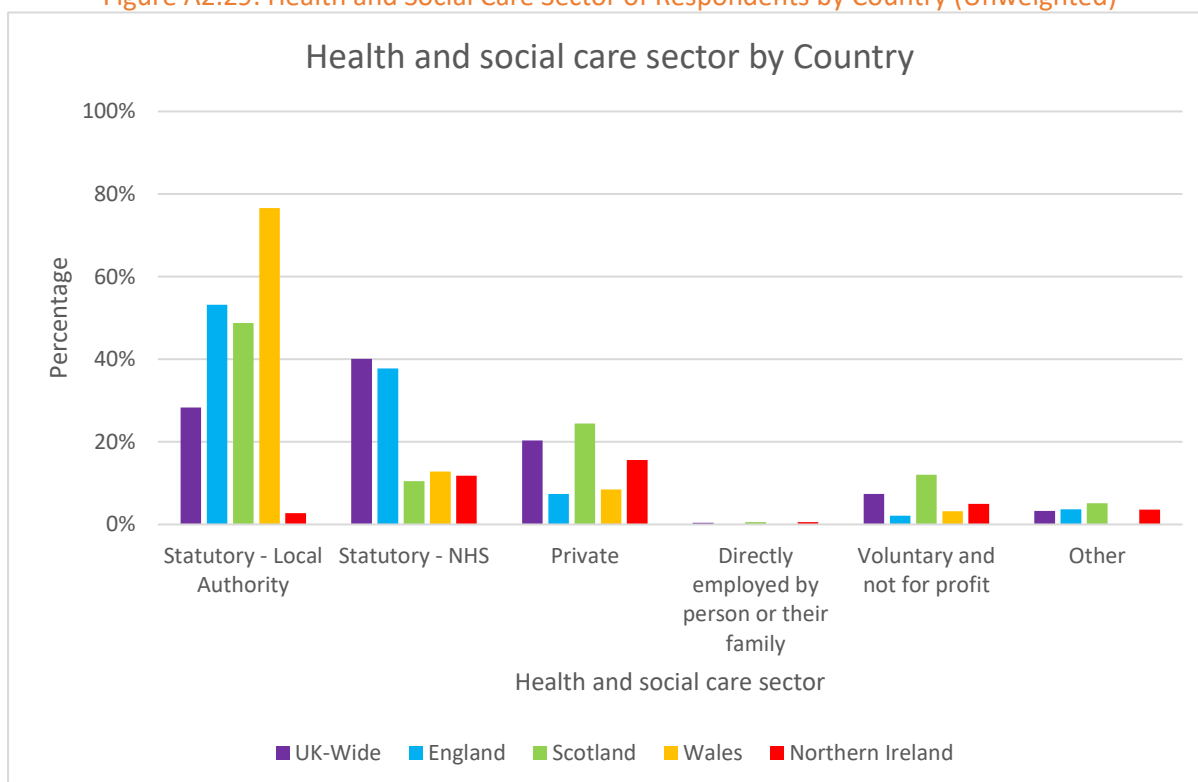


Table A2.28: Health and Social Care Sector of Respondents by Country (Weighted by Occupation)

Health and social care sector	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Statutory – HSC Trust	4.6%	0.0%	3.5%	0.0%	66.9%
Statutory – Local Authority	28.3%	25.7%	37.7%	53.8%	2.0%
Statutory – NHS	40.1%	65.7%	16.4%	21.2%	14.4%
Private	20.3%	10.0%	27.4%	21.2%	15.6%
Directly employed by person or their family	0.4%	0.0%	0.6%	0.0%	0.6%
Voluntary and not for profit	7.4%	2.1%	13.5%	3.8%	3.4%
Other	3.3%	2.1%	5.0%	0.0%	3.1%

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

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

Health and social care sector	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Statutory – HSC Trust	532 (38.1%)	0 (0.0%)	11 (3.4%)	0 (0.0%)	521 (66.7%)
Statutory – Local Authority	355 (25.4%)	100 (53.2%)	162 (48.8%)	72 (76.6%)	21 (2.7%)
Statutory – NHS	210 (15.1%)	71 (37.8%)	35 (10.5%)	12 (12.8%)	92 (11.8%)
Private	225 (16.1%)	14 (7.4%)	81 (24.4%)	8 (8.5%)	122 (15.6%)
Directly employed by person or their family	7 (0.5%)	0 (0.0%)	2 (0.6%)	0 (0.0%)	5 (0.6%)
Voluntary and not for profit	86 (6.2%)	4 (2.1%)	40 (12.0%)	3 (3.2%)	39 (5.0%)
Other	52 (3.7%)	7 (3.7%)	17 (5.1%)	0 (0.0%)	28 (3.6%)
No. of respondents who answered the question	1395	188	332	94	781

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 by Region)

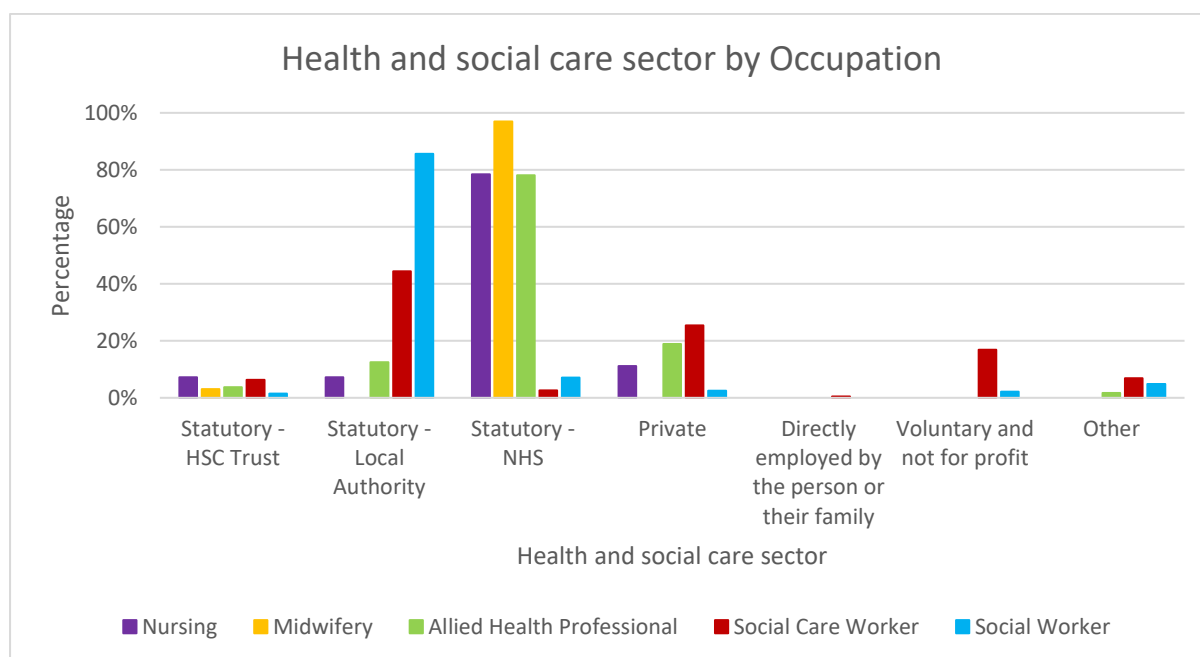


Figure A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)

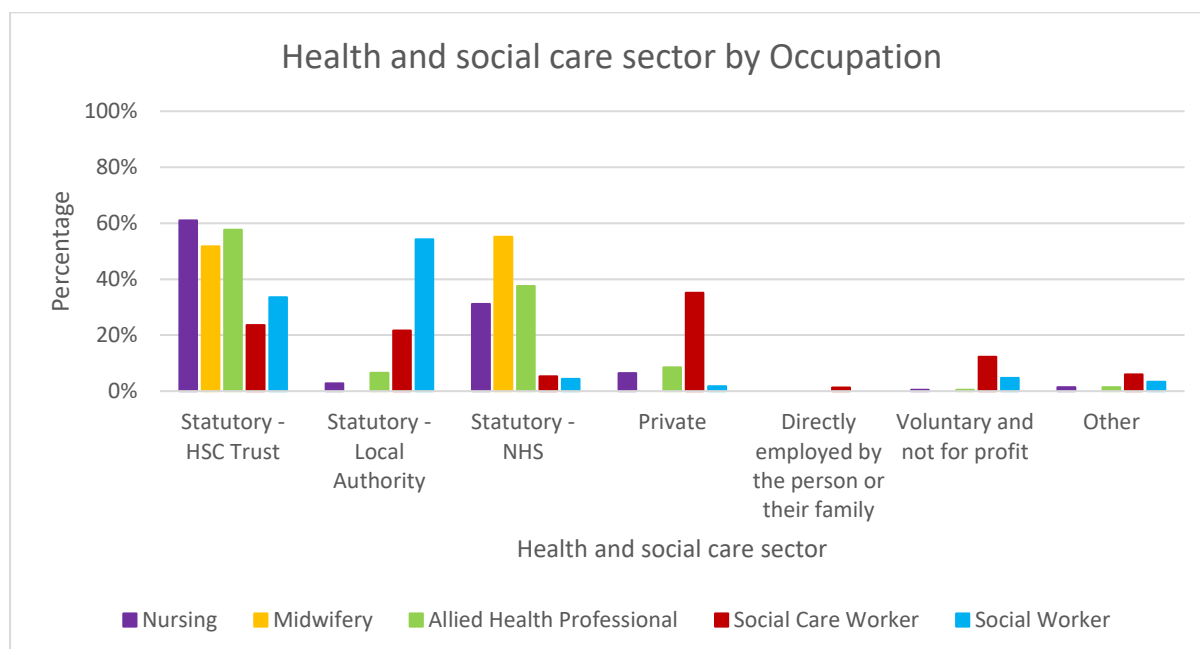


Table A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)

Occupation	Health and social care sector						
	Statutory – HSC Trust	Statutory – Local Authority	Statutory – NHS	Private	Directly employed by the person or their family	Voluntary and not for profit	Other
Nursing	7.2%	7.2%	78.4%	11.1%	0.0%	0.0%	0.0%
Midwifery	3.0%	0.0%	97.0%	0.0%	0.0%	0.0%	0.0%
AHP	3.7%	12.5%	78.1%	18.9%	0.0%	0.0%	1.7%
Social Care Worker	6.3%	44.4%	2.6%	25.4%	0.5%	16.9%	6.9%
Social Worker	1.5%	85.6%	7.1%	2.5%	0.0%	2.2%	4.8%

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

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

Occupation	Health and social care sector							No. of respondents who answered the question
	Statutory – HSC Trust	Statutory – Local Authority	Statutory – NHS	Private	Directly employed by the person or their family	Voluntary and not for profit	Other	
Nursing	133 (61.0%)	6 (2.8%)	68 (31.2%)	14 (6.4%)	0 (0.0%)	1 (0.5%)	3 (1.4%)	218
Midwifery	15 (51.7%)	0 (0.0%)	16 (55.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	29
AHP	123 (57.7%)	14 (6.6%)	80 (37.6%)	18 (8.5%)	0 (0.0%)	1 (0.5%)	3 (1.4%)	213
Social Care Worker	125 (23.6%)	115 (21.7%)	28 (5.3%)	186 (35.2%)	7 (1.3%)	65 (12.3%)	32 (6.0%)	529
Social Worker	136 (33.5%)	220 (54.2%)	18 (4.4%)	7 (1.7%)	0 (0.0%)	19 (4.7%)	14 (3.4%)	406

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):

More than half of respondents were not line managers.

Summary (Unweighted results):

Over two thirds of respondents were not line managers.

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

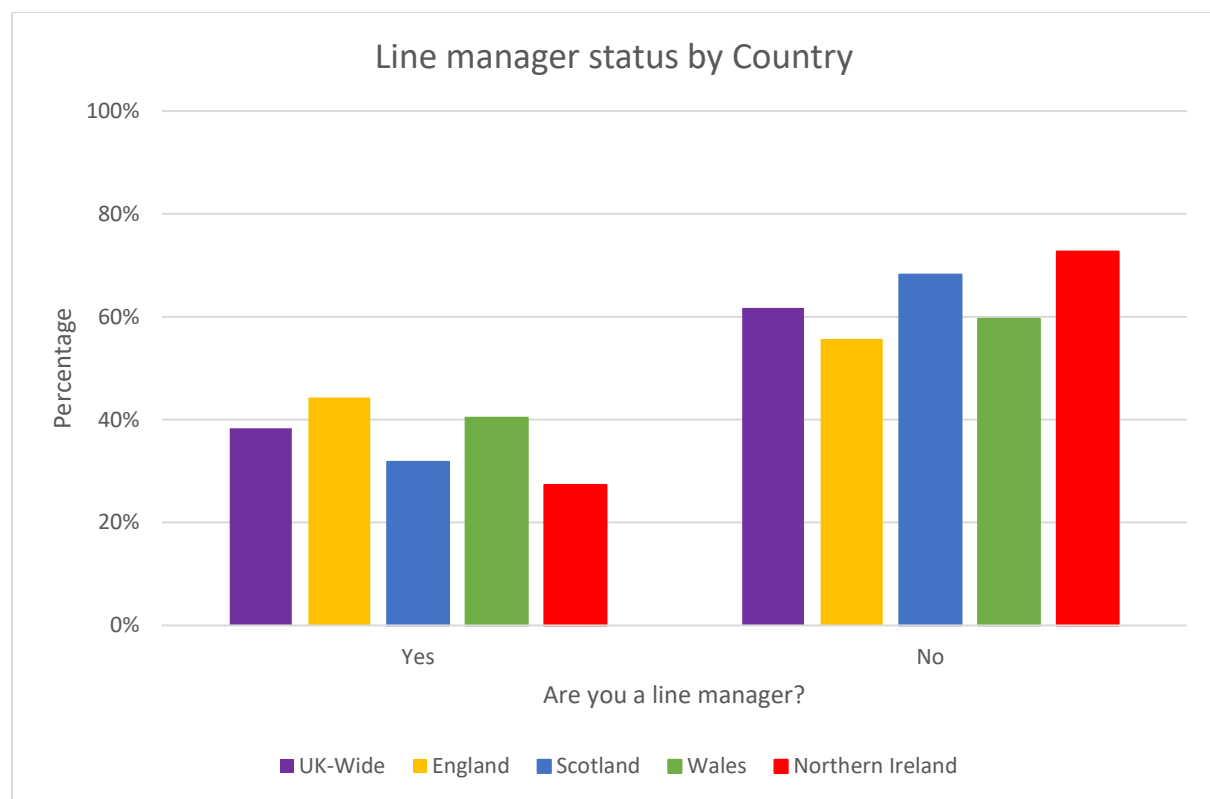


Figure A2.33: Line Manager Status of Respondents by Country (Unweighted)

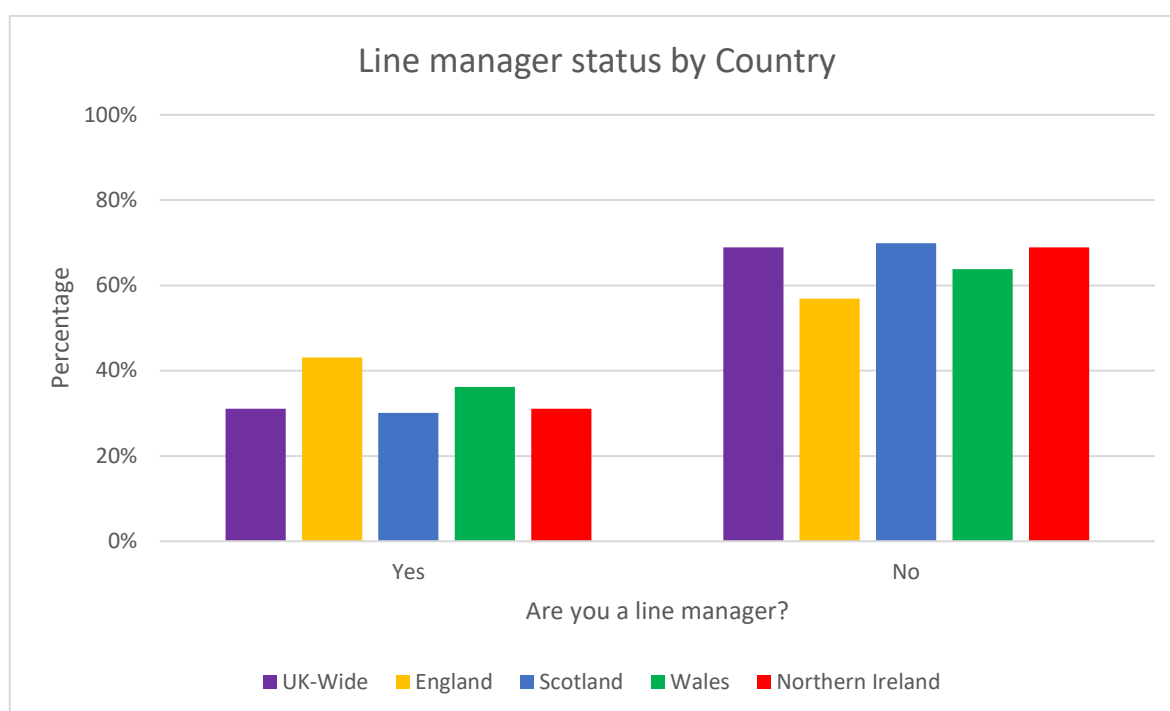


Table A2.32: Line Manager Status of Respondents by Country (Weighted by Occupation)

Are you a line manager?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	38.3%	44.3%	31.8%	40.4%	27.3%
No	61.7%	55.7%	68.2%	59.6%	72.7%
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	434 (31.1%)	81 (43.1%)	100 (30.1%)	34 (36.2%)	219 (28.0%)
No	961 (68.9%)	107 (56.9%)	232 (69.9%)	60 (63.8%)	562 (72.0%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

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

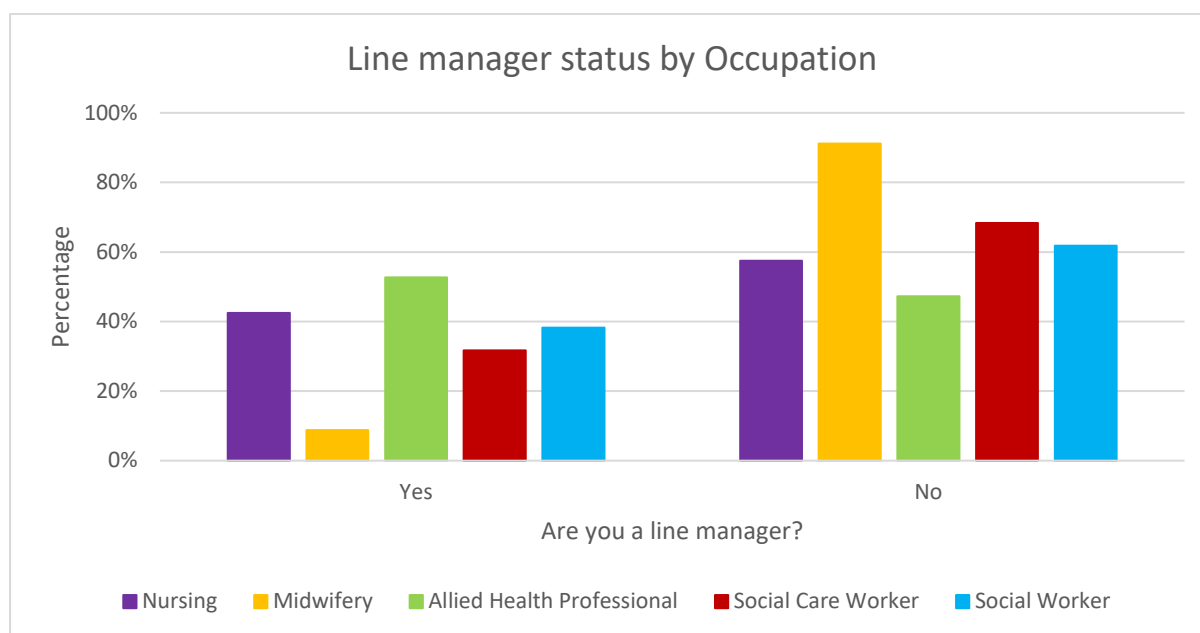


Figure A2.35: Line Manager Status of Respondents by Occupation (Unweighted)

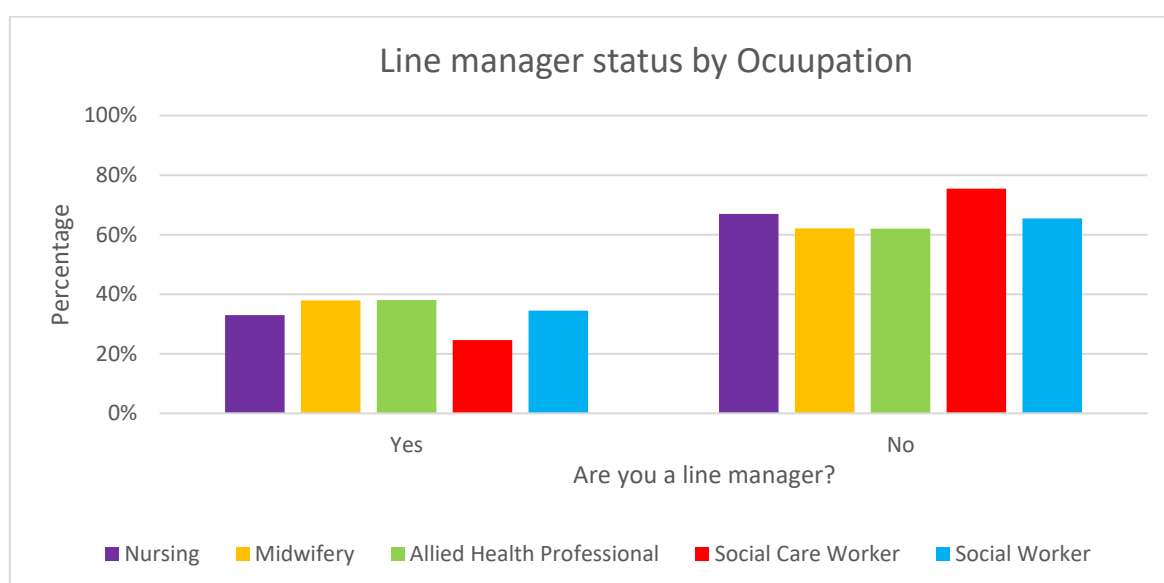


Table A2.34: Line Manager Status of Respondents by Occupation (Weighted by Region)

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	42.5%	57.5%	100%
Midwifery	8.8%	91.2%	100%
AHP	52.7%	47.3%	100%
Social Care Worker	31.7%	68.3%	100%
Social Worker	38.2%	61.8%	100%

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

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	72 (33.0%)	146 (67.0%)	218 (100%)
Midwifery	11 (37.9%)	18 (62.1%)	29 (100%)
AHP	81 (38.0%)	132 (62.0%)	213 (100%)
Social Care Worker	130 (24.6%)	399 (75.4%)	529 (100%)
Social Worker	140 (34.5%)	266 (65.5%)	406 (100%)

A2.10 Job Tenure of Respondents

Summary (Weighted results):

The majority of respondents were employed on a permanent basis.

Summary (Unweighted results):

The majority of respondents were employed on a permanent basis.

Figure A2. 36: Job Tenure by Country (Weighted by Occupation)

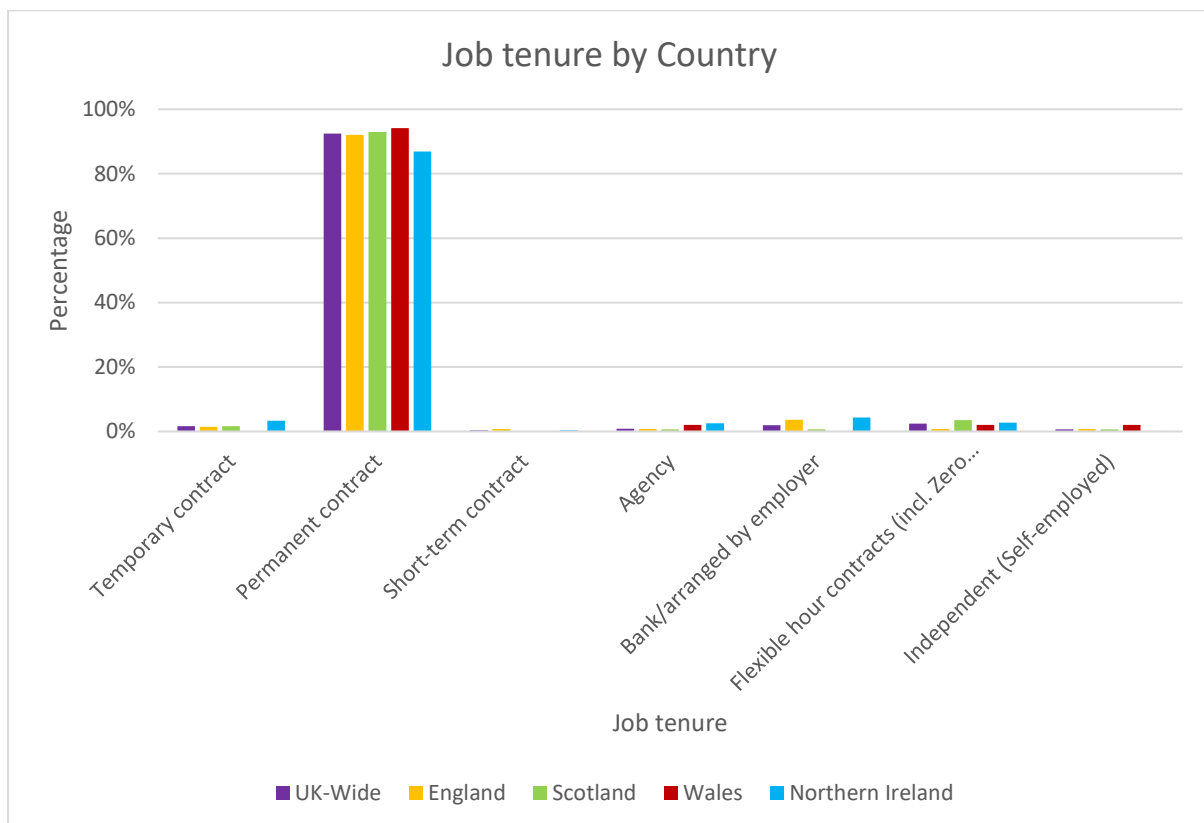


Figure A2. 37: Job Tenure by Country (Unweighted)

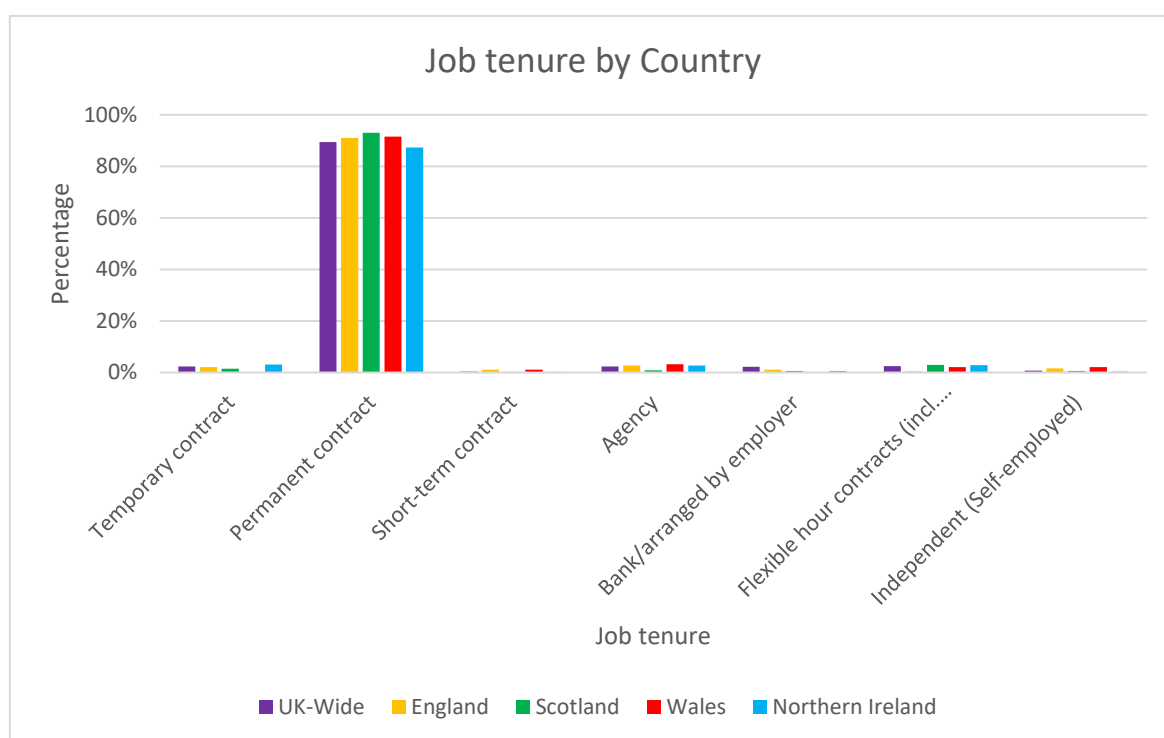


Table A2. 36: Job Tenure by Country (Weighted by Occupation)

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary	1.6%	1.4%	1.6%	0.0%	3.3%
Permanent	92.3%	92.1%	93.0%	94.1%	86.9%
Agency	.3%	0.7%	0.6%	2.0%	2.5%
Bank	.8%	3.6%	0.6%	0.0%	4.3%
Flexible (zero hours)	1.9%	0.7%	3.5%	2.0%	2.7%
Independent (Self-employed)	2.4%	0.7%	0.6%	2.0%	0.1%
Total	100%	100%	100%	100%	100%

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

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary contract	33 (2.4%)	4 (2.1%)	5 (1.5%)	0 (0.0%)	24 (3.1%)
Permanent contract	1246 (89.4%)	171 (91.0%)	308 (93.1%)	86 (91.5%)	681 (87.3%)
Short-term contract	6 (0.4%)	2 (1.1%)	1 (0.3%)	1 (1.1%)	2 (0.3%)
Agency	32 (2.3%)	5 (2.7%)	3 (0.9%)	3 (3.2%)	21 (2.7%)
Bank/arranged by employer	31 (2.2%)	2 (1.1%)	2 (0.6%)	0 (0.0%)	27 (3.5%)
Flexible hour contracts (incl. Zero hour contracts)	35 (2.5%)	1 (0.5%)	10 (3.0%)	2 (2.1%)	22 (2.8%)
Independent (Self-employed)	10 (0.7%)	3 (1.6%)	2 (0.6%)	2 (2.1%)	3 (0.4%)
Total	1393 (100%)	188 (100%)	331 (100%)	94 (100%)	780 (100%)

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

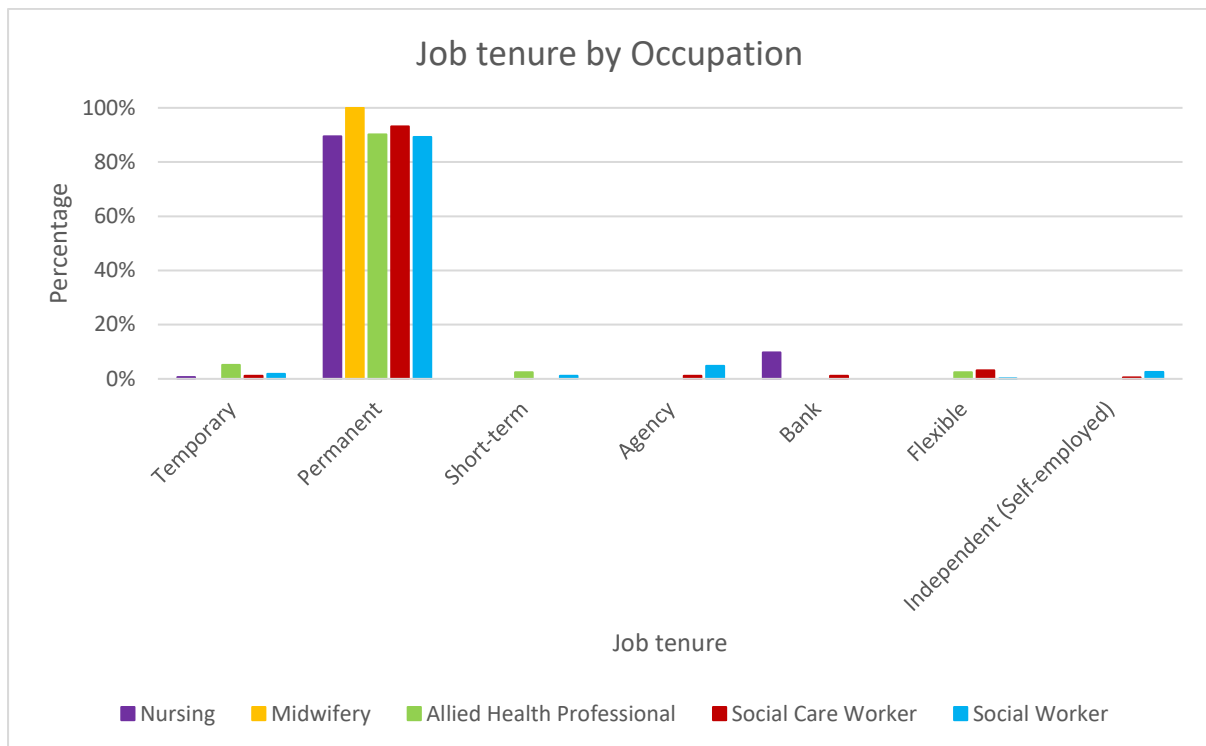


Figure A2. 39: Job Tenure by Occupation (Unweighted)

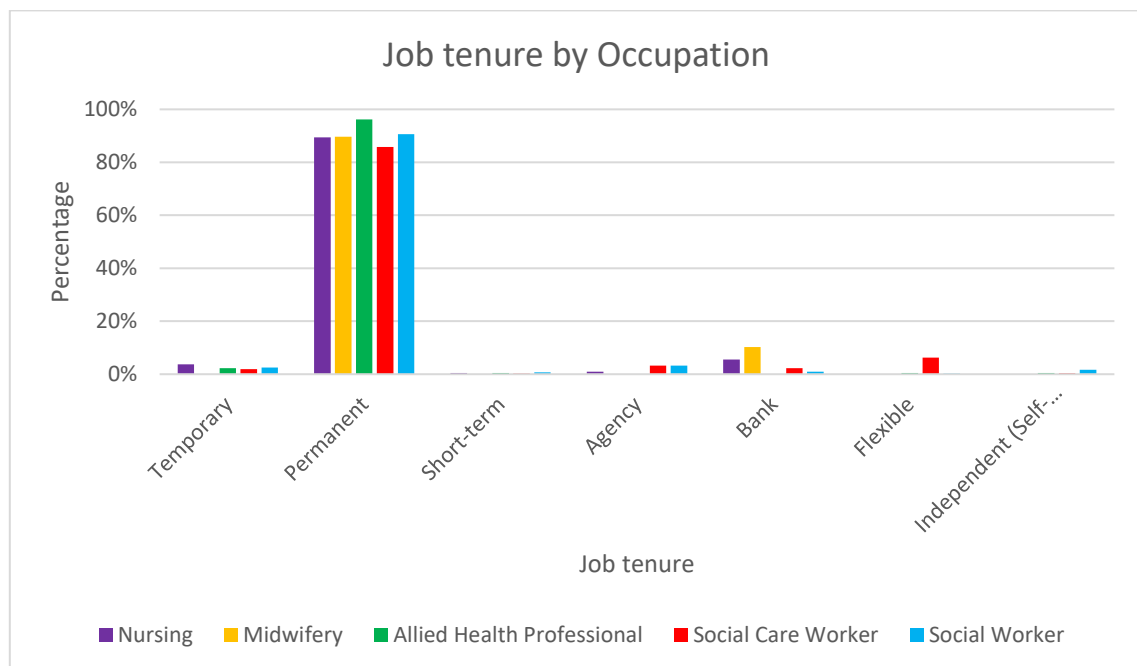


Table A2. 38: Job Tenure by Occupation (Weighted by Region)

Occupation	Job tenure							Total
	Temporary contract	Permanent contract	Short-term contract	Agency	Bank/arranged by employer	Flexible hour contracts (incl. Zero hour contracts)	Independent (Self-employed)	
Nursing	0.7%	89.5%	0.0%	0.0%	9.8%	0.0%	0.0%	100%
Midwifery	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%
AHP	5.1%	90.2%	2.4%	0.0%	0.0%	2.4%	0.0%	100%
Social Care Worker	1.1%	93.1%	0.0%	1.1%	1.1%	3.2%	0.5%	100%
Social Worker	1.9%	89.3%	1.1%	4.8%	0.0%	0.1%	2.6%	100%

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

Occupation	Job tenure							Total
	Temporary contract	Permanent contract	Short-term contract	Agency	Bank/arranged by employer	Flexible hour contracts (incl. Zero hour contracts)	Independent (Self-employed)	
Nursing	8 (3.7%)	194 (89.4%)	1 (0.5%)	2 (0.9%)	12 (5.5%)	0 (0.0%)	0 (0.0%)	217 (100%)
Midwifery	0 (0.0%)	26 (89.7%)	0 (0.0%)	0 (0.0%)	3 (10.3%)	0 (0.0%)	0 (0.0%)	29 (100%)
AHP	5 (2.3%)	205 (96.2%)	1 (0.5%)	0 (0.0%)	0 (0.0%)	1 (0.5%)	1 (0.5%)	213 (100%)
Social Care Worker	10 (1.9%)	453 (85.8%)	1 (0.2%)	17 (3.2%)	12 (2.3%)	33 (6.3%)	2 (0.4%)	528 (100%)
Social Worker	10 (2.5%)	368 (90.6%)	3 (0.7%)	13 (3.2%)	4 (1.0%)	1 (0.2%)	7 (1.7%)	406 (100%)

A2.17 Respondents Employed Full- or Part-Time

Summary (Weighted results):

The majority of respondents were employed full-time. Northern Ireland had the highest proportion of respondents employed on a part-time basis. Midwifery had the highest proportion employed full-time, whereas nursing had the highest proportion employed part-time.

Summary (Unweighted results):

The majority of respondents were employed full-time (75.1%). Northern Ireland had the highest proportion of respondents (26.8%) employed on a part-time basis. Midwifery had the highest proportion employed full-time, whereas nursing had the highest proportion employed part-time.

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

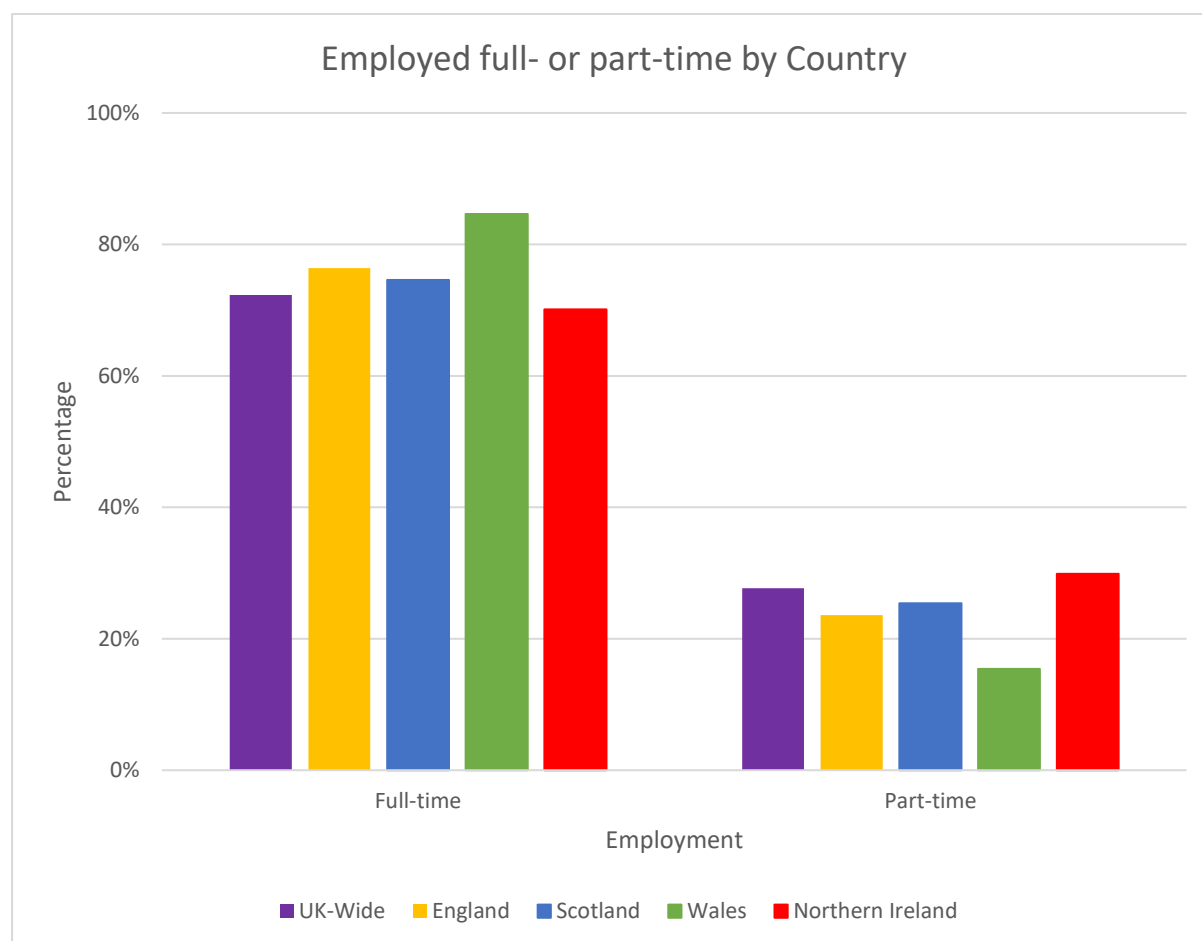


Figure A2. 41: Employed Full- or Part-Time by Country (Unweighted)

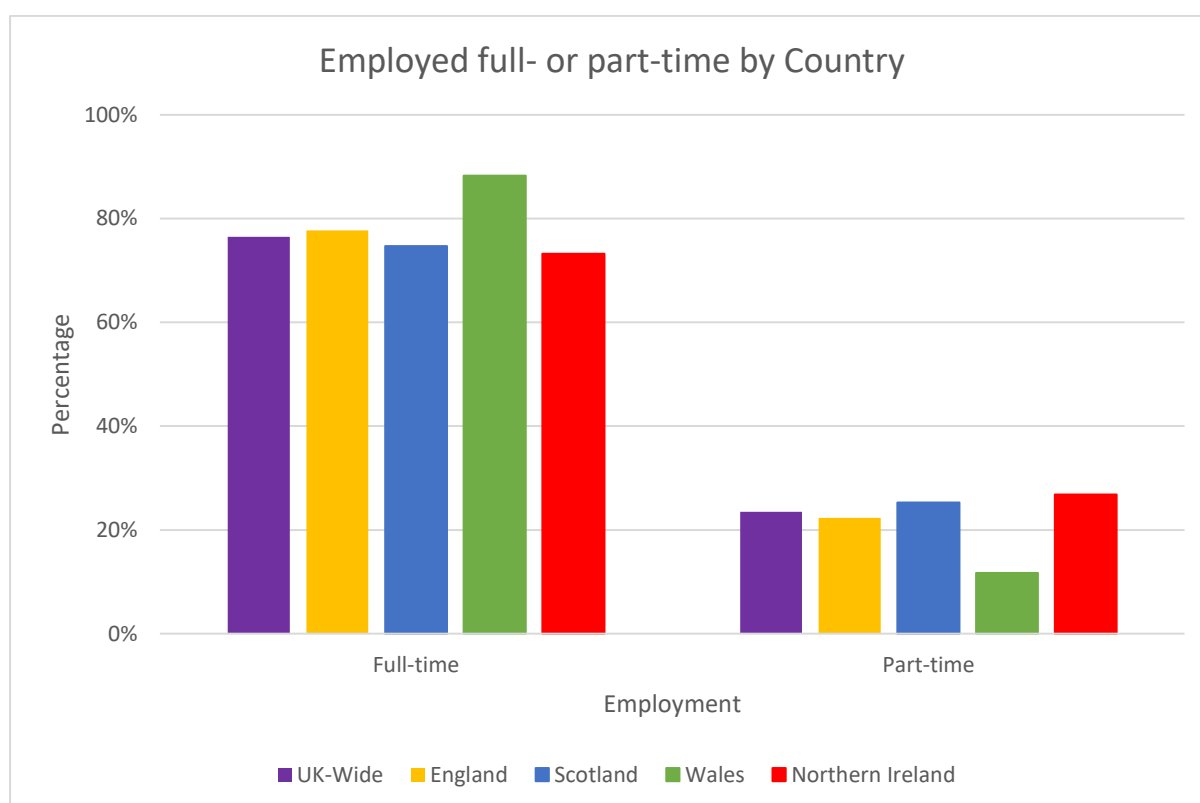


Table A2. 40: Employed Full- or Part-Time by Country (Weighted by Occupation)

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	76.5%	76.4%	74.6%	84.6%	70.1%
Part-time	23.5%	23.6%	25.4%	15.4%	29.9%
Total	100%	100%	100%	100%	100%

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

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	1048 (75.2%)	146 (77.7%)	248 (74.7%)	83 (88.3%)	571 (73.2%)
Part-time	346 (24.8%)	42 (22.3%)	84 (25.3%)	11 (11.7%)	209 (26.8%)
Total	1394 (100%)	188 (100%)	332 (100%)	94 (100%)	780 (100%)

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

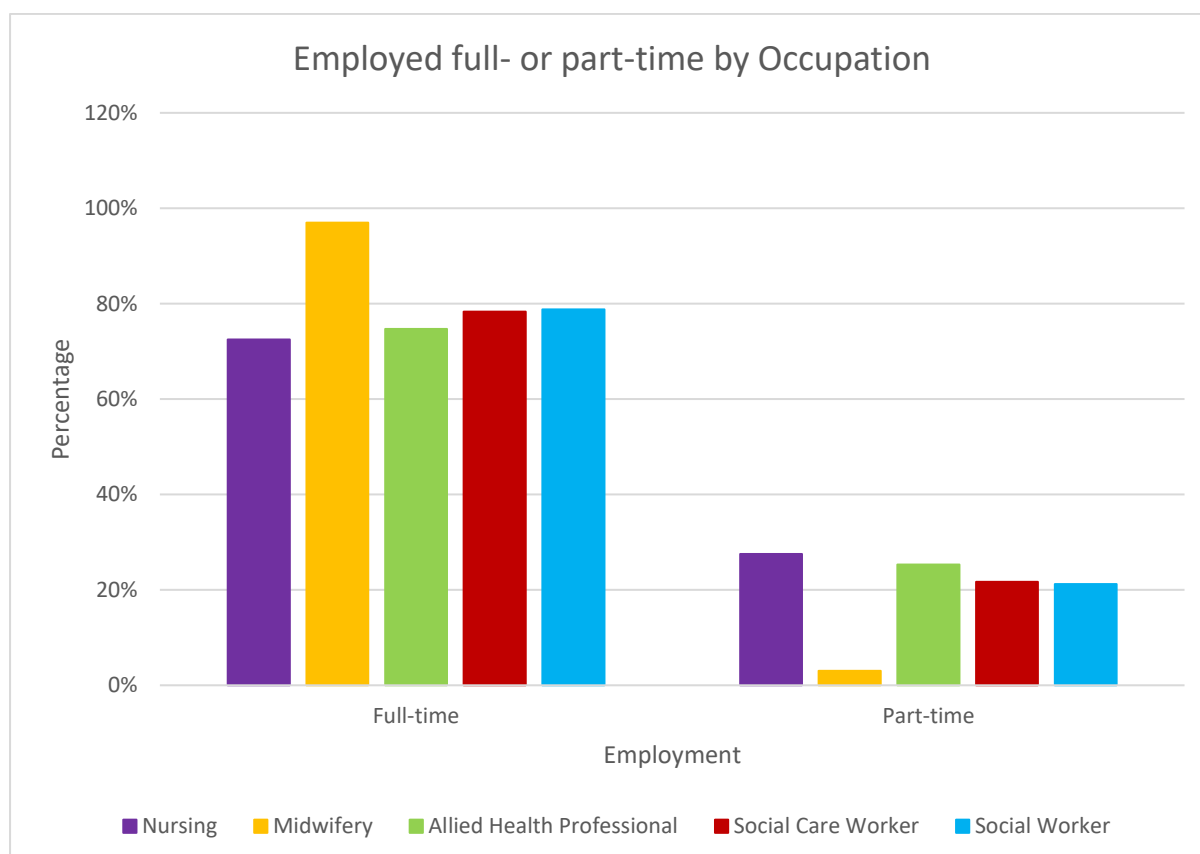


Figure A2. 43: Employed Full- or Part-Time by Occupation (Unweighted)

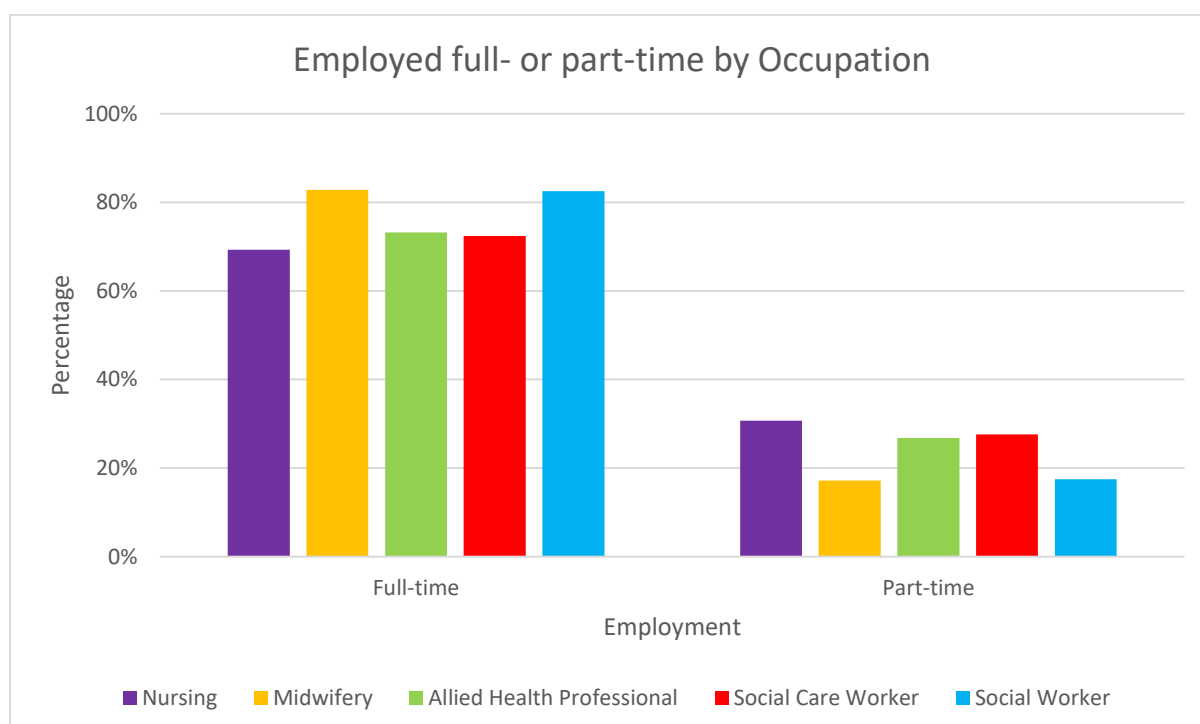


Table A2. 42: Employed Full- or Part-Time by Occupation (Weighted by Region)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	72.5%	27.5%	100%
Midwifery	97.0%	3.0%	100%
AHP	74.7%	25.3%	100%
Social Care Worker	78.3%	21.7%	100%
Social Worker	78.8%	21.2%	100%

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

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	151 (69.3%)	67 (30.7%)	218 (100%)
Midwifery	24 (82.8%)	5 (17.2%)	29 (100%)
AHP	156 (73.2%)	57 (26.8%)	213 (100%)
Social Care Worker	383 (72.4%)	146 (27.6%)	529 (100%)
Social Worker	334 (82.5%)	71 (17.5%)	405 (100%)

A2.18 Respondents' Number of Hours Worked per Week

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

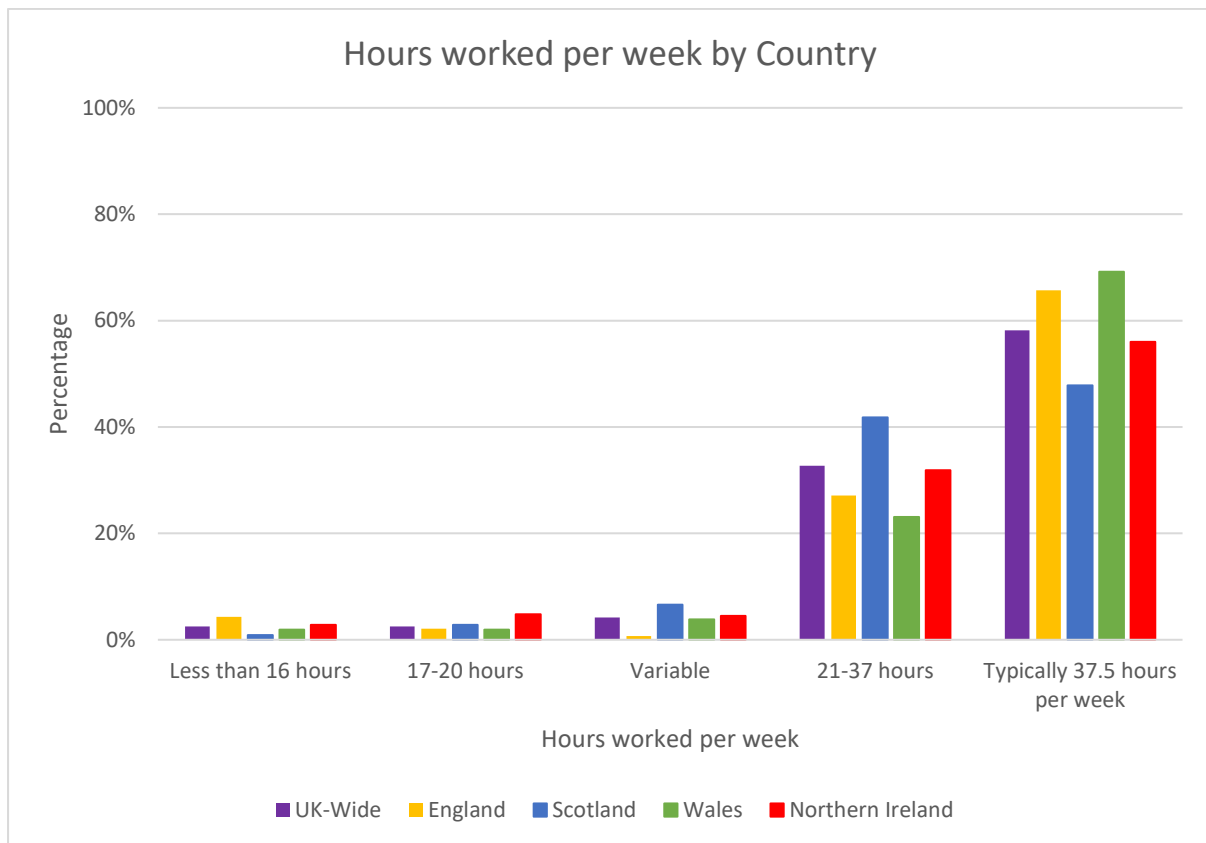


Figure A2. 45: Number of Hours Worked per Week by Country (Unweighted)

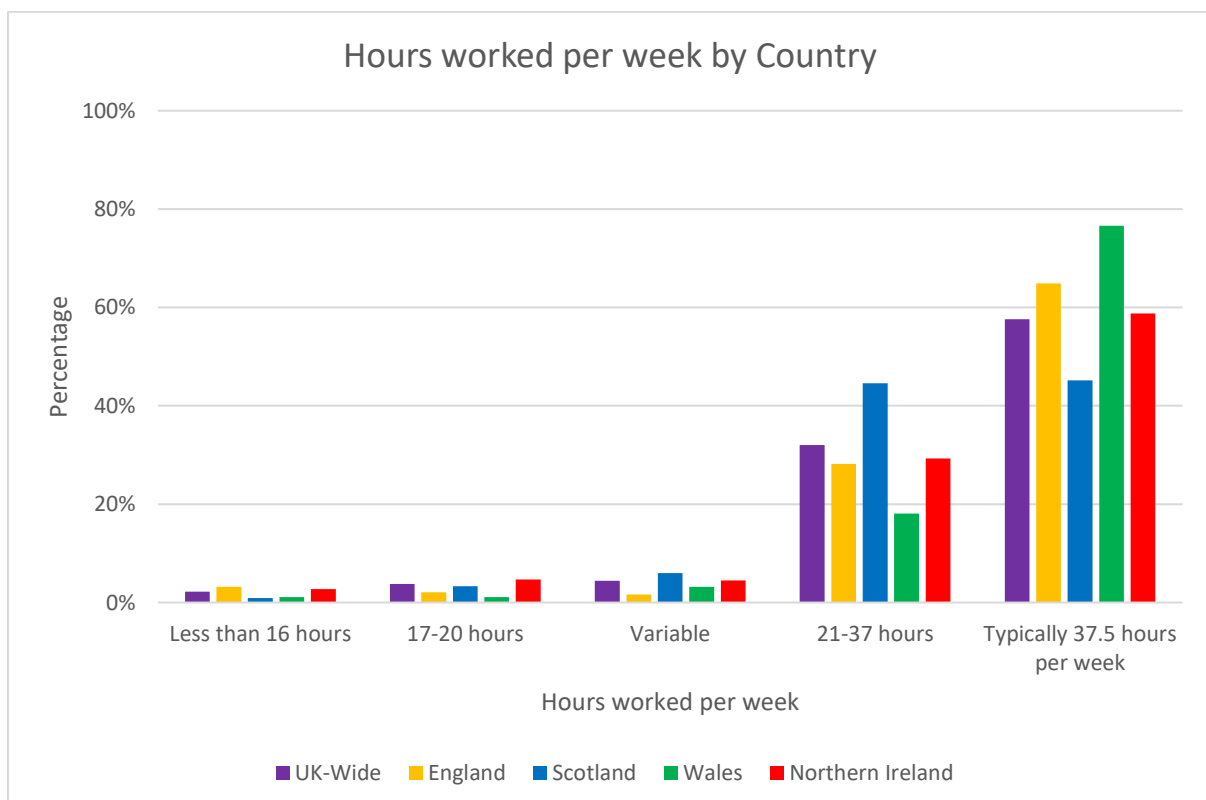


Table A2. 44: Number of Hours Worked per Week by Country (Weighted by Occupation)

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	2.5%	4.3%	0.9%	1.9%	2.8%
17-20 hours	2.5%	2.1%	2.8%	1.9%	4.8%
Variable	4.2%	0.7%	6.6%	3.8%	4.5%
21-37 hours	32.7%	27.1%	41.8%	23.1%	31.9%
Typically 37.5 hours per week	58.2%	65.7%	47.8%	69.2%	56.0%
Total	100%	100%	100%	100%	100%

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

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	31 (2.2%)	6 (3.2%)	3 (0.9%)	1 (1.1%)	21 (2.7%)
17-20 hours	53 (3.8%)	4 (2.1%)	11 (3.3%)	1 (1.1%)	37 (4.7%)
Variable	61 (4.4%)	3 (1.6%)	20 (6.0%)	3 (3.2%)	35 (4.5%)
21-37 hours	447 (32.0%)	53 (28.2%)	148 (44.6%)	17 (18.1%)	229 (29.3%)
Typically, 37.5 hours per week	803 (57.6%)	122 (64.9%)	150 (45.2%)	72 (76.6%)	459 (58.8%)
Total	1395 (100%)	188 (100%)	322 (100%)	94 (100%)	781 (100%)

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

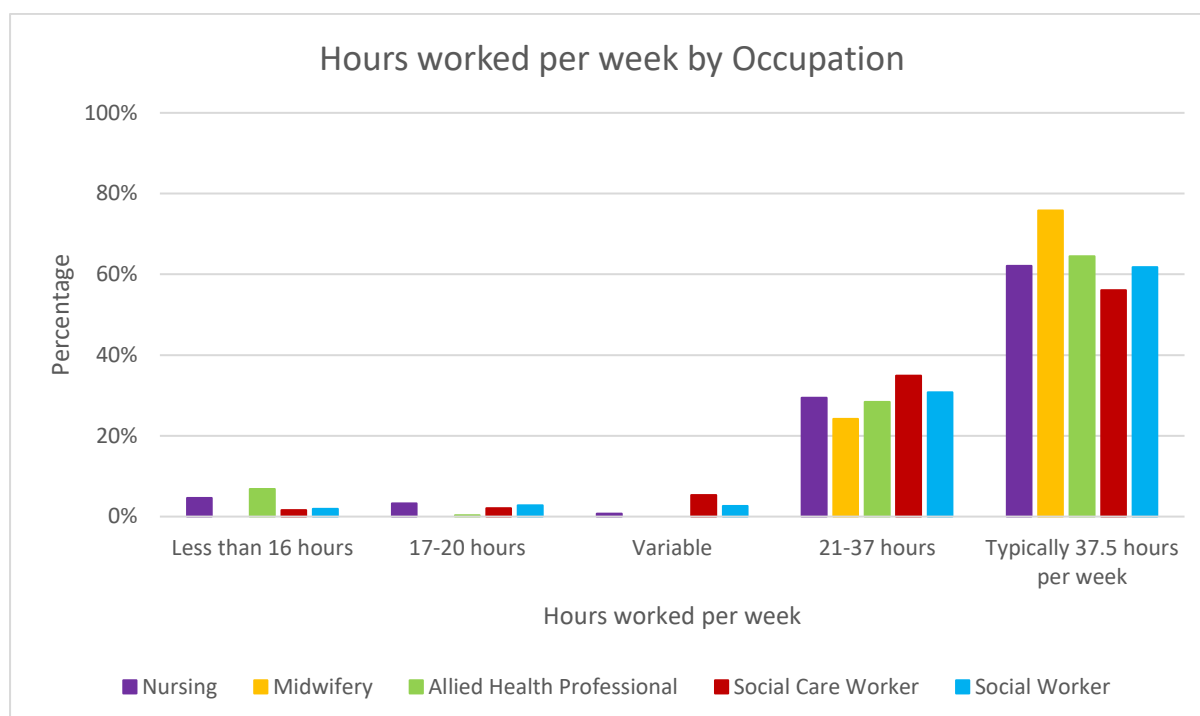


Figure A2. 47: Number of Hours Worked per Week by Occupation (Unweighted)

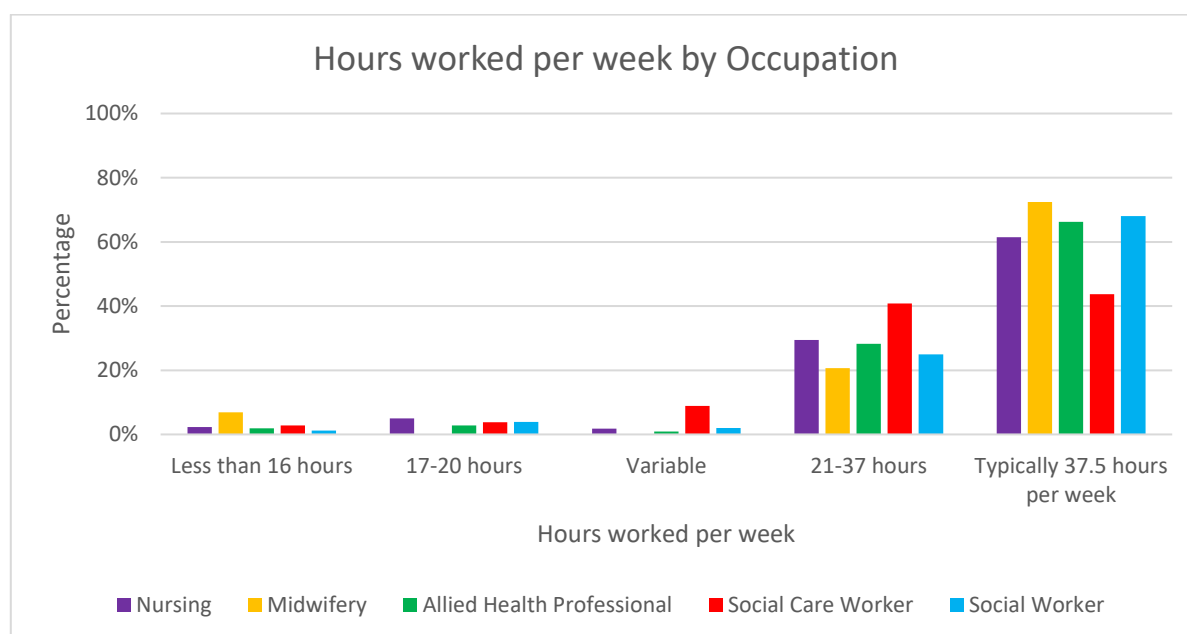


Table A2. 46: Number of Hours Worked per Week by Occupation (Weighted by Region)

Occupation	How many hours of work per week do you typically do?					Total
	Less than 16 hours	17-20 hours	Variable	21-37 hours	Typically 37.5 hours per week	
Nursing	4.6%	3.3%	0.7%	29.4%	62.1%	100%
Midwifery	0.0%	0.0%	0.0%	24.2%	75.8%	100%
AHP	6.8%	0.3%	0.0%	28.4%	64.5%	100%
Social Care Worker	1.6%	2.1%	5.3%	34.9%	56.1%	100%
Social Worker	1.9%	2.8%	2.6%	30.8%	61.8%	100%

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

Occupation	How many hours of work per week do you typically do?					Total
	Less than 16 hours	17-20 hours	Variable	21-37 hours	Typically 37.5 hours per week	
Nursing	5 (2.3%)	11 (5.0%)	4 (1.8%)	64 (29.4%)	134 (61.5%)	218 (100%)
Midwifery	2 (6.9%)	0 (0.0%)	0 (0.0%)	6 (20.7%)	21 (72.4%)	29 (100%)
AHP	4 (1.9%)	6 (2.8%)	2 (0.9%)	60 (28.2%)	141 (66.2%)	213 (100%)
Social Care Worker	15 (2.8%)	20 (3.8%)	47 (8.9%)	216 (40.8%)	231 (43.7%)	529 (100%)
Social Worker	5 (1.2%)	16 (3.9%)	8 (2.0%)	101 (24.9%)	276 (68.0%)	406 (100%)

A2.19 Respondents Typically Working Overtime

Summary (Weighted results):

Respondents were asked if they typically work overtime and the most frequent response UK-wide was '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 Northern Ireland. Both nurses and AHPs were the least likely to work overtime.

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

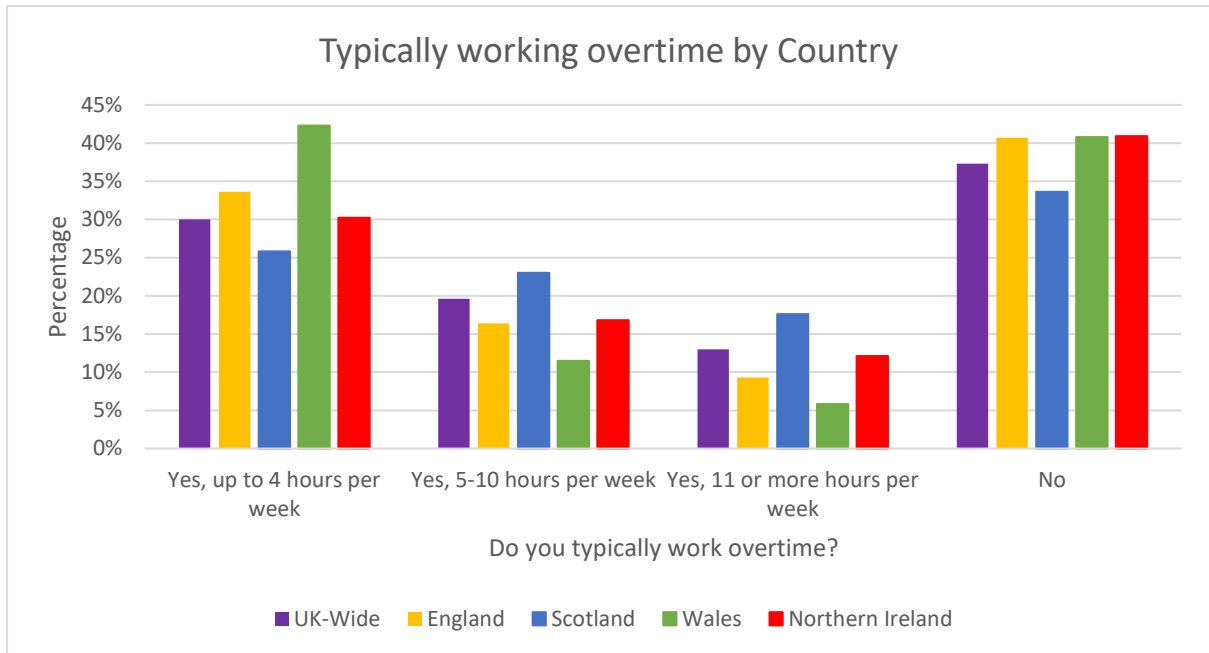


Figure A2. 49: Typically Working Overtime by Country (Unweighted)

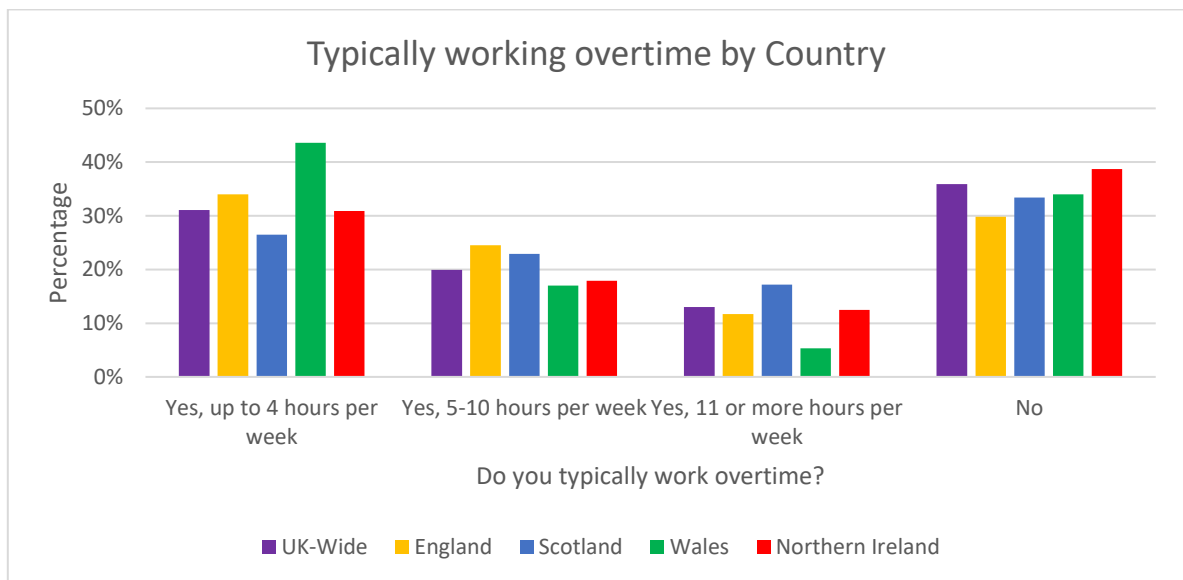


Table A2. 48: Typically Working Overtime by Country (Weighted by Occupation)

Do you typically work overtime?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, up to 4 hours per week	30.0%	33.6%	25.8%	42.3%	30.2%
Yes, 5-10 hours per week	19.6%	16.4%	23.0%	11.5%	16.8%
Yes, 11 or more hours per week	13.0%	9.3%	17.6%	5.8%	12.1%
No	37.3%	40.7%	33.6%	40.4%	40.9%
Total	100%	100%	100%	100%	100%

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

Do you typically work overtime?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, up to 4 hours per week	434 (31.1%)	64 (34.0%)	88 (26.5%)	41 (43.6%)	241 (30.9%)
Yes, 5-10 hours per week	278 (19.9%)	46 (24.5%)	76 (22.9%)	16(17.0%)	140 (17.9%)
Yes, 11 or more hours per week	182 (13.0%)	22 (11.7%)	57 (17.2%)	5 (5.3%)	98 (12.5%)
No	501 (35.9%)	56 (29.8%)	111 (33.4%)	32 (34.0%)	302 (38.7%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

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

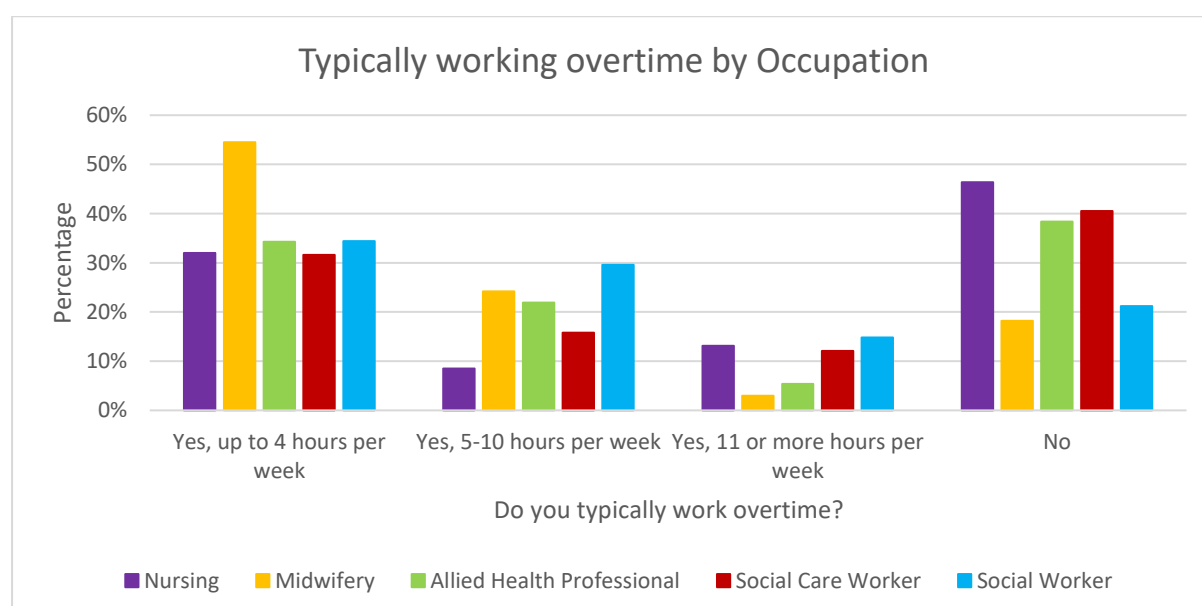


Figure A2. 51: Typically Working Overtime by Occupation (Unweighted)

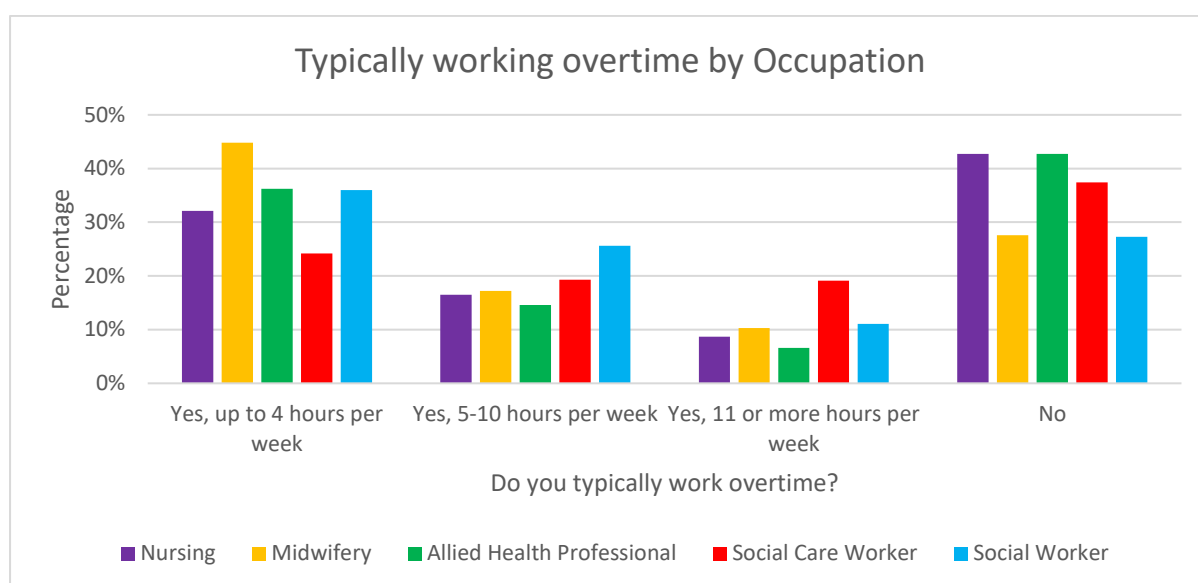


Table A2. 50: Typically Working Overtime by Occupation (Weighted by Region)

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	32.0%	8.5%	13.1%	46.4%	100%
Midwifery	54.5%	24.2%	3.0%	18.2%	100%
AHP	34.3%	21.9%	5.4%	38.4%	100%
Social Care Worker	31.6%	15.8%	12.1%	40.5%	100%
Social Worker	34.4%	29.6%	14.8%	21.2%	100%

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

Occupation	Do you typically work overtime?				Total
	Yes, up to 4 hours per week	Yes, 5-10 hours per week	Yes, 11 or more hours per week	No	
Nursing	70 (32.1%)	36 (16.5%)	19 (8.7%)	93 (42.7%)	218(100%)
Midwifery	13 (44.8%)	5 (17.2%)	3 (10.3%)	8 (27.6%)	29 (100%)
AHP	77 (36.2%)	31 (14.6%)	14 (6.6%)	91 (42.7%)	213 (100%)
Social Care Worker	128 (24.2%)	102(19.3%)	101 (19.1%)	198 (37.4%)	529 (100%)
Social Worker	146 (36.0%)	104 (25.6%)	45 (11.1%)	111 (27.3%)	406 (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 March 2022.

Summary (Weighted results):

Scotland have been working the most overtime since March 2022 and nurses are the most likely occupation to have not worked any overtime.

Summary (Unweighted results):

England have been working the most overtime since March 2022 and AHPs are the most likely occupation to have not worked any overtime.

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

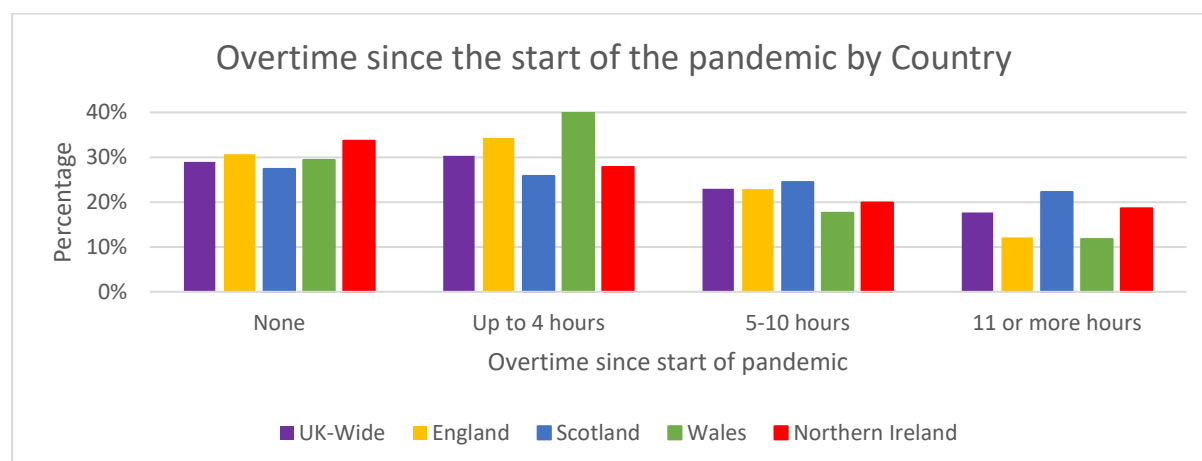


Figure A2. 53: Overtime since March 2022-present by Country (Unweighted)

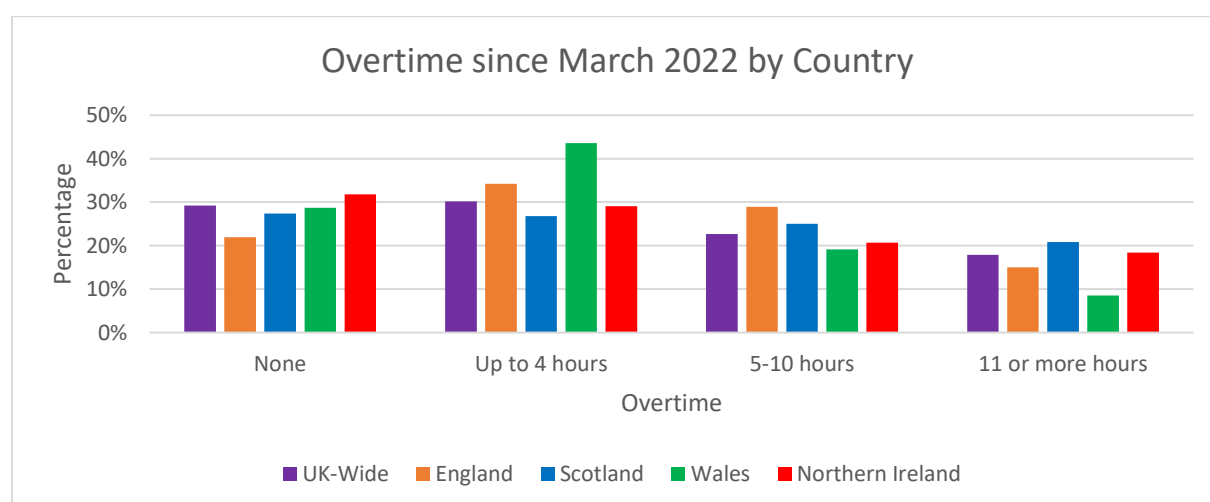


Table A2. 52: Overtime since March 2022-present by Country (Weighted by Occupation)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	29.0%	30.7%	27.4%	29.4%	33.7%
Up to 4 hours	30.3%	34.3%	25.8%	41.2%	27.8%
5-10 hours	23.0%	22.9%	24.5%	17.6%	19.9%
11 or more hours	17.7%	12.1%	22.3%	11.8%	18.6%
Total	100%	100%	100%	100%	100%

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

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	407 (29.2%)	41 (21.9%)	91 (27.4%)	27 (28.7%)	248 (31.8%)
Up to 4 hours	421 (30.2%)	64 (34.2%)	89 (26.8%)	41 (43.6%)	227 (29.1%)
5-10 hours	317 (22.7%)	54 (28.9%)	83 (25.0%)	18 (19.1%)	162 (20.7%)
11 or more hours	249 (17.9%)	28 (15.0%)	69 (20.8%)	8 (8.5%)	144 (18.4%)
Total	1394 (100%)	187 (100%)	332 (100%)	94 (100%)	781 (100%)

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

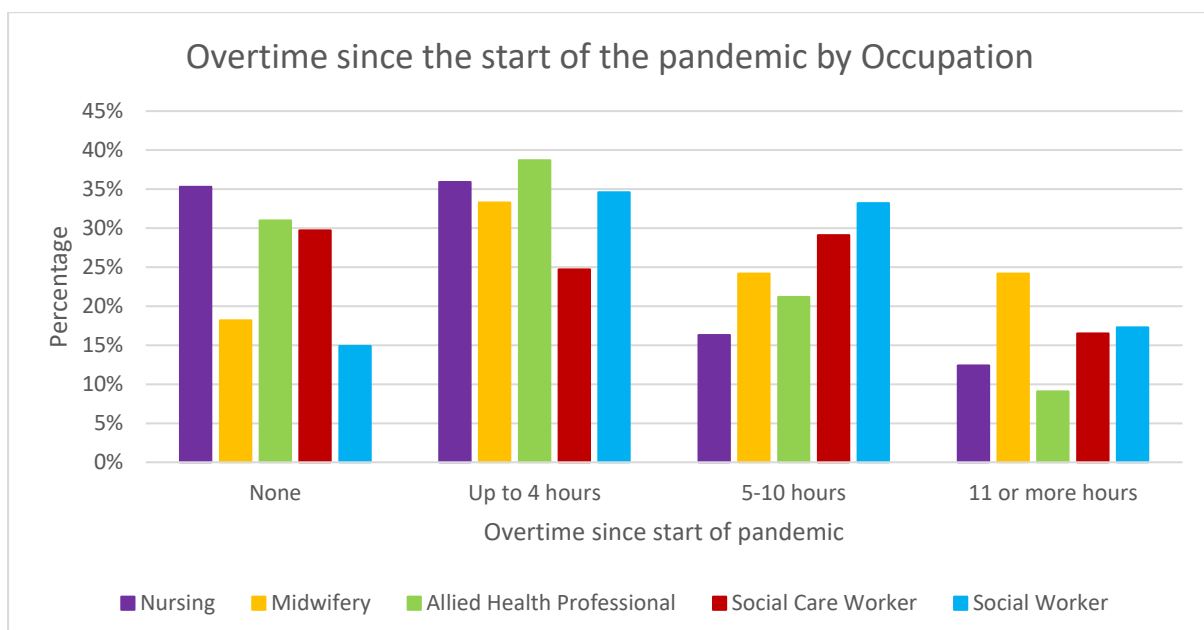


Figure A2. 55: Overtime since March 2022-present by Occupation (Unweighted)

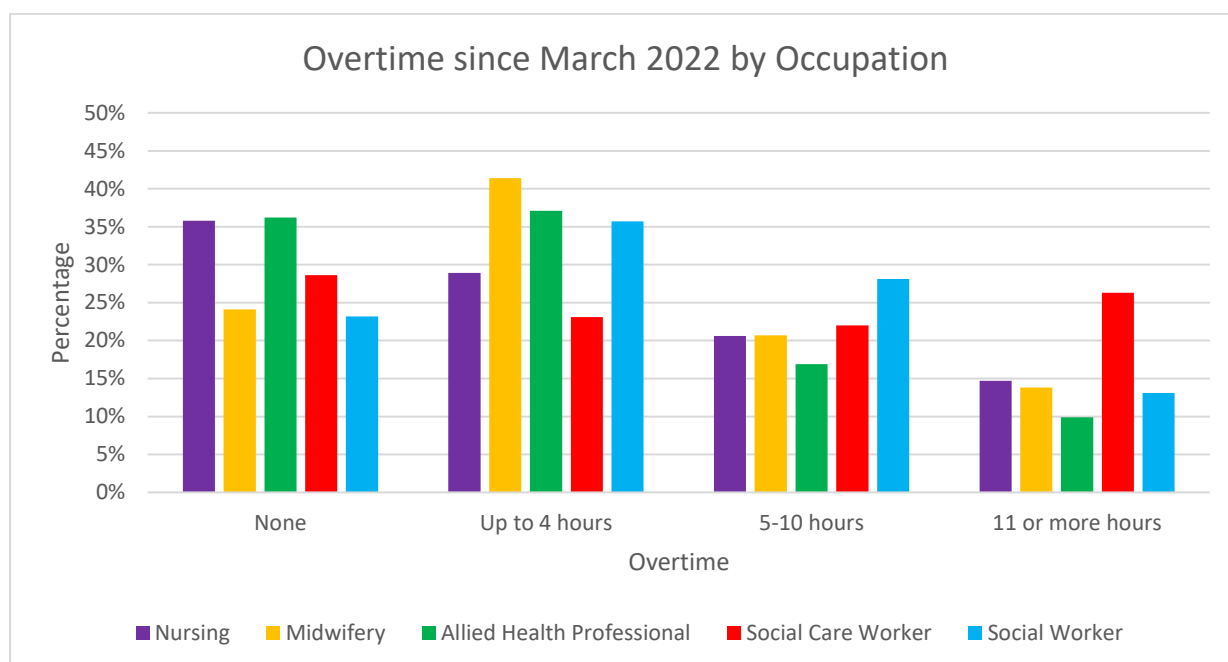


Table A2. 54: Overtime since March 2022-present by Occupation (Weighted by Region)

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	35.3%	35.9%	16.3%	12.4%	100%
Midwifery	18.2%	33.3%	24.2%	24.2%	100%
AHP	31.0%	38.7%	21.2%	9.1%	100%
Social Care Worker	29.7%	24.7%	29.1%	16.5%	100%
Social Worker	14.9%	34.6%	33.2%	17.3%	100%

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

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	78 (35.8%)	63 (28.9%)	45 (20.6%)	32 (14.7%)	218 (100%)
Midwifery	7 (24.1%)	12 (41.4%)	6 (20.7%)	4 (13.8%)	29 (100%)
AHP	77 (36.2%)	79 (37.1%)	36 (16.9%)	21 (9.9%)	213 (100%)
Social Care Worker	151 (28.6%)	122 (23.1%)	116 (22.0%)	139 (26.3%)	528 (100%)
Social Worker	94 (23.2%)	145 (35.7%)	114 (28.1%)	53 (13.1%)	406 (100%)

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

Summary (Weighted results):

Over one quarter of respondents (27.9%) had not taken any sick days in the previous 12 months.

Summary (Unweighted results):

Near a third of respondents (32.9%) had not taken any sick days in the previous 12 months. Respondents in Northern Ireland were the least likely to take sick days and those in England were the most likely.

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

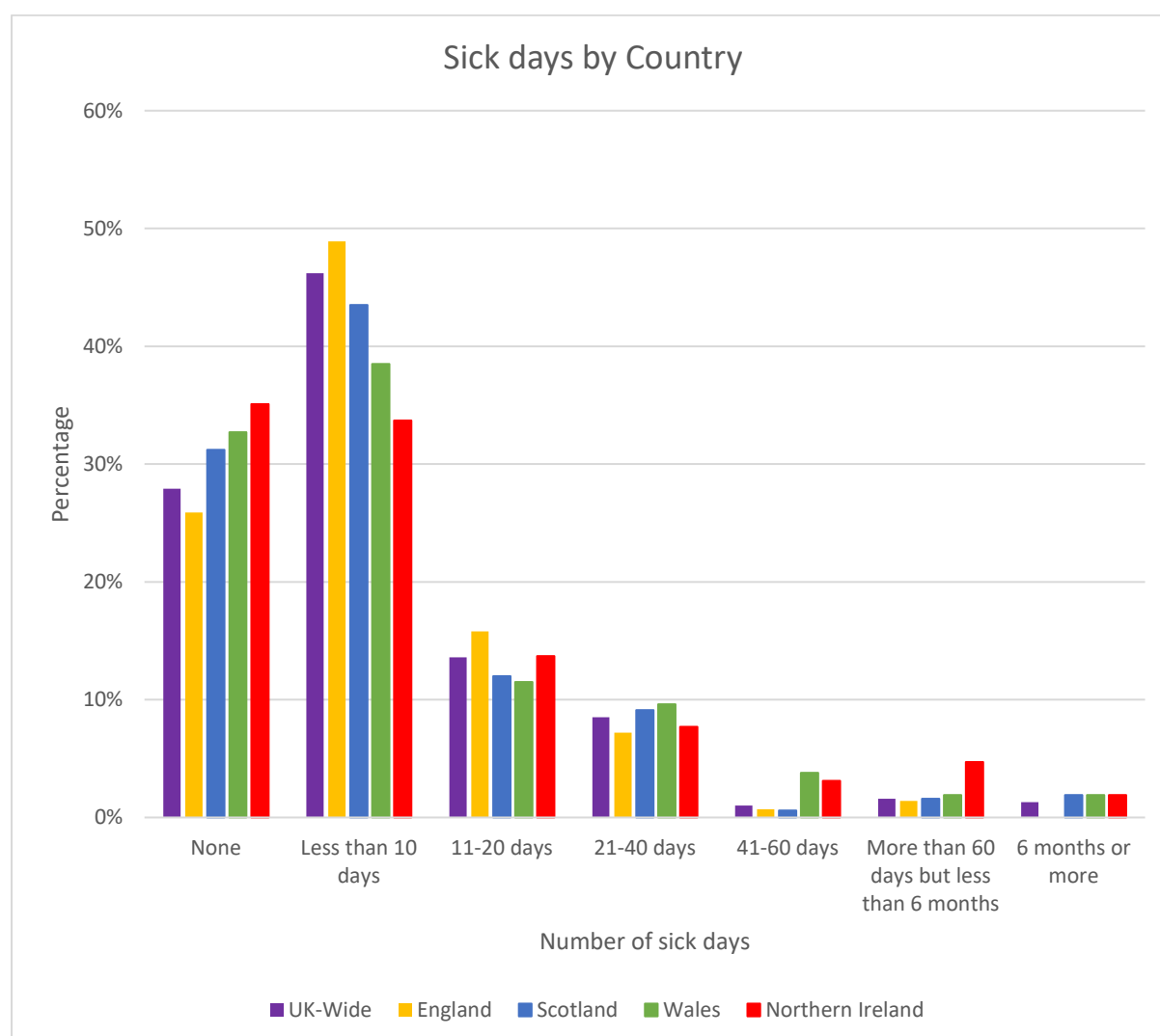


Figure A2. 57: Sick Days by Country (Unweighted)

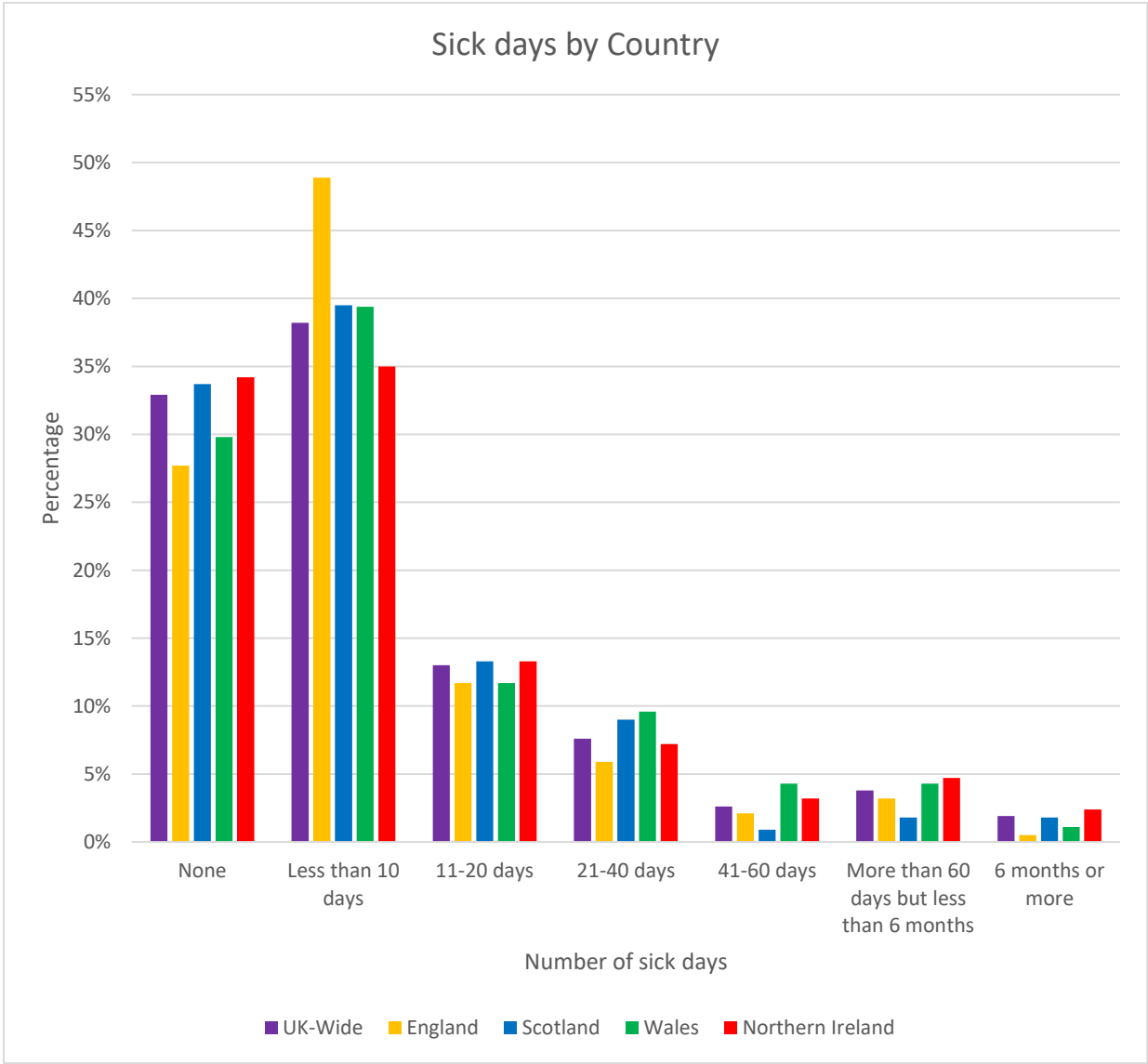


Table A2. 56: Sick Days by Country (Weighted by Occupation)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	27.9%	25.9%	31.2%	32.7%	35.1%
Less than 10 days	46.2%	48.9%	43.5%	38.5%	33.7%
Between 11-20 days	13.6%	15.8%	12.0%	11.5%	13.7%
Between 21-40 days	8.5%	7.2%	9.1%	9.6%	7.7%
Between 41-60 days	1.0%	0.7%	0.6%	3.8%	3.1%
More than 60 days but less than 6 months	1.6%	1.4%	1.6%	1.9%	4.7%
6 months or more	1.3%	0.0%	1.9%	1.9%	1.9%
Total	100%	100%	100%	100%	100%

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

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	459 (32.9%)	52 (27.7%)	112 (33.7%)	28 (29.8%)	267 (34.2%)
Less than 10 days	533 (38.2%)	92 (48.9%)	131 (39.5%)	37 (39.4%)	273 (35.0%)
Between 11-20 days	181 (13.0%)	22 (11.7%)	44 (13.3%)	11 (11.7%)	104 (13.3%)
Between 21-40 days	106 (7.6%)	11 (5.9%)	30 (9.0%)	9 (9.6%)	56 (7.2%)
Between 41-60 days	36 (2.6%)	4 (2.1%)	3 (0.9%)	4 (4.3%)	25 (3.2%)
More than 60 days but less than 6 months	53 (3.8%)	6 (3.2%)	6 (1.8%)	4 (4.3%)	37 (4.7%)
6 months or more	27 (1.9%)	1 (0.5%)	6 (1.8%)	1 (1.1%)	19 (2.4%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

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

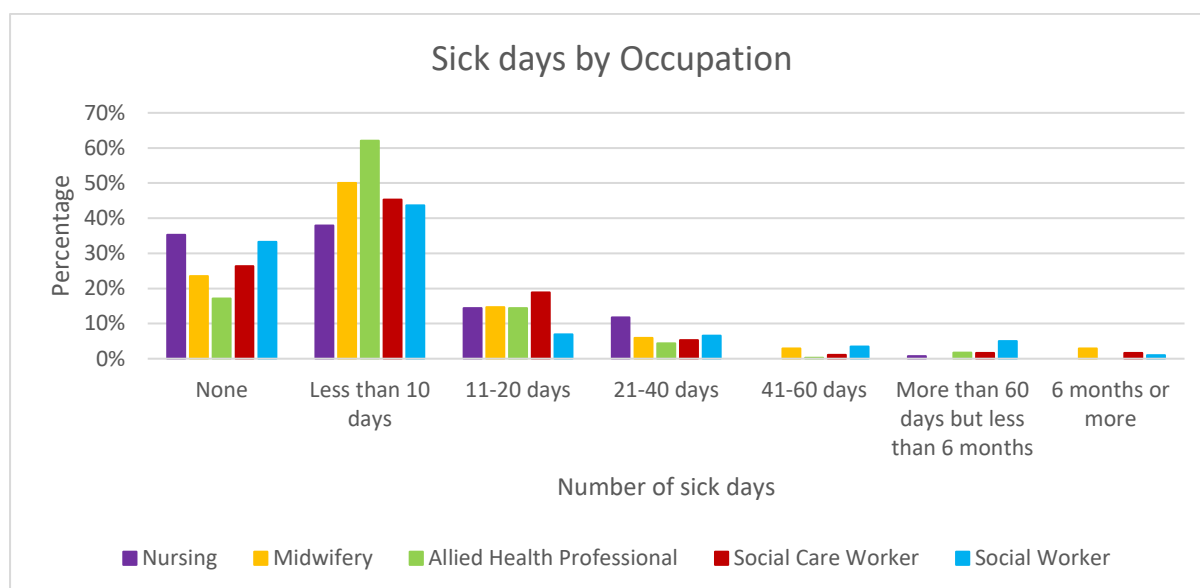


Figure A2. 59: Sick Days by Occupation (Unweighted)

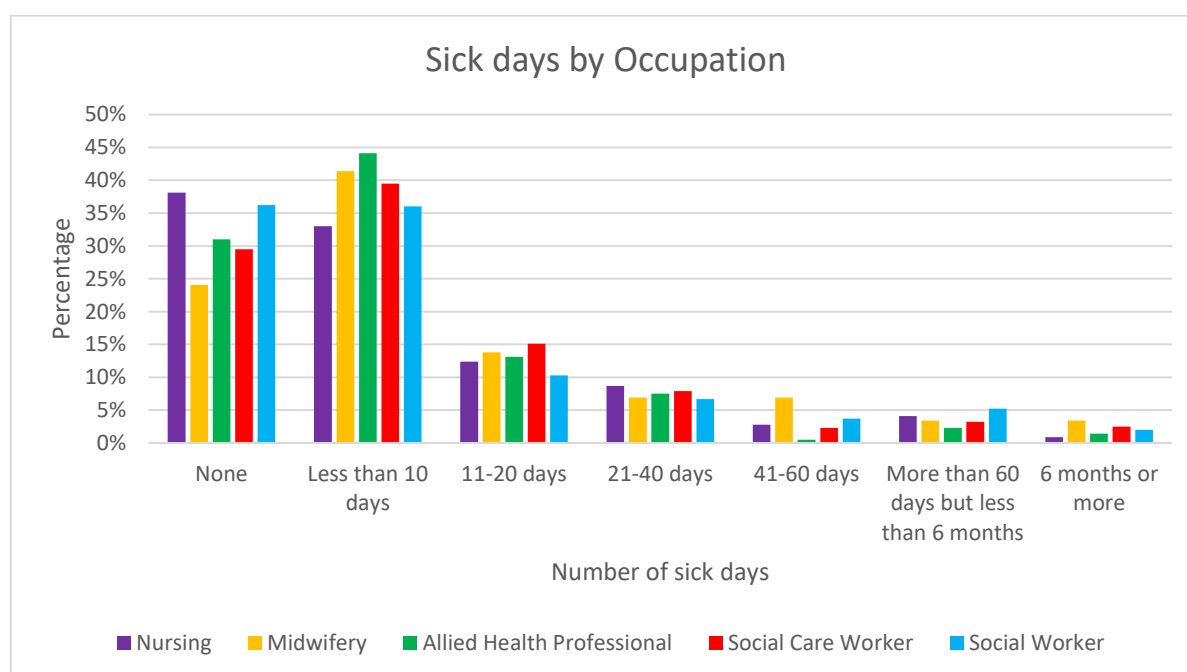


Table A2. 58: Sick Days by Occupation (Weighted by Region)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	35.3%	23.5%	17.1%	26.3%	33.3%
Less than 10 days	37.9%	50.0%	62.1%	45.3%	43.7%
Between 11-20 days	14.4%	14.7%	14.4%	18.9%	6.9%
Between 21-40 days	11.8%	5.9%	4.4%	5.3%	6.6%
Between 41-60 days	0.0%	2.9%	0.3%	1.1%	3.5%
More than 60 days but less than 6 months	0.7%	0.0%	1.7%	1.6%	5.0 %
6 months or more	0.0%	2.9%	0.0%	1.6%	1.0%
Total	100%	100%	100%	100%	100%

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

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	83 (38.1%)	7 (24.1%)	66 (31.0%)	156 (29.5%)	147 (36.2%)
Less than 10 days	72 (33.0%)	12 (41.4%)	94 (44.1%)	209 (39.5%)	146 (36.0%)
Between 11-20 days	27 (12.4%)	4 (13.8%)	28 (13.1%)	80 (15.1%)	42 (10.3%)
Between 21-40 days	19 (8.7%)	2 (6.9%)	16 (7.5%)	42 (7.9%)	27 (6.7%)
Between 41-60 days	6 (2.8%)	2 (6.9%)	1 (0.5%)	12 (2.3%)	15 (3.7%)
More than 60 days but less than 6 months	9 (4.1%)	1 (3.4%)	5 (2.3%)	17 (3.2%)	21 (5.2%)
6 months or more	2 (0.9%)	1 (3.4%)	3 (1.4%)	13 (2.5%)	8 (2.0%)
Total	218 (100%)	29 (100%)	213 (100%)	529 (100%)	406 (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):

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

Summary (Unweighted results):

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

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

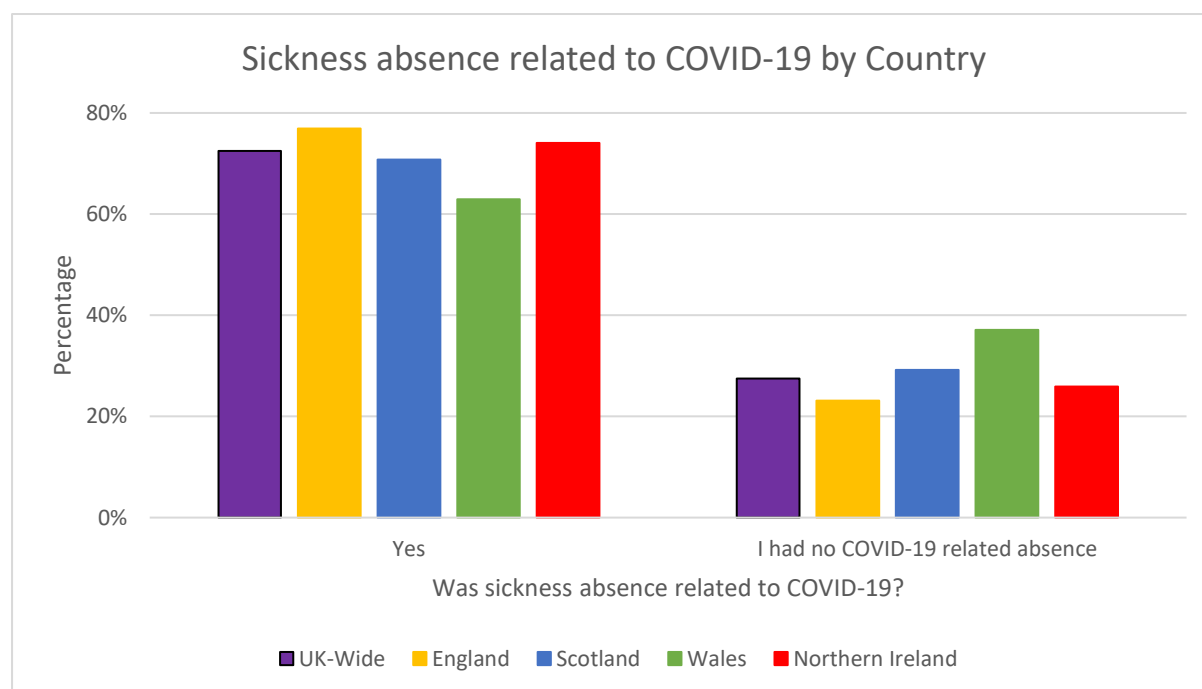


Figure A2. 61: Sickness Absence Related to COVID-19 by Country (Unweighted)

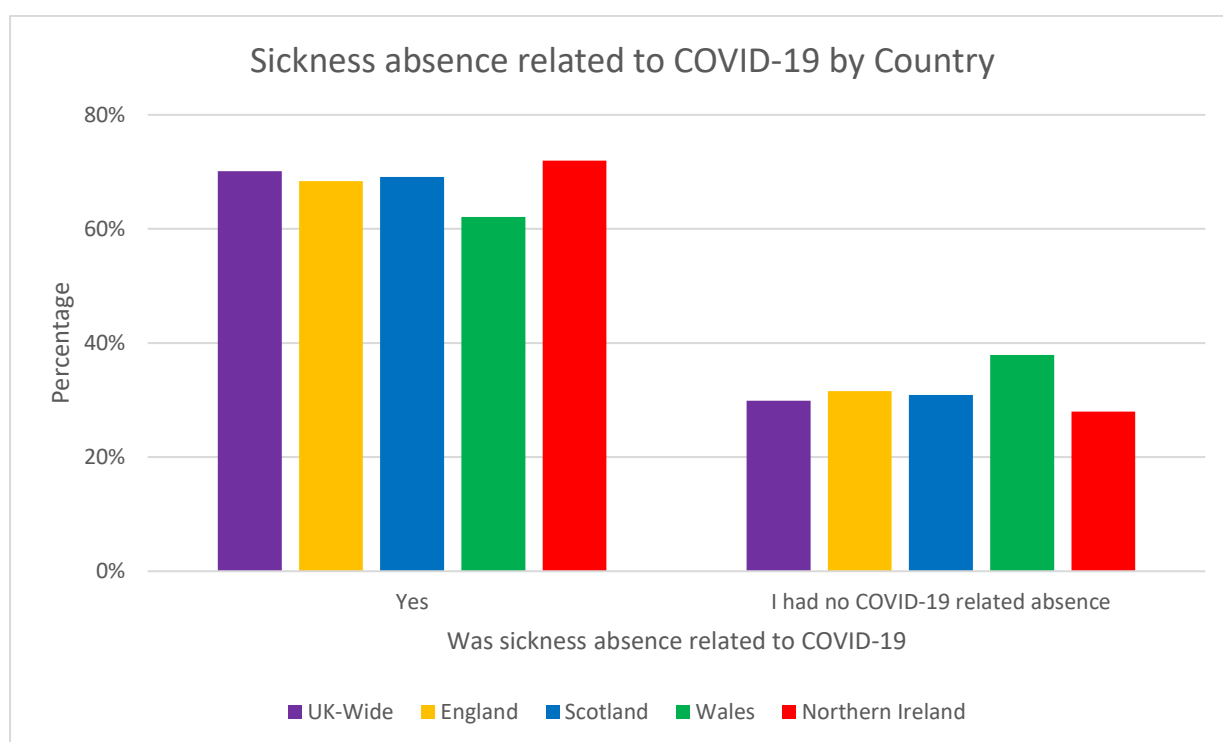


Table A2. 60: Sickness Absence Related to COVID-19 by Country (Weighted by Occupation)

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	72.5%	76.9%	70.8%	62.9%	74.1%
I had no COVID-19 related absence	27.5%	23.1%	29.2%	37.1%	25.9%
Total	100%	100%	100%	100%	100%

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

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	655 (70.1%)	93 (68.4%)	152 (69.1%)	41 (62.1%)	370 (72.0%)
I had no COVID-19 related absence	280 (29.9%)	43 (31.6%)	68 (30.9%)	25 (37.9%)	144 (28.0%)
Total	936 (100%)	136 (100%)	220 (100%)	66 (100%)	514 (100%)

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

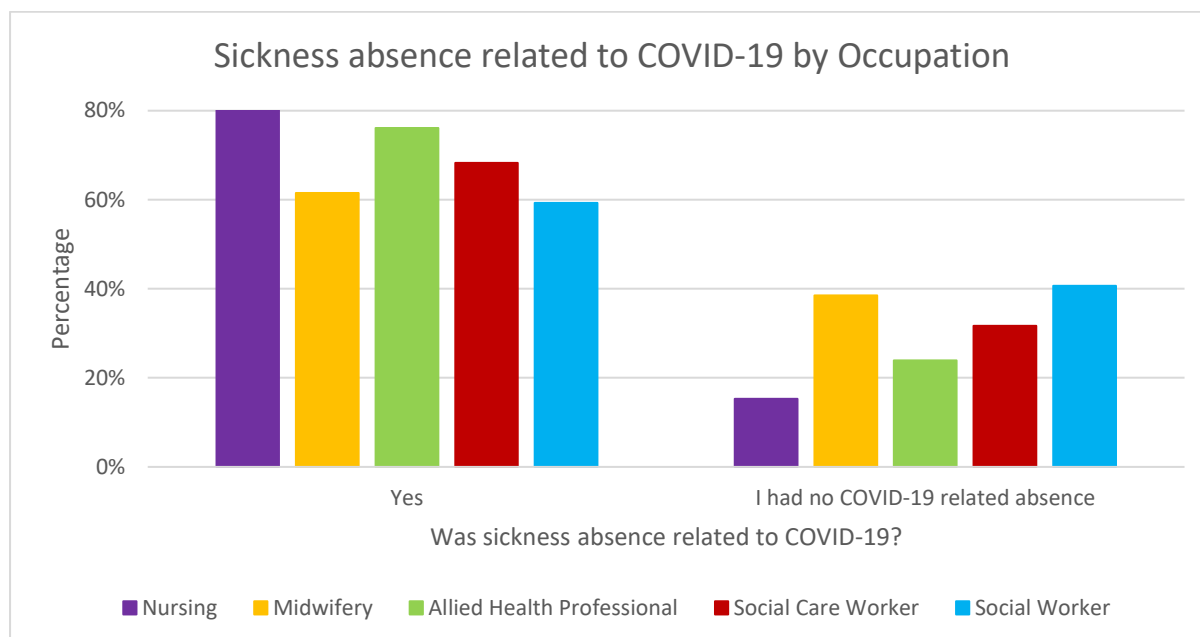


Figure A2. 63: Sickness Absence Related to COVID-19 by Occupation (Unweighted)

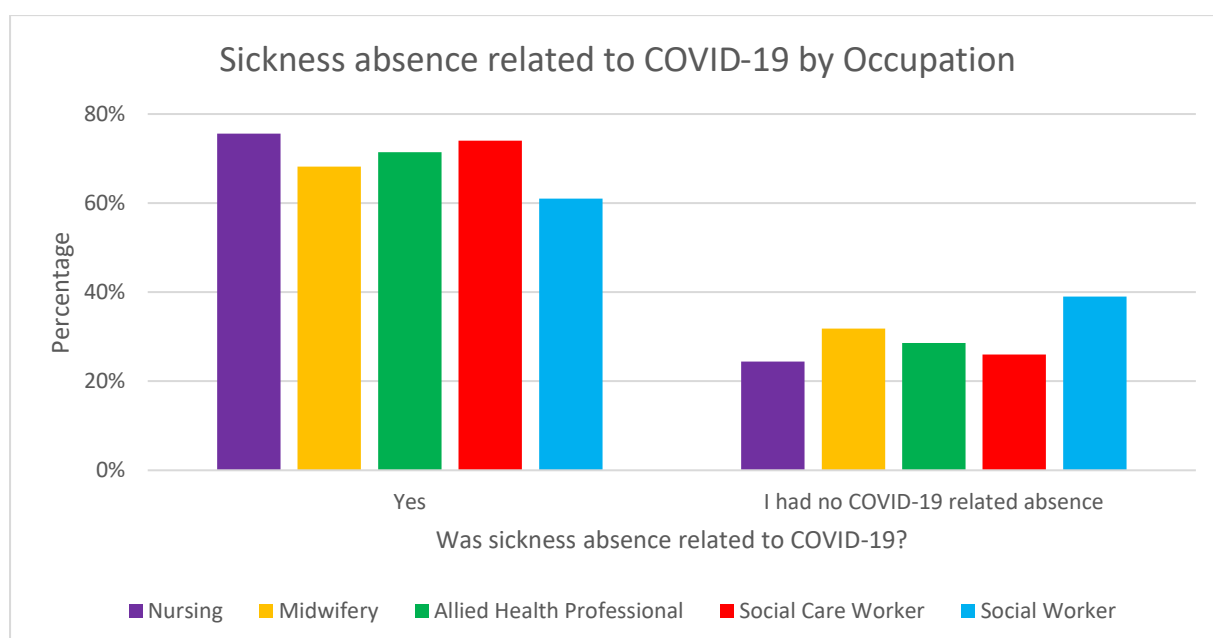


Table A2. 62: Sickness Absence Related to COVID-19 by Occupation (Weighted by Region)

Occupation	Was sickness absence related to COVID-19?		Total
	Yes	I had no COVID-19 related absence	
Nursing	84.7%	15.3%	100%
Midwifery	61.5%	38.5%	100%
AHP	76.1%	23.9%	100%
Social Care Worker	68.3%	31.7%	100%
Social Worker	59.3%	40.7%	100%

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

Occupation	Was sickness absence related to COVID-19?		Total
	Yes	I had no COVID-19 related absence	
Nursing	102 (75.6%)	33 (24.4%)	135 (100%)
Midwifery	15 (68.2%)	7 (31.8%)	22 (100%)
AHP	105 (71.4%)	42 (28.6%)	147 (100%)
Social Care Worker	276 (74.0%)	97 (26.0%)	373 (100%)
Social Worker	158 (70.1%)	101 (39.0%)	259 (100%)

A2.23 Respondents' Sick Pay

Summary (Weighted results):

UK-wide, most respondents reported getting employer pay.

Summary (Unweighted results):

UK-wide, most respondents (41.5%) reported getting employer pay.

