Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic 7th May – 3rd July 2020: findings from a UK Survey

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FOREWORD

Working during a pandemic was not generally anticipated in the United Kingdom (UK). The UK health and social care workforce is the focus of this report which sets out findings from a UK wide survey that measured aspects around quality of working life, well-being and coping whilst working during the height of the COVID-19 pandemic. The survey opened on 7th May and data collection ran until 3rd July 2020. This is the first of three surveys to be conducted by this research team focusing on the work experiences and coping of health and social care staff in relation to the COVID-19 emergency.

The target professions for this study included nurses, midwives, Allied Health Professionals (AHPs), social workers and social care workers (working in home care and care homes). Potential participants were accessed with the support of professional bodies and regulators including Royal College of Midwives, Royal College of Nursing, Unison, Unite, Allied Health Professions Federation, the Royal College of Occupational Therapists, Northern Ireland Practice and Education Council, and Northern Ireland Social Care Council. The online magazine Community Care © helped publicise the survey among UK social workers.

The survey asked both quantitative and qualitative questions and responses have enabled us to undertake both statistical analysis and analysis of free text responses. The measurement scales used for the quantitative side of the study were first from the Work-Related Quality of Life Scale (WRQoL). This measured general wellbeing, home-work interface, stress at work, control at work, working conditions, and job and career satisfaction. The second scale, the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWB), measured mental well-being. Both these scales were used in a previous UK study of social workers by the research team in 2018, so this has enabled comparison of findings collected pre-COVID about working conditions and well-being with this present survey.

A third scale, the Carver Brief Cope Scale measured several coping strategies: self-distraction, active coping, denial, substance use, using emotional support, using instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. Lastly, the Clark Work and Family Stressors Scale captured information about strategies for dealing with family and work segmentation, areas to improve skills, recreation, relaxation and exercise.

The qualitative questions included in the survey asked people about their work experiences during this time and assisted in the development of the study's 'Good Practice Guidance and Recommendations' which are provided in our summary conclusions.

The research team plans to conduct two further surveys in November 2020 and May 2021. We are committed to providing stakeholders with results in a timely manner to inform employers and policy makers in real time, about the needs of the workforce during a 12-month period of great uncertainty from May 2020 until May 2021 and beyond.

The research team would like to extend our sincere thanks to all those who participated in this survey and those who provided support for its dissemination and our funders who enabled this research to happen in such a timely manner.

"The daily "Rock around the pond" that takes place every day gets everybody moving and it has boosted the staff morale no end. The service users spectate from balconies and Windows or participate by dancing round the ponds edge. Party favourites are YMCA Music man and Agadoo. We even performed the social distancing Conga. Absolutely outstanding. I feel that the daily briefings/meetings straight after the party are brilliant. All information and updates are passed over and in full to all staff. It allows everyone to take it all in and support each other through this."

(Social Care Worker)

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1. Background

One of the top causes of death globally are lower respiratory infections, with new diseases continuing to emerge (Bradley and Bryan, 2019; Koh, 2011). These include the severe acute respiratory syndrome virus (SARS) and the Middle Eastern respiratory syndrome virus (MERS). During December 2019, a novel coronavirus emerged (COVID-19), and by was March 2020, was designated a global pandemic, and all countries were urged to take 'urgent and aggressive action' to manage the risk to public health and risk to life (WHO 2020). While it has been made clear that trying to fight this pandemic is everybody's business (WHO 2020), the main burden for caring for and treating people who are ill in the UK falls to the understaffed and underfunded health and social care sector and those who work in it.

Previous studies undertaken with health care staff during a SARS and Middle East respiratory syndrome coronavirus (MERS-CoV) highlighted their stress and revealed some coping strategies (Khalid, et al 2015). While staff nurses admitted worrying about infecting their families and colleagues, they were able to cope by adopting certain strategies, such as deriving support from colleagues, benefiting from their employer's recognition of their efforts, and receiving infection control guidance and equipment (Lee et al, 2005; Khalid et al, 2015). With the context of the COVID-19 pandemic, Chen (2020) found that hospital medical staff in China were reluctant to engage with psychological support and were more concerned about how to deal with patients' anxieties, staff's need for uninterrupted sleep, and having sufficient personal protective equipment. A study in England of domiciliary social care personal assistants found considerable uncertainty, questions of parity, and anxiety about the wellbeing of their employers/clients (Woolham et al 2020). Again, in relation to nurses, the first wave of a major longitudinal study of nurses (the ICON study) conducted through the Royal College of Nursing (2020), reported that 88% of nurses continue to worry about risks to their family due to their clinical role and about risks to their own health. Some of these respondents also reported experiences of continued depression, anxiety, and stress, with some emerging signs of post-traumatic stress disorders.

There is limited evidence about how wider health and social care workers cope with meeting the challenges of caring for patients or service users, while potentially putting their own health at risk, although more is emerging from some groups (see also West et al 2020 in relation to nurses and midwives). It is for this reason that we undertook this survey.

1.1 Aim

This study explored the impact of providing health and social care during the COVID-19 pandemic on nurses, midwives, Allied Health Professionals (AHPs), social care workers and social workers working in the UK.

1.2 Objectives

1. To gather relevant demographic information from a cross sectional convenience sample of nurses, midwives, AHPs, social care workers and social workers in the UK.
2. To determine the perspectives of nurses, midwives, AHPs, social care workers and social workers on the challenges they are facing while providing health and social care during a declared pandemic.
3. To measure wellbeing, quality of working life and home and work interface.
4. To find out what coping strategies are used by frontline staff during the time of a pandemic.
5. To explore health and care workers' perspectives on employers' supports, improvements on employer supports and suggestions for employers' support for future pandemics based on their experience and learning from the current COVID-19 pandemic.

2. Methodology:

2.1 Research Instrument

An online survey questionnaire designed to meet the objectives of the study was developed after reviewing the relevant literature. This was predominantly a quantitative questionnaire that contained valid and reliable scales, and comprised 6 sections including:

1. Demographics: age, gender, ethnicity, disability status, marital/partner status, caring responsibilities, professional area of work, job tenure and role, time of gaining professional qualification, hours of work, additional working hours/overtime
2. Quality of Working Life Scale (WRQoL) addressing Objective 2 of this study (24 items).
3. Short Warwick Edinburgh Mental Well-being Scale (SWEWBS) addressing Objective 3 (7 items).
4. Brief COPE Scale addressing Objective 4 (28 Items)
5. Clark et al. Coping with Work and Family Stressors Scale addressing Objective 4 (15 items)
6. Qualitative questions to explore workforce perspective in greater detail addressing Objective 5 (7 questions)

The Work-Related Quality of Life Scale (WRQoL) (Van Laar, 2007) gauged the perceived quality of life of respondents. The Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS) enabled the monitoring of mental wellbeing and the Brief COPE Scale (Carver 1997) measured 14 different coping strategies. The Brief COPE scale rates how respondents coped while working in health and social care during the COVID-19 pandemic. A further 15 selected items, from Clark et al's (2014) 'Coping with Work and Family Stressors Scale', captured information about strategies for dealing with family and work segmentation, improving skills/efficiency (training), recreation/relaxation and exercise.

There were seven additional open-ended questions with an option for respondents to add any additional information they wished to tell us about working in health and social care services during the COVID-19 pandemic in the UK.

2.2 Study Respondents: Sampling, Access and Recruitment

Participants were nurses, midwives, AHPs, social care workers and social workers in the UK who had signed up to receive newsletters or journals from professional associations, workplace unions and regulators such as Royal College of Nursing (RCN), Royal College of Midwives (RCM), the Northern Ireland Practice and Education Council (NIPEC), Northern Ireland Social Care Council (NISCC), the Royal College of Occupational Therapists and the British Dietetic Association, and the social work journal Community Care. In order to reach as many respondents as possible, social media platforms such as Twitter and Facebook were also used to advertise the survey and provided an electronic link to the Participant Information Sheet, consent and survey.

The survey drew on a convenience sample of those who choose to participate following receipt of communication in a newsletter/journal from RCN/RCM/NIPEC/ NI SCC and other professional associations and workplace unions or those who accessed the survey through social media. Submitted survey data were anonymized prior to analysis. Respondents were advised that their details would not be shared, nor be identifiable to researchers in any subsequent publications. For this reason, respondents were informed that withdrawal of individual response data on request was not possible after submission of their response.

NB: The original study Protocol can be viewed in Appendix 1.

2.2.1 Sample Profile

There were 3290 responses with most of the responses (n=1897) coming from Northern Ireland, while n=1062 responses were from England, n=146 were from Scotland, and n=185 were from Wales. Most of the sample were social workers and social care workers, followed by AHPs.

Figure 2.1: Occupation of Respondents

Table 2.1 below shows that 76.8% of nurses were from Northern Ireland (NI), whilst 18.7% were from England and 2.5% Wales and the lowest number of nursing respondents were from Scotland (2%). Most midwifery respondents were from NI (45%), followed by Wales (29.4%), England (22.8%) and Scotland (2.8%). The majority of AHPs were from NI (45.2%), followed by England (43.2%) and Wales and Scotland at the lowest end of participation with 6.7% and 4.9% respectively. Most social care workers were from NI (74.3%) and England (15.4%), while Scotland and Wales had 6.8% and 3.5% respectively. Most social worker respondents were from England at 48.8% and NI at 44.1% with 2.6% from Scotland and 4.5% Wales.

Table 2.1 Country of Respondents by Occupation

Occupation	England	Scotland	Wales	NI	Total
Nursing	18.7%	2.0%	2.5%	76.8%	100%
Midwifery	22.8%	2.8%	29.4%	45.0%	100%
Allied Health Professional	43.2%	4.9%	6.7%	45.2%	100%
Social Care Work	15.4%	6.8%	3.5%	74.3%	100%
Social Work	48.8%	2.6%	4.5%	44.1%	100%

Most respondents were female across all professions, and all midwives who responded were female. Respondents were mainly from the 30-59 age bracket. The fewest number of respondents were aged 16-19 and over 60 years of age. In Scotland, respondents were generally younger than in the other countries, whereas those from England and Wales were older. The majority of AHP and social worker respondents fell into the 50-59 age bracket, whilst the other professions were mainly in the younger 40-49 age range. Respondents from England reported the highest prevalence of disability. Social workers and AHP respondents were most likely to report a disability. Most of the sample were in the Band 6 pay band across all countries of the UK, with the exception of Northern Ireland respondents who were mostly in Bands 2 or 3, and the majority of these were midwives.

Overall, most respondents were married. Those in NI were more likely to be single or divorced than the rest of the UK. As noted, over half, 57%, of respondents were from NI, 33% were from England and 5% were from Scotland and Wales. Almost all respondents were of white ethnic origin in all four countries, but England was the most ethnically diverse. Social work was the most ethnically diverse profession in this sample. Overall, most respondents worked in the community. AHPs, social workers and social care workers mainly worked in community settings, but most nurses and midwife respondents were working in a hospital setting. Most respondents had 11-20 years' work experience while those with over 30 years' experience were nurses. Just over half (51%) of all respondents across all countries worked with older people or other adults, followed closely by those who worked with children, in mental health services or midwifery (see Figure 2.2).

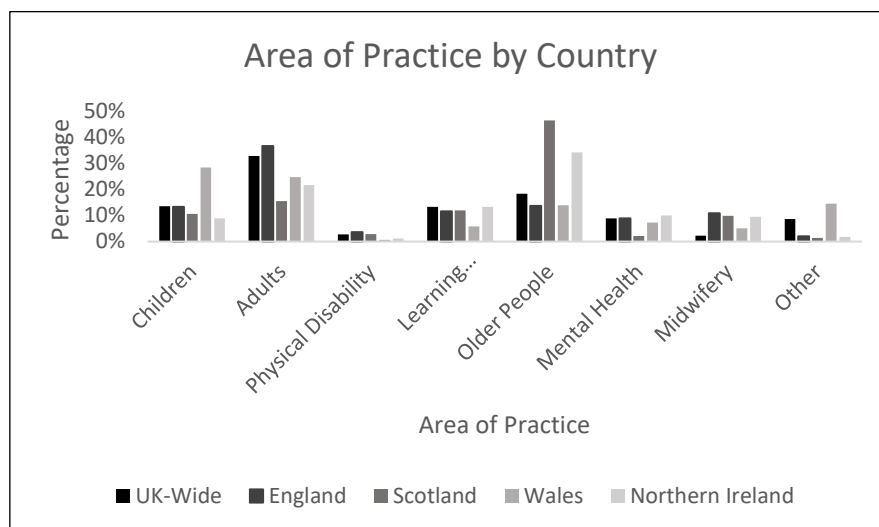Figure 2.2: Area of Practice by Country

Table 2.2: Area of Practice by Country

Area of Practice	UK-Wide	England	Scotland	Wales	NI
Children	13.5%	13.3%	10.5%	28.3%	8.8%
Adults	32.7%	36.4%	15.4%	24.6%	21.6%
Physical Disability	2.7%	3.6%	2.8%	0.7%	1.1%
Learning Disability	13.3%	11.5%	11.9%	5.8%	13.2%
Older People	18.3%	13.6%	46.2%	13.8%	34.0%
Mental Health	8.9%	8.8%	2.1%	7.2%	10.0%
Midwifery	2.2%	10.8%	9.8%	5.1%	9.5%
Other	8.6%	2.0%	1.4%	14.5%	1.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Only 0.5% of respondents reported that they had come out of retirement to support the workforce during the COVID-19 pandemic. Respondents from all occupations included staff who had come out of retirement, but this was a low percentage ranging from 0.3% for social care workers and AHPs, 0.5% nurses and 0.6% for midwives and social workers. Most respondents were employed on a permanent basis with NI having the largest proportion of agency (temporary) staff at 6.2%, while Wales had the lowest level of agency workers at 0.5%. Scotland had the highest number of part-timers employed, making up just under one third (31.2%). Most respondents worked full-time, typically 37.5 hours per week. This was the case across occupations, but midwives were most likely to work part-time hours. Respondents in NI worked the highest number of hours' overtime. Nurses and social care workers worked the most overtime.

2.3 Data Analysis

The survey results were analysed using SPSS 24 ©. Descriptive statistics provide frequency distribution for both nominal and ordinal data along with percentages and cumulative percentages. A series of inferential statistics was analysed. Qualitative data were analysed for emerging themes. In total, seven open-ended questions were included in the survey asking about the impact of COVID-19 on work and family life, asking about the nature of and amount of employer support expected and offered, and the type of employer support deemed "good practice" for future pandemics as well as normal day-to-day practice.

2.4 Ethical Considerations

The research team was aware that health and social care workers employed on the front line during a pandemic were already under pressure. However, it was important to carry out this research at this time to find out what their work life was like and what coping strategies they used.

While completion of the survey was on a voluntary basis, it was possible that during the completion of the survey that respondents, may have become distressed. Therefore, respondents were provided with relevant support contact information.

Respondents were assured that as their data were anonymous, no identifiable information would be available publicly.

All permissions for use of survey scales were obtained.

Please Note: The full Protocol for this study is included in Appendix 1.

NB: Appendices provide Tables and Figures to illustrate the demographic findings, scale analysis and multiple regression analysis.

3. Findings: Changing Conditions, Connections, Communication

Responses to open-ended questions were read by country and analysed using thematic analysis across the disciplines: nursing, midwifery, AHPs, social care workers and social workers. The recurring responses were evidenced across all countries and disciplines, showing dominant themes under three broad areas of "conditions", "connection", and communication". Three groups were identified across all responses. These include those who had generally positive accounts, those who admitted some work-related challenges during the pandemic whilst also citing areas for improvement. A final group reported generally negative experiences relating to working during the pandemic.

We are presenting the qualitative results under the emerging themes of changing conditions, connection and communication. These initial sections give an insight into the respondents' emotions and experiences when working through the pandemic. The following sections then use descriptive, scale analysis and multiple regression analysis to report the quantitative results that relate to respondents' outcomes for coping strategies during the pandemic and their Quality of Working Life, and Wellbeing.

What was the experience of health and social care staff through the pandemic?

3.1 Changing Conditions

The onset of the virus rapidly brought several changing conditions that impacted the health and wellbeing of respondents. Respondents commented on the stress associated with changes to safety risk, work routines, work intensity and work/ home life.

3.1.1 Safety

Many respondents reported additional concerns about safety and noted their fear of contracting the virus themselves and/or passing it on to family members or those they were caring for. One respondent talked of being in "*Extremely stressful situations and fear of contacting COVID due to the amount of exposure.*" (Northern Ireland, Social Care Worker).

In relation to staff safety, many respondents reported that it "*has been very carefully considered and prioritised*" (England, social worker), and in particular expressed appreciation for the opportunity to work from home to enable social distancing and alleviate safety concerns. On the other hand, many raised concerns about safety, particularly around the provision of personal protective equipment (PPE). This was particularly true for health and care staff working in residential care and those who provided domiciliary (home based) services. One respondent noted:

> "*I feel that risk is massively undervalued and under discussed, with regards to our own personal safety. This has been highline more under Covid with regards to PPE….. our PPE did not reflect our role and the risk we face*" (England, Social Worker).

Some had purchased their own PPE as provision was delayed and then rationed or was only provided sporadically.

There were also safety concerns raised about availability of sick pay for some groups of health and social care workers, and the associated risk of spreading the virus if these workers were not covered. It was identified that contracting COVID-19 or having to self-isolate would have different impacts on agency (temporarily employed) compared to non-agency (permanent) staff as their entitlements to Statutory Sick Pay (SSP) differed. One respondent reported that agency staff with COVID-19 continued to work as they could not afford to take time off, placing service recipients and colleagues at greater risk, and causing further stress for their colleagues

3.1.2 Work Routines and Redeployment

Work routines also changed significantly for many respondents. One respondent mentioned that there was a "*new way of working total change in service delivery*" (Northern Ireland, Midwifery). This was often due to the restrictions associated with COVID-19 and some staff's inability to visit service users face-to-face. Instead, IT (phones and computers) were used to stay in touch: "*Change in the operation of the service with a significant increase in videocalls rather than face to face contacts.*" (Northern Ireland, Allied Health Professional).

When asked about changes to the respondents' place of work, the impact of working from home was also a dominant theme. Many respondents noted how they valued the opportunity to work from home because it enabled additional flexibility. On the other hand, working from home was also thought to cause feelings of isolation and many respondents did not feel prepared to work from home. A lack of IT, office equipment and IT support were cited as important practical challenges. Some employers had, however, provided equipment and some financial support to set up home working, but this was not consistent across the workforce. The working from home policies had also the potential to raise contention, particularly among frontline care home and hospital staff who were unable to work from home due to the nature of their jobs. This had given rise to some resentment and was thought to require careful management.

Many respondents also reported significant changes to their work because of redeployment across services. At least one in ten of all respondents had been redeployed due to the pandemic. AHPs, Nurses and Midwives were most likely to be redeployed, with social workers and care workers least likely. For those who were redeployed, between 20-40% felt unprepared for redeployment.

Table 3.1: Percentage of Respondents who were Redeployed by Occupation

Occupation	Percentage
Nursing	16.5%
Midwifery	28.2%
Allied Health Professional (AHP)	16.6%
Social Care Worker	10.5%
Social Worker	11.1%

Figure 3.1: Preparedness for Redeployment by Country
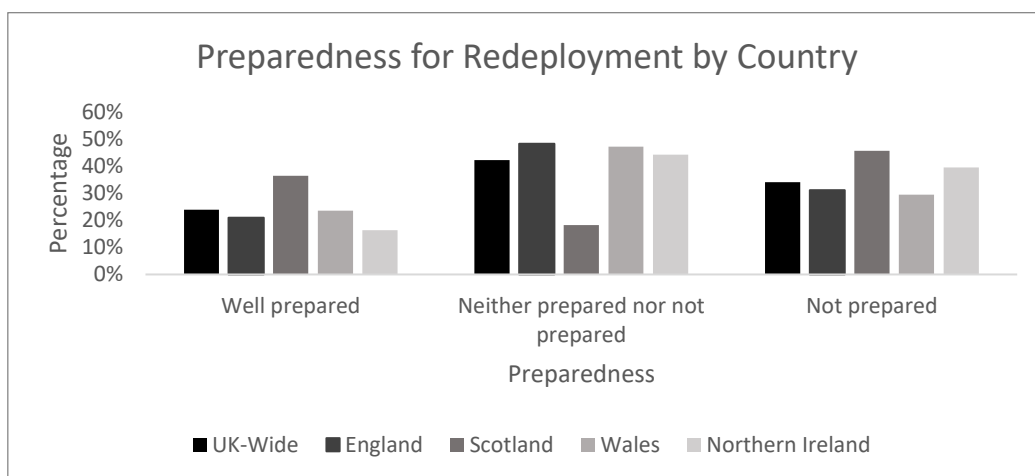
Respondents noted their appreciation for staff who were redeployed to their teams to give additional support, but it was also noted that the redeployment of staff created additional challenges for those who remained in post and lost team members through redeployment.

Many respondents explained the additional stress they experienced when 'skeleton' teams were left behind.

> "*Some staff are being redeployed to other roles which places an increased demand in other staff case load and the intensity of work they can complete the patients*" (England, Social Worker).

3.1.3 Work Intensity

Changes to the intensity of work were also explained by several other factors and differed across occupations and care settings. For example, different experiences were often due to front-line versus non front-line status of the workplace and the prioritisation of certain services at the start of the pandemic. Unsurprisingly, those individuals working in acute COVID-19 response settings experienced a significant increase in demand while those in auxiliary areas experienced significant reductions. High service demand was also often discussed in the context of exposure to COVID-19 which led to high staff absence levels as illustrated by the following quote:

> "*We have been running with a depleted team due to staff off due to illness, shielding, stress due to the service demand*" (Northern Ireland, Social Worker).

In consequence, the increase in service demand and reduction in staff levels in many areas led to work intensification and longer working hours for those still in work. Supporting these findings, around one-fifth of respondents took a COVID-19 related sickness absence with nurses more likely than any other profession to have a COVID-19 related absence. One respondent commented on rapid decision making by senior managers without consideration or staff consultation, and how this impacted on staff absence and the service. Around one-fifth of respondents had a COVID-19 related sickness absence. Nurses were more likely than any other profession to have a COVID-19 related sickness absence but absence was experienced across the health and social care sector at least at a rate of one in ten.

> "*…..clear and concise guidance for staff and inform and consult before decisions are made at the highest level and communicated to all staff which have a large impact on operation service, for example our Chief Exec sent a mass email (before lockdown) in the evening informing staff who fell into an at risk category not to attend work. This wiped out over 20% of workforce without prior warning.*" (Social Care Manager, England).

Figure 3.2: Sick Days by Occupation
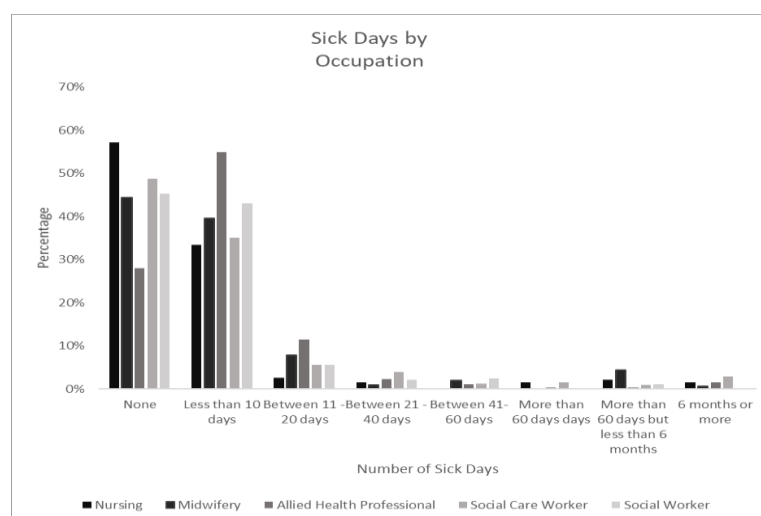
3.1.4 Work/Home Life

Respondents also reported on stress in their private lives related to increased caring responsibilities, childcare and/or the addition of home schooling. NI respondents had the highest prevalence of simultaneously being family carers in their private lives as well as being employed in health and social care. Social care workers were most likely to have family or friend caring responsibilities alongside their job, whilst midwives were the least likely. Approximately two-thirds of all respondents reported that their caring responsibilities changed due to the pandemic. Social worker respondents were slightly more likely to have their caring role change due to the pandemic. Home life and work therefore had simultaneously changed for many respondents. One respondent commented on what additional employer supports would be helpful.

> *"More understanding of the impact on family life - for example of working from home and having caring responsibilities; of financial uncertainty; of worry about being unwell or dying; of the responsibility for staff, volunteers and recipients of services well-being…"* (Scotland, Social Worker).

3.2 Connections with employers, service users and the public

The findings suggest that emotional and psychological support was important to help mitigate negative effects from working during the pandemic. These supports included employers' and managers' overall recognition for their employees' work under these unusual circumstances. They also included regular contact, including checks on staff welfare, which were described as 'keeping in touch' as well as more formal supervision and opportunities for case discussions: *"Having very supportive leaders that I can approach at any time with any problem, they have gone that extra mile to enable me to cope in the toughest of times and in very difficult circumstances."* (Scotland, Social Care Worker)

However, it was suggested that the level of support was often down to individual line managers. Some respondents were very satisfied with their line managers' support. Other respondents were very dissatisfied, noting low or poor responses from managers when issues arose, leaving a feeling of being abandoned without leadership or direction:

> *"PPE and all is great for the physical ability to feel safe…. but emotional support by senior management has lacked. No one has visited us… even if they stand in the car park, it would have shown staff they were supported."* (Northern Ireland, Social Worker)

> *"We haven't heard of our manager barely at all through the pandemic. We have had no direction or advice on our job roles through this all."* (Wales, Nursing)

This created a 'them and us' feeling between management and frontline staff, with the latter in particular feeling undervalued.

While relationships with managers were discussed in both negative and positive ways, a large majority of respondents voiced concerns about the people they were working with. There were extensive responses on how the pandemic had affected service users/patients, and how the changes had affected interactions and relationships with them, as outlined in the following quote:

> *"I am working from home. No face to face contact, so can't physically see if children are safe. Most vulnerable are at risk and numbers have increased"* (Scotland, Social Worker)

One respondent commented on how the lockdown had affected their service users, which in turn increased work-related stress for the staff:

"Service users all have learning disabilities, and some have no understanding of what's going on or why they can't go to shops etc. therefore results in frustration and challenging behaviour which can be stressful for staff" (Northern Ireland, Social Care Worker).

Respondents were also asked about their thoughts relating to the 'Clap for Carers' which was initiated for the public to express their appreciation to health and social care workers. While most respondents recognised that the initiative was well intentioned by the public, some felt that the campaign was being used by politicians as a diversion from the real problems of underfunding of health and social care sector,

"Completely futile and a political stunt designed to shift focus away from chronic underfunding and poor handling of the pandemic." (England, Social Worker)

There were also feelings that this initiative overlooked the contribution of some health and social care workers and that some workers were still not being recognised for their role in society.

*"It felt like it was only for NHS workers and carers, care home staff and social workers were not talked about as being who the clap was for." (*England, Social Worker).

3.3 Communication

Communication was highlighted as an important factor in the assessment of the respondents' experiences throughout the pandemic, however the effectiveness of communication from management and between team members was variable across occupations and across countries. When respondents reported positive feelings and experiences of support, they noted the importance and impact of regular and timely communication from management and senior leadership. Some respondents also noted that communication from management and amongst teams had become more effective during the pandemic, often citing how IT enabled this. Some noted how they welcomed the increased 'check ins' from managers and how IT enabled this effectively. On the other hand, respondents also raised frustrations about IT platforms for communication, particularly when they started working from home.

Respondents further highlighted frustrations about the communication from management and senior leadership about changes to guidelines and work routines. Some respondents noted that managers and employers expected frontline workers to keep up to date with the changing government guidance themselves. In addition, for many respondents, communication was not sufficiently tailored and/or specific to their occupation and place of work. Respondents further thought that communication often caused confusion rather than clarity, as outlined in the two quotes below.

"For example- we had resuscitation protocols sent to us…for someone with suspected COVID-19. It said if someone was collapsed to ring the call bell (where are call bells in patient homes??) to not attempt resuscitation until you were gowned in full PPE (which has to be done with a buddy and in the community we work alone and when this protocol came out we still didn't have any PPE to use). This is one of many examples where guidelines had been written by someone who has clearly never worked outside of the hospital setting and quite frankly it gets frustrating, demoralising and exhausting." (England, Nursing)

This type of frustration was not only attributed to the pandemic context, but from the perspective of some respondents, was identified as an underlying problem that existed pre-COVID and was then exacerbated throughout COVID, as explained below:

"They may not fully understand how their decisions impact us or the people we support, this seemed more apparent during Covid. This creates flawed decisions,

> *something we often see when we have new administration cycle…... Communication and collaboration must improve, and could be achieved by having more front line workers partaking in executive discussions to inform their decision making process"* (England, Social Worker).

To improve the timeliness and effectiveness of decision making, many respondents also called for greater autonomy. However, there was simultaneously a sense of realism and understanding that the pandemic was unprecedented, and that managers were also having to react daily to changing government guidelines. The quote below describes a further stressor associated with a lack of clear communication:

> *"Sometimes the information sent out…was contradictory so that at times I felt supported to work remotely and other times I didn't. This was extremely stressful and worrying."* (England, AHP)

Rapid decision making that was not informed by those delivering services became a recurring theme that respondents highlighted, and they asked for more consultation with front line workers and clear and timely information.

> *"Clear and timely information - there has been lots of last minute decisions made with what feels like little thought or consideration for the staff and the impact these decisions might have."* (AHP, England)

### 3.3.1 What were Respondents Coping Mechanisms?

Coping is a diverse concept; therefore, a range of possible coping methods was measured. Social support and the need to connect with others were a recurring thread in the qualitative findings, especially for those feeling isolated from colleagues and managers. Survey respondents completed a series of questions about ways they might cope with stress, called the Carver COPE. This asks about 14 coping types, each measured by response to two statements. For example, the statement "I've been trying to get help or advice from people about what to do" measures coping by use of *Instrumental Support*. Participants tick a box to say if they have been doing this a lot, a little, a medium amount or not at all. Advice seeking is one of the support seeking behaviours, which also includes expressing emotions. Coping can also be proactive, such as positive reframing, or trying to view stresses in a new light. There are also examples of avoidance coping, such as turning to work as a means of self-distraction, or of altering consciousness, which can range from prayer or meditation on one hand, to substance use on the other.

We found significant differences in all but 5 of the 14 Carver Coping Scale domains across countries. These differences were in: Use of instrumental support; Self-distraction; Denial; Substance use; Use of instrumental support; Positive reframing; Humour; Acceptance; Religion; and Self-blame. In Northern Ireland, substance use and positive reframing scored highest as coping mechanisms. This compares to Scotland where more people turned to religion and used self-distraction. In Wales, people used instrumental support, acceptance and self-blame to cope. In England, people were less likely than other parts of the UK to use self-distraction or acceptance as a coping mechanism.

There were significant gender differences in all but two of the Carver Coping domains. The two that did not show significant differences were Behavioural disengagement and Positive reframing. Females scored significantly higher than males on use of active coping, denial, substance use and use of emotional support.

There were also significant differences across age groups in all of the Carver Coping domains. Those aged 16-19 scored higher than any of the other age groups on use of self-distraction, instrumental support, positive reframing, humour, acceptance and religion as coping mechanisms.

Figure 3.3: UK-wide Carver Coping Scores
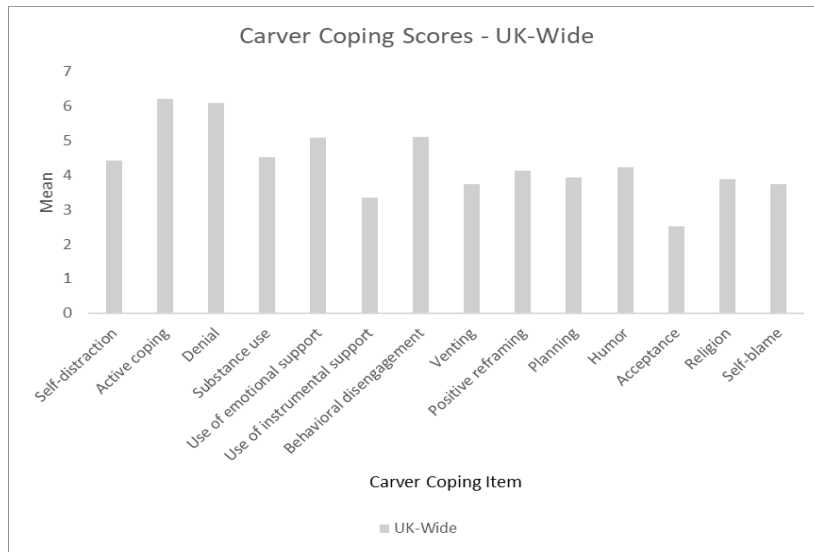
There were significant differences across occupations in all but three of the Carver Coping domains, these are Active Coping; Use of Emotional Support and Acceptance. Nurses scored higher on the use of Self-Distraction, Venting and Religion but significantly lower on use of Acceptance as a coping mechanism. Use of Denial, Active Coping and Emotional support showed higher mean scores across all professional groups.

Table 3.2: Mean Carver Coping Scores by Occupation

Carver Domain	Nursing	Midwifery	AHP	Social Care	Social Worker
Self-distraction	4.56	4.42	4.27	4.45	4.29
Active coping	6.43	6.04	6.20	6.22	6.21
Denial	6.32	6.05	6.19	5.96	6.02
Substance use	4.44	4.30	4.98	4.53	4.62
Use of emotional support	5.25	5.22	5.17	5.09	5.16
Use of instrumental support	3.43	3.52	3.61	3.21	3.51
Behavioural disengagement	5.12	5.02	5.37	5.16	5.27
Venting	4.00	3.79	3.95	3.71	3.87
Positive reframing	4.13	4.10	4.56	4.10	4.31
Planning	4.04	4.23	4.06	3.86	4.03
Humour	4.47	4.58	4.22	4.11	4.21
Acceptance	2.52	2.55	2.54	2.52	2.53
Religion	4.06	4.00	3.74	3.65	3.91
Self-blame	3.92	3.69	3.98	3.61	3.93

3.3.2 Clark Coping Scores by Country, Gender and Age

The Clark Coping Scale measures Family Work Segmentation, Work Family Segmentation, Work to improve Skills/Efficiency, Recreation, Relaxation and Exercise. This scale asks more specific questions about coping with work stress and interaction with one's work environment and organisational structure. For example, participants are asked about efforts they have made to improve their efficiency, such as through investing time in self-organisation and verbalising and sharing work pressures with others. These questions also capture the spillover

of work pressure to personal wellbeing such as through exercise, as well as to family functioning and the ability to devote time to family.

There were significant differences in three of the Clark Coping Scale domains across countries: Work to improve skills/efficiency; Recreation /relaxation; and Exercise. People in England scored higher on use of Recreation and Relaxation. Those in Wales scored higher on working to improve Skills/Efficiency and Exercise and Work Family Segmentation. In NI, respondents scored higher on using Family Work segmentation than any other country. There were significant differences in mean scores across all Clark Coping Domains by gender. Females were more likely than males to work to improve skills/efficiency, whilst males were more likely to cope using exercise.

There were significant differences across all Clark Coping domains between age groups. Those aged 60-65 scored higher than any other age group in the use of Recreation/Relaxation to cope, whilst younger people were more likely to work to Improve skills or Exercise.

Figure 3.4: Clark Coping Scores by Country

Table 3.3: Clark Coping Scores by Country

	Mean Clark Scores				
Clark Domain	**UK-Wide**	**England**	**Scotland**	**Wales**	**Northern Ireland**
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
Work to improve skills/efficiency	4.48	4.46	4.53	4.56	4.31
Recreation /relaxation	3.75	3.87	3.47	3.70	3.57
Exercise	3.96	4.07	3.51	4.07	3.89

3.3.3 How was Quality of Working Life Impacted?

The day to day quality of working life was captured in qualitative responses and also by the results from the WRQoL scale results. This measures Job and Career Satisfaction, Stress at Work, General Well-being, Home-Work Interface, Control at Work and Working Conditions. The questions give an in-depth picture of working life, examining the following key aspects. Control at Work assesses whether respondents feel they are involved in key decisions (e.g., "I feel able to voice opinions and influence changes in my area of work"); Job Career Satisfaction (JCS) looks at whether organisations provide a roadmap and direction of travel for employees, as opposed to firefighting each problem as it arises (e.g., "I have a clear set of goals and aims to enable me to do my job"); Stress at Work (SAW) asks for responses to statements such as "I often feel under pressure at work"; Working Conditions (WCS) asks about the safety and appropriateness of the work environment; and Home-Work Interface concerns the organization's active efforts to understand and adjust for pressures outside of work (e.g., "My employer provides adequate facilities and flexibility for me to fit work in around my family life"). All statements are responded to on a 5-point scale from Strongly Agree to Strongly Disagree, and can be aggregated to six discrete measures or one composite measure.

There were significant differences in all the quality of working life areas across countries. England respondents scored highest in Stress at Work, whilst those in Wales scored highest in Job and Career Satisfaction, General Well-being, and Working Conditions. Respondents from Scotland scored lowest for all quality of working life items. The highest total score for quality of working life was in Wales (83.94). The Stress at Work responses were reverse scored for consistency with the other WRQoL scales so that a high score on this domain implies lower stress.

Figure 3.5 Quality of Working Life Scores by Country
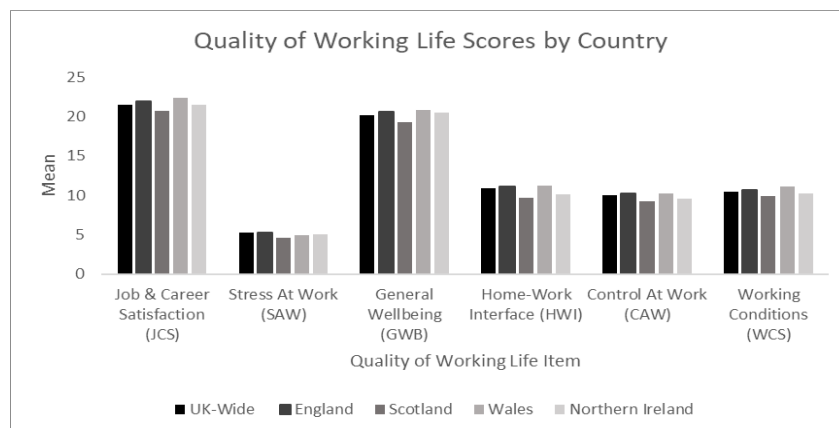
We explored levels of quality of working life by country, lower, average and high scores across percentages of respondents who scored across these levels. UK wide levels of quality of working life were in the higher category and England had the highest level of respondents reporting higher quality of work life, followed by Wales and then Northern Ireland. More respondents from Scotland reported a lower level of quality of working life than the other countries. There were significant gender differences across all the quality of working life domains with males reporting a significantly higher total quality of working life score than females.

