University of St Mark & St John

Health and Wellbeing

Unregulated social care workers: their lived experiences in the workplace and the development of a new conceptual approach to supervision support

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This study is inspired by my late Mum and the millions of other unregulated health and social care workers, who strive tirelessly to help take care of our vulnerable and in need. I would like to give profound thanks to my supervisors Professor Pam Dawson and Dr Alister McCormick, for their continued support and guidance throughout what has been a difficult and unprecedented time for us all, and for helping me adapt to a PhD online.

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Abstract

This study aimed to explore the lived experiences of unregulated social care workers' (USCWs) and supervisors' social care practice and supervision; to explore how individual wellbeing is experienced and managed in the workplace; investigate perceptions of factors affecting engagement with and effectiveness of supervision encounters; and generate ideas for future support and supervision approaches. The health and social care sector workforce is in crisis, impacting on quality of care, worker health and wellbeing, recruitment, retention and service user safety and accessibility. The workforce is exposed to increased risks of harm from workplace violence, abuse, distress, burnout, financial insecurity, and systemic inequality. Yet the beneficial workplace support process of supervision, remains ill-defined, unstructured and underutilised. The lack of literature pertaining to unregulated social care workers stalls progress toward conceptualising a more effective, responsive, and compassionate organisational wellbeing response. This thesis reports on research which aimed to address this gap in the literature.

An ongoing, iterative comprehensive literature review informed three integrated phases of research. In Phase One, 14 unregulated social care workers from a variety of services participated in semi-structured interviews to explore their everyday lived, and supervision experiences, and how these experiences impact on wellbeing and practice. Results demonstrated that the unregulated social care workforce is commonly exposed to experiences of workplace abuse and violence, exploitation, increased risk and vulnerability, burnout, and exhaustion. They are likely impacted by wider systemic inequalities, detrimental mental health, and wellbeing issues, have lived experience of vulnerability and unmet needs, and are unlikely to have access to effective workplace support and supervision processes.

In Phase Two, nine managers from a variety of social care services and with supervisory responsibilities, took part in semi-structured interviews exploring their experiences with the supervision process. Results demonstrated that managers with supervisory responsibilities found the supervision process ill-defined and inconsistent; were largely unsupported with its effective delivery; lacked specific supervision skills training, and perceived supervision as a beneficial wellbeing and practice support tool that many organisations were unable to take advantage of. Phases One and Two were underpinned by an interpretative phenomenological analysis (IPA) approach, which complemented the insider/researcher nature of the inquiry. In

Phase Three, participants were invited to take part in two online focus groups to discuss the creation of supervision training for supervisees. Phase Three was undertaken as a collaborative reflexive feedback session and this feedback, alongside Phases One and Two, was integrated to inform a new approach to the supervision process and supervision training.

The results from this study provide three recommendations for future research and important advancements around understanding the unique health, wellbeing, and support needs of the unregulated social care workforce. These include: exploring worker wellbeing from a holistic lived experience perspective; uncovering how prior lived experiences can impact on worker ability to tolerate stressful and harmful workplaces; applying a phenomenological lens to the unregulated social care workforce; recommending widening the scope of human factors theory by contributing a psychosocial aspect to the framework; applying a human factors and trauma informed approach to the supervision process; conceptually structuring the unregulated social care supervision process for the first time; and introducing a practical, user-led approach to supervision training for supervisees.

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Author's declaration

The candidate confirms that the work submitted is her own work. The candidate confirms that appropriate credit has been given within the PhD thesis where reference has been made to the work of others. The candidate confirms that this thesis has not been submitted for any other award.

Abbreviations used

BMJ	British Medical Journal
CHW	Community Health Worker
CQC	Care Quality Commission
ER	Emergency Room
GOV.UK	Government United Kingdom
H&SC	Health and Social care
HBM	Health Belief Model
HCA	Healthcare Assistant
HCP	Healthcare Professional
HF	Human Factors
HSE	Health and Safety Executive
HuFTI	Human Factors and Trauma Informed
ILM	Institute of Leadership and Management
IPA	Interpretative Phenomenological Analysis
NGO	Non-Governmental Organisation
NHCHC	National Health Care for the Homeless Council
NHLBI	National Heart, Lung and Blood Institute
NHS	National Health Service
NTS	Non-Technical Skills
ONS	Office for National Statistics
PFA	Psychological First Aid
PPE	Personal Protective Equipment
PTSD	Post-Traumatic Stress Disorder
RCN	Royal College of Nursing

SCIE	Social Care Institute for Excellence
SCT	Social Cognitive Theory
SSRG	Subject Specialism Research Group
TI	Trauma Informed
UK	United Kingdom
USC	Unregulated Social care
USCW	Unregulated Social Care Worker
WHO	World Health Organisation

Chapter One

Introduction

1.1 Chapter Overview:

This chapter provides an overview of the study, why the topic was selected and how an insider/researcher approach impacted on the research process. Situating the inquiry in a wider context, the current state of the health and social care sector, workforce statistics and recruitment and retention helps contextualise the social care workplace. Who the workforce is, their role as carers and their health and wellbeing experiences, provides a more personal approach to contextualising worker need and vulnerability. A thesis structure followed by a chapter summary concludes Chapter One.

1.2 Why this inquiry?

I have worked as an unregulated social care worker (USCW) with some of the most vulnerable and harmful members of my community for over 20 years. During this time, I was verbally abused, punched, bitten, bullied, marginalised and frightened, and at no time did I ever receive effective organisational support to help me manage these harmful experiences. I am aware that effective support happens, it is just that good practice tends to take place in silos in this sector, and I was not in one of those silos. After many years of working in dangerous and emotionally harmful workplace situations and coming to realise that I was not safe in this caring environment, and that no one seemed to care that I wasn't safe, I left.

A fourfold rise in mental health issues has been noted in the NHS since the start of the COVID-19 pandemic (de Castella, 2021), with healthcare professional wellbeing becoming a cause of major public health concern and threat to the quality and sustainability of healthcare delivery in the UK (Taylor et al., 2022). There are no identifiable comparative statistics for the unregulated social care workforce at this time, but studies evidence that USCWs have also been subject to the triggering of mental health problems as a result of COVID-19 (Nyashanu et al., 2022; Unison, 2021). Poor work-related mental health, compassion fatigue, exhaustion, and inadequate support, however, are nothing new for the health and social care sector (Cetrano et al., 2017; Gray-Stanley & Muramatsu, 2011; Hall et al., 2016; Potter et al., 2010).

In response to my own harmful experiences in the unregulated social care workplace, and continued, worsening worker mental health (Ford, 2023), this thesis aimed to explore the everyday lived experiences of unregulated social care workers, to develop a more evidence-based and responsive approach to experiences of risk and their supervision needs.

The need for research in this area is twofold. Firstly, the health and social care sector (within which unregulated social care workers sit), is in crisis (Alderwick et al., 2019; E. Baines, 2022; BMA, 2022a), with increasing staffing difficulties and worsening worker wellbeing issues, which can negatively impact on patient/service user wellbeing and safety (Hall et al., 2016; Sawatzky et al., 2021; Wåhlin et al., 2020; Wolvaardt, 2019). Secondly, the extant literature on unregulated social care workers (USCWs) is extremely poor, lacking in volume of research and depth of theoretical conceptualisation. Therefore, despite the crucial role this workforce plays within the economy, providing a safety net when we become vulnerable and at risk, this workforce, and those who staff it, are largely unrepresented in empirical and theoretical literature.

This thesis contributes a more informed, meaningful, and empathic appreciation of the social care workforce's lived experiences, which can help frame their workplace support needs in a more refined and productive way. A secure, satisfied, and respected worker is likely a more productive and committed one (Salas-Vallina et al., 2020; J. K. Singh & Jain, 2013; Tekingündüz et al., 2017), and we know that worker wellbeing impacts on how effectively and safely individuals do their job (Baylina et al., 2018). It therefore makes sense for organisations to want to ensure their staff teams are supported well. This is never more paramount than in health and social care, where the very lives of vulnerable patients and service users, are in the hands of often stressed and exhausted workers (Nantsupawat et al., 2016; Salyers et al., 2017).

It is widely accepted that social care workers are mistreated, under-supported, underpaid, and subject to abusive and violent workplace environments that negatively impact on worker wellbeing (Arnetz et al., 2015; Bhattacharjee & Sarkar, 2022; HSE, 2023a; Søvold et al., 2021; Tepper, 2000; Zhong et al., 2022). As an insider/researcher, I can straddle both the psychological and the sociological complexities of this phenomenon, framing the problem from both wider and more nuanced perspectives. It is this duality of lens that has enabled me to forge ahead in a more knowledgeable and meaningful way. This chapter introduces my role as an insider/researcher and sets the scene for the chapters to follow by situating and contextualising the unregulated social care worker and their wellbeing needs more fully.

1.3 Attending to the Inquiry as Insider

My status as insider/researcher is made more explicit in Chapter Three, where a position statement enables the reader to fully appreciate the work and lived experiences that motivated and informed the study. The concept of insider/researcher is introduced in the opening chapter to reflect the important role insider status is perceived to have played in relation to the overall richness, candour, and insight of this study, and to reassure the reader that considerations have been made in relation to researcher reflexivity, rigour, credibility, and transparency. A concomitant outcome of undertaking research within your own field, is that the researcher becomes an insider, and within insider studies there needs to be a clear understanding of the researcher's position, and how this position may influence the findings (Bell, 2021a). Researcher reflexivity is an important aspect of qualitative research quality control (Berger, 2015), requiring the researcher to turn the critical lens back onto themselves (Finefter-Rosenbluh, 2017), whilst establishing and maintaining an appropriate degree of psychosocial distance to the researched (Greene, 2014).

Generally, insider/researchers have some form of membership to the group or individual they are studying, sharing characteristics and experiences that can enhance relational connection, interaction, and openness (Bell, 2021; Greene, 2014). Bonner & Tolhurst (2002) identified key advantages of being an insider/researcher, including: having a greater understanding of the culture being studied; facilitating a more natural and relaxed interview space that does not alter the flow of social interaction; and having an established sense of relational connection and knowing that promotes a space of trust, and the telling of individual truths. Additionally, insider/researchers often have a more informed understanding of the internal politics and hierarchies involved in organisations, know how best to approach people in these circumstances, and in general, know how things tend to work (Unluer, 2012). Insiders can also possess wider knowledge that outsiders might need time and a variety of experiences to acquire (Smyth & Holian, 2007), and may require less time to prepare and acclimate to the needs of their study participants.

Alongside these benefits, Bonner and Tolhurst (2002) note that problems can also arise in the form of unconscious bias toward interpretations and findings; focusing on dramatic events rather than the more routine; and the researcher being perceived as advocate by some, including the researcher themselves. It is this last aspect of the insider dynamic that this researcher initially felt more aligned with, however, through a consistent, open, and reflective/reflexive process, the narrative of insider as helper was compassionately challenged, understood, and managed. As the inquiry progressed, the insider 'self-checking' process became organic, refined, and directed toward the wider research objective, resulting in a broader philosophical and contextual approach to the inquiry. Complementing this wider, more objective approach to the inquiry, the sector USCWs work in and who the unregulated social care workforce are, is presented next.

1.4 The Current State of The Health and Social Care Sector

Finding the means to effectively support the unregulated social care workforce is of critical importance during the worst global health crisis in a hundred years (Adiga et al., 2020), dwindling resources, an ageing population and workforce, a cost-of-living crisis, and the impact of Brexit (BMA, 2022a; Dayan et al., 2021; NHS Providers, 2022; Nicol, 2017). The perfect storm of rising demand coupled with falling public funding has created a UK social care sector exemplified by low wages, staffing cuts, workplace stress, poor quality employment opportunities, and recruitment and retention issues (Fox et al., 2021; Skills for Care, 2022c; Zoeckler, 2018). The devaluation of a sector that individuals are unwilling to work in (McGilton et al., 2020), has also led to poor worker wellbeing, motivation, morale, and job satisfaction (Johari & Omar, 2019; Nocon et al., 2019; Sabitova et al., 2020; J. K. Singh & Jain, 2013; Tekingündüz et al., 2017). The health and social care workforce crisis is one of the biggest challenges facing the nation's health and wellbeing (BMA, 2022c; Oliver, 2022) and an immediate, ameliorative response is required.

Since first discussed in the 1950s, and under the belief that community care was cheaper and more desirable, concerns around the ability of the government and local authorities to manage growing health care needs and inequalities, have not diminished (Thane, 2009). Health policy as an economic and labour force issue is one of the most important resources in any health care system (Hofmarcher et al., 2016), however, health care reform that aims to balance the provision of quality care and support for both service user and worker has yet to manifest. In an ageing society, staffed by an ageing workforce, and dealing with rising health care demands, maintaining and growing this workforce is critical for the health and social care sector (Nancarrow et al., 2014).

1.4.1 Workforce statistics

The single greatest risk to the provision of quality care and worker wellbeing is the current health and social care workforce crisis (E. Baines, 2022; Britnell, 2019; McGilton et al., 2020; Oliver, 2022; Rivlin & Lumley, 2023; The King's Fund, 2019). Of the estimated 1.62 million adult social care jobs as of 2021/22, 1.225 million of these involve direct care (Skills for Care, 2022c), and will be likely viewed as unskilled (Albert, 2020; Kadri et al., 2018). There are 75,000 fewer direct carers than in 2019/2020, although this does not include the almost one million adults who provide significant amounts of additional care and support to vulnerable adults, from the voluntary and charitable sectors (Tabassum, 2022).

According to Skills for Care (2022a), an independent charity in health and social care workforce development, the sector has seen a shift away from local authority jobs toward independent sector jobs with an increase of over 130,000 independent roles since 2012-2013. There are approximately 823,000 domiciliary carers in the UK (Skills for Care, 2021), however, with over 950,000 people in need of home care in the UK (Berg, 2021), staffing issues, and worsening wellbeing have impacted on levels and quality of care (Ravalier et al., 2022). This trend looks set to continue given an ageing population whose preferred method of care is home care (Age UK, 2020), and an additional need of 480,000 direct care and support workers by 2035 (Skills for Care, 2022c). In 2016 the Welsh Government commissioned research (Atkinson et al., 2016) to identify the factors that affect the recruitment and retention of domiciliary care workers, and the extent to which these factors impact upon quality of care provision. The study found that a well-trained, well-paid, and secure workforce was required to deliver high quality care, and that whilst these characteristics were found in local authority settings, they were often lacking in the independent social care sector.

1.4.2 Recruitment and retention

In relation to employment opportunities in health and social care in 2021/2022, around 50 per cent of the workforce usually worked full-time hours and 50 per cent part-time (Foster, 2022). A quarter of the workforce were employed on zero contract hours which increased to 42 per cent for domiciliary workers, with those employed by independent domiciliary care services proportionally higher at 55 per cent (Foster, 2022). The rate of zero contract hours remains relatively stable (Skills for Care, 2022b), and is an issue that has been recognised by UNISON (2020) as one that negatively impacts on worker's rights and standards of living opportunities. With 66% of workers paid under the National Living Wage (Skills for Care, 2022d), low wages and insecure hours continue to contribute to problematic retention and recruitment.

Alongside worsening sickness rates, particularly for workers struggling with mental health illnesses (The King's Fund, 2019), adult social care is facing increasingly problematic recruitment and retention challenges particularly with men and younger workers (The Health Foundation, 2022). While demand for social care is expected to continue to expand, difficulties in attracting staff continues (UNISON, 2020). The Adult and Social Care Recruitment and Retention Strategy 2014 – 2017 (Skills for Care, 2014), claimed that substantial progress had been made in sector recruitment. However, the Skills for Care Recruitment and Retention in Adult Social Care: Secrets of Success (Figgett, 2017, p. 5), went on to note that "there is a real and enduring challenge for employers within the sector to recruit, develop and retain the right people to deliver high quality, person-centred care and support services".

With a staff vacancy rate of 165,000 posts, up 52% from 2021/2022, the vacancy rate in adult social care is over ten percent, the highest since records began, and the highest of any occupational sector (Skills for Care, 2022c). As De Groot et al., (2018) note, in-depth knowledge is needed about what workers find attractive about their role in order to make recommendations for future recruitment, training models and improved staff retention, and this study begins to explore this need further. Brexit has placed further uncertainty and increased pressure on a sector already in crisis, with salary and educational requirements of new immigration rules rendering it largely unfeasible to recruit unregulated social care workers from outside of the UK (Dayan et al., 2021). Designing an immigration system that accommodates and safeguards both skilled and 'unskilled' workers is therefore imperative if we are to maintain service provisions (Simpkin & Mossialos, 2017). To compound matters further, whilst navigating the impact of Brexit on the health care sector, the COVID-19 pandemic hit the UK. Nowhere was the impact of COVID-19 felt more keenly than the health and social care sector, and a slow economic return and cost of living crisis is likely to worsen wider determinants of health inequality, employment, and access to health services (Dayan et al., 2021).

1.5 Who are the unregulated social care workforce?

The term unregulated social care worker (USCW) refers to individuals who provide social care services and do not hold a registerable qualification requiring statutory regulation. These services may be carried out in a residential/institution or home/community setting. Workers who visit people in their own home or in community-based locations are often referred to as domiciliary or community care workers and may be employed in many different roles (National Careers Service, n.d.; Your World healthcare, 2019). For example USCWs may support people and their families living at home with a wide variety of physical and/or cognitive difficulties. Community/domiciliary support workers often work alone with vulnerable individuals out in the community, including those with a learning disability, the homeless, individuals with substance misuse problems, offenders and victims in need of support, and sex workers. Residential community support workers work with service users who reside temporarily or permanently in specialised services, including learning disability and behavioural units, homeless and bail hostels, rehabilitation services, mother and baby units, and domestic abuse support facilities.

Unregulated workers also provide care for older people living in nursing and residential homes, but they are often referred to, and researched about, as a distinct workforce group. The nursing/care home unregulated care role is subject to a wider research focus than other social care workers (Beattie et al., 2023; Cooper et al., 2016; Fisher et al., 2021; Haunch et al., 2022; Islam et al., 2017; Lindmark et al., 2023; Perruchoud et al., 2022), although social care workers are sometimes included (Neill et al., 2022). This wider research focus may reflect the structured and co-dependent relationship care home workers have with on-site and visiting regulated healthcare professionals, making them a workforce of research interest due to their critical impact on the overall outcomes of regulated nursing and allied healthcare interventions.

The wider spectrum of unregulated social care worker roles therefore sit outside the more traditional nursing/care home role from the perspective of research literature and, although research on care home workers has relevance to wider social care, it does not address some of the distinctive aspects of unregulated social care work. For example, working in the community commonly involves lone-working or working with only one other and, as such, workers do not benefit from the support, safety and guidance more readily available in residential/nursing care home settings. In these care settings it is a statutory requirement that a regulated healthcare professional be always on site to provide support and guidance (Berg, 2021; QNI, 2023), although staffing issues for registered nurses can impact on the availability of this support (Grabowski, 2022). For the purposes of this study, it is the USCWs listed above (outside of residential/nursing care homes) who are focused on, given their distinctive role and poor representation in the extant literature. This study attempts to address the gap in knowledge that exists specific to the unregulated social care worker employed outside the scope of residential/nursing homes, and the following sections help situate and provide a clearer understanding of the barriers and inequalities USCWs are exposed to in their everyday lives.

1.5.1 Care work as women's work

The health and social care sector are host to a highly gendered workforce with approximately 85-95 per cent of roles filled by women in social care, particularly domiciliary care (Foster, 2022), and where men are over-represented in more senior and administrative roles than in direct care roles (Boniol et al., 2019; Foster, 2022). That most care work is delivered by women can also result in the work being undervalued in research (Criado-Perez, 2019), as well as remuneration (H. Armstrong, 2009). In contrast, women make up 48% of the wider workforce beyond health and social care (Francis-Devine & Powell, 2023). The health and social care sector employ one in five women, and combined with charitable and voluntary service providers, this number rises to one-in-four (Francis-Devine & Powell, 2023).

Given the amount of gender discrimination research in other areas of employment, Newman (2014) notes that the lack of attention around gender discrimination for both men and women in the health and social care sector is striking. The 2019 Working Paper on Gender Equity in the Health and Social Care Workforce (Boniol et al., 2019), suggests that gender transformative policies are needed to address inequities and eliminate gender-based discrimination; remove barriers to full-time, quality employment; and support access to professional development and leadership. In practice, practical changes have yet to be realised. However, enhancing skills and support provisions, and widening the empirical evidence base on community and frontline workers, can help support a more gender sensitive and intersectional understanding of the lived experiences of this workforce (Rubery & Grimshaw, 2007; Shannon et al., 2019).

Societal gender expectations and norms, low wages, and poor progression routes, not only place women at the front of both informal and formal care roles, but they also inhibit men from seeking employment as care and support workers, creating an exclusive and sometimes isolating experience in the workplace (Ross, 2017). As Western societies struggle with demand outstripping an ageing health and social care workforce, it is critical for policy makers to develop strategies to attract and retain male workers (Moskos & Isherwood, 2019). As 'women's work', caring work has been designed to meet the needs of women and the rest of society through part-time, flexible, low-paid, and low status conditions (P. Armstrong & Armstrong, 2004; Hester, 2018; Stace, 2013). However, with ever increasing vacancies and a dwindling worker pool to recruit from, it is unclear how policy makers plan to attract younger and male workers without exposing the long-held, inherent gender, racial, class and pay inequalities found within the sector (BMA, 2021a; Montgomery et al., 2017; Virtanen et al., 2003).

1.5.2 Worker health and wellbeing

It is widely acknowledged that the health and social care workforce experiences increased employee sickness, turnover and burnout (Gray-Stanley & Muramatsu, 2011; Potter et al., 2010; Rehder et al., 2021), alongside increased risk of personal harm and inequality, both in and out of the workplace (J. Allen & Sesti, 2018; Arnetz et al., 2015; Ham et al., 2021; Winchester, 2021). Higher rates of stress-related sickness are found in health care professionals when compared with other sectors (ONS, 2021), and work-related stress and mental health often go hand in hand (HSE, 2022d). Statistically, women also have significantly higher rates of work-related stress, depression and anxiety compared with the average for all persons (HSE, 2020). Alongside the stressful healthcare workplace environment, current workforce shortages in this sector are also taking a significant toll on the health and wellbeing of staff, supported by evidence of gender discrimination and inequalities in pay and career progression (The King's Fund, 2018).

It is estimated that one in six of all workers in the UK will experience a common mental health condition such as anxiety or depression, in any given week (Mental Health Foundation, 2022).

However, a 2018 survey from the mental health charity Mind, found that of all those surveyed, 48 per cent said they had experienced a mental health problem in their current job (Mind, 2018). Women are twice as likely to be diagnosed with an anxiety disorder, such as PTSD (Olff, 2017); have a one in four risk of being the victim of a sexual assault after the age of 16 (Rape Crisis, n.d.); and might be one of the 1.7 million women who contacted the police as a victim of domestic violence/abuse in England and Wales in 2021/2022 (ONS, 2022). Women are also disproportionally impacted with mental health problems, and lower household income when compared to men (Belle, 1990; GOV.UK, 2021; Halima Begum & Rahima Begum, 2022; The Women's Mental Health Taskforce, 2018).

These vulnerable women are likely to be represented within this workforce given one in five women are employed in the health and social care sector (Foster, 2022; Gershlick & Charlesworth, 2019), and will be managing these personal stresses, often amongst others, alongside workplace abuse and violence. Women still bear the brunt of systemic inequalities through welfare cuts, pay gaps, and inherent social, physical, and emotional vulnerabilities (Charlton, 2023; Seedat & Rondon, 2021). They are also likely to experience barriers to progression due to lone parenting and other caring responsibilities (L. Jones, 2019; Rabindrakumar, 2018), and where being working class means that opportunities for upward social mobility is more often about chance than choice (Blandford, 2019).

The context of this inquiry is a highly gendered and ageing workforce exposed to an increased likelihood of experiencing comorbid health and wellbeing inequalities, alongside poor-quality workplace environments and harmful workplace experiences (D. Baines & Armstrong, 2019; Fox et al., 2021; Skills for Care, 2022a; Witter et al., 2017). In response, this study aims to explore USCW worker experiences more comprehensively and use them to find a more relational, responsive, and effective approach to the supervision process.

1.6 Thesis Structure

This thesis is structured in a sequence of chapters that supports the reader to follow the natural development of the inquiry and consider the impact of my insider/researcher status on the direction and synthesis of the overall findings and recommendations. Chapter Two describes the nature of the literature review and the challenges faced given the paucity of extant findings related to the topic of study. The comprehensive literature review took the form of an exploratory, scoping exercise that took advantage of grey literature (e.g., statutory, charity and professional bodies) in the absence of more theoretical and empirical findings. Theories were selected, in parts, contributing to a wider conceptual jigsaw that evolved and transformed as new knowledge was iteratively analysed and synthesised alongside the interview findings. Chapter Three takes the reader through the philosophical and methodological processes of the study and presents a researcher position statement. Recognising that as a constructivist relativist, my own lived experiences impact on my worldview, and that these experiences can have value within a naturalistic inquiry, an interpretative phenomenological analysis (IPA) approach is used, to enhance the quality of this contribution.

Chapter Four introduces the first of three data collection phases. Focusing on the main subject of inquiry, Chapter Four presents the Phase One worker interviews, supported by a brief conceptual analysis and interpretation of the data. The Phase One findings are thematically considered under the overarching concept of risk, and the following superordinate themes of: Health and Wellbeing; Vulnerability and Exploitation; and Support and Supervision. In response to the Phase One supervision experiences shared, Chapter Five explores the supervision experiences of supervisors, to gauge a more holistic understanding of the overall supervision process. By way of a member reflection and group sharing opportunity, Chapter Six brings together the feedback from two focus group sessions, where both worker and manager participants were supported to explore the future provision of supervision training.

Bringing the thesis to a close, Chapter Seven sets out to refine, contextualise and conceptualise USCW lived experiences and barriers to wellbeing equality, through an evidence-based and theoretically informed approach to understanding their needs more holistically. Structuring the supervision process for the first time, this chapter goes on to provide the foundation for a new conceptual supervision process framework, supported by the creation of a tentative supervision training model.

1.7 Chapter Summary

This chapter introduces the reader to the study by contextualising the unregulated social care workforce in terms of who they are, the current situation, difficulties with recruitment and retention, gender issues in care work and worker health and wellbeing. A guide to the chapters to follow has been provided to give the reader an insight into the structure and form of the thesis.

Chapter Two

Literature Review

2.1 Chapter Overview

This literature review provides a critique of a range of types of literature from various sources and aims to form an analytical and synthesised composite of theoretical constructs, comparative empirical findings, and grey literature. It is presented in a narrative style, drawing from a wide perspective on a selection of theories, and empirical and regulatory knowledge pertaining to USCW wellbeing and the supervision process. A paucity of literature directly pertaining to USCWs necessitated a wide literature review approach, which also meant the review applied a more holistic view of unregulated social care worker support and wellbeing needs than first anticipated.

Given the inherently risk-laden nature of the health and social care workplace environment, literature on risk is reviewed in relation to the health and social care sector as well as to the individual, including health behaviour models, perceptions of risk and tolerance, and social cognitive theory. The supervision process sits within a hierarchical workplace system that supports worker performance, safe practice and role fulfilment, and a human factors approach to healthcare systems is included. Identifying the wellbeing needs of this workforce is essential if a more productive, responsive, and compassionate understanding of their wellbeing and practice needs is to be achieved. In response, health and social care worker experiences with workplace violence and burnout, will be also explored. An improved approach to supervision is sought, and considerations of current approaches and experiences of supervision will conclude the literature review.

2.2 Literature review approach

This empirical study was undertaken using a Comprehensive Literature Review approach underpinned by Onwuegbzie & Frels (2016) seven steps model. Onwuegbuzie and Frels recognise that developing and refining a search strategy is an iterative and fluid process that develops as the study progresses and new information is analysed and synthesised. An exercise situationally sensitive to the ethical and cultural considerations of the researcher and of the time, the iterative search process supports the ongoing and exploratory nature of qualitative phenomenological inquiry (Onwuegbzie & Frels, 2016).

This study contributes a more informed and innovative theoretical and conceptual approach to understanding how the under researched, unregulated social care worker experiences their life world, what this means for their wellbeing and practice, and what can be done to help improve this situation. As so little is known about this worker group, grey literature plays a significant role in contextualising the study group in relation to cultural, social, economic and wellbeing barriers and vulnerabilities (e.g., financial insecurity, mental health, and increased exposure to exploitation and abuse). These hidden, USCW worker vulnerabilities, add ethical weight to the worthiness and resonance of this study given the health and social care sector in England and Wales is experiencing a workforce crisis (Alderwick et al., 2019; BMA, 2022a), which is responsible for a “gridlocked” (CQC, 2022, para. 11) health and social care system “on its knees” (Baines, 2022, para. 1).

As an insider/researcher, the search strategy is representative of practical and wider theoretical approaches and considerations, which draw from the researcher's biography as human being, unregulated social care worker and researcher (Griffith, 1998). A lack of current extant literature was supported by lived experience expert (LEE) knowledge (Vázquez et al., 2023), which helped drive and shape the direction of the search, analysis, and synthesis process. Recognising that my own beliefs and opinions played an important part in knowing what areas to explore in the literature, first person language is used to create transparency about how the seven steps model was applied (Onwuegbzie & Frels, 2016). Additionally, first-hand knowledge of the USCW role, and the wider health and social care sector, supported an informed appreciation around which worker groups were best placed to offer comparisons that can help highlight same and similar issues to the USCW group. On occasion however, other occupational groups such as construction, and the emergency services have been used, to help give meaning to USCW experiences of risk perception, and responses to unpredictable and dangerous workplace events.

2.3 Exploration Phase

A scoping search strategy was initially employed given preliminary searches indicated that the term ‘unregulated social care worker’ yielded few results. Unregulated social care workers undertake same and similar duties to regulated health and social care workers, share the same service user groups and workplace environments, and encounter the same types of physical and emotional stressors (Brand et al., 2017; Diver et al., 2021; Hall et al., 2016; McFadden et al., 2021). Regulated and unregulated health and social care workers (e.g., nurses, doctors, allied care workers, healthcare assistants and social workers), were therefore considered comparable occupational groups for the purpose of this inquiry. It should be noted however, that a sensitive approach was taken in relation to the comparisons made, given unregulated workers on lower incomes are likely to encounter increased and/or different barriers to wellbeing, social mobility, and equality of opportunity, than their regulated counterparts (L. Allen et al., 2022; Blandford, 2019; Boardman et al., 2015; Thomson et al., 2022).

2.3.1 Step One: Exploring beliefs and topics

Utilising my insider knowledge and relevant workplace experience, I was able to offer a highly informed situational perspective that supported a more nuanced and sensitive understanding of the topic of study. My perspective as a practitioner and researcher emphasises individual wellbeing, and my empathic approach to practice and research seeks to understand the lived experiences of individuals as active participants in their lifeworld (Bland & DeRobertis, 2019). I value health and social care worker contributions as colleagues, skilled human beings, and as a grateful service user, and it is these values that underpin the belief that this workforce is worthy of improved support and compassionate care.

The topic-specific belief (Onwuegbuzie & Frels, 2016) that the unregulated social care workforce is commonly subject to poor support, exhaustion, high levels of stress and exploitation, is based on extensive personal experience and is what drives this inquiry and the literature review. The literature review is therefore influenced by my opinions in the sense that it has had an impact on the selection of theoretical considerations, and how aspects of these constructs can apply to USCWs in real, experiential terms. Selecting a topic for study is an inherently biased exercise regardless of the position of the researcher (Onwuegbuzie & Frels, 2016), and it is vital that the researcher consistently challenge any bias, ensuring rigour and transparency throughout the research process. A lack of extant literature created the need to explore a more diverse range of available materials, which in turn led to improved clarity and context which sparked ideas for other searches and new directions of thought.

Passion for a worthy topic of study is important but can expose researchers to biased 'opinion creep', although arguably it is often a strong opinion that initially motivates the drive for social change impact. Conducting a literature review provides new knowledge, opens researchers to new ideas and experiences, challenges held beliefs and perceptions, and supports a reflective and reflexive approach to learning. New knowledge can also help keep opinion creep in check, and in this case functioned as a tool for personal and academic cognitive growth. Additionally, consistent reflective check-ins with supervisors, and the frequent sharing of drafts for critical feedback during the analysis process, helped to manage and understand personal opinion contributions and ensure reflexivity.

2.3.2 Step two: Initiating the search

Effective literature search strategies contribute to the quality and rigour of an academic study, and a comprehensive approach was employed using the following electronic search databases: SCOPUS, Google Scholar, University search engine Discovery, Pubmed, Jstor, Directory of Open Access Journals, EBSCO, BMJ, PsycINFO and SSRG. Given the paucity of empirical findings and the lack of focus on USCWs, grey literature was sourced online to help provide a more nuanced and wider understanding of the issues faced by the USCW community group. These sources included: the Health and Safety Executive (HSE), The King's Fund, Skills for Care, legislative and regulatory guidance, The Health Foundation, Nursing Times, Nuffield Trust, women's services, and mental health Non-Governmental Organisations (NGOs).

The first hurdle in the search process was knowing what terms to search for, given health and social care workers who are not regulated and not employed by the NHS have no overarching generic job title. In practice however, they will be called (domiciliary) care workers, support workers, and substance misuse workers, to name but a few. The following 'generic' search terms were therefore initially employed: health + care + social + worker + wellbeing. The term 'carer' was also used, however, this commonly resulted in materials relating to informal carers, and as such was removed from the search terms. The initial search terms yielded a wide range of journals, books and articles, however health care assistants (HCAs), the most closely aligned to USCWs who provide personal care and minor medical procedures, were only included in a small number of studies. Despite the inclusion of some HCAs, studies appeared to find accessing HCA participant groups difficult, resulting in a disproportionate number of findings relating to professional health and social care worker experiences, health, wellbeing, and workplace challenges.

Additional search topics were identified as the iterative evaluation, analysis and synthesis process progressed, and exploratory reading opened more meaningful literature and terms that changed both thinking processes and direction of review. As the data collection for this study began, areas of interest from the semi-structured interview schedules, participant responses and ongoing analysis prompted searches that used combinations of additional key words: healthcare; mental health; needs; burnout; inequalities; violence; COVID–19; support; and supervision. Again, search findings pointed to literature on the regulated health and social care sector, which commonly focussed on narrow lines of inquiry, and failed to take in to account the more holistic and wider external, sociological, and psychosocial factors, inequalities and gender issues faced by the unregulated workforce. Nevertheless, the emergence of the COVID-19 pandemic, provided a renewed focus on the health and wellbeing of healthcare workers, and USCWs may benefit from this wider effort. Whilst still lacking wider representation for USCWs, this renewed focus has placed health and social care worker health and wellbeing more firmly in the spotlight and enriched this literature review.

The concept of risk played a fundamental role in understanding USCWs lived and wellbeing experiences and opportunities, and as the study thematically and theoretically progressed, this helped underpin and guide the literature review further. From the theory of risk, an array of relevant theoretical considerations emerged, and the following terms were included: safety; risk perception; individual risk; tolerance; trauma; childhood; empathy; social cognitive theory; self-efficacy; human factors; and health behaviour models. The supervision process for health and social care workers was repeatedly revisited throughout the inquiry, and as search terms and terminology became more refined and philosophical considerations clearer, the terms effective + supervision + abusive + wellbeing, were used.

2.3.3 Step three: Storing and organising the information

All electronic documents were stored on the referencing tool Mendeley, before being sorted into more specific sub-sections for future reading and selection/deselection. After reading, salient notes were made on index cards, where the type of research, number of participants and relevant outcomes were noted.

2.3.4 Step four: Selecting / deselecting information

Rooted in naturalistic philosophy (Lincoln & Guba, 1985), the paradigmatic diversity of qualitative research means that quality criteria are neither feasible nor expected (Yadav, 2022), and no strict quality criteria were applied to the selection of literature. However, a relativist epistemological approach to research criteria 'can' evidence quality, if emerging concepts and theories work to explain how the theoretical concepts fit and is understandable to those interested in the inquiry (Levers, 2013). Shaped by my worldview (Guba, 1990), literature was chosen for evaluation and analysis based on USCW transferability (Lincoln & Guba, 1985), my own beliefs and experiences as insider, and as an ongoing iterative response to the discovery of useful relevant sources and unfolding interview findings. The selection and deselection of suitable literature was a continual, non-linear process that became more refined as the study progressed and new information was uncovered and synthesised (Onwuegbuzie & Frels, 2016). The initial selection process was a lengthy and frustrating exercise given it had been quickly realised that very few papers focused on the unregulated social care worker group, and as such, papers were selected even if their contributions appeared minor.

2.3.4a Selection Criteria

- Materials were written in English.
- AND Any document with a combination of the terms health; care; healthcare; social worker; wellbeing; and supervision.
- AND Qualitative Studies that explore comparative worker roles including nurses, social workers, healthcare assistants and doctors in relation to workplace wellbeing and supervision.
- AND mixed methods and quantitative studies that provided some form of contextualisation of the USCW group.
- OR Grey literature, including statutory, statistical, charitable and professional materials.
- OR Community Health Workers (CHWs) and the supervision process.

2.3.4b Deselection Criteria

- Job role too far removed from the USCW scope of responsibilities and experiences to provide a reliable comparison.

- Literature relating to informal carers

2.3.5 Step five: Expanding the search

Reflecting the highly iterative nature of the literature review process, the term “community health worker” (CHW) was found in an international paper relating to supervision experiences, during the discussion phase somewhat late in the study. Providing a unique and highly pertinent comparison to the USCW role, CHWs are community members who provide minor medical intervention support and personal/social care, in other parts of the world, predominantly Africa and South Asia (Masis et al., 2021; NHLBI, 2014). This discovery opened a new set of search terms, although cultural, social and gender differences were evident and taken into consideration. However, the search for community + health + worker + supervision, yielded several highly comparable outcomes given support and supervision processes in health and social care workforces around the world share common worker wellbeing aims (WHO, 2006). A paucity of empirical literature on the lived experiences of CHWs mirrored the lack of qualitative knowledge on USCWs in the UK however, perhaps reflecting the complex nature of understanding the issues faced by this worker group, and why current studies have yet to suggest more practical and solution focused practice recommendations.

2.3.6 Step six: Analysing / synthesising information

The search for new meaning, when there was currently so little, influenced a continuous approach to analysis and synthesis. The constant feeding in of new information from diverse sources resulted in a fluid, iterative and forward moving stream of thoughts and links to new ideas. Exploring unregulated social care worker wellbeing drove the initial analysis process, with more quantitative materials able to provide contextualisation and ideas for future theoretical considerations. Analysis was approached with an open mind, given papers with even minor contributions had been selected, and plurality of job role title meant I could find unknown USCW roles and discover new search terms.

The lack of empirical findings on this worker group necessitated an innovative and creative approach and the analysis process initially began with consideration of grey literature.

Knowing that the USC workplace is highly gendered, low paid, stressful, sometimes dangerous, and poorly supported, I started to look at wider demographics by way of trying to better understand the personal impact of inequality and harm on individuals. To build upon this grey literature however, a worker group that could provide comparative empirical knowledge was required. Regulated and unregulated health and social care workers such as doctors, nurses, healthcare assistants and social workers were subsequently identified as suitable comparison groups for analysis, given their role and environmental similarities.

As the data collection progressed and aspects of theoretical constructs became more relevant and meaningful, I was able to separate out aspects of theoretical constructs and bring them together, create philosophical links between them and USCW experiences, and use extant empirical literature to evidence these phenomena in comparative worker groups. Synthesis repeatedly occurred through insightful insider observation, and reflection on the patterns and relationships identified between empirical findings, other literature, and theory. As one of few studies to apply a phenomenological lens to the wellbeing and support needs of USCWs, analysis and synthesis of literature was ongoing throughout the study.

2.3.7 Step seven: Presenting the comprehensive literature review report

The information contained within this comprehensive literature review will provide the reader with a wider understanding of how aspects of existing theoretical constructs and empirical findings can be used to synthesise new meaning and guide courses of positive action for the unregulated social care workforce. An integrative, narrative approach will be used to communicate written findings, broken down into relevant theoretical constructs that help frame the related empirical studies that follow.

2.4 How Theory and Empirical Studies Have been Considered in the Literature Review

Theories have been selected on the grounds of holding some form of meaning to the study group, the researcher as insider, and the worker groups used as comparisons. Several significant, established theoretical constructs are primarily considered, not necessarily in whole, but in relevant part and in relation to specific aspects of the study group. Grey literature is used to help provide wider contextualisation for the theoretical constructs, given risk in health and social care is managed in a more practical, physical sense than it would be in finance for example. Additionally, empirical findings are framed within theoretical constructs to inform practice knowledge, and where possible theoretical and analytical gaps are addressed.

First, aspects of risk, and risk in health and social care will be discussed as a central underpinning tenet of the health and social care sector. Concepts of risk from both service user and worker perspective are considered, given the close and often intimate experience of the carer/service user relationship. Risk is then discussed in more personal ways, with risk to health and wellbeing introduced through health belief model (HBM) approaches and social cognitive theory (SCT). An important aspect of both HBMs and SCT is self-efficacy. High self-efficacy plays a key role in worker wellbeing and practice and is included for discussion alongside empathy as markers for effective skills for practice, wellbeing buffers and pro-social behaviours. Self-efficacy and empathy are also included to help inform new approaches to training, support, and supervision processes. Human factors theory provides a structured framework through which to view empirical findings on supervision of workers within care sectors and workers' individual supervision needs. To conclude the review, extant literature on the health and social care supervision process is explored.

2.5 Aspects of Risk

The term "risk" can be defined as the known potential for loss and/or harm to occur (Webster, 2021). Risk can be aleatory (random) or epistemic (resulting from a lack of knowledge) (Hora, 1996) and from a pragmatic viewpoint, it is important to clearly understand the difference, since it then becomes clear which risks have the potential of being minimised or eradicated (Kiureghian & Ditlevsen, 2009). The notion of risk is a widespread concept in contemporary society (Lupton, 2006; B. J. Taylor & McKeown, 2013) and use of the term "risk" in the increasing discourse of interdisciplinary literature is so diverse that arguably there are hardly any connections between them (Garland, 2003).

As a theoretical concept, the term risk has a range of different meanings and implications to different people in different environments. Understanding how people interpret risk and the actions they take based on these interpretations, is a vital consideration in risk management, given it allows for a more subjective understanding for assessment purposes (Aven, 2016; Eiser et al., 2012). Risk continues to be a major focus of scientific and economic concern, however it is also now the subject of myriad cultural, historical and political inquiries, as well as being a prominent theme of the social theories generated to interpret and understand our world (Garland, 2003).

In the social sciences, risk is traditionally defined as the uncertainty about, and severity of, events and consequences of activities with respect to something that individuals and groups value (Aven & Renn, 2009). In social care, Taylor (2013, p. 165) defines risk as “a time-bounded decision-making situation where the outcomes are uncertain, and where benefits are sought, but undesirable outcomes are possible”. In this way, risk can be situated within, and representative of, the fluid, in-the-moment, uncertain nature of health and social care work, and where vulnerable individuals can be unpredictable and harmful to worker wellbeing (Manthorpe, 2007). For the unregulated social care worker, risk can be experienced as damage to self, service user, colleague, member of the public and material goods (Arnetz et al., 2015; Dickson & Dolnicar, 2004; Ham et al., 2021; Ruco et al., 2022; Webster, 2021).

2.5.1 Risk Management

Risk management relates to the practices and policies we put in place to minimise or eliminate unacceptable risks (Aven, 2016; Webster, 2021), and is a process that determines exposure to risk and the actions then put in place to manage it. Keeping service users, employees and bystanders safe is a moral, ethical and legal responsibility for employers (British Safety Council, 2023; Minett, 2022; Webster, 2021). However, creating risk assessments that can achieve this can be a difficult process when considering the wide-spectrum of aleatory, epistemic and decision making factors found in this often complex, unpredictable and stressful workplace environment (Verbano & Turra, 2010). Ferdosi et al., (2020) created a simple framework for the management of risk in healthcare organisations that included the following phases: establishing the context, risk assessment, risk treatment, monitoring and review, and communication and consultation. Based on the findings, a comprehensive, yet simple risk management framework was developed for executive use, alongside tools and techniques for use at every phase. However, managers should endeavour to use a variety of risk management tools and methods based on specific service need, and not just under an assumption that one or two risk assessment tools are comprehensive.

Explored further in sections 2.7 and 7.8, human factors (HF) theory was originally developed in the field of engineering as a way of better understanding what and why led to human error, the wider consequences of these incidences, and how to manage the relationships between systems, equipment and users/human beings more safely and productively (CIEHF, 2018). In health and social care (H&SC), HF is becoming increasingly used in risk management (Verbano & Turra, 2010), as the benefits from understanding how patient safety can be improved become more apparent (Flin et al., 2009; Russ et al., 2013; Streimelweger et al., 2015).

Patients can get tired, scared and emotional which can lead to unpredictable and uncertain behaviour in the health and social care sector (Phipps, 2019). Workers are also subject to epistemic risk through a number of additional factors, including: poor and/or lack of effective training, negative organisational cultures around safety and supervision, the uncertainty of lone working, short staffing, failure to handover important patient information, and a lack of open and honest communication between organisations and workers (Epstein, 2021; Taylor, 2023). Exposure to epistemic risk can lead to H&SC worker harm and burnout, compassion fatigue and poor role commitment (Hall et al., 2016; Hunt et al., 2017; Søvold et al., 2021), which in turn can negatively impact on patient safety (Nantsupawat et al., 2016; Hall et al., 2016). A lack of knowledge, guidance and certainty when working with vulnerable and at risk patients can lead to poor outcomes for all stakeholders, which for patient and worker can sometimes result in serious harm, and even death (Sud & Szawarski, 2018; Anderson & Abrahamson, 2017). Epistemic risk management and uncertainties for H&SC professionals and their patients however, can be positively impacted upon by the implementation of an organisational HF approach (Flin et al., 2009; Hibbert et al., 2016; Verbano & Turra, 2010), and the input of appropriate HF training, peer learning/support and improved supervision processes (Damery et al., 2021; Hignett & Lang, 2018).

Exploring wider systems and user thinking in more subjective, practical terms can affect real and timely change in relation to managing risk and reducing uncertainty in the H&SC sector. Applying a HF method to improve two healthcare risk management tools, Bañez et al., (2021) conducted 16 semi-structured interviews with participants experienced in risk management, quality improvement and patient safety. The purpose of the study was to help identify usability areas of interest in order to raise risk management awareness across organisations and improve ease of use of risk assessment tools. Interview questions aimed at better understanding organisational risk identification processes and opportunities for improving the assessment tools were explored, alongside identifying how well existing reports aligned with organisational needs and expectations.

Results indicated that participants found the tools informative, easy to use and that submitting self-assessments was a streamlined and satisfying process. Improvement of use feedback focused on simplifying the layout of the sections, making data entry more efficient, templates lacking opportunities to communicate valuable information and data viewing challenges. A human factors approach to risk assessment usability and accessibility, was able to identify both strengths and weaknesses of the assessment tools, and generate new ideas about how to manage issues in the future. Using a HF approach in H&SC in this way can help develop our scope of understanding around the complex and multi-level aspect of risk factors in the H&SC sector, including how systems, individuals and tools can interact more safely and effectively.

However, whilst HF in H&SC offers a promising approach to improving patient safety, there are issues with organisational structures and cultures, including an unwillingness to change ways of working, and a difficulty integrating HF experts into the sector (Perry et al., 2021; Timmons et al., 2015). Alongside limited empirical data specifically on the H&SC sector, none of the studies identified concentrated on worker risk management through a HF approach. Instead, focusing on how patient risk and safety can be reduced, with H&SC workers sometimes vicariously benefiting from these measures. Given human error in the American healthcare sector is responsible for more deaths per year than vehicle fatalities (Institute of Medicine, 2000; Makary & Daniel, 2016), there is likely more uncertainty around why workers make errors than inadequate training, exhaustion and poor workplace support.

Understanding the why of human error in H&SC requires a more human and compassionate approach, and one that recognises individuals drawn into the helping professions are more likely to experience vulnerability and/or harm both in and out of the workplace (Dunning, 2006; Heaslip, 2012). In this instance, it is organisational, researcher and policy-maker lack of knowledge that is responsible for workforce epistemic risk factors, and further studies are needed to help fill this knowledge gap, diminish uncertainty and improve risk and safety for all H&SC stakeholders.

2.5.2 Risk in Health and Social Care: Perceptions of Service User Risk

Assessing and managing service user risk is part of the commonplace of health and social care worker training, conversation, and practice (Shaw &Shaw, 2001; Stevens & Hassett, 2012; Wåhlin et al., 2020). According to the Health and Safety Executive (HSE, 2021b), assessing service user risk requires a sensible, balanced decision to be made between the needs, freedom, and dignity of the individual and their safety. The risk assessment process requires that a proper check of the risk be made; that those who might be affected by the risk are spoken with, and that the obvious risk signs were managed, considering the reasonableness of any risk taking by others (HSE, 2023b). Risk assessments in care should enable people to safely live fulfilled lives, rather than be a mechanism for restricting rights and freedoms (HSE, 2021b). Also, many care providers and regulators find it hard not to slip towards a risk averse approach for a multitude of reasons, including perceived impact on service user, understaffing, a lack of resources, prior bad experiences and a fear of the consequences when things go wrong (CQC, 2018; HSE, 2021b).

Risks assessments are not value free and should not be made by those with no knowledge of the complex issues involved, since they require a deeper understanding of the available evidence in relation to our general knowledge about the event or situation observed (Aven, 2016). Studies show however, that ineffective safety measures and poor outcomes can result because of inadequate consultation with a sufficiently wide group of stakeholders, including immediate carers as unique experts (Jackson et al., 2019; Kaya et al., 2019). This study aims to widen stakeholder considerations and consultations, promoting a more user-led, informed and responsive approach to worker/service user risk and safety.

2.5.3 Risk in Health and Social Care: Perceptions of Worker Risk

The provision of health and social care is an inherently risky and hazardous profession (Fenn & Egan, 2012; HSE, 2021a, 2022a; Joseph & Joseph, 2016; McFadden et al., 2021; Rasool et al., 2021). Both the USCW role and service user behaviour pose risks to the health and wellbeing of workers through exhaustion, physical violence and verbal abuse, increased stress, and emotional burnout, and job and/or financial insecurity (Gray-Stanley & Muramatsu, 2011; Hall et al., 2016; Potter et al., 2010). Health and social care worker health and safety recommendations and standards are regulated by the Health and Safety Executive (HSE), and the Care Quality Commission (CQC), although content is often generic and/or does not apply to specific support needs of the health and social care workforce.

The Health and Safety Executive (HSE, 2022c) ‘do’ consider healthcare workers a key occupational risk group however, although risks are largely identified as pathogenic and hazardous/substance related, leaving more clinical and staffing related issues to be managed elsewhere. Wider considerations are made around the managing of violence in the workplace, with this issue being dealt with under more generic workplace health and safety regulations (HSE, 2021a). As with occasions of violence and aggression, risk to worker wellbeing is dealt with through generic work-related stress (HSE, 2022d) and lone working recommendations (HSE, 2022b). Risk in the health and social care sector is also predominantly conceptualised through the lens of service user health and safety (Brennan et al., 2020b; Donaldson et al., n.d.; Milligan, 2007; Vosper & Hignett, 2018; Wåhlin et al., 2020), although there is a growing body of work around the concept of "second victims" (Wu, 2000). This study highlights the need for a more refined and compassionate understanding of the impact violence and aggression specifically has on USCW wellbeing, and can provide a more practical solution to help manage these harmful experiences more effectively.

2.5.4 Second victims

Introduced by Wu (2000) to help draw attention to those involved in workplace patient safety events and the negative outcomes that flow from them (Vanhaecht et al., 2022), 'second victims' have been found to experience often long lasting emotional distress following on from adverse incidences in the healthcare workplace (Ozeke et al., 2019; Ullström et al., 2014). Adverse events that occur within healthcare settings can lead to two victims; the patient and the healthcare professional/s involved in the incident (Ozeke et al., 2019; Seys et al., 2013). The concept of second victims refers to the latter of these stakeholders and focuses on the personal impact of medical error, patient distress, death and violence towards healthcare professionals (HCPs) (Ozeke et al., 2019; Strametz et al., 2021; Ullström et al., 2014). At the time of writing, no second victim studies outside of healthcare could be found, although home health care has been explored (Grasmo et al., 2021) which provides a meaningful comparison to others lone-working in the community. Despite its official definition referring only to healthcare workers ((Vanhaecht et al., 2022), the concept of second victims can help support the phenomenon of vicarious trauma (BMA, 2022), random violence and unsafe service user behaviour, experiences spoken about frequently during the Phase One interviews.

Using data from 21 semi-structured interviews with HCPs who had experienced an adverse event, Ullström et al., (2014) found that some had experienced initial feelings of shock and disbelief immediately after the incident, leaving them feeling sad, anxious and experiencing flashbacks, alongside longer term feelings of guilt and shame. These incidences were so traumatic for two participants that they had not fully returned to their role, with poor organisational support and recognition of the concept of second victims thought to contribute to a lack of self-help seeking, openness and trust between the HCPs and their organisation.

Given its brief history we do not have the luxury of being able to explore the notion of second victims through more longitudinal and varied data collection opportunities. It is interesting, however, that in this study, the more experienced USCWs felt 'less' stressed, anxious and guilty about negative workplace incidences than USCWs with less experience. It may therefore be beneficial to further understand who and why some people become second victims, and whether this status changes over time, is impacted upon by previous lived experiences, and ongoing support and spaces for reflection. Exploring how challenging and unpredictable working conditions affect homecare workers experience of occupational health through semi-structured interviews, Grasmo et al., (2021) found that challenging incidences such as violence by service users, was considered stressful by workers. Alongside feeling stressed, individuals also found that the unpredictable working conditions they encountered in service user homes contributed to their increased exposure to environmental hazards and unhealthy physical workloads, despite the implementation of ergonomic work practices (Grasmo et al., 2021).

Whilst the term 'second victim' opens up the spectrum of who can be a victim, which can be beneficial for workers whose needs and challenges are often overlooked by the needs and challenges of the service user, there are also concerns about the term's use. Ozeke et al., (2019) found that some authors, including Wu, are recommending the term be abandoned given it could be seen as insensitive to the patient who whilst a part of the cause of the second victim's status, are likely equally, if not more so, distressed and shocked by unexpected and uncontrollable negative healthcare events. The term 'victim' also suggests a 'perpetrator' is involved and the patient may lose their own victim status. Additionally, labelling healthcare professionals involved in unanticipated medical errors or other negative patient outcomes as second victims, obscures the fact that some healthcare professionals and healthcare systems can be at fault (Clarkson et al., 2019).

2.5.5 Personal Risk: Health Belief Models

Personal risk to USCW wellbeing can be viewed through a wider health belief model lens, to understand how individual health behaviour changes in the workplace can be implemented and sustained. The term 'health' can be used to broadly describe a relative state influenced by social, cultural, and emotional phenomena, including physical and mental health, education, housing, diet, substance use and other behaviours (Alegría et al., 2018). The concept of wellbeing, which forms part of individual overall health, is not as clearly defined (McLeod & Wright, 2016), although Dodge et al., (2012) conclude that a more appropriate way of looking at wellbeing would be to centre it around a state of emotional and physiological balance that is affected by life events and challenges. In this way, a more subjective and relativist approach is considered, given individuals are uniquely different, and experience and manage unpredictable life events, risks and challenges through different learned behaviours and perceptions of risk (Oltedal et al., 2004; Ropeik, 2012).

Health behaviour models seek to manage risk to health by supporting health behaviour changes; improving our understanding of how health-related behaviours can be maintained; and serve as a guiding framework for health behaviour interventions (E. C. Green & Murphy, 2020; Janz et al., 1984; Maiman & Becker, 1974; Rosenstock, 1974). In healthcare, HBMs may, for example, be used to support nurse education and training around patient infection prevention. Applying the same HBM lens to worker health and wellbeing, however, may also help identify preventative ways for managing worker exhaustion, burnout, mental health, and musculoskeletal illnesses more effectively, although this would necessitate wider system engagement, which can be problematic in multi-level organisations.

Moving away from more wider applications of health behaviour risk management strategies, and in the pursuit of a more individualised understanding of risk to health, Kriger (2021) undertook a small, creative study, investigating the corporal embodiment and understanding of the participants' own health risk perceptions and experiences. Using Luhmann's (1993) paradox of unity that posits that two discrete moments in time can become unified at another point in time through the physical mediator of the body, Kriger suggests that there are more subjective ontological aspects of risk that require further public health risk consideration. From the findings, four approaches to the embodiment of personal health risk were presented; The ‘shit happens’ approach; The sequelae approach; The risk as heuristic approach; and The knowledge approach.

The shit happens approach was characterised by two main features: the underlying belief that negative health outcomes are random; and that individuals have little control over the most important aspects that shape health. This aleatory aspect of risk was compounded by the knowledge approach, where individuals felt that a lack of information about health risks, what causes them, and how to effectively manage them, contributed to increased epistemic risk factors. In contrast to the randomness of the ‘shit happens’ approach to health risk, the sequelae approach asserts that both past and present actions can pose direct implications on the future embodiment of health risks. For Kriger’s participants, the routine and accumulative nature of actions and behaviours acted as hallmarks of the sequelae approach, and repetition was noted as a meaningful factor of how health risks were perceived and managed in the future. Perceiving that life is too complex to understand what aspects of our past link to our embodied presents and futures, risk as heuristic approach posits that in life it is easier to use self-learned, imperfect problem solving mechanisms than worry about what might never happen. This approach was observed to be aligned with the age of the participants, with older individuals making more concerted efforts to stave off and manage future health risks than their younger counterparts.

Unlike more traditional HBM frameworks, Kriger’s four approaches help expand our understanding of who and what are considered relevant in relation to how risk presents and is embodied by individuals. The focus on the individual highlights that context and sociocultural influences need factoring in if we are to fully appreciate how risk is experienced by individuals living under social hierarchies and oppressive forces. These findings help widen approaches to health risk management beyond only ‘expert configurations’ and into individuals’ everyday experiences (Kriger, 2021) by recognising that both aleatory and epistemic risks impact on how individuals embody and perceive future risks in more subjective ways.

2.5.6 Critique of Health Belief Model Approaches to Social Science Research

Health belief models clearly underpin important public and individual health benefits in the form of wider health screening, vaccinations, public education and HIV protective behaviours (Alaszewski & Coxon, 2009; Champion & Skinner, 2008; Emmanuel, 2015; Jeihooni &

Rakhshani, 2019). However, the perception that all individuals possess the appropriate common sense, knowledge, and cognitive ability to understand the need, or want, to change harmful behaviours, has been critiqued as limiting, reductive and lacking in a wider understanding of individual human behaviour (Alegría et al., 2018; Champion & Skinner, 2008; Orji et al., 2012).

2.6 Social Cognitive Theory

According to Bandura (1998) a wider, more comprehensive approach to individual health risk behaviours is required if we are to change the practices of social systems that have widespread detrimental effects on our health, rather than solely changing the habits of individuals. In response to HBM thinking, Bandura's social cognitive theory (SCT) set out to deal with the roles played by cognitive, vicarious, self-reflective, and self-regulatory processes in psychosocial functioning, and how environmental factors, motivations and influences help shape us, and our life courses (Bandura, 1977, 1986). Social cognitive theory asserts that possessing the confidence and skills to succeed motivates the likelihood of engagement in certain behaviours (Bandura, 1977). Engagement in healthy behaviour is further influenced by social determinants such as working life conditions, income, environment and early childhood development, and the impact these determinants have on individual choice and decision-making capabilities and opportunities (WHO, 2023).

In healthcare, SCT can be used to assist in our understanding of the role personal and environmental factors can have on an individual's health behaviours, prognosis, and prevention (Sebastian et al., 2021). Whilst In healthcare education, SCT can help facilitate knowledge between healthcare professionals and other stakeholders such as service users and colleagues (Manjarres-Posada et al., 2020).

2.6.1 The Role of Self-Efficacy and Empathy on Risk Perception

Instrumental in HBM approaches, and a central component of SCT, self-efficacy provides the foundation for human agency, a sense of control, and the self-belief that individuals can cope and manage whatever life throws at them (Bandura, 1977; Benight & Bandura, 2004; Pérez-Fuentes et al., 2019). Self-efficacy can enhance or impede motivation and is directly related to behaviour (Bandura, 1986; Luszczynska & Schwarzer, 2015). It is also considered a powerful antecedent for engagement and job performance; a buffer against burnout (Barbaranelli et al., 2018), and an important component of health behaviour and health risk assessment (O'Leary, 1985; Pérez-Fuentes et al., 2019; Schwarzer & Fuchs, 1995).

Those with high self-efficacy traits are thought to feel more confident in performing challenging tasks and/or coping in novel situations, whilst those with perceived low self-inefficacy are prone to suffering distress and negative emotions, such as anxiety and depression (Bandura, 1997). Also, where an HBM intervention requires significant skill to achieve and sustain health behaviour change, effective self-efficacy has been viewed as a particularly strong predictor of success (Ayers et al., 1997). Furthermore, empathic self-efficacy, defined as a more altruistic approach to self-determining action (Eklund et al., 2012), has been found to have positive associations with good health and wellbeing, which in the health and social care workplace can help foster feelings of compassion satisfaction and role reward (Berg-Poppe et al., 2022; Ioannidou & Konstantikaki, 2008; Pérez-Fuentes et al., 2019; Shrestha et al., 2021).

Empathy refers to the capacity to relate to and share another's state of mind (Depow et al., 2021; Greenberg et al., 2018; Ioannidou & Konstantikaki, 2008; Riess, 2017), is a pro-social behaviour, and has an important part to play in health risk perception and healthcare work (Grignoli et al., 2021; Kerasidou et al., 2021; Moudatsou et al., 2020; Tone & Tully, 2014; Yu et al., 2021). Empathy has two distinct components: emotional empathy, which involves feeling the emotions of another, and cognitive empathy, which relates to the appropriate self-regulation of the emotion felt in response (Depow et al., 2021; Hunt et al., 2017; Riess, 2017). In care, health professionals with high levels of empathy have been observed as operating more efficiently and fulfilling their role in eliciting therapeutic change more effectively (Moudatsou et al., 2020).

2.6.2 Role Modelling

An aspect of SCT, role modelling can be a highly motivational and educational experience in the health and social care workplace, especially given current workforce shortages require workers to hit the professional ground running (Baldwin et al., 2017). Role-modelling provides important opportunities for personal and professional development, yet the term itself is poorly defined, researched, and means different things to different people and groups (Horsburgh & Ippolito, 2018). Role modelling remains one crucial area where standards are elusive, and where repeated negative experiences can adversely impact on learner development and professional character formation (Kenny et al., 2003). Role modelling primarily works in two ways. Firstly, that the actions and character of others (e.g. supervisors and leaders) motivates people to aspire to be like them, and secondly, that individuals believe by paying attention to that person's behaviour, they will learn something (Bandura, 1977; Gibson, 2004; Zagenczyk et al., 2009).

Social cognitive theory, and the important role of self-efficacy, fundamentally impacts on how we perceive risk and the actions we then take to mitigate them. However, how we learn to be appropriately cautious, risk averse or risk tolerant depends on how individuals have learned to perceive risk from role models and other influential forces. Risk perception is central to risk assessment, which in health and social care, can at times mean the difference between life and death for vulnerable service users. How risk perception is formed, understood, and managed, is therefore discussed next, given self-efficacy and risk perception are thought to be reliable predictors of preventive health behaviour (Diotaiuti et al., 2021), which for USCWs can mean managing workplace wellbeing before it reaches burnout, and/or the need for time away from the role.

2.6.3 Risk Perception

Risk perception relates to an individual's perceived ability to discern a certain amount of risk or susceptibility to a threat, has a prominent role to play in the decisions people make, and is inescapably subjective (Ferrer & Klein, 2015; Inouye, 2017; Renn, 2004; Slovic & Weber, 2002). Risk perceptions are a constructed reality, formed from a collection of experiences and beliefs relative to the information available at the time, and common sense (Renn, 2004). Although arguably, common sense is something often assumed by others and poorly defined, which in the health and social care workplace can lead to workers feeling unable to seek role clarity, ask questions, access support and poor service user/worker outcomes (Brault et al., 2014; Ly et al., 2018). Risk perception is not static, and life events can impact on levels of risk perception (Li et al., 2023). In healthcare, worker risk perception requires revisiting to ensure workers and supervisors are taking the necessary reflective and active steps to ensure risk assessments are consistent and safe (Fiandra et al., 2008; Ropeik, 2012).

Risk perceptions are important precursors to health-related behaviours, and it is commonly assumed that a person's knowledge and certainty about a risk determines how they will perceive it (Paek & Hove, 2017). How individuals perceive risk is relatively shaped by an unconscious, emotional and heuristic processes, given the human brain is hard-wired to react quickly and defensively to perceived threats of any kind (V. J. Brown, 2014). The accurate perception of risk is affected by a complex variety of macro, meso and micro factors, and getting risk wrong is a common aspect of risk perception both in the moment, and in relation to longer-term consequences (Inouye, 2017; Ropeik, 2012). This study helps to uncover the different factors related to worker risk perceptions, how worker lived experiences can help shape these perceptions, and suggests that the supervision process can provide the suitable environment for risk and risk perceptions to be explored and understood.

2.6.4 Macro, Meso and Micro Factors of Risk Perception

Macro-level factors in relation to healthcare risk perception refer to organisational and leadership cultures of safety and understanding of risk; legal and regulatory influences and requirements; and economic barriers and enablers that are largely out of the control of the individual (Inouye, 2017; Sawatzky et al., 2021; T. Smith et al., 2019). The approach to safety and understanding of risk among managers and supervisors can have a profound impact on employee perceptions of risk, and studies have found a correlation between positive and caring organisational approaches to safety and decreased individual risk taking (Fleming & Buchan, 2002; Inouye, 2017). Conversely, workers were found to have decreased safety compliance and consideration when they rated the safety climate of their organisation as poor (Garcia et al., 2004; Giurgiu et al., 2015). Believing that safety information and support is not accessible is also associated with lower safety efficacy and safety compliance, as are levels of enforcement, severity of consequences and an employee's level of trust in an organisation (Inouye, 2017).

Research into this complex phenomenon needs to go beyond psychological analysis, to include broader social, cultural, biological and environmental explanations of risk behaviour (Giurgiu et al., 2015; Inouye, 2017; Sitkin & Pablo, 1992). However, and despite organisational and regulatory barriers and restrictions, Smith et al. (2019) found that nurses still find their roles rewarding and enjoyable despite the risks. Positive macro gains were observed in the form of standardisation and clarity of role, high levels of education, accreditation, experience, and responsibility, that afforded nurses higher levels of remuneration and autonomy (Smith et al., 2019), which may not transfer to unregulated care workers.

Meso-level factors fall between the macro and micro-levels and concern the interactions and collaborations between individuals and organisations, and individuals within organisations (Niskanen et al., 2016). They include peer and community pressures that influence individual behaviour, and how people perceive and tolerate risks in these situations. In the workplace, this may present as inexperienced employees adopting unsafe short-cuts while performing job tasks, because more experienced workers are doing so, and the need to fit in as motivation for complicity (Inouye, 2017). At a local level, meso-level factors can impact on rates of pay, the availability of job opportunities, limited staffing and support, inadequate breaks during shifts, quality improvement and performance monitoring (Smith et al., 2019).

Micro-level factors affect risk perception and risk tolerance, and relate to an individual level of knowledge, experience and confidence around an event or situation (Inouye, 2017). It is also thought that those who are less informed are less likely to take risks than those who possess more knowledge and experience (Inouye, 2017). Whilst increased knowledge may lessen decision making anxiety, micro-level factors may lead to optimism bias, which can promote an individuals’ tendency to believe that a negative event will not happen to them, or that they are more adept at prohibiting harm than others might be (Fragkaki et al., 2021; Inouye, 2017).

Individual, micro-level factors of risk perception characteristics are thought to be relatively stable cross-culturally (Renn & Rohrmann, 2000). They are shaped by demographic factors such as age, gender, physical and mental health status, occupation, residence, personal value basis, group identity and income, with those on higher incomes evidencing higher risk perception levels than those with more financial insecurity (Renn & Rohrmann, 2000; Wang et al., 2022). There are little to no available studies around the consequence of prior personal trauma in relation to individual and occupational risk perception outside of COVID-19 or research on adolescents. However, studies have repeatedly evidenced a link between risk perception and the impact of increased mental stress, sleep deprivation, pandemics and PTSD in healthcare workers (Geng et al., 2021; Jalloh et al., 2018; Yin et al., 2021).

2.6.5 Risk Tolerance

Risk tolerance refers to a person's capacity to accept a certain amount of risk (Inouye, 2017). As with risk perception, risk tolerance is a constructed, relative and heuristic process, shaped and influenced by an individual’s characteristics, lived experiences, behaviours and expectations (Cavalheiro et al., 2012) and is largely based on heterogenous demographics and characteristics (Galizzi & Tempesti, 2014). In literature, risk tolerance is predominantly discussed through the quantitative lens of individual, financial and investment risk tolerance, and more traditionally risky workplace environments such as construction (Cavalheiro et al., 2012; Galizzi & Tempesti, 2014; Y. Singh et al., 2022). Although few, quantitative studies on organisational and occupational risk tolerance, including healthcare have been considered (Zacchi et al., 2022).

Validating the concept that demographics and traits have a significant part to play in risk tolerance situations (Cavalheiro et al., 2012; Galizzi & Tempesti, 2014; Y. Singh et al., 2022), Zacchi et al., (2022) also found that mood, whilst not providing any overall impact on risk tolerance, did highlight that cognitive biases are made when managers experience exhaustion and burnout. These cognitive biases led to managers making riskier organisational decisions (Zacchi et al., 2022), which in healthcare can result in errors, harm and fatalities. Burnout and exhaustion have become increasingly problematic for workers in the health and social care sector (Cetrano et al., 2017; Converso et al., 2021; Nocon et al., 2019; Rehder et al., 2021), which can negatively affect mood and impact on safe practice. Studies that specifically explore supervisor risk perception and mood in the health and social care sector would therefore be highly beneficial, particularly within the supervision setting.