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

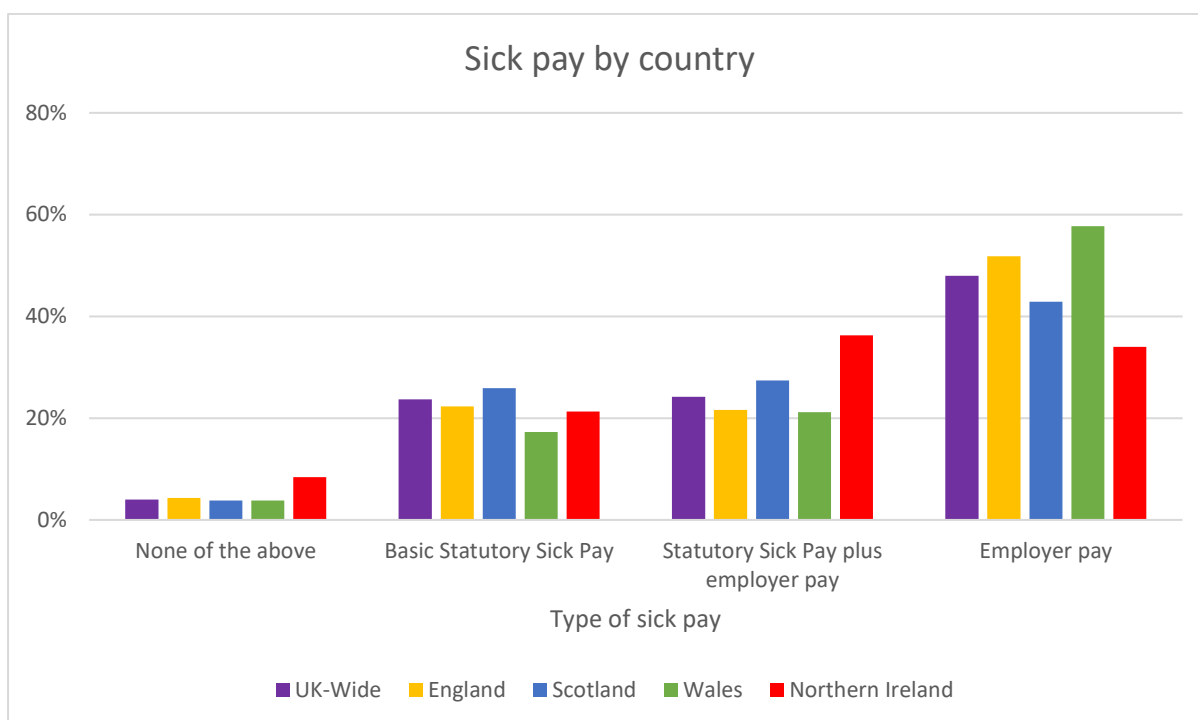


Figure A2. 65: Respondents' Sick Pay by Country (Unweighted)

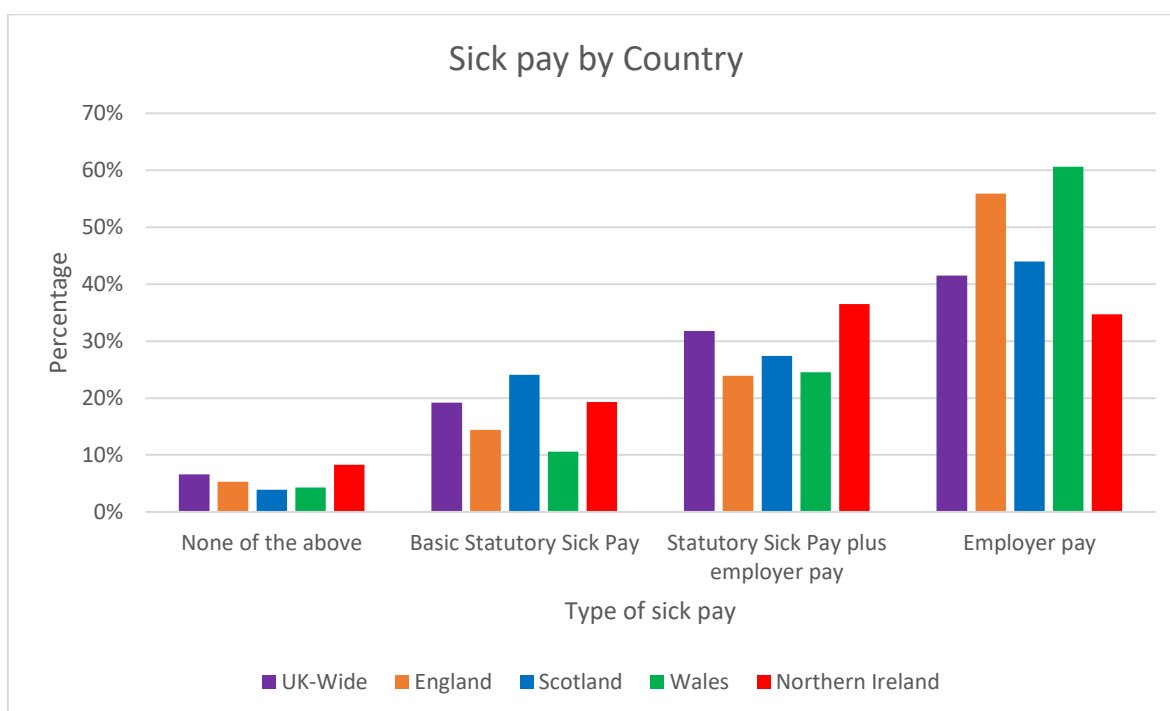


Table A2. 64: Respondents' Sick Pay by Country (Weighted by Occupation)

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None of the above	4.0%	4.3%	3.8%	3.8%	8.4%
Basic Statutory Sick Pay	23.7%	22.3%	25.9%	17.3%	21.3%
Statutory Sick Pay plus employer pay	24.2%	21.6%	27.4%	21.2%	36.3%
Employer pay	48.0%	51.8%	42.9%	57.7%	34.0%
Total	100%	100%	100%	100%	100%

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

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None of those mentioned	92 (6.6%)	10 (5.2%)	18 (13.0%)	6 (6.3%)	123 2(9.9%)
Basic Statutory Sick Pay (SSP)	268 (19.2%)	25 (12.9%)	23 (16.7%)	21 (22.1%)	274 (22.1%)
Statutory Sick Pay (SSP) plus employer pay	444 (31.8%)	49 (25.3%)	38 (27.5%)	16 (16.8%)	396 (32.0%)
Employer Pay	579 (41.5%)	100 (56.7%)	52 (42.8%)	52 (54.7%)	446 (36.0%)
Total	1395 (100%)	188(100%)	332 (100%)	94 (100%)	781 (100%)

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

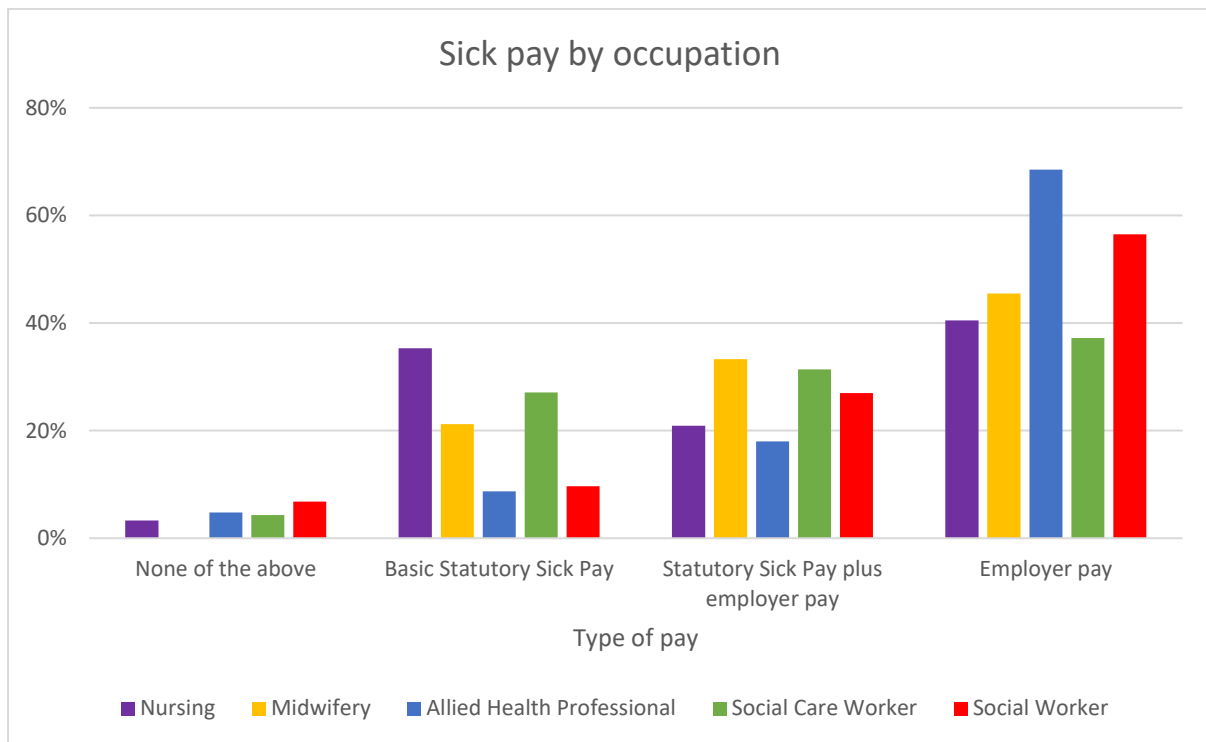


Figure A2. 67: Respondents' Sick Pay by Occupation (Unweighted)

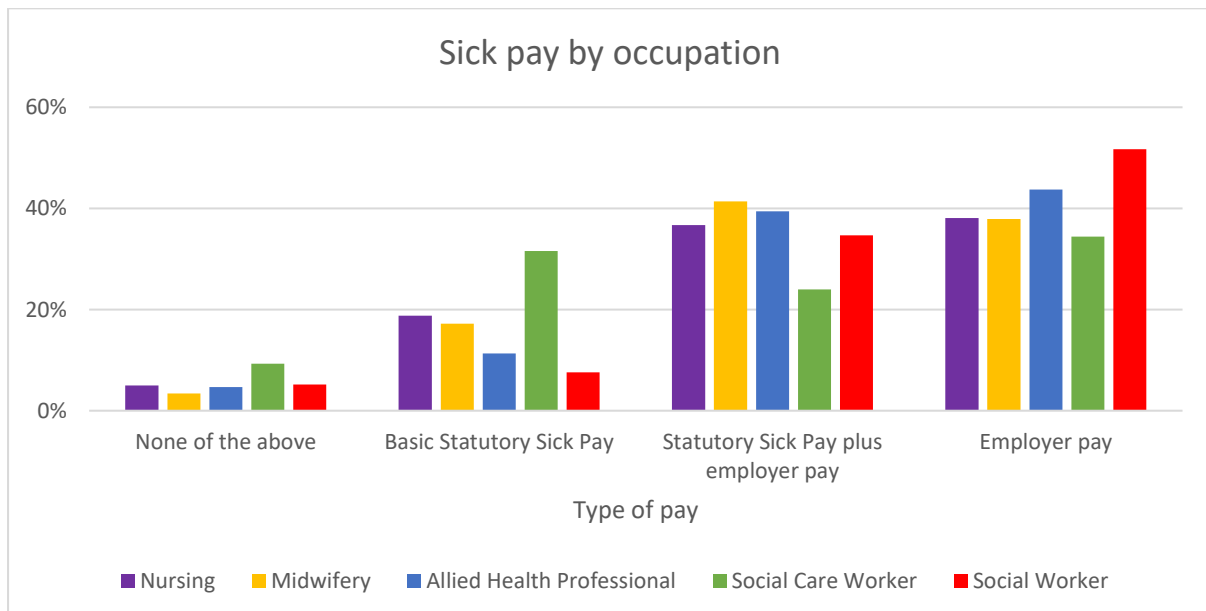


Table A2. 66: Respondents' Sick Pay by Occupation (Weighted by Region)

Occupation	Type of sick pay				Total
	None of the others	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	Employer Pay	
Nursing	3.3%	35.3%	20.9%	40.5%	100%
Midwifery	0.0%	21.2%	33.3%	45.5%	100%
AHP	4.8%	8.7%	18.0%	68.5%	100%
Social Care Worker	4.3%	27.1%	31.4%	37.2%	100%
Social Worker	6.8%	9.7%	27.0%	56.5%	100%

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

Occupation	Type of sick pay				Total
	None of the others	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	Employer Pay	
Nursing	11 (5.0%)	41 (18.8%)	80 (36.7%)	83 (38.1%)	218 (100%)
Midwifery	1 (3.4%)	5 (17.2%)	12 (41.4%)	11 (37.9%)	29 (100%)
AHP	10 (4.7%)	24 (11.3%)	84 (39.4%)	93 (43.7%)	213 (100%)
Social Care Worker	49 (9.3%)	167 (31.6%)	127 (24.0%)	182 (34.4%)	529 (100%)
Social Worker	21 (5.2%)	31 (7.6%)	141 (34.7%)	210 (51.7%)	406 (100%)

A2.15 Respondents' Years of Experience

Summary (Weighted results):

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

Summary (Unweighted results):

Almost one third of respondents UK-wide (28.9%) 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 midwives and nurses.

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

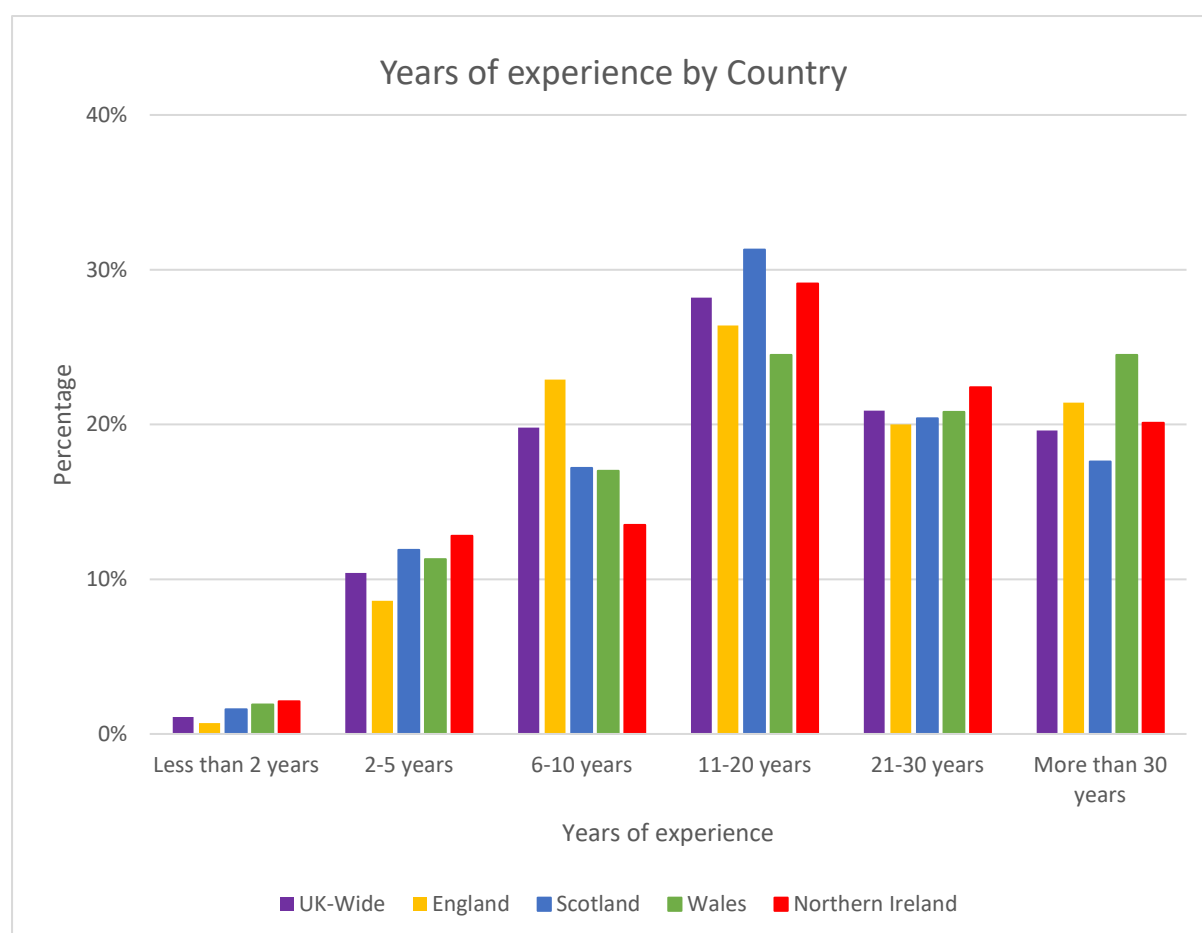


Figure A2. 69: Years of Experience by Country (Unweighted)

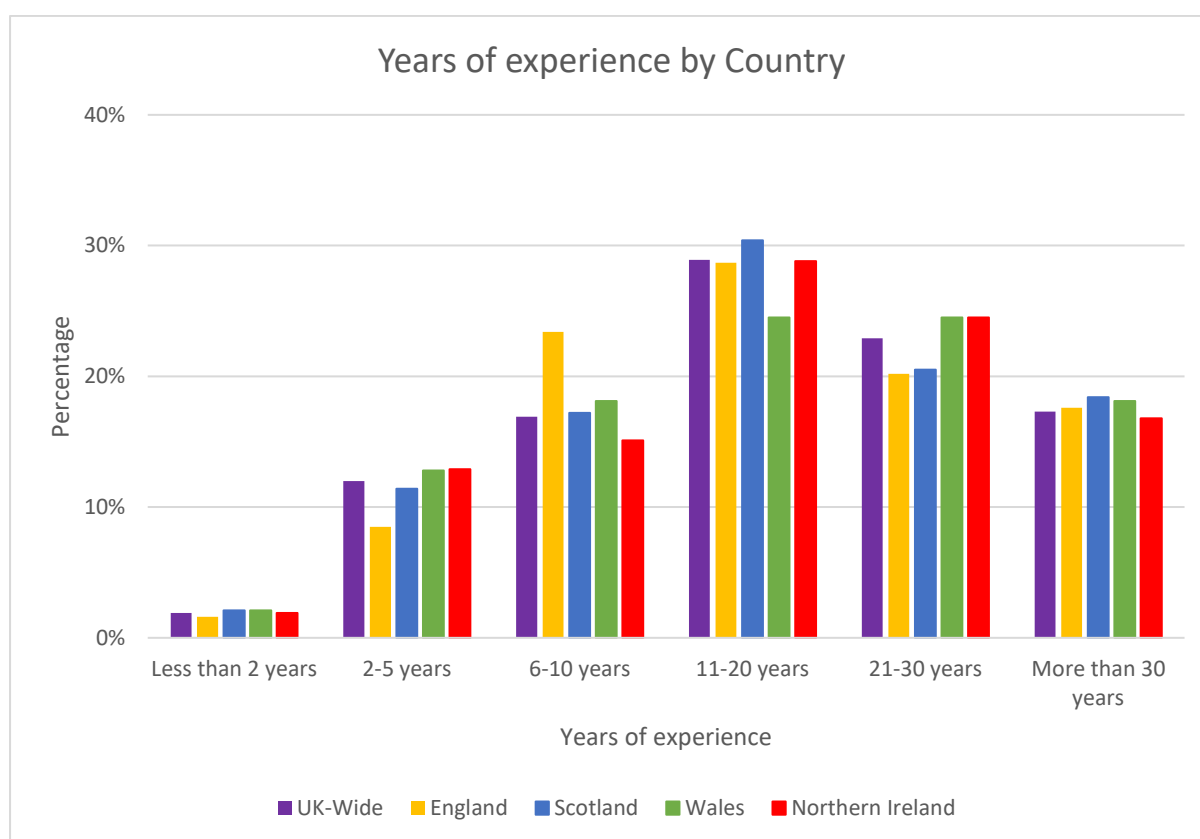


Table A2. 68: Years of Experience by Country (Weighted by Occupation)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	1.1%	0.7%	1.6%	1.9%	2.1%
2-5 years	10.4%	8.6%	11.9%	11.3%	12.8%
6-10 years	19.8%	22.9%	17.2%	17.0%	13.5%
11-20 years	28.2%	26.4%	31.3%	24.5%	29.1%
21-30 years	20.9%	20.0%	20.4%	20.8%	22.4%
More than 30 years	19.6%	21.4%	17.6%	24.5%	20.1%
Total	100%	100%	100%	100%	100%

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

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	27 (1.9%)	3 (1.6%)	7 (2.1%)	2 (2.1%)	15 (1.9%)
2-5 years	167 (12.0%)	16 (8.5%)	38 (11.4%)	12 (12.8%)	101 (12.9%)
6-10 years	236 (16.9%)	44 (23.4%)	57 (17.2%)	17 (18.1%)	118 (15.1%)
11-20 years	403 (28.9%)	54 (28.7%)	101 (30.4%)	23 (24.5%)	225 (28.8%)
21-30 years	320 (22.9%)	38 (20.2%)	68 (20.5%)	23 (24.5%)	191 (24.5%)
More than 30 years	242 (17.3%)	33 (17.6%)	61 (18.4%)	17 (18.1%)	131 (16.8%)
Total	1395 (100%)	188 (100%)	322 (100%)	94 (100%)	781 (100%)

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

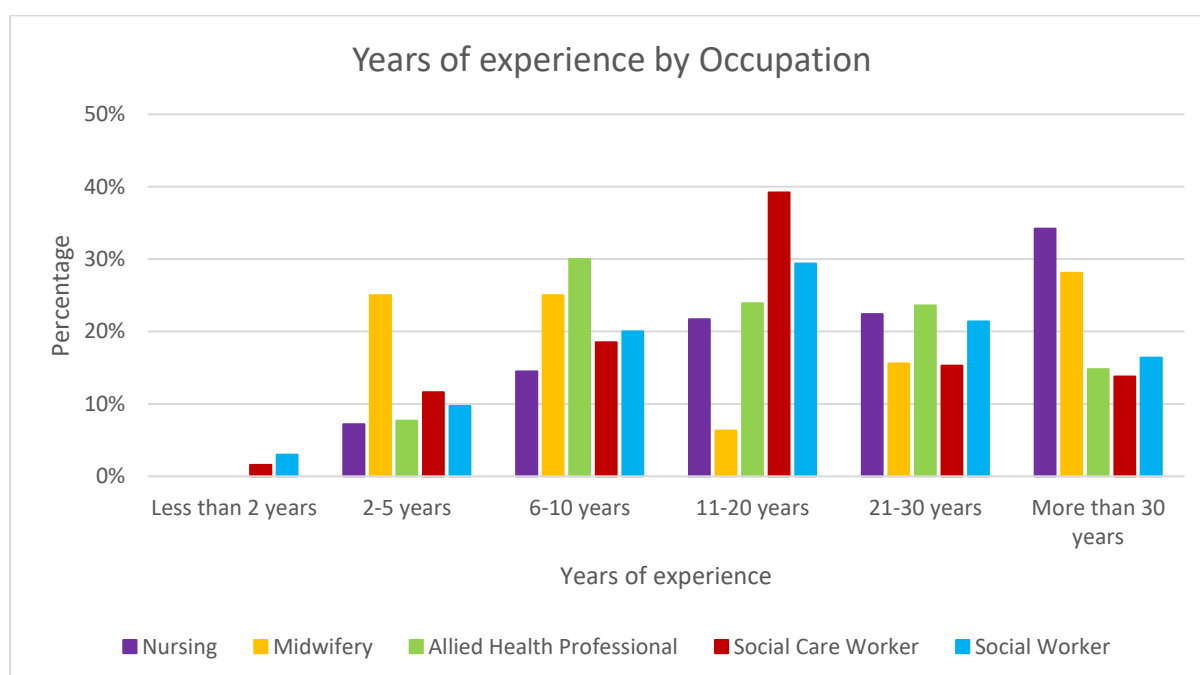


Figure A2. 71: Years of Experience by Occupation (Unweighted)

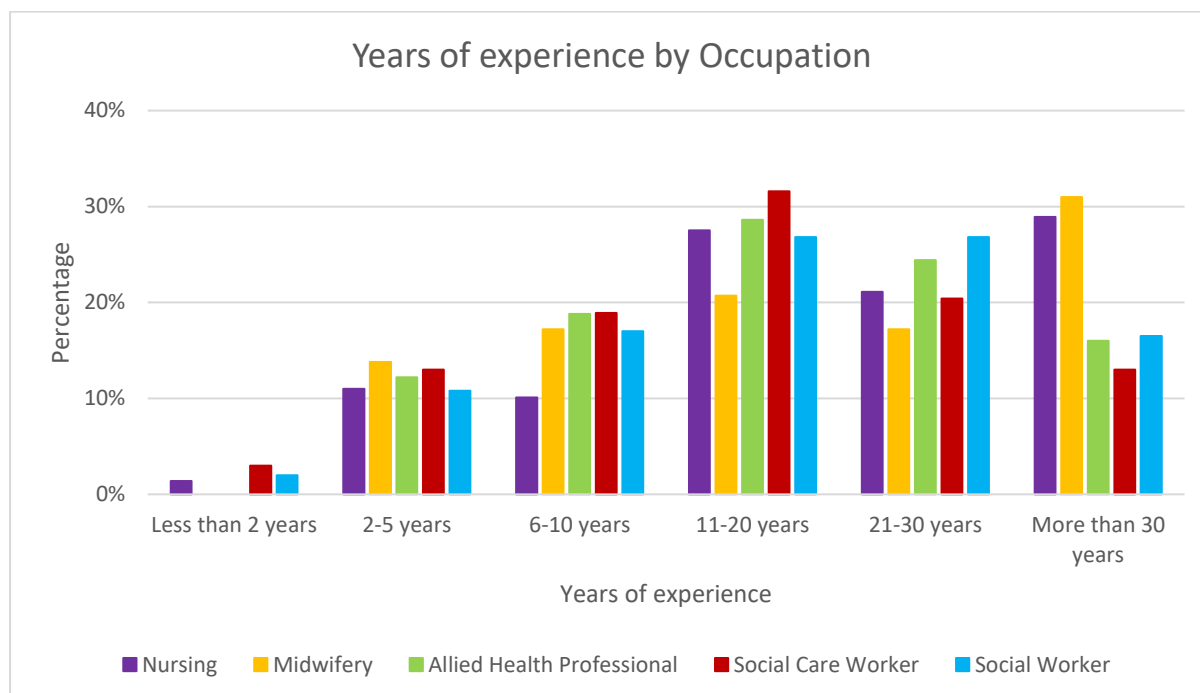


Table A2. 70: Years of Experience by Occupation (Weighted by Region)

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	0.0%	7.2%	14.5%	21.7%	22.4%	34.2%	100%
Midwifery	0.0%	25.0%	25.0%	6.3%	15.6%	28.1%	100%
AHP	0.0%	7.7%	30.0%	23.9%	23.6%	14.8%	100%
Social Care Worker	1.6%	11.6%	18.5%	39.2%	15.3%	13.8%	100%
Social Worker	3.0%	9.7%	20.0%	29.4%	21.4%	16.4%	100%

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

Occupation	Years of experience						Total
	Less than 2 years	2-5 years	6-10 years	11-20 years	21-30 years	More than 30 years	
Nursing	3 (1.4%)	24 (11.0%)	22 (10.1%)	60 (27.5%)	46 (21.1%)	63 (28.9%)	218 (100%)
Midwifery	0 (0.0%)	4 (13.8%)	5 (17.2%)	6 (20.7%)	5 (17.2%)	9 (31.0%)	29 (100%)
AHP	0 (0.0%)	26 (12.2%)	40 (18.8%)	61 (28.6%)	52 (24.4%)	34 (16.0%)	213 (100%)
Social Care Worker	16 (3.0%)	69 (13.0%)	100 (18.9%)	167 (31.6%)	108 (20.4%)	69 (13.0%)	529 (100%)
Social Worker	8 (2.0%)	44 (10.8%)	69 (17.0%)	109 (26.8%)	109 (26.8%)	67 (16.5%)	406 (100%)

A2.16 Respondents' Main Area of Practice

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

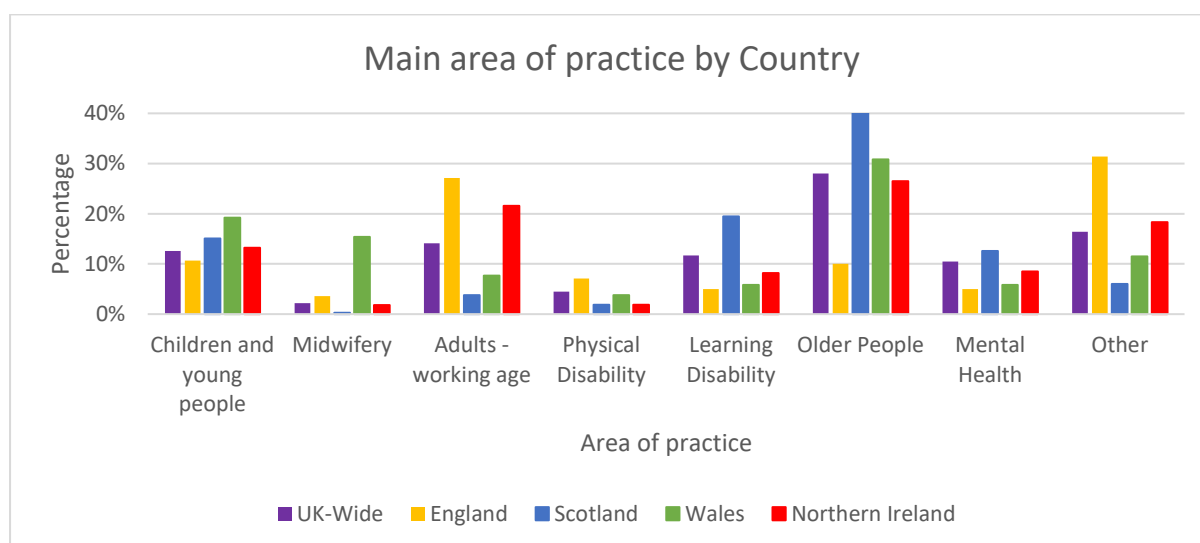


Figure A2. 73: Main Area of Practice by Country (Unweighted)

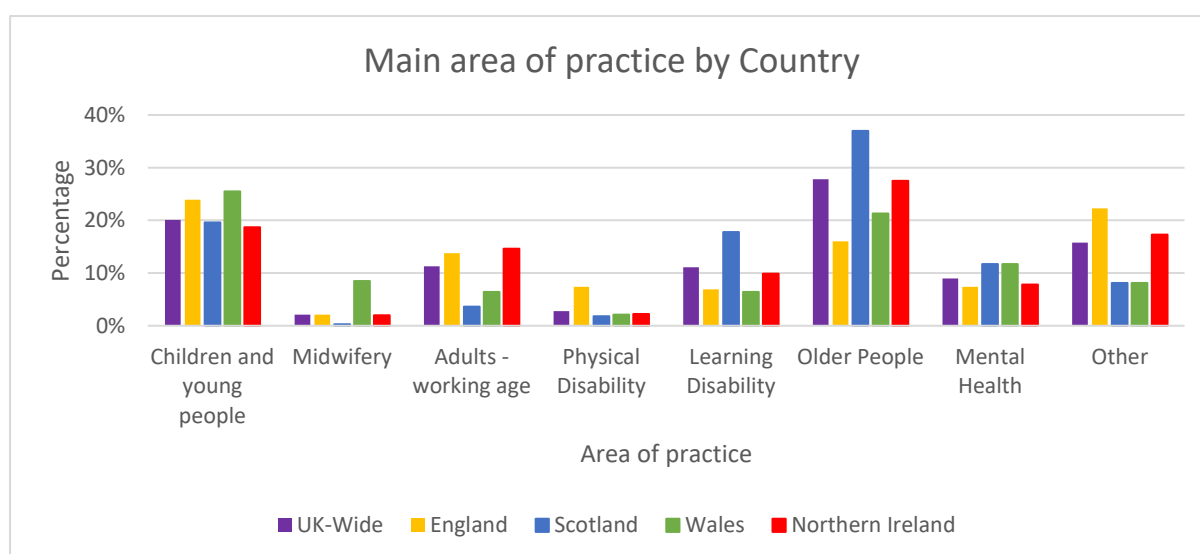


Table A2. 72: Main Area of Practice by Country (Weighted by Occupation)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	12.6%	10.7%	15.1%	19.2%	13.2%
Midwifery	2.2%	3.6%	0.3%	15.4%	1.8%
Adults	14.1%	27.1%	3.8%	7.7%	21.6%
Physical Disability	4.5%	7.1%	1.9%	3.8%	1.9%
Learning Disability	11.7%	5.0%	19.5%	5.8%	8.2%
Older People	28.0%	10.0%	40.9%	30.8%	26.5%
Mental Health	10.5%	5.0%	12.6%	5.8%	8.5%
Other	16.4%	31.4%	6.0%	11.5%	18.3%
Total	100%	100%	100%	100%	100%

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

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	280 (20.1%)	45 (23.9%)	65 (19.6%)	24 (25.5%)	146 (18.7%)
Midwifery	29 (2.1%)	4 (2.1%)	1 (0.3%)	8 (8.5%)	16 (2.0%)
Adults	158 (11.3%)	26 (13.8%)	12 (3.6%)	6 (6.4%)	114 (14.6%)
Physical Disability	39 (2.8%)	14 (7.4%)	6 (1.8%)	2 (2.1%)	17 (2.2%)
Learning Disability	155 (11.1%)	13 (6.9%)	59 (17.8%)	6 (6.4%)	77 (9.9%)
Older People	388 (27.8%)	30 (16.0%)	123 (37.0%)	20 (21.3%)	215 (27.5%)
Mental Health	125 (9.0%)	14 (7.4%)	39 (11.7%)	11 (11.7%)	61 (7.8%)
Other	221 (15.8%)	42 (22.3%)	27 (8.1%)	17 (18.1%)	135 (17.3%)
Total	1395 (100%)	188 (100%)	332 (100%)	94 (100%)	781 (100%)

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

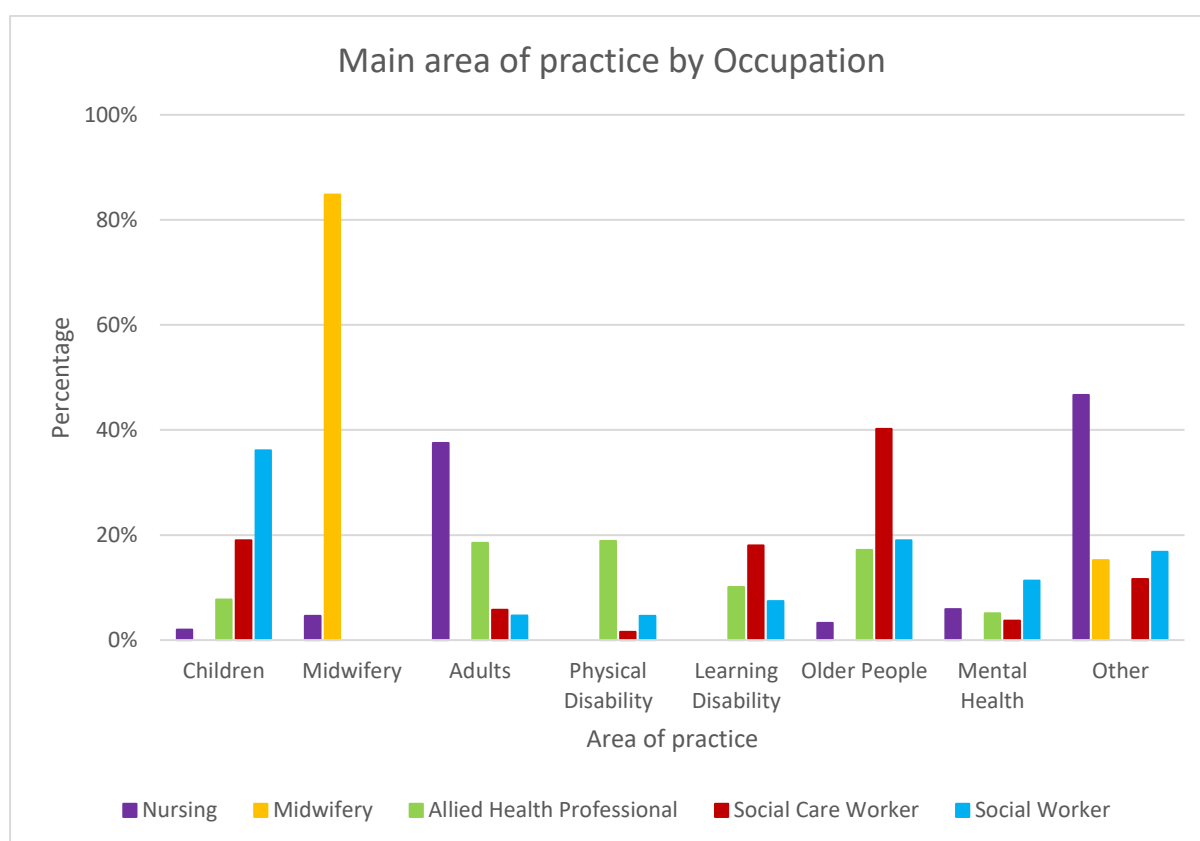


Figure A2. 75: Main Area of Practice by Occupation (Unweighted)

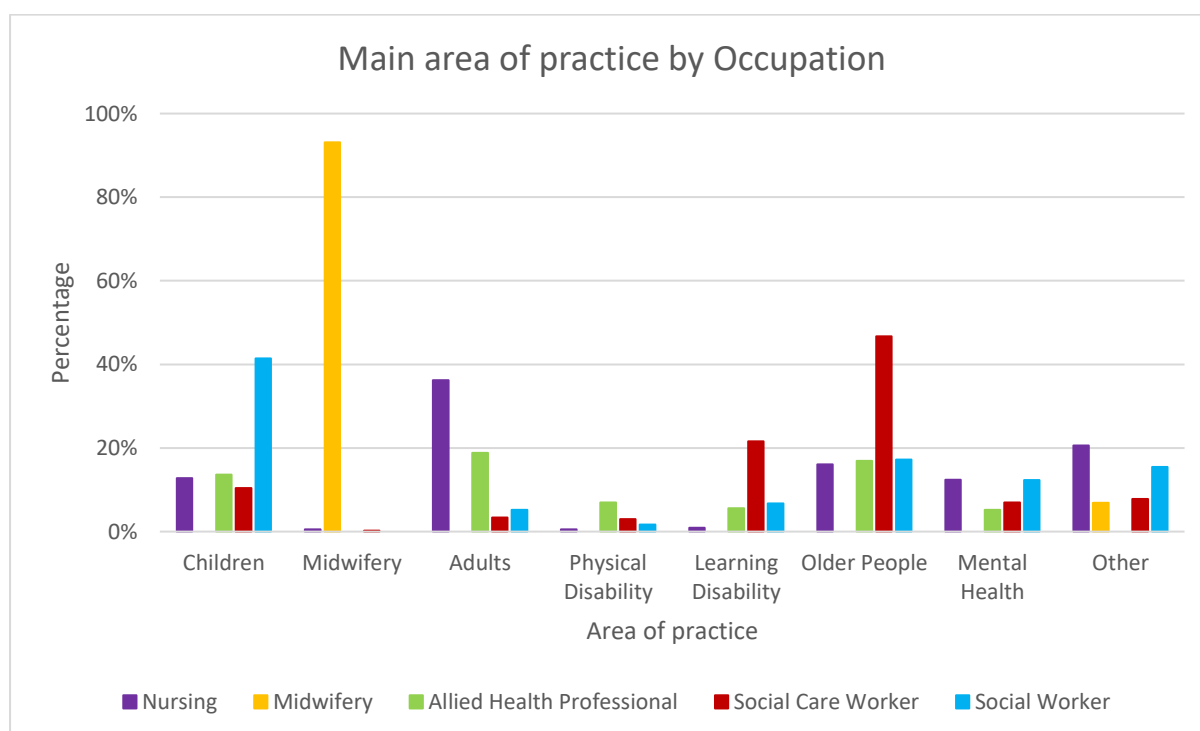


Table A2. 74: Main Area of Practice by Occupation (Weighted by Region)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	2.0%	0.0%	7.7%	19.0%	36.1%
Midwifery	4.6%	84.8%	0.0%	0.0%	0.0%
Adults	37.5%	0.0%	18.5%	5.8%	4.7%
Physical Disability	0.0%	0.0%	18.9%	1.6%	4.6%
Learning Disability	0.0%	0.0%	10.1%	18.0%	7.4%
Older People	3.3%	0.0%	17.2%	40.2%	19.0%
Mental Health	5.9%	0.0%	5.1%	3.7%	11.3%
Other	46.7%	15.2%	22.6%	11.6%	16.8%
Total	100%	100%	100%	100%	100%

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

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	28 (12.8%)	0 (0.0%)	29 (13.6%)	55 (10.4%)	168 (41.4%)
Midwifery	1 (0.5%)	27 (93.1%)	0 (0.0%)	1 (0.2%)	0 (0.0%)
Adults	79 (36.2%)	0 (0.0%)	40 (18.8%)	18 (3.4%)	21 (5.2%)
Physical Disability	1 (0.5%)	0 (0.0%)	15 (7.0%)	16 (3.0%)	7 (1.7%)
Learning Disability	2 (0.9%)	0 (0.0%)	12 (5.6%)	114 (21.6%)	27 (6.7%)
Older People	35 (16.1%)	0 (0.0%)	36 (16.9%)	247 (46.7%)	70 (17.2%)
Mental Health	27 (12.4%)	0 (0.0%)	11 (5.2%)	37 (7.0%)	50 (12.3%)
Other	45 (20.6%)	2 (6.9%)	70 (32.9%)	41 (7.8%)	63 (15.5%)
Total	218 (100%)	29 (100%)	213 (100%)	529 (100%)	406 (100%)

A2.24 Impact of COVID-19 on Services

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

Summary (Weighted results):

UK-wide, only 4.1% of respondents reported that their service was not impacted, and it was stepped down. More than half of the respondents (57.7%) felt overwhelmed by increased pressures. Social workers and social care workers were the most impacted of the examined occupational groups.

Summary (Unweighted results):

UK-wide, 2.9% of respondents reported that their service was not impacted and it was stepped down. Over half of the respondents (58.1%) felt overwhelmed by increased pressures, particularly those in Wales. Midwifery was the most impacted of the examined occupational groups.

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

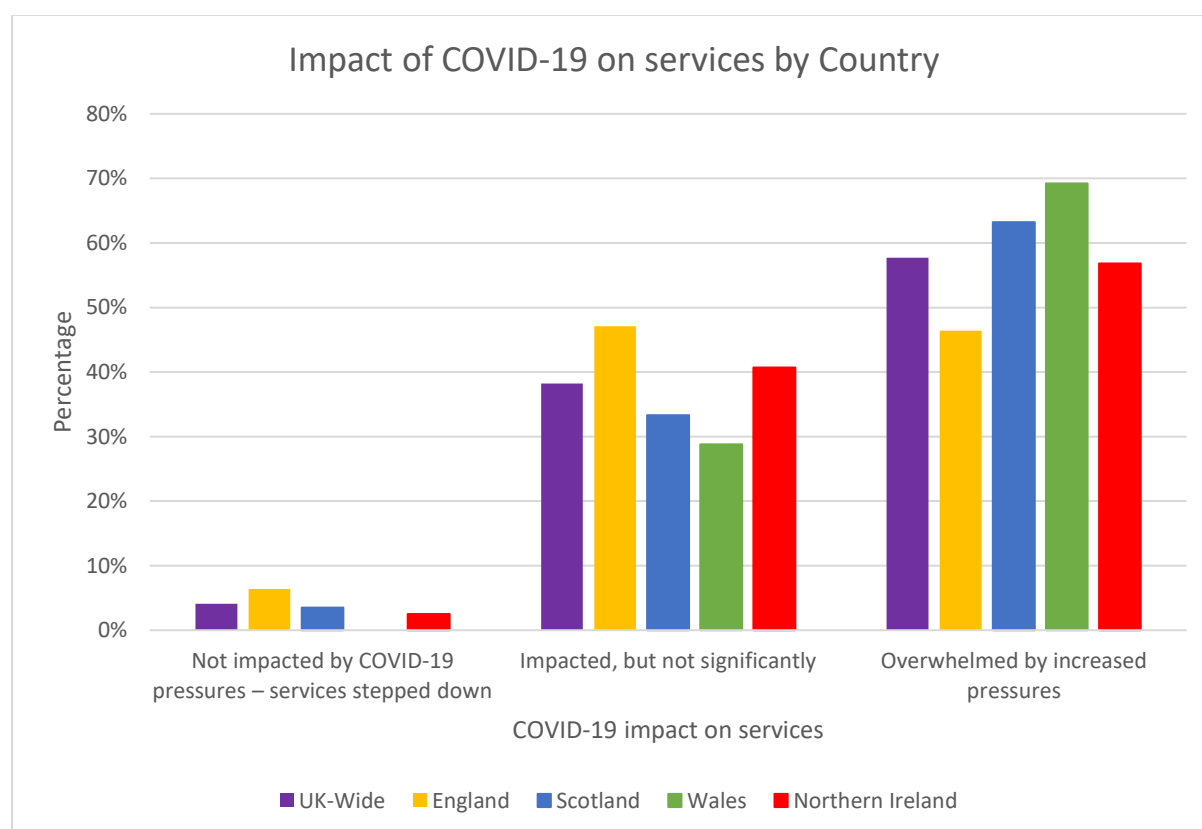


Figure A2. 77: Impact of COVID-19 on Services by Country (Unweighted)

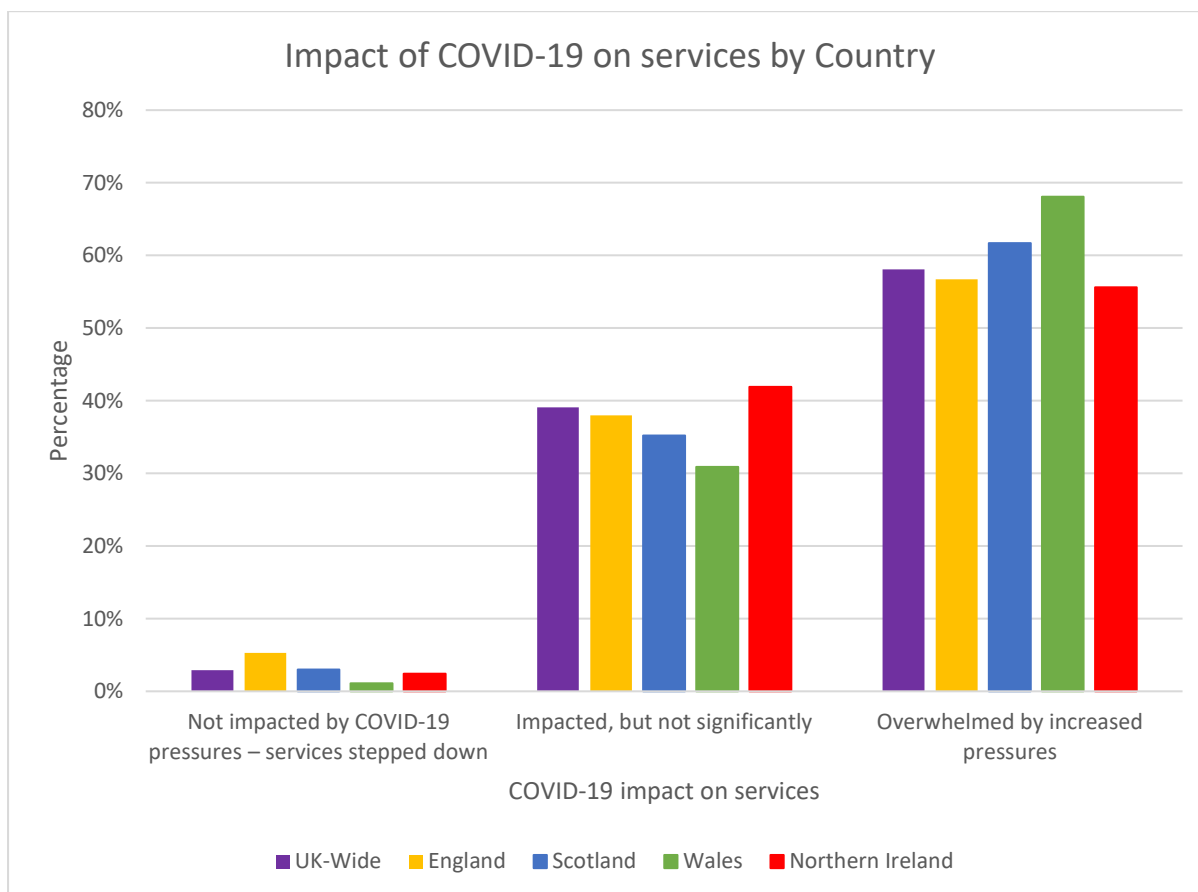


Table A2. 76: Impact of COVID-19 on Services by Country (Weighted by Occupation)

Impact of COVID-19 on services	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Not impacted by COVID-19 pressures – services stepped down	4.1%	6.4%	3.5%	1.9%	2.5%
Impacted, but not significantly	38.2%	47.1%	33.3%	28.8%	40.7%
Overwhelmed by increased pressures	57.7%	46.4%	63.2%	69.2%	56.8%
Total	100%	100%	100%	100%	100%

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

Impact of COVID-19 on services	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Not impacted by COVID-19 pressures – services stepped down	40 (2.9%)	10 (5.3%)	10 (3.0%)	1 (1.1%)	19 (2.4%)
Impacted, but not significantly	544 (39.1%)	71 (38.0%)	117 (35.2%)	29 (30.9%)	544 (39.1%)
Overwhelmed by increased pressures	809 (58.1%)	106 (56.7%)	205 (61.7%)	64 (68.1%)	809 (58.1%)
Total	1393 (100%)	187 (100%)	332 (100%)	94 (100%)	1393 (100%)

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

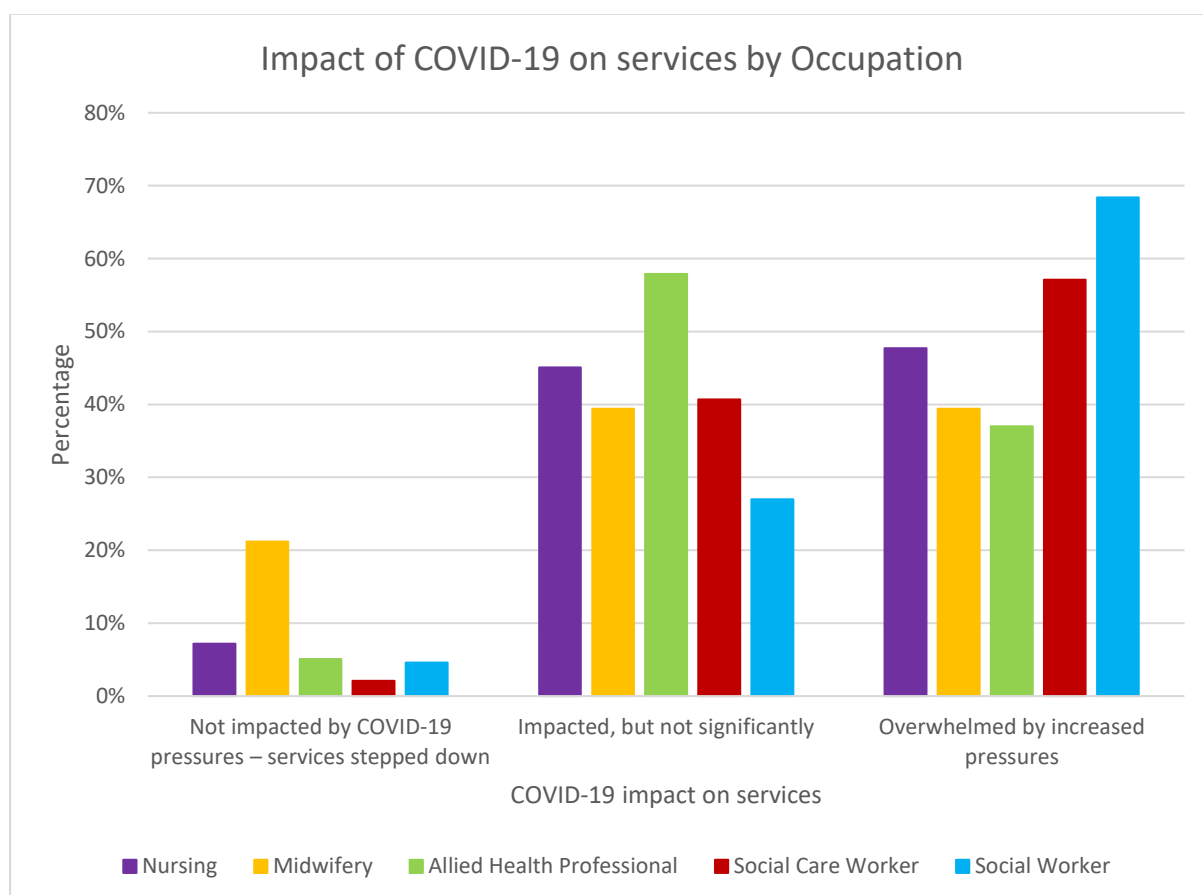


Figure A2. 79: Impact of COVID-19 on Services by Occupation (Unweighted)

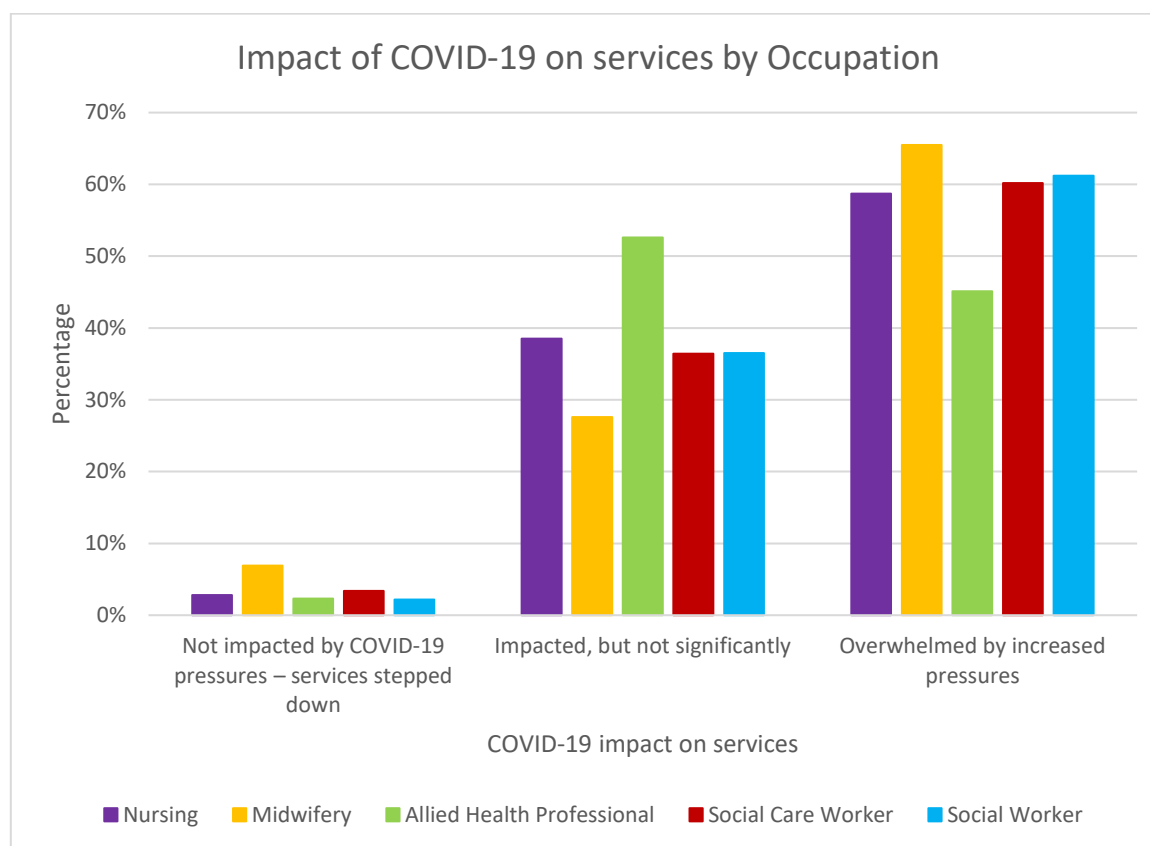


Table A2. 78: Impact of COVID-19 on Services by Occupation (Weighted by Region)

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	7.2%	45.1%	47.7%	100%
Midwifery	21.2%	39.4%	39.4%	100%
AHP	5.1%	57.9%	37.0%	100%
Social Care Worker	2.1%	40.7%	57.1%	100%
Social Worker	4.6%	27.0%	68.4%	100%

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

Occupation	Impact of COVID-19 on services			Total
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures	
Nursing	6 (2.8%)	84 (38.5%)	128 (58.7%)	218 (100%)
Midwifery	2 (6.9%)	8 (27.6%)	19 (65.5%)	29 (100%)
AHP	5 (2.3%)	112 (52.6%)	96 (45.1%)	213 (100%)
Social Care Worker	18 (3.4%)	192 (36.4%)	318 (60.2%)	528 (100%)
Social Worker	9 (2.2%)	148 (36.5%)	248 (61.2%)	405 (100%)

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

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

Summary (Weighted results):

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

Summary (Unweighted results):

A majority of the respondents did not work from home during the pandemic (77.2%). Respondents from Wales were the most likely to work from home (52.1%) before the pandemic and those from Northern Ireland were the least likely (84.6%). Social work respondents were mostly likely to work from home (48.8%) while Social Care workers were least likely to work from home (90.0%).

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

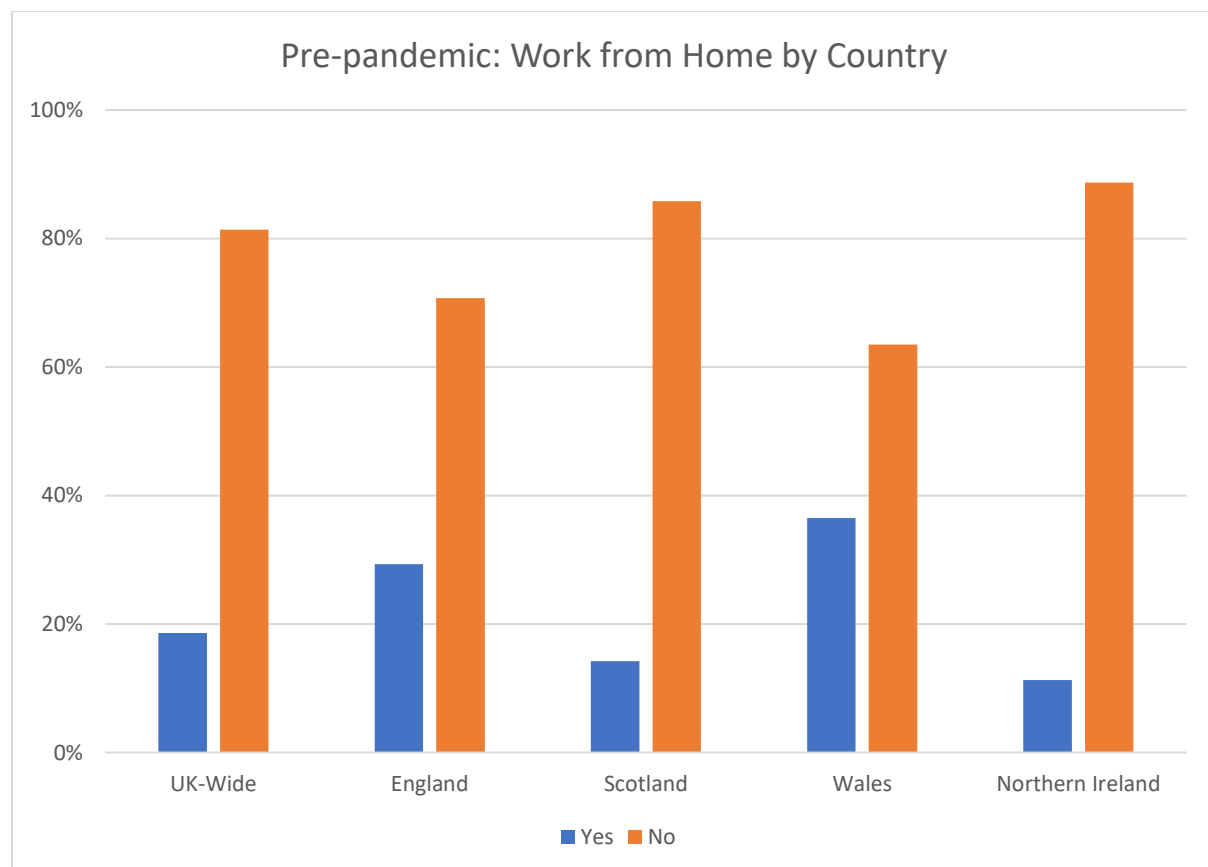


Figure A2. 81: Respondents working from home by Country (Unweighted)

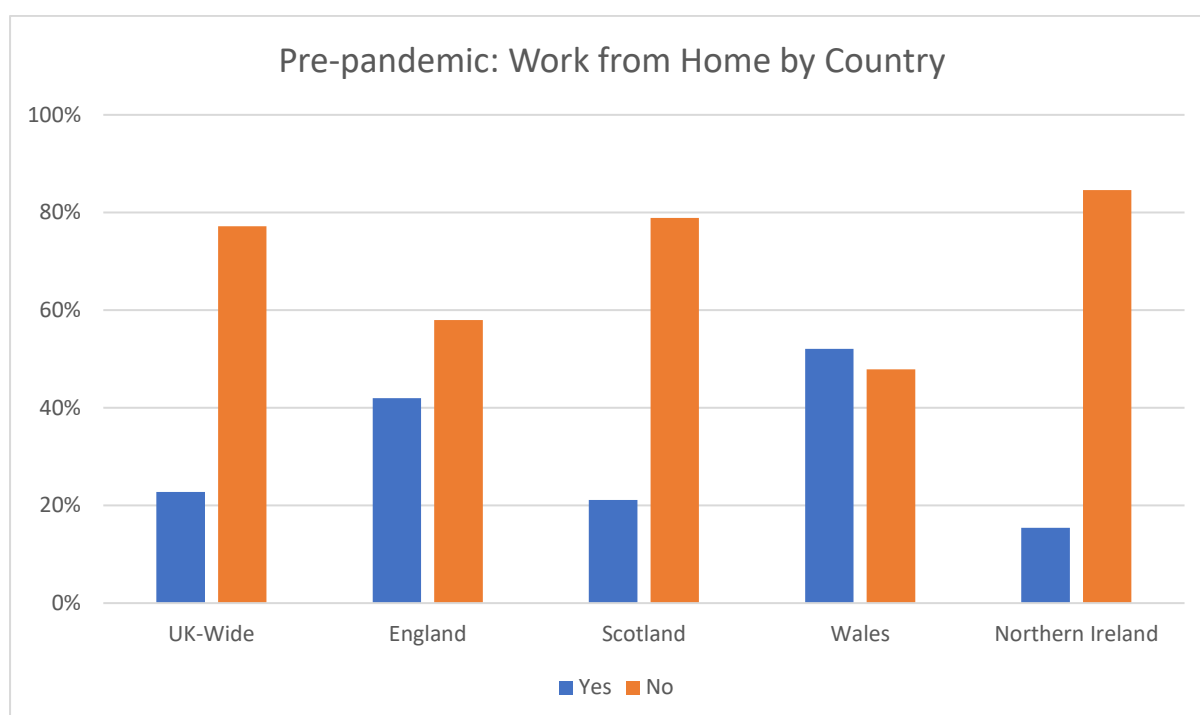


Table A2. 80: Respondents working from home by Country (Weighted by Occupation)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	18.6%	29.3%	14.2%	36.5%	11.3%
No	81.4%	70.7%	85.8%	63.5%	88.7%
Total	100%	100%	100%	100%	100%

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

Had you been able to work from home pre-pandemic?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	318 (22.8%)	79 (42.0%)	70 (21.1%)	49 (52.1%)	120 (15.4%)
No	1075 (77.2%)	109 (58.0%)	261 (78.9%)	45 (47.9%)	660 (84.6%)
Total	1393 (100%)	188 (100%)	331 (100%)	94 (100%)	780 (100%)

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

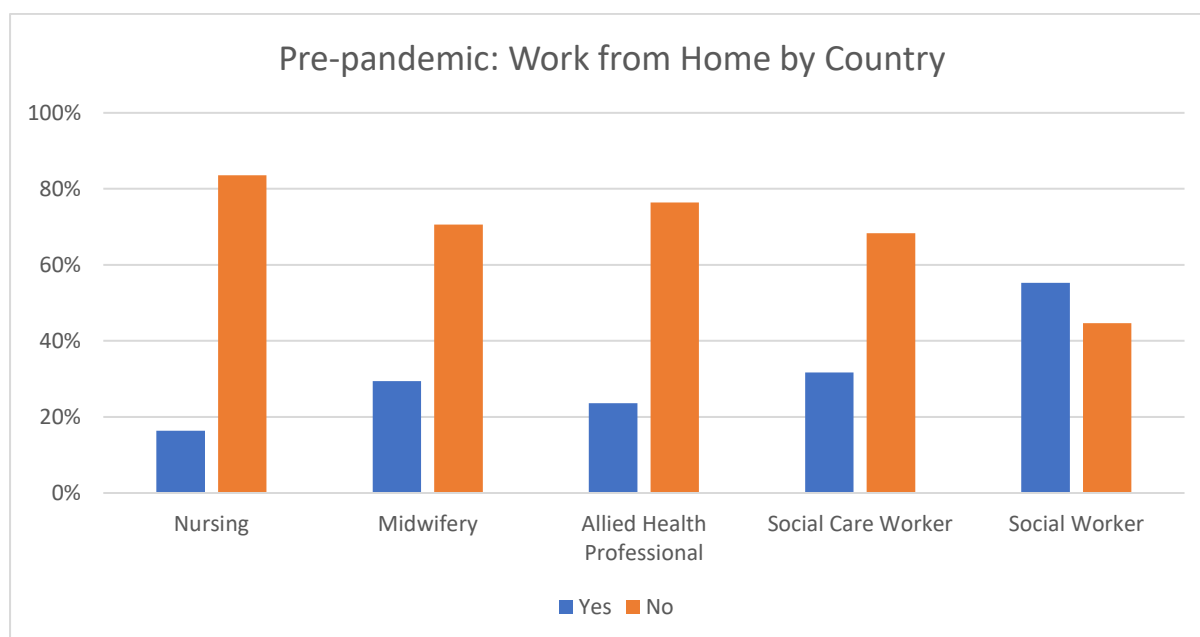


Figure A2. 83: Respondents working from home by Occupation (Unweighted)

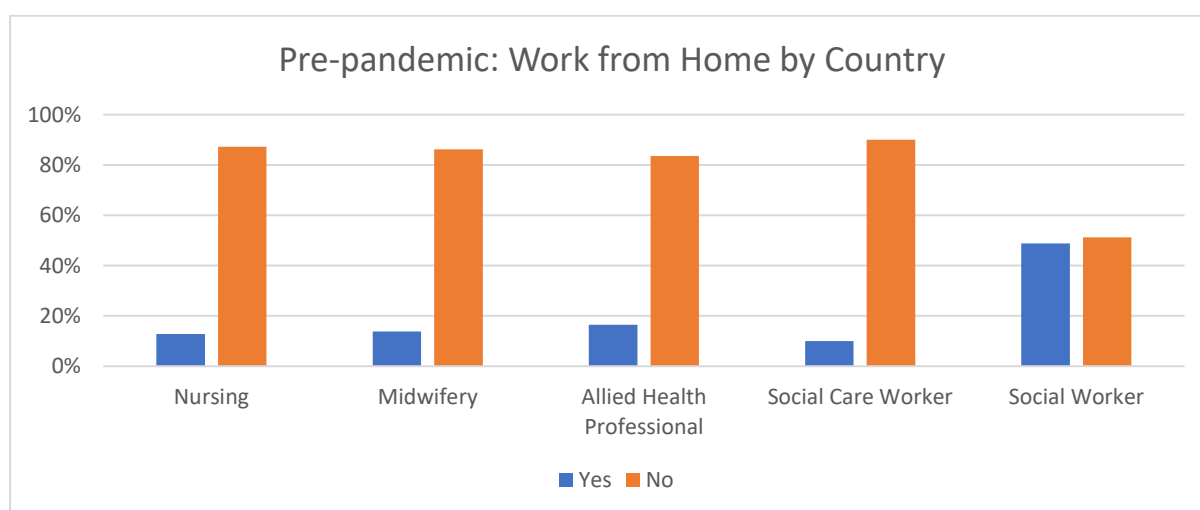


Table A2. 82: Respondents working from home by Occupation (Weighted by Region)

Occupation	Did you work from home pre-pandemic?		Total
	Yes	No	
Nursing	16.4%	83.6%	100%
Midwifery	29.4%	70.6%	100%
AHP	23.6%	76.4%	100%
Social Care Worker	31.7%	68.3%	100%
Social Worker	55.3%	44.7%	100%

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

Occupation	Did you work from home pre-pandemic?		Total
	Yes	No	
Nursing	28 (12.8%)	190 (87.2%)	218 (100%)
Midwifery	4 (13.8%)	25 (86.2%)	29 (100%)
AHP	35 (16.5%)	177 (83.5%)	212 (100%)
Social Care Worker	53 (10.0%)	475 (90.0%)	528 (100%)
Social Worker	198 (48.8%)	208 (51.2%)	406 (100%)

A2.18 Respondents working from home during the pandemic.

Respondents were asked if they are currently working from home?

Summary (Weighted results):

Over two-thirds of respondents were not able to work from home currently. Northern Irish respondents were least likely to work from home while Welsh respondents were more likely to work at home.

Summary (Unweighted results):

Near two thirds of the respondents were not able to work from home at this point of the COVID-19 pandemic, Nov 2022 --Feb 2023 (62.2%). Northern Ireland workers were least likely to work from home, while Welsh workers were more likely to work at home. Social workers were the mostly likely group to work from home all or some of the time.

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

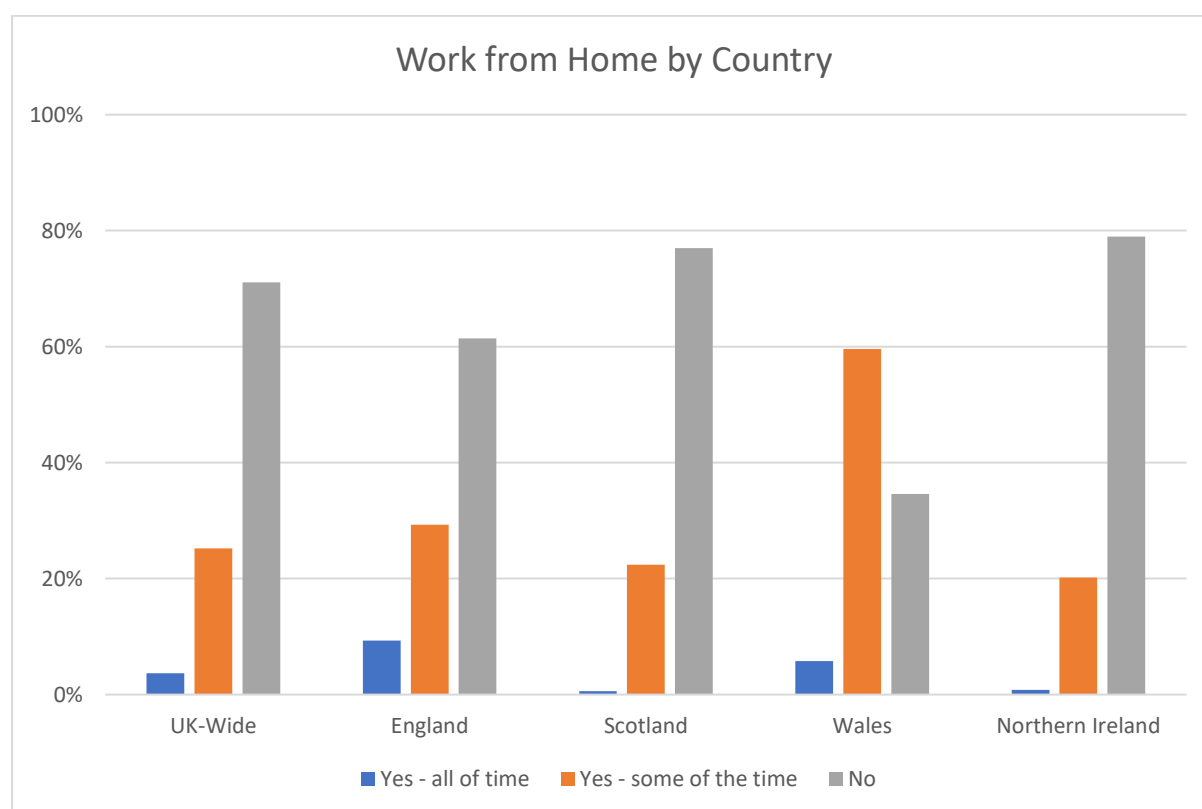


Figure A2. 85: Respondents working from home by Country (Unweighted)

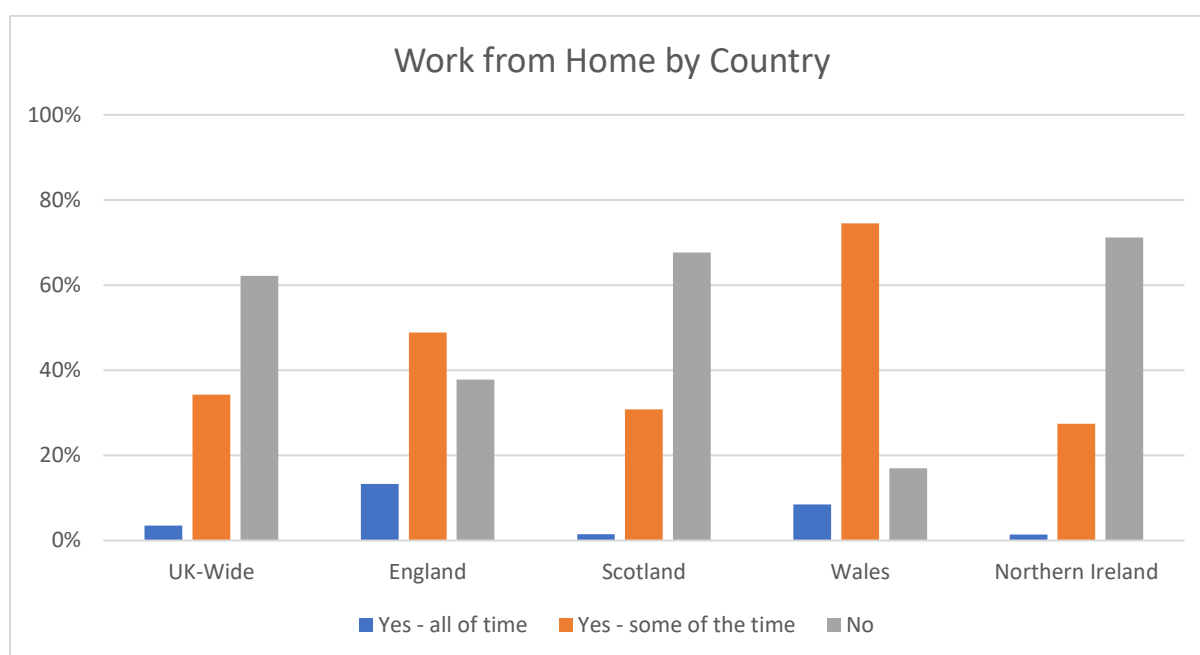


Table A2. 84: Respondents working from home by Country (Weighted by Occupation)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes – all of time	3.7%	9.3%	0.6%	5.8%	0.8%
Yes – some of the time	25.2%	29.3%	22.4%	59.6%	20.2%
No	71.1%	61.4%	77.0%	34.6%	79.0%
Total	100%	100%	100%	100%	100%

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

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes – all of time	49 (3.5%)	25 (13.3%)	5 (1.5%)	8 (8.5%)	11 (1.4%)
Yes – some of the time	478 (34.3%)	92 (48.9%)	102 (30.8%)	70 (74.5%)	214 (27.4%)
No	867 (62.2%)	71 (37.8%)	224 (67.7%)	16 (17.0%)	556 (71.2%)
Total	1394 (100%)	188 (100%)	331 (100%)	94 (100%)	781 (100%)

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

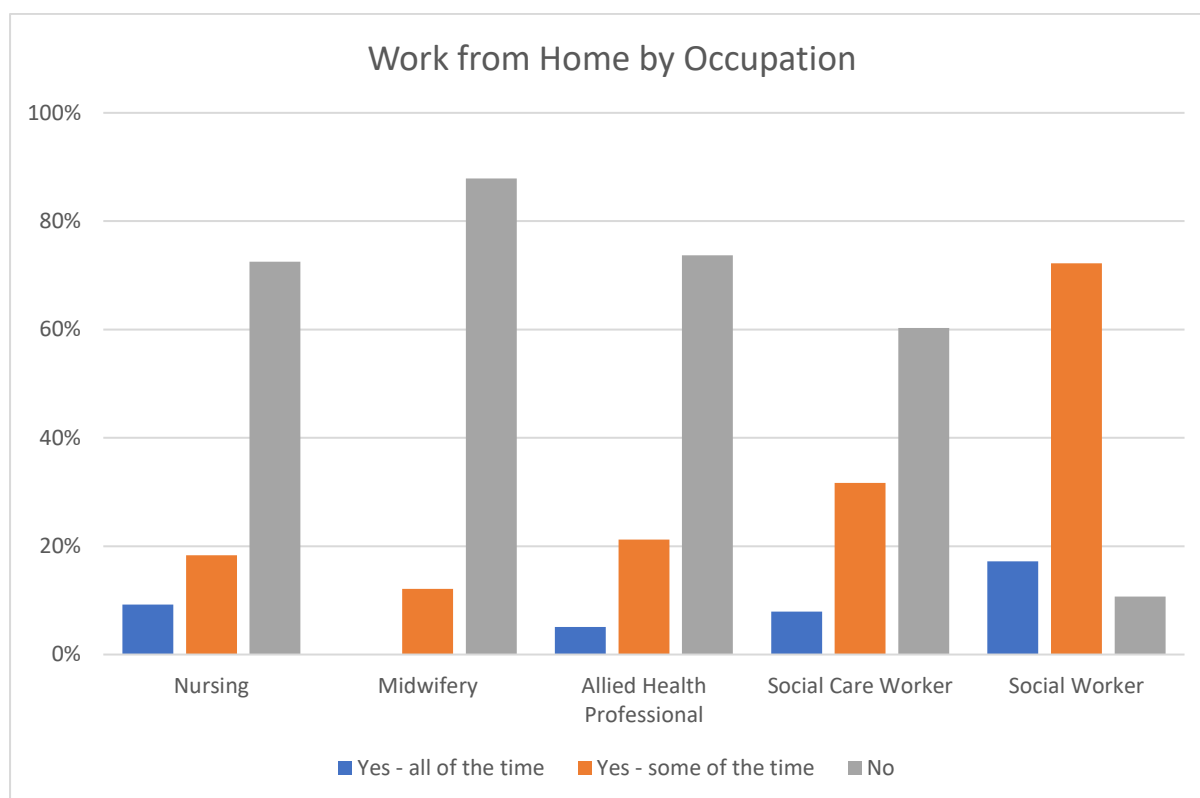


Figure A2. 87: Respondents working from home by Occupation (Unweighted)

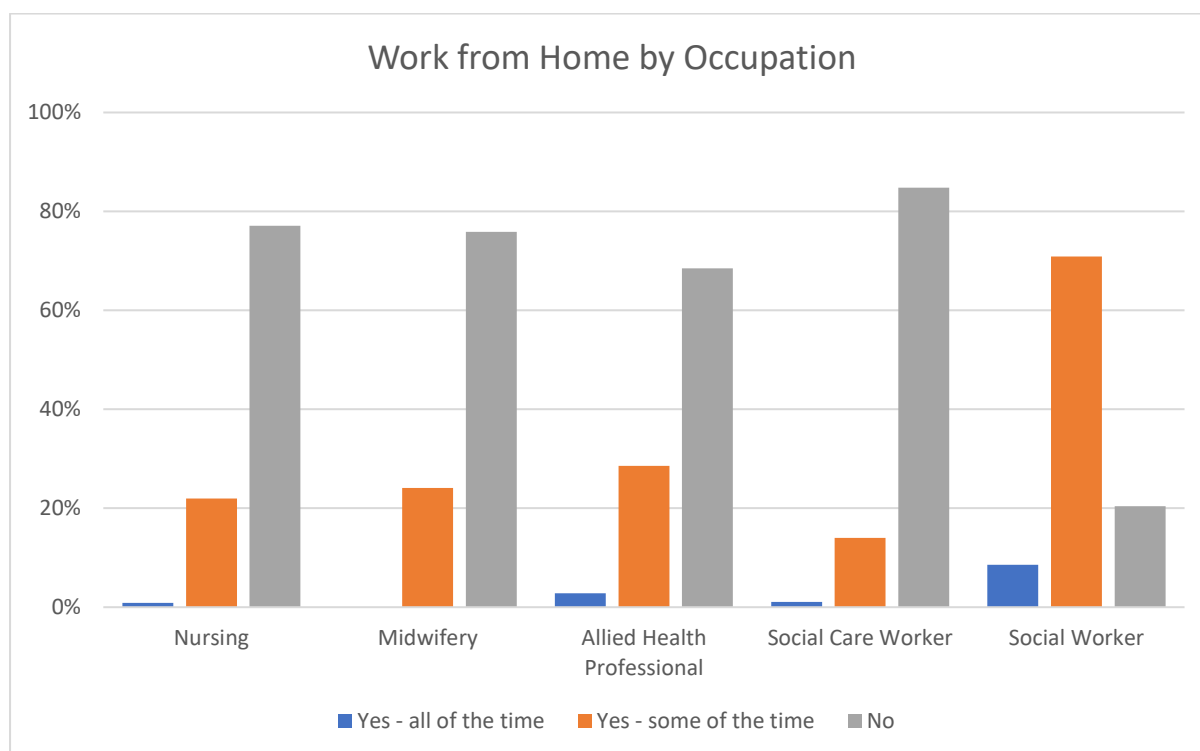


Table A2. 86: Respondents working from home by Occupation (Weighted by Region)

Occupation	Are you working from home?			
	Yes – all of time	Yes – some of the time	No	Total
Nursing	9.2%	18.3%	72.5%	100%
Midwifery	0.0%	12.1%	87.9%	100%
AHP	5.1%	21.2%	73.7%	100%
Social Care Worker	7.9%	31.7%	60.3%	100%
Social Worker	17.2%	72.2%	10.7%	100%

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

Occupation	Are you working from home?			
	Yes – all of time	Yes – some of the time	No	Total
Nursing	2 (0.9%)	48 (22.0%)	168 (77.1%)	218 (100%)
Midwifery	0 (0.0%)	7 (24.1%)	22 (75.9%)	29(100%)
AHP	6 (2.8%)	61 (28.6%)	146 (68.5%)	213 (100%)
Social Care Worker	6 (1.1%)	74 (14.0%)	448 (84.8%)	528 (100%)
Social Worker	35 (8.6%)	288 (70.9%)	83 (20.4%)	406 (100%)

A2.19 Respondents Considering Changing their Employer.

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

- Early retirement
- Pay is currently too low for the work done.

- Considering more specialist roles
- Difficulty balancing work-home life
- To be closer to home
- Considering private sector due to better pay
- Not appreciated or respected by current employer
- To get a permanent post
- To further career development
- Personal reasons
- Being constantly overlooked for promotion
- Pressures within the healthcare system are impacting ability to be effective and impacting safety
- Hostility from public and fellow workers
- Frustration at current systems and support
- Unsupportive management
- Lack of clear communication from management
- Stress related issues impacting physical and mental health
- Poor working conditions
- Gaslighting by colleagues and constant bullying

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

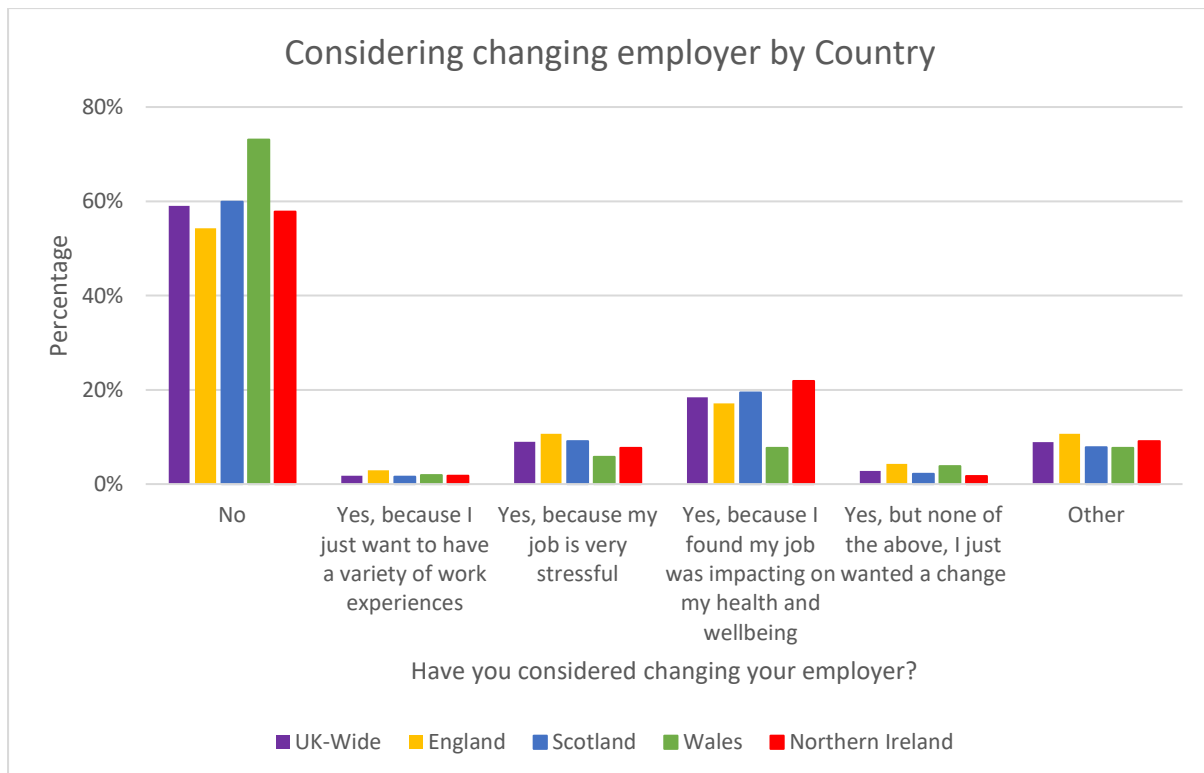


Figure A2. 89: Considering Changing Employer by Country (Unweighted)

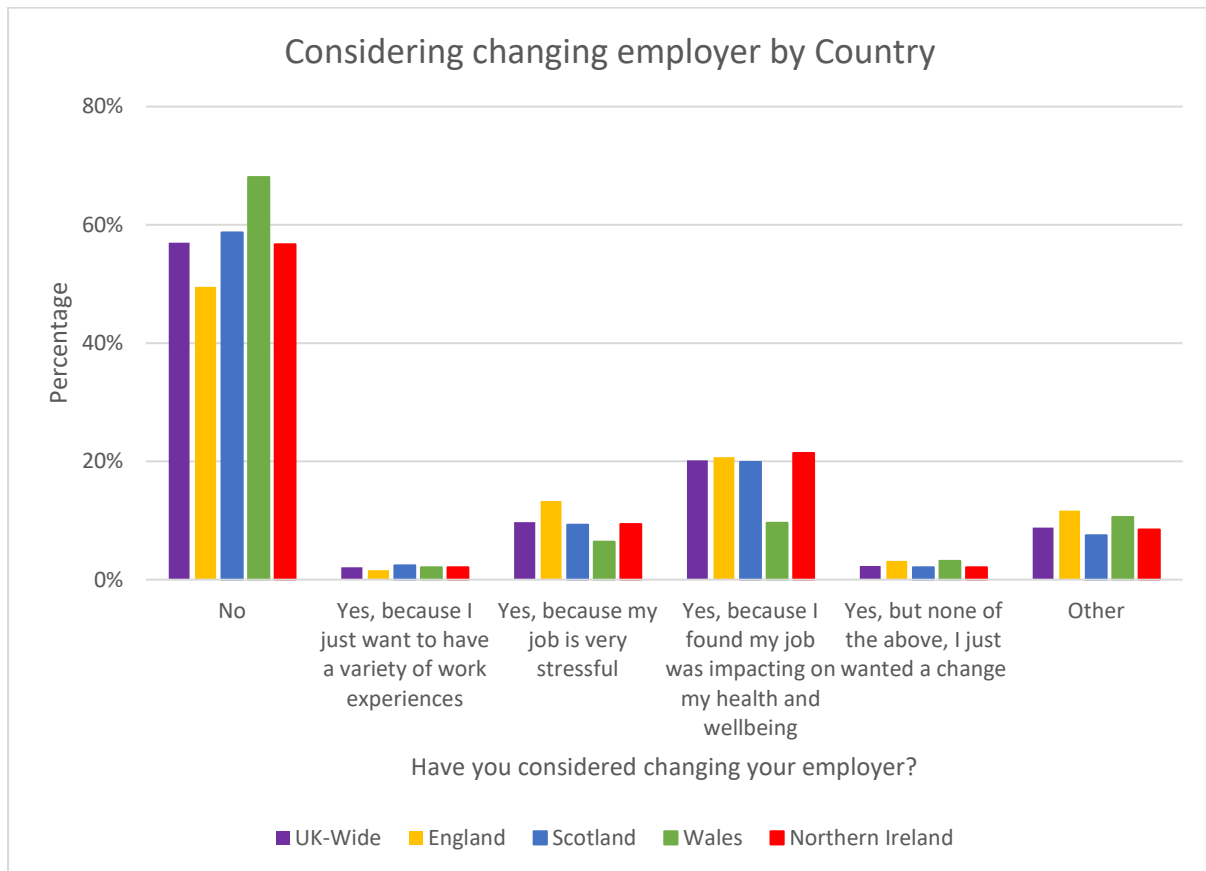


Table A2. 88: Considering Changing Employer by Country (Weighted by Occupation)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	59.0%	54.3%	59.9%	73.1%	57.8%
Yes, because I just want to have a variety of work experiences	1.8%	2.9%	1.6%	1.9%	1.8%
Yes, because my job is very stressful	9.0%	10.7%	9.1%	5.8%	7.7%
Yes, because I found my job was impacting on my health and well-being	18.4%	17.1%	19.4%	7.7%	21.9%
Yes, but none of the above, I just wanted a change	2.8%	4.3%	2.2%	3.8%	1.7%
Other	8.9%	10.7%	7.8%	7.7%	9.1%
Total	100%	100%	100%	100%	100%

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

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	794 (57.0%)	93 (49.5%)	195 (58.7%)	64 (68.1%)	442 (56.7%)
Yes, because I just want to have a variety of work experiences	29 (2.1%)	3 (1.6%)	8 (2.4%)	2 (2.1%)	16 (2.1%)
Yes, because my job is very stressful	135 (9.7%)	25 (13.3%)	31 (9.3%)	6 (6.4%)	73 (9.4%)
Yes, because I found my job was impacting on my health and well-being	281 (20.2%)	39 (20.7%)	66 (19.9%)	9 (9.6%)	167 (21.4%)
Yes, but none of the above, I just wanted a change	32 (2.3%)	6 (3.2%)	7 (2.1%)	3 (3.2%)	16 (2.1%)
Other	123 (8.8%)	22 (11.7%)	25 (7.5%)	10 (10.6%)	66 (8.5%)
Total	1394 (100%)	188 (100%)	332 (100%)	94 (100%)	780 (100%)

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

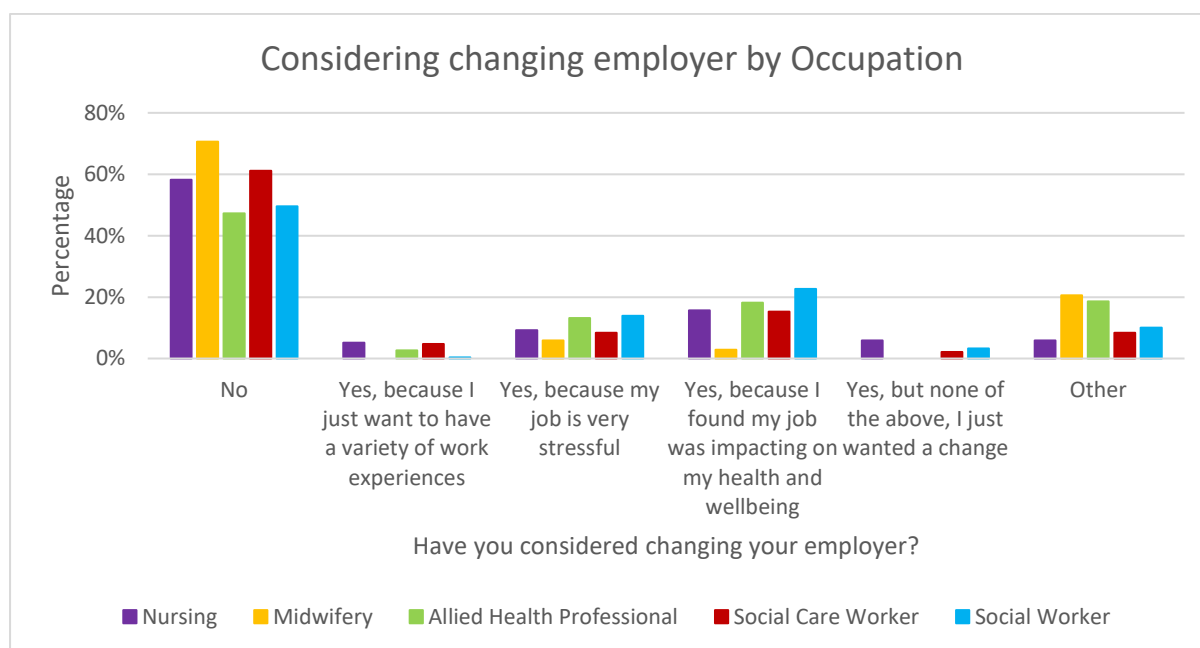


Figure A2. 91: Considering Changing Employer by Occupation (Unweighted)

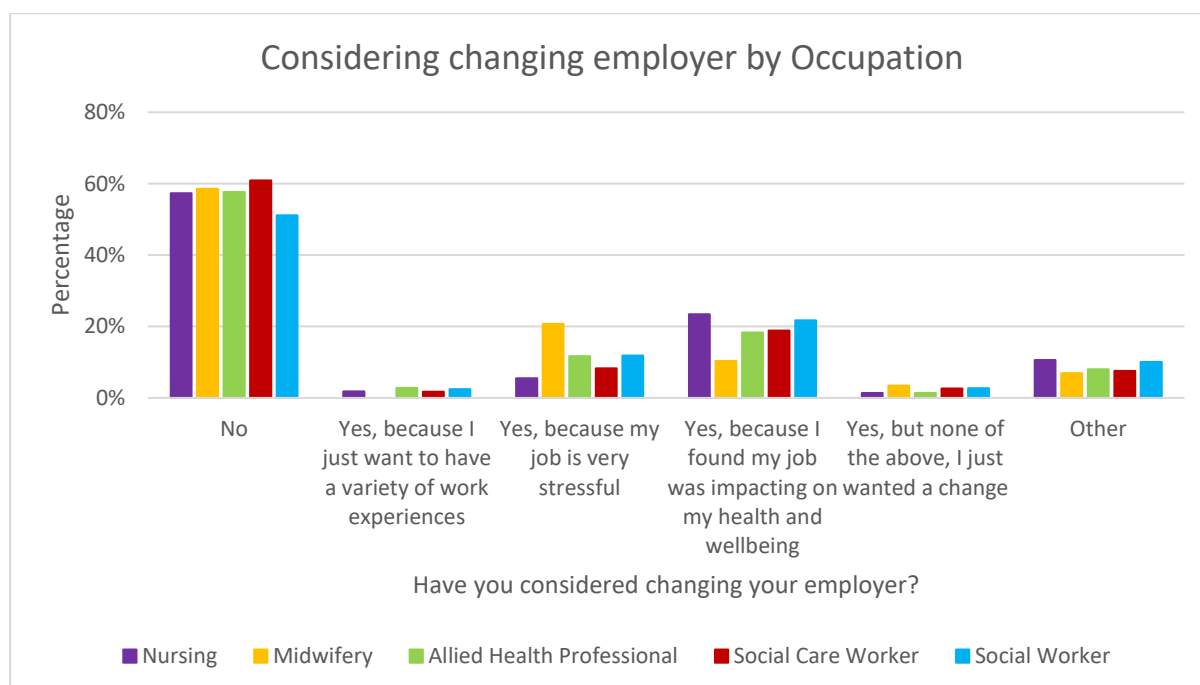


Table A2. 90: Considering Changing Employer by Occupation (Weighted by Region)

Occupation	Have you considered changing your employer?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and well-being	Yes, but none of the above, I just wanted a change	Other	
Nursing	58.2%	5.2%	9.2%	15.7%	5.9%	5.9%	100%
Midwifery	70.6%	0.0%	5.9%	2.9%	0.0%	20.6%	100%
AHP	47.3%	2.7%	13.2%	18.2%	0.0%	18.6%	100%
Social Care Worker	61.1%	4.7%	8.4%	15.3%	2.1%	8.4%	100%
Social Worker	49.6%	0.4%	13.9%	22.7%	3.3%	10.1%	100%

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

Occupation	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and well-being	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	125 (57.3%)	4 (1.8%)	12 (5.5%)	51 (23.4%)	3 (1.4%)	23 (10.6%)	218 (100%)
Midwifery	17 (58.6%)	0 (0.0%)	6 (20.7%)	3 (10.3%)	1 (3.4%)	2 (6.9%)	29 (100%)
AHP	123 (57.7%)	6 (2.8%)	25 (11.7%)	39 (18.3%)	3 (1.4%)	17 (8.0%)	213 (100%)
Social Care Worker	322 (60.9%)	9 (1.7%)	44 (8.3%)	100 (18.9%)	14 (2.6%)	40 (7.6%)	529 (100%)
Social Worker	207 (51.1%)	10 (2.5%)	48 (11.9%)	88 (21.7%)	11 (2.7%)	41 (10.1%)	405 (100%)

A2.20 Respondents Considering Changing their Occupation.

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

Summary (Weighted results):

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

Summary (Unweighted results):

Respondents from Wales and AHPs and social 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;

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

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

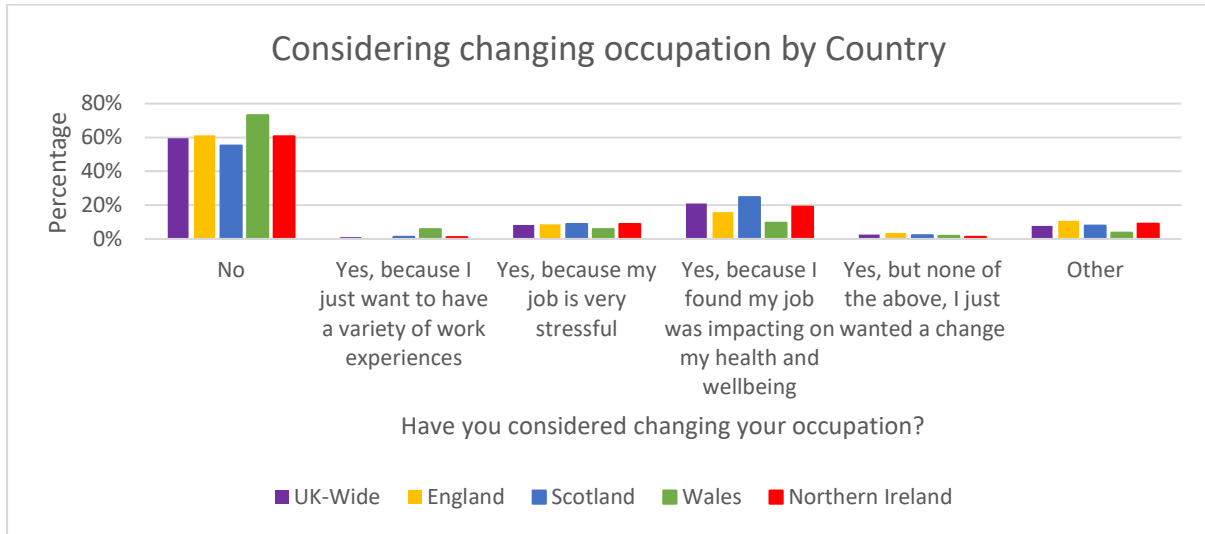


Figure A2. 93: Considering Changing Occupation by Country (Unweighted)

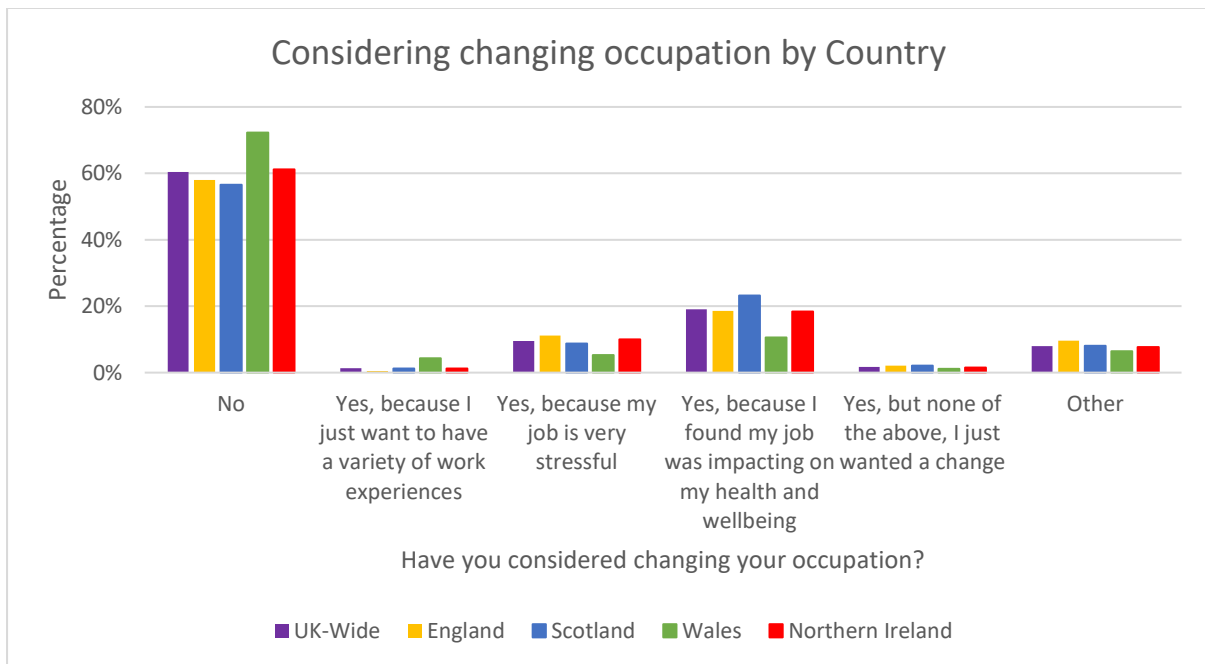


Table A2. 92: Considering Changing Occupation by Country (Weighted by Occupation)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	59.5%	61.2%	55.2%	73.1%	60.7%
Yes, because I just want to have a variety of work experiences	1.1%	0.0%	1.3%	5.8%	1.1%
Yes, because my job is very stressful	8.2%	8.6%	8.8%	5.8%	8.9%
Yes, because I found my job was impacting on my health and well-being	20.9%	15.8%	24.8%	9.6%	19.0%
Yes, but none of the above, I just wanted a change	2.5%	3.6%	2.2%	1.9%	1.2%
Other	7.7%	10.8%	7.8%	3.8%	9.1%
Total	100%	100%	100%	100%	100%

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

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	843 (60.4%)	109 (58.0%)	188 (56.6%)	68 (72.3%)	478 (61.2%)
Yes, because I just want to have a variety of work experiences	18 (1.3%)	1 (0.5%)	4 (1.2%)	4 (4.3%)	9 (1.2%)
Yes, because my job is very stressful	133 (9.5%)	21 (11.2%)	29 (8.7%)	5 (5.3%)	78 (10.0%)
Yes, because I found my job was impacting on my health and well-being	266 (19.1%)	35 (18.6%)	77 (23.2%)	10 (10.6%)	144 (18.4%)
Yes, but none of the above, I just wanted a change	24 (1.7%)	4 (2.1%)	7 (2.1%)	1 (1.1%)	12 (1.5%)
Other	111 (8.0%)	18 (9.6%)	27 (8.1%)	6 (6.4%)	60 (7.7%)
Total	1395 (100%)	188 (100%)	322 (100%)	94 (100%)	781 (100%)

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

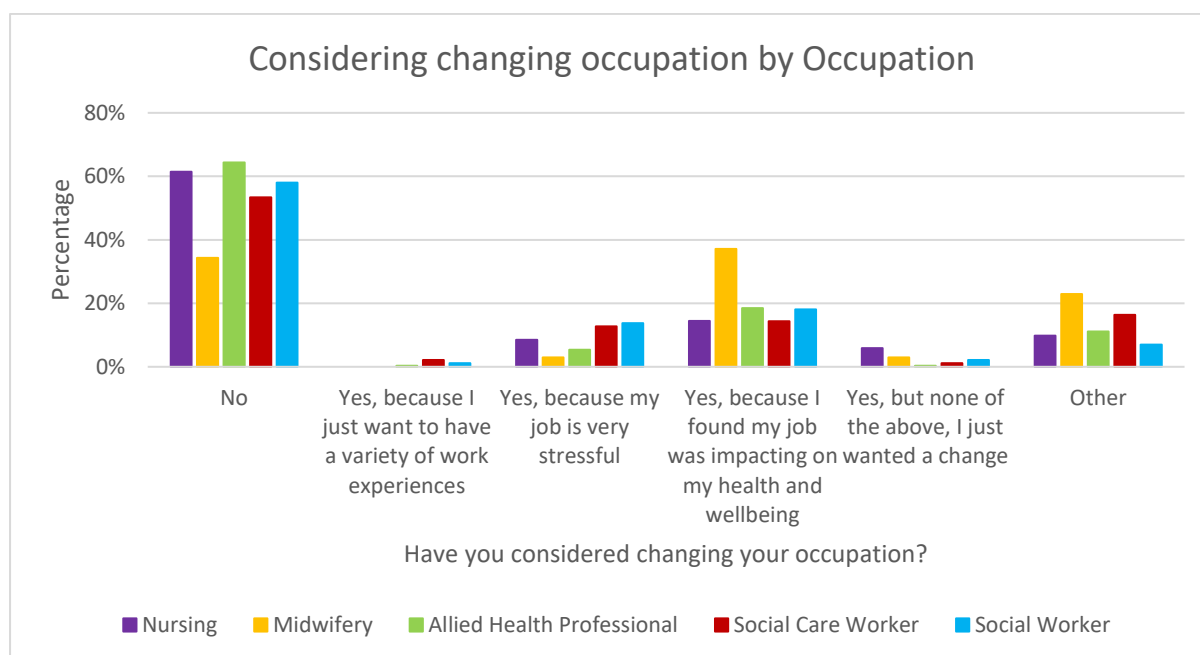


Figure A2. 95: Considering Changing Occupation by Occupation (Unweighted)

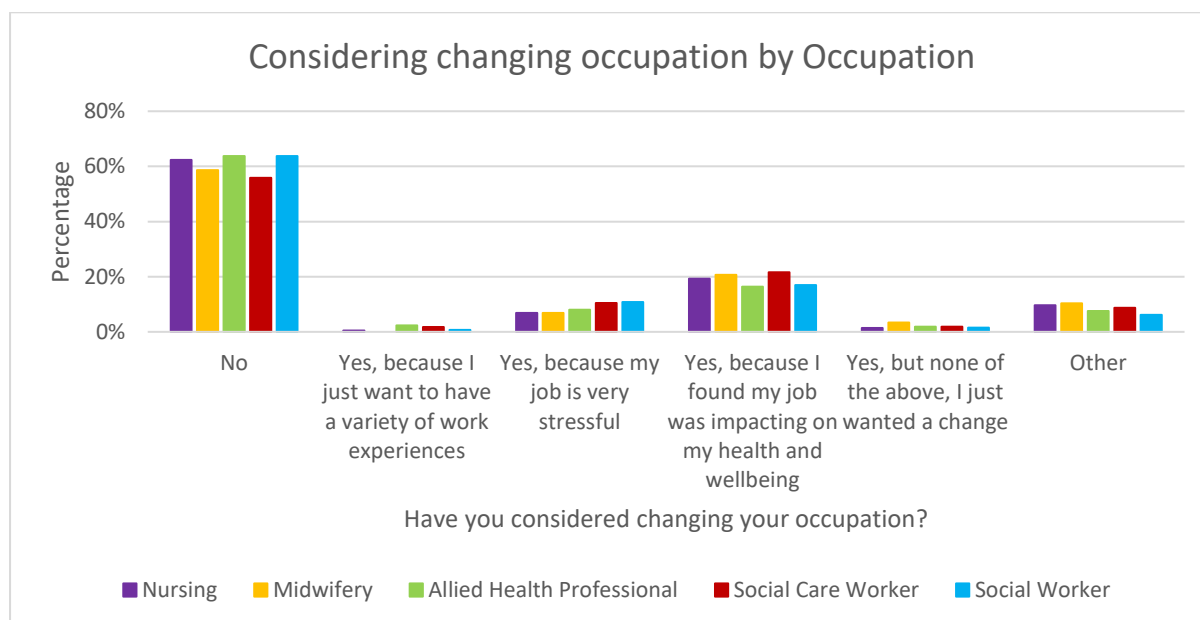


Table A2. 94: Considering Changing Occupation by Occupation (Weighted by Region)

Occupation	Have you considered changing your occupation?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and well-being	Yes, but none of the above, I just wanted a change	Other	
Nursing	61.4%	0.0%	8.5%	14.4%	5.9%	9.8%	100%
Midwifery	34.3%	0.0%	2.9%	37.1%	2.9%	22.9%	100%
AHP	64.4%	0.3%	5.4%	18.5%	0.3%	11.1%	100%
Social Care Worker	53.4%	2.1%	12.7%	14.3%	1.1%	16.4%	100%
Social Worker	58.0%	1.1%	13.7%	18.1%	2.1%	7.0%	100%

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

Occupation	Have you considered changing your occupation?						
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and well-being	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	136 (62.4%)	1 (0.5%)	15 (6.9%)	42 (19.3%)	3 (1.4%)	21 (9.6%)	218 (100%)
Midwifery	17 (58.6%)	0 (0.0%)	2 (6.9%)	6 (20.7%)	1 (3.4%)	3 (10.3%)	29 (100%)
AHP	136 (63.8%)	5 (2.3%)	17 (8.0%)	35 (16.4%)	4 (1.9%)	16 (7.5%)	213 (100%)
Social Care Worker	295 (55.8%)	9 (1.7%)	55 (10.4%)	114 (21.6%)	10 (1.9%)	46 (8.7%)	529 (100%)
Social Worker	259 (63.8%)	3 (0.7%)	44 (10.8%)	69 (17.0%)	6 (1.5%)	25 (6.2%)	406 (100%)

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

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

Summary (Weighted results):

More respondents felt that a pay increase, manager support, and well-being support were reasons to change their mind about wanting to leave. Those who selected 'other' indicated, curbing bullying and harassment from managers, better staffing levels, job recognition and more services available etc., could change their mind about wanting to leave.

Summary (Unweighted results):

Nearly two-thirds of respondents felt that a pay increase would change their mind about wanting to leave. This was closely followed by manager support and well-being support. Some respondents felt that they had other reasons to change their mind about wanting to leave for example, better staffing levels, fully resourced teams, and reduced workloads, followed by further training and development, job rotation, home-work balance, to feel valued, and to improve morale.

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

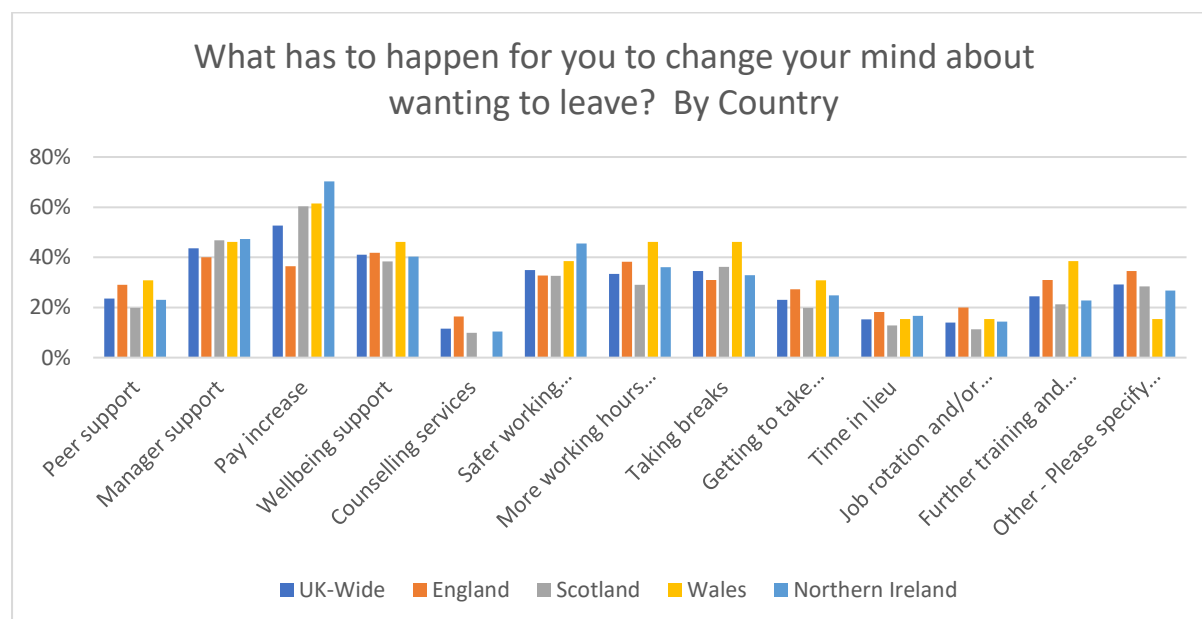


Figure A2. 97: What has to happen for you to change your mind about wanting to leave by Country (Unweighted)

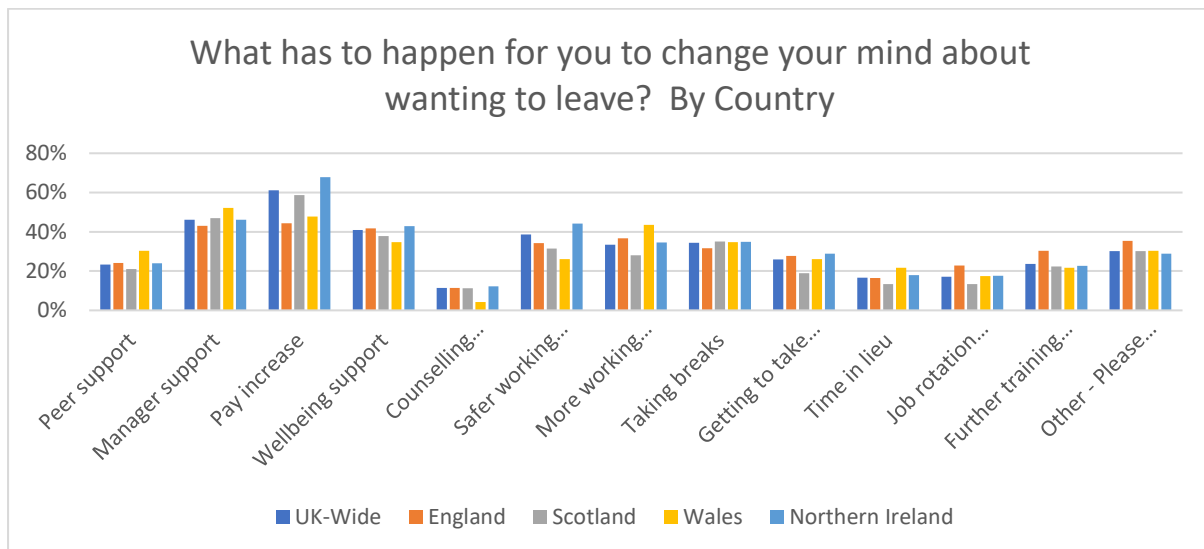


Table A2. 96: What has to happen for you to change your mind about wanting to leave by Country (Regions Weighted by Occupation)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	23.6%	29.1%	19.9%	30.8%	23.1%
Manager support	43.6%	40.0%	46.8%	46.2%	47.3%
Pay increase	52.6%	36.4%	60.3%	61.5%	70.3%
Well-being support	41.1%	41.8%	38.3%	46.2%	40.3%
Counselling services	11.5%	16.4%	9.9%	0.0%	10.4%
Safer working conditions	34.9%	32.7%	32.6%	38.5%	45.5%
More working hours flexibility	33.4%	38.2%	29.1%	46.2%	36.0%
Taking breaks	34.5%	30.9%	36.2%	46.2%	32.9%
Getting to take annual leave	23.0%	27.3%	19.9%	30.8%	24.8%
Time in lieu	15.2%	18.2%	12.8%	15.4%	16.7%
Job rotation and/or change of duties	14.0%	20.0%	11.3%	15.4%	14.4%
Further training and development	24.4%	30.9%	21.3%	38.5%	22.8%
Other – Please specify below	29.2%	34.5%	28.4%	15.4%	26.8%

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

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	128 (23.4%)	19 (24.1%)	30 (21.0%)	7 (30.4%)	72 (23.9%)
Manager support	252 (46.2%)	34 (43.0%)	67 (46.9%)	12 (52.2%)	139 (46.2%)
Pay increase	334 (61.2%)	35 (44.3%)	84 (58.7%)	11 (47.8%)	204 (67.8%)
Well-being support	224 (41.0%)	33 (41.8%)	54 (37.8%)	8 (34.8%)	129 (42.9%)
Counselling services	63 (11.5%)	9 (11.4%)	16 (11.2%)	1 (4.3%)	37 (12.3%)
Safer working conditions	211 (38.6%)	27 (34.2%)	45 (31.5%)	6 (26.1%)	133 (44.2%)
More working hours flexibility	183 (33.5%)	29 (36.7%)	40 (28.0%)	10 (43.5%)	104 (34.6%)
Taking breaks	188 (34.4%)	25 (31.6%)	50 (35.0%)	8 (34.8%)	105 (34.9%)
Getting to take annual leave	142 (26.0%)	22 (27.8%)	27 (18.9%)	6 (26.1%)	87 (28.9%)
Time in lieu	91 (16.7%)	13 (16.5%)	19 (13.3%)	5 (21.7%)	54 (17.9%)
Job rotation and/or change of duties	94 (17.2%)	18 (22.8%)	19 (13.3%)	4 (17.4%)	53 (17.6%)
Further training and development	129 (23.6%)	24 (30.4%)	32 (22.4%)	5 (21.7%)	68 (22.6%)
Other – Please specify below	165 (30.2%)	28 (35.4%)	43 (30.1%)	7 (30.4%)	87 (28.9%)
Total no of respondents answering question	546	79	143	23	301

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

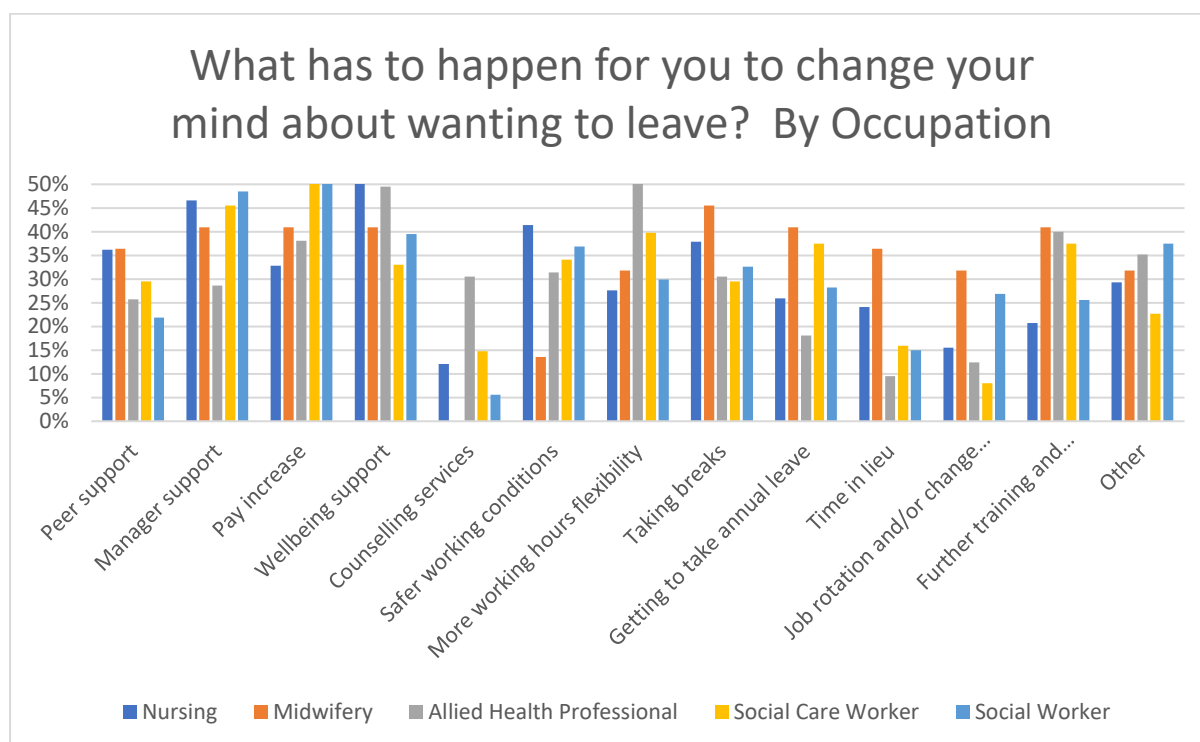


Figure A2. 99: What has to happen for you to change your mind about wanting to leave by Occupation (Unweighted)

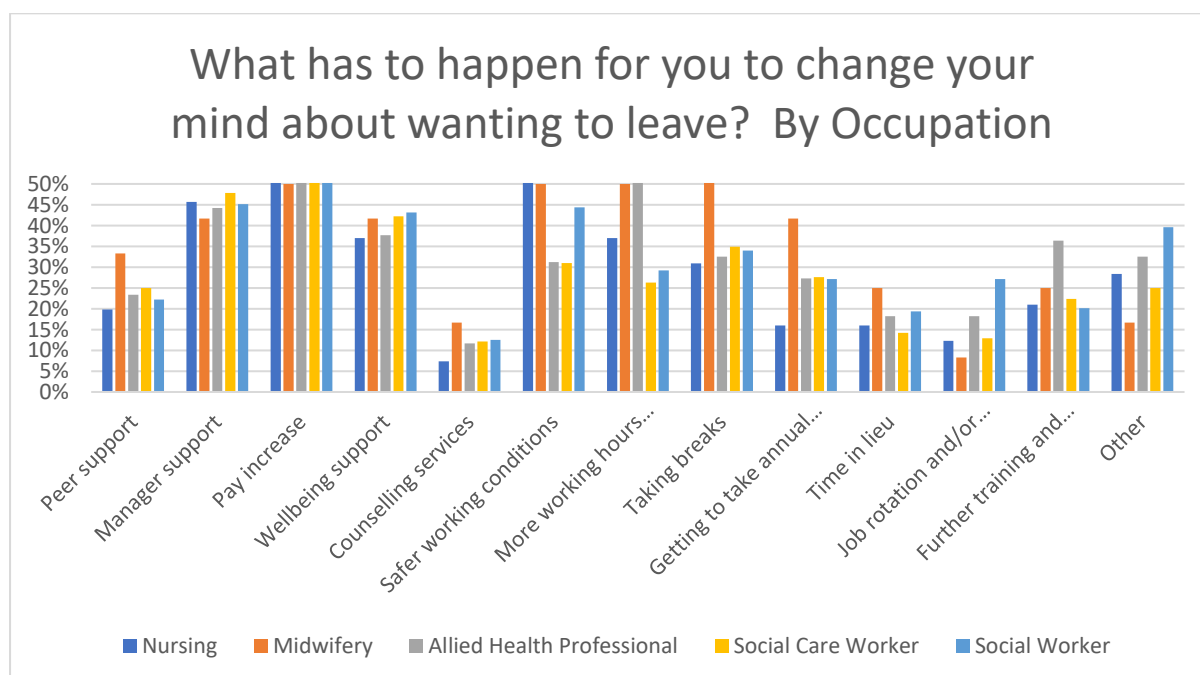


Table A2. 98: What has to happen for you to change your mind about wanting to leave by Occupation (Weighted by Region)

What has to happen for you to change your mind about wanting to leave?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	36.2%	36.4%	25.7%	29.5%	21.9%
Manager support	46.6%	40.9%	28.6%	45.5%	48.5%
Pay increase	32.8%	40.9%	38.1%	63.6%	51.1%
Well-being support	51.7%	40.9%	49.5%	33.0%	39.5%
Counselling services	12.1%	0.0%	30.5%	14.8%	5.6%
Safer working conditions	41.4%	13.6%	31.4%	34.1%	36.9%
More working hours flexibility	27.6%	31.8%	58.1%	39.8%	29.9%
Taking breaks	37.9%	45.5%	30.5%	29.5%	32.6%
Getting to take annual leave	25.9%	40.9%	18.1%	37.5	28.2%
Time in lieu	24.1%	36.4%	9.5%	15.9%	15.0%
Job rotation and/or change of duties	15.5%	31.8%	12.4%	8.0%	26.9%
Further training and development	20.7%	40.9%	40.0%	37.5%	25.6%
Other – Please specify below	29.3%	31.8%	35.2%	22.7%	37.5%

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

What has to happen for you to change your mind about wanting to leave?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	16 (19.8%)	4 (33.3%)	18 (23.4%)	58 (25.0%)	32 (22.2%)
Manager support	37 (45.7%)	5 (41.7%)	34 (44.2%)	111 (47.8%)	65 (45.1%)
Pay increase	55 (67.9%)	6 (50.0%)	45 (58.4%)	151 (65.1%)	77 (53.5%)
Well-being support	30 (37.0%)	5 (41.7%)	29 (37.7%)	98 (42.2%)	62 (43.1%)
Counselling services	6 (7.4%)	2 (16.7%)	9 (11.7%)	28 (12.1%)	18 (12.5%)
Safer working conditions	45 (55.6%)	6 (50.0%)	24 (31.2%)	72 (31.0%)	64 (44.4%)
More working hours flexibility	30 (37.0%)	6 (50.0%)	44 (57.1%)	61 (26.3%)	42 (29.2%)
Taking breaks	25 (30.9%)	8 (66.7%)	25 (32.5%)	81 (34.9%)	49 (34.0%)
Getting to take annual leave	13 (16.0%)	5 (41.7%)	21 (27.3%)	64 (27.6%)	39 (27.1%)
Time in lieu	13 (16.0%)	3 (25.0%)	14 (18.2%)	33 (14.2%)	28 (19.4%)
Job rotation and/or change of duties	10 (12.3%)	1 (8.3%)	14 (18.2%)	30 (12.9%)	39 (27.1%)
Further training and development	17 (21.0%)	3 (25.0%)	28 (36.4%)	52 (22.4%)	29 (20.1%)
Other – Please specify below	23 (28.4%)	2 (16.7%)	25 (32.5%)	58 (25.0%)	57 (39.6%)
Total of respondents answering question	81	12	77	232	144

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

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

Summary (Weighted results):

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

Summary (Unweighted results):

A majority of respondents stated no that they were still in the same job with the same contractual working hours (72.7%).

