



Health and social care workers' **quality of working life and coping** while working during the COVID-19 pandemic 24th November 2021 - 4th February 2022



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Findings from a UK Survey



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REPORT 4

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FOREWORD

The Research Team is delighted to present this report from Phase 4 of our Health and Social Care Workforce Study (November 2021-February 2022). Over the last two years there has been unprecedented demand on health and social care workers due to the ongoing COVID-19 (SARS-CoV-2) pandemic. The nurses, midwives, Allied Health Professionals (AHPs), social care workers and social workers who have taken part in this study provide valuable evidence of how their health and wellbeing have been affected and how they have coped as the pandemic has progressed. As we move towards learning to 'live with' COVID-19, all health and social care employers must reflect on the legacy of the pandemic for their services and understand the needs of staff as they not only rebuild services but also support staff health and wellbeing effectively.

The data in this and previous phases of the study provide compelling evidence of how practitioners feel about their work and what they want employers to do to support them. Indeed, through actively sharing the findings of this research with health and social care employers, professional bodies, workplace unions, human resources and occupational health departments, the data are already helping to sustain and develop good support and other initiatives for health and social care staff.

While pay remains outside of some health and social care employers' control, this report provides evidence that other working conditions including individualised flexibility, a healthy work-life balance, effective two-way communication and visibility of managers, are vital to retaining staff in health and social care services. This report contains recommendations that require attention from employers, trade unions, staff groups, and those with regulatory oversight of health and social care employees.

We are grateful to all those who have given their time to respond to the survey and take part in focus groups often in the face of the relentless demands of service delivery and pressures from staff sickness and absence.

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 wellbeing of health and social care staff

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1. Background

1.1 Aim

This study builds upon the findings from the Phase 1 (data collected between May – July 2020), Phase 2 (data collected between November-January 2021) and Phase 3 (data collected between May-July 2021) surveys and focus groups to further explore the impact of providing health and social care during the COVID-19 (SARS-CoV-2) pandemic in the United Kingdom (UK). The study focuses specifically on the experiences of nurses, midwives, allied health professionals (AHPs), social care workers and social workers. Our Survey (24th Nov 2021- 4th February 2022), followed by focus groups with human resource (HR) staff from health and social care, managers and frontline workers, sought to gain further understanding of how the COVID-19 pandemic has affected their work and home life and affected their health and wellbeing during this phase of the pandemic.

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 United Kingdom;
2. To examine the perspectives of nurses, midwives, Allied Health Professionals, social care workers and social workers on the challenges they are facing while providing health and social care during the COVID-19 pandemic, including their perspectives on employers' supports and potential ways to improve these;
3. To assess wellbeing, quality of working life and levels of burnout in this population;
4. To find out what coping strategies are used by this population to deal with work-related stressors and the effects of these on respondents' wellbeing, quality of working life and levels of burnout.

2. Methodology

2.1. Primary Research Instrument-Survey

The data for the current report were collected using an online survey questionnaire, which was adapted from the questionnaires used in Phases 1, 2 and 3 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 questionnaire was predominantly

quantitative but contained three open-ended qualitative questions. The main parts of the questionnaire covered as follows:

- **Demographic and work-related information:** age, sex, country of work, occupational group, ethnicity, disability status, relationship status, caring responsibilities, job tenure, hours of work, working overtime, working at home, considering changing one's occupation and/or employer, the effects of the pandemic on one's place of work, impact of COVID-19 on morale, employer support/use of any employer support and whether the respondents have received flu immunisation or COVID-19 vaccination(s).
- **Open-ended questions:** three questions related to 1) the impact of COVID-19 on respondents' place of work, 2) changing job or contractual working hours, and 3) respondents' experience of how the pandemic changed the management of work and non-work responsibilities.
- **Mental wellbeing:** Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS; NHS Health Scotland, 2008).
- **Quality of working life:** Work-Related Quality of Life scale (WRQOL; Easton & van Laar, 2018).
- **Burnout:** Copenhagen Burnout Inventory (Kristensen, Borritz, Villadsen, & Christensen, 2005).
- **Coping with COVID-19-related occupational demands:** 20 items from Brief COPE (Coping Orientation to Problems Experienced, Carver, 1997).
- **Coping with work-related stressors:** 15 items from Clark, Michel, Early and Baltes (2014).

2.1.1. Mental Wellbeing

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

Table 2.1: Categories created by SWEMWBS scores

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

2.1.2. Quality of Working Life

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

Table 2.2: Categories created by WRQOL scores

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

2.1.3. Burnout

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

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

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

Table 2.3: Cut-off points for Burnout scores

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

2.1.4. Coping with COVID-19 Related Occupational Demands

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

2.1.5 Coping with Work-Related Stressors

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

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

There were three open-ended questions asked of survey respondents:

1. Between July 2021 and now what was the impact of COVID-19 on your specific place of work, in relation to patient/service user numbers and service demand?
2. Why have you changed your job or contractual working hours or left your job (e.g., financial reasons, job changes, family/caring responsibilities)? Please state.
3. How did the experience of the pandemic change the way you now manage work and non-work responsibilities?

It was expected that these would elicit further detail about the most important aspects of respondents' work and homelife during the pandemic and how it had affected their health and wellbeing.

2.2. Study Respondents: Sampling, Access and Recruitment

Respondents were nurses, midwives, AHPs, social care workers and social workers in the UK who were working in health and social care during the COVID-19 pandemic during the Phase 4 study period (November 2021-February 2022). A wide variety of recruitment channels and methods were utilised to reach as many potential respondents as possible. These included The Northern Ireland Social Care Council, Social Care Wales, the five Northern Ireland Health and Social Care Trusts, Community Care magazine, Nursing and Midwifery Council, the Health and Care Professions Council, Northern Ireland Practice and Education Council, Royal College of Midwives, Royal College of Nursing, AHP Federation and AHPs Professional Associations such as the Royal College of Occupational Therapists (RCOT), British Association of Social Workers, and College of Podiatry. Support was also provided by the Chief Nursing and AHP Officers from across the UK. These regulatory bodies, unions, associations and lead professionals used a variety of methods to disseminate the study information, including newsletters,

direct emails, or social media platforms. The study website was also used to raise awareness about the study among the health and social care staff.

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

2.2.1 Sample Profile

A total of 1,758 individuals responded to the survey. Most of the responses came from Northern Ireland (n = 795), followed by Scotland (n = 492), England (n = 376) and then Wales (n = 95). Most of the sample were AHPs (see Figure 2.1).

Figure 2.1: Occupation of Respondents (Unweighted)

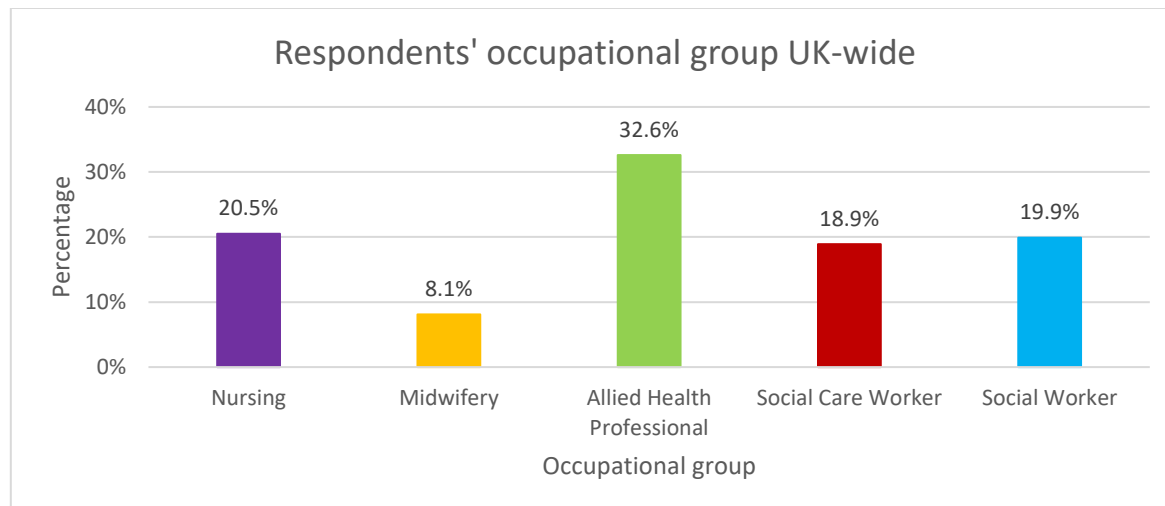


Table 2.4 below shows that of the 361 nursing respondents, 42.1% were from Northern Ireland, 38.0% from Scotland; 17.2% were from England, and 2.8% from Wales. A total of 171 midwives responded to the survey. Overall, most respondents (52.8%) were from England, 33.1% from Northern Ireland, 9.9% from Scotland and only 4.2% from Wales. The majority of AHPs were again from Northern Ireland (42.9%), followed by Scotland (34.6%) then England (16.2%) and the smallest number were from Wales (6.3%). A total of 51.1% of social care workers were from Northern Ireland, 35.7% were from

Scotland, 9.0% from Wales and the remaining 4.2% were from England. The largest proportion of social workers in the sample were from Northern Ireland (51.6%), followed by England (37.8%), Scotland (6.9%) and Wales (3.7%).

Table 2.4: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	62 (17.2%)	137 (38.0%)	10 (2.8%)	152 (42.1%)	361 (100%)
Midwifery	75 (52.8%)	14 (9.9%)	6 (4.2%)	47 (33.1%)	142 (100%)
AHP	93 (16.2%)	198 (34.6%)	36 (6.3%)	246 (42.9%)	573 (100%)
Social Care Worker	14 (4.2%)	119 (35.7%)	30 (9.0%)	170 (51.1%)	333 (100%)
Social Worker	132 (37.8%)	24 (6.9%)	13 (3.7%)	180 (51.6%)	349 (100%)

Most respondents were female (82.0% UK-wide) with a similar gender distribution across countries. Most midwives in the sample were female (97.2%) while nursing had the highest proportion of males (13.8%). Respondents were primarily in the 30-59 years age group (82.8% UK-Wide) with only a small proportion from the 66+ age group (0.5% UK-Wide). Scotland had the highest proportion of respondents from the 50-59 age group (40.4% within Scotland). Most respondents were of White ethnic origin (93.0% UK-wide). England had the highest proportion of respondents who identified as belonging to an ethnicity other than White (8.1% within England) and social work was the most diverse occupational group, with 14.7% of social workers identifying as not White. England had the highest proportion of respondents with a disability (12.9% within England) and social workers were the most likely occupation to report having a disability (18.2% within social work). Most respondents UK-wide were married (55.0%) or cohabiting (16.8%). UK-wide, 36.1% of respondents considered themselves to be a carer outside of work while 57.1% did not. Northern Ireland had the highest proportion of respondents who were carers outside of work (62.4% within Northern Ireland).

Over half of all the respondents worked in the community (53.3% UK-wide), while 30.4% (UK-wide) worked in a hospital. Most worked in the statutory health and social care sectors (77.3% UK-wide), but over half of social care workers (59.3% of social care workers) worked in non-statutory services (private or voluntary sector). UK-wide, 10.2% of respondents had been redeployed due to COVID-19,

but 40.5% of these felt unprepared for their new role. Only 1.4% of respondents UK-wide had come out of retirement to support the workforce during the pandemic and these were mostly nurses. Most respondents were employed on a permanent basis (91.1% UK-wide) and the majority was employed full-time (72.7% UK-wide), typically working 37.5 hours per week (60.4% UK-wide). England had the highest proportion of respondents employed on a part-time basis (30.8% within England). A total of 36.1% of respondents UK-wide typically did not work overtime, but since the start of the pandemic, slightly less, 32.2% UK-wide, did not do any overtime. Overall, respondents have been working significantly more hours of overtime since the start of the pandemic compared to before it. Under half of the respondents (46.0% UK-wide) had taken no sick days in the previous 12 months, 54.0% had taken one or more sick days in the previous 12 months, 39.9% (UK-wide) of these said that at least some of their sickness absence was related to COVID-19. When sick, most respondents (51.0% UK-wide) reported getting pay from their employer.

Respondents were asked if they had received the flu vaccination, with 70.1% saying yes and 23.8% indicating no. Nurses had the highest percentage of respondents taking the flu vaccination (78.5% within nursing). Respondents were also asked if they had received the COVID-19 vaccination, 80.0% had received both doses and the booster, while 3.6% did not wish to receive the COVID-19 vaccination for several reasons as detailed in Appendix 2. Social care workers had the highest percentage amongst the occupations taking part in this study not taking up the COVID-19 vaccination (8.3% of social care workers).

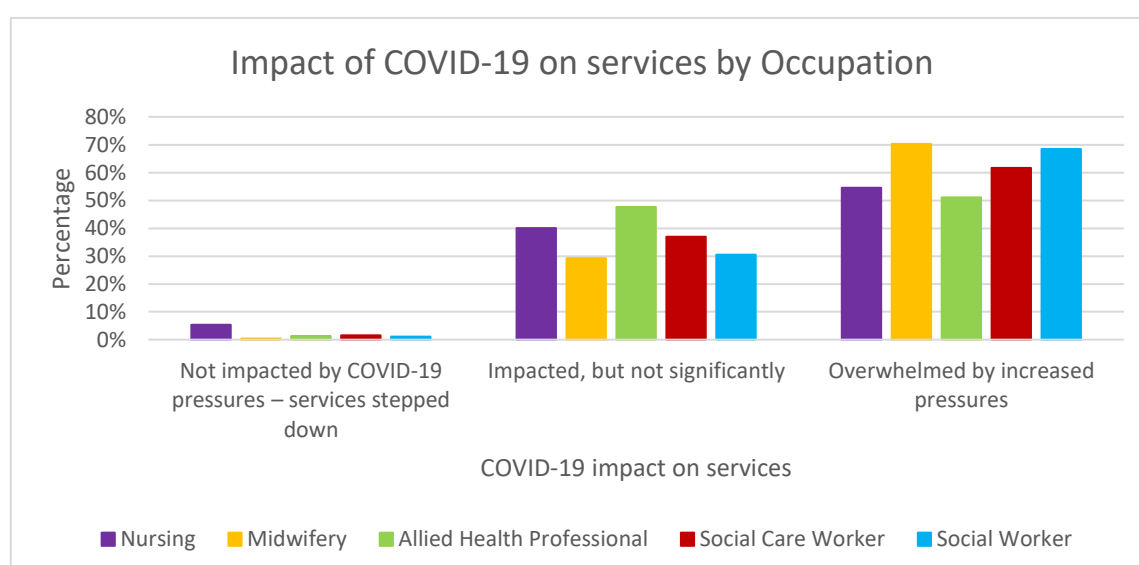
A large proportion of respondents UK-wide had either 11-20 years of work experience (27.1.0%) or 21-30 years (23.5%). Wales had the highest proportion of those with 11-20 years of experience (32.7% within Wales) and those with more than 30 years of experience were primarily nurses (31.0% of nurses). The main area of practice for most respondents was work with older people (34.7% UK-wide) and adults (23.4% UK-wide). Of those who were family carers, most respondents cared for their children (59.9% UK-wide), 56.9% lived with the person they cared for and 67.5% (UK-wide) reported that their caring responsibilities had changed during the COVID-19 pandemic.

Respondents were asked whether they worked from home before the pandemic, over half of respondents did not work from home at all (63.3% UK wide). During the COVID-19 pandemic, 20.0% were able to work from home all the time, while 33.5% could work from home some of the time. Social workers were most likely to work from home all of the time (34.7% of social workers), while

Midwives had the lowest percentage working from home (17.7% of midwives). Over half of respondents indicated that their morale was low at work during the COVID-19 pandemic (52.0% UK wide), with 66.2% of midwives reporting low morale and 65.3% of social workers reporting low morale. Respondents were also asked about the impact of COVID-19 on their work. UK-wide, only 2.9% reported that their service had not been impacted (services stepped down due to COVID-19) with 59.8% reporting feeling overwhelmed by increased pressures.

As shown in Figure 2.2, midwives and social workers were the most impacted occupational groups (70.3% of midwives and 68.4% of social workers). That said, significant percentages of respondents expressed feeling overwhelmed in all occupational groups. Respondents were also asked whether they had considered changing their employer or occupation since the start of the pandemic. Under half of the respondents UK-wide (42.9%) had not considered changing their employer, with the highest proportion of these being from Wales (49.0% within Wales). Similarly, over a third of the respondents UK-wide (45.8%) had not considered changing their occupation and again, Wales had the highest proportion of these (52.1% within Wales). Over half of respondents were still in the same job on the same contractual working hours (56.4% UK Wide), while a fifth had changed their job in the health and social care sector (21.7% UK wide) since the start of the pandemic. Nearly two-thirds of respondents did not take up employer support (62.0% UK wide), with Northern Ireland having the most respondents not likely to take up employer support (77.2% within Northern Ireland). AHPs were most likely to take up employer support (49.5% within AHPs) while social care workers were least likely to take up employer support (26.0% within social care workers).

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



2.3 Focus Groups

Three focus groups were conducted to gain deeper insights into the health and social care workforce (Social Work, Social Care, Nursing, Midwifery and AHPs) and the impact of COVID-19 on their work, one with health and social care human resource (HR) professionals, one with managers and one with frontline workers (January 2022). Participants were mainly from Northern Ireland. Each group began with a brief introduction of the research study before discussion commenced. These views contributed to our recommendations for improving quality of working life and wellbeing for health and social care professionals even beyond the pandemic. Table 2.5 below shows the country and occupational group of the 23 participants.

Table 2.5: Focus Group Participants

Focus group	Country	Occupation
Human Resources (HR)	Northern Ireland	HR Manager Care Home
	Northern Ireland	HR Learning & Development Manager
	Northern Ireland	Senior Organisation Development Manager
	Northern Ireland	Assistant Director of Human Resources
	Northern Ireland	HR Manager Care Home
	Northern Ireland	HR Organisation Development Manager
	Northern Ireland	HR Manager Nursing Home
	Northern Ireland	HR Manager Care Home
Managers	Northern Ireland	Social Care
	Northern Ireland	Social Work
	Northern Ireland	Social Work
	Northern Ireland	Social Work
	Northern Ireland	Nursing
	Northern Ireland	AHP
Front Line workers	England/NI	Social Work
	Scotland	Nursing
	Wales	Social Work
	Northern Ireland	AHP
	Northern Ireland	Social Care
	Northern Ireland	Social Care
	Northern Ireland	Social Work
	Northern Ireland	Social Work
	Northern Ireland	Social Work

2.4 Data Analysis

Survey data were analysed using SPSS 27. Presented are primarily descriptive statistics, specifically frequencies, percentages, mean values of the measured constructs, and some correlations. Sub-groups were compared using analyses of variance (ANOVA), independent samples t-tests and chi-square tests. Multiple regression analyses were used to examine the association between coping strategies and mental wellbeing, quality of working life and burnout, and also to compare findings

from Phase 1, Phase 2 and Phase 3 of the study. Analyses were conducted both with raw and weighted data. The data were weighted using respondents' country of work and occupational group to adjust for potential bias accruing from under-representation of large groups. Weighted responses are summarised in Section 3. Appendices provide more detailed results, including the unweighted response summaries. The analyses were conducted with all available data. Some participants had missing data and therefore the sample total for the different analyses differs throughout this report.

Qualitative questions from the survey were analysed using thematic analysis. Initial coding was based on respondents' identification of groups, according to those who were 'overwhelmed', 'impacted but not significantly' and 'not impacted at all'. Members of the research team read responses to identify recurring themes and outliers across professional groups and countries. Thematic analysis was also used to analyse data from the focus groups. The results of these are presented together with the survey findings in Sections 3.2.1 and 3.2.2. of the main part of this report, with further insights provided in Appendix 10.

2.5 Ethical Considerations

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

3. Findings

The following sections provide a summary of the quantitative and qualitative findings from Phase 4, with particular attention given to changes from the three previous phases.

3.1. Quantitative Findings

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

3.1.1. Mental Wellbeing

Mental wellbeing was assessed using the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS; NHS Health Scotland, 2008). The overall UK wide mean wellbeing score in our sample was 20.85, which is nearly three points below the population mean of 23.61 (NHS Health Survey for England, 2011). This is also lower than the mean score of 20.95 reported in Phase 1 of the study, however, it has improved from the mean score of 20.10 reported in Phase 2 of the study and the mean score of 20.25 reported in Phase 3 (Table 3.1).

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

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	20.95	21.15	20.74	21.25	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85
Phase 4	20.85	20.98	20.27	20.8	20.69

Multiple regression analysis revealed that this was a **significant difference in wellbeing from Phase 1 to Phase 4**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 1.336$, $p < .001$). There was **no significant difference in wellbeing from Phase 2 to Phase 4**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 0.119$, $p > .05$). There was no **significant difference in wellbeing from Phase 3 to Phase 4**, again, even after accounting for respondents' country of work,

occupational group, sex, age, ethnicity and disability status ($\beta = 0.035, > .05$). A decrease in wellbeing, was observed across all four countries and all five occupational groups between Phases 1 and 3. Between Phases 2 and 4, wellbeing increased across all countries, except Northern Ireland which showed a decrease between these phases, with all occupations' wellbeing improving slightly except AHPs which showed a slight decline. Between Phases 3 and 4, wellbeing increased slightly in England and Wales but decreased in Northern Ireland and Scotland. Wellbeing increased in all occupations except within AHPs from Phases 3 to 4 (Table 3.2).

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

Study phase	Country				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 1	21.15	20.91	21.38	20.98	21.14
Phase 2	20.10	19.92	20.73	20.02	20.07
Phase 3	20.58	19.23	20.72	19.70	19.31
Phase 4	20.85	20.98	20.27	20.80	20.69

When the wellbeing scores were converted to indicate probable or possible cases of depression/anxiety, it was found that UK-wide, 12.4% were probable (likely) cases of anxiety or depression and a further 20.1% were possible cases of anxiety or depression (Table 3.3). With the overall average wellbeing score increasing slightly from Phase 3 to Phase 4, fewer participants were now in the Likely Condition category, with more now scoring within the Possible Condition range. Taken together, the estimated proportion of sub-20 scores has declined slightly over the course of the study, though by less than two percentage points from Phase 3 to Phase 4.

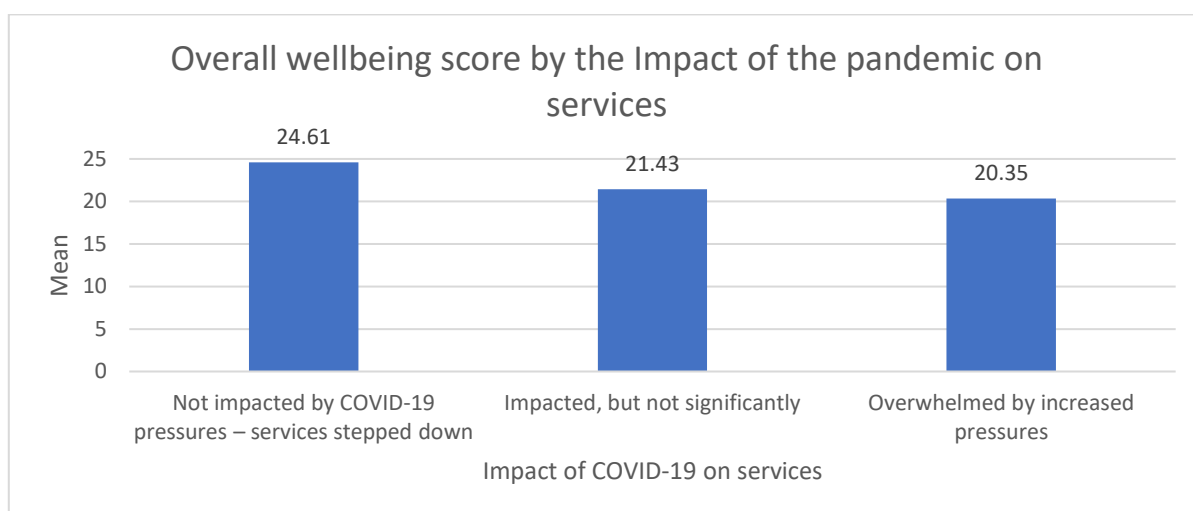
Table 3.3: Wellbeing scores translated to anxiety/depression scores UK wide (Weighted)

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

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

- Older respondents had significantly better wellbeing than younger respondents.
- Respondents from the Asian ethnic group scored significantly higher on wellbeing than those from the White ethnic group.
- Respondents who had a disability had significantly lower wellbeing scores than those who did not have a disability.
- Respondents who felt overwhelmed by increased pressures scored significantly lower on wellbeing than those who only felt some impact of COVID-19 or those who were not impacted by COVID-19 pressures but had services stepped down to due to COVID-19 (see Figure 3.1).

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



Overall compared to Phases 2 and 3 of the study which also measured impact, overall wellbeing scores for those overwhelmed increased in Phase 4 (Table 3.4).

Table 3.4: Overall wellbeing scores by those overwhelmed working in the pandemic (Weighted)

Study phase	Respondents overwhelmed	
	Mean wellbeing score	Percentage of respondents
Phase 2	19.66	49.3%
Phase 3	19.26	62.1%
Phase 4	20.35	59.8%

In Phase 4, 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 wellbeing scores:

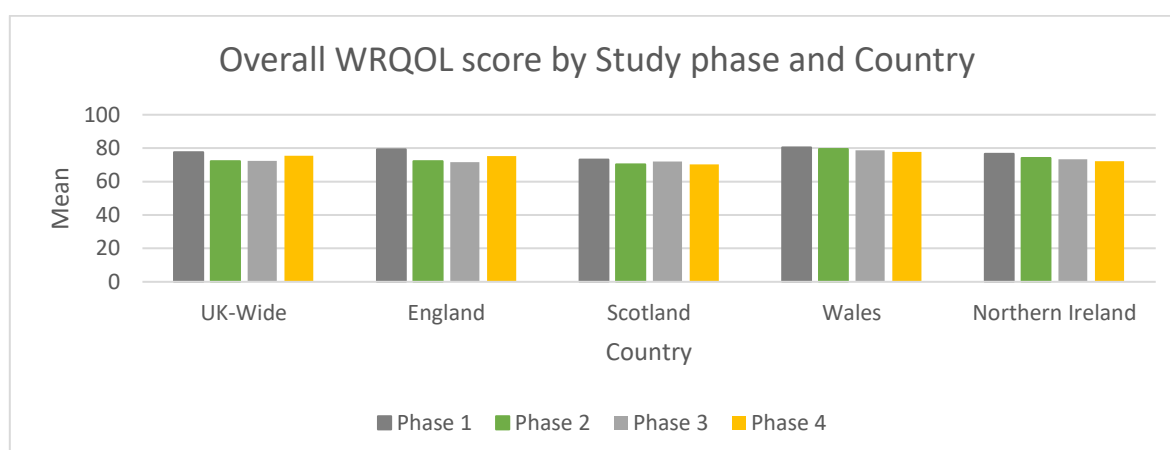
- Active coping, Positive reframing, Acceptance, Use of emotional support, Work-family segmentation, Working to improve skills/efficiency, Recreation and relaxation, and Exercise, all predicted higher wellbeing scores
- Family-work segmentation, Planning, Venting, Substance use, Behavioural disengagement,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

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

3.1.2. Quality of Working Life

Quality of working life was assessed using the Work-Related Quality of Life (WRQOL) Scale (Easton and Van Laar, 2018). The overall WRQOL score across the UK was 75.42, which is lower compared to the 77.59 in Phase 1 of the study but a slight improvement compared to 72.13 in Phase 2 and 72.45 in Phase 3. A multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed that this **decrease in the quality of working life from Phase 1 to Phase 4 of the study was statistically significant** ($\beta = -7.645$, $p < .001$). There was also a statistically **significant difference in the quality of working life from Phase 2 to Phase 4 which included a slight increase in quality of working life from Phase 2 to Phase 4**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 1.742$, $p = .002$). **There was no statistically significant difference between Phase 3 and Phase 4** even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -0.833$, $p > .05$). As shown in Figure 3.2, there was also a decrease from Phase 1 to Phase 4 on all domains of the quality of working life and these decreases were again statistically significant. Also shown in Figure 3.13, in Phase 4, there was a decrease from Phase 2 to Phase 3 in Stress at Work, general wellbeing, home-work interface and working conditions while an increase in job career satisfaction and control at work. All changes were significant except for stress at work and working conditions.

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



As shown in Table 3.5, in Phase 4, the decrease in mean WRQOL scores was observed across two countries (Scotland and Northern Ireland), with Wales reporting higher WRQOL scores. Similarly, Table 3.6 shows an increase in the mean WRQOL of life across the three phases (Phase 2 to Phase 4), with the highest score observed in nurses in Phase 4. However, a decrease in WRQOL was observed for midwives and social workers.

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

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	77.59	79.33	73.07	80.35	76.63
Phase 2	72.13	72.21	70.37	79.46	74.06
Phase 3	72.45	71.54	71.92	78.69	73.29
Phase 4	75.42	75.30	70.28	77.67	72.12

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

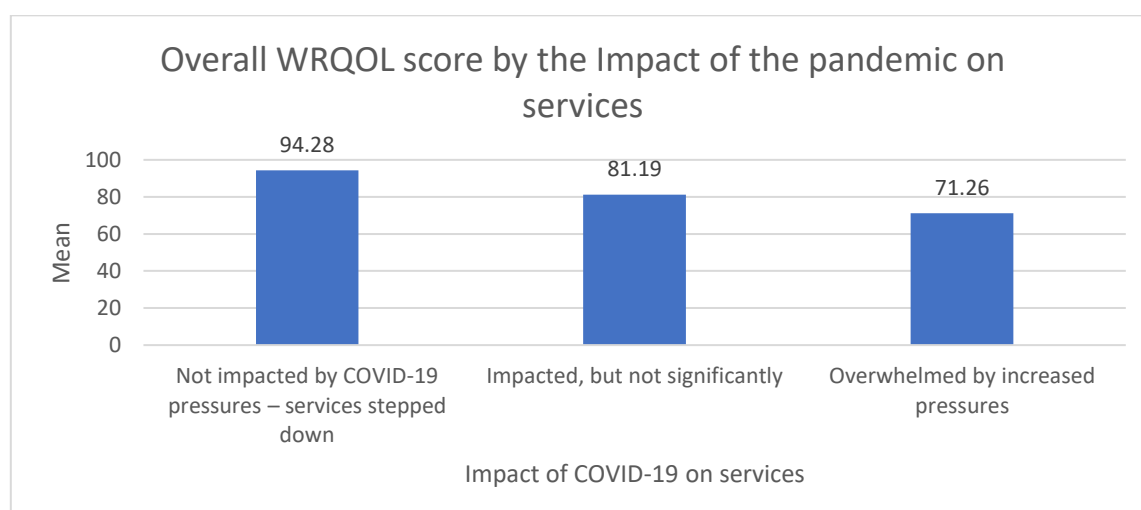
Study phase	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 1	72.54	78.56	81.16	78.34	80.63
Phase 2	70.01	66.95	74.41	73.24	73.67
Phase 3	73.77	64.35	73.79	71.15	69.92
Phase 4	78.37	63.76	73.92	72.78	68.39

When the WRQOL scores were converted to Lower, Average, or Higher quality of working life, we found that UK-wide, 36.9% of respondents had lower quality of working life, 25.5% had average quality of working life and 37.5% had higher quality of working life in Phase 4. This compares to Phase 3 in which 50.0% of respondents had lower quality of working life, 19.5% had average quality of working life and 30.5% had higher quality of working life. While in Phase 2, 46.7% of respondents had lower quality of working life, 26.0% had average quality of working life and 27.3% had higher quality of working life and 30.4%, 27.1%, and 42.5% for higher, average and lower quality of working life respectively in Phase 1 of the study.

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

- Females had significantly lower quality of working life than males.
- Older age groups reported significantly better quality of working life than some of the younger age groups.
- Respondents from the mixed ethnic group had significantly lower quality of working life than all the other ethnic groups.
- Respondents without disability had a significantly higher quality of working life than those who had a disability.
- Line managers and those who were not line managers did not differ significantly in their quality of working life scores
- Respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact or those who felt no impact (see Figure 3.3).

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



We used multiple regressions to examine which coping strategies impacted upon the quality of working life scores. In Phase 4, 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, Family-work segmentation, Work-family segmentation, Working to improve skills/efficiency, and Recreation and relaxation, all of which predicted higher quality of working life scores.
- Planning, Venting, Behavioural disengagement, Self-blame, and Exercise, all of which 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 4, the personal burnout score across the UK was 62.62, which is higher compared to 61.4 in Phase 2 of the study but lower than 63.20 in Phase 3. The work-related burnout score across the UK was 58.65 in Phase 4, which is higher compared to 56.73 in Phase 2 of the study but lower than 59.79 in Phase 3. The client-related burnout score across the UK was 25.24 in Phase 4, which is lower compared to 27.97 in Phase 2 and 29.46 in Phase 3 of the study.

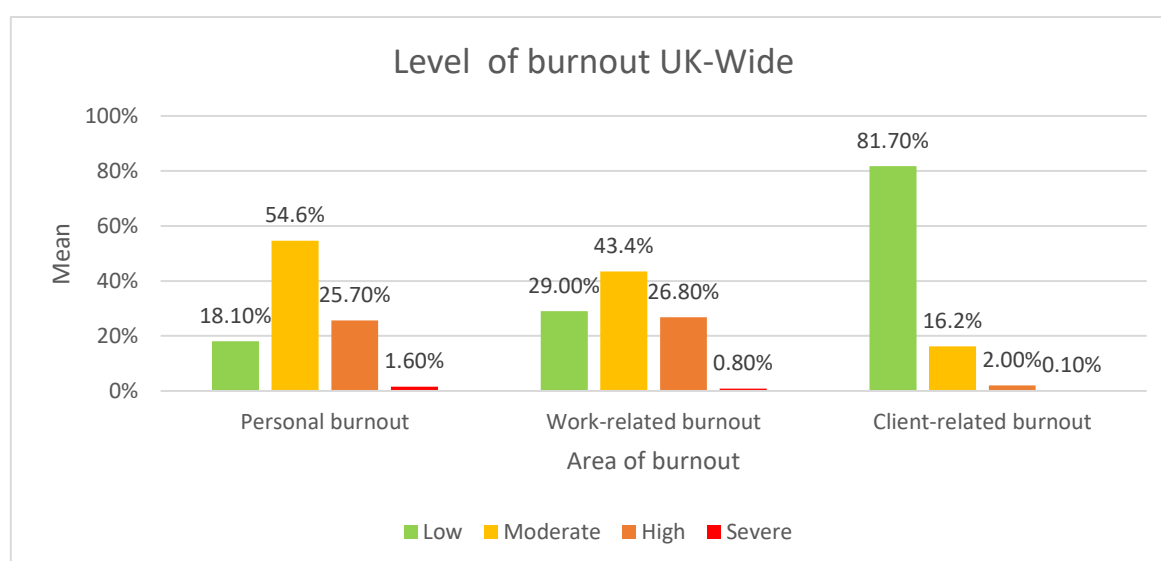
Multiple regression analysis revealed that this was a **significant difference in personal burnout from Phase 2 to Phase 4**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 2.001$, $p = .005$). There was also **significant difference in work-related burnout** ($\beta = .772$, $p < .001$) but not **client-related burnout** ($\beta = 1.140$, $p > .05$) **from Phase 2 to Phase 4** even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that there was **no significant difference in personal burnout from Phase 3 to Phase 4**, after accounting for respondents' country of work, occupational group, sex,

age, ethnicity and disability status ($\beta = 1.021$, $p > .05$) and no significant difference in client-related burnout ($\beta = .382$, $p > .05$). There was a significant difference in work-related burnout ($\beta = 1.740$, $p = .020$) but not from Phase 3 to Phase 4 even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Overall, in Phase 4 we found that client-related burnout was much lower than personal and work-related burnout, suggesting that clients or patients/service users are rarely the reason for staff burnout. There were no significant differences between the countries in mean personal burnout scores ($F = .877$, $df = 3$, $p > .05$), or in mean work-related burnout scores ($F = 2.23$, $df = 3$, $p > .05$). No significant differences between countries were also found in mean client-related burnout scores ($F = .693$, $df = 3$, $p > .05$). Burnout scores for each domain (personal, work and client) were converted to low, moderate, high or severe burnout (Figure 3.4).

Figure 3.4: Level of burnout UK-wide



We found that UK-wide in Phase 4 for personal burnout, 25.3% of respondents had low burnout, 46.4% moderate, 23.7% high and 1.6% faced severe burnout (see Figure 3.4). This compares to 21.9% of respondents having low burnout, 42.9% moderate, 28.6% high and 6.6% faced severe burnout in Phase 3 and 28.3% with low burnout, 46.4% with moderate, 23.7% with high and 4.6% with severe personal burnout in Phase 2. (Table 3.7).

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

Personal Burnout	Low	Moderate	High/Severe
Phase 2	21.9%	42.9%	35.2%
Phase 3	28.3%	46.4%	23.7%
Phase 4	18.1%	54.6%	27.3%

In terms of work-related burnout in Phase 4, 33.7% of respondents had low burnout, 45.0% moderate, 19.7% high and 1.6% faced 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 Phase 2 work-related burnout, 33.7% experienced low burnout, 45.0% experienced moderate burnout and a further 21.3% experienced high or severe burnout (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%

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

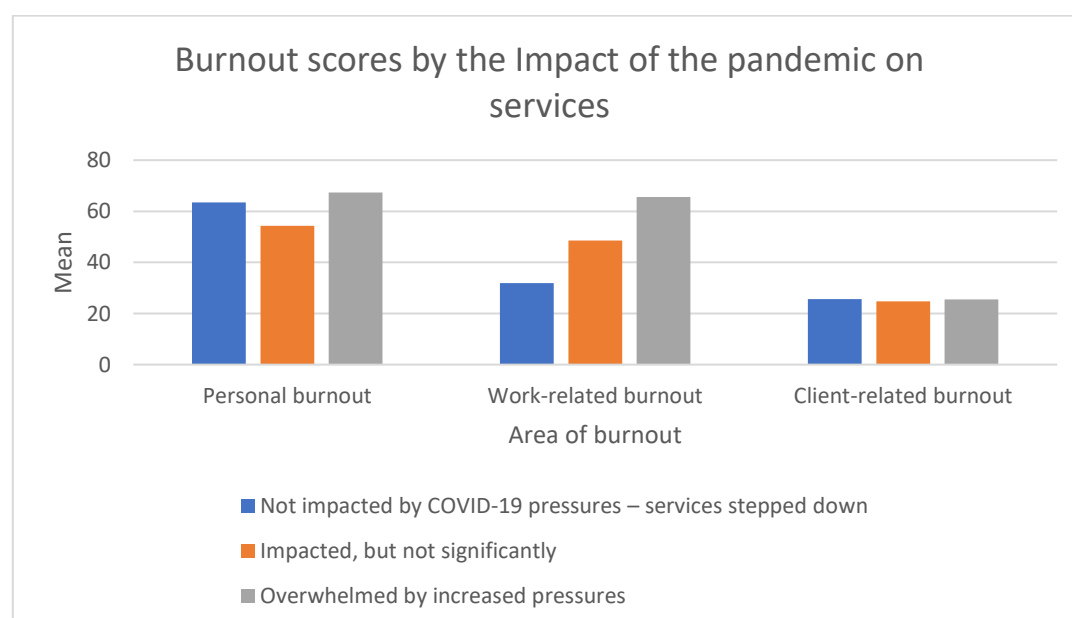
Table 3.9. Level of client-related burnout UK wide across the Phases (Weighted)

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%

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

- Females experienced significantly higher levels of personal and work-related burnout but had lower client-related burnout than males.
- The older age groups generally experienced significantly lower personal, client-related and work-related burnout than the younger age groups.
- There were no significant differences between the ethnic groups in mean personal burnout scores or work-related burnout scores. There were significant differences between the ethnic groups in mean client burnout scores. Specifically, the respondents from the Black ethnic group scored significantly lower than the White and Asian ethnic groups.
- Respondents without a disability experienced significantly less personal and client-related burnout than those who were unsure of whether they had a disability.
- Line managers experienced significantly more personal and work-related burnout and significantly less client-related burnout.
- Respondents who felt that their service was overwhelmed by increased pressures experienced significantly more personal and work-related burnout than those who felt impacted but not significantly (see Figure 3.5).

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



As shown in Table 3.10, we found strong negative correlations between personal burnout and wellbeing scores and a moderate negative correlation between personal burnout and quality of

working life, work-related burnout and wellbeing scores, and work-related burnout and quality of working life scores. There were also weak, but statistically significant, negative correlations between client-related burnout and wellbeing scores, and client-related burnout and quality of working life scores. This indicates that as burnout in any area increased, respondents' wellbeing and quality of working life decreased. Considering the association between burnout, wellbeing and quality of working life, another area of interest for the survey was whether respondents have considered leaving their current employer and how this impacts burnout.

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

Burnout area	Wellbeing	Quality of working life
Personal	-.470	-.496
Work-related	-.541	-.684
Client-related	-.290	-.375

In relation to respondents having considered changing their employer since the start of the pandemic, we found significant associations between all areas of burnout and respondents considering this option (Personal burnout: $\chi^2 = 241.25$, $df = 15$, $p < .001$; Work-related burnout: $\chi^2 = 304.32$, $df = 15$, $p < .001$; Client-related burnout: $\chi^2 = 88.14$, $df = 15$, $p < .001$). Specifically, respondents who were experiencing high/severe levels of personal burnout were very likely to report having considered changing their employer since the start of the pandemic for two specific reasons; 1) the job being very stressful, and 2) the job impacting on their health and wellbeing. Those experiencing low levels of personal burnout were less likely to have considered changing their employer for these reasons. The same was found for work-related burnout and client-related burnout.

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

Personal burnout:

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

Work-related burnout:

- Active coping, Use of emotional support, Use of instrumental support, Work-family segmentation, Working to improve skills/efficiency, and Recreation and Relaxation all predicted lower burnout scores.
- Planning, Venting, Substance use, Behavioural disengagement, Self-blame, and Family-work segmentation, all predicted higher burnout scores.

Client-related burnout:

- Active coping, use of emotional support, working to improve skills/efficiency and exercise predicted lower burnout scores.
- Planning, Venting, Behavioural disengagement, and Self-blame 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

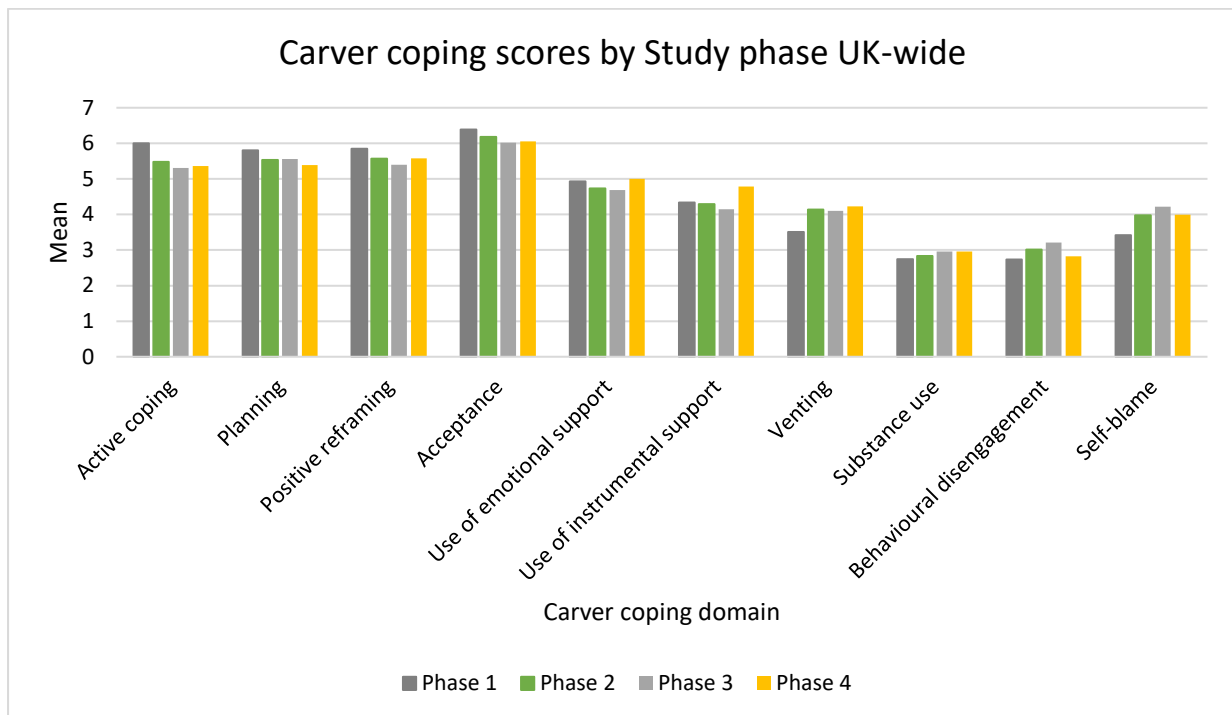
UK-wide, there seemed to be **an overall decrease in the use of most of the positive coping strategies and an increase in the use of negative coping strategies from Phase 1 and Phase 2 to Phase 4** as shown in Figure 3.6. Between **Phase 3 to Phase 4 of the study**, there were slight improvements in the use of positive coping strategies and a decrease in most of the negative strategies except venting which increased. A multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status, showed that the decrease in respondents' use of active coping ($\beta = -0.909$, $p < .001$), planning ($\beta = -0.556$, $p < .001$), positive reframing ($\beta = -0.704$, $p < .001$), acceptance ($\beta = -0.686$, $p < .001$) and emotional support ($\beta = -0.611$, $p < .001$) were statistically significant from Phase 1 to Phase 4; and the increase in the use

of use of instrumental support ($\beta = 0.473$, $p < .001$), venting ($\beta = .905$, $p < .001$), substance use ($\beta = 1.696$, $p < .001$), behavioural disengagement ($\beta = 2.389$, $p < .001$) and self-blame ($\beta = 1.567$, $p < .001$) was also statistically significant.

Between Phase 2 to Phase 4, a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status, showed that the decrease in respondents' use of active coping ($\beta = -0.213$, $p < .001$), planning ($\beta = -0.139$, $p < .05$), positive reframing ($\beta = -0.298$, $p < .001$), acceptance ($\beta = -0.215$, $p < .001$), emotional support, ($\beta = -0.161$, $p < .05$) and substance use ($\beta = -.115$, $p < .05$). were statistically significant. There was an increase in the use of self-blame between Phase 2 to Phase 4 that was statistically significant ($\beta = 0.198$, $p < .05$). However, there was no significant differences in instrumental support ($\beta = -0.066$, $p > .05$), use of venting ($\beta = 0.017$, $p > .05$), and behavioural engagement ($\beta = 0.097$, $p > .05$) between Phase 2 to Phase 4.

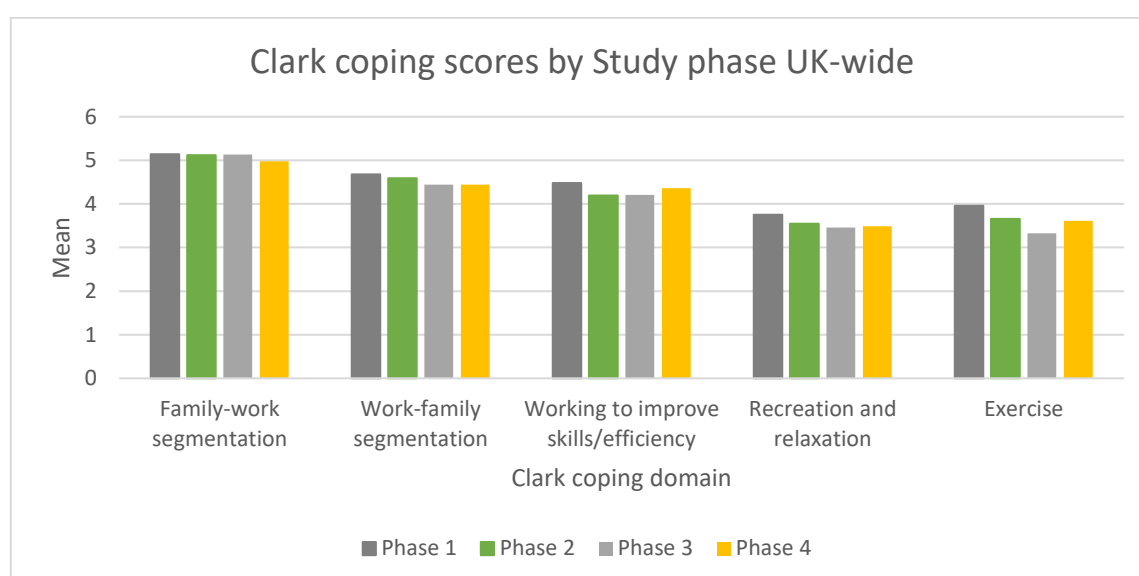
Between Phase 3 to Phase 4, a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status, showed that the decreases in respondents' use of positive reframing ($\beta = -0.151$, $p < .05$), and substance use ($\beta = -0.141$, $p < .05$), were statistically significant. There was an increase in the use of self-blame between Phase 2 to Phase 3 that was statistically significant ($\beta = 0.227$, $p < .001$). However, there were no significant differences in active coping ($\beta = -0.032$, $p > .05$), planning ($\beta = -0.040$, $p > .05$), acceptance ($\beta = -0.609$, $p > .05$), emotional support ($\beta = -0.062$, $p > .05$), use of instrumental support ($\beta = -0.033$, $p > .05$), use of venting ($\beta = 0.003$, $p > .05$), self-blame ($\beta = -0.072$, $p > .05$) and behavioural engagement ($\beta = 0.097$, $p > .05$) between Phase 2 to Phase 4.

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



Looking at Clark et al. (2014) coping strategies (Figure 3.7), a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed **significant difference between Phase 1 and 4** in respondents' work-family segmentation ($\beta = -0.196$, $p < .005$), working to improve skills/efficiency ($\beta = -0.246$, $p < .005$), recreation and relaxation ($\beta = -0.363$, $p < .001$) and Exercise ($\beta = -0.343$, $p < .001$) but **no significant difference in use of** family-work segmentation ($\beta = 0.064$, $p > .05$) from Phase 1 to Phase 4 of the study. Between Phases 2 to 4, a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed **no significant difference in respondents' use of family-work segmentation** ($\beta = -0.061$, $p > .05$), **use of work-family segmentation** ($\beta = -0.025$, $p > .05$), **working to improve skills/efficiency** ($\beta = -0.025$, $p > .05$), **recreation and relaxation** ($\beta = -0.075$, $p > .05$) and **exercise** ($\beta = -0.025$, $p > .05$). Between Phases 3 to 4, a multiple regression analysis, which controlled for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status showed **no significant difference in respondents' use of family-work segmentation** ($\beta = -0.036$, $p > .05$), **use of work-family segmentation** ($\beta = -0.019$, $p > .05$), **working to improve skills/efficiency** ($\beta = -0.014$, $p > .05$), **recreation and relaxation** ($\beta = -0.046$, $p > .05$) and **exercise** ($\beta = -0.060$, $p > .05$).

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



3.2. Findings: Qualitative responses

Responses to the three open-ended questions in the survey were examined using a thematic analysis approach. Members of the research team familiarised themselves with the data, generated initial codes, agreed and reviewed common themes, and then collated and presented the data as outlined below. Also included in this analysis were data from the three focus groups that were held with Human Resources (HR) professionals, managers and frontline workers in January 2022. The overarching themes that emerged in Phase 4 (November 2021-February 2022) have similarities to the themes identified in Phase 1 (April – July 2020), Phase 2 (November 2020-January 2021) and Phase 3 (May 2021 – July 2021) of the study such as changing conditions, connections, communication and work-life balance.

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

The following questions were asked in the Phase 4 survey:

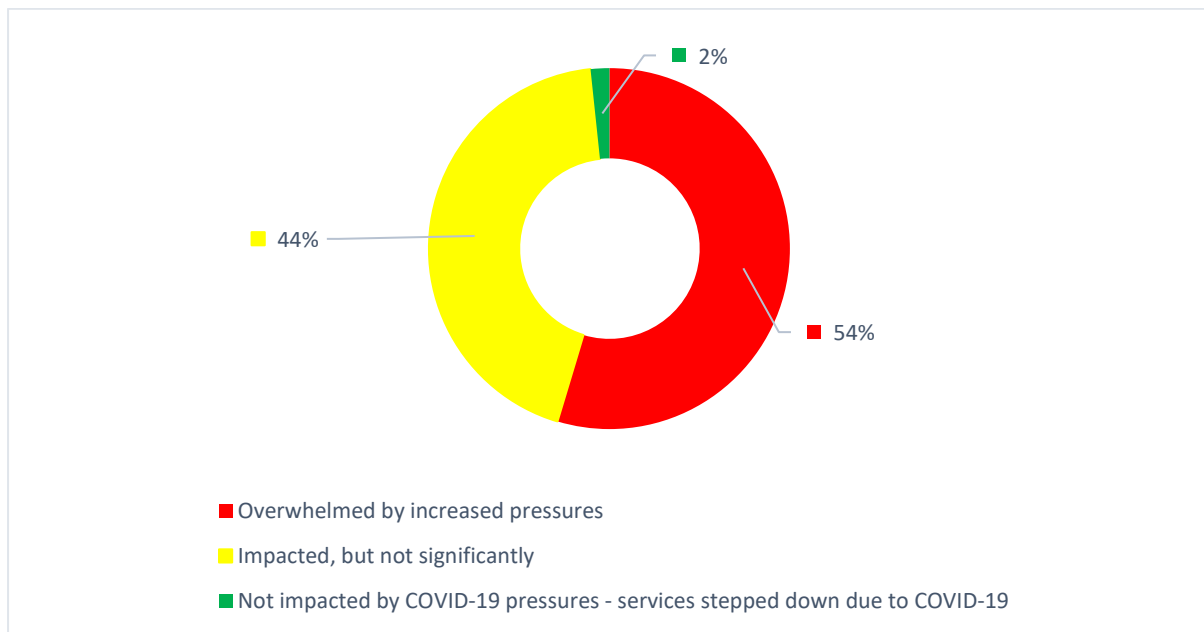
- **Q29.** Between July 2021 and now what was the impact of COVID-19 on your specific place of work, in relation to patient/service user numbers and service demands?
- **Q35.** Why have you changed your job or contractual working hours or left your job (e.g. financial reasons, job changes, family/caring responsibilities, etc)?
- **Q54.** How did the experience of the pandemic change the way you now manage work and non-work responsibilities?

Generally, across the three opened ended questions, responses suggested that exhaustion and burnout were increasing amongst health and social care workers. While the pandemic restrictions lifted these did not occur substantially within health and social care. The data revealed that staff recruitment and retention problems continued due to lack of opportunities, unsatisfactory pay, increased workload and lack of support within this sector. Communication between managers, HR and frontline workers were still indicating difficulties and miscommunication seemed a major factor leading to stress at work. In the following section, we discuss each open-ended question in greater detail to highlight the challenges that the health and social care sector staff face as the COVID-19 pandemic continues to affect working conditions, as services rebuild and patients and service users are seeking a return to business as usual within health and social care provision.

Responses to open-ended Q29

Out of the 1,758 survey participants, 1,496 individuals responded to the open-ended question Q29 *“Between July 2021 and now, what was the impact of COVID-19 on your specific place of work, in relation to patient / service user numbers and service demand?”* For the respondents that answered Q29, over half felt overwhelmed working during the pandemic (Figure 3.8). Almost all respondents elaborated on the effect of COVID-19 on increasing work demand in the context of increasing staff shortages due to staff illness, staff absence, staff turnover and inability to recruit and retain new staff. This was presented as a vicious cycle: as work demand rose this affected staff wellbeing, staff sick leave, staff turnover and was, in turn, further increasing staff shortages. With worsening staff shortages, more work demands affected the remaining members of staff negatively leading to a feedback loop of worse wellbeing and health outcomes. As one social worker put it: *“Staff shortages are crippling teams and then more staff go off sick (Social Care Worker, Community, Northern Ireland)”*. This vicious cycle of work demand and staff shortages was then discussed in relation to how it affected the (mental) health of staff as well as that of patients, service users and their families.

Figure 3.8 Impact on working during the pandemic by Q29 respondents.



Increased work demands

Respondents identified that increased work demand was caused by persistently high or increasing numbers of COVID-19 infected people, who required care due to COVID-19 but who also required extra care for other non-related conditions. A midwife from England, for example, mentioned that *“There were also increasingly higher numbers of women affected with COVID-19 leading to increased acuity (preterm birth / Caesarean Section) in this group of women”* (Midwife, Hospital, England). A hospital nurse from Northern Ireland specified that COVID-19 positive patients required additional care: *“lots of covid positive patients- needed extra checks pre chemotherapy/ surgery etc”* (Nurse, Hospital, Northern Ireland).

Furthermore, respondents reported having higher work demands associated with COVID-19 related services, such as being deployed to COVID-19-intensive care units or COVID-19 vaccination clinics. These services were seen as in addition to normal work demand. An AHP from Northern Ireland suggested that additional services had to be covered on top of normal services created: *“Huge pressure to cover 'normal'... on top of that having to provide support to the mass vaccination programme... without back fill”* (AHP, Hospital, Northern Ireland).

There was also debate about how work demand was created by perceptions of increasing complexity of cases coming into health services. These cases were not necessarily COVID-19 patients but patients who had not sought medical advice due to fear of catching COVID-19. Other patients had not been able to seek medical advice earlier due to closure of (specialised) services. In response to the delay in seeking medical advice, these patients then presented with complex and/or advanced illnesses. An AHP from Wales elaborated on this: *“We have seen increased admissions to the ward and increased referrals to the community/outpatient service, all due to delayed access to care the year prior as well as switching off of some non-essential services to allow for potential re-deployment of some team members.”* (AHP, Hospital/Community, Wales). An AHP from England specified that: *“Rehab [rehabilitation] of post op [operation] is more complex as have been waiting for surgery for longer”* (AHP, England, Hospital/Other) and a colleague from Northern Ireland outlined how these complexities occurred in one specialism: *“The pressures on podiatry services are unprecedented. We have seen a huge increase in the complexity of our patients. Reduced access to services such as vascular and orthopaedic surgery and lack of beds has meant that people who should have had surgical interventions haven't”* (AHP, Hospital/Community, Northern Ireland). Complexity of cases also affected other professions, including Social Work, *“Referrals of serious harm including domestic homicide and child death hugely increased”* (Social Worker, Community, England), where respondents saw increased complexities of cases due to services being stood down or understaffed.

A few respondents, especially those within Allied Health Professions, mentioned that their work was increased as patients cancelled treatments or appointments due to fear of Covid-19. This often required the rescheduling of appointments and undermined productivity.

Staff Shortages

Most respondents mentioned that their services were (increasingly) short-staffed and discussed staff shortages as a direct or indirect result of the pandemic. At the time of the survey in late 2021 and early 2022, many respondents mentioned staff being off sick with or shielding from COVID-19 (including staff suffering from Long COVID). For example, a nurse from England reported that the *“impact of COVID-19 on staff sickness levels (Long COVID) increased workload”* (Nurse, Community England) and an AHP from Scotland confirmed the pressures from *“Colleagues off sick / isolating”* (AHP, Scotland). However, our respondents also mentioned that staff were off sick due to COVID-19-related mental health problems, including burnout, after working under pandemic conditions. These narratives were found across countries and professions: *“We lost a lot of staff and as a consequence,*

remaining staff had to take on more work. It has always been a high turnover job anyway but the stress of this was more keenly felt in recent months due to the pandemic” (Social Care Worker, Community, England). Furthermore, in addition to staff absences due to illness, staff shortages were still being caused by staff re-deployment, which was sometimes perceived as a permanent staff reduction in a service: *“Staff on maternity leave not replaced. Re-deployed staff not returned to service (Nurse, Hospital, Northern Ireland)”*.

There was a further narrative about staff proactively leaving the employer or profession but remaining gainfully employed in either a different health and social care setting or leaving the sector altogether. Reasons cited were the then proposed mandatory vaccine requirement for care homes *“Care provision is in a critical state as providers have lost staff either due to the mandatory vaccine requirement for care homes or staff have left the sector” (Social Care Worker, England)* or to take advantage of better pay or working conditions *“junior staff leaving to go to agencies for better pay” (Nurse, Northern Ireland)*; or due to job-related pressures that affected individuals’ health, which made continuing to stay in the job unfeasible:

“Tired staff, less tolerant, less engaged, some staff left/leaving” (some leaving professions) (Nurse, Other setting, England).

“Due to the pressure of covid. Staff left and people did not want to work in this sector so the company had to close” (Social Care Worker, Other setting, Northern Ireland).

Some respondents also talked about staff shortages caused by early retirement: *“our staffing numbers have decreased due to illness, people leaving the service and taking retirement, often earlier than previously planned (Nurse, Community, Scotland).* While all professions across all countries noted some staff were leaving, most also reported difficulties in attracting and retaining new staff. Respondents reported that some job advertisements had either received no response: *“We have had an advert out for a locum since September with no suitable offers to date” (AHP, Hospital, Scotland)* or only a few applicants *“There are vacancies in AHP services and nursing services as staff Posts advertised are not having many applicants in some cases” (AHP, Other setting, Northern Ireland).* There were further narratives about unsuccessful recruitment processes as well as the inability to retain new recruits.

“Recruitment to vacancy delayed, then finally recruited but candidate declined position 2 months later so staffing remains depleted” (Nurse, Community, England).

“Constantly recruiting staff [but] unable to retain most” (Social Care Worker, Community, Wales).

If new staff could be recruited this caused some disruptions for existing staff as new staff had to be trained. Some respondents reported that either no time was allocated to conduct this training (*“Influx of staff to train, no allocation of time to undertake it (Social Care Worker, Community, Wales)”*) or that training had to be delivered in new online or remote forms, which required additional time to design and implement:

“All training delivery transferred to online. A transitional period to upskill and transfer learning materials to an online learning environment took time and effort. This impacted training and delivery across the Trusts and region” (Social Worker, Community, Northern Ireland).

Lastly, new or re-deployed staff sometimes did not have the service-specific qualifications and skills required to support a ward or service at the required capacity causing disruptions to services as outlined in the following two quotes:

“A lot of wards are run by agency [locum or temporary staff] and it can be chaotic as no regime or familiarity with ward” (AHP, Hospital, Northern Ireland).

“My substantive post has seen extraordinary pressures on it. Staff are leaving like never seen before and at time cover is from agency or bank staff that whilst are good are often not skilled in the area” (Nurse, Hospital/Community, Northern Ireland).

Therefore, because work demand was on the rise or consistently high, and while services experienced difficulties filling vacancies with qualified staff, some specialist services were still not available to service users:

“Delayed discharges for people with LD [learning disability] and autism from long stay LD hospitals as providers cannot provide specialist and consistent support teams” (Social Worker, Hospital, Community, England).

“Cancellation of elective surgeries and increase in traumatic/accidental injuries has changed the caseload” (AHP, Hospital, Scotland).

Furthermore, respondents reported that waiting for treatments and services had increased, which in some cases affected the success of treating the illness. These waiting lists were the result of either a backlog of cases that could not be treated due to service closure or because services were now operating under reduced capacity due to social distancing guidelines.

“Still working through backlog and growing waiting lists from July 2021. Difficult to triage referrals and people becoming more complex medically and particularly unwell” (AHP, Other setting, Northern Ireland).

“Service users numbers coming to the Centre were cut dramatically...Some support (a few hours) was given in the home of service users not attending the Centre. Unfortunately for a few, no support was offered” (Social Care Worker, Community, Scotland).

In consequence, there was a perception that being on a waiting list was negatively affecting patients. *“Increased waiting lists for outpatient appointments and ever increasing waiting lists for surgery which were in a bad position prior to covid and are now astronomically long” (Nurse, Hospital, Northern Ireland).* The following quote shows an extreme case of how staff shortages affected service users, although most respondents addressed similar concerns about staff shortages related to Covid:

“At one point we had one care assistant which was myself and one nurse due to the rest being off with Covid, to take care of 86 residents who all had covid. 13 died in one week. We had no PPE, no support, and no management as they were also off with covid” (Social Care worker, Hospital/Care Home/Day Care, Northern Ireland).

Concerns for health and wellbeing

Respondents' concerns for their own health and wellbeing as well as their concerns for their service users were expressed in the context of work demand and staff shortages. Staff concerns for their own health and wellbeing continued to centre on experiences of stress, exhaustion and burnout in relation to high work demand and lack of breaks and rest periods. There was some indication that the pandemic had highlighted already existing problems with working conditions, as explained by a midwife from Wales (*“Exposed poor working conditions that already existed, Burn out” (Midwife, Community, Wales)*). Most respondents, however, elaborated on the effect of working conditions under pandemic conditions. This included staff isolation from service users and colleagues under social restrictions and when face-to-face services were closed:

“Constantly 'fighting fire'. Every day becoming a slog. Working through breaks neglecting ourselves during the working day” (Nurse, Community, Scotland).

“We have had so many staff off work we are severely short staffed, staff aren’t getting proper rest breaks, days off, some weeks I’m working 60 plus hours and I worked three whole months without a single day off! Staff are at breaking point and morale is so very low” (Social Care Worker, Community, Northern Ireland).

“This is an increasing pressure as we have not been able to see and talk to each other unless on a screen. Social work is innately problem solving, but not having a team base and continued uncertainty after so many months uncertainty takes its toll on us all. Morale is hard to keep up” (Social Worker, Other Setting, England).

In addition to working conditions, respondents also identified the death of service users as a cause of exhaustion, stress and burnout, as exemplified by a nurse (*“PTSD of some staff in relation to deaths” Nurse, Hospital, England*) and a social care worker (*“It was very hard as we lost some residents it broke my heart” Social Care Worker, Community, Scotland*). Furthermore, respondents voiced concerns about their own training as well as long-term staff development due to lack of time and resources to train new staff:

“The impact of the pandemic on social work education and training has been significant with much of the teaching being done online. There are limits to learning from direct work with service users. Many social workers are under so much pressure that they don’t have time for learning and development” (Social Worker, Other setting, Northern Ireland).

Many respondents voiced concerns for their patients, service users and carers. This was often in relation to the increasing complexity of cases due to long waiting lists and lack of time and resources available to look after people:

“More patients waiting for non-emergency surgery, a rapid increase in the number of patients with terminal disease, an increase in demand of nursing care due to a lack of social support for patients in the community” (Nurse, Other setting, Scotland).

This caused concern that service users would develop more complex conditions that would be more difficult to manage:

“The vast majority of people were discharged to care homes that would not then allow in professionals like therapists, nurses or social care staff. The homes themselves were not culturally or practically set up to rehab [rehabilitate] people....The knock on of this was that the care homes are now full of people who would not otherwise be there and have a

significantly longer life expectancy. This has now meant that finding a placement is very challenging for those who really needed them” (Social Care Worker, Hospital, England).

Respondents also felt that the pandemic adversely affected patients’, service users’ and carers’ - but also the general population’s - mental health due to greater isolation. There were comments that people missed their loved ones but also that the general population was increasingly struggling to cope with the effects of the pandemic:

“Massive impact, the loss we have had, the mental health deterioration in our patients. Seeing them heartbroken for not been able to see their loved ones. Not being able to recognise or even understand us with our masks on” (Social Care Worker, Care Home, Wales).

“As I am a frontline mental health nurse practitioner, I am assessing people who are struggling to cope with their own lives during these difficult circumstances. I have found that people who would normally have coped with day to day life are now struggling. Since the pandemic started the number of people who we see has doubled” (Nurse, Hospital, Scotland).

“Young people’s development and mental health have been impacted on and we are seeing and likely to continue to see increased referral”. (AHP, Other setting, Northern Ireland).

Concern was expressed by some respondents for the wellbeing of carers who were under additional pressure to care for relatives in the absence of many support services:

“Significant impact was felt by Carers and people with dementia due to reduce support services leading to increased stress and anxiety. People that needed respite found it difficult to access these services due to COVID infections within care homes and increased demand due to carer stress impacted in lack of services such as day care and voluntary groups. As a result, an increase in people needing emotional support from our service” (Nurse, Other setting, England).

Vicious Cycle of work

A third main theme was in relation to how the vicious cycle of work demand and staff shortages had affected some services more than others. A minority of respondents elaborated on competition for

resources between services. While there was a feeling of unity in previous surveys, we increasingly heard of perceived competition for resources and recognition between services:

"I have responsibility to provide planned and unscheduled care across both acute hospital and community care settings....The focus to maintain hospital service ensured that resources were prioritised to sustain acute services but there was no collegiate or corporate support to support community / domiciliary care services. ... Homecare prioritisation was a poor third place behind Hospitals and Nursing Homes" (Nurse, Other setting, Northern Ireland).

"The system is failing and it's only getting worse because Social Care is always the forgotten sector and none of our representatives fight anywhere near hard enough for us. The Education sector have people protesting in higher places all the time, where is our support to lobby the government to make life for us minions on the ground and the people we're trying to support?" (Social Worker, Community, England).

This narrative about competition for resources included a discussion about perceived fairness of work distribution. Some respondents felt that the closure of some services had added to their own workloads because they had to cover the work themselves, even though they were not qualified or this was not part of their job description:

"The demand for our service has increased hugely. Services typically used have gone or are limited therefore social workers have picked up work that they previously haven't done" (Social Worker, Community, Wales).

"District nursing (DN) seen overwhelming increase in service demand - all ages isolating as GPs would not see patients or (COVID) positive cases at home. Service was used to fill this gap patients were seen who did not meet DN criteria. DN picking up deficit of for disciplines when they were redeployed or their services were stretched" (Nurse, Community, Northern Ireland).

"Patients not been seen by GP phone community nurses instead. Increase in patients requiring care at home as no hospital beds. Increasingly ill patients left at home because of no hospital beds, GP expect us to look after these patients without them visiting these patients at home. ... Low team morale when GP opted out of Covid -19 boosters so did School nurses However Community nurse were expected to design plan and execute mass vaccination clinics" (Nurse, Community, Scotland).

A few respondents expressed a “we against them” mentality, suggesting that they felt left out, ignored or undervalued by society, employers or other health and social care workers in relation to their involvement in the pandemic. There is indication that this narrative was more often voiced by social workers compared to the other four occupational groups:

“In essence SWs (are) told their assessment is worthless and can be shelved. District nurses are flat out and very stressed but they aren’t told their assessments can be ignored. Creates feeling of lack of respect for SW. Constant praise for acute and district nursing...no one considering social care or community hospitals” (Social Worker, Other setting, Northern Ireland)

“We are often as a social work community team absent from focus on the impact of covid-19 as we are not acute nor nurses or doctors” (Social Worker, Community, Northern Ireland)

We lastly found that a small group of respondents talked about communication with and connections to line managers and employers. These were strong and dominant narratives in previous surveys, but these topics received less attention in Phase 4. Nevertheless, a few respondents still reported a lack of perceived leadership or communication:

“Very short staffed, increasing pressure on remaining staff. Lack of support from management left feeling undervalued” (Social Care Worker, Care Home, Scotland).

“Lack of clear information, lack of visible and clear leadership, over emphasis on COVID and not enough on everyday work which was being missed because of obsession with COVID” (Nurse, Hospital, Northern Ireland).

“Complete implosion of management. Management off sick with no contingency planning. Poor management planning of resources” (Social Worker, Community, England).

“Managers’ attitude towards us, Lack of support from employers... Pressure from employers and management when off sick to return early, ...Lack of support of any kind from NISCC...NISCC reported they were suspending our fees but then knocked us for 2 years’ worth of fees in January 2021. They we’re unheard of during the pandemic but when it was fee time they issued threats that registrants would be unable to work unless they paid. ... Lack of empathy by employers and managers.....no wonder staff are leaving the NHS in droves.....constant bullying and threatening of staff” (Social Worker, Community, Northern Ireland).

Finally, some respondents elaborated on changing guidelines and resulting lack of clarity in guidelines that made their work more difficult:

“The volume of government guidance and changes and how it might affect social workers was significant. The number of government meetings I attended on a weekly basis to ensure a voice for social workers - at least 4 different groups that initially met every week” (Social Worker, Other setting, Scotland).

“Constant daily changes to protocols, high death rates, high sickness levels, low morale, exhaustion, insurmountable stress” (AHP, Hospital, England).

“Feeling vulnerable not enough information given by my work ... need more consultation with work force feel left to get on with things using your own initiative and help of work colleagues to help you out. Never seem to get same information” (Social Care Worker, Community, Scotland).

“Changing covid guidance and rules/laws and having to keep on top of it, Expectation from staff that I know everything to do with covid and all the rules, Confusion” (Social Care worker, line manager, Community, Scotland).

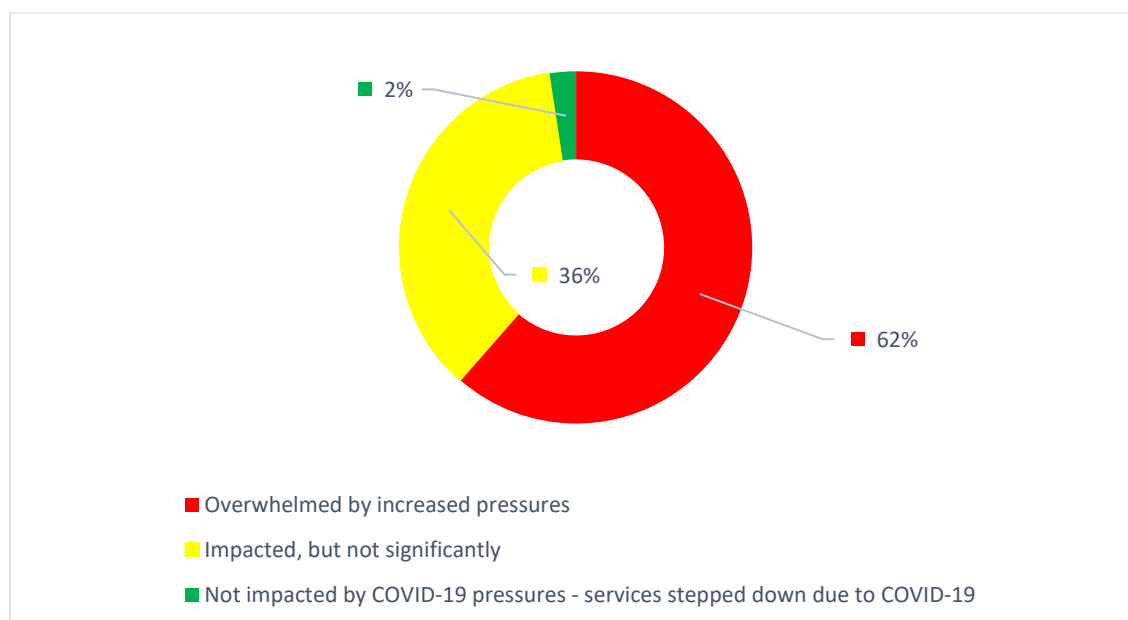
In summary, almost all respondents commented on increasing work demand and increasing staff shortages, which for some created a vicious cycle of long working days, regular overtime, an inability to take breaks and holidays, and, as a result, led to stress, exhaustion and burnout. Concern was expressed for respondents’ own (mental) health but also for the (mental) health of patients, service users and carers. This cycle was seen across professions and countries, and – almost two years since the start of the pandemic - many respondents did not see light at the end of the tunnel. There were some narratives that showed despair and resignation. In particular, we heard narratives that may reveal increasing levels of competition or unfairness between services and indication of an emerging “us against them” mentality.

Responses to open-ended Q35

Out of the 1,758 survey participants, only 250 individuals responded to the open-ended question Q35 “Why have you changed your job or contractual working hours or left your job (e.g. financial reasons, job changes, family/caring responsibilities)?” For the respondents that answered Q35, nearly two thirds had felt overwhelmed working during the pandemic (Figure 3.9). Several reasons were identified for changing or leaving jobs and they are summarised under the following nine themes: need for greater job flexibility, financial reasons, workplace support and leadership, impact of stress

on health and wellbeing, workplace bullying, home work-life balance, new opportunities and promotion, less patient facing, and needs of service or contractual issues.

Figure 3.9. Impact on working during the pandemic by Q35 respondents.



Need for Job flexibility

Some respondents reported the need for greater flexibility in their working hours, which was not being accommodated in their current role and they had actively sought a role that offered their desired level of flexibility, such as hours at work or numbers of hours worked. In addition, increasing pressure and demand placed on staff led to some reducing their hours, retraining, or moving to a lower band or lower paid post:

"Flexible retirement (retire and return) I did continue to work full time as the abatement rule was suspended at the start of the pandemic, however eventually I did decrease my hours as felt I could no longer continue to work full time with increasing pressures/demands" (Nurse, Community, England).

"I've been retrained and have been involved in the Vaccination Program. There is increased flexibility in working hours, staff support and time for breaks in this role" (Midwife, Hospital, Northern Ireland).

"I left a job as mental health practitioner in GP surgery due to stress levels and workload. I moved to a lower band job with more hours so I wouldn't reduce my income. My new job

has more flexible hours and option to work from home which helps me in my personal role as carer for elderly relatives” (Social Worker, Hospital/Community, Northern Ireland).

Moving to a role offering a choice around which day they worked was important for some staff as was being able to work from home for those caring for others:

“I get to choose the days I work. I try now to work less days (have clients who have a higher CHC/care rate (more money for their care package)) and also work with people who are more laid-back and offer more downtime” (Social Care worker/Personal Assistant, Community, Scotland)

“I have caring responsibilities for elderly parents so work from home more especially in out of hours services” (Nursing, Hospital /Community, Northern Ireland)

Staff also actively sought to make changes to their hours of work as they helped to support the needs of their partner and family life, with the added advantage of better pay for some, which was not the initial motivation:

“I have changed to a different specialist role. I changed because this role was part of a Quality Improvement idea I submitted and saw through to completion and because I wanted to work clinically again. I have reduced my hours to support my family as my partner was made redundant during the furlough period and has started a new business” (Midwifery, Hospital, England).

“I moved to agency with differed local authorities. Provides me with the freedom to leave if I wish. Better pay” (Social Worker, Other, England).

Financial reasons

Financial reasons were however highlighted amongst some respondents as an important factor in changing or choosing to change their job, contractual working hours or leaving their job. This included the opportunity to work less hours for more money and taking the trade-off of less money for less stress:

“Far too much travel money spent on petrol and no mileage allowances, and not enough pay doing domiciliary care” (Social Care Worker, Community, Northern Ireland).

“Taken a substantial pay decrease to be in a less stressful role” (Social Care Worker, Community, Northern Ireland).

The pressure of increased cost of living was also a reason why some respondents were moving to jobs with better pay or because they were working hours that they were not getting paid for:

“Also financial reasons... I have increased my hours by 15hrs a week due to cost of living increase” (Nurse, Other settings, Scotland).

“Couldn’t do my job part time and was constantly working unpaid overtime” (AHP, Hospital, Northern Ireland).

“I am starting a new job in the coming weeks with less hours and more money - also has flexible working hours as part of my new role” (AHP, GP Practice Based, Scotland).

“Was doing the extra hours so might as well get paid for them” (Nursing, Hospital, Northern Ireland).

Workplace support and leadership

Feelings of a lack of support and respect in the workplace particularly from management were highlighted by many frontline workers:

“Lack of support from management, unable to have current role and responsibilities clearly defined. Continual ask to help out in the clinical areas without the appropriate training/ support, lack of awareness of role and work pressures. Loss of trust and undervalued” (Nurse, Hospital, Northern Ireland).

“Due to poor management and being gaslighted by previous manager” (Social Worker, Community, England).

“I am still at the same Trust but left my last team due to lack of team leader support, being expected to work 16 hours days and that being normal, working in excess of 60 hours in a week without time back in lieu or overtime payment. I am also currently dealing with a regulatory complaint that has severely impacted my mental health due to fabrication of events on the complainant’s part (but am well supported by my employer/senior management/current team leader, just not by the previous team leader)” (Midwifery, Community, England).

One nurse highlighted that while the pressures existed prior to COVID-19, that the pandemic had made things so much worse with a lack of leadership and clarity of guidance.

“Pressures of working in an unfit system to deal with patients even before the pandemic the pressures of the pandemic has just flipped it over the edge. Compared to other professionals, nurses “put up with” a lot more understaffing, lack of leadership, poor manager support, lack of updated guidance, opportunity to change practice than any other profession I know” (Nursing, Hospital, Northern Ireland).

This lack of clarity and support within many workplaces left employees feeling demoralised and impacted on their mental health and wellbeing:

“I was in the third sector and the lack of clarity for third sector organisations made me feel unsafe in working. It was impacting my mental health” (AHP, Community, Scotland).

“I left my job ay 2021 to move to a team that I knew had better support from management and therefore more supportive peers and better morale. I still feel anxious as this move is only temporary and I will need to go back to my substantive role in April” (AHP, Other settings, Northern Ireland).

Impact of workplace stress on health and wellbeing

Increased stress, workloads and pressures in the workplace led to many respondents feeling burnt out, with several highlighting that they reduced hours or that they left their jobs as a consequence of this:

“I took 3 months out of work in April, May and June because I felt I had reached burnout. This was a formal beat break to be able to feel better. On coming back to work, I asked to reduce my hours for general and mental health” (AHP, Hospital, Wales).

“For my health and wellbeing, I chose to reduce my working hours through a retire and return option” (AHP, Community, England).

“Stress as a newly qualified midwife and working conditions was impacting on my wellbeing. Everyone was running on empty and irritated having to train/work with someone with less experience when they were short staffed. I also couldn’t tolerate the shift work/ nights. The pandemic made me realise what is important in life and my health and well-being is the most important rather than running myself into the ground” (Nurse, Community, England).

Some staff moved roles as they were stressed and feeling unsupported with unrealistic expectations, to a role in which they were happier:

"I was very unhappy working in higher education due to feeling unsupported, overwhelmed with workload and having no time to fulfil all aspects of my job role (research) due to teaching pressures and need to provide pastoral support and sort out student issues. The work environment was very toxic and this was exacerbated via remote and online working. I moved back to the NHS to take up a position I have worked towards for many years, but I may not have seen the opportunity had I not been so unhappy and unsupported in my previous role" (Midwife, Hospital, England).

However, many reduced hours or left a role because of unrealistic expectations or the stress was impacting on their health and wellbeing.

"I reduced my working hours feel the job is burning me out" (Social Worker, Other setting, Northern Ireland).

"I cut my hours as it was too stressful doing 12 hours plus overtime. Management use emotional blackmail to make you do overtime!" (Social Care Worker, Care Home, Scotland)

"I have moved to a less stressful job with a more realistic workload. My previous job involved a lot of responsibility and more weekly tasks than could be fitted into the working week. Plus more tasks being allocated as each month passed" (Social Worker, Community, Northern Ireland).

Some respondents left their job completely as the demands were negatively impacting on their health and wellbeing. Others reported the stressful impact of being redeployed to the point that moving to a job with less security and benefits was preferable:

"I have left Social Work completely due to the demands of the job which were severely impacting upon my physical and mental health" (Social Worker, Hospital, England).

"I left my substantive post in HSC due to continual redeployment to COVID ICU [intensive care unit]. The stress was making me ill. I went to work in the private sector for 5 months but had to leave due to work life balance. I now work exclusively bank [temporarily] in the area I used to work. It means I can't be redeployed, but not paying into pension, and don't get sick pay" (Nursing, Hospital, Northern Ireland).

“Redeployment was the main reason. At the beginning I worked in day services for LD [learning disability] for adults. I was moved 3 times until I was seconded. I returned to my substance post in August and was not supported by manager so I applied to return to the care home as I had support from management and staff team as they had worked through covid and we all understood the importance of team work and supporting each other” (Social Care worker, Care Home, Scotland).

Others however reported that their main source of stress was lack of leadership and the ways of working which were impacting negatively on them with subsequent changes in staff as some staff were replaced with less experienced staff or not at all:

“Lack of compassionate leadership and too stressful an environment leading to reduction in health and wellbeing. Demand outweighing capacity - targets unachievable on a sustained basis” (AHP, Hospital/GP Practice based, Northern Ireland).

“My health and wellbeing was becoming seriously affected. Sitting at a laptop for 8 hours a day. No peer support. Extra demands being placed on staff by managers. Colleagues leaving as soon as they find another job. No replacement staff until months (or years) after they have gone. I am the 13th Member of staff to leave this team in less than a year. All staff that have replaced experienced workers are newly qualified workers that need training and have little experience in the field. If I did not leave this job, it would surely send me to my grave” (Social Care Worker, Community England).

Workplace Bullying and toxic working environment

Additionally, bullying in the workplace was highlighted by several respondents leading to sickness, taking time off work and some leaving their job to get away from the bully. Some referred to toxic and unfriendly working environments and coercive management styles as contributing to them leaving their job:

“Was being bullied in last role by new manager which led to work related sickness for stress” (Social Worker, Hospital, England).

“I changed my job out of the acute sector into community due redeployment twice in 2019 and 2020. I found I was expected to work in an environment i was unfamiliar with which caused me stress. The 12 hour shifts impacted my ability to care for a family member who I had specific and complex care needs. My manager adopted a coercive

style of management and I felt very unsupported and unsafe in the environment” (Social Care Worker, Community, Northern Ireland)

Feeling bullied and being in an unfriendly workplace, one respondent had changed their job for a *“better supportive manager not as much bullying or cultural issues”* (Nurse, Hospital, Scotland). Another respondent reported feeling unsafe in their job due to abuse from the public; it was not clear if this was patients or family members in this GP Practice setting: *“unsafe to do the job, abuse from the public”* (AHP, GP Practice Based, Northern Ireland).

Home-work life balance

Respondents mentioned how their own family and caring responsibilities had a huge impact on their decision to change job or contractual working hours with family reasons such as childcare and elderly parents and better home-work life balance frequently reported:

“To ensure I have a work/life/balance for good health and wellbeing. This was impossible as a manager in service delivery. I have moved to a consultative role in strategic planning” (AHP, Other settings, Northern Ireland).

“Overwhelmed by the workload/ cases I am case holding and the impact of this on my family and relationships. Often up until 11pm or midnight doing admin and writing assessments” (Social Worker, Other settings, England).

One respondent had reduced their hours to give them time to recover and to be able to keep working:

“I needed to have more recovery time from work (longer weekend) to enable me to build up more resilience and keep working safely and maintain my wellbeing” (Social Worker, Other, England)

New opportunities/promotion/career change

Respondents often changed roles following seeking and achieving promotion or through taking opportunities that arose when looking for a new challenge. However, while not all new roles turned

out as hoped many did seem to have been the right decision. Some respondents had made a career or sector change:

“Promotion and at the time better working conditions, however that changed within 2 months of taking up post” (Nursing, Hospital/Community, Northern Ireland)

“To feel better about life, varying opportunities in now role so a challenge and feel I could make a difference. More appreciation of skills and less micromanagement” (Nurse, Community, England).

“Needed a change, wanted to progress my career and project experience” (Nurse, Other setting, Northern Ireland).

“I was working in GP land but lacked any capacity for promotion. I wanted a professional challenge not just a challenge to meet demand” (Nurse, Community, Scotland).

“I reduced my hours in the main job and took on small contract in the research department - career progression and professional development” (Nurse, Other setting, Northern Ireland).

“I have been promoted due to opportunities available due to the pandemic” (Nurse, Hospital, Scotland).

Sometimes taking up new opportunities and promotions offered not only new challenges and professional development but also more flexibility and better pay.

“Better pay and employee benefits within the trust, more challenging role. More opportunity to progress within the Trust. More opportunity for learning and development” (Social Worker, GP Practice Based, Northern Ireland).

“Higher band position became available career progression reduced clinical hours by half, non-clinical role for other half of hours” (Midwifery, Community, Northern Ireland).

Some respondents changed careers during the pandemic or took up further study

“Had worked in retail for over 15 years and had always considered becoming a care worker. Began working in care within the first year of covid and have been since” (Social Care Worker, Care Home/Day Care, Northern Ireland).

"I was finding my health and wellbeing were impacted by work. I changed my hours by dropping from full- to part-time so that I could return to University to do a Master's in Public Health" (AHP, Hospital, Scotland).

"I have changed job to undertake further nursing studies and advanced clinical training at a Master's level. I am on a full-time contract which involves working in district nurse practice and being at university" (Nurse, Community, Scotland).

"I moved from law to health and social care in November 2020 because there was a hiring freeze in the legal profession at that time. I greatly enjoy health and social care work and would like to stay here but I want to change to a different employer" (AHP, Community, Northern Ireland).

Less patient facing

Interestingly, while the quantitative measures indicate that working with clients is least likely to cause burnout, some respondents indicated that they chose another role to move away from client facing work:

"I changed my job to be less patient facing. Clinical education" (Nursing, Hospital, England).

"To reduce stress of frontline practice" (Social worker, Community, England).

"The pressure of clinical frontline working was taking a toll on my mental and physical health, and I wanted a better balance. I also wanted more flexible working practices to allow me to stay well" (AHP, Community, Scotland).

Needs of service or contractual issues

Hours of work had sometimes changed during the pandemic to meet the needs of the service. For some this had been an enforced development:

"Our hours have been changed throughout the pandemic to fit the demand of the service. At the beginning we were forced to change our hours to 8am-8pm. I am now working 8-6 to cover the demand of the workforce with an additional day off in the week" (Social Worker, Community, England).

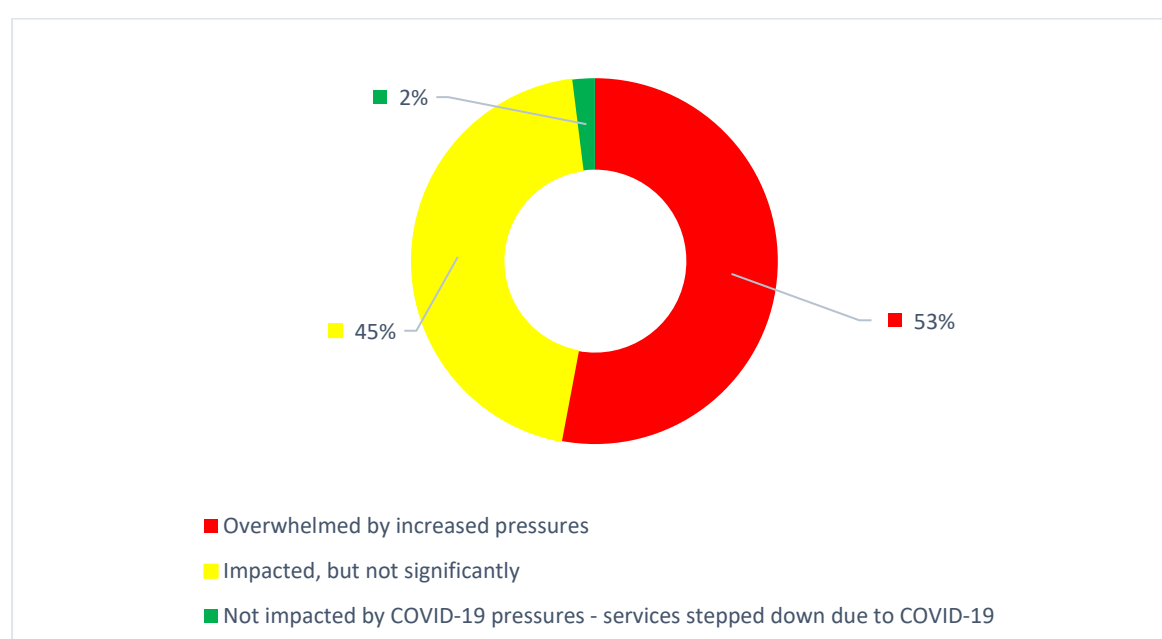
"Increased Hours to support Colleagues" (Midwife, Hospital, NI).

Despite the challenges of recruiting staff, some staff changed their jobs for contractual reasons, including temporary contracts which were not extended with one respondent reporting; *“Unfairly dismissed in one instance and position came to an end in the other” (Social Worker, Community, England).*

Responses to open-ended question Q54

Out of the 1,758 survey participants, 1,112 individuals responded to the open-ended question Q54 *“How did the experience of the pandemic change the way you now manage work and non-work related responsibilities?”* For those who answered Q54, nearly two-thirds reported being overwhelmed working during the pandemic (Figure 3.10). Responses to the same question in Phase 3 revealed changing attitudes to work and non-work life as the pandemic wore on. During Phase 4, the COVID-19 variant omicron emerged and disruption and uncertainty continued to be present in both the personal and working lives of respondents. Within this context, findings from Phase 4 reveal that many individuals have reflected deeply about their work life balance during this period. Most respondents to this question gave detailed and personal responses. Overall, the message emerging was that individuals found it increasingly difficult to segment work and home life in the manner they preferred without significant efforts to put in place appropriate temporal, physical and/or cognitive boundaries.

Figure 3.10. Impact on working during the pandemic by Q35 respondents



The following section outlines 1) the impact that changing work and home commitments continued to have on individuals, 2) how boundaries were managed by individuals, 3) how self-care rituals, new ways of working and employer supports helped individuals cope with changing demands at home and at work, and finally, 4) the impact that changing work and non-work responsibilities had on individuals' overall health and well-being, their relationships with others and their career intentions. Some respondents reported no change in how they managed their work and non-work responsibilities, but these were very much in the minority.

Work and non-work priorities

Respondents reported that work priorities increasingly dominated, often at the expense of non-work commitments and the individual's aspirations for a better work-life balance. Many respondents, commented that it was very difficult to 'switch off' due to increasing workload, increasing sense of responsibility, increasing urgency and the constant state of crisis. Respondents described this scenario as being exacerbated by staff shortages, and that a "needs must" attitude was adopted (AHP, Hospital, Scotland) despite individuals feeling "relentless" pressure (Midwife, Hospital, Scotland). These feelings were expressed by both those working from home and on-site, and respondents from all occupations seemed to be frustrated by the vicious cycle of necessary overtime just to "stay on top" (Social Worker, Community, Northern Ireland) of work demands:

"It is more difficult to switch off from work when working from home. However working from home allows time to catch up outside of working hours but this is not ideal either as it ends up working overtime just to stay on top. Without this my own mental health would suffer with anxiety about what I haven't been able to achieve in working hours" (Social Worker, Community, Northern Ireland).

Many respondents explained how increasing work demands and pressures affected their non-work life. They described difficulties around taking annual leave, or how they chose to avoid other non-work activities because they feel simply exhausted. An AHP from Northern Ireland commented:

"This exhaustion means I have been less enthusiastic with activities at home and non-work responsibilities are sometimes put off which can lead to frustration if you have agreed to do something at the weekend but need to turn off or have some time to myself" (AHP, Hospital, Northern Ireland).

Referring to non-work responsibilities, some respondents also commented on the ongoing difficulties that COVID-19 created for childcare and schooling and how this impacted work commitments. Many respondents inferred that some elements of work or home life were sacrificed as the pandemic progressed. One respondent described how she would *“prioritise non-work responsibilities as much as I’m able”*, but then also suggested, *“there is usually some form of penalty for this - annual leave being declined, reduced training opportunities, organisational restructuring etc”* (Midwife, Hospital, England). On the other hand, another respondent expressed conflicted feelings about the family sacrifices she made while working through the pandemic:

“Felt guilty for the significant impact working in healthcare had upon my son, extremely difficult to manage as a single parent. Stresses at work and stresses at home and guilt attached to both. For periods of time I wish I worked anywhere but in the NHS because of the impact on my family but equally I was motivated to be there for the staff and team and to be part of the clinical workforce that responded to this situation” (AHP, Hospital, England).

Boundaries between work and non-work life

Respondents recognised the need to address boundaries between work and non-work lives, but they also reported how it was increasingly difficult to set and maintain these boundaries with relentless work demands. Temporal boundaries were often breached given the need for overtime, longer working days, or inability to take annual leave. One AHP manager in Scotland described a *“culture of always on”* and the effort needed to *“protect days off as days completely off”* (AHP, Hospital/Community, Scotland). Protecting time seemed, for some, to require a conscious effort, with one social worker stating:

“I make myself have a cut off time from work in the evening and try not to work at weekends” (Social Worker, Other setting, Northern Ireland).

For those working from home, many respondents suggested their work life balance improved significantly because they were able to work from home or work flexibly. Many commented favourably on being able to avoid commuting, having more time for family, and being more productive and efficient addressing both work and non-work duties. However, despite this benefit, others who worked from home also described the detrimental effects of breaching the spatial and cognitive boundaries normally established between work and home. Respondents referred to the absence of spatial boundaries to explain their inability to *‘switch off’* at home. Many respondents mentioned how

the boundaries between work and home were increasingly ‘blurred’, how it was “*becoming more difficult to separate*” (AHP, Hospital, Northern Ireland) or how it “*all merged into one*” (Social Worker, Other setting, England). The spatial boundary of having a separate office was regarded as an enabler by some, for setting and maintaining appropriate cognitive boundaries between work and non-work life, especially when working with traumatic or distressing cases. One respondent described how the “*trauma pervades your personal space*” when working from the living room, making it “*harder to switch off and walk away*” (Nurse, Other setting, England). An AHP described how “*Home no longer seems such a refuge at the end of the day*” (AHP, Other setting, Wales). A social worker from Northern Ireland described remote working being associated with “*less head space/ reflection time between meetings*”, while another wished to “*remove my home office from the house so that I can separate my work life and home life as it crosses the boundaries too much*” (Social Worker, Hospital/Community, Wales).

We found that some respondents who worked on-site or in an office could benefit from the spatial boundary between work and life, describing how they could “*leave work at work*” (Nurse, Community, Scotland) but, similar to those working from home, many other respondents working on-site still found it increasingly difficult to protect cognitive boundaries. An AHP from Northern Ireland mentioned it was “*difficult to not let thoughts of work overwhelm outside of work thoughts*” (AHP, Hospital, Northern Ireland). Another reflected:

“Some days it is possible to walk out and forget the day, other days this is not possible and our daily experiences in the work place have an effect on our own time. Staff will be affected by what they have seen and experienced in this pandemic for a very long time. It is already happening with levels of absence, work related stress and staff leaving the health service” (AHP, Hospital, Northern Ireland).

Coping with changing demands of work and non-work responsibilities

Similar to findings in Phase 3, many individuals described how the experience of the pandemic has encouraged them to reframe or reorient their perspective and practice regarding work-life balance. Many reported how they prioritise work, family and non-work commitments. Given the challenges, many respondents declared a renewed gratitude “*for all that I have*” (Social Worker, Care Home, Northern Ireland). Another respondent stated it was important to “*Concentrate more on what makes me happy*” (Midwife, Hospital, England). Positive reframing was also described in relation to the level of control one had over the day, with several respondents expressing sentiments such as:

"I value my family and my health much more and have learnt to live in the moment and not worry about the future as it is out of my control" (Social Worker, Hospital, Northern Ireland).

Others highlighted the importance of self-care, and *"giving yourself time"* (AHP, Hospital, Northern Ireland) when trying to respond to the various demands of work and non-work responsibilities. Respondents cited various coping mechanisms such as exercise, being outside, sea swimming, taking regular breaks, mindfulness, reading, good sleep, gardening, and DIY. However, although many acknowledged the importance of 'self-care', some expressed difficulties finding the time to devote to themselves without adding more pressure. One AHP from England reported:

"I'm still exhausted. I'm a middle manager and feel i have no support for myself. I am trying to separate work and non-work and do more self-care activities. I take more time for myself now and I'm getting better at putting myself first, but this has a detrimental effect on my work" (AHP, Community, England).

A social worker stated ruefully:

"There isn't a lot of time for fun. Even walking is now about remaining healthy as opposed to just having a leisurely walk" (Social Worker, Other setting, Northern Ireland).

Many respondents also reported the development of new attributes and approaches to working that have helped them cope with the changing demands at work and home. Becoming emotionally resilient, voicing opinion, learning to say no, digital and virtual working, and creative working were all cited as having a positive impact on respondents' ability to cope. However, beyond the individual level, employers and managers were reported to play a critical role in enabling the appropriate balance between work and non-work responsibilities and supporting employees to cope throughout difficult times. Several respondents commented positively on the impact of their specific line manager. Some highlighted the flexibility of managers in allowing individuals to manage non-work responsibilities, and others commented more generally about the support offered by their managers and peers. Some respondents described being more honest with their managers about how they are coping, however as one AHP described, the support needed was not always forthcoming:

"I have also tried being more honest with my supervisors and friends about my struggles, which I think has not worked well, as they then do not show empathy or compassion (perhaps they are worn out too) and then I feel more deflated" (AHP, Hospital, England).

Employer support for coping with the demands of work was widely criticised in the responses to Q54. Respondents described feeling 'untrusting' of management, how employers were unsupportive through Long-Covid symptoms, how senior management 'promise and don't deliver', how they are 'not being heard'. To sum up the sentiments expressed by several respondents, one AHP stated:

"There has been no 'down-time', wellbeing services provided by employer have been offering lip service only 'its ok to not be ok'. Not genuinely looking to support exhausted and emotionally worn out staff. Working in the pandemic has been like working on the front line of a battle. I have experienced so much death - it has been heart breaking and devastating. I have lost numerous nurse colleagues and friends who feel burnt-out with the whole situation. Real support has not yet been offered. I don't know how long everyone can keep coping with it all. Real support is required" (AHP, Hospital, Scotland).

The impact of changing work and non-work responsibilities

The various challenges of managing the boundaries between work and home impacted a breadth of relationships both at work and at home. Some respondents felt their family had suffered because of the demands of work. A social worker from Northern Ireland described how her inability to switch off from work caused stress in family relationships. Relationships at work were also reported to have suffered. Some felt isolated and acknowledged that connection with colleagues was important for good working relationships. Others described the emergence of 'toxic' work environments or their workplace having a "culture of blame, recrimination and bullying" (Nurse, Hospital, Northern Ireland), exacerbated by a workforce that is "burnout" (Nurse, Hospital, Northern Ireland). A social worker from Northern Ireland described:

"I see people getting angrier in each of the sectors and my worry is we will all turn on each other instead of using our collective voice to speak truth to power and demand change" (Social Worker, Other Setting, Northern Ireland).

On the other hand, respondents also acknowledged the importance of relationships with peers and being understanding about the personal and professional challenges being experienced. One Midwife from England commented:

"It has made me try to appreciate the stresses that everyone has and how differently we deal with them" (Midwife, Hospital, England).

However, given the increasing demands and the increasing stress on relationships at work and home, many respondents described the enduring impact on their commitment and workplace morale. Several respondents reported being more stressed, feeling more exhausted, feeling exploited, feeling undervalued, being *"just a number"* (Nurse, Hospital, Scotland). Several reported that their 'good will' or willingness to go above and beyond was now exhausted. As a result, some included reflections on their career in health and social care, with some reporting they were intending to leave their profession or employer. An illustrative selection of responses is presented below:

"No longer do extra shifts as much due to extreme tiredness and not being appreciated. Considering leaving" (Midwife, Hospital, England).

"My employer has set me up to fail in my current job. I have no intentions of returning" (Social Care worker, Community, Wales).

"I wish I could give up my job. I'd be much happier" (AHP, Hospital, Scotland).

"I am now I am seeking for a change in direction as I still love nursing and supporting persons through health and well-being challenges" (Nurse, Community, Scotland).

"I used to enjoy my job, I don't have any pleasure in it whatsoever these days and if I could get out of being a social worker then I would walk away from it immediately" (Social worker, Community, England).

"I know I am very much replaceable and don't feel appreciated in my role, so now questioning why I would stay somewhere I am not valued" (Social Care worker, Community, Northern Ireland).

The explanations offered by respondents regarding their intention to leave employment were often attributed to dissatisfaction with management, difficult working relationships, being unable to deliver a quality service and, most often, the increasing impact on individual health and wellbeing. A minority of respondents described their experiences as *"traumatising"* (Nurse, Hospital, Northern Ireland) and several had taken up offers of support such as a social care worker from Northern Ireland who

described taking up four weeks of counselling, although was not sure that this had been sufficient. Another respondent mentioned being depressed, another as feeling like a 'punchbag'. A social care worker from Northern Ireland reflected on how the pandemic experience had changed them:

"It has changed me as a person, I don't recognise who I am anymore. It's been so long since I have had free time and when I do work is constantly on the phone for shifts to be covered. My phone never stops and when I put it on silence I'm constantly thinking do they need me? My identity is gone, I'm no longer the mum, grandmother, daughter, wife or friend I am an HSCNI Robot, my brain is now programmed to working and I'm lost when I'm not doing this which causes so much guilt within myself" (Social Care Workers, Community, Northern Ireland).

The overall sentiment from respondents was one of feeling exhausted, physically, emotionally and mentally. This overall fatigue was described as not only affecting working lives, but also non-work lives. A nurse from Scotland described the interaction of work and non-work responsibilities and the impact of this on their wellbeing:

"Less time, energy and motivation to do the things I enjoy or would normally do to relax. Increased caring responsibilities have added to this. Changed job 6 months ago for career development opportunity but ever increasing demands have resulted in me working significant additional hours (at least 10-15 per week) and unfortunately no capacity to get that time back due to volume of work. Feel emotionally (& physically) exhausted most days. Increased caring responsibilities make it difficult to get time to myself. Staff support takes up a huge amount of energy as many staff are struggling and resilience is low - impacts on professional behaviours within teams and adds to the workload" (Nurse, Other setting, Scotland).

As reported in the Phase 4 survey findings, the picture emerging from the responses is bleak for staff retention. Many health and social care workers acknowledged in this survey that they were struggling and, despite efforts to manage, some are reconsidering their futures within their profession or with their employer so they can prioritise their own health and wellbeing.

3.2.2. Focus group discussions

Three focus groups were conducted with HR professionals, managers and frontline workers in January 2022. A total of 23 participants provided deeper insights into work in the health and social care sector between July 2021 and January 2022 and the main impact that the pandemic has had on working conditions, control at work and home-life balance. Participants also answered questions which focused on their own experiences working during the pandemic how this changed from the first wave of the COVID-19 pandemic in March 2020 to January 2022, their use of coping strategies, work-related quality of life, and employer support.

Frontline workers Focus group debate

The subjects emerging from the frontline workers focus group in Phase 4 can be summarised under two main themes: ***Lack of Control*** and ***Support***.

Lack of Control

Participants had experienced a range of frustrations and challenges that they felt unable to control, which led to increased workload and stress. Greater pressure from remote working, lack of services, staff shortages, lack of IT, lack of management support, pressure to do extra hours, all led to a sense of loss of control over their work:

“But control at work, stress at work and working conditions have (been) hugely problematic because like everyone else we've had a lot, a large amount of staff off sick and because of the pandemic, mental health referrals have literally went through the roof” (Nurse, Community, Scotland).

“Yeah I found this last phase incredibly frustrating and really tiring and, and it really makes me question, am I achieving anything, am I achieving anything for my clients?” (Social Worker, Children, Community, Wales).

Participants described frustration at being unable to complete their role to the standard they want to, noting the impact of remote working and PPE (personal protective equipment) on effective assessments and communications and the lack of support services to refer people to:

"I would say both stress at work and working conditions. I think those for me go together and it's the limitation on the services that we can access them creates a huge level of pressure on stress upon us on the front line" (Social Worker, Community, Northern Ireland).

"Especially getting used to PPE we would have enough lot of a lot of demand for clients and that was a massive, massive barrier. To go in with PPE which is like aliens going into their home" (Social Care Worker, Community, Northern Ireland).

A perceived shift in public support over the pandemic from 'clapping for carers' to increasing anger at the lack of services and waiting times has left staff facing some family members' frustrations and emotions at their needs not being met. Some participants felt they were left to explain why services were not available even though this was outside their control. While some felt staff in health and social care had not been listened to pre-pandemic and that many of problems pre-dated it, they considered Covid 19 has resulted in overwhelming pressure on an already stretched service and workforce:

"We have people like clapping at the start, now people are getting more and more frustrated by the lack of services and its, its, its impact on us as we are the face of the service so we're getting their frustration" (Social Worker, Community, Northern Ireland).

"so I feel a bit like we've always been underfunded, we've always been understaffed, we've always been overloaded, we've always been overstretched, but now you're really seeing the result" (Social Worker, Children, Community, Wales).

Support

In terms of support to enable staff to do their work, participants discussed the impact of management support, wellbeing services and concerns for newly qualified staff, and maintaining appropriate home/work boundaries. It was clear from the focus group participants that, over time, they have found it increasingly challenging to work at home and maintain work-home life separation. Some felt that this was not recognised and that permission to return to offices was slow to come:

(we have) "extremely challenging individuals, a lot of people with emotionally unstable personality disorder and different types of personality disorders screaming at them before last year abuse, you know calling you for everything. And that's all fine and well at work, but when you're in your own home that's my own home, that is my personal and private

space and I don't want to be tainted in any way, shape or form" (Nurse, Community, Scotland)

"It doesn't go away when you put down the phone. All around yes, you and my kids can feel it" (Social Worker, Children, Community, Wales).

Participants had contrasting experiences of management support ranging from poor experience to excellent. They agreed that management support was important but also spoke of the need for support and contact with colleagues which was difficult for those working remotely:

"I've been very lucky we have the company I work in they are very, very good looking after their staff, you know and new put measures and have, have catered if people want to work in the office" (Social Care Worker, Community, Northern Ireland).

"When I started the job I just felt like a number, I felt like someone that you know, as soon as they've sucked all the juice out of me I'll be discarded and they will get someone else in and that's not been my experience in any of my previous jobs" (Social Worker, Community, Northern Ireland/England).

There was also some concern about the sufficiency of support for newly qualified staff, with worry that they would leave the profession as a result:

"They are not getting the support they need from, from more experienced social workers, or indeed line managers, many themselves are only two years qualified, this is not acceptable" (Social Worker, Community, Northern Ireland).

"there's just a couple of newly qualified social workers and my team they feel very despondent and feel very upset that they have been kind of left to the wolves as it were, and so I feel like it's a really awful time to be a newly qualified social worker" (Social Worker, Community, Northern Ireland/England).

There was an acknowledgement that some psychological support was on offer, however several felt that their high workload needed to be resolved initially as this was the source of much of the pressure. There was also a concern that staff might be made to feel they cannot cope when the workload demands are so high, transferring blame from management to the frontline:

"It's not good enough, give them somebody staff care number and making them like they're not able to cope, you know, this is not a situation where well, no one would be able to cope" (Social Worker, Community, Northern Ireland).

"Like podcasts things and well-being groups that we could go and attend physically and virtually so the NHS [anonymised] have put a lot of stuff out there, but and I'm going to sound really ungrateful here, but I feel it's like a tick box exercise, I feel like it's just they've had to do this because your mental health within mental health services has always been an issue for us so why is it all of a sudden, just because of the pandemic that this has been brought out?" (Nurse, Community, Scotland).

The focus group discussion continued to give examples of the challenges being experienced by frontline workers which were exacerbated for some by the sense of a shift in the locus of control and inability to influence working conditions. There was a suggestion that professional values were a motivating factor in staff *'going the extra mile'*, in many instances working extremely long hours:

"..like the earlier phases, it was like well we'll get through this and we're just going to get it done, the very first one, and now we're in this phase where like we're all learning, there isn't there isn't that sense of relief coming there's not that window opening up where we can get around to it now it's just ongoing I mean like they've lifted not working from home but they're not" (Social Worker, Children, Community, Wales).

"I don't think things have gotten easier, since if the start of the pandemic, in fact, I think it could be worse because people are mentally and physically exhausted" (Social Worker, Community, Northern Ireland).

Human Resources Focus group discussion

The emerging themes of the Human Resources (HR) staff focus group discussion, included feeling forgotten, ways of coping, presenteeism among staff, and staff support initiatives.

Feeling forgotten and absorbing others stress

HR staff thought they had been largely forgotten about as their work seems rather behind the scenes, but they too had been working extra hours during the pandemic and were now being the object of some staff venting their frustration and anger, particularly in relation to the time needed to recruit staff:

"It is a team that is forgotten and is actually struggling I think in terms of working additional hours and feeling the pressure to try and support the organisation".

"That butting heads with operations has created really stress, as operations (colleagues) don't really understand the legal HR stuff to get that staff in and they are wondering why there are such delays but then also too there hasn't been the people to recruit, so recruitment for us is a constant battle and retaining is a constant battle, retaining those staff".

Ways of coping

HR participants acknowledged that it was important for them to find ways to deal with the additional stress. As the pandemic progressed, exercise was high on the list of coping mechanisms and getting back into office in 'bubbles' to minimise infection risk was said to have improved their morale:

"What I do is walk, run at lunch time, go for half an hour to just get out of the office and we don't talk about work and we don't talk about issues, we just talk about what has been on the TV last night and that has really, really helped".

As above, collegial support helped improve morale and ability to cope:

"...one thing that has made a distinct difference to us was, we did a period of exclusive home working for our support team and then we did a period where we were in bubbles and we were mixed and we noticed a distinct improvement in just morale and relationships across the team when were able to give everyone back into the one place, even if it was just a day or two at time, or one or two days of the week".

Presenteeism

HR participants were aware of increased presenteeism where colleagues felt that they could not take leave or a day off in case something happened:

"...Stress at work and the sense of like presentism and the sense that I can't be away and that you know, the whole of the Northern Ireland health system will fall down if I happen to take a week off and I'm not here. There is a wee bit of that and its nearly like, a psychological response to the pressure that there has been, that people are now feeling that they have to be there and that they can't step away from the desk for a while..."

"I have come up against, with the organisations I work with is about annual leave. It is about the sense that you just can't get a break, you can't get a day..."

Staff Support Initiatives

HR professionals reported constantly seeking out new ways to support staff. However, while several initiatives had been well received, they noted a reluctance among some staff to take up that support. Some HR participants provided examples of staff initiatives that had been developed to meet the needs of staff for support at different times including making use of informal opportunities for chats and wellbeing appraisals:

“...I have had a lot of good chats this way, we have gotten more creative in the informal touchpoints when the formal ones were being compromised.”

“...So we introduced a wellbeing appraisal that really simplified it, in terms of checking in with an individual, finding out how they are, checking up with them and see what support they needed from me going forward as a manager and what could we signpost them too and we found that went very well...”

However, others observed that staff were not always keen to come forward for support:

“...what we have noticed in our staff, there is maybe more of a reluctance to come forward to access support and help... I think at the start people were happy to have those check in calls and having a conversation about how they are feeling, but my sense is people are over having those conversations and are tired about accessing this support and you know because it is still going on, it is maybe just what is it going to do now, as it is still going on, is it going to help, so that would be my perspective on the supporting of staff, people aren't as reaching out as much as they were”.

Respondents found that signposting or telling staff about specific initiatives was important as staff didn't always know what they needed. Some 'in reach' services, where support went into the clinical settings rather than expecting staff to come out, was also noted as effective:

‘...we have a psychologist who sits in our team who looks after staff wellbeing and what they did, rather than wait for people to reach out for support, particularly, when things were really bad, they did an in reach service, where they would go wards and walk around and actually encourage people to have a conversation, so going out to them so they wouldn't have to go and access, they were there to support them in their own environment. So we think that worked really well and found it more worthwhile the more they did it’.

Managers Focus Group discussion

Discussion arising from the manager focus group can be summarised under the following themes, staff recruitment and retention, working conditions and communication.

Recruitment and retention

Managers noted that recruitment and retention of health and social care workers were proving more difficult in the last few years and that the pandemic had exacerbated these problems. The pandemic had provided people with new opportunities to change jobs or careers, and some staff were now taking up new opportunities in other fields:

“There just appears to be no staff available to recruit nobody wants to come into the health care sector, especially into the care home sector, where I work. You know I have been recruiting continuously throughout the pandemic and getting little or nothing. It doesn't matter how I advertise doesn't matter that we've been able to increase the pay now there's just nobody wants to apply for the care sector for the roles I suppose that we have available at the moment” (Care Home Manager, Northern Ireland).

“I work in a day service which is Monday to Friday and no evening work or weekend work and we're finding the exact same thing we can't get any staff. We put the adverts out, and maybe get 20 people that you're supposed to interview and only on one will turn up, it doesn't matter we've also increased our pay and we're sort of pushing all of those schemes we have place and we just can't get the staff in through the doors” (Day Care Manager, Northern Ireland).

“We are the training ground for the Trust. Once they get are able to tick the boxes about experience they move on to get better, better terms and conditions and we just can't match them” (Social Care Manager, Community, Northern Ireland).

Working conditions

Stress at work, burnout, work-life balance, staff sickness and increased paperwork were noted by the managers as major challenges to the working conditions of the health and social care sector. Firstly, as the pandemic has continued and service demand increases, the stress levels of employees and management have continued to rise largely due to factors beyond managers' control. With increased workloads and changing guidance, all managers reported that exhaustion is a recurrent element within their workforce and felt it was leading to increased burnout:

“Stress at work, external control issues arising, outside your control cause the most stress” (Nurse Manager, Community, Northern Ireland).

“I think everybody's sufferings from what I term COVID burnout, everybody's just so fed up we're exhausted” (Care Home Manager, Northern Ireland).

“I mean where's your work life balance, you know. I mean, I think, as a manager you put your care home first but then it starts to take its toll on you, you know and then you'll burnout and then you're no good to your family or the care home and that's the pressure that you're under because you're trying to support the staff by dealing with you know, rather than a resident who is non-compliant” (Social Care Manager, Community, Northern Ireland).

“The problem is our staff rate, sickness has through the roof and it's not just to do with COVID and I think it's staff getting burnt out and so we're normally you know you'd have a small amount of staff off sick and my staff sickness levels have, have increased significantly” (Social Care Manager, Community, Northern Ireland).

All managers observed that work demands had increased greatly throughout the COVID-19 pandemic, and, while restrictions had eased across the UK, demands on their workforce continue. With limited resources and increased administration, managers noted that their work had become even more challenging than pre-pandemic:

“The paperwork has just quadrupled in plus, plus, plus, plus, it's just a complete nightmare” (Care Home Manager, Northern Ireland).

This increase in work through extra administration was stated to have worsened with higher staff turnover not just on the frontline but within administrative roles in the health and social care sector. This has changed the work of managers, adding to the stress and already high workload they face:

“People are leaving and they're maybe not direct care role but they're leaving, but the organization isn't replacing them because the money isn't there. So you lose your, your admin or (there is) an area manager that's not replacing it, what happens is that workload just gets loaded on to you, then, on top of all of the extra paperwork” (Social Care Manager, Community, Northern Ireland).

Communication

Managers highlighted that differences in communication affected how they were able to conduct their jobs. One manager had resigned from one post during the pandemic because the conflicting information and guidance became too much for them:

"I managed a care home and I actually resigned my position in October that I have another business in social care, so I went into that and I was in health and social care 30 years and I had enough, because of the confusion, one Trust tells you one thing, ...one Trust has you another and you're trying to relay that back (to) your staff and you're getting nowhere and then you're terrified of doing the wrong thing, because obviously in the care home sector we get it on the neck, and you know and, and just that whole confusions which then impact on staff morale." (Social Care Manager, Community, Northern Ireland).

Another highlighted that when guidance was received over the weekend this made it harder to tell staff and families:

"They're very bad at the issuing instructions to care homes after they've released the information to the public. Yeah so we're getting the information second hand and somebody's mom and dad or some there's already heard the news we haven't even been told, and use of the new guidelines have happened, and they often to tell you the truth, they send everything out at five o'clock on a Friday" (Care Home Manager, Northern Ireland).

The general discussion in the focus group highlighted the frustrations of managers, particularly in regards to communications from authorities, whom several felt were also not listening or understanding what was really happening at service level:

"Where's the leadership where's the Community, you know the clarity of communication where's the accountability?" (AHP Manager, Community, Northern Ireland).

"I think they have to listen to the frontline workers and actually, I mean listen to what everybody is saying and take on board and tips and learn and from that" (Social Care Manager, Community, Northern Ireland).

Participants in the managers' focus group voiced a need for a greater understanding of health and social care work among policy makers and greater recognition of the work that was being done, particularly on the frontline. One participant stated:

“I think there is no understanding either just know about the people on the on the ground and that are actually working in it. You know you see them go on about it and visiting the nurses in the hospital and they have called into this care home and that is not enough to motivate... Everybody we all have stories to tell about how it has impacted us, like to visit a care home for half an hour and ring a bell or clap that is not enough” (Social Care Manager, Community, Northern Ireland).

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

In summary, on reviewing the data from the Phase 4 open-ended question responses and the three focus groups, the themes arising can be categorised into three overall themes. These overarching themes from Phase 4 (November 2021-February 2022) have similarities to the themes identified in Phase 1 (April – July 2020), Phase 2 (November 2020-January 2021) and Phase 3 (May 2021-July 2021) of the study. Overall, the themes identified in Phase 4 can be categorised in three overarching themes, **referred to as the “3 c’s” in the previous three reports– changing conditions, communication and connections** – as well as views on health and wellbeing, career outcomes and work-life balance (Table 3.11). Findings revealed that the health and social care workforce is continuing to struggle with the changes implemented due to the COVID-19 pandemic. These changes have increased work demands, increased staff burnout and stress, reduced staff morale and job satisfaction. The lack of support and recognition for this workforce is now beginning to take its toll on already exhausted workers with greater peer and management support needed. The changes to working conditions have been frustrating for employees due to an inability to retain staff and difficulties in recruiting new staff. With increased workloads and changing working patterns, managers and HR professionals have been dealing with the brunt of staff frustrations.

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

Overarching theme	Sub-themes
Connections	• Feeling forgotten • Importance of peer support • Concern for service users/patients • Workplace support and leadership • Feeling valued
Communications	• Lack of understanding • Absent leadership and guidance • Brunt of staff frustrations/backlash from employees • Pressured by management • Negative attitudes and bullying

	• Lack of clarity on reopening of services
Changing conditions	• Staff illness • Staff shortages • Inability to recruit and retain staff • Shift in locus of control • Job flexibility • Extra hours • Increased pressures to remote working • Career outcomes and opportunities • Impact on health and wellbeing • Increased exhaustion and burnout • Need to change financial circumstances • Importance of coping strategies • Importance of coping strategies • Staff initiatives • Increased work demand • Changes to contractual working hours or occupation • Home-work life • New opportunities/promotion • Work and non-work priorities • Work boundaries

4. Discussion

4.1. Summary of Findings and Comparison with Other Literature

4.1.1. Main Messages

The findings from the Phase 4 survey specifically focus on the experiences of nurses, midwives, AHPs, social care workers and social workers in the UK who were working in health and social care services during the COVID-19 pandemic during the Phase 4 study period (November 2021-February 2022). The findings build upon previous survey responses collected during Phase 1 (May – July 2020), Phase 2 (November-January 2021) and Phase 3 (May-July 2021) studies to further explore the impact of providing health and social care during the COVID-19 pandemic in the UK. The survey responses and focus groups data were collected and collated during the November 2021-February 2021 period when the four countries of the UK were experiencing the spread of the COVID-19 Omicron variant, although there were continuing reductions of most public restrictions during this data collection period.

The Phase 1 survey in May-July 2020 received 3,290 responses, the Phase 2 survey between November 2020-January 2021 received 3,499, the Phase 3 survey in May-July 2021 received 2,721 responses while Phase 4 received 1,758 responses. This fourth survey supports the previous themes identified in Phases 1, 2 and 3 of the study as discussed in sections 3.3 and 3.4 of this report. The findings of the overall study revealed consistent themes of work-life balance, changing conditions/context,

communication and connections across health and social care job roles and demonstrate the continuing challenges of dealing with the impact of COVID-19 in respect of workload demand and changing work patterns. Recruitment and retention problems have increased burdens on remaining staff while exhaustion and burnout remain a strong feature of the workplace context in this phase of the study.

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

Phase 4 respondents continued to highlight how employment conditions were being affected by increased workloads as result of staff shortages, staff recruitment problems and general staff exhaustion due to Covid-19. This was characterised by difficulties in communication pathways between management and the frontline, increased administration, lack of resources, exhaustion due to longer working hours and shortages of staff. These findings add to the growing literature on what could be triggers for increasing mental health problems amongst health and social care workers during the COVID-19 pandemic (Couper et al. 2022; Nyashanu et al. 2022; Augherson et al. 2021; Denning et al. 2021; Gemine et al. 2021) with several respondents voicing anxiety about increasing service demand, lack of clear guidance, staff shortages which adversely impacted physical and mental health and a perceived reduction in quality of care.

The Phase 4 study findings highlight sustained workforce pressures with many respondents feeling exhausted, reporting staff morale to be low, and burnout to be at higher levels than it was in pre-pandemic times. Most respondents reported that this was affecting their services with over half feeling that services were still overwhelmed (59.8%), or their service was impacted but not significantly (37.3%) and only a small number of respondents (2.9%) reporting that their services were not impacted at all. While over 50% of all occupational groups responding to this survey felt overwhelmed by these increased pressures, midwives reported the largest impact on their services during this period (70.3%). In Phase 1 9.0% of respondents were probable (likely) cases of anxiety or depression and a further 33.0% were possible cases of anxiety or depression. In Phase 2 these numbers stood at 17.7% and 22% respectively; in Phase 3 these numbers were 20.7% were probable (likely) cases of anxiety or depression and a further 14.4% were possible cases of anxiety or depression. In this Phase 4 12.4% were probably (likely) and a further 20.1% were possible cases of anxiety and depression. These findings suggest that the possibility of developing anxiety and/or depression may have increased between Phases 1 and 4 due to the severity of the challenges that COVID-19 was continuing to place on the workforce.

Mental health problems were further impacted by a perceived deterioration in communication between employers and managers with respondents indicating reduced levels of support from line managers since the beginning of the pandemic. Managers and HR staff also indicated that overall support for the sector declined across the pandemic, making it harder for them to cope and to support their staff. In the Phase 4 findings, managers talked about the pressure of trying to support staff with the additional pressure from difficulties recruiting new staff particularly in social care. There were contrasting experiences of management support ranging from negative experiences to positive and excellent support. It was noted that communication and contact with colleagues, alongside flexible and hybrid working (i.e. being able to work from home and in the office) helped improve the working conditions damaged/changed by the pandemic. There was an acknowledgement that psychological support was offered by employers, however some thought that high workloads need to be addressed before this type of support can be effective.

4.1.3. Burnout

Phase 4 findings revealed the significantly higher burnout levels among midwives and social workers across all three domains of personal, work-related and client-related burnout. Respondents from Scotland consistently reported more burnout than respondents from Wales, England and Northern Ireland on all three areas of burnout and midwives scored significantly higher than respondents from all other occupations. Respondents who worked in the areas of midwifery, learning disability services or with children had higher scores of personal, work-related and client-related burnout than those working in other areas of practice. Line managers experienced higher scores in personal burnout and work-related burnout while those who were not line managers experienced higher client-related burnout presumably because they had more contact with service users or patients. Respondents who felt their services were overwhelmed by the increased pressures related to COVID-19 had significantly higher personal and work-related burnout than those impacted but not significantly, nor those few who were not impacted.

Our survey findings are confirmed by other studies including newly published reports on maternity services in the UK (eg House of Commons, Ockenden Report, 2022) which have highlighted a toxic work culture in some Trusts and environments where bullying thrives, impacting negatively on outcomes for mothers and babies. Bullying has also been highlighted as one of the top five workplace concerns by the Trades Union Congress (2021) and our survey suggests the potential growth in blame and feelings of inequity between services. The findings from Phase 4 indicate that respondents were

exhausted and already stressed at work, with the addition constant bullying creating a toxic workplace leading to burnout as has been highlighted by other reviews and studies (Hussein, 2022; van Stolk, 2021; Kline and Lewis, 2019).

While the Phase 4 multiple regression analyses have highlighted several coping strategies which were significantly associated with burnout scores, our findings reveal strong links between burnout and intention to change employment specifically where respondents were experiencing severe levels of personal burnout. These findings resonate with other UK studies of recruitment and retention. Anderson et al. (2021) considered that workplans, education and training within the health and social care sector are inadequate and result in poor morale and difficulties with staff recruitment and retention. Likewise, Ferry et al. (2021) reported that 79% of the UK health workforce in their survey had moderate-severe burnout caused by increased stress, problems with staff support in the workplace, and not being able to do their job properly.

4.1.4. Mental Wellbeing

Our Phase 4 findings showed reduced average wellbeing scores between Phase 1 and Phase 4 UK wide and between all occupations except in nursing where wellbeing scores increased from Phase 1. Between Phase 2, 3 and 4 wellbeing continued to increase UK wide, however across the occupations there were increases from Phase 3 to Phase 4. However, at all time points, average wellbeing scores were under population norms of wellbeing of 23.6 (Fat et al. 2017; NHS, 2011) suggesting the pandemic has had a major impact on the wellbeing of health and social care workers. These findings are also lower than previous UK reports pre-pandemic in which Durkin et al. (2016) reported a mean score of 25.2 (3.1) amongst community nurses. During the pandemic, O'Connor et al. (2021) conducted a general national survey and reported mean wellbeing scores of 22.27, 22.64 and 22.92 across three time points, suggesting wellbeing scores may be lower in health and social care workers UK wide. In the US, a study by Cindrich et al. (2021) examined wellbeing in University affiliated individuals and reported a mean score of 24.2. Similar to this study, Smith et al. (2021) reported similar mean scores among UK-based respondents of all occupations 20.8 (5.1) and Dawson and Golijani-Moghaddam (2021) reported a similar score of 20.21 in a general UK population, suggesting the pandemic has impacted all workforces. Wellbeing scores were lowest for respondents who felt a high impact of the COVID-19 pandemic on their jobs, with social workers and midwives exhibiting the lowest wellbeing scores in our study. Conversion of the Phase 4 wellbeing scores as indications of depression/anxiety suggest an increase in the severity of mental health problems between the previous phases and should be of concern to primary care services as well as employers.

4.1.5. Quality of Working Life

In Phase 4, England, Scotland and Northern Ireland respondents demonstrated lower overall WRQOL scores than those from Wales. When respondents were categorised into those with lower, average and higher quality of working life, Scotland had the highest proportion of respondents with “lower quality of working life” (55.0%) and Wales had the highest proportion with “higher quality of working life” (52.1%). The overall WRQOL score decreased from Phase 1 of the study to Phase 4, both UK-wide and across the individual countries. There was also a decrease in the majority of the WRQOL domain scores across the countries. Comparing Phase 2 and Phase 4 there was a slight increase in overall WRQOL scores UK wide but, on further examination, there was a decrease in overall WRQOL in Wales, Scotland and Northern Ireland between these study phases, while Scotland exhibited a slight increase in overall WRQOL between Phases 2 and 4. There were increases in UK wide WRQoL between Phases 3 and 4, however Scotland and Northern Ireland showed a decrease in WRQoL scores. Midwives exhibited the lowest overall WRQOL similar to our previous survey findings, while nurses reported slightly higher scores in Phase 4 compared to Phase 3. Also in Phase 4, social workers showed a decrease in WRQoL scores compared to Phase 3. In comparison to other literature, the findings from the Phase 4 ($75.42/23 = 3.28$) are lower than the mean normative score of 3.44 ($78.09/23 = 3.40$) from the UK NHS workforce study (Easton and Van Laar, 2018). Qualitative responses suggested that health and social care workers had lower morale and less job satisfaction by February 2022, which could arise from a shift of locus of control and increase in stress at work.

4.1.6. Coping

The Phase 4 multiple regression analyses demonstrated a statistically significant decrease in respondents’ use of active coping strategies from Phase 1 to Phase 4. There was also a statistically significant increase in the use of venting, substance use, behavioural disengagement, and self-blame from Phase 1 to Phase 4 (full details of the regressions can be found in Appendix 9). Family work segmentation continued to decrease over the Phases with the lowest score reported during Phase 4. However, participation in activities such as exercise, recreation and relaxation increased from Phase 3 to Phase 4 which accords with some of the qualitative data suggesting that some of the health and social care workforce acknowledge the importance of looking after their own mental and physical wellbeing and by taking advantage, where possible, of increased job flexibility arising from working from home, hybrid working or flexi-working. Employers may wish to consider promoting exercise and other recreational activities through discounts, publicity, and other negotiated arrangements if not already offered.

4.2. Limitations and Strengths

This was a cross-sectional survey based on a convenience sample of health and social care workers and therefore the findings cannot be considered representative of them all and causality cannot be determined. There was also an uneven distribution of responses across the four UK countries and across work settings and types, and while results were weighted, the findings are not representative across countries nor occupational groups or types of employers. Another limitation associated with the convenience sample for the survey is that some participants may have been motivated to complete the survey due to personal bias or specific negative/positive experiences, which could potentially skew the results. Sample attrition occurred in Phase 4 suggesting that changes in publicity will be needed to increase response rate for Survey 5. It is also important to note that any comparisons across the four phases of the study must be viewed tentatively, as the four 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 continues three previous phases of research examining the health and social care workforce. Therefore, while cross-sectional it follows different experiences at different time points during the COVID-19 pandemic. Another strength is the examination of five different occupations within the health and social care sector, as several studies only include specific occupational groups such as nurses or social workers.

4.3. Implications

This study has important implications for the health and social care workforce and its stakeholders. This study has collected 'real time' data during four different stages of the COVID-19 pandemic over a two-year period (2020-2022) and has informed employers, regulators, policy makers, professional bodies, and workplace unions about how the workforce has been impacted and what needs to be done to support the workforce now and in the future.

Nearly two-thirds of employees did not take up employer support (62.0% UK wide), with Northern Ireland respondents least likely to take up employer support (77.2% within Northern Ireland). This study highlights some of the reasons for this, several respondents noted that the wellbeing services were not suitable or, even if referred to a service, they had not yet received an appointment. Other respondents suggested that a lack of management support was behind their low uptake of employer support as they felt undervalued by their managers.

Overall, respondents identified other reasons why take up of support was low. These ranged from the 'costs' of taking up such support such as having to give up annual leave to attend these initiatives or feeling that the support being offered would not meet their needs. These findings have implications for the development of effective employer or occupational health services and is an area that will be further examined in our Phase 5 survey and focus groups in May-July 2022. Additionally, these findings suggest that employers need to review the accessibility and trustworthiness of current initiatives and develop stronger training, educational and development programmes for all staff. Another implication of these findings is that the recruitment and retention of staff within the health and social care sector need to be better supported by policy makers. Employers need to improve the image of work within this sector with some respondents stating that each occupation needs to be viewed as a career with a development pathway and not just as a vocation.

4.3. Good Practice Recommendations: November 2021-February 2022

The Good Practice Recommendations from the previous three phases were reviewed in the context of findings from Phase 4. These Good Practice Recommendations are organised under the main themes of analysis from previous Phases: Changing Conditions, Connections and Communication, with the addition of a work-life balance section in the recommendations this phase.

4.3.1. Changing Conditions

Organisational and Individual Level

1. **HEALTH AND SAFETY:** In Phase 1, we noted that for those staff who need to be in the workplace, social distancing, hand washing, and appropriate Personal Protective Equipment (PPE) should be available. Infection Prevention and Control (IPC) were then a major challenge and employers needed to alleviate concerns about spreading infection in workplaces while increasing access for members of the public, patients, service users, and their families. Employers now need to ensure that there are plans for other possible crises, such as fire and flood, as well as global, national or local outbreaks of viral infections. These are the responsibilities of authorities but need to take into account the experience and views of frontline workforces by listening to their advice and suggestions.
2. **TRAINING FOR REDEPLOYMENT, SKILL MIX AND SKILL ACQUISITION:** While redeployment of staff is now infrequent, all training and development will need to equip staff with the ability to, where

possible, perform multiple or new roles and 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 users and patient groups. Evidence is needed about what sort of training and system change should inform these developments and guide commissioning decisions.

Policy and Organisational Level

3. **TERMS AND CONDITIONS GENERAL:** We noted in our first report that employers in the health and social care sector should address the coverage of Statutory Sick Pay for their staff. This recommendation stands.
4. **FLATTER HIERARCHIES:** In our first survey report we called for research on patient and service user outcomes to see whether greater autonomy and flatter hierarchies make a positive difference to service quality. We suggest that local forum and national planning consider the right balance between clinical or professional judgment and guidelines using the experience of the pandemic to inform these deliberations. We are hopeful that the national inquiry into the management of the pandemic will consider these questions.
5. **STAFF WELLBEING AND RETENTION:** Our fourth survey confirms that a large proportion of staff are experiencing moderate to severe levels of burnout and some will need time to recover from a prolonged period of unprecedented stress and pressure or may feel that moving jobs will assist. Taking holidays, being recognised and feeling appreciated remain important. The setting up of wellbeing services and other forms of employer help, while appreciated by many, did not meet the needs of others. The risk remains that some staff will leave prematurely owing to stress or reduced work-based quality of life, with some evidence that this is already happening. Employers need to be proactive in understanding why staff are leaving and what if anything can be done to change their decision, such as offering more flexible working hours or a change in place of work. 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 wellbeing appraisals as highlighted in the HR Focus Group. While frontline staff may be the target for such initiatives, our study also reveals the risks of burnout among managers and this needs to be addressed.
6. **CHANGE OF CULTURE:** Workplace bullying and what might be called a toxic work culture were highlighted by some respondents as reasons for staff leaving. There is increasing evidence of the

presence of bullying as endemic in many health and social care workplaces. Concerted efforts that are resourced and sustained over time are required to address this behaviour and system failings and need to start within education and training as well as governance.

4.3.2. Work-Life Balance

Organisational Level

1. PUTTING INTO PRACTICE THE ADVANTAGES OF MORE FLEXIBILITY IN EMPLOYMENT: During the pandemic most employers provided, as far as possible, increased flexibility around working hours, location of working, while recognising additional childcare or other caring responsibilities of individual members of staff. Flexibility continues to be highly valued by staff with a recognition that homeworking is not available to staff in all roles. As the level of the pandemic subsides, staff will need to feel that their needs, wellbeing 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 with start to happen with those involved in student or trainee education preparing the workforce of the future for these different ways of working within agencies and organisations.
2. EQUITY IN HOME WORKING WHEN POSSIBLE: We recommended that policies about working from home (if appropriate) should be fair and seen to be fair in our first report. We are now seeing that home working is mainly role dependent, with hybrid models of working, 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 though online communications when people are working at home.

4.3.3. Connections

Organisational and Individual Level

1. ANNUAL LEAVE AND REGULAR BREAKS: Managers still need to ensure, where possible, that staff are supported, enabled and encouraged to take leave and breaks, and where possible, arrange for their work and responsibilities to be covered. Managers, of course, need to practice what they preach.

2. CONNECTION: Evidence-based good practice guidance on communication to meet the broad range of health and social care staff could be assembled by national bodies with strong input from the frontline. Our surveys were electronic, and we recognise that staff with limited IT skills may need support in developing online communication skills. Also some staff have limited access to computers and work email during work time – both of these are important contributors to staff engagement and connection and could be audited by employers.

Organisational Level

3. MANAGEMENT VISIBILITY: Managers should be visible, either in person (if possible) or virtually, so that staff feel they are valued and that work pressures are understood. They, the managers, should also be valued explicitly and have opportunities for peer support and professional development.
4. SUPPORTIVE SUPERVISION: Staff concerns need to be addressed whether they are individual concerns or those that can be discussed in peer or group supervision. This point applies to managers and those who supervise managers. This recommendation stands.

4.3.4. Communication

Organisational and Individual Level

1. ORGANISATIONAL SUPPORT: Respondents provided several accounts of employers and managers signposting staff to organisational supports, counselling, mentoring or coaching, or Occupational Health (if required). However, while these resources need sustaining if they are to enable staff to manage the aftermath and emotional impact of working during the pandemic and its legacy; as noted above some staff feel that their needs are not being met and need to be asked what else can be done. Discussion with primary care colleagues about local supports that may be more accessible to health and social care workers would seem timely and may be more acceptable to some than employer provision for a variety of reasons.
2. COMMUNICATION: Both corporate and employer communications are appreciated but timing and amount were thought by some to be onerous during the height of the pandemic. It continues to be important that communication is relevant and timely, particularly as hybrid working looks set to continue for some staff.

3. TEAM SUPPORT: Team or peer support are critical to coping, wellbeing and morale. Ideas about how to sustain a positive team culture and climate should be nurtured so that support is available to all team members including managers whose needs appear often overlooked but who, our research shows, are under considerable pressure themselves. Meaningful interaction with colleagues may be helpful in fostering good working relationships 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.

Policy and Organisational Level

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

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Appendix 1: Weighting Representativeness for Country, Region and Occupation

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

Estimating the true population

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

Social Work

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

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

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

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

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

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

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

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

Social Care

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

Nurses and Midwives

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

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

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

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

Table A1. 1: Regional aggregation for NHS Digital

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

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

Allied Health Professionals

The Health and Care Professions Council publishes a summary of registrants by profession, totalling 281,461 covering the entire UK. We subtracted biomedical and clinical scientists as these workers were not within the rubric of the study target (i.e., patient-facing workers). This gave a total of 252,053. <https://www.hcpc-uk.org/about-us/insights-and-data/the-register/> Given the diversity of the occupation, it was difficult to obtain any regional breakdown of AHPs. Therefore, we distributed this numbers regionally using the combined average of the other professions (social work, nursing and midwifery).

Regional Aggregation for Weighting

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

Note: *As we go through the pandemic sample attrition occurs in a random way. This has consequences for the data, for example in this Phase (Phase 4), the number and representation of English Social Care workers 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 and Phase 3 reports, as we found no evidence of major changes in staffing levels between Nov 2021 and Feb 2022.

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

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

A2.1 Country and Occupation of Respondents

Summary (Weighted results):

Not reported.

Summary (Unweighted results):

Just under half of respondents (n = 795, 45.2%) indicated that they currently work in Northern Ireland and almost a third (n = 492, 28.0%) work in Scotland. Another 21.4% (n = 376) work in England, with respondents working in Wales representing the smallest proportion of all survey respondents (n = 95, 5.4%). Most of the respondents worked as AHPs (n= 573, 32.6%), followed by nurses n=361, 20.8%), social workers (n=348, 19.9%) and social care workers (n=333, 18.9%). Midwives represented the smallest proportion of respondents (n=142, 8.1%).

Figure A2. 1: Country of Respondents (Unweighted)

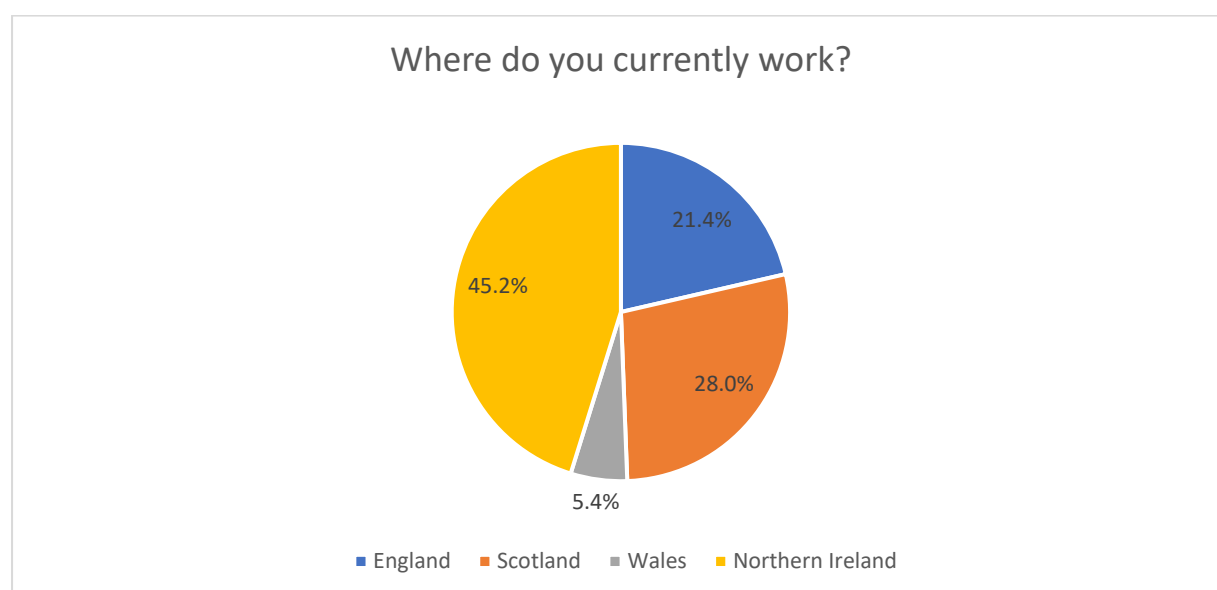


Table A2. 1: Country of Respondents (Unweighted)

Country	n (%)
England	376 (21.4%)
Scotland	492 (28.0%)
Wales	95 (5.4%)
Northern Ireland	795 (45.2%)
Total	1758 (100%)

Figure A2.2: Occupation of Respondents (Unweighted)

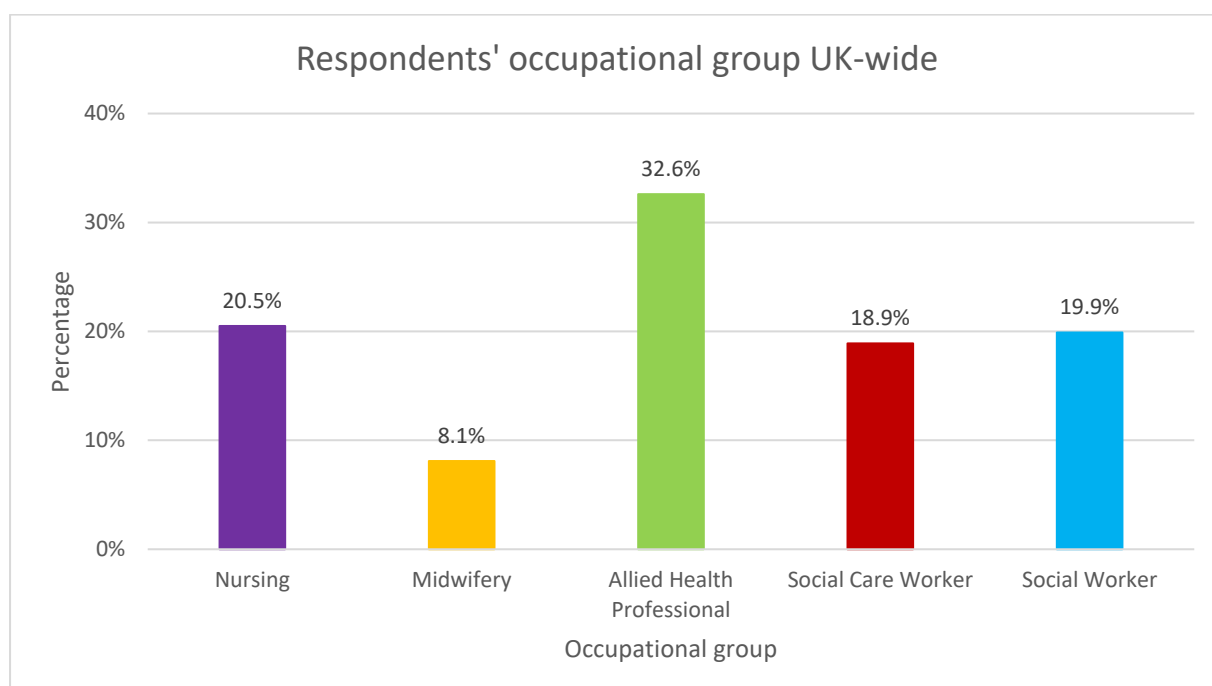


Table A2.2: Occupation of Respondents (Unweighted)

Occupation	UK-Wide n (%)
Nursing	361 (20.5%)
Midwifery	142 (8.1%)
AHP	573 (32.6%)
Social Care Worker	333 (18.9%)
Social Worker	348 (19.9%)
Total	1758 (100%)

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

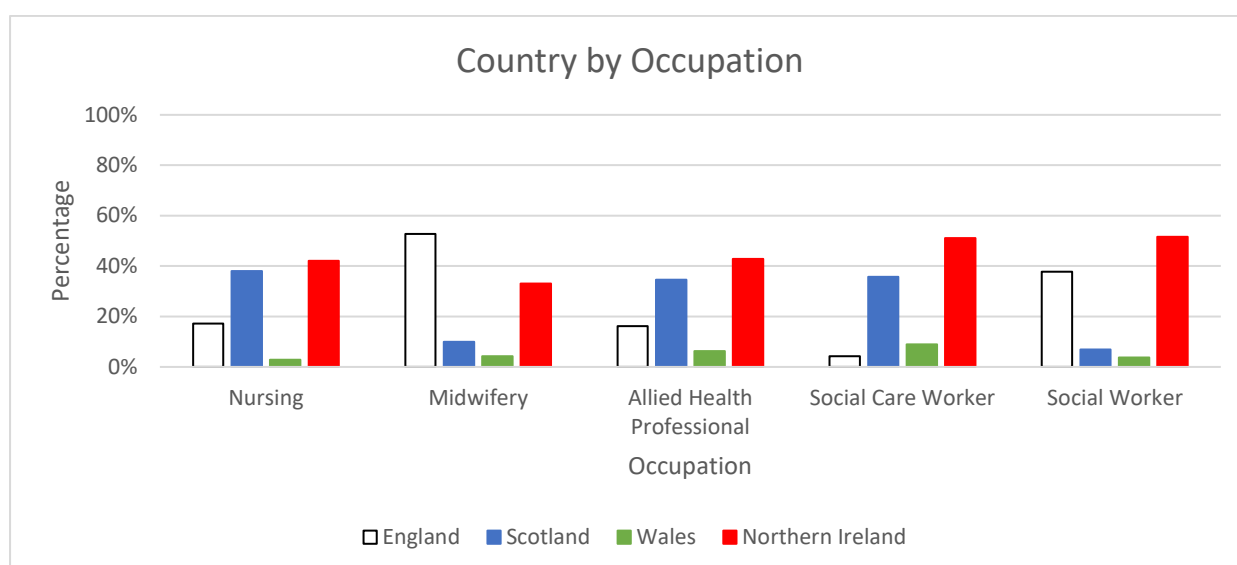


Table A2. 3: Country of Respondents by Occupation (Unweighted)

Occupation	Country				Total
	England	Scotland	Wales	Northern Ireland	
Nursing	62 (17.2%)	137 (38.0%)	10 (2.8%)	152 (42.1%)	361 (20.5%)
Midwifery	75 (52.8%)	14 (9.9%)	6 (4.2%)	47 (33.1%)	142 (8.1%)
AHP	93 (16.2%)	198 (34.6%)	36 (6.3%)	246 (42.9%)	573 (32.6%)
Social Care Worker	14 (4.2%)	119 (35.7%)	30 (9.0%)	170 (51.1%)	333 (18.9%)
Social Worker	132 (37.8%)	24 (6.9%)	13 (3.7%)	180 (51.6%)	348 (19.9%)

A2.2 Sex of Respondents

Summary (Weighted results):

The vast majority of respondents were female (82.0%), with a similar sex distribution across countries. Most midwifery respondents were female (97.2%). Social care workers had the highest proportion of males (20.0%).