Seeking a more holistic approach to risk tolerance, Galizzi et al., (2014), found that construction workers who were more prone to risk taking tended to experience fewer recurrent injuries than those more risk averse, suggesting that this first experience 'changes' worker risk perception and tolerance levels. Galizzi et al., also found that demanding family stressors, social norms, working conditions, measures of socioeconomic status, health, and safety problems experienced by workers impacted on risk tolerance. However, unsafe events experienced in a worker's youth, remained among some of the most important factors explaining the occurrence of recurrent workplace injuries. While using a more traditionally physical approach to workplace risk tolerance and injury, Galizzi et al., do help to shed light on the nature of early exposure to risk and safety, and how these experiences can help shape and determine individual risk tolerance levels in the health and social care workforce.

2.6.6 Distress Tolerance

A relatively recent concept in psychological research and discourse, distress tolerance relates to an individual’s ability to tolerate stressful states and perform goal-oriented tasks within that stressful state (Stemke, 2013). It is the ability to effectively withstand adverse internal thoughts and feelings, traumatic memories and intrusive thoughts, and is primarily linked with psychopathological literature and understanding how mental health disorders are linked to a patient’s prior experiences and behaviours (Larrazabal et al., 2022; Stemke, 2013). However, given the psychologically stressful, vicarious, risk-laden, dangerous, and uncertain nature of working with vulnerable adults in the health and social care workplace, distress tolerance will be briefly considered in relation to better understanding worker risk perception and risk tolerance.

Distress tolerance can be broadly viewed as having two components. The first is an internal component, or the individual's perceived ability to withstand negative emotions and other aversive states, such as feeling anxious when faced with an unknown situation (Leyro et al., 2010). The second is an external component, which focuses on the individual's actual behavioural responses to those feelings (Leyro et al., 2010). Zvolensky et al., (2010) note that individuals with lower levels of distress tolerance may be prone to ineffectively respond to distress and distressing situations, and as a result may try to avoid difficult emotions and challenging experiences. In contrast, people with higher levels of distress tolerance, may feel more able to adaptively respond to distress or distressing events, which in turn can promote more positive physical and mental health outcomes (Larrazabal et al., 2022). Whilst only scantly applied in wider occupational literature, distress tolerance has yet to be used as a lens through which to understand how health and social care workers are able to tolerate the distress and anger of others, whilst managing their own psychological and wellbeing needs.

2.7 Human Factors Theory

Originating from the field of engineering and aviation safety, human factors (HF) attempt to mitigate risk through wider systems thinking. Human factors is an umbrella theory encompassing environmental, organisational, and individual characteristics and factors, and the relationships between them that affect day-to-day working, human safety, wellbeing and overall system performance (O’Connor & O’Dea, 2021; Stramler, 1993; White, 2012). Human factors differentiate from other theoretical contributions to risk in terms of its person-centred, user led, systems approach that can lead to higher levels of safety, improved user satisfaction, sustained cost savings over time, and better quality, consistent outputs (Hignett et al., 2018; 2019; Milligan, 2007).

Human factors theory considers human strengths and weaknesses in the design of systems and technology (Henriksen et al., 2008), acknowledging that human error is a consistent variable, and that this knowledge can help improve systems and processes to manage these human variables more safely and productively (Milligan, 2007). Organisational transparency and multi-level system dialogues can also help foster trust and openness with employees (Rawlins & Rawlins, 2008; Schnackenberg & Tomlinson, 2016), which are important indicators for worker engagement, role fulfilment and safety compliance (Brown et al., 2015). The Health and Safety Executive (HSE, 2023a) acknowledge that people's behaviour is affected by the characteristics and culture of the workplace, and that workers and work groups also respond to the messages and cues they receive from managers and supervisors. In relation to overall supervisory duties, the HSE note that the supervisory role is an important one, and that problems can emerge because of poorly defined responsibilities, heavy workloads, inadequate resources, or because of removing supervisory roles altogether (HSE, 2021a).

2.7.1 Human Factors in Health Care

Traditionally, paternalistic models in medicine viewed patients as passive recipients of care, although this model is slowly changing to one where patients and healthcare workers form a partnership toward the common goal of improved health (O'Connor & O'Dea, 2021). This shift recognises that a more person-centred approach to healthcare benefits patient safety and recovery, and that patient values and expectations inform positive healthcare experiences (Gluyas, 2015). The goals of human factors in healthcare are twofold (Russ et al., 2012): firstly they support the cognitive and physical work of healthcare professionals such as increased worker satisfaction, efficiency, and training (Karsh et al., 2006), and secondly they promote proactive quality, safe care for patients (e.g. patient/user friendly health technologies) (O'Connor & O'Dea, 2021; Saleem et al., 2009).

The National Quality Board (2013) recognises that HF impact on human behaviour, knowledge and risk management in the clinical setting (Verbano & Turra, 2010), enhancing performance through the effects of teamwork, a trusted workplace culture and positive organisational influences (CIEHF, 2019; Dempsey et al., 2006). A human factors approach has yet to be integrated within all areas of unregulated social care (Phipps, 2019), although as discussed in 2.7, HF has been used in health and social care risk management approaches. The use of HF may not be explicit in unregulated social care however, given the non-technical and often lone-working aspect of the role, and that social care providers are commonly independent of larger, regulated healthcare providers such as the NHS. Consequently, the HF literature reviewed is set in healthcare environments, although the case is made for a human factors approach for the social care sector (Hignett & Lang, 2018).

2.8 Human Factors Empirical Research

Empirical literature where aspects of human factors have been investigated, including healthcare research, non-technical skills, simulated learning and situational awareness, is analysed in an integrative manner, followed by a concluding critique on human factors.

2.8.1 Human Factors in Healthcare Research

Asserting that the experience and human factors of providing care are often overlooked at high decision-making levels, Privitera (2018) explored burnout through the wellness surveys of 528 advanced healthcare practitioners, including nurses, doctors, and surgeons. Privitera found that the extended vigilance and accountability required in the role bled into practitioner down-time, and that the human factor-based risk vs. benefit paradigm needed rethinking. Hypervigilance, high levels of responsibility and emotionally taking work home are not unique to physicians. Workers in all health and social care roles struggle to find healthy work/life balances (Barck-Holst et al., 2022; Picton, 2021; RCN, 2021), and currently, healthcare settings do not grasp the health and wellbeing risks of such extended vigilance and cognitive attention (Privitera, 2018). Workplace initiatives were also found to be a drain on worker resources, as physicians struggled to cope with new learning, whilst maintaining performance and patient safety standards.

In response to the wellness surveys, Privitera (2018) was able to utilise existing organisational resources, in recognising that reduction of burnout and improvement in clinician wellbeing is critical to patient safety, and that burnout is a driving and justifying force to build wellness programmes. However, a lack of relational connection and feedback between workers and organisations inhibited productive communication, and recommendations are made for improved provider well-being systems to help promote sharing and safe practice. Studies using a human factors framework (Henriksen et al., 2008; Holden et al., 2013), have a tool that can help explore workplace issues more holistically when applied systematically throughout an organisation (National Quality Board, 2013). However, how parts of a system then respond to this new human factor knowledge, is another consideration. Therefore, human factors as a change theory, requires a wider organisational buy-in and understanding of psychosocial and individual behaviour, if effective change is to occur and be sustained.

Using a small group of experts Roth (2014) explored the human side of nursing, identifying that which makes nurses vulnerable to mistakes, to better understand the causes. Findings suggested that the causes of medical errors in hospitals fell into three areas: the biophysical state of the individual nurse; the environment of the clinical unit; and tolerated general risk situations. Roth also found that night nurses perceived fatigue as less of a contributory factor for error, than day shift nurses, recognising that human factors are capricious and compounded by wider support failures that escalate the potential for errors. This may suggest that night nurses had become normalised and tolerant to fatigue, and that they no longer situationally recognised it as an element of human error and risk. In much the same way, this study aims to highlight the human side of unregulated social care work, to better understand the causes of poor worker wellbeing, practice and retention.

2.8.2 Non-Technical Skills

A sub-set of human factors (Casali et al., 2019; Gordon et al., 2015), non-technical skills (NTS), are the social and cognitive skills that underpin clinical or technical skills (White, 2012). Non-technical skills include situational awareness (knowing what is going on around you), decision-making, leadership, communication and teamwork, and managing personal resources such as fatigue and wellbeing (Flin & Agnew, 2017). There is growing evidence that practitioners need to improve on their NTS (White, 2012), given in healthcare, studies are beginning to show that the NTS of clinical staff are related to positive patient outcomes (Hull et al., 2012). However, whilst other industries have adapted their NTS to match occupational and technological need, healthcare has struggled to agree on a standardised NTS framework for practice (Johnson & Aggarwal, 2019).

Studies on NTS in healthcare tend to focus on medical and surgical processes and literature reviews (Carayon & Hoonakker, 2019; Casali et al., 2019; Crossley et al., 2011; Hull et al., 2012; Yule, Flin, Paterson-Brown, & Maran, 2006). However, these findings are highly transferable to other areas in health and social care given that NTS are a critical component of community care (Carayon & Hoonakker, 2019). Recognising the gap in literature pertaining to NTS and scrub nurses, Mitchell et al., (2011) undertook semi-structured interviews with twenty-five experienced scrub nurses and nine surgeons, to explore the perceived importance of NTS in operating theatres. Identifying the main social and cognitive skills raised by participants, Mitchell et al., found that situational awareness, communication, teamwork, task management and coping with stress, were all perceived as key to successful scrub nurse role performance.

Like scrub nurses, USCWs are commonly exposed to chaotic and fast paced, high pressure workplace environments, where communication, teamwork and coping with stress play an important part of safe practice and individual wellbeing. Non-technical skills are often learned through experience, and it this awareness that helps us understand and respond to the more nuanced cues and behaviours of others, although less experienced nurses may feel inhibited to speak up (Umoren et al., 2022). The surgeons in the Mitchell et al., (2011) study acknowledged that hierarchical structures still preclude the free flow of information between nurses and doctors, however, the more experienced nurses tended to feel that they spoke on the unconscious patient's behalf, and as such felt more compelled to speak out. The similarly hierarchical and unequal nature of the unregulated social care workforce can also inhibit open and honest dialogue with managers and seniors, highlighting the importance of NTS acquisition for USCWs as a tool for improved worker communication, organisational trust and collaboration, and service user wellbeing and safety.

2.8.3 Simulated learning and Situational Awareness

Outside of mandatory training, unregulated social care workers will be expected to undertake some form of hands-on, practical learning. Simulated learning can offer workers an excellent opportunity to practice and develop situational awareness, risk perception and role comprehension in a safe, supportive and reflective space (Fore & Sculli, 2013). However, USCW training largely consists of learning more practical skills such as equipment use, medication dispensing, and occasionally some form of breakaway training, with little to no consideration around worker NTS, or ways to enhance worker wellbeing through them.

Gordon et al., (2017) highlighted the anxieties that are often associated with interdisciplinary working in healthcare, and that simulations can provide the means to ease these anxieties.

Undertaking three simulated ward experiences followed by two focus groups, Gordon et al., identified that current NTS safety interventions have failed to address the 'how' and the 'why' of human error, leaving a clear gap in knowledge, and that clarity as to how NTS are regulated through simulation learning has yet to be addressed. Practice simulations in nursing have also been observed as providing a safe and educational space for learning, and statistical improvements in knowledge/skill, critical thinking ability and/or confidence after simulation training have also been identified (Cant & Cooper, 2010).

Given the scope for both worker and service user risk and harm in the unregulated social care workplace, simulated learning can provide USCWs with a safe, reflective and supportive space to share good practice, and learn about/develop NTS. Non-technical skills are an important aspect of USCW practice and integrating NTS, and the opportunity for real-life practice scenarios, into unregulated social care workforce training can help improve communication, decision-making and situational awareness skills.

2.8.4 Critique of Human Factors

Human factors largely fail to consider the impact of tolerance and normalisation of poor practices, prior held beliefs and lived experiences on worker performance and wellbeing. Therefore, a better understanding of the views of healthcare workers who make an error but do not report it, is needed, and must be provided in an environment where healthcare workers feel they can admit to errors without shame, guilt and blame (Brborović et al., 2019; GOV.UK, 2016; Parker & Davies, 2020; Wolvaardt, 2019). A significant aspect of enabling workers to feel safe and confident about coming forward after making, or nearly making errors, is a workplace culture of trust, open communication and leadership. These NTS form an important part of how organisations foster 'just' environments and have a significant role to play in supporting teamwork, decision making and worker resources (Bies, 2000; Wolvaardt, 2019).

Despite the title, HF approaches in healthcare pays little to no human-centred attention to the workforce, whose individual wellbeing needs are superseded by those of vulnerable service users, and overlooked by managers, organisations, regulators, and policy makers. The impact of individual worker health and wellbeing on patient safety remains largely unexplored outside of fatigue and work overload, pointing to a gap in the HF literature. Human factors has yet to find standardisation within health and social care, given it is still the worker who tends to bear the brunt of practice errors (Brborović et al., 2019; Wise, 2018; Wolvaardt, 2019) despite a no blame culture (GOV.UK, 2016). Defendants of this culture, however, typically fail to distinguish between blaming someone and holding them accountable (Parker & Davies, 2020).

Henriksen et al., (2008) note that the term human factors also lacks explanatory power by not describing anything other than human involvement in the error, explicitly placing blame on people and suggesting some sort of human shortcoming or lack of attentiveness was at fault. Adding that "when human error is viewed as a cause rather than a consequence, it serves as a cloak for our ignorance" (Henriksen et al., 2008 p. 9). This ignorance is further compounded by a lack of understanding about the experiences, wellbeing and support needs of the health and social care workforce as a group, and as individuals.

The unregulated social care sector is a complex, multi-level institution, with a supervision process that has yet to be theoretically or conceptually structured. In a bid to educate our ignorance, a human factors approach to the supervision process can help widen our understanding of how and why this important workplace support process is largely failing to meet worker need, who is accountable for the process, and what can be done to start addressing this issue more holistically and responsively.

2.9 The Wellbeing Needs of the Workforce

This section will explore two areas of health and social care workplace experience; violence and aggression, and work-related stress and burnout, both of which function as significant contributors to poor worker wellbeing and sickness absences (Converso et al., 2021).

2.9.1 Workplace Experiences of Violence and Aggression

Little empirical research has been undertaken on aggression directed at unregulated workers in the care and support environments and how workers respond to it (Nyberg et al., 2021; Lachs et al., 2013; Rapaport et al., 2018). Workplace violence can be defined as abuse, and intimidation or an attack in circumstances that relate to an individual's employment, and that involves an explicit challenge to their safety, wellbeing, or health (Mento et al., 2020). Workplace violence is recognised as an occupational hazard in healthcare (Mcphaul & Lipscomb, 2004) and for Rapaport (2018) and Scott et al (2011), it is an innate part of care work that is intrinsically interwoven with compassion, care, concern for the client, unmet need, and constraints on staff responses.

Workplace violence has been documented in all sectors, but female dominated sectors are at particular risk (Newman, 2014), with violence, or the threat of violence serving as the most consistent predictor for long-term sick leave (Aagestad et al., 2014). It is widely acknowledged that healthcare workers experience aggression and violence from service users, that these harmful experiences are underreported, and that worker wellbeing is worsened as a result (Arnetz et al., 2015; Denney, 2010; HSE, 2023b; Mento et al., 2020; Zelnick et al., 2013). It is worth noting however, that the COVID-19 pandemic has increased the reporting of violent incidences against health and social care workers, which due to under-reporting is likely the tip of the iceberg (Devi, 2020).

Exploring worker perceptions and implications of violence and abuse in dementia care home environments through a literature review of 196 papers, Scott et al., (2011) found that an accumulation of violence and abuse toward dementia care workers can lead to emotional exhaustion, depersonalisation, feeling undervalued, unsupported and lacking in the necessary skills. They also found that the magnitude, expectation and acceptance of violence and abuse became a normalised part of the dementia carer role, going on to assert that this phenomenon was unique to the dementia care setting. Whilst it is widely acknowledged that dementia care home workers are exposed to violence and abuse from residents (Albert, 2018; Boström et al., 2012; Cooper, 2014; Gates et al., 2013), lone workers, mental health and substance misuse workers, amongst many others are equally exposed to persistent levels of violence, abuse and harm (Phoo & Reid, 2022). Arguably all individuals who work with vulnerable, unpredictable and cognitively impaired individuals are exposed to increased aleatory risk factors. However, given USCWs who work in the community often do so alone, the lack of self-protective training and peers to call on for support and guidance further impacts on levels of epistemic risk.

Survey responses and systematic literature reviews, whilst helpful in understanding the what, do not help us in understanding how emotional experiences are embodied by individuals, or what they are, or are not, doing to personally manage associated work-related stress and burnout. Alongside widening understanding around USCW experiences with workplace violence, this study begins to contextualise the impact of violent and abusive workplace incidences experienced by USCWs, many of whom will not have access to peer support and/or effective supervision.

2.9.2 Work Related Stress and Burnout

Work-related stress can have a negative influence and impact on healthcare professionals' physical and emotional wellbeing and their overall quality of life (Koinis et al., 2015; Olagunju et al., 2021; Ravalier et al., 2020). Current data on social care sickness absence by days lost was not available at the time of writing, although from wider data on caring, leisure and other service occupations, the social care workforce has experienced an increase in sickness absences (ONS, 2020, 2021). A mixed methods study of stress in 1,677, NHS employees including 1,644 survey responses, found that levels were 46% higher than the national average and that a lack of support and understanding from management was cited as a significant influence on poor mental health and wellbeing at work (Ravalier et al., 2020). Recommendations for practice change were made around improving communication and peer support, although without guidance, practical support, or funding they are unlikely to get off the ground.

Identifying a gap in the literature, Schiff & Lane, (2019) surveyed 472 frontline homelessness workers, noting that a large group of respondents who had contact with homeless clients were negatively impacted upon in more significantly harmful ways than other emergency services such as the police or ER nurses. Schiff and Lane suggested that trauma informed approaches to social care be expanded into the workforce, as it was recognised that a desire to help others can be motivated by previous psychosocial problems and traumatic past experiences. Schiff and Lane also recommended that trauma informed approaches to social care are expanded to include trauma responses in the workforce. However, a deeper, more phenomenological understanding around what drives workers into knowingly harmful roles, and how we can support them through the supervision process would be beneficial. Originally conceived as a psychosocial response to public health disasters and emergencies, Psychological First Aid (PFA) training is emerging as a beneficial tool to help frontline healthcare professionals manage responses to crises, and will be discussed next as an example of the types of training that can enhance supervision outcomes for distressed and traumatised USCWs.

2.9.3 Psychological First Aid training

Psychological First Aid (PFA) training is an evidence-based psychological intervention used to help mitigate acute stress and foster resilience for those affected by crisis both in the short and long term (Wang et al., 2021, 2022; Zafar et al., 2021). Underpinned by Stevan Hobfoll's five principles of psychosocial care: a sense of safety, calming, self and community efficacy, social connectedness, and hope (Dückers, 2013; Ursano, 2021), PFA training has been shown to enhance participant confidence, knowledge, self-care and emergency preparedness (Eweida et al., 2023; Lalani & Drolet, 2020; Zafar et al., 2021). Whilst Hobfoll's principles still influence organisations and policy makers (Snider et al., 2011), PFA training is now being utilised as a tool to help the wellbeing of those who provide care for distressed, traumatised and unpredictable others on a more day-to-day basis (Schoultz et al., 2022; Tessier et al., 2022; Wang et al., 2021). Validating the potential benefits of using a trauma informed approach to supervision and the managing of adverse events in the unregulated social care workplace, PFA training has been utilised in healthcare and social work as an effective mental health tool (Schoultz et al., 2022; Tessier et al., 2022). As support grows for its use, consideration should be made for wider accessibility to the training beyond its initial application of public health disaster and emergency management (Everly, 2020).

With no fixed framework of content and delivery, PFA training can be utilised to meet the varied cognitive and physical needs of specific users, and for healthcare professionals this may include the following areas: understanding PFA, recognising post trauma and PTSD reactions, understanding normal stress responses, how to provide peer support, recognising compassion fatigue and burnout and ways to provide continuing support for self and colleagues (NHS, 2023). Psychological First Aid training and its awareness of both the short and longer-term impacts of trauma, can help situate the need for a less 'disaster' led, but still immediate approach to supporting USCWs, who on a daily basis manage one service user crisis to another over long periods of time. At the time of writing, no empirical studies on the use of PFA could be found outside of nursing homes and health care/social work professionals, and whilst this does not mean PFA training is not being used in these settings, the emerging body of work from the healthcare sector can provide an effective comparison to the workplace training, support and supervision needs of USCWs.

In healthcare PFA training is being used to help ameliorate the elevated risk of stress, burnout and mental health for frontline healthcare workers dealing with patient crises and public health emergencies (Søvold et al., 2021). The COVID-19 pandemic caused unprecedented levels of demand, strain and harm on health and social care systems across the globe (Hayes & Walters, 2020; McGilton et al., 2020; Samuel, 2020; Schoultz et al., 2022; Smith, 2020; WHO, 2021) and the use of PFA training is increasingly considered an effective psychological tool to extend mental health support to communities such as healthcare professionals and HCAs (Everly, 2020).

Surveying 64 student nurses both pre and post PFA training, Eweida et al., (2023) found that pre-PFA training, students were experiencing high levels of psychological distress and low resilience capacity as a response to the COVID-19 pandemic. Post PFA training, the students noted a significant reduction in psychological distress and likewise, a significant increase in feeling of resilience capacity. The psychological benefits of PFA training for healthcare workers are widely shared (Eweida et al., 2023; Lalani & Drolet, 2020; Movahed et al., 2022; NHS, 2023; Zafar et al., 2021), however, the quality and standard of training delivery can impact on how PFA training is understood and subsequently utilised.

Whilst acknowledging the promising potential for increased psychological wellbeing for frontline health care professionals who complete PFA training, Wang et al., (2021) undertook a scoping review which also highlighted that inadequate empirical data, guidance, reporting, training evaluation and unclear training outcomes needed to be strengthened before PFA training can fully enhance preparedness for future crises. Like Wang et al., Movahed et al., (2022) also found that PFA training programmes were often lacking in quality, being short in duration, without practical interactions and post training supervision, although again, they found PFA training to be of significant benefit to participants. Recipient experiences with PFA also remains understudied (Tessier et al., 2022), although Tessier et al found that PFA intervention helped address the immediate support needs of emergency medical workers who found the time-sensitive nature of the intervention, and closeness with peers, beneficial in reducing stigma and increasing help-seeking behaviours.

Psychological First Aid training is predominantly observed as a psychological tool to help frontline health and emergency workers manage the emotional impact of critical events. As such its application perhaps precludes the more mundane, yet nonetheless distressing and traumatic daily events of service user deaths, normalised violence and abuse, vicarious trauma and the commonplace, accumulative stress of the chaotic USCW workplace. Also missing from consideration for the provision of PFA training to wider groups, is the impact of worker lived experience of trauma and crisis and how these experiences affect individual behaviour and responses during times of increased stress. As Everly (2020) notes, the application of PFA can be far more wider reaching than first imagined. Therefore, understanding the ongoing impact of normalised and tolerated crises and emergencies, can help provide a more compassionate and meaningful lens through which to view the demands placed on often isolated and unsupported H&SC workers.

Psychological First Aid training clearly offers a promising psychological intervention to support those exposed to traumatic events, and it is becoming evident that PFA is an important aspect of psychological interventions and core mental health principles during pandemics and other disasters (Ursano, 2021). However, in practice the availability of PFA can be limited by a lack of resources and onsite mental health professionals (Wang et al., 2022), which combined with inadequate empirical data, poor quality training and record keeping may contribute to limited accessibility.

2.10 The Provision of Supervision in Health and Social Care

The consequences of difficult workplace incidences include physical, emotional, financial and psychosocial harm, and if not managed effectively by the worker and the organisation, can result in increased sickness absence, poor retention, poor job satisfaction and burnout (Ham et al., 2021; Lim et al., 2022a; Mento et al., 2020; Sebastian et al., 2021). Shifting the focus to available workplace support provisions, the health and social care supervision process is explored further.

Supervision is a process that sits within wider health and social care systems of practice, worker wellbeing support and service user safety. Effective supervision, as an essential component of work in the adult care sector, should represent a safe space where individuals get the opportunity to reflect, learn and feel supported, and should be standard practice for all staff members in adult social care (Hawkins & Shohet, 2012; Carpenter et al., 2012; SCIE, 2017; Skills for Care, 2020; Tobias et al., 2016). Field & Brown, (2019) describe supervision in social care as the action of directing and observing what someone does or how it is done, reflecting the legal, professional, organisational requirements and the personalities of those involved. Tomlinson, (2015) saw clinical supervision as having patient-safety and the quality of patient care as its primary purpose, whilst others appreciate the process as a more reflective, supportive, and relational goal-oriented alliance between the worker and the organisation (Gonge & Buus, 2011; Spence et al., 2001).

2.10.1 The State of Supervision in the Sector

Supervision delivery expectations fall under the Health and Social Care Act 2008 (Regulated Activities): Regulation 18 (CQC, 2023), although no clear guidance is offered around the type and/or structure supervision can take, and there are no sanctions available around poor provisions of supervision. However supervision is defined and regulated for in the health and social care sector, some unregulated workers may not be receiving supervision at all, and the failure of supervision provision for social care workers needs urgent attention (Rothwell et al., 2021). Care workers have also found themselves increasingly taking on more of the skilled responsibilities that were once tasked to registered nurses and social workers (UNISON, 2016). In response, effective supervision processes can help assess and support USCWs in accessing the right training, provide opportunities for reflection and learning, monitor worker and service user wellbeing and risk, and provide more general workplace support (Knox et al., 2021; SCIE, 2017; Tobias et al., 2016).

Regular and effective clinical supervision for individuals in the health and social care sector is a valuable tool in helping to reduce stress and burnout (C. T. Jones & Branco, 2020; Knox et al., 2021; Swedberg et al., 2013). However, previous studies have found both low availability and acceptance of its value, particularly amongst health care assistants (McCarron et al., 2018a). Recognised as a vital aspect of safe practice in social care, limited quality and consistency of supervision has been implicated in serious incident reviews (Bourn & Hafford-Letchfield, 2011; Donovan, 2016; GOV.UK, 2022a). Additionally, increasing care needs and demands in an ageing society living longer with disease (Age UK, 2019), and a declining workforce (Skills for Care, 2022a), continues to place additional pressure on the quality and provision of supervision.

2.10.2 The Benefits of Supervision

Research suggests that good supervision benefits wellbeing by providing an opportunity for peer support and stress relief, as well as a means of promoting professional accountability and skill; job satisfaction; knowledge development; staff commitment and retention; and positive mutually reinforcing experiences (Brunero & Stein-Parbury, 2008; Carpenter et al., 2012; Koivu et al., 2012; SCIE, 2017). Allbutt et al., (2017) perceived supervision to be beneficial when individuals participated fully, were given the chance to reflect and constructively challenge, were respected and had access to supervision that was consistent, protected, and suitable to the employee's circumstances.

It is acknowledged that effective clinical supervision can provide a beneficial space for nurses and social workers to discuss their emotional and physical labour, training and support needs (Carpenter et al. 2012; McCarron et al. 2017) yet despite the development of a number of definitions and models of supervision, it remains ill-defined (Ducat & Kumar, 2015). The provision of quality care is also enhanced when social care workers have access to structured, competent, and professional supervisory support (HCPC, 2022). Identified as being supportive of worker and service user wellbeing, Carpenter et al., (2012) also note that positive relationships between supervisor and supervisee and a space where workers can reflect and feel heard, can reduce staff turnover and increase commitment to the organisation.

2.10.3 The Impact of Abusive Supervision

Abusive supervision refers to an employee's perception of the extent to which a supervisor undertakes a sustained display of hostile verbal and nonverbal behaviours, excluding physical contact (Tepper, 2000). Abusive supervisory behaviours include but are not limited to being rude and disrespectful; breaking promises; invading privacy and sharing confidential employee information; humiliating employees in front of others; wrongly blaming employees for errors; purposely withholding information (Bies, 2000; Tepper et al., 2017); having loud and angry tantrums (Bies, 2000) and "petty tyranny" (Ashforth, 1997, p. 1).

"Stemming from the injustices that characterise the social exchange processes between supervisors and their subordinates" (Oyewunmi & Oyewunmi, 2022, p. 2), abusive supervision is common in the workplace (Estes, 2013; Kemper, 2016; Martinko et al., 2013; Tepper et al., 2017). Recognising a gap in the literature, Tepper (2000) examined the consequences of abusive supervision from an employee perspective. Tepper found that the experience of abusive supervision, much like other experiences of relational abuse, left employees feeling a sense of enduring powerlessness about how to address the problem, which was further compounded by financial responsibilities and worsening wellbeing. Employees often feel pressured to remain in abusive supervisory relationships until such times as the employee or the supervisor leaves the organisation, or the supervisor changes their abusive behaviour, and commonly, it is the employee who goes on to quit (Lavoie-Tremblay et al., 2016; Simard & Parent-Lamarche, 2022; Tepper, 2000).

Stein et al., (2020) asserted that abusive supervisors act intentionally and with a purpose, but that their immediate intent is not always necessarily to actively cause harm to the supervisee. Intent is an important aspect of abusive supervision (Stein et al., 2020), however supervisors may have other objectives and antecedents. These include using abusive supervision as a motivator for high performance (Stein et al., 2020); are supervising in a way both socially and professionally modelled to them (Bandura, 1977; Tepper et al., 2017); and/or are abusing the supervision space as a manifestation of unmet mental health, wellbeing and professional support needs (Tepper, 2007).

Whilst some studies have evidenced a positive correlation between abusive supervision and increased employee motivation (Zhu & Zhang, 2019), studies largely find that abusive supervision has far reaching harmful consequences such as subordinate employees experiencing high levels of insomnia and exhaustion; poor ethical practice considerations; worsening mental health and workplace attitude; substance misuse and work/family conflict (Mackey et al., 2013; Martinko et al., 2013; Shih et al., 2022; Zhang et al., 2018). Oyewunmi and Oyewunmi (2022) found a negative relationship between abusive supervision and worker behaviour, recommending an urgent reengineering of the toxic, vicious circle of abusive supervisors. They note that employees who wish to express concerns about abusive supervision are often impacted upon by mediating factors including the perceived receptiveness of their superiors; fear of retaliation; a lack of empowerment and agency; and the normalisation of abusive behaviours (Estes, 2013; Fischer et al., 2021; Tepper, 2000; Tepper et al., 2017).

Studies demonstrate a high rate of abusive supervision amongst healthcare workers (Estes, 2013; Lavoie-Tremblay et al., 2016; Shih et al., 2022; Simard & Parent-Lamarche, 2022; Zhang et al., 2021). Building on this and adding to the literature on whistleblowing intent in healthcare, Oyewunmi and Oyewunmi (2022) interviewed and surveyed 180 healthcare assistants to assess the likelihood of whistleblowing intention, and reasons behind decisions not to. The study found that abusive supervision was a common occurrence for many of the participants, who stated that their low status as healthcare assistants left them believing that their voices would not be listened to if they did speak out. However, the data also suggested that age and length of service was a mediator for perceptions of abusive supervision, with increasing age and experience positively impacting on abusive supervision perception. Given Oyewunmi and Oyewunmi recognised that normalisation can be a critical factor for tolerance to abusive supervision, and that normalisation is difficult to conceive and measure, older and more experienced worker perception of abusive supervision may in fact be representative of increased tolerance and normalisation through over-exposure.

Of the 391 usable nurse questionnaire responses, Estes (2013) found that 46% (182) had experienced abusive supervision, with 143 of this group going on to add that the experience had negatively impacted on their performance. Responses to abusive supervision experiences included: taking longer breaks; not following supervisor instructions; daydreaming; intentionally working more slowly; putting little effort into their role; and being late for work. Recommending a more fair and responsive approach to supervision, Estes proposed seeking guidance from nursing staff who would be able to identify the attitudes and behaviours that they value in a supervisor, subsequently integrating these qualities throughout an organisation. However, abusive supervision continues to be problematic within healthcare (Oyewunmi & Oyewunmi, 2022). Martinko et al., (2013) lamented that studies on abusive supervision have reached saturation point, but there is still much to be done and known, around how we mitigate for this damaging and toxic workplace experience. Following Estes (2013) lead, and in response to the lack of specific USCW literature around ‘their’ supervision experiences and needs, this study begins to help address this knowledge gap.

2.11 Community Health Workers

An absence of research on the lived and supervision experiences of the 1.5 million unregulated social care workers in England and Wales (Skills for Care, 2023), contributes to a lack of understanding and support for this occupational group. However, unregulated social care workers, or Community Health Workers (CHWs) as they are known in other countries, have been more widely considered. It should be noted however, that much like supervision experiences for unregulated social care workers, CHW supervision is also an under-researched area with a paucity of empirical studies (O’Donovan et al., 2018).

Predominantly found in African and South Asian nations, CHWs are laypeople who provide an important supportive role for primary health care services (O'Donovan et al., 2022), performing minor medical procedures such as wound cleaning and dressing, administration of medication and health monitoring (NHLBI, 2014). Alongside this they provide a link between professional health care workers and patients, and patients with their communities (WHO, 2021b). The term community health worker, has also been applied to unregulated workers, employed in roles who work with community groups presenting with non-medical issues as their primary concern such as homelessness, substance misuse and mental health (NHCHC, n.d.). In this context, the most key factor in a CHW's success within the community healthcare workplace, and with vulnerable clients, is thought to be the presence of a consistent, supportive and sensitive supervisor, given it is appreciated that lived experiences can impact on the worker and their performance (NHCHC, n.d.).

2.11.1 Supervision for Community Health Workers

Studies on supervision for CHWs make for similar reading in relation to the types of supervision enablers and barriers experienced by unregulated social care workers here in the UK. Appearing to garner wider stakeholder contribution and expertise, the provision, approach and perception of supervision for CHWs did in some studies appear more positive, holistic, appreciative, trauma informed and structured (O. Brown et al., 2020; O'Donovan et al., 2018). Poorly trained, junior and unskilled supervisors contributed to poor worker performance, as did irregular and infrequent sessions and supervision as a fault-finding exercise (Ndima et al., 2015). In addition, O'Donovan et al., (2022) noted a lack of evidence on what effective supervision is for CHWs, and that a wide variety of supervisor-supervisee relationships and inconsistent supervisory skills, prevents a more standardised approach to supervisory best practice (Schwarz et al., 2019). Recognising that CHWs work in the periphery of health care systems, Tseng et al., (2019), found that a lack of onsite supervision was demotivating, decreased CHW community credibility, that more experienced supervisors demonstrated more motivational and training strategies, and that supervision engagement should be a two-way process. Additionally, Daniels et al., (2010) highlighted the need for greater attention to supervisor experiences which can help inform future policy making, planning and the implementation of peer CHW programmes.

Challenging more traditional supervision models and approaches characterised by controlling, authoritative attitudes and checklists, Vallières et al., (2018) devised a robust six item measure of perceived supervision based on the feedback of over 1,000 CHWs from seven nations. Regular supervisory contact, two-way communication and joint problem-solving elements were seen as critical factors of the supervision process, with a supportive supervision approach being preferred by the CHWs, given it favours shared performance goals, mentoring and two-way communication (Kok & Muula, 2013; Marquez & Kean, 2002).

Supportive supervision approaches such as mentoring and effective communication (Ludwick et al., 2018), have been shown to increase productivity, role motivation and job satisfaction (Frimpong et al., 2011; Willis-Shattuck et al., 2008). Vallieres et al., (2018) also recognised that regular supervision alone was insufficient as a marker for successful engagement, and that workers who did not feel supported, compared to those who did, were found to be less productive (Frimpong et al., 2011). Consequently, CHW perceptions of the supervisory relationship is likely a more important predictor of work-related outcomes than frequency alone, and by only assessing the frequency of supervision and training of supervisors, these measures crucially ignore CHW perceptions of the supervisory process (Vallières et al., 2018). As a result, more studies that explore how CHWs experience supervision, and improved supervision delivery are needed (O'Donovan et al., 2022).

2.11.2 Further Considerations

Community health worker supervision studies highlight the shared nature of the CHW and USCW role, and the supervision enablers, barriers, and wider issues they both face. There are, however, fundamental differences that impact on making direct comparisons. Cultural and social/gender differences to the UK workforce were evident in the CHW studies and reviews, with an increased representation of men as CHWs (Crispin et al., 2012; McKague & Harrison, 2019), and voluntary CHWs as commonplace and highly valued members of primary healthcare teams (O'Donovan et al., 2022). This could suggest a different approach to the image and social construct of caring for others, as one done by both women and men, and where voluntarily CHWs are perceived as a normal and respected part of primary healthcare. Despite this however, supervision for CHWs still appears as ill-defined and inconsistent as it is for USCWs in the UK. Regulatory, funding and governmental constraints are also fundamentally different in the UK given we have a national health service, although adequate funding for health and social care is an issue experienced globally (Browne, 2021; Masis et al., 2021). However, research that looks to formalise support in more practical terms has yet to be explored despite attempts at structuring and standardising the CHW supervision process.

2.12 Chapter Summary

This chapter provides a comprehensive review of the extant literature found in relation to the unregulated social care workforce and evidences how the inquiry iteratively evolved through the ongoing analysis and synthesis process. However, much of what is known and extrapolated from the hundreds of health and social care documents considered, largely related to professional or allied professional healthcare and social care worker experiences. This highlighted a lack of empirical research focused on the personal and working lives of unregulated social care workers, despite what studies there are making an increasingly critical call for more effective supervision processes and sensitively tailored policy frameworks.

In addition to this, many of the empirical studies reviewed employed quantitative or mixed methods data collection in the form of questionnaires and surveys, which whilst helpful in contextualising USCW wider demographics and characteristics, meant that the 'how' or 'why' of a situation was seldom considered. Research in the unregulated social care sector lacks theoretical underpinning and conceptualisation, and in this instance the overarching concept of risk provided a meaningful platform from which USCW experiences can be better understood and managed. Given the aim of this inquiry was to better understand worker lived experiences and how these experiences impact on wellbeing, risk was conceived as risk to worker health and wellbeing.

Building on concepts of risk, aspects of health behaviour models were discussed, with a focus on worker wellbeing and practice development leading to the introduction of human factors and trauma informed approaches to worker care, training, and the supervision process. Under the health risk umbrella, it became clear that the unregulated social care workforce is exposed to myriad risks in the form of physical, emotional, financial and psychosocial harm. What also remains to be further explored for USCWs and starts to be addressed here, is the impact of personal lived experiences of risk on worker wellbeing, its impact on job intention, risk-taking, risk tolerance and performance, and how these needs can be managed and supported more effectively through the supervision process. Not yet considered in relation to USCWs, distress tolerance provides an interesting perspective on how USCWs tolerate and manage working with increased levels of service user distress, trauma responses and mental health, and warrants further investigation.

This study aims to provide a more meaningful understanding of the lived experiences of the unregulated social care workforce, their wellbeing needs, and supervision experiences to affect positive change for the USCW supervision process. Wider reading demonstrated that unregulated health care workers from around the world experience poor supervision provisions, with equally poor levels of research into the phenomenon. Exploring wider systems impact on supervision processes, abusive supervision, worker wellbeing and practice, the need for a new approach to the USCW supervision process is evident. The following methodology chapter helps to frame this approach. Reflecting the subjective and phenomenological nature of the study, the methodology represents the natural setting of a constructivist relativist inquiry and is underpinned by an interpretative phenomenological analysis (IPA) approach.

Chapter Three

Methodology

3.1 Chapter Overview

This chapter introduces the methodology of the study and describes in detail how this research was conducted, its aims, objectives, and justification for the qualitative and interpretative analytical nature of the study. Phase One and Phase Two of the study was carried out using interpretative phenomenological analysis (IPA), which focused on USCW experiences and the supervision process. Phase Three, which explored a new approach to supervision training, completed the data collection process. Interviews consisted of face-to-face, one-to-one, semi-structured interviews, that sought to uncover more about the individual lives, wellbeing needs and supervision experiences of USCWs. Phase Three was introduced in response to Phases One and Two, by means of a user-group reflection and ideas sharing exercise, situated around the process and delivery of supervision, and how the addition of supervision training might improve the supervision process.

Given the insider nature of the researcher, and the goal of identifying specific meaning and experiences for unregulated social care workers, a critique of the philosophical approach underpinning this inquiry provides a key aspect of data analysis and interpretation. The three phases of the research design are described, including details about the research participants, data collection and interview approaches, and how the findings across the three phases were analysed. Attention is given to ethical considerations, factors affecting the quality and credibility of qualitative research, and a position statement is presented, which situates the researcher's background and relevant workplace and lived experiences.

3.2 Research Aim

This study aimed to explore the lived experiences of unregulated social care workers' (USCWs) and supervisors' social care practice and supervision; identify how individual wellbeing was experienced and managed in the workplace; investigate perceptions of factors affecting engagement with and effectiveness of supervision encounters, and generate ideas for future support and supervision approaches.

3.3 Research Objectives

- To explore the lived experiences of unregulated social care workers, including their supervision encounters, and identify how these experiences affect their emotional and physical wellbeing.

- To investigate supervisors' experiences of providing and engaging with supervision and their perceptions of factors that impact on their ability to provide effective supervision for unregulated social care workers.

- To explore a new approach to the delivery of the supervision process.

3.4 Study design

The design of the inquiry reflects the ongoing exploratory nature of the Phase One interview process, where new knowledge and ideas helped to guide and shape Phases Two and Three. The original Phase One interview schedule drew from the extensive workplace experiences of the researcher as insider, which enabled a more nuanced, shared understanding of the real-world issues this workforce can be exposed to. However, COVID-19 changed the way individuals were required to work, and Phase One is representative of how USCWs were feeling after the first lockdown, adding a new perspective to the stressors of the role. It had already been anticipated that managers with supervisory responsibilities would be approached to participate in Phase Two, however, the Phase One findings helped focus the interview schedule on worker wellbeing and the supervision process, given these two factors had emerged as being critical to safe and effective USCW practice. An additional phase had been provisionally anticipated and Phase Three focus groups were added in response to Phases One and Two findings highlighting that worker (supervisee) and managers (supervisees/supervisors), both struggled to define what effective supervision was, or how to use it. Phase Three participants were recruited from Phases One and Two and were brought together in two mixed focus groups to discuss the creation of a supervision training module.

The study design was philosophically considered to reflect the sensitive and emotive nature of the subject area, and interviewees were encouraged to take their time in responding and feel reassured that they could say as much or as little as was felt comfortable. A conversational approach to the interviews encouraged rich and candid sharing, with the interview schedule applied in a fluid and iterative manner as the interviewer responded to the ebb and flow of the interviewee's thoughts and reflections.

3.5 Philosophical Perspective

All phases of the study were underpinned by a critical constructivist and relativist ontological philosophical approach, which sought to undertake the investigation in its natural setting whilst recognising the impact of wider societal forces (Appleton et al., 2002; Bentley, 2003; Guba, 1990; Guba & Lincoln, 1981; Guba & Lincoln, 1994). Critical constructivist and relativist philosophical perspectives support the assumption that the notion of reality is one simultaneously yet independently constructed by the interviewee and the researcher as a subjective, individual, relative, and fluid experience (Kivunja & Kuyini, 2017). The application of both critical constructivist and relativist research paradigms serves to gain a more insightful understanding of research participant perspectives, the events that arise from those perspectives and their associated connection to wider social systems and individual lived experiences (Bogna et al., 2020).

Individual beliefs and experiences are formed, shaped and evolved through the co-construction, applied meaningfulness and sense-making of external social factors, which is experienced in the form of the political, cultural, gender, social and economic values and influences of the time (Guba & Lincoln, 1994; Moon & Blackman, 2014). A critical constructivist and relativist approach to analysis helped to support the identification and interpretation of how the participants experienced and related to their own individual worldview, and how they perceived and managed workplace events in response to those beliefs and feelings. These cultural perspectives and influences join individuals' and communities' past and current experiences, not only through the phenomenological factors of the time (Mohatt et al., 2014), but also through shared social feelings and interpersonal contexts (Eslinger et al., 2021).

The unregulated social care workforce is subject to both personal and workplace power inequalities, barriers, and vulnerabilities due to the inherently risk-laden nature of the social care sector (Christensen & Manthorpe, 2016; Stanley et al., 2007; Swedberg et al., 2013; Wåhlin et al., 2020). For the USCWs, an unequal balance of power is experienced through several mediators, including hierarchical management structures, service user needs as dominant workplace consideration, and as a workforce struggling with a cultural, social, and political misperception of skills and needs. Both historical and on-going processes serve to impact on current subjective and objective cultural and individual interpretations and norms. It is therefore important to recognise that the highly gendered and economically insecure nature of the participant group (Bielicki et al., 2020; Kadri et al., 2018; Nguyen & Velayutham, 2018), should also be viewed through the lens of the historical decision making and cultural perspectives that led to these contemporary influences.

The study supported a transactional and subjectivist epistemology (Lincoln & Guba, 2000), implying that the standards of rational belief are those of the individual believer and/or those of the believer's community and society as they are lived, experienced, and constituted in their consciousness (Moon & Blackman 2014). The unregulated social care workforce is subject to complex historical and current external political, economic, cultural and global influences and antecedents. As such, understanding their wellbeing support needs and the workplace impact of specific lived experiences requires an appropriate choice of methodology, taking into consideration not only methods of data collection and analysis, but also the influence of the unique experiences and positionality of the researcher.

3.5.1 Statement of Position

This position statement highlights the key philosophical themes considered when attempting to understand how my own state of privilege, intersectionality, bias, and other components of my worldview, shaped my position in relation to this scholarly work (Carter et al., 2014; Holmes, 2020). To ensure methodological and data transparency, honesty, and integrity in qualitative research, it is important to understand the philosophical, experiential and psychosocial relationships between the subject of inquiry and the investigator (Steltenpohl et al., 2022; Tuval-Mashiach, 2017). This positional information helps support the reader to make up their own mind about the quality of the findings, and is situated immediately after the philosophical perspective section, to help add a wider, more individual, philosophical context around how this study was conceived and addressed.

Before I go on to present the findings and recommendations in the following chapters, and in the spirit of self-reflexivity, I would like to acknowledge my own position as an educated, White woman in good physical and emotional health; an individual who is able to exert a relatively high degree of choice and control over their life and someone who does not currently experience harm or abuse. I have over 25 years of experience working in the unregulated social care sector as both worker and supervisor, predominantly within more complex needs and specialised community support settings, education and learning disabilities. I am the first in my family to have attended university, although a history of adverse childhood experiences meant the opportunity was less successful and emancipating than hoped for; fraught with my own unmet mental health needs; impacted upon by unpredictable family-related issues and caring responsibilities for my late Mum, who was an alcoholic and victim of domestic abuse and violence.

At aged 40, a somewhat typical workplace event triggered a post-traumatic stress response which initiated contact with a trauma therapist. Eighteen months of weekly Eye Movement Desensitisation and Reprocessing (EMDR) treatment for Complex Post-Traumatic Stress Disorder, enabled me to emerge from a 28-year long panic attack, and begin learning how to take better self-compassionate, and self-aware care of myself. It was this timely therapeutic intervention and the profound reflective learning and growth that followed, that inspired and motivated me to return to Higher Education and this research journey.

I am a carer, and my Mum was a carer. When I was a little girl, she would take me to the older persons residential home she worked at, and I would sit and listen to the residents' stories and help them out with little things. She later went on to work as a domiciliary care worker, riding her pushbike and ringing her bell as she cycled around the town. At 18 I walked into a local YMCA and volunteered to work with the homeless men who resided there, and I have been passionately caring about the lives of others ever since, although I cannot recall a time when I had not cared deeply about the wellbeing and opportunities of vulnerable and unequal others.

As an individual interested in the lived experience voices of others, and easily able to create a space of reliable safety and relational connection, my peers would often feel able to, or need to, share with me their own personal lived experience struggles and challenges. Over time I became increasingly aware of how frequently they would disclose personal histories of violence, abuse, neglect, and trauma, alongside workplace stressors and experiences of harm. As a highly inquisitive, hypervigilant, and empathic individual, this phenomenon, given its close relation to my own experiences, interests me profoundly. I am also privy to the lack of effective, compassionate, and responsive support and supervision available within the unregulated social care sector, and it is this that motivates me to find a better way of supporting this valuable, vital and worthy workforce.

These shared lived experiences and personal characteristics have enabled me, as both insider and researcher, to comfortably identify with this uniquely hidden social group from an authentic, relatable, reflexive, and sincere perspective. My status as insider/researcher was shared by all participants as a positive and beneficial aspect of the study, and one of the main reasons they believed they would be listened to, understood, and taken seriously. It is difficult to imagine how these lived experiences could not impact on my worldview and as with all qualitative inquiry, any subject of study cannot be viewed value free (Gillani, 2021). However, given my journey as victim, worker and researcher uniquely places me in a space of increased experiential expertise, insight, and knowledge, this provides an opportunity for “value-adding” analysis (Eakin & Gladstone, 2020, p.1) that contributes wider meaning making, informed shared connections, sensitivity to the subject of the inquiry, and the ability to make suggestions for real change.

I acknowledge that at the start of this research journey, my emotional attachment and positionality as unregulated social care worker and trauma victim influenced this project to a significant extent. However, I have been able to draw upon my determination, resilience, reflexivity, willingness to challenge my own preconceptions, doubts, and optimism, to ensure the research process from conception through to summation, honoured the participants’ views and beliefs, with a consistent focus on ‘their’ voice. Over time, I have been able to trace the ontological and epistemological spaces of divergence and convergence between myself, my focus of study and those who participated within it and have reflectively and reflexively developed and grown in conjunction with ongoing academic knowledge building, and goals for future postdoctoral investigations.

As a saver, a helper, and a fixer, I was required to suspend my innate drive to make everything better, instead, providing this hidden community the opportunity to be heard and made visible as they are. My supervisors, aware of my compassionate and therapeutic experience of interviewing vulnerable adults in the social care sector, encouraged me to consistently reflect on my role as interviewer and observer, challenging my desire to comfort and console. My motivation to inform real social impact for this workforce, and a consistent, reflective self-checking-in process, supported an effective and swift reframing of role, purpose, and skills as a researcher.

As a childhood survivor of domestic abuse and violence, and with the benefit of compassionate reasoning and understanding, I have been able to utilise significant post-traumatic growth skills including increased situational and self-awareness, resilience, adaptability, attention to detail, strong communication and social skills, increased empathy and self-efficacy, and the drive to raise the life world opportunities for others through applied research. It is this keenness for justice and equality that drives a goal for accessible philosophical and theoretical empowerment, and the dissemination of authentic, meaningful, and resonant knowledge sharing. Given my history, I am consistently mindful of my own wellbeing, which requires ongoing reflexive consideration of my own vulnerabilities, need for self-care, authenticity, self-protection, and patience.

Whilst it was my personal experiences, ideas and unique perspective as insider/researcher that helped create this study, it was the participants who graciously and candidly shared their own experiences, beliefs and ideas that then helped to bring wider meaning, understanding and light to this hidden, under-studied and 'perceived' hard-to-reach community group. The reflexive appreciation of my positionality supports a philosophical and experiential alignment with the IPA process. An IPA methodology encourages the researcher to consider the interpretations of their own lived experiences and expertise alongside those of the researched, adding a credible and sensitive approach to the investigative experience. I have written in the first person on occasions in forthcoming sections, to highlight where my unique position has influenced the methodology and method of this study.

3.5.2 Phenomenology

To introduce this section, I offer a brief explanation of why interpretative phenomenological analysis (IPA) was chosen as the study's methodology. Interpretative phenomenological analysis speaks to me as an individual, as a practitioner and as a researcher. I believe that the experiences of individuals, and how they subjectively make sense of them, can hold a real sense of meaningful transferability and value to others, connecting us and providing reassurance that we are not alone. The aim of the study was not to merely describe what was going on for some of the USC workforce at that time, but to create a genuine feeling of sensitive and authentic interpretation, understanding and relational connection between the participants and the reader. The worsening state of social care is an important and urgent issue that negatively impacts on the safety and wellbeing of individuals daily, and an IPA approach has helped uncover and make sense of both the unique, and the shared experiences of this under-researched workforce group. It is the impassioned voices of individuals that can often have the most power for positive change, and one of the aims of the study is that readers are left with an increased sense of empathy, compassion and respect for this valuable workforce.

An IPA methodology was chosen for this study because I judged that it represents the best methodological option given the needs of the study, my own philosophical leanings and the opportunity to be creative and progressive. A paucity of empirical data and extant literature on the lived experiences of unregulated social care workers compounded this, meaning a creative approach to exploring the issue was required. The lack of rigid structures and processes was seen as a challenge but as a solution focused practitioner, the challenge was appreciated as an important part of furthering the analysis and synthesis process which wholly benefitted the study. As further validation for the use of an IPA methodology, the discipline of phenomenology is briefly explored before moving on to IPA in more detail.

Interpretive phenomenological analysis is underpinned by phenomenology, idiography, and hermeneutics (Noon, 2018). Phenomenology was launched by Edmund Husserl who attempted to construct a philosophy of pure subjectivism, in response to the pure objectivism of naturalistic inquiry that had dominated philosophical reasoning (Farber, 2017). The phenomenological approach contests that anything outside of immediate individual experience must be ignored, reducing the external world to the contents of idiographic, particular consciousness' (Groenewald, 2004; Smith et al., 2013). Following this tenet, Husserl developed transcendental phenomenology, a philosophical approach grounded in the concept of setting aside (bracketing) preconceived ideas, to view and record phenomena through unclouded lenses, thereby allowing the essence of true meaning of what it is to be a 'human being' to emerge (Dörfler & Stierand, 2020; Eatough & Smith, 2017; Mabaquiao, 2005; Sheehan, 2014). Husserl went on to recognise that without the context of experiences, consciousness would be meaningless (Moran, 2000), however, his idiographic approach to inquiry provides a meaningful contribution to qualitative inquiry and IPA. An idiographic study seeks to offer insights into how a particular individual behaves and makes sense of a particular situation, and in this IPA study, represented a commitment to a sense of detail to both the individual, and the wider group the individuals belonged to (Smith et al., 2013).

Expanding on Husserl's work, Martin Heidegger's hermeneutic approach had at its aim, the interpretation of phenomena, the uncovering of hidden meaning, and that researcher interpretations and life-world experiences are not to be suspended, but used to further our understanding of the nature of human existence (Dowling, 2004). The study of hermeneutics also known as the art of understanding and interpretation (Alsaigh & Coyne, 2021), emphasises the use of ordinary language to describe what it is like to 'be' human in the world (Rapport, 2005). In this IPA study, the use of shared 'common' language and relational experiences between insider as researcher, and the researched, supported an authentic interpretation and analysis process.

Not bound by a structured, process driven methodology of universal principles, interpretive phenomenology also requires more explicit guidelines and quality frameworks to promote ease and success of use (Alsaigh & Coyne, 2021). At its core, this study sought to use hermeneutics as a way of better understanding the lived experiences of USCWs and how they interpreted these experiences in their own language. The exploration of interpretation was two-fold. First, the investigation of how participants interpreted their life-world and made sense of these experiences. Second, the inclusion of my own empathic and suspicious interpretation of what was and what was not being said, was included for analytical consideration.

Hermeneutics was expanded upon further by the work of HansGeorg Gadamer, who contended that individuals only understand their being through language, positioning conversation as the key element of the hermeneutic process (Nigar, 2020). Conversations and stories are used to make sense of everyday life, and for research purposes, represent interaction, creativity and freedom (Feldman et al., 2004; Nigar, 2020). Narrative phenomenological research involves the collection and interpretation of stories to better understand how individuals make sense of their life-world experiences and perceptions (Feldman et al., 2004), and in person-centred health and social care, these stories matter (Martinsen et al., 2012; Mccloud et al., 2012; Moules, 2019; Webber, 2020). As insider/researcher, there was already a sense of relational connection with the participants, and this was reflected in the conversational and candid ways the participants easily shared their stories. This sense of ease created a space of narrative freedom and the participants reflected and made sense of their world as they spoke.

Whilst proposing a similar approach to hermeneutics as Gadamer, Paul Ricoeur contested that interpretive distance is required from the narrative in order to gain an adequate viewpoint, which Gadamer perceived as a capitulation into positivism and the natural sciences (Bohorquez, 2010). Ricoeur distinguished between two forms of hermeneutics, introducing a hermeneutics of faith and a hermeneutics of suspicion, although he went on to refer to hermeneutics and suspicion as separate terms (Bigger, 2011). A hermeneutics of faith strives to give authentic voice to the participant, while the researcher, viewing the narrative from the viewpoint of the hermeneutics of suspicion, is able to strip away conventional understandings of language and gain new insights and meaning beyond the text itself (Josselson, 2004). Research can therefore be both faithful to the participant's narrative 'and' be suspicious of hidden and disguised meaning, particularly when interviewing vulnerable individuals who live and work within hierarchical and unequal systems, as was the case in this study. As insider/researcher, distance and detachment from the participant group was something that initially needed reframing. Given my insider status I was already aware that this workforce is vulnerable and at risk, and that they may hide and disguise meaning to avoid facing difficult feelings. As such, the data is faithful to the participants' lived experiences whilst an empathic and suspicious mindset was maintained from the outset.

Emerging from the field of phenomenology during the mid-twentieth century, Merleau-Ponty defined phenomenology as the study of essences, including the essence of perception (Scott, 2002), claiming that human beings connect with one another through more than just language (Nixon, 2020; Pish, 2016). He viewed science as mistakenly categorising the phenomenology of perception (the way things look) into categories of the world that simply need to be explained, emphasising that senses can arise 'after' perception has taken place (McClamrock, 1990). Merleau-Ponty's thoughts also provide a useful contribution to the understanding of and responding to racism, sexism, ableism and ageism, and how acts of violence and oppression are corporally perceived and sensed before and after they occur (Toadvine, 2016). According to Baldwin (2013), Merleau-Ponty's arguments draw on idealistic assumptions that are too weak to dissuade those sympathetic to the natural sciences. However, Merleau-Ponty's approach brings much to the complex feelings and interpretations uncovered by this study, providing an important sense of appreciation for the corporeal and embodied impacts of difficult lived experiences and violence on this vulnerable workforce.

In their essence, phenomenological studies are Husserlian in nature, and it is this rich, descriptive approach to understanding the experiences of individuals that was employed in this study. However, the aim of this study was not to merely describe the life-worlds of individuals, but to try and understand and find shared meaning in order to improve future conditions for the group. Utilising an IPA methodology, a Heideggarian hermeneutic approach was employed, however, given the context of the USCW, the approaches of Ricoeur and Merleau-Ponty were also felt important, given the highly physical and emotional nature of intimately caring for vulnerable others. Consideration was given to the a priori and experiential knowledge already known about the workforce, and that participants likely had lived experience of vulnerability, and workplace tolerance to financial, physical and emotional harm. The normalisation of these experiences required the use of a suspicious lens around understanding how the participants' life-worlds were perceived and managed, and the stories they may tell themselves to pacify and cope with these difficult experiences. As an underrepresented, under researched, undervalued, and vulnerable workforce community that cares for our most vulnerable, a phenomenological understanding of how this workforce responds to their life world experiences can be of great value to academics, theorists, risk assessors and policymakers alike. Building on the discipline of phenomenology, IPA is discussed in more detail next.

3.5.3 Interpretative Phenomenological Analysis (IPA)

Like its phenomenological predecessors, interpretative phenomenological analysis (IPA) involves an idiographic, detailed, and highly descriptive focus on the participant's life world, which seeks to explore how individuals make sense of their personal and social experiences (Alase, 2017). Interpretative phenomenological analysis is concerned with subjective, personal perceptions, and how these forces impact on the self, and the self as part of a wider shared community (Smith et al., 2013). At the same time, it is also emphasised that IPA research is a dynamic exercise, with an active, considered role for the researcher (Peat et al., 2019; J. A. Smith & Osborn, 2015), and one which adds experiential value to the analytical and interpretative process (Eakin & Gladstone, 2020).

The IPA active researcher role has become increasingly noted as an effective methodology in psychology and health studies (Alase, 2017; Briggs, 2010; Mole et al., 2019; J. A. Smith & Osborn, 2015), recognising that within the exploration of the idiographic, there are also wider pro-social benefits to be learned (Ahn et al., 2016; Pack et al., 2017). The benefits of applying an IPA approach to this inquiry are twofold. Firstly, the unregulated social care workforce is scantly represented in the literature, which means policy makers, academics, organisations, and professional bodies know very little about them either as a group or as individuals. Secondly, due to the vulnerable and often hidden nature of the USCW role, workers may feel more comfortable with sharing their experiences with someone they can directly relate with (Stephens & Knight, 2022). It is this opportunity to develop relationships with participants (Alase, 2017), and capture the phenomenon of individual human consciousness', that has also likely contributed to IPA becoming a preferred method of choice when researchers seek to study what an experience means to a particular group of people (Biggerstaff & Thompson, 2008; Grossoehme, 2014).

Part of a family of phenomenological and psychological approaches that seeks to examine a subject as far as possible in its own terms (Smith & Osborn, 2015; Willig & Stainton Rogers, 2017), IPA also acknowledges that individuals are influenced by the world in which they live in, and experience (Peat et al., 2019). Taking an idiographic approach to social inquiry (Biggerstaff & Thompson, 2008), IPA supports research that focuses on the individual, and the individual as part of a larger community. As such, IPA is commonly characterised by small and specific participant sets, and a highly iterative, immersive approach to data exploration, interpretation, analysis and write up (Smith et al., 2013).

Through the introduction of an additional hermeneutic consciousness, IPA builds upon the discipline of phenomenology (Smith & Osborn, 2015). This consciousness is recognised as a relational expert, someone able to contribute to the understanding of the participant's unique interpretation of their life-world, and add value to the process itself. Consequently, my shared lived experiences enabled a more knowledgeable and insightful analysis and data interpretation process. Interpretative phenomenological analysis is therefore a double-hermeneutic process. This means that the lived experiences and how they are individually and culturally embodied and interpreted, by both participant and researcher, are considered and challenged during the analytical and interpretative phases (Smith et al., 2013). IPA draws upon the fundamentals of hermeneutics (Noon, 2018) and its specific role in the methodology of the study is explored further next.

3.5.4 Hermeneutics and Interpretative Phenomenological Analysis

Hermeneutical philosophy has a much longer history than IPA (J. A. Smith, 2007), and attends to the study of interpretation and how the world is experienced in the individual embodied sense, and not how it is conceptually imagined (Mccaffrey et al., 2012; Regan, 2012; Suddick et al., 2020). The hermeneutic circle also supports a rich introspective and on-going dialogue for the researcher (Mccaffrey et al., 2012), who is encouraged to reflexively consider their own life-world experiences in relation to participant experiences. In this instance, a constant, critical, and compassionate lens was used when exploring and challenging my own difficult workplace experiences, recognising that passion for change can at times impede self-reflexivity and participant focus. As the IPA study progresses this attention to experiential interpretation can also help enrich the quality, rigour and meaningfulness of the data analysis and write up process (Paterson & Higgs, 2015).

Occupationally, hermeneutic phenomenology can also help support a wider understanding of how unregulated social care workers experience challenging events. If we view unregulated social care workers as users of policy and organisational cultural practice, which includes supervision (SCIE, 2017), understanding their interpretative experiences of policies and support provisions can help shape future support and policy decision making. In response, the IPA hermeneutic circle, can provide a space for on-going dialogue (Mccaffrey et al., 2012), relational understanding and reflexive learning, which is ideally suited to understanding the ongoing supervision process in the health and social care sector.

3.6 Method

The method used reflected the qualitative nature of the study, in that it sought to identify and describe the phenomenological experiences of unregulated social care workers and how these experiences can help develop future support and supervision processes. As insider/researcher, and practitioner experienced in interviewing and supporting vulnerable adults, a degree of knowledge and expertise around the expected needs of the participants was utilised when selecting the method and mode of enquiry, given interview questions can elicit difficult emotional responses.

3.7 Ethical Considerations

Ethics in research pertains to the concept of doing good for others, whilst avoiding harm to those involved in the research process (Orb et al., 2001), although harm and risk are relative notions that cannot always be avoided when discussing sensitive or taboo issues (Wiles, 2013). Ethical reflexivity in qualitative research, is a core feature as ethical questions and situations can arise in every phase of the research process (W.-M. Roth & Von Unger, 2018). Harm can be prevented or reduced through the application of appropriate ethical principles, and in health research, attention must be paid to the participant who is being asked to share sometimes difficult lived experiences, including experiences about those in positions of power over them (Aluwihare-Samaranayake, 2012). Those taking part in qualitative studies can be exposed to the risk of increased anxiety through social, situational, cultural and physiological mediators including: the general anxiety of being in a new, formal situation; unequal researcher-researched status dynamics; the (over)sharing of difficult and hidden lived experiences and that publication of research findings may have personal and professional repercussions (Aluwihare-Samaranayake, 2012; Richards et al., 2002).

The small nature of local service delivery also meant that anonymity and confidentiality was critical to ensure those who participated felt safe to do so. However, my researcher status as compassionate, empathetic insider, and as experienced, self-aware social care practitioner positively contributed to a relaxed, easy and engaging interview space, where vulnerable participants could feel safe and listened to. A competent and confident approach to my own social care practice required me to reflexively monitor my language and responses during the interviews, to ensure my researcher "hat" was always worn. Perceived as beneficial for the purposes of this worker group inquiry however, an insider/researcher status offered additional perspectives through which literature and empirical findings were assessed.

Given the occupational status of the participant group as social care workers, advice around ethical considerations was initially sought from the local NHS Research Ethics Committee. As all participants worked for independent social care organisations, the Committee was satisfied that the researcher's University Research Ethics Committee would be able to address necessary ethical considerations. As insider/researcher and social care practitioner, identifying and managing the impact of risk and harm is a familiar exercise, and one that fostered an insightful and sensitive approach to participant safety considerations. In consideration of these potential safety considerations, participating gatekeeper organisations were approached to offer a post-interview confidential space for study participants to access if needed. The ethical approval sought, covered all three phases of the study, and the study was given consent with Ethical Approval Number EP121 (See Appendix 1).

After speaking with unregulated social care managers, those who were happy to support their staff to participate in the research were sent an introductory contact statement by email (see Appendix 2) for dissemination amongst their staff teams. Workers who expressed an interest in taking part were sent an information sheet (see Appendix 3) and consent form (see Appendix 6) to sign and return prior to interview and/or focus group. This process was repeated for Phase Two (see Appendix 4). Verbal consent was sought again at the start of Phases One and Two interviews, with focus group members individually asked to verbally give consent at the start of their session. Throughout all three phases, interviewees were reminded that they did not have to respond to questions that they were not comfortable answering, that they could withdraw their participation at any time and their data deleted, and that all information would be anonymised. Participant demographics were only sought in Phase One (workers) to reflect the worker focus of the inquiry. Participants were also advised that there may be additional opportunities to engage in further research and to indicate whether this was something they would be interested in doing. Those who went on to participate in Phase Three were again sent a participant information sheet (see Appendix 5), consent form (see Appendix 6), asked to give verbal consent and advised that they could withdraw their participation at any time. Additionally, ethics is considered alongside other quality criteria.

3.8 Sampling and Recruitment

Following approval from the University’s Ethics Committee for all three research phases, participants were initially sought from local, independent unregulated social care providers. Supporting an IPA approach to inquiry (Pietkiewicz & Smith, 2012, Smith et al., 2013), purposive sampling was employed to invite USCWs, aged 18 years and over and who worked for gatekeeper providers, to participate in the study. Purposive sampling is widely used in qualitative research for the identification and selection of information-rich cases related to the phenomenon of interest (Palinkas et al., 2015). Calls for USCW participation was initially discussed with service managers via email or the telephone, with reassurances around USCW post-interview support sought, and that the organisation was happy to share the invitation to interview with their staff-teams. I also offered to join a team meeting to explain the research further if needed. Managers who agreed to participate were sent an information/contact sheet for wider dissemination to the staff team.

To encourage breadth and depth of workplace and service user experiences, social care agency, domiciliary and residential services managers known to me were contacted via telephone and email. These services included learning disability, older persons, and more specialised community support service user groups. As a local practitioner and community member, approaching and networking with individuals and organisations was an enjoyable and productive activity, but whilst a great degree of interest in the research was shown, most did not get back to me about the opportunity. An approach to the local social care commissioner, garnered interest from gatekeepers.

3.9 Participants

3.9.1 Phase One

Between ten and 15 interviews were initially sought, which is in keeping with quality small scale IPA studies (Smith et al., 2013). Fourteen staff members holding the post of unregulated social care worker accepted the invitation for interview. Of the participant group, 13 were British, and one European, 10 identified as women and four as men. One participant shared that they lived as a transgender man. Three of the participants described themselves as gay. Participants were aged between 21 and 60 years with an average age of 45 years, and eight were parents.

3.9.2 Phase Two

Initially, between five and seven supervisors from a range of services were sought for the Phase Two interview process. However, after the research opportunity was more widely shared by others, the Phase Two interview phase resulted in nine supervisors taking part from nine services. As the aim of the study was to explore the lived and supervision experiences of USCWs, data beyond their role and sector was not sought from the Phase Two participants.

3.9.3 Phase Three

Phase Three participants were invited from the Phase One and Phase Two participant pool. Eight agreed to take part in a focus group, although two were required to cover shifts at their place of work and one had technological difficulties on the day. Five participants (three Phase Two and two Phase One) eventually took part in the Phase Three focus group.

3.9.3 Participant Characteristics

All participants were pseudonymised. More detailed participant tables of the three data collection phases can be found in the Findings Chapters.

