

## COVID-19 and the Wellbeing of the Adult Social Care Workforce: Evidence from the UK

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Changing more than a name

### *About the research*

The [Retention and Sustainability of Social Care Workforce \(RESSCW\)](#) project is a collaboration between the University of Kent, University College London, The Business School (formerly Cass) at City, University of London, and Skills for Care. It aims to help social care providers, commissioners, regulators and policy-makers understand the specific organisational and individual drivers of staff retention in the social care sector. It runs between 2019 and 2022.

RESSCW is funded by the Health Foundation's Efficiency Research Programme (award reference number: 1325587). The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. The views expressed are entirely those of the authors.

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## Executive summary

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The coronavirus pandemic has badly hit the social care sector in Britain. The impact on the health of care recipients, and the operation of care settings has been well documented. However, the experience of the social care workforce has been less fully explored. This report presents and discusses the findings from a 'pulse' survey of care workers undertaken in July/August 2020. We show that many care workers experienced increased workloads, reduced feelings of safety at work, and increased levels of stress, some of which significantly differed by care setting. However, many remained committed to the sector, despite the challenges. The results highlight the need for the development of tailored practical strategies and guidance to support care workers' wellbeing at work. An adequate level of supply of relevant equipment and testing along with relevant training remain crucial for both the workforce and service quality. While the COVID-19 pandemic has exacerbated the effect of long-standing cracks in the social care sector, an urgent response is required to maintain the ability of the sector and its workforce to meet the escalating demands for social care.

## Introduction

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The coronavirus pandemic has badly hit the social care sector in Britain. From March to June 2020, 29.3% of deaths of care home residents involved COVID-19, representing a total of 19,394 cases.<sup>1</sup> It is estimated that more than half (56%) of care homes providing dementia care or care for older adults aged 65 years and over had at least one confirmed case of COVID-19 among staff or residents.<sup>2</sup> Domiciliary care services also registered high excess deaths (2020: 6,523 deaths of domiciliary care recipients in England from April to June; the 3-year average for the same period: 2,895 deaths), with 12.6% of all deaths (819) involving COVID-19.<sup>3</sup>

The social care workforce in the UK was stretched to the limit even before the COVID-19 pandemic. The sector has been facing considerable challenges in recruiting and retaining staff. A recent report by Skills for Care indicates that the sector faces 112,000 unfilled vacancies in any given day.<sup>4</sup> These shortages are attributed to an array of factors including the increasingly fragmented structure of the sector, low pay and insecure employment, among others. These factors are linked to chronic underfunding of the sector<sup>5</sup> as well as lack of career development opportunities for the workforce. Care work is emotionally involving, and the profile of workers highlights its gender skew and the reliance on migrant workers.

The impact of the COVID-19 pandemic on health and social care is unprecedented. Its impact on hospitals and the NHS more broadly has been covered extensively whereas the social care sector has received far less attention. As a result, early on in the pandemic many of the problems faced by care homes went unreported. These problems included for example, a higher number of suspected COVID-19 related deaths in many care homes; hospitals refusing admissions from care homes; the discharge of hospital patients who may have had COVID-19 to care homes or domiciliary care; a lack of testing in care homes; a lack of sufficient supplies of Personal Protective Equipment (PPE); and a failure to recognise that the use of agency staff was spreading the virus between care homes. Until now, there is still a lack of consistent guidance regarding isolating suspected cases and the impact of restrictions on the quality of life of vulnerable people, especially those who live in care homes or rely on receiving regular care at home. A recent analysis by the Health Foundation indicates that the policy response specific to the impact of the pandemic on the social care sector was fragmented and may have come 'too late'.<sup>6</sup> In particular, there has been a considerable gap in understanding the

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<sup>1</sup><https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deaths-involving-covid-19-in-the-care-sector-in-england-and-wales/deaths-occurring-up-to-12-june-2020-and-registered-up-to-20-june-2020-provisional#deaths-data>

<sup>2</sup><https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/impact-of-coronavirus-in-care-homes-in-england-and-wales/26-may-to-19-june-2020>

<sup>3</sup><https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deaths-involving-covid-19-in-the-care-sector-in-england-and-wales/deaths-occurring-up-to-12-june-2020-and-registered-up-to-20-june-2020-provisional#deaths-data>

<sup>4</sup><https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>

<sup>5</sup><https://committees.parliament.uk/publications/3120/documents/29193/default/>

<sup>6</sup><https://www.health.org.uk/publications/reports/adult-social-care-and-covid-19-assessing-the-policy-response-in-england>

implications for the social care workforce, especially in relation to sustainability and retention as well as the wellbeing of care workers themselves.

## About this study and its aims

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This report is part of a more extensive study on the Retention and Sustainability of the Social Care Workforce (RESSCW), funded by the Health Foundation. The original research started in 2019 before the onset of COVID-19.<sup>7</sup> During the course of the study it became clear that we needed to pay particular attention to the impact of COVID-19 on various workforce outcomes. This study links to the overall aims of the RESSCW project with a specific focus on the effects of COVID-19 on social care workforce retention and sustainability. Specifically, we aim to address the following research questions:

1. What are the implications of COVID-19 for care workers' general wellbeing, working conditions, and desire to stay or leave the employer and/or sector?
2. Do any of these implications differ by specific individual and work characteristics?
3. Do any of these implications differ by care settings, especially between domiciliary and residential care?

This study consists of three interlinked elements. A timely 'pulse' online survey of the social care workforce and two rounds of a larger longitudinal care workers' survey to be undertaken in 2021. This report presents and discusses the findings from the 'pulse' online survey, which was completed by 296 frontline care workers from across the UK between 3 July and 10 August 2020. For more details on the study design and achieved sample, see Appendix A. Additionally, the 'pulse' survey will inform a set of telephone interviews with stakeholders, and the interviews will contribute to the development of the longitudinal care workers' survey.