Figure 3.6 Total Quality of Working Life Score by Country
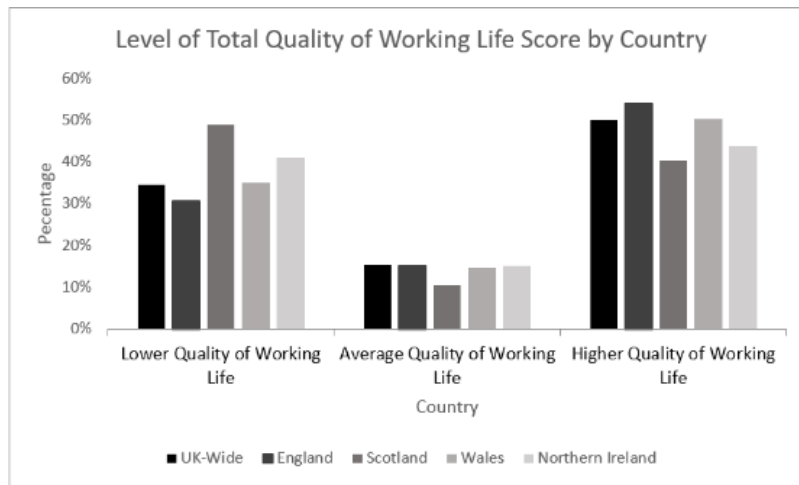
Additionally, more UK wide respondents reported higher quality of working life in levels of Job and Career Satisfaction, Home-Work Interface, and marginally in Working Conditions. This figure shows that across all respondents there is a mixed picture of quality of working life, across all the domains. (See also Table 3.4 for a further breakdown of this variation.)

Figure 3.7 Level of Quality of Working Life Scores – UK Wide
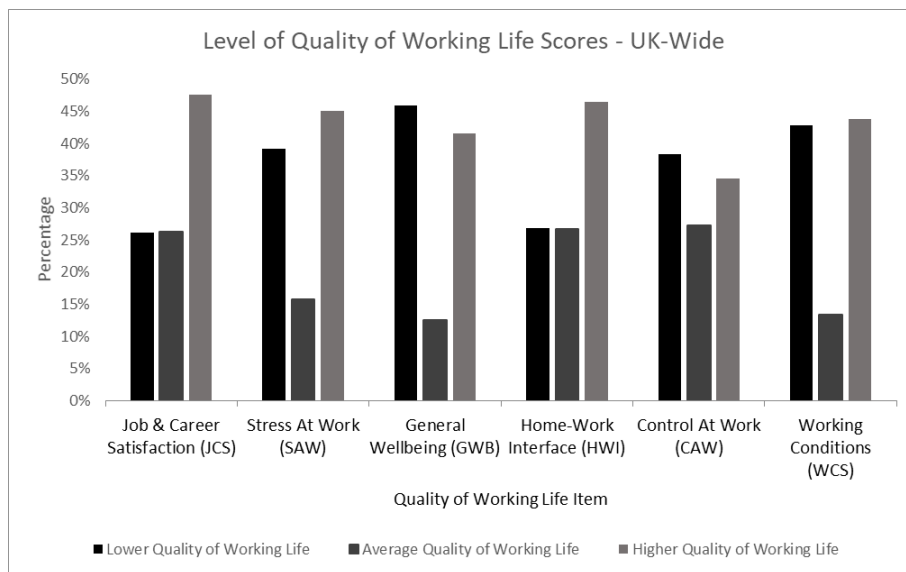
Table 3.4: Level of Quality of Working Life Scores - UK-Wide

Quality of Working Life Domain	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
Job & Career Satisfaction (JCS)	26.1%	26.3%	47.6%	**100%**
Stress At Work (SAW)	39.2%	15.7%	45.1%	**100%**
General Wellbeing (GWB)	45.9%	12.5%	41.6%	**100%**
Home-Work Interface (HWI)	26.8%	26.7%	46.5%	**100%**
Control At Work (CAW)	38.3%	27.2%	34.5%	**100%**
Working Conditions (WCS)	42.8%	13.4%	43.8%	**100%**
Quality of Working Life Total	34.6%	15.4%	50.0%	**100%**

There were significant differences across all quality of working life domains between age groups. There was also a significant difference in the quality of working life total scores between age groups. Scores tend to increase as people get older, so this correlates with the wellbeing scale results and is aligned to McFadden, et al's (2019) findings in the ageing social work workforce study, showing a significant positive correlation between age, wellbeing and quality of working life.

3.3.4 How was Wellbeing Impacted?

The relationship between sickness levels and well-being is important to consider in the current context. We measured wellbeing using a scale called Warwick-Edinburgh. Seven statements are presented, each referring to a positive state of mind (e.g. "I have been feeling relaxed) and respondents are asked to check a box along a five-point scale to indicate how often in the past two weeks this statement reflects their experience (e.g. 'Rarely', or 'All of the Time'). These five-point responses can then be summed. Scores of 7-17 signify *likely* cases of either depression or anxiety, while 18-20 indicates *possible* cases of depression or anxiety (Shah, et al 2018). A small number (9%) of our respondents to our survey registered in the *likely* range, while a further 33% fell in the *possible* range. The overall average score in our population was almost two points below published population averages. This, along with the cumulative 42% of respondents at sub-20 scores (compared to around 17% in the general population), suggests that our sample had considerably lower wellbeing than the general population. For example, a population mean for well-being using the Short Warwick Edinburgh Wellbeing Scale was found to be 23.61 (Health Survey for England, 2011).

We found that overall mean wellbeing scores were slightly higher for the NI sample than UK wide. There was a significant difference in mean total wellbeing scores across countries (F=3.767, df=3, p<0.05). There was no significant difference in mean total wellbeing scores across occupations (F=1.932, df=4, p>0.05).

Table 3.5: Total Wellbeing Score by Occupation

Occupation	Mean Wellbeing Score
Nursing	21.15
Midwifery	20.91
Allied Health Professional	21.51
Social Care Worker	21.14
Social Worker	21.14

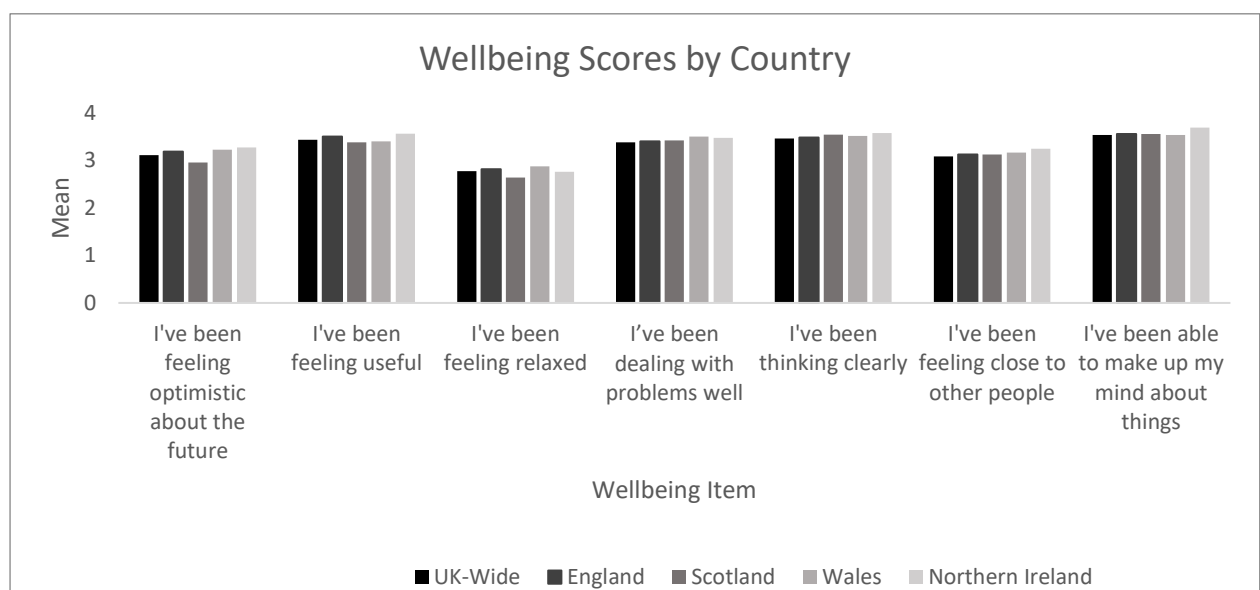Figure 3.8: Wellbeing Scores by Country

Table 3.6: Wellbeing Scores by Country

Wellbeing Item	UK-Wide	England	Scotland	Wales	NI
I've been feeling optimistic about the future	3.11	3.18	2.95	3.22	3.27
I've been feeling useful	3.43	3.50	3.38	3.40	3.56
I've been feeling relaxed	2.77	2.81	2.64	2.87	2.76
I've been dealing with problems well	3.38	3.40	3.42	3.50	3.47
I've been thinking clearly	3.46	3.48	3.54	3.51	3.57
I've been feeling close to other people	3.08	3.12	3.12	3.16	3.24
I've been able to make up my mind about things	3.53	3.55	3.55	3.53	3.69
Overall mean Wellbeing Score	20.95	21.15	20.74	21.25	21.61

3.3.5 Wellbeing by Gender, Age, Ethnicity and Disability

Males reported a higher level of wellbeing than females and this difference in wellbeing scores across gender was significant. There was also a significant difference in wellbeing scores across age groups. As noted above, as people age, they generally report higher wellbeing scores. There was a significant difference in mean total wellbeing scores across ethnicities, with Black people reporting the highest wellbeing scores. There was a significant difference in wellbeing scores by disability. Those who reported no disability had a higher well-being score. This was the same for the McFadden et al (2019) study. Further information on the analysis of well-being across gender, disability, ethnicity and age is reported in the Appendix.

3.4 Multiple Regression Results

3.4.1 Multiple Regression Model Predicting Wellbeing Score

Multiple regression modelling was used to examine the coping factors that predict Mental Wellbeing (SWEMWBS) scores whilst controlling for various demographic variables (age, gender, ethnicity, disability), as well as country of work, occupational group and number of sick day absences in the previous 12 months.

The results indicated that the model accounted for approximately 34% of the variance in Mental Wellbeing scores. The following coping variables each uniquely predicted higher Wellbeing scores, namely, use of Active Coping, Emotional Support, Work Family Segmentation, Relaxation and Exercise. Lower Wellbeing scores were associated with higher Disengagement and Substance Use. No group differences emerged in terms of age, disability or ethnicity but males reported higher scores than females. Preparedness for re-deployment was added to the model but was not significantly associated with changes in Mental Wellbeing scores (see appendix 8 for more details).

3.4.2 Multiple Regression Model Predicting Quality of Working Life Score
In the same way multiple regression modelling was used to predict Work Related Quality of Life (WRQoL) scores using the same predictor variables as in the previous analysis.

The results indicated that the model accounted for approximately 25% of the variance in WRQoL scores. The following variables each uniquely predicted higher WRQoL scores,

namely, use of Active Coping, Emotional Support, Work Family Segmentation, Family Work Segmentation and Relaxation. Lower WRQoL scores were associated with higher Disengagement and higher Family Work Segmentation. No differences were evident in relation to age, occupational group or gender but those with a disability recorded lower WRQol scores on average. The number of days absent due to sickness in the previous 12 months was associated with lower WRQoL scores. Adding the experience of re-deployment to the model showed that those who felt prepared for re-deployment tended to report higher WRQol scores than those who felt unprepared or unsure (see appendix 8 for more details).

4. Interpreting the Main Messages

The research questions addressed in this report focused on the challenges that nurses, midwives, AHPs, social care workers and social workers faced, working in health and social care during the first wave of the COVID-19 pandemic, and examined what they were doing to cope with these challenges. We asked questions to identify the challenges, what has mitigated or exacerbated them, and how staff have coped. We were interested in positive and negative coping and how a range of factors impacted on feelings of wellbeing and quality of working life. We used statistical regression modelling to find out if coping mechanisms predicted wellbeing and if coping methods were related to working quality of life. We accounted for this across occupational groups and regions of the UK so that we can draw comparisons and learning to share with employers, professional bodies, regulators and relevant stakeholders.

4.1 Limitations

This cross-sectional survey was based on a convenience sample of health and social care workers and therefore the results cannot be interpreted as a representative sample. Furthermore, there is not an even distribution of responses across the four UK countries nor across work settings and types, so the results cannot be considered representative across countries nor occupational groups. Another limitation worth noting is the self-report nature of the survey as participants may have been motivated to complete the survey due to personal bias or negative experiences which have the potential to skew the results. Results should be read with these limitations in mind.

4.2 Discussion and Recommendations

Overall, COVID-19 has amplified some of the strengths of the UK health and social care workforce. They have risen to the challenge but at some cost. The recommendations from this study therefore reflect not just learning from the COVID-19 pandemic but also sheds light on some wider rewards from health and social care working conditions and some endemic problems. While a global pandemic may be a rare but catastrophic event, there are crises at times (of different proportions) and multiple everyday difficult contexts for which the health and social care workforce always needs to be well-prepared, resilient, and well-supported. These recommendations are specific to COVID-19 however for employers and policy makers. Many apply across health and social care in the context of increased interest in working together from across the UK.

Our survey has revealed the considerable commonalities of human service work but also differences. These apply particularly to the location of work; being on the frontline means different things if a person is working on a hospital unit or in a care home, generally with people who are very ill or at some risk of death. There are different tensions and risks from using the home as an office and yet further differences when working in other people's homes and travelling. Commonalities among the workforce are their stated altruistic concerns for service users and patients; the very reason why most people work in health and social care. While others have rightly suggested that compassion is important in relation to human services work (West et al 2020), our survey also points to the importance of employment rights, terms and conditions (equipment, safety, sick pay, communications and information).

Our survey is not the final word, of course, but suggests some new areas for workforce thinking and HR practice. For example, what enabled some people to view their experiences during the first wave of COVID-19 as generally positive; did this relate to their disposition or to their work context? There may be much to learn from this group and to find out whether they were generally satisfied with work pre-COVID-19 or if they were particularly impressed by their managers' actions or local contexts. For example, in some cases, respondents noted how practices and routines for line management and team communication had become more effective in response to the pandemic, leading to feelings of being better supported than before. It is important for employers and managers to identify where changes to their approach led to more beneficial outcomes for workers, and evaluate how these changes can be

sustained in a post-COVID-19 work environment. We were able to compare results from McFadden (et al 2019) that shows a consistent level of social worker well-being prior to and during the COVID-19 pandemic. This was in terms of age band and gender.

We have noted some differences between groups in terms of their coping mechanisms that may be of interest to HR and employers more generally. For example, while not all younger staff are keen on exercise, we found that younger staff and men reported this was important to their wellbeing; is there room to offer rewards around this such as discounts or incentives? While IT proved so valuable in terms of communications and support, can we be confident that all workers are IT literate and not further disadvantaged by limits of access or capability. Has COVID-19 prompted new skills in this area? Again, there is room for employers to consider these points in their After-Action Reviews or Lessons Learned reviews following the first wave of the virus.

Our findings suggest that emotional and psychological support for staff was important in helping reduce the risks of negative work effects during the pandemic. For employers this means enabling this to be part of workplace culture since it is unlikely to manifest itself during a pandemic or crisis if not already existing. Such skills have to be learned, infuse an organisation and its work units or teams. There are potential needs to explore if they are provided and received by staff at all levels. This would seem a corporate responsibility, not just an individual responsibility. As noted above, the provision of emotional and psychological support for staff is not just needed during a pandemic but should be the hallmarks of human service work.

Other findings throw a light on the redeployment of staff, which one in ten of our respondents overall had experienced, although this was not evenly spread with redeployment relating to one in five of our health respondents. While many felt neither unprepared or prepared there are questions to explore about team and individual working when under pressure or in extreme circumstances and what is to be adopted or rejected from new ways of working. While implementation scientists are likely to be working on such questions, it may take time for the evidence to come forward about patient/service user outcomes. In the meantime, some practices are likely to become widely adopted regardless of evidence but because they have improved work or services. Our study suggests however, the importance of taking care of those who took on extra work when their colleagues were redeployed or on sick leave and the possible risk of burnout or exhaustion. Trends in applications for early retirement may be a way of monitoring if these stresses have become overlooked. Employers also could take advantage of aspects of redeployment which seemed to have been interesting if not exciting. This experience may have given rise to new ambitions that could be harnessed.

Finally, our study raises the linked importance of family and work; unsurprising in the largely female dominated sectors of health and social care employment. We have no quick answers here but our findings suggest that for some staff the process of 'segmenting' work and family life was a positive coping practice. The long-term implications of this will need to be explored.

4.3 Good Practice Guidance

4.3.1 Improving Work Context and Conditions

1. Employers need to provide as far as possible increased flexibility around working hours, location of working, and recognition of additional childcare or other caring responsibilities to support the workforce during a pandemic or other crisis. The nature of a pandemic means that these are not easy to provide, of course, but communication and understanding of their importance will help staff feel that their needs, wellbeing and circumstances are being considered. Talking with staff and their representatives about this would be one first step.

2. Training and development to equip staff with the ability to, where possible, perform multiple or new roles should be commissioned and rolled out. While this form of skill mix might be thought vital during times of high service demand where low staff levels affect the availability of critical skills within teams, it might also be helpful during 'normal' service delivery. This will need attention from employers, professional bodies, regulators, educational and training bodies, and service users and patient groups.

3. Some respondents called for more involvement in decision making, more autonomy and flatter hierarchies to equip staff with the ability to make faster, well-informed decisions in times of crisis. This was also thought to improve service delivery during normal service delivery times. Research is needed on patient/service user outcomes to see whether this view is borne out by the evidence. It would need to be integrated with the current reliance on evidence-based guidelines.

4. Policies about working from home (if appropriate) should be developed and equitably applied to avoid division and discontent and undermining of leadership and organisational commitment. If staff request or are asked to work from home, they should be able to access equipment and technology support, to have relevant expenses met, and to be assured of supervision and peer support.

5. For those staff who need to be in the workplace steps should be taken to ensure social distancing, handwashing, use of sanitisers for shared equipment and use of large spaces to reduce the risk of viral spread. Workplaces need to ensure that there are plans for any crisis, such as fire and flood, not just pandemics. The flexible use of rota systems could assist in the number of employees needing to be present at one time and could be undertaken quickly in any crisis with the development of technology.

6. The "Clap for Carers" campaign may be an opportunity to re-examine both the societal recognition of the work done by health and social care workers but to also increase funding and the deployment of NHS and social care services, as well as the pay of health and social care workers (and making pay, terms and conditions fair for all).

7. Employers in the health and social care sector should ensure that their staff should not have to solely rely on Statutory Sick Pay in the event of illness. Policy and practice around staff sick pay should be reviewed and ameliorated urgently where necessary by employers.

8. Further consideration is needed about the most effective way of supporting and deploying temporary or agency staff who may have limited sick pay entitlements to Statutory Sick Pay (SSP). This could reduce the risks of staff going to work when unwell or infectious and does not, of course, apply only to the COVID-19 context.

9. Plans to obtain and sustain supplies, and to deploy appropriate PPE, should be developed by employers and public health bodies at times of crises such as pandemics for staff in direct contact with people. Such plans should be regularly reviewed by a regulator.

4.3.2 Improving Connections and Communication

1. Connection to colleagues and managers is critical during a pandemic or any other crisis, and regular and frequent communication is required, in person or virtual, to increase personal and professional connection and employee engagement and organisational commitment. This needs to be tailored to the needs of the service, the team or individuals. There should be development of evidence-based good practice guidance that meets the broad range of health and social care services by national bodies.

2. Employers are accountable and hold corporate responsibility for ensuring that employees are provided with up to date guidelines. Any change to guidelines should be monitored by those holding management responsibility to interpret changes and guide staff and other managers on best practice recommendations. This should result in clear messages and reduce the risk of contradictory or confusing guidance.

3. Managers should be visible, either in person (if possible) or virtually, so that workers feel they are as valued as those in management positions.

4. Staff concerns for service user or patient wellbeing needs to be taken seriously by management and evidenced by opportunities to discuss individual concerns in peer or one to one supervision. Staff empathy is an important driver for motivation, job satisfaction and commitment and needs fostering.

5. Managers need to ensure where possible that staff are supported and encouraged to take leave if possible or to carry it over without penalty in crisis situations.

6. Staff concerns about contracting infections should be viewed as an indication of their commitment to their job and concern for the wellbeing of their families and themselves. Staff's concerns should be listened to and reasonable actions taken to alleviate concerns.

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6. Appendices

Appendix 1: Original Study Research Protocol

Health and social care workers' quality of working life and coping while working during a Covid-19 Pandemic

Research Question: 'What are the challenges that nurses, midwives, AHPs, social care workers and social workers face working in health and social care during a pandemic and what are they doing to cope with them?

Aim: This study aims to explore the impact of providing health and social care during a pandemic on nurses, midwives, AHPs, social care workers and social workers.

Objectives:

1. To gather relevant demographic information from a cross sectional convenience sample of nurses, midwives, AHPS, social care workers and social workers in the UK.
2. To determine nurses, midwives, AHPs, social care workers and social workers perspectives on the challenges they are facing while providing health and social care during a pandemic.
3. To measure mental health and wellbeing, quality of working life and home and work interface.
4. To find out what coping strategies are used by frontline staff during the time of a pandemic.
5. To explore health care workers perspectives on employers supports, improvements on employer supports and suggestions for employers' support for future pandemics based on their experience and learning from the current COVID-19 pandemic.

Methodology:

The chosen method is an online survey which affords anonymous responses, at low cost and is easily distributed to a large number of participants across a wide geographical area (Sarantakos, 2005). The survey is designed to meet the objectives of the study and is informed by a review of the literature. This predominantly quantitative questionnaire will contain validated and reliable standardised scales, and will comprise 6 sections (See Appendix 1 for Scale information):

1. Demographics: age, gender, ethnicity, disability, marital/partner status, caring responsibilities, professional area of work, job tenure and role, time of professional qualification, hours of work, additional hours (over contracted hours) (Objective 1 – 17 items).
2. Quality of Working Life Scale (QOWLS) Objective 2 – 24 items
3. Short Warwick Edinburgh Mental Well-being Scale (SWEMWS) Objective 3 – 7 items
4. Brief COPE Scale [iii] Objective 4 - 28 Items
5. Clark et al. Coping with Work and Family Stressors Scale [iv]- Objective 4-15 items
6. Qualitative questions to explore workforce perspective- Objective 5- 4 items

The Quality of Working Life Scale (QOWLS) contains 24 items, each using a Likert scale measure which gauges the perceived quality of life of employees as measured through six psychosocial sub-factors. The Short Warwick Edinburgh Mental Well-being Scale (SWEWS) (7 items) enables the monitoring of mental wellbeing. Carver (1997) originally developed the brief COPE to measure 14 different coping strategies: self-distraction, active coping, denial, substance use, using emotional support, using instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion and self-blame. Brief COPE has been used widely (Meyer, 2001; Welbourne et al., 2007) and has

acceptable reliability (Carver, 1997; Muhonen & Torkelson, 2005). Respondents rate each item on a 4-point scale from 1 (I haven't been doing this at all) to 4 (I've been doing this a lot) to indicate how they coped while working in health and social care during the COVID-19 pandemic. A further 15 selected items from Clark' et al's (2014) Coping with Work and Family Stressors Scale will capture information about strategies for dealing with family and work segmentation, work to improve skills/efficiency, recreation /relaxation and exercise.

There are some additional open-ended questions and at the end of the survey, participants can add any additional information or perspectives that they may have about working in health and social care during COVID-19.

Participants:

Nurses, midwives, AHPs, social care workers and social workers in the UK who have signed up to receive newsletters or journals from professional associations, workplace unions and regulators such as Royal College of Nursing (RCN), Royal College of Midwives (RCM), the Northern Ireland Practice and Education Council (NIPEC), Northern Ireland Social Care Council (NISCC), the Royal College of Occupational Therapists, British Dietetic Association and others. In order to reach as wide a population of nurses, midwives, AHPs, social care workers and social workers in the UK as possible who are working in health and social care during the COVID-19 pandemic, social media platforms such as Twitter and Facebook will also be used to advertise the survey and provide an electronic link to the Participant Information Sheet, consent and survey.

Inclusion criteria:

Nurses, midwives, AHPS, social care workers and social workers at any band who are currently employed or self-employed (including agency workers), within any area of health and social care in the UK during the COVID-19 Pandemic.

Exclusion Criteria:

Health and social care professionals who are not nurses, midwives, AHPS, social care workers and social workers at any band who are currently employed or self-employed (including agency workers), working in Health and Social Care in the United Kingdom during the COVID-19 Pandemic.

Sampling:

The survey will draw on a convenience sample of those who choose to participate following receipt of communication in a newsletter/journal from RCN/RCM/NIPEC/ NI SCC and other professional associations and workplace Unions or those who have accessed the survey on social media. The number of nurses and midwives in the UK is 660,213 and 37,255 respectively (NMC Register 2019). Using the Raosoft sample calculator (http://www.raosoft.com/samplesize.html) with a confidence interval of 95%, the sample we would like to recruit is 384 nurses and 381 midwives. The number of AHPs working in health and social care in the UK is 152,000 (Allied Health Professions Federation, 2020). Using the Raosoft sample calculator (http://www.raosoft.com/samplesize.html) with a confidence interval of 95%, the sample we would like to recruit is 384. The number of social care workers and social workers in Northern Ireland is 37779 and 6357 respectively. Using the Raosoft sample calculator (http://www.raosoft.com/samplesize.html) with a confidence interval of 95%, the sample we would like to recruit 381 social care workers and 363 social workers.

Access and Recruitment:

Nurses, midwives, AHPs, social care workers and social workers who have signed up to receive professional newsletters or journals from professional associations, workplace unions and regulators will have access to information about the research and can open a link to the survey from the invitation to take part in the research. In addition, nurses, midwives, AHPs,

social care workers and social workers will be able to access information about the research and can open a link to the survey via social media such as Twitter and Facebook. All participants will be encouraged to share the invitation to the research with nursing, midwifery, AHPs, social care workers and social worker colleagues who work in the UK.

Submitted survey data will be anonymous as the Qualtrics © software on which the survey is hosted, enables the IP address of the survey respondent to be deleted. The participants will be advised that their details will not be shared, nor be identifiable to researchers in any subsequent publications. They will able to withdraw from the study at any time by not completing the survey. Clicking on the arrow to proceed after the PIS and completion of the survey will indicate consent.

Data Collection:

A short invitation to take part in the survey will include a link to the Participant Information Sheet and the survey. Participants will be requested to indicate that they have read the Participant Information prior to completing the survey by clicking on an arrow that will take them to the survey. The survey will be open for 4 weeks. The guidance provided by INVOLVE (2014) re the use of social media to actively involve people in research has been followed.

Development of the questionnaire:

The survey has been informed by a review of the literature and is made up of a combination of 4 previously validated questionnaires with open ended questions which are specifically designed to elicit the quality of working life and coping strategies of the participants who were working in health and social care during a pandemic. The draft survey has been reviewed and commented on by academics with expertise in questionnaire development, nurses, midwives, AHPs, social care workers and Social workers. Amendments have been made in response to that feedback.

Data Analysis:

The survey results will be analysed using SPSS 24. Descriptive statistics will provide frequency distribution for both nominal and ordinal data along with percentages and cumulative percentages. A series of inferential statistics will be analysed to examine findings. Qualitative data will be analysed for themes Braun and Clarke's (2006) thematic analysis framework.

Ethical Considerations:

The research team is aware that health and social care workers employed on the front line during a pandemic are already under pressure. However, it is important to carry out this research at this time as we need to find out what their work life is like at this time and what coping strategies they are using. The findings of this study will produce an evidence base that UK employers can use to make evidence informed, organisational level policy adjustments which will impact on the decisions about the support needs of the workforce, particularly during a pandemic. All permissions for use of scales have been sought.

While staff will be volunteering to undertake the survey, it is possible that during the completion of the survey that they may become distressed. Therefore, at both the bottom of the Participant Information Sheet and the end of the survey, the participants are provided with information about who to contact if they need support via a Distress Protocol.

Consent:

As this survey is online, participants will be requested to indicate that they have read the Participant Information prior to completing the questionnaire by clicking on an arrow at the end of the Participant Information Sheet, which will bring them to the first page of the survey.

Completion of the survey will be considered to be an indication of participants' voluntary consent.

Anonymity and Confidentiality:

The participants will access the survey through an anonymised link. Care will be taken when using the demographic information to ensure that no participant can be identified. No personal identification such as name or address will be collected.

Data Storage and Protection:

All of the electronic research materials and data will be anonymously stored on a password protected computer in a room in Ulster University, for 10 years.   The materials will then be destroyed in line with the University policy. https://internal.ulster.ac.uk/research/rg/0613%20data%20handling%20procedure%20V1.pdf

All paper-based research materials will be stored in a locked filing cabinet in the University for 10 years and then destroyed in line with University GDPR and Data Protection legislation and policy.

Appendix 2: Weighting Representativeness for Country, Region and Occupation
Given the high level of representation of participants from Northern Ireland and of social workers in the sample, a two-factor weighting by occupation and region was applied to all summary statistics of the sample. Comparisons by occupation are weighted by region and comparisons by region are weighted by occupation.

Estimating the true population

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

Social Work

Social Work England, Social Care Wales, the Scottish Social Services Council and the Northern Ireland Social Care Council 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%3fresourceId%3d2447&resourceId=2447

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

https://niscc.info/storage/resources/boc-niscc-reportv02-1-1.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/england-2018/content

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 37779 social care workers, compared to 6357 social care 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 NI.

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 A2.1: 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 on the survey, we used the ratio of adult social services social workers in the regions. For example, of the combined 2915 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, totaling 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/registrant-snapshot-1-apr-2020/

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

Regional Aggregation for Weighting

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

Therefore, the following regions were combined for the calculation of weights:

Table A2.2: 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 A2.3: Final Estimated Population and Distribution

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

Table A2.4 Observations by Region and Occupation (where responses were provided by participants)

	London	South	Midlands and East	North & Yorkshire	England (Region Not Specified)	Scotland	Wales	Northern Ireland	Total
Nursing	8.0	9.0	5.0	7.0	29.0	4.0	5.0	152.0	190.0
	0.26%	0.29%	0.16%	0.23%	0.95%	0.13%	0.16%	4.98%	6.22%
Midwifery	15.0	7.0	1.0	3.0	26.0	5.0	53.0	81.0	165.0
	0.49%	0.23%	0.03%	0.10%	0.85%	0.16%	1.74%	2.65%	5.40%
AHP	23.0	40.0	46.0	28.0	137.0	19.0	26.0	175.0	357.0
	0.75%	1.31%	1.51%	0.92%	4.49%	0.62%	0.85%	5.73%	11.69%
Social Care Worker	21.0	48.0	26.0	59.0	154.0	55.0	34.0	925.0	1168.0
	0.69%	1.57%	0.85%	1.93%	5.04%	1.80%	1.11%	30.29%	38.24%
Social Worker	111.0	130.0	103.0	175.0	519.0	33.0	58.0	564.0	1174.0
	5.83%	7.66%	5.93%	8.91%	28.32%	3.80%	5.76%	62.12%	100.00%

Weights were calculated by dividing the observed percentage by the estimated true percentage within cells for two-factor weights, within rows for occupational weights and within columns for regional weights.

Appendix 3: Descriptive Results – Tables and Charts

A3.1 Gender of Respondents

The majority of respondents are female. The gender distribution across country is similar. All midwifery respondents are female, whilst Nursing has the highest percentage of males.
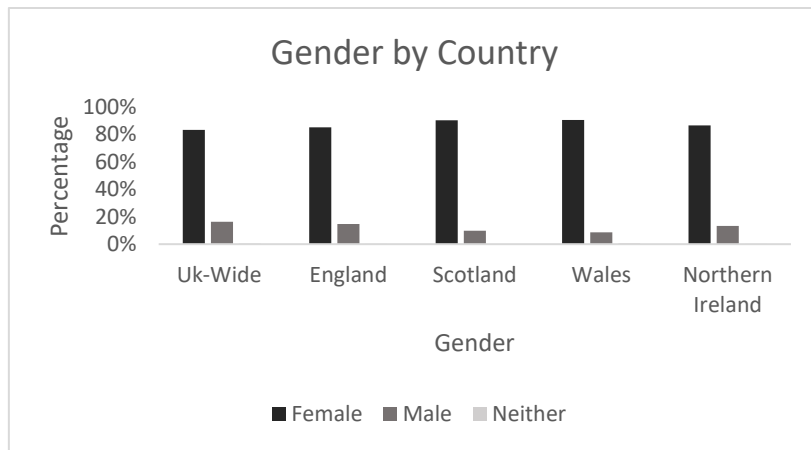
Figure A3.1: Gender by Country

Table A3.1: Gender by Country

Gender	UK-Wide	England	Scotland	Wales	Northern Ireland
Female	83.3%	85.1%	90.3%	90.6%	86.5%
Male	16.3%	14.6%	9.7%	8.7%	13.4%
Neither	0.4%	0.3%	0.0%	0.7%	0.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.2: Gender by Occupation
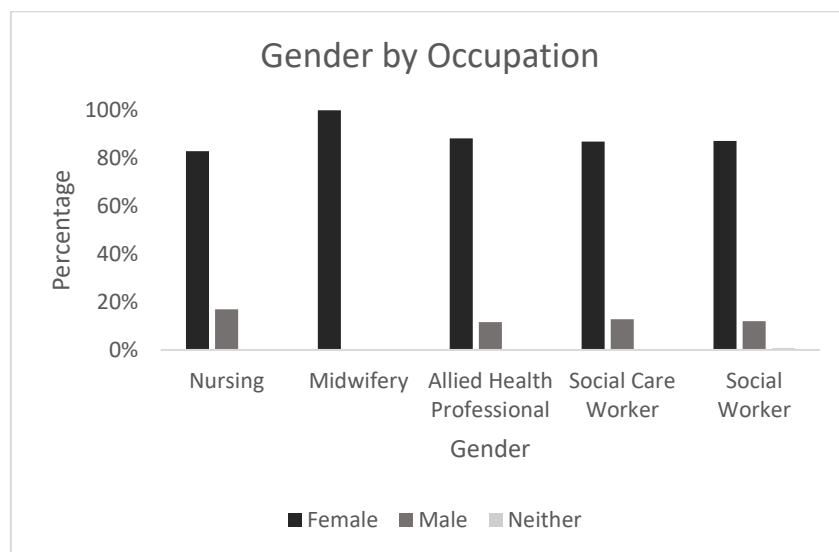
Table A3.2: Gender by Occupation

Occupation	Female	Male	Neither	Total
Nursing	83.0%	17.0%	0.0%	**100%**
Midwifery	100.0%	0.0%	0.0%	**100%**
Allied Health Professional	88.3%	11.6%	0.1%	**100%**
Social Care Worker	86.9%	12.8%	0.3%	**100%**
Social Worker	87.2%	12.0%	0.8%	**100%**

A3.2 Age of Respondents

The respondents were mainly from the 30-59 age bracket. The fewest number of respondents were 16-19 and 60+. Respondents in Scotland are generally younger than in the other countries in the UK, whereas England and Wales are older.

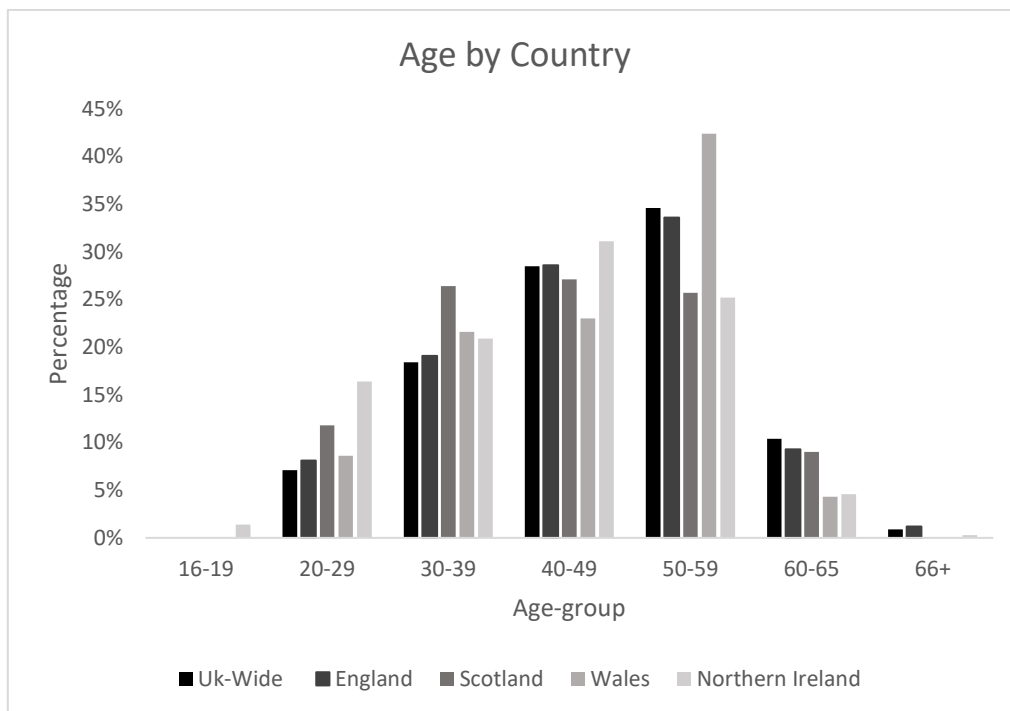Figure A3.3: Age of Respondents by Country

Table A3.3: Age of Respondents by Country

Age-group	UK-Wide	England	Scotland	Wales	Northern Ireland
16-19	0.1%	0.0%	0.0%	0.0%	1.4%
20-29	7.1%	8.1%	11.8%	8.6%	16.4%
30-39	18.4%	19.1%	26.4%	21.6%	20.9%
40-49	28.5%	28.6%	27.1%	23.0%	31.1%
50-59	34.6%	33.6%	25.7%	42.4%	25.2%
60-65	10.4%	9.3%	9.0%	4.3%	4.6%
66+	0.9%	1.2%	0.0%	0.0%	0.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

The majority of Nursing and Social Worker respondents fall into the 50-59 age bracket, whilst the other professions are mainly in the younger 40-49 age range.
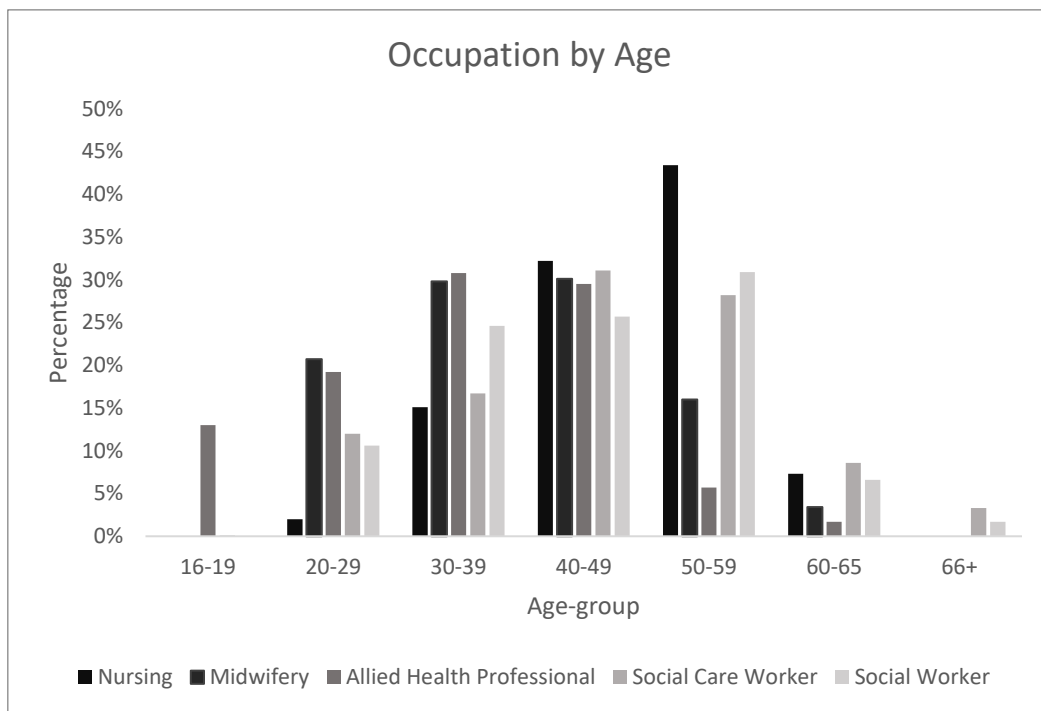
Figure A3.4: Age of Respondents by Occupation

Table A3.4: Age of Respondents by Occupation

Occupation	16-19	20-29	30-39	40-49	50-59	60-65	66+	Total
Nursing	0.0%	2.0%	15.1%	32.2%	43.4%	7.3%	0.0%	**100%**
Midwifery	0.0%	20.7%	29.8%	30.1%	16.0%	3.4%	0.0%	**100%**
Allied Health Professional	0.0%	13.0%	19.2%	30.8%	29.5%	5.7%	1.7%	**100%**
Social Care Worker	0.1%	12.0%	16.7%	31.1%	28.2%	8.6%	3.3%	**100%**
Social Worker	0.0%	10.6%	24.6%	25.7%	30.9%	6.6%	1.7%	**100%**

A3.3 Ethnic Origin of Respondents

Almost all participants were white in all four countries of the UK and England was the most ethnically diverse.