Table 1

Participants

		Age Range	Gender
Phase One	14 unregulated social care workers	21-60	10 women 4 men
Phase Two	9 social care managers with supervisory responsibilities		7 women 2 men

3.10 Approach to the Interviews Phases One and Two

Prior, wider reading suggested that the USCW group was a hard-to-reach community group for research purposes (Law, 2016; Long, 2017) and it felt important to ensure the Phase One interview opportunities were accessible and welcoming. However, that the researcher was also insider appeared to act as a motivator for engagement and a buffer against any uncomfortableness felt when discussing more difficult work and lived experiences. Different considerations were had around the interview approach for Phase Two participants, who, as supervisors may have felt defensive or unwilling to share their own poor experiences around supervision and their own supervision learning needs. As both insider and skilled practice-led interviewer, I was able to foster a comfortable and relational connection with the interviewees, which led to participants feeling able to share sometimes difficult lived experiences and workplace events.

Prior to interview, Phases One and Two participants were advised that interviews would last between 60 and 90 minutes and reminded that they could stop the interview at any time with no reason given. The shortest Phase One interview lasted 52 minutes and the longest 122 minutes. In Phase Two, the shortest was 55 minutes and the longest 109 minutes. The mean interview duration for Phase One was 90 minutes and for Phase Two, 77 minutes. Phase One interviews were conducted between October 1st 2020 and December 31st 2020, Phase Two in August 2021, and Phase Three in January 2022.

Both Phase One and Phase Two interviews were facilitated using semi-structured questions that addressed initial and emergent research aims and objectives. Semi-structured interviews represent a flexible interview guide that provides a clear set of instructions for interviewers, and can provide reliable, comparable qualitative data to ascertain participants' perspectives regarding an experience pertaining to the research topic in their own terms (D. Cohen & Crabtree, 2008; McIntosh & Morse, 2015). The semi-structured interview process enabled the researcher to address several more specific and guided topics, whilst encouraging participants to engage in a more meandering, conversational and relaxed approach to sharing their stories and experiences. Responsive and probing questions were employed as the interview developed, and interviewees were given the space to take time to reflect upon the questions and their answers (Adams, 2015; Rabionet, 2011). After sharing my own insider status with the Phase One participants, most interviewees shared that the researcher's position as insider/researcher had been instrumental in encouraging them to participate and had made sharing easier. However, this initially served to trigger a sense of increased burden of responsibility and advocacy in me as insider, which ongoing required reflexively and sensitively managing as researcher.

3.11 Approach to the Focus Groups Phase Three

By means of a member reflection and information sharing session (Clarke & Braun, 2013), Phase Three of the study was added in the form of two online focus groups, both lasting approximately 60 minutes. Focus groups, although a relatively contemporary research method, have become a popular framework for social inquiry (Smith et al., 2013), and are particularly suited to uncovering unexpected aspects of social experiences, as the process concentrates more on the frames of reference of the groups analysed, than on those of the researcher (Morgan & Spanish, 1984). Focus groups allow multiple voices to be heard, drawing a larger sample in to a small data collection event (Smith et al., 2013), and this type of group interaction is thought to be better at reflecting the socially constructed nature of knowledge (T. Moore et al., 2015).

The COVID-19 workplace landscape saw many employees move parts, if not all, of their role from the workplace to the homeplace (Okuyan & Begen, 2022), and as such online focus groups were felt to be more accessible, safe, and easy to organise (Okuyan & Begen, 2022). Consideration was given to whether moving the focus groups online would exclude some participants and all those who engaged in either Phase One and Phase two, were offered technological support and practice runs prior to their focus group. All Phase Three participants were advised that they could turn off their cameras, and they did not have to provide any personal and identifying details if so wished.

Focus groups are traditionally carried out in person, and supported by a moderator who facilitates the discussion and keeps participants focused on the topic of interest (Reid & Reid, 2005). An observer is commonly employed to take notes on the session (Acocella, 2012). The moderator’s role is to create a comfortable environment where individuals feel able to contribute and share freely, and it is advisable that these discussions take place among people who share similar interests and who feel equal (Acocella, 2012). As an experienced and competent group facilitator and moderator, the researcher felt confident in ensuring a relaxed, enjoyable, and productive focus group experience. Participants gave their permission for the focus groups to be recorded for the purposes of transcription and analysis and were encouraged to use the chat function if needed, which mitigated the need for an additional moderator.

An online group context requires a different set of engagement rules, given only one person at a time can be heard, and there is generally a lack of visual cues which can add to a sense frustration and impatience for some participants (Tates et al., 2009). An online forum can also expose participants to other disadvantages including technical difficulties and distractions, with two Phase Three participants experiencing internet connection difficulties on the day which hampered engagement. Online focus groups have, however, been noted to offer more time to collect one’s thoughts and reflect before choosing what to contribute, given more confident participants may dominate in-person discussions (T. Moore et al., 2015; Reynolds, 2022).

3.12 Data Collection

Reflecting the needs and ethical expectations of the time, the collection of qualitative interview data strictly adhered to COVID related social distancing guidelines. This meant that Phases One and Two interviews were initially offered as an online activity, however it became apparent that several Phase One participants did not feel confident with using online meeting platforms at that time and requested that their interview be carried out in person. All social distancing and sanitising guidelines were adhered to on these occasions and interviews were held away from the participants workplace to ensure confidentiality, anonymity, and freedom of speech. Concerns were initially voiced around how online interviews might conversationally and relationally differ from more traditional face-to-face contact. However, those who opted for an online interview were by this time familiar with new ways of online communication and working patterns and appeared relaxed and happy to engage through this platform.

3.12.1 Phase One

Each Phase One participant was introduced to the research aims prior to interview and some demographic data was sought. The research aims covered the following five areas of interest: the participant’s motivators and experience of their role; difficulties and challenges that they may experience; the participant’s support networks; their experience of supervision; and what they would like to see in the supervision process in the future. To gather the lived experience of workers in their terms, the interview questions were broad with follow up questions prepared to meet the overall research aims. The full interview guide can be found in Appendix 7.

As the Phase One participants talked about their experiences, additional prompts using how, what, and why questions were used. This helped to promote a person-centred experience where the participant was able to lead the interview and exert a degree of control over their interview experience. In interviews where the participant did not organically include the information sought, prompts were again used. After discussing an area of inquiry, the researcher introduced the next set of questions, reminding the interviewee that any questions they found uncomfortable or difficult could be missed, and that they were free to discuss current and past health and social care roles and supervision experiences.

3.12.2 Phase Two

As with Phase One, Phase Two participants were introduced to the research aims prior to interview and were advised that the research questions would concentrate on supervision experiences as both supervisor and supervisee. Given manager wellbeing needs were not the focus of the study, additional demographics were not sought beyond their role, gender, qualification, and area of practice. A semi-structured approach to questions was adopted given the specific goal of the interviews, however a person-centred focus was encouraged, where the participant was able to lead and exert a degree of control over their interview experience. Prompts were again used in instances where the participant did not organically include the information sought. The interview questions were based on four themes: the journey of managers and those in leadership roles; reasons for choosing to work in management and leadership roles in this sector; the demands and challenges of the role; and the supervision process and the support and training they receive and/or would like to receive. The full interview guide can be found in Appendix 8.

3.12.3 Phase Three

All Phase Three participants had taken part in either Phase One or Phase Two of the initial data collection process and as such, had already been introduced to the researcher and the aims of the study. Phase Three took the form of an online focus group and as such, whilst questions were established as engaging and directive prompts, conversational flow amongst the focus group members was encouraged as much as possible, with individuals reminded of previous comments when ideas stalled within the constraints of the online focus group format. The overall focus group question is provided below, this was followed by additional engagement and exploration questions which can be found in Appendix 9.

Overall Focus Group Question – “What might supervision training for unregulated social care workers include and how could supervision training for unregulated social care workers be more effectively designed and delivered?”

3.13 Data Analysis

3.13.1 Phase One

Phase One of the study was influential in determining how the following study phases would be approached and facilitated in relation to the ongoing focus of the inquiry. Consequently, a significant amount of attention was applied to this phase given the depth, richness, candour, and overall aim of the data collected. All interviews were transcribed verbatim by the researcher, which helped to nurture a sense of deep and meaningful engagement with the findings, before being printed hard copy and thematically organised on flip chart paper.

The Phase One data analysis took approximately six months to complete. Overall, there were approximately 22 hours of interview data to analyse, and the richness, candour and depth of the responses and reflections necessitated an iterative, immersive, and reflective approach. The interviews were repeatedly listened to prior to transcription, to get an accurate and embodied sense of what was being said and how. Participant voices were central to the authenticity of the study, given their lack of representation in literature, and the iterative process was considered paramount to identifying and understanding this new knowledge. Pauses, laughter, sighs, and intakes of breath were all noted and transcribed, given they added meaningful non-linguistic responses and evidenced feelings that words were unable to express.

After all 14 interviews were transcribed, each interview was read and re-read (Alase, 2017; Biggerstaff & Thompson, 2008), with areas of thematic interest highlighted in various colours to create a visual appreciation of the themes throughout all the interviews. As practitioner, I am accustomed to an immersive, hands-on approach to understanding and assessing the experiences and needs of others, and a preferred ‘long table’ method of analysing the data was used, with all interviews printed and assorted according to thematic colour coding. These excerpts were then organised onto flip chart paper and further connections and sub themes identified (Jeong & Othman, 2016). What to include and what not to include was a fluid, highly reflective-reflexive process, which observed the data grow and develop as the iterative and analysis process progressed.

I am an experienced practitioner with complex, vulnerable, and often distressed service users, which fostered a sense of confidence and competence around managing any emotional or difficult disclosures. However, the repeated listening to the voices of traumatised, disappointed, angry, and frustrated colleagues did illicit some difficult feelings, and I employed a reflective writing strategy, whilst taking full advantage of supervisory support to help understand and manage these feelings effectively and productively. After this lengthy and challenging process, 13 sub-themes were identified within the data. From these 13 subthemes, three overall superordinate themes were constructed that represented both individual and shared experiences. A shift in focus from the explicit to the conceptual was consistently utilised to reflectively understand what, and how, participants experienced and understood their world and their place within it.

3.13.2 Phase Two

Phase Two data acted as a complementary and wider information finding exercise. As such, the data was reflected upon and conceptually considered both in the context of the Phase Two participants' experiences, and what their experiences could add to understanding the supervision experiences of the Phase One USCWs more fully. Given the worker and supervision focus of Phase Two, overall lived experiences were not actively solicited from the Phase Two participants, however, some did share personal wellbeing issues and experiences of poor practice, which served to provide meaningful comparisons with the Phase One findings.

As with Phase One, Phase Two interviews were repeatedly listened to before transcription, in order to familiarise the researcher with the interviewees' individual speech patterns and vernacular. Again, non-linguistic responses were noted. Transcripts were printed and thematically colour coded. The findings from Phase Two were then analysed alongside the Phase One findings, paying specific attention to supervision experiences, wellbeing considerations and recommendations for effective, compassionate, and progressive supervision processes moving forward. Phase Three was introduced to take advantage of the expertise, knowledge, wisdom, and ideas of the Phases One and Two participants, in the form of a focus group to discuss the creation of a new approach to supervision training.

3.13.3 Phase Three

As a reflective and experience/ideas sharing participant led exercise, the Phase Three focus groups were not subject to the same philosophical analytical process as Phases One and Two. Phase Three was approached as a reflection in action exercise as the participants chatted and reflected upon their experiences and what had been said before. The findings were subsequently evaluated and reflected upon and thematically sorted into sets of shared principles that reflected the participants' viewpoints, experiences and ideas.

3.14 Quality Criteria

In this study, the building of a trusted rapport between the researcher and the researched was vital given the hope of gathering rich, in-depth, and valuable data, and the role of researcher, as both insider and outsider, required consistent and mindful attention (Bell, 2021a; Bhattacharjee & Sarkar, 2022). I am an experienced practitioner and interviewer within the unregulated social care sector, and significant thought and consideration was taken to ensure that boundaries and quality criteria were met. Feedback from all interviewees noted that the insider status of the researcher enabled them to feel more relaxed, safe, open, and understood, which arguably contributed to the rich, lengthy and personal experiences shared by the participants. Post interview, several participants shared that they felt that they had 'offloaded' and that the interview had felt like a supervision, with one Phase One participant sharing from the outset that offloading had been the primary reason for accepting the invitation to interview. However, whilst offloading had proved beneficial for some of the Phase One participants, the research interviews had not been intended as supervision or counselling. As such, these candid interviews left me briefly feeling concerned for their workplace wellbeing, and sad that they had experienced such harmful lived experiences.

The most notably cited system for the quality checking process in qualitative research, is that developed by Guba and Lincoln (1994, 1995). Guba and Lincoln continue to advocate for four key concepts (credibility, transferability, dependability, and confirmability) that can be used to assess the quality of qualitative research (Ellis & Levy, 2008), and where the goal is to minimise investigator bias by acknowledging researcher predispositions (Maher et al., 2018). Moving away from postpositivist quality criteria parallels (Burke, 2016; Carminati, 2018), and in response to the complex nature of human beings, social researchers have increasingly adapted and expanded upon more traditional concepts of qualitative research quality criteria. These relative responses seek to meet participant and community group needs more authentically, moving away from universal and fixed criteria (Forero et al., 2018; Tracy & Hinrichs, 2017a), and stretching researchers' understanding of how design decisions impact the integrity of qualitative data (Lub, 2015).

Guided by Tracy (2010; 2017) and supported by a relativist approach for judging the rigour of qualitative research (Sparkes & Smith, 2009), the researcher invites the reader to consider eight key markers of quality including (a) worthy topic, (b) rich rigour, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence. The researcher took care to consider all eight quality markers given the vulnerability of the participant group, the Covid 19 pandemic, and an ongoing, worsening crisis in the health and social care sector. Each of the eight markers was considered independently and in direct relation to the topic of study, and its contribution to the quality and meaningfulness of the inquiry. The following four markers were subsequently identified as having significant relevance to the overall motivations and aims of the study: worthy topic; significant contribution; rich rigour and resonance (including generalisability and transferability).

3.14.1 Worthiness

As Tracy (2010, 2017) notes, good qualitative research is relevant, timely, significant, interesting, or evocative, with topics often emerging from disciplinary priorities which are theoretically or conceptually compelling. Worthy topics just as easily grow from timely societal or personal events (Tracy, 2010), however, just as there are widely diverging views on what constitutes a ‘good life’, there is no universal agreement on what constitutes a ‘research-worthy problem’ (Ellis & Levy, 2008). Unregulated social care workers continue to experience problematic workforce wellbeing, recruitment, retention and funding issues, and I believe that understanding USCW wellbeing needs more fully is fundamental to supporting the creation of a more sustainable, productive and effective workplace wellbeing support environment. This worthy topic, which presents a good qualitative research endeavour (Tracy, 2010), can not only help to widen our understanding of the support needs of this vital workforce, but it can also vicariously help to support overall service provision, positive service user experiences and improve the status and perception of the sector.

3.14.2 Significant Contribution

Given the paucity of empirical data focused on the unregulated social care workforce and their experiences with supervision, this work provides a significant contribution to current knowledge, and lays a firm foundation for a new approach to supervision, and subsequent inquiries in this area. Not only did the interview process yield credible, rich, rigorous, and candid data, these largely hidden experiences were repeatedly analysed in multiple ways with the researcher immersing themselves within the data to ensure credibility, transparency and respect for the difficult and challenging experiences shared. The interview process provides the reader with a rich, rigorous, subjective, and meaningful selection of direct interview quotes and reflections from those directly impacted upon by the challenging nature of this highly stressful and challenging workplace. Underpinning these experiences are accounts and reflections of the personal lived experiences of the participants, the difficulties they face as individuals subject to poor quality employment, increasing inequality, and a pandemic, and lays the groundwork for a new approach to supervision in this sector. The study also provides significant philosophical and theoretical contributions in the form of attending to knowledge gaps in health and social care human factors approaches and understanding of individual risk.

3.14.3 Rich Rigour

High quality qualitative research is characterised by rich, complex and abundant data, which uses flexible, analytical tools that mirror the complexity and nuanced nature of the phenomena being studied (Tracy, 2010; Tracy & Hinrichs, 2017). Possessing an abundance of data and a head full of theories is not enough to guarantee quality (Tracy, 2010), and attention was paid to providing a welcoming, reflexive, and sensitively ethical approach to the needs of this vulnerable workforce. Additional Phase One interviewee support was sought from the participating organisations in the form of a confidential post-interview space to discuss the interview, if needed.

I am a highly reflective and reflexive practitioner, continually and rigorously examining my own philosophical and cultural positionality as both insider and outsider, and critically recognising how my own experiences and privileges can impact upon my expectations of, and interactions with, research participants. Self-reflexivity, was used to persistently observe, evaluate, and pastorally support my performance, practice and wellbeing. This was completed using a reflective diary and supervisory feedback and guidance, which supported ongoing reflexivity as the study progressed and changed in response to the findings. Tracy (2010, 2017) asserts that self-reflexivity is reported to be one of the most celebrated aspects of qualitative research and I ensured that this process was undertaken throughout.

3.14.4 Resonance

Resonance has an effect on others that prompts them to see what is being said as important, and of having value to them as individuals and as part of a wider community (St.Amant & Graham, 2019). Meier & Wege, (2016) propose that writing with resonance may be a way to further the impact of academic work by facilitating a better understanding of the research, and sharing an understanding that draws on the reader’s prior experiences and embodied knowledge. Writing with resonance also helps foster an inclination in the reader to engage with, contribute to, and bring forward a specific field of research by extending the ways readers can relate to and experience our findings using rich, compelling, and evocative quotes and storytelling (Tracy, 2010, 2017), and this study is abundant in empirical data. There are millions of workers employed in caring roles in the UK and many others in similar, human support roles and as such, this rich, candid, and compelling study has the potential to resonate with a significant number of the wider workforce and other related professionals. Research that seeks to understand and improve USCW wellbeing and safer practice also has the potential to resonate with users of social care services, policy makers and researchers, academics, and other professionals, which adds to the generalisability and transferability of the study.

3.14.5 Generalisability and Transferability

Smith (2018) presents four different types of generalisabilities relating to qualitative research: naturalistic generalisation, transferability, analytical generalisability, and intersectional generalisability. As insider, the tacit knowledge shared between the researcher, the researched and all those engaged in this process, provided a naturalistic, generalisable aspect to the data collection and analysis process. This naturalistic generalisability added an authentic context to all aspects of the process given it was a shared appreciation of the study's inquiry, that encouraged ongoing and widespread support and participation. The naturalistic generalisation of this study's findings is aimed at readers of all genders, ages, ethnicities, and sectors in the hope of connection, relatability and outcome adoption given they too are likely to recognise the feelings and experiences shared by the participants, given caring for others is innate within us as a social group.

Those not specifically employed in the health and social care sector, but employed in similarly challenging and stressful public services roles, may find the data particularly resonant and transferable in equally profound and meaningful ways. Transferability is not solely concerned with providing readers with the evidence that a study's findings are generalisable to other situations and contexts (Carminati, 2018). "Transferability is achieved when readers feel as though the story of the research overlaps with their own situation and they intuitively transfer the research to their own action" (Tracy, 2010, p. 845). Through the gathering of direct testimonies that provide rich, meaningful, and resonant narratives, findings can become transferable through the evocative storytelling and imagery that also produces vicarious emotional experiences in the reader (Tracy, 2010).

Through rich and vivid descriptions, use of quotes and the calibre of writing, some writers make transferability easier for their readers than others, however, it is eventually up to the reader to make connections between the researcher’s findings and their own life experiences (Tracy & Hinrichs, 2017; Smith, 2018). Finally, intersectional generalisability, which seeks to dig deeply and respectfully within social community groups subject to oppression, exploitation and marginalisation (Hays & McKibben, 2021), reflected the wider cultural issues involved in this complex issue.

3.15 Chapter Summary

This chapter explored how a critical constructivist and relativist philosophical perspective underpinned this qualitative study, providing a theoretical, design and analytical process that recognised the participants as experts in their own world view, and as both individuals and groups. An appropriate purposive sampling method, supported a specific set of eligibility criteria, ensuring only the voices of the unregulated social care workforce were collected. All three of the data collection phases supported a semi-structured, naturalistic, unregulated social care worker led approach, with researcher as practice and lived experience insider, which helped foster a sensitive, relational, and safe interview environment. Phase Three concluded the data collection process, providing a shared space for member reflection, discussion, and supervision user feedback. The IPA process for Phase One was a deeply immersive and lengthy exercise given the amount of information shared and the double hermeneutic process adopted. The highly personal and at times emotional nature of the information shared, and a sensitivity to the potential for vulnerability within the interview groups, was keenly reflected in the approach to quality criteria, rigour, and data reliability.

The following chapter presents the findings from the first of three data collection phases. The Phase One findings represent the experiences, beliefs and lived experience challenges of 14 unregulated social care workers and offers the reader a novel insight into the hidden and unseen lives of those working in the adult social care sector.

Chapter Four

Phase One Findings

4.1 Chapter Overview

This chapter presents the Phase One interview findings and how they have been thematically considered. Phase One aimed to explore the everyday lived and supervision experiences of unregulated social care workers (USCWs), how these experiences impacted on their wellbeing and invited the USCWs to share their future vision for supervision. From the 13 emergent themes initially identified in the Phase One findings, seven subordinate themes were created. These seven themes are: workplace experiences; lived experience and disclosures, external influences, and forces; worker skills and responsibilities; training and learning; support and supervision; and a vision for supervision. As the iterative analysis process became more refined, it became clear that the concept of risk to worker health provided an overarching lens through which to view USCW experiences and how these experiences impacted on their emotional and physical health.

The concept of risk to health as an overarching thematic thread was applied to the seven emergent subordinate themes which resulted in the development of three superordinate themes. These superordinate themes are mental health and wellbeing, vulnerability and exploitation, and support and supervision experiences. The superordinate themes were selected to represent wider aspects of participant risk in this specific sector, and each superordinate theme is supported by a brief conceptual analysis, followed by subthemes, interpretation of the data and supportive quotes.

The COVID-19 pandemic had not been factored into the initial conceptual study aims and objectives, but as the pandemic continued it naturally became an embedded aspect of data collection and analysis. The aim of this study was to explore everyday emotional lived experiences for those working in the social care workplace, and at this time, these every day experiences meant that they were working with increased risks of COVID-19 transmission and client/self-care. COVID-19 was subsequently raised as an additional and wide-reaching risk and stressor and something that exacerbated already extremely difficult workplace circumstances. COVID-19 and working through a pandemic in social care, has therefore been added as an additional discussive thread that impacted on all superordinate themes, but is not treated here as an overarching or superordinate theme.

4.1.1 Thematic Overview

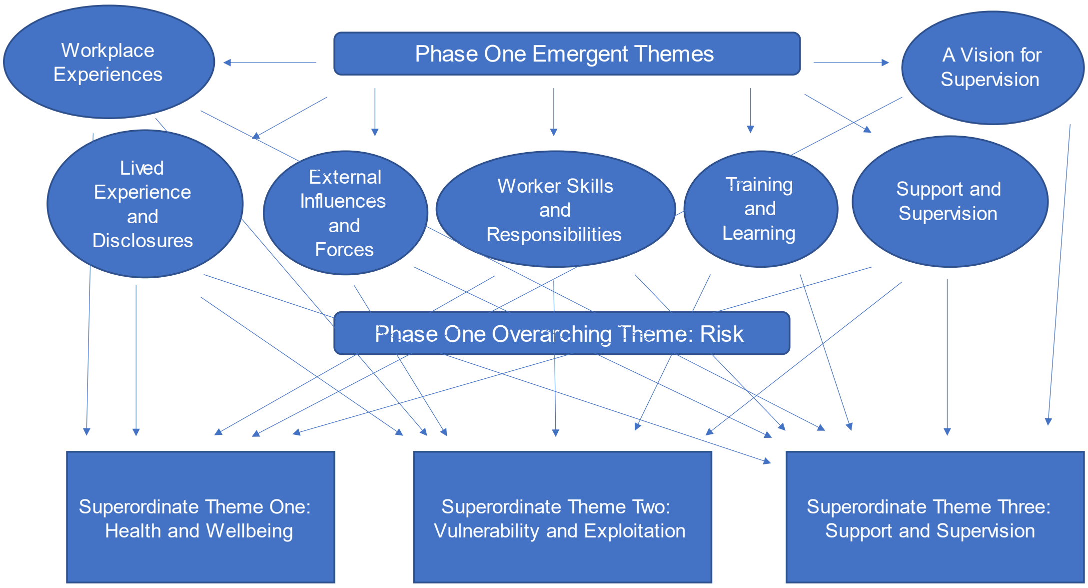
The diagram below shows the progressive flow of the thematic analysis process. Initially seven emergent themes were identified from the Phase One findings. The seven emergent themes largely reflect the question scheme asked during the Phase One interview, and the interview excerpts that appeared to hold meaning to the 14 participants as both individuals and as a worker group. As insider/researcher, the Phase One questions were based on the overall aims of the study and shaped by practical experience and the desire for future support and supervision change in the sector.

The emergent subordinate themes represent a more nuanced and individualised approach to worker considerations and experiences, each reflecting an area within USCW practice that can impact on their health and wellbeing. Lived experience and disclosures was not one of the original areas for interview purposes, but the level of disclosure and candour during the Phase One interviews warranted its inclusion as a subordinate theme. The superordinate themes, however, are representative of wider, more holistic considerations, with the concept of risk to the USCW being identified as an overarching thematic thread that was visible throughout all Phase One interviews. Unregulated social care worker health and wellbeing is central to the inquiry and is explored as a superordinate theme. Vulnerability and exploitation are included in response to the Phase One comments, which highlight a complex and insidious pattern of sector behaviours where workers are subject to a myriad of unfair and unequal workplace situations and practices. Support and supervision are included as a superordinate theme that recognises the important and at times harmful role of the supervision process.

4.1.1a Phase One Thematic Overview

Figure 1

Phase One Thematic Overview



4.2 Participants

The participant group consisted of 10 women and four men, with an average age of 45 years. All participants were given pseudonyms. The participants had a range of previous work experience before joining the adult social care sector including jobs in retail, health and beauty, childcare, factory work, food services, and education. They undertook a wide range of caring and supportive roles including personal care with sometimes physically and emotionally challenging and dangerous clients; medication dispensing and wound care; personal development support; advice and guidance; and more specialist support. All worked in regulated services in unregulated roles. Six participants worked in specialist support services, three worked in domiciliary care agencies and five were employed in residential type services. Most worked full time, and four were employed on zero hours contracts.

4.2.1 Table of Phase One Participants

Table 2

Phase One Participants

Name	Age	Employment	Highest Qualification
Jackie	*51-60*	*Specialist Support*	*Master's degree*
Carrie	*41-50*	*Specialist Support*	*Bachelor's Degree*
Susie	*51-60*	*Specialist Support*	*NVQ2*
Emma	*31-40*	*Domiciliary Care*	*Bachelor's Degree*
Helen	*51-60*	*Specialist Support*	*NVQ2*
Rachel	*31-40*	*Residential*	*Foundation Degree*
Jake	*41-50*	*Domiciliary Care*	*NVQ2*
Liam	*31-40*	*Residential*	*Bachelor's Degree*
Keith	*51-60*	*Domiciliary Care*	*A Level*
Lucy	*41-50*	*Residential*	*Bachelor's Degree*
Jenny	*41-50*	*Residential*	*Bachelor's Degree*
Pam	*51-60*	*Domiciliary Care*	*NVQ2*
Tony	*21-30*	*Specialist Support*	*Master's degree*
Cathy	*51-60*	*Specialist Support*	*Bachelor's Degree*

4.3 Superordinate Themes

Three superordinate themes were identified within the research data: mental health and wellbeing, vulnerability and exploitation, and support and supervision. These themes represent an interrelated approach to the participants' workplace and personal experiences, which helped to situate and explore instances of individual and organisational risk and how these risks played out within the social care workplace environment. The superordinate themes are purposefully broad to represent the overall complexity and richness of the data gathered and to allow for the thematic discussion of risk as an overarching theme. Each superordinate theme is further explored through the selection of related subthemes. These subthemes examine a more nuanced approach to the data, particularly the participants' every day emotional and supervision experiences, and how they impact on wellbeing, practice and morale.

4.4 Superordinate Theme One: Mental Health and Wellbeing

The mental health and wellbeing of the Phase One USCWs was central to the study aims, as such, interview questions and prompts sought to explore how experiences left the participants feeling, and what this meant for them within wider workplace, and personal contexts. The superordinate theme of Mental health and wellbeing is supported by subthemes which initially explored how Phase One participants perceived their own mental health and wellbeing in relation to their caring and support role. By this time, the COVID-19 pandemic and associated restrictions had been in place for over six months, and the Phase One USCWs spoke of feeling exhausted, stressed, and worried. COVID-19, whilst not originally factored into the study, is included as a subtheme to reflect the impact on Phase One USCW mental health and wellbeing at that time.

It became quickly apparent that workplace health and wellbeing was linked to personal experiences of health and wellbeing, and the role of difficult lived experiences, although not originally considered, was also included as a subtheme for further analysis. The subthemes of stressful working patterns and staffing issues commonly placed the Phase One USCWs in frustrating and physically and/or emotionally harmful situations, particularly during the first lockdown. Worker health and wellbeing underpins this study, and the following sections help provide a wider perspective around more harmful aspects of the unregulated social care worker role.

4.4.1 The mental health and wellbeing of the Phase One participants

Difficult work-related and personal lived experiences, featured in every Phase One interview. Participants frequently spoke of feeling stressed, anxious, scared, triggered, guilty, exhausted, and frustrated, which had a detrimental effect on their mental health. The adverse impact of mental health challenges on their wellbeing placed them at increased risk of burnout and related sickness absences, reflecting the challenging nature of the social care role. When asked about her own wellbeing, Helen, a specialist support worker felt that her role with victims of trauma had impacted on her health, and she paused before saying:

> ...Yeah, I, I, I if I'm being honest with you, [ ] my, my own sort of emotional wellbeing, has suffered as a result of um I think I, I'm a real empath and for me that has caused me a great deal of angst because I feel everybody's situation very, very deeply. I feel other people's pain and and can't switch that off, but I think you get to a realisation that if I don't um put up some sort of protection mechanism, um, I'm going to end up seriously um you know doing myself damage.

The risk of continued vicarious harm exposed Helen to increasingly poor wellbeing and she recognised that the chance of damaging her mental health further was a real possibility. Still, her drive to help others and connect with them in meaningful and beneficial ways, helped foster supportive and positive relationships with her service users which she shared felt like a privilege. Despite her own distress and exhaustion, Helen seemed unable, or unwilling, to stop working at this intensity, perhaps feeling a sense of responsibility to try and meet the ever increasing and extreme needs of those who presented to her service during the first lockdown.

Jake, who had worked in care for over 15 years, was dealing with a history of complex trauma, and at times struggled to care for his own wellbeing needs. As an agency worker, he had felt unable to say no to work due to the fear of not earning enough money to pay his bills, and it was this financial worry that Jake felt had placed him at increasing risk of burnout and poor health:

> My mental health about 10 years ago probably five years ago if I'm honest was shocking, absolutely shocking I didn't give one care about myself it had got to that point where it was just work, it was tunnel vision because it's been programmed into you that if you don't work you won't get any work, if you don't work you can't pay your bills and it's, it's this psychological roundabout that you can't get off until you actually go no, hang on, I can't do it, and you fall off the roundabout.

The following subthemes were identified as further impacting on mental health and wellbeing: the impact of COVID-19, the role of lived experience and participant disclosures; staffing issues; and stressful work patterns and practices.

4.4.2 The impact of COVID-19

The COVID-19 pandemic greatly impacted on the participant’s mental health and wellbeing, and when asked if working throughout the pandemic had impacted on his own wellbeing and stress levels, Liam, who works as a support worker with young adults with learning disabilities, paused before quietly saying:

> ...They’re very, very, very high. I would be erm I would be feeling stress... I would start getting anxiety problems on the Friday night because I'd be getting anxious about getting anxious on Saturday, so I would get the Sunday feeling on on Friday

> night, and then it would go all the way through until I finally arrived at at work and find out where I am.

COVID-19 had also impacted on Liam's external mental health support network, and he shared that he had been receiving mental health support prior to lockdown:

> Um, I was receiving counselling up until COVID and then that was just completely abandoned. I was signed off and told if I want to get more NHS assistance I need to go back through the doctors when things get back to normal but that's never been followed up [ ] that was quite an abandonment really.

As a result of short staffing during the pandemic and not knowing if he was going to be placed in the high care dependency unit, in full PPE, Liam had been left feeling extremely anxious and stressed for two days prior to shifts. His desire for his situation and needs to be acknowledged was raised on several occasions during his interview, and his frustrations and concerns around working with COVID-19 had left him angry and exhausted, calling the situation "hell" and "dire".

Many of the participants shared that they had developed close relationships with some of their clients and the worry of accidentally passing on COVID-19 to a vulnerable client added to their already significant stress levels. Pam, a domiciliary care worker, became tearful when she spoke of her client's experiences during the first lockdown and it was clear her client's worries had vicariously become part of her own during this frightening time, adding:

> People have become afraid of lots of things, clients have been, have become afraid to go out now, because they've been stuck in for such a long time they're now afraid to 'go' out [ ] they're afraid, they're afraid of everything, they're afraid of who comes to see them, they're afraid of them going out, they're afraid who, like their daughter comes to visit, they're afraid of where she's been, who she's meeting, then it causes arguments.

The pandemic brought its own unique workplace issues for the participants, and concerns around the risk of increased cross-transmission were shared, with some services initially unwilling to use agency workers as Liam noted:

> They were finding it hard to cover weekend shifts because of the situation (COVID-19) and they didn't want to use agency they wanted to use all in house. Because they were finding it hard to cover shifts, they decided to motivate staff to pick up weekend shifts, so they would cut the overtime on weekdays, and only give it on weekends, which obviously had the complete opposite effect, all the overtime was dropped by everyone in the first month and then it slowly started building back up.

At times however, agency workers had to be used and as Rachel recalled:

> You have agency come in and we're trying to check whether they're well enough so we're doing all that, you know, here's all the PPE and can we do temperatures? No one's asked us to do that but as staff, we like we want to protect ourselves as well you know.

These safety measures (e.g., taking temperatures, providing gloves and masks, and verbally checking with the individual), organised by Rachel and other staff members in the absence of any management or external advice and guidance, were quickly implemented to safeguard both themselves and their clients. She very much felt that her management team had failed to fully appreciate, or indeed care about the staff teams' increasingly risk-laden workplace situation and vulnerability, which she felt was exacerbated further by the management team's absence and lack of contact throughout the first lockdown.

The added stress raised by inadequate PPE provisions left some participants vulnerable to increased exposure to risk of infection and transmission, and the confusing mixed messages they received from their providers seemed to worsen this risk. Both Pam and Rachel had struggled with accessing PPE, with Rachel recalling:

> …um for the first 12 weeks of lockdown, we had no PPE we had no masks, we had to demand it we were like "can we not have some masks please?" We were given, we were given one a day, one! They were like don't touch your face that was the advice until they got more PPE and then they said, oh, you can have five masks a day now, but be careful with the gloves because if we run out you got to use your bare hands.

Rachel was angry given the risks of increased transmission to self, service users and family members, that inadequate provisions of PPE exposed them to. Mindful of the increased COVID-19 risks for her client group, these risk measures, whilst unofficial, were felt necessary given the increased vulnerability of their clients. Rachel also spoke of wanting to protect her own personal COVID-19 bubble, which the increased precautions helped with. Stepping up to take responsibility for personal health and safety risks in often chaotic environments felt like nothing new for many of the participants as they went on to share personal lived experiences of trauma and violence.

4.4.2 The role of lived experiences and participant disclosures

All participants disclosed lived experiences with mental health issues such as anxiety, addiction, panic disorders and stress, and most talked about having lived experience of trauma, commonly domestic abuse as children and/or adults. They universally felt that having the right experiences and individual characteristics to work as a carer or support worker required that “something extra”, and that this something extra was important to the role. It was believed that training alone could not teach this quality, with Helen noting: “I don't know what training can equip you for dealing with, sometimes ya know hurting [ ] or broken people and you know, what can you do to train to be equipped for that?”

This “something extra” was, for Keith and Tony, shared lived experiences which they both felt enabled them to draw upon relational compassion and empathy between them and their clients. When asked about where he thought his drive to show others compassion and empathy came from, Tony reflected before saying:

> I think it comes from my past experience, I think it comes from a place of damage a lot of the time, I think it gives you that sixth sense and that kind of electricity to be able to instantly see someone that's damaged… I know people talk about in the LGBTQ community about having a gaydar I think you can have like a broken-dar, err for people that's that's kind of unwritten and you can see and say right I want to help someone.

Keith, who works as a support worker, felt that for those who naturally possessed the qualities of compassion and empathy, they were always going to care about others be it in a formal or informal capacity. When asked where he thought the skills of compassion and empathy came from, he thought for a while before saying: “Um... Possibly lived experience.”

Jake disclosed lived experience of chronic child abuse and violence which he felt added to his struggle in being able to put himself first. When asked if he thought other carers might feel the same, he said:

> It is difficult… I think doing good for other people becomes that replacement for doing good for yourself erm I mean you could be completely neglecting yourself [ ] I haven't looked after myself because it's so much easier to give it to somebody else [ ] It's been programmed into me erm it's one of those things that actually I've always had to look after somebody else [ ] so it's always been about somebody else.

For some workers, previous lived experiences of trauma impacted on how they might respond to challenging clients and situations in their everyday working lives. These prior lived experiences exposed them to risk-laden and unpredictable workplace situations which they at times found triggering, distressing and a struggle to tolerate. When asked whether she had experienced any challenges in her role, Emma, who is a domiciliary carer, said:

> ...What I'm struggling with at the moment is that he (the client) is drinking and when he becomes drunk he becomes aggressive and because of domestic violence from my childhood from my Dad that triggers things inside me, so I'm getting slowly to the point that if this is gonna carry on, I'm going to have to say um, please don't send me there again [ ] It feels like I'm back where I was [ ] and I'm just... I wanna cry.

Cathy works in a specialist advice and guidance service with criminal justice victims and perpetrators. Most of the staff team are students on placement or volunteers and Cathy is aware that individuals may struggle to work with some of the service users:

> ...Um there's always going to be a trigger when we interview volunteers or staff members [ ] we get sex offenders [ ] but because there are lots of people that will say, “don't expect me to work with a sex offender, end of”, and if that's your attitude this is not the right place to be [ ] but it could be a trigger [ ] I didn't expect

> to see such a big trigger from bereavement. Just last week somebody started to talk about bereavement and somebody's lost a grandmother and just out of the blue it hit her.

Many of the participants felt that the kinds of emotional skills required to be a good social care worker, couldn’t always be taught. These participants found that their own difficult lived experiences helped them to understand, relate and connect with their client’s issues in more meaningful and knowledgeable ways. The need to possess self-awareness to safely manage difficult and potentially triggering events was especially noted by some, who felt that it acted as a kind of positive buffer against the risk of stress and harm of the social care workplace. For Jackie, a specialist intervention and support worker, her own shared experience of trauma had seemingly enabled and empowered her to connect and relate to the needs and experiences of her client group, and she said this of her own lived experiences:

> I’ve been through an abusive relationship [ ] So that side of things, ya know I had a massive awareness about it... [ ] My ex-husband had a drinking and drug problem and like I say he was very abusive, so I had that fundamental stuff there and I've always been really interested in psychology, and mindfulness and wellbeing and all that kind of stuff [ ] so there's a lot of things that I could really hone it in to [ ] it’s about actually knowing your own capabilities and your own self.

Cathy shared Jackie’s lived experiences and went on to say this of her practice as a domestic abuse survivor:

> I have a very high threshold with stuff um because of yeah some of the things I experienced mostly from men I would say… [ ] Um... Maybe, maybe there's a slight arrogance that I suppose I think I'm gonna be alright you know [ ] I could have the most dangerous person in front of me and I just tell them, get out of the office now I'm not tolerating that without a qualm in the world [ ] other people have been in the corner like “oh my God why didn't you press the alarm?”

This somewhat blasé and acknowledged arrogance from Cathy, arguably placed her and her colleagues in an increased space of risk of harm given she worked with known dangerous offenders in a confined space. Much like Jackie, who felt that she’d gone through so much in life that there was nothing that could trigger her anymore, Cathy had reasoned that her lived experiences had prepared her for every client eventuality and felt secure in these self-assurances. She appeared to mindfully reflect as she spoke, however, going on to say that maybe this could be over-confidence and that it could all go wrong someday.

Carrie was aware that many of her colleagues had not yet been able to process and understand their lived experiences in the same way as she had about her own history of addiction, saying:

> I've had my own life experiences and stuff which took me into this role, but um [ ] I've seen a lot of staff come through that have been wounded healers, and you know, you can see that in their practise.. They were, you know, trying to fix themselves by trying to fix somebody else really... [ ] It can be quite dangerous I think if you don't address what you need to address.

Carrie’s own lived experiences seemed to enable her to recognise, relate and appreciate that some of her colleagues were still struggling with their own lived experience triggers, which she spoke about sensitively and with compassion. She frequently raised the importance of worker self-awareness and self-care in this sector, but that in her experience, it was not something actively talked about or promoted within organisations.

Like Carrie, Cathy and Jackie also believed that their lived experiences, when accompanied by self-awareness and focused reflective introspection and learning, helped enable their own workplace wellbeing and productivity. This self-aware and mindful practice appeared to facilitate positive and meaningful connections with clients and colleagues, which in turn helped to buffer the impact of other workplace and personal stressors. Making some form of positive workplace meaning from difficult lived experiences came easy for many of the participants, however, many had also experienced vicarious trauma in their role, and it was unclear whether they were always aware that this was what they were being subjected to. Workplace stress was not just noted because of service user interaction, and how the unregulated social care workers experienced the 24/7 working patterns within the sector, was also raised as an additional stressor.

4.4.3 Stressful working patterns

Participants, particularly those employed in zero contract domiciliary roles, spoke of working long hours and with being frustrated and stressed with the lack of allocated travel time between service users, no breaks and short notice additional calls. Those attached to residential and satellite services experienced more structured hours and shifts, although these participants had at times physically and emotionally struggled with working 24-, 36- and 48-hour shifts, especially throughout the first COVID-19 lockdown. For those participants in domiciliary care roles, their shift patterns and organisational practises left them exhausted, and at times feeling coerced in to accepting unwanted additional client calls and shifts. The cutting of travel time between calls also left these lone workers vulnerable to abusive behaviour from frustrated and angry clients.

Pam, a domiciliary care worker on a zero-hours contract, entered the service after her cleaning round became more personal care. She had originally agreed to work between 35 and 40 hours per week, but this was frequently pushed up to 60 despite her feeling increasingly stressed, tired and frustrated. When asked about her hours, she said this of a recent shift experience:

> I do a lot of split shifts and then I get a phone call, please can you just do this one more client? Please can you do it at the end, of your shift? [ ] I ended up getting in at four minutes to midnight [ ] I was exhausted.

Working split shifts (working in the morning and then returning in the evening) appeared to expose those participants in domiciliary care worker roles to an increased likelihood that additional calls could be added to their list, shortening the time between the first and second split shift. The gap between shifts was used by the participants to rest, eat and take care of personal errands and family responsibilities, however this time was increasingly encroached upon when asked to pick up extra calls. Leaving exhausted and frazzled workers rushing between service users, the lack of travel time exposed both worker and service user to an increased potential for practise errors and rising stress levels, as Pam went on to add:

> There’s no travel time, so I'm getting stressed because I don't got any travel time whatsoever not even a minute between the calls… [ ] It’s please can you help please can you help? We've got four down we're desperate all this sort of stuff.

> It’s this that gets to me… [ ] I got a phone call at 10 to seven, bear in mind I didn't I didn't go to bed til one o'clock this morning, ten to seven the phone's goin and I didn't answer the phone so they sent me a text message [ ] I just ignored it. I feel guilty, but I felt angry this morning that they even had the nerve after me going out and being bullied basically into doing the extra call.

As domiciliary care workers, both Jake and Emma also spoke of being asked to pick up additional calls, usually on the same day and at short notice. Like Pam, their supervisors would overly exercise the use of the word ‘please’, say they were ‘desperate’ for their help, and beg and cajole them in to saying yes. It was here that Pam’s guilt turned to anger and despite Pam’s self-confessed difficulty in saying no at times, she had clearly had enough at this point, although this too left her with feelings of guilt.

The lack of travel time between clients was seen as problematic by all the participants in domiciliary care roles and for Emma, this exposed her to an increased risk of verbal abuse from clients:

> …You've got no traveling time between people… You're stressing around because you're rushing from one to another then you get late then somebody shouts at you because you're late but it's not your fault because um you've got no time.

She added:

> I don't have a single five minutes travel time between them and it takes me about 10 minutes to get from one place to another sometimes and finding parking... [ ] and then you're 10 minutes late here, another 10 minutes here and then you’re like an hour late at the very end.

Asked what that felt like, Emma said:

> It's stressful, it's frustrating, because you you feel like “oh she's waiting for me” because I need to you know change her pad or she is hungry or thirsty, so you try to rush and get there as fast as you can.

When asked what he found difficult about his role, Jake paused before saying: “The hours were difficult… Zero-contract hours are awful.” He went on to say:

> I’ve worked places when I was on agency I was zero-contract hours, you have no stability you look at your rota that week and you think God I've got two shifts that's not gonna pay the rent... [ ] and you end up borrowing [ ] and actually I'm in the mental state I can't go to work but I've got to and it's, it's just a vicious circle it really is... [ ] if you're on that zero-hour contract you grab as many hours as you can [ ] and you end up working seven days a week.

Asked why he continued if it was making him unwell, he replied: “Because of that fear if nobody else is there and I need my wages to come in… You're stuck between financial and physical abuse really.” The persistent threat of not having enough work for the following week, meant that Jake ‘grabbed’ as many hours as he could, living with the vulnerability of wage insecurity and the stress of debt. This anxiety drove him to work seven days a week which he admitted to doing for months on end at times, leading to physical exhaustion and emotional burnout. Jake described his life as a “vicious circle”, which wholly encapsulated his feelings of being unable to get off this roundabout, exposing him to increasing physical and emotional vulnerability, exploitation and wage insecurity.

Emma’s concerns however were very much focused on her client’s wellbeing and what being late may mean for them, despite the fact cutting travel time had resulted with Emma being exposed to difficult verbal abuse. The removal of travel time between homecare service users did not remove the need for the participants to travel between service user homes given they were still carrying out the same duties at the expected same quality. The removal of travel time did however mean that these participants and their clients were placed at increased risk of harm and any associated emotional and physical future impacts.

4.4.4 Staffing issues

Staffing issues were identified by the participants as one of the most significant causes of poor working conditions and increased related stressors. Staff sickness led to understaffed shifts, overworking, and additional responsibilities and duties on the already stretched participant workload. When asked whether they had short-staffing issues in their service, Emma replied: “Yes, very, very, very much... sickness every single day… Sickness or people have an accident.” Both Jake and Rachel spoke about their colleagues calling in sick, although they both talked about this happening due to their apparent unwillingness to work as opposed to them being genuinely unwell, which frustrated them. When asked if it was common for workers to call in sick, Jake replied:

> Very common, very common… Erm there are some that'll go actually, do you know what, I know this weekend's a nightmare cos we've only got half the staff on [ ] so I'm not goin in and, and that then just makes it worse for the people that are on and then you get that resentment between staff.

Pam was also mindful that staff sickness wasn't necessarily as a result from staff being unwell and added that the extra calls she'd been asked to do because of staff sickness were, in her opinion, a result of issues between the care company and the care staff, adding: "…They messed the wages up for the girls that were on that run so they decided ah we'll go sick, so they've gone sick." Genuine sickness negatively impacted on staffing and wellbeing for the participants but the idea of workers calling in sick for other reasons left some participants annoyed and frustrated. The added sickness stressor of staff being off with COVID-19 was not specifically mentioned by the participants in relation to workplace absences. However, some colleagues had chosen to be furloughed, or were shielding due to increased medical risk, which added considerable stress to those who remained in post.

On his first day as domiciliary care worker, staff sickness meant that Jake's induction period was cut short from a week to one day, and he recalled: "When I first started, it was supposed to be a week of shadowing and then out on your own, my working on my own started on the second day." When asked what that had felt like at the time, he recalled that it was:

> Terrifying... I'd been put… I was responsible now for these people that I was visiting and these people that I'd never met before… [ ] I remember being worried that I was going to hurt somebody or cause somebody harm by not doing something or doing something I shouldn't [ ] It felt like I was being thrown in at the deep end… It was a baptism of fire erm thankfully I only got slightly singed at the time (laughter) [ ] but to be honest I think the baptism of fire suited me.

For Jake, staff sickness meant his first lone social care role was undertaken after only one day of induction training, exposing him to heightened states of fear and vulnerability. Jake described the experience as terrifying but then went on to say that that had suited him, perhaps evidencing his resilience and aptitude for problem-solving. These attributes were shared by all participants, to varying degrees, and with varying levels of awareness and ability.

Staff sickness left the participants at increased risk of harmful health and safety outcomes, exhaustion, feeling resentful with colleagues, lacking in morale and concerned that they might make errors. Genuine sickness was managed, but it was common for there to be mistrust around why some colleagues failed to show up for their shift, which added to the risk of rising resentment and poor teamwork. Participants also felt that these absences were often left unchallenged due to the fear of workers leaving, adding to already problematic staffing issues.

The COVID-19 pandemic had a significant impact on more specialist social care service delivery, with many organisations choosing to close or work from home where possible. For Helen, who was employed full time with an open access specialised support service, this meant that she saw a marked increase in inquiries and support needs, noting:

> The pressure has ramped up really, because we've noticeably seen a significant rise in the number of women accessing our service because other services that are not working at the moment. It's left a gaping hole so you know on a daily basis there are a lot of crisis calls coming in, it’s really extreme.

For Helen’s service, like many others during the first lockdown, she found herself working in a reduced team with reduced access to external support services and changes to how clients accessed help. As one of only a handful of public-facing support services open during lockdown, Helen’s already reduced team tried to fill the gap, which served to further exacerbate an already stretched and stressful workplace environment. As other participants had raised, she too had felt an increased sense of responsibility and given she was often unable to help those who presented and as the ‘face’ of the service, felt an increased sense of accountability, frustration and distress which she was concerned would lead to burnout.

The unpredictable working patterns and often ill-considered expectations placed on the participants at this time left many feeling angered, stressed, exhausted and guilty. Staffing issues commonly impacted on working conditions and manager expectations, with increased staff sickness/shielding and turnover leading to some participants feeling isolated, frightened at increased risk of harm and ignored. The poor mental health and wellbeing experiences shared by the participants helped identify and frame the direction of Superordinate Theme Two where the data will now be explored through the lenses of vulnerability and exploitation.

4.5 Superordinate Theme Two: Vulnerability and Exploitation

Overshadowed by the explicit vulnerability and risk of harm associated with their specific service user groups, the Phase One participants did not speak about themselves as being vulnerable individuals. However, they did acknowledge that at times they were at risk of harm and recognised that some of their colleagues were particularly vulnerable. The findings, however, clearly evidenced that participants were at times left with extremely difficult feelings after being placed in vulnerable and exploitative workplace situations, although no participant specifically used the term exploitation to describe what was happening to them.

The potential for increased risk to wellbeing was not only confined to the workplace, given the participants had also disclosed personal histories of trauma and/or mental health, alongside additional COVID 19 health risks and transmission concerns. The superordinate theme of vulnerability and exploitation will be further explored through the following subthemes: the natural carer; when saying “no” feels like it’s not an option; feeling minimised in the role; and experiences with violent service users.

4.5.1 The natural carer

The natural carer is defined within this study as an individual who possesses a passion for helping and caring for others, and all Phase One participants spoke of feeling drawn and pulled into a helping role. They spoke of feeling rewarded, happy and worried as their clients thrived and struggled during their time with them, with many sharing how much they loved their role and service user groups. The participant/client relationship was consequently seen as a highly motivating factor by all, and it was clear the participants were emotionally invested in these relational dynamics. This emotional investment, and a drive to help others, was recognised by many of the participants as something that could be taken advantage of by organisations, especially given the current short staffing issues services were experiencing at that time. Despite their frustrations and anger with often harmful and unfair workplace conditions, poor standards of pay, COVID-19 worries and inadequate support, the interviewees still spoke of feeling driven and pulled into working within the sector. These poor conditions, seldom raised or complained about, were continued to be tolerated by the arguably vulnerable Phase One participants.

Pam started the interview by explaining what her responsibilities were in her current role:

> I do whatever it takes to make that person's life better [ ] Just... I love the way that I leave them [ ] I know they're all safe and tucked up or you know they're fed well, looked after, clean, you know, I love every part of my job [ ] I love the interaction with the people and I love all that side of it and I love, I love looking after people.

She went on to add:

> I think it's the nurturing side of it… It's kind of like the Mumsy bit. I think it's kind of that and then course with the kids growing up and leaving home and having just me, my husband, and my little dog to look after it wasn't enough. When my Mum died I was lost because I looked after my Mum all the time so when she died I was kind of like, shit.

Helen shared a natural inclination to help others, saying:

> I have a real love of people and I always have done, and I think I've always been wired that way so even when I was um a child, I think I would spend time with older people, you know, elderly people, and always be the person that was looking out for them and caring for them.

However, she went on to add that being ‘wired’ this way could be emotionally draining when clients did not achieve their hoped-for outcomes. Recognising her powerlessness, she said:

> I am someone who's um I'm used to being able to, you know, fix stuff and when you can’t, you can't fix that, you know, and you cannot change it, it's out of your control and it feels so so um... difficult and heart breaking, it's just absolutely heart breaking and heart wrenching.

For Jake, continuing in a role he sometimes found distressing and unfair, centred around the personal satisfaction and fulfilment he felt from the caring role. When asked why he enjoyed caring for others so much, he replied:

> It made all the difference that one person said thank you [ ] I hadn't felt needed before so yeah it made a huge difference... Huge difference to my life, huge difference to my mental wellbeing, huge difference, actually being in the call with a person and all your attentions on them and all their attentions on you.

Loving to help people was frequently mentioned by the participants, and many talked of being the sort of individual who had always actively sought out the opportunity to support others. Helping others was viewed as rewarding and an important personal experience for all Phase One participants, although they did recognise that this characteristic could be taken advantage of and exploited, especially when they felt unable to say no to managerial and service user requests. This innate characteristic seemingly played an important part in the participants being able to tolerate and understand the more stressful and challenging aspects of the role and wanting to give back factored highly. The participants also found their work hugely rewarding at times with Liam saying:

> I think you definitely get a sense of achievement when you've done things [ ] in the job that I'm in now, we were able to take one client to his sister's wedding [ ] and being able to bring them together and do that kind of thing it's just amazingly rewarding and it's brilliant.

Some participants were aware that they and other workers may well be meeting their own needs within the carer/client dynamic, and as Cathy spoke, she reflected on whether she had initially worked with children because they had needed her. Jake shared how much he loved making the lives of others better, and his repeated use of the term “huge difference” seemingly evidenced how rewarding these relationships had been to his life at that time. However, these positive relational and emotional benefits highlighted a potential for increased exposure to unfairness, exploitation, and vulnerability, given participants shared being bullied and cajoled in to accepting additional hours and/or responsibilities, and not feeling able to say no to them.

Some participants commonly acted under the belief that clients would be placed at risk if they did not go the extra mile or accept the extra shift, would feel guilty about saying no, or were worried about being excluded from working for previously turning down shifts, as Jake explained: “…if you turn down a shift, management will say don't give her any shifts next week. I've heard management say it, I've heard the planners go oh we just won't, we'll take their work off them next week."

Many participants spoke of feeling like a number, or just another body to cover the shift, which seemingly served to minimise and hide the true emotional and physical impact of their role and removed others, outside of their personal frame of reference, from genuinely relating to how they were feeling and coping. Possessing the innate characteristic to care for and about others, was also felt to have been commodified and depersonalised, and the participants spoke of numerous occasions where they or their peers had felt taken for granted and their natural inclination to care about others, taken advantage of.

4.5.2 When saying "no" feels like it's not an option

All workers recognised that their roles can be subject to being asked and told to do things that they were not comfortable with but felt, in the circumstances, they had little choice but to do them anyway. Requests were usually complied with even when workers were unsure of how to complete a task or worried about the physical and or emotional consequences of it. These requests commonly exploited the needs and vulnerabilities of the worker by means of apparent manipulation and coercion, although it cannot be stated if this behaviour was knowingly perpetrated and understood by the participants management teams.

Several of the participants spoke of feeling powerless in refusing work or additional responsibilities from their management teams. Emma spoke of going to work with a violent client who had previously struck her and had threatened to stab her if she returned. This had been passed on to Emma's manager, but she still went back. When asked why, she said:

> Because it was on my rota… because I was meant to go there… because the managers told me to so I didn't want to lose my job because of that, I didn't know, I wasn't sure what rights I have or not.

Pam had had similar experiences where she hadn't felt listened to when trying to say no to extra calls. By doing the extra call on this occasion, Pam arrived home much later in the night than usual and encountered her partner's annoyance:

> He (Pam's partner) wasn't very happy, he said what time bloody time do you call this what you been doing? And I explained to him, and he said why did you say

> yes? I said because I was made to feel so guilty... I said no... I said I was made to feel so guilty for saying no, that I did it anyway.

Jake also struggled to say no to extra shifts, particularly when the idea of the clients being exposed to increased risk of discomfort or harm was used as a motivator. The participants commonly put the needs of service users before their own and in times of short staffing, these concerns appeared magnified, with Jake noting:

> If you're one of those daft ones that care, you put the clients first and you think to yourself, actually, that carer is not going to work today, nobody's gonna see x, y, and z and they're not going to get their medication, they're not gonna have their food, they're going to be dehydrated, they're not going to have seen anyone and you go right, I'll have to do it.

Having a “right, I’ll have to do it” approach to accepting unwanted work, exposed Jake to increasing exploitation, vulnerability, and worsening wellbeing. He referred to himself and others as being “daft” because they cared, perhaps recognising the unfair situation he had seemingly placed himself in. As he spoke, he did however take some time to reflect on why and how he felt this situation may have arisen:

> Erm… Some people are like me er we don't stand up for ourselves... [ ] we just scuttle it away in our heads erm sometimes looking back on it you think oh my God why, why, why did I put up with that?

In the workplace, Susie, who works with extremely vulnerable and potentially dangerous clients, struggles to say no when clients make requests of her she reflected:

> Ya know… I might be in the middle of eating my dinner and somebody needs something so I will go, and they (her colleagues) go "oh why did you do that? that's just stupid and that" and I go because they needed me… you know, it's, that's me… That's me.

Susie shared that she liked to feel needed, and it appeared that she was reluctant, or unable, to say no to service user requests. Whilst Susie felt it her job to meet every client need and request, her more experienced colleagues may have found this behaviour challenging, given it exposed both Susie and her team mates to client exploitation, unrealistic expectations and potential client/worker conflict, as Helen, who also works with challenging clients noted:

> I think you, you can be strong in the sense of, you have to have good boundaries, because obviously some of the clients you work with, they would run rings around you so you do, you have to have a strength.

For the participants, saying no left some feeling guilty and worried about the potential consequences, given for Jake, saying no to shifts had the very real possibility of being excluded from the rota, or a client could be placed at risk. Helen believed that having inner strength and boundaries helped buffer workers from exploitation and increasing vulnerability, recognising that in some instances, the client is not necessarily the most vulnerable within the worker/client dynamic. Not feeling able to say no in the workplace, exposed some participants to problematic boundary issues which were arguably reinforced by managers, when coercing and bullying them in to covering shifts. For some participants, even when they had felt able to say no, no one seemed to be listening.

4.5.3 Feeling minimised in the role

Within the interviews, many participants spoke of feeling that they were seen in the workplace as just another replaceable number or another body to cover a shift. Little consideration appeared to be given to the participants regarding the scope and skill of the many different responsibilities carried out by them daily. This depersonalised approach often left the workers feeling ignored, unacknowledged, taken for granted and underappreciated both remuneratively and psychosocially. Pam, when asked how she would like to be seen by management, quietly said: “I’d like… basically, to feel that I’m, I’m worth more than I’m led to believe, or that ‘they make me’ feel because I feel my job is important.” This sentiment was echoed by all, and a sense of a lack of respect, dignity, agency, and care was a source of frustration, disappointment and anger for the participants.

When asked what skills the participants thought were needed to do their job, they commonly cited communication, listening, empathy and compassion, attributes frequently referenced in support and care worker job descriptions. For Pam, this question left her feeling angry and much like the other participants, she too struggled to list the skills she thought necessary to be a good carer, but she did say this:

> Well, I'm unskilled aren't I according to Boris (Johnson), I'm unskilled... I think I've got every street wise skill that you could mention... I know how to nurture, I know how to care, how to clean, how to cook, I know how to look after somebody's body that they don't understand themselves, I know a lot, a lot.

Whilst Pam and the other participants did not appear to be able to reel off a long list of specific skills in that moment, they absolutely did recognise and feel that they provided a valuable, meaningful and necessary service. The belief that this was taken for granted and a convenience for others who perhaps did not want to engage in the messy business of disease, injury and hurt, was not lost on them. The ignored, hidden, misunderstood and objectified nature of this work, may have added to why the participants felt they were being treated like commodities, just another number or body, and robots.

As Carrie reflected:

> You have that kind of mentality of I think when your staff are being treated as just a commodity [ ] you just get this whole culture of actually forgetting there's a human being at the end of all of this [ ] the staff team are human beings and they have lives… [ ] if you treat people as human beings and you acknowledge that they might be having a bad day or whatever erm... that makes them feel valued and recognised within a setting. And… I think that... the more you value your staff um the better they're going to perform.

Rachel echoed this feeling:

> We're just like a number to them they haven't thought about us as people, we're just a commodity to make them money, because they get money for us coming in and looking after their clients and they haven't thought about us at all… [ ] you do realise you are, you, if you left they'd just hire someone else they don't, they don't look at your loyalty and how long you've worked there and how well you're doing your job.

This disconnect was recognised by Pam who was angry with how carers were treated, adding that she felt decision and policy makers, were not currently in the best position to make practice and client decisions. When asked why she thought that she said:

> Well they don't know, how could they know because they're not going out there, they're not experiencing these things themselves [ ] How could they know, they don't know this person, they only know this person by a piece of paper that's in front of them.

Participants often felt that their efforts, skills, and risks were minimised and underappreciated, with many believing that a lack of real understanding around the role had led to it not being viewed as a professional, skilled and valuable one. The unregulated social care role is fraught with the potential for physical and emotional harm, and alongside other hidden aspects of risk and vulnerability, experiences with violent service users was raised as just another part of the job.

4.5.4 Experiences with violent clients

The stressful and sometimes dangerous nature of the work often meant that participants had witnessed, or been subjected to, client violence and anger which they largely dealt with by minimising and justifying client intent and capacity. Exposure and tolerance to dangerous service user behaviour had been seemingly normalised and accepted as just a part of their job, which arguably served to place the Phase One USCWs in an increased space of vulnerability and exploitation. The normalisation of dangerous service user behaviours poses both an individual and an organisational risk, given the significant impact poor wellbeing and sickness can have on the provision of effective and safe community health services.

Although Jenny did say that the police should be called when workers had been harmed by service users, at no time when discussing experiences with violent and abusive clients did the participants refer to themselves as victims, with Jenny noting:

> If this was a member of the public that had been attacked you would call the police, this is what we’d do, why didn't 'you' do it, because it was their norm [ ] even now they do not contact the police and it's in bold "you must contact the police".

Liam, a part time support worker with learning disabled young adults, talked about being physically attacked but accepting it:

> I started my care career working with people with severe autism so I have, I've been hit and bit and spat at and scratched but it's from people who don't know how to express their emotions, so I've got a very different take on physical abuse and how you how you accept it.

Emma, employed on a zero-hour domiciliary care contract recalled how it felt to work with a new client with a history of violence:

> The first few times I was scared I'm not gonna lie it was frightening it was like, you feel like you're gonna panic but you just try to like remember what you need to do… [ ] Your heartbeat would go really fast.

When asked what kept her going back despite her fear, Emma replied: "Um... because I know that it's not her fault the way she is."

The likelihood for serious injury in some social care workplaces was largely accepted by Carrie, who had previously worked in a challenging behaviour unit for young adults. She, recalled this of her time there:

> I know personally... I would kind of go in and think am I gonna get bitten today am I going to get something thrown at me [ ] there's quite a few people that would be off sick because you know they'd have teeth knocked out or things like that. We were working with some quite violent young people [ ] and they, there was no consideration for the safety of the staff.

Carrie, Liam, and Emma's experience of tolerating risk in terms of the probability of real harm was shared by other interviewees, who had become accustomed to what were at times extremely distressing and dangerous client behaviours. The lack of accountability and responsibility taking for violent and harmful acts from clients as a wider organisational and sector concept, had been seemingly normalised by the participants and rationalised as the result of client ill-health and a lack of capacity.

Both Carrie and Liam spoke about the importance of reflection and self-awareness as being valuable in relation to communicating their needs and buffering workplace stressors, and it appeared that this helped to mitigate any associated difficult feelings. However, being able to rationalise and understand why and when clients might be violent did not help to mitigate the probability of physical harm occurring and, as such, the expectation and worry about violence still needed managing. Carrie went on to place the responsibility of worker and client risk/safety on to the service provider, recognising the limits of her own accountability and duty to manage safe workspaces, adding: “...realistically they weren't, I mean the homes weren't addressing the stuff that needed addressing.”

For Rachel, a part-time support worker with increasing health care responsibilities, putting up with violence from service users had been written into organisational policy and accepted as part of her role:

> Basically, it’s a risk that we take and that yeah, there is a policy about it, we obviously cannot hit back, but that we are in danger of it. It’s in our job description so we just gotta put up with it.

It sounded very much as if having a policy and it being part of their job description had formalised the likelihood and risk of physical harm for Rachel and her colleagues. She sounded frustrated with her perceived powerlessness, giving the impression that these difficult experiences had been minimised by management and accepted as ‘just the way things are’ by staff. Having to tolerate physical aggression had left Rachel feeling angry, unimportant, and unable to say no. Client violence had historically been infrequent but as the client’s needs became more complex, so had their levels of support and it was this that Rachel felt left them exposed to increasing vulnerability, exploitation and an increased probability of physical and emotional harm, adding:

> We have far much more responsibility but with no more pay or consideration, or, or gratitude [ ] It’s soul destroying really, because especially with this year of COVID, we've had no managerial support at all and we're doing everything off our own backs.

Jake, a domiciliary care worker for over 15 years, used the phrase “bless her heart” when talking about an experience of physical violence from a client:

> I didn’t notice her hand come off the trolley it came straight back… straight got me straight in the chest [ ] I was on the floor bless her heart, I have to say bless her heart cos it winded me.

When asked about his other experiences with client physical violence Jake added: “It is common, and it shouldn’t be.” Despite admitting that violence should not be a commonplace experience for workers, Jake persistently minimised the impact of client violence and abuse directed at him, continually justifying it away whilst simultaneously recognising that violence and abuse toward his colleagues was unacceptable.

Jenny’s service supports individuals with learning disabilities, substance misuse issues and histories of offending, including sexual offence. She made numerous references to workplace violence and physical assault:

> At the time when it happened I, I do remember feeling not frightened which is actually a scare in itself cos if you become immune to that, if you think that that’s ok, you’ve crossed the line. What’s going on for you if you think that being threatened with a knife, regardless of your gender and size etc etc is okay?

Jenny described employing a coping strategy of detachment that had increasingly left her numb to violent and dangerous situations, and she recognised that her personal lived experience of domestic abuse and violence had perhaps left her vulnerable to this type of unhealthy yet familiar risk-taking behaviour. However, despite her own remonstrations about workers not calling the police after violent incidences, Jenny did not call them on this occasion either. She went on to share that it was the incident with the knife that had triggered her thinking about reaching out for mental health support, and taking some time out to recover.

The thread of not holding clients and organisations to account in relation to experiences of violence and abuse was noted throughout all interviews. The Phase One participant group evidenced a more compassionate and accepting approach to tolerating dysfunctional and potentially harmful incidences with clients and favoured the belief that service users, as vulnerable individuals, were not responsible for their harmful behaviours. Organisational responsibility around violent client experiences was largely framed by the participants as a need for more regular, effective, and compassionate support mechanisms. Carrie, however, noted that the ‘organisation’ should be the one to minimise the likelihood of violent behaviour occurring, which she believed can be achieved through the implementation of improved behavioural strategies and increased staffing levels.

A compassionate and tolerant approach to this aspect of the job appeared to help buffer and mitigate the impact of violent client behaviours, given it was felt the assaults were nothing personal and that a certain type of resilience was needed for this type of role. Others recognised this but shared that they continued to feel scared, anxious and vulnerable about working with known violent service users. Participants largely recognised that being exposed to physically harmful behaviour was part of the job and had accepted and in many cases justified it, despite the known risks.

The reluctance to challenge, report and even recognise the scope for potential wellbeing risk and harm, exposed many of the participant group to a likelihood of increased physical and emotional vulnerability and exploitation. Their willingness and ability to move past difficult and even frightening client facing experiences, seemed to help minimise the seriousness of these events, which over the time, appeared to some way leave the participants feeling immunised to this kind of risk and harm in the future.

4.6 Superordinate Theme Three: Support and Supervision

Supervision, as a space for social care workers to reflect, prioritise work with clients and receive guidance and support around areas that need development, played an important role in the participant's work life experiences, although commonly a negative one. All participants had received at least one supervision, although for many they were infrequent, lacking in skill and understanding of the process, punitive and felt done to, not done with. The participants spoke of the support networks they have access to at home and at work, although they largely felt this was inadequate and that those outside of the sector were unable to relate to how challenging and rewarding their roles really were. The following areas were identified within the data for further exploration: experiences with workplace support; personal support networks; experiences with supervision (including experiences with both ineffective and effective supervision); training and learning; and a vision for supervision.