## Findings

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### The impact of COVID-19 on frontline staff self-isolation, working hours and pay

We were keen to understand the impact of the pandemic on care workers' working hours and level of pay. The results show that from a total of 296 respondents, 165 (56%) increased their working hours, and 52 (18%) had to self-isolate (see Figure 1). While there were differences in the level of self-isolation by ethnic background, perhaps reflecting the vulnerability of BAME workers, any further conclusions should be tempered given the small sample size for some groups.



*Have been working 55 hours per week with rarely a day off since March.*

*Care worker, home care for older people*

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<sup>7</sup>For further information see <https://www.pssru.ac.uk/resscw/frontpage/>.



*I came out of isolation as how could I ask my staff to be at risk if I wasn't battling the risk myself. Care work needs so much more recognition, so much more pride and a lot less negative press.*

*Manager, home care for older people*

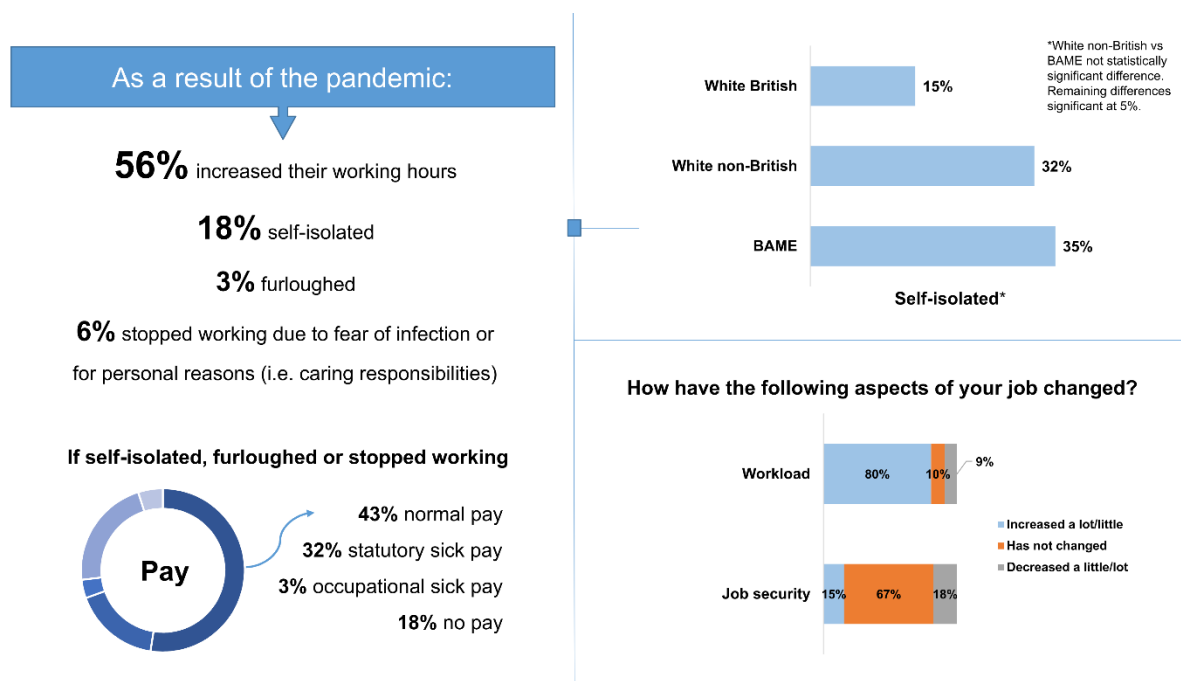


Figure 1: Impact of COVID-19 on work characteristics

A sixth of those who needed to self-isolate, were furloughed or stopped working did not receive *any* pay.<sup>8</sup> The implications of having to self-isolate with no or limited pay (such as statutory sick pay) were considerable for workers who are typically paid minimum wages. Despite the financial instability for some workers, almost one in five (18%) felt that their job security (i.e. job is secure and unlikely to be made redundant) had declined since the COVID-19 outbreak.

“

*I was off work sick for five weeks in total, ....., the most I've been off work in my whole career .... I only received SSP! As a carer on the national living wage, it will take quite a while to recover from 5 weeks of SSP!*

*Care worker, care home for older people*

*Support Workers cannot access occupational sick pay, so if need to isolate will receive SSP - approx. £96 per week, which is not a living income & represents a national threat to public health as staff cannot afford to isolate.*

*Manager, home care for older people*

<sup>8</sup><https://www.employment-studies.co.uk/resource/potential-impact-covid-19-government-policy-adult-social-care-workforce>

*I was off 5 weeks with COVID symptoms but felt under pressure to go back too soon re money worries on ssp.*

*Care worker, home care for older people*

*I stopped working because if my partner got it from me, we would have financial difficulties.*

*Domiciliary care, older people*

Workers in residential care were significantly more likely than those in domiciliary care (including supported living) to have increased their working hours since the start of the pandemic. This may be linked to the fact that some home care workers stopped working due to the fear of infection or were furloughed.<sup>9</sup> Indeed, 7 out of 10 respondents indicating that they stopped working due to the fear of infection were home care workers. Similarly, 8 out of 10 of those reporting being furloughed were home care workers.