Summary (Unweighted results):

The vast majority of respondents were female (88.6%), with a similar sex distribution across countries. A majority of midwifery respondents were female (98.6%). Social workers had the highest proportion of males (15.8%).

Figure A2. 4: Sex by Country (Weighted)

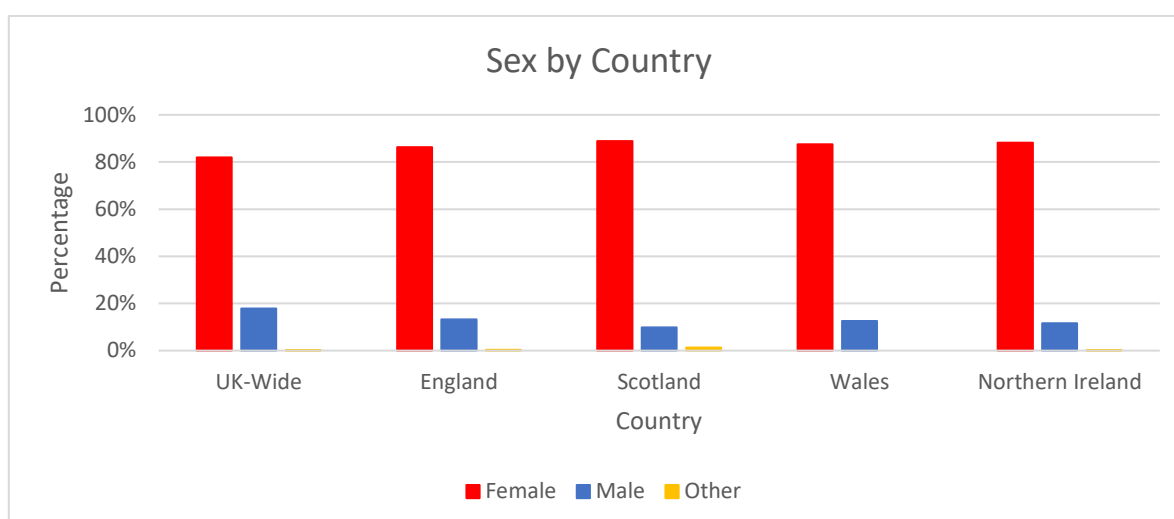


Figure A2.5: Sex by Country (Unweighted)

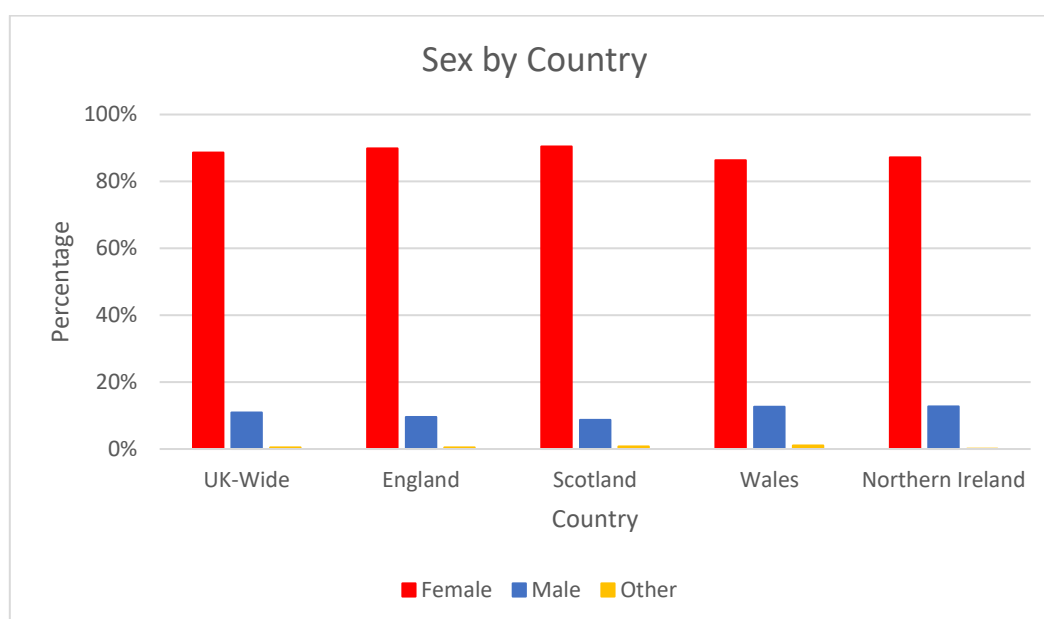


Table A2.4: Sex by Country (Weighted)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	86.3%	88.8%	87.5%	88.2%	86.3%
Male	13.3%	9.8%	12.5%	11.6%	13.3%
Other	0.4%	1.3%	0.0%	0.2%	0.4%
Total	100%	100%	100%	100%	100%

Table A2.5: Sex by Country (Unweighted)

Sex	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	1558 (88.6%)	338 (89.9%)	445 (90.4%)	82 (86.3%)	693 (87.2%)
Male	192 (10.9%)	36 (9.6%)	43 (8.7%)	12 (12.6%)	101 (12.7%)
Others	8 (0.5%)	2 (0.5%)	4 (0.8%)	1 (1.1%)	1 (0.1)
Total	1758 (100%)	756 (100%)	459 (100%)	1094 (100%)	1189 (100%)

Figure A2.6: Sex by Occupation (Weighted)

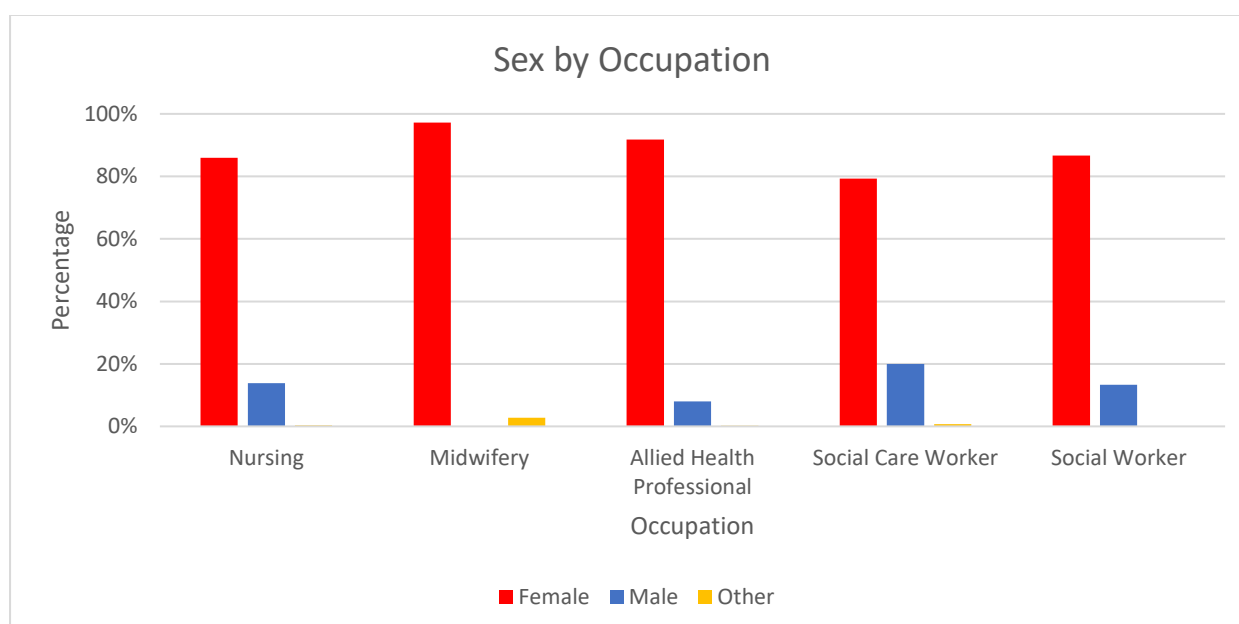


Figure A2.7: Sex by Occupation (Unweighted)

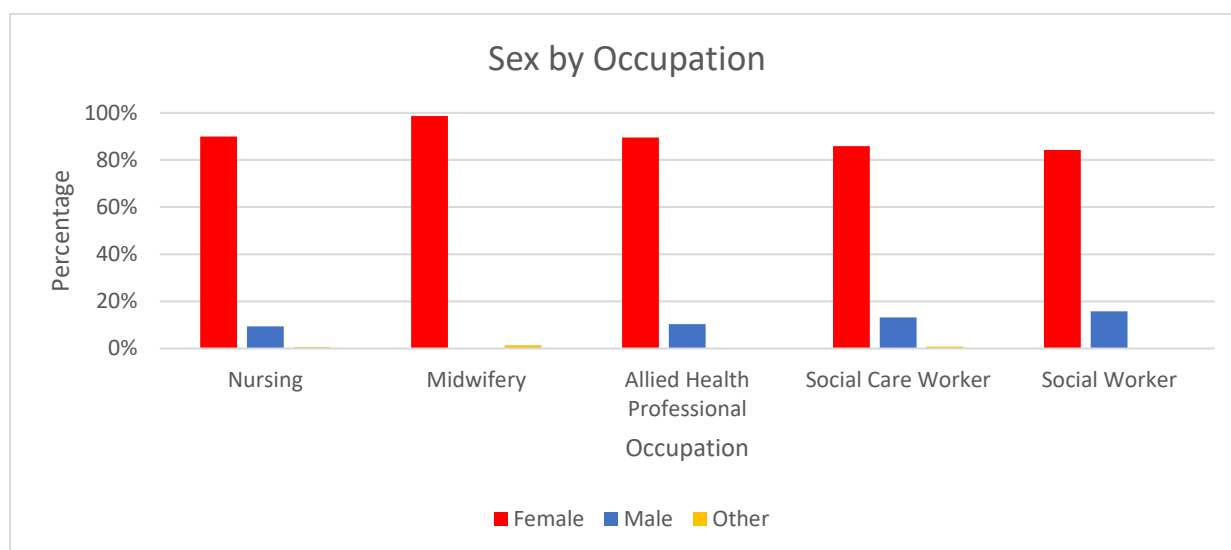


Table A2 6: Sex by Occupation (Weighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	85.9%	13.8%	0.3%	100%
Midwifery	97.2%	0.0%	2.8%	100%
AHP	91.8%	8.0%	0.2%	100%
Social Care Worker	79.3%	20.0%	0.7%	100%
Social Worker	86.7%	13.3%	0.0%	100%

Table A2.7: Sex by Occupation (Unweighted)

Occupation	Sex			Total
	Female	Male	Other	
Nursing	325 (90.0%)	34 (9.4%)	2 (0.6%)	361 (20.5%)
Midwifery	140 (98.6%)	0 (0.0%)	2 (1.4%)	142 (8.1%)
AHP	513 (89.5%)	59 (10.3%)	1 (0.2%)	573 (32.6%)
Social Care Worker	286 (85.9%)	44 (13.2%)	3 (0.9%)	333 (18.9%)
Social Worker	294 (84.2%)	55 (15.8%)	0 (0.0%)	348 (19.9%)

A2.3 Age of Respondents

Summary (Weighted results):

The majority of respondents were aged 30-59 years, with only a small proportion from the 66+ age group. Scotland had the highest proportion of the 50-59 year-old respondents (40.4%).

Summary (Unweighted results):

The majority of respondents were aged 50-59 years, with only a small proportion from the 66+ age group. Scotland had the highest proportion of the 50-59 year-old respondents (37.0%).

Note: In both the weighted and unweighted results from regression and comparison analysis, the 16-19 age group was merged with the 20-29 age group as only nine respondents from this category answered the survey which was too small for subgroup comparisons.

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

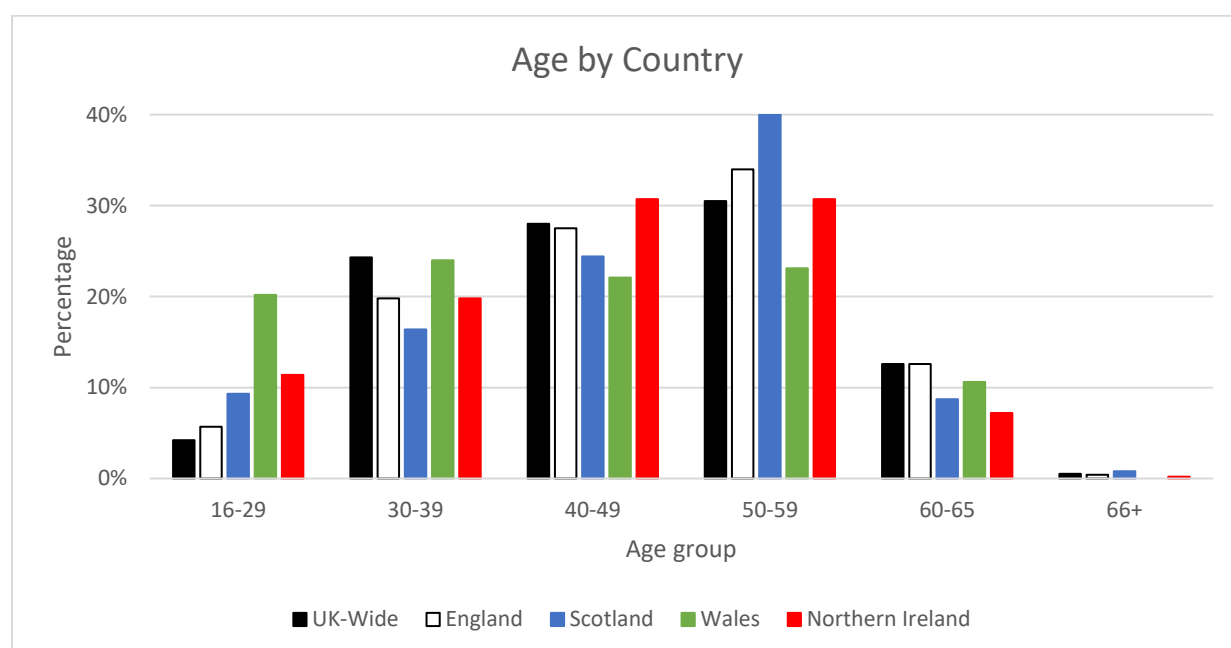


Figure A2.9: Age of Respondents by Country (Unweighted)

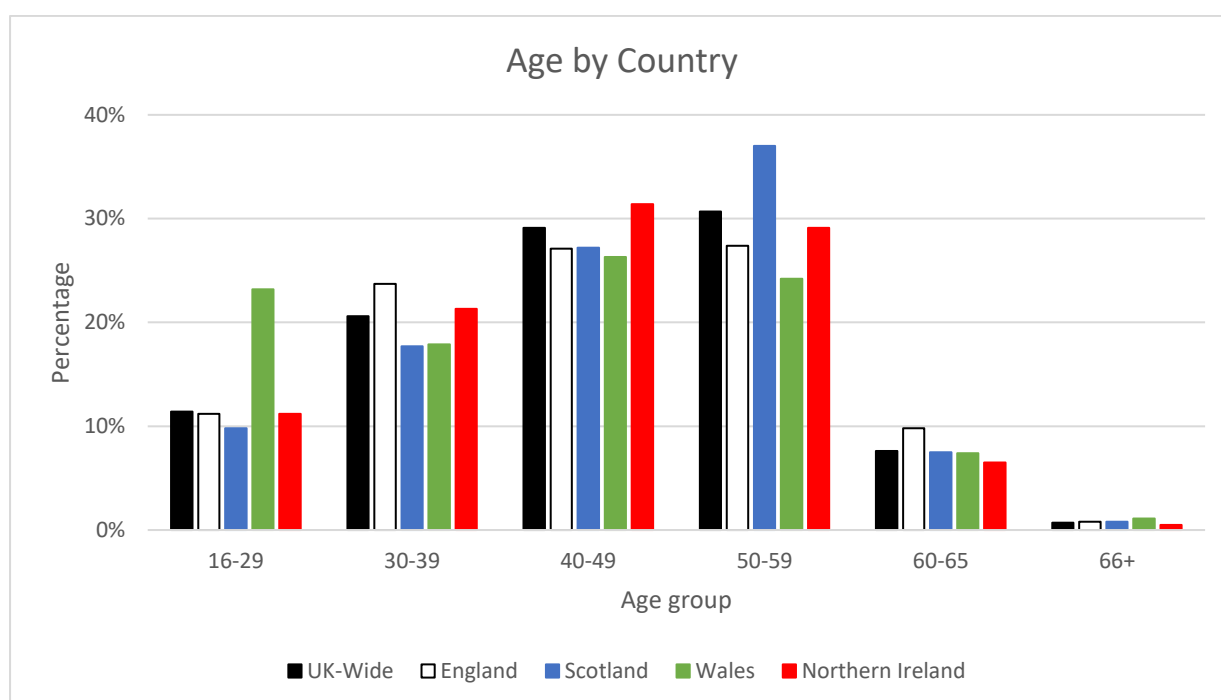


Table A2.8: Age of Respondents by Country (Weighted)

Age group	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
16-29	4.2%	5.7%	9.3%	20.2%	11.4%
30-39	24.3%	19.8%	16.4%	24.0%	19.8%
40-49	28.0%	27.5%	24.4%	22.1%	30.7%
50-59	30.5%	34.0%	40.4%	23.1%	30.7%
60-65	12.6%	12.6%	8.7%	10.6%	7.2%
66+	0.5%	0.4%	0.8%	0.0%	0.2%
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	201 (11.4%)	42 (11.2%)	48 (9.8%)	22 (23.2%)	89 (11.2%)
30-39	362 (20.6%)	89 (23.7%)	87 (17.7%)	17 (17.9%)	169 (21.3%)
40-49	511 (29.1%)	102 (27.1%)	134 (27.2%)	25 (26.3%)	250 (31.4%)
50-59	539 (30.7%)	103 (27.4%)	182 (37.0%)	23 (24.2%)	231 (29.1%)
60-65	133 (7.6%)	37 (9.8%)	37 (7.5%)	7 (7.4%)	52 (6.5%)
66+	12 (0.7%)	3 (0.8%)	4 (0.8%)	1 (1.1%)	4 (0.5%)
Total	1758 (100%)	376 (100%)	492 (100%)	95 (100%)	795 (100%)

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

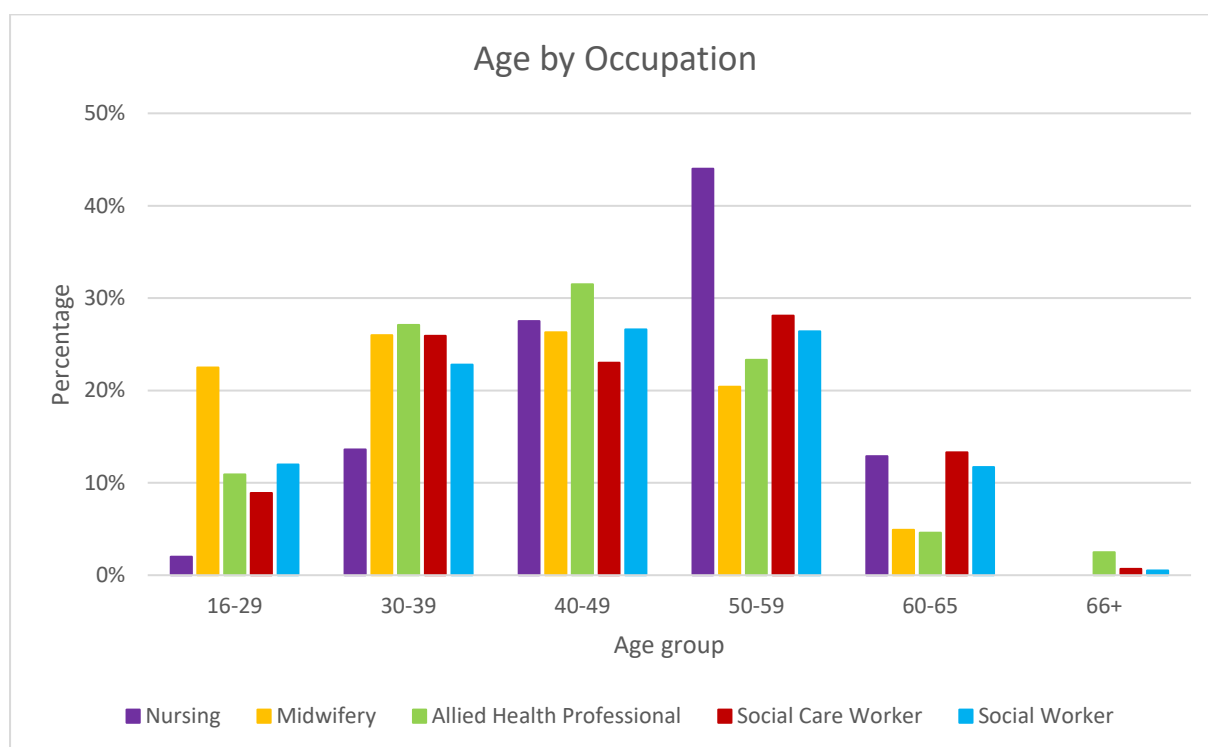


Figure A2.11: Age of Respondents by Occupation (Unweighted)

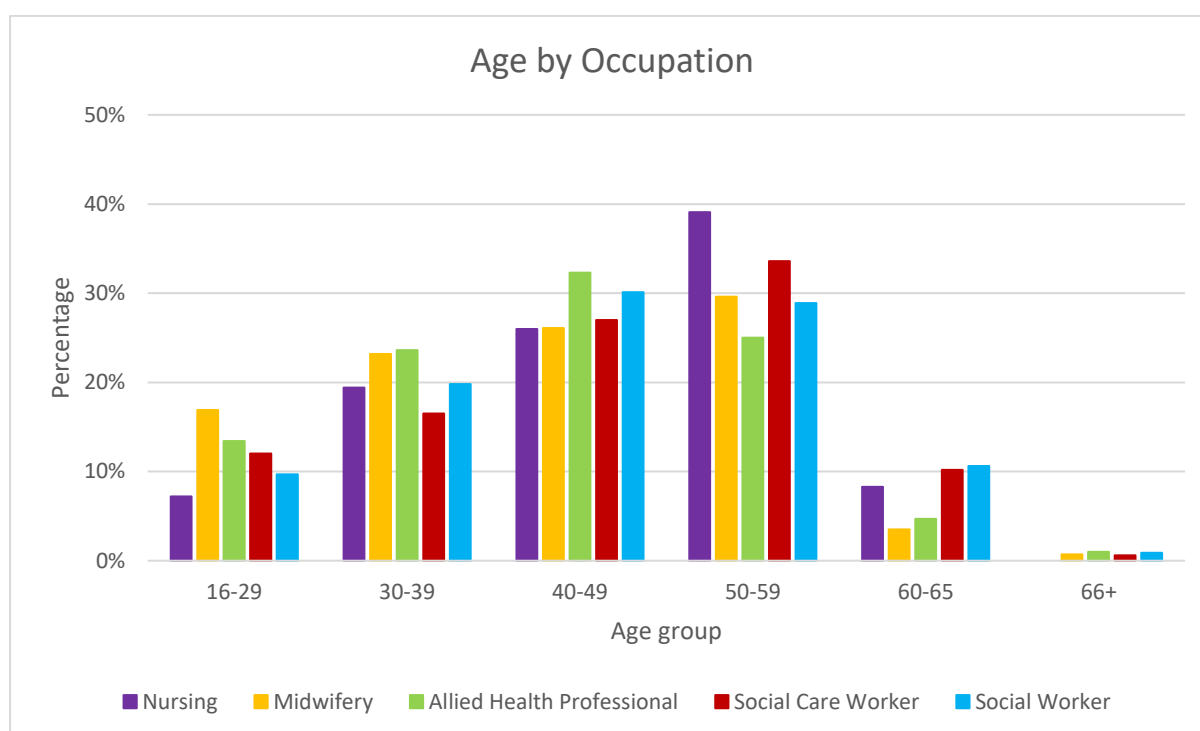


Table A2.10: Age of Respondents by Occupation (Weighted)

Occupation	Age group						Total
	16-29	30-39	40-49	50-59	60-65	66+	
Nursing	2.0%	13.6%	27.5%	44.0%	12.9%	0.0%	100%
Midwifery	22.5%	26.0%	26.3%	20.4%	4.9%	0.0%	100%
AHP	10.9%	27.1%	31.5%	23.3%	4.6%	2.5%	100%
Social Care Worker	8.9%	25.9%	23.0%	28.1%	13.3%	0.7%	100%
Social Worker	12.0%	22.8%	26.6%	26.4%	11.7%	0.5%	100%

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

Occupation	Age group						Total
	16-29	30-39	40-49	50-59	60-65	66+	
Nursing	26 (7.2%)	70 (19.4%)	94 (26.0%)	141 (39.1%)	30 (8.3%)	0 (0.0%)	361 (100%)
Midwifery	24 (16.9%)	33 (23.2%)	37 (26.1%)	42 (29.6%)	5 (3.5%)	1 (0.7%)	142 (100%)
AHP	77 (13.4%)	135 (23.6%)	185 (32.3%)	143 (25.0%)	27 (4.7%)	6 (1.0%)	573 (100%)
Social Care Worker	40 (12.0%)	55 (16.5%)	90 (27.0%)	112 (33.6%)	34 (10.2%)	2 (0.6%)	333 (100%)
Social Worker	34 (9.7%)	69 (19.8%)	105 (30.1%)	101 (28.9%)	37 (10.6%)	3 (0.9%)	349 (100%)

A2.4 Ethnic Origin of Respondents

Summary (Weighted results):

The vast majority of respondents were of white ethnic origin (93.0%). England was the most ethnically diverse country, with 8.1% of respondents identifying as not white. Social Workers were the most ethnically diverse occupational group, with 14.7% identifying as not white.

Summary (Unweighted results):

The vast majority of respondents were of white ethnic origin (96.9%). England was the most ethnically diverse country, with 8.5% of respondents identifying as not white. Social Workers were the most ethnically diverse occupational group, with 5.4% identifying as not white.

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

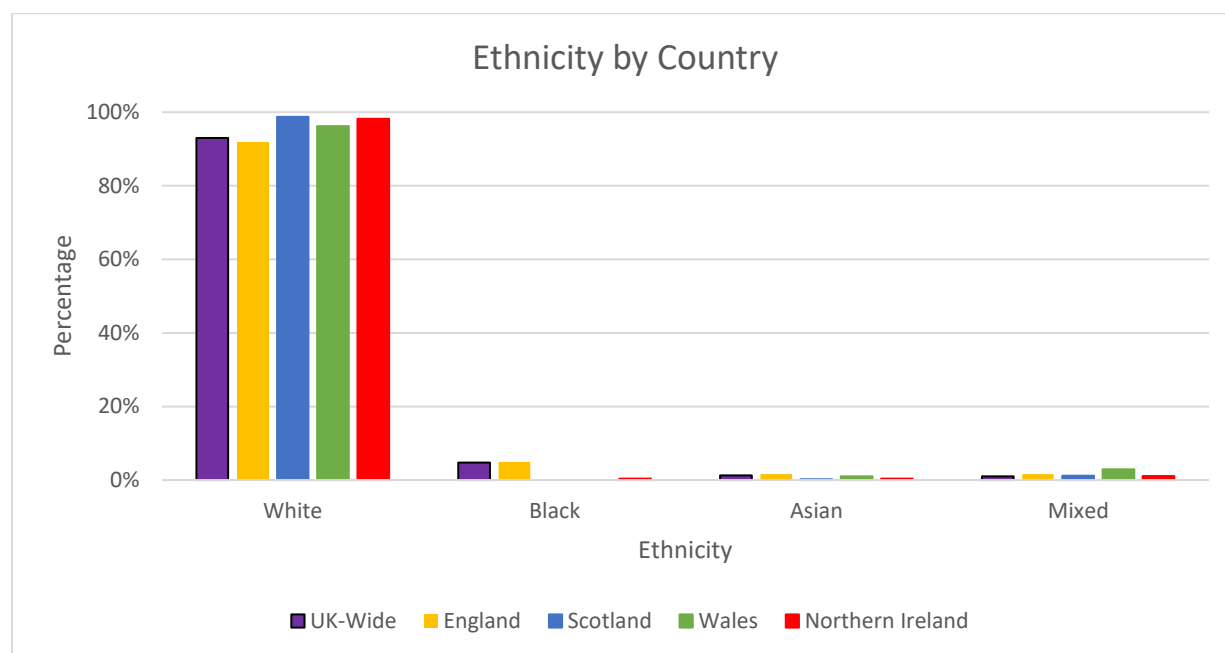


Figure A2.13: Ethnic Origin of Respondents by Country (Unweighted)

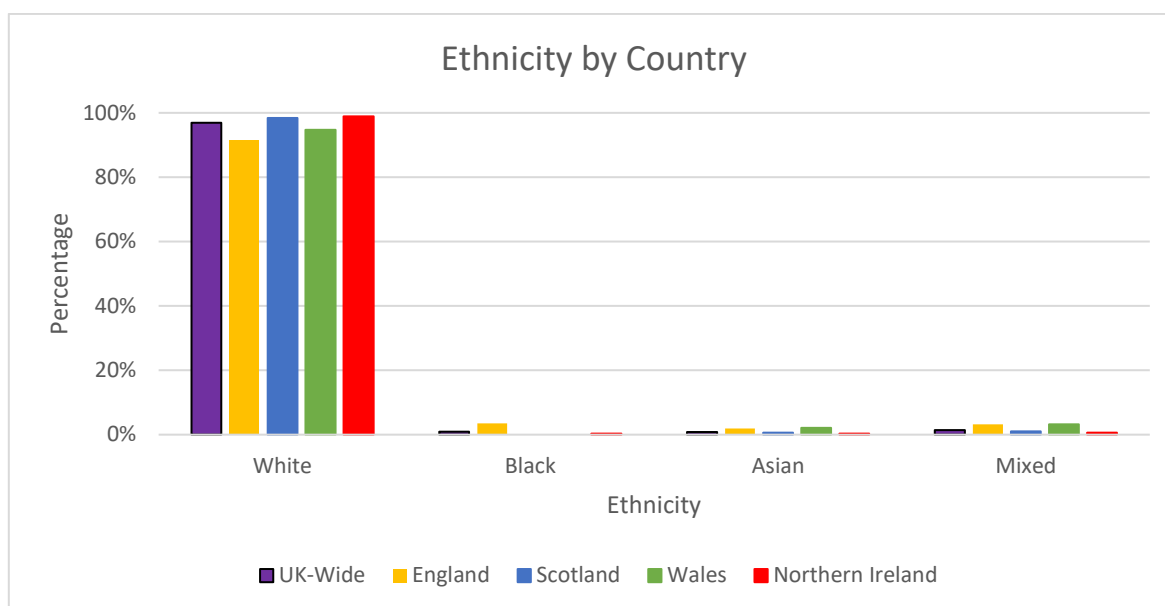


Table A2.12: Ethnic Origin of Respondents by Country (Weighted)

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	93.0%	91.9%	98.7%	96.2%	98.2%
Black	4.7%	4.9%	0.0%	0.0%	0.4%
Asian	1.3%	1.6%	0.2%	1.0%	0.4%
Mixed	1.0%	1.6%	1.2%	2.9%	1.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

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

Ethnicity	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
White	1700 (96.9%)	344 (91.5%)	483 (98.4%)	89 (94.7%)	784 (98.9%)
Black	15 (0.9%)	13 (3.5%)	0 (0.0%)	0 (0.0%)	2 (0.3%)
Asian	14 (0.8%)	7 (1.9%)	3 (0.6%)	2 (2.1%)	2 (0.3%)
Mixed	25 (1.4%)	12 (3.2%)	5 (1.0%)	3 (3.2%)	5 (0.6%)
Total	1754 (100.0%)	376 (100.0%)	491 (100.0%)	94 (100.0%)	793 (100.0%)

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

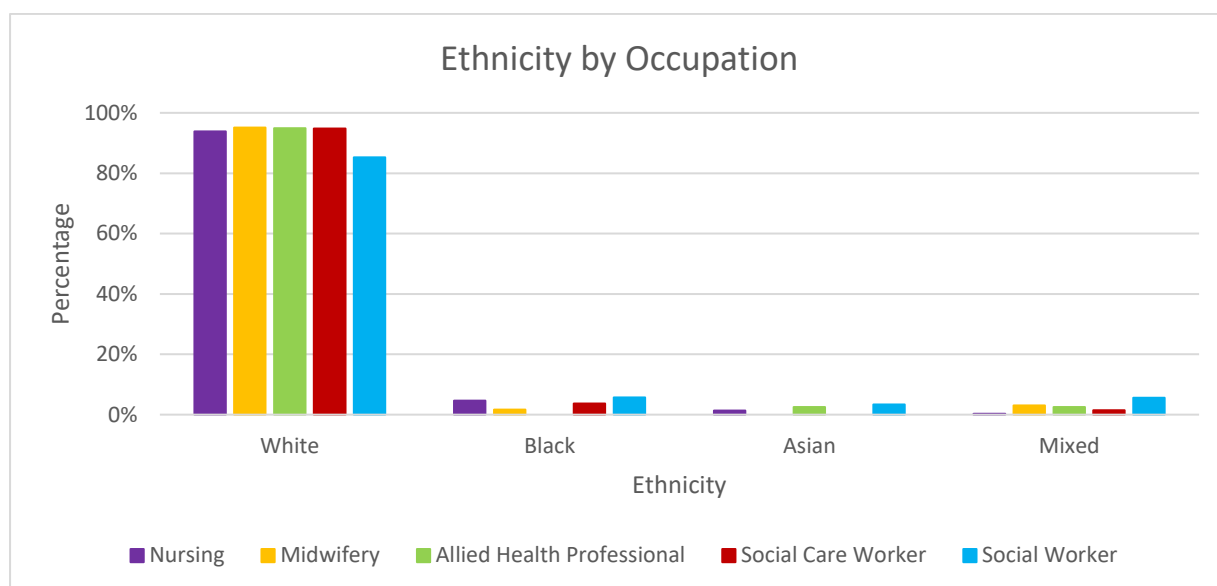


Figure A2.15: Ethnic Origin of Respondents by Occupation (Unweighted)

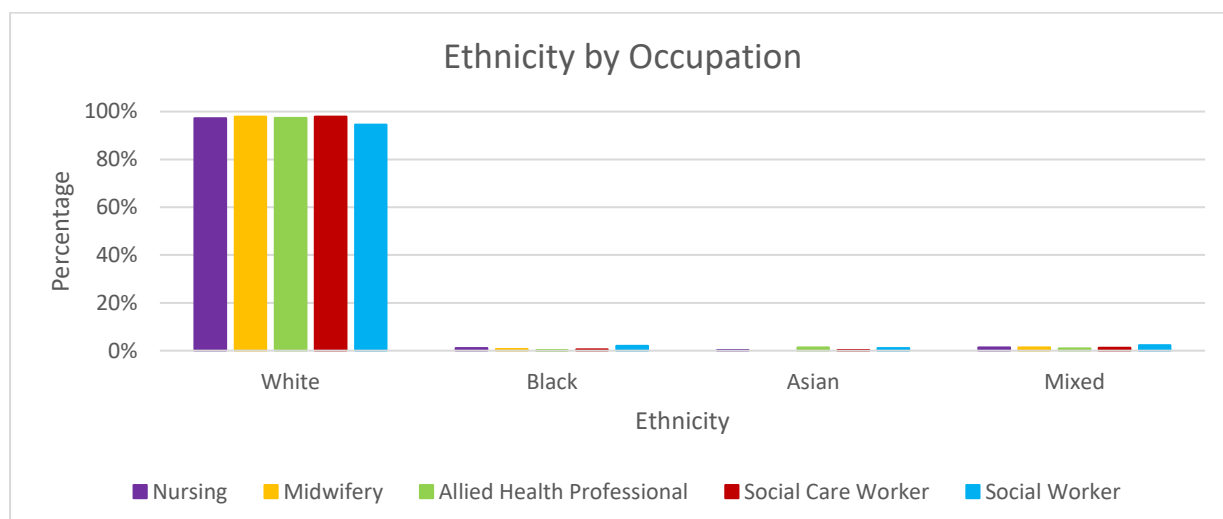


Table A2.14: Ethnic Origin of Respondents by Occupation (Weighted)

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	93.8%	4.6%	1.3%	0.3%	100%
Midwifery	95.1%	1.7%	0.0%	3.1%	100%
AHP	94.9%	0.0%	2.5%	2.5%	100%
Social Care Worker	94.8%	3.7%	0.0%	1.5%	100%
Social Worker	85.3%	5.7%	3.4%	5.6%	100%

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

Occupation	Ethnicity				Total
	White	Black	Asian	Mixed	
Nursing	351 (97.2%)	4 (1.1%)	1 (0.3%)	5 (1.4%)	361 (100%)
Midwifery	139 (97.9%)	1 (0.7%)	0 (0.0%)	2 (1.4%)	142 (100%)
AHP	557 (97.4%)	1 (0.2%)	8 (1.4%)	6 (1.0%)	572 (100%)
Social Care Worker	323 (97.9%)	2 (0.6%)	1 (0.3%)	4 (1.2%)	330 (100%)
Social Worker	330 (94.6%)	7 (2.0%)	4 (1.1%)	8 (2.3%)	349 (100%)

A2.5 Respondents with a Disability

Summary (Weighted results):

England had the highest proportion of respondents with a disability (12.9%). Of the different professions, social workers were the most likely ones to report having a disability (18.2%).

Summary (Unweighted results):

England had the highest proportion (14.4%) of respondents with a disability. Of the different professions, social workers (15.0%) were the most likely ones to report having a disability.

Figure A2.16: Disability by Country (Weighted)

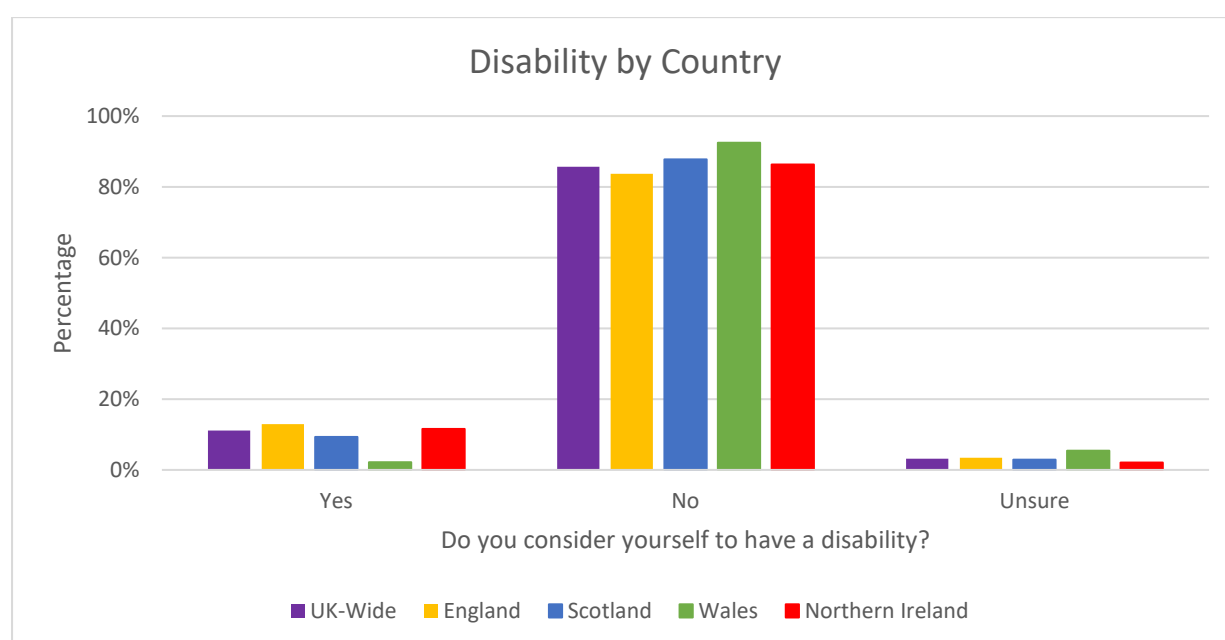


Figure A2.17: Disability by Country (Unweighted)

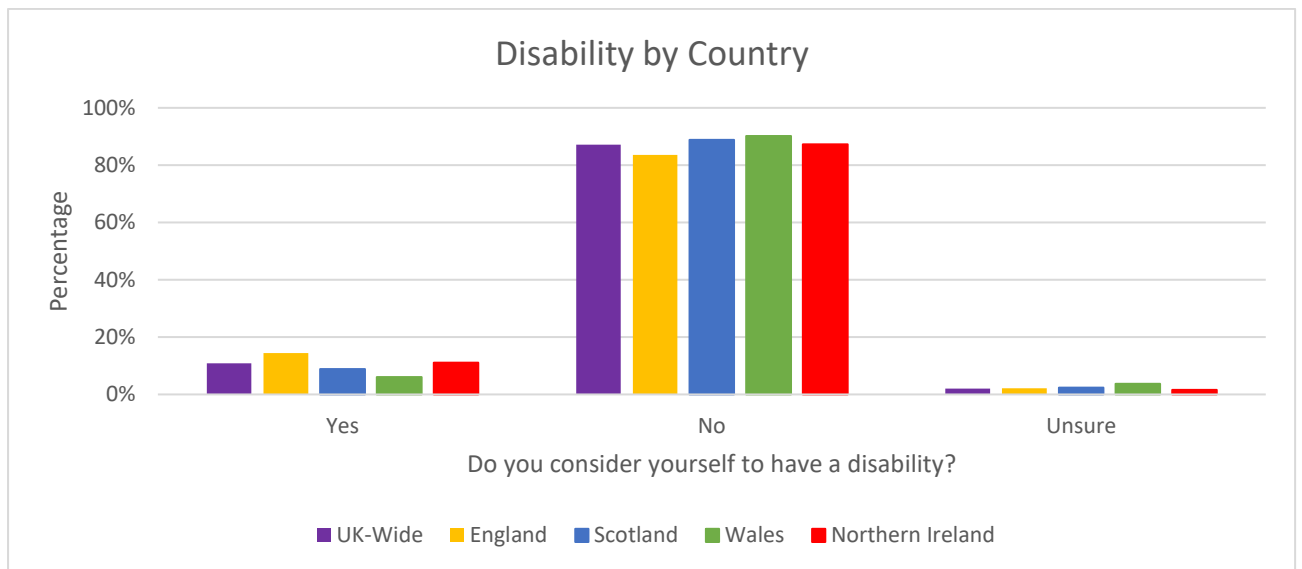


Table A2.16: Disability by Country (Weighted)

Do you consider yourself to have a disability?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	11.1%	12.9%	9.3%	2.2%	11.6%
No	85.7%	83.7%	87.8%	92.5%	86.3%
Unsure	3.2%	3.4%	2.9%	5.4%	2.1%
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	173 (10.9%)	49 (14.4%)	40 (8.8%)	5 (6.1%)	79 (11.1%)
No	1383 (87.1%)	285 (83.6%)	405 (88.8%)	74 (90.2%)	619 (87.3%)
Unsure	32 (2.0%)	7 (2.1%)	11 (2.4%)	3 (3.7%)	11 (1.6%)
Total	1588 (100%)	341 (100%)	456 (100%)	92 (100%)	709 (100%)

Figure A2.18: Disability by Occupation (Weighted)

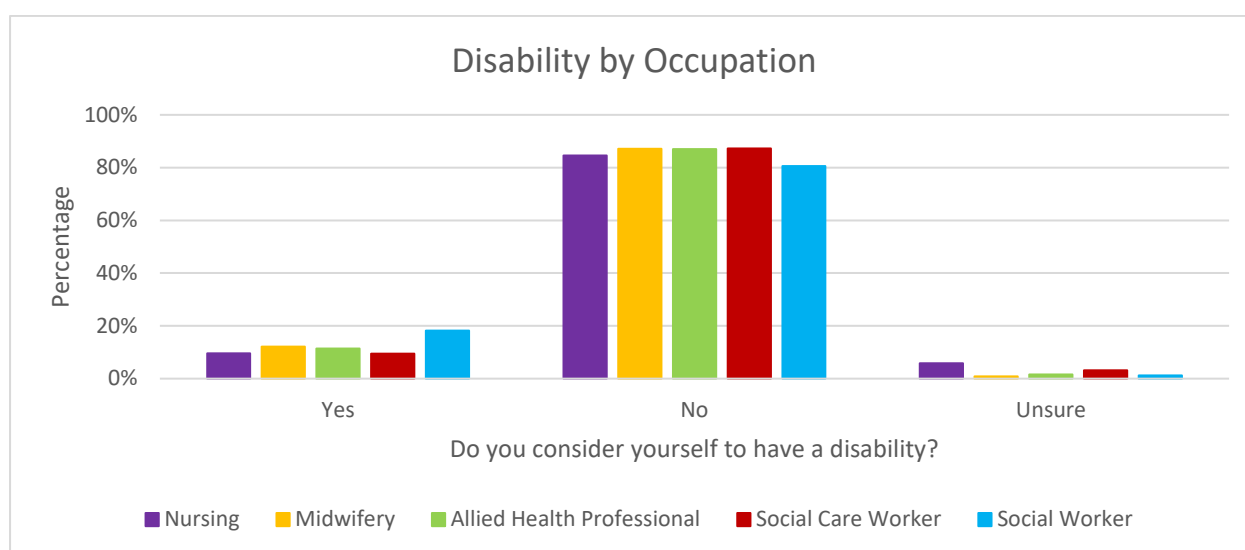


Figure A2.19: Disability by Occupation (Unweighted)

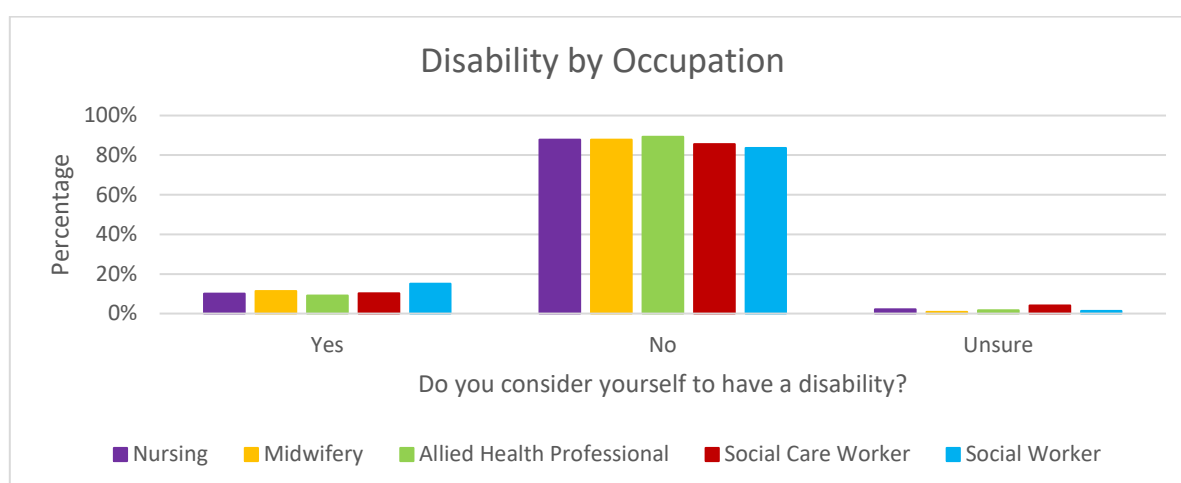


Table A2.18: Disability by Occupation (Weighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	9.6%	84.6%	5.8%	100%
Midwifery	12.1%	87.1%	0.9%	100%
AHP	11.4%	87.0%	1.6%	100%
Social Care Worker	9.5%	87.3%	3.2%	100%
Social Worker	18.2%	80.6%	1.2%	100%

Table A2.19: Disability by Occupation (Unweighted)

Occupation	Do you consider yourself to have a disability?			Total
	Yes	No	Unsure	
Nursing	34 (10.0%)	(87.9%)	7 (2.1%)	339 (100%)
Midwifery	14 (11.3%)	(87.9%)	1 (0.8%)	124 (100%)
AHP	47 (9.1%)	(89.3%)	8 (1.6%)	515 (100%)
Social Care Worker	30 (10.3%)	(85.6%)	12 (4.1%)	291 (100%)
Social Worker	48 (15.0%)	267 (83.7%)	4 (1.3%)	319 (100%)

A2.6 Respondents' Relationship Status

Summary (Weighted results):

Over half the respondents reported they were married (55.0%).

Summary (Unweighted results):

Over half the respondents reported they were married (57.6%).

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

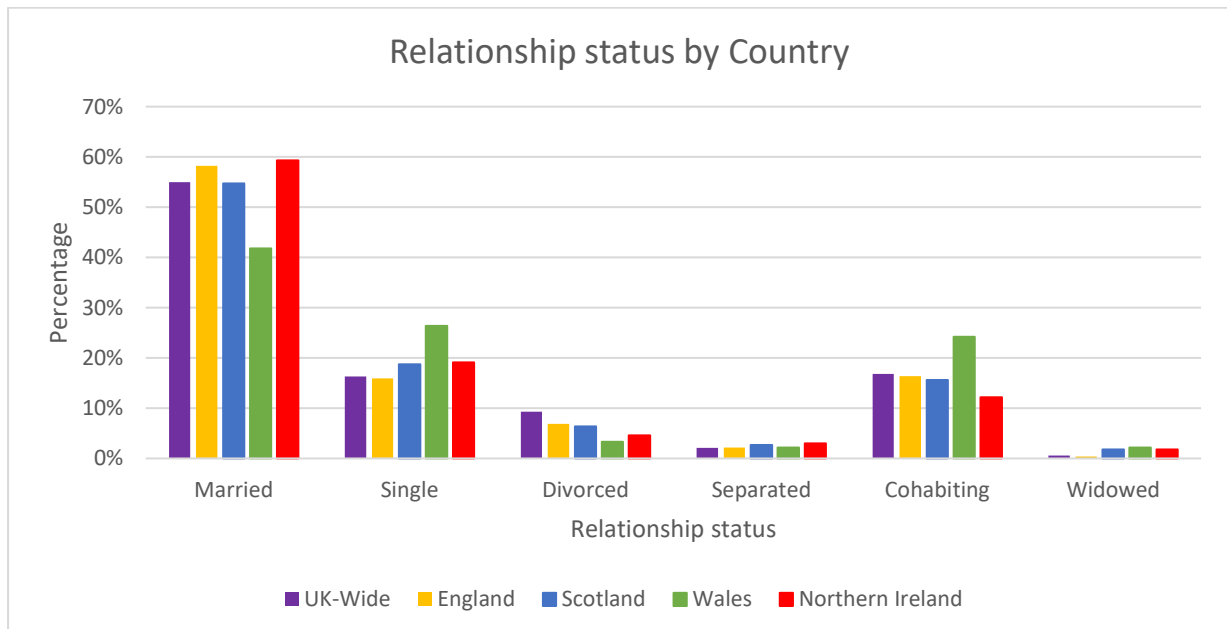


Figure A2.21: Relationship Status by Country (Unweighted)

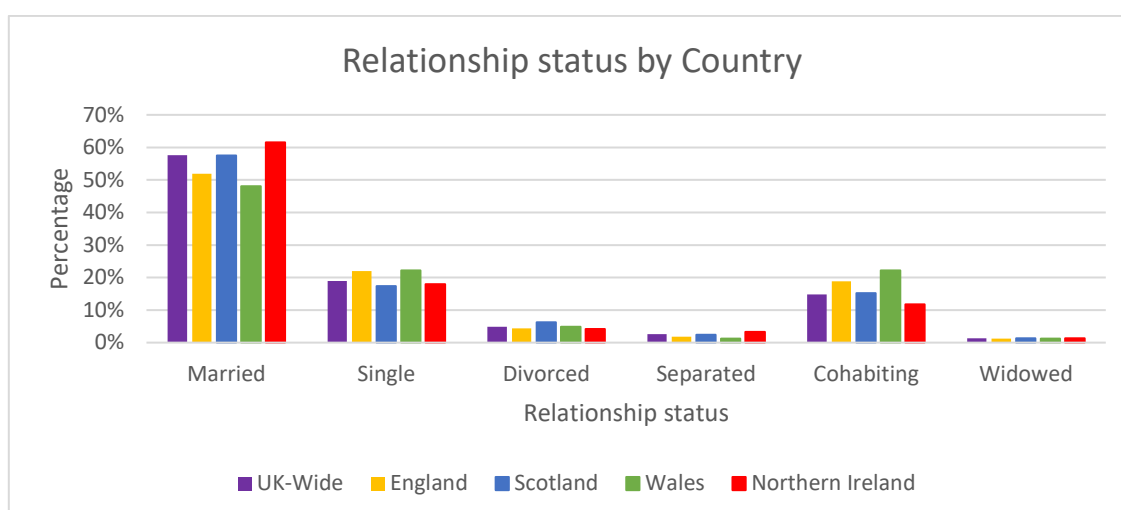


Table A2 20:: Relationship Status by Country (Weighted)

Relationship status	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	55.0%	58.2%	54.7%	41.8%	59.3%
Single	16.3%	15.9%	18.7%	26.4%	19.1%
Divorced	9.3%	6.9%	6.4%	3.3%	4.6%
Separated	2.1%	2.2%	2.7%	2.2%	3.0%
Cohabiting	16.8%	16.4%	15.6%	24.2%	12.2%
Widowed	0.6%	0.4%	1.8%	2.2%	1.8%
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	911 (57.6%)	177 (51.9%)	261 (57.5%)	39 (48.1%)	434 (61.5%)
Single	299 (18.9%)	75 (22.0%)	79 (17.4%)	18 (22.2%)	127 (18.0%)
Divorced	77 (4.9%)	15 (4.4%)	28 (6.2%)	4 (4.9%)	30 (4.2%)
Separated	41 (2.6%)	6 (1.8%)	11 (2.4%)	1 (1.2%)	23 (3.3%)
Cohabiting	234 (14.8%)	64 (18.8%)	69 (15.2%)	18 (22.2%)	83 (11.8%)
Widowed	20 (1.3%)	4 (1.2%)	6 (1.3%)	1 (1.2%)	9 (1.3%)
Total	1582 (100%)	241 (100%)	454 (100%)	81 (100%)	706 (100%)

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

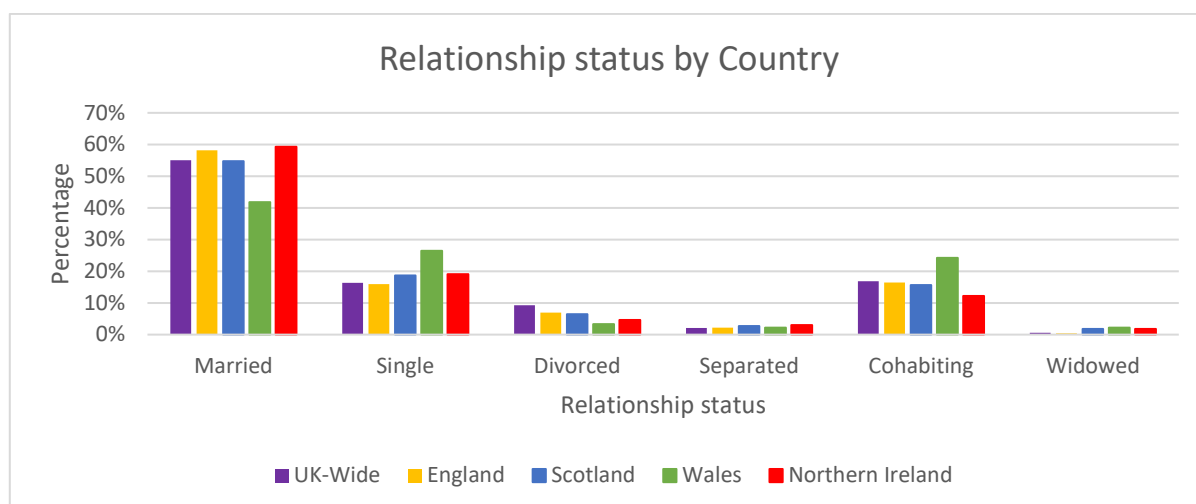


Figure A2.23: Relationship Status by Occupation (Unweighted)

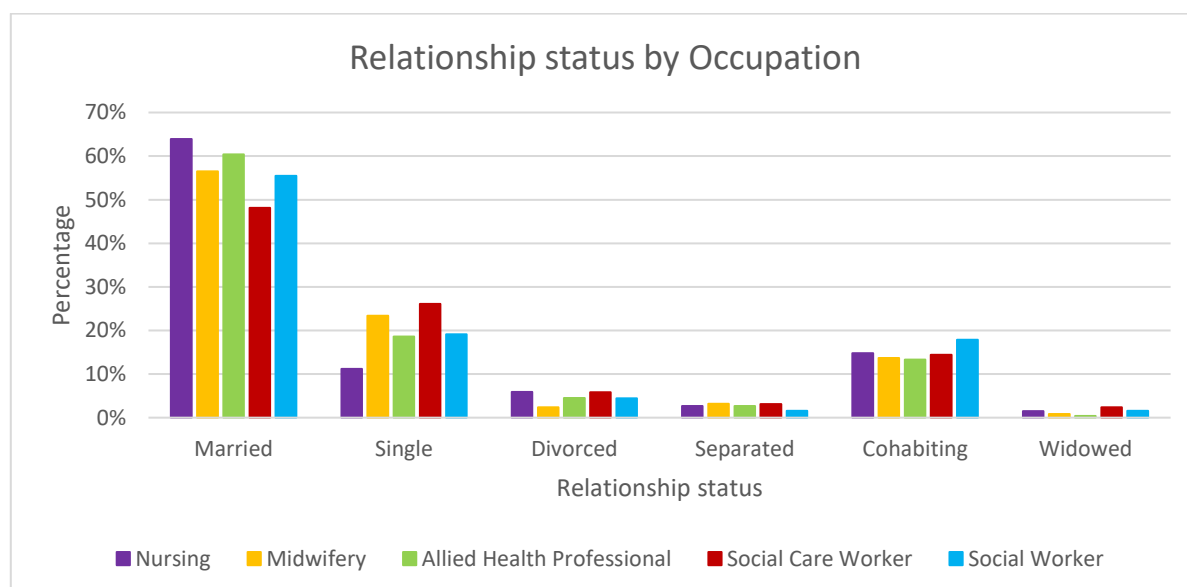


Table A2.22: Relationship Status by Occupation (Weighted)

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	55.0%	58.2%	54.7%	41.8%	59.3%	55.0%	100%
Midwifery	16.3%	15.9%	18.7%	26.4%	19.1%	16.3%	100%
AHP	9.3%	6.9%	6.4%	3.3%	4.6%	9.3%	100%
Social Care Worker	2.1%	2.2%	2.7%	2.2%	3.0%	2.1%	100%
Social Worker	16.8%	16.4%	15.6%	24.2%	12.2%	16.8%	100%

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

Occupation	Relationship status						Total
	Married	Single	Divorced	Separated	Cohabiting	Widowed	
Nursing	216 (63.9%)	38 (11.2%)	20 (5.9%)	9 (2.7%)	50 (14.8%)	5 (1.5%)	338 (100%)
Midwifery	70 (56.5%)	29 (23.4%)	3 (2.4%)	4 (3.2%)	17 (13.7%)	1 (0.8%)	124 (100%)
AHP	308 (60.4%)	95 (18.6%)	23 (4.5%)	14 (2.7%)	68 (13.3%)	2 (0.4%)	510 (100%)
Social Care Worker	140 (48.1%)	76 (26.1%)	17 (5.8%)	9 (3.1%)	42 (14.4%)	7 (2.4%)	291 (100%)
Social Worker	177 (55.5%)	61 (19.1%)	14 (4.4%)	5 (1.6%)	57 (17.9%)	5 (1.6%)	319 (100%)

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

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

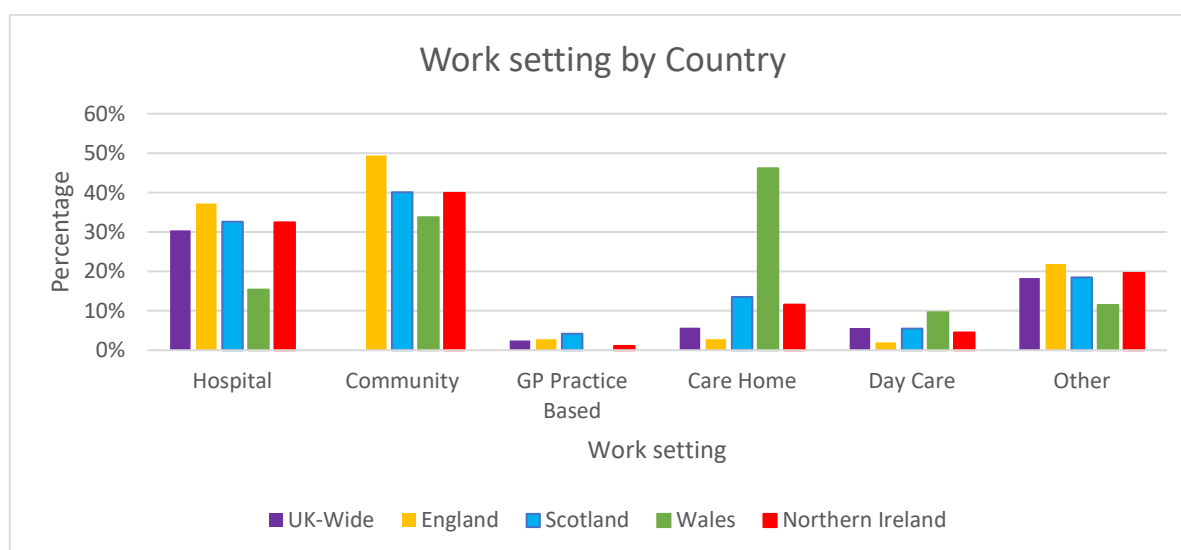


Figure A2.25: Work Setting by Country (Unweighted)

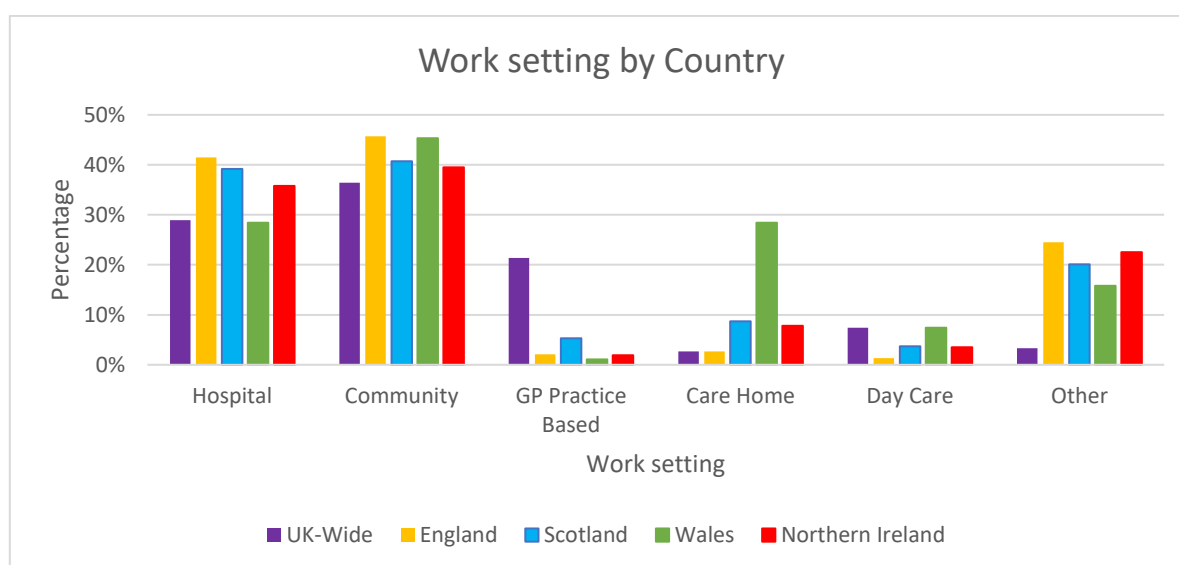


Table A2.24: Work Setting by Country (Weighted)

Work setting	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	30.4%	37.2%	32.6%	15.4%	32.4%
Community	53.3%	49.4%	40.1%	33.7%	39.9%
GP Practice	2.5%	2.8%	4.2%	0.0%	1.1%
Care Home	5.7%	2.8%	13.5%	46.2%	11.6%
Day Care	5.6%	2.0%	5.5%	9.6%	4.5%
Other	18.3%	21.9%	18.5%	11.5%	19.6%

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

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

Work setting	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	507 (28.9%)	156 (41.5%)	193 (39.2%)	27 (28.4%)	284 (35.8%)
Community	639 (36.4%)	172 (45.7%)	200 (40.7%)	43 (45.3%)	314 (39.5%)
GP Practice	376 (21.4%)	8 (2.1%)	26 (5.3%)	1 (1.1%)	15 (1.9%)
Care Home	47 (2.7%)	10 (2.7%)	43 (8.7%)	27 (28.4%)	62 (7.8%)
Day Care	130 (7.4%)	5 (1.3%)	18 (3.7%)	7 (7.4%)	28 (3.5%)
Other	58 (3.3%)	92 (24.5%)	99 (20.1%)	15 (15.8%)	179 (22.5%)
No. of respondents who answered the question	1757	376	492	95	794

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

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

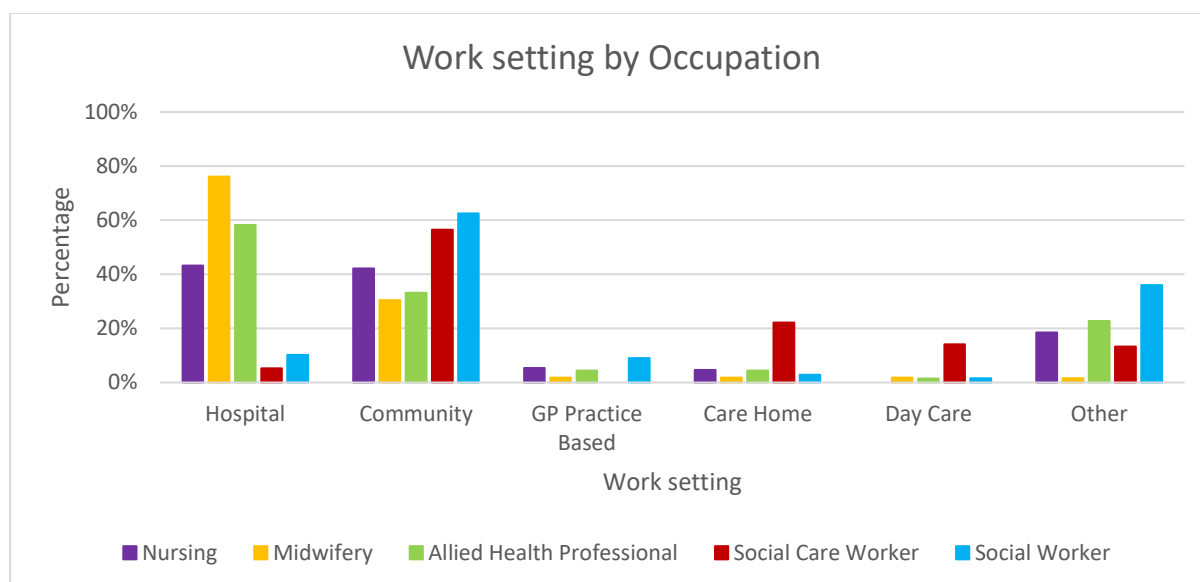


Figure A2.27: Work Setting by Occupation (Unweighted)

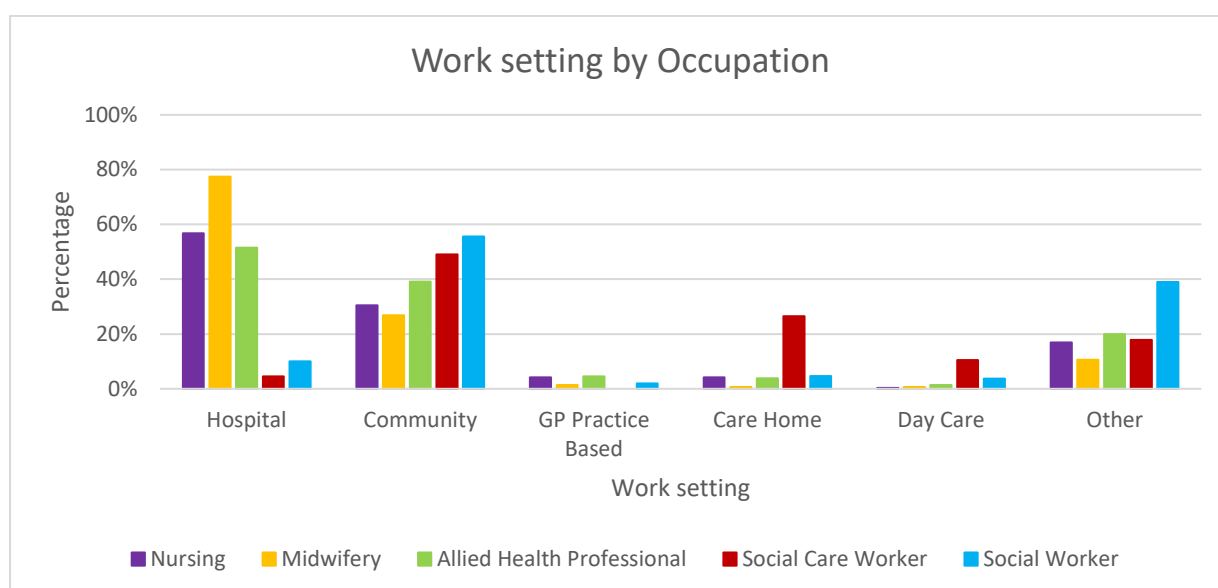


Table A2.26: Work Setting by Occupation (Weighted)

Occupation	Work setting					
	Hospital	Community	GP Practice	Care Home	Day Care	Other
Nursing	43.2%	42.2%	5.3%	4.6%	0.0%	18.5%
Midwifery	76.1%	30.5%	1.8%	1.8%	1.8%	1.6%
AHP	58.2%	33.2%	4.4%	4.4%	1.5%	22.7%
Social Care Worker	5.2%	56.5%	0.0%	22.2%	14.1%	13.3%
Social Worker	10.2%	62.5%	9.0%	2.9%	1.6%	36.0%

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	205 (56.8%)	110 (30.5%)	15 (4.2%)	15 (4.2%)	1 (0.3%)	61 (16.9%)	361
Midwifery	110 (77.5%)	38 (26.8%)	2 (1.4%)	1 (0.7%)	1 (0.7%)	15 (10.6%)	142
AHP	295 (51.5%)	224 (39.1%)	26 (4.5%)	22 (3.8%)	8 (1.4%)	114 (19.9%)	573
Social Care Worker	15 (4.5%)	163 (49.1%)	0 (0.0%)	88 (26.5%)	35 (10.5%)	59 (17.8%)	332
Social Worker	35 (10.0%)	194 (55.6%)	7 (2.0%)	16 (4.6%)	13 (3.7%)	136 (39.0%)	349

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

A2.8 Health and Social Care Sector of Respondents

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

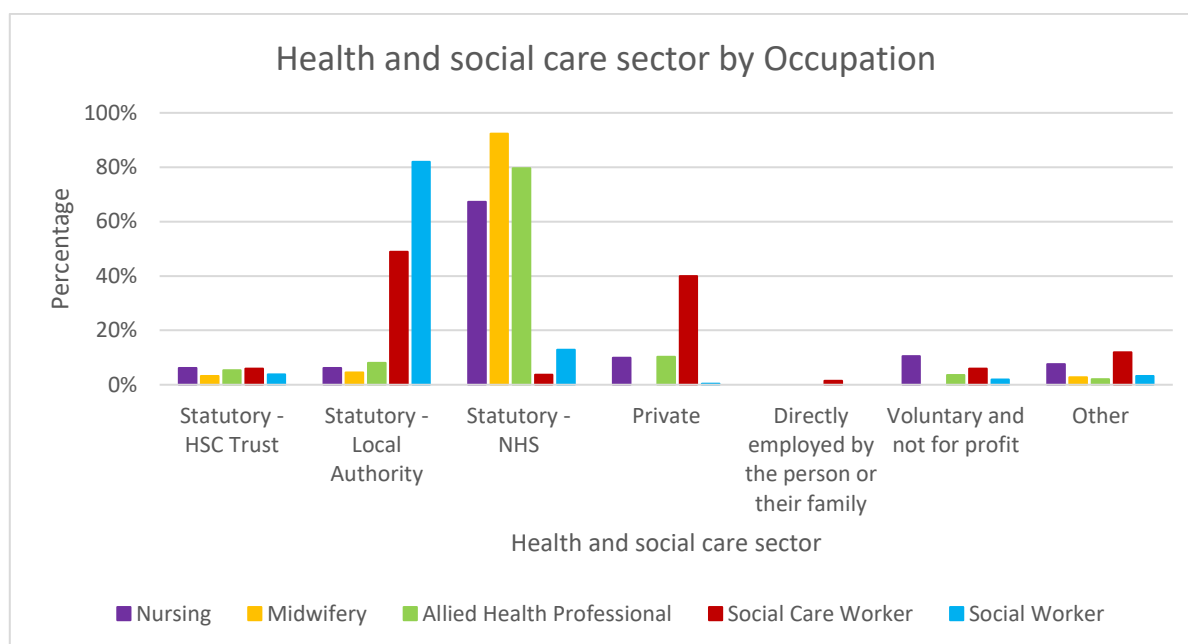


Figure A2.29: Health and Social Care Sector of Respondents by Country (Unweighted)

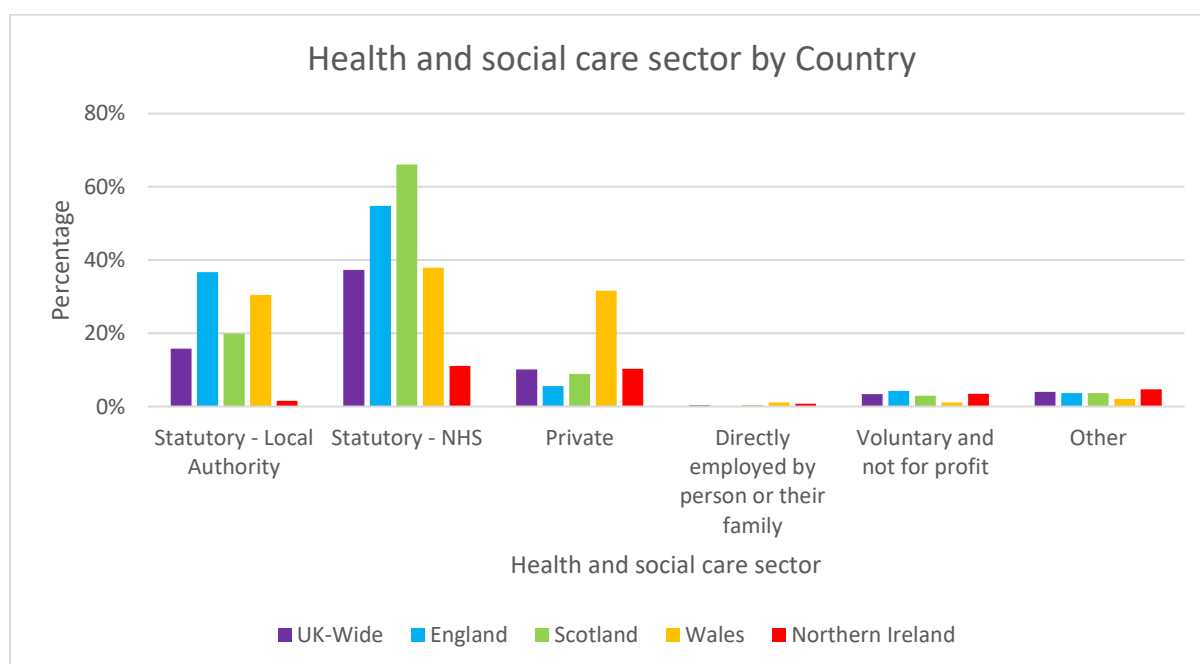


Table A2.28: Health and Social Care Sector of Respondents by Country (Weighted)

Health and social care sector	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Statutory – HSC Trust	3.7%	1.2%	6.7%	0.0%	66.7%
Statutory – Local Authority	33.6%	29.6%	25.9%	27.9%	1.0%
Statutory – NHS	40.0%	53.8%	52.9%	19.2%	9.7%
Private	20.4%	9.7%	13.0%	53.8%	18.1%
Directly employed by person or their family	0.2%	0.0%	6.7%	1.9%	1.0%
Voluntary and not for profit	7.3%	8.5%	5.0%	0.0%	4.8%
Other	4.4%	5.6%	5.5%	1.9%	4.6%

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	603 (34.3%)	6 (1.6%)	6 (1.2%)	1 (1.1%)	590 (74.3%)
Statutory – Local Authority	278 (15.8%)	138 (36.7%)	98 (19.9%)	29 (30.5%)	13 (1.6%)
Statutory – NHS	655 (37.3%)	206 (54.8%)	325 (66.1%)	36 (37.9%)	88 (11.1%)
Private	177 (10.1%)	21 (5.6%)	44 (8.9%)	30 (31.6%)	82 (10.3%)
Directly employed by person or their family	6 (0.3%)	0 (0.0%)	2 (0.4%)	1 (1.1%)	3 (0.8%)
Voluntary and not for profit	60 (3.4%)	16 (4.3%)	15 (3.0%)	1 (1.1%)	28 (3.5%)
Other	71 (4.0%)	14 (3.7%)	18 (3.7%)	2 (2.1%)	37 (4.7%)
No. of respondents who answered the question	1757	376	492	95	794

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

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

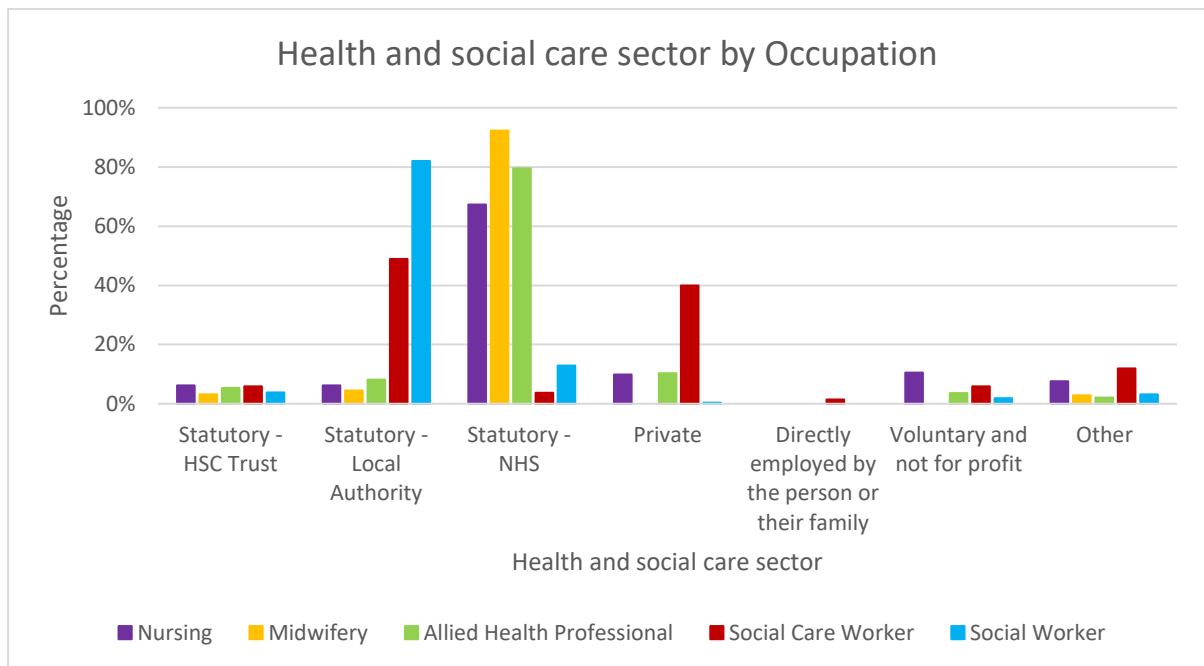


Figure A2.31: Health and Social Care Sector of Respondents by Occupation (Unweighted)

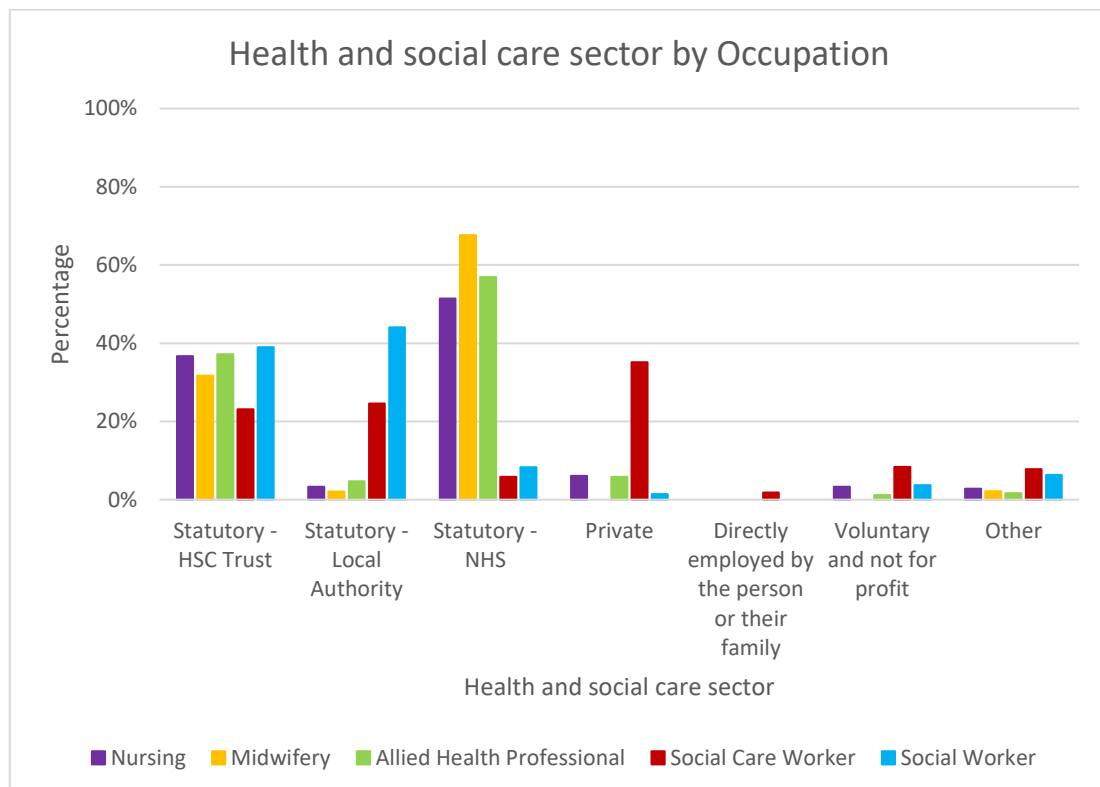


Table A2.30: Health and Social Care Sector of Respondents by Occupation (Weighted)

Occupation	Health and social care sector						
	Statutory – HSC Trust	Statutory – Local Authority	Statutory – NHS	Private	Directly employed by the person or their family	Voluntary and not for profit	Other
Nursing	6.2%	6.2%	67.3%	9.9%	0.0%	10.5%	7.6%
Midwifery	3.2%	4.5%	92.3%	0.0%	0.0%	0.0%	2.8%
AHP	5.3%	8.1%	79.6%	10.3%	0.0%	3.6%	2.1%
Social Care Worker	5.9%	48.9%	3.7%	40.0%	1.5%	5.9%	11.9%
Social Worker	3.8%	82.0%	12.9%	0.4%	0.0%	1.9%	3.2%

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	132 (36.7%)	12 (3.3%)	185 (51.4%)	22 (6.1%)	0 (0.0%)	12 (3.3%)	10 (2.8%)	360
Midwifery	45 (31.7%)	3 (2.1%)	96 (67.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (2.1%)	142
AHP	213 (37.2%)	27 (4.7%)	326 (56.9%)	33 (5.8%)	0 (0.0%)	7 (1.2%)	10 (1.7%)	573
Social Care Worker	77 (23.1%)	82 (24.6%)	19 (5.8%)	117 (35.1%)	6 (1.8%)	28 (8.4%)	26 (7.8%)	333
Social Worker	136 (39.0%)	154 (44.1%)	29 (8.3%)	5 (1.4%)	0 (0.0%)	13 (3.7%)	22 (6.3%)	349

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

A2.9 Line Manager Status of Respondents

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

Summary (Weighted results):

Almost two thirds of respondents were not line managers.

Summary (Unweighted results):

Over two thirds of respondents were not line managers.

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

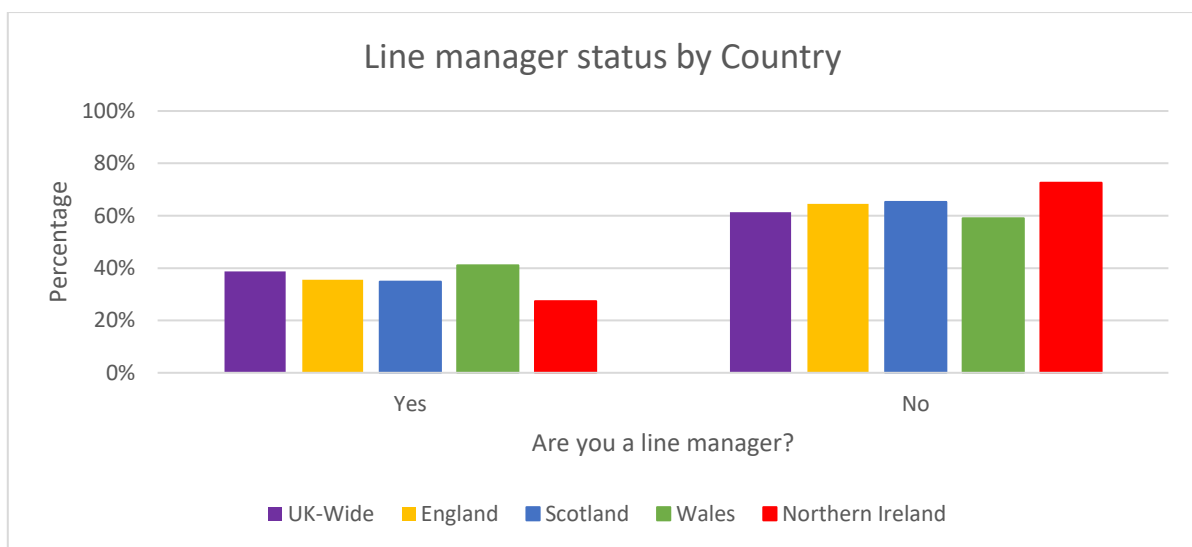


Figure A2.33: Line Manager Status of Respondents by Country (Unweighted)

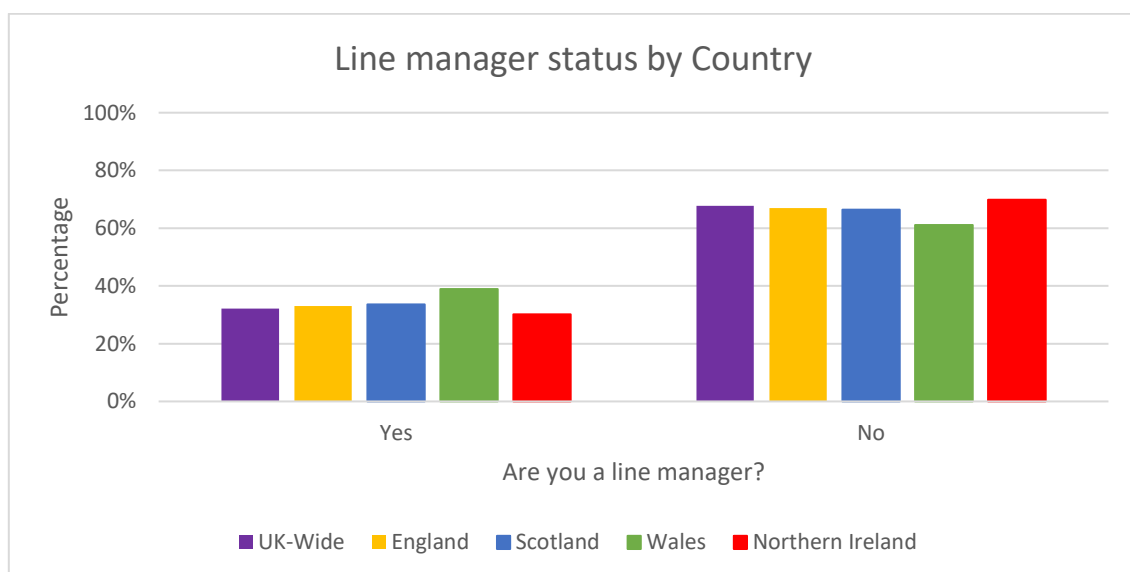


Table A2.32: Line Manager Status of Respondents by Country (Weighted)

Are you a line manager?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	38.7%	35.6%	34.8%	41.0%	27.4%
No	61.3%	64.5%	65.2%	59.0%	72.6%
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	566 (32.2%)	124 (33.0%)	165 (33.6%)	37 (38.9%)	240 (30.2%)
No	1191 (67.8%)	252 (67.0%)	3226 (66.4%)	58 (61.1%)	555 (69.8%)
Total	1757 (100%)	539 (100%)	745 (100%)	321 (100%)	1116 (100%)

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

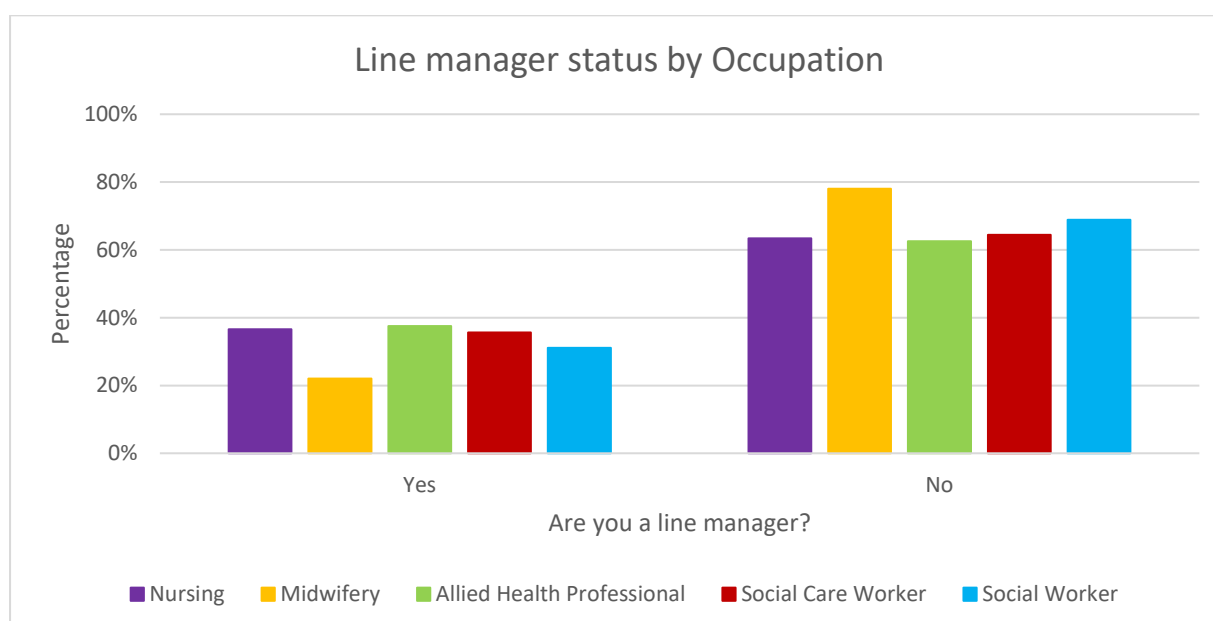


Figure A2.35: Line Manager Status of Respondents by Occupation (Unweighted)

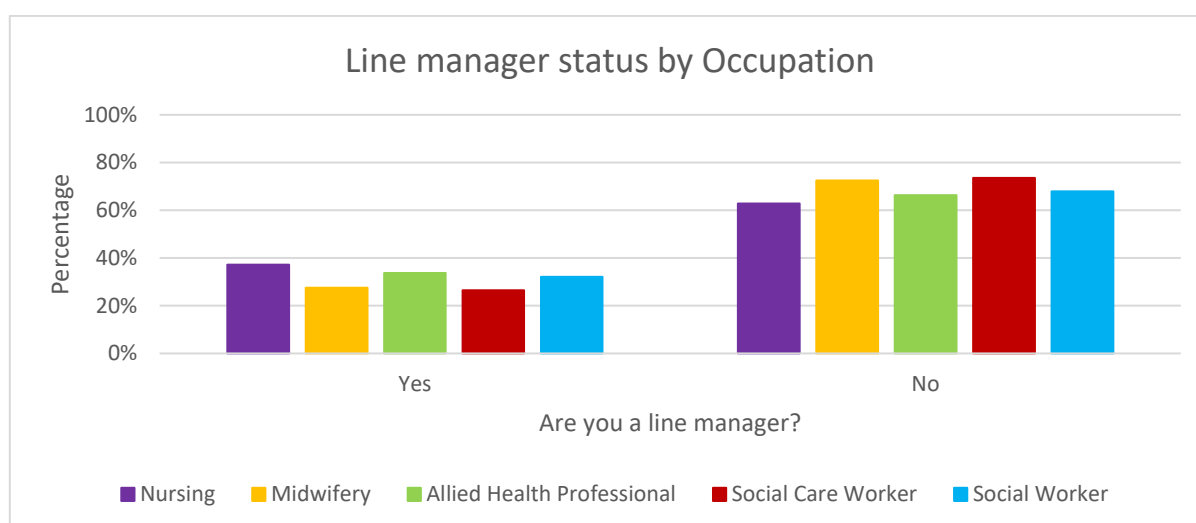


Table A2.34: Line Manager Status of Respondents by Occupation (Weighted)

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	36.6%	63.4%	100%
Midwifery	22.0%	78.0%	100%
AHP	37.5%	62.5%	100%
Social Care Worker	35.6%	64.4%	100%
Social Worker	31.1%	68.9%	100%

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

Occupation	Are you a line manager?		Total
	Yes	No	
Nursing	134 (37.2%)	226 (62.8%)	360 (100%)
Midwifery	39 (27.5%)	103 (72.5%)	142 (100%)
AHP	193 (33.7%)	380 (66.3%)	573 (100%)
Social Care Worker	88 (26.4%)	245 (73.6%)	333 (100%)
Social Worker	112 (32.1%)	237 (67.9%)	349 (100%)

A2.10 Pay Scale of Respondents

Summary (Weighted results):

Participants were divided into those who worked for the NHS or the HSC Trust were subsequently asked questions about their pay scale. Across the countries, the most frequently reported pay scale for NHS/HSC Trust staff was Band 5. Outside of the trust, more than £45,000 was the most common pay scale.

Summary (Unweighted results):

Participants were divided into those who worked for the NHS or the HSC Trust were subsequently asked questions about their pay scale however only 28 people answered this question. Across the countries, the most frequently reported pay scale for NHS/HSC Trust staff was Band 5 and 6. Outside of the trust, £30,000-£34,999 was the most common pay scale.

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

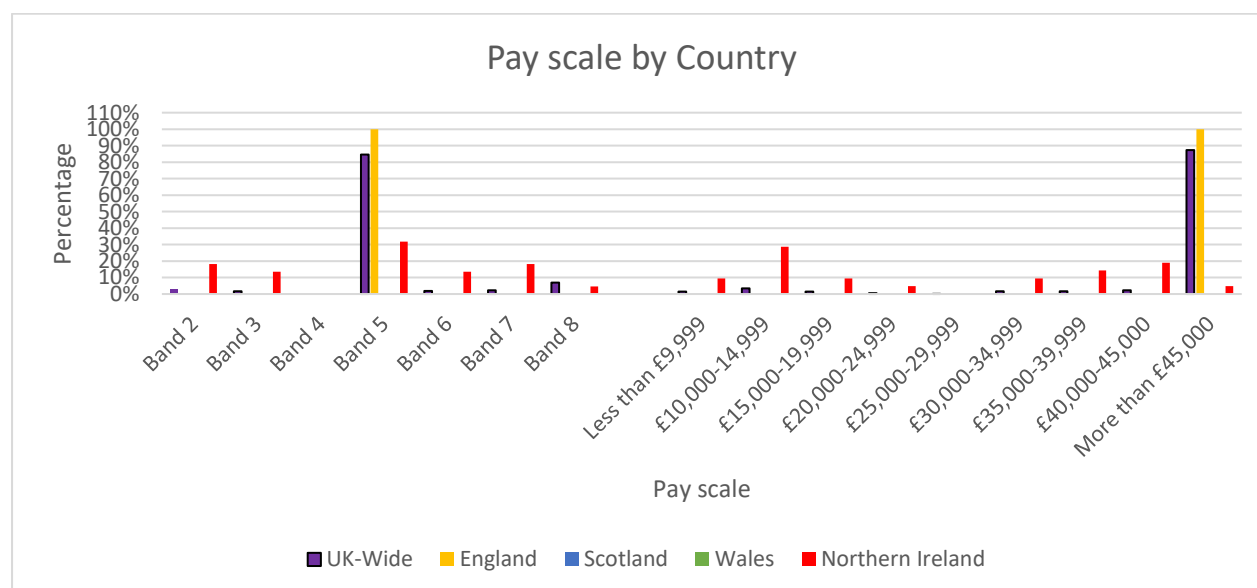


Figure A2.37: Pay Scale of Respondents by Country (Unweighted)

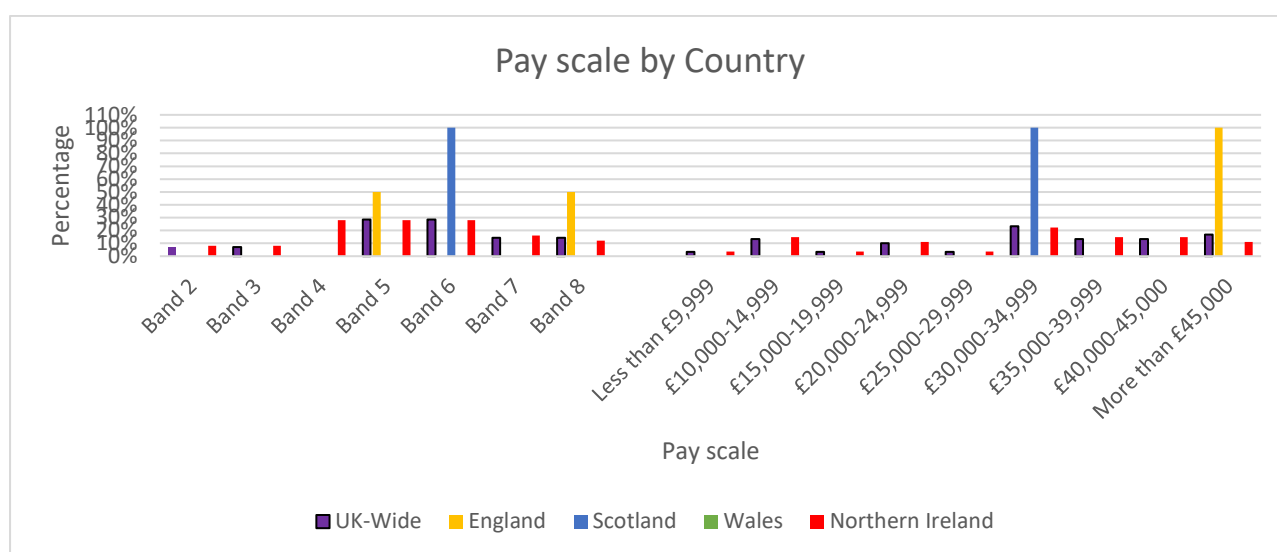


Table A2.36: Pay Scale of Respondents by Country (Weighted)

Pay scale	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
NHS or HSC Trust staff					
Band 2	2.7%	0.0%	0.0%	0.0%	18.2%
Band 3	1.6%	0.0%	0.0%	0.0%	13.6%
Band 4	0.0%	0.0%	0.0%	0.0%	0.0%
Band 5	84.5%	100.0%	0.0%	0.0%	31.8%
Band 6	1.9%	0.0%	0.0%	0.0%	13.6%
Band 7	2.3%	0.0%	0.0%	0.0%	18.2%
Band 8	6.9%	0.0%	0.0%	0.0%	4.5%
Total	100%	100%	0%	0%	100%
Other staff					
Less than £9,999	1.4%	0.0%	0.0%	0.0%	9.5%
£10,000-14,999	3.5%	0.0%	0.0%	0.0%	28.6%
£15,000-19,999	1.4%	0.0%	0.0%	0.0%	9.5%
£20,000-24,999	0.6%	0.0%	0.0%	0.0%	4.8%
£25,000-29,999	0.2%	0.0%	0.0%	0.0%	0.0%
£30,000-34,999	1.7%	0.0%	0.0%	0.0%	9.5%
£35,000-39,999	1.6%	0.0%	0.0%	0.0%	14.3%
£40,000-45,000	2.3%	0.0%	0.0%	0.0%	19.0%
More than £45,000	87.3%	100.0%	0.0%	0.0%	4.8%
Total	100%	100%	0%	0%	100%

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

Pay scale	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
NHS or HSC Trust staff					
Band 2	2 (7.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (8.0%)
Band 3	2 (7.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (8.0%)
Band 4	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0%)
Band 5	8 (28.6%)	1 (50.0%)	0 (0.0%)	0 (0.0%)	7 (28.0%)
Band 6	8 (28.6%)	0 (0.0%)	100.0%	0 (0.0%)	7 (28.0%)
Band 7	4 (14.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (16.0%)
Band 8	4 (14.3%)	1 (50.0%)	0 (0.0%)	0 (0.0%)	3 (12.0%)
Total	28 (100%)	2 (100%)	1 (100%)	0 (0%)	25 (100%)
Other staff					
Less than £9,999	1 (3.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.7%)
£10,000-14,999	4 (13.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (14.8%)
£15,000-19,999	1 (3.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.7%)
£20,000-24,999	3 (10.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (11.1%)
£25,000-29,999	1 (3.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.7%)
£30,000-34,999	7 (23.3%)	0 (0.0%)	1 (100.0%)	0 (0.0%)	6 (22.2%)
£35,000-39,999	4 (13.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (14.8%)
£40,000-45,000	4 (13.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (14.8%)
More than £45,000	5 (16.7%)	2 (100.0%)	0 (0.0%)	0 (0.0%)	3 (11.1%)
Total	30 (100%)	2 (100%)	1 (100%)	0 (0%)	27 (100%)

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

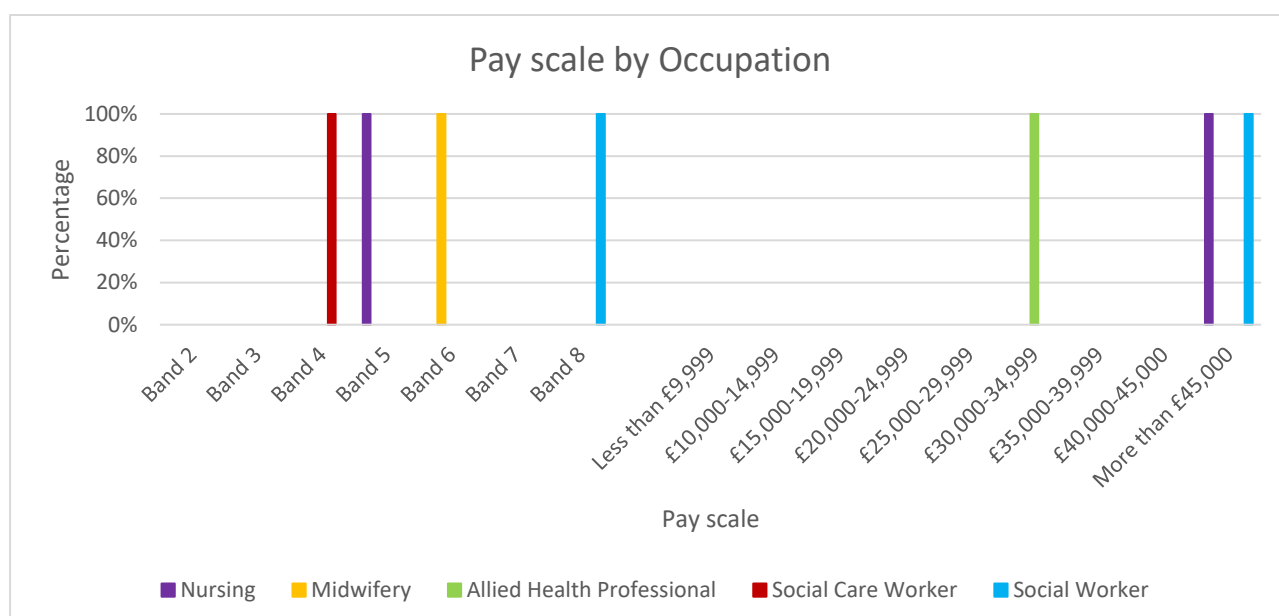


Figure A2.39: Pay Scale of Respondents by Occupation (Unweighted)

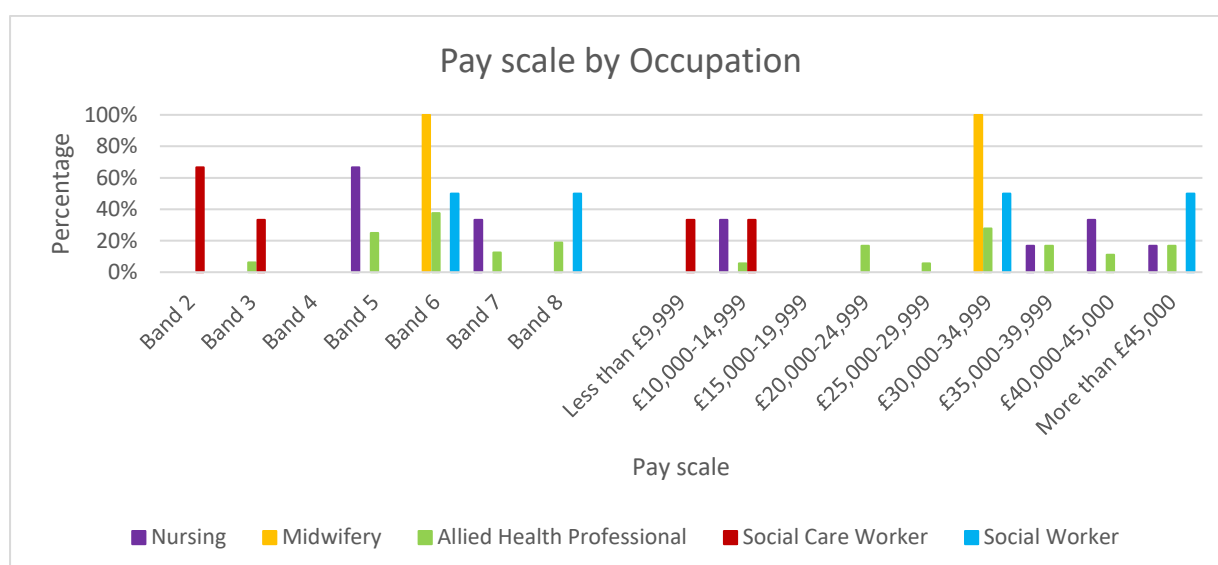


Table A2.38: Pay Scale of Respondents by Occupation (Weighted)

Pay scale	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
NHS or HSC Trust staff					
Band 2	0.0%	0.0%	0.0%	0.0%	0.0%
Band 3	0.0%	0.0%	0.0%	0.0%	0.0%
Band 4	0.0%	0.0%	0.0%	100.0%	0.0%
Band 5	100.0%	0.0%	0.0%	0.0%	0.0%
Band 6	0.0%	100.0%	0.0%	0.0%	0.0%
Band 7	0.0%	0.0%	0.0%	0.0%	0.0%
Band 8	0.0%	0.0%	0.0%	0.0%	100.0%
Total	100%	100%	0%	100%	100%
Other staff					
Less than £9,999	0.0%	0.0%	0.0%	0.0%	0.0%
£10,000-14,999	0.0%	0.0%	0.0%	0.0%	0.0%
£15,000-19,999	0.0%	0.0%	0.0%	0.0%	0.0%
£20,000-24,999	0.0%	0.0%	0.0%	0.0%	0.0%
£25,000-29,999	0.0%	0.0%	0.0%	0.0%	0.0%
£30,000-34,999	0.0%	0.0%	100.0%	0.0%	0.0%
£35,000-39,999	0.0%	0.0%	0.0%	0.0%	0.0%
£40,000-45,000	0.0%	0.0%	0.0%	0.0%	0.0%
More than £45,000	100.0%	0.0%	0.0%	0.0%	100.0%
Total	100%	0%	100%	0%	100%

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

Pay scale	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
NHS or HSC Trust staff					
Band 2	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (66.7%)	0 (0.0%)
Band 3	0 (0.0%)	0 (0.0%)	1 (6.3%)	1 (33.3%)	0 (0.0%)
Band 4	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Band 5	4 (66.7%)	0 (0.0%)	4 (25.0%)	0 (0.0%)	0 (0.0%)
Band 6	0 (0.0%)	1 100.0%	6 (37.5%)	0 (0.0%)	1 (50.0%)
Band 7	2 (33.3%)	0 (0.0%)	2 (12.5%)	0 (0.0%)	0 (0.0%)
Band 8	0 (0.0%)	0 (0.0%)	3 (18.8%)	0 (0.0%)	1 (50.0%)
Total	6 (100%)	1 (100%)	16 (100%)	3 (100%)	2 (100%)
Other staff					
Less than £9,999	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (33.3%)	0 (0.0%)
£10,000-14,999	2 (33.3%)	0 (0.0%)	1 (5.6%)	1 (33.3%)	0 (0.0%)
£15,000-19,999	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (33.3%)	0 (0.0%)
£20,000-24,999	0 (0.0%)	0 (0.0%)	3 (16.7%)	0 (0.0%)	0 (0.0%)
£25,000-29,999	0 (0.0%)	0 (0.0%)	1 (5.6%)	0 (0.0%)	0 (0.0%)
£30,000-34,999	0 (0.0%)	1 (100.0%)	5 (27.8%)	0 (0.0%)	1 (50.0%)
£35,000-39,999	1 16.7%	0 (0.0%)	3 (16.7%)	0 (0.0%)	0 (0.0%)
£40,000-45,000	2 (33.3%)	0 (0.0%)	2 (11.1%)	0 (0.0%)	0 (0.0%)
More than £45,000	1 (16.7%)	0 (0.0%)	3 (16.7%)	0 (0.0%)	1 (50.0%)
Total	6 (100%)	1 (100%)	18 (100%)	3 (100%)	2 (100%)

A2.11 Respondents Redeployed due to COVID-19

Summary (Weighted results):

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

Summary (Unweighted results):

The vast majority of respondents were not redeployed due to COVID-19 (87.5%).

Figure A2.40: Redeployment by Country (Weighted)

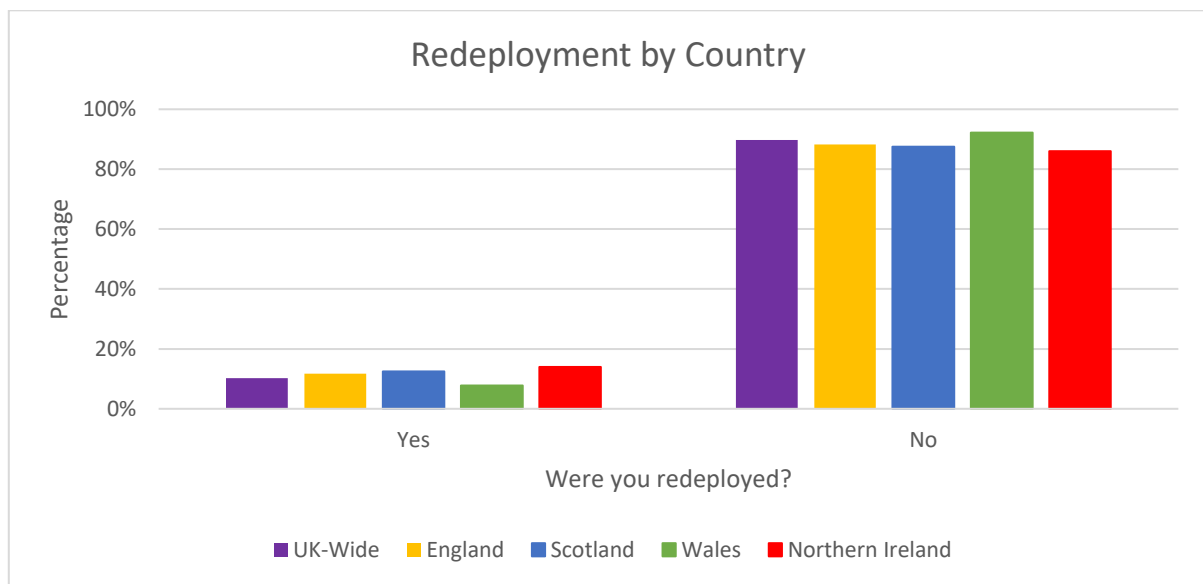


Figure A2.41: Redeployment by Country (Unweighted)

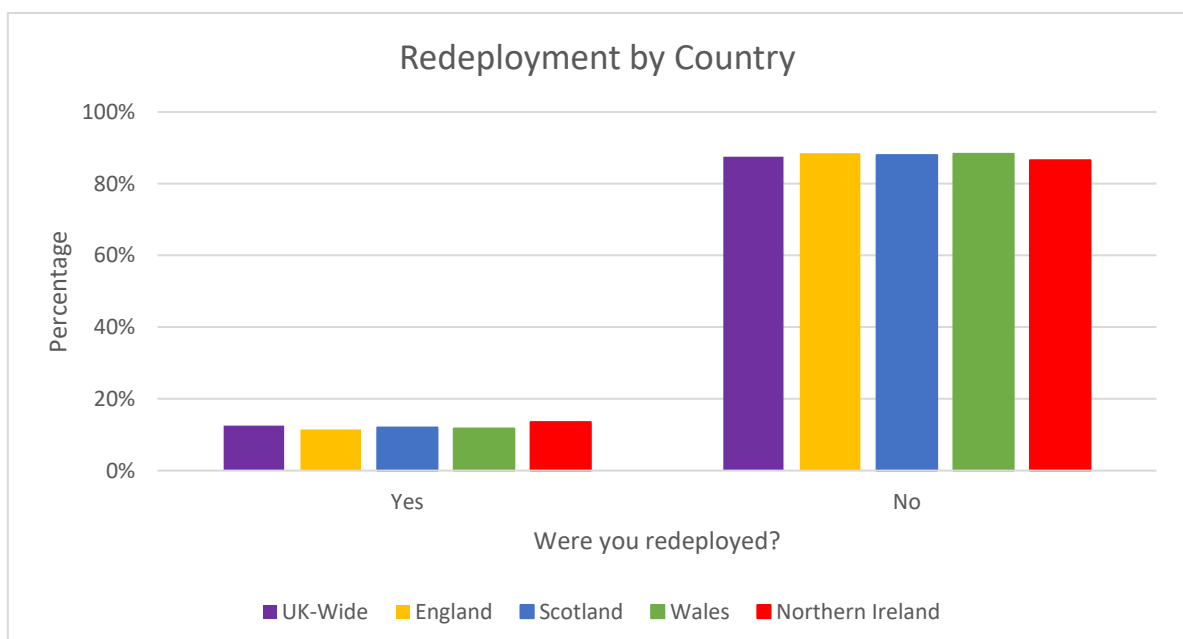


Table A2.40: Table A2.44: Redeployment by Country (Weighted)

Were you redeployed?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	10.2%	11.7%	12.5%	7.8%	14.0%
No	89.8%	88.3%	87.5%	92.2%	86.0%
Total	100%	100%	100%	100%	100%

Table A2.41: Redeployment by Country (Unweighted)

Were you redeployed?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	220 (12.5%)	43 (11.5%)	59 (12.0%)	11 (11.7%)	107 (13.5%)
No	1533 (87.5%)	331 (88.5%)	433 (88.0%)	83 (88.3%)	686 (86.5%)
Total	1754 (100%)	374 (100%)	492 (100%)	94 (100%)	793 (100%)

Figure A2.42: Redeployment by Occupation (Weighted)

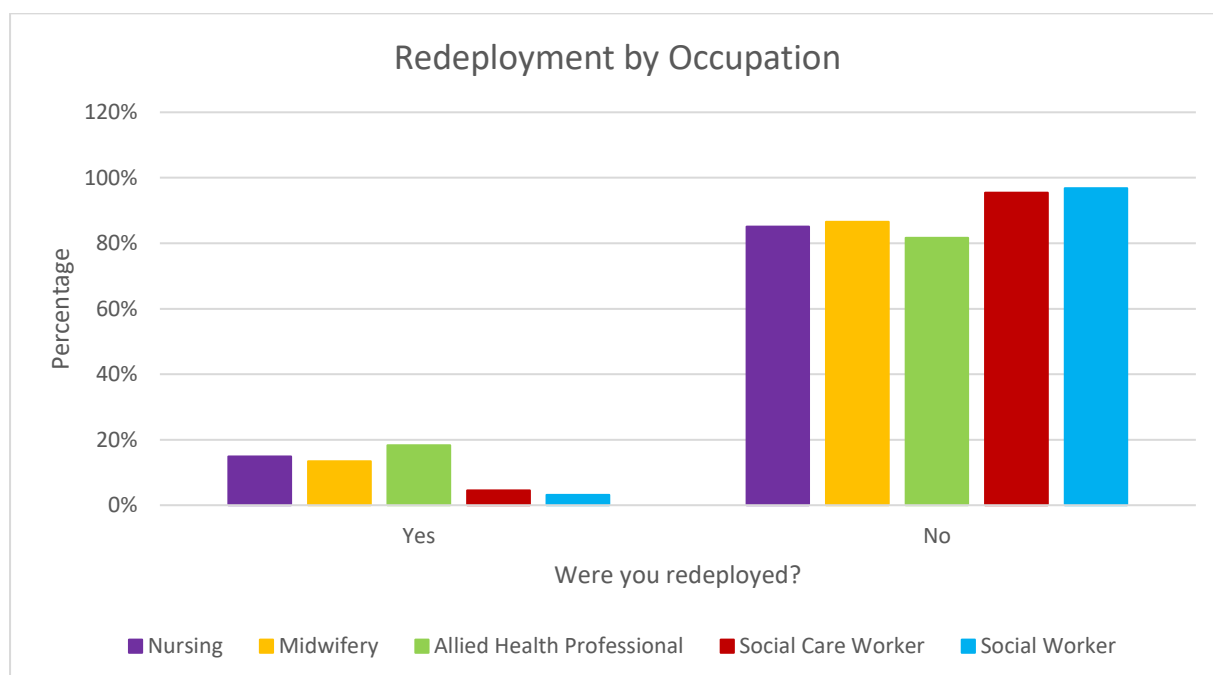


Figure A2.43: Redeployment by Occupation (Unweighted)

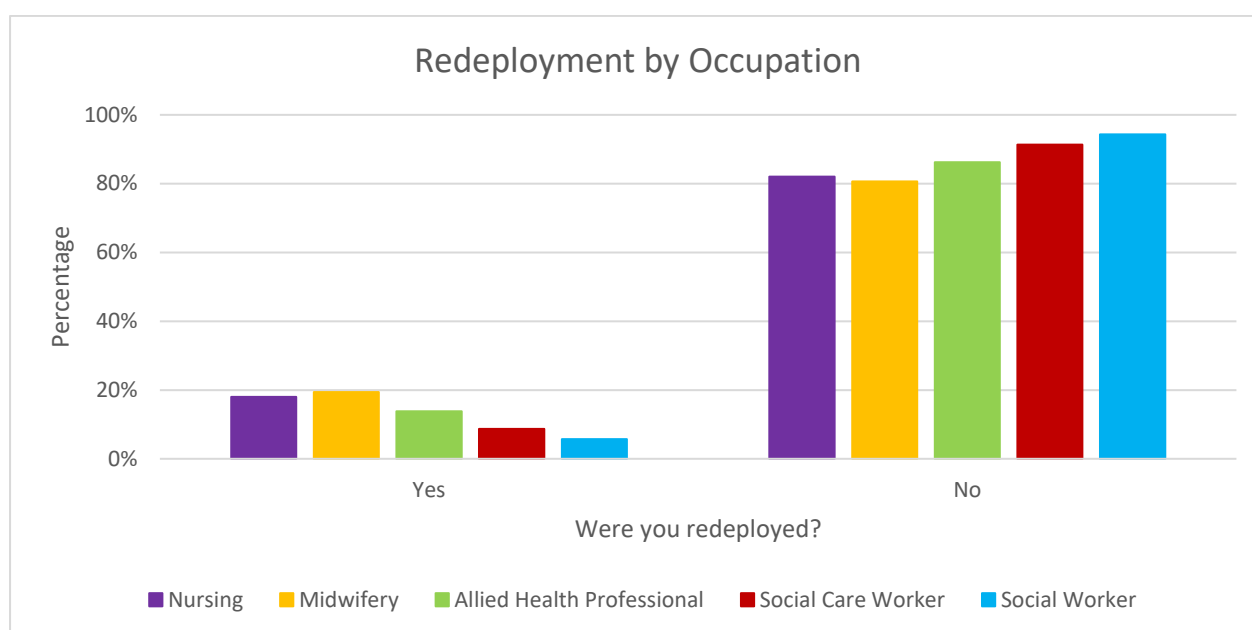


Table A2.42: Redeployment by Occupation (Weighted)

Occupation	Were you redeployed?		Total
	Yes	No	
Nursing	14.9%	85.1%	100%
Midwifery	13.4%	86.6%	100%
AHP	18.3%	81.7%	100%
Social Care Worker	4.5%	95.5%	100%
Social Worker	3.2%	96.8%	100%

Table A2.43: Redeployment by Occupation (Unweighted)

Occupation	Were you redeployed?		Total
	Yes	No	
Nursing	65 (18.0%)	296 (82.0%)	361 (100%)
Midwifery	27 (19.4%)	112 (80.6%)	139 (100%)
AHP	79 (13.8%)	493 (86.2%)	572 (100%)
Social Care Worker	29 (8.7%)	303 (91.3%)	332 (100%)
Social Worker	20 (5.7%)	329 (94.3%)	349 (100%)

A2.12 Preparedness of Redeployed Respondents

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

Summary (Weighted results):

Overall, respondents from Northern Ireland felt the least prepared. Nurses were most likely to report that they felt unprepared.

Summary (Unweighted results):

Under 20 per cent of respondents UK-Wide (19.1%) felt well prepared for redeployment. Just under half of Welsh respondents felt neither prepared nor not prepared (45.9%). Overall, respondents from Northern Ireland felt the least prepared. Social care workers were most likely to report that they felt unprepared.

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

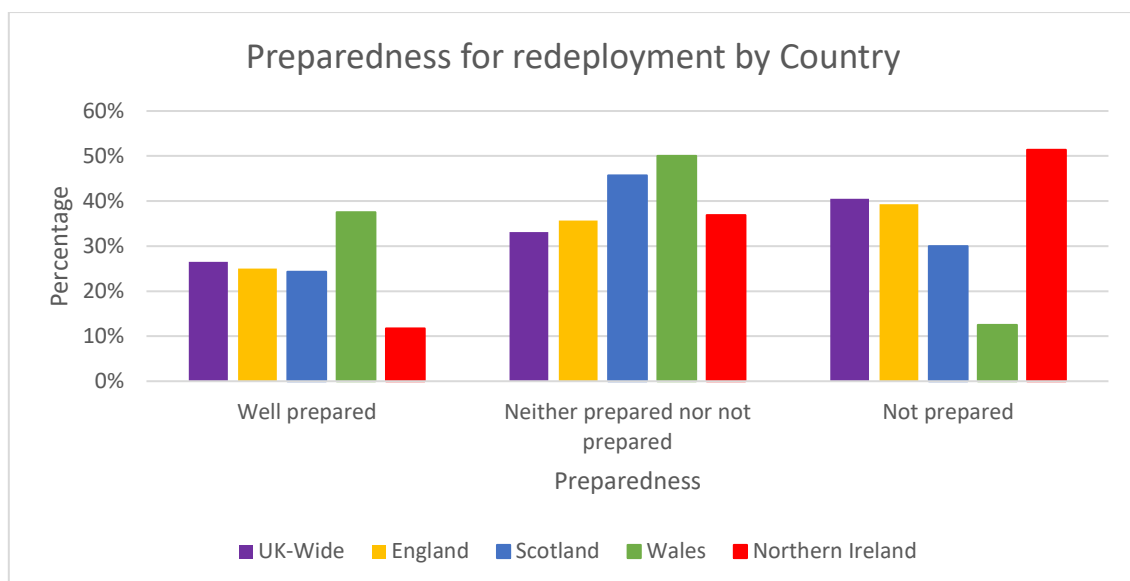


Figure A2.45: Preparedness for Redeployment by Country (Unweighted)

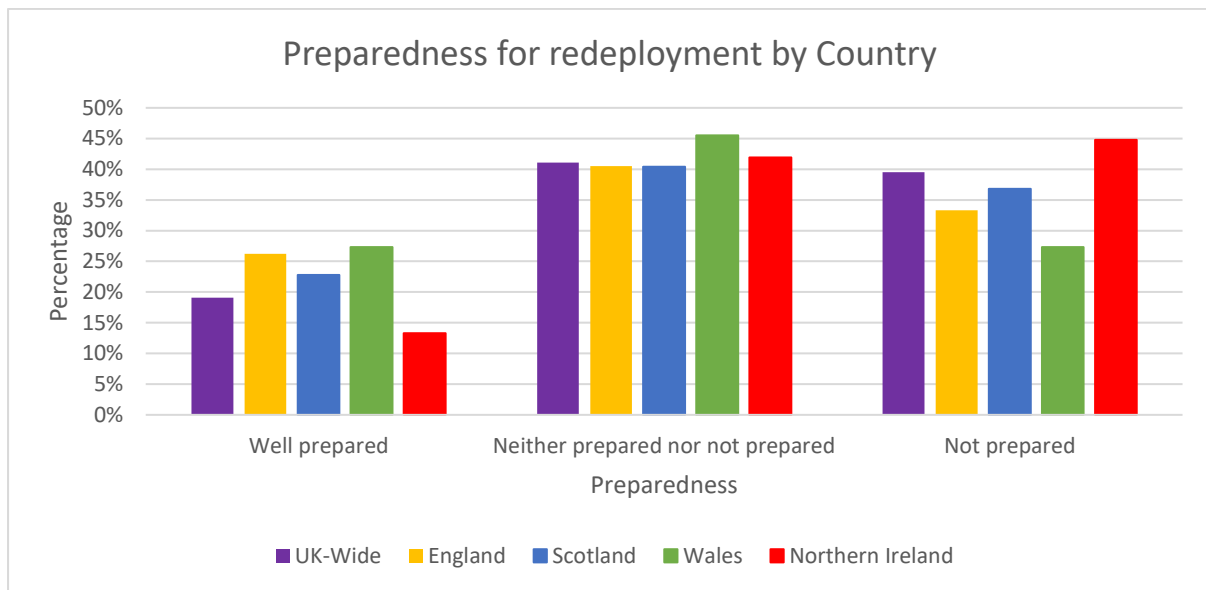


Table A2.44: Preparedness for Redeployment by Country (Weighted)

Preparedness for redeployment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	26.5%	25.0%	24.3%	37.5%	11.7%
Neither prepared nor not prepared	33.1%	35.7%	45.7%	50.0%	36.9%
Not prepared	40.5%	39.3%	30.0%	12.5%	51.4%
Total	100%	100%	100%	100%	100%

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

Preparedness for redeployment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	41 (19.1%)	11 (26.2%)	13 (22.8%)	3 (27.3%)	14 (13.3%)
Neither prepared nor not prepared	89 (41.1%)	17 (40.5%)	23 (40.4%)	5 (45.5%)	44 (41.9%)
Not prepared	85 (39.5%)	14 (33.3%)	21 (36.8%)	3 (27.3%)	47 (44.8%)
Total	1543 (100%)	42 (100%)	57 (100%)	11 (100%)	105 (100%)

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

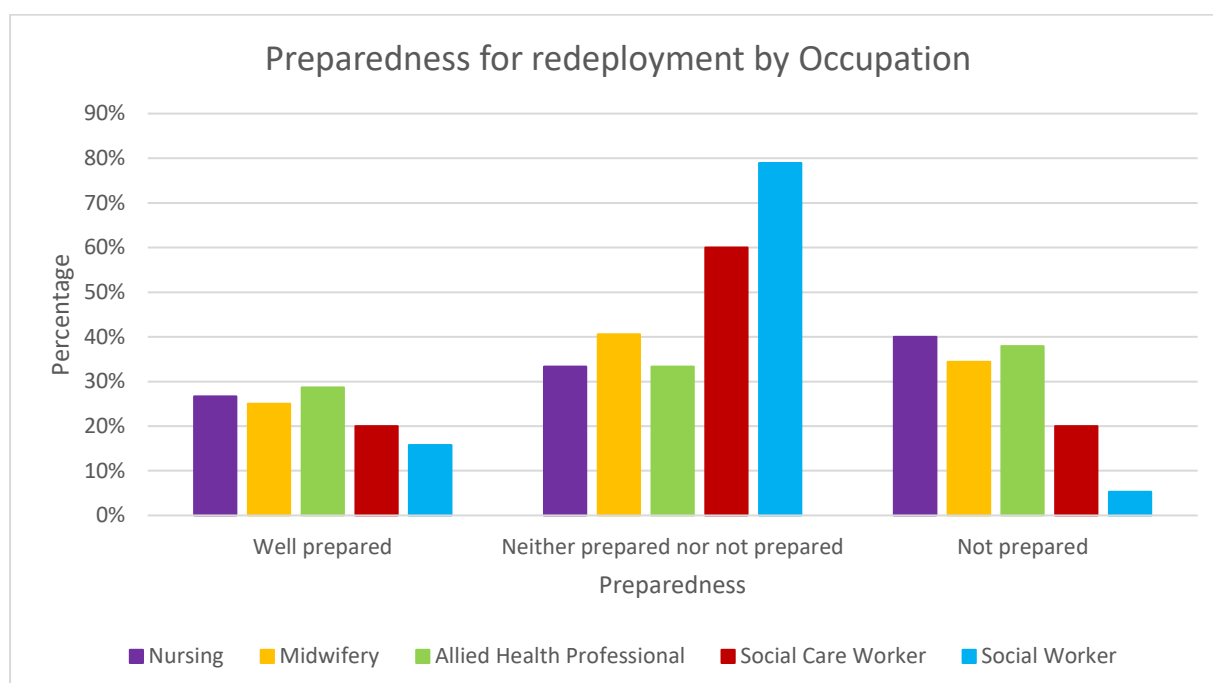


Figure A2.47: Preparedness for Redeployment by Occupation (Unweighted)

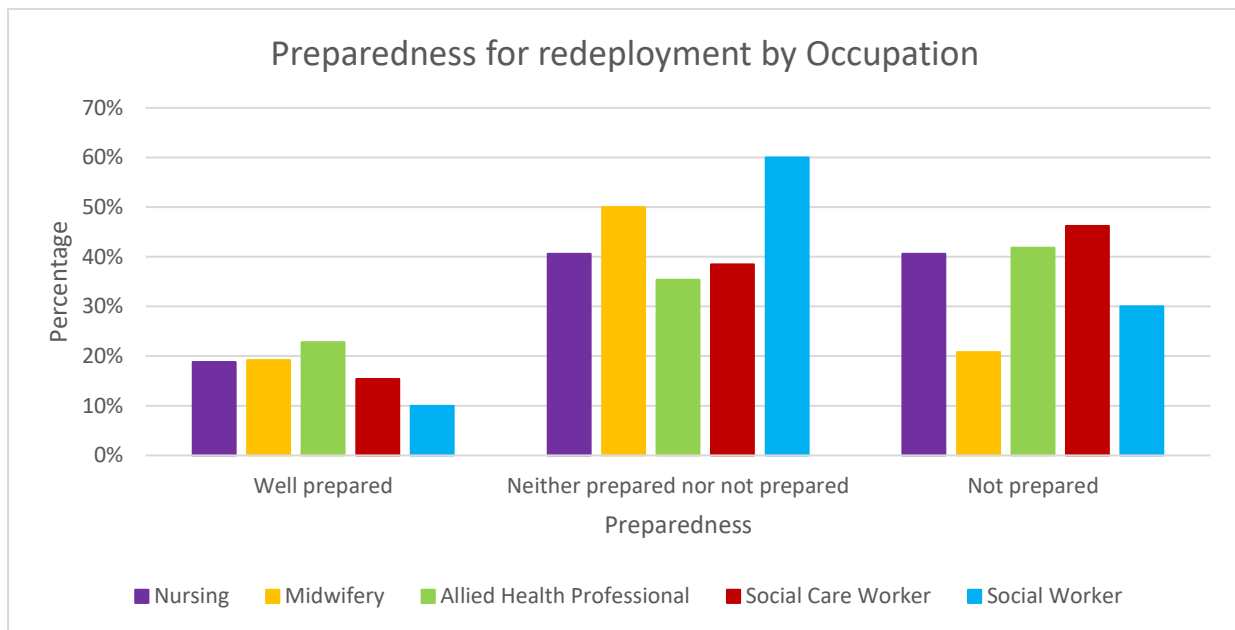


Table A2.46: Preparedness for Redeployment by Occupation (Weighted)

Occupation	Preparedness for redeployment			Total
	Well prepared	Neither prepared nor not prepared	Not prepared	
Nursing	26.7%	33.3%	40.0%	100%
Midwifery	25.0%	40.6%	34.4%	100%
AHP	28.7%	33.3%	37.9%	100%
Social Care Worker	20.0%	60.0%	20.0%	100%
Social Worker	15.8%	78.9%	5.3%	100%

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

Occupation	Preparedness for redeployment			Total
	Well prepared	Neither prepared nor not prepared	Not prepared	
Nursing	12 (18.8%)	26 (40.6%)	26 (40.6%)	64 (100%)
Midwifery	5 (19.2%)	13 (50.0%)	8 (20.8%)	26 (100%)
AHP	18 (22.8%)	28 (35.4%)	33 (41.8%)	79 (100%)
Social Care Worker	4 (15.4%)	10 (38.5%)	12 (46.2%)	26 (100%)
Social Worker	2 (10.0%)	12 (60.0%)	6 (30.0%)	20 (100%)

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

Summary (Weighted results):

UK-wide, only 1.4% of respondents came out of retirement to support the workforce during the COVID-19 pandemic, and these were either nurses, midwives or AHPs.

Summary (Unweighted results):

UK-wide, only 1.0% of respondents came out of retirement to support the workforce during the COVID-19 pandemic.

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



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

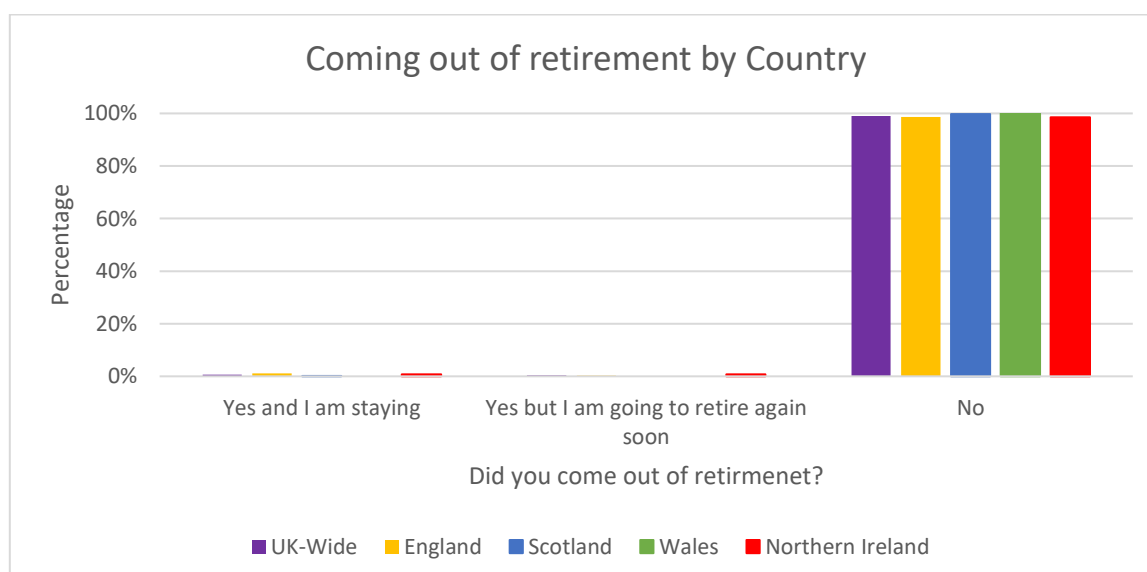


Table A2.48: Coming out of Retirement to Support the Workforce by Country (Weighted)

Did you come out of retirement?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	1.3%	1.6%	0.0%	0.0%	0.9%
No	0.1%	0.0%	0.0%	0.0%	1.2%
Total	100%	100%	100%	100%	100%

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

Did you come out of retirement?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes and I am staying	11 (0.6%)	4 (1.1%)	1 (0.2%)	(0.0%)	6 (0.8%)
Yes but I am going to retire again soon	7 (0.4%)	1 (0.3%)	0 (0.0%)	0 (0.0%)	6 (0.8%)
No	1728 (99.0%)	367 (98.7%)	489 (99.8%)	94 (100.0%)	779 (98.5%)
Total	1746 (100%)	535 (100%)	734 (100%)	318 (100%)	1109 (100%)

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

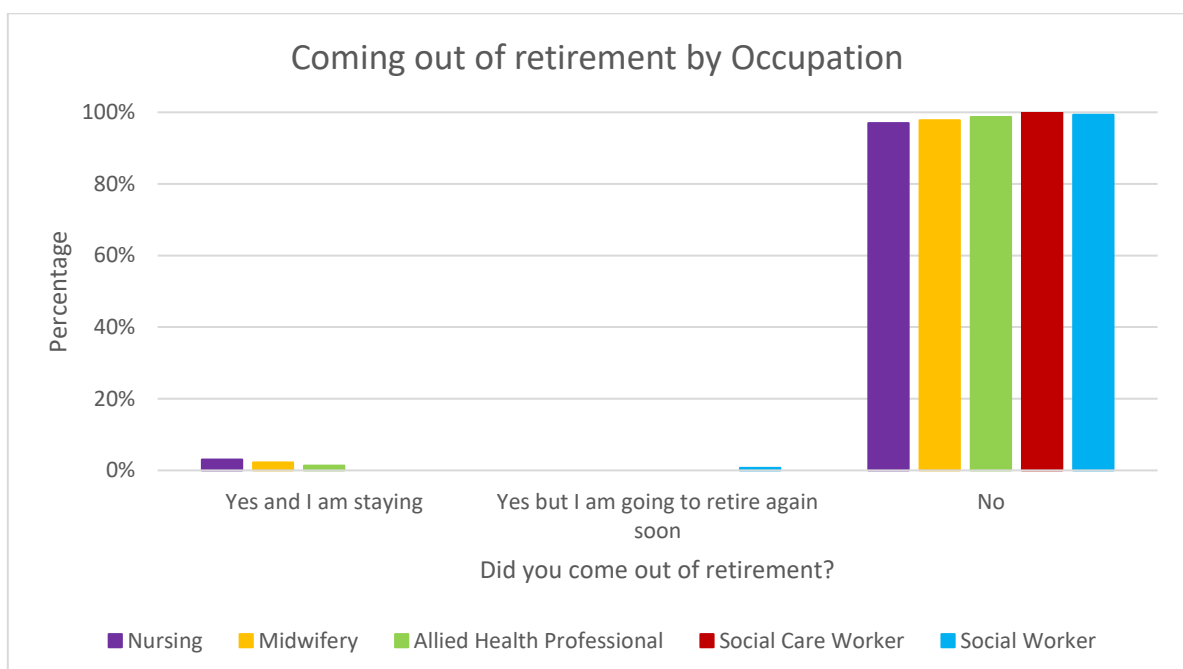


Figure A2.51: Coming out of Retirement to Support the Workforce by Occupation (Unweighted)



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

Occupation	Did you come out of retirement?		Total
	Yes	No	
Nursing	3.0%	0.0%	100%
Midwifery	2.2%	0.0%	100%
AHP	1.3%	0.0%	100%
Social Care Worker	0.0%	0.0%	100%
Social Worker	0.0%	0.7%	100%

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

Occupation	Did you come out of retirement?			Total
	Yes and I am staying	Yes but I am going to retire again soon	No	
Nursing	4 (1.1%)	3 (0.8%)	351 (98.0%)	358 (100%)
Midwifery	3 (2.2%)	0 (0.0%)	135 (97.8%)	138 (100%)
AHP	3 (0.5%)	0 (0.0%)	569 (99.5%)	572 (100%)
Social Care Worker	1 (0.3%)	2 (0.6%)	327 (99.1%)	330 (100%)
Social Worker	0 (0.0%)	2 (0.6%)	346 (99.4%)	348 (100%)

A2.14 Job Tenure of Respondents

Summary (Weighted results):

The majority of respondents were employed on a permanent basis.

Summary (Unweighted results):

The majority of respondents were employed on a permanent basis.

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

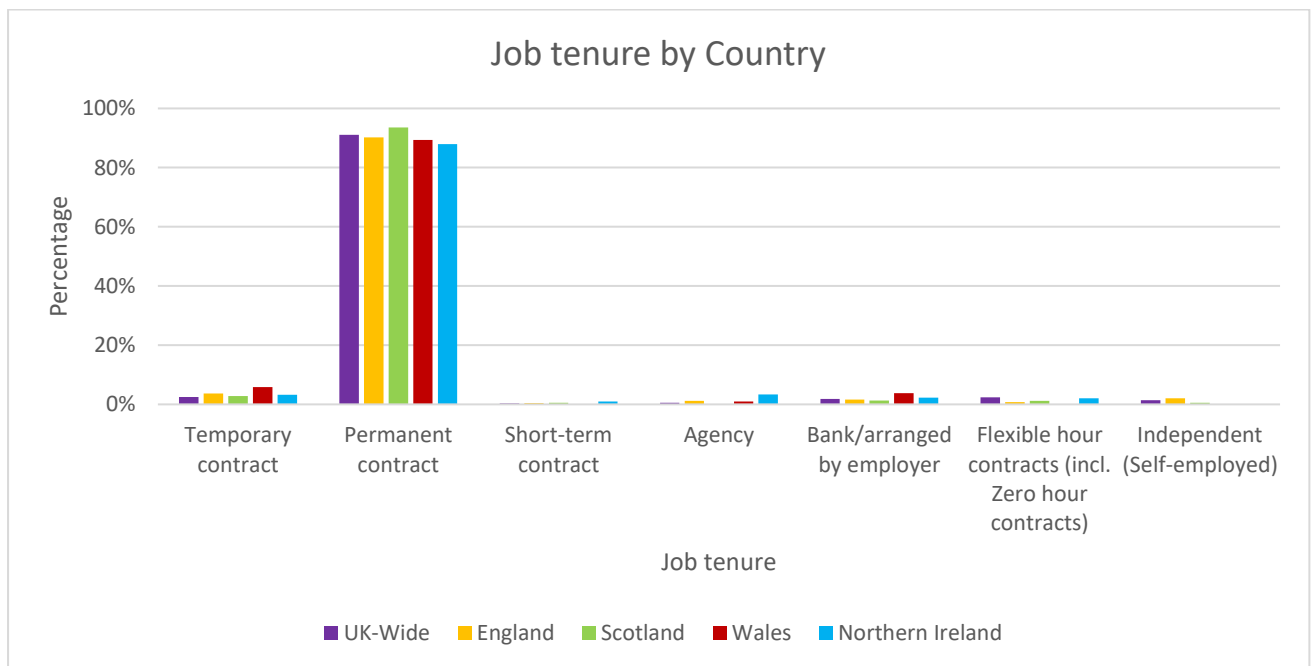


Figure A2. 53: Job Tenure by Country (Unweighted)

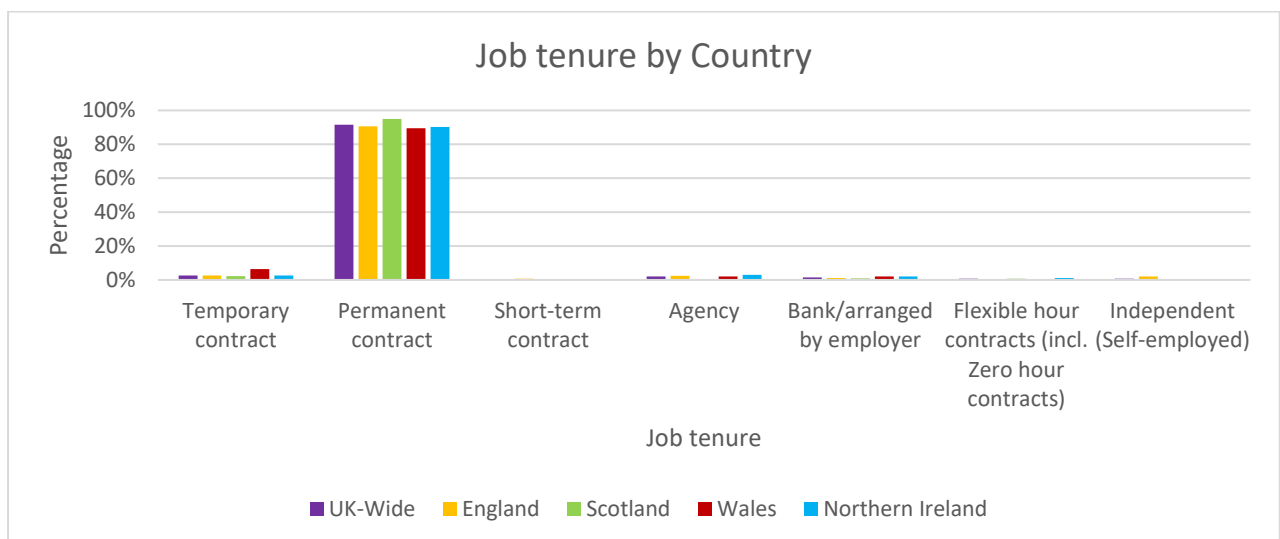


Table A2.52: Job Tenure by Country (Weighted)

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary	2.5%	3.7%	2.8%	5.8%	3.2%
Permanent	91.1%	90.2%	93.6%	89.4%	87.9%
Agency	0.3%	0.4%	0.5%	0.0%	1.0%
Bank	0.5%	1.2%	0.0%	1.0%	3.3%
Independent (Self-employed)	1.8%	1.6%	1.3%	3.8%	2.3%
Total	100%	100%	100%	100%	100%

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

Job tenure	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary contract	48 (2.7%)	10 (2.7%)	11 (2.2%)	6 (6.3%)	21 (2.7%)
Permanent contract	1603 (91.6%)	338 (90.6%)	466 (94.9%)	85 (89.5%)	714 (90.3%)
Short-term contract	9 (0.5%)	3 (0.8%)	2 (0.4%)	0 (0.0%)	4 (0.5%)
Agency	35 (2.0%)	9 (2.4%)	0 (0.0%)	2 (2.1%)	24 (3.0%)
Bank/arranged by employer	27 (1.5%)	4 (1.1%)	5 (1.0%)	2 (2.1%)	16 (2.0%)
Flexible hour contracts (incl. Zero hour contracts)	14 (0.8%)	1 (0.3%)	4 (0.8%)	0 (0.0%)	9 (1.1%)
Independent (Self-employed)	14 (0.8%)	8 (2.1%)	3 (0.6%)	0 (0.0%)	3 (0.4%)
Total	1750 (100%)	373 (100%)	491 (100%)	95 (100%)	791 (100%)

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

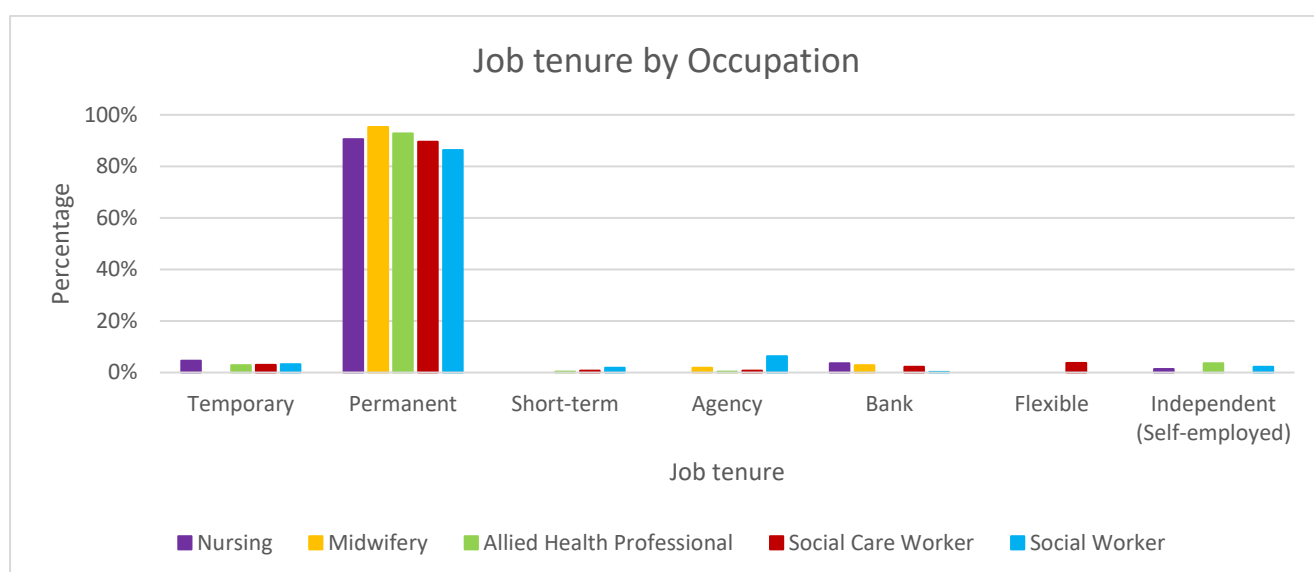


Figure A2.55: Job Tenure by Occupation (Unweighted)

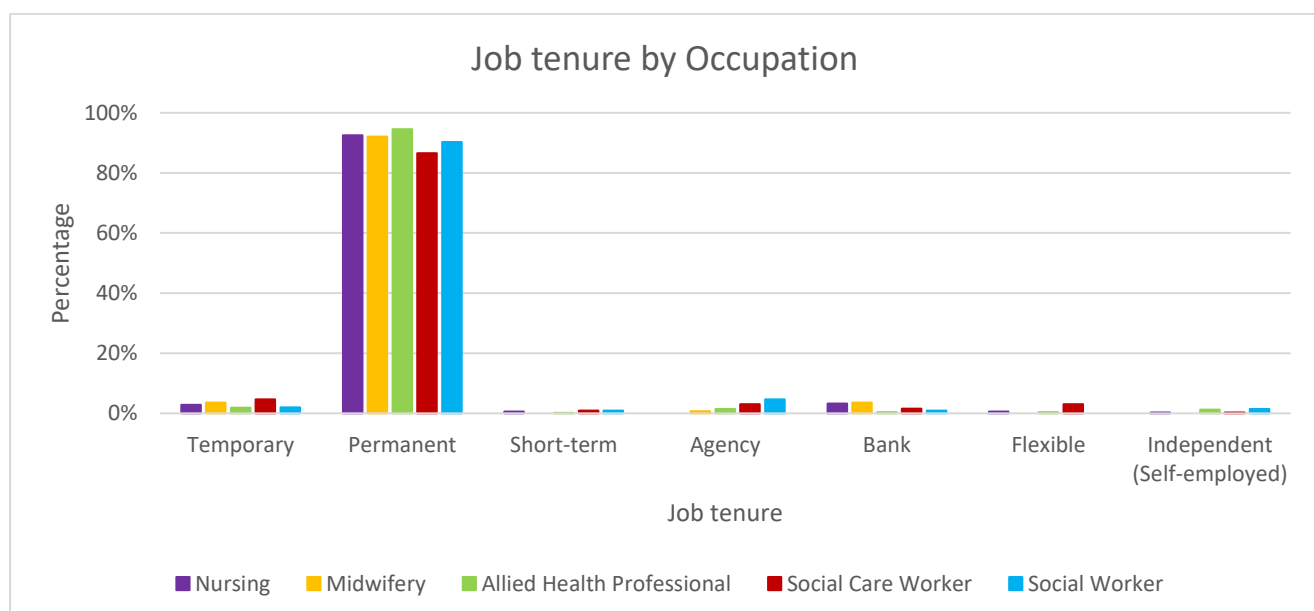


Table A2.54: Job Tenure by Occupation (Weighted)

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	4.6%	90.5%	0.0%	0.0%	3.6%	0.0%	1.3%	100%
Midwifery	0.0%	95.3%	0.0%	1.8%	2.9%	0.0%	0.0%	100%
AHP	2.8%	92.8%	0.4%	0.4%	0.0%	0.0%	3.6%	100%
Social Care Worker	3.0%	89.6%	0.7%	0.7%	2.2%	3.7%	0.0%	100%
Social Worker	3.2%	86.3%	1.8%	6.3%	0.2%	0.0%	2.2%	100%

Table A2.55: 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	10 (2.8%)	324 (92.5%)	2 (0.6%)	0 (0.0%)	12 (3.3%)	2 (0.6%)	1 (0.3%)	361 (100%)
Midwifery	5 (3.6%)	129 (92.1%)	0 (0.0%)	1 (0.7%)	5 (3.6%)	0 (0.0%)	0 (0.0%)	140 (100%)
AHP	11 (1.9%)	540 (94.6%)	1 (0.2%)	8 (1.4%)	2 (0.4%)	2 (0.4%)	7 (1.2%)	571 (100%)
Social Care Worker	15 (4.6%)	285 (86.6%)	3 (0.9%)	10 (3.0%)	5 (1.5%)	10 (3.0%)	1 (0.3%)	329 (100%)
Social Worker	7 (2.0%)	315 (90.3%)	3 (0.9%)	16 (4.6%)	3 (0.9%)	0 (0.0%)	5 (1.4%)	349 (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 Wales. Of those with more than 30 years of experience, the majority were nurses.