4.6.1 Experiences with workplace support

Workplace support was identified as an essential part of the social care role, given the scope for difficult and at times harmful workplace experiences. Risk in the social care workplace can be both daily and unexpected and support for these potentially hazardous conditions was seemingly inadequate for the participants' needs. Pam repeatedly stated that she did not feel cared for or supported by her company, but that wanting to be cared about also felt selfish. In response to the absence of supervision throughout her career in care, she said:

> It sounds selfish really but sometimes I'd like a bit of support, you know, I'm out there giving everybody support so who supports me, with my job? It can't be said to my husband, because I can't tell him things, but I can tell my manager. I'm not, I don't feel like I'm getting support that way... At all.

She went on to say: “We don't get that space to have a conversation, I've, I've phoned on call, and I didn't even get my phone calls returned, I'll send a text message, I don't even get me text messages replied to.” When asked how that made her feel, she quietly responded: “Like I'm nothing, they think I'm a nothing.”

Jake had only recently experienced support from a manager that he thought skilled, effective and genuinely supportive of him and his needs, adding:

> Now I have that back up, me, and my manager we work so closely together that we know we can ring each other at three o'clock in the morning and go, “oh my God what a night on call”, and you can vent that, whereas before I wasn’t able to.

Jake had previously felt disappointed and demotivated by the lack of care and consideration paid to him and his colleagues, and when asked whether this lack of care for the carers impacted on the clients, replied:

> Absolutely, absolutely because I’ve seen carers give up and go, do you know what, managers don’t care about me why should I care about the job? It’s always been important to me that actually, if staff are happy, you know, it knocks on, if you know you’re coming to work, and actually I like my job because management listens to me when I have my supervisions and they actually take it on board and things change, but if that’s not happening, people are just urgh I can’t really be bothered to go to work I’ll call in sick.

Emma chose to leave her last domiciliary care company after becoming increasingly frustrated with the lack of care and support from her management team:

> There was such a lack of support from the management it was unbelievable it made four of us leave the company [ ] Um if I’m honest [ ] if it gets to the point

> that I need some help or support I think work would always be the last thing I go to because I feel like they don't care as much.

Like other participants struggling with managing the new COVID 19 guidelines, Lucy has also struggled with the practice changes around COVID 19 and had felt unsupported with this:

> I found that really stressful, and didn't find myself particularly well supported with that either, and just constantly got in trouble and told off for not doing the right thing, whereas really, I didn't quite know what I was doing.

Workplace support was largely felt to be inadequate and poorly delivered, although Jake shared how great it had been to finally work with a manager he had found knowledgeable, relatable, accessible, and compassionate. A lack of care and support for staff had resulted in Emma and several colleagues leaving the service, evidencing the importance of top-down support for those doing the 'heavy lifting'. Not caring or supporting workers was seen by the participants as demotivating, disrespectful and baffling, particularly given they were in the business of caring and supporting others.

4.6.2 Personal Support Networks

When asked about external support networks, many of the workers had very little to say and felt that their friends and families did not, or could not appreciate why they did the work that they did. Whilst Jackie cherished her workplace supervision support, she added:

> My family and my friends don't get it. They don't understand how I can work with these kinds of clients. I don't really talk to anybody outside of my job. [ ] I brought up my children pretty much on my own so I've always kind of been used to that anyway so I don't necessarily look for it.

When asked about whether she had personal support networks Lucy replied:

> Yeah, I have, but I'm not very good because I come from a stiff upper lip family where we don't talk about our feelings, we just get on with it and ya know, it's just a generational thing. [ ] We've always sorted stuff out within the family we don't ask for help, so I found that really hard.

Susie had previously been employed part time but had recently changed sectors and shift patterns. This had impacted on how often she was able to catch up with friends outside of the workplace, sharing: “I’ve got a couple of other friends that I see but I used to see them more when I was part time now, I’m shift working full time, it’s harder seeing them ya know.”

Susie did not feel able to talk with her husband about her emotional stressors and she believed that sharing how she was really feeling would be a sign that she was no longer coping. When asked what she did to manage any difficult emotions she laughed and said:

> I probably drink wine, smoke... I eat too much. Drink too much… after 25 years I’ve just started smoking again which I don’t get that bit, but you know... I probably don’t want to talk about my feelings… [ ] I don’t go deep... I think it’s very much things that happen to you in life it’s all about coping... And if I start talking, I think right, I’m not coping... I cover up, so I very much cover up my life and my bits.

Helen felt unable to share her workplace experiences with friends and family due to their sensitive and distressing nature, saying:

> I don’t really talk to anybody else about it, and other than maybe like colleagues in work who know you know what’s going on..[ ] I have a couple of good friends that I um know yeah, even though they, they don’t, they wouldn’t know what was going on [ ] but they just know, obviously in general that the job can be quite difficult so they would just check in with me, just make sure that I’m okay.

Helen had also found her religious faith extremely important as a space for personal support, adding:

> I’ve got a faith, so I find for me, my faith, if I’m being honest with you is what gets me through. Um, you know I know everybody’s different with, um, you know, what gets them through, but I think for me, yeah, my, you know, my faith does get me through.

A lack of external support and a space to safely offload was shared by many of the participants leaving them in what felt like isolated spaces at times, especially as effective supervision was unavailable to most. There was a sense that friends and families just “didn’t get it”, which seemed to reinforce the participants previous comments about believing you had to be a certain type of person to work in the social care sector.

The confidential nature of working with vulnerable others and perhaps the absence of relatable experience of wanting to work in this sector, may have led others to feel a certain sense of frustration and confusion as to why their loved ones continued to place themselves in these high-risk situations. Given this work can sometimes be dangerous and often stressful, this feeling of not getting it may also reflect more of a sense of disconnect with the role itself. The comments from friends and loved ones may also represent the worry they feel for the participant's safety and wellbeing in knowingly deleterious workspaces.

4.6.3 Experiences with Supervision

Some participants were motivated to participate in the research because they knew it was going to explore supervision processes and experiences. For others however, supervision was largely an unknown part of their job but was nonetheless something that they intrinsically felt was not meeting their support needs or motivating them in their role. The participants wanted the supervision process to help them feel better supported, understood, and motivated in their role, instead, it was often punitive, anxiety provoking and/or repeatedly rescheduled. Those who spoke of receiving what they considered to be good supervision prefaced this by saying that they knew how fortunate they were, lending a sense of luck around what should be a standard and consistent management support process. It was recognised by the participants that the supervision they had, and in many cases had not, been receiving was a potentially beneficial, yet underutilised, space for sharing, relationship building, growth and learning.

Lucy had previous experience in delivering supervisions to others but found in her current post that supervision didn't seem to be considered as an important part of her role:

> I find it a paper pushing exercise, and my manager literally sits and types in a box while I'm talking which I find really off-putting cos she's not even looking at me, and I feel like it's an inconvenience.

All the participants were aware that the supervision space was commonly used as a platform for reprimanding workers, and many had been in receipt of what was described by some as a 'bollocking'. Lucy, however, repeatedly shared that she continually felt 'told off', that these experiences were demotivating and that she had been seeking a new job for some time. When asked what being told off felt like, she replied:

> It's absolutely soul destroying, I've never worked anywhere that's battered my self-esteem like it has working here... [ ] Here, I feel like I'm a leper basically, I'm not respected at all and being told off makes me feel small, insignificant... Um it makes me feel undervalued, disrespected and basically useless.

When asked about her supervision experiences, Emma, who has worked in the sector for almost three years, felt like she had nothing to contribute as she had only had one supervision. The experience was a difficult one, filled with criticism and confusion, which had left her mistrustful and anxious about future supervisions, given she had thought she was doing well.

Rachel had felt extremely let down by her management team, particularly during the first lockdown. When asked about supervision Rachel laughed and said: "I haven't had one for three and a half years... I haven't had one... The last supervision I had was because I asked for it." When asked if she was supposed to be receiving supervision, she replied:

> Well, we've had, we've had a look at this um it's not best practice to… You don't have to have it, it's not best practice apparently... [ ] I think we should have it every three months like it says in our contract, but we don't.

When asked about supervision within her service, she said that she and her teammates had looked in to whether supervision was best practise and that the advice she had received from a colleague was that it was not. Despite regular supervision and annual appraisals being part of her contract, Rachel felt that even if she did raise the issue, nothing would be done about it.

In Susie's previous role, supervision would take the form of a quick chat with her manager who she was good friends with. This happened in place of the more formal supervision that her teacher colleagues were provided with. In her new role Susie now gets more regular supervision, although COVID 19 had impacted upon this. Regarding supervision, Susie noted that:

> We do, we get supervision, which we were supposed to get supervision monthly which we did initially, but the quick 10 minute one... just a quick like tick the

> boxes, are you ok, any issues all the rest… that hasn't happened for the last couple of months.

Susie also had access to group supervision, although she found that: "…group supervision is harder isn't it because you always get the dominant ones, so you'll always get the dominant ones that will do it or if you say summat they'll put you down that your decision's wrong."

Helen has also had experience with group supervision, she reflected that:

> Um we had group supervision and for me, you know even looking back on it, it just wasn't what I wanted... [ ] you have that feeling of, you feel like you're hogging the time because it's group supervision, and then you think, oh, this looks like it's all about me, so then you might go into another group supervision and then not talk about all that stuff that's really upsetting you because you're holding on to it because you don't want it to look like, oh it's her again… [ ] But despite that, um, you know, I suppose, because I'm so desperate to offload stuff and it was a case of having to really, being honest with you, you know, it's like needs must isn't it.

Both Susie and Helen's experience of group supervision seemed to come from two different perspectives and understanding of their specific supervision needs at that time. As a more experienced worker, Helen appeared to appreciate the potential benefits of supervision more easily than Susie, although Susie's experience of supervision had been confined within the COVID-19 restricted supervision landscape. Helen still found the group supervision process not as effect as she would have liked, but her desperation to offload superseded any difficult feelings around 'hogging' the space, which resulted in her getting her needs met despite the awkwardness. Susie, however, was less experienced in the sector and clearly found asserting herself in an environment she is unfamiliar with, challenging, especially as she voiced feeling openly criticised by more dominant and experienced colleagues.

Helen had previously been offered one-to-one supervision sessions and recalled: "We were supposed to have one-to-one supervision with our line manager but that didn't happen as regular as it should have happened", adding:

> In an ideal scenario, I would want supervision done by somebody that's got nothing to do with my team, because I don't feel like I could be 100% honest about certain things [ ] I also felt that it was very much rushed because it was like we were, we were going through an agenda.

Keith had been with his organisation for five years and had spent most of his previous working life in a factory before deciding he wanted to give something back. When asked about his support and supervision experiences. He said:

> I've had supervision once... That was a tick box thing because they've had to do it [ ] My manager's just someone who's come from a recruitment background so have they had any HR training? [ ] I'm probably more qualified to take supervision.

Within the interviews, all participants, even those with experiences of effective supervision, spoke of having experienced the process as a largely tick box exercise. The phrase 'ticking boxes' was also used to describe other organisational behaviours as Susie shared when asked whether she thought her organisation really cared for their worker's wellbeing:

> I think they do. But I think they're very clever in making sure they're ticking all the boxes and all the bits they need to do. So, I think some things are an exercise for them to be ticking their boxes.

The supervision process felt largely meaningless and anxiety provoking and many of the participants felt dread around the process. Things discussed were, on occasion, shared with other staff members, and privacy in busy services was shattered by ringing phones, doors being knocked and paper-thin walls. Not needing a supervision commonly translated as a means of telling the worker that they were doing alright and as Rachel put it: "I guess I'm doing a good job cos they aint told me otherwise."

Several of the participants spoke of supervisions being pre-written. On these occasions, they were simply required to sign them to say they had been done and as Jake recalled:

> I've worked in numerous places where they've gone oh, we didn't actually do your supervision but can you sign this piece of paper to say we did? [ ] I know this sounds awful but it wouldn't surprise me if they make em up. I have seen

> companies make up things it's, "we've got a CQC (Care Quality Commission) visiting tomorrow can you sign this bit of paper?".

Liam had had minimal opportunities in regard to supervision and he too spoke of being given supervision forms that had already been filled out, saying: "I've had some supervisions which have been pre written… Just read that through, and that's what we're going to cover so then you can tick off on it." He also raised the process of supervision as a space where workers were told off, noting: "They happen when someone needs one, like someone's done something… so no, I don't think they put too much emphasis on it."

All participants felt that their organisations did not place enough importance or emphasis on the supervision space, although some believed that time and money played a big part as to why it was not being provided. They felt there was always something else that took precedence over worker supervisions, and they were often cancelled or not seen as an integral part of the worker support process. A lack of supervision training was also noted as problematic, given supervisors were seemingly just expected to know how to deliver this complex and highly skilled support process.

Poor supervisions were largely seen as the norm and were consistently viewed as a source of stress, frustration and anxiety. Domiciliary care workers had little to no experience with the supervision process and were unsure as to their entitlement to it and its purpose. The lack of supervision placed the participants in increased spaces of risk and harm, given they were not afforded the opportunity to discuss client and/or personal wellbeing concerns, explore professional development and training needs and establish positive and trusted relationships with their supervisors.

4.6.4 Experiences with Effective Supervision

Whilst absent and ineffective supervision was seen as largely the norm, four of the 14 participants had at times experienced positive and rewarding supervision opportunities. Jackie felt she was able to use her supervision well, although she was aware that not everyone is lucky enough to share her experiences, noting:

> I have cherished supervision, and I have used my supervision really well and I think it's really, really important to be able to have personal supervision to talk about

> your personal stuff, cos ya know, I've had issues along the way that has impacted, and ya know it's been quite difficult to come to work with.

Jake recalls what it felt like to finally work for a manager who he felt gave him the right support, he said:

> Having somebody to listen, having er a manager that gave a shit... about everybody and she changed my outlook on care, she changed my outlook on the sector, she changed my outlook on me [ ] You can tell yourself that you're good at your job, and your clients can tell you, but actually to have that feedback from supervision is huge.

Those with positive experiences of the supervision process, agreed that it was a hugely beneficial space to offload about the physical and emotional stress in their roles. Those sharing effective supervision experiences could also reflect on poor supervisions and this served to further highlight how fortunate they were to have access to these important support opportunities. This good fortune appeared to magnify a custom of poor supervision practice, given 'luck' was thought to play a big part in what should be a standard aspect of the role.

Experiencing good supervision also helped these participants with their own practice given they too had had cause to deliver supervision at certain times in their role. In the absence of more formal training, these supervision experiences were thought to provide beneficial opportunities for positive modelling and learning for the participant, whilst poor supervision experiences taught them what not to do. As Jake reflected, having effective supervision was 'huge' and it felt like this amazing feedback had been extremely meaningful and empowering for him at the time and still.

4.6.5 Inappropriate Sharing and Disclosures

It was recognised by the participants that personal issues can impact on their working life and given the emotional and sometimes distressing nature of the role, that workplace experiences can impact on their personal life. They consequently wanted and needed their supervisors to ask how 'they' were doing but that this rarely happened. At times, Jake had found it necessary to speak with other carers about the sharing of their personal issues with clients, although he was able to appreciate why they might have felt the need to do this, saying:

> I've had to pull carers in and gone "stop talking about your private life cos I guarantee you, you tell that one client every single carer's gonna know by the end of the week" [ ] they're not being listened to by management... You know, if you've got a rubbishy home life, and you're not being listened to at home, the only people you see are your clients, and they become closer to you than some of your family members [ ] it sometimes just happens because actually, you empathise with that person they empathise with you and it's, it becomes very messy and untidy at times.

This was echoed by Pam who had also felt the need to raise the same issue with colleagues. She too was appreciative and understanding as to why workers sometimes cross these boundaries but was mindful of placing additional worries on to clients, many of whom were already dealing with significant emotional and physical health issues. Recognising the need for carers to 'download', she said:

> They download sometimes [ ] I've got one girl that's got a son who's autistic, and um she'll discuss him with the client, and I just say you shouldn't, because you're offloading your baggage onto them and they've got enough of their own to deal with and you're giving them yours to deal with.

Both Jake and Pam work as domiciliary care workers and as such, their workplaces are the homes of clients. Unless the client required two workers, they and their colleagues usually worked alone within this vulnerable dynamic and close relationships were sometimes formed. Whilst Pam recognised that her colleagues needed to offload, she considered this practice unfair for the vulnerable clients. However, without effective support and supervision, it is likely that some care workers may continue to use clients as confidantes.

4.7 Training and Learning

Training was seen as an important part of the health and social care role in regard to supporting safe practise, although many felt that it was what you learned on the job or who you were as a person that had the most impact on social care delivery. For Jake, however, he recalled that his first job as a domiciliary care worker required no training: "When I started 17 years ago I didn't have any training, no training whatsoever, I had my one shadow shift as I said and was out to work the next day."

He reflected on training now and thought that:

> Training has gone out the window in a lot of places… [ ] it's those simple fundamental bits of care that people aren't trained in [ ] I can remember doing moving and handling training in a hospital and it's massive and there's loads of space and there isn't carpet or dogs or that cat that won't let you anywhere near the owner, it's all fake.

When asked about the training provision with her domiciliary care service, Emma replied: “I did quite a lot of training um mostly online training, you do lots of online training.” After being asked what that was like, she went on to add: “Er you get some knowledge, but most you learn when, you actually learn when you're working with the people that's the best thing really to do but you do some online training.”

Cathy works for a charity and money for training is scant. They do however, take advantage of free training that’s often available within the sector. When asked whether she enjoyed these largely E-Learning training opportunities, she laughed and said:

> I know it sounds awful, but I switch off a bit, it doesn't go in, um, I think the way I learn more by if I'm in a group and someone relates it to a story or a situation, it sticks with me more or if I see a little television clip or something.

Whilst Helen can access training in the workplace, she also supports her own learning:

> I do a lot of stuff as well even if sort of in my own time so I listen to a lot of, you know podcasts... [ ] I've been listening to a lot of stuff [ ] about trauma, which obviously I haven't been taught in my organisation. I haven't had any training around this um but this week after listening to those podcasts I found myself talking to a client about what I'd heard [ ] so I'm, you know, haven't had the training and that but you know I'm just gonna go for it [ ] if I feel it's going to be helpful to a client.

Training was recognised as being both an essential and tolerated aspect of the caring role and all participants understood the importance of well delivered progressive and accessible learning opportunities in supporting professional development. Frustrations arose when training created additional staffing disruptions and time constraints, especially when it was scheduled to conflict with other duties and shift patterns. Not all participants were paid for completing training, which made some less likely to be motivated to engage and complete it in a timely fashion, or at all. As Keith noted: “I have to do it in my own hours [ ] so I'm thinking why should I do all this training and so I'm just stuck at the same level I'm at cos I refuse to do the training (laughs)”.

Frustration was shared around the types of training offered, with some recognising that there were theories and emerging practices that were not offered but would, most likely, prove beneficial and supportive in the workplace. On these occasions, participants would seek out their own learning, in their own time but were seemingly reluctant to share this with their organisations. Several of the participants also spoke of literacy issues with two going on to share they had dyslexia. This meant that not only did they find the increasing amount of paperwork challenging, but it also made training more difficult, especially if specific support had not been put in place. COVID-19 also meant that much of the training moved to being delivered online. There were both positive and negative experiences of this, with most of the participants preferring face-to-face training but recognising that this was not always possible. For one participant, a hearing impairment also made online training inaccessible and difficult to follow.

Most participants enjoyed the increased accessibility online training could afford workers but recognised that not all workers are comfortable with using IT or had access to the right equipment with Pam noting: “It’s difficult because I'm not very good with technology.” Those who preferred a face-to-face training environment, also said that they appreciated the opportunity for additional learning and sharing from the other attendees, which they felt was lost online.

Outside of the COVID-19 restrictions, whether training could be best facilitated online or face-to-face was wholly determined by the subject, with training that required a more discussive, emotional, physical, and experiential element being preferred as a face-to-face option. For Carrie, regardless of how the training was delivered, it was the lack of revisiting it that she thought made recall and adoption more difficult adding: “updates would be helpful I think, like I know... if I think about all the medication stuff.” Training refreshers were not specifically raised by the other participants, however, for those in residential and domiciliary services with satellite units, the issue of forgetting medication and medical procedures was also raised as a contributing factor for additional stress and worry.

4.8 A Vision for supervision

As part of the semi-structured interview, all participants were asked what their ideal supervision would look like. Given how challenging many had found the supervision process much of the time, this opportunity was received with relish by some who had clearly taken the time to reflect on their experiences in preparation for the interview. From the participant responses, the following subthemes were identified for further exploration: the supervision environment, approaches to supervision, and the skills of the supervisor.

4.8.1 The Supervision environment

Where a supervision took place was commonly the first thing the participants raised when sharing their perfect supervision. A supervision space away from the service that was private and confidential was suggested by many of the participants, and all wanted a comfortable, informal, and welcoming space to meet in. Many were currently expected to engage in a supervision in busy offices or where workers and clients could interrupt at any time, and Carrie took a moment to reflect on the question before saying:

> Erm... Probably not doing it at work, erm like, if I have supervision B will stick a sign on her door but her door will still get knocked, residents will still try and just walk in erm, and that's not B’s fault that's just the nature of the people that we work with in the project because everybody thinks that their drama is the most important thing in that moment in time. Erm, so I think the setting is important, so if you have a more relaxed setting where you can have a cup of tea or coffee, um, and it not be kind of like your normal working setting, makes you just go a bit more relaxed and you're open to exploring things and stuff.

Cathy works in a busy building in an open office and finding empty rooms to have a supervision can be problematic. Like Carrie, Cathy would appreciate the chance to have her supervisions away from the office:

> Personally I think it's quite nice offsite, I think that's the biggest one for me because when I have it on site, um, so I'm talking about face to face ones obviously, here there's always someone who knocks on the door and who

> interrupts, there might be a genuinely good reason whatever [ ] or A’s mobile's ringing, it's just I don't feel totally switched off.

Susie had found her limited experiences with supervision frustrating given the lack of time put aside for them and it was common for there to be disruptions and distractions:

> You can hear sort of bits, and people are always walking in and out, or phones going cos we have phones in the offices where you go in, and bits like that. So, it's not a quiet space it's not the kind of space where you wouldn't be interrupted.

Much like Susie, Emma had limited experiences with supervision but when asked to reflect, felt that where a supervision took place was important:

> Thinking about it now, I would first like to, maybe it would be quite nice to not do it in the work offices you know, not feeling like you're going into work maybe. [ ] I think the environment around us is important as well, so let's just not say to a person “come into my office we're gonna do a supervision today”, I feel like, you know, you've been punished or something.

Liam felt that the supervision space itself should be more respected, reflecting that:

> I think time needs to be given to it where it isn’t like, “oh, I’ve got to get this done today”. There needs to be time there… It needs to be maybe organised so that there are additional staff to cover and then people don’t feel like “ah well, I still got to do this, and we’ve got to get lunch on the go and I don’t really want to be here”. It needs to be more breathable.

Susie echoed this when asked what she thought managers could do to improve the supervision experience for workers, she paused, before saying: “...Probably like block out the time, go somewhere, block out the time and obviously, even if it's just an informal chance to talk because you never get to know them.” Susie raised the issue of blocking out the supervision time on two successive occasions in this short response, emphasising the importance of protecting this space, before going on to reflect some more:

> I think they're probably too busy [ ] she's got so much on 'her' (her supervisor) plate it's having that time isn't it [ ] and I think lots of meetings get prioritised over staff and supervision. So, it's like “great I can do this now before you go home

> after a night shift, let's quickly go and do it". You know, it's prioritising maybe supervision as maybe being more important.

It felt as if Susie was making apologies for her manager, justifying to herself as to why she was not being effectively supported and perhaps evidencing the need for a more relational supervision experience given she felt that she did not know her manager. The tone quickly changed, however, and the tentative apologies turned into reflection as Susie asserted the notion that perhaps supervisions are as important as other aspects of their manager's role and should therefore be equally prioritised.

For Jackie, however, supervision was all about the sharing of feelings, and she confidently spoke of a real love and enjoyment of the process. When asked what an ideal supervision would look like, she reflected for a moment:

> …I think um… Supervision. I suppose it's; we're talking about your feelings. And I think, you know, and again, you know, I'll go back to somewhere where you can feel seen and heard, because I think that's really, really important.

In stark contrast to Susie, Jackie relished the opportunity to explore and process her feelings, which she recognised as an important part of supporting her wellbeing in an often-distressing workplace environment. It was clear that she passionately believed that investing in the supervision process would likely prove highly beneficial for her and her colleagues. Jackie also recognised that her approach to supervision was largely one not shared by her colleagues and when asked why she thought that was, said:

> I'm not sure. I'm honestly not sure. I know some people. Some people just hate it. And they're like "oh my God I hate doing a supervision", especially the group stuff. Because you know, I don't want to talk in front of anyone.

It seemed difficult for Jackie to understand why her colleagues didn't love supervision as much as she did, although she did recognise that she was largely in the minority on this issue. Jackie went on to share some challenges and frustrations around her new supervisory role and responsibilities, and her difficulty in appreciating her colleague's dislike of the supervision process may have contributed to these frustrations.

4.8.2 Approaches to supervision

Most participants raised a general lack of understanding about the supervision process. Some didn’t really know what supervision was at all, and others just wanted to be asked the genuine question of “how are you?” and feel that their supervisor cared about the answer. The first thing that Pam asked for, was to be put first, saying:” I'd like to be asked how I'm feeling before they ask me how everybody else is feeling”. All participants shared that they felt their organisations did not place enough importance on their approach to staff supervision and wellbeing but that they very much recognised its potential for real wellbeing and practice benefits, with Liam noting: “I think more importance, to be more passionate about it and to help staff understand why it's important.”

When Lucy was asked what vision for supervision she would create, she spoke for seven straight minutes. She had previously spoken at length about how her own supervisions were ‘soul-destroying’ and ‘self-esteem bashing’ for her, and she brightened as she spoke:

> I... would... Let people know in advance, um I would, they would have their supervisions planned throughout the year at equal intervals then if things came up then fair enough but they would all be planned [ ] we'd be settling back for a nice little chat with a cup of coffee, comfy seats and somewhere to write things down, there would be an opportunity to say how you are in the beginning [ ] I think it needs to be flexible, you know, you can't plan it in one hour before you're about to do handover because you're literally gonna have to go five minutes late [ ] So in terms of staff I always pick a time where it's less busy so that they're not going to be called in to do care [ ] It would be person-centred and it would be about things that I could help them with [ ] the format itself I think should have headings but it shouldn't be in boxes because boxes make it look make it umm look like a value basis thing [ ] it should be much more open ended [ ] The form's also very unfriendly and it's boxes, I think boxes put people off when it's, I don't see why it's in boxes but, maybe it's important for targets... I don't know.

Lucy referred to her dislike of the prescriptive boxes on the supervision forms on numerous occasions after having already referred to an intense dislike of feeling trapped in supervision rooms/boxes, due to her lived experience of domestic abuse. The use of boxes and closed rooms around the supervision process left Lucy feeling anxious and panicked and she expressed feelings of powerlessness around the situation. The notion of boxes as limiting the space for communication and knowledge sharing seemed like a sensible and productive idea, given all that was required was to remove them.

As for her unease with the locked supervision space, it appeared that a history of overly critical and 'soul destroying' supervision experiences with her service manager had inhibited Lucy from feeling able to share and manage this important piece of personal information with her supervisor more easily. Lucy's lived experience highlighted both the importance of the supervisory space as a mental health and wellbeing issue and that a relational and trusted supervisor/supervisee connection enables this type of sensitive information to be safely and comfortably shared.

Carrie thought that the supervision process itself was too forward moving in its often tightly structured format, giving little space to the importance of addressing issues in the now but recognising that time and motivation were needed to engage in this way:

> I think we should look at supervision as not being quite so linear, ya know, it's what's going on for you at that moment that you might need a once-a-week supervision that's around something that's quite challenging, and that space could be very productive in supporting you and actually keeping the project going… [ ] I don't know if people go about making that space.

With Rachel, it felt like she had been waiting throughout the whole of the interview for the opportunity to talk about the kind of supervision she would like to create in her workplace, and she took a big intake of breath as she excitedly started to speak:

> I would have a monthly team meeting, which is um just to get everyone in, are we working on the same page what's working, what's not working and then I would make sure like I had an open-door policy. If you need to speak to me about anything and then um you know let's chat. I just think it's, you know, for someone to get the best out of their workers they need to care and just to make sure everyone's on the same page with it all.

She quickly added:

> I think the culture would change, wouldn't be so negative, it wouldn't be them against us sort of um yeah, I just think people feel happier knowing that they could go speak and be listened to, instead of just it being quite a bitchy environment, it would be back to being compassionate um and just feeling valued because I feel that's the main issue we have.

Rachel lit up, as did many of the participants, when asked to create their vision for supervision and it was clear that they all recognised that supervisions needed to be better. Her own experiences and reflections around workplace and personal support needs helped Rachel to think about aspects of the role that workers found difficult, which in turn supported her in understanding what she could do to make things better. Ultimately, however, what Rachel wanted for herself, and her colleagues was to feel happy, listened to, acknowledged, respected, valued and supported by a skilled supervisor.

4.8.3 Supervisor Skills

Fraught manager-worker relationships were common and recalling what it felt like to work with ineffective managers, elicited angry, frustrated and disappointed responses, leaving participants feeling used, unimportant and lacking in value. For those who worked in high-trauma environments, the skills of the supervisor were considered hugely important, alongside possessing relatable knowledge, experience and an ability to understand the challenges of that specific role. A sense that the supervisor-supervisee role was commonly misused, unused and abused ran throughout the interviews and the participants unanimously agreed that supervisors needed more training and opportunities to acquire better supervision skills. As Jake noted:

> Yeah, definitely if they haven't got the tools to actually give a decent supervision, or the ability to give a decent supervision, you're not gonna get one if they've just been told "ask this and this, get em to sign it at the bottom", then that's just gonna continue, it's just bad practice.

He went on to add that he had never been offered any supervision training, prior to starting his supervision responsibilities. Jenny also felt that workers weren't invested in enough by managers during the supervision exchange and wanted to be stretched and stimulated more:

> Give me something that is going to make me go “shit I aint thought about that”, yeah, I'll do that... I think there are more people who would like to do that err because we could be, the supervision that goes out, we get set into this mindset of oh it's only so and so they don’t like being pushed too much, well actually when push comes to shove everyone likes a bit of a challenge. Everyone likes a bit of a challenge everyone likes, you need to be stimulated, if you don't get stimulated you get complacent.

Jenny, much like the other participants, enjoyed the opportunity to grow and learn in her role and in the sector, but felt this experience had to be led by experienced, skilled, trusted and respected supervisors. Helen echoed this by adding that it was important to her that she felt her supervisor could relate to her work experiences, her personal experiences and the impact of her role on her wellbeing, noting:

> I think the, you know, the people that are going to be... whoever's going to deliver that supervision, they need that type of experience um and they need that skill set to be able to sort of relate to it really, um, and I think, you know, there needs to be that regular sort of checking when you're doing this type of work.

Helen’s repeated use of the word ‘need’ wholly evidenced the importance of supervisor skill within the supervision dynamic, and as the interview progressed, she became increasingly reflective and thoughtful with her answers around the supervision process. Toward the end, she said this of her own sense of wellbeing and the importance of supervision to her work and personal life:

> If you're not processing those feelings with somebody else and you're just pushing them down I just wonder whether you get to a point of, you know, a saturation point that actually your heart does have to harden because… you're, you're, you can't deal with it any other way so you almost have to switch that bit off, um, I don't know, and I think it's important to keep your heart soft in this work, does that make sense?

Having to harden your heart was a phrase used by Helen on several occasions during the interview, as if trying to convince herself that this self-confessed empath could learn to be less hurt by her work. For Helen, having the opportunity to effectively process her feelings with a skilled compassionate supervisor would enable her to share the impact of her highly emotional and on-going workplace struggle, and it was clear that it was of great importance to her.

Helen believed that the supervision space could provide the right mechanism to meet her emotional workplace support needs but that at present it was patchy and failed to adopt the same trauma principles that she was encouraged to use in her own practice. The appreciation that supervision was not meeting her needs, was not unique to Helen and all participants believed it was not functioning in a responsive and meaningful way across the sector, although pockets of good practice had been identified. How supervision was understood, managed, and delivered in this sector was felt to be not just inadequate, but at times harmful, with participants talking about it as a space for ‘a bollocking’ or just something for their organisation to tick off.

Poor supervision processes were felt to expose workers to increased situations of risk through the lack of a space to offload, process and learn, although some had also felt lucky to have been in receipt of effective supervision, which they thought helped to provide a safety net around them and their practice needs. A lack of, or ineffective supervision, also meant an increase in the probability of future risk of harm to the participants given they were subsequently not afforded an opportunity to effectively identify, discuss and manage risk in the scope of their everyday duties.

The participants universally thought that the provision of effective and responsive supervision in the social care sector would only be a good thing for them and their service users safety and wellbeing, but that when done well, supervision also had the potential for positive relational growth, knowledge sharing and professional development. They understood the emotional and physical impacts of their job and despite the vulnerable and sometimes exploitative situations they had been placed in, loved what they did. A demonstration of appreciation and care from employers was sought, and the provision of an effective supervision framework was thought to be a good starting point.

4.9 Chapter Summary

This chapter explored the inherently stressful, challenging, and potentially harmful nature of the unregulated social care workplace environment, and the inherently vulnerable and at-risk nature of those who work within it. As well as being a central aspect of the study, mental health and wellbeing was an important aspect of the USCW concerns about working in the unregulated social care sector. Difficult personal lived experiences were compounded by experiences of workplace violence, abuse and exploitation, and poor workplace wellbeing and practice support, which placed the USCWs at increased risk of ill-health, exhaustion, and burnout. The Covid-19 lockdowns had been exceptionally difficult for the USCWs who noted a lack of PPE (personal protective equipment) and confusing guidance changes which caused additional stress and worries. The pandemic also impacted on the availability and accessibility of health and support services, which for some USCWs meant external support networks dwindled.

All participants shared mental health concerns, with many going on to disclose prior lived experiences with violence and abuse. Lived experiences were thought to provide that ‘something extra’ to the caring role which they largely felt couldn’t be taught. Because of difficult lived experiences, and the inherently risky nature of the USCW role, all the USCWs talked of how they and their colleagues had at times felt psychologically and/or physiologically triggered in their role. Triggering, much like occasions of violence and abuse was tolerated and managed as part of the job, although these triggering events often left the USCWs with negative aftereffects such as feeling panicked and upset. Good wellbeing and compassionate self-awareness were identified by some USCWs as a buffer for distressing and difficult workplace events, with many USCWs viewing lived experience of trauma as ‘good work experience’.

How care work is ‘done’ was also stressful for many of the USCWs, especially for those on zero-hour contracts; home care workers and those who worked in residential settings. Zero-hour contracts left USCWs feeling financially insecure, with one USCW accepting shifts daily for months on end through fear of the work ending. This perpetual treadmill led to ill-health and exhaustion. Staff sickness added to the USCWs stress levels and cynicism around absences led to mistrust and resentment amongst staff teams. The COVID-19 pandemic further added to staffing pressures.

Possessing the characteristics of a “natural” carer exposed participants to both increased role fulfilment and exploitation, and many USCWs felt unable to say no to manager and service user requests due to feelings of guilt, and/or a lack of agency. Experiences with workplace violence and abuse were common and were not adequately addressed by the participants' service provider. Several participants had good personal support networks. Others however, felt that friends and family were unable to appreciate why they continued to work in a job where they were placed in physically and emotionally harmful workplace spaces for low pay, which seemed to compound for them the notion that the caring role requires a certain type of individual to 'get it'.

Supervision experiences were explored, and the reality of what this workplace support mechanism is really like for this workforce sample, evidences a broken system, that most know little to nothing about. Supervision was largely seen as a tick box exercise holding little value or meaning to workers or organisations and one that elicited feelings of dread and frustration for most of the USCWs. Poor supervision was seen as the norm, although effective supervision did happen and was seen as beneficial to both worker wellbeing and practice. All participants shared ideas for improving the supervision space offering valuable insights and ideas around improving the process. There is no supervision training for supervisees and mandatory training was described as inadequate, boring, inaccessible, and not reflecting the current practice or wellbeing needs of the workforce.

The already established supervision space was subsequently identified as a point for continued focus and wider data collection given its potential for enhancing positive practice, and for negatively impacting on worker wellbeing when ineffectively delivered. Phase Two data builds upon Phase One by exploring the supervision process through the lens of the supervisor and by providing an opportunity to juxtapose the perceptions and experiences of supervisors with those of the USCWs in Phase One.

Chapter Five

Phase Two Findings

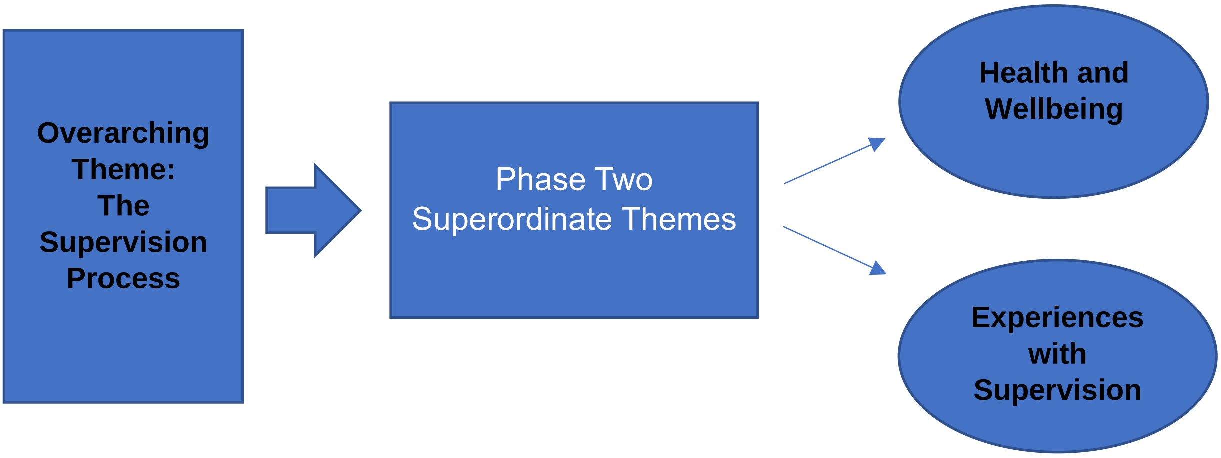
5.1 Chapter Overview

This chapter expands the inquiry into the unregulated social care worker supervision process, exploring the experiences of supervisors', who are also supervisees. As a Phase One superordinate theme, supervision was identified as a workplace support mechanism that was largely failing to meet the participants' workplace needs. In response, Phase Two sought to explore the supervision experience from the social care supervisor's perspective and gather a wider understanding of the supervision process. Two superordinate themes were identified within the data: the role of wellbeing in supervision, and the supervision experience through the lens of the supervisor. Phase Two further explores supervision, by trying to understand how individuals learn to become supervisors, how supervisee wellbeing is managed through the supervision process, supervisor experiences and support needs as supervisor/supervisee, and what they considered good supervision practice now, and for the future.

5.1.1 Phase Two Thematic Overview

Figure 2

Phase Two Thematic Overview



5.2 The Participants

All participants held managerial and supervisory roles within their organisation, and were in receipt of supervision, although one Phase Two participant did not receive regular supervision. They were employed in a variety of settings including learning disabilities, agency social care, charitable/voluntary services and children and families. Some had joined social care after careers in other sectors including banking, factory work and childcare and others had worked their way up since joining as unregistered social care workers. Four participants were approached directly and five approached the researcher after becoming aware of the study from the local Care Commissioning Group. The participant group consisted of seven women and two men (see 5.3.1 Table 3).

5.2.1 Table of Participants

Table 3

Phase Two Participants

Supervisors	Service Area
Cathy	Voluntary/Specialist
Maggie	Social Care
Paul	Charitable/Specialist
Steve	Learning Disabilities
Sarah	Charitable/Children and Young People
Ruth	Learning Disabilities
Katie	Social Care
Sally	Charitable/Specialist
Alison	Charitable/Young Adults

5.3 Superordinate Theme One: Health and wellbeing

All participants evidenced a clear understanding of the importance of workplace and worker wellbeing, although some evidenced a more nuanced appreciation than others. The participants recognised the challenging, stressful, and sometimes dangerous nature of the work and could empathise with their staff teams and for some, share their own stories of first job nightmares, difficult supervisions, and the learning that came from those experiences. All participants had started off in less senior posts and could remember how the caring role impacted on their own wellbeing and they often brought this to their supervision delivery and learning. As managers however, new challenges and responsibilities also came with additional worries and stressors to wellbeing.

5.3.1 The emotional impact of the supervisory role

Both Phase One and Phase Two participants were invited to discuss their wellbeing needs in relation to the supervision process. In contrast with the Phase One participants (supervisees) who discussed their own needs, the Phase Two participants (supervisors) appeared more interested in discussing the wellbeing needs of their staff teams and how they managed these needs through the supervision process. They did however, all acknowledge the importance of good wellbeing in being able to work safely and effectively. Those who did share workplace and personal wellbeing experiences, spoke of times where they felt stressed and worried about their additional supervisory responsibilities, which alongside personal mental health and family issues, placed them in an increased space of risk to wellbeing.

When asked about his first experiences in the social care sector, Steve was keen to share that it was reflecting on that time that had helped him to understand, relate and empathise with the professional and personal wellbeing needs of his staff teams more effectively now. Asked how he felt before his first shift, Steve laughed and said:

> Apprehensive, a little bit kind of nervous, a bit worried almost what I was going in to, I really didn't know what to expect [ ] It was a bit like whoa, I felt like I'd been dropped in at the deep end [ ] It sets you up with a real sense of ya know, I'm gonna get whacked here by somebody.

He also very much appreciated that these shared experiences with his supervisees also had the potential to add relational stress and extra responsibility to the management and supervisory role, adding:

> You can kind of potentially take on a lot of what your team’s burdens are [ ] you can go to supervisions and what you then do is you take on everybody's worries or stresses or whatever they've got going on, that just doesn't help yourself, and you then lose your effectiveness I think.

Ruth, who also worked as a manager in a learning disability support service, worried about her staff members at times but very much saw it as part of who she was as an individual:

> I think I take things to heart a little bit, I'm a bit of a softy really [ ] I have worried about a person [ ] I was thinking about her, what could I do to help her [ ] she's not just my employee.

Maggie had started her career in social care as a home care worker, before going on to become a senior manager. She was able to draw upon her own experiences and learning in the supervision space, using them to empathise with her team's workplace and personal challenges whilst recognising the impact on her own wellbeing:

> I think I'm quite paternalistic with my staff and with managing any group, you've got to know who the people are, [ ] it's an additional pressure because you're managing their emotions as well as managing my own, I'm then managing somebody else's but they're managing somebody else's, so you're ending up getting the worker, through the manager, right through to you and then you have to process, not only your own, but theirs and somebody else's… It's an emotional pressure.

Whilst all participants had more formalised supervisory roles, Katie, a recruitment officer for a social care employment agency, had found herself in this role due to the long-term absence of a service manager. The responsibility of providing agency workers with supervision had been absorbed into her recruitment role and, whilst she enjoyed the opportunity to connect with the support workers, she found that it sometimes left her feeling worried about them, adding: "Because it's me and I take everything on… [ ] I then take on their stress, I then, at night, am thinking "oh God, is she gonna be ok cos the bailiff's gonna be knocking on the door."

Katie had been happy to take on the role of supervisor and felt that her own experiences as a support worker enabled her to understand the challenges of the role. However, she had not been supported with the appropriate training, or acknowledgement around her own support and wellbeing needs as a supervisor and individual. The burden of the additional responsibility left Katie feeling "mugged off" at times and exposed to increasing stress. Katie shared her history of mental and physical ill-health and how this added pressure, which was at times difficult to manage:

> I do like to fix people [ ] I'm taking it on... I'm then crying at night and then I'll easily sit here and tell them the right thing to do... Yeah, I mean I can say that nobody knows about the issues that I live with daily, my anxiety my OCD, nobody knows about that. I worry about everything constantly anyway. So, it just adds to my own to my own stresses and worries.

Taking on the stresses and worries of workers because of the supervision process was shared by most participants. How they managed and dealt with this aspect of their supervisory role, however, was seemingly buffered and reasoned away by using reflective introspection and self-awareness, although not all could do this effectively. The skill and ability to recognise and manage the stressors of others was seen as hugely important, given the multi-directional way managers receive information and demands. Empathy, compassion, and reflection enabled some managers to nurture meaningful and productive relationships with staff members, which at times added to their stress levels and supervision needs, and Steve reflected on the importance of supervision for his own personal and workplace wellbeing:

> For some people, it’s (supervision) the only space, I mean for myself personally I have quite a hectic personal life as well [ ] I think that’s one of the ones that’s really overlooked and especially in kind of management, leader roles, you’re expected to be available 24 hours a day seven days a week um and I know for myself, for my own wellbeing, I need to switch off at certain points [ ] because you will just worry, your stress levels will go up.

The role of supervisor could leave participants feeling worried, preoccupied and stressed. These additional pressures, particularly when unsupported by their own appropriate supervision, left some of the participants exposed to sometimes difficult emotional stressors. As Steve recognised, supporting vulnerable staff teams was something that needed to be switched off from and that supervision for manager wellbeing was important if they were to deliver productive supervisions with others.

5.3.2 Understanding supervisee wellbeing needs

For the participants, their own experiences and understanding of supervision and wellbeing, played an important part in how they then identified and managed staff team wellbeing needs through the supervision process. Phase Two participants were asked what kinds of workplace and personal difficulties they thought their staff team might experience and what this might mean for worker emotional health, wellbeing, and practice. When asked if he thought his staff members were dealing with their own individual wellbeing issues, Steve said:

> Yeah, there's you… There's quite often a lot of things on a personal level that people come into supervisions with, when you kind of, it might manifest itself as a work related issue initially and then you kind of pick that apart and talk to them about it, sometimes they won't open up to you, sometimes they will and then you can kind of offer a bit more support with that, um, and there's usually something that manifests itself as a work thing, whether it's lateness or there's something going on at home that's causing that lateness, and being able to get some opportunity to essentially talk about it when there's not going to be other people to talk about it, sometimes really helps and there is, you do see a lot of it and there's usually a reason when things like that happen.

For many of the Phase One participants, supervision was infrequent and patchy, and they often felt that they were not being listened to by unskilled supervisors. When asked how he thought not being listened to felt for supervisees, Steve quickly replied: “It's horrendous, like frustrated, you lose motivation, you just feel like you're not going anywhere.”

Steve recalled his very first supervision as a space for a telling off and recognised that this was still not uncommon of worker expectations:

> If they're (workers) expecting to walk into supervision to be told off they're going to be defensive, they're gonna be probably upset, especially with the sort of people that have been in the sector for a really long time and who have had negative experiences of supervision, thinking right, okay, my supervision is ‘what have I done now?’

Steve recognised that supervisions that leave workers defensive and upset are not the type of supportive experiences where individuals can talk candidly and safely about their practice and wellbeing needs. He had reflected on his own and others’ negative experiences and felt he used his relational skills to ensure that most workers were comfortable in approaching him for supervision. Steve recognised this, using these experiences, reflective thinking, and relational skills to help encourage his staff teams to safely and productively manage challenging workplace experiences and personal issues with him. Steve felt that most workers were comfortable in approaching him for supervision, and when asked if he was aware of any workers struggling with difficult personal and/or wellbeing issues, he said:

> In their private lives, absolutely. So things like relationship breakdowns erm child care issues and people's own mental health [ ] we're people working with people and it's really tough and you need to be, ya know, the job for me mentally and physically is exhausting at times and you need to be able to, in most cases, be on top form straight away from first thing in the morning to last thing at night [ ] you need to be supporting a person who needs constant reassurance or whatever, um, and if you've got something that is mentally affecting your mental wellbeing, then you know you can't be on 100% and then that just has a knock on effect.

This kind of supervision experience was echoed by Katie who felt that at times, supervisors could be seen as someone to offload their worries and wellbeing issues with:

> The stories I've heard over the years off people, they're just going through such trauma [ ] We’ve somewhat become their, their confidant, their counsellor [ ] I have one lady who has bailiffs at her door, very very very often. I have one whose son is in and out of prison constantly, I have one that I know is in an abusive relationship. I have one that I visited very regularly, who I had concerns after complaints had come in, that she was asking for food constantly on shift, I asked if I could pop round and she'd got no TV, she'd sold it for gas.

As a supervisor in a social care support agency, Katie’s staff teams are on zero contract hours. She went on to note that constantly looking for shifts adds extra stress and pressure to workers and that this can lead to burnout and worsening wellbeing adding:

> I find that most agency workers will take on too much work, because they're scared that next week there's going to be no work and then next week there is work, so they take the work again and, yeah, you know, and they keep going and yep, I did agency work for a few months, and I absolutely hated it. I was constantly stressed about where my next hours were gonna come from so you just take, you take and you just burnout because you just take it [ ] I think that's definitely a con, of working for an agency on a zero hours contract.

Being penalised for not accepting agency shifts was raised in Phase One as an added stressor, and Katie was asked if she had ever encountered this practice: “Not for us, we are definitely not ones that will blacklist you, I know some agencies that will blacklist you.” Asked what that meant, she replied:

> So basically if you say no to three shifts right that's it, they put a little mark next to your name, you're a pain in the ass, you know [ ] So, no we don't, but I will admit, if you're going to tell me no to ten shifts I'm going to start forgetting about you, that does instinctively happen, so we don't physically blacklist anyone but you can't help but goin, I'm not gonna ring you anymore, what's the point, I've got five minutes to cover a shift, I'm gonna ring the person that does it all the time.

Cathy undertakes both client facing and supervisory roles within her service and has supervised many volunteers and students over the years. When asked what kind of issues her staff might be dealing with outside of the workplace, she replied:

> I think over the years and the amount of supervisions I've done with all the different volunteers and people, I mean, you know, it's been a lot of personal stuff [ ] I've had at least two of them that have been sexually assaulted um and you know parents breaking up, the responsibility of getting their brothers and sisters to school, you know, it's just been a whole host of things.

Asked if she thought it was common for workers to be dealing with challenging personal issues, Cathy thought for a moment before answering: “…I think you'll often find people that are attracted to this kind of work do have some kind of difficult backgrounds and stuff like that.”

Maggie’s team works with extremely vulnerable and complex needs cases and ensuring her teams practised a healthy work/life balance was an important aspect of her supervisory role. However, she recognised that personal lives impacted on work lives and vice versa and that nurturing good worker wellbeing enabled her team to manage personal issues as they arose, saying:

> We've got the high end stuff so we've got that but also on a personal level with, you know, work life balance issues we've got marriages that break up [ ] we’ve got

> child care issues, you know, we've got workers saying actually I’ve had to see a psychiatrist, I’ve got a five year old I can’t do this job any more, we've got that and that's the issues we get to be honest.

Paul, a manager in a community outreach service, felt the organisation had become more mindful of the worker’s wellbeing needs:

> I think we've certainly in the last 12 months become far more in tune with the needs of staff [ ] because you've had COVID which has been incredibly stressful for everybody and then, and then you've had COVID plus, you know, hearing the horrendous stuff that we do on a daily basis and seeing things that are really unpleasant.

He was happy to share that he still perhaps thought too little of the challenging nature of the worker’s role at times and that there were worker personal needs that he had not considered, reflecting:

> To be honest I think I still underestimate err the stressful nature of our work and actually it is difficult [ ] I'm just kinda thinking so so I think as employers, we've got to become far more in our sector far more compassionate about our staff...
> Do you have to have experienced trauma…? I kind of sit on the fence on that one...
> I think yes.

Maggie recognised that life experience can be a valuable tool for social care workers and was able to balance her own, sometimes difficult feelings, through practising self-awareness, self-care, and empathy: “I think life experience is incredible for social care across the board. You know [ ] we’ve all got life histories, we’ve all got stuff behind us but we also have to know what triggers us.”

Maggie had started her social care career as an agency worker which had allowed her to experience first-hand, a discrepancy between how social care professionals and those considered ‘unqualified’ were managed and supported. She felt that social care workers were seen as having less value in the sector than their professional counterparts, which exposed them to exploitative practises and underappreciated skill sets:

> I think it's about value, isn't it, and I think you get your university space and you get your professional status, I’m not saying it’s consistent but there is an expectation that there is that level of intelligence if you like, for want of a better word and then that by being a home carer [ ] you haven't got that level of intelligence, which of course is complete bollocks and that's not true. However, they are the unsung sort of saviours [ ] I couldn't do my job without those unqualified workers.

All managers spoke of supervision as being an important aspect of their role, and that they appreciated the impact caring for vulnerable and sometimes dangerous service users can have on worker wellbeing and practice. Workers presenting with debt worries, childcare issues, poor mental health, relationship breakdowns and domestic abuse left many of the Phase Two participants with additional worry and stress for their staff teams. For Katie, the lack of formal supervisory role support and her unwillingness to request a supervision meant that she was taking serious and distressing issues on board, leaving her tearful and at times unable to sleep, which subsequently impacted upon her own wellbeing.

Talking about personal wellbeing issues with supervisees was seen as the norm for the supervisors, and that this was a necessary aspect of supervision for supervisees given the sometimes distressing and frustrating nature of the social care role. Phase Two participants appreciated that intimate work with vulnerable people often meant being exposed to increased risks and that the social care workforce itself is vulnerable. Good wellbeing, resilience and self-awareness was seen by many participants as an essential part of an effective worker’s tool kit and safety net, and that supervision was one of few spaces available within the sector to help foster and hone these self-care skills and practices.

5.3.3 Managing staff sickness and turnover

For Phase One participants, staff sickness commonly left services understaffed, overstretched and stressed. Staff sickness and staff turnover for the Phase Two managers however was commonly low, although COVID 19 had impacted on sickness levels in detrimental ways. Although for Katie, an agency recruitment manager, staffing levels had always been problematic, with the pandemic serving to exacerbate this. She said this of her current recruitment drive:

> I've tried money even though people are with an agency because of their finances, I've tried money, I've upped my refer a friend from £150 to a grand... That's how desperate I am right now, to a grand, a grand and I've had one taker and that's for the whole of July and the whole of August. We are desperado right now for staff, I turned away, nearly 700 hours last week, how many packages, how many old ladies were in hospital that can't leave the hospital and go home to their loved ones because I've got nobody to provide support for them?

Paul believed that the high sector staff turnover and sickness rates were about who was being employed in services and that ‘how’ we attract workers who are going to stay in the sector required more attention, adding: “I think there’s a recruitment issue, and I don't believe you can teach people to be personable, I really don't. I think it's one of these things that you've either got or you haven't got.” Paul also felt that management recruitment was important in relation to supervisory duties and that an ineffective supervisor could impact on staff turnover, adding:

> That's the thing about appointing people, isn't it, getting the right people with those values and skills is a skill in itself cos, you know, they might think they're the best manager in the world but if they're pissing everybody else off and not giving anybody any support, you're gonna have a turnover of staff on your hands which is a problem.

Drawing upon his own experiences as a support worker and supervisor, Steve evidenced a wider understanding and appreciation for the kinds of reasons why some workers find themselves needing additional personal support. He recognised that issues could present in different ways and that sometimes, it was about unpicking this with the supervisee in order to truly understand what was going on for them before it led to absences. Overall, Steve’s organisation had manageable sickness rates and their staff turnover was low. When asked what he thought managers could do to minimise staff sickness and turnover, he replied:

> So for me, it's a quick response to why someone's off [ ] we can also go to our HR team to let them know this person's been off for longer than 2 weeks and we can potentially look at what external support we can offer.

Ruth managed a day service staff team and shared that they enjoyed a very low staff sickness rate, and that turnover was also low. When asked if she thought that was common amongst other services she laughed and quickly said:

> No… Well, I know from experience from residential supported living that it's a different story. It just seems that a lot of sickness occurs [ ] I think it's the younger ones that come in and it's not for them erm and they sort of don't realise where they are with their life and they just chuck it in straight away.

Katie managed high agency staff turnover and ongoing recruitment issues, but staff sickness was very low. She went on to say that she was aware of high sickness rates in more residential type services, and when asked why she thought that was, Katie paused before saying:

> ...I think it's because they get to choose when they work so it's on them isn't it and you feel a little bit more that you've got to do the shift because you chose it as opposed to being put on a contract where you didn't choose to work next Thursday you know, so I think people have more of an ownership over their shift because they chose to do it.

Maggie’s team rarely took time off with sickness and believed that supporting her team to be self-determining, confident, skilled, and assertive individuals helped both them and her to manage their wellbeing more effectively in a very challenging workplace environment:

> I’ve developed a bunch of very autonomous people and we will engage each other in a really challenging conversation we will disagree on stuff [ ] but that creates really strong systems where we have no sickness hardly, unless it's, if it's surgery, I think I've had one worker in 11 years off with stress.

It was clear that the emotional health and wellbeing needs of the participants’ staff teams, were themselves, at times, a cause of stress and concern, which some felt very deeply. It was recognised that personal emotional needs were shared by workers both in and outside of the supervision space, and that these feelings are sometimes visible given the often emotionally and physically challenging nature of the social care role. This meant that participants approached supervision with engaging, compassionate, coaching, and mentoring type skills, which they felt were more suitable and effective in these particular workplace circumstances.

5.4 Superordinate Theme Two: The supervision experience through the lens of the supervisor

Alongside delivering supervision, all Phase Two participants received supervision, although not all were currently in receipt of regular, or what they considered to be effective supervision. Phase Two participant experiences with the supervision process are further explored by the following subthemes: the lows and highs of receiving supervision; learning from experience: how supervisors learn to supervise; and getting it right: how can we make the best of supervision? These subthemes are connected through the thread of learning to be a supervisor, what supervision means to supervisors as individuals, and how they would like supervision to be seen and delivered now and in the future.

5.4.1 The lows and highs of receiving supervision

Most Phase Two participants had at some time experienced what they recognised as being ineffective and unproductive supervisions and that for some, these early experiences had in some way inspired them to want to do better. Poor or non-existent supervisions had seemingly been just as educational as effective ones, and participants were able to reflect and understand the supervision role as a space where more productive performance and wellbeing support could be offered. It was clear that supervision was perceived by the participants as hit and miss, largely miss, and that conversations with workers from other providers reinforced this view, as Steve noted:

> Talking to people that I know that work for other providers or other organisations and they just say, “oh we just don't get supervised”, or “we're just kind of left to our own devices” or “the supervisor left and they've not replaced them”.

All participants had completed an Institute of Leadership and Management (ILM) Level 5 qualification and around half had access to additional independent management skills training. Steve had his ILM Level 5 and had completed additional coaching and mentoring training, which he had found highly useful in the supervision space. When asked what the supervision element of his ILM had been like at that time, he replied: “There was a little bit, not a massive amount if I can remember rightly, erm yeah, could be a lot better, I mean it focused more on kind of management systems and processes.”

Most poor supervision experiences had been encountered when the participants were employed in less senior roles. When asked about his own supervisee experiences, Steve laughed periodically as he recalled what they were like when he first entered the sector:

> I've probably had quite a range of supervisions [ ] supervision was just ya know 45 minutes of telling off around something you haven't done right [ ] I remember my first supervision that I had with my previous manager it was one line and it said, probation signed off [ ] I was just like was that it? [ ] I mean I've walked into a supervision with another manager where a pre typed up supervision was put in front of me and it's like sign that.

He added:

> I generally feel supervision is that tick box exercise and that it's not really, truly valued potentially, I think that ya know, there needs to be a greater emphasis on, on supervision that is beneficial rather than it being an exercise, I think that um supervision is getting pushed.

Phase One participants raised the issue of supervisions being cancelled or rescheduled and when asked how that might leave supervisees feeling, Steve quickly replied: "It says it's not valuable, it says [ ] my time's too important to meet with you. It says that I'm not really interested at this moment in time in what you're gonna be saying." Asked why he thought his supervisors hadn't consistently delivered effective or timely supervisions for him, Steve thought for a moment before saying:

> I think it was because they were probably pushed for time, um, they needed to make sure that we're compliant with our regulations around supervisions [ ] um, and if you're having poor experiences in supervision that has a knock on effect, cos people just give that experience of poor supervision on to the next person.

Whilst he thought poor supervision experiences can have a knock-on effect in relation to poor practice, role-modelling, wellbeing and morale, Steve very much appreciated that effective supervision experiences also had the power to be informative, relational, inspiring and influential, recalling:

> Then the new manager came in and he talked to me about, you know, what aspirations were [ ] gave me sort of objectives to work towards [ ] I learned a lot from that that manager because yeah, I mean he was really invested in the people that we were supporting and getting things right, and also really took time out to listen to staff and I mean, he encouraged you know, he asked me questions I'd never really thought about in supervision and I thought, ya know, he's actually giving me some, ya know, I can see where I wanna go now.

Despite his laughter, Steve was serious about his supervisory duties and responsibilities, and it was clear, that these earlier experiences had very much impacted upon him and his delivery of supervision. His own supervision journey had seemingly enabled him to empathise and relate to the experiences of his staff team and he used this to facilitate what he believed were productive and aspirational supervisions. Investing in people was important to Steve and he animatedly compared supervision in the past and present:

> The first style like right at the beginning, you know, I don't feel like I'm a part of anything, um I am here almost like a number but it almost felt like I was just there to fill a space a little bit [ ] whereas now we've almost gone the complete opposite in that [ ] I want to be able to [ ] support people and listen to people [ ] it makes it feel like you're a part of something, um and I know my thoughts and ideas will be listened to and taken seriously and considered in the wider context.

Alison had worked with young people for over 20 years and is in receipt of both external and organisational supervision. She has worked with many supervisors, although she still remembers her first:

> As you can imagine, over the years I've had numerous supervisors, and I've learned from everyone. So when I go to supervision, it's about being held in confidence, being trusted, and having the knowledge that I can learn from the supervisor [ ] the first supervisor I ever had, he was larger than life, I was a trainee and I still remember his name now and he walked through the door, and I was like in awe of him.

Both Steve and Alison had been able to use inspirational supervision experiences to help build on their own supervision skills, knowledge, and understanding of the process. They still vividly remembered these meaningful supervisions, and it was clear that they had been important, to them both.

As a support worker, Ruth had enjoyed regular supervision. She had very much appreciated the opportunity to discuss her progress and where she was going but had not experienced the same kind of regular supervisions as a manager saying:

> I suppose I just want to know I'm doing alright to be honest... I think I am but… I never get told I'm not [ ] As a worker I had regular supervision when I was employed as a worker/team leader, not so much in management. I've had one supervision in this position, so that's one in five years by my line manager [ ] I asked for it because I was doing my diploma 5.

Ruth had very little management supervision and shared that she sought feedback, advice, and support from her deputy manager rather than her line manager. She wondered if she wasn’t offered any supervision currently as she was doing well in her role, saying:

> I think it'd be good to have some sort of get together [ ] maybe once a year at least, just so I can... Like now I think I could do with one so I'm gonna ask for one particularly after COVID... I don't know... Well… I don't know, I just think perhaps he thinks I'm doing alright and I don't need it.

Katie has supervision every 6 months which she considered to be regular and wholly beneficial as a space to “get things off her chest”. She also found them reassuring, saying:

> I get a bit of a chufty badge dun I, I know I'm good at my job and everything's going well so mentally it makes me feel better after the supervision. I know I'm good at my job, I know I can do this.

Katie shared that she was also able to request supervisions, but had never done so, adding: “I do think I hold things in [ ] I will wait. I know I will wait for supervision because I feel like I can just go bleurgh.” Despite Katie finding supervision comforting, it was also an anxiety provoking experience for her, adding:

> I'm a bloody nervous wreck as I go into the room even though I'm a good employee, I really am the dogs at my job, um, so I still worry, I'm gonna get the sack [ ] That's my initial thought.

Asked whether she worried about having a supervision in the days leading up to it, Katie laughed before saying:

> Most probably… Like 3,4... I will not sleep and I'm really aggie [ ] I'll have the quickest shower because I want to get here quick, I'm like he'll walk in say who wants to do supervision first "me" because I want to get it over with. [ ] Once they told me I'm not gonna lose my job, and I feel better, my shoulders drop (laughing) I just go well can I tell you, I will say well can I take this moment to talk to you about so and so and then it all comes out and I'm not told off for that, but I am told, you could have just picked up the phone two weeks ago.

Katie persistently feared, despite consistent positive feedback, that she was going to be sacked at the start of each supervision and they were subsequently highly stressful experiences for her. Each supervision prompted expectations of a 'telling off', and she awarded herself a "chufty badge" when the telling off did not materialise. The polarity of emotions expressed around her supervision experiences was striking and Katie was visibly agitated yet laughed throughout this part of the interview. It was however clear that supervisions were an important space for her and that she was keen to work on her own supervisory skills.

Paul's first supervision experiences were: "Shit… Shit! (laughing) Shit, they were really not good." When asked why, Paul continued:

> Well because it was never about me was it…. It was often about the manager telling me all his problems, whoa ang on a minute this is my supervision… So it's either that or I've done something wrong and I was in for a big bollocking [ ] or you would get the manager that was new and you'd be sitting there going what we supposed to be doing and you say er supervision and they'd go "ahh, where's the form?" er "how do we do that?", and you just think God ok.. and you just went through the process thinking they can tick their box she can put it in the file, she'll tell her, she'll, he or she will tell their manager I've done all my supervisions.

Paul sounded exasperated with his early supervision experiences and after speaking about it with friends in the sector, realised that there was more to the supervision process than he had been led to believe:

> I guess you speak to other people, and they go, that don't sound right, and I go this is what I've had for years and then they go nah that's not really what it's about and you go isn't it? Cos you start to believe that's what it's about [ ] just a tick box and it's more and more about the supervisor than about you [ ] and it isn't until you speak to other people that you go that's really not what it's all about… And I guess exploring and understanding that then made me think, okay, well, if ever I'm in this position, they will not be like this.

Paul was frustrated and animated throughout, and it was clear supervision was something that he felt had an important part to play in managing social care workforce wellbeing and practice. He very much recognised that it was an organisational responsibility to deliver effective worker wellbeing support, which was something his own organisation was investing in, adding: "We've introduced lots of handover catch ups in the morning [ ] so on a daily basis we can kinda say how's everybody feeling?" Despite their own investment in staff support, Paul appreciated that overall, sector supervision skills were patchy and that managers were largely unsupported in this aspect of their role:

> My question always is, well, how much time and effort you've invested in that manager and actually you know, we've got to equip them with the skills to be able to do that and then certainly in social care I mean, there's a massive pressure on people isn't there.

This was echoed by Steve who noted: "One of the things I've experienced in social care is people aren't always supported to develop these roles... People move up and it depends on the quality of the support you've got to develop in that role."

5.4.2 Learning from Experience: How Supervisors Learn to Supervise

How participants had experienced supervision as the supervisee played a big role in how they now delivered it, adopting and adapting both effective and less helpful experiences. Despite previous experiences, the participants were all keen for their supervision delivery to be engaging, accessible and meaningful to their staff teams, and they were interested in learning new supervisory skills and approaches. However, many had had no real instruction around how to specifically facilitate, plan and use the supervision process, and for Ruth this meant that she had initially "winged" it:

> I just did what I thought was good, I just winged it basically… (laughs) [ ] I don't know if I’m doin it right [ ] I sort of took the lead from the manager at the time. I'm a different manager to the previous manager and they were a different manager to that manager, but I have pulled on different, um, strengths from them and made it my own sort of thing I think.

Katie echoed a lack of training around delivering supervision and acknowledged that her staff team of approximately 100 agency support workers had never been formally introduced to the supervision process either. Of those 100 or so workers, Katie saw about ten per cent of those per year for a ‘supervision’, and staff were not regularly scheduled in given these conversations were unpaid and, in the worker’s, own time. It quickly became apparent that what Katie thought of as supervision was more likely seen as a ‘chat’ for the worker and she reflected as she spoke:

> I think they see it as a chat… [ ] Paperwork based I would classify it as a supervision, I've had a meet with them… Well... I will generally say to them I'm going to class this is a supervision is that ok? But now I wonder if they don't change their mind and withhold stuff? Thinking about it now, I wonder if they do? I don't think about it at the time if I'm being honest, but thinking about it, do they then go "ughh, it's a bit formal now innit”... It's a bit boss and employee now as opposed to I've just popped in for a chat with Katie ya know.

Katie’s lack of supervisor support and training, alongside the staff team’s lack of knowledge around their role as supervisee, resulted in a supervision experience that left her worried that what she was doing was not meeting the worker’s formal supervision needs. Katie also raised the issue of agency workers receiving organisational supervision and how challenging that can be when they often went to different services and were perhaps not seen as part of a service’s established staff team.

For Steve, ‘doing’ supervisions helped him appreciate the importance of the process more, adding:

> I think doing the supervisions gave me a better understanding of why supervisions are needed. I remember that first supervision really quite well, um, and I remember being kind of a little bit knocked back by that sort of line of questioning,

> it was like actually it's made me think completely differently and to remember it now ya know.

He also felt that it was important to have some experience in the role the supervisor was overseeing adding: “I think it really helps, it definitely helps um because you can empathise with them on a level and have an understanding of what's, what's going on, especially if you've got newer staff that have come in.” Steve felt it was hugely important for his staff team to feel listened to and that the workers knew he could relate from his own experiences, adding:

> Yeah, it massively impacts on people because if you've got a workforce that feels they're listened to, that are empowered, that are given opportunities to progress, or learn and reflect, they're taking all of that and being really motivated to go in and provide the best level of support. If someone cares about you, they're going to put that back into their job role.

Paul’s approach to delivering supervision purposefully focused on the personal issues of his staff team first, before going on to support performance and problem-solving skills, believing that performance could also be managed in other worker/manager spaces. He believed that developing a coaching and mentoring style relationship with his team members nurtured a more open and candid conversation, which he found enabling and formative. He said:

> I will always, always do that kind of personal check in with people and again I guess as you get to know people and they trust you and you build a relationship with them, people start opening up. So it's always been that kind of check in about you as a person and then we kinda get in to the work stuff and it's very much that kind of reflective practice stuff, nearly adopting a kind of coaching mechanism, not giving people the answers, and getting them to kind of think about how they could have done it differently.