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

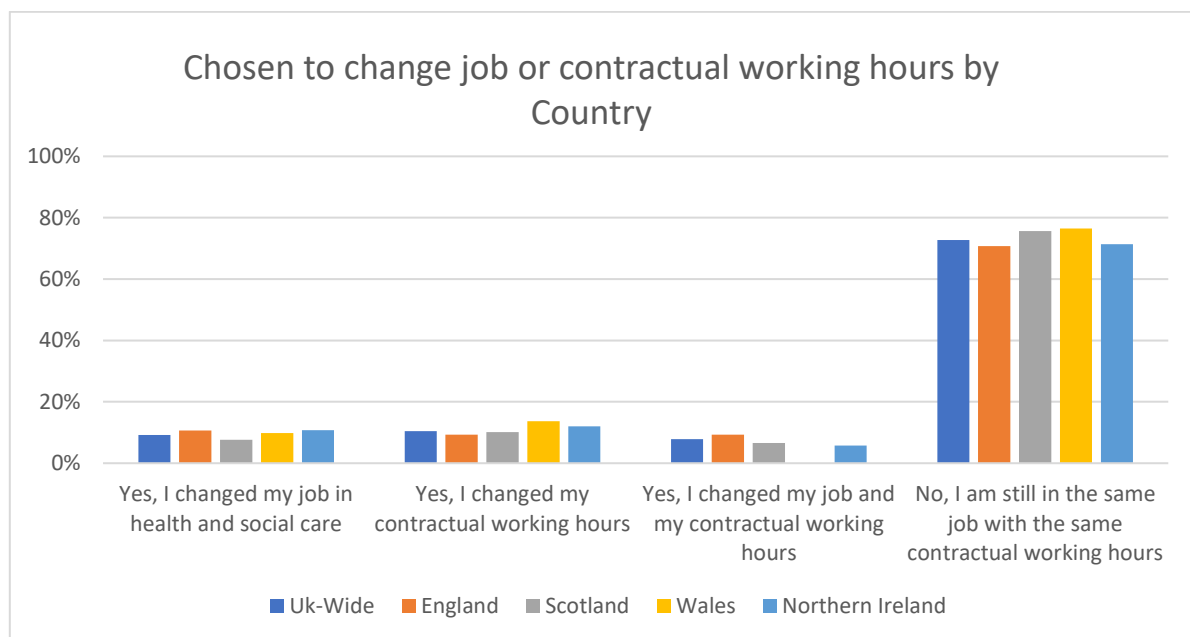


Figure A2. 101: Chosen to change job or contractual working hours by Country (Unweighted)

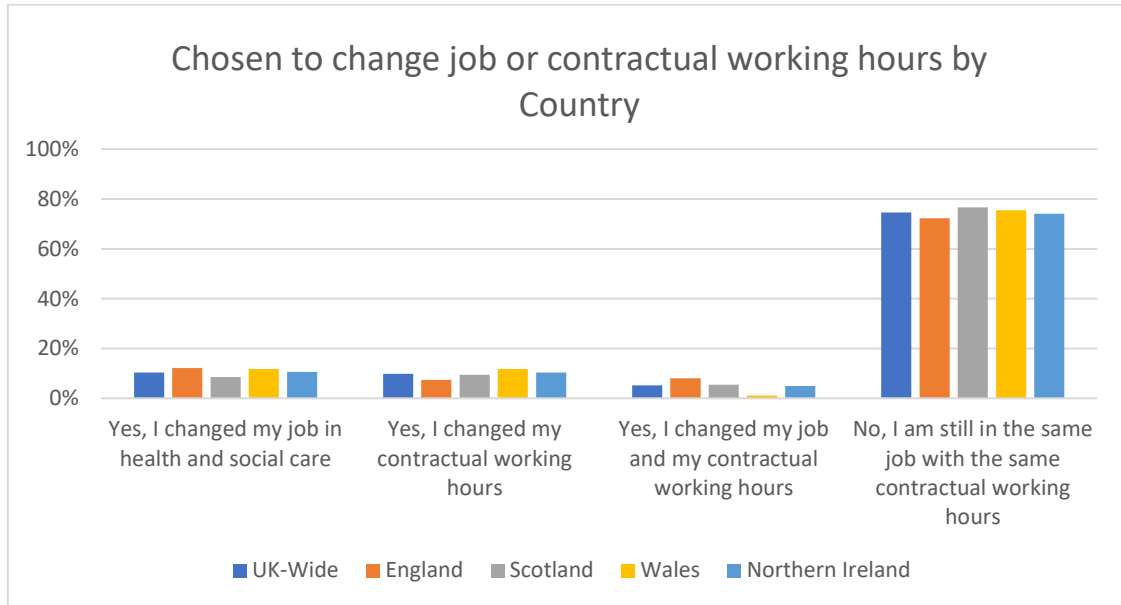


Table A2. 100: Chosen to change job or contractual working hours by Country (Weighted by Occupation)

	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, I changed my job in health and social care	9.2%	10.7%	7.6%	9.8%	10.8%
Yes, I changed my contractual working hours	10.4%	9.3%	10.1%	13.7%	12.0%
Yes, I changed my job and my contractual working hours	7.8%	9.3%	6.6%	0.0%	5.8%
No, I am still in the same job with the same contractual working hours	72.7%	70.7%	75.7%	76.5%	71.4%
Total	100%	100%	100%	100%	100%

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

	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, I changed my job in health and social care	145 (10.4%)	23 (12.2%)	28 (8.5%)	11 (11.7%)	83 (10.6%)
Yes, I changed my contractual working hours	136 (9.8%)	14 (7.4%)	31 (9.4%)	11 (11.7%)	80 (10.3%)
Yes, I changed my job and my contractual working hours	73 (5.2%)	15 (8.0%)	18 (5.4%)	1 (1.1%)	39 (5.0%)
No, I am still in the same job with the same contractual working hours	1039 (74.6%)	136 (72.3%)	254 (76.7%)	71 (75.5%)	578 (74.1%)
Total	1393 (100%)	188 (100%)	331 (100%)	94 (100%)	780 (100%)

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

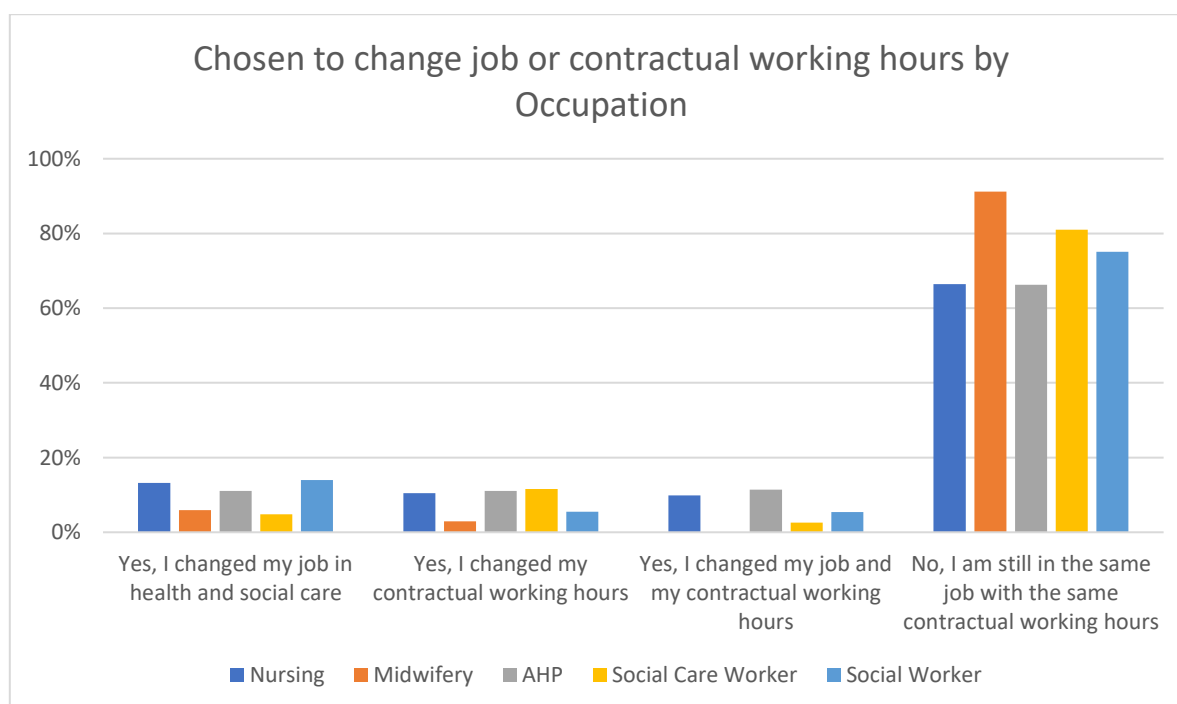


Figure A2. 103: Chosen to change job or contractual working hours by Occupation (Unweighted)

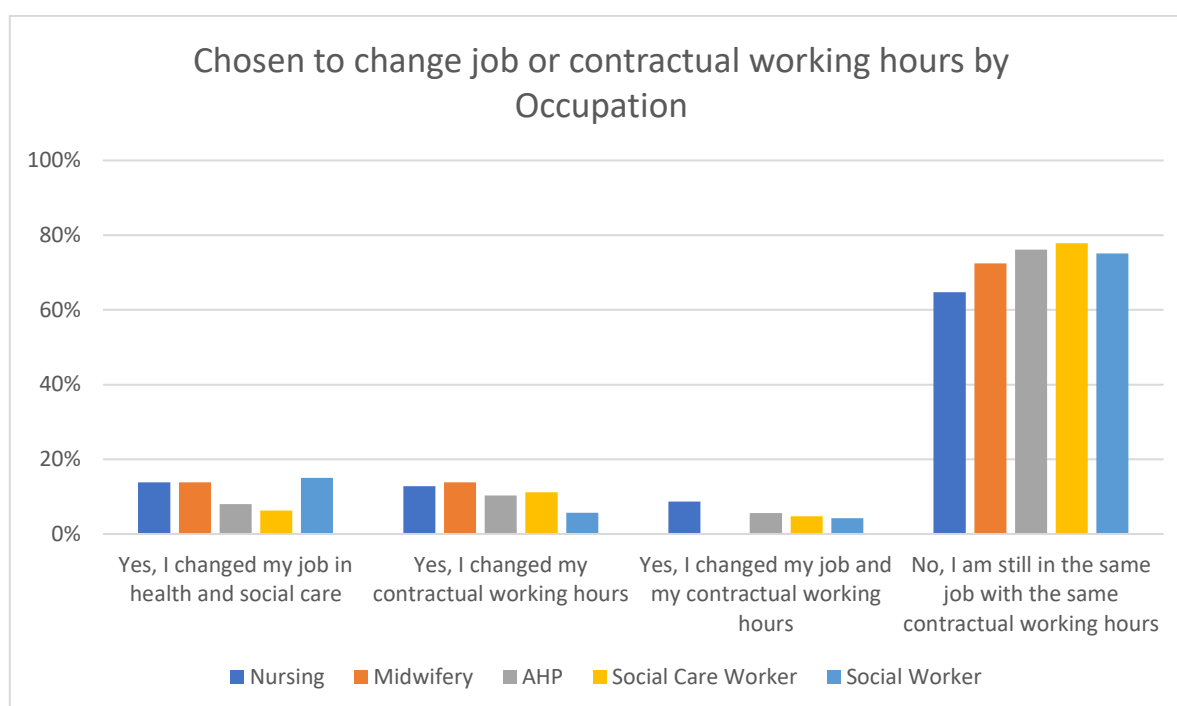


Table A2. 102: Chosen to change job or contractual working hours by Occupation (Weighted by Region)

Occupation	Yes, I changed my job in health and social care	Yes, I changed my contractual working hours	Yes, I changed my job and my contractual working hours	No, I am still in the same job with the same contractual working hours	Total
Nursing	13.2%	10.5%	9.9%	66.4%	100%
Midwifery	5.9%	2.9%	0.0%	91.2%	100%
AHP	11.1%	11.1%	11.4%	66.3%	100%
Social Care	4.8%	11.6%	2.6%	81.0%	100%
Social Work	14.0%	5.5%	5.4%	75.1%	100%

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

Occupation	Yes, I changed my job in health and social care	Yes, I changed my contractual working hours	Yes, I changed my job and my contractual working hours	No, I am still in the same job with the same contractual working hours	Total
Nursing	30 (13.8%)	28 (12.8%)	19 (8.7%)	141 (64.7%)	218(100%)
Midwifery	4 (13.8%)	4 (13.8%)	0 (0.0%)	21 (72.4%)	29 (100%)
AHP	17 (8.0%)	22 (10.3%)	12 (5.6%)	162 (76.1%)	213 (100%)
Social Care	33 (6.3%)	59 (11.2%)	25 (4.7%)	410 (77.8%)	527 (100%)
Social Work	61 (15.0%)	23 (5.7%)	17 (4.2%)	305 (75.1%)	406 (100%)

A2.23 Respondents taking up employer support

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

Summary (Weighted results):

Most respondents did not take up employer support. Those in Wales were more likely to take up employer support, while those in Northern Ireland were least likely to take up employer support. Out of all occupations social care workers were most likely to take up employer well-being support while midwifery was least likely to take up support.

Summary (Unweighted results):

A majority of respondents did not take up employer support (74.4%). Those in Wales were more likely to take up employer support (39.4%) while those in Scotland were least likely to take up employer support (76.2%). Out of all occupations, social workers were most likely to take up employer well-being support while AHPs were least likely to take up support.

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

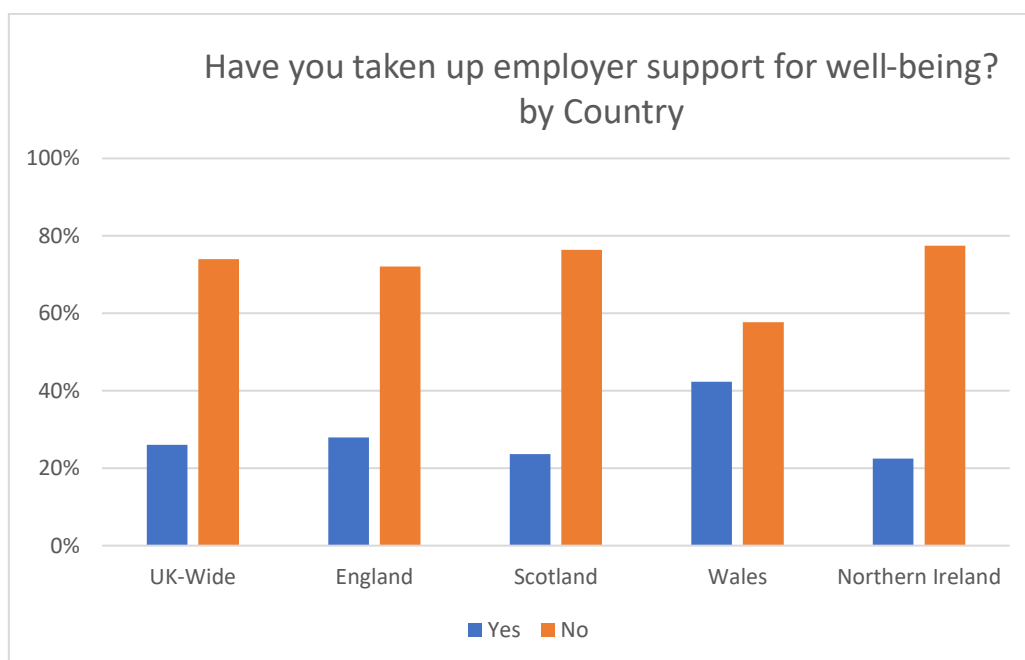


Figure A2. 105: Taken up Employer support by Country (Unweighted)

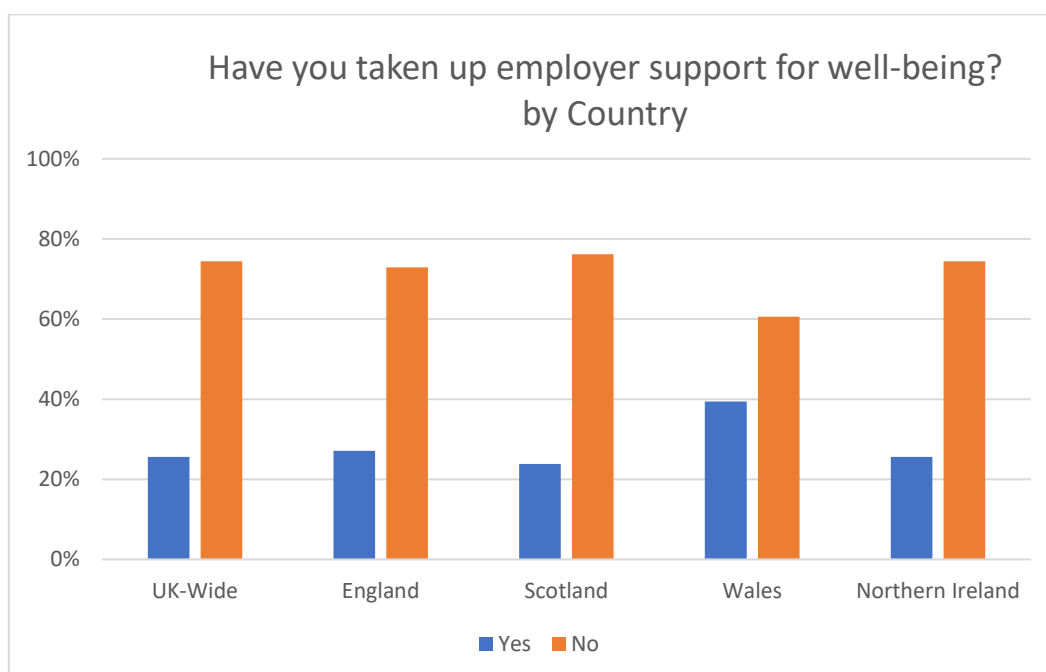


Table A2. 104: Taken up employer support by Country (Weighted by Occupation)

Have you taken up employer support for well-being?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	26.0%	27.9%	23.6%	42.3%	22.5%
No	74.0%	72.1%	76.4%	57.7%	77.5%
Total	100%	100%	100%	100%	100%

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

Have you taken up employer support for well-being?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	357 (25.6%)	51 (27.1%)	79 (23.8%)	37 (39.4%)	190 (24.3%)
No	1038 (74.4%)	137 (72.9%)	253 (76.2%)	57 (60.6%)	591 (75.7%)
Total	1395 (100%)	188 (10%)	332(100%)	94 (100%)	781 (100%)

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



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



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

Have you taken up employer support for well-being?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	26.1%	12.1%	22.9%	34.2%	26.9%
No	73.9%	87.9%	77.1%	65.8%	73.1%
Total	100%	100%	100%	100%	100%

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

Have you taken up employer support for well-being?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	52 (23.9%)	7 (24.1%)	49 (23.0%)	124 (23.4%)	125(30.8%)
No	166 (76.1%)	22 (75.9%)	164 (77.0%)	405 (76.6%)	281 (69.2%)
Total	218 (100%)	29 (100%)	213 (100%)	529 (100%)	406 (100%)

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

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

Summary (Weighted results):

Respondents indicated they took up manager support and well-being support.

Summary (Unweighted results):

Respondents indicated they took up manager support or well-being support.

Those who reported other (n=47), specified that the following was the support they had taken up from their employer to support their well-being:

- Attending occupational health
- Access to voluntary services
- Cognitive Behavioural Therapy
- Changing working hours
- Flexible/Hybrid working
- Reduced caseload
- Exercise classes or part funded access to local leisure facilities
- Staff supporting meetings and briefs
- Online well-being support (e.g., 'Feeling Good' well-being App offered by management)

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

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

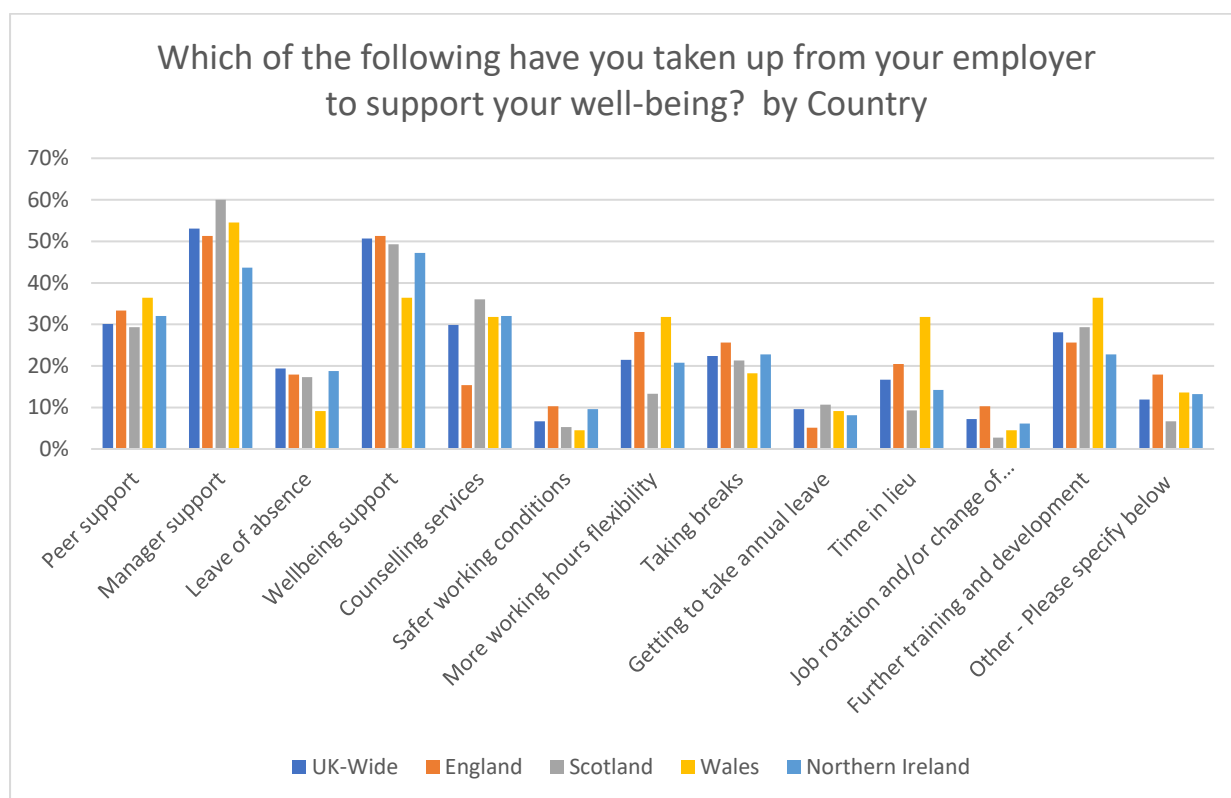


Figure A2. 109: What have you taken up from your employer to support your well-being by Country (Unweighted)

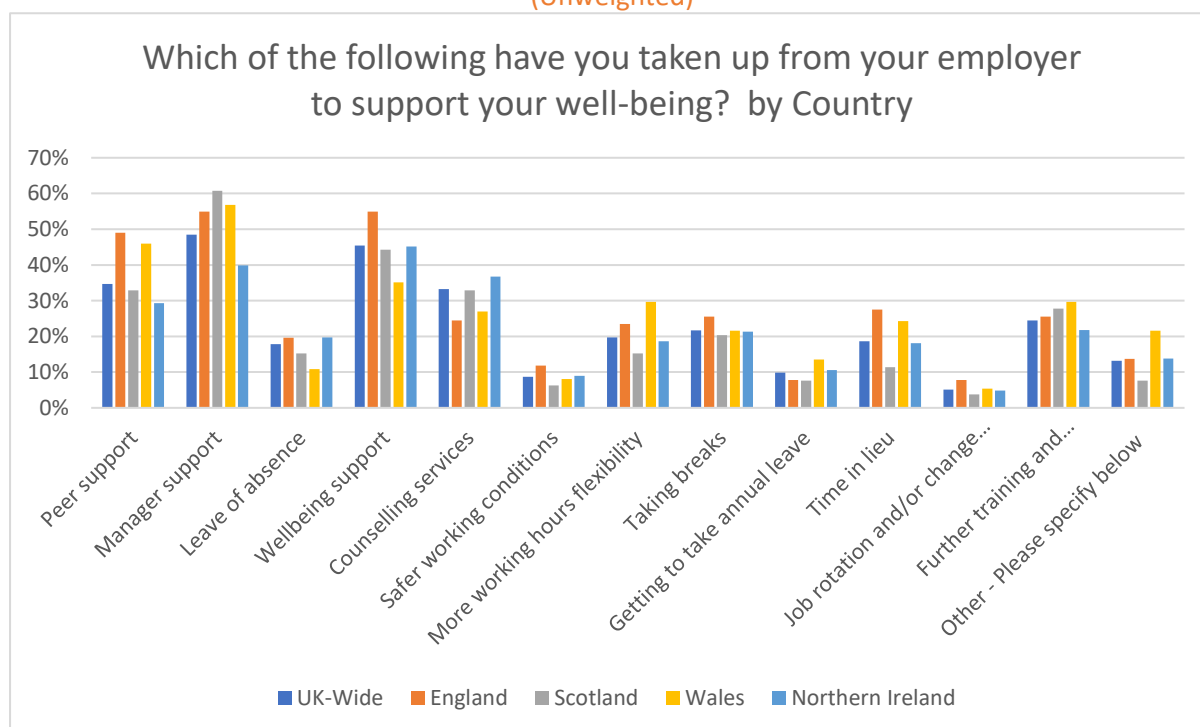


Table A2. 108: What have you taken up from your employer to support your well-being by Country
(Weighted by Occupation)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	28.5%	33.3%	29.3%	36.4%	32.0%
Manager support	50.1%	51.3%	60.0%	54.5%	43.7%
Leave of absence	18.3%	17.9%	17.3%	9.1%	18.8%
Well-being support	47.9%	51.3%	49.3%	36.4%	47.2%
Counselling services	28.2%	15.4%	36.0%	31.8%	32.0%
Safer working conditions	6.5%	10.3%	5.3%	4.5%	9.6%
More working hours flexibility	20.3%	28.2%	13.3%	31.8%	20.8%
Taking breaks	21.1%	25.6%	21.3%	18.2%	22.8%
Getting to take annual leave	9.0%	5.1%	10.7%	9.1%	8.1%
Time in lieu	15.8%	20.5%	9.3%	31.8%	14.2%
Job rotation and/or change of duties	6.8%	10.3%	2.7%	4.5%	6.1%
Further training and development	26.5%	25.6%	29.3%	36.4%	22.8%
Other – Please specify below	11.3%	17.9%	6.7%	13.6%	13.2%

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

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	123 (34.7%)	25 (49.0%)	26 (32.9%)	17 (46.0%)	55 (29.3%)
Manager support	172 (48.5%)	28 (54.9%)	48 (60.8%)	21 (56.8%)	75 (39.9%)
Leave of absence	63 (17.8%)	10 (19.6%)	12 (15.2%)	4 (10.8%)	37 (19.7%)
Well-being support	161 (45.4%)	28 (54.9%)	35 (44.3%)	13 (35.1%)	85 (45.2%)
Counselling services	118 (33.2%)	13 (24.5%)	26 (32.9%)	10 (27.0%)	69 (36.7%)
Safer working conditions	31 (8.7%)	6 (11.8%)	5 (6.3%)	3 (8.1%)	17 (9.0%)
More working hours flexibility	70 (19.7%)	12 (23.5%)	12 (15.2%)	11 (29.7%)	35 (18.6%)
Taking breaks	77 (21.7%)	13 (25.5%)	16 (20.3%)	8 (21.6%)	40 (21.3%)
Getting to take annual leave	35 (9.9%)	4 (7.8%)	6 (7.6%)	5 (13.5%)	20 (10.6%)
Time in lieu	66 (18.6%)	14 (27.5%)	9 (11.4%)	9 (24.3%)	34 (18.1%)
Job rotation and/or change of duties	18 (5.1%)	4 (7.8%)	3 (3.8%)	2 (5.4%)	9 (4.8%)
Further training and development	87 (24.5%)	13 (25.5%)	22 (27.8%)	11 (29.7%)	41 (21.8%)
Other – Please specify below	47 (13.2%)	7 (13.7%)	6 (7.6%)	8 (21.6%)	26 (13.8%)
No. of respondents who answered the question	355	51	79	37	188

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

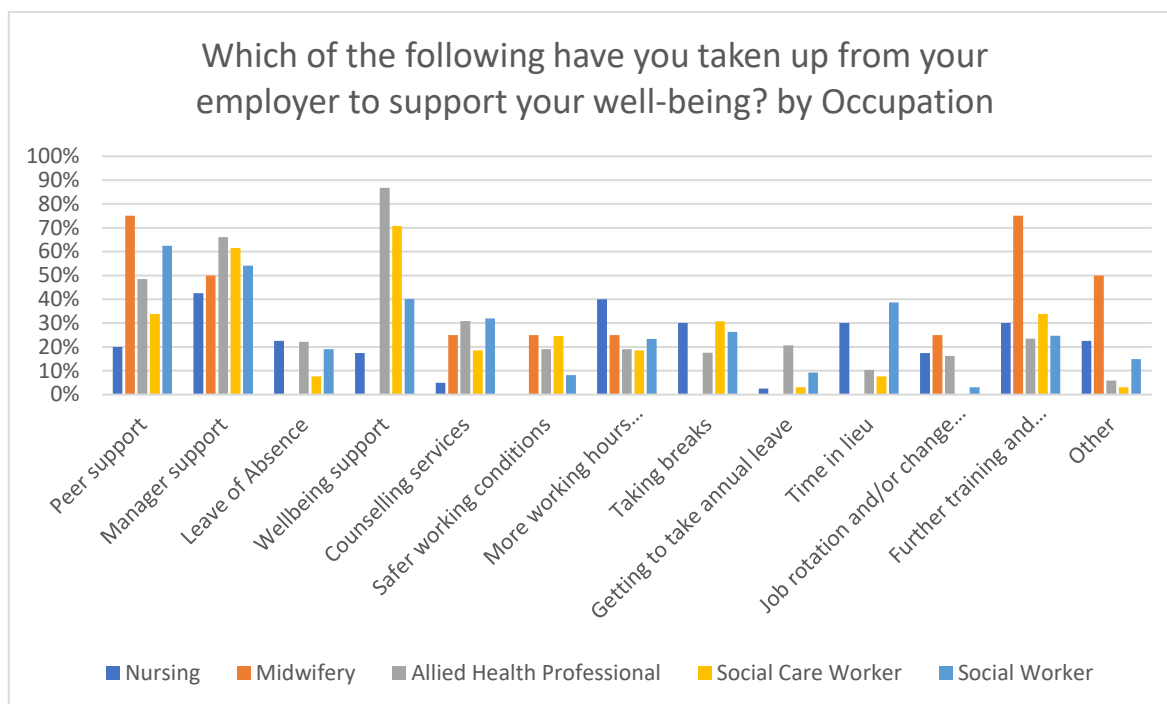


Figure A2. 111: What have you taken up from your employer to support your well-being by Occupation (Unweighted)

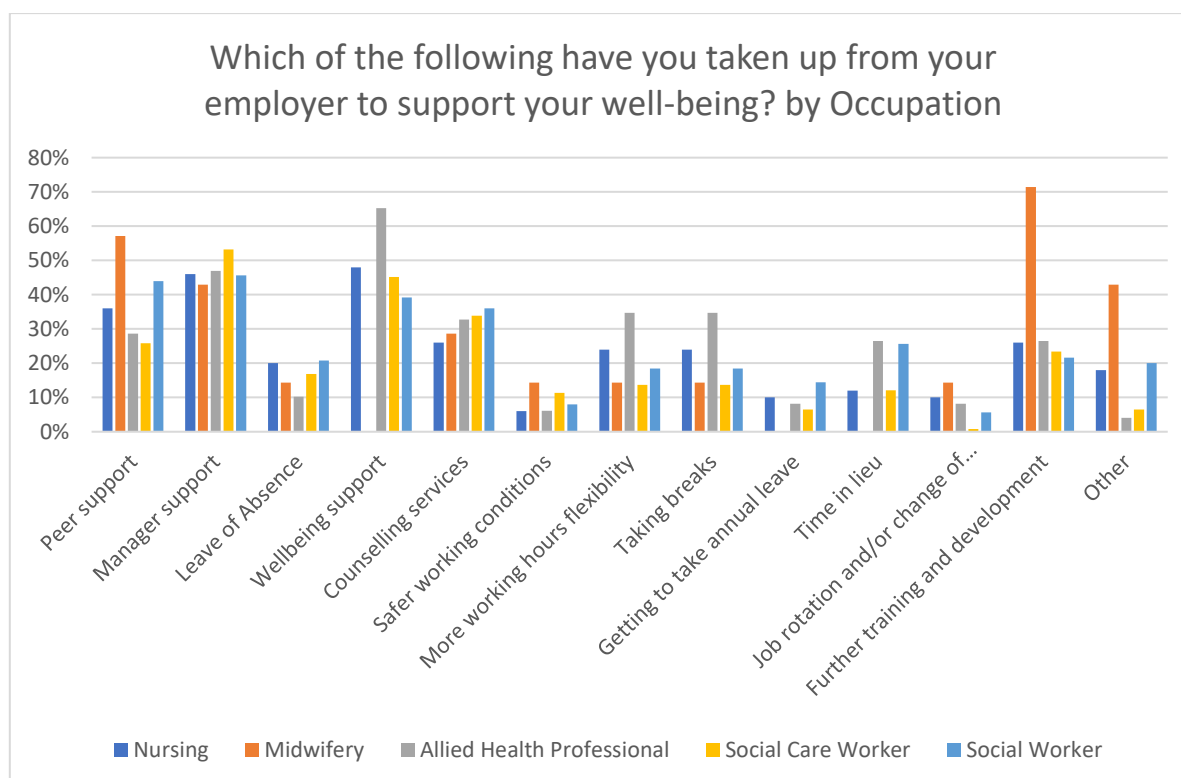


Table A2. 110: What have you taken up from your employer to support your well-being by Occupation (Weighted by Region)

What has to happen for you to change your mind about wanting to leave?	Occupation				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	20.0%	75.0%	48.5%	33.8%	62.4%
Manager support	42.5%	50.0%	66.1%	61.5%	54.1%
Leave of absence	22.5%	0.0%	22.1%	7.7%	19.1%
Well-being support	17.5%	0.0%	86.8%	70.8%	40.2%
Counselling services	5.0%	25.0%	30.9%	18.5%	32.0%
Safer working conditions	0.0%	25.0%	19.1%	24.6%	8.2%
More working hours flexibility	40.0%	25.0%	19.1%	18.5%	23.2%
Taking breaks	30.0%	0.0%	17.6%	30.8%	26.3%
Getting to take annual leave	2.5%	0.0%	20.6%	3.1%	9.3%
Time in lieu	30.0%	0.0%	10.3%	7.7%	38.7%
Job rotation and/or change of duties	17.5%	25.0%	16.2%	0.0%	3.1%
Further training and development	30.0%	75.0%	23.5%	33.8%	24.7%
Other – Please specify below	22.5%	50.0%	5.9%	3.1%	14.9%

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

What has to happen for you to change your mind about wanting to leave?	Occupation				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	18 (36.0%)	4 (57.1%)	14 (28.6%)	32 (25.8%)	55 (44.0%)
Manager support	23 (46.0%)	3 (42.9%)	23 (46.9%)	66 (53.2%)	57 (45.6%)
Leave of absence	10 (20.0%)	1 (14.3%)	5 (10.2%)	21 (16.9%)	26 (20.8%)
Well-being support	24 (48.0%)	0 (0.0%)	32 (65.3%)	56 (45.2%)	49 (39.2%)
Counselling services	13 (26.0%)	2 (28.6%)	16 (32.7%)	42 (33.9%)	45 (36.0%)
Safer working conditions	3 (6.0%)	1 (14.3%)	3 (6.1%)	14 (11.3%)	10 (8.0%)
More working hours flexibility	12 (24.0%)	1 (14.3%)	17 (34.7%)	17 (13.7%)	23 (18.4%)
Taking breaks	12 (24.0%)	0 (0.0%)	14 (28.6%)	25 (20.2%)	26 (20.8%)
Getting to take annual leave	5 (10.0%)	0 (0.0%)	4 (8.2%)	8 (6.5%)	18 (14.4%)
Time in lieu	6 (12.0%)	0 (0.0%)	13 (26.5%)	15 (12.1%)	32 (25.6%)
Job rotation and/or change of duties	5 (10.0%)	1 (14.3%)	4 (8.2%)	1 (0.8%)	7 (5.6%)
Further training and development	13 (26.0%)	5 (71.4%)	13 (26.5%)	29 (23.4%)	27 (21.6%)
Other – Please specify below	9 (18.0%)	3 (42.9%)	2 (4.1%)	8 (6.5%)	25 (20.0%)
No. of respondents who answered the question	50	7	49	124	125

A2.25 Reasons for not taking employer support.

Summary (Weighted results):

In Wales, 43.3% felt employer support was not needed, while one-half of AHPs felt it was not needed.

Summary (Unweighted results):

In Wales, one-third of respondents felt employer support was not needed. A total of n= 247 (23.9%) selected other as their reason for not taking employer support.

The reasons behind this were reported as the following:

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

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

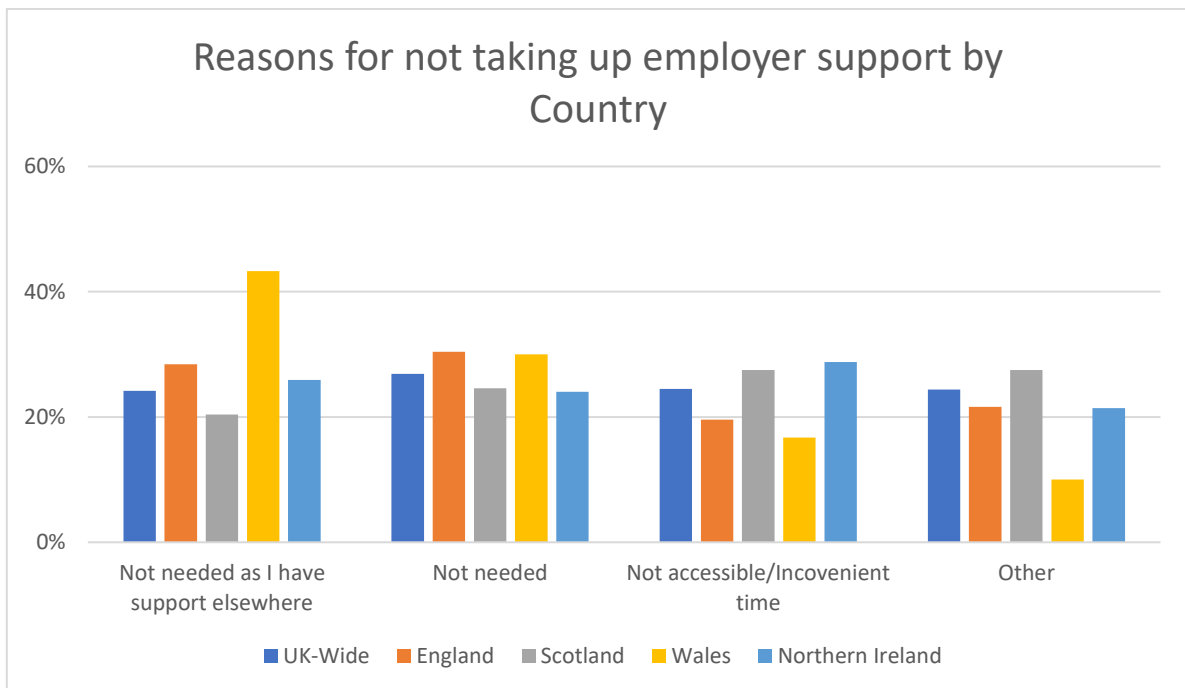


Figure A2. 113: Reasons for not taking up employer support by Country (Unweighted)

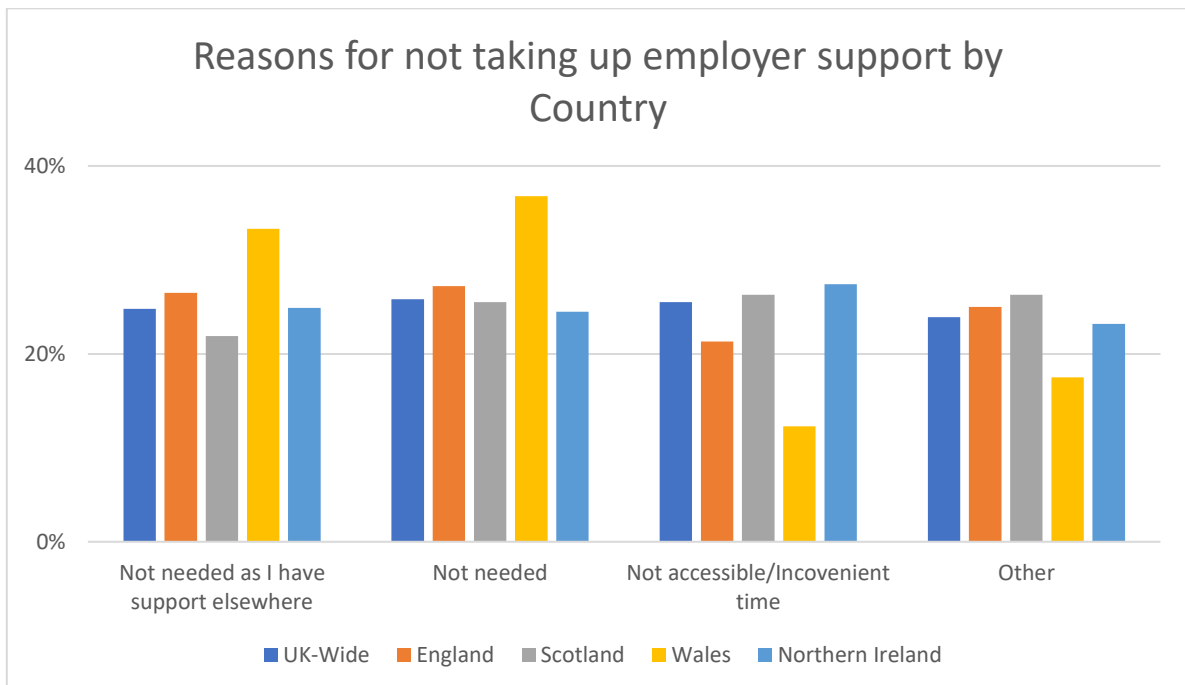


Table A2. 112: Reasons for not taking up employer support by Country (Weighted by Occupation)

Country	UK-Wide	England	Scotland	Wales	Northern Ireland
Not needed as I have support elsewhere	24.2%	28.4%	20.4%	43.3%	25.9%
Not needed	26.9%	30.4%	24.6%	30.0%	24.0%
Not accessible or Inconvenient time	24.5%	19.6%	27.5%	16.7%	28.8%
Other	24.4%	21.6%	27.5%	10.0%	21.4%
Total	100%	100%	100%	100%	100%

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

Country	UK-Wide	England	Scotland	Wales	Northern Ireland
Not needed as I have support elsewhere	257 (24.8%)	36 (26.5%)	55 (21.9%)	19 (33.3%)	147 (24.9%)
Not needed	267 (25.8%)	37 (27.2%)	64 (25.5%)	21 (36.8%)	145 (24.5%)
Not accessible or Inconvenient time	264 (25.5%)	29 (21.3%)	66 (26.3%)	7 (12.3%)	162 (27.4%)
Other	247 (23.9%)	34 (25.0%)	66 (26.3%)	10 (17.5%)	137 (23.2%)
Total	1035 (100%)	136 (100%)	251 (100%)	57 (100%)	591 (100%)

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

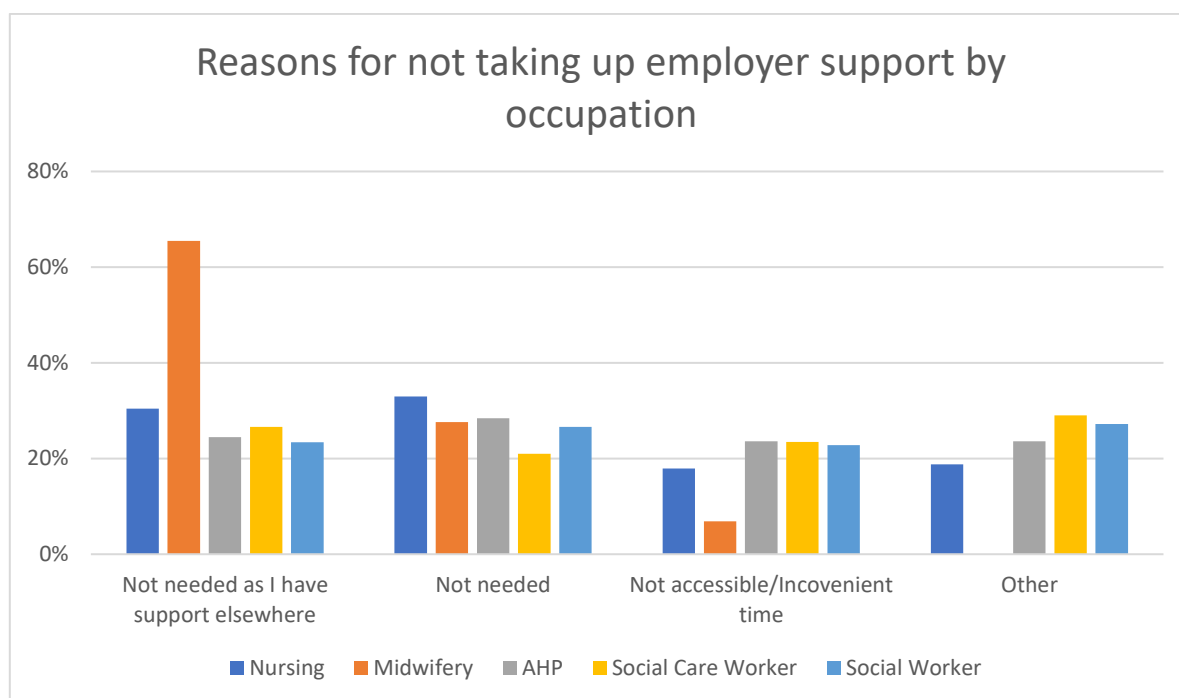


Figure A2. 115: Reasons for not taking up employer support by Occupation (Unweighted)

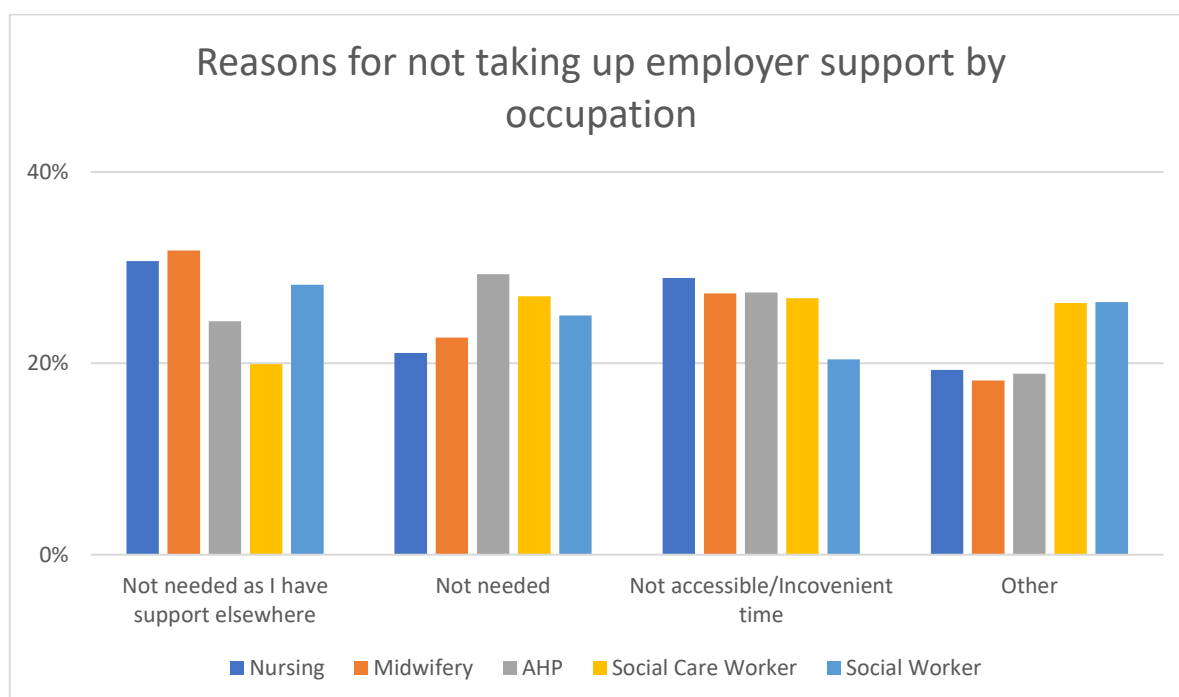


Table A2. 114: Reasons for not taking up employer support by Occupation (Weighted by Region)

Occupation	Not needed as I have support elsewhere	Not needed	Not accessible or Inconvenient time	Other	Total
Nursing	30.4%	33.0%	17.9%	18.8%	100%
Midwifery	65.5%	27.6%	6.9%	0.0%	100%
AHP	24.5%	28.4%	23.6%	23.6%	100%
Social Care Worker	26.6%	21.0%	23.4%	29.0%	100%
Social Worker	23.4%	26.6%	22.8%	27.2%	100%

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

Occupation	Not needed as I have support elsewhere	Not needed	Not accessible or Inconvenient time	Other	Total
Nursing	51 (30.7%)	35 (21.1%)	48 (28.9%)	32 (19.3%)	166 (100%)
Midwifery	7 (31.8%)	5 (22.7%)	6 (27.3%)	4 (18.2%)	22 (100%)
AHP	40 (24.4%)	48 (29.3%)	45 (27.4%)	31 (18.9%)	164 (100%)
Social Care Worker	80 (19.9%)	109 (27.0%)	108 (26.8%)	106 (26.3%)	403 (100%)
Social Worker	79 (28.2%)	70 (25.0%)	57 (20.4%)	74 (26.4%)	280 (100%)

A2.26 Respondents' Region of Work

Summary (Weighted results):

Not reported.

Summary (Unweighted results):

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

Table A2. 116: Responses by Region (Unweighted)

Region	n (%)
England: London	27 (1.9%)
England: North West	21 (1.5%)
England: South East	40 (2.9%)
England: West Midlands	26 (1.9%)
England: East of England	7 (0.5%)
England: Yorkshire and the Humber	20 (1.4%)
England: North East	13 (0.9%)
England: East Midlands	15 (1.1%)
England: South West	19 (1.4%)
Scotland	332 (23.8%)
Wales	94 (6.7%)
Northern Ireland	781 (56.0%)
Total	1395

Figure A2. 116: Responses by Region (Unweighted)

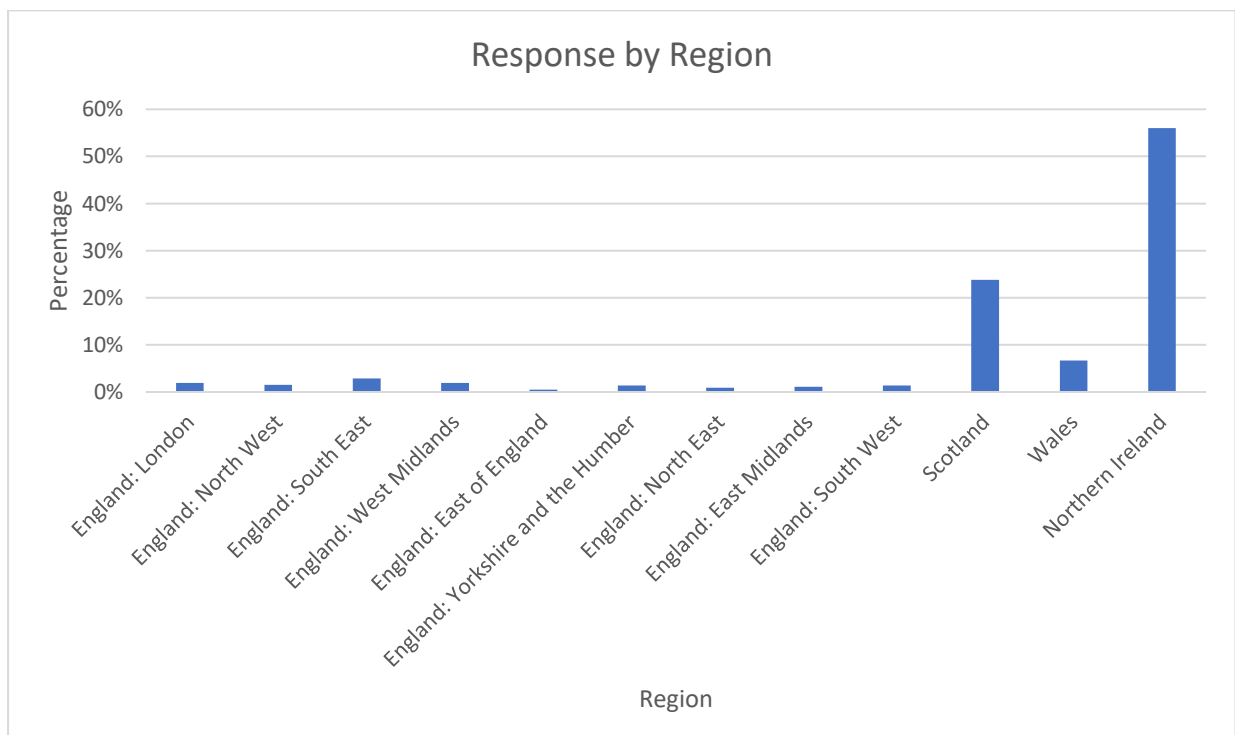


Figure A2. 117: Region by Occupation (Unweighted)

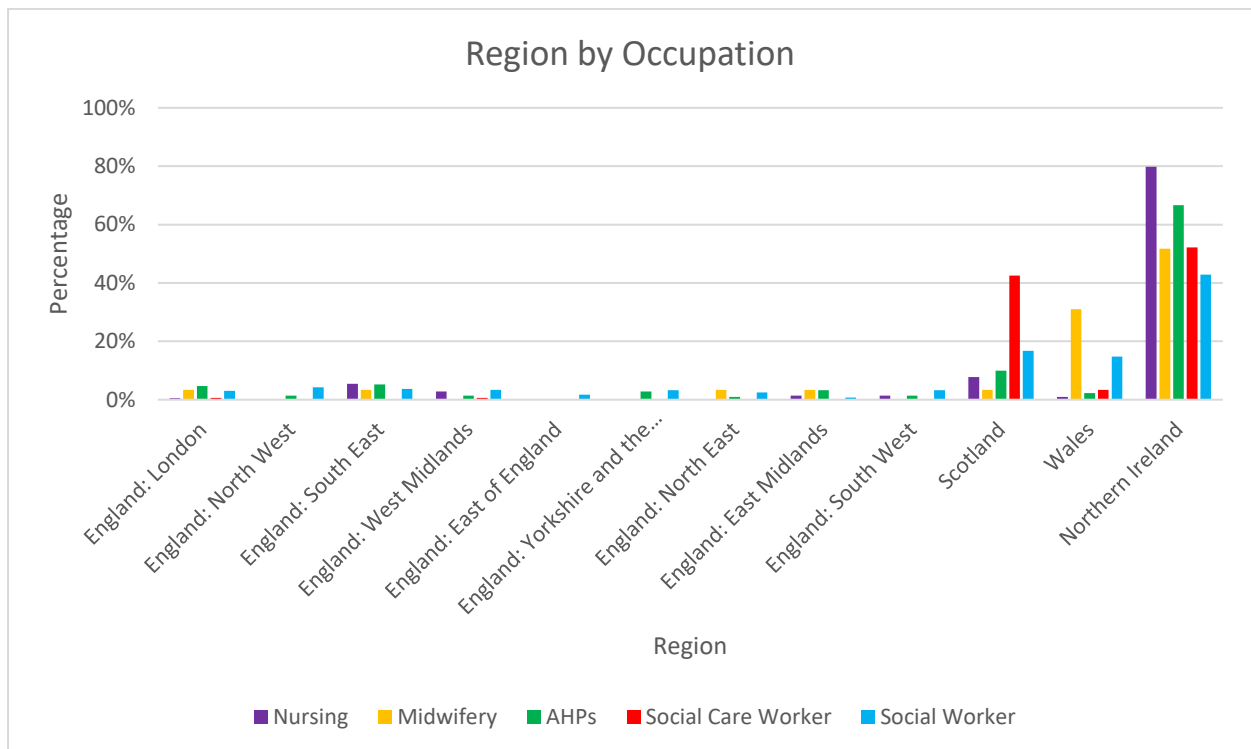


Table A2. 117: Region by Occupation (Unweighted)

Region	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
England: London	1 (0.5%)	1 (3.4%)	10 (4.7%)	3 (0.6%)	12 (3.0%)
England: North West	0 (0.0%)	0 (0.0%)	3 (1.4%)	1 (0.2%)	17 (4.2%)
England: South East	12 (5.5%)	1 (3.4%)	11 (5.2%)	1 (0.2%)	15 (3.7%)
England: West Midlands	6 (2.8%)	0 (0.0%)	3 (1.4%)	3 (0.6%)	14 (3.4%)
England: East of England	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	7 (1.7%)
England: Yorkshire and the Humber	0 (0.0%)	0 (0.0%)	6 (2.8%)	1 (0.2%)	13 (0.9%)
England: North East	0 (0.0%)	1 (3.4%)	2 (0.9%)	0 (0.0%)	10 (2.5%)
England: East Midlands	3 (1.4%)	1 (3.4%)	7 (3.3%)	1 (0.2%)	3 (0.7%)
England: South West	3 (1.4%)	0 (0.0%)	3 (1.4%)	0 (0.0%)	13 (3.2%)
Scotland	17 (7.8%)	1 (3.4%)	21 (9.9%)	225 (42.5%)	68 (16.7%)
Wales	2 (0.9%)	9 (31.0%)	5 (2.3%)	18 (3.4%)	60 (14.8%)
Northern Ireland	174 (79.8%)	15 (51.7%)	142 (66.7%)	276 (52.2%)	174 (42.9%)
Total	218 (100%)	29 (100%)	213(100%)	529 (100%)	406 (100%)

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

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

A3.1 Well-being Scores by Country

Summary (Weighted results):

Summary (Unweighted results):

There was no significant difference in the overall mean well-being scores between the regions ($F = 1.675$, $df = 3$, $p = .170$). When the scores were converted to possible or probable cases of anxiety/depression, a total of 13.9% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 22.7% were possible cases.

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

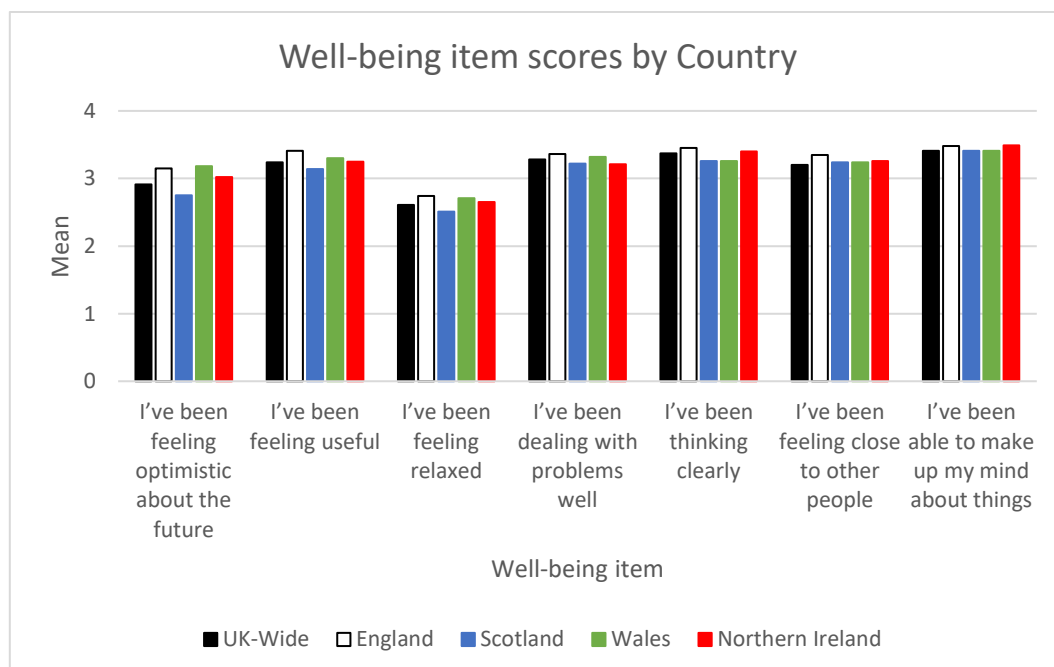


Figure A3. 2: Mean Well-being Item Scores by Country (Unweighted)

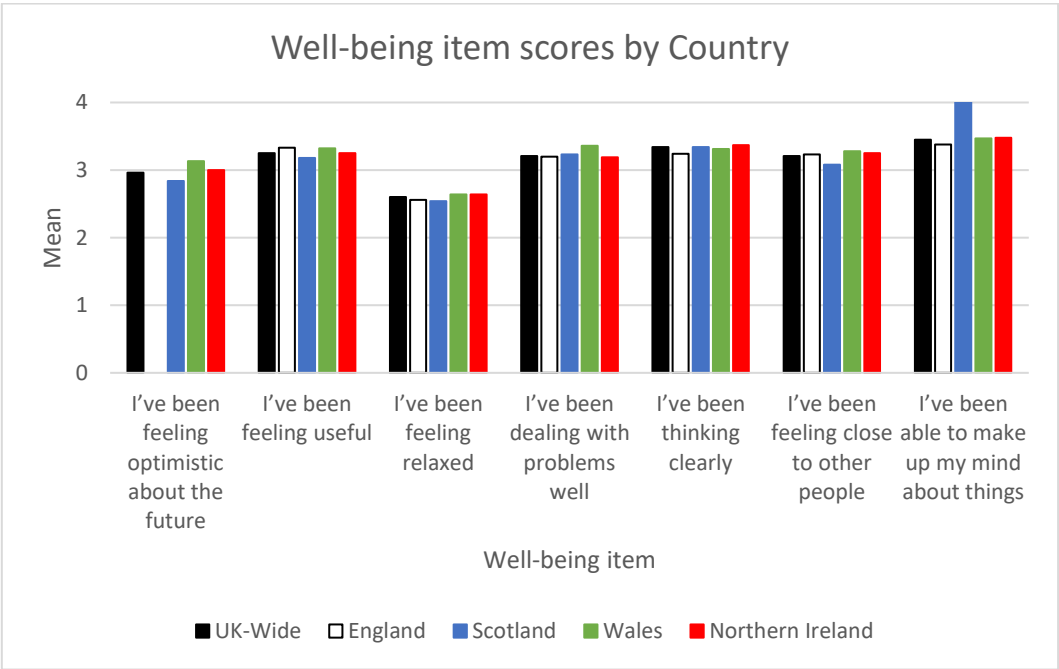


Figure A3.3: Mean Overall Well-being Score by Country (Weighted by Occupation)

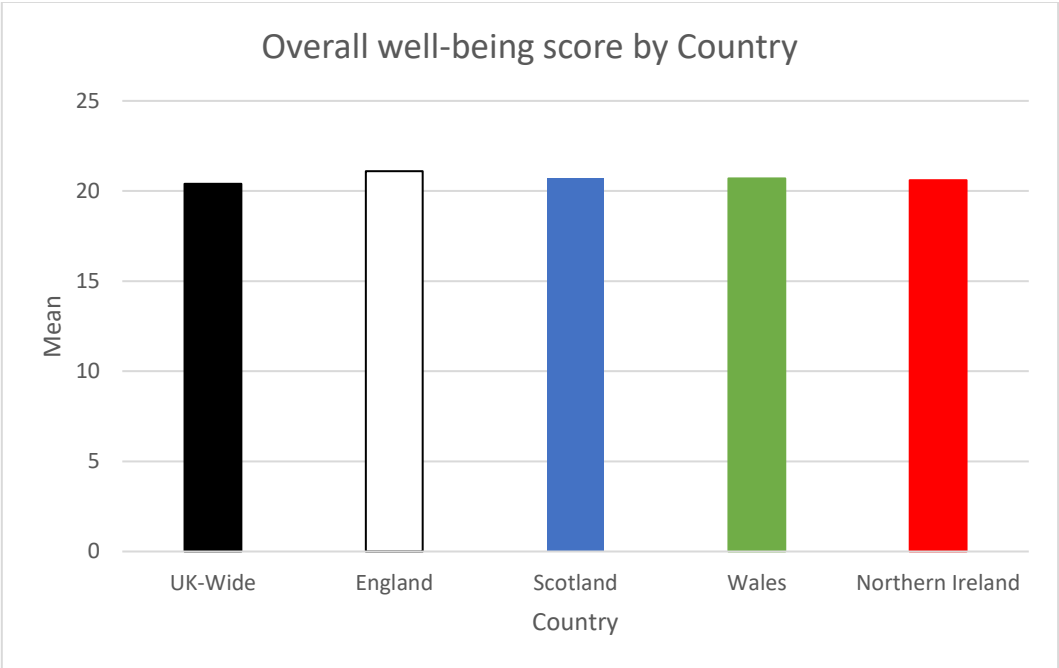


Figure A3.4: Mean Overall Well-being Score by Country (Unweighted)

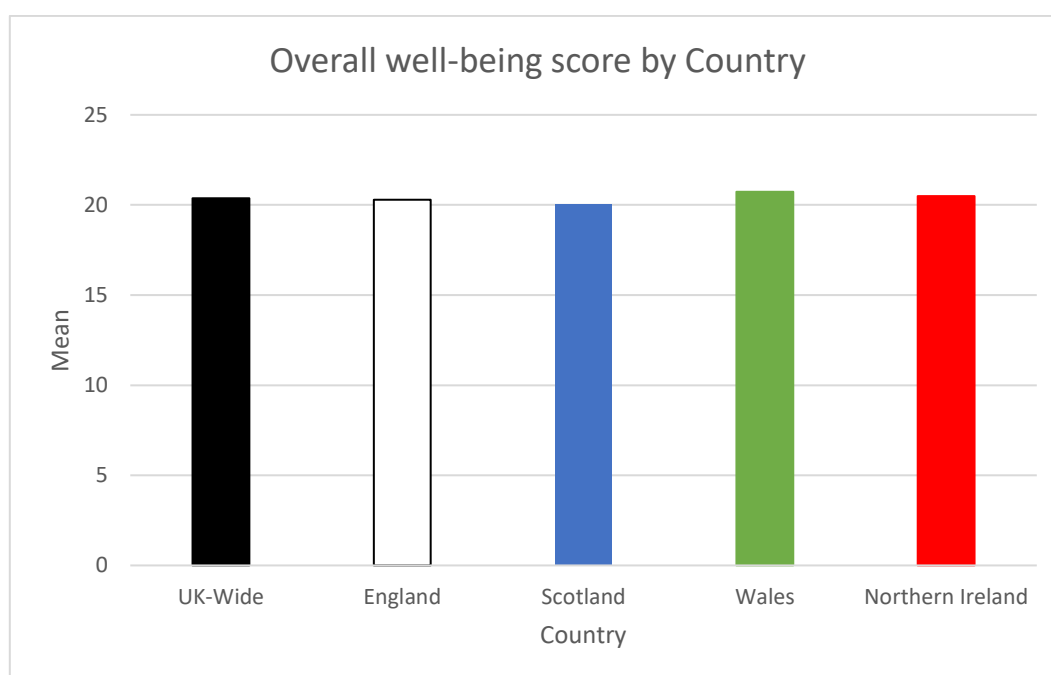


Table A3. 1: Mean Overall and Item Well-being Scores by Country (Weighted by Occupation)

Well-being item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	2.91	3.15	2.75	3.18	3.02
I've been feeling useful	3.24	3.41	3.14	3.30	3.25
I've been feeling relaxed	2.61	2.74	2.51	2.71	2.65
I've been dealing with problems well	3.28	3.36	3.22	3.32	3.21
I've been thinking clearly	3.37	3.45	3.32	3.26	3.40
I've been feeling close to other people	3.20	3.35	3.08	3.24	3.26
I've been able to make up my mind about things	3.41	3.48	3.39	3.41	3.49
Mean overall well-being score	20.4	21.1	19.9	20.7	20.6

Table A3.2: Mean Overall and Item Well-being Scores by Country (Unweighted)

Well-being item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	2.96	2.93	2.84	3.13	3.00
I've been feeling useful	3.25	3.33	3.18	3.32	3.25
I've been feeling relaxed	2.60	2.56	2.54	2.64	2.64
I've been dealing with problems well	3.21	3.20	3.23	3.36	3.19
I've been thinking clearly	3.34	3.24	3.34	3.31	3.37
I've been feeling close to other people	3.21	3.23	3.08	3.28	3.25
I've been able to make up my mind about things	3.45	3.38	3.40	3.47	3.48
Mean overall well-being score	20.37	20.29	20.03	20.73	20.49

Figure A3.5: Overall Well-being Score Converted to Depression/Anxiety by Country (Weighted by Occupation)

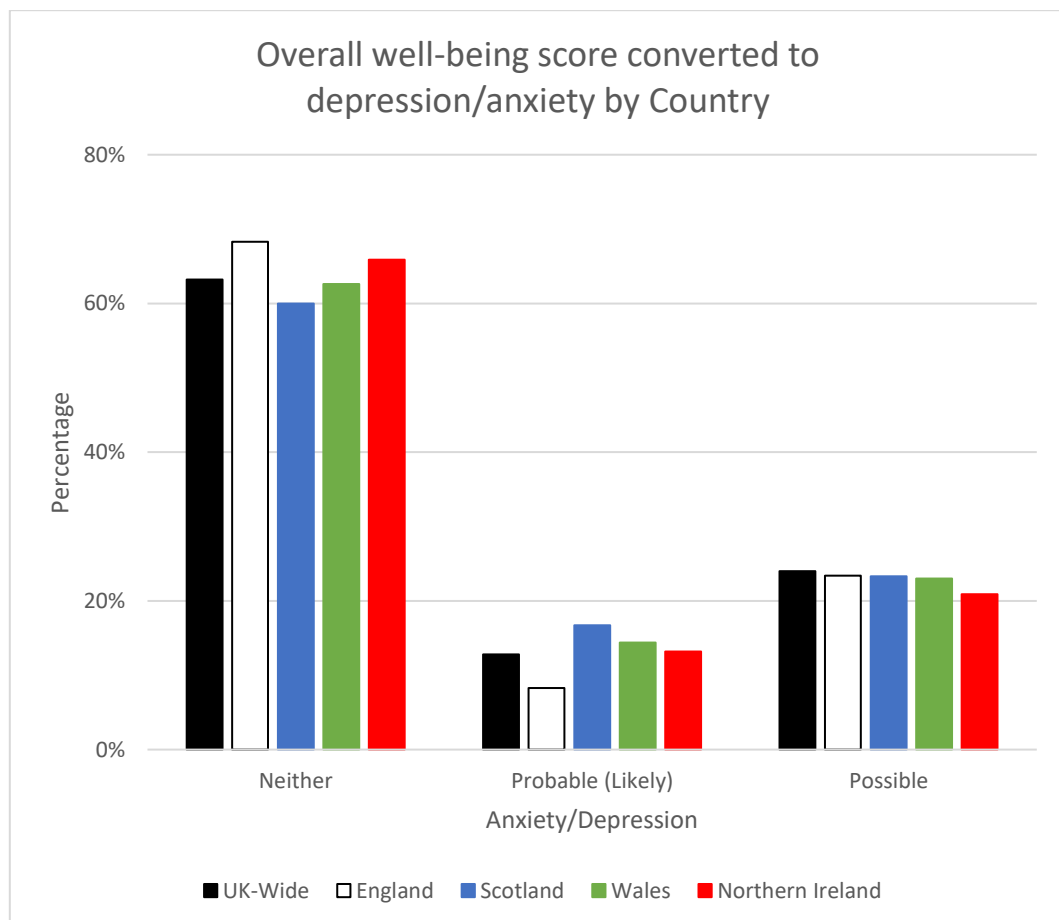


Figure A3.6: Overall Well-being Score Converted to Depression/Anxiety by Country (Unweighted)

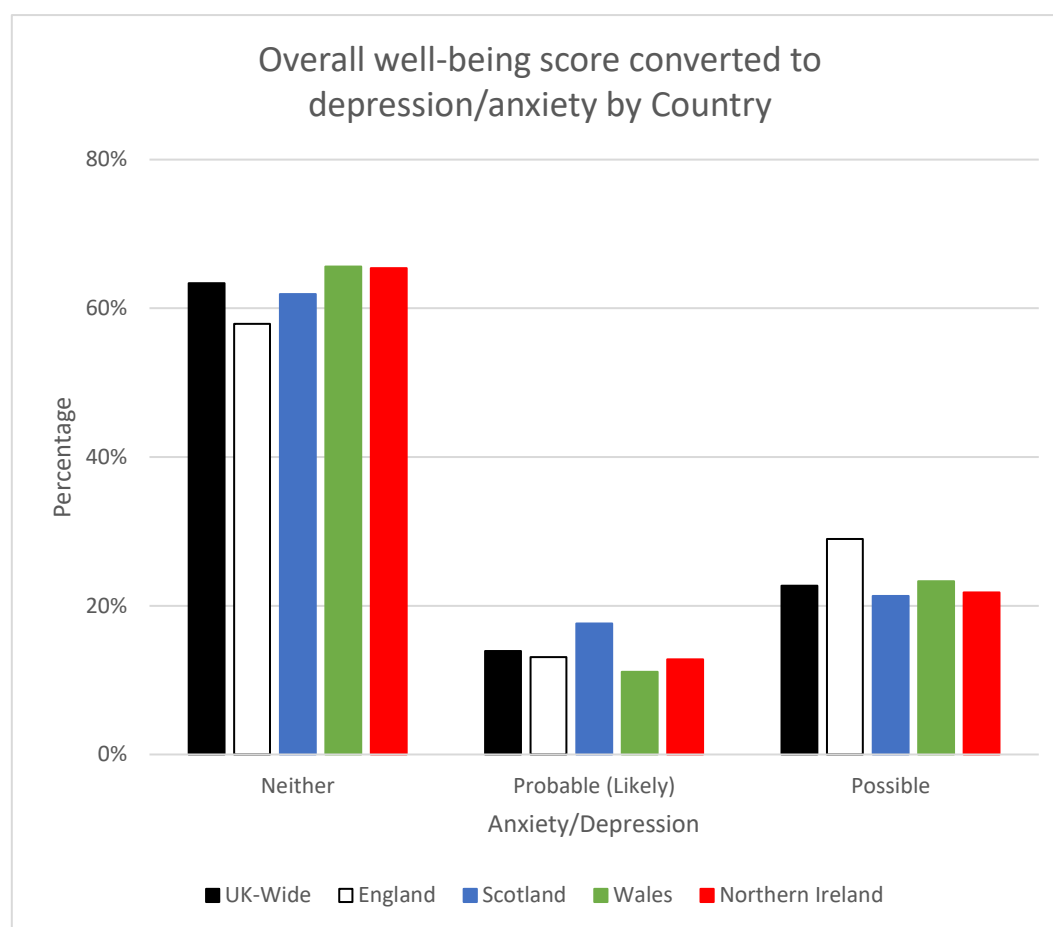


Table A3.3: Overall Well-being Score Converted to Depression/Anxiety by Country (Weighted by Occupation)

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	63.2%	68.3%	60.0%	62.6%	65.9%
Probable (Likely)	12.8%	8.3%	16.7%	14.4%	13.2%
Possible	24.0%	23.4%	23.3%	23.0%	20.9%
Total	100%	100%	100%	100%	100%

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

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	850 (63.4%)	106 (57.9%)	195 (61.9%)	59 (65.6%)	490 (65.4%)
Probable (Likely)	186 (13.9%)	24 (13.1%)	56 (17.6%)	10 (11.1%)	96 (12.8%)
Possible	305 (22.7%)	53 (29.0%)	68 (21.3%)	21 (23.3%)	163 (21.8%)
Total	1341 (100%)	183 (100%)	319 (100%)	90 (100%)	749 (100%)

A3.2 Well-being Scores by Occupation

Summary (Weighted results):

There were significant differences in the overall mean well-being scores across occupational groups ($F = 12.617$, $df = 4$, $p < .001$). Specifically, the overall well-being scores were significantly higher in nursing than in social workers.

Summary (Unweighted results):

There were significant differences in the overall mean well-being scores across occupational groups ($F = 7.817$, $df = 4$, $p = .001$). Specifically, the overall well-being scores were significantly higher in AHPs and nursing than in social care workers.

Figure A3.7: Mean Overall Well-being Score by Occupation (Weighted by Region)

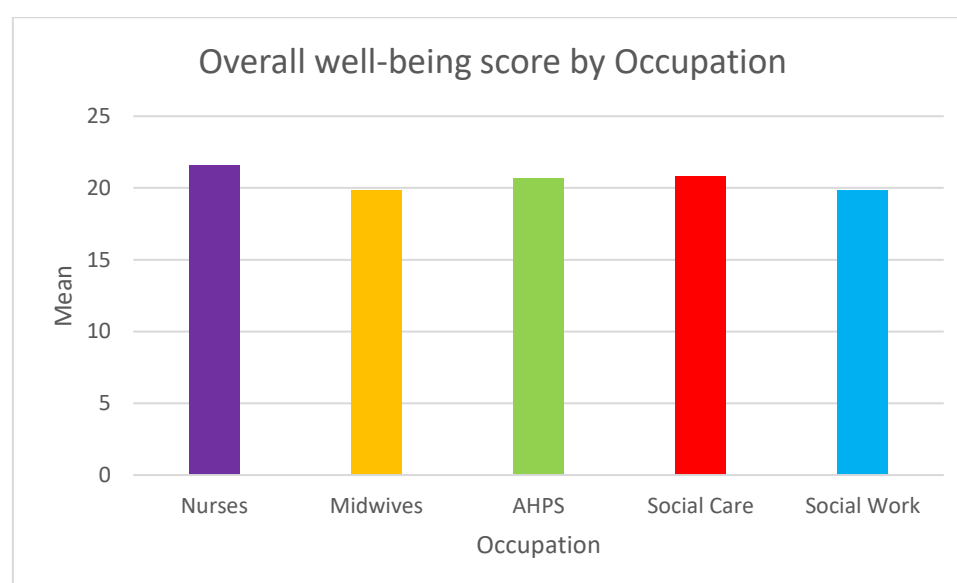


Figure A3.8: Mean Overall Well-being Score by Occupation (Unweighted)

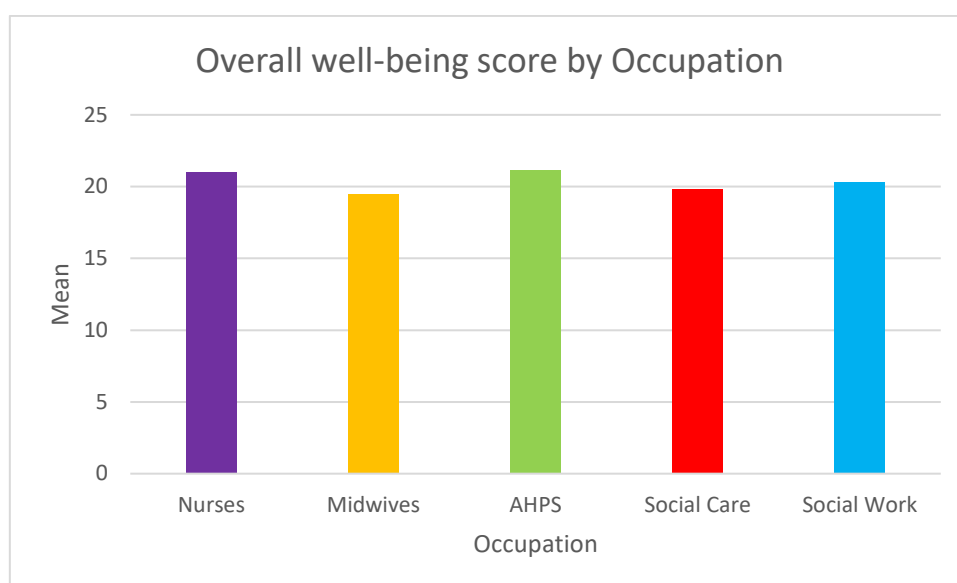


Table A3.5: Mean Overall Well-being Score by Occupation (Weighted by Region)

Occupation	Mean overall well-being score
Nursing	21.6
Midwifery	19.8
AHP	20.7
Social Care Worker	20.8
Social Worker	19.8

Table A3.6: Mean Overall Well-being Score by Occupation (Unweighted)

Occupation	Mean overall well-being score
Nursing	21.02
Midwifery	19.44
AHP	21.14
Social Care Worker	19.85
Social Worker	20.34

Figure A3.9: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Weighted by Region)

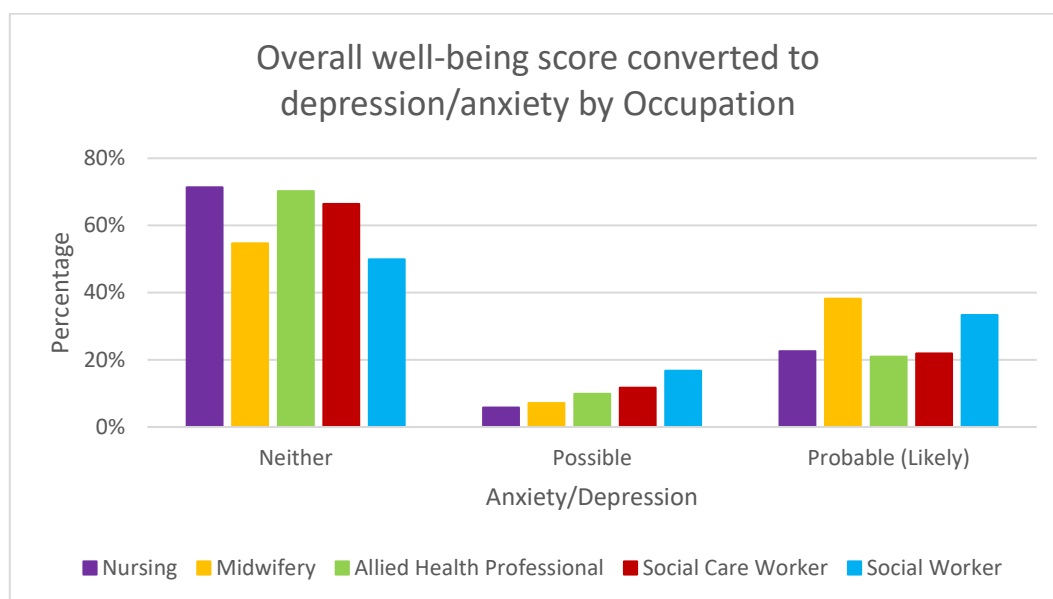


Figure A3.10: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Unweighted)

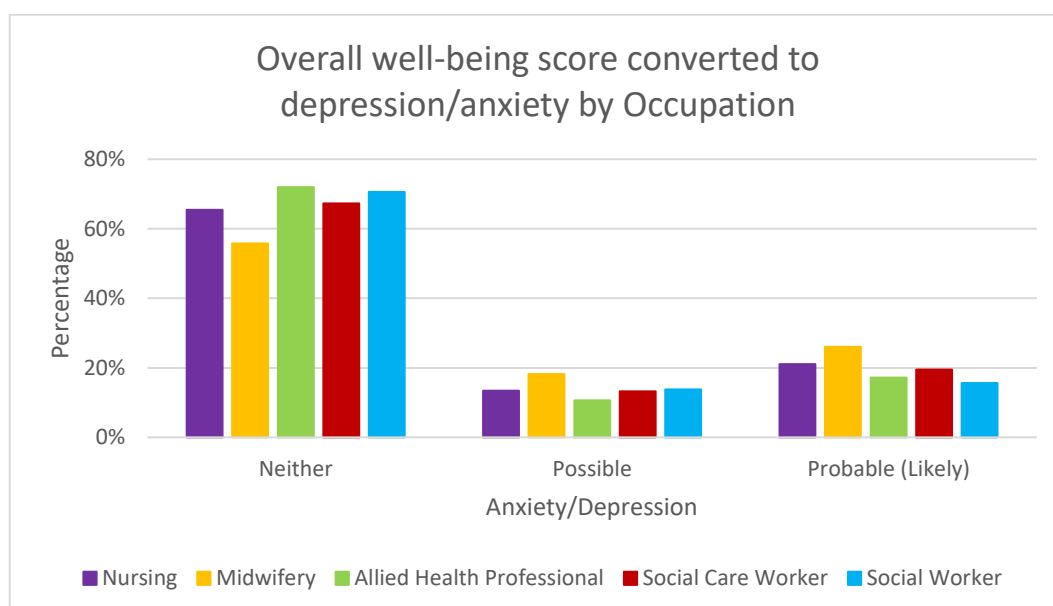


Table A3.7: Overall Well-being Score Converted to Depression/Anxiety by Occupation (Weighted by Region)

Case of anxiety/depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	71.7%	54.7%	70.2%	66.4%	49.9%
Probable (Likely)	5.8%	7.1%	8.9%	11.7%	16.8%
Possible	22.6%	38.2%	20.9%	21.9%	33.3%
Total	100%	100%	100%	100%	100%

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

Case of anxiety/ depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	143 (70.4%)	14 (51.9%)	149 (70.6%)	294 (58.3%)	250 (63.1%)
Probable (Likely)	21 (10.3%)	6 (22.2%)	20 (9.5%)	88 (17.5%)	51 (12.9%)
Possible	39 (19.2%)	7 (25.9%)	42 (19.9%)	122 (24.2%)	95 (24.0%)
Total	203 (100%)	27 (100%)	211 (100%)	504 (100%)	396(100%)

A3.3 Well-being Scores by Sex

Only 13 respondents in the full sample stated their sex to be transgender, non-binary, intersex, other or preferred not to state which category of gender they identified with. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

Males and females differed significantly on their overall mean well-being scores ($t = 2.049$, $df=1235$, $p = .041$), with females having significantly higher well-being scores than their male counterparts.

Summary (Unweighted results):

Males and females did not differ significantly on their overall mean well-being scores ($t = 1.726$, $df=1325$, $p = .085$).

Figure A3.11: Mean Overall Well-being Score by Sex (Weighted)

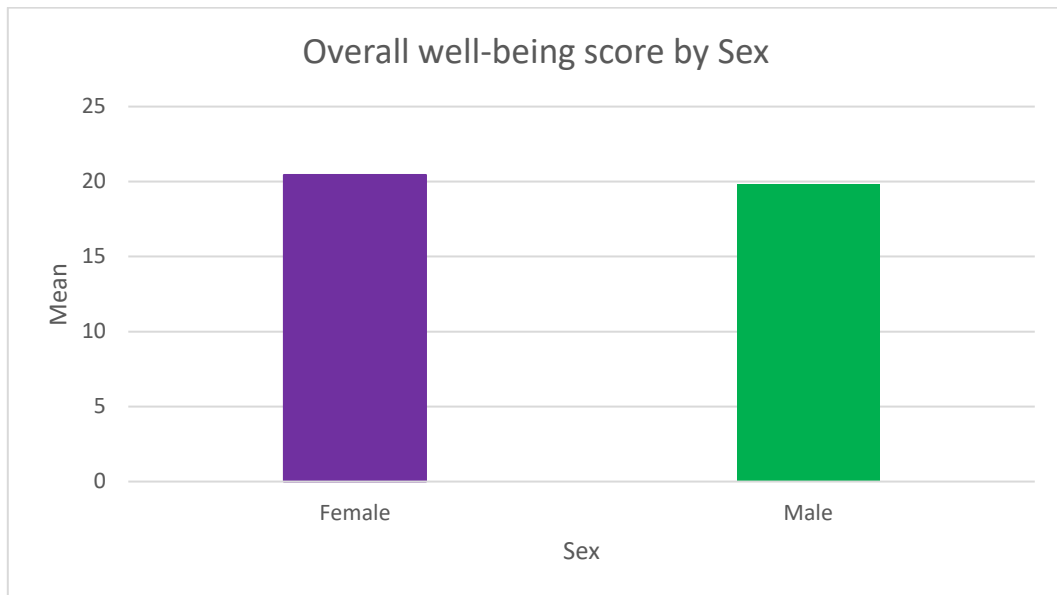


Figure A3.12: Mean Overall Well-being Score by Sex (Unweighted)

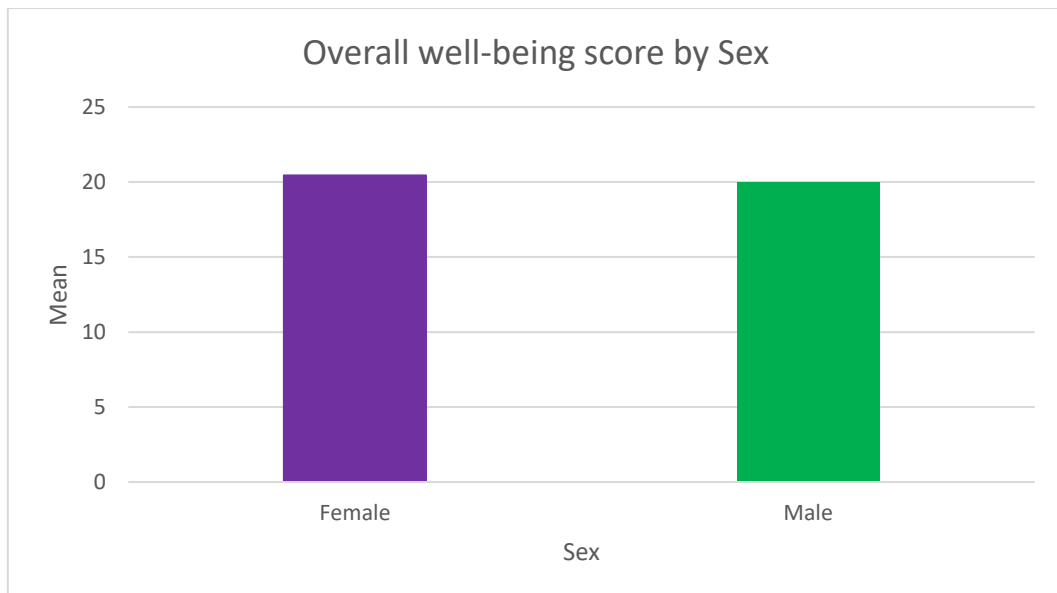


Table A3.9: Mean Overall Well-being Score by Sex (Weighted)

Sex	Mean overall well-being score
Female	20.44
Male	19.86

Table A3.10: Mean Overall Well-being Score by Sex (Unweighted)

Sex	Mean overall well-being score
Female	20.44
Male	19.99

A3.4 Well-being Scores by Age

Summary (Weighted results):

There were significant differences across the age groups in their overall mean well-being scores ($F = 9.979$, $df = 4$, $p < .001$). Specifically, those aged 16-29 scored significantly lower well-being than the 60+ age groups.

Summary (Unweighted results):

There were significant differences across the age groups in their overall mean well-being scores ($F = 2.909$, $df = 4$, $p = .021$). Specifically, those aged 16-29 scored significantly lower well-being than those from the 60+ age group.

Figure A3.13: Mean Overall Well-being Score by Age (Weighted)

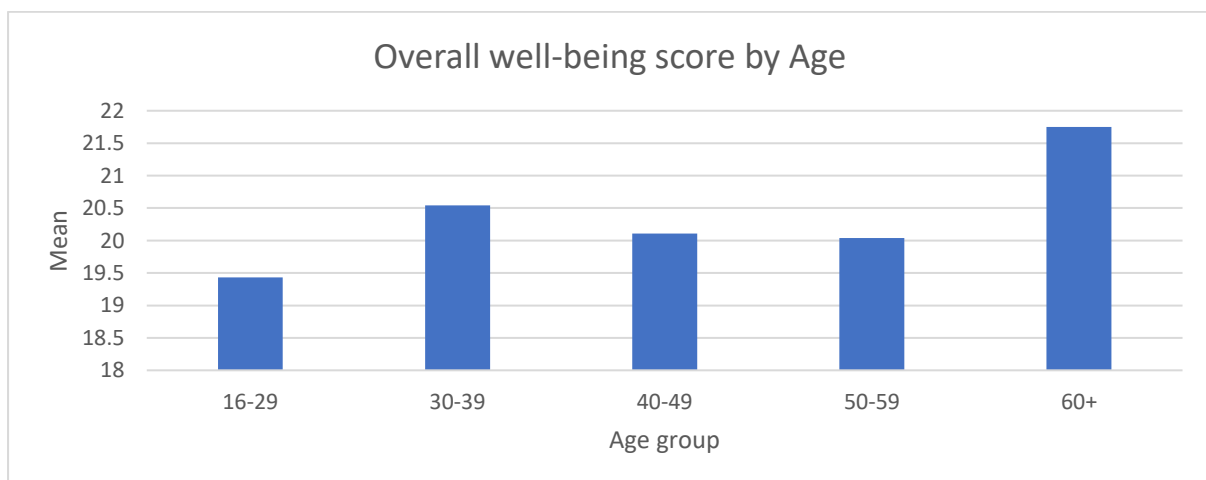


Figure A3.14: Mean Overall Well-being Score by Age (Unweighted)

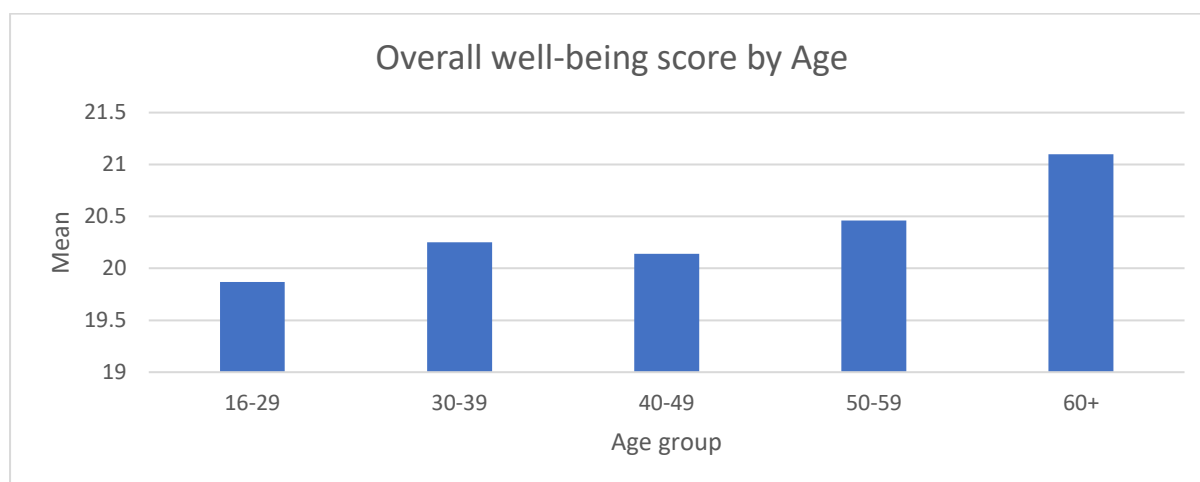


Table A3.11: Mean Overall Well-being Score by Age (Weighted)

Age	Mean overall well-being score
16-29 years	19.43
30-39 years	20.54
40-49 years	20.11
50-59 years	20.04
60+ years	21.75

Table A3.12: Mean Overall Well-being Score by Age (Unweighted)

Age	Mean overall well-being score
16-29 years	19.87
30-39 years	20.25
40-49 years	20.14
50-59 years	20.46
60+ years	21.10

A3.5 Well-being Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups on their overall mean well-being scores ($F = 3.778$, $df = 3$, $p = .010$). Specifically, respondents who identified as Asian scored significantly higher in well-being scores than both, White and Mixed ethnic groups.

Summary (Unweighted results):

There were no significant differences between the ethnic groups on their overall mean well-being scores ($F = 1.982$, $df = 3$, $p = .115$).

Figure A3.15: Mean Overall Well-being Score by Ethnicity (Weighted)

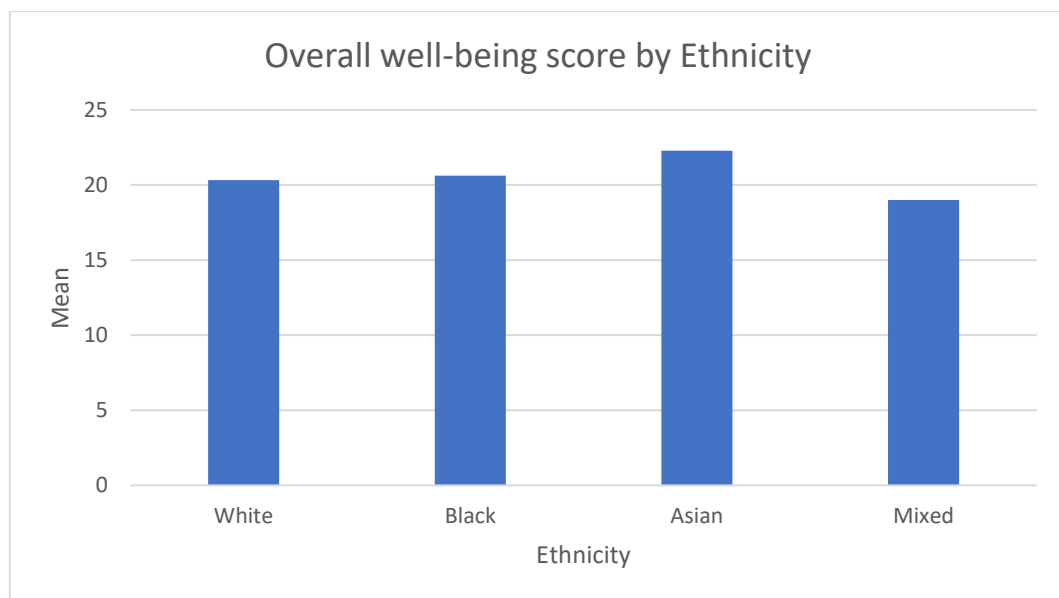


Figure A3.16: Mean Overall Well-being Score by Ethnicity (Unweighted)

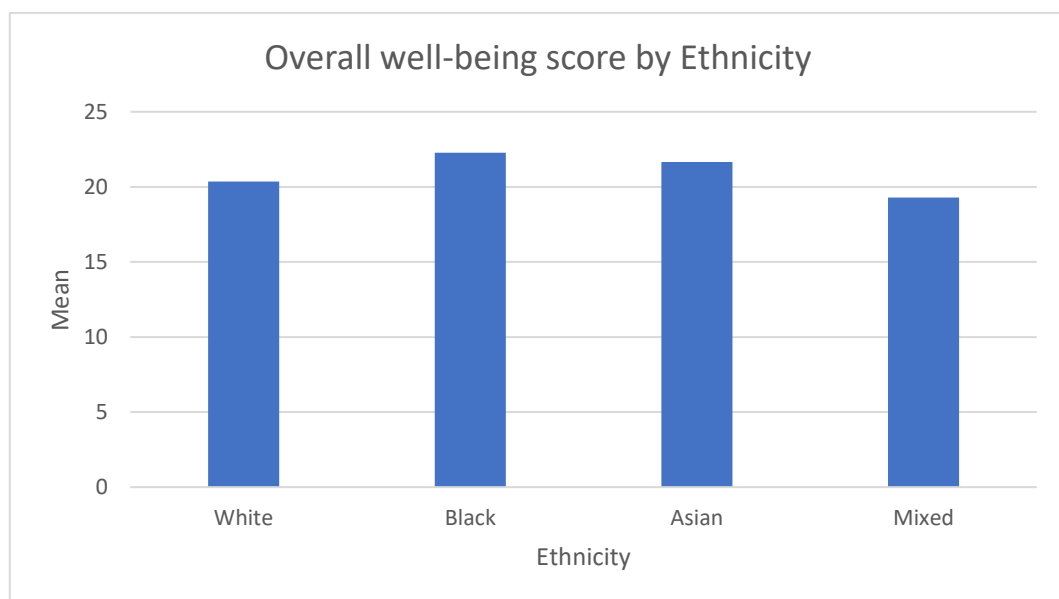


Table A3.13: Mean Overall Well-being Score by Ethnicity (Weighted)

Ethnicity	Mean overall well-being score
White	20.32
Black	20.63
Asian	22.30
Mixed	19.00

Table A3.14: Mean Overall Well-being Score by Ethnicity (Unweighted)

Ethnicity	Mean overall well-being score
White	20.35
Black	22.28
Asian	21.65
Mixed	19.28

A3.6 Well-being Scores by Disability

Summary (Weighted results):

There were no significant differences between respondents on their overall mean well-being scores based on their disability status.

Summary (Unweighted results):

There were significant differences between respondents on their overall mean well-being scores based on their disability status ($F = 7.482$, $df = 2$, $p < .001$). Specifically, respondents who considered themselves to not have a disability reported significantly higher well-being scores than those with a disability.

Figure A3.17: Mean Overall Well-being Score by Disability (Weighted)

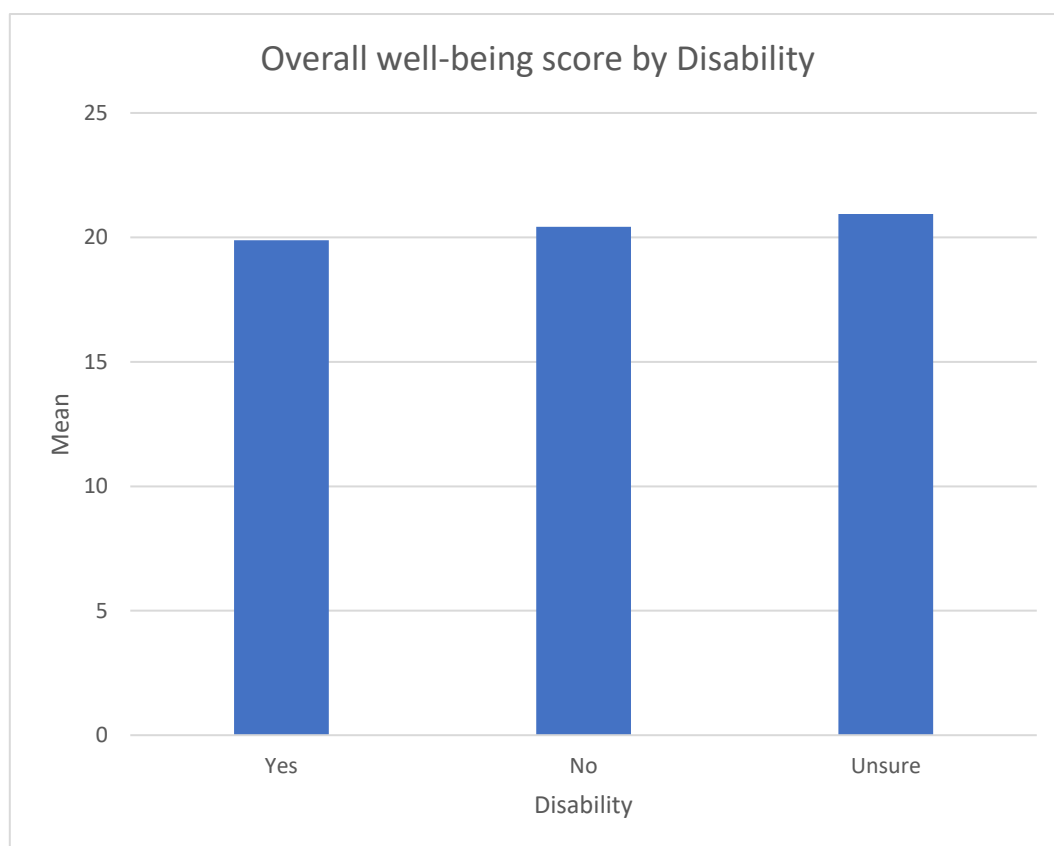


Figure A3.18: Mean Overall Well-being Score by Disability (Unweighted)

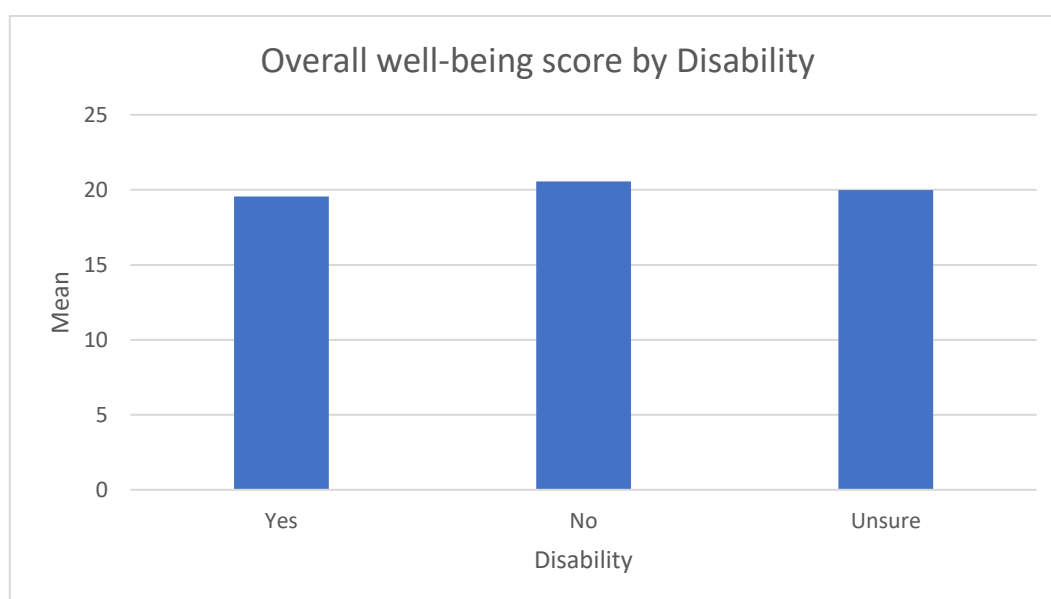


Table A3.15: Mean Overall Well-being Score by Disability (Weighted)

Do you consider yourself to have a disability?	Mean overall well-being score
Yes	19.88
No	20.42
Unsure	20.94

Table A3.16: Mean Overall Well-being Score by Disability (Unweighted)

Do you consider yourself to have a disability?	Mean overall well-being score
Yes	19.55
No	20.55
Unsure	19.98

A3.7 Well-being Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences in the overall mean well-being scores between respondents who worked in different areas of practice ($F = 6.190$, $df = 7$, $p < .001$). Specifically, respondents who worked with adults scored significantly higher than those in children, in physical disabilities, in learning disabilities, with older people, and within mental health.

Summary (Unweighted results):

There were significant differences in the overall mean well-being scores between respondents who worked in different areas of practice ($F = 4.203$, $df = 7$, $p < .001$). Specifically, respondents who selected 'other' scored significantly higher than those who worked with children, those who worked with learning disabilities, and those who worked with older people.

Figure A3.19: Mean Overall Well-being Score by Area of Practice (Weighted)

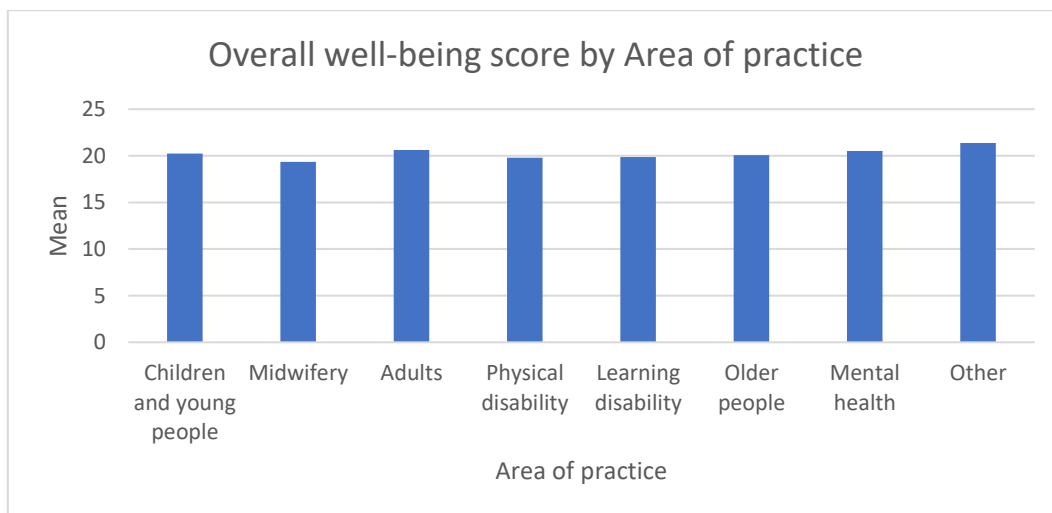


Figure A3.20: Mean Overall Well-being Score by Area of Practice (Unweighted)

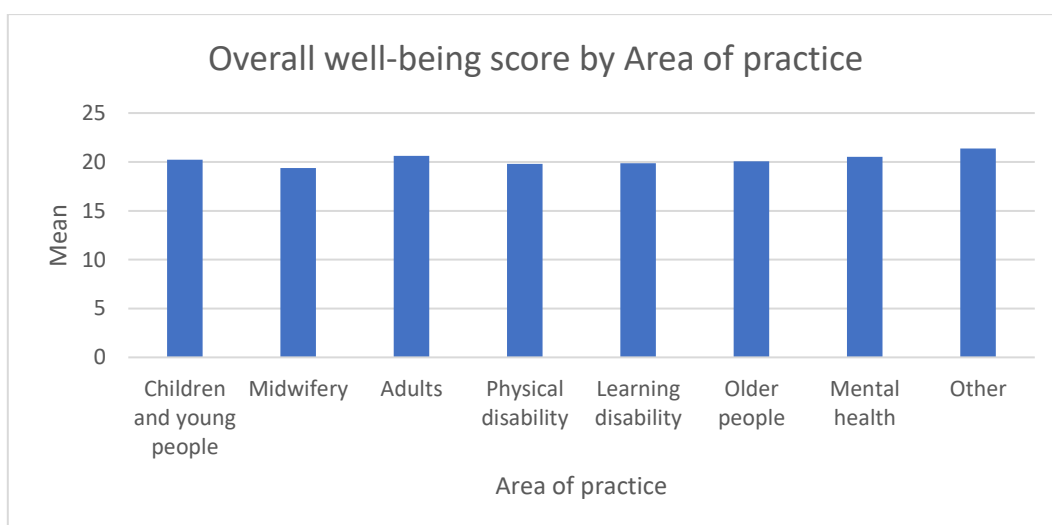


Table A3.17: Mean Overall Well-being Score by Area of Practice (Weighted)

Main area of practice	Mean overall well-being score
Children	19.84
Midwifery	19.80
Adults	21.59
Physical disability	19.41
Learning disability	19.96
Older people	20.30
Mental health	19.71
Other	20.85

Table A3.18: Mean Overall Well-being Score by Area of Practice (Unweighted)

Main area of practice	Mean overall well-being score
Children	20.24
Midwifery	19.36
Adults	20.63
Physical disability	19.81
Learning disability	19.86
Older people	20.06
Mental health	20.51
Other	21.38

A3.8 Well-being Scores by Line Manager Status

Summary (Weighted results):

There was a significant difference in the overall mean well-being scores between respondents who were line managers and those who were not ($t = -2.287$, $df = 1130.76$, $p = .011$).

Summary (Unweighted results):

There was no significant difference in the overall mean well-being scores between respondents who were line managers and those who were not ($t = -.427$, $df = 1339$, $p = .669$).