Summary (Unweighted results):

Almost one third of respondents UK-wide (27.6%) reported having between 11-20 years of work experience. The highest proportion of these were in Northern Ireland. Of those with more than 30 years of experience, the majority were nurses and midwives.

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

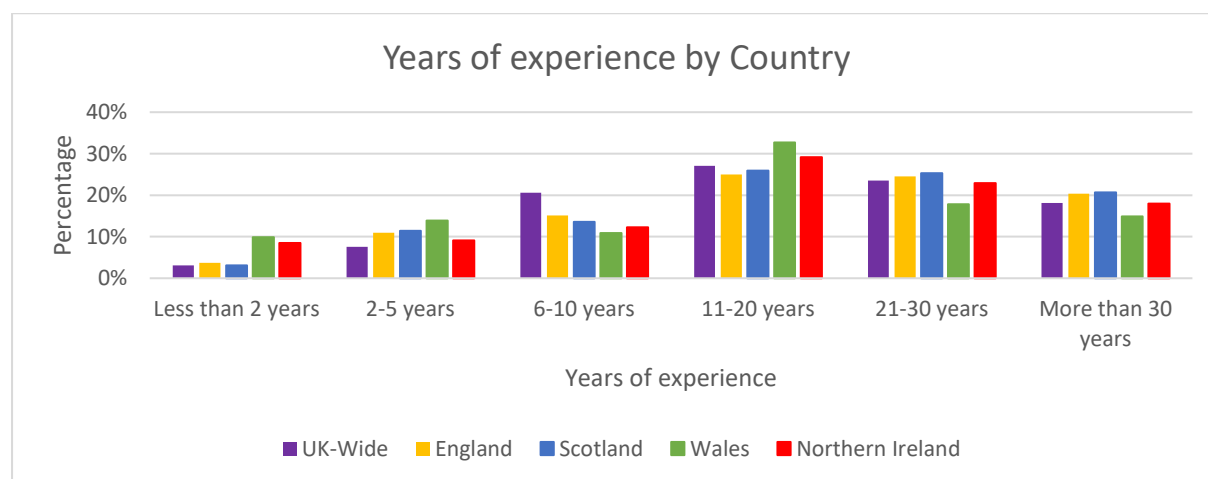


Figure A2.57: Years of Experience by Country (Unweighted)

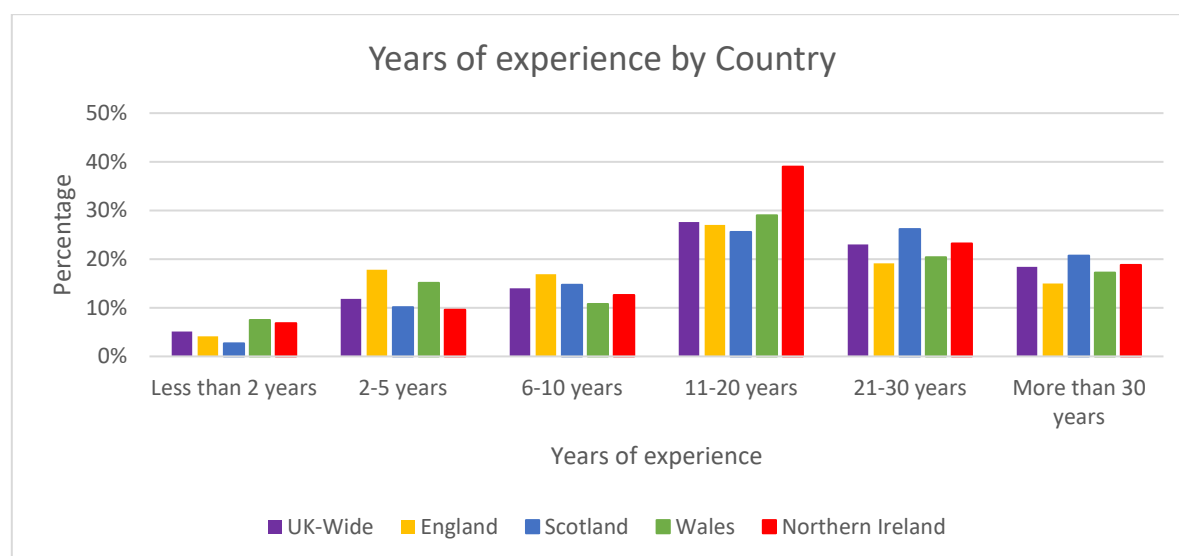


Table A2.56: Years of Experience by Country (Weighted)

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	3.1%	3.7%	3.1%	9.9%	8.5%
2-5 years	7.6%	11.0%	11.4%	13.9%	9.1%
6-10 years	20.6%	15.1%	13.6%	10.9%	12.3%
11-20 years	27.1%	25.0%	25.9%	32.7%	29.2%
21-30 years	23.5%	24.5%	25.3%	17.8%	22.9%
More than 30 years	18.1%	20.4%	20.7%	14.9%	18.0%
Total	100%	100%	100%	100%	100%

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

Years of experience	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	87 (5.1%)	15 (4.1%)	13(2.7%)	7 (7.5%)	52 (6.8%)
2-5 years	202 (11.8%)	65 (17.8%)	49 (10.1%)	14 (15.1%)	74 (9.6%)
6-10 years	240 (14.0%)	62 (16.9%)	71 (14.7%)	10 (10.8%)	97 (12.6%)
11-20 years	473 (27.6%)	99 (27.0%)	124 (25.6%)	27 (29.0%)	223 (39.0%)
21-30 years	394 (23.0%)	70 (19.1%)	127 (26.2%)	19 (20.4%)	178 (23.2%)
More than 30 years	315 (18.4%)	55 (15.0%)	100 (20.7%)	16 (17.2%)	144 (18.8%)
Total	1711 (100%)	366 (100%)	484 (100%)	93 (100%)	768 (100%)

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

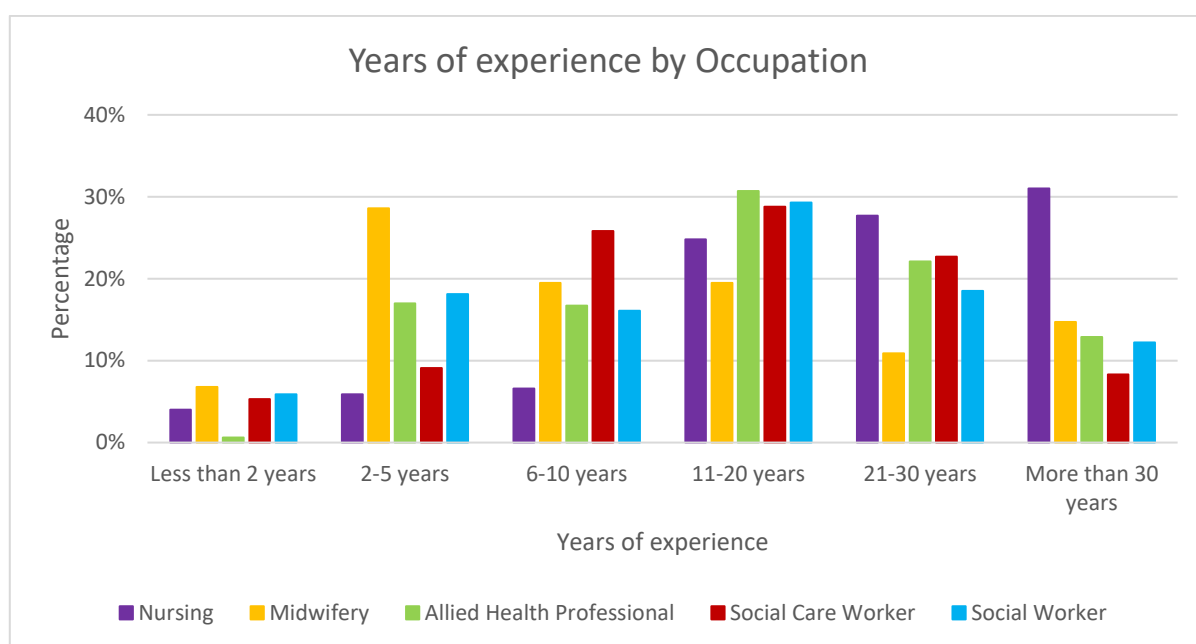


Figure A2.59: Years of Experience by Occupation (Unweighted)

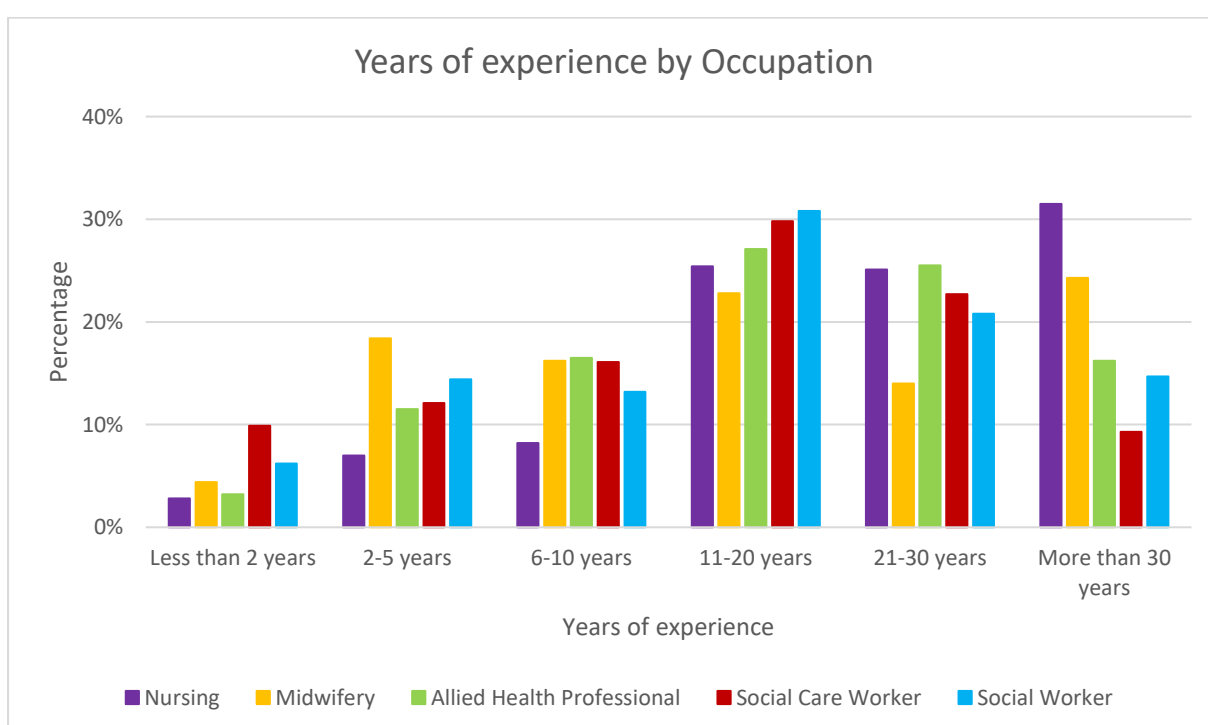


Table A2.58: Years of Experience by Occupation (Weighted)

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	4.0%	5.9%	6.6%	24.8%	27.7%	31.0%	100%
Midwifery	6.8%	28.6%	19.5%	19.5%	10.9%	14.7%	100%
AHP	0.6%	17.0%	16.7%	30.7%	22.1%	12.9%	100%
Social Care Worker	5.3%	9.1%	25.8%	28.8%	22.7%	8.3%	100%
Social Worker	5.9%	18.1%	16.1%	29.3%	18.5%	12.2%	100%

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

Occupation	Years of experience						Total
	Less than 2 years	2-5 years	6-10 years	11-20 years	21-30 years	More than 30 years	
Nursing	10 (2.8%)	25 (7.0%)	29 (8.2%)	90 (25.4%)	89 (25.1%)	112 (31.5%)	355 (100%)
Midwifery	6 (4.4%)	25 (18.4%)	22 (16.2%)	31 (22.8%)	19 (14.0%)	33 (24.3%)	136 (100%)
AHP	18 (3.2%)	64 (11.5%)	92 (16.5%)	151 (27.1%)	142 (25.5%)	90 (16.2%)	557 (100%)
Social Care Worker	32 (9.9%)	39 (12.1%)	52 (16.1%)	96 (29.8%)	73 (22.7%)	30 (9.3%)	322 (100%)
Social Worker	21 (6.2%)	49 (14.4%)	45 (13.2%)	105 (30.8%)	71 (20.8%)	50 (14.7%)	341 (100%)

A2.16 Respondents' Main Area of Practice

Summary (Weighted results):

Older people was the most frequently reported area of practice by respondents.

Summary (Unweighted results):

Older people and Other were the most frequently reported areas of practice by respondents.

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

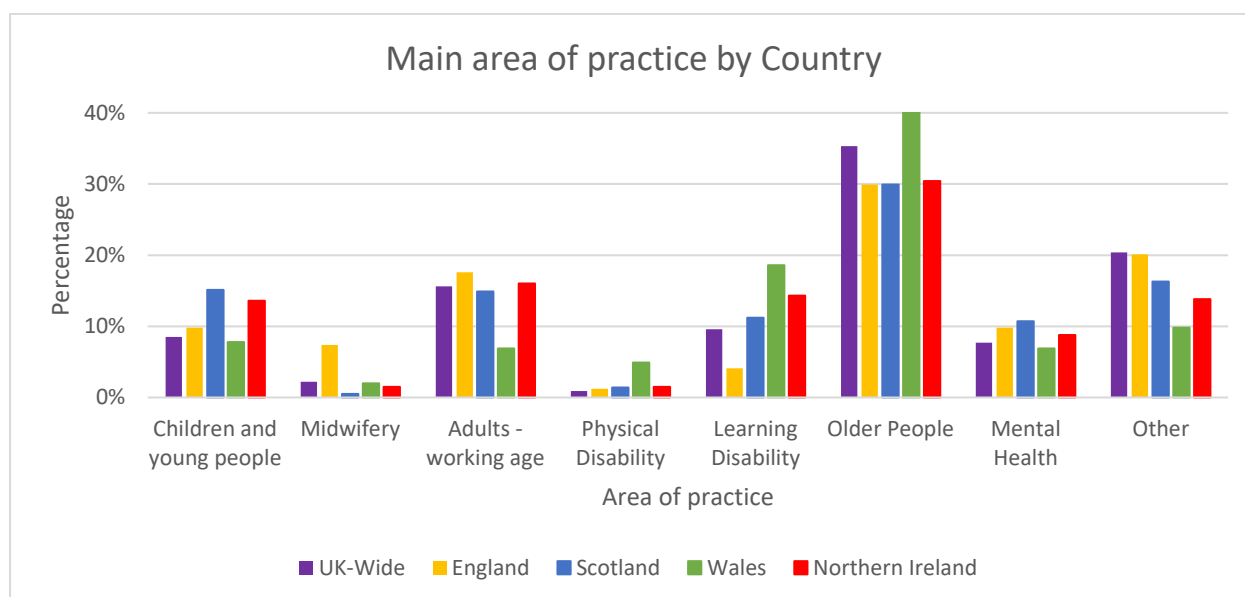


Figure A2.61: Main Area of Practice by Country (Unweighted)

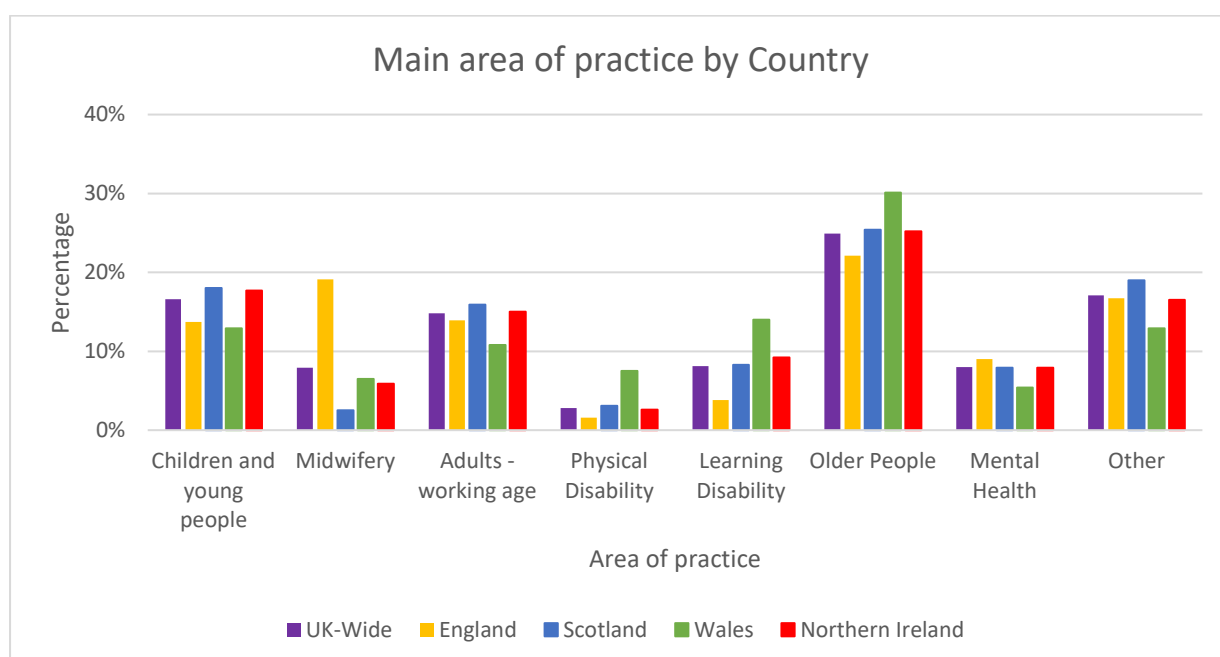


Table A2.60: Main Area of Practice by Country (Weighted)

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	8.5%	9.8%	15.1%	7.8%	13.6%
Midwifery	2.2%	7.4%	0.5%	2.0%	1.5%
Adults	15.6%	17.6%	14.9%	6.9%	16.0%
Physical Disability	0.9%	1.2%	1.4%	4.9%	1.5%
Learning Disability	9.6%	4.1%	11.2%	18.6%	14.3%
Older People	35.3%	29.9%	29.9%	43.1%	30.4%
Mental Health	7.7%	9.8%	10.7%	6.9%	8.8%
Other	20.4%	20.1%	16.3%	9.8%	13.8%
Total	100%	100%	100%	100%	100%

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

Main area of practice	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	285 (16.6%)	50 (13.7%)	87 (18.0%)	12 (12.9%)	136 (17.7%)
Midwifery	133 (7.9%)	70 (19.1%)	12 (2.5%)	6 (6.5%)	45 (5.9%)
Adults	253 (14.8%)	51 (13.9%)	77 (15.9%)	10 (10.8%)	115 (15.0%)
Physical Disability	48 (2.8%)	6 (1.6%)	15 (3.1%)	7 (7.5%)	20 (2.6%)
Learning Disability	138 (8.1%)	14 (3.8%)	40 (8.3%)	13 (14.0%)	71 (9.2%)
Older People	426 (24.9%)	81 (22.1%)	123 (25.4%)	28 (30.1%)	194 (25.2%)
Mental Health	137 (8.0%)	38 (9.0%)	38 (7.9%)	5 (5.4%)	61 (7.9%)
Other	292 (17.1%)	61 (16.7%)	92 (19.0%)	12 (12.9%)	127 (16.5%)
Total	1712 (100%)	366 (100%)	484 (100%)	93 (100%)	769 (100%)

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

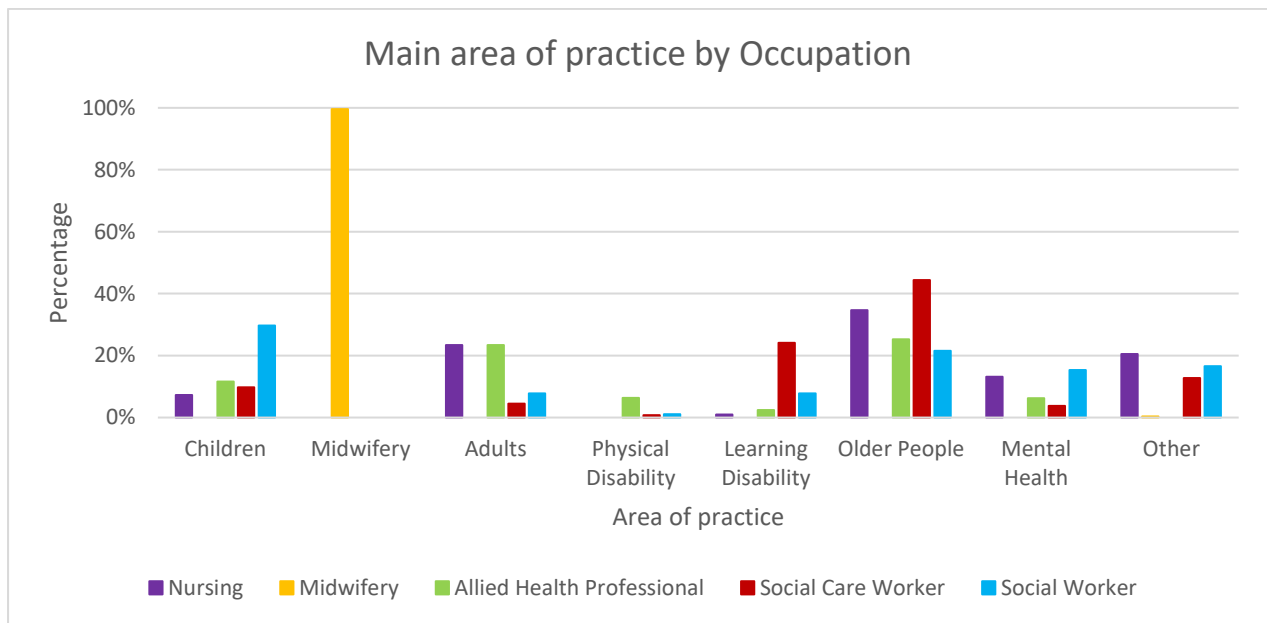


Figure A2.63: Main Area of Practice by Occupation (Unweighted)

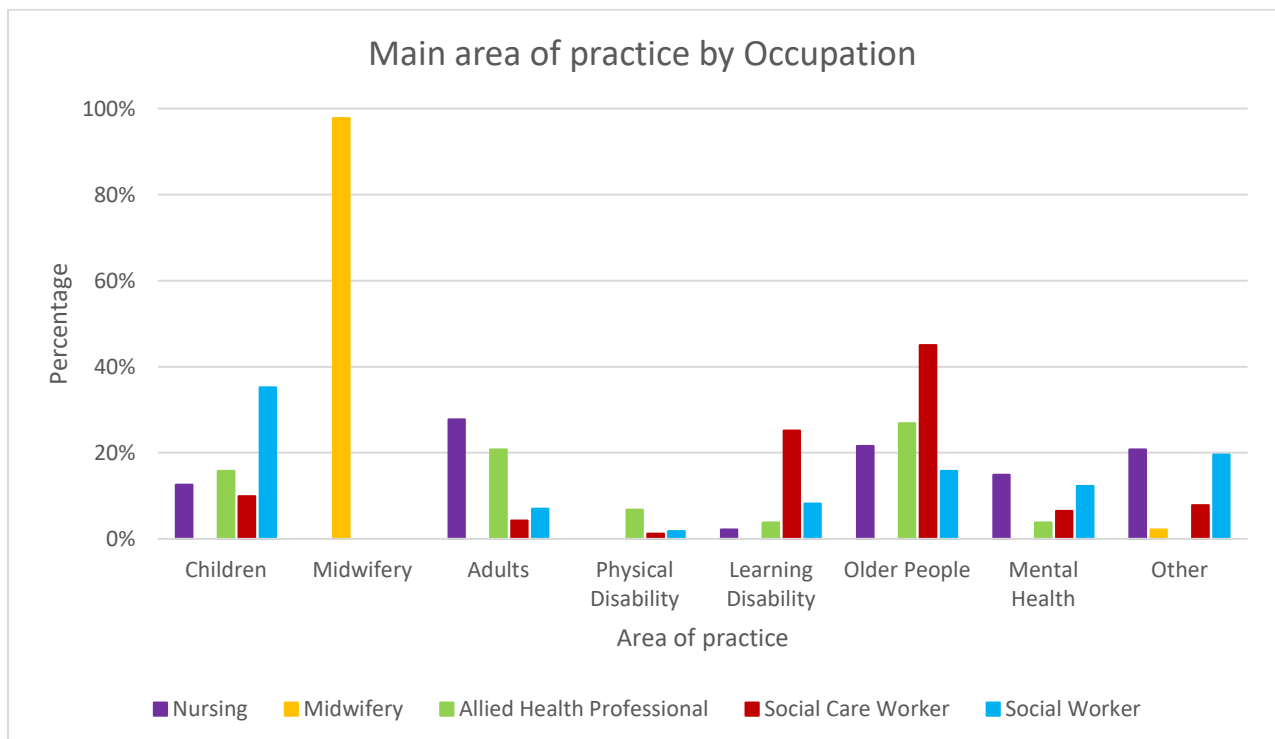


Table A2 62: Main Area of Practice by Occupation (Weighted)

Main area of practice	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Children	7.3%	0.0%	11.6%	9.8%	29.7%
Midwifery	0.0%	99.6%	0.0%	0.0%	0.0%
Adults	23.4%	0.0%	23.4%	4.5%	7.8%
Physical Disability	0.0%	0.0%	6.4%	0.8%	1.1%
Learning Disability	1.0%	0.0%	2.4%	24.1%	7.8%
Older People	34.7%	0.0%	25.3%	44.4%	21.5%
Mental Health	13.2%	0.0%	6.2%	3.8%	15.3%
Other	20.5%	0.4%	24.7%	12.8%	16.6%
Total	100%	100%	100%	100%	100%

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

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

A2.17 Respondents Employed Full- or Part-Time

Summary (Weighted results):

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

Summary (Unweighted results):

The majority of respondents were employed full-time (74.9%). Scotland had the highest proportion of respondents (31.9%) employed on a part-time basis. Social workers had the highest proportion employed full-time, whereas nurses had the highest proportion employed part-time.

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

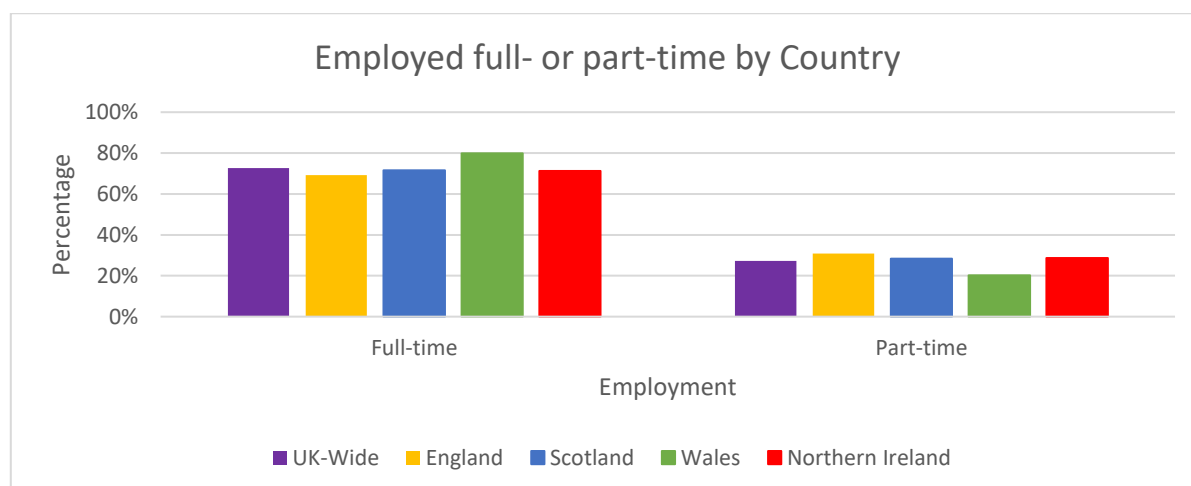


Figure A2.65: Employed Full- or Part-Time by Country (Unweighted)

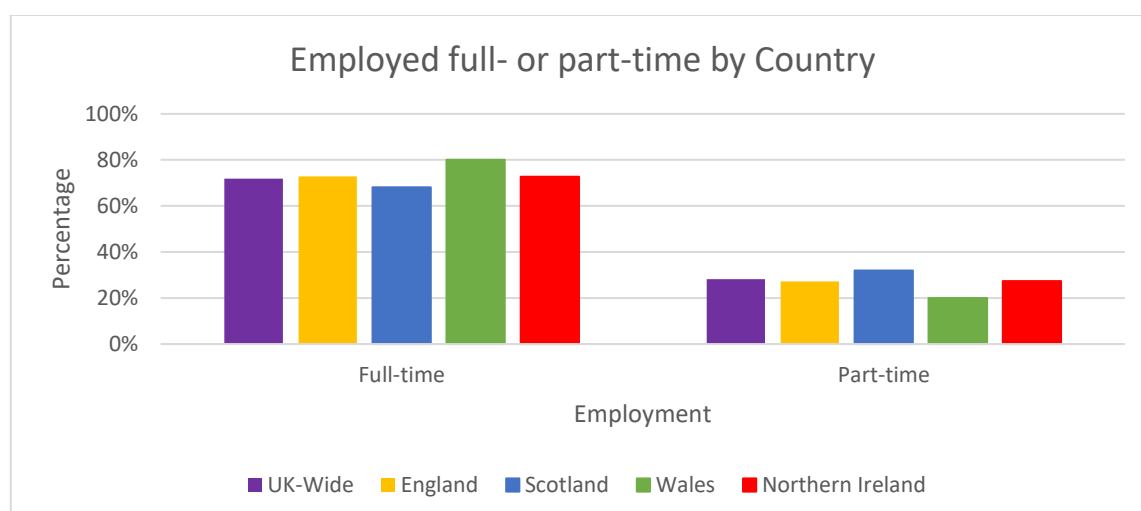


Table A2.64: Employed Full- or Part-Time by Country (Weighted)

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	72.7%	69.2%	71.6%	79.8%	71.3%
Part-time	27.3%	30.8%	28.4%	20.2%	28.7%
Total	100%	100%	100%	100%	100%

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

Employment	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Full-time	1262 (71.8%)	273 (72.8%)	335 (68.1%)	76 (80.0%)	578 (72.7%)
Part-time	495 (28.2%)	102 (27.2%)	157 (31.9%)	19 (20.0%)	217 (27.3%)
Total	1757 (100%)	100%	100%	100%	100%

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

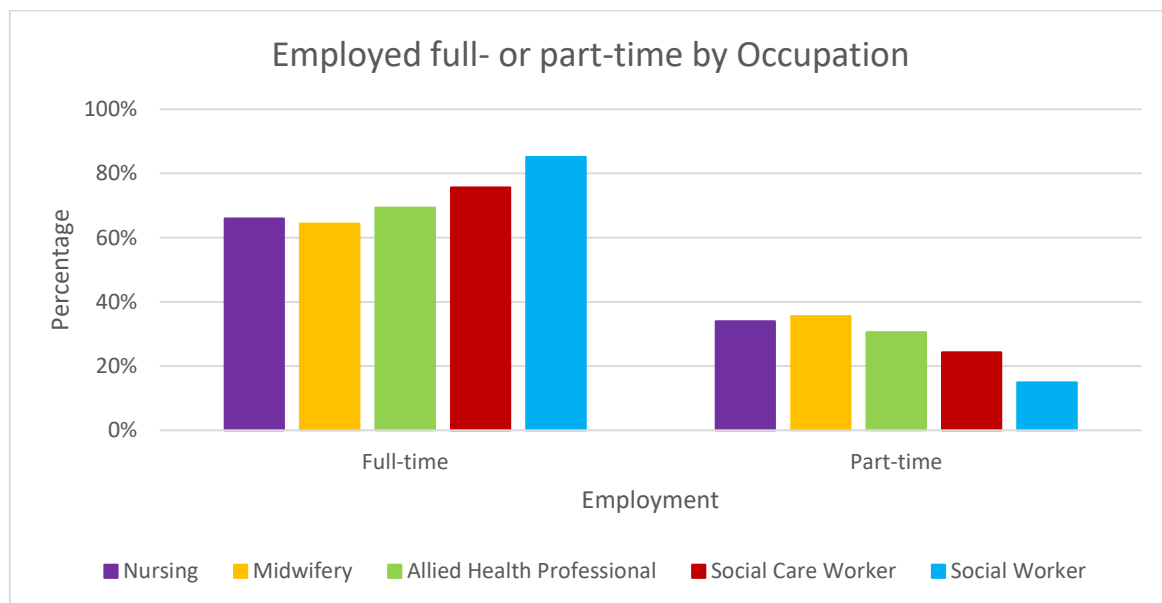


Figure A2.67: Employed Full- or Part-Time by Occupation (Unweighted)

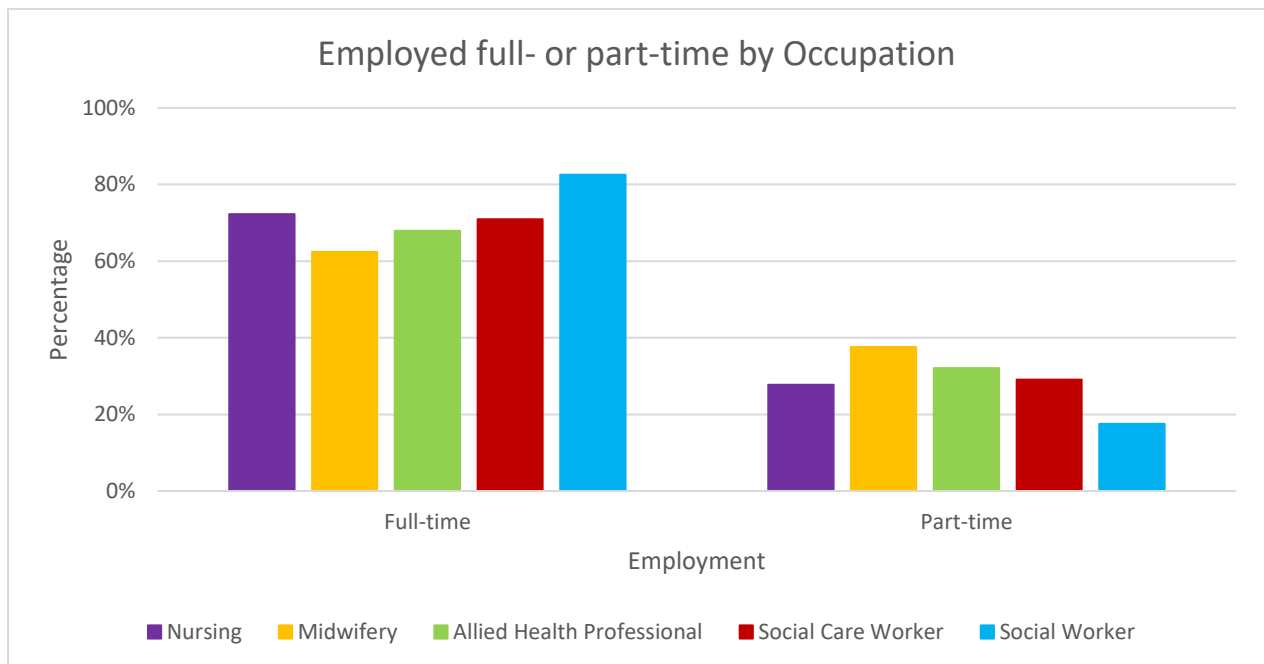


Table A2.66: Employed Full- or Part-Time by Occupation (Weighted)

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	66.0%	34.0%	100%
Midwifery	64.4%	35.6%	100%
AHP	69.4%	30.6%	100%
Social Care Worker	75.7%	24.3%	100%
Social Worker	85.1%	14.9%	100%

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

Occupation	Employment		Total
	Full-time	Part-time	
Nursing	261 (72.3%)	100 (27.7%)	361 (100.0%)
Midwifery	88 (62.4%)	53 (37.6%)	141 (100.0%)
AHP	389 (67.9%)	184 (32.1%)	573 (100.0%)
Social Care Worker	236 (70.9%)	97 (29.1%)	333 (100.0%)
Social Worker	288 (82.5%)	61 (17.5%)	349 (100.0%)

A2.18 Respondents' Number of Hours Worked per Week

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

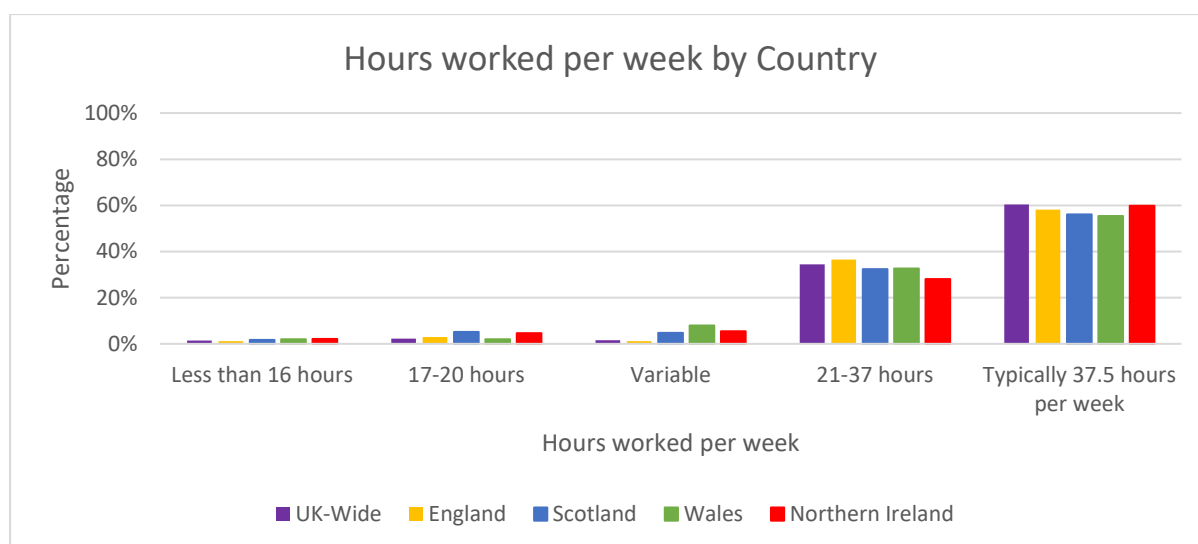


Figure A2.69: Number of Hours Worked per Week by Country (Unweighted)

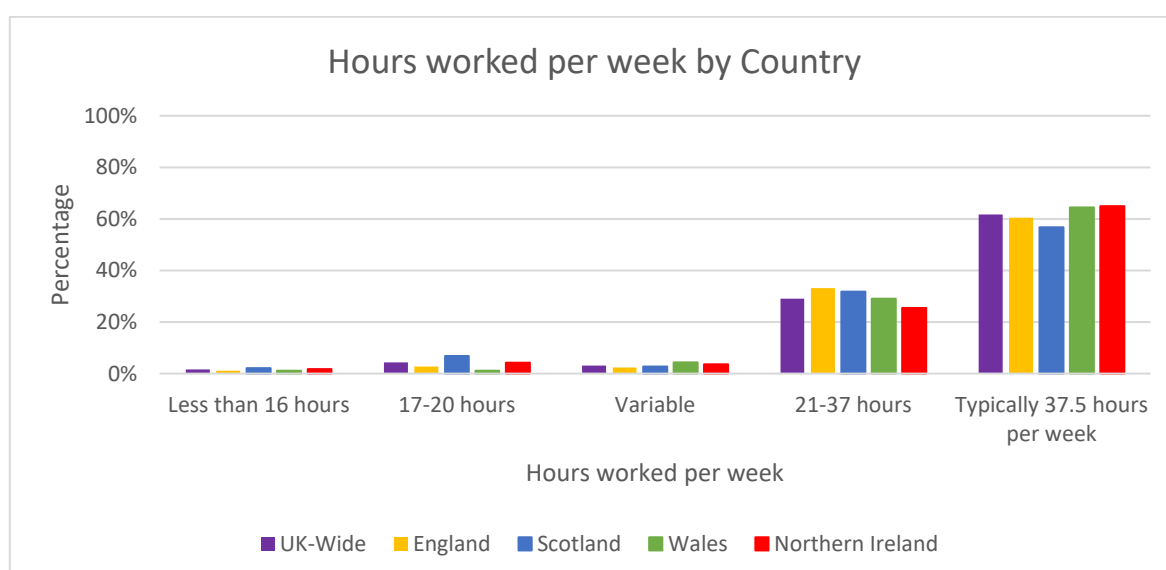


Table A2.68: Number of Hours Worked per Week by Country (Weighted)

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	1.4%	1.2%	1.7%	2.0%	2.1%
17-20 hours	2.3%	2.9%	5.2%	2.0%	4.6%
Variable	1.6%	1.2%	4.7%	7.9%	5.5%
21-37 hours	34.4%	36.5%	32.3%	32.7%	28.0%
Typically 37.5 hours per week	60.4%	58.2%	56.1%	55.4%	59.8%
Total	100%	100%	100%	100%	100%

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

How many hours of work per week do you typically do?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 16 hours	28 (1.6%)	4 (1.1%)	10 (2.1%)	1 (1.1%)	13 (1.7%)
17-20 hours	77 (4.4%)	10 (2.7%)	33 (6.8%)	1 (1.1%)	33 (4.2%)
Variable	54 (3.1%)	9 (2.4%)	13 (2.7%)	4 (4.3%)	28 (3.6%)
21-37 hours	504 (29.1%)	123 (33.2%)	155 (31.8%)	27 (29.0%)	199 (25.5%)
Typically 37.5 hours per week	1068 (61.7%)	224 (60.5%)	276 (56.7%)	60 (64.5%)	508 (65.0%)
Total	1731 (100%)	370 (100%)	487 (100%)	93 (100%)	781 (100%)

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

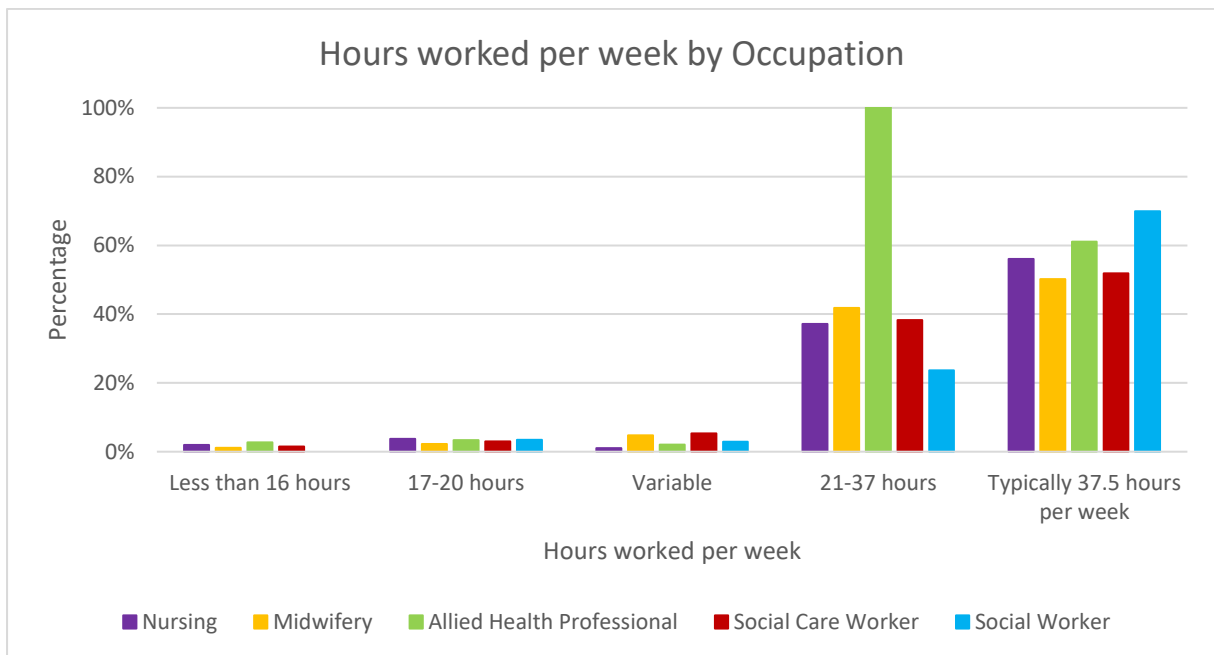


Figure A2.71: Number of Hours Worked per Week by Occupation (Unweighted)

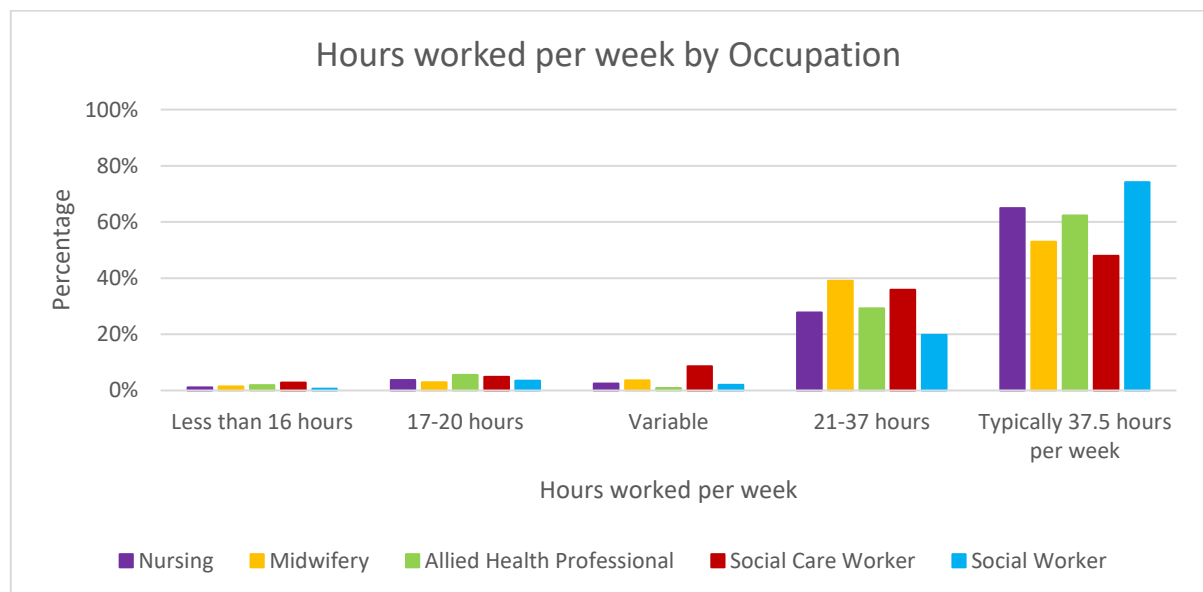


Table A2.70: Number of Hours Worked per Week by Occupation (Weighted)

Occupation	How many hours of work per week do you typically do?				Total
	Less than 16 hours	17-20 hours	Variable	Typically 37.5 hours per week	
Nursing	2.0%	3.7%	1.0%	37.2%	100%
Midwifery	1.1%	2.2%	4.8%	41.8%	100%
AHP	2.7%	3.4%	2.1%	307.0%	100%
Social Care Worker	1.5%	3.0%	5.3%	38.3%	100%
Social Worker	0.0%	3.5%	2.9%	23.7%	100%

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

Occupation	How many hours of work per week do you typically do?					Total
	Less than 16 hours	17-20 hours	Variable	21-37 hours	Typically 37.5 hours per week	
Nursing	4 (1.1%)	13 (3.7%)	9 (2.5%)	99 (27.8%)	231 (64.9%)	356 (100%)
Midwifery	2 (1.4%)	4 (2.9%)	5 (3.6%)	54 (39.1%)	73 (52.9%)	138 (100%)
AHP	11 (1.9%)	32 (5.6%)	5 (0.9%)	166 (29.3%)	353 (62.3%)	567 (100%)
Social Care Worker	9 (2.8%)	16 (4.9%)	28 (8.6%)	117 (35.9%)	156 (47.9%)	326 (100%)
Social Worker	2 (0.6%)	12 (3.5%)	7 (2.0%)	68 (19.8%)	255 (74.1%)	344 (100%)

A2.19 Respondents Typically Working Overtime

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

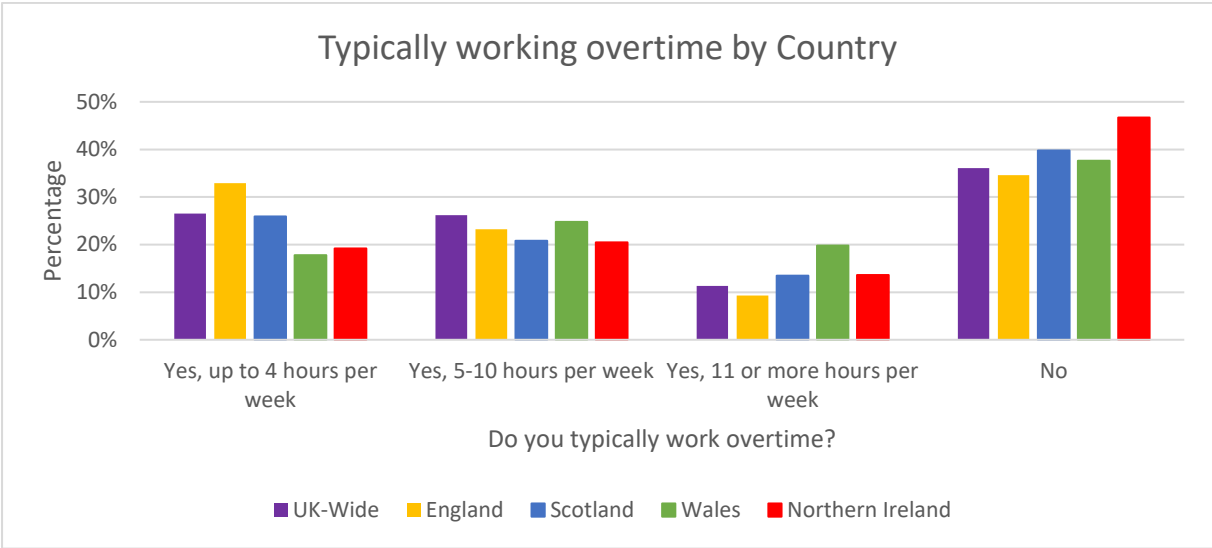


Figure A2.73: Typically Working Overtime by Country (Unweighted)

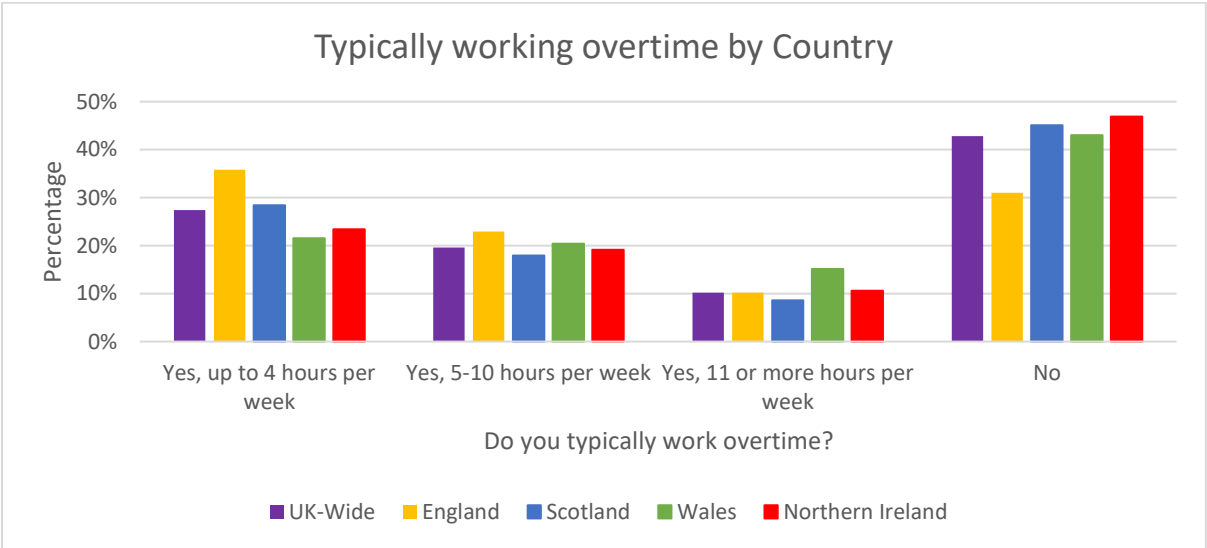


Table A2.72: Typically Working Overtime by Country (Weighted)

Do you typically work overtime?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, up to 4 hours per week	26.5%	32.9%	25.9%	17.8%	19.2%
Yes, 5-10 hours per week	26.2%	23.2%	20.8%	24.8%	20.5%
Yes, 11 or more hours per week	11.3%	9.3%	13.5%	19.8%	13.6%
No	36.1%	34.6%	39.8%	37.6%	46.7%
Total	100%	100%	100%	100%	100%

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

Do you typically work overtime?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, up to 4 hours per week	464 (27.4%)	133 (35.8%)	138 (28.4%)	20(21.5%)	183 (23.4%)
Yes, 5-10 hours per week	340 (19.6%)	85 (22.9%)	87 (17.9%)	19 (20.4%)	149 (19.1%)
Yes, 11 or more hours per week	177 (10.2%)	38 (10.2%)	42 (8.6%)	14 (15.1%)	83 (10.6%)
No	741 (42.8%)	115 (31.0%)	219 (45.1%)	40 (43.0%)	367 (46.9%)
Total	1732 (100.0%)	371 (100.0%)	486 (100.0%)	93 (100.0%)	782 (100.0%)

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

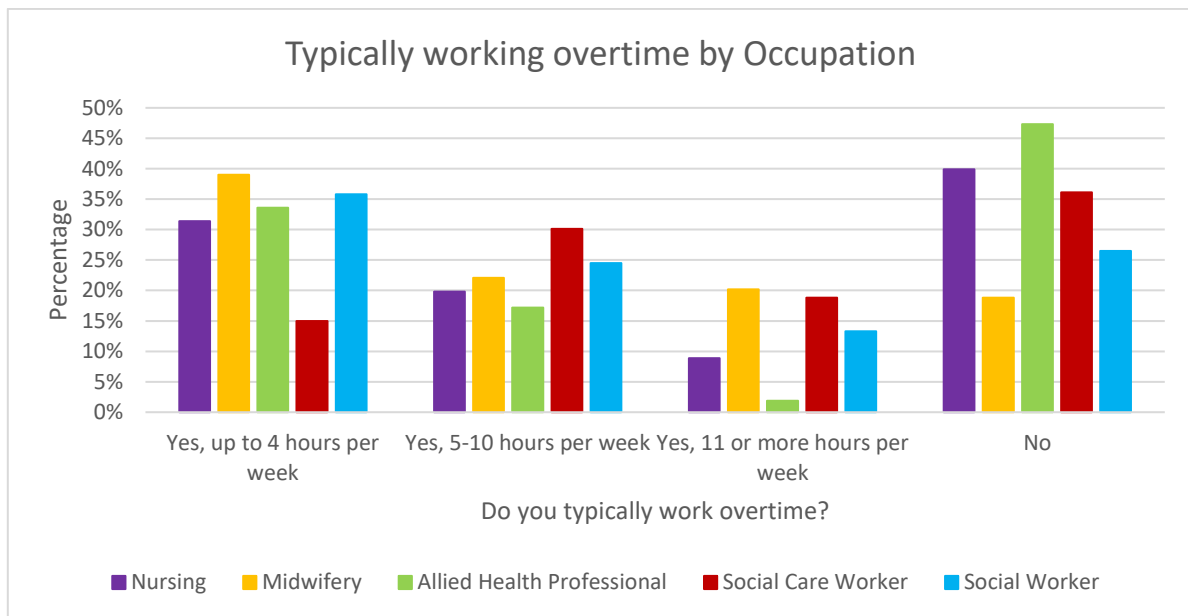


Figure A2.75: Typically Working Overtime by Occupation (Unweighted)

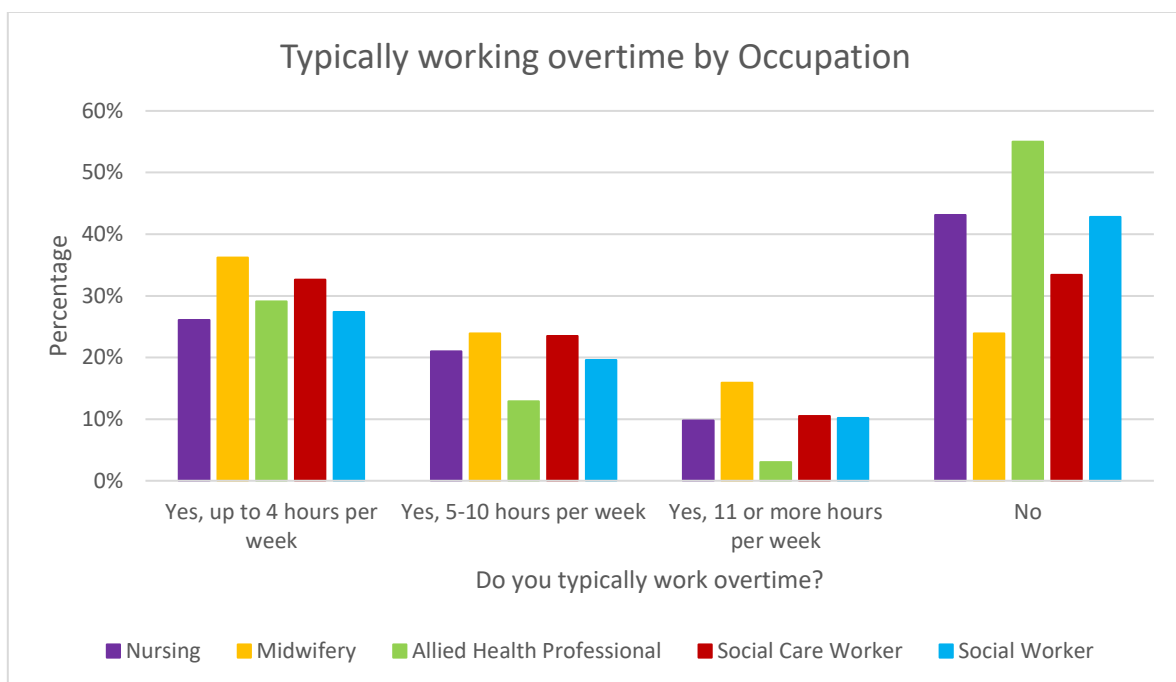


Table A2.74: Typically Working Overtime by Occupation (Weighted)

Occupation	Do you typically work overtime?				Total
	Yes, up to 4 hours per week	Yes, 5-10 hours per week	Yes, 11 or more hours per week	No	
Nursing	31.4%	19.8%	8.9%	39.9%	100%
Midwifery	39.0%	22.1%	20.2%	18.8%	100%
AHP	33.6%	17.2%	1.9%	47.3%	100%
Social Care Worker	15.0%	30.1%	18.8%	36.1%	100%
Social Worker	35.8%	24.5%	13.3%	26.5%	100%

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

Occupation	Do you typically work overtime?				Total
	Yes, up to 4 hours per week	Yes, 5-10 hours per week	Yes, 11 or more hours per week	No	
Nursing	93 (26.1%)	75 (21.0%)	35 (9.8%)	154 (43.1%)	357 (100%)
Midwifery	50 (36.2%)	33 (23.9%)	22 (15.9%)	33 (23.9%)	138 (100%)
AHP	165 (29.1%)	73 (12.9%)	17 (3.0%)	312 (55.0%)	567 (100%)
Social Care Worker	54 (32.6%)	78 (23.5%)	67 (10.5%)	127 (33.4%)	344 (100%)
Social Worker	112 (27.4%)	81 (19.6%)	36 (10.2%)	115 (42.8%)	1732 (100%)

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

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

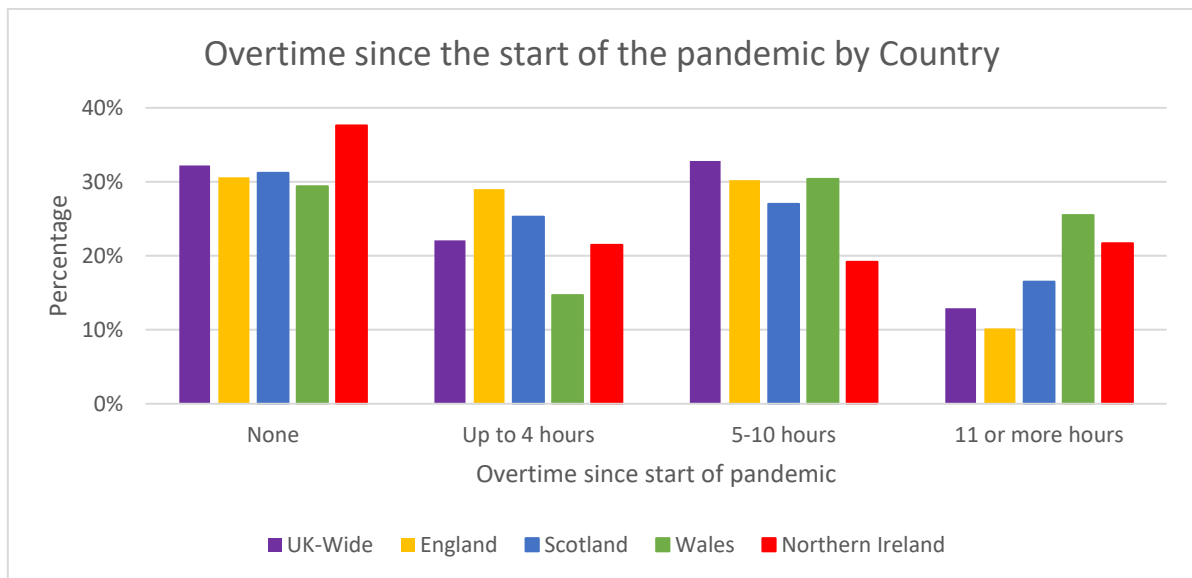


Figure A2.77: Overtime since the Start of the Pandemic by Country (Unweighted)

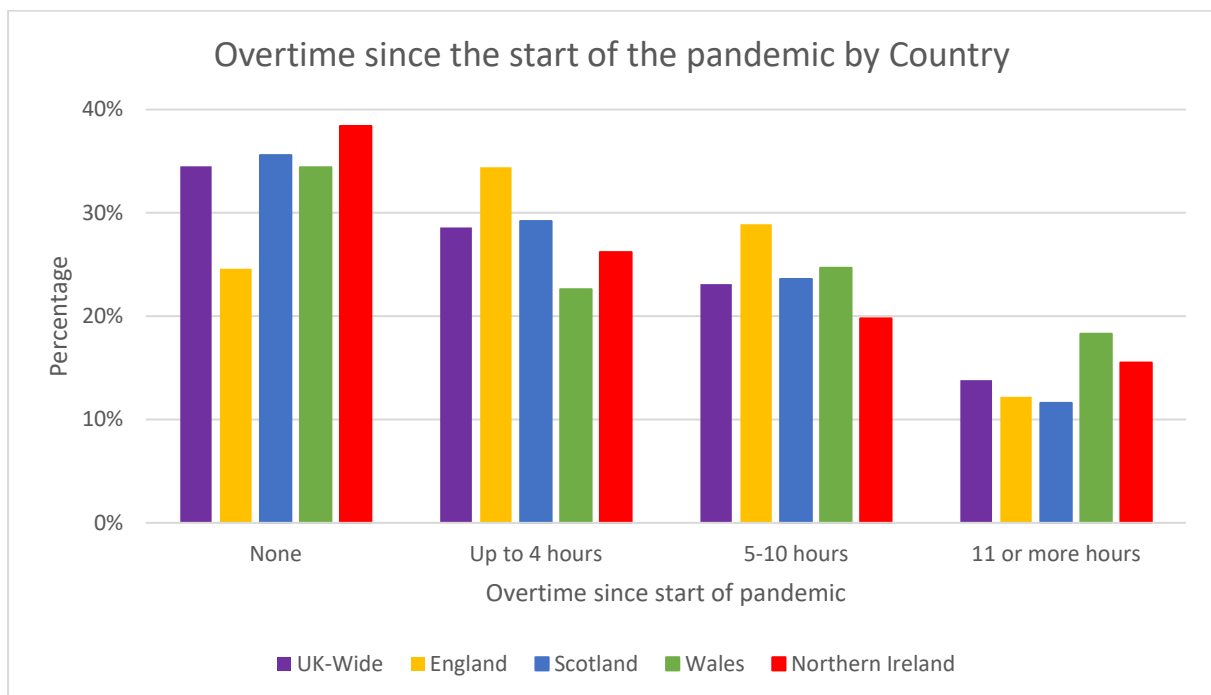


Table A2.76: Overtime since the Start of the Pandemic by Country (Weighted)

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	32.2%	30.6%	31.2%	29.4%	37.6%
Up to 4 hours	22.1%	29.0%	25.3%	14.7%	21.5%
5-10 hours	32.8%	30.2%	27.0%	30.4%	19.2%
11 or more hours	12.9%	10.2%	16.5%	25.5%	21.7%
Total	100%	100%	100%	100%	100%

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

Overtime per week since the start of the pandemic	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	595 (34.5%)	91 (24.6%)	172 (35.6%)	32 (34.4%)	300 (38.4%)
Up to 4 hours	494 (28.6%)	127 (34.4%)	141 (29.2%)	21 (22.6%)	205 (26.2%)
5-10 hours	399 (23.1%)	107 (28.9%)	114 (23.6%)	23 (24.7%)	155 (19.8%)
11 or more hours	239 (13.8%)	45 (12.2%)	56 (11.6%)	17 (18.3%)	121 (15.5%)
Total	1727 (100%)	370 (100%)	483 (100%)	93 (100%)	781 (100%)

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

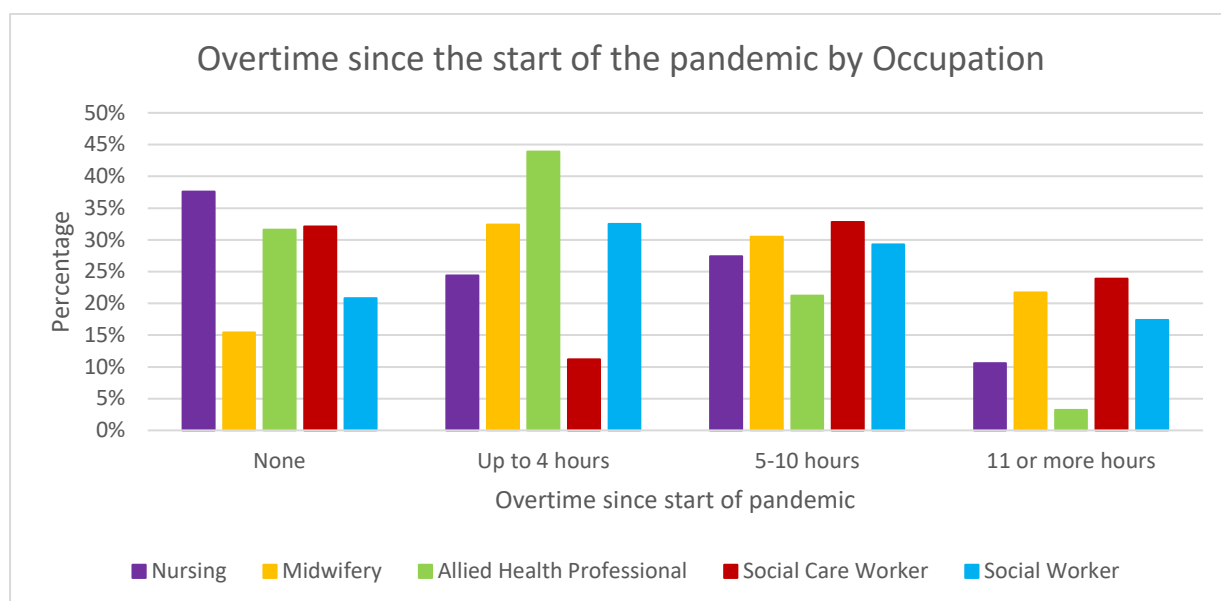


Figure A2.79: Overtime since the Start of the Pandemic by Occupation (Unweighted)

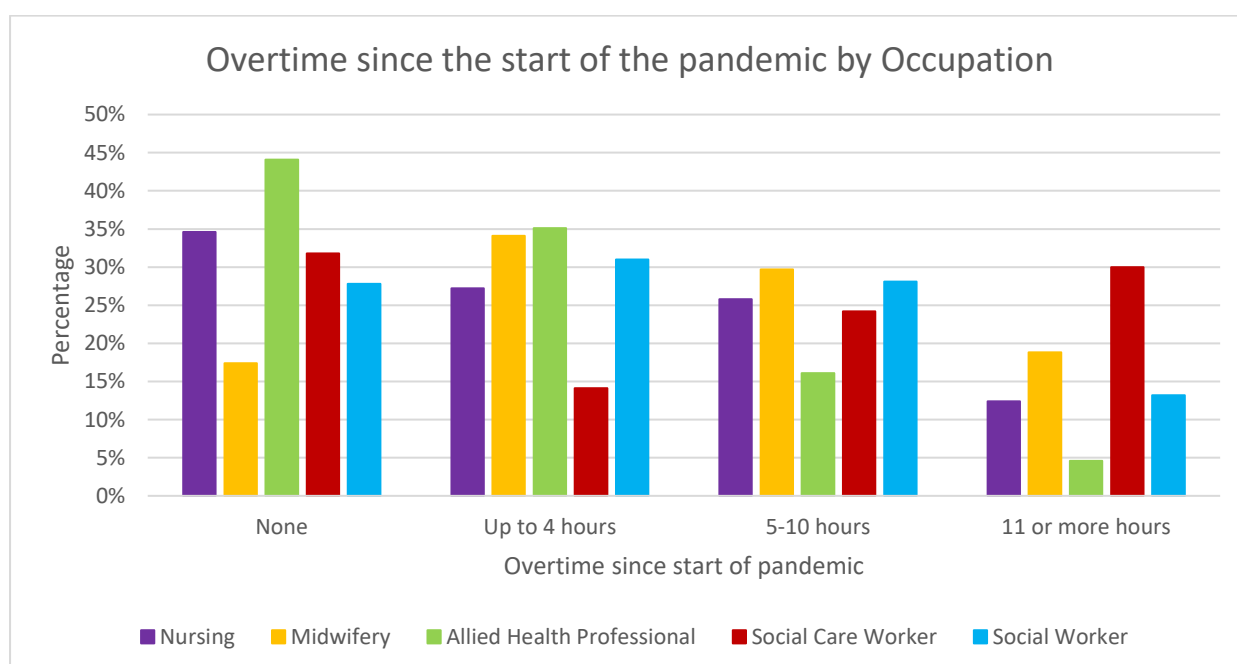


Table A2.78: Overtime since the Start of the Pandemic by Occupation (Weighted)

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	37.6%	24.4%	27.4%	10.6%	100%
Midwifery	15.4%	32.4%	30.5%	21.7%	100%
AHP	31.6%	43.9%	21.2%	3.2%	100%
Social Care Worker	32.1%	11.2%	32.8%	23.9%	100%
Social Worker	20.8%	32.5%	29.3%	17.4%	100%

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

Occupation	Overtime per week since the start of the pandemic				Total
	None	Up to 4 hours	5-10 hours	11 or more hours	
Nursing	123 (34.6%)	97 (27.2%)	92(25.8%)	44 (12.4%)	356 (100%)
Midwifery	24 (17.4%)	47 (34.1%)	41 (29.7%)	26 (18.8%)	138 (100%)
AHP	249 (44.1%)	198 (35.1%)	91 (16.1%)	26 (4.6%)	564 (100%)
Social Care Worker	104 (31.8%)	46 (14.1%)	79 (24.2%)	98 (30.0%)	327 (100%)
Social Worker	95 (27.8%)	106 (31.0%)	96 (28.1%)	45 (13.2%)	342 (100%)

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

Summary (Weighted results):

About half of the respondents (46.0%) had not taken any sick days in the previous 12 months.

Summary (Unweighted results):

About half of the respondents (52.2%) had not taken any sick days in the previous 12 months. Respondents in Northern Ireland were the least likely to take sick days and those in England were the most likely.

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

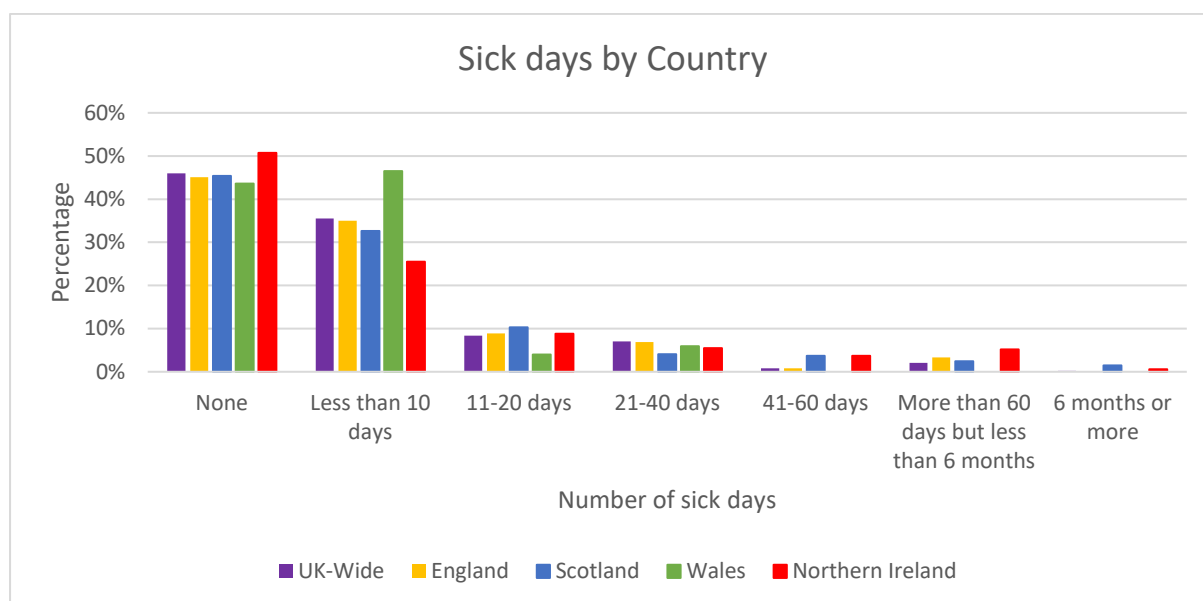


Figure A2.81: Sick Days by Country (Unweighted)

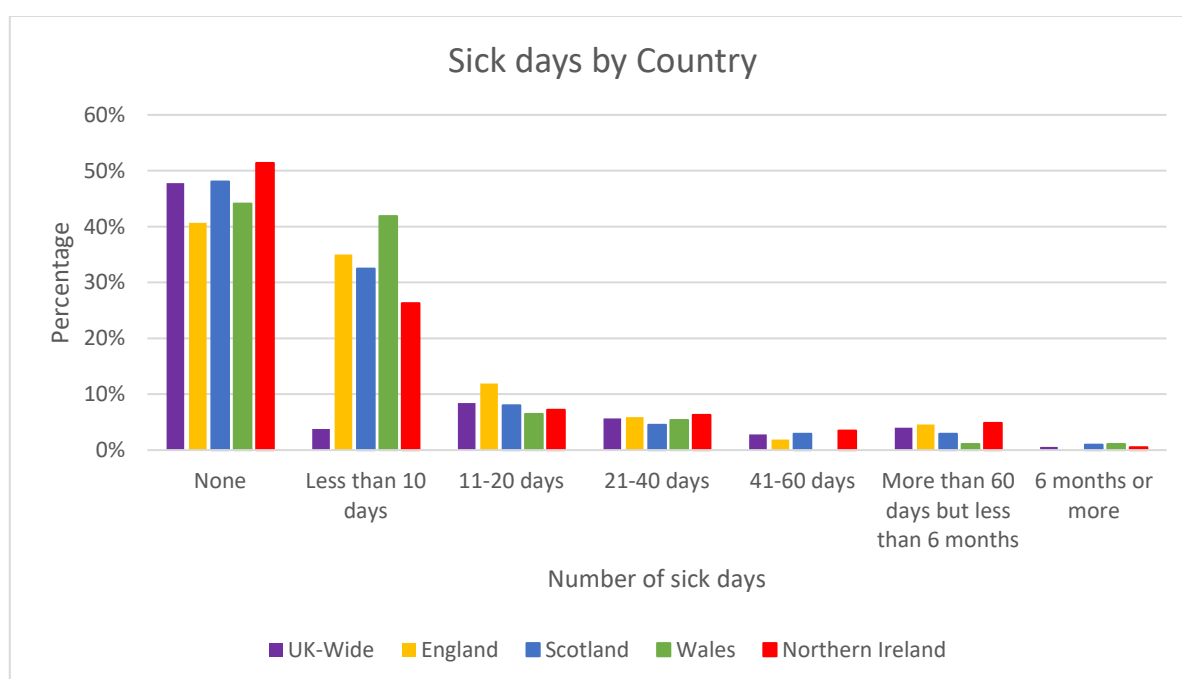


Table A2.80: Sick Days by Country (Weighted)

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	46.0%	45.1%	45.4%	43.6%	50.7%
Less than 10 days	35.5%	35.0%	32.6%	46.5%	25.5%
Between 11-20 days	8.4%	8.9%	10.3%	4.0%	8.8%
Between 21-40 days	7.0%	6.9%	4.1%	5.9%	5.5%
Between 41-60 days	0.8%	0.8%	3.7%	0.0%	3.7%
More than 60 days but less than 6 months	2.1%	3.3%	2.4%	0.0%	5.2%
6 months or more	0.2%	0.0%	1.5%	0.0%	0.6%
Total	100%	100%	100%	100%	100%

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

Number of sick days in previous 12 months	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
None	47.8%	40.7%	48.1%	44.1%	51.4%
Less than 10 days	3.8%	35.0%	32.5%	41.9%	26.3%
Between 11-20 days	8.4%	11.9%	8.0%	6.5%	7.2%
Between 21-40 days	5.7%	5.9%	4.5%	5.4%	6.3%
Between 41-60 days	2.8%	1.9%	2.9%	0.0%	3.5%
More than 60 days but less than 6 months	4.0%	4.6%	2.9%	1.1%	4.9%
6 months or more	0.6%	0.0%	1.0%	1.1%	0.5%
Total	1758 (100%)	371 (100%)	486 (100%)	93 (100%)	782 (100%)

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

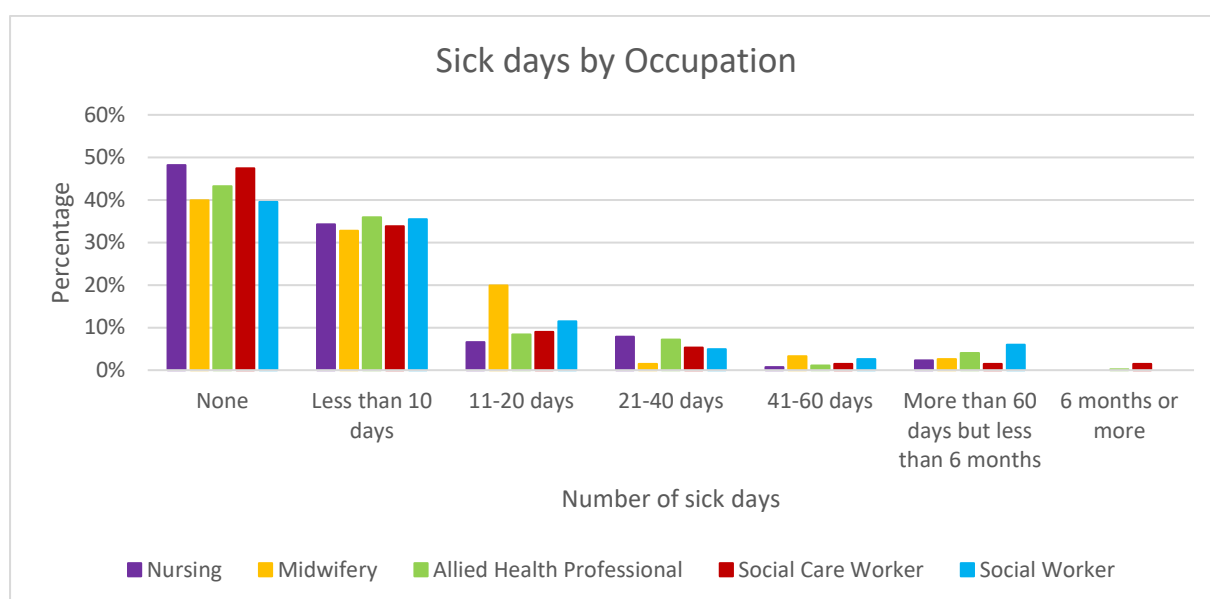


Figure A2.83: Sick Days by Occupation (Unweighted)

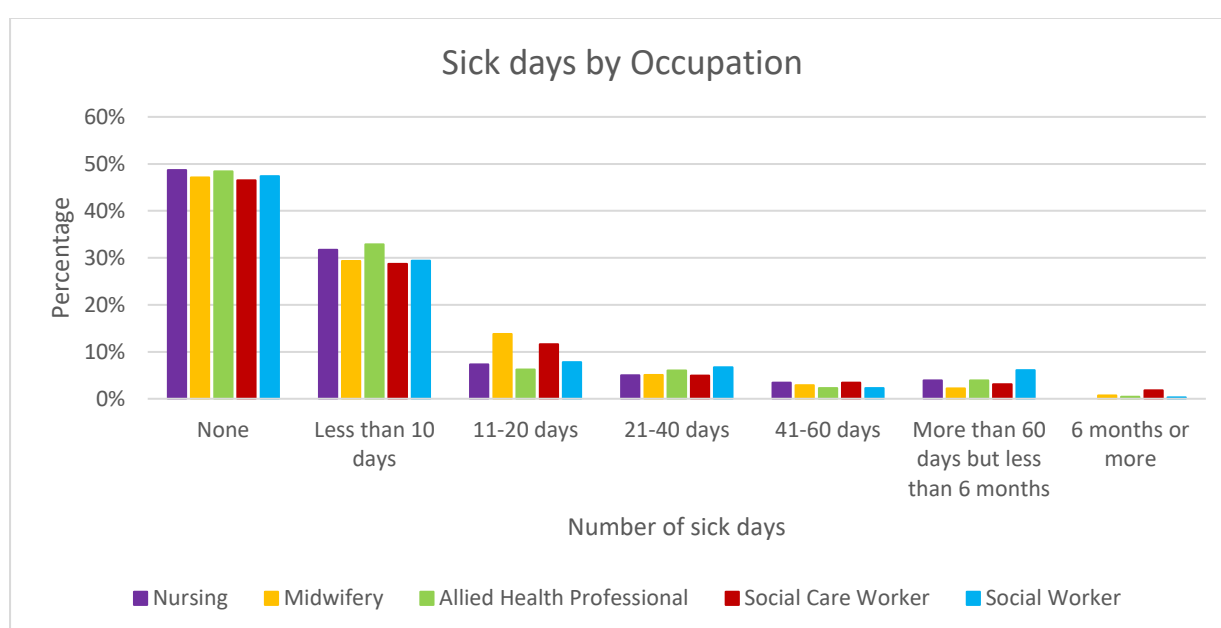


Table A2.82: Sick Days by Occupation (Weighted)

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	48.2%	39.9%	43.2%	47.4%	39.5%
Less than 10 days	34.3%	32.8%	35.9%	33.8%	35.5%
Between 11-20 days	6.6%	19.9%	8.4%	9.0%	11.5%
Between 21-40 days	7.9%	1.5%	7.2%	5.3%	4.9%
Between 41-60 days	0.7%	3.3%	1.1%	1.5%	2.6%
More than 60 days but less than 6 months	2.3%	2.6%	4.0%	1.5%	6.0%
6 months or more	0.0%	0.0%	0.2%	1.5%	0.0%
Total	100%	100%	100%	100%	100%

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

Number of sick days in previous 12 months	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
None	174 (48.7%)	65 (47.1%)	274 (48.4%)	152 (46.5%)	163 (47.4%)
Less than 10 days	113 (31.7%)	39 (29.3%)	186 (32.9%)	94 (28.7%)	101 (29.4%)
Between 11-20 days	26 (7.3%)	19 (13.8%)	35 (6.2%)	38 (11.6%)	27 (7.8%)
Between 21-40 days	18 (5.0%)	7 (5.1%)	34 (6.0%)	16 (4.9%)	23 (6.7%)
Between 41-60 days	12 (3.4%)	4 (2.9%)	13 (2.3%)	11 (3.4%)	8 (2.3%)
More than 60 days but less than 6 months	14 (3.9%)	3 (2.2%)	22 (3.9%)	10 (3.1%)	21 (6.1%)
6 months or more	0 (0.0%)	1 (0.7%)	2 (0.4%)	6 (1.8%)	1 (0.3%)
Total	357 (100%)	138 (100%)	566 (100%)	327 (100%)	344 (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):

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

Summary (Unweighted results):

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

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

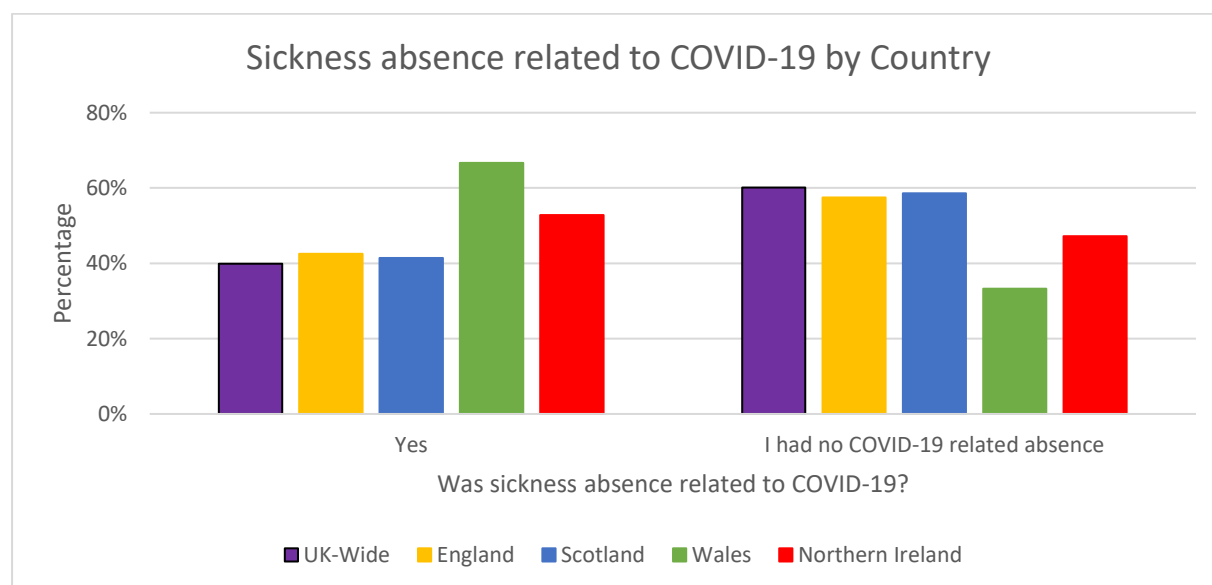


Figure A2.85: Sickness Absence Related to COVID-19 by Country (Unweighted)

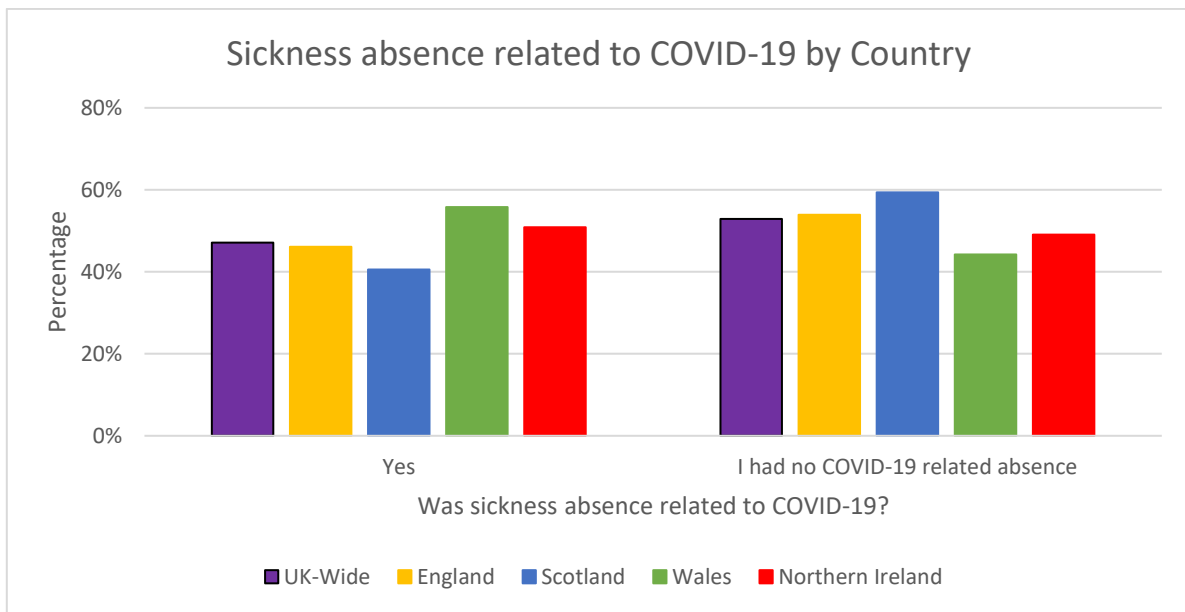


Table A2.84: Sickness Absence Related to COVID-19 by Country (Weighted)

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	39.9%	42.5%	41.4%	66.7%	52.8%
I had no COVID-19 related absence	60.1%	57.5%	58.6%	33.3%	47.2%
Total	100%	100%	100%	100%	100%

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

Was sickness absence related to COVID-19?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	421 (47.1%)	100 (46.1%)	102 (40.6%)	29 (55.8%)	190 (50.9%)
I had no COVID-19 related absence	472 (52.9%)	117 (53.9%)	149 (59.4%)	23 (44.2%)	183 (49.1%)
Total	893 (100%)	217 (100%)	251 (100%)	52 (100%)	373 (100%)

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

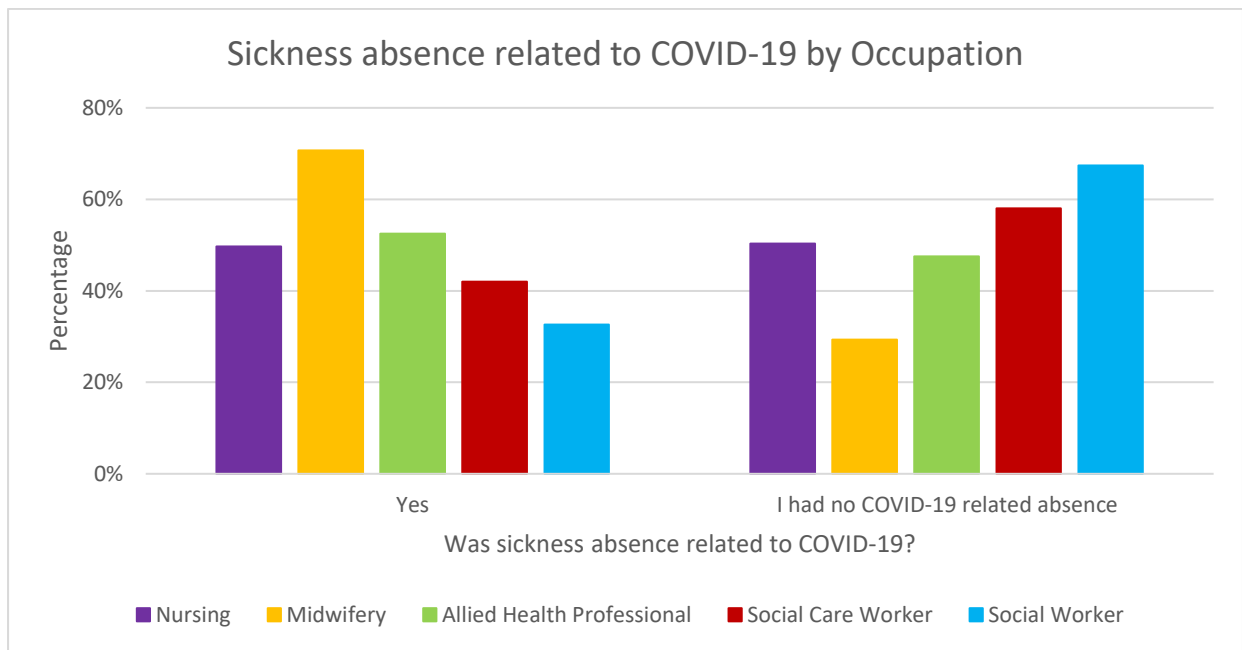


Figure A2.87: Sickness Absence Related to COVID-19 by Occupation (Unweighted)

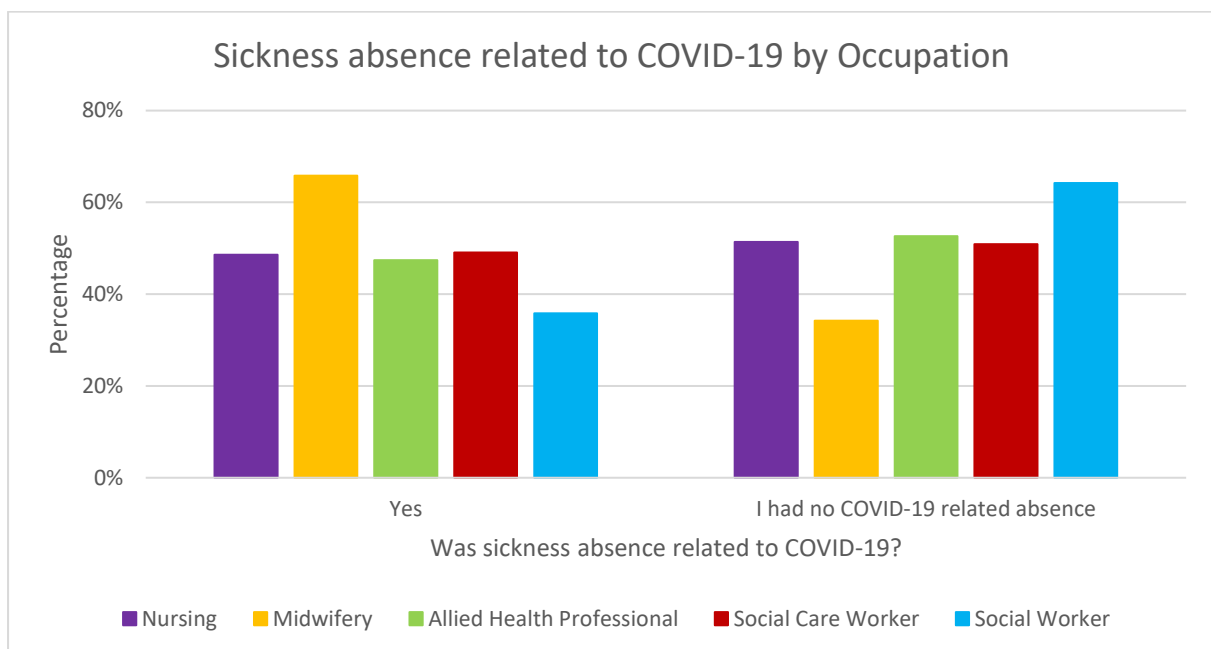


Table A2.86: Sickness Absence Related to COVID-19 by Occupation (Weighted)

Occupation	Was sickness absence related to COVID-19?		Total
	Yes	I had no COVID-19 related absence	
Nursing	49.7%	50.3%	100%
Midwifery	70.7%	29.3%	100%
AHP	52.5%	47.5%	100%
Social Care Worker	42.0%	58.0%	100%
Social Worker	32.6%	67.4%	100%

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

Occupation	Was sickness absence related to COVID-19?		Total
	Yes	I had no COVID-19 related absence	
Nursing	89 (48.6%)	94 (51.4%)	183 (100%)
Midwifery	48 (65.8%)	25 (34.2%)	73 (100%)
AHP	136 (47.4%)	151 (52.6%)	287 (100%)
Social Care Worker	84 (49.1%)	87 (50.9%)	171 (100%)
Social Worker	64 (35.8%)	115 (64.2%)	179 (100%)

A2.23 Respondents' Sick Pay

Summary (Weighted results):

UK-wide, most respondents reported getting employer pay.

Summary (Unweighted results):

UK-wide, most respondents (50.2 %) reported getting employer pay.

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

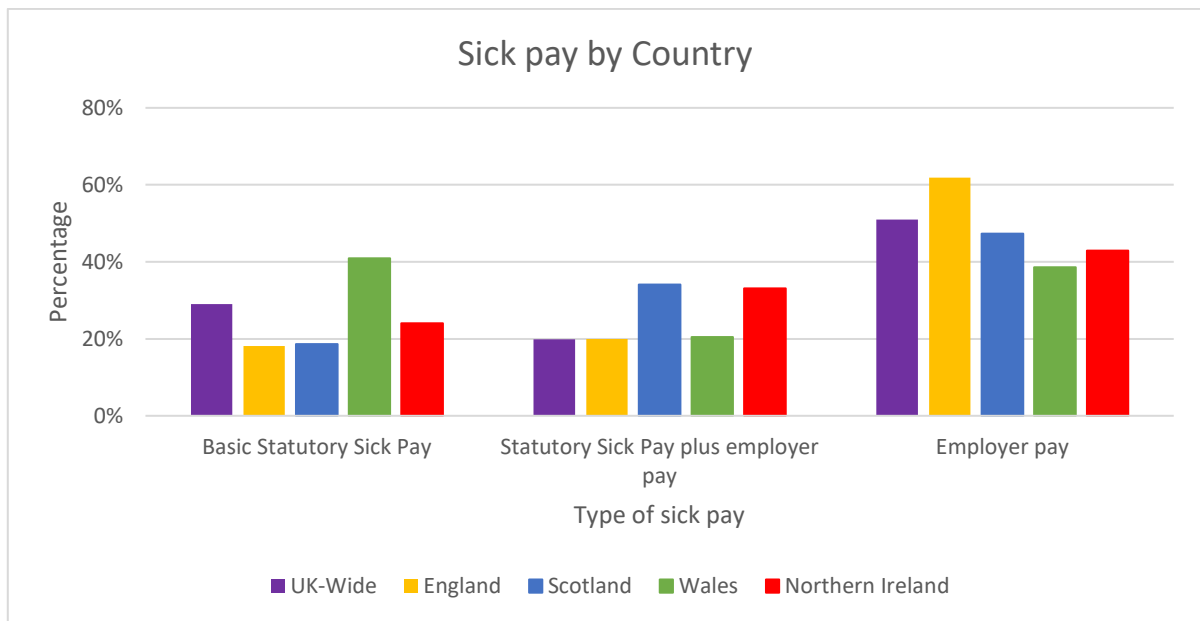


Figure A2.89: Respondents' Sick Pay by Country (Unweighted)

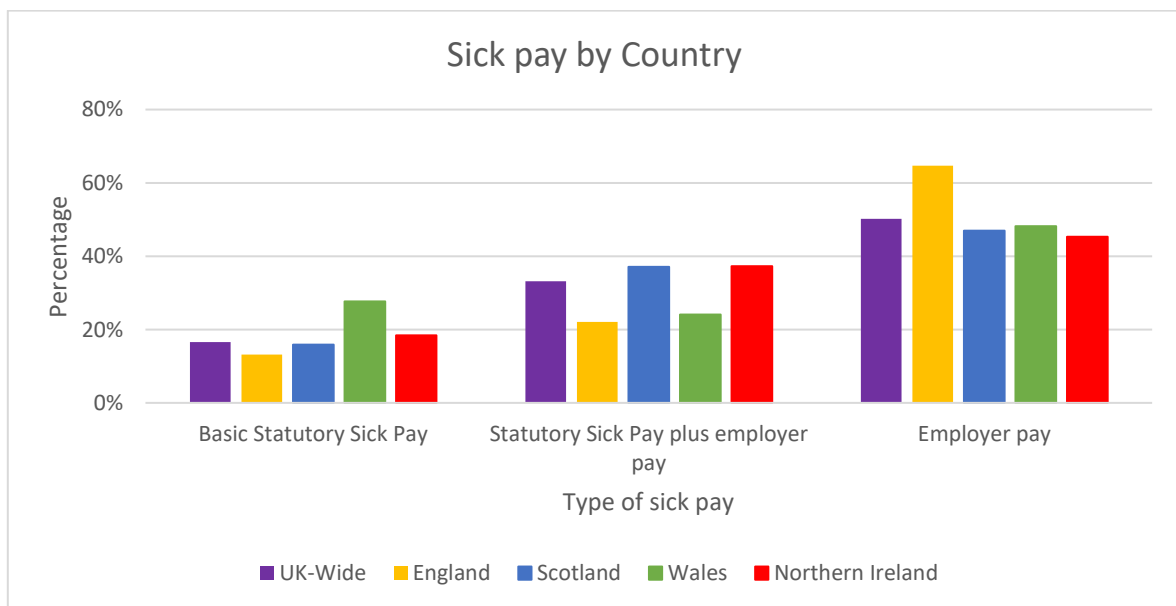


Table A2.88: Respondents' Sick Pay by Country (Weighted)

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Basic Statutory Sick Pay	29.0%	18.1%	18.6%	40.9%	24.0%
Statutory Sick Pay plus employer pay	19.9%	20.0%	34.1%	20.5%	33.1%
Employer pay	51.0%	61.9%	47.3%	38.6%	42.9%
Total	100%	100%	100%	100%	100%

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

Type of sick pay	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Basic Statutory Sick Pay (SSP)	248 (16.6%)	43 (13.2%)	69 (15.9%)	23 (27.7%)	113 (18.4%)
Statutory Sick Pay (SSP) plus employer pay	496 (33.2%)	72 (22.1%)	161 (37.1%)	20 (24.1%)	243 (37.3%)
None of the above	750 (50.2%)	211 (64.7%)	204 (47.0%)	40 (48.2%)	295 (45.3%)
Total	1494 (100%)	326 (100%)	434 (100%)	83 (100%)	651 (100%)

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

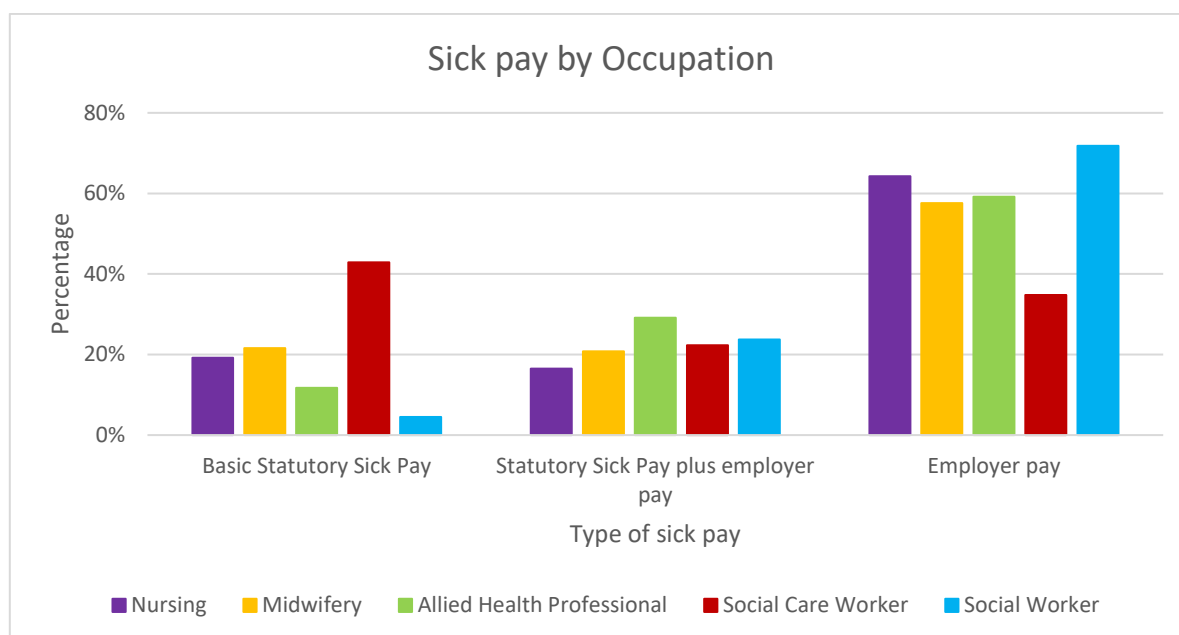


Figure A2.91: Respondents' Sick Pay by Occupation (Unweighted)

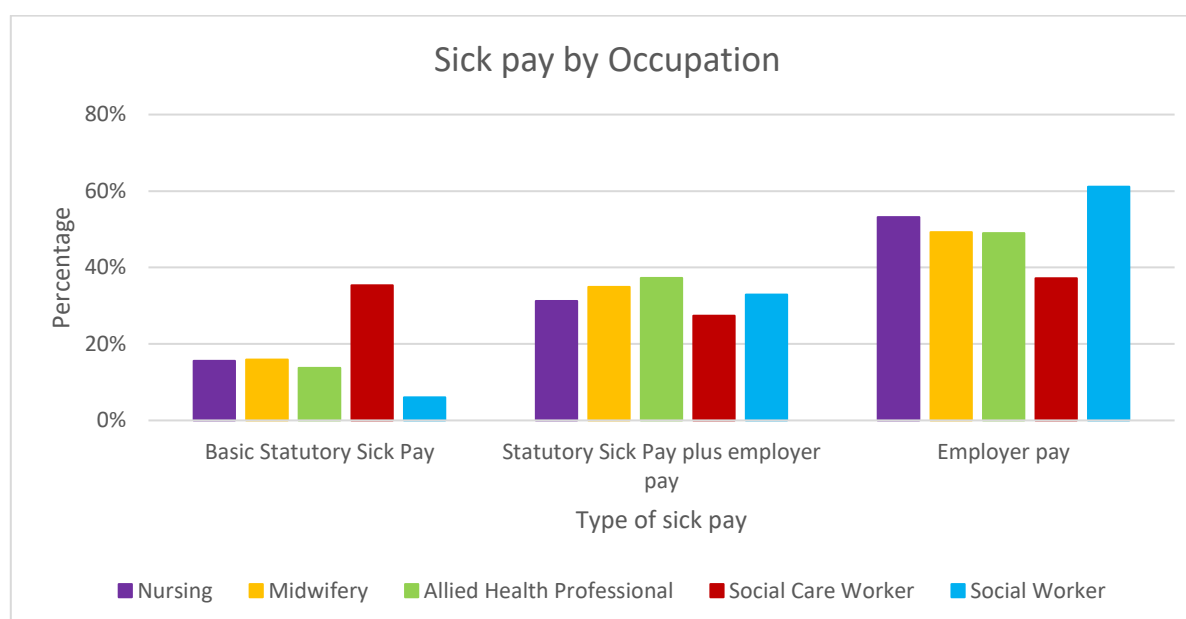


Table A2.90: Respondents' Sick Pay by Occupation (Weighted)

Occupation	Type of sick pay			Total
	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	Employer Pay	
Nursing	19.2%	16.5%	64.3%	100%
Midwifery	21.6%	20.8%	57.6%	100%
AHP	11.7%	29.1%	59.2%	100%
Social Care Worker	42.9%	22.3%	34.8%	100%
Social Worker	4.5%	23.7%	71.8%	100%

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

Occupation	Type of sick pay			Total
	Basic Statutory Sick Pay (SSP)	Statutory Sick Pay (SSP) plus employer pay	Employer Pay	
Nursing	48 (15.6%)	96 (31.2%)	164 (53.2%)	308 (100%)
Midwifery	20 (15.9%)	44 (34.9%)	62 (49.2%)	126 (100%)
AHP	68 (13.7%)	185 (37.3%)	243 (49.0%)	496 (100%)
Social Care Worker	94 (35.3%)	73 (27.4%)	99 (37.2%)	266 (100%)
Social Worker	18 (6.0%)	98 (32.9%)	182 (61.1%)	298 (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 2.9% of respondents reported that their service was not impacted and it was stepped down. More than half of the respondents (59.8%) felt overwhelmed by increased pressures. Social workers and midwives were the most impacted of the examined occupational groups.

Summary (Unweighted results):

UK-wide, only 1.9% of respondents reported that their service was not impacted and it was stepped down. Over half of the respondents (53.8%) felt overwhelmed by increased pressures, particularly those in England. Midwives were the most impacted of the examined occupational groups.

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

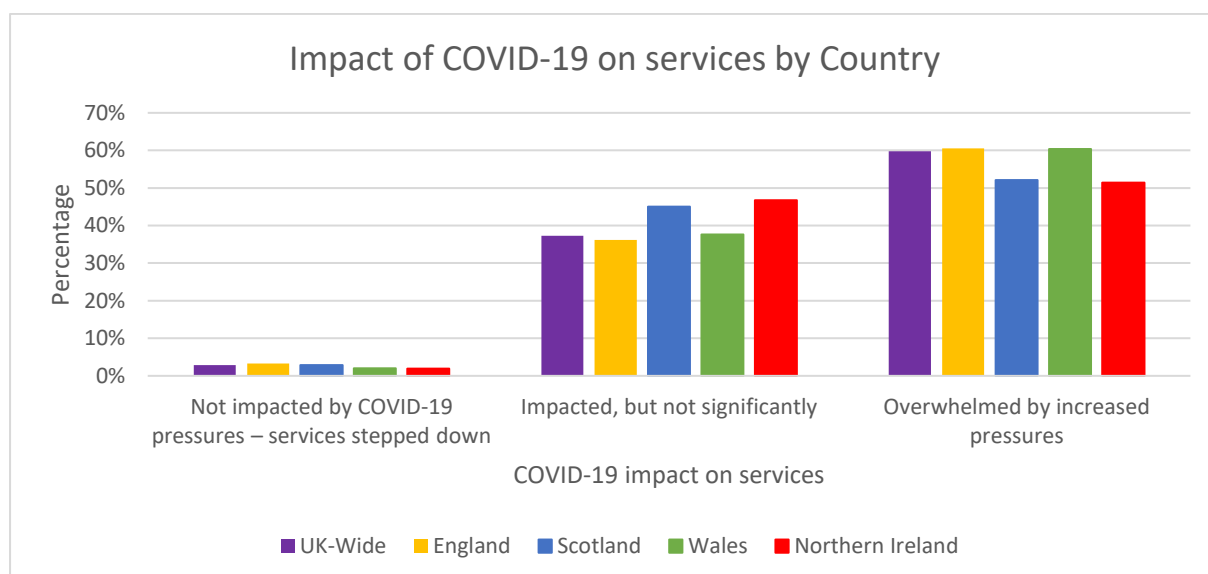


Figure A2.93: Impact of COVID-19 on Services by Country (Unweighted)

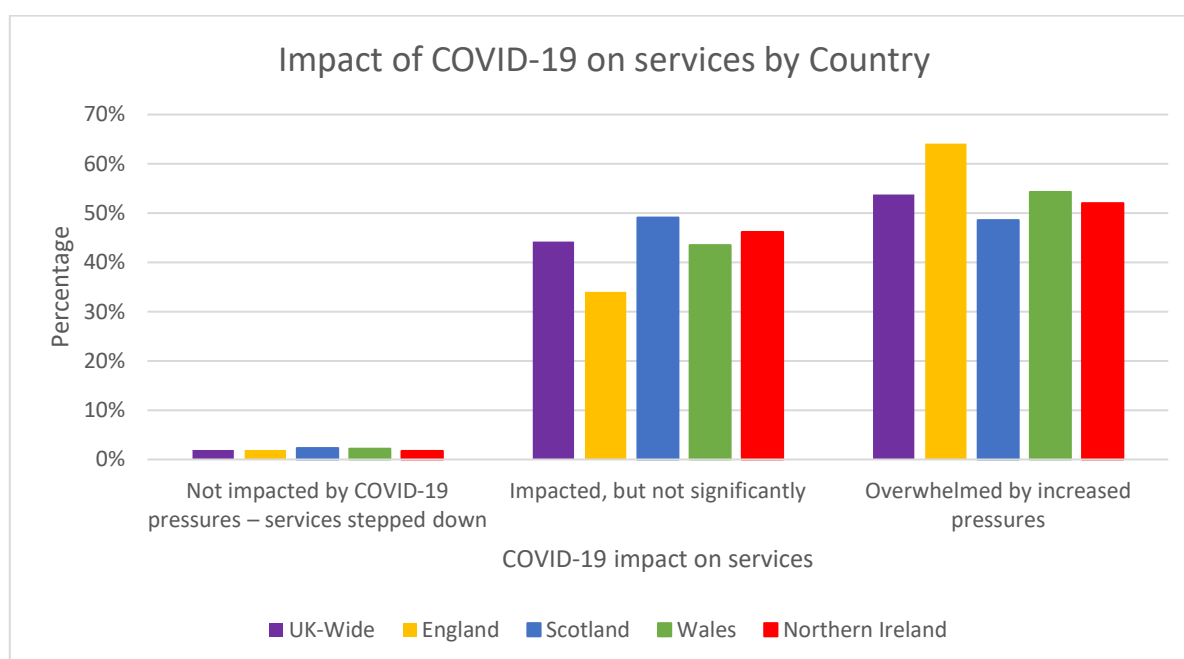


Table A2.92: Impact of COVID-19 on Services by Country (Weighted)

Impact of COVID-19 on services	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Not impacted by COVID-19 pressures – services stepped down	2.9%	3.3%	2.9%	2.0%	1.9%
Impacted, but not significantly	37.3%	36.2%	45.0%	37.6%	46.7%
Overwhelmed by increased pressures	59.8%	60.5%	52.1%	60.4%	51.4%
Total	100%	100%	100%	100%	100%

Table A2.93: 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	33 (1.9%)	7 (1.9%)	11 (2.3%)	2 (2.2%)	13 (1.7%)
Impacted, but not significantly	750 (44.2%)	124 (34.0%)	236 (49.1%)	40 (43.5%)	350 (46.2%)
Overwhelmed by increased pressures	912 (53.8%)	234 (64.1%)	234 (48.6%)	50 (54.3%)	394 (52.0%)
Total	1695 (100%)	365 (100%)	481 (100%)	92 (100%)	757 (100%)

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

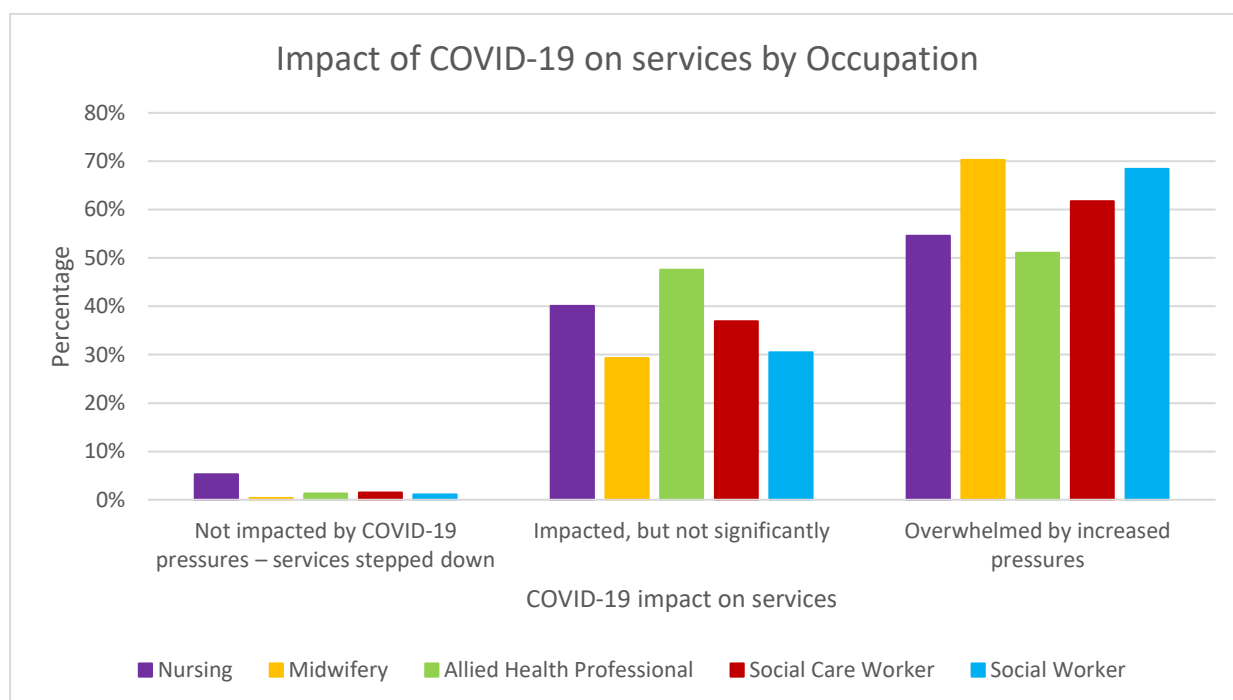


Figure A2.95: Impact of COVID-19 on Services by Occupation (Unweighted)

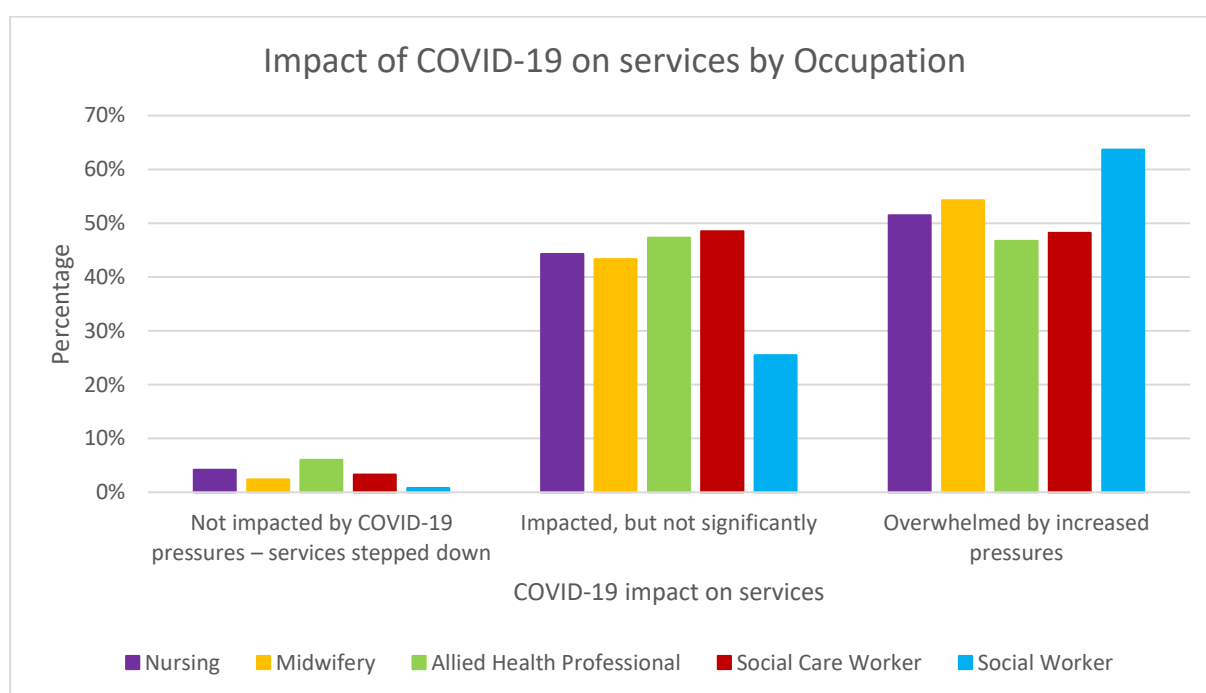


Table A2.94: Impact of COVID-19 on Services by Occupation (Weighted)

Occupation	Impact of COVID-19 on services			Total
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures	
Nursing	5.3%	40.1%	54.6%	100%
Midwifery	0.4%	29.3%	70.3%	100%
AHP	1.3%	47.6%	51.1%	100%
Social Care Worker	1.5%	36.9%	61.7%	100%
Social Worker	1.1%	30.5%	68.4%	100%

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

Occupation	Impact of COVID-19 on services			Total
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures	
Nursing	9 (2.5%)	151 (42.5%)	195(54.9%)	355 (100%)
Midwifery	3 (2.2%)	44 (32.4%)	89 (65.4%)	136 (100%)
AHP	7 (1.3%)	297 (54.2%)	244 (44.5%)	548 (100%)
Social Care Worker	10 (3.1%)	141 (44.2%)	168 (52.7%)	319 (100%)
Social Worker	4 (1.2%)	117 (34.7%)	216 (64.1%)	337 (100%)

A2.25 Flu Vaccination uptake

Respondents were asked whether they had received their Flu Vaccination.

Summary (Weighted results):

UK-wide, 70.7% of respondents reported that they had received their flu vaccination. Nurses were the group with the highest uptake of the Flu vaccination.

Summary (Unweighted results):

UK-wide, 70.1% of respondents reported that they had received their flu vaccines. Out of all the countries, Scotland had the highest uptake of the flu vaccination in this population (80.5%). AHPs were the group with the highest uptake of flu vaccination followed by Nurses.

Figure A2.96: Flu Vaccination uptake by Country (Weighted)

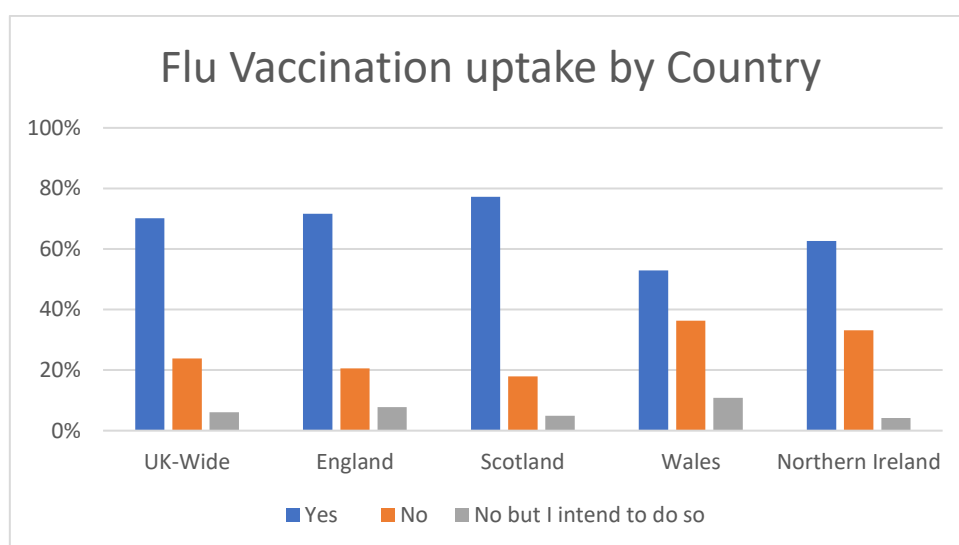


Figure A2.97: Flu Vaccination uptake by Country (Unweighted)

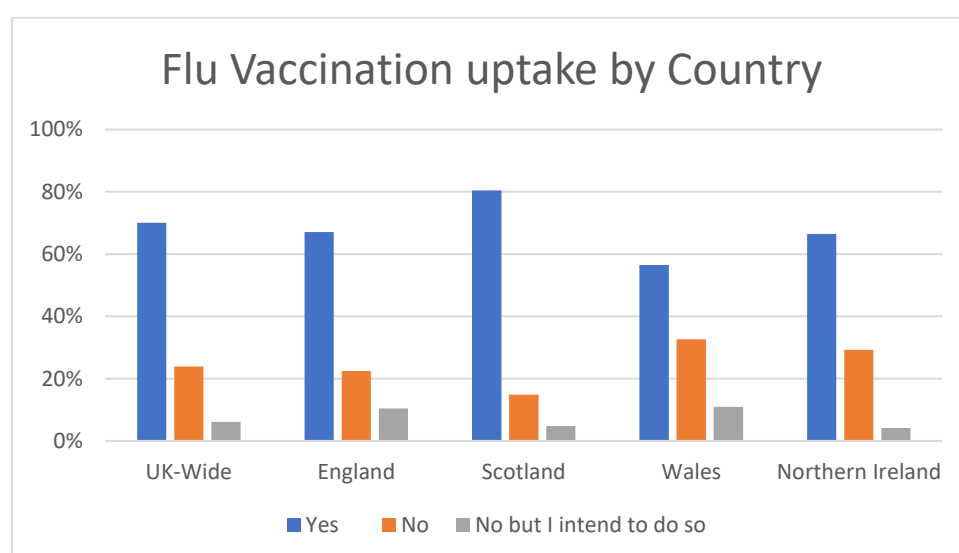


Table A2.96: Vaccination uptake by Country (Weighted)

Have you received your vaccination?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes- both	70.1%	71.6%	77.2%	52.9%	62.6%
Yes – one	23.8%	20.6%	17.9%	36.3%	33.2%
No – not yet	6.1%	7.8%	4.9%	10.8%	4.2%
No – medically exempt	70.1%	71.6%	77.2%	52.9%	62.6%
No – other	23.8%	20.6%	17.9%	36.3%	33.2%
Total	100%	100%	100%	100%	100%

Table A2.97: Flu Vaccination uptake by Country (Unweighted)

Have you received your vaccination?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	1187 (70.1%)	245 (67.1%)	387 (80.5%)	52 (56.5%)	503 (66.5%)
No	404 (23.9%)	82 (22.5%)	71 (14.8%)	30 (32.6%)	221 (29.2%)
No but I intend to do so	103 (6.1%)	38 (10.4%)	23 (4.8%)	10 (10.9%)	32 (4.2%)
Total	1694 (100%)	365 (100%)	481 (100%)	92 (100%)	756 (100%)

Figure A2.98: Flu Vaccination uptake by Occupation (Weighted)

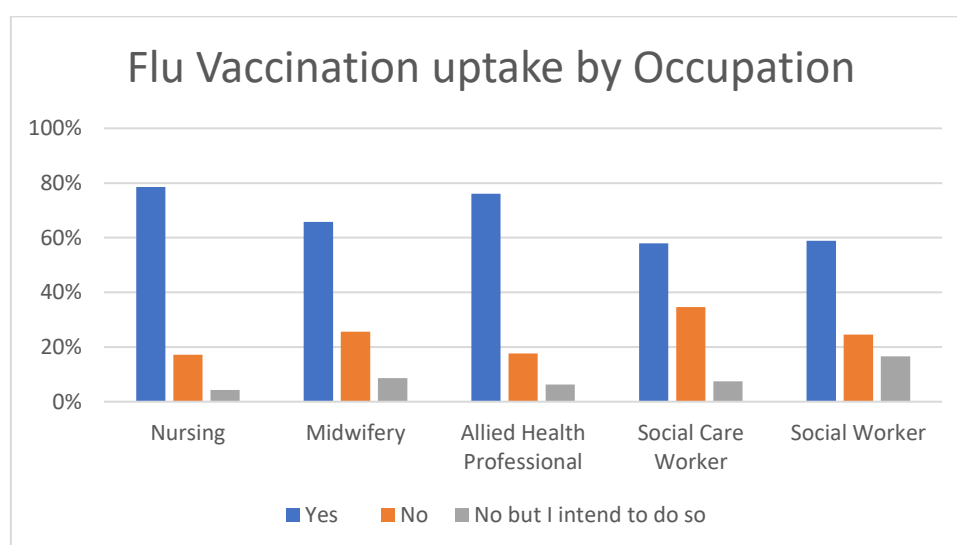


Figure A2.99: Flu Vaccination by Occupation (Unweighted)

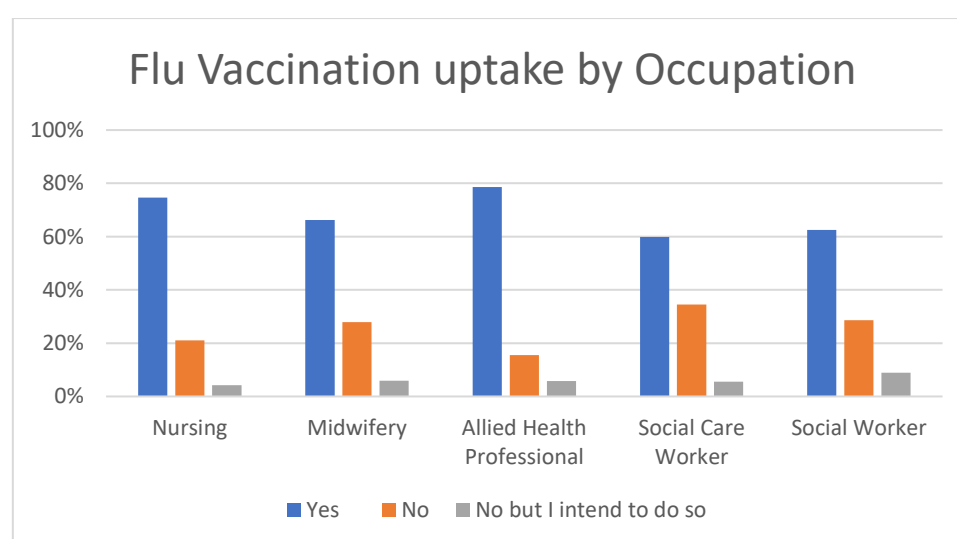


Table A2.98: Flu Vaccination uptake by Occupation (Weighted)

Occupation	Have you received a Flu vaccination?			Total
	Yes	No	No but I intend to do so	
Nursing	78.5%	17.2%	4.3%	100%
Midwifery	65.8%	25.6%	8.6%	100%
AHP	76.1%	17.7%	6.3%	100%
Social Care Worker	57.9%	34.6%	7.5%	100%
Social Worker	58.9%	24.5%	16.6%	100%

Table A2.99: Vaccination uptake by Occupation (Unweighted)

Occupation	Have you received a Flu vaccination?			Total
	Yes	No	No but I intend to do so	
Nursing	265 (74.6%)	75 (21.1%)	15 (4.2%)	355 (100%)
Midwifery	90 (66.2%)	38 (27.9%)	8 (5.9%)	136 (100%)
AHP	431 (78.6%)	85 (15.5%)	32 (5.8%)	548 (100%)
Social Care Worker	191 (59.9%)	110 (34.5%)	18 (5.6%)	319 (100%)
Social Worker	210 (62.5%)	96 (28.6%)	30 (8.9%)	336 (100%)

A2.26 COVID-19 Vaccination uptake

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

Summary (Weighted results):

UK-wide, 80.0% of respondents reported that they had received both of their vaccines and a booster. Nurses were the group with the highest uptake of both vaccinations followed by AHPs.

Summary (Unweighted results):

UK-wide, 81.3% of respondents reported that they had received both their COVID-19 vaccinations and their booster. Out of all the countries, Wales had the highest uptake of the COVID-19 vaccination in this population (96.9%). Nurses were the group with the highest uptake of the COVID-19 vaccination followed by AHPs.

Respondents reported other (n=73) as the reason for not taking the vaccination had a range of reasons including;

- Own choice and do not wish to get the vaccination
- Religious reasons
- Personal beliefs
- Natural immunity
- Not enough research
- Having had COVID and deemed it mild.
- Waiting until trials are completed.
- Pregnancy
- Against vaccination propaganda
- Frightened of its effect on health
- Vaccinations have been politicised
- Medical History

Figure A2.100: COVID-19 Vaccination uptake by Country (Weighted)

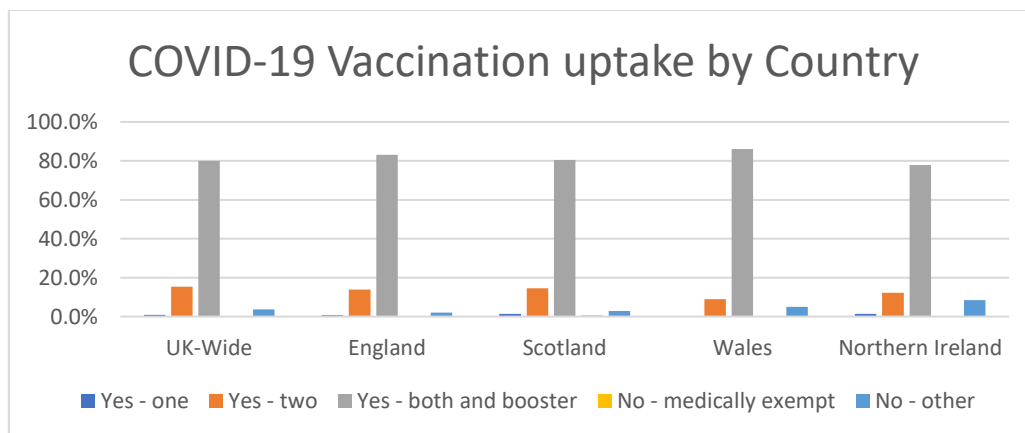


Figure A2.101: COVID-19 Vaccination uptake by Country (Unweighted)

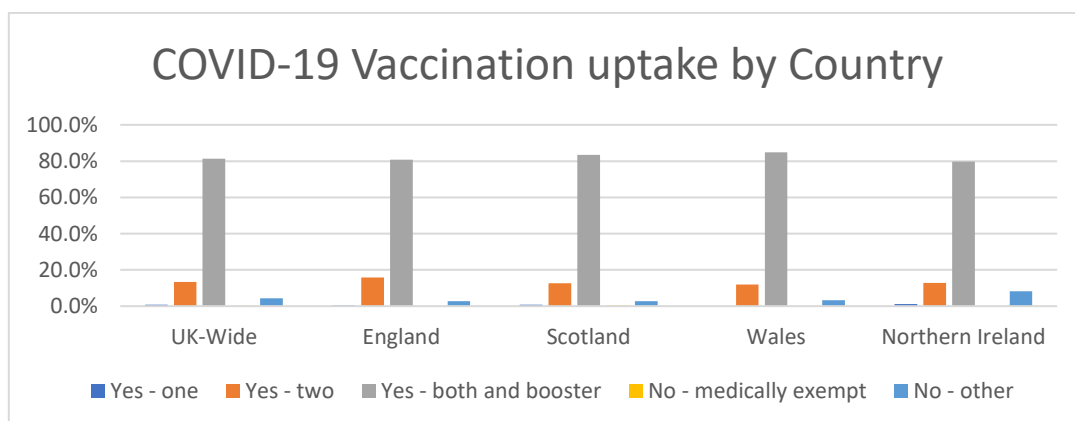


Table A2.100: Vaccination uptake by Country (Weighted)

Have you received your vaccination?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes- both	0.9%	0.8%	1.4%	0.0%	1.4%
Yes – one	15.4%	13.9%	14.5%	8.9%	12.2%
Yes – both and booster	80.0%	83.2%	80.5%	86.1%	77.8%
No – medically exempt	0.1%	0.0%	0.7%	0.0%	0.0%
No – other	3.6%	2.0%	2.9%	5.0%	8.5%
Total	100%	100%	100%	100%	100%

Table A2.101: Vaccination uptake by Country (Unweighted)

Have you received your vaccination?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes- both	14 (0.8%)	2 (0.5%)	4 (0.8%)	0 (0.0%)	8 (1.1%)
Yes – one	228 (13.4%)	58 (15.9%)	61 (12.7%)	11 (12.0%)	98 (12.9%)
Yes – both and booster	1379 (81.3%)	295 (80.8%)	401 (83.4%)	78 (84.8%)	605 (79.8%)
No – medically exempt	2 (0.1%)	0 (0.0%)	2 (0.4%)	0 (0.0%)	0 (0.0%)
No – other	73 (4.3%)	10 (2.7%)	13 (2.7%)	3 (3.3%)	47 (8.2%)
Total	1696 (100%)	365 (100%)	481 (100%)	92 (100%)	758 (100%)

Figure A2.102: COVID-19 Vaccination uptake by Occupation (Weighted)

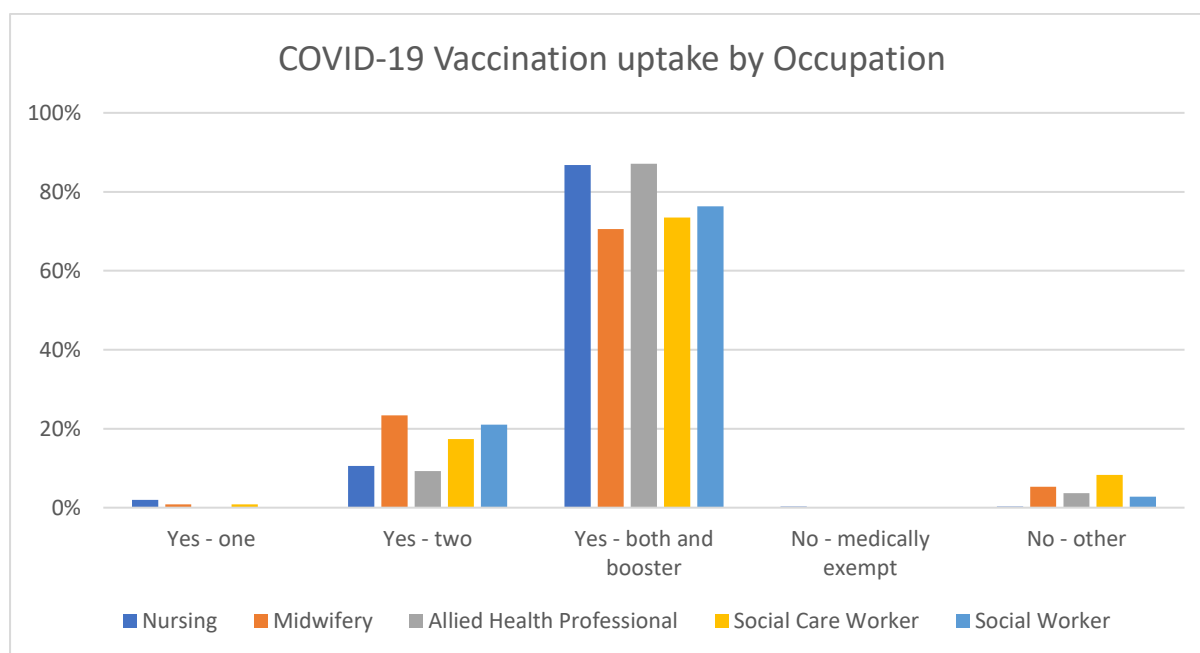


Figure A2.103: COVID-19 Vaccination by Occupation (Unweighted)

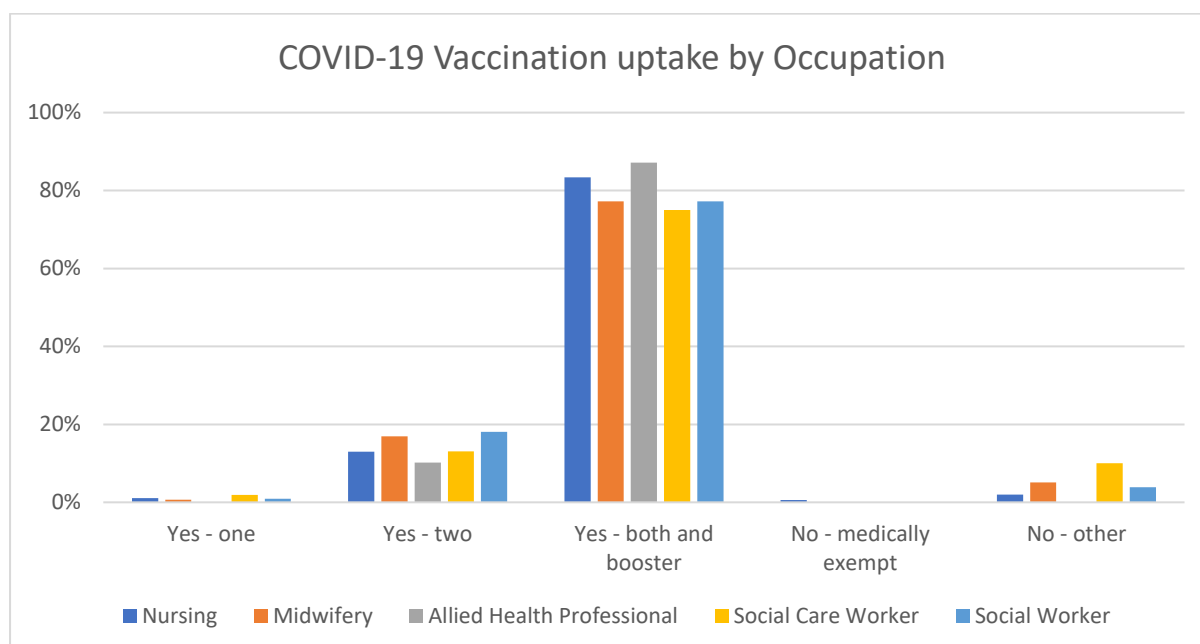


Table A2.102: Vaccination uptake by Occupation (Weighted)

Occupation	Have you received your vaccination?					Total
	Yes- both	Yes – one	Yes – both and booster	No – medically exempt	No – other	
Nursing	2.0%	10.6%	86.8%	0.3%	0.3%	100%
Midwifery	0.8%	23.4%	70.6%	0.0%	5.3%	100%
AHP	0.0%	9.3%	87.1%	0.0%	3.7%	100%
Social Care Worker	0.8%	17.4%	73.5%	0.0%	8.3%	100%
Social Worker	0.0%	21.0%	76.3%	0.1%	2.8%	100%

Table A2.103: Vaccination uptake by Occupation (Unweighted)

Occupation	Have you received your vaccination?					Total
	Yes- both	Yes – one	Yes – both and booster	No – medically exempt	No – other	
Nursing	4 (1.1%)	46 (13.0%)	296 (83.4%)	2 (0.6%)	7 (2.0%)	355 (100%)
Midwifery	1 (0.7%)	23 (16.9%)	105 (77.2%)	0 (0.0%)	7 (5.1%)	136 (100%)
AHP	0 (0.0%)	56 (10.2%)	478 (87.2%)	0 (0.0%)	14 (2.6%)	548 (100%)
Social Care Worker	6 (1.9%)	42 (13.1%)	240 (75.0%)	0 (0.0%)	32 (10.0%)	320 (100%)
Social Worker	3 (0.9%)	61 (18.1%)	260 (77.2%)	0 (0.0%)	13 (3.9%)	337 (100%)

A2.27 Respondents working from home – pre-pandemic

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

Summary (Weighted results):

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

Summary (Unweighted results):

A majority of the respondents did not work from home during the pandemic (77.8%). Respondents from England were the most likely to work from home (31.5%) before the pandemic and those from Scotland were the least likely (15.4%). Social work respondents were mostly likely to work from home (49.1%) while Social Care workers were least likely to work from home (10.0%).