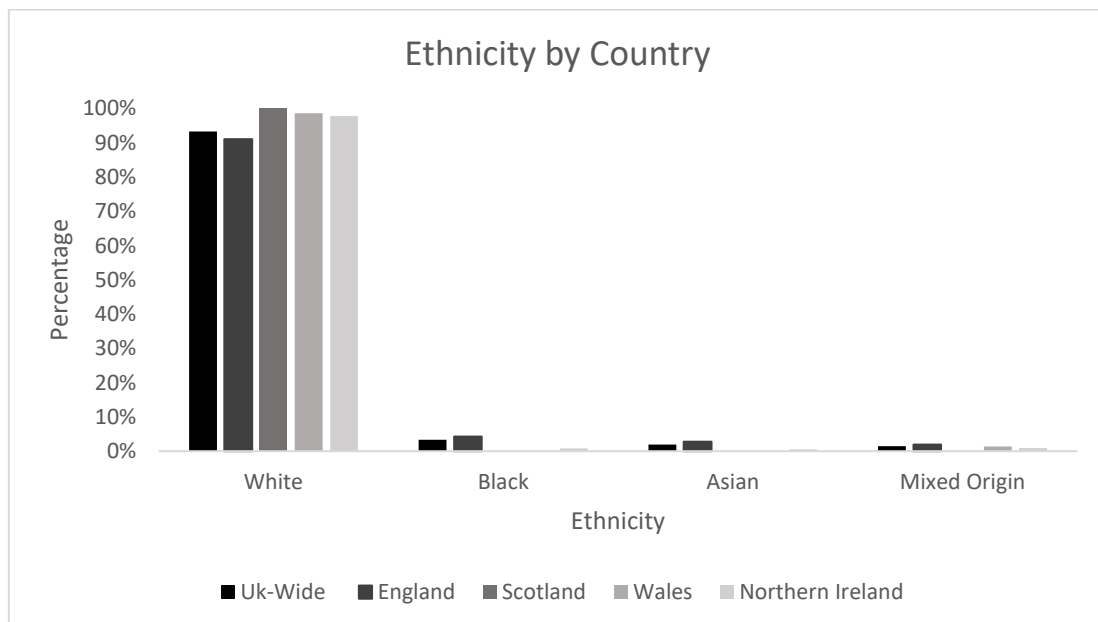Figure A3.5: Ethnic Origin of Respondents by Country

Table A3.5: Ethnic Origin of Respondents by Country

Ethnicity	UK-Wide	England	Scotland	Wales	Northern Ireland
White	93.3%	91.1%	100.0%	98.6%	97.8%
Black	3.3%	4.3%	0.0%	0.0%	0.8%
Asian	1.9%	2.8%	0.0%	0.0%	0.5%
Mixed Origin	1.5%	1.9%	0.0%	1.4%	0.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.6: Ethnicity by Occupation

Ethnicity by Occupation
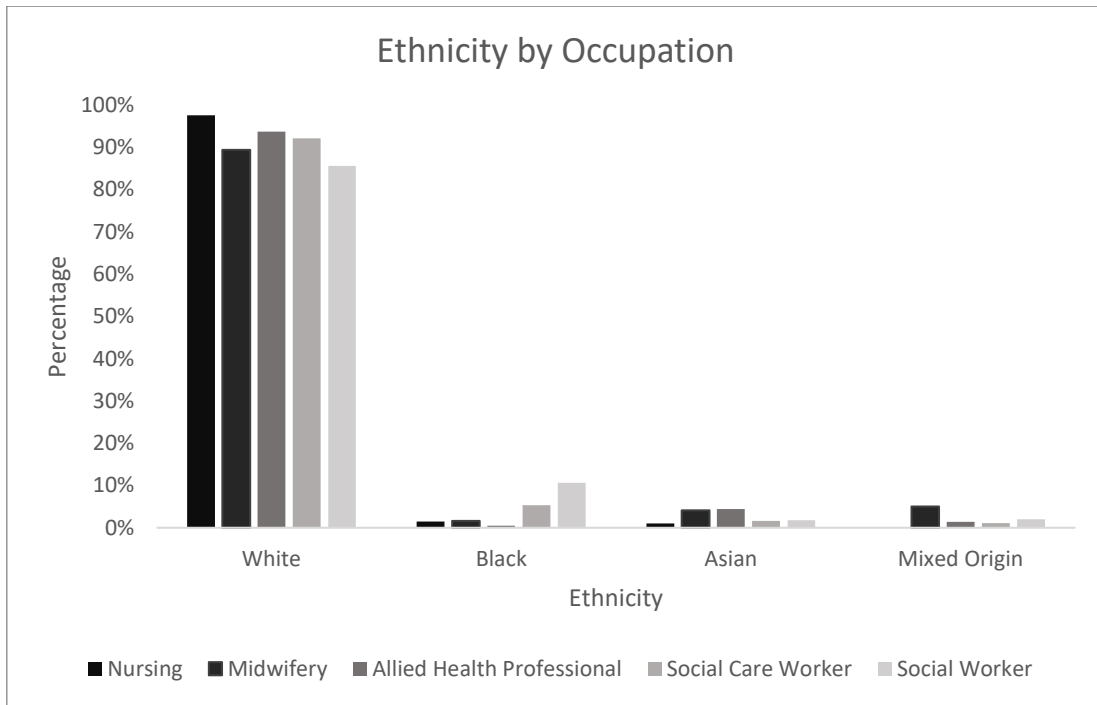
Table A3.6: Ethnicity by Occupation

Occupation	White	Black	Asian	Mixed Origin	Total
Nursing	97.6%	1.5%	1.0%	0.0%	**100%**
Midwifery	89.4%	1.6%	4.1%	5.0%	**100%**
Allied Health Professional	93.7%	0.5%	4.4%	1.4%	**100%**
Social Care Worker	92.1%	5.3%	1.6%	1.1%	**100%**
Social Worker	85.6%	10.6%	1.8%	2.0%	**100%**

A3.4 Country of Respondents

Over half (57%) of the respondents were from Northern Ireland. Given the skewedness towards respondents from Northern Ireland, as well as Social Workers and Social Care Workers, the results presented in this report have been weighted by Region and Occupation.
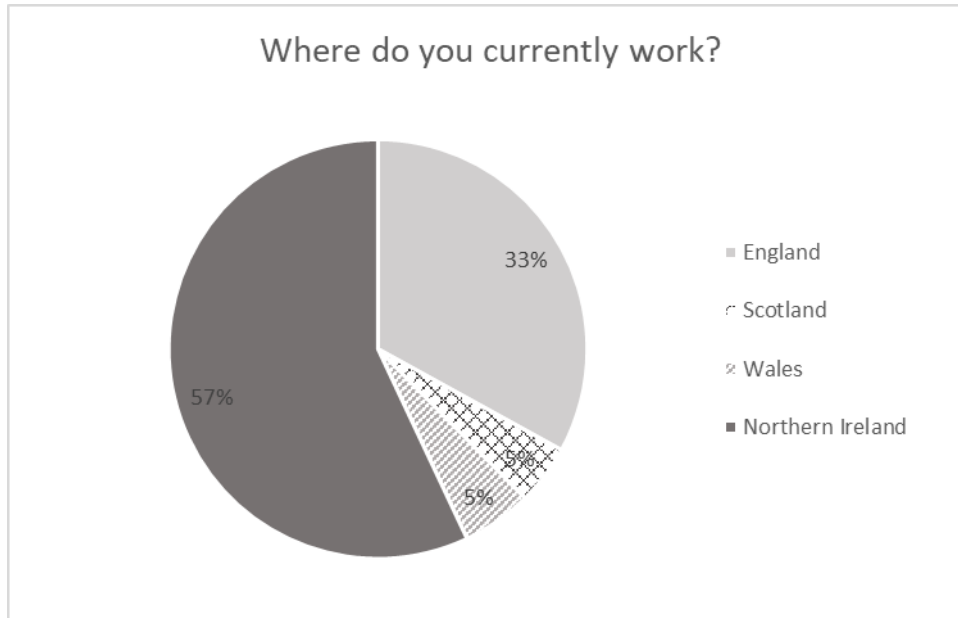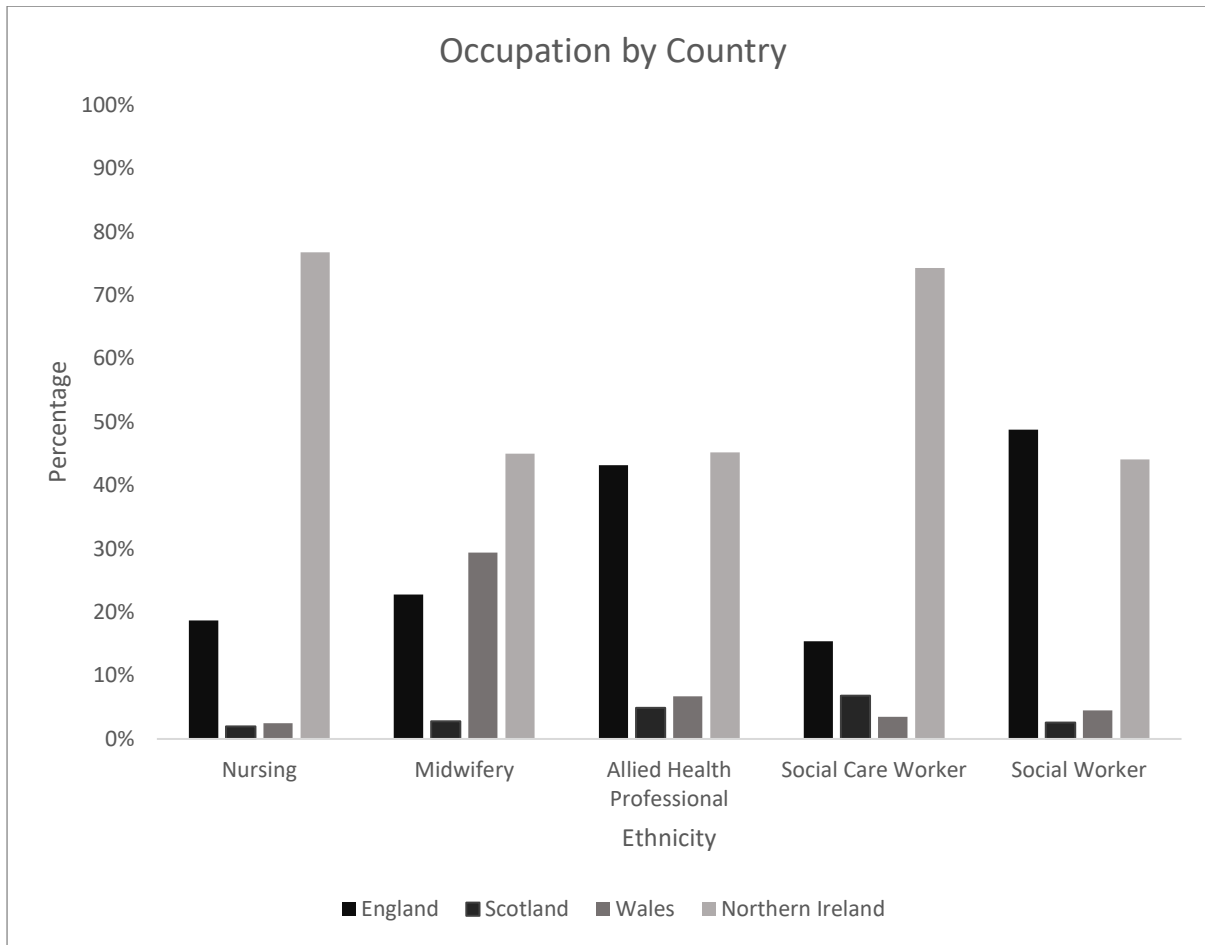
Figure A3.7: Country of Respondents

Table A3.7: Country of Respondents by Occupation

Occupation	England	Scotland	Wales	Northern Ireland	Total
Nursing	18.7%	2.0%	2.5%	76.8%	**100%**
Midwifery	22.8%	2.8%	29.4%	45.0%	**100%**
Allied Health Professional	43.2%	4.9%	6.7%	45.2%	**100%**
Social Care Worker	15.4%	6.8%	3.5%	74.3%	**100%**
Social Worker	48.8%	2.6%	4.5%	44.1%	**100%**

Figure A3.8: Occupation by Country

Occupation by Country

Percentage

Ethnicity

■ England   ■ Scotland   ■ Wales   ■ Northern Ireland

A3.5 Respondents working in Hospital, Community-Based, or Both

The majority of respondents work in the community.

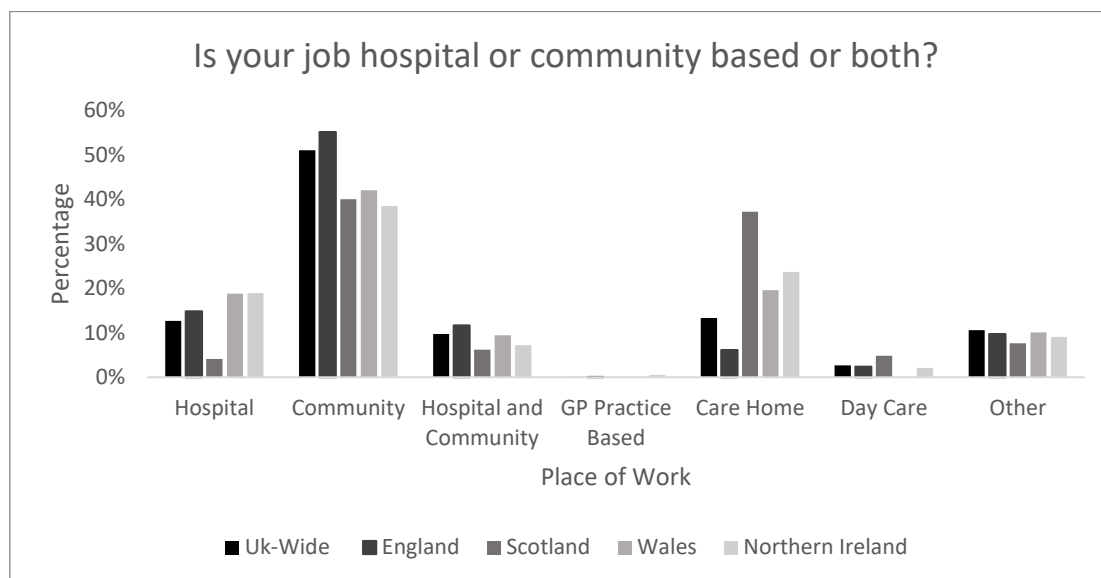Figure A3.9: Hospital, Community-Based, or Both by Country

Table A3.8: Hospital, Community-Based, or Both by Country

Is your job hospital or community based or both?	UK-Wide	England	Scotland	Wales	Northern Ireland
Hospital	12.7%	14.8%	4.1%	18.8%	18.9%
Community	51.0%	55.1%	40.0%	42.0%	38.5%
Hospital and Community	9.7%	11.7%	6.2%	9.4%	7.2%
GP Practice Based	0.1%	0.1%	0.0%	0.0%	0.5%
Care Home	13.3%	6.1%	37.2%	19.6%	23.7%
Day Care	2.7%	2.4%	4.8%	0.0%	2.1%
Other	10.6%	9.7%	7.6%	10.1%	9.1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.9: Hospital, Community-Based, or Both by Occupation

Occupation	Hospital	Community	Hospital and Community	GP Practice Based	Care Home	Day Care	Other	Total
Nursing	26.1%	39.6%	4.3%	0.0%	14.0%	1.4%	14.5%	**100%**
Midwifery	51.1%	13.2%	30.7%	0.0%	0.0%	4.1%	0.9%	**100%**
Allied Health Professional	11.8%	51.1%	25.4%	0.2%	2.4%	0.3%	8.8%	**100%**
Social Care Worker	0.9%	58.1%	4.7%	0.0%	21.2%	3.2%	11.9%	**100%**
Social Worker	6.4%	70.3%	13.2%	0.2%	0.5%	0.1%	9.4%	**100%**

Figure A3.10: Hospital, Community-Based, or Both by Place of Occupation
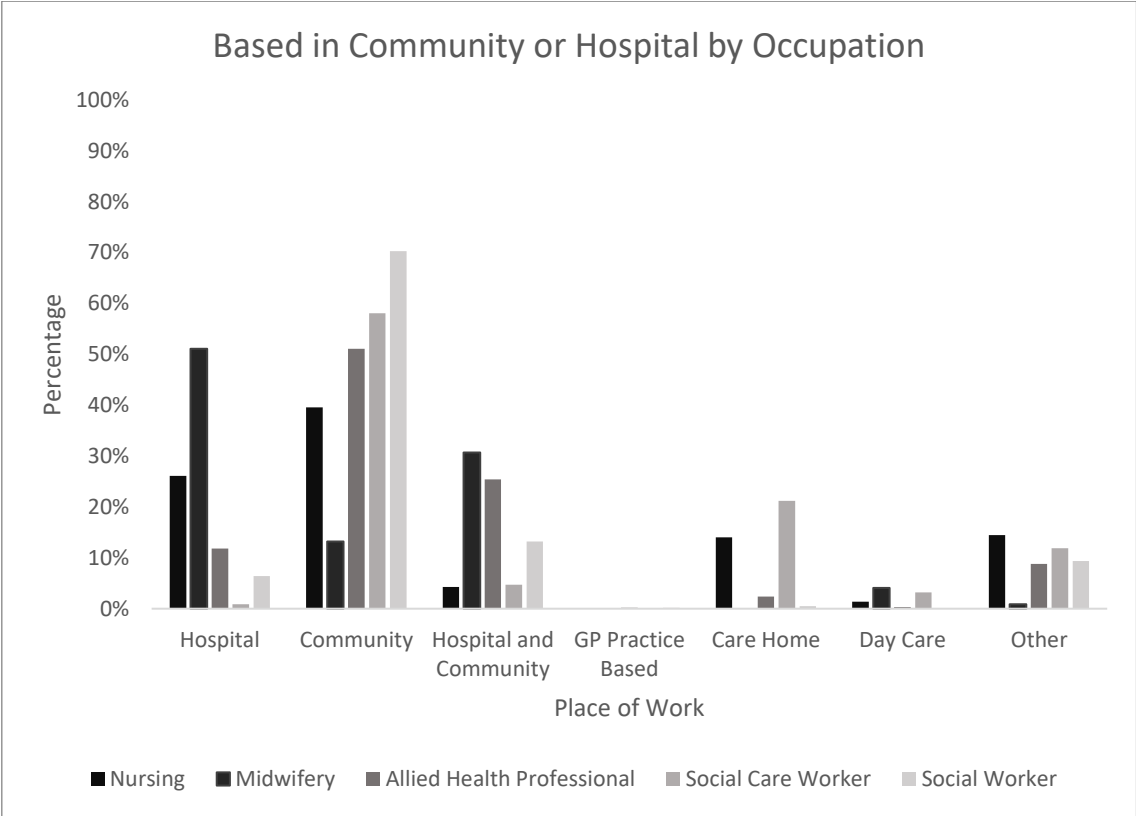
The majority of midwives work in hospitals. Respondents from all other professions are most likely to work in the community.

A3.6 Occupation of Respondents

Most of the sample are Social Work and Social Care Workers, followed by AHPs.

Figure A3.11: Occupation of Respondents

Table A3.10: Occupation of Respondents

Occupation	UK-Wide	No
Nursing	6.0%	199
Midwifery	5.5%	180
Allied Health Professional	11.8%	388
Social Care Worker	37.8%	1245
Social Worker	38.9%	1282
Total	**100%**	**3294**

NB: The survey received 3290 responses; of the responses 1897 were from Northern Ireland, 1062 were from England, 146 were from Scotland and 185 were from Wales. Most of the sample were social workers (1282) and social care workers (1245), followed by AHPs (388), nurses (199) and midwives (190). The difference between the country responses rates and professional occupational rates are explained by some respondents not indicating which country they were from.

A3.7 Banding of Respondents

The majority of the sample are in Band 6 across all countries of the UK, with the exception of NI which had most in Bands 2 or 3, and the majority of these are midwives.
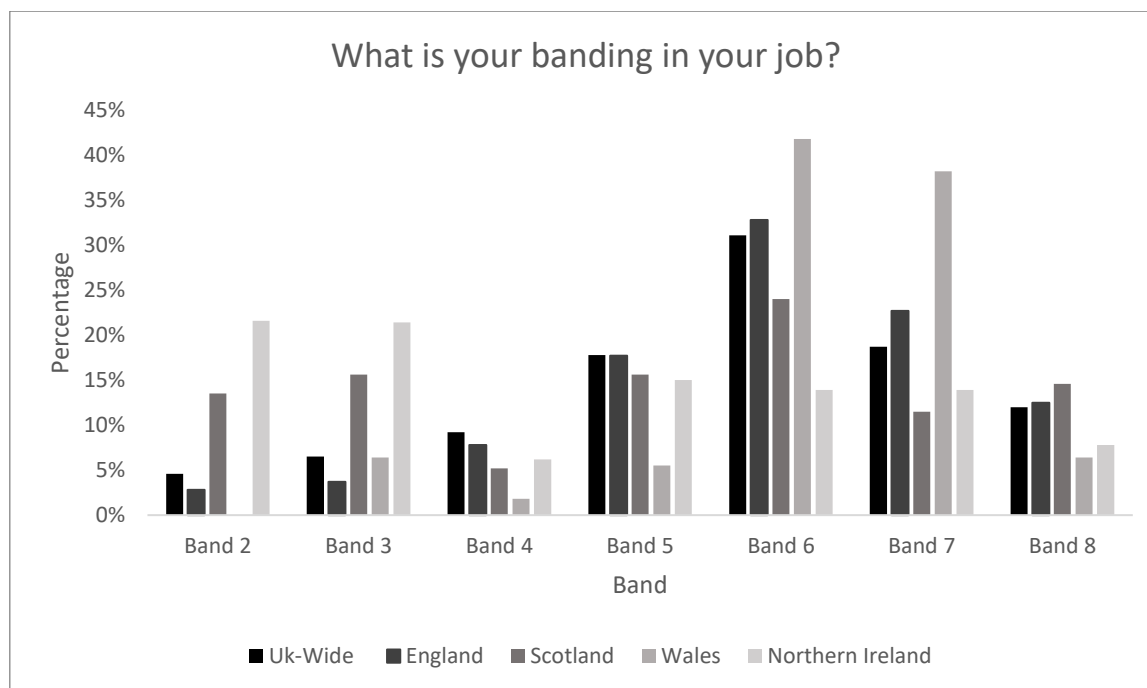
Figure A3.12: Banding of Respondents by Country

Table A3.11: Banding of Respondents by Country

Band	UK-Wide	England	Scotland	Wales	Northern Ireland
Band 2	4.6%	2.8%	13.5%	0.0%	21.6%
Band 3	6.5%	3.7%	15.6%	6.4%	21.4%
Band 4	9.2%	7.8%	5.2%	1.8%	6.2%
Band 5	17.8%	17.7%	15.6%	5.5%	15.0%
Band 6	31.1%	32.8%	24.0%	41.8%	13.9%
Band 7	18.7%	22.7%	11.5%	38.2%	13.9%
Band 8	12.0%	12.5%	14.6%	6.4%	7.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.13: Banding of Respondents by Occupation
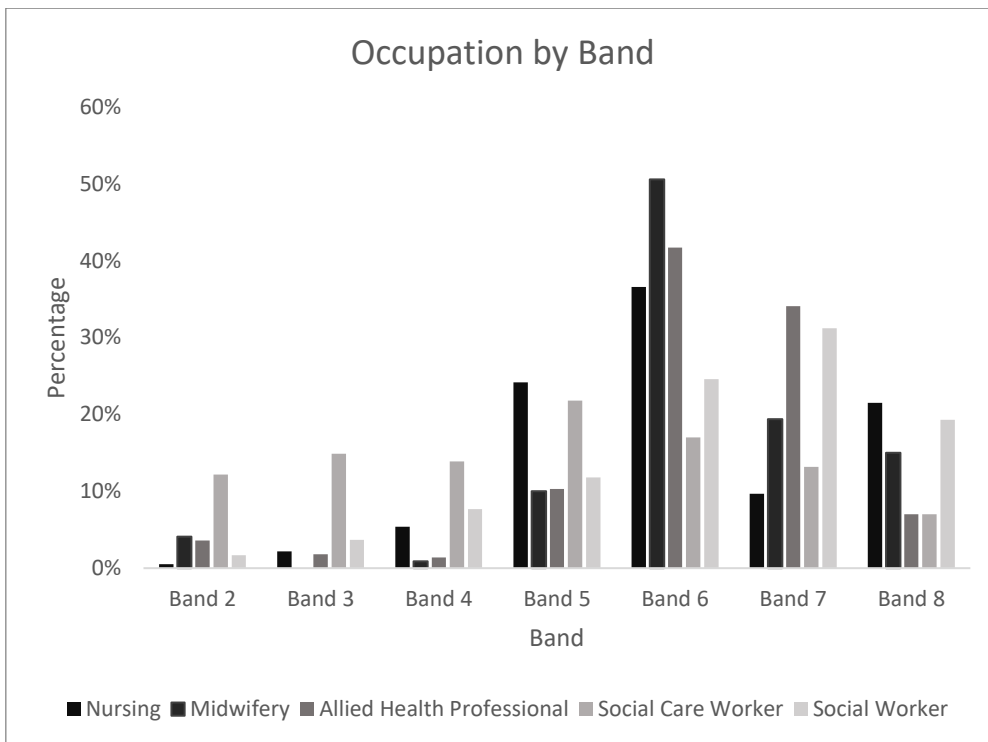
Table A3.12: Banding by Occupation

Occupation	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Total
Nursing	0.5%	2.2%	5.4%	24.2%	36.6%	9.7%	21.5%	**100%**
Midwifery	4.1%	0.0%	0.9%	10.0%	50.6%	19.4%	15.0%	**100%**
Allied Health Professional	3.6%	1.8%	1.4%	10.3%	41.7%	34.1%	7.0%	**100%**
Social Care Worker	12.2%	14.9%	13.9%	21.8%	17.0%	13.2%	7.0%	**100%**
Social Worker	1.7%	3.7%	7.7%	11.8%	24.6%	31.2%	19.3%	**100%**

A3.8 Respondents Redeployed due to COVID-19

The vast majority were not redeployed due to Covid-19. Those redeployed were mainly midwives.
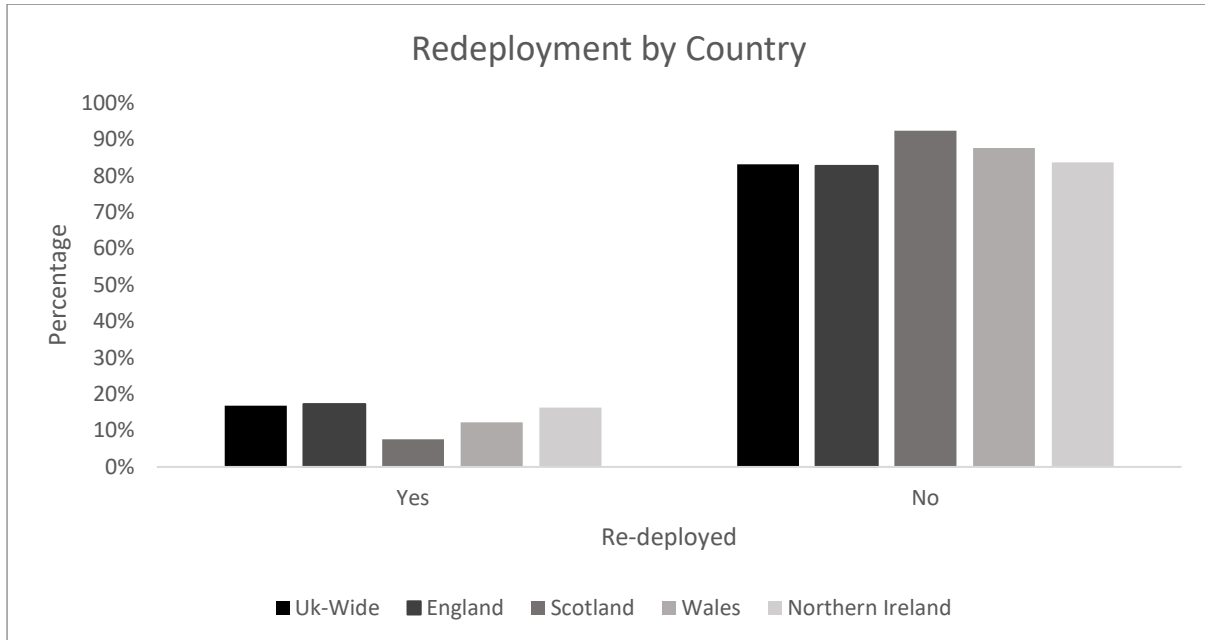
Figure A3.14: Redeployment by Country

Table A3.13: Redeployment by Country

Redeployed	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	16.8%	17.3%	7.6%	12.3%	16.3%
No	83.2%	82.7%	92.4%	87.7%	83.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.15: Redeployment by Occupation
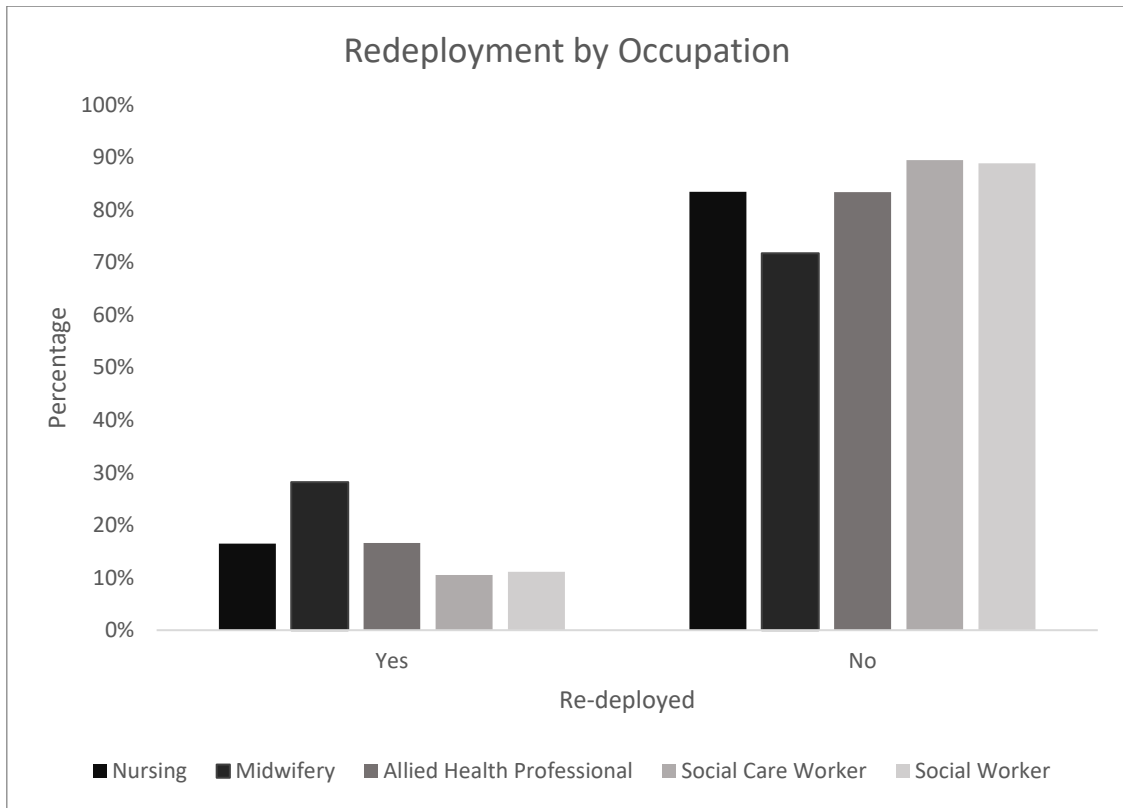
Table A3.14: Redeployment by Occupation

Occupation	Yes	No	Total
Nursing	16.5%	83.5%	**100%**
Midwifery	28.2%	71.8%	**100%**
Allied Health Professional	16.6%	83.4%	**100%**
Social Care Worker	10.5%	89.5%	**100%**
Social Worker	11.1%	88.9%	**100%**

A3.9 Preparedness of Redeployed Respondents

Respondents from Scotland reported feeling least prepared for redeployment. Nurses were least prepared of all the professions.
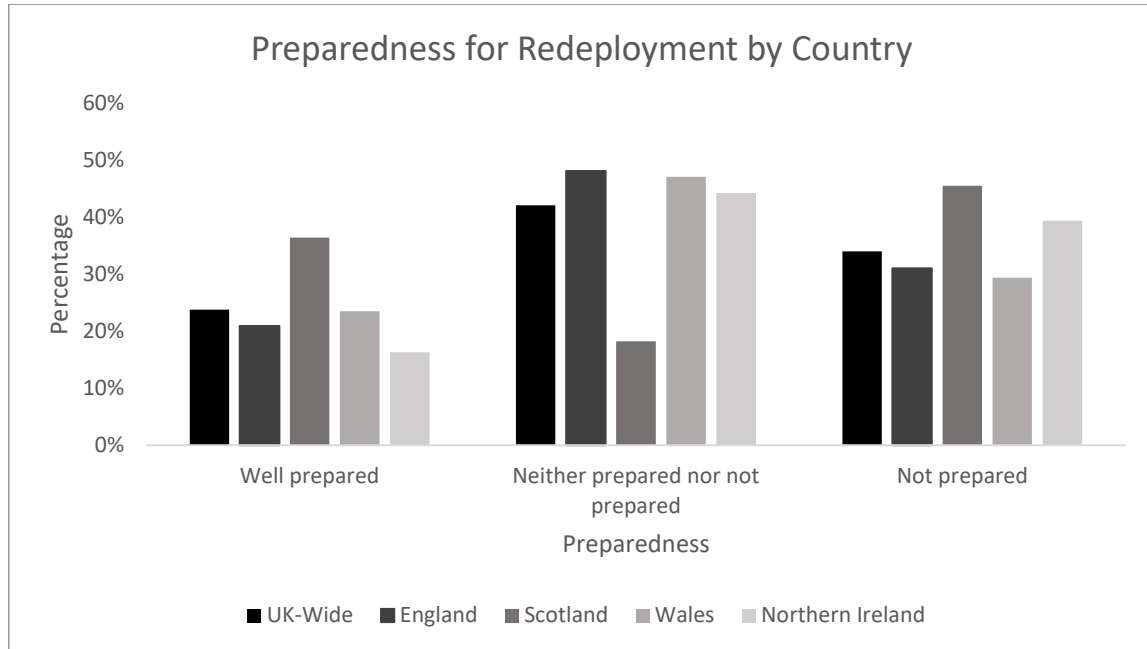
Figure A3.16: Preparedness for Redeployment by Country

Table A3.15: Preparedness for Redeployment by Country

Prepared	UK-Wide	England	Scotland	Wales	Northern Ireland
Well prepared	23.8%	20.9%	36.4%	23.5%	16.3%
Neither prepared nor not prepared	42.1%	48.1%	18.2%	47.1%	44.2%
Not prepared	34.0%	31.0%	45.5%	29.4%	39.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

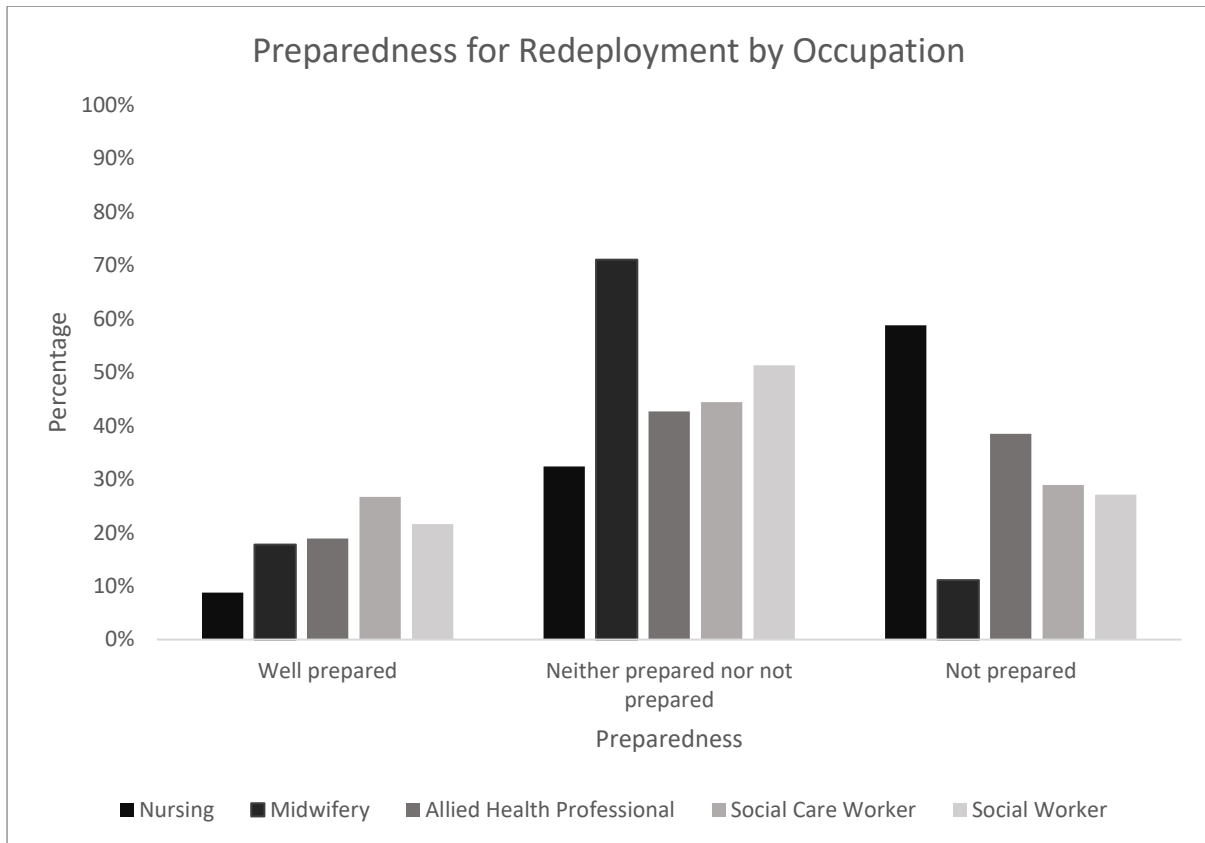Figure A3.17: Preparedness for Redeployment by Occupation

Table A3.16: Preparedness for Redeployment by Occupation

Occupation	Well prepared	Neither prepared nor not prepared	Not prepared	Total
Nursing	8.8%	32.4%	58.8%	**100%**
Midwifery	17.8%	71.1%	11.1%	**100%**
Allied Health Professional	18.9%	42.7%	38.5%	**100%**
Social Care Worker	26.7%	44.4%	28.9%	**100%**
Social Worker	21.6%	51.3%	27.1%	**100%**

A3.10 Respondents Coming Out of Retirement to Support Workforce during COVID-19

Only 0.4% of respondents reported that they had come out of retirement to support the workforce during the COVID-19 pandemic.