While just over half of the respondents said they increased their *working hours*, 81% (239 respondents) indicated increased *workload* since the onset of COVID-19.<sup>10</sup> This difference might be attributed to staff covering for other workers who had to self-isolate. Furthermore, years worked in social care was a significant determinant of increased workload and working hours, with less experienced workers (under two years) less likely to report such changes (see Appendix B, Table B1). This may also be linked to more experienced care workers stepping in to support or train<sup>11</sup> volunteers or workers who are new to the sector. In addition, results show that a large majority (71%) of staff reported their work-life balance decreased since the onset of the pandemic.

## Level of preparedness for COVID-19

The survey results indicate that one in five care workers perceived to have not received adequate COVID-19 training while one in six did not receive clear guidance nor had necessary PPE to do their job safely and effectively (see Figure 2). Nearly half of the respondents (44%) felt less safe at work, with the lack of clear guidance being a significant determinant of this reduced perceived job safety since the onset of the pandemic (see Appendix B, Table B1). There were differences in receipt of COVID-related training amongst ethnic groups. However, we should be cautious of the small sample size for some groups in this case. Overall, despite the lack of relevant training, guidance and equipment, 117 respondents (40%) felt that support from their managers and co-workers increased a lot/little since the onset of COVID-19, perhaps mediated by high infection rates. Indeed, increased support was found to be marginally significantly associated with higher number of reported COVID-19 cases at a local level (see Appendix B, Table B1).

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<sup>9</sup>We acknowledge that for example, the fear of infection and clients' families stepping in to provide care might have contributed to some home care workers being furloughed or having to stop working without pay. However, the survey did not collect such detailed information, thus these reasons can only be speculative.

<sup>10</sup>Only 6% of those who reported increased working hours did not further report increased workload since the onset of COVID-19.

<sup>11</sup>Several volunteers joined the health and social care sectors through the volunteering drive initiated by the government. <https://www.gov.uk/government/news/government-outlines-further-plans-to-support-health-and-social-care-system-in-fight-against-covid-19>

Furthermore, access to timely tests was an issue, where 18 respondents (6%) said they had experienced COVID-19 symptoms but were not able to have a test (see Figure 2). The lack of relevant testing was only marginally significantly associated with reduced job safety as a result of the pandemic (see Appendix B, Table B1). Care workers responding to our survey felt that the government had failed them, particularly concerning making testing available and accessible. The latter was especially evident among live-in carers and home care workers.

“ At no point was any (policy/guidance) reference made to live-in carers/community carers in the private sector.

*Self-employed live-in carer, older people*

*I feel completely let down by our government and governing bodies such as CQC/NICE there was no clear guidance we are all in the dark doing the best we can day by day.*

*Manager, care home for older people*

*I have heard a lot about home staff being regularly tested, but neither myself nor my colleagues have been offered any testing to date.*

*Care worker, home care for older people*

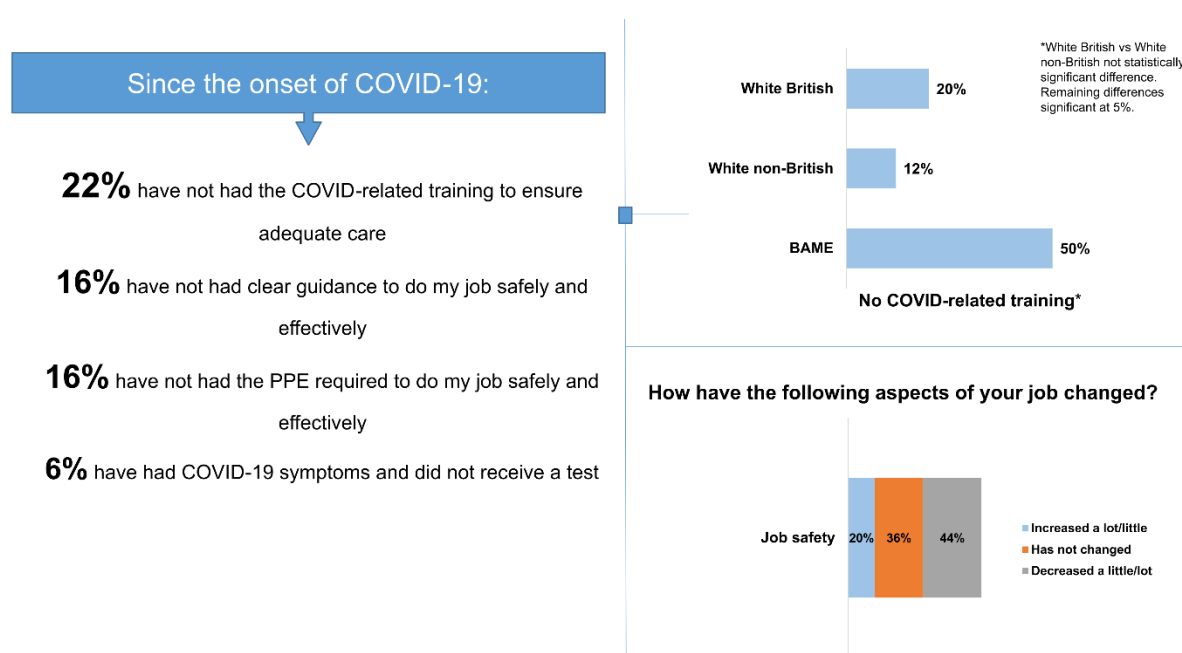


Figure 2: COVID-19 training, guidance, access to PPE and job safety

## Impact of COVID-19 on workers' health and wellbeing

The findings relating to increased workload and reduced feelings of safety at work appear to have had a clear impact on workers' general health. Nearly half of the respondents (47%) indicated their general-health had worsened since the onset of COVID-19 (see Figure 3). When distinguishing between care settings, a significantly larger percentage of residential

care workers (53%) reported worsened health than those in domiciliary care or other settings (41%).