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

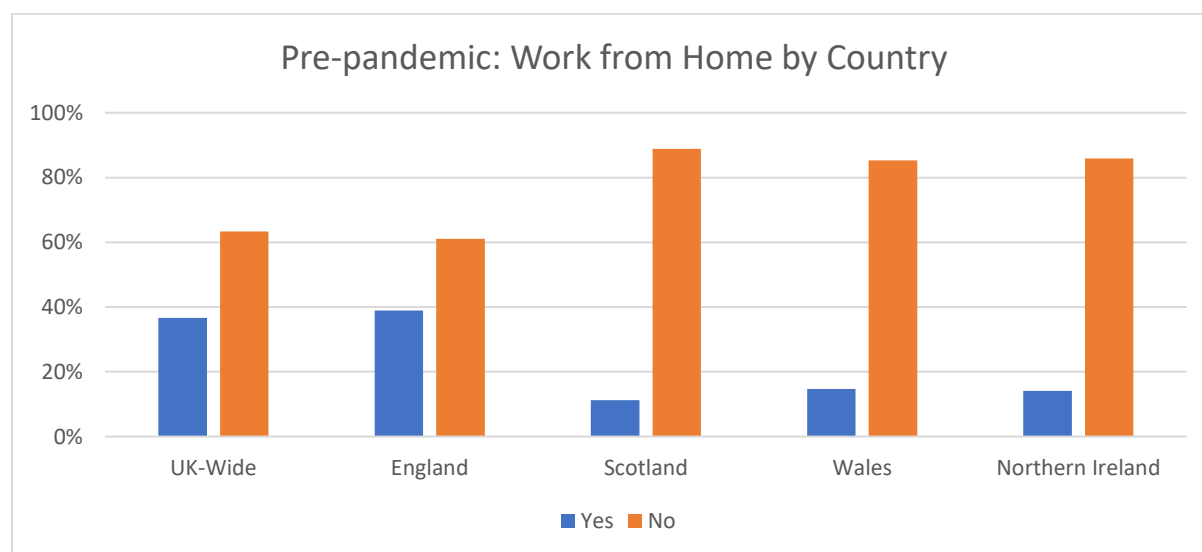


Figure A2.105: Respondents working from home by Country (Unweighted)

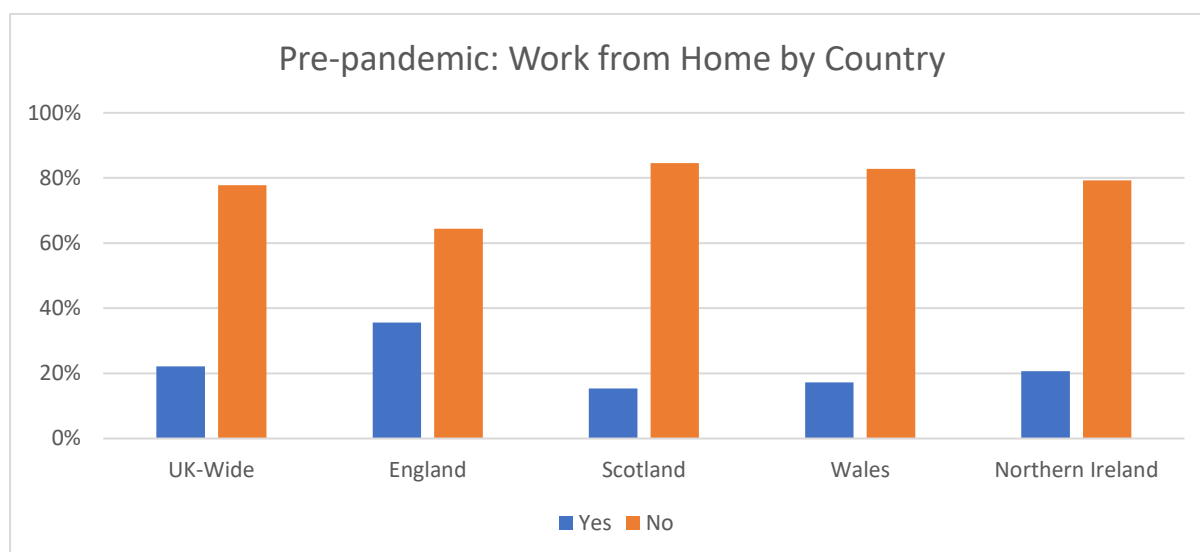


Table A2.104: Respondents working from home by Country (Weighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	36.7%	38.9%	11.2%	14.7%	14.1%
No	63.3%	61.1%	88.8%	85.3%	85.9%
Total	100%	100%	100%	100%	100%

Table A2.105: 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	378 (22.2%)	130 (35.6%)	74 (15.4%)	16 (17.2%)	158 (20.7%)
No	1372 (77.8%)	235 (64.4%)	408 (84.6%)	77 (82.8%)	607 (79.3%)
Total	1705 (100%)	365 (100%)	482 (100%)	93 (100%)	765 (100%)

Figure A2.106: Respondents working from home by Occupation (Weighted)

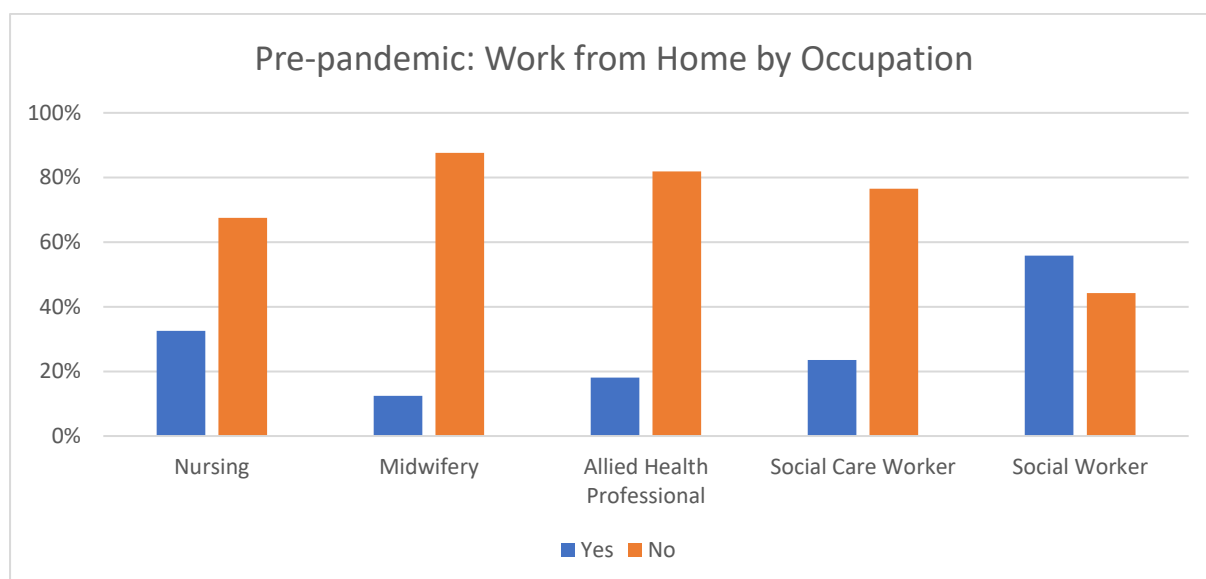


Figure A2.107: Respondents working from home by Occupation (Unweighted)

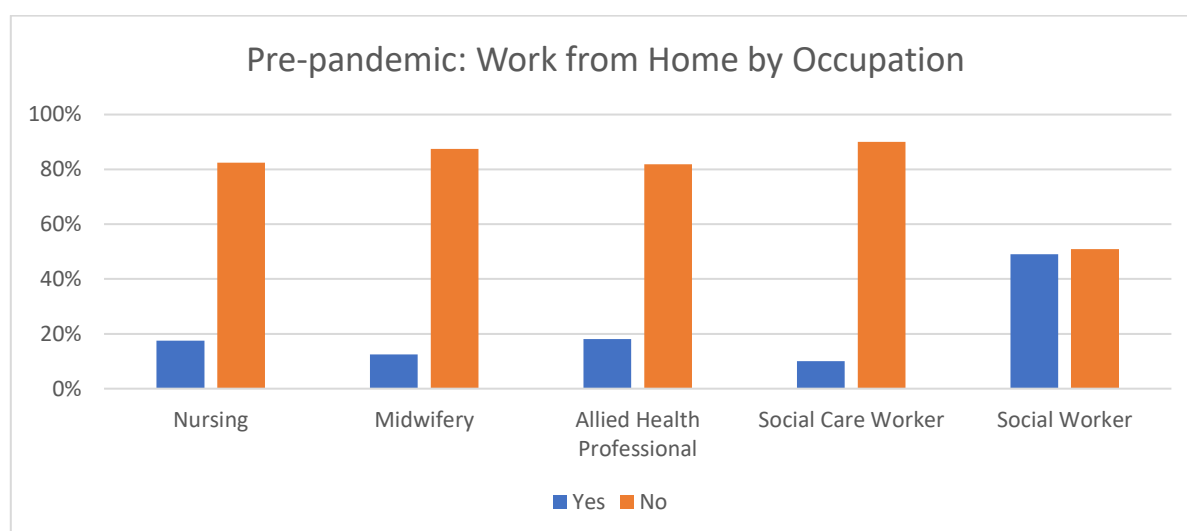


Table A2.106: Respondents working from home by Occupation (Weighted)

Occupation	Did you work from home pre-pandemic?		Total
	Yes	No	
Nursing	32.5%	67.5%	100%
Midwifery	12.4%	87.6%	100%
AHP	18.1%	81.9%	100%
Social Care Worker	23.5%	76.5%	100%
Social Worker	55.8%	44.2%	100%

Table A2.107: Respondents working from home by Occupation (Unweighted)

Occupation	Did you work from home pre-pandemic?		Total
	Yes	No	
Nursing	62 (17.5%)	292 (82.5%)	354 (100%)
Midwifery	17 (12.5%)	119 (87.5%)	136 (100%)
AHP	100 (18.1%)	454 (81.9%)	554 (100%)
Social Care Worker	32 (10.0%)	289 (90.0%)	321 (100%)
Social Worker	167 (49.1%)	173 (50.9%)	340 (100%)

A2.28 Respondents working from home during the pandemic

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

Summary (Weighted results):

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

Summary (Unweighted results):

Over half the respondents were not able to work from home since the start of the pandemic (55.9%). Scotland workers were least likely to work from home, while English workers were more likely to work at home. Social workers were the mostly likely group to work from home all or some of the time.

Figure A2.108: Respondents working from home by Country (Weighted)

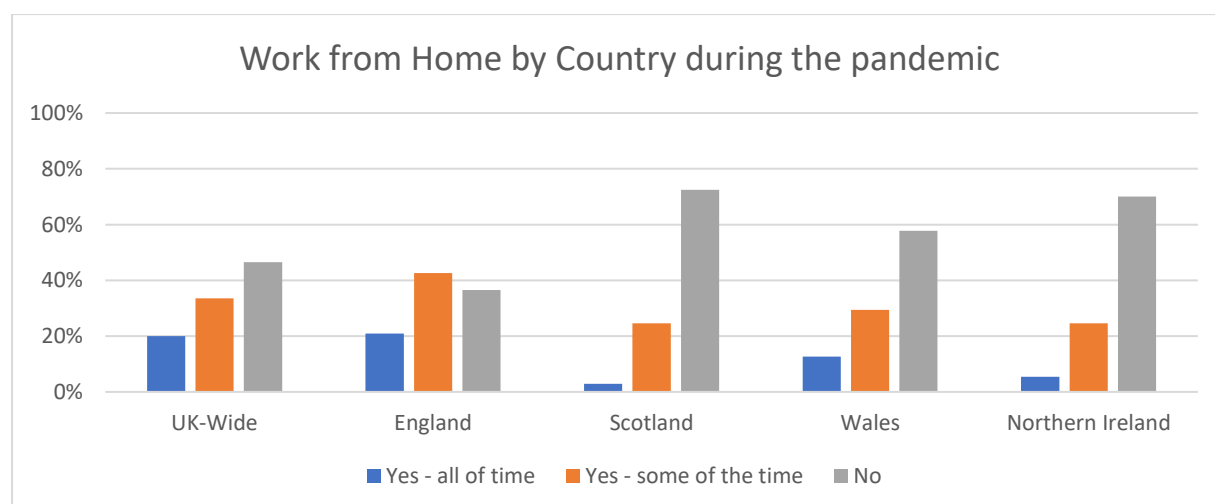


Figure A2.109: Respondents working from home by Country (Unweighted)

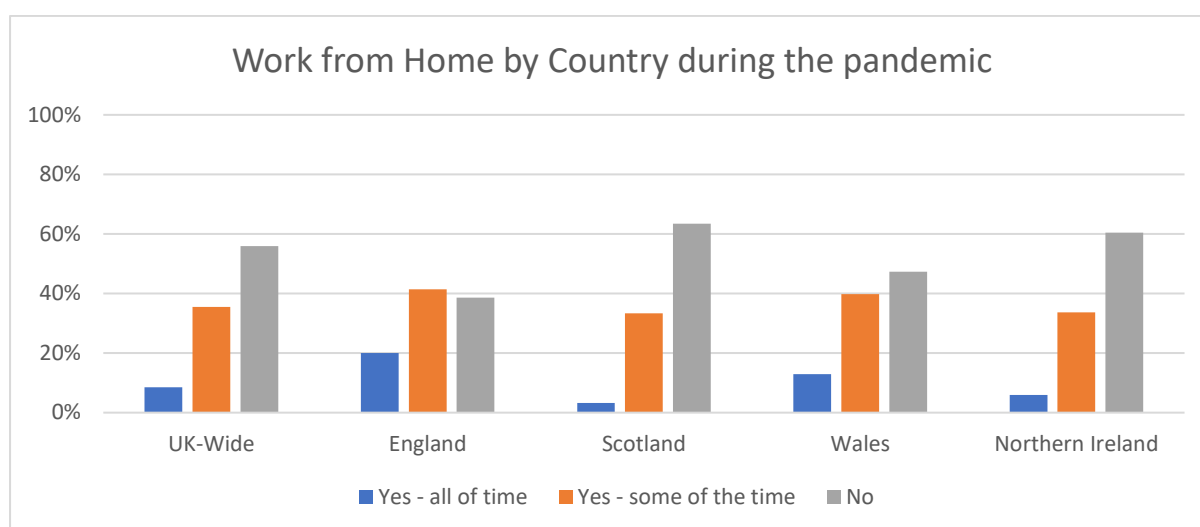


Table A2.108: Respondents working from home by Country (Weighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes – all of time	20.0%	20.9%	2.9%	12.7%	5.4%
Yes – some of the time	33.5%	42.6%	24.6%	29.4%	24.6%
No	46.5%	36.5%	72.5%	57.8%	70.1%
Total	100%	100%	100%	100%	100%

Table A2.109: Respondents working from home by Country (Unweighted)

Are you working from home?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes – all of time	146 (8.5%)	73 (20.0%)	16 (3.3%)	12 (12.9%)	45 (5.9%)
Yes – some of the time	607 (35.5%)	151 (41.4%)	161 (33.3%)	37 (39.8%)	258 (33.7%)
No	955 (55.9%)	141 (38.6%)	307 (63.4%)	44 (47.3%)	463 (60.4%)
Total	1708 (100%)	365 (100%)	484 (100%)	93 (100%)	766 (100%)

Figure A2. 110: Respondents working from home by Occupation (Weighted)

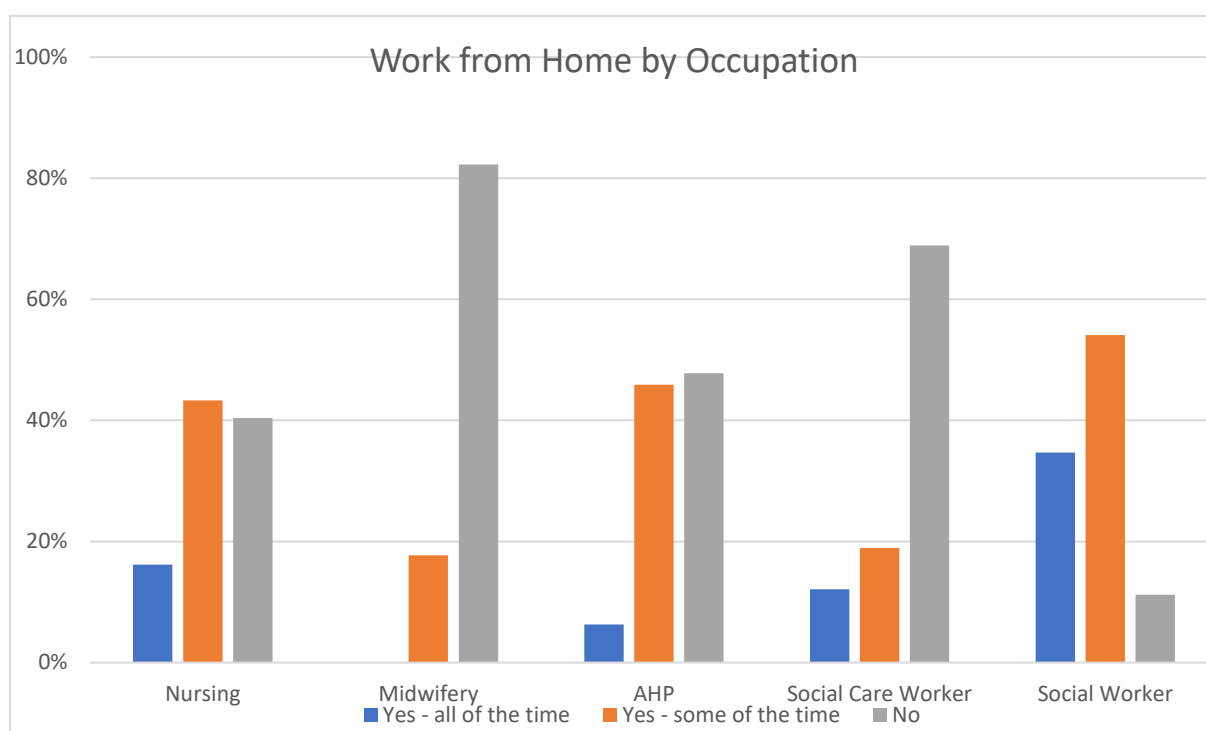


Figure A2. 111: Respondents working from home by Occupation (Unweighted)

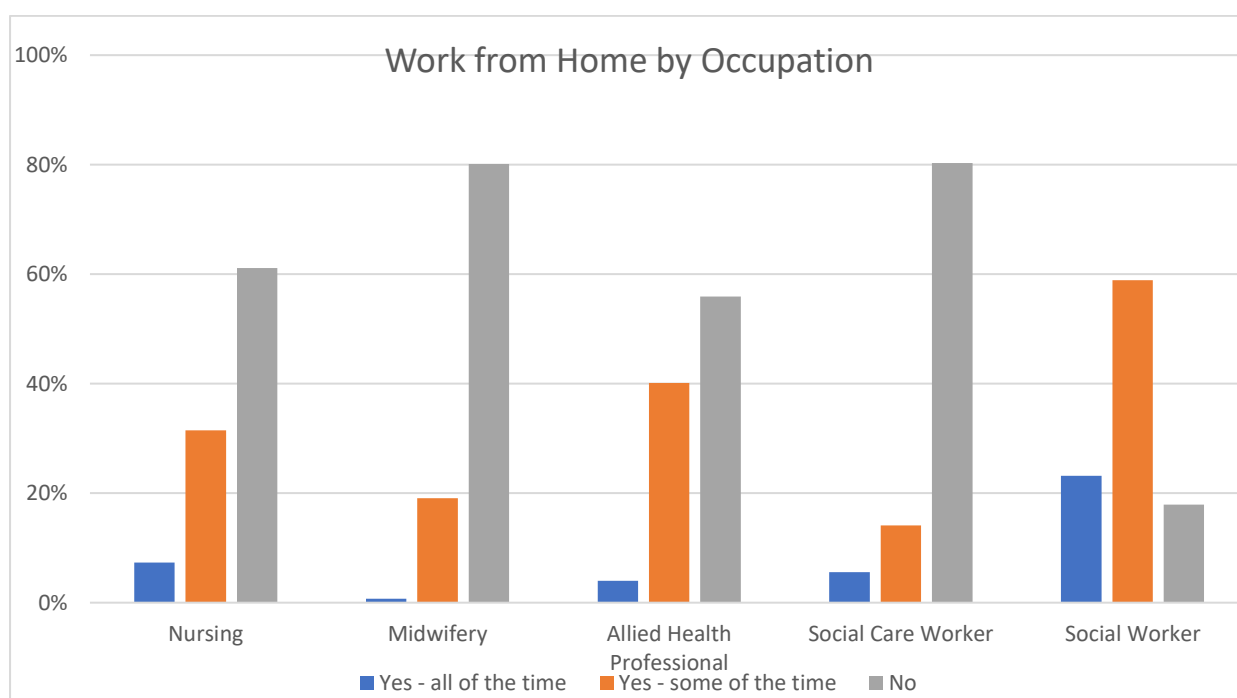


Table A2. 110: Respondents working from home by Occupation (Weighted)

Occupation	Are you working from home?			
	Yes – all of time	Yes – some of the time	No	Total
Nursing	16.2%	43.3%	40.4%	100%
Midwifery	0.0%	17.7%	82.3%	100%
AHP	6.3%	45.9%	47.8%	100%
Social Care Worker	12.1%	18.9%	68.9%	100%
Social Worker	34.7%	54.1%	11.2%	100%

Table A2. 111: 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	26 (7.3%)	112 (31.5%)	217 (61.1%)	355 (100%)
Midwifery	1 (0.7%)	26 (19.1%)	109 (80.1%)	136 (100%)
AHP	22 (4.0%)	223 (40.1%)	311 (55.9%)	556 (100%)
Social Care Worker	18 (5.6%)	45 (14.1%)	257 (80.3%)	320 (100%)
Social Worker	79 (23.2%)	201 (58.9%)	61 (17.9%)	341 (100%)

A2.29 Respondents Morale

Respondents were asked how they would you rate your morale between July 2021 and now? Respondents scored their morale on a scale of 1 to 10, which was then recoded into low, moderate or high morale.

Summary (Weighted results):

Respondents from Scotland were most likely to have reported a lower morale between July 2021 to February 2022 and Wales were most likely to have reported higher levels of morale than the other UK countries. Midwives had the highest percentage of respondents reporting low morale (66.2%).

Summary (Unweighted results):

Respondents from England were most likely to have reported a lower morale between July 2021 to February 2022 and Wales were most likely to have reported higher levels of morale than the other UK countries. Midwives had the highest percentage of respondents reporting low morale (64.0%).

Figure A2. 112: Respondents morale by Country (Weighted)

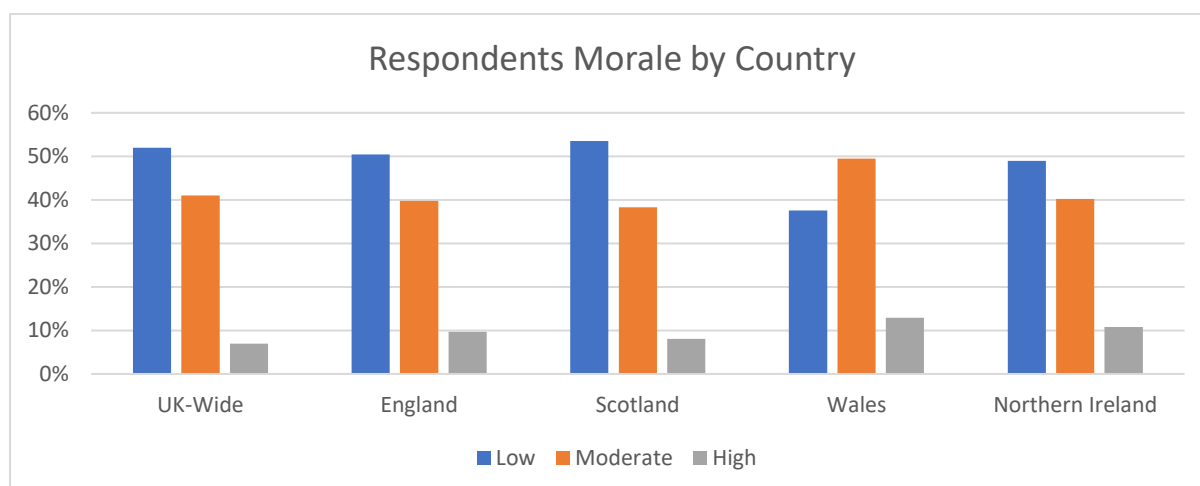


Figure A2. 113: Respondents morale by Country (Unweighted)

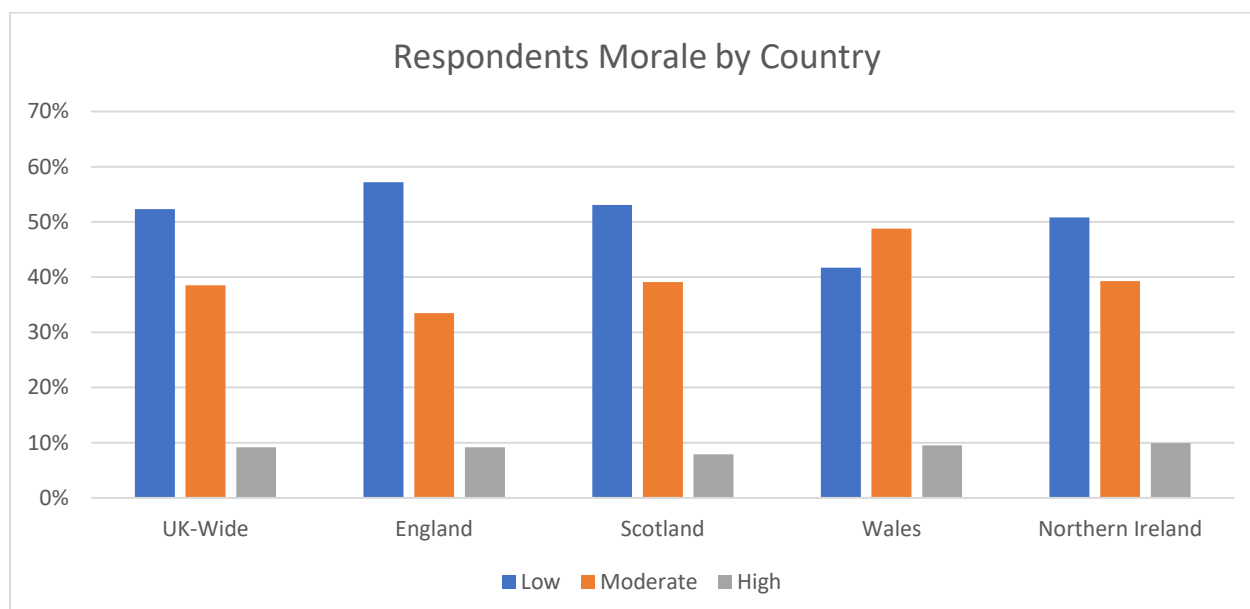


Table A2. 112: Respondents impact on COVID on their morale by Country (Weighted)

What has been the impact of working through COVID-19, on your morale?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Low Impact	52.0%	50.4%	53.5%	37.6%	49.0%
Moderate Impact	41.0%	39.8%	38.3%	49.5%	40.2%
High Impact	7.0%	9.7%	8.1%	12.9%	10.8%
Total	100%	100%	100%	100%	100%

Table A2.113: Respondents impact on COVID on their morale by Country (Unweighted)

How would you rate your morale between July 2021 and now?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Low	(52.3%)	198 (57.2%)	243 (53.1%)	35 (41.7%)	364 (50.8%)
Moderate	(38.5%)	116 (33.5%)	179 (39.1%)	41 (48.8%)	282 (39.3%)
High	(9.2%)	32 (9.2%)	36 (7.9%)	8 (9.5%)	71 (9.9%)
Total	1605 (100%)	346 (100%)	458 (100%)	84 (100%)	717 (100%)

Figure A2. 114: Respondents morale by Occupation (Weighted)

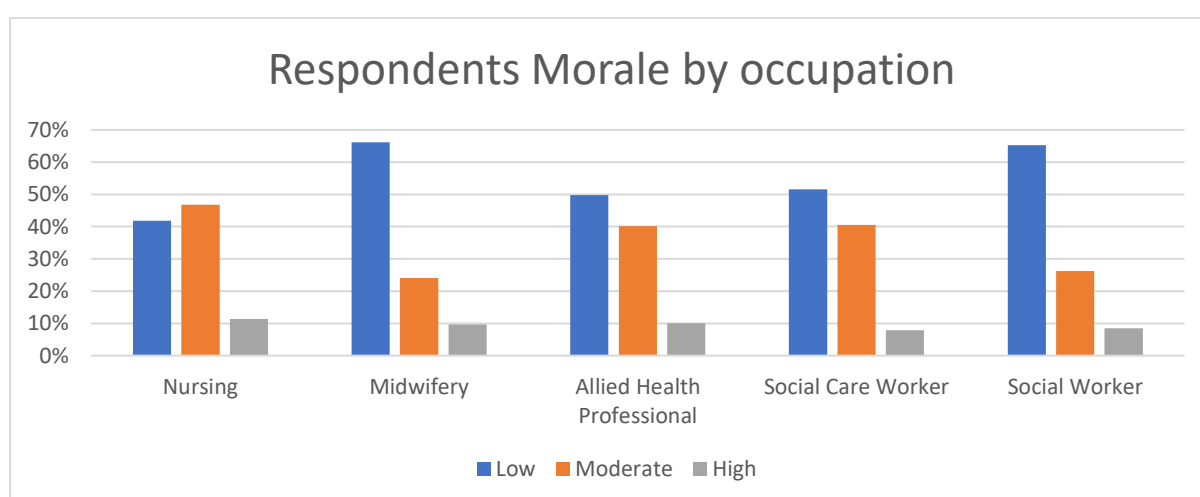


Figure A2. 115: Respondents morale by Occupation (Unweighted)

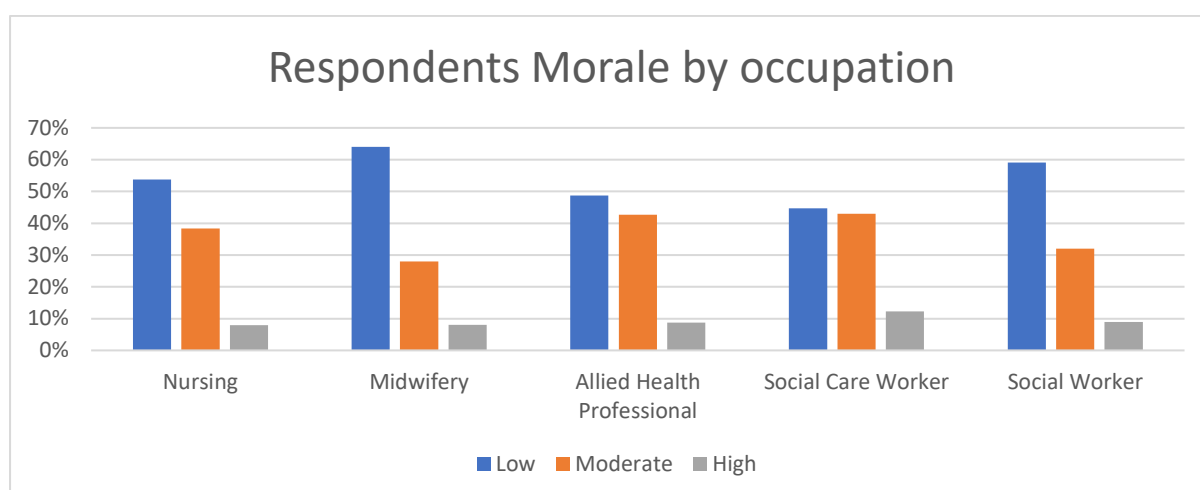


Table A2.114: Respondents morale by Occupation (Weighted)

Occupation	How would you rate your morale between July 2021 and now?			
	Low	Moderate	High	Total
Nursing	41.8%	46.8%	11.4%	100%
Midwifery	66.2%	24.1%	9.7%	100%
AHP	49.8%	40.1%	10.1%	100%
Social Care Worker	51.6%	40.5%	7.9%	100%
Social Worker	65.3%	26.2%	8.5%	100%

Table A2.115: Respondents impact on COVID on their morale by Occupation (Unweighted)

Occupation	How would you rate your morale between July 2021 and now?			
	Low	Moderate	High	Total
Nursing	184 (53.8%)	131 (38.3%)	27 (7.9%)	342 (100%)
Midwifery	80 (64.0%)	35 (28.0%)	10 (8.0%)	125 (100%)
AHP	253 (48.7%)	222 (42.7%)	45 (8.7%)	520 (100%)
Social Care Worker	131 (44.7%)	126 (43.0%)	36 (12.3%)	293 (100%)
Social Worker	192 (59.1%)	104 (32.0%)	29 (8.9%)	325 (100%)

A2.30 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;

- Promotion opportunities
- Against mandates
- Because the flexibility of working from home might end
- Better pay, hours and recognition
- Personal circumstances
- Unprofessionalism in the workplace
- Unmanageable and increased stress
- Family
- Loss of autonomy and flexibility
- No job security – temporary contracts
- Not valued or supported
- Lack of trust
- Poor work-life balance
- Unrealistic work demands
- Reduce work commute
- Considering retirement
- Further education
- Relocation
- No adequate sick pay provision
- Impact on morale
- Having to complete tasks and take on responsibilities outside of role.
- Lack of personal and professional development when working at home.

Figure A2. 116: Considering Changing Employer by Country (Weighted)

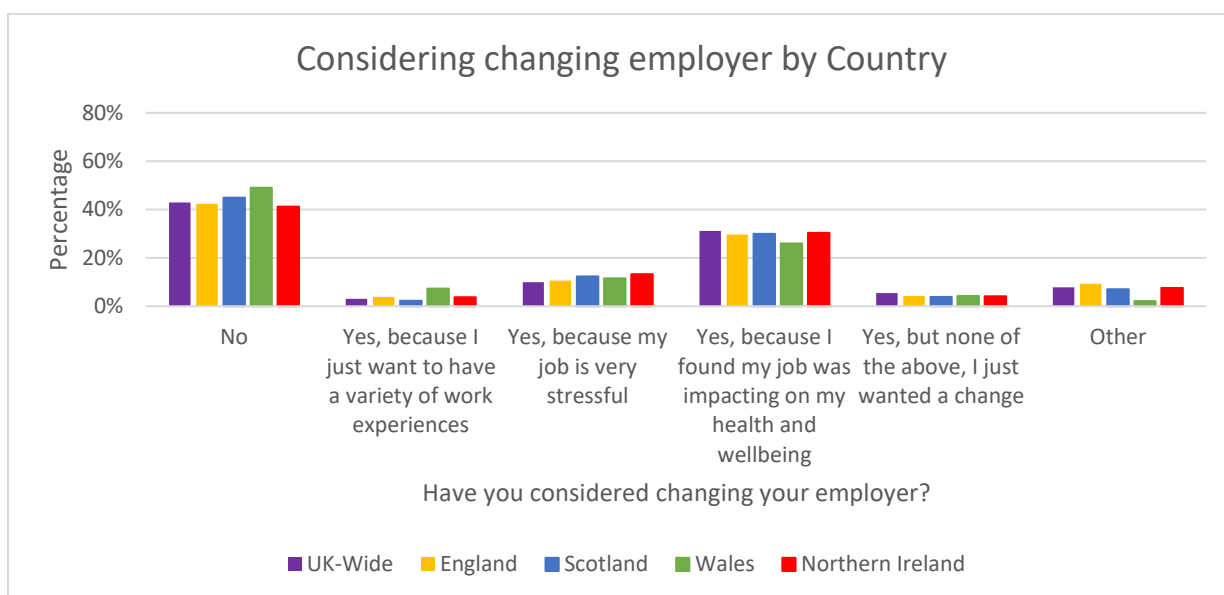


Figure A2.117: Considering Changing Employer by Country (Unweighted)

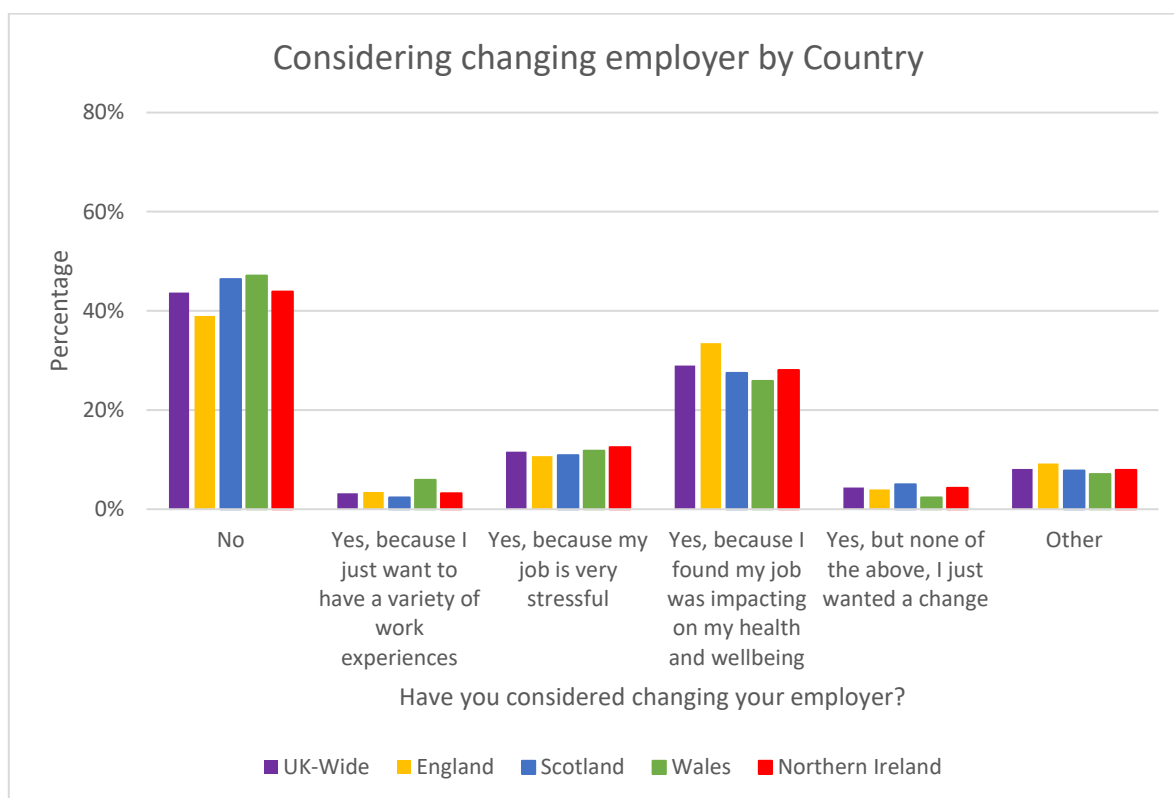


Table A2.116: Considering Changing Employer by Country (Weighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	42.9%	42.4%	44.9%	49.0%	41.2%
Yes, because I just want to have a variety of work experiences	3.0%	3.8%	2.2%	7.3%	3.7%
Yes, because my job is very stressful	9.9%	10.6%	12.3%	11.5%	13.3%
Yes, because I found my job was impacting on my health and wellbeing	31.1%	29.7%	29.9%	26.0%	30.3%
Yes, but none of the above, I just wanted a change	5.4%	4.2%	3.8%	4.2%	4.1%
Other	7.8%	9.3%	7.0%	2.1%	7.5%
Total	100%	100%	100%	100%	100%

Table A2.117: Considering Changing Employer by Country (Unweighted)

Have you considered changing your employer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	703 (43.7%)	135 (39.0%)	213 (46.4%)	40 (47.1%)	315 (43.9%)
Yes, because I just want to have a variety of work experiences	51 (3.2%)	12 (3.5%)	11 (2.4%)	5 (5.9%)	23 (3.2%)
Yes, because my job is very stressful	187 (11.6%)	37 (10.7%)	50 (10.9%)	10 (11.8%)	90 (12.5%)
Yes, because I found my job was impacting on my health and wellbeing	466 (29.0%)	116 (33.5%)	126 (27.5%)	22 (25.9%)	202 (28.1%)
Yes, but none of the above, I just wanted a change	70 (4.4%)	14 (4.0%)	23 (5.0%)	2 (2.4%)	31 (4.3%)
Other	131 (8.1%)	32 (9.2%)	36 (7.8%)	6 (7.1%)	57 (7.9%)
Total	1608 (100%)	346 (100%)	459 (100%)	85 (100%)	718 (100%)

Figure A2.118: Considering Changing Employer by Occupation (Weighted)

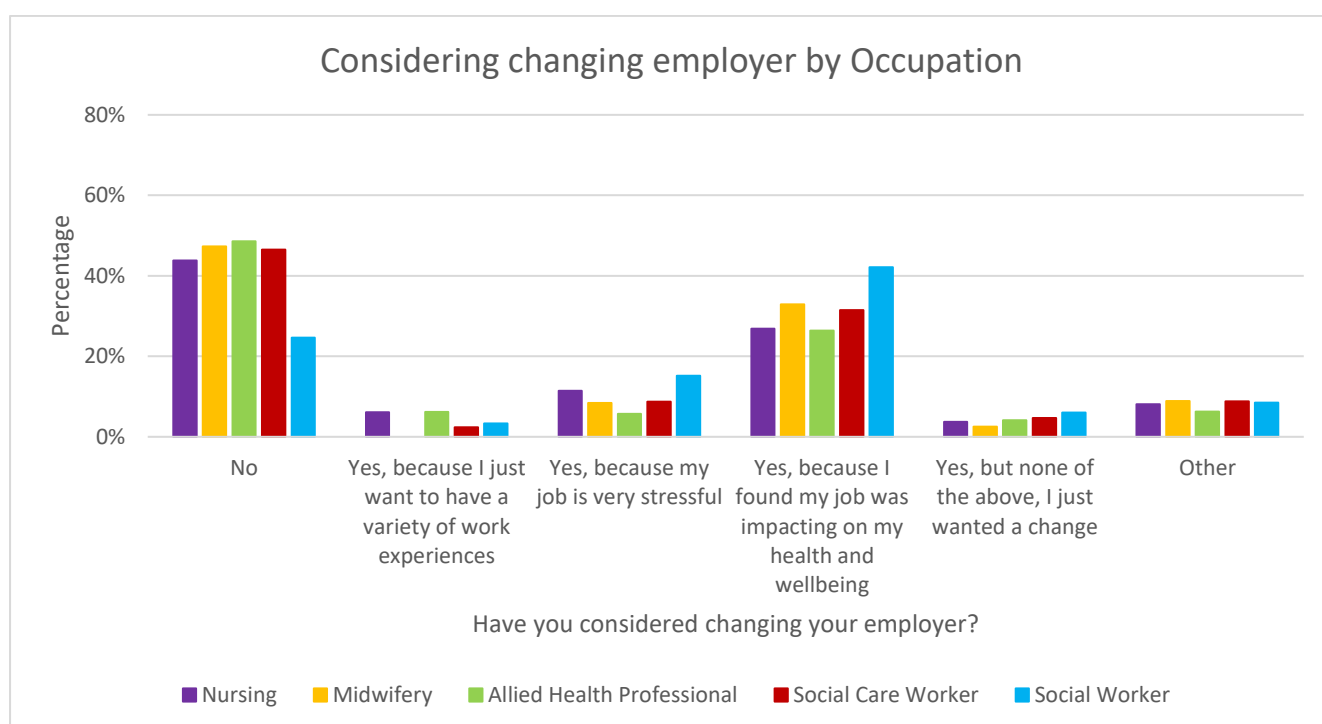


Figure A2.119: Considering Changing Employer by Occupation (Unweighted)

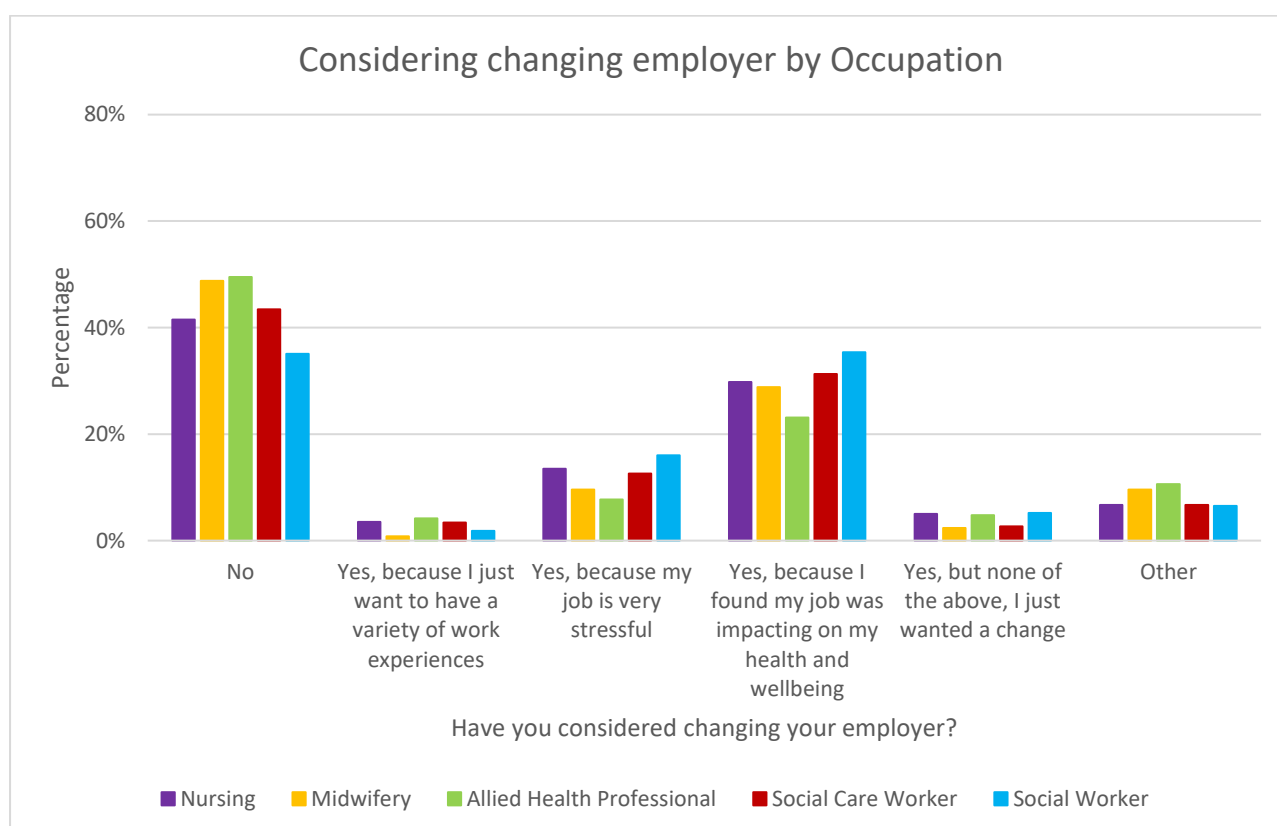


Table A2.118: Considering Changing Employer by Occupation (Weighted)

Occupation	Have you considered changing your employer?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	
Nursing	43.8%	6.1%	11.4%	26.9%	3.7%	8.1%	100%
Midwifery	47.3%	0.0%	8.4%	32.9%	2.5%	8.9%	100%
AHP	48.6%	6.2%	5.7%	26.4%	4.1%	6.3%	100%
Social Care Worker	46.5%	2.4%	8.7%	31.5%	4.7%	8.8%	100%
Social Worker	24.6%	3.3%	15.2%	42.1%	6.0%	8.5%	100%

Table A2.119: Considering Changing Employer by Occupation (Unweighted)

Occupation	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	142 (41.5%)	12 (3.5%)	46 (13.5%)	102 (29.8%)	17 (5.0%)	23 (6.7%)	342 (100%)
Midwifery	61 (48.8%)	1 (0.8%)	12 (9.6%)	36 (28.8%)	3 (2.4%)	12 (9.6%)	125 (100%)
AHP	257 (49.5%)	22 (4.2%)	40 (7.7%)	120 (23.1%)	25 (4.8%)	55 (10.6%)	519 (100%)
Social Care Worker	129 (43.4%)	10 (3.4%)	37 (12.6%)	93 (31.3%)	8 (2.7%)	20 (6.7%)	297 (100%)
Social Worker	114 (35.1%)	6 (1.8%)	52 (16.0%)	115 (35.4%)	17 (5.2%)	21 (6.5%)	325 (100%)

A2.31 Respondents Considering Changing their Occupation

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

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

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

Figure A2.120: Considering Changing Occupation by Country (Weighted)

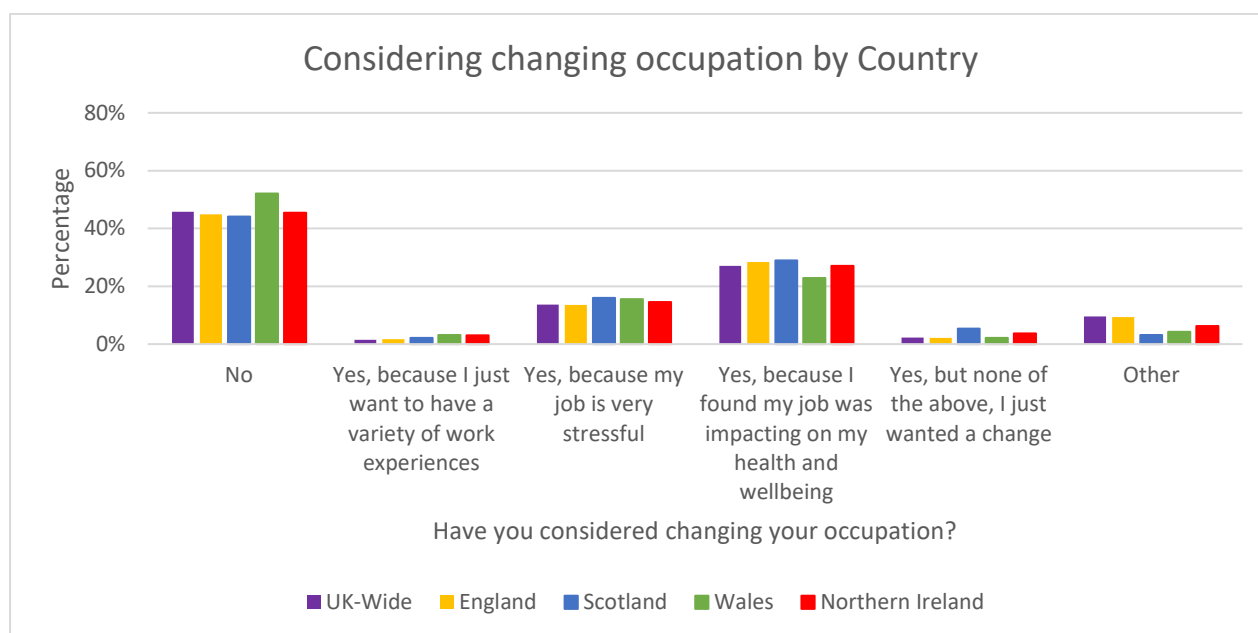


Figure A2.121: Considering Changing Occupation by Country (Unweighted)

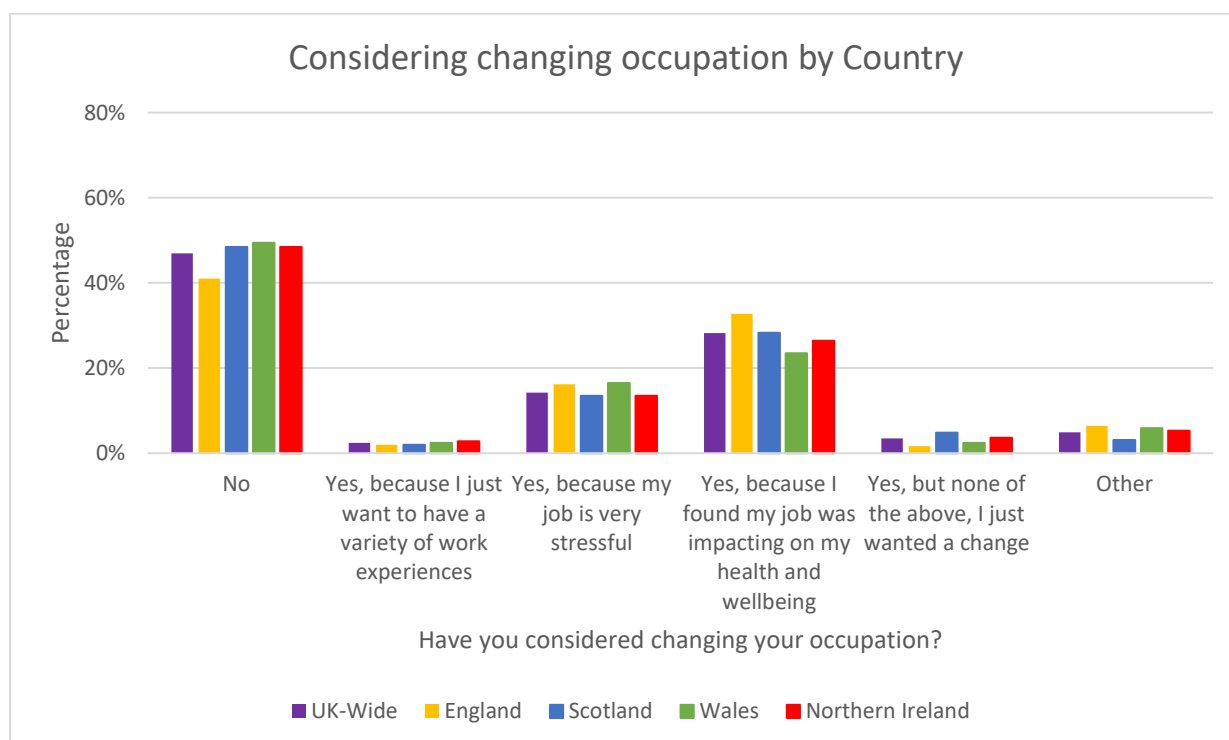


Table A2.120: Considering Changing Occupation by Country (Weighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	45.8%	44.9%	44.1%	52.1%	45.5%
Yes, because I just want to have a variety of work experiences	1.5%	1.7%	2.2%	3.1%	3.0%
Yes, because my job is very stressful	13.7%	13.6%	16.0%	15.6%	14.5%
Yes, because I found my job was impacting on my health and wellbeing	27.1%	28.4%	29.0%	22.9%	27.1%
Yes, but none of the above, I just wanted a change	2.3%	2.1%	5.4%	2.1%	3.7%
Other	9.6%	9.3%	3.2%	4.2%	6.2%
Total	100%	100%	100%	100%	100%

Table A2.121: Considering Changing Occupation by Country (Unweighted)

Have you considered changing your occupation?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
No	754 (46.9%)	142 (41.0%)	222 (48.4%)	42 (49.4%)	348 (48.4%)
Yes, because I just want to have a variety of work experiences	38 (2.4%)	7 (2.0%)	9 (2.0%)	2 (2.4%)	20 (2.8%)
Yes, because my job is very stressful	229 (14.2%)	56 (16.2%)	62 (13.5%)	14 (16.5%)	97 (13.5%)
Yes, because I found my job was impacting on my health and wellbeing	453 (28.2%)	113 (32.7%)	130 (28.3%)	20 (23.5%)	190 (26.4%)
Yes, but none of the above, I just wanted a change	56 (3.5%)	6 (1.7%)	22 (4.8%)	2 (2.4%)	26 (3.6%)
Other	79 (4.9%)	22 (6.4%)	14 (3.1%)	5 (5.9%)	38 (5.3%)
Total	1609 (100%)	346 (100%)	459 (100%)	85 (100%)	719 (100%)

Figure A2.122: Considering Changing Occupation by Occupation (Weighted)

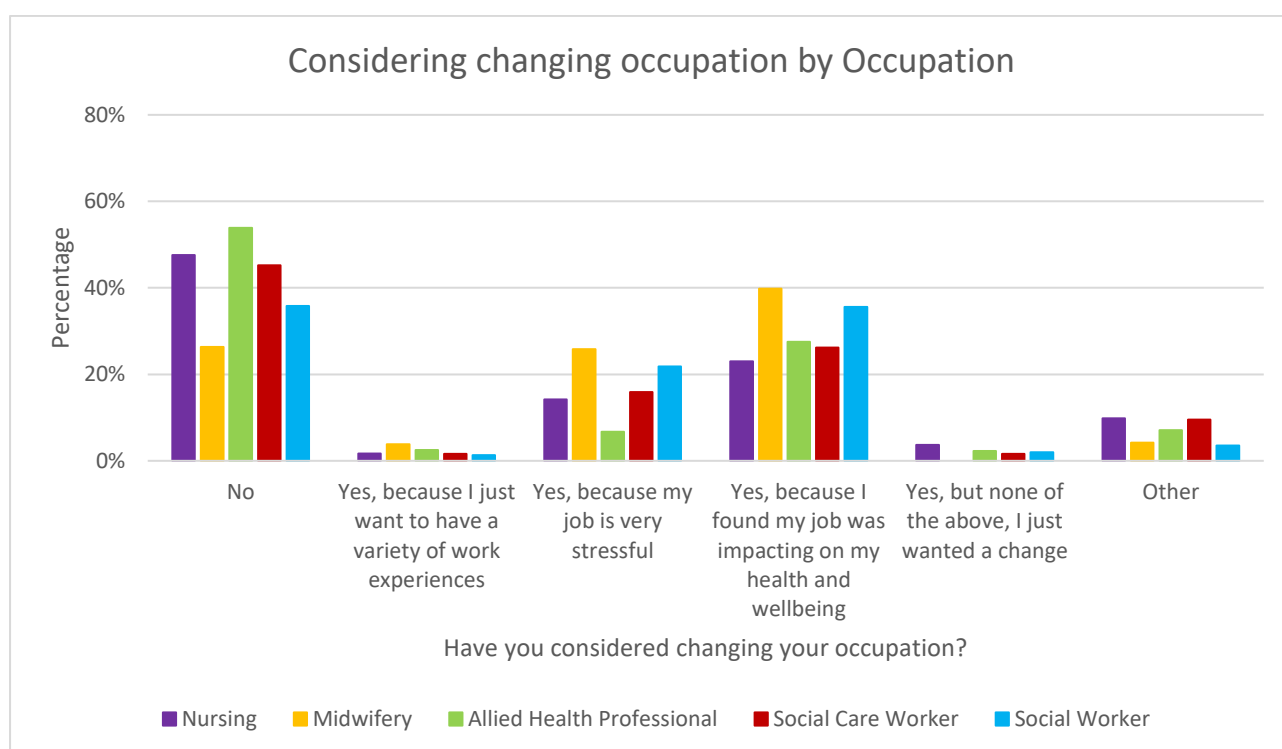


Figure A2.123: Considering Changing Occupation by Occupation (Unweighted)

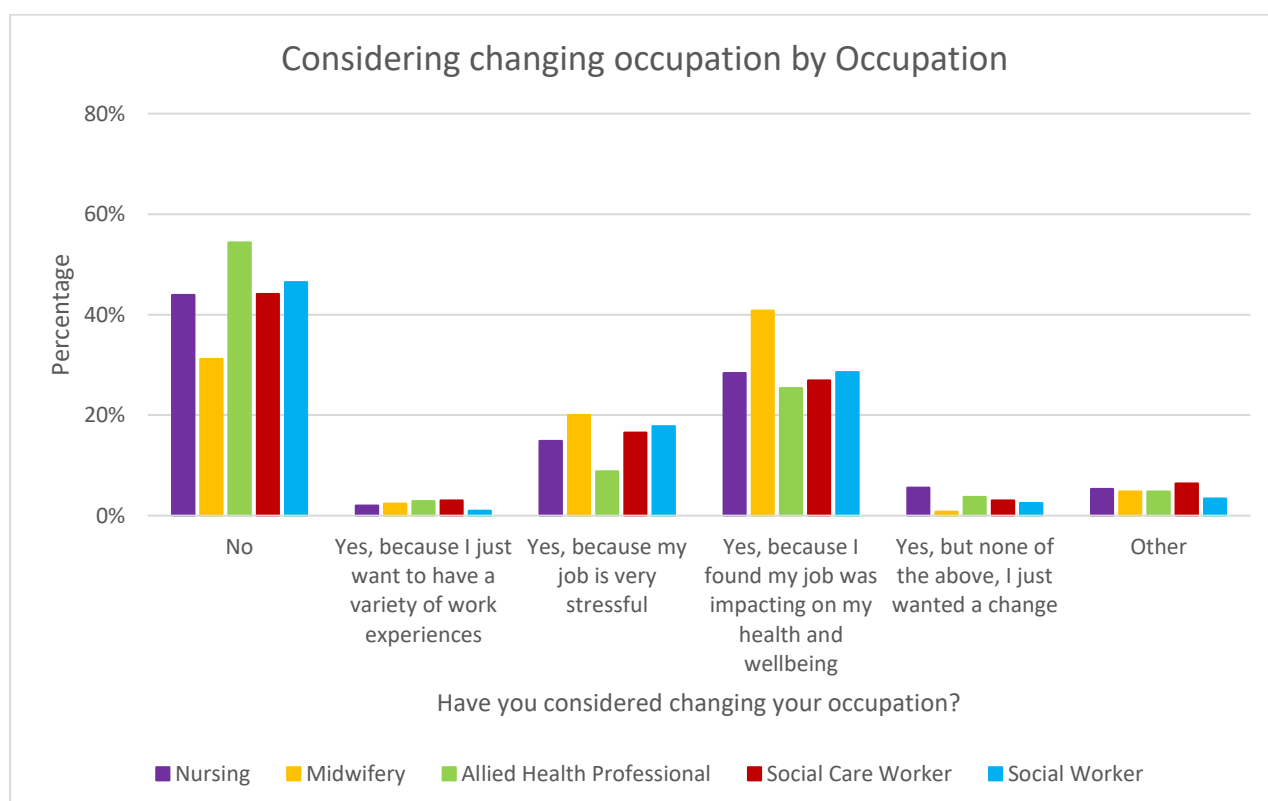


Table A2.122: Considering Changing Occupation by Occupation (Weighted)

Occupation	Have you considered changing your occupation?						Total
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	
Nursing	47.6%	1.7%	14.2%	23.0%	3.7%	9.8%	100%
Midwifery	26.3%	3.8%	25.8%	39.8%	0.0%	4.2%	100%
AHP	53.9%	2.5%	6.7%	27.5%	2.3%	7.1%	100%
Social Care Worker	45.2%	1.6%	15.9%	26.2%	1.6%	9.5%	100%
Social Worker	35.8%	1.3%	21.8%	35.6%	2.0%	3.5%	100%

Table A2.123: Considering Changing Occupation by Occupation (Unweighted)

Occupation	Have you considered changing your occupation?						
	No	Yes, because I just want to have a variety of work experiences	Yes, because my job is very stressful	Yes, because I found my job was impacting on my health and wellbeing	Yes, but none of the above, I just wanted a change	Other	Total
Nursing	150 (43.9%)	7 (2.0%)	51 (14.9%)	97 (28.4%)	19 (5.6%)	18 (5.3%)	342 (100%)
Midwifery	39 (31.2%)	3 (2.4%)	25 (20.0%)	51 (40.8%)	1 (0.8%)	6 (4.8%)	125 (100%)
AHP	283 (54.4%)	15 (2.9%)	46 (8.8%)	132 (25.4%)	18 (3.7%)	25 (4.8%)	520 (100%)
Social Care Worker	131 (44.1%)	9 (3.0%)	49(16.5%)	80 (26.9%)	9 (3.0%)	19 (6.4%)	297 (100%)
Social Worker	151 (46.5%)	4 (1.0%)	58 (17.8%)	93 (28.6%)	8 (2.5%)	11 (3.4%)	325 (100%)

A2.32 Respondents reasons for why they might change their mind about wanting to leave.

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

Figure A2.124: What has to happen for you to change your mind about wanting to leave by Country (Weighted)

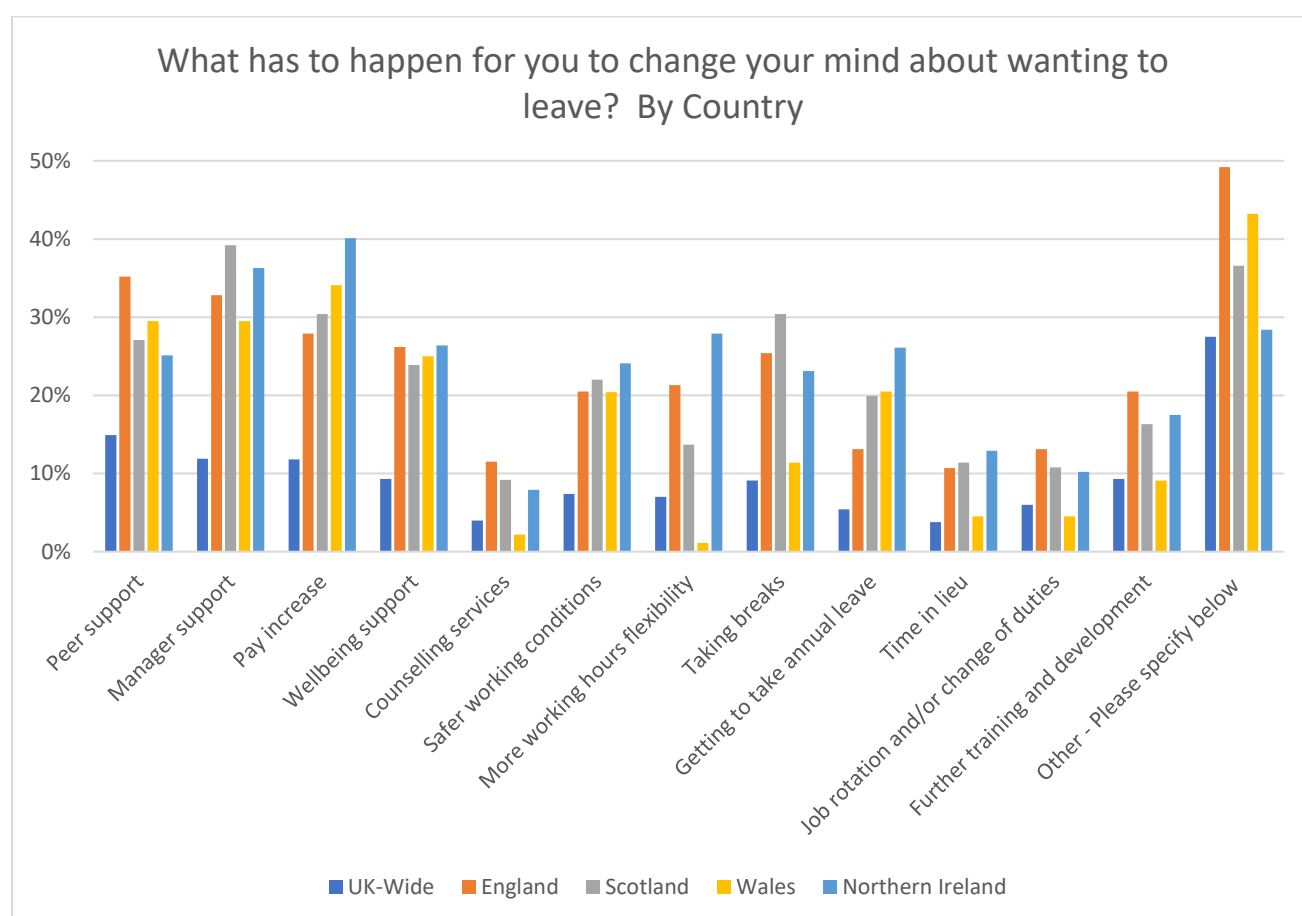


Figure A2.125: What has to happen for you to change your mind about wanting to leave by Country (Unweighted)

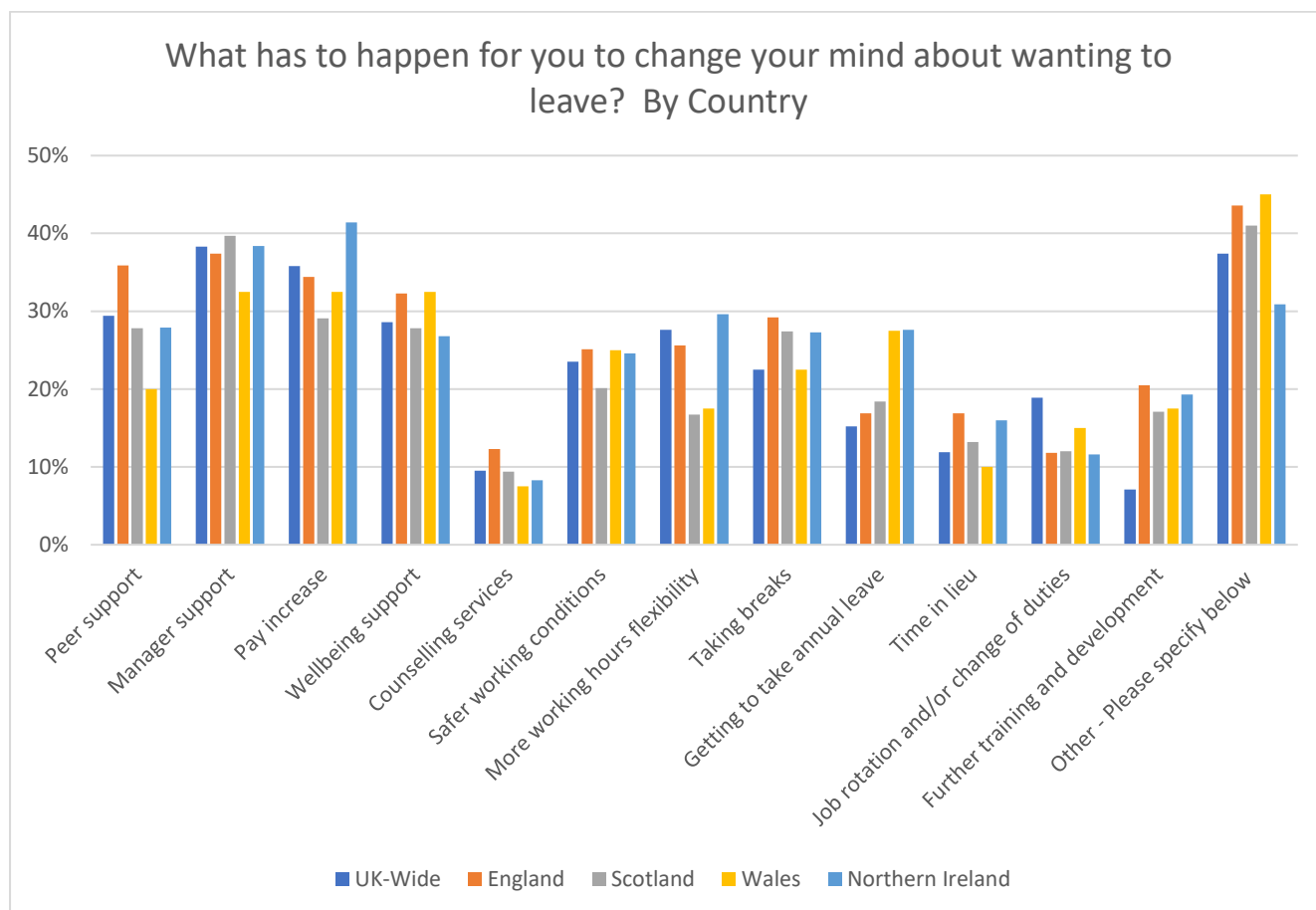


Table A2.124: What has to happen for you to change your mind about wanting to leave by Country (Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	14.9%	35.2%	27.1%	29.5%	25.1%
Manager support	11.9%	32.8%	39.2%	29.5%	36.3%
Pay increase	11.8%	27.9%	30.4%	34.1%	40.1%
Wellbeing support	9.3%	26.2%	23.9%	25.0%	26.4%
Counselling services	4.0%	11.5%	9.2%	2.2%	7.9%
Safer working conditions	7.4%	20.5%	22.0%	20.4%	24.1%
More working hours flexibility	7.0%	21.3%	13.7%	1.1%	27.9%
Taking breaks	9.1%	25.4%	30.4%	11.4%	23.1%
Getting to take annual leave	5.4%	13.1%	19.9%	20.5%	26.1%
Time in lieu	3.8%	10.7%	11.4%	4.5%	12.9%
Job rotation and/or change of duties	6.0%	13.1%	10.8%	4.5%	10.2%
Further training and development	9.3%	20.5%	16.3%	9.1%	17.5%
Other – Please specify below	27.5%	49.2%	36.6%	43.2%	28.4%

Table A2.125: 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	244 (29.4%)	70 (35.9%)	65 (27.8%)	8 (20.0%)	10 (27.9%)
Manager support	318 (38.3%)	73 (37.4%)	93 (39.7%)	13 (32.5%)	139 (38.4%)
Pay increase	298 (35.8%)	67 (34.4%)	68 (29.1%)	13 (32.5%)	150 (41.4%)
Wellbeing support	238 (28.6%)	63 (32.3%)	65 (27.8%)	13 (32.5%)	97 (26.8%)
Counselling services	79 (9.5%)	(12.3%)	(9.4%)	(7.5%)	(8.3%)
Safer working conditions	195 (23.5%)	24 (25.1%)	22 (20.1%)	3 (25.0%)	30 (24.6%)
More working hours flexibility	203 (27.6%)	49 (25.6%)	47 (16.7%)	10 (17.5%)	89 (29.6%)
Taking breaks	229 (22.5%)	57 (29.2%)	64 (27.4%)	9 (22.5%)	99 (27.3%)
Getting to take annual leave	187 (15.2%)	33 (16.9%)	43 (18.4%)	11 (27.5%)	10 (27.6%)
Time in lieu	126 (11.9%)	33 (16.9%)	31 (13.2%)	4 (10.0%)	58 (16.0%)
Job rotation and/or change of duties	99 (18.9%)	23 (11.8%)	28 (12.0%)	6 (15.0%)	4 (11.6%)
Further training and development	157 (7.1%)	40 (20.5%)	40 (17.1%)	7 (17.5%)	7 (19.3%)
Other – Please specify below	311 (37.4%)	85 (43.6%)	96 (41.0%)	18 (45.0%)	112 (30.9%)
Total no of respondents answering question	831	195	234	40	362

Figure A2.126: What has to happen for you to change your mind about wanting to leave by Occupation (Weighted)

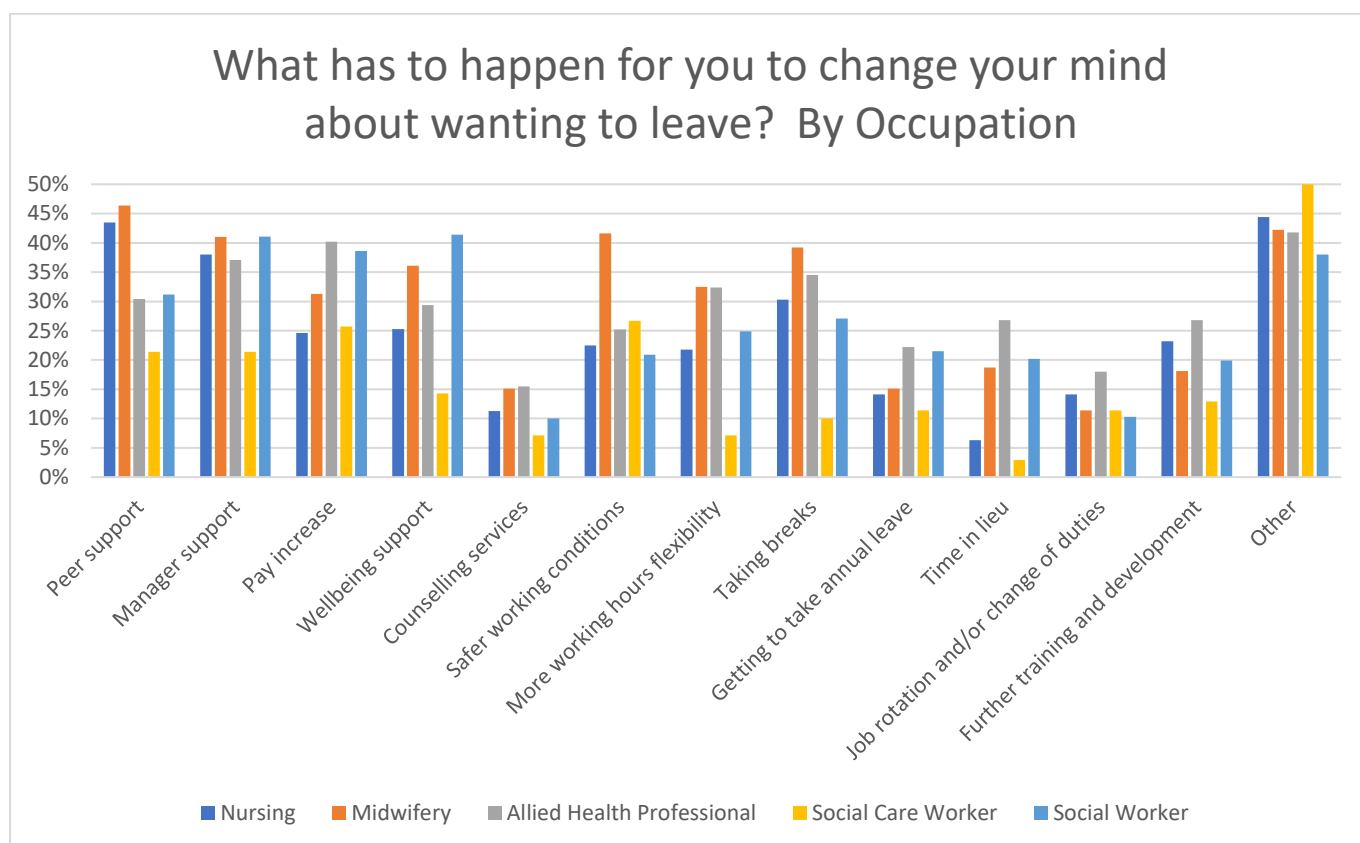


Figure A2.127: What has to happen for you to change your mind about wanting to leave by Occupation (Unweighted)

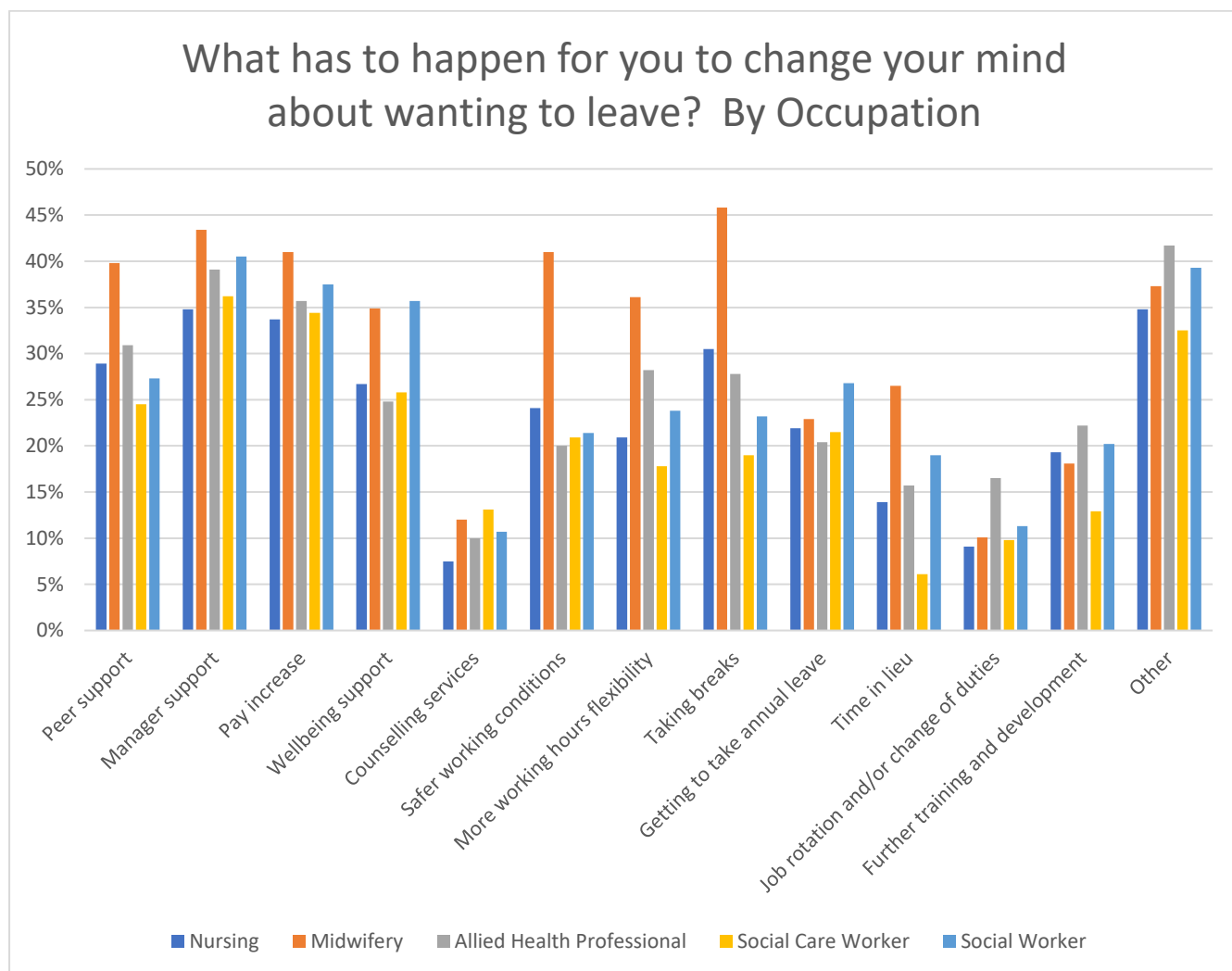


Table A2.126: What has to happen for you to change your mind about wanting to leave by Occupation(Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	43.5%	46.4%	30.4%	21.4%	31.2%
Manager support	38.0%	41.0%	37.1%	21.4%	41.1%
Pay increase	24.%	31.3%	40.2%	25.7%	38.6%
Wellbeing support	25.3%	36.1%	29.4%	14.3%	41.4%
Counselling services	11.3%	15.1%	15.5%	7.1%	10.0%
Safer working conditions	22.5%	41.6%	25.2%	26.7%	20.9%
More working hours flexibility	21.8%	32.5%	32.4%	7.1%	24.9%
Taking breaks	30.3%	39.2%	34.5%	10.0%	27.1%
Getting to take annual leave	14.1%	15.1%	22.2%	11.4%	21.5%
Time in lieu	6.3%	18.7%	26.8%	2.9%	20.2%
Job rotation and/or change of duties	14.1%	11.4%	18.0%	11.4%	10.3%
Further training and development	23.2%	18.1%	26.8%	12.9%	19.9%
Other – Please specify below	44.4%	42.2%	41.8%	50.0%	38.0%

Table A2.127: 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	54 (28.9%)	33 (39.8%)	71 (30.9%)	40 (24.5%)	46 (27.3%)
Manager support	65 (34.8%)	36 (43.4%)	90 (3.9%)	59 (36.2%)	68 (40.5%)
Pay increase	63 (33.7%)	34 (41.0%)	82 (35.7%)	56 (34.4%)	63 (37.5%)
Wellbeing support	50 (26.7%)	29 (34.9%)	57 (24.8%)	42 (25.8%)	60 (35.7%)
Counselling services	14 (7.5%)	10 (12.0%)	23 (10.0%)	14 (13.1%)	18 (10.7%)
Safer working conditions	45 (24.1%)	34 (41.0%)	46 (20.0%)	34 (20.9%)	36 (21.4%)
More working hours flexibility	39 (20.9%)	30 (36.1%)	65 (28.2%)	29 (17.8%)	40 (23.8%)
Taking breaks	57 (30.5%)	38 (45.8%)	64 (27.8%)	31 (19.0%)	39 (23.2%)
Getting to take annual leave	41 (21.9%)	19 (22.9%)	47 (20.4%)	35 (21.5%)	45 (26.8%)
Time in lieu	26 (13.9%)	22 (26.5%)	36 (15.7%)	10 (6.1%)	32 (19.0%)
Job rotation and/or change of duties	17 (9.1%)	9 (10.1%)	38 (16.5%)	16 (9.8%)	19 (11.3%)
Further training and development	36 (19.3%)	15 (18.1%)	51 (22.2%)	21 (12.9%)	34 (20.2%)
Other – Please specify below	65 (34.8%)	31 (37.3%)	96 (41.7%)	53 (32.5%)	66 (39.3%)
Total of respondents answering question	187	83	230	163	168

A2.33 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):

Just over half of the respondents reported to still being in the same job, with the same contractual working hours.

Summary (Unweighted results):

Two thirds of respondents stated no that they were still in the same job with the same contractual working hours (66.9%).

Figure A2. 128: Chosen to change job or contractual working hours by Country (Weighted)

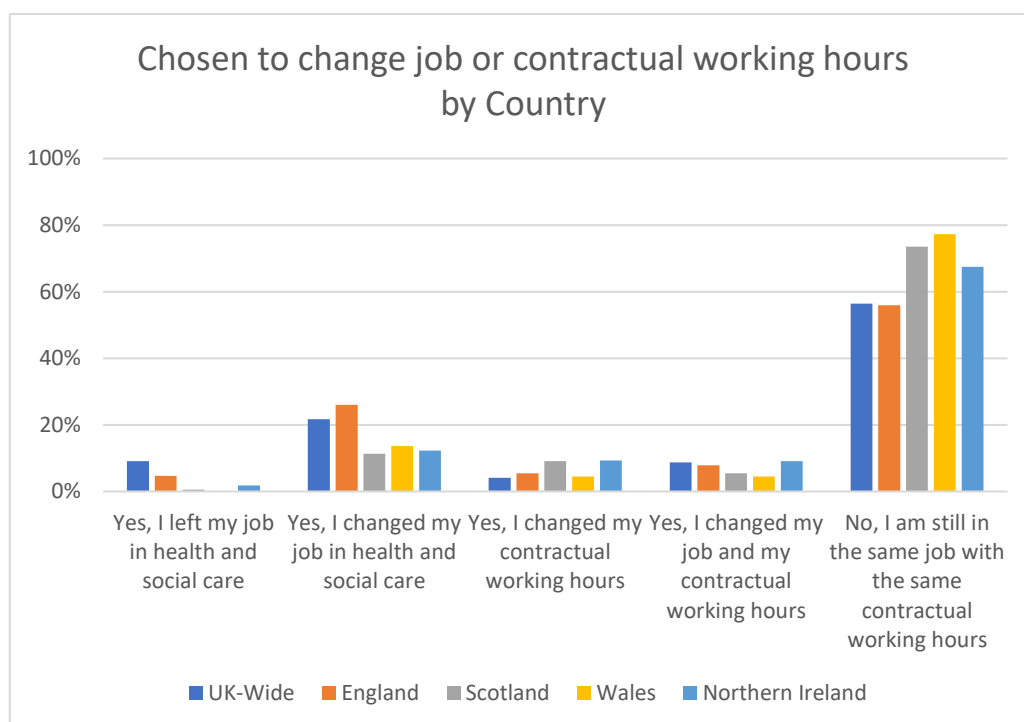


Figure A2. 129: Chosen to change job or contractual working hours by Country (Unweighted)

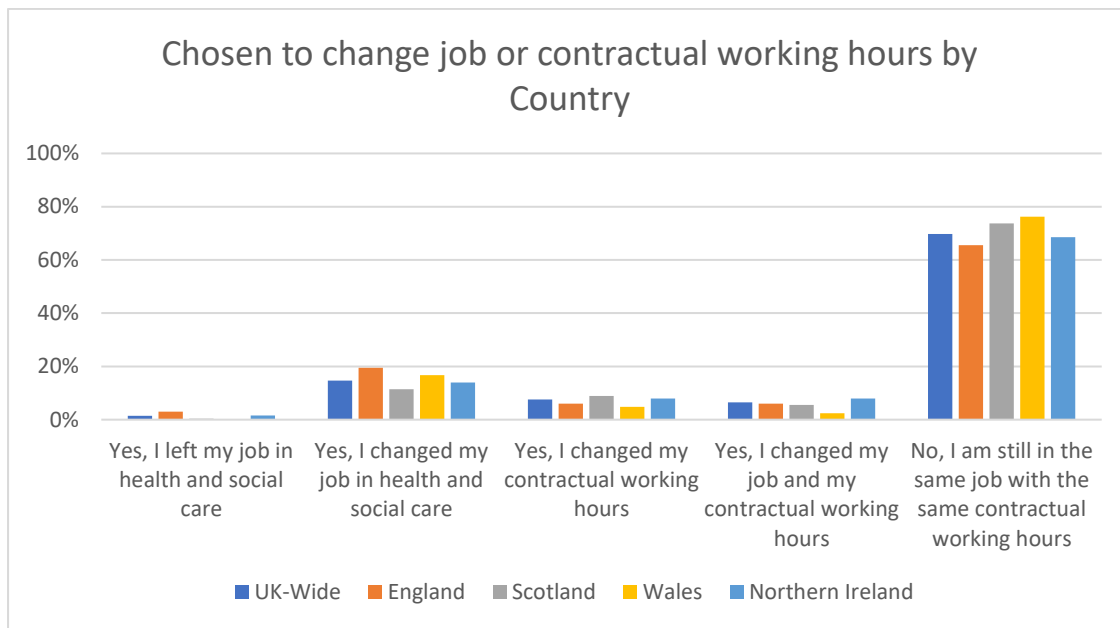


Table A2. 128: Chosen to change job or contractual working hours by Country (Weighted)

	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, I left my job in health and social care	9.1%	4.7%	0.6%	0.0%	1.8%
Yes, I changed my job in health and social care	21.7%	26.0%	11.3%	13.6%	12.3%
Yes, I changed my contractual working hours	4.1%	5.5%	9.1%	4.5%	9.3%
Yes, I changed my job and my contractual working hours	8.7%	7.9%	5.5%	4.5%	9.1%
No, I am still in the same job with the same contractual working hours	56.4%	55.9%	73.5%	77.3%	67.5%
Total	100%	100%	100%	100%	100%

Table A2. 129: Chosen to change job or contractual working hours by Country (Unweighted)

	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, I left my job in health and social care	13 (1.5%)	6 (3.0%)	1 (0.4%)	0 (0.0%)	6 (1.6%)
Yes, I changed my job in health and social care	124 (14.7%)	39 (19.5%)	27 (11.4%)	7 (16.7%)	51 (13.9%)
Yes, I changed my contractual working hours	64 (7.6%)	12 (6.0%)	21 (8.9%)	2 (4.8%)	29 (7.9%)
Yes, I changed my job and my contractual working hours	55 (6.5%)	12 (6.0%)	13 (5.5%)	1 (2.4%)	29 (7.9%)
No, I am still in the same job with the same contractual working hours	588 (69.7%)	131 (65.5%)	174 (73.7%)	32 (76.2%)	251 (68.6%)
Total	844 (100%)	200 (100%)	236 (100%)	42 (100%)	366 (100%)

Figure A2. 130: Chosen to change job or contractual working hours by Occupation (Weighted)

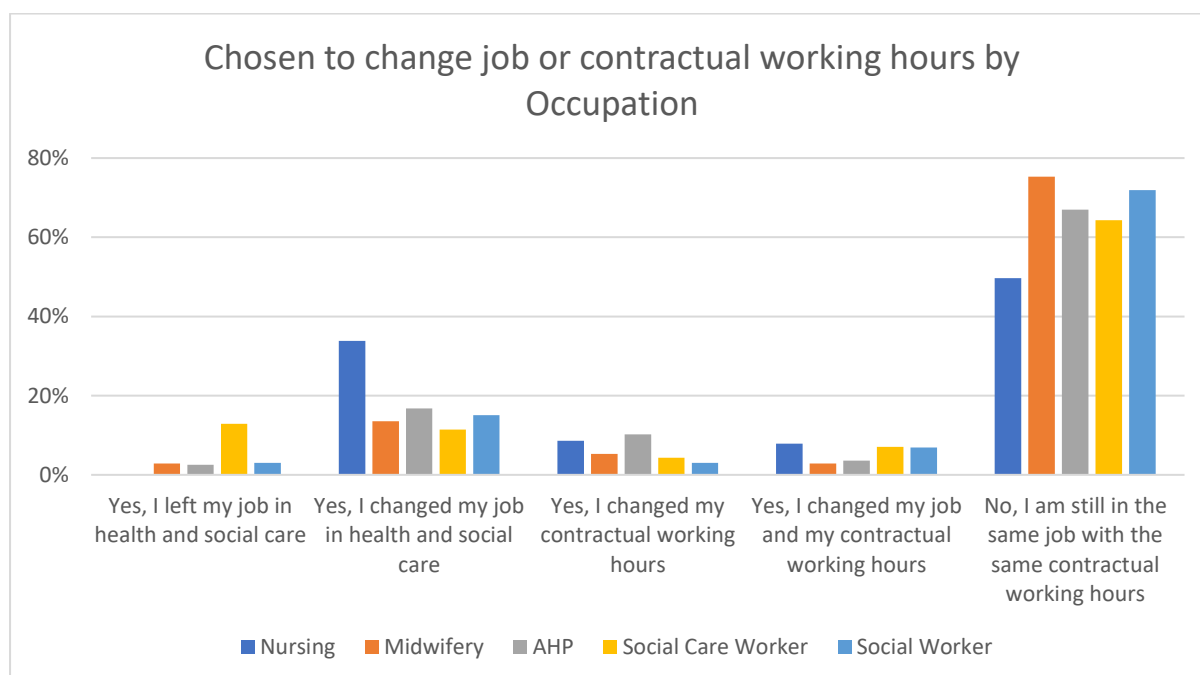


Figure A2. 131: Chosen to change job or contractual working hours by Occupation (Unweighted)

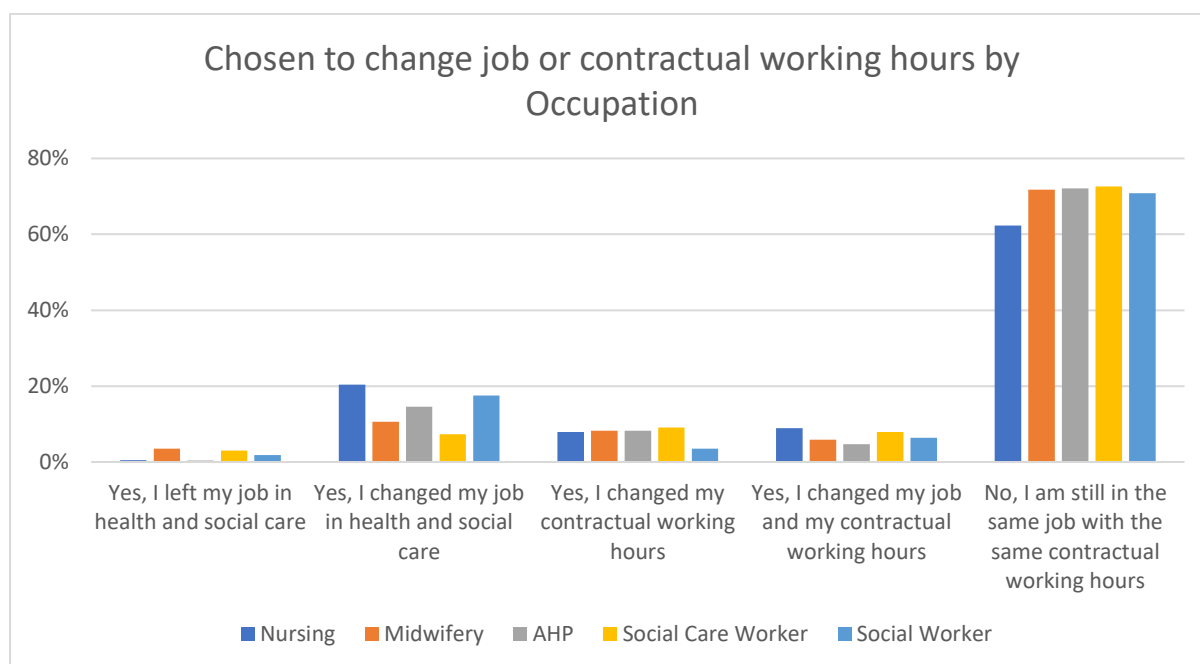


Table A2. 130: Chosen to change job or contractual working hours by Occupation (Weighted)

Occupation	Yes, I left my job in health and social care	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	0.0%	33.8%	8.6%	7.9%	49.7%	100%
Midwifery	2.9%	13.5%	5.3%	2.9%	75.3%	100%
AHP	2.5%	16.8%	10.2%	3.6%	67.0%	100%
Social Care	12.9%	11.4%	4.3%	7.1%	64.3%	100%
Social Work	3.0%	15.1%	3.0%	6.9%	71.9%	100%

Table A2. 131: Chosen to change job or contractual working hours by Occupation (Unweighted)

Occupation	Yes, I left my job in health and social care	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	1 (0.5%)	39 (20.4%)	17 (8.9%)	15 (7.9%)	119 (62.3%)	191 (100%)
Midwifery	3 (3.5%)	9 (10.6%)	7 (8.2%)	5 (5.9%)	61 (71.8%)	85 (100%)
AHP	1 (0.4%)	34 (14.6%)	19 (8.2%)	11 (4.7%)	168 (72.1%)	233 (100%)
Social Care	5 (3.0%)	12 (7.3%)	15 (9.1%)	13 (7.9%)	119 (72.6%)	164 (100%)
Social Work	3 (1.8%)	30 (17.5%)	6 (3.5%)	11 (6.4%)	121 (70.8%)	171 (100%)

A2.33 Respondents taking up employer support

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

Summary (Weighted results):

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

Summary (Unweighted results):

A majority of respondents did not take up employer support (70.9%). Those in England were more likely to take up employer support (40.1%) while those in Northern Ireland were least likely to take up employer support (24.8%). Out of all occupations, social workers were most likely to take up employer wellbeing support while social care workers were least likely to take up support.

Figure A2.132: Taken up Employer support by Country (Weighted)

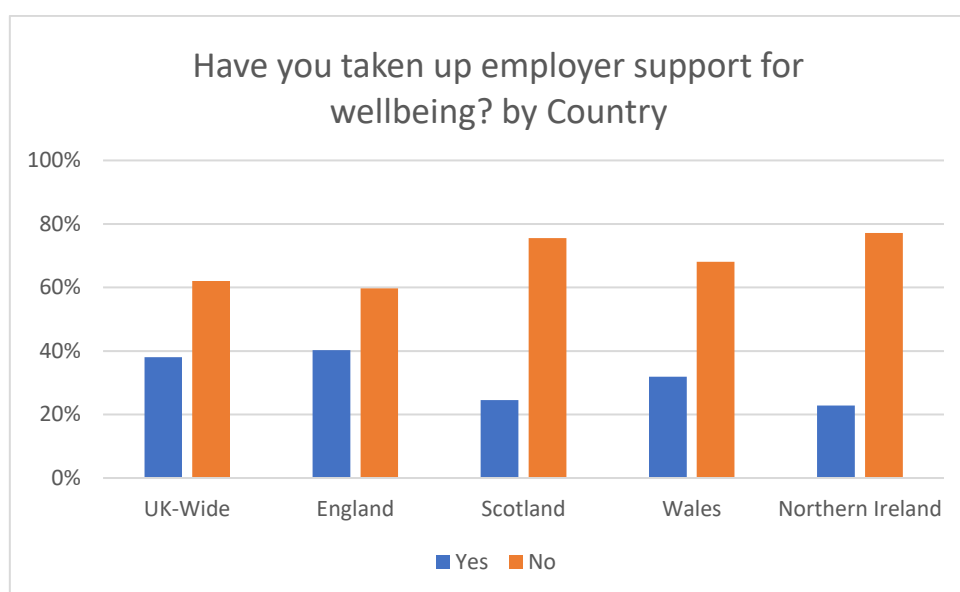


Figure A2.133: Taken up Employer support by Country (Unweighted)

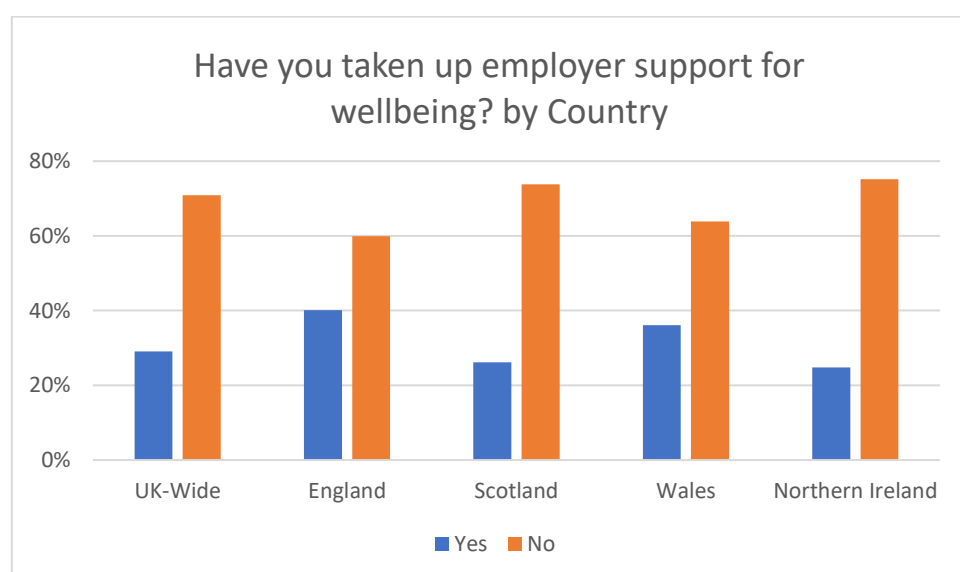


Table A2.132: Taken up employer support by Country (Weighted)

Have you taken up employer support for wellbeing?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	38.0%	40.3%	24.5%	31.9%	22.8%
No	62.0%	59.7%	75.5%	68.1%	77.2%
Total	100%	100%	100%	100%	100%

Table A2.133: Taken up employer support by Country (Unweighted)

Have you taken up employer support for wellbeing?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	464 (29.1%)	137 (40.1%)	120 (26.2%)	30 (36.1%)	177 (24.8%)
No	1132 (70.9%)	205 (59.9%)	338 (73.8%)	53 (63.9%)	436 (75.2%)
Total	1596 (100%)	342 (100%)	458 (100%)	83 (100%)	713 (100%)

Figure A2.134: Taken up Employer support by Occupation (Weighted)

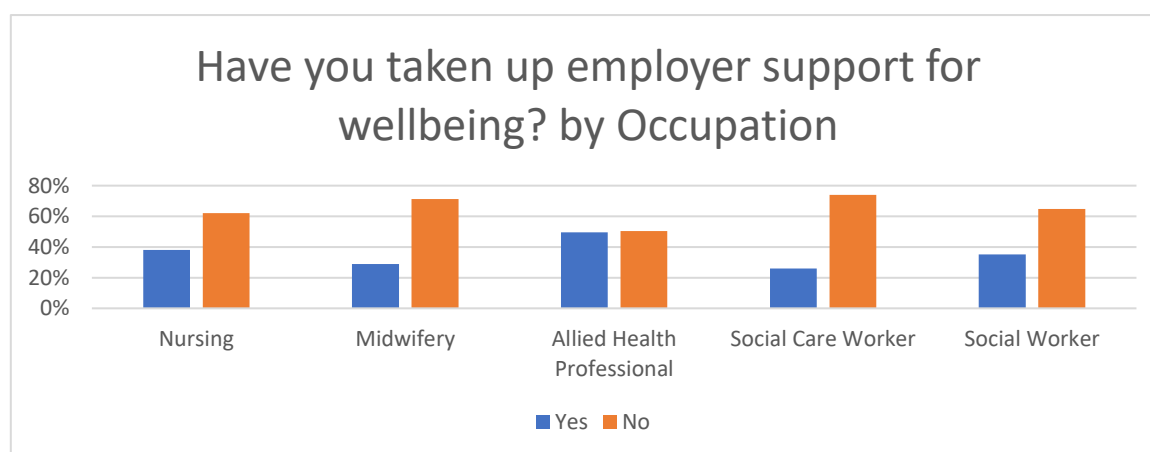


Figure A2.135: Taken up Employer support by Occupation (Unweighted)



Table A2.134: Taken up employer support by Occupation (Weighted)

Have you taken up employer support for wellbeing?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	38.0%	28.8%	49.5%	26.0%	
No	62.0%	71.2%	50.5%	74.0%	64.9%
Total	100%	100%	100%	100%	100%

Table A2.135: Taken up employer support by Occupation (Unweighted)

Have you taken up employer support for wellbeing?	Country				
	Nursing	Midwifery	AHP	Social Care	Social Work
Yes	104 (30.%)	29 (23.4%)	168 (32.6%)	57 (19.3%)	106 (33.1%)
No	237 (69.5%)	95 (76.6%)	348 (67.4%)	238 (80.7%)	214 (66.9%)
Total	341 (100%)	124 (100%)	516 (100%)	295 (100%)	320 (100%)

A2.34 Respondents on what employer support they have taken up

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

Summary (Weighted results):

Respondents indicated they took up peer support or manager support.

Summary (Unweighted results):

Half of the respondents indicated to that the support they had taken up from their employer was peer support and wellbeing support.

Those who reported other (n=60), specified that the following was the support they had taken up from their employer to support their wellbeing:

- Therapy sessions of their choice
- Wellbeing seminars
- Ability to book office desk time rather than work from home
- Clinical supervision

- Coaching
- Cycle to work scheme
- Colleague support
- Change of job role
- Generic emails re: Unmind app for wellbeing
- Greater flexibility in terms of hybrid working – half home and half office
- Access to external support
- Access to occupational health
- Paid overtime
- Online CBT
- Reflective practice
- Support for weight loss
- Help setting boundaries to make increased work more manageable
- Ability to change hours to part-time.

However several noted that the wellbeing 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 . Others noted that they had no management support, but it was the support of their team/colleagues that helped get them through the pandemic. The loss of annual leave or suggestion of counselling did not meet the needs of the respondents in the survey. One respondent indicated that ‘there is a culture within social work of just get on with it.’

Figure A2.136: What have you taken up from your employer to support your wellbeing by Country (Weighted)

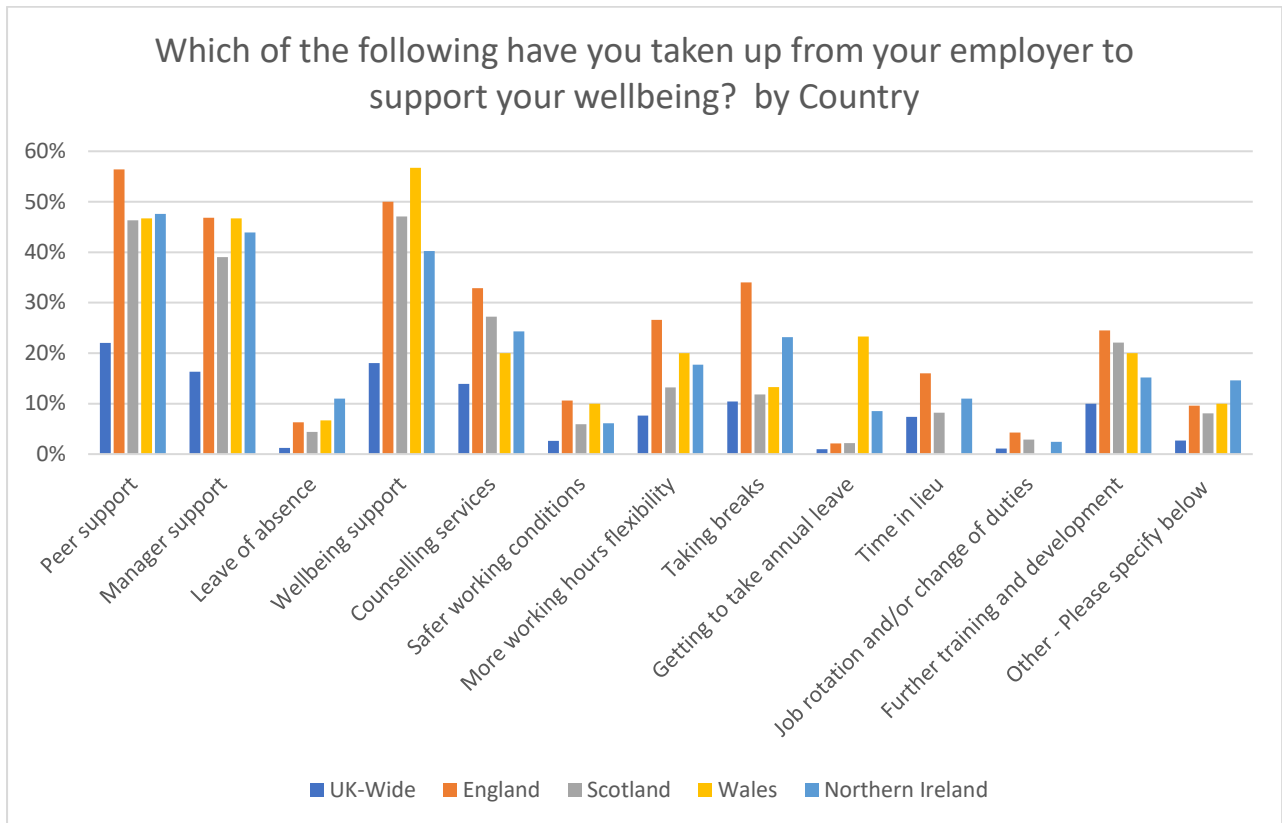


Figure A2.137: What have you taken up from your employer to support your wellbeing by Country (Unweighted)

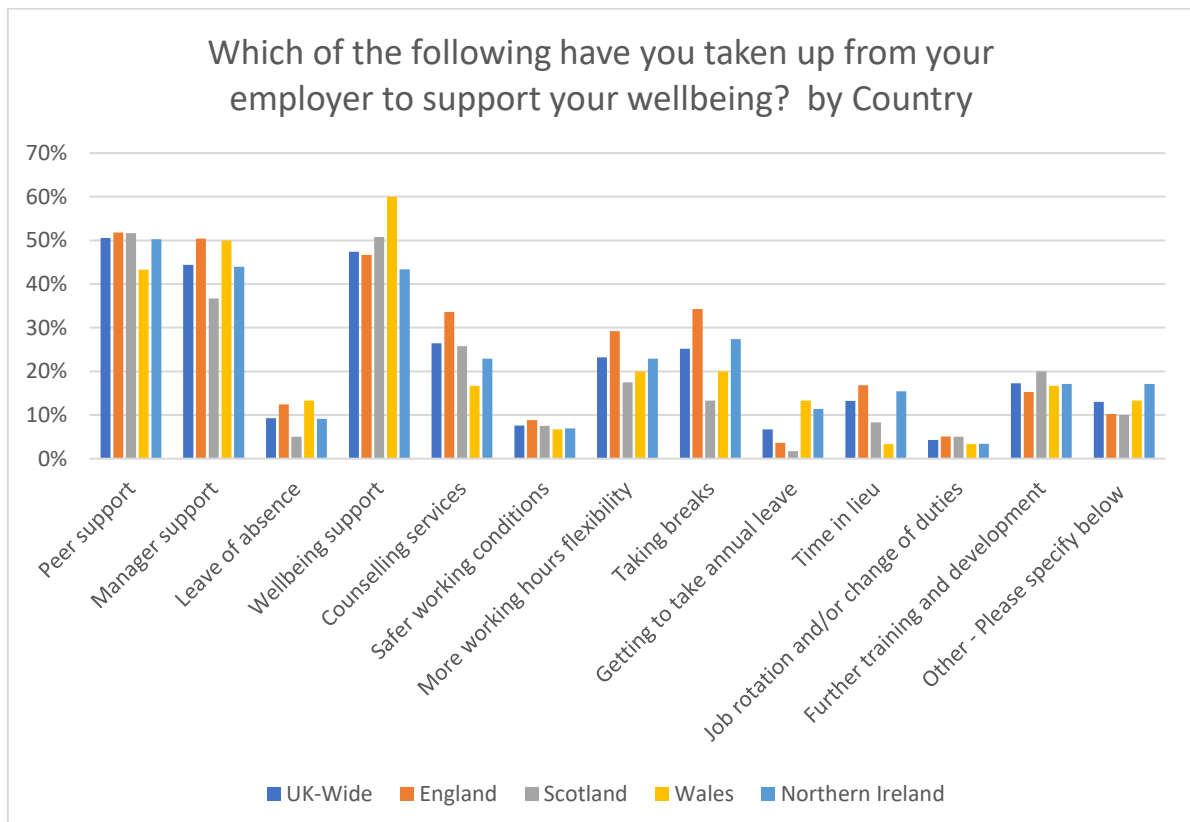


Table A2.136: What have you taken up from your employer to support your wellbeing by Country (Weighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	22.0%	56.4%	46.3%	46.7%	47.6%
Manager support	16.3%	46.8%	39.0%	46.7%	43.9%
Leave of absence	1.2%	6.3%	4.4%	6.7%	11.0%
Wellbeing support	18.0%	50.0%	47.1%	56.7%	40.2%
Counselling services	13.9%	32.9%	27.2%	20.0%	24.3%
Safer working conditions	2.6%	10.6%	5.9%	10.0%	6.1%
More working hours flexibility	7.6%	26.6%	13.2%	20.0%	17.7%
Taking breaks	10.4%	34.0%	11.8%	13.3%	23.2%
Getting to take annual leave	1.0%	2.1%	2.2%	23.3%	8.5%
Time in lieu	7.4%	16.0%	8.2%	0.0%	11.0%
Job rotation and/or change of duties	1.1%	4.3%	2.9%	0.0%	2.4%
Further training and development	10.0%	24.5%	22.1%	20.0%	15.2%
Other – Please specify below	2.7%	9.6%	8.1%	10.0%	14.6%

Table A2.137: What have you taken up from your employer to support your wellbeing by Country (Unweighted)

What has to happen for you to change your mind about wanting to leave?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Peer support	234 (50.6%)	71 (51.8%)	62 (51.7%)	13 (43.3%)	88 (50.3%)
Manager support	205 (44.4%)	69 (50.4%)	44 (36.7%)	15 (50.0%)	77 (44.0%)
Leave of absence	43 (9.3%)	17 (12.4%)	6 (5.0%)	4 (13.3%)	16 (9.1%)
Wellbeing support	219 (47.4%)	64 (46.7%)	61 (50.8%)	18 (60.0%)	76 (43.4%)
Counselling services	122 (26.4%)	46 (33.6%)	31 (25.8%)	5 (16.7%)	40 (22.9%)
Safer working conditions	35 (7.6%)	12 (8.8%)	9 (7.5%)	2 (6.7%)	12 (6.9%)
More working hours flexibility	107 (23.2%)	40 (29.2%)	21 (17.5%)	6 (20.0%)	40 (22.9%)
Taking breaks	117 (25.2%)	47 (34.3%)	16 (13.3%)	6 (20.0%)	48 (27.4%)
Getting to take annual leave	31 (6.7%)	5 (3.6%)	2 (1.7%)	4 (13.3%)	20 (11.4%)
Time in lieu	61 (13.2%)	23 (16.8%)	10 (8.3%)	1 (3.3%)	27 (15.4%)
Job rotation and/or change of duties	20 (4.3%)	7 (5.1%)	6 (5.0%)	1 (3.3%)	6 (3.4%)
Further training and development	80 (17.3%)	21 (15.3%)	24 (20.0%)	5 (16.7%)	30 (17.1%)
Other – Please specify below	60 (13.0%)	14 (10.2%)	12 (10.0%)	4 (13.3%)	30 (17.1%)
No. of respondents who answered the question	462	137	120	30	175

Figure A2.138: What have you taken up from your employer to support your wellbeing by Occupation (Weighted)

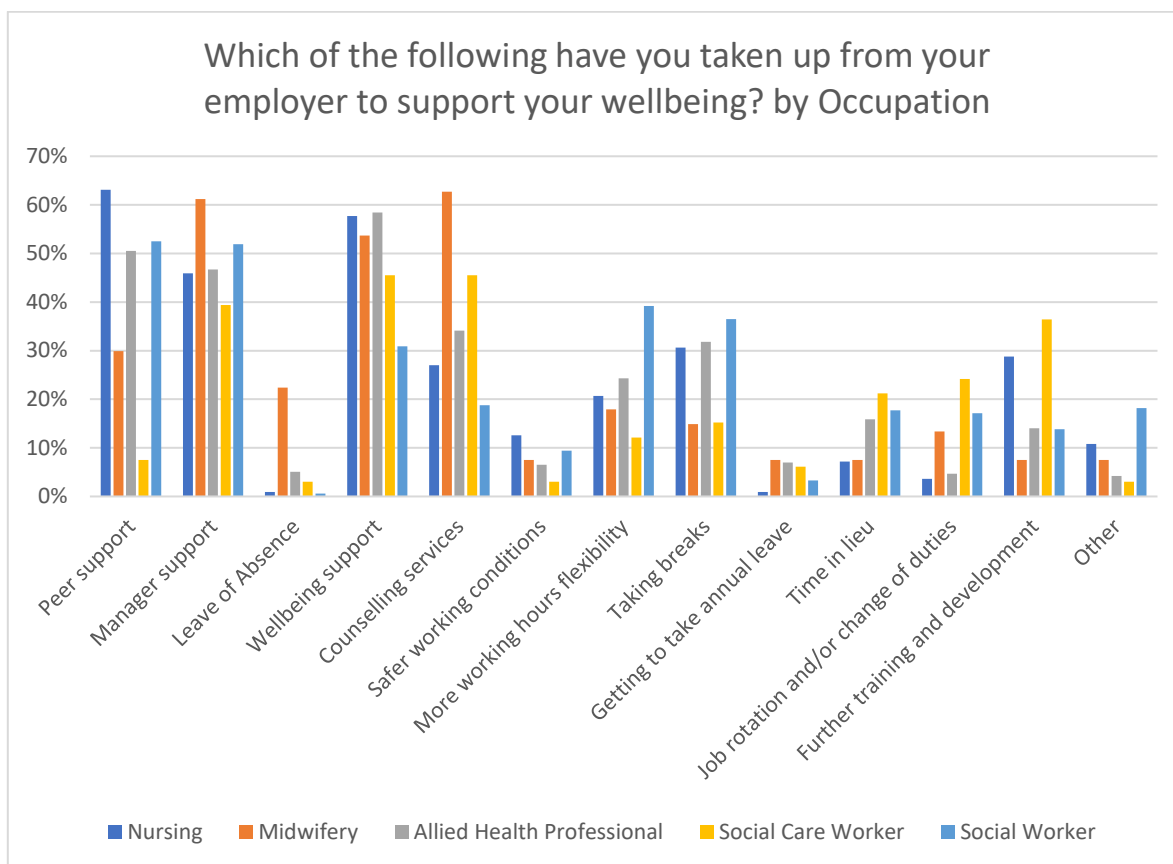


Figure A2.139: What have you taken up from your employer to support your wellbeing by Occupation (Unweighted)

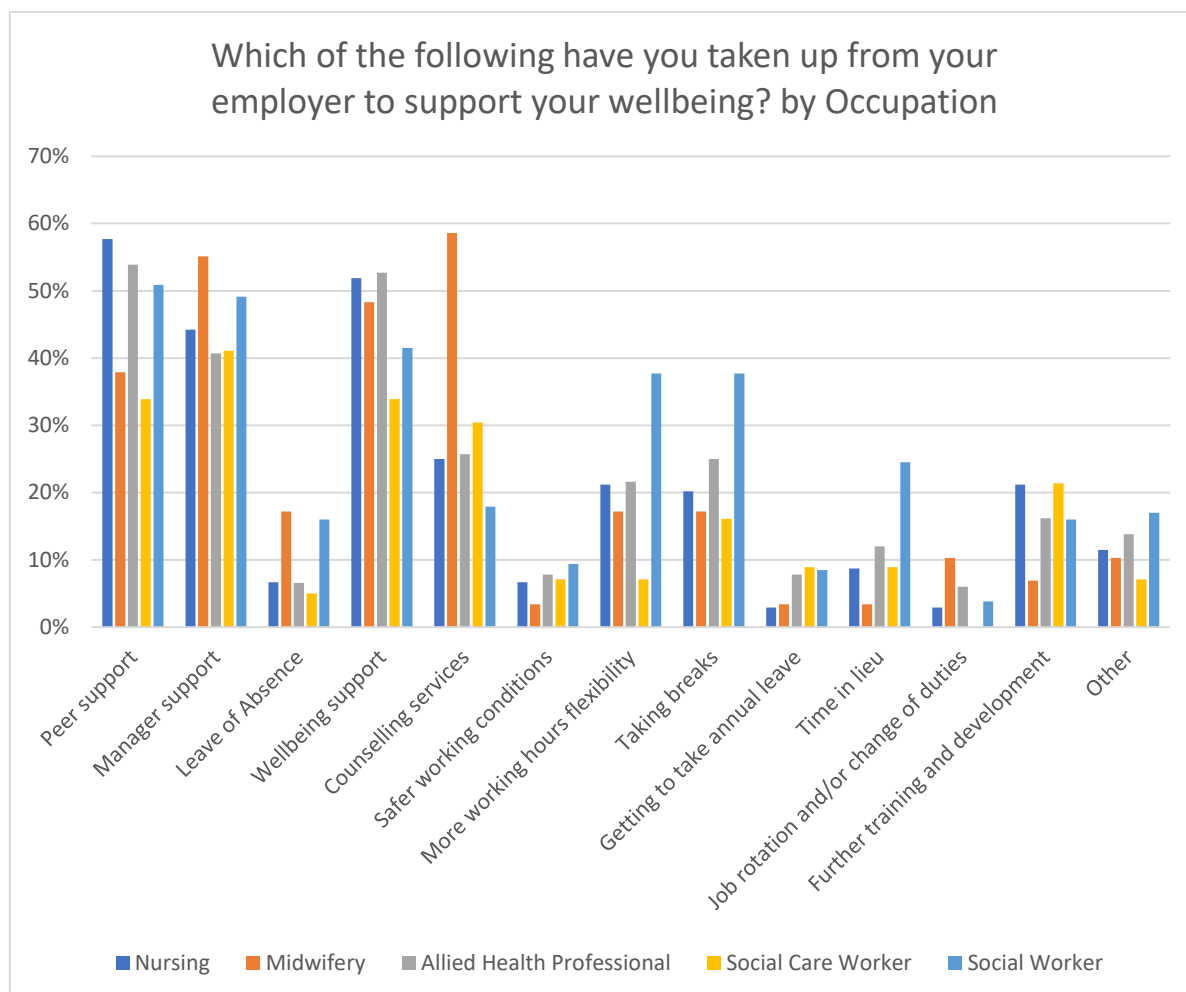


Table A2.138: What have you taken up from your employer to support your wellbeing by Occupation(Weighted)

What has to happen for you to change your mind about wanting to leave?	Occupation				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	63.1%	29.9%	50.5%	7.5%	52.5%
Manager support	45.9%	61.2%	46.7%	39.4%	51.9%
Leave of absence	0.9%	22.4%	5.1%	3.0%	0.6%
Wellbeing support	57.7%	53.7%	58.4%	45.5%	30.9%
Counselling services	27.0%	62.7%	34.1%	45.5%	18.8%
Safer working conditions	12.6%	7.5%	6.5%	3.0%	9.4%
More working hours flexibility	20.7%	17.9%	24.3%	12.1%	39.2%
Taking breaks	30.6%	14.9%	31.8%	15.2%	36.5%
Getting to take annual leave	0.9%	7.5%	7.0%	6.1%	3.3%
Time in lieu	7.2%	7.5%	15.9%	21.2%	17.7%
Job rotation and/or change of duties	3.6%	13.4%	4.7%	24.2%	17.1%
Further training and development	38.8%	7.5%	14.0%	36.4%	13.8%
Other – Please specify below	10.8%	7.5%	4.2%	3.0%	18.2%

Table A2.139: What have you taken up from your employer to support your wellbeing by Occupation (Unweighted)

What has to happen for you to change your mind about wanting to leave?	Occupation				
	Nursing	Midwifery	AHP	Social Care	Social Worker
Peer support	60 (57.7%)	11 (37.9%)	90 (53.9%)	19 (33.9%)	54 (50.9%)
Manager support	46 (44.2%)	16 (55.1%)	68 (40.7%)	23 (41.1%)	52 (49.1%)
Leave of absence	7 (6.7%)	5 (17.2%)	11 (6.6%)	3 (5.0%)	17 (16.0%)
Wellbeing support	54 (51.9%)	14 (48.3%)	88 (52.7%)	19 (33.9%)	44 (41.5%)
Counselling services	26 (25.0%)	17 (58.6%)	43 (25.7%)	17 (30.4%)	19 (17.9%)
Safer working conditions	7 (6.7%)	1 (3.4%)	13 (7.8%)	4 (7.1%)	10 (9.4%)
More working hours flexibility	22 (21.2%)	5 (17.2%)	36 (21.6%)	4 (7.1%)	40 (37.7%)
Taking breaks	21 (20.2%)	5 (17.2%)	42 (25.0%)	9 (16.1%)	40 (37.7%)
Getting to take annual leave	3 (2.9%)	1 (3.4%)	13 (7.8%)	5 (8.9%)	9 (8.5%)
Time in lieu	9 (8.7%)	1 (3.4%)	20 (12.0%)	5 (8.9%)	26 (24.5%)
Job rotation and/or change of duties	3 (2.9%)	3 (10.3%)	10 (6.0%)	0 (0.0%)	4 (3.8%)
Further training and development	22 (21.2%)	2 (6.9%)	27 (16.2%)	12 (21.4%)	17 (16.0%)
Other – Please specify below	13 (11.5%)	3 (10.3%)	23 (13.8%)	4 (7.1%)	18 (17.0%)
No. of respondents who answered the question	104	29	167	56	106

A2.36 Respondents' Caring Responsibilities

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

Summary (Weighted results):

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

Summary (Unweighted results):

Northern Ireland had the highest proportion of respondents who definitely considered themselves to be a carer and England had the highest proportion of those who definitely did not consider themselves to be a carer. AHPs were the least likely group to report being a carer (reporting ‘definitely not’) and Midwives were the most likely (reporting ‘definitely yes’).

Figure A2.140: Caring Responsibilities by Country (Weighted)

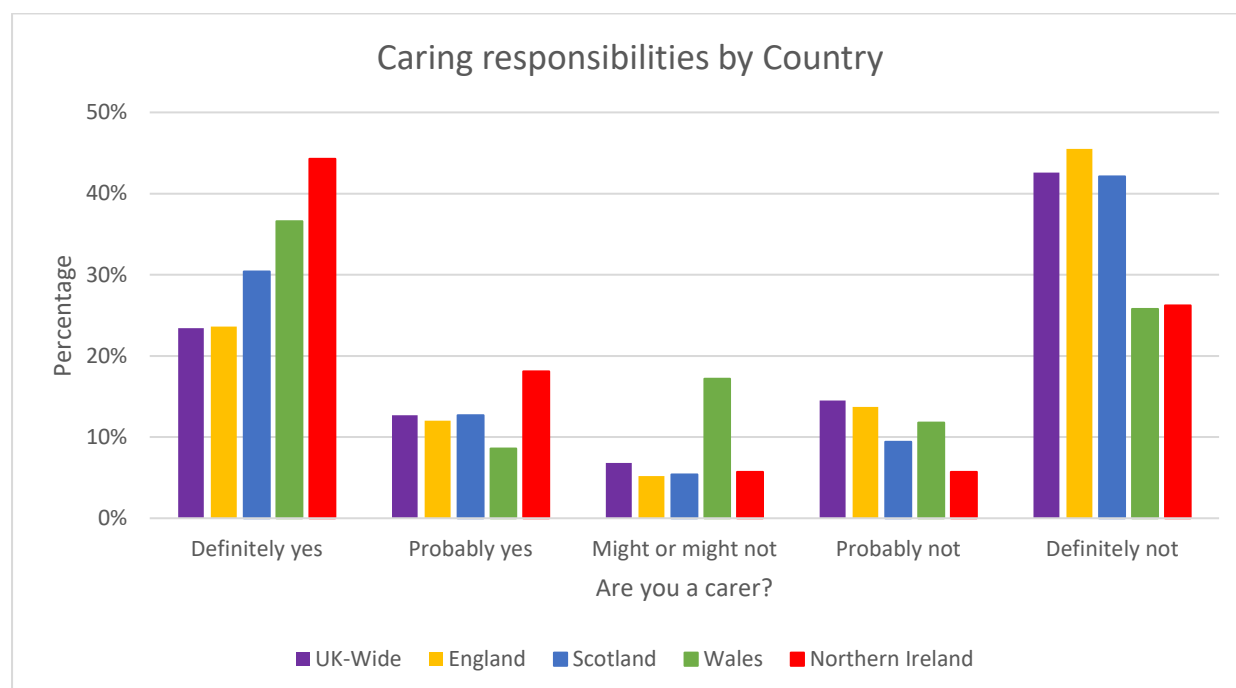


Figure A2.141: Caring Responsibilities by Country (Unweighted)

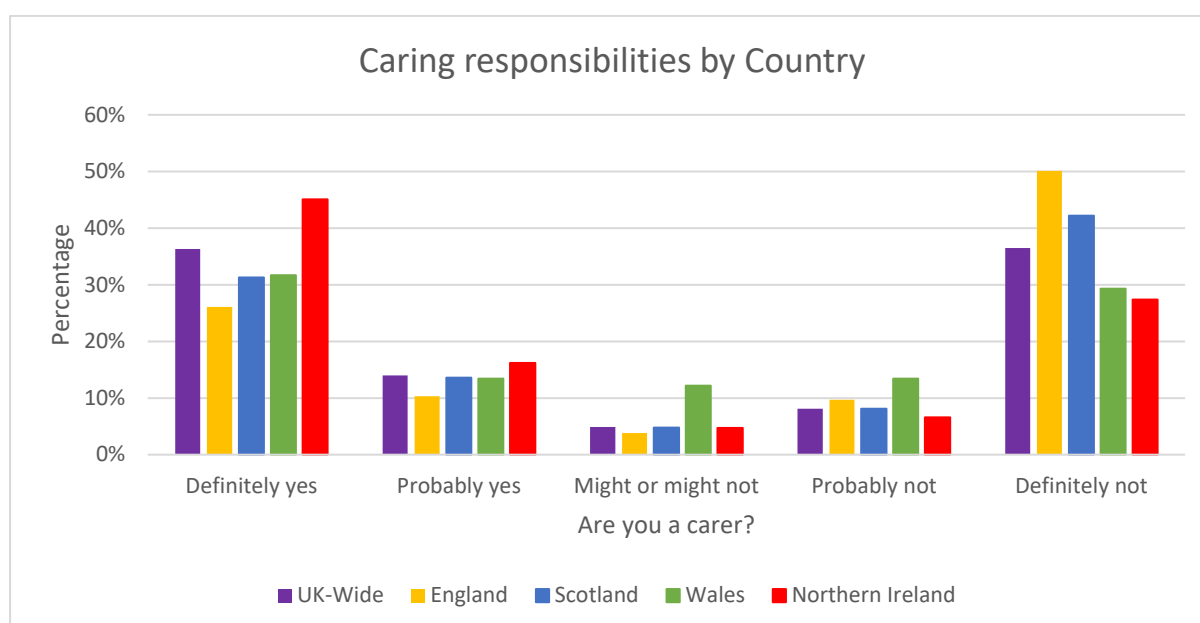


Table A2.140: Caring Responsibilities by Country (Weighted)

Do you consider yourself to be a carer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	23.4%	23.6%	30.4%	36.6%	44.3%
Probably yes	12.7%	12.0%	12.7%	8.6%	18.1%
Might or might not	6.8%	5.2%	5.4%	17.2%	5.7%
Probably not	14.5%	13.7%	9.4%	11.8%	5.7%
Definitely not	42.6%	45.5%	42.1%	25.8%	26.2%
Total	100%	100%	100%	100%	100%

Table A2.141: Caring Responsibilities by Country (Unweighted)

Do you consider yourself to be a carer?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	577 (36.3%)	89 (26.1%)	143 (31.3%)	26 (31.7%)	319 (45.1%)
Probably yes	223 (14.0%)	35 (10.3%)	62 (13.6%)	11 (13.4%)	115 (16.2%)
Might or might not	78 (4.9%)	13 (3.8%)	22 (4.8%)	10 (12.2%)	33 (4.7%)
Probably not	128 (8.1%)	33 (9.7%)	37 (8.1%)	11 (13.4%)	47 (6.6%)
Definitely not	582 (36.5%)	171 (50.1%)	193 (42.2%)	24 (29.3%)	194 (27.4%)
Total	1588 (100%)	341 (100%)	457 (100%)	82 (100%)	708 (100%)

Figure A2.142: Caring Responsibilities by Occupation (Weighted)

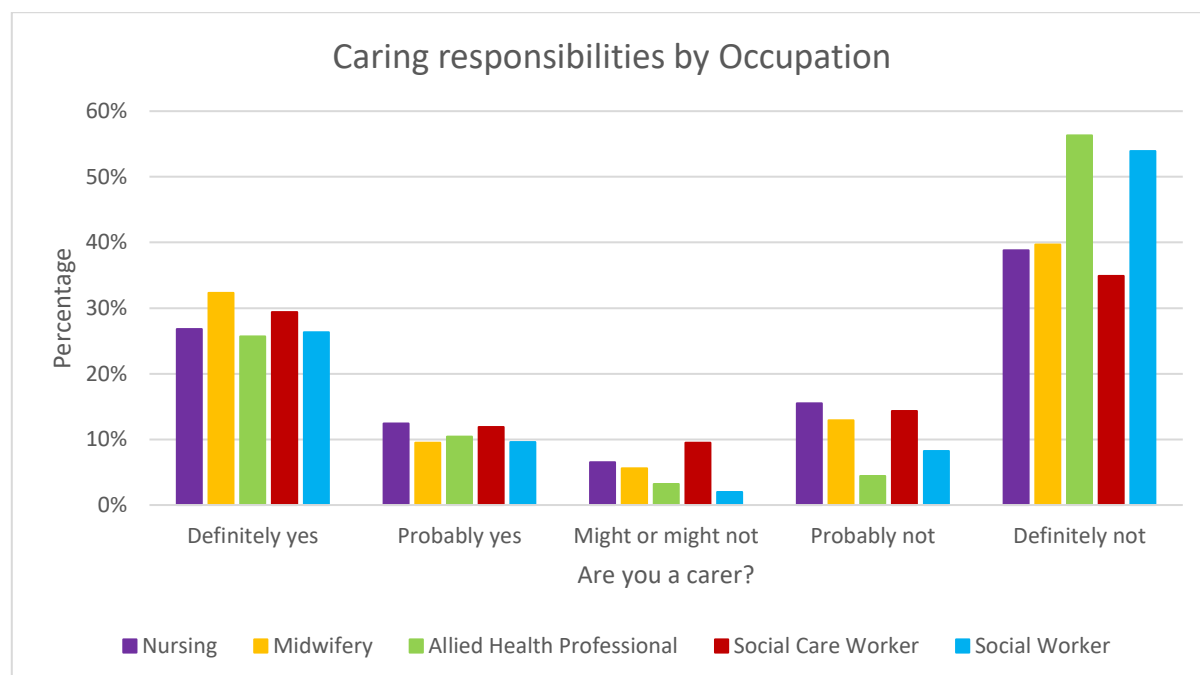


Figure A2.143: Caring Responsibilities by Occupation (Unweighted)

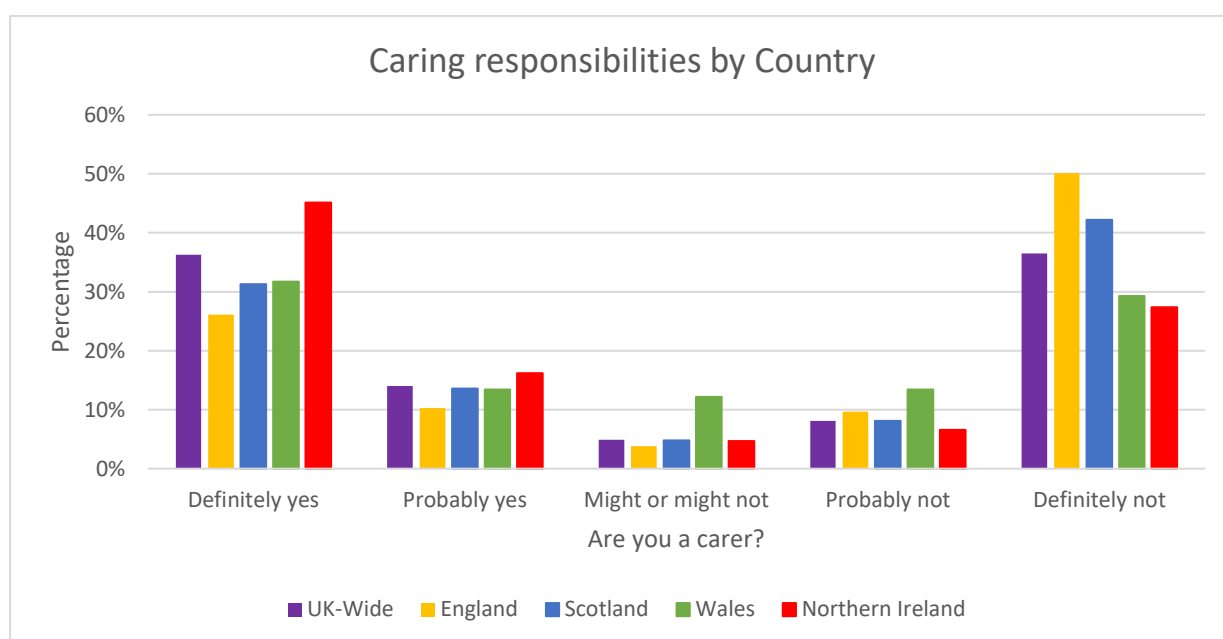


Table A2.142: Caring Responsibilities by Occupation (Weighted)

Occupation	Do you consider yourself to be a carer?					Total
	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	
Nursing	26.8%	12.4%	6.5%	15.5%	38.8%	100%
Midwifery	32.3%	9.5%	5.6%	12.9%	39.7%	100%
AHP	25.7%	10.4%	3.2%	4.4%	56.3%	100%
Social Care Worker	29.4%	11.9%	9.5%	14.3%	34.9%	100%
Social Worker	26.3%	9.6%	2.0%	8.2%	53.9%	100%

Table A2.143: Caring Responsibilities by Occupation (Unweighted)

Occupation	Do you consider yourself to be a carer?					Total
	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	
Nursing	112 (33.0%)	45 (13.3%)	20 (5.9%)	36 (10.6%)	126 (37.2%)	339 (100%)
Midwifery	50 (40.3%)	14 (11.3%)	5 (4.0%)	11 (8.9%)	44 (35.5%)	124 (100%)
AHP	188 (36.5%)	63 (12.2%)	19 (3.7%)	35 (6.8%)	210 (40.8%)	515 (100%)
Social Care Worker	112 (38.5%)	50 (17.2%)	23 (7.9%)	21 (7.2%)	85 (29.2%)	291 (100%)
Social Worker	115 (36.1%)	51 (16.0%)	11 (3.4%)	25 (7.8%)	117 (36.7%)	319 (100%)

A2.37 Who Respondents Care for

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

Summary (Weighted results):

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

Summary (Unweighted results):

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

Figure A2.144: Who Respondents Care for by Country (Weighted)

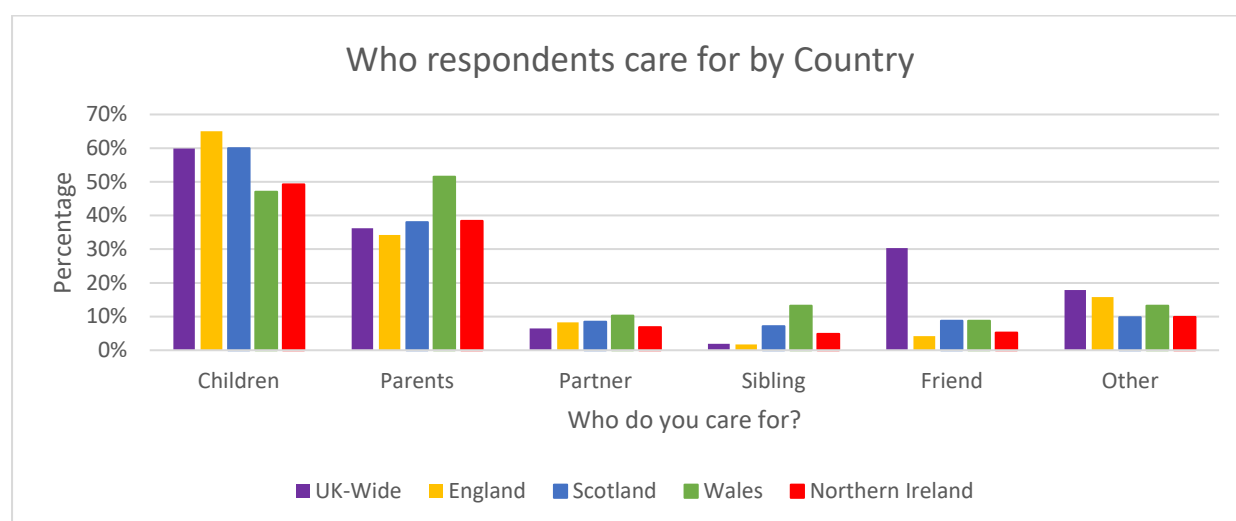


Figure A2.145: Who Respondents Care for by Country (Unweighted)

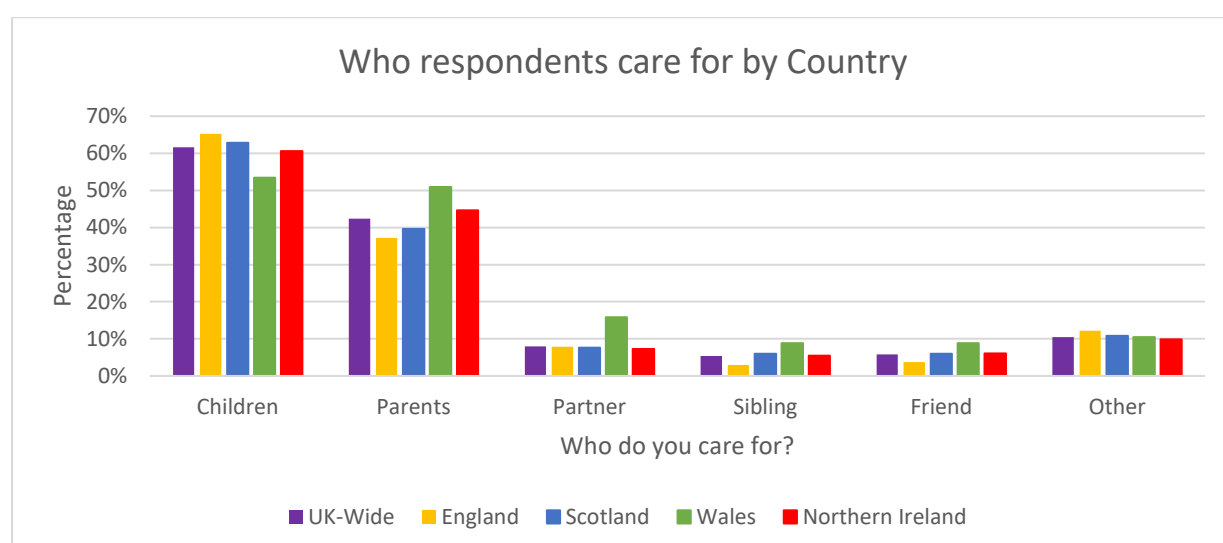


Table A2.144: Who Respondents Care for by Country (Weighted)

Who do you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	59.9%	65.0%	60.0%	47.1%	49.2%
Parents	36.2%	34.2%	38.0%	51.5%	38.4%
Partner	6.5%	8.3%	8.5%	10.3%	6.9%
Sibling	1.9%	1.7%	7.1%	13.2%	4.9%
Friend	30.3%	4.2%	8.8%	8.8%	5.2%
Other	17.9%	15.8%	9.8%	13.2%	9.9%

Table A2.145: Who Respondents Care for by Country (Unweighted)

Who do you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	595 (61.6%)	107 (65.2%)	157 (62.8%)	31 (53.4%)	300 (60.6%)
Parents	410 (42.4%)	61 (37.2%)	99 (39.6%)	29 (50.9%)	221 (44.6%)
Partner	77 (8.0%)	13 (7.9%)	19 (7.6%)	9 (15.8%)	36 (7.3%)
Sibling	52 (5.4%)	5 (3.0%)	15 (6.0%)	5 (8.8%)	27 (5.5%)
Friend	56 (5.8%)	6 (3.7%)	15 (6.0%)	5 (8.8%)	30 (6.1%)
Other	101 (10.5%)	20 (12.2%)	27 (10.8%)	6 (10.5%)	48 (9.9%)
No. of respondents who answered the question	966	164	250	57	495

Figure A2.146: Who Respondents Care for by Occupation (Weighted)

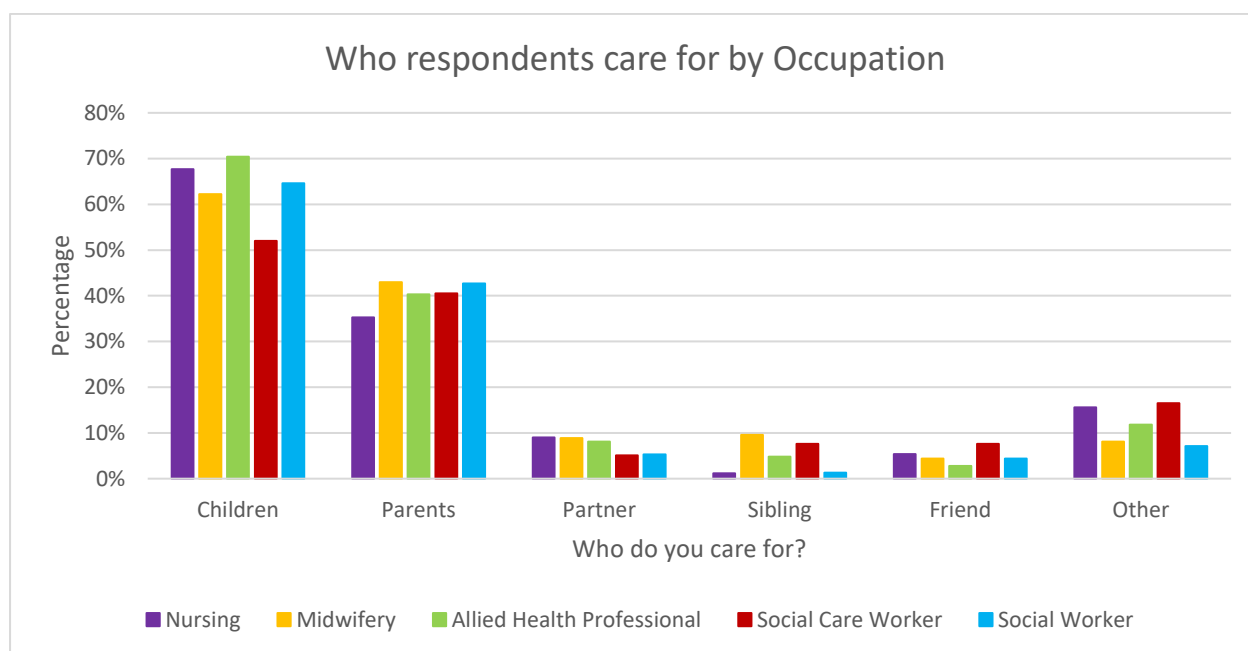


Figure A2.147: Who Respondents Care for by Occupation (Unweighted)

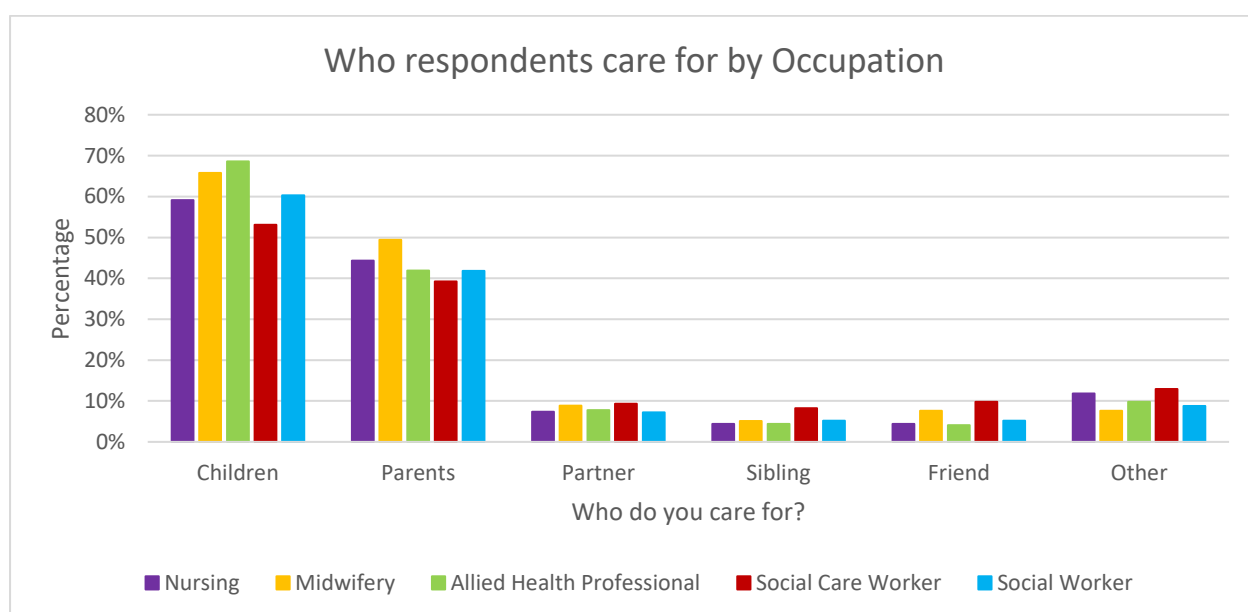


Table A2.146: Who Respondents Care for by Occupation (Weighted)

Occupation	Who do you care for?					
	Children	Parents	Partner	Sibling	Friend	Other
Nursing	67.7%	35.3%	9.0%	1.2%	5.4%	15.6%
Midwifery	62.2%	43.0%	8.9%	9.6%	4.4%	8.1%
AHP	70.4%	40.3%	8.1%	4.8%	2.8%	11.8%
Social Care Worker	52.0%	40.5%	5.1%	7.6%	7.6%	16.5%
Social Worker	64.6%	42.7%	5.3%	1.3%	4.4%	7.1%

Table A2.147: Who Respondents Care for by Occupation (Unweighted)

Occupation	Who do you care for?						No. of respondents who answered the question
	Children	Parents	Partner	Sibling	Friend	Other	
Nursing	120 (59.1%)	90 (44.3%)	15 (7.4%)	9 (4.4%)	9 (4.4%)	24 (11.8%)	203
Midwifery	52 (65.8%)	39 (49.4%)	7 (8.9%)	4 (5.1%)	6 (7.6%)	6 (7.6%)	79
AHP	203 (68.6%)	124 (41.9%)	23 (7.8%)	13 (4.4%)	12 (4.1%)	29 (9.8%)	296
Social Care Worker	103 (53.1%)	76 (39.2%)	18 (9.3%)	16 (8.2%)	19 (9.8%)	25 (12.9%)	194
Social Worker	117 (60.3%)	81 (41.8%)	14 (7.2%)	10 (5.2%)	10 (5.2%)	17 (8.8%)	194

A2.38 Respondents Living with the Person They Care for

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

Summary (Weighted results):

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

Summary (Unweighted results):

Scotland had the highest (60.2%) and Wales the lowest (55.2%) proportion of respondents (55.2%) who were living with the person they were caring for.