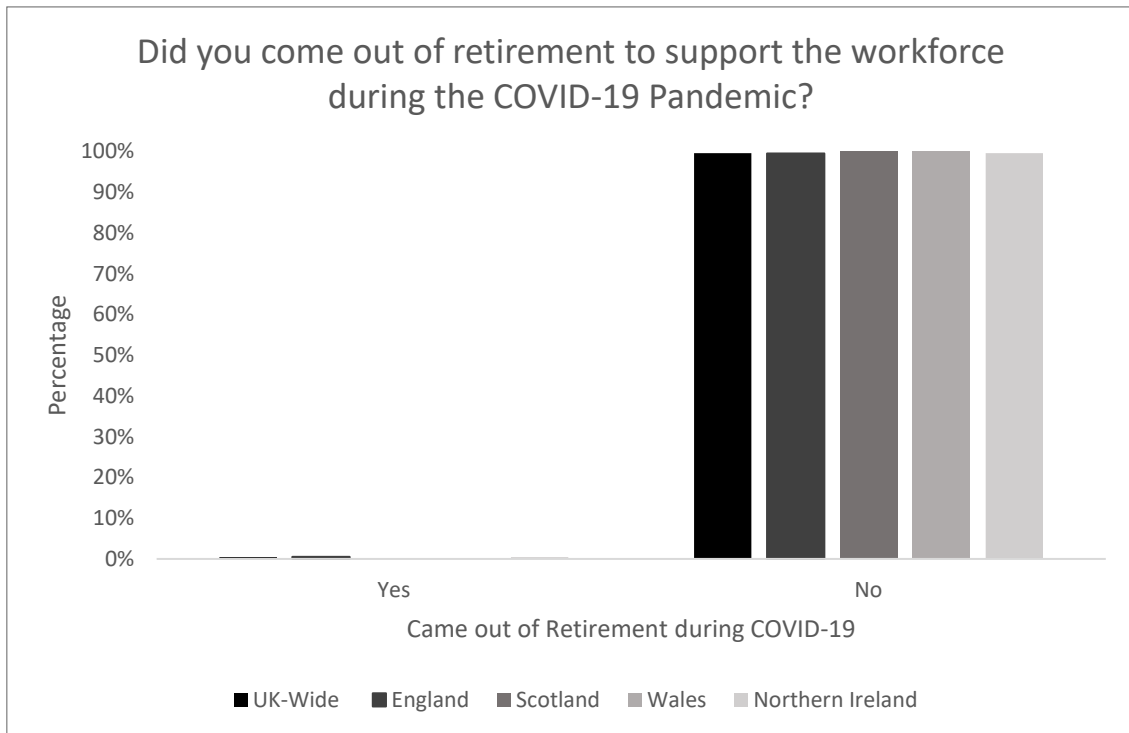Figure A3.18: Respondents that Came Out of Retirement to Support the Workforce during COVID-19 by Country

Table A3.17: Out of Retirement by Country

Did you come out of retirement	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	0.4%	0.5%	0.0%	0.0%	0.4%
No	99.6%	99.5%	100.0%	100.0%	99.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

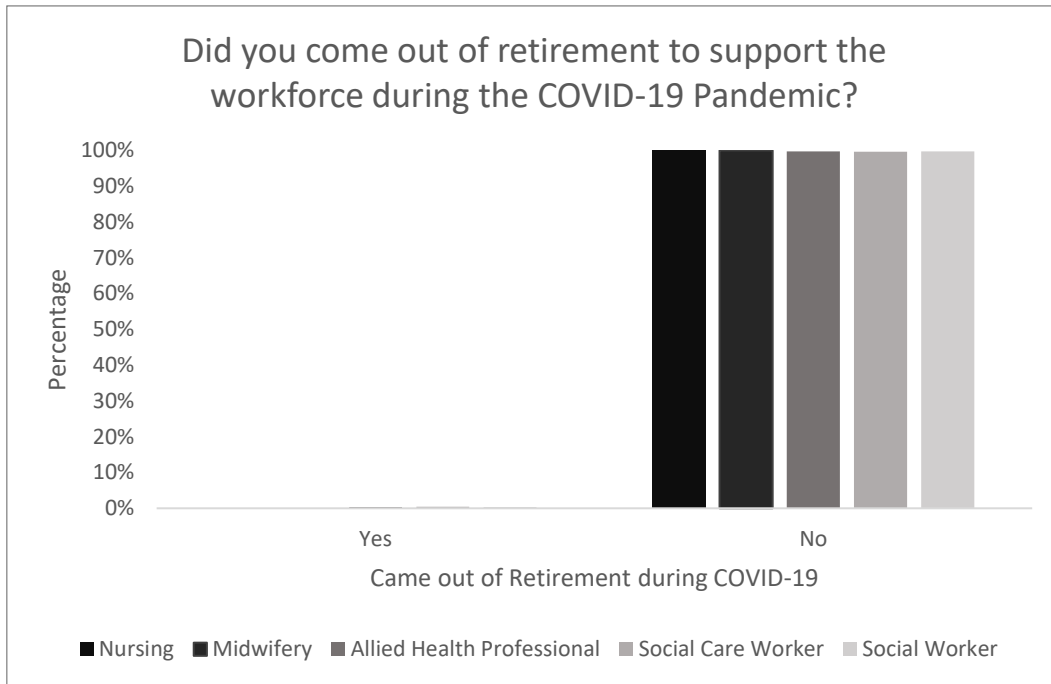Figure A3.19: Respondents that Came Out of Retirement to Support the Workforce during COVID-19 by Occupation

Did you come out of retirement to support the workforce during the COVID-19 Pandemic?

Table A3.18: Out of Retirement by Occupation

Occupation	Yes	No	Total
Nursing	0.0%	100.0%	**100%**
Midwifery	0.0%	100.0%	**100%**
Allied Health Professional	0.3%	99.7%	**100%**
Social Care Worker	0.4%	99.6%	**100%**
Social Worker	0.3%	99.7%	**100%**

A3.11 Job Tenure of Respondents

Most respondents are employed on a permanent basis. NI has the largest proportion of agency staff.
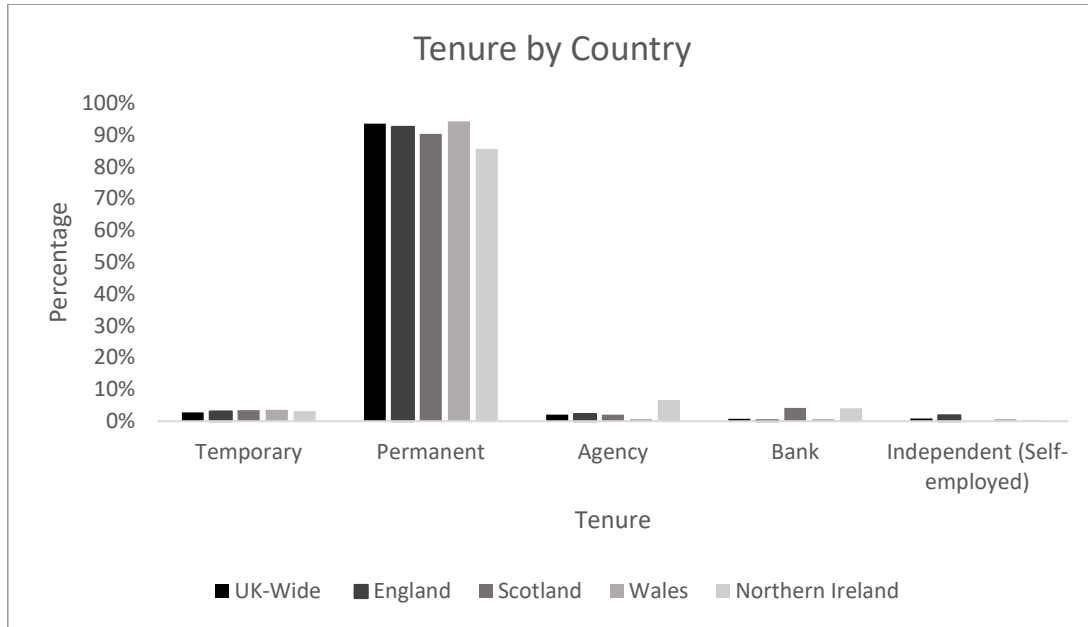
Figure A3.20: Tenure by Country

Table A3.19: Tenure by Country

Tenure	UK-Wide	England	Scotland	Wales	Northern Ireland
Temporary	2.8%	3.1%	3.5%	3.6%	3.2%
Permanent	93.5%	92.5%	90.3%	94.2%	85.6%
Agency	2.1%	2.3%	2.1%	0.7%	6.7%
Bank	0.8%	0.3%	4.2%	0.7%	4.1%
Independent (Self-employed)	0.9%	1.9%	0.0%	0.7%	0.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Figure A3.21: Tenure by Occupation
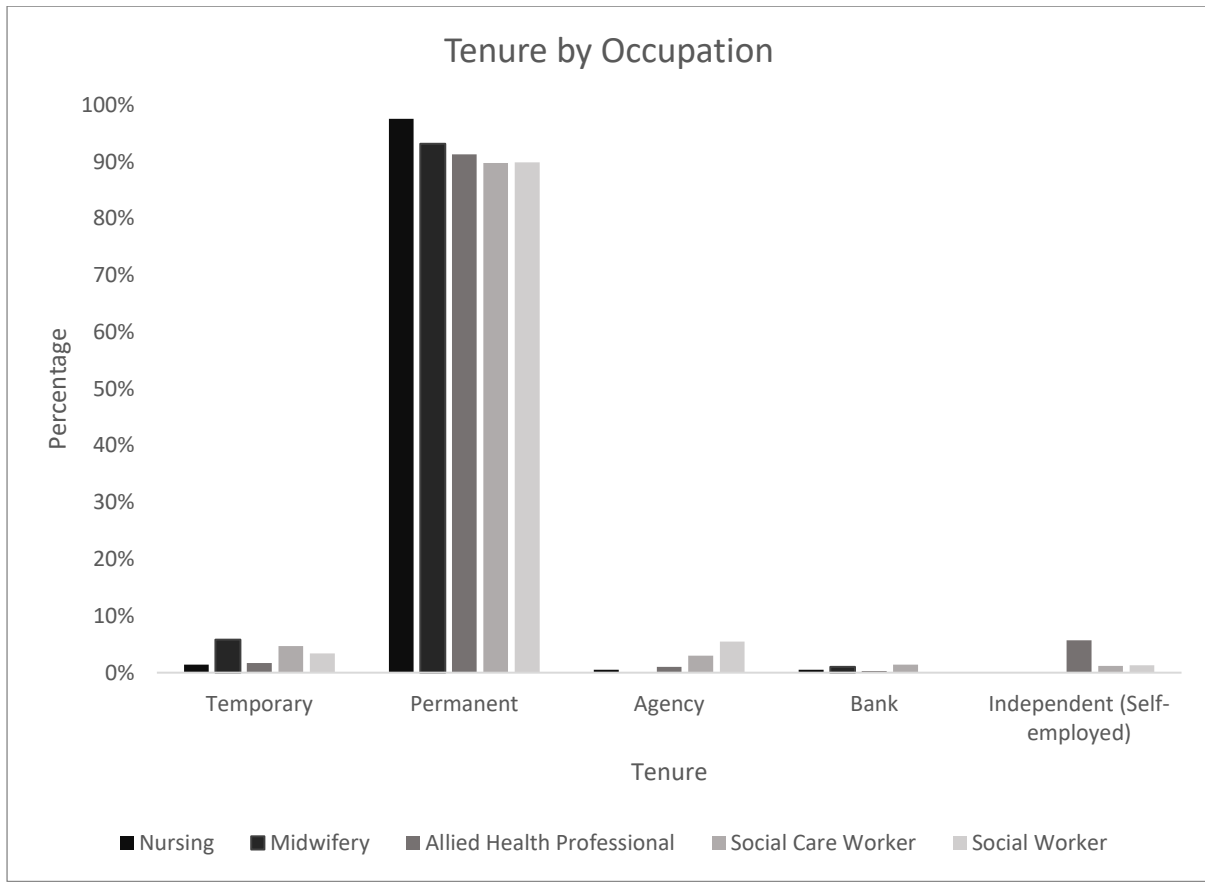
Table A3.20: Tenure by Occupation

Occupation	Temporary	Permanent	Agency	Bank	Independent (Self-employed)	Total
Nursing	1.4%	97.6%	0.5%	0.5%	0.0%	**100%**
Midwifery	5.8%	93.2%	0.0%	1.0%	0.0%	**100%**
Allied Health Professional	1.7%	91.3%	1.0%	0.3%	5.7%	**100%**
Social Care Worker	4.7%	89.8%	3.0%	1.4%	1.2%	**100%**
Social Worker	3.4%	89.9%	5.5%	0.0%	1.3%	**100%**

A3.12 Respondents' Years of Experience

The majority of respondents have 11-20 years' work experience. Of those with over 30 years' experience, many of these are nurses.
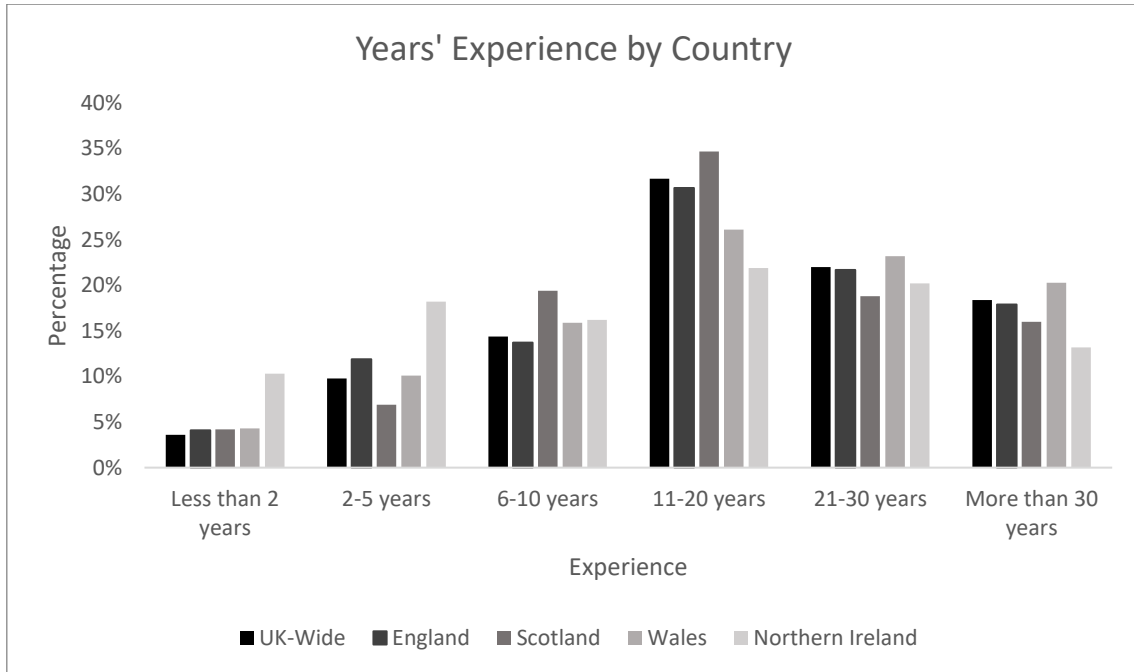
Figure A3.22: Years' Experience by Country

Table A3.21: Years of Experience by Country

Years' Experience	UK-Wide	England	Scotland	Wales	Northern Ireland
Less than 2 years	3.6%	4.1%	4.2%	4.3%	10.3%
2-5 years	9.8%	11.9%	6.9%	10.1%	18.2%
6-10 years	14.4%	13.7%	19.4%	15.9%	16.2%
11-20 years	31.7%	30.7%	34.7%	26.1%	21.9%
21-30 years	22.0%	21.7%	18.8%	23.2%	20.2%
More than 30 years	18.4%	17.9%	16.0%	20.3%	13.2%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.22: Years of Experience by Occupation

Occupation	Less than 2 years	2-5 years	6-10 years	11-20 years	21-30 years	More than 30 years	Total
Nursing	0.5%	1.9%	8.3%	33.0%	21.4%	35.0%	**100%**
Midwifery	11.4%	7.8%	41.4%	19.2%	10.1%	10.1%	**100%**
Allied Health Professional	5.4%	14.3%	17.3%	28.0%	18.5%	16.5%	**100%**
Social Care Worker	6.0%	19.8%	13.0%	26.9%	25.3%	9.0%	**100%**
Social Worker	8.9%	15.2%	15.7%	27.9%	21.5%	10.9%	**100%**

Figure A3.23: Years' Experience by Occupation

A3.13 Respondents' Area of Practice

Almost one third (32.7%) of the respondents work with Adults. These were mainly based in England.

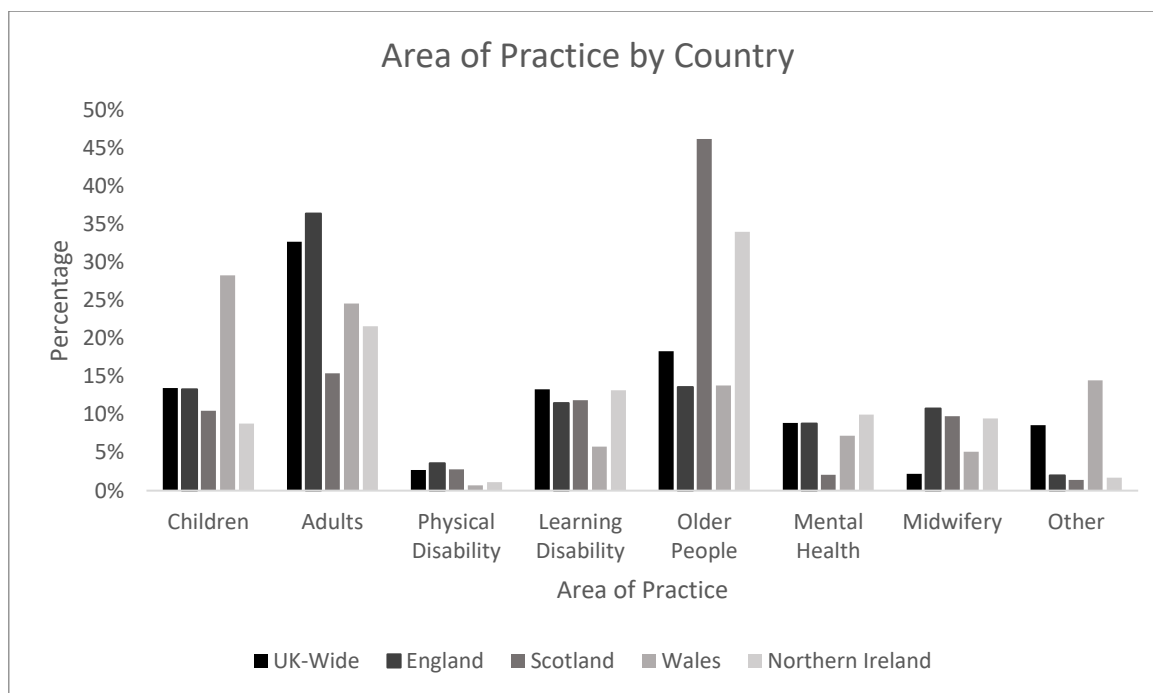Figure A3.24: Area of Practice by Country

Table A3.23: Area of Practice by Country

Area of Practice	UK-Wide	England	Scotland	Wales	Northern Ireland
Children	13.5%	13.3%	10.5%	28.3%	8.8%
Adults	32.7%	36.4%	15.4%	24.6%	21.6%
Physical Disability	2.7%	3.6%	2.8%	0.7%	1.1%
Learning Disability	13.3%	11.5%	11.9%	5.8%	13.2%
Older People	18.3%	13.6%	46.2%	13.8%	34.0%
Mental Health	8.9%	8.8%	2.1%	7.2%	10.0%
Midwifery	2.2%	10.8%	9.8%	5.1%	9.5%
Other	8.6%	2.0%	1.4%	14.5%	1.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.24: Area of Practice by Occupation

Occupation	Children	Adults	Physical Disability	Learning Disability	Older People	Mental Health	Midwifery	Other	T
Nursing	9.2%	38.3%	1.0%	12.1%	16.0%	12.1%	11.2%	0.0%	1
Midwifery	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	1.0%	94.8%	1
Allied Health Professional	5.7%	33.9%	5.4%	7.2%	23.8%	9.6%	14.4%	0.0%	1
Social Care Worker	20.0%	25.5%	4.6%	15.0%	20.2%	6.6%	8.0%	0.0%	1
Social Worker	33.5%	29.7%	0.9%	8.4%	7.4%	13.3%	6.9%	0.0%	1

Figure A3.25: Area of Practice by Occupation
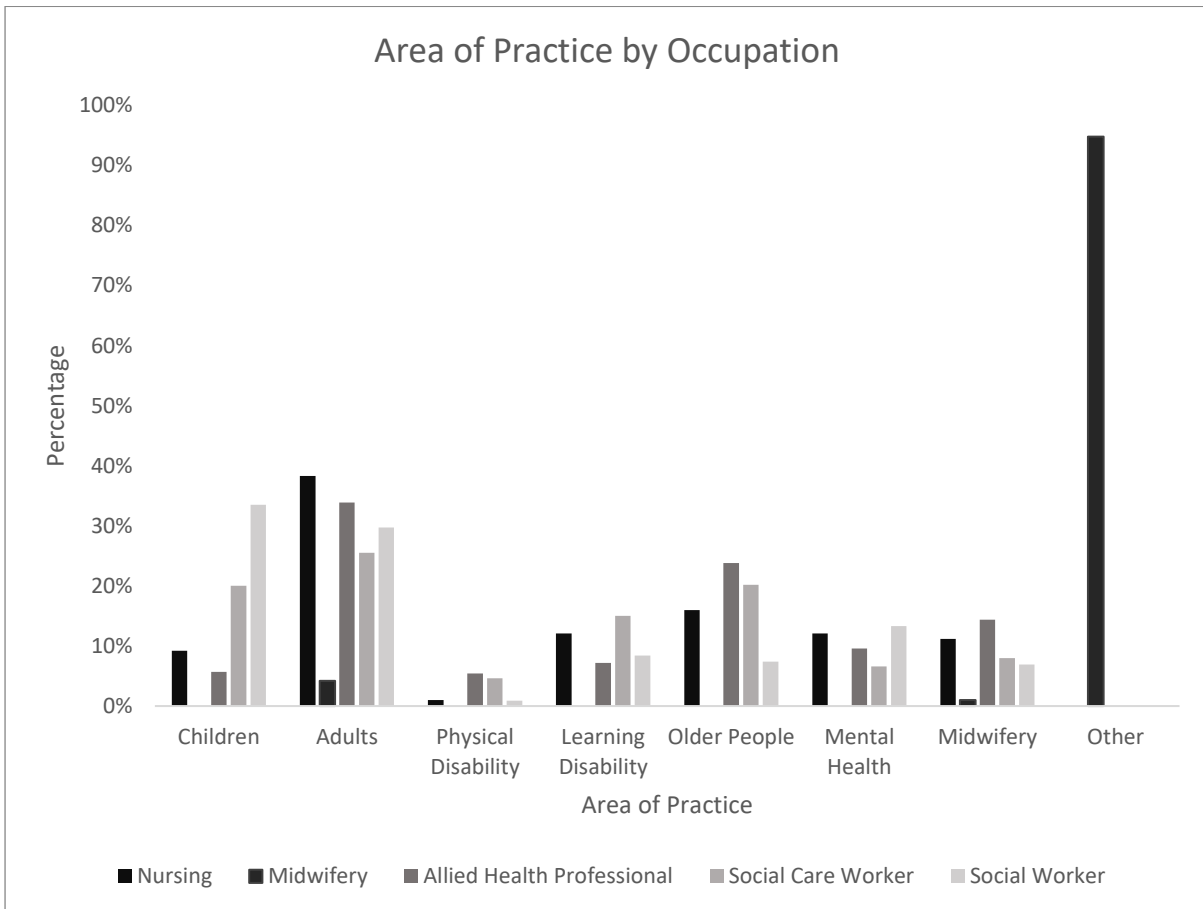
A3.14 Respondents Employed Full- or Part-Time

Scotland has the highest number of part-time employed, making up over one third (36.2%) Allied Health Professionals are most likely to be employed part-time than other professions.
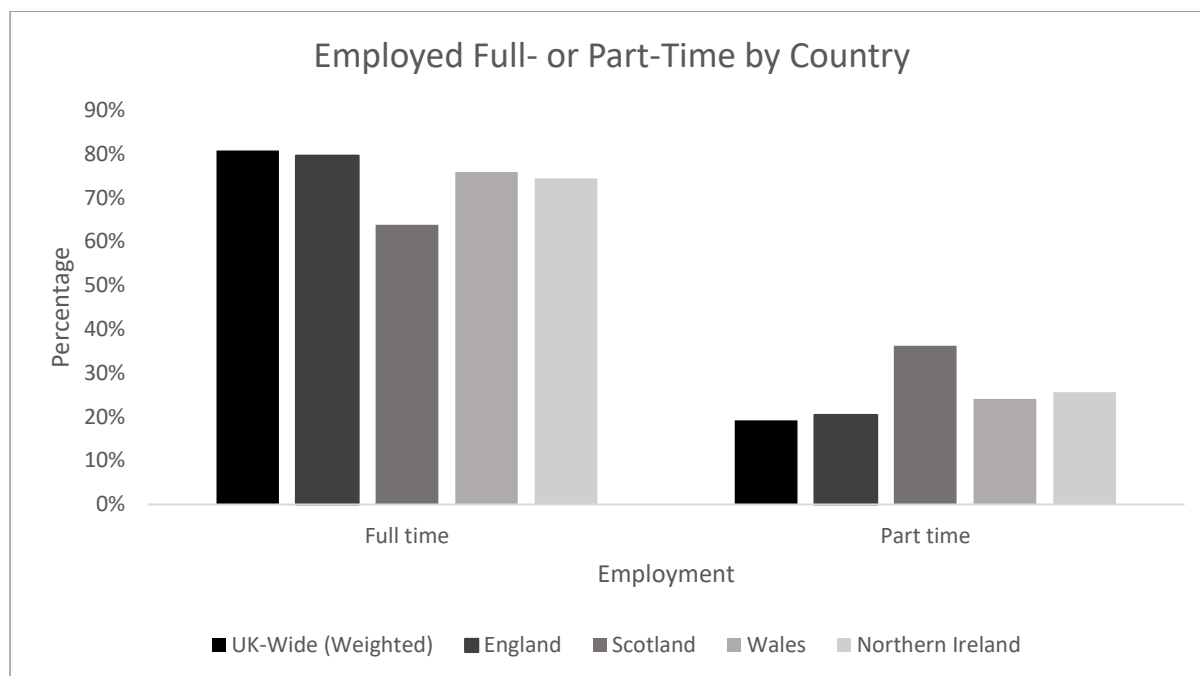
Figure A3.26: Employed Full- or Part-Time by Country

Table A3.25: Employed Full- or Part-Time by Country

Employed	UK-Wide	England	Scotland	Wales	Northern Ireland
Full time	80.8%	79.6%	63.8%	75.9%	74.4%
Part time	19.2%	20.4%	36.2%	24.1%	25.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.26: Employed Full- or Part-Time by Occupation

Occupation	Full time	Part time	Total
Nursing	83.7%	16.3%	**100%**
Midwifery	71.4%	28.6%	**100%**
Allied Health Professional	69.4%	30.6%	**100%**
Social Care Worker	79.2%	20.8%	**100%**
Social Worker	86.3%	13.7%	**100%**

Figure A3.27: Employed Full- or Part-Time by Occupation
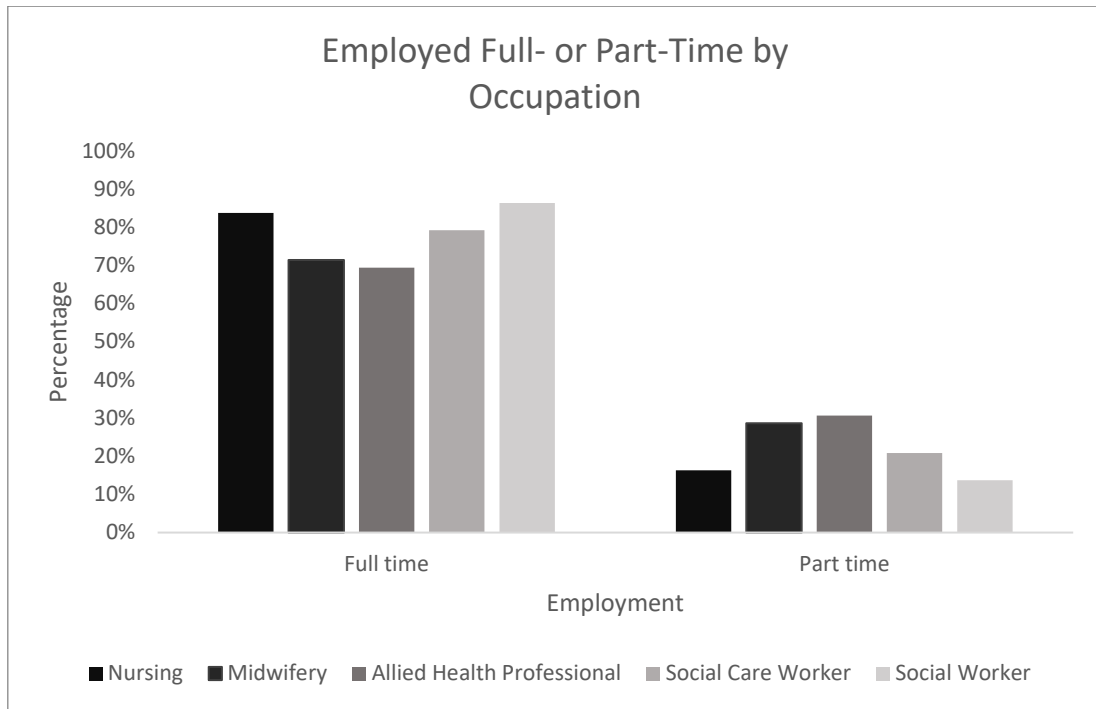
A3.15 Respondents' Hours Worked Per Week

The majority of respondents work full-time, typically 37.5 hours per week. This is also the case across occupations but midwives are most likely to work part -time hours.