“ *The level of stress has increased dramatically. Securing adequate supplies of PPE and the costs involved has been difficult to cope with.*

*Manager, home care for older people*

*This [the pandemic] has been and will continue to be a very worrying and stressful time for everyone working in the care sector, especially care home settings.*

*Manager, care home for older people*

*I love my job, but I am physically and mentally drained, it has made me feel like my life is running away from me. I'm not living; I'm just surviving.*

*Care worker, care home with nursing for older people*

The implications of COVID-19 on care workers' wellbeing appear to be significant, with 177 respondents (60%) indicating that the amount of time their jobs made them feel depressed, gloomy or miserable had increased since COVID-19 struck. An even larger proportion (81%) highlighted that the amount of time their jobs made them feel tense, uneasy or worried grew over the same period (see Figure 3). Nine in ten (137 out of 154) respondents (89%) working in residential care reported increased feelings of tension, uneasiness and worry compared to 104 out of 142 (73%) of those working in domiciliary care or other settings. The increased feelings of tension and depression were significantly higher for those aged 25 to 34 than those in their late forties/early fifties (see Appendix B, Table B1). This result might be related to younger care workers having less experience dealing with similar stressful situations. Over half of the respondents (67%) reported that feelings of calmness and contentedness in their job had decreased since the onset of COVID-19. In comparison, 55% indicated that their enthusiasm and optimism had been reduced since the beginning of the pandemic.

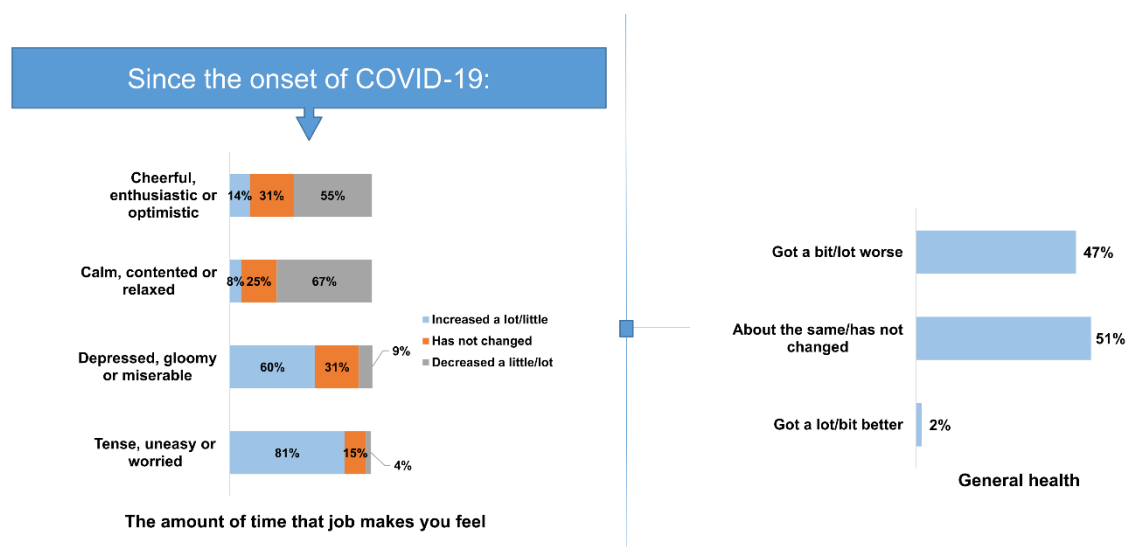


Figure 3: Change in job feelings and general health since the onset of COVID-19

Respondents have explained further in their free-text answers some of the possible sources of worries and anxiety. Issues related to securing adequate supplies of PPE, the impact of lockdown on users' and own health as well as public attitudes were all factors mentioned by participants.



*So yes, I've had many, many worries and sleeplessness nights, and I fear for the future but never have I felt more proud to do what I do.*

*Manager, care home without nursing for older people*

*Externally I've felt very undervalued and unappreciated. Bad press hasn't helped. Little or no thanks from the families of the people we support too.*

*Support worker, care home for adults with learning disabilities*

*I feel that social care is viewed as the lowest of the low by the majority of people and the government, I worked directly with COVID-19 patients but did not get any thanks it was and still is all about rewards for NHS workers.*

*Manager, care home for older people*

## **Desire to remain in current job and the social care sector**

The experience of care workers during COVID-19 has been generally on the negative side, with two-fifths (42%) indicating being a little or a lot less satisfied, and a third (31%) indicating that their desire to remain working in the social care sector has decreased a little or a lot. The feelings of being neglected by various governmental bodies, increased workload, lack of PPE, among others, have contributed to these aspects. Indeed, for example, 84 out of 124 respondents (68%) with reduced job satisfaction also reported that they felt less safe at work. In contrast, 59 (48%) said that they received less support from their managers and/or colleagues since the onset of the pandemic.



*I have been with the same employer for 15 years managing a domiciliary care service for a charity, previously with a good level of job satisfaction. Since the pandemic began, job satisfaction has reduced hugely. We are dictated in our working methods by the government, treated as poor relations to the NHS, scrambling to find PPE.*

*Manager, home care for older people*

*I moved to bank staff when the schools closed to homeschooling my children. I was scared, and no one knows how we are going to deal with the COVID-19 in my care home. There was a lack of communication and uncertainty! I felt not safe, and I will be protected by my company. That is why I just removed myself for the nursing home I worked for two years; only I kept the less working job with less risk to get infected by the virus.*

*Care worker, care home for older people*

*Very little support from management throughout the pandemic, no change in workload/expectations/timeframes despite the additional challenges personally and professionally.*

Nevertheless, 67 respondents (23%) indicated their job satisfaction (main job) has increased while 134 (45%) said their feeling of pride in telling people what work they do had increased since the onset of COVID-19 (see Figure 4). Further, 149 respondents (50%) did not desire to leave their current employer. These feelings may have stemmed from a sense of public responsibility among care workers during the pandemic.