Figure A3.21: Mean Overall Well-being Score by Line Manager Status (Weighted)

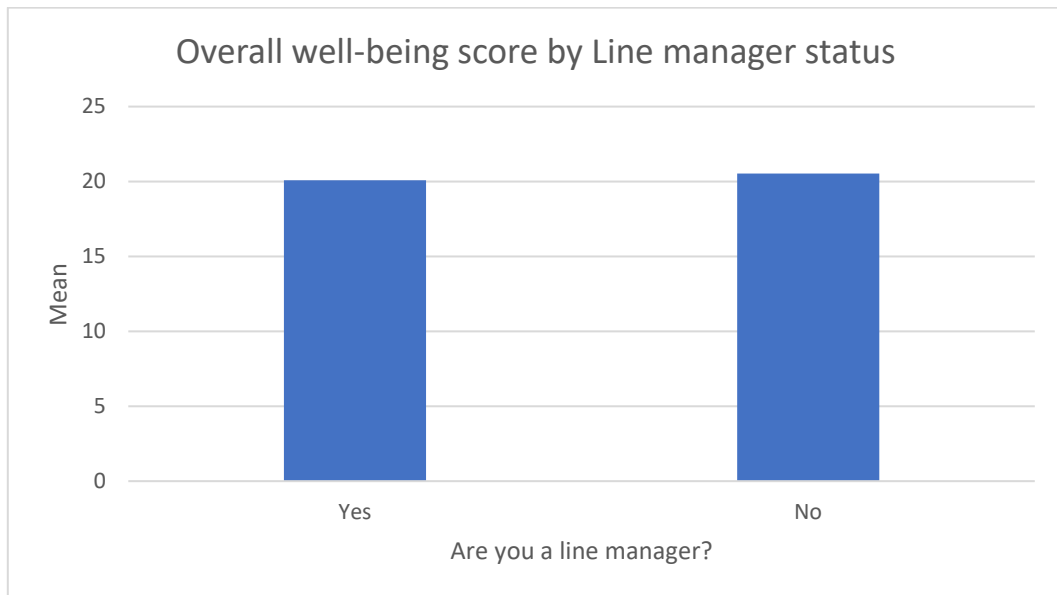


Figure A3.22: Mean Overall Well-being Score by Line Manager Status (Unweighted)

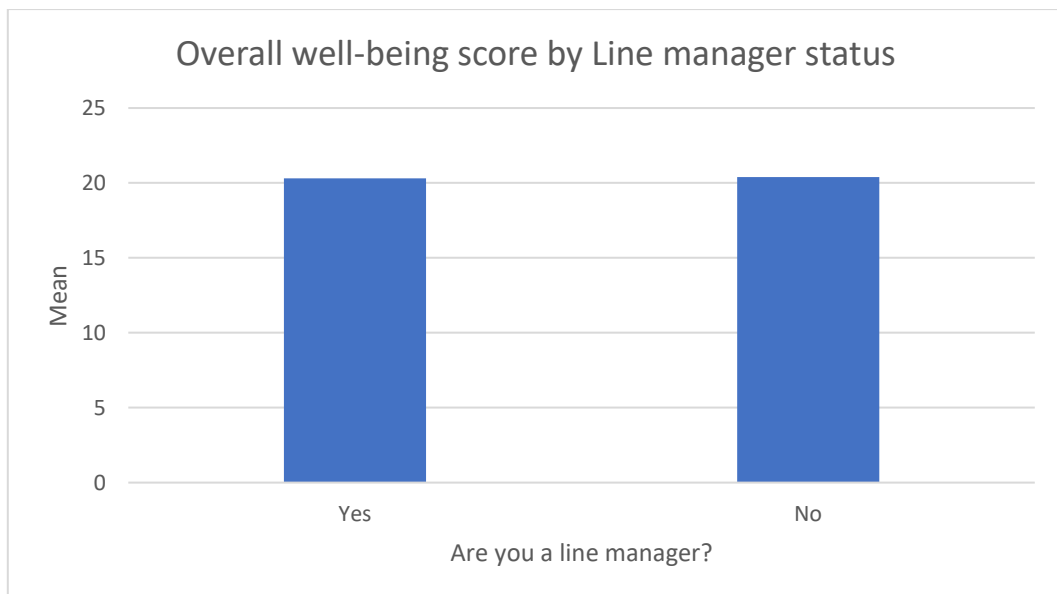


Table A3.19: Mean Overall Well-being Score by Line Manager Status (Weighted)

Are you a line manager?	Mean overall well-being score
Yes	20.09
No	20.53

Table A3.20: Mean Overall Well-being Score by Line Manager Status (Unweighted)

Are you a line manager?	Mean overall well-being score
Yes	20.31
No	20.39

A3.9 Well-being Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in the overall mean well-being scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ($F = 43.400$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures.

Summary (Unweighted results):

There were significant differences in the overall mean well-being scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ($F = 34.947$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19 and those who were not impacted by COVID-19 pressures.

Figure A3.23: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Weighted)

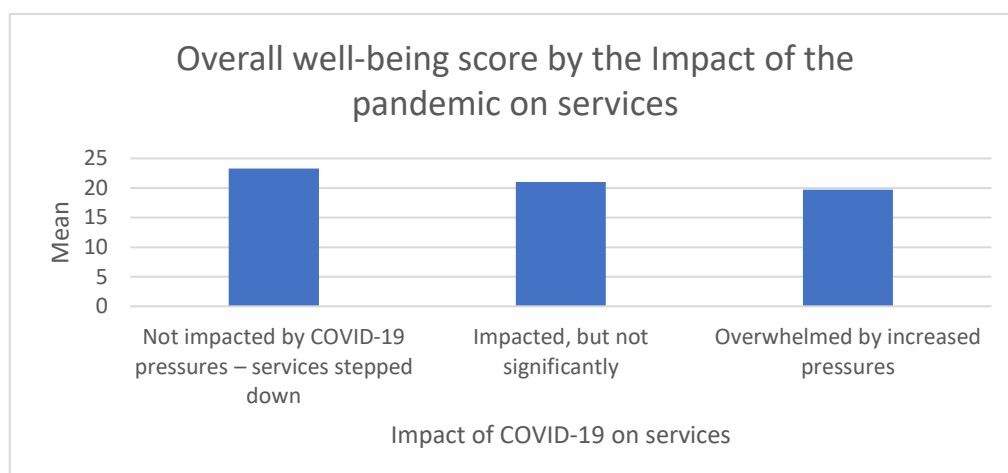


Figure A3.24: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Unweighted)

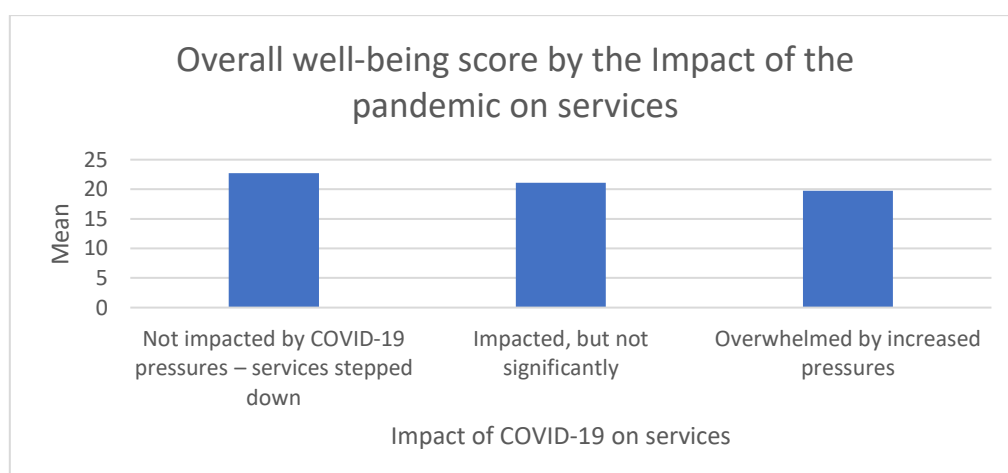


Table A3.21: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Weighted)

Impact of the pandemic on services	Mean overall well-being score
Not impacted by COVID-19 pressures – services stepped down	23.31
Impacted, but not significantly	21.02
Overwhelmed by increased pressures	19.70

Table A3.22: Mean Overall Well-being Score by the Impact of the Pandemic on Services (Unweighted)

Impact of the pandemic on services	Mean overall well-being score
Not impacted by COVID-19 pressures – services stepped down	22.74
Impacted, but not significantly	21.12
Overwhelmed by increased pressures	19.75

A3.10 Well-being Scores by the Uptake of Employer Support

Summary (Weighted results):

There were no significant differences on overall well-being scores between those who took employer support and those who did not ($t = .728$, $df=1245$, $p = .467$).

Summary (Unweighted results):

There were significant differences on overall well-being scores between those who took employer support and those who did not ($t = -2.305$, $df=647.497$, $p = .021$).

Figure A3. 25: Mean Overall Well-being Score by the Uptake of Employer Support (Weighted)

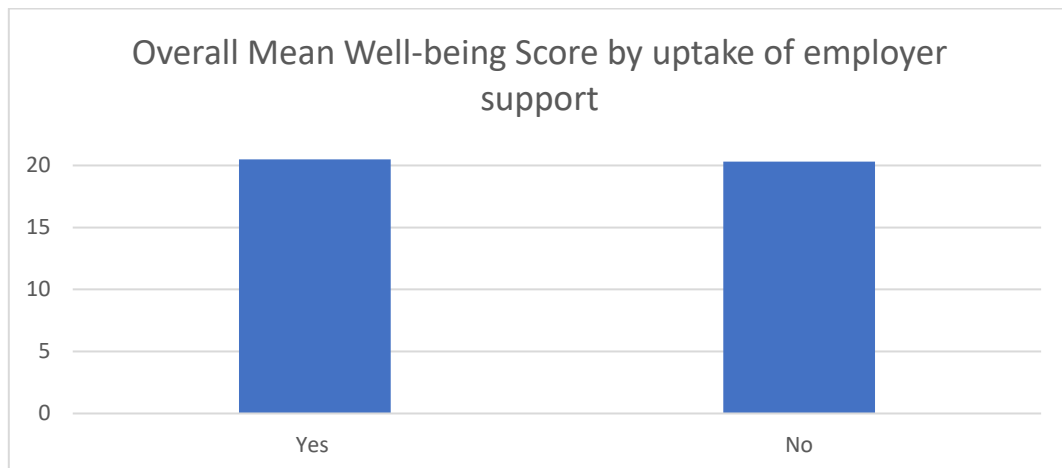


Figure A3. 26: Mean Overall Well-being Score by the Uptake of Employer Support (Unweighted)

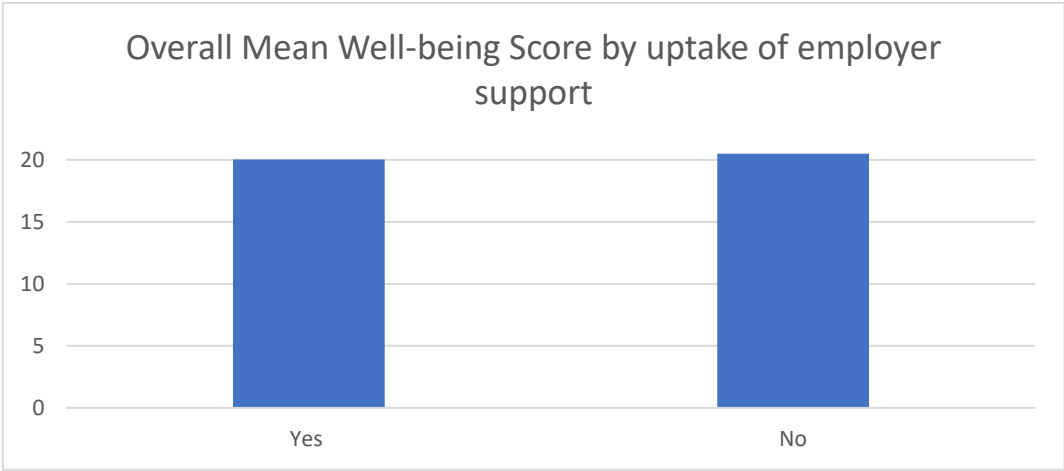


Table A3. 23:Mean Overall Well-being Score by the Uptake of Employer Support (Weighted)

Uptake of employer support	Mean overall well-being score
Yes	20.48
No	20.32

Table A3. 24: Mean Overall Well-being Score by the Uptake of Employer Support (Unweighted)

Uptake of employer support	Mean overall well-being score
Yes	20.02
No	20.49

Appendix 4: Quality of Working Life (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of respondents' quality of working life, which was measured using the Work-Related Quality of Life (WRQOL) scale. Higher scores on all domains indicate better quality of working life (e.g., higher score on the Stress at Work domain means less stress experienced by respondents and hence better quality of working life). Scores are comparable within domains, but not across them, due to different numbers of items contributing to each domain. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

For direct comparisons across reports (i.e., across Phase 1, Phase 2, Phase 3, Phase 4, Phase 5, and Phase 6), 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 ($F = 11.981$, $df = 3$, $p < .001$). Specifically, the overall WRQOL score was significantly higher in Wales compared to Scotland and Northern Ireland. When respondents were categorised into those with lower, average and higher quality of working life, Scotland had the highest proportion of respondents with “lower quality of working life” (54.9%) and England had the highest proportion with “higher quality of working life” (38.7%).

Summary (Unweighted results):

There were significant differences in the overall mean WRQOL scores across countries ($F = 8.252$, $df = 3$, $p < .001$). Specifically, the overall WRQOL score was significantly higher in Wales compared to England, Scotland, and Northern Ireland. When respondents were categorised into those with lower, average and higher quality of working life, Scotland had the highest proportion of respondents with “lower quality of working life” (53.0%) and Wales had the highest proportion with “higher quality of working life” (36.3%).

Figure A4. 1: Mean Quality of Working Life Scores by Country (Weighted by Occupation)

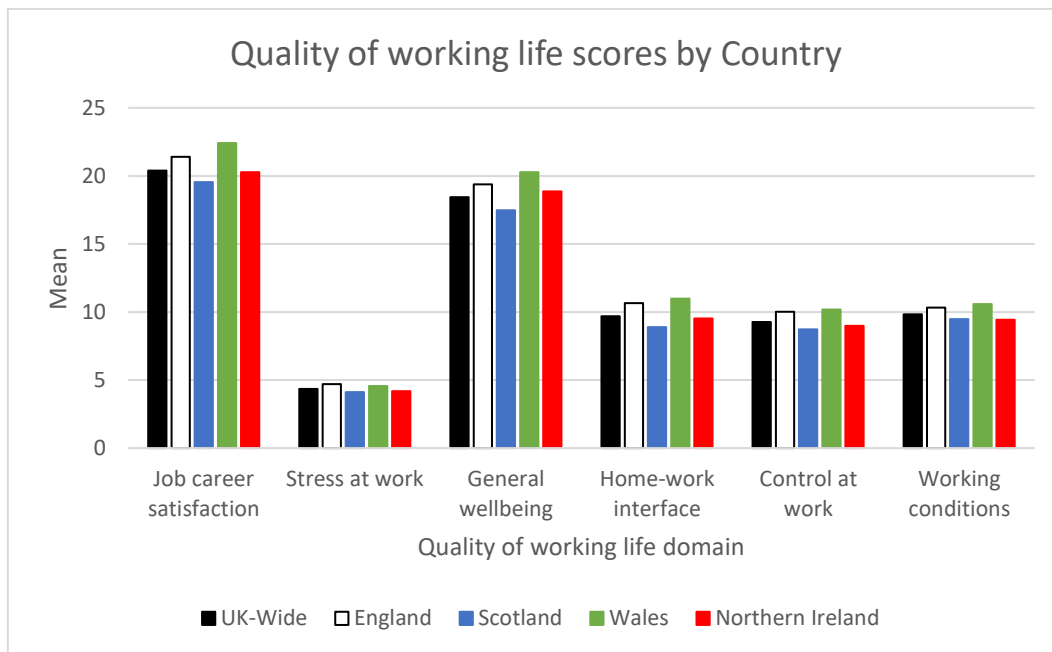


Figure A4. 2: Mean Quality of Working Life Scores by Country (Unweighted)

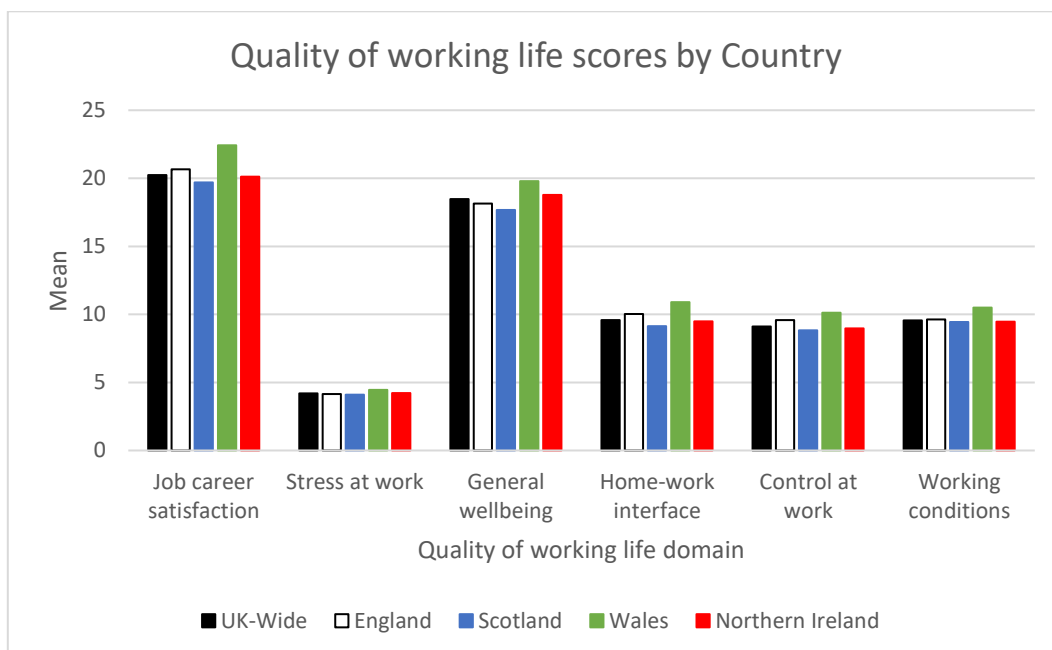


Figure A4.3: Mean Overall Quality of Working Life Score by Country (Weighted by Occupation)

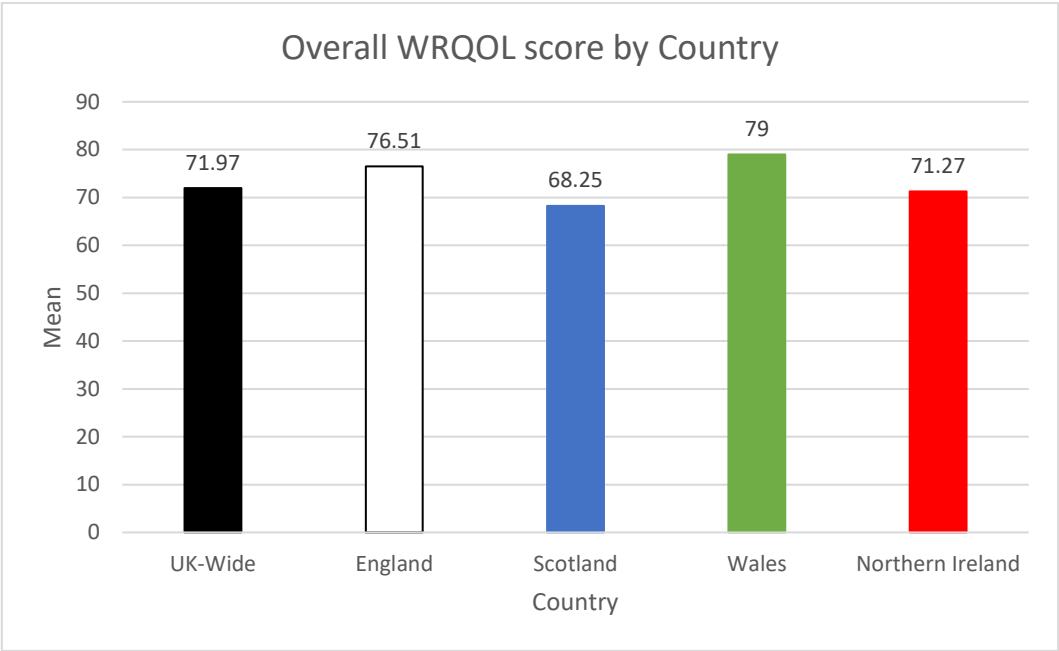


Figure A4.4: Mean Overall Quality of Working Life Score by Country (Unweighted)

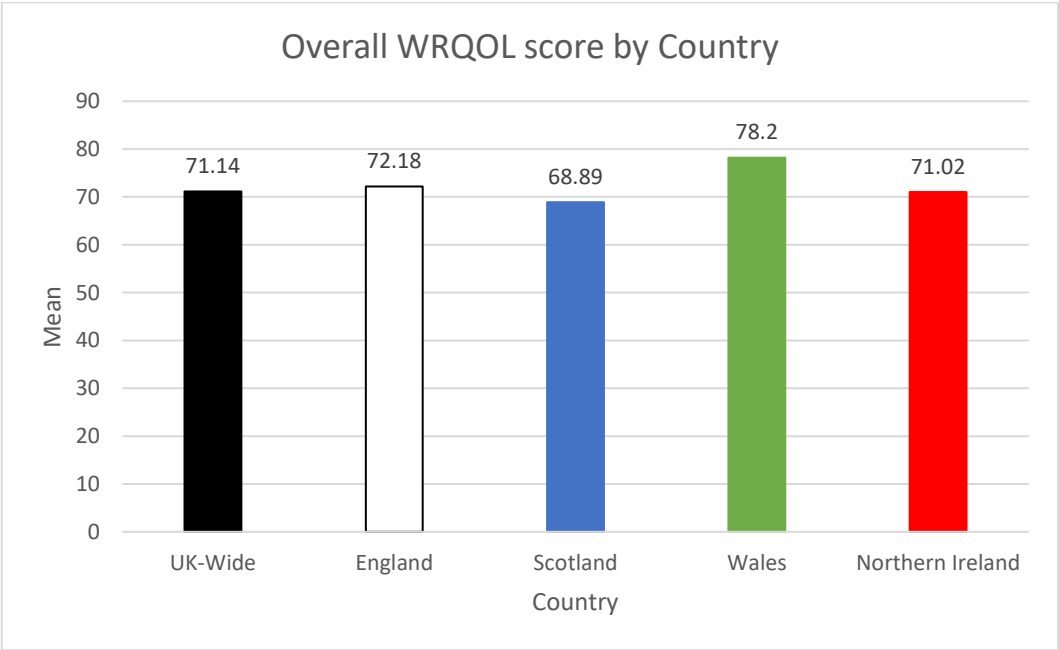


Table A4. 1: Mean Quality of Working Life Scores by Country (Weighted by Occupation)

WRQOL domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Job career satisfaction	20.40	21.40	19.55	22.42	20.27
Stress at work	4.35	4.70	4.11	4.56	4.19
General well-being	18.43	19.38	17.48	20.28	18.86
Home-work interface	9.69	10.65	8.89	10.98	9.53
Control at work	9.27	10.01	8.73	10.17	8.99
Working conditions	9.82	10.33	9.48	10.58	9.44
Overall WRQOL Score	71.97	76.51	68.25	79.00	71.27

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	20.24	20.66	19.69	22.42	20.13
Stress at work	4.19	4.15	4.10	4.46	4.21
General well-being	18.48	18.14	17.68	19.79	18.77
Home-work interface	9.57	10.04	9.13	10.09	9.48
Control at work	9.10	9.58	8.83	10.12	8.97
Working conditions	9.55	9.63	9.45	10.51	9.46
Overall WRQOL score	71.04	72.18	68.89	78.20	71.02

Figure A4.5: Level of Quality of Working Life Scores – UK-Wide (Weighted)

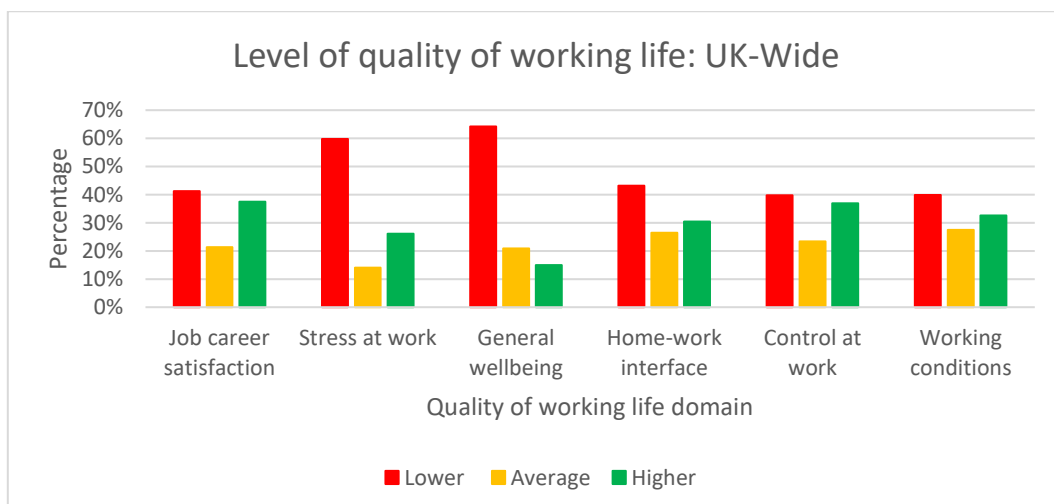


Figure A4.6: Level of Quality of Working Life Scores – UK-Wide (Unweighted)

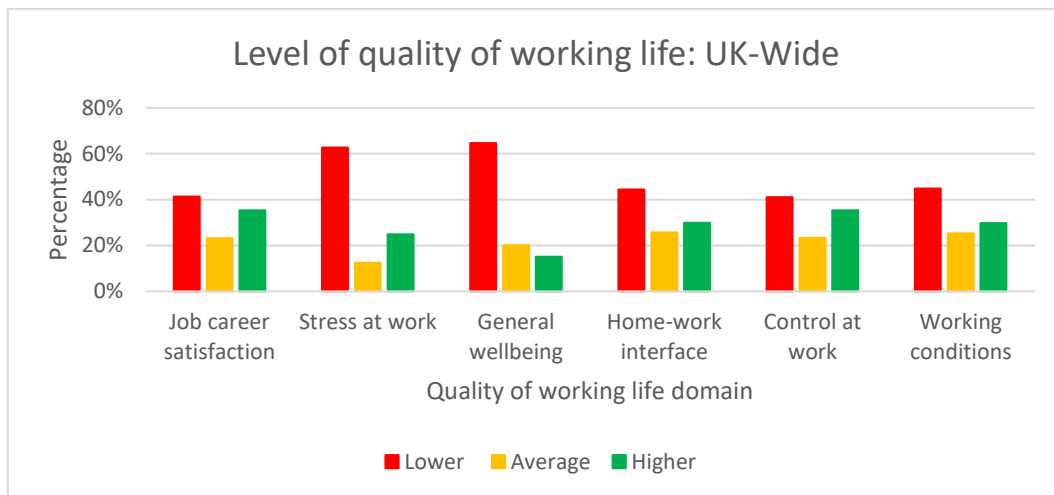


Table A4.3: Level of Quality of Working Life Scores – UK-Wide (Weighted)

WRQOL domain	Level of WRQOL			Total
	Lower	Average	Higher	
Job career satisfaction	41.2%	21.3%	37.5%	100%
Stress at work	59.8%	14.0%	26.1%	100%
General well-being	64.2%	20.9%	14.9%	100%
Home-work interface	43.2%	26.4%	30.4%	100%
Control at work	39.7%	23.4%	36.9%	100%
Working conditions	39.9%	27.5%	32.6%	100%
Overall WRQOL	49.9%	23.6%	26.5%	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	41.4%	23.2%	35.4%	1369 (100%)
Stress at work	62.7%	12.4%	24.9%	1371 (100%)
General well-being	64.7%	20.2%	15.1%	1369 (100%)
Home-work interface	44.4%	25.7%	29.9%	1389 (100%)
Control at work	41.1%	23.4%	35.4%	1369 (100%)
Working conditions	44.9%	25.3%	29.7%	1369 (100%)
Overall WRQOL	50.2%	24.2%	25.6%	1365 (100%)

Figure A4.7: Level of Overall Quality of Working Life by Country (Weighted by Occupation)

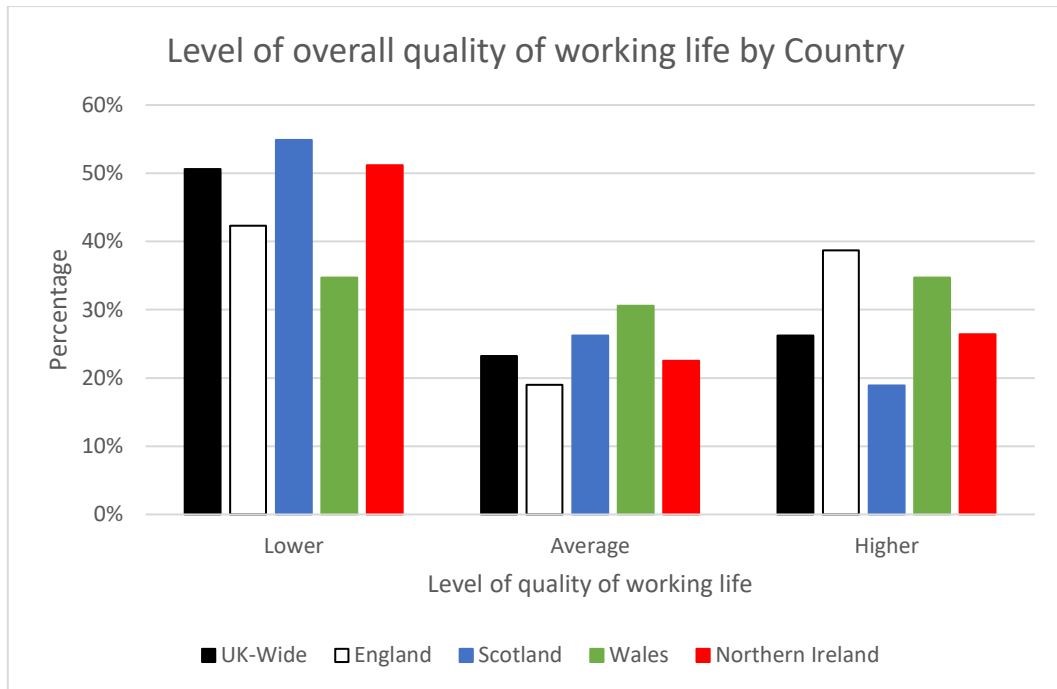


Figure A4.8: Level of Overall Quality of Working Life by Country (Unweighted)

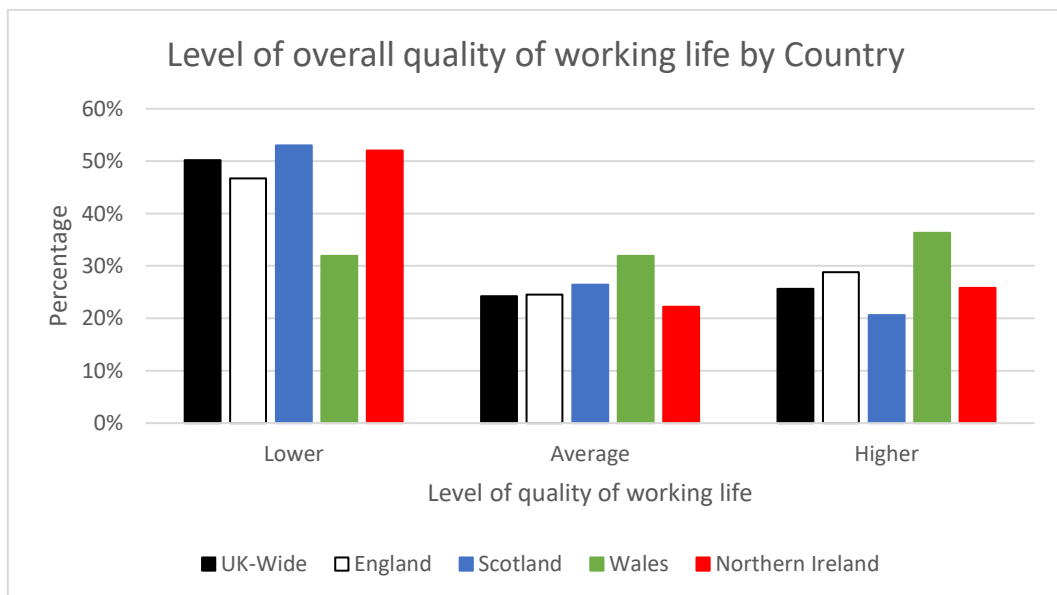


Table A4.5: Level of Overall Quality of Working Life by Country (Weighted by Occupation)

Level of WRQOL	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower	50.6%	42.3%	54.9%	34.7%	51.2%
Average	23.2%	19.0%	26.2%	30.6%	22.5%
Higher	26.2%	38.7%	18.9%	34.7%	26.4%
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	50.2%	46.7%	53.0%	31.9%	52.0%
Average	24.2%	24.5%	26.4%	31.9%	22.2%
Higher	25.6%	28.8%	20.6%	36.3%	25.8%
Total	1395 (100%)	184 (100%)	330 (100%)	91 (100%)	760 (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 ($F = 17.303$, $df = 4$, $p < .001$). Specifically, nurses scored significantly higher than midwives, social care workers, and social workers.

Summary (Unweighted results):

There were significant differences in the overall mean WRQOL score between the occupational groups ($F = 6.733$, $df = 4$, $p < .001$). Specifically, AHPs scored significantly higher than social care workers and midwifery.

Figure A4.9: Mean Quality of Working Life Scores by Occupation (Weighted by Region)

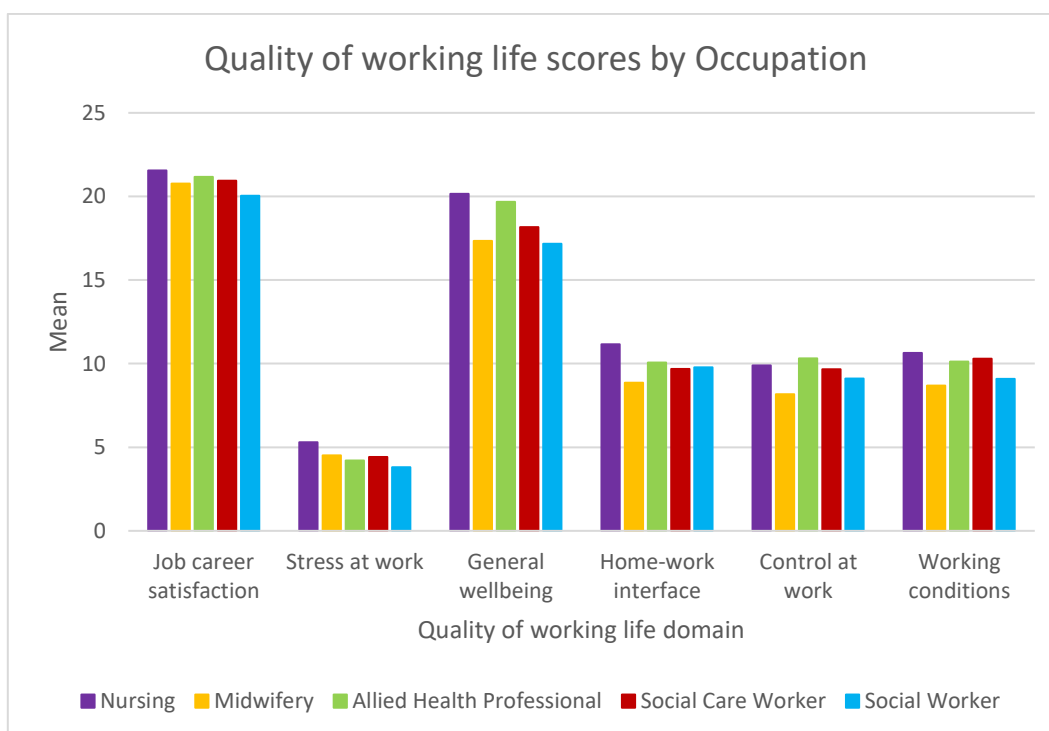


Figure A4.10: Mean Quality of Working Life Scores by Occupation (Unweighted)

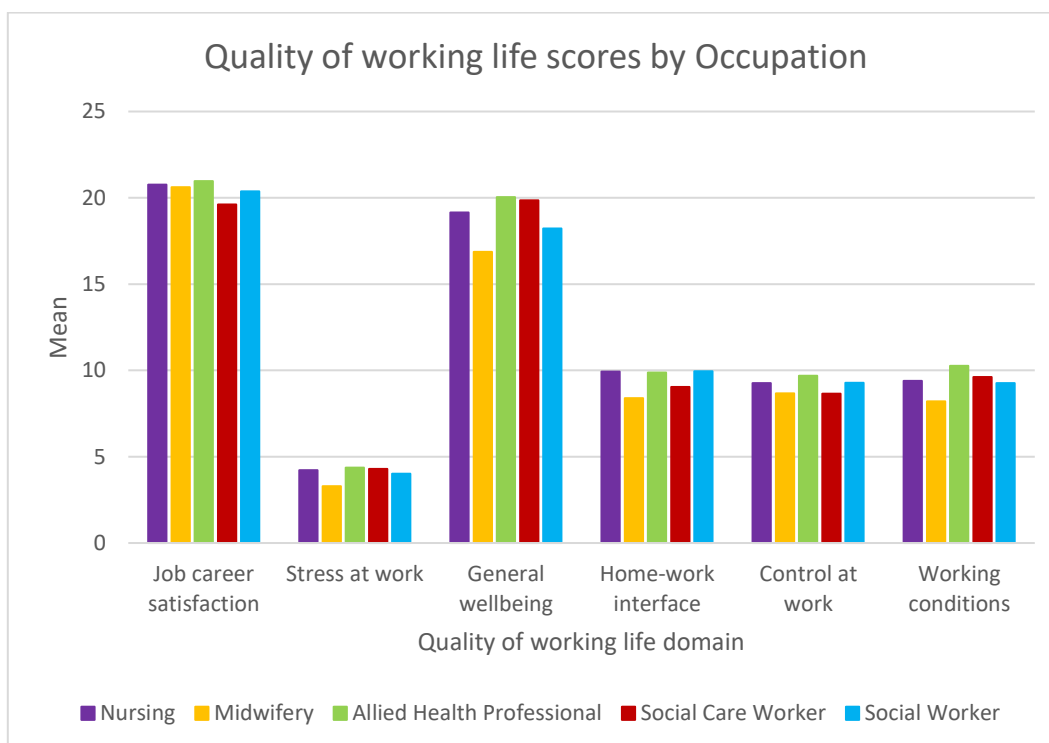


Figure A4.11: Mean Overall Quality of Working Life Score by Occupation (Weighted by Region)

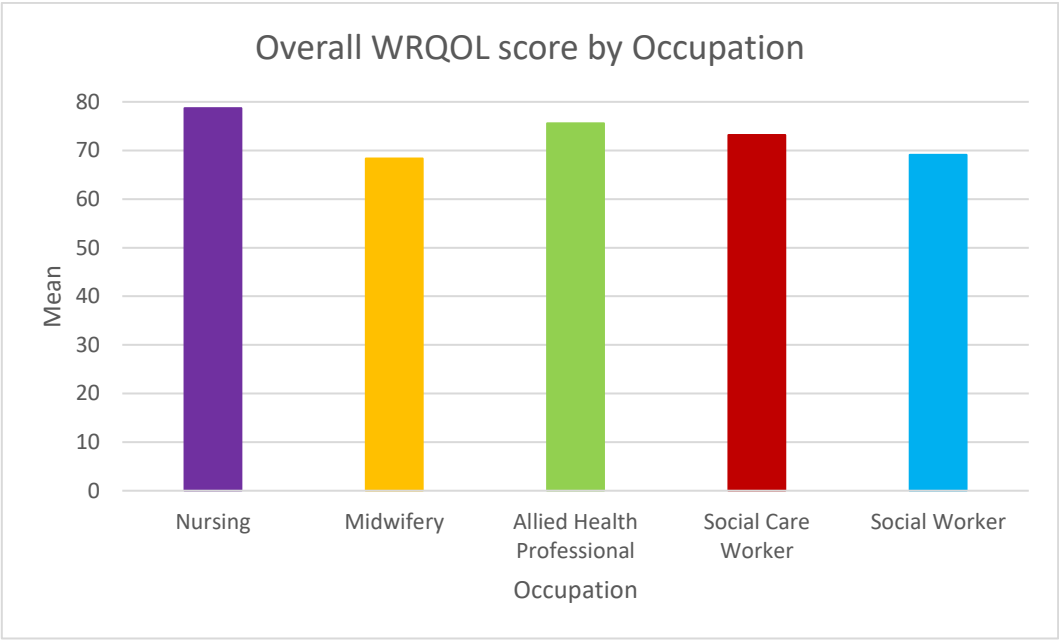


Figure A4.12: Mean Overall Quality of Working Life Score by Occupation (Unweighted)

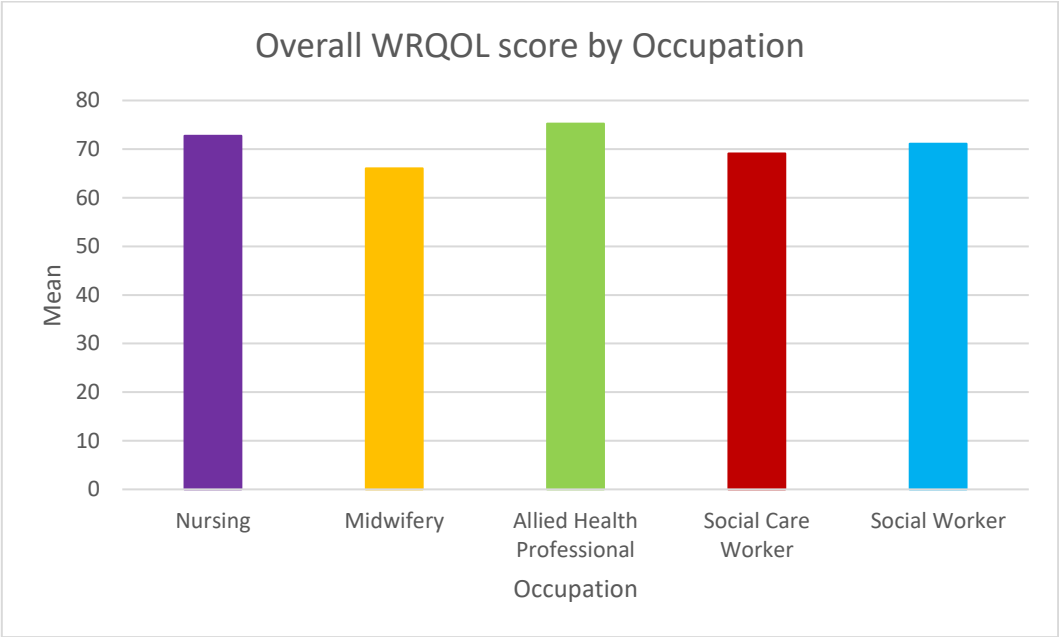


Table A4.7: Mean Quality of Working Life Scores by Occupation (Weighted by Region)

WRQOL domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Job career satisfaction	21.55	20.77	21.17	20.95	20.05
Stress at work	5.29	4.52	4.20	4.41	3.81
General well-being	20.15	17.35	19.68	18.16	17.17
Home-work interface	11.16	8.86	10.07	9.68	9.77
Control at work	9.90	8.18	10.32	9.67	9.10
Working conditions	10.65	8.68	10.13	10.30	9.09
Overall WRQOL score	78.70	68.34	75.58	73.18	69.10

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	20.76	20.61	20.97	19.62	20.38
Stress at work	4.22	3.29	4.37	4.30	4.01
General well-being	19.15	16.86	20.05	19.86	18.23
Home-work interface	9.94	8.39	9.88	9.05	9.95
Control at work	9.27	8.68	9.70	8.66	9.28
Working conditions	9.40	8.21	10.26	9.61	9.27
Overall WRQOL score	72.74	66.04	75.24	69.10	71.11

Figure A4.13: Level of Overall Quality of Working Life by Occupation (Weighted by Region)

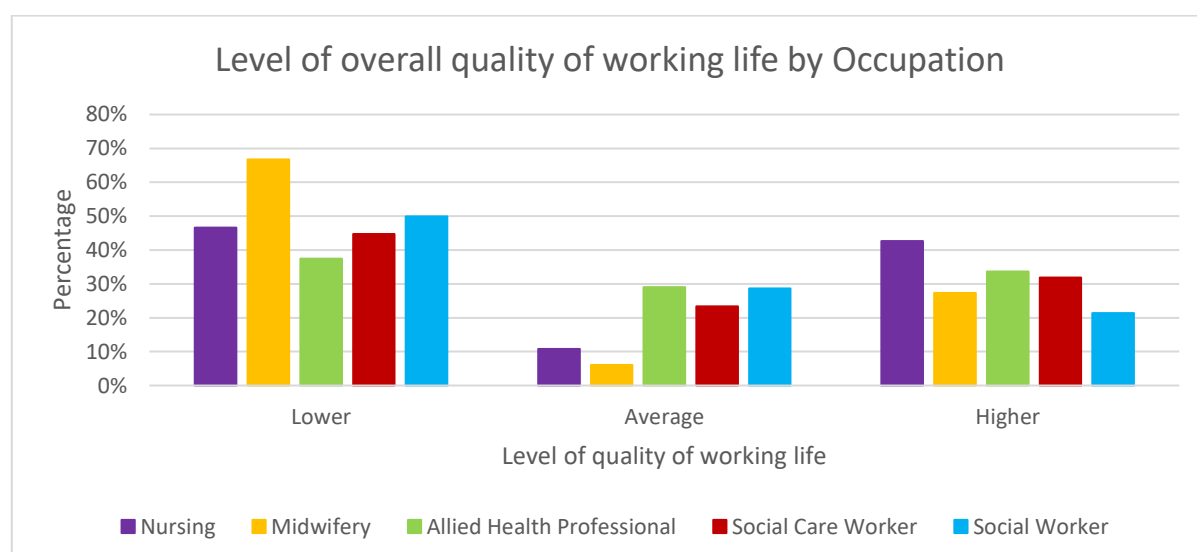


Figure A4.14: Level of Overall Quality of Working Life by Occupation (Unweighted)

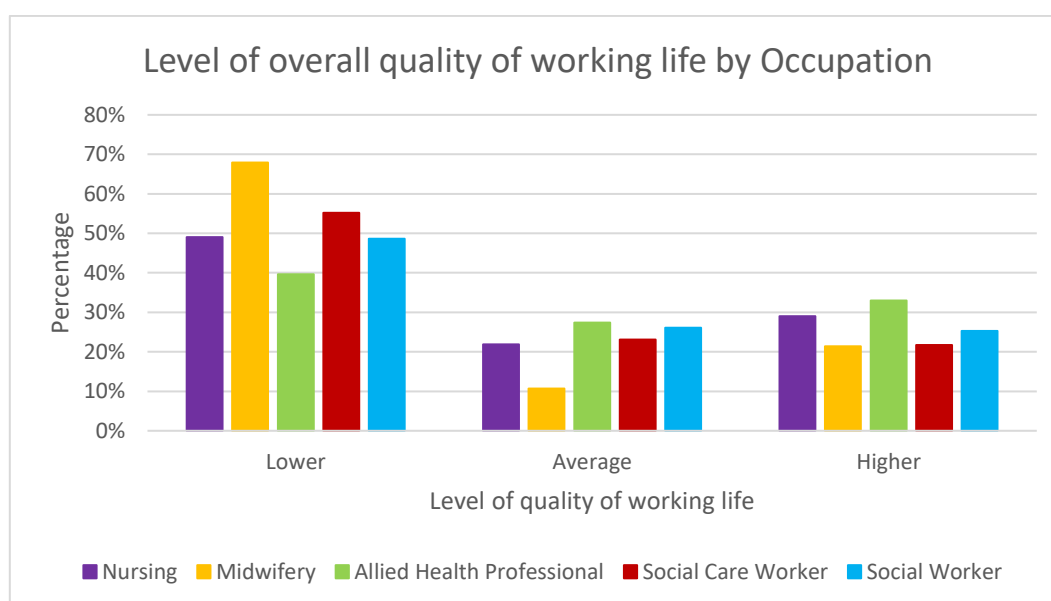


Table A4.9: Level of Overall Quality of Working Life by Occupation (Weighted by Region)

Level of WRQOL	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Lower	46.6%	66.7%	37.4%	44.7%	49.9%
Average	10.8%	6.1%	29.0%	23.4%	28.7%
Higher	42.6%	27.3%	33.7%	31.9%	21.4%
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	49.0%	67.9%	39.6%	55.2%	48.6%
Average	21.9%	10.7%	27.4%	23.1%	26.1%
Higher	29.0%	21.4%	33.0%	21.7%	25.3%
Total	210(100%)	28 (100%)	212 (100%)	516 (100%)	399 (100%)

A4.3 Quality of Working Life Scores by Sex

Only 11 respondents in the full sample stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

There was a significant difference in mean overall WRQOL scores between males and females ($t = -2.703$, $df = 1258$, $p = .007$).

Summary (Unweighted results):

Males and females did not differ significantly in their mean overall WRQOL score ($t = 1.712$, $df = 1362$, $p = .087$).

Figure A4.15: Mean Quality of Working Life Scores by Sex (Weighted)

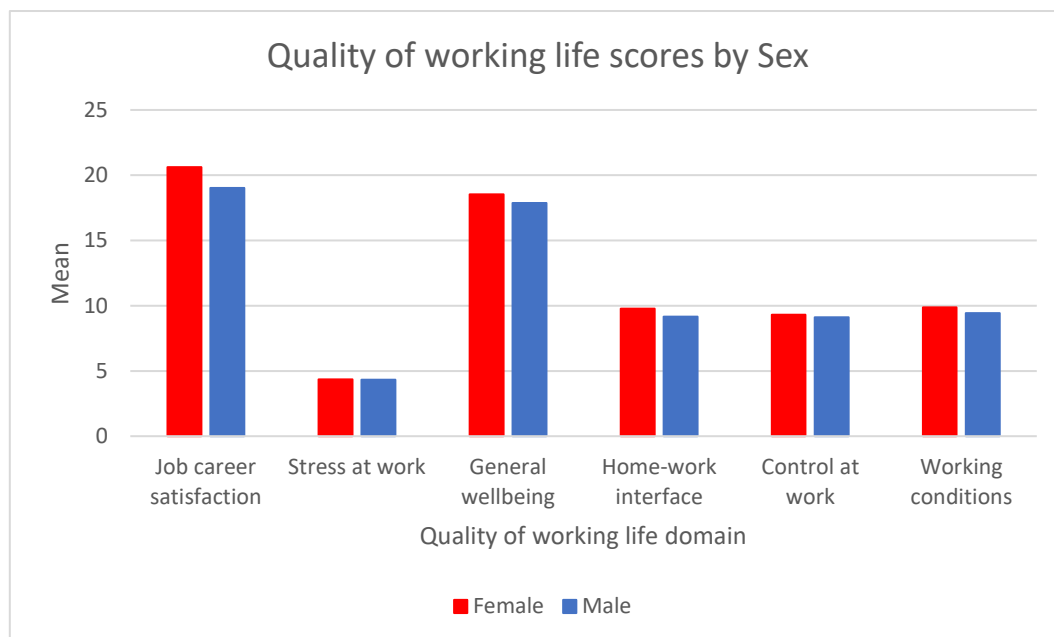


Figure A4.16: Mean Quality of Working Life Scores by Sex (Unweighted)

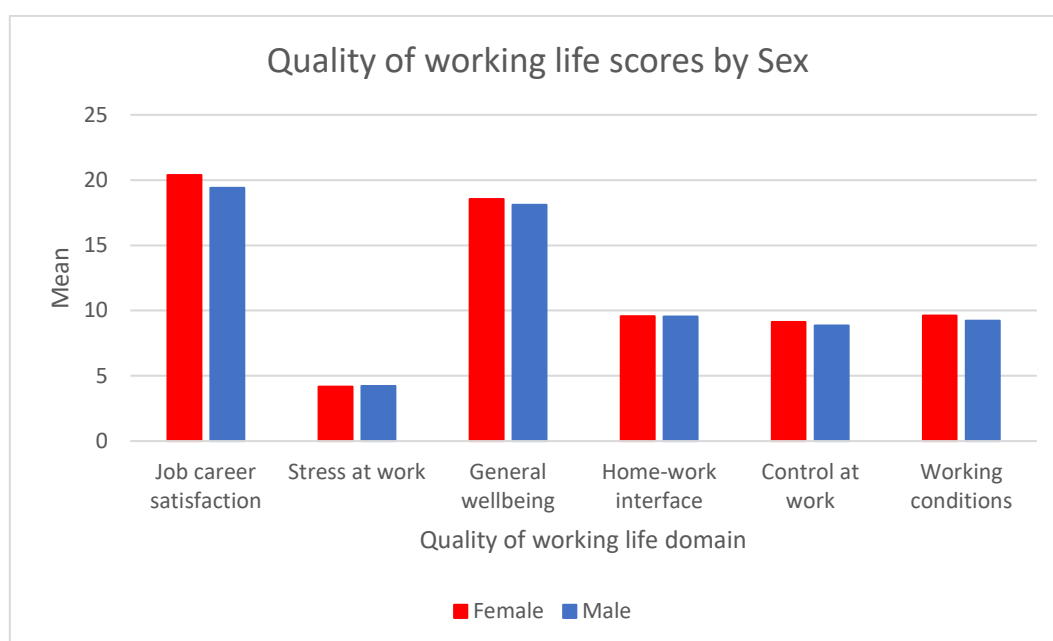


Figure A4.17: Mean Overall Quality of Working Life Score by Sex (Weighted)

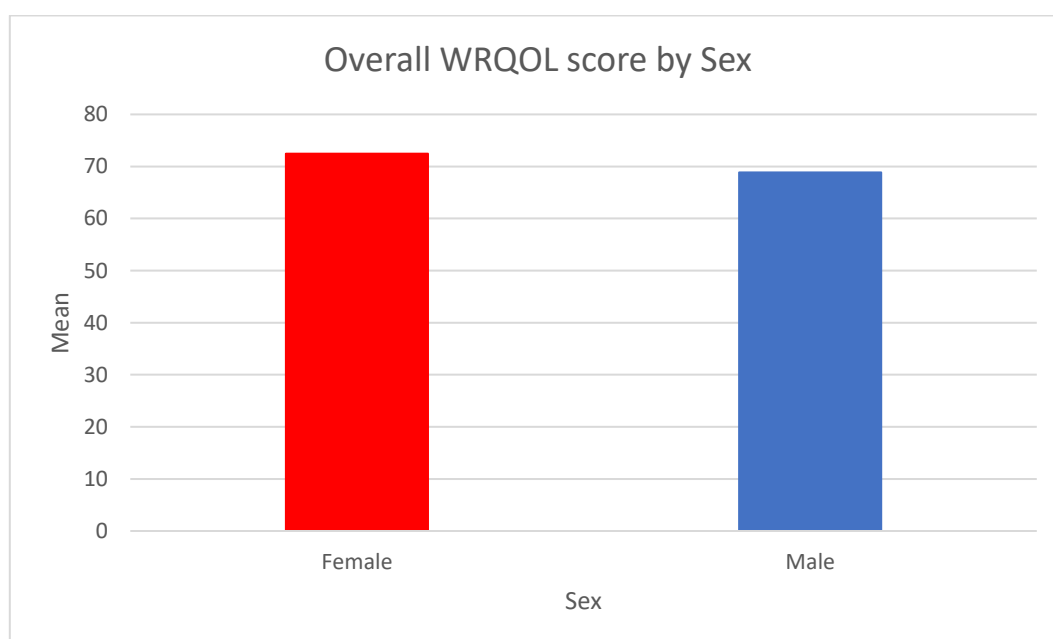


Figure A4.18: Mean Overall Quality of Working Life Score by Sex (Unweighted)

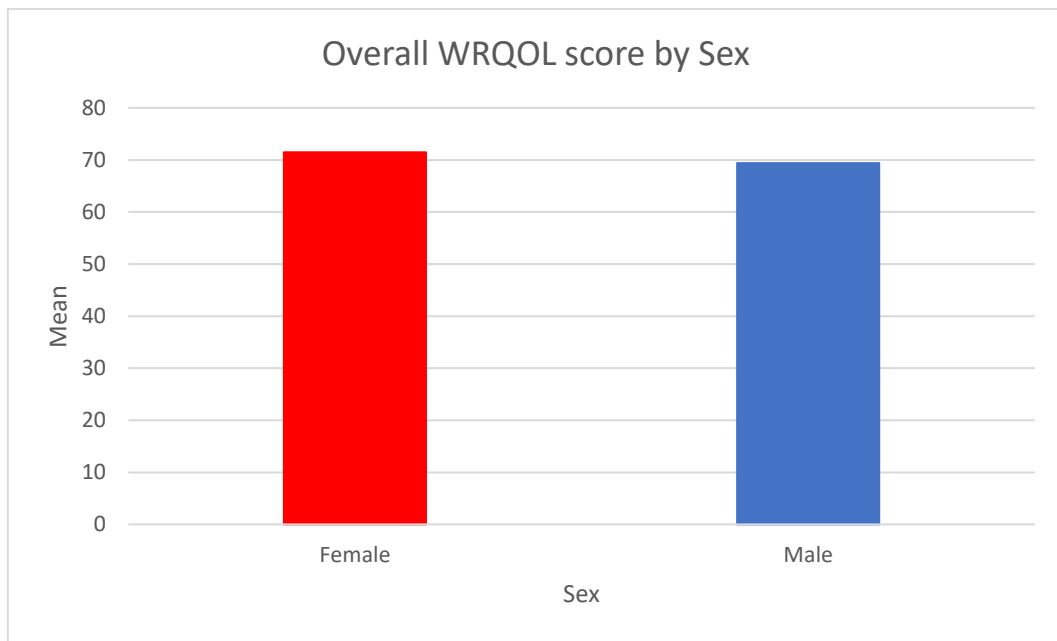


Table A4.11: Mean Quality of Working Life Scores by Sex (Weighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.62	19.01
Stress at work	4.36	4.32
General well-being	18.52	17.86
Home-work interface	9.78	9.15
Control at work	9.30	9.10
Working conditions	9.88	9.43
Overall WRQOL score	72.46	68.86

Table A4.12: Mean Quality of Working Life Scores by Sex (Unweighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.40	19.40
Stress at work	4.18	4.23
General well-being	18.56	18.11
Home-work interface	9.57	9.54
Control at work	9.14	8.87
Working conditions	9.61	9.23
Overall WRQOL score	71.46	69.38

Figure A4.19: Level of Overall Quality of Working Life by Sex (Weighted)

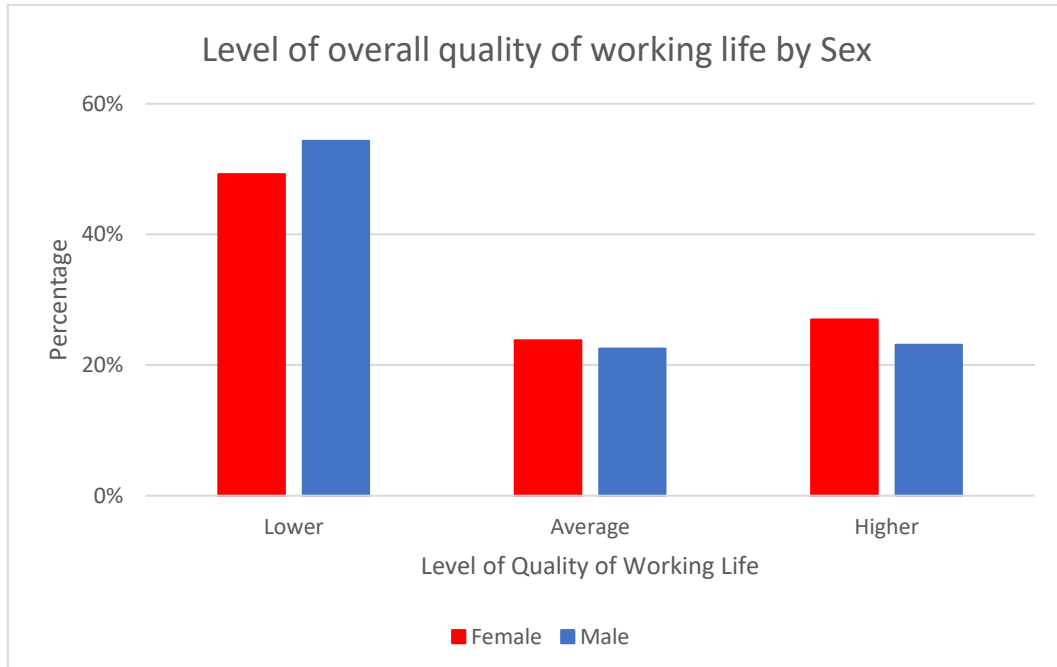


Figure A4.20: Level of Overall Quality of Working Life by Sex (Unweighted)

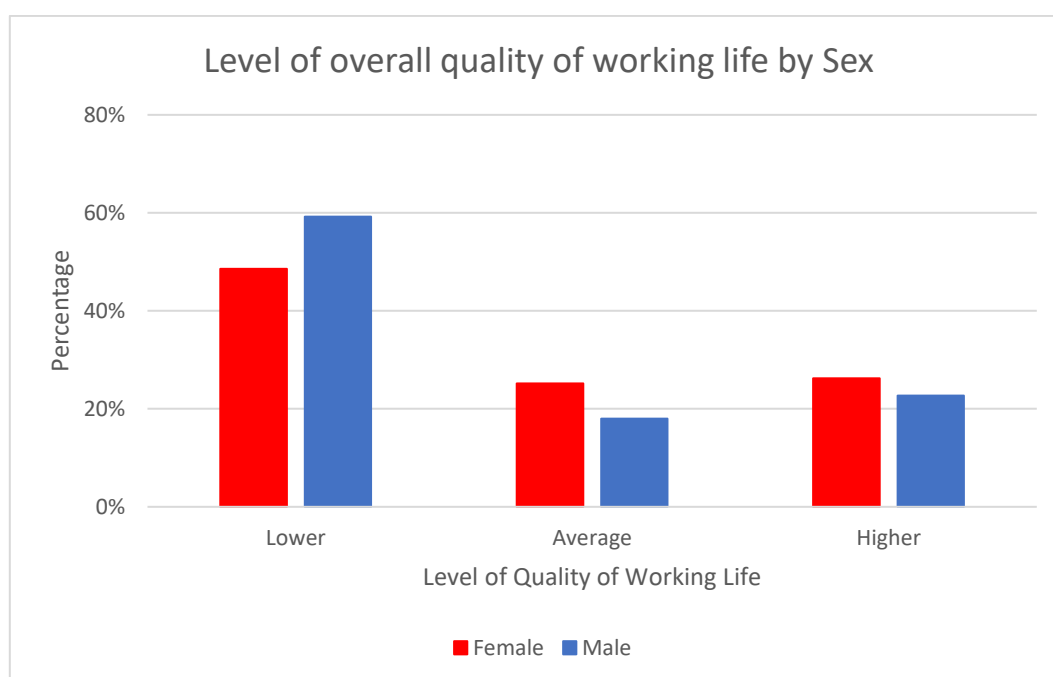


Table A4.13: Level of Overall Quality of Working Life by Sex (Weighted)

Level of WRQOL	Sex	
	Female	Male
Lower	49.2%	54.3%
Average	23.8%	22.5%
Higher	27.0%	23.1%
Total	100%	100%

Table A4.14: Level of Overall Quality of Working Life by Sex (Unweighted)

Level of WRQOL	Sex	
	Female	Male
Lower	48.6%	59.2%
Average	25.2%	18.0%
Higher	26.2%	22.7%
Total	1153 (100%)	211 (100%)

A4.4 Quality of Working Life Scores by Age

Summary (Weighted results):

There appeared to be significant differences in the mean overall WRQOL score across age groups ($F = 14.791$, $df = 4$, $p < .001$). Specially those respondents in the 16-29 age group scored significantly lower than those in the 30-39 and the 60+ age groups.

Summary (Unweighted results):

There appeared to be significant differences in the mean overall WRQOL score across age groups ($F = 2.604$, $df = 4$, $p = .034$). Specially those respondents in the 16-29 age group scored significantly lower than those in the 30-39 and the 60+ age groups.

Figure A4.21: Mean Quality of Working Life Scores by Age (Weighted)

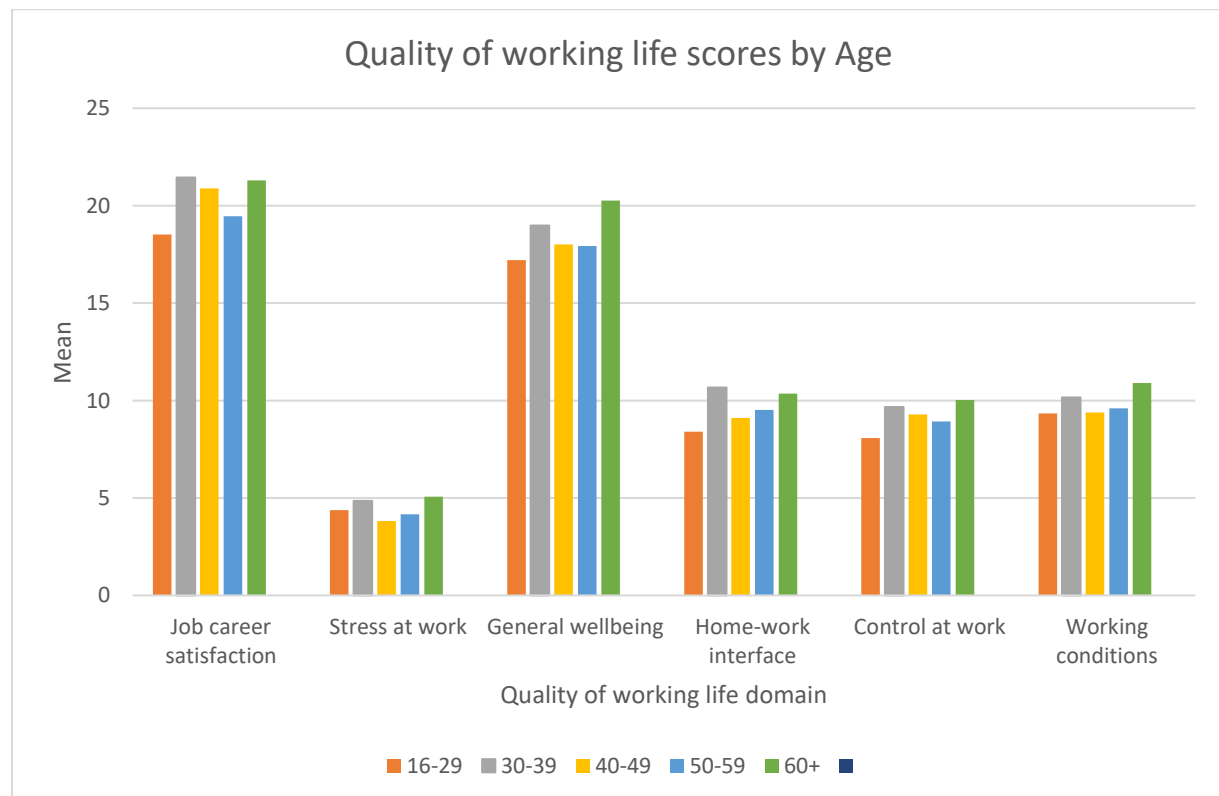


Figure A4.22: Mean Quality of Working Life Scores by Age (Unweighted)

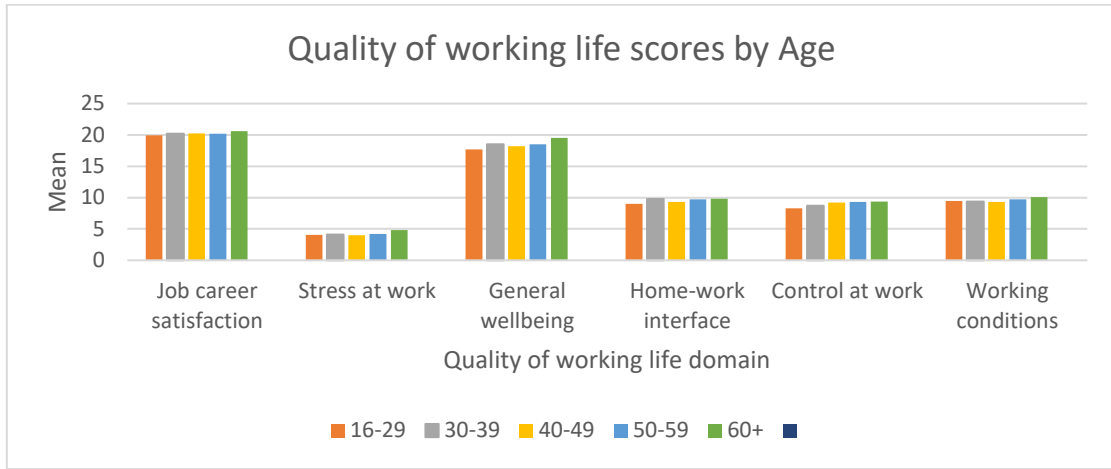


Figure A4.23: Mean Overall Quality of Working Life Score by Age (Weighted)

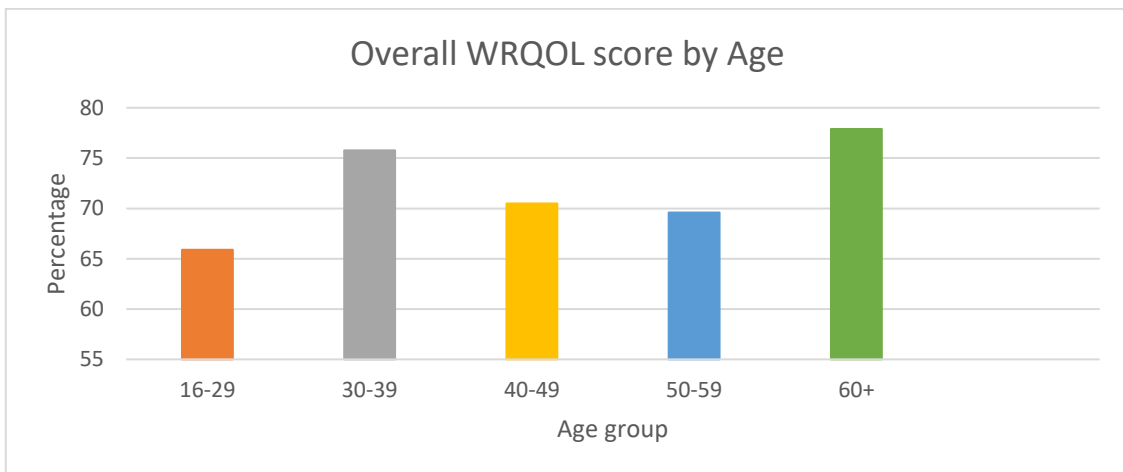


Figure A4.24: Mean Overall Quality of Working Life Score by Age (Unweighted)

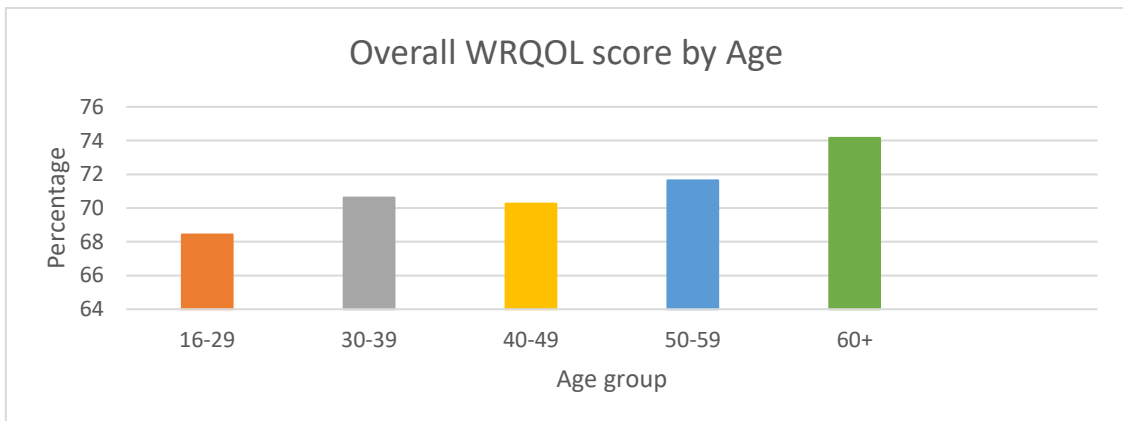


Table A4.15: Mean Quality of Working Life Scores by Age (Weighted)

WRQOL domain	Age				
	16-29	30-39	40-49	50-59	60-65
Job career satisfaction	18.52	21.45	20.88	19.45	21.29
Stress at work	4.38	4.85	3.82	4.17	5.07
General well-being	17.20	18.98	18.01	17.92	20.26
Home-work interface	8.40	10.67	9.10	9.52	10.35
Control at work	8.07	9.67	9.29	8.93	10.02
Working conditions	9.33	10.16	9.38	9.60	10.90
Overall WRQOL score	65.89	75.77	70.49	69.59	77.89

Table A4.16: Mean Quality of Working Life Scores by Age (Unweighted)

WRQOL domain	Age				
	16-29	30-39	40-49	50-59	60+ +
Job career satisfaction	19.92	20.20	20.26	20.20	20.60
Stress at work	4.07	4.08	3.98	4.23	4.82
General well-being	17.67	18.49	18.21	18.50	19.53
Home-work interface	9.01	9.77	9.29	9.71	9.81
Control at work	8.31	8.72	9.20	9.30	9.34
Working conditions	9.45	9.36	9.31	9.70	10.06
Overall WRQOL score	68.43	70.62	70.26	71.64	74.16

Figure A4.25: Level of Overall Quality of Working Life by Age (Weighted)

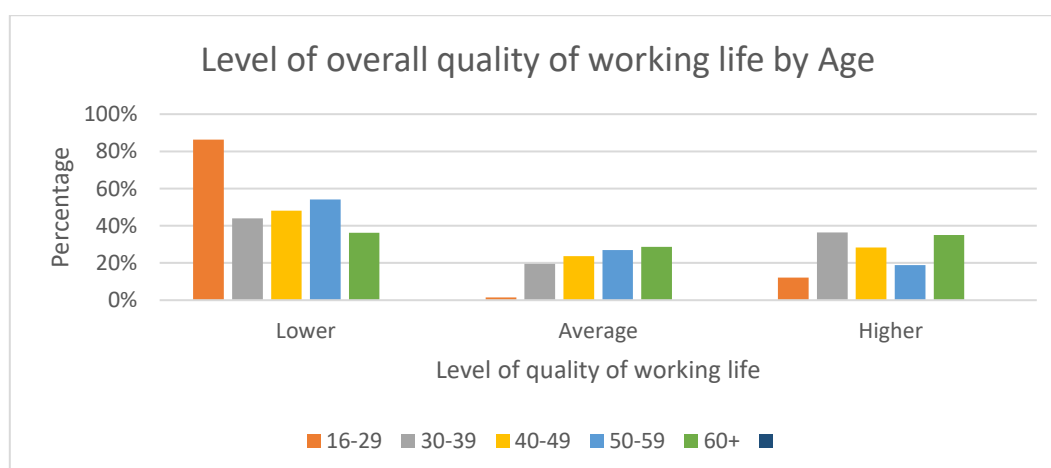


Figure A4.26: Level of Overall Quality of Working Life by Age (Unweighted)

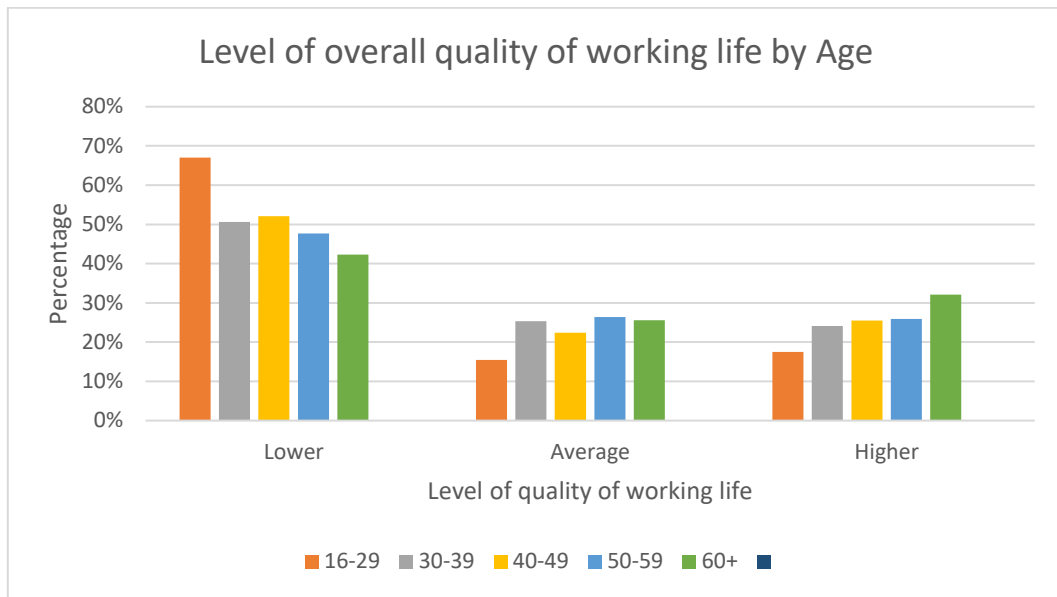


Table A4.17: Level of Overall Quality of Working Life by Age (Weighted)

Level of WRQOL	Age				
	16-29	30-39	40-49	50-59	60+
Lower	86.4%	44.0%	48.1%	54.2%	36.2%
Average	1.5%	19.6%	23.6%	27.0%	28.7%
Higher	12.1%	36.4%	28.3%	18.8%	35.1%
Total	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+
Lower	67.0%	50.6%	52.1%	47.7%	42.3%
Average	15.5%	25.3%	22.4%	26.4%	25.6%
Higher	17.5%	24.1%	25.5%	25.9%	32.1%
Total	97 (100%)	261 (100%)	384 (100%)	455 (100%)	168 (100%)

A4.5 Quality of Working Life Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in their mean overall WRQOL scores ($F = 12.189$, $df = 3$, $p < .001$). Those of Asian ethnicity reported higher scores than all other ethnicities.

Summary (Unweighted results):

There were no significant differences between the ethnic groups in their mean overall WRQOL scores ($F = 2.101$, $df = 3$, $p = .098$).

Figure A4.27: Mean Quality of Working Life Scores by Ethnicity (Weighted)

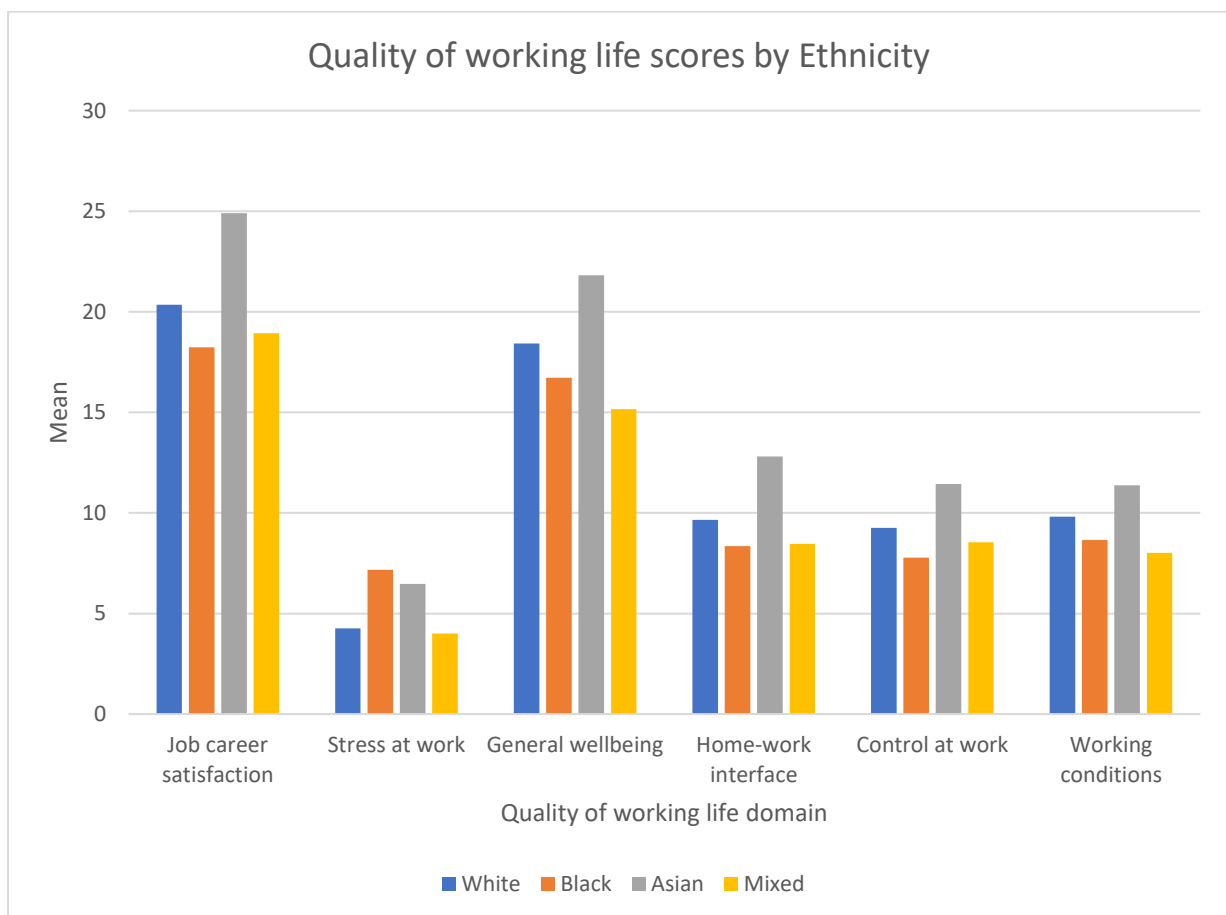


Figure A4.28: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

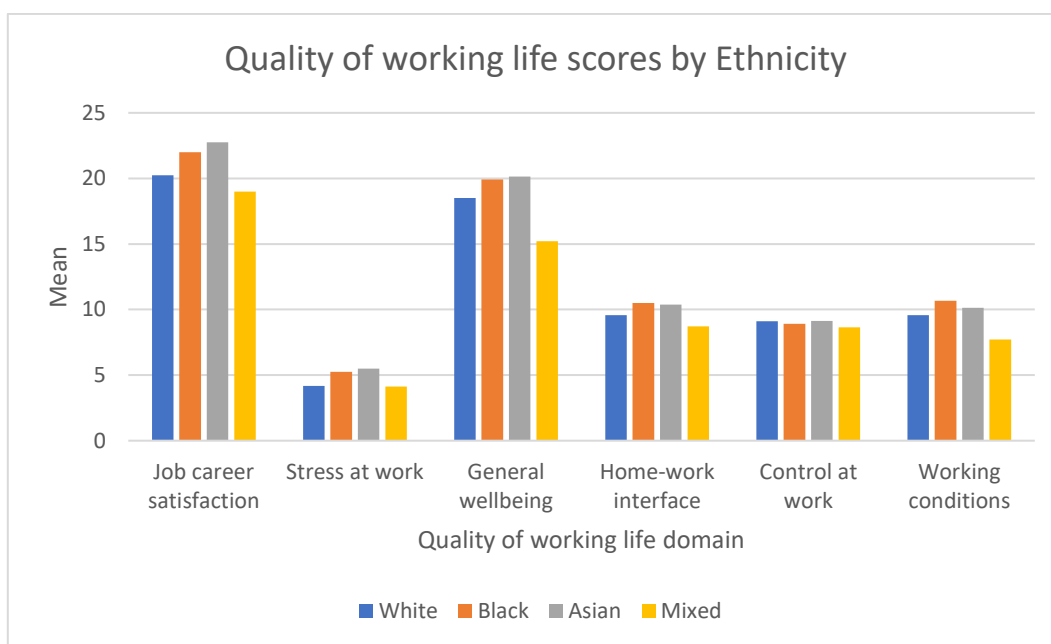


Figure A4.29: Mean Overall Quality of Working Life Score by Ethnicity (Weighted)

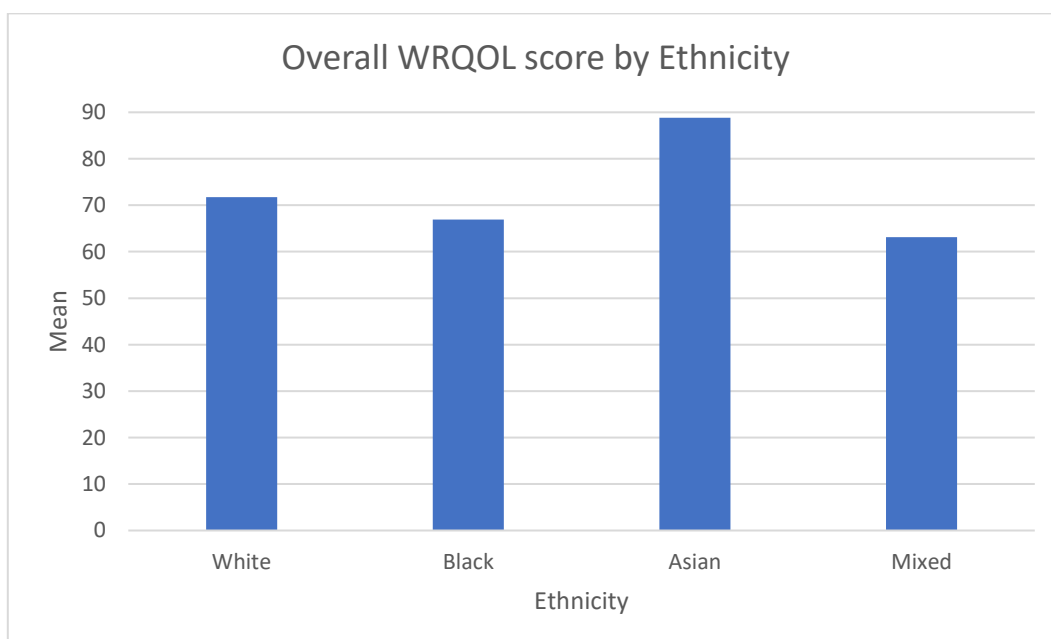


Figure A4.30: Mean Overall Quality of Working Life Score by Ethnicity (Unweighted)

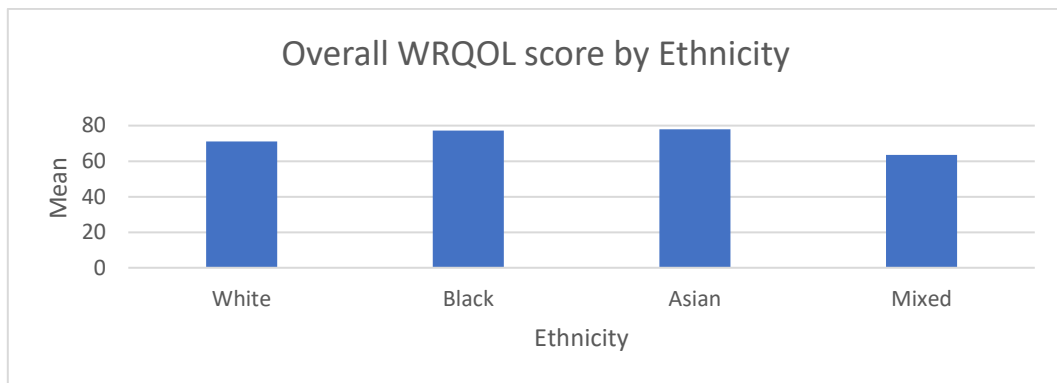


Table A4.19: Mean Quality of Working Life Scores by Ethnicity (Weighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	20.35	18.24	24.90	18.93
Stress at work	4.26	7.18	6.47	4.01
General well-being	18.42	16.72	21.82	15.16
Home-work interface	9.66	8.35	12.80	8.46
Control at work	9.25	7.78	11.44	8.54
Working conditions	9.82	8.65	11.38	8.01
Overall WRQOL score	71.77	66.92	88.81	63.11

Table A4.20: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	20.24	22.00	22.75	19.00
Stress at work	4.17	5.25	5.50	4.14
General well-being	18.50	19.92	20.13	15.21
Home-work interface	9.56	10.50	10.38	8.71
Control at work	9.11	8.92	9.13	8.64
Working conditions	9.56	10.67	10.13	7.71
Overall WRQOL score	71.14	77.25	78.00	63.43

Figure A4.31: Level of Overall Quality of Working Life by Ethnicity (Weighted)

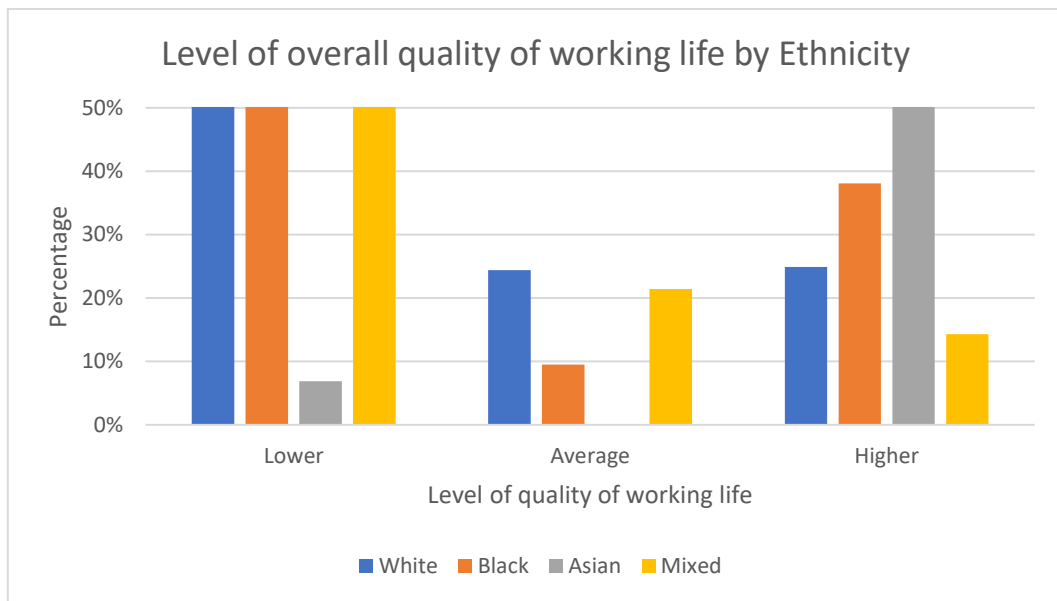


Figure A4.32: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

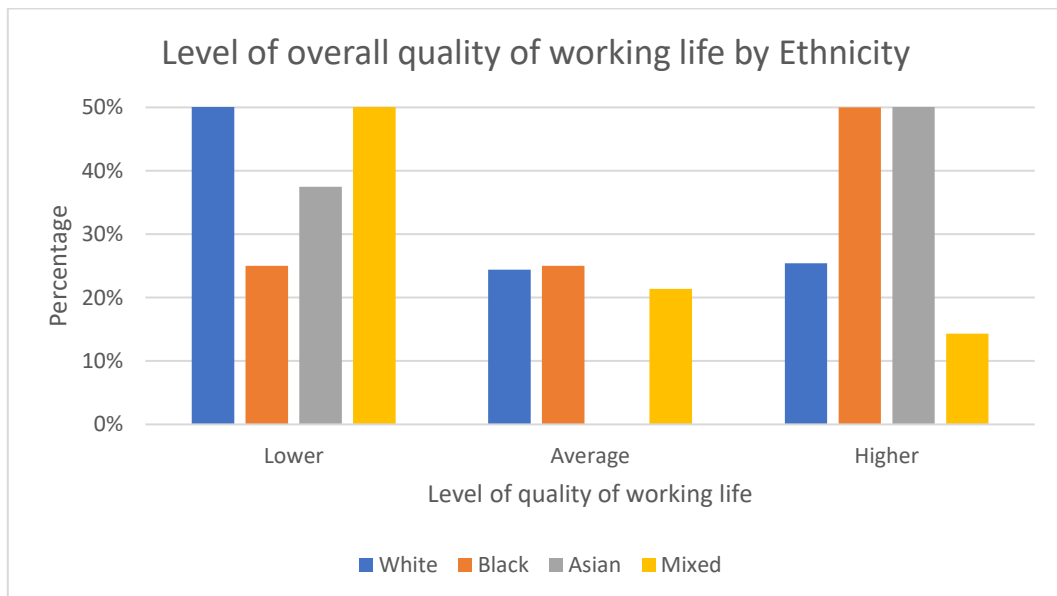


Table A4.21: Level of Overall Quality of Working Life by Ethnicity (Weighted)

Level of WRQOL	Ethnicity			
	White	Black	Asian	Mixed
Lower	50.7%	52.4%	6.9%	64.3%
Average	24.4%	9.5%	0.0%	21.4%
Higher	24.9%	38.1%	93.1%	14.3%
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	50.3%	25.0%	37.5%	64.3%
Average	24.4%	25.0%	0.0%	21.4%
Higher	25.4%	50.0%	62.5%	14.3%
Total	1329 (100%)	12 (100%)	8 (100%)	14 (100%)

A4.6 Quality of Working Life Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in the mean overall WRQOL scores ($F = 6.960$, $df = 2$, $p < .001$). 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 ($F = 15.919$, $df = 2$, $p < .001$). Specifically, respondents without a disability scored significantly higher than those with a disability.

Figure A4.33: Mean Quality of Working Life Scores by Disability (Weighted)

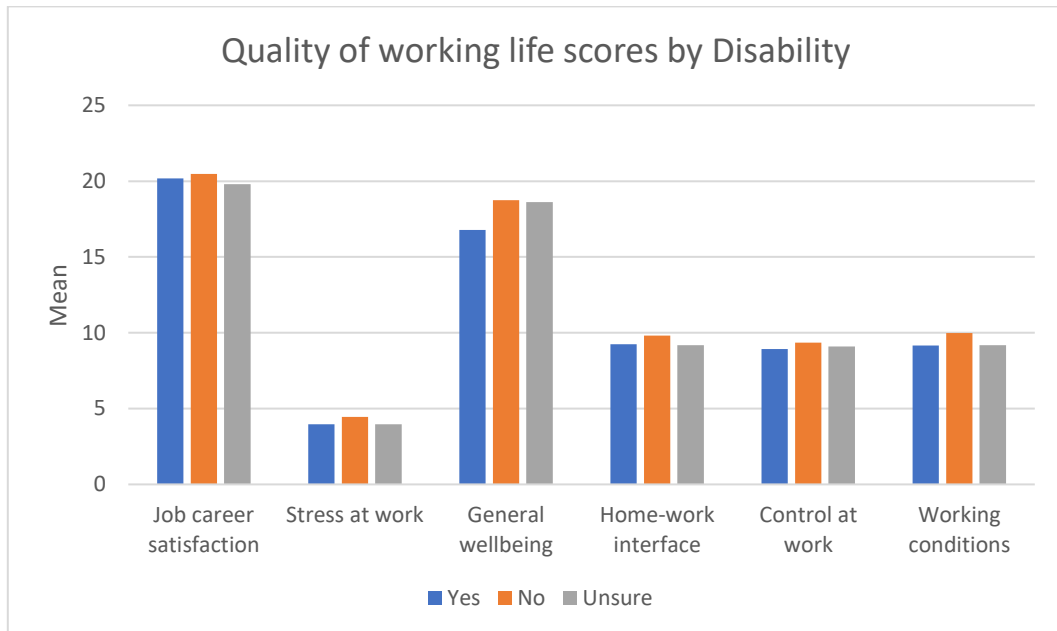


Figure A4.34: Mean Quality of Working Life Scores by Disability (Unweighted)

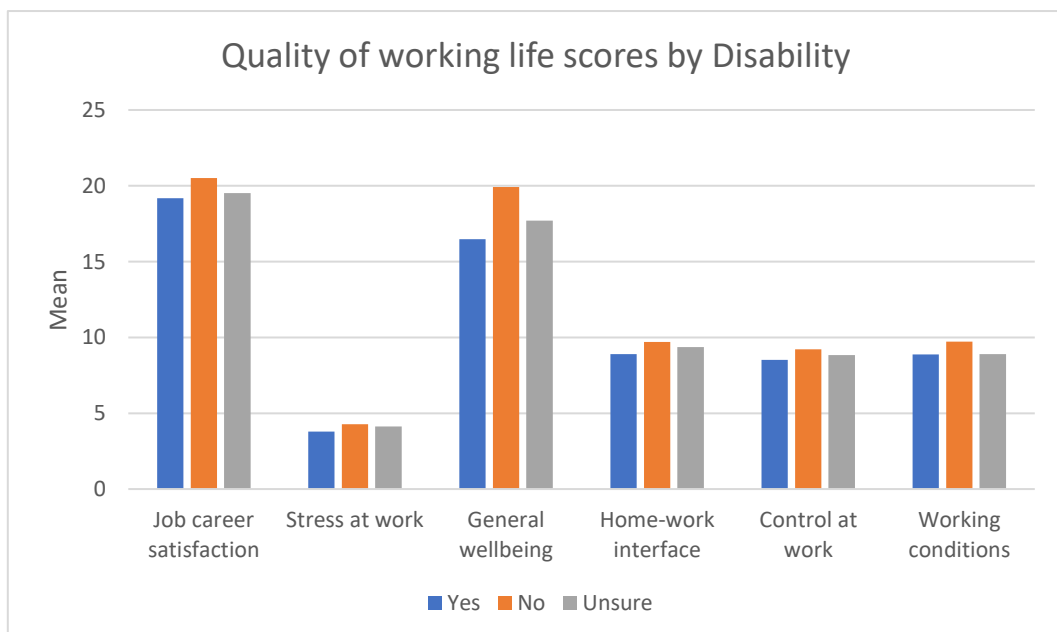


Figure A4.35: Mean Overall Quality of Working Life Score by Disability (Weighted)

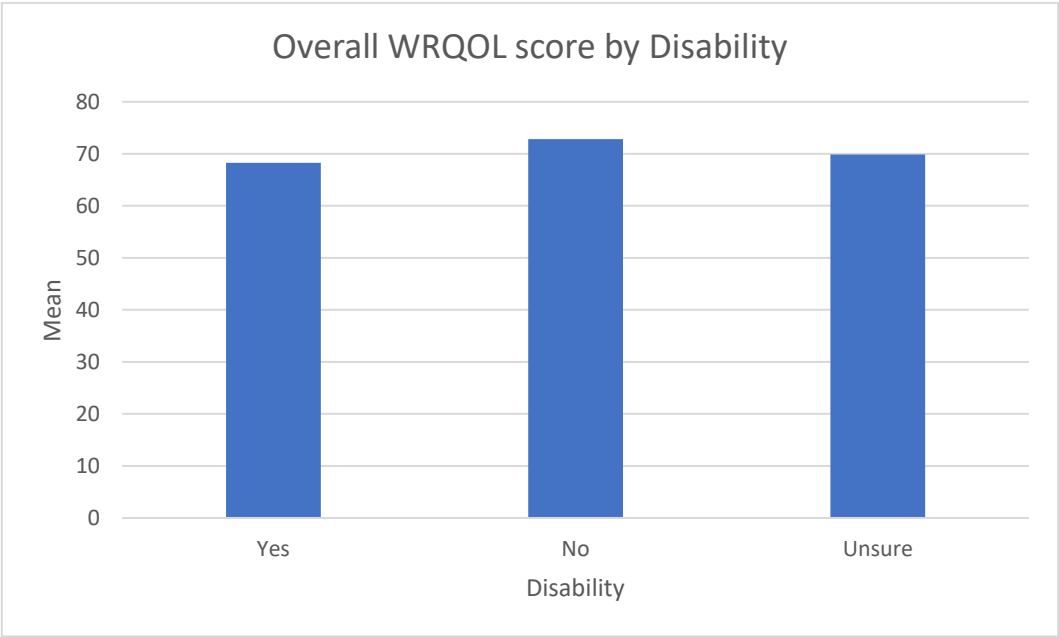


Figure A4. 36: Mean Overall Quality of Working Life Score by Disability (Unweighted)

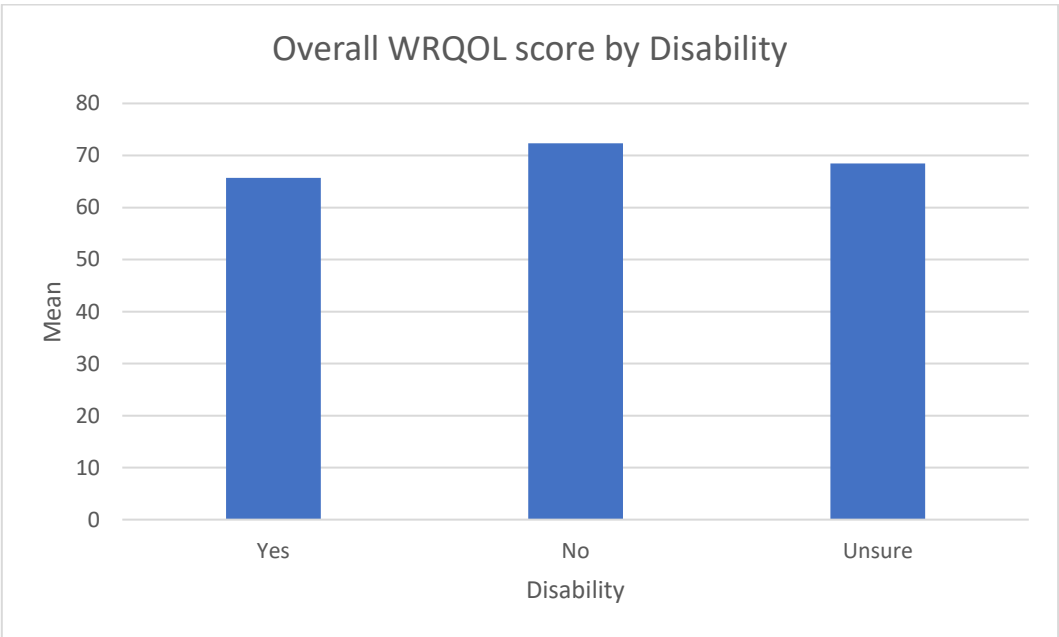


Table A4.23: Mean Quality of Working Life Scores by Disability (Weighted)

WRQOL domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Job career satisfaction	20.19	20.48	19.80
Stress at work	3.96	4.45	3.96
General well-being	16.79	18.75	18.62
Home-work interface	9.25	9.81	9.19
Control at work	8.93	9.35	9.10
Working conditions	9.15	9.99	9.18
Overall WRQOL score	68.27	72.83	69.85

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	19.17	20.50	19.51
Stress at work	3.78	4.27	4.13
General well-being	16.47	19.92	17.71
Home-work interface	8.90	9.70	9.37
Control at work	8.51	9.22	8.84
Working conditions	8.87	9.72	8.90
Overall WRQOL score	65.70	72.33	68.46

Figure A4.37: Level of Overall Quality of Working Life by Disability (Weighted)

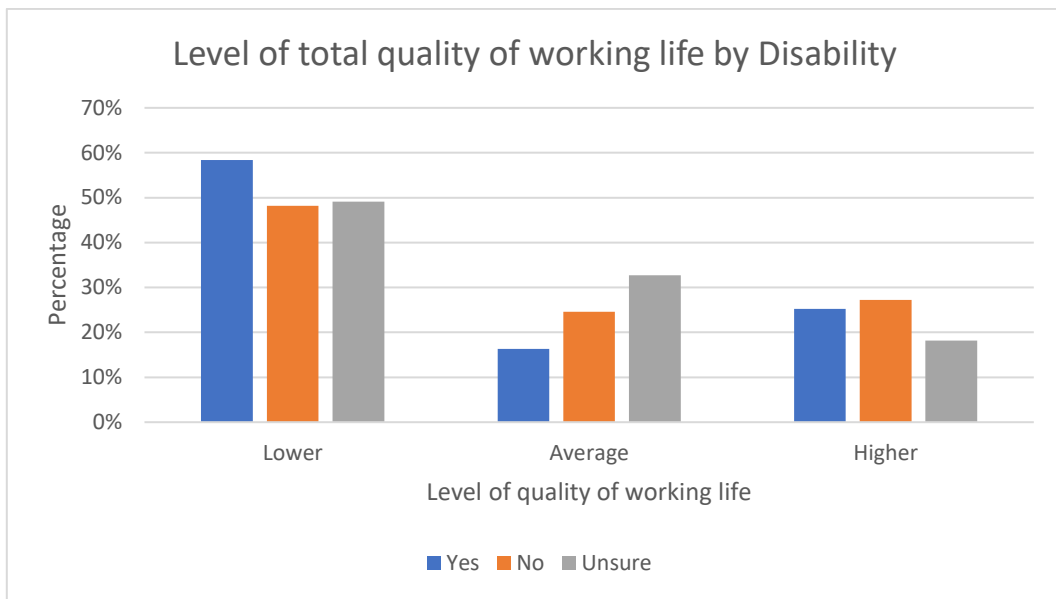


Figure A4.38: Level of Overall Quality of Working Life by Disability (Unweighted)

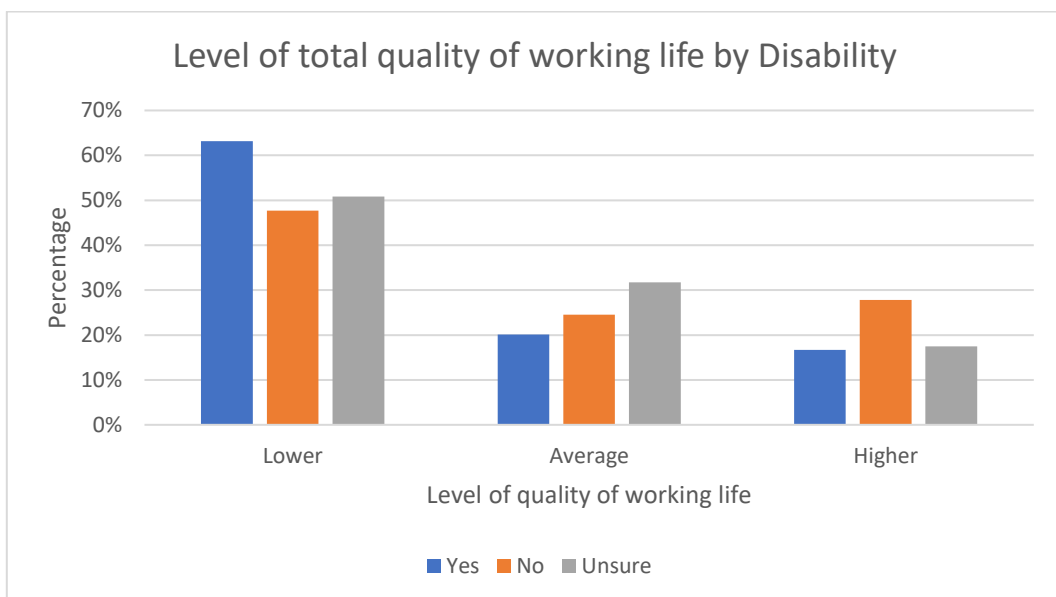


Table A4.25: Level of Overall Quality of Working Life by Disability (Weighted)

Level of WRQOL	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Lower	58.4%	48.2%	49.1%
Average	16.3%	24.6%	32.7%
Higher	25.2%	27.2%	18.2%
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	63.2%	47.7%	50.8%
Average	20.1%	24.5%	31.7%
Higher	16.7%	27.8%	17.5%
Total	209 (100%)	1093 (100%)	63 (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 ($F = 17.461$, $df = 7$, $p < .001$). Specifically, respondents working with adults scored significantly higher than those working in all the other listed areas of practice.

Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their main area of practice ($F = 4.689$, $df = 7$, $p < .001$). Specifically, respondents who selected 'other' as their main area of practice scored significantly higher than those working with children and young people, those working in the area of learning disability, and those working with older people.

Figure A4.39: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

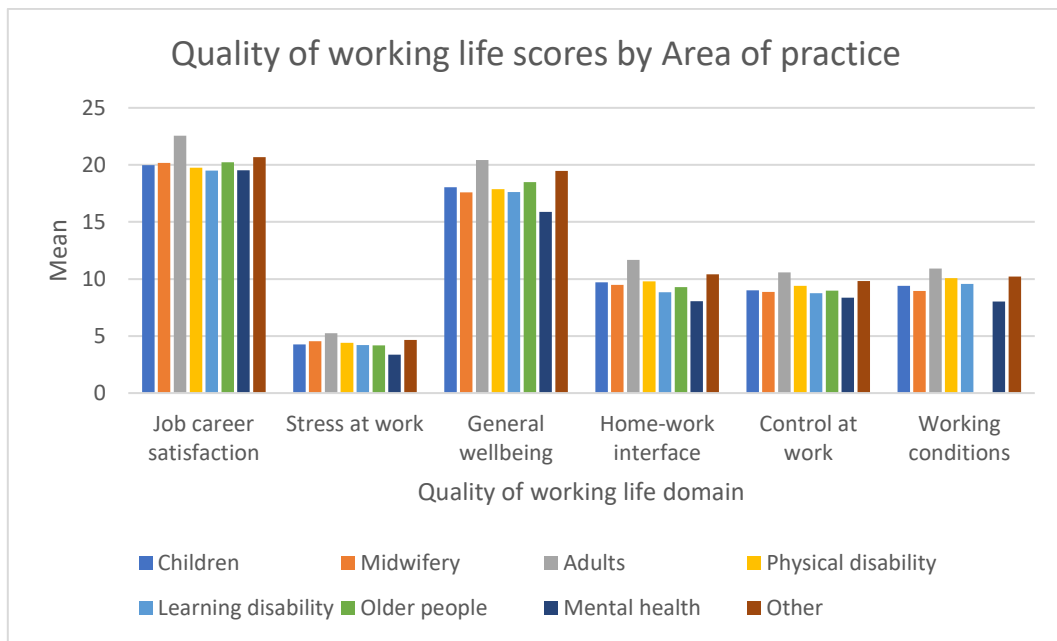


Figure A4.40: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

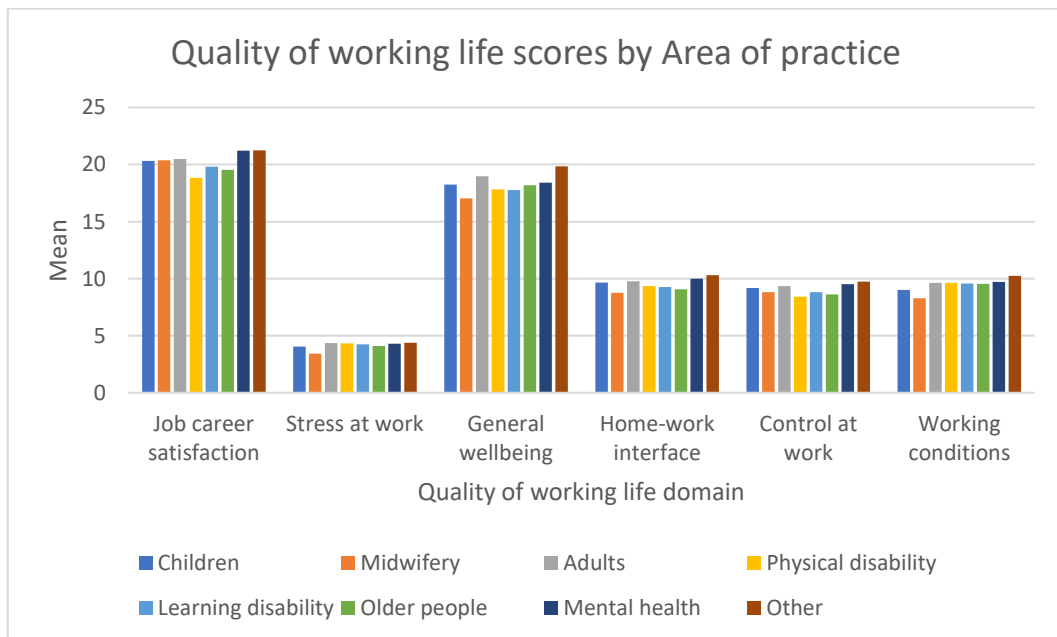


Figure A4.41: Mean Overall Quality of Working Life Score by Main Area of Practice (Weighted)

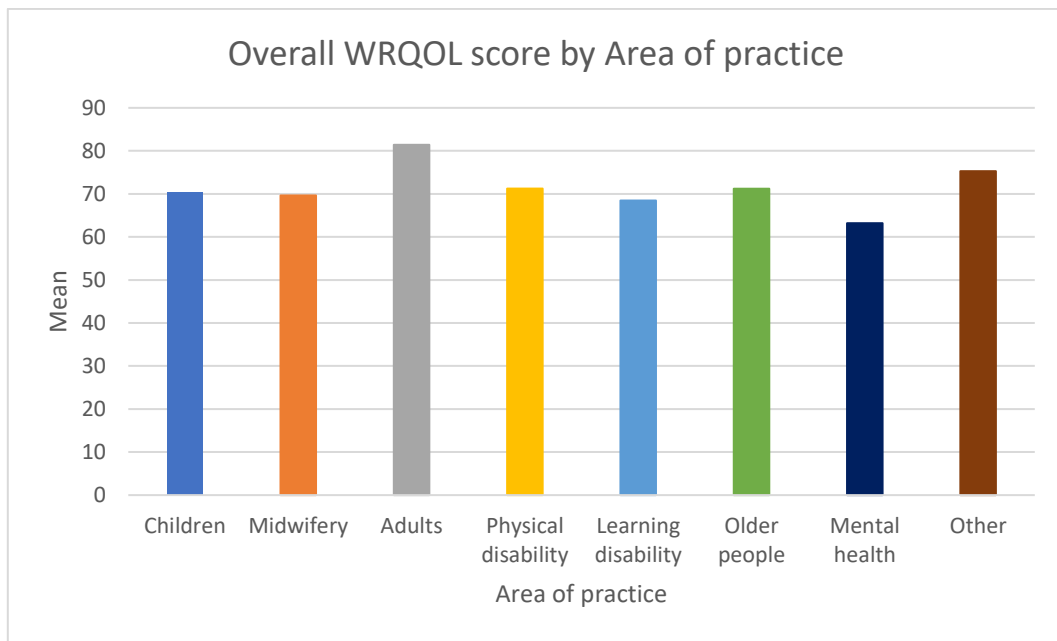


Figure A4.42: Mean Overall Quality of Working Life Score by Main Area of Practice (Unweighted)

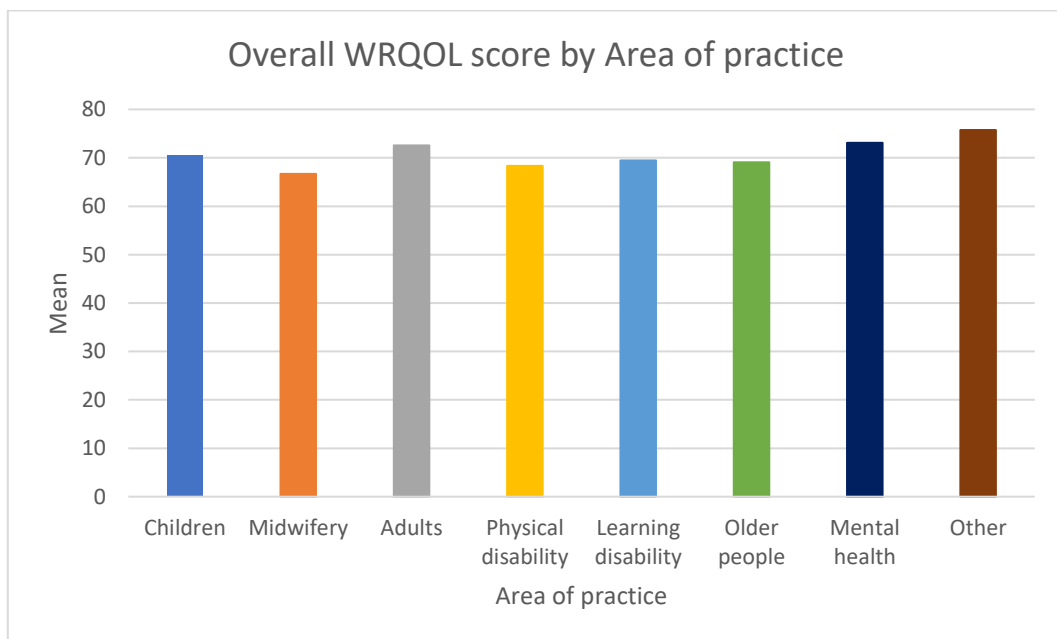


Table A4.27: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

WRQOL domain	Main area of practice							
	Children and young people	Midwifery	Adults - working age	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	19.98	20.17	22.55	19.74	19.49	20.22	19.54	20.69
Stress at work	4.26	4.54	5.25	4.40	4.20	4.18	3.37	4.66
General well-being	18.04	17.60	20.44	17.86	17.61	18.48	15.88	19.46
Home-work interface	9.72	9.49	11.66	9.78	8.85	9.29	8.04	10.42
Control at work	9.02	8.88	10.59	9.40	8.74	8.99	8.35	9.83
Working conditions	9.40	8.95	10.92	10.06	9.57	10.05	8.02	10.22
Overall WRQOL score	70.42	69.64	81.41	71.24	68.46	71.21	63.19	75.28

Table A4.28: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

WRQOL domain	Main area of practice							
	Children and young people	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	20.32	20.36	20.48	18.82	19.80	19.53	21.21	21.24
Stress at work	4.04	3.43	4.35	4.32	4.25	4.11	4.31	4.38
General well-being	18.25	17.04	18.96	17.82	17.77	18.18	18.40	19.85
Home-work interface	9.66	8.75	9.77	9.34	9.26	9.07	9.98	10.29
Control at work	9.17	8.82	9.36	8.42	8.82	8.63	9.51	9.74
Working conditions	9.02	8.29	9.64	9.63	9.56	9.54	9.70	10.24
Overall WRQOL score	70.46	66.68	72.56	68.34	69.46	69.07	73.10	75.74

Figure A4.43: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

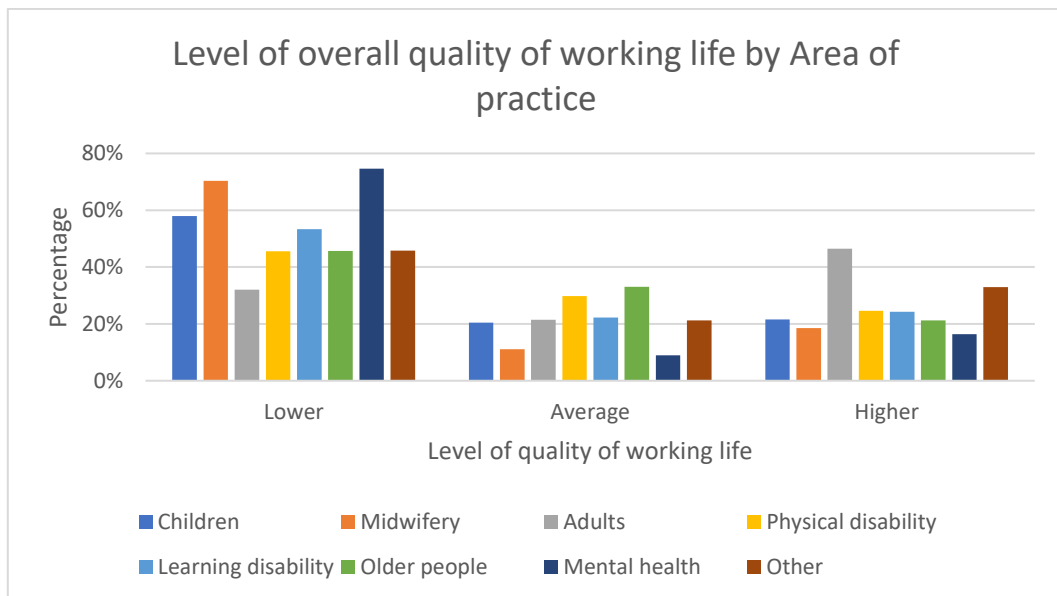


Figure A4.44: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

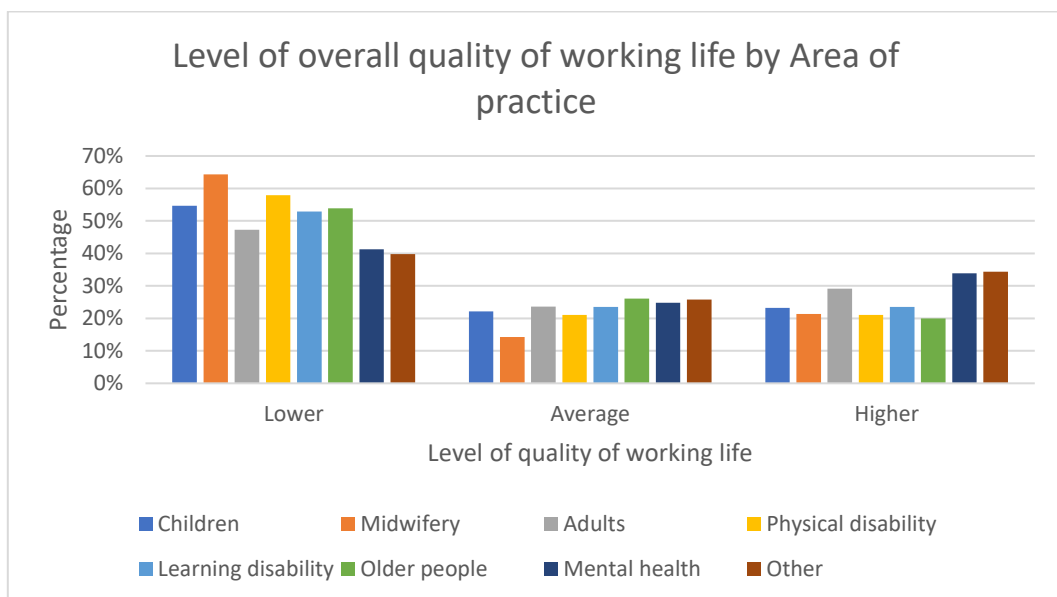


Table A4.29: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

Level of WRQOL	Main area of practice							
	Children and young people	Midwifery	Adults-working age	Physical disability	Learning disability	Older people	Mental health	Other
Lower	58.0%	70.4%	32.0%	45.6%	53.4%	45.7%	74.6%	45.8%
Average	20.4%	11.1%	21.5%	29.8%	22.3%	33.1%	9.0%	21.2%
Higher	21.6%	18.5%	46.5%	24.6%	24.3%	21.2%	16.4%	33.0%
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 and young people	Midwifery	Adults-working age	Physical disability	Learning disability	Older people	Mental health	Other
Lower	54.7%	64.3%	47.3%	57.9%	52.9%	53.9%	41.3%	39.8%
Average	22.1%	14.3%	23.6%	21.1%	23.5%	26.1%	24.8%	25.8%
Higher	23.2%	21.4%	29.1%	21.1%	23.5%	20.0%	33.9%	34.4%
Total	276 (100%)	28 (100%)	148 (100%)	38 (100%)	153 (100%)	380 (100%)	121 (100%)	221 (100%)

A4.8 Quality of Working Life Scores by Line Manager Status

Summary (Weighted results):

There was a significant difference in the mean overall WRQOL scores between respondents who were line managers and those who were not ($t = 3.409$, $df = 1269$, $p < .001$); line managers scored significantly higher.