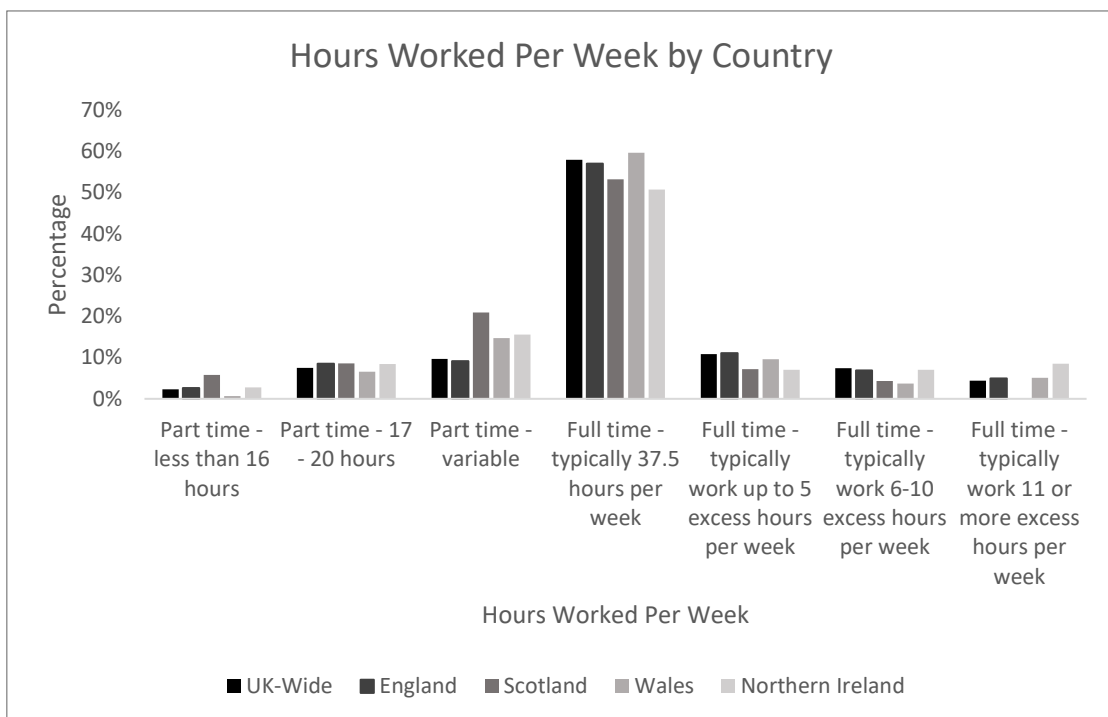Figure A3.28: Hours Worked Per Week by Country

Table A3.27: Hours Worked Per Week by Country

Hours	UK-Wide	England	Scotland	Wales	Northern Ireland
Part time - less than 16 hours	2.3%	2.6%	5.8%	0.7%	2.8%
Part time - 17 - 20 hours	7.5%	8.5%	8.6%	6.6%	8.4%
Part time - variable	9.7%	9.1%	20.9%	14.7%	15.6%
Full time - typically 37.5 hours per week	57.9%	57.0%	53.2%	59.6%	50.7%
Full time - typically work up to 5 excess hours per week	10.8%	11.1%	7.2%	9.6%	7.0%
Full time - typically work 6-10 excess hours per week	7.4%	6.9%	4.3%	3.7%	7.0%
Full time - typically work 11 or more excess hours per week	4.4%	4.9%	0.0%	5.1%	8.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

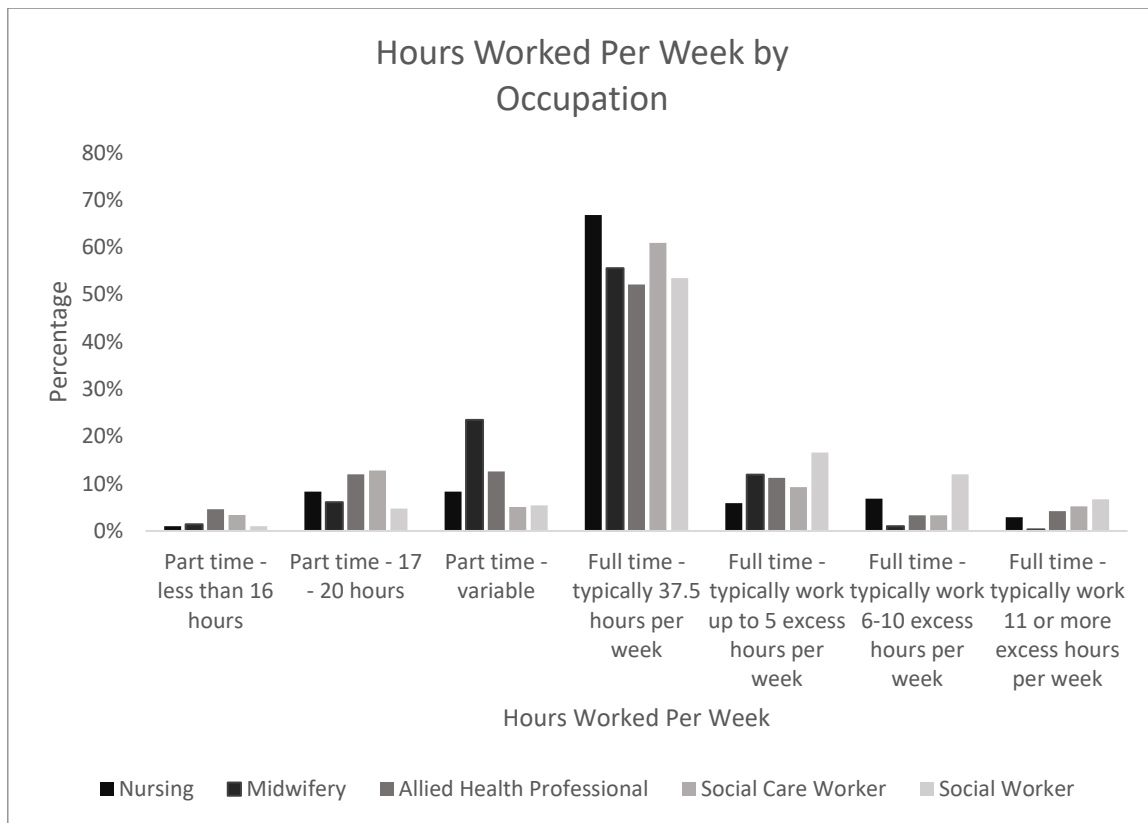Figure A3.29: Hours Worked Per Week by Occupation

Table A3.28: Hours Worked Per Week by Occupation

Occupation	Part time - less than 16 hours	Part time - 17 - 20 hours	Part time - variable	Full time - typical 37.5 hours per week	Full time - typical work up to 5 excess hours per week	Full time - typical work 6-10 excess hours per week	Full time - typical work 11 or more excess hours per week	Total
Nursing	1.0%	8.3%	8.3%	66.8%	5.9%	6.8%	2.9%	**100%**
Midwifery	1.4%	6.1%	23.5%	55.6%	11.9%	1.0%	0.3%	**100%**
Allied Health Professional	4.6%	12.0%	12.6%	52.1%	11.2%	3.3%	4.2%	**100%**
Social Care Worker	3.4%	12.8%	5.1%	60.9%	9.3%	3.3%	5.2%	**100%**
Social Worker	1.0%	4.7%	5.4%	53.5%	16.6%	12.0%	6.7%	**100%**

A3.16 Respondents' Overtime Hours

Respondents in Northern Ireland work the highest number of hours overtime. Nurses and Social Care Workers work the most overtime.
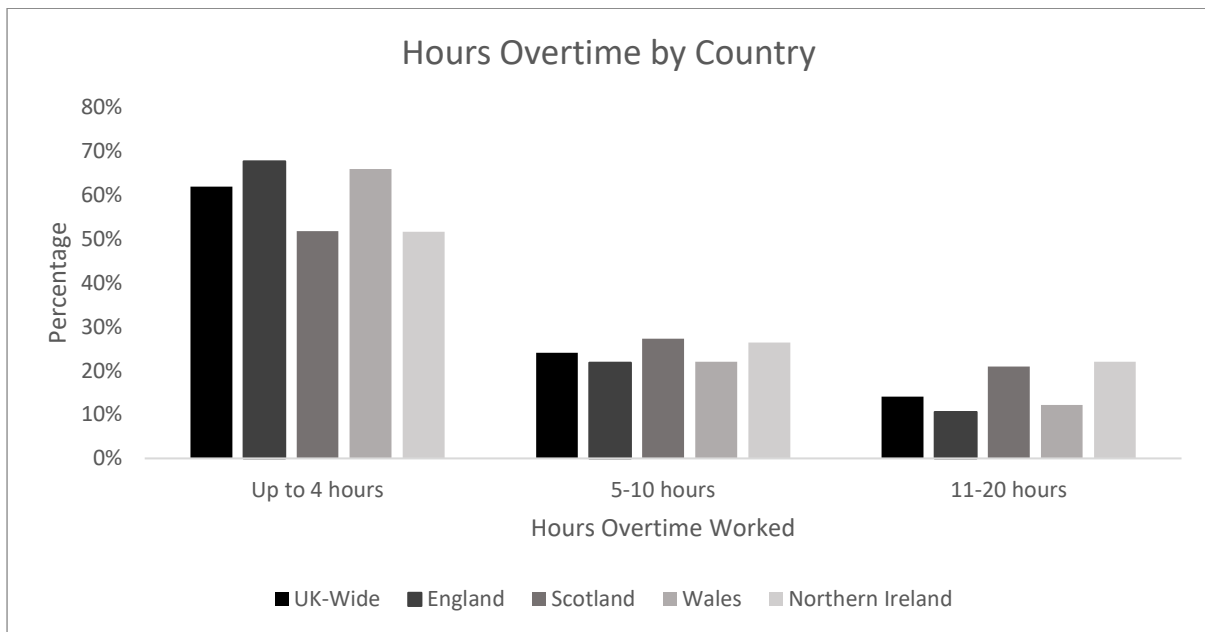
Figure A3.30: Hours Overtime by Country

Table A3.29: Hours Overtime by Country

Hours Overtime	UK-Wide	England	Scotland	Wales	Northern Ireland
Up to 4 hours	61.9%	67.7%	51.8%	65.9%	51.6%
5-10 hours	24.1%	21.8%	27.3%	22.0%	26.4%
11-20 hours	14.1%	10.6%	20.9%	12.2%	22.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.30: Hours Overtime by Occupation

Occupation	Up to 4 hours	5-10 hours	11-20 hours	Total
Nursing	56.9%	29.3%	13.8%	**100%**
Midwifery	68.2%	20.7%	11.1%	**100%**
Allied Health Professional	76.0%	17.5%	6.5%	**100%**
Social Care Worker	65.0%	22.4%	12.6%	**100%**
Social Worker	64.5%	27.0%	8.6%	**100%**

Figure A3.31: Hours Overtime by Occupation
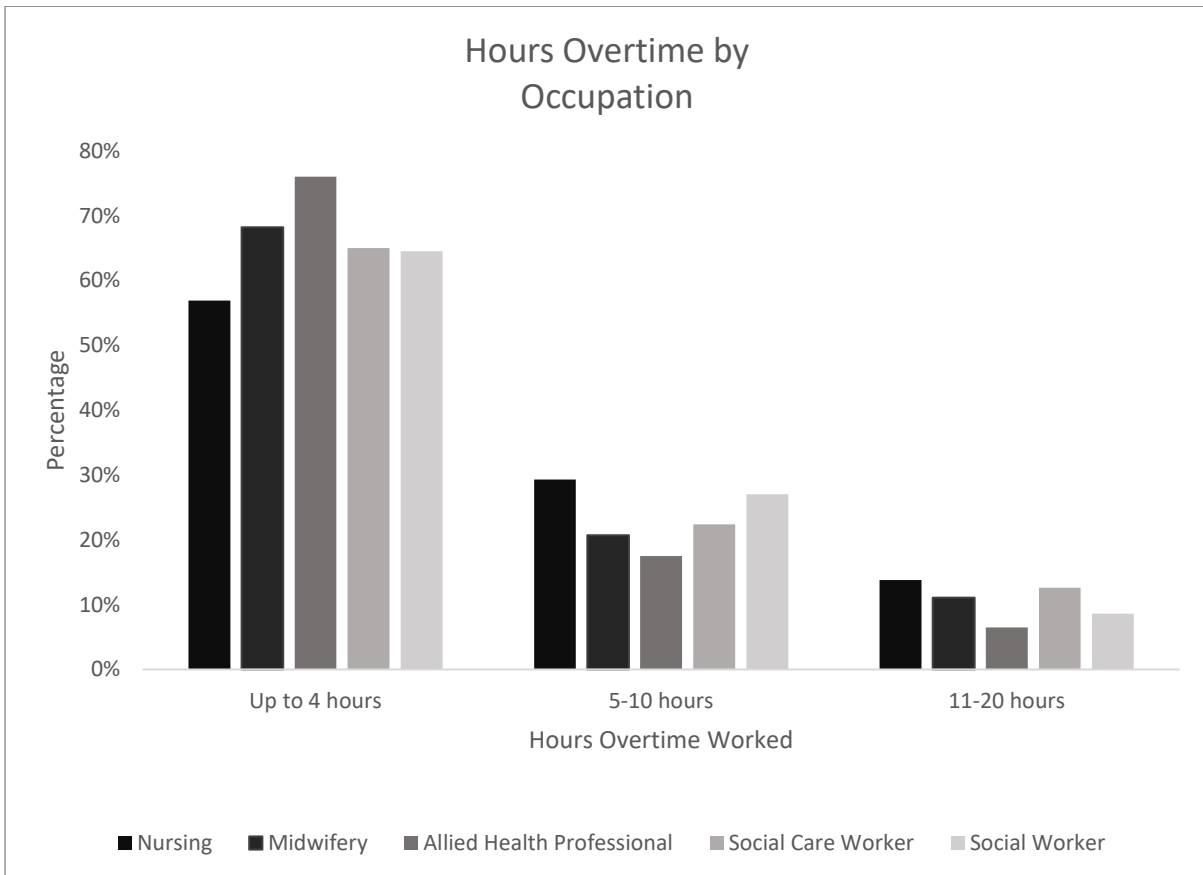
A3.17 Respondents' Number of Sick Days

Respondents in Scotland were the least likely to take days off sick.
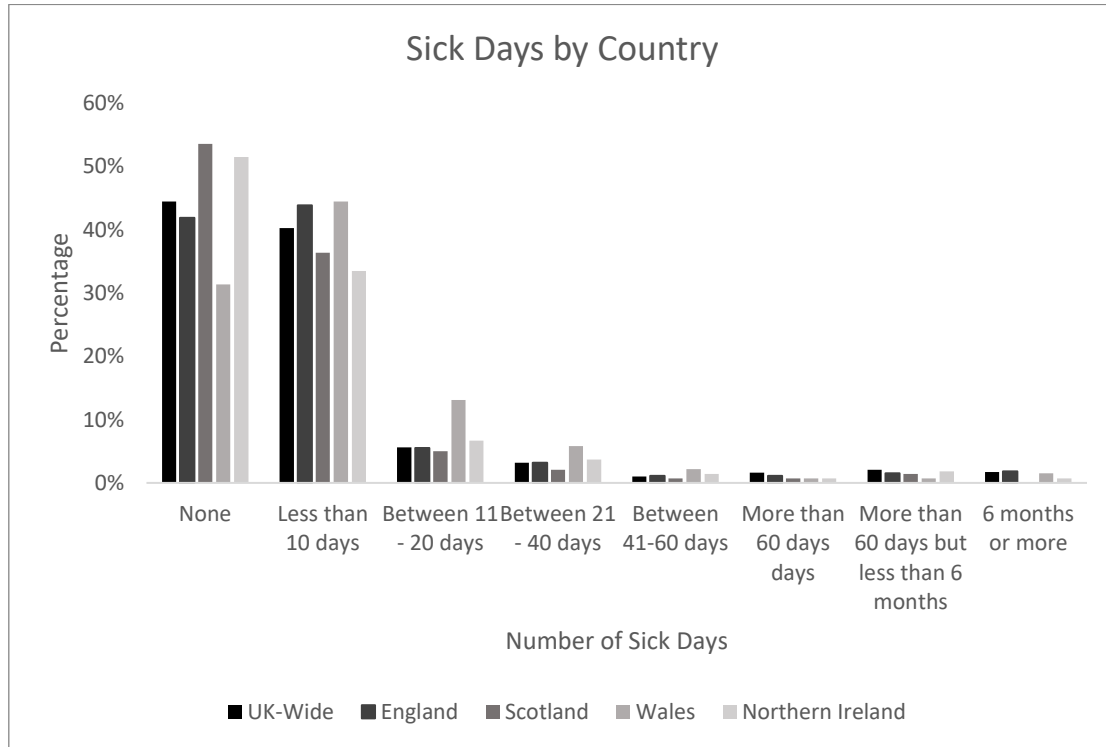
Figure A3.32: Sick Days by Country

Table A3.31: Sick Days by Country

Sick days	UK-Wide	England	Scotland	Wales	Northern Ireland
None	44.5%	41.9%	53.6%	31.4%	51.5%
Less than 10 days	40.3%	43.9%	36.4%	44.5%	33.5%
Between 11 - 20 days	5.6%	5.5%	5.0%	13.1%	6.7%
Between 21 - 40 days	3.2%	3.2%	2.1%	5.8%	3.7%
Between 41-60 days	1.0%	1.1%	0.7%	2.2%	1.4%
More than 60 days	1.6%	1.1%	0.7%	0.7%	0.7%
More than 60 days but less than 6 months	2.1%	1.5%	1.4%	0.7%	1.8%
6 months or more	1.7%	1.8%	0.0%	1.5%	0.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.32: Sick Days by Occupation

Occupation	None	Less than 10 days	Between 11 - 20 days	Between 21 - 40 days	Between 41-60 days	More than 60 days	More than 60 days but less than 6 months	6 months or more	%
Nursing	57.2%	33.5%	2.6%	1.5%	0.0%	1.5%	2.1%	1.5%	100
Midwifery	44.4%	39.6%	7.8%	1.0%	2.0%	0.0%	4.4%	0.7%	100
Allied Health Professional	28.0%	54.9%	11.4%	2.3%	1.1%	0.4%	0.3%	1.5%	100
Social Care Worker	48.7%	35.1%	5.6%	3.9%	1.3%	1.5%	1.0%	2.9%	100
Social Worker	45.3%	43.1%	5.6%	2.1%	2.4%	0.1%	1.1%	0.1%	100

Figure A3.33: Sick Days by Occupation
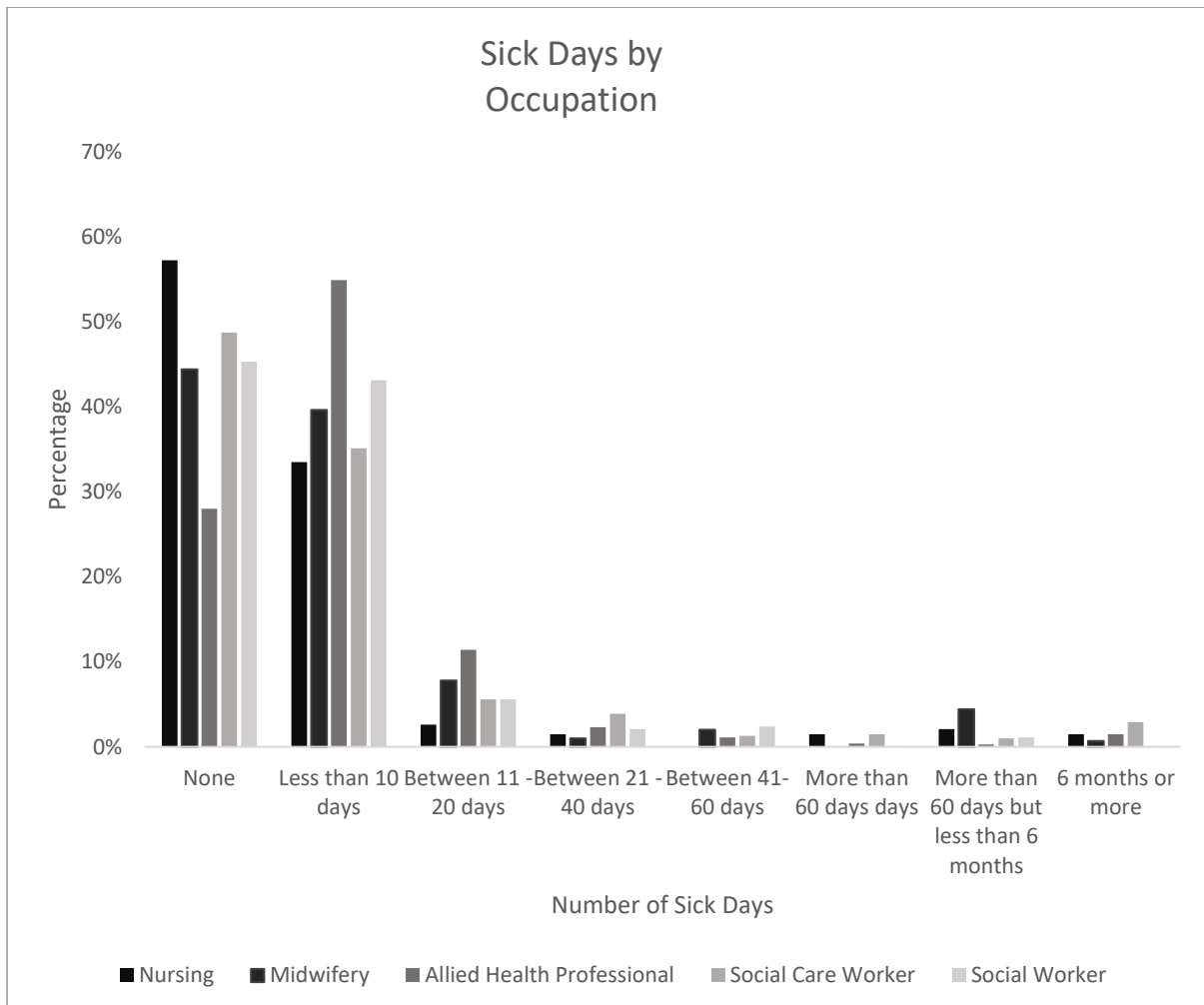
A3.18 Sickness Absence Related to COVID-19

Around one-fifth of respondents had a COVID-19 related sickness absence. Nurses were more likely than any other profession to have a COVID-19 related sickness absence.

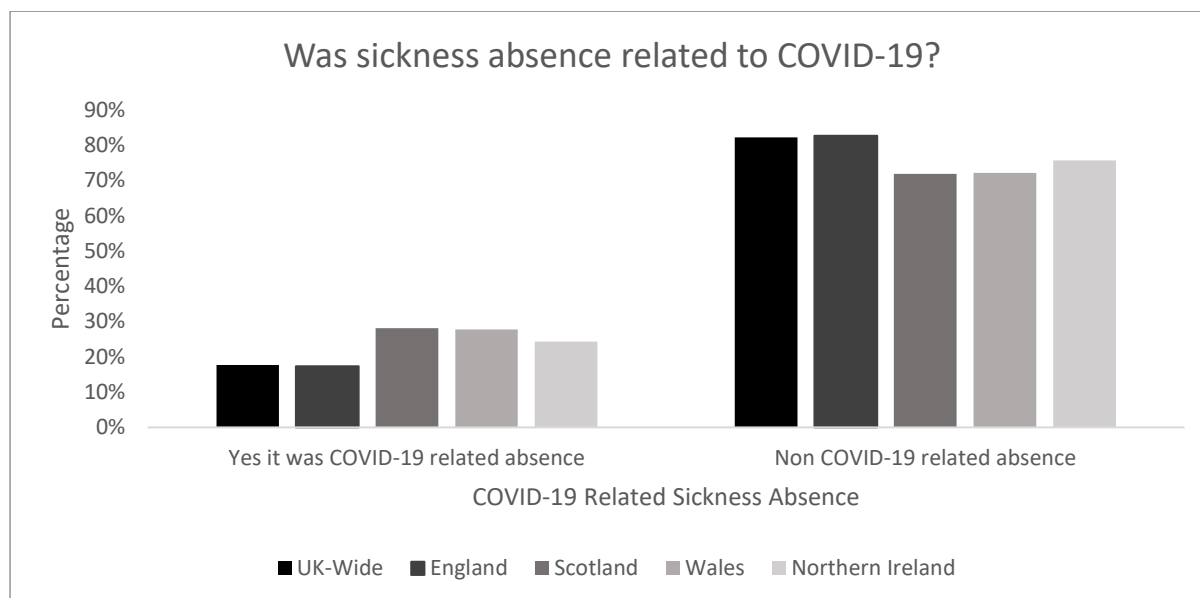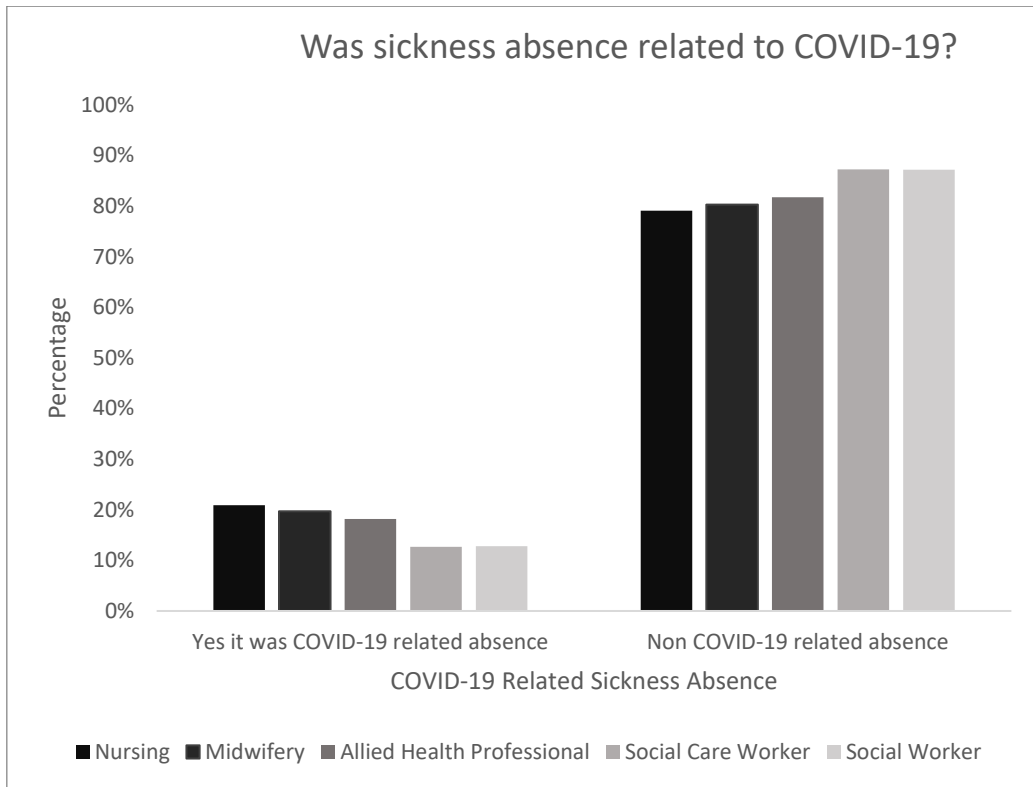Figure A3.34: Sickness Absence Related to COVID-19 by Country

Table A3.33: Absence Due to COVID-19 by Country

Sickness related to COVID-19	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes, it was COVID-19 related absence	17.7%	17.3%	28.1%	27.8%	24.3%
Non COVID-19 related absence	82.3%	82.7%	71.9%	72.2%	75.7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.34: Absence Due to COVID-19 by Occupation

Occupation	Yes, it was COVID-19 related absence	Non COVID-19 related absence	Total
Nursing	20.9%	79.1%	**100%**
Midwifery	19.7%	80.3%	**100%**
Allied Health Professional	18.2%	81.8%	**100%**
Social Care Worker	12.7%	87.3%	**100%**
Social Worker	12.8%	87.2%	**100%**

Figure A3.35: Sickness Absence Related to COVID-19 by Occupation

Was sickness absence related to COVID-19?

[Bar chart showing percentages by occupation for two categories. Y-axis: Percentage (0% to 100%). X-axis: COVID-19 Related Sickness Absence.

"Yes it was COVID-19 related absence": Nursing ~21%, Midwifery ~20%, Allied Health Professional ~18%, Social Care Worker ~13%, Social Worker ~13%.

"Non COVID-19 related absence": Nursing ~79%, Midwifery ~80%, Allied Health Professional ~81%, Social Care Worker ~87%, Social Worker ~87%.

Legend: Nursing, Midwifery, Allied Health Professional, Social Care Worker, Social Worker]

A3.19 Respondents with a Disability

Respondents in England reported the highest prevalence of disability. Social Care Workers and Allied Health Professionals respondents are most likely to report a disability.
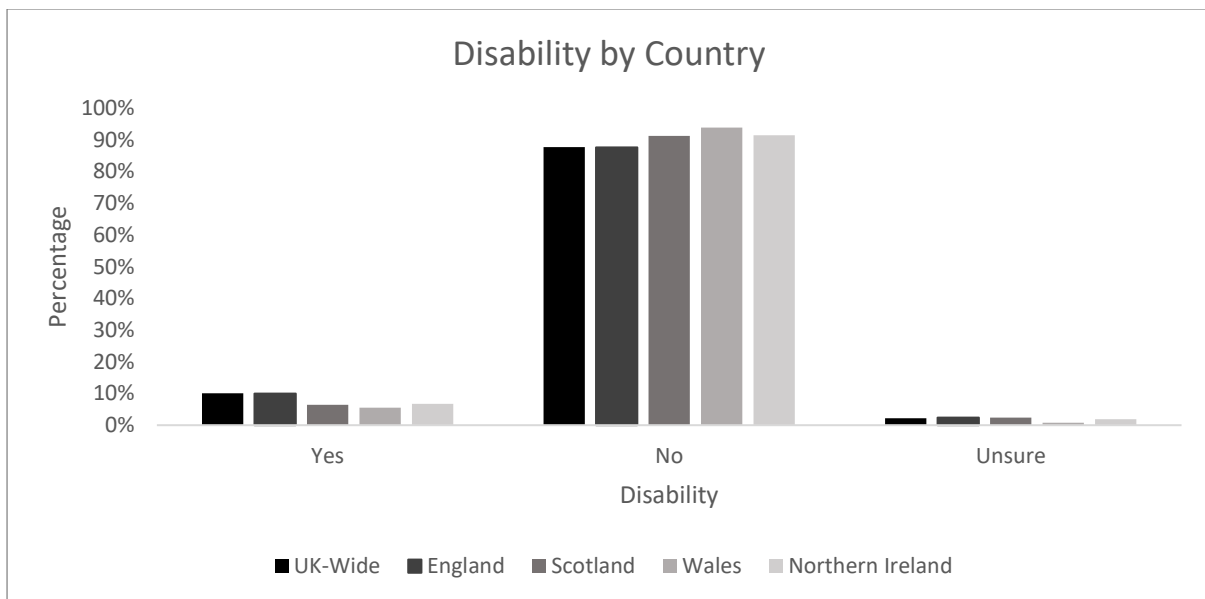
Figure A3.36: Disability by Country

Disability by Country

[Bar chart showing percentages by country for three categories. Y-axis: Percentage (0% to 100%). X-axis: Disability.

"Yes": UK-Wide ~10%, England ~10%, Scotland ~6%, Wales ~5%, Northern Ireland ~6%.

"No": UK-Wide ~88%, England ~88%, Scotland ~91%, Wales ~94%, Northern Ireland ~92%.

"Unsure": UK-Wide ~2%, England ~3%, Scotland ~2%, Wales ~1%, Northern Ireland ~2%.

Legend: UK-Wide, England, Scotland, Wales, Northern Ireland]

Table A3.35: Disability by Country

Disability	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	10.1%	10.0%	6.4%	5.5%	6.7%
No	87.7%	87.6%	91.2%	93.8%	91.4%
Unsure	2.2%	2.4%	2.4%	0.8%	1.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.36: Disability by Occupation

Occupation	Yes	No	Unsure	Total
Nursing	3.9%	94.4%	1.7%	**100%**
Midwifery	5.1%	94.9%	0.0%	**100%**
Allied Health Professional	16.5%	82.5%	1.0%	**100%**
Social Care Worker	11.1%	84.8%	4.1%	**100%**
Social Worker	8.8%	87.6%	3.6%	**100%**

Figure A3.37: Disability by Occupation
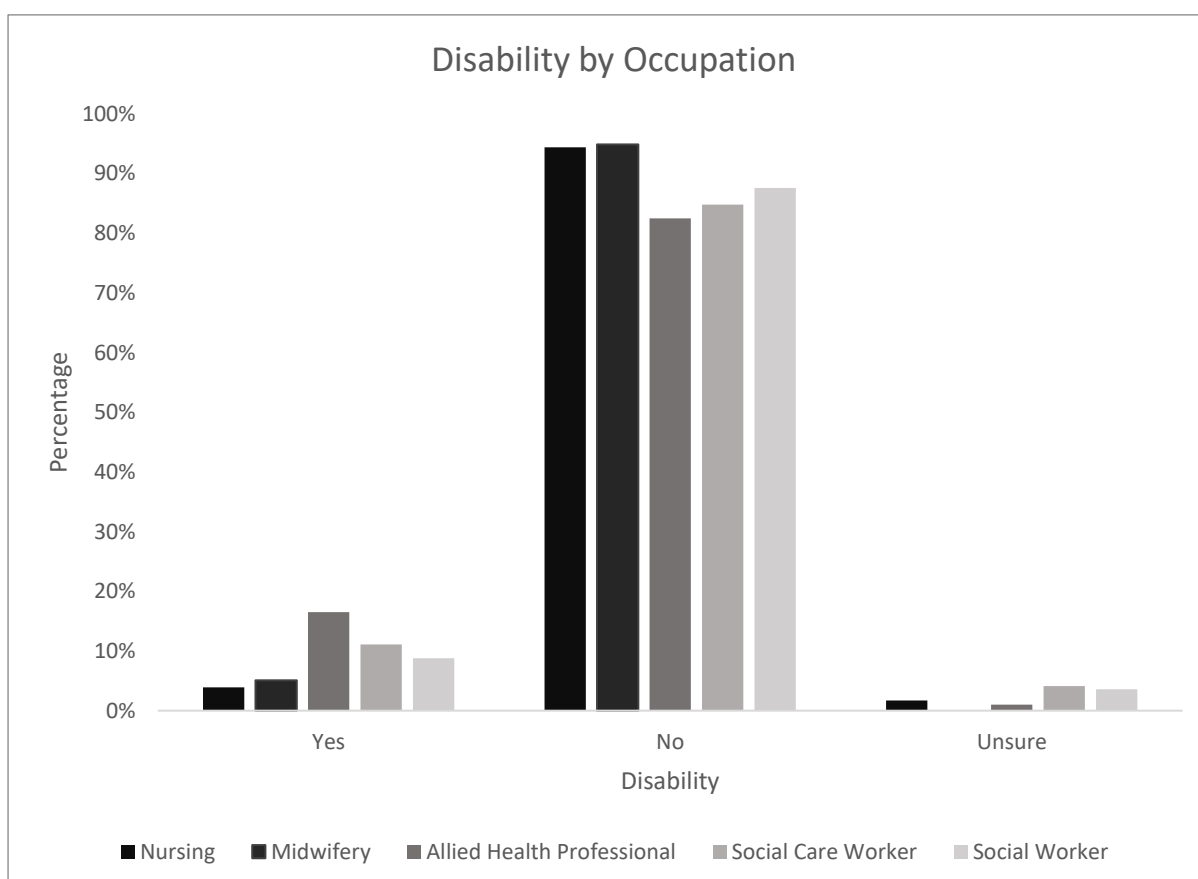
A3.20 Respondents' Relationship Status

Overall, the majority of respondents are married. Those in Wales are more likely to be single than the rest of the UK.
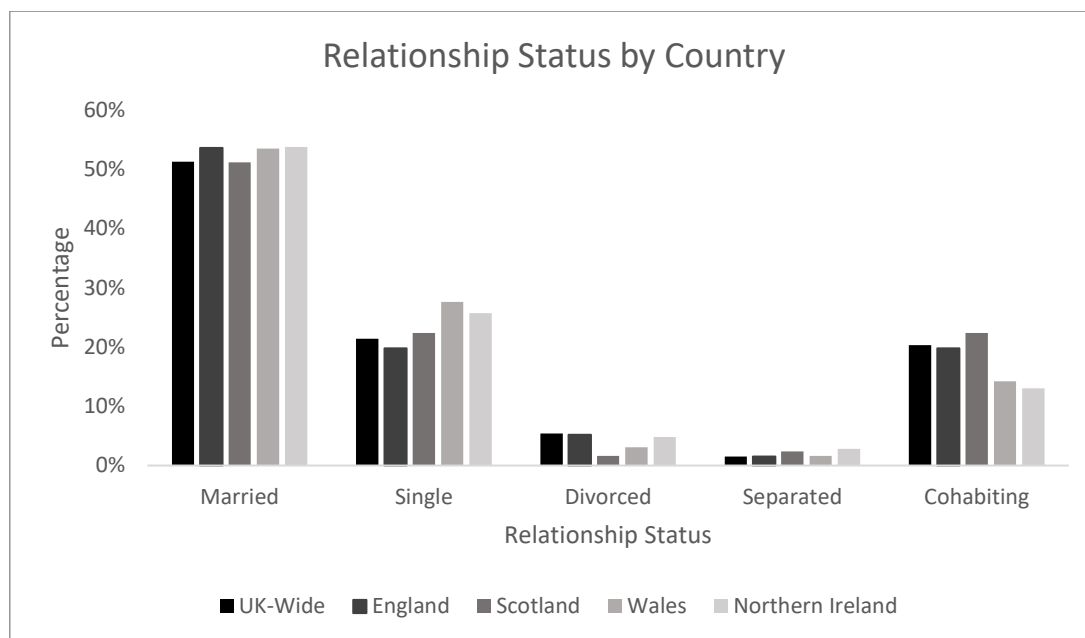
Figure A3.38: Relationship Status by Country

Table A3.37: Relationship Status by Country

Relationship Status	UK-Wide	England	Scotland	Wales	Northern Ireland
Married	51.3%	53.6%	51.2%	53.5%	53.8%
Single	21.4%	19.8%	22.4%	27.6%	25.7%
Divorced	5.4%	5.2%	1.6%	3.1%	4.8%
Separated	1.5%	1.5%	2.4%	1.6%	2.8%
Cohabiting	20.3%	19.8%	22.4%	14.2%	13.0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.38: Relationship Status by Occupation

Occupation	Married	Single	Divorced	Separated	Cohabiting	Total
Nursing	65.4%	13.0%	4.3%	0.0%	17.3%	**100%**
Midwifery	61.8%	16.5%	6.7%	1.2%	13.8%	**100%**
Allied Health Professional	48.6%	18.3%	6.8%	1.9%	24.4%	**100%**
Social Care Worker	45.3%	26.5%	3.4%	2.6%	22.1%	**100%**
Social Worker	45.0%	21.6%	4.2%	1.9%	27.3%	**100%**

Figure A3.39: Relationship Status by Occupation
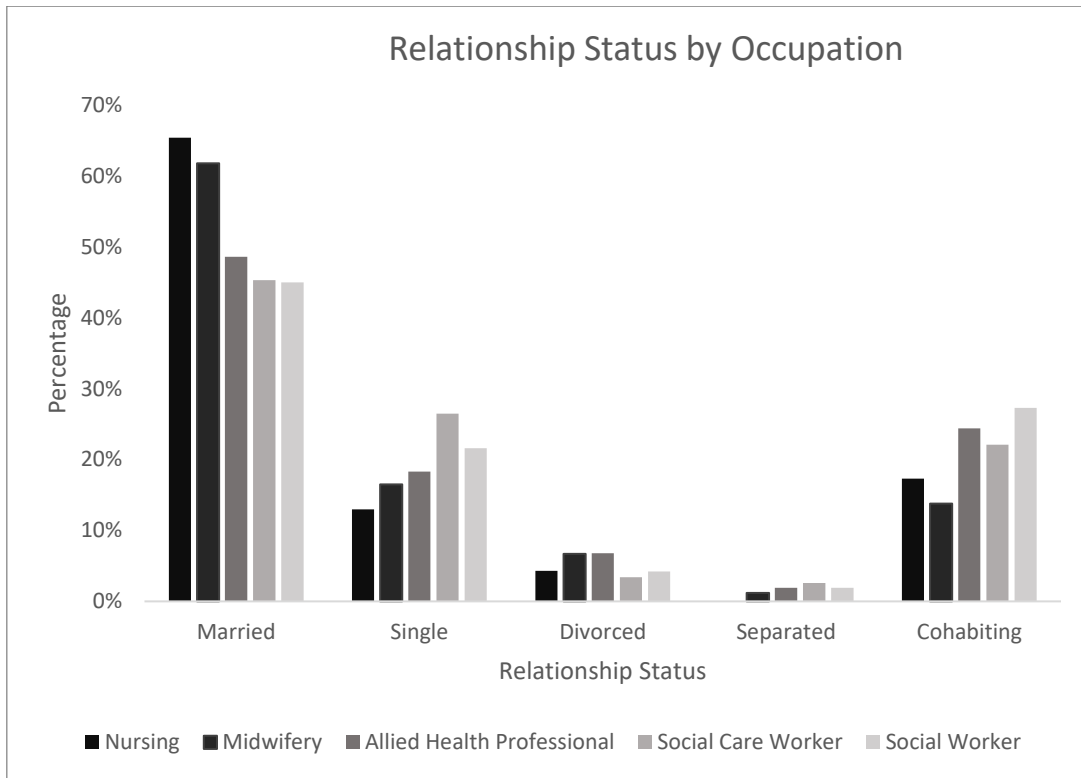
A3.21 Caring Responsibilities of Respondents

NI have the highest prevalence of Carers. Social Care Workers are most likely to have caring responsibilities, whilst Nurses are the least likely.
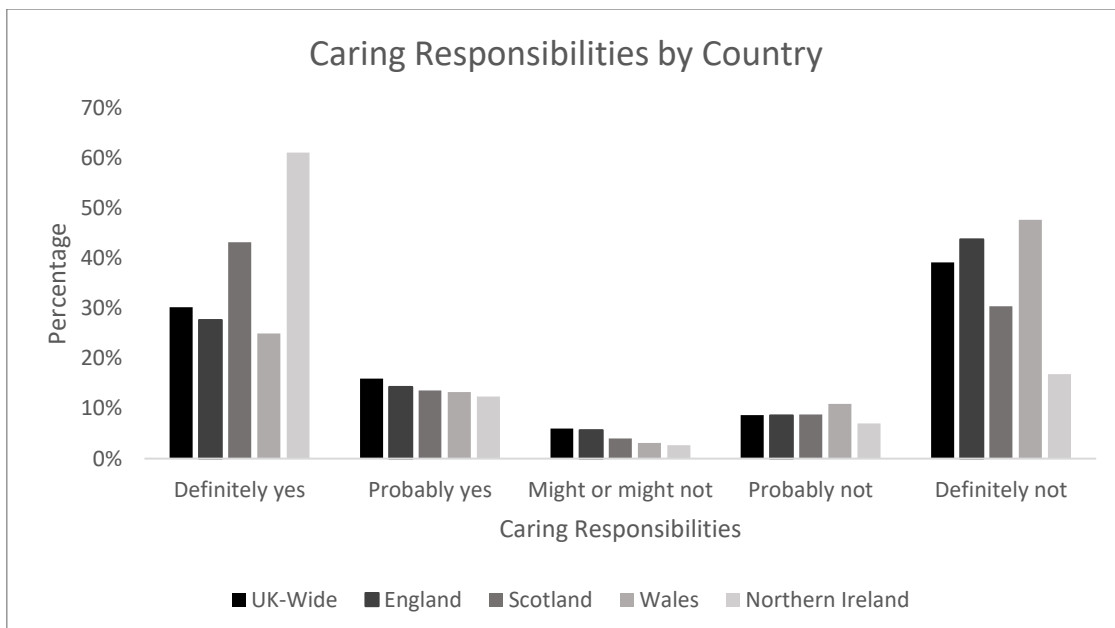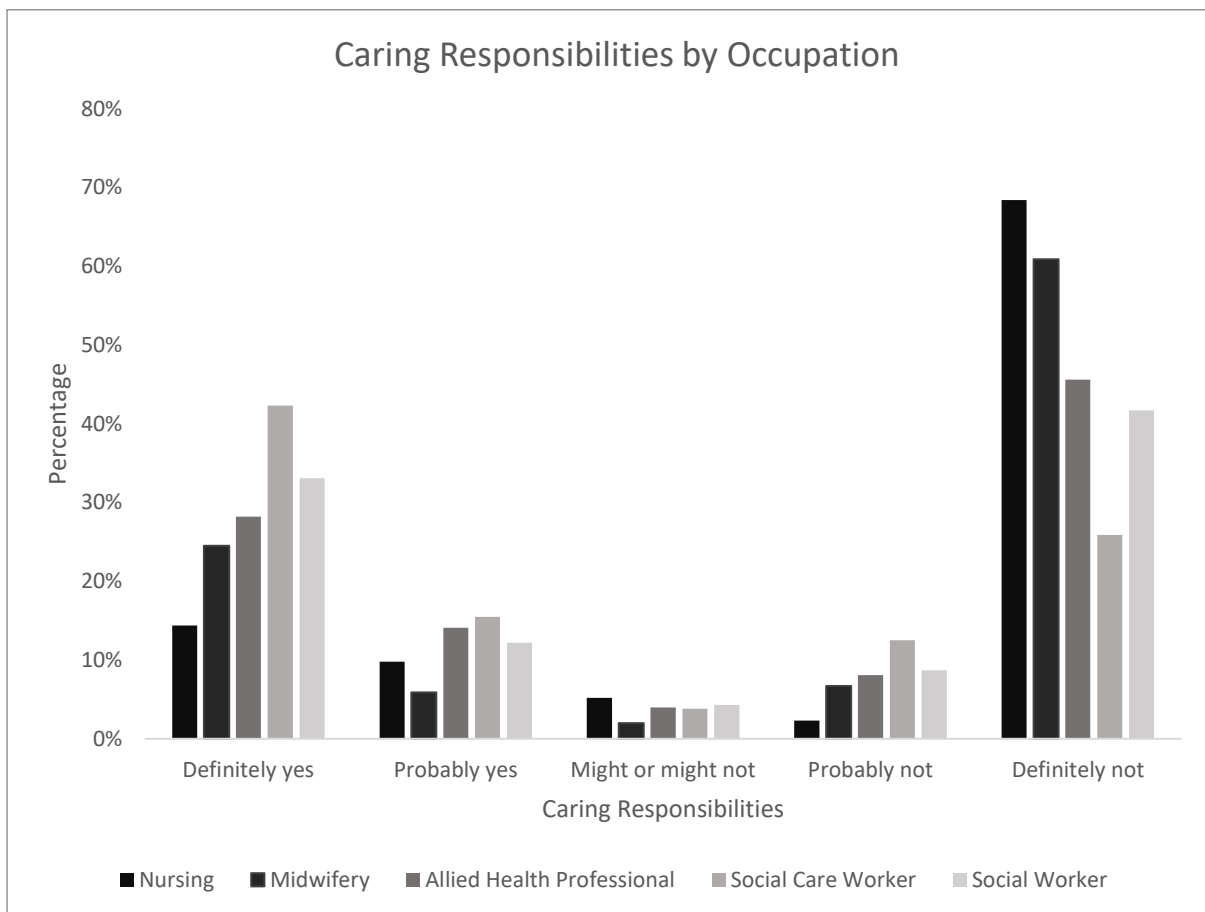
Figure A3.40: Caring Responsibilities by Country

Table A3.39: Caring Responsibilities by Country

Carer	UK-Wide	England	Scotland	Wales	Northern Ireland
Definitely yes	30.2%	27.7%	43.2%	25.0%	61.1%
Probably yes	16.0%	14.3%	13.6%	13.3%	12.4%
Might or might not	6.0%	5.7%	4.0%	3.1%	2.7%
Probably not	8.7%	8.6%	8.8%	10.9%	7.0%
Definitely not	39.2%	43.8%	30.4%	47.7%	16.9%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.40: Caring responsibilities by Occupation

Occupation	Definitely yes	Probably yes	Might or might not	Probably not	Definitely not	Total
Nursing	14.4%	9.8%	5.2%	2.3%	68.4%	**100%**
Midwifery	24.5%	5.9%	2.0%	6.7%	60.9%	**100%**
Allied Health Professional	28.2%	14.1%	4.0%	8.1%	45.6%	**100%**
Social Care Worker	42.3%	15.5%	3.8%	12.5%	25.9%	**100%**
Social Worker	33.1%	12.2%	4.3%	8.7%	41.7%	**100%**

Figure A3.41: Caring Responsibilities by Occupation

A3.22 Respondents' Change in Caring Responsibilities During COVID-19

Around two-thirds of all respondents reported that their caring responsibilities did change due to the pandemic. Social Worker respondents were slightly more likely to have caring role change due to the pandemic.