Half of the respondents felt that the quality of care they were providing had not changed since the onset of COVID-19, and 39% thought that the quality of care they were providing had increased. There were no significant differences in quality of care provided by care setting. Just over half (54%) of those reporting that they offered higher quality of care, received more support from their managers and/or colleagues despite the increased feeling of being less safe at work since the onset of the pandemic.

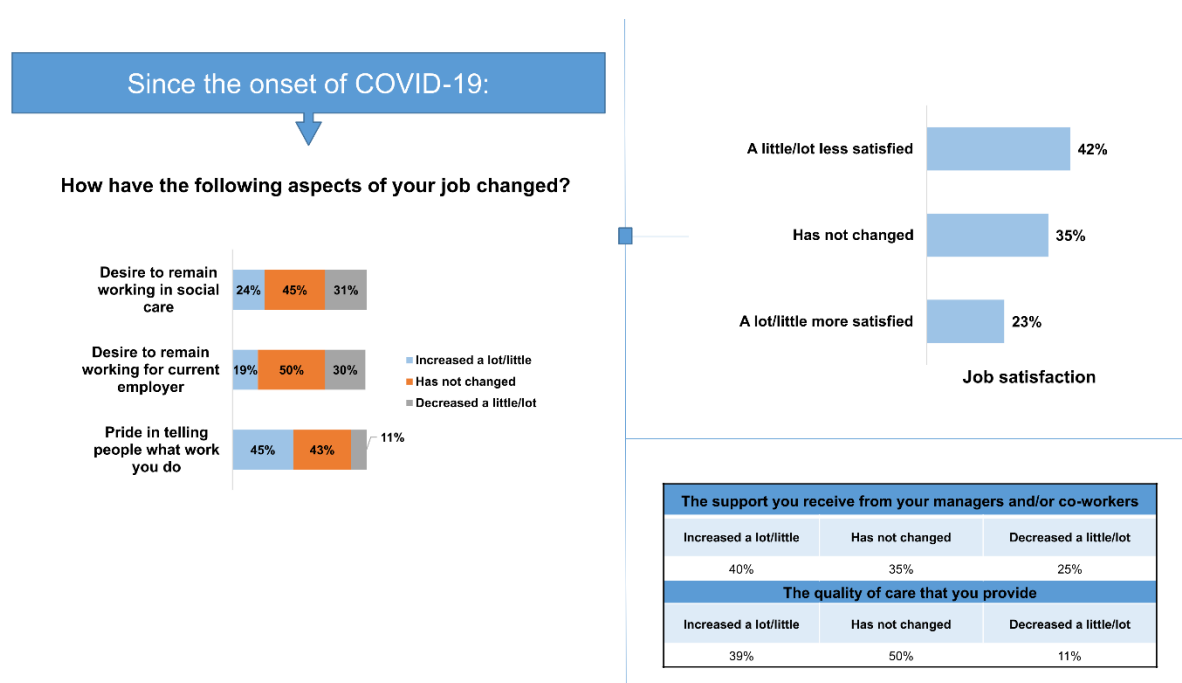


Figure 4: Job satisfaction job aspects since the onset of COVID-19

## Discussion

The analysis of this survey points to many important issues that require immediate policy attention. The evidence of increased workload, stress and feelings of being unsafe at work calls for practical strategies and guidance to support care workers' wellbeing at work. It is notable that while most care workers responding to this survey felt undervalued and neglected, many remain committed to the sector.

It is crucial, for both the workforce and service quality, to ensure an adequate level of supply of PPE and testing along with necessary training related to effective use of equipment, infection control and social distancing. The findings relating to the adverse experience observed among care workers from ethnic minorities require further investigation of the potential reasons for such discrepancies. The results further show that those in residential

care were more likely to report increased working hours/workload and were more likely to report worsened health and increased feelings of tension, uneasiness and worry. These differences suggest the need for developing support mechanisms that are tailored to different groups of workers.

The COVID-19 pandemic has exacerbated the effect of long-standing cracks in the social care sector. The situation requires an urgent response to maintain the ability of the sector and its workforce to meet the escalating demands for social care. Any policy or practical support mechanisms need to acknowledge the significant implications on a workforce already suffering from long-standing recruitment and retention challenges. The impact of COVID-19 on the way care work is delivered and organised necessitates a reassessment of potential mechanisms meant to protect care workers, service users and their families. These would require both adequate funding as well as a more connected approach across both the health and social care sectors.

### Limitations of the 'pulse' survey

While the 'pulse' survey provides timely insights into the care workers' perspectives of the impact of the COVID-19 crisis, the short time frame and the lack of a sampling frame (e.g. national register of all care workers) limit the ability to generate a representative sample (or even a proxy representative sample). The achieved survey sample was over-represented by frontline care workers who have been in the care sector for a relatively long period of time, with workers from minority and non-British ethnic backgrounds under-represented when compared to the national workforce. Furthermore, the respondents to the survey were recruited mainly through social media, capturing those being active on those platforms, which might have further contributed to the under-representation of care workers from minority and non-British ethnic groups.

### Next steps

As part of our research on the implications of COVID-19 for the social care workforce, we will conduct qualitative interviews with different stakeholders and launch two rounds of a more extensive longitudinal survey of the social care workforce in 2021.