Summary (Unweighted results):

There was a significant difference in the mean overall WRQOL scores between respondents who were line managers and those who were not ($t = 3.373$, $df = 1363$, $p < .001$); line managers scored significantly higher.

Figure A4.45: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

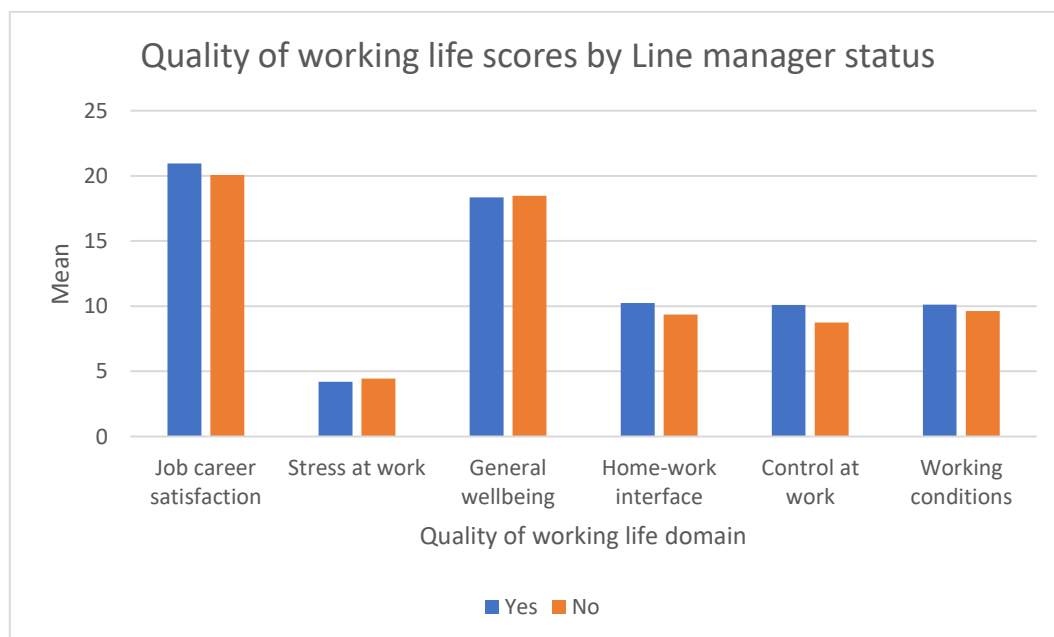


Figure A4.46: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

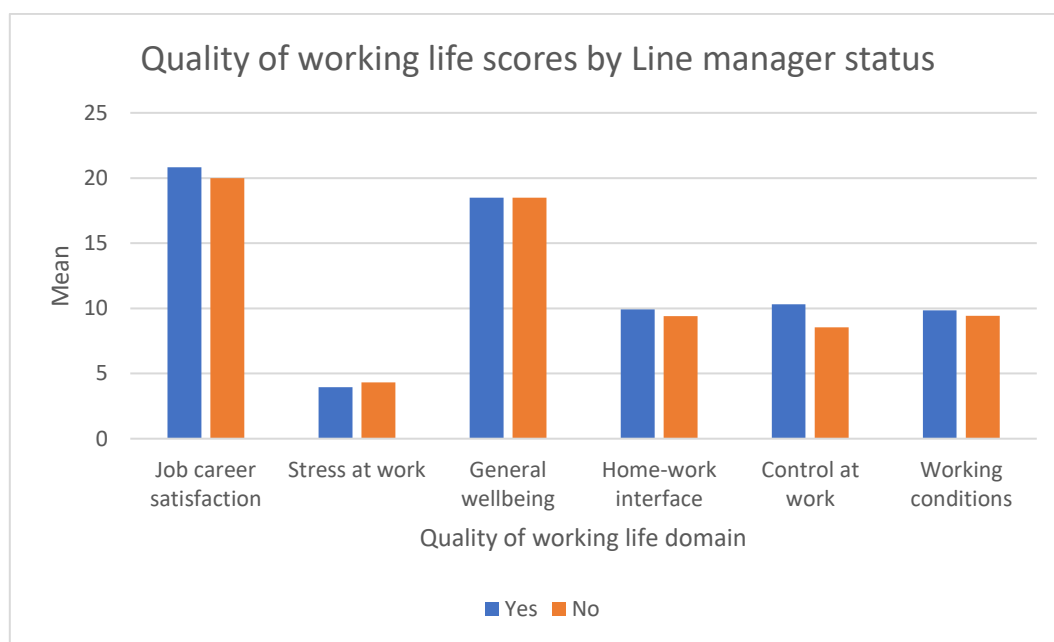


Figure A4.47: Mean Overall Quality of Working Life Score by Line Manager Status (Weighted)

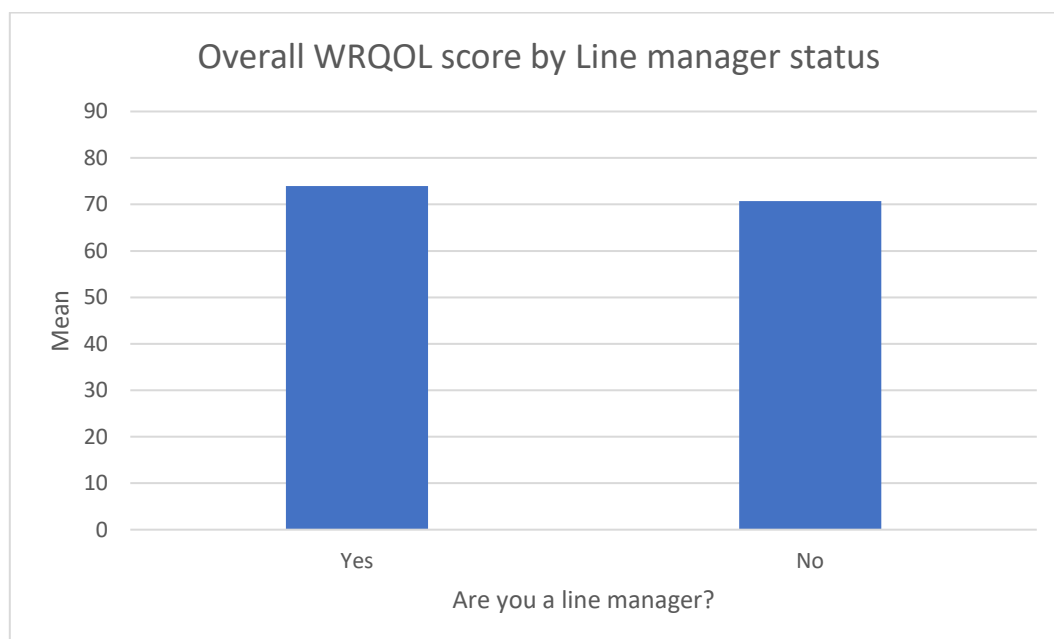


Figure A4.48: Mean Overall Quality of Working Life Score by Line Manager Status (Unweighted)

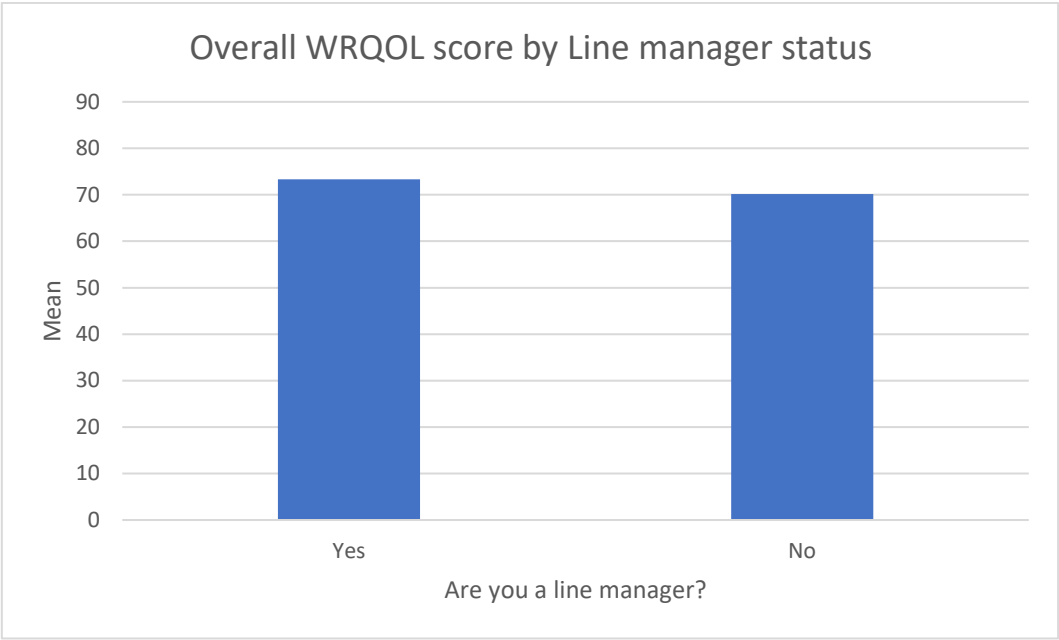


Table A4.31: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

WRQOL Domain	Are you a line manager?	
	Yes	No
Job career satisfaction	20.96	20.06
Stress at work	4.20	4.45
General well-being	18.35	18.48
Home-work interface	10.24	9.35
Control at work	10.09	8.75
Working conditions	10.11	9.64
Overall WRQOL score	73.95	70.72

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	20.82	19.98
Stress at work	3.94	4.31
General well-being	18.48	18.49
Home-work interface	9.91	9.41
Control at work	10.32	8.54
Working conditions	9.85	9.42
Overall WRQOL score	73.32	70.14

Figure A4.49: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

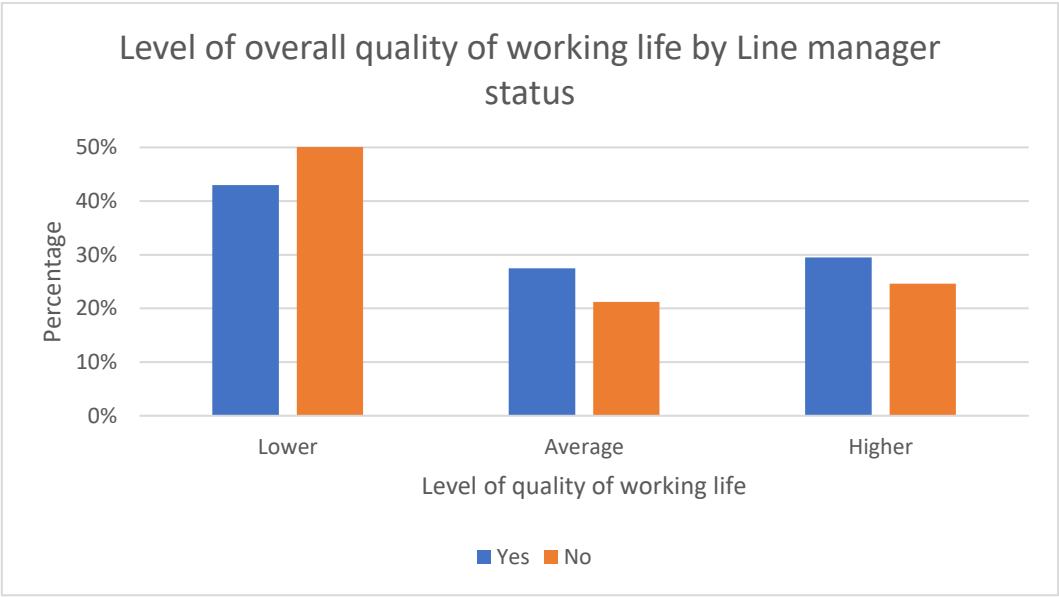


Figure A4.50: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

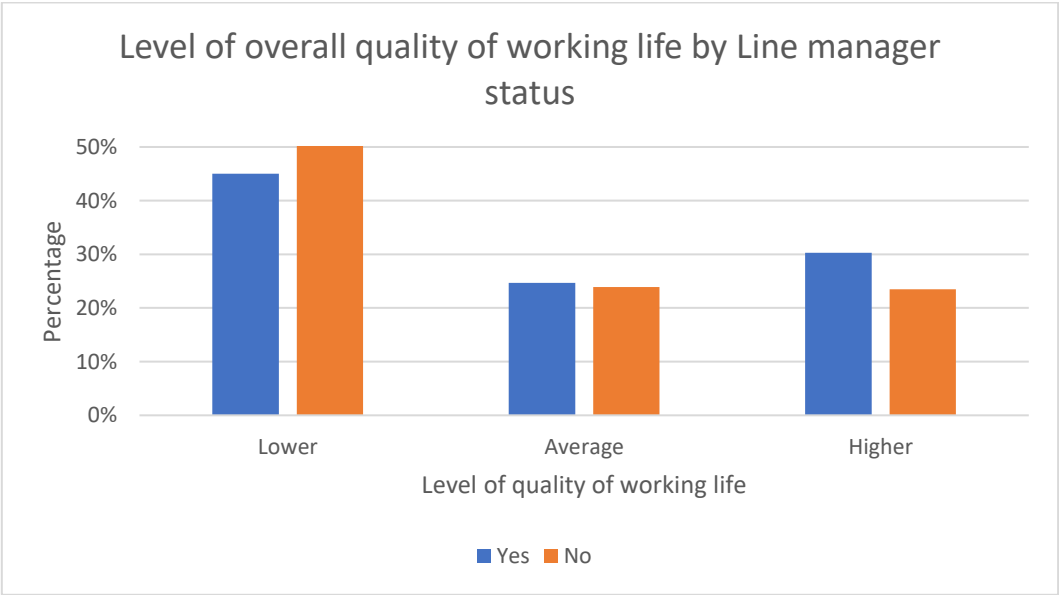


Table A4.33: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

Level of WRQOL	Are you a line manager?	
	Yes	No
Lower	43.0%	54.2%
Average	27.5%	21.2%
Higher	29.5%	24.6%
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	45.0%	52.6%
Average	24.7%	23.9%
Higher	30.3%	23.5%
Total	429 (100%)	936 (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 ($F = 66.108$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact of COVID-19.

Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 61.540$, $df = 2$, $p < .001$). 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)

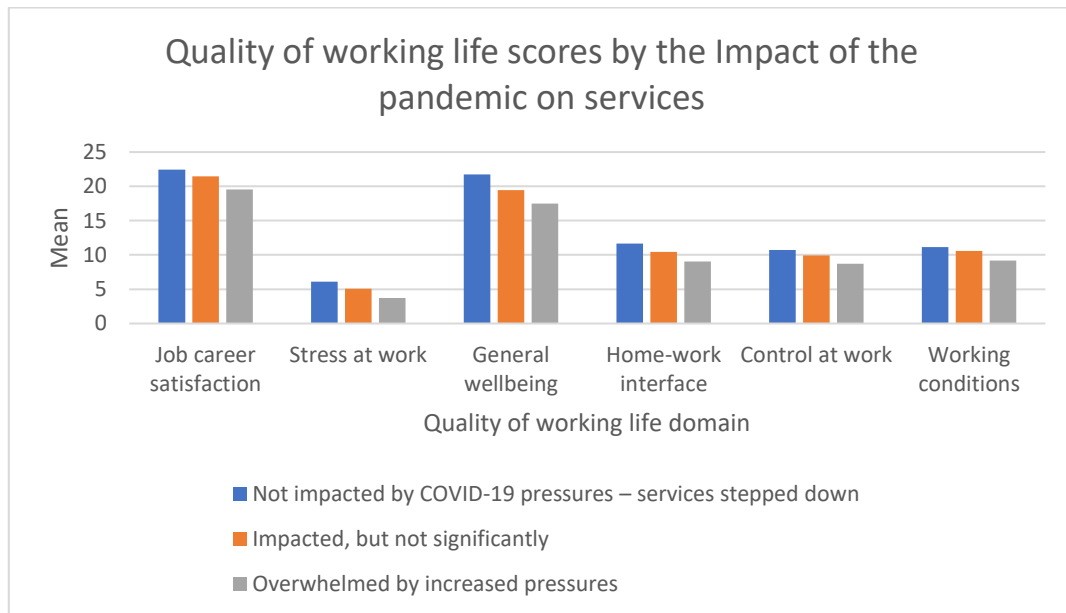


Figure A4.52: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)

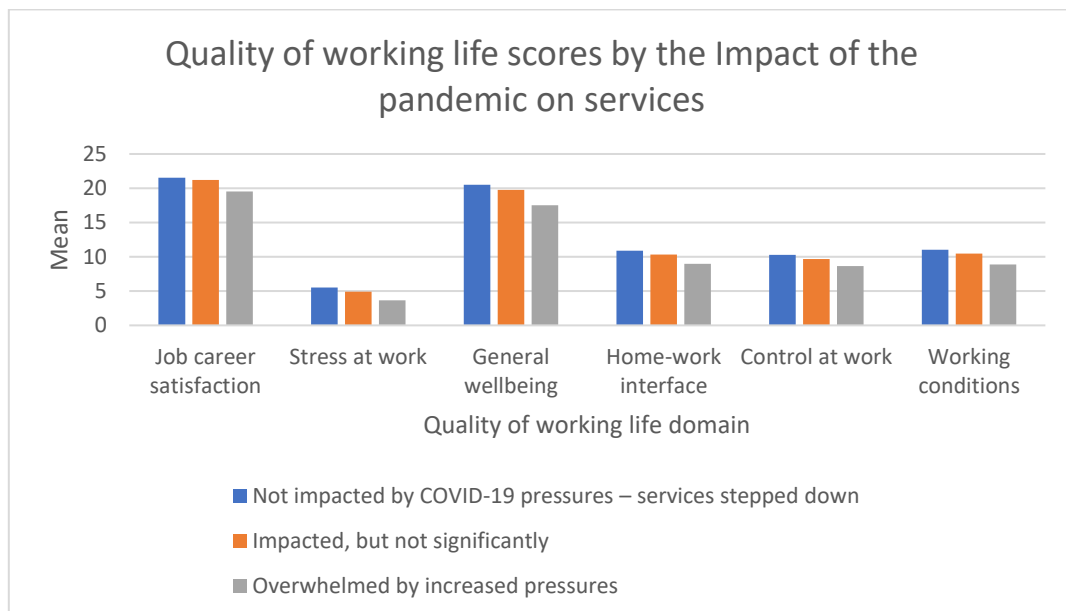


Figure A4. 53: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Weighted)

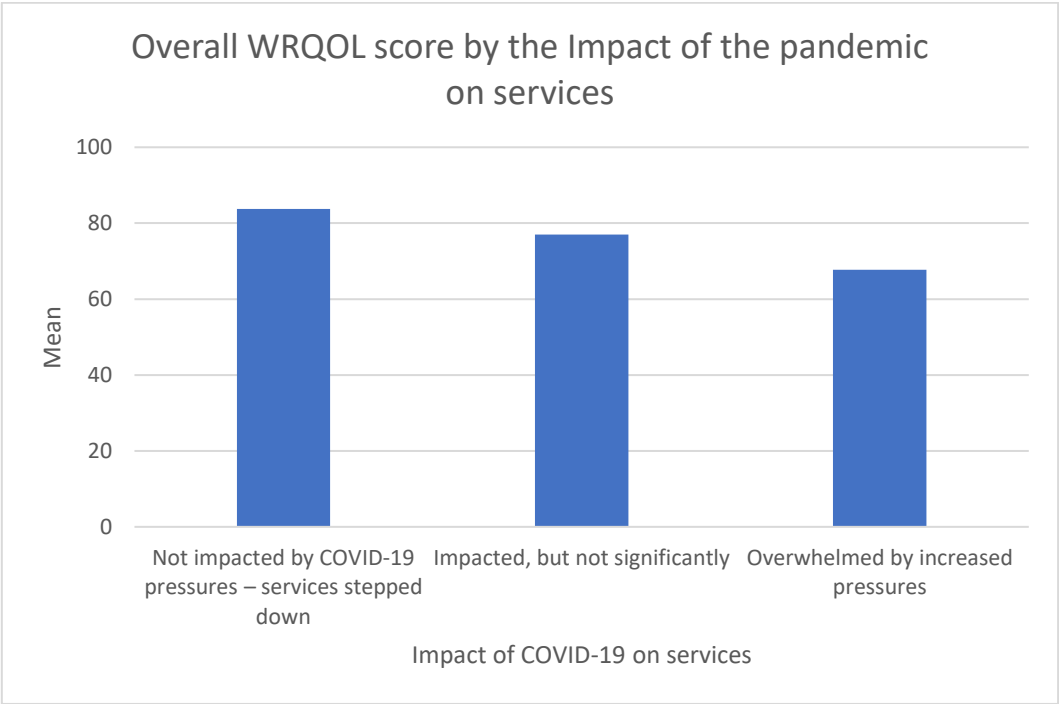


Figure A4. 54: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Unweighted)

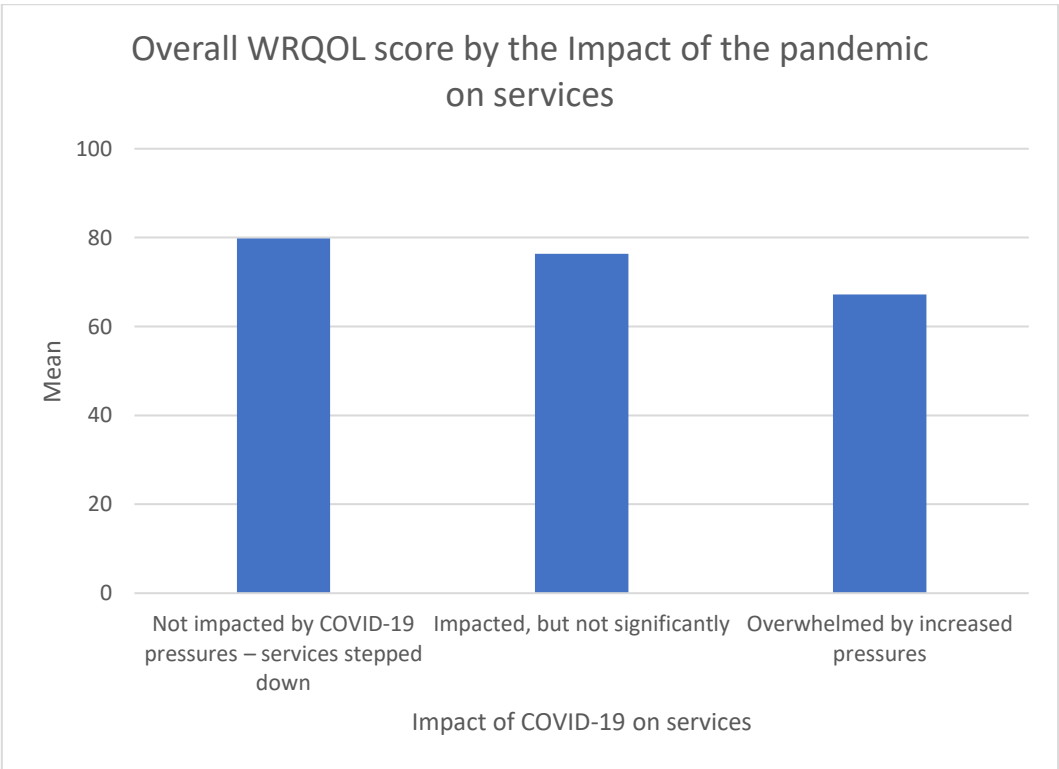


Table A4.35: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)

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	22.45	21.45	19.55
Stress at work	6.09	5.09	3.73
General well-being	21.76	19.46	17.50
Home-work interface	11.64	10.46	9.04
Control at work	10.72	9.93	8.72
Working conditions	11.13	10.60	9.20
Overall WRQOL score	83.79	76.99	67.75

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	21.55	21.22	19.52
Stress at work	5.53	4.90	3.64
General well-being	20.50	19.76	17.54
Home-work interface	10.89	10.33	8.98
Control at work	10.29	9.66	8.65
Working conditions	11.05	10.47	8.86
Overall WRQOL score	79.82	76.35	67.19

Figure A4. 55: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

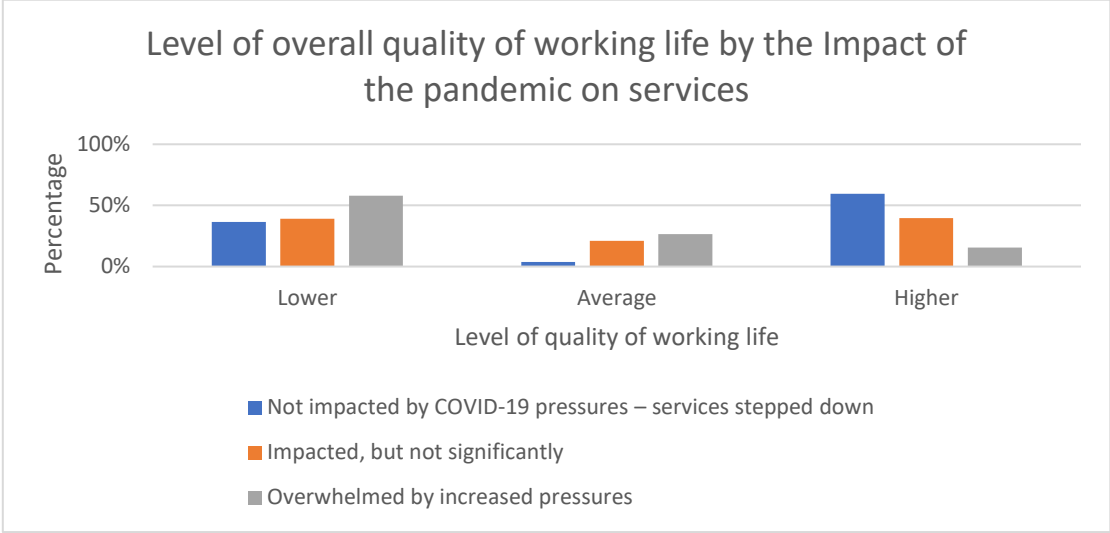


Figure A4. 56: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

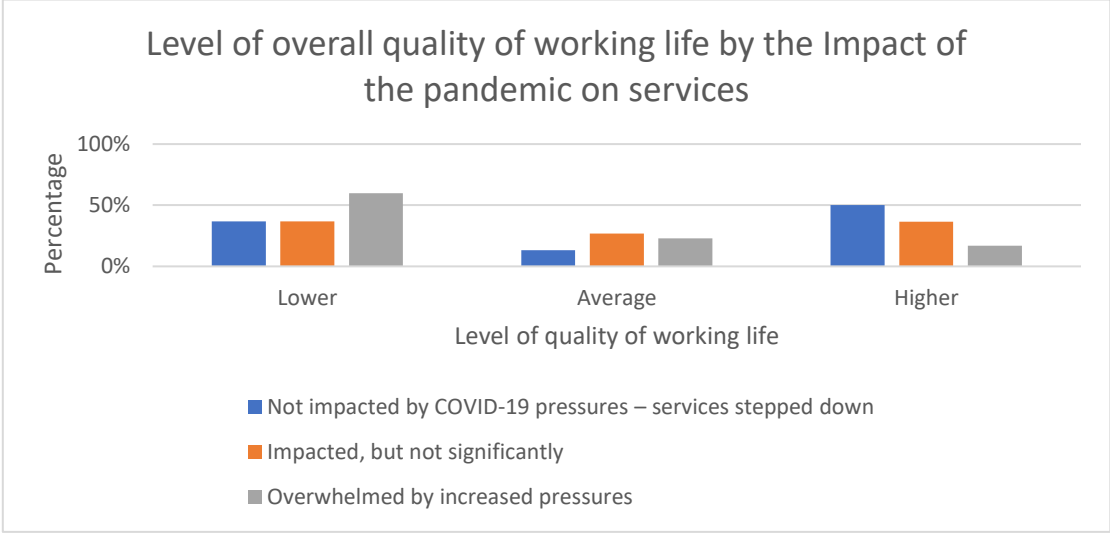


Table A4.37: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

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	36.5%	39.2%	58.0%
Average	3.8%	21.1%	26.6%
Higher	59.6%	39.6%	15.4%
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	14 (36.8%)	198 (36.7%)	471 (59.9%)
Average	5 (13.2%)	144 (26.7%)	181 (23.0%)
Higher	19 (50.0%)	197 (36.5%)	134 (17.0%)
Total	38 (100%)	539 (100%)	786 (100%)

A4.10. WRQOL Scores by the Uptake of Employer Support

Summary (Weighted results):

There were no significant differences on overall well-being scores between those who took employer support and those who did not ($t = -.388$, $df=1269$, $p > 0.05$). Those respondents who took employer support only had a slightly higher WRQOL score than those who did not.

Summary (Unweighted results):

There were no significant differences on overall well-being scores between those who took employer support and those who did not ($t = -.428$, $df=1363$, $p > 0.05$).

Figure A4. 57: Mean Quality of Working Life Scores by Uptake of Employer Support (Weighted)

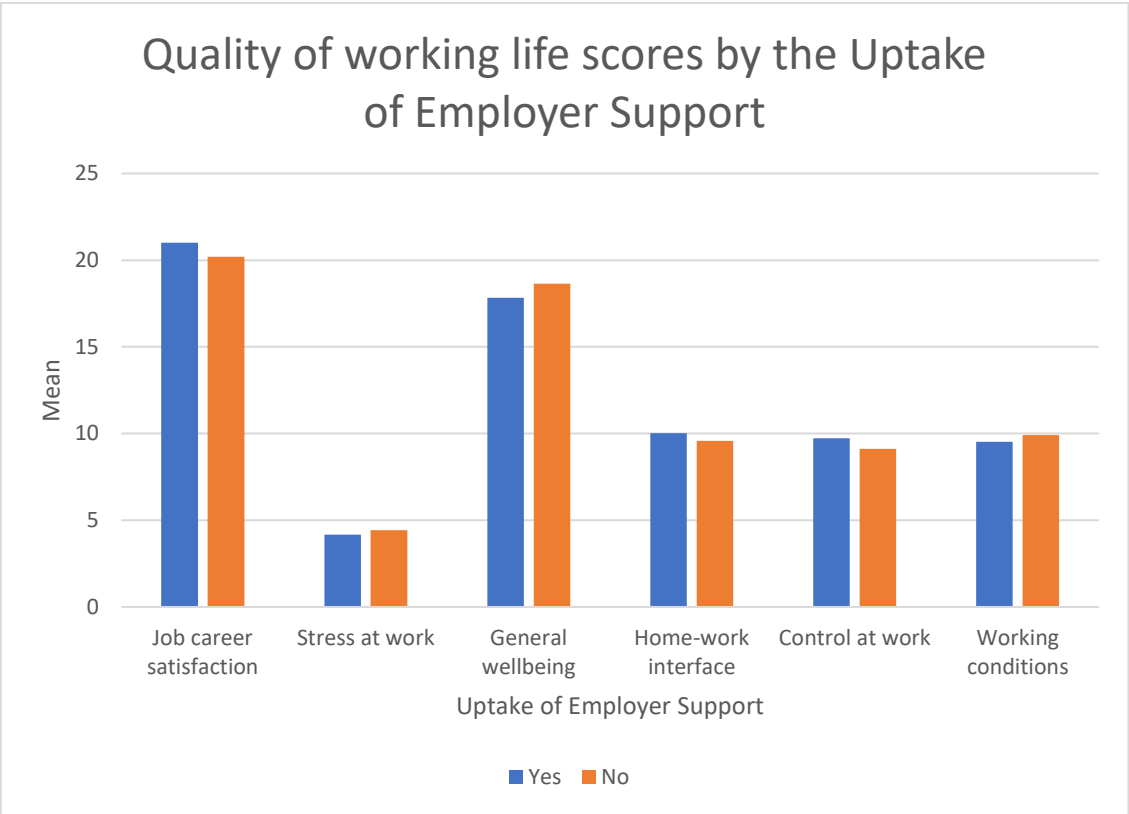


Figure A4. 58: Mean Quality of Working Life Scores by Uptake of Employer Support (Unweighted)

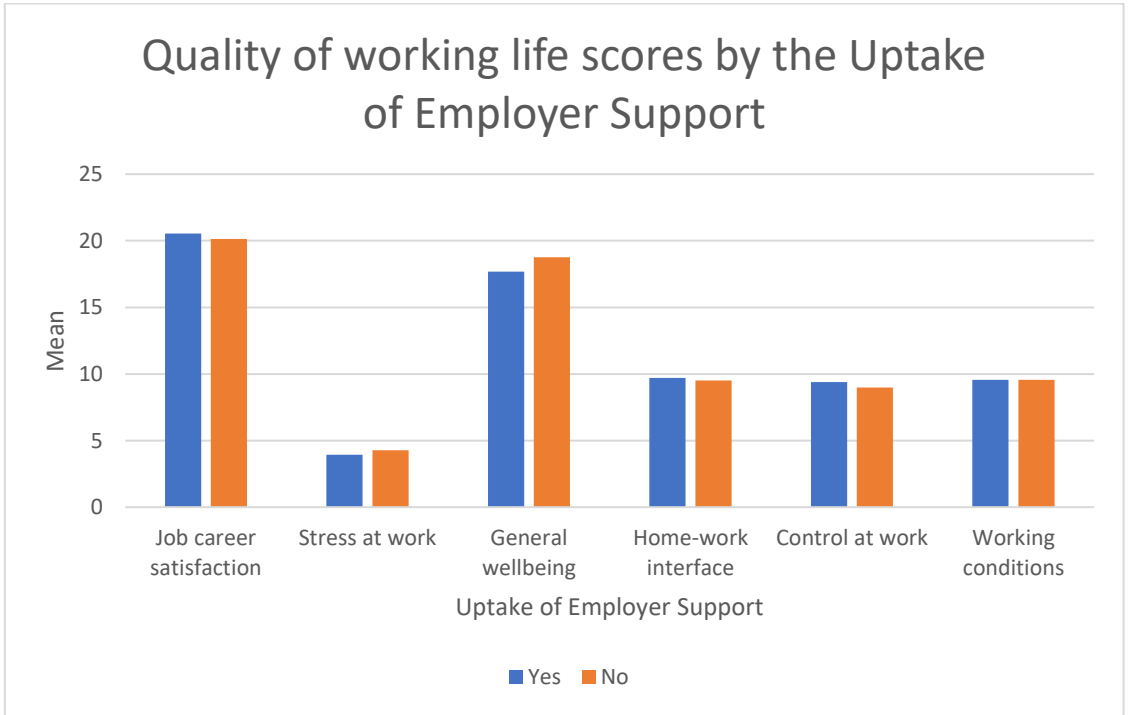


Figure A4. 59: Mean Overall Quality of Working Life Score by the Uptake of Employer Support (Weighted)

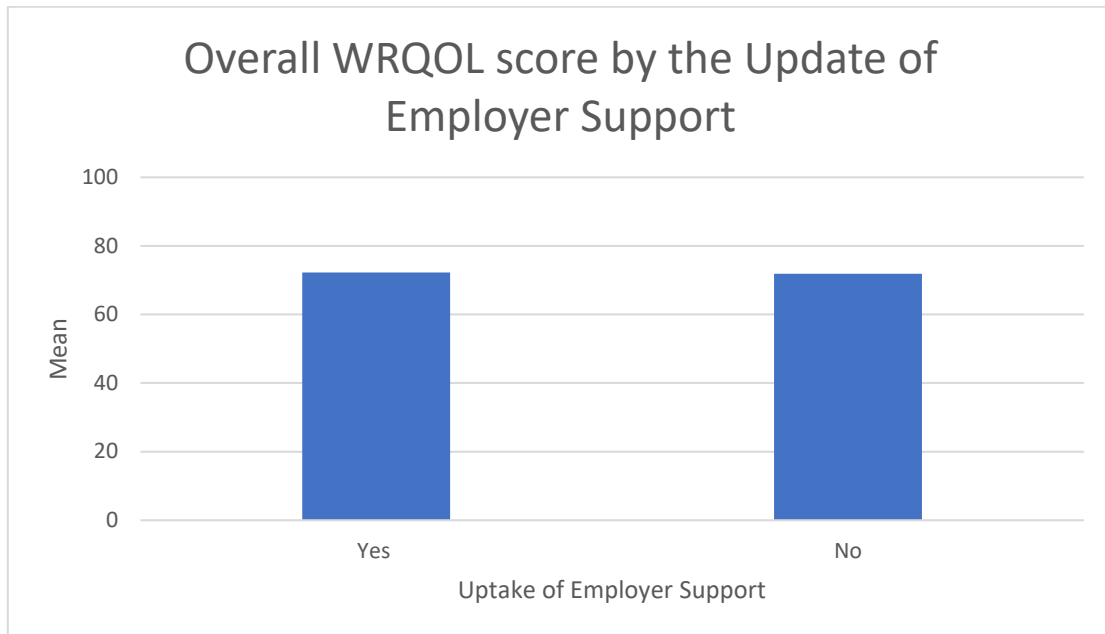


Figure A4. 60: Mean Overall Quality of Working Life Score by the Uptake of Employer Support (Unweighted)

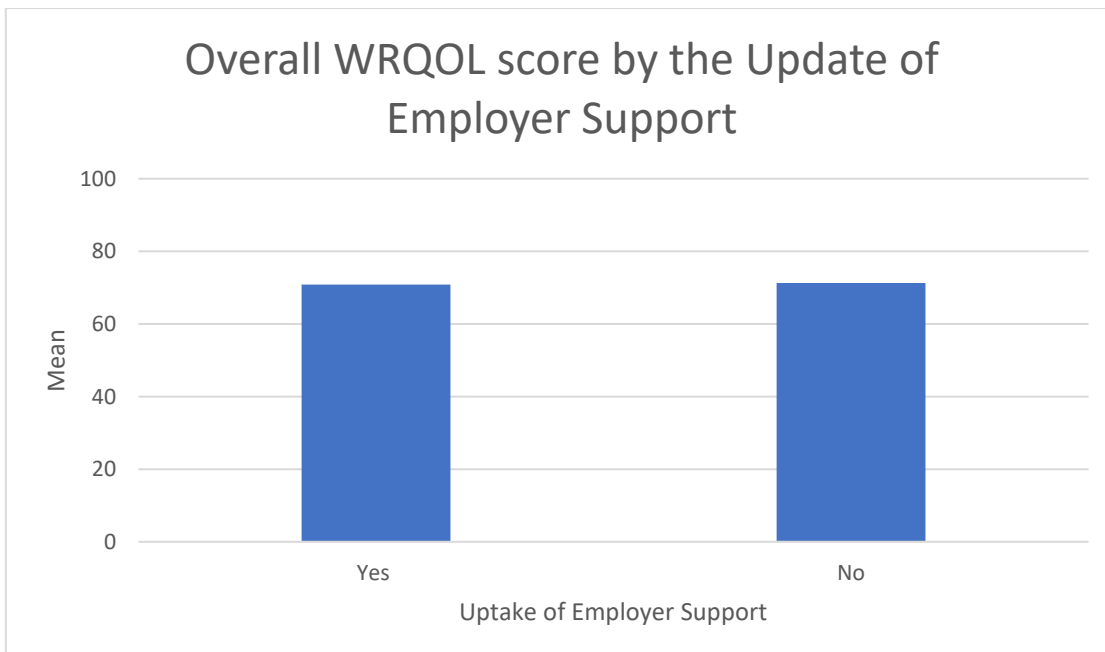


Table A4. 39: Mean Overall Quality of Working Life Score by the Uptake of Employer Support

WRQOL Domain	Uptake of employer support	
	Yes	No
Job career satisfaction	21.00	20.19
Stress at work	4.17	4.42
General well-being	17.83	18.64
Home-work interface	10.02	9.58
Control at work	9.73	9.11
Working conditions	9.53	9.92
Overall WRQOL score	72.28	71.87

Table A4. 40: Mean Overall Quality of Working Life Score by the Uptake of Employer Support
(Unweighted)

WRQOL Domain	Uptake of employer support	
	Yes	No
Job career satisfaction	20.55	20.14
Stress at work	3.93	4.28
General well-being	17.67	18.77
Home-work interface	9.71	9.52
Control at work	9.40	8.99
Working conditions	9.56	9.55
Overall WRQOL score	70.82	71.25

Figure A4. 61: Level of Overall Quality of Working Life by Employer Uptake (Weighted)

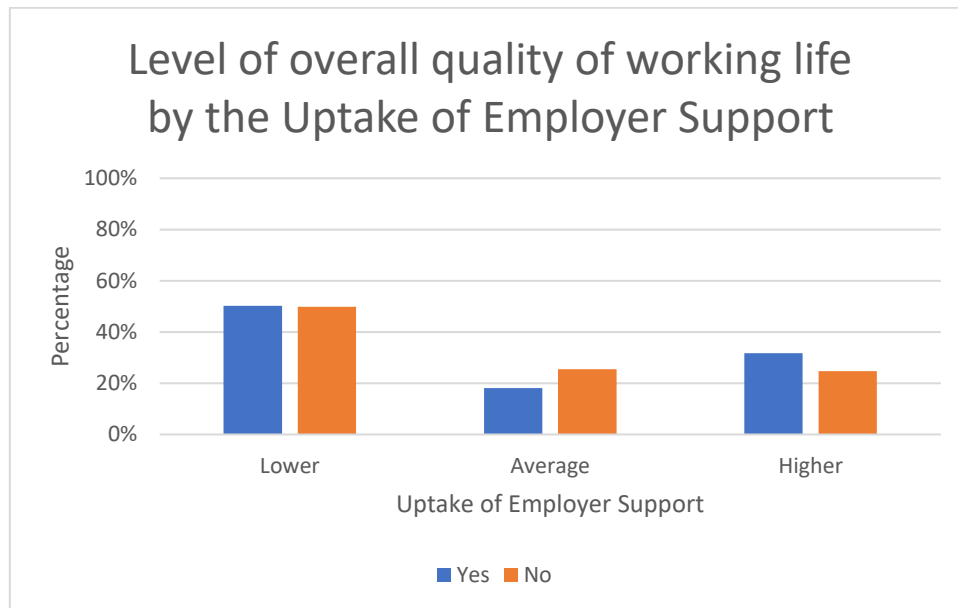


Figure A4. 62: Level of Overall Quality of Working Life by Employer Uptake (Unweighted)

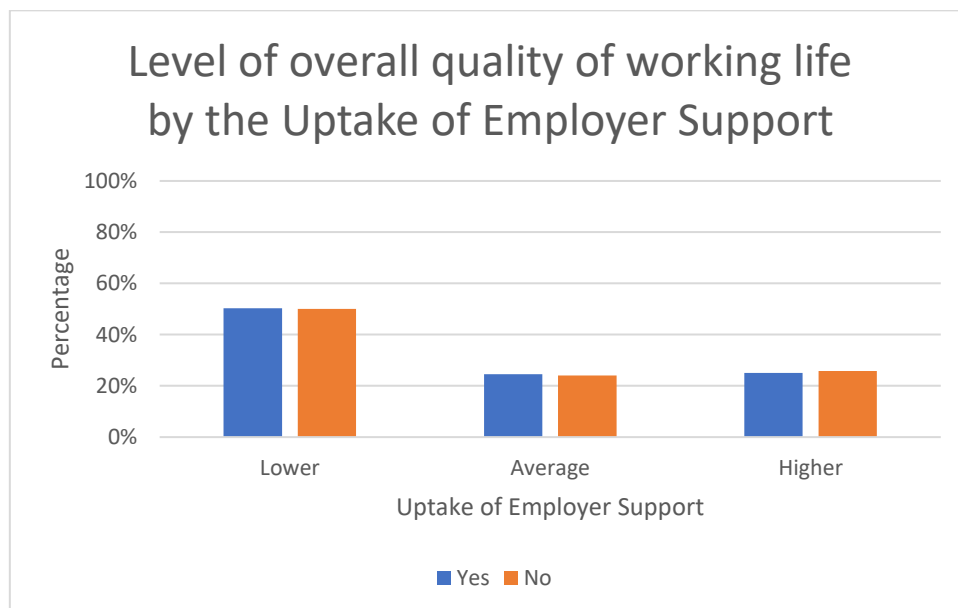


Table A4.41: Level of Overall Quality of Working Life by Uptake of Employer Support (Weighted)

Level of WRQOL	Impact of the pandemic on services	
	Yes	No
Lower	50.2%	49.8%
Average	18.1%	25.5%
Higher	31.7%	24.7%
Total	100%	100%

Table A4.42: Level of Overall Quality of Working Life by Uptake of Employer Support (Unweighted)

Level of WRQOL	Impact of the pandemic on services	
	Yes	No
Lower	176 (50.3%)	509 (50.1%)
Average	86 (24.6%)	244 (24.0%)
Higher	88 (25.1%)	262 (25.8%)
Total	350 (100%)	1015 (100%)

Appendix 5: Copenhagen Burnout Inventory (Unweighted) – Tables and Charts

This section provides detailed results of respondents' burnout, which was measured using the Copenhagen Burnout Inventory. Weighted results are presented in **blue font**. Unweighted (i.e. raw) results are presented in **orange font**.

A5.1 Burnout Scores by Country

Summary (Weighted results):

There were significant differences between the countries in mean personal burnout scores ($F = 3.995$, $df = 3$, $p = .008$) and in mean work-related burnout scores ($F = 4.366$, $df = 3$, $p = .005$), but no significant difference in mean client-related burnout scores ($F = .230$, $df = 3$, $p = .875$).

Summary (Unweighted results):

There were no significant differences between the countries in mean personal burnout scores ($F = .697$, $df = 3$, $p = .554$), in mean work-related burnout scores ($F = .296$, $df = 3$, $p = .829$) or in mean client-related burnout scores ($F = 1.404$, $df = 3$, $p = .240$).

Figure A5. 1: Mean Burnout Scores by Country (Weighted by Occupation)

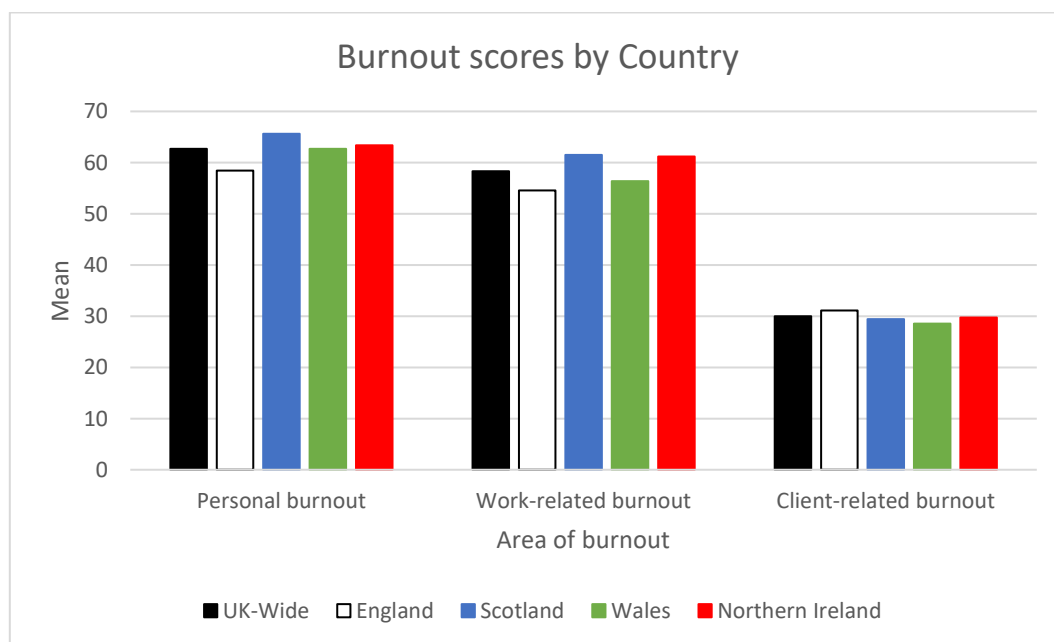


Figure A5.2: Mean Burnout Scores by Country (Unweighted)

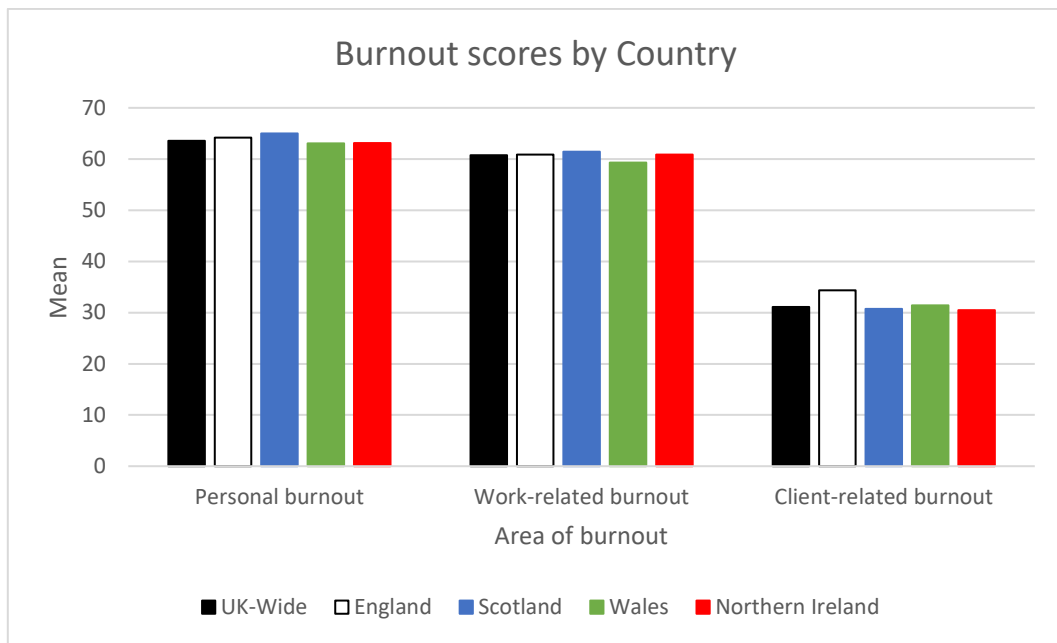


Table A5. 1: Mean Burnout Scores by Country (Weighted by Occupation)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	62.69	58.44	65.63	62.66	63.37
Work-related burnout	58.33	54.53	61.48	56.39	61.17
Client-related burnout	30.01	31.08	29.39	28.52	29.74

Table A5.2: Mean Burnout Scores by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	63.56	64.20	65.00	63.04	63.13
Work-related burnout	60.75	60.86	61.44	59.33	60.84
Client-related burnout	31.12	34.33	30.71	31.39	30.46

Figure A5.3: Level of Personal Burnout by Country (Weighted by Occupation)

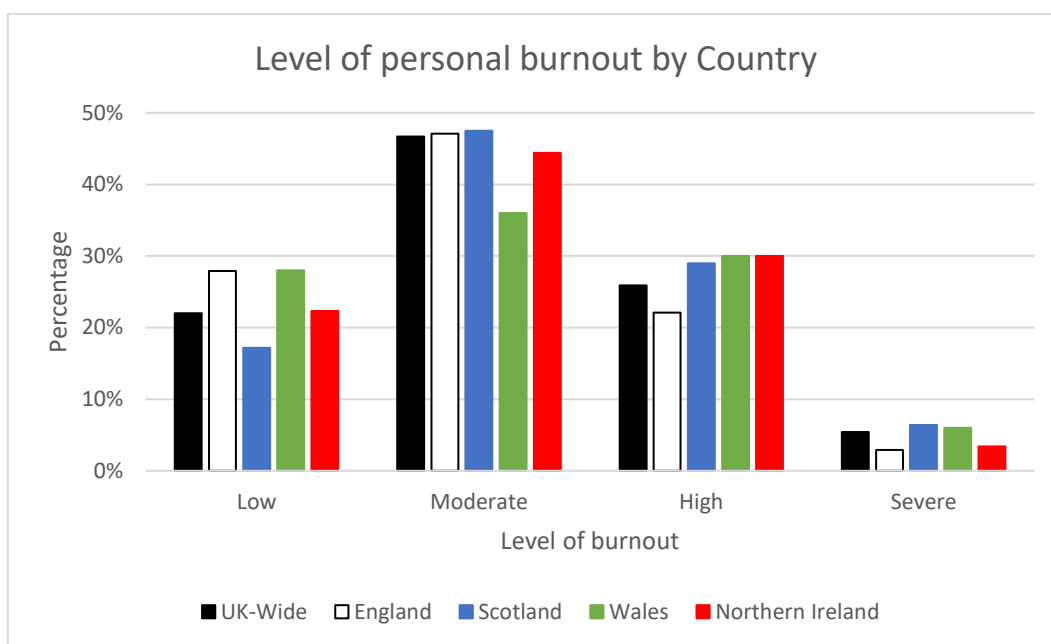


Figure A5.4: Level of Personal Burnout by Country (Unweighted)

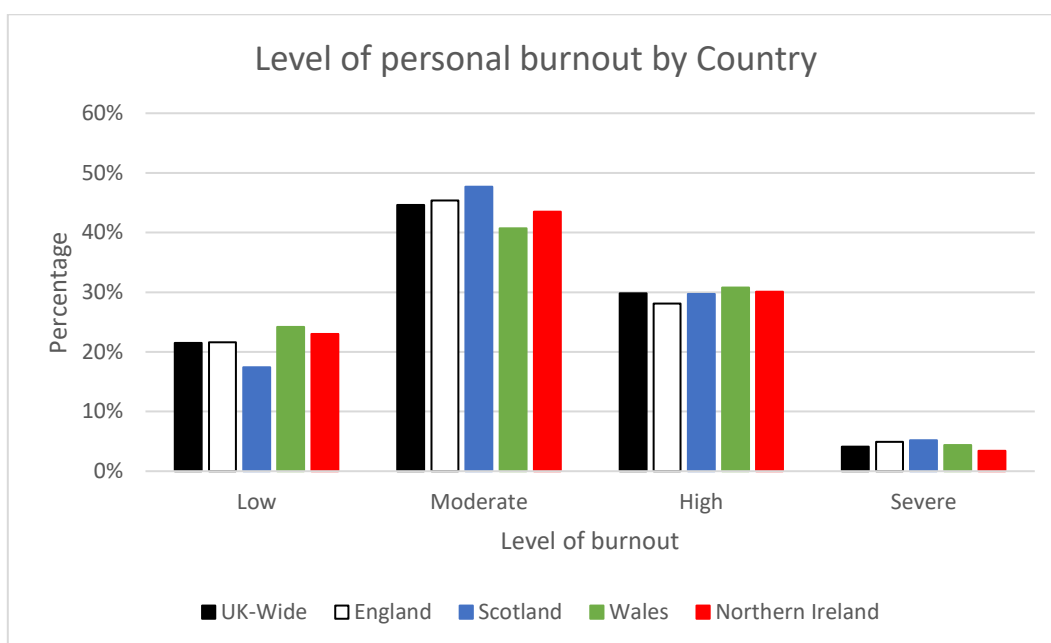


Figure A5.5: Level of Work-Related Burnout by Country (Weighted by Occupation)

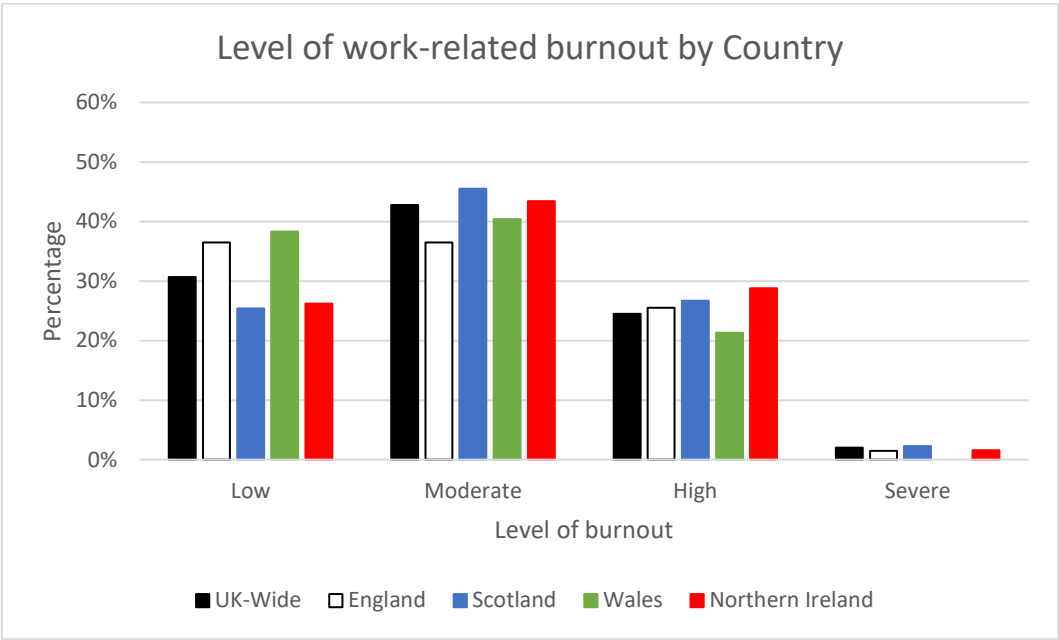


Figure A5.6: Level of Work-Related Burnout by Country (Unweighted)

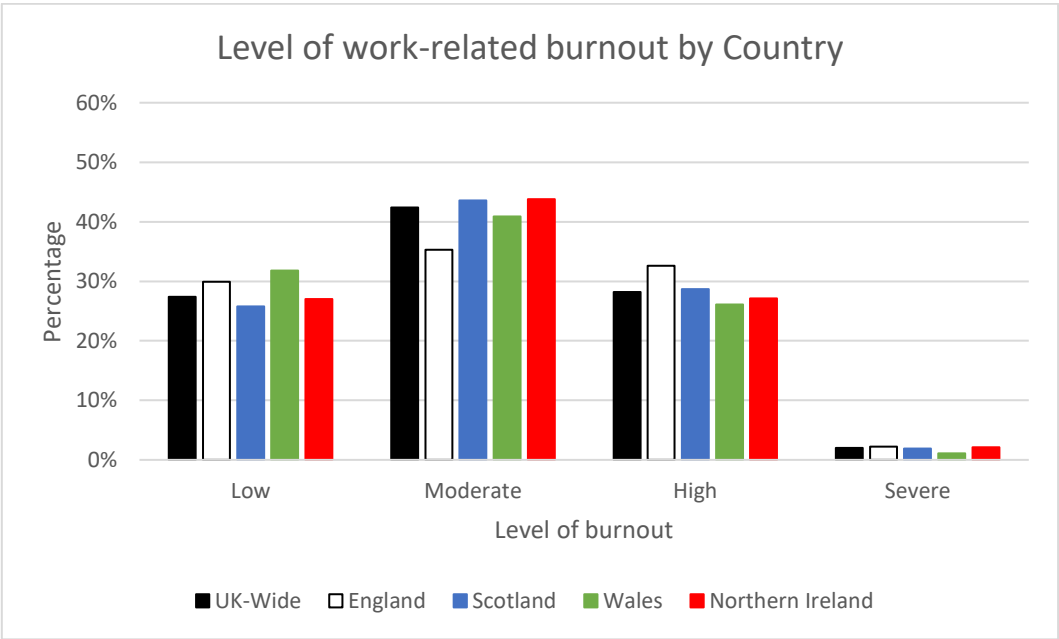


Figure A5.7: Level of Client-Related Burnout by Country (Weighted by Occupation)

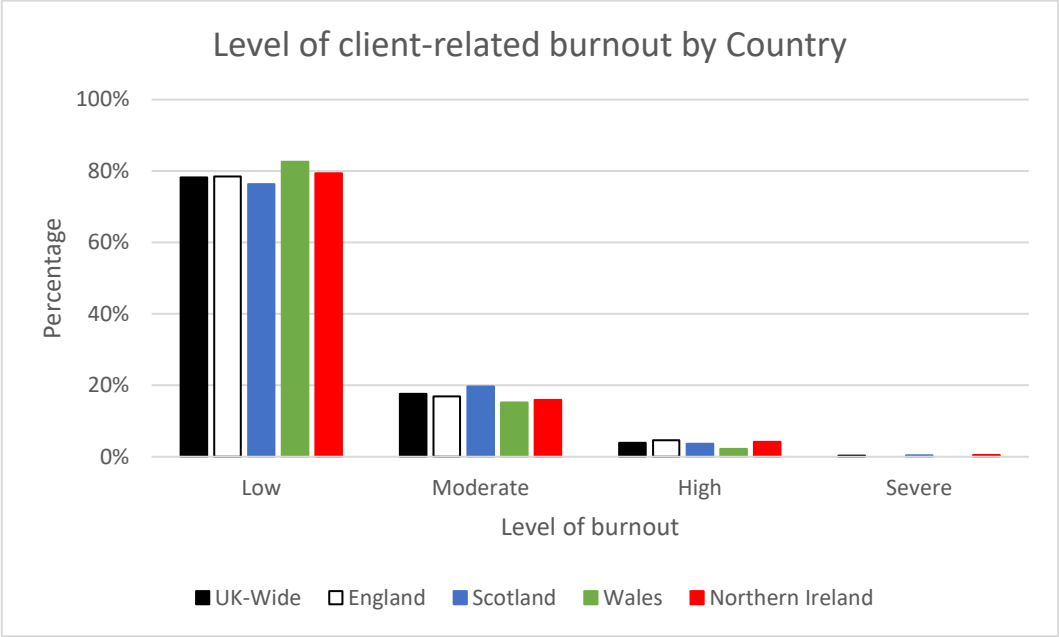


Figure A5.8: Level of Client-Related Burnout by Country (Unweighted)

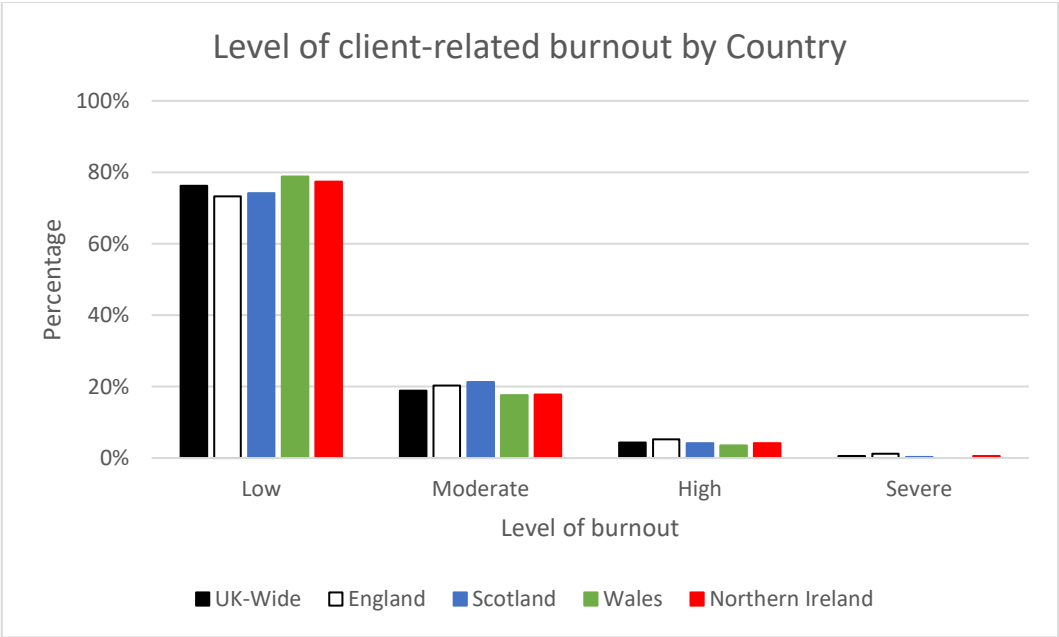


Table A5.3: Level of Burnout by Country (Weighted by Occupation)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout:					
Low	22.0%	27.9%	17.2%	28.0%	22.3%
Moderate	46.7%	47.1%	47.5%	36.0%	44.4%
High	25.9%	22.1%	29.0%	30.0%	30.0%
Severe	5.4%	2.9%	6.4%	6.0%	3.4%
Total	100%	100%	100%	100%	100%
Work-related burnout:					
Low	30.7%	36.5%	25.4%	38.3%	26.2%
Moderate	42.8%	36.5%	45.5%	40.4%	43.4%
High	24.5%	25.5%	26.7%	21.3%	28.8%
Severe	2.0%	1.5%	2.3%	0.0%	1.6%
Total	100%	100%	100%	100%	100%
Client-related burnout:					
Low	78.2%	78.5%	76.3%	82.6%	79.4%
Moderate	17.6%	16.9%	19.7%	15.2%	15.9%
High	3.9%	4.6%	3.6%	2.2%	4.2%
Severe	0.3%	0.0%	0.4%	0.0%	0.5%
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	293 (21.5%)	40 (21.6%)	57 (17.4%)	22 (24.2%)	174 (23.0%)
Moderate	607 (44.6%)	84 (45.4%)	156 (47.7%)	37 (40.7%)	330 (43.5%)
High	405 (29.8%)	52 (28.1%)	97 (29.7%)	28 (30.8%)	228 (30.1%)
Severe	56 (4.1%)	9 (4.9%)	17 (5.2%)	4 (4.4%)	26 (3.4%)
Total	1361 (100%)	185 (100%)	327 (100%)	91 (100%)	758 (100%)
Work-related burnout:					
Low	365 (27.4%)	55 (29.9%)	81 (25.8%)	28 (31.8%)	201 (27.0%)
Moderate	564 (42.4%)	65 (35.3%)	137 (43.6%)	36 (40.9%)	326 (43.8%)
High	375 (28.2%)	60 (32.6%)	90 (28.7%)	23 (26.1%)	202 (27.1%)
Severe	27 (2.0%)	4 (2.2%)	6 (1.9%)	1 (1.1%)	16 (2.1%)
Total	1331 (100%)	184 (100%)	314 (100%)	88 (100%)	745 (100%)
Client-related burnout:					
Low	941 (76.2%)	126 (73.3%)	213 (74.2%)	67 (78.8%)	535 (77.4%)
Moderate	234 (18.9%)	35 (20.3%)	61 (21.3%)	15 (17.6%)	123 (17.8%)
High	53 (4.3%)	9 (5.2%)	12 (4.2%)	3 (3.5%)	29 (4.2%)
Severe	7 (0.6%)	2 (1.2%)	1 (0.3%)	0 (0.0%)	4 (0.6%)
Total	1235 (100%)	172 (100%)	287 (100%)	85 (100%)	691 (100%)

A5.2 Burnout Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean personal burnout scores ($F = 23.542$, $df = 4$, $p < .001$). Specifically, social workers scored significantly higher than nurses, AHPs, and social care workers.

There were also significant differences between the occupational groups in mean work-related burnout scores ($F = 20.615$, $df = 4$, $p < .001$). Specifically, social workers scored significantly higher than nurses, AHPs, and social care workers.

There were also significant differences between the occupational groups in mean client-related burnout scores ($F = 9.195$, $df = 4$, $p < .001$). Specifically, social workers 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 ($F = 4.526$, $df = 4$, $p < .001$). Specifically, AHPs scored significantly lower than midwives, social care workers, and social workers.

There were also significant differences between the occupational groups in mean work-related burnout scores ($F = 4.421$, $df = 4$, $p < .001$). Specifically, midwives scored significantly higher than AHPs.

There were also significant differences between occupational groups found in mean client-related burnout scores ($F = 3.672$, $df = 4$, $p = .006$). Specifically, social workers scored significantly higher than both nursing and social care workers.

Figure A5.9: Mean Burnout Scores by Occupation (Weighted by Region)

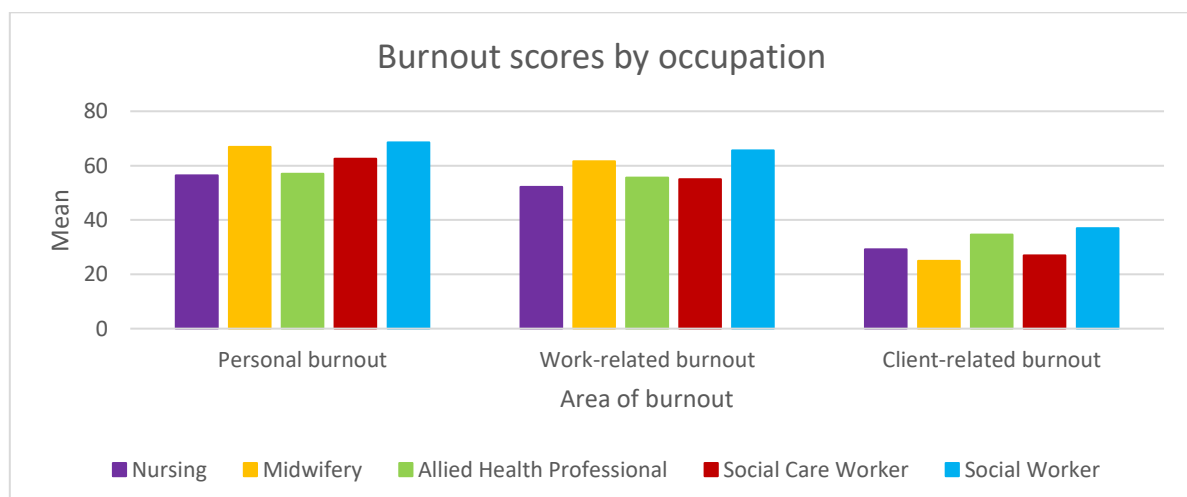


Figure A5.10: Mean Burnout Scores by Occupation (Unweighted)

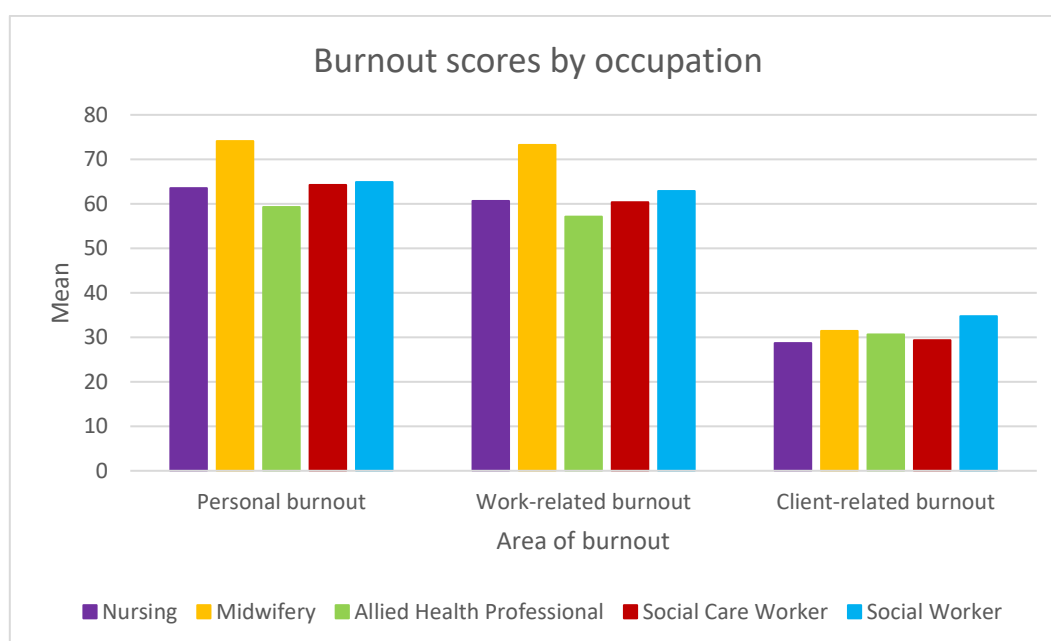


Table A5.5: Mean Burnout Scores by Occupation (Weighted by Region)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	56.40	66.86	56.98	62.58	68.59
Work-related burnout	52.17	61.59	55.60	54.94	65.63
Client-related burnout	29.19	24.97	34.64	27.01	36.95

Table A5.6: Mean Burnout Scores by Occupation (Unweighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	63.54	74.13	59.31	64.21	64.86
Work-related burnout	60.65	73.21	57.09	60.38	62.86
Client-related burnout	28.73	31.42	30.65	29.36	34.74

Figure A5.11: Level of Personal Burnout by Occupation (Weighted by Region)

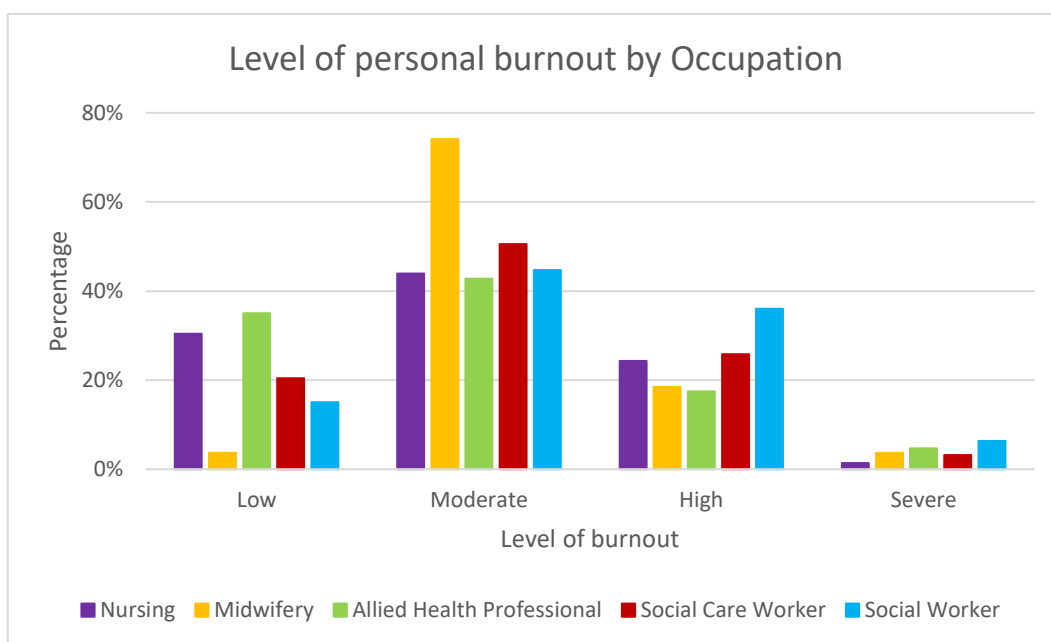


Figure A5.12: Level of Personal Burnout by Occupation (Unweighted)

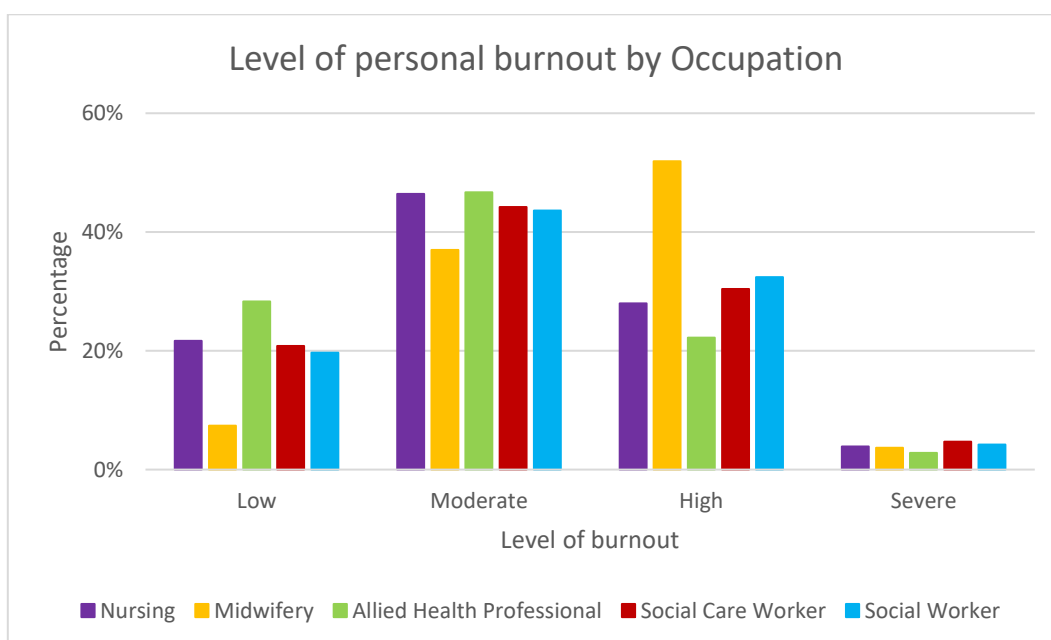


Figure A5.13: Level of Work-Related Burnout by Occupation (Weighted by Region)

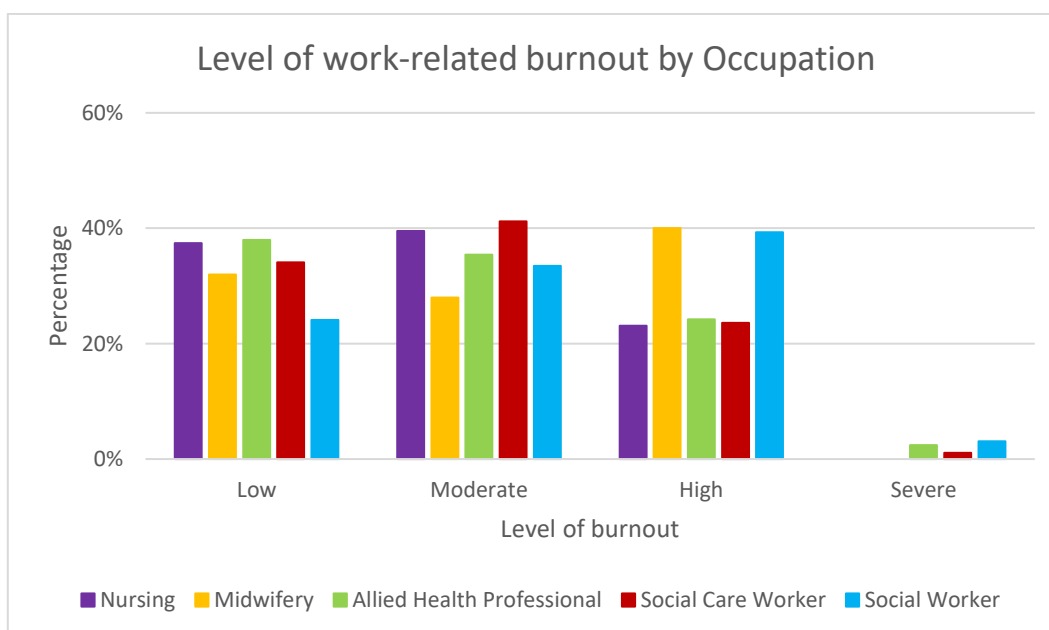


Figure A5.14: Level of Work-Related Burnout by Occupation (Unweighted)

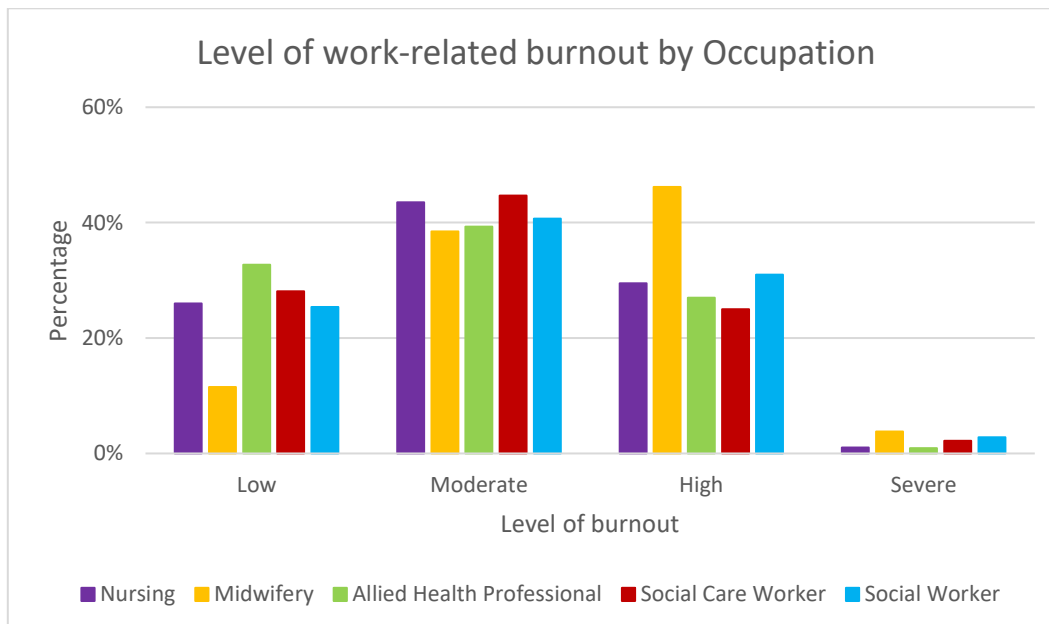


Figure A5.15: Level of Client-Related Burnout by Occupation (Weighted by Region)

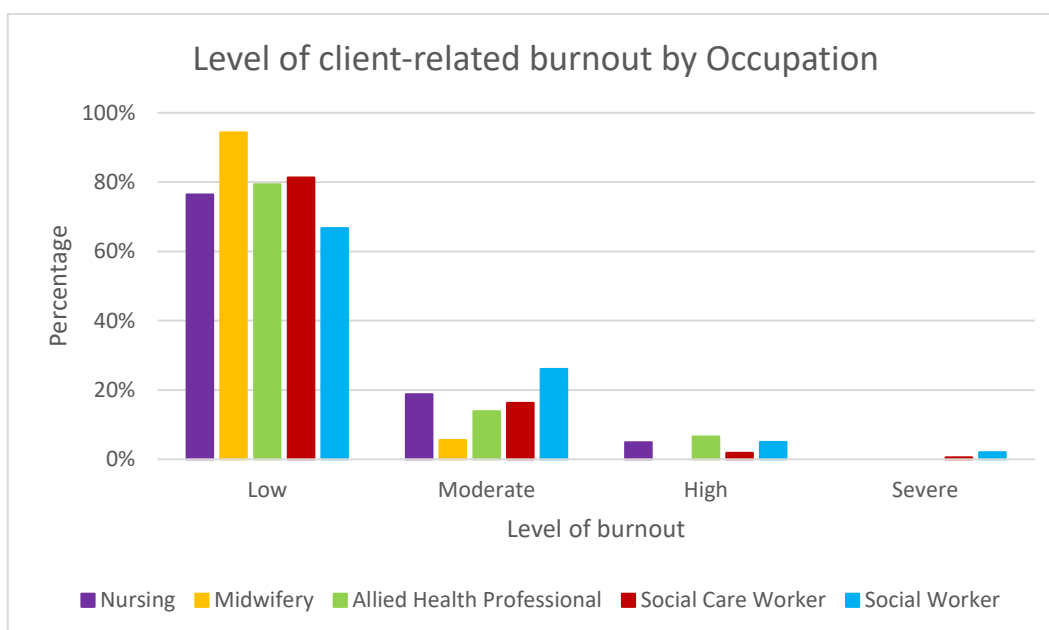


Figure A5.16: Level of Client-Related Burnout by Occupation (Unweighted)

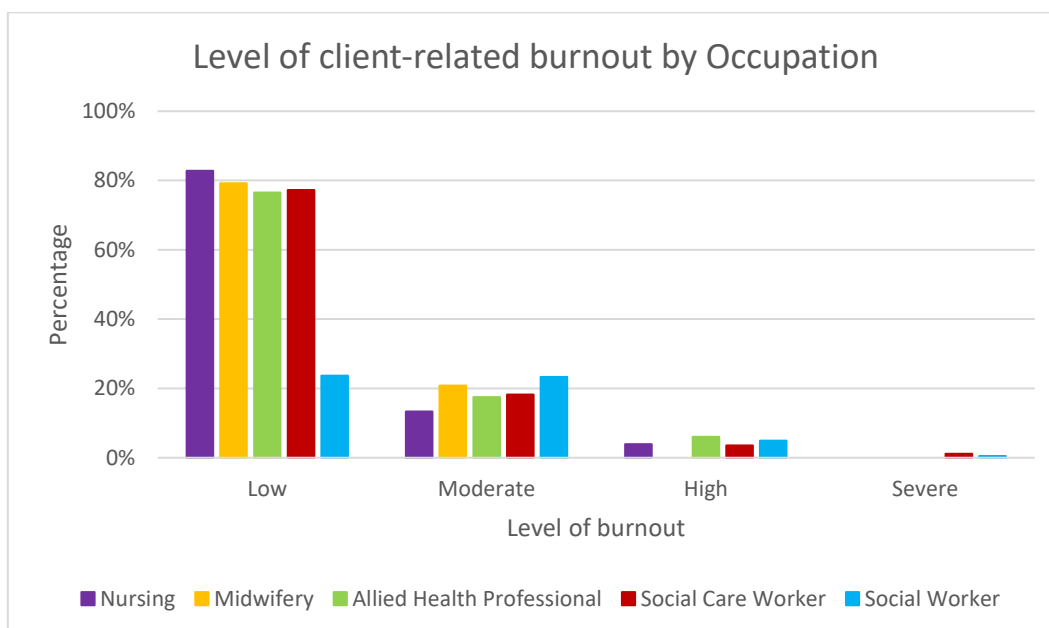


Table A5.7: Level of Burnout by Occupation (Weighted by Region)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout:					
Low	30.4%	3.7%	35.0%	20.4%	15.0%
Moderate	43.9%	74.1%	42.8%	50.5%	44.7%
High	24.3%	18.5%	17.5%	25.8%	36.0%
Severe	1.4%	3.7%	4.7%	3.2%	6.3%
Total	100%	100%	100%	100%	100%
Work-related burnout:					
Low	37.4%	32.0%	38.0%	34.1%	24.1%
Moderate	39.5%	28.0%	35.4%	41.2%	33.5%
High	23.1%	40.0%	24.2%	23.6%	39.3%
Severe	0.0%	0.0%	2.4%	1.1%	3.1%
Total	100%	100%	100%	100%	100%
Client-related burnout:					
Low	76.4%	94.4%	79.4%	81.3%	66.7%
Moderate	18.8%	5.6%	13.9%	16.3%	26.1%
High	4.9%	0.0%	6.6%	1.9%	5.0%
Severe	0.0%	0.0%	0.0%	0.6%	2.1%
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	45 (21.7%)	2 (7.4%)	60 (28.3%)	107 (20.8%)	79 (19.7%)
Moderate	96 (46.4%)	10 (37.0%)	99 (46.7%)	227 (44.2%)	175 (43.6%)
High	58 (28.0%)	14 (51.9%)	47 (22.2%)	156 (30.4%)	130 (32.4%)
Severe	8 (3.9%)	1 (3.7%)	6 (2.8%)	24 (4.7%)	17 (4.2%)
Total	207 (100%)	27 (100%)	212 (100%)	514 (100%)	401 (100%)
Work-related burnout:					
Low	52 (26.0%)	3 (11.5%)	69 (32.7%)	141 (28.1%)	100 (25.4%)
Moderate	87 (43.5%)	10 (38.5%)	83 (39.3%)	224 (44.7%)	160 (40.7%)
High	59 (29.5%)	12 (46.2%)	57 (27.0%)	125 (25.0%)	122 (31.0%)
Severe	2 (1.0%)	1 (3.8%)	2 (0.9%)	11 (2.2%)	11 (2.8%)
Total	200 (100%)	26 (100%)	211 (100%)	501 (100%)	393 (100%)
Client-related burnout:					
Low	149 (82.8%)	19 (79.2%)	153 (76.5%)	357 (77.3%)	263 (71.3%)
Moderate	24 (13.3%)	5 (20.8%)	35 (17.5%)	84 (18.2%)	86 (23.3%)
High	7 (3.9%)	0 (0.0%)	12 (6.0%)	16 (3.5%)	18 (4.9%)
Severe	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (1.1%)	2 (0.5%)
Total	180 (100%)	24 (100%)	200 (100%)	462 (100%)	369 (100%)

A5.3 Burnout Scores by Sex

Only 15 respondents in the full sample for burnout stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

There were significant differences between males and females in mean personal burnout scores ($t = 2.634$, $df = 1262$, $p = .009$). Specifically, females scored significantly higher than males.

There were no significant differences between males and females in mean work-related burnout scores ($t = .187$, $df = 1237$, $p = .852$).

There were significant differences between males and females in mean client-related burnout scores ($t = -5.073$, $df = 1152$, $p < .001$). Males scored significantly higher than females.

Summary (Unweighted results):

There were significant differences between males and females in mean personal burnout scores ($t = 3.628$, $df = 1358$, $p < .001$). Specifically, females scored significantly higher than males.

There were no significant differences between males and females in mean work-related burnout scores ($t = .666$, $df = 11328$, $p = .505$).

There were significant differences between males and females in mean client-related burnout scores ($t = -4.475$, $df = 1232$, $p < .001$). Males scored significantly higher than females.

Figure A5.17: Mean Burnout Scores by Sex (Weighted)

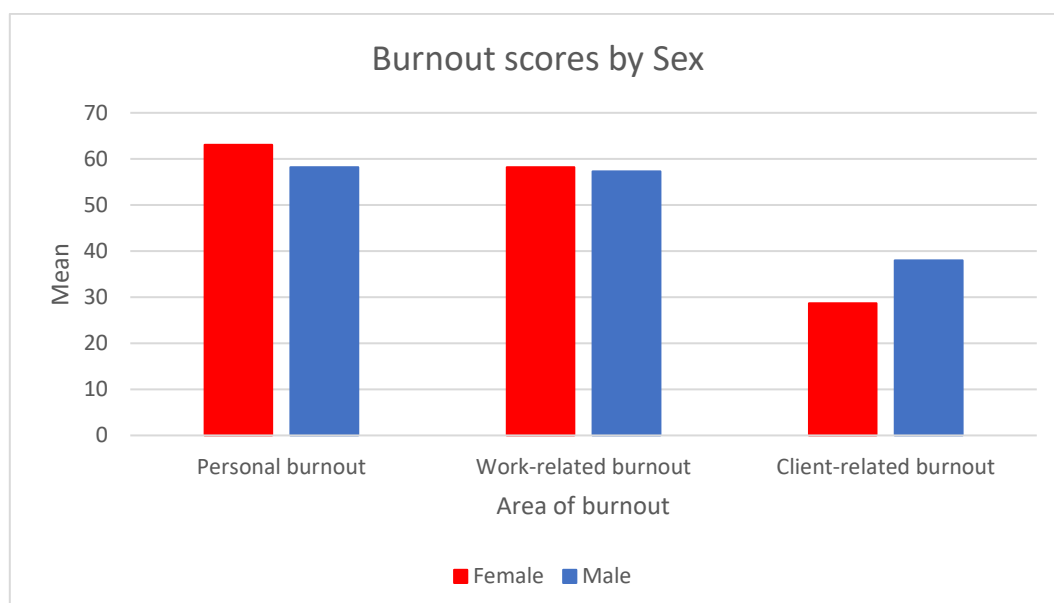


Figure A5.18: Mean Burnout Scores by Sex (Unweighted)

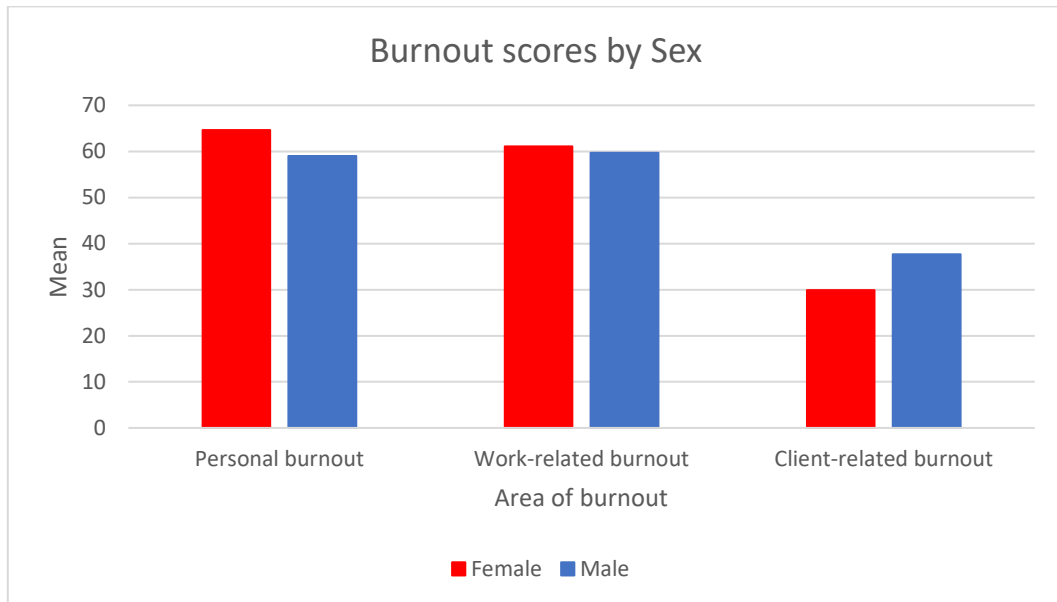


Table A5.9: Mean Burnout Scores by Sex (Weighted)

Burnout	Sex	
	Female	Male
Personal burnout	63.07	58.22
Work-related burnout	58.19	57.26
Client-related burnout	28.71	37.98

Table A5.10: Mean Burnout Scores by Sex (Unweighted)

Burnout	Sex	
	Female	Male
Personal burnout	64.61	58.97
Work-related burnout	61.10	59.68
Client-related burnout	29.88	37.65

Figure A5.19: Level of Personal Burnout by Sex (Weighted)

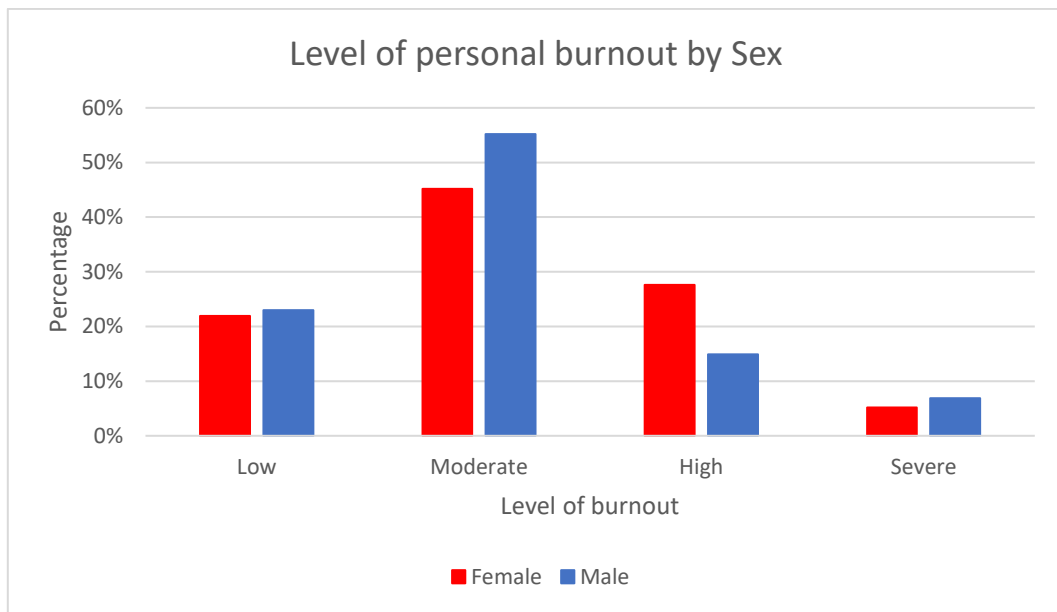


Figure A5.20: Level of Personal Burnout by Sex (Unweighted)

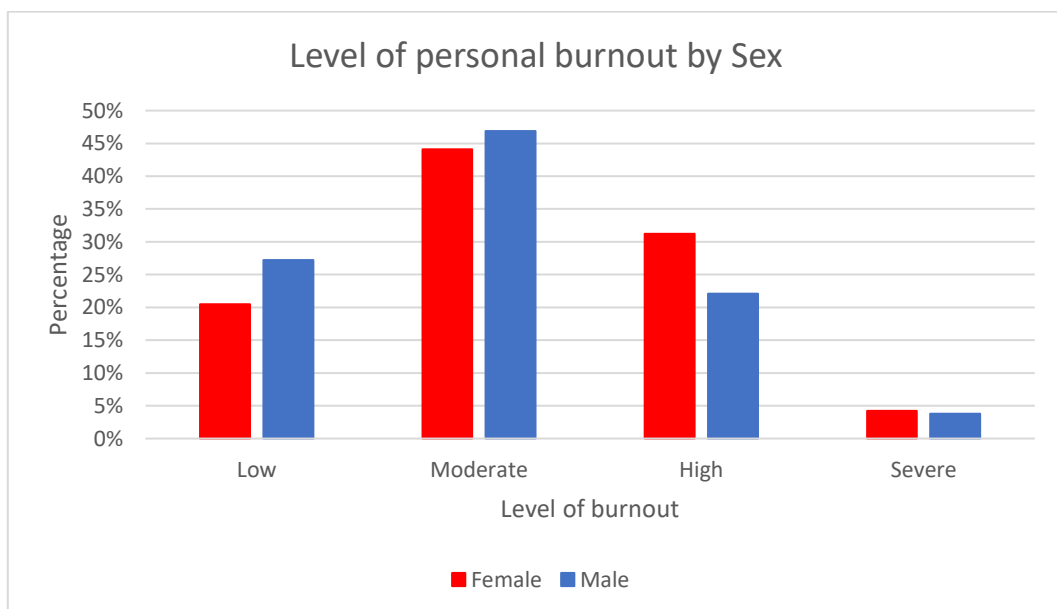


Figure A5.21: Level of Work-Related Burnout by Sex (Weighted)

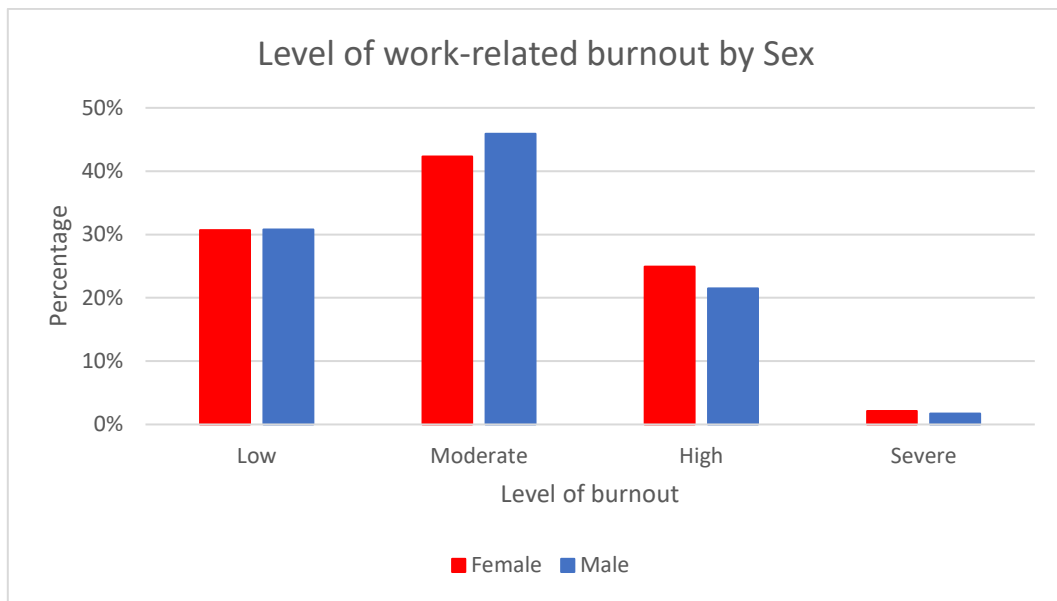


Figure A5.22: Level of Work-Related Burnout by Sex (Unweighted)

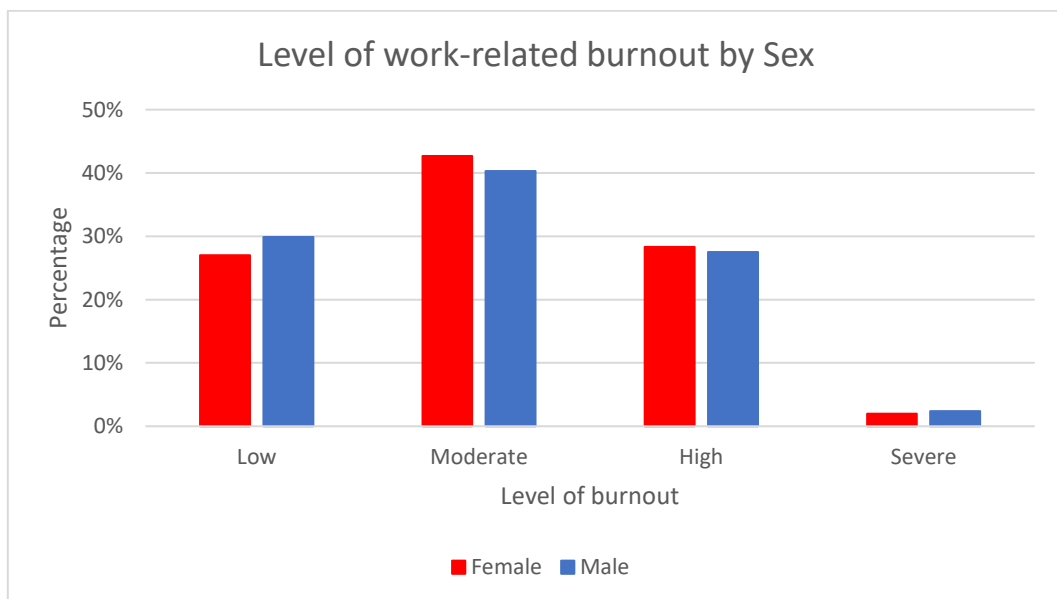


Figure A5.23: Level of Client-Related Burnout by Sex (Weighted)

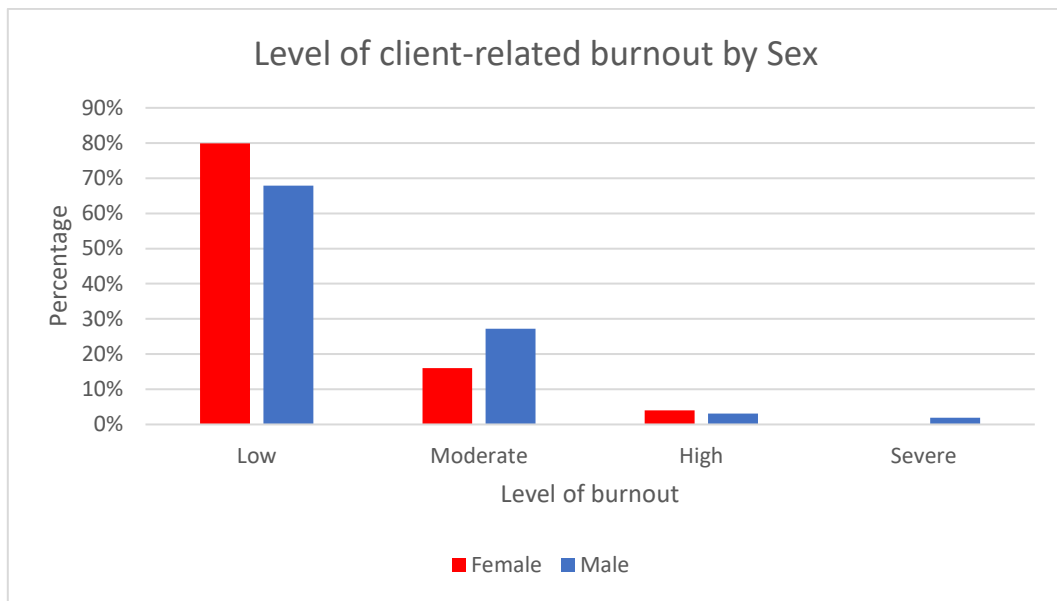


Figure A5.24: Level of Client-Related Burnout by Sex (Unweighted)

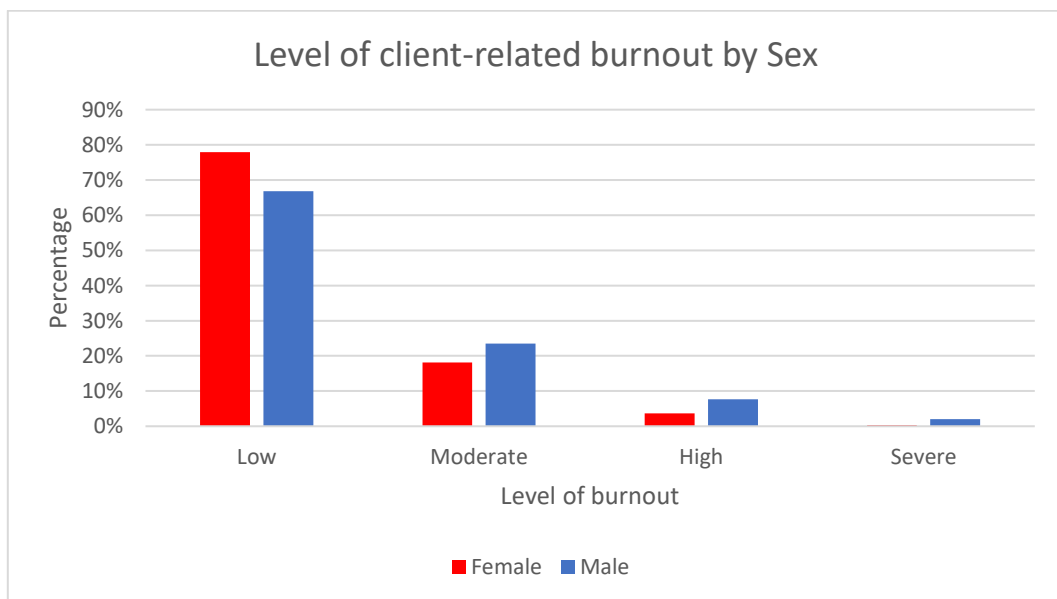


Table A5.11: Level of Burnout by Sex (Weighted)

Burnout	Sex	
	Female	Male
Personal burnout:		
Low	21.9%	23.0%
Moderate	45.2%	55.2%
High	27.6%	14.9%
Severe	5.2%	6.9%
Total	100%	100%
Work-related burnout:		
Low	30.7%	30.8%
Moderate	42.3%	45.9%
High	24.9%	21.5%
Severe	2.1%	1.7%
Total	100%	100%
Client-related burnout:		
Low	79.9%	67.9%
Moderate	16.0%	27.2%
High	4.0%	3.1%
Severe	0.1%	1.9%
Total	100%	100%

Table A5.12: Level of Burnout by Sex (Unweighted)

Burnout	Sex	
	Female	Male
Personal burnout:		
Low	235 (20.5%)	58 (27.2%)
Moderate	506 (44.1%)	100 (46.9%)
High	358 (31.2%)	47 (22.1%)
Severe	48 (4.2%)	8 (3.8%)
Total	1147 (100%)	213 (100%)
Work-related burnout:		
Low	302 (27.0%)	63 (29.9%)
Moderate	478 (42.7%)	85 (40.3%)
High	317 (28.3%)	58 (27.5%)
Severe	22 (2.0%)	5 (2.4%)
Total	1119 (100%)	211 (100%)
Client-related burnout:		
Low	809 (77.9%)	131 (66.8%)
Moderate	188 (18.1%)	46 (23.5%)
High	38 (3.7%)	15 (7.7%)
Severe	3 (0.3%)	4 (2.0%)
Total	1038 (100%)	196 (100%)

A5.4 Burnout Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean personal burnout scores ($F = 15.772$, $df = 4$, $p < .001$). The 60+ scored significantly lower than all other age groups.

There were significant differences between the age groups in mean work-related burnout scores ($F = 17.557$, $df = 4$, $p < .001$). Specifically, the 60+ scored significantly lower than all other age groups.

There were also significant differences between the age groups in mean client-related burnout scores ($F = 9.787$, $df = 4$, $p < .001$). Specifically, the 16-29 age group scored significantly higher than all other age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean personal burnout scores ($F = 11.683$, $df = 4$, $p < .001$). The 60+ age group scored significantly lower than the 16-29, 30-39 and 40-49 age groups.

There were significant differences between the age groups in mean work-related burnout scores ($F = 13.491$, $df = 4$, $p < .001$). Specifically, the 60+ age group scored significantly lower than the 16-29, 30-39 and 40-49 age groups.

There were also significant differences between the age groups in mean client-related burnout scores ($F = 5.874$, $df = 4$, $p < .001$). Specifically, the 16-29 age group scored significantly higher than the 50-59 and 60+ age groups.