Ruth likes to have an ‘open-door’ policy with her workers and encourages them to approach her when needed, although they do not always utilise this opportunity:

> I don't shout and scream and things like that I'm very, well I've been told I'm approachable and if there's any issues, I'd rather they come to me before a supervision, not wait for supervision cos in that way it's all just building up and

> that and it blows up in supervision, if there's something in a supervision I'll deal with it properly and fairly.

Katie adopts the same open-door approach to delivering supervision, despite admitting that she would never approach her own supervisor outside of the supervision space, unless it was an emergency. For her staff team, supervisions are offered on an “if and when” basis but there is some discrepancy as to what constitutes a supervision. This lack of regulated supervision opportunity commonly meant that when workers did reach out to her, it was to seek help with more personal issues. Given Katie doesn’t “if and when” with her own supervisor, she was asked whether she thought her workers can “if and when” with her. She thought for some time before saying:

> ...Yes, completely (laughing). Yeah, it's something that we have discussed before, not at length not, not enough to be fair, during an induction, I always try and say to them I'm always here, genuinely I'm always here and you can call me 24 seven… but they don't.

Asked why she thought they might not feel able to speak with her, she added:

> Because they see me as their boss... I don't know, is there that thing that you're going to get judged [ ] they're gonna worry about their work, is someone gonna call me and say I'm struggling with my mental health right now and we're gonna go I'm not putting you on shift [ ] because I've felt that when I've said to people about my mental health are they gonna think that I'm failing at my job? [ ] I help them to pay the bills, so why would they want to tell me something that might cause them to lose money and not pay their bills?

For Katie, supervision largely related to worker health and financial difficulties, and she had previously shared that she acted as somewhat of a counsellor or confidant for her workers. When asked about supervision content, at no time did Katie raise the issue of practice or performance issues, with supervision being delivered only when the worker was seemingly in personal trouble. In comparison, Paul actively delivered supervision as a regularly scheduled, formative process where his staff team were encouraged to use the space to reflect and discuss challenging issues, both personal and work based. For Katie and her staff team, the lack of attention paid to the supervision process and its lack of regularity and formalisation, seemingly confused Katie’s understanding of how to deliver supervision and what an effective supervision should look like.

It was acknowledged that supervisions were not always delivered according to plan and some participants laughed and cringed as they recounted negative encounters. When asked what a poor supervision experience felt like for him as a supervisor, Steve laughed before saying: “If you've gone in there feeling a little bit stressed or anxious or a little worried you kind of walk out feeling worse and I've done that a few times.”

Participants had previously spoken about how having supervisory responsibilities had at times led to feeling worried and stressed about their staff team’s wellbeing, which consequently negatively impacted upon their own. However, they largely recognised that supervision was an important aspect of productive social care worker delivery, and that the supervisor had a vital role in enabling this process, despite the potential for associated emotional stressors. Having the opportunity to facilitate supervision had enabled the participants to develop their own supervisory skills and most were keen to pursue more specific training, especially around coaching and mentoring. It was subsequently clear throughout that the participant’s enjoyed this aspect of their role and many were actively working to improve on the organisational supervision experience now and for the future.

5.4.3 Getting it Right: How can we get the best from supervision?

The participants were asked about positive supervision delivery experiences, with many seeming to enjoy the opportunity to share what they considered effective and beneficial supervision practices and approaches. For Sally, a supervisor in specialist intervention support, getting it right meant an encouraging space for learning and growth. She noted:

> So, for me I think it's, it makes you practice more creatively, it improves your interventions, it helps people with their own self-care. It helps to understand where there’s transference and I think it helps to keep people safe where client groups service users may be behaving in a particular way.

They also recognised however, that supervision was largely a subjective and personal experience that needed sector wide improvements and more workforce specific improvements, alongside the provision of a set of standardised and enforceable best practice guidelines. Participants were also keen to develop worker support and supervision processes in line with trauma informed principles, given the benefits of this approach with vulnerable others. No participant was aware of specific social care supervisor trends/practices or quality assurances, and they universally agreed that this was disappointing, especially as they used the supervision process so beneficially.

When asked how we can start improving the supervision process, Sarah thought for a moment before replying:

> I think some of it is understanding trauma, um, because it's about what you experienced has an impact on you and I don't think people know that, or realise it [ ] you know literally, what you're experiencing at work and home and your previous experiences, and then it's about how you access support for that, and supervision is one way of unloading and then helping to also build resilience. So, I think that that's probably the starting point.

As a manager in a social care agency, Katie described her office team as “pen-pushers and receptionists”. This had been identified by Katie’s senior leadership team as being problematic given the office staff struggled to identify and relate with the often difficult and upsetting incidences experienced by the workers. Katie believed that by employing office staff with care work experience, care and support worker needs were beginning to be better understood, given workers had previously raised that they had not always felt listened to by the service, adding:

> One of our previous managers said, we're finding that people are calling up and they're crying at the end of the day because they've been beaten up on shift today, or a service user has died, and we can't recognise the feelings that they're going through because to us we’re thinking we will have just lost 12 hours, or a service user dies and they're thinking I've just lost the care package… They're not thinking, they're not thinking of the service users, the family the carer, the carer that's been working with them for the last three years.

Both Sarah and Katie recognised the importance of appreciating the wide-reaching emotional impact of the social care role and that working in a trauma informed way could be beneficial. They believed that those supporting workers should themselves be supported to be aware of potentially traumatic and challenging workplace and personal lived experiences, in order to promote a relational and safe space where workers can offload and build resilience. Understanding complex trauma and the unregulated social care worker experience was raised numerous times by Phase One participants as an important attribute for organisations and supervisors, but one that they felt was largely absent.

Paul felt that supervision should be a relational space where the supervisor and supervisee can feel able to connect and feel listened to. He reflected:

> For me it's very much, it's always been about reflective practice, um, and it's always been about a personal conversation with the individuals, fellow human beings.. Look it's not beyond the realms of possibility to click on if you're having a shit time at home because life has gone pear shaped for you, that will impact on work. So, let's have a conversation about it ya know, you may say I don't want to talk about it, which is fine.

Maggie felt that worker/individual authenticity had been ‘coached’ out of social care and that her colleagues were now investing in new relational approaches and perspectives around the supervision process. Having these types of ‘conversation’ and being open and accessible to listening, was seen as a desirable aspect of the supervision experience but that there wasn’t always a space made available. When asked why she thought that was, Maggie replied:

> I think it goes back to the business model but the business model in social care doesn't work. Social care is not a business and it shouldn’t be treated as such [ ] it shouldn't be and we all know it [ ] I think because we've got this sort of model that’s promoted, it’s not conducive to promoting humane practises and dignity and respect [ ] it’s the value of humans, and the business model does not value humans, it values turnover.

Several participants saw the supervision space through a more coaching and mentoring type lens and felt that there was a space for something else other than ‘supervision’. When asked what this might look like, Steve replied:

> Yeah, yeah definitely I mean now I tap into a, one of our senior leaders [ ] she is a coach and mentor as well [ ] I find that like really, really great to be honest. I think being a leader or a manager you definitely need some of those coaching and

> mentoring skills to be able to get the best out of people. There is a training need there, I mean finding good quality, coaching training is really quite difficult.

How we go about improving the supervision space and the good practices that could lead to more meaningful supervision experiences were a source of both concern and hope for the Phase Two participants. Most had had minimal specific supervision training, and all felt that this would be beneficial to both supervisor and supervisee. Very few had ever spoken with their staff teams about the supervision process, and none had provided specific training for workers to maximise supervision productivity and outcomes. With no sector standardisation, guidance, monitoring, or enforcement around the supervision process, the Phase Two participants were subsequently undertaking supervisions in largely different ways to one another.

Most participants were unhappy with the term ‘supervision’, commenting that they felt it overly authoritative and that it lacked the right structure, approach, and content for the unregistered social care worker. Employing a more coaching and mentoring type approach was viewed as beneficial and perceived as a more equal and effective space where workers could offload, reflect, share, and learn. They recognised that working with vulnerable individuals was risk-laden and emotionally challenging, although they appreciated how rewarding, fun and meaningful the role could also be for workers.

5.5 Chapter Summary

Phase Two was undertaken in response to the Phase One USCW findings that the supervision processes they had experienced had often been emotionally harmful, inconsistent, unskilled, and lacking in benefit. The Phase Two participants echoed the Phase One responses, affirming that in their experience, the supervision process is ill-defined, poorly supported and can be used for punitive and/or abusive purposes. Worker wellbeing was important to the Phase Two participants, who recognised from their own workplace experiences that the unregulated social care role can be a highly stressful and dangerous one.

The supervisory role added relational stressors and burdens for some participants, and they recognised that they were individuals with high levels of empathy and concern for the wellbeing and care of others. The additional burden of supervision contributed to some supervisors feeling worried for their workers, and the importance of supervisor wellbeing and support was raised on many occasions. The Phase Two participants appreciated that the supervision space played an important role in identifying and managing worker wellbeing and practice risk, and that supporting individual health, wellbeing and personal issues was observed as a normal aspect of the supervision process. As supervisees, some participants still felt anxious around their own supervision experiences and were able to empathise with how their workers might feel about this process.

Most Phase Two participants described the unregulated social care supervision process as unstructured, ill-defined, and poorly supported. With often little to no supervisor training, the supervisors drew on previous lived experiences, developing their supervisory skills through trial and error, and learning from both poor and effective prior supervision experiences as supervisees. The supervision space was also seen as a valuable opportunity for reflective learning and problem-solving, and where good wellbeing and best practice can be role-modelled and further developed.

Attracting the ‘right’ kind of individual into the supervisory role was raised, given it was acknowledged that a poor supervisor can negatively impact on staff retention, worker wellbeing and commitment to role. A lack of transition support from worker to supervisor was also noted, alongside inadequate formal opportunities to develop supervisory skills. Low staff sickness was thought to relate to effective, compassionate, and open supervision and management, and that supervision can have both negative and positive consequences on the overall culture of an organisation. All Phase Two participants were keen to share what they perceived as beneficial supervision practices. Most participants shared supervision goals and ideas for the future, alongside their frustrations with the lack of focus and attention the supervision process in the unregulated social care sector receives. Introducing a more coaching and mentoring approach to the supervision process was favoured by all, with some raising the need to change the title of ‘supervision’ to one less authoritative and more collaborative.

As either supervisor or supervisee, most Phase Two participants felt that the supervision process in the unregulated social care sector was largely failing to effectively meet the needs of its workforce, struggling to find definition and its place within organisations, and was often an unnecessarily challenging experience. The relationship between the supervisor and the supervisee is an important one, and knowing more about the challenges, barriers, and enablers of supervision delivery from the supervisor's perspective can help situate where supervisor learning and support is most needed.

A general lack of understanding, innovative training opportunities and appreciation of workforce specific support needs was thought to be instrumental in placing workers at increased risks of harm. This unhelpful paradigm translated into a lack of effective and safe spaces where workers could offload, process, and develop. How we improve on this meaningful and beneficial process, however, was perceived as a joint organisational and individual task, given the absence of anything professionally structured, conceptually grounded and homogenised throughout the sector. Phase Three was subsequently introduced by way of integrating Phases One and Two participants together in two joint focus groups with the aim of discussing the introduction of more standardised supervision training.

Chapter Six

Phase Three: A New Approach to Supervision Training

6.1 Chapter Overview

The aim of Phase Three was to get a better understanding of what and how supervision training for the USCWs can look like by means of individual and group reflection and exploring new ideas. Building on the experiences, perceptions, and ideas of the Phases One and Two USCW participants, the Phase Three contributions were analysed and presented in a narrative style. Purposeful focus group conversations were designed to support the Phase One (workers) and Phase Two (supervisors) experiences and perceptions of supervision and identify what might be considered better practice moving forward as users of the supervision process. The themes identified represent the viewpoints and ideas of the focus group participants and how and why they would like to see the supervision training process constructed and conceptualised in the future. The themes are organised by key discussion areas and emergent strategies with the aim of providing more interactive and responsive supervision training resources, and improving the reputation and effectiveness of supervision in the sector.

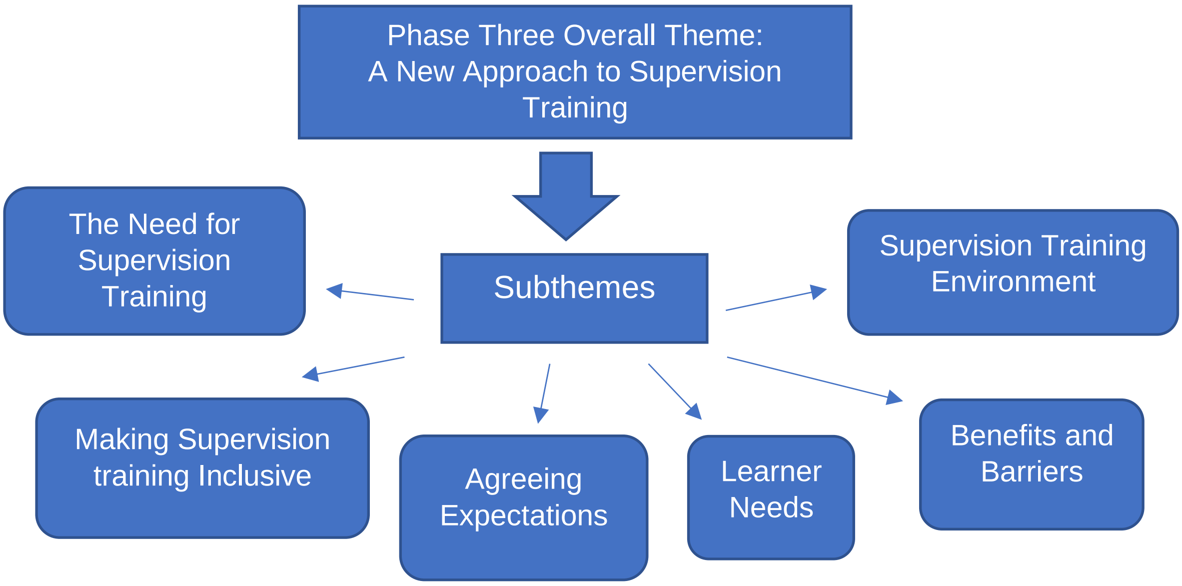
The overall theme of a new approach to supervision training guided the Phase Three analysis process. The following sub-themes represent the following areas of discussion: the need for supervision training; making supervision training inclusive (for all organisational levels); agreeing expectations (between supervisee and organisation); supervision training delivery; learner needs; benefits and barriers to introducing supervision training; and how can we move forward from here? (See 6.1.1 Figure 3).

The themes explore making supervision training work for the unregulated social care workforce through an exploratory lens, where those involved in the social care workplace supervision process were encouraged to discuss and share their ideas on supervision training needs and goals. This led to two rich, fun, relaxed and innovative sessions where knowledgeable voices were able to bring reflection, lived experience and fresh ideas to the table.

6.1.1 Phase Three Thematic Overview

Figure 3

Phase Three Themes



6.2 The Participants

Eleven Phase One (P1) and seven Phase Two (P2) participants who had agreed to be approached for further research opportunities were contacted to take part in an online focus group. Nine agreed to take part (five Phase One and four Phase Two). Of the nine, one had technical difficulties on the day and three had to cover sickness absences in their workplace. The remaining five participants took part in two online focus groups. The groups consisted of two Phase One participants (Susie P1 and Jake P1) and three Phase two participants (Ruth P2, Steve P2 and Cathy P2). The groups had been briefed on the subject area of the focus group and that they would be discussing why, what, and how supervision training might help improve the supervision experience for the unregulated social care workforce (see 6.2.1 Table 4).

6.2.1 Focus Group Participant Table

Table 4

Phase Three Participants

Participant	Service	Data Collection Phase
Ruth	Learning Disabilities	P2
Jake	Domiciliary	P1
Cathy	Specialist	P2
Steve	Learning Disabilities	P2
Susie	Specialist	P1

6.3 The Need for Supervision Training

All but one of the Phase Three participants were highly experienced in the adult social care sector and had previously acknowledged a general lack of supervision awareness and training in this workplace during their one-to-one interviews. Only one of the Phase Three participants had previously attended some form of supervision training. The groups were encouraged to talk about whether there was even a need for some kind of supervision training for the unregulated social care workforce. Steve (P2) had this to say:

> Yes, I absolutely think there is, I mean from my point of view, one of the things that we can come up against or come across is that, especially people that are new to the sector um have never experienced supervision before and they have no concept of what a supervision potentially is. There's also the other thing that um I've come across is where people have experienced really bad supervisions.

Cathy (P2) followed on, adding:

> You need to have some sort of session around what is expected from both parties in a supervision I think, and what a structured good supervision kinda looks like. You don't know if you're getting bad supervision if you don't know what supervision’s meant to look like [ ] I think there should be a standardised supervision framework nationally, but I think beyond that there may be a case for running additional training cos some people [ ] have different needs don't they.

Both Cathy (P2) and Steve (P2) also believed that some kind of training was needed to help alter the current negative perception of supervision, and make it work more effectively for this highly valuable and vulnerable workforce.

6.4 Making Supervision Training Inclusive

When asked who the supervision training should be for, both Ruth (P2) and Susie (P1) immediately raised the need for some form of supervision training for managers, with Ruth (P2) saying: “I think there should be a training module for managers to start with cos when I first went in to the management position [ ] I wasn't given any guidance from anybody really”. However, as the groups continued to discuss who the training should be aimed at, all participants went on to agree that they were keen for it to be a shared space for both supervisee and supervisor, given separate training was maybe part of the problem. Cathy (P2) reflected on her own experiences and likened the preferred type of supervision training to an after-work activity she attended:

> It's a little bit like my exercise class at Y. There's workers in there but there's also service users, and I think it's good cos the purpose of the class is to exercise and we're all there in that space for the same common purpose and I think it works better cos why does it need to be us and them?

A training opportunity where both workers and managers had the same space to share and learn about the benefits and goals of the supervision process was felt to help place both parties on a more even keel, with Susie (P1) adding: “You're all starting from the same footing aren't you... You've all got an understanding of what you can all achieve in it and what you want to achieve from both sides.” Ruth (P2) agreed, sharing that she thought everyone starting on the same page could lead to better outcomes for all stakeholders, adding: “it should be a bit of togetherness rather than them and us”.

Jake (P1) also agreed but thought it a wider issue, adding:

> There needs to be more training from above, and everybody needs to be on board with the same sort of thing, not just we'll leave that to that group of managers, um, us the directors won't bother ya know, it needs to be across the board.

Steve (P2) saw supervision training as something that everybody needed to do whether they worked as a social care support worker or a CEO, given we should all be getting effective supervision in this sector, noting:

> We're all supervised, so if everyone did the same training and shared experiences of supervision, I think that would help break some of those barriers down ya know [ ] I have supervision, our CEO has supervision, everybody has supervision [ ] I think we all need to do that (the training) just so there's kind of, even kind of an expectation across a minimum standard of what you should get in supervision, um, whether that's working adult social care, children's services, all sides of the sector ya know [ ] everybody should be kind of in the same, the same understanding of what supervision is, regardless of whether or not you've worked for 20 years or 20 weeks.

At this introductory level, it was universally agreed that supervision training should involve all USCWs given cleaners, workers and managers can all become involved in unexpected, challenging, and distressing incidences when working with vulnerable, unpredictable and risk-laden service user groups. They felt that a more standardised approach to the supervision process where everyone started off on the same page would be hugely beneficial. In this way, supervisions and the professional development and wellbeing support they represent, could be better managed and tracked across services as workers move and change role.

The need for more specialised supervision training and support for social care managers was raised in both Phases One (workers) and Two (managers), and again here. However, it was also thought that a shared understanding of the fundamentals of supervision was necessary, particularly for the participants who often felt disappointed and frustrated with their supervision experiences. After establishing who the participants thought the introduction to supervision training should be for, they were then asked to discuss what information they thought unregulated social care workers needed to know about the supervision process.

6.5 Agreeing Expectations

It was considered instrumental to the success of the training that what was included within it reflected the needs of those using it. The participants were therefore asked to discuss what they thought would be helpful for workers to know about supervision and what to expect from the process. Susie (P1) started by saying: “Maybe training to teach you about what supervision is about. What are the aims, what the goals are and what you want to achieve from it”, a sentiment that was shared by all. Cathy (P2) voiced that she had been thinking about the focus group topic and had made some notes:

> Firstly, information about what supervision is, um, what is the purpose of supervision, the importance of preparation, um, because I've done supervisions where people haven't come prepared and it's not as beneficial I don't think, um, the importance of it being a two way process as well, it isn't all about the one person, it needs to work both ways.

Jake (P1) thought it important that workers were supported to understand that supervision, when done effectively, was a beneficial and enjoyable experience noting: “It's knowing that supervision isn't a negative thing [ ] I think it's making it more of a positive experience”. He went on to share that workers should be advised to expect the supervision space to be a safe and confidential one, where worker concerns and requests should be listened to and acted upon where appropriate. He went on to say:

> You always hope, you always like to think that your staff know that we're listening, um, so that reassurance that what is said is gonna be used or something's going to be implemented or that changes actually happen, ya know [ ] I think it's that reassurance that workers need, I know I do.

Steve (P2) felt that what was needed in training was a foundational basis from which supervisors could move forward and develop from, and where expectations and shared goals can be agreed with supervisees. He commented:

> I think that you could get it down to probably some very broad areas that are specific to supervision in general [ ] It would give a basis to what is expected within a supervision, what is expected of everyone involved and it will just give that kind of clear outline um of what needs to be followed, what needs to be covered [ ] and then it will be about taking that set of standards I'd imagine, and taking the broader kind of um headings as such and making it specific to where you are.

Susie (P1) was relatively new to the social care sector and had not known what to expect from a supervision or what she should be doing to prepare for one. She had already raised the need for workers to know what a supervision is, its aims and goals, but thought that the training could also help both managers and workers to appreciate that supervision should be an ongoing, reflective and learning process:

> I think an important part would be the feedback from it (supervision) [ ] I think when you have your next supervision, maybe checking in over your last one, sort of reflecting over that ya know, are there any sort of points that you needed to work on, so start with going back over it.

Cathy (P2) and Steve (P2) are experienced managers and they too felt that supervision needed to be looked at as a more continuous developmental process where previous supervisions, practice experiences and training can be revisited, reflected upon and learned from, with Cathy (P2) adding:

> There needs to be a follow up process from the last supervision so taking forward what was agreed at the last supervision, if it's moved on, if it hasn't, why not, look at barriers perhaps, how we can move it on, what training might be needed.

Steve (P2) felt that it was important for both workers and managers to understand why supervision is done in a regulatory sense. He had mentioned compliance earlier and was asked if he would include it in the training, answering:

> I would mention it, it's got to be mentioned, because it's the reason… the reason why you're doing it, um, and that then gives that information that you're being open with your team and remember why you're doing it as well. And they then have the understanding and expectation that they can go back and say “oh, we're not having it” and it should be happening.

Cathy (P2) agreed, adding:

> I would mention it, but I wouldn't labour the point too much because the minute it starts coming on heavy with rules and stuff people switch off, but yeah people have to do this so this is the reason why, but just mention it.

The participants thought the training should consist of a much more standardised and foundational approach to understanding what supervision is in the social care sector, what it is used for, how it can help, and what are the responsibilities of both supervisor and supervisee. It was thought that these fundamental basics could help provide a platform from which a set of skills, accountabilities and shared expectations could be agreed upon, normalised, and developed as workers progressed in their social care career.

This ‘done with and not done to’ approach was thought to help promote a sense of shared ownership over the process, although they recognised that some workers and managers would find it more useful and meaningful than others. A more grounded and informed approach to the core aspects, principles and aims of supervision was felt necessary, although it was recognised that services would need to add more specific elements to their own supervision frameworks depending on worker and client need.

‘How’ we deliver the ‘what’ helps us to understand the best way of achieving an accessible and easy to adopt training module, that meets the needs of the learner and creates meaningful attachment to the supervision process. The following theme seeks to explore the ‘how’ of supervision training from both worker and manager perspectives and how supervision might be best delivered and disseminated within the workforce.

6.6 Supervision Training Delivery

How information around the supervision process could be shared with learners, was met with animated discussions and the participants had a lot to say about it. Susie (P1) thought that training shouldn’t be too long and that half a day would be about right. The others agreed, sharing that maintaining concentration and energy levels after a lunch break was often a struggle with Cathy (P2) mooting: “probably best kept to a few hours so it's engaging [ ] people sometimes lose the focus [ ] with like lunch time, everybody after lunch is a bit bleurgh, so it's [ ] short, snappy supervision training."

Refresher training was briefly mentioned, with Susie (P1) noting: “you might have to keep revisiting the training to make sure you're still using the same model that you've all agreed on.” The participants were encouraged to talk about the idea of refresher training further, however the conversation quickly returned to disseminating the training in the first instance and how best that could be done.

For Ruth (P2), the term training seemed a bit serious, although she recognised there was the need for her workers to have a better understanding of the supervision process:

> Well, I don't think I would call it training, I would sort of maybe... They do need to have something, but I don't know if it would warrant training [ ] um, like a small chit chat with the manager or as a group to say this is what supervision is, this is what I'd like from you, this is what you should expect from us etc.

Ruth (P2) had earlier raised the need for management supervision training given she had initially needed to 'wing' this part of her role and that she thought there was more she could learn. The informality of a "chit-chat" appeared to suggest she favoured a more relaxed and open approach to supervision, which suited her management style. A more regulated and standardised process however is likely needed to formalise, normalise, and professionalise this process for everyone, to help ensure a smooth and effective transfer of worker support between roles and services.

6.7 The Supervision Training Environment

Disseminating supervision training/knowledge was universally thought best done in a group, giving participants the opportunity to learn from others, network, relate, and share experiences. Cathy (P2) thought the best way of delivering supervision training was in a wider, mixed forum with different types of services, and she reflected on what 'she' would enjoy about the experience:

> I think groups of um people [ ] maybe share it, I like, I like erm shared experiences as well. So you know, not just taking erm one organisation or type of service provider or whatever it may be and sharing that cos it gives everybody, it gives ideas doesn't it, um, that that ya know there are almost some ground rules that everybody is equal in the room.

The participants were asked to discuss what they thought would be the best way of delivering this kind of training with Susie (P1) immediately saying: "face-to-face." All agreed that face-to-face would be the best way to deliver this training, as Steve (P2) reflected:

> ...I think it's got to be a face-to-face process because supervision is a face-to-face process that people engage in, both parties engage and if you're kind of sat there doing a talk [ ] people aren't gonna get anything from that.

The participants were also very much aware that not everyone would be able to access the training in a face-to-face way and that there would need to be alternative means of disseminating the learning. Jake (P1) worked as a domiciliary carer and finding the often-unpaid time to attend training was sometimes problematic. He felt that supervision training was a much needed and beneficial workplace support opportunity and that it was important for workers to be supported in accessing it, even if it meant meeting the workers where they are, suggesting: "you could actually show the person that you're keen to promote this and actually go and see them somewhere, you could go meet them."

Online training as a first point of contact was considered less than ideal but that it could be a good option if the group, size, dynamics and activities were well organised and delivered. Supervision as a passive, online tick box tool however, was seen as ineffective, given the lack of reassurance around the learner's understanding of the content and the space to learn from the experiences of others, as Susie (P1) pointed out:

> I think if it's online it's your interpretation and you've got no way of asking questions or answering back to get it clarified is the only thing with online, whereas, I think, small groups and especially if you get shift workers, isn't it, it's finding the time that you can do that, but I would say small groups and deliver it out as quickly as you can but... face to face definitely.

Asked what 'he' thought, Jake (P1) paused before saying: "...I don't know, a workshop one afternoon where people roleplay supervision to see what they'd want to find out from it [ ] it's making people feel more involved in the whole process." Given unregulated social care training often involves a degree of observed practice to ensure workers are completing a task or procedure correctly, trainers roleplaying a supervision or short videos of case studies might give learners the chance to take part, observe and critique. The groups had been talking about mixed service, large scale training sessions, much like how safeguarding or health and safety can be delivered, and Jake added:

> That sort of forum could lend itself then to tables doing a case study on each other, like using each other doing a supervision as practice [ ] so a bit of networking and a case study and a chance to see where people are, how they do things.

Cathy agreed and, thinking about her own experiences of larger workshops and training, talked about the benefits and potential barriers of roleplaying:

> I do see the benefits of it (roleplay) because whenever I go to training and there's roleplaying, I like to get involved um and I have to say I do usually learn something from it and take something away from it, but I'm reasonably confident at doing things like that, but um, I think there's a lot of people who would be turned off by that.

The requirement to participate in a role play 'would' likely turn some people off given the sometimes-frightening nature of practicing publicly, and that decisions to take part must be given safely and voluntarily. This could be overcome, however, by encouraging learners to observe and make comments on pre-recorded supervision roleplays/case studies. Trainers could also undertake a roleplay in the moment and encourage attendees to try it for themselves or discuss what they liked or did not like about what they saw. This could promote a safe space for critical discussion, reflection, and the opportunity to share with others, whilst sensitively encouraging participation, engagement and ownership of the process.

6.8 Learner needs

The literacy considerations of how information was communicated to learners was picked up by Susie (P1) and Jake (P1), both of whom had previously disclosed struggling with the more written aspects of their role. In terms of the language used in the training materials, Jake (P1), who has dyslexia, added:

> It does need to be simplified. It's got to be in layman's terms, without the jargon because jargon confuses me, abbreviations confuse me, I hate abbreviations on things. So actually putting it in plain simple language that can be understood clearly by everybody in an ideal world.

Susie (P1), who also struggles with some of the more administrative parts of her work, agreed:

> I think it (the training) does need to be simple, but you don't want to make it simple so that it's too simple isn't it… Ya know you're all trained and educated but it does need to have clearer jargon in it, yep.

As a new piece of training, Jake (P1) initially thought that there would be no barriers to how it was received, before raising literacy again, noting:

> Literacy can be a huge issue and a big barrier, um, we obviously have a lot of people working for us [ ] where English wasn't their first language [ ] there's no point us chucking training and supervisions at people if they don't understand it.

Susie followed this, adding: “Using unfamiliar words, jargon and things like that um the people that have been in care longer are a bit more cynical maybe and think what's the point of that sort of thing.” Jake (P1) had worked in care for over 15 years, and in response to the topic of what workers might do when faced with complicated and wordy training replied: “Well they switch off don't they... they don't listen, they won't get involved.”

How the training was delivered was considered of paramount importance by the participants given it reflected accessibility, relatability, and adoption possibilities, although Susie (P1) did point out the need for refreshers to ensure the model was being understood and adhered to over time. Raised in Phase One as a negative issue with the training process, finding a way of checking for learning post-training was included for discussion.

6.8.1 Checking for understanding

The focus group participants were asked to discuss how to check if the information delivered was being understood. Ruth (P2) thought that some form of evaluation would be beneficial, adding that doing a supervision soon after the training would help check for understanding of the supervision process, and give the new supervisee the opportunity to put this learning into practice. Both Cathy (P2) and Steve (P2), also supervisors, agreed with Ruth (P2), with Steve (P2) noting:

> Personally, after they'd attended the training, I'd do a supervision with them and ask about what they've learned and what they've taken from it, is there anything that wasn't clear, and have an open conversation around their understanding on it and whether they found it helpful or not, how can we move forward from here?

Cathy (P2) followed, adding:

> Absolutely, that first supervision afterwards [ ] it gives you an amazing kind of starting point [ ] So yeah, just to check what's kind of been missed or [ ] if something's really resonated with somebody ya know and explore that. It's all that kind of checking of knowledge isn't it through having a good discussion about it.

Whilst only Susie (P1) raised the concept of refresher training, a high turnover of staff in this sector would likely necessitate consideration around the frequency and need for this type of training. Whether a worker required a refresher could be addressed once a manager has had the opportunity to assess a worker’s understanding of the supervision process and identify any related training needs.

6.9 Benefits and Barriers to Introducing Supervision Training for Supervisees

Whilst introducing supervision training for supervisees was thought to be a hugely beneficial and empowering activity, the participants recognised that alongside the potentially positive impacts, there could be barriers. Understanding what works, and the potential barriers to accessing these benefits, helps us to appreciate how we can mitigate for and manage these barriers more responsively in the future.

Given its poor reputation in the sector, rebranding the supervision process was seen as by far the most significant factor when motivating USCWs to engage with supervision training. This barrier, however, may well be organically addressed should the training start to improve the supervision experience more widely, improving its perception and reputation within the sector. This theme will be further explored through the subthemes of: benefits of the supervision training process, and barriers to supervision training engagement.

6.9.1 Benefits of the supervision training process

The perceived benefits shared by the participants outnumbered the barriers. Thinking along more general lines, Jake (P1) felt that the training could make improvements to the overall worker and manager relationship, becoming more effective over time, saying:

> It (shared supervision training) just makes things more open between them (supervisee/supervisor) I think. it's that understanding and the trust which needs to be in place because if it's not there, then you're just banging your head against

> the wall aren't ya [ ] It might actually cut the time down that we spend on supervision because actually, if somebody only needs a quick check in, then absolutely fantastic.

For Cathy (P2), “knowledge is power” and she had this to say about the perceived benefits of the training: “I think in terms of positives, it's better understanding, communication and people knowing what supervision's about... That it needs to be in their terms and their language.” Susie (P1) also felt that being introduced to new knowledge around the supervision process would empower and positively benefit the supervisee in several ways, adding:

> You can really move things forward that are worrying you or your manager but in a safe space [ ] If you had the knowledge, you've had the training, you could plan beforehand what issues you had and what you wanted to do and in what way... It's just being valued, isn't it, that you're being listened to.

Ruth (P2) also felt that the relationship between the supervisor and supervisee could be positively impacted upon by the training, musing:

> They would maybe know that the manager's there for them… That they... That they can trust the manager to listen and act on their requests, build up that rapport and trust. [ ] It'd be great if they could walk away from their supervision thinking “that went well, I know there's a few issues but we got a plan now and it was a place where I can talk and be listened to” [ ] it would instil a bit more, erm, well it would take away the trepidation hopefully.

Steve (P2) thought that the training could positively impact on the power imbalance between supervisee and supervisor, helping the supervision relationship feel more equal and more meaningful, observing:

> It gives you empowerment in terms of being a supervisee ya know… [ ] it probably brings a bit of a power balance to an unequal power balance in that sense. If you're shown a certain way of doing something, you're expecting it to be done that way.

He went on to say:

> We have to cover supervisions and if you've got like a framework to work towards the person being supervised will know what that framework is and if you're not following it [ ] I think it kind of gives that balance of like, not balance of power as such, but it gives that shared responsibility in supervision.

When the subject of accountability was raised, it was seen as having both a potentially positive and potentially negative impact, although Ruth (P2) thought that accountability around the supervision process was an important part of learning, even if that ‘did’ lead to potentially difficult conversations, adding:

> But that's (accountability) what you want though isn't it… [ ] accountability on both sides though so it's not just one way cos managers are gonna set tasks and goals or whatever for the staff, so they need to be accountable and live up to their side of it as well... So, it works both ways.

Steve (P2) agreed as he openly reflected:

> I think it'll make everybody accountable for their role within it um from the supervisor, the person being supervised, um, everybody's gonna have some accountability in that process as it is a two-way process. If you've got expectations, you're kind of starting from that point with the training expectations on the table um… This is your accountability in this process.

For those struggling to understand and deliver effective supervisions, training was thought to potentially expose them to new expectations, accountabilities and demands which, they reflected, might be challenging for managers given an historical lack of manager supervision training and support in this area. Despite this potential difficulty, they still felt that supervision training was overall, a positive step forward. The participants agreed about ‘drawing a line’ under current attitudes to supervision which they hoped would afford under skilled and under supported managers a safe and productive space within which to learn and develop. This drawing of the line was intended as recognition that ‘all’ workers had been under supported around the supervision process, and the participants very much appreciated that managers and supervisors did not know what they had not had the opportunity and support to learn. As such the participants did not want to infer a culture of blame, when what is needed now is to move forward positively together as a sector.

The focus group participants also felt that there was a wider need to challenge, tackle and support the issues of absent and ineffective supervision within organisations. They recognised the wellbeing and practice benefits supervision can potentially provide and were tired of skirting around this important issue simply because it is complex and at times a difficult one. Participants recognised that change can be challenging and scary for some but that a supported, positive, inclusive and innovative approach to supervision for this specific workforce was long overdue. Who might be responsible for this challenging change was not discussed further, although Steve (P2) did raise Care Quality Commission (CQC) compliance as a marker for effective supervision being undertaken in the social care workplace. He went on to add however, that the quality of a supervision is not assessed for, and this is perhaps something that can be considered in the future.

6.9.2 Barriers to supervision training engagement

The focus groups were also asked to think about what potential barriers might inhibit the scope of uptake, attendance, and adoption of supervision training and what could be done to mitigate and manage this. Jake (P1) laughed before saying: “I'm not gonna lie but it won't be easy because people are so set in their ways.”

“Time!” was almost shouted out by Jake (P1) when the conversation on barriers to engagement was ending. He went on to say:

> But that's it isn't it, everything these days is “let's do it as quick as we can because of time restraints” and you get that don't you, you appreciate if you're taken off like your job to do it, but sometimes I think we've got to give some things time.

Ruth (P2) agreed adding: “Maybe just um, not for me perhaps, but other companies might struggle to give staff the time to do it... If they're domiciliary or something like that.” Susie (P1) also agreed but thought some level of flexibility on when you could do the training was needed given the unpredictable nature of working in the social care sector, although she went on to reflect that flexibility in care is hard.

Steve (P2) thought that some barriers might come with the trainers themselves, given an earlier comment about changing hearts and minds:

> Umm… I think other barriers to the training are probably things like you're gonna have to have someone who's really good at engaging people on the training, that it's almost the skill of the trainer as such, [ ] if you do a really dull session on er supervision people aren't going to engage in it [ ] because they didn't take anything away from the training, they need to be able to take, to go from the training and go actually I'm really looking forward to having supervision as opposed to [ ] that was a waste of a couple of hours of my time. I think that's very important, I think that could probably be one of the biggest barriers to training on supervisions.

How training and information sharing is disseminated, however, was seen as a bigger barrier than being introduced to new knowledge and skills. The participants suggested that trainers need to be able to engage learners in what for them is largely an unwelcomed and challenging workplace experience, and that this required a positive and accessible approach. The concept of affording workers and managers the time to both complete this training, check for learning, and continue to adhere to the guidance was also largely seen as a values issue.

6.10 "How can we move forward from here?"

The focus groups were asked to consider what next? The question was immediately met by Jake (P1) quipping: "honesty's always a good place to start" as the other participants agreed and laughed. Susie (P1) thought that a candid and open conversation with the supervisors was a good place to start:

> I think we probably need to sit down with the managers with the staff group isn't it and work out a way forward. What, what is it that everybody needs, what do they want from it? What are we achieving? And come up with what works for the majority isn't it, you're always gonna get people that it's not gonna work for or whatever, but for the majority.

However, as soon as Ruth (P2) said: "um… Maybe draw a line under what's happened prior to this and then start a fresh with a new template, with a new insight into supervision and appraisal", both Jake (P1) and Susie (P1) agreed that this seemed like a beneficial idea. Jake (P1) as a more experienced carer joined the discussion adding:

> It needs to be like Ruth (P2) was saying, that line needs to be drawn and we need to move forward in a more positive way [ ] it's about drawing that line and moving forward and showing them that change is actually a good thing [ ] it needs to keep moving ahead and moving forward and that needs to be seen as a positive from everybody.

Susie (P1) came at the issue of supervision competency from a different perspective as a relatively new worker in the social care sector. She had joined a new service with more experienced colleagues and reflected on what might have worked better when the service opened:

> With supervision we've all started at the same time with it but I think in some ways if we had drawn the line and it all came in for the new ones and the old ones, it's the same speak, same talk isn't it, you're all starting off on the same footing and going from there.

The drawing of the line under current supervision practices was a popular idea and all felt it would be beneficial if all workers, all those who received supervision, regardless of their role and experience, could move forward positively together. Supervision, whilst being largely seen as a frustrating and challenging aspect of their role much of the time, was also seen by the participants as something they were keen to start enjoying and making the most of and as Ruth (P2) said: "If anything's done it's better than having nothing, so whatever you do is gonna be beneficial to services." Most importantly, supervision being portrayed and delivered as a positive tool was seen as crucial with Susie (P1) adding: "I think trying to make it as positive as we can, isn't it, selling it as a good thing, that it's helpful for both of you."

The participants thought that supervision training attended by both supervisees and supervisors would be beneficial, helping to support wider systems change in the approach and perception of the supervision process. They recognised that poor supervision was largely a result of inadequate supervision support, experience, skills and training and as such, they wanted to start a fresh, with both parties on the same page and taking shared accountability for the experience. As a tool to get the best from the supervision process, supervision training for supervisees, completed as part of an induction/ongoing process, was agreed upon by all participants as essential.

6.11 Chapter Summary

Building on the findings from Phases One and Two, this chapter further evidences the need for supervision training for supervisees in the unregulated social care sector. The need for supervision training is not confined to supervisees however, with all participants suggesting there was also a need for more specialised supervisor training. Participants noted that without supervision training, workers cannot know what to expect from the process or be able to determine if the supervisions they are receiving are effective and appropriate. All workers, regardless of role or length of service should be in receipt of effective supervision. Therefore, participants felt that supervision training for supervisees should be attended by all organisational levels. This integrative approach was thought to add a sense of shared ownership, togetherness and accountability taking between supervisees and organisations. A standardised supervision framework can also help worker wellbeing and practice needs be tracked across services as individuals move and change role.

It was thought that supervision training would enable and empower both supervisees and supervisors to understand and take accountability for their part in the supervision process, and better appreciate what is expected from them both. The training can help workers understand the aims, goals, and benefits of supervision, what it is and is not, how to prepare for supervision, the role of the supervisee and supervisor and the regulation that underpins the process. Supervision should be an ongoing developmental and supportive process, where supervision feels more 'done with' than 'done to'.

The training should not last for more than half a day, be face-to-face, in a group setting, shared with other social care services and offer attendees the opportunity to observe or practice an effective supervision. The COVID-19 pandemic had accustomed the participants to online training, but all agreed that an online, passive, tick box type exercise would not be appropriate for supervision training. The participants wanted the opportunity to ask questions, seek clarification and learn from others about the supervision process and an online forum was thought to inhibit the ebb and flow of conversations. However, well facilitated and engaging online group supervision training sessions were considered a good substitute for those who were unable to attend in person and it was important that the training was flexible and accessible to reflect the working patterns of the sector. Learner needs in the form of literacy and language support were raised, and training materials that avoided the use of jargon and overly complex language was preferable.

The supervisors in the group suggested that they would follow up supervision training with their staff teams by scheduling in a supervision to check for understanding and start the supervision relationship in a positive and collaborative tone. The participants believed that supervision training could help improve the relationship between supervisee and supervisor by enabling a more open, productive, and collaborative experience which might promote less of a sense of ‘them and us’. Standardised supervision training was thought to provide a framework for good supervision practice and offer a more balanced, shared appreciation of the process. The participants wanted to move forward, draw a line under what had been before and positively engage in a new way of supporting worker wellbeing and practice. Better monitoring of supervision quality by regulators was also suggested and a fresh start with the supervision process was looked forward to by all participants.

Concluding the study, the final chapter attempts to create a more refined theoretical and conceptual appreciation of the complex wellbeing needs of the unregulated social care workforce and goes on to propose a new approach to the unregulated social care worker supervision process.

Chapter Seven

Discussion

7.1 Chapter Overview

This study aimed to explore the lived experiences of unregulated social care workers' (USCWs) and supervisors' social care practice and supervision; to explore how individual wellbeing is experienced and managed in the workplace; investigate perceptions of factors affecting engagement with and effectiveness of supervision encounters, and generate ideas for future support and supervision approaches. To do this, 23 unregulated social care workers (14 workers and nine managers with supervisory responsibilities) were interviewed. It is important to note that Phase One of this research was conducted between October and December 2020, Phase Two in August 2021, and Phase Three, January 2022. During this time, the participants had worked through two lockdowns and the worries of an ongoing COVID-19 Pandemic, and although COVID-19 was not a focus of this study it was raised as part of the participants normal working day at that time.

This chapter will firstly give a brief outline of the study aims and an overview of the situational context of the study before discussing the key findings and insights from Phases One, Two and Three. The discussion takes an integrated approach, drawing from all three phases, which were conceptually linked and conducted sequentially as the findings were analysed and synthesised. Theories of health risk, trauma informed approaches and human factors are used to build a conceptual framework and model for supervision practice and supervision training from the findings of the study. Limitations are commonly perceived as negatives but due to the highly reflective and reflexive nature of this study, were experienced as learning and problem-solving opportunities, and are noted within the discussion as strengths and weaknesses. The chapter ends with three recommendations for both practical and empirical studies, including an immediate supervision training pilot, followed by the conclusion of this thesis.

All participants used at least one of the terms 'trauma', 'traumatised and/or 'triggered', with some using these words often, and in relation to personal feelings of work-related wellbeing.

In response to this, applying a trauma informed lens to the supervision approach of USCWs is discussed as part of worker and manager lived experience considerations. The findings across all phases have influenced the creation of a human factors approach to the supervision process, including the delivery and training of supervision through a more trauma informed lens.

7.2 Contextualising the Study and Identifying the Unregulated Social Care Workforce

As noted in 1.5, this study focused on the varied roles found within the unregulated social care sector, outside of the more traditional nursing/care home environment. That is not to say that nursing/care home workers do not struggle with the same kind of challenges that other unregulated social care workers face, but that they are subject to a wider research effort, perhaps due to their critical impact on the overall outcomes of regulated nursing and allied healthcare provisions. As such, this study aimed to raise awareness of the experiences of USCWs who work outside of the traditional social care workplace environment, including direct homecare and more specialised care and support worker interventions.

Unregulated workers are those employed in social care roles that do not fall under a specific regulatory body aside from the Care Quality Commission (CQC). The CQC provide overarching regulatory guidance for the health and social care sector, including the provision of supervision. In addition, health care professional regulatory bodies commonly provide more specialised supervision support for the supervisory role. Poor supervision provision is not only confined to the unregulated social care sector however, with studies identifying similarly inadequate supervision experiences for regulated health and social care workers (Cunningham et al., 2021; McCarron et al., 2018b; Rowe et al., 2022; Tobias et al., 2016).

Underpinning this inquiry is a workforce with a history of poor quality employment and worker support (Casey & Webb, 2021; Kreitzer et al., 2020), the impact of COVID-19 (Alnazly et al., 2021; Jeleff et al., 2022; Smith, 2020), a projected need for nearly half a million more social care workers by 2035 (GOV.UK, 2021; Skills for Care, 2022a), and a vacancy rate of over ten per cent and rising (Skills for Care, 2023). If we are to succeed in fostering a more sustainable, quality and skilled workforce to help meet current, and future need, we must learn how to support the practice and wellbeing needs of the social care workforce more effectively and act now.

7.3 Introduction to discussion of key findings

Key findings illustrated a workforce subject to risk of physical, emotional, financial and psychosocial harm, and risk of exposure to vulnerability and exploitation. These harmful risk factors were experienced by the unregulated social care workers in the form of threats and actual physical violence and harm, abusive, threatening and offensive language, and vicarious trauma. As vulnerable workers employed in a highly gendered, inherently stressful, dangerous, and poorly funded sector, they also experienced financial and job insecurity, were perceived as low status, low skill, unequal, and lacking in agency and power. As vulnerable individuals, the social care workers and managers disclosed experiencing detrimental, and at times, debilitating mental health issues, with many going on to share personal histories of childhood and/or adult domestic abuse.

Inadequate support and supervision provisions compounded risk to health and wellbeing, given supervision was largely seen by all participants as inconsistent and delivered by unskilled and unsupported supervisors. For some it was a space to be reprimanded, and as a support mechanism, appeared to hold little value and importance to organisations. Meaningful experiences of effective supervision were shared, and whilst infrequent, they seemingly made a positive impact on the participants, who were able to use these experiences and skills in their role and personal lives. Both Phase One (workers) and Phase Two participants (managers) agreed that supervision for unregulated social care workers was largely not working, requiring a more knowledgeable, skilled, responsive, compassionate, and contemporary approach to training and delivery. All those who participated across the three phases will be referred to collectively in this discussion as unregulated social care workers (USCWs).

Hidden and unseen harmful experiences pose a risk to individual worker health, and health risk theory helps provide a meaningful and compassionate conceptual lens through which to view this workforce’s needs. The term ‘hidden’ is used here to refer to people and risk-laden behaviours that are out of sight, or out of theoretical and philosophical conceptual reach at that time; as opposed to ‘unseen’, which refers to people and risk-laden behaviours that are visible but ignored and overlooked, whether deliberate or otherwise. Adding rigour and sensitivity to the quality of the interpretative analysis process and supported by in-depth knowledge of the sector and the role, an insider/researcher status, naturalistic and inherently compassionate lens serves to add value to the inquiry (Eakin & Gladstone, 2020). The themes from Phases One and Two and the insights from Phase Three are integrated for this discussion, given all phases, were built on each other conceptually and developed sequentially, representing a wide perspective of unregulated social care worker wellbeing, support and learning needs.

7.4 Health Risk in the Social Care Workplace

Risk for the unregulated social care worker can be both aleatory and epistemic (Kiureghian & Ditlevsen, 2009), representing the sometimes random nature of service user behaviour and how a lack of information and knowledge can impact on safe and effective outcomes for stakeholders. Aleatory and epistemic risks were evidenced on numerous occasions when participants spoke of finding themselves in workplace situations where unexpected and challenging events had occurred. This was often compounded by a lack of knowledge about service user history of behaviour, where to seek support from, and how to formally manage different types of risk. A lack of active risk assessment training, dialogue between organisation and worker and effective supervision, often meant that workers learned to manage physical and emotional risks through peer observation and communication and continuing experiential practice. As such, the concept of risk was not perceived or understood through any established risk management model. For the Phase One participants risk was seen as just part of the job, which may reflect how the potential for harm was both normalised and tolerated, although some had started to question organisational accountability for their and their colleague’s wellbeing and safety.

Even in situations where there was a wealth of worker knowledge, information and expertise, service users with unpredictable cognitive, physical and behavioural issues, commonly subjected Phase One participants to aleatory experiences of risk, which whilst managed, left many feeling stressed, anxious, triggered and overwhelmed. The occurrence of aleatory risk in the unregulated social care sector is unavoidable and the participants recognised this. The participants also recognised that an effective supervision space can offer them an opportunity to assess, reflect, share and learn from these occupational hazards. This supportive space, alongside an improved HF approach to NTS training, can help prepare workers to respond and manage difficult and often lone-working events more safely and productively.

7.4.1 The social care risk assessment process

In social care, assessing health risk is recognised as a fundamental aspect of safely and proactively caring for and supporting emotionally and physically vulnerable others (Manthorpe, 2007; Rantala et al., 2022; Stevens & Hassett, 2012; Wåhlin et al., 2020). However, health risk in social care is unlike more traditional forms of risk phenomenon, given human beings can be uniquely unpredictable and spontaneous. From the perspective of the social care worker, service users with diminished cognitive capacity and understanding of risk and harm, can be difficult to predict and manage in this chaotic and stressful workplace environment.

The risk assessment process in social care is aimed at providing a more person-centred and informed approach to service user health and safety risk (Phelan, 2015), although workplace legislation (HSE, 2023b) makes it clear that employers have a duty to protect and support workers employed in violent and harmful spaces. The USCWs, despite experiencing frequently violent and distressing incidences, made no mention of being involved in, or reading about, organisational risk assessment support measures toward worker health and safety. However, they did mention undertaking organisational health and safety and service user support training. Several participants also disclosed that on occasion they had felt unable to say no to management instructions to return to work with known violent and abusive clients, despite sharing with their managers that they had felt frightened for their own safety and wellbeing.

Service user and workplace risk assessments typically focus on measurable and person-centred determinants. Rarely, however, is one of those determinants the mental health and wellbeing of the worker. Research suggests that positive worker mental health and wellbeing plays a critical role in overall service user and organisational safety and wellbeing (J. M. Adams, 2019; Krekel & Ward, 2019; Kundi et al., 2020), and that individuals and groups with raised wellbeing perform better in their jobs than those with lower wellbeing (Warr & Nielsen, 2018). In the pursuit of understanding social care worker wellbeing more fully, this study has begun to identify the hidden and unseen experiences of unregulated social care workers and how these experiences impact on practice and exposure to health risk. What effective and responsive workplace supervision could look like from the USCW perspective requires a wider, more compassionate understanding of USCW experiences and needs, and this study begins this process.

7.4.2 Hidden and unseen health risk: unregulated social care worker wellbeing

Much is known about the detrimental impact risks of violence, abuse and inadequate organisational support has on regulated health and social care worker health and wellbeing (Curran et al., 2021; Fox et al., 2021; Nyberg et al., 2022; Robertson et al., 2021; Wressell et al., 2018; Zelnick et al., 2018). In contrast, very little is known about these same health risks for their unregulated social care counterparts (McFadden et al., 2021; Rehder et al., 2021; Zelnick et al., 2018). In the absence of more specific wellbeing research for the USCW group, more generic health risk models and theories are considered.

7.4.3 Health belief models

In relation to wider, practical public health concerns and risks, traditional health belief models (HBMs) suggest that increased knowledge of health challenges, an enhanced perception of personal risk, and in later models, building a sense of self-efficacy to undertake the changes required, can help manage health risk choices more effectively (Becker, 1974; Champion & Skinner, 2008; E. C. Green & Murphy, 2020; Janz et al., 1984; Rosenstock, 1974). Health belief model-based education can also provide a wider framework toward healthcare worker wellbeing and service user risk perceptions, by increasing knowledge and enhancing self-efficacy through training and effective workplace support (Amraei et al., 2020).

Overall, HBMs help support a wider public view on preventative health related behaviours, and the risks associated with them (e.g., smoking), and the factors that influence these risks and behaviours (Champion & Skinner, 2008; Janz et al., 1984). However, with no clear operational guidelines, assessing health risk and the links between perceived susceptibility, severity, and overall threat perception, HBMs can be subjectively inconsistent (Abraham & Sheeran, 2005). The HBM has also been criticised as being reductionist, lacking in emotional, cultural, and social causative consideration, and ignores that people do not always do, or are unable to do, the cognitive reasoning required to assess risk to health effectively (Davidhizar, 1983; Orji et al., 2012).

Extending health belief model thinking into occupational health, this study highlights that HBMs are inadequate at explaining the complex and often disempowering impact of the inherent social determinants, and inequalities experienced by those in the USCW study group (Alegría et al., 2013). Ineffective workplace support resources, and the psychological pressure of financial insecurity and mental health (Hahm et al., 2008) can also serve to inhibit feelings of control, making it difficult for the USCWs to make personal positive health behaviour decisions in their work role.

7.4.4 Approaches to health risk

Ferrer & Klein (2015) (2015) and Ropeik (2012) suggest that individual health risk perceptions are a critical determinant of health behaviour. Nevertheless, the nature of this association may depend on the profile of different types of risk perceptions, and the accuracy of such perceptions, given it is a highly personal and subjective process which can be based upon imperfect feedback (Kriger, 2021). Human beings are also prone to getting risk wrong, “that is, we are sometimes more afraid than the evidence suggests we need be, and sometimes not afraid as the evidence says we ought to be” (Ropeik, 2012, p. 1222).

Health risk approaches that require optimal states for behaviour change also fail to consider the hidden and unseen risks experienced by the USCWs. In these situations, vulnerable individuals can become unable to recognise appropriate levels of risk because of lived experiences, over-exposure, and desensitisation, which in time becomes cognitively accepted and normalised (Mrug et al., 2015, 2016). Health risk-taking behaviour in the form of USCWs persistently placing themselves in dangerous and hazardous workplace situations, was a consistent thread in the data. Putting themselves at risk was seemingly accepted as part of a normalised and tolerated aspect of the role by workers, which was situated within organisational hierarchical power structures, learned behaviour, and disempowering current and prior lived experiences.

7.4.5 Understanding ‘personal’ health risk

Emotional ‘triggers’, in the form of painful reminders and feelings, alert trauma survivors about potentially harmful forthcoming risks, although empirical studies on trigger warnings suggest that they can be ineffective and can create additional emotional distress (P.J. Jones et al., 2020). Kriger’s (2021) ‘The Shit Happens Approach’ offers a more meaningful understanding of the tolerated and everyday aspects of working with unpredictable and vulnerable service users where anything can happen in social care services that are understaffed, under supported and underfunded. Kriger is able to provide a more individualised understanding of aleatory risk, recognising that when random events that pose a risk take place, individuals do not always act in the way they are supposed to. ‘The Sequelae Approach’, used here to refer to the impact of past and present experiences on future decision making, was described as a form of ‘triggering’ of unwanted thoughts and feelings by many of the USCWs. ‘The Sequelae Approach’ also highlights that these historical experiences were still part of some of the participants’ present life world, and that their past difficult lived experiences had at times detrimentally impacted on their thoughts and behaviours in the workplace.

7.4.6 How unregulated social care workers experience health risk

Phase One USCWs spoke of managing the risks and challenges of unpredictable and uncontrollable workplace events by putting on a smile (see also Hochschild, 2012), and getting on with the job at hand; whilst at times managing triggered autonomic stress responses in the form of feelings of panic and anxiety (Henley et al., 2011; Jones et al., 2020; Seligowski et al., 2020; van der Kolk, 2000). Those who spoke of experiencing triggered and unpredictable feelings after violent and challenging service user incidences also felt that supervision was the most appropriate space within which to debrief, reflect, process, and learn.

A significant aspect of managing a risk or hazard is adequately identifying it (Covello & Mumpower, 1985; Damodar Vishnu Lele, 2012; HSE, 2023b; Suckling et al., 2003). However, given repeated and even single exposures to stressful, situational events can desensitise individuals to the physiological and endocrine responses to stressful environmental factors (Armario et al., 2004; Funk, 2003; Mrug et al., 2015, 2016), perceptions of risk may become distorted. Perceptions of personal health risk and safety were consistently downgraded and normalised by the participants, remaining unseen and hidden until voiced and reflected upon.

Arguably, not choosing to place yourself in harm’s way as a low-paid, under supported USCW would be a reasonable decision given the health consequences of persistent harmful events. However, participants appeared to repeatedly, and mostly willingly, place themselves in emotionally and physically hazardous spaces, commonly placing the wellbeing and organisational needs of the service and service users before their own (Egan et al., 2019; Hofmeyer et al., 2020). Whilst beneficial and favourable to the organisation and service user group (Hayes & Walters, 2020), agreeableness and a willingness to do whatever was needed of them exposed participants to vulnerability and health risk in the form of increased stress, exhaustion, and low morale (Brand et al., 2017; Selamu et al., 2017). Most participants felt unable to challenge the hazardous work they were expected to undertake, given the hierarchical structure of the workplace (Fernandopulle, 2021), their own financial insecurity, and how powerless they felt in being able to affect real change within their services and lives.

7.4.7 Personal factors, characteristics and individual health risk

Self-efficacy is an important aspect of both HBMs and Social Cognitive Theory (SCT) and refers to an individual's belief about their ability to control and manage their surroundings and life events (Bandura, 1977; Pérez-Fuentes et al., 2019). Bandura (1977, 1997, 2005) views self-efficacy as situational and learned, in that individuals may be able to demonstrate self-efficacious behaviour in one environment, but not in another. The USCWs showed situational self-efficacy, sharing that they felt confident, competent and in control when directly engaging with service users (Pérez-Fuentes et al., 2019). In contrast, they often felt anxious, frustrated, lacking in agency and doubtful of their skills and contributions during supervisions, or other direct contact with management and related professionals.

Empathy relates to the capacity to relate to, and share, another's state of mind (Depow et al., 2021; Greenberg et al., 2018; Ioannidou & Konstantikaki, 2008; Riess, 2017); and possessing empathic self-efficacy has been found to have positive associations with prosocial behaviour, good health and wellbeing, and feelings of compassion satisfaction (Berg-Poppe et al., 2022; Ioannidou & Konstantikaki, 2008; Pérez-Fuentes et al., 2019; Shrestha et al., 2021). However, the important interpersonal skill sets of empathy and self-efficacy may also, paradoxically, confer health risk for depression, anxiety, burnout, and compassion fatigue in workers when present at extreme levels, and in combination with certain individual characteristics and contexts (Tone & Tully, 2014). Risk to health and wellbeing is further exacerbated when effective workplace support and supervision is inadequate (Ludwick et al., 2018).

For USCWs, working in already stressful, dangerous, and distressing workplace environments, empathy was at times seen as a "risky strength" (Tone & Tully, 2014, p. 1). This "strength" led to serious concerns about burnout and compassion fatigue in general, and these feelings had been especially prominent during the first six to 12 months of the COVID-19 pandemic. Other frontline health and social care workers were also exposed to extreme psychological pressure because of the COVID-19 pandemic, increasing and exacerbating risks of developing psychological symptoms and mental health disorders (Alnazly et al., 2021; Lluch-Sanz et al., 2022; Rolin et al., 2022; Zerach & Levi-Belz, 2022). However, high levels of compassion fatigue and burnout had been identified in some professional health and social care groups prior to the pandemic (R. E. Adams et al., 2006; Cetrano et al., 2017; Lluch-Sanz et al., 2022; Potter et al., 2010). Risk to unregulated social care worker health and wellbeing was not confined to experiences of violence, abuse and exploitation in the workplace, and the unregulated social care workers shared experiencing a wide range of financial, emotional, and lived experience challenges.

Social, cultural, and individual inequalities were identified by the social care workers in the form of disproportionate informal caring responsibilities, low wage, low status and insecure jobs, funding cuts, poor quality workplace environments and opportunities for role progression. Workers spoke of feeling invisible, lacking in agency and decision-making power, and were often subject to increased exposure to coercion, violence, and abuse. In addition, we need only look to wider workforce demographics and statistics to recognise that these individuals are also impacted upon by myriad intersecting systems of political, gender, social and cultural barriers, and inequalities (Bennett, 2015; ONS, 2015; Ravalier et al., 2019; Zelnick et al., 2018).

7.5 A Trauma Informed Approach to Understanding Worker Wellbeing Need

Many of the unregulated social care workers voluntarily disclosed having been a victim of childhood abuse, adult domestic abuse, or both. It is now widely recognised that histories of trauma, particularly complex childhood trauma, can impact on the overall health, wellbeing, social and cultural opportunities, and interactions of victims, and that these experiences can continue to negatively impact on the individual throughout the course of their life (Boullier & Blair, 2013; Downey & Crummy, 2022; Felitti et al., 1998; Lovell et al., 2022; Miller et al., 2022). In response to research demonstrating that incidences of trauma are widespread across society (Sweeney et al., 2018), Trauma Informed (TI) approaches to helping others process and manage trauma, emerged.

7.5.1 Trauma informed approaches to care

A trauma informed (TI) approach to care provides a framework for system change intervention and seeks to transform organisational culture and practices to address the high prevalence and impact of trauma and re-traumatisation on patients, and healthcare professionals (Emsley et al., 2022). However, TI approaches to practice have yet to find an adequate definition or set of specific strategies to ensure that services are in fact trauma-informed, and empirical evidence is needed to help promote more effective and sustainable strategies of implementation (Guevara et al., 2021).

Trauma Informed care and training has been found to have moderate to significant positive changes on worker and client satisfaction outcomes, and worker self-efficacy (Berg-Poppe et al., 2022; Hales et al., 2019; Miller et al., 2022). Whilst not in mainstream use, TI support has also been considered in relation to regulated health and social care worker support and supervision (Berger et al., 2018; Borders et al., 2022; Knight, 2018; Knight & Borders, 2018). Trauma Informed support directed at workers, largely focuses on direct and indirect trauma experiences that result from client interaction. This consideration does not extend, however, to the impact of traumatic lived experiences brought into the workplace by vulnerable workers, or the role organisations and wider systems play. Some of the managers in this study had attempted to implement a more TI approach to their supervision processes, although this only occurred in services that already used a TI approach to service user support.

Viewing worker support and supervision needs based on service user impact fails to consider the worker as an individual human being, which supports the experiences of many of the Phase One social care workers who spoke of feeling easily replaceable, like just another number or body, and a robot without feelings. In stark contrast, organisational and worker attention to TI care with service users compassionately recognises vulnerable adults as unique individuals. A TI approach to care is a whole person, empowering approach to caring, which promotes healing and recovery; reaps wellbeing and psychosocial rewards; and helps mitigate future health risk (Knight, 2019; Levenson, 2017).

7.5.2 Worker responses to trauma in the workplace

References to feeling heightened states of anxiety and fear in response to unpredictable, dangerous, and critical workplace events, were commonly shared by participants, who said that at times they had felt frightened, panicked and triggered. These types of emotional responses are commonly accompanied by physiological changes to an individual's homeostasis. These changes affect memory processing, reprocessing and response time; and increase the heart rate, triggering a surge of oxygen rich blood, readying the body for a fight, flight, freeze, flop, or friend response (Henley et al., 2011; van der Kolk, 2000; Yaribeygi et al., 2017). Despite feeling these stress responses in the moment, the USCWs said they were able to calmly perform the task at hand and put the physical and emotional needs of the client first. Although some did note an increased heart rate, and a feeling of being on autopilot during these highly stressful moments. An effective and responsive supervision process would be beneficial in these instances, providing an opportunity to safely offload, reflect and identify future practice implications, learning and wellbeing needs.

7.5.3 Vicarious trauma

Following Felitti et al.'s (1998) seminal publication on the impact of Adverse Childhood Experiences (ACEs) and risk of disease outcome, there has been increasing interest around the impact of trauma on human behaviour, neurobiology, physiology and responses throughout the life course. Literature has also started to expose the vicarious and secondary impact of traumatic and distressing service user facing experiences, and how this is embodied by workers as bystanders (K. Cohen & Collens, 2013; Horvath et al., 2020).

Despite the lack of research around vicarious trauma and empathy-based stress in the unregulated social care workforce (Hilton et al., 2020), studies have examined vicarious trauma experiences of regulated health and social care professionals (Ham et al., 2021; Roberts et al., 2022). Vicarious trauma refers to the process of physiological change resulting from empathetic engagement with trauma survivors, which can take a toll on the emotional wellbeing of those who support and care for them, adding to worker health risk factors (BMA, 2022d; Dewey & Horsley, 2022; Rauvola et al., 2019; Sutton et al., 2022). Organisational factors, including a lack of support and increased service user/worker ratios have also been identified as additional risk factors for vicarious trauma. Improved supervision processes and knowledge sharing can be implemented to ameliorate the impact of vicarious trauma and empathy-based stress on health risk (PCAR, 2020), given the potential for increased empathy within this workforce.

The term "second victim" (Wu, 2000) has also been used to refer to the psychological harm experienced by healthcare professionals as a result of witnessing or being involved in serious patient safety incidences. For lone USCWs however, the concept of the second victim may not be immediately apparent given the Phase One participants had seemingly normalised violent and abusive experiences and often had no one with them to recognise, or care, that harm had occurred. Several of the participants also stated that they believed their lived experiences of violence and abuse had normalised unexpected and violent events which meant they did not feel stressed, shocked or anxious when they occurred, calling this lived experience ‘good work experience’. To compound a lack of second victim recognition further, most Phase One participants were not in receipt of regular or effective supervision to help them understand their second victim status or know how to manage it appropriately at that time, and in the future.

At no time during the interviews, despite their status as victims of violence in and outside of the workplace, did any of the participants refer to themselves as victims, and using the term second victim may not land as well with USCWs as it does with healthcare professionals. That is not to say that individuals do not recognise their victim status, but that for some, acknowledging it is perhaps too painful to confront and manage. This study highlights the exposure to intersectional inequality experienced by the participants, and it is this exposure that has seemingly increased many of the participants’ capacity for tolerance and resilience when confronted by unpredictable, chaotic, harmful and shocking service user safety events. Whilst this increased tolerance and resilience, borne from lived experiences of violence and abuse, is beneficial in complex and challenging social care workplace environments, there is a distinct lack of recognition, acknowledgement and concern for their victim status. This lack of healthy concern is alarming given it speaks of a lack of self-care and self-awareness, both hugely important skills for good worker wellbeing. The introduction of the term second victim to the unregulated social care sector would need to consider how workers may receive this ‘label’, although it is a useful tool to help inform individuals that their safety and support needs are important. The supervision process can also provide a space for these tentative discussions.

7.5.4 An organisational response to trauma in the workplace

A more TI approach to supervision to help manage USCW stress responses and improve wellbeing, is a necessary contribution to the discussion. The provision of TI supervision is most found in counselling services (C. T. Jones & Branco, 2020) and social care settings that work with individuals managing trauma, and the psychosocial consequences of trauma such as homelessness and mental health (Radis, 2020). There is a notable dearth of literature available to help supervisors provide supervision that is sensitive and responsive to the consequences of working with service users with histories of trauma (Knight, 2018), nor is there any literature on how to support workers with their own trauma histories. What little supportive supervisory materials there are, however, have yet to be applied to USCW support and their supervision needs.

Organisations that provide TI supervision recognise that individuals who work with hurt and traumatised service users are exposed to increased rates of compassion fatigue, vicarious trauma, and secondary traumatic stress (C. T. Jones & Branco, 2020). Both theorists and researchers agree that vicarious trauma is an inevitable consequence of working with traumatised others (Knight, 2018), and that trauma is ubiquitous in our world (Knight & Borders, 2020). Six key principles have been identified to help provide a more TI approach to care (GOV.UK, 2022; PCAR, 2020): physical and psychological safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical and gender issues.

Transferring these principles to the USCW supervision process can help meet many of the needs identified within all phases of the interview findings such as: wanting to feel a sense of safety and trust that what is shared in supervision is confidential; that they are actively listened to and empowered to reflect and learn; that supervision is done with, not done to; and that the supervisor understands them and their situation. Trauma informed approaches to service user care requires an organisation to be able to demonstrate an understanding of the complexity of trauma (Berger & Quiros, 2014), which is arguably difficult to assess and monitor in multi-level/agency services. In contrast, trauma informed supervision can be facilitated and (in)directly modelled to workers by a skilled supervisor who is trauma informed trained, but who does not necessarily supervise individuals employed in more traditional trauma related care environments.