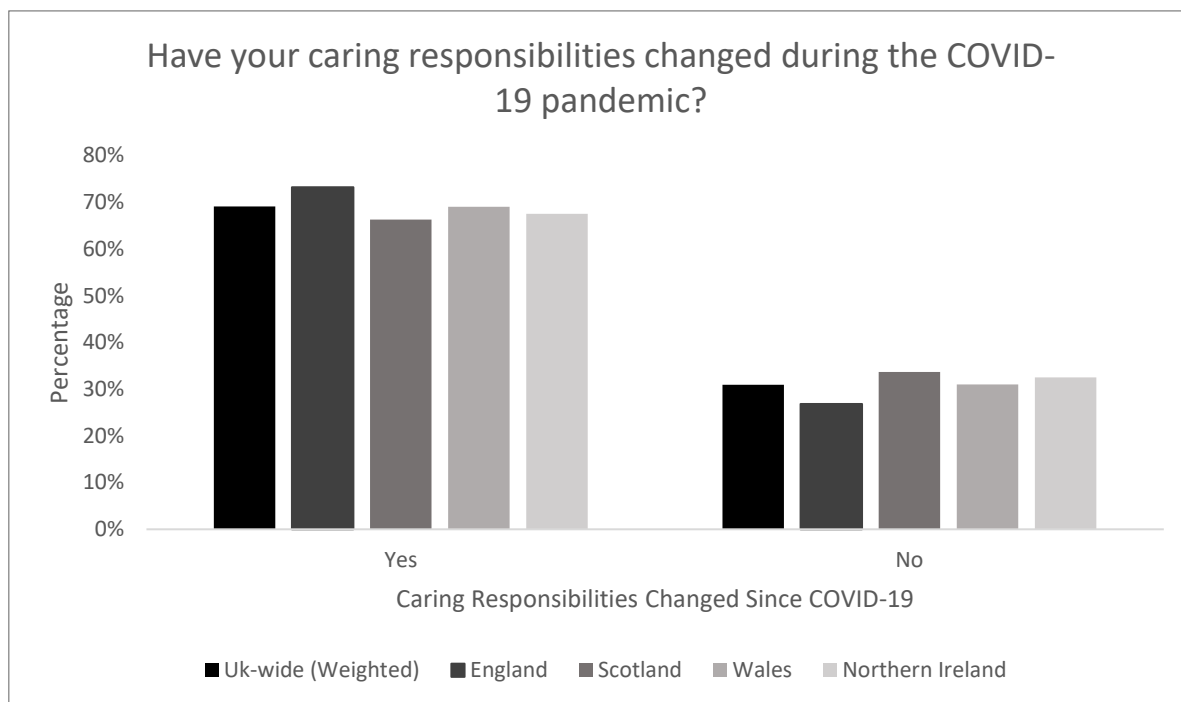Figure A3.42: Change in Caring Responsibilities During the Pandemic by Country

Table A3.41: Caring Responsibility Change by Country

Caring responsibilities changed	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	69.1%	73.2%	66.3%	69.0%	67.5%
No	30.9%	26.8%	33.7%	31.0%	32.5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.42: Caring Responsibility Change by Occupation

Occupation	Yes	No	Total
Nursing	75.4%	24.6%	**100%**
Midwifery	65.6%	34.4%	**100%**
Allied Health Professional	71.1%	28.9%	**100%**
Social Care Worker	69.9%	30.1%	**100%**
Social Worker	77.5%	22.5%	**100%**

Figure A3.43: Change in Caring Responsibilities During the Pandemic by Occupation
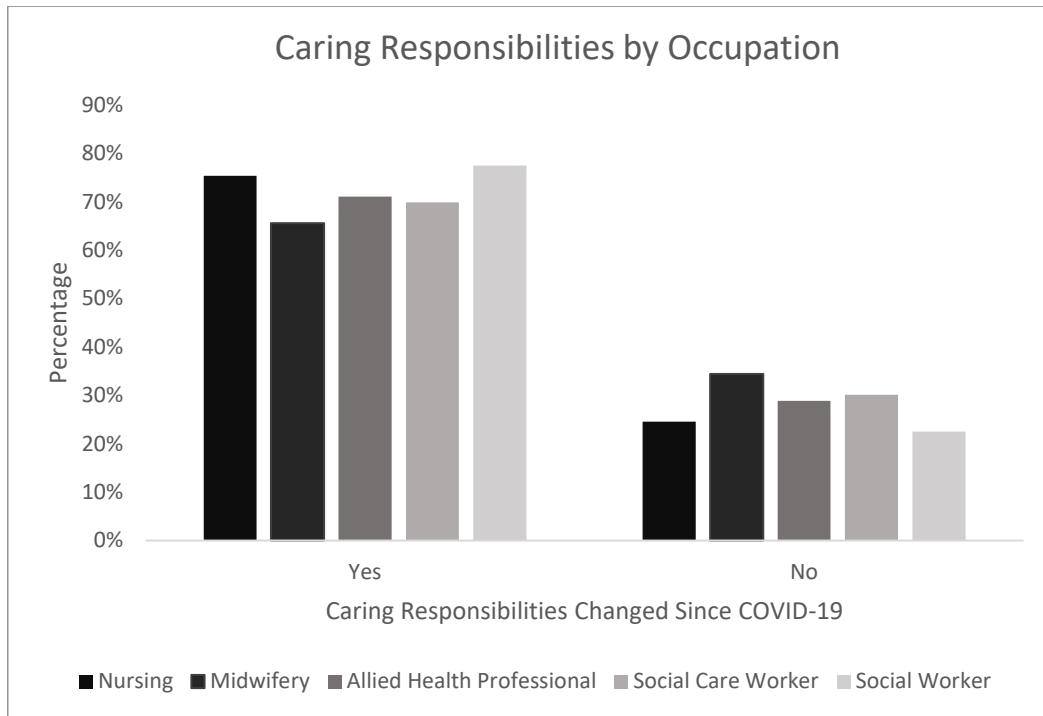
A3.23 Respondents' Opinion on Helpfulness of the 'Clap for Carers'

Around one third believed that the 'Clap for Carers' was a helpful response, whilst 14% thought it was not. The majority had other comments which will be analysed through the qualitative analysis. Midwives were least likely to say that this was a positive response.
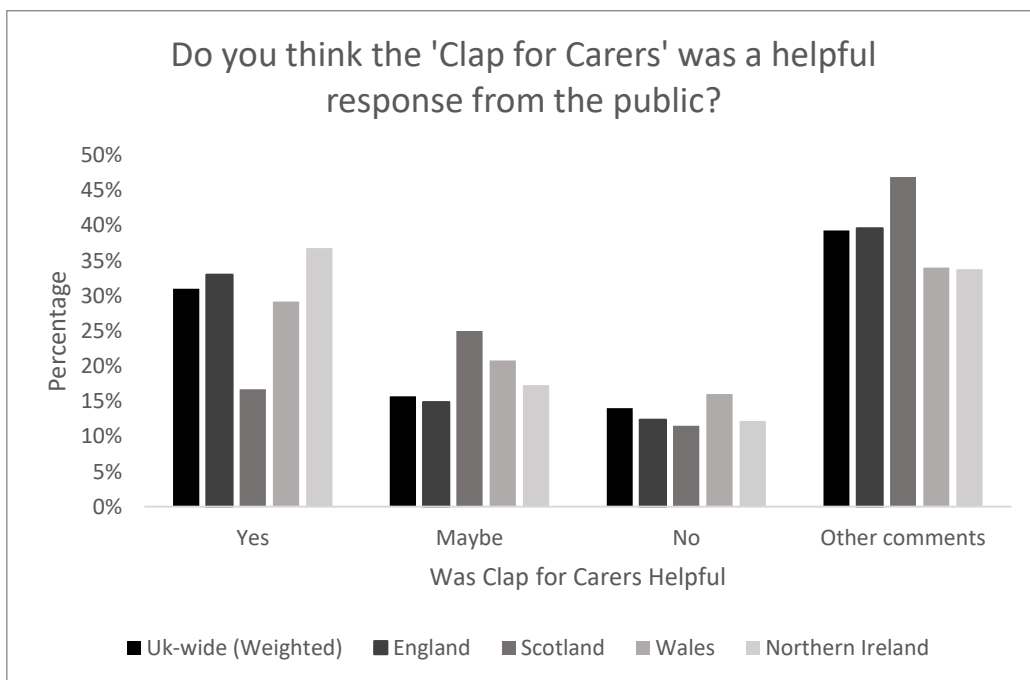
Figure A3.44: Opinion of 'Clap for Carers' by Country

Table A3.43: Opinion of 'Clap for Carers' by Country

Do you think the 'Clap for Carers' was a helpful response from the public?	UK-Wide	England	Scotland	Wales	Northern Ireland
Yes	31.0%	33.0%	16.7%	29.2%	36.8%
Maybe	15.7%	14.9%	25.0%	20.8%	17.3%
No	14.0%	12.4%	11.5%	16.0%	12.2%
Other comments	39.3%	39.6%	46.9%	34.0%	33.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Table A3.44: Opinion of 'Clap for Carers' by Occupation

Occupation	Yes	Maybe	No	Other comments	Total
Nursing	22.9%	8.3%	16.7%	52.1%	**100%**
Midwifery	21.2%	22.1%	16.8%	39.8%	**100%**
Allied Health Professional	38.6%	16.8%	12.0%	32.5%	**100%**
Social Care Worker	32.6%	21.7%	10.1%	35.6%	**100%**
Social Worker	29.0%	17.6%	15.1%	38.4%	**100%**

Figure A3.45: Opinion of 'Clap for Carers' by Occupation
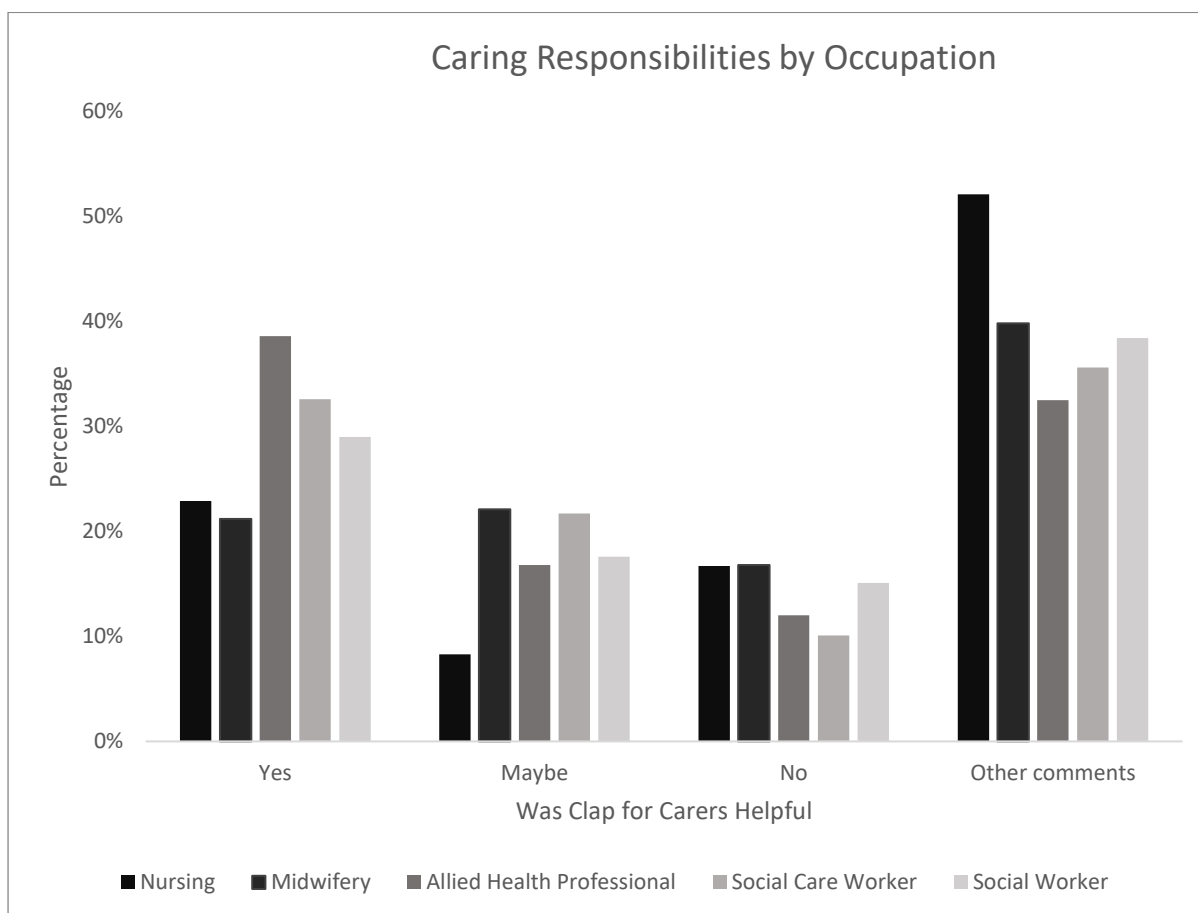
A3.24 Respondents' Region of Work
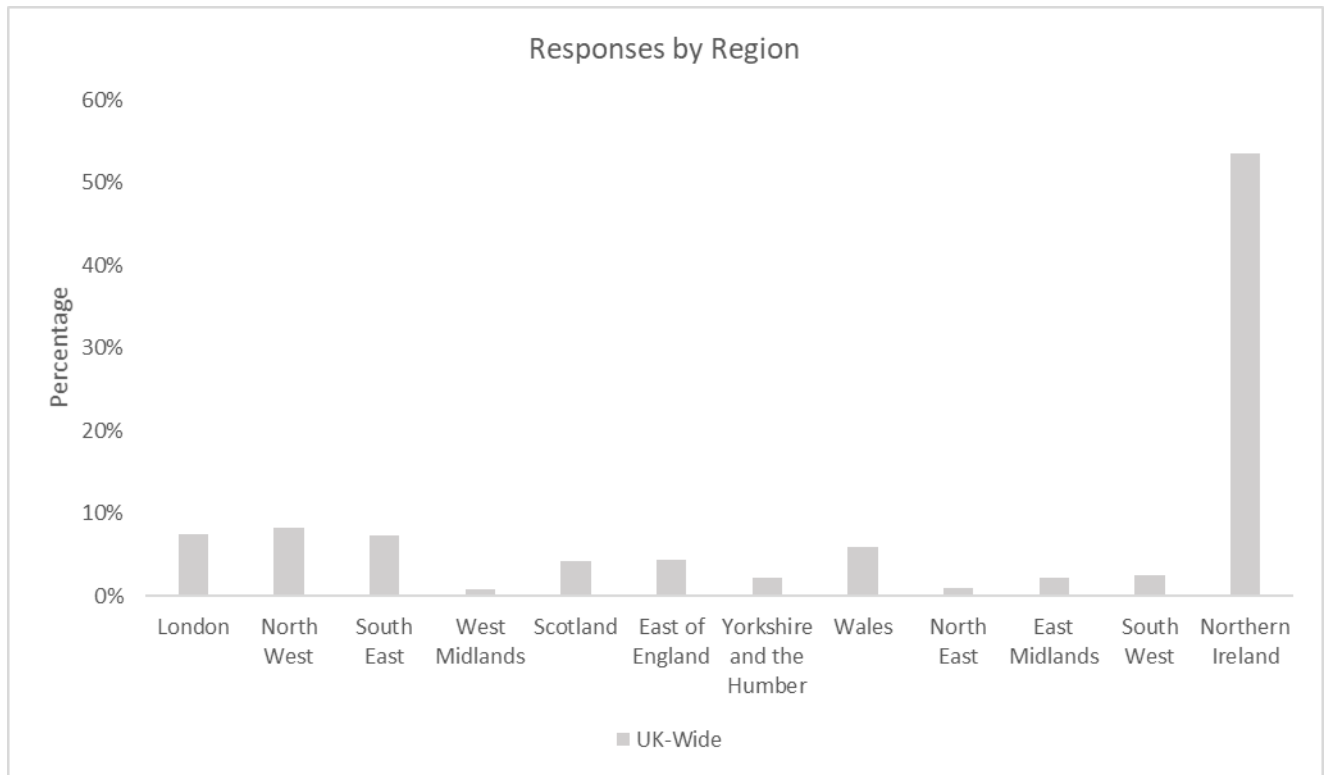
Figure A3.46: Responses by Region

Table A3.45: Responses by Region

Region	UK-Wide
London	7.5%
North West	8.3%
South East	7.4%
West Midlands	0.8%
Scotland	4.3%
East of England	4.4%
Yorkshire and the Humber	2.2%
Wales	5.9%
North East	1.0%
East Midlands	2.3%
South West	2.5%
Northern Ireland	53.5%
Total	**100%**

Figure A3.47: Region by Occupation

Region by Occupation
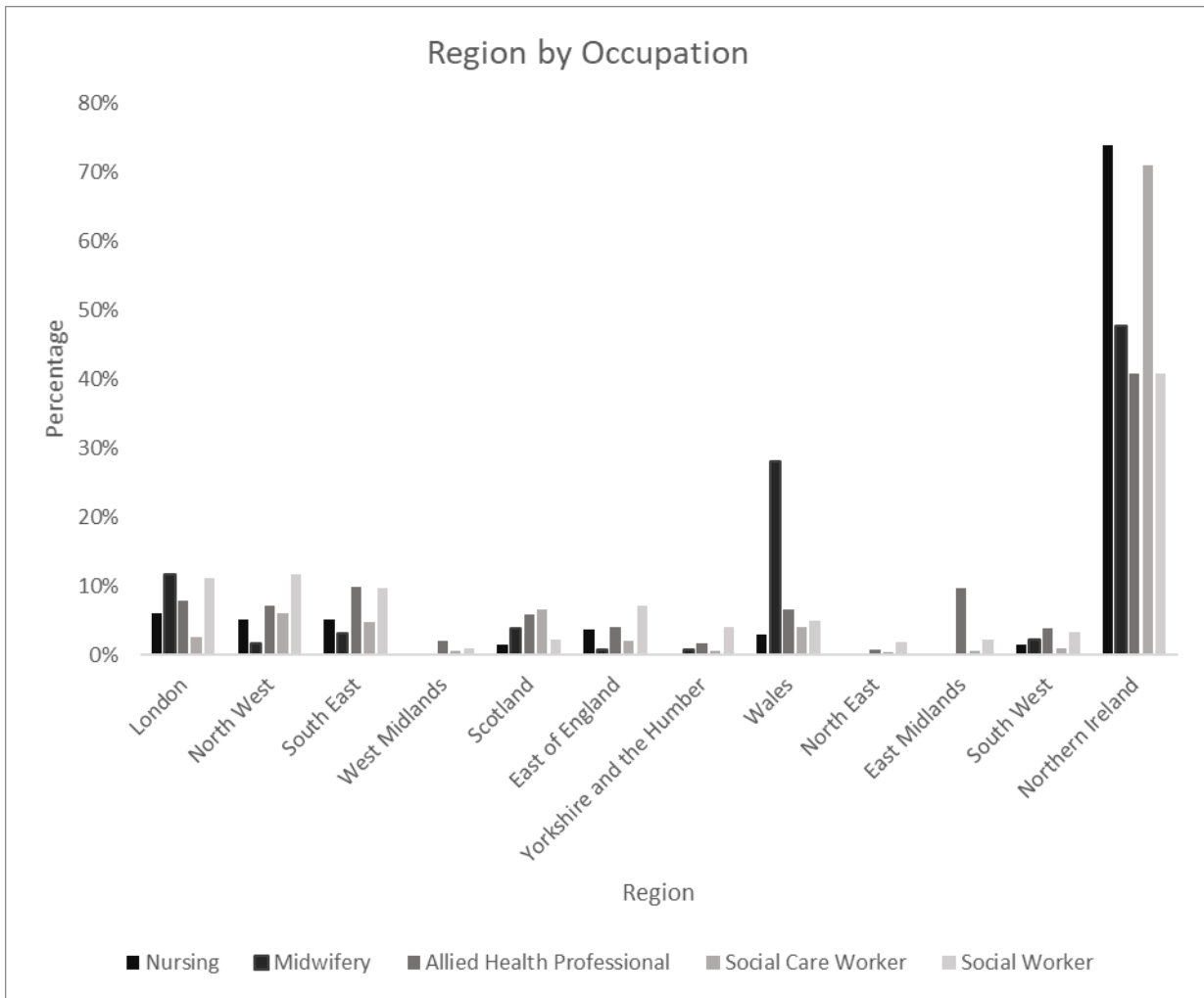
Table A3.46: Region by Occupation

Occupation	London	North West	South East	West Midlands	Scotland	East of England	Yorkshire and the Humber	Wales	North East	East Midlands	South West	Northern Ireland	Total
Nursing	6.0%	5.2%	5.2%	0.0%	1.5%	3.7%	0.0%	3.0%	0.0%	0.0%	1.5%	73.9%	**100%**
Midwifery	11.7%	1.6%	3.1%	0.0%	3.9%	0.8%	0.8%	28.1%	0.0%	0.0%	2.3%	47.7%	**100%**
Allied Health Professional	7.9%	7.2%	9.9%	2.1%	5.8%	4.1%	1.7%	6.5%	0.7%	9.6%	3.8%	40.8%	**100%**
Social Care Worker	2.5%	6.1%	4.8%	0.5%	6.6%	2.0%	0.6%	4.1%	0.4%	0.6%	1.0%	70.9%	**100%**
Social Worker	11.1%	11.7%	9.7%	1.0%	2.3%	7.1%	4.0%	4.9%	1.8%	2.2%	3.3%	40.7%	**100%**

Appendix 4: Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) – Tables and Charts

A4.1 Wellbeing Scores by Country

Overall mean wellbeing scores are slightly higher for the NI sample than UK wide. There is a significant difference in mean total wellbeing scores across countries (F=3.767, df=3, p<0.05).
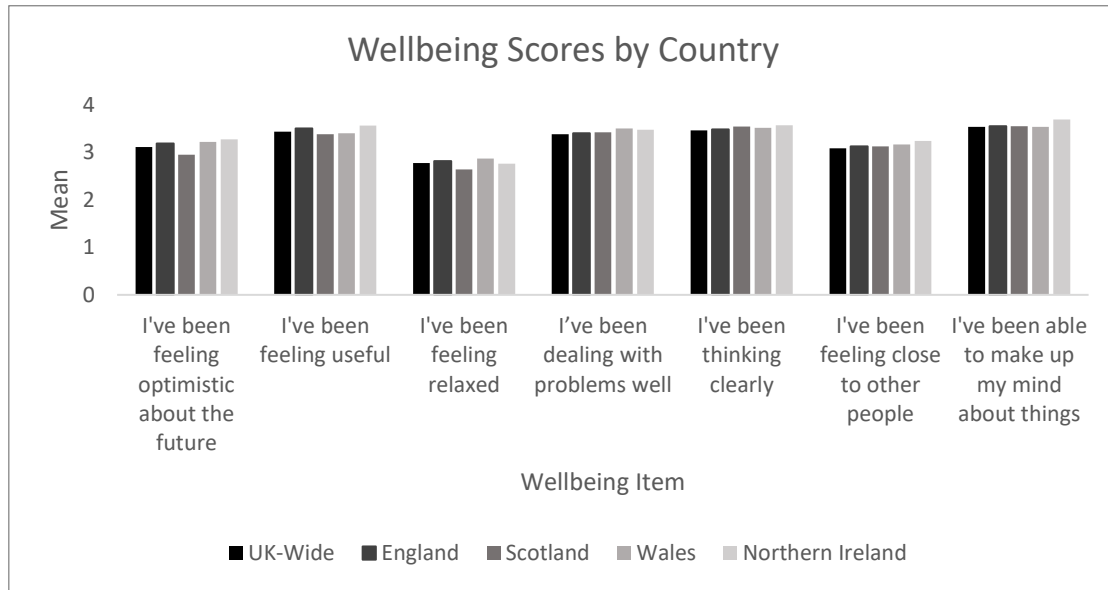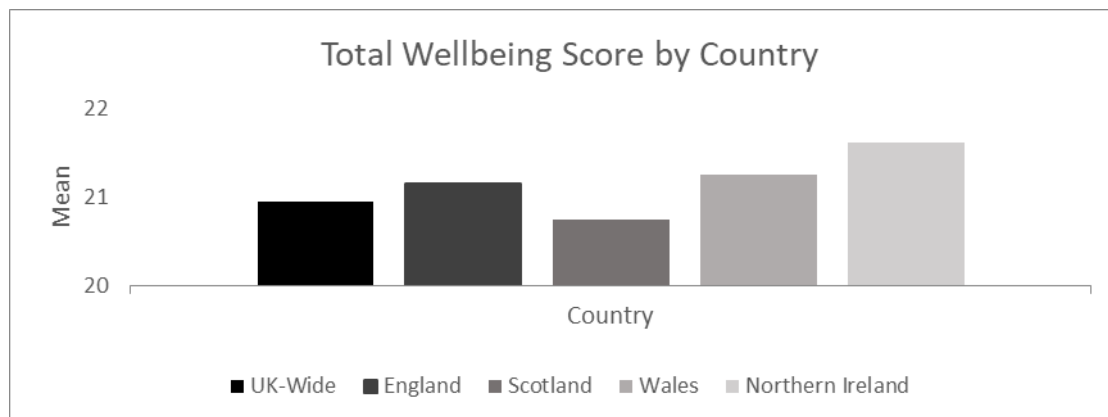
Figure A4.1: Wellbeing Scores by Country

Figure A4.2: Total Wellbeing Score by Country

Table A4.1: Wellbeing Scores by Country

Wellbeing Item	UK-Wide	England	Scotland	Wales	Northern Ireland
I've been feeling optimistic about the future	3.11	3.18	2.95	3.22	3.27
I've been feeling useful	3.43	3.50	3.38	3.40	3.56
I've been feeling relaxed	2.77	2.81	2.64	2.87	2.76
I've been dealing with problems well	3.38	3.40	3.42	3.50	3.47
I've been thinking clearly	3.46	3.48	3.54	3.51	3.57
I've been feeling close to other people	3.08	3.12	3.12	3.16	3.24
I've been able to make up my mind about things	3.53	3.55	3.55	3.53	3.69
Overall mean Wellbeing Score	20.95	21.15	20.74	21.25	21.61

A4.2 Wellbeing Scores by Occupation

There is no significant difference in mean total wellbeing scores across occupations (F=1.932, df=4, p>0.05).
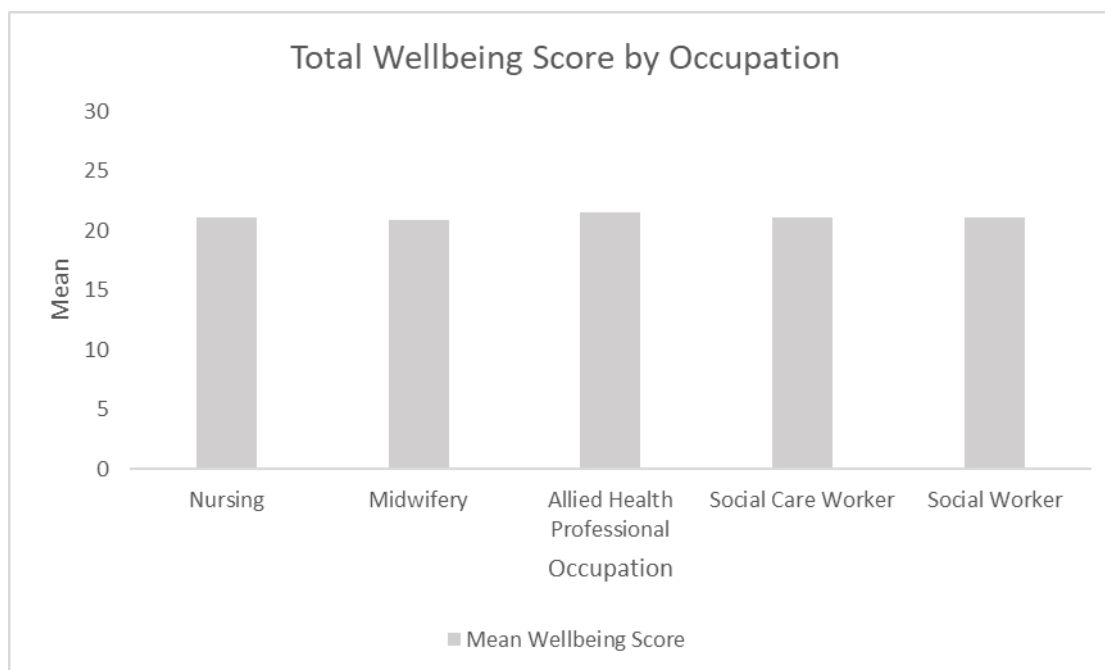
Figure A4.3: Total Wellbeing Score by Occupation

Table A4.2: Total Wellbeing Score by Occupation

Occupation	Mean Wellbeing Score
Nursing	21.15
Midwifery	20.91
Allied Health Professional	21.51
Social Care Worker	21.14
Social Worker	21.14

A2.3 Wellbeing Scores by Gender

Males report a higher level of wellbeing than female and this difference in wellbeing scores across gender is significant (F=15.342, df=2, p<0.001).
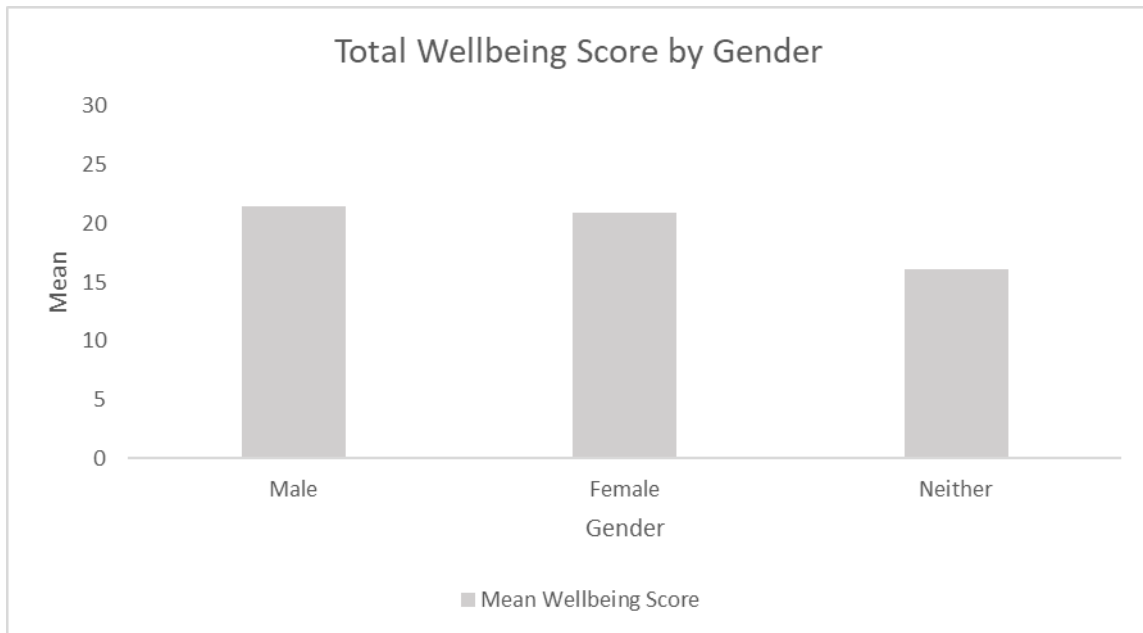
Figure A4.4: Total Wellbeing Score by gender

Table A4.3: Comparing 2018 and 2020 Wellbeing Scores by Gender

Gender	Mean Wellbeing Score		
	COVID-19 Study 2020	SWAS - UK Social Workers	SWAS - NI Social Workers
Male	21.41	21.00	21.53
Female	20.88	21.09	21.77
Neither	16.14	-	-

A4.4 Wellbeing Scores by Age

There is a significant difference in wellbeing scores across age-groups (F=24.418, df=6, p<0.001). As people get older, they generally report higher well-being scores. This was the same in the 2018 ageing workforce study.
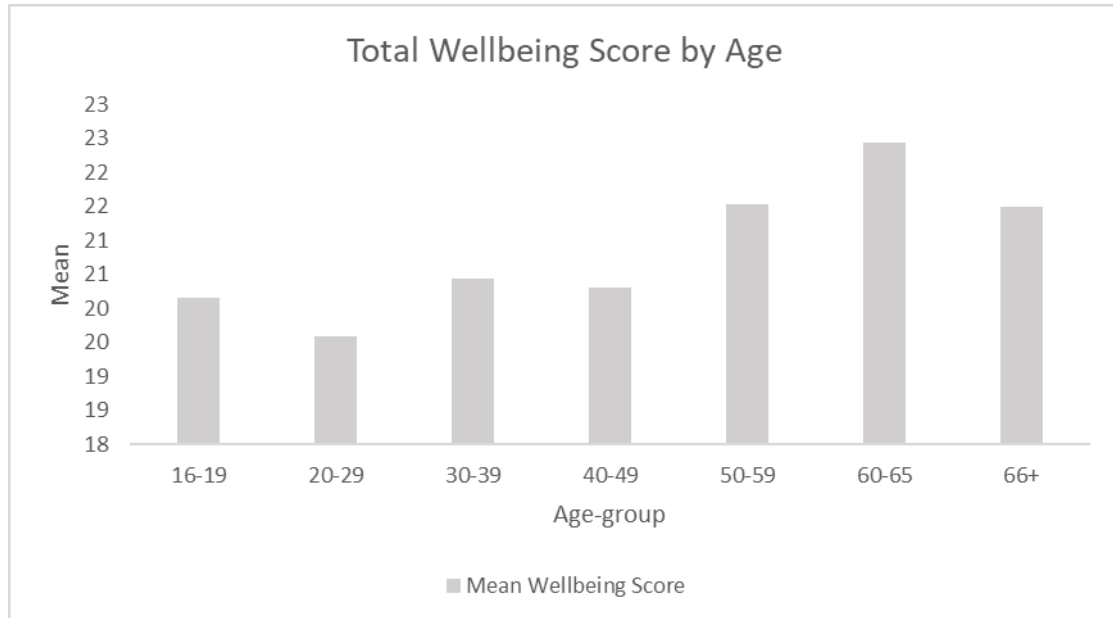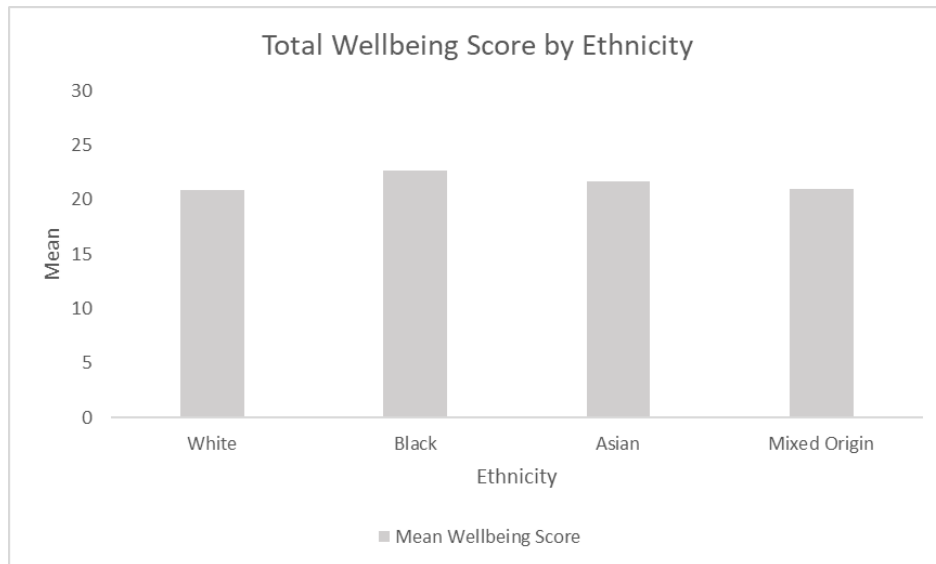
Figure A4.5: Total Wellbeing Score by Age

Table A4.4: Comparing 2018 and 2020 Wellbeing Scores by Age

Age group	Mean Wellbeing Score		
	COVID-19 Study 2020	SWAS – UK Social Workers 2018	SWAS – NI Social Workers 2018
18-24	20.16	19.23	20.85
25-34	19.59	20.90	21.78
35-44	20.44	20.85	21.09
45-54	20.30	21.15	21.81
55-59	21.53	20.77	21.78
60-64	22.44	21.45	23.26
65+	21.50	22.76	24.75

A4.5 Wellbeing Scores by Ethnicity

There is a significant difference in mean total wellbeing scores across ethnicities, with Black people reporting the highest scores (F=8.303, df=3, p<0.001).