Figure A5.25: Mean Burnout Scores by Age (Weighted)

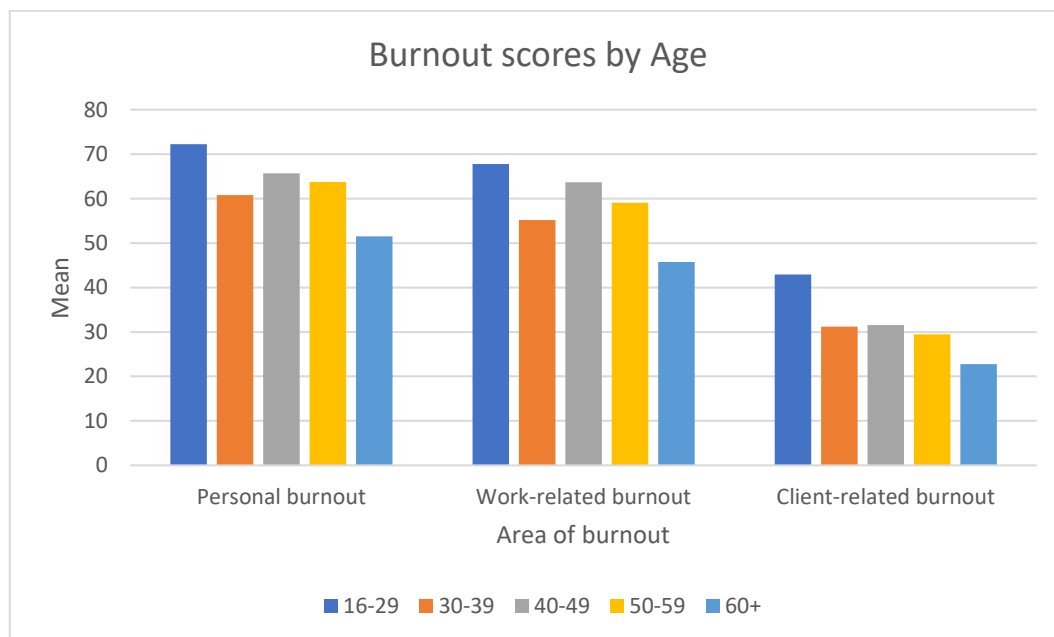


Figure A5.26: Mean Burnout Scores by Age (Unweighted)

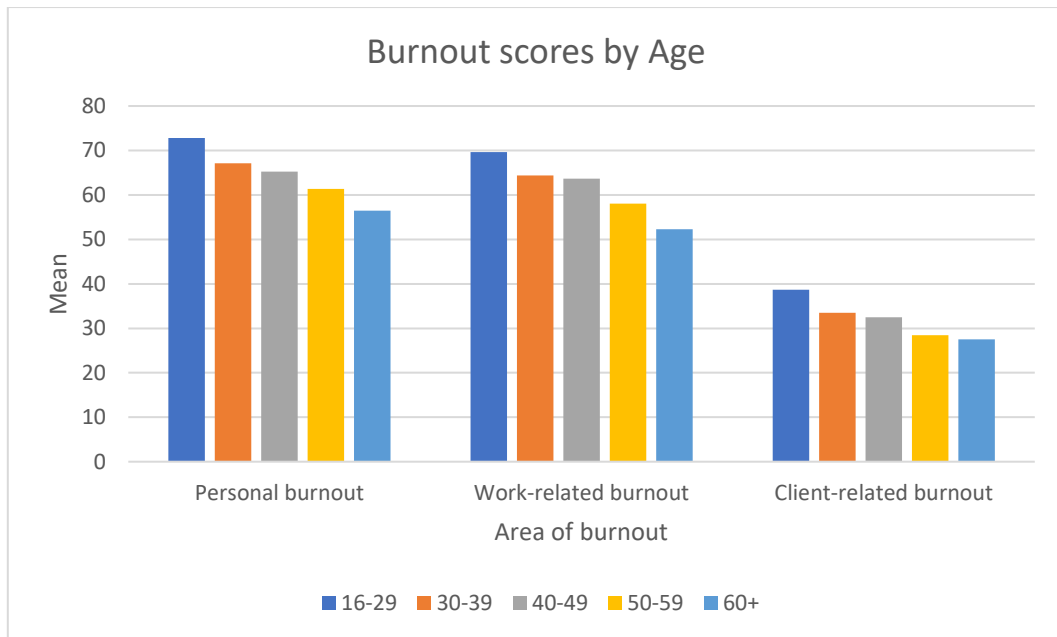


Table A5.13: Mean Burnout Scores by Age (Weighted)

Burnout	Age				
	16-29	30-39	40-49	50-59	60+
Personal burnout	72.27	60.81	65.71	63.77	51.53
Work-related burnout	67.77	55.16	63.67	59.07	45.76
Client-related burnout	42.96	31.21	31.56	29.45	22.74

Table A5.14: Mean Burnout Scores by Age (Unweighted)

Burnout	Age				
	16-29	30-39	40-49	50-59	60+
Personal burnout	72.84	67.13	65.24	61.37	56.43
Work-related burnout	69.66	64.38	63.63	58.03	52.31
Client-related burnout	38.70	33.49	32.49	28.46	27.53

Figure A5.27: Level of Personal Burnout by Age (Weighted)

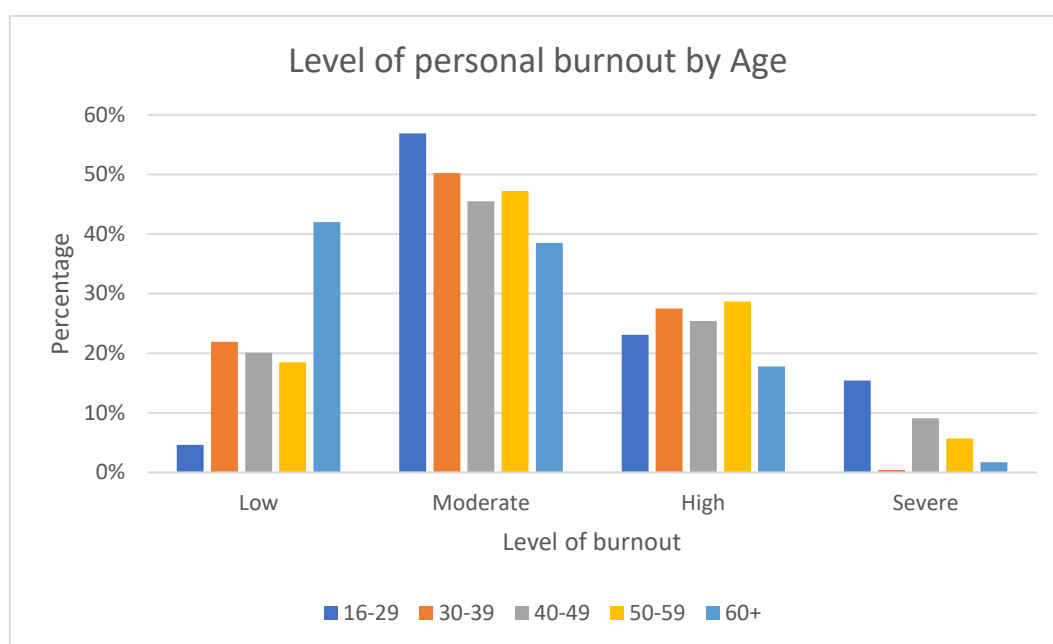


Figure A5.28: Level of Personal Burnout by Age (Unweighted)

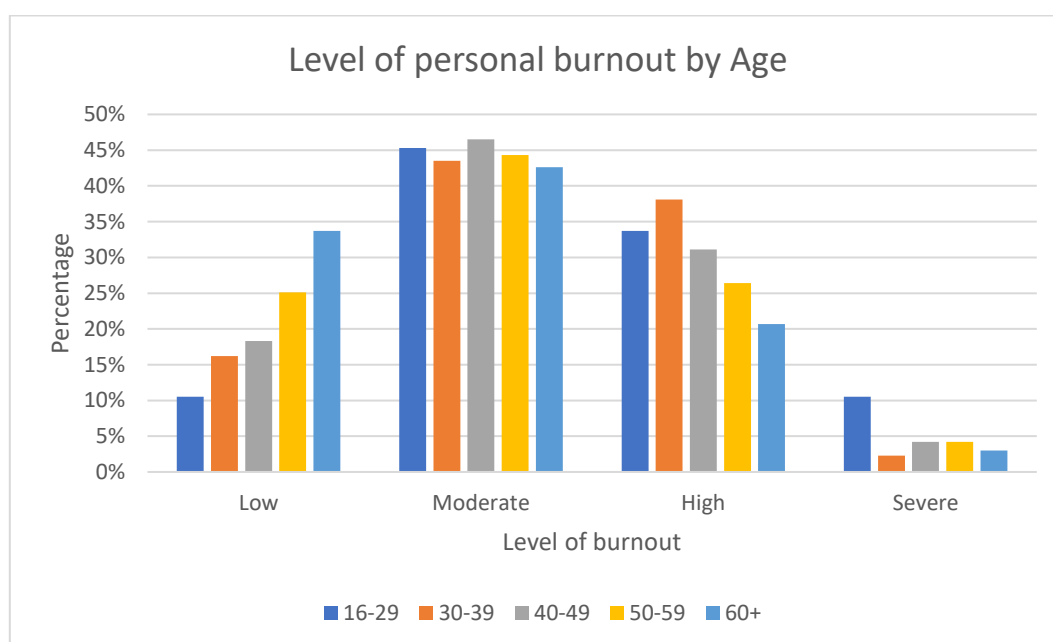


Figure A5.29: Level of Work-Related Burnout by Age (Weighted)

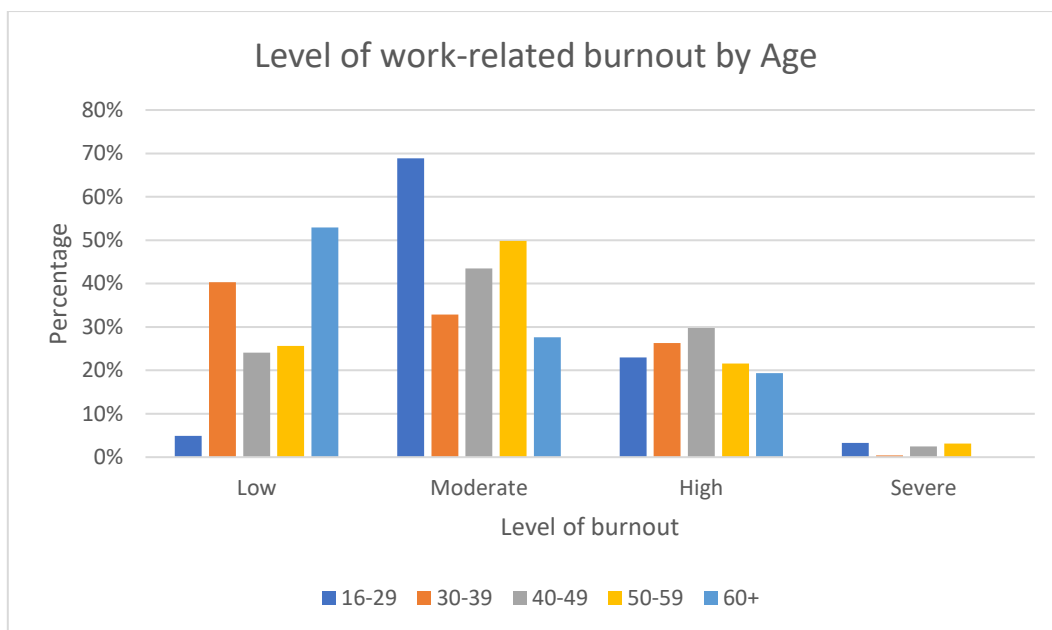


Figure A5.30: Level of Work-Related Burnout by Age (Unweighted)

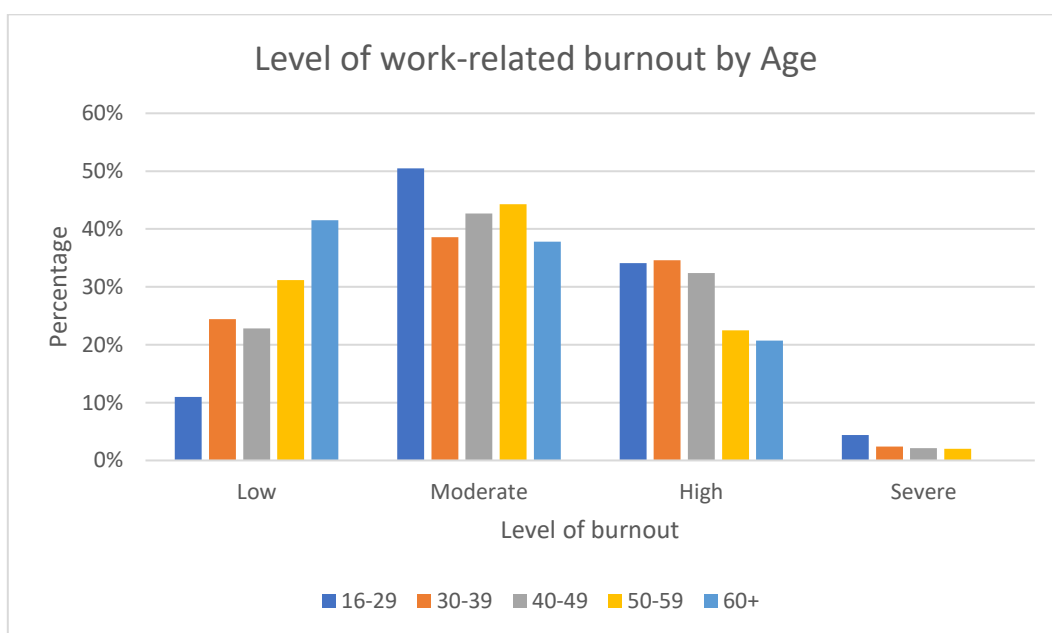


Figure A5.31: Level of Client-Related Burnout by Age (Weighted)

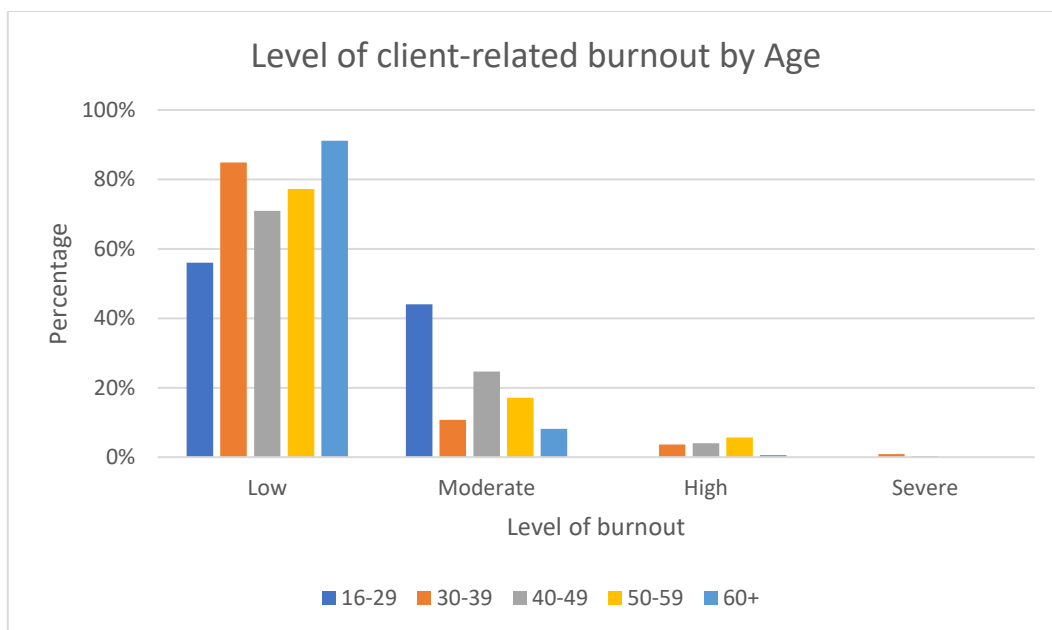


Figure A5.32: Level of Client-Related Burnout by Age (Unweighted)

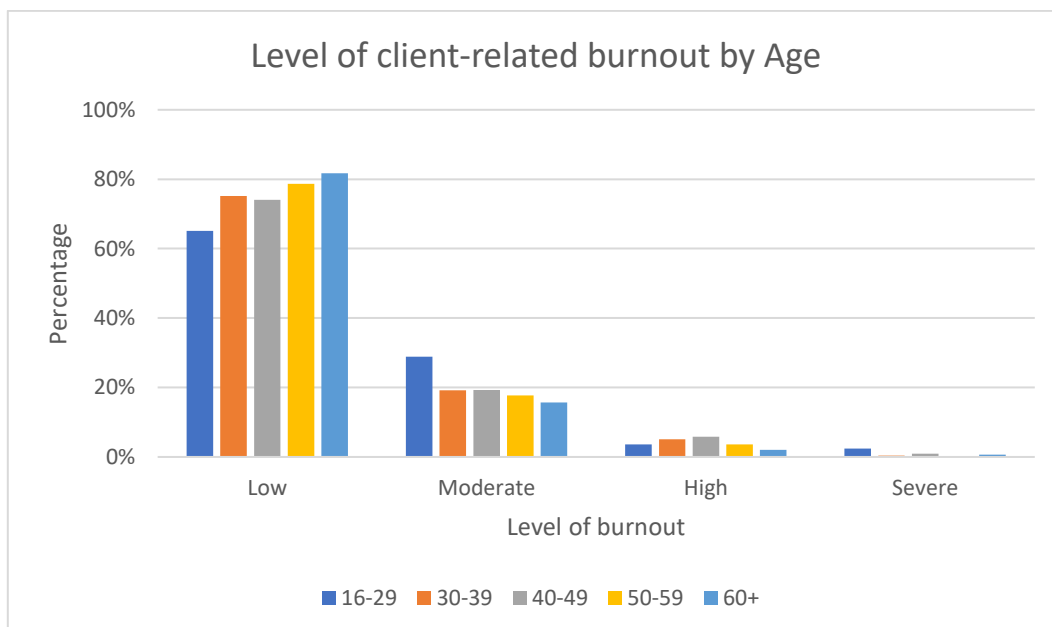


Table A5.15: Level of Burnout by Age (Weighted)

Burnout	Age				
	16-29	30-39	40-49	50-59	60+
Personal burnout:					
Low	4.6%	21.9%	20.1%	18.5%	42.0%
Moderate	56.9%	50.2%	45.5%	47.2%	38.5%
High	23.1%	27.5%	25.4%	28.7%	17.8%
Severe	15.4%	0.4%	9.1%	5.7%	1.7%
Total	100%	100%	100%	100%	100%
Work-related burnout:					
Low	4.9%	40.3%	24.1%	25.6%	52.9%
Moderate	68.9%	32.9%	43.5%	49.8%	27.6%
High	23.0%	26.3%	29.8%	21.6%	19.4%
Severe	3.3%	0.4%	2.5%	3.1%	0.0%
Total	100%	100%	100%	100%	100%
Client-related burnout:					
Low	56.0%	84.9%	71.0%	77.2%	91.2%
Moderate	44.0%	10.7%	24.7%	17.1%	8.2%
High	0.0%	3.6%	4.0%	5.7%	0.6%
Severe	0.0%	0.9%	0.3%	0.0%	0.0%
Total	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+
Personal burnout:					
Low	10 (10.5%)	42 (16.2%)	70 (18.3%)	114 (25.1%)	57 (33.7%)
Moderate	43 (45.3%)	113 (43.5%)	178 (46.5%)	201 (44.3%)	72 (42.6%)
High	32 (33.7%)	99 (38.1%)	119 (31.1%)	120 (26.4%)	35 (20.7%)
Severe	10 (10.5%)	6 (2.3%)	16 (4.2%)	19 (4.2%)	5 (3.0%)
Total	95 (100%)	260 (100%)	383 (100%)	454 (100%)	169 (100%)
Work-related burnout:					
Low	10 (11.0%)	62 (24.4%)	86 (22.8%)	139 (31.2%)	68 (41.5%)
Moderate	46 (50.5%)	98 (38.6%)	161 (42.7%)	197 (44.3%)	62 (37.8%)
High	31 (34.1%)	88 (34.6%)	122 (32.4%)	100 (22.5%)	34 (20.7%)
Severe	4 (4.4%)	6 (2.4%)	8 (2.1%)	9 (2.0%)	0 (0.0%)
Total	91 (100%)	254 (100%)	377 (100%)	445 (100%)	164 (100%)
Client-related burnout:					
Low	54 (65.1%)	176 (75.2%)	257 (74.1%)	329 (78.7%)	125 (81.7%)
Moderate	24 (28.9%)	45 (19.2%)	67 (19.3%)	74 (17.7%)	24 (15.7%)
High	3 (3.6%)	12 (5.1%)	20 (5.8%)	15 (3.6%)	3 (2.0%)
Severe	2 (2.4%)	1 (0.4%)	3 (0.9%)	0 (0.0%)	1 (0.7%)
Total	83 (100%)	234 (100%)	347 (100%)	418 (100%)	153 (100%)

A5.5 Burnout Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean personal burnout scores ($F = 14.168$, $df = 3$, $p < .001$). Specifically, the Asian ethnic group scored significantly lower than all other ethnic groups.

There were significant differences between the ethnic groups in mean work-related burnout scores ($F = 28.509$, $df = 3$, $p < .001$). Specifically, the Asian ethnic group scored significantly lower than all other ethnic groups.

There were significant differences between the ethnic groups in mean client-related burnout scores ($F = 10.343$, $df = 3$, $p < .001$). Specifically, the Black ethnic group scored significantly higher than the White or Asian ethnic groups.

Summary (Unweighted results):

There were no significant differences between the ethnic groups in any areas of burnout.

Figure A5.33: Mean Burnout Scores by Ethnicity (Weighted)

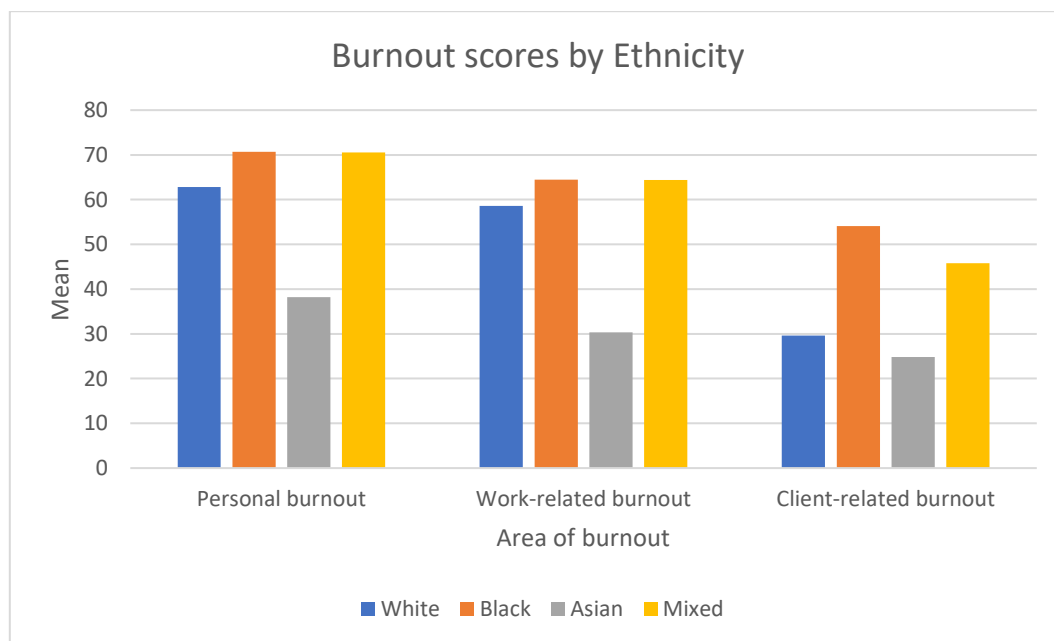


Figure A5.34: Mean Burnout Scores by Ethnicity (Unweighted)

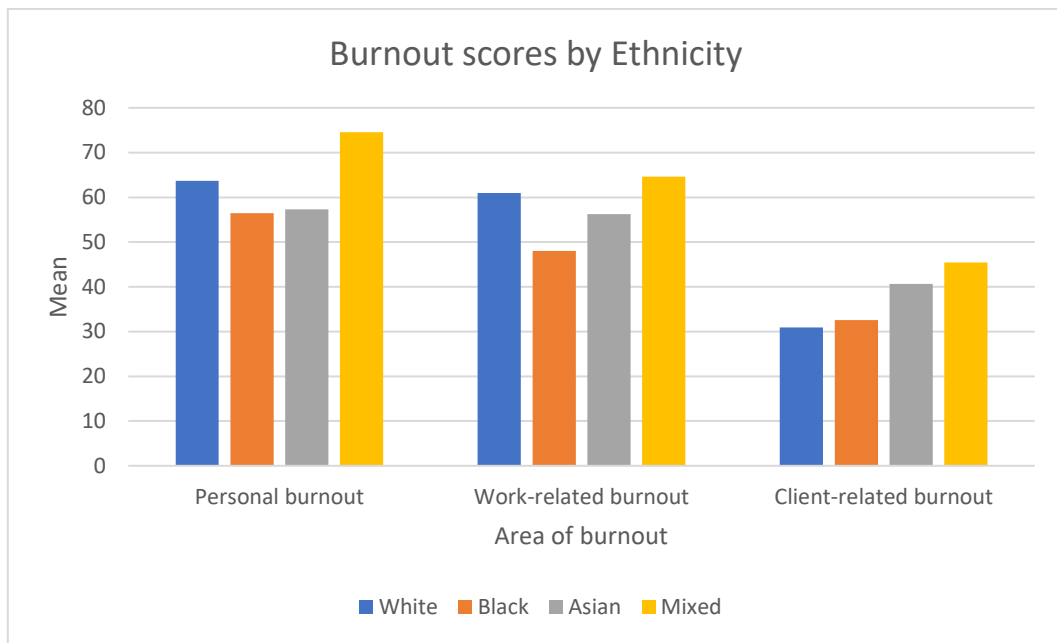


Table A5.17: Mean Burnout Scores by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	62.80	70.67	38.18	70.54
Work-related burnout	58.61	64.46	30.35	64.36
Client-related burnout	29.59	54.07	24.86	45.78

Table A5.18: Mean Burnout Scores by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	63.70	56.44	57.29	74.58
Work-related burnout	60.98	48.05	56.25	64.64
Client-related burnout	30.95	32.58	40.63	45.42

Figure A5.35: Level of Personal Burnout by Ethnicity (Weighted)

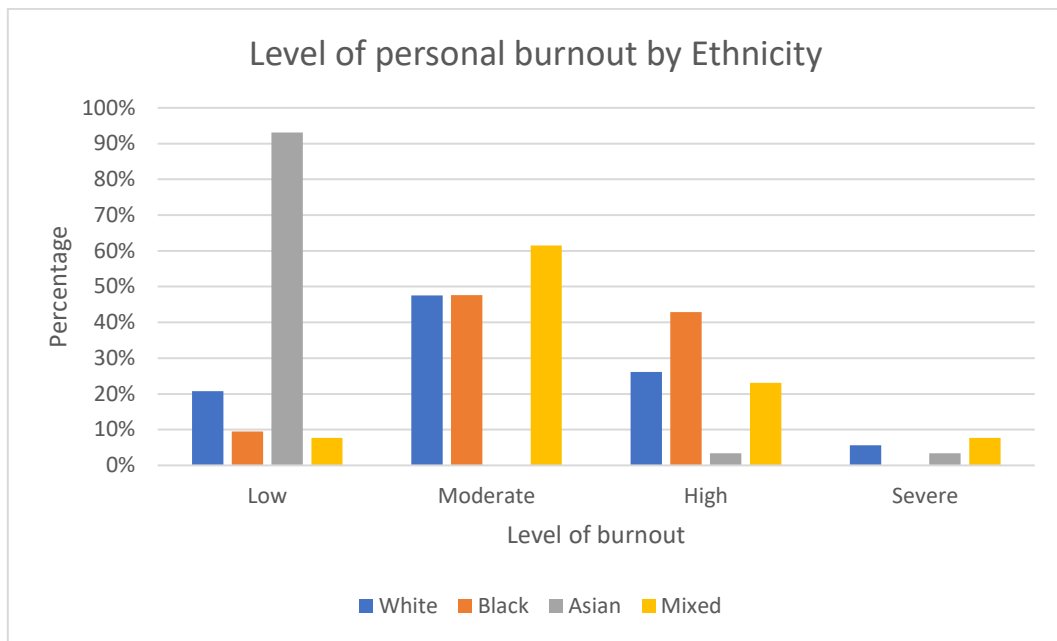


Figure A5.36: Level of Personal Burnout by Ethnicity (Unweighted)

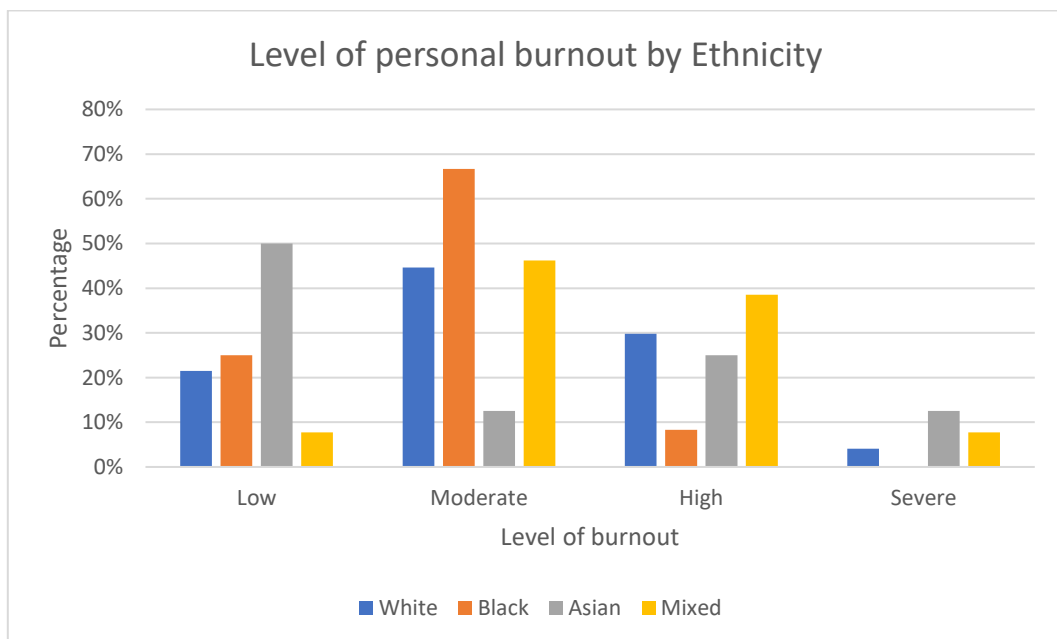


Figure A5.37: Level of Work-Related Burnout by Ethnicity (Weighted)

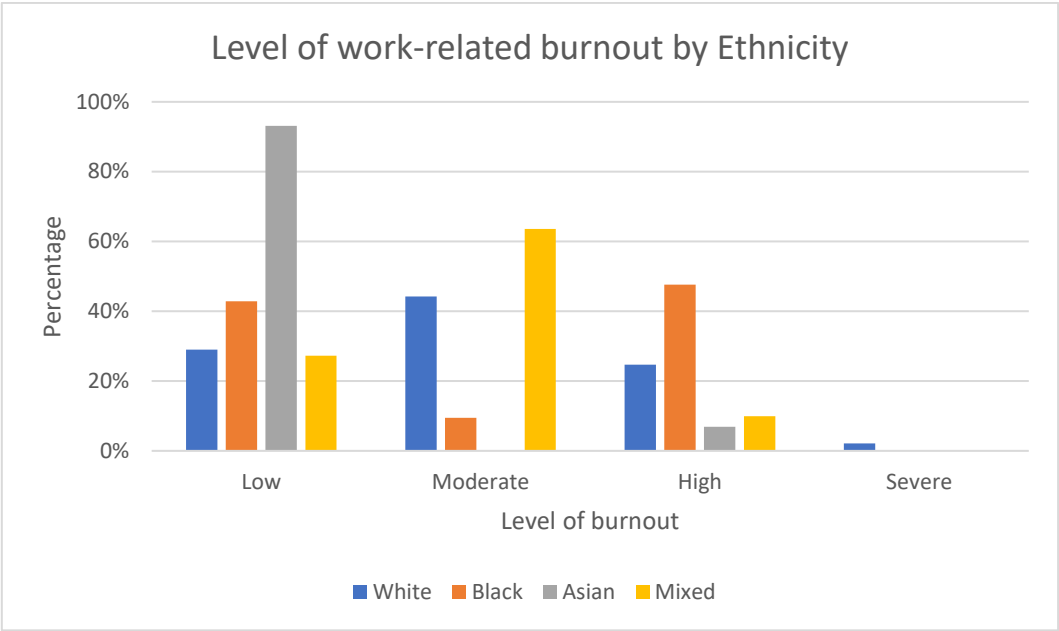


Figure A5.38: Level of Work-Related Burnout by Ethnicity (Unweighted)

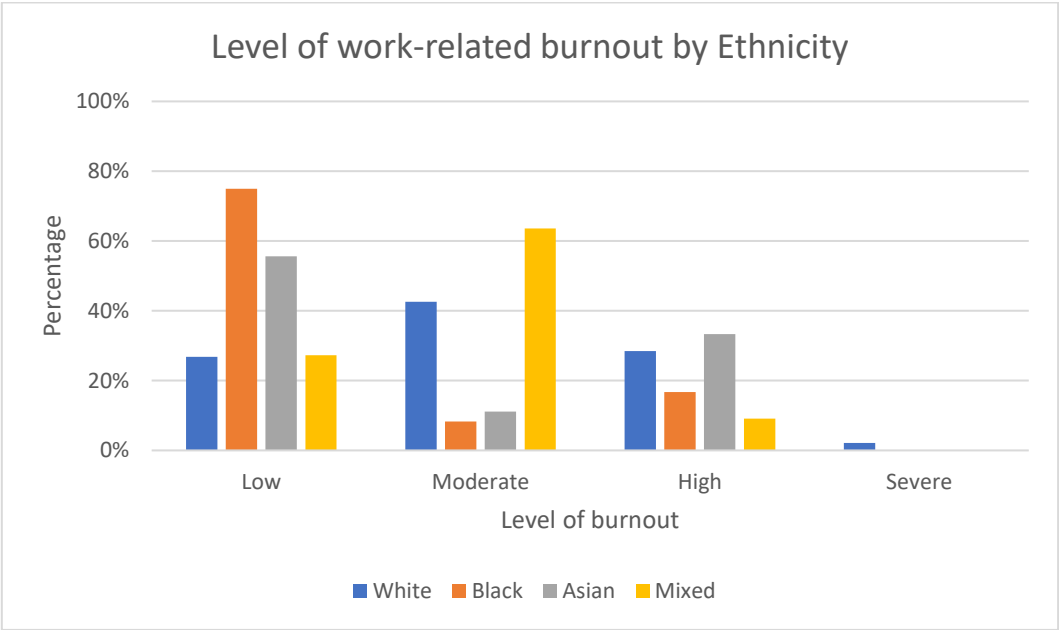


Figure A5.39: Level of Client-Related Burnout by Ethnicity (Weighted)

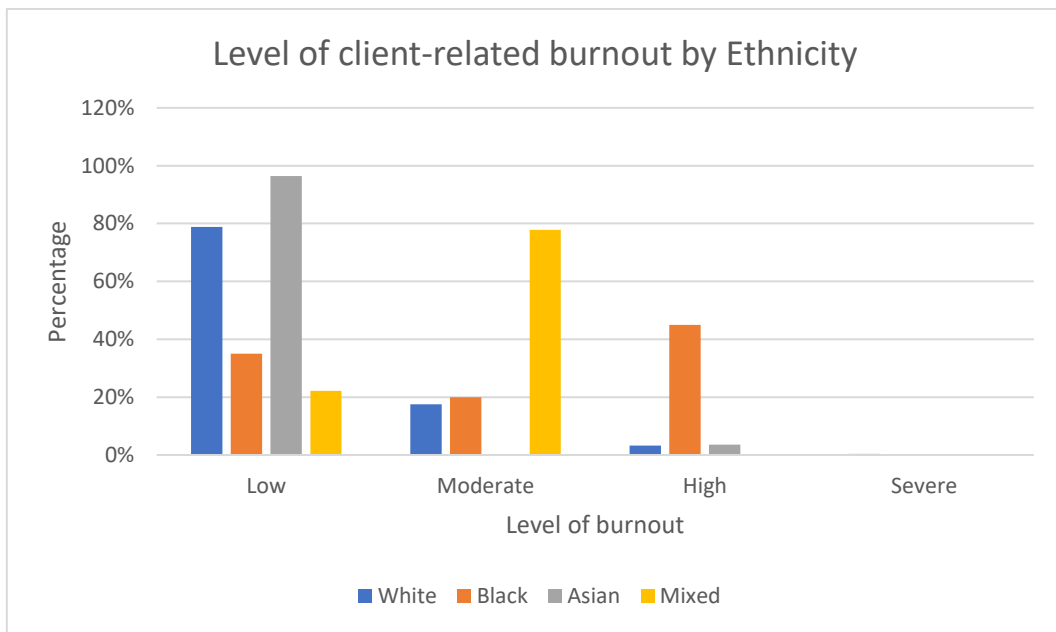


Figure A5.40: Level of Client-Related Burnout by Ethnicity (Unweighted)

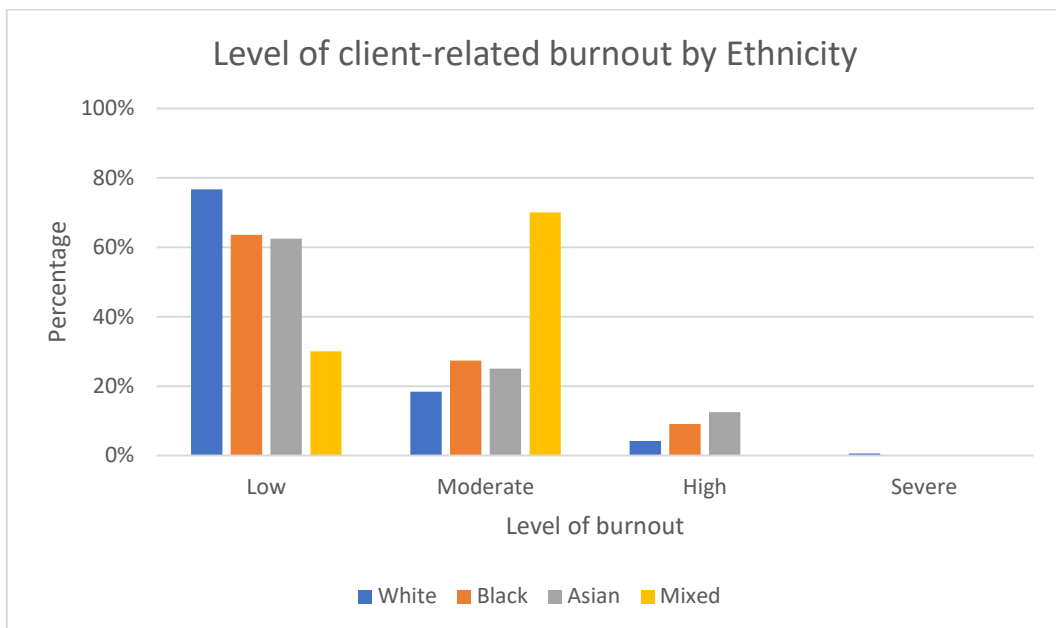


Table A5.19: Level of Burnout by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout:				
Low	20.8%	9.5%	93.1%	7.7%
Moderate	47.5%	47.6%	0.0%	61.5%
High	26.1%	42.9%	3.4%	23.1%
Severe	5.6%	0.0%	3.4%	7.7%
Total	100%	100%	100%	100%
Work-related burnout:				
Low	29.0%	42.9%	93.1%	27.3%
Moderate	44.2%	9.5%	0.0%	63.6%
High	24.7%	47.6%	6.9%	9.9%
Severe	2.1%	0.0%	0.0%	0.0%
Total	100%	100%	100%	100%
Client-related burnout:				
Low	78.8%	35.0%	96.4%	22.2%
Moderate	17.5%	20.0%	0.0%	77.8%
High	3.2%	45.0%	3.6%	0.0%
Severe	0.4%	0.0%	0.0%	0.0%
Total	100%	100%	100%	100%

Table A5.20: Level of Burnout by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout:				
Low	285 (21.5%)	3 (25.0%)	4 (50.0%)	1 (7.7%)
Moderate	592 (44.6%)	8 (66.7%)	1 (12.5%)	6 (46.2%)
High	395 (29.8%)	1 (8.3%)	2 (25.0%)	5 (38.5%)
Severe	54 (4.1%)	0 (0.0%)	1 (12.5%)	1 (7.7%)
Total	1326 (100%)	12 (100%)	8 (100%)	13 (100%)
Work-related burnout:				
Low	348 (26.8%)	9 (75.0%)	5 (55.6%)	3 (27.3%)
Moderate	553 (42.6%)	1 (8.3%)	1 (11.1%)	7 (63.6%)
High	369 (28.5%)	2 (16.7%)	3 (33.3%)	1 (9.1%)
Severe	27 (2.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	1297 (100%)	12 (100.0%)	9 (100.0%)	11 (100.0%)
Client-related burnout:				
Low	924 (76.7%)	7 (63.6%)	5 (62.5%)	3 (30.0%)
Moderate	222 (18.4%)	3 (27.3%)	2 (25.0%)	7 (70.0%)
High	51 (4.2%)	1 (9.1%)	1 (12.5%)	0 (0.0%)
Severe	7 (0.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	1204 (100%)	11 (100%)	8 (100%)	10 (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 ($F = 22.288$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who had a disability.

There were significant differences between respondents based on their disability status in mean work-related burnout scores ($F = 9.421$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who had a disability.

There were no significant differences between respondents based on their disability status in mean client burnout scores ($F = 2.200$, $df = 2$, $p = .111$).

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean personal burnout scores ($F = 24.873$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who had a disability.

There were also significant differences between respondents based on their disability status in mean work-related burnout scores ($F = 14.227$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who had a disability.

There were significant differences between respondents based on their disability status in mean client burnout scores ($F = 6.172$, $df = 2$, $p = .002$). Specifically, those who did not have a disability scored significantly lower than those who had a disability.

Figure A5.41: Mean Burnout Scores by Disability (Weighted)

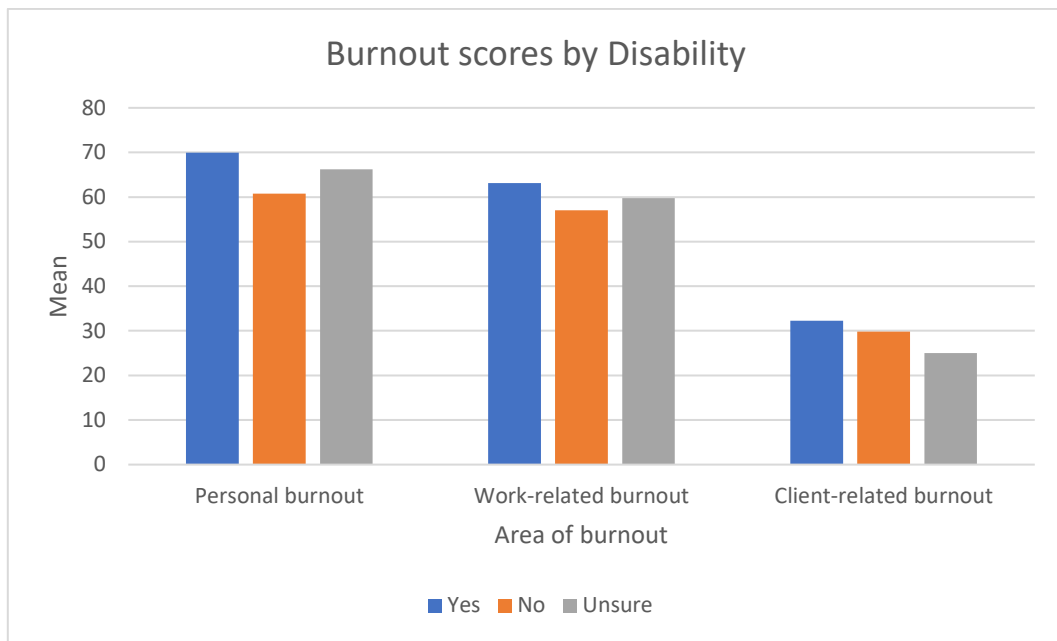


Figure A5.42: Mean Burnout Scores by Disability (Unweighted)

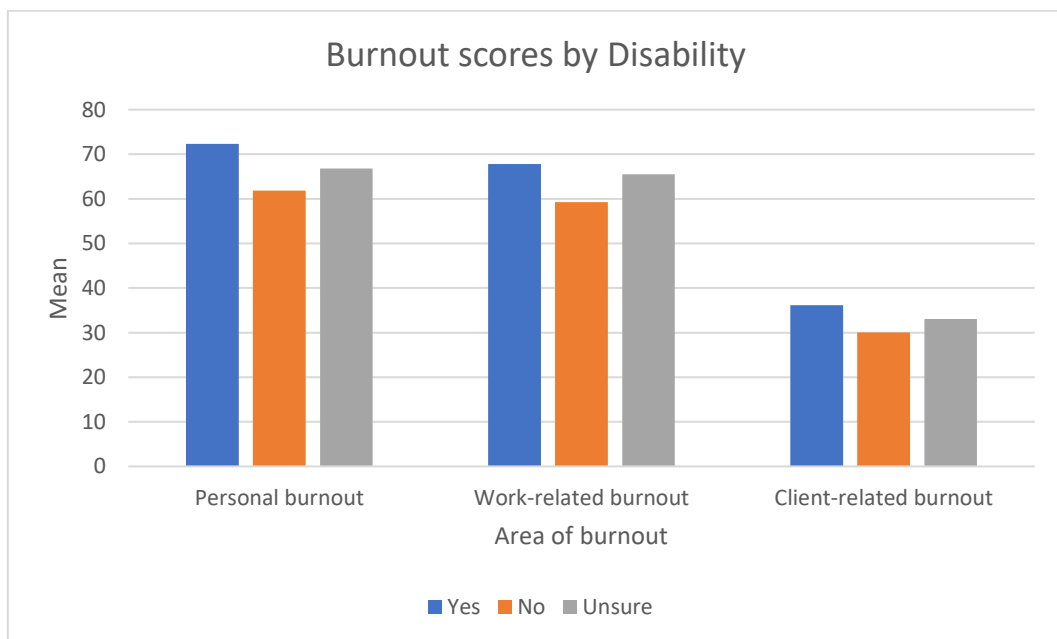


Table A5.21: Mean Burnout Scores by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	69.98	60.74	66.20
Work-related burnout	63.10	57.01	59.73
Client-related burnout	32.24	29.83	24.99

Table A5.22: Mean Burnout Scores by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	72.31	61.86	66.82
Work-related burnout	67.78	59.28	65.51
Client-related burnout	36.13	30.04	33.03

Figure A5.43: Level of Personal Burnout by Disability (Weighted)

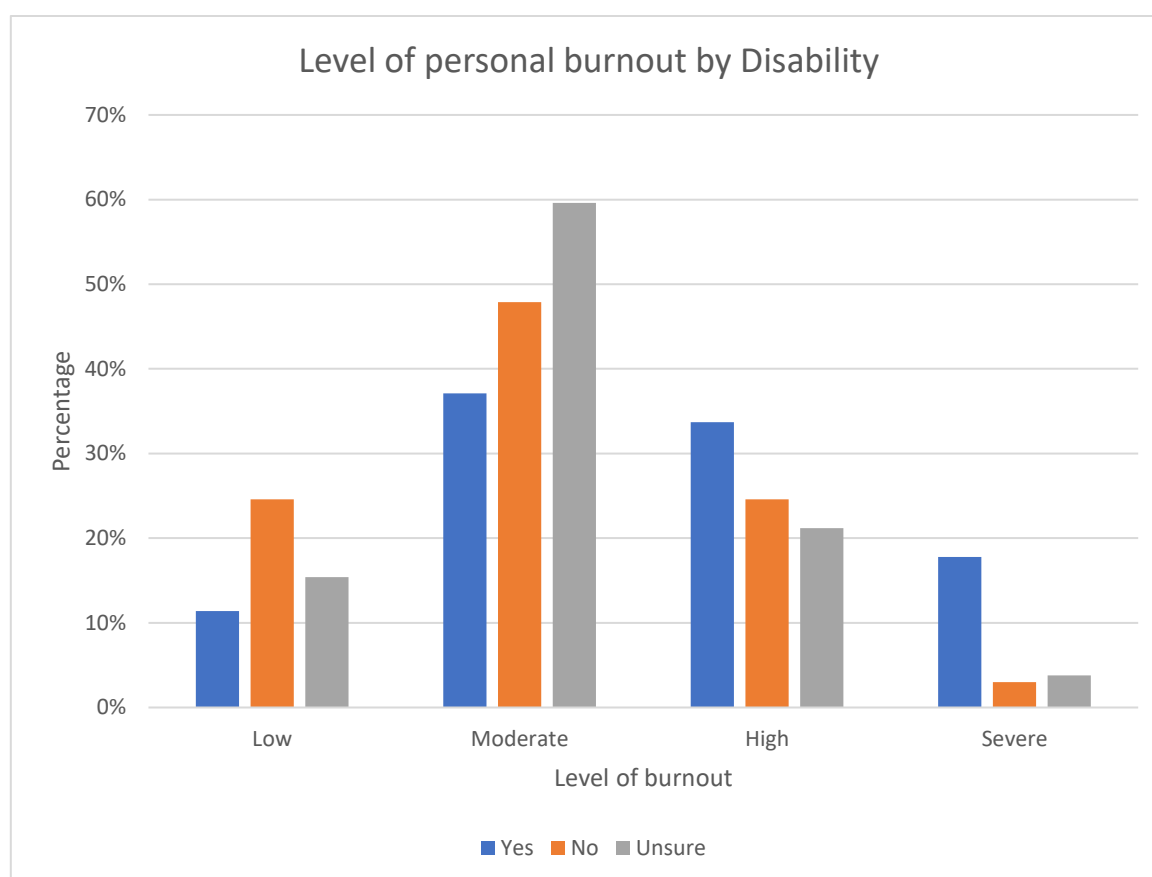


Figure A5.44: Level of Personal Burnout by Disability (Unweighted)

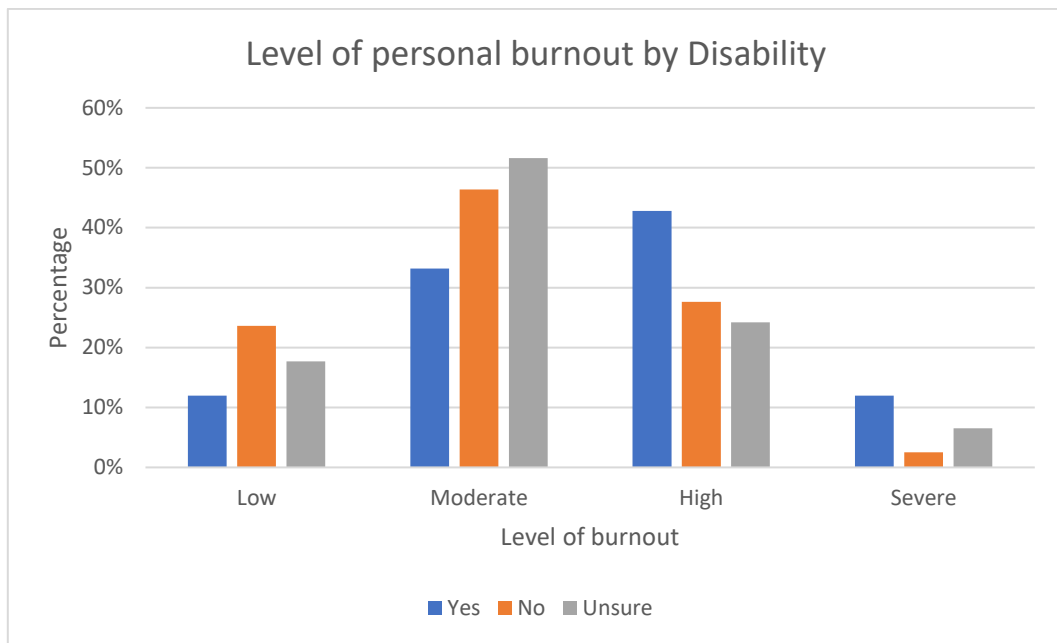


Figure A5.45: Level of Work-Related Burnout by Disability (Weighted)

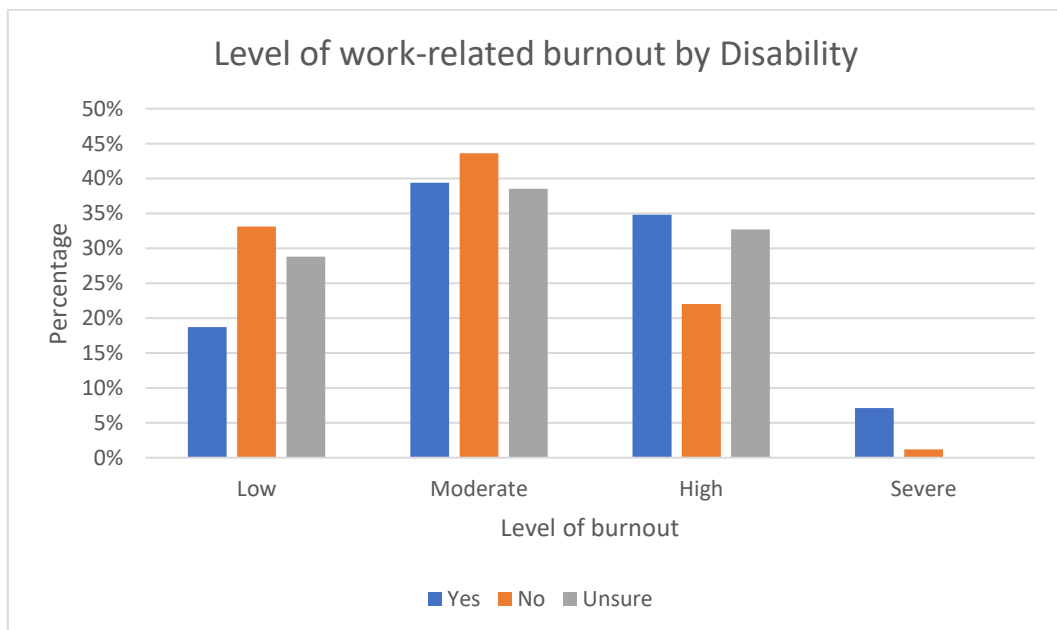


Figure A5.46: Level of Work-Related Burnout by Disability (Unweighted)

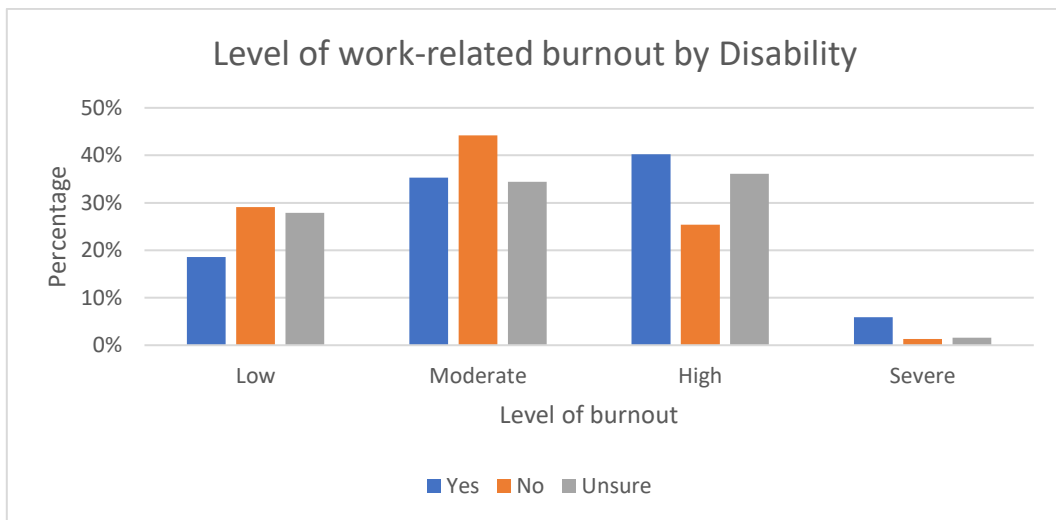


Figure A5.47: Level of Client-Related Burnout by Disability (Weighted)

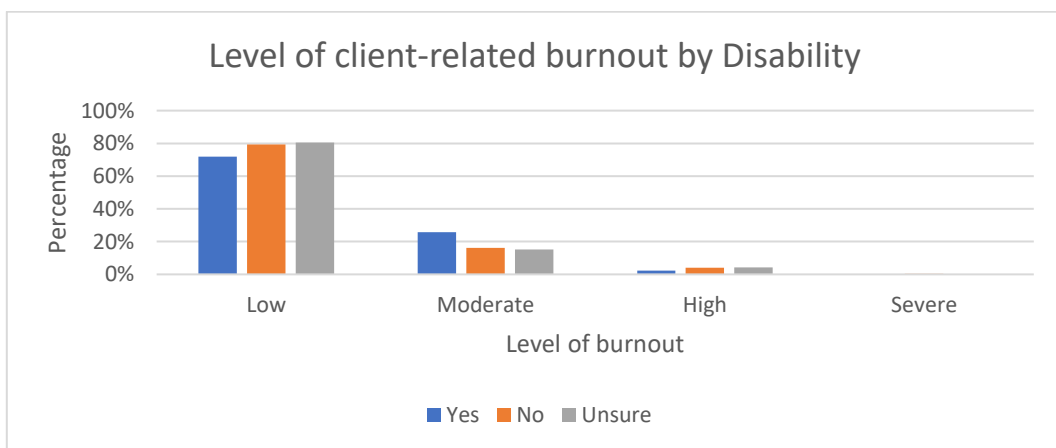


Figure A5.48: Level of Client-Related Burnout by Disability (Unweighted)

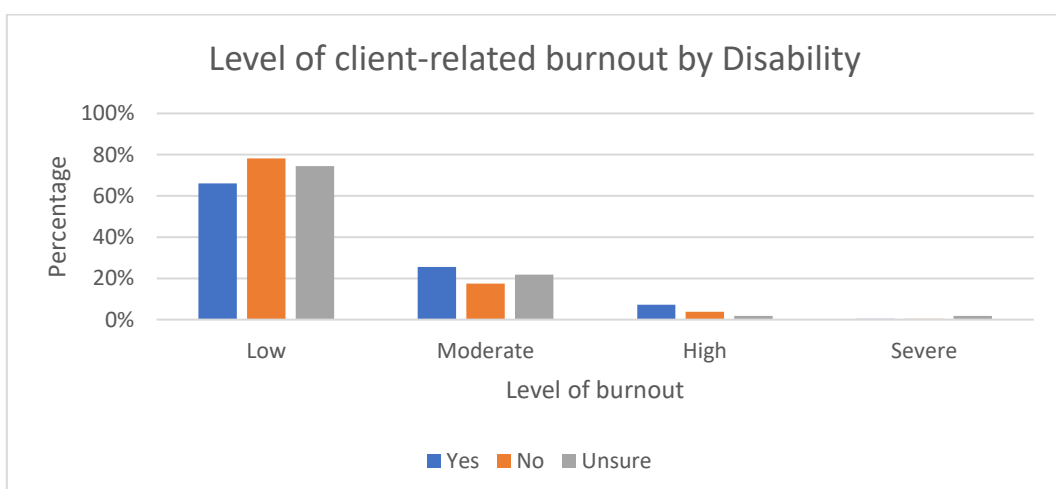


Table A5.23: Level of Burnout by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout:			
Low	11.4%	24.6%	15.4%
Moderate	37.1%	47.9%	59.6%
High	33.7%	24.6%	21.2%
Severe	17.8%	3.0%	3.8%
Total	100%	100%	100%
Work-related burnout:			
Low	18.7%	33.1%	28.8%
Moderate	39.4%	43.6%	38.5%
High	34.8%	22.0%	32.7%
Severe	7.1%	1.2%	0.0%
Total	100%	100%	100%
Client-related burnout:			
Low	71.9%	79.4%	80.4%
Moderate	25.8%	16.2%	15.2%
High	2.2%	4.1%	4.3%
Severe	0.0%	0.3%	0.0%
Total	100%	100%	100%

Table A5.24: Level of Burnout by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout:			
Low	25 (12.0%)	257 (23.6%)	11 (17.7%)
Moderate	69 (33.2%)	506 (46.4%)	32 (51.6%)
High	89 (42.8%)	301 (27.6%)	15 (24.2%)
Severe	25 (12.0%)	27 (2.5%)	4 (6.5%)
Total	208 (100%)	1091 (100%)	62 (100%)
Work-related burnout:			
Low	38 (18.6%)	310 (29.1%)	17 (27.9%)
Moderate	72 (35.3%)	471 (44.2%)	21 (34.4%)
High	82 (40.2%)	271 (25.4%)	22 (36.1%)
Severe	12 (5.9%)	14 (1.3%)	1 (1.6%)
Total	204 (100%)	1066 (100%)	61 (100%)
Client-related burnout:			
Low	127 (66.1%)	773 (78.2%)	41 (74.5%)
Moderate	49 (25.5%)	173 (17.5%)	12 (21.8%)
High	14 (7.3%)	38 (3.8%)	1 (1.8%)
Severe	4 (0.4%)	4 (0.4%)	1 (1.8%)
Total	192 (100%)	988 (100%)	55 (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 ($F = 12.410$, $df = 7$, $p < .001$). Specifically, respondents working with adults scored significantly lower in personal burnout than those working with children, learning disability, with older people, and in mental health.

There were also significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 13.621$, $df = 7$, $p < .001$). Specifically, respondents working with adults scored significantly lower in work-related burnout than those working with children, learning disability, with older people, and in mental health.

Significant differences were also found in the mean client-related burnout scores ($F = 6.849$, $df = 7$, $p < .001$). Respondents working with adults of working age scored lower than those working in mental health.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean personal burnout scores ($F = 3.415$, $df = 7$, $p < .001$). Specifically, respondents working in 'other' scored significantly lower than those working in midwifery and those working with older people.

There were significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 3.018$, $df = 7$, $p = .004$). Specifically, respondents working in 'other' scored significantly lower than those working in midwifery and those working with older people

There were significant differences between respondents based on their main area of practice in mean client-related burnout scores ($F = 2.287$, $df = 7$, $p = .026$). Specifically, respondents working with children scored significantly higher than those working in 'other'.

Figure A5.49: Mean Burnout Scores by Main Area of Practice (Weighted)

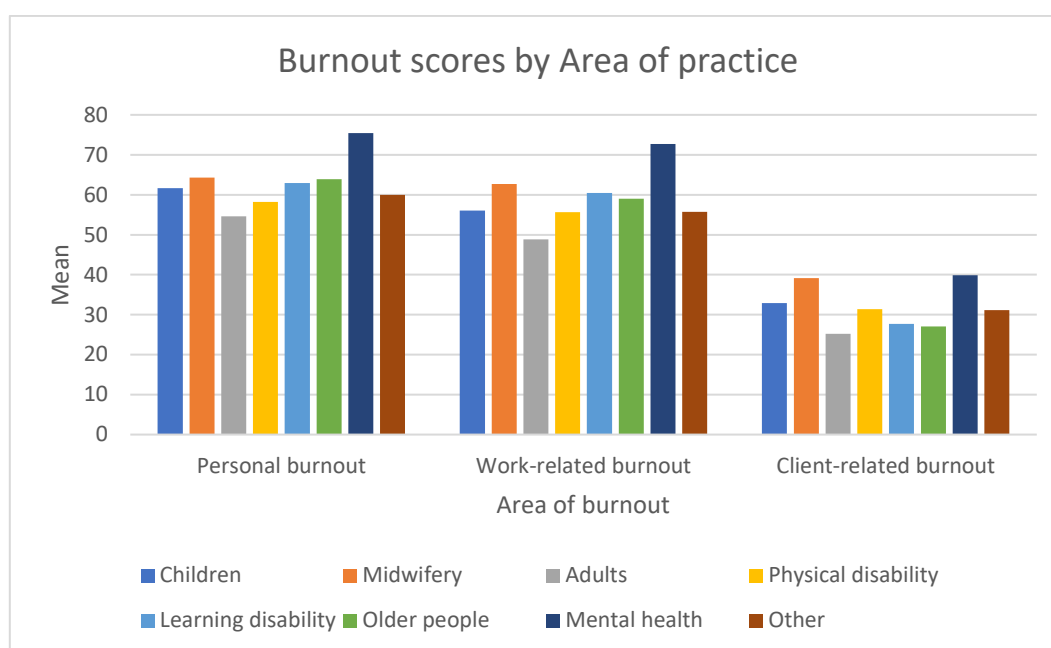


Figure A5.50: Mean Burnout Scores by Main Area of Practice (Unweighted)

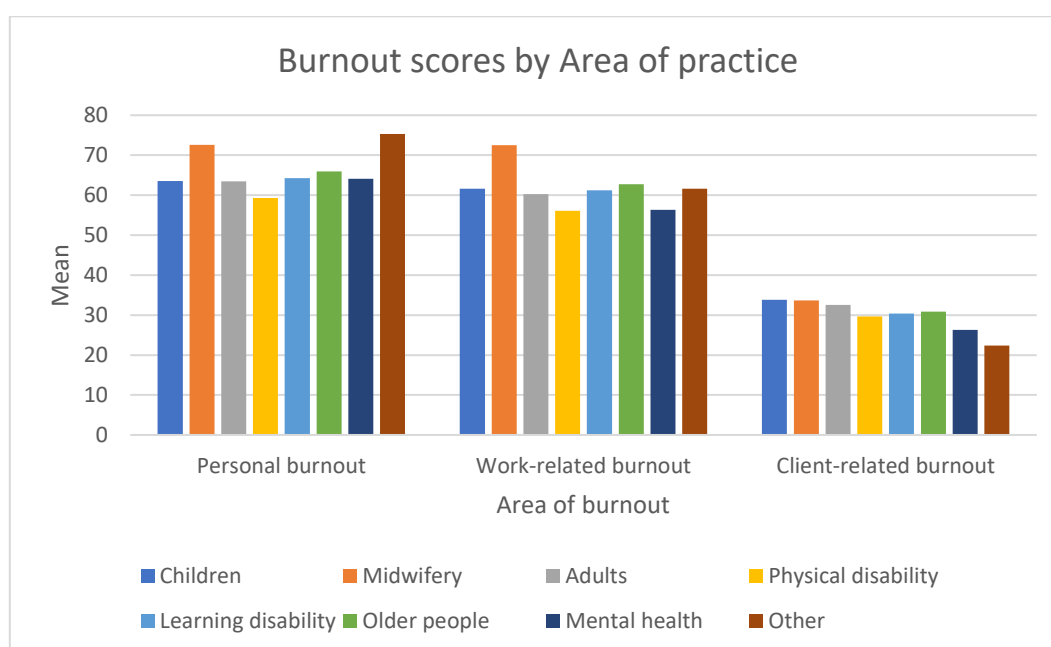


Table A5.25: Mean Burnout Scores by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout	61.62	64.28	54.60	58.22	62.90	63.93	75.47	60.00
Work-related burnout	56.05	62.72	48.83	55.61	60.48	59.02	72.68	55.70
Client-related burnout	32.92	39.16	25.23	31.40	27.72	27.04	39.89	31.18

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	63.57	72.57	63.46	59.31	64.26	65.97	64.08	59.38
Work-related burnout	61.59	72.47	60.23	56.09	61.18	62.72	61.28	56.36
Client-related burnout	33.86	33.68	32.54	29.66	30.39	30.85	33.87	26.32

Figure A5.51: Level of Personal Burnout by Main Area of Practice (Weighted)

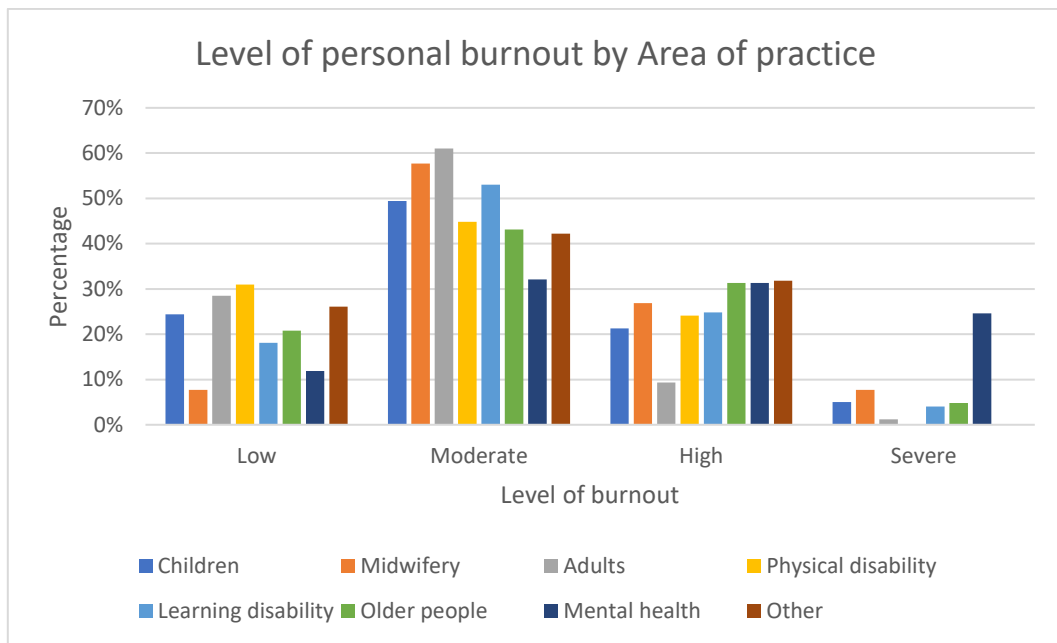


Figure A5.52: Level of Personal Burnout by Main Area of Practice (Unweighted)

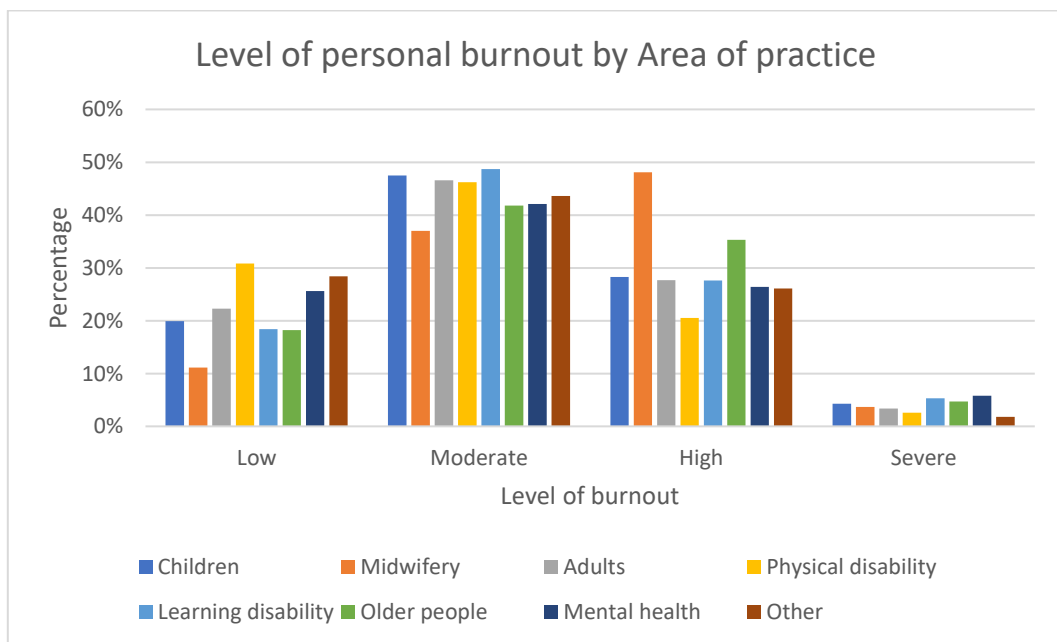


Figure A5.53: Level of Work-Related Burnout by Main Area of Practice (Weighted)

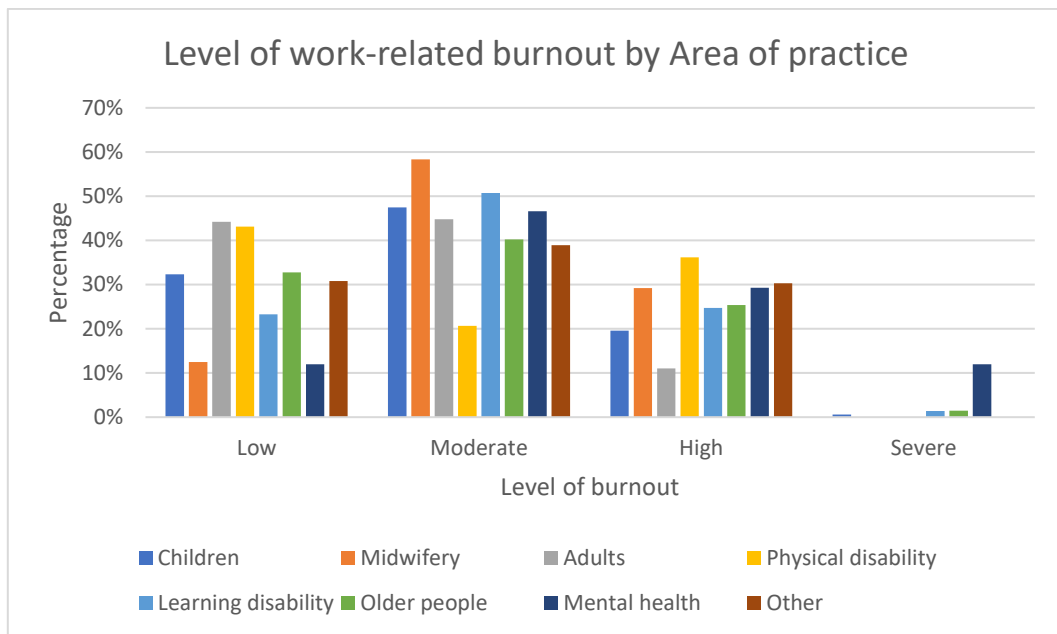


Figure A5.54: Level of Work-Related Burnout by Main Area of Practice (Unweighted)

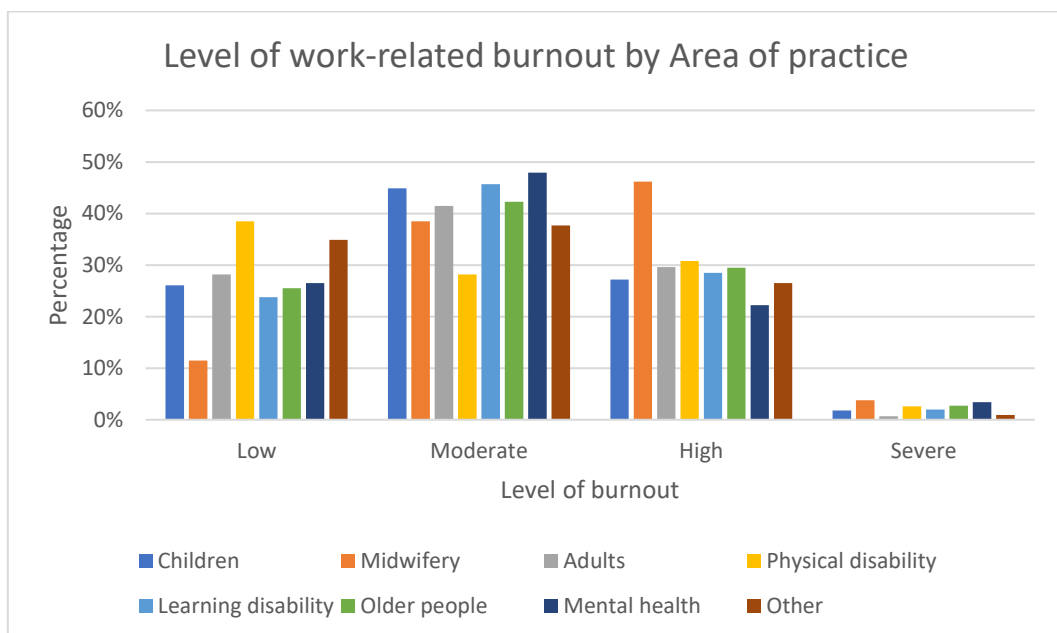


Figure A5.55: Level of Client-Related Burnout by Main Area of Practice (Weighted)

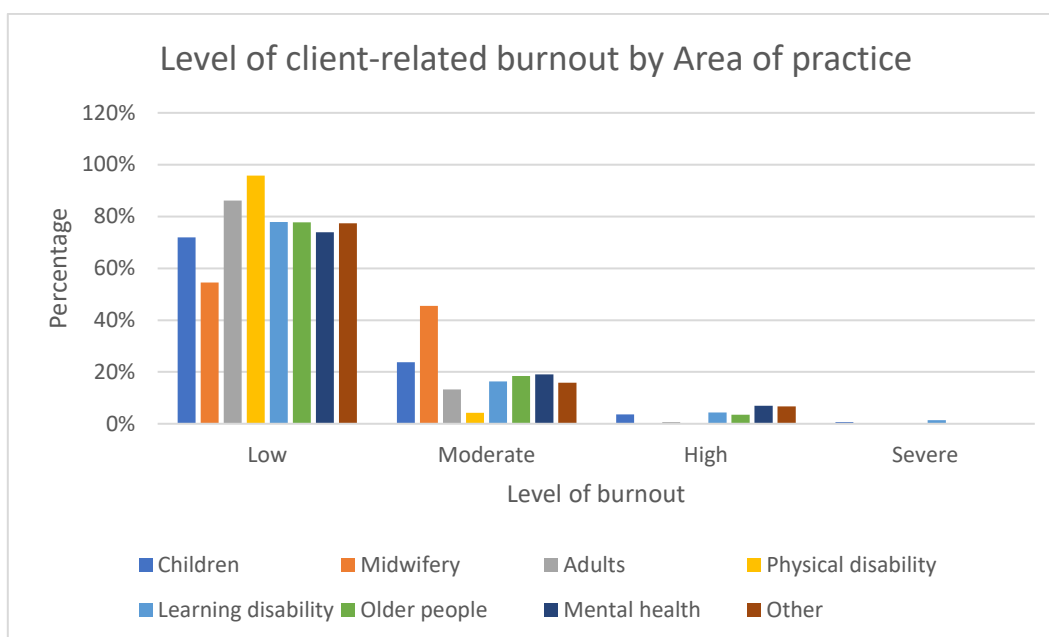


Figure A5.56: Level of Client-Related Burnout by Main Area of Practice (Unweighted)

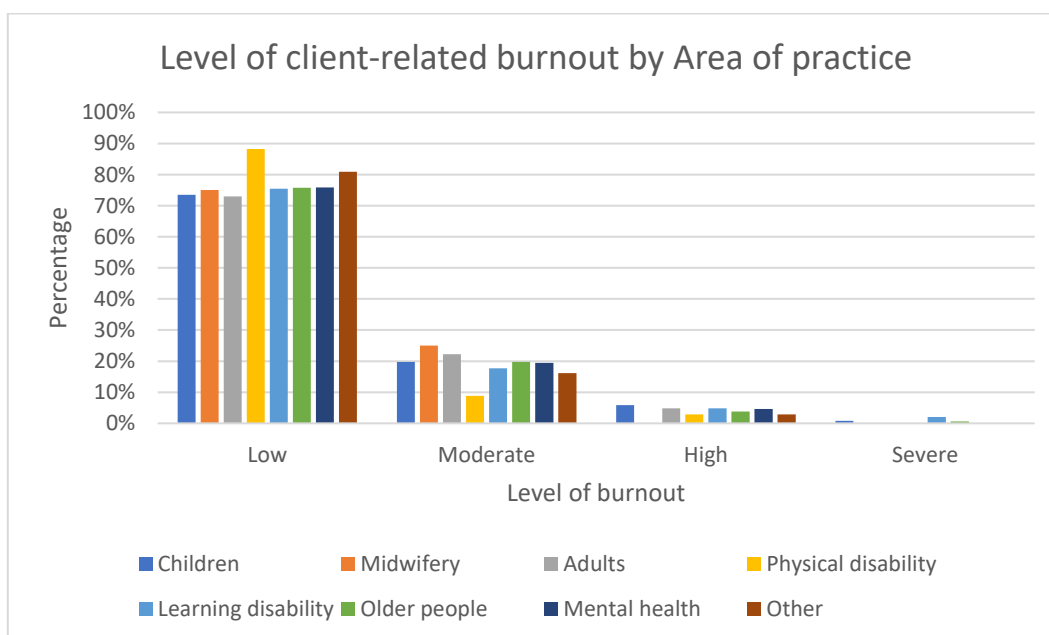


Table A5.27: Level of Burnout by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout:								
Low	24.4%	7.7%	28.5%	31.0%	18.1%	20.8%	11.9%	26.1%
Moderate	49.4%	57.7%	61.0%	44.8%	53.0%	43.1%	32.1%	42.2%
High	21.3%	26.9%	9.3%	24.1%	24.8%	31.3%	31.3%	31.8%
Severe	5.0%	7.7%	1.2%	0.0%	4.0%	4.8%	24.6%	0.0%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Work-related burnout:								
Low	32.3%	12.5%	44.2%	43.1%	23.3%	32.8%	12.0%	30.8%
Moderate	47.5%	58.3%	44.8%	20.7%	50.7%	40.2%	46.6%	38.9%
High	19.6%	29.2%	11.0%	36.2%	24.7%	25.4%	29.3%	30.3%
Severe	0.6%	0.0%	0.0%	0.0%	1.4%	1.5%	12.0%	0.0%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Client-related burnout:								
Low	71.9%	54.5%	86.1%	95.8%	77.9%	77.8%	73.9%	77.4%
Moderate	23.7%	45.5%	13.3%	4.2%	16.4%	18.4%	19.1%	15.9%
High	3.6%	0.0%	0.6%	0.0%	4.3%	3.5%	7.0%	6.7%
Severe	0.7%	0.0%	0.0%	0.0%	1.4%	0.3%	0.0%	0.0%
Total	100%	100%	100%	100%	100%	100%	100%	100%

Table A5.28: Level of Burnout by Main Area of Practice (Unweighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout:								
Low	55 (19.9%)	3 (11.1%)	33 (22.3%)	12 (30.8%)	28 (18.4%)	69 (18.2%)	31 (25.6%)	62 (28.4%)
Moderate	131 (47.5%)	10 (37.0%)	69 (46.6%)	18 (46.2%)	74 (48.7%)	159 (41.8%)	51 (42.1%)	95 (43.6%)
High	78 (28.3%)	13 (48.1%)	41 (27.7%)	8 (20.5%)	42 (27.6%)	134 (35.3%)	32 (26.4%)	57 (26.1%)
Severe	12 (4.3%)	1 (3.7%)	5 (3.4%)	1 (2.6%)	8 (5.3%)	18 (4.7%)	7 (5.8%)	4 (1.8%)
Total	276 (100%)	27 (100%)	148 (100%)	39 (100%)	152 (100%)	380 (100%)	121 (100%)	218 (100%)
Work-related burnout:								
Low	71 (26.1%)	3 (11.5%)	40 (28.2%)	15 (38.5%)	36 (23.8%)	94 (25.5%)	31 (26.5%)	75 (34.9%)
Moderate	122 (44.9%)	10 (38.5%)	59 (41.5%)	11 (28.2%)	69 (45.7%)	156 (42.3%)	56 (47.9%)	81 (37.7%)
High	74 (27.2%)	12 (46.2%)	42 (29.6%)	12 (30.8%)	43 (28.5%)	109 (29.5%)	26 (22.2%)	57 (26.5%)
Severe	5 (1.8%)	1 (3.8%)	1 (0.7%)	1 (2.6%)	3 (2.0%)	10 (2.7%)	4 (3.4%)	2 (0.9%)
Total	272 (100%)	26 (100%)	142 (100%)	39 (100%)	151 (100%)	369 (100%)	117 (100%)	215 (100%)
Client-related burnout:								
Low	186 (73.5%)	18 (75.0%)	92 (73.0%)	30 (88.2%)	111 (75.5%)	257 (75.8%)	82 (75.9%)	165 (80.9%)
Moderate	50 (19.8%)	6 (25.0%)	28 (22.2%)	3 (8.8%)	26 (17.7%)	67 (19.8%)	21 (19.4%)	33 (16.2%)
High	15 (5.9%)	0 (0.0%)	6 (4.8%)	1 (2.9%)	7 (4.8%)	13 (3.8%)	5 (4.6%)	6 (2.9%)
Severe	2 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (2.0%)	2 (0.6%)	0 (0.0%)	0 (0.0%)
Total	253 (100%)	24 (100%)	126 (100%)	34 (100%)	147 (100%)	339 (100%)	108 (100%)	204 (100%)

A5.8 Burnout Scores by Line Manager Status

Summary (Weighted results):

There were no significant differences between respondents based on their line manager status in mean person burnout scores ($t = .474$, $df = 1079.156$, $p = .639$).

There were no significant differences between respondents based on their line manager status in mean work-related burnout scores ($t = 1.123$, $df = 1085.817$, $p = .262$).

There were significant differences between respondents based on their line manager status in mean client-related burnout scores ($t = -2.395$, $df = 1152$, $p = .017$); respondents who were line managers scored significantly lower than those who were not line managers.

Summary (Unweighted results):

There were no significant differences between respondents based on their line manager status in mean personal burnout scores ($t = -.474$, $df = 1359$, $p = .636$).

There no were significant differences between respondents based on their line manager status in mean work-related burnout scores ($t = 1.033$, $df = 1329$, $p = .302$).

There were significant differences between respondents based on their line manager status in mean client-related burnout scores ($t = -3.538$, $df = 1233$, $p < .001$); 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)

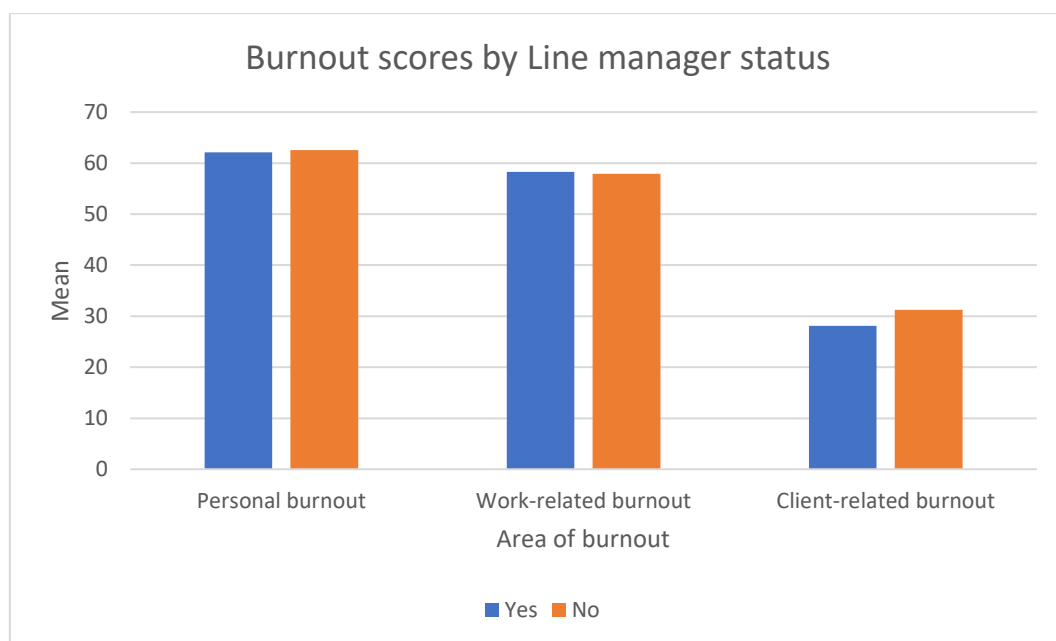


Figure A5.58: Mean Burnout Scores by Line Manager Status (Unweighted)

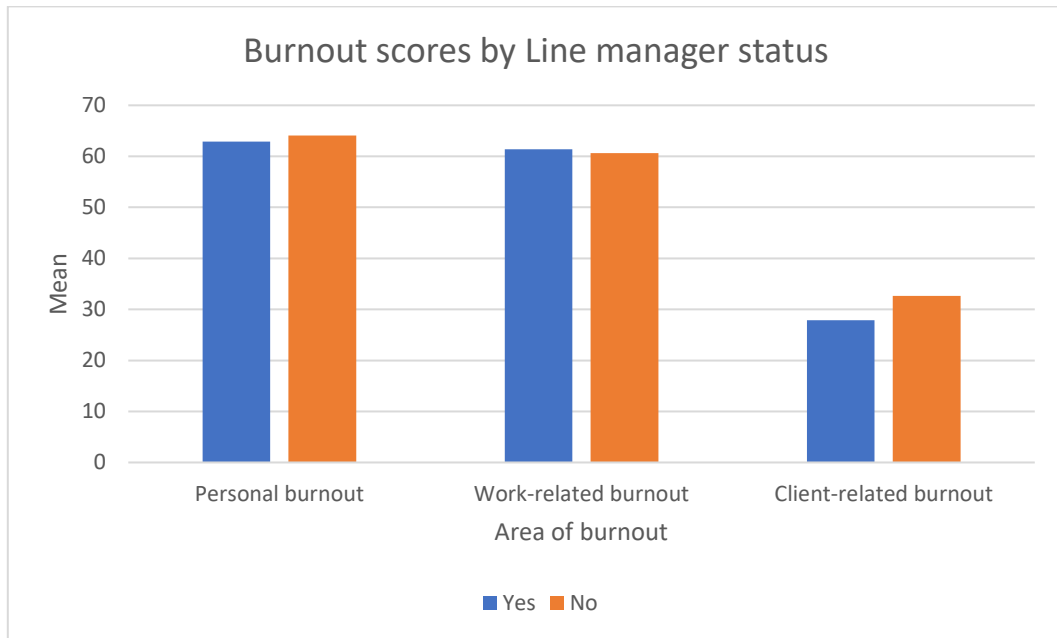


Table A5.29: Mean Burnout Scores by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	62.13	62.56
Work-related burnout	58.29	57.91
Client-related burnout	28.10	31.24

Table A5.30: Mean Burnout Scores by Line Manager Status (Unweighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	62.92	64.08
Work-related burnout	61.40	60.63
Client-related burnout	27.85	32.67

Figure A5.59: Level of Personal Burnout by Line Manager Status (Weighted)

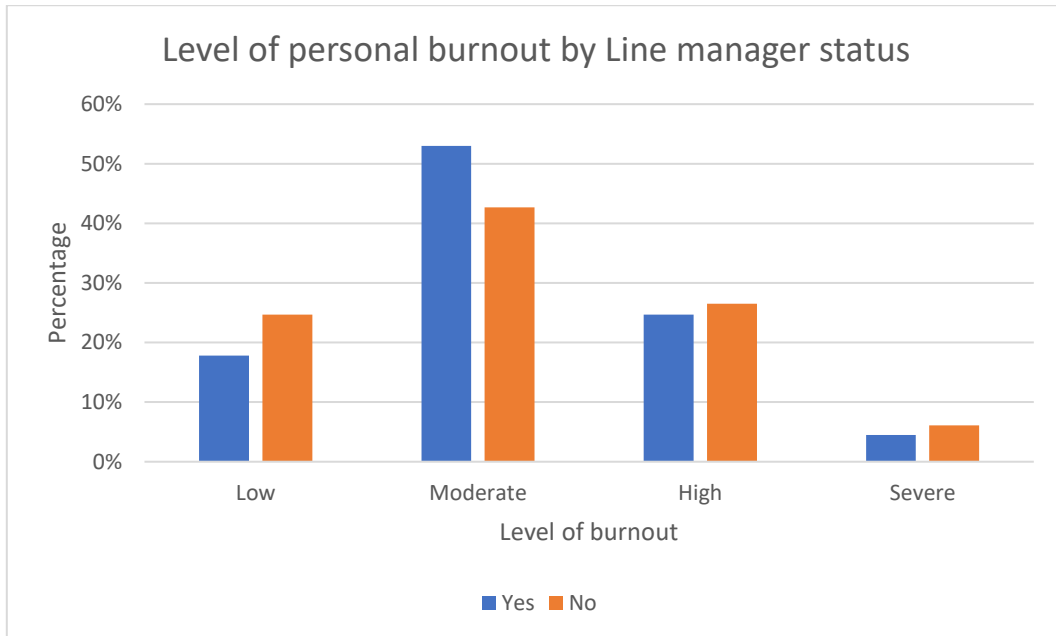


Figure A5.60: Level of Personal Burnout by Line Manager Status (Unweighted)

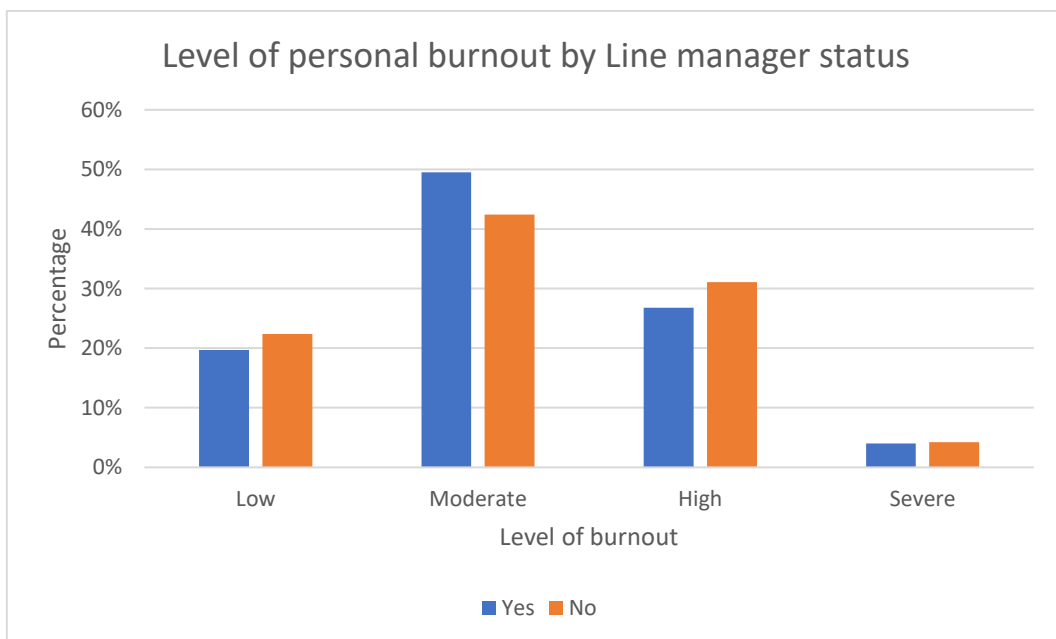


Figure A5.61: Level of Work-Related Burnout by Line Manager Status (Weighted)

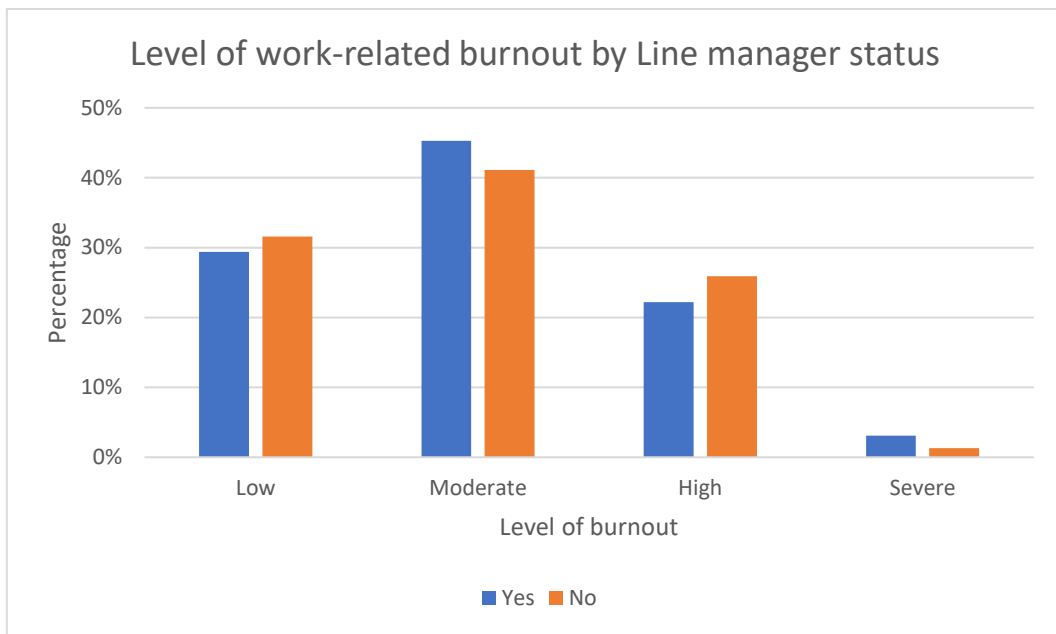


Figure A5.62: Level of Work-Related Burnout by Line Manager Status (Unweighted)

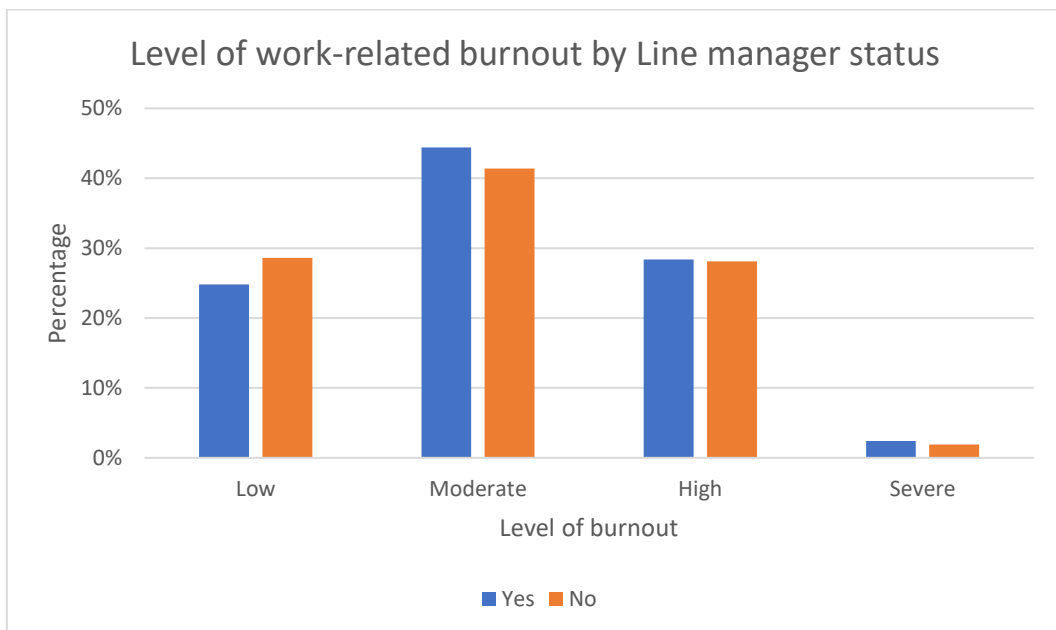


Figure A5.63: Level of Client-Related Burnout by Line Manager Status (Weighted)

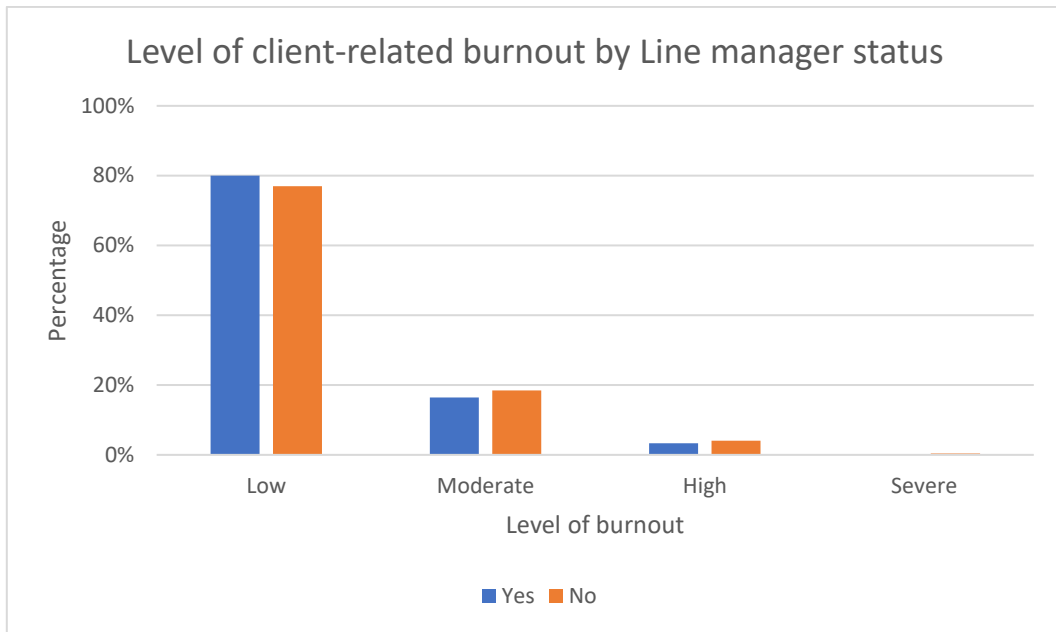


Figure A5.64: Level of Client-Related Burnout by Line Manager Status (Unweighted)

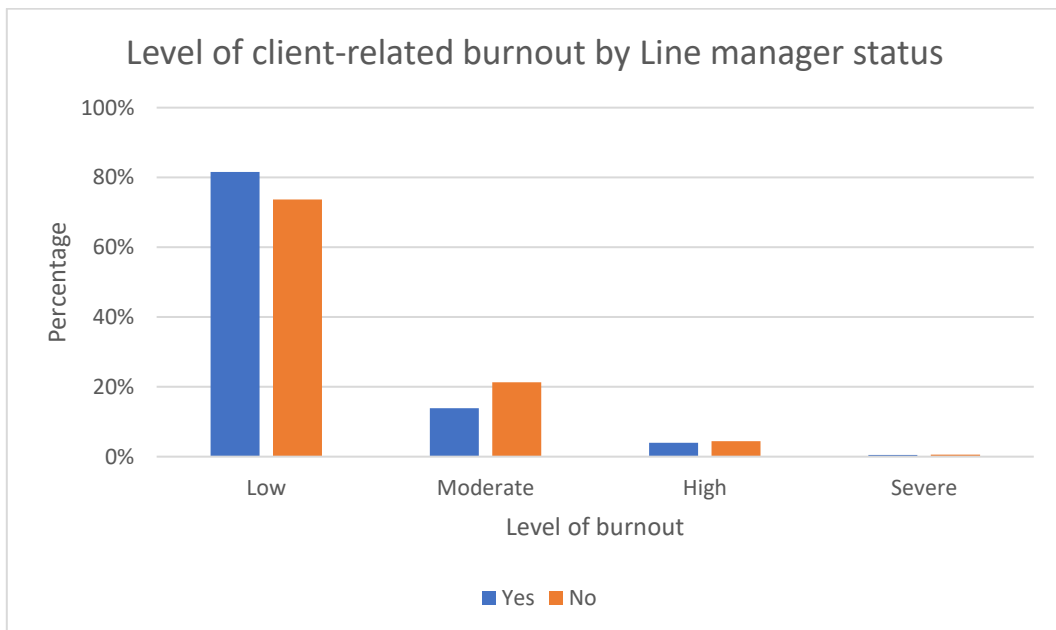


Table A5.31: Level of Burnout by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout:		
Low	17.8%	24.7%
Moderate	53.0%	42.7%
High	24.7%	26.5%
Severe	4.5%	6.1%
TOTAL	100%	100%
Work-related burnout:		
Low	29.4%	31.6%
Moderate	45.3%	41.1%
High	22.2%	25.9%
Severe	3.1%	1.3%
TOTAL	100%	100%
Client-related burnout:		
Low	80.0%	77.0%
Moderate	16.4%	18.5%
High	3.3%	4.1%
Severe	0.2%	0.4%
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	84 (19.7%)	209 (22.4%)
Moderate	211 (49.5%)	396 (42.4%)
High	114 (26.8%)	291 (31.1%)
Severe	17 (4.0%)	39 (4.2%)
TOTAL	426 (100%)	935 (100%)
Work-related burnout:		
Low	105 (24.8%)	260 (28.6%)
Moderate	188 (44.4%)	376 (41.4%)
High	120 (28.4%)	255 (28.1%)
Severe	10 (2.4%)	17 (1.9%)
TOTAL	423 (100%)	908 (100%)
Client-related burnout:		
Low	323 (81.6%)	618 (73.7%)
Moderate	55 (13.9%)	179 (21.3%)
High	16 (4.0%)	37 (4.4%)
Severe	2 (0.5%)	5 (0.6%)
TOTAL	396 (100%)	839 (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 ($F = 85.112$, $df = 2$, $p < .001$). Specifically, those who overwhelmed scored significantly higher than those not impacted and those only impacted but not significantly.

There were also significant differences in mean work-related burnout scores between respondents who experienced different levels of pressure on their service due to the COVID-19 pandemic ($F = 84.962$ $df = 2$, $p < .001$). Specifically, those who overwhelmed scored significantly higher than those not impacted and those only impacted but not significantly.

There were also significant differences in mean work-related burnout scores between respondents who experienced different levels of pressure on their service due to the COVID-19 pandemic ($F = 9.177$ $df = 2$, $p < .001$). Specifically, those who overwhelmed scored significantly higher than those not impacted.

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 ($F = 94.643$, $df = 2$, $p < .001$). 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 ($F = 127.644$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact and those who felt no impact.

Significant differences existed in client-related burnout scores between respondents who experienced different levels of pressure on their service were also found ($F = 11.498$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than those who were impacted but not significantly.

Figure A5.65: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

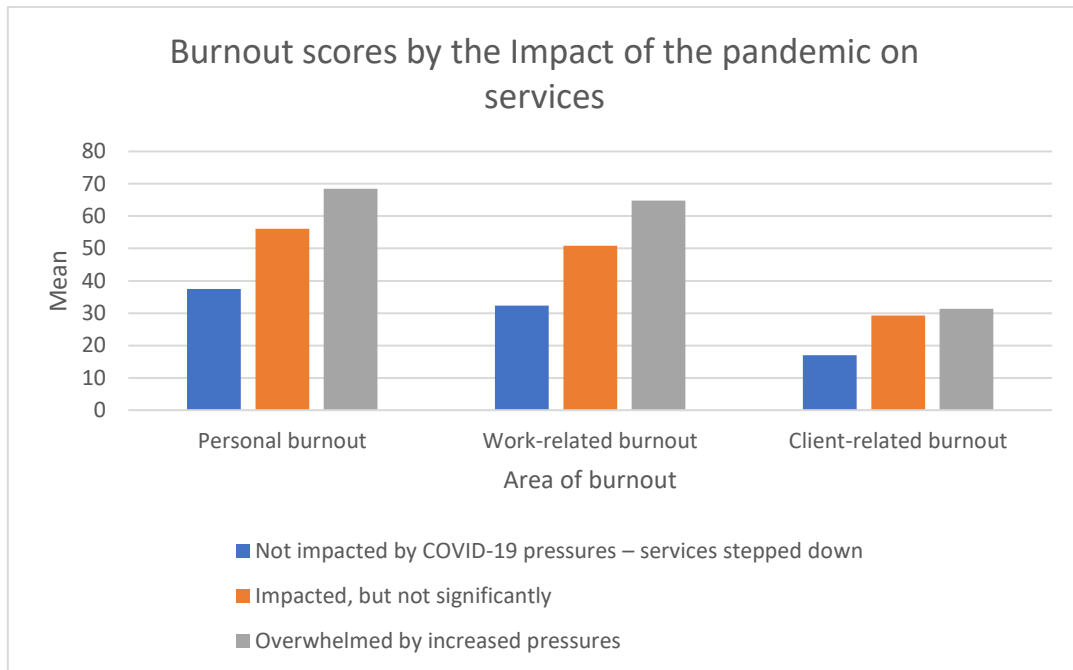


Figure A5.66: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

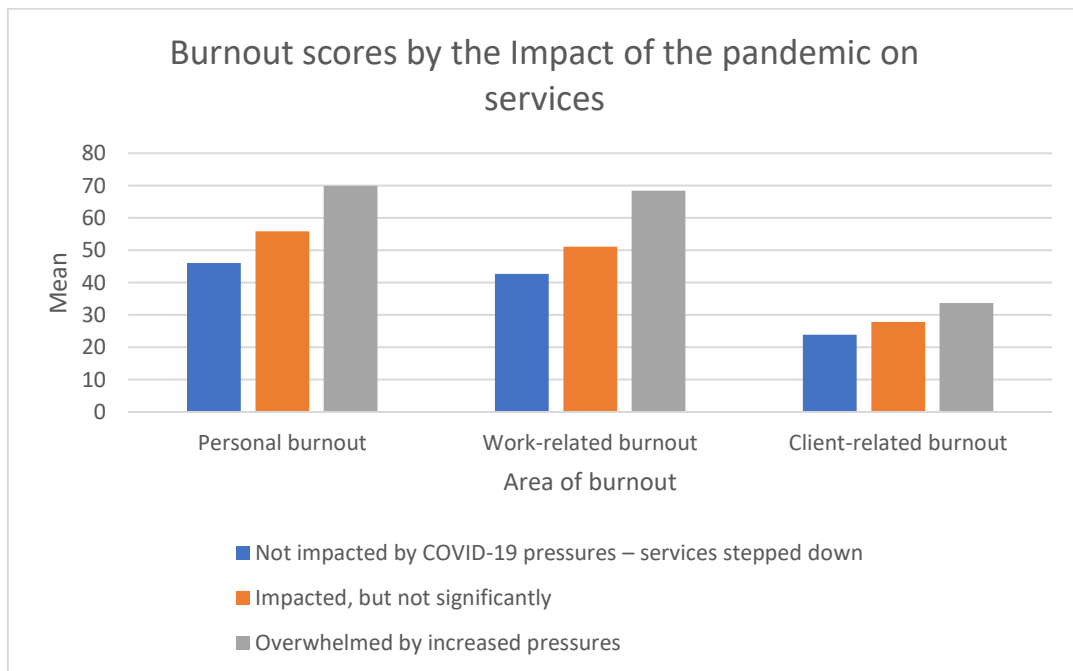


Table A5.33: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout	37.46	56.04	68.46
Work-related burnout	32.33	50.80	64.81
Client-related burnout	17.02	29.26	31.36

Table A5.34: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout	46.10	55.83	69.91
Work-related burnout	42.74	51.10	68.40
Client-related burnout	23.92	27.85	33.66

Figure A5.67: Level of Personal Burnout by the Impact of the Pandemic on Services (Weighted)

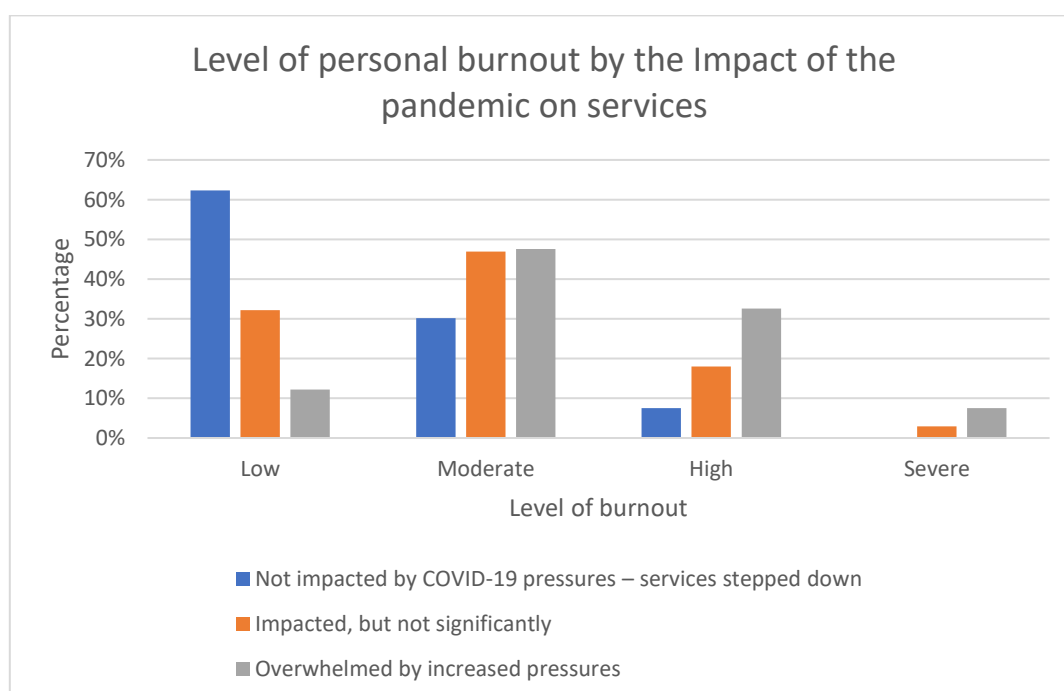


Figure A5.68: Level of Personal Burnout by the Impact of the Pandemic on Services (Unweighted)

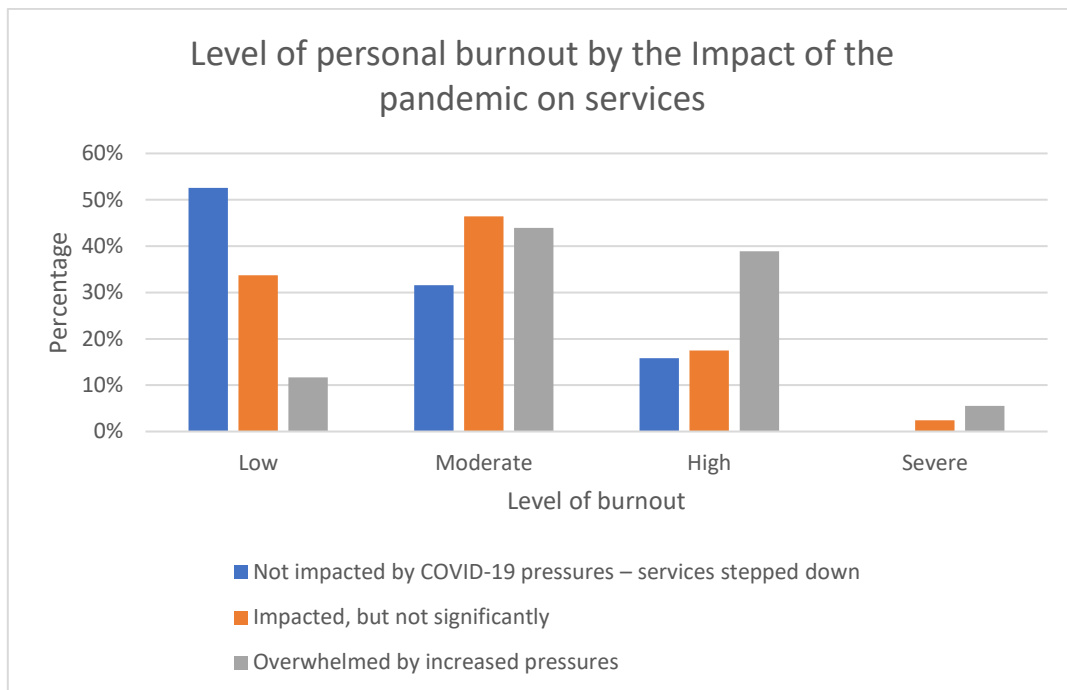


Figure A5.69: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Weighted)

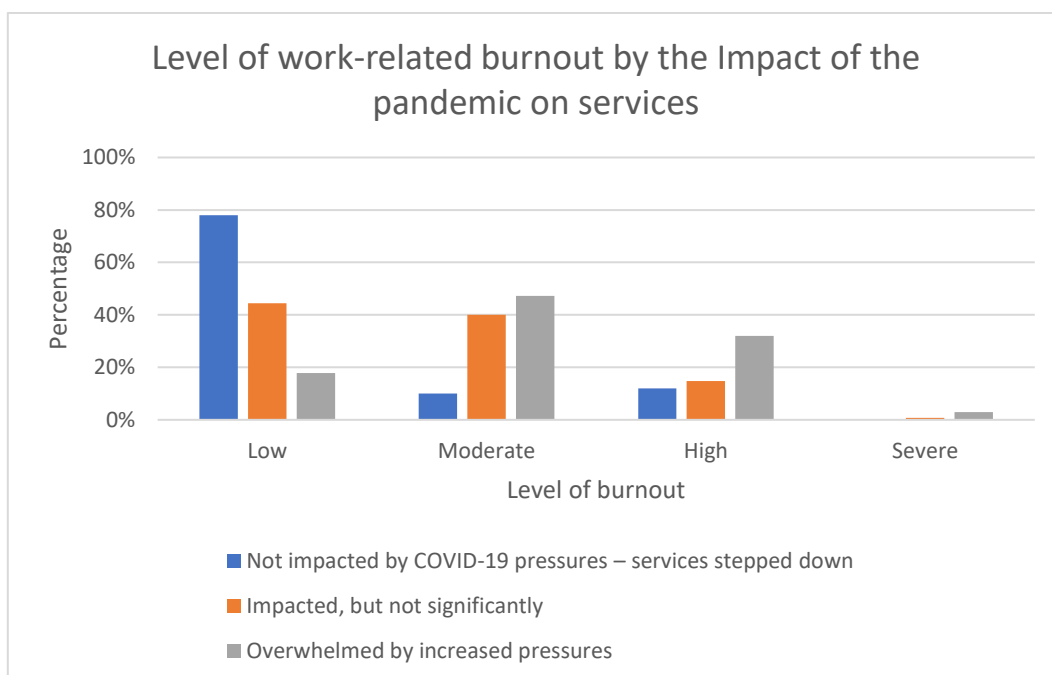


Figure A5.70: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

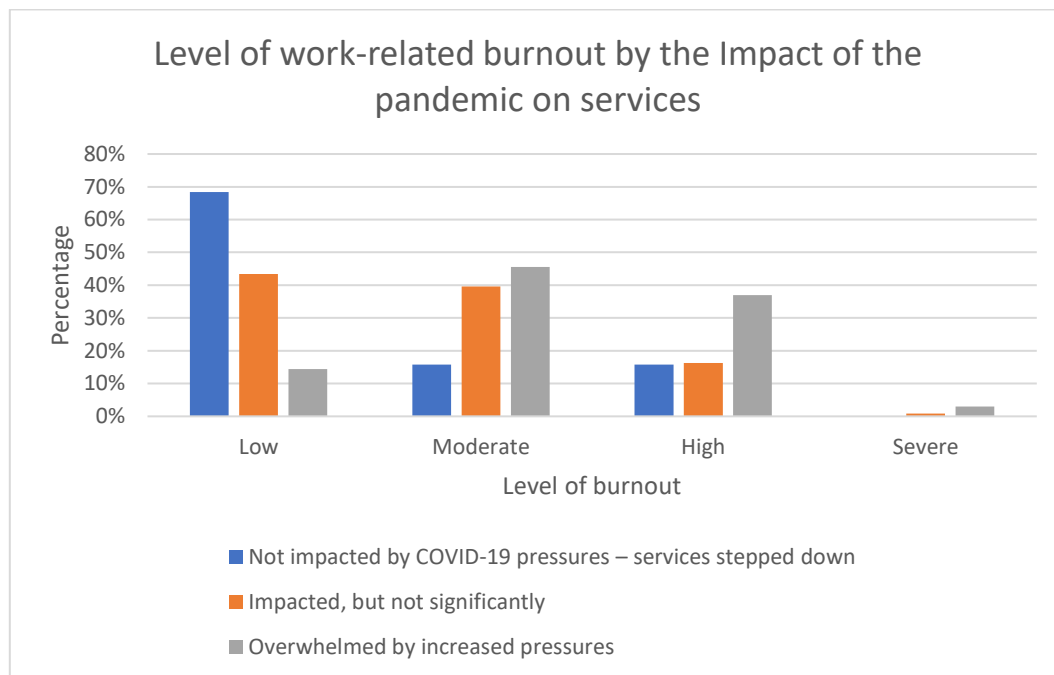


Figure A5.71: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Weighted)

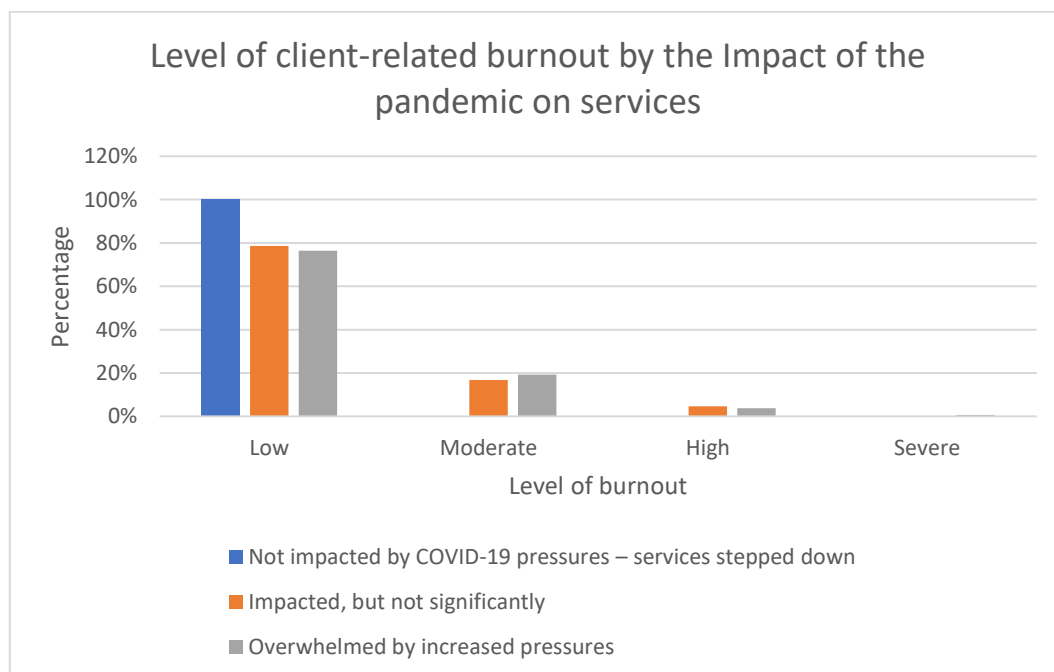


Figure A5.72: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

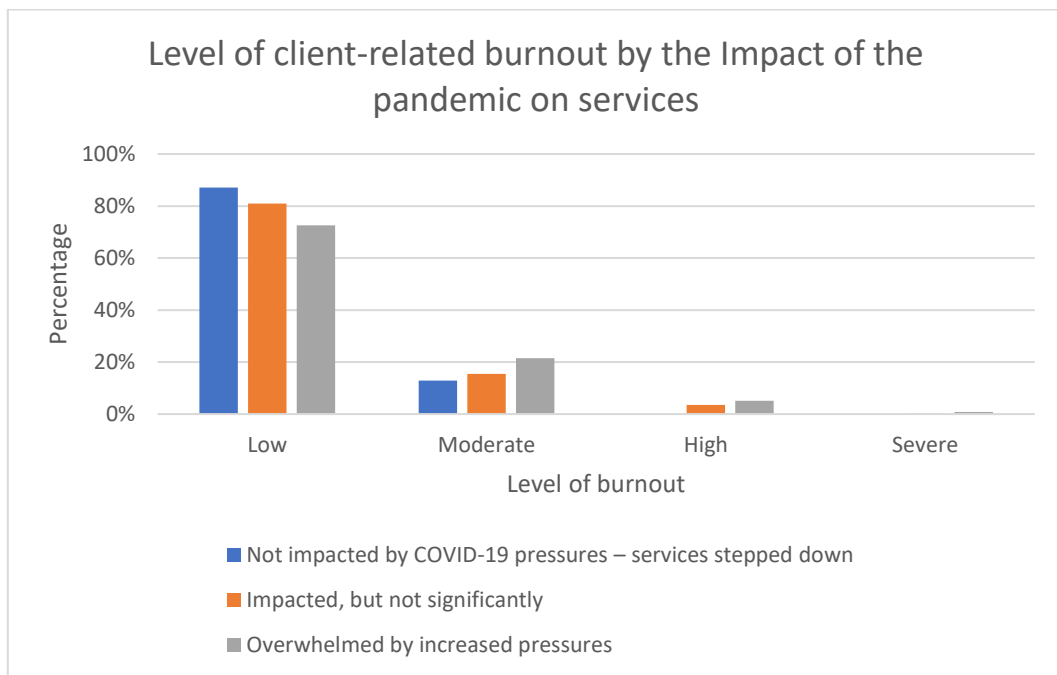


Table A5.35: Level of Burnout by the Impact of the Pandemic on Services (Weighted)

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	62.3%	32.2%	12.2%
Moderate	30.2%	46.9%	47.6%
High	7.5%	18.0%	32.6%
Severe	0.0%	2.9%	7.5%
TOTAL	100%	100%	100%
Work-related burnout:			
Low	78.0%	44.5%	17.8%
Moderate	10.0%	40.0%	47.2%
High	12.0%	14.8%	32.0%
Severe	0.0%	0.8%	3.0%
TOTAL	100%	100%	100%
Client-related burnout:			
Low	100%	78.6%	76.4%
Moderate	0.0%	16.8%	19.3%
High	0.0%	4.6%	3.7%
Severe	0.0%	0.0%	0.6%
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	20 (52.6%)	181 (33.7%)	92 (11.7%)
Moderate	12 (31.6%)	249 (46.4%)	344 (43.9%)
High	6 (15.8%)	94 (17.5%)	305 (38.9%)
Severe	0 (0.0%)	13 (2.4%)	43 (5.5%)
TOTAL	38 (100%)	537 (100%)	784 (100%)
Work-related burnout:			
Low	26 (68.4%)	229 (43.4%)	110 (14.4%)
Moderate	6 (15.8%)	209 (39.6%)	348 (45.6%)
High	6 (15.8%)	86 (16.3%)	282 (37.0%)
Severe	0 (0.0%)	4 (0.8%)	23 (3.0%)
TOTAL	38 (100%)	528 (100%)	763 (100%)
Client-related burnout:			
Low	27 (87.1%)	397 (80.9%)	516 (72.6%)
Moderate	4 (12.9%)	76 (15.5%)	153 (21.5%)
High	0 (0.0%)	17 (3.5%)	36 (5.1%)
Severe	0 (0.0%)	1 (0.2%)	6 (0.8%)
TOTAL	31 (100%)	491 (100%)	711 (100%)

A5.10 Burnout Scores by Uptake of Employer Support

Summary (Weighted results):

There were significant differences in personal burnout scores between respondents based on whether they took on employer support or not ($t = 3.246$, $df = 1262$, $p < .001$). Respondents who took employer support reported higher scores of personal burnout.