Figure A2.148: Respondents Living with the Person They Care for by Country (Weighted)

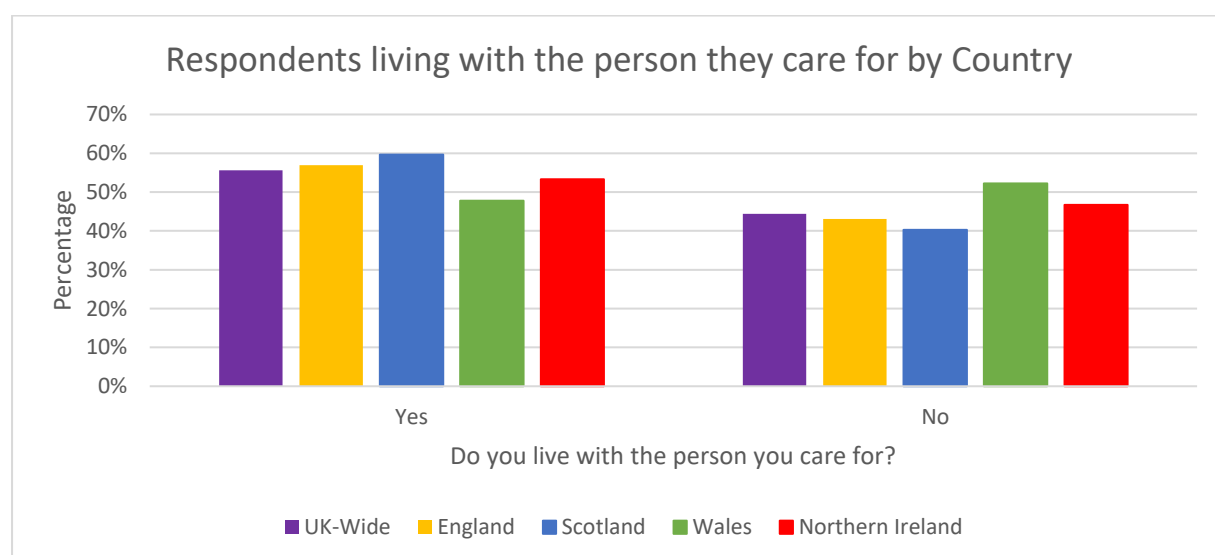


Figure A2.149: Respondents Living with the Person They Care for by Country (Unweighted)

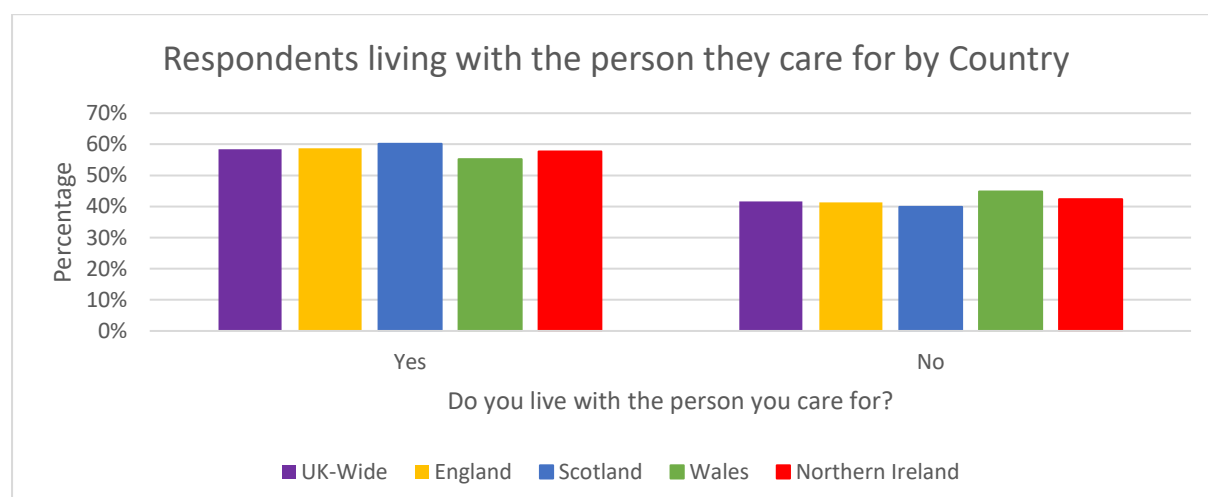


Table A2.148: Respondents Living with the Person They Care for by Country (Weighted)

Do you live with the person you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	55.6%	56.9%	59.7%	47.8%	53.3%
No	44.4%	43.1%	40.3%	52.2%	46.7%
Total	100%	100%	100%	100%	100%

Table A2.149: Respondents Living with the Person They Care for by Country (Unweighted)

Do you live with the person you care for?	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	574 (58.4%)	98 (58.7%)	153 (60.2%)	32 (55.2%)	291 (57.7%)
No	409 (41.6%)	69 (41.3%)	101 (39.9%)	26 (44.8%)	213 (42.3%)
Total	983 (100%)	167 (100%)	254 (100%)	58 (100%)	504 (100%)

Figure A2.150: Respondents Living with the Person They Care for by Occupation (Weighted)



Figure A2.151: Respondents Living with the Person They Care for by Occupation (Unweighted)

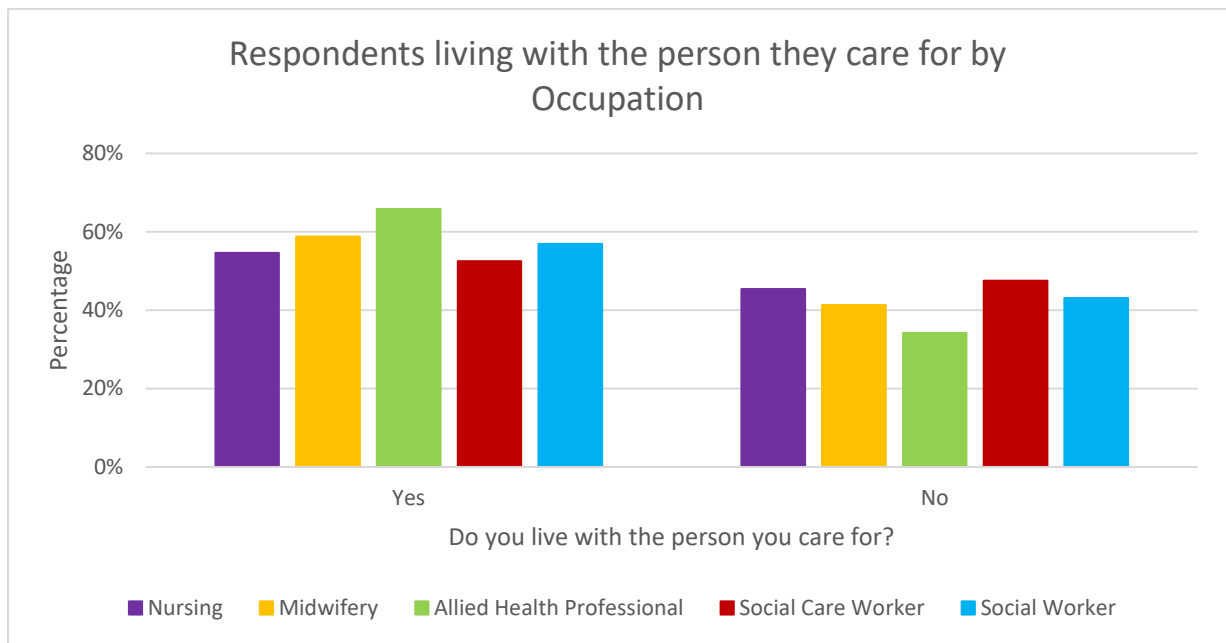


Table A2.150: Respondents Living with the Person They Care for by Occupation (Weighted)

Occupation	Do you live with the person you care for?		Total
	Yes	No	
Nursing	57.1%	42.9%	100%
Midwifery	55.0%	45.0%	100%
AHP	67.4%	32.6%	100%
Social Care Worker	53.2%	46.8%	100%
Social Worker	55.7%	44.3%	100%

Table A2.151: Respondents Living with the Person They Care for by Occupation (Unweighted)

Occupation	Do you live with the person you care for?		Total
	Yes	No	
Nursing	113 (54.6%)	94 (45.4%)	207 (100%)
Midwifery	47 (58.8%)	33 (41.3%)	80 (100%)
AHP	198 (65.8%)	103 (34.2%)	301 (100%)
Social Care Worker	104 (52.5%)	94 (47.5%)	198 (100%)
Social Worker	112 (56.9%)	85 (43.1%)	197 (100%)

A2.39 Respondents' Change in Caring Responsibilities During COVID-19

Summary (Weighted results):

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

Summary (Unweighted results):

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

Figure A2.152: Change in Caring Responsibilities During the Pandemic by Country (Weighted)

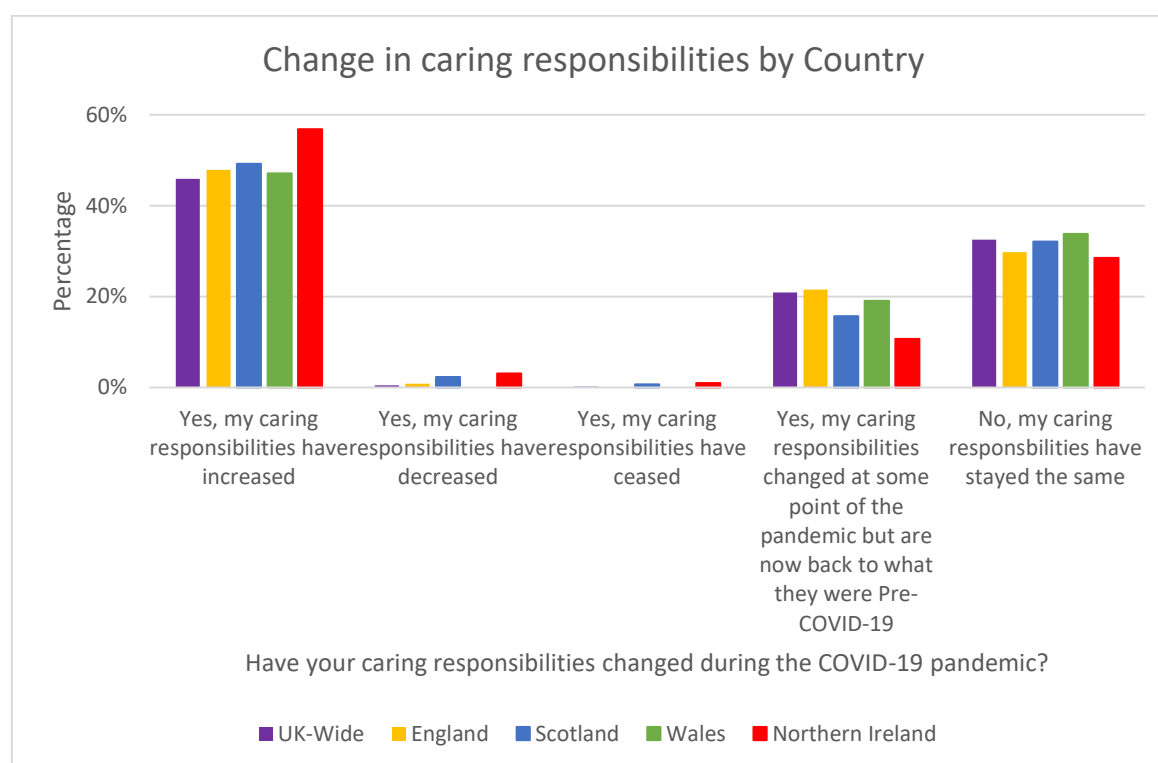


Figure A2.153: Change in Caring Responsibilities During the Pandemic by Country (Unweighted)

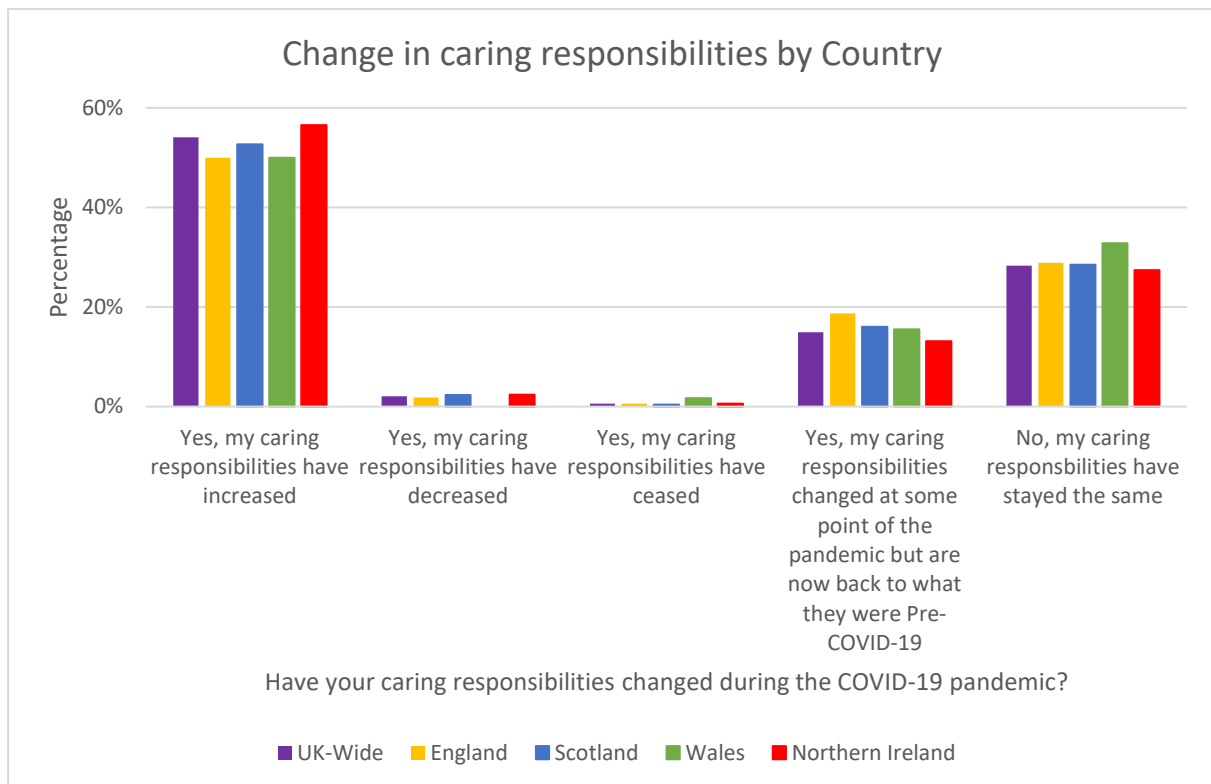


Table A2.152: Change in Caring Responsibilities During the Pandemic by Country (Weighted)

Have your caring responsibilities changed during the pandemic?	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, my caring responsibilities have increased	45.9%	47.9%	49.2%	47.1%	56.8%
Yes, my caring responsibilities have decreased	0.5%	0.8%	2.3%	0.0%	3.1%
Yes, my caring responsibilities have ceased	0.2%	0.0%	0.7%	0.0%	1.0%
Yes, my caring responsibilities changed at some point during the pandemic but are now back to what they were Pre-COVID-19	20.9%	21.5%	15.7%	19.1%	10.7%
No, my caring responsibilities have stayed the same	32.5%	29.8%	32.1%	33.8%	28.5%
Total	100%	100%	100%	100%	100%

Table A2.153: Change in Caring Responsibilities During the Pandemic by Country (Unweighted)

Have your caring responsibilities changed during the pandemic?	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, my caring responsibilities have increased	532 (54.1%)	83 (50.0%)	135 (52.7%)	29 (50.0%)	285 (56.5%)
Yes, my caring responsibilities have decreased	21 (2.1%)	3 (1.8%)	6 (2.3%)	0 (0.0%)	12 (2.4%)
Yes, my caring responsibilities have ceased	6 (0.6%)	1 (0.6%)	1 (0.4%)	1 (1.7%)	3 (0.6%)
Yes, my caring responsibilities changed at some point during the pandemic but are now back to what they were Pre-COVID-19	247 (14.9%)	31 (18.7%)	41 (16.0%)	9 (15.5%)	66 (13.1%)
No, my caring responsibilities have stayed the same	278 (28.3%)	48 (28.9%)	73 (28.5%)	19 (32.8%)	138 (27.4%)
Total	984 (100%)	166 (100%)	256 (100%)	58 (100%)	504 (100%)

Figure A2.154: Change in Caring Responsibilities During the Pandemic by Occupation (Weighted)

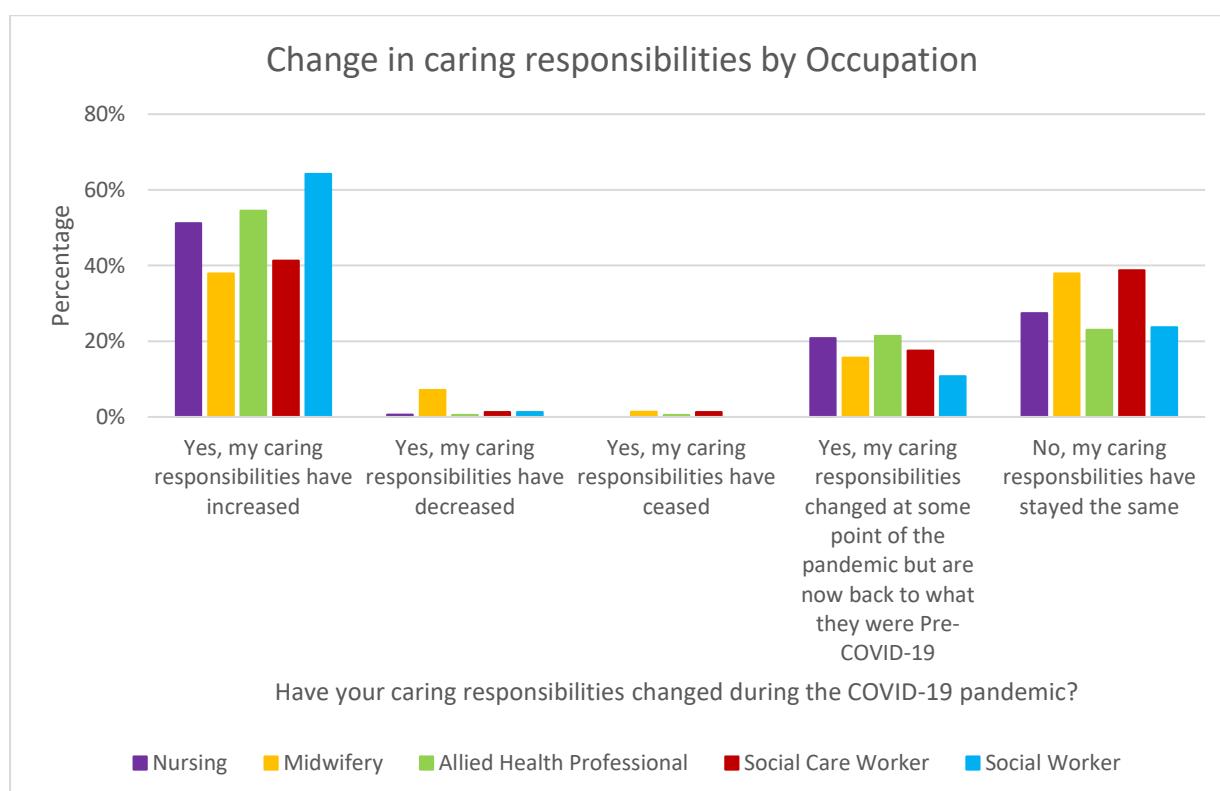


Figure A2.155: Change in Caring Responsibilities During the Pandemic by Occupation (Unweighted)

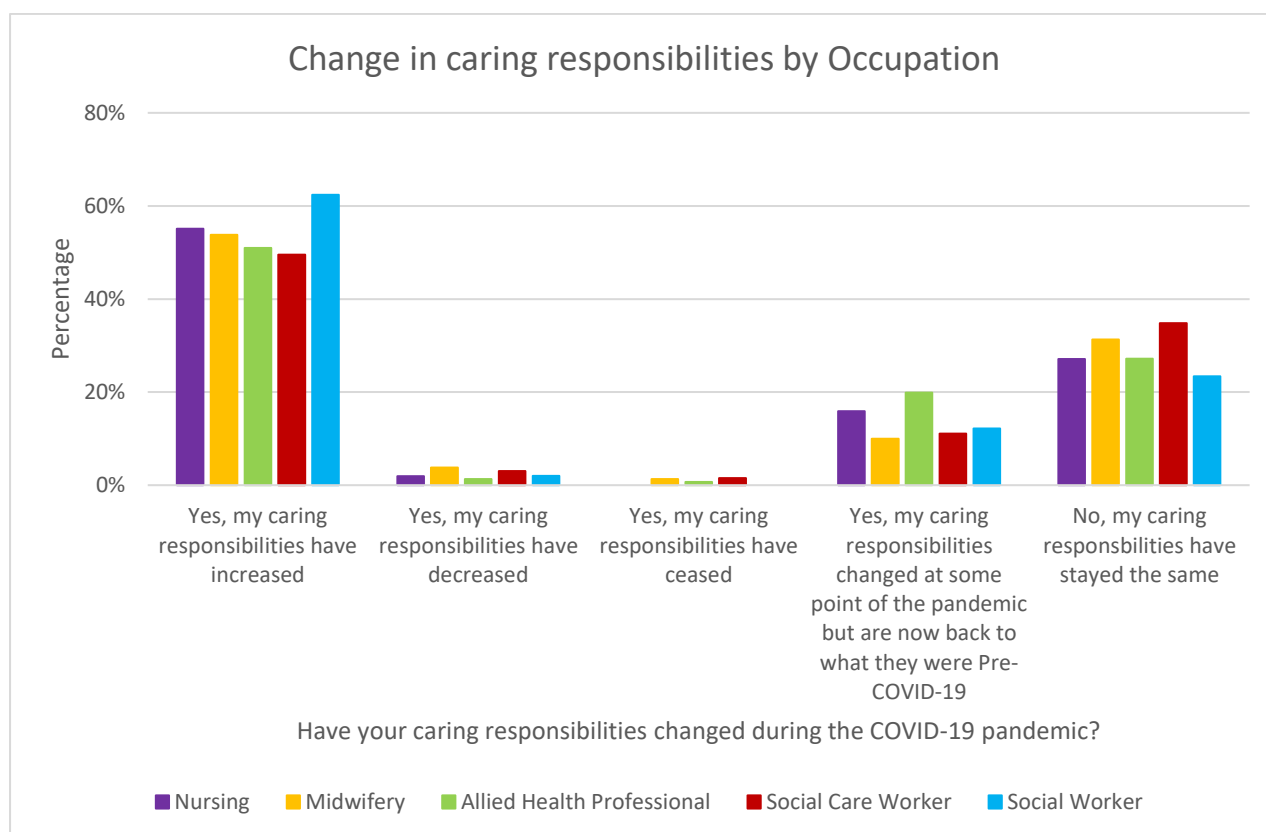


Table A2.154: Change in Caring Responsibilities During the Pandemic by Occupation (Weighted)

Occupation	Yes, my caring responsibilities have increased	Yes, my caring responsibilities have decreased	Yes, my caring responsibilities have ceased	Yes, my caring responsibilities changed at some point in the pandemic but are now back to what they were Pre-COVID-19	No, my caring responsibilities have stayed the same	Total
Nursing	51.2%	0.6%	0.0%	20.8%	27.4%	100%
Midwifery	37.9%	7.1%	1.4%	15.7%	37.9%	100%
Allied Health Professional	54.5%	0.5%	0.5%	21.4%	23.0%	100%
Social Care Worker	41.3%	1.3%	1.3%	17.5%	38.8%	100%
Social Worker	64.2%	1.3%	0.0%	10.8%	23.7%	100%

Table A2.155: Change in Caring Responsibilities During the Pandemic by Occupation (Unweighted)

Occupation	Yes, my caring responsibilities have increased	Yes, my caring responsibilities have decreased	Yes, my caring responsibilities have ceased	Yes, my caring responsibilities changed at some point in the pandemic but are now back to what they were Pre-COVID-19	No, my caring responsibilities have stayed the same	Total
Nursing	114 (55.1%)	4 (1.9%)	0 (0.0%)	33 (15.9%)	56 (27.1%)	207 (100%)
Midwifery	43 (53.8%)	3 (3.8%)	1 (1.3%)	8 (10.0%)	25 (31.3%)	80 (100%)
Allied Health Professional	154 (51.0%)	4 (1.3%)	2 (0.7%)	60 (19.9%)	82 (27.2%)	302 (100%)
Social Care Worker	98 (49.5%)	6 (3.0%)	3 (1.5%)	22 (11.1%)	69 (34.8%)	198 (100%)
Social Worker	123 (62.4%)	4 (2.0%)	0 (0.0%)	24 (12.2%)	46 (23.4%)	197 (100%)

A2.40 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 A2.156: Responses by Region (Unweighted)

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

Figure A2.156: Responses by Region (Unweighted)

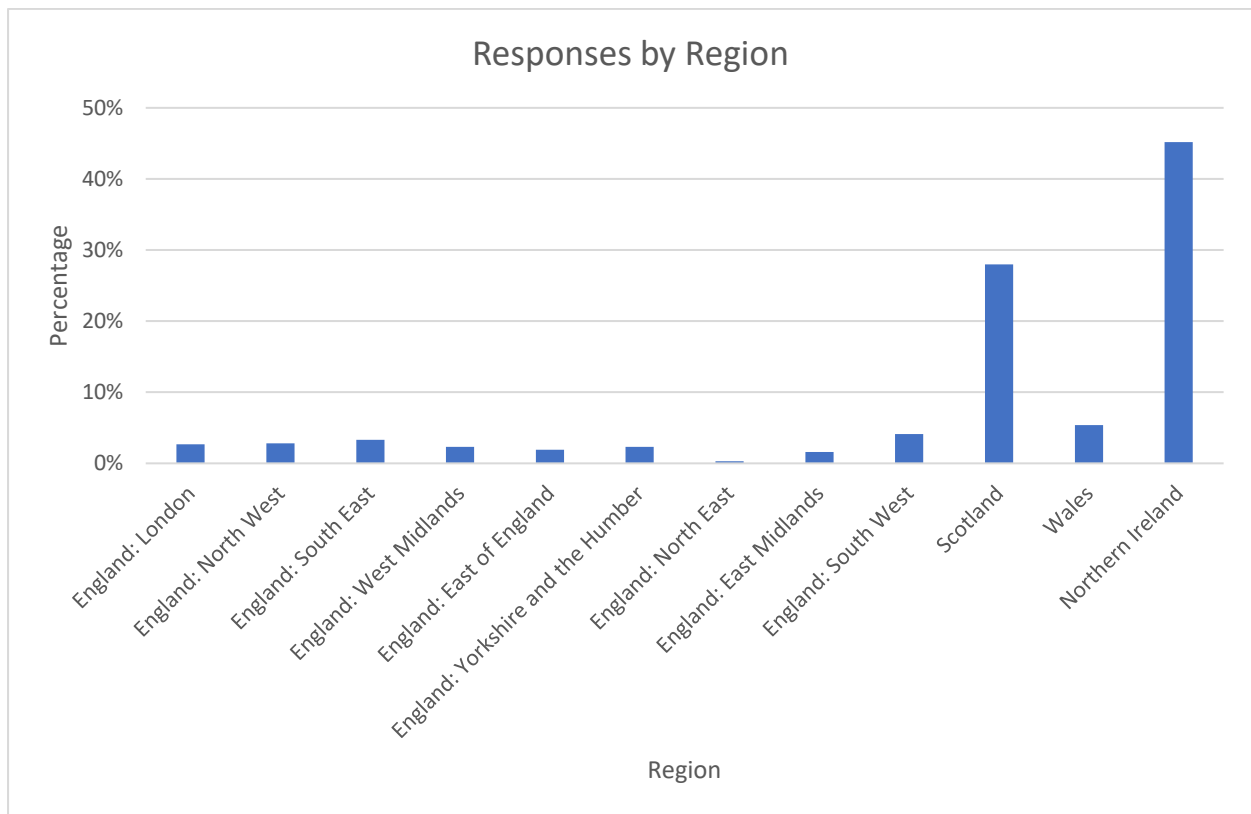


Figure A2.157: Region by Occupation (Unweighted)

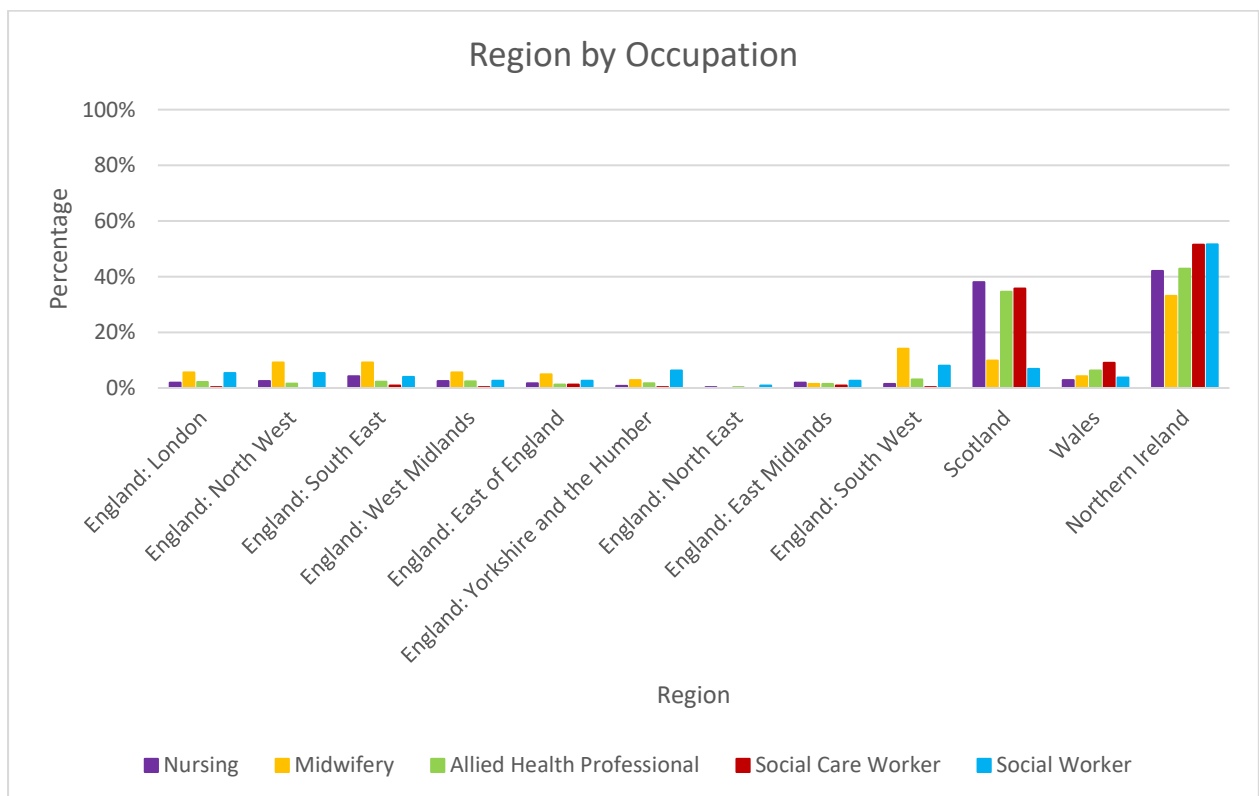


Table A2.157: Region by Occupation (Unweighted)

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

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

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

A3.1 Wellbeing Scores by Country

Summary (Weighted results):

There was a significant difference in the overall mean wellbeing scores across countries ($F = 2.68$, $df = 3$, $p < .05$). When the scores were converted to possible or probable cases of anxiety/depression, a total of 12.4% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 20.1% were possible cases.

Summary (Unweighted results):

There was no significant difference in the overall mean wellbeing scores across countries ($F = 1.663$, $df = 3$, $p = .173$). When the scores were converted to possible or probable cases of anxiety/depression, a total of 12.8% of respondents UK-wide were probable (likely) cases of anxiety or depression and a further 20.7% were possible cases.

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

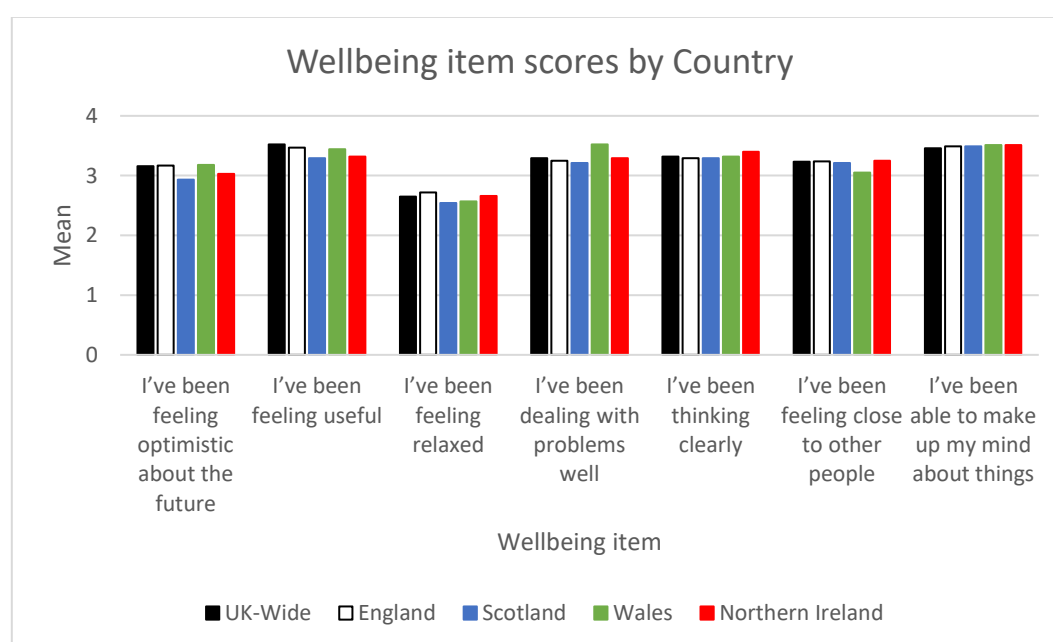


Figure A3. 2: Mean Wellbeing Item Scores by Country (Unweighted)

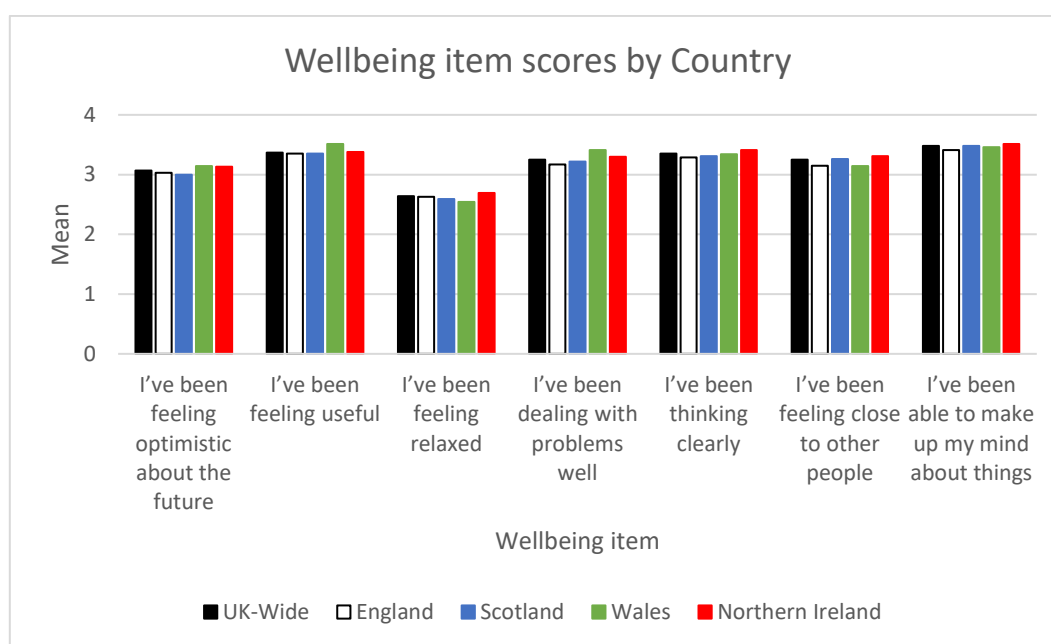


Figure A3.3: Mean Overall Wellbeing Score by Country (Weighted)

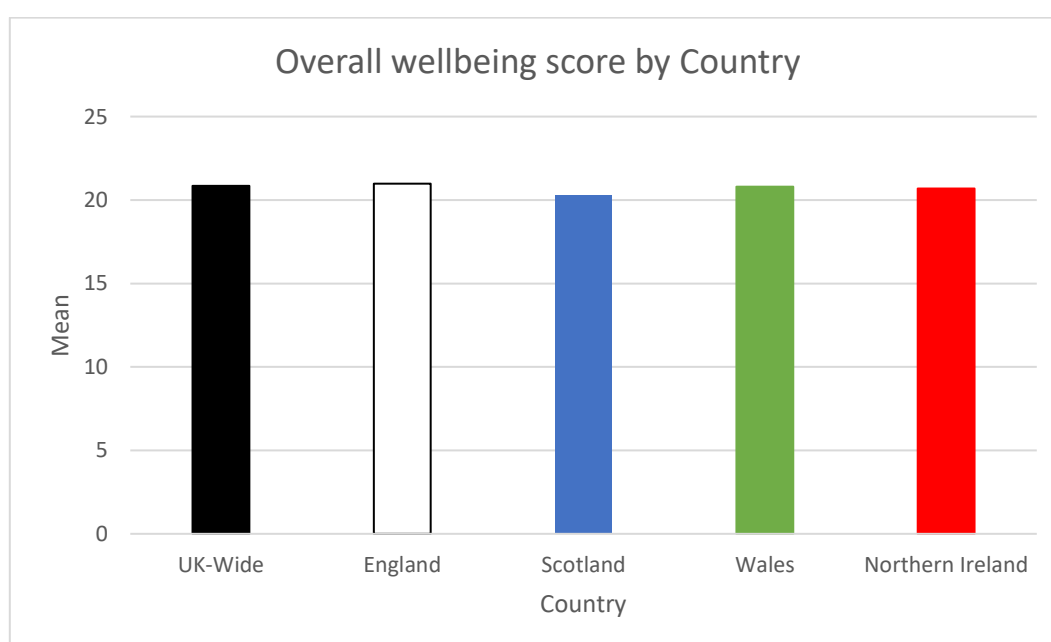


Figure A3.4: Mean Overall Wellbeing Score by Country (Unweighted)

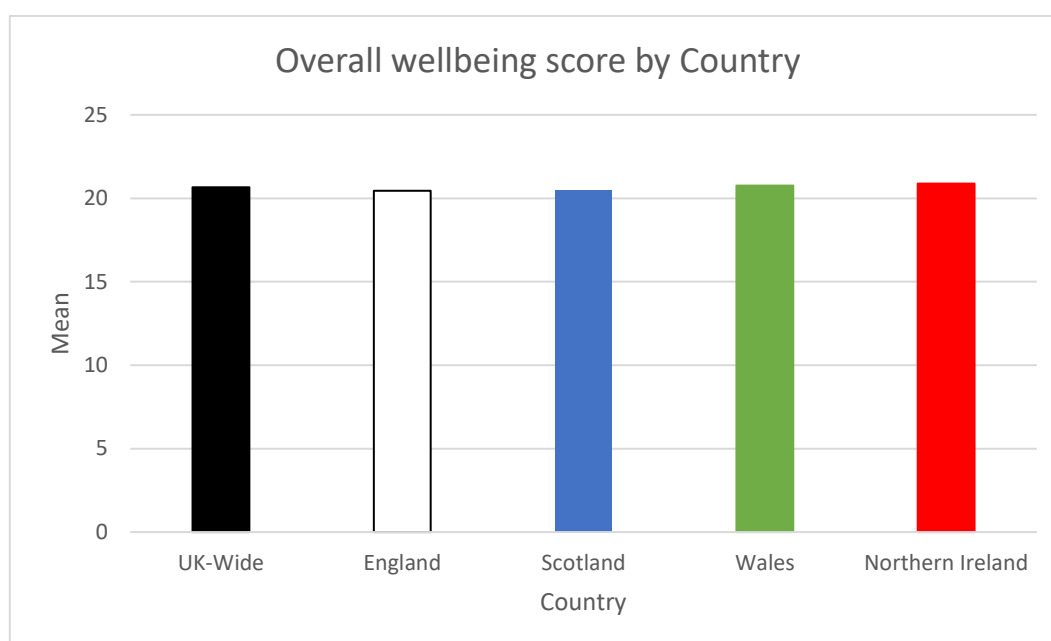


Table A3. 1: Mean Overall and Item Wellbeing Scores by Country (Weighted)

Wellbeing item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	3.16	3.17	2.93	3.18	3.03
I've been feeling useful	3.52	3.47	3.29	3.44	3.32
I've been feeling relaxed	2.65	2.72	2.54	2.57	2.66
I've been dealing with problems well	3.29	3.25	3.21	3.52	3.29
I've been thinking clearly	3.32	3.29	3.29	3.32	3.4
I've been feeling close to other people	3.23	3.24	3.21	3.05	3.25
I've been able to make up my mind about things	3.46	3.49	3.49	3.51	3.51
Mean overall wellbeing score	20.85	20.98	20.27	20.8	20.69

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

Wellbeing item	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	3.07	3.03	3.00	3.14	3.13
I've been feeling useful	3.37	3.35	3.35	3.51	3.38
I've been feeling relaxed	2.64	2.63	2.59	2.54	2.69
I've been dealing with problems well	3.25	3.17	3.22	3.41	3.3
I've been thinking clearly	3.35	3.29	3.31	3.34	3.41
I've been feeling close to other people	3.25	3.15	3.26	3.14	3.31
I've been able to make up my mind about things	3.48	3.41	3.48	3.46	3.51
Mean overall wellbeing score	20.66	20.45	20.47	20.76	20.88

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

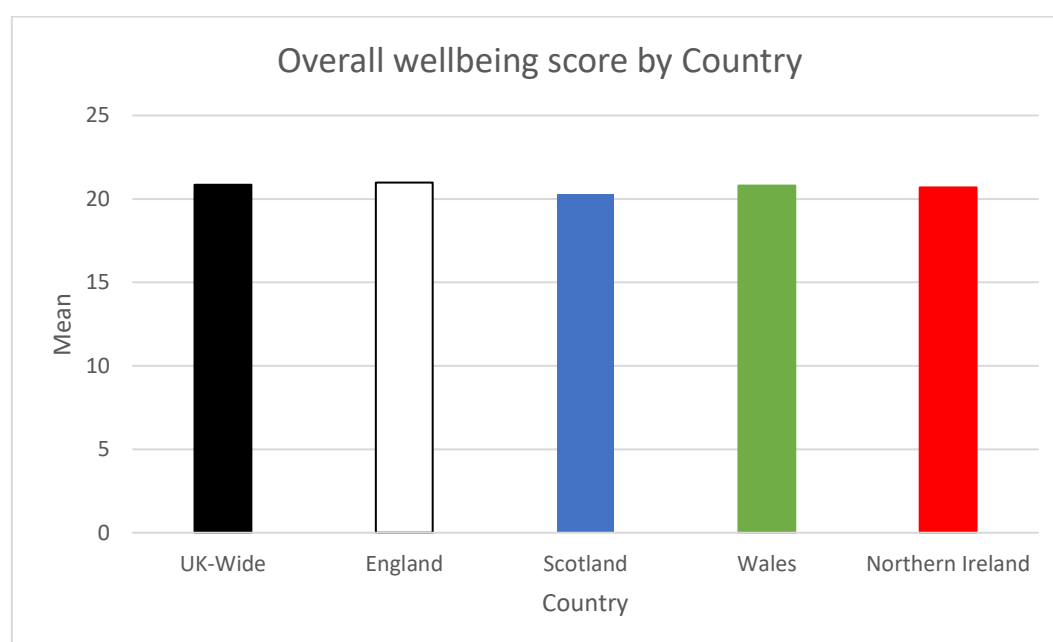


Figure A3.6: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Unweighted)

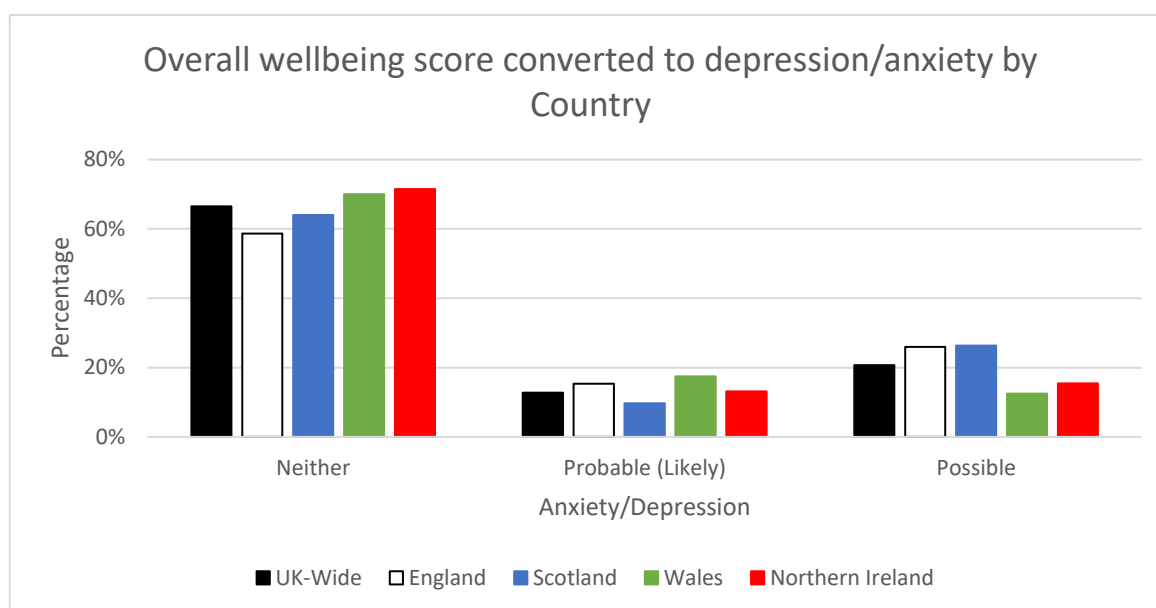


Table A3.3: Overall Wellbeing Score Converted to Depression/Anxiety by Country (Weighted)

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	67.6%	64.3%	63.9%	72.2%	71.1%
Probable (Likely)	12.4%	12.6%	11.3%	17.3%	14.2%
Possible	20.1%	23.1%	24.8%	10.5%	14.6%
Total	100%	100%	100%	100%	100%

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

Case of anxiety/depression	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Neither	1015 (66.5%)	192 (58.7%)	285 (64.0%)	56 (70.0%)	482 (71.5%)
Probable (Likely)	195 (12.8%)	50 (15.3%)	43 (9.7%)	14 (17.5%)	88 (13.1%)
Possible	316 (20.7%)	95 (26.0%)	117 (26.3%)	10 (12.5%)	104 (15.4%)
Total	1526 (100%)	327 (100%)	445 (100%)	80 (100%)	674 (100%)

A3.2 Wellbeing Scores by Occupation

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores across occupational groups ($F = 14.87$, $df = 4$, $p = .001$). Specifically, the overall wellbeing score was significantly lower in midwives than in nurses or AHPs.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores across occupational groups ($F = 5.33$, $df = 4$, $p < .001$). Specifically, the overall wellbeing scores were significantly higher in AHPs than in midwives, social care workers and social workers.

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

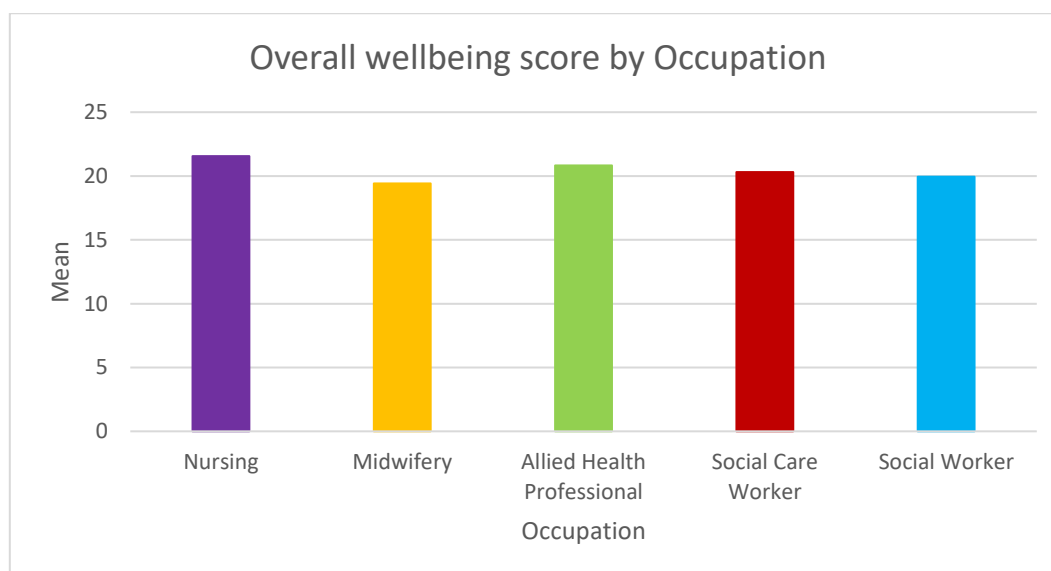


Figure A3.8: Mean Overall Wellbeing Score by Occupation (Unweighted)

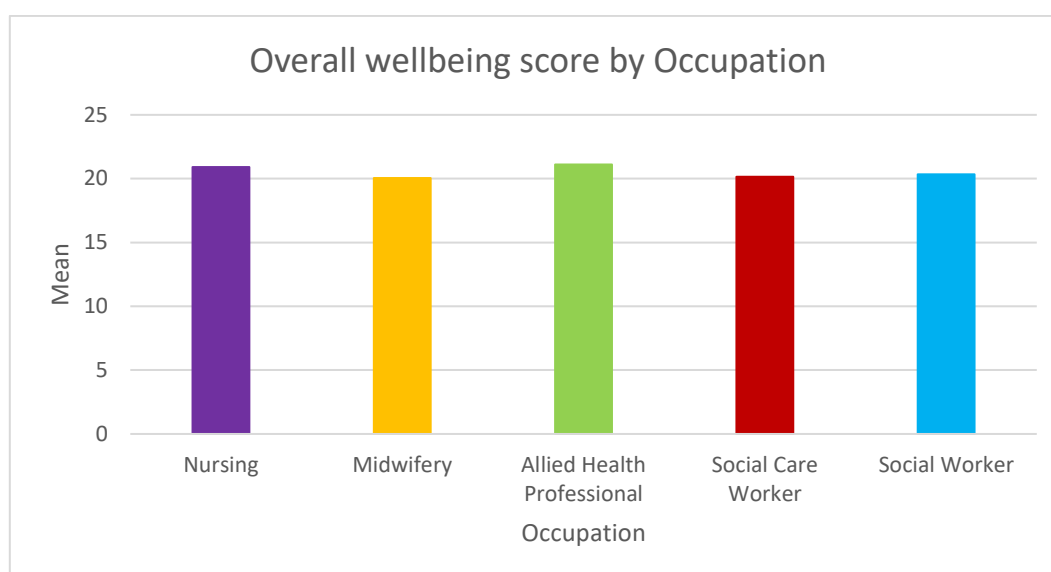


Table A3.5: Mean Overall Wellbeing Score by Occupation (Weighted)

Occupation	Mean overall wellbeing score
Nursing	21.56
Midwifery	19.42
AHP	20.83
Social Care Worker	20.31
Social Worker	19.95

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

Occupation	Mean overall wellbeing score
Nursing	20.91
Midwifery	20.05
AHP	21.11
Social Care Worker	20.15
Social Worker	20.34

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

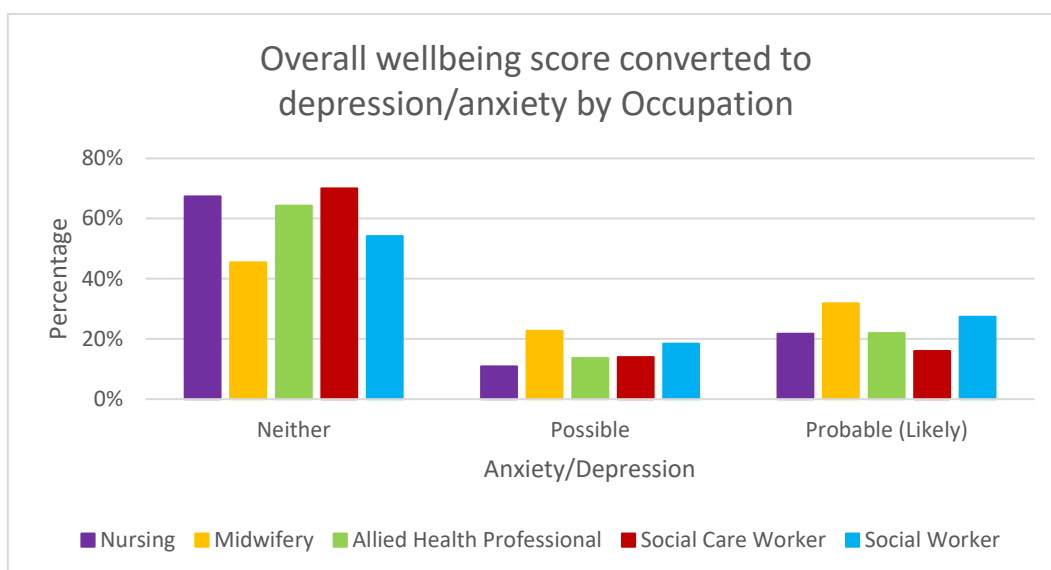


Figure A3.10: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Unweighted)

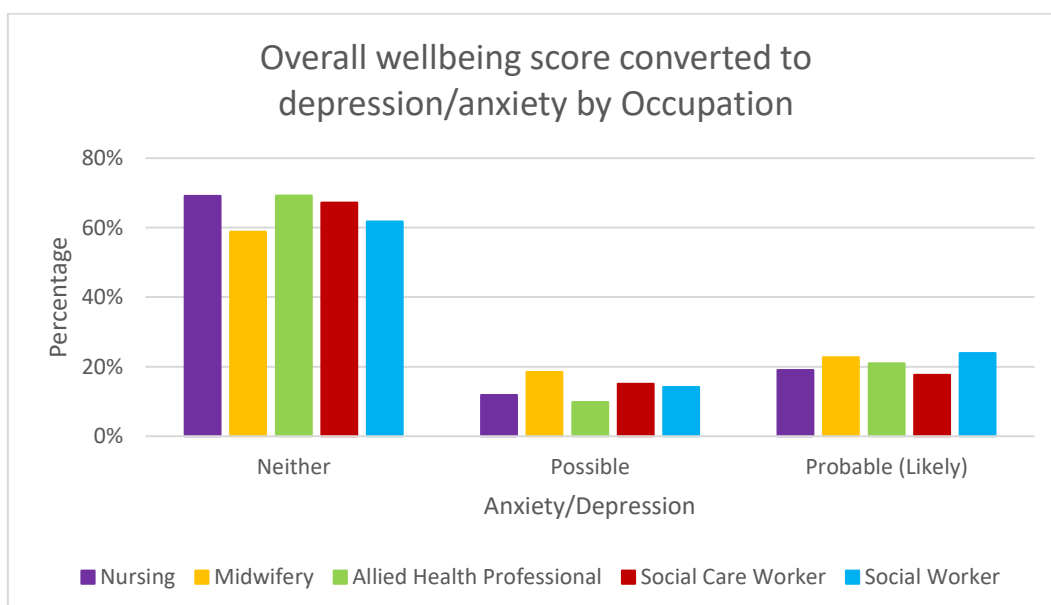


Table A3.7: Overall Wellbeing Score Converted to Depression/Anxiety by Occupation (Weighted)

Case of anxiety/depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	67.4%	45.5%	64.3%	70.0%	54.2%
Probable (Likely)	10.9%	22.7%	13.7%	14.0%	18.5%
Possible	21.7%	31.8%	22.0%	16.0%	27.4%
Total	100%	100%	100%	100%	100%

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

Case of anxiety/ depression	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Neither	226 (69.1%)	70 (58.8%)	346 (69.2%)	182 (67.2%)	191 (61.8%)
Probable (Likely)	39 (11.9%)	22 (18.5%)	49 (9.8%)	41 (15.1%)	44 (14.2%)
Possible	62 (19.0%)	27 (22.7%)	105 (21.0%)	48 (17.7%)	74 (23.9%)
Total	327 (100%)	119 (100%)	500 (100%)	271 (100%)	309 (100%)

A3.3 Wellbeing Scores by Sex

Only 6 respondents in the full sample stated their sex to be transgender, non-binary, intersex, other or preferred not to state which category of gender they identified with. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

Comparing males and females, there was no significant difference in their overall mean wellbeing score ($t = -1.27$, $df = 394.31$, $p > .05$).

Summary (Unweighted results):

Males and females did not differ significantly on their overall mean wellbeing scores ($t = -.160$, $df=1518$, $p>0.05$).

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

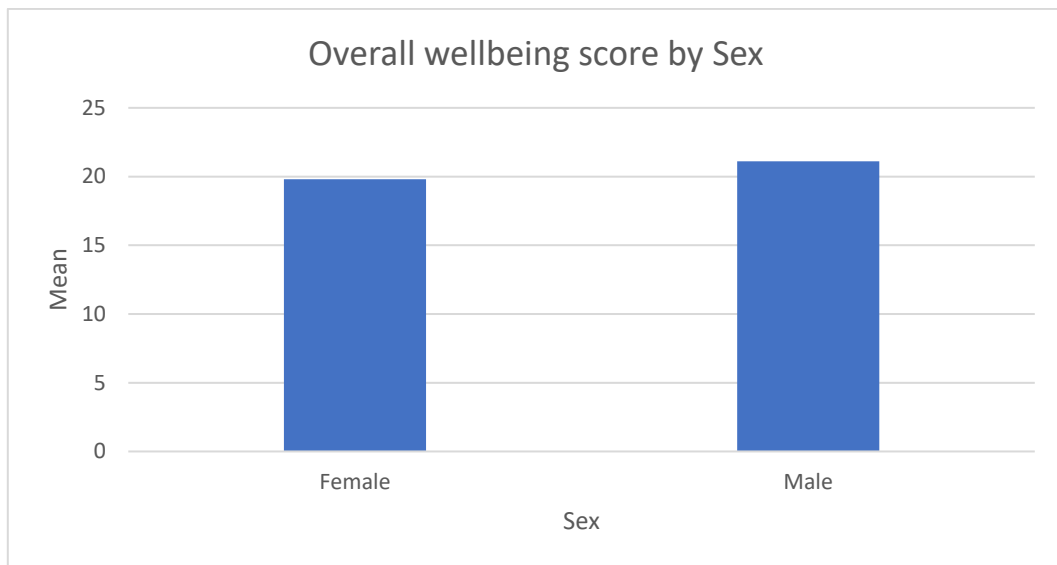


Figure A3.12: Mean Overall Wellbeing Score by Sex (Unweighted)

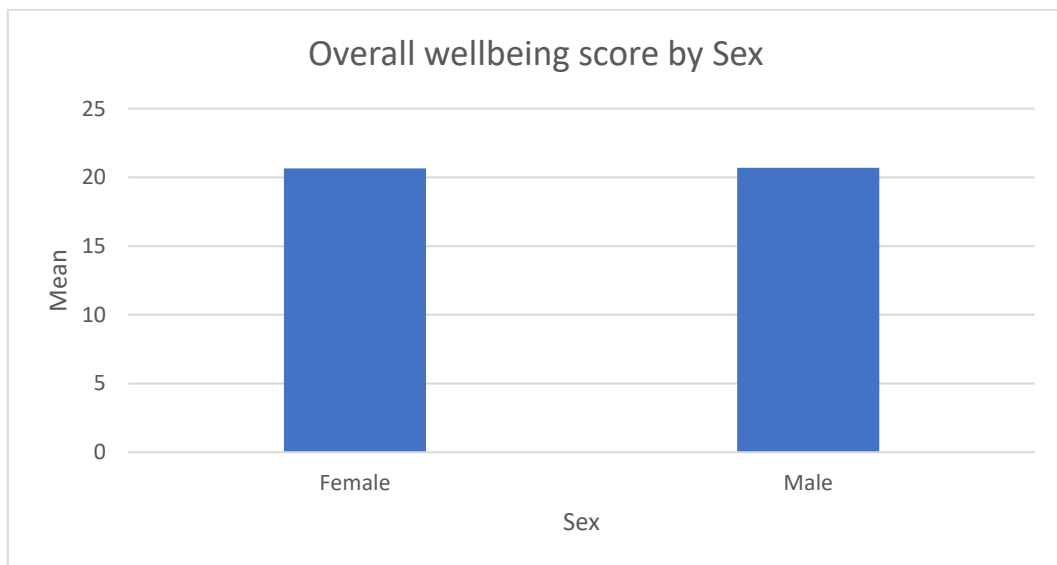


Table A3.9: Mean Overall Wellbeing Score by Sex (Weighted)

Sex	Mean overall wellbeing score
Female	19.80
Male	21.10

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

Sex	Mean overall wellbeing score
Female	20.66
Male	20.70

A3.4 Wellbeing Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in their overall mean wellbeing scores ($F = 6.57$, $df = 5$, $p < .001$). Most of the older age groups had higher wellbeing scores compared to the younger age groups. Specifically, the wellbeing score was significantly higher in the 60-65 group compared to the 16-29, 30-39, 40-49 and 50-59 age groups.

Summary (Unweighted results):

There were significant differences across the age groups in their overall mean wellbeing scores ($F = 3.922$, $df = 5$, $p = .002$). The overall wellbeing scores were higher in the older age groups compared to the younger age groups. Specifically, the wellbeing scores were significantly higher on average in the 60-65 age group than in the 16-29 and 30-39-age groups.

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

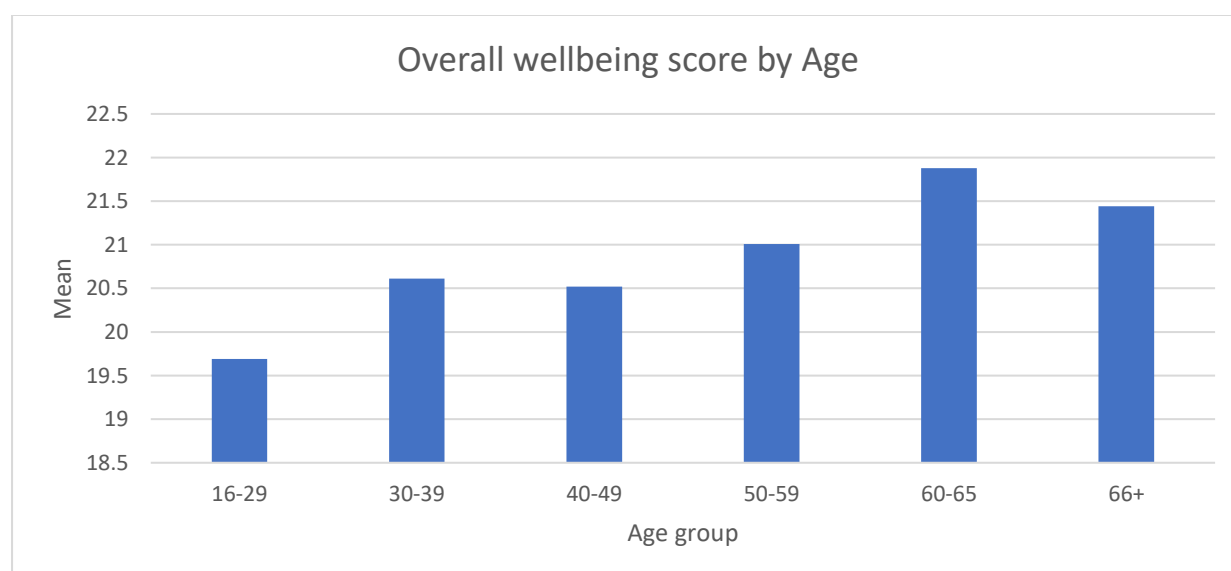


Figure A3.14: Mean Overall Wellbeing Score by Age (Unweighted)

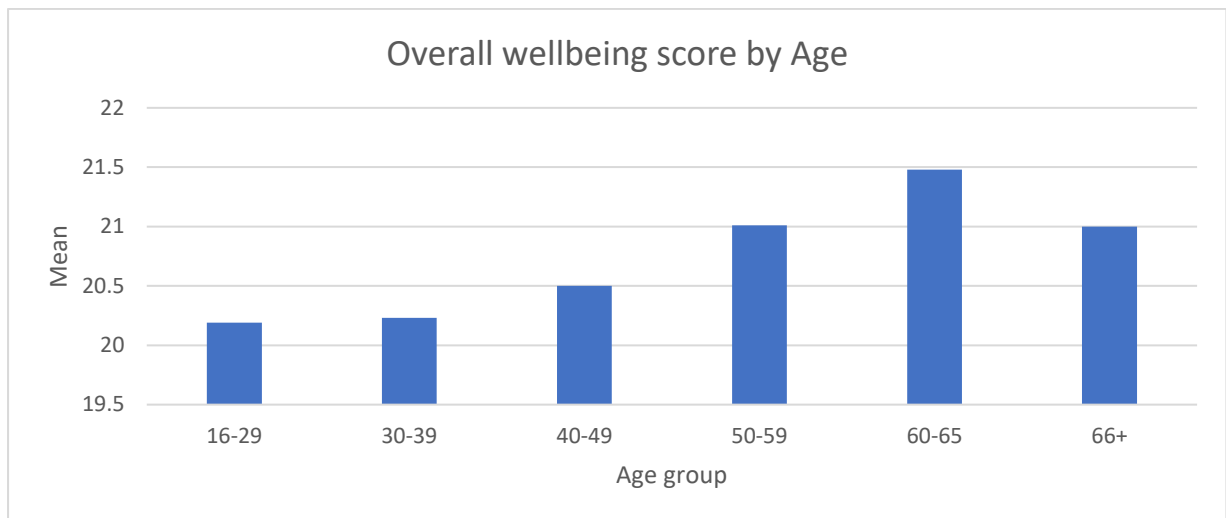


Table A3.11: Mean Overall Wellbeing Score by Age (Weighted)

Age	Mean overall wellbeing score
16-29 years	19.69
30-39 years	20.61
40-49 years	20.52
50-59 years	21.01
60-65 years	21.88
66+ years	21.44

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

Age	Mean overall wellbeing score
16-29 years	20.19
30-39 years	20.23
40-49 years	20.5
50-59 years	21.01
60-65 years	21.48
66+ years	21.00

A3.5 Wellbeing Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups on their overall mean wellbeing scores ($F = 17.93$, $df = 3$, $p < .001$). Specifically, respondents who identified as black had significantly higher wellbeing scores than all the other ethnic groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups on their overall mean wellbeing scores ($F = 2.797$, $df = 3$, $p = .04$). Specifically, respondents who identified as Asian had significantly higher wellbeing scores than those who identified as White.

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

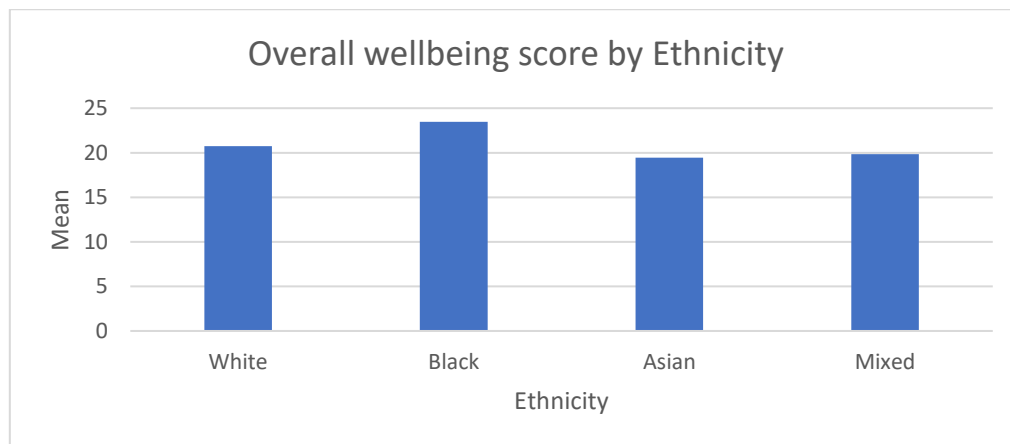


Figure A3.16: Mean Overall Wellbeing Score by Ethnicity (Unweighted)

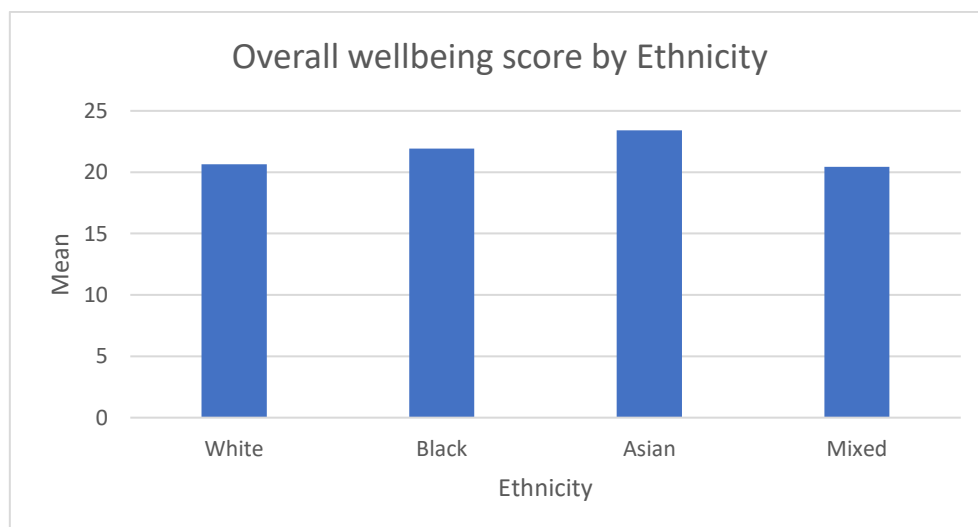


Table A3.13: Mean Overall Wellbeing Score by Ethnicity (Weighted)

Ethnicity	Mean overall wellbeing score
White	20.74
Black	23.47
Asian	19.45
Mixed	19.85

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

Ethnicity	Mean overall wellbeing score
White	20.64
Black	21.92
Asian	23.42
Mixed	20.44

A3.6 Wellbeing Scores by Disability

Summary (Weighted results):

There were significant differences between respondents on their overall mean wellbeing scores based on their disability status ($F = 33.03$, $df = 2$, $p < .001$). Specifically, respondents who considered themselves to not have a disability than those who were unsure or those who had a disability.

Summary (Unweighted results):

There were significant differences between respondents on their overall mean wellbeing scores based on their disability status ($F = 15.209$, $df = 2$, $p < .001$). Specifically, respondents who considered themselves to have a disability reported significantly lower wellbeing scores than those without a disability.

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

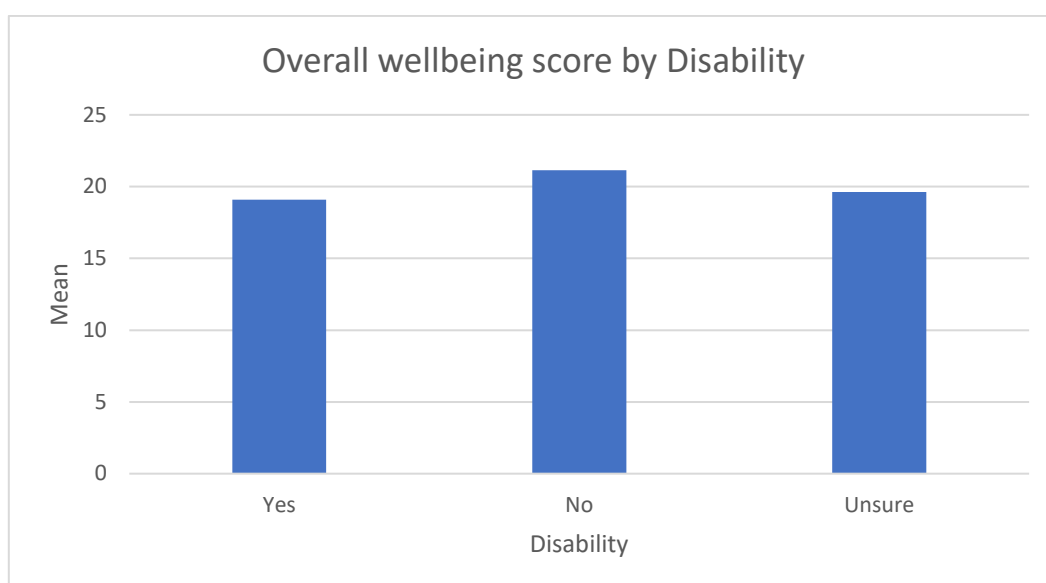


Figure A3.18: Mean Overall Wellbeing Score by Disability (Unweighted)

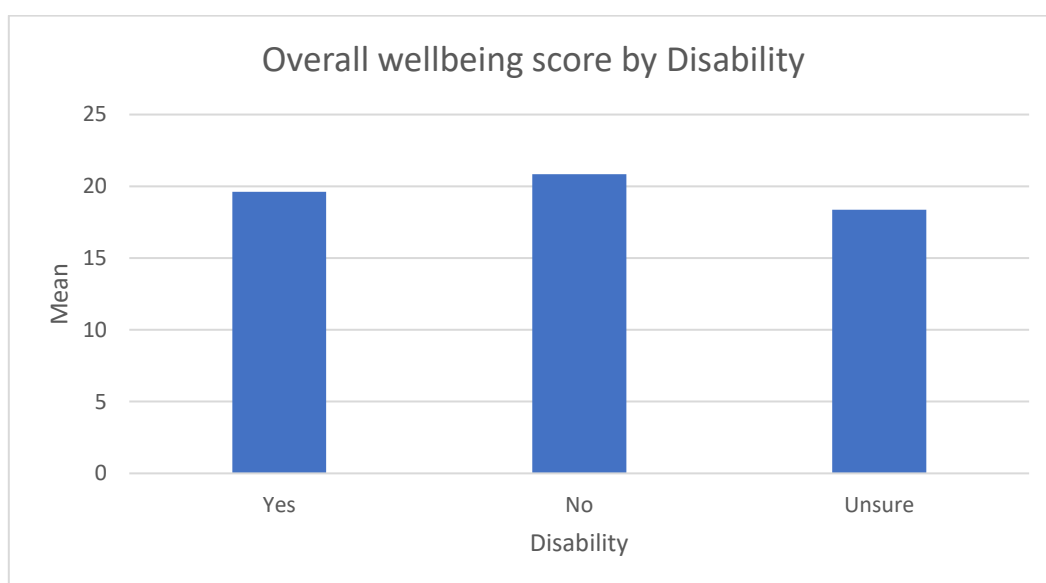


Table A3.15: Mean Overall Wellbeing Score by Disability (Weighted)

Do you consider yourself to have a disability?	Mean overall wellbeing score
Yes	19.08
No	21.14
Unsure	19.63

Table A3.16: Mean Overall Wellbeing Score by Disability (Unweighted)

Do you consider yourself to have a disability?	Mean overall wellbeing score
Yes	19.61
No	20.84
Unsure	18.36

A3.7 Wellbeing Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who worked in different areas of practice ($F = 11.062$, $df = 7$, $p = .001$). Specifically, respondents who worked with their main area of practice being children scored significantly higher than those who worked in midwifery, in learning disability, with older people or in the 'Other' occupation.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores between respondents who worked in different areas of practice ($F = 3.188$, $df = 7$, $p = .002$). Multiple comparison tests revealed no statistically significant differences, although there was a trend towards higher scores in those who worked with children, in mental health or other as their area of practice.

Figure A3.19: Mean Overall Wellbeing Score by Area of Practice (Weighted)

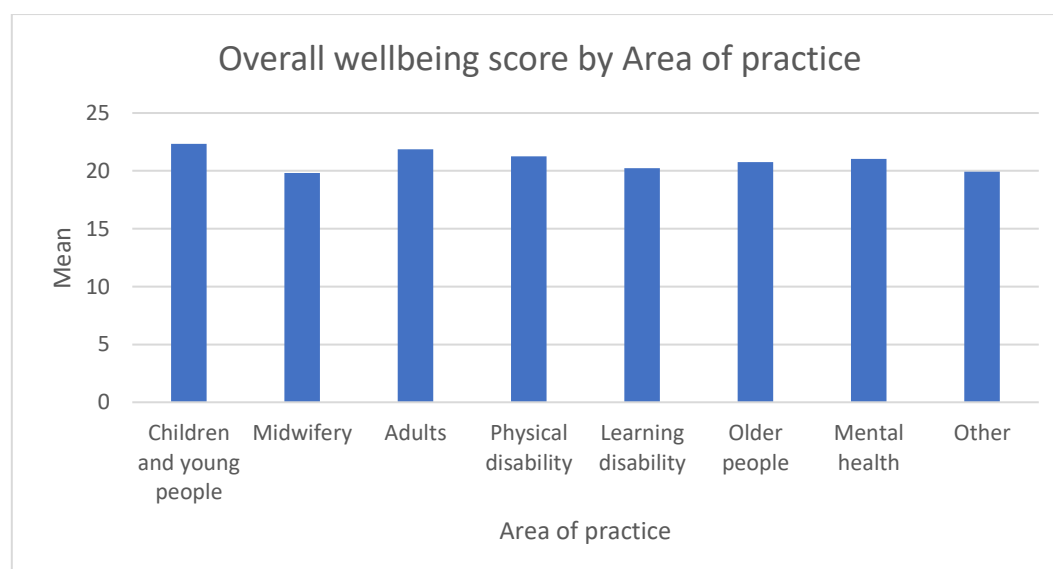


Figure A3.20: Mean Overall Wellbeing Score by Area of Practice (Unweighted)

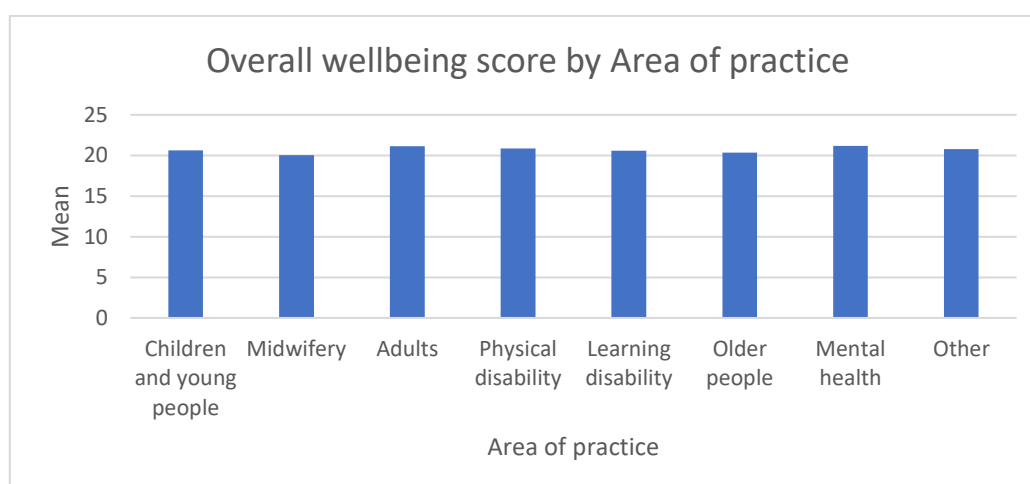


Table A3.17: Mean Overall Wellbeing Score by Area of Practice (Weighted)

Main area of practice	Mean overall wellbeing score
Children	22.33
Midwifery	19.81
Adults	21.86
Physical disability	21.26
Learning disability	20.23
Older people	20.75
Mental health	21.04
Other	19.92

Table A3.18: Mean Overall Wellbeing Score by Area of Practice (Unweighted)

Main area of practice	Mean overall wellbeing score
Children	20.61
Midwifery	20.04
Adults	21.12
Physical disability	20.86
Learning disability	20.60
Older people	20.35
Mental health	21.16
Other	20.80

A3.8 Wellbeing Scores by Line Manager Status

Summary (Weighted results):

There was no significant difference in the overall mean wellbeing scores between respondents who were line managers and those who were not ($t = -6.828$, $df = 1696.66$, $p = .383$).

Summary (Unweighted results):

There was no significant difference in the overall mean wellbeing scores between respondents who were line managers and those who were not ($t = 1.645$, $df = 1523$, $p = .100$).

Figure A3.21: Mean Overall Wellbeing Score by Line Manager Status (Weighted)

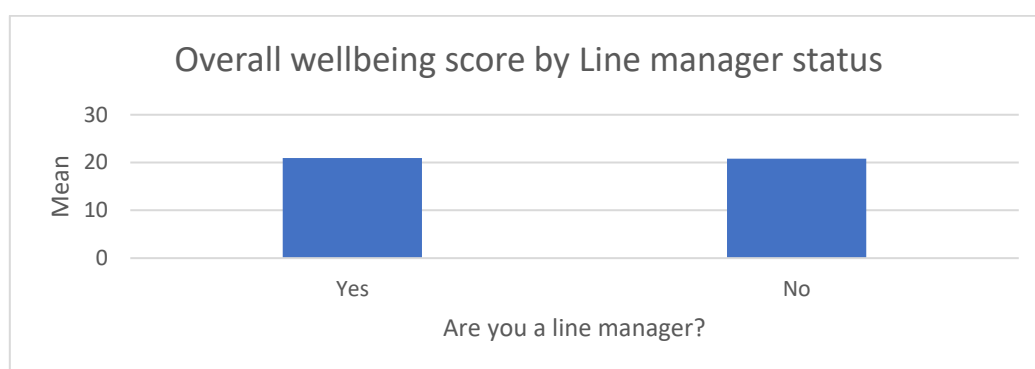


Figure A3.22: Mean Overall Wellbeing Score by Line Manager Status (Unweighted)

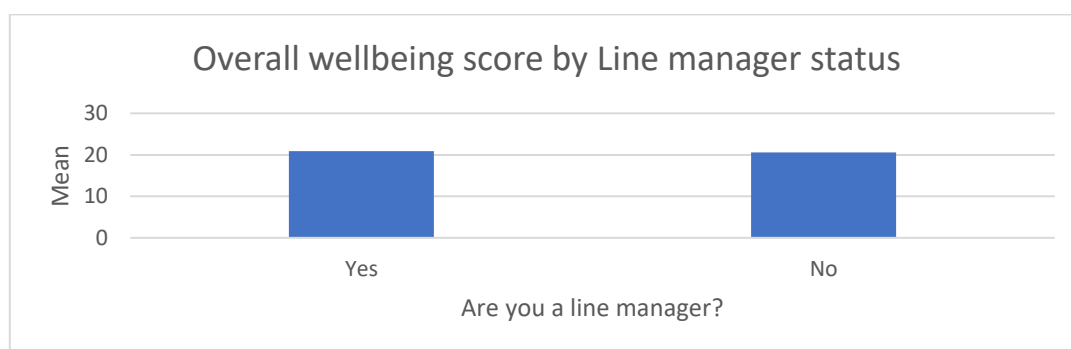


Table A3.19: Mean Overall Wellbeing Score by Line Manager Status (Weighted)

Are you a line manager?	Mean overall wellbeing score
Yes	20.94
No	20.80

Table A3.20: Mean Overall Wellbeing Score by Line Manager Status (Unweighted)

Are you a line manager?	Mean overall wellbeing score
Yes	20.87
No	20.56

A3.9 Wellbeing Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in the overall mean wellbeing scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ($F = 47.40$, $df = 2$, $p < .001$). Specifically, respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact of COVID-19 or those who were not impacted by COVID-19 pressures but had services stepped down due to COVID-19.

Summary (Unweighted results):

There were significant differences in the overall mean wellbeing scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to COVID-19 ($F = 42.333$, $df = 2$, $p < .001$). 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 Wellbeing Score by the Impact of the Pandemic on Services (Weighted)

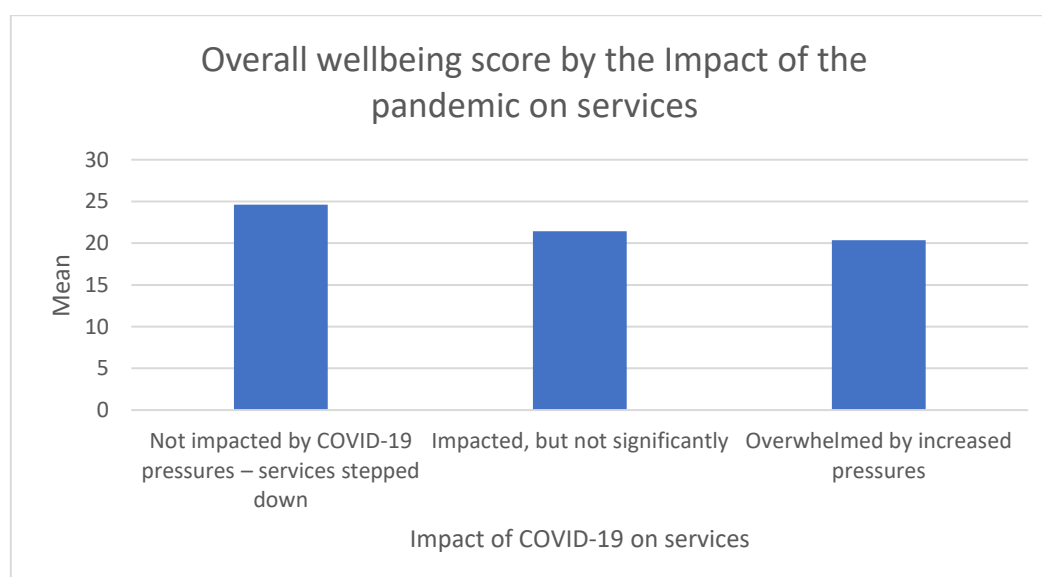


Figure A3.24: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Unweighted)

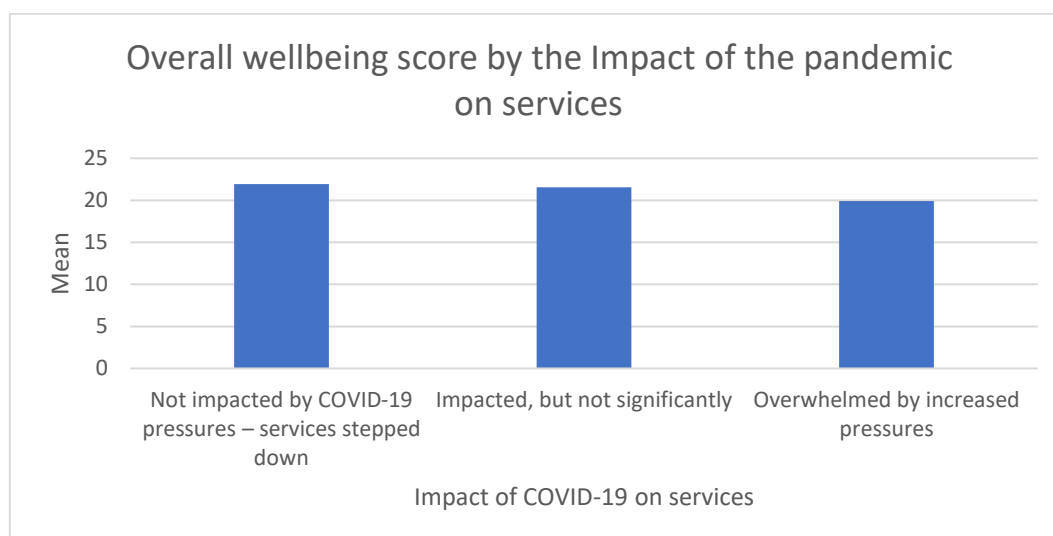


Table A3.21: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Weighted)

Impact of the pandemic on services	Mean overall wellbeing score
Not impacted by COVID-19 pressures – services stepped down	24.61
Impacted, but not significantly	21.43
Overwhelmed by increased pressures	20.35

Table A3.22: Mean Overall Wellbeing Score by the Impact of the Pandemic on Services (Unweighted)

Impact of the pandemic on services	Mean overall wellbeing score
Not impacted by COVID-19 pressures – services stepped down	21.91
Impacted, but not significantly	21.54
Overwhelmed by increased pressures	19.91

Appendix 4: Quality of Working Life (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of respondents' quality of working life, which was measured using the Work-Related Quality of Life (WRQOL) scale. Higher scores on all domains indicate better quality of working life (e.g., higher score on the Stress at Work domain means less stress experienced by respondents and hence better quality of working life). Scores are comparable within domains, but not across them, due to different numbers of items contributing to each domain. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

For direct comparisons across reports (i.e., across Phase 1, Phase 2 and Phase 3 surveys), please see Appendix 9.

A4.1 Quality of Working Life Scores by Country

Summary (Weighted results):

There were significant differences in the overall mean WRQOL scores across countries ($F = 8.02$, $df = 3$, $p < .001$). 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” (55.0%) and Wales had the highest proportion with “higher quality of working life” (52.3%).

Summary (Unweighted results):

There were no significant differences in the overall mean WRQOL scores across countries ($F = 1.849$, $df = 3$, $p = .136$). When respondents were categorised into those with lower, average and higher quality of working life, England had the highest proportion of respondents with “lower quality of working life” (52.1%) and Wales had the highest proportion with “higher quality of working life” (42.3%).

Figure A4. 1: Mean Quality of Working Life Scores by Country (Weighted)

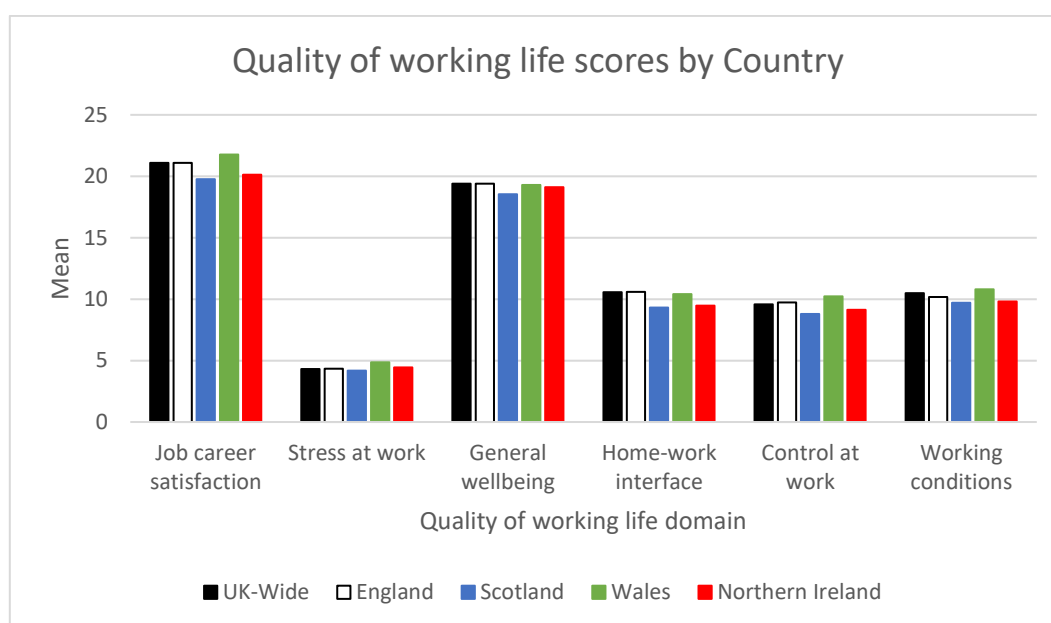


Figure A4. 2: Mean Quality of Working Life Scores by Country (Unweighted)

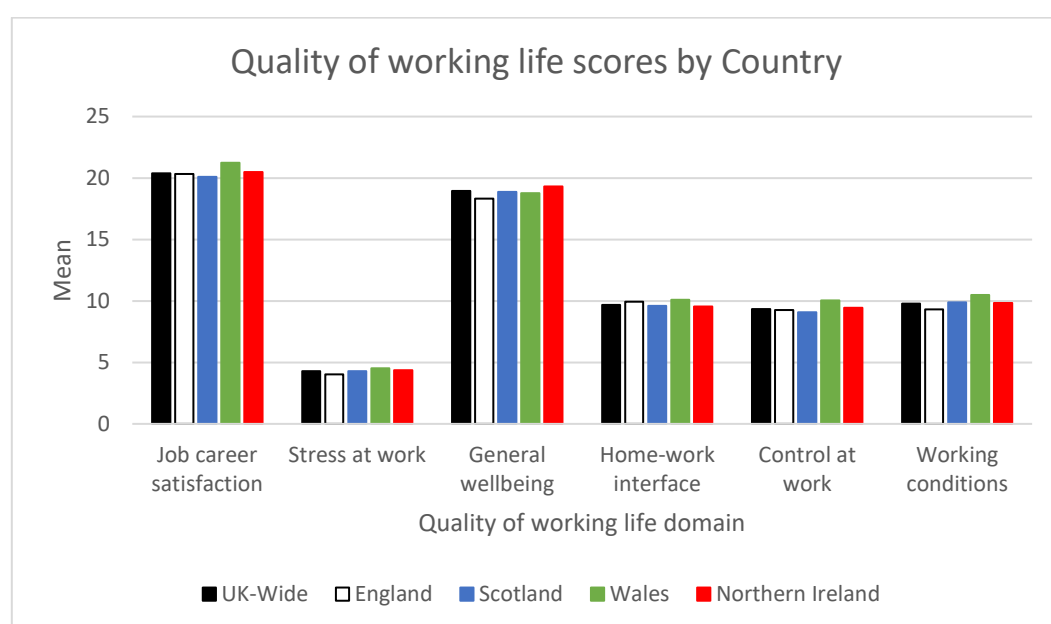


Figure A4.3: Mean Overall Quality of Working Life Score by Country (Weighted)

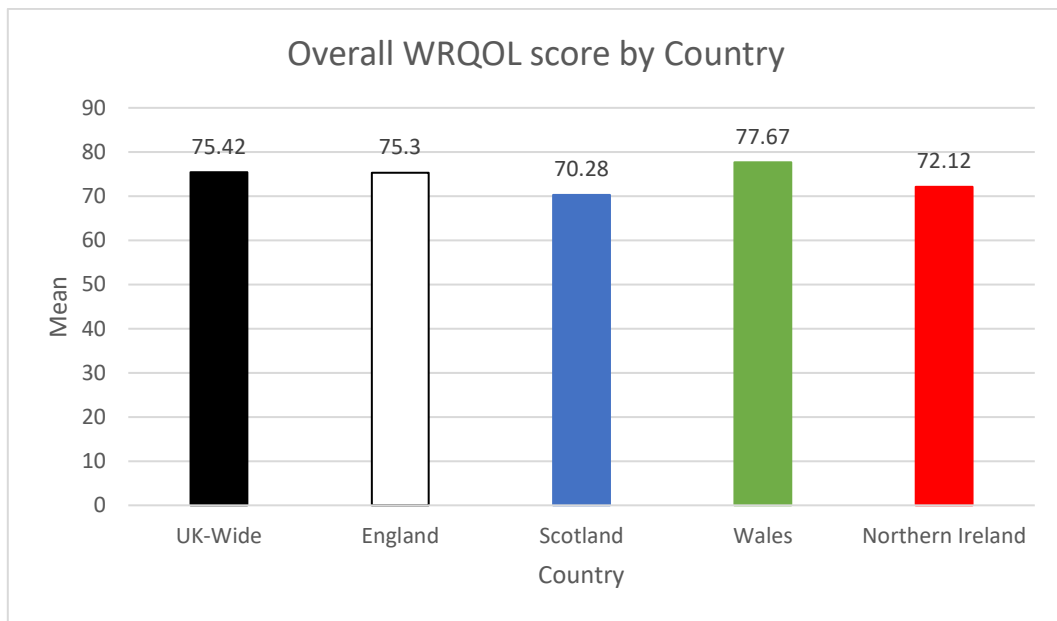


Figure A4.4: Mean Overall Quality of Working Life Score by Country (Unweighted)

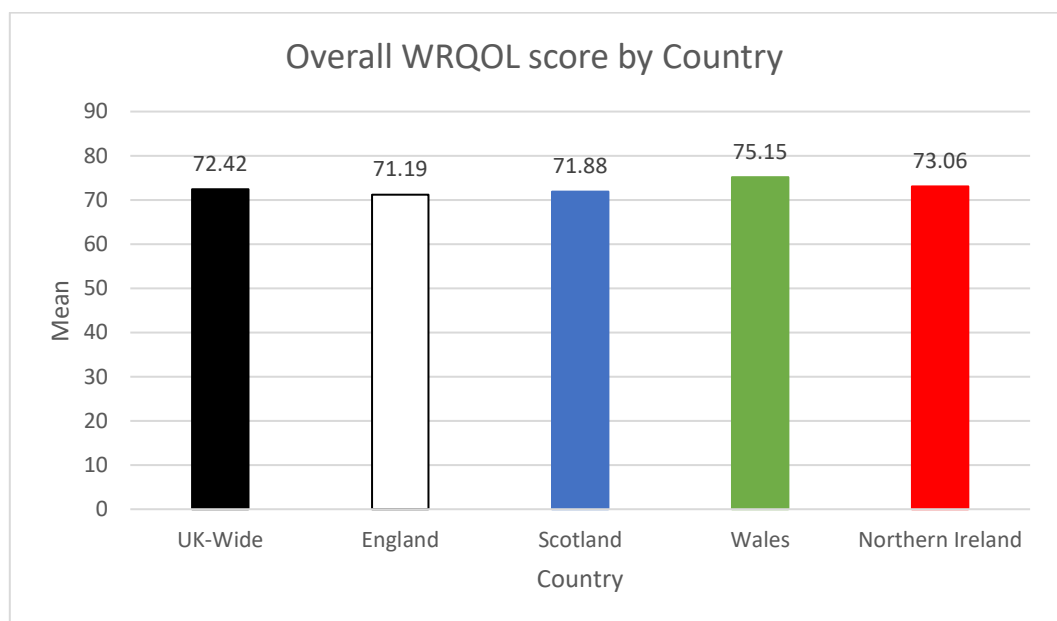


Table A4. 1: Mean Quality of Working Life Scores by Country (Weighted)

WRQOL domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Job career satisfaction	21.09	21.08	19.75	21.77	20.13
Stress at work	4.31	4.34	4.18	4.87	4.45
General wellbeing	19.39	19.40	18.55	19.30	19.10
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	9.70	10.81	9.82
Overall WRQOL Score	75.42	75.3	70.28	77.67	72.12

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	20.38	20.34	20.10	21.24	20.49
Stress at work	4.28	4.04	4.29	4.51	4.37
General wellbeing	18.94	18.32	18.86	18.76	19.31
Home-work interface	9.69	9.95	9.61	10.1	9.56
Control at work	9.33	9.25	9.08	10.05	9.45
Working conditions	9.77	9.31	9.88	10.49	9.83
Overall WRQOL score	72.42	71.19	71.88	75.15	73.06

Figure A4.5: Level of Quality of Working Life Scores – UK-Wide (Weighted)

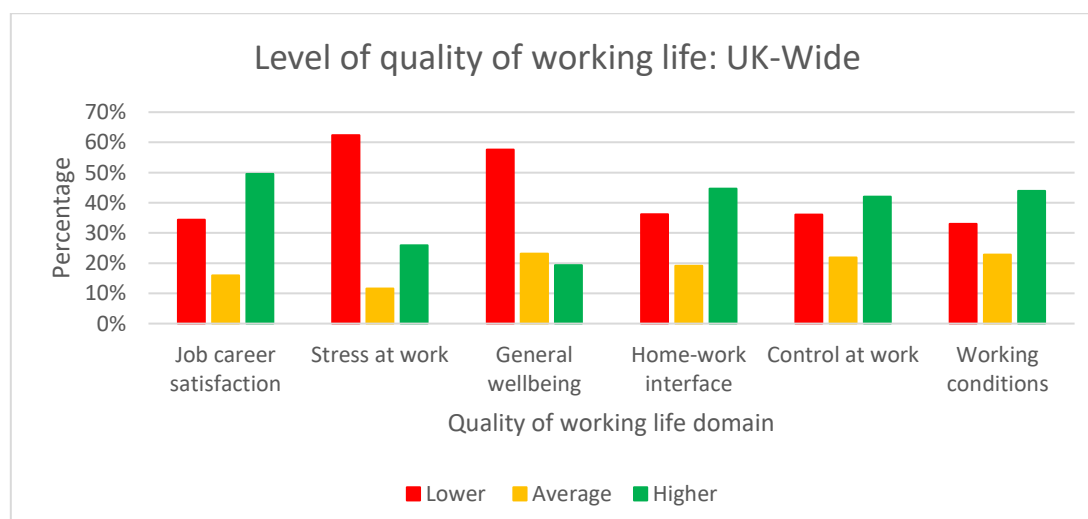


Figure A4.6: Level of Quality of Working Life Scores – UK-Wide (Unweighted)

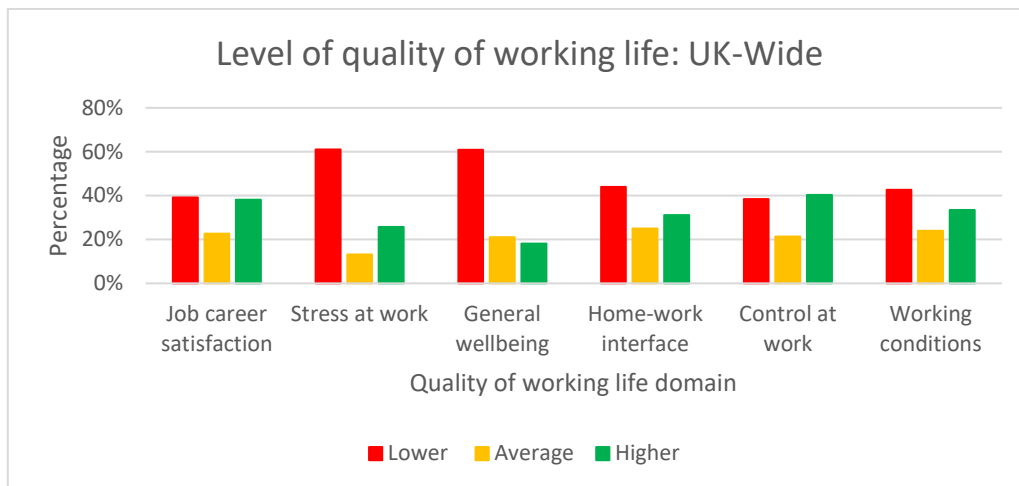


Table A4.3: Level of Quality of Working Life Scores – UK-Wide (Weighted)

WRQOL domain	Level of WRQOL			Total
	Lower	Average	Higher	
Job career satisfaction	34.4%	16.0%	49.5%	100%
Stress at work	62.4%	11.6%	25.9%	100%
General wellbeing	57.6%	23.2%	19.3%	100%
Home-work interface	36.2%	19.1%	44.7%	100%
Control at work	36.1%	21.9%	42.0%	100%
Working conditions	33.0%	22.8%	43.9%	100%
Overall WRQOL	36.9%	25.6%	37.4%	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	39.2%	22.7%	38.1%	1534 (100%)
Stress at work	61.0%	13.2%	25.7%	1540 (100%)
General wellbeing	60.9%	21.0%	18.2%	1531 (100%)
Home-work interface	43.9%	25.0%	31.1%	1551 (100%)
Control at work	38.4%	21.3%	40.3%	1538 (100%)
Working conditions	42.6%	24.0%	33.5%	1536 (100%)
Overall WRQOL	47.1%	23.4%	29.4%	1523 (100%)

Figure A4.7: Level of Overall Quality of Working Life by Country (Weighted)

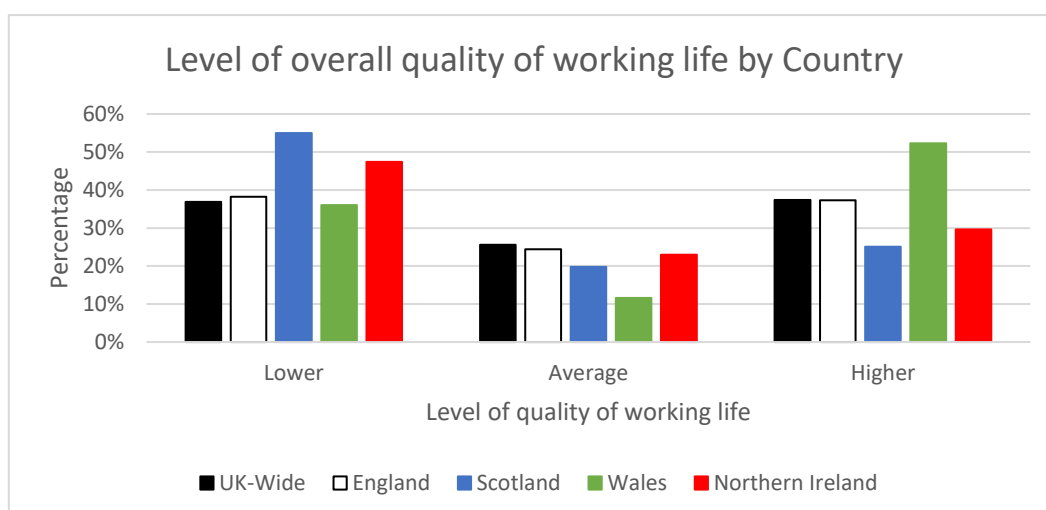


Figure A4.8: Level of Overall Quality of Working Life by Country (Unweighted)

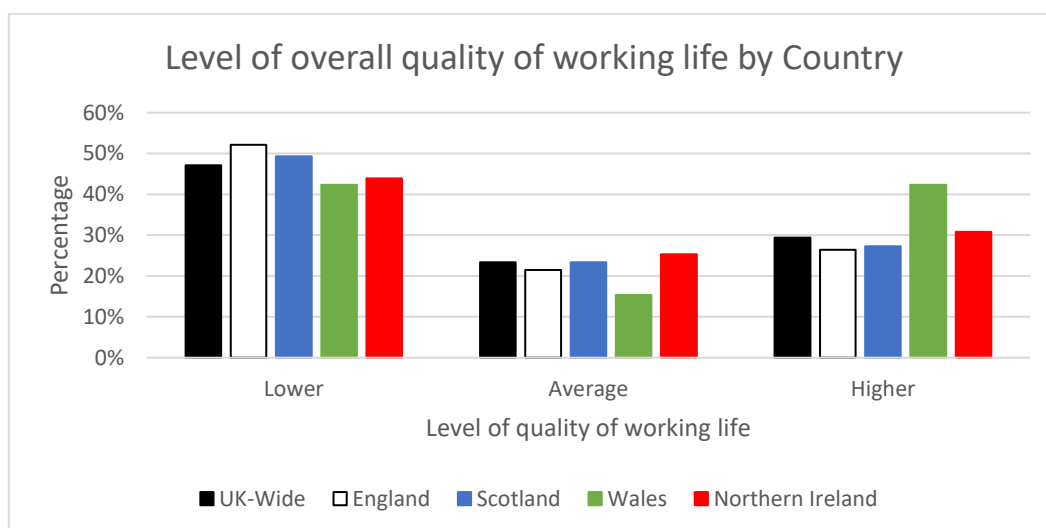


Table A4.5: Level of Overall Quality of Working Life by Country (Weighted)

Level of WRQOL	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower	36.9%	38.2%	55.0%	36.0%	47.4%
Average	25.6%	24.4%	19.8%	11.6%	23.0%
Higher	37.4%	37.3%	25.1%	52.3%	29.6%
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	47.1%	52.1%	49.3%	42.3%	43.9%
Average	23.4%	21.5%	23.4%	15.4%	25.3%
Higher	29.4%	26.4%	27.3%	42.3%	30.8%
Total	1523 (100%)	326 (100%)	444 (100%)	78 (100%)	675 (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 ($F = 33.61$, $df = 4$, $p < .001$). Specifically, midwives scored significantly lower than nurses, AHPs, social care workers and social workers.

Summary (Unweighted results):

There were significant differences in the overall mean WRQOL score between the occupational groups ($F = 8.800$, $df = 4$, $p = .001$). Specifically, midwives scored significantly lower than nurses and AHPs.

Figure A4.9: Mean Quality of Working Life Scores by Occupation (Weighted)

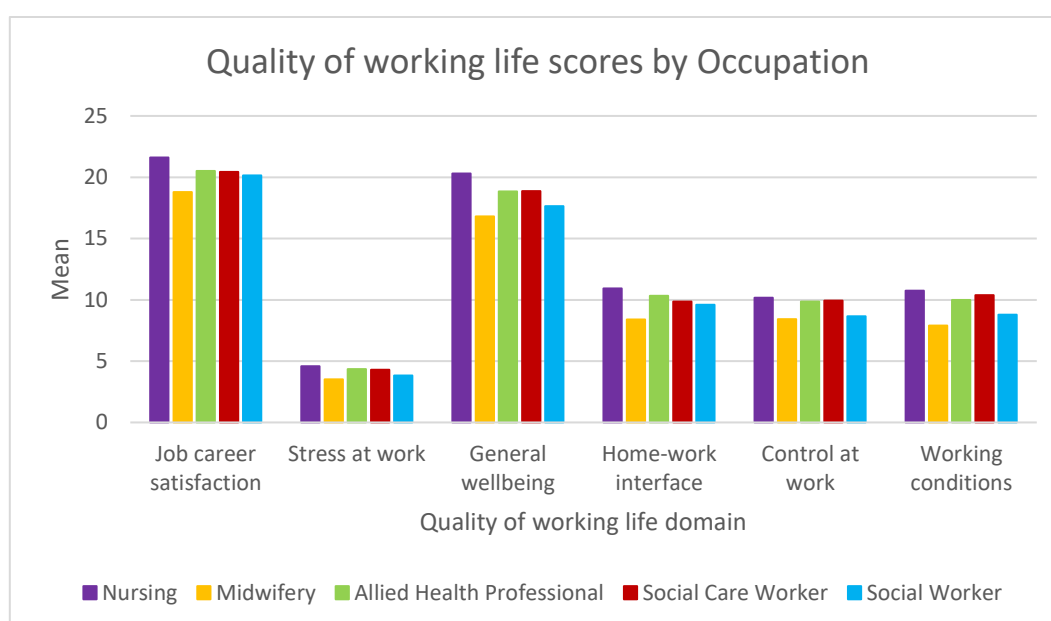


Figure A4.10: Mean Quality of Working Life Scores by Occupation (Unweighted)

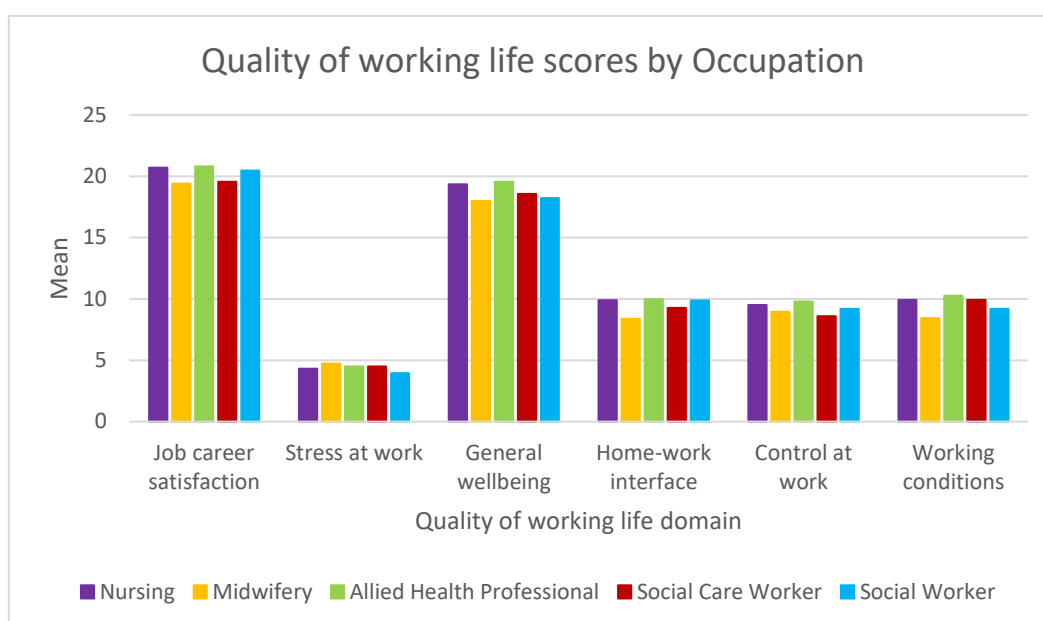


Figure A4.11: Mean Overall Quality of Working Life Score by Occupation (Weighted)

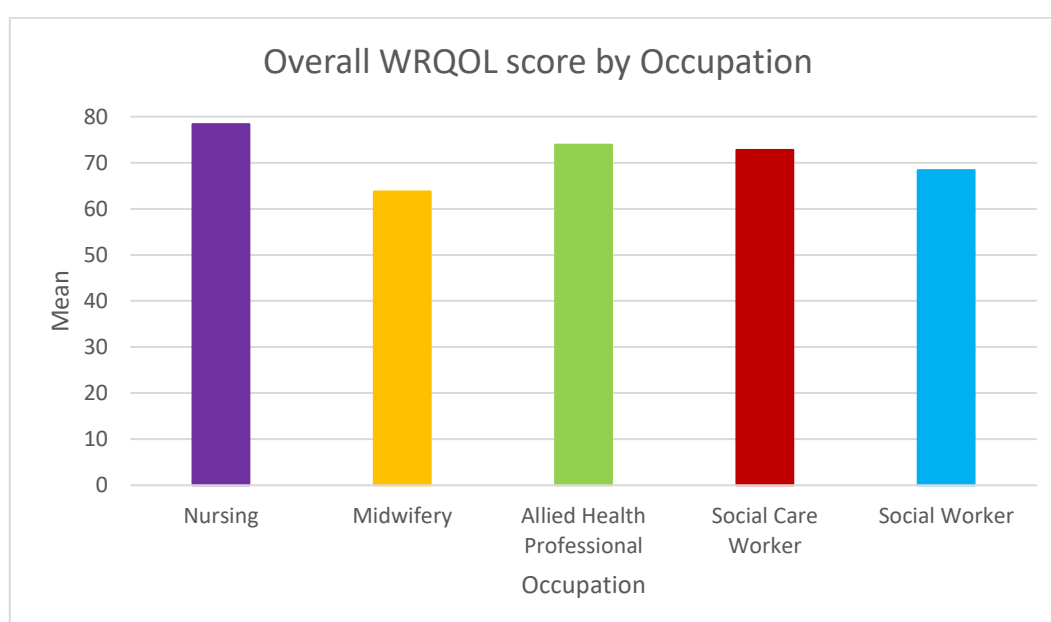


Figure A4.12: Mean Overall Quality of Working Life Score by Occupation (Unweighted)

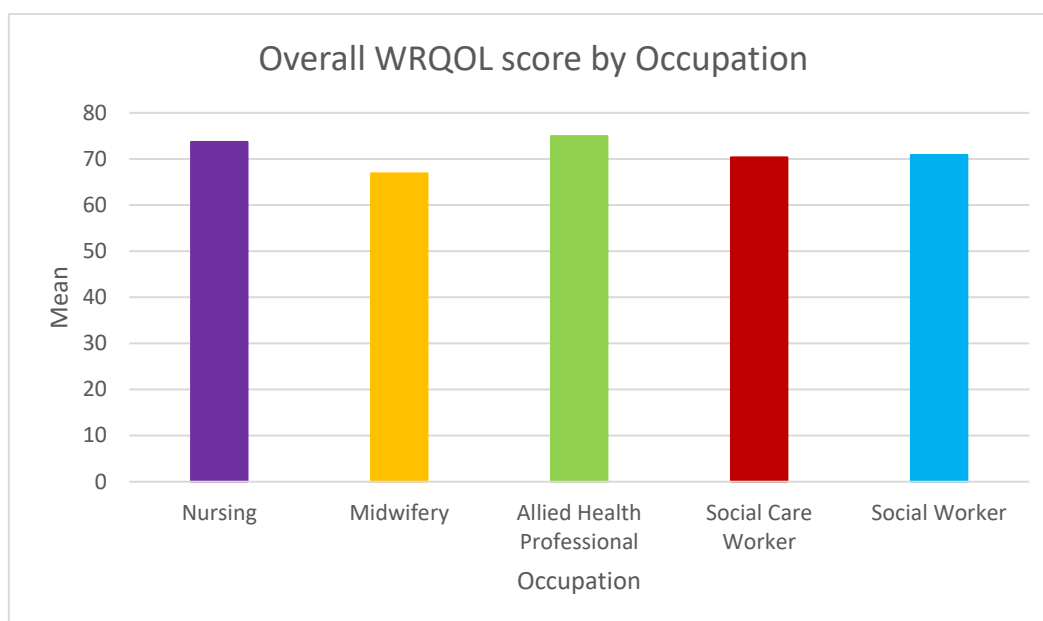


Table A4.7: Mean Quality of Working Life Scores by Occupation (Weighted)

WRQOL domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Job career satisfaction	21.62	18.8	20.51	20.44	20.15
Stress at work	4.58	3.52	4.36	4.31	3.82
General wellbeing	20.31	16.81	18.85	18.87	17.64
Home-work interface	10.92	8.39	10.33	9.85	9.6
Control at work	10.17	8.41	9.85	9.95	8.67
Working conditions	10.74	7.89	9.99	10.37	8.8
Overall WRQOL score	78.37	63.76	73.92	72.78	68.39

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	20.70	19.40	20.81	19.55	20.45
Stress at work	4.31	4.72	4.50	4.49	3.95
General wellbeing	19.34	17.98	19.56	18.55	18.21
Home-work interface	9.90	8.39	9.96	9.28	9.88
Control at work	9.51	8.96	9.79	8.59	9.19
Working conditions	9.92	8.43	10.25	9.93	9.19
Overall WRQOL score	73.69	66.87	74.95	70.34	70.86

Figure A4.13: Level of Overall Quality of Working Life by Occupation (Weighted)

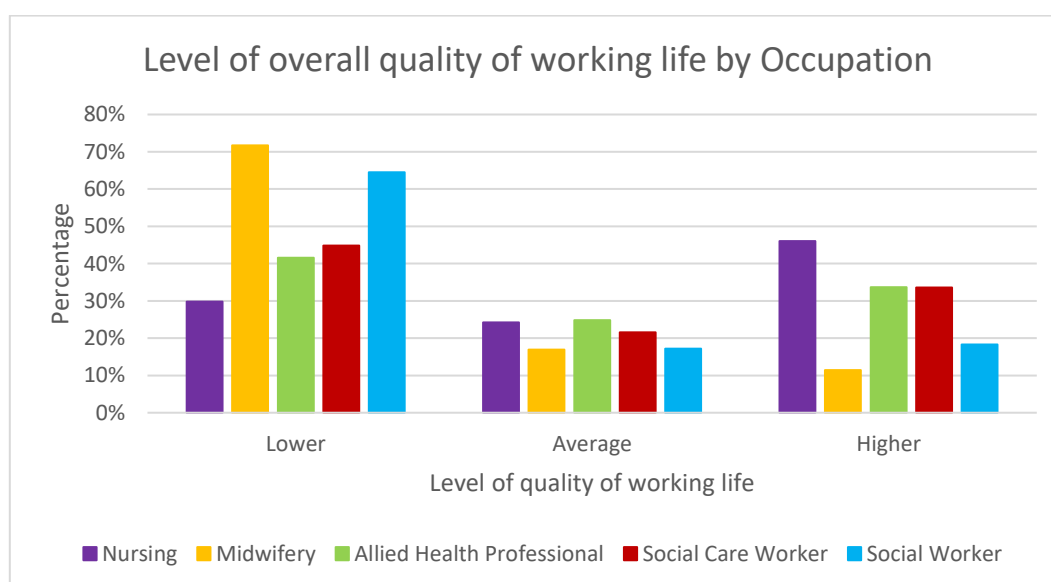


Figure A4.14: Level of Overall Quality of Working Life by Occupation (Unweighted)

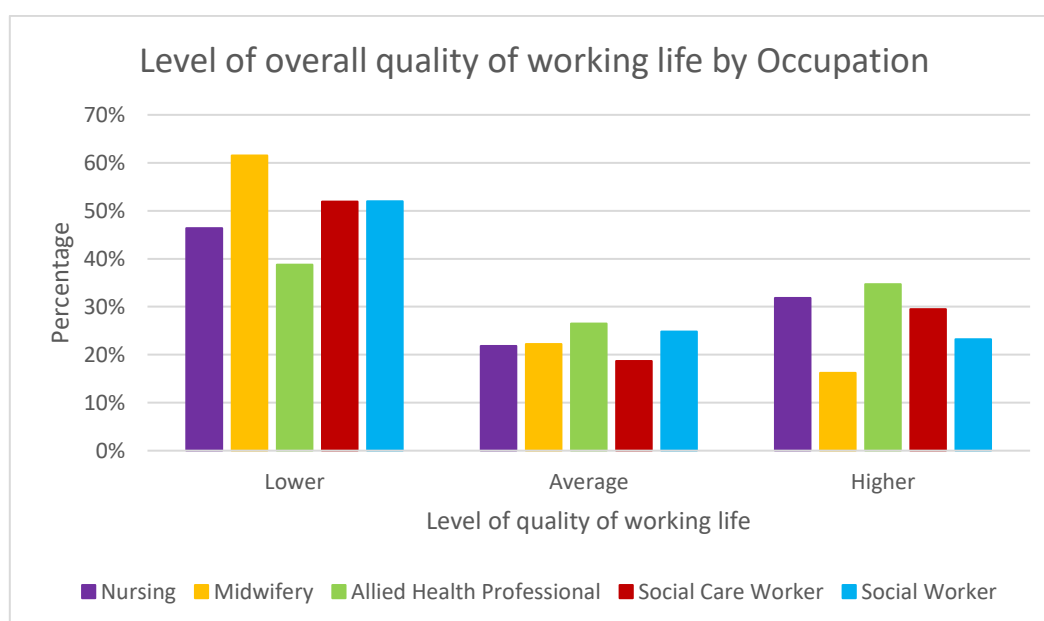


Table A4.9: Level of Overall Quality of Working Life by Occupation (Weighted)

Level of WRQOL	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Lower	29.8%	71.7%	41.6%	44.8%	64.5%
Average	24.2%	16.9%	24.8%	21.6%	17.2%
Higher	46.0%	11.4%	33.7%	33.6%	18.3%
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	46.4%	61.5%	38.8%	51.9%	52.0%
Average	21.8%	22.2%	26.5%	18.7%	24.8%
Higher	31.8%	16.2%	34.7%	29.5%	23.2%
Total	330 (100%)	117 (100%)	502 (100%)	268 (100%)	306 (100%)

A4.3 Quality of Working Life Scores by Sex

Only 6 respondents in the full sample stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

Males and females differed significantly in their mean overall WRQOL score ($t = -3.60$, $df = 366.09$, $p < .001$). Specifically, females had significantly lower WRQOL scores than males.

Summary (Unweighted results):

Males and females did not differ significantly in their mean overall WRQOL score ($t = .370$, $df = 193.083$, $p = .712$).

Figure A4.15: Mean Quality of Working Life Scores by Sex (Weighted)

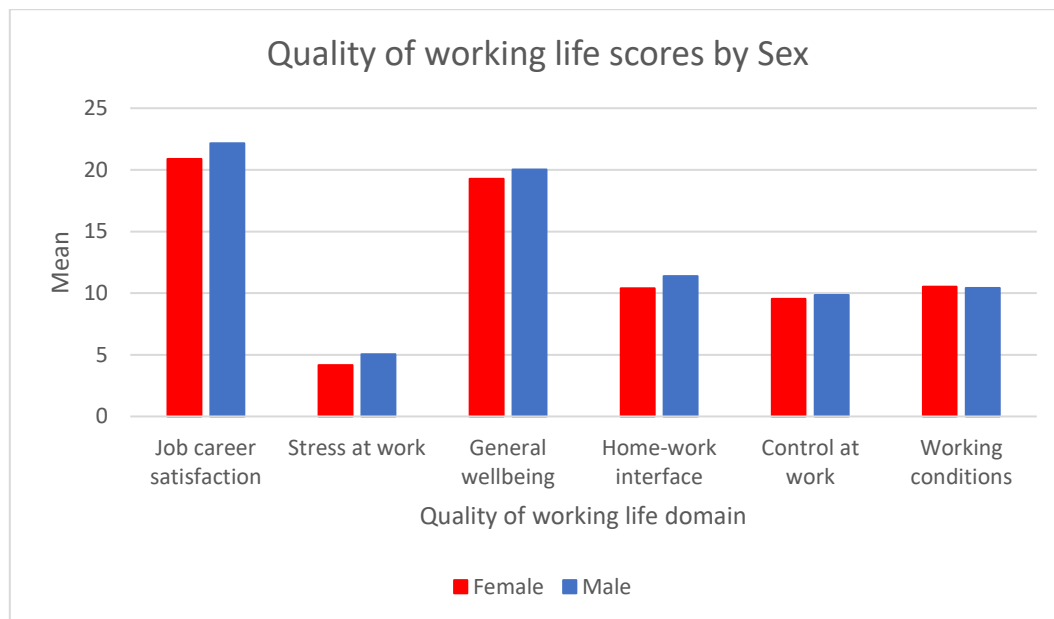


Figure A4.16: Mean Quality of Working Life Scores by Sex (Unweighted)

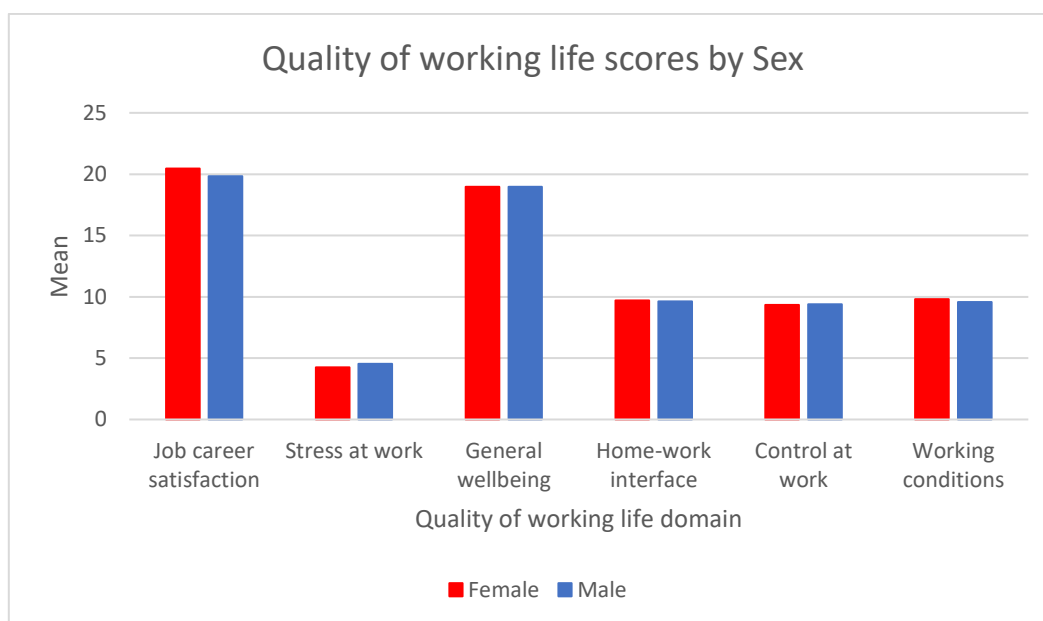


Figure A4.17: Mean Overall Quality of Working Life Score by Sex (Weighted)

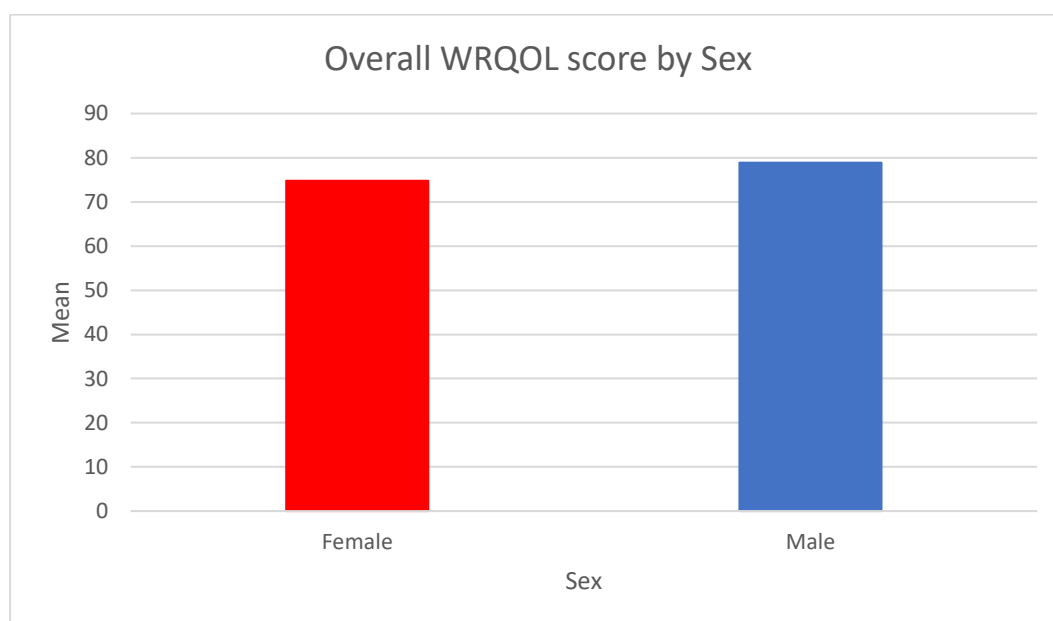


Figure A4.18: Mean Overall Quality of Working Life Score by Sex (Unweighted)

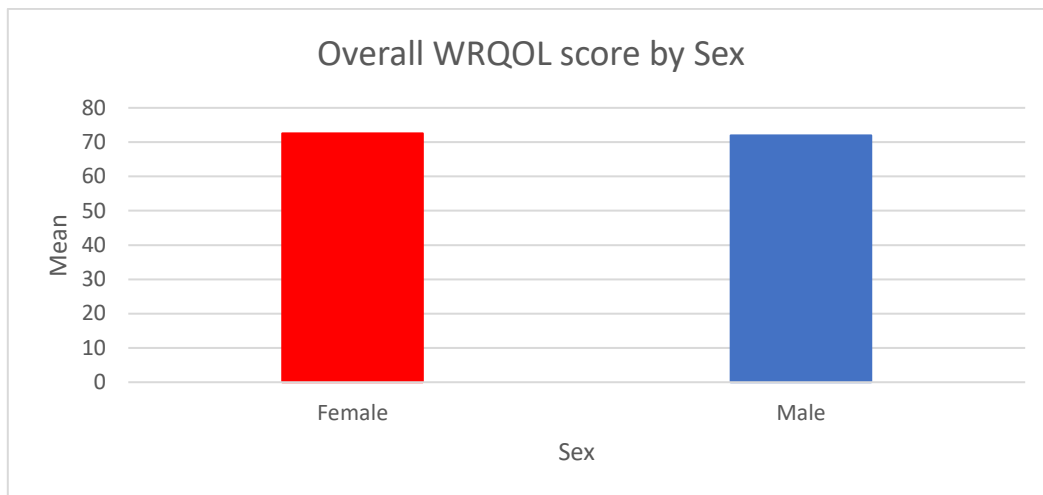


Table A4.11: Mean Quality of Working Life Scores by Sex (Weighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.89	22.16
Stress at work	4.17	5.04
General wellbeing	19.28	20.02
Home-work interface	10.40	11.39
Control at work	9.53	9.84
Working conditions	10.52	10.41
Overall WRQOL score	74.79	78.89

Table A4.12: Mean Quality of Working Life Scores by Sex (Unweighted)

WRQOL domain	Sex	
	Female	Male
Job career satisfaction	20.46	19.84
Stress at work	4.26	4.54
General wellbeing	18.96	18.96
Home-work interface	9.71	9.62
Control at work	9.34	9.39
Working conditions	9.8	9.57
Overall WRQOL score	72.55	71.96

Figure A4.19: Level of Overall Quality of Working Life by Sex (Weighted)

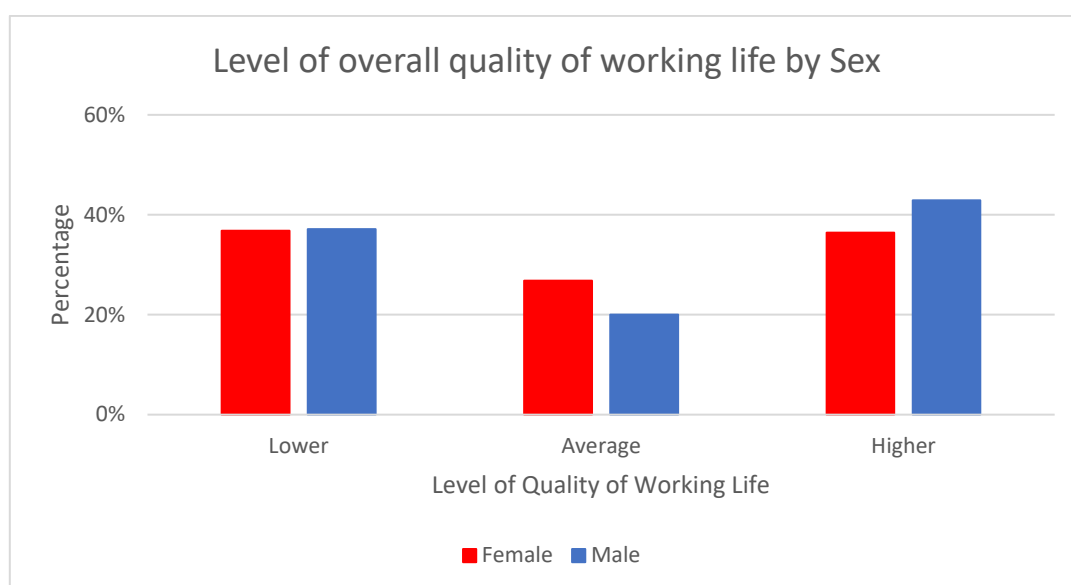


Figure A4.20: Level of Overall Quality of Working Life by Sex (Unweighted)

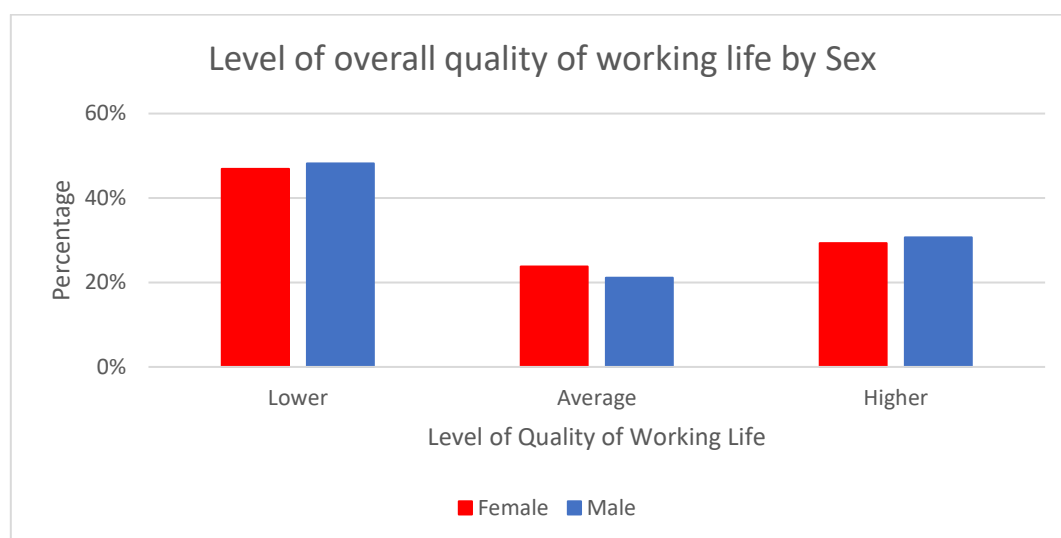


Table A4.13: Level of Overall Quality of Working Life by Sex (Weighted)

Level of WRQOL	Sex	
	Female	Male
Lower	36.8%	37.1%
Average	26.8%	20.0%
Higher	36.4%	42.9%
Total	100%	100%

Table A4.14: Level of Overall Quality of Working Life by Sex (Unweighted)

Level of WRQOL	Sex	
	Female	Male
Lower	46.9%	48.2%
Average	23.8%	21.1%
Higher	29.3%	30.7%
Total	1350 (100%)	166 (100%)

A4.4 Quality of Working Life Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in the mean overall WRQOL scores ($F = 18.89$, $df = 5$, $p < .001$). Specifically, 16-29 age group scored significantly lower than the 30-39, 40-49, 60-65 and 66+ age groups.

Summary (Unweighted results):

There appeared to be significant differences in the mean overall WRQOL score across age groups ($F = 5.990$, $df = 5$, $p < .001$). Specifically, 16-29 age group scored significantly lower than the 60-65; the 30-39 scored significantly lower than the 50-59 and 60-65 age groups.

Figure A4.21: Mean Quality of Working Life Scores by Age (Weighted)

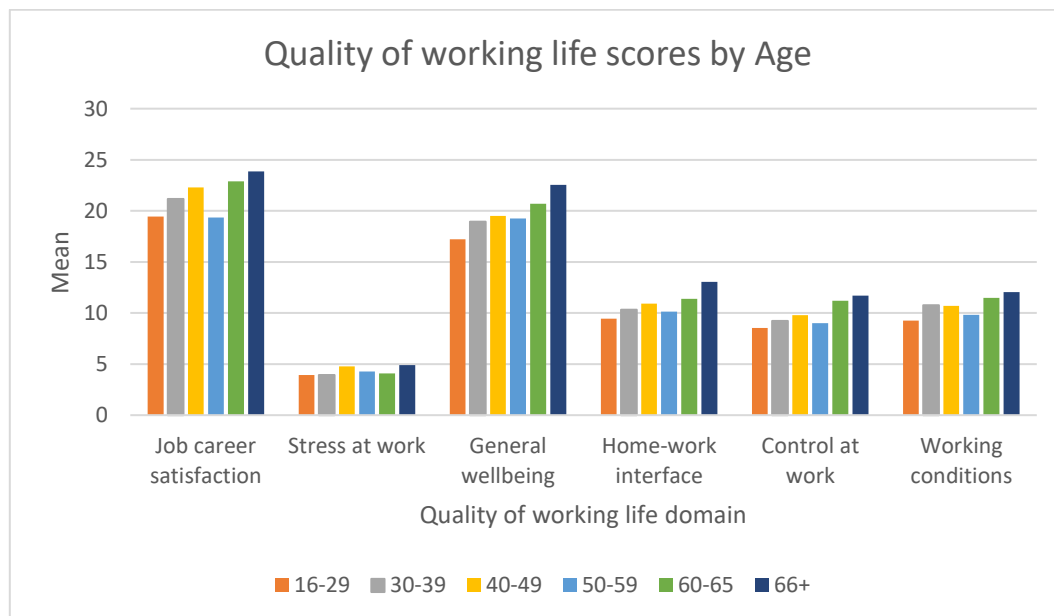


Figure A4.22: Mean Quality of Working Life Scores by Age (Unweighted)

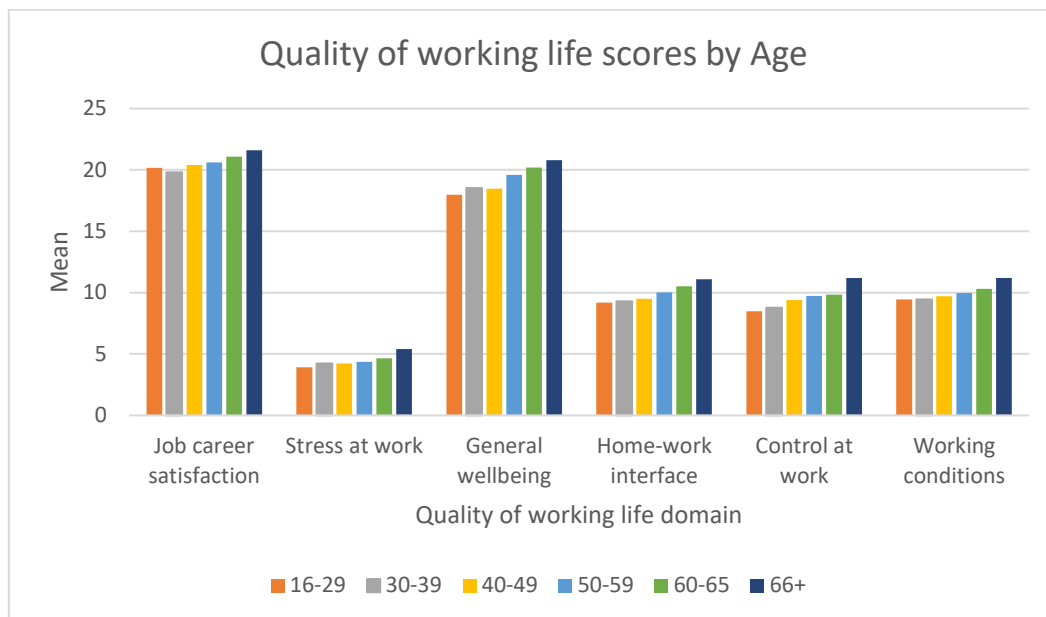


Figure A4.23: Mean Overall Quality of Working Life Score by Age (Weighted)

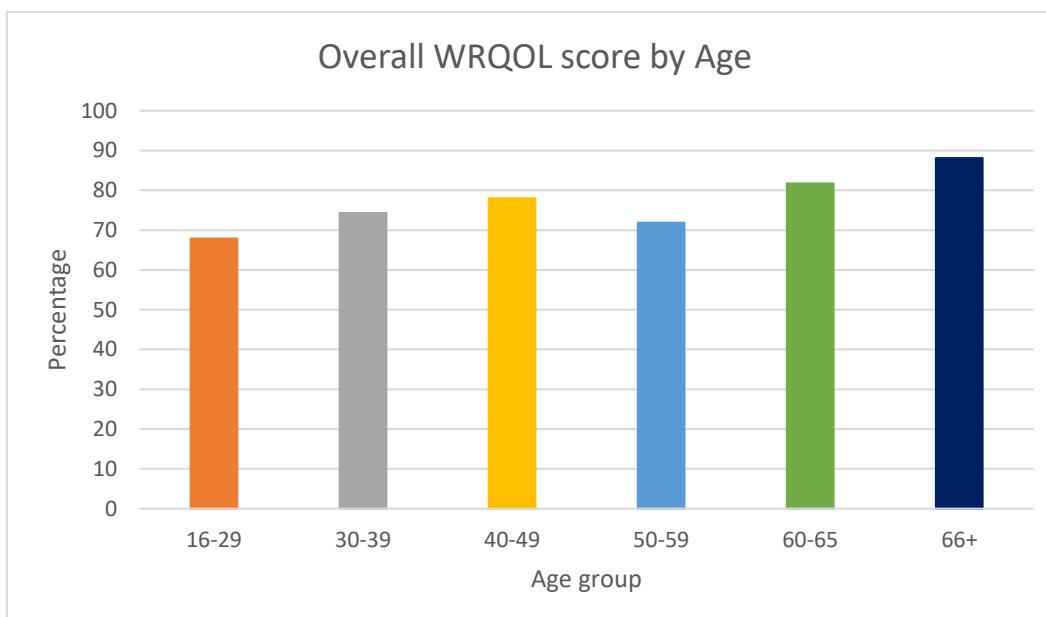


Figure A4.24: Mean Overall Quality of Working Life Score by Age (Unweighted)

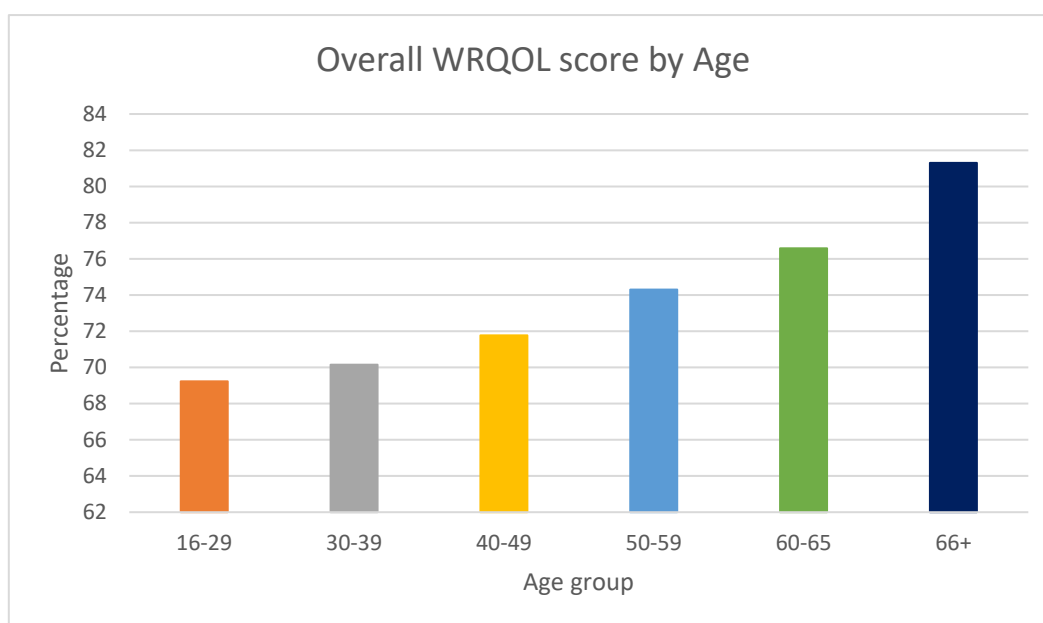


Table A4.15: Mean Quality of Working Life Scores by Age (Weighted)

WRQOL domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Job career satisfaction	19.44	21.16	22.30	19.35	22.90	23.85
Stress at work	3.94	3.93	4.78	4.29	4.08	4.91
General wellbeing	17.21	18.95	19.50	19.26	20.70	22.53
Home-work interface	9.44	10.31	10.93	10.14	11.4	13.05
Control at work	8.53	9.23	9.79	9.01	11.21	11.71
Working conditions	9.26	10.75	10.71	9.81	11.47	12.04
Overall WRQOL score	67.88	74.32	78.00	71.87	81.72	88.10

Table A4.16: Mean Quality of Working Life Scores by Age (Unweighted)

WRQOL domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Job career satisfaction	20.16	19.80	20.40	20.62	21.08	21.60
Stress at work	3.91	4.24	4.23	4.36	4.66	5.40
General wellbeing	17.97	18.53	18.47	19.6	20.20	20.80
Home-work interface	9.18	9.30	9.51	10.03	10.51	11.10
Control at work	8.49	8.77	9.40	9.73	9.84	11.20
Working conditions	9.45	9.44	9.71	9.97	10.31	11.20
Overall WRQOL score	69.23	70.15	71.77	74.30	76.58	81.30

Figure A4.25: Level of Overall Quality of Working Life by Age (Weighted)

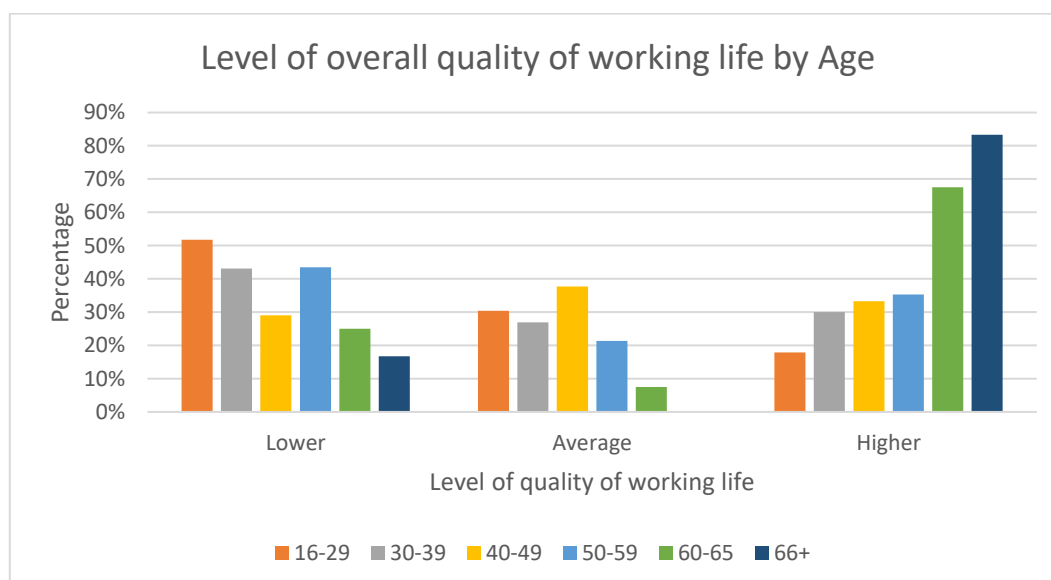


Figure A4.26: Level of Overall Quality of Working Life by Age (Unweighted)

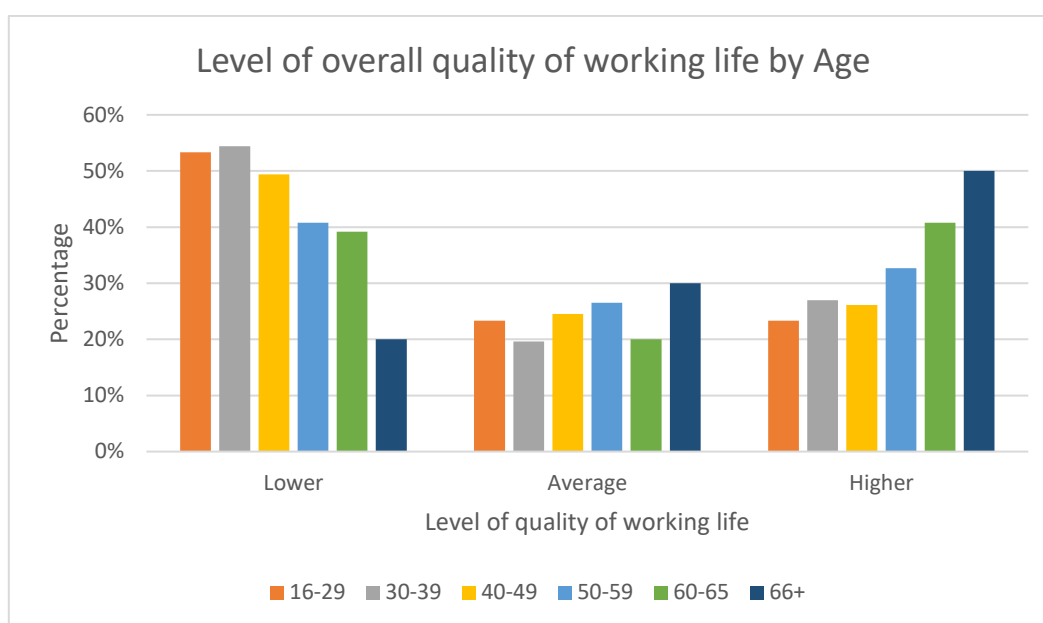


Table A4.17: Level of Overall Quality of Working Life by Age (Weighted)

Level of WRQOL	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Lower	51.8%	43.1%	29.0%	43.5%	25.0%	16.7%
Average	30.4%	26.9%	37.7%	21.3%	7.5%	0.0%
Higher	17.9%	30.0%	33.3%	35.3%	67.5%	83.3%
Total	100%	100%	100%	100%	100%	100%

Table A4.18: Level of Overall Quality of Working Life by Age (Unweighted)

Level of WRQOL	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Lower	53.3%	54.4%	49.4%	40.8%	39.2%	20.0%
Average	23.3%	19.6%	24.5%	26.5%	20.0%	30.0%
Higher	23.3%	27.0%	26.1%	32.7%	40.8%	50.0%
Total	150 (100%)	318 (100%)	445 (100%)	480 (100%)	120 (100%)	10 (100%)

A4.5 Quality of Working Life Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in the mean overall WRQOL score ($F = 6.17$, $df = 3$, $p < .001$). Specifically, respondents who identified as Mixed ethnicity scored significantly lower than all the other ethnic groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups in their mean overall WRQOL scores ($F = 4.184$, $df = 3$, $p = .006$). Specifically, respondents who identified as Asian scored significantly higher than those who identified as White or Mixed Ethnicity.