As a support consideration, trauma informed supervision feels like a natural direction for the USCW supervision process to follow, given the shared trauma histories of many of the Phase One USCWs, and that they provide care and support, often alone, to vulnerable and sometimes triggering and harmful service users. It is widely recognised that the health and social care role is a highly stressful, risky and sometimes harmful one (Arnetz et al., 2015; Ham et al., 2021; HSE, 2021a; Lim et al., 2022b; Zelnick et al., 2013), yet little has been done to improve support for USCWs working in often extreme circumstances. As observed in other caring roles (Berger & Quiros, 2014; PCAR, 2020; Radis, 2020), a trauma informed approach to USCW supervision can help provide a beneficial and sustainable mechanism for buffering the physical and physiological impact of ongoing exposure to service user distress, vicarious trauma, and violence.

In support of TI training, Psychological First Aid training can also help provide unregulated social care organisations and supervisors with the skills and knowledge to improve the effectiveness of the supervision process, thus positively impacting on both epistemic and aleatory risk factors. Psychological First Aid training for employers and managers can not only provide USCWs with a more immediate TI response to help manage and reflect on unpredictable and psychologically harmful SU safety events, but also support an ongoing PFA focused approach 'through' the supervision process.

7.6 The unregulated social care role as extreme work

Whilst several of the participants had occasionally undertaken some form of de-escalation or break-away training to help prepare and mitigate risk to health from violent service users, many had not. Originally coined by Lyng (1990) in response to limiting social boundaries and an overly risk-adverse world, 'edgework', in occupational terms, traditionally refers to professions where a known reasonable risk of harm and even death exists such as in the emergency services, security, or the military (Guo et al., 2021; The United States Army, 2019; Ward et al., 2020). More recently however, the term 'extreme work' (Granter et al., 2019) (Granter et al., 2019) has been used. Extreme work refers to work characterised by its intensity, long hours and the normalisation of severe workplace behaviours and cultures, such as undertaking potentially harmful or unsanitary work activities (Hewlett & Luce, 2006; Ward et al., 2020).

Both edgework and extreme work literature are commonly focused on White middle-class men (Gascoigne et al., 2015; Newmahr, 2011) and as such, direct comparisons with the predominantly female, working-class social care industry may prove challenging. However, similarities to both edgework and extreme work are evident in the form of acknowledged exposure to service user violence and abuse, long, anti-social hours, toxic workplace cultures and supervision, and poor support and training resources (Bülbül & Taştan, 2017; Rasool et al., 2021).

For those engaging in more traditional edgework roles, risk can be managed and mitigated for through repeated training and stress-inducing role plays. These real-life simulations serve to help foster individual, team cohesion, and desensitise individuals to traumatic events that can trigger more debilitating autonomic stress responses, and suppress adaptive physiological behaviours (Guo et al., 2021; The United States Army, 2019). The term 'extreme work', whilst providing a more general understanding of unregulated social care workplace experiences, may also serve to minimise the more harmful and dangerous aspects of the role by failing to appreciate that for some participants, the spectre of violence and psychological harm was ever present (Ward et al., 2020).

7.6.1 Preparation and training for extreme work

Lyng (1990) assumed that those who engage in edgework do so voluntarily and with an understanding of the potential risks and consequences of their choices. For participants in this study the risk or consequence of harm was not always obvious, as they were arguably at minimal risk of death or life-threatening harm, although fatalities have occurred (Lewis, 2023; Mclelland, 2016; McNicoll, 2013; Turner, 2019). However, the COVID-19 pandemic now poses the single greatest risk to social care work related deaths (Samuel, 2020; WHO, 2021a). Unregulated social care workers frequently placed themselves at often unknown and/or unseen risk of harm to health and wellbeing, whilst having had no formal and consistent drill-type, desensitisation training or simulation opportunities. Several of the Phase One and Two unregulated social care workers did however share that they had previously been offered post-incident support after especially difficult and traumatic workplace events, but that this support was often not consistent, nor did it extend passed the immediate aftermath of the event. It was therefore unclear as to where their ability to cope and manage these sometimes triggering and unexpected events emanated from, although many of the Phase One participants considered their sometimes dangerous and unpredictable childhood and adult environments, as good 'work experience'.

Drill exercises link tacit and formal knowledge through action and experience (Müller et al., 2019). They provide an opportunity for experiential learning under real conditions, which is necessary for increasing knowledge, quality of information and communication systems, and can provide useful insights on how to improve response protocols (Granter et al., 2019; Guo et al., 2021; Müller et al., 2019; E. Skryabina et al., 2017; E. A. Skryabina et al., 2020). Drill exercises seek to hone, enhance and cement patterns of individual and team behaviour, readying the brain for action under pressure, given the impact of fear and trauma responses on the endocrine and sympathetic nervous systems (BMA, 2022d; Davis, 2017).

With the home setting looking to be the preferred environment for care in the future (Age UK, 2020), more individual workers will be managing often challenging, distressing, and exhausting care responsibilities alone. For this specific workforce however, group drill training, group thinking and the use of impersonal rules (Alvinius, 2014; Terpstra et al., 2019) is not a good fit given the unregulated social care worker role is an intimate and often isolated one. Whilst the more traditional structure of occupational drill exercises may not be a good fit for the social care sector, the concept of situational desensitisation and self-efficacy development would be beneficial. Given the often unpredictable and complex nature of service user interactions, and the risks that can flow from them, a wider systems approach to designing and implementing responsive and effective support and training in the social care sector is needed

7.7 The individual wellbeing impact of working with traumatised service users

As self-proclaimed empaths, many of the Phase One USCWs spoke of the emotional impact of working with traumatised and distressed service users. The carer/client relationship can be an intimate and complex one (Kornhaber et al., 2016), and the USCWs often spoke fondly of their service user groups despite the negative impact on their wellbeing. The drive to help vulnerable others appeared to buffer these difficult feelings, although at times, especially during the COVID-19 pandemic, they would feel overwhelmed by them.

7.7.1 The Impact of COVID-19 on Worker Wellbeing

The COVID-19 pandemic placed an increasing moral burden on health and social care workers, leading to a rise in the psychological states of moral distress and/or moral injury (BMA, 2021b). Occupationally, moral distress relates to a situational workplace event that places an individual in a space of ethical and moral dissonance and mistrust between their moral values and expectations, and those of their employer (Čartolovni et al., 2021; BMA, 2021b). In contrast, moral injury refers to sustained moral distress which can lead to impaired function, and longer-term psychological harm such as feelings of guilt and shame, and in some cases, more serious mental health issues (Čartolovni et al., 2021; Barnes et al., 2019; BMA, 2021b; Zerach & Levi-Belz, 2022). Not being able to provide sufficient quality of care can also have a negative impact on healthcare staff (BMA, 2022b, 2022d), and the COVID-19 pandemic left many of the USCW organisations short staffed, lacking personal protective equipment, facing reduced clinical care levels, and watching service users die before their time.

7.7.2 Moral Distress and Moral Injury

The concept of moral distress and moral injury was not specifically raised in the interviews. The USCWs 'did' however talk about feeling frustrated, angry, and frightened for their service users during the COVID-19 pandemic lockdowns and the impact of associated restrictions. However, for many of the unregulated social care workers, working with vulnerable and marginalised adult groups had already exposed them to feelings of moral distress prior to the pandemic. Most unregulated social care workers witnessed and participated in decisions made by more senior others, about the lives of service users considered unable to make reasonable and safe life choices for themselves. For some, this felt unfair, restrictive, and infantilising. It is widely acknowledged that there is a need to protect 'vulnerable adults' in certain healthcare circumstances (Dunn et al., 2008; McCarthy et al., 2017; S. Moore, 2018; Motamedi et al., 2022), and several of the Phase One USCWs went on to share service user safety concerns. Although these risks had been acted upon formally, most did not believe their concerns were taken seriously or followed up, adding to their sense of moral distress and lack of voice. Whilst not spoken of as moral distress, the supervision process for many also harboured a sense of unfairness, powerlessness and being done to, eliciting a sense of frustration and silent outrage at how they were sometimes spoken to.

7.7.3 The relationship between trauma and empathy

Increased feelings of role satisfaction were noted by Lightman & Kevins (2019), who found broad evidence that non-professional care workers were observed to experience a substantively increased feeling of job fulfilment than their professional colleagues. Profound feelings of empathy and care towards service users were frequently raised, and the Phase One USCWs voiced a willingness to go the extra mile, and above and beyond their duties to meet service user needs. Increased empathy was identified as 'caring too much' and of having 'too soft a heart', however, empathy also seemed to act as an enabler and mitigant, supporting the participants in being able to view this often-difficult role as rewarding, enjoyable, motivational, and meaningful. Whilst caring too much was sometimes seen as a detrimental personal quality, those who self-identified as being highly empathic, also found great pride, joy, and satisfaction in this characteristic.

By recognising that some individuals may possess an increased likelihood of experiencing enhanced empathy, we can now start to consider how relationships with others are formed, experienced and managed by workers, and what this means for future practice, learning and wellbeing support frameworks. Given empathy is a core component of care/support work person specifications, ensuring USCWs have a healthy, balanced, and manageable relationship with empathy is vital when mitigating for specific role related risks, stressors and emotional burdens.

The findings, however, painted a picture of people taking advantage of others' empathy and exploiting it to meet the needs of the service users and the organisation. In a workforce facing critical staffing vacancies, sickness, and stress, those who consistently agreed to take on extra hours often felt unable to say no due to feelings of guilt, concern for client welfare, and an unequal status imbalance based on a system of power and control between worker and organisation (Dai et al., 2022; Simeonova et al., 2022). Increased empathy levels in the unregulated social care workforce is also likely politically and culturally exploited (Hayes & Walters, 2020), given the huge related social, cultural, and economic benefits that stem from these individuals entering and remaining in low paid and low quality caring roles (Hayes, 2017).

7.7.4 Trauma, Empathy and the Unregulated Social Care Worker Role

Faced with numerous barriers and inequalities, but seemingly able to resiliently manage and in some cases actively thrive, this USCW sample evidenced the complex and difficult nature of both the USCW role, and the lived experiences of those who perform this vital job. Warranting further consideration and a more nuanced understanding of the complex processes taking place, is the ability of USCWs to consistently and appropriately manage difficult and sometimes dangerous situations without any formal training. Unregulated social care workers are expected to show consistent care, respect, empathy and professionalism to vulnerable but sometimes difficult, disrespectful, and harmful service users. Understanding how wider lived experiences can impact on a worker's ability to demonstrate appropriate levels of empathy will therefore be discussed.

Empathy in everyday life is generally associated with good wellbeing (Depow et al., 2021), however, abnormal levels of empathy (reduced/increased) have seldom been explored in non-offender populations; although, individual exposure to violence and distress has also been noted to increase sensitivity to the suffering of others (Canevello et al., 2021). Whilst few in number, studies are emerging where incidences of increased empathy have been noted in those with histories of trauma (Greenberg et al., 2018), although researchers are also exploring how empathy may be impacted upon by gender and genetics (Knafo et al., 2009; Warrier et al., 2018). Empathy may also be a positive product of post-traumatic growth (Greenberg et al., 2018), which can be a mediator for other attributes that manifest in a variety of positive and pro-social ways such as volunteering (Freedle & Oliveira, 2021).

Post-traumatic growth is associated with feelings of increased relational connection with others, personal strength, and self-awareness, and these characteristics were evidenced by some of the USCWs as self-efficacy, self-care, appropriate boundary setting and empathy (Tedeschi, 2020; Tedeschi & Calhoun, 2004). Findings also suggest that increased support may be beneficial when promoting and sustaining prosocial post-traumatic growth behaviours after adversity and trauma (Liu et al., 2021). However, most of the participants who shared histories of trauma were largely unsupported in the workplace and appeared to struggle with many of the skills and characteristics aligned with post-traumatic growth theory.

Tedeschi and Calhoun (2004) discussed traumatised individuals not just returning to a baseline of homeostatic comfort and safety after experiencing post-traumatic growth, but of noting improvements. However, many of those who disclosed difficult lived experiences went on to share that these had occurred during childhood. In this case, the participants may not be able to cognitively appreciate what this ‘normal’ homeostatic baseline is, given the impact of trauma on immature neural and physiological development can be sometimes profound and long-lasting, (Felitti et al., 1998; Knafo et al., 2009; Levy et al., 2017, 2019; van der Kolk, 2000). By starting to acknowledge that for some workers, difficult lived experiences may lead to increased and arguably unhealthy levels of empathy and tolerant compliance, we might better understand what it is that motivates and drives people to join and remain in this highly stressful, poorly paid and harmful sector. In an effort to understand and support USCW wellbeing and safe practice more effectively, a human factors approach to the problem is discussed next.

7.8 Applying Human Factors Theory to the Unregulated Social Care Sector

In healthcare, HF goals are twofold: supporting healthcare professional cognitive and physical practice, and promoting high quality, safe care for patients (Russ et al., 2012). Human Factors in health care is largely focused on service user health and safety, with the worker acting as the mediator for this outcome (National Quality Board, 2013; Vosper & Hignett, 2018), which may explain why it has so far struggled to find application to worker health and wellbeing. As a result, systems are sometimes produced that exhibit little or no understanding of, or empathy with, worker needs or capabilities and wider systems impact (de Winter & Hancock, 2021). Nor do they specifically acknowledge lived experience impact, human foibles, and a propensity for human error (de Winter & Hancock, 2021; Henriksen et al., 2008). Human factors can however, provide workers with additional non-technical skill sets and a wider appreciation of organisational and systemic accountability and impact.

7.8.1 Human factors and situational awareness

Much in the same way drill exercises can help individuals and teams prepare for stressful and unpredictable workplace events, a HF approach can help to enhance situational awareness and preparedness, through stress-inducing workplace simulations and reflective debriefing opportunities (O’Connor & O’Dea, 2021). A critical component deemed essential for improving clinical practice, situational awareness refers to an individual’s ability to effectively identify, process and manage what is going on around them (Brennan et al., 2020b). Situational awareness is an important factor of healthcare practice given human error plays a significant role in service user safety (Brennan et al., 2020a; C. P. L. Jones et al., 2018), and a HF approach has been found to be beneficial in the healthcare workplace in relation to training, and individual/team non-technical skills (Gluyas et al., 2019; B. Green et al., 2016).

Situational awareness and its impact on ‘worker’ health and safety has yet to enjoy the same level of consideration, despite a well-documented link between healthcare worker stress and patient wellbeing, increased absenteeism, turnover and worker injury (Brand et al., 2017; Hall et al., 2016; Selamu et al., 2017; Zeller et al., 2013). For the USCWs, opportunities to identify and develop situational awareness were largely absent, given many worked alone, and/or did not have access to effective support and supervision. In relation to support and supervision processes, organisational and supervisor situational awareness training around the complex stressors, vulnerabilities and practice needs of individual workers, can also help provide a more holistic, relational and productive means for the creation of effective worker support models.

7.8.2 Mind the gap: Human factors approaches in unregulated social care

Human factors research continues to evaluate surface level problems, rather than explore or acknowledge more systemic factors (Fagbule, 2020), and fails to recognise USCWs characteristics, alongside worker, manager, and wider professional contributions. This study contributes to the HF knowledge gap in how hidden and unseen psychological human characteristics and systemic experiences can impact on worker wellbeing, performance and worker/service user safety. A more psychosocial approach to HF therefore can contribute to both service user and worker safety.

The Phase One participants were expected to manage and consistently respond, often whilst working alone, in compassionate, empathic, and professional ways, largely without the benefit of any specific NTS training or effective supervision. The USCWs shared that most learning was self-directed, isolated and without feedback, and that feeling desensitised to chaotic and dangerous workplace environments was in part felt to be related to prior difficult lived experiences. This self-directed behaviour, whilst presenting outwardly as adaptive and appropriately responsive in the moment, was commonly also attached to hidden and unseen feelings of panic and distress. Limited in its understanding of individual worker behaviour and lived experiences impact, HF can, however, provide the social care sector with a wider, more adaptive theoretical framework upon which to structure and manage the supervision and wellbeing needs of USCWs. This approach not only adds to the dearth of knowledge around USCW practice and wellbeing needs but contributes to the existing HF framework with the inclusion of a more psychosocial approach to managing risk and human error. Utilising some of the theoretical concepts discussed above and interview findings across all three phases, a new approach to the supervision process is discussed next.

7.9 A New Approach to the Supervision Process

This section firstly sets out a proposed conceptual framework, situating effective supervision for USCWs as a visual representation of the relationships between impacting intrinsic and extrinsic factors (operating from inside/operating from outside). The framework draws together findings and insight from all phases of this study, and uses human factors and trauma informed care to analyse the perceived supervision inadequacies expressed by participants across Phases One, Two and Three. The conceptual framework provides a theoretical and empirical bridge into the development of a unique model for supervision training, the 'Human Factors and Trauma Informed (HuFTI) Supervision Training Model'. This training model makes explicit what needs to be done to improve the preparation for, and the delivery of, supervision training at all levels of a social care organisation.

Providing a more effective supervision and supervision training process is not a panacea for improving worker health, wellbeing, and performance. The supervision process sits within a wider, complex system of socio-economic, psychosocial, and socio-political factors that serve to compound risk to worker health and wellbeing. These circumstances are briefly explored further below and identified as extrinsic factors in the new supervision process framework. Extrinsic factors are often less visible and largely beyond the control of individuals and organisations. Intrinsic factors relate to more specific individual worker and organisational characteristics needs, and experiences, and for the purposes of this worker specific inquiry, intrinsic factors are considered in more detail.

Improving the supervision process can provide the opportunity for workers to be empowered, upskilled, and supported to better manage the stressors they are subjected to from extrinsic and intrinsic forces. Alongside practical and cognitive contributions, supervision provides an ideal space for identifying and assessing wellbeing and practice risk, offering a more structured framework to manage and mitigate these risks moving forward. The creation of a conceptualised framework for the unregulated social care worker supervision and supervision training process provides a psychosocial, practical and timely contribution toward improved worker and service user safety in this sector.

7.9.1 A conceptual framework for supervision

All Phases explored ways to improve the supervision process for all stakeholders, alongside identifying the wellbeing needs of the unregulated social care workforce. As the analysis and synthesis of all phases iteratively progressed, it became clear that a human factors approach could be used to help clarify and structure the supervision process more effectively. The HF discipline approaches workplace safety and productivity by learning about the wider forces that can negatively impact on how processes take place within organisations (C. K. Roth, 2014).

In supervision, HF can provide a framework through which the different aspects and levels of accountability of the supervision process can be identified (Fagbule, 2020; B. Green et al., 2016; Henriksen et al., 2008). A human factors approach can also help support the learning of non-technical skills, which are highly valued in healthcare (White, 2012; Yule, Flin, Paterson-Brown, & Maran, 2006; Yule, Flin, Paterson-Brown, Maran, et al., 2006) and can help improve patient safety outcomes through more effective training and support (Griffiths & Lees, 1995).

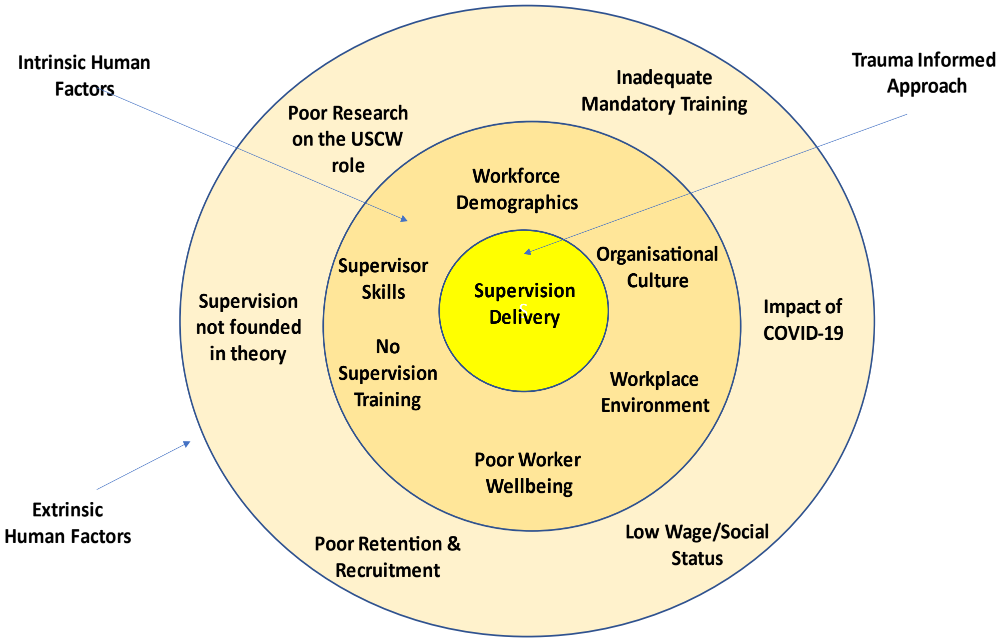
On its own, a HF framework can offer the supervision process a more structured and practical approach to a wider understanding of systems impact, how supervision can be better managed through training and help improve the culture of the supervision process. Adding a more psychosocial approach to how and why individuals interact and respond to organisational supervision processes in the way they do, however, contributes a more meaningful and relational aspect to the subjective worker experience of supervision. Improved understanding of worker lived experiences informs our understanding of how to better manage these needs and responses, supporting a more compassionate and productive supervision environment. The contribution of a trauma informed approach to supervision adds this contextualisation, humanising individual workers, and recognising that in the health and social care sector, there is more to worker health and wellbeing than fatigue and stress (C. A. Brown et al., 2017; Jalilian et al., 2019).

7.9.2 Introducing a new conceptual framework for supervision

A human factors approach, complemented by a trauma informed understanding of worker wellbeing needs, is adopted to propose a unique conceptual framework for understanding and managing the supervision process more effectively (see Figure 4, p.227). Supervision delivery is at the centre of the supervision process model and is underpinned by a trauma informed approach to care. Six intrinsic factors have been identified from the findings as aspects of the supervision process that can impact on the provision of effective supervision, alongside suggestions for active organisational change. Additionally, six extrinsic factors are presented that contextualise wider systemic barriers and sets the current landscape of the sector during a pandemic.

Figure 4

Conceptual Supervision Process Framework



7.9.3 A trauma informed approach to the delivery of supervision

A trauma informed approach to the delivery of supervision can provide a more compassionate and responsive understanding of the difficult and harmful workplace situations experienced by this workforce, including the impact of negative supervision experiences, and is incorporated into this conceptual framework for supervision. The six key principles of providing a TI approach to care with service users (Berger & Quiros, 2014; GOV.UK, 2022b; Guevara et al., 2021; Levenson, 2017; PCAR, 2020) have been adapted for use with supervisees in the supervision space. The six principles are presented here as a good practice guide for the delivery of trauma informed USCW supervision and help to set a practical context ahead of presenting a conceptual model.

- ***Principle One: Physical and Psychological Safety*** – That the supervision space is a physically and emotionally comfortable safe environment, and that it is suitable for the levels of comfort, privacy and confidentiality needed in this highly sensitive workplace environment.

- ***Principle Two: Trustworthiness and Transparency*** – That all organisational levels/supervisees work toward completing an ‘Introduction to Supervision’ training, to ensure there is clear understanding and transparency around the supervision process throughout the organisation. The supervisee also needs to be able to trust supervisory confidentiality if they are to share personal issues, service user concerns, and observed risks and training needs without fear of inaction and/or negative outcomes for them.
- ***Principle Three: Peer Support*** – That the supervisor, as an experienced peer, actively wants to support worker practice and wellbeing, and can communicate knowledgeably about the supervisee’s workplace experiences and concerns. This form of peer support can provide an effective space for peer-to-peer support and modelling skills within wider staff teams.
- ***Principle Four: Collaboration and Mutuality*** – The supervision process is a two-way street, requiring a collaborative approach between supervisor and supervisee, and supervisor and organisation. Understanding the wellbeing needs of the workforce is mutually beneficial for the worker, the service user, and the organisation, given the negative impact on risk and safety poor worker wellbeing can have.
- ***Principle Five: Empowerment, voice and choice*** – Empowerment in relation to the supervision process, commences with the process being founded in training for the first time. Supervision knowledge can empower all stakeholders to take control of their individual supervision contribution, hold others accountable when the supervision process breaks down, and identify training and skills gaps. The effective supervision space can provide supervisees with a reflective learning environment, that encourages open and honest discussion, and the chance to be heard and taken seriously. The supervision format for each organisation is likely to be different, but what is discussed and in what order, should be agreed between the supervisor and supervisee, making sure that documents are user friendly for those with additional learning needs such as dyslexia. Supervisees would benefit from a choice of accessible supervision platforms such as online, telephone, face-to-face, and suitable times, given the 24 hours, and in the community nature of the USCW role.
- ***Principle Six: Cultural, historical and gender issues*** – Supervision in health and social care struggles with a culturally and historically poor reputation. Many USCWs have

had poor experiences with supervision and these poor prior experiences, pose a challenge to the introduction of a new approach to workplace support in this sector. The health and social care sector employ one in five women in the UK and is home to an ageing workforce. Awareness of more generic women's issues (e.g., familial caring responsibilities and the menopause for example), may help workers manage their wellbeing and work/life balance more actively, alongside more sensitive issues such as domestic violence and sexual assault, and how these factors can impact on worker wellbeing and practice. Additionally, a more nuanced understanding of male worker experiences in a largely female workplace environment, may help more 'direct care' recruitment and retention opportunities for male workers.

A trauma informed approach to supervision delivery directly responds to the needs and concerns raised within the USCW interviews by providing a safe, confidential and comfortable supervision space that feels collaborative, mutually responsive and beneficial, and where workers feel seen and heard. Cultural, historical and gender issues help contextualise the wider forces USCWs are exposed to, and can support a more considered, compassionate and informed response to worker practice and individual support needs. Together, a human factors and trauma informed approach to the supervision process can provide a more holistic, supportive and productive response to USCW wellbeing and organisational/individual practice.

7.9.3a Intrinsic Human Factors

Intrinsic human factors impact on workers and organisations in more personal and immediate ways. They affect the way supervision is experienced and delivered within organisations and can directly impact on how effective supervision processes can be facilitated and engaged with. Intrinsic human factors act as tangible, observable mediators that can be acted upon by individuals and organisations.

- ***Workforce Demographics*** – For organisations to identify and understand the overall and individual characteristics of their workforce such as gender, cultural, socioeconomic, and what this can mean in terms of wider worker wellbeing/safety considerations and training needs.

- ***Organisational Culture*** – Positive supervision cultures are adopted by the workforce and that organisations recognise an effective supervision culture is largely a top-down process, taking accountability for this role in the supervision process.
- ***Workplace Environment*** – That supervision is delivered in a safe, comfortable, and private environment, and considers the service user environment in relation to supporting worker needs.
- ***Poor Worker Wellbeing*** – The highly emotive nature of the role necessitates a wider worker wellbeing approach that considers a more holistic understanding of the types of risks and stressors experienced by the USCW workforce, given their demographic and characteristics.
- ***No Supervision Training*** – Supervision training should be a requirement for all those engaging with the supervision process. The training should be co-designed, user/needs led and accessible.
- ***Supervisor Skills*** – The delivery of effective supervision is an acquired skill. Acquired skills require initial and ongoing training and support for supervisors. Non-technical skills training (e.g., situational awareness, decision making, teamwork) to be considered as a mediator for both safe practice and effective supervision.

7.9.3b Extrinsic Human Factors

Extrinsic human factors represent the wider, indirect, and more unobservable systemic processes and barriers that impact on the direct provision of effective supervision. Individuals and organisations will have less agency and power to positively impact on these factors, although they are likely to feel the wider consequences of these forces.

- ***Supervision not Founded in Theory*** – The supervision process has never been conceptually founded in the health and social care sector. As such, providers and users of the process have no standards to learn or be guided from and are commonly left confused as to what supervision is, or how to use it. This has led to a piecemeal approach and poor supervision experiences.
- ***Inadequate Mandatory Training*** – Mandatory training focuses on the skills required to provide safe, efficient, and standardised care to service users, but has yet to include a 'worker' focused approach to safe and standardised worker care. This tends to reflect a workplace understanding of policy makers and not necessarily the workforce.

- ***Poor Research on the USCW Role*** – The unregulated social care workforce is subject to a dearth of theoretical and empirical data from which policy makers, organisations and workers can learn and develop practice and identify worker wellbeing needs. This impacts on the provision of responsive training development and support measures and fails to evidence the current situation and needs of the workforce.
- ***Impact of COVID-19*** – The pandemic has made an already stressful workplace environment, more challenging, and for many, has impacted on the provision of supervision. COVID-19 has also impacted on retention and recruitment, impacting on the availability of workers and skilled supervisors to engage in supervision.
- ***Low Wage/Social Status*** – A low wage sector economy, faced with increasingly reduced funding opportunities and career progression routes, contributes to a sector where undertaking the additional unpaid workload burden of what is commonly a poor supervision experience, is often considered not worth the effort. Low wage = low skills = low status = low support needs.
- ***Poor Retention and Recruitment*** – Short staffing means that supervisions are often rescheduled, do not occur regularly, or do not occur at all. A high turnover of staff, and no supervision skills induction training, adds to a lack of knowledge and understanding around the importance of the supervision space.

Both intrinsic and extrinsic factors work together to provide the foundation for a tentative conceptual supervision training model, that seeks to make wider sense of the supervision process, understand how it can become more responsive, effective and user friendly, and appreciate wider systemic forces and influences. It should be noted that the tentative conceptual supervision framework can be used as a fluid tool to reflect short and longer-term sector/workforce threats and trends, which are naturally subject to change.

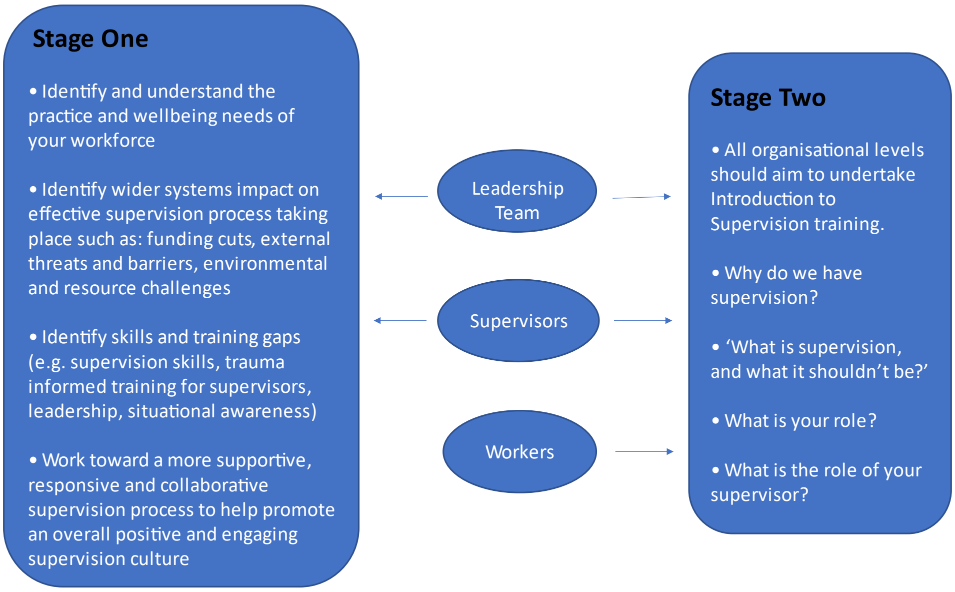
7.9.4 Human Factors and Trauma Informed Approach (HuFTI) Supervision Training model

This section will present a tentative new supervision training model, underpinned by the Conceptual Supervision Process Framework (see Figure 5). Phase Three was undertaken with the specific aim of finding a way to improve the current practical supervision situation for USCWs through some form of supervision training. The HuFTI training model begins to address intrinsic aspects of organisational and individual roles and responsibilities in working toward collaborative, productive, and meaningful supervision experiences. The model should be used as a co-participatory, ongoing process, that reflects the ever-changing landscape of the transient adult social care workforce.

7.9.4a Supervision Training Model

Figure 5

Human Factors and Trauma Informed (HuFTI) Supervision Training Model



Stage One

- Identify and understand the practice and wellbeing needs of your workforce
- Identify wider systems impact on effective supervision process taking place such as: funding cuts, external threats and barriers, environmental and resource challenges
- Identify skills and training gaps (e.g. supervision skills, trauma informed training for supervisors, leadership, situational awareness)
- Work toward a more supportive, responsive and collaborative supervision process to help promote an overall positive and engaging supervision culture

Stage Two

- All organisational levels should aim to undertake Introduction to Supervision training.
- Why do we have supervision?
- 'What is supervision, and what it shouldn't be?'
- What is your role?
- What is the role of your supervisor?

Stage One of the HuFTI supervision training model explores the cultural, wellbeing and more philosophical aspects of effective supervision processes, and is aimed at an organisational level. Stage Two of the training model involves ways to make the supervision training learning environment more inclusive, responsive to need, and productive; and offers training content suggested by the Phase Three focus group participants.

7.9.5 Stage One

Identify and understand the practice and wellbeing needs of your workforce: Combining both a HF and TI approach to improved supervision, this process involves getting to know your workforce, the daily workplace, and personal challenges they face, and how support and training can be best implemented to meet these needs. As evidenced across all three Phases, good worker health and wellbeing was recognised as essential to safe and consistent practice.

Identify wider systems impact on effective supervision processes: Recognising that the important and beneficial process of supervision sits within a set of wider impacting systems and forces, offers organisations a HF approach to managing these external factors more effectively. Raising organisational awareness of the wider barriers to effective supervision with all staffing levels (Allbutt et al., 2017; Rothwell et al., 2021), can help improve organisational supervision culture and skills, and situate accountability and responsibility more fairly (HSE, 2021a). For example, individual organisations taking steps to improve the overall poor reputation of supervision by starting to actively address the support and wellbeing inequalities of this vulnerable workforce.

Identify skills and training gaps: There are currently no provisions for supervision training for supervisees in the health and social care sector, and management supervision training remains unstandardised, ill-defined, and sporadic (Rees et al., 2020). Identifying and managing supervision skills and training gaps can enable workers to feel more prepared and take an active role in the supervision process (SCIE, 2017). The implementation of non-technical skills training can also help form the foundation for effective communication, decision-making, situational awareness, teamwork and leadership skills, all valuable qualities that can be used in the supervision process and beyond (Fore & Sculli, 2013; Gordon et al., 2015, 2017b; Toner, 2009; White, 2012). Those who supervise staff working with vulnerable and challenging service users, will benefit from undertaking a TI approach to supervision delivery training module.

Supervision culture: The Phase Three findings evidenced a concern that the poor reputation and culture of supervision in the sector presented as the biggest overall barrier to engagement with supervision training. Human factors recognises that worker behaviour is influenced by the culture within which an organisation operates (HSE, 2022a). The application of a new conceptual supervision process framework, however, begins the job of transforming the culture and reputation of supervision by providing standards and structures from which stakeholders can seek understanding, clarity, reassurance and accountability. Setting the right cultural tone around the supervision process (SCIE, 2017) can also help motivate supervision training engagement within the workforce and encourage supervision skills development, which can reap wider benefits outside of the supervision space.

7.9.6 Stage Two

When asked who should attend supervision training, all those who participated in Phase Three agreed that supervision training was something needed by all unregulated social care staff members, regardless of position, length of service or experience. The participants believed that everyone using and delivering the same supervision support principles would benefit the overall supervision training experience and help improve its reputation both organisationally and in the sector (HCPC, 2022). Sharing the supervision training space was also thought to lead to increased transparency, accountability, trust and mutual collaboration between the supervisee and their employer (Rothwell et al., 2021; SCIE, 2017). The participants believed that everyone using and delivering the same supervision support principles would benefit the overall supervision training experience and help improve its reputation both organisationally and in the sector (HCPC, 2022).

Getting the learning environment right: The learning environment matters, and for the Phase Three USCWs, this environment had to feel inclusive, engaging, open and relaxed. To aid learning and understanding, the participants felt it was important that the training was delivered in a cross-service, face-to-face group setting. It was agreed that a tick box type of online passive training experience would not facilitate the learning needed to mediate effective supervision experiences and would not support the USCW learners to ask questions, seek reassurances and connect with peers. The opportunity to share supervision experiences, skill sets and expectations with others in the same, or different role, was also thought to be hugely valuable as an opportunity for collaborative learning and mutual peer support (Chiriac, 2014; Mcenhill et al., 2016). As an extension to the training environment, supervision shortly after the supervision training session to check understanding of the training content, was raised by several of the Phase Three supervisors, thinking it would help cement learning, provide a safe space for questions, and commence the supervision relationship in a positive and structured way.

Supervision Training Content: Given the absence of any standardised supervision induction training and that for many, supervision did not take place at all, many of the Phase One USCWs did not really know what to expect from the supervision process, and this uncertainty led to feelings of anxiety, mistrust and a lack of agency. To make the supervision process more user friendly, empowering, and transparent, the focus group participants wanted to learn how to make supervision work for them, and they wanted this information in terms they can understand and relate to. As such, the Phase Three USCWs recommended including the following ‘Introduction to Supervision’ training content:

- What are the regulatory requirements for supervision in this sector?

- What is supervision?
- What should happen in a supervision?
- What should not happen in a supervision?
- What is my role within the supervision dynamic?
- What is my supervisor's role within the supervision dynamic?

What this feedback demonstrates is that despite supervision being used in healthcare since the 1990s and in social care since 2008, there is still confusion about what it is, and how to apply it in practice (Butterworth, 2022). An initial lack of conceptual framework, standardisation, and guidance since its introduction into health and social care, has served to confound supervision as an often-throwaway workplace gesture, with all participants finding the concept elusive, non-descript and often problematic. The HuFTI model seeks to structure the supervision process for the first time, creating a foundation from which to build and develop. The framework encourages a mindful approach to the supervision process, recognising that all organisational levels have an important part to play in making the supervision space effective, and contextualising the important role of worker wellbeing in enhancing service user safety (Carayon et al., 2014; Snowdon et al., 2017).

7.10 Moving toward a more effective supervision process

Moving forward, all participants were keen to 'draw a line' under the current supervision provisions and create something new and meaningfully fit for purpose. They recognised that supervisors and organisations had been subjected to a lack of training and support and that together the sector can help build a more supportive, informed and skilled approach to supervision to promote both worker and service user wellbeing and safety.

The contribution of a new conceptual supervision process framework begins the founding process for supervision in the unregulated social care sector for the first time. Recognising that supervision has an important role to play in worker, service user and organisational wellbeing, places worker support at the heart of safe and sustainable delivery of care and support. The addition of a Human Factors and Trauma Informed (HuFTI) supervision training model underpinned by the new conceptual framework, can provide all organisational levels with a practical, accessible, and more compassionate way forward to improving the effectiveness of the supervision process. Without responsive and effective worker health and safety, individuals will continue to be placed in spaces of unnecessary risk (de Winter & Hancock, 2021; Henriksen et al., 2008), and as the empirical findings and literature tells us, supervision is currently largely failing to meet the wellbeing and safety needs of health and social care workers.

7.11 Further Considerations and Implications for the Implementation of Supervision Training

For individuals and organisations to take full advantage of the supervision process, an environmental and cultural space must be created for this change to take place. We know that effective supervision when done well, improves role commitment, staff retention, reduces sickness absences and enhances worker and service user safety (Brunero & Stein-Parbury, 2008; Hawkins & Shohet, 2012; Knox et al., 2021; Tobias et al., 2016), yet many still struggle to implement supervision productively. We also know that abusive supervision is common in the health and social care sector which contributes to disgruntled workers, poor wellbeing and high staff turnover (Bhattacharjee & Sarkar, 2022; Bormann & Gellatly, 2022; Estes, 2013; Tepper et al., 2017). Underpinned by human factors, the new supervision training model aims to make clearer sense of the supervision process and provide organisations and individuals with a wider, more informed understanding of how and why effective supervisions must take place, and who to hold account when this does not happen.

Looking at incidences of poor supervision delivery and supervisee outcomes both in the data and the literature, it is easy to see why the blame for ineffective supervision often tends to lie with the supervisor or the supervisee (Field & Brown, 2019; Lee et al., 2019; Mackey et al., 2013; Martin et al., 2021; Shi et al., 2022; Zhang et al., 2021). The issue of poor supervision is more complicated than mere human shortcomings however. Firstly, individuals without the right training, experiences, qualities, resources, support and supervision can make for inadequate supervisors and/or supervisees; and secondly, they are also subject to wider forces that impact on their ability and capacity to be effective in their supervision role.

A human factors approach has already been used successfully in the health and social care sector to help support safer, more productive and informed working practices (Bañez et al., 2021; Hibbert et al., 2016; Jones et al., 2018; Timmins et al., 2015;). Its application to the proposed training model complements and promotes the overall goal of improved worker safety and wellbeing, and provides a structured framework upon which to begin the process of transparency, accountability, standardisation and compliance. Human factors champions a knowledgeable, skilled, supported and committed workforce through the provision of non-technical skills (NTS) training (e.g. communication skills; leadership skills; team-work skills; decision-making skills; and awareness), and focuses on how users manage equipment and processes in practice (Casali et al., 2019; Mitchell et al., 2011; Yule et al., 2006). Despite confusions around scope of use and the skills required for effective delivery, the supervision process itself sits nicely within the HF umbrella given at its heart is the safe and progressive provision of high quality health and social care, although how it is being currently understood and used requires improvement and modernisation.

The provision of effective supervision and a positive supervision culture is a largely top-down process (Field & Brown, 2016; NHS England, 2023; Skills for Care, 2020) that requires organisational buy-in and an improved sector-wide approach if it is to achieve widespread generalisability and sustainability. The appropriate use of supervision, however, is an individual, organisational and regulatory issue and for this issue to be ameliorated, all stakeholders must be encouraged to take responsibility for the part they play within the process. A human factors approach can expose and lay bare the scope of responsibility and accountability for all those involved with supervision, helping them understand how their role impacts and what can be done to improve their contribution to the process. The absence and/or poor delivery of supervision, can result from a variety of factors including: staff shortages, poor recruitment, increased responsibilities, inadequate training and resources and worsening wellbeing/sickness absences (Allbutt et al., 2017; Bourn & Hafford-Letchfield, 2018; Rothwell et al., 2021; Sarre et al., 2018), and the HuFTI supervision training model alone cannot directly address these issues. However, it can start to consider and help mitigate them through the provision of a user-informed, accessible training model, offering a more structured, formal, empowering and knowledgeable place for users of the supervision process to start.

Given the impact of workforce, time, money and resources constraints, supervision training may also represent just another unnecessary piece of unpaid training for already overstretched workers and organisations. The training also constitutes the first piece of training USCWs will undertake that focuses on them and their supervision/wellbeing needs which may illicit difficult feelings for some. Many of the participants in Phase One noted that they found it difficult to put their needs first, although they also recognised that supervision was a formal part of their role, and they wanted to make better use of it. The training should be implemented and offered in a considerate and supportive way, recognising that psychological and cultural barriers to supervision training engagement exist that require sensitive management and reframing.

Supervision has been used poorly in the unregulated social care sector since its introduction, and it will take time to fully integrate the training and new approach into current practice and workplace culture. Wider implementation of the training can be rolled out, with an extended timeframe for completion of two years, for example, to accommodate this cultural shift whilst emphasising the value of the training to the worker and the organisation. A significant proportion of unregulated social care work is undertaken on a zero-hours basis, involves lone-working and/or changeable shift patterns, making it challenging to attend easily and without related costs to the individual or their organisation. To address the issue of accessibility, the implementation of supervision training for all supervisees will be considered as a more standardised and commonplace activity.

The case for regulating the activity of supervision is not a case for regulating the unregulated social care sector. Already regulated by the CQC (Regulation 18), supervision 'must' be given to those who work in regulated health and social care services even if the role itself is not regulated (CQC, 2023). The term 'regulated' in relation to the provision of supervision is, however, arguably a toothless one when in practice all that is needed is for organisations to evidence supervisions are taking place, and in cases where this is not occurring, there are no enforceable sanctions available. The CQC do not provide any standardised training for organisations to meet this regulation, nor do they measure quality and effectiveness of supervision provision, despite its regulated status. Therefore it is not that the supervision process or the absence of related training needs further regulation, but that the current regulation itself requires improvement, underpinned by theory and empirical evidence. The lack of regulatory guidance in this case seemingly reflects the lack of theoretical, conceptual and user understanding of the supervision process in this sector.

Despite a paucity of empirical evidence related to the benefits and positive causal links of health service regulation, (Bullock & Browne, 2020; Dunbar et al., 2023; Sutherland & Leatherman, 2006), regulation is used in health and social care to provide the governance and oversight for the provision of high quality care (Dunbar et al., 2023). Acknowledging that health and social care roles, activities and services require a light touch in relation to regulation, the government recognises that a combination of regulatory and individual approaches are needed to strike the right balance of freedoms and safety measures (DHSC, 2019; Great Britain Law Commission et al., 2014). Regulations in health and social care are primarily concerned with the rights, risks and safety of patients and service users (Browne et al., 2021; Mathias, n.d.), with worker health, safety and practice requirements in the unregulated social care sector regulated by the HSE and CQC (CQC, 2022; HSE, 2022a, 2022b, 2023). Whilst the concept of supervision is scantly covered, neither the HSE nor the CQC have made adequate provisions for the safe, effective and standardised use of the supervision process in the unregulated social care sector. This new conceptual framework and training model can begin to address this knowledge gap and puts forward a case for both organisational and individual responsibility taking in relation to ensuring effective supervisions are taking place.

It seems shortsighted and unrealistic for both organisations and workers to meet a regulation for which there is no generic training, and it is no wonder the regulation remains hard to pin down and deliver. To recognise this status an argument is put forward for the inclusion of supervision training for supervisees within the Care Certificate. The Care Certificate is provided by Health Education England and is used in social care to induct and assess new members of staff (Taylor, 2022). Whilst completion of the Care Certificate is not a legal requirement, there is an 'expectation' that new workers to the sector, or those undertaking inductions to new services will be supported to complete the training partially, or in full, dependent on need (UNISON, 2015). Training regulation for health and social care services, 'is' enforceable however, and comes under the purview of the CQC, who will expect to see organisations undertaking induction programmes that meet Care Certificate standards (HEE, 2023; NHS Employers, 2023; UNISON, 2015). The certificate is made up of fifteen standards that set out the knowledge, skills and behaviours expected from social care workers, and is part of the wider induction process (Taylor, 2022). The Care Certificate is designed to help safeguard service users, and in turn, safeguards USCWs by providing a clear set of safe and high standards (Haigh, 2019). Supervision, however, plays an important role in assessing whether these standards are being met and what can be done to meet any further learning needs, yet learning how to use supervision effectively is not one of the current Care Certificate standards.

By including the training within the Care Certificate and/or as part of the protected space of the induction/learning environment, the regulated activity of effective supervision for supervisees can begin to become the norm. Initially, attendance on the new training could be staggered to include new Care Certificate learners and those going through a new service induction. Although to promote a more individual and self-efficacious approach, volunteers from the wider workforce should be immediately encouraged and accommodated, alongside referrals for those who have been identified as likely benefitting from the training. The provision of effective supervision is noted as a ‘must’ by the CQC (CQC, 2023), and the new training model reflects and acknowledges the importance of the supervision process in relation to both service user and worker health and safety. Consequently, all workers in receipt of supervision should be encouraged to complete the training as soon as is practically possible. Given the complexity of the issue and the potential for large-scale impact, a feasibility study of the training pilot should also be considered before implementation.

7.12 Next Steps: Feasibility Study

When planning to undertake a project of this nature, exploring feasibility prospects and pitfalls can help benefit the overall concept and delivery of the intervention by identifying potential risks and uncertainties before the project begins (In, 2017; Pearson et al., 2020). A feasibility study, or pilot, is a way of evaluating whether a project has a chance of being practically successful, especially when there is an opportunity for large scale impact (Martins, 2023). In this case, we need to consider the impact training can have on supervisees, service users and organisations, given the facilitation of effective supervision takes additional skills, time, commitment and effort.

In healthcare, which has been the focus of increased resource-constrained conditions, the failure to translate effective healthcare ideas into interventions, necessitates the improved use of evidence-based feasibility strategies to optimise outcomes for improved public health

(Bauer et al., 2015; Pearson et al., 2020). Early conceptual health education models indicate that interventions (e.g. new policies, regulations, equipment or practice) should focus on changeable behaviours; be based on empirical evidence; be relevant to the target group; and have the potential to meet the goals of the intervention (Bartholomew et al., 2006; Bowen et al., 2009). Using these markers, the goals of this supervision training intervention will be further explored. Improved supervision provisions require a change in supervisee, supervisor and organisational behaviour and training for supervisors is already established, although largely elective. How supervision is understood, delivered and utilised is therefore a changeable behaviour and one that has been observed to improve through additional training and support (Lee et al., 2019; Rees et al., 2020). The basis for this intervention is the empirical evidence gathered from current users of the unregulated social care supervision process who universally agreed that supervision lacks standardisation and effective delivery. The intervention is therefore relevant to the target group, has been identified as being needed by supervisees and supervisors, is aligned with the specific wants and needs from the target audience, and is considered to have the potential to be successful given there is nothing currently in place to meet supervisee needs.

There is significant literature on the need for improved supervision in regulated health and social care (Bhattacharjee & Sarkar, 2022; Fischer et al., 2021; Knox et al., 2021; Martin et al., 2021; Tobias et al., 2016) and a large public health provider has already been contacted in relation to the implementation of a pilot. In recognition of the need for improved supervision and the benefits of effective supervision, a provisional agreement to provide participants to engage in the training is in place. Supervision training for ‘supervisees’ has not been previously considered by health and social care regulators, therefore a feasibility study can provide valuable feedback around its likelihood for success and the need for any improvements. The scope of the training intervention is two-fold. As a top-down process, stage one of the training process involves engaging with leadership teams and supervisors through the service provider, to help raise awareness of workforce demographics and the needs and vulnerabilities associated with the H&SC workforce. Additionally, stage one can help organisations and individuals identify supervision skills with the aim of promoting a more mutually beneficial, transparent, collaborative, safe, supportive and compassionate approach to why and how the provision of effective supervision is important for worker, service user and organisational wellbeing.

A feasibility study can help support the identification of barriers and enablers during this stage given the impact of resource, time and economic constraints. Organisational change requires an accessible, influential and meaningful approach for stakeholders if it is to be adopted and assimilated into practice (Nilsen et al., 2020; Weiner, 2009). Therefore understanding the organisational barriers to the uptake and implementation of the stage one process during the feasibility study can help streamline and troubleshoot in readiness for future wider dissemination. Stage one of the training process will be approached first, but it is recognised that stages one and two can be run concurrently to reflect the workforce need for an ongoing/rolling supervision training intervention.

The content for stage two of the intervention, supervision training for supervisees, has already been empirically established by the study participants during all three phases of the study, and can be organised into a training presentation. Subsequently, one of the purposes of the feasibility study would be to ascertain whether the training needs raised are representative of wider unregulated social care workforce supervision needs, or if additional elements require further consideration. An important goal of the training is to help establish role accountability during the supervision process, and that workers, regardless of length of service or role, complete the training together. Supervision was identified as a culturally challenging and frustrating workplace support experience for many participants and a feasibility study would be able to show whether this inclusive approach is feasible, given a shared training space may inhibit the voices of either or both supervisee or supervisor.

In relation to more practical elements of training delivery, a feasibility study can also help establish whether less or more time is needed than the half-day originally planned, and whether an in person or online approach is more favoured given time, travel and shift constraints. For evaluation purposes, data can be gathered through both quantitative and qualitative means, in the form of questionnaires, learner feedback sheets, semi-structured interviews and focus groups. Quantitative data, gathered more immediately and undertaken throughout both stages one and two, can help provide first impressions and analyses around how participants are experiencing the training content and delivery. Data gathered at these early stages can help provide snapshots of how learners felt before and after training, whether the language and resources used are accessible and what they liked and disliked about delivery and content. Qualitative data gathered after the training has been taken back into the workplace, can help support a more meaningful understanding of what the experience of supervision training means for supervisees and how they are, or intend to, implement the new learning moving forward. To measure the ongoing impact of the training on worker wellbeing and practice, both supervisees and organisations will be approached post training. Revisiting the experiences of participants can help improve our understanding of the effectiveness of the pilot and whether changes, which could be identified through the use and delivery of supervision over a 6-12 month period, have noted any improvements to supervision frequency, worker wellbeing/sickness absences, performance and/or areas that require further consideration.

7.13 Transferability of the Training Model

Effective supervision can improve worker wellbeing, attendance and commitment to the role, and it can reduce sickness absences, errors, and turnover (Brunero & Stein-Parbury, 2008; Knight, 2018; Koivu et al., 2012; Tobias et al., 2016). Nevertheless, effective supervision requires learned skills to manage well (Rothwell et al., 2021). These positive outcomes are likely beneficial to all stakeholders in jobs that have a supervision requirement and not just those represented in the study sample, and as such the learning of these supervision skills is important. Whilst the training model is derived from the findings, arguments, and intervention ideas relating to some populations of the unregulated social care workforce, the model does not solely focus on the supervision needs of those sub-populations. Instead, the model provides an adaptive framework that helps support and improve awareness of the fundamentals of the effective process and delivery of supervision, which can then be shared across other sectors.

The study sample included home care and learning disability support workers, alongside more specialised workers providing homelessness, substance misuse, mental health, behavioural and offender support. It is not just that these individuals share challenging occupational and environmental similarities with more traditional caring roles (e.g. nursing home care workers, doctors, nurses and other allied professionals), they will also likely work with the same vulnerable and sometimes harmful service users given their often complex needs. A resident of a homeless hostel, for example, will be receiving support from the hostel worker, but running alongside this, may also have health, housing, criminal justice and social work support interventions in place. Should this resident be physically violent toward one, or all of these workers, regardless of role and regulated status, that worker should have access to an effective supervision process to help manage the experience.

The training model does not only achieve transferability through direct occupational comparison but by understanding that the status of the worker as a vulnerable, feeling human being, requires support regardless of regulated or unregulated status. The transferability between a study sample and the wider audience occurs when the audience feels a sense of overlapping resonance that they can meaningfully and intuitively apply to their own circumstances (Tracey, 2010). In this case, it is the supervision training model itself that provides the vehicle for transferability to take place. This occurs, not just through observable occupational similarities, but by recognising that the effective process of supervision can subjectively help individuals feel more empowered to take control of their practice and workplace wellbeing needs. The need for improved supervision in both the regulated and unregulated health and social care professions, not represented within the participant sample, is also well noted (Estes, 2013; Knox et al., 2021; Koivu et al., 2012; McLaughlin et al., 2019; Rees et al., 2020.

Furthermore, there are other occupational sectors who work with distressed individuals and in challenging workplace environments, and who will also have access to supervision as a worker wellbeing support mechanism, such as the emergency services and probation/prison officers (Coley, 2020; College of Policing, n.d.; GOV.UK, 2022c). Understanding the current state of supervision delivery and engagement in occupations outside of the sample group, and as well as their specific needs, requires further testing. However, the training can help provide a valuable framework from which all those in receipt of supervision can benefit and learn, given the training is not role specific but more ‘supervision process’ specific. The impact of poor supervision is a transferable issue for potentially millions of workers and their vulnerable service users, and the proposed training begins the process of unpicking how we can start to standardise and improve this vital workplace support process.

7.14 Chapter Summary

This chapter provides the first attempt at presenting a theoretically and empirically conceptualised understanding of the unregulated social care workforce's unique wellbeing, practice, and support needs, and sets the current context of a workforce in crisis. With a projected need for nearly half a million more USCWs by 2035, there is an urgent need for improved workforce wellbeing, retention, and recruitment. The workforce is exposed to risk in myriad ways, which impacts on their physical and emotional health and wellbeing, which has wider harmful psychosocial and financial consequences. Inadequate support and supervision compounds these risks further.

Exposure to violence, abuse and the traumas of others is common in the health and social care sector, as is being required to work in poor quality workplace environments. The workforce, and the risks they encounter are both hidden and unseen, meaning that their needs and skills can be over/underestimated, leading to inadequate training and support, and increased risk to worker and service user safety. The relationship between worker experiences of personal vulnerability and increased empathy for vulnerable others, also appeared to enhance levels of compassion and role commitment. However, these characteristics are also factors for burnout, exploitation and abuse from others, and need understanding and managing better in a sector where an empathic and relational approach to care is essential.

Traditional health risk models and concepts fail to explain and subsequently manage more complex, subjective, and psychosocial aspects of health risk behaviour, and a more holistic and nuanced understanding of how and why individuals behave in the way they do, is needed. The inclusion of a more trauma informed approach to understanding the experiences and needs of the unregulated social care workforce can help provide a more nuanced, compassionate, and safer way of working. Complemented by a human factors framework which can provide a more holistic perspective on unregulated social care worker supervision provisions, a human factors and trauma informed approach to the USCW supervision process is presented as a practical means of improving both worker wellbeing and safe practice.

The following sections discuss the strengths, weaknesses, and recommendations of the inquiry. In a study where the aim was to create the platform for a new approach to understanding and therefore effectively managing worker wellbeing, limitations were seen as steppingstones to success as the iterative analysis process became more progressively synthesised. Three recommendations are proposed, grounded within the study, with some requiring more urgent attention than others, although the overall lack of extant data on this vital workforce requires immediate rectification. The conclusion closes the study.

7.15 Strengths and Weaknesses

Unshackled by a lack of extant theoretical and empirical literature and emboldened by lived experience, I was free to enjoy the opportunity to be creative, self-determining, and brave. This freedom resulted in a fluid, exploratory and progressive approach. A lack of prior literature, theoretical underpinning, and general lack of consideration around the USCW group, meant I was free to forge ahead and attempt to break new ground. Limitations are described here as strengths and weaknesses, as each literary and theoretical cul-de-sac led to a more creative and wider problem-solving approach. As insider/researcher and solution focused practitioner, the concept of limitations is attached to the philosophical concept of change, growth, and resilience, which is viewed here as a strength. Weaknesses and limitations can also be viewed as a natural pathway to improved systems of thinking, understanding, and action, and are viewed here as necessary for progress and innovation.

Whilst the approach to recruitment was purposive, and in line with IPA guidance on small sample sizes (Smith et al., 2013), the diverse range of roles within the unregulated social care sector meant participants would likely present with a variety of different responsibilities, experiences, and workplace environments, which is representative of the wider USCW group. However, what each participant shared with the next, was their passion for helping others, exposure to risk of individual harm to wellbeing, and poor supervision experiences. As a study group, these same factors are also representative of the extant literature on regulated health and social care workers, and this sample can offer an authentic and representative perspective on wider health and social care worker experiences.

The concept of this study was developed prior to the COVID-19 pandemic, although by the time the Phase One data collection process began, the participants had already worked through the first lockdown. COVID-19 changed the way in which this study was executed, with most interviews being conducted online. Initially this was perceived as a significant limitation given the researcher’s extensive face to face interviewing experience, and there were concerns about how the interviews would flow and be relationally facilitated. Despite some participants feeling unable to comfortably use online meeting forums, and that some potential participants may have been put off by the online process, offering online interviews did give participants flexibility, and a safe and comfortable space within which to share.

Online platforms can also encourage active listening, given online interviewing promotes a one person only speaking model. Despite its initial limitations, the COVID-19 pandemic has situated online meetings as the new norm, with some Phase One face-to-face interview participants, successfully engaging in Phase Three through online meeting platforms. In relation to the Phase Three data collection phase, several participants were unable to attend due to covering shifts at short notice, which is commonplace in this sector. Technological difficulties poses a persistent limitation to online engagement for us all, and one participant was unable to join in. In these instances, the smaller online focus group numbers did not detract from the atmosphere or flow of the session.

7.16 Recommendations

Given the breadth and depth of the interview data and the scope of the subsequent findings, recommendations will be approached in relation to immediate actions and longer-term considerations. Improvements to worker wellbeing support and supervision requires immediate attention to help stem increasingly problematic practice, recruitment and retention issues, amid a cost-of-living crisis and a COVID 19 pandemic.

7.16.1 Supervision training pilot and evaluation for workers

The first recommendation is suggested with a sense of urgency and involves the development and delivery of a more effective, compassionate, safe, and productive supervision training experience, given the potential for positive worker growth, wellbeing, increased commitment to role and improved management of risk. Underpinned by the HuFTI model, the training should be piloted to test its feasibility before wider dissemination. This research provides a candid and comprehensive look at the wellbeing and supervision experiences and needs of a cohort of unregulated social care workers, and a further study can help scope and pilot introduction to supervision training sessions to a broader audience. This would require the support of a provider(s), who would help facilitate participant involvement and a practical space within which to deliver the study and gather feedback for evaluation.

The supervision process is an established part of workplace support in health and social care. However, it is largely not being delivered effectively, or at all at times. By starting to optimise current organisational supervision processes, we can make an immediate impact without the need for additional and difficult structural changes and responsibilities. It is recognised that for many, the introduction of an effective supervision process will require change, and that change can be difficult. It is therefore recommended that future studies explore using insiders as researchers and training facilitators, given a sense of shared relational empathy and experience proved beneficial in gathering rich and meaningful experiences. Wider dissemination once the training has been successfully tested is immediately recommended, with the resulting 'Introduction to Supervision Training' module introduced into current care training frameworks to promote and normalise best supervision standards throughout the sector.

7.16.2 The provision of a trauma informed approach to USCW supervision and overall worker wellbeing

This recommendation pertains to the carrying out of studies that seek to explore the provision of a more trauma informed approach to supervision and overall worker wellbeing, given this workforce is exposed to both personal and occupational trauma. Empirical data, that seeks to specifically understand and support the relationship between empathy and worker lived experiences is highly recommended, given current studies do not represent this worker group. It is further recommended that to gather this sensitive knowledge, an interpretative phenomenological analysis (IPA) methodological approach is utilised.

The IPA methodology helps to facilitate a double hermeneutical circle, which supports both subjective and shared social experiences. In this way, individuals are encouraged to share their understanding of their world and their place within it. As hidden and unseen and as vulnerable and exploited, the unregulated social care workforce benefits from a more considerate, nuanced, and subjective approach to research impact. Interpretative phenomenological analysis also recognises the hermeneutic role of the researcher, encouraging insider approaches to skilled interpretation and philosophical reflexivity.

Given the study participants felt the nature of the insider/researcher role fostered a safer and more relaxed interview environment, an IPA approach can help provide a more accessible and responsive methodological approach to future studies within this occupational group.

Studies of this kind would benefit from a more supportive and mindful approach to researcher wellbeing given the potential for exposure to distressing and triggering narratives is inadequately covered in current IPA literature.

7.16.3 Exploring the relationship between lived experiences and choice of occupation

It is finally recommended that further research explore the relationship between unregulated health and social care worker lived experiences and how this can prime and impact on their occupational choices, and the non-technical skills required within these occupations. The comprehensive sharing of both lived experience trauma and mental health challenges by the research participants, provides the foundation for this recommendation. Additionally recommended is further exploration around how these findings can help improve recruitment, training, and wider workplace support provisions.

7.17 Conclusion and Contributions to Knowledge

The aim of this thesis was to uncover the lived and supervision experiences of a group of unregulated social care workers, how these experiences impacted on their wellbeing and what can be done to improve wellbeing through the supervision process. There are over four million social care, healthcare, voluntary and charitable workers in England and Wales, many of whom will share experiences and demographics with the participants in this study. However, whilst studies persistently evidence worker wellbeing as critical to service user health and safety in regulated health and social care, the situation worsens for unregulated and regulated workers alike, their service users and the sector.

This thesis makes a welcomed contribution to knowledge by making the unregulated social care worker visible as human being for the first time. The study attests to the wider barriers, inequalities and vulnerabilities unregulated social care workers are exposed to, and adds meaningful discourse to the vital conversations around nurturing and sustaining a committed, productive, and valued health and social care workforce. This study phenomenologically explores the hidden and unseen wellbeing, risks and supervision experiences/needs of unregulated social care workers, and proposes a way forward to improve USCW workplace wellbeing through more effective supervision, providing a starting point for much needed empirical and theoretical future research.

Methodologically, this inquiry represents an innovative phenomenological approach to exploring the wellbeing of the unregulated social care workforce. The IPA approach was selected based on the status of the researcher as an insider in the sector and former social care practitioner. Future research would benefit from adopting a similar participatory approach, as this inquiry successfully fostered an open, relational, and trusted response from participants, with most noting that the researcher's status as insider was instrumental in them engaging so candidly and enthusiastically with the interview process.

Phase One provides an authentic, candid, and at times emotional glimpse into the individual lives and struggles of USCWs and represents an authentic sector specific phenomenological inquiry into the lives of this too often ignored workforce. Uncovering widespread experiences of both workplace and personal risk, vulnerability and exploitation, this thesis opens a dialogue around the relationship between lived experiences of prior victimisation and inequality, and how these factors seemingly helped shape and prime the Phase One participants for work within the low-paid, harmful, unequal, and risk-laden unregulated social care workplace.

The Phase Two findings echoed and validated the challenging, unstructured, and inadequate supervision experiences shared by the Phase One participants. Phase Two reinforced the image of supervision as largely ineffective in practice, having a poor reputation throughout the sector, and lacking in any form of conceptual foundation, structure and appropriate training. Phase Two does, however, contribute to knowledge around the wellbeing impact of supervision on the supervisor, with some examples of good supervision practice.

Findings from Phases One, Two, and Three, integrated with a human factors and trauma informed approach to support, underpin a new conceptual supervision process framework, which provides a bridge into the novel Human Factors, Trauma Informed (HuFTI) supervision training model. Conceptually, the new supervision process framework provides a wider appreciation of the intrinsic and extrinsic factors that serve as barriers to the provision of effective supervision. The framework enables organisations, professionals, and policy makers to identify and go on to more effectively manage the wider forces that impact on worker wellbeing and poor supervisions. Building on the conceptual supervision framework, a human factors trauma informed (HuFTI) supervision training model, provides a two-stage process for cultural change, supervision delivery and learning. Effective supervision can benefit worker wellbeing, practice, and service user safety, yet most USCWs have little to no idea what supervision is, or how it can be used to improve practice, commitment to role and recruitment.

The provision of a supervision training module that helps empower and educate workers, supervisors, and organisations to manage and understand the importance of not only caring for service users but for each other, is an important step forward for this hidden and unseen workforce. A poor supervision process is only part of the problem, and this vulnerable workforce sit within a wider, complex system of inequality, socio-economic, psychosocial, and socio-political factors that serve to compound risk to worker health and wellbeing. What improving the supervision process can do however, is provide the opportunity for workers to reflect, learn, and be supported to better manage the stressors they are subjected to from wider forces.

To conclude, this thesis makes an innovative contribution to new knowledge as the first conceptual attempt at contextualising, framing, and understanding the lived and supervision experiences of the unregulated social care workforce, and the risks to worker wellbeing of unsafe work practices. Through the iterative analysis and synthesis of extant literature and new empirical findings, this study forges ahead by uncovering hidden and unseen worker risk, exploitation, and vulnerability, and provides a conceptual framework for supervision and a model for supervision training, which provide the foundation for practice development and future research.