There were significant differences in work-related burnout scores between respondents based on whether they took on employer support or not ($t = 3.081$, $df = 1237$, $p = .002$). Respondents who took employer support reported higher scores of work-related burnout.

There were no significant differences in client-related burnout scores between respondents based on whether they took on employer support or not ($t = 1.855$, $df = 1152$, $p = .064$).

Summary (Unweighted results):

There were significant differences in personal burnout scores between respondents based on whether they took on employer support or not ($t = 5.495$, $df = 1359$, $p < .001$). Respondents who took employer support reported higher scores of personal burnout.

There were significant differences in work-related burnout scores between respondents based on whether they took on employer support or not ($t = 3.824$, $df = 1329$, $p < .001$). Respondents who took employer support reported higher scores of work-related burnout.

There were no significant differences in client-related burnout scores between respondents based on whether they took on employer support or not ($t = .258$, $df = 1233$, $p = .797$).

Figure A5. 73: Mean Burnout Scores by Uptake of Employer Support (Weighted)

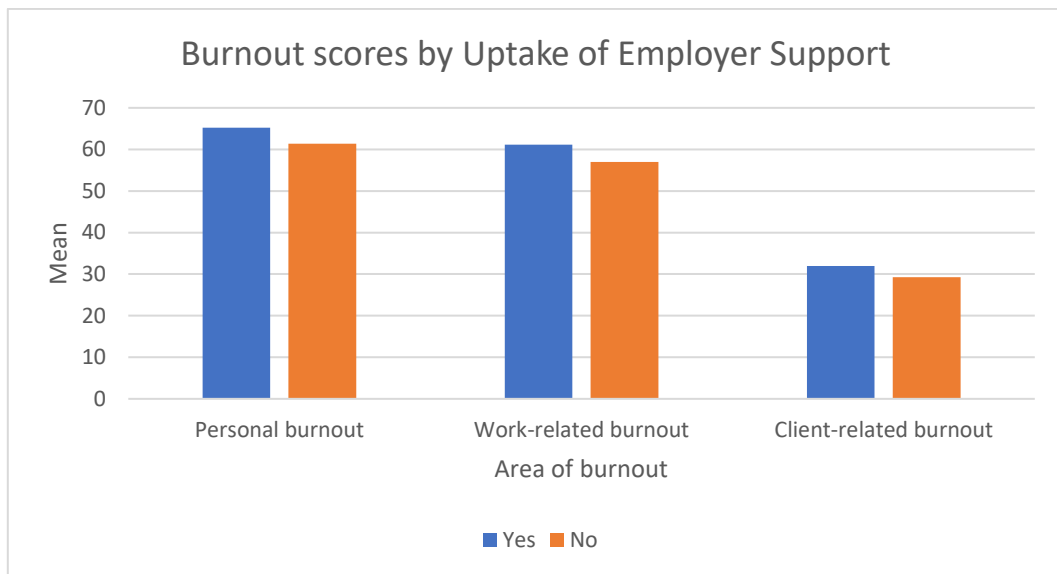


Figure A5. 74: Mean Burnout Scores by Uptake of Employer Support (Unweighted)

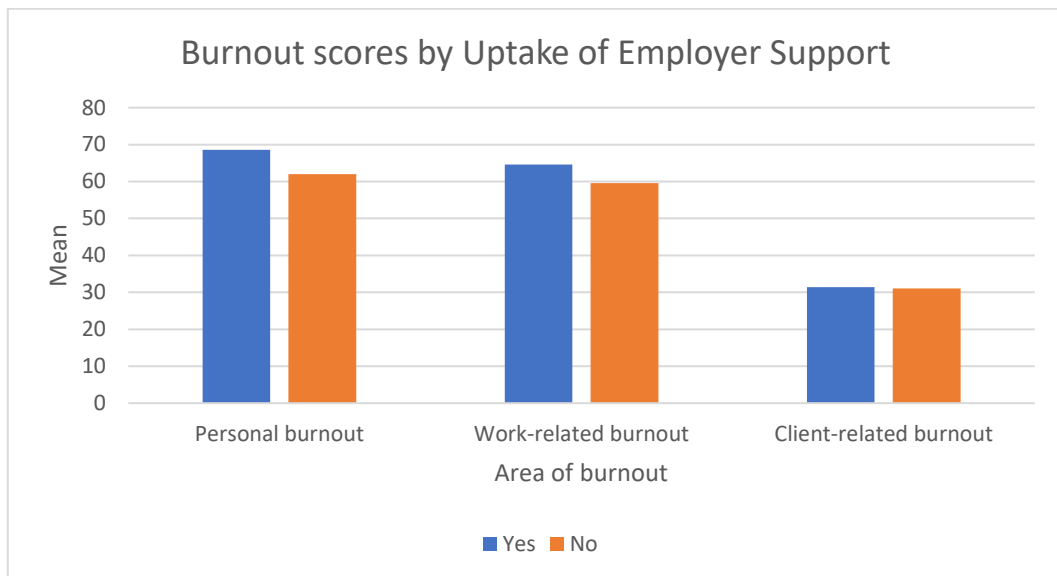


Table A5. 37: Mean Burnout Scores by Uptake of Employer Support (Weighted)

Burnout	Uptake of Employer Support	
	Yes	No
Personal burnout	65.23	61.36
Work-related burnout	61.14	56.95
Client-related burnout	31.98	29.30

Table A5. 38: Mean Burnout Scores by Uptake of Employer Support (Unweighted)

Burnout	Uptake of Employer Support	
	Yes	No
Personal burnout	68.55	61.99
Work-related burnout	64.60	59.56
Client-related burnout	31.40	31.02

Figure A5. 75: Level of Personal Burnout by Uptake of Employer Support (Weighted)

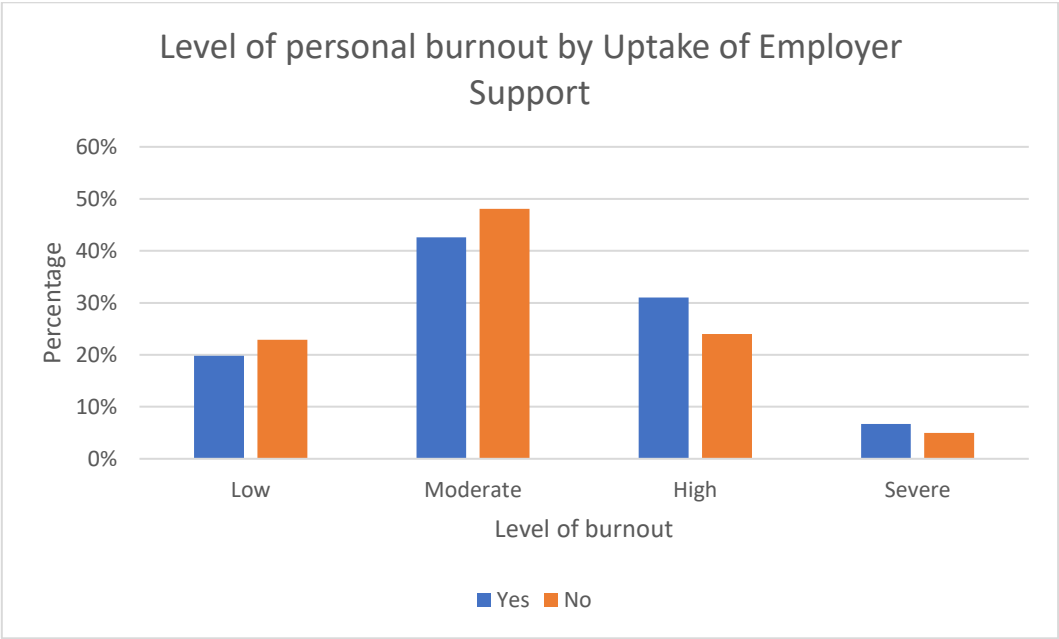


Figure A5.76: Level of Personal Burnout by Uptake of Employer Support Unweighted)

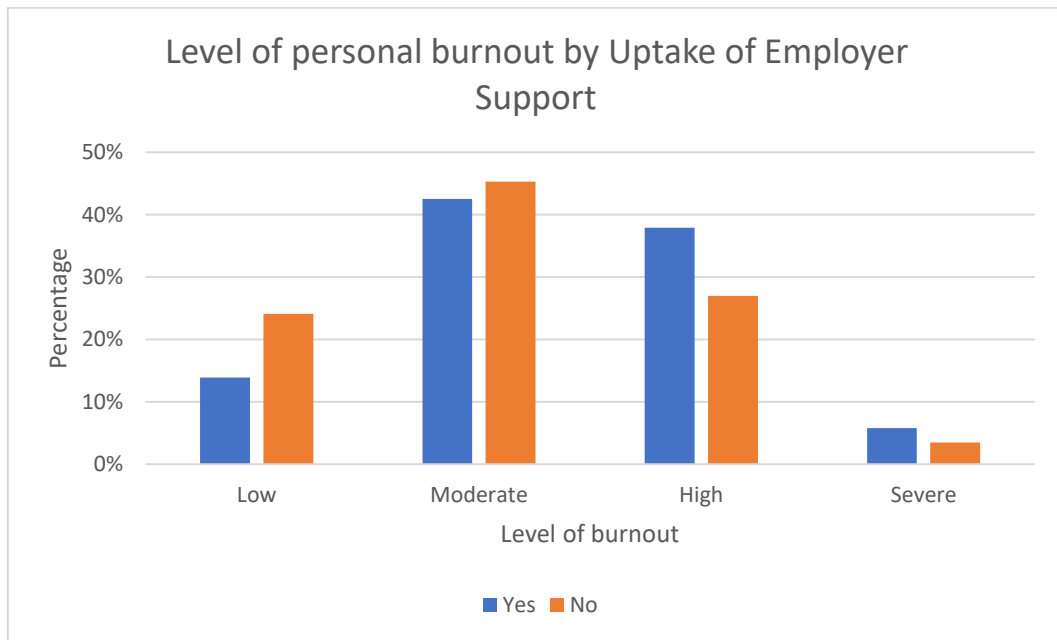


Figure A5. 77: Level of Work-Related Burnout by Uptake of Employer Support (Weighted)

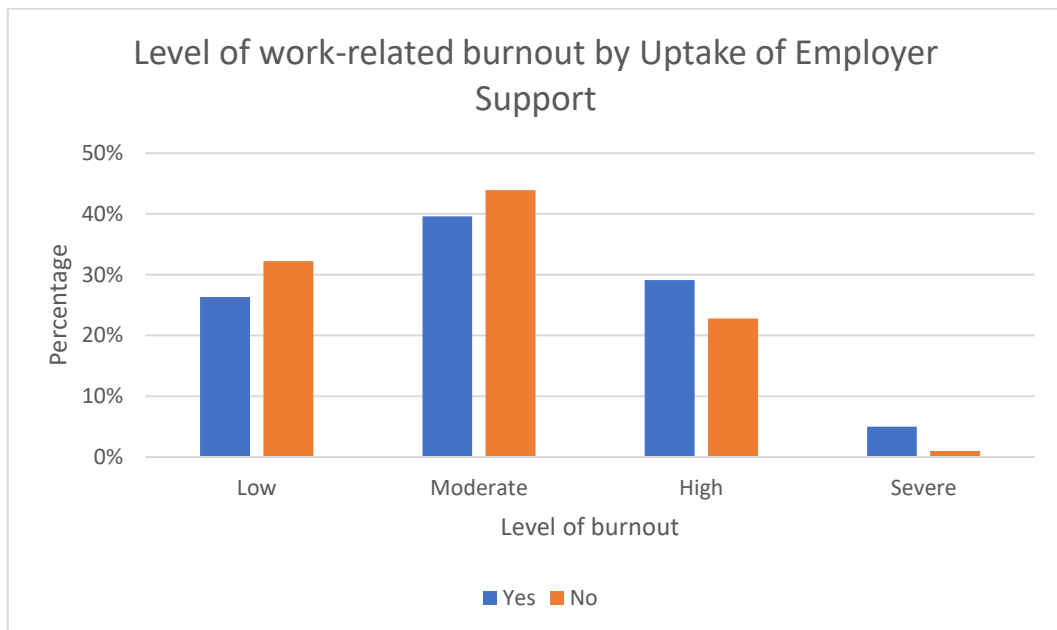


Figure A5. 78: Level of Work-Related Burnout by Uptake of Employer Support (Unweighted)

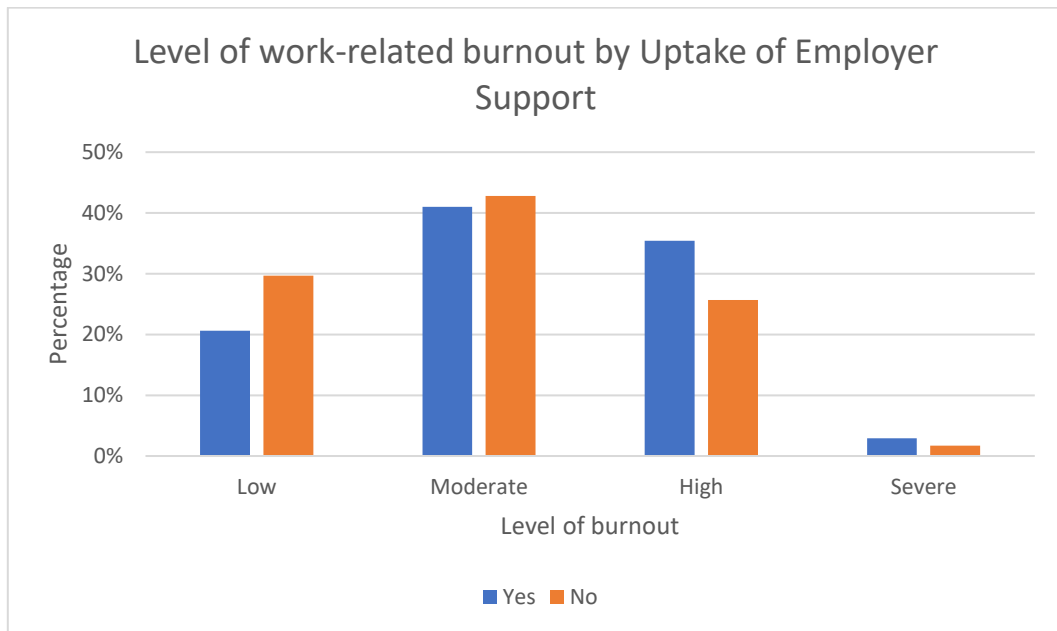


Figure A5. 79: Level of Client-Related Burnout by Uptake of Employer Support (Weighted)

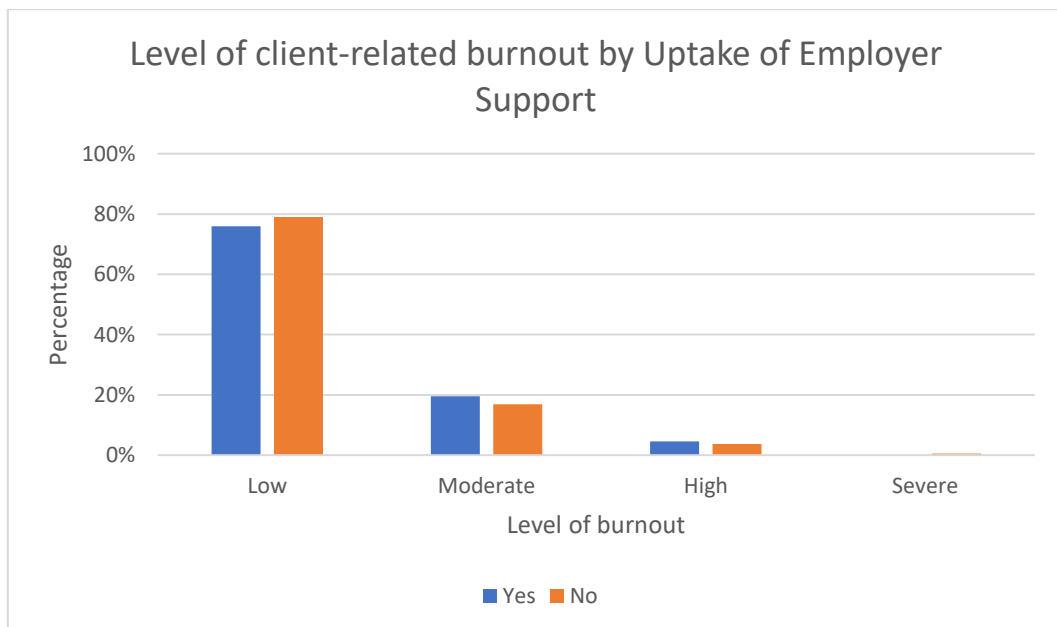


Figure A5.80: Level of Client-Related Burnout by Uptake of Employer Support (Unweighted)

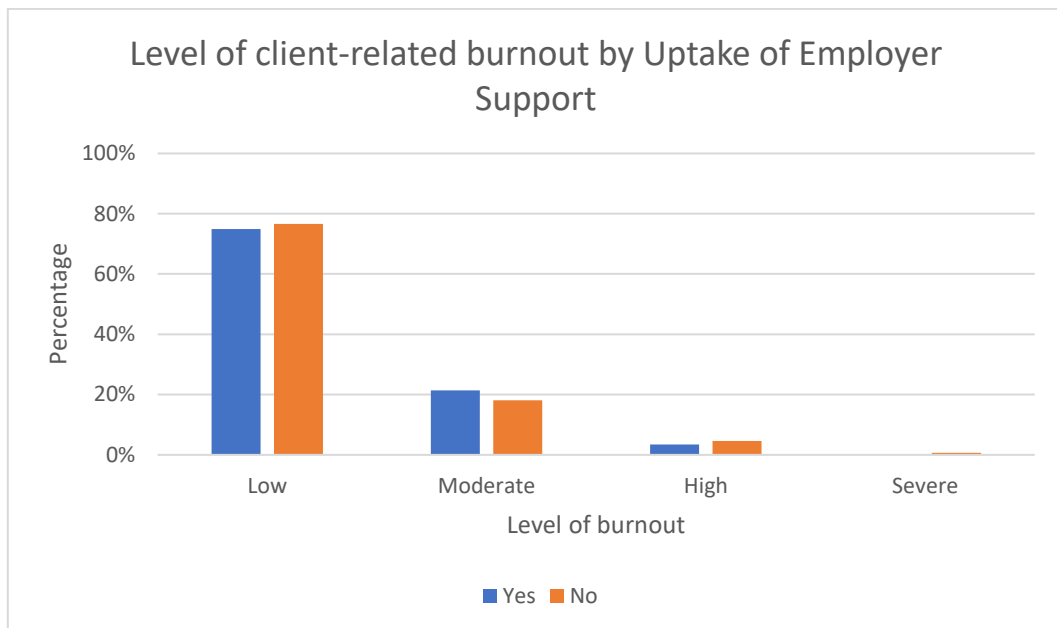


Table A5. 39: Level of Burnout Uptake of Employer Support (Weighted)

Burnout	Uptake of Employer Support	
	Yes	No
Personal burnout:		
Low	19.8%	22.9%
Moderate	42.6%	48.1%
High	31.0%	24.0%
Severe	6.7%	5.0%
TOTAL	100%	100%
Work-related burnout:		
Low	26.3%	32.2%
Moderate	39.6%	43.9%
High	29.1%	22.8%
Severe	5.0%	1.0%
TOTAL	100%	100%
Client-related burnout:		
Low	75.9%	79.0%
Moderate	19.5%	16.9%
High	4.6%	3.7%
Severe	0.0%	0.5%
TOTAL	100%	100%

Table A5. 40: Level of Burnout by Uptake of Employer Support (Unweighted)

Burnout	Uptake of Employer Support	
	Yes	No
Personal burnout:		
Low	48 (13.9%)	245 (24.1%)
Moderate	147 (42.5%)	460 (45.3%)
High	131 (37.9%)	274 (27.0%)
Severe	20 (5.8%)	36 (3.5%)
TOTAL	346 (100%)	1015 (100%)
Work-related burnout:		
Low	70 (20.6%)	295 (29.7%)
Moderate	139 (41.0%)	425 (42.8%)
High	120 (35.4%)	255 (25.7%)
Severe	10 (2.9%)	17 (1.7%)
TOTAL	339 (100%)	992 (100%)
Client-related burnout:		
Low	242 (74.9%)	699 (76.6%)
Moderate	69 (21.4%)	165 (18.1%)
High	11 (3.4%)	42 (4.6%)
Severe	1 (0.3%)	6 (0.7%)
TOTAL	323(100%)	912 (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 by Occupation results):

There were no significant differences across countries in mean scores on any of the ten examined Carver coping domains.

Summary (Unweighted results):

There were no significant differences across countries in mean scores of the ten examined Carver coping domains.

Figure A6. 1: Mean Carver Coping Scores by Country (Weighted by Occupation)

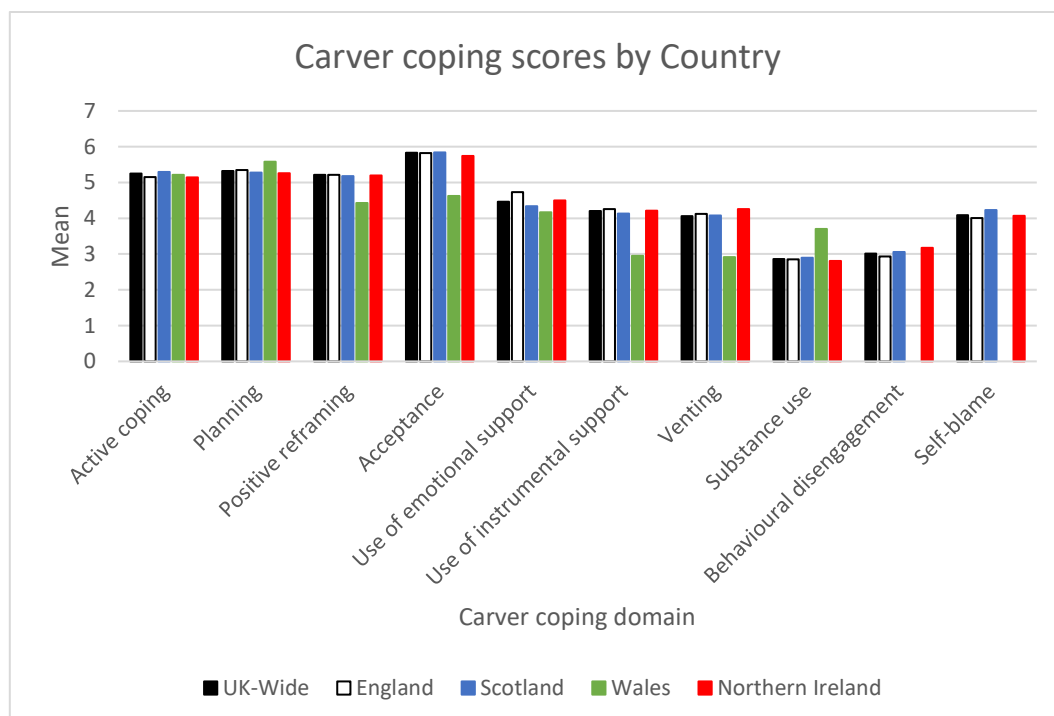


Figure A6. 2: Mean Carver Coping Scores by Country (Unweighted)

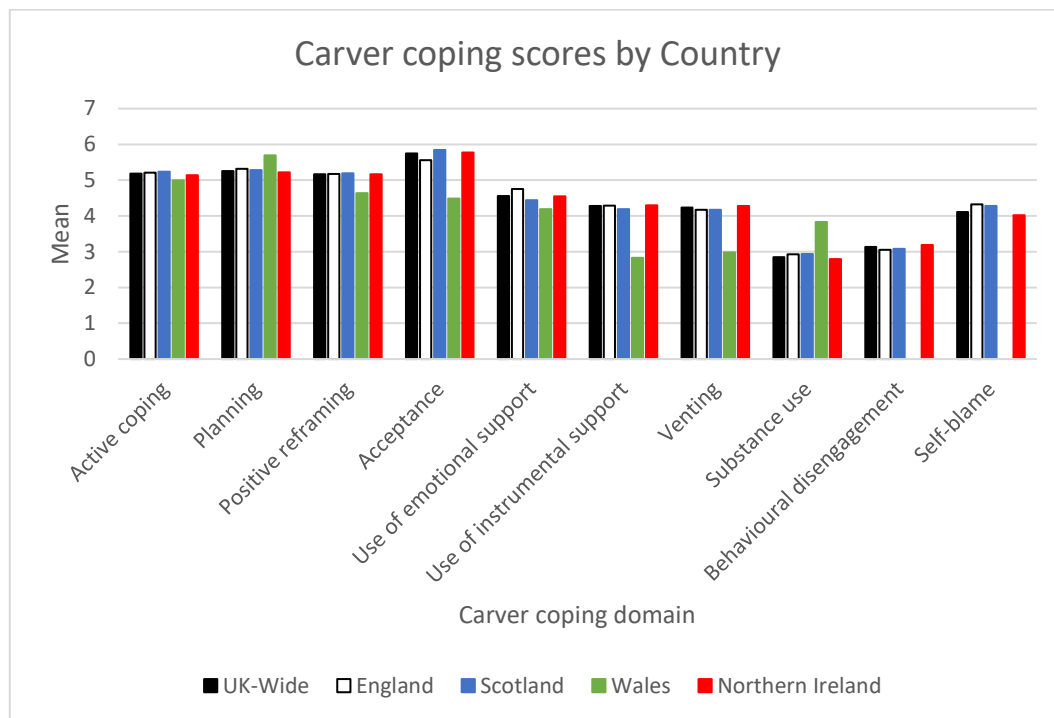


Table A6. 1: Mean Carver Coping Scores by Country (Weighted by Occupation)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.25	5.15	5.29	5.36	5.14
Planning	5.32	5.35	5.28	5.39	5.26
Positive reframing	5.21	5.21	5.18	5.21	5.20
Acceptance	5.83	5.82	5.84	5.58	5.74
Use of emotional support	4.46	4.73	4.34	4.43	4.50
Use of instrumental support	4.20	4.26	4.13	4.62	4.21
Venting	4.06	4.12	4.08	4.17	4.26
Substance use	2.86	2.85	2.90	2.95	2.81
Behavioural disengagement	3.01	2.93	3.06	2.91	3.17
Self-blame	4.09	4.01	4.23	3.70	4.07

Table A6. 2: Mean Carver Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.18	5.21	5.24	5.21	5.14
Planning	5.25	5.32	5.28	5.19	5.22
Positive reframing	5.16	5.17	5.19	4.99	5.16
Acceptance	5.75	5.56	5.84	5.69	5.77
Use of emotional support	4.56	4.75	4.44	4.64	4.55
Use of instrumental support	4.28	4.29	4.19	4.48	4.30
Venting	4.23	4.17	4.17	4.19	4.28
Substance use	2.85	2.93	2.94	2.83	2.79
Behavioural disengagement	3.13	3.05	3.08	2.98	3.19
Self-blame	4.11	4.32	4.28	3.83	4.02

A6.2 Carver Coping Scores by Occupation

Summary (Weighted by Region results):

There were significant differences between the occupational groups in mean scores on nine of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 5.149$, $df = 4$, $p < .001$), where social care workers scored significantly higher than nurses, AHPs, and social workers.
- Planning ($F = 2.890$, $df = 4$, $p = .021$), where social care workers scored significantly higher than nurses, AHPs, and social workers.
- Positive reframing ($F = 3.298$, $df = 4$, $p = .011$), where social care workers scored significantly higher than social workers.
- Acceptance ($F = 3.953$, $df = 4$, $p = .003$), where nurses scored significantly higher than social workers.
- Instrumental support ($F = 5.923$, $df = 4$, $p < .001$), where nurses scored significantly lower than AHPs and midwives.
- Venting ($F = 5.276$, $df = 4$, $p < .001$), where midwives scored significantly higher than all other occupations.
- Substance use ($F = 2.806$, $df = 4$, $p = .025$), where social workers scored significantly higher than AHPs.

- Behavioural disengagement ($F = 7.746$, $df = 4$, $p < .001$), where AHPs scored significantly lower than midwives and social workers.
- Self-blame ($F = 8.634$, $df = 4$, $p < .001$), where social workers scored significantly higher than nurses and social care workers.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on three out of the ten examined Carver coping domains. These differences were found in:

- Use of emotional support ($F = 6.339$, $df = 4$, $p < .001$), where social care workers scored significantly lower than social workers.
- Use of instrumental support ($F = 3.074$, $df = 4$, $p = .016$), where social workers had higher scores than social care workers.
- Behavioural disengagement ($F = 4.644$, $df = 4$, $p < .001$), where social care workers scored significantly higher than AHPs.

Figure A6.3: Mean Carver Coping Scores by Occupation (Weighted by Region)

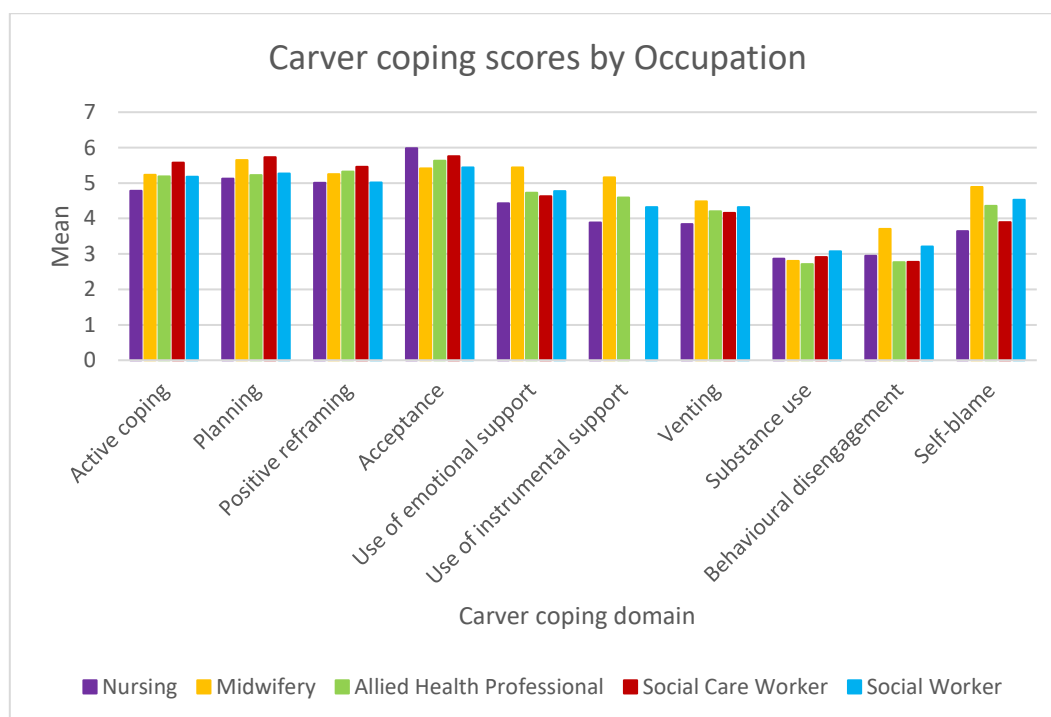


Figure A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

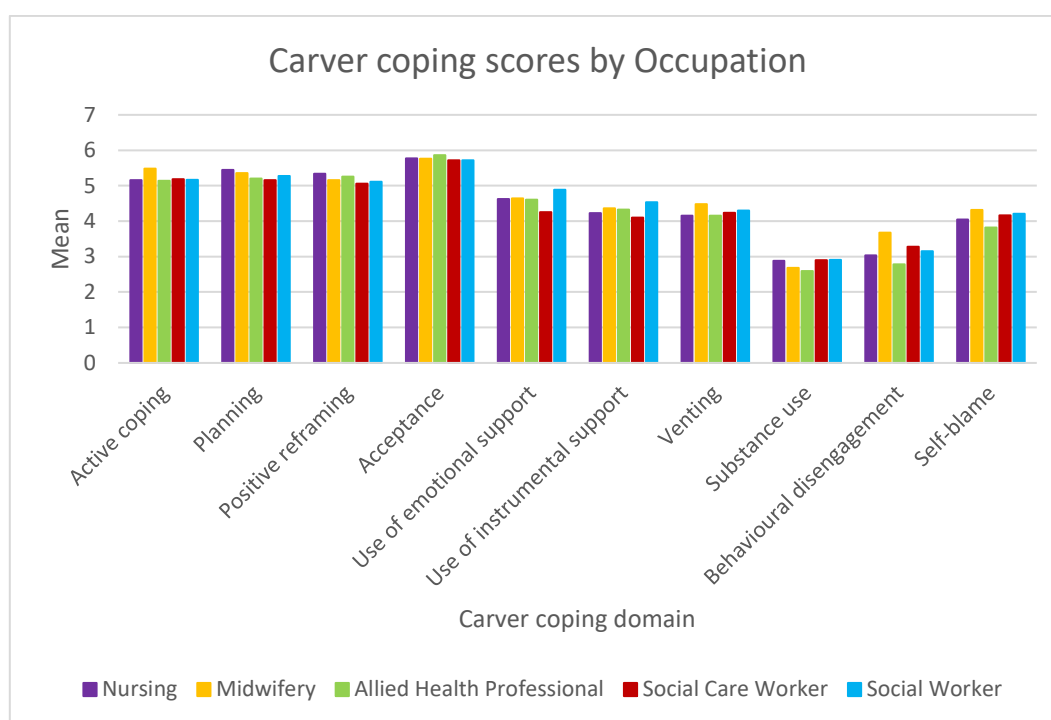


Table A6.3: Mean Carver Coping Scores by Occupation (Weighted by Region)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	4.78	5.23	5.19	5.68	5.18
Planning	5.12	5.65	5.22	5.73	5.27
Positive reframing	5.01	5.25	5.32	5.46	5.02
Acceptance	5.98	5.41	5.63	5.76	5.44
Use of emotional support	4.43	5.44	4.73	4.63	4.77
Use of instrumental support	3.89	5.16	4.59	4.30	4.23
Venting	3.84	4.48	4.20	4.16	4.23
Substance use	2.87	2.80	2.71	2.91	3.07
Behavioural disengagement	2.95	3.71	2.77	2.78	3.21
Self-blame	3.64	4.89	4.36	3.90	4.53

Table A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.16	5.48	5.14	5.18	5.17
Planning	5.45	5.36	5.20	5.16	5.27
Positive reframing	5.34	5.16	5.26	5.06	5.11
Acceptance	5.77	5.76	5.86	5.72	5.72
Use of emotional support	4.62	4.64	4.61	4.25	4.89
Use of instrumental support	4.23	4.36	4.33	4.10	4.53
Venting	4.15	4.48	4.15	4.24	4.30
Substance use	2.88	2.68	2.59	2.90	2.91
Behavioural disengagement	3.03	3.68	2.78	3.28	3.15
Self-blame	4.05	4.32	3.82	4.16	4.21

A6.3 Carver Coping Scores by Sex

There were 7 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 three out of the ten examined Carver coping domains. These differences were in:

- Positive reframing ($t = 2.422$, $df = 1192$, $p = .016$), where females scored significantly higher than males.
- Acceptance ($t = 1.997$, $df = 1192$, $p = .046$), where females scored significantly higher than males.
- Substance use ($t = -2.595$, $df = 199.274$, $p = .010$), where females scored significantly lower than males.

Summary (Unweighted results):

There were significant differences between males and females in mean scores on two out of the ten examined Carver coping domains. These differences were found in:

- Substance use ($t = -5.142$, $df = 244.061$, $p < .001$), where females scored significantly lower than males.
- Behavioural engagement ($t = -2.760$, $df = 253.134$, $p = .006$), where males scored significantly higher than females.

Figure A6.5: Mean Carver Coping Scores by Sex (Weighted)

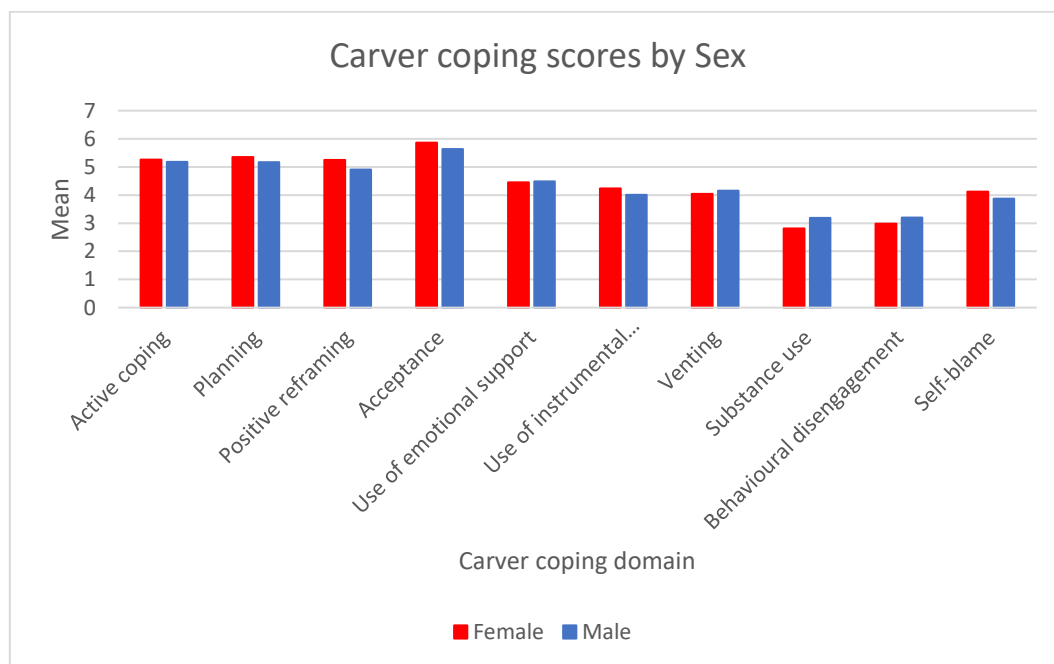


Figure A6.6: Mean Carver Coping Scores by Sex (Unweighted)

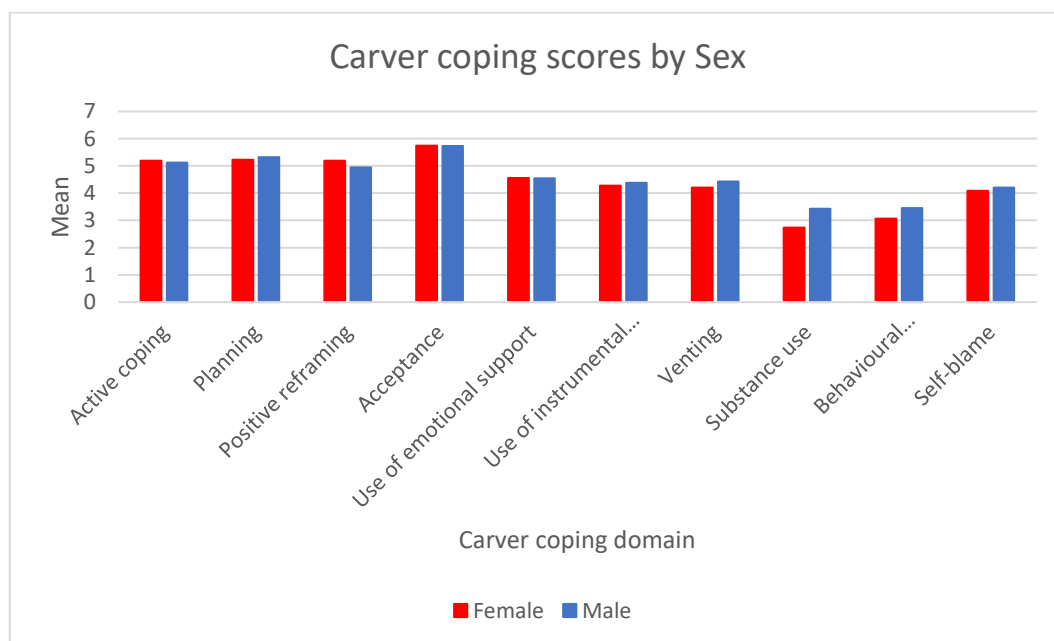


Table A6.5: Mean Carver Coping Scores by Sex (Weighted)

Coping domain	Sex	
	Female	Male
Active coping	5.26	5.18
Planning	5.35	5.17
Positive reframing	5.25	4.91
Acceptance	5.86	5.63
Use of emotional support	4.45	4.48
Use of instrumental support	4.24	4.01
Venting	4.04	4.15
Substance use	2.81	3.19
Behavioural disengagement	2.98	3.20
Self-blame	4.12	3.87

Table A6.6: Mean Carver Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Active coping	5.19	5.12
Planning	5.23	5.32
Positive reframing	5.19	4.94
Acceptance	5.75	5.73
Use of emotional support	4.56	4.54
Use of instrumental support	4.27	4.38
Venting	4.20	4.43
Substance use	2.73	3.43
Behavioural disengagement	3.07	3.45
Self-blame	4.09	4.21

A6.4 Carver Coping Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean scores on all ten Carver coping domains. These differences were in:

- Active coping ($F = 12.348$, $df = 4$, $p < .001$), where the 16-29 age group scored significantly lower than the 30-39 and 40-49 age groups.
- Planning ($F = 7.490$, $df = 4$, $p < .001$), where the 30-39 group had significantly higher scores than the 50-59 and 60+ age groups.
- Positive reframing ($F = 13.483$, $df = 4$, $p < .001$), where the 30-39 group had significantly higher scores than the 50-59 and 60+ age groups.
- Acceptance ($F = 6.056$, $df = 4$, $p < .001$), where the 30-39 age group scored significantly higher than all other age groups.
- Use of emotional support ($F = 12.841$, $df = 4$, $p < .001$), where the 30-39 age group scored significantly higher than all other age groups.
- Use of instrumental support ($F = 14.444$, $df = 4$, $p < .001$), where 40-49 groups had significantly higher scores than the 50-59 and 60+ age groups.
- Venting ($F = 14.921$, $df = 4$, $p < .001$), where the 60+ age group scored significantly lower than all other age groups.
- Substance use ($F = 6.730$, $df = 4$, $p < .001$), where the 16-29 age group scored significantly higher than the 50-59 and the 60+ age groups.
- Behavioural disengagement ($F = 5.859$, $df = 4$, $p < .001$), where the 16-29 age group scored significantly higher than all other age groups.
- Self-blame ($F = 13.744$, $df = 4$, $p < .001$), where the 60+ age group scored significantly lower than all other age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on four out of the ten examined Carver coping domains. These differences were in:

- Venting ($F = 6.192$, $df = 4$, $p < .001$), where the 16-29 age group scored significantly higher than the 40-49, 50-59 and the 60+ age groups.
- Substance use ($F = 3.102$, $df = 4$, $p = .015$), where the 40-49 age group scored significantly higher than the 50-59 age group

- Behavioural disengagement ($F = 2.809$, $df = 4$, $p = .024$), where the 16-29 age group scored significantly higher than the 30-39, 50-59 and the 60+ age groups.
- Self-blame ($F=16.136$, $df = 4$, $p < .001$), where the 50-59 age group scored significantly lower than the 16-29, 30-39, and the 40-49 age groups.

Figure A6.7: Mean Carver Coping Scores by Age (Weighted)

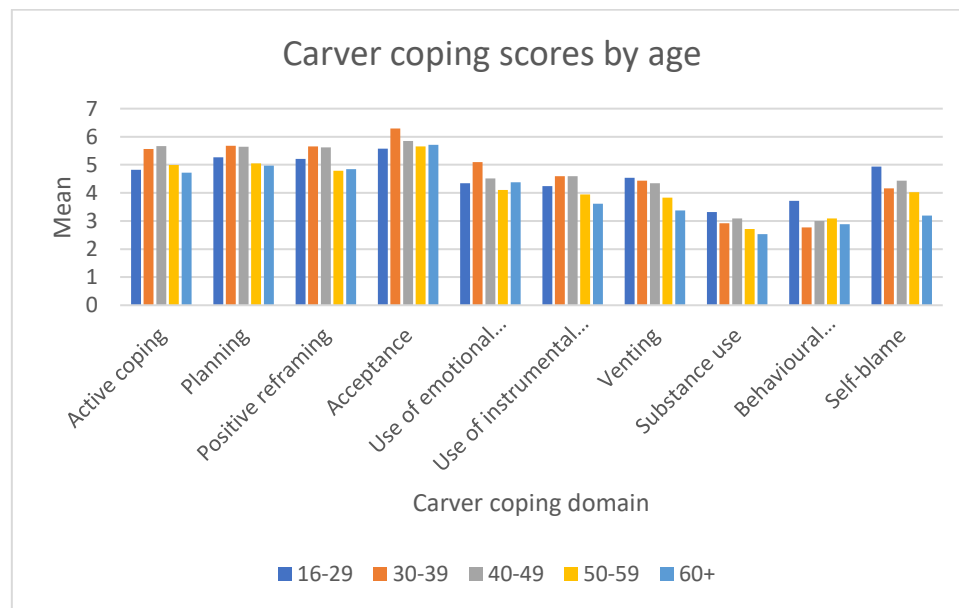


Figure A6.8: Mean Carver Coping Scores by Age (Unweighted)

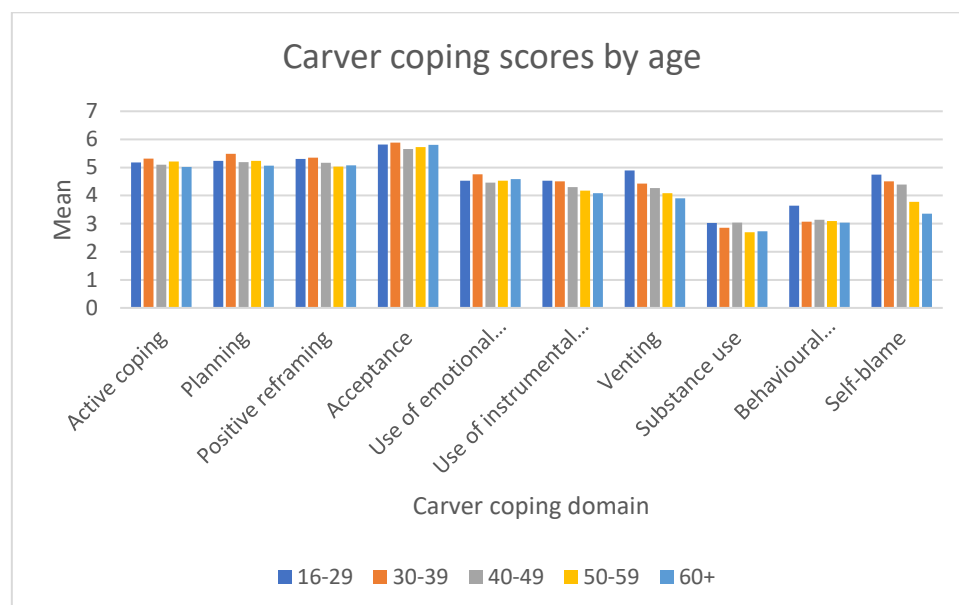


Table A6.7: Mean Carver Coping Scores by Age (Weighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60-65
Active coping	4.82	5.65	5.67	4.99	4.72
Planning	5.27	5.68	5.64	5.05	4.97
Positive reframing	5.21	5.65	5.62	4.79	4.85
Acceptance	5.57	6.29	5.85	5.66	5.71
Use of emotional support	4.35	5.10	4.52	4.10	4.38
Use of instrumental support	4.24	4.59	4.59	3.94	3.62
Venting	4.54	4.44	4.34	3.83	3.38
Substance use	3.32	2.92	3.09	2.72	2.53
Behavioural disengagement	3.72	2.77	3.00	3.09	2.88
Self-blame	4.94	4.16	4.43	4.02	3.19

Table A6.8: Mean Carver Coping Scores by Age (Unweighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60+
Active coping	5.18	5.32	5.10	5.21	5.02
Planning	5.24	5.48	5.19	5.23	5.06
Positive reframing	5.30	5.35	5.17	5.03	5.08
Acceptance	5.82	5.88	5.66	5.72	5.80
Use of emotional support	4.53	4.76	4.46	4.53	4.58
Use of instrumental support	4.53	4.50	4.30	4.18	4.08
Venting	4.89	4.43	4.27	4.08	3.90
Substance use	3.02	2.85	3.03	2.69	2.73
Behavioural disengagement	3.64	3.07	3.14	3.09	3.04
Self-blame	4.74	4.50	4.39	3.78	3.35

A6.5 Carver Coping Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on eight out of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 6.595$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than the Black and Asian ethnic groups.
- Planning ($F = 11.568$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than all other ethnic groups.
- Positive reframing ($F = 10.946$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than the Black ethnic groups.
- Acceptance ($F = 5.660$, $df = 3$, $p < .001$), where respondents identifying as White ethnicity scored significantly lower than those identifying as Black ethnicity.
- Use of instrumental support ($F = 9.569$, $df = 3$, $p < .001$), where the Asian ethnic group scored significantly higher than White and Black ethnic groups
- Venting ($F = 21.199$, $df = 3$, $p < .001$), where the White ethnic group scored significantly lower than the Black and Asian Ethnic groups.
- Substance use ($F = 3.103$, $df = 3$, $p = .026$), where the White scored significantly higher than the Asian ethnic group.
- Self-blame ($F = 5.425$, $df = 3$, $p < .001$), where respondents identifying as Asian scored significantly lower than all other ethnic groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups in mean scores on one out of the ten examined Carver coping domains. These differences were in:

- Positive reframing ($F = 4.570$, $df = 3$, $p = .003$), where respondents identifying as White scored significantly lower than the Black ethnic groups.

Figure A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

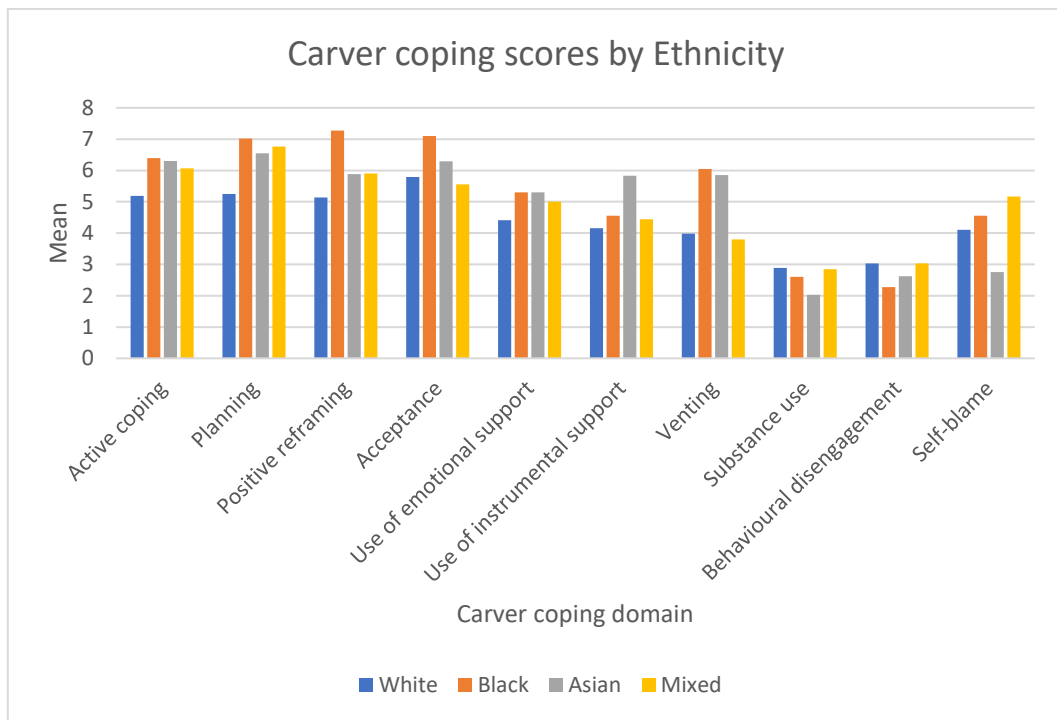


Figure A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

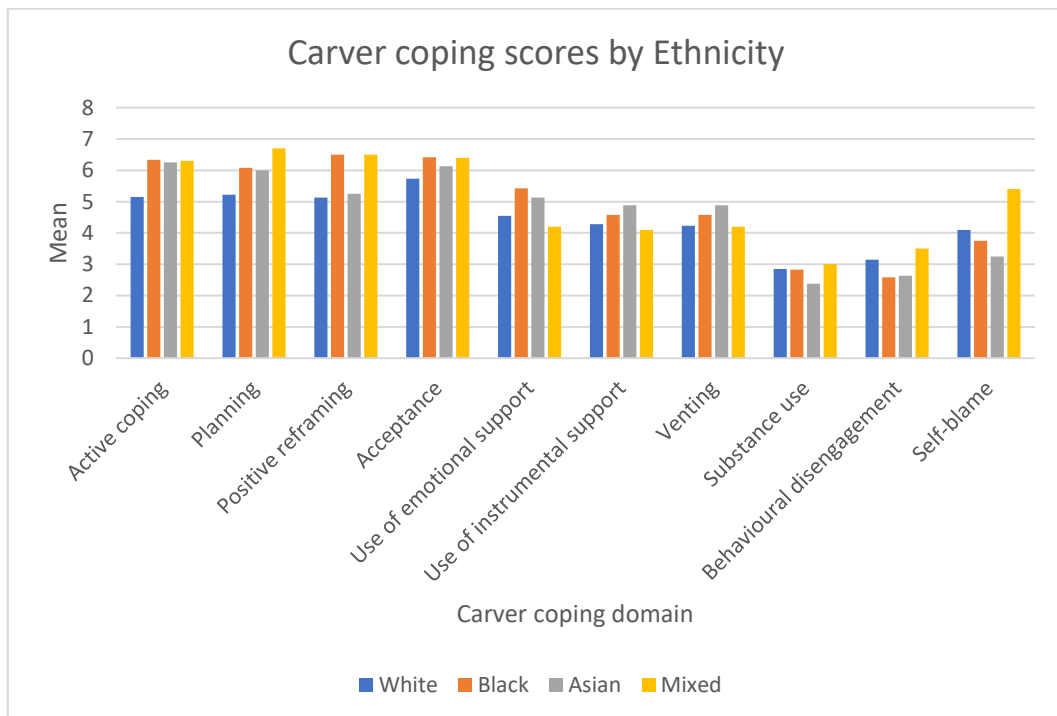


Table A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.19	6.39	6.30	6.07
Planning	5.25	7.02	6.55	6.76
Positive reframing	5.14	7.27	5.88	5.90
Acceptance	5.79	7.10	6.29	5.56
Use of emotional support	4.41	5.30	5.30	5.00
Use of instrumental support	4.16	4.55	5.83	4.44
Venting	3.98	6.05	5.85	3.80
Substance use	2.89	2.60	2.03	2.85
Behavioural disengagement	3.03	2.27	2.62	3.03
Self-blame	4.10	4.55	2.75	5.17

Table A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.15	6.33	6.25	6.30
Planning	5.22	6.08	6.00	6.70
Positive reframing	5.13	6.50	5.25	6.50
Acceptance	5.73	6.42	6.13	6.40
Use of emotional support	4.55	5.42	5.13	4.20
Use of instrumental support	4.28	4.58	4.88	4.10
Venting	4.23	4.58	4.88	4.20
Substance use	2.85	2.83	2.38	3.00
Behavioural disengagement	3.14	2.58	2.63	3.50
Self-blame	4.10	3.75	3.25	5.40

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 six out of the ten examined Carver coping domains. These differences were found in:

- Active coping ($F = 12.377$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability.
- Planning ($F = 8.141$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability.
- Emotional support ($F = 5.576$, $df = 2$, $p = .004$), where respondents with a disability scored significantly higher than those without a disability.
- Instrumental support ($F = 14.368$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability.
- Substance use ($F = 9.227$, $df = 2$, $p < .001$), where respondents with a disability scored significantly higher than those without a disability and those who were unsure.
- Self-blame ($F = 7.124$, $df = 2$, $p < .002$), where respondents with a disability scored significantly higher than those without a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on three out of the ten examined Carver coping domains. These differences were in:

- Planning ($F = 7.240$, $df = 2$, $p < .001$), where respondents who had a disability scored significantly higher than those with no disability.
- Behavioural disengagement ($F = 5.369$, $df = 2$, $p = .005$), where respondents who had a disability scored significantly higher than those with no disability.
- Self-blame ($F = 9.708$, $df = 2$, $p < .001$), where respondents who had a disability scored significantly higher than those with no disability.

Figure A6.11: Mean Carver Coping Scores by Disability (Weighted)

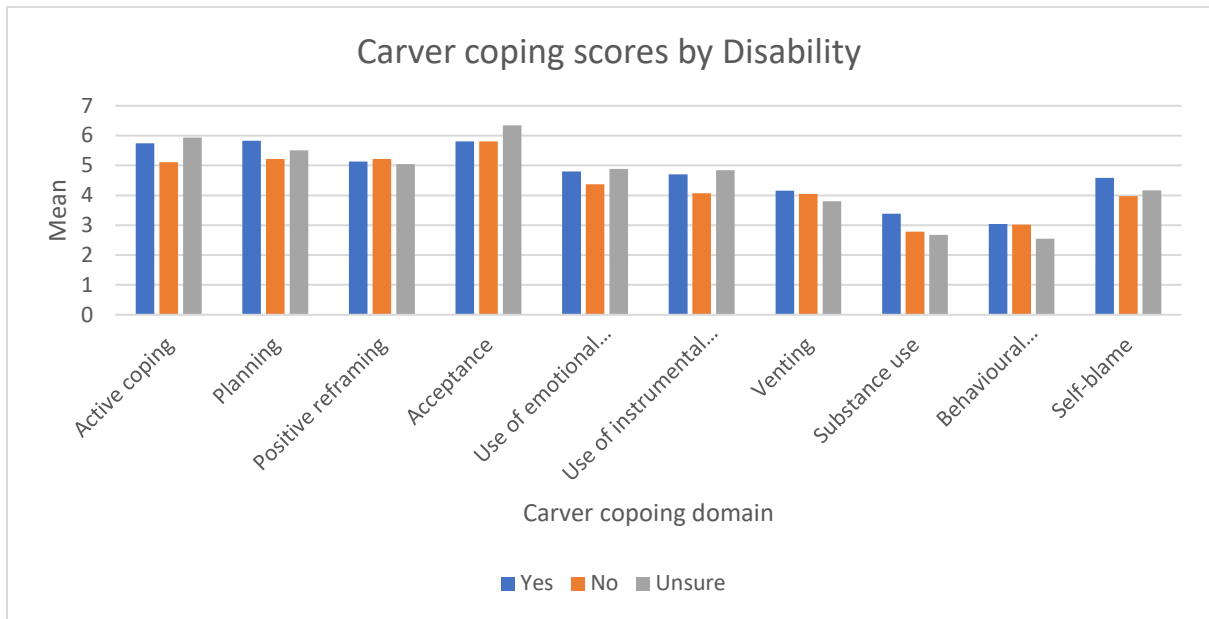


Figure A6.12: Mean Carver Coping Scores by Disability (Unweighted)

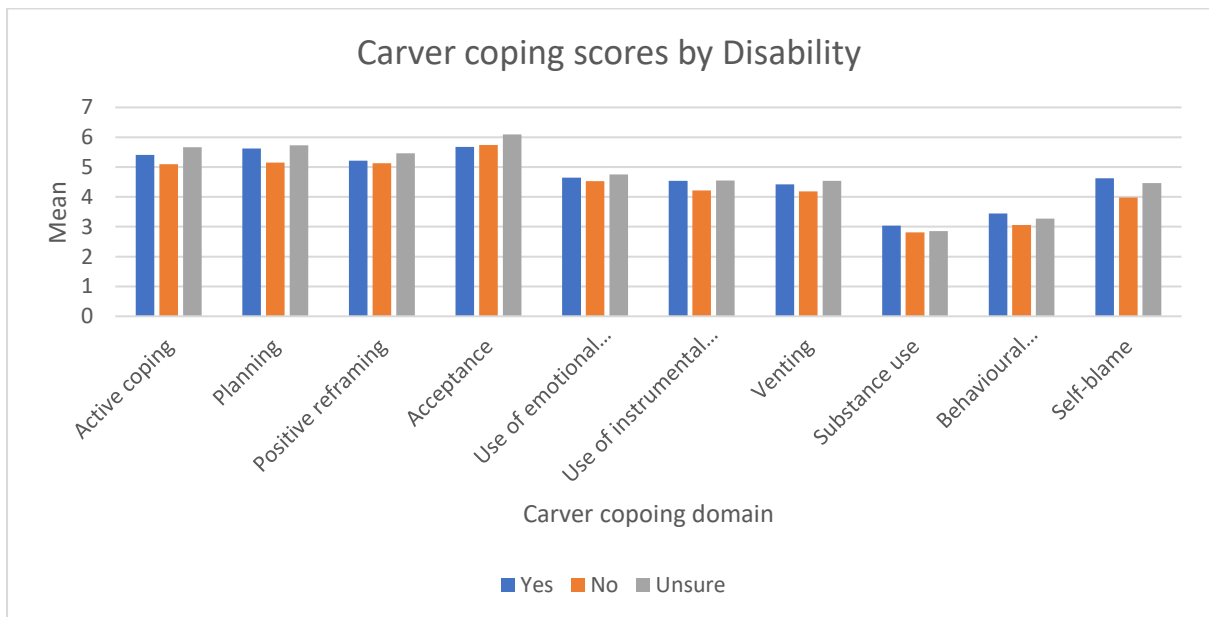


Table A6.11: Mean Carver Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Active coping	5.74	5.11	5.94
Planning	5.83	5.22	5.51
Positive reframing	5.13	5.22	5.05
Acceptance	5.81	5.81	6.35
Use of emotional support	4.80	4.37	4.89
Use of instrumental support	4.70	4.07	4.84
Venting	4.16	4.05	3.80
Substance use	3.39	2.78	2.68
Behavioural disengagement	3.04	3.02	2.55
Self-blame	4.59	3.98	4.17

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	5.10	5.66
Planning	5.62	5.15	5.73
Positive reframing	5.21	5.13	5.46
Acceptance	5.68	5.74	6.09
Use of emotional support	4.65	4.53	4.75
Use of instrumental support	4.54	4.22	4.55
Venting	4.42	4.18	4.54
Substance use	3.04	2.81	2.86
Behavioural disengagement	3.44	3.06	3.27
Self-blame	4.62	3.98	4.46

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 seven out of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 2.948$, $df = 7$, $p = .005$), where those working with children and young people scored significantly lower than those working with adults of working age and in mental health.
- Planning ($F = 3.196$, $df = 7$, $p = .002$), where those working with children and young people scored significantly lower than those working with adults of working age, with older people, in mental health and in the area of 'other'.
- Positive reframing ($F = 3.396$, $df = 7$, $p = .001$), where those working with children and young people scored significantly lower than those working with adults of working age and with older people.
- Acceptance ($F = 5.898$, $df = 7$, $p < .001$), where respondents working with adults of working age scored significantly higher than all other areas of practice.
- Use of emotional support ($F = 2.938$, $df = 7$, $p = .005$), where respondents working with older people scored significantly lower than those who selected 'other' as their area of practice.
- Substance use ($F = 2.417$, $df = 7$, $p = .018$), where respondents working in the area of learning disability scored significantly higher than those who selected 'other' as their area of practice.
- Behavioural disengagement ($F = 3.659$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly higher than those working with adults.

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 ($F = 2.537$, $df = 7$, $p = .014$), where respondents working with older people scored significantly lower than those working with children and those who selected 'other' as their area of practice.
- Behavioural disengagement ($F = 2.934$, $df = 7$, $p = .005$), where respondents working with older people scored significantly lower than those who selected 'other' as their area of practice.

Figure A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

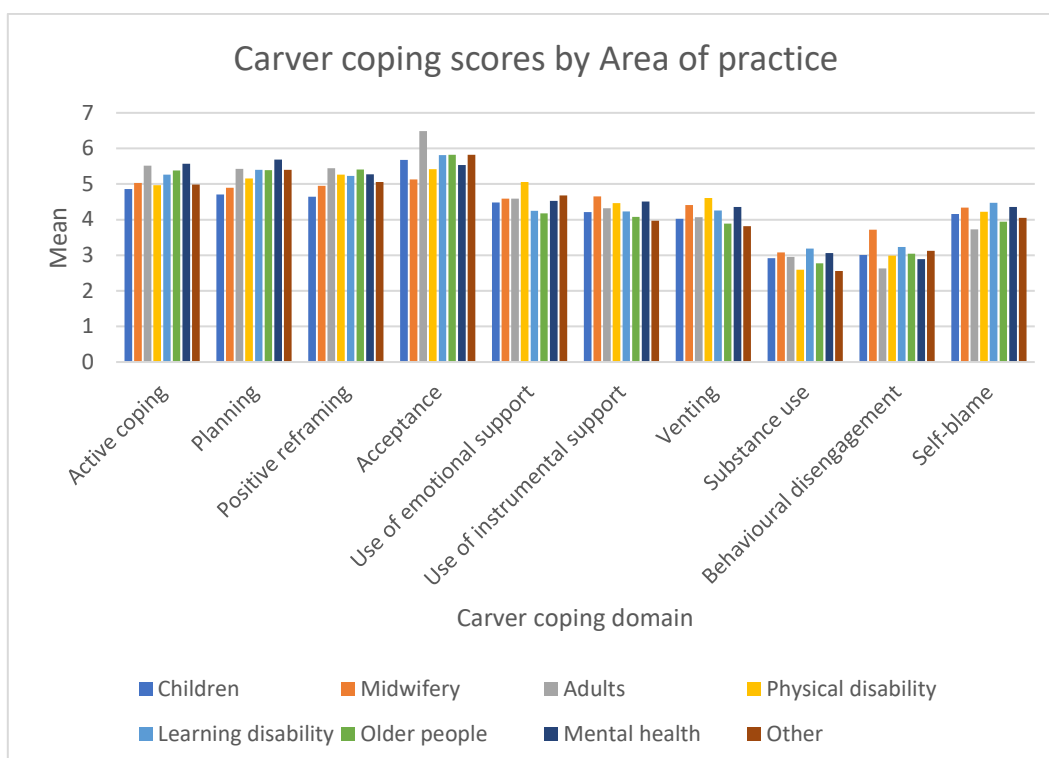


Figure A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)

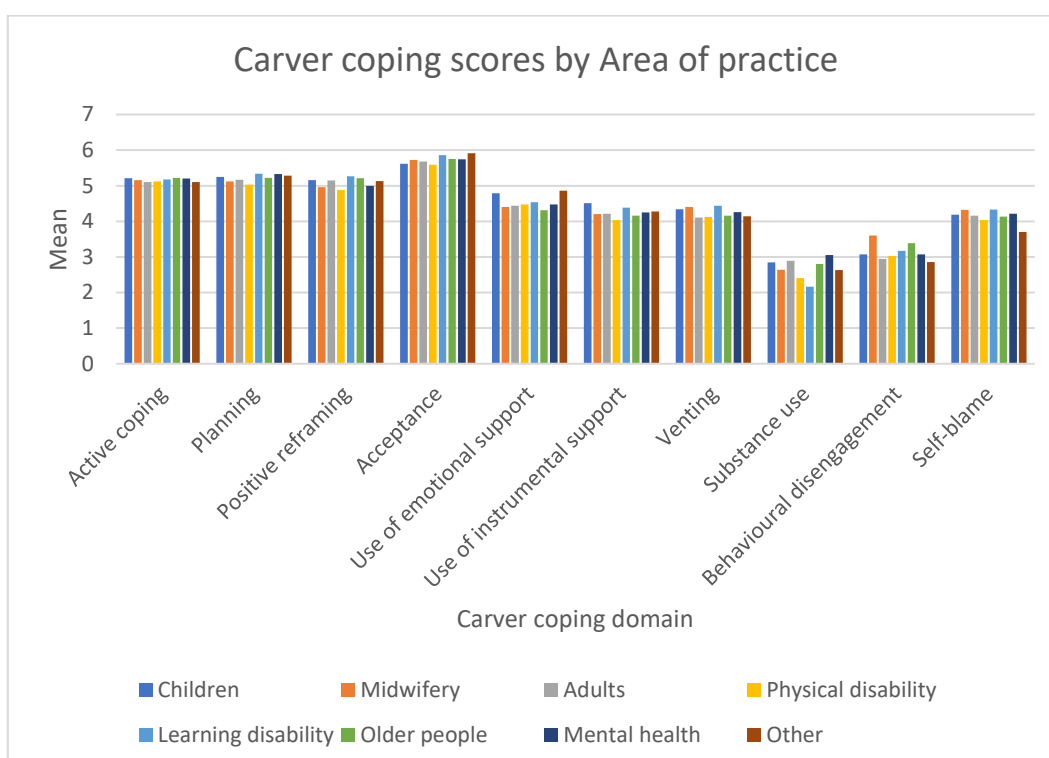


Table A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Active coping	4.86	5.03	5.52	4.97	5.26	5.38	5.57	4.99
Planning	4.71	4.90	5.43	5.16	5.40	5.39	5.69	5.40
Positive reframing	4.64	4.95	5.44	5.26	5.23	5.41	5.27	5.06
Acceptance	5.68	5.13	6.49	5.42	5.81	5.82	5.53	5.82
Use of emotional support	4.48	4.59	4.59	5.06	4.25	4.18	4.53	4.68
Use of instrumental support	4.21	4.65	4.32	4.46	4.23	4.08	4.51	3.97
Venting	4.02	4.41	4.07	4.61	4.26	3.89	4.36	3.82
Substance use	2.92	3.08	2.95	2.59	3.19	2.77	3.06	2.56
Behavioural disengagement	3.01	3.72	2.63	2.99	3.23	3.04	2.89	3.12
Self-blame	4.16	4.34	3.73	4.22	4.47	3.94	4.36	4.05

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	5.21	5.16	5.10	5.12	5.18	5.22	5.20	5.10
Planning	5.25	5.12	5.17	5.03	5.34	5.22	5.33	5.28
Positive reframing	5.16	4.96	5.15	4.88	5.27	5.21	5.00	5.13
Acceptance	5.62	5.72	5.68	5.59	5.86	5.75	5.74	5.91
Use of emotional support	4.79	4.40	4.44	4.47	4.54	4.31	4.47	4.86
Use of instrumental support	4.51	4.20	4.21	4.03	4.38	4.16	4.25	4.28
Venting	4.34	4.40	4.11	4.12	4.44	4.16	4.26	4.14
Substance use	2.85	2.64	2.89	2.41	2.16	2.80	3.05	2.63
Behavioural disengagement	3.07	3.60	2.95	3.03	3.17	3.39	3.07	2.86
Self-blame	4.19	4.32	4.16	4.03	4.33	4.13	4.21	3.70

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 one of the ten Carver coping domains. These differences were in:

- Venting ($t = -3.974$, $df = 1080.698$, $p < .001$), where line managers scored significantly lower than those who were not line managers.

Summary (Unweighted results):

There were significant differences between respondents who were line managers and those who were not in mean scores on two out of the ten examined Carver coping domains. These differences were in:

- Planning ($t = 2.930$, $df = 1279$, $p = .003$), where line managers scored significantly higher than those who were not line managers.
- Positive reframing ($t = 2.055$, $df = 1279$, $p = .040$), where line managers scored significantly higher than those who were not line managers.
- Venting ($t = -2.204$, $df = 844.303$, $p = .028$), 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)

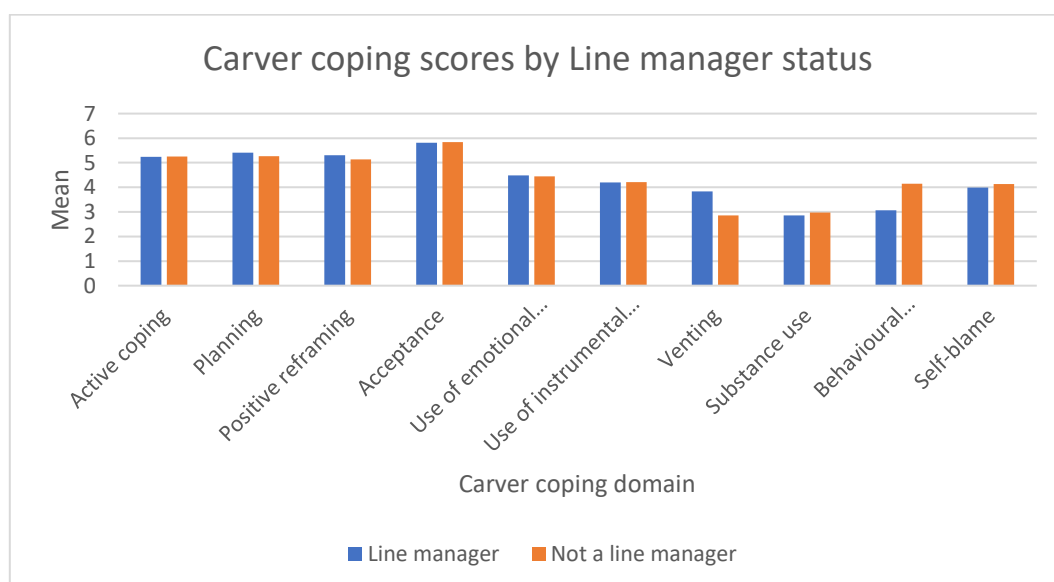


Figure A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

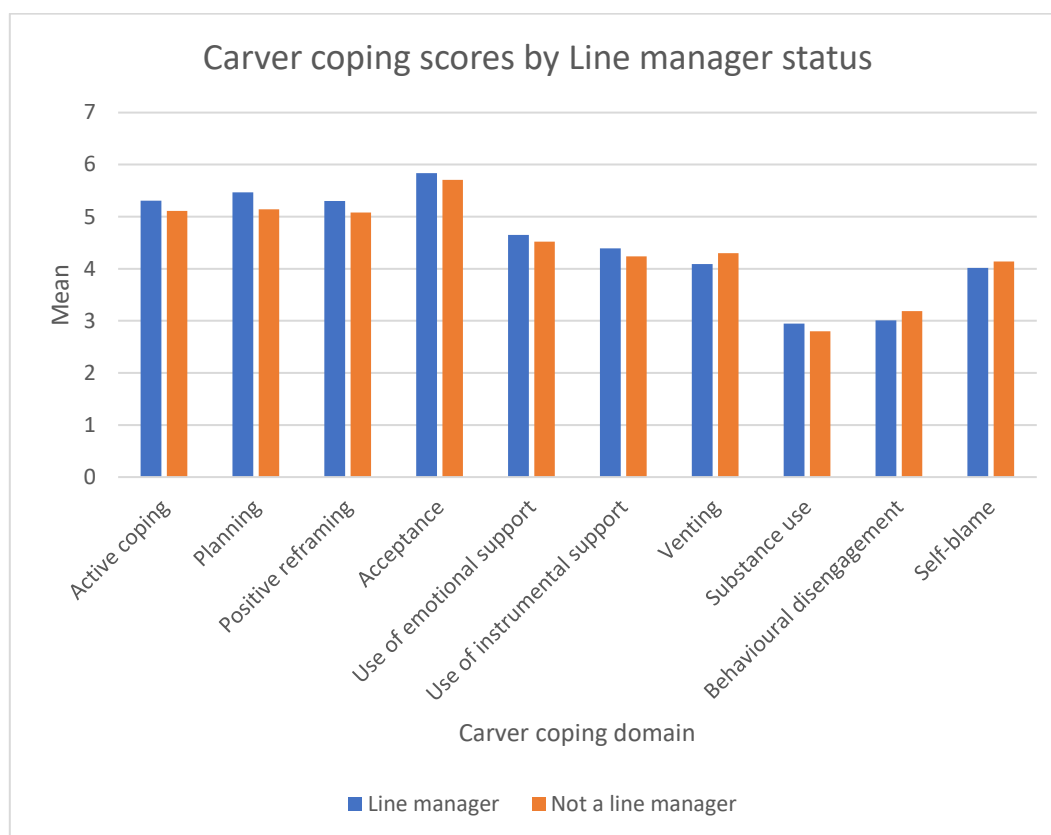


Table A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.24	5.25
Planning	5.41	5.27
Positive reframing	5.31	5.13
Acceptance	5.82	5.84
Use of emotional support	4.48	4.44
Use of instrumental support	4.20	4.21
Venting	3.83	4.21
Substance use	2.86	2.86
Behavioural disengagement	3.06	2.97
Self-blame	3.99	4.15

Table A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.31	5.11
Planning	5.47	5.14
Positive reframing	5.30	5.08
Acceptance	5.84	5.71
Use of emotional support	4.65	4.52
Use of instrumental support	4.39	4.24
Venting	4.09	4.30
Substance use	2.95	2.80
Behavioural disengagement	3.01	3.19
Self-blame	4.02	4.14

A6.9 Carver Coping Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean scores in all ten examined Carver coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Active coping ($F = 5.048$, $df = 2$, $p = .007$), where respondents who were overwhelmed by increased pressures scored significantly higher than those who were not impacted.
- Planning ($F = 7.342$, $df = 2$, $p < .001$), where respondents who were overwhelmed by increased pressures scored significantly higher than those who were not impacted and those who were impacted but not significantly.
- Positive reframing ($F = 9.763$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly lower than those who were impacted and those who were overwhelmed by the pressures.
- Acceptance ($F = 17.679$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly lower than those who were impacted and those who were overwhelmed by the pressures.

- Emotional support ($F = 10.344$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly lower than those who were impacted and those who were overwhelmed by the pressures.
- Use of instrumental support ($F = 4.636$, $df = 2$, $p = .010$), where respondents who were overwhelmed by increased pressures scored significantly higher than those who were not impacted.
- Venting ($F = 5.498$, $df = 2$, $p = .004$), where respondents who were not impacted scored significantly higher than those who were impacted and those who were overwhelmed by the pressures.
- Substance use ($F = 5.563$, $df = 2$, $p = .004$), where respondents who were not impacted scored significantly lower than those who were impacted and those who were overwhelmed by the pressures.
- Behavioural disengagement ($F = 5.398$, $df = 2$, $p = .005$), where respondents who were overwhelmed by the pressures scored significantly higher than those who were not impacted.
- Self-blame ($F = 8.754$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly lower than those who were impacted and those who were overwhelmed by the pressures.

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:

- Active coping ($F = 5.125$, $df = 2$, $p = .006$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who were impacted but not significantly.
- Planning ($F = 8.864$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Positive reframing ($F = 6.584$, $df = 2$, $p = .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Acceptance ($F = 4.872$, $df = 2$, $p = .008$), where respondents who were not impacted scored significantly lower than the other two groups.
- Instrumental support ($F = 7.579$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.

- Venting ($F = 8.371$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who were impacted but not significantly.
- Behavioural disengagement ($F = 8.246$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those who were impacted but not significantly.
- Self-blame ($F = 18.680$, $df = 2$, $p < .001$), 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)

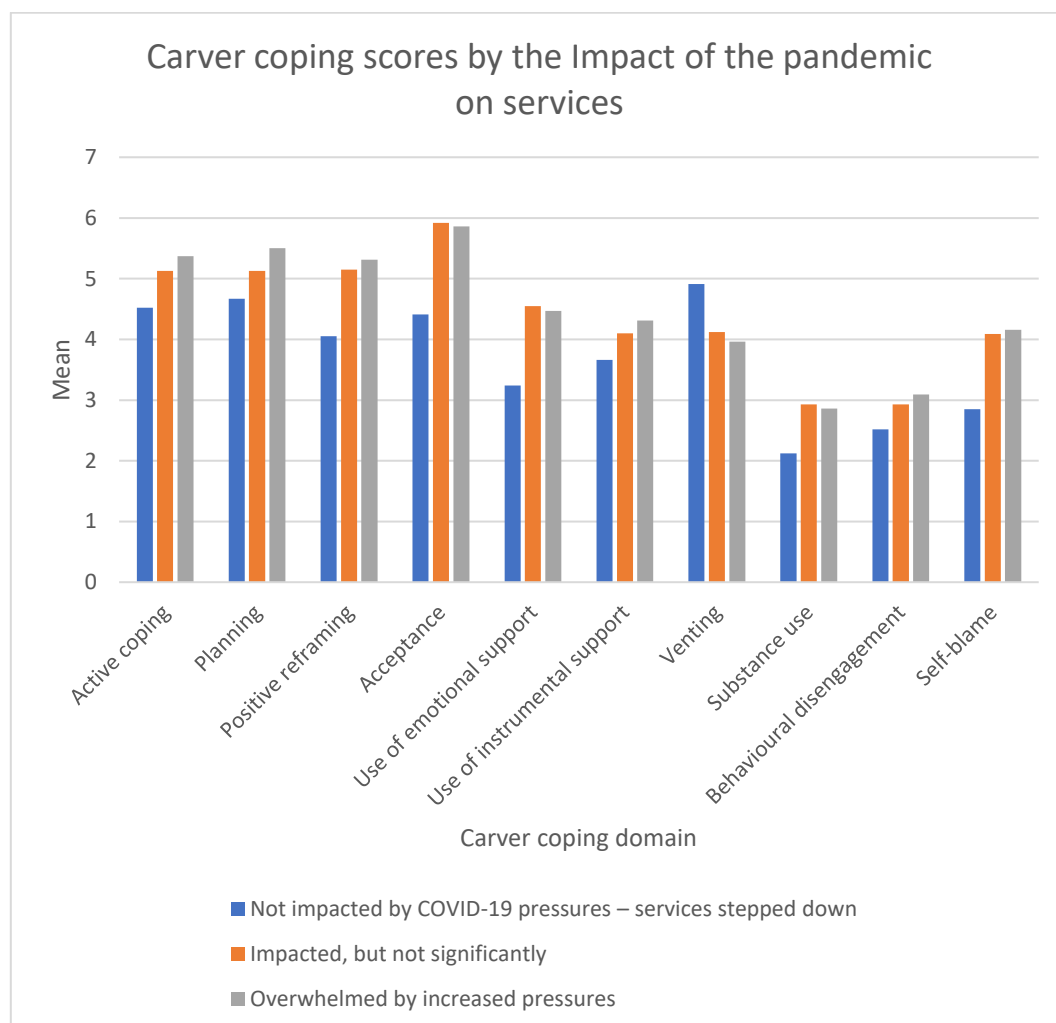


Figure A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)

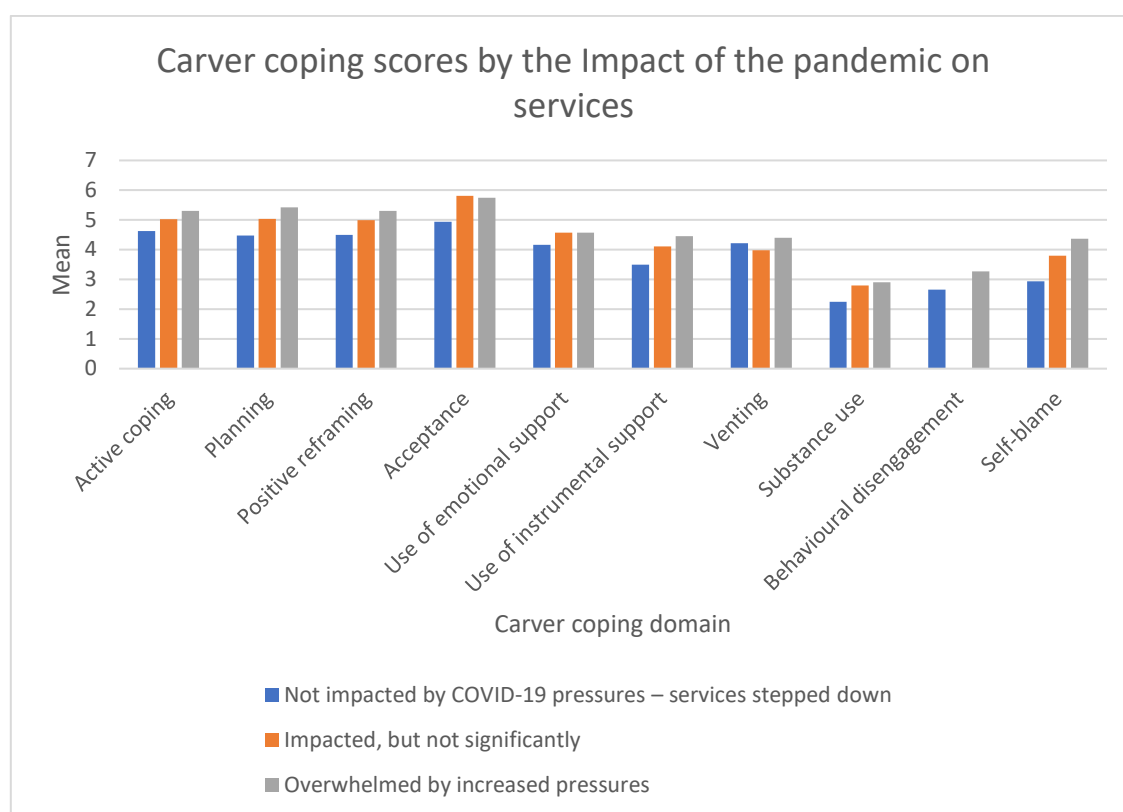


Table A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

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	4.52	5.13	5.37
Planning	4.67	5.13	5.50
Positive reframing	4.05	5.15	5.31
Acceptance	4.41	5.92	5.86
Use of emotional support	3.24	4.55	4.47
Use of instrumental support	3.66	4.10	4.31
Venting	4.91	4.12	3.96
Substance use	2.12	2.93	2.86
Behavioural disengagement	2.52	2.93	3.09
Self-blame	2.85	4.09	4.16

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	4.63	5.02	5.30
Planning	4.47	5.03	5.42
Positive reframing	4.50	4.99	5.30
Acceptance	4.94	5.81	5.75
Use of emotional support	4.16	4.57	4.57
Use of instrumental support	3.50	4.11	4.45
Venting	4.22	3.98	4.40
Substance use	2.25	2.80	2.90
Behavioural disengagement	2.66	2.96	3.27
Self-blame	2.94	3.80	4.37

A6.10 Carver Coping Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between those who used employer support and those that did not use employer support in mean scores on five out of the ten Carver coping domains. These differences were in:

- Active coping ($t = 5.190$, $df = 1191$, $p < .001$), where those who took employer support scored significantly higher than those who did not access employer support.
- Planning ($t = 4.809$, $df = 1193$, $p < .001$), where those who took employer support scored significantly higher than those who did not access employer support.
- Emotional support ($t = 3.165$, $df = 1192$, $p = .002$), where those where those who took employer support scored significantly higher than those who did not access employer support.
- Instrumental support ($t = 5.888$, $df = 1181$, $p < .001$), where those who took employer support scored significantly higher than those who did not access employer support.
- Venting ($t = 6.075$, $df = 542.320$, $p < .001$), where those who took employer support scored significantly higher than those who did not access employer support.

Summary (Unweighted results):

There were significant differences those who used employer support and those that did not use employer support in mean scores on seven out of the ten examined Carver coping domains. These differences were in:

- Active coping ($t = 5.852$, $df = 1278$, $p < .001$), where those who took support from their employer had significantly higher scores than those who did not take support.
- Planning ($t = 6.833$, $df = 622.672$, $p < .001$), where those who took support from their employer had significantly higher scores than those who did not take support.
- Positive reframing ($t = 3.809$, $df = 1279$, $p < .001$), where those who took support from their employer had significantly higher scores than those who did not take support.
- Use of emotional support ($t = 5.915$, $df = 1277$, $p < .001$), where those who took support from their employer had significantly higher scores than those who did not take support.
- Use of instrumental support ($t = 8.670$, $df = 1272$, $p < .001$), where those who took support from their employer had significantly higher scores than those who did not take support.
- Venting ($t = 4.088$, $df = 1269$, $p < .001$), where those who took support from their employer had significantly higher scores than those who did not take support.
- Self-blame ($t = 3.634$, $df = 1274$, $p < .001$), where those who took support from their employer had significantly higher scores than those who did not take support.

Figure A6. 19: Mean Carver Coping Scores by Uptake of Employer Support (Weighted)

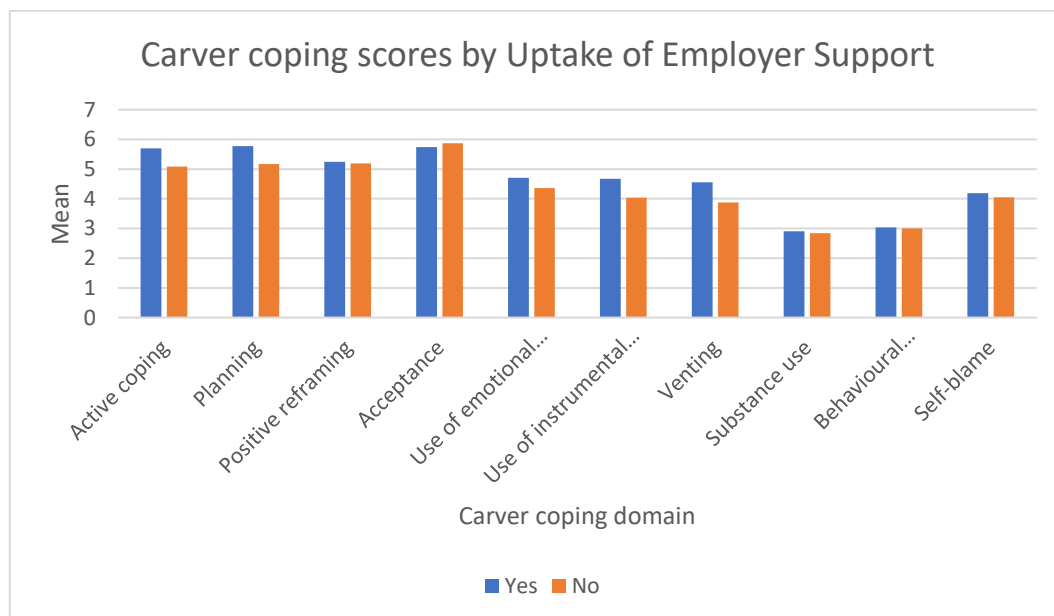


Figure A6. 20: Mean Carver Coping Scores by Uptake of Employer Support (Unweighted)

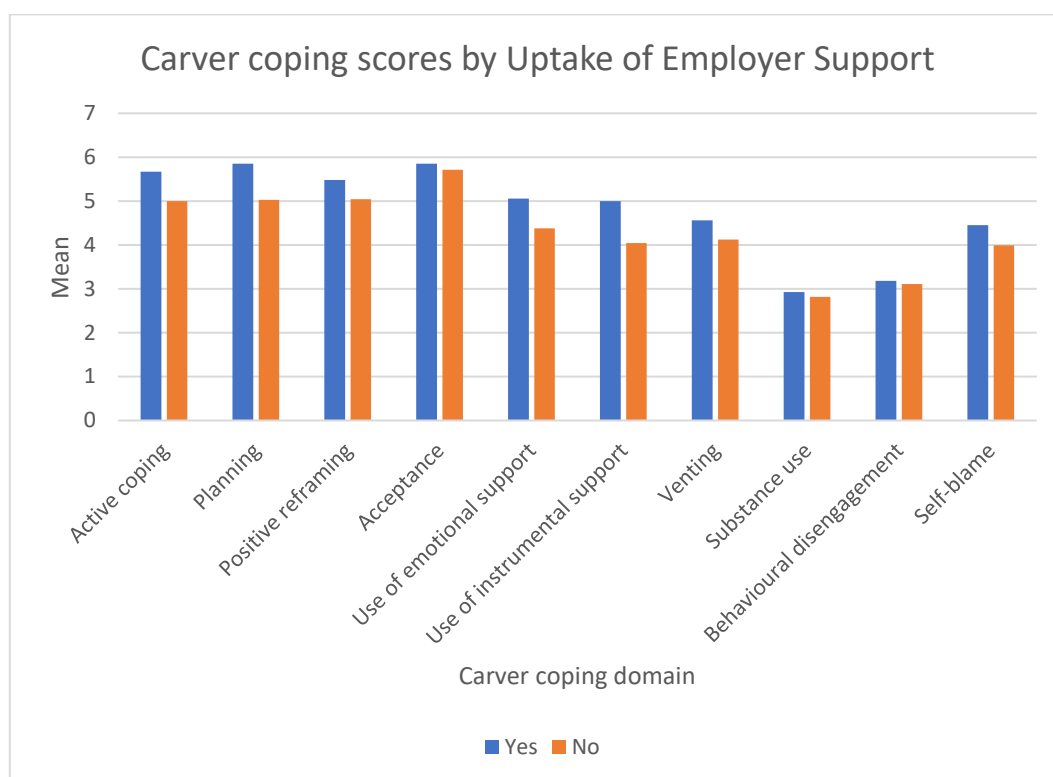


Table A6. 19: Mean Carver Coping Scores by Uptake of Employer Support (Weighted)

Coping domain	Update of employer support	
	Yes	No
Active coping	5.70	5.08
Planning	5.77	5.17
Positive reframing	5.24	5.19
Acceptance	5.74	5.87
Use of emotional support	4.71	4.36
Use of instrumental support	4.67	4.04
Venting	4.56	3.88
Substance use	2.91	2.84
Behavioural disengagement	3.03	3.00
Self-blame	4.19	4.05

Table A6. 20: Mean Carver Coping Scores by Uptake of Employer Support (Unweighted)

Coping domain	Uptake of employer support?	
	Yes	No
Active coping	5.67	5.00
Planning	5.85	5.03
Positive reframing	5.48	5.04
Acceptance	5.85	5.71
Use of emotional support	5.06	4.38
Use of instrumental support	5.00	4.04
Venting	4.56	4.12
Substance use	2.93	2.82
Behavioural disengagement	3.18	3.11
Self-blame	4.45	3.99

Appendix 7: Clark Coping Scale (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of how respondents coped with work-related stressors. This was measured using 15 items (five domains) from Clark et al.'s scale. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A7.1 Clark Coping Scores by Country

Summary (Weighted by Occupation 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:

- Working to improve skills/efficiency ($F = 3.462$, $df = 3$, $p = .016$), those in Scotland scored significantly lower than those in England.
- Recreation and relaxation ($F = 3.080$, $df = 3$, $p = .027$), those in England scored significantly higher than those in Scotland.
- Exercise ($F = 4.220$, $df = 3$, $p = .006$), those in Northern Ireland and England scored significantly higher than those in Scotland.

Summary (Unweighted results):

There were significant differences between the countries in mean scores on two out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 6.640$, $df = 3$, $p < .001$), those in Northern Ireland scored significantly higher than those in England or Wales.
- Work-family segmentation ($F = 3.178$, $df = 3$, $p = .023$), those in Wales scored significantly higher than those in England.

Figure A7. 1: Mean Clark Coping Scores by Country (Weighted by Occupation)

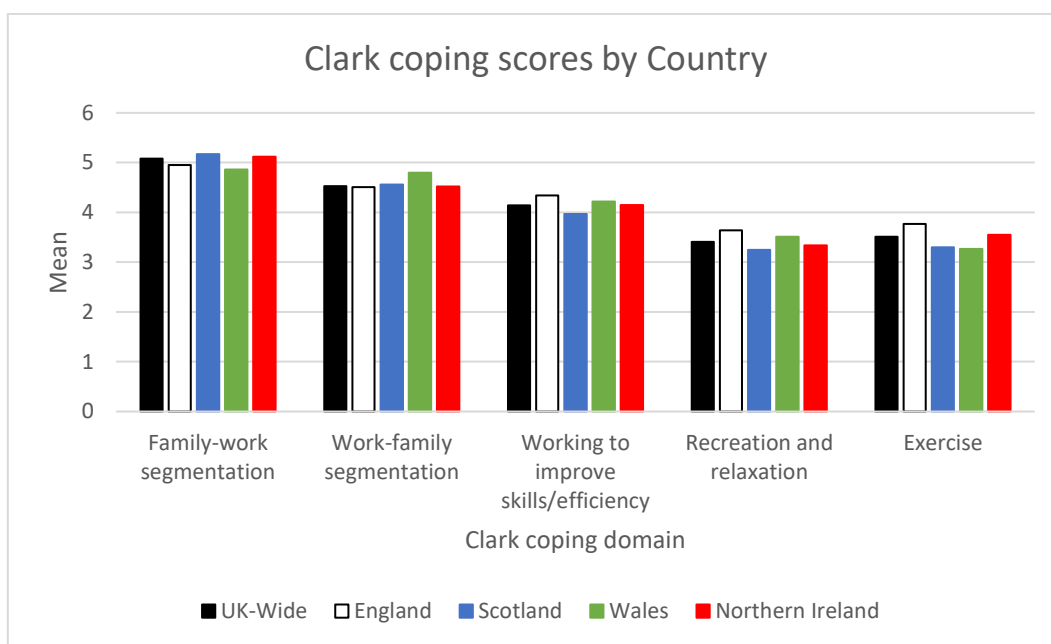


Figure A7. 2: Mean Clark Coping Scores by Country (Unweighted)

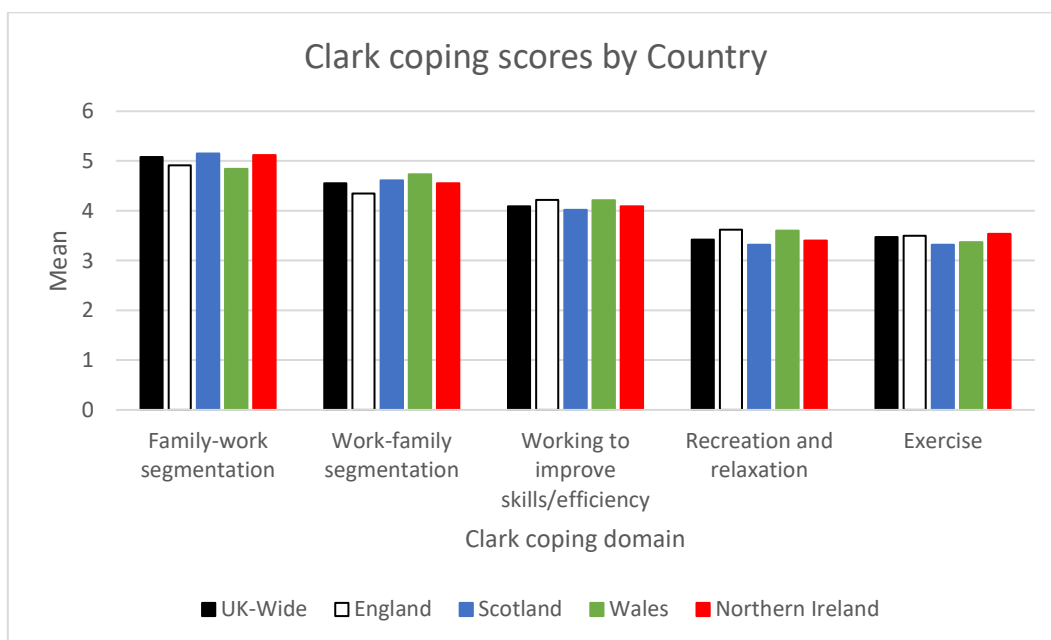


Table A7. 1: Mean Clark Coping Scores by Country (Weighted by Occupation)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family-work segmentation	5.08	4.95	5.17	4.86	5.12
Work-family segmentation	4.53	4.51	4.56	4.80	4.52
Working to improve skills/efficiency	4.14	4.34	3.97	4.22	4.15
Recreation and relaxation	3.41	3.64	3.25	3.51	3.34
Exercise	3.51	3.77	3.30	3.27	3.55

Table A7. 2: Mean Clark Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family-work segmentation	5.08	4.91	5.15	4.84	5.12
Work-family segmentation	4.55	4.35	4.61	4.73	4.55
Working to improve skills/efficiency	4.09	4.22	4.02	4.21	4.09
Recreation and relaxation	3.42	3.62	3.32	3.60	3.40
Exercise	3.47	3.50	3.32	3.37	3.54

A7.2 Clark Coping Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on four Clark coping domains:

- Family-work segmentation ($F = 5.975$, $df = 4$, $p < .001$), where nurses scored significantly higher than AHPs, social care workers. and social workers.
- Work-family segmentation ($F = 8.286$, $df = 4$, $p < .001$), where social workers scored significantly lower than nursing, AHPs and social care workers.
- Working to improve skills/efficiency ($F = 7.811$, $df = 4$, $p < .001$), where nurses scored significantly higher than midwives and social workers.

- Recreation and relaxation ($F = 3.491$, $df = 4$, $p = .008$), where AHPs scored significantly higher than social workers.
- Exercise ($F = 28.895$, $df = 4$, $p < .001$), where AHPs scored significantly higher than social care workers and social workers.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on four Clark Coping domains:

- Working to improve skills/efficiency ($F = 9.298$, $df = 4$, $p < .001$), where social care workers scored significantly lower than nursing, AHPs, and social workers.
- Recreation and relaxation ($F = 9.010$, $df = 4$, $p < .001$), where social care workers scored significantly lower than AHPs and social workers.
- Exercise ($F = 10.599$, $df = 4$, $p < .001$), where AHPs were significantly higher than midwives, social care workers, and social workers

Figure A7.3: Mean Clark Coping Scores by Occupation (Weighted by Region)

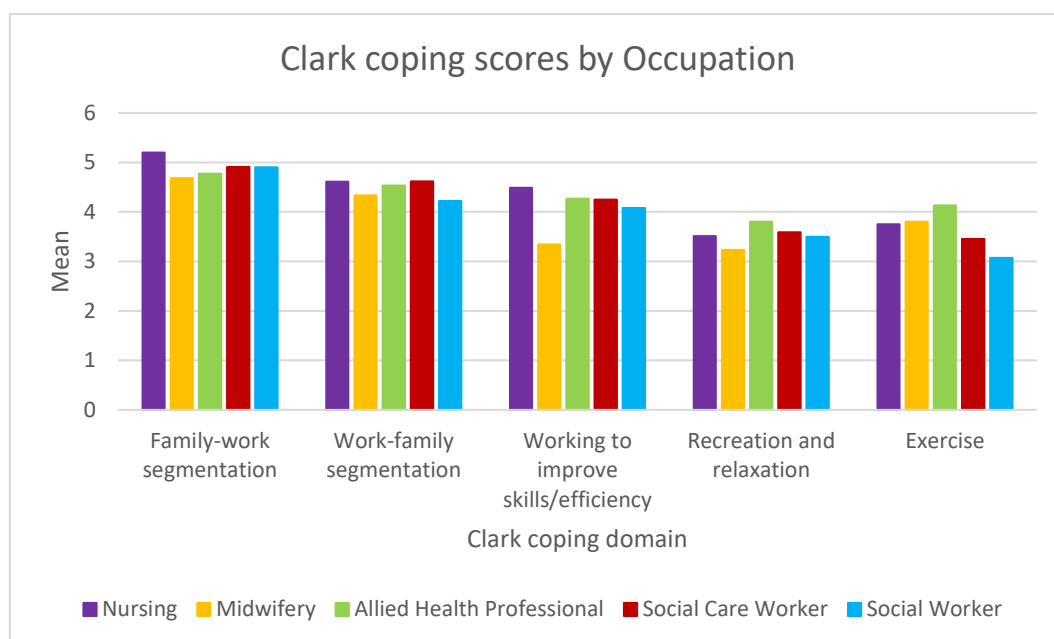


Figure A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

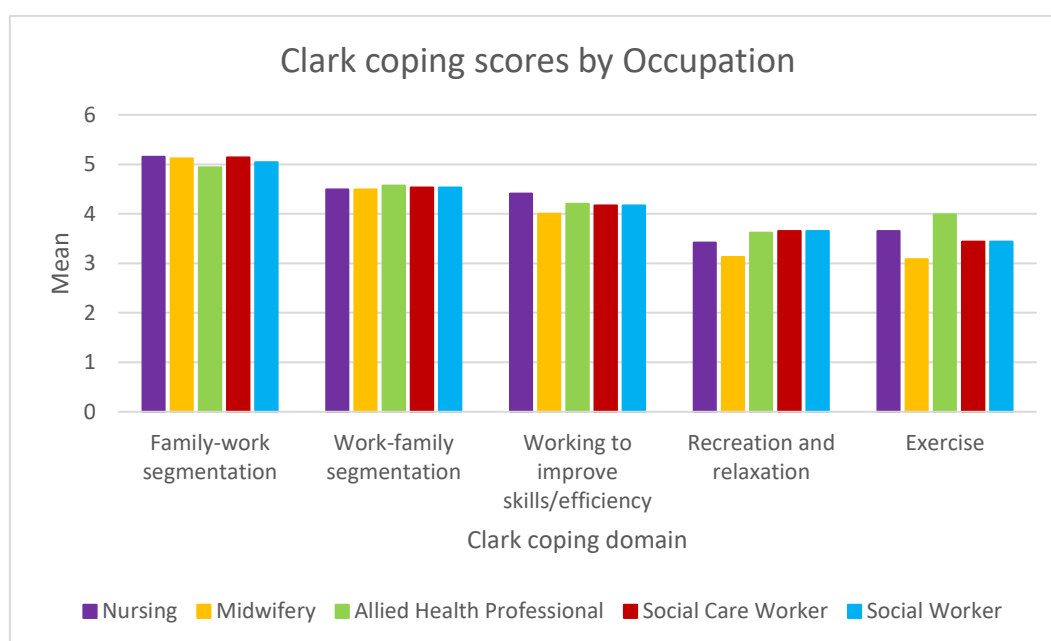


Table A7.3: Mean Clark Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	5.20	4.68	4.77	4.91	4.90
Work-family segmentation	4.61	4.33	4.53	4.62	4.22
Working to improve skills/efficiency	4.49	3.34	4.27	4.25	4.08
Recreation and relaxation	3.51	3.23	3.80	3.59	3.50
Exercise	3.75	3.80	4.13	3.45	3.07

Table A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	5.15	5.12	4.94	5.14	5.04
Work-family segmentation	4.49	4.49	4.57	4.57	4.53
Working to improve skills/efficiency	4.41	4.00	4.20	3.88	4.17
Recreation and relaxation	3.42	3.13	3.62	3.18	3.65
Exercise	3.65	3.08	3.99	3.23	3.44

A7.3 Clark Coping Scores by Sex

Only seven 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 three out of the five examined Clark coping domains. These differences were in:

- Working to improve skills/efficiency ($t = 4.205$, $df = 227.862$, $p < .001$), where females scored significantly higher than males.
- Recreation and relaxation ($t = -3.619$, $df = 1159$, $p < .001$), where females scored significantly lower than males.
- Exercise ($t = -3.049$, $df = 234.313$, $p = .003$), where females scored significantly lower than males.

Summary (Unweighted results):

There were significant differences between males and females in mean scores on two out of the five examined Clark coping domains. These differences were in:

- Working to improve skills/efficiency ($t = 3.618$, $df = 1247$, $p < .001$), where females scored significantly higher than males.
- Recreation and relaxation ($t = -3.397$, $df = 1242$, $p < .001$), where females scored significantly lower than males.

Figure A7.5: Mean Clark Coping Scores by Sex (Weighted)

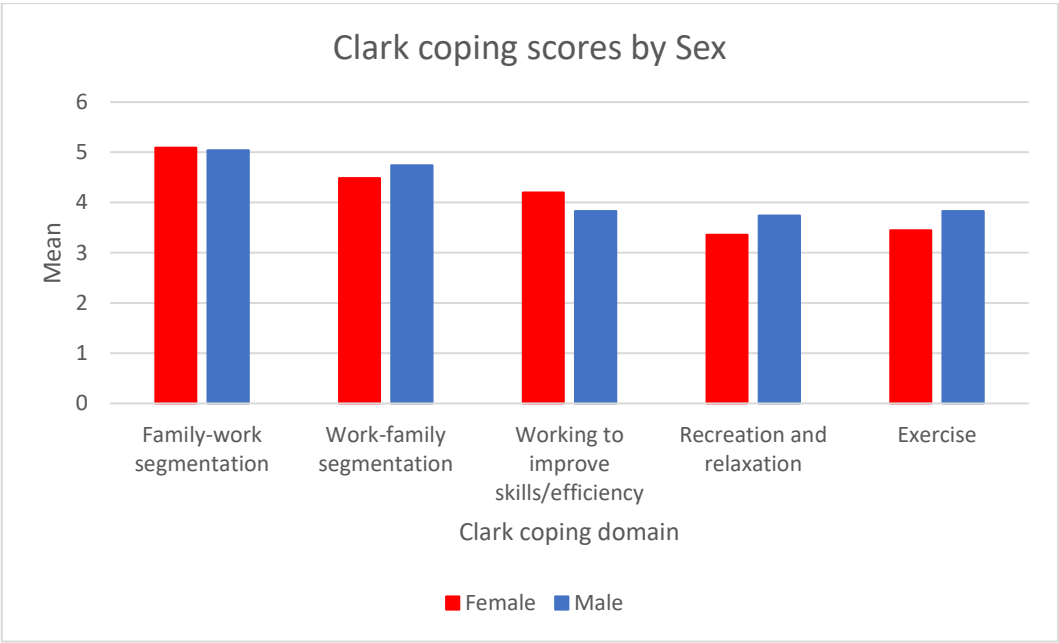


Figure A7.6: Mean Clark Coping Scores by Sex (Unweighted)

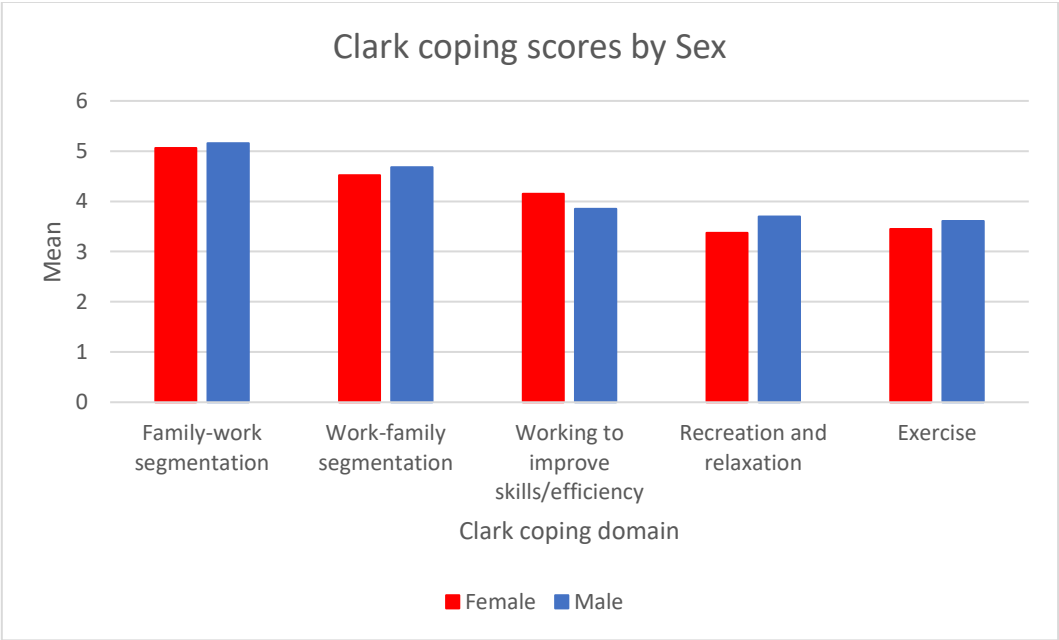


Table A7.5: Mean Clark Coping Scores by Sex (Weighted)

Coping Domain	Sex	
	Female	Male
Family-work segmentation	5.09	5.04
Work-family segmentation	4.49	4.74
Working to improve skills/efficiency	4.20	3.83
Recreation and relaxation	3.36	3.74
Exercise	3.45	3.83

Table A7.6: Mean Clark Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Family-work segmentation	5.06	5.16
Work-family segmentation	4.52	4.68
Working to improve skills/efficiency	4.15	3.85
Recreation and relaxation	3.37	3.70
Exercise	3.45	3.61

A7.4 Clark Coping Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean scores on four Clark coping domains. These differences were in:

- Family-work segmentation ($F = 7.029$, $df = 4$, $p < .001$), where the 30-39 age group scored significantly lower than the 50-59 and 60+ age groups.
- Work-family segmentation ($F = 10.736$, $df = 4$, $p < .001$), where the 60+ age group scored significantly higher than all other age groups.
- Working to improve skills/efficiency ($F = 5.838$, $df = 4$, $p = .003$), where the 50-59 age group scored significantly lower than the 30-39 and 40-49 age groups.
- Exercise ($F = 7.597$, $df = 4$, $p < .001$), where the 60+ age group scored significantly lower than the 16-29, 30-39, 40-49 age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on two out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ($F = 5.468$, $df = 4$, $p < .001$), where the 30-39 age group is significantly lower than the 40-49, 50-59 and 60+ age groups.
- Exercise ($F = 2.955$, $df = 4$, $p = .019$); where the 30-39 age group scored significantly lower than the 50-59 and 60+ age groups.

Figure A7.7: Mean Clark Coping Scores by Age (Weighted)

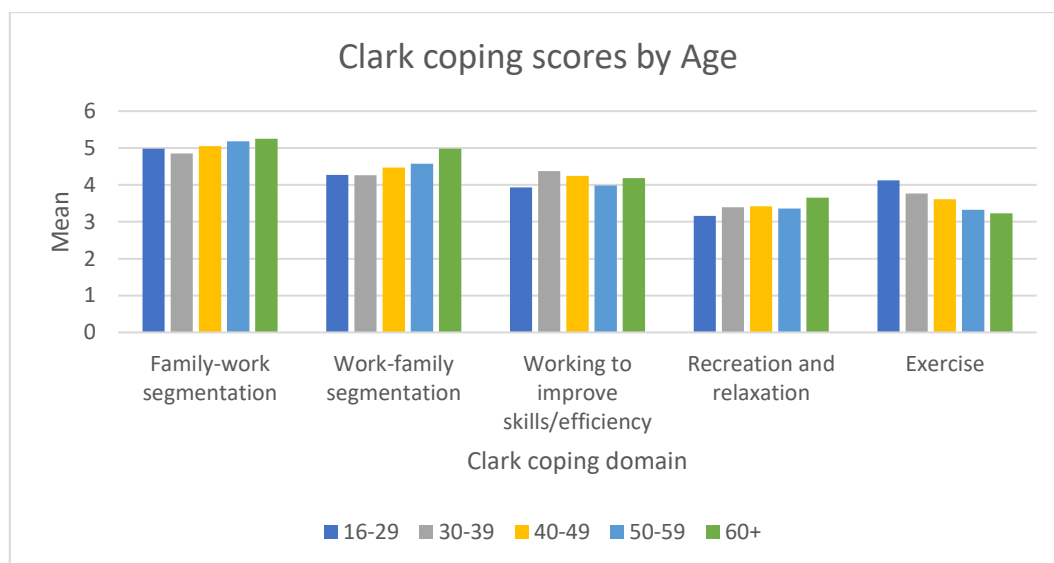


Figure A7.8: Mean Clark Coping Scores by Age (Unweighted)

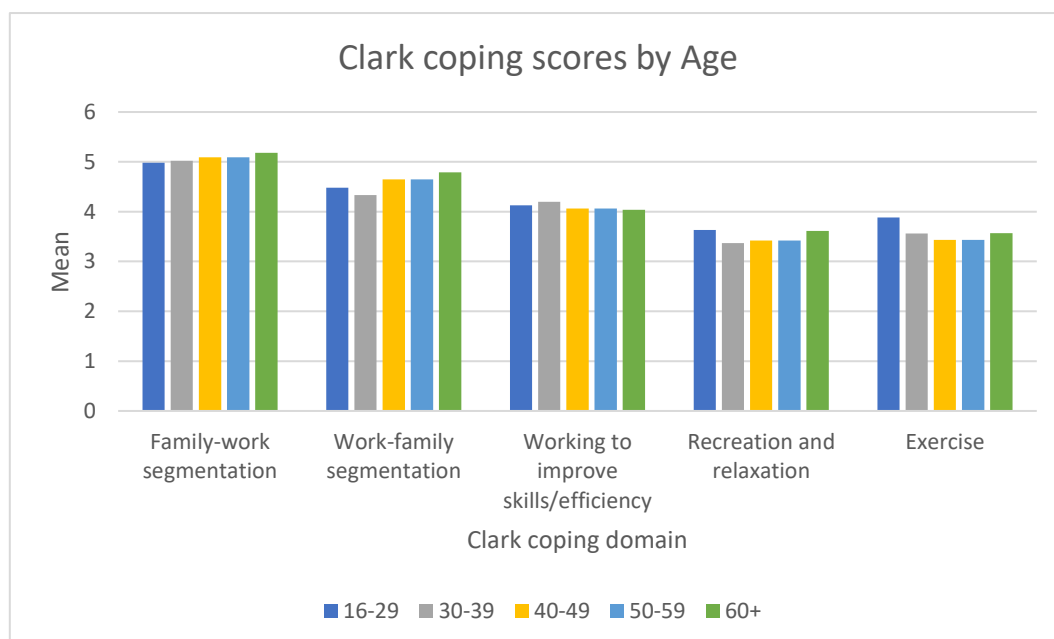


Table A7.7: Mean Clark Coping Scores by Age (Weighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60+
Family-work segmentation	4.98	4.85	5.05	5.18	5.25
Work-family segmentation	4.27	4.26	4.47	4.57	4.98
Working to improve skills/efficiency	3.93	4.37	4.24	3.98	4.18
Recreation and relaxation	3.16	3.39	3.42	3.36	3.65
Exercise	4.12	3.77	3.61	3.32	3.23

Table A7.8: Mean Clark Coping Scores by Age (Unweighted)

Coping domain	Age				
	16-29	30-39	40-49	50-59	60+
Family-work segmentation	4.98	5.02	5.09	5.09	5.18
Work-family segmentation	4.48	4.33	4.48	4.65	4.79
Working to improve skills/efficiency	4.13	4.20	4.11	4.06	4.04
Recreation and relaxation	3.63	3.37	3.34	3.42	3.61
Exercise	3.88	3.56	3.33	3.43	3.57

A7.5 Clark Coping Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on four examined Clark coping domains. These differences were in:

- Work-family segmentation ($F = 8.730$, $df = 3$, $p < .001$), where respondents from the Black ethnicity group scored significantly lower than all other ethnic groups.
- Working to improve skills/efficiency ($F = 13.872$, $df = 3$, $p < .001$), where respondents from the White ethnic group scored significantly lower than the Black and Asian ethnic groups.
- Recreation and relaxation ($F = 4.931$, $df = 3$, $p = .002$), where respondents from the Black ethnic group scored significantly higher than those in the White Ethnic group.