Figure A4.27: Mean Quality of Working Life Scores by Ethnicity (Weighted)

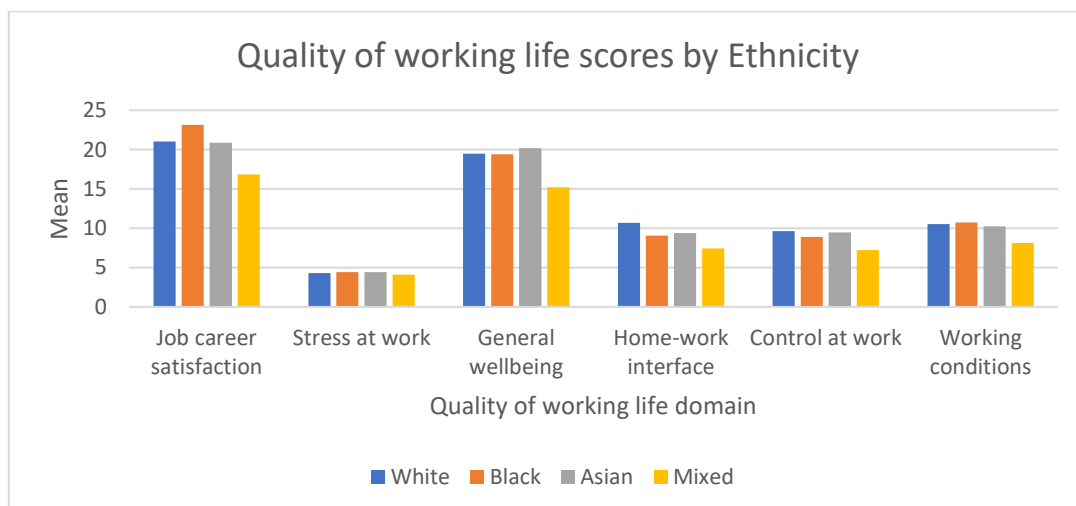


Figure A4.28: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

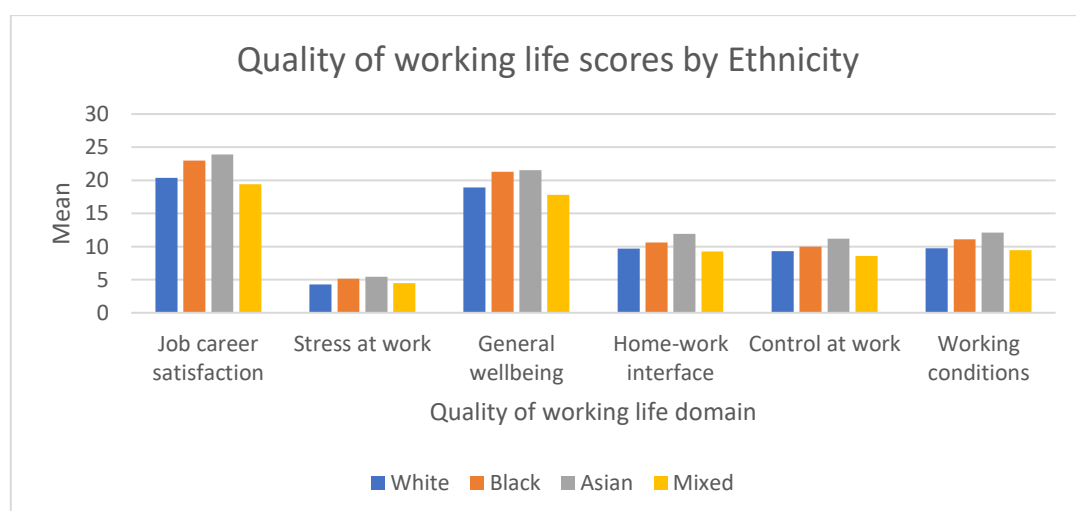


Figure A4.29: Mean Overall Quality of Working Life Score by Ethnicity (Weighted)

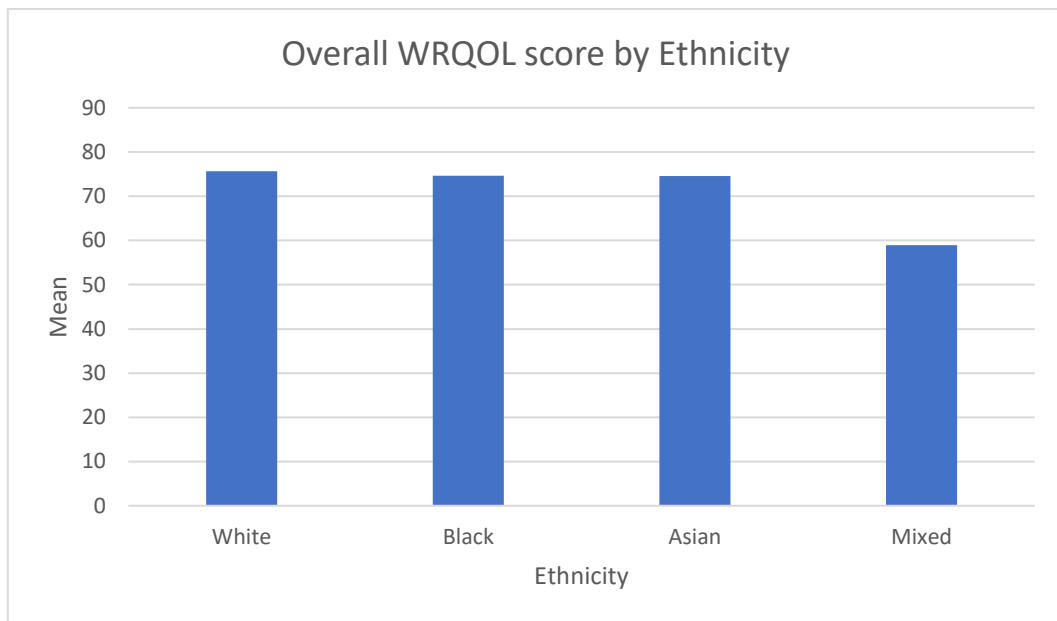


Figure A4.30: Mean Overall Quality of Working Life Score by Ethnicity (Unweighted)

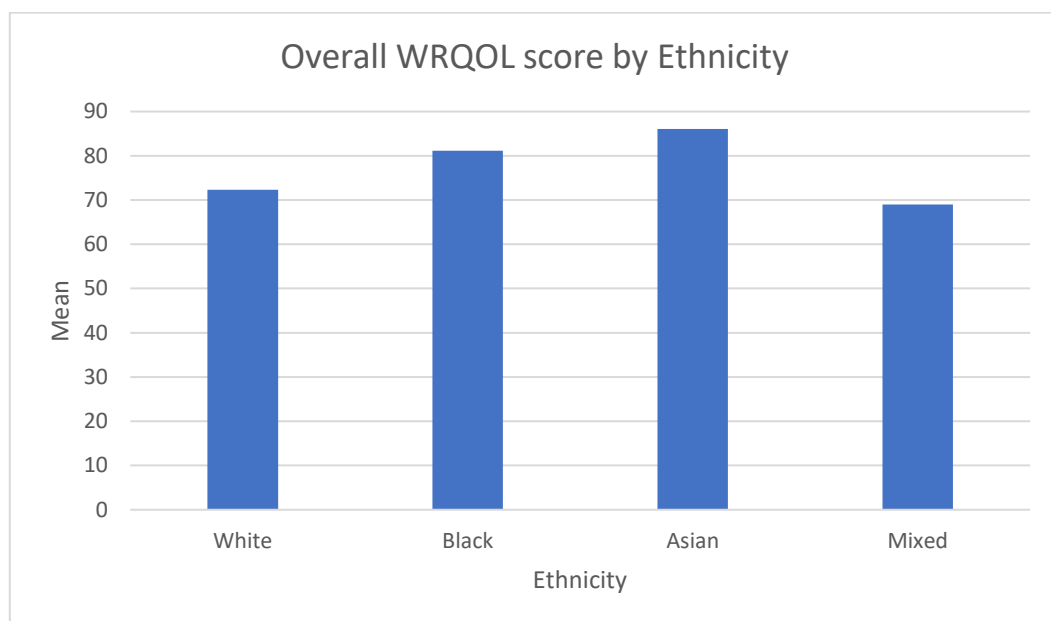


Table A4.19: Mean Quality of Working Life Scores by Ethnicity (Weighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	21.03	23.16	20.88	16.82
Stress at work	4.31	4.43	4.41	4.08
General wellbeing	19.48	19.42	20.19	15.23
Home-work interface	10.69	9.07	9.37	7.42
Control at work	9.64	8.89	9.45	7.24
Working conditions	10.51	10.72	10.26	8.14
Overall WRQOL score	75.65	74.68	74.56	58.92

Table A4.20: Mean Quality of Working Life Scores by Ethnicity (Unweighted)

WRQOL domain	Ethnicity			
	White	Black	Asian	Mixed
Job career satisfaction	20.35	23	23.91	19.39
Stress at work	4.26	5.15	5.45	4.48
General wellbeing	18.92	21.3	21.55	17.83
Home-work interface	9.67	10.62	11.91	9.26
Control at work	9.32	10	11.18	8.57
Working conditions	9.74	11.07	12.09	9.43
Overall WRQOL score	72.29	81.15	86.09	68.96

Figure A4.31: Level of Overall Quality of Working Life by Ethnicity (Weighted)

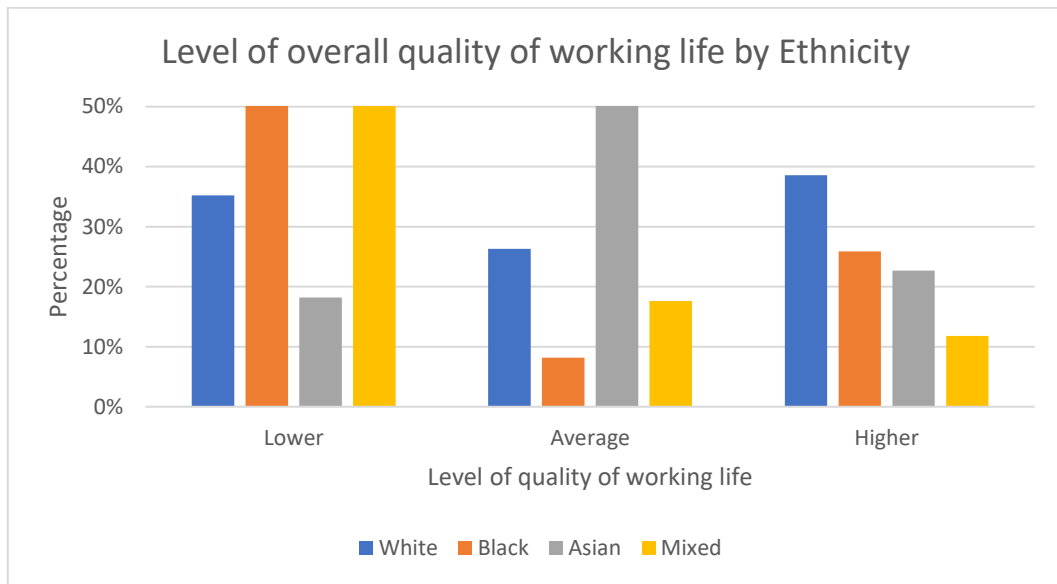


Figure A4.32: Level of Overall Quality of Working Life by Ethnicity (Unweighted)

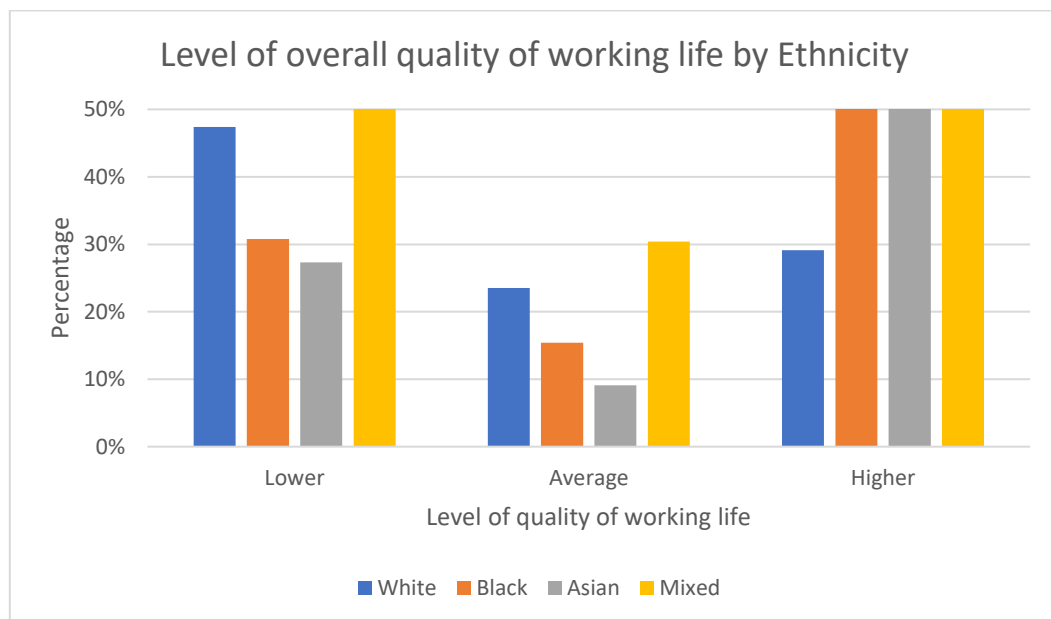


Table A4.21: Level of Overall Quality of Working Life by Ethnicity (Weighted)

Level of WRQOL	Ethnicity			
	White	Black	Asian	Mixed
Lower	35.2%	65.9%	18.2%	70.6%
Average	26.3%	8.2%	59.1%	17.6%
Higher	38.6%	25.9%	22.7%	11.8%
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	47.4%	30.8%	27.3%	52.2%
Average	23.5%	15.4%	9.1%	30.4%
Higher	29.1%	53.8%	63.8%	63.6%
Total	1474 (100%)	13 (100%)	11 (100%)	23 (100%)

A4.6 Quality of Working Life Scores by Disability

Summary (Weighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their disability status ($F = 4.790$, $df = 2$, $p < .01$). Specifically, respondents without a disability scored significantly higher than those with a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in the mean overall WRQOL scores ($F = 9.27$, $df = 2$, $p < .001$). 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)

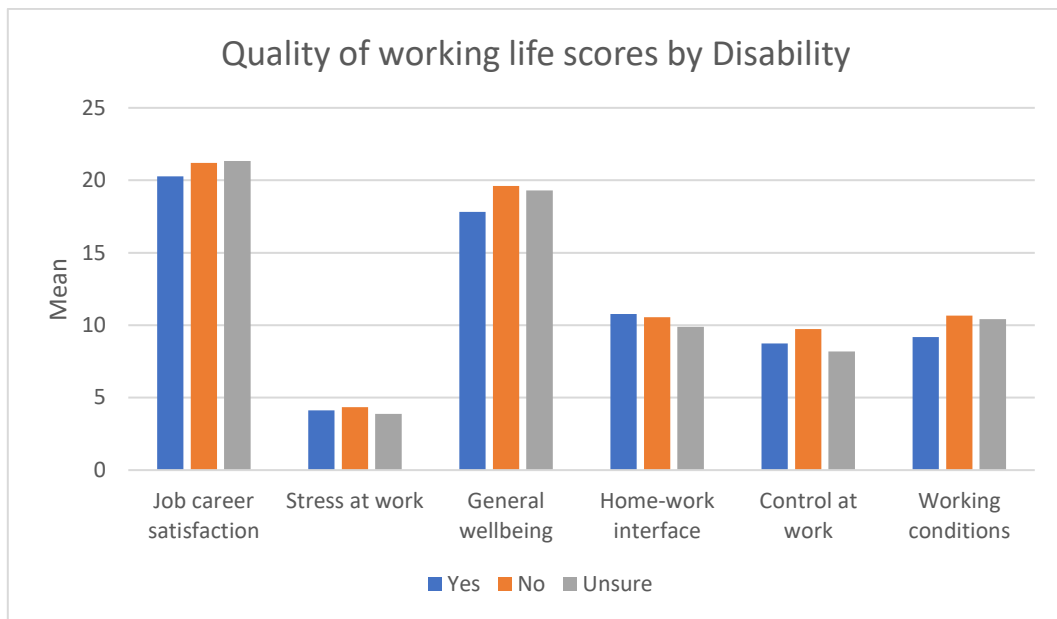


Figure A4.34: Mean Quality of Working Life Scores by Disability (Unweighted)

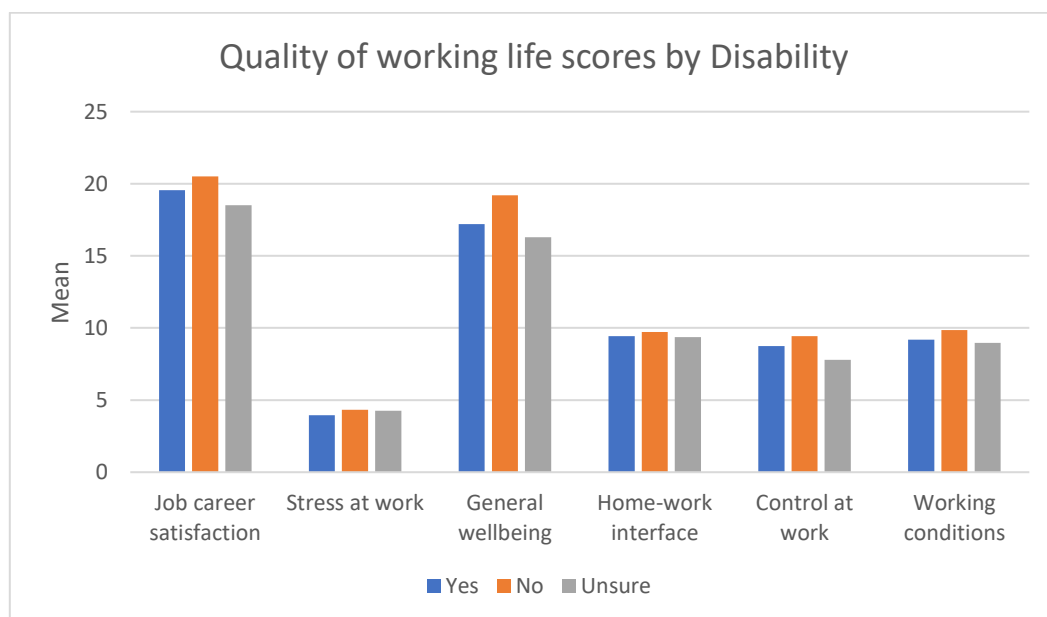


Figure A4.35: Mean Overall Quality of Working Life Score by Disability (Weighted)

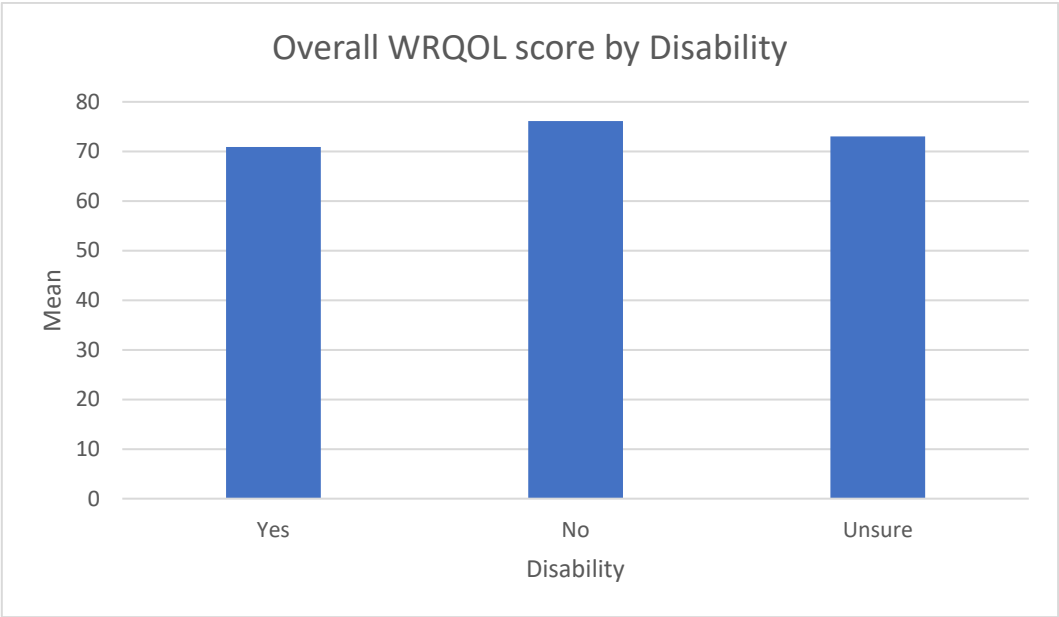


Figure A4. 36: Mean Overall Quality of Working Life Score by Disability (Unweighted)

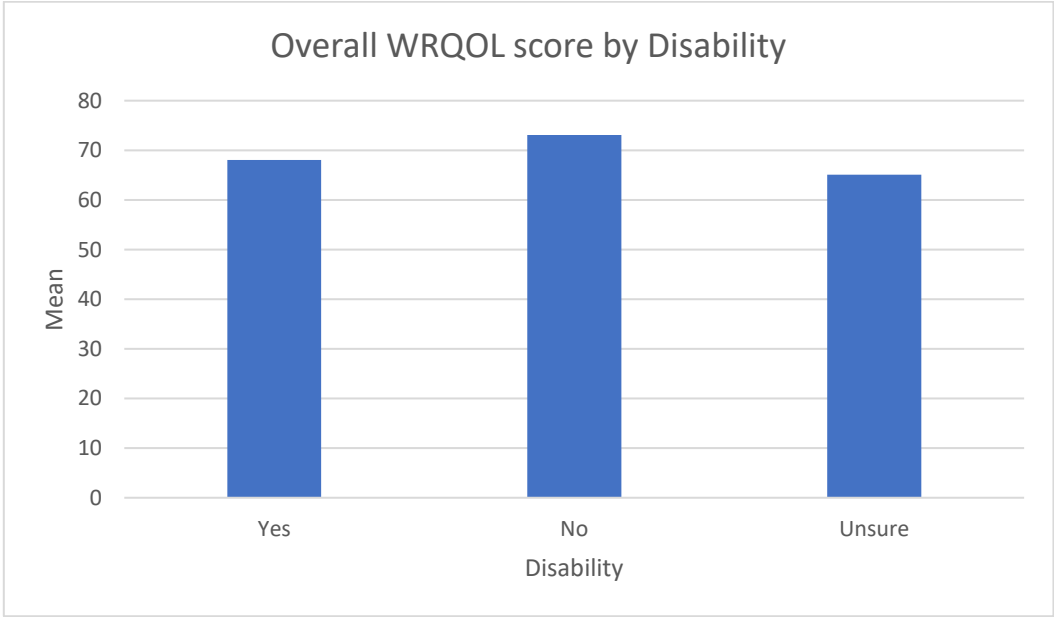


Table A4.23: Mean Quality of Working Life Scores by Disability (Weighted)

WRQOL domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Job career satisfaction	20.28	21.19	21.34
Stress at work	4.13	4.35	3.88
General wellbeing	17.81	19.60	19.30
Home-work interface	10.78	10.55	9.90
Control at work	8.74	9.74	8.18
Working conditions	9.19	10.67	10.42
Overall WRQOL score	70.93	76.10	73.02

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	19.56	20.52	18.52
Stress at work	3.96	4.32	4.27
General wellbeing	17.20	19.21	16.30
Home-work interface	9.44	9.72	9.37
Control at work	8.74	9.44	7.80
Working conditions	9.20	9.85	8.97
Overall WRQOL score	68.07	73.11	65.07

Figure A4.37: Level of Overall Quality of Working Life by Disability (Weighted)

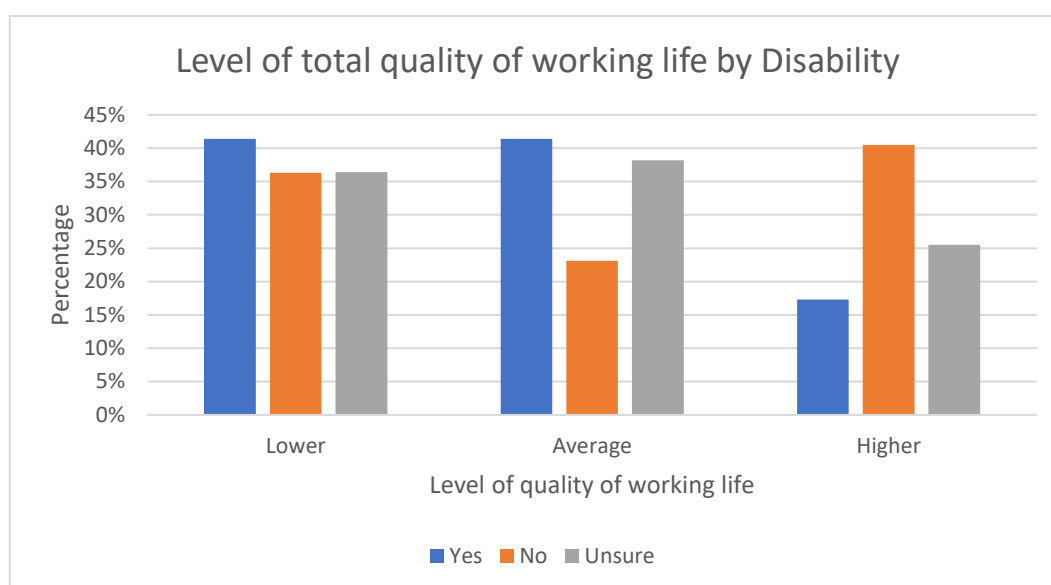


Figure A4.38: Level of Overall Quality of Working Life by Disability (Unweighted)

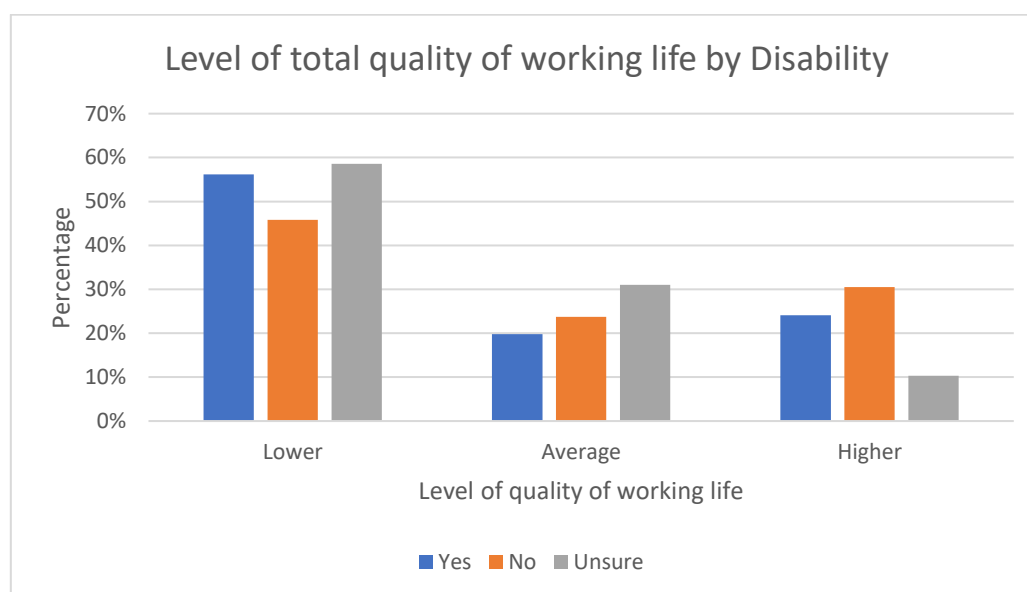


Table A4.25: Level of Overall Quality of Working Life by Disability (Weighted)

Level of WRQOL	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Lower	41.4%	36.3%	36.4%
Average	41.4%	23.1%	38.2%
Higher	17.3%	40.5%	25.5%
Total	100%	100%	100%

Table A4.26: Level of Overall Quality of Working Life by Disability (Unweighted)

Level of WRQOL	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Lower	56.2%	45.8%	58.6%
Average	19.8%	23.7%	31.0%
Higher	24.1%	30.5%	10.3%
Total	162 (100%)	1332 (100%)	29 (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 ($F = 19.80$, $df = 7$, $p < .001$). Specifically, respondents working with 'Older people' scored significantly higher than those working in the area of children and young people, midwifery, adults of working age, learning disability, mental health, and other.

Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents based on their main area of practice ($F = 3.236$, $df = 7$, $p = .002$). Specifically, respondents working in midwifery scored significantly lower than those working with children and young people, adults of working age, those working in mental health and those in the area of 'other'.

Figure A4.39: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

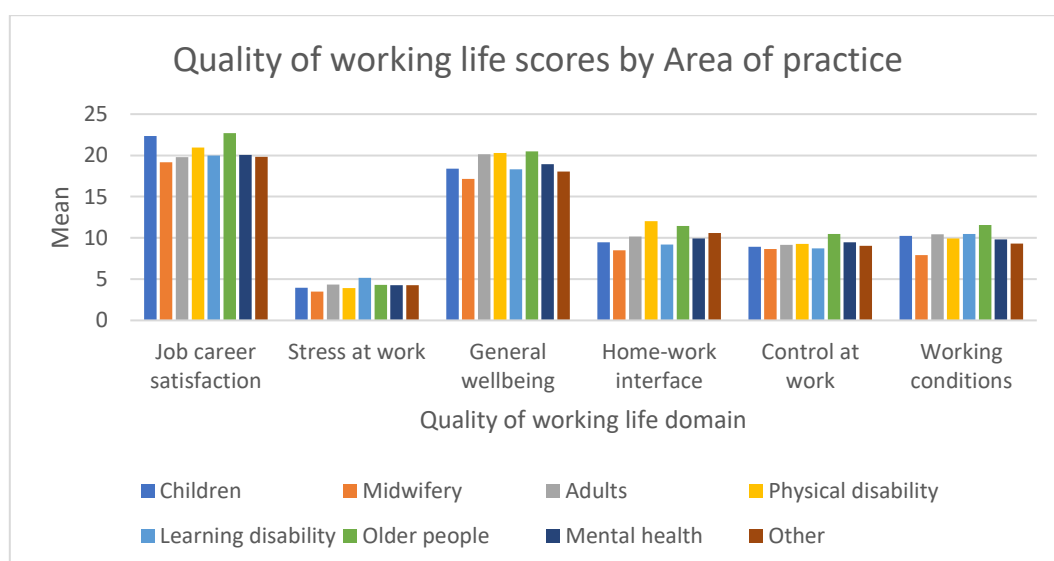


Figure A4.40: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

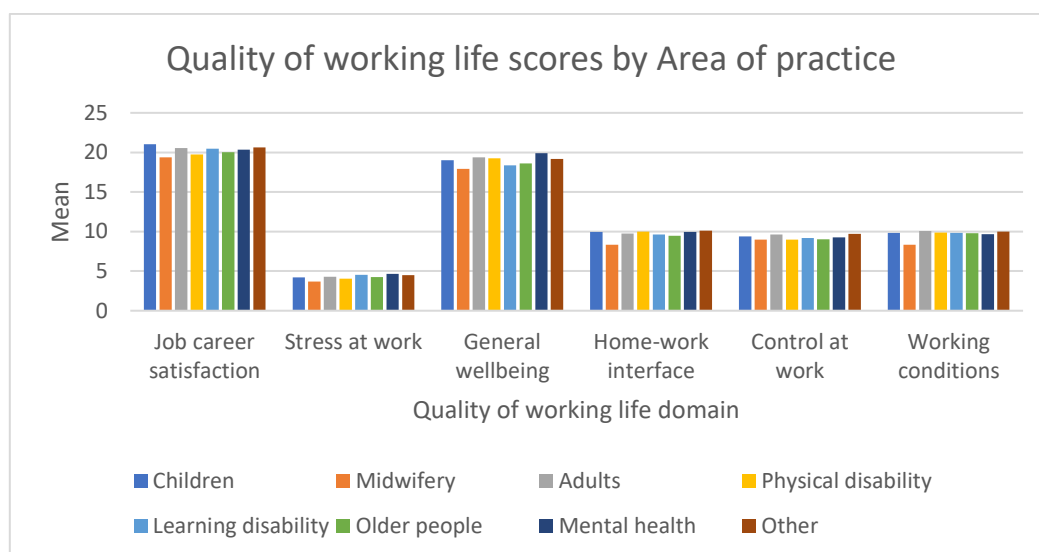


Figure A4.41: Mean Overall Quality of Working Life Score by Main Area of Practice (Weighted)

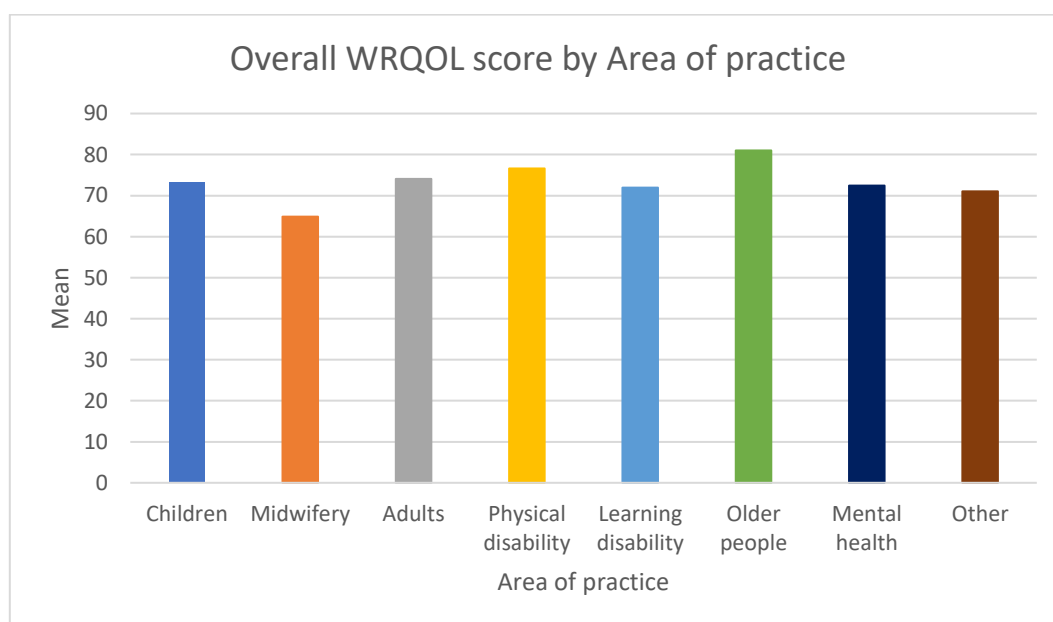


Figure A4.42: Mean Overall Quality of Working Life Score by Main Area of Practice (Unweighted)

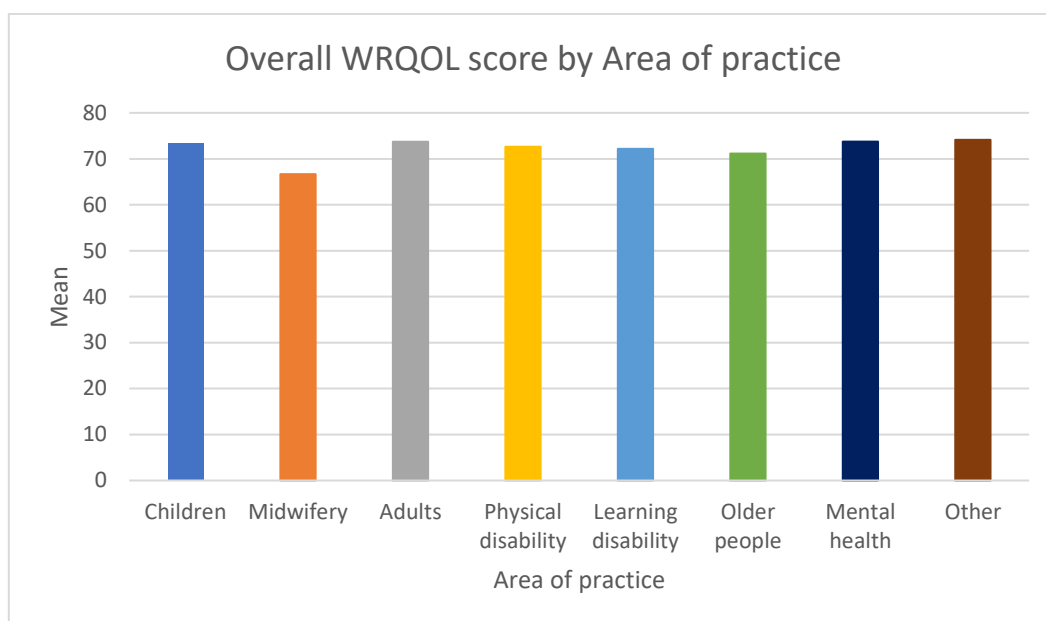


Table A4.27: Mean Quality of Working Life Scores by Main Area of Practice (Weighted)

WRQOL domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	22.34	19.17	19.8	20.94	19.97	22.68	20.07	19.82
Stress at work	3.95	3.51	4.36	3.92	5.16	4.3	4.26	4.25
General wellbeing	18.41	17.13	20.14	20.29	18.31	20.5	18.95	18.04
Home-work interface	9.46	8.48	10.17	12.02	9.2	11.46	9.94	10.59
Control at work	8.93	8.64	9.17	9.29	8.74	10.47	9.46	9.04
Working conditions	10.26	7.92	10.43	9.95	10.48	11.58	9.82	9.30
Overall WRQOL score	73.17	64.87	74.07	76.61	71.94	81.00	72.44	71.03

Table A4.28: Mean Quality of Working Life Scores by Main Area of Practice (Unweighted)

WRQOL domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Job career satisfaction	21.02	19.37	20.53	19.75	20.48	20.04	20.33	20.64
Stress at work	4.19	3.7	4.28	4.05	4.54	4.23	4.64	4.48
General wellbeing	19.01	17.94	19.38	19.26	18.37	18.61	19.92	19.17
Home-work interface	9.95	8.35	9.77	10.00	9.63	9.47	9.94	10.12
Control at work	9.4	8.97	9.63	8.98	9.20	9.03	9.25	9.73
Working conditions	9.84	8.35	10.08	9.89	9.85	9.79	9.66	10.01
Overall WRQOL score	73.38	66.66	73.71	72.63	72.17	71.14	73.74	74.13

Figure A4.43: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

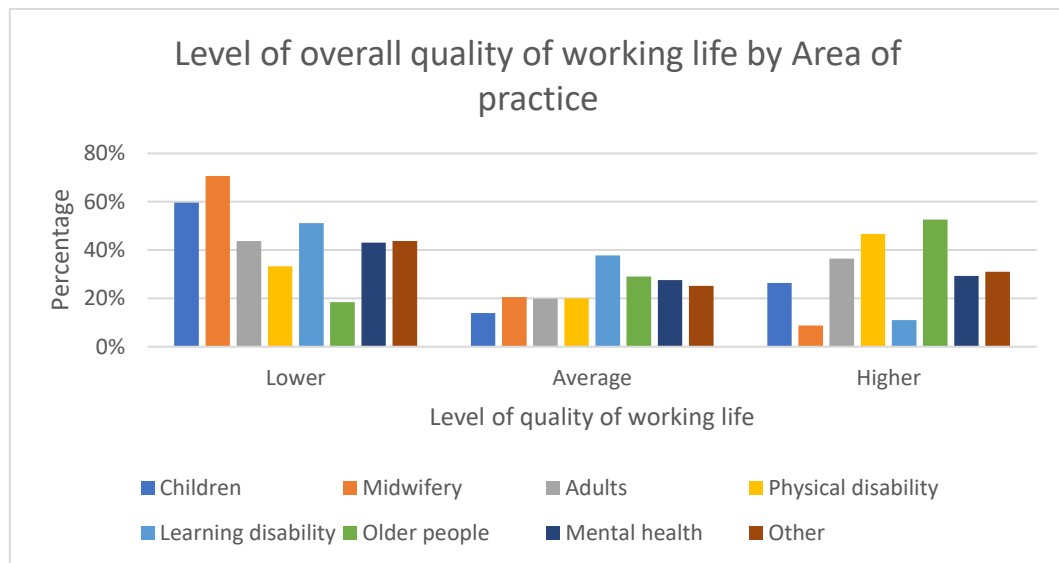


Figure A4.44: Level of Overall Quality of Working Life by Main Area of Practice (Unweighted)

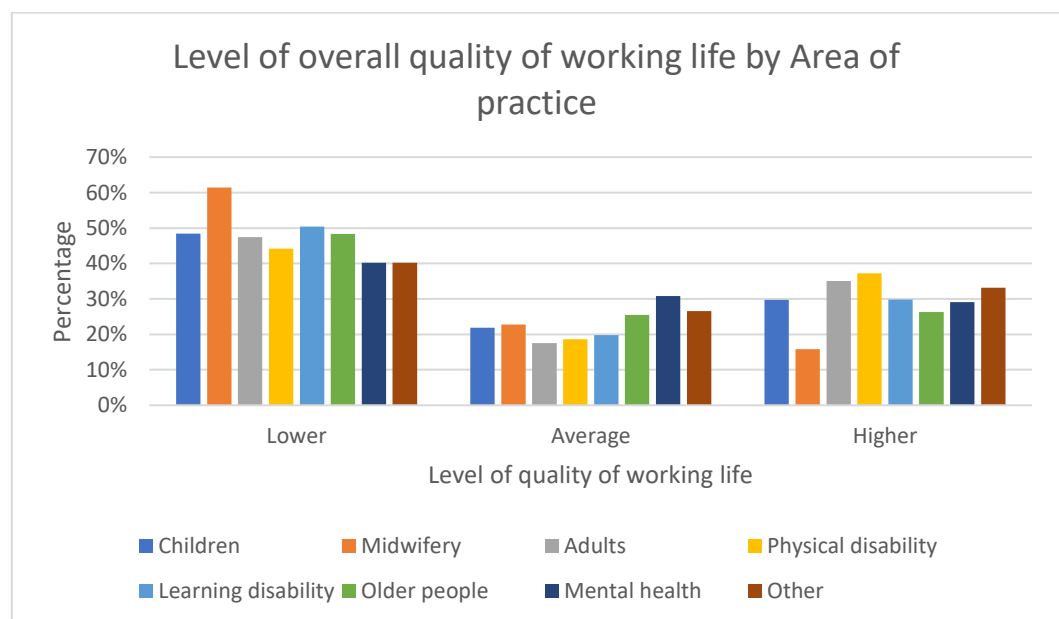


Table A4.29: Level of Overall Quality of Working Life by Main Area of Practice (Weighted)

Level of WRQOL	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Lower	59.7%	70.6%	43.7%	33.3%	51.2%	18.4%	43.1%	43.8%
Average	13.9%	20.6%	19.9%	20.0%	37.8%	29.0%	27.6%	25.2%
Higher	26.4%	8.8%	36.5%	46.7%	11.0%	52.6%	29.3%	31.0%
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	124 (48.4%)	70 (61.4%)	108 (47.4%)	19 (44.2%)	61 (50.4%)	180 (48.3%)	47 (40.2%)	109 (40.2%)
Average	5 6(21.9%)	26 (22.8%)	40 (17.5%)	8 (18.6%)	24 (19.8%)	95 (25.5%)	36 (30.8%)	72 (26.6%)
Higher	76 (29.7%)	18 (15.8%)	80 (35.1%)	16 (37.2%)	36 (29.8%)	98 (26.3%)	90 (29.1%)	90 (33.2%)
Total	256 (100%)	114 (100%)	228 (100%)	43 (100%)	121 (100%)	373 (100%)	117 (100%)	271 (100%)

A4.8 Quality of Working Life Scores by Line Manager Status

Summary (Weighted results):

There was no significant difference in the mean overall WRQOL score between line managers and those who were not line managers ($t = 2.19$, $df = 1629.723$, $p > 0.05$).

Summary (Unweighted results):

There was a significant difference in the mean overall WRQOL scores between respondents who were line managers and those who were not ($t = 4.208$, $df = 1520$, $p < .001$); line managers scored significantly higher.

Figure A4.45: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

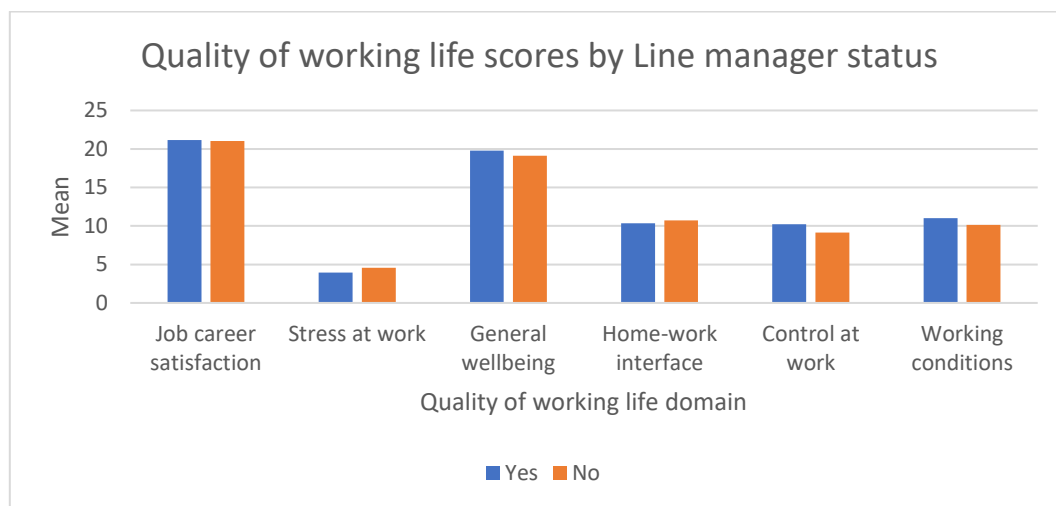


Figure A4.46: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

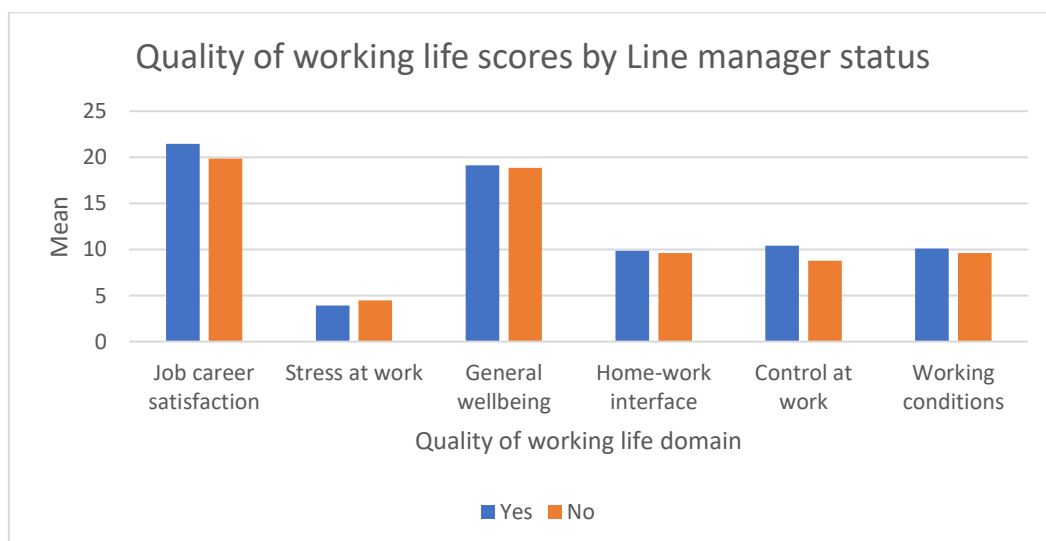


Figure A4.47: Mean Overall Quality of Working Life Score by Line Manager Status (Weighted)

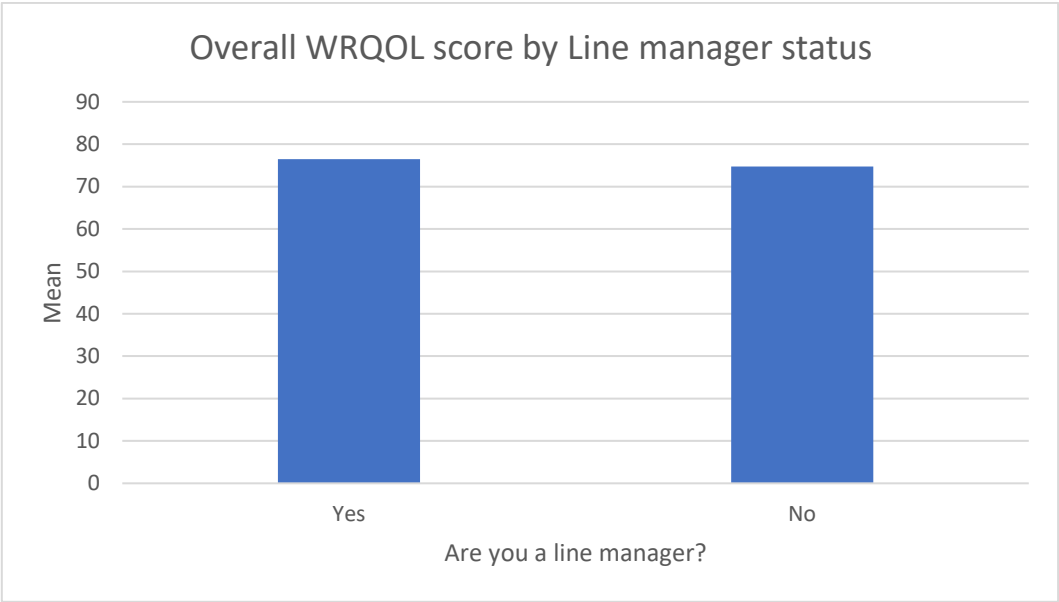


Figure A4.48: Mean Overall Quality of Working Life Score by Line Manager Status (Unweighted)

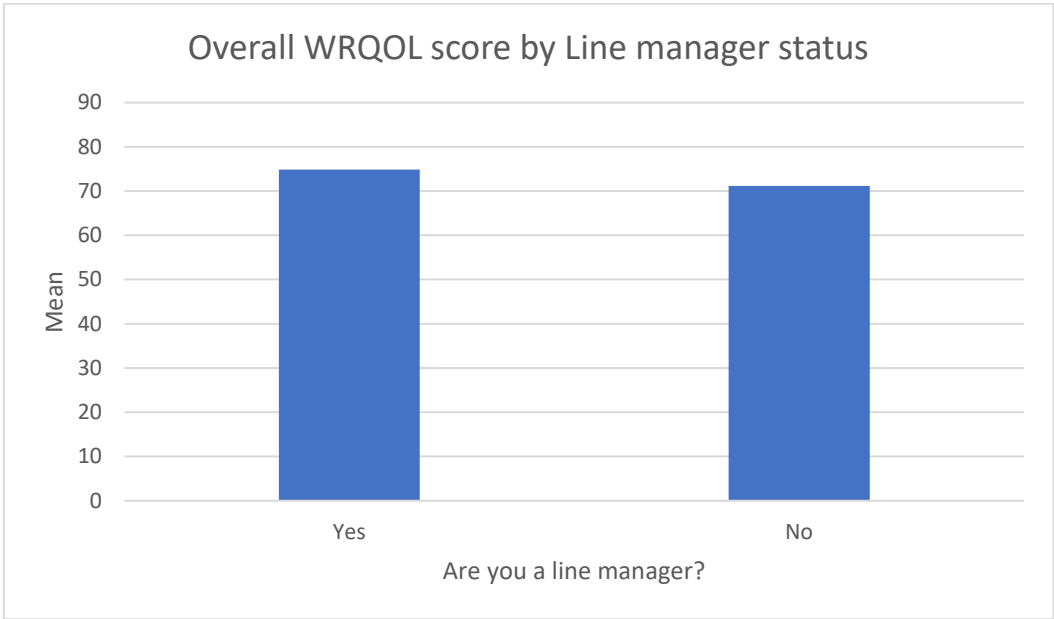


Table A4.31: Mean Quality of Working Life Scores by Line Manager Status (Weighted)

WRQOL Domain	Are you a line manager?	
	Yes	No
Job career satisfaction	21.14	21.05
Stress at work	3.93	4.58
General wellbeing	19.78	19.13
Home-work interface	10.34	10.70
Control at work	10.21	9.14
Working conditions	11.03	10.13
Overall WRQOL score	76.46	74.71

Table A4.32: Mean Quality of Working Life Scores by Line Manager Status (Unweighted)

WRQOL Domain	Are you a line manager?	
	Yes	No
Job career satisfaction	21.44	19.84
Stress at work	3.92	4.47
General wellbeing	19.14	18.84
Home-work interface	9.85	9.60
Control at work	10.41	8.78
Working conditions	10.10	9.60
Overall WRQOL score	74.87	71.16

Figure A4.49: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

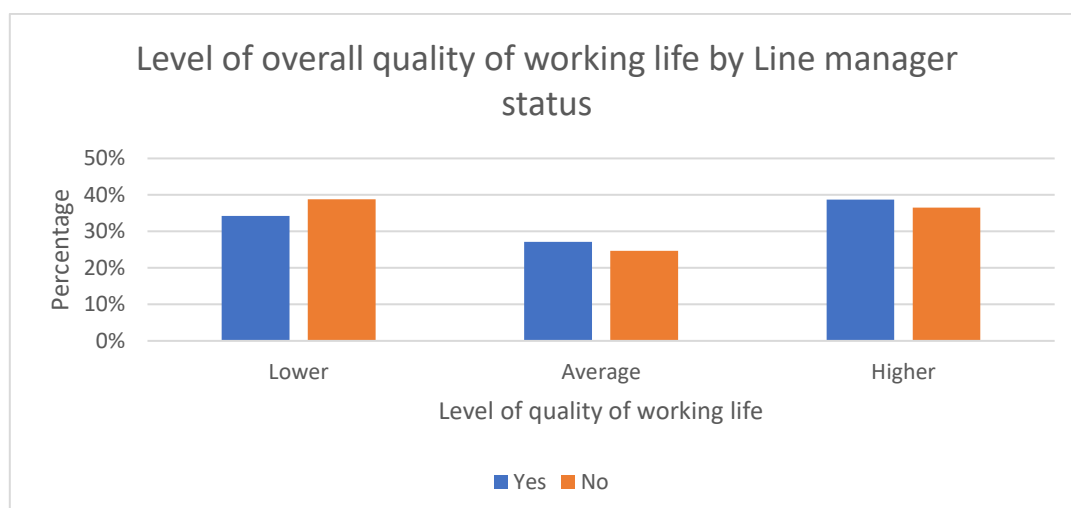


Figure A4.50: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

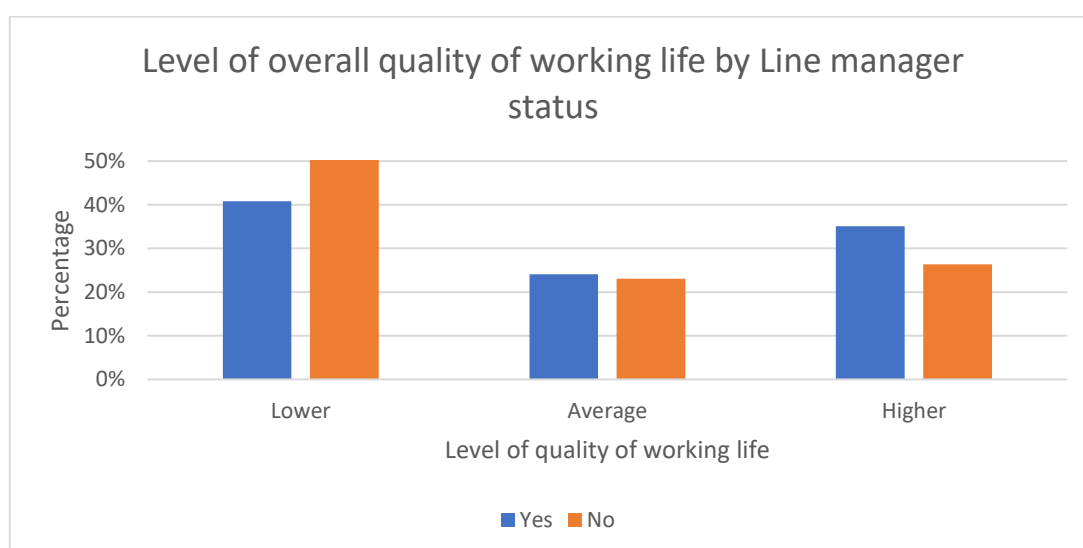


Table A4.33: Level of Overall Quality of Working Life by Line Manager Status (Weighted)

Level of WRQOL	Are you a line manager?	
	Yes	No
Lower	34.2%	38.8%
Average	27.1%	24.7%
Higher	38.7%	36.5%
Total	100%	100%

Table A4.34: Level of Overall Quality of Working Life by Line Manager Status (Unweighted)

Level of WRQOL	Are you a line manager?	
	Yes	No
Lower	210 (40.8%)	508 (50.4%)
Average	124 (24.1%)	233 (23.1%)
Higher	181 (35.1%)	266 (26.4%)
Total	515 (100%)	1007 (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 ($F = 118.822$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact or those who felt no impact.

Summary (Unweighted results):

There were significant differences in the mean overall WRQOL scores between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic ($F = 101.845$, $df = 2$, $p < .001$). 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)

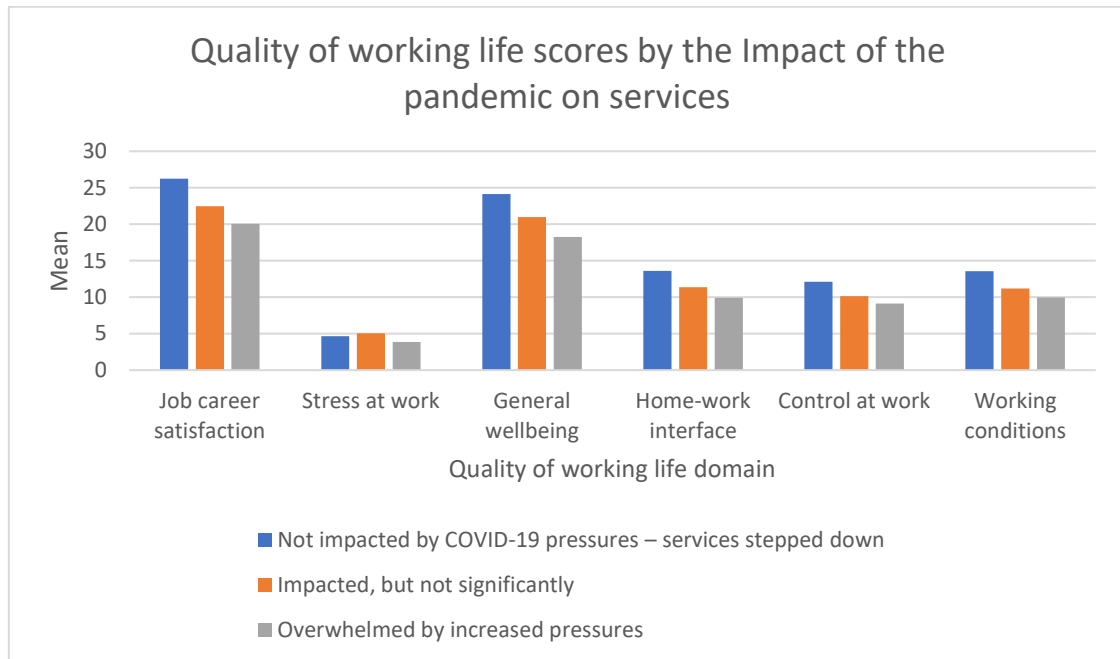


Figure A4.52: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Unweighted)

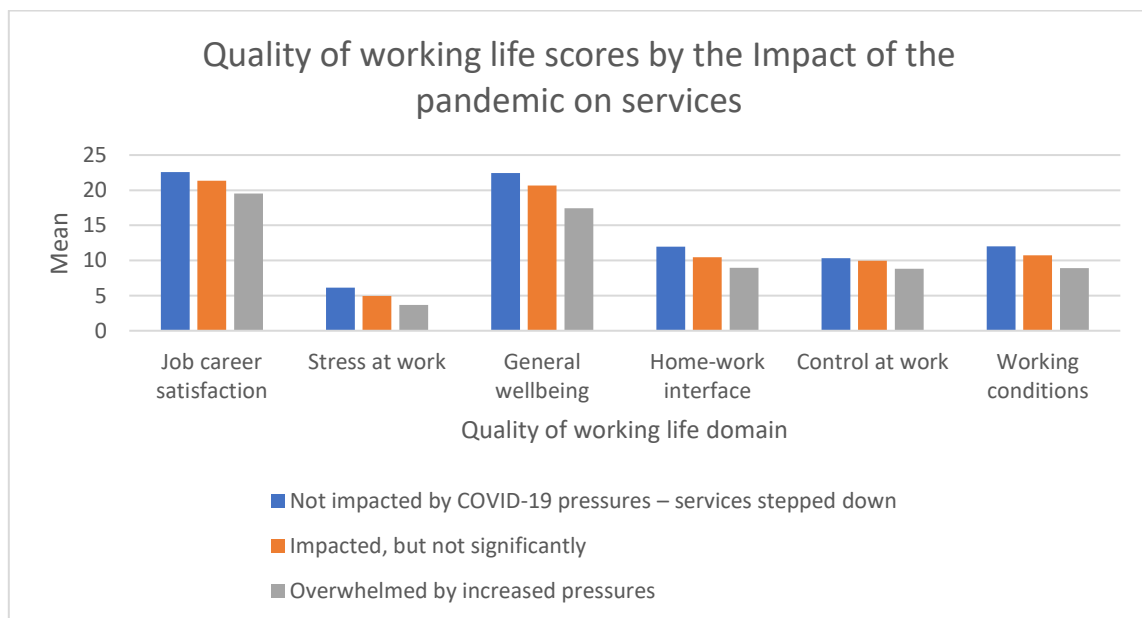


Figure A4. 53: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Weighted)

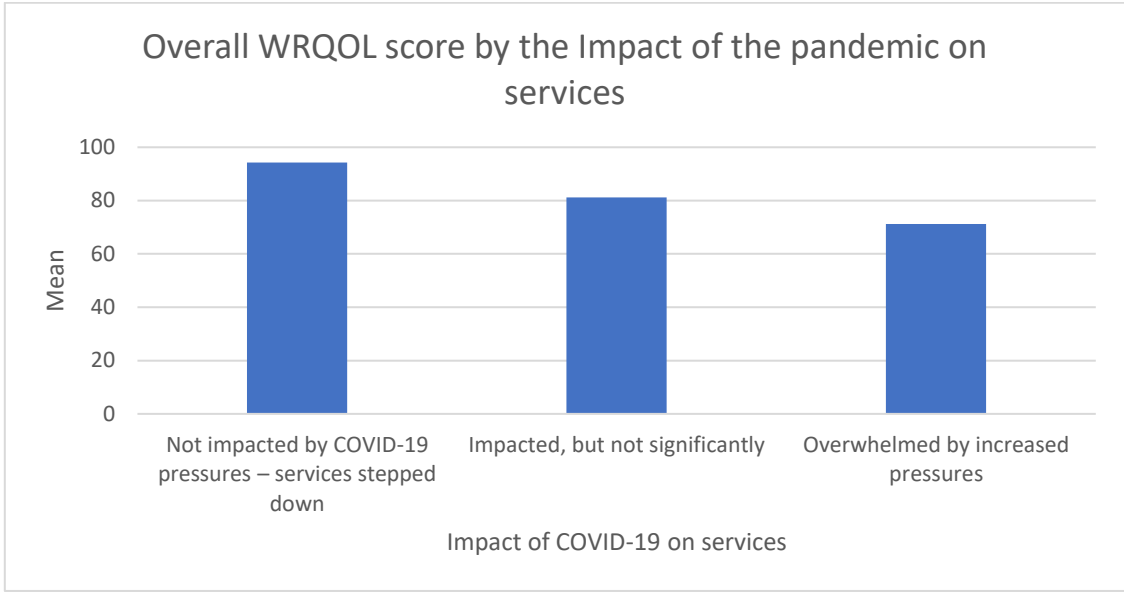


Figure A4.54: Mean Overall Quality of Working Life Score by the Impact of the Pandemic on Services (Unweighted)

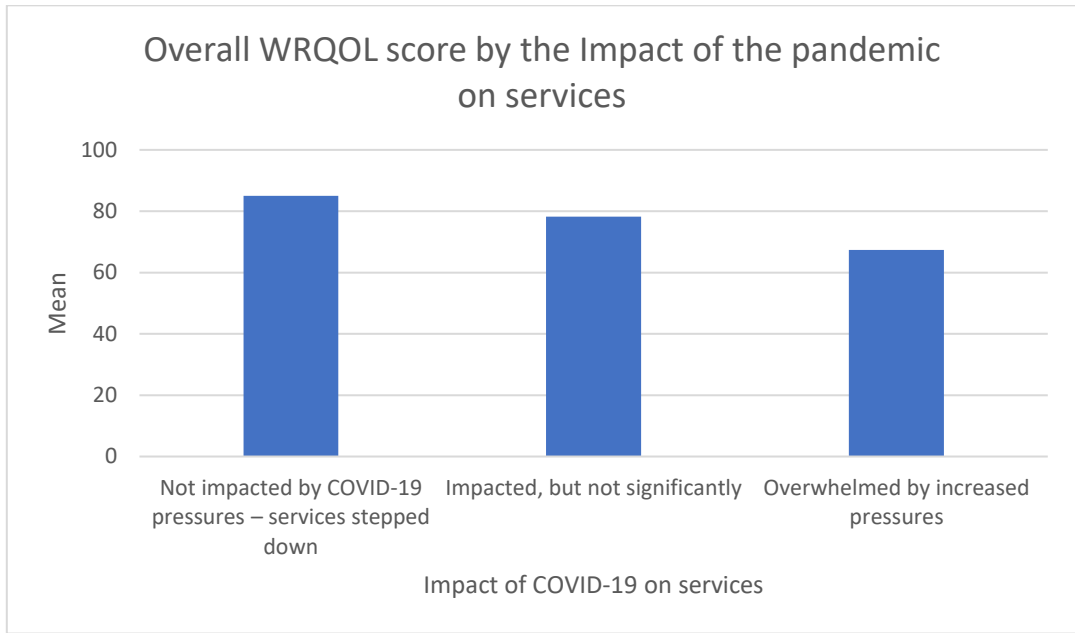


Table A4.35: Mean Quality of Working Life Scores by the Impact of the Pandemic on Services (Weighted)

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	26.22	22.48	20.06
Stress at work	4.65	5.04	3.88
General wellbeing	24.13	20.97	18.27
Home-work interface	13.62	11.37	9.94
Control at work	12.13	10.12	9.14
Working conditions	13.55	11.18	9.96
Overall WRQOL score	94.28	81.19	71.26

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	22.57	21.35	19.52
Stress at work	6.14	4.95	3.68
General wellbeing	22.45	20.66	17.43
Home-work interface	11.97	10.47	8.97
Control at work	10.31	9.95	8.80
Working conditions	12.00	10.74	8.91
Overall WRQOL score	85.04	78.21	67.33

Figure A4.55: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

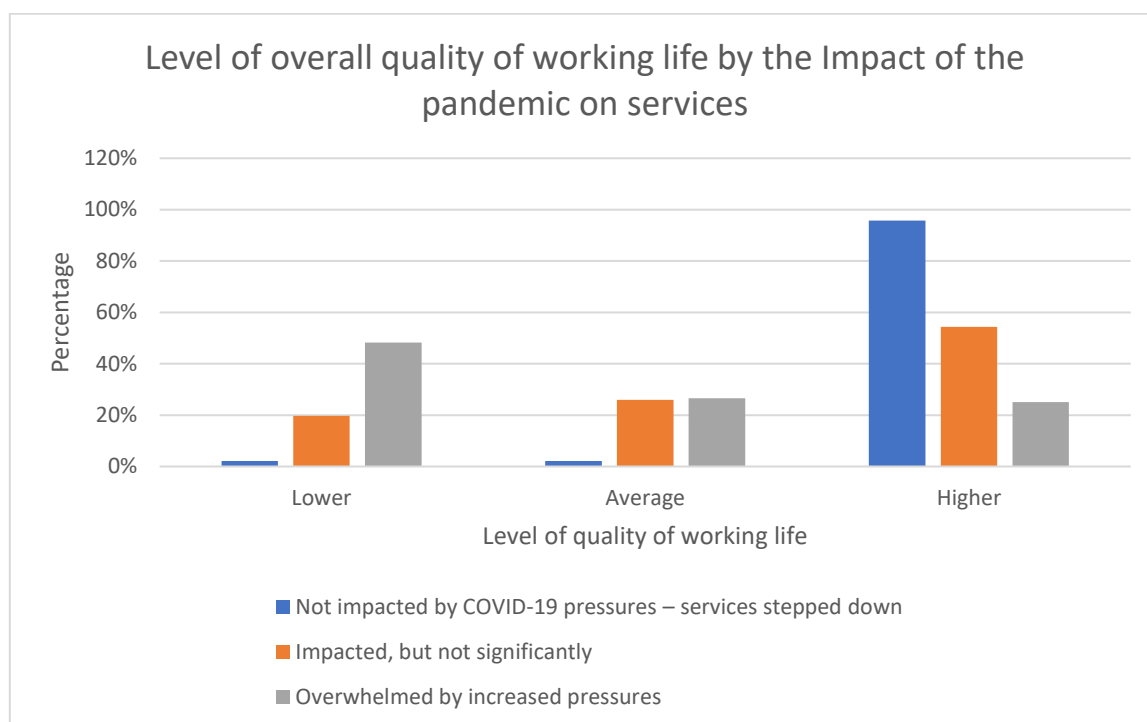


Figure A4.56: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

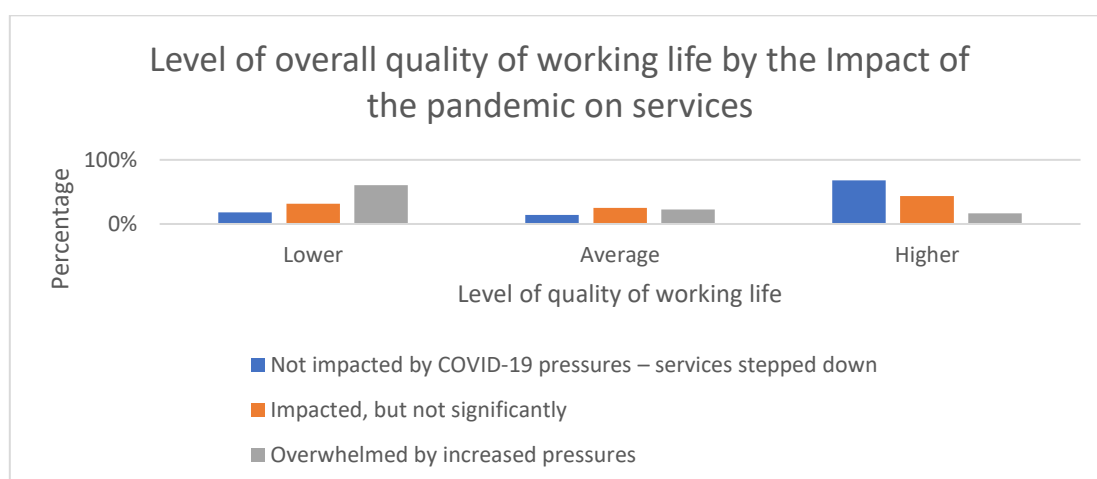


Table A4.37: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Weighted)

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	2.1%	19.7%	48.3%
Average	2.1%	25.9%	26.6%
Higher	95.7%	54.4%	25.1%
Total	100%	100%	100%

Table A4.38: Level of Overall Quality of Working Life by the Impact of the Pandemic on Services (Unweighted)

Level of WRQOL	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Lower	5 (17.9%)	210 (31.5%)	503 (60.7%)
Average	4 (14.3%)	167 (25.1%)	186 (22.5%)
Higher	19 (67.9%)	289 (43.4%)	139 (16.8%)
Total	28 (100%)	666 (100%)	828 (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 no significant differences between the countries in mean personal burnout scores ($F = .877$, $df = 3$, $p > .05$), or in mean work-related burnout scores ($F = 2.23$, $df = 3$, $p > .05$). There were also no significant differences between countries were also found in mean client-related burnout scores ($F = .693$, $df = 3$, $p > .05$).

Summary (Unweighted results):

There were no significant differences between the countries in mean personal burnout scores ($F = 2.39$, $df = 3$, $p = .067$), in mean work-related burnout scores ($F = 1.20$, $df = 3$, $p = .310$) or in mean client-related burnout scores ($F = .511$, $df = 3$, $p = .695$).

Figure A5. 1: Mean Burnout Scores by Country (Weighted)

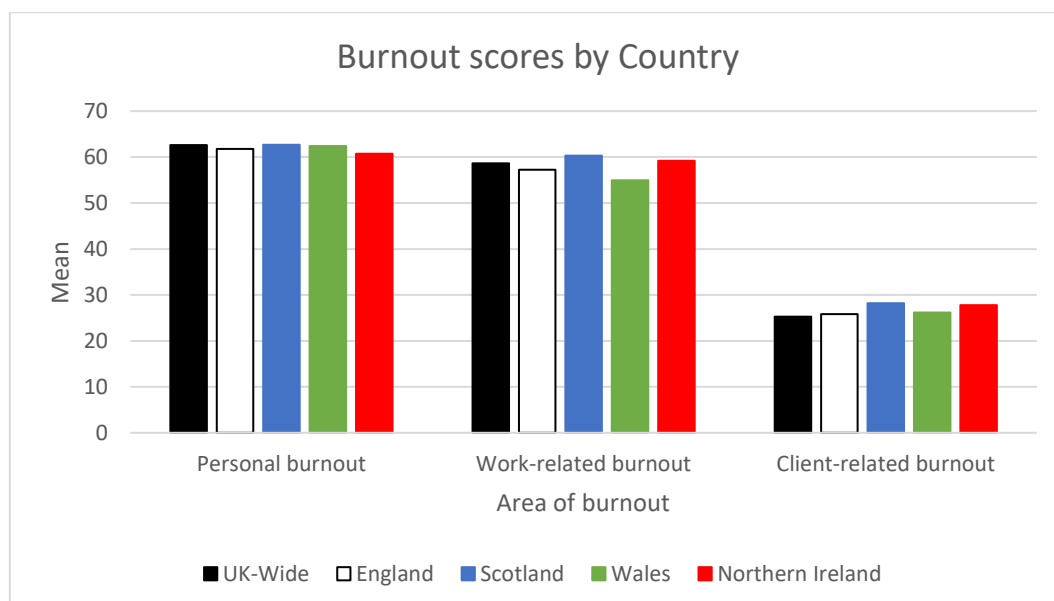


Figure A5.2: Mean Burnout Scores by Country (Unweighted)

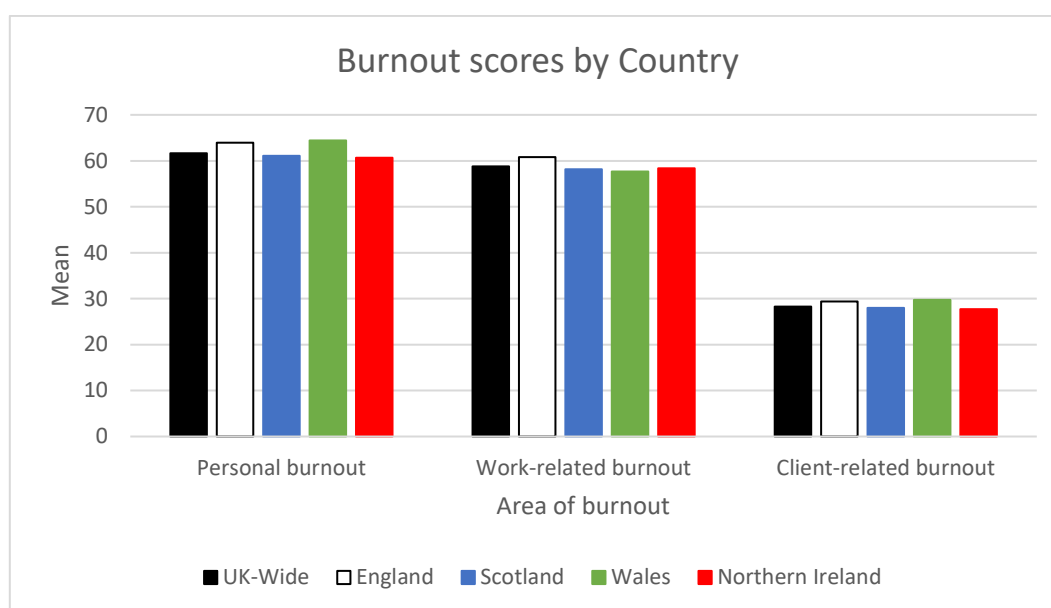


Table A5. 1: Mean Burnout Scores by Country (Weighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	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

Table A5.2: Mean Burnout Scores by Country (Unweighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout	61.67	63.92	61.09	64.43	60.63
Work-related burnout	58.79	60.82	58.19	57.68	58.34
Client-related burnout	28.27	29.38	27.99	29.74	27.72

Figure A5.3: Level of Personal Burnout by Country (Weighted)

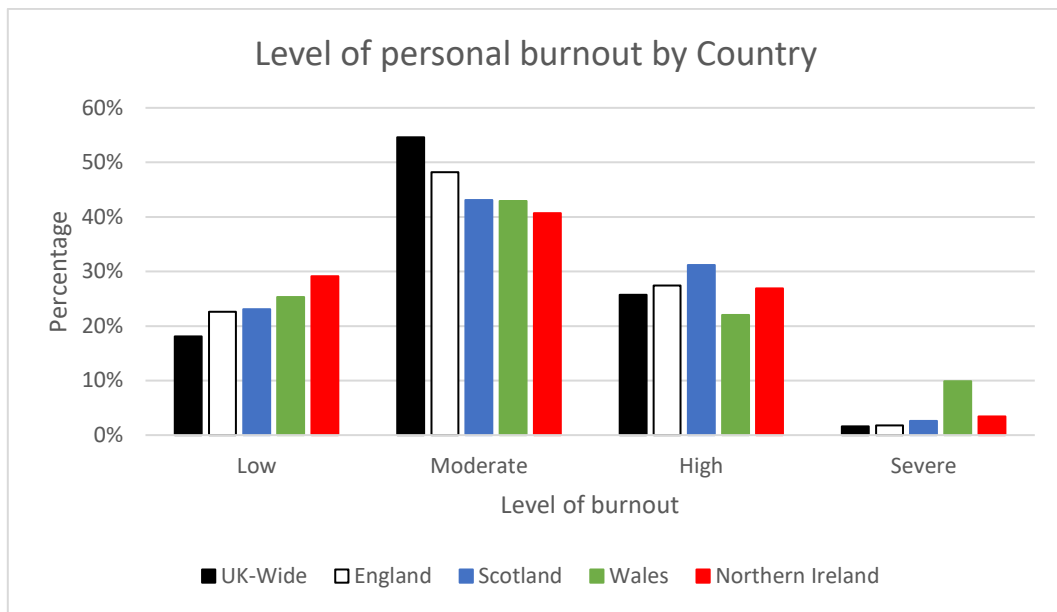


Figure A5.4: Level of Personal Burnout by Country (Unweighted)

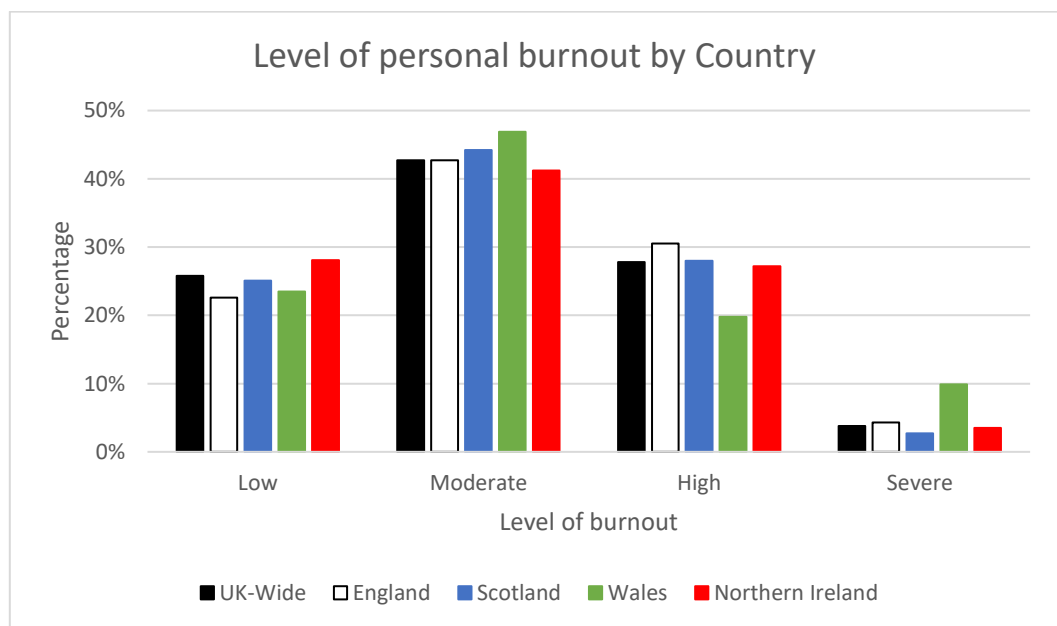


Figure A5.5: Level of Work-Related Burnout by Country (Weighted)

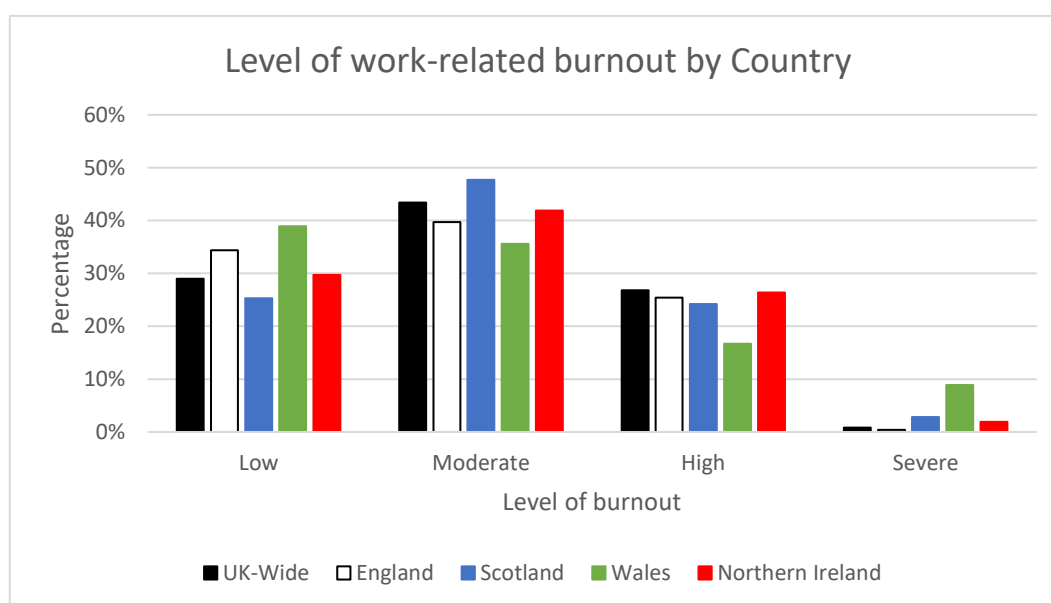


Figure A5.6: Level of Work-Related Burnout by Country (Unweighted)

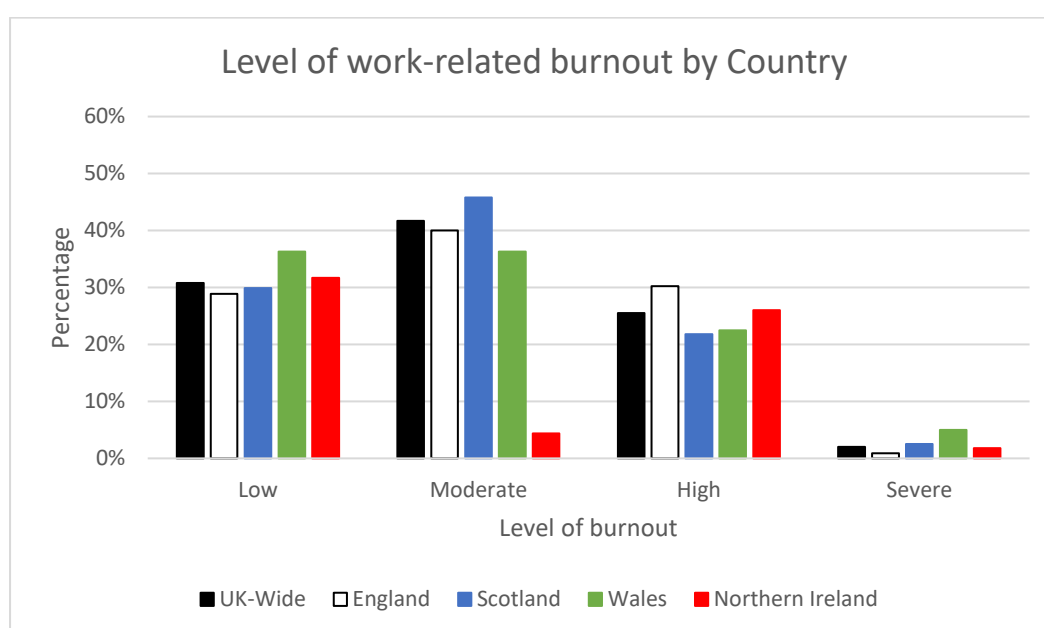


Figure A5.7: Level of Client-Related Burnout by Country (Weighted)

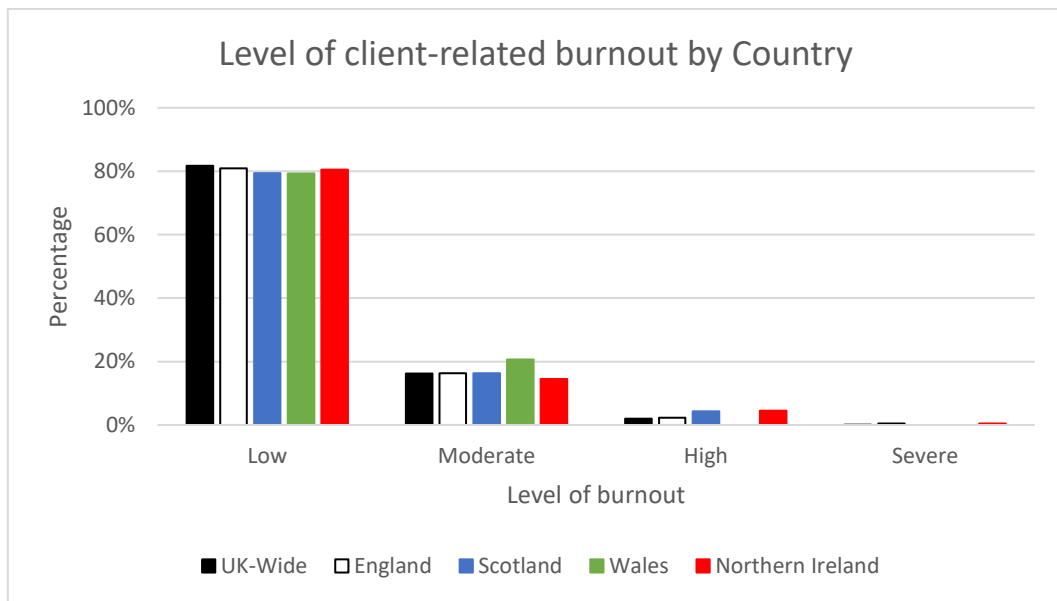


Figure A5.8: Level of Client-Related Burnout by Country (Unweighted)

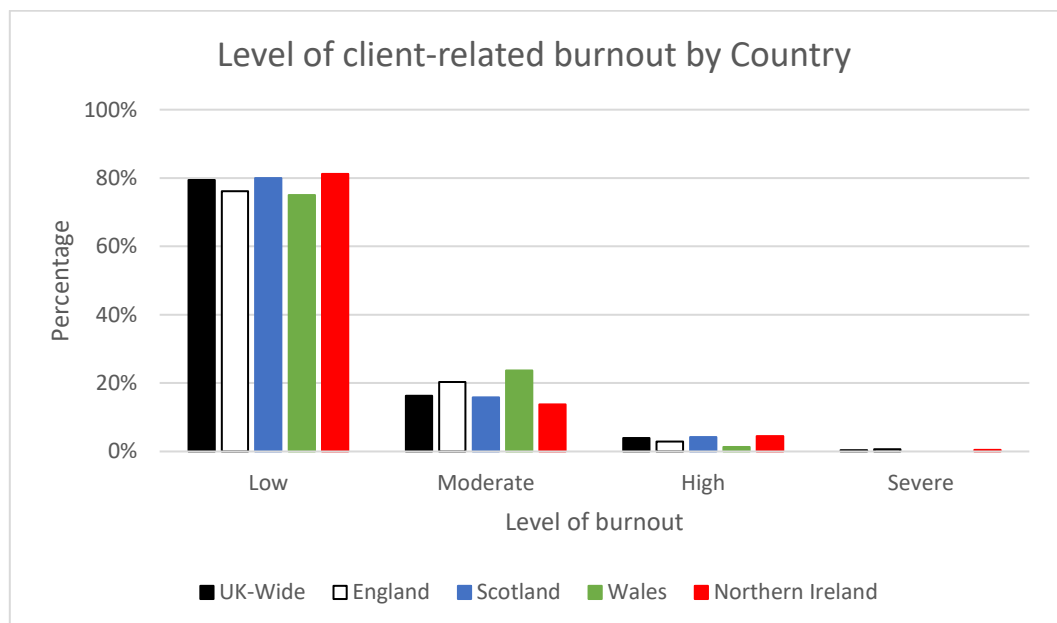


Table A5.3: Level of Burnout by Country (Weighted)

Burnout	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Personal burnout:					
Low	18.1%	22.6%	23.1%	25.3%	29.1%
Moderate	54.6%	48.2%	43.1%	42.9%	40.7%
High	25.7%	27.4%	31.2%	22.0%	26.9%
Severe	1.6%	1.8%	2.6%	9.9%	3.4%
Total	100%	100%	100%	100%	100%
Work-related burnout:					
Low	29.0%	34.4%	25.3%	38.9%	29.7%
Moderate	43.4%	39.7%	47.7%	35.6%	41.9%
High	26.8%	25.4%	24.2%	16.7%	26.4%
Severe	0.8%	0.4%	2.8%	8.9%	1.9%
Total	100%	100%	100%	100%	100%
Client-related burnout:					
Low	81.7%	80.9%	79.4%	79.3%	80.5%
Moderate	16.2%	16.3%	16.3%	20.7%	14.5%
High	2.0%	2.3%	4.3%	0.0%	4.5%
Severe	0.1%	0.5%	0.0%	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	396 (25.8%)	74 (22.6%)	112 (25.1%)	19 (23.5%)	191 (28.1%)
Moderate	655 (42.7%)	150 (42.7%)	197 (44.2%)	38 (46.9%)	280 (41.2%)
High	426 (27.8%)	100 (30.5%)	125 (28.0%)	16 (19.8%)	185 (27.2%)
Severe	58 (3.8%)	14 (4.3%)	12 (2.7%)	8 (9.9%)	24 (3.5%)
Total	1535 (100%)	328 (100%)	446 (100%)	81 (100%)	680 (100%)
Work-related burnout:					
Low	468 (30.8%)	94 (28.9%)	133 (29.9%)	29 (36.3%)	212 (31.7%)
Moderate	633 (41.7%)	130 (40.0%)	204 (45.8%)	29 (36.3%)	270 (4.4%)
High	387 (25.5%)	98 (30.2%)	97 (21.8%)	18 (22.5%)	174 (26.0%)
Severe	30 (2.0%)	3 (0.9%)	11 (2.5%)	4 (5.0%)	12 (1.8%)
Total	1518 (100%)	325 (100%)	445 (100%)	80 (100%)	668 (100%)
Client-related burnout:					
Low	1121 (79.4%)	233 (76.1%)	352 (80.0%)	57 (75.0%)	506 (81.2%)
Moderate	230 (16.3%)	62 (20.3%)	64 (15.8%)	18 (23.7%)	86 (13.8%)
High	55 (3.9%)	9 (2.9%)	17 (4.2%)	1 (1.3%)	28 (4.5%)
Severe	5 (0.4%)	2 (0.7%)	0 (0.0%)	0 (0.0%)	3 (0.5%)
Total	1411 (100%)	306 (100%)	406 (100%)	76 (100%)	623 (100%)

A5.2 Burnout Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean personal burnout scores ($F = 16.03$, $df = 4$, $p < .001$). Specifically, Midwives scored significantly higher than all other occupations.

There were also significant differences between the occupational groups in mean work-related burnout scores ($F = 24.99$, $df = 4$, $p < .001$). Specifically, Midwives scored significantly higher than all other occupations.

Significant differences between occupational groups were also found in mean client-related burnout scores ($F = 12.37$, $df = 4$, $p < .001$). Midwives scored significantly higher than nurses, AHPs and social care workers.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean personal burnout scores ($F = 6.70$, $df = 4$, $p < .001$). Specifically, AHPs scored significantly lower than social workers or midwives.

There were also significant differences between the occupational groups in mean work-related burnout scores ($F = 10.56$, $df = 4$, $p < .001$). AHPs scored significantly lower than all other occupations examined.

There were no significant differences between occupational groups were also found in mean client-related burnout scores ($F = 1.91$, $df = 4$, $p = .106$).

Figure A5.9: Mean Burnout Scores by Occupation (Weighted)

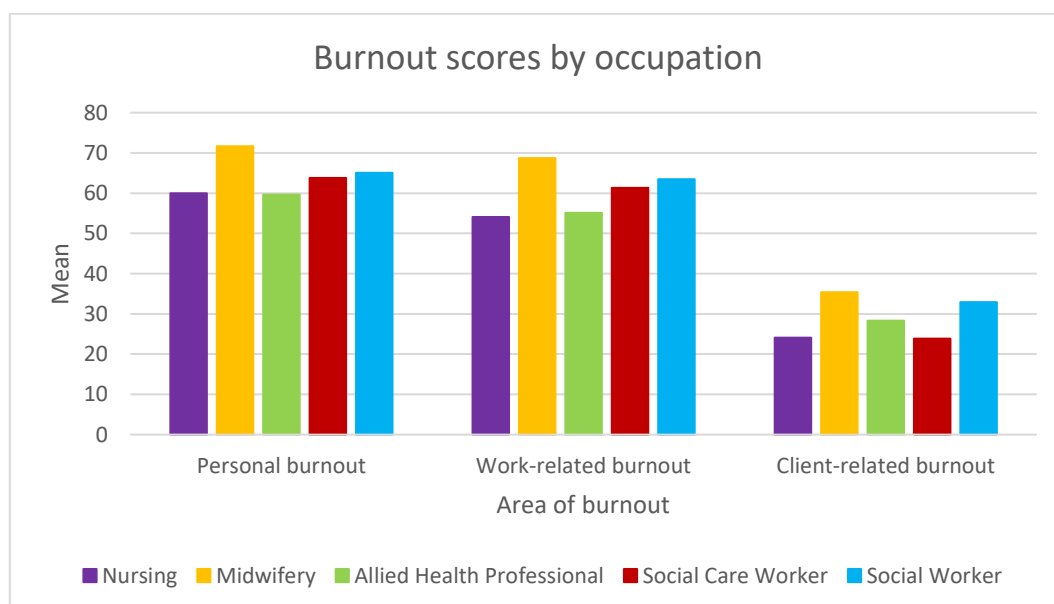


Figure A5.10: Mean Burnout Scores by Occupation (Unweighted)

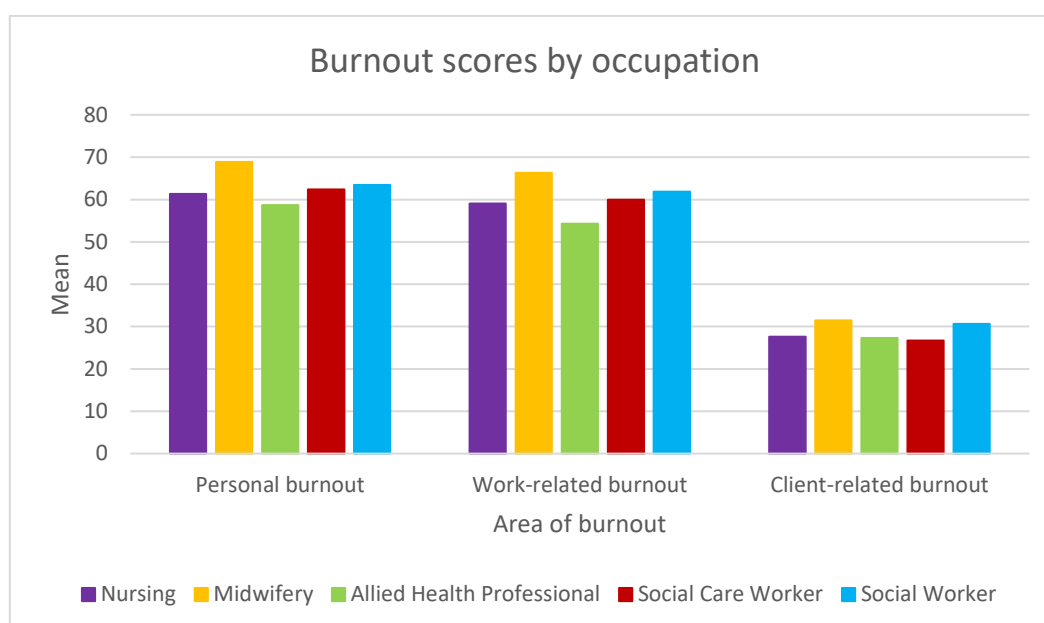


Table A5.5: Mean Burnout Scores by Occupation (Weighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	59.97	71.69	59.66	63.8	65.08
Work-related burnout	54.06	68.69	55.1	61.28	63.45
Client-related burnout	24.08	35.36	28.33	23.84	32.90

Table A5.6: Mean Burnout Scores by Occupation (Unweighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout	61.31	68.87	58.71	62.4	63.43
Work-related burnout	59.04	66.34	54.31	59.93	61.82
Client-related burnout	27.63	31.46	27.34	26.70	30.60

Figure A5.11: Level of Personal Burnout by Occupation (Weighted)

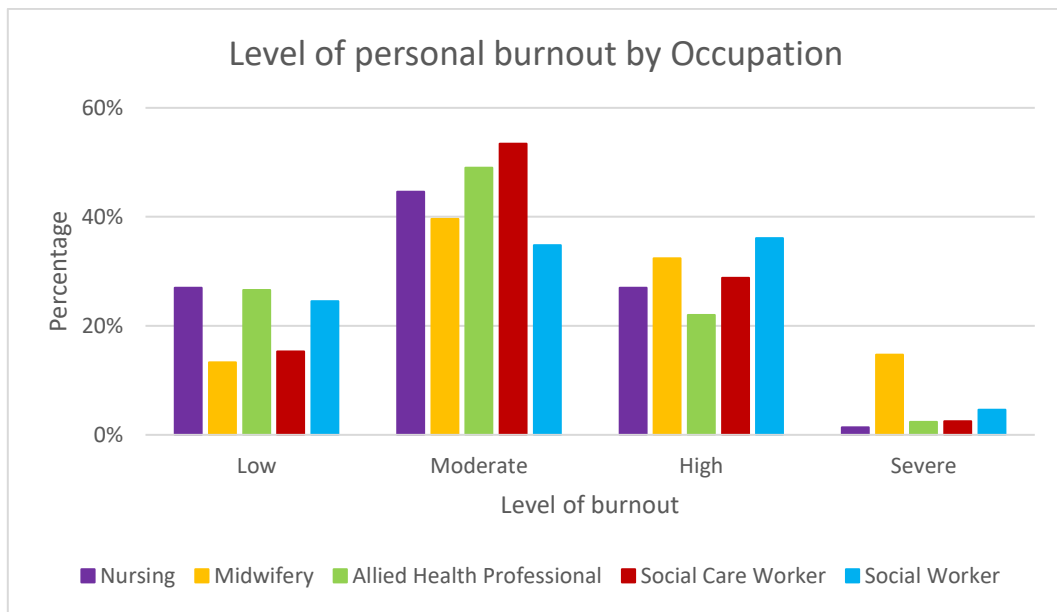


Figure A5.12: Level of Personal Burnout by Occupation (Unweighted)

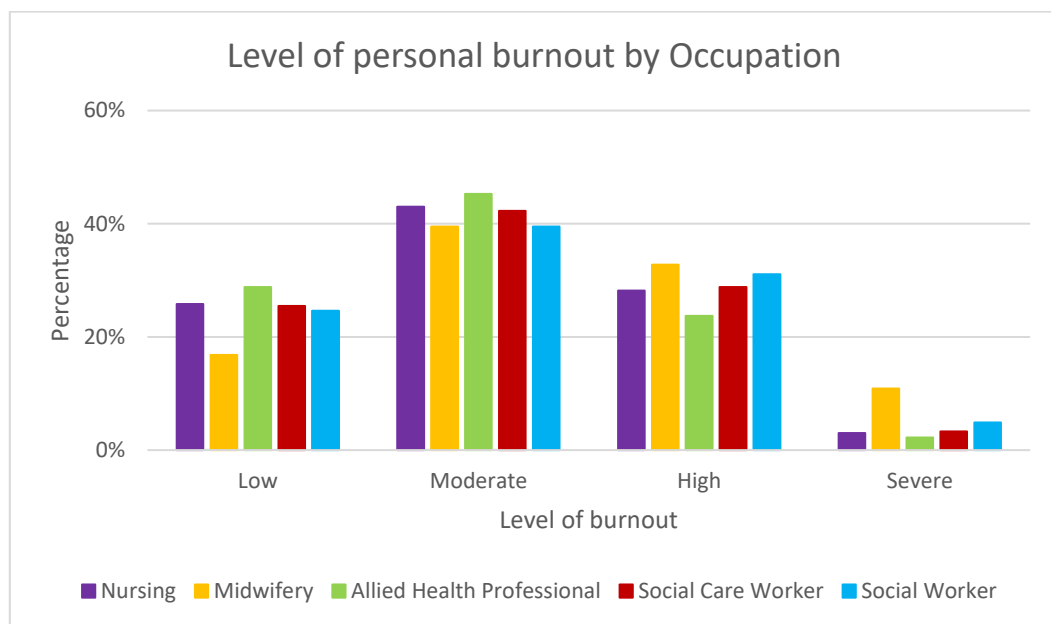


Figure A5.13: Level of Work-Related Burnout by Occupation (Weighted)

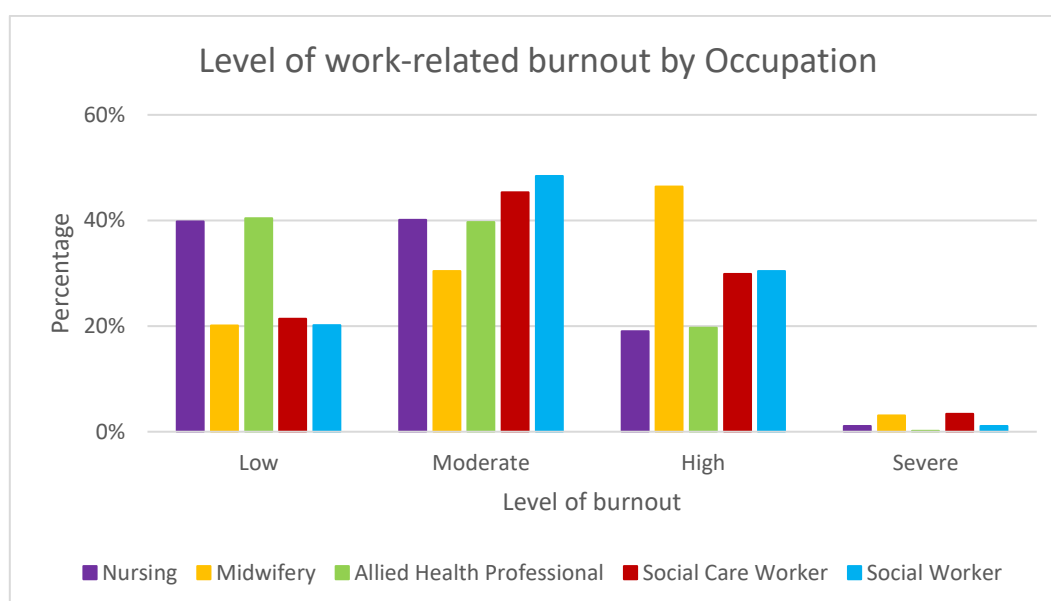


Figure A5.14: Level of Work-Related Burnout by Occupation (Unweighted)

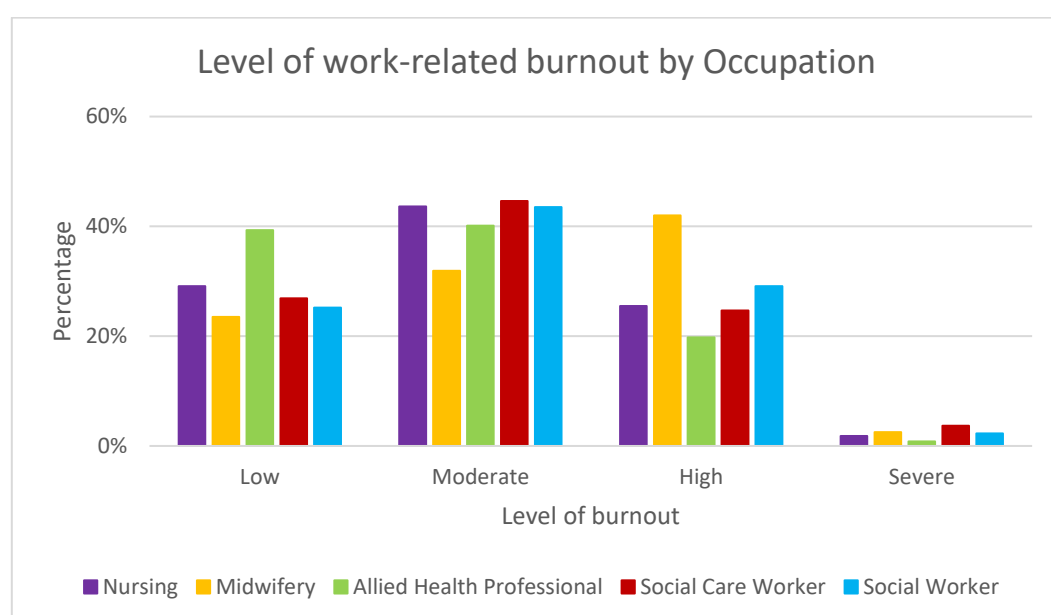


Figure A5.15: Level of Client-Related Burnout by Occupation (Weighted)

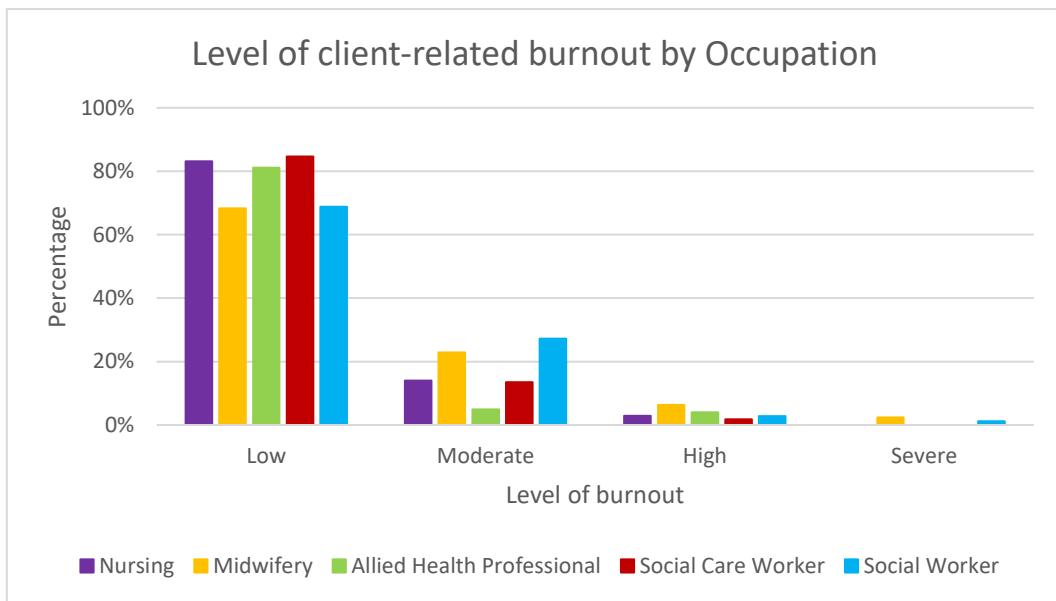


Figure A5.16: Level of Client-Related Burnout by Occupation (Unweighted)

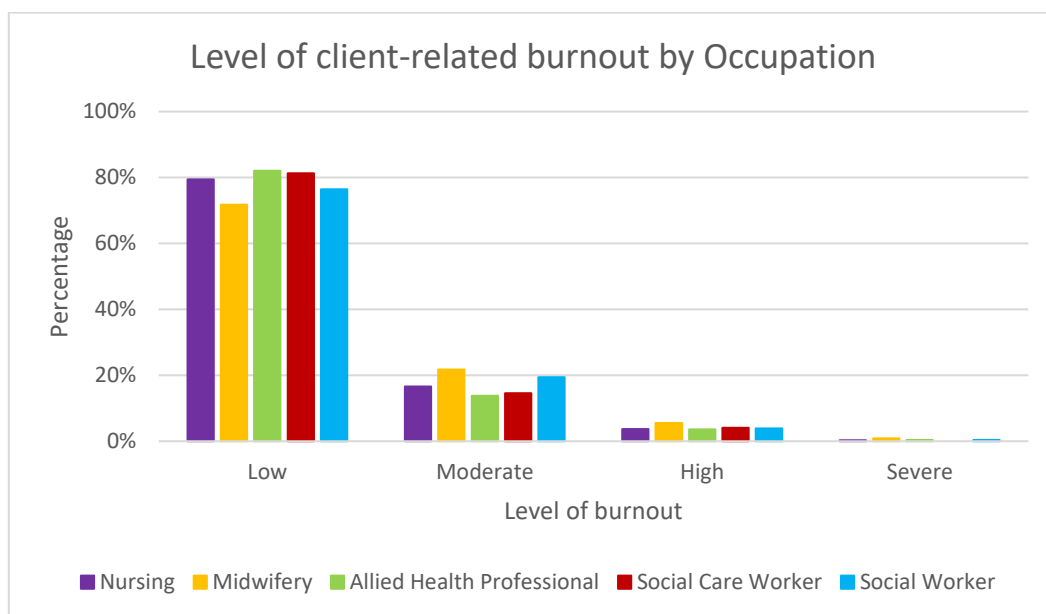


Table A5.7: Level of Burnout by Occupation (Weighted)

Burnout	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Personal burnout:					
Low	27.0%	13.3%	26.6%	15.3%	24.5%
Moderate	44.6%	39.6%	49.0%	53.4%	34.8%
High	27.0%	32.4%	22.0%	28.8%	36.1%
Severe	1.4%	14.7%	2.4%	2.5%	4.6%
Total	100%	100%	100%	100%	100%
Work-related burnout:					
Low	39.8%	20.1%	40.4%	21.4%	20.2%
Moderate	40.1%	30.4%	39.7%	45.3%	48.4%
High	19.0%	46.4%	19.7%	29.9%	30.4%
Severe	1.1%	3.1%	0.2%	3.4%	1.1%
Total	100%	100%	100%	100%	100%
Client-related burnout:					
Low	83.1%	68.3%	81.1%	84.7%	68.8%
Moderate	14.0%	22.9%	4.9%	13.5%	27.2%
High	2.9%	6.3%	4.0%	1.8%	2.8%
Severe	0.0%	2.4%	0.0%	0.0%	1.2%
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	85 (25.8%)	20 (16.8%)	145 (28.8%)	70 (25.5%)	76 (24.6%)
Moderate	142 (43.0%)	47 (39.5%)	228 (45.3%)	116 (42.3%)	122 (39.5%)
High	93 (28.2%)	39 (32.8%)	119 (23.7%)	79 (28.8%)	96 (31.1%)
Severe	10 (3.0%)	13 (10.9%)	11 (2.2%)	9 (3.3%)	15 (4.9%)
Total	330 (100%)	119 (100%)	503 (100%)	274 (100%)	309 (100%)
Work-related burnout:					
Low	95 (29.1%)	28 (23.5%)	195 (39.3%)	73 (26.9%)	77 (25.2%)
Moderate	142 (43.6%)	38 (31.9%)	199 (40.1%)	121 (44.6%)	133 (43.5%)
High	83 (25.5%)	50 (42.0%)	98 (19.8%)	67 (24.7%)	89 (29.1%)
Severe	6 (1.8%)	3 (2.5%)	4 (0.8%)	10 (3.7%)	7 (2.3%)
Total	326 (100%)	119 (100%)	496 (100%)	271 (100%)	306 (100%)
Client-related burnout:					
Low	239 (79.4%)	79 (71.8%)	386 (82.1%)	200 (81.3%)	217 (76.4%)
Moderate	50 (16.6%)	24 (21.8%)	65 (13.8%)	36 (14.6%)	55 (19.4%)
High	11 (3.7%)	6 (5.5%)	17 (3.6%)	10 (4.1%)	11 (3.9%)
Severe	1 (0.3%)	1 (0.9%)	2 (0.4%)	0 (0.0%)	1 (0.4%)
Total	301 (100%)	110 (100%)	470 (100%)	246 (100%)	284 (100%)

A5.3 Burnout Scores by Sex

Only 4 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 ($t = 3.66$, $df = 388.44$, $p < .001$). Specifically, females scored significantly higher than males.

There were significant differences between males and females in mean work-related burnout scores ($t = 3.36$, $df = 1692$, $p < .001$). Specifically, females scored significantly higher than males.

There were significant differences between males and females in mean client-related burnout scores ($t = -3.03$, $df = 1633$, $p = .003$). Males scored significantly higher than females.

Summary (Unweighted results):

There were significant differences between males and females in mean personal burnout scores ($t = 4.01$, $df = 1526$, $p < .001$). Specifically, females scored significantly higher than males.

There were significant differences between males and females in mean work-related burnout scores ($t = 2.19$, $df = 1510$, $p = .029$).

There were significant differences between males and females in mean client-related burnout scores ($t = -3.01$, $df = 1404$, $p = .003$). Males scored significantly higher than females.

Figure A5.17: Mean Burnout Scores by Sex (Weighted)

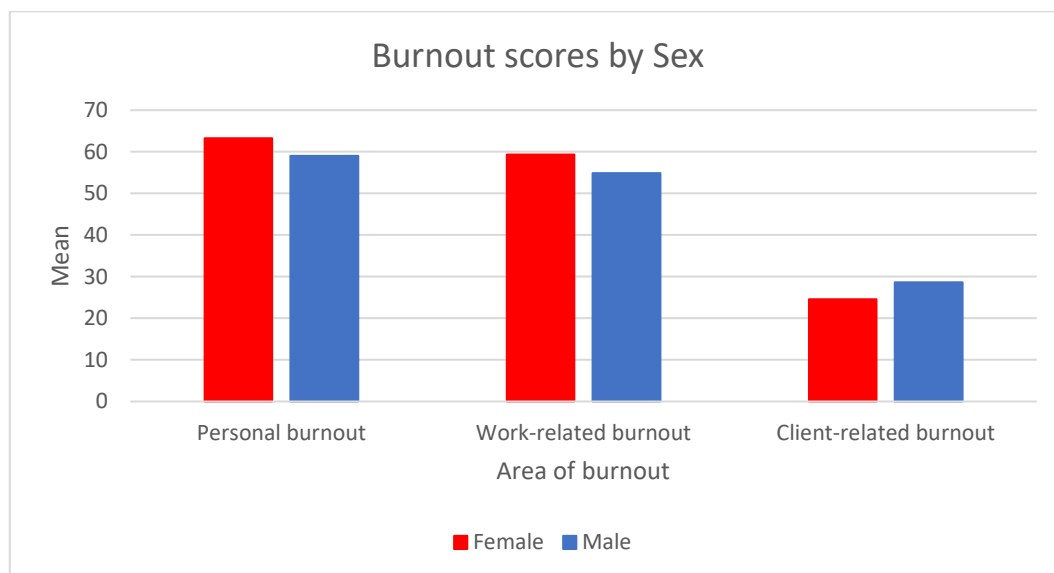


Figure A5.18: Mean Burnout Scores by Sex (Unweighted)

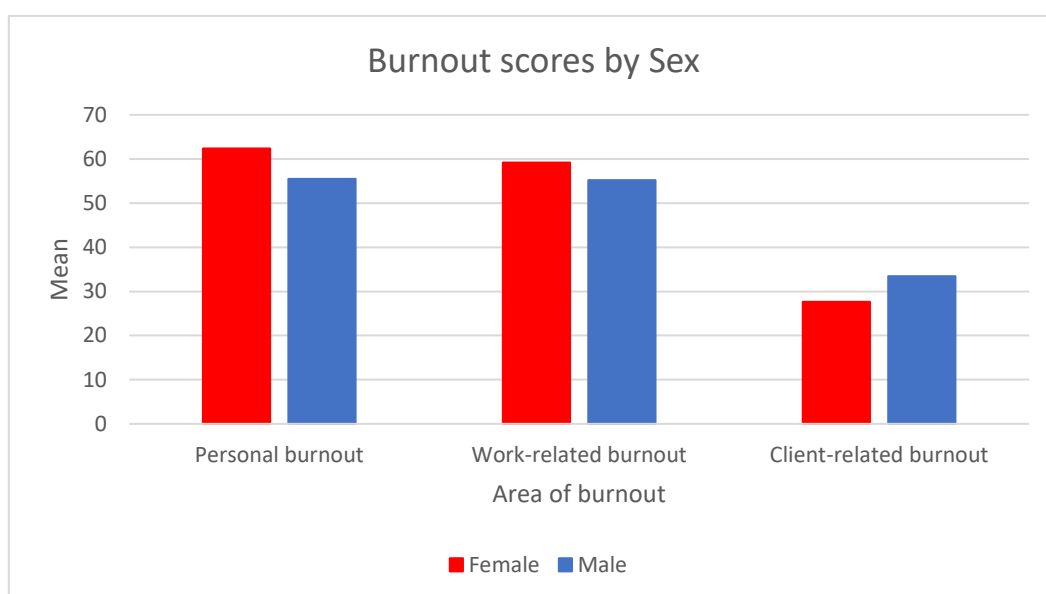


Table A5.9: Mean Burnout Scores by Sex (Weighted)

Burnout	Sex	
	Female	Male
Personal burnout	63.3	59.04
Work-related burnout	59.35	54.91
Client-related burnout	24.55	28.62

Table A5.10: Mean Burnout Scores by Sex (Unweighted)

Burnout	Sex	
	Female	Male
Personal burnout	62.40	55.5
Work-related burnout	59.18	55.20
Client-related burnout	27.63	33.42

Figure A5.19: Level of Personal Burnout by Sex (Weighted)

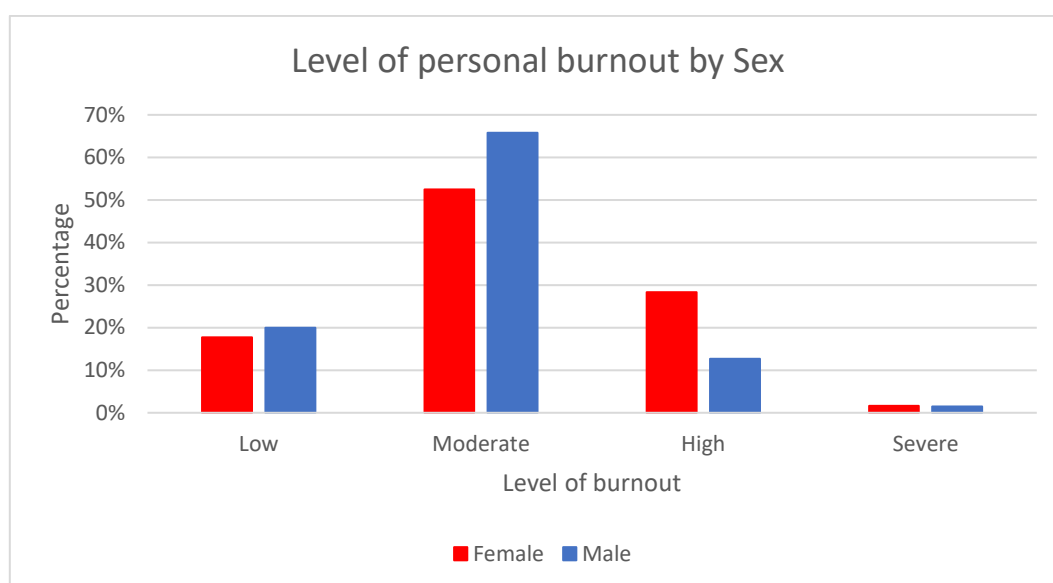


Figure A5.20: Level of Personal Burnout by Sex (Unweighted)

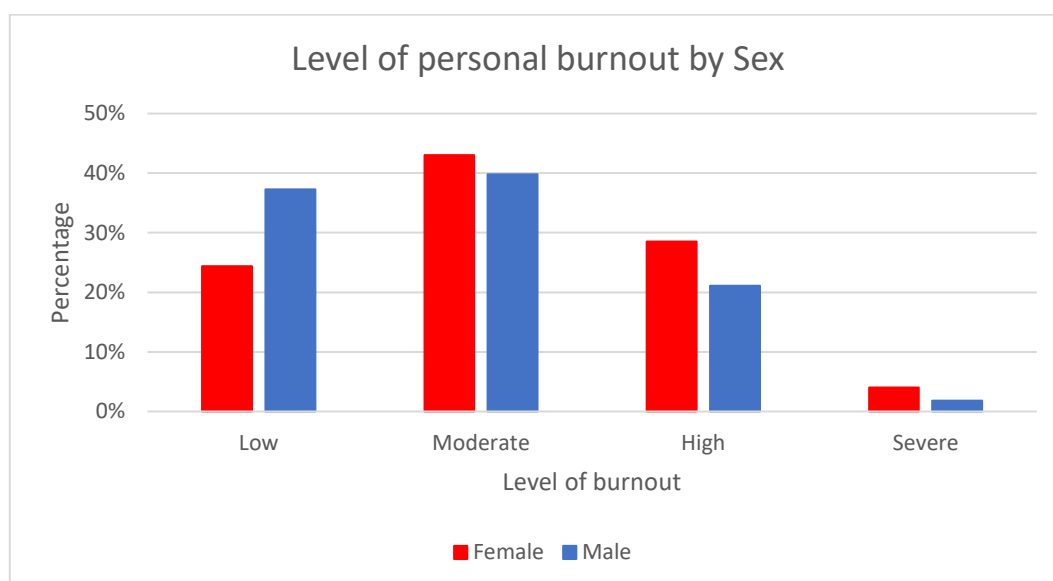


Figure A5.21: Level of Work-Related Burnout by Sex (Weighted)

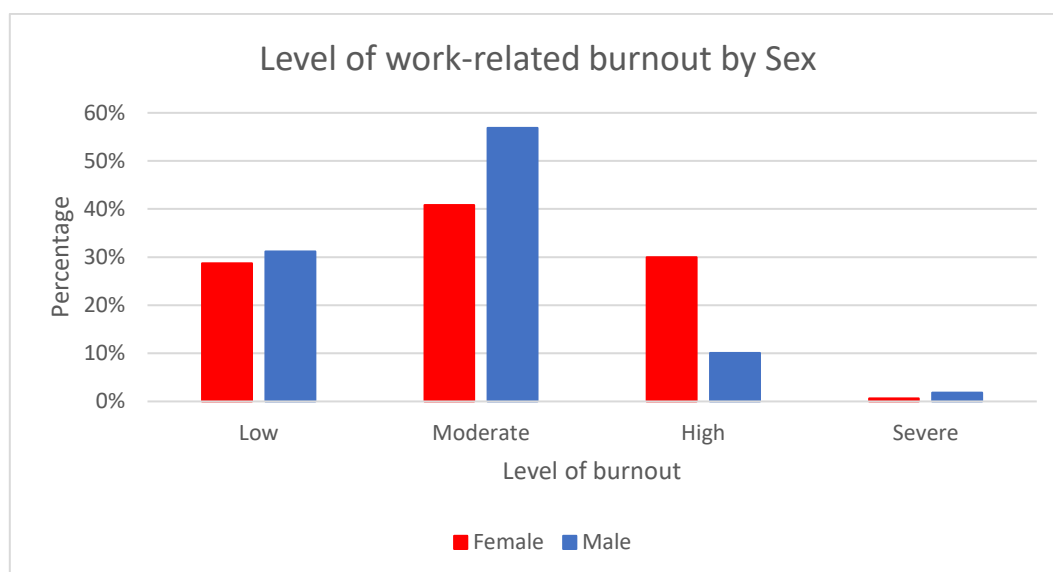


Figure A5.22: Level of Work-Related Burnout by Sex (Unweighted)

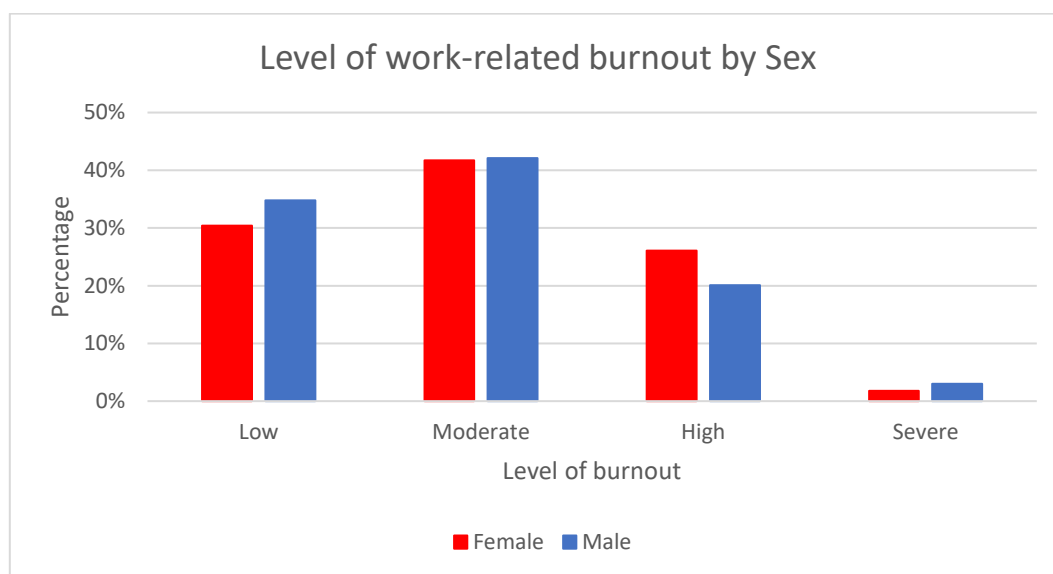


Figure A5.23: Level of Client-Related Burnout by Sex (Weighted)

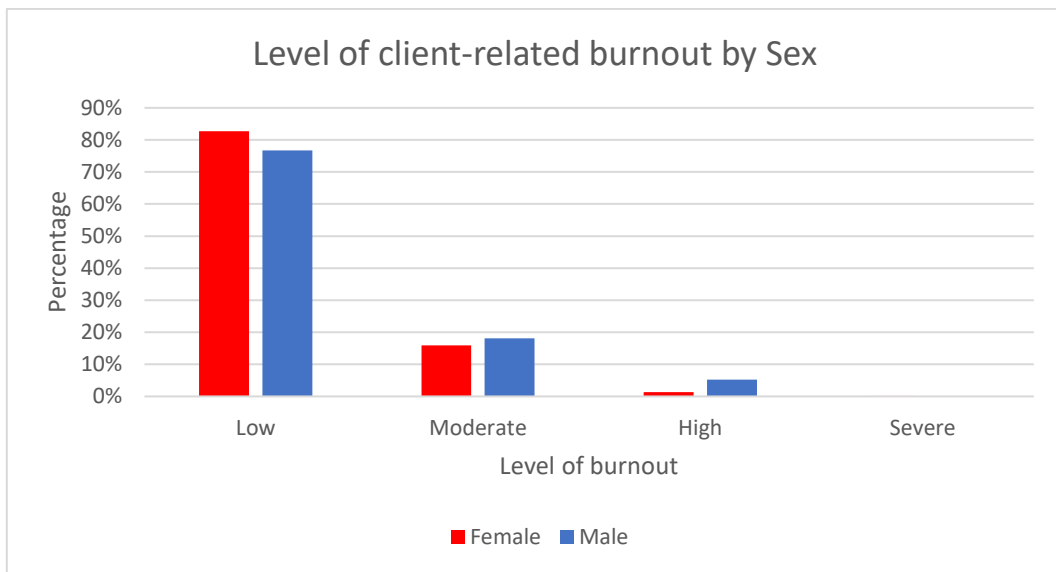


Figure A5.24: Level of Client-Related Burnout by Sex (Unweighted)

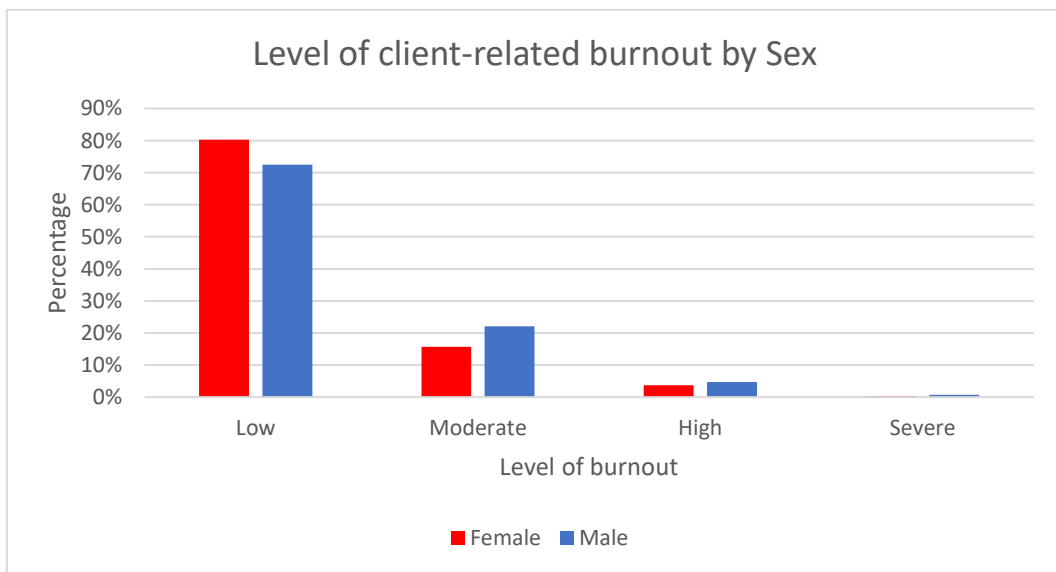


Table A5.11: Level of Burnout by Sex (Weighted)

Burnout	Sex	
	Female	Male
Personal burnout:		
Low	17.7%	20.0%
Moderate	52.5%	65.8%
High	28.3%	12.7%
Severe	1.6%	1.5%
Total	100%	100%
Work-related burnout:		
Low	28.7%	31.2%
Moderate	40.8%	56.9%
High	30.0%	10.1%
Severe	0.6%	1.8%
Total	100%	100%
Client-related burnout:		
Low	82.7%	76.7%
Moderate	15.9%	18.1%
High	1.3%	5.2%
Severe	0.1%	0.0%
Total	100%	100%

Table A5.12: Level of Burnout by Sex (Unweighted)

Burnout	Sex	
	Female	Male
Personal burnout:		
Low	333 (24.4%)	62 (37.3%)
Moderate	586 (43.0%)	66 (39.8%)
High	388 (28.5%)	35 (21.1%)
Severe	55 (4.0%)	3 (1.8%)
Total	1362 (100%)	166 (100%)
Work-related burnout:		
Low	410 (30.4%)	57 (34.8%)
Moderate	562 (41.7%)	69 (42.1%)
High	352 (26.1%)	33 (20.1%)
Severe	24 (1.8%)	5 (3.0%)
Total	1348 (100%)	164 (100%)
Client-related burnout:		
Low	1009 (80.3%)	108 (72.5%)
Moderate	197 (15.7%)	33 (22.1%)
High	47 (3.7%)	7 (4.7%)
Severe	4 (0.3%)	1 (0.7%)
Total	1257 (100%)	149 (100%)

A5.4 Burnout Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean personal burnout scores ($F = 30.41$, $df = 5$, $p < .001$). The 60-65 age group scored significantly lower than all other age groups except 66+.

There were significant differences between the age groups in mean work-related burnout scores ($F = 22.04$, $df = 5$, $p < .001$). Specifically, the 16-29 and 30-39 age groups scored significantly higher than the 40-49, 50-59, 60-65 and 66+ age groups.

There were also significant differences between the age groups in mean client related burnout scores ($F = 12.86$, $df = 5$, $p < .001$). Specifically, the 40-49 age group scored significantly higher than the 30-39 and 50-59 age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean personal burnout scores ($F = 17.08$, $df = 5$, $p < .001$). The 50-59 age group had significantly lower levels of personal burnout than the 16-29, 30-39 and 40-49 age groups however it had a significantly higher level of personal burnout than the 60-65 age group. The 60-65 age group was significantly lower than all the age groups except the 66+ group.

There were significant differences between the age groups in mean work-related burnout scores ($F = 10.04$, $df = 5$, $p < .001$). Specifically, the 16-29 age group scored significantly higher than the 50-59, 60-65 and 66+ age groups. The 40-49 age group scored significantly higher than the 50-59 and 60-65 age groups.

There were also significant differences between the age groups in mean client-related burnout scores ($F = 5.82$, $df = 5$, $p < .001$). Specifically, the 16-20 age group scored significantly higher than the 50-59 and 60-65 age groups.

Figure A5.25: Mean Burnout Scores by Age (Weighted)

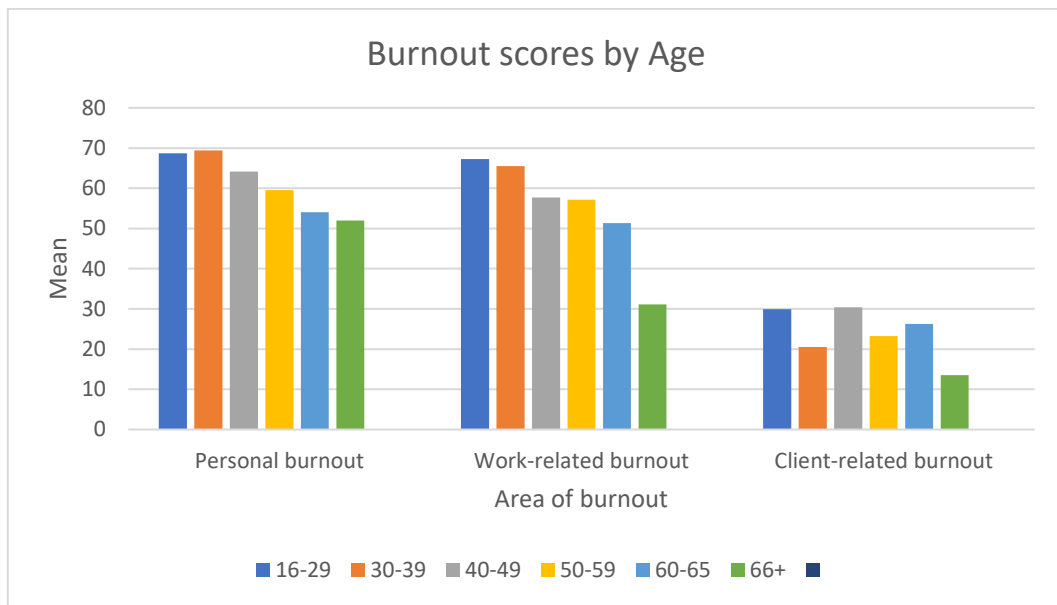


Figure A5.26: Mean Burnout Scores by Age (Unweighted)

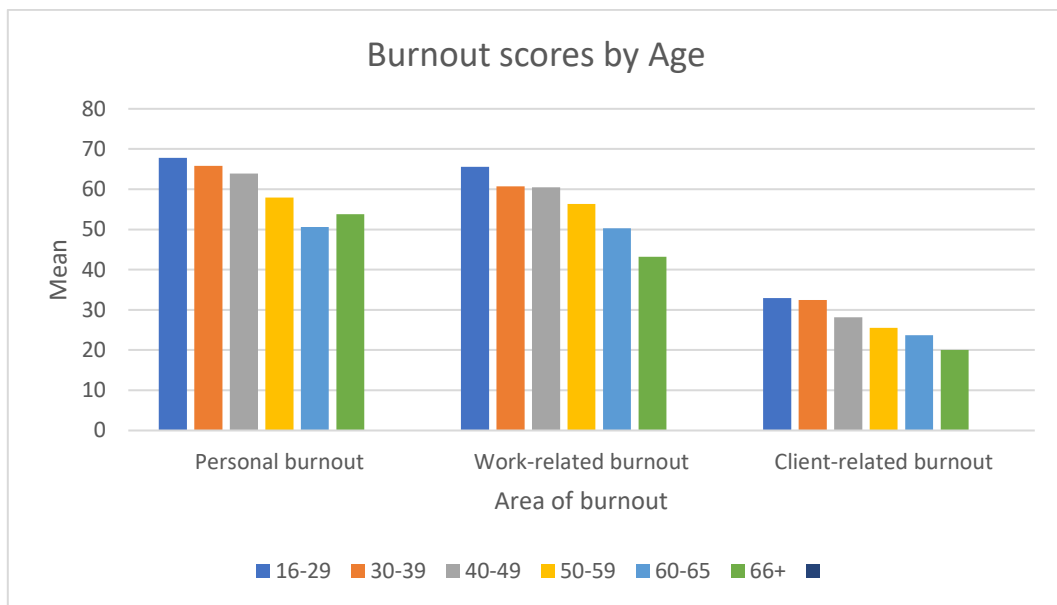


Table A5.13: Mean Burnout Scores by Age (Weighted)

Burnout	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Personal burnout	68.73	69.42	64.15	59.55	54.02	52.00
Work-related burnout	67.28	65.50	57.72	57.13	51.30	31.13
Client-related burnout	29.92	20.51	30.37	23.26	26.27	13.49

Table A5.14: Mean Burnout Scores by Age (Unweighted)

Burnout	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Personal burnout	67.8	65.84	63.91	57.95	50.58	53.79
Work-related burnout	65.55	60.73	60.5	56.38	50.29	43.18
Client-related burnout	32.91	32.48	28.15	25.56	23.73	20.00

Figure A5.27: Level of Personal Burnout by Age (Weighted)

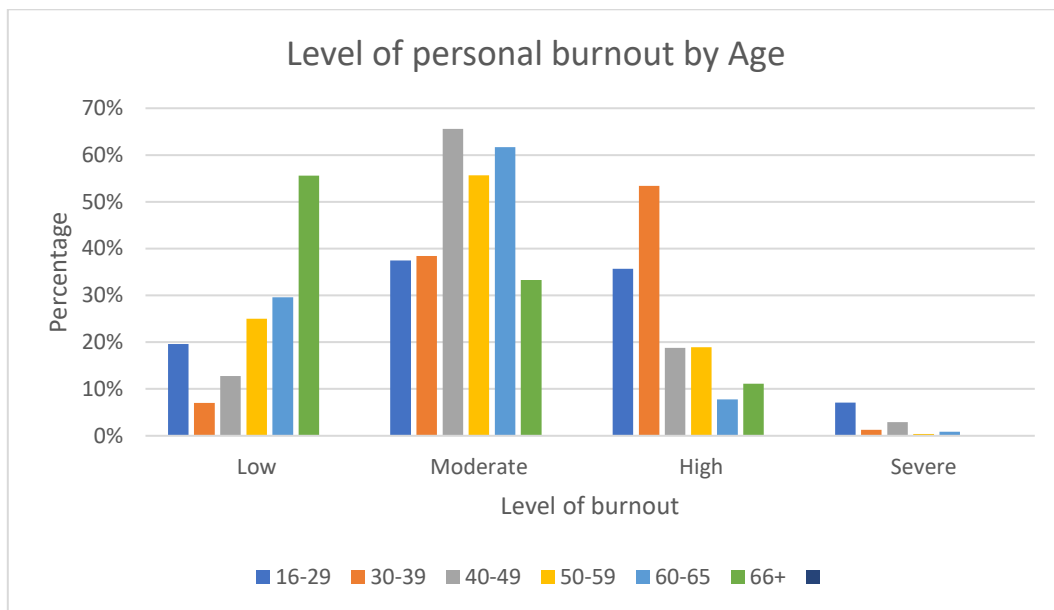


Figure A5.28: Level of Personal Burnout by Age (Unweighted)

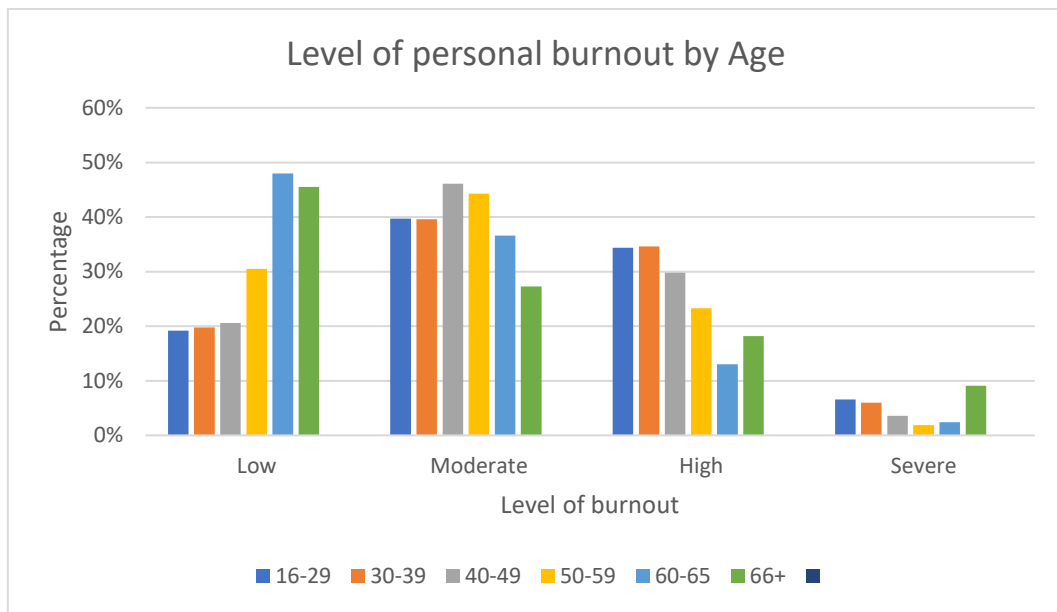


Figure A5.29: Level of Work-Related Burnout by Age (Weighted)

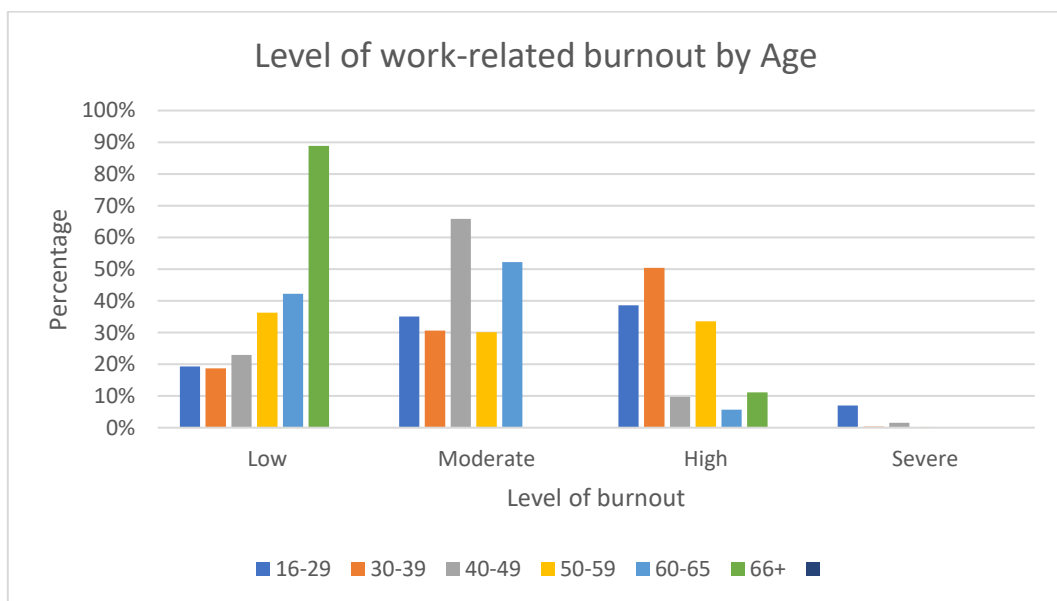


Figure A5.30: Level of Work-Related Burnout by Age (Unweighted)

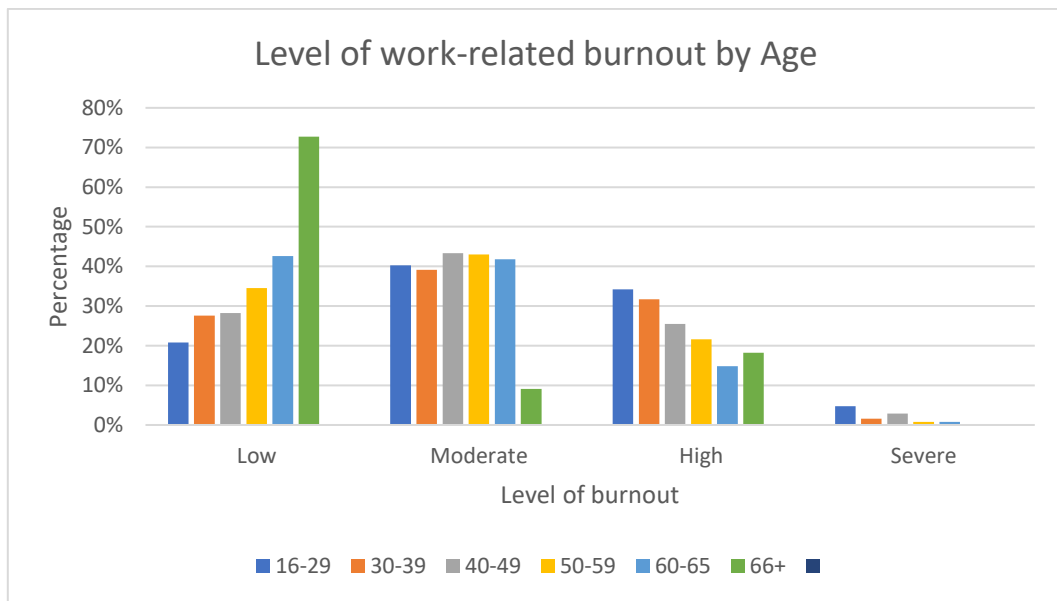


Figure A5.31: Level of Client-Related Burnout by Age (Weighted)

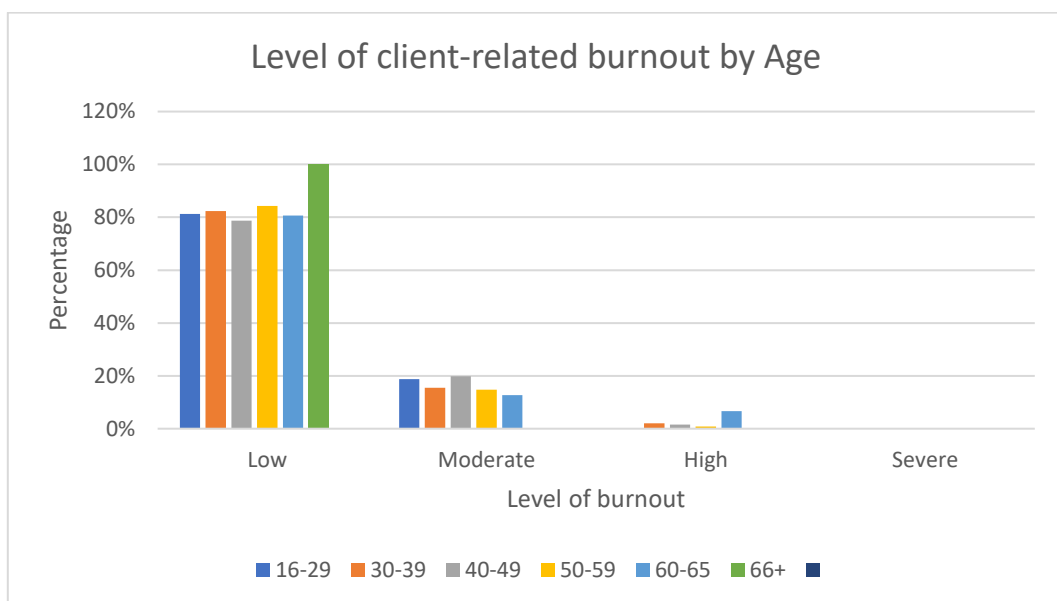


Figure A5.32: Level of Client-Related Burnout by Age (Unweighted)

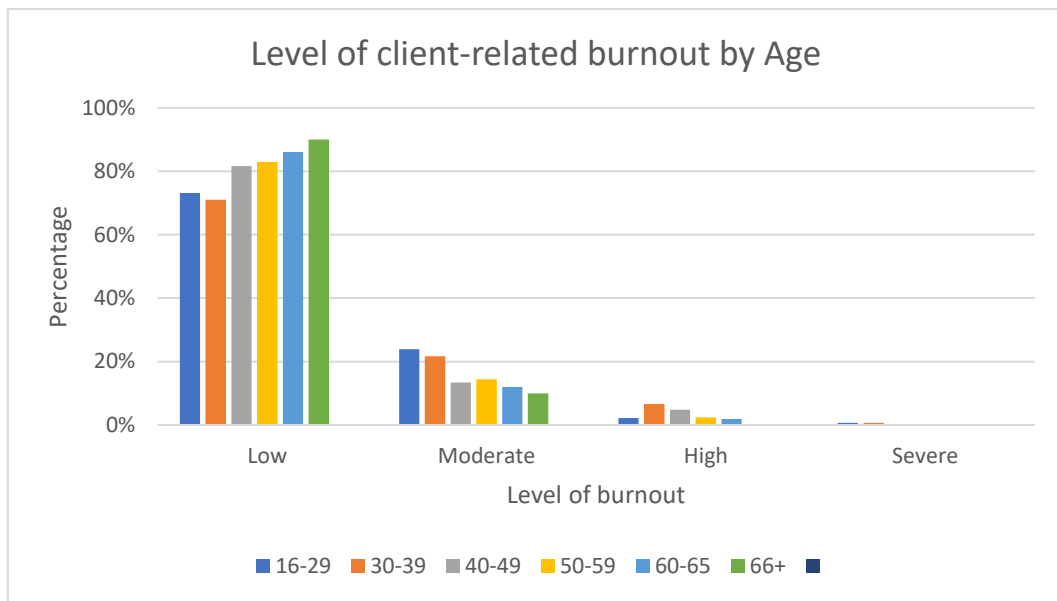


Table A5.15: Level of Burnout by Age (Weighted)

Burnout	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Personal burnout:						
Low	19.6%	7.0%	12.8%	25.0%	29.6%	55.6%
Moderate	37.5%	38.4%	65.6%	55.7%	61.7%	33.3%
High	35.7%	53.4%	18.8%	18.9%	7.8%	11.1%
Severe	7.1%	1.3%	2.9%	0.4%	0.9%	0.0%
Total	100%	100%	100%	100%	100%	100%
Work-related burnout:						
Low	19.3%	18.7%	22.9%	36.3%	42.2%	88.9%
Moderate	35.1%	30.6%	65.8%	30.1%	52.2%	0.0%
High	38.6%	50.4%	9.7%	33.5%	5.7%	11.1%
Severe	7.0%	0.3%	1.6%	0.2%	0.0%	0.0%
Total	100%	100%	100%	100%	100%	100%
Client-related burnout:						
Low	81.3%	82.4%	78.7%	84.3%	80.7%	100.0%
Moderate	18.8%	15.5%	19.8%	14.7%	12.7%	0.0%
High	0.0%	2.1%	1.5%	0.8%	6.6%	0.0%
Severe	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%
Total	100%	100%	100%	100%	100%	100%

Table A5.16: Level of Burnout by Age (Unweighted)

Burnout	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Personal burnout:						
Low	29 (19.2%)	63 (19.8%)	92 (20.6%)	148 (30.5%)	59 (48.0%)	5 (45.5%)
Moderate	60 (39.7%)	128 (39.6%)	206 (46.1%)	215 (44.3%)	45 (36.6%)	3 (27.3%)
High	52 (34.4%)	110 (34.6%)	133 (29.8%)	113 (23.3%)	16 (13.0%)	2 (18.2%)
Severe	10 (6.6%)	19 (6.0%)	16 (3.6%)	9 (1.9%)	3 (2.4%)	1 (9.1%)
Total	151 (100%)	318 (100%)	447 (100%)	485 (100%)	123 (100%)	11 (100%)
Work-related burnout:						
Low	31 (20.8%)	86 (27.6%)	125 (28.2%)	166 (34.5%)	52 (42.6%)	8 (72.7%)
Moderate	60 (40.3%)	122 (39.1%)	192 (43.3%)	207 (43.0%)	51 (41.8%)	1 (9.1%)
High	51 (34.2%)	99 (31.7%)	113 (25.5%)	104 (21.6%)	18 (14.8%)	2 (18.2%)
Severe	7 (4.7%)	5 (1.6%)	13 (2.9%)	4 (0.8%)	1 (0.8%)	0 (0.0%)
Total	149 (100%)	312 (100%)	443 (100%)	481 (100%)	122 (100%)	11 (100%)
Client-related burnout:						
Low	98 (73.1%)	206 (71.0%)	341 (81.6%)	374 (82.9%)	93 (86.1%)	9 (90.0%)
Moderate	32 (23.9%)	63 (21.7%)	56 (13.4%)	65 (14.4%)	13 (12.0%)	1 (10.0%)
High	3 (2.2%)	19 (6.6%)	20 (4.8%)	11 (2.4%)	2 (1.9%)	0 (0.0%)
Severe	1 (0.7%)	2 (0.7%)	1 (0.2%)	1 (0.2%)	0 (0.0%)	0 (0.0%)
Total	134 (100%)	290 (100%)	418 (100%)	451 (100%)	108 (100%)	10 (100%)

A5.5 Burnout Scores by Ethnicity

Summary (Weighted results):

There were no significant differences between the ethnic groups in mean personal burnout scores ($F = 1.72$, $df = 3$, $p > .05$) or work-related burnout scores ($F = 2.48$, $df = 3$, $p < .001$).

There were significant differences between the ethnic groups in mean client burnout scores ($F = 4.78$, $df = 3$, $p = .003$). Specifically, the black ethnic group scored significantly lower than the White and 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)

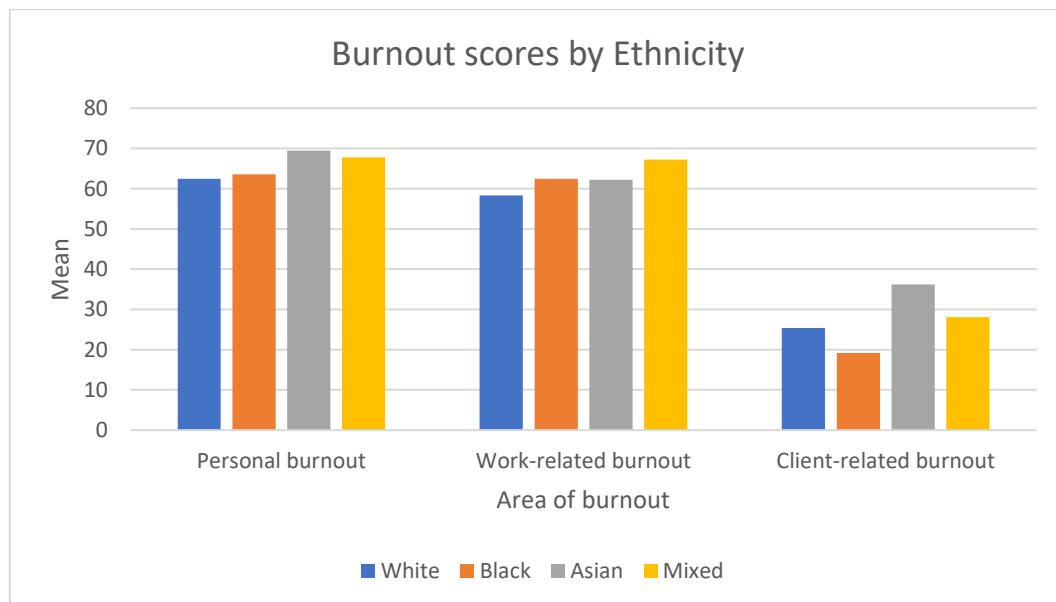


Figure A5.34: Mean Burnout Scores by Ethnicity (Unweighted)

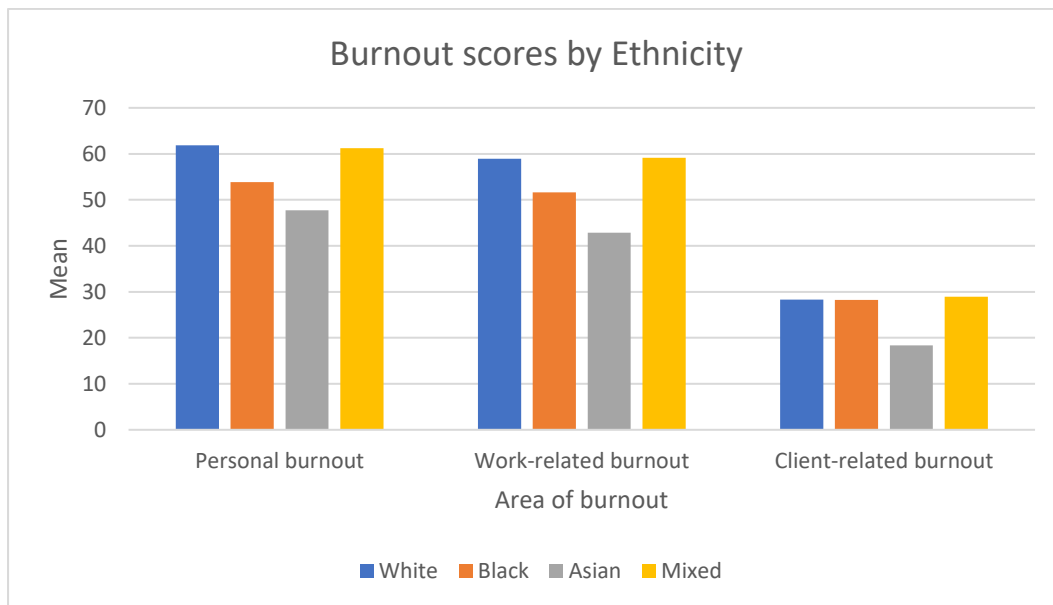


Table A5.17: Mean Burnout Scores by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	62.42	63.54	69.46	67.81
Work-related burnout	58.30	62.49	62.20	67.26
Client-related burnout	25.41	19.15	36.19	28.07

Table A5.18: Mean Burnout Scores by Ethnicity (Unweighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout	61.85	53.85	47.73	61.23
Work-related burnout	58.96	51.65	42.86	59.16
Client-related burnout	28.32	28.21	18.33	28.96

Figure A5.35: Level of Personal Burnout by Ethnicity (Weighted)

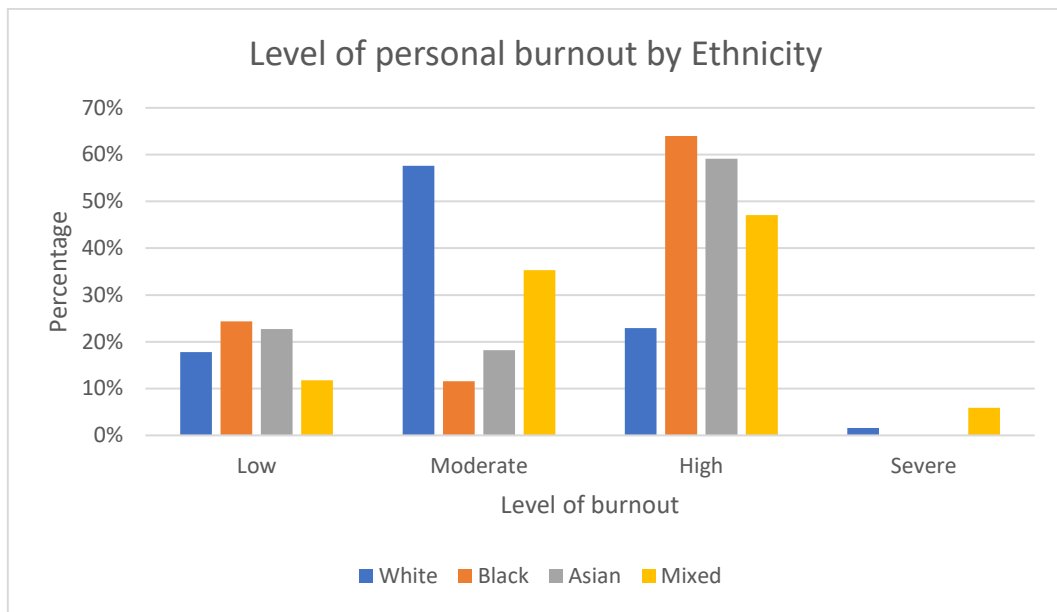


Figure A5.36: Level of Personal Burnout by Ethnicity (Unweighted)

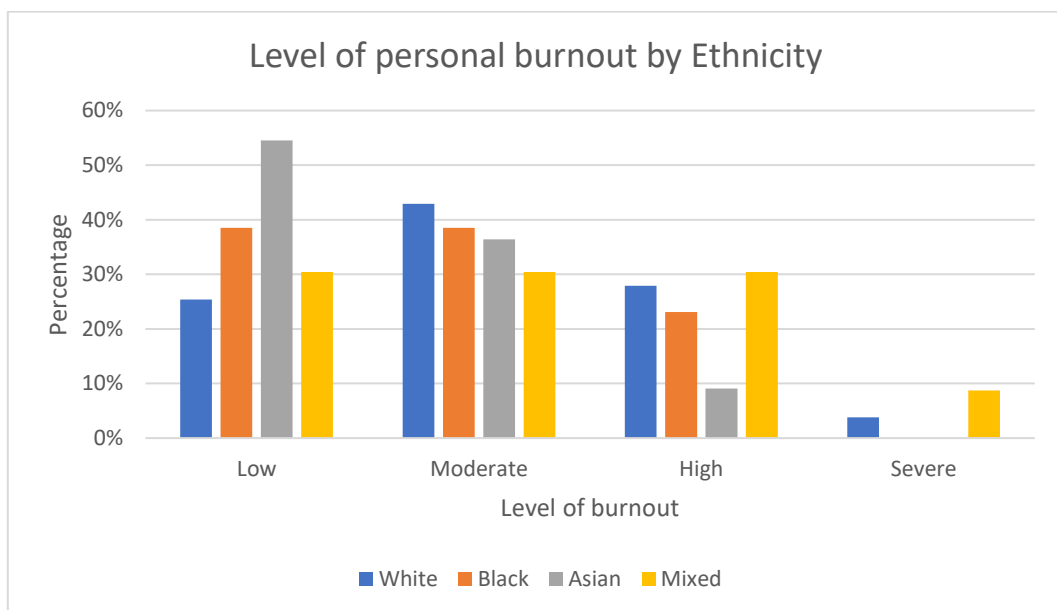


Figure A5.37: Level of Work-Related Burnout by Ethnicity (Weighted)

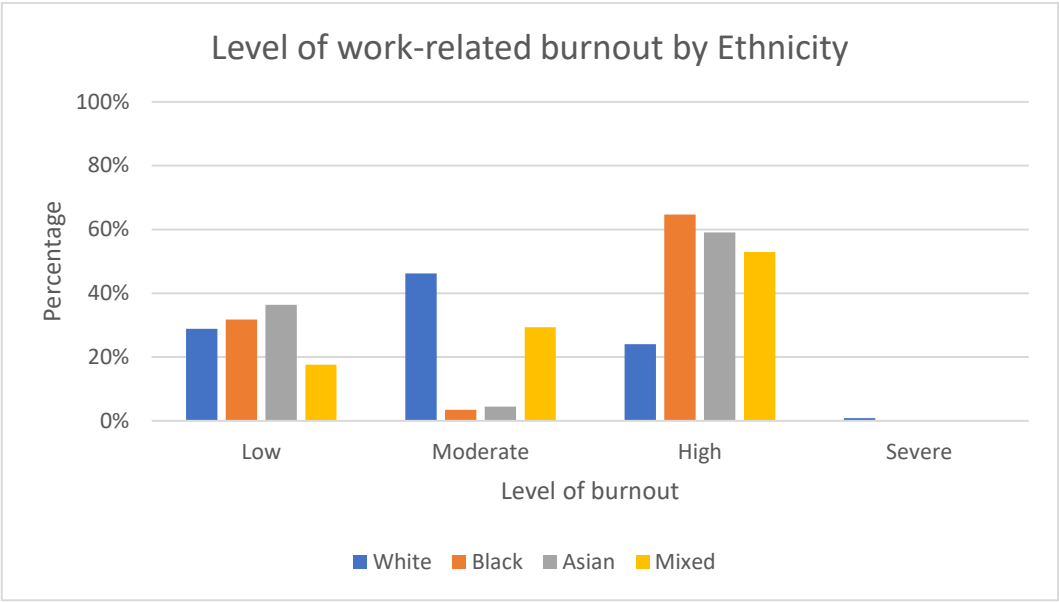


Figure A5.38: Level of Work-Related Burnout by Ethnicity (Unweighted)

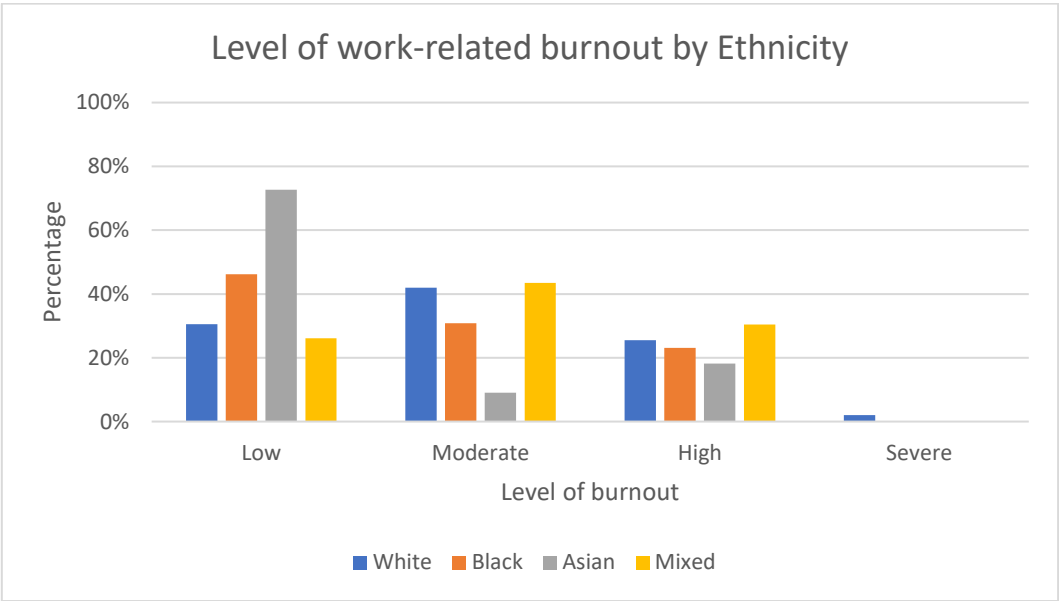


Figure A5.39: Level of Client-Related Burnout by Ethnicity (Weighted)

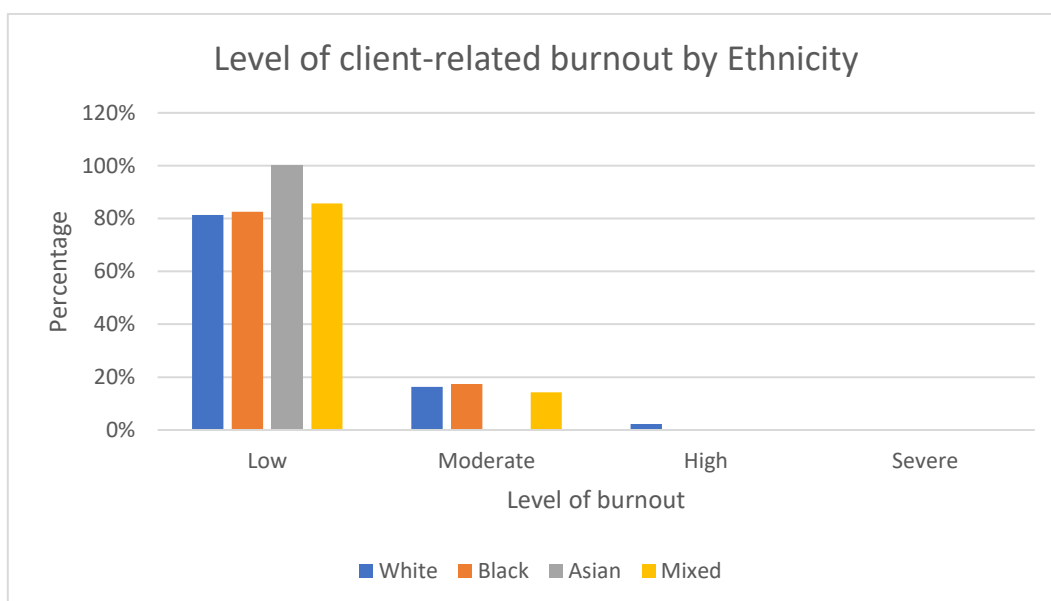


Figure A5.40: Level of Client-Related Burnout by Ethnicity (Unweighted)

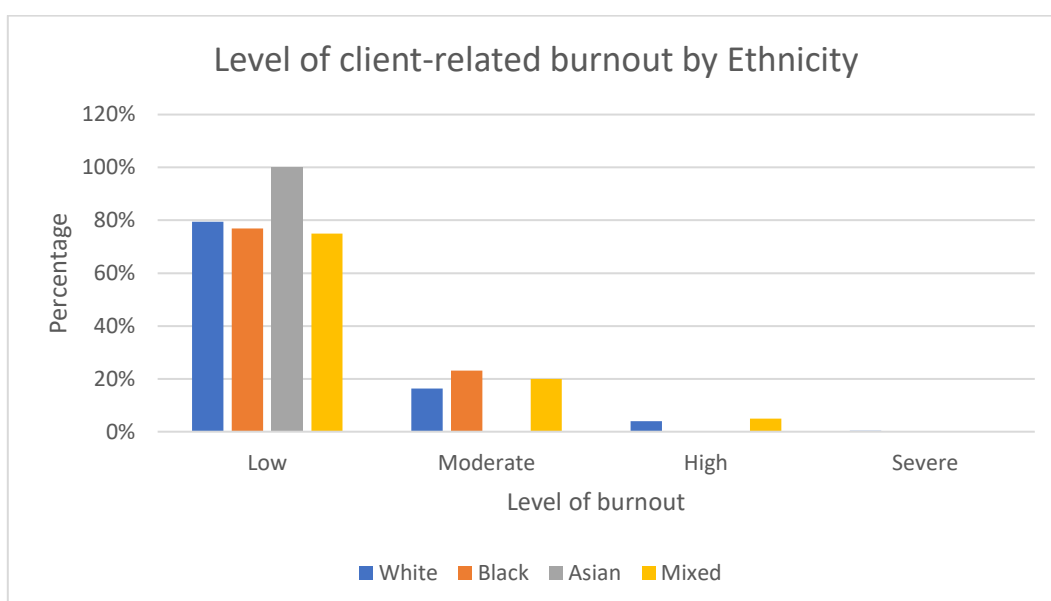


Table A5.19: Level of Burnout by Ethnicity (Weighted)

Burnout	Ethnicity			
	White	Black	Asian	Mixed
Personal burnout:				
Low	17.8%	24.4%	22.7%	11.8%
Moderate	57.6%	11.6%	18.2%	35.3%
High	22.9%	64.0%	59.1%	47.1%
Severe	1.6%	0.0%	0.0%	5.9%
Total	100%	100%	100%	100%
Work-related burnout:				
Low	28.9%	31.8%	36.4%	17.6%
Moderate	46.2%	3.5%	4.5%	29.4%
High	24.0%	64.7%	59.1%	52.9%
Severe	0.9%	0.0%	0.0%	0.0%
Total	100%	100%	100%	100%
Client-related burnout:				
Low	81.4%	82.6%	100.0%	85.7%
Moderate	16.3%	17.4%	0.0%	14.3%
High	2.2%	0.0%	0.0%	0.0%
Severe	0.1%	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	378 (25.4%)	5 (38.5%)	6 (54.5%)	7 (30.4%)
Moderate	637 (42.9%)	5 (38.5%)	4 (36.4%)	7 (30.4%)
High	415 (27.9%)	3 (23.1%)	1 (9.1%)	7 (30.4%)
Severe	56 (3.8%)	0 (0.0%)	0 (0.0%)	2 (8.7%)
Total	1486 (100%)	13 (100%)	11 (100%)	23 (100%)
Work-related burnout:				
Low	448 (30.5%)	6 (46.2%)	8 (72.7%)	6 (26.1%)
Moderate	617 (42.0%)	4 (30.8%)	1 (9.1%)	10 (43.5%)
High	374 (25.5%)	3 (23.1%)	2 (18.2%)	7 (30.4%)
Severe	30 (2.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	1469 (100%)	13 (100%)	11 (100%)	23 (100%)
Client-related burnout:				
Low	1085 (79.4%)	10 (76.9%)	10 (100.0%)	15 (75.0%)
Moderate	222 (16.3%)	3 (23.1%)	0 (0.0%)	4 (20.0%)
High	54 (4.0%)	0 (0.0%)	0 (0.0%)	1 (5.0%)
Severe	5 (0.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	1366 (100%)	13 (100%)	10 (100%)	20 (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 ($F = 40.61$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who were not sure of whether or not they had a disability.

There were significant differences between respondents based on their disability status in mean work-related burnout scores ($F = 5.73$, $df = 2$, $p = .003$). Specifically, those who were unsure of if they had a disability scored significantly higher than those who had a disability and those that did not have a disability.

There were significant differences between respondents based on their disability status in mean client burnout scores ($F = 4.20$, $df = 2$, $p = .015$). Specifically, those who did not have a disability scored significantly higher than those who did have a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean personal burnout scores ($F = 17.23$, $df = 2$, $p < .001$). Specifically, those who did not have a disability scored significantly lower than those who did have a disability and those who were unsure of whether or not they had a disability.

There were also significant differences between respondents based on their disability status in mean work-related burnout scores ($F = 5.13$, $df = 2$, $p = .006$). Those who did not have a disability scored significantly lower than those who did have a disability.

Significant differences between respondents based on their disability status were also found in mean client-related burnout scores ($F = 4.84$, $df = 2$, $p = .008$). Those who did not have a disability scored significantly lower than those who did have a disability.

Figure A5.41: Mean Burnout Scores by Disability (Weighted)

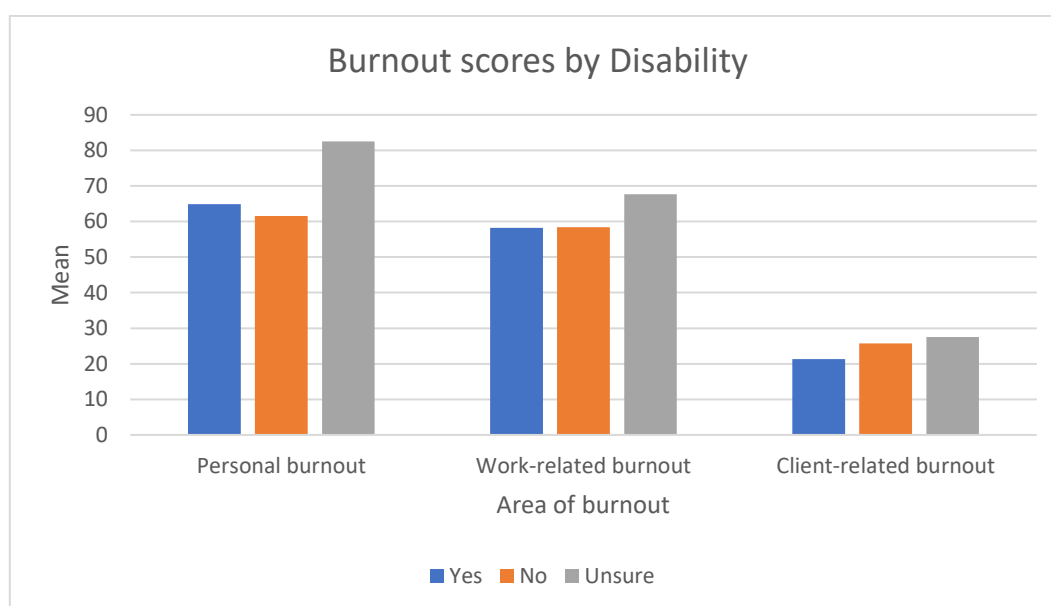


Figure A5.42: Mean Burnout Scores by Disability (Unweighted)

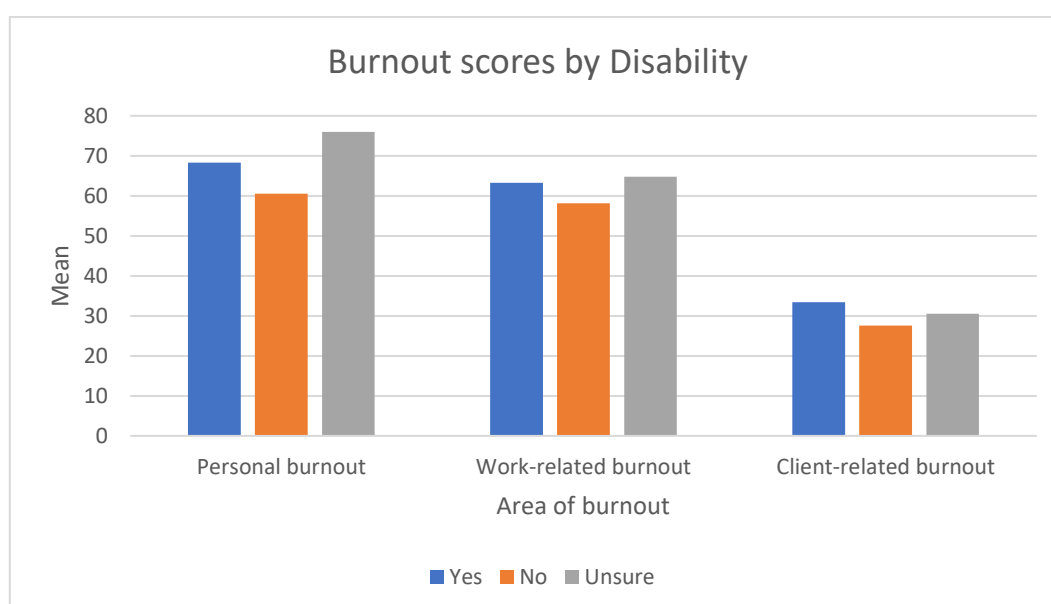


Table A5.21: Mean Burnout Scores by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	64.87	61.56	82.5
Work-related burnout	58.25	58.36	67.64
Client-related burnout	21.35	25.69	27.49

Table A5.22: Mean Burnout Scores by Disability (Unweighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout	68.28	60.55	75.97
Work-related burnout	63.28	58.11	64.76
Client-related burnout	33.44	27.58	30.51

Figure A5.43: Level of Personal Burnout by Disability (Weighted)

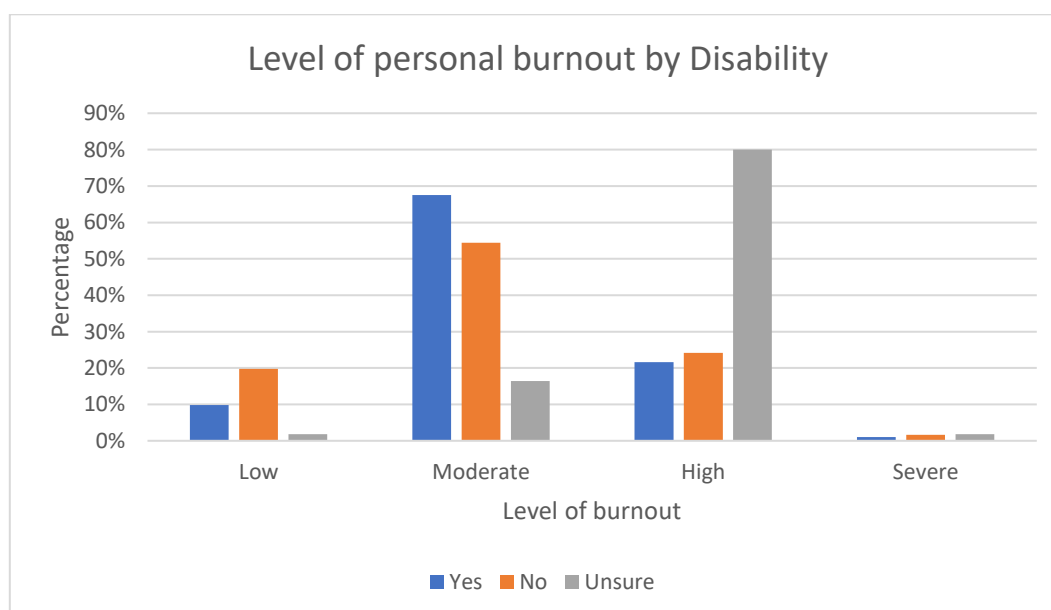


Figure A5.44: Level of Personal Burnout by Disability (Unweighted)

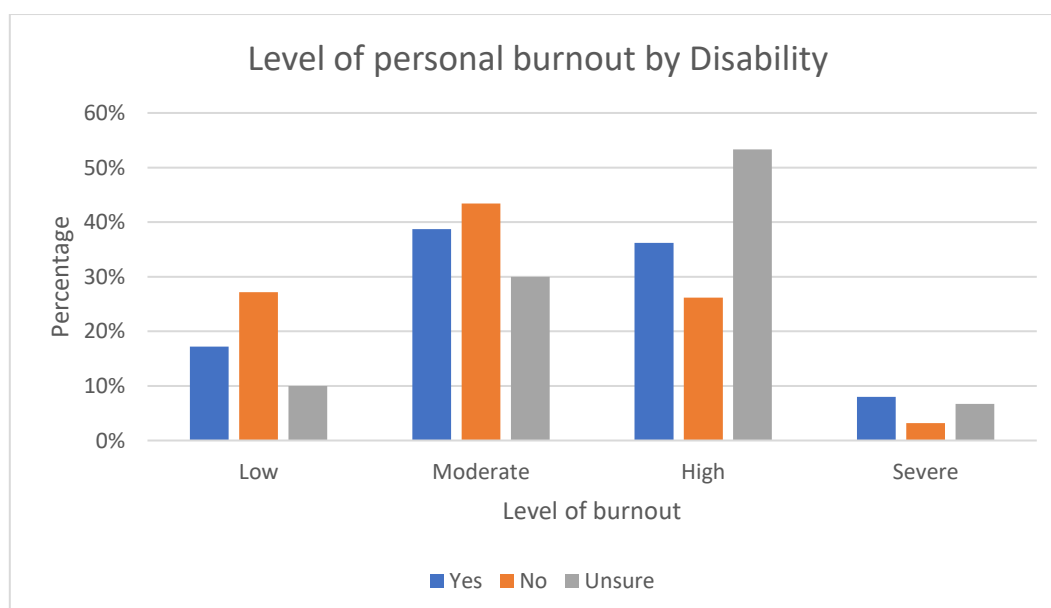


Figure A5.45: Level of Work-Related Burnout by Disability (Weighted)

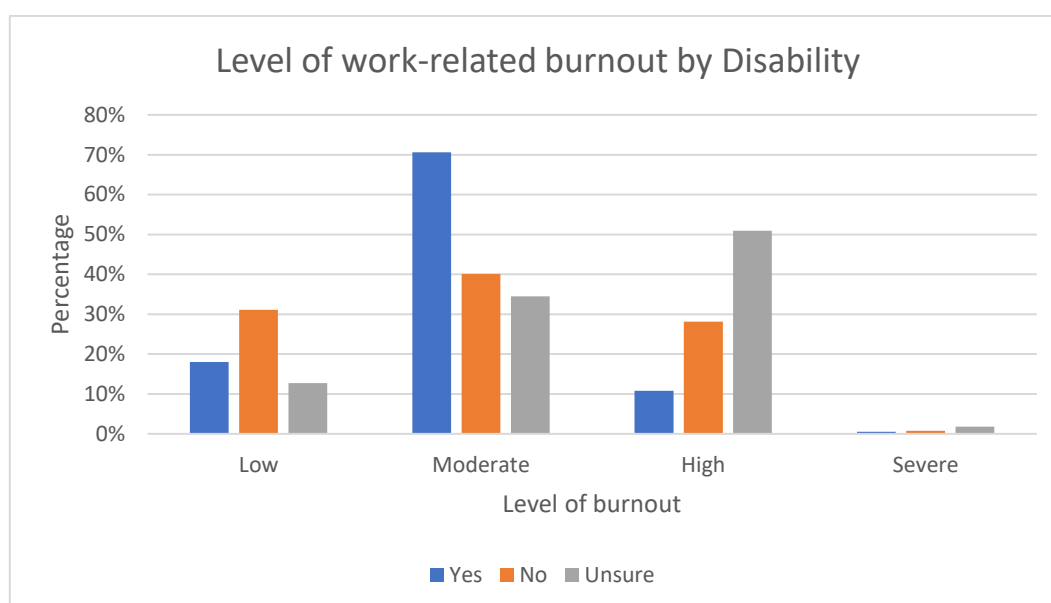


Figure A5.46: Level of Work-Related Burnout by Disability (Unweighted)

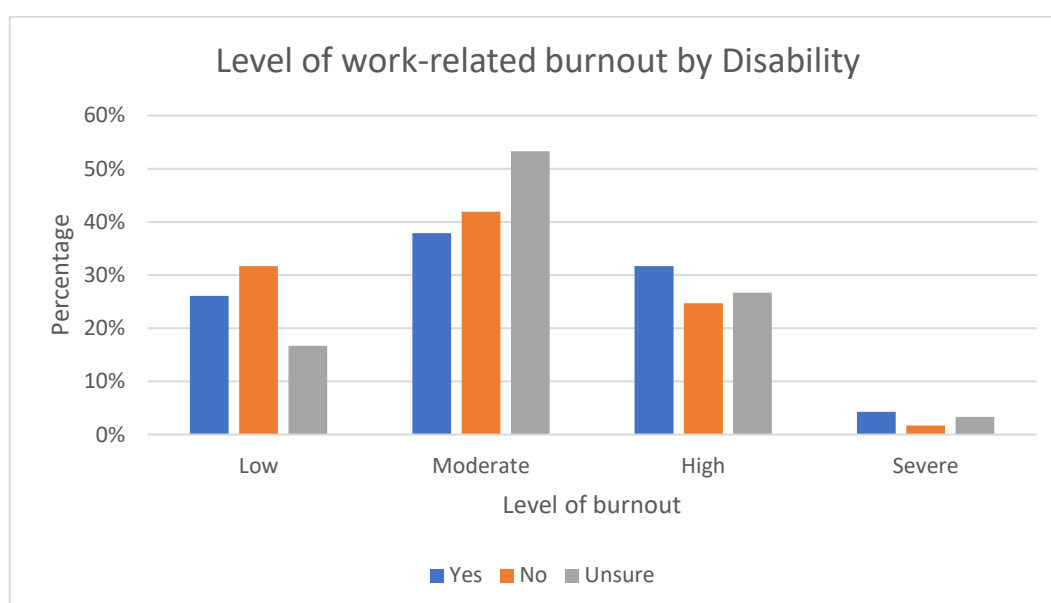


Figure A5.47: Level of Client-Related Burnout by Disability (Weighted)

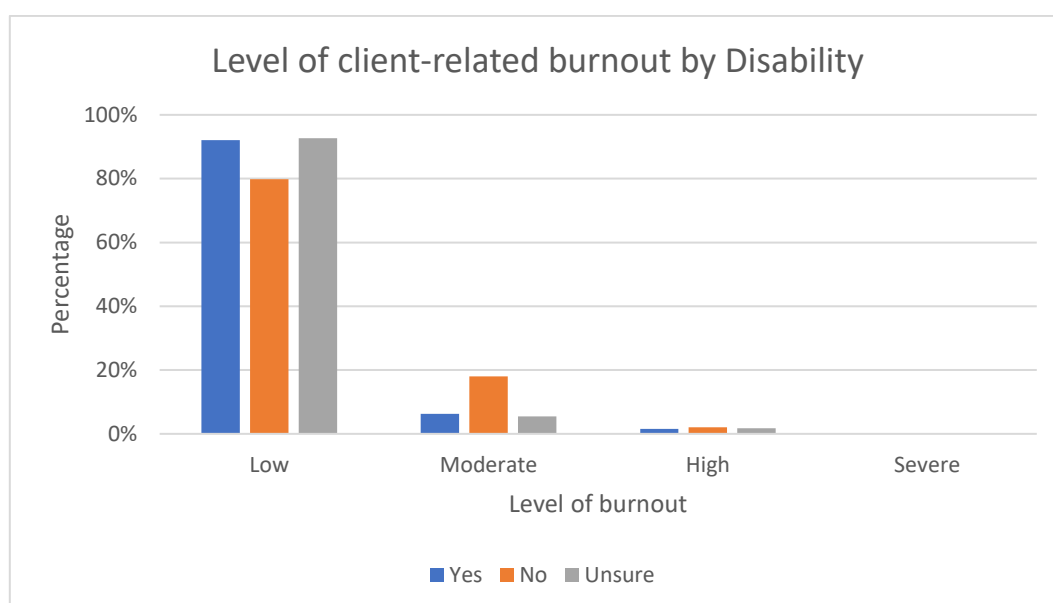


Figure A5.48: Level of Client-Related Burnout by Disability (Unweighted)

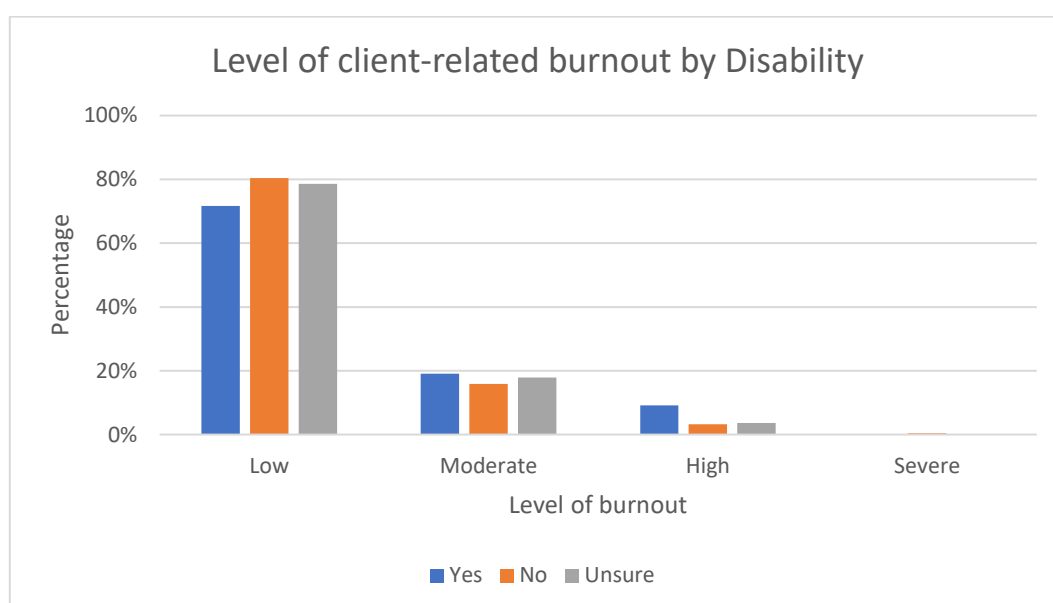


Table A5.23: Level of Burnout by Disability (Weighted)

Burnout	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Personal burnout:			
Low	9.8%	19.8%	1.8%
Moderate	67.5%	54.4%	16.4%
High	21.6%	24.2%	80.0%
Severe	1.0%	1.6%	1.8%
Total	100%	100%	100%
Work-related burnout:			
Low	18.0%	31.1%	12.7%
Moderate	70.6%	40.1%	34.5%
High	10.8%	28.1%	50.9%
Severe	0.5%	0.8%	1.8%
Total	100%	100%	100%
Client-related burnout:			
Low	92.1%	79.8%	92.7%
Moderate	6.3%	18.0%	5.5%
High	1.6%	2.1%	1.8%
Severe	0.0%	0.1%	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	28 (17.2%)	365 (27.2%)	3 (10.0%)
Moderate	63 (38.7%)	583 (43.4%)	9 (30.0%)
High	59 (36.2%)	351 (26.2%)	16 (53.3%)
Severe	13 (8.0%)	43 (3.2%)	2 (6.7%)
Total	163 (100%)	1342 (100%)	30 (100%)
Work-related burnout:			
Low	42 (26.1%)	421 (31.7%)	5 (16.7%)
Moderate	61 (37.9%)	556 (41.9%)	16 (53.3%)
High	51 (31.7%)	328 (24.7%)	8 (26.7%)
Severe	7 (4.3%)	22 (1.7%)	1 (3.3%)
Total	161 (100%)	1327 (100%)	66 (100%)
Client-related burnout:			
Low	109 (71.7%)	990 (80.4%)	22 (78.6%)
Moderate	29 (19.1%)	196 (15.9%)	5 (17.9%)
High	14 (9.2%)	40 (3.2%)	1 (3.6%)
Severe	0 (0.0%)	5 (0.4%)	0 (0.0%)
Total	152 (100%)	1231 (100%)	28 (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 ($F = 10.93$, $df = 7$, $p < .001$). Specifically, respondents working with children and young people scored significantly higher in personal burnout than those working with adults of working age, with older people, in mental health or in the area of 'other'.

There were also significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 5.12$, $df = 7$, $p < .001$). Respondents working in midwifery had higher scores than those working with adults of working age or those in the area of practice 'other'.

Significant differences were also found in the mean client-related burnout scores ($F = 7.38$, $df = 7$, $p < .001$). Respondents working with adults of working age scored higher than those working in learning disability, with older people and in the area of practice 'other'.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean personal burnout scores ($F = 4.06$, $df = 7$, $p < .001$). Specifically, respondents working in midwifery scored significantly higher than those working with children, in the area of mental health or those in 'other' areas.

There were significant differences between respondents based on their main area of practice in mean work-related burnout scores ($F = 4.43$, $df = 7$, $p < .001$). Specifically, respondents working in midwifery scored significantly higher than those working with children, in the area of mental health or those in 'other' areas.

There were no significant differences between respondents based on their main area of practice in mean client-related burnout scores ($F = 1.52$, $df = 7$, $p = .157$).

Figure A5.49: Mean Burnout Scores by Main Area of Practice (Weighted)

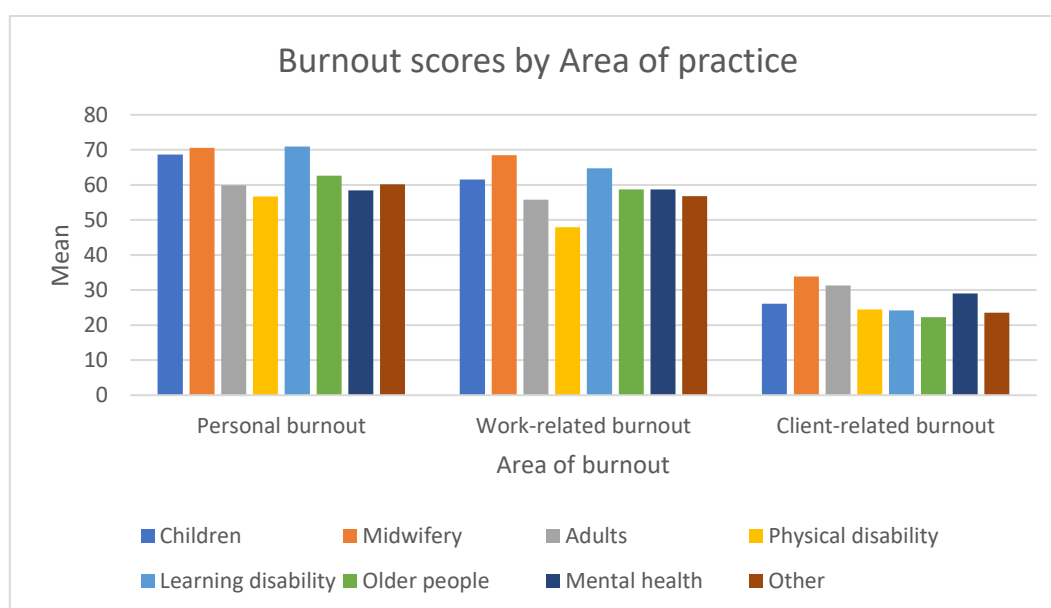


Figure A5.50: Mean Burnout Scores by Main Area of Practice (Unweighted)

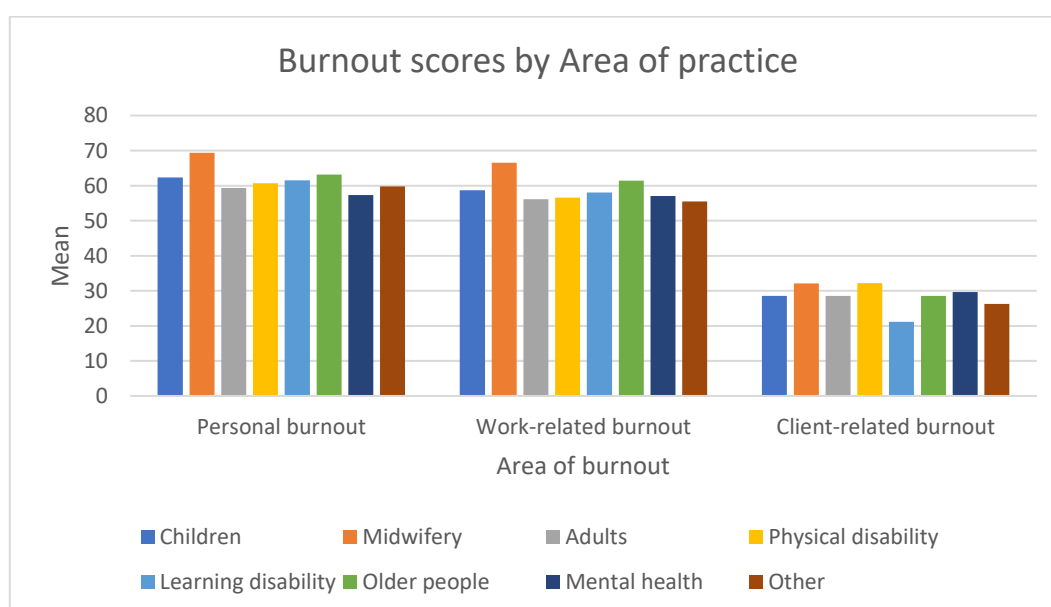


Table A5.25: Mean Burnout Scores by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout	68.63	70.61	59.95	56.71	70.92	62.68	58.42	60.14
Work-related burnout	61.59	68.46	55.82	47.96	64.70	58.74	58.74	56.80
Client-related burnout	26.11	33.83	31.30	24.46	24.17	22.24	29.02	23.51

Table A5.26: Mean Burnout Scores by Main Area of Practice (Unweighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout	62.31	69.40	59.30	60.71	61.53	63.16	57.28	59.78
Work-related burnout	58.68	66.55	56.15	56.56	58.06	61.46	57.02	55.50
Client-related burnout	28.52	32.07	28.56	32.24	21.12	28.57	29.6	26.27

Figure A5.51: Level of Personal Burnout by Main Area of Practice (Weighted)

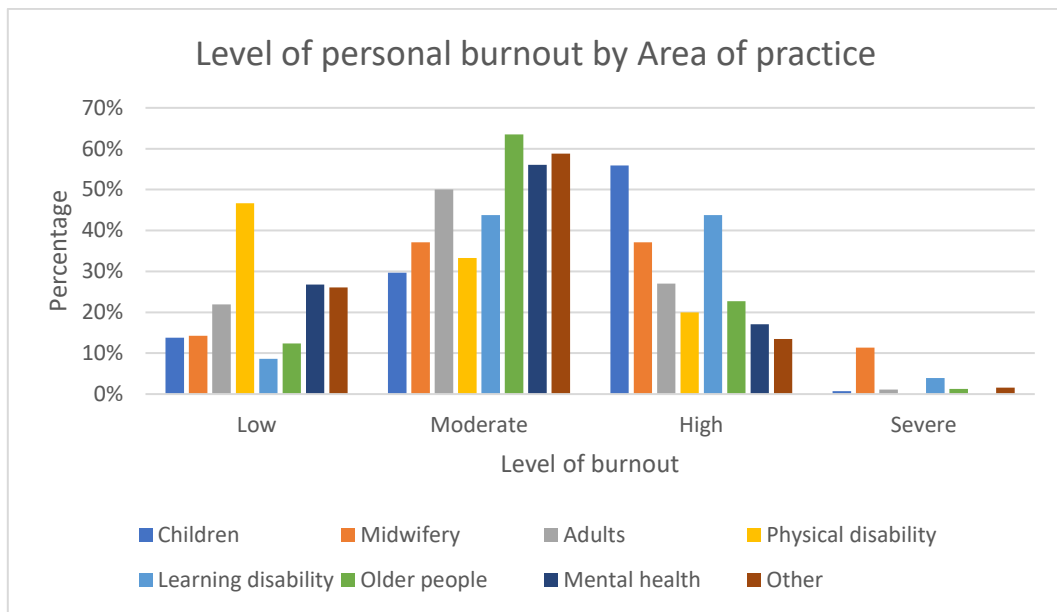


Figure A5.52: Level of Personal Burnout by Main Area of Practice (Unweighted)

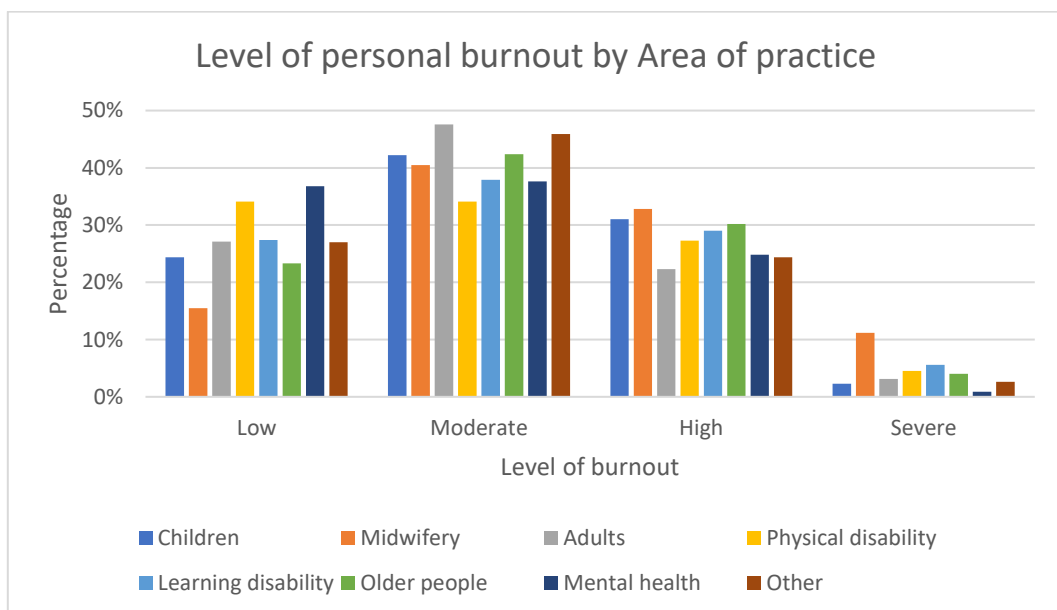


Figure A5.53: Level of Work-Related Burnout by Main Area of Practice (Weighted)

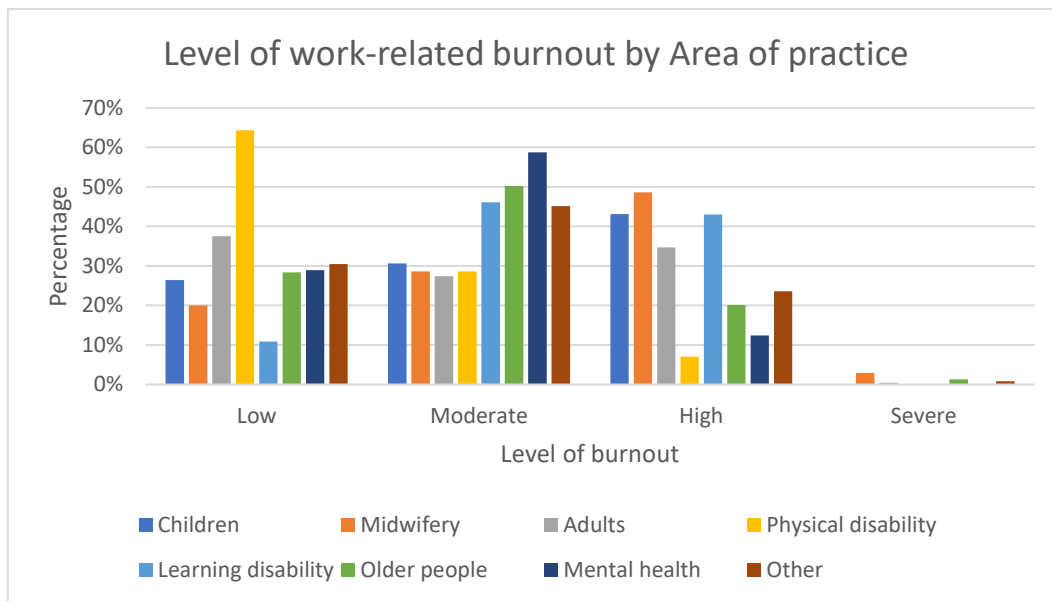


Figure A5.54: Level of Work-Related Burnout by Main Area of Practice (Unweighted)

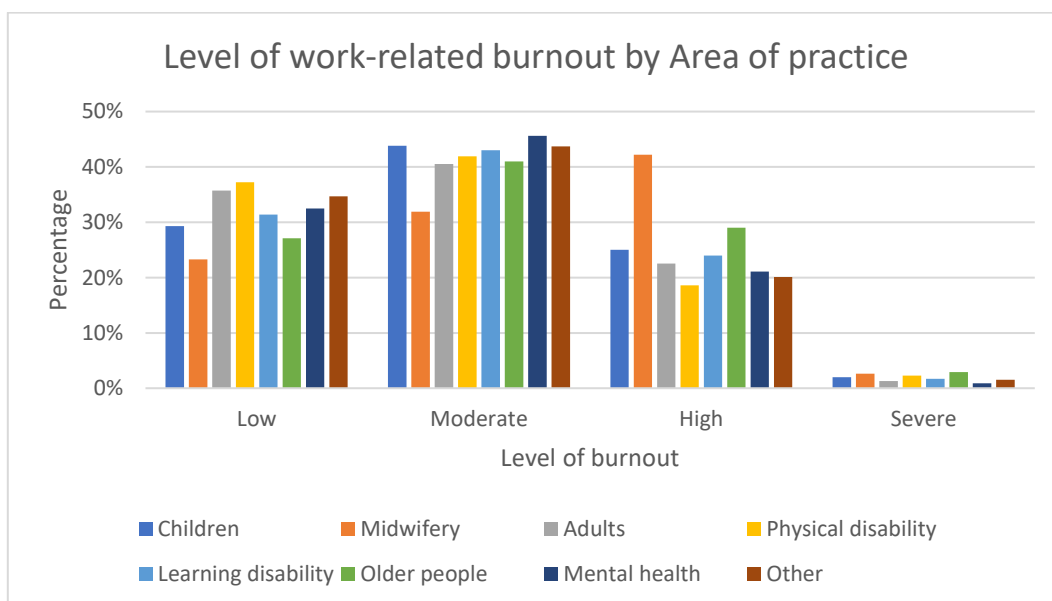


Figure A5.55: Level of Client-Related Burnout by Main Area of Practice (Weighted)

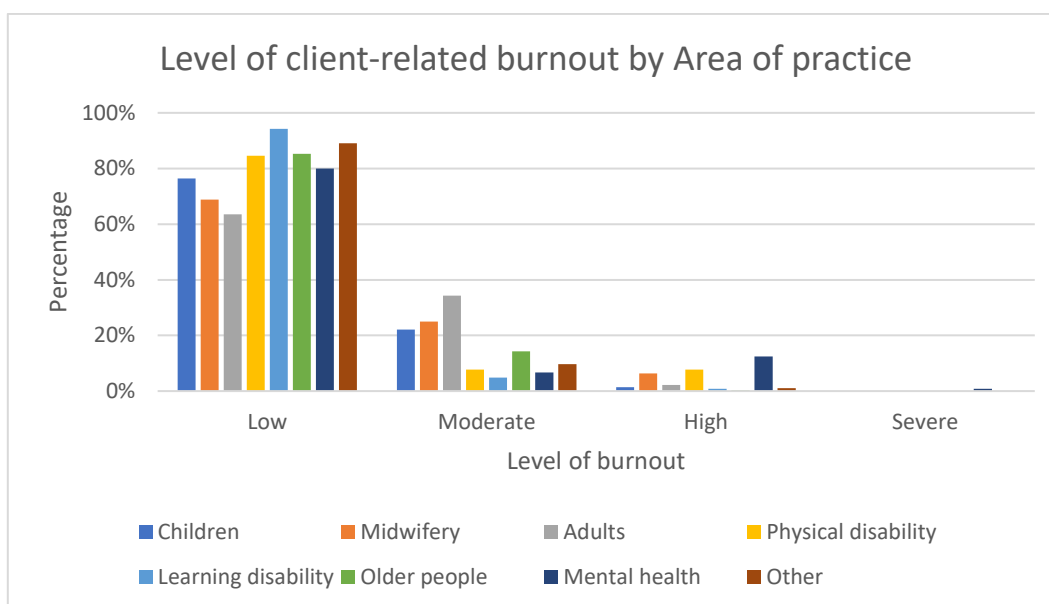


Figure A5.56: Level of Client-Related Burnout by Main Area of Practice (Unweighted)

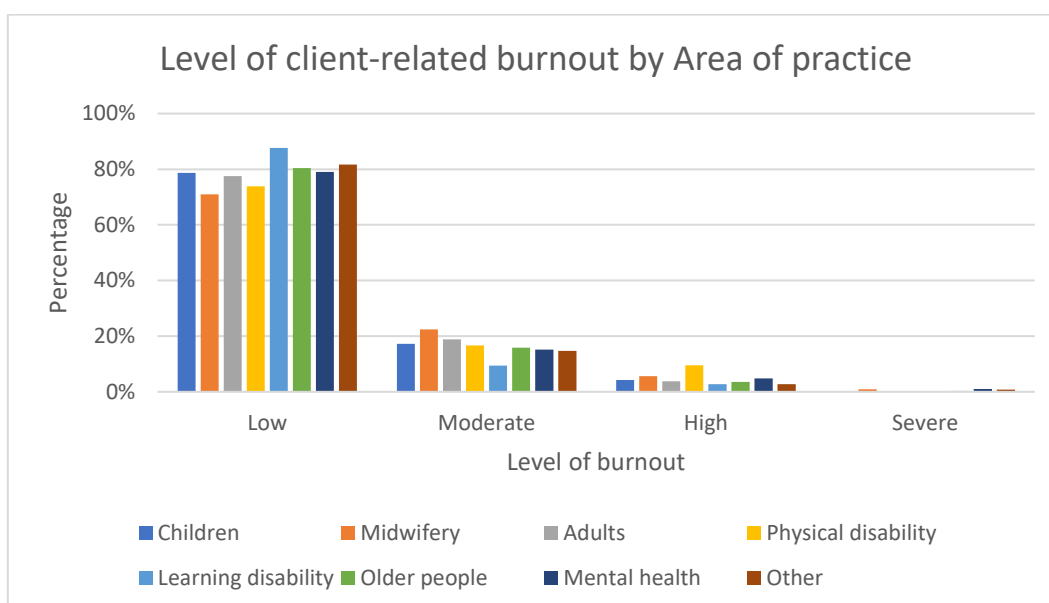


Table A5.27: Level of Burnout by Main Area of Practice (Weighted)

Burnout	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Personal burnout:								
Low	13.8%	14.3%	21.9%	46.7%	8.6%	12.4%	26.8%	26.1%
Moderate	29.7%	37.1%	50.0%	33.3%	43.8%	63.5%	56.1%	58.8%
High	55.9%	37.1%	27.0%	20.0%	43.8%	22.7%	17.1%	13.5%
Severe	0.7%	11.4%	1.1%	0.0%	3.9%	1.3%	0.0%	1.6%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Work-related burnout:								
Low	26.4%	20.0%	37.5%	64.3%	10.9%	28.4%	28.9%	30.5%
Moderate	30.6%	28.6%	27.4%	28.6%	46.1%	50.2%	58.7%	45.1%
High	43.1%	48.6%	34.7%	7.1%	43.0%	20.1%	12.4%	23.6%
Severe	0.0%	2.9%	0.4%	0.0%	0.0%	1.3%	0.0%	0.8%
Total	100%	100%	100%	100%	100%	100%	100%	100%
Client-related burnout:								
Low	76.4%	68.8%	63.5%	84.6%	94.3%	85.3%	80.0%	89.1%
Moderate	22.1%	25.0%	34.3%	7.7%	4.9%	14.3%	6.7%	9.7%
High	1.4%	6.3%	2.2%	7.7%	0.8%	0.3%	12.5%	1.1%
Severe	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	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	63 (24.4%)	18 (15.5%)	62 (27.1%)	15 (34.1%)	34 (27.4%)	88 (23.3%)	43 (36.8%)	73 (27.0%)
Moderate	109 (42.2%)	47 (40.5%)	109 (47.6%)	15 (34.1%)	47 (37.9%)	160 (42.4%)	44 (37.6%)	124 (45.9%)
High	80 (31.0%)	38 (32.8%)	51 (22.3%)	12 (27.3%)	36 (29.0%)	114 (30.2%)	29 (24.8%)	66 (24.4%)
Severe	6 (2.3%)	13 (11.2%)	7 (3.1%)	2 (4.5%)	7 (5.6%)	15 (4.0%)	1 (0.9%)	7 (2.6%)
Total	258 (100%)	116 (100%)	229 (100%)	44 (100%)	124 (100%)	377 (100%)	117 (100%)	270 (100%)
Work-related burnout:								
Low	75 (29.3%)	27 (23.3%)	81 (35.7%)	16 (37.2%)	38 (31.4%)	101 (27.1%)	37 (32.5%)	93 (34.7%)
Moderate	112 (43.8%)	37 (31.9%)	92 (40.5%)	18 (41.9%)	52 (43.0%)	153 (41.0%)	52 (45.6%)	117 (43.7%)
High	64 (25.0%)	49 (42.2%)	51 (22.5%)	8 (18.6%)	29 (24.0%)	108 (29.0%)	24 (21.1%)	54 (20.1%)
Severe	5 (2.0%)	3 (2.6%)	3 (1.3%)	1 (2.3%)	2 (1.7%)	11 (2.9%)	1 (0.9%)	4 (1.5%)
Total	256 (100%)	116 (100%)	227 (100%)	43 (100%)	121 (100%)	373 (100%)	114 (100%)	268 (100%)
Client-related burnout:								
Low	188 (78.7%)	75 (71.0%)	165 (77.5%)	31 (73.9%)	93 (87.7%)	279 (80.4%)	83 (79.0%)	206 (81.7%)
Moderate	41 (17.2%)	24 (22.4%)	40 (18.8%)	7 (16.7%)	10 (9.4%)	55 (15.9%)	16 (15.2%)	37 (14.7%)
High	10 (4.2%)	6 (5.6%)	8 (3.8%)	4 (9.5%)	3 (2.8%)	12 (3.5%)	5 (4.8%)	7 (2.8%)
Severe	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.3%)	1 (1.0%)	2 (0.8%)
Total	239 (100%)	107 (100%)	213 (100%)	42 (100%)	106 (100%)	347 (100%)	105 (100%)	252 (100%)

A5.8 Burnout Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between respondents based on their line manager status in mean person burnout scores ($t = 2.48$, $df = 1705$, $p = .013$); line managers scored significantly higher than respondents who were not line managers.

There were significant differences between respondents based on their line manager status in mean work-related burnout scores ($t = 3.76$, $df = 1695$, $p < .001$); line managers scored significantly higher than respondents who were not line managers.

There were also significant differences between respondents based on their line manager status in mean client-related burnout scores ($t = -2.09$, $df = 1635$, $p = .036$); 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 ($t = .59$, $df = 1532$, $p = .953$). There were no significant differences between respondents based on their line manager status in mean work-related burnout scores ($t = 1.72$, $df = 1515$, $p = .086$).

There were significant differences between respondents based on their line manager status in mean client-related burnout scores ($t = -4.47$, $df = 1408$, $p < .001$); 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)

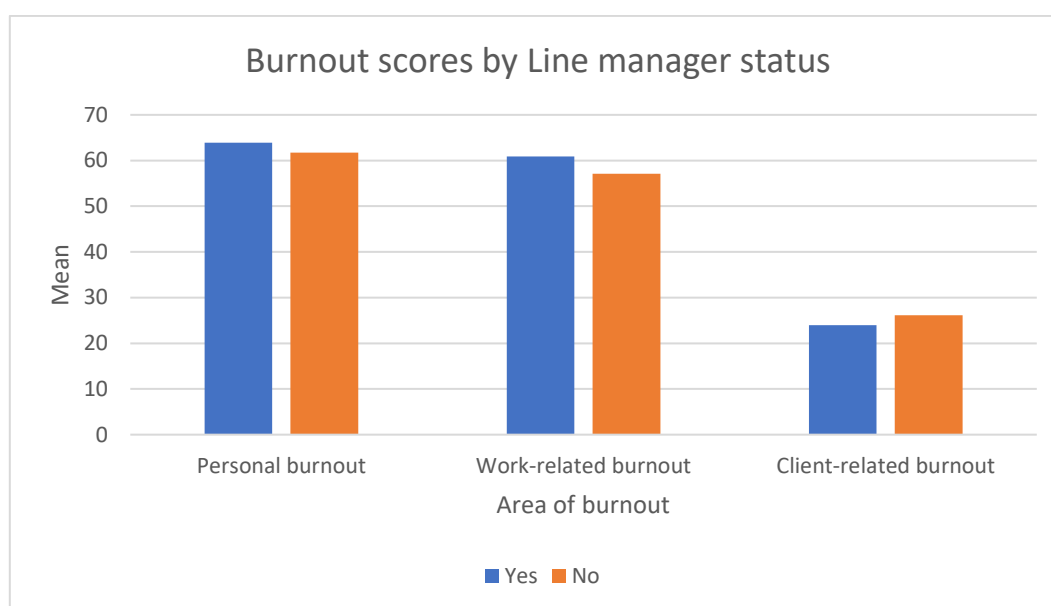


Figure A5.58: Mean Burnout Scores by Line Manager Status (Unweighted)

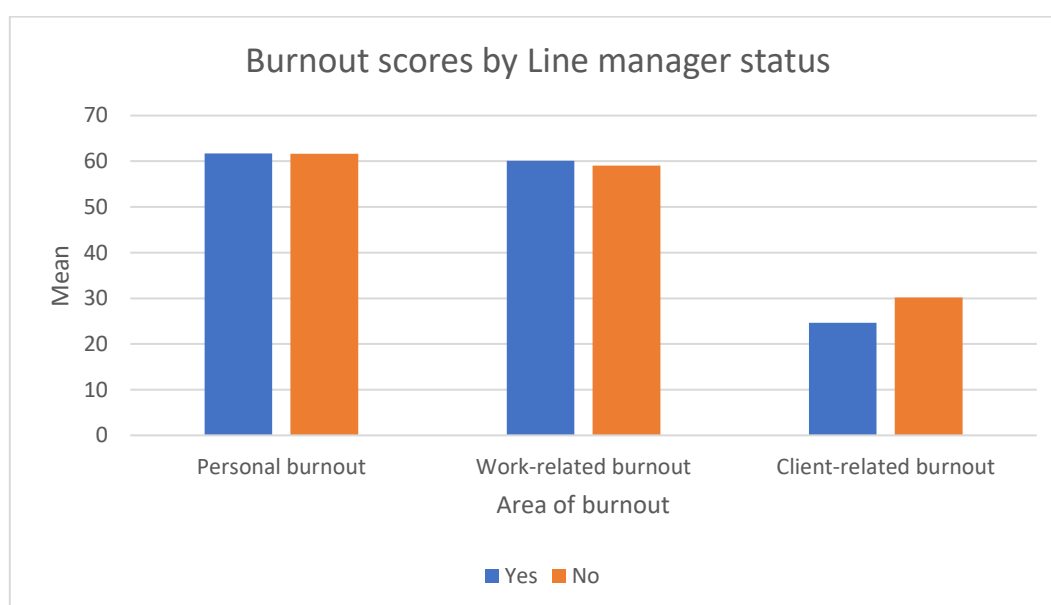


Table A5.29: Mean Burnout Scores by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	63.91	61.73
Work-related burnout	60.89	57.14
Client-related burnout	23.99	26.12

Table A5.30: Mean Burnout Scores by Line Manager Status (Unweighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout	61.70	61.64
Work-related burnout	60.13	59.08
Client-related burnout	24.61	30.18

Figure A5.59: Level of Personal Burnout by Line Manager Status (Weighted)

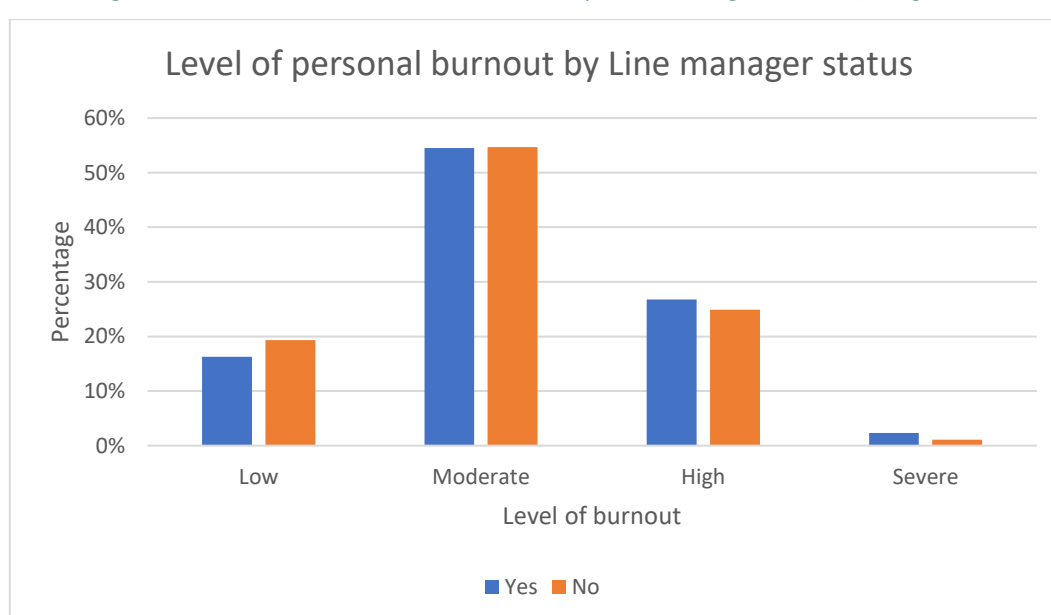


Figure A5.60: Level of Personal Burnout by Line Manager Status (Unweighted)

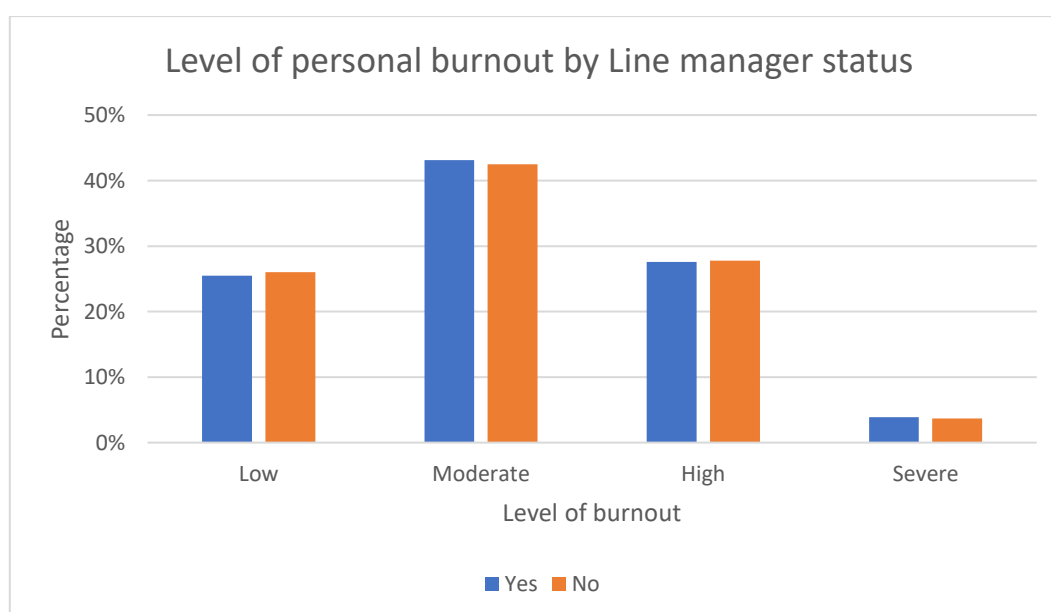


Figure A5.61: Level of Work-Related Burnout by Line Manager Status (Weighted)

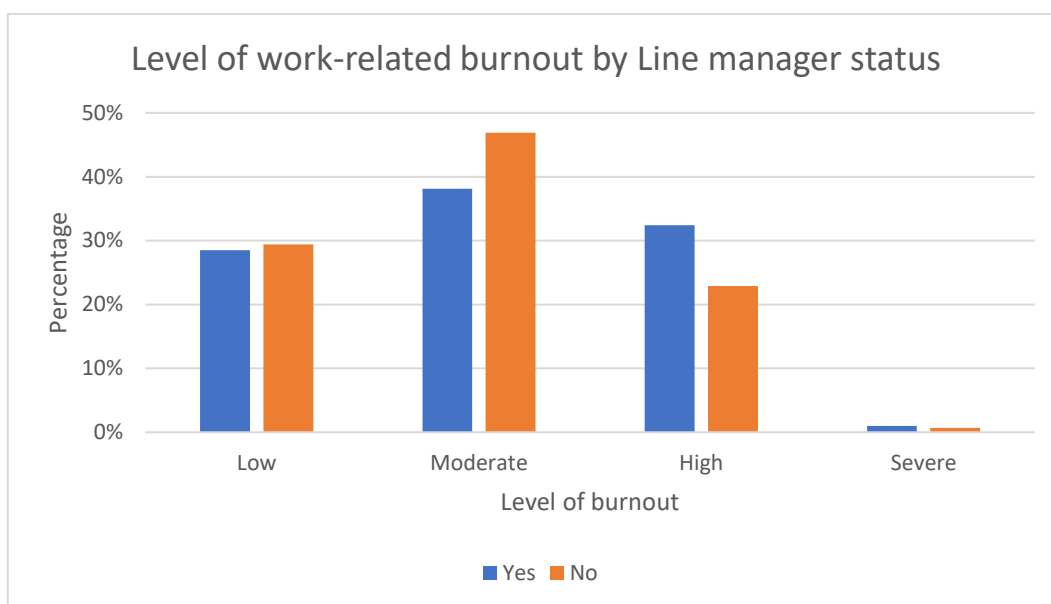


Figure A5.62: Level of Work-Related Burnout by Line Manager Status (Unweighted)

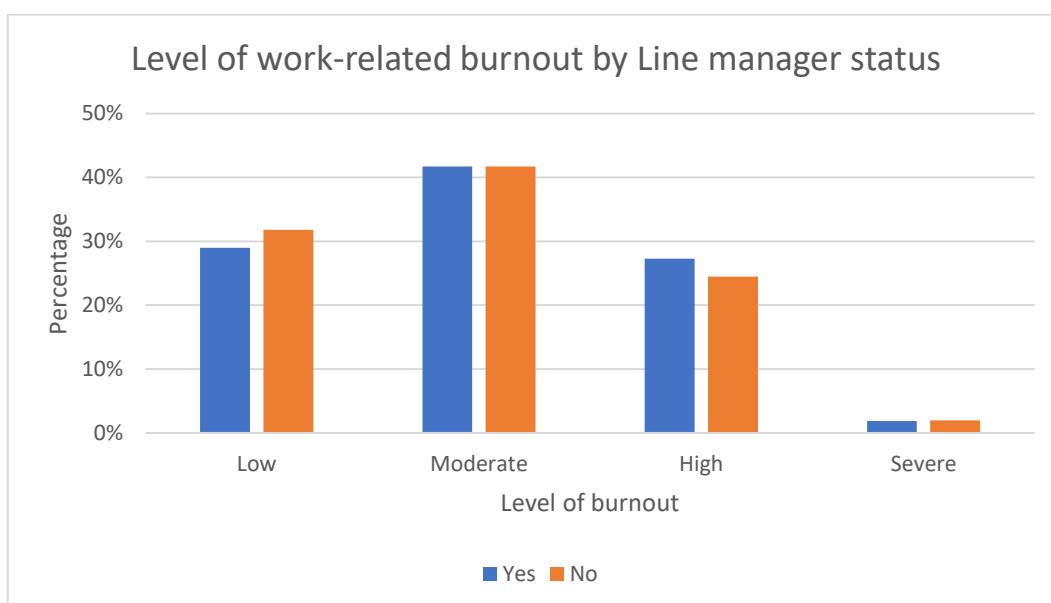


Figure A5.63: Level of Client-Related Burnout by Line Manager Status (Weighted)

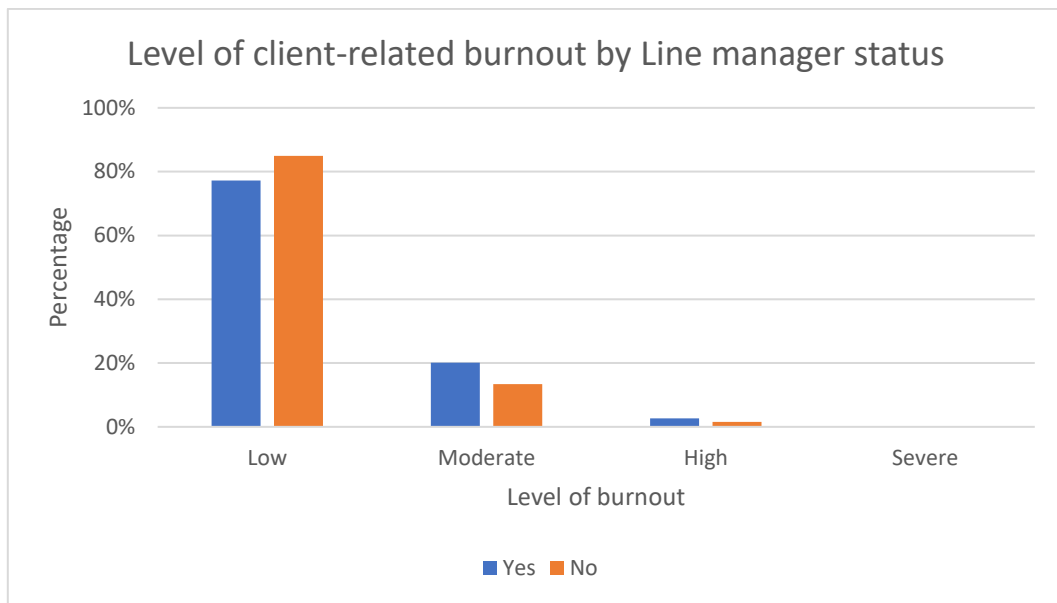


Figure A5.64: Level of Client-Related Burnout by Line Manager Status (Unweighted)

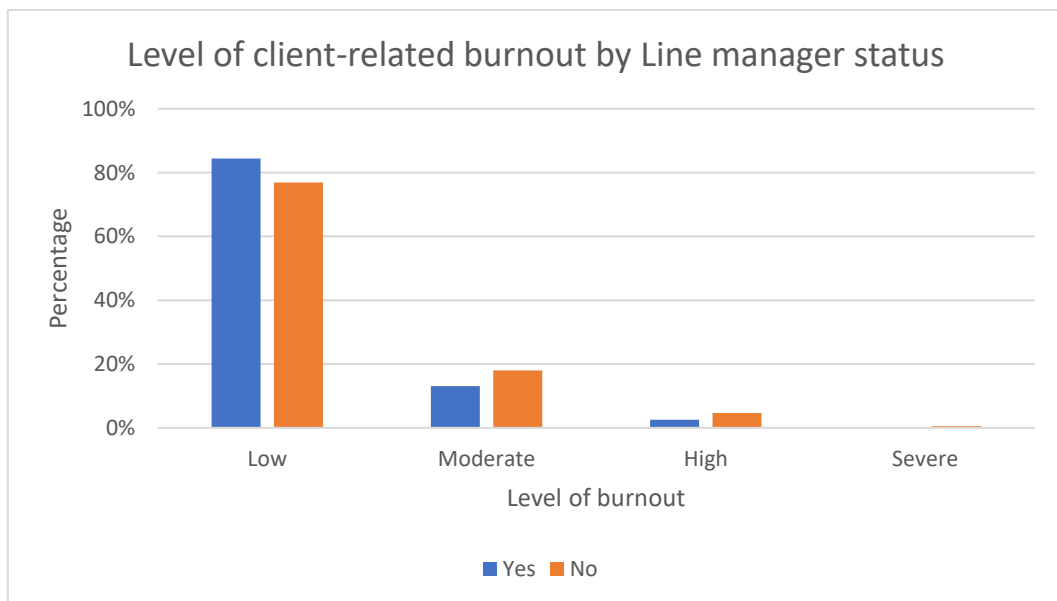


Table A5.31: Level of Burnout by Line Manager Status (Weighted)

Burnout	Are you a line manager?	
	Yes	No
Personal burnout:		
Low	16.3%	19.3%
Moderate	54.5%	54.7%
High	26.8%	24.9%
Severe	2.3%	1.1%
TOTAL	100%	100%
Work-related burnout:		
Low	28.5%	29.4%
Moderate	38.1%	46.9%
High	32.4%	22.9%
Severe	1.0%	0.7%
TOTAL	100%	100%
Client-related burnout:		
Low	77.2%	84.9%
Moderate	20.1%	13.4%
High	2.7%	1.6%
Severe	0.0%	0.1%
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	132 (25.5%)	264 (26.0%)
Moderate	223 (43.1%)	432 (42.5%)
High	143 (27.6%)	282 (27.8%)
Severe	20 (3.9%)	38 (3.7%)
TOTAL	518 (100%)	1016 (100%)
Work-related burnout:		
Low	149 (29.0%)	319 (31.8%)
Moderate	214 (41.7%)	319 (41.7%)
High	140 (27.3%)	246 (24.5%)
Severe	10 (1.9%)	20 (2.0%)
TOTAL	513 (100%)	1004 (100%)
Client-related burnout:		
Low	405 (84.4%)	715 (76.9%)
Moderate	63 (13.1%)	167 (18.0%)
High	12 (2.5%)	43 (4.6%)
Severe	0 (0.0%)	5 (0.5%)
TOTAL	480 (100%)	930 (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 ($F = 115.28$, $df = 2$, $p < .001$). Specifically, those who impacted by not significantly had lower scores than those not impacted and those overwhelmed by the increased pressures.

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 ($F = 228.93$, $df = 2$, $p < .001$). Those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact.

There were no significant differences in mean client-related burnout scores between respondents who were also found ($F = .243$, $df = 2$, $p > .05$).

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 ($F = 105.13$, $df = 2$, $p < .001$). 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 ($F = 153.82$, $df = 2$, $p < .001$). Specifically, those who felt overwhelmed by increased pressures scored significantly higher than those who only felt some impact and those who felt no impact.

Significant differences in client-related burnout scores between respondents who experienced different levels of pressure on their service were also found ($F = 18.12$, $df = 2$, $p < .001$). 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)

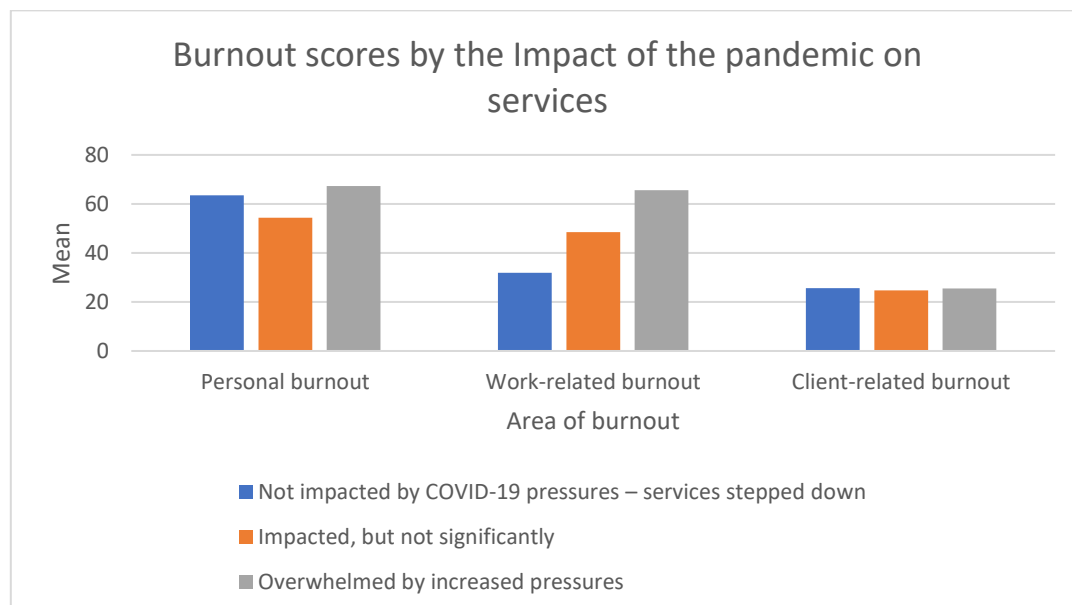


Figure A5.66: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

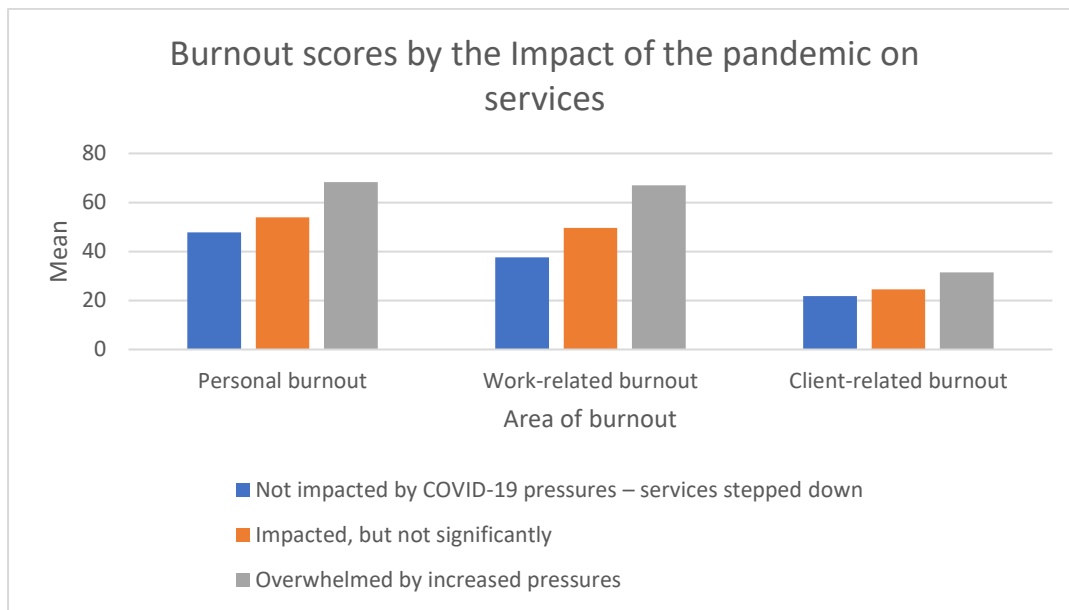


Table A5.33: Mean Burnout Scores by the Impact of the Pandemic on Services (Weighted)

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	63.53	54.38	67.30
Work-related burnout	31.94	48.55	65.62
Client-related burnout	25.62	24.77	25.49

Table A5.34: Mean Burnout Scores by the Impact of the Pandemic on Services (Unweighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout	47.84	53.99	68.33
Work-related burnout	37.56	49.57	66.95
Client-related burnout	21.79	24.54	31.48

Figure A5.67: Level of Personal Burnout by the Impact of the Pandemic on Services (Weighted)

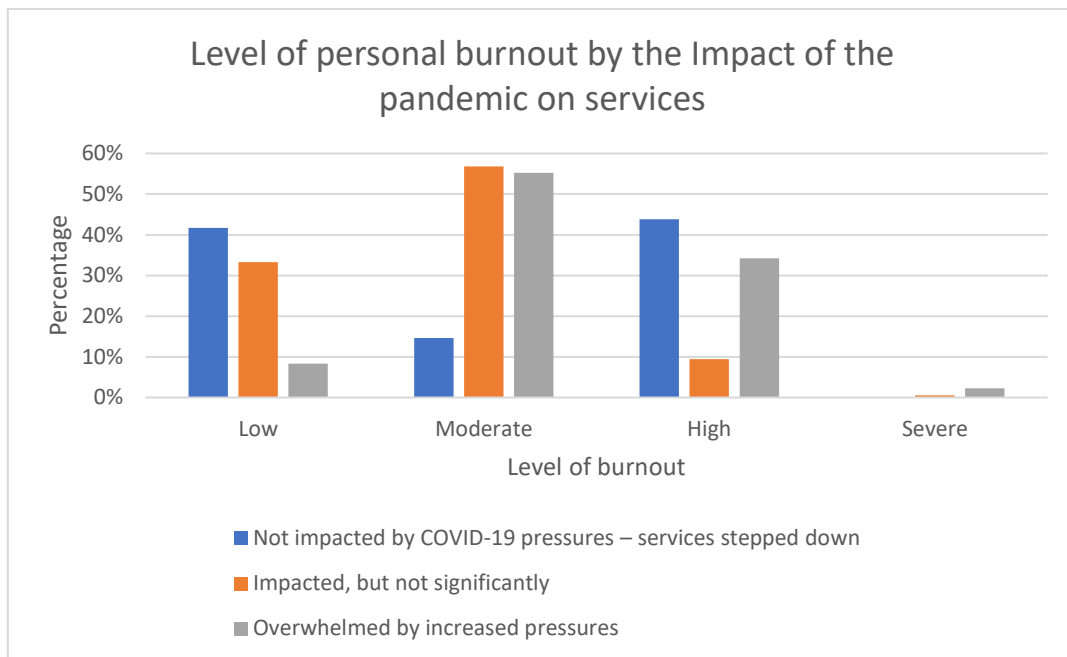


Figure A5.68: Level of Personal Burnout by the Impact of the Pandemic on Services (Unweighted)

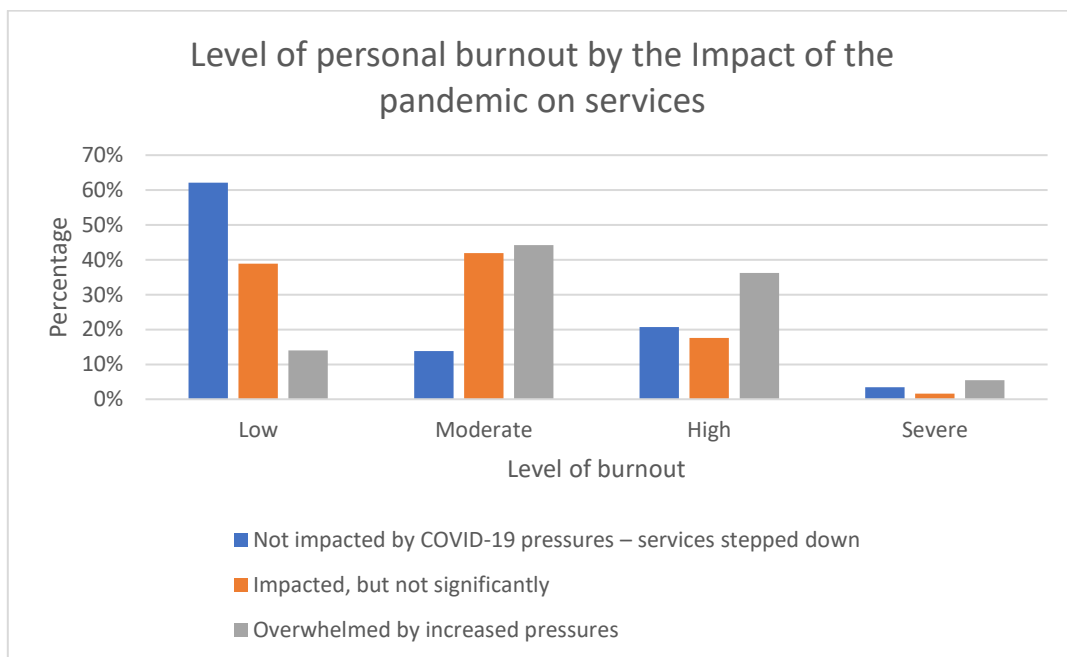


Figure A5.69: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Weighted)

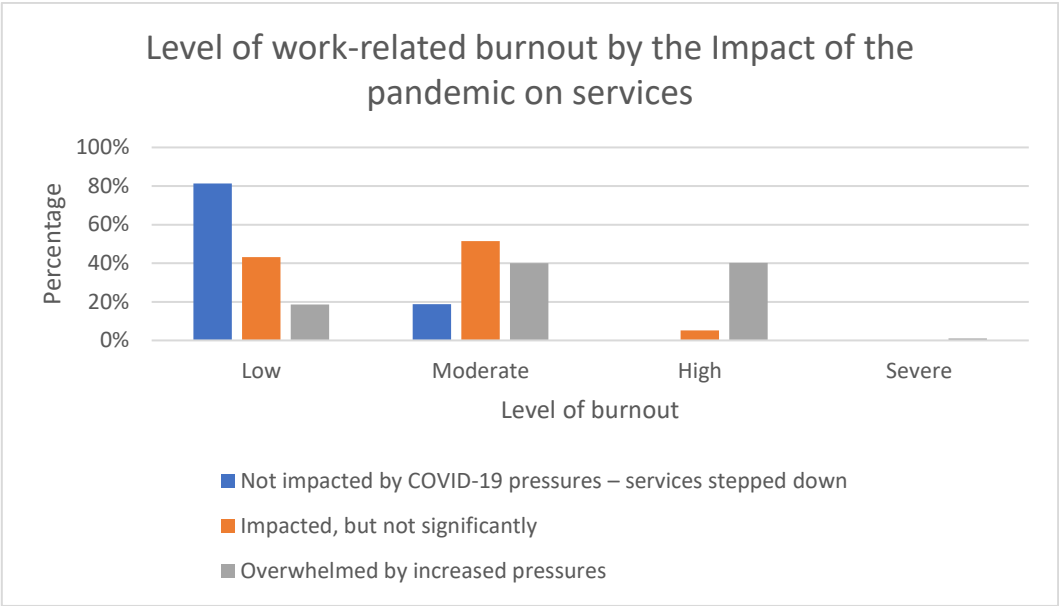


Figure A5.70: Level of Work-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

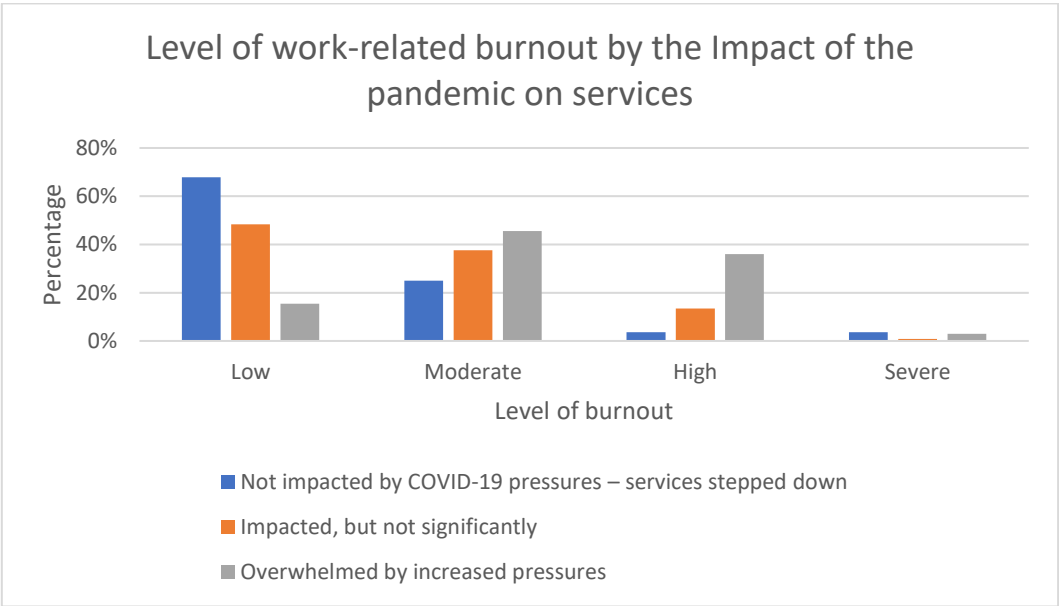


Figure A5.71: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Weighted)

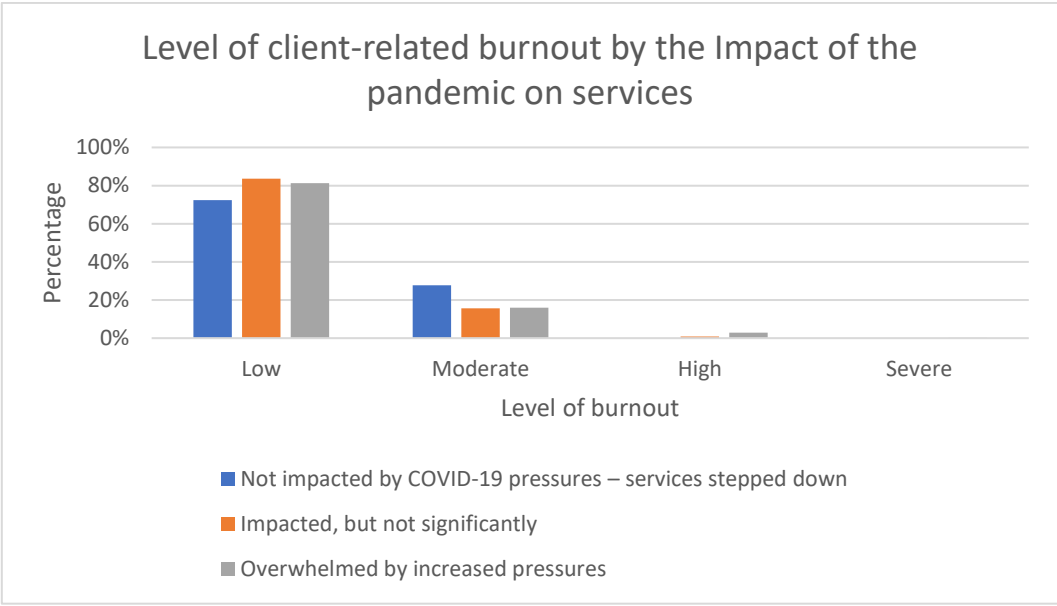


Figure A5.72: Level of Client-Related Burnout by the Impact of the Pandemic on Services (Unweighted)

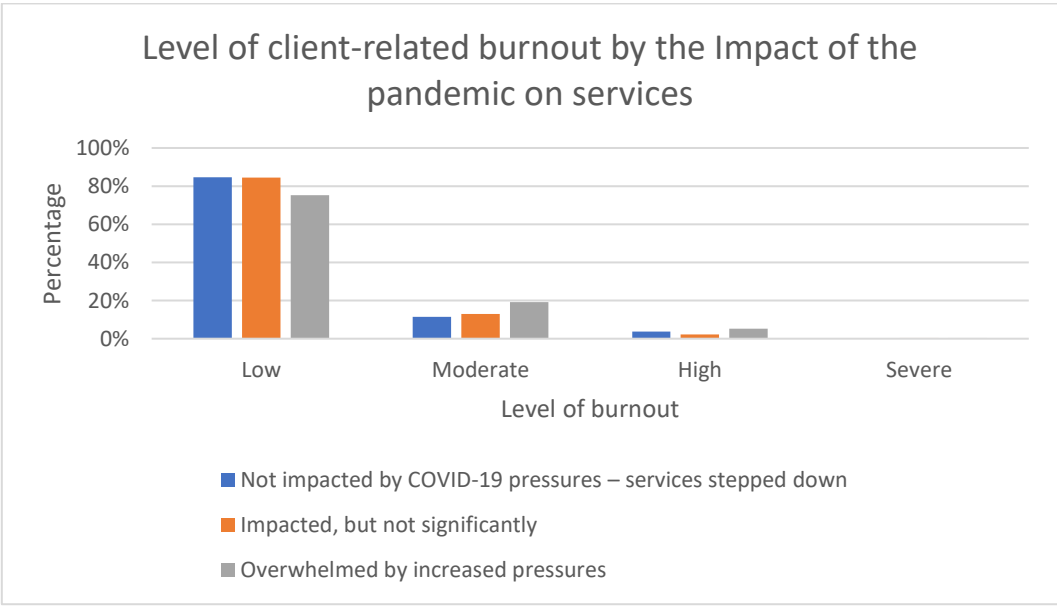


Table A5.35: Level of Burnout by the Impact of the Pandemic on Services (Weighted)

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	41.7%	33.3%	8.3%
Moderate	14.6%	56.8%	55.2%
High	43.8%	9.4%	34.2%
Severe	0.0%	0.5%	2.3%
TOTAL	100%	100%	100%
Work-related burnout:			
Low	81.3%	43.2%	18.6%
Moderate	18.8%	51.4%	40.0%
High	0.0%	5.2%	40.2%
Severe	0.0%	0.2%	1.1%
TOTAL	100%	100%	100%
Client-related burnout:			
Low	72.3%	83.6%	81.2%
Moderate	27.7%	15.6%	15.9%
High	0.0%	0.9%	2.8%
Severe	0.0%	0.0%	0.1%
TOTAL	100%	100%	100%

Table A5.36: Level of Burnout by the Impact of the Pandemic on Services (Unweighted)

Burnout	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Personal burnout:			
Low	18 (62.1%)	261 (38.9%)	117 (14.0%)
Moderate	4 (13.8%)	281 (41.9%)	369 (44.2%)
High	6 (20.7%)	118 (17.6%)	302 (36.2%)
Severe	1 (3.4%)	11 (1.6%)	46 (5.5%)
TOTAL	29 (100%)	671 (100%)	834 (100%)
Work-related burnout:			
Low	19 (67.9%)	321 (48.3%)	128 (15.5%)
Moderate	7 (25.0%)	250 (37.6%)	375 (45.5%)
High	1 (3.6%)	89 (13.4%)	297 (36.0%)
Severe	1 (3.6%)	5 (0.8%)	24 (2.9%)
TOTAL	28 (100%)	665 (100%)	824 (100%)
Client-related burnout:			
Low	22 (84.6%)	525 (84.5%)	574 (75.2%)
Moderate	3 (11.5%)	80 (12.9%)	146 (19.1%)
High	1 (3.8%)	14 (2.3%)	40 (5.2%)
Severe	0 (0.0%)	2 (0.3%)	3 (0.4%)
TOTAL	26 (100%)	621 (100%)	763 (100%)

Appendix 6: Carver Coping Scale (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of how respondents coped with COVID-19 related occupational demands, which was measured using 20 items from the Brief COPE scale. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A6.1 Carver Coping Scores by Country

Summary (Weighted results):

There were significant differences across countries in mean scores on two out of the ten examined Carver coping domains. These differences were in:

- Acceptance ($F = 2.68$, $df = 3$, $p = .046$), where Wales scored significantly higher than Scotland or Northern Ireland.
- Substance use ($F = 3.70$ $df = 3$, $p = .011$), where Northern Ireland scored significantly lower than England or Scotland.
- Self-blame ($F = 4.166$ $df = 3$, $p = .006$), where Scotland scored significantly higher than Northern Ireland.

There also appeared to be a significant difference between the countries in the use of Instrumental support ($F = 2.61$, $df = 3$, $p = .05$), but multiple comparison tests revealed no statistically significant differences between the countries, although there was a trend towards higher scores in using instrumental support as a coping strategy by those in Wales. There also appeared to be a significant difference between the countries in the use of behavioural disengagement as a coping strategy ($F = 2.65$, $df = 3$, $p = .048$); but multiple comparison tests revealed no statistically significant differences between the countries, although there was a trend towards higher scores in using behavioural engagement as a coping strategy by those in England.

Summary (Unweighted results):

There were significant differences across countries in mean scores on only one out of the ten examined Carver coping domains. These differences were in:

- Self-blame ($F = 3.59$, $df = 3$, $p = .013$), where Wales scored significantly higher than Northern Ireland.

Figure A6. 1: Mean Carver Coping Scores by Country (Weighted)

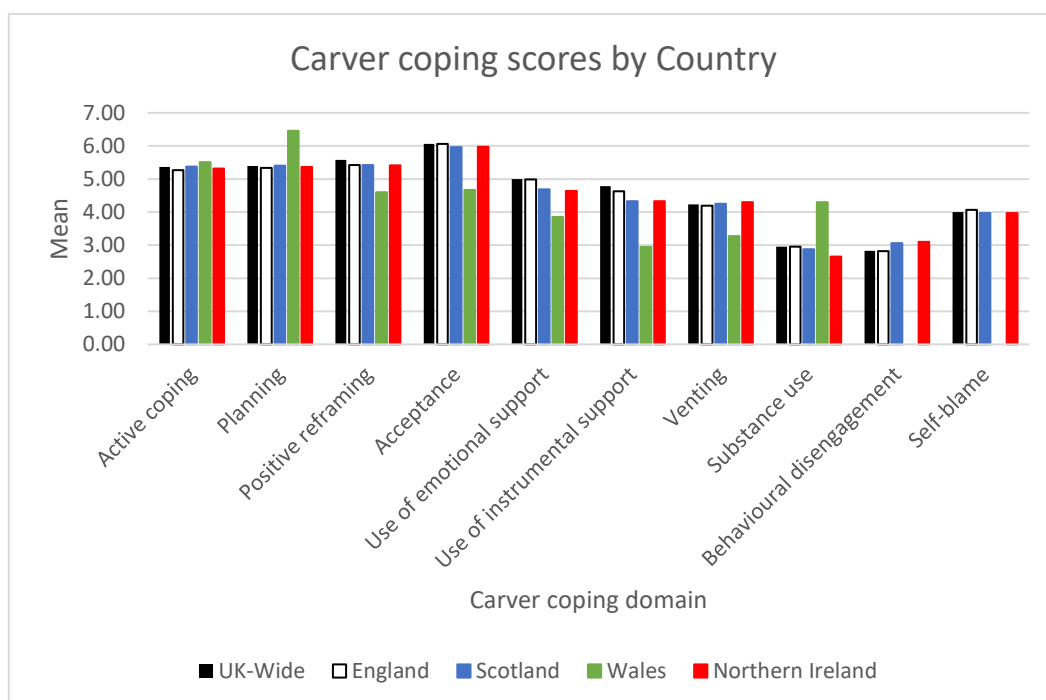


Figure A6. 2: Mean Carver Coping Scores by Country (Unweighted)

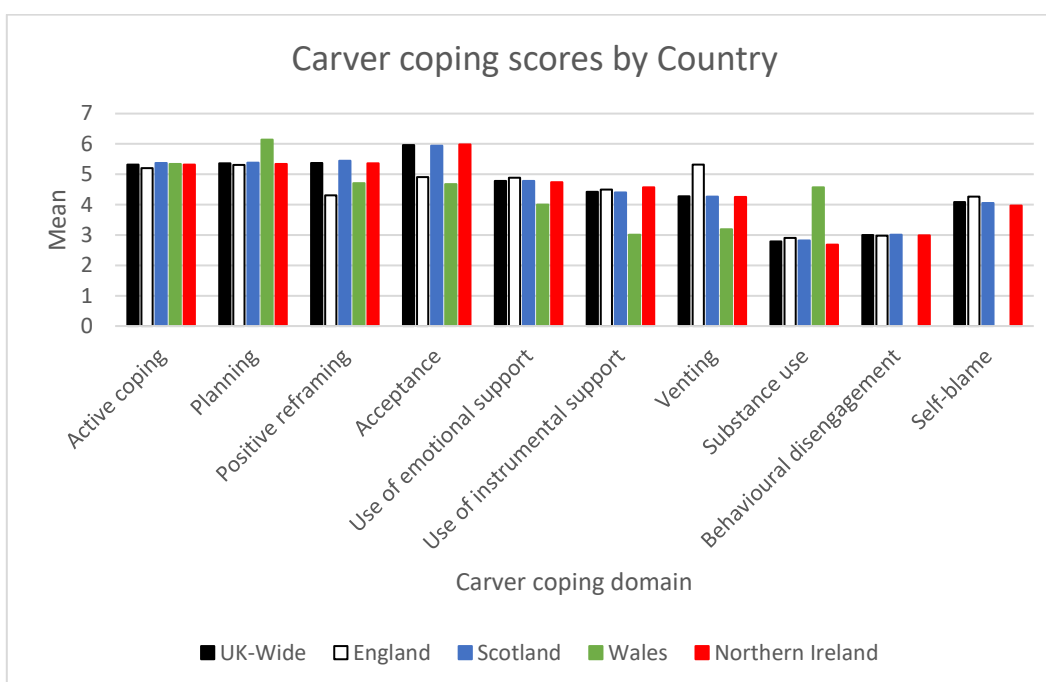


Table A6. 1: Mean Carver Coping Scores by Country (Weighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.36	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

Table A6. 2: Mean Carver Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Active coping	5.32	5.2	5.37	5.51	5.32
Planning	5.36	5.31	5.38	5.54	5.34
Positive reframing	5.37	4.31	5.45	5.34	5.36
Acceptance	5.96	4.91	5.94	6.14	5.98
Use of emotional support	4.78	4.89	4.78	4.71	4.74
Use of instrumental support	4.42	4.5	4.4	4.68	4.57
Venting	4.27	5.32	4.26	4	4.25
Substance use	2.79	2.9	2.82	3.01	2.68
Behavioural disengagement	3.00	2.98	3.01	3.19	2.99
Self-blame	4.09	4.26	4.05	4.57	3.97

A6.2 Carver Coping Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on five of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 3.92$, $df = 4$, $p = .004$), where AHPs scored significantly higher than midwives or social workers.
- Acceptance ($F = 9.13$, $df = 4$, $p < .001$), where nurses scored significantly higher than midwives and social workers.
- Substance use ($F = 9.10$, $df = 4$, $p = .001$), where midwives scored significantly higher than AHPs and social care workers.
- Behavioural disengagement ($F = 5.81$, $df = 4$, $p < .001$), where nurses scored significantly higher than AHPs.
- Self-blame ($F = 9.76$, $df = 4$, $p < .001$), where midwives scored significantly higher than all other occupation groups.

There also appeared to be a significant difference between the countries in the use of positive reframing ($F = 2.86$, $df = 4$, $p = .022$), but multiple comparison tests revealed no statistically significant differences between the occupations, although there was a trend towards higher scores in using positive reframing as a coping strategy by those in working in Social Care.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on four out of the ten examined Carver coping domains. These differences were found in:

- Use of emotional support ($F = 3.13$, $df = 4$, $p < .014$), where social care workers scored significantly lower than nurses and AHPs.
- Substance use ($F = 2.46$, $df = 4$, $p = .044$), but a post hoc revealed no significant difference between the groups.
- Behavioural disengagement ($F = 2.756$, $df = 4$, $p = .027$), where AHPs scored significantly lower than Social Care Workers.
- Self-blame ($F = 4.06$, $df = 4$, $p = .003$), where midwives scored significantly higher than nurses, AHPs and Social Care Workers.

Figure A6.3: Mean Carver Coping Scores by Occupation (Weighted)

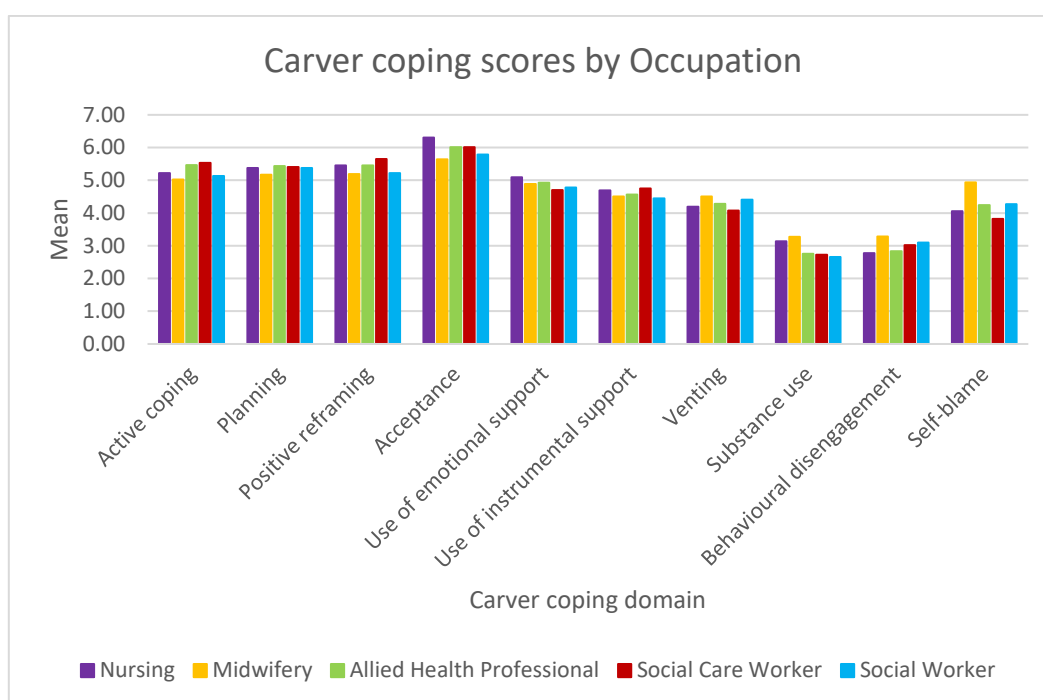


Figure A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

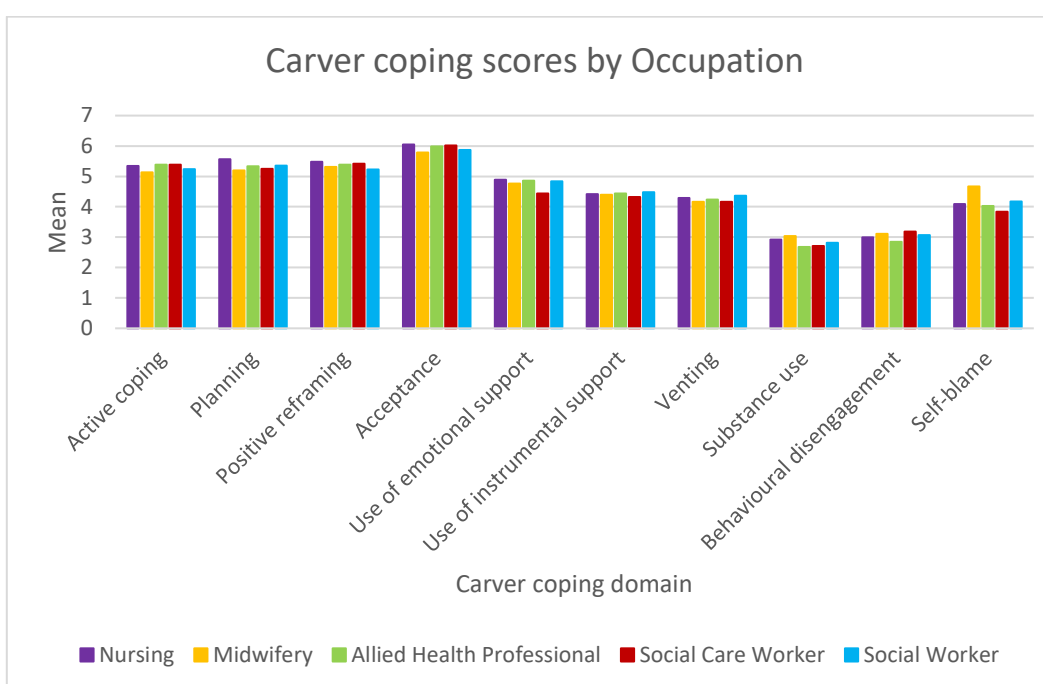


Table A6.3: Mean Carver Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.22	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

Table A6.4: Mean Carver Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Active coping	5.34	5.13	5.38	5.38	5.24
Planning	5.56	5.19	5.33	5.25	5.35
Positive reframing	5.48	5.31	5.38	5.42	5.23
Acceptance	6.05	5.79	5.98	6.02	5.87
Use of emotional support	4.89	4.76	4.86	4.44	4.84
Use of instrumental support	4.42	4.39	4.44	4.32	4.48
Venting	4.29	4.16	4.24	4.16	4.36
Substance use	2.92	3.04	2.68	2.71	2.81
Behavioural disengagement	2.99	3.11	2.85	3.18	3.07
Self-blame	4.09	4.67	4.03	3.84	4.17

A6.3 Carver Coping Scores by Sex

There were 4 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 eight out of the ten examined Carver coping domains. These differences were in:

- Active coping ($t = -2.44$, $df = 456.96$, $p = .015$), where females scored significantly lower than males.
- Positive reframing ($t = -3.82$, $df = 535.42$, $p < .001$), where females scored significantly lower than males.
- Acceptance ($t = -3.23$, $df = 525.80$, $p = .001$), where females scored significantly lower than males.
- Use of emotional support ($t = -8.52$, $df = 439.03$, $p < .001$), where females scored significantly lower than males.
- Use of instrumental support ($t = -3.96$, $df = 432.63$, $p < .001$), where females scored significantly lower than males.
- Venting ($t = -3.19$, $df = 336.87$, $p = .002$), where females scored significantly lower than males.
- Substance use ($t = -5.72$, $df = 322.56$, $p < .001$), where females scored significantly lower than males.
- Self-blame ($t = 4.44$, $df = 327.65$, $p < .001$), where females scored significantly higher than males.

Summary (Unweighted results):

There were significant differences between males and females in mean scores on two out of the ten examined Carver coping domains. These differences were found in:

- Acceptance ($t = -1.98$, $df = 1459$, $p = .048$), where females scored significantly lower than males.
- Behavioural engagement ($t = -2.03$, $df = 187.999$, $p = .043$), where males scored significantly higher than females.

Figure A6.5: Mean Carver Coping Scores by Sex (Weighted)

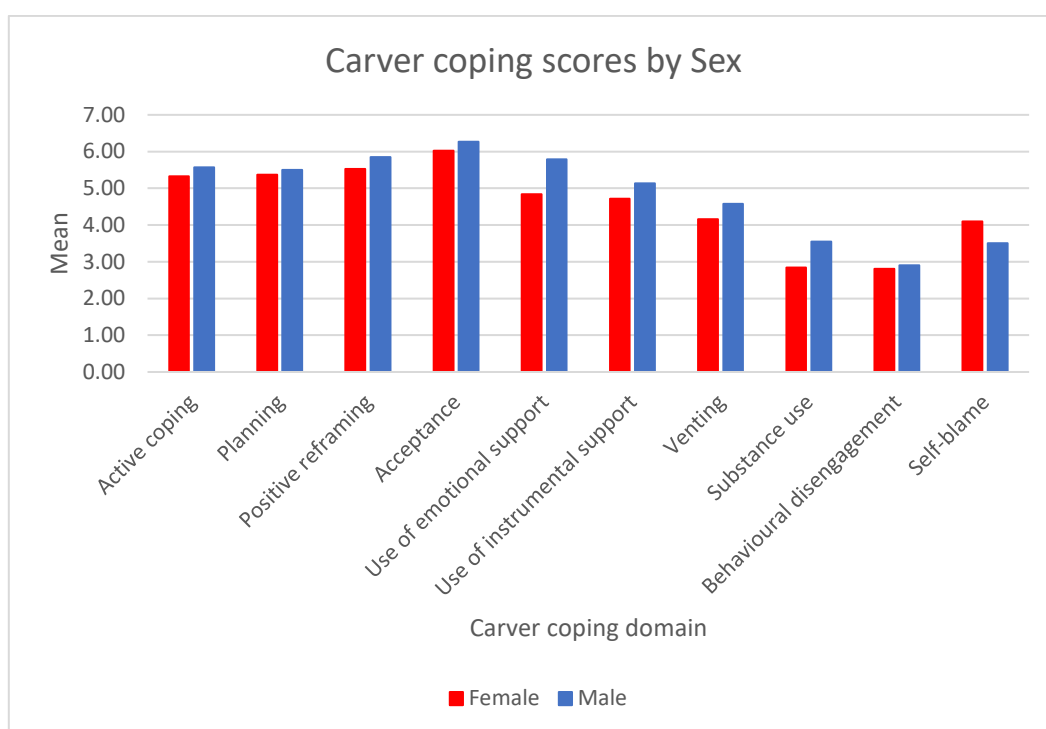


Figure A6.6: Mean Carver Coping Scores by Sex (Unweighted)

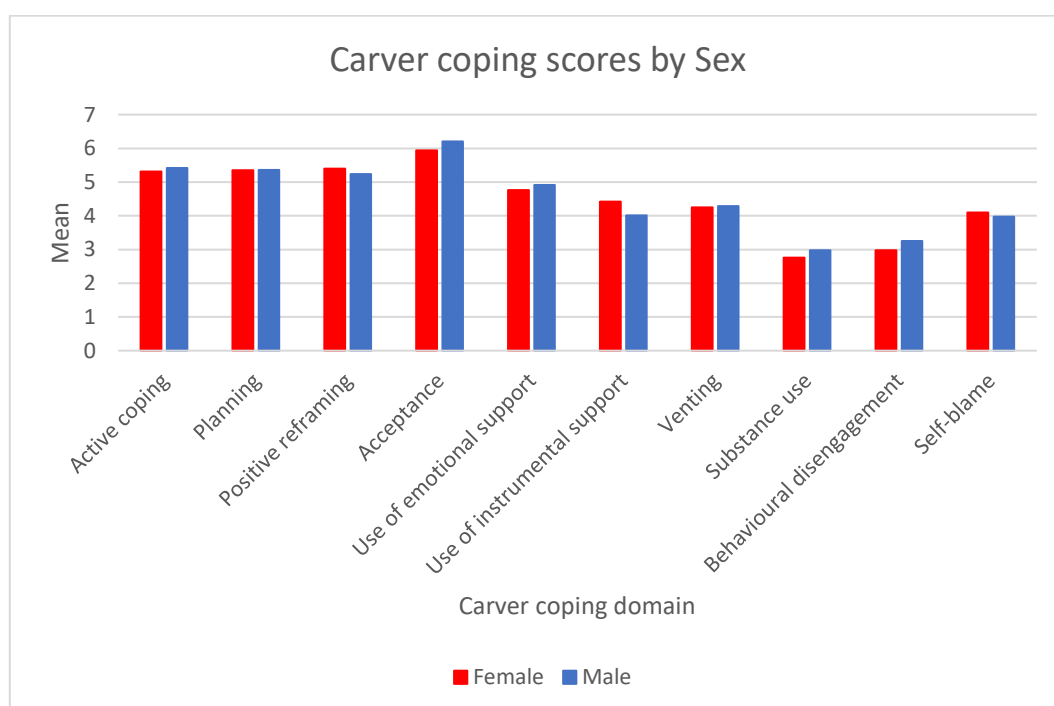


Table A6.5: Mean Carver Coping Scores by Sex (Weighted)

Coping domain	Sex	
	Female	Male
Active coping	5.32	5.57
Planning	5.37	5.50
Positive reframing	5.52	5.85
Acceptance	6.02	6.27
Use of emotional support	4.84	5.79
Use of instrumental support	4.72	5.13
Venting	4.16	4.58
Substance use	2.84	3.55
Behavioural disengagement	2.81	2.91
Self-blame	4.10	3.50

Table A6.6: Mean Carver Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Active coping	5.31	5.42
Planning	5.35	5.36
Positive reframing	5.4	5.24
Acceptance	5.94	6.2
Use of emotional support	4.76	4.91
Use of instrumental support	4.42	4.01
Venting	4.25	4.29
Substance use	2.76	2.98
Behavioural disengagement	2.98	3.25
Self-blame	4.1	3.97

A6.4 Carver Coping Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean scores on all ten Carver coping domains. These differences were in:

- Active coping ($F = 4.07$, $df = 5$, $p = .001$), where the 30-39 age group scored significantly higher than the 40-49 and the 50-59 age groups
- Positive reframing ($F = 4.96$, $df = 5$, $p < .001$), where the 40-49 group had significantly higher scores than the 16-29, 30-39, 50-59 and 60-65 age groups.
- Acceptance ($F = 11.87$, $df = 5$, $p < .001$), where the 40-49 group had significantly higher scores than the 30-39, 50-59 and 60-65 age groups.
- Use of emotional support ($F = 4.05$, $df = 5$, $p < .001$), where the 40-49 group had significantly higher scores than the 50-59 and 60-65 age groups.
- Use of instrumental support ($F = 18.14$, $df = 5$, $p < .001$), where the 30-39 and 40-49 groups had significantly higher scores than the 50-59 and 60-65 age groups.
- Venting ($F = 9.24$, $df = 5$, $p < .001$), where the 30-39 group had significantly higher scores than the 40-49, 50-59 and 60-65 age groups.
- Substance use ($F = 7.96$, $df = 5$, $p = .001$), where the 60-65 age group scored significantly lower than the 30-39, 40-49, 50-59 age groups.
- Behavioural disengagement ($F = 7.33$, $df = 5$, $p < .001$), where the 60-65 age group scored significantly lower than the 16-29, 30-39, 50-59 age groups.
- Self-blame ($F = 8.44$, $df = 5$, $p < .001$), where the 16-29 age group scored significantly higher than the 40-49, 50-59, and 60-65 age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on five out of the ten examined Carver coping domains. These differences were in:

- Venting ($F = 6.337$, $df = 5$, $p < .001$), the 40-49, 50-59 and 60-65 age groups scored significantly lower than the 16-29 and 30-39 age groups.
- Self-blame ($F = 9.726$, $df = 5$, $p = .044$), where the 16-29 age group scored significantly higher than the 40-49, 50-59, 60-65 and 66+ age groups.

Figure A6.7: Mean Carver Coping Scores by Age (Weighted)

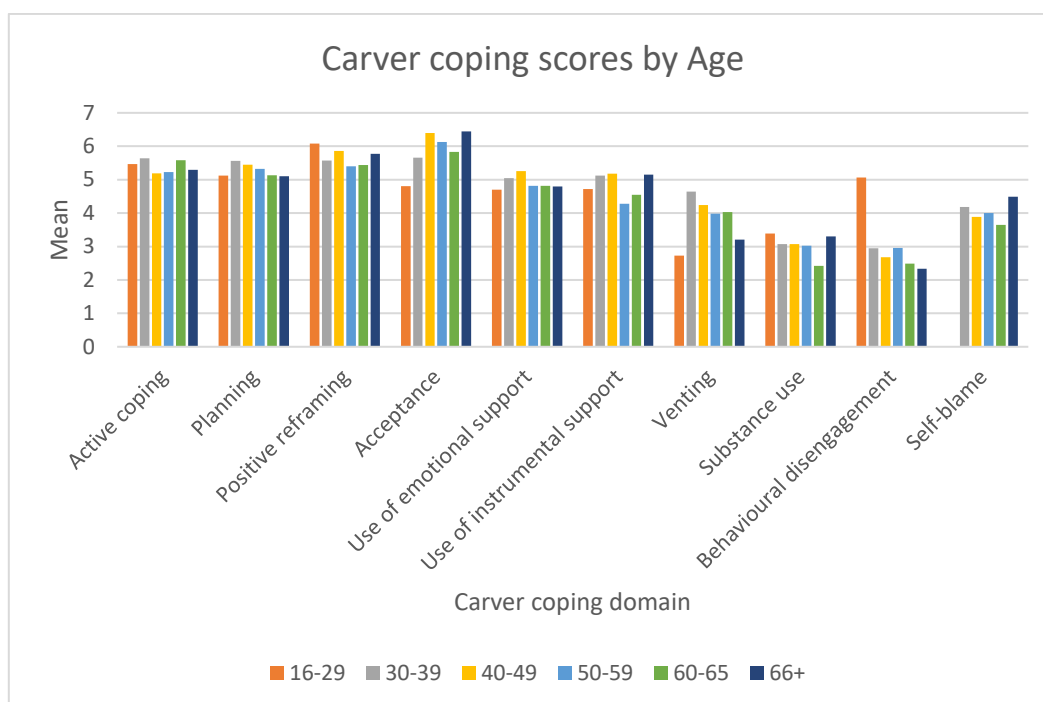


Figure A6.8: Mean Carver Coping Scores by Age (Unweighted)

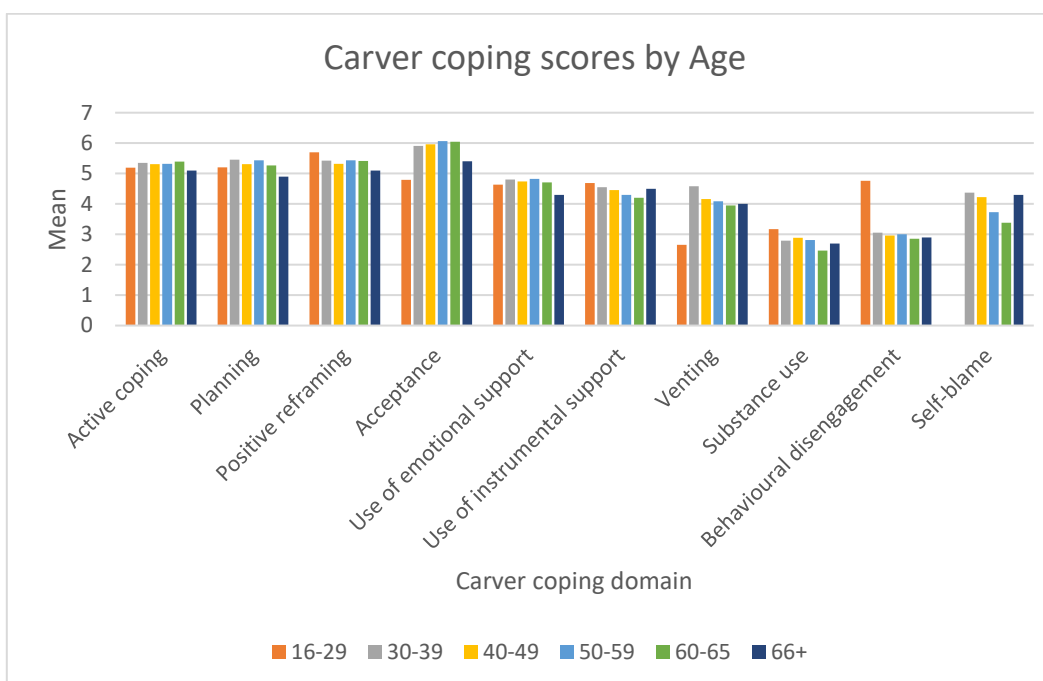


Table A6.7: Mean Carver Coping Scores by Age (Weighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Active coping	5.35	5.64	5.19	5.23	5.58	5.29
Planning	5.47	5.56	5.45	5.32	5.13	5.10
Positive reframing	5.12	5.57	5.86	5.40	5.44	5.77
Acceptance	6.08	5.66	6.40	6.13	5.83	6.44
Use of emotional support	4.81	5.05	5.26	4.82	4.82	4.80
Use of instrumental support	4.70	5.12	5.18	4.28	4.55	5.15
Venting	4.72	4.64	4.24	3.98	4.03	3.21
Substance use	2.73	3.07	3.07	3.02	2.42	3.30
Behavioural disengagement	3.39	2.95	2.68	2.96	2.49	2.33
Self-blame	5.06	4.18	3.89	4.00	3.65	4.49

Table A6.8: Mean Carver Coping Scores by Age (Unweighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Active coping	5.27	5.35	5.31	5.32	5.39	5.10
Planning	5.19	5.45	5.31	5.43	5.27	4.90
Positive reframing	5.20	5.42	5.32	5.43	5.41	5.10
Acceptance	5.70	5.91	5.96	6.07	6.04	5.40
Use of emotional support	4.79	4.80	4.74	4.82	4.71	4.30
Use of instrumental support	4.63	4.55	4.45	4.30	4.20	4.50
Venting	4.69	4.58	4.16	4.09	3.95	4.00
Substance use	2.65	2.79	2.89	2.81	2.46	2.70
Behavioural disengagement	3.17	3.05	2.96	3.00	2.85	2.90
Self-blame	4.76	4.37	4.22	3.73	3.38	4.30

A6.5 Carver Coping Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on ten out of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 40.05$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than Black and Asian ethnic groups.
- Planning ($F = 36.55$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than Black and Asian ethnic groups.
- Positive reframing ($F = 33.53$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than Black and Asian ethnic groups.
- Acceptance ($F = 21.02$, $df = 3$, $p = .001$), where respondents identifying as White scored significantly lower than Black and Asian ethnic groups.
- Use of emotional support ($F = 12.07$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than Black and Asian ethnic groups.
- Use of instrumental support ($F = 35.71$, $df = 3$, $p < .001$), where the black ethnic group scored significantly higher than all other ethnic groups.
- Venting ($F = 19.64$, $df = 3$, $p < .001$), where the black ethnic group scored significantly higher than all other ethnic groups.
- Substance use ($F = 14.89$, $df = 3$, $p < .001$), where the White scored significantly higher than the Black ethnic group.
- Behavioural disengagement ($F = 12.52$, $df = 3$, $p < .001$), where the black ethnic group scored significantly higher than all other ethnic groups.
- Self-blame ($F = 6.63$, $df = 3$, $p < .001$), where respondents identifying as White scored significantly lower than Black and Asian ethnic groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups in mean scores on six out of the ten examined Carver coping domains. These differences were in:

- Active coping ($F=6.47$, $df=3$, $p < .001$), where respondents of White Ethnicity scored significantly lower than the Asian ethnic groups.
- Planning ($F=3.76$, $df=3$, $p = .011$), where respondents of White Ethnicity scored significantly lower than the Asian ethnic group.
- Positive reframing ($F=4.48$, $df=3$, $p = .004$), where respondents of White Ethnicity scored significantly lower than the Asian ethnic group, while the Asian ethnic group had higher scores than the Mixed ethnic group.
- Acceptance ($F=4.43$, $df=3$, $p = .004$), where respondents of White Ethnicity scored significantly lower than the Asian ethnic groups.

- Emotional support ($F=2.69$, $df=3$, $p=.045$), however a post hoc between the individual countries revealed no significant difference.
- Substance use ($F = 2.70$, $df = 3$, $p = .044$), where respondents from the Asian ethnic group scored significantly lower than the Mixed ethnic group.

Figure A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

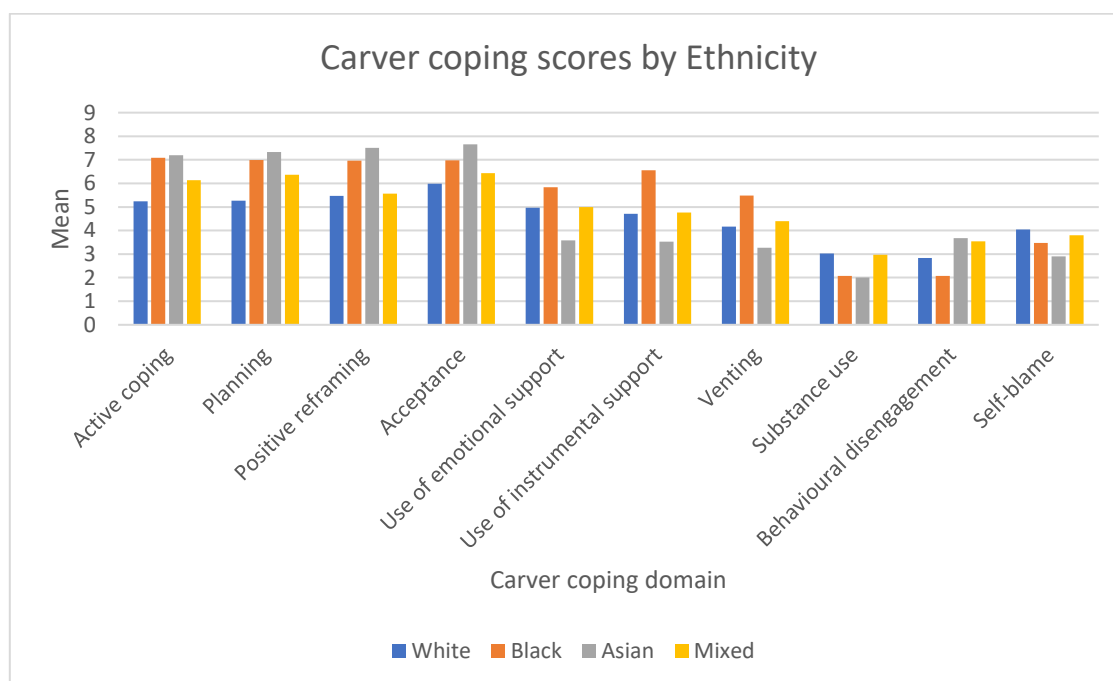


Figure A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

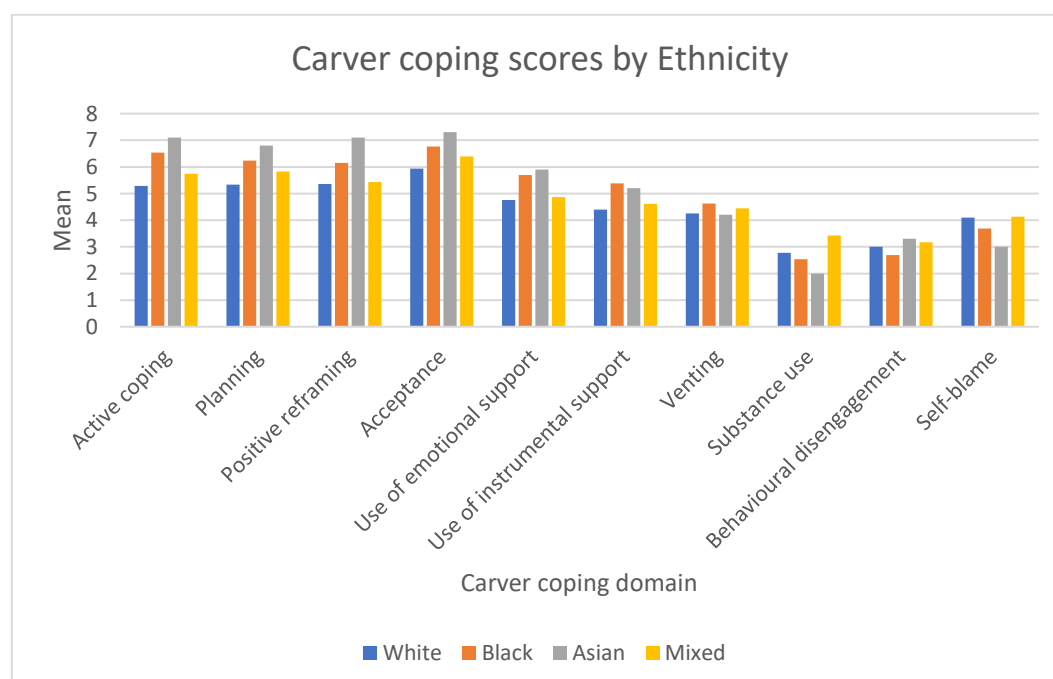


Table A6.9: Mean Carver Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.24	7.08	7.2	6.14
Planning	5.27	6.99	7.33	6.37
Positive reframing	5.47	6.96	7.51	5.57
Acceptance	5.98	6.97	7.66	6.43
Use of emotional support	4.97	5.84	3.58	5.00
Use of instrumental support	4.71	6.56	3.53	4.76
Venting	4.17	5.48	3.27	4.40
Substance use	3.02	2.07	2.00	2.97
Behavioural disengagement	2.84	2.08	3.68	3.54
Self-blame	4.04	3.47	2.90	3.80

Table A6.10: Mean Carver Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Active coping	5.29	6.54	7.10	5.74
Planning	5.33	6.23	6.80	5.83
Positive reframing	5.36	6.15	7.10	5.43
Acceptance	5.94	6.77	7.30	6.39
Use of emotional support	4.76	5.69	5.90	4.87
Use of instrumental support	4.40	5.38	5.20	4.61
Venting	4.25	4.62	4.20	4.45
Substance use	2.78	2.54	2.00	3.43
Behavioural disengagement	3.00	2.69	3.30	3.17
Self-blame	4.10	3.69	3.00	4.13

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 ($F = 33.00$, $df = 2$, $p < .001$), where respondents with a disability scored significantly lower than those without a disability and those who were unsure whether or not they had a disability.
- Planning ($F = 17.07$, $df = 2$, $p < .001$), where respondents with a disability scored significantly lower than those without a disability and those who were unsure whether or not they had a disability.
- Use of emotional support ($F = 6.17$, $df = 2$, $p = .002$), where respondents with a disability scored significantly lower than those without a disability.
- Use of instrumental support ($F = 3.78$, $df = 2$, $p = .023$), where respondents with a disability scored significantly lower than those without a disability.
- Venting ($F = 5.70$, $df = 2$, $p = .003$), where respondents with a disability scored significantly lower than those without a disability.
- Substance use ($F = 9.28$, $df = 2$, $p < .001$), where respondents with a disability scored significantly lower than those without a disability.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on one out of the ten examined Carver coping domains. These differences were in:

- Self-blame ($F = 7.24$, $df = 2$, $p < .001$), where respondents who were unsure of their disability scored significantly higher than those without a disability and those with a disability.

Figure A6.11: Mean Carver Coping Scores by Disability (Weighted)

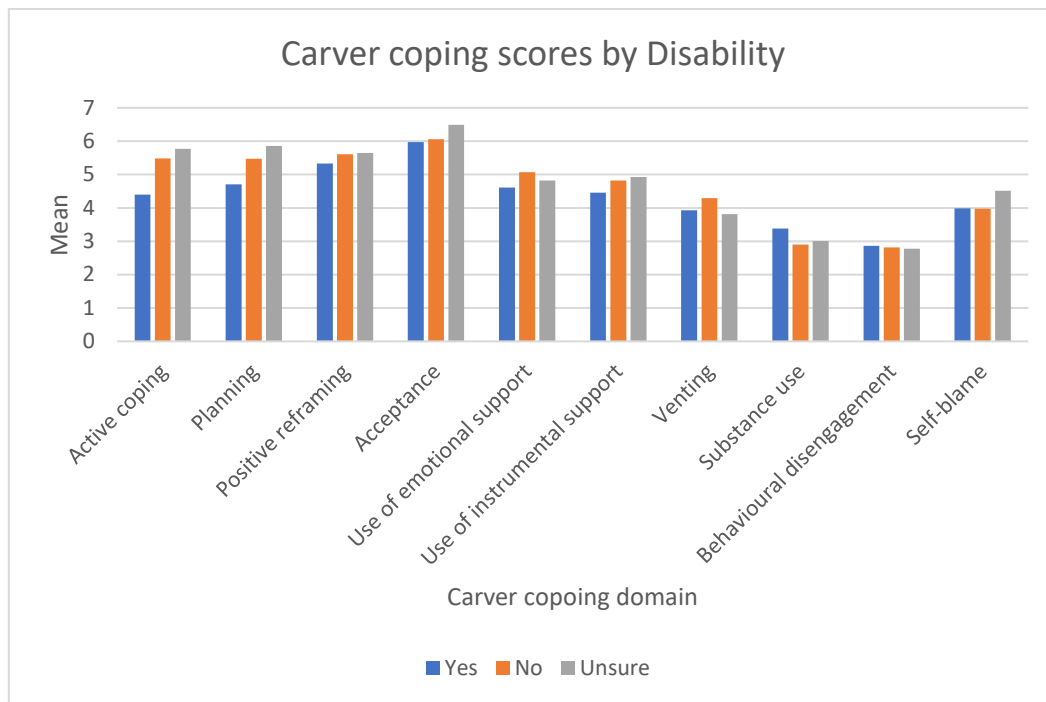


Figure A6.12: Mean Carver Coping Scores by Disability (Unweighted)

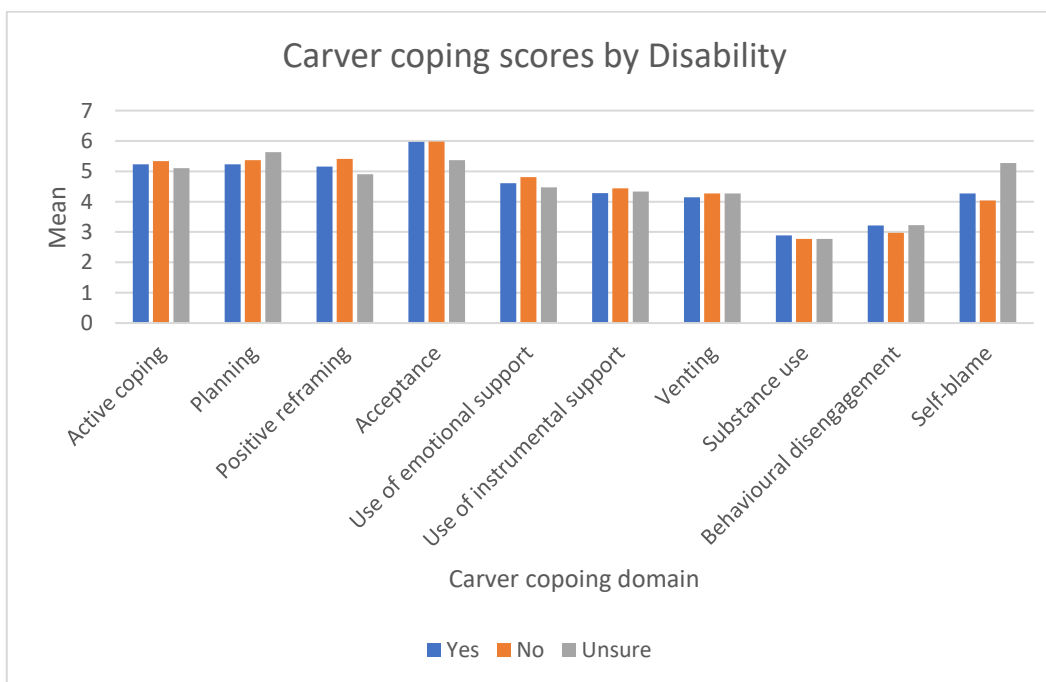


Table A6.11: Mean Carver Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Active coping	4.40	5.48	5.77
Planning	4.71	5.47	5.86
Positive reframing	5.33	5.61	5.65
Acceptance	5.97	6.06	6.49
Use of emotional support	4.61	5.07	4.82
Use of instrumental support	4.46	4.82	4.93
Venting	3.93	4.29	3.81
Substance use	3.38	2.90	3.01
Behavioural disengagement	2.86	2.82	2.78
Self-blame	3.99	3.98	4.51

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	5.23	5.34	5.10
Planning	5.23	5.37	5.63
Positive reframing	5.16	5.41	4.90
Acceptance	5.97	5.98	5.37
Use of emotional support	4.61	4.81	4.47
Use of instrumental support	4.28	4.44	4.33
Venting	4.14	4.27	4.27
Substance use	2.89	2.77	2.77
Behavioural disengagement	3.21	2.97	3.23
Self-blame	4.27	4.04	5.27

A6.7 Carver Coping Scores by Main Area of Practice

Summary (Weighted results):

There were significant differences between respondents based on their main area of practice in mean scores on ten out of the ten examined Carver coping domains. These differences were in:

- Active coping ($F = 8.33$, $df = 7$, $p < .001$), where those working with children and young people scored significantly higher than all other areas of practice.
- Planning ($F = 10.94$, $df = 7$, $p < .001$), where those working with children and young people scored significantly higher than all other areas of practice.
- Positive reframing ($F = 11.78$, $df = 7$, $p < .001$), where those working with children and young people scored significantly higher than all other areas of practice.
- Acceptance ($F = 12.54$, $df = 7$, $p < .001$), where respondents working with children and young people scored significantly higher than those working in learning disability, mental health and in the area of practice 'other.'
- Use of emotional support ($F = 7.44$, $df = 7$, $p < .001$), where respondents working with children and young people scored significantly higher than those working with adults of working age, in physical disability, in learning disability, mental health and in the area of practice 'other.'
- Use of instrumental support ($F = 25.82$, $df = 7$, $p < .001$), where respondents working with children and young people scored significantly higher than those working with adults of working age, in midwifery, in physical disability, with older people, in mental health and in the area of practice 'other.'
- Venting ($F = 22.03$, $df = 7$, $p < .001$), where respondents working with children scored significantly higher than those working with adults, older people, in the area of mental health or 'other' services.
- Substance use ($F = 3.09$, $df = 7$, $p < .001$), where respondents working with older people scored significantly lower than those in the area of practice 'other'.
- Behavioural disengagement ($F = 21.85$, $df = 7$, $p < .001$), where respondents working with children scored significantly than those in learning disability but higher than those working with older people. Those working with adults of working age scored significantly lower than those in learning disability, working with older people, and in the area of 'other'.
- Self-blame ($F = 4.15$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly higher than those working with adults of working age and with older people.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean scores on one out of the ten examined Carver coping domains. These differences were in:

- Self-blame ($F = 2.89$, $df = 7$, $p = .005$), where respondents working in midwifery scored significantly higher than working with adults or in 'other' areas of practice.

Figure A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

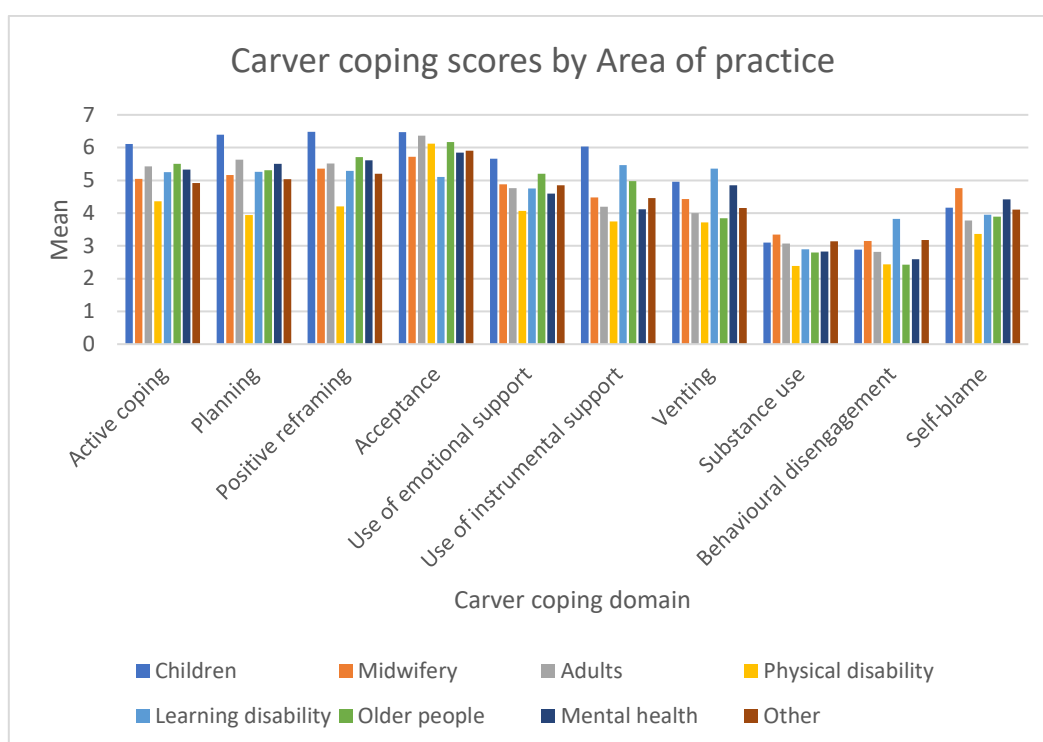


Figure A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)

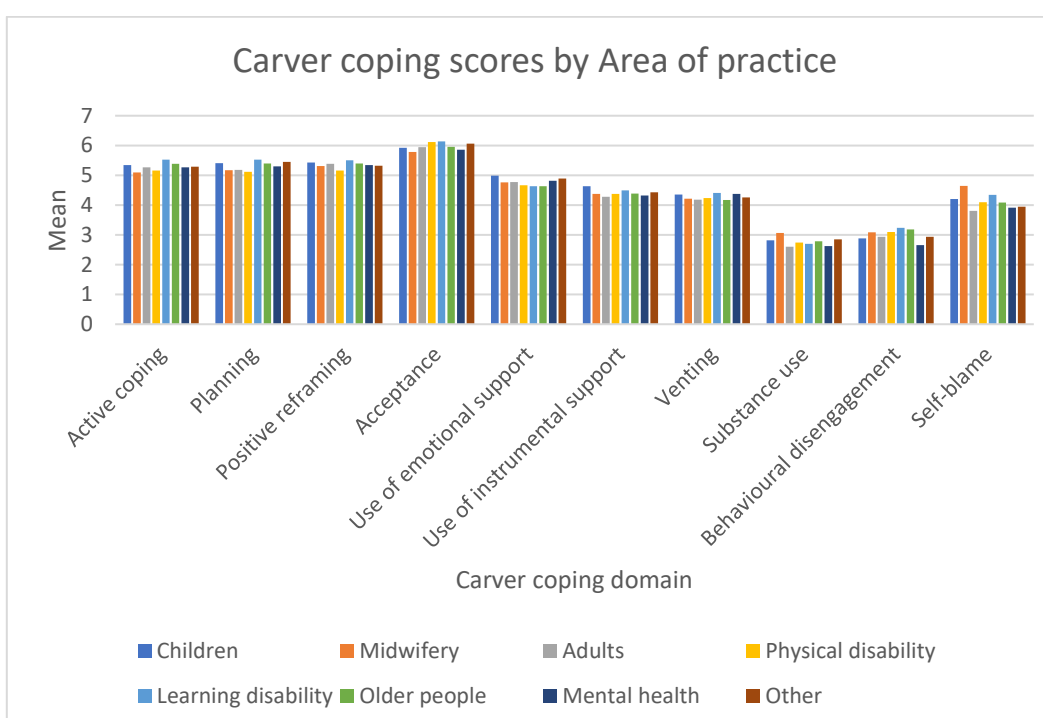


Table A6.13: Mean Carver Coping Scores by Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Active coping	6.11	5.05	5.43	4.36	5.25	5.5	5.33	4.92
Planning	6.39	5.16	5.63	3.94	5.26	5.31	5.50	5.04
Positive reframing	6.48	5.36	5.51	4.21	5.29	5.71	5.61	5.20
Acceptance	6.47	5.72	6.36	6.12	5.10	6.17	5.85	5.91
Use of emotional support	5.66	4.88	4.76	4.07	4.75	5.20	4.60	4.85
Use of instrumental support	6.03	4.48	4.20	3.75	5.47	4.98	4.12	4.46
Venting	4.96	4.43	4.00	3.72	5.36	3.84	4.85	4.16
Substance use	3.10	3.35	3.07	2.39	2.90	2.80	2.83	3.14
Behavioural disengagement	2.89	3.15	2.82	2.44	3.82	2.43	2.59	3.18
Self-blame	4.17	4.76	3.78	3.36	3.95	3.89	4.42	4.11

Table A6.14: Mean Carver Coping Scores by Area of Practice (Unweighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Active coping	5.34	5.10	5.27	5.16	5.53	5.39	5.27	5.29
Planning	5.41	5.17	5.18	5.12	5.53	5.40	5.30	5.45
Positive reframing	5.43	5.31	5.38	5.16	5.50	5.40	5.34	5.32
Acceptance	5.92	5.78	5.94	6.12	6.14	5.95	5.86	6.06
Use of emotional support	4.99	4.76	4.77	4.67	4.63	4.63	4.82	4.89
Use of instrumental support	4.63	4.38	4.28	4.37	4.49	4.39	4.32	4.43
Venting	4.35	4.21	4.18	4.24	4.41	4.17	4.37	4.26
Substance use	2.82	3.06	2.60	2.74	2.70	2.78	2.62	2.85
Behavioural disengagement	2.88	3.09	2.93	3.100	3.24	3.18	2.65	2.93
Self-blame	4.20	4.64	3.81	4.1	4.34	4.08	3.91	3.94

A6.8 Carver Coping Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between those who were line managers and those who were not in mean scores on eight out of the ten Carver coping domains. These differences were in:

- Active coping ($t = 13.13$, $df = 1531.94$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Planning ($t = 11.41$, $df = 1417.52$, $p < .001$), where line managers scored significantly higher than those who were not line managers
- Positive reframing ($t = 9.31$, $df = 1409.82$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Acceptance ($t = 4.54$, $df = 1400.36$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Use of emotional support ($t = 5.81$, $df = 1593.45$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Use of instrumental support ($t = 5.38$, $df = 1560.87$, $p < .001$), where line managers scored significantly lower than those who were not line managers.
- Venting ($t = 4.09$, $df = 1585.34$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Behavioural disengagement ($t = -2.45$, $df = 1679$, $p = .014$), 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 five out of the ten examined Carver coping domains. These differences were in:

- Active coping ($t = 3.69$, $df = 1469$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Planning ($t = 3.71$, $df = 1470$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Positive reframing ($t = .825$, $df = 1467$, $p = .019$), where line managers scored significantly higher than those who were not line managers.
- Acceptance ($t = 2.73$, $df = 1464$, $p = .006$), where line managers scored significantly higher than those who were not line managers.

- Instrumental support ($t = 2.11$, $df = 1465$, $p = .035$), where line managers scored significantly higher than those who were not line managers.
- Venting ($t = -2.22$, $df = 1072.05$, $p = .027$), where line managers scored significantly lower than those who were not line managers.
- Behavioural disengagement ($t = -2.30$, $df = 1137.87$, $p = .022$), 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)

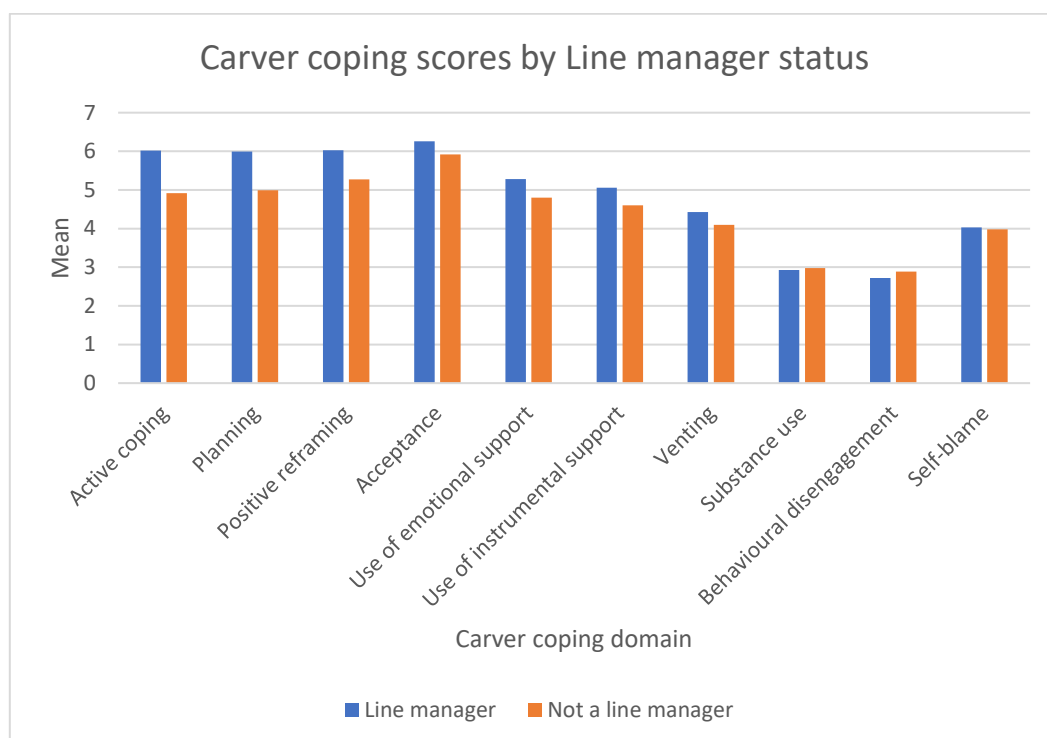


Figure A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

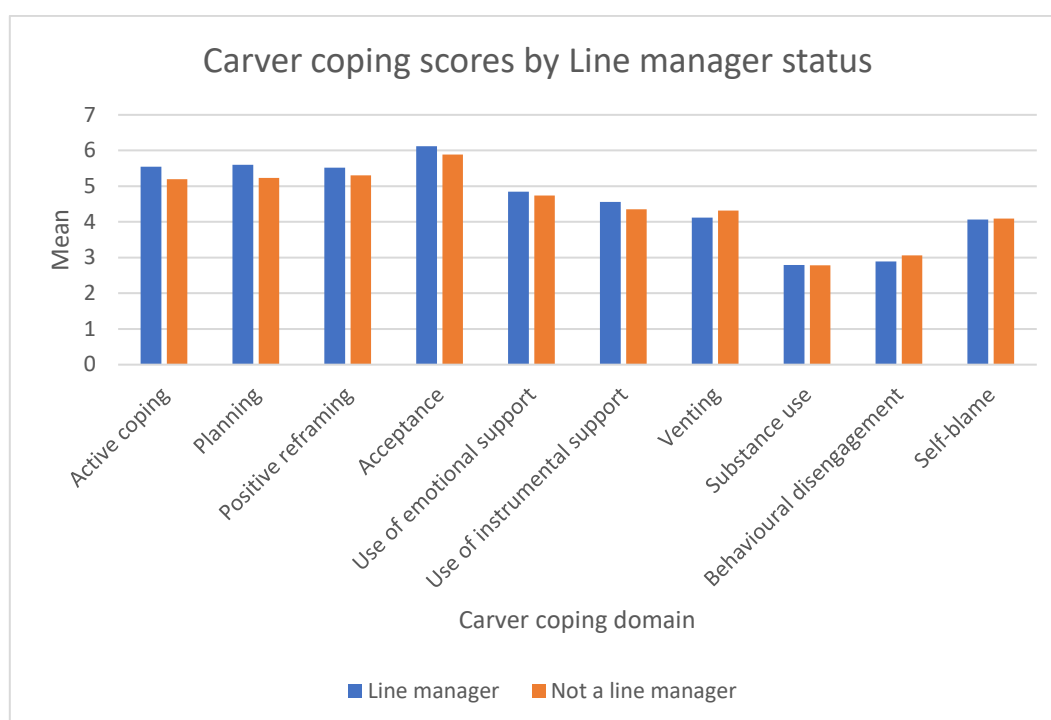


Table A6.15: Mean Carver Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	6.02	4.92
Planning	5.99	4.99
Positive reframing	6.03	5.27
Acceptance	6.26	5.92
Use of emotional support	5.28	4.8
Use of instrumental support	5.06	4.6
Venting	4.43	4.1
Substance use	2.93	2.98
Behavioural disengagement	2.72	2.89
Self-blame	4.03	3.98

Table A6.16: Mean Carver Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Active coping	5.55	5.20
Planning	5.60	5.23
Positive reframing	5.52	5.30
Acceptance	6.12	5.89
Use of emotional support	4.85	4.74
Use of instrumental support	4.56	4.35
Venting	4.12	4.32
Substance use	2.79	2.78
Behavioural disengagement	2.89	3.06
Self-blame	4.07	4.09

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 ($F = 39.26$, $df = 2$, $p < .001$), where respondents who were impacted but not significantly scored significantly higher than those who were not impacted and those who were overwhelmed by the pressures.
- Planning ($F = 61.38$, $df = 2$, $p < .001$), where respondents who were impacted but not significantly scored significantly lower than those who were not impacted and those who were overwhelmed by the pressures.
- Positive reframing ($F = 41.59$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups. Those overwhelmed by increased pressures scored significantly lower than the other two groups.
- Acceptance ($F = 16.48$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups.
- Use of emotional support ($F = 21.42$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than the other two groups.

- Use of instrumental support ($F = 13.26$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups.
- Venting ($F = 45.29$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups. Those overwhelmed by increased pressures scored significantly lower than the other two groups.
- Substance use ($F = 59.31$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups.
- Behavioural disengagement ($F = 93.37$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups.
- Self-blame ($F = 30.83$, $df = 2$, $p < .001$), where respondents who were not impacted scored significantly higher than the other two groups.

Summary (Unweighted results):

There were significant differences in mean scores on six out of the ten examined Carver coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Active coping ($F = 3.03$, $df = 2$, $p = .049$), but multiple comparisons between the countries revealed no significant difference.
- Planning ($F = 8.502$, $df = 2$, $p = .003$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Use of emotional support ($F = 3.85$, $df = 2$, $p = .022$), where respondents who felt overwhelmed by increased pressures scored significantly higher than those felt some impact.
- Venting ($F = 11.34$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Substance use ($F = 4.70$, $df = 2$, $p = .009$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Behavioural disengagement ($F = 20.13$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.
- Self-blame ($F = 19.19$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly higher than the other two groups.

Figure A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

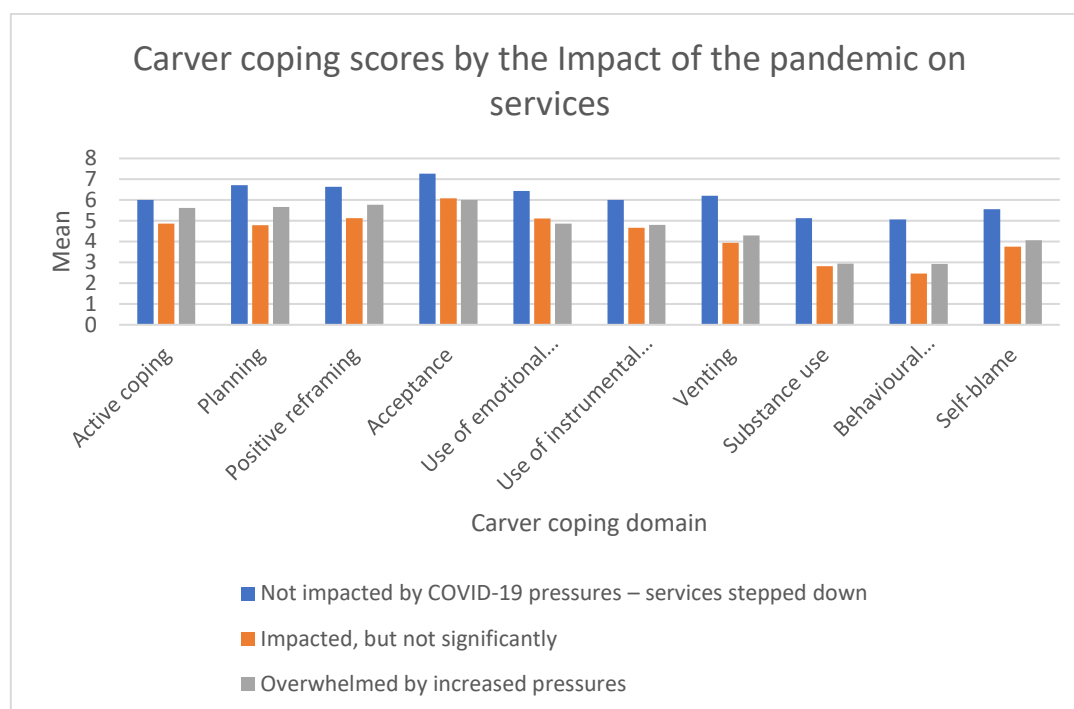


Figure A6.18: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Unweighted)

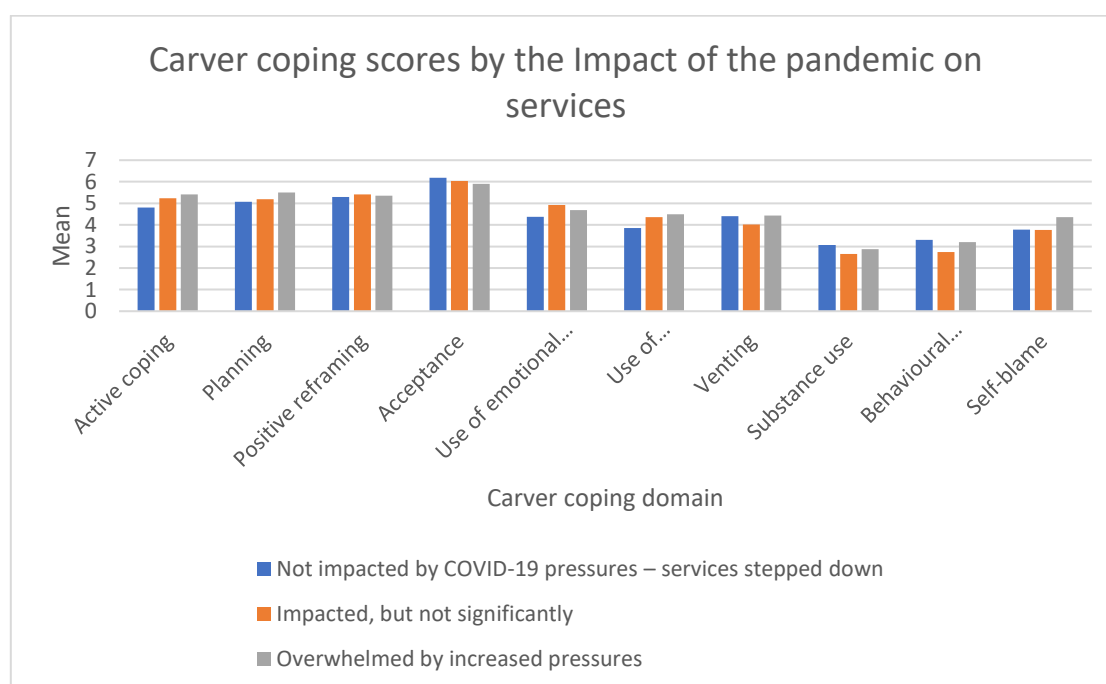


Table A6.17: Mean Carver Coping Scores by the Impact of the Pandemic on Services (Weighted)

Coping domain	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Active coping	6.01	4.86	5.62
Planning	6.72	4.79	5.67
Positive reframing	6.64	5.13	5.78
Acceptance	7.26	6.08	6.00
Use of emotional support	6.43	5.11	4.87
Use of instrumental support	6.00	4.66	4.8
Venting	6.20	3.94	4.3
Substance use	5.12	2.82	2.94
Behavioural disengagement	5.07	2.46	2.93
Self-blame	5.56	3.76	4.06

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	4.81	5.24	5.41
Planning	5.07	5.19	5.51
Positive reframing	5.30	5.41	5.35
Acceptance	6.19	6.03	5.91
Use of emotional support	4.37	4.92	4.69
Use of instrumental support	3.85	4.36	4.50
Venting	4.41	4.02	4.44
Substance use	3.07	2.66	2.88
Behavioural disengagement	3.30	2.74	3.21
Self-blame	3.78	3.76	4.36

Appendix 7: Clark Coping Scale (Weighted and Unweighted) – Tables and Charts

This section provides detailed results of how respondents coped with work-related stressors. This was measured using 15 items (five domains) from Clark et al.'s scale. Weighted results are presented in **blue font**. Unweighted (i.e., raw) results are presented in **orange font**.

A7.1 Clark Coping Scores by Country

Summary (Weighted results):

There were significant differences between the countries in mean scores on two out of the five examined Clark coping domains. These differences were in:

- Work-family ($F = 4.79$, $df = 3$, $p = .018$), where respondents from Northern Ireland scored significantly lower than those in Scotland.
- Working to improve skills/efficiency ($F = 3.88$, $df = 3$, $p = .09$), where respondents from Northern Ireland scored significantly lower than those in England.

Summary (Unweighted results):

There were significant differences between the countries in mean scores on one out of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ($F = 2.71$, $df = 3$, $p = .044$), multiple comparison revealed no significant differences between individual countries however respondents from England scored lower than those from the other three countries.

Figure A7. 1: Mean Clark Coping Scores by Country (Weighted)

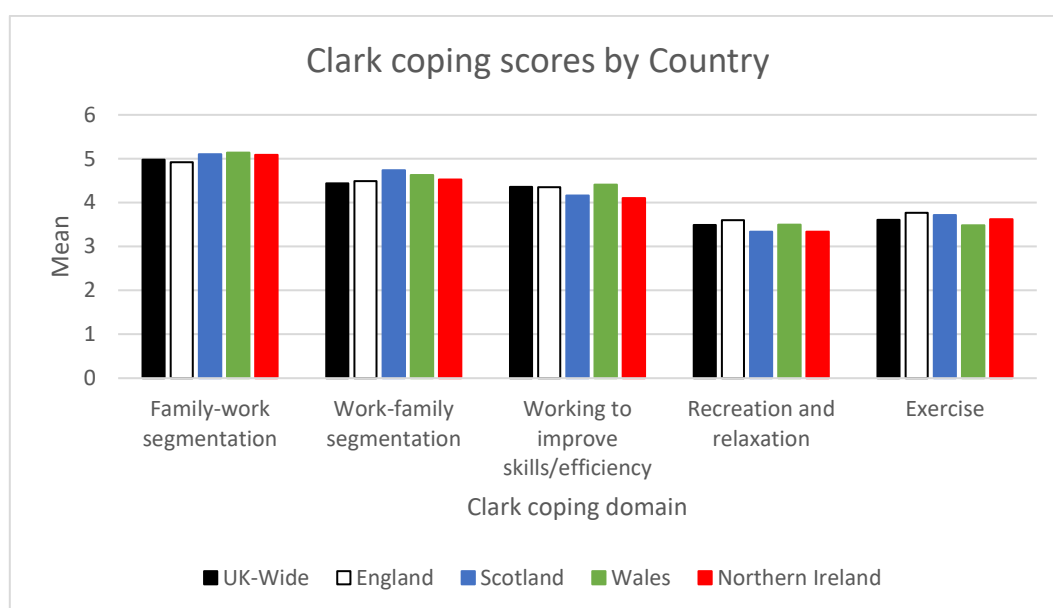


Figure A7. 2: Mean Clark Coping Scores by Country (Unweighted)

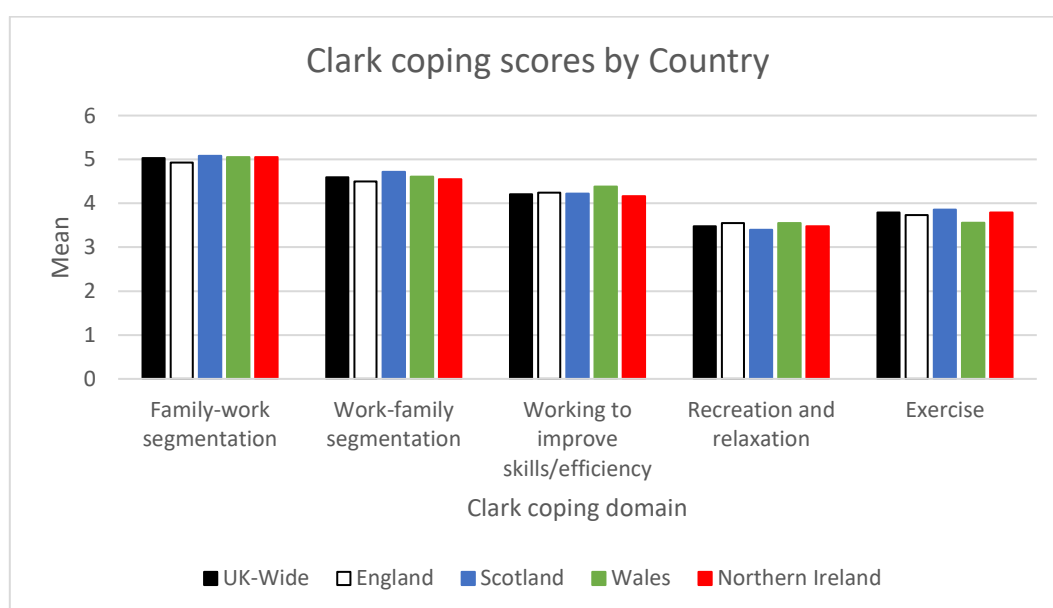


Table A7. 1: Mean Clark Coping Scores by Country (Weighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family-work segmentation	4.98	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	4.1
Recreation and relaxation	3.49	3.6	3.34	3.5	3.34
Exercise	3.61	3.77	3.72	3.48	3.62

Table A7. 2: Mean Clark Coping Scores by Country (Unweighted)

Coping domain	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Family-work segmentation	5.03	4.93	5.08	5.05	5.05
Work-family segmentation	4.59	4.50	4.72	4.61	4.55
Working to improve skills/efficiency	4.21	4.24	4.22	4.38	4.16
Recreation and relaxation	3.48	3.55	3.40	3.55	3.48
Exercise	3.79	3.73	3.86	3.56	3.79

A7.2 Clark Coping Scores by Occupation

Summary (Weighted results):

There were significant differences between the occupational groups in mean scores on three Clark coping domains:

- Working to improve skills/efficiency ($F = 8.08$, $df = 4$, $p < .001$), where midwives scored significantly lower than nurses, AHPs and Social workers.
- Recreation and relaxation ($F = 12.34$, $df = 4$, $p < .001$), where midwives scored significantly lower than nurses, AHPs and Social workers.
- Exercise ($F = 29.58$, $df = 4$, $p < .001$), where AHPs scored significantly higher than all other occupations.

Summary (Unweighted results):

There were significant differences between the occupational groups in mean scores on all three Clark Coping domains:

- Working to improve skills/efficiency ($F = 3.59$, $df = 4$, $p = .006$), where social care workers scored significantly lower than AHPs.
- Recreation and relaxation ($F = 7.89$, $df = 4$, $p < .001$), midwives scored significantly lower than AHPs and social workers
- Exercise ($F = 11.90$, $df = 4$, $p < .001$), where AHPs were significantly higher than nurses social care workers and social workers.

Figure A7.3: Mean Clark Coping Scores by Occupation (Weighted)

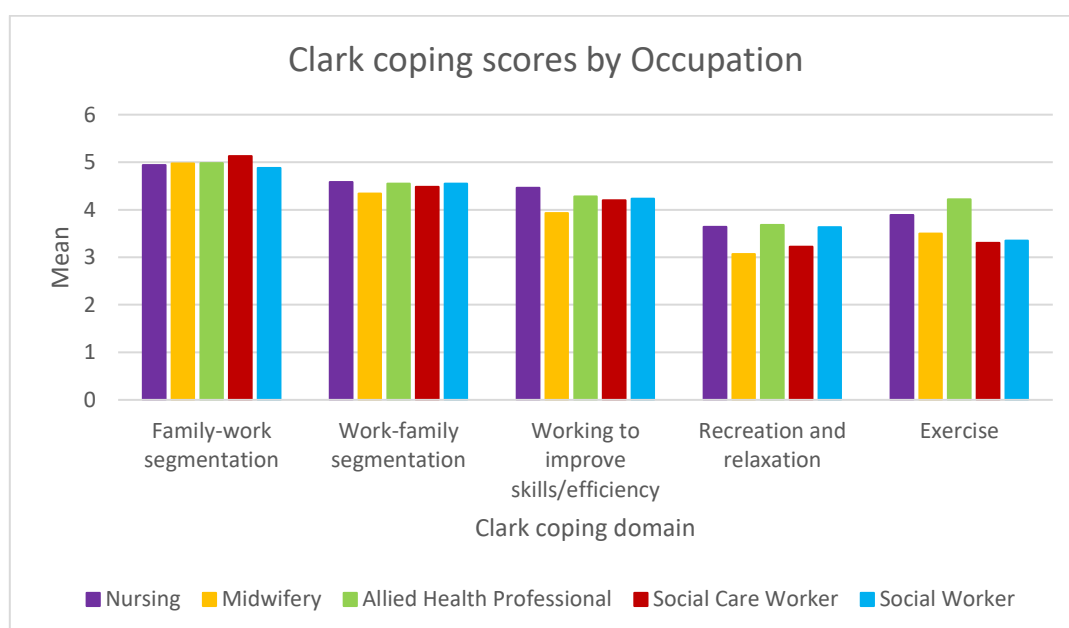


Figure A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

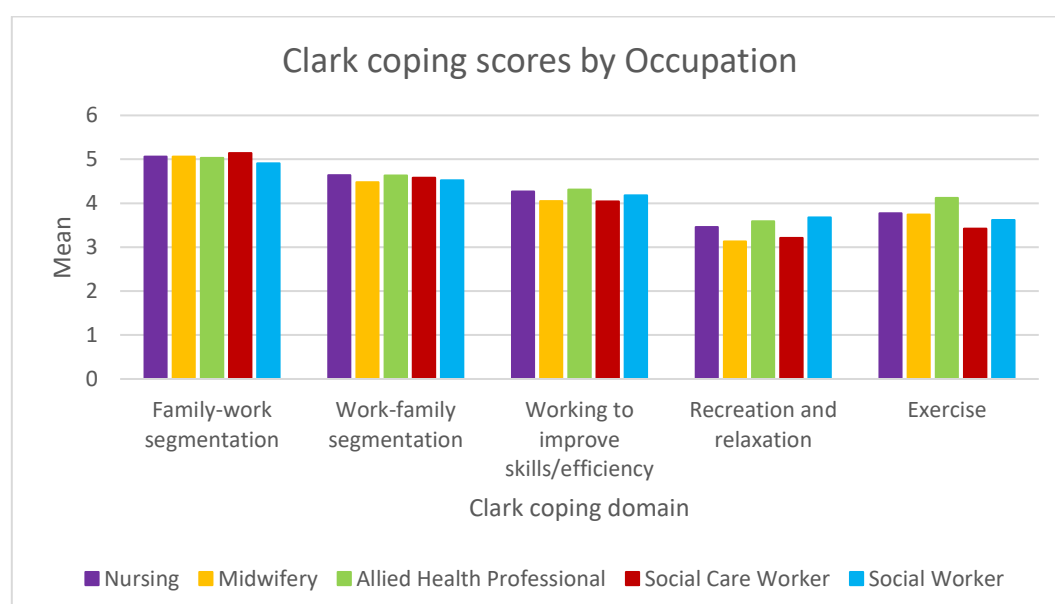


Table A7.3: Mean Clark Coping Scores by Occupation (Weighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	4.94	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

Table A7.4: Mean Clark Coping Scores by Occupation (Unweighted)

Coping domain	Occupation				
	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Family-work segmentation	5.06	5.06	5.03	5.14	4.91
Work-family segmentation	4.64	4.48	4.63	4.58	4.52
Working to improve skills/efficiency	4.27	4.05	4.31	4.04	4.18
Recreation and relaxation	3.46	3.13	3.59	3.21	3.68
Exercise	3.77	3.74	4.12	3.42	3.62

A7.3 Clark Coping Scores by Sex

Only three respondents who answered questions on the Clark coping scale stated their sex to be 'Other'. These respondents were excluded from analyses based on sex, as the estimates would likely be unreliable due to the small sample size.

Summary (Weighted results):

There were significant differences between males and females in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($t = -2.264.79$, $df = 1639$ $p = .024$), where females scored significantly lower than males.
- Work-family segmentation ($t = -4.918$, $df = 451,64$ $p = < .001$), where females scored significantly lower than males.

- Working to improve skills/efficiency ($t = -3.99$ $df = 573.59$ $p < .001$), where females scored significantly lower than males.
- Recreation and relaxation ($t = -6.28$, $df = 426.77$, $p < .001$), where females scored significantly lower than males.

Summary (Unweighted results):

There were significant differences between males and females in mean scores on two out of the five examined Clark coping domains. These differences were in:

- Working to improve skills/efficiency ($t = 2.16$, $df = 1424$, $p = .031$), where females scored significantly higher than males.
- Recreation and relaxation ($t = -1.96$, $df = 1423$, $p = .05$), where males scored significantly higher than females.

Figure A7.5: Mean Clark Coping Scores by Sex (Weighted)

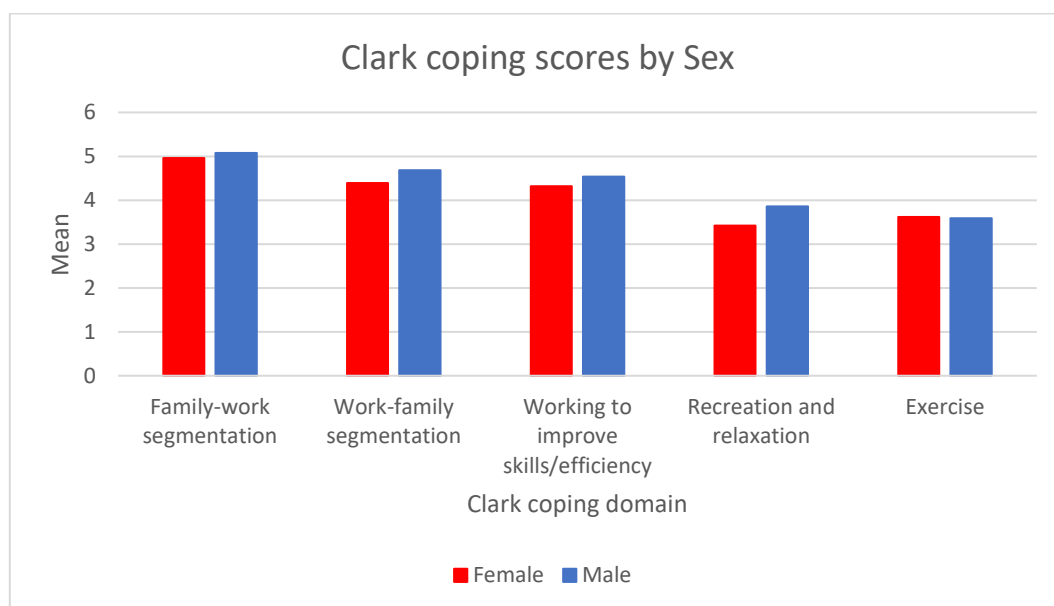


Figure A7.6: Mean Clark Coping Scores by Sex (Unweighted)

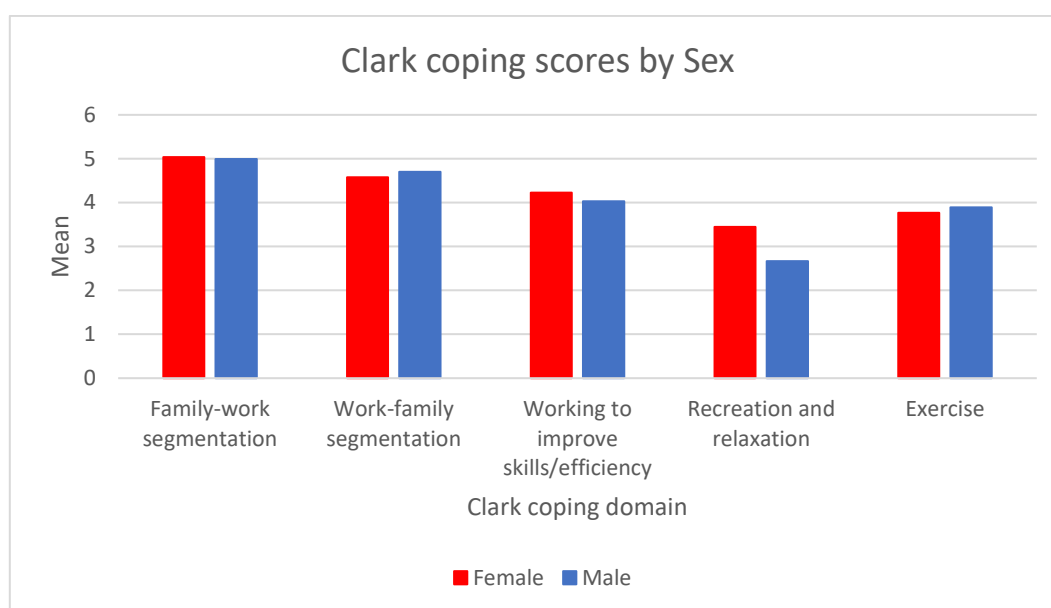


Table A7.5: Mean Clark Coping Scores by Sex (Weighted)

Coping Domain	Sex	
	Female	Male
Family-work segmentation	4.96	5.08
Work-family segmentation	4.39	4.68
Working to improve skills/efficiency	4.32	4.54
Recreation and relaxation	3.42	3.86
Exercise	3.62	3.59

Table A7.6: Mean Clark Coping Scores by Sex (Unweighted)

Coping domain	Sex	
	Female	Male
Family-work segmentation	5.04	4.99
Work-family segmentation	4.58	4.70
Working to improve skills/efficiency	4.23	4.03
Recreation and relaxation	3.45	2.67
Exercise	3.77	3.89

A7.4 Clark Coping Scores by Age

Summary (Weighted results):

There were significant differences between the age groups in mean scores on all five Clark coping domains. These differences were in:

- Family-work segmentation ($F = 14.59$, $df = 5$, $p < .001$), where the 60-65 age group scored significantly lower than 30-39, 40-49, 50-59 and 66+ age groups.
- Work-family segmentation ($F = 10.33$, $df = 5$, $p < .001$), where the 40-49 age group scored significantly higher than the 30-39, 50-59 and 60-65 age groups.
- Working to improve skills/efficiency ($F = 2.29$, $df = 5$, $p = .044$), where the post-hoc revealed no significant differences between any age group.
- Recreation and relaxation ($F = 24.40$, $df = 5$, $p < .001$), where the 60-65 age group scored significantly higher than all age groups.
- Exercise ($F = 19.74$, $df = 5$, $p < .001$), where the 30-39 age group scored significantly lower than all other age groups.

Summary (Unweighted results):

There were significant differences between the age groups in mean scores on four out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 3.15$, $df = 5$, $p = .008$), where the 30-39 age group scored significantly lower than the 40-49 and 50-59 age groups.
- Work-family segmentation ($F = 5.51$, $df = 5$, $p < .001$), where the 16-29 age group is significantly lower than the 40-49, 50-59 and 60-65 age groups.
- Recreation and relaxation ($F = 4.34$, $df = 5$, $p < .001$); where the 60-65 age group scored significantly higher than the 16-29, 30-39 and 40-49 age groups.
- Exercise ($F = 2.77$, $df = 5$, $p = .017$); where the 60-65 age group scored significantly higher than the 16-29, 30-39 and 40-49 age groups.

Figure A7.7: Mean Clark Coping Scores by Age (Weighted)

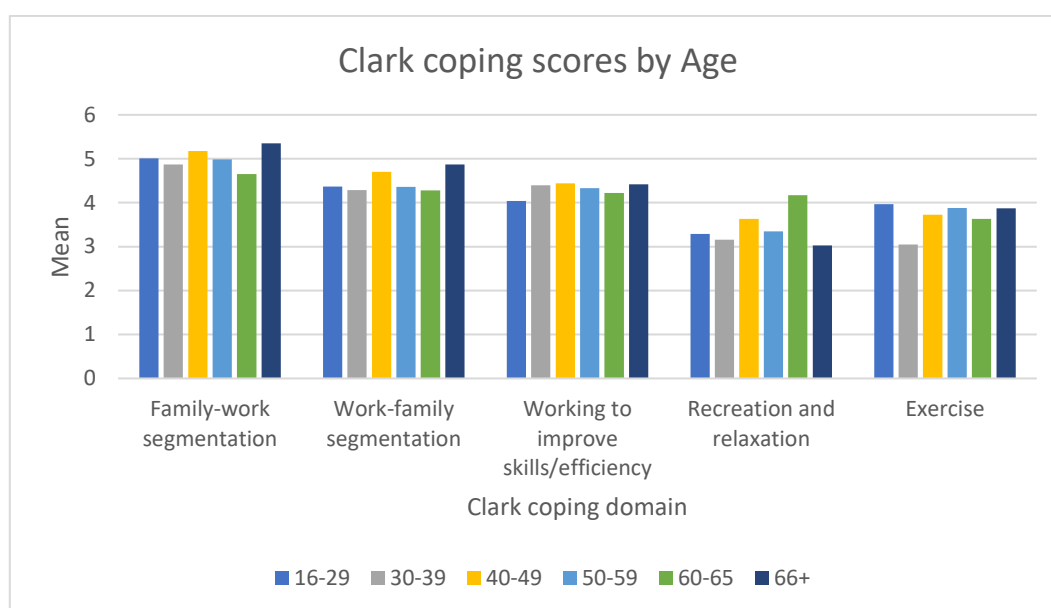


Figure A7.8: Mean Clark Coping Scores by Age (Unweighted)

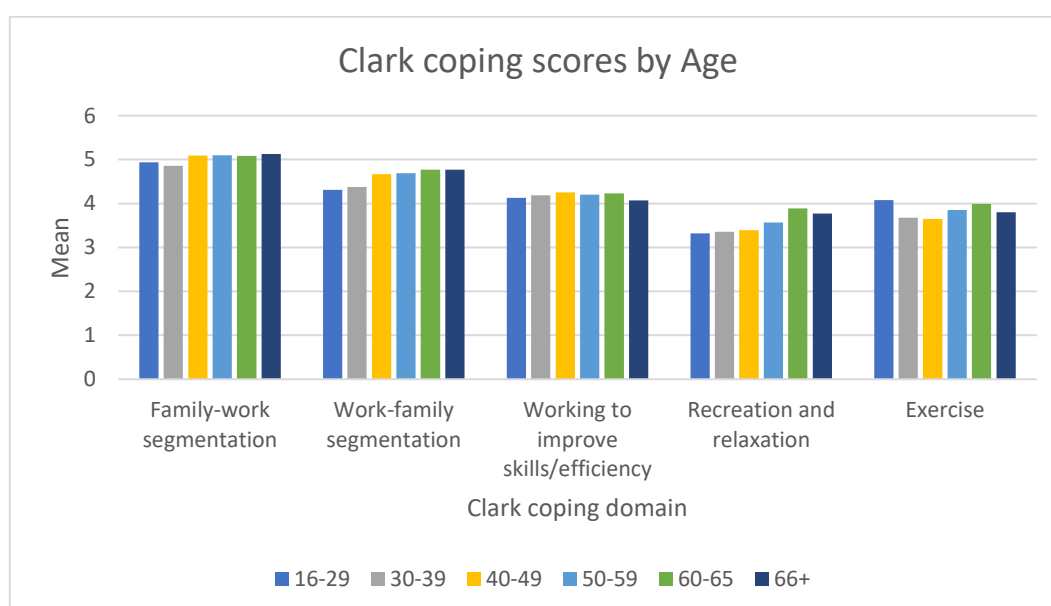


Table A7.7: Mean Clark Coping Scores by Age (Weighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Family-work segmentation	5.01	4.87	5.18	4.99	4.65	5.35
Work-family segmentation	4.37	4.29	4.70	4.36	4.28	4.87
Working to improve skills/efficiency	4.04	4.40	4.44	4.33	4.22	4.42
Recreation and relaxation	3.29	3.16	3.63	3.35	4.17	3.03
Exercise	3.97	3.05	3.73	3.88	3.63	3.87

Table A7.8: Mean Clark Coping Scores by Age (Unweighted)

Coping domain	Age					
	16-29	30-39	40-49	50-59	60-65	66+
Family-work segmentation	4.94	4.86	5.09	5.10	5.08	5.13
Work-family segmentation	4.31	4.38	4.67	4.69	4.77	4.77
Working to improve skills/efficiency	4.13	4.19	4.25	4.20	4.23	4.07
Recreation and relaxation	3.32	3.36	3.39	3.57	3.89	3.77
Exercise	4.08	3.68	3.65	3.85	3.99	3.8

A7.5 Clark Coping Scores by Ethnicity

Summary (Weighted results):

There were significant differences between the ethnic groups in mean scores on all five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 3.66$, $df = 3$, $p = .012$), where respondents from the Asian ethnic group scored significantly higher than those in the White or Black Ethnic groups.
- Work-family segmentation ($F = 7.20$, $df = 3$, $p < .001$), where respondents from the Asian ethnic group scored significantly higher than those in the White or Black ethnic groups.
- Working to improve skills/efficiency ($F = 9.13$, $df = 3$, $p < .001$), where respondents from the White ethnic group scored significantly lower than the Black and Asian ethnic groups
- Recreation and relaxation ($F = 5.89$, $df = 3$, $p < .001$), where respondents from the black ethnic group scored significantly lower than those in the Asian ethnic group.

- Exercise ($F = 3.24$, $df = 3$, $p = .021$), where respondents from the Asian ethnic group scored significantly higher than those in the White or Black Ethnic groups.

Summary (Unweighted results):

There were significant differences between the ethnic groups in mean scores in two out of the five examined Clark coping domains. These differences were in:

- Working to improve skills/efficiency ($F = 3.50$, $df = 3$, $p = .015$), where respondents from the Asian ethnic group scored significantly higher than those in the White ethnic group.
- Recreation and relaxation ($F = 3.05$, $df = 3$, $p = .028$), where respondents from the Asian ethnic group scored significantly higher than those in the White ethnic group.

Figure A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

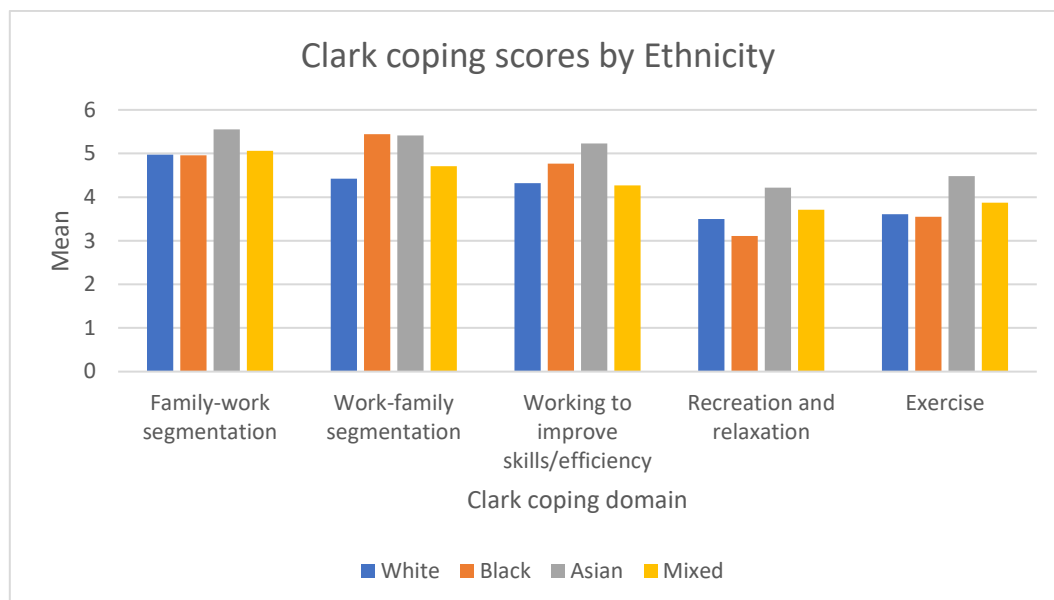


Figure A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

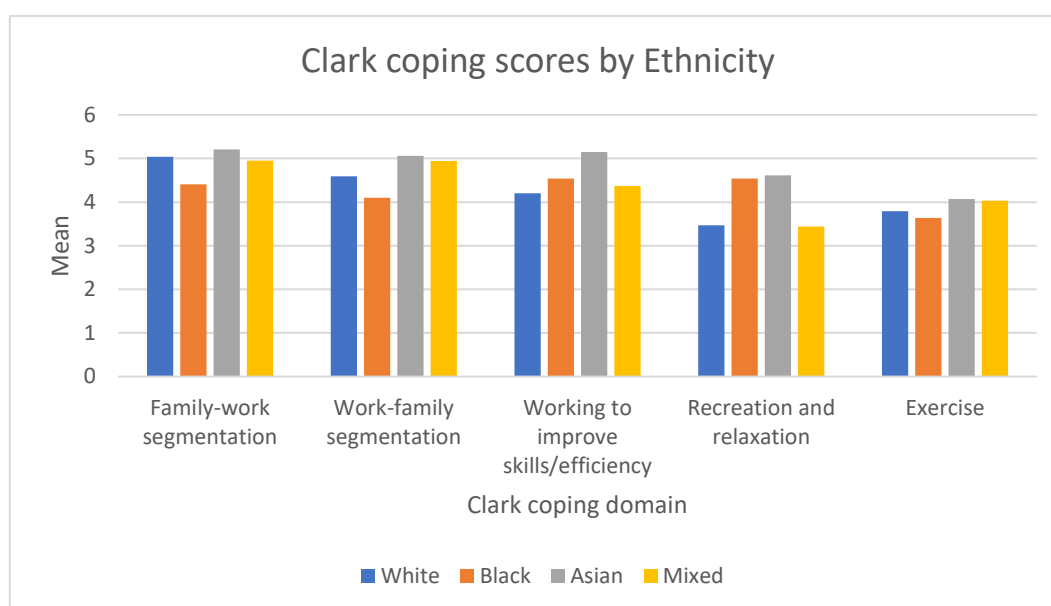


Table A7.9: Mean Clark Coping Scores by Ethnicity (Weighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	4.97	4.96	5.55	5.06
Work-family segmentation	4.42	5.44	5.41	4.71
Working to improve skills/efficiency	4.32	4.77	5.23	4.27
Recreation and relaxation	3.50	3.11	4.22	3.71
Exercise	3.61	3.55	4.48	3.87

Table A7.10: Mean Clark Coping Scores by Ethnicity (Unweighted)

Coping domain	Ethnicity			
	White	Black	Asian	Mixed
Family-work segmentation	5.04	4.41	5.21	4.95
Work-family segmentation	4.59	4.1	5.06	4.94
Working to improve skills/efficiency	4.2	4.54	5.15	4.37
Recreation and relaxation	3.47	4.54	4.61	3.44
Exercise	3.79	3.64	4.07	4.03

A7.6 Clark Coping Scores by Disability

Summary (Weighted results):

There were significant differences between respondents based on their disability status in mean scores on three out of the five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 13.41$, $df = 2$, $p < .001$), where respondents who had no disability scored significantly lower than the other two groups.
- Work-family segmentation ($F = 6.32$, $df = 2$, $p = .002$), where respondents who were unsure of whether or not they had a disability scored significantly lower than the other two groups.
- Working to improve skills/efficiency ($F = 15.67$, $df = 2$, $p < .001$), where respondents who had no disability scored significantly lower than the other two groups.

Summary (Unweighted results):

There were significant differences between respondents based on their disability status in mean scores on one out of the five examined Clark coping domains. These differences were in:

- Exercise ($F = 7.99$, $df = 2$, $p < .001$), where respondents without a disability scored significantly higher than those with a disability.

Figure A7.11: Mean Clark Coping Scores by Disability (Weighted)

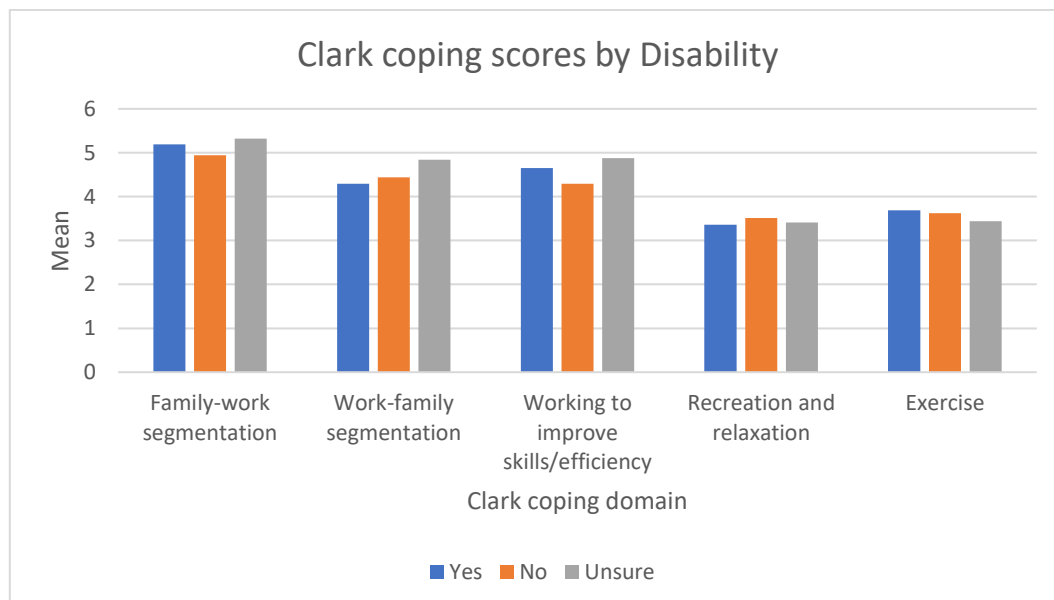


Figure A7.12: Mean Clark Coping Scores by Disability (Unweighted)

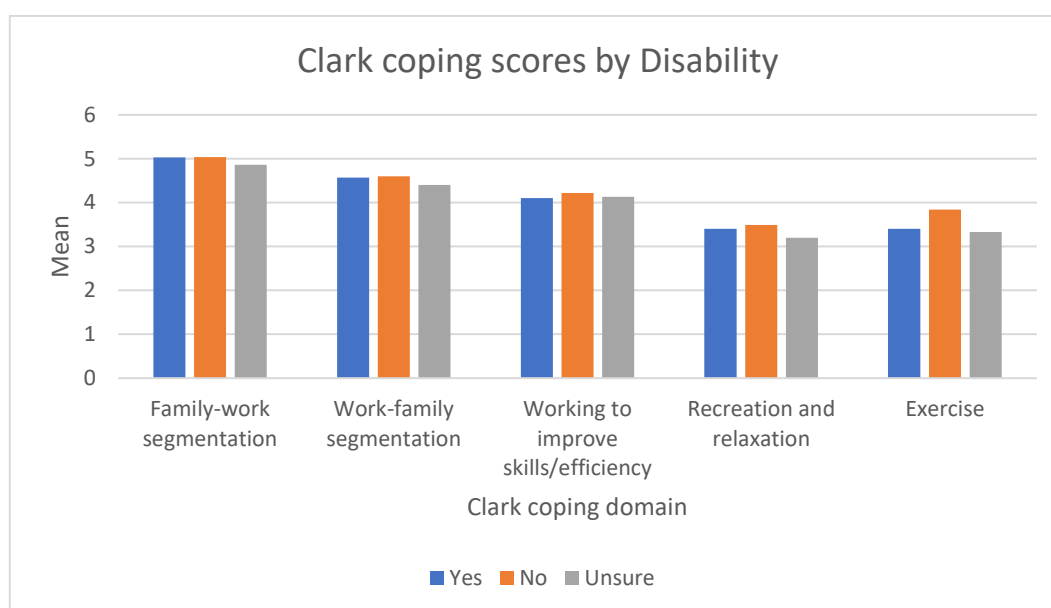


Table A7.11: Mean Clark Coping Scores by Disability (Weighted)

Coping domain	Do you consider yourself to have a disability?		
	Yes	No	Unsure
Family-work segmentation	5.19	4.94	5.32
Work-family segmentation	4.29	4.44	4.84
Working to improve skills/efficiency	4.65	4.29	4.88
Recreation and relaxation	3.36	3.51	3.41
Exercise	3.69	3.62	3.44

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	5.03	5.04	4.86
Work-family segmentation	4.57	4.60	4.40
Working to improve skills/efficiency	4.10	4.22	4.13
Recreation and relaxation	3.40	3.49	3.20
Exercise	3.40	3.84	3.33

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 ($F = 14.65$, $df = 7$, $p < .001$), where respondents working with children and young people scored significantly higher than those working with adults of working age and those in the area of practice 'other'. Those working with adults of working age, scored significantly lower than those working in learning disability, with older people, in mental health and those in the area of practice 'other'.
- Work-family segmentation ($F = 8.51$, $df = 7$, $p < .001$), where respondents working with adults of working age, scored significantly lower than those working in learning disability, with older people, and those working in mental health.
- Working to improve skills/efficiency ($F = 23.14$, $df = 7$, $p < .001$), where respondents working with children scored significantly higher than those working in midwifery, with those working in the area of learning disability and those in the area of practice 'other'.
- Recreation and relaxation ($F = 6.43$, $df = 7$, $p < .001$), where respondents working in mental health scored significantly higher than those working in the areas of children and young people, midwifery, with adults of working age, learning disability, with older people and those in the area of practice 'other'.
- Exercise ($F = 19.80$, $df = 7$, $p < .001$), where respondents working with adults of working age scored significantly higher than those working with children and young people, in midwifery, in the area of learning disability, within mental health, with older people and those in the area of practice 'other'.

Summary (Unweighted results):

There were significant differences between respondents based on their main area of practice in mean scores in all five examined Clark coping domains. These differences were in:

- Family-work segmentation ($F = 3.02$, $df = 7$, $p = .004$), where respondents working with children and young people had significantly lower scores than those working with physical disability and those working with older people.
- Working to improve skills/efficiency ($F = 2.03$, $df = 7$, $p = .048$), however multiple comparison tests revealed no significant differences.

- Recreation and relaxation ($F = 3.93$, $df = 7$, $p < .001$), where respondents working in midwifery scored significantly lower than those working with children, mental health or 'other' services.
- Exercise ($F = 2.74$, $df = 7$, $p = .008$), where respondents working with older people scored significantly lower than those working with adults and within 'other' services.

Figure A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

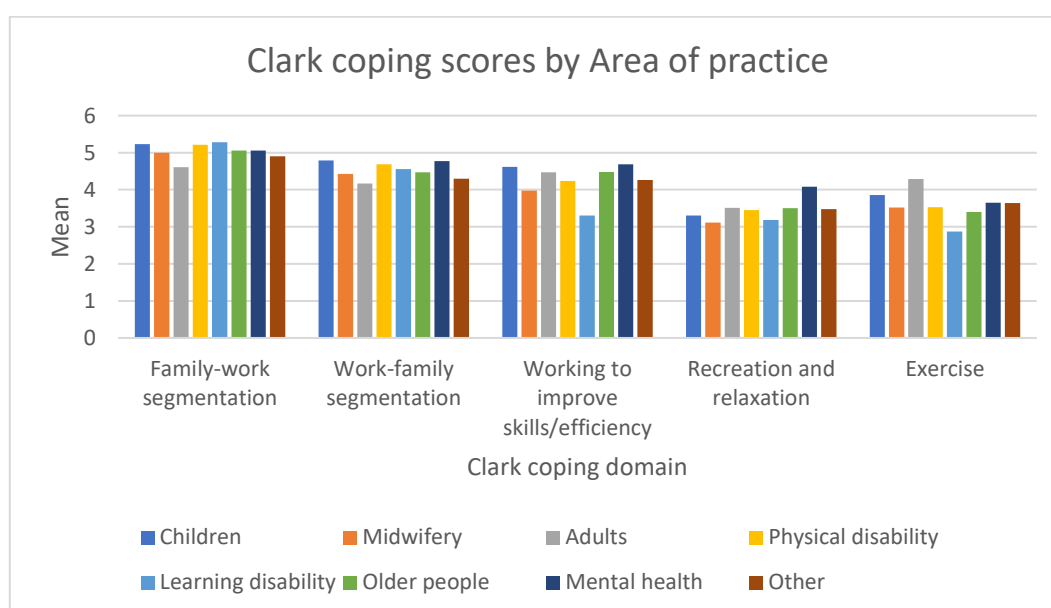


Figure A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)

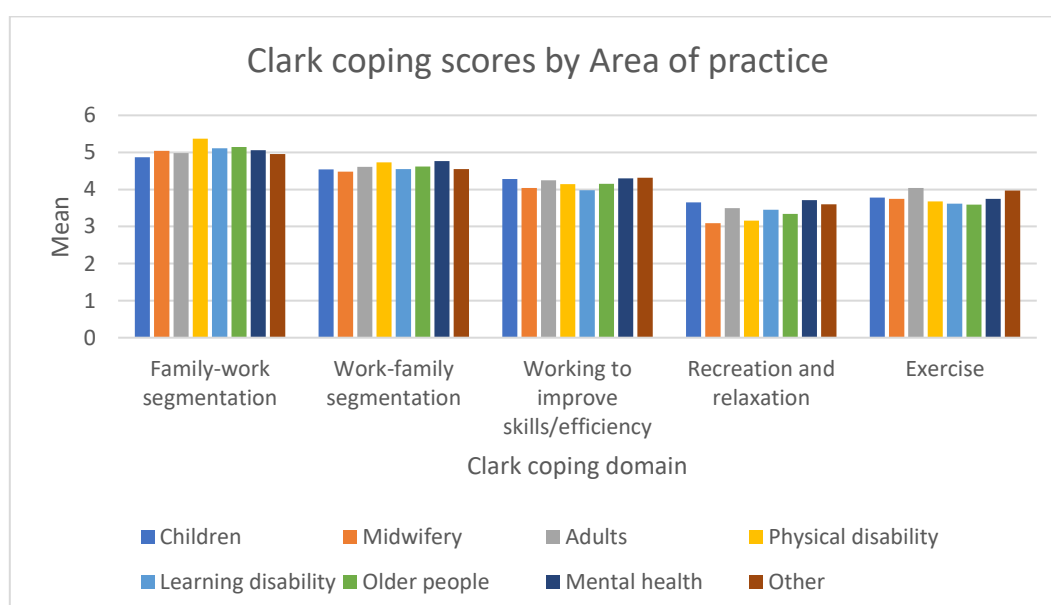


Table A7.13: Mean Clark Coping Scores by Main Area of Practice (Weighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Family-work segmentation	5.23	5.00	4.61	5.21	5.28	5.06	5.06	4.90
Work-family segmentation	4.79	4.43	4.17	4.69	4.56	4.47	4.77	4.30
Working to improve skills/efficiency	4.62	3.98	4.47	4.24	3.30	4.48	4.69	4.26
Recreation and relaxation	3.30	3.11	3.51	3.45	3.18	3.50	4.08	3.48
Exercise	3.86	3.52	4.29	3.53	2.87	3.40	3.65	3.64

Table A7.14: Mean Clark Coping Scores by Main Area of Practice (Unweighted)

Coping domain	Main area of practice							
	Children	Midwifery	Adults	Physical disability	Learning disability	Older people	Mental health	Other
Family-work segmentation	4.87	5.04	4.98	5.37	5.11	5.15	5.06	4.96
Work-family segmentation	4.54	4.48	4.61	4.73	4.55	4.62	4.77	4.55
Working to improve skills/efficiency	4.28	4.04	4.25	4.14	3.98	4.15	4.30	4.32
Recreation and relaxation	3.65	3.09	3.50	3.16	3.45	3.34	3.71	3.60
Exercise	3.78	3.75	4.04	3.68	3.62	3.59	3.75	3.97

A7.8 Clark Coping Scores by Line Manager Status

Summary (Weighted results):

There were significant differences between respondents who were line managers and those who were not in mean scores on four of the five examined Clark coping domains. These differences were in:

- Work-family segmentation ($t = -7.23$, $df = 1373.96$, $p < .001$), where line managers scored significantly lower than those who were not line managers.
- Working to improve skills/efficiency ($t = 4.91$, $df = 1441.72$, $p < .001$), where line managers scored significantly higher than those who were not line managers.
- Recreation and relaxation ($t = 2.80$, $df = 2576$, $p = .005$), where line managers scored significantly higher than those who were not line managers.
- Exercise ($t = -2.58$, $df = 2571$, $p = .010$), where line managers scored significantly lower than those who were not line managers.

Summary (Unweighted results):

There were significant differences between respondents who were line managers and those who were not in mean scores on one out of the five examined Clark coping domains. The differences were in:

- Working to improve skills/efficiency ($t = 2.19$, $df = 1428$, $p = .028$), where line managers scored significantly higher than those who were not line managers.

Figure A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

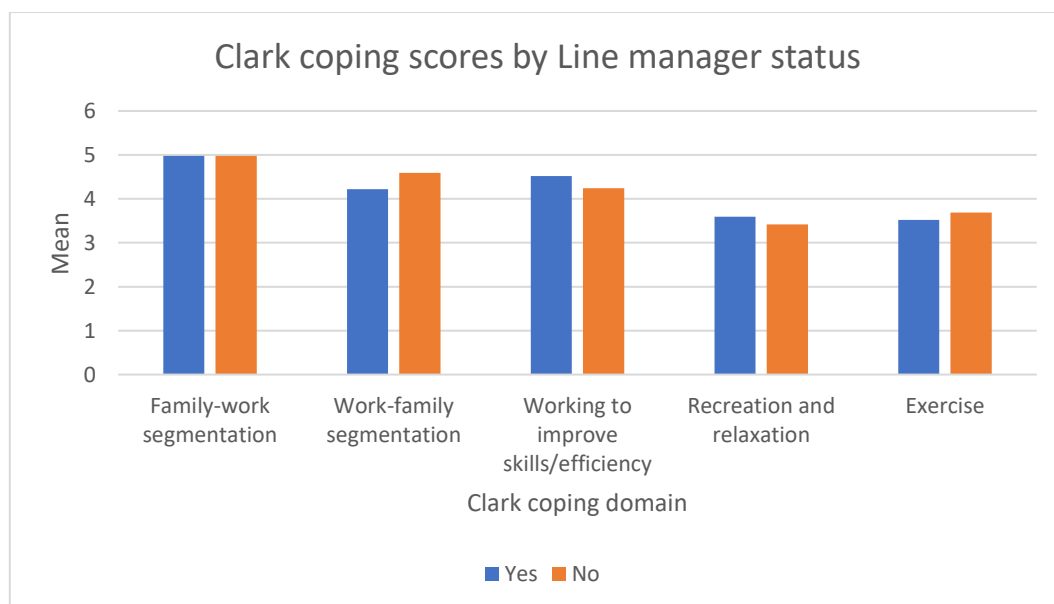


Figure A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

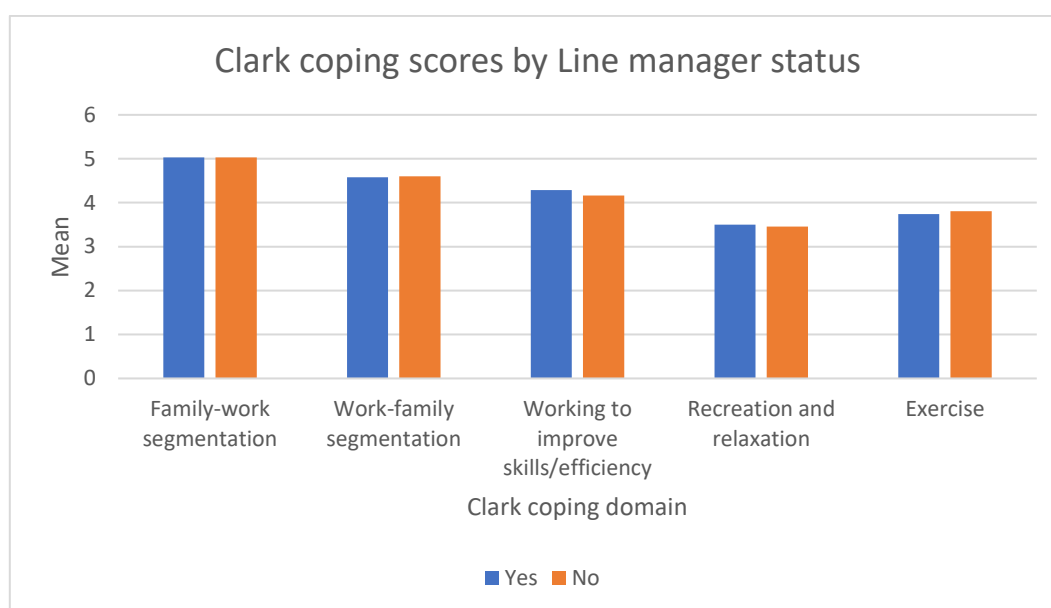


Table A7.15: Mean Clark Coping Scores by Line Manager Status (Weighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	4.98	4.98
Work-family segmentation	4.22	4.59
Working to improve skills/efficiency	4.52	4.24
Recreation and relaxation	3.59	3.42
Exercise	3.52	3.69

Table A7.16: Mean Clark Coping Scores by Line Manager Status (Unweighted)

Coping domain	Are you a line manager?	
	Yes	No
Family-work segmentation	5.03	5.03
Work-family segmentation	4.58	4.60
Working to improve skills/efficiency	4.29	4.16
Recreation and relaxation	3.50	3.46
Exercise	3.74	3.81

A7.9 Clark Coping Scores by the Impact of the Pandemic on Services

Summary (Weighted results):

There were significant differences in mean scores on all five examined Clark coping domains between respondents who experienced different levels of pressure on their service (i.e., no impact, some impact, being overwhelmed) due to the COVID-19 pandemic. These differences were in:

- Family-work segmentation ($F = 3.35$, $df = 2$, $p = .035$), where respondents who were impacted but not significantly scored significantly lower than those not impacted by COVID-19 pressures.
- Work-family segmentation ($F = 7.84$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who were felt some impact and those not impacted.
- Working to improve skills/efficiency ($F = 4.65$, $df = 2$, $p = .010$), where respondents who were not impacted by the COVID-19 pressures scored significantly higher than those impacted and those overwhelmed.
- Recreation and relaxation ($F = 39.91$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who were impacted some and those who were not impacted.
- Exercise ($F = 55.56$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who were impacted some and those who were not impacted.

Summary (Unweighted results):

There were significant differences in mean scores on 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 ($F = 3.04$, $df = 2$, $p = .048$), multiple comparison tests revealed no significant differences between the groups.
- Working to improve skills/efficiency ($F = 4.96$, $df = 2$, $p = .007$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact.
- Recreation and relaxation ($F = 12.91$, $df = 2$, $p < .001$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact.

- Exercise ($F = 6.40$, $df = 2$, $p = .002$), where respondents who felt overwhelmed by increased pressures scored significantly lower than those who only felt some impact.

Figure A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

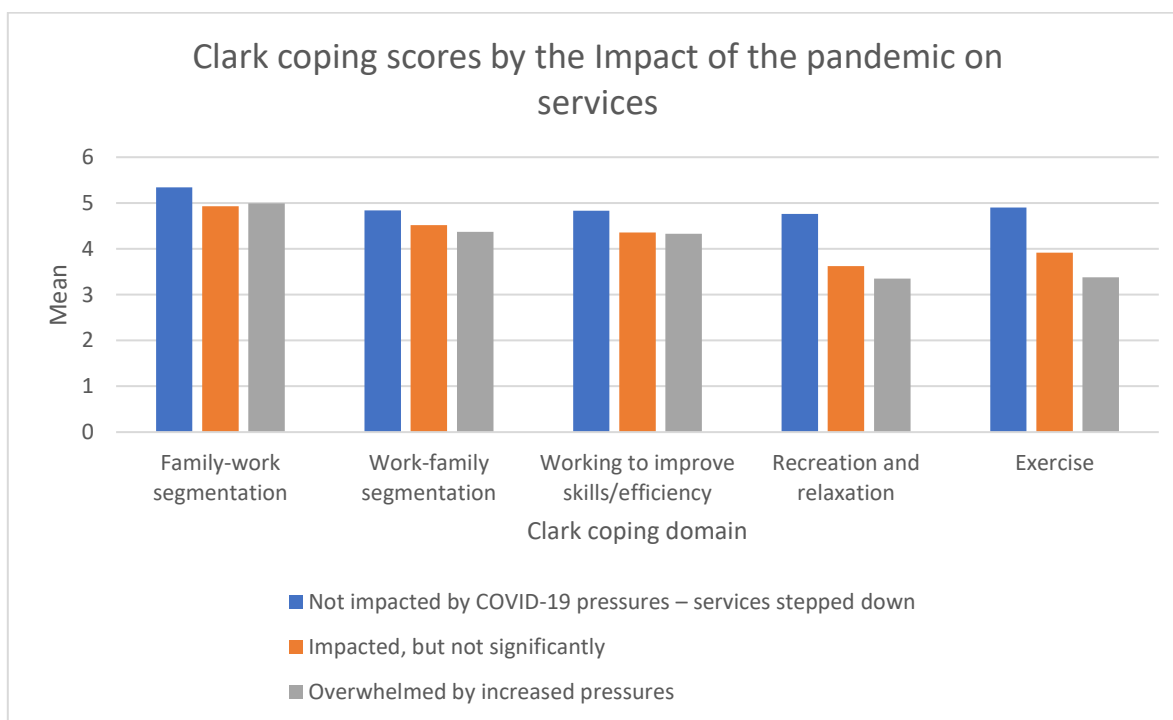


Figure A7.18: Mean Clark Coping Scores by Effects of the Pandemic on Services (Unweighted)

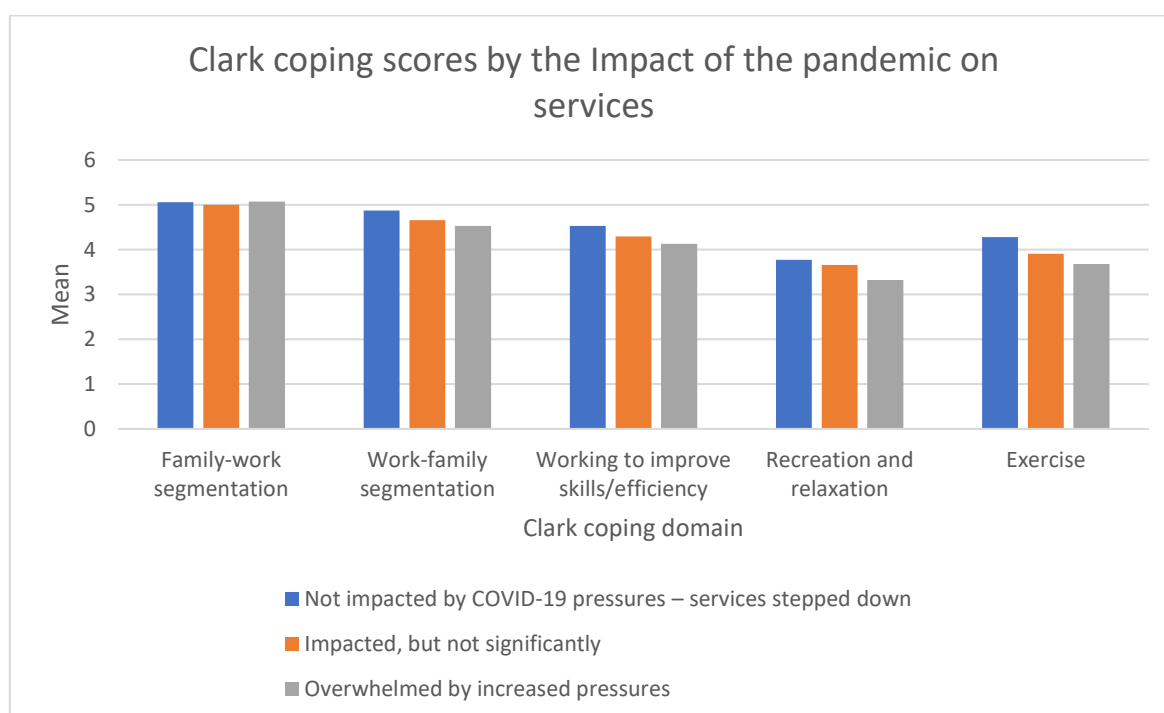


Table A7.17: Mean Clark Coping Scores by Effects of the Pandemic on Services (Weighted)

Coping domain	Impact of the pandemic on services		
	Not impacted by COVID-19 pressures – services stepped down	Impacted, but not significantly	Overwhelmed by increased pressures
Family-work segmentation	5.34	4.93	4.99
Work-family segmentation	4.84	4.52	4.37
Working to improve skills/efficiency	4.83	4.36	4.33
Recreation and relaxation	4.76	3.62	3.35
Exercise	4.90	3.92	3.38

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	5.06	5.00	5.07
Work-family segmentation	4.87	4.66	4.53
Working to improve skills/efficiency	4.53	4.29	4.13
Recreation and relaxation	3.77	3.66	3.32
Exercise	4.28	3.91	3.68

Appendix 8: Multiple Regression Results (Unweighted)

A8.1 Multiple Regression Model Predicting Wellbeing Scores

Research question: Do coping mechanisms predict Wellbeing scores when controlling for demographic, occupational and country of work variables?

Method: A multiple linear regression model was constructed with the Wellbeing scores (SWEMWBS) as the outcome variable using the following variables as covariates:

- Age (dummy coded; reference category: 16-29 years)
- Sex (males and females only; reference category: Female)
- Disability status (dummy coded; reference category: No disability)
- Ethnic group (dummy coded; reference category: White)
- Country of work (dummy coded; reference category: England)
- Occupational group (dummy coded; reference category: Nursing)
- Number of sick days in previous 12 months (dummy coded; reference category: No sick days)
- Line manager status (reference category: Not a line manager)
- Effects of the pandemic on services (dummy coded; reference category: Not impacted)
- Carver coping domains (continuous variables)
- Clark coping domains (continuous variables)

plus

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 45.6% of the variance (adjusted $R^2 = .440$, $F(41, 1356) = 27.77$ $p < .001$).

The following coping strategies predicted overall wellbeing score (SWEMWBS):

1. **Carver's Active coping**; respondents with higher Active coping scores had higher Wellbeing scores ($\beta = .088$, $p = .007$).
2. **Carver's Planning**; respondents with higher Planning scores had lower Wellbeing scores ($\beta = -.115$, $p < .001$).

3. **Carver's Acceptance**; respondents with higher Acceptance scores had higher Wellbeing scores ($\beta = .158, p < .001$).
4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher Wellbeing scores ($\beta = .192, p < .001$).
5. **Carver's Use of instrumental support**; respondents with higher use of instrumental scores had lower Wellbeing scores ($\beta = -.079, p = .006$).
6. **Carver's Venting**; respondents with higher venting scores had lower Wellbeing scores ($\beta = -.053, p = .028$).
7. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower Wellbeing scores ($\beta = -.098, p < .001$).
8. **Carver's Self-blame**; respondents with higher Self-blame scores had lower Wellbeing scores ($\beta = -.294, p < .001$).
9. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower Wellbeing scores ($\beta = -.081, p = .010$).
10. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher Wellbeing scores ($\beta = .110, p = .003$).
11. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher Wellbeing scores ($\beta = .105, p < .001$).
12. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher Wellbeing scores ($\beta = .055, p = .023$).
13. **Clark et al.'s Exercise**; respondents with higher Exercise scores had higher Wellbeing scores ($\beta = .062, p = .043$).

Other variables predicting the overall wellbeing score:

14. **Disability**; respondents who had a disability had lower wellbeing scores than those who did not have a disability ($\beta = -.074, p < .001$). Also respondents who were unsure if they had a disability had lower wellbeing scores than those who did not have a disability ($\beta = -.042, p = .038$).
15. **Occupational group**; Social workers ($\beta = -.054, p = .038$) all had lower wellbeing scores than nurses. Social care workers ($\beta = -.064, p = .012$) all had lower wellbeing scores than nurses.
16. **Effects of the pandemic**; respondents who were overwhelmed by the pandemic ($\beta = -.213, p = .006$) all had lower wellbeing scores than those whose services were not impacted at all.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, the results showed those who felt unprepared ($\beta = -.065$, $p = .002$) for redeployment had lower wellbeing scores than those who felt well prepared.

Additionally, 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 ($\beta = -.105$, $p < .001$) had lower wellbeing 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 ($\beta = -.081$, $p < .001$) had lower wellbeing 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

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 45.3% of the variance (adjusted $R^2 = .436$, $F(41, 1343) = 27.10$, $p < .001$). The following coping strategies predicted overall work-related quality of life score (WRQOL):

1. **Carver's Planning**; respondents with higher Planning scores had lower WRQOL scores ($\beta = -0.163$, $p < .001$).
2. **Carver's Positive reframing**; respondents with higher Positive reframing scores had higher WRQOL scores ($\beta = 0.074$, $p = .0091$).
3. **Carver's Acceptance**; respondents with higher Acceptance scores had higher WRQOL scores ($\beta = 0.087$, $p < .001$).

4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had higher WRQOL scores ($\beta = 0.142$, $p < .001$).
5. **Carver's Venting**; respondents with higher Venting scores had lower WRQOL scores ($\beta = -0.098$, $p < .001$).
6. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had lower WRQOL scores ($\beta = -0.154$, $p < .001$).
7. **Carver's Self-blame**; respondents with higher Self-blame scores had lower WRQOL scores ($\beta = -0.171$, $p < .001$).
8. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had lower WRQOL scores ($\beta = -0.096$, $p < .001$).
9. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had higher WRQOL scores ($\beta = 0.063$, $p = .012$).
10. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had higher WRQOL scores ($\beta = 0.130$, $p < .001$).
11. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had higher WRQOL scores ($\beta = 0.120$, $p < .001$).
12. **Exercise**; respondents with higher Exercise scores had lower WRQOL scores ($\beta = -0.050$, $p = .030$).

Other variables predicting the overall WRQOL score:

13. **Disability**; respondents with a disability ($\beta = -0.059$, $p = .005$) had lower WRQOL scores than those who did not have a disability.
14. **Ethnicity**; respondents who reported Asian ethnicity ($\beta = 0.048$, $p = .022$) had higher WRQOL scores than those of White Ethnicity.
15. **Country of work**; respondents working in Scotland ($\beta = -0.58$, $p = .043$) had lower WRQOL scores than those working in England.
16. **Occupation**; respondents who worked as midwives ($\beta = -0.49$, $p = .038$) or as social workers ($\beta = -0.59$, $p = .025$) had lower WRQOL scores than those working as nurses.
17. **Number of sick days in previous 12 months**; respondents who took 11-20 sick days ($\beta = -0.085$, $p = .001$); those who took 21-40 sick days ($\beta = -0.052$, $p = .015$); those who took 41-60 ($\beta = -0.052$, $p = .013$) and those who took more than 60 sick days ($\beta = -0.045$, $p = .036$) all had lower WRQOL scores than those who took no sick days.
18. **Line manager status**; respondents who were line managers had higher WRQOL scores than those who were not line managers ($\beta = 0.081$, $p < .001$).

19. **Effects of the pandemic on services;** respondents who felt impacted but not significantly ($\beta = -0.343$, $p < .001$) and respondents who felt overwhelmed by increased pressures ($\beta = -0.553$, $p < .001$) had lower WRQOL scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, the results showed that respondents who felt unprepared ($\beta = -0.071$, $p < .001$) for redeployment had lower WRQOL scores than those who felt well prepared.

Additionally, respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = -0.262$, $p < .001$) had WRQOL scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = -0.212$, $p < .001$) 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

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 44.7% of the variance (adjusted $R^2 = .430$, $F(41, 1356) = 26.71$, $p < .001$).

The following coping strategies predicted personal burnout scores:

1. **Carver's Active coping**; respondents with higher Active coping scores had lower Personal burnout scores ($\beta = -0.110$, $p = .047$).
2. **Carver's Planning**; respondents with higher Planning scores had higher Personal burnout scores ($\beta = 0.151$, $p < .001$).
3. **Carver's Acceptance**; respondents with higher Acceptance scores had lower Personal burnout scores ($\beta = -0.063$, $p = .011$).

4. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Personal burnout scores ($\beta = -0.103$, $p < .001$).
5. **Carver's Use of instrumental support**; respondents with higher Use of instrumental support scores had higher Personal burnout scores ($\beta = 0.074$, $p = .012$).
6. **Carver's Venting**; respondents with higher Venting scores had higher Personal burnout scores ($\beta = 0.053$, $p = .029$).
7. **Carver's Substance use**; respondents with higher Substance use scores had higher Personal burnout scores ($\beta = 0.062$, $p = .004$).
8. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Personal burnout scores ($\beta = 0.119$, $p < .001$).
9. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Personal burnout scores ($\beta = 0.238$, $p < .001$).
10. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Personal burnout scores ($\beta = 0.099$, $p < .001$).
11. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had lower Personal burnout scores ($\beta = -0.111$, $p < .001$).
12. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had lower Personal burnout scores ($\beta = -0.053$, $p = .030$).
13. **Clark et al.'s Exercise**; respondents with higher Exercise scores had lower Personal burnout scores ($\beta = -0.101$, $p < .001$).

Other variables predicting the personal burnout score:

14. **Age**; respondents aged 50-59 ($\beta = -0.088$, $p = .017$), those aged 60-65 ($\beta = -0.099$, $p < .001$) and those aged 66+ ($\beta = -0.051$, $p = .016$) all had lower personal burnout scores than those aged 16-29.
15. **Sex**; males had lower personal burnout scores than females ($\beta = -0.070$, $p < .001$).
16. **Disability**; respondents with a disability ($\beta = 0.079$, $p < .001$) and those who were unsure of disability ($\beta = 0.057$, $p = .005$) had higher personal burnout scores than those who did not have a disability.
17. **Ethnicity**; respondents who were Asian had lower personal burnout scores than those of White ethnicity ($\beta = -0.041$, $p = .049$).
18. **Number of sick days in previous 12 months**; respondents who took less than 10 sick days ($\beta = 0.048$, $p = .033$), those who took 11-20 sick days ($\beta = 0.055$, $p = .011$), and those who took 21-40 sick days ($\beta = 0.048$, $p = .023$) all had higher personal burnout scores than those who took no sick days.

17. Effects of the pandemic on services; respondents who felt their services had felt overwhelmed by increased pressures ($\beta = 0.429$, $p < .001$) and those who had been impacted but not significantly ($\beta = 0.232$, $p = .003$) had higher personal burnout scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict personal burnout scores.

Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes for wanting to leave ($\beta = 0.134$, $p < .001$) had higher personal burnout scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 0.128$, $p < .001$) 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

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 45.5% of the variance (adjusted $R^2 = .438$, $F(41, 1356) = 46.051$, $p < .001$).

The following coping strategies predicted personal burnout scores:

1. **Carver's Active coping**; respondents with higher Active coping scores had lower Work-related burnout scores ($\beta = -0.140$, $p < .001$).
2. **Carver's Planning**; respondents with higher Planning scores had higher Work-related burnout scores ($\beta = 0.182$, $p < .001$).
3. **Carver's Use of emotional support**; respondents with higher Use of emotional support scores had lower Work-related burnout scores ($\beta = -0.128$, $p < .001$).

4. **Carver's Use of instrumental support**; respondents with higher Use of instrumental support scores had higher Work-related burnout scores ($\beta = 0.065$, $p = .026$).
5. **Carver's Venting**; respondents with higher Venting scores had higher Work-related burnout scores ($\beta = 0.106$, $p < .001$).
6. **Carver's Substance use**; respondents with higher Venting scores had higher Work-related burnout scores ($\beta = 0.05$, $p = .019$).
7. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Work-related burnout scores ($\beta = 0.139$, $p < .001$).
8. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Work-related burnout scores ($\beta = 0.165$, $p < .001$).
9. **Clark et al.'s Family-work segmentation**; respondents with higher Family-work segmentation scores had higher Work-related burnout scores ($\beta = 0.119$, $p < .001$).
10. **Clark et al.'s Work-family segmentation**; respondents with higher Work-family segmentation scores had lower Work-related burnout scores ($\beta = -0.109$, $p < .001$).
11. **Clark et al.'s Working to improve skills/efficiency**; respondents with higher Working to improve skills/efficiency scores had lower Work-related burnout scores ($\beta = -0.085$, $p < .001$).
12. **Clark et al.'s Recreation and relaxation**; respondents with higher Recreation and relaxation scores had lower Work-related burnout scores ($\beta = -0.087$, $p < .001$).

Other variables predicting the work-related burnout score:

13. **Age**; respondents aged 30-39 ($\beta = -0.066$, $p = .042$), those aged 50-59 ($\beta = -0.088$, $p = 0.17$), those aged 60-65 ($\beta = -0.088$, $p = .001$) and those aged 66+ ($\beta = -0.078$, $p < .001$) all had lower work-related burnout scores than those aged 16-29.
14. **Ethnicity**; respondents of Asian ethnicity ($\beta = -0.042$, $p = .042$) had lower work-related burnout scores than those of White ethnicity.
15. **Number of sick days in previous 12 months**; respondents who took 11-20 sick days ($\beta = 0.053$, $p = .014$) had higher work-related burnout scores than those who took no sick days.
16. **Line manager**; respondents who were line managers ($\beta = 0.05$, $p = .019$) had higher work-related burnout scores than those who were not line managers.
17. **Effects of the pandemic on services**; respondents who felt overwhelmed by increased pressures ($\beta = 0.607$, $p < .001$) or impacted but not significantly ($\beta = 0.351$, $p < .001$) had higher work-related burnout scores than those who felt no impact.

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither

prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict work-related burnout scores.

Respondents were asked if they wanted to leave their employer during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 0.204$, $p < .001$) had higher work-related burnout scores than those who did not intend on leaving their employer.

Respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 0.184$, $p < .001$) 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

- How prepared respondents felt for their redeployment role (dummy coded; reference category: Well prepared)
- Intent to leave employer (dummy coded; reference category: No)
- Intent to leave occupation (dummy coded; reference category: No)

Results: The model explained 20.7% of the variance (adjusted $R^2 = .182$, $F(41, 2114) = 8.47$, $p < .001$).

The following coping strategies predicted client-related burnout scores:

1. **Carver's Active coping**, respondents with lower Active coping scores had higher Client-related burnout scores ($\beta = -0.082$, $p = .041$).
2. **Carver's Planning**, respondents with higher Planning scores had higher Client-related burnout scores ($\beta = 0.118$, $p = .005$).
3. **Carver's Use of emotional support**; respondents with lower use of emotional support scores had higher Client-related burnout scores ($\beta = -0.111$, $p = .001$).

4. **Carvers Venting**; respondents with higher Venting scores had higher Client-related burnout scores ($\beta = 0.123$, $p < .001$).
5. **Carver's Behavioural disengagement**; respondents with higher Behavioural disengagement scores had higher Client-related burnout scores ($\beta = 0.137$, $p < .001$).
6. **Carver's Self-blame**; respondents with higher Self-blame scores had higher Client-related burnout scores ($\beta = 0.082$, $p = .008$).
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 ($\beta = -0.147$, $p < .001$).
8. **Clark et al.'s Exercise**; respondents with higher Exercise scores had higher Client-related burnout scores ($\beta = 0.061$, $p = .028$).

Other variables predicting the client-related burnout score:

9. **Sex**; males had higher client-related burnout scores than females ($\beta = 0.074$, $p = .003$).
10. **Disability**; respondents with a disability ($\beta = 0.061$, $p = .016$) 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 11-20 sick days ($\beta = 0.063$, $p = .016$) had higher client-related burnout scores than those who took no sick days.
12. **Line manager status**; respondents who were line managers had lower client-related burnout scores than those who were not line managers ($\beta = -0.082$, $p = .001$).

Note: Not all employees were redeployed during COVID-19. Those who indicated that they had been redeployed were asked about how prepared they felt for redeployment (well-prepared/neither prepared nor not prepared/not prepared). When this variable was added to the regression model, it did not predict client-related burnout scores.

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 ($\beta = .137$, $p < .001$) had higher client-related burnout scores than those who did not intend on leaving their employer. Additionally, respondents were asked if they wanted to leave their occupation during COVID-19. When this variable was added to the regression model, the results showed that respondents who answered yes to wanting to leave ($\beta = 0.226$, $p < .001$) 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) and Phase 4 (Nov 2021-Feb 2022).

This section presents descriptive comparisons of data from Phase 1 (May – July 2020) and Phase 2 (November 2020 – February 2021) and Phase 3 (May – July 2021) with Phase 4 (November 2021-February 2022) of the study. Presented are weighted results, with weights calculated separately for each phase of the study to account for the different distribution of respondents across country and occupational group in the two phases of the study, thus enabling a more direct comparison. Some results from Phase 1 presented here may be slightly different from those presented in the first report. This is because some calculations were changed in order to make the three phases of the survey directly comparable.

A9.1 Wellbeing Scores by Study Phase and Country

The overall mean wellbeing scores decreased from Phase 1 of the study to Phase 4, both UK-wide and across the individual countries. Between Phase 2 to Phase 4 of the study, the overall mean wellbeing scores increased slightly across all countries. However between Phases 3 and 4, while the UK wide average increased, respondents in Scotland and Northern Ireland, reported a decrease in wellbeing scores.

UK-wide analysis: Using regression analysis, the decrease in the overall mean wellbeing scores between Phase 1 and Phase 4 of the study was found to be statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -1.336$, $p < .001$). There was a slight increase in the overall mean wellbeing scores between Phase 2 and Phase 4 of the study which was found to not be statistically significant when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 0.119$, $p = .333$). There was a slight increase in the overall mean wellbeing scores between Phase 3 and Phase 4 of the study which was found to not be statistically significant when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 0.035$, $p = .778$).

Figure A9. 1: Mean Overall Wellbeing Score by Study Phase and Country (Weighted)

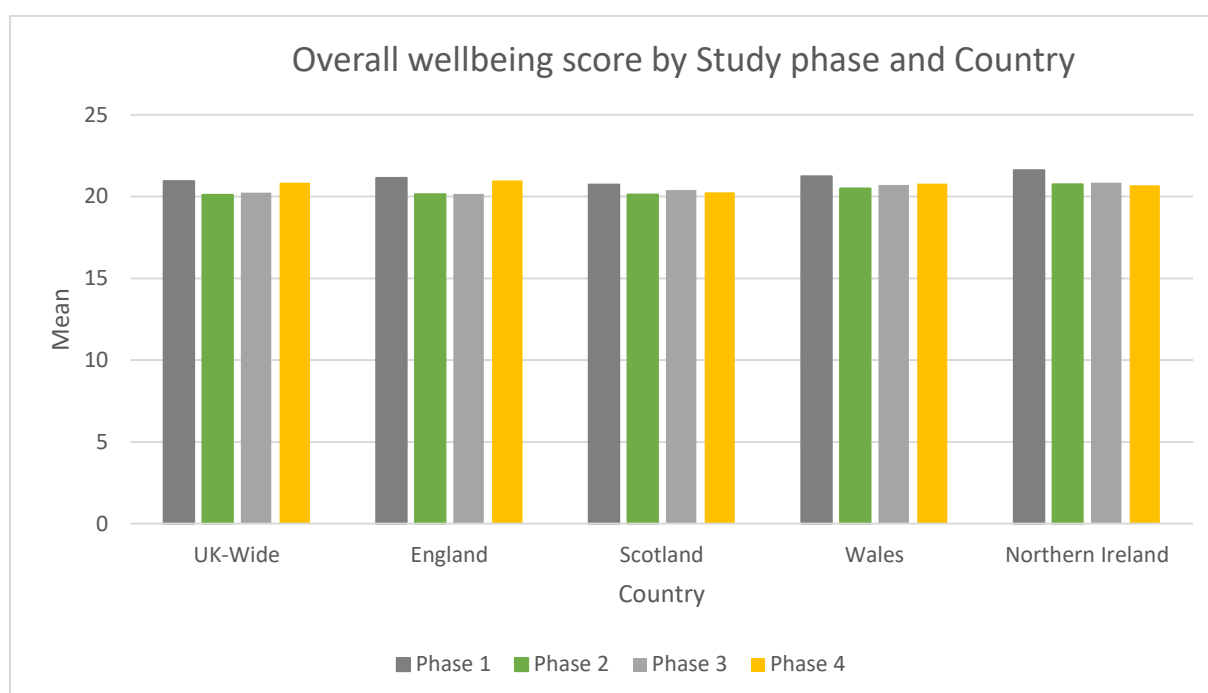


Table A9. 1: Mean Overall Wellbeing Score by Study Phase and Country (Weighted)

Study phase	Country				
	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1	20.95	21.15	20.74	21.25	21.61
Phase 2	20.10	20.14	20.13	20.50	20.76
Phase 3	20.25	20.16	20.40	20.71	20.85
Phase 4	20.85	20.98	20.27	20.80	20.69

A9.2 Wellbeing Scores by Study Phase and Occupation

All occupational groups showed a decrease in their overall mean wellbeing scores from Phase 1 of the study to Phase 4 except nurses who showed an increase. Between Phase 2 and Phase 4 nurses, AHPs and social care workers showed an increase in overall wellbeing scores while midwives and social workers continued to show a decrease in wellbeing. Between Phase 3 and Phase 4 all occupations examined showed an increase in overall wellbeing scores.

Figure A9. 2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)

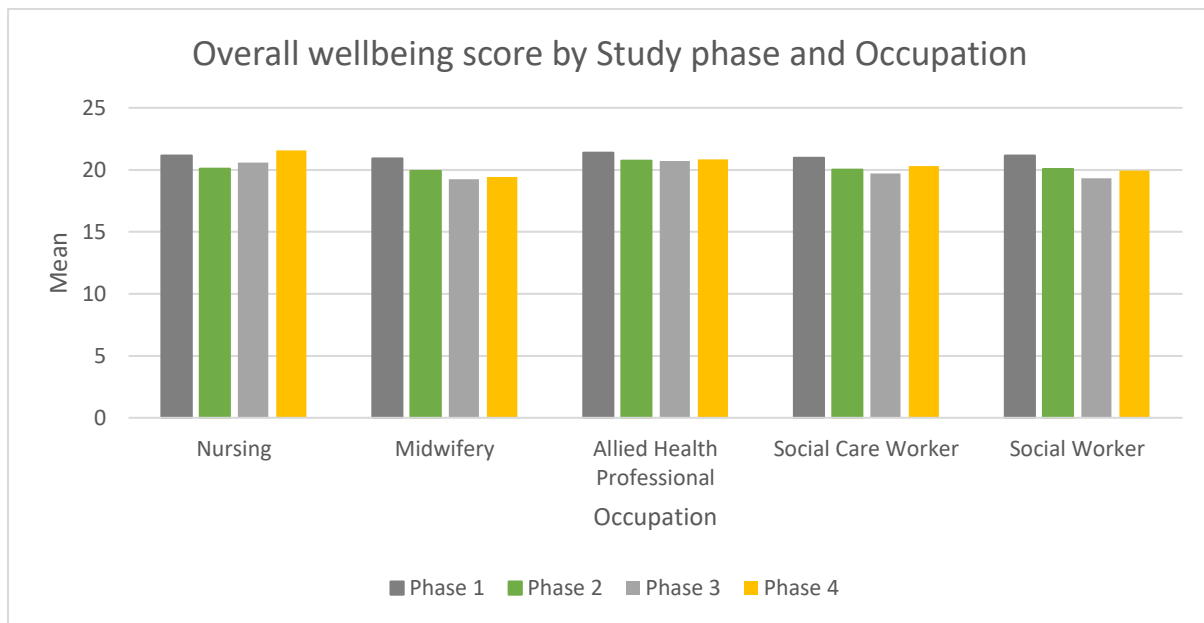


Table A9. 2: Mean Overall Wellbeing Score by Study Phase and Occupation (Weighted)

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

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 4, both UK-wide and across the individual countries. There was also a decrease in the majority of the WRQOL domain scores across the countries. Between Phase 2 and 4, there was an increase in all countries except Wales which decreased. Comparing Phase 3 and Phase 4 there was an increase in WRQOL UK wide but a decrease in Scotland, Wales and Northern Ireland between these study phases.

UK-wide analysis: Using regression analysis, the decrease in the overall WRQOL scores between Phase 1 and Phase 4 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 ($\beta = 7.645$,

$p < .001$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -1.399$, $p < .001$).
- Stress at work: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.913$, $p < .001$).
- Working conditions: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -1.005$, $p < .001$).
- Control at work: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.783$, $p < .001$).
- General wellbeing: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -2.348$, $p < .001$).
- Home-work interface: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -1.016$, $p < .001$).

Using regression analysis, the change in the overall WRQOL scores between Phase 2 and Phase 4 of the study was found to be statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -1.742$, $p = .002$). The results for WRQOL domain scores (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Job career satisfaction: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.478$, $p < .004$).
- Stress at work: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.159$, $p = .016$).
- Working conditions: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.214$, $p = .026$).
- Control at work: No significant change in scores from Phase 2 to Phase 4 ($\beta = -0.195$, $p = .061$).
- General wellbeing: No significant change in scores from Phase 2 to Phase 4 ($\beta = -0.226$, $p = .176$).
- Home-work interface: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.443$, $p < .001$).

Using regression analysis, the change in the overall WRQOL scores between Phase 3 and Phase 4 of the study was found not to be statistically significant, when controlling for the effects of respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = -0.833$, $p = .127$). 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 4 ($\beta = -0.134$, $p = .415$).

- Stress at work: There was a significant increase scores from Phase 3 to Phase 4 ($\beta = -0.224$, $p < .001$).
- Working conditions: There was a significant decrease in scores from Phase 3 to Phase 4 ($\beta = -0.230$, $p = .012$).
- Control at work: No significant change in scores from Phase 3 to Phase 4 ($\beta = -0.079$, $p = .423$).
- General wellbeing: No significant change in scores from Phase 3 to Phase 4 ($\beta = -0.047$, $p = .779$).
- Home-work interface: No significant change in scores from Phase 3 to Phase 4 ($\beta = -0.117$, $p = .244$).

Figure A9. 3: Mean Overall Quality of Working Life Score by Study Phase and Country (Weighted)

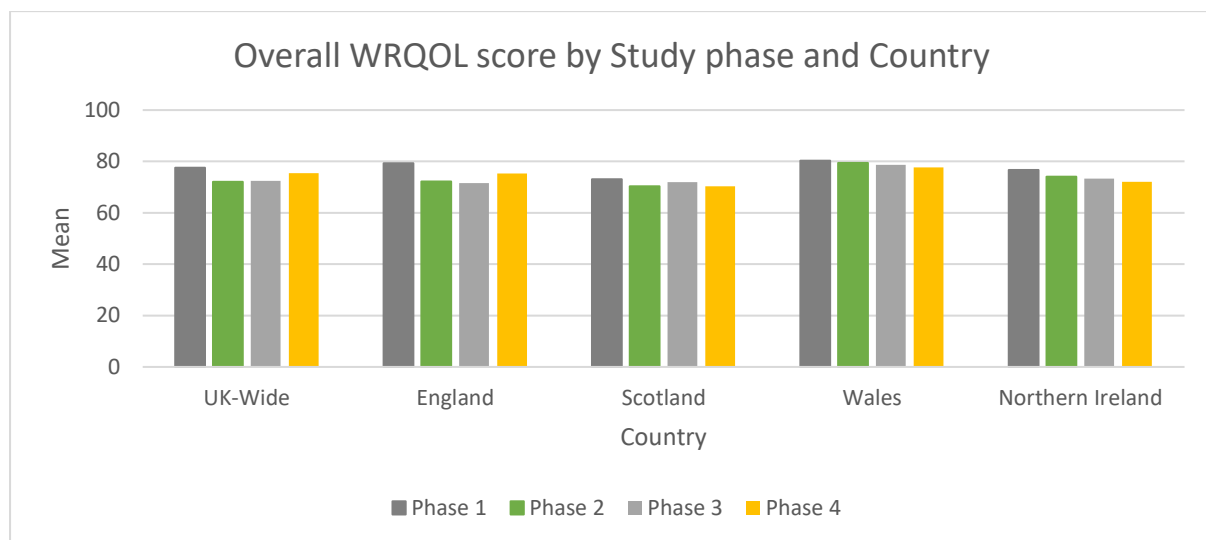


Table A9. 3: Mean Quality of Working Life Score by Study Phase and Country (Weighted)

Study phase	Country				
WRQOL domain	UK-Wide	England	Scotland	Wales	Northern Ireland
Phase 1					
Job career satisfaction	21.03	21.48	20.23	21.93	21.06
Stress at work	5.23	5.22	4.57	4.98	5.06
General wellbeing	20.16	20.65	19.32	20.85	20.55
Home-work interface	10.84	11.11	9.71	11.26	10.18
Control at work	9.97	10.27	9.22	10.26	9.57
Working conditions	10.49	10.71	9.87	11.13	10.23
Overall WRQOL score	77.59	79.33	73.07	80.35	76.63
Phase 2					
Job career satisfaction	20.31	20.39	19.89	22.32	20.91
Stress at work	4.43	4.36	4.56	4.87	4.37
General wellbeing	18.23	18.21	18.44	19.73	19.37
Home-work interface	9.95	10.03	9.19	10.97	9.99
Control at work	9.22	9.28	8.75	10.44	9.37
Working conditions	9.96	9.90	9.54	11.12	9.95
Overall WRQOL score	72.13	72.21	70.37	79.46	74.06
Phase 3					
Job career satisfaction	20.57	20.34	19.95	21.96	20.28
Stress at work	4.26	4.24	4.72	4.73	4.75
General wellbeing	17.97	17.89	18.62	19.75	19.36
Home-work interface	9.87	9.72	9.63	10.89	9.66
Control at work	9.82	9.73	8.97	10.27	9.14
Working conditions	10.05	9.73	10.03	11.15	10.05
Overall WRQOL score	72.45	71.54	71.92	78.69	73.29
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 wellbeing	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

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 4 for Nurses, but decreased for other all occupational groups. The overall WRQOL scores increased from Phase 2 of the study to Phase 4 for nurses but decreased for all other groups. The overall WRQOL scores increased from Phase 3 of the study to Phase 4 for nurses, AHPs and Social care workers but decreased for midwives and social workers.

Figure A9. 4: Mean Overall Quality of Working Life Score by Study Phase and Occupation (Weighted)

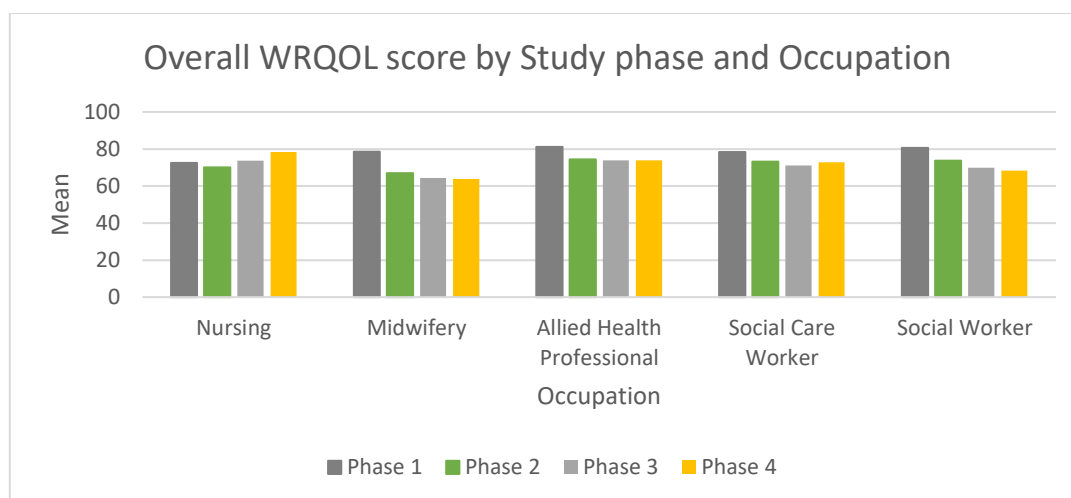


Table A9. 4: Mean Quality of Working Life Score by Study Phase and Occupation (Weighted)

Study phase	Occupation				
WRQOL domain	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 1					
Job career satisfaction	19.15	21.67	22.22	21.27	22.28
Stress at work	5.25	4.55	5.02	5.25	4.81
General wellbeing	19.77	20.91	21.19	20.02	20.75
Home-work interface	10.11	10.68	11.29	10.82	11.32
Control at work	8.79	9.96	10.47	10.31	10.58
Working conditions	9.82	10.79	10.99	10.62	10.80
Overall WRQOL score	72.54	78.56	81.16	78.34	80.63
Phase 2					
Job career satisfaction	19.96	19.27	20.42	20.50	21.32
Stress at work	4.24	3.63	4.53	4.70	4.06
General wellbeing	17.65	18.07	19.04	18.64	18.34
Home-work interface	9.47	8.23	10.62	9.91	10.56
Control at work	9.08	9.17	9.61	9.13	9.63
Working conditions	9.61	8.61	10.26	10.31	9.73
Overall WRQOL score	70.01	66.95	74.41	73.24	73.67
Phase 3					
Job career satisfaction	20.83	19.2	20.5	20.07	20.23
Stress at work	4.55	3.2	4.47	4.43	4.03
General wellbeing	18.8	16.97	18.7	17.67	17.4
Home-work interface	9.96	7.96	10.1	9.43	9.92
Control at work	9.78	8.47	10.15	9.44	9
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 wellbeing	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

A9.4 Burnout Scores by Study Phase and Country

The overall personal and work-related scores increased from Phase 2 of the study to Phase 4 UK Wide. Client related burnout in these Phases decreased UK Wide, however on further analysis, Scotland, Wales and Northern Ireland showed increases in client-related burnout. Between Phase 3 and Phase

4, overall personal, work-related and client-related burnout scores decreased UK wide, however on a country level, Scotland, Wales and Northern Ireland showed increases in all domains of burnout.

Multiple regression analysis revealed that this was a **significant difference in personal burnout from Phase 2 to Phase 3**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 2.001$ $p = .005$). There was also **significant difference in work-related burnout** ($\beta = 0.772$, $p < .001$). There was **no significant difference in client-related burnout** ($\beta = 1.140$, $p = .149$) **from Phase 2 to Phase 4** even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status.

Multiple regression analysis revealed that this was **no significant difference in personal burnout from Phase 3 to Phase 4**, even after accounting for respondents' country of work, occupational group, sex, age, ethnicity and disability status ($\beta = 1.021$, $p = .141$). There was a **significant difference in work-related burnout** ($\beta = 1.740$, $p = .020$) but **no significant difference in client-related burnout** ($\beta = 0.382$, $p = .625$) **from Phase 3 to Phase 4** 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 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 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 burnout	25.24	25.83	28.21	26.17	27.76

Figure A9. 5: Personal Burnout Score by Study phase and Country (Weighted)

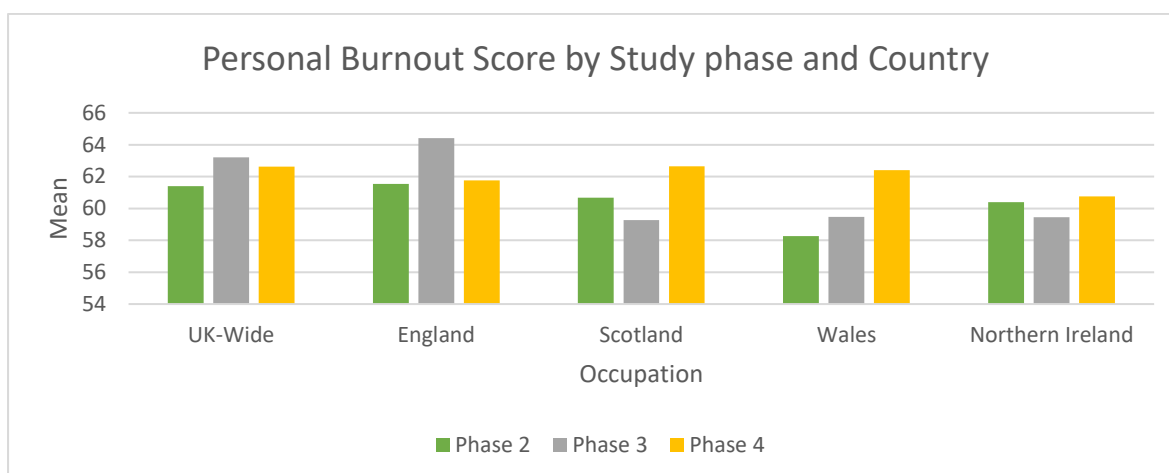


Figure A9. 6: Work-related Burnout Score by Study phase and Country (Weighted)

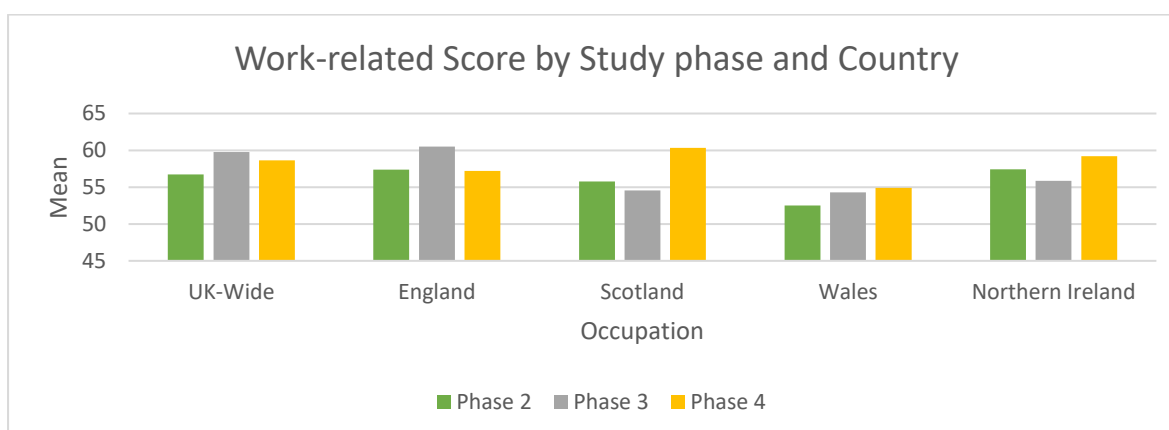
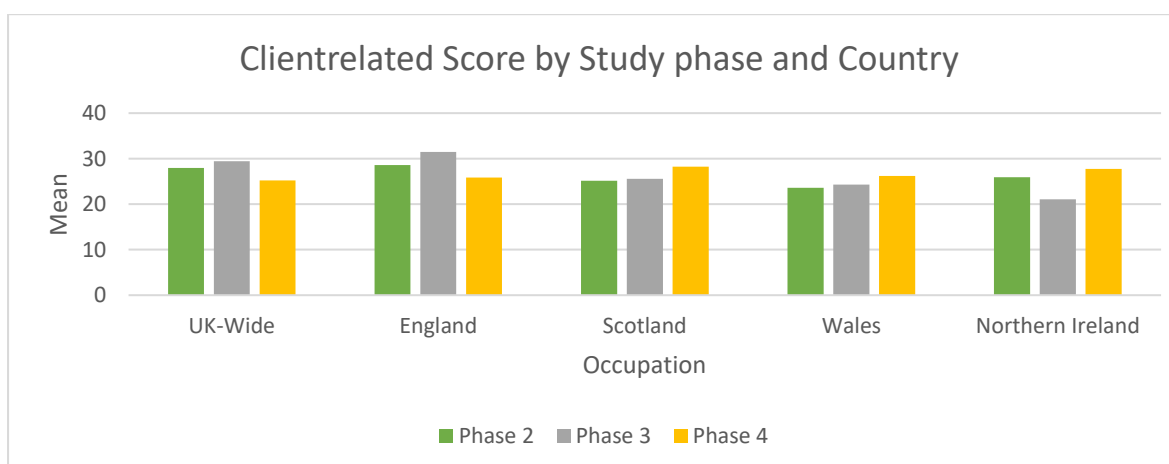


Figure A9. 7: Client-related Burnout Score by Study phase and Country (Weighted)



A9.4 Burnout Scores by Study Phase and Occupation

Between Phase 2 and 4, personal burnout increased for midwives, social care workers, social workers and AHPs but decreased for Nurses. Work-related burnout decreased in nursing, but increased in all other occupations. Client-related burnout decreased in nursing and social care workers but increased for midwives, AHPs and social workers. Comparing Phase 3 and Phase 4, personal burnout decreased for all occupations. Work-related burnout decreased for nurses, midwives, AHPs and social workers but increased for social care workers. In terms of client-related burnout, nurses, AHPs and social care workers had lower client-related burnout in Phase 4 compared to Phase 3, however, midwives and social workers reported increases in client-related burnout.

Table A9. 6: Burnout Scores by Study Phase and Occupation

Study phase	Occupation				
Domain	Nursing	Midwifery	AHP	Social Care Worker	Social Worker
Phase 2					
Personal burnout	63.32	65.73	57.32	59.98	62.87
Work-related burnout	58.61	65.78	54.77	54.49	60.63
Client burnout	28.19	31.02	28.01	25.58	30.68
Phase 3					
Personal burnout	61.29	73.21	62.12	64.37	67.00
Work-related burnout	57.47	71.54	56.16	58.8	64.06
Client burnout	27.75	34.36	30.37	27.33	32.56
Phase 4					
Personal burnout	59.97	71.69	59.66	63.80	65.08
Work-related burnout	54.06	68.69	55.10	61.28	63.45
Client burnout	24.08	35.36	28.33	23.84	32.90

Figure A9. 8: Personal Burnout Score by Study phase and Occupation (Weighted)

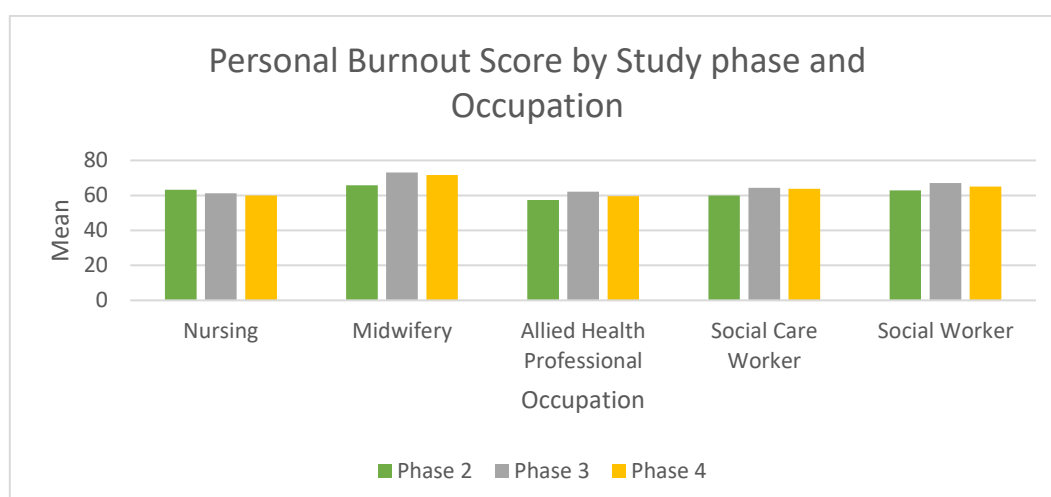


Figure A9. 9: Work-related Burnout Score by Study phase and Occupation (Weighted)

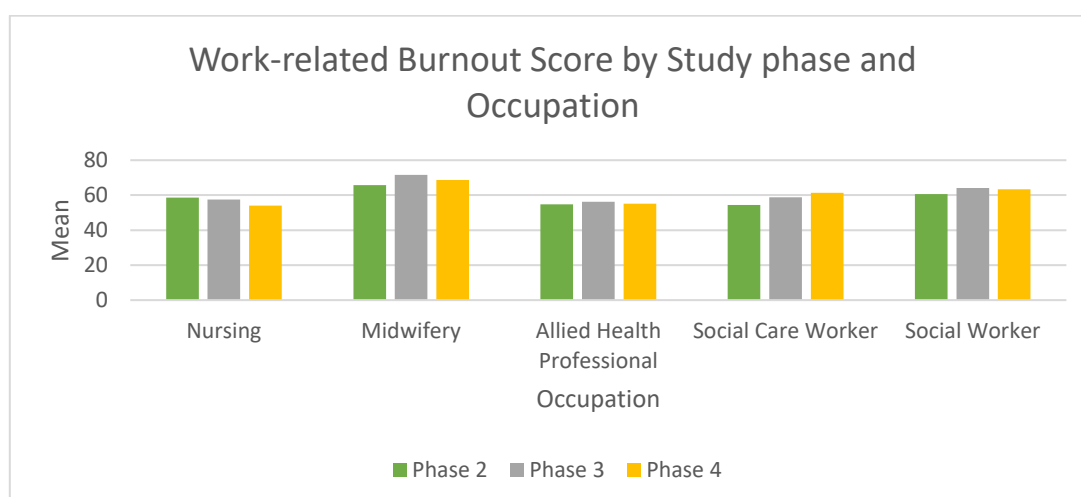
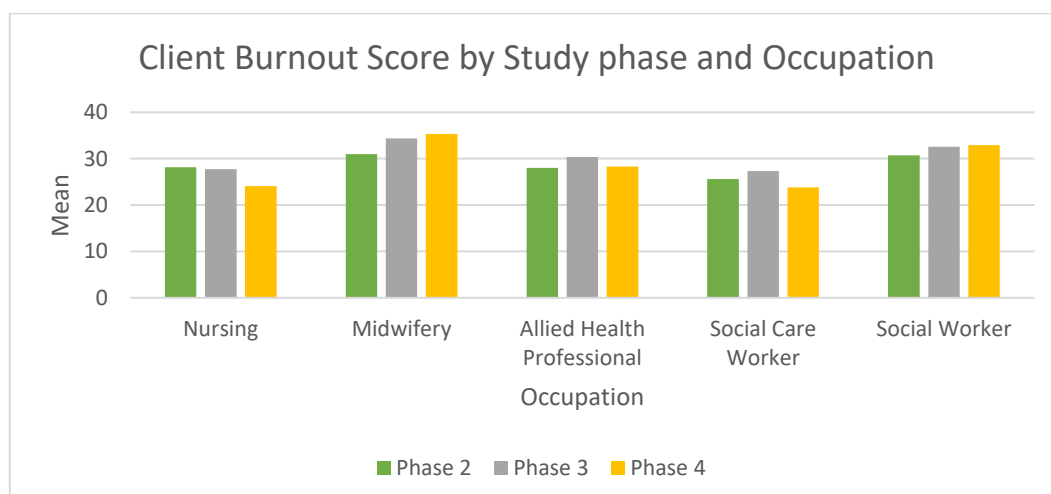


Figure A9. 10: Client-related Burnout Score by Study phase and Occupation (Weighted)



A9.6 Carver Coping Scores by Study Phase and Country

UK-wide there was a decrease in the use of positive coping strategies and an increase in the use of negative coping strategies from Phase 1 of the study to Phase 4. A similar pattern was observed across the countries for the majority of coping domains.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 4 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 4 ($\beta = -0.909$, $p < .001$).
- Planning: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.556$, $p < .001$).
- Positive reframing: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.704$, $p < .001$).
- Acceptance: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.686$, $p < .001$).
- Use of emotional support: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -.611$, $p < .001$).
- Use of instrumental support: Significant increase in scores from Phase 1 to Phase 4 ($\beta = 0.473$, $p < .001$).
- Venting: Significant increase in scores from Phase 1 to Phase 4 ($\beta = 0.905$, $p < .001$).
- Substance use: Significant increase in scores from Phase 1 to Phase 4 ($\beta = 1.696$, $p < .001$).
- Behavioural disengagement: Significant increase in scores from Phase 1 to Phase 4 ($\beta = 2.389$, $p < .001$).
- Self-blame: Significant increase in scores from Phase 1 to Phase 3 ($\beta = 1.567$, $p < .001$).

UK-wide there was a decrease in the use of positive coping strategies and an increase in the use of negative coping strategies from Phase 2 of the study to Phase 4. A similar pattern was observed across the countries for the majority of coping domains.

UK-wide analysis: Using regression analysis, the differences between Phase 2 and Phase 4 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 4 ($\beta = -0.213$, $p < .001$).
- Planning: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.139$, $p = .038$).
- Positive reframing: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.298$, $p < .001$).
- Acceptance: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.215$, $p < .001$).

- Use of emotional support: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.161$, $p = .013$).
- Use of instrumental support: No significant change in scores from Phase 2 to Phase 4 ($\beta = -0.066$, $p = .307$).
- Venting: No significant change in scores from Phase 2 to Phase 4 ($\beta = 0.017$, $p = .779$).
- Substance use: Significant decrease in scores from Phase 2 to Phase 4 ($\beta = -0.115$, $p = .034$).
- Behavioural disengagement: No significant change in scores from Phase 2 to Phase 4 ($\beta = 0.097$, $p = .060$).
- Self-blame: Significant increase in scores from Phase 3 to Phase 4 ($\beta = 0.198$, $p = .003$).

UK-wide there was a decrease in the use of planning as a positive coping strategy and an increase in venting as a negative coping strategy from Phase 3 of the study to Phase 4.

UK-wide analysis: Using regression analysis, the differences between Phase 3 and Phase 4 of the study on the different Carver coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Active coping: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.032$, $p = .600$).
- Planning: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.040$, $p = .540$).
- Positive reframing: Significant change in scores from Phase 3 to Phase 4 ($\beta = -0.151$, $p = .012$).
- Acceptance: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.069$, $p = .204$).
- Use of emotional support: Decrease in scores from Phase 3 to Phase 4 but not significant ($\beta = -0.062$, $p = .317$).
- Use of instrumental support: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.033$, $p = .596$).
- Venting: No significant change in scores between Phase 3 and Phase 4 ($\beta = 0.003$, $p = .961$).
- Substance use: Significant change in scores from Phase 3 to Phase 4 ($\beta = -0.141$, $p = .008$).
- Behavioural disengagement: No significant change in scores between Phase 3 and Phase 4 ($\beta = 0.007$, $p = .896$).
- Self-blame: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.072$, $p = .271$).

Figure A9. 11: Mean Carver Coping Scores by Study Phase UK-wide (Weighted)

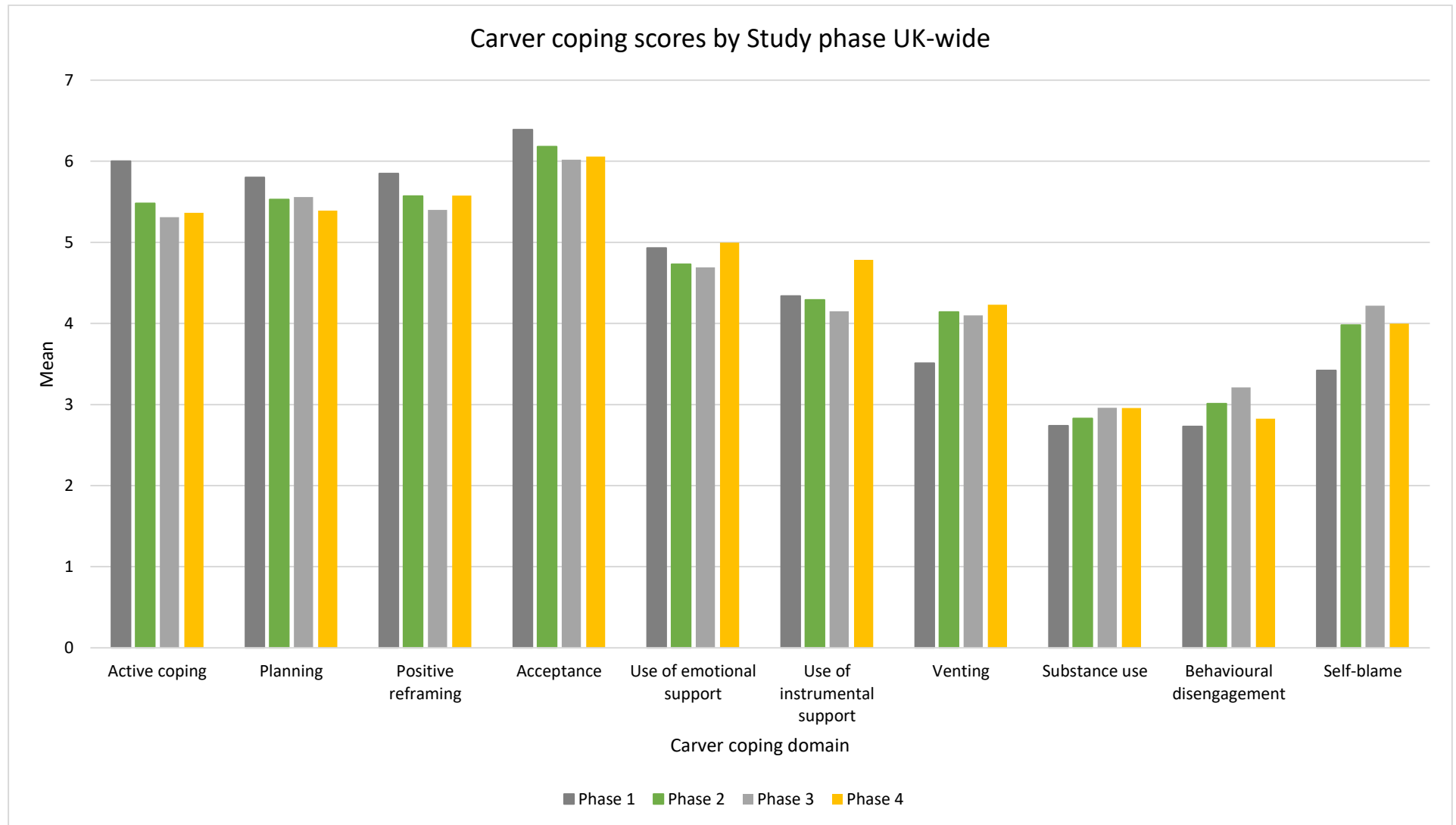


Table A9. 7: Mean Carver Coping Scores by Study Phase and Country (Weighted)

Study phase	Country				
Coping domain	UK-Wide	England	Scotland	Wales	Northern Ireland
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

A9.4 Carver Coping Scores by Study Phase and Occupation

There was also a slight decrease in the use of positive coping strategies and a slight increase in the use of negative coping strategies from Phase 1 of the study to Phase 4 across the occupational groups. From Phase 2 to Phase 4 there was a lot more variation in the use of strategies; within nursing, active coping, planning, positive reframing, emotional support, substance use, behavioural disengagement and self-blame decreased, while acceptance, instrumental support and venting, all increased; within midwifery, active coping, planning, positive reframing, acceptance, venting, substance use, behavioural disengagement and self-blame decreased, while emotional support and instrumental support increased. For AHPs there was an increase in self-blame, behavioural disengagement, instrumental support while active coping, planning, positive reframing, acceptance, emotional support, venting and substance use decreased. Social care workers exhibited increases in positive reframing, emotional support, instrumental support and venting, and decreases in active coping, planning, acceptance, substance use, behavioural disengagement and self-blame. Social workers had an increase in venting, behavioural disengagement, use of emotional support and use of instrumental support while showing decreases in active coping, planning, positive reframing, acceptance, substance use and self-blame.

Comparing Phase 3 to Phase 4, nurses had an increase in positive coping strategies such as active coping, acceptance, emotional support and instrumental support but had further increases in negative strategies, venting and substance use. In midwives, emotional support increased however all other positive strategies continued to decline, additionally negative strategies, behavioural disengagement and self-blame increased. Across AHPs all positive coping strategies declined, except instrumental support which increased, across this occupation venting and self-blame also increased. For social care workers, all positive strategies increased except planning which decreased, unlike the other occupations examined, in Phase 4 social care workers showed a decrease in usage of negative coping strategies. Social workers showed a decrease in both the use of positive strategies and negative strategies.

Table A9. 8: Mean Carver Coping Scores by Study Phase and Occupation (Weighted)

Study phase	Occupation				
Coping domain	Nursing	Midwifery	AHPs	Social Care Worker	Social Worker
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

A9.5 Clark Coping Scores by Study Phase and Country

There was a slight decrease in the use of some Clark et al.'s coping strategies from Phase 1 of the study to Phase 4 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 1 and Phase 2 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: Slight decrease in scores from Phase 1 to Phase 4 but not significant ($\beta = 0.001$, $p = .987$).
- Work-family segmentation Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.196$, $p = .002$).
- Working to improve skills/efficiency: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.276$, $p < .001$).
- Recreation and relaxation: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.363$, $p < .001$).
- Exercise: Significant decrease in scores from Phase 1 to Phase 4 ($\beta = -0.343$, $p < .001$).

There was a slight decrease in the use of some Clark et al.'s coping strategies from Phase 4 of the study to Phase 4 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 2 and Phase 4 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: Decrease in scores from Phase 2 to Phase 4 but not significant ($\beta = -.061$, $p = .077$).
- Work-family segmentation: Decrease in scores from Phase 2 to Phase 4 but not significant ($\beta = -0.025$, $p = .542$).
- Working to improve skills/efficiency: Decrease in scores from Phase 2 to Phase 4 but not significant ($\beta = -0.025$, $p = .536$).
- Recreation and relaxation: Decrease in scores from Phase 2 to Phase 4 but not significant ($\beta = -0.075$, $p = .104$).
- Exercise: Decrease in scores from Phase 2 to Phase 4 but not significant ($\beta = -0.025$, $p = .629$).

There was a slight decrease in the use of family-work segmentation from Phase 3 of the study to Phase 4 UK-wide.

UK-wide analysis: Using regression analysis, the differences between Phase 2 and Phase 3 of the study on the different Clark coping strategies (accounting for the effects of country of work, occupational group, sex, age, ethnicity and disability status) were as follows:

- Family-work segmentation: No significant change in scores between Phase 3 and Phase 4 ($\beta = -.036$, $p = .282$).
- Work-family segmentation: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.019$, $p = .631$).
- Working to improve skills/efficiency: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.014$, $p = .714$).
- Recreation and relaxation: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.046$, $p = .303$).
- Exercise: No significant change in scores between Phase 3 and Phase 4 ($\beta = -0.060$, $p = .225$).

Figure A9. 12: Mean Clark Coping Scores by Study Phase UK-wide (Weighted)

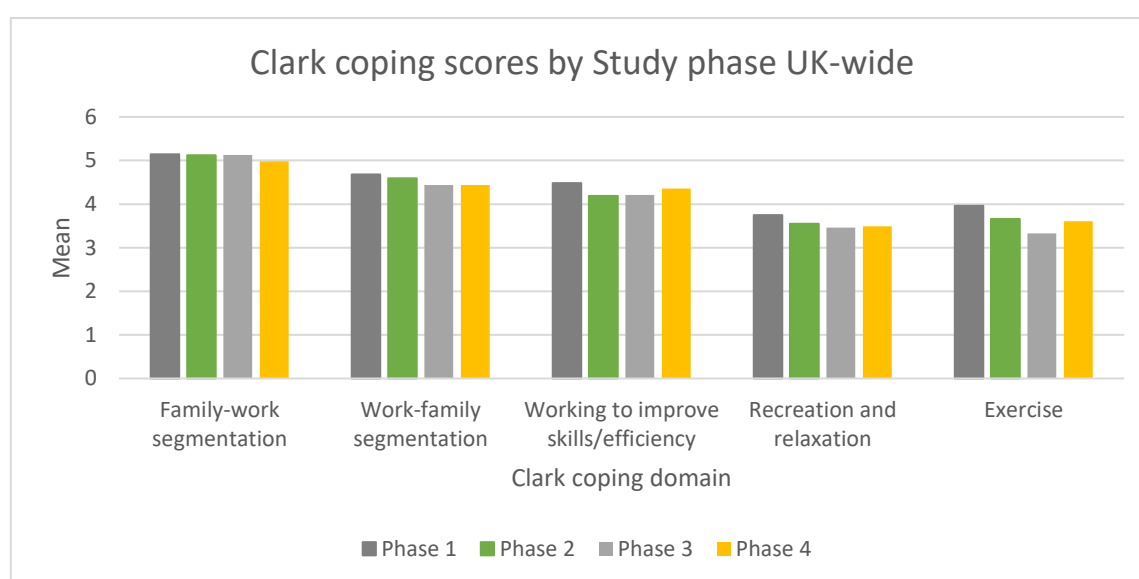


Table A9. 9: Mean Clark Coping Scores by Study Phase and Country (Weighted)

Study phase	Country				
Coping domain	UK-Wide	England	Scotland	Wales	Northern Ireland
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

A9.6 Clark Coping Scores by Study Phase and Occupation

Across the occupational groups, there was a decrease in the use of some Clark et al.'s coping strategies, but also increase in the use of others for some groups.

Table A9. 10: Mean Clark Coping Scores by Study Phase and Occupation (Weighted)

Study phase	Occupation				
Coping domain	Nursing	Midwifery	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

Appendix 10: Summary of focus group findings

Focus groups were held with both HR, managers and frontline workers in January 2022. The challenges of dealing with individual circumstances alongside changes to working conditions during the COVID-19 pandemic emerged as a strong theme throughout the frontline workers' focus group. The issues of recruitment and backlash were strong themes which emerged from the HR and manager focus groups. Responses to focus group questions that were conducted with managers and frontline workers were examined using a thematic analysis approach. The overarching themes that emerged from the Phase 4 focus groups were: **Changes in working conditions, connections, communication and coping**, these findings are interlinked with the survey responses in the main report. The main themes uncovered are outlined in Table A10.1. and a word cloud was created to highlight the key words discussed by the participants and provide data visualisation (Figure A10.1).

Table A10. 1: Themes uncovered from focus group transcripts

Overarching themes
Recruitment and retention
Working conditions
Communication
Lack of support
Lack of control
Presenteeism
Ways of coping
Staff support initiatives
Feeling forgotten

Figure A10. 1: Word cloud of key words from qualitative analysis.