References

Aagestad, C., Tyssen, R., Johannessen, H. A., Gravseth, H. M., Tynes, T., & Sterud, T. (2014). Psychosocial and organizational risk factors for doctor-certified sick leave: A prospective study of female health and social workers in Norway. *BMC Public Health*, *14*(1). https://doi.org/10.1186/1471-2458-14-1016

Abraham, C., & Sheeran, P. (2015). The health belief model. *Predicting and Changing Health Behaviour*, *2*, 30–69. https://www.researchgate.net/publication/290193215

Abrahams, C. (2020, June 26). *The future of care for older people*. Age UK. https://www.ageuk.org.uk/discover/2020/06/the-future-of-care-for-older-people/

Acocella, I. (2012). The focus groups in social research: Advantages and disadvantages. *Quality and Quantity*, *46*(4), 1125–1136. https://doi.org/10.1007/s11135-011-9600-4

Adams, J. M. (2019). The value of worker well-being. *Public Health Reports*, *134*(6), 583–586. https://doi.org/10.1177/0033354919878434

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, *76*(1), 103–108. https://doi.org/10.1037/0002-9432.76.1.103

Adiga, A., Dubhashi, D., Lewis, B., Marathe, M., Venkatramanan, S., & Vullikanti, A. (2020). Mathematical models for COVID-19 pandemic: A comparative analysis. *Journal of the Indian Institute of Science*, *100*(4), 793–807. https://doi.org/10.1007/s41745-020-00200-6

Ahn, J., Dik, B. J., Rickard, K., Fisher, G., & Eakman, A. M. (2016). *The experience of career change driven by a sense of calling: An interpretative phenomenological analysis approach* [Colorado State University]. https://api.mountainscholar

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies*, *5*(2), 9. https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

Alaszewski, A., & Coxon, K. (2009). Uncertainty in everyday life: Risk, worry and trust. *Health, Risk and Society* (Vol. 11, Issue 3, pp. 201–207). https://doi.org/10.1080/13698570902906454

Albert, A. (2020, May 18). *Care workers vital during COVID-19 but are unwelcome and unskilled in immigration bill*. Homecare.Co.Uk. https://www.homecare.co.uk/news/article.cfm/id/1626007/Care-workers-needed-during-covid-19-but-unwelcome-and-called-unskilled-in-immigration-bill

Alderwick, H., Tallack, C., & Watt, T. (2019, August 30). *What should be done to fix the crisis in social care? Five priorities for government*. The Health Foundation. https://www.health.org.uk/publications/long-reads/what-should-be-done-to-fix-the-crisis-in-social-care

Alegría, M., Fortuna, L. R., Lin, J. Y., Norris, F. H., Gao, S., Takeuchi, D. T., Jackson, J. S., Shrout, P. E., & Valentine, A. (2013). Prevalence, risk, and correlates of posttraumatic stress disorder across ethnic and racial minority groups in the United States. *Medical Care*, *51*(12), 1114–1123. https://doi.org/10.1097/MLR.0000000000000007

Alegría, M., NeMoyer, A., Falgàs Bagué, I., Wang, Y., & Alvarez, K. (2018). Social determinants of mental health: where we are and where we need to go. *Current Psychiatry Reports* (Vol. 20, Issue 11). Current Medicine Group LLC 1. https://doi.org/10.1007/s11920-018-0969-9

Allbutt, H., Colthart, I., El-Farargy, N., Sturgeon, C., Vallis, J., & Lough, M. (2017). Understanding supervision in health and social care through the experiences of practitioners in Scotland. *Journal of Integrated Care*, *25*(2), 120–130. DOI:10.1108/JICA-11-2016-0046 https://www.researchgate.net/publication/316138067_Understanding_supervision_in_health_and_social_care_through_the_experiences_of_practitioners_in_Scotland

Allen, J., & Sesti, F. (2018). *Health inequalities and women-addressing unmet needs*. https://www.bma.org.uk/media/2116/bma-womens-health-inequalities-report-aug-2018.pdf

Allen, L., Williamson, S., Berry, E., & Alderwick, H. (2022, October 11). *The cost of caring: Poverty and deprivation among residential care workers in the UK*. The Health Foundation. https://www.health.org.uk/sites/default/files/pdf/2022-10/2022%20-%20The%20cost%20of%20caring.pdf

Alnazly, E., Khraisat, O. M., Al-Bashaireh, A. M., & Bryant, C. L. (2021). Anxiety, depression, stress, fear and social support during COVID-19 pandemic among Jordanian healthcare workers. *PLoS ONE*, *16*(3 March). https://doi.org/10.1371/journal.pone.0247679

Alsaigh, R., & Coyne, I. (2021). Doing a hermeneutic phenomenology research underpinned by Gadamer's philosophy: A framework to facilitate data analysis. *International Journal of Qualitative Methods*, *20*. https://doi.org/10.1177/16094069211047820

Aluwihare-Samaranayake, D. (2012). Article ethics in qualitative research: A view of the participants' and researchers' world from a critical standpoint. *International Journal of Qualitative Methods*. https://doi.org/10.1177/160940691201100208

Alvinius, A. (2012). The inadequacy of bureaucratic organizations organizational adaptation through boundary spanning in a civil-military context. *Res Militaris* (Vol. 3, Issue 1). https://www.researchgate.net/publication/262814192

Amraei, S., Malekshahi, F., Goudarzi, F., & Ebrahimzadeh, F. (2020). Using an educational program based on health belief model to improve the preventive behaviors of nurses against cardiovascular diseases. *Journal of Education and Health Promotion*, *9*(1). https://doi.org/10.4103/jehp.jehp_620_19

Anderson, J. G., & Abrahamson, K. (2017). Your health care may kill you: Medical errors. *Studies in Health Technology and Informatics*, *234*, 13–17. https://doi.org/10.3233/978-1-61499-742-9-13

Antão, H. S., Sacadura-Leite, E., Manzano, M. J., Pinote, S., Relvas, R., Serranheira, F., & Sousa-Uva, A. (2020). Workplace violence in healthcare: A single-center study on causes, consequences and prevention strategies. *Acta Medica Portuguesa*, *33*(1), 31–37. https://doi.org/10.20344/amp.11465

Appleton, J. V, Pgcea, R., Hospital, R., Bn, L. K., Appleton, J., Appleton, J., & Appleton, J. V. (2002). Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health services research. *Journal of Advanced Nursing*, *40*(6), 641–648. https://doi.org/10.1046/j.1365-2648.2002.02424.x

Armario, A., Vallès, A., Dal-Zotto, S., Márquez, C., & Belda, X. (2004). A single exposure to severe stressors causes long-term desensitisation of the physiological response to the homotypic stressor. *Stress* (Vol. 7, Issue 3, pp. 157–172). https://doi.org/10.1080/10253890400010721

Armstrong, P., & Armstrong, H. (2004). Thinking it through: Women, work and caring in the new millennium. *Canadian Woman Studies*, *12*(4), 5. https://www.researchgate.net/publication/279510606_Thinking_it_Through_Women_and_Work_in_the_New_Millennium

Armstrong, P., & Armstrong, H. (2009). Precarious employment in the health care sector. *Gender and the contours of precarious employment* (1st ed., pp. 256–270). https://www.researchgate.net/publication/265157933

Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. (2015). Underreporting of workplace violence: Comparison of self-report and actual documentation of hospital incidents. *Workplace Health and Safety*, *63*(5), 200–210. https://doi.org/10.1177/2165079915574684

Ashforth, B. E. (1997). Petty tyranny in organizations: A preliminary examination of antecedents and consequences. *Canadian Journal of Administrative Sciences*, *14*(2), 126–140. https://doi.org/10.1111/j.1936-4490.1997.tb00124.x

Atkinson, C., Crozier, S., & Lewis, L. (2016). Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care. *Welsh Government*. https://www.gov.wales/sites/default/files/statistics-and-research/2019-07/160317-factors-affect-recruitment-retention-domiciliary-care-workers-final-en.pdf

Aven, T. (2016). Risk assessment and risk management: Review of recent advances on their foundation. *European Journal of Operational Research*, *253*(1), 1–13. https://doi.org/10.1016/j.ejor.2015.12.023

Aven, T., & Renn, O. (2009). On risk defined as an event where the outcome is uncertain. *Journal of Risk Research*, *12*(1), 1–11. https://doi.org/10.1080/13669870802488883

Ayers, S., Baum, A., McManus, C., Newman, S., Wallston, K., Weinman, J., & West, R. (Eds.). (2014). *Cambridge handbook of psychology, health and medicine* (2nd ed.). Cambridge University Press. doi:10.1017/CBO9780511543579 https://assets.cambridge.org/97805218/79972/frontmatter/9780521879972_frontmatter.pdf

Baines, D., & Armstrong, P. (2019). Non-job work/unpaid caring: Gendered industrial relations in long-term care. *Gender, Work and Organization*, *26*(7), 934–947. https://doi.org/10.1111/gwao.12293

Baines, E. (2022, October 21). Workforce crisis responsible for ‘gridlocked’ health and social care system. *Nursing Times*. https://www.nursingtimes.net/news/workforce/workforce-crisis-responsible-for-gridlocked-health-and-social-care-system-21-10-2022/

Baldwin, A., Mills, J., Birks, M., & Budden, L. (2017). Reconciling professional identity: A grounded theory of nurse academics’ role modelling for undergraduate students. *Nurse Education Today*, *59*, 1–5. https://doi.org/10.1016/j.nedt.2017.08.010

Baldwin, T. (2013). Merleau-Ponty’s phenomenological critique of natural science. *Royal Institute of Philosophy Supplements*, *72*, 189–219. https://doi.org/10.1017/S1358246113000118

Bandura, A. (1997). *Self-efficacy: The exercise of control*. Freeman. https://psycnet.apa.org/record/1997-08589-000

Bandura, A. (1998). Health promotion from the perspective of social cognitive theory. *Psychology and Health*, *13*(4), 623–649. https://doi.org/10.1080/08870449808407422

Bandura, A. (2006). Adolescent development from a agentic perspective. F. Pajares & T. Urdan (Eds.), *Self-Efficacy Beliefs of Adolescents* (pp. 307–337). Information Age Publishing, Inc. https://www.scirp.org/(S(351jmbntvnsjt1aadkposzje))/reference/ReferencesPapers.aspx?ReferenceID=1536375

Bandura, A. J. (1977). *Social learning theory*. Prentice Hall. https://psycnet.apa.org/record/1979-05015-000

Bandura, A., & National Institute of Mental Health. (1986). Social foundations of thought and action: A social cognitive theory. *APA PsycNet*. Prentice Hall, Inc. https://psycnet.apa.org/record/1985-98423-000

Bañez, C., Carruthers, J., Gelmi, S., Kraft, A., Gaulton, C., & Hall, T. (2021). Applying human factors methods to improve healthcare risk management tools. *Proceedings of the International Symposium on Human Factors and Ergonomics in Health Care*, *10*(1), 185–187. https://doi.org/10.1177/2327857921101124

Barbaranelli, C., Fida, R., Paciello, M., & Tramontano, C. (2018). 'Possunt, quia posse videntur': They can because they think they can. Development and validation of the Work Self-Efficacy scale: Evidence from two studies. *Journal of Vocational Behavior*, *106*, 249–269. https://doi.org/10.1016/j.jvb.2018.01.006

Barck-Holst, P., Nilsonne, Å., Åkerstedt, T., & Hellgren, C. (2022). Reduced working hours and work-life balance. *Nordic Social Work Research*, *12*(4), 450–463. https://doi.org/10.1080/2156857X.2020.1839784

Barnes, H. A., Hurley, R. A., & Taber, K. H. (2019). Moral injury and PTSD: Often co-occurring yet mechanistically different. *Journal of Neuropsychiatry Clinical Neuroscience*, *31*(2). https://doi.org/10.1176/appi.neuropsych.19020036

Bartholomew, L. K., Parcel, G. S., Kok, G., & Gottlieb, N. H. (2006). *Planning Health Promotion Programs: An intervention mapping approach*. Jossey-Bass. https://www.academia.edu/35513035/PLANNING_HEALTH_PROMOTION_PROGRAMS_An_Intervention_Mapping_Approach

Battistelli, F., & Galantino, M. G. (2019). Dangers, risks and threats: An alternative conceptualization to the catch-all concept of risk. *Current Sociology*, *67*(1), 64–78. https://doi.org/10.1177/0011392118793675

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC Psychology*, *3*(1). https://doi.org/10.1186/S40359-015-0089-9

Baylina, P., Barros, C., Fonte, C., Alves, S., & Rocha, Á. (2018). Healthcare workers: Occupational health promotion and patient safety. *Journal of Medical Systems*, *42*(9). https://doi.org/10.1007/s10916-018-1013-7

Becker, M. H. (1974). The health belief model and sick role behavior. *Health Education Monographs*, *2*(4). https://doi.org/10.1177/109019817400200407

Bell, D. (2021, July). *The challenges and benefits of insider research within a professional doctoral study*. http://sure.sunderland.ac.uk/id/eprint/15062

Belle, D. (1990). Poverty and women's mental health. *American Psychologist*, *45*(3), 385–389. https://doi.org/10.1037/0003-066X.45.3.385

Benight, C. C., & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behaviour Research and Therapy*, *42*(10), 1129–1148. https://doi.org/10.1016/j.brat.2003.08.008

Bennett, F. (2015, June 30). *Poverty in the UK: the need for a gender perspective*. Women's Budget Group. https://wbg.org.uk/analysis/title-needed/

Bentley, M. L. (2003). *Introducing critical constructivism: Critical consciousness through a critical constructivist pedagogy*. http://web.utk.edu/~mbentle1

Berg, V. (2021, April 29). *Home care facts and stats: Number of providers, service users & workforce*. Homecare. https://www.homecare.co.uk/advice/home-care-facts-and-stats-number-of-providers-service-users-workforce

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Berger, R., & Quiros, L. (2014). Supervision for trauma-informed practice. *Traumatology*, *20*(4), 296–301. https://doi.org/10.1037/h0099835

Berger, R., Quiros, L., & Benavidez-Hatzis, J. R. (2018). The intersection of identities in supervision for trauma-informed practice: Challenges and strategies. *Clinical Supervisor*, *37*(1), 122–141. https://doi.org/10.1080/07325223.2017.1376299

Berg-Poppe, P., Anis Abdellatif, M., Cerny, S., LaPlante, K., Merrigan, M., & Wesner, C. (2022). Changes in knowledge, beliefs, self-efficacy, and affective commitment to change following trauma-informed care education for pediatric service providers. *Psychological Trauma : Theory, Research, Practice and Policy*, *14*(4), 535–544. https://doi.org/10.1037/tra0001083

Bhattacharjee, A., & Sarkar, A. (2022). Abusive supervision: a systematic literature review. *Management Review Quarterly*, 1–34. https://doi.org/10.1007/s11301-022-00291-8

Bielicki, J. A., Duval, X., Gobat, N., Goossens, H., Koopmans, M., Tacconelli, E., & van der Werf, S. (2020). Monitoring approaches for health-care workers during the COVID-19 pandemic. *The Lancet Infectious Diseases*, *20*(10), e261–e267. https://doi.org/10.1016/S1473-3099(20)30458-8

Bies, R. J. (2000). Interactional (in)justice the sacred and the profane. In J. Greenberg (Ed.), *Advances in organizational justice* (pp. 89–118). Stanford University Press. http://web.mit.edu/curhan/www/docs/Articles/15341_Readings/Justice/Interactional(In)JusticeTheSacredAndTheProfane_Bies.pdf

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare. *Qualitative Research in Psychology*, *5*(3), 214–224. https://doi.org/10.1080/14780880802314304

Bland, A. M., & DeRobertis, E. M. (2019). Humanistic perspective. *Encyclopedia of Personality and Individual Differences* (pp. 1–19). Springer International Publishing. https://doi.org/10.1007/978-3-319-28099-8_1484-2

BMA. (2021a). *Racial inequality in health and social care workplaces*. British Medical Association. https://www.bma.org.uk/media/3905/bma-response-to-ehrc-race-inquiry-feb-2021.pdf

BMA. (2021b). *Moral distress and moral injury Recognising and tackling it for UK doctors*. https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf

BMA. (2022a, January 17). *Vicarious trauma: Signs and strategies for coping*. https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

BMA. (2022b, April 5). *Strength in numbers: Stronger workforce planning in the health and care bill*. https://www.bma.org.uk/media/5492/strength-in-numbers-briefing-on-lords-consideration-of-commons-amends_050422.pdf

BMA. (2022c, June 8). *BMA warns of social care crisis as current system is 'deeply flawed' and in need of 'urgent reform.'* British Medical Association. https://www.bma.org.uk/bma-media-centre/bma-warns-of-social-care-crisis-as-current-system-is-deeply-flawed-and-in-need-of-urgent-reform

BMA. (2022d, November 30). *Moral distress in the NHS and other organisations*. British Medical Association. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/creating-a-healthy-workplace/moral-distress-in-the-nhs-and-other-organisations

Boardman, J., Dogra, N., & Hindley, P. (2015). Mental health and poverty in the UK-time for change? *BJPsych International*, *12*(2). doi: 10.1192/s2056474000000210. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5618908/

Bogna, F., Raineri, A., & Dell, G. (2020). Critical realism and constructivism: merging research paradigms for a deeper qualitative study. *Qualitative Research in Organizations and Management: An International Journal*, *15*(4), 461–484. https://doi.org/10.1108/QROM-06-2019-1778

Bohorquez, C. E. (2010). *Paul Ricoeur's hermeneutic detours and distanciations: A Study of the hermeneutics of Hans-Georg Gadamer and Paul Ricoeur* [Thesis, Boston College]. https://dlib.bc.edu/islandora/object/bc-ir:101183

Bonner, A., & Tolhurst, G. (2002). Insider-outsider perspectives of participant observation. *Nurse Researcher*, *9*(4), 7–19. https://doi.org/10.7748/nr2002.07.9.4.7.c6194

Borders, L. D. A., Lowman, M. M., Eicher, P. A., & Phifer, J. K. (2022). Trauma-informed supervision of trainees: Practices of supervisors trained in both trauma and clinical supervision. *Traumatology*, *29*(2), 125–136. https://doi.org/10.1037/trm0000382

Boström, A. M., Squires, J. E., Mitchell, A., Sales, A. E., & Estabrooks, C. A. (2012). Workplace aggression experienced by frontline staff in dementia care. *Journal of Clinical Nursing*, *21*(9–10), 1453–1465. https://doi.org/10.1111/j.1365-2702.2011.03924.x

Boullier, M., & Blair, M. (2013). Adverse childhood experiences. *Paediatrics and Child Health*, *28*(3), 132–137. https://www.cdc.gov/violenceprevention/acestudy/about.html.

Bourn, D. F., & Hafford-Letchfield, P. (2011). The role of social work professional supervision in conditions of uncertainty. *The International Journal of Knowledge Culture and Change Management*, *10*(9), 41–56. https://eprints.mdx.ac.uk/id/eprint/7160

Bowen, D. J., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., Bakken, S., Kaplan, C. P., Squiers, L., Fabrizio, C., & Fernandez, M. (2009). How We Design Feasibility Studies. *American Journal of Preventive Medicine*, *36*(5), 452–457. https://doi.org/10.1016/j.amepre.2009.02.002

Brand, S. L., Coon, J. T., Fleming, L. E., Carroll, L., Bethel, A., & Wyatt, K. (2017). Whole-system approaches to improving the health and wellbeing of healthcare workers: A systematic review. *PLoS ONE*, *12*(12). https://doi.org/10.1371/journal.pone.0188418

Brault, I., Kilpatrick, K., D'Amour, D., Contandriopoulos, D., Chouinard, V., Dubois, C.-A., Perroux, M., & Beaulieu, M.-D. (2014). Role clarification processes for better integration of nurse practitioners into primary healthcare teams: A multiple case study. *Nursing Research and Practice*, *2014*, 1–9. https://doi.org/10.1155/2014/170514

Brborović, O., Brborović, H., Nola, I. A., & Milošević, M. (2019). Culture of blame—an ongoing burden for doctors and patient safety. *International Journal of Environmental Research and Public Health*, *16*(23). https://doi.org/10.3390/ijerph16234826

Brennan, P. A., Holden, C., Shaw, G., Morris, S., & Oeppen, R. S. (2020). What can we do to improve individual and team situational awareness to benefit patient safety? *British Journal of Oral and Maxillofacial Surgery* (Vol. 58, Issue 4, pp. 404–408). Churchill Livingstone. https://doi.org/10.1016/j.bjoms.2020.01.030

Briggs, D. (2010). *A qualitative study using interpretative phenomenological analysis to explore chartered counselling psychologists experiences of supervision* [Thesis, University of Wolverhampton].

https://wlv.openrepository.com/bitstream/handle/2436/132953/Briggs_DCounsPsych%20thesis.pdf?sequence=1&isAllowed=y

British Safety Council. (2023). *The Health and Safety at Work Act explained*. British Safety Council. https://www.britsafe.org/training-and-learning/find-the-right-course-for-you/informational-resources/health-and-safety-legislation-what-you-need-to-know/

Britnell, M. (2019). Human: Solving the global workforce crisis in healthcare. *Oxford University Press Google Books*. Oxford University Press. https://doi.org/10.1093/oso/9780198836520.001.0001

Brown, C. A., Schell, J., & Pashniak, L. M. (2017). Occupational therapists' experience of workplace fatigue: Issues and action. *Work*, *57*(4), 517–527. https://doi.org/10.3233/WOR-172576

Brown, O., Kangovi, S., Wiggins, N., & Alvarado, S. (2020). Supervision strategies and community health worker effectiveness in health care settings. *NAM Perspectives*. https://api.semanticscholar.org/CorpusID:216235512

Brown, S., Gray, D., McHardy, J., & Taylor, K. (2015). Employee trust and workplace performance. *Journal of Economic Behavior and Organization*, *116*, 361–378. https://doi.org/10.1016/j.jebo.2015.05.001

Brown, V. J. (2014). Risk perception: It's personal. *Environmental Health Perspectives*, *122*(10), 276–279. https://doi.org/10.1126/science.3563507

Browne, J. (2021, September 7). *Fair social care: Priorities and funding options*. Tony Blair Institute for Global Change. https://institute.global/policy/fair-social-care-

Browne, J., Bullock, A., Poletti, C., & Cserző, D. (2021). Recent research into healthcare professions regulation: a rapid evidence assessment. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06946-8

Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing. *Australian Journal of Advanced Nursing*, *25*(2), 86–94.

https://www.researchgate.net/publication/230802446_The_effectiveness_of_clinical_supervision_in_nursing_An_evidence-based_literature_review

Bülbül, S., & Taştan, S. B. (2017). Toxic workplace environment: In search for the toxic behaviours in organizations with a research in healthcare sector. *Postmodern Openings*, *8*(1), 83–109. https://doi.org/10.18662/po/2017.0801.07

Bullock, A., & Browne, J. (2020, August 24). *An independent review Of health & social care regulatory research*. Professional Standards Authority. https://www.professionalstandards.org.uk/news-and-blog/blog/detail/blog/2020/08/24/a-review-of-research-into-health-and-social-care-regulation

Burke, S. (2016). Rethinking validity and trustworthiness in qualitative inquiry: How might we judge the quality of qualitative research in sport and exercise sciences? B. Smith & A. C. Sparkes (Eds.), *Routledge handbook of qualitative research in sport and exercise* (1st ed.). Routledge. http://ebookcentral.proquest.com/lib/stmarkstjohn/detail.action?docID=4684241.

Butler, J. (2022). Sexual ideology and phenomenological description: A feminist critique of Merleau-Ponty's Phenomenology of Perception. In K. Maitra & J. McWeeny (Eds.), *Feminist Philosophy of Mind*. Oxford Academic. https://doi.org/10.1093/oso/9780190867614.003.0010

Butterworth, T. (2022, January 17). What is clinical supervision and how can it be delivered in practice. *Nursing Times*, *118*(2), 20–22. https://www.nursingtimes.net/roles/nurse-managers/what-is-clinical-supervision-and-how-can-it-be-delivered-in-practice-17-01-2022/

Canevello, A., Hall, J., & Walsh, J. I. (2021). Empathy-mediated altruism in intergroup contexts: The roles of posttraumatic stress and posttraumatic growth. *Emotion*, *22*(8), 1699–1712. https://doi.org/10.1037/emo0000803

Cant, R. P., & Cooper, S. J. (2010). Simulation-based learning in nurse education: Systematic review. *Journal of Advanced Nursing* (Vol. 66, Issue 1, pp. 3–15). https://doi.org/10.1111/j.1365-2648.2009.05240.x

Carayon, P., & Hoonakker, P. (2019). Human factors and usability for health information technology: Old and new challenges. *Yearbook of Medical Informatics*, *28*(1), 71–77. https://doi.org/10.1055/s-0039-1677907

Carayon, P., Wetterneck, T. B., Rivera-Rodriguez, A. J., Hundt, A. S., Hoonakker, P., Holden, R., & Gurses, A. P. (2014). Human factors systems approach to healthcare quality and patient safety. *Applied Ergonomics*, *45*(1), 14–25. https://doi.org/10.1016/j.apergo.2013.04.023

Carminati, L. (2018). Generalizability in qualitative research: A tale of two traditions. *Qualitative Health Research* (Vol. 28, Issue 13, pp. 2094–2101). SAGE Publications Inc. https://doi.org/10.1177/1049732318788379

Carter, C., Lapum, J., Lavallee, L. F., & Martin, L. S. (2014). Explicating positionality: A journey of dialogical and reflexive storytelling. *International Journal of Qualitative Methods*, *13*, 362–376. https://journals.sagepub.com/doi/pdf/10.1177/160940691401300118

Casali, G., Cullen, W., & Lock, G. (2019). The rise of human factors: Optimising performance of individuals and teams to improve patients' outcomes. *Journal of Thoracic Disease*, *11*, S998–S1008. https://doi.org/10.21037/jtd.2019.03.50

Casey, B., & Webb, M. (2021). Experiences of mental health support workers in mental healthcare practice: Three visual arts narratives. *Journal of Psychiatric and Mental Health Nursing*, *28*(6), 1018–1028. https://doi.org/10.1111/jpm.12775

Caspar, E. A., Lo Bue, S., Magalhães De Saldanha da Gama, P. A., Haggard, P., & Cleeremans, A. (2020). The effect of military training on the sense of agency and outcome processing. *Nature Communications*, *11*(1). https://doi.org/10.1038/s41467-020-18152-x

Cavalheiro, E. A., Mendes Vieira, K., & Sérgio Ceretta, P. (2012). The determinants of risk tolerance: A behavioural analysis. *Corporate Ownership & Control*, *9*(2). DOI:10.22495/cocv9i2c5art2

Cetrano, G., Tedeschi, F., Rabbi, L., Gosetti, G., Lora, A., Lamonaca, D., Manthorpe, J., & Amaddeo, F. (2017). How are compassion fatigue, burnout, and compassion satisfaction affected by quality of working life? Findings from a survey of mental health staff in Italy. *BMC Health Services Research*, *17*(1). https://doi.org/10.1186/s12913-017-2726-x

Champion, V. L., & Skinner, C. S. (2008). The health belief model. In K. Glanz, B. K. Rimer, & K. Viswanath (Eds.), *Health Behaviour and Health Education* (pp. 45–65). Jossey Bass. https://psycnet.apa.org/record/2008-17146-003

Charlton, E. (2023, January 26). *Women are bearing the brunt of the cost of living crisis*. World Economic Forum. https://www.weforum.org/agenda/2023/01/cost-of-living-crisis-women-gender-gap/

Chiriac, E. H. (2014). Group work as an incentive for learning "students" experiences of group work. *Frontiers in Psychology*, *5*. https://doi.org/10.3389/fpsyg.2014.00558

Christensen, K., & Manthorpe, J. (2016). Personalised risk: new risk encounters facing migrant care workers. *Health, Risk and Society*, *18*(3–4), 137–152. https://doi.org/10.1080/13698575.2016.1182628

CIEHF. (2018). Human factors and healthcare evidencing the impact of human factors training to support improvements in patient safety and to contribute to cultural change. *Chartered Institute of Ergonomics and Human Factors*. https://www.hee.nhs.uk/sites/default/files/documents/Health%20Education%20England%20and%20CIEHF%20-%20Human%20Factors%20and%20Healthcare%20Report.pdf

Clarke, V., & Braun, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage Publications. https://www.researchgate.net/publication/256089360

Clarkson, M. D., Haskell, H., Hemmelgarn, C., & Skolnik, P. (2019). Abandon the term "second victim." *BMJ*, *364*. https://eurekamag.com/research/066/631/066631098.php

Cohen, D., & Crabtree, B. (2008). *Semi-structured Interviews*. http://www.qualres.org/HomeSemi-3629.html

Coley, D. (2020). Probation staff supervision: Valuing ‘me time’ within congested spaces. *Probation Journal*, *67*(3), 228–245. https://doi.org/10.1177/0264550520926581

College of Policing. (n.d.). *Effective supervision*. College of Policing. https://www.college.police.uk/guidance/effective-supervision

Converso, D., Sottimano, I., & Balducci, C. (2021). Violence exposure and burnout in healthcare sector: Mediating role of work ability. *Medicina Del Lavoro*, *112*(1), 58–67. https://doi.org/10.23749/mdl.v112i1.9906

Cooper, J. (2014, November 11). *Service users with dementia and autism most likely to assault social care staff*. Community Care. https://www.communitycare.co.uk/2014/11/11/service-users-dementia-autism-likely-assault-social-care-staff/#:~:text=A%20literature%20review%2C%20combined%20with,dealing%20with%20abuse%20or%20violence.

Covello, V. T., & Mumpower, J. (1985). Risk analysis and risk management: An historical perspective. *Risk Analysis* , *5*(2), 103–120. file:///D:/Thesis%20Literature/Risk_Analysis_and_Risk_Management_An_His.pdf

CQC. (2017). *What’s a regulated activity*. Care Quality Commission. https://services.cqc.org.uk/public/glossary/regulated_activity#:~:text=A%20regulated%20activity%20is%20one,require%20treatment%20for%20substance%20misuse

CQC. (2018). *CQC’s risk tolerance statement 2018-19*. Care Quality Commission. https://www.cqc.org.uk/sites/default/files/CQC_Risk_Tolerance_Statement_18-19.pdf

CQC. (2022, October 21). *Gridlocked health and care system leading to deterioration in people's access to and experience of care*. Care Quality Commission. https://www.cqc.org.uk/press-release/gridlocked-health-and-care-system-leading-deterioration-peoples-access-and-experience

CQC. (2023, August 11). *Regulation 18: Staffing*. Care Quality Commission. https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing

Criado-Perez, C. (2019). *Invisible women: Exposing data bias in a world designed for men*. Abrams Press.

Crispin, N., Wamae, A., Ndirangu, M., Wamalwa, D., Wangalwa, G., Watako, P., & Mbiti, E. (2012). Effects of selected socio-demographic characteristics of community health workers on performance of home visits during pregnancy: a cross-sectional study in Busia District, Kenya. *Global Journal of Health Science*, *4*(5), 78–90. https://doi.org/10.5539/gjhs.v4n5p78

Crossley, J., Marriott, J., Purdie, H., & Beard, J. D. (2011). Prospective observational study to evaluate NOTSS (Non-Technical Skills for Surgeons) for assessing trainees' non-technical performance in the operating theatre. *British Journal of Surgery*, *98*(7), 1010–1020. https://doi.org/10.1002/bjs.7478

Cunningham, I., Lindsay, C., & Roy, C. (2021). Diaries from the front line—Formal supervision and job quality among social care workers during austerity. *Human Resource Management Journal*, *31*(1), 187–201. https://doi.org/10.1111/1748-8583.12289

Curran, E., Rosato, M., Ferry, F., & Leavey, G. (2021). Mental ill-health among health and social care professionals: an analysis using administrative data. *International Journal of Population Data Science Journal Website: Www.Ijpds.Org*, *6*(1). https://doi.org/10.23889/ijpds.v5i4.1649

Dahl, C. M., Boss, P., & Dahl Pauline Boss Background, C. M. (2005). The use of phenomenology for family therapy research: The search for meaning. *Research Methods in Family Therapy*, 63–84. http://digitalcommons.luthersem.edu/faculty_articleshttp://digitalcommons.luthersem.edu/faculty_articles/215

Dai, Y., Li, H., Xie, W., & Deng, T. (2022). Power distance belief and workplace communication: The mediating role of fear of authority. *International Journal of Environmental Research and Public Health*, *19*(5). https://doi.org/10.3390/ijerph19052932

Damery, S., Flanagan, S., Jones, J., & Jolly, K. (2021). The effect of providing staff training and enhanced support to care homes on care processes, safety climate and avoidable harms: Evaluation of a care home quality improvement programme in England. *International Journal of Environmental Research and Public Health*, *18*(14). https://doi.org/10.3390/ijerph18147581

Daniels, K., Nor, B., Jackson, D., Ekström, E.-C., & Doherty, T. (2010). Supervision of community peer counsellors for infant feeding in South Africa: an exploratory qualitative study. *Human Resources for Health*, *8*, 6. doi: 10.1186/1478-4491-8-6. https://pubmed.ncbi.nlm.nih.gov/20353561/

Darwin Holmes, A. G. (2020). Researcher positionality: A consideration of its influence and place in qualitative research - A New Researcher Guide. *International Journal of Education*, *8*(4), 1–10. https://doi.org/10.34293/education.v8i4.3232

Davidhizar, R. (1983). Critique of the health-belief model. *Journal of Advanced Nursing467*, *8*(6), 467–472. https://doi.org/10.1111/j.1365-2648.1983.tb00473.x

Davis, K. E. (2017). *Trauma in emergency services: A systematic review of posttraumatic growth in firefighters and an investigation into post-traumatic stress symptoms in ambulance clinicians: severity and associations with self-compassion, psychological inflexibility and wellbeing* [Thesis, University of Edinburgh]. https://era.ed.ac.uk/bitstream/handle/1842/25687/Davis2017.pdf?sequence=3&isAllowed=y

Dayan, M., Mccarey, M., Hervey, T., Fahy, N., Greer, S. L., Jarman, H., Stewart, E., Bristow, D., Dennison, R., Buckingham, H., Edwards, Z., Patel, M., Keen, S., & Kirkup, P. (2021, December 21). *Going it alone: Health and Brexit in the UK*. Nuffield Trust. https://www.nuffieldtrust.org.uk/research/going-it-alone-health-and-brexit-in-the-uk de Castella, T. (2021, April 30). “Staggering rise” in mental health issues among NHS staff since Covid-19. *Nursing Times*. https://www.nursingtimes.net/news/workforce/staggering-rise-in-mental-health-issues-among-nhs-staff-since-covid-19-30-04-2021/

De Groot, K., Maurits, E. E. M., & Francke, A. L. (2018). Attractiveness of working in home care: An online focus group study among nurses. *Health and Social Care in the Community*, *26*(1), e94–e101. https://doi.org/10.1111/hsc.12481

de Winter, J. C. F., & Hancock, P. A. (2021). Why human factors science is demonstrably necessary: historical and evolutionary foundations. *Ergonomics* (Vol. 64, Issue 9, pp. 1115–1131). Taylor and Francis Ltd. https://doi.org/10.1080/00140139.2021.1905882

Denney, D. (2010). Violence and social care staff: Positive and negative approaches to risk. *British Journal of Social Work*, *40*(4), 1297–1313. https://doi.org/10.1093/bjsw/bcq025

Dempsey, P. G., Wogalter, M. S., & Hancock, P. A. (2006). *Defining Ergonomics/Human Factors*. http://www.iea.cc/ergonomics/

Dewey, K., & Horsley, S. (2022). Applying the principles of trauma-informed care in intellectual disability services. *Learning Disability Practice*. https://doi.org/10.7748/ldp.2022.e2179

DHSC. (2022, January 6). *Healthcare regulation: Deciding when statutory regulation is appropriate*. GOV.UK. https://www.gov.uk/government/consultations/healthcare-regulation-deciding-when-statutory-regulation-is-appropriate/healthcare-regulation-deciding-when-statutory-regulation-is-appropriate

Diotaiuti, P., Valente, G., Mancone, S., Falese, L., Bellizzi, F., Anastasi, D., Langiano, E., Dominski, F. H., & Andrade, A. (2021). Perception of risk, self-efficacy and social trust during the diffusion of covid-19 in Italy. *International Journal of Environmental Research and Public Health*, *18*(7). https://doi.org/10.3390/ijerph18073427

Dodge, R., Daly, A., Huyton, J., & Sanders, L. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing*, *2*(3), 222–235. https://doi.org/10.5502/ijw.v2i3.4

Donovan, T. (2016, March 21). Lack of reflective supervision hindered action in baby death case. *Community Care*. https://www.communitycare.co.uk/2016/03/21/lack-reflective-supervision-hindered-action-baby-death-case/

Dörfler, V., & Stierand, M. (2020). Bracketing: a phenomenological theory applied through transpersonal reflexivity. *Journal of Organizational Change Management*, *34*(4), 778–793. https://doi.org/10.1108/JOCM-12-2019-0393

Dowling, M. (2004). Hermeneutics: an exploration. *Nurse Researcher*, *11*(4), 30–39. https://doi.org/10.7748/nr2004.07.11.4.30.c6213

Downey, C., & Crummy, A. (2022). The impact of childhood trauma on children's wellbeing and adult behavior. *European Journal of Trauma and Dissociation*, *6*(1). https://doi.org/10.1016/j.ejtd.2021.100237

Ducat, W. H., & Kumar, S. (2015). A systematic review of professional supervision experiences and effects for allied health practitioners working in non-metropolitan health care settings. *Journal of Multidisciplinary Healthcare* (Vol. 8, pp. 397–407). Dove Medical Press Ltd. https://doi.org/10.2147/JMDH.S84557

Dückers, M. L. A. (2013). Five essential principles of post-disaster psychosocial care: Looking back and forward with Stevan Hobfoll. *European Journal of Psychotraumatology*, *4*(SUPPL.). https://doi.org/10.3402/ejpt.v4i0.21914

Dunbar, P., Keyes, L. M., & Browne, J. P. (2023). Determinants of regulatory compliance in health and social care services: A systematic review using the Consolidated Framework for Implementation Research. *PLoS ONE*, *18*(4 April). https://doi.org/10.1371/journal.pone.0278007

Dunn, M. C., Clare, I. C. H., & Holland, A. J. (2008). To empower or to protect? Constructing the ‘vulnerable adult’ in English law and public policy. *Legal Studies*, *28*(2), 234–253. https://doi.org/10.1111/j.1748-121X.2008.00085.x

Dunning, T. (2006). Caring for the wounded healer-nurturing the self. *Journal of Bodywork and Movement Therapies*, *10*(4), 251–260. https://doi.org/10.1016/j.jbmt.2005.05.001

Eakin, J. M., & Gladstone, B. (2020). “Value-adding” analysis: Doing more with qualitative data. *International Journal of Qualitative Methods*, *19*, 1–13. https://doi.org/10.1177/1609406920949333

Egan, H., Keyte, R., McGowan, K., Peters, L., Lemon, N., Parsons, S., Meadows, S., Fardy, T., Singh, P., & Mantzios, M. (2019). ‘You before me’: A qualitative study of health care professionals’ and students’ understanding and experiences of compassion in the workplace, self-compassion, self-care and health behaviours. *Health Professions Education*, *5*(3), 225–236. https://doi.org/10.1016/j.hpe.2018.07.002

Eklund, J., Loeb, C., Hansen, E. M., & Anderson-Wallin, A. C. (2012). Who cares about others?: Empathic self-efficacy as an antecedent to prosocial behavior. *Current Research in Social Psychology*, *20*. https://psycnet.apa.org/record/2014-38248-001

Ellis, T., & Levy, Y. (2008). Framework of Problem-Based Research: A Guide for Novice Researchers on the Development of a Research-Worthy Problem. *Informing Science: The International Journal of an Emerging Transdiscipline*, *11*, 017–033. https://doi.org/10.28945/438

Emmanuel, A. (2015). A literature review of the factors that influence breastfeeding: An application of the health believe model. *International Journal of Nursing and Health Science*, *2*(3), 28–36. http://www.openscienceonline.com/journal/ijnhs

Emsley, E., Smith, J., Martin, D., & Lewis, N. V. (2022). Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives. *BMC Health Services Research*, *22*(1). https://doi.org/10.1186/s12913-022-08461-w

Epstein, R. M. (2021). Facing epistemic and complex uncertainty in serious illness: The role of mindfulness and shared mind. *Patient Education and Counseling*, *104*(11), 2635–2642. https://doi.org/10.1016/j.pec.2021.07.030

Eslinger, P. J., Anders, S., Ballarini, T., Boutros, S., Krach, S., Mayer, A. V., Moll, J., Newton, T. L., Schroeter, M. L., de Oliveira-Souza, R., Raber, J., Sullivan, G. B., Swain, J. E., Lowe, L., & Zahn, R. (2021). The neuroscience of social feelings: mechanisms of adaptive social functioning. *Neuroscience and Biobehavioral Reviews* (Vol. 128, pp. 592–620). Elsevier Ltd. https://doi.org/10.1016/j.neubiorev.2021.05.028

Estes, B. C. (2013). Abusive supervision and nursing performance. *Nursing Forum*, *48*(1), 3–16. https://doi.org/10.1111/nuf.12004

Everly, G. S. (2020). Psychological First Aid (PFA) To Expand Mental Health Support and Foster Resiliency in Underserved and Access-Compromised Areas. *Crisis, Stress and Human Resilience: An International Journal*, *I*(4), 227–232. https://www.crisisjournal.org/article/12297-psychological-first-aid-pfa-to-expand-mental-health-support-and-foster-resiliency-in-underserved-and-access-compromised-areas

Fagbule, O. (2020). A holistic approach towards human factors in information security and risk. In R. Guizzardi, J. Ralyté, & X. Franch (Eds.), *International Conference on Research Challenges in Information Science* (pp. 585–594). Springer. DOI:10.1007/978-3-030-50316-1_42

Farber, M. (2017). *The foundation of Phenomenology: Edmund Husserl and the quest for a rigorous science of philosophy*. Routledge. https://doi.org/10.4324/9781315132099

Feldman, M. S., Sköldberg, K., Brown, R. N., & Horner, D. (2004). Making sense of stories: A rhetorical approach to narrative analysis. *Journal of Public Administration Research and Theory*, *14*(2), 147–170. https://doi.org/10.1093/jopart/muh010

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S., & Perma-Nente, K. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults The Adverse Childhood Experiences (ACE) study. *American Journal of Preventative Medicine*, *14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Fenn, P., & Egan T. (2012). Risk management in the NHS: Governance, finance and clinical risk. *Clinical Medicine*, *12*(1), 25–28. doi: 10.7861/clinmedicine.12-1-25

Ferdosi, M., Rezayatmand, R., & Taleghani, Y. M. (2020). Risk management in executive levels of healthcare organizations: Insights from a scoping review (2018). *Risk Management and Healthcare Policy*, *13*, 215–243. https://doi.org/10.2147/RMHP.S231712

Fernandopulle, N. (2021). To what extent does hierarchical leadership affect health care outcomes? *Medical Journal of the Islamic Republic of Iran*, *35*(117). doi: 10.47176/mjiri.35.117

Ferrer, R., & Klein, W. M. (2015). Risk perceptions and health behavior. *Current Opinion in Psychology*, *5*, 85–89. https://doi.org/10.1016/j.copsyc.2015.03.012

Fiandra, U., Raciti, I. M., Mosso, R., Calipari, G., & Rapellino, M. (2008). The perception of health care risk: Patients, health care staff and society. *Blood Transfusion*, *6*(2), 93–100. https://doi.org/10.2450/2008.0045-07

Field, R., & Brown, K. (2019). *Effective leadership, management and supervision in health and social care* (K. Brown, Ed.; 3rd ed.). Sage. https://www.perlego.com/book/1431987/effective-leadership-management-and-supervision-in-health-and-social-care-pdf

Finefter-Rosenbluh, I. (2017). Incorporating perspective taking in reflexivity: A method to enhance insider qualitative research processes. *International Journal of Qualitative Methods*, *16*(1). https://doi.org/10.1177/1609406917703539

Finlay, L. (1999). Applying Phenomenology in Research: Problems, principles and practice. *British Journal of Occupational Therapy*, *62*(7), 299–306. https://doi.org/10.1177/030802269906200705

Fischer, T., Tian, A. W., Lee, A., & Hughes, D. J. (2021). Abusive supervision: A systematic review and fundamental rethink. *Leadership Quarterly*, *32*(6). https://doi.org/10.1016/j.leaqua.2021.101540

Fleming, M., & Buchan, D. (2002). Risk is in the eye of the beholder. *The Safety and Health Practitioner*, *20*(10), 30–32. https://www.thecampbellinstitute.org/wp-content/uploads/2017/05/Campbell-Institute-Risk-Perception-WP.pdf

Flin, R., Jackson, J., & Sarac, C. (2009). *Human factors in patient safety: Review of topics and tools*. https://www.researchgate.net/publication/266050169

Flin, R., & Agnew, C. (2017). *Human factors and ergonomics for the Gulf Cooperation Council: Processes, technologies and practices* (S. M. Samman, Ed.; 1st ed.). CRC Press. https://doi.org/10.1201/b21145

Ford, M. (2023, February 1). Mental health at perilous low, warn nursing staff. *Nursing Times*. https://www.nursingtimes.net/news/nurse-wellbeing/exclusive-mental-health-at-perilous-low-warn-nursing-staff-01-02-2023/

Fore, A. M., & Sculli, G. L. (2013). A concept analysis of situational awareness in nursing. *Journal of Advanced Nursing*, *69*(12), 2613–2621. https://doi.org/10.1111/jan.12130

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Services Research*, *18*(1). https://doi.org/10.1186/s12913-018-2915-2

Forrest-Lawrence, P. (2019). Case Study Research. P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 317–331). Springer. https://doi.org/10.1007/978-981-10-5251-4_67

Foster, D. (2022). Adult social care workforce in England. In *House of Commons Library*. House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/cbp-9615/

Fox, M. A., Niemeier, R. T., Hudson, N., Siegel, M. R., & Dotson, G. S. (2021). Cumulative risks from stressor exposures and personal risk factors in the workplace: Examples from a scoping review. *Public Health*, *18*, 5850. https://doi.org/10.3390/ijerph

Fragkaki, I., Maciejewski, D. F., Weijman, E. L., Feltes, J., & Cima, M. (2021). Human responses to Covid-19: The role of optimism bias, perceived severity, and anxiety. *Personality and Individual Differences*, *176*. https://doi.org/10.1016/j.paid.2021.110781

Francis-Devine, B., Buchanan, I., & Powell, A. (2023). UK labour market statistics. In *House of Commons Library*. House of Commons Library. https://researchbriefings.files.parliament.uk/documents/CBP-9366/CBP-9366.pdf

Franz, S., Zeh, A., Schablon, A., Kuhnert, S., & Nienhaus, A. (2010). Aggression and violence against health care workers in Germany - A cross sectional retrospective survey. *BMC Health Services Research*, *10*(51), 1–8. https://doi.org/10.1186/1472-6963-10-51

Freedle, A., & Oliveira, E. (2021). From isolation to connection: Empathy, prosocial behavior, and posttraumatic growth after pregnancy loss. *Illness, Crisis and Loss*, *31*(2). https://doi.org/10.1177/10541373211063427

Frimpong, J. A., Helleringer, S., Awoonor-Williams, J. K., Yeji, F., & Phillips, J. F. (2011). Does supervision improve health worker productivity? Evidence from the Upper East Region of Ghana. *Tropical Medicine and International Health*, *16*(10), 1225–1233. https://doi.org/10.1111/j.1365-3156.2011.02824.x

Funk, G. B., Baldacci, H. B., Pasold, T., & Baumgardner, J. (2004). Violence exposure in real-life, video games, television, movies, and the internet: is there desensitization? *Journal of Adolesence*, *27*(1), 23–29. https://doi.org/10.1016/j.adolescence.2003.10.005

Galizzi, M., & Tempesti, T. (2014). *Workers' perceptions of risk and occupational injuries*. https://www.hsph.harvard.edu/wp-content/uploads/sites/1273/2014/03/Risk_Perception_Galizzi_Tempesti_March_update.pdf

Garcia, A. M., De, F., & Sociales, C. (2004). Why do workers behave unsafely at work? Determinants of safe work practices in industrial workers. *Occupational and Environmental Medicine*, *61*, 239–246. https://doi.org/10.1136/oem.2002.005629

Garland, D. (2003). The rise of risk. A. Doyle & D. Ericson (Eds.), *Risk and Morality*. University of Toronto Press. https://doi.org/10.3138/9781442679382-005

Gascoigne, C., Parry, E., & Buchanan, D. (2015). Extreme work, gendered work: How extreme jobs and the discourse of 'personal choice' perpetuate gender inequality. *Organization*, *22*(4), 457–475. https://doi.org/10.1177/1350508415572511

Gates, D. M., Fitzwater, E., & Meyer, U. (2013). Violence against caregivers in nursing homes: Expected, tolerated, and accepted. *Journal of Gerontological Nursing*, *25*(4), 12–22. https://doi.org/10.3928/0098-9134-19990401-05

Geng, S., Zhou, Y., Zhang, W., Lou, A., Cai, Y., Xie, J., Sun, J., Zhou, W., Liu, W., & Li, X. (2021). The influence of risk perception for COVID-19 pandemic on posttraumatic stress disorder in healthcare workers: A survey from four designated hospitals. *Clinical Psychology and Psychotherapy*, *28*(5), 1146–1159. https://doi.org/10.1002/cpp.2564

Gershlick, B., & Charlesworth, A. (2019, November 27). *Health and social care workforce*. The Health Foundation. https://www.health.org.uk/publications/long-reads/health-and-social-care-workforce

Gibson, D. E. (2004). Role models in career development: New directions for theory and research. *Journal of Vocational Behavior*, *65*(1), 134–156. https://doi.org/10.1016/S0001-8791(03)00051-4

Gill, M. J. (2020). Phenomenology as qualitative methodology. In N. Mik-Meyer & M. Järvinen (Eds.), *Qualitative analysis: Eight approaches* (pp. 73–94). Sage.

https://www.researchgate.net/publication/341104030_Phenomenology_as_qualitative_methodology/link/5ead8f31a6fdcc7050a28d14/download

Giurgiu, D. I., Jeoffrion, C., Grasset, B., Dessomme, B. K., Moret, L., Roquelaure, Y., Caubet, A., Verger, C., Laraqui, C. E. H., Lombrail, P., Geraut, C., & Tripodi, D. (2015). Psychosocial and occupational risk perception among health care workers: a Moroccan multicenter study. *BMC Research Notes*, *8*(1). https://doi.org/10.1186/s13104-015-1326-2

Gluyas, H. (2015). Patient-centred care: Improving healthcare outcomes. *Nursing Standard*, *23*(30), 50–57. DOI: 10.7748/ns.30.4.50.e10186

Gluyas, H., Stomski, N., Andrus, P., Walters, J., Morrison, P., Williams, A., Hopkins, M., & Sandy, M. (2019). Performance based situation awareness observations in a simulated clinical scenario pre and post an educational intervention. *Nurse Education in Practice*, *36*, 20–27. https://doi.org/10.1016/j.nepr.2019.02.011

Gonge, H., & Buus, N. (2011). Model for investigating the benefits of clinical supervision in psychiatric nursing: A survey study. *International Journal of Mental Health Nursing*, *20*(2), 102–111. https://doi.org/10.1111/j.1447-0349.2010.00717.x

Gordon, M., Baker, P., Catchpole, K., Darbyshire, D., & Schocken, D. (2015). Devising a consensus definition and framework for non-technical skills in healthcare to support educational design: A modified Delphi study. *Medical Teacher*, *37*(6), 572–577. http://clok.uclan.ac.uk/12404/http://www.uclan.ac.uk/research/www.clok.uclan.ac.uk

Gordon, M., Fell, C. W. R., Box, H., Farrell, M., & Stewart, A. (2017). Learning health 'safety' within non-technical skills interprofessional simulation education: a qualitative study. *Medical Education Online*, *22*(1), 1272838. https://doi.org/10.1080/10872981.2017.1272838

GOV.UK. (2016, March 10). *From a blame culture to a learning culture*. https://www.gov.uk/government/speeches/from-a-blame-culture-to-a-learning-culture

GOV.UK. (2021, November 18). *Gender spotlight*. Office for Health Improvement and Disparities. https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-spotlights/gender-covid-19-mental-health-and-wellbeing-surveillance-report

GOV.UK. (2022a). *The child safeguarding practice review panel: Annual report 2021*. www.nationalarchives.gov.uk/doc/open-government-licence/version/3

GOV.UK. (2022b, November 2). *Working definition of trauma-informed practice*. Office for Health Improvement and Disparities. https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

GOV.UK. (2022c, December 21). *Pathways and barriers to leadership in fire and rescue services - GOV.UK*. Home Office. https://www.gov.uk/government/publications/pathways-and-barriers-to-leadership-in-fire-and-rescue-services/pathways-and-barriers-to-leadership-in-fire-and-rescue-services

Grasmo, S. G., Liaset, I. F., & Redzovic, S. E. (2021). Home care workers' experiences of work conditions related to their occupational health: a qualitative study. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06941-z

Gray-Stanley, J. A., & Muramatsu, N. (2011). Work stress and burnout among direct care workers: Do work social support and locus of control make a difference? *Res Dev Disabil*, *32*(3), 1065–1074. https://doi.org/10.1016/j.ridd.2011.01.025

Green, B., Tsiroyannis, C., & Brennan, P. (2016). Human factors - recognising and minimising errors in our day to day practice. *Oral Diseases*, *22*(1), 19–22. https://doi.org/10.1111/odi.12384

Green, E. C., Murphy, E., Gryboski, K., Sweeny, K., Robbins, M. L., & Cohen, L. M. (2020). *The health belief model*. https://www.researchgate.net/publication/353934789_Green_Murphy_Gryboski_Health_Belief_Model_2020

Greenberg, D. M., Baron-Cohen, S., Rosenberg, N., Fonagy, P., & Rentfrow, P. J. (2018). Elevated empathy in adults following childhood trauma. *PLoS ONE*, *13*(10). https://doi.org/10.1371/journal.pone.0203886

Greene, M. J. (2014). On the inside looking in: Methodological insights and challenges in conducting qualitative insider research. *The Qualitative Report*, *19*. DOI:10.46743/2160-3715/2014.1106

Griffith, A. I. (1998). Insider/outsider epistemological privilege and mothering work. *Human Studies*, *21*, 361–367. https://doi.org/10.1023/A:1005421211078

Griffiths, C. W., & Lees, A. (1995). Training needs analysis: A human factors analysis tool. *Quality and Reliability Engineering International* , *11*(6), 435–438. https://doi.org/10.1002/qre.4680110607

Grignoli, N., Petrocchi, S., Bernardi, S., Massari, I., Traber, R., Malacrida, R., & Gabutti, L. (2021). Influence of empathy disposition and risk perception on the psychological impact of lockdown during the coronavirus disease pandemic outbreak. *Frontiers in Public Health*, *8*. https://doi.org/10.3389/fpubh.2020.567337

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods*, *3*(1), 42–55. https://doi.org/10.1177/160940690400300104

Grossoehme, D. H. (2014). Overview of qualitative research. *Journal of Health Care Chaplaincy*, *20*(3), 109–122. https://doi.org/10.1080/08854726.2014.925660

Guba E. G, & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105–117). Sage Publications, Inc. https://psycnet.apa.org/record/1994-98625-005

Guevara, A. M. M., Johnson, S. L., Elam, K., Rivas, T., Berendzen, H., & Gal-Szabo, D. E. (2021). What does it mean to be trauma-informed? A multi-system perspective from practitioners serving the community. *Journal of Child and Family Studies*, *30*(11), 2860–2876. https://doi.org/10.1007/s10826-021-02094-z

Guo, R., Sun, M., Fan, Z., Zhang, C., & Tao, H. (2021). The role of military training in improving psychological resilience and reducing depression among college freshmen. *Frontiers in Psychology*, *12*. https://doi.org/DOI=10.3389/fpsyt.2021.641396

Hahm, H. C., Speliotis, A. E., & Bachman, S. S. (2008). Failure to receive health care among people with mental illness: Theory and implications. *Journal of Social Work in Disability and Rehabilitation*, *7*(2), 94–114. https://doi.org/10.1080/15367100802081110

Haigh, S. (2019). *The Care Certificate and its impact on health care assistants identifying and managing the deteriorating patient: A service evaluation*. University of Huddersfield. https://pure.hud.ac.uk/ws/portalfiles/portal/16443927/Care_20Certificate_20study_20Journal_20entry_20V2.pdf

Hales, T. W., Green, S. A., Bissonette, S., Warden, A., Diebold, J., Koury, S. P., & Nochajski, T. H. (2019). Trauma-informed care outcome study. *Research on Social Work Practice*, *29*(5), 529–539. https://doi.org/10.1177/1049731518766618

Halima Begum, M., & Rahima Begum, M. (2022). Feminization of poverty: Effects on women's health. *IOSR Journal Of Humanities And Social Science (IOSR-JHSS*, *27*(1), 16–22. https://doi.org/10.9790/0837-2710011622

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: A systematic review. In *PLoS ONE* (Vol. 11, Issue 7). Public Library of Science. https://doi.org/10.1371/journal.pone.0159015

Ham, E., Ricciardelli, R., Rodrigues, N. C., Hilton, N. Z., & Seto, M. C. (2021). Beyond workplace violence: Direct and vicarious trauma among psychiatric hospital workers. A qualitative study. *Journal of Nursing Management*, *30*(6), 1482–1489. https://doi.org/10.1111/jonm.13420

Hawkins, P., & Shohet, R. (2012). *Supervision in the helping professions* (4th ed.). McGraw-Hill.

Hayes, L. B. (2017). *Stories of care: A labour of law, gender and class at work* (1st ed.). Palgrave Socio Legal Studies.

Hayes, L., & Walters, H. (2020, June 5). COVID-19 and the exploitation of care workers for political profit. *Futures of Work*. https://futuresofwork.co.uk/2020/06/05/covid-19-and-the-exploitation-of-care-workers-for-political-profit/

Hays, D. G., & McKibben, W. B. (2021). Promoting rigorous research: Generalizability and qualitative research. *Journal of Counseling and Development*, *99*(2), 178–188. https://doi.org/10.1002/jcad.12365

HCPC. (2021, September 27). *The benefits and outcomes of effective supervision*. Health and Care Professionals Council. https://www.hcpc-uk.org/standards/meeting-our-standards/supervision-leadership-and-culture/supervision/the-benefits-and-outcomes-of-effective-supervision/

Heaslip, V. (2012). *The impact of staff vulnerability; does nurses' vulnerability affect their ability to care?* Bournemouth University. https://eprints.bournemouth.ac.uk/20505/1/Staff%20Vulnerability%20-%20June%2029%2012.pdf

HEE. (2023). *Care Certificate*. Health Education England. https://www.hee.nhs.uk/our-work/care-certificate

Hellström, T. (2008). Transferability and naturalistic generalization: New generalizability concepts for social science or old wine in new bottles? *Quality and Quantity*, *42*(3), 321–337. https://doi.org/10.1007/s11135-006-9048-0

Henley, D. E., Kaye, J. M., & Lightman, S. L. (2011). The endocrine response to stress. *Oxford textbook of endocrinology and diabetes*. Oxford Academic. https://doi.org/10.1093/med/9780199235292.003.2249

Henriksen, K., Dayton, E., Keyes, M. A., Carayon, P., & Hughes, R. (2008). Understanding adverse events: A human factors framework. R. J. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based*

Handbook for Nurses. Agency for Healthcare Research and Quality (US). https://pubmed.ncbi.nlm.nih.gov/21328766/

Hester, H. (2018). Care under capitalism: The crisis of “women’s” work. *IPPR Progressive Review*, *24*(4), 343–352. https://doi.org/https://doi.org/10.1111/newe.12074

Hewlett, S. A., & Luce, C. B. (2006, December). Extreme jobs: The dangerous allure of the 70-hour workweek. *Harvard Business Review*, *84*(12), 49–59. https://hbr.org/2006/12/extreme-jobs-the-dangerous-allure-of-the-70-hour-workweek

Hibbert, P. D., Healey, F., Lamont, T., Marela, W. M., Warner, B., & Runciman, W. B. (2016). Patient safety’s missing link: Using clinical expertise to recognize, respond to and reduce risks at a population level. *International Journal for Quality in Health Care*, *28*(1), 114–121. https://doi.org/10.1093/intqhc/mzv091

Hignett, S., & Lang, A. (2018). Human factors in health and social-care. *Human factors in health and social care*. CIEHF. https://www.ergonomics.org.uk/Healthcare

Hilton, Z., Ham, E., Rodrigues, N., Kirsch, B., Chapovalov, O., & Seto, M. (2020). Contribution of critical events and chronic stressors. *Psychiatric Services (Washington, D.C.)*, *71*(3), 221–227. DOI: 10.1176/appi.ps.201900226

Hochschild, A. R. (2012). *The managed heart: Commercialization of human feelings*. University of California Press.

Hofmarcher, M. M., Festl, E., & Bishop-Tarver, L. (2016). Health sector employment growth calls for improvements in labor productivity. *Health Policy*, *120*(8), 894–902. https://doi.org/10.1016/j.healthpol.2016.06.001

Hofmeyer, A., Taylor, R., & Kennedy, K. (2020). Knowledge for nurses to better care for themselves so they can better care for others during the Covid-19 pandemic and beyond. *Nurse Education Today*, *94*. https://doi.org/10.1016/j.nedt.2020.104503

Holden, R. J., Carayon, P., Gurses, A. P., Hoonakker, P., Hundt, A. S., Ozok, A. A., & Rivera-Rodriguez, A. J. (2013). SEIPS 2.0: a human factors framework for studying and improving the work of healthcare professionals and patients. *Ergonomics*, *56*(11), 1669–1686. https://doi.org/10.1080/00140139.2013.838643

Hora, S. C. (1996). Aleatory and epistemic uncertainty in probability elicitation with an example from hazardous waste management. *Reliability Engineering and System Safety*, *54*, 217–223. https://doi.org/10.1016/S0951-8320(96)00077-4

Horsburgh, J., & Ippolito, K. (2018). A skill to be worked at: Using social learning theory to explore the process of learning from role models in clinical settings. *BMC Medical Education*, *18*(1). https://doi.org/10.1186/s12909-018-1251-x

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the key tenets of Heidegger's philosophy for interpretive phenomenological research. *International Journal of Qualitative Methods*, *15*(1). https://doi.org/10.1177/1609406916680634

Horvath, M. A. H., Massey, K., Essafi, S., & Majeed-Ariss, R. (2020). Minimising trauma in staff at a sexual assault referral centre: What and who is needed? *Journal of Forensic and Legal Medicine*, *74*, 1–6. https://doi.org/10.1016/j.jflm.2020.102029

HSE. (2021a). *Human factors ergonomics: Supervision*. Health and Safety Executive. https://www.hse.gov.uk/humanfactors/topics/supervision.htm

HSE. (2021b, July 6). *Sensible risk assessments in care settings*. https://www.hse.gov.uk/healthservices/sensible-risk-assessment-care-settings.htm#:~:text=Making%20sensible%20risk%20assessment%20decisions&text=This%20requires%20a%20balanced%20decision,for%20restricting%20their%20reasonable%20freedoms

HSE. (2022a). *Lone working*. Health and Safety Executive. https://www.hse.gov.uk/lone-working/

HSE. (2022b). *Stress and mental health at work*. Health and Safety Executive. https://www.hse.gov.uk/stress/

HSE. (2022c, May 13). *Risks to healthcare workers*. Health and Safety Executive. https://www.hse.gov.uk/biosafety/healthcare.htm

HSE. (2023a, March 13). *Violence in health and social care*. https://www.hse.gov.uk/healthservices/violence/index.htm

HSE. (2023b). *Human factors and ergonomics*. https://www.hse.gov.uk/humanfactors/

Hull, L., Arora, S., Aggarwal, R., Darzi, A., Vincent, C., & Sevdalis, N. (2012). The impact of nontechnical skills on technical performance in surgery: A systematic review. *Journal of the American College of Surgeons* (Vol. 214, Issue 2, pp. 214–230). https://doi.org/10.1016/j.jamcollsurg.2011.10.016

Hunt, P. A., Denieffe, S., & Gooney, M. (2017). Burnout and its relationship to empathy in nursing: A review of the literature. *Journal of Research in Nursing*, *22*(1–2). https://doi.org/10.1177/1744987116678902

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenology*. https://www.scirp.org/%28S%28351jmbntvnsjt1aadkozje%29%29/reference/referencespapers.aspx?referenceid=445081

In, J. (2017). Introduction of a pilot study. *Korean Journal of Anesthesiology*, *70*(6), 601–605. https://doi.org/10.4097/kjae.2017.70.6.601

Inouye, J. (2017). Risk perception. *The Campbell Institute*. https://www.thecampbellinstitute.org/wp-content/uploads/2017/05/Campbell-Institute-Risk-Perception-WP.pdf

Institute of Medicine. (2000). Errors in health care: A leading cause of death and injury. L. T. Kohn, J. M. Corrigan, & M. S. Donaldson (Eds.), *To err is human: Building a safer health system*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK225187/

Ioannidou, F., & Konstantikaki, V. (2008). Empathy and emotional intelligence: What is it really about? *International Journal of Caring Sciences*, *1*(3), 118–123. http://www.internationaljournalofcaringsciences.org/docs/Vol1_Issue3_03_Ioannidou.pdf

Jackson, H., Wray, J., Gardiner, E., & Flanagan, T. (2019). Involving carers in risk assessment: a study of a structured dialogue between mental health nurses and carers. *Journal of Research in Nursing*, *24*(5), 330–341. https://doi.org/10.1177/1744987119851533

Jalilian, H., Shouroki, F. K., Azmoon, H., Rostamabadi, A., & Choobineh, A. (2019). Relationship between job stress and fatigue based on job demand-control-support model in hospital nurses. *International Journal of Preventive Medicine*, *10*(1). https://doi.org/10.4103/ijpvm.IJPVM_178_17

Jalloh, M. F., Li, W., Bunnell, R. E., Ethier, K. A., O'Leary, A., Hageman, K. M., Sengeh, P., Jalloh, M. B., Morgan, O., Hersey, S., Marston, B. J., Dafae, F., & Redd, J. T. (2018). Impact of Ebola experiences and risk perceptions on mental health in Sierra Leone, July 2015. *BMJ Global Health*, *3*(2). https://doi.org/10.1136/bmjgh-2017-000471

Janz, N. K., Becker, M. H., Associate, R., & Becker Is Professor, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly*, *11*(1), 1–47. DOI: 10.1177/109019818401100101

Jeihooni, A. K., & Rakhshani, T. (2019). The effect of educational intervention based on health belief model and social support on promoting skin cancer preventive behaviors in a sample of Iranian farmers. *Journal of Cancer Education*, *34*(2), 392–401. https://doi.org/10.1007/s13187-017-1317-1

Jeleff, M., Traugott, M., Jirovsky-Platter, E., Jordakieva, G., & Kutalek, R. (2022). Occupational challenges of healthcare workers during the COVID-19 pandemic: a qualitative study. *BMJ Open*, *12*, 54516. https://doi.org/10.1136/bmjopen-2021-054516

Jeong, H., & Othman, J. (2016). Using interpretative phenomenological analysis from a realist perspective. *Qualitative Report*, *21*(3), 558–570. https://doi.org/10.46743/2160-3715/2016.2300

Johari, F. S., & Omar, R. (2019). Exploring factors impacting on psychological well-being of health care workers. *International Journal of Academic Research in Business and Social Sciences*, *9*(2), 1210–1222. https://doi.org/10.6007/ijarbss/v9-i2/5711

Johnson, A. P., & Aggarwal, R. (2019). Assessment of non-technical skills: Why aren't we there yet? *BMJ Quality and Safety*, *28*(8), 606–608. https://doi.org/10.1136/bmjqs-2018-008712

Jones, C. P. L., Fawker-Corbett, J., Groom, P., Morton, B., Lister, C., & Mercer, S. J. (2018). Human factors in preventing complications in anaesthesia: A systematic review. *Anaesthesia*, *73*, 12–24. https://doi.org/10.1111/anae.14136

Jones, C. T., & Branco, S. F. (2020). Trauma-informed supervision: Clinical supervision of substance use disorder counselors. *Journal of Addictions and Offender Counseling*, *41*(1), 2–17. https://doi.org/10.1002/jaoc.12072

Jones, L. (2019). *Women's progression in the workplace*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/840404/KCL_Main_Report.pdf

Jones, P. J., Bellet, B. W., & McNally, R. J. (2020). Helping or harming: The effect of trigger warnings on individuals with trauma histories. *Clinical Psychological Science*, *8*(2). https://doi.org/10.1177/2167702620921341

Joseph, B., & Joseph, M. (2016). The health of the healthcare workers. *Indian Journal of Occupational Medicine*, *20*(2), 71–72. doi: 10.4103/0019-5278.197518 https://pubmed.ncbi.nlm.nih.gov/28194078/

Josephsson, S., Öhlén, J., Mondaca, M., Guerrero, M., Luborsky, M., & Lindström, M. (2022). Using Ricoeur's notions on narrative interpretation as a resource in supporting person-centredness in health and social care. *Nursing Philosophy*, *23*(3). https://doi.org/10.1111/nup.12398

Kadri, A., Rapaport, P., Livingston, G., Cooper, C., Robertson, S., & Higgs, P. (2018). Care workers, the unacknowledged persons in person-centred care: A secondary qualitative analysis of UK care home staff interviews. *PLoS ONE*, *13*(7). https://doi.org/10.1371/journal.pone.0200031

Karsh, B. T., Holden, R. J., Alper, S. J., & Or, C. K. L. (2006). A human factors engineering paradigm for patient safety: Designing to support the performance of the healthcare professional. *Quality and Safety in Health Care*, *15*(SUPPL. 1), 59–65. https://doi.org/10.1136/qshc.2005.015974

Kaya, G. K., Ward, J. R., & John Clarkson, P. (2019). A framework to support risk assessment in hospitals. *International Journal for Quality in Health Care*, *31*(5), 393–401. https://doi.org/10.1093/intqhc/mzy194

Kemper, S. (2016). *Abusive supervision in the workplace: An examination of current research and a proposal for preventive measures* [Portland State University]. https://doi.org/10.15760/honors.248

Kenny, N. P., Mann, K. V, & Macleod, H. (2003). Role modeling in physicians' professional formation: Reconsidering an essential but untapped educational strategy. *Academic Medicine*, *78*(12), 1203–1210. DOI: 10.1097/00001888-200312000-00002

Kerasidou, A., Bærøe, K., Berger, Z., & Caruso Brown, A. E. (2021). The need for empathetic healthcare systems. *Journal of Medical Ethics*, *47*(12), E27. https://doi.org/10.1136/medethics-2019-105921

Kiureghian, A. D., & Ditlevsen, O. (2009). Aleatory or epistemic? Does it matter? *Structural Safety*, *31*(2), 105–112. https://doi.org/10.1016/j.strusafe.2008.06.020

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education*, *6*(5), 26. https://doi.org/10.5430/ijhe.v6n5p26

Knafo, A., Zahn-Waxler, C., Davidov, M., Van Hulle, C., Robinson, J. A. L., & Rhee, S. H. (2009). Empathy in early childhood: Genetic, environmental, and affective contributions. *Annals of the New York Academy of Sciences*, *1167*, 103–114. https://doi.org/10.1111/j.1749-6632.2009.04540.x

Knight, C. (2018). Trauma-informed supervision: Historical antecedents, current practice, and future directions. *Clinical Supervisor*, *37*(1), 7–37. https://doi.org/10.1080/07325223.2017.1413607

Knight, C. (2019). Trauma informed practice and care: Implications for field instruction. *Clinical Social Work Journal*, *47*(1), 79–89. https://doi.org/10.1007/s10615-018-0661-x

Knight, C., & Borders, L. D. A. (2018). Trauma-informed supervision: Core components and unique dynamics in varied practice contexts. *Clinical Supervisor*, *37*(1), 1–6. https://doi.org/10.1080/07325223.2018.1440680

Knox, S., Goertz, M., Mak, T. W., Pinto-Coelho, K. G., & Hill, C. E. (2021). Immediacy in supervision: supervisees' perspectives on positive and negative events. *Journal of Psychotherapy Integration*, 1–18. https://doi.org/10.1037/int0000270

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *PubMed*, *24*(1), 174–184. https://doi.org/10.1046/j.1365-2648.1996.17224.x

Koinis, A., Giannou, V., Drantaki, V., Angelaina, S., Stratou, E., & Saridi, M. (2015). The impact of healthcare workers job environment on their mental-emotional health. Coping strategies: the case of a local general hospital. *Health Psychology Research*, *3*(1). https://doi.org/10.4081/hpr.2015.1984

Koivu, A., Saarinen, P. I., & Hyrkas, K. (2012). Who benefits from clinical supervision and how? The association between clinical supervision and the work-related well-being of female hospital nurses. *Journal of Clinical Nursing*, *21*(17–18), 2567–2578. https://doi.org/10.1111/j.1365-2702.2011.04041.x

Kok, M., & Muula, A. S. (2013). Motivation and job satisfaction of health surveillance assistants in Mwanza, Malawi: An explorative study. *Malawi Medical Journal*, *25*(1), 5–11. https://pubmed.ncbi.nlm.nih.gov/23717748/

Kornhaber, R., Walsh, K., Duff, J., & Walker, K. (2016). Enhancing adult therapeutic interpersonal relationships in the acute health care setting: An integrative review. *Journal of Multidisciplinary Healthcare* (Vol. 9, pp. 537–546). Dove Medical Press Ltd. https://doi.org/10.2147/JMDH.S116957

Kreitzer, L., Brintnell, S. E., & Austin, W. (2020). Institutional barriers to healthy workplace environments: From the voices of social workers experiencing compassion fatigue. *British Journal of Social Work*, *50*(7), 1942–1960. https://doi.org/10.1093/bjsw/bcz147

Krekel, C., & Ward, G. (2019). *Employee well-being, productivity, and firm performance: Evidence and case studies*. http://dx.doi.org/10.2139/ssrn.3356581

Kriger, D. (2021). What is risk? Four approaches to the embodiment of health risk in public health. *Health, Risk and Society*, *23*(3–4), 143–161. https://doi.org/10.1080/13698575.2021.1929864

Kundi, Y. M., Aboramadan, M., Elhamalawi, E. M. I., & Shahid, S. (2020). Employee psychological well-being and job performance: exploring mediating and moderating mechanisms. *International Journal of Organizational Analysis*, *29*(3), 736–754. https://doi.org/10.1108/IJOA-05-2020-2204

Lachs, M. S., Rosen, T., Teresi, J. A., Eimicke, J. P., Ramirez, M., Silver, S., & Pillemer, K. (2013). Verbal and physical aggression directed at nursing home staff by residents. *Journal of General Internal Medicine*, *28*(5), 660–667. https://doi.org/10.1007/s11606-012-2284-1

Larrazabal, M. A., Naragon-Gainey, K., & Conway, C. C. (2022). Distress tolerance and stress-induced emotion regulation behavior. *Journal of Research in Personality*, *99*. https://doi.org/10.1016/j.jrp.2022.104243

Lavoie-Tremblay, M., Fernet, C., Lavigne, G. L., & Austin, S. (2016). Transformational and abusive leadership practices: Impacts on novice nurses, quality of care and intention to leave. *Journal of Advanced Nursing*, *72*(3), 582–592. https://doi.org/10.1111/jan.12860

Law, E. (2016). *Research in care homes issues of participation and citizenship* [Thesis, University of Sterling]. http://hdl.handle.net/1893/25305

Lee, S., Denniston, C., Edouard, V., Palermo, C., Pope, K., Sutton, K., Waller, S., Ward, B., & Rees, C. (2019). Supervision training interventions in the health and human services: Realist synthesis protocol. *BMJ Open*, *9*(5). https://doi.org/10.1136/bmjopen-2018-025777

Lele, D. V. (2012). Risk assessment: A hidden tool for health, safety and environment management. *Indian Journal of Occupational and Environmental Medicine*, *16*(2), 57–58. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3617507/

Levenson, J. (2017). Trauma-informed social work practice. *Social Work (United States)*, *62*(2), 105–113. https://doi.org/10.1093/sw/swx001

Levers, M. J. D. (2013). Philosophical paradigms, grounded theory, and perspectives on emergence. *SAGE Open*, *3*(4). https://doi.org/10.1177/2158244013517243

Lewis, S. (2023, March 10). *Care worker dies in stabbing incident as resident appears in court*. Care Home Professional. https://www.carehomeprofessional.com/care-worker-dies-in-stabbing-incident-as-resident-appears-in-court/

Leyro, T. M., Zvolensky, M. J., & Bernstein, A. (2010). Distress tolerance and psychopathological symptoms and disorders: A review of the empirical literature among adults. *Psychological Bulletin*, *136*(4), 576–600. https://doi.org/10.1037/a0019712

Li, T., Wang, X., Yu, Y., & Yu, G. (2023). Exploring the dynamic characteristics of public risk perception and emotional expression during the COVID-19 pandemic on Sina Weibo. *Systems*, *11*(1), 1–17. https://doi.org/10.3390/systems11010045

Lightman, N., & Kevins, A. (2019). Bonus or burden? Care work, inequality, and job satisfaction in eighteen European countries. *European Sociological Review*, *35*(6), 825–844. https://doi.org/10.1093/esr/jcz032

Lim, M. C., Jeffree, M. S., Saupin, S. S., Giloi, N., & Lukman, K. A. (2022). Workplace violence in healthcare settings: The risk factors, implications and collaborative preventive measures. *Annals of Medicine and Surgery* (Vol. 13, Issue 73). Elsevier Ltd. https://doi.org/10.1016/j.amsu.2022.103727

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications, Inc. http://dx.doi.org/10.1016/0147-1767(85)90062-8

Liu, A., Wang, W., & Wu, X. (2021). Self-compassion and posttraumatic growth mediate the relations between social support, prosocial behavior, and antisocial behavior among adolescents after the Ya'an earthquake. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2020.1864949

Lluch-Sanz, C., Galiana, L., Doménech-Vañó, P., & Sansó, N. (2022). The Impact of the COVID-19 pandemic on burnout, compassion fatigue, and compassion satisfaction in healthcare personnel: A systematic review of the literature published during the first year of the pandemic. *Healthcare (Switzerland)*, *10*(2). https://doi.org/10.3390/healthcare10020364

Long, A. (2017, June 30). *The challenges of research in the care home setting*. British Geriatrics Society. https://www.bgs.org.uk/blog/the-challenges-of-research-in-the-care-home-setting

Lovell, R. C., Greenfield, D., Johnson, G., Eljiz, K., & Amanatidis, S. (2022). Optimising outcomes for complex trauma survivors: assessing the motivators, barriers and enablers for implementing trauma informed practice within a multidisciplinary health setting. *BMC Health Services Research*, *22*(1). https://doi.org/10.1186/s12913-022-07812-x

Lub, V. (2015). Validity in qualitative evaluation: linking purposes, paradigms, and perspectives. *International Journal of Qualitative Methods*, *14*(5). https://doi.org/10.1177/1609406915621406

Ludwick, T., Turyakira, E., Kyomuhangi, T., Manalili, K., Robinson, S., & Brenner, J. L. (2018). Supportive supervision and constructive relationships with healthcare workers support CHW performance: Use of a qualitative framework to evaluate CHW programming in Uganda. *Human Resources for Health*, *16*(1). https://doi.org/10.1186/s12960-018-0272-1

Lupton, D. (1999). Sociology and risk. In *Risk*. Routledge.