- Exercise ($F = 6.086$, $df = 3$, $p < .001$), where respondents from the White ethnicity group scored significantly lower than Black and Asian ethnic groups.

Summary (Unweighted results):

There were no significant differences between the ethnic groups in mean scores in any of the five examined Clark coping domains.

Figure A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

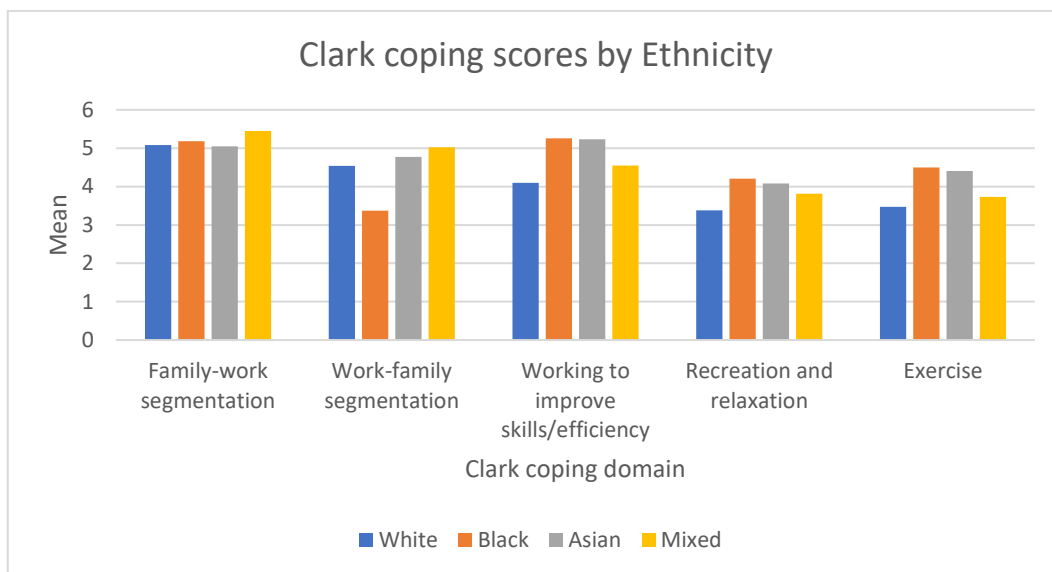


Figure A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

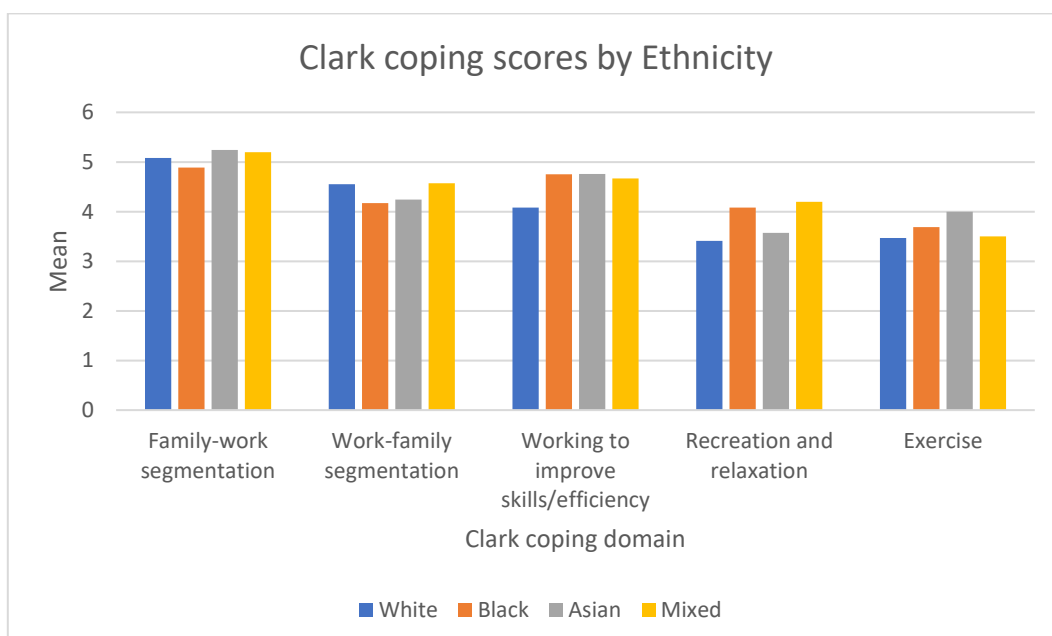


Table A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	5.08	5.18	5.05	5.45
Work-family segmentation	4.54	3.37	4.77	5.02
Working to improve skills/efficiency	4.10	5.26	5.23	4.55
Recreation and relaxation	3.38	4.21	4.08	3.81
Exercise	3.47	4.50	4.41	3.73

Table A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	5.08	4.89	5.24	5.20
Work-family segmentation	4.55	4.17	4.24	4.57
Working to improve skills/efficiency	4.08	4.75	4.76	4.67
Recreation and relaxation	3.41	4.08	3.57	4.20
Exercise	3.47	3.69	4.00	3.50

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 two out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ($F = 4.958$, $df = 2$, $p = .007$), where respondents who had a disability scored significantly lower than those who were unsure if they had a disability.
- Exercise ($F = 11.662$, $df = 2$, $p < .001$), where respondents who had a disability scored significantly lower than those without a disability and those who were unsure if they had a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on one out of the five examined Clark coping domains. These differences were in:

- Exercise ($F = 8.383$, $df = 2$, $p < .001$), where respondents without a disability scored significantly higher than those with a disability.

Figure A7.11: Mean Clark Coping Scores by Disability (Weighted)

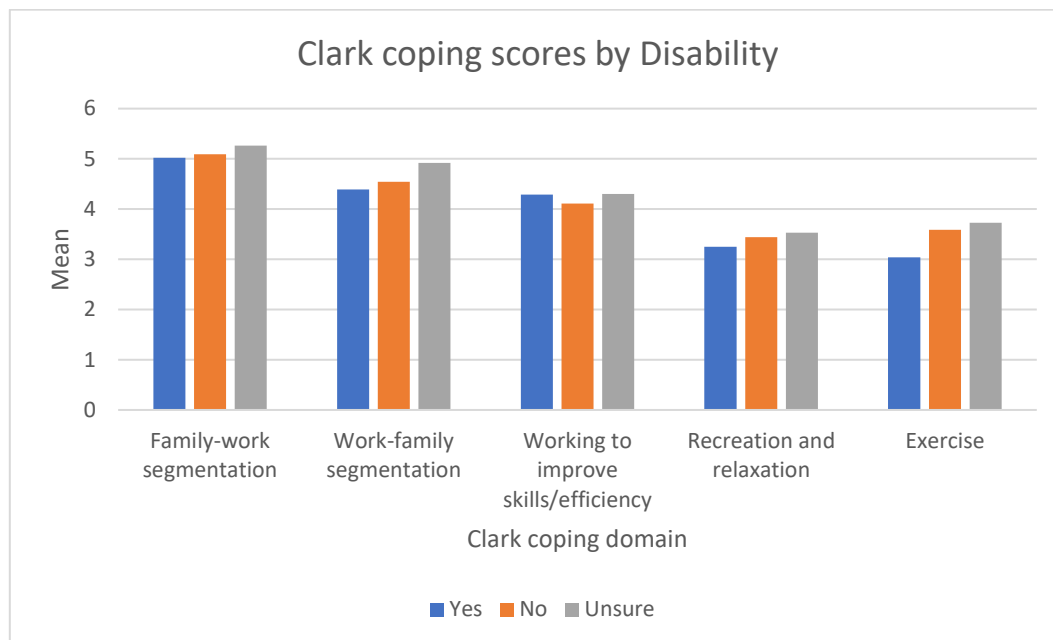


Figure A7.12: Mean Clark Coping Scores by Disability (Unweighted)

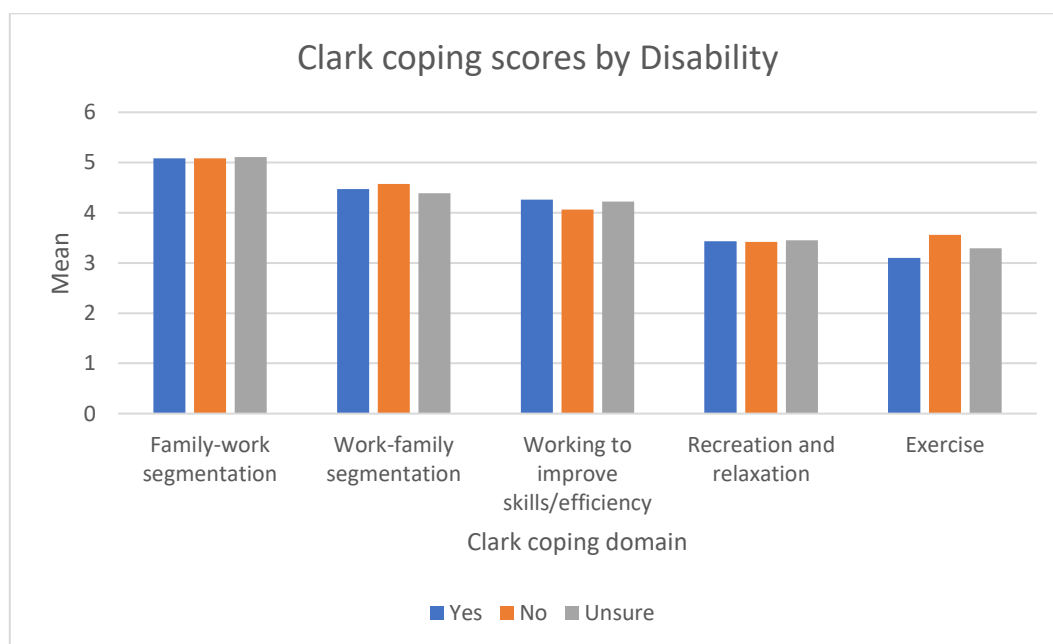


Table A7.11: Mean Clark Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Family-work segmentation	5.02	5.09	5.26
Work-family segmentation	4.39	4.54	4.92
Working to improve skills/efficiency	4.29	4.11	4.30
Recreation and relaxation	3.25	3.44	3.53
Exercise	3.04	3.59	3.73

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	5.08	5.08	5.11
Work-family segmentation	4.47	4.57	4.39
Working to improve skills/efficiency	4.26	4.06	4.22
Recreation and relaxation	3.43	3.42	3.45
Exercise	3.10	3.56	3.29

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 ($F = 5.816$, $df = 7$, $p < .001$), where respondents working in the area of midwifery scored significantly lower than all those working in all other areas of practice examined.
- Work-family segmentation ($F = 3.846$, $df = 7$, $p < .001$), where respondents working with adults scored significantly higher than those working in the area of physical disability, learning disability and mental health.
- Working to improve skills/efficiency ($F = 7.345$, $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those working in mental health and those in the area of practice 'other'.

- Recreation and relaxation ($F = 5.474$, $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those working with children and young people, mental health, and those in the area of practice 'other'.
- Exercise ($F = 9.997$, $df = 7$, $p < .001$), where respondents who selected 'other' as their area of practice scored significantly higher than those working with children and young people, adults, learning disability, and older people.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean scores in three examined Clark coping domains. These differences were in:

- Working to improve skills/efficiency ($F = 4.316$ $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those working with children and young people, adults, and those who selected 'other' as their area of practice.
- Recreation and relaxation ($F = 6.073$, $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those working with children and young people, mental health, and those who selected 'other' as their area of practice.
- Exercise ($F = 5.578$, $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those working with children and young people and those who selected 'other' as their area of practice.

Figure A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

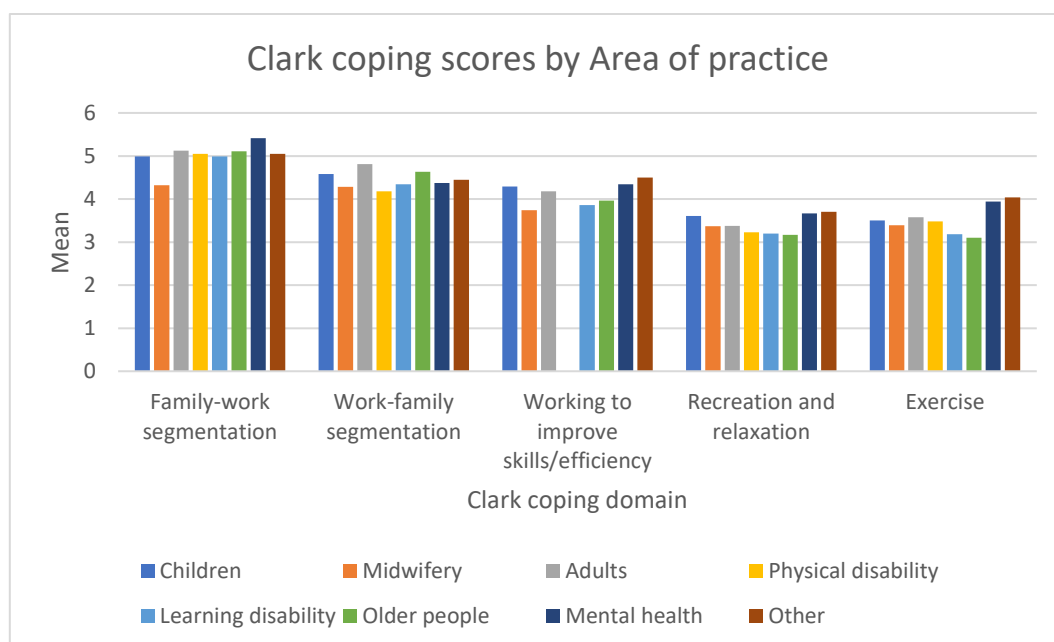


Figure A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)

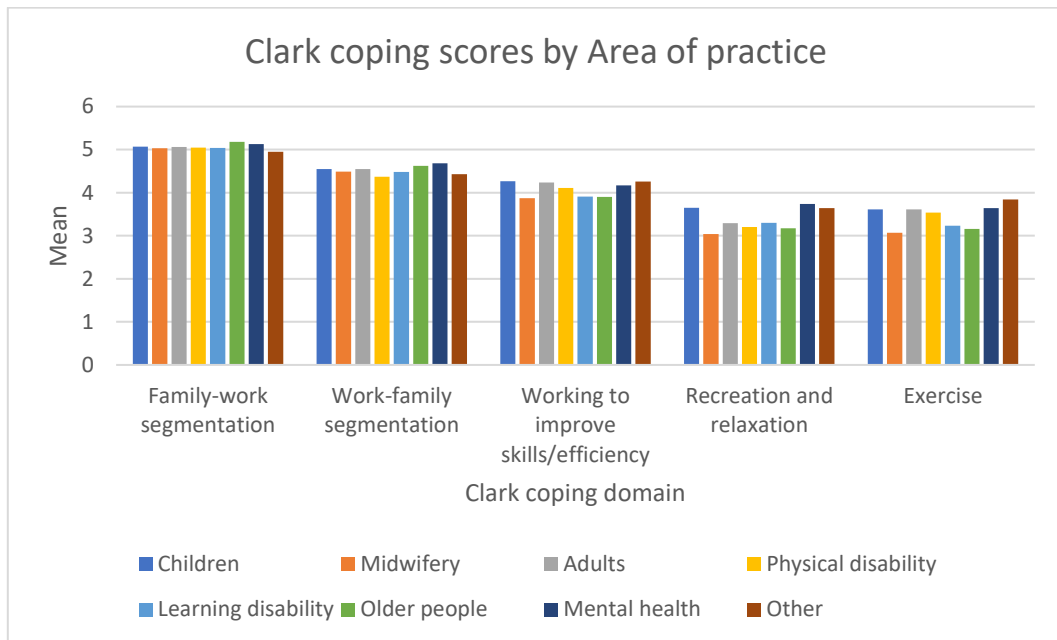


Table A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Family-work segmentation	4.99	4.32	5.12	5.05	4.99	5.11	5.41	5.05
Work-family segmentation	4.58	4.28	4.81	4.18	4.34	4.63	4.37	4.45
Working to improve skills/efficiency	4.29	3.74	4.18	3.84	3.86	3.96	4.34	4.50
Recreation and relaxation	3.61	3.37	3.38	3.23	3.20	3.17	3.67	3.70
Exercise	3.50	3.39	3.58	3.45	3.18	3.10	3.94	4.04

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	5.07	5.03	5.06	5.05	5.04	5.18	5.13	4.95
Work-family segmentation	4.55	4.49	4.55	4.37	4.48	4.62	4.68	4.43
Working to improve skills/efficiency	4.27	3.87	4.24	4.11	3.91	3.90	4.17	4.26
Recreation and relaxation	3.65	3.04	3.29	3.20	3.30	3.17	3.74	3.64
Exercise	3.61	3.07	3.61	3.54	3.23	3.16	3.64	3.84

A7.8 Clark Coping Scores by Line Manager Status

Summary (Weighted results):

There were no significant differences between respondents who were line managers and those who were not in mean scores of all the five examined Clark coping domains.

Summary (Unweighted results):

There were no significant differences between respondents who were line managers and those who were not in mean scores of all the five examined Clark coping domains.

Figure A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

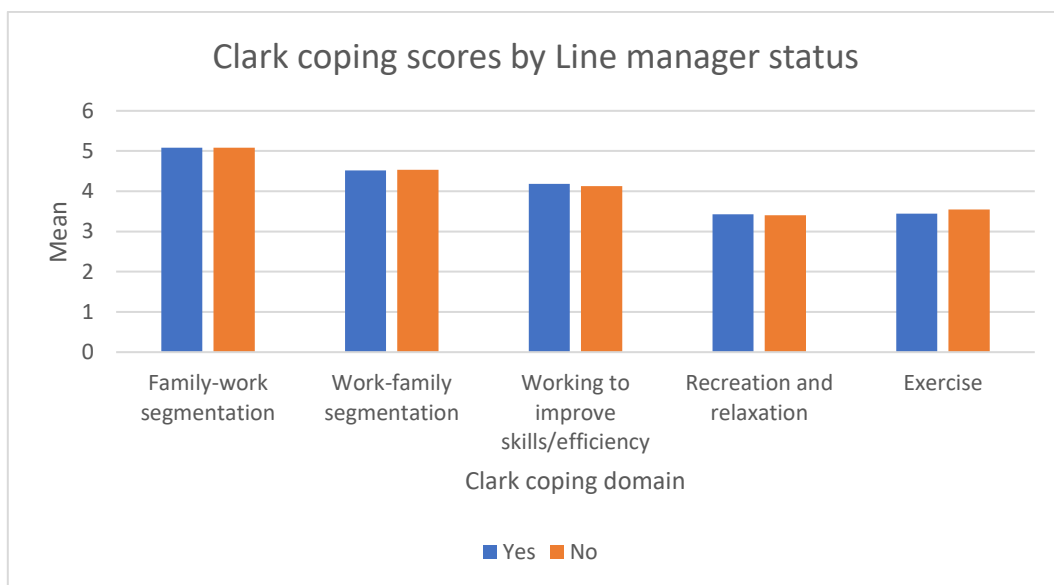


Figure A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

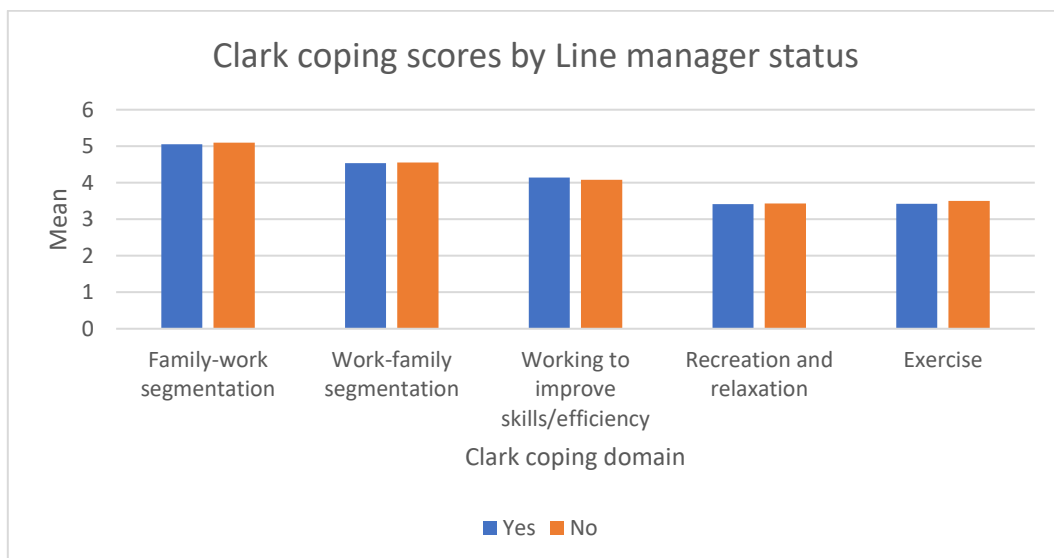


Table A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	5.08	5.08
Work-family segmentation	4.52	4.53
Working to improve skills/efficiency	4.18	4.13
Recreation and relaxation	3.43	3.40
Exercise	3.44	3.55

Table A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	5.05	5.10
Work-family segmentation	4.54	4.55
Working to improve skills/efficiency	4.14	4.08
Recreation and relaxation	3.41	3.43
Exercise	3.42	3.50

A7.9 Clark Coping Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean scores on four 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 ($F = 4.770$, $df = 2$, $p = .009$), where respondents who were impacted but not significantly by COVID-19 scored significantly higher than those overwhelmed by increased pressures.

- Working to improve skills/efficiency ($F = 4.058$, $df = 2$, $p = .018$), where respondents who were not impacted by COVID-19 pressures scored significantly higher than those who were overwhelmed by the increased pressures and those who were impacted but not significantly.
- Recreation and relaxation ($F = 27.006$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those not impacted by COVID-19 pressures and those who were impacted but not significantly.
- Exercise ($F = 7.068$, $df = 2$, $p < .001$), where respondents who were not impacted by COVID-19 pressures scored significantly higher than those who were impacted but not significantly and those who felt overwhelmed by the 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 ($F = 7.649$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt impacted but not significantly.
- Working to improve skills/efficiency ($F = 3.622$, $df = 2$, $p = .027$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact.
- Recreation and relaxation ($F = 11.965$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact.
- Exercise ($F = 5.430$, $df = 2$, $p = .004$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact and those who felt no impact.

Figure A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

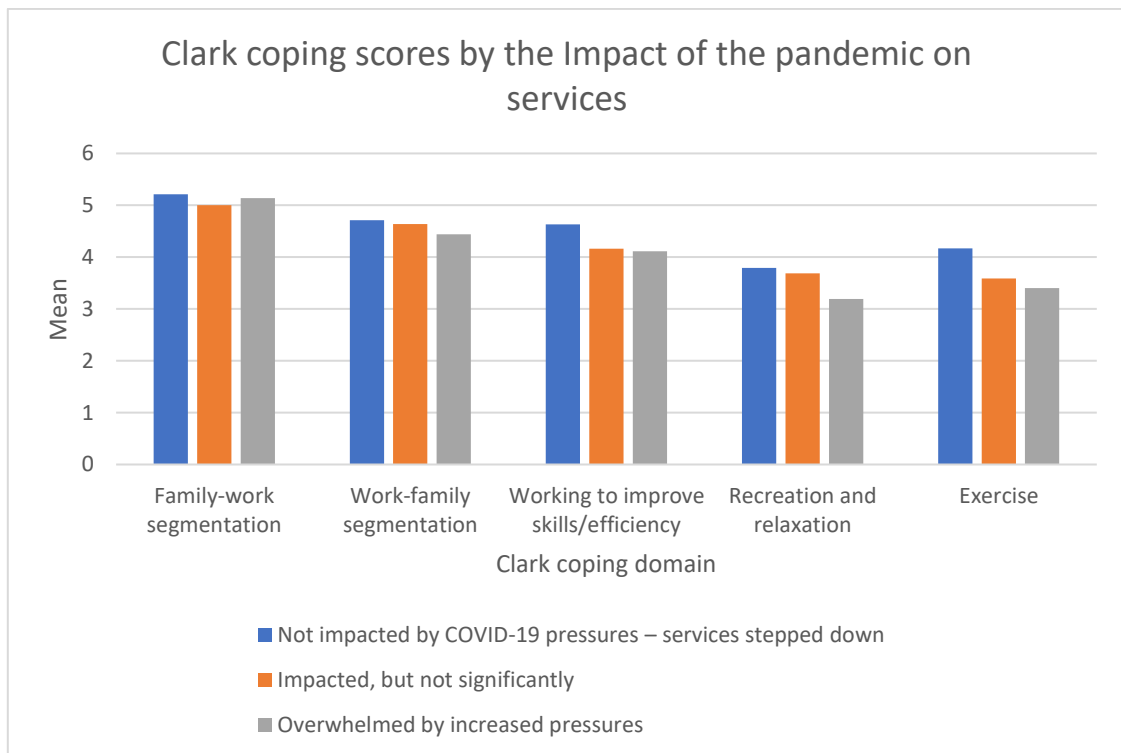


Figure A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)

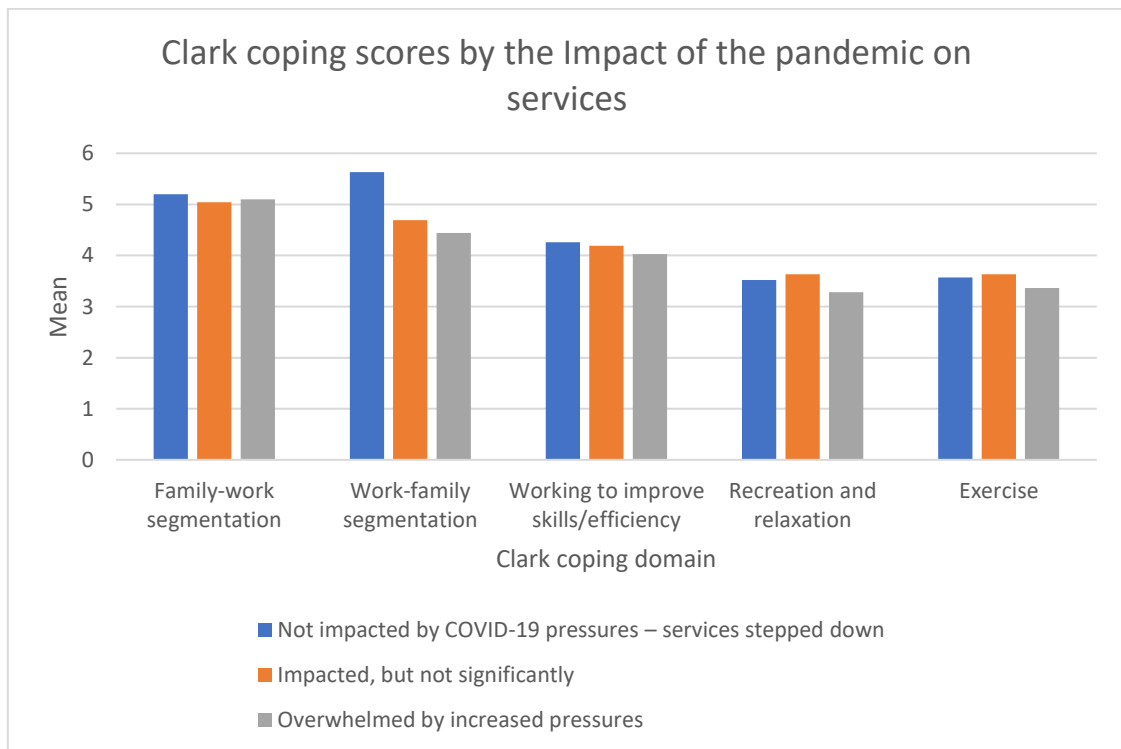


Table A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

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	5.21	5.00	5.14
Work-family segmentation	4.71	4.64	4.44
Working to improve skills/efficiency	4.63	4.16	4.11
Recreation and relaxation	3.79	3.69	3.19
Exercise	4.17	3.59	3.40

Table A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)

Coping domain	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Family-work segmentation	5.20	5.04	5.10
Work-family segmentation	5.63	4.69	4.44
Working to improve skills/efficiency	4.26	4.19	4.03
Recreation and relaxation	3.52	3.63	3.28
Exercise	3.57	3.63	3.36

A7.9 Clark Coping Scores by Uptake of Employer Support

Summary (Weighted results):

There were significant differences in mean scores on one out of the five examined Clark coping domains between respondents who took employer support and those who did not. These differences were in:

- Working to improve skills and efficiency ($t = 2.524$, $df = 1164$, $p = .012$), where those who took employer support scored significantly higher than those who did not.

Summary (Unweighted results):

There were significant differences in mean scores on one out of the five examined Clark coping domains between respondents who took employer support and those who did not. These differences were in:

- Working to improve skills and efficiency ($t = 3.610$, $df = 1248$, $p < .001$), where those who took employer support scored significantly higher than those who did not.

Figure A7.19: Mean Clark Coping Scores by Uptake of Employer Support (Weighted)

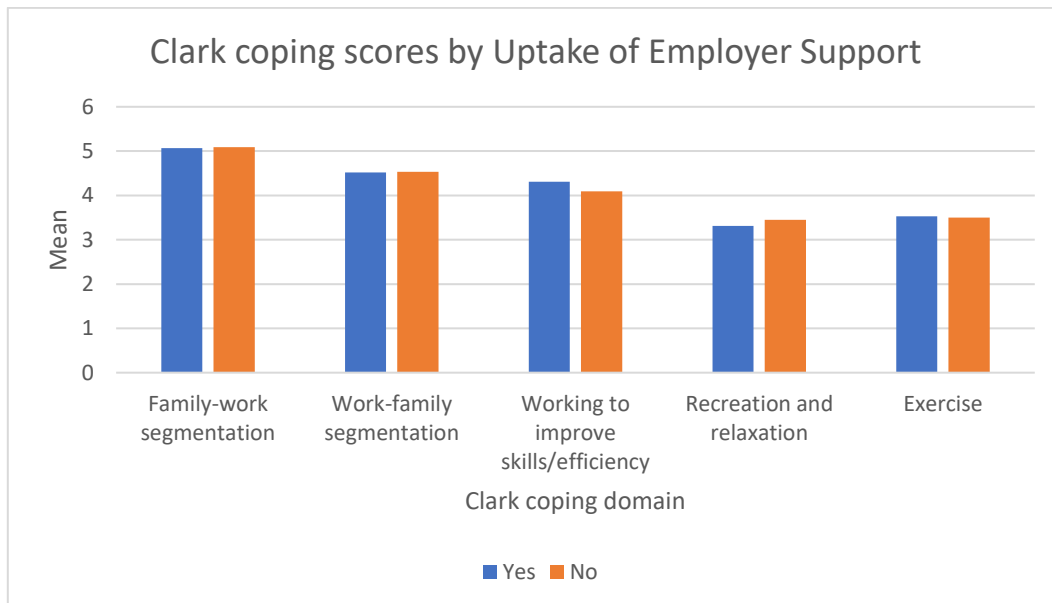


Figure A7.20: Mean Clark Coping Scores by Uptake of Employer Support (Unweighted)

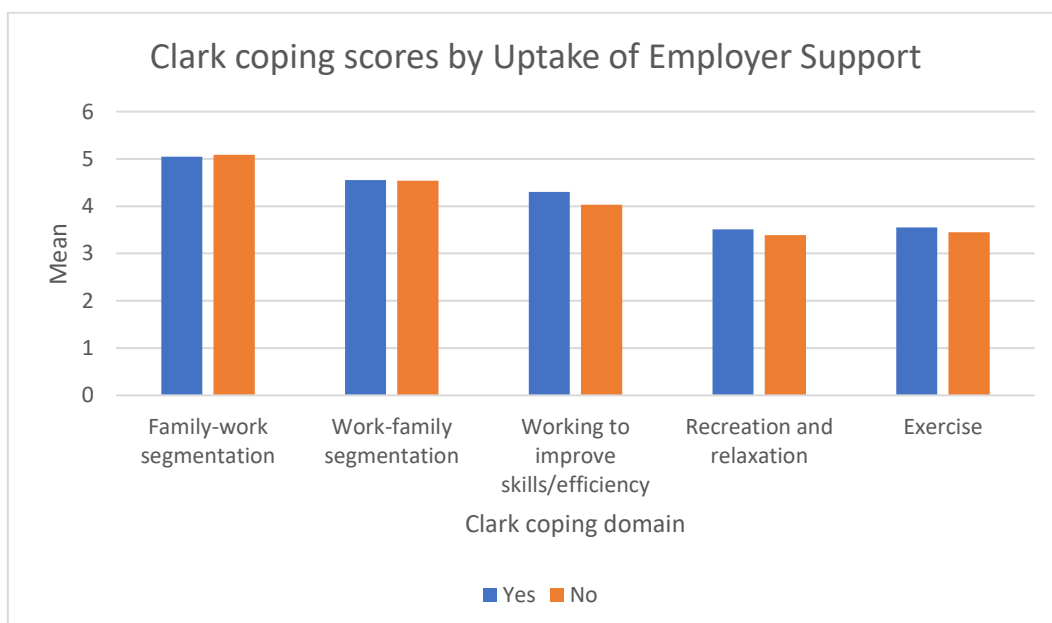


Table A7. 19: Mean Clark Coping Scores by Uptake of Employer Support (Weighted)

Coping domain	Uptake of Employer Support	
	Yes	No
Family-work segmentation	5.07	5.09
Work-family segmentation	4.52	4.53
Working to improve skills/efficiency	4.31	4.09
Recreation and relaxation	3.31	3.45
Exercise	3.53	3.50

Table A7. 20: Mean Clark Coping Scores by Uptake of Employer Support (Unweighted)

Coping domain	Uptake of Employer Support	
	Yes	No
Family-work segmentation	5.05	5.09
Work-family segmentation	4.55	4.54
Working to improve skills/efficiency	4.30	4.03
Recreation and relaxation	3.51	3.39
Exercise	3.55	3.45

Appendix 8: Multiple Regression Results (Unweighted)

A8.1 Multiple Regression Model Predicting Well-being Scores (Weighted)

Research question: Do coping mechanisms predict Well-being scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Well-being scores (SWEMWBS) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 41.2% of the variance (adjusted $R^2 = .392$, $F(40, 1166) = 20.447$, $p < .001$). The following coping strategies predicted overall well-being score (SWEMWBS):

1. **Carver's Acceptance:** respondents with higher Acceptance scores had higher Well-being scores ($\beta = .274$, $p < .001$).
2. **Carver's Use of emotional support;** respondents with higher Use of emotional support scores had higher Well-being scores ($\beta = .385$, $p < .001$).
3. **Carver's Use of instrumental support;** respondents with higher use of instrumental scores had lower Well-being scores ($\beta = -.192$, $p = .004$).

4. **Substance use:** respondents with higher use of substance use had lower Well-being scores ($\beta = -.121, p = .042$).
5. **Carver's Behavioural disengagement:** respondents with higher Behavioural disengagement scores had lower Well-being scores ($\beta = -.260, p < .001$).
6. **Carver's Self-blame:** respondents with higher Self-blame scores had lower Well-being scores ($\beta = -.519, p < .001$).
7. **Clark et al.'s Family-work segmentation;** respondents with higher Family-work segmentation scores had lower Well-being scores ($\beta = -.347, p < .001$).
8. **Work-family segmentation:** respondents with higher Work-family segmentation scores had higher Well-being scores ($\beta = .276, p < .001$).
9. **Clark et al.'s Working to improve skills/efficiency;** respondents with higher Working to improve skills/efficiency scores had higher Well-being scores ($\beta = .204, p = .016$).
10. **Clark et al.'s Recreation and relaxation;** respondents with higher Recreation and relaxation scores had higher Well-being scores ($\beta = .255, p < .001$).
11. **Clark et al.'s Exercise;** respondents with higher Exercise scores had higher Well-being scores ($\beta = .189, p = .002$).

Other variables predicting the overall well-being score:

12. **Effects of the pandemic;** respondents who were overwhelmed by the pandemic ($\beta = -2.083, p < .001$) and those who were impacted but not significantly all had lower well-being scores than those whose services were not impacted at all ($\beta = -1.438, p = .006$).
13. **Occupational group:** those who worked as social care workers had lower well-being scores than those who worked in Nursing ($\beta = -.652, p = .011$).
14. **Number of sick days in previous 12 months;** respondents who took less than 10 sick days ($\beta = -.386, p = .044$), 11-20 sick days ($\beta = -.793, p = .002$), and those who took more than 60 sick days ($\beta = -1.004, p = .008$) all had lower well-being scores than those who took no sick days.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ($\beta = -.957, p < .001$) had lower well-being scores than those who did not intend on leaving their employer. Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that

respondents who answered yes for wanting to leave ($\beta = -.960$, $p < .001$) had lower well-being scores than those who did not intent on leaving their occupation.

A8.2 Multiple Regression Model Predicting Quality of Working Life Scores

Research question: Do coping mechanisms predict Work-Related Quality of Life (WRQOL) scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Work-related quality of life scores (WRQOL) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 41.8% of the variance (adjusted $R^2 = .39.8$, $F(40, 1166) = 20.913$, $p < .001$). 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 ($\beta = -1.494$, $p < .001$).
2. **Carver's Positive reframing;** respondents with higher positive reframing scores had higher WRQOL scores ($\beta = .702$, $p = .023$).

3. **Carver's Acceptance**; respondents with higher Acceptance scores had higher WRQOL scores ($\beta = .633, p = .018$).
4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher WRQOL scores ($\beta = 1.598, p < .001$).
5. **Carver's Venting**; respondents with higher Venting scores had lower WRQOL scores ($\beta = -.682, p = .000$).
6. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower WRQOL scores ($\beta = -1.652, p < .001$).
7. **Carver's Self-blame**; respondents with higher Self-blame scores had lower WRQOL scores ($\beta = -1.026, p < .001$).
8. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower WRQOL scores ($\beta = -3.313, p < .001$).
9. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher WRQOL scores ($\beta = 2.226, p < .001$).
10. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher WRQOL scores ($\beta = 1.429, p < .001$).
11. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher WRQOL scores ($\beta = 1.514, p < .001$).

Other variables predicting the overall WRQOL score:

12. **Disability**; respondents who were had a disability ($\beta = -3.341, p = .001$) had lower WRQOL scores than those who did not have a disability.
13. **Ethnicity**; respondents who were mixed-ethnicity ($\beta = -8.561, p = .037$) had lower WRQOL scores than those who had white ethnicity.
14. **Country of work**; respondents working in Wales ($\beta = 5.931, p < .001$) had higher WRQOL scores than those working in England.
15. **Occupational group**; those who worked as social workers had lower WRQOL scores than those who worked in Nursing ($\beta = -2.581, p = .035$).
15. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days ($\beta = -2.630, p = .003$), 11-20 sick days ($\beta = -5.243, p < .001$), those who took 21-40 sick days ($\beta = -6.205, p < .001$); those who took 41-60 ($\beta = -6.982, p = .003$) and those who took more than 60 sick days ($\beta = -9.369, p > .001$) all had lower WRQOL scores than those who took no sick days.
16. **Line manager status**; respondents who were line managers had higher WRQOL scores than those who were not line managers ($\beta = 2.720, p < .001$).

17. **Effects of the pandemic on services;** respondents who felt overwhelmed by increased pressures ($\beta = -9.317, p < .001$) had lower WRQOL scores than those who felt no impact.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = -10.210, p < .001$) had lower WRQOL scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = -10.242, p < .001$) had lower WRQOL scores than those who did not intend on leaving their occupation.

A8.3 Multiple Regression Model Predicting Personal Burnout Scores

Research question: Do coping mechanisms predict Personal Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Personal burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- Intent to leave employer (dummy coded; reference category: No)

- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 40.7% of the variance (adjusted $R^2 = .387$, $F(40, 1169) = 20.043$, $p < .001$). The following coping strategies predicted personal burnout scores:

1. **Carver's Planning;** respondents with higher Planning scores had higher personal burnout scores ($\beta = .959$, $p = .033$).
2. **Carver's Use of emotional support;** respondents with higher Use of emotional support scores had lower Personal burnout scores ($\beta = -.977$, $p = .006$).
3. **Carver's Behavioural disengagement;** respondents with higher Behavioural disengagement scores had higher Personal burnout scores ($\beta = 1.757$, $p < .001$).
4. **Carver's Self-blame;** respondents with higher Self-blame scores had higher Personal burnout scores ($\beta = 2.591$, $p < .001$).
5. **Clark et al.'s Family-work segmentation;** respondents with higher Family-work segmentation scores had higher Personal burnout scores ($\beta = 2.527$, $p < .001$).
6. **Clark et al.'s Work-family segmentation;** respondents with lower Work-family segmentation scores had higher Personal burnout scores ($\beta = 1.619$, $p < .001$).
7. **Clark et al.'s Exercise;** respondents with higher Exercise scores had lower Personal burnout scores ($\beta = -1.273$, $p < .001$).

Other variables predicting the personal burnout score:

8. **Age;** respondents aged 40-49 ($\beta = -3.993$, $p = .028$), those aged 50-59 ($\beta = -4.921$, $p = .007$) and those aged 60+ ($\beta = -7.909$, $p < .001$) all had lower personal burnout scores than those aged 16-29.
9. **Sex;** males had lower personal burnout scores than females ($\beta = -5.262$, $p < .001$).
10. **Disability;** respondents with a disability ($\beta = 6.114$, $p < .001$) had higher personal burnout scores than those who did not have a disability.
11. **Number of sick days in previous 12 months;** respondents who took less than 10 sick days ($\beta = 3.508$, $p = .002$), those who took 11-20 sick days ($\beta = 7.190$, $p < .001$), those who took 21-40 sick days ($\beta = 4.043$, $p = .034$), those who took 41-60 sick days ($\beta = 6.671$, $p = .022$), and those who took more than 60 sick days ($\beta = 6.416$, $p = .004$), all had higher personal burnout scores than those who took no sick days.
12. **Effects of the pandemic on services;** respondents who felt their services had felt overwhelmed by increased pressures ($\beta = 16.005$, $p < .001$) and those who felt impacted but

not significantly ($\beta = 7.084, p = .022$) had higher personal burnout scores than those who felt no impact.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ($\beta = 6.427, p < .001$) had higher personal burnout scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 5.913, p < .001$) had higher personal burnout scores than those who did not intend on leaving their employer.

A8.4 Multiple Regression Model Predicting Work-Related Burnout Scores

Research question : Do coping mechanisms predict Work-Related Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Work-related burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 43.7% of the variance (adjusted $R^2 = .418$, $F(40, 1169) = 22.676$, $p < .001$). The following coping strategies predicted personal burnout scores:

1. **Carver's Planning;** respondents with higher Planning scores had higher Work-related burnout scores ($\beta = 1.776$, $p < .001$).
2. **Carver's Acceptance;** respondents with higher acceptance scores had lower Work-related burnout scores ($\beta = -.916$, $p = .009$).
3. **Carver's Use of emotional support;** respondents with higher Use of emotional support scores had lower work-related burnout scores ($\beta = -.876$, $p = .018$).
4. **Carver's Venting;** respondents with lower venting scores had lower work-related burnout scores ($\beta = .878$, $p = .010$).
5. **Carver's Behavioural disengagement;** respondents with higher Behavioural disengagement scores had higher Work-related burnout scores ($\beta = 2.137$, $p < .001$).
6. **Carver's Self-blame;** respondents with higher Self-blame scores had higher Work-related burnout scores ($\beta = 2.236$, $p < .001$).
7. **Clark et al.'s Family-work segmentation;** respondents with higher Family-work segmentation scores had higher Work-related burnout scores ($\beta = 3.582$, $p < .001$).
8. **Clark et al.'s Work-family segmentation;** respondents with higher Work-family segmentation scores had lower Work-related burnout scores ($\beta = -2.572$, $p < .001$).
9. **Clark et al.'s Recreation and relaxation;** respondents with higher Recreation and relaxation scores had lower Work-related burnout scores ($\beta = -1.314$, $p = .006$).

Other variables predicting the work-related burnout score:

10. **Age;** respondents aged 50-59 ($\beta = -5.459$, $p = 0.04$), and those aged 60+ ($\beta = -8.590$, $p < .001$) all had lower work-related burnout scores than those aged 16-29.
11. **Disability;** respondents who had a disability ($\beta = 3.998$, $p = .004$) had higher work-related burnout scores than those who did not have a disability.
12. **Occupation;** respondents who worked in Midwifery ($\beta = 7.835$, $p = .032$) had higher work-related burnout scores than those who worked in nursing.
13. **Number of sick days in previous 12 months;** respondents who took less than 10 days ($\beta = 2.837$, $p = .016$), those who took 11-20 sick days ($\beta = 56.868$, $p < .001$), and those who had

more than 60 days sick leave ($\beta = 9.275, p < .001$) had higher work-related burnout scores than those who took no sick days.

14. **Effects of the pandemic on services;** respondents who felt overwhelmed by increased pressures ($\beta = 17.141, p < .001$) had higher work-related burnout scores than those who felt no impact.

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 10.873, p < .001$) had higher work-related burnout scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 11.321, p < .001$) had higher work-related burnout scores than those who did not intend on leaving their employer.

A8.5 Multiple Regression Model Predicting Client-Related Burnout Scores

Research question: Do coping mechanisms predict Client-Related Burnout Scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Client-related burnout scores as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 22.1% of the variance (adjusted $R^2 = .193$, $F(40, 1152) = 8.149$, $p < .001$).

The following coping strategies predicted client-related burnout scores:

1. **Carver's Emotional support:** respondents with lower Emotional support scores had higher Client-related burnout scores ($\beta = -1.208$, $p = .007$).
2. **Carver's Venting;** respondents with higher Venting scores had higher Client-related burnout scores ($\beta = 1.346$, $p = .001$).
3. **Carver's Substance use;** respondents with higher substance use scores had higher Client-related burnout scores ($\beta = 1.003$, $p = .020$).
4. **Carver's Behavioural disengagement:** respondents with higher Behavioural disengagement scores had higher Client-related burnout scores ($\beta = 1.911$, $p < .001$).

5. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Client-related burnout scores ($\beta = 1.054, p = .005$).
6. **Clark et al.'s Work-family segmentation**: respondents with lower Work-family segmentation scores had higher Client-related burnout scores ($\beta = -2.050, p < .001$).
7. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Client-related burnout scores ($\beta = -2.418, p < .001$).

Other variables predicting the client-related burnout score:

8. **Sex**; males had higher client-related burnout scores than females ($\beta = 6.270, p < .001$).
9. **Disability**; respondents who had a disability ($\beta = 3.371, p = .045$) had higher work-related burnout scores than those who did not have a disability.
10. **Ethnicity**; respondents who were mixed-ethnicity ($\beta = 12.980, p = .047$) had higher client-related burnout scores than those who had white ethnicity.
11. **Occupation**; respondents who worked as social workers ($\beta = 3.861, p = .048$) had higher client-related burnout scores than those who worked in nursing.
12. **Line manager status**; respondents who were line managers had lower client-related burnout scores than those who were not line managers ($\beta = -4.681, p < .001$).

Note: Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ($\beta = 6.266, p < .001$) had higher client-related burnout scores than those who did not intend on leaving their employer. Additionally, respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 8.705, p < .001$) had higher client-related burnout scores than those who did not intend on leaving their employer.

Appendix 9: Comparison of Phase 1 (May – July 2020), Phase 2 (Nov 2020 – Feb 2021), Phase 3 (May – July 2021), Phase 4 (Nov 2021-Feb 2022), Phase 5 (May-July 2022) and Phase 6 (Nov 2022 – January 2023).

This section presents descriptive comparisons of data from Phase 1 (May – July 2020) and Phase 2 (November 2020 – February 2021) Phase 3 (May – July 2021, Phase 4 (November 2021-February 2022), Phase 5 (May – July 2022) with Phase 6 (Nov 2022 – January 2023) 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 six phases of the study, thus enabling a more direct comparison.

Note: regression coefficients used in this report are unstandardised.

A9.1 Well-being Scores by Study Phase and Country

The overall mean well-being scores decreased from Phase 1 of the study to Phase 6, both UK-wide and within the individual countries. Between Phase 2 to Phase 6 of the study, the overall mean well-being scores UK-wide increased slightly and across the countries England and Wales, whereas both Scotland and Northern Ireland showed a slight decrease. However, between Phases 3 and 6, while the UK-wide average increased, respondents in Scotland, Wales and Northern Ireland reported a decrease in well-being scores. Between Phase 4 and Phase 6, the overall mean well-being decreased UK-wide and in Scotland, Wales, and Northern Ireland, but respondents in England, reported an increase in well-being scores. Between Phase 5 and Phase 6, the overall mean well-being decreased UK-wide and in Scotland and Northern Ireland, but respondents in England and Wales reported an increase in well-being scores.

UK-wide analysis: Using regression analysis, the decrease in the overall mean well-being scores between Phase 1 and Phase 6 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 ($\beta = -.943, p < .001$). There was a slight increase in the overall mean well-being scores between Phase 2 and Phase 6 of the study which was found to be **not statistically significant** when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = .068, p = .610$). The difference in the overall mean well-being scores between Phase 3 and Phase 6 of the study was **not statistically significant** when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -.144, p = .286$).

Similarly, the slight decrease in the overall mean well-being scores between Phase 4 and Phase 6 was **not statistically significant** when adjusting for the same covariates ($\beta = -.026, p = .877$). Finally, the slight decrease in the overall mean well-being scores between Phase 5 and Phase 6 of the study was **statistically significant** when adjusting for the same covariates ($\beta = -.342, p = .027$).

Figure A9. 1: Mean Overall Well-being Score by Study Phase and Country (Weighted)

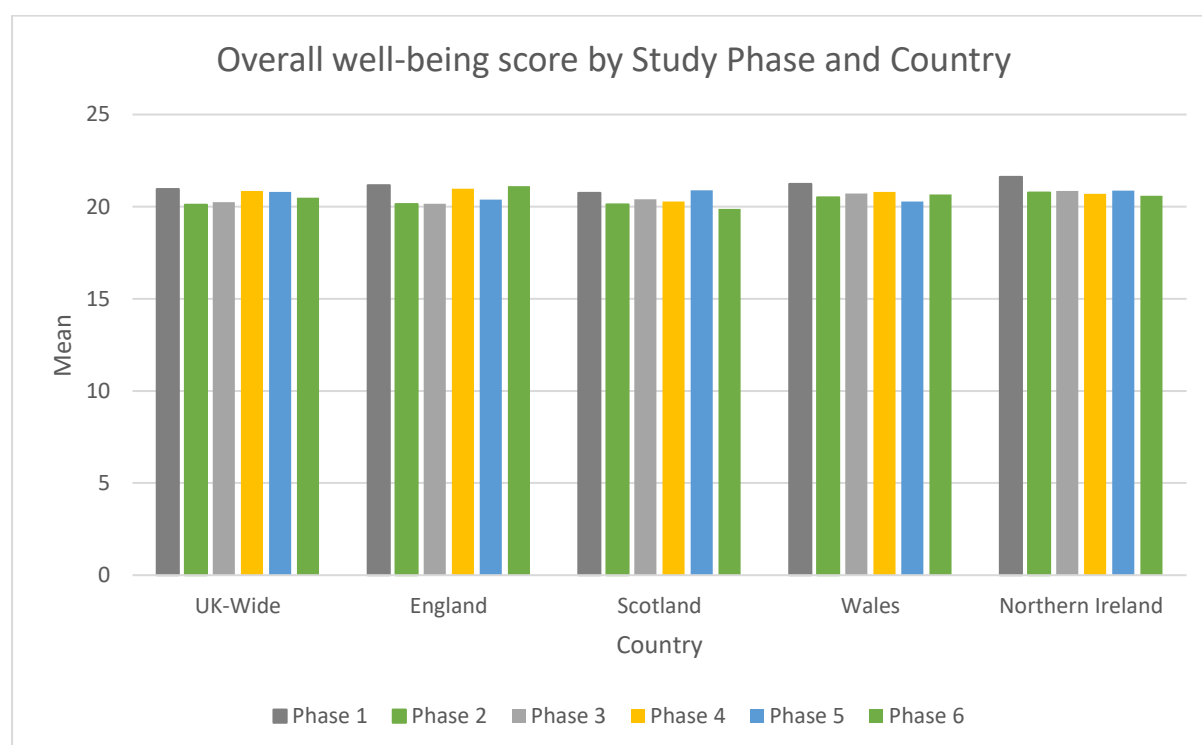


Table A9. 1: Mean Overall Well-being Score by Study Phase and Country (Weighted)

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	20.95	21.16	20.74	21.24	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85
Phase 4	20.85	20.98	20.28	20.80	20.69
Phase 5	20.80	20.39	20.89	20.28	20.87
Phase 6	20.48	21.11	19.88	20.66	20.59

A9.2 Well-being Scores by Study Phase and Occupation

Those who worked as Midwives, AHPs, Social care workers, and Social workers showed a decrease in their overall mean well-being scores from Phase 1 of the study to Phase 6, while Nurses showed an

increase. Between Phase 2 and Phase 6, those who worked as Midwives, AHPs, and Social workers showed a decrease in their overall mean well-being scores from Phase 1 of the study to Phase 6, while Nurses and Social care workers showed an increase. Between Phase 3 and Phase 6, AHPs, showed a decrease in overall well-being scores while Nurses, Midwives, Social care workers and Social workers showed an increase in overall well-being scores. Between Phase 4 and Phase 6, AHPs and Social workers showed a decrease in overall well-being scores while Nurses, Midwives, and Social care workers showed an increase in overall well-being scores. Between Phase 5 and Phase 6, Midwifery, AHPs, Social care workers, and Social workers showed a decrease in overall well-being scores while Nurses showed an increase in overall well-being scores.

Figure A9. 2: Mean Overall Well-being Score by Study Phase and Occupation (Weighted by Region)

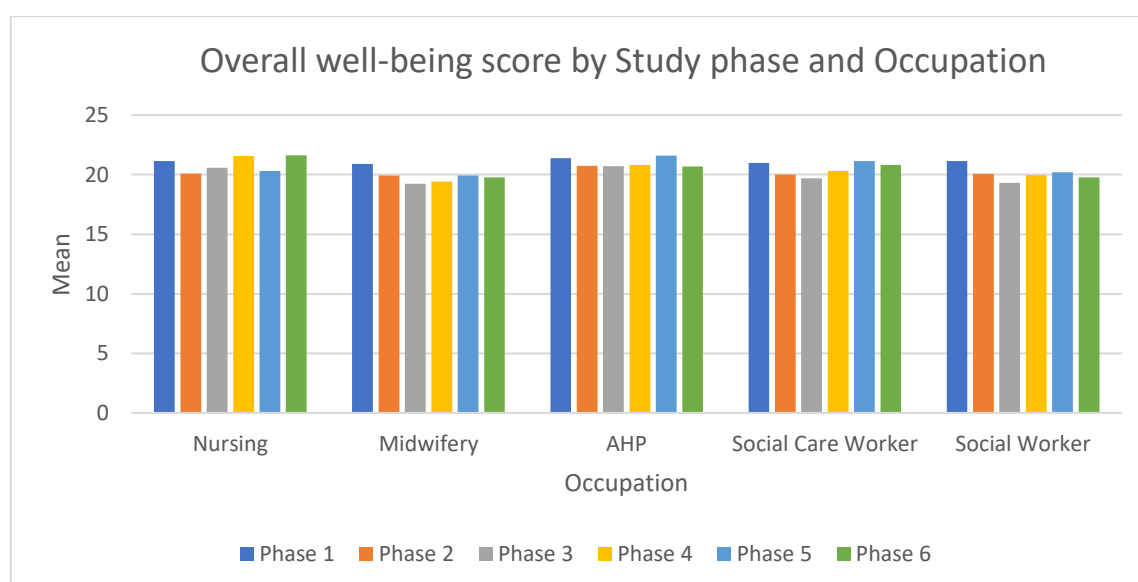


Table A9. 2: Mean Overall Well-being Score by Study Phase and Occupation (Weighted by Region)

Study phase	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 1	21.15	20.91	21.38	20.98	21.14
Phase 2	20.10	19.92	20.73	20.02	20.07
Phase 3	20.58	19.23	20.72	19.70	19.31
Phase 4	21.56	19.42	20.83	20.31	19.95
Phase 5	20.32	19.93	21.60	21.15	20.19
Phase 6	21.63	19.76	20.68	20.82	19.76

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 6, both UK-wide and across the individual countries except for Wales where an increase in the overall quality of working life scores was observed. Between Phase 2 and 6, there was a decrease UK-wide, but respondents in England and Wales had overall WRQOL scores which increased. Comparing Phase 3 and Phase 6 there was a decrease UK-wide, but respondents in England and Wales had overall WRQOL scores which increased. Between Phase 4 and Phase 6, there was a decrease UK-wide, but respondents in England and Wales had overall WRQOL scores which increased. Between Phase 5 and Phase 6, there was a decrease UK-wide, but respondents in England and Wales had overall WRQOL scores which increased.

UK-wide analysis: Using regression analysis, the decrease in the overall WRQOL scores between Phase 1 and Phase 6 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 ($\beta = -5.712$, $p < .001$). The results for WRQOL domain scores (controlling for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: Significant decrease in scores from Phase 1 to Phase 6 ($\beta = -.954$, $p < .001$).
- Stress at work: Significant decrease in scores from Phase 1 to Phase 6 ($\beta = -.755$, $p < .001$).
- Working conditions: Significant decrease in scores from Phase 1 to Phase 6 ($\beta = -.670$, $p < .001$).
- Control at work: Significant decrease in scores from Phase 1 to Phase 6 ($\beta = -.660$, $p < .001$).
- General well-being: Significant decrease in scores from Phase 1 to Phase 6 ($\beta = -1.863$, $p < .001$).
- Home-work interface: Significant decrease in scores from Phase 1 to Phase 6 ($\beta = -.836$, $p < .001$).

Using regression analysis, the change in the overall WRQOL scores between Phase 2 and Phase 6 of the study was **statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -1.844$, $p = .002$). The results for WRQOL domain scores (controlling for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: Significant decrease in scores from Phase 2 to Phase 6 ($\beta = -.417$, $p = .020$).
- Stress at work: Significant decrease in scores from Phase 2 to Phase 6 ($\beta = -.222$, $p = .002$).

- Working conditions: Significant decrease in scores from Phase 2 to Phase 6 ($\beta = -.375, p < .001$).
- Control at work: Significant decrease in scores from Phase 2 to Phase 6 ($\beta = -.264, p = .020$).
- General well-being: No significant change in scores from Phase 2 to Phase 6 ($\beta = -.179, p = .318$).
- Home-work interface: Significant reduction in scores from Phase 2 to Phase 6 ($\beta = -.356, p = .001$).

Using regression analysis, the change in the overall WRQOL scores between Phase 3 and Phase 6 of the study was **statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -1.368, p = .022$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: No significant change in scores from Phase 3 to Phase 6 ($\beta = -.059, p = .739$).
- Stress at work: Significant decrease in scores from Phase 3 to Phase 6 ($\beta = -.374, p < .001$).
- Working conditions: Significant decrease in scores from Phase 3 to Phase 6 ($\beta = -.349, p < .001$).
- Control at work: No significant change in scores from Phase 3 to Phase 6 ($\beta = -.097, p = .372$).
- General well-being: No significant change in scores from Phase 3 to Phase 6 ($\beta = -.295, p = .101$).
- Home-work interface: No significant change in scores from Phase 3 to Phase 6 ($\beta = -.188, p = .087$).

Using regression analysis, the change in the overall WRQOL scores between Phase 4 and Phase 6 of the study was **not statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = .299, p = .703$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: No significant change in scores from Phase 4 to Phase 6 ($\beta = .352, p = .133$).
- Stress at work: No significant change in scores from Phase 4 to Phase 6 ($\beta = -.098, p = .265$).
- Working conditions: No significant change in scores from Phase 4 to Phase 6 ($\beta = .002, p = .985$).
- Control at work: No significant change in scores from Phase 4 to Phase 6 ($\beta = .081, p = .578$).

- General well-being: No significant change in scores from Phase 4 to Phase 6 ($\beta = .017, p = .266$).
- Home-work interface: No significant change in scores from Phase 4 to Phase 6 ($\beta = -.022, p = .877$).

Using regression analysis, the change in the overall WRQOL scores between Phase 5 and Phase 6 of the study was **not statistically significant**, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -.897, p = .203$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: No significant change in scores from Phase 5 to Phase 6 ($\beta = .056, p = .790$).
- Stress at work: Significant decrease in scores from Phase 5 to Phase 6 ($\beta = -.258, p < .001$).
- Working conditions: No significant change in scores from Phase 5 to Phase 6 ($\beta = -.185, p = .129$).
- Control at work: No significant change in scores from Phase 5 to Phase 6 ($\beta = -.060, p = .643$).
- General well-being: Significant decrease in scores from Phase 5 to Phase 6 ($\beta = -.623, p = .003$).
- Home-work interface: No significant change in scores from Phase 5 to Phase 6 ($\beta = .212, p = .104$).

Figure A9. 3: Mean Overall Quality of Working Life Score by Study Phase and Country (Weighted)

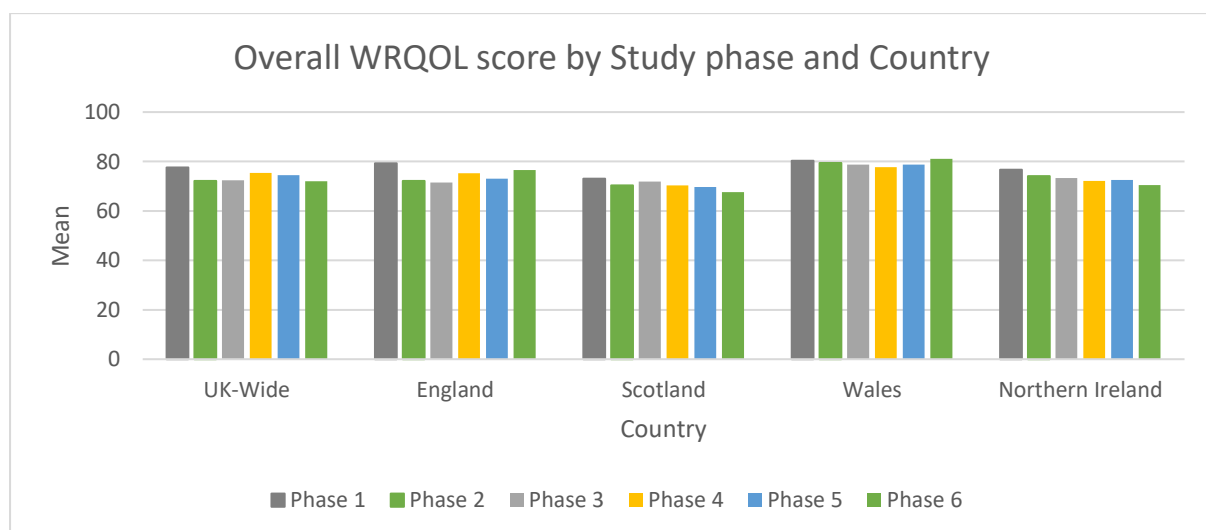


Table A9. 3: Mean Quality of Working Life Score by Study Phase and Country (Weighted)

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 well-being	20.16	20.65	19.32	20.85	20.55
Home-work interface	10.84	11.11	9.71	11.26	10.18
Control at work	9.97	10.27	9.22	10.26	9.57
Working conditions	10.49	10.71	9.87	11.13	10.23
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 well-being	18.23	18.21	18.44	19.73	19.37
Home-work interface	9.95	10.03	9.19	10.97	9.99
Control at work	9.22	9.28	8.75	10.44	9.37
Working conditions	9.96	9.90	9.54	11.12	9.95
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 well-being	17.97	17.89	18.62	19.75	19.36
Home-work interface	9.87	9.72	9.63	10.89	9.66
Control at work	9.82	9.73	8.97	10.27	9.14
Working conditions	10.05	9.73	10.03	11.15	10.05
Overall WRQOL score	72.45	71.54	71.92	78.69	73.29
Phase 4					
Job career satisfaction	21.09	21.08	19.75	21.77	20.13
Stress at work	4.31	4.34	4.18	4.87	4.45
General well-being	19.39	19.4	18.55	19.3	19.1
Home-work interface	10.56	10.59	9.32	10.41	9.48
Control at work	9.57	9.72	8.79	10.24	9.13
Working conditions	10.49	10.18	9.7	10.81	9.82
Overall WRQOL score	75.42	75.3	70.28	77.67	72.12
Phase 5					
Job career satisfaction	20.72	20.55	19.71	22.95	20.02
Stress at work	4.54	4.31	4.45	4.28	4.58
General well-being	19.3	18.9	18.30	19.88	19.55
Home-work interface	10.1	9.86	8.62	10.38	9.48
Control at work	9.74	9.70	8.65	10.56	9.07
Working conditions	10.08	9.76	9.82	10.64	9.81
Overall WRQOL score	74.49	73.10	69.64	78.70	72.54
Phase 6					
Job career satisfaction	20.40	21.36	19.45	22.57	20.03
Stress at work	4.35	4.67	4.06	4.87	4.22
General well-being	18.43	19.46	17.30	21.17	18.62

Home-work interface	9.69	10.67	8.80	11.22	9.43
Control at work	9.27	10.00	8.62	10.42	8.82
Working conditions	9.82	10.32	9.36	10.83	9.40
Overall WRQOL score	71.97	76.49	67.59	81.10	70.51

A9.4 Quality of Working Life Scores by Study Phase and Occupation

The overall WRQOL scores increased from Phase 1 of the study to Phase 6 for Nurses but decreased for other all occupational groups. The overall WRQOL scores increased from Phase 2 of the study to Phase 6 for nurses, AHPs, Social Care workers but decreased in midwifery and social work groups. The overall WRQOL scores increased from Phase 3 of the study to Phase 6 for nurses, midwives, AHPs and Social care workers but decreased in social workers. The overall WRQOL scores increased from Phase 4 of the study to Phase 6 for midwives, AHPs and Social care workers but decreased in nurses and social workers.

Figure A9. 4: Mean Overall Quality of Working Life Score by Study Phase and Occupation (Weighted by Region)

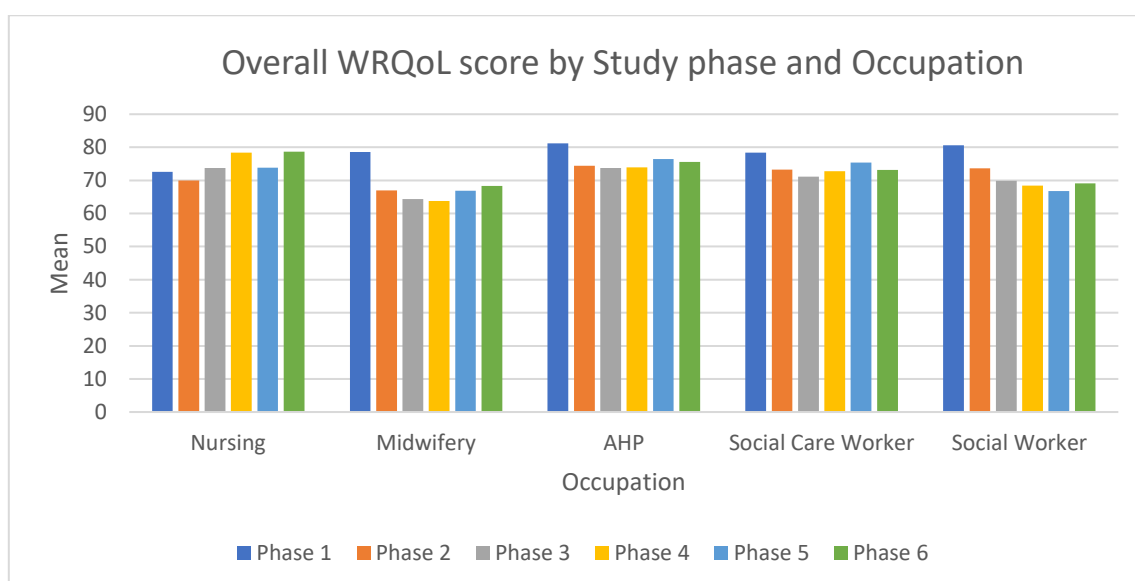


Table A9. 4: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted by Region)

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 well-being	19.77	20.91	21.19	20.02	20.75
Home-work interface	10.11	10.68	11.29	10.82	11.32
Control at work	8.79	9.96	10.47	10.31	10.58
Working conditions	9.82	10.79	10.99	10.62	10.80
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 well-being	17.65	18.07	19.04	18.64	18.34
Home-work interface	9.47	8.23	10.62	9.91	10.56
Control at work	9.08	9.17	9.61	9.13	9.63
Working conditions	9.61	8.61	10.26	10.31	9.73
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	3.20	4.47	4.43	4.03
General well-being	18.8	16.97	18.7	17.67	17.4
Home-work interface	9.96	7.96	10.1	9.43	9.92
Control at work	9.78	8.47	10.15	9.44	9
Working conditions	9.88	8.29	10.26	10.24	9.3
Overall WRQOL score	73.77	64.35	73.79	71.15	69.92
Phase 4					
Job career satisfaction	21.62	18.8	20.51	20.44	20.15
Stress at work	4.58	3.52	4.36	4.31	3.82
General well-being	20.31	16.81	18.85	18.87	17.64
Home-work interface	10.92	8.39	10.33	9.85	9.60
Control at work	10.17	8.41	9.85	9.95	8.67
Working conditions	10.74	7.89	9.99	10.37	8.80
Overall WRQOL score	78.37	63.76	73.92	72.78	68.39
Phase 5					
Job career satisfaction	20.97	19.17	20.95	20.43	19.14
Stress at work	4.27	3.83	4.65	5.03	3.98
General well-being	18.93	17.45	20.63	19.84	17.41
Home-work interface	9.96	9.17	10.03	10.06	8.66
Control at work	9.91	8.63	9.96	8.42	8.48
Working conditions	9.78	8.69	10.16	10.53	8.94
Overall WRQOL score	73.81	66.89	76.42	75.41	66.75
Phase 6					
Job career satisfaction	21.55	20.77	21.17	20.95	20.12

Stress at work	5.29	4.52	4.20	4.41	3.81
General well-being	20.15	17.35	19.68	18.16	17.19
Home-work interface	11.16	8.83	10.07	9.69	9.77
Control at work	9.90	8.18	10.32	9.67	9.10
Working conditions	10.65	8.86	10.13	10.30	9.10
Overall WRQOL score	78.70	68.34	75.58	73.18	69.10

A9.4 Burnout Scores by Study Phase and Country

The overall personal burnout, work-related burnout and client-related scores increased from Phase 2 of the study to Phase 6 UK-wide. In Scotland, Wales, and Northern Ireland, personal scores increased, whereas in England it decreased. England and Wales experienced a decrease in work-related burnout scores, whereas Scotland and Northern Ireland experienced an increase. All countries surveyed experienced an increase in client-related burnout from phase 2 to phase 6.

Between Phase 3 and Phase 6, overall personal and work-related burnout scores decreased UK-wide, whereas an increase was observed in client-related burnout. On a country level, England and Wales experienced a decrease in work-related burnout scores, whereas Scotland and Northern Ireland experienced an increase. All countries surveyed experienced an increase in client-related burnout from phase 3 to phase 6.

Between Phase 4 and Phase 6, UK-wide personal and client-related burnout increased while work-related burnout scores decreased. In England, personal and work-related burnout scores decreased while client-related burnout increased, Scotland and Northern Ireland showed increases in personal, work-related, and client-related burnout scores. Wales showed decreases in personal, work-related, and client-related burnout between phase 4 and phase 6.

Between Phase 5 and Phase 6, UK-wide personal, work-related, and client-related burnout increased. In England, personal and work-related burnout scores decreased while client-related burnout increased. Scotland and Northern Ireland showed increases in personal, work-related, and client-related burnout scores. Wales showed decreases in personal, and work-related burnout, and an increase in client-related burnout between phase 5 and phase 6.

Multiple regression analysis revealed that there was a **significant difference in personal burnout** from Phase 2 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 2.473$ $p < .001$). There was also a **significant difference** in work-related burnout ($\beta = 3.400$, $p < .001$) and a **significant difference** in client-related burnout ($\beta = 4.320$, $p < .001$) from Phase 2 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was a **significant difference** in personal burnout from Phase 3 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity, and disability status ($\beta = 2.766, p < .001$). There was also a **significant difference** in work-related burnout ($\beta = 3.186, p < .001$) and client-related burnout ($\beta = 2.219, p < .001$) from Phase 3 to Phase 6 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was **no significant difference** in personal burnout from Phase 4 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = .713, p = .465$). There was also **no significant difference** in work-related burnout ($\beta = 1.061, p = .313$) or client-related burnout ($\beta = 1.707, p = .133$) from Phase 4 to Phase 6 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was **no significant difference** in personal burnout from Phase 5 to Phase 6, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 1.691, p = .055$). There was a **significant difference** in work-related burnout ($\beta = 2.392, p = .011$) and also in client-related burnout ($\beta = 2.648, p = .008$) from Phase 5 to Phase 6 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	61.40	61.53	60.68	58.26	60.39
Work-related burnout	56.73	57.36	55.78	52.53	57.43
Client-related burnout	27.97	28.58	25.12	23.61	25.93
Phase 3					
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
Phase 4					
Personal burnout	62.62	61.77	62.65	62.41	60.75
Work-related burnout	58.65	57.22	60.33	54.92	59.22
Client-related burnout	25.24	25.83	28.21	26.17	27.76
Phase 5					
Personal burnout	61.10	63.83	63.32	62.88	61.43
Work-related burnout	56.51	59.11	59.08	56.56	57.70

Client-related burnout	25.88	28.31	25.66	22.69	28.88
Phase 6					
Personal burnout	62.69	58.40	66.11	58.64	63.76
Work-related burnout	58.33	54.80	61.24	52.47	61.26
Client-related burnout	30.01	31.80	29.08	25.53	30.25

Figure A9. 5: Personal Burnout Score by Study phase and Country (Weighted)

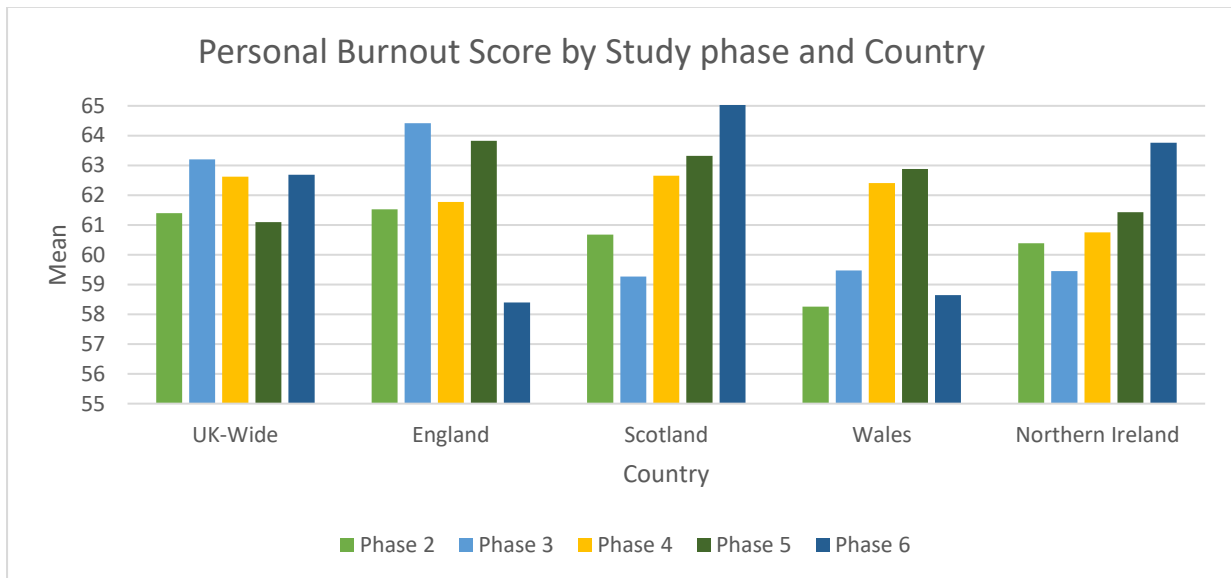


Figure A9. 6: Work-related Burnout Score by Study phase and Country (Weighted)

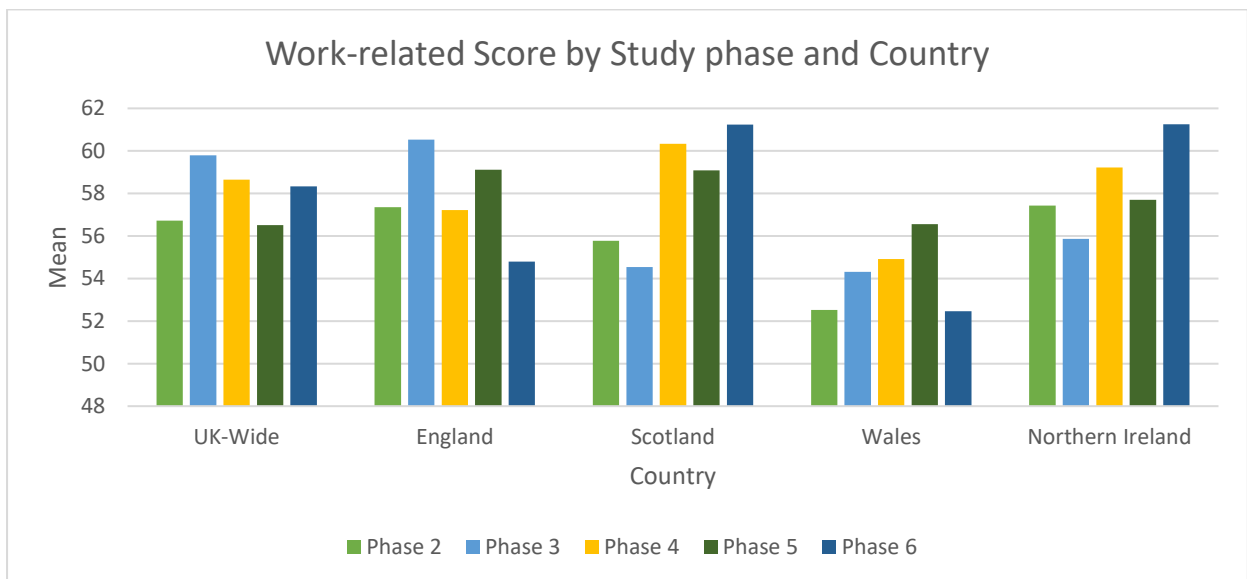
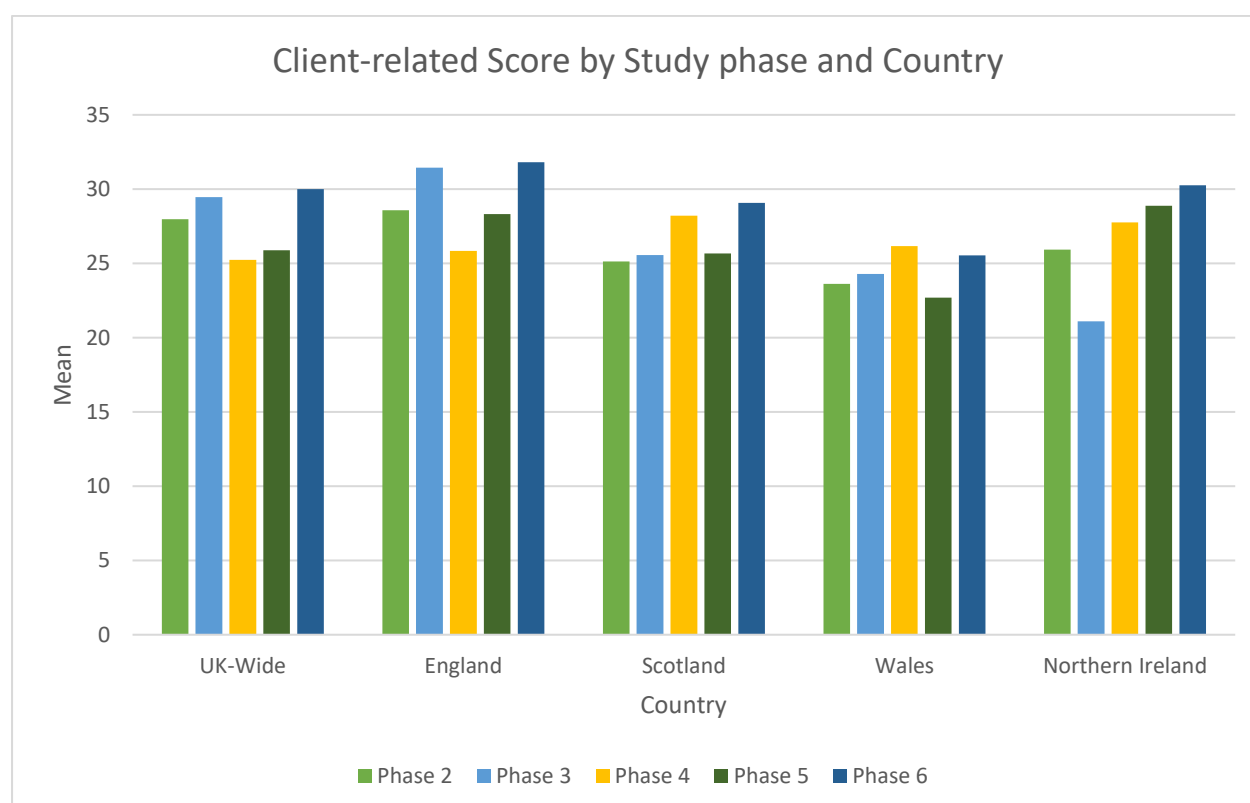


Figure A9. 7: Client-related Burnout Score by Study phase and Country (Weighted)



A9.4 Burnout Scores by Study Phase and Occupation

Between Phase 2 and 6, personal burnout decreased for nurses whereas midwifery, AHPs, social care workers, and social workers observed an increase. Work-related burnout decreased for nurses and AHPs whereas midwifery, social care workers, and social workers observed an increase. Client-related burnout increased for nurses, AHPs, social care workers, and social workers whereas midwifery experienced a decrease between phase 2 and phase 6.

Comparing Phase 3 and Phase 6, personal burnout decreased for nursing, midwifery, and AHPs whereas an increase was observed in both social care workers and social workers. Work-related burnout decreased for nurses, midwives, AHPs, and social care workers but increased for social workers. Client-related burnout increased for nursing, AHPs and social workers whereas midwifery and social care workers experienced a decrease.

Between Phase 4 and 6, personal burnout decreased for all occupations but increased for social workers. Work-related burnout increased in midwifery and social work occupations, but decreased in nursing, AHP and social care occupations. Client-related burnout increased for all occupations except midwifery where a decrease was observed.

Between Phase 5 and 6, personal burnout decreased for nursing, midwifery, and AHPs but increased for social care workers and social workers. Work-related burnout increased in midwifery and social care worker occupations, but decreased in nursing, AHP and social worker occupations. Client-related burnout increased for all occupations except midwifery where a decrease was observed.

Table A9. 6: Burnout Scores by Study Phase and Occupation (Weighted by Region)

Study phase	Occupation				
Domain	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 2					
Personal burnout	62.76	66.76	56.78	59.91	62.89
Work-related burnout	57.58	66.21	54.59	54.38	60.47
Client-related burnout	28.19	31.02	28.01	25.58	30.68
Phase 3					
Personal burnout	61.39	72.63	62.01	63.03	67.39
Work-related burnout	57.39	71.02	55.23	59.18	64.26
Client-related burnout	27.75	34.36	30.37	27.34	32.56
Phase 4					
Personal burnout	60.16	70.69	59.69	64.33	65.29
Work-related burnout	53.96	67.70	54.95	61.89	63.58
Client-related burnout	24.08	35.36	28.33	23.84	32.90
Phase 5					
Personal burnout	64.46	69.71	57.29	56.95	66.40
Work-related burnout	58.88	67.25	54.46	51.53	66.55
Client-related burnout	27.20	34.55	26.72	23.35	35.76
Phase 6					
Personal burnout	56.19	69.39	56.96	63.67	69.32
Work-related burnout	51.88	69.33	55.10	56.49	66.41
Client-related burnout	29.19	24.97	34.64	27.01	36.95

Figure A9. 8: Personal Burnout Score by Study phase and Occupation (Weighted by Region)

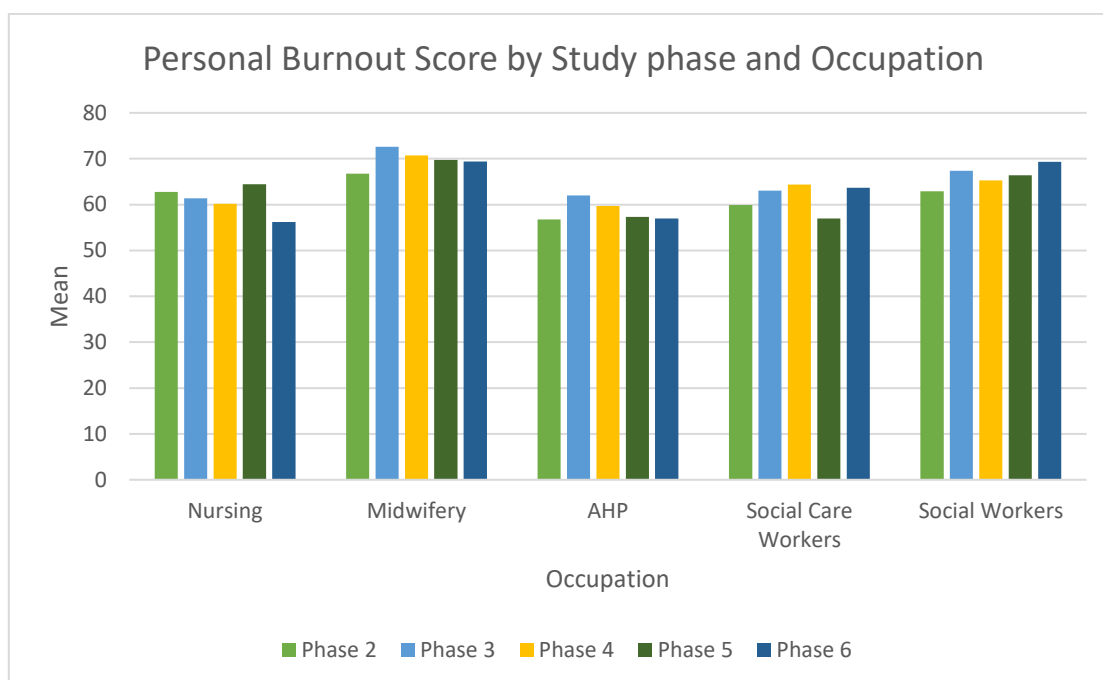


Figure A9. 9: Work-related Burnout Score by Study phase and Occupation (Weighted by Region)

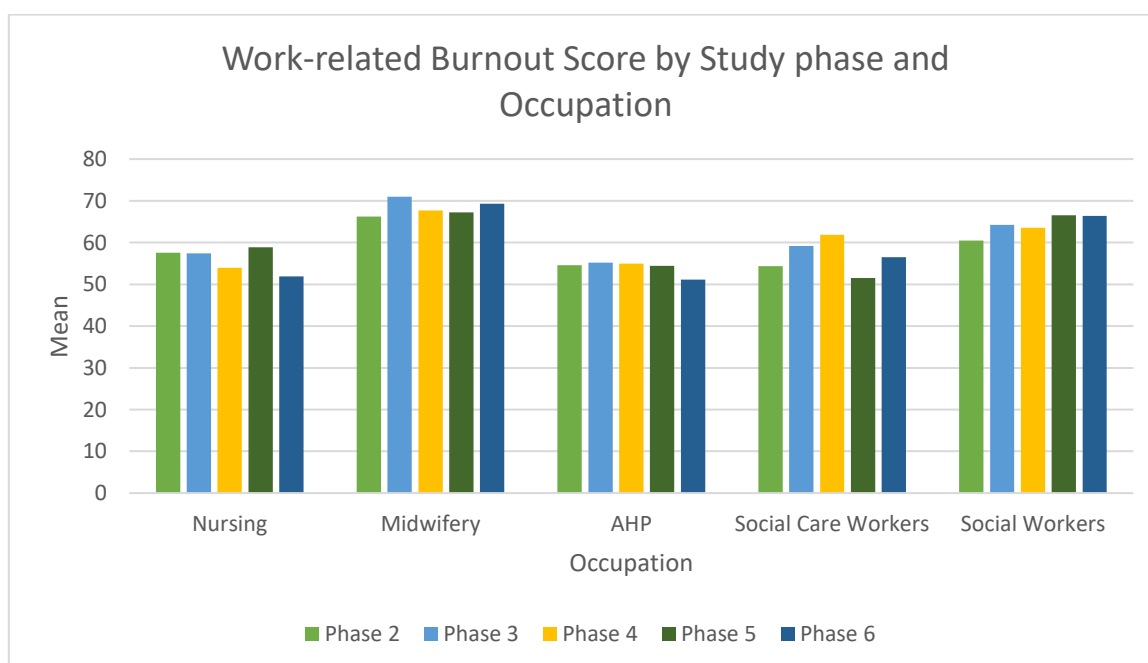
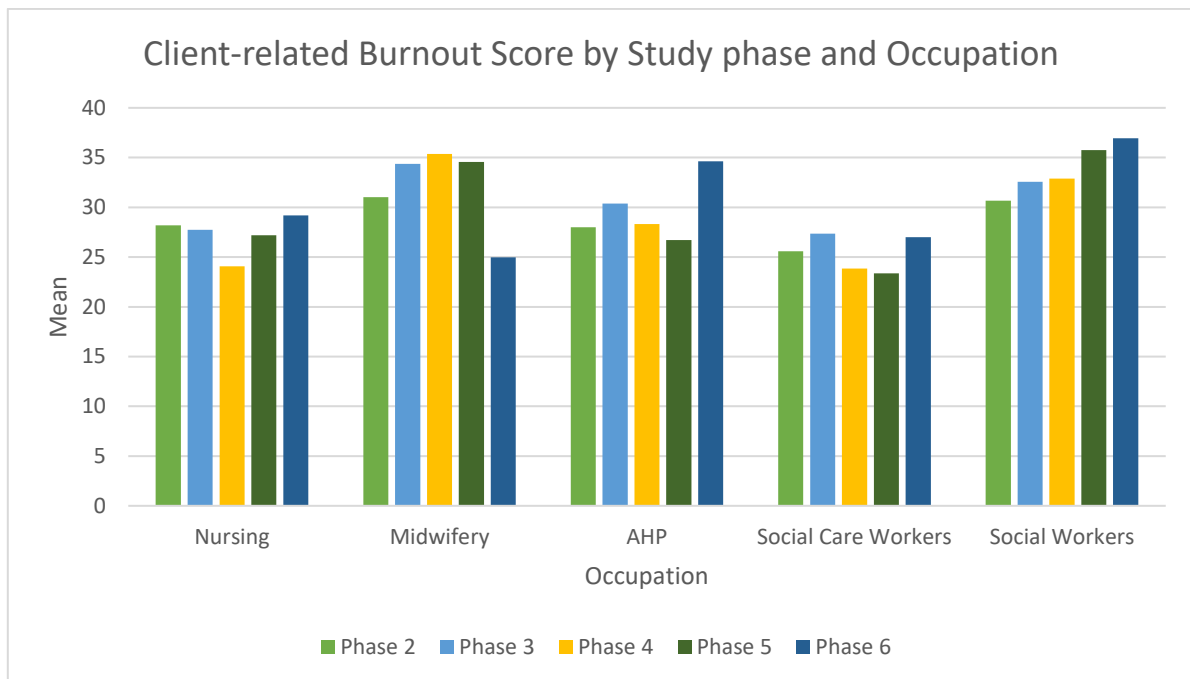


Figure A9. 10: Client-related Burnout Score by Study phase and Occupation (Weighted by Region)



A9.6 Carver Coping Scores by Study Phase and Country

UK-wide there was a significant decrease in the use of all positive coping strategies and an increase in the use of negative coping strategies such as Venting, Behavioural disengagement, and Self-blame from Phase 1 of the study to Phase 6.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 6 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 6 ($\beta = -.942, p < .001$).
- Planning: **Significant decrease** in scores from Phase 1 to Phase 6 ($\beta = -.668, p < .001$).
- Positive reframing: **Significant decrease** in scores from Phase 1 to Phase 6 ($\beta = -.798, p < .001$).
- Acceptance: **Significant decrease** in scores from Phase 1 to Phase 6 ($\beta = -.744, p < .001$).
- Use of emotional support: **Significant decrease** in scores from Phase 1 to Phase 6 ($\beta = -.427, p < .001$).
- Use of instrumental support: **Significant decrease** in scores from Phase 1 to Phase 6 ($\beta = -.190, p = .006$).
- Venting: **Significant increase** in scores from Phase 1 to Phase 6 ($\beta = .728, p < .001$).
- Substance use: No significant change in scores from Phase 1 to Phase 6 ($\beta = .084, p = .135$).

- Behavioural disengagement: **Significant increase** in scores from Phase 1 to Phase 6 ($\beta = .482, p < .001$).
- Self-blame: **Significant increase** in scores from Phase 1 to Phase 6 ($\beta = .810, p < .001$).

UK-wide there was a significant decrease in the use of all positive coping strategies and an increase in the use of negative coping strategies such as Self-blame from Phase 2 of the study to Phase 6.

UK-wide analysis: Using regression analysis, the differences between Phase 2 and Phase 6 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 6 ($\beta = -.376, p < .001$).
- Planning: **Significant decrease** in scores from Phase 2 to Phase 6 ($\beta = -.276, p < .001$).
- Positive reframing: **Significant decrease** in scores from Phase 2 to Phase 6 ($\beta = -.465, p < .001$).
- Acceptance: **Significant decrease** in scores from Phase 2 to Phase 6 ($\beta = -.408, p < .001$).
- Use of emotional support: **Significant decrease** in scores from Phase 2 to Phase 6 ($\beta = -.272, p < .001$).
- Use of instrumental support: **Significant decrease** in scores from Phase 2 to Phase 6 ($\beta = -.190, p = .007$).
- Venting: No significant change in scores from Phase 2 to Phase 6 ($\beta = .024, p = .718$).
- Substance use: No significant change in scores from Phase 2 to Phase 6 ($\beta = -.093, p = .121$).
- Behavioural disengagement: No significant change in scores from Phase 2 to Phase 6 ($\beta = .109, p = .057$).
- Self-blame: **Significant increase** in scores from Phase 2 to Phase 6 ($\beta = .186, p = .011$).

UK-wide there was a significant decrease in the use of most positive coping strategies and no significant change in the use of negative coping strategies from Phase 3 of the study to Phase 6.

UK-wide analysis: Using regression analysis, the differences between Phase 3 and Phase 6 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 between Phase 3 and Phase 6 ($\beta = -.152, p = .026$).
- Planning: **Significant decrease** in scores between Phase 3 and Phase 6 ($\beta = -.145, p = .046$).
- Positive reframing: **Significant decrease** in scores from Phase 3 to Phase 6 ($\beta = -.353, p < .001$).
- Acceptance: **Significant decrease** in scores between Phase 3 and Phase 6 ($\beta = -.258, p < .001$).

- Use of emotional support: **Significant decrease** in scores from Phase 3 to Phase 6 ($\beta = -.220, p = .002$).
- Use of instrumental support: No significant change in scores between Phase 3 and Phase 6 ($\beta = -.119, p = .082$).
- Venting: No significant change in scores between Phase 3 and Phase 6 ($\beta = -.070, p = .299$).
- Substance use: No significant change in scores between Phase 3 and Phase 6 ($\beta = -.099, p = .097$).
- Behavioural disengagement: No significant change in scores between Phase 3 and Phase 6 ($\beta = .083, p = .144$).
- Self-blame: No significant change in scores between Phase 3 and Phase 6 ($\beta = -.063, p = .396$).

UK-wide there was a significant decrease in the use of some positive coping strategies and no significant change in the use of negative coping strategies from Phase 4 of the study to Phase 6..

UK-wide analysis: Using regression analysis, the differences between Phase 4 and Phase 6 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 between Phase 4 and Phase 6 ($\beta = -.188, p = .031$).
- Planning: No significant change in scores between Phase 4 and Phase 6 ($\beta = 0-.127, p = .172$).
- Positive reframing: **Significant decrease** in scores between Phase 4 and Phase 6 ($\beta = -.180, p = .038$).
- Acceptance: **Significant decrease** in scores between Phase 4 and Phase 6 ($\beta = -.194, p = .016$).
- Use of emotional support: **Significant decrease** in scores between Phase 4 and Phase 6 ($\beta = -.219, p = .014$).
- Use of instrumental support: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.173, p = .051$).
- Venting: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.065, p = .450$).
- Substance use: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.069, p = .350$).
- Behavioural disengagement: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.027, p = .711$).
- Self-blame: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.125, p = .182$).

UK-wide there was a significant decrease in the use of some positive coping strategies and no significant change in the use of negative coping strategies from Phase 5 of the study to Phase 6.

UK-wide analysis: Using regression analysis, the differences between Phase 5 and Phase 6 of the study on the different Carver coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Active coping: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.083, p = .292$).
- Planning: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.057, p = .492$).
- Positive reframing: **Significant decrease** in scores between Phase 5 and Phase 6 ($\beta = -.193, p = .013$).
- Acceptance: **Significant decrease** in scores between Phase 5 and Phase 6 ($\beta = -.255, p < .001$).
- Use of emotional support: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.014, p = .858$).
- Use of instrumental support: No significant change in scores between Phase 5 and Phase 6 ($\beta = .034, p = .688$).
- Venting: No significant change in scores between Phase 5 and Phase 6 ($\beta = .108, p = .165$).
- Substance use: No significant change in scores between Phase 5 and Phase 6 ($\beta = .007, p = .911$).
- Behavioural disengagement: No significant change in scores between Phase 5 and Phase 6 ($\beta = .089, p = .180$).
- Self-blame: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.080, p = .342$).

Figure A9. 11: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)

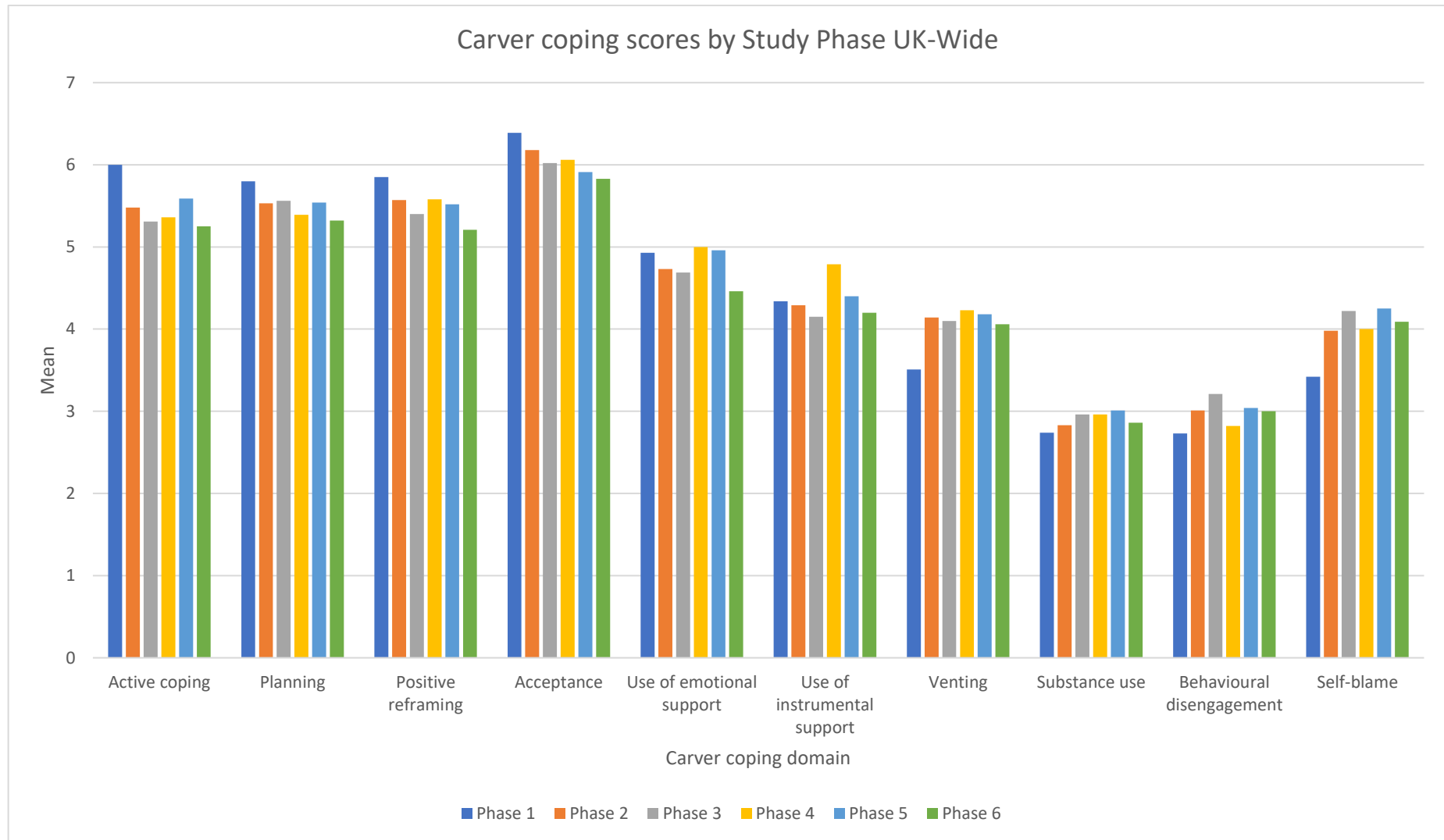


Table A9. 7: Mean Carver Coping Scores by Study Phase and Country (Weighted by Occupation)

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
Phase 4					
Active coping	5.36	5.27	5.38	5.56	5.32
Planning	5.39	5.33	5.40	5.61	5.36
Positive reframing	5.58	5.42	5.42	5.51	5.41
Acceptance	6.06	6.06	5.96	6.46	5.97
Use of emotional support	5.00	4.99	4.69	4.60	4.64
Use of instrumental support	4.79	4.63	4.33	4.67	4.32
Venting	4.23	4.19	4.25	3.85	4.30
Substance use	2.96	2.95	2.88	2.95	2.66
Behavioural disengagement	2.82	2.82	3.06	3.27	3.10
Self-blame	4.00	4.07	3.97	4.30	3.97

Phase 5					
Active coping	5.59	5.15	5.48	5.61	5.19
Planning	5.54	5.26	5.42	5.58	5.3
Positive reframing	5.52	5.19	5.18	5.66	5.41
Acceptance	5.91	5.88	6.2	6.18	5.91
Use of emotional support	4.96	4.7	4.58	4.98	4.45
Use of instrumental support	4.4	4.12	4.17	4.42	4.29
Venting	4.18	4.14	3.92	4.56	4.06
Substance use	3.01	3.15	2.62	2.98	2.82
Behavioural disengagement	3.04	3.25	2.87	3.17	3.1
Self-blame	4.25	4.34	4.13	4.42	3.97
Phase 6					
Active coping	5.25	5.14	5.30	5.37	5.13
Planning	5.32	5.34	5.30	5.40	5.25
Positive reframing	5.21	5.21	5.18	5.21	5.20
Acceptance	5.83	5.82	5.85	5.58	5.73
Use of emotional support	4.46	4.72	4.34	4.43	4.50
Use of instrumental support	4.20	4.26	4.13	4.62	4.21
Venting	4.06	4.11	4.10	4.17	4.26
Substance use	2.86	2.83	2.92	2.95	2.81
Behavioural disengagement	3.00	2.92	3.08	2.92	3.17
Self-blame	4.09	3.98	4.26	3.69	4.05

A9.4 Carver Coping Scores by Study Phase and Occupation

There was also a decrease in the use of positive coping strategies by all occupations such as, active coping, planning, positive reframing, and acceptance, and a slight increase in the use of negative coping strategies particularly behavioural disengagement and self-blame where all occupations seen an increase from Phase 1 of the study to Phase 6.

From Phase 2 to Phase 6, there was a lot more variation in the use of strategies; within nursing there was decrease in the use of all positive coping strategies and increase in the use of negative coping strategies such as behavioural disengagement and self-blame. Midwives saw an increase in active coping, planning, emotional support, and a decrease in all negative coping strategies. AHPs reported decreases in all strategies except substance use and self-blame. While Social Care workers had increased instrumental support, venting, and substance use and decreased in all other strategies. In Social Work, there was a decrease in all strategies except behavioural disengagement.

Comparing Phase 3 to Phase 6, nurses had a decrease in all coping strategies except acceptance where an increase was observed. In midwives, all strategies increased except for acceptance, substance use, and self-blame. Across AHPs all positive coping strategies declined, except instrumental support, across this occupation venting, and self-blame also increased. Social care

workers showed an increase in all coping strategies except for acceptance, substance use and behavioural disengagement where a decrease was observed. Social workers showed a decrease in all coping strategies except for behavioural disengagement where a increase was observed.

Comparing Phase 4 to Phase 6, nurses had a decrease in all coping strategies except for behavioural disengagement where an increase was observed. In midwives, all positive strategies increased except acceptance where a decrease was observed, additionally negative strategies, venting, and behavioural disengagement increased. Across AHPs there were decreases in all coping strategies except self-blame where an increase was observed. For social care workers, positive strategies active coping and planning increased and an increase in usage of negative coping strategies, venting, substance use and self-blame. Social workers showed an increase in active coping, substance use, behavioural disengagement, and self-blame.

Comparing Phase 5 to Phase 6, nurses had a decrease in all coping strategies except for acceptance and planning where an increase was observed. In midwives, all strategies increased except acceptance and substance use where a decrease was observed. Across AHPs there were decreases in all coping strategies except instrumental support and self-blame where an increase was observed. For social care workers, positive strategies planning increased and an increase in usage of negative coping strategies, venting and substance use. Social workers showed a decrease in active coping, acceptance, emotional support, instrumental support, and venting.

Table A9. 8: Mean Carver Coping Scores by Study Phase and Occupation (Weighted by Region)

Study phase	Occupation				
Coping domain	Nursing	Midwifery	AHPs	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
Phase 4					
Active coping	5.22	5.02	5.46	5.53	5.13
Planning	5.37	5.17	5.43	5.41	5.38
Positive reframing	5.46	5.19	5.46	5.65	5.22
Acceptance	6.30	5.64	6.02	6.01	5.78
Use of emotional support	5.09	4.89	4.93	4.70	4.78
Use of instrumental support	4.69	4.51	4.57	4.75	4.44
Venting	4.20	4.50	4.28	4.08	4.41
Substance use	3.13	3.27	2.76	2.72	2.66
Behavioural disengagement	2.77	3.28	2.84	3.02	3.09
Self-blame	4.06	4.94	4.24	3.82	4.27
Phase 5					
Active coping	4.95	5.18	5.89	5.86	5.32
Planning	5.10	5.44	5.55	5.64	5.21
Positive reframing	5.03	5.07	5.54	5.80	4.98
Acceptance	5.81	5.97	5.80	6.14	5.84
Use of emotional support	4.56	4.95	5.02	4.82	4.80
Use of instrumental support	3.97	4.49	4.45	4.40	4.37
Venting	4.06	4.52	4.19	4.07	4.26
Substance use	3.2	3.5	2.84	2.75	2.93
Behavioural disengagement	3.2	3.55	2.81	2.97	3.16
Self-blame	4.34	4.58	4.05	4.04	4.36
Phase 6					
Active coping	4.78	5.23	5.18	5.69	5.17
Planning	5.12	5.65	5.21	5.75	5.25
Positive reframing	5.01	5.25	5.31	5.46	5.02
Acceptance	5.98	5.41	5.62	5.76	5.45
Use of emotional support	4.43	5.44	4.69	4.64	4.78
Use of instrumental support	3.89	5.16	4.59	4.30	4.24
Venting	3.84	5.48	4.17	4.17	4.23

Substance use	2.87	2.80	2.67	2.92	3.07
Behavioural disengagement	2.95	3.71	2.73	2.79	3.22
Self-blame	3.63	4.89	4.30	3.91	4.53

A9.5 Clark Coping Scores by Study Phase and Country

There was a decrease in the use of all Clark et al.'s coping strategies from Phase 1 of the study to Phase 6 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 6 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: **Significant change** in scores from Phase 1 to Phase 6 ($\beta = -.165, p < .001$).
- Work-family segmentation: **Significant change** in scores from Phase 1 to Phase 6 ($\beta = -.416, p < .001$).
- Working to improve skills/efficiency: **Significant change** in scores from Phase 1 to Phase 6 ($\beta = -.296, p < .001$).
- Recreation and relaxation: **Significant change** in scores from Phase 1 to Phase 6 ($\beta = -.404, p < .001$).
- Exercise: **Significant change** in scores from Phase 1 to Phase 6 ($\beta = -.689, p < .001$).

There was a decrease in the use of all Clark et al.'s coping strategies from Phase 2 of the study to Phase 6 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 2 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores from Phase 2 to Phase 6 ($\beta = -.041, p = .248$).
- Work-family segmentation: No significant change in scores from Phase 2 to Phase 6 ($\beta = -.065, p = .147$).
- Working to improve skills/efficiency: No significant change in scores from Phase 2 to Phase 6 ($\beta = -.044, p = .324$).
- Recreation and relaxation: **Significant change** in scores from Phase 2 to Phase 6 ($\beta = -.104, p = .040$).
- Exercise: **Significant change** in scores from Phase 2 to Phase 6 ($\beta = -.145, p = .012$).

There was a slight decrease in the use of family-work segmentation, working to improve skills/efficiency, and recreation and relaxation, whereas an increase in work-family segmentation and, and exercise from Phase 3 of the study to Phase 6 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 3 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores between Phase 3 and Phase 6 ($\beta = .026, p = .462$).
- Work-family segmentation: No significant change in scores between Phase 3 and Phase 6 ($\beta = .047, p = .291$).
- Working to improve skills/efficiency: No significant change in scores between Phase 3 and Phase 6 ($\beta = -.068, p = .120$).
- Recreation and relaxation: **Significant change** in scores between Phase 3 and Phase 6 ($\beta = .142, p = .004$).
- Exercise: **Significant change** in scores between Phase 3 and Phase 6 ($\beta = -.300, p < .001$).

There was slight increase in the use of family-work segmentation from Phase 4 of the study to Phase 6 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 4 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores between Phase 4 and Phase 6 ($\beta = .018, p = .694$).
- Work-family segmentation: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.011, p = .850$).
- Working to improve skills/efficiency: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.013, p = .820$).
- Recreation and relaxation: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.010, p = .872$).
- Exercise: No significant change in scores between Phase 4 and Phase 6 ($\beta = -.124, p = .087$).

There was slight increases in the use of family-work segmentation, work-family segmentation and exercise whereas working to improve skills/efficient and recreation and relaxation decreased from Phase 5 of the study to Phase 6 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 5 and Phase 6 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.022, p = .578$).
- Work-family segmentation: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.056, p = .282$).
- Working to improve skills/efficiency: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.047, p = .362$).
- Recreation and relaxation: No significant change in scores between Phase 5 and Phase 6 ($\beta = -.003, p = .961$).
- Exercise: **Significant change** in scores between Phase 5 and Phase 6 ($\beta = -.172, p = .008$).

Figure A9. 12: Mean Clark Coping Scores by Study Phase UK-wide (Weighted by Occupation)

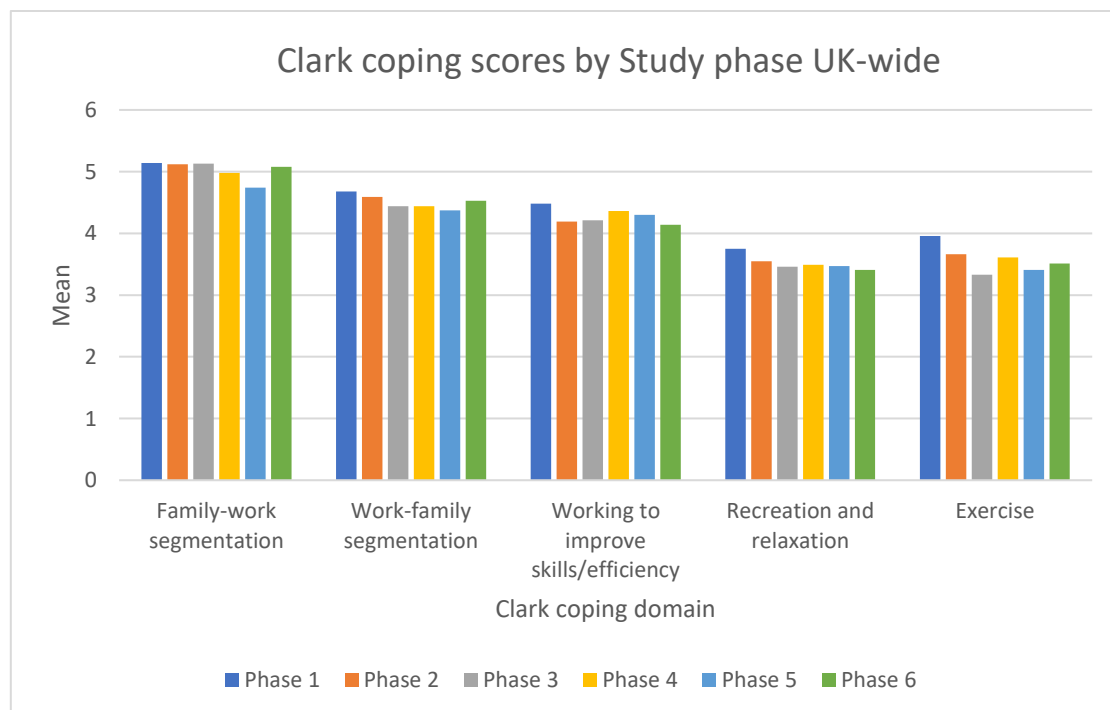


Table A9. 9: Mean Clark Coping Scores by Study Phase and Country (Weighted by Occupation)

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
Phase 4					
Family-work segmentation	4.98	4.92	5.1	5.14	5.09
Work-family segmentation	4.44	4.49	4.74	4.63	4.53
Working to improve skills/efficiency	4.36	4.35	4.16	4.41	4.10
Recreation and relaxation	3.49	3.6	3.34	3.5	3.34
Exercise	3.61	3.77	3.72	3.48	3.62
Phase 5					
Family-work segmentation	4.74	4.71	5.36	5	5.16
Work-family segmentation	4.37	4.25	4.79	4.79	4.69
Working to improve skills/efficiency	4.3	4.3	4.25	4.19	4.18
Recreation and relaxation	3.47	3.35	3.3	3.24	3.43
Exercise	3.41	3.5	3.35	3.54	3.78
Phase 6					
Family-work segmentation	5.08	4.96	5.17	4.86	5.12
Work-family segmentation	4.53	4.51	4.56	4.80	4.52
Working to improve skills/efficiency	4.14	4.33	4.00	4.22	4.15
Recreation and relaxation	3.41	3.64	3.25	3.52	3.35
Exercise	3.51	3.77	3.28	3.28	3.55

A9.6 Clark Coping Scores by Study Phase and Occupation

Between Phase 1 and 6, all occupations showed a decrease in the use of all Clark et al.'s coping strategies except for midwives who showed an increase in exercise. Comparing Phase 2 and Phase 6, nurses showed a decrease in work-family segmentation and an increase in the other coping strategies.

In midwifery, work-family segmentation, recreation and relaxation, and exercise scores increased. While AHPs experienced a decrease in scores in both family-work segmentation and work-family segmentation. In social care workers, increased scores in working to improve skills/efficiency and recreation and relaxation was observed. Whereas social workers experienced a decrease in all Clark et al.'s coping strategies.

Between Phase 3 and 6, nurses showed a decrease in recreation and relaxation. Midwives and AHPs showed a decrease in family-work segmentation and working to improve skills/efficiency. Social Care workers showed a decrease in family-work segmentation while social workers showed an increase in family-work segmentation. Comparing Phase 4 and Phase 6, nurses reported decreases in recreation and relaxation, and exercise as coping strategies, whereas midwives showed increases in recreation and relaxation, and exercise, AHPs showed increases in recreation and relaxation, social care workers had decreases in family-work segmentation, while social workers increased in family-work segmentation.

Comparing Phase 5 and Phase 6, nurses and AHPs showed increases in all Clark et al.'s coping strategies. Midwives showed a decrease in both family-work segmentation and working to improve skills/efficiency whereas social care workers showed decreases in family-work segmentation, work-family segmentation, and working to improve skills/efficiency. Social workers showed increases in both work-family segmentation and working to improve skills/efficiency.

Table A9. 10: Mean Clark Coping Scores by Study Phase and Occupation (Weighted by Region)

Study phase	Occupation				
Coping domain	Nursing	Midwifery	AHPs	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	3.60	3.33	3.66
Exercise	3.60	3.57	3.93	3.16	3.75
Phase 4					
Family-work segmentation	4.94	4.97	4.98	5.13	4.88
Work-family segmentation	4.58	4.34	4.55	4.48	4.55
Working to improve skills/efficiency	4.46	3.93	4.28	4.20	4.23
Recreation and relaxation	3.64	3.07	3.68	3.22	3.63
Exercise	3.89	3.50	4.22	3.30	3.35
Phase 5					
Family-work segmentation	4.71	5.06	4.41	4.98	4.94
Work-family segmentation	4.29	4.11	4.23	4.67	4.20
Working to improve skills/efficiency	4.36	3.88	4.24	4.28	4.11
Recreation and relaxation	3.31	3.18	3.49	3.54	3.61
Exercise	3.52	3.32	3.80	3.40	3.61
Phase 6					
Family-work segmentation	5.20	4.68	4.80	4.91	4.93
Work-family segmentation	4.60	4.33	4.54	4.62	4.26
Working to improve skills/efficiency	4.48	3.34	4.27	4.27	4.12
Recreation and relaxation	3.52	3.23	3.80	3.60	3.51
Exercise	3.75	3.80	4.12	3.45	3.09