# Appendix A

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## About the 'pulse' survey

### Rationale and aims

What was missing from all the policy guidance and media attention during the COVID-19 pandemic was a focus on the impact of this dramatic event on the care workers' wellbeing and ability to perform their work despite conflicting advice, and a high risk of infection to themselves and their families. To understand some of these implications and to present the perspectives of frontline workers themselves, we designed a 'pulse' survey of care workers.

The 'pulse' survey aimed to capture the perceived, and timely, subjective and objective implications of the COVID-19 crisis on care workers' turnover, retention, working conditions and ability to provide quality care across different social care settings.

### Design

The survey was designed by the RESSCW research team with input from the project's steering group members and the Health Foundation. The aim was for a short questionnaire to be completed within 20 minutes and included a small set of questions with pre-coded responses together with some free-text options. The survey included questions on income loss, health and safety at work, job security, changing working conditions and the perceived impact of COVID-19 on the workers' general health and wellbeing and their ability to perform their job safely. The survey was piloted with five individuals working in the sector in June 2020. Based on the pilot and feedback, we changed some of the questions' wording and order. The survey was implemented in Qualtrics and optimised for use on mobile devices (smartphones and tablets).

### Recruitment

In the absence of a care worker register and because many workers might be working in different settings simultaneously, it was not possible to target groups of workers by specific settings. Instead, we maximised the coverage of the survey by working in partnership with the project's steering group members, who agreed to distribute a link to the survey to their membership groups. Furthermore, we approached existing formal and informal groups of care workers via social media (e.g. Facebook groups, Twitter), and individuals who have previously engaged in research with the RESSCW team.

The survey ran between 3 July and 10 August 2020. We anticipated the survey to return between 200-300 responses. The survey was completed by 296 frontline care workers from across the UK.

### Analysis

We conducted an initial descriptive statistical analysis to understand the key characteristics of the sample and associations with various outcomes. We further linked the survey data, using the recorded latitude and longitude of respondents, to local COVID-19 total cases and



deaths reported (to 3 October 2020)<sup>12</sup> to account for the intensity of any COVID-19 effect in different localities.

In the second stage of analysis, we conducted several robust regressions, accounting for the presence of outliers in the sample, focusing on the following outcomes:

1. Desire to quit current job;
2. Desire to leave the care sector;
3. Changes in perceived workers' workload since the onset of the pandemic;
4. Changes in perceived workers' health and wellbeing since the onset of the pandemic;
5. Level of preparedness (i.e. COVID-19-related training, equipment and testing).

We examined these outcomes controlling for different personal (e.g. age, gender, ethnicity, nationality) and job-related characteristics including work setting (residential versus domiciliary care), care sector (e.g. local authority, private, agency), job role (all hands-on or mostly care work versus some or no care work), number of years working in the social care sector and contract permanency (main job). We also accounted for local COVID-19 total cases and deaths as well as any regional variation.<sup>13</sup>

## Ethics

We applied for and received amended ethical approval to the existing project ethics application to the University of Kent School of Social Policy, Sociology and Social Research SRC Ethics Committee [SRCEA id 240].

## Achieved sample

The survey achieved a total sample of 296 respondents, the majority of whom were female (92%) and white-British (85%). Over half of the respondents were between the ages of 35 and 54 years old. The largest response was from the South of England (24%), closely followed by the Midlands (22%).

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<sup>12</sup><https://www.bbc.co.uk/news/uk-51768274>

<sup>13</sup>Missing data was limited to less than ten cases and replaced with the average to retain the full sample. The only exception was the geographic location of respondents, with 13 missing cases, which was replaced randomly.

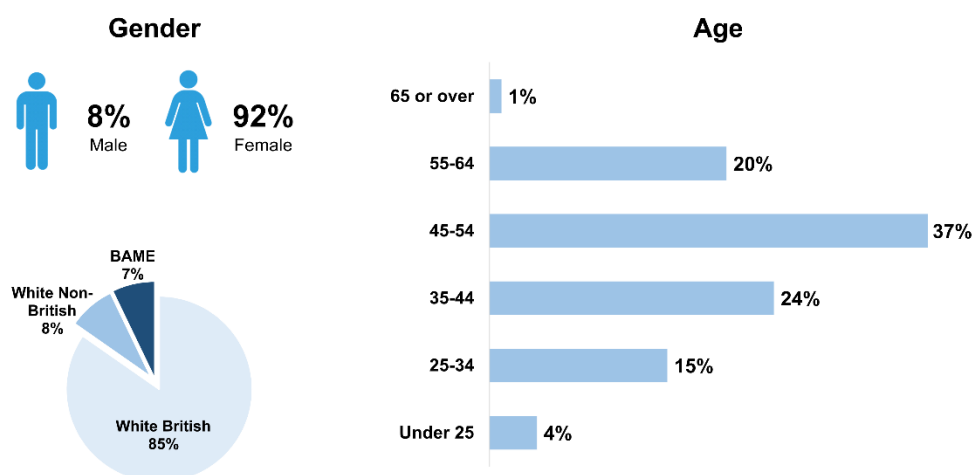


Figure A1: Respondents profile<sup>14</sup>

We captured the views of an experienced group of care workers who, on average, have been working in social care in the UK for six to ten years, with only 2% joining the sector since the onset of COVID-19. Nearly three-quarters of them had guaranteed-hours contracts (temporary or permanent) and over half worked in the private sector. Respondents also included self-employed care workers (9%) who received little acknowledgement and support during the pandemic.

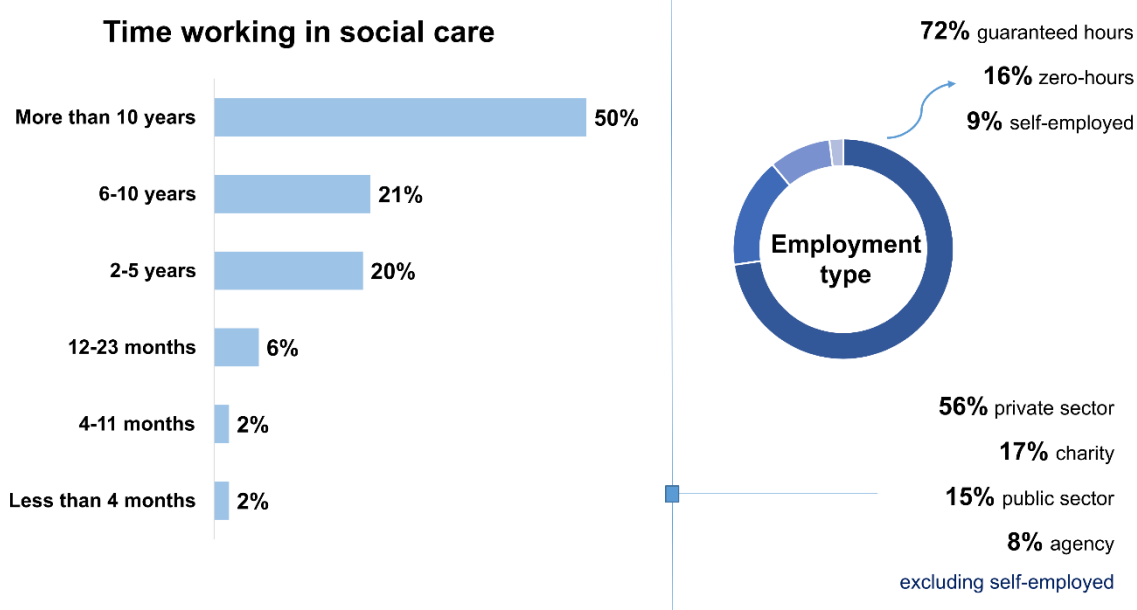
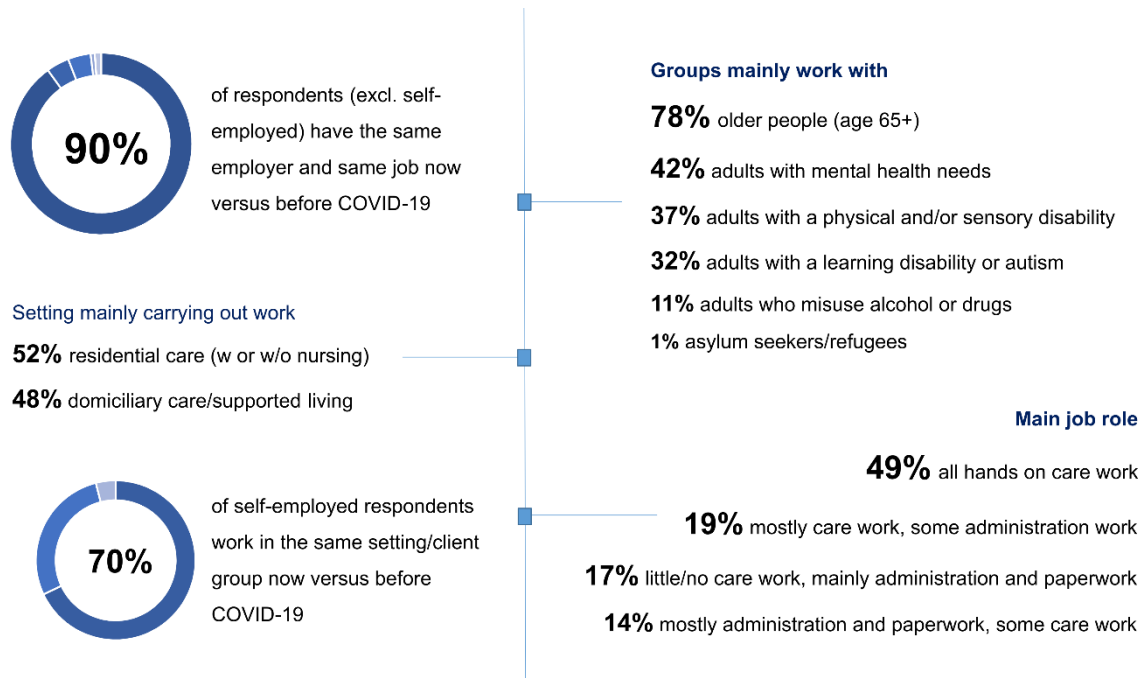


Figure A2: Length of work in the sector, employment and contract type

<sup>14</sup>This was derived from responses to ethnicity and nationality as follows: White British: White/White British ethnic background with British nationality; White Non-British: White/White British ethnic background with EU/EEA/Non-EU (non-British) nationality; Black Asian and minority ethnic group (BAME): Asian/Asian British/Black/African/Caribbean/Black British/other ethnic background. We grouped non-British and British BAME together due to sample size considerations but we acknowledge that there might be differences between the two groups that we are not able to identify in this analysis.

The survey also captured views from both domiciliary and residential care settings and engaged with those working with different service user groups. However, the vast majority worked with older people (65+), followed by a significant minority working with adults with mental health needs or physical/sensory disabilities. It was interesting to see that 70% of self-employed respondents continued working in the same setting as before COVID-19.