Luszczynska, A., & Schwarzer, R. (2015). Social cognitive theory. *Predicting Health Behaviour*, 127–169. https://www.researchgate.net/publication/284667057

Ly, O., Sibbald, S. L., Verma, J. Y., & Rocker, G. M. (2018). Exploring role clarity in interorganizational spread and scale-up initiatives: The “INSPIRED” COPD collaborative. *BMC Health Services Research*, *18*(1). https://doi.org/10.1186/s12913-018-3474-2

Lyng, S. (1990). Edgework: A social psychological analysis of voluntary risk taking. *American Journal of Sociology*, *95*(4). https://doi.org/10.1086/229379

Mabaquiao, N. M. (2005). Husserl’s theory of intentionality. *Philosophia: An International Journal of Philosophy*, *34*(1), 24–49. https://philpapers.org/archive/MABHTO.pdf

Mackey, J. D., Ellen, B. P., Hochwarter, W. A., & Ferris, G. R. (2013). Subordinate social adaptability and the consequences of abusive supervision perceptions in two samples. *Leadership Quarterly*, *24*(5), 732–746. https://doi.org/10.1016/j.leaqua.2013.07.003

Maher, C., Hadfield, M., Hutchings, M., & de Eyto, A. (2018). Ensuring rigor in qualitative data analysis. *International Methods of Qualitative Research*, *17*(1). https://doi.org/10.1177/1609406918786362

Maiman, L. A., & Becker, M. H. (1974). The health belief model: Origins and correlates in psychological theory. *Health Education Monographs*, *2*(4). https://doi.org/10.1177/109019817400200404

Makary, M. A., & Daniel, M. (2016). Medical error: The third leading cause of death in the US. *BMJ*, *353*. https://www.bmj.com/content/353/bmj.i2139

Manjarres-Posada, N. I., Onofre-Rodríguez, D. J., & Benavides-Torres, R. A. (2020). Social cognitive theory and health care: Analysis and evaluation. *International Journal of Social Science Studies*, *8*(4), 132. https://doi.org/10.11114/ijsss.v8i4.4870

Manthorpe, J. (2007). Managing risk in social care in the United Kingdom. *Health, Risk and Society* (Vol. 9, Issue 3, pp. 237–239). https://doi.org/10.1080/13698570701526032

Marquez, L., & Kean, L. (2002). Making supervision supportive and sustainable: New approaches to old problems. In *Maximising Access and Quality* (Vol. 3, Issue 4). https://pdf.usaid.gov/pdf_docs/PNACS924.pdf

Martin, P., Lizarondo, L., Kumar, S., & Snowdon, D. (2021). Impact of clinical supervision on healthcare organisational outcomes: A mixed methods systematic review. *PLoS ONE*, *16*(11 November). https://doi.org/10.1371/journal.pone.0260156

Martinko, M. J., Harvey, P., Brees, J. R., & Mackey, J. (2013). A review of abusive supervision research. *Journal of Organizational Behavior*, *34*(SUPPL 1). https://doi.org/10.1002/job.1888

Masis, L., Gichaga, A., Zerayacob, T., Lu, C., & Perry, H. B. (2021). Community health workers at the dawn of a new era. *Health Research Policy and Systems*, *19*. https://doi.org/10.1186/s12961-021-00751-9

Mathias, H. (n.d.). *Scotland’s Health and Social Care Standards*. www.behaviouralinsights.co.uk

Mccaffrey, G., Raffin-Bouchal, S., & Moules, N. J. (2012). Hermeneutics as research approach: A reappraisal. *International Journal of Qualitative Methods*, *2012*(3). https://doi.org/10.1177/160940691201100303

McCarron, R. H., Eade, J., & Delmage, E. (2018). The experience of clinical supervision for nurses and healthcare assistants in a secure adolescent service: Affecting service improvement. *Journal of Psychiatric and Mental Health Nursing*, *25*(3), 145–156. https://doi.org/10.1111/jpm.12447

McCarthy, M., Hunt, S., & Milne-Skillman, K. (2017). 'I know it was every week, but I can't be sure if it was every day: Domestic violence and women with learning disabilities. *Journal of Applied Research in Intellectual Disabilities*, *30*(2), 269–282. https://doi.org/10.1111/jar.12237

Mccloud, C., Harrington, A., & King, L. (2012). Understanding people's experience of vitreo-retinal day surgery: A Gadamerian-guided study. *Journal of Advanced Nursing*, *68*(1), 94–103. https://doi.org/10.1111/j.1365-2648.2011.05720.x

Mcenhill, L., Steadman, K., & Bajorek, Z. (2016). *Peer support for employment: a review of the evidence*. https://www.base-uk.org/sites/default/files/knowledge/Peer%20support%20for%20employment%20%3A%20a%20review%20of%20the%20evidence/peersupportworkfoundation.pdf

McFadden, P., Ross, J., Moriarty, J., Mallett, J., Schroder, H., Ravalier, J., Manthorpe, J., Currie, D., Harron, J., & Gillen, P. (2021). The role of coping in the wellbeing and work-related quality of life of UK health and social care workers during COVID-19. *International Journal of Environmental Research and Public Health*, *18*(2). https://doi.org/10.3390/ijerph18020815

McGilton, K. S., Escrig-Pinol, A., Gordon, A., Chu, C. H., Zúñiga, F., Sanchez, M. G., Boscart, V., Meyer, J., Corazzini, K. N., Jacinto, A. F., Spilsbury, K., Backman, A., Scales, K., Fagertun, A., Wu, B., Edvardsson, D., Lepore, M. J., Leung, A. Y. M., Siegel, E. O., … Bowers, B. (2020). Uncovering the devaluation of nursing home staff during COVID-19: are we fuelling the next health care crisis? *Journal of the American Medical Directors Association*, *21*(7), 962–965. https://doi.org/10.1016/j.jamda.2020.06.010

McIntosh, M. J., & Morse, J. M. (2015). Situating and constructing diversity in semi-structured interviews. *Global Qualitative Nursing Research*, *2*. https://doi.org/10.1177/2333393615597674

Mcintyre, R., & Smith, D. W. W. (1989). Theory of intentionality. J. N. Mohanty & W. R. McKenna (Eds.), *Husserl's Phenomenology: A textbook* (pp. 147–179). University Press of America. http://www.csun.edu/~vcoao087/pubs/intent.pdf

McKague, K., & Harrison, S. (2019). Gender and health social enterprises in Africa: A research agenda. *International Journal for Equity in Health*, *18*(1). https://doi.org/10.1186/s12939-019-0994-2

McLaughlin, Á., Casey, B., & McMahon, A. (2019). Planning and implementing group supervision: a case study from homeless social care practice. *Journal of Social Work Practice*, *33*(3), 281–295. https://doi.org/10.1080/02650533.2018.1500455

Mclelland, E. (2016, March 2). Mental health patient Michael Meanza 'snapped' and killed a care worker in Acton. *Mail Online*. https://www.dailymail.co.uk/news/article-3473268/Mental-health-patient-snapped-battered-care-worker-death-fire-extinguisher-asked-turn-TV-down.html

McLeod, J., & Wright, K. (2016). What does wellbeing do? An approach to defamiliarize keywords in youth studies. *Journal of Youth Studies*, *19*(6), 776–792. https://doi.org/10.1080/13676261.2015.1112887

McNicoll, A. (2013, May 29). Man who killed care worker on lone home visit 'should have been detained.' *Community Care*. https://www.communitycare.co.uk/2013/05/29/man-who-killed-care-worker-on-lone-home-visit-should-have-been-detained/

Mcphaul, K. M., & Lipscomb, J. A. (2004). Workplace violence in health care: Recognized but not regulated. *The Online Issue of Issues in Nursing*, *9*(3). http://ldihealtheconomist.com/media/nv09.pdf

Meier, N., & Wege, C. (2016). Writing with resonance. *Journal of Management Inquiry*, *26*(2), 193–201. https://doi.org/10.1177/1056492616673911

Mental Health Foundation. (n.d.). *Men and women: Statistics*. Mental Health Foundation. Retrieved August 7, 2023, from https://www.mentalhealth.org.uk/explore-mental-health/statistics/men-women-statistics

Mental Health Foundation. (2022, July 22). *Ten workplace mental health statistics you should know in 2022*. https://mhfaengland.org/mhfa-centre/blog/10-workplace-mental-health-statistics-2022/

Mento, C., Silvestri, M. C., Bruno, A., Muscatello, M. R. A., Cedro, C., Pandolfo, G., & Zoccali, R. A. (2020). Workplace violence against healthcare professionals: A systematic review. *Aggression and Violent Behavior*, *51*. https://doi.org/10.1016/j.avb.2020.101381

Miller, A., Trochmann, M., & Drury, I. (2022). Trauma-informed public management: A step toward addressing hidden inequalities and improving employee wellbeing. *Public Administration Quarterly*, 238–257. https://doi.org/10.37808/paq.46.3.3

Milligan, F. J. (2007). Establishing a culture for patient safety - The role of education. *Nurse Education Today*, *27*(2), 95–102. https://doi.org/10.1016/j.nedt.2006.03.003

Mind. (2018, September 11). *Half of workers have experienced poor mental health in current job*. Mind. https://www.mind.org.uk/news-campaigns/news/half-of-workers-have-experienced-poor-mental-health-in-current-job/

Minett, A. (2022, April 26). *Who Is responsible for workplace health and safety*. Contractors Health and Safety Assessment Scheme (CHAS). https://www.chas.co.uk/blog/contractor-health-safety/

Mitchell, L., Flin, R., Yule, S., Mitchell, J., Coutts, K., & Youngson, G. (2011). Thinking ahead of the surgeon. An interview study to identify scrub nurses' non-technical skills. *International Journal of Nursing Studies*, *48*(7), 818–828. https://doi.org/10.1016/j.ijnurstu.2010.11.005

Mole, L., Kent, B., Hickson, M., & Abbott, R. (2019). "It's what you do that makes a difference" An interpretative phenomenological analysis of health care professionals and home care workers experiences of nutritional care for people living with dementia at home. *BMC Geriatrics*, *19*(1). https://doi.org/10.1186/s12877-019-1270-4

Montgomery, T., Mazzei, M., Baglioni, S., & Sinclair, S. (2017). Who cares? The social care sector and the future of youth employment. *Policy and Politics*, *45*(3), 413–429. https://doi.org/10.1332/030557316X14778312165186

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, *28*(5), 1167–1177. https://doi.org/10.1111/cobi.12326

Moore, S. (2018). Oops! It's happened again! Evidence of the continuing abuse of older people in care homes. *The Journal of Adult Protection*, *20*(4). DOI:10.1108/JAP-06-2017-0026

Moore, T., McKee, K., & McCoughlin, P. (2015). Online focus groups and qualitative research in the social sciences: their merits and limitations in a study of housing and youth. *People, Place and Policy Onlin*, *9*(1), 17–28. https://doi.org/10.3351/ppp.0009.0001.0002

Moran, D. (2000). *Introduction to phenomenology*. Routledge. https://ds.amu.edu.et/xmlui/bitstream/handle/123456789/13348/0415183723.Routledge.Introduction.to.Phenomenology.Feb.2000.pdf?sequence=1&isAllowed=y

Moran, D. (2013). Edmund Husserl and Phenomenology. In A. Bailey (Ed.), *Philosophy of Mind: The key thinkers* (pp. 37–58). Bloomsbury.

Morgan, D. L., & Spanish, M. T. (1984). Focus groups: A new tool for qualitative research. *Qualitative Sociology*, *7*, 253–270. https://doi.org/10.1007/BF00987314

Moskos, M., & Isherwood, L. (2019). 'The wrong sex'? Understanding men's representation in the Australian aged care sector. *Journal of Industrial Relations*, *61*(1), 105–128. https://doi.org/10.1177/0022185618811862

Motamedi, A., Ludvigsson, M., & Simmons, J. (2022). Factors associated with health care providers speaking with older patients about being subjected to abuse. *Journal of Elder Abuse and Neglect*, *34*(1), 20–37. https://doi.org/10.1080/08946566.2021.2014378

Moudatsou, M., Stavropoulou, A., Philalithis, A., & Koukouli, S. (2020). The role of empathy in health and social care professionals. In *Healthcare (Switzerland)* (Vol. 8, Issue 1). MDPI AG. https://doi.org/10.3390/healthcare8010026

Moules, N. J. (2019). “Protecting” the sufferer. *Journal of Applied Hermeneutics*. https://jmss.org/index.php/jah/article/view/61824

Mrug, S., Madan, A., Cook, E. W., & Wright, R. A. (2015). Emotional and physiological desensitization to real-life and movie violence. *Journal of Youth and Adolescence*, *44*(5), 1092–1108. https://doi.org/10.1007/s10964-014-0202-z

Mrug, S., Madan, A., & Windle, M. (2016). Emotional desensitization to violence contributes to adolescents’ violent behavior. *Journal of Abnormal Child Psychology*, *44*(1), 75–86. https://doi.org/10.1007/s10802-015-9986-x

Müller, A., Mora, V., Rojas, E., Díaz, J., Fuentes, O., Giron, E., Gaytan, A., & van Etten, J. (2019). Emergency drills for agricultural drought response: a case study in Guatemala. *Disasters*, *43*(2), 410–430. https://doi.org/10.1111/disa.12316

Nancarrow, S., Bradbury, J., Pit, S. W., & Ariss, S. (2014). Intention to stay and intention to leave: Are they two sides of the same coin? A cross-sectional structural equation modelling study among health and social care workers. *Journal of Occupational Health*, *56*(4), 292–300. https://doi.org/10.1539/joh.14-0027-OA

Nantsupawat, A., Nantsupawat, R., Kunaviktikul, W., Turale, S., & Poghosyan, L. (2016). Nurse burnout, nurse reported quality of care, and patient outcomes in Thai hospitals. *Journal of Nursing Scholarship*, *48*(1), 83–90. https://doi.org/10.1111/jnu.12187

National Careers Service. (n.d.). *Social care: Explore careers*. GOV.UK. Retrieved September 28, 2023, from https://nationalcareers.service.gov.uk/job-categories/social-care

National Quality Board. (2013). *Human factors in healthcare a concordat from the National Quality Board*. https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

Ndima, S. D., Sidat, M., Give, C., Ormel, H., Kok, M. C., & Taegtmeyer, M. (2015). Supervision of community health workers in Mozambique: A qualitative study of factors influencing motivation and programme implementation. *Human Resources for Health*, *13*(1). https://doi.org/10.1186/s12960-015-0063-x

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education*, *8*(2), 90–97. https://doi.org/10.1007/s40037-019-0509-2

Newmahr, S. (2011). Chaos, order, and collaboration: Toward a feminist conceptualization of edgework. *Journal of Contemporary Ethnography*, *40*(6), 678–708. https://doi.org/10.1177/0891241611425177

Newman, C. (2014). Time to address gender discrimination and inequality in the health workforce. *Human Resources for Health*, *12*(1). https://doi.org/10.1186/1478-4491-12-25

Nguyen, T., & Velayutham, S. (2018). Street-level discretion, emotional labour and welfare frontline staff at the Australian employment service providers. *Australian Journal of Social Issues*, *53*(2), 158–172. https://doi.org/10.1002/ajs4.35

NHCHC. (2023). *Supervision of CHWs*. National Healthcare for the Homelessness Council. https://nhchc.org/research/publications/chws/supervision-of-chws/#:~:text=It%20is%20the%20responsibility%20of,and%20taking%20care%20of%20yourself.

NHLBI. (2014, June). *Role of community health workers*. National Heart, Lung and Blood Institute. https://www.nhlbi.nih.gov/health/educational/healthdisp/role-of-community-health-workers.htm#:~:text=CHWs%20offer%20interpretation%20and%20translation,such%20as%20first%20aid%20and

NHS Employers. (2023, October 5). *Care certificate*. NHS Employers. https://www.nhsemployers.org/articles/care-certificate

NHS Providers. (2022). Rising living costs: The impact on NHS, staff and patients. *NHS Providers*. https://nhsproviders.org/media/694201/nhs-providers-cost-of-living-survey-briefing-september-2022.pdf

Nicol, E. (2017). The ageing population in healthcare: a challenge to, and in the workforce. *Clinical Medicine (London)*, *17*(4), 291–292. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6297645/

Nigar, N. (2020). Hermeneutic phenomenological narrative enquiry: A qualitative study design. *Theory and Practice in Language Studies*, *10*(1), 10–18. https://doi.org/10.17507/tpls.1001.02

Nilsen, P., Seing, I., Ericsson, C., Birken, S. A., & Schildmeijer, K. (2020). Characteristics of successful changes in health care organizations: an interview study with physicians, registered nurses and assistant nurses. *BMC Health Services Research*, *20*(1). https://doi.org/10.1186/s12913-020-4999-8

Niskanen, T., Louhelainen, K., & Hirvonen, M. L. (2016). A systems thinking approach of occupational safety and health applied in the micro-, meso- and macro-levels: A Finnish survey. *Safety Science*, *82*, 212–227. https://doi.org/10.1016/j.ssci.2015.09.012

NMC. (2018, July 23). *What do practice supervisors do?* The Nursing and Midwifery Council. https://www.nmc.org.uk/supporting-information-on-standards-for-student-supervision-and-assessment/practice-supervision/what-do-practice-supervisors-do/

Nocon, R. S., Fairchild, P. C., Gao, Y., Gunter, K. E., Lee, S. M., Quinn, M., Huang, E. S., & Chin, M. H. (2019). Provider and staff morale, job satisfaction, and burnout over a 4-year medical home intervention. *Journal of General Internal Medicine*, *34*(6), 952–959. https://doi.org/10.1007/s11606-019-04893-z

Noon, E. J. (2017). An Interpretative Phenomenological Analysis of the Barriers to the Use of Humour in the Teaching of Childhood Studies. *Journal of Perspectives in Applied Academic Practice*, *5*(3). https://doi.org/10.14297/jpaap.v5i3.255

Noon, E. J. (2018). View of interpretive phenomenological analysis: An appropriate methodology for educational research. *Journal of Perspectives in Applied Academic Practice*, *6*(1). https://doi.org/10.14297/jpaap.v6i1.304

Nyashanu, M., Pfende, F., & Ekpenyong, M. S. (2022). Triggers of mental health problems among frontline healthcare workers during the COVID-19 pandemic in private care homes and domiciliary care agencies: Lived experiences of care workers in the Midlands region, UK. *Health and Social Care in the Community*, *30*(2), e370–e376. https://doi.org/10.1111/hsc.13204

Nyberg, A., Kecklund, G., Hanson, L. M., & Rajaleid, K. (2021). Workplace violence and health in human service industries: A systematic review of prospective and longitudinal studies. *Occupational and Environmental Medicine*, *78*(2), 69–81. https://doi.org/10.1136/oemed-2020-106450

O'Connor, P., & O'Dea, A. (2021). *An introduction to human factors for healthcare workers*. http://hdl.handle.net/10147/630666.

O'Donovan, J., O'Donovan, C., Kuhn, I., Sachs, S. E., & Winters, N. (2018). Ongoing training of community health workers in low-income and middle-income countries: A systematic scoping review of the literature. *BMJ Open*, *8*(4). https://doi.org/10.1136/bmjopen-2017-021467

Okuyan, C. B., & Begen, M. A. (2022). Working from home during the COVID-19 pandemic, its effects on health, and recommendations: The pandemic and beyond. *Perspectives in Psychiatric Care*, *58*(1), 173–179. https://doi.org/10.1111/ppc.12847

Olagunju, A. T., Bioku, A. A., Olagunju, T. O., Sarimiye, F. O., Onwuameze, O. E., & Halbreich, U. (2021). Psychological distress and sleep problems in healthcare workers in a developing context during COVID-19 pandemic: Implications for workplace wellbeing. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, *110*. https://doi.org/10.1016/j.pnpbp.2021.110292

O'Leary, M. (1985). Self-efficacy and health. *Behaviour Research and Therapy*, *23*(4), 437–451. https://doi.org/10.1016/0005-7967(85)90172-X

Olff, M. (2017). Sex and gender differences in post-traumatic stress disorder: an update. *European Journal of Psychotraumatology*, *8*(sup4). https://doi.org/10.1080/20008198.2017.1351204

Oliver, D. (2022). David Oliver: We're further than ever from solving the social care crisis. *The BMJ*. https://doi.org/10.1136/bmj.o2474

Oltedal, S., Moen, B.-E., Klempe, H., & Rundmo, T. (2004). *Explaining risk perception. An evaluation of cultural theory*. Rotunde. https://www.coursehero.com/file/190182716/Cultural-theorypdf/

ONS. (2018). *Women most at risk of experiencing partner abuse in England and Wales: years ending 2015-2017*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/womenmostatriskofexperiencingpartnerabuseinenglandandwales/yearsendingmarch2015to2017

ONS. (2020, March 3). *Sickness absence in the UK labour market 2020*. Office for National Statistics. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2020#:~:text=The%20UK%20sickness%20absence%20rate,throughout%20the%20data%20time%20series.

ONS. (2021, April 29). *Sickness absence in the UK labour market 2021*. Office for National Statistics. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2021#:~:text=The%20sickness%20absence%20rate%20in,to%204.6%20days%20per%20worker.

ONS. (2022, November 25). *Domestic abuse in England and Wales overview*. Office for National Statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2022

Orb, A., Eisenhauer, L., & Wynaden, D. (2000). Ethics in qualitative research. *Journal of Nursing Scholarship*, *33*(1), 93–96. http://www.columbia.edu/~mvp19/RMC/M5/QualEthics.pdf

Orji, R., Vassileva, J., & Mandryk, R. (2012). Towards an effective health interventions design: An extension of the health belief model. *Online Journal of Public Health Information*, *4*(3). https://doi.org/10.5210/ojphi.v4i3.4321

Oyewunmi, A. E., & Oyewunmi, O. A. (2022). Speaking silence: Abusive supervision, subordinates' citizenship behavior, and whistleblowing intention. *SAGE Open*, *12*(1). https://doi.org/10.1177/21582440221079912

Ozeke, O., Ozeke, V., Coskun, O., & Budakoglu, I. I. (2019). Second victims in health care: Current perspectives. *Advances in Medical Education and Practice*, *10*, 593–603. https://doi.org/10.2147/AMEP.S185912

Paek, H., & Hove, T. (2017). Risk perceptions and risk characteristics. *Oxford Research Encyclopaedia*. Oxford University Press. https://doi.org/10.1093/acrefore/9780190228613.013.283

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Park, K. F., & Shapira, Z. (2017). Risk and uncertainty. In M. Augier & D. Teece (Eds.), *The Palgrave Encyclopedia of Strategic Management* (07 ed., pp. 1–7). Palgrave Macmillan. https://doi.org/10.1057/978-1-349-94848-2_250-1

Parker, J., & Davies, B. (2020). No blame no gain? From a no blame culture to a responsibility culture in medicine. *Journal of Applied Philosophy*, *37*(4), 646–660. https://doi.org/10.1111/japp.12433

Paterson, M., & Higgs, J. (2015). Using hermeneutics as a qualitative research approach in professional practice. *The Qualitative Report*, *10*(2). https://doi.org/10.46743/2160-3715/2005.1853

PCAR. (2020). A Guide to Trauma-Informed Supervision. In *Pennsylvania Coalition Against Rape*. https://pcar.org/sites/default/files/resource-pdfs/trauma_informed_supervision_guide_508.pdf

Pearson, N., Naylor, P. J., Ashe, M. C., Fernandez, M., Yoong, S. L., & Wolfenden, L. (2020). Guidance for conducting feasibility and pilot studies for implementation trials. *Pilot and Feasibility Studies*, *6*(1). https://doi.org/10.1186/s40814-020-00634-w

Peat, G., Rodriguez, A., & Smith, J. (2019). Interpretive phenomenological analysis applied to healthcare research. *Evidence-Based Nursing*, *22*(1), 7–9. https://doi.org/10.1136/ebnurs-2018-103017

Pérez-Fuentes, M. del C., Molero Jurado, M. del M., del Pino, R. M., & Gázquez Linares, J. J. (2019). Emotional intelligence, self-efficacy and empathy as predictors of overall self-esteem in nursing by years of experience. *Frontiers in Psychology*, *10*. https://doi.org/10.3389/fpsyg.2019.02035

Perry, S. J., Catchpole, K., Rivera, A. J., Henrickson Parker, S., & Gosbee, J. (2021). 'Strangers in a strange land': Understanding professional challenges for human factors/ergonomics and healthcare. *Applied Ergonomics*, *94*. https://doi.org/10.1016/j.apergo.2019.103040

Phelan, A. (2015). Protecting care home residents from mistreatment and abuse. *Risk Management and Healthcare Policy*, *8*, 215–223. https://doi.org/10.2147/RMHP.S70191

Phipps, D. (2019, May 16). *Bringing practitioners and their work together: Human factors in health and social care regulation*. Professional Standards Authority Health and Social Care. https://www.professionalstandards.org.uk/news-and-blog/blog/detail/blog/2019/05/16/bringing-practitioners-and-their-work-together-human-factors-in-health-and-social-care-regulation

Phoo, N. N. N., & Reid, A. (2022). Determinants of violence towards care workers working in the home setting: A systematic review. *American Journal of Industrial Medicine*, *65*(6), 447–467. https://doi.org/10.1002/ajim.23351

Picton, A. (2021). Work-life balance in medical students: self-care in a culture of self-sacrifice. *BMC Medical Education*, *21*(1). https://doi.org/10.1186/s12909-020-02434-5

Pietkiewicz, I., & Smith, J. A. (2012). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal*, *18*(2), 361–369. https://doi.org/10.14691/CPPJ.20.1.7

Pickett, L. (2017). *Professional regulation in health and social care*. https://researchbriefings.files.parliament.uk/documents/CBP-8094/CBP-8094.pdf

Pish, M. (2016). *Frantz Fanon's critique of Maurice Merleau-Ponty's corporeal schema*. State University of New York College . http://hdl.handle.net/1951/67610

Polit, D. F., & Beck, C. T. (2010). Generalization in quantitative and qualitative research: Myths and strategies. *International Journal of Nursing Studies*, *47*(11), 1451–1458. https://doi.org/10.1016/j.ijnurstu.2010.06.004

Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipriano, D., Norris, L., & Olsen, S. (2010). Compassion fatigue and burnout: Prevalence among oncology nurses. *Clinical Journal of Oncology Nursing*, *14*(5). https://doi.org/10.1188/10.CJON.E56-E62

Privitera, M. (2018). Addressing human factors in burnout and the delivery of healthcare: Quality & safety imperative of the quadruple aim. *Health*, *10*(5). https://doi.org/DOI: 10.4236/health.2018.105049 https://www.scirp.org/(S(czeh2tfqw2orz553k1w0r45))/reference/referencespapers.aspx?referenceid=2835186

PSA. (2016). *Right-touch assurance: A methodology for assessing and assuring occupational risk of harm*. https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-(october-2016).pdf?sfvrsn=f21a7020_0

Rabindrakumar, S. (2018). *One in four: A profile of single parents in the UK*. https://www.gingerbread.org.uk/wp-content/uploads/2018/02/One-in-four-a-profile-of-single-parents-in-the-UK.compressed.pdf

Radis, B. (2020). Reflections on facilitating a trauma-informed clinical supervision group with housing first staff. *Social Work with Groups*, *43*(1–2), 46–51. https://doi.org/10.1080/01609513.2019.1638654

Rantala, M., Lindholm, M., & Tappura, S. (2022). *Supporting occupational health and safety risk assessment skills: A case study of five companies*. *19*(3). https://doi.org/10.3390/ijerph19031720

Rape Crisis. (n.d.). *Statistics about rape, sexual assault and sexual abuse: England & Wales*. Rape Crisis (England and Wales). Retrieved August 9, 2023, from https://rapecrisis.org.uk/get-informed/statistics-sexual-violence/

Rapport, F. (2005). Hermeneutic phenomenology: The science of interpretation of texts. I. Holloway (Ed.), *Qualitative research in health care* (p. 125). Open University Press. https://lsms.ac/wp-content/uploads/2023/02/11_.pdf#page=144

Rasool, S. F., Wang, M., Tang, M., Saeed, A., & Iqbal, J. (2021). How toxic workplace environment effects the employee engagement: The mediating role of organizational support and employee wellbeing. *International Journal of Environmental Research and Public Health*, *18*(5), 1–17. https://doi.org/10.3390/ijerph18052294

Rauvola, ,R, Vega, D., & Lavigne, K. (2019). Compassion fatigue, secondary traumatic stress, and vicarious traumatization: A qualitative review and research agenda. *Occupational Health Science*, *3*, 297–336. https://doi.org/10.1007/s41542-019-00045-1

Ravalier, J. M., McVicar, A., & Boichat, C. (2020). Work stress in NHS employees: A mixed-methods study. *International Journal of Environmental Research and Public Health*, *17*(18), 1–14. https://doi.org/10.3390/ijerph17186464

Ravalier, J., McFadden, P., Gillen, P., Mallett, J., Nicholl, P., Neill, R., Manthorpe, J., Moriarty, J., Schroder, H., & Curry, D. (2023). Working conditions and well-being in UK social care and social work during COVID-19. *Journal of Social Work*, *23*, 165–188. https://doi.org/10.1177/14680173221109483

Ravalier, J., Morton, R., Russell, L., & Rei Fidalgo, A. (2019). Zero-hour contracts and stress in UK domiciliary care workers. *Health and Social Care in the Community*, *27*(2), 348–355. https://doi.org/10.1111/hsc.12652

Rawlins, B. R., & Rawlins, B. L. (2008). Measuring the relationship between organizational transparency and employee trust. *Public Relations Journal*, *2*(2), 1–21. https://scholarsarchive.byu.edu/facpubhttps://scholarsarchive.byu.edu/facpub/885

RCN. (2021, November 18). *Healthy workplace, healthy you*. Royal College of Nursing; Royal College of Nursing. https://www.rcn.org.uk/healthy-workplace/healthy-workplaces/Work-life-balance

Rees, C. E., Lee, S. L., Huang, E., Denniston, C., Edouard, V., Pope, K., Sutton, K., Waller, S., Ward, B., & Palermo, C. (2020). Supervision training in healthcare: a realist synthesis. *Advances in Health Sciences Education*, *25*(3), 523–561. https://doi.org/10.1007/s10459-019-09937-x

Regan, P. (2012). *Hans-Georg Gadamer's philosophical hermeneutics: Concepts of reading, understanding and interpretation*. *IV*(2), 2067–3655. https://www.researchgate.net/publication/273447378_Hans-Georg_Gadamer's_philosophical_hermeneutics_Concepts_of_reading_understanding_and_interpretation

Rehder, K., Adair, K. C., & Sexton, J. B. (2021). The science of health care worker burnout assessing and improving health care worker well-being. *Archives of Pathology and Laboratory Medicine*, *145*(9), 1095–1109. https://doi.org/10.5858/arpa.2020-0557-RA

Renn, O. (2004). Perception of risks. *Toxicology Letters*, *149*(1–3), 405–413. https://doi.org/10.1016/j.toxlet.2003.12.051

Renn, O., & Rohrmann, B. (2000). Cross-cultural risk perception: State and challenges. In O. Renn & B. Rohrmann (Eds.), *Technology, risk and society* (Vol. 13, pp. 211–233). Springer US. https://doi.org/10.1007/978-1-4757-4891-8_6

Reynolds, J. (n.d.). *Combining face-to-face and online focus groups can reap benefits*. 2022. Retrieved August 9, 2023, from https://www.research-live.com/article/news/combining-facetoface-and-online-focus-groups-can-reap-benefits/id/5096782

Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: Are there special issues for health services research? *Family Practice*, *19*(2). https://doi.org/DOI: 10.1093/fampra/19.2.135 https://pubmed.ncbi.nlm.nih.gov/11906977/

Riess, H. (2017). The science of empathy. *Journal of Patient Experiences*, *4*(2), 74–77. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5513638/

Rivlin, A., & Lumley, T. (2023, January 9). *Why is the world now facing a medical recruitment crisis*. World Economic Forum. https://www.weforum.org/agenda/2023/01/medical-recruitment-crisis-davos23/

Roberts, C., Darroch, F., Giles, A., & van Bruggen, R. (2022). You're carrying so many people's stories: Vicarious trauma among fly-in fly-out mental health service providers. *International Journal of Studies in Health and Wellbeing*, *17*(1). https://doi.org/10.1080/17482631.2022.2040089

Robertson, J., Jayne, C., & Oakman, J. (2021). Work-related musculoskeletal and mental health disorders: Are workplace policies and practices based on contemporary evidence? *Safety Science*, *138*. https://doi.org/10.1016/j.ssci.2020.105098

Rolin, S. N., Flis, A., & Davis, J. J. (2022). Work coping, stress appraisal, and psychological resilience: Reaction to the COVID-19 pandemic among health care providers. *Psychology and Neuroscience*, *15*(2), 131–146. https://doi.org/10.1037/pne0000257

Rosenstock, I. M. (1974). Historical origins of the health belief model. *Health Education and Behaviour*, *2*(4). https://doi.org/https://doi.org/10.1177/109019817400200403

Ross, D. (2017). Challenges for men in a female dominated environment challenges for men in a female dominated. *Health and Social Care*, *2*(1), 4–20. http://openjournals.ljmu.ac.uk/lhsc

Roth, C. K. (2014). Human factors contributing to nursing errors. *The Journal of Nursing Administration*, *45*(5), 263–269. http://hdl.handle.net/10950/206

Roth, W. M., & Von Unger, H. (2018). Current perspectives on research ethics in qualitative research. *Qualitative Social Research*, *19*(3), 1–12. http://www.qualitative-research.net/

Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: A rapid evidence review. *BMJ Open*, *11*(9). https://doi.org/10.1136/bmjopen-2021-052929

Rowe, S. Y., Ross-Degnan, D., Peters, D. H., Holloway, K. A., & Rowe, A. K. (2022). The effectiveness of supervision strategies to improve health care provider practices in low- and middle-income countries: secondary analysis of a systematic review. *Human Resources for Health*, *20*(1). https://doi.org/10.1186/s12960-021-00683-z

Rubery, J., & Grimshaw, D. (2007). *Undervaluing women's work* (53). https://www.researchgate.net/publication/267854289_Undervaluing_Women%27s_Work#:~:text=In%20traditional%20labor%20markets%2C%20women%20face%20what%20Grimshaw,in%20education%20or%20from%20their%20own%20work%20experience.

Russ, A. L., Fairbanks, R. J., Karsh, B.-T., Militello, L. G., & Saleem, J. J. (2013). The science of human factors: separating fact from fiction. *Quality and Safety*, *22*(10), 802–808. https://doi.org/10.1136/bmjqs

Sabitova, A., Hickling, L. M., & Priebe, S. (2020). Job morale: A scoping review of how the concept developed and is used in healthcare research. *BMC Public Health*, *20*(1). https://doi.org/10.1186/s12889-020-09256-6

Salas-Vallina, A., Pozo-Hidalgo, M., & Gil-Monte, P. R. (2020). Are happy workers more productive? The mediating role of service-skill use. *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.00456

Saleem, J. J., Russ, A. L., Sanderson, P., Johnson, T. R., Zhang, J., & Sittig, D. F. (2009). Current challenges and opportunities for better integration of human factors research with development of clinical information systems. *IMIA Yearbook of Medical Informatics*, 48–58. https://pubmed.ncbi.nlm.nih.gov/19855872/

Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The relationship between professional burnout and quality and safety in healthcare: A meta-analysis. *Journal of General Internal Medicine*, *32*(4), 475–482. https://doi.org/10.1007/s11606-016-3886-9

Samuel, M. (2020, April 20). Covid-19 deaths among social care staff far outstripping those in healthcare. *Community Care*. https://www.communitycare.co.uk/2020/05/11/covid-19-deaths-among-social-care-staff-far-outstripping-healthcare/

Sarre, S., Maben, J., Aldus, C., Schneider, J., Wharrad, H., Nicholson, C., & Arthur, A. (2018). The challenges of training, support and assessment of healthcare support workers: A qualitative study of experiences in three English acute hospitals. *International Journal of Nursing Studies*, *79*, 145–153. https://doi.org/10.1016/j.ijnurstu.2017.11.010

Sawatzky, R., Kwon, J. Y., Barclay, R., Chauhan, C., Frank, L., van den Hout, W. B., Nielsen, L. K., Nolte, S., & Sprangers, M. A. G. (2021). Implications of response shift for micro-, meso-, and macro-level healthcare decision-making using results of patient-reported outcome measures. *Quality of Life Research*, *30*(12), 3343–3357. https://doi.org/10.1007/s11136-021-02766-9

Schiff, J. M., & Lane, A. M. (2019). PTSD symptoms, vicarious traumatization, and burnout in front line workers in the homeless sector. *Community Mental Health Journal*, *55*(3), 454–462. https://doi.org/10.1007/s10597-018-00364-7

Schnackenberg, A. K., & Tomlinson, E. C. (2016). Organizational transparency: A new perspective on managing trust in organization-stakeholder relationships. *Journal of Management*, *42*(7), 1784–1810. https://doi.org/10.1177/0149206314525202

Schwarz, D., Kim, J.-H., Ratcliffe, H., Awoonor-Williams, J. K., Nimako, B., Otupiri, E., Lipsitz, S., Hirschhorn, L., & Bitton, A. (2019). The status of Ghanaian community health workers' supervision and service delivery: descriptive analyses from the 2017 Performance Monitoring and Accountability 2020 survey. *Gates Open Research*, *3*, 1468. https://doi.org/10.12688/gatesopenres.12979.1

Schwarzer, R., & Fuchs, R. (1995). Self-efficacy and health behaviours. *Predicting health behaviour: Research and practice with cognition models*. Open University Press. https://userpage.fu-berlin.de/gesund/publicat/conner9.htm

SCIE. (2017, January). *Effective supervision in a variety of settings*. Social Care Institute for Excellence. https://www.scie.org.uk/publications/guides/guide50/

Seedat, S., & Rondon, M. (2021). Women's wellbeing and the burden of unpaid work. *The BMJ*, *374*. https://doi.org/10.1136/bmj.n1972

Selamu, M., Thornicroft, G., Fekadu, A., & Hanlon, C. (2017). Conceptualisation of job-related wellbeing, stress and burnout among healthcare workers in rural Ethiopia: A qualitative study. *BMC Health Services Research*, *17*(1). https://doi.org/10.1186/s12913-017-2370-5

Seligowski, A. V, Harnett, N. G., Berker, J. B., & Ressler, J. K. (2020). Nervous and endocrine system dysfunction in posttraumatic stress: An overview and consideration of sex as a biological variable. *Biol Psychiatry Cogni Neurosci Neuroimaging*, *5*(4), 381–391. doi: 10.1016/j.bpsc.2019.12.006

Seys, D., Wu, A. W., Gerven, E. Van, Vleugels, A., Euwema, M., Panella, M., Scott, S. D., Conway, J., Sermeus, W., & Vanhaecht, K. (2013). Health care professionals as second victims after adverse events: A systematic review. *Evaluation and the Health Professions*, *36*(2), 135–162. https://doi.org/10.1177/0163278712458918

Schoultz, M., McGrogan, C., Beattie, M., Macaden, L., Carolan, C., Polson, R., & Dickens, G. (2022). Psychological first aid for workers in care and nursing homes: systematic review. *BMC Nursing*, *21*(1). https://doi.org/10.1186/s12912-022-00866-6

Schwarz, D., Kim, J.-H., Ratcliffe, H., Awoonor-Williams, J. K., Nimako, B., Otupiri, E., Lipsitz, S., Hirschhorn, L., & Bitton, A. (2019). The status of Ghanaian community health workers' supervision and service delivery: descriptive analyses from the 2017 Performance Monitoring and Accountability 2020 survey. *Gates Open Research*, *3*, 1468. https://doi.org/10.12688/gatesopenres.12979.1

Schwarzer, R., & Fuchs, R. (1995). Self-efficacy and health behaviours. *Predicting health behaviour: Research and practice with cognition models*. Open University Press. https://userpage.fu-berlin.de/gesund/publicat/conner9.htm

SCIE. (2017, January). *Effective supervision in a variety of settings*. Social Care Institute for Excellence. https://www.scie.org.uk/publications/guides/guide50/

Scott, A., Ryan, A., James, I., & Mitchell, E. A. (2011). Perceptions and implications of violence from care home residents with dementia: A review and commentary. *International Journal of Older People Nursing*, *6*(2), 110–122. https://doi.org/10.1111/j.1748-3743.2010.00226.x

Seedat, S., & Rondon, M. (2021). Women's wellbeing and the burden of unpaid work. *The BMJ*, *374*. https://doi.org/10.1136/bmj.n1972

Selamu, M., Thornicroft, G., Fekadu, A., & Hanlon, C. (2017). Conceptualisation of job-related wellbeing, stress and burnout among healthcare workers in rural Ethiopia: A qualitative study. *BMC Health Services Research*, *17*(1). https://doi.org/10.1186/s12913-017-2370-5

Seligowski, A. V, Harnett, N. G., Berker, J. B., & Ressler, J. K. (2020). Nervous and endocrine system dysfunction in posttraumatic stress: An overview and consideration of sex as a biological variable. *Biol Psychiatry Cogni Neurosci Neuroimaging*, *5*(4), 381–391. doi: 10.1016/j.bpsc.2019.12.006

Shannon, G., Minckas, N., Tan, D., Haghparast-Bidgoli, H., Batura, N., & Mannell, J. (2019). Feminisation of the health workforce and wage conditions of health professions: An exploratory analysis. *Human Resources for Health*, *17*(1). https://doi.org/10.1186/s12960-019-0406-0

Shaw A, & Shaw I. (2001). Risk research in a risk society. *The Journal of the Social Services Research Group*, *19*(1). http://ssrg.org.uk/rpp-19-1-alison-shaw-ian-shaw-risk-research-in-a-risk-society/

Sheehan, S. (2014). A conceptual framework for understanding transcendental phenomenology through the lived experiences of biblical leaders. *Emerging Leadership Journeys*, *7*(1). https://www.regent.edu/journal/emerging-leadership-journeys/understanding-transcendental-phenomenology/

Shih, F. C., Yeh, S. C. J., & Hsu, W. L. (2022). Abusive supervision and employee well-being of nursing staff: Mediating role of occupational stress. *Journal of Advanced Nursing*, *79*(2), 664–675. https://doi.org/10.1111/jan.15538

Shorey, S., & Ng, E. D. (2022). Examining characteristics of descriptive phenomenological nursing studies: A scoping review. *Journal of Advanced Nursing*, *78*(7), 1968–1979. https://doi.org/10.1111/jan.15244

Shrestha, S., Alharbi, R. J., Wells, Y., While, C., & Rahman, M. A. (2021). Caring self-efficacy of direct care workers in residential aged care settings: A mixed methods scoping review. *Geriatric Nursing*, *42*(6), 1429–1445. https://doi.org/10.1016/j.gerinurse.2021.09.014

Simard, K., & Parent-Lamarche, A. (2022). Abusive leadership, psychological well-being, and intention to quit during the COVID-19 pandemic: a moderated mediation analysis among Quebec’s healthcare system workers. *International Archives of Occupational and Environmental Health*, *95*(2), 437–450. https://doi.org/10.1007/s00420-021-01790-z

Simeonova, B., Galliers, R. D., & Karanasios, S. (2022). Power dynamics in organisations and the role of information systems. *Information Systems Journal*, *32*(2), 233–241. https://doi.org/10.1111/isj.12373

Simpkin, V. L., & Mossialos, E. (2017). Brexit and the NHS: Challenges, uncertainties and opportunities. *Health Policy*, *121*(5), 477–480. https://doi.org/10.1016/j.healthpol.2017.02.018

Singh, J. K., & Jain, M. (2013). A study of employees’ job satisfaction and its impact on their performance. *Journal of Indian Research*, *1*(4), 105–111. https://www.academia.edu/34254779/A_STUDY_OF_EMPLOYEES_JOB_SATISFACTION_AND_ITS_IMPACT_ON_THEIR_PERFORMANCE

Singh, Y., Adil, M., & Haque, S. M. I. (2022). Personality traits and behaviour biases: the moderating role of risk-tolerance. *Quality and Quantity*, *57*, 3549–3573. https://doi.org/10.1007/s11135-022-01516-4

Sitkin, S. B., & Pablo, A. L. (1992). Reconceptualizing the determinants of risk behavior. *The Academy of Management Review*, *17*(1), 9–36. https://doi.org/10.5465/amr.1992.4279564

Skills for Care. (2020, April). *Effective supervision A practical guide for adult social care managers and supervisors*. Skills for Care; Skills for Care. https://www.skillsforcare.org.uk/resources/documents/Support-for-leaders-and-managers/Managing-people/Supervision/Effective-supervision-guide.pdf

Skills for Care. (2022a). *The state of the adult social care sector and workforce in England*. Skills for Care. 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

Skills for Care. (2022b, December). *Pay rates*. Skills for Care. https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/Topics/Pay-rates.aspx

Skills for Care. (2023, June). *The size and structure of the adult social care sector and workforce in England*. Skills for Care. https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-size-and-structure-of-the-adult-social-care-sector-and-workforce-in-England.aspx

Skryabina, E. A., Betts, N., Reedy, G., Riley, P., & Amlôt, R. (2020). The role of emergency preparedness exercises in the response to a mass casualty terrorist incident: A mixed methods study. *International Journal of Disaster Risk Reduction*, *46*. https://doi.org/10.1016/j.ijdrr.2020.101503

Skryabina, E., Reedy, G., Amlôt, R., Jaye, P., & Riley, P. (2017). What is the value of health emergency preparedness exercises? A scoping review study. *International Journal of Disaster Risk Reduction*, *21*, 274–283. https://doi.org/10.1016/j.ijdrr.2016.12.010

Slovic, P., & Weber, E. U. (2002). Perception of risk posed by extreme events. *Risk management strategies in an uncertain world*. https://www.researchgate.net/publication/209805350_Perception_of_Risk_Posed_by_Extreme_Events

Smith, B. (2018). Generalizability in qualitative research: misunderstandings, opportunities and recommendations for the sport and exercise sciences. *Qualitative Research in Sport, Exercise and Health*, *10*(1), 137–149. https://doi.org/10.1080/2159676X.2017.1393221

Smith, C. (2020). The structural vulnerability of healthcare workers during COVID-19: Observations on the social context of risk and the equitable distribution of resources. *Social Science and Medicine*, *258*. https://doi.org/10.1016/j.socscimed.2020.113119

Smith, D. W. (2003). Phenomenology. *Stanford Encyclopedia of Philosophy*. https://plato.stanford.edu/entries/phenomenology/#:~:text=Phenomenology%20as%20we%20know%20it,Investigations%20(1900%E2%80%9301).

Smith, J. A. (2007). Hermeneutics, human sciences and health: Linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(1), 3–11. https://doi.org/10.1080/17482620601016120

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, *9*(1), 41–42. https://doi.org/10.1177/2049463714541642

Smith, T., McNeil, K., Mitchell, R., Boyle, B., & Ries, N. (2019). A study of macro-, meso- and micro-barriers and enablers affecting extended scopes of practice: The case of rural nurse practitioners in Australia. *BMC Nursing*, *18*(1). https://doi.org/10.1186/s12912-019-0337-z

Smyth, A., & Holian, R. (2007). Researching education from the Inside: Credibility issues in research from within organisations. P. Sikes & A. Potts (Eds.), *Researching education from the inside* (1st ed.). Routledge.

Snider, Leslie., Van Ommeren, M., Schafer, Alison., World Health Organization., War Trauma Foundation., & World Vision International. (2011). *Psychological first aid : guide for field workers*. World Health Organization. https://www.who.int/publications/i/item/9789241548205

Snowden, D., Leggat, S., & Taylor, N. (2017). Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience: A systematic review. *Health Services Research*, *17*, 786. https://doi.org/https://doi.org/10.1186/s12913-017-2739-5

Social Work England. (2020, January 20). *Supervisors and reporters*. Social Work England. https://www.socialworkengland.org.uk/concerns/supervisors-and-reporters/

Social Work England. (2023). *Supervision*. Social Work England. https://www.socialworkengland.org.uk/cpd/supervision/

Song, W., Li, J., Li, H., & Ming, X. (2020). Human factors risk assessment: An integrated method for improving safety in clinical use of medical devices. *Applied Soft Computing Journal*, *86*. https://doi.org/10.1016/j.asoc.2019.105918

Šotić, A., & Rajić, R. (2015). The review of the definition of risk. *Online Journal of Applied Knowledge Management*, *3*(3), 17–26. http://www.iiakm.org/ojakm/articles/2015/volume3_3/OJAKM_Volume3_3pp17-26.pdf

Søvold, L. E., Naslund, J. A., Kousoulis, A. A., Saxena, S., Qoronfleh, M. W., Grobler, C., & Münter, L. (2021). Prioritizing the mental health and well-Being of healthcare workers: An urgent global public health priority. *Frontiers in Public Health*, *9*. https://doi.org/10.3389/fpubh.2021.679397

Sparkes, A. C., & Smith, B. (2009). Judging the quality of qualitative inquiry: Criteriology and relativism in action. *Psychology of Sport and Exercise*, *10*(5), 491–497. https://doi.org/10.1016/j.psychsport.2009.02.006

Spence, S. H. ;, Wilson, J. ;, Kavanagh, D. ;, Strong, J. ;, & Worrall, L. (2001). Clinical supervision in four mental health professions: A review of the evidence. *Behaviour Change*, *18*, 135. DOI:10.1375/bech.18.3.135

Stace, H. (2013). *Disability care as women's work*. Women's Studies Association of Aotearoa New Zealand. https://thechp.syr.edu/women-and-disability-women-and-care/

St.Amant, K., & Graham, S. S. (2019). Research that resonates: A perspective on durable and portable approaches to scholarship in technical communication and rhetoric of science. *Technical Communication Quarterly*, *28*(2), 99–111. https://doi.org/10.1080/10572252.2019.1591118

Stanley, N., Manthorpe, J., & White, M. (2007). Depression in the profession: Social workers' experiences and perceptions. *British Journal of Social Work*, *37*(2), 281–298. https://doi.org/10.1093/bjsw/bcl058

Strametz, R., Koch, P., Vogelgesang, A., Burbridge, A., Rösner, H., Abloescher, M., Huf, W., Ettl, B., & Raspe, M. (2021). Prevalence of second victims, risk factors and support strategies among young German physicians in internal medicine (SeViD-I survey). *Journal of Occupational Medicine and Toxicology*, *16*(1). https://doi.org/10.1186/s12995-021-00300-8

Stein, M., Vincent-Höper, S., Schümann, M., & Gregersen, S. (2020). Beyond mistreatment at the relationship level: Abusive supervision and illegitimate tasks. *International Journal of Environmental Research and Public Health*, *17*(8). https://doi.org/10.3390/ijerph17082722

Steltenpohl, C. N., Lustick, H., Meyer, M. S., Lee, L. E., Stegenga, S. M., Reyes, L. S., & Renbarger, R. L. (2022). Rethinking transparency and rigor from a qualitative open science perspective. *Journal of Trial and Error*. https://doi.org/10.36850/mr7

Stemke, C. A. (2013). Distress tolerance and mental health outcomes. *Modern Psychological Studies*, *18*(2), 127–136. https://scholar.utc.edu/mpsAvailableat:https://scholar.utc.edu/mps/vol18/iss2/13

Stephens, M., & Knight, A. (2022). 'Things won't improve if they're Just left to fester': A qualitative study exploring how UK care home staff perceive and experience engagement in health research. *Journal of Long-Term Care*, *0*(2022), 268. https://doi.org/10.31389/jltc.137

Stevens, I., & Hassett, P. (2012). Non-linear perspectives of risk in social care: using complexity theory and social geography to move the focus from individual pathology to the complex human environment. *European Journal of Social Work*, *15*(4), 503–513. https://doi.org/10.1080/13691457.2012.702309

Stramler, J. (1993). *The dictionary for human factors/ergonomics* (H. James & J. Stramler, Eds.; 1st ed.). Taylor Francis. https://doi.org/10.1201/9780203736890

Streimelweger, B., Wac, K., & Seiringer, W. (2015). Improving Patient Safety through Human-factor-based Risk Management. *Procedia Computer Science*, *64*, 79–86. https://doi.org/10.1016/j.procs.2015.08.466

Suckling, R., Ferris, M., & Price, C. (2003). Risk identification, assessment and management in public health practice: A practical approach in one public health department. *Journal of Public Health Medicine*, *25*(2), 138–143. https://doi.org/10.1093/pubmed/fdg029

Sud, A., & Szawarski, P. (2018). Classic cases revisited – Death of a nurse and the anatomy of error. *Journal of the Intensive Care Society*, *19*(2), 155–160. https://doi.org/10.1177/1751143717735203

Suddick, K. M., Cross, V., Vuoskoski, P., Galvin, K. T., & Stew, G. (2020). The work of hermeneutic phenomenology. *International Journal of Qualitative Methods*, *19*. https://doi.org/10.1177/1609406920947600

Sutherland, K., & Leatherman, S. (2006). *Regulation and quality improvement A review of the evidence*. https://www.health.org.uk/publications/regulation-and-quality-improvement

Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: A systematic review and narrative synthesis. *European Journal of Psychotraumatology*, *13*(1). https://doi.org/10.1080/20008198.2021.2022278

Swedberg, L., Chiriac, E. H., Törnkvist, L., & Hylander, I. (2013). From risky to safer home care: Health care assistants striving to overcome a lack of training, supervision, and support. *International Journal of Qualitative Studies on Health and Well-Being*, *8*(1). https://doi.org/10.3402/qhw.v8i0.20758

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances*, *24*(5), 319–333. https://doi.org/10.1192/bja.2018.29

Tates, K., Zwaanswijk, M., Otten, R., Van Dulmen, S., Hoogerbrugge, P. M., Kamps, W. A., & Bensing, J. M. (2009). Online focus groups as a tool to collect data in hard-to-include populations: Examples from paediatric oncology. *BMC Medical Research Methodology*, *9*(1). https://doi.org/10.1186/1471-2288-9-15

Taylor, B. (2013). *Professional decision making in social work* (K. Brown, Ed.; 2nd ed.). Learning Matters.

Taylor, B. J., & McKeown, C. (2013). Assessing and managing risk with people with physical disabilities: The development of a safety checklist. *Health, Risk and Society*, *15*(2), 162–175. https://doi.org/10.1080/13698575.2013.764973

Taylor, C., Mattick, K., Carrieri, D., Cox, A., & Maben, J. (2022). "The WOW factors": Comparing workforce organization and well-being for doctors, nurses, midwives and paramedics in England. *British*

Medical Bulletin (Vol. 141, Issue 1, pp. 60–79). Oxford University Press. https://doi.org/10.1093/bmb/ldac003

Taylor, J. (2022, December 14). *What is The Care Certificate?* The Access Group. https://www.theaccessgroup.com/en-gb/blog/hsc-what-is-the-care-certificate/

Tedeschi, R. (2020, June). Growth after trauma. *Harvard Business Review*. https://hbr.org/2020/07/growth-after-trauma

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, *15*(1), 1–18. https://doi.org/10.1207/s15327965pli1501_01

Tekingündüz, S., Top, M., Tengilimoğlu, D., & Karabulut, E. (2017). Effect of organisational trust, job satisfaction, individual variables on the organisational commitment in healthcare services. *Total Quality Management and Business Excellence*, *28*(5–6), 522–541. https://doi.org/10.1080/14783363.2015.1099428

Tepper, B. J. (2000). Consequences of abusive supervision. *Source: The Academy of Management Journal*, *43*(2), 178–190. https://www.researchgate.net/publication/228079372_Consequences_of_Abusive_Supervision

Tepper, B. J., Simon, L., & Park, H. M. (2017). Abusive supervision. *Annual Review of Organizational Psychology and Organizational Behavior*, *4*, 123–152. https://doi.org/10.1146/annurev-orgpsych-041015-062539

Terpstra, J., Fyfe, N. R., & Salet, R. (2019). The abstract police: A conceptual exploration of unintended changes of police organisations. *Police Journal*, *92*(4), 339–359. https://doi.org/10.1177/0032258X18817999

Tessier, M., Lamothe, J., & Geoffrion, S. (2022). Psychological First Aid intervention after exposure to a traumatic event at work among emergency medical services workers. *Annals of Work Exposures and Health*, *66*(7), 946–959. https://doi.org/10.1093/annweh/wxac013

The King’s Fund. (2018, November 15). *The health care workforce in England: make or break?* https://www.kingsfund.org.uk/publications/health-care-workforce-england

The King’s Fund. (2019). *The King’s Fund strategy 2020-24 - Towards, better, fairer health and care*. The King’s Fund. https://www.kingsfund.org.uk/sites/default/files/2020-01/kings-fund-strategy-2020-24.pdf

The United States Army. (2019, January 25). The importance of battle drills. *Risk Management Magazine*. https://www.army.mil/article/216557/the_importance_of_battle_drills#:~:text=Well%2Drehearsed%20and%20executed%20battle,safe%20and%20in%20the%20fight.

The Women’s Mental Health Taskforce. (2018). *The women’s mental health taskforce final report*. https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report

Thomson, R. M., Igelström, E., Purba, A. K., Shimonovich, M., Thomson, H., McCartney, G., Reeves, A., Leyland, A., Pearce, A., & Katikireddi, S. V. (2022). How do income changes impact on mental health and wellbeing for working-age adults? A systematic review and meta-analysis. *The Lancet Public Health*, *7*(6), e515–e528. https://doi.org/10.1016/S2468-2667(22)00058-5

Timmons, S., Baxendale, B., Buttery, A., Miles, G., Roe, B., & Browes, S. (2015). Implementing human factors in clinical practice. *Emergency Medicine Journal*, *32*(5), 368–372. https://doi.org/10.1136/emermed-2013-203203

Toadvine, T. (2016). Maurice Merleau-Ponty. *Stanford Encyclopedia of Philosophy*. https://plato.stanford.edu/entries/merleau-ponty/

Tobias, C., Ives, J. E., & Garnham, A. P. (2016). Nursing supervision: Challenges and opportunities for success. *Learning Disability Practice*, *19*(6), 33–38. https://doi.org/10.7748/ldp.2016.e1734

Tomlinson, J. (2015). Using clinical supervision to improve the quality and safety of patient care: A response to Berwick and Francis. *BMC Medical Education*, *15*(1). https://doi.org/10.1186/s12909-015-0324-3

Tone, E. B., & Tully, E. C. (2014). Empathy as a risky strength: A multilevel examination of empathy and risk for internalizing disorders. *Development and Psychopathology*, *26*, 1547–1565. https://doi.org/10.1017/S0954579414001199

Toner, E. (2009). *Creating situational awareness*. National Academic Press. https://www.ncbi.nlm.nih.gov/books/NBK32848/

Tracy, S. J. (2010). Qualitative quality: Eight a"big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837–851. https://doi.org/10.1177/1077800410383121

Tracy, S. J., & Hinrichs, M. M. (2017). Big Tent Criteria for Qualitative Quality. *The International Encyclopedia of Communication Research Methods*, 1–10. https://doi.org/10.1002/9781118901731.iecrm0016

Treloar, C., Hopwood, M., Yates, K., & Mao, L. (2015). Doing the devils work": Emotional labour and stigma in expanding needle and syringe programs. *Drugs: Education, Prevention and Policy*, *22*(5), 437–443. https://doi.org/10.3109/09687637.2015.1057553

Tseng, Y. H., Griffiths, F., De Kadt, J., Nxumalo, N., Rwafa, T., Malatji, H., & Goudge, J. (2019). Integrating community health workers into the formal health system to improve performance: A qualitative study on the role of on-site supervision in the South African programme. *BMJ Open*, *9*(2). https://doi.org/10.1136/bmjopen-2018-022186

Turner, A. (2019, September 10). *Woman murdered in Birmingham “was social care worker.”* Community Care. https://www.communitycare.co.uk/2019/08/20/woman-killed-birmingham-social-care-worker-carrying-home-visits-reports-say/

Tuval-Mashiach, R. (2017). Raising the curtain: The importance of transparency in qualitative research. *Qualitative Psychology*, *4*(2), 126–138. https://doi.org/10.1037/qup0000062

Ullström, S., Sachs, M. A., Hansson, J., Øvretveit, J., & Brommels, M. (2014). Suffering in silence: A qualitative study of second victims of adverse events. *BMJ Quality and Safety*, *23*(4), 325–331. https://doi.org/10.1136/bmjqs-2013-002035

Umoren, R., Kim, S., Gray, M. M., Best, J. A., & Robins, L. (2022). Interprofessional model on speaking up behaviour in healthcare professionals: A qualitative study. *BMJ Leader*, *6*(1), 15–19. https://doi.org/10.1136/leader-2020-000407

UNISON. (2015). A UNISON branch guide. In *UNISON*. UNISON. https://www.unison.org.uk/content/uploads/2015/04/On-line-Catalogue23121.pdf

UNISON. (2016a). Care on the cheap. In *UNISON*. UNISON. https://www.unison.org.uk/content/uploads/2016/09/24063-1.pdf

UNISON. (2016b, September 23). *Health care assistants being used as 'nurses on the cheap' says UNISON*. UNISON. https://www.unison.org.uk/news/press-release/2016/09/health-care-assistants-being-used-as-nurses-on-the-cheap-says-unison/

UNISON. (2021, January 28). *Covid pressures triggering mental health issues among health staff*. UNISON. https://www.unison.org.uk/news/press-release/2021/01/covid-pressures-triggering-mental-health-issues-among-health-staff/#:~:text=Fear%20of%20getting%20sick%20(60,and%20increased%20workload%20(49%25).

Unluer, S. (2012). Being an insider researcher while conducting case study research. *Qualitative Report*, *17*(29). https://doi.org/10.46743/2160-3715/2012.1752

Ursano, R. J. (2021). Principles of Psychological First Aid: Core elements of disaster care, COVID-19 pandemic care and supportive psychotherapy. *Psychiatry (New York)*, *84*(4), 309–310. https://doi.org/10.1080/00332747.2021.2005379

Vallières, F., Hyland, P., McAuliffe, E., Mahmud, I., Tulloch, O., Walker, P., & Taegtmeyer, M. (2018). A new tool to measure approaches to supervision from the perspective of community health workers: A prospective, longitudinal, validation study in seven countries. *BMC Health Services Research*, *18*(1). https://doi.org/10.1186/s12913-018-3595-7

van der Kolk, B. (2000). Posttraumatic stress disorder and the nature of trauma. *Dialogues in Clinical Neuroscience*, *2*(1), 7–22. https://doi.org/10.31887/dcns.2000.2.1/bvdkolk

Vanhaecht, K., Seys, D., Russotto, S., Strametz, R., Mira, J., Sigurgeirsdóttir, S., Wu, A. W., Põlluste, K., Popovici, D. G., Sfetcu, R., Kurt, S., & Panella, M. (2022). An evidence and consensus-based definition of second victim: A strategic topic in healthcare quality, patient safety, person-centeredness and human resource management. *International Journal of Environmental Research and Public Health*, *19*(24). https://doi.org/10.3390/ijerph192416869

Vázquez, E., Kim, M., & Santaella, M. E. (2023). Lived experience experts: A name created by us for us. *Expert Review of Hematology*, *16*(sup1), 7–11. https://doi.org/10.1080/17474086.2023.2178410

Verbano, C., & Turra, F. (2010). A human factors and reliability approach to clinical risk management: Evidence from Italian cases. *Safety Science*, *48*(5), 625–639. https://doi.org/10.1016/j.ssci.2010.01.014

Virtanen, P., Liukkonen, V., Vahtera, J., Kivimäki, M., & Koskenvuo, M. (2003). Health inequalities in the