Figure A4.6: Total Wellbeing Score by Ethnicity

A4.5 Wellbeing Scores by Disability

There is a significant difference in wellbeing scores by disability (F=57.475, df=2, p<0.001). Those who reported no disability had a higher well-being score. This was the same for the 2018 study.

Figure A4.7: Total Wellbeing Score by Disability

Table A4.5: Comparing 2018 and 2020 Wellbeing Scores by Disability

	Mean Wellbeing Score		
Disability	**COVID-19 Study 2020**	**SWAS - UK Social Workers**	**SWAS - NI Social Workers**
Yes	18.99	19.88	20.49
No	21.22	21.28	21.86
Unsure	19.76	-	-

A4.6 Wellbeing Scores by Job Area

There is a significant difference in wellbeing scores across job areas (F=27.760, df=7, p<0.001). Those who work in Midwifery report the lowest wellbeing scores (18.42) and those who work with Children report the highest (21.93). Looking at these figures by occupation, Nurses who work with Physical Disabilities report the lowest wellbeing scores (17.43), whilst those who work in Midwifery report the highest (25.03).

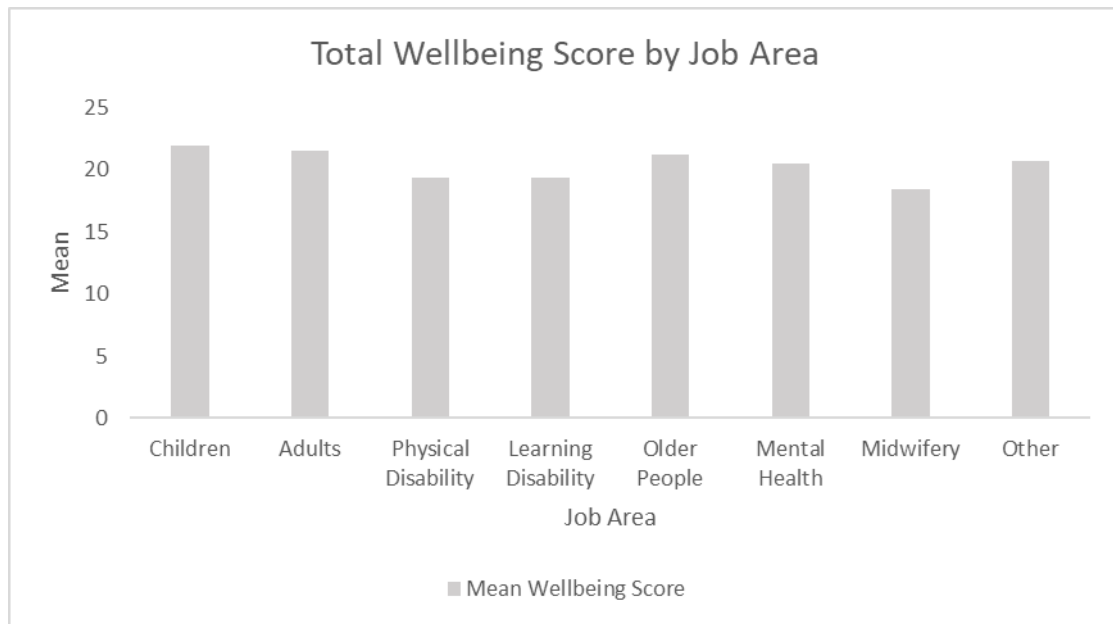Figure A4.8: Total Wellbeing Score by Job Area

Table A4.6: Wellbeing Scores by Job Area

Area of Practice	Mean Wellbeing Score
Children	21.93
Adults	21.52
Physical Disability	19.38
Learning Disability	19.31
Older People	21.23
Mental Health	20.50
Midwifery	18.42
Other	20.69

Appendix 5: Quality of Working Life Scale (WRQoL) – Tables and Charts

A5.1 Quality of Working Life Scores by Country

There are significant differences in all of the quality of working life domains across countries. England score highest in Stress at Work (SAW), whilst Wales score highest in Job & Career Satisfaction (JCS), General Wellbeing (GWB), and Working Conditions WCS. It should be noted that a high SAW score means lower stress at work. Scotland scores lowest in all quality of working life items. The highest total score for quality of working life was in Wales (83.94).
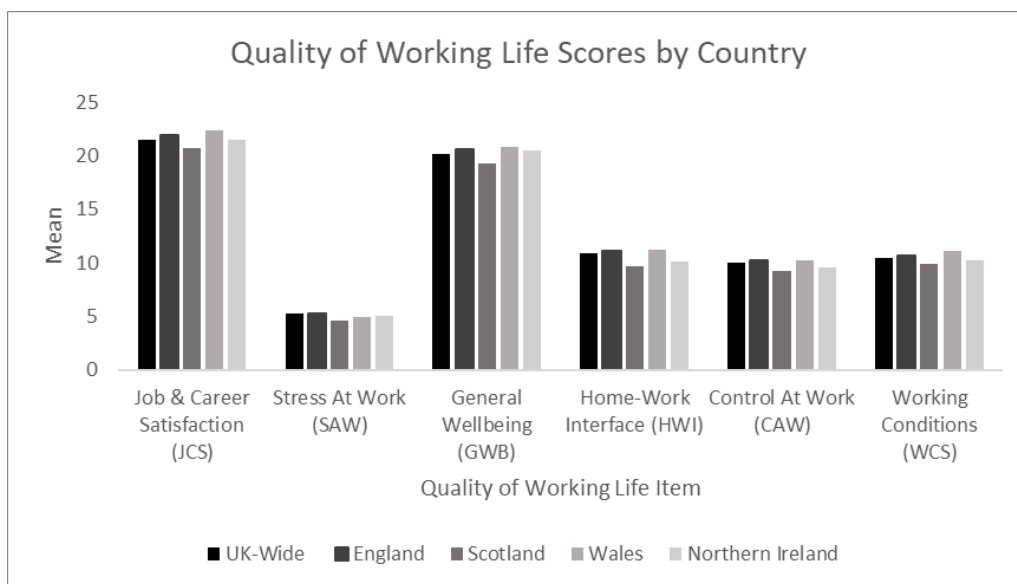
Figure A5.1: Quality of Working Life Scores by Country

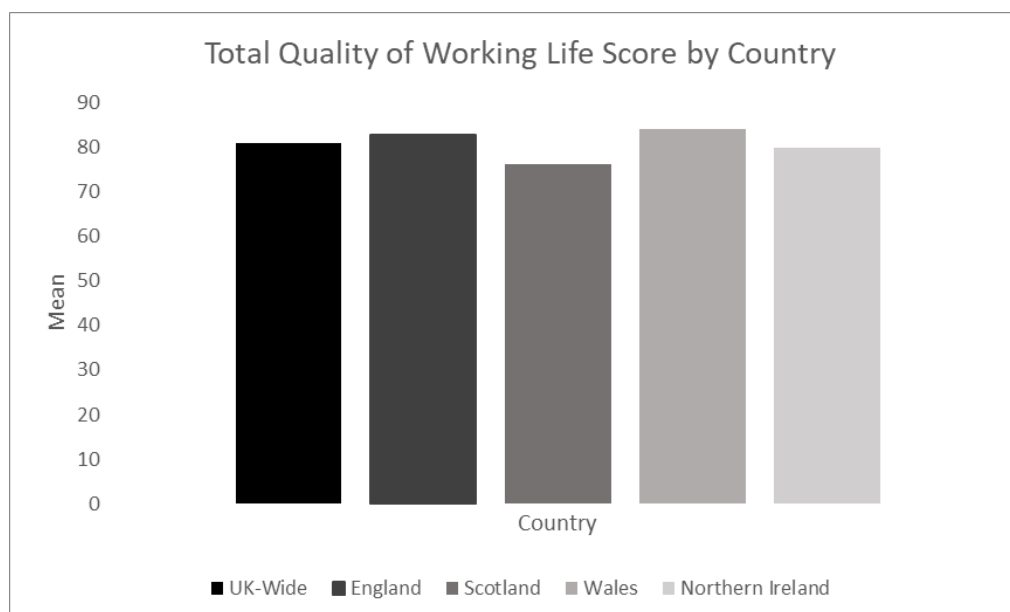Figure A5.2: Total Quality of Working Life Score by Country

Table A5.1: Quality of Working Life Scores by Country

WRQL Domain	UK-Wide	England	Scotland	Wales	Northern Ireland
Job & Career Satisfaction (JCS)	21.48	21.95	20.77	22.38	21.48
Stress At Work (SAW)	5.23	5.22	4.57	4.98	5.06
General Wellbeing (GWB)	20.17	20.65	19.32	20.85	20.55
Home-Work Interface (HWI)	10.84	11.11	9.71	11.26	10.18
Control At Work (CAW)	9.97	10.27	9.22	10.26	9.57
Working Conditions (WCS)	10.49	10.71	9.87	11.13	10.23
Total Mean Quality of Working Life Score	80.94	82.74	76.22	83.94	79.94

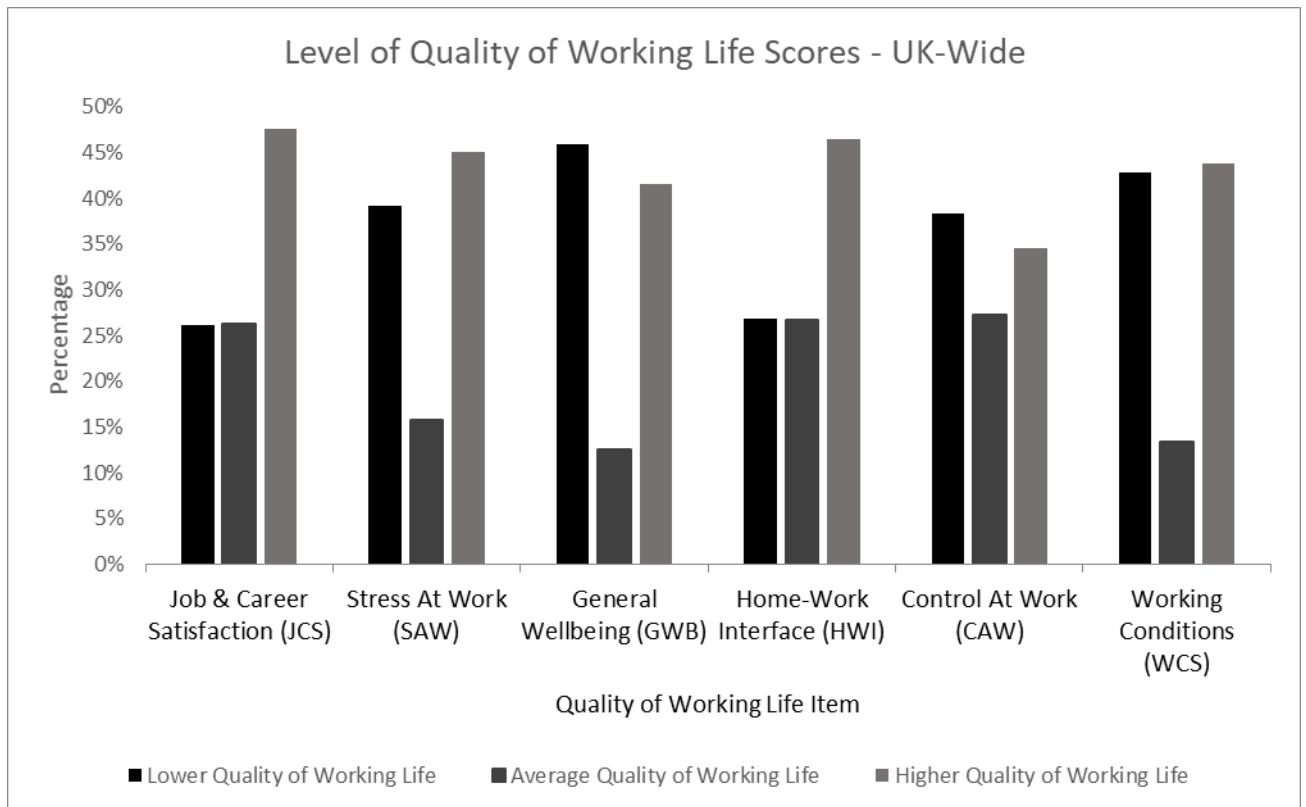Figure A5.3: Level of Quality of Working Life Scores - UK-Wide

Table A5.2: Level of Quality of Working Life Scores - UK-Wide

Quality of Working Life Domain	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
Job & Career Satisfaction (JCS)	26.1%	26.3%	47.6%	**100%**
Stress At Work (SAW)	39.2%	15.7%	45.1%	**100%**
General Wellbeing (GWB)	45.9%	12.5%	41.6%	**100%**
Home-Work Interface (HWI)	26.8%	26.7%	46.5%	**100%**
Control At Work (CAW)	38.3%	27.2%	34.5%	**100%**
Working Conditions (WCS)	42.8%	13.4%	43.8%	**100%**
Quality of Working Life Total	34.6%	15.4%	50.0%	**100%**

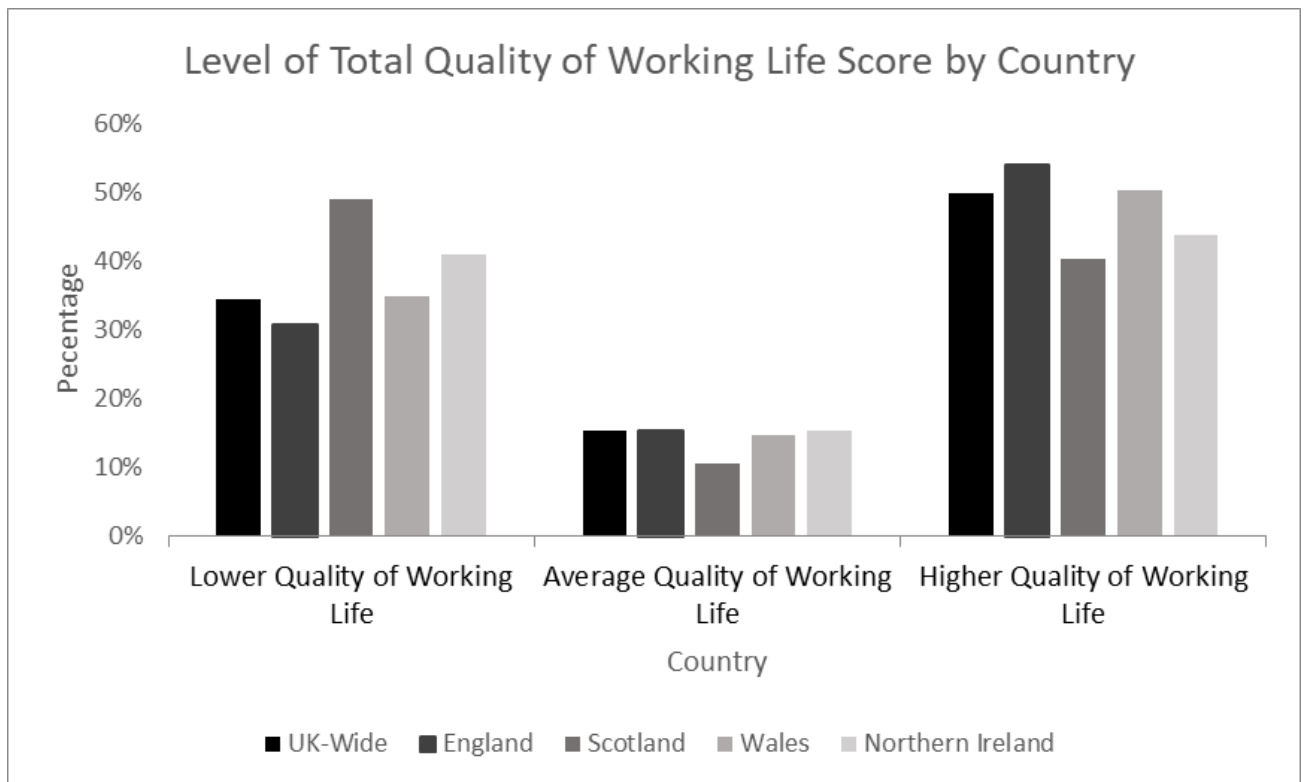Figure A5.4: Level of Total Quality of Working Life Score by Country

Table A5.3: Level of Total Quality of Working Life Score by Country

Level of Quality of Working Life	UK-Wide	England	Scotland	Wales	Northern Ireland
Lower Quality of Working Life	34.6%	30.7%	49.0%	35.0%	41.0%
Average Quality of Working Life	15.4%	15.3%	10.6%	14.7%	15.3%
Higher Quality of Working Life	50.0%	54.0%	40.4%	50.4%	43.8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

A5.2 Quality of Working Life Scores by Gender

There are significant gender differences across all of the quality of working life domains. Males report a significantly higher total quality of working life score ($F=13.292$, $df=2$, $p<0.001$).

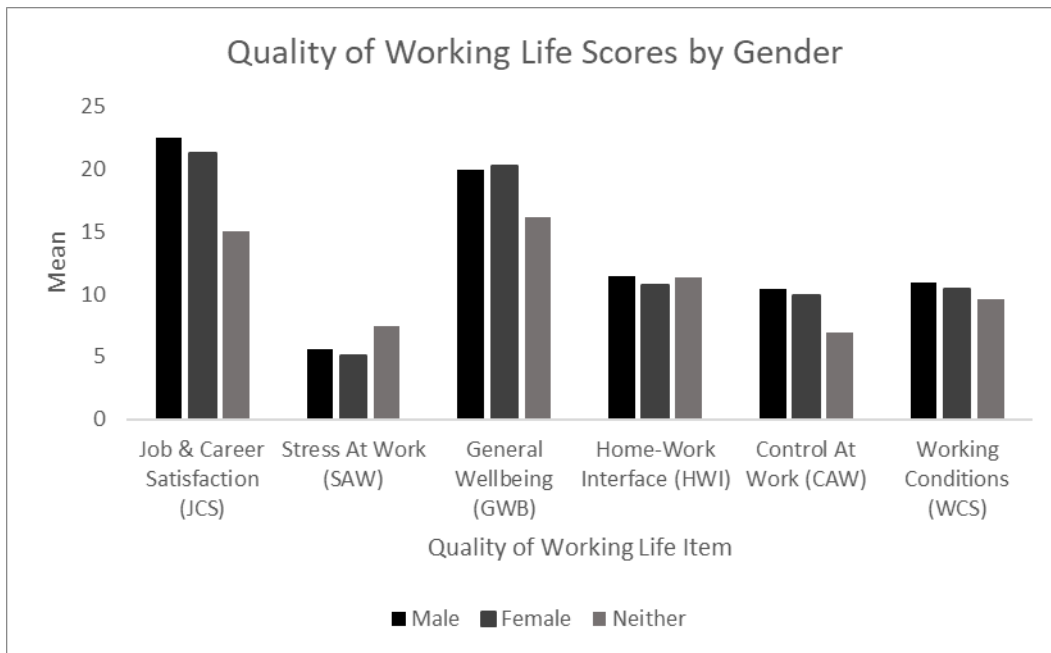Figure A5.5: Quality of Working Life Scores by Gender

Table A5.4: Quality of Working Life Scores by Gender

Quality of Working Life Domain	Mean Quality of Working Life						
	COVID-19 Study 2020			SWAS – UK Social Workers 2018		SWAS – NI Social Workers 2018	
	Male	Female	Neither	Male	Female	Male	Female
JCS	22.50	21.29	15.08	20.48	20.04	20.75	20.48
SAW	5.64	5.13	7.44	4.58	4.37	4.75	4.32
GWB	19.96	20.23	16.21	19.59	19.16	20.03	20.04
HWI	11.43	10.71	11.34	10.15	9.47	10.06	9.69
CAW	10.43	9.89	6.97	10.06	9.34	10.15	9.65
WCS	10.89	10.41	9.63	9.53	9.28	9.88	9.52
Quality of Working Life Total	84.06	80.31	67.12	74.44	71.71	75.92	73.75

Figure A5.6: Total Quality of Working Life Score by Gender
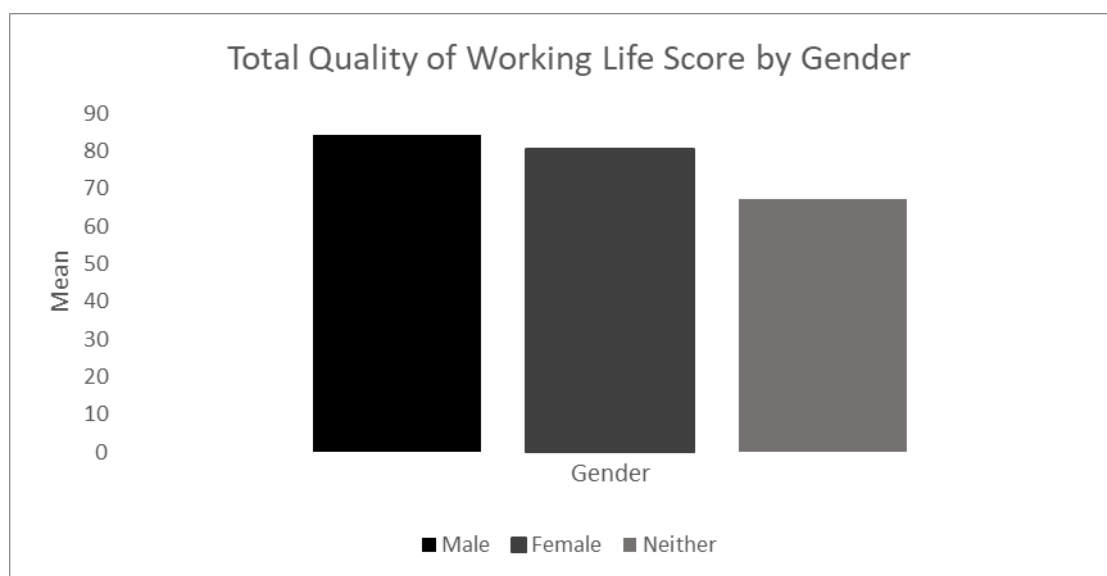
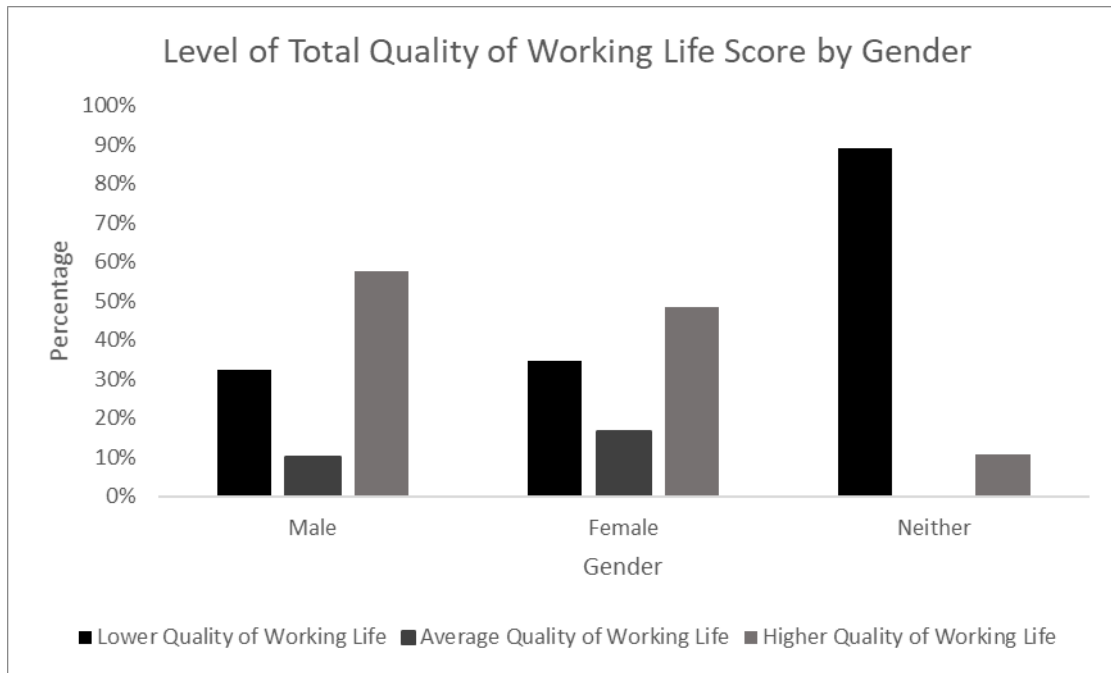Figure A5.7: Level of Total Quality of Working Life Score by Gender

Table A5.5: Level of Total Quality of Working Life Score by Gender

Level of Quality of Working Life	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
Male	32.3%	10.0%	57.7%	**100%**
Female	34.8%	16.6%	48.6%	**100%**
Neither	89.2%	0.0%	10.8%	**100%**

A5.3 Quality of Working Life Scores by Age

There are significant differences across all quality of working life domains between age groups. There is also a significant difference in the quality of working life total between age groups (F=31.028, df=6, p<0.001). Scores tend to increase as people get older, so this should correlate with the wellbeing scale results and is aligned to 2018 findings for social workers in the ageing social work workforce study. These scores align to the findings in the 2018 Social Work Study showing that there is a significant positive correlation (0.556) between wellbeing and quality of working life.

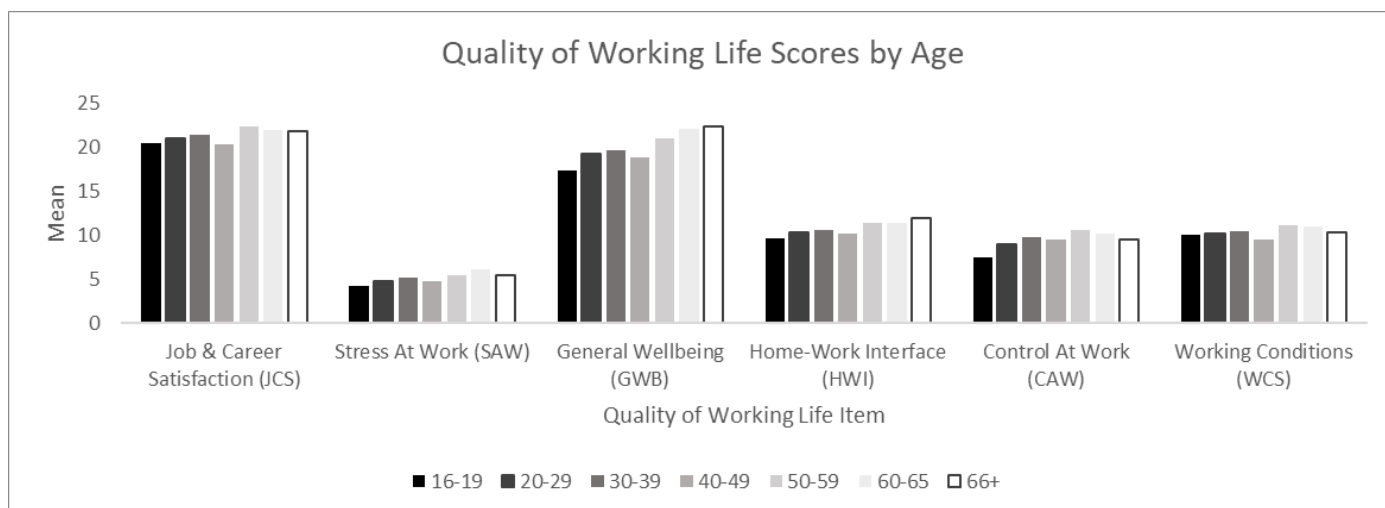Figure A5.8: Quality of Working Life Scores by Age

Table A5.6: Quality of Working Life Scores by Age

| Age group | Mean Quality of Working Life | | | |
	COVID-19 Study 2020	Age group	SWAS – UK Social Workers 2018	SWAS – NI Social Workers 2018
16-19	71.67	18-24	69.25	71.20
20-29	77.10	25-34	69.87	70.81
30-39	79.95	35-44	71.47	72.48
40-49	75.32	45-54	72.49	74.54
50-59	85.31	55-59	70.99	76.36
60-65	85.92	60-64	75.47	79.71
66+	83.99	65+	77.23	82.33

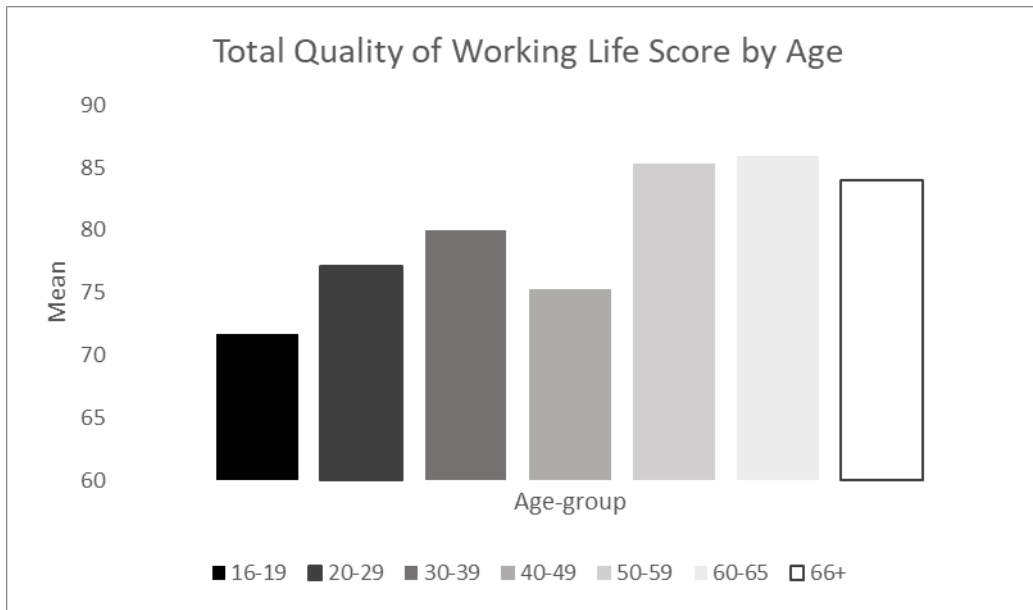Figure A5.9: Total Quality of Working Life Score by Age

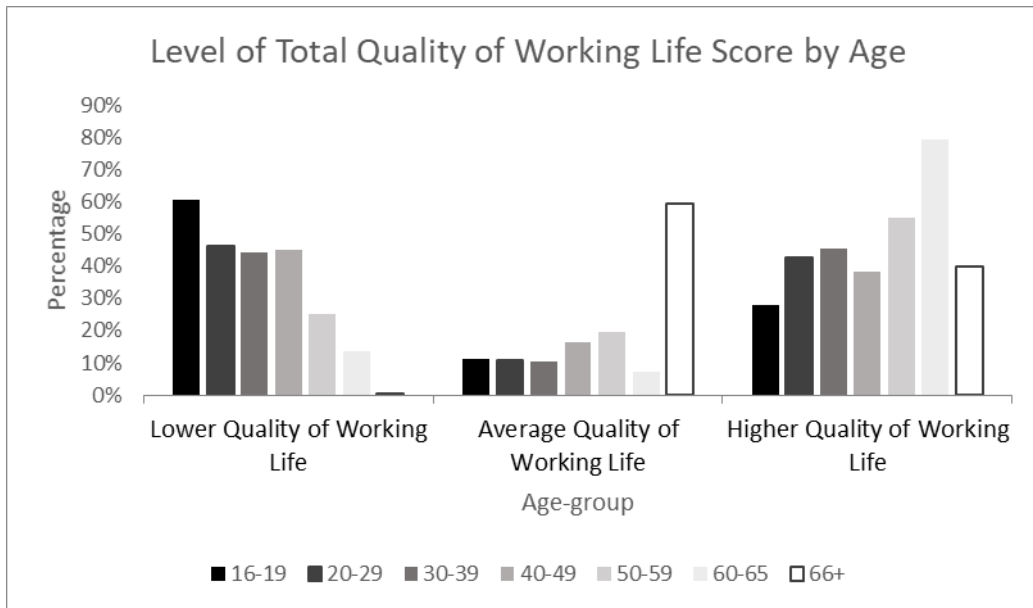Figure A5.10: Level of Total Quality of Working Life Score by Age

Table A5.7: Level of Total Quality of Working Life Score by Age

Quality of Working Life Domain	Lower Quality of Working Life	Average Quality of Working Life	Higher Quality of Working Life	Total
16-19	60.8%	11.2%	28.0%	**100%**
20-29	46.4%	10.8%	42.8%	**100%**
30-39	44.2%	10.4%	45.4%	**100%**
40-49	45.0%	16.5%	38.4%	**100%**
50-59	25.3%	19.6%	55.1%	**100%**
60-65	13.4%	7.2%	79.3%	**100%**
66+	0.6%	59.4%	40.0%	**100%**

A5.4 Quality of Working Life Scores by Occupation

There are significant differences in all of the quality of working life domains across occupations and also the total quality of working life. Allied Health Professionals score highest in the four of the domains and have the highest overall quality of working life score (84.91).

Allied Health Workers reported high JCS than other professions. Midwives reported most stress at work (lowest score), followed by Social Workers, then Allied Health Workers.