*Figure A3: Care setting, service users' profile and main role*

## Appendix B

Table B1 reports the findings from four robust linear estimations, where significant effects were identified. Each specification has a different (yes/no) dependent variable and a set of consistent socio-demographic and job-related independent variables, as mentioned above. The dependent variables for which findings are reported were: (1) increased support (SUPPORT), if responded 'increased a lot/little' to 'How have the following aspects of your job changed since the onset of COVID-19: the support you receive from your managers and/or co-workers'; (2) increased working hours and workload (HARD WORK) if selected 'I increased my working hours' since the onset of COVID-19 or responded with 'increased a lot/little' to 'How have the following aspects of your job changed since the onset of COVID-19: your workload'; (3) less safe at work (LESS SAFE) if responded 'increased a lot/little' to 'How have the following aspects of your job changed since the onset of COVID-19: the extent to which you feel safe at work'; (4) more tense and depressed (TENSE/DEPRESSED) if responded 'increased a lot/little' to 'Since the onset of COVID-19, has the amount of time that job makes you feel tense, uneasy or worried' or 'depressed, gloomy or miserable'.

*Table B1: Robust linear estimation results related to increased support, increased working hours and workload, feelings of being less safe at work and more tense and depressed*

	SUPPORT	HARD WORK	LESS SAFE	TENSE/DEPRESSED
<b>INDEPENDENT VARIABLES</b>				
<b>Local COVID-related variables</b>				
Total cases: $\geq 1,515^+$	-0.222* (0.122)	-0.123 (0.124)	0.300** (0.124)	0.046 (0.126)
Total deaths: $\geq 206^+$	0.175 (0.120)	0.178 (0.121)	-0.249** (0.122)	-0.080 (0.124)
<b>Gender</b>				
Female	-0.061 (0.119)	-0.133 (0.120)	-0.033 (0.121)	0.006 (0.123)
<b>Ethnicity and nationality</b>				
White British	base case	base case	base case	base case
White Non-British	0.017 (0.126)	-0.044 (0.127)	-0.047 (0.128)	0.160 (0.130)
BAME	0.196 (0.141)	-0.173 (0.141)	-0.069 (0.143)	-0.207 (0.146)
<b>Age group</b>				
<25 years old	0.000 (0.182)	0.298 (0.183)	-0.112 (0.185)	0.085 (0.189)
25-34 years old	-0.062 (0.106)	0.071 (0.105)	-0.074 (0.108)	0.225** (0.110)
35-44 years old	-0.148* (0.087)	0.122 (0.086)	-0.108 (0.089)	0.060 (0.090)
45-54 years old	base case	base case	base case	base case
55+ years old	-0.137 (0.088)	-0.138 (0.089)	-0.070 (0.090)	-0.149 (0.091)
<b>Employer</b>				
Public sector	base case	base case	base case	base case
Private sector (i.e. for-profit)	-0.078 (0.106)	0.125 (0.106)	-0.121 (0.107)	-0.127 (0.109)
Charity	-0.084 (0.125)	-0.145 (0.126)	-0.247* (0.127)	-0.142 (0.130)
Agency	-0.174 (0.170)	0.139 (0.171)	-0.185 (0.172)	0.046 (0.175)
Individual employer (i.e. person/family)	-0.198 (0.206)	0.248 (0.208)	0.069 (0.209)	0.024 (0.213)
Self-employed	-0.203 (0.168)	0.109 (0.170)	-0.283 (0.171)	-0.012 (0.174)
<b>Care setting</b>				
Domiciliary care (incl. supported living)	base case	base case	base case	base case
Residential care	0.101 (0.074)	0.096 (0.075)	0.059 (0.075)	0.064 (0.076)
<b>Job role</b>				
All hands-on/mostly care	-0.130* (0.077)	-0.068 (0.077)	-0.086 (0.078)	-0.102 (0.080)
<b>Social care experience</b>				
<2 years	-0.128 (0.127)	-0.284** (0.126)	0.092 (0.129)	0.098 (0.131)
2-5 years	-0.057 (0.087)	-0.028 (0.088)	0.087 (0.089)	0.028 (0.090)
6-10 years	-0.048 (0.090)	-0.052 (0.092)	0.070 (0.092)	-0.032 (0.093)
>10 years	base case	base case	base case	base case

<b>Employment contract</b>				
Permanent	-0.003 (0.109)	0.131 (0.109)	-0.090 (0.110)	0.159 (0.112)
<b>COVID-related testing, training and equipment</b>				
No COVID-19 training	-0.147 (0.095)	-	0.174* (0.097)	0.073 (0.098)
No PPE	-0.094 (0.100)	-	0.197* (0.102)	-0.040 (0.104)
No COVID-19 clear guidance	-0.158 (0.102)	-	0.259** (0.104)	0.198* (0.106)
No COVID-19 test received	0.025 (0.136)	-	0.252* (0.139)	0.039 (0.141)
<b>User type dummies<sup>++</sup></b>	Yes	Yes	Yes	Yes
<b>North-South controls<sup>^</sup></b>	Yes	Yes	Yes	Yes
<b>Observations</b>	296	296	296	296
<b>R-squared</b>	0.159	0.151	0.220	0.144

<sup>+</sup> a median cut was used to generate this variable; <sup>++</sup> These include dummies for older people (65+), adults with learning disability or autism, adults with a physical and/or sensory disability, adults with mental health needs, adults who misuse alcohol or drugs, other users; <sup>^</sup> controls for Midlands, London, South and Northern Ireland/Scotland/Wales (North was the base case); \*\*\* p<0.01, \*\* p<0.05, \* p<0.1; standard errors are reported in parentheses.