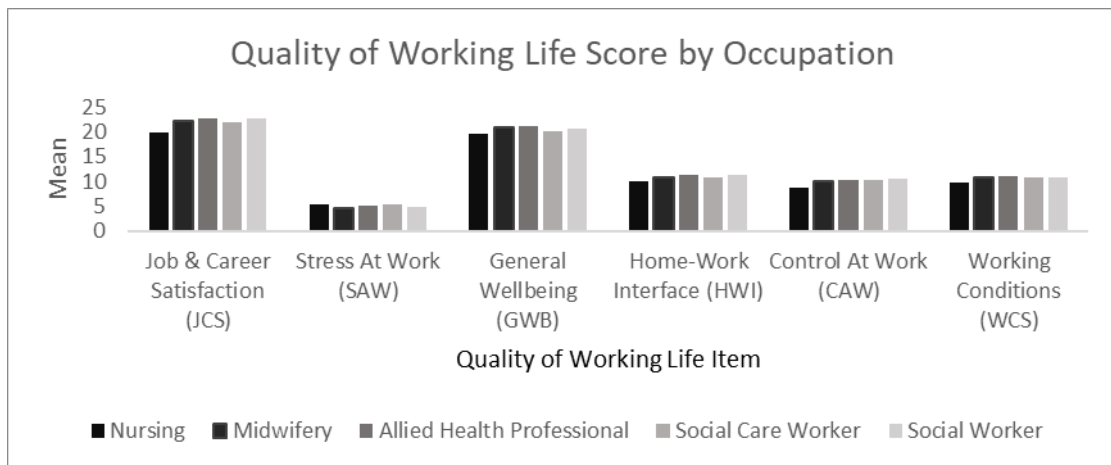Figure A5.11: Quality of Working Life Scores by Occupation

Table A5.8: Quality of Working Life Scores by Occupation

Quality of Working Life Domain	Mean Quality of Working Life				
	Nursing	Midwifery	Allied Health Professional	Social Care Worker	Social Worker
Job & Career Satisfaction (JCS)	19.85	22.21	22.73	21.92	22.70
Stress At Work (SAW)	5.25	4.55	5.13	5.29	4.82
General Wellbeing (GWB)	19.77	20.91	21.32	20.16	20.75
Home-Work Interface (HWI)	10.11	10.68	11.26	10.92	11.34
Control At Work (CAW)	8.79	9.96	10.41	10.40	10.63
Working Conditions (WCS)	9.82	10.79	11.02	10.68	10.85
Quality of Working Life Total	75.63	82.12	84.91	82.31	84.43

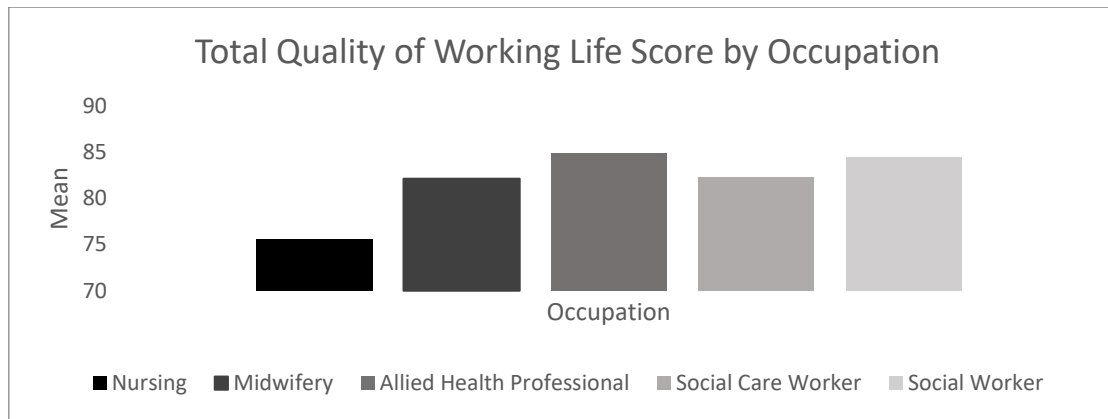Figure A5.12: Total Quality of Working Life Score by Occupation

Table A5.9: Level of Total Quality of Working Life Score by Occupation

Quality of Working Life Domain	Nursing	Midwifery	Allied Health Professional	Social Care Worker	Social Worker
Lower Quality of Working Life	49.9%	29.7%	30.4%	33.7%	26.6%
Average Quality of Working Life	6.8%	11.3%	15.9%	19.2%	17.2%
Higher Quality of Working Life	43.3%	59.0%	53.7%	47.1%	56.2%
Total	100%	100%	100%	100%	100%

Figure A5.13: Level of Total Quality of Working Life Score by Occupation

Level of Total Quality of Working Life Score by Occupation
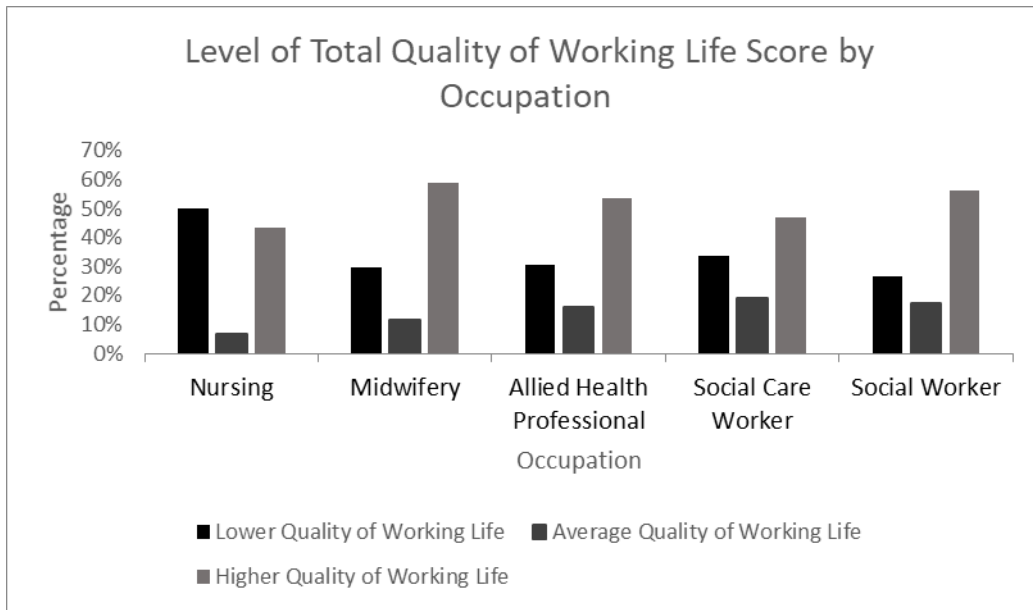
Appendix 6: Carver Coping Scale – Tables and Charts

A6.1 Carver Coping Scores by Country

There are significant differences in all but five of the Carver Coping Scale domains across countries. These differences were in: Self-distraction; Denial; Substance use; Use of instrumental support; Positive reframing; Humour; Acceptance; Religion; and Self-blame.

In Northern Ireland, substance use (5.14) and positive reframing (4.75) scored highest as coping mechanisms. This compares to Scotland where people turned to religion (4.37) and used self-distraction (4.79). In Wales, people use instrumental support (3.60), acceptance (2.69) and self-blame to cope (3.96). In England, people were less likely than other parts of the UK to use self-distraction (4.31) or acceptance (2.50) as a coping mechanism.

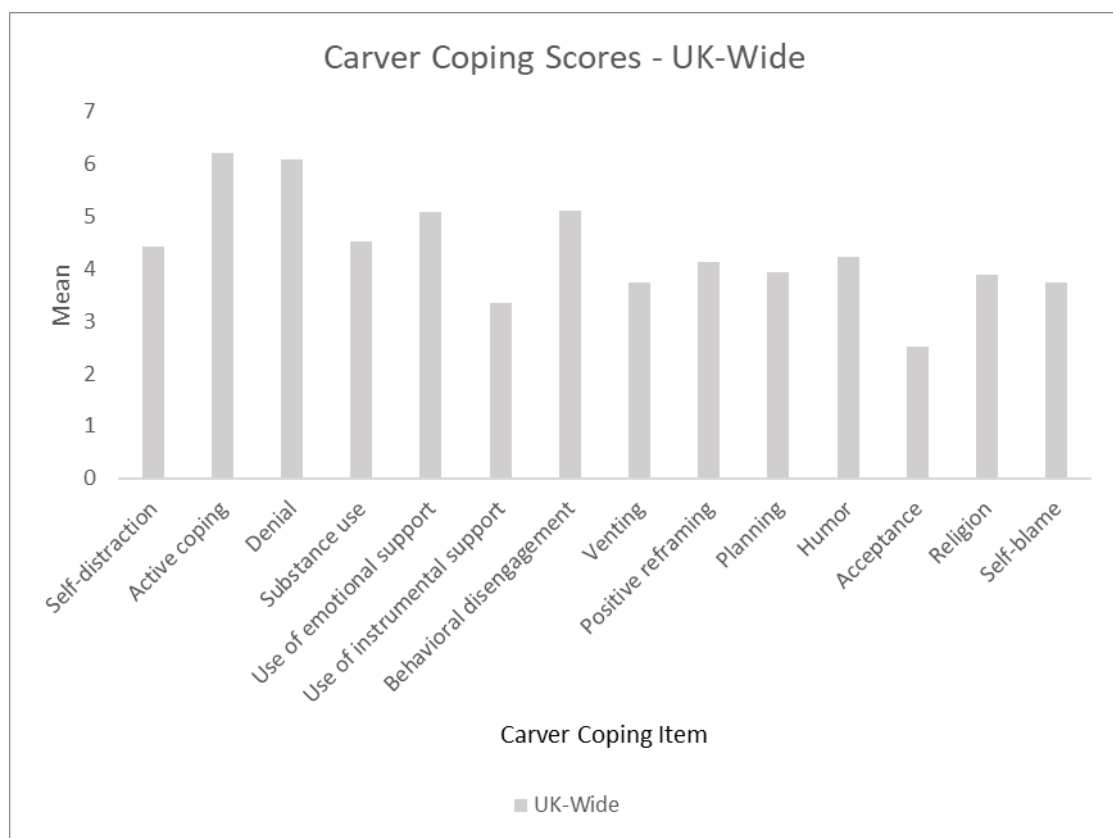Figure A6.1: UK-wide Carver Coping Scores

Table A6.1: Carver Coping Scores by Country

Carver Domain	UK-Wide	England	Scotland	Wales	Northern Ireland
Self-distraction	4.42	4.31	4.79	4.58	4.73
Active coping	6.21	6.24	6.61	6.38	6.30
Denial	6.10	6.13	6.26	6.41	6.06
Substance use	4.53	4.62	4.72	4.41	5.14
Use of emotional support	5.08	5.09	5.36	5.33	5.15
Use of instrumental support	3.36	3.41	3.42	3.60	3.26
Behavioural disengagement	5.12	5.21	5.08	5.40	5.15
Venting	3.75	3.76	3.97	3.84	3.71
Positive reframing	4.14	4.26	4.27	3.93	4.75
Planning	3.93	3.98	3.76	4.04	3.89
Humour	4.24	4.14	4.81	4.09	4.19
Acceptance	2.52	2.50	2.57	2.69	2.65
Religion	3.89	3.79	4.37	4.02	3.64
Self-blame	3.73	3.81	3.62	3.96	3.63

A6.2 Carver Coping Scores by Gender

There are significant gender differences in all but two of the Carver Coping domains. The two that did not show significant differences were Behavioural disengagement and Positive reframing. Females are more likely than females to use active coping, denial, substance use and use of emotional support than males.

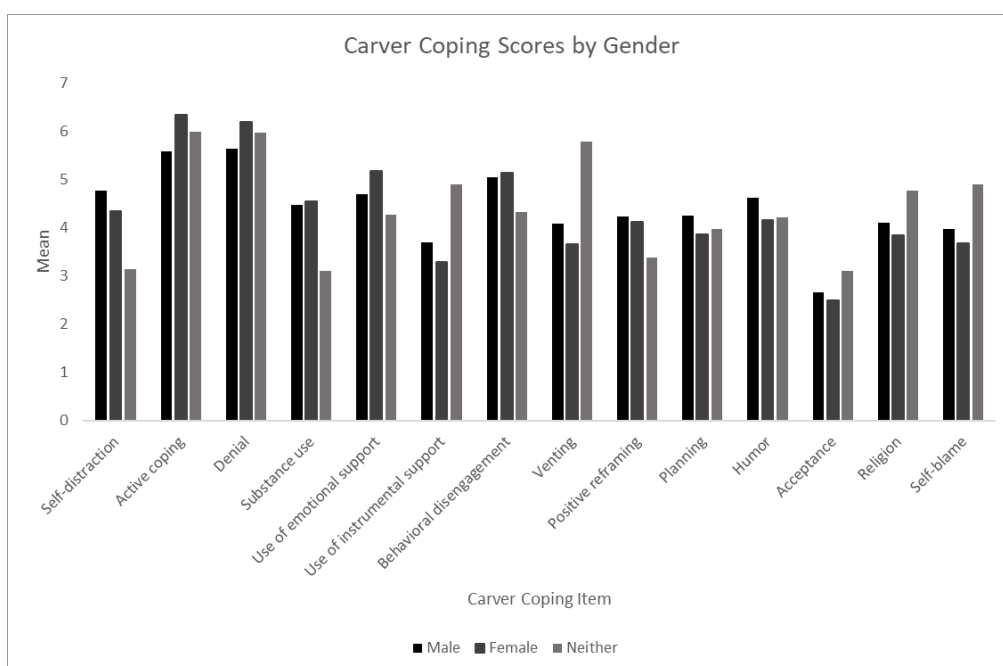Figure A6.2: Carver Coping Scores by Gender

Table A6.2: Carver Coping Scores by Gender

Carver Domain	Mean Carver Score		
	Male	**Female**	**Neither**
Self-distraction	4.77	4.35	3.14
Active coping	5.58	6.35	6.00
Denial	5.64	6.20	5.97
Substance use	4.47	4.55	3.11
Use of emotional support	4.70	5.17	4.27
Use of instrumental support	3.69	3.28	4.89
Behavioural disengagement	5.05	5.14	4.33
Venting	4.08	3.66	5.79
Positive reframing	4.22	4.13	3.38
Planning	4.25	3.86	3.98
Humour	4.62	4.16	4.21
Acceptance	2.65	2.49	3.09
Religion	4.10	3.83	4.76
Self-blame	3.97	3.67	4.90

A6.3 Carver Coping Scores by Age

There are significant differences across age groups all of the Carver Coping domains. Those aged 16-19 were more likely than any other age group to use self-distraction (4.77), instrumental support (3.99), positive reframing (5.11), humour (5.43), acceptance (3.10) and religion (5.10) as coping mechanisms.

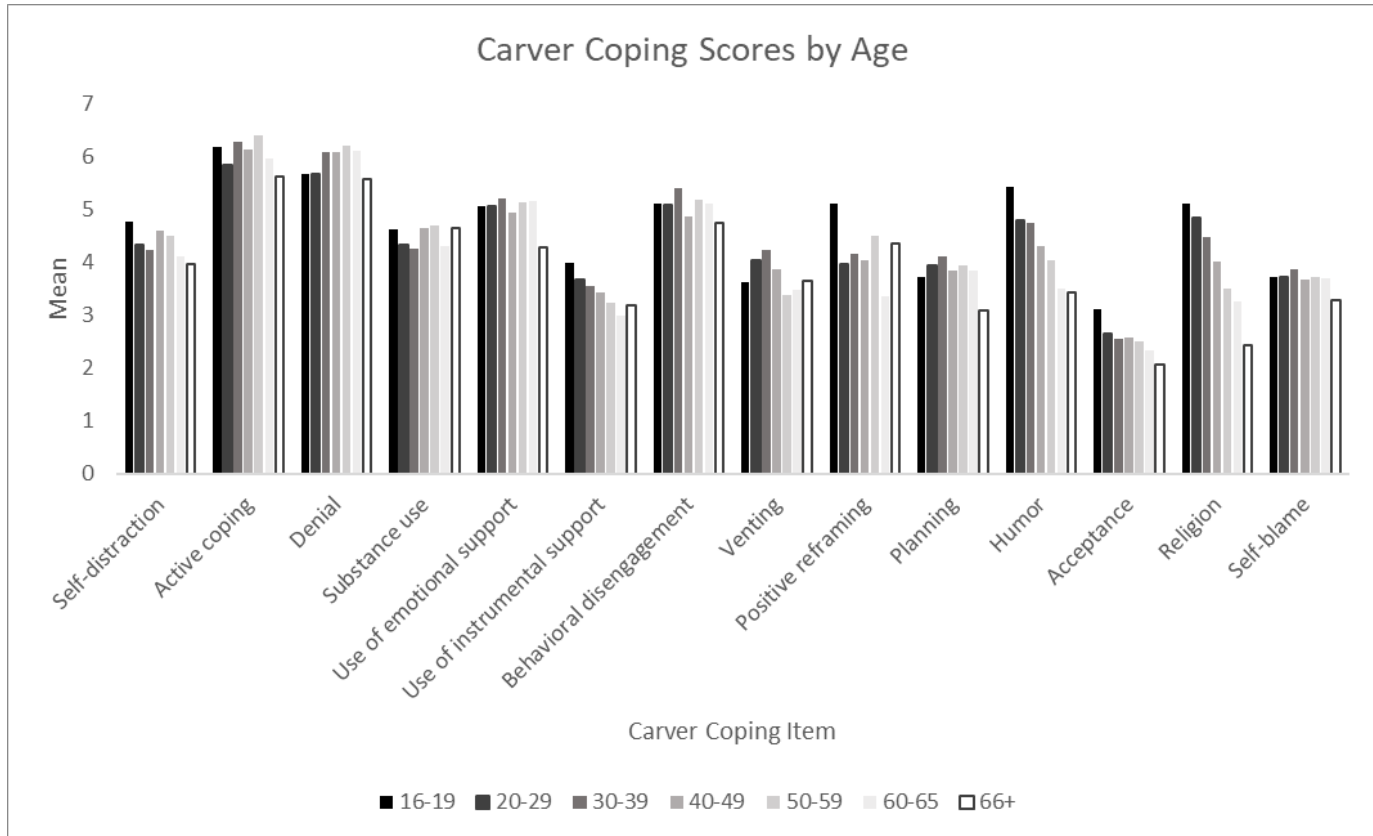Figure A6.3: Carver Coping scores by Age

Table A6.3: Carver Coping scores by Age

Carver Domain	Mean Carver Score						
	16-19	20-29	30-39	40-49	50-59	60-65	66+
Self-distraction	4.77	4.32	4.23	4.60	4.50	4.12	3.96
Active coping	6.17	5.85	6.27	6.13	6.40	5.97	5.62
Denial	5.67	5.66	6.09	6.08	6.21	6.10	5.57
Substance use	4.62	4.32	4.25	4.64	4.70	4.29	4.65
Use of emotional support	5.06	5.06	5.20	4.94	5.13	5.16	4.28
Use of instrumental support	3.99	3.68	3.55	3.44	3.23	2.99	3.18
Behavioural disengagement	5.11	5.09	5.39	4.87	5.19	5.10	4.75
Venting	3.62	4.03	4.24	3.87	3.39	3.48	3.64
Positive reframing	5.11	3.96	4.16	4.03	4.49	3.35	4.35
Planning	3.73	3.93	4.11	3.85	3.94	3.83	3.09
Humour	5.43	4.78	4.75	4.31	4.04	3.51	3.42
Acceptance	3.10	2.66	2.54	2.58	2.50	2.33	2.08
Religion	5.10	4.83	4.48	4.02	3.49	3.25	2.43
Self-blame	3.73	3.71	3.87	3.68	3.72	3.70	3.28

A6.4 Carver Coping Scores by Occupation

There are significant differences across occupations in all but three of the Carver Coping domains, these are Active coping; Use of emotional support and Acceptance. Nurses are most likely to use self-distraction (4.56), venting (4.00) and religion (4.06) and least likely to use Acceptance as a coping mechanism (2.52).

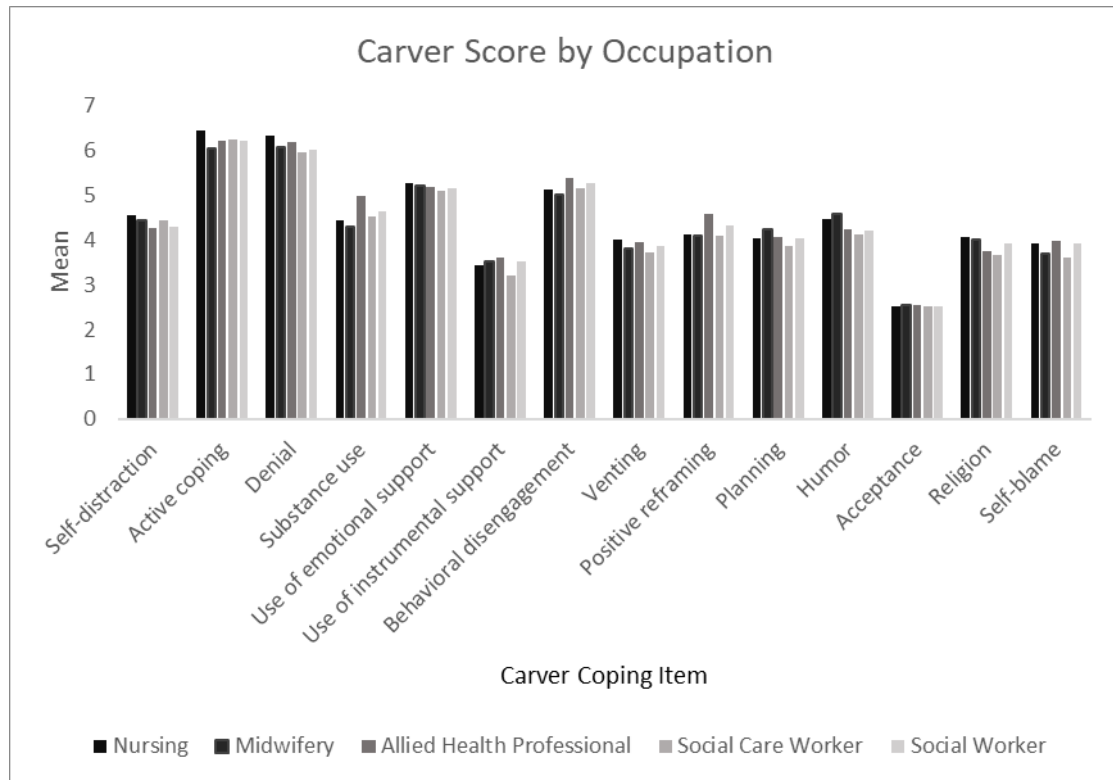Figure A6.4: Carver Coping Scores by Occupation

Table A6.4: Carver Coping Scores by Occupation

Carver Domain	Mean Carver Score				
	Nursing	Midwifery	Allied Health Professional	Social Care Worker	Social Worker
Self-distraction	4.56	4.42	4.27	4.45	4.29
Active coping	6.43	6.04	6.20	6.22	6.21
Denial	6.32	6.05	6.19	5.96	6.02
Substance use	4.44	4.30	4.98	4.53	4.62
Use of emotional support	5.25	5.22	5.17	5.09	5.16
Use of instrumental support	3.43	3.52	3.61	3.21	3.51
Behavioural disengagement	5.12	5.02	5.37	5.16	5.27
Venting	4.00	3.79	3.95	3.71	3.87
Positive reframing	4.13	4.10	4.56	4.10	4.31
Planning	4.04	4.23	4.06	3.86	4.03
Humour	4.47	4.58	4.22	4.11	4.21
Acceptance	2.52	2.55	2.54	2.52	2.53
Religion	4.06	4.00	3.74	3.65	3.91
Self-blame	3.92	3.69	3.98	3.61	3.93

Appendix 7: Clark Coping Scale – Tables and Charts

A7.1 Clark Coping Scores by Country

There are significant differences in three of the Clark Coping Scale domains across countries: Work to improve skills/efficiency; Recreation /relaxation; and Exercise. People in England were more likely to use were most likely to use recreation and relaxation (3.87). Those in Wales were most likely to work to improve skills/efficiency (4.56) and exercise (4.07).

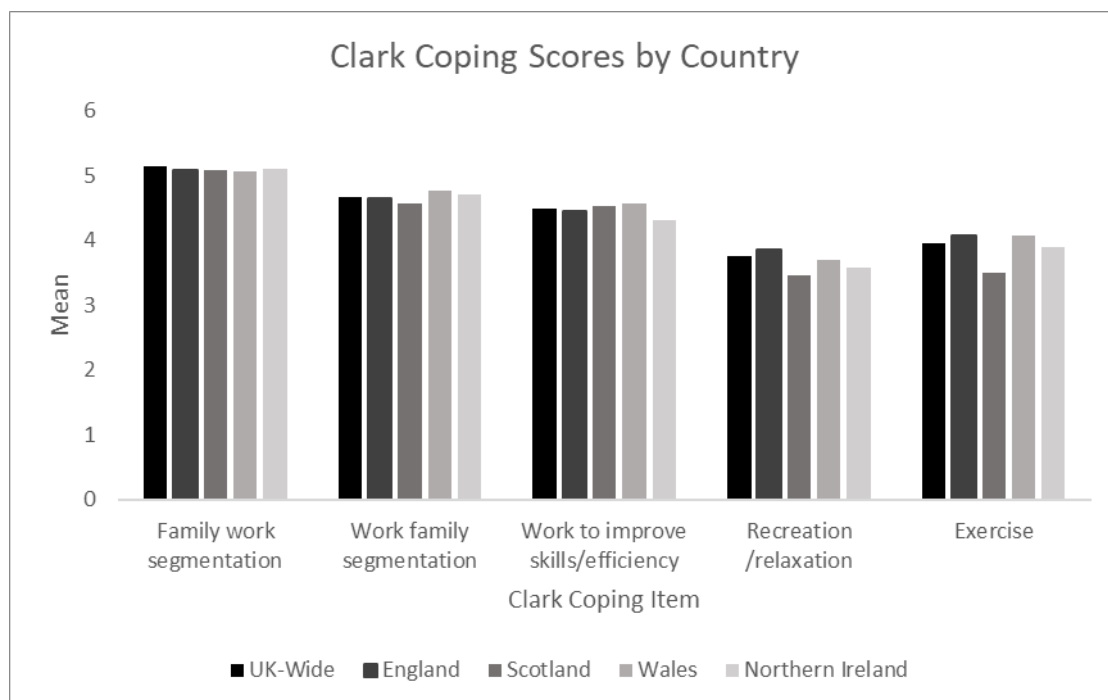Figure A7.1: Clark Coping Scores by Country

Table A7.1: Clark Coping Scores by Country

Clark Domain	Mean Clark Score				
	UK-Wide	England	Scotland	Wales	Northern Ireland
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
Work to improve skills/efficiency	4.48	4.46	4.53	4.56	4.31
Recreation /relaxation	3.75	3.87	3.47	3.70	3.57
Exercise	3.96	4.07	3.51	4.07	3.89

A7.2 Clark Coping Scores by Gender

There were significant differences in mean scores across all Clark Coping Domains by gender. Females were more likely than males to work to improve skills/efficiency (4.53), whilst males were more likely to cope using exercise (4.29).
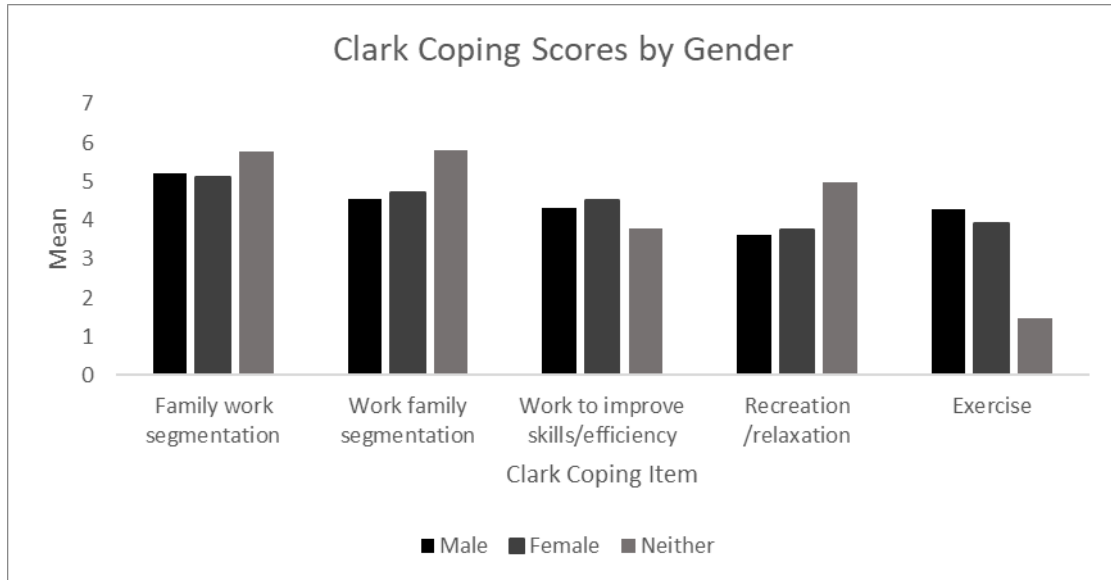
Figure A7.2: Clark Coping Scores by Gender

Table A7.2: Clark Coping Scores by Gender

Clark Domain	Mean Clark Score		
	Male	Female	Neither
Family work segmentation	5.22	5.12	5.77
Work family segmentation	4.55	4.70	5.81
Work to improve skills/efficiency	4.30	4.53	3.80
Recreation /relaxation	3.64	3.77	4.97
Exercise	4.29	3.90	1.47

A7.3 Clark Coping Scores by Age

There are significant differences across all Clark Coping domains between age groups. Those aged 60-65 were more likely than any other age group to use recreation/relaxation to cope, whilst younger people were more likely to work to improve skills or exercise.
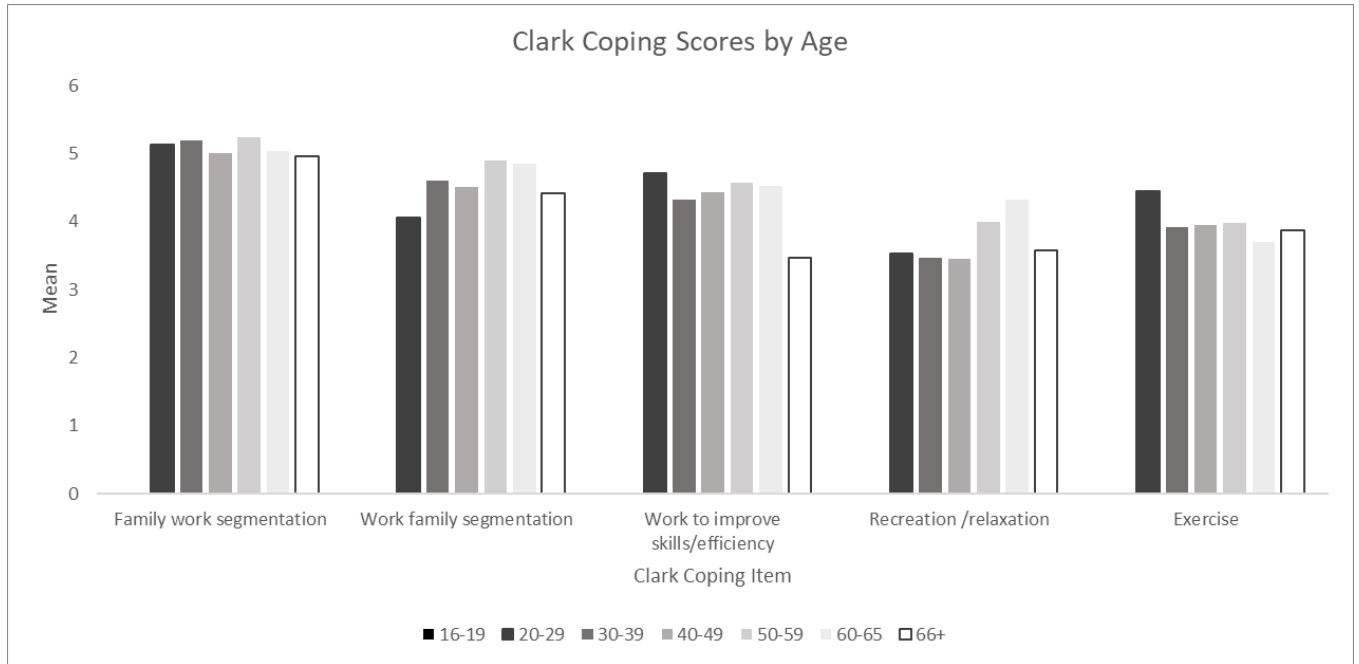
Figure A7.3: Clark Coping scores by Age

Table A7.3: Clark Coping Scores by Age

Clark Domain	Mean Clark Score						
	16-19	20-29	30-39	40-49	50-59	60-65	66+
Family work segmentation	-	5.14	5.19	5.01	5.24	5.03	4.96
Work family segmentation	-	4.06	4.61	4.52	4.91	4.86	4.42
Work to improve skills/efficiency	-	4.72	4.33	4.43	4.58	4.53	3.46
Recreation /relaxation	-	3.53	3.47	3.46	4.01	4.33	3.58
Exercise	-	4.45	3.93	3.96	3.98	3.71	3.88

A7.4 Clark Coping Scores by Occupation

There are significant differences in all of the Clark Coping Scale domains across occupations. Social Workers were more likely than any other occupation group to use recreation/relaxation (4.014) as a coping mechanism. Social Care workers tend to use work-family segmentation, whilst Allied Health Workers use exercise.
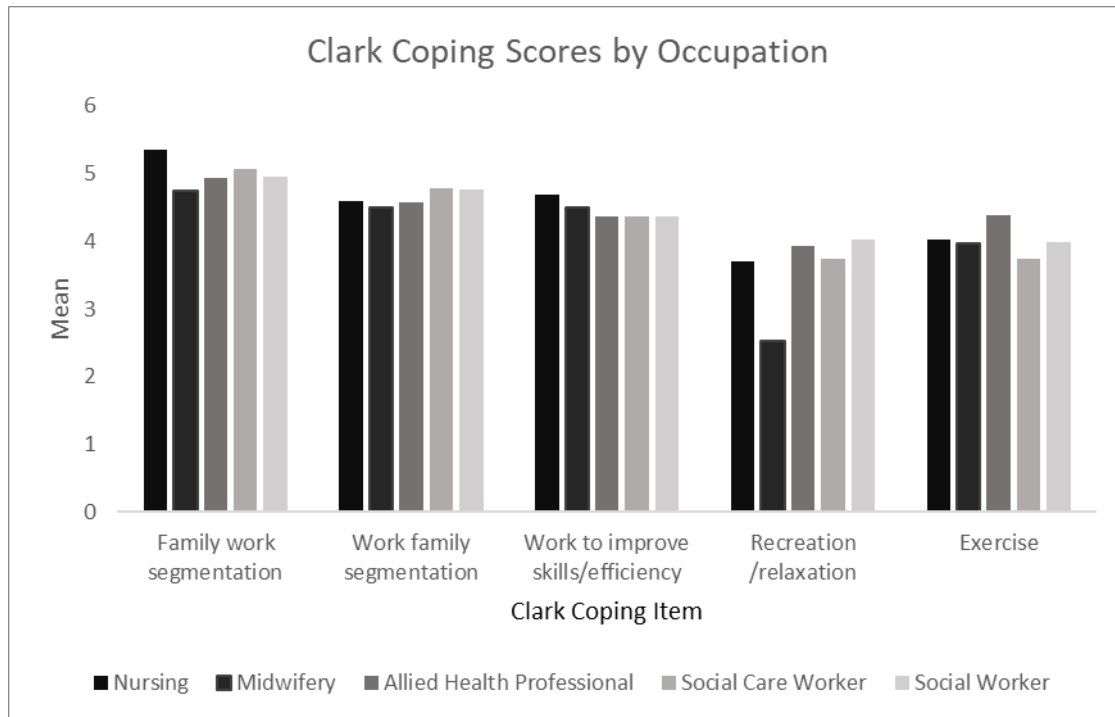
Figure A7.4: Clark Coping Scores by Occupation

Table A7.4: Clark Coping Scores by Occupation

Clark Domain	Mean Clark Score				
	Nursing	Midwifery	Allied Health Professional	Social Care Worker	Social Worker
Family work segmentation	5.36	4.74	4.93	5.06	4.96
Work family segmentation	4.59	4.50	4.58	4.78	4.77
Work to improve skills/efficiency	4.68	4.50	4.37	4.37	4.37
Recreation /relaxation	3.70	2.54	3.93	3.75	4.04
Exercise	4.04	3.97	4.39	3.75	4.00

Appendix 8: Multiple Regression Results

A8.1 Multiple Regression Model Predicting Wellbeing Score

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 SWEMHS scores as the outcome variable using the following variables as covariates:

- Age (dummy coded)
- Gender (dummy coded)
- Disability status
- Ethnic group (dummy coded)
- Country of work (dummy coded)
- Professional group (dummy coded)
- Number of sick days in previous 12 months (dummy coded)
- Carver Coping sub-scales
- Clark Coping sub-scales

    plus
- How prepared employees felt about their redeployment role (dummy coded).

The results indicated that the model explained 35% of the variance (adj. R^2=.34, $F_{(34, 2356)}$= 36.5, $p<0.001$). It was found that the following significantly predicted total wellbeing score (SWEMWBS):

1. No overall differences were observed in SWEMHS wellbeing scores across occupational groups, age, ethnic groups or disability status.
2. Respondents from Northern Ireland reported higher Wellbeing scores on average than those from England (β=0.05, p=.021).

Coping Strategies

3. Carver Active Coping scale - Those who reported higher Active Coping scores reported significantly higher wellbeing scores (β = 0.19, $p<0.001$).
4. Carver Disengagement scale - Those who reported higher Disengagement scores reported significantly lower Wellbeing scores (β = -0.34, $p<0.001$).
5. Carver Emotional Support - Higher scores on use of Emotional Support were associated with higher wellbeing scores (β = 0.15, $p<0.001$).
6. Carver Substance Abuse - Higher Substance Use as a form of coping was linked to lower Wellbeing scores (β = -0.08, $p<0.001$).
7. Clark Relaxation - Those who reported higher scores on use of Relaxation tended to report significantly higher Wellbeing scores (β = 0.08, $p<0.001$).
8. Clark Exercise - Those who reported higher scores on use of Exercise likewise tended to report higher Wellbeing scores (β = 0.07, $p<0.001$).

Note: Not all employees were redeployed. When added to the model, reported feelings of preparedness for re-deployment did not significantly explain variation in Mental Wellbeing scores.

A8.2 Multiple Regression Model Predicting Quality of Working Life Score

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 WRQoL scores as the outcome variable using the following variables as covariates:

- Age (dummy coded)
- Gender (dummy coded)
- Disability status
- Ethnic group (dummy coded)
- Country of work (dummy coded)
- Professional group (dummy coded)
- Number of sick days in previous 12 months (dummy coded)
- Carver Coping sub-scales
- Clark Coping sub-scales
  plus
- How prepared employees felt about their redeployment role (dummy coded).

The results indicated that the model explained 26% of the variance (adj. R^2 =.25, $F_{(33, 2315)}$= 24.07, p<0.001).

1. No overall differences were observed in WRQoL scores when compared by age, gender, occupational group or ethnicity.
2. Respondents from Northern Ireland (β= -0.14, p<.001) and Scotland (β= -0.06, p=.003) reported lower average WRQoL scores than those from England.
3. Those with a disability tended to report lower scores (β= -0.06, p<.001).
4. The number of absences due to sickness (past 12 months) were associated with lower WRQoL scores.

Coping Strategies

5. Carver Active Coping scale - Those who reported higher Active Coping scores reported significantly higher WRQoL scores (β = 0.10, p<0.001).
6. Carver Disengagement scale - Those who reported higher Disengagement scores reported significantly lower WRQoL scores (β = -0.31, p<0.001).
7. Carver Emotional Support - Higher scores on use of Emotional Support were associated with higher WRQoL scores (β = 0.14, p<0.001).
8. Clark Relaxation/recreation - Those who reported higher scores on use of Relaxation/recreation tended to report higher WRQoL scores on average (β = 0.15, p<0.001).
9. Work Family Segmentation – Higher scores on Work Family Segmentation were associated with higher WRQoL scores (β = 0.13, p<.001).
10. Family Work Segmentation – Higher scores on Family Work Segmentation were associated with lower WRQoL scores (β = -0.08, p<.001).

Note: Not all employees experienced re-deployment. Those who were re-deployed were asked about how prepared they felt for redeployment. Those respondents who felt prepared

showed higher WRQoL scores than those who felt unprepared (β = -0.29, p<.001) and those who felt unsure (β = -0.14, p=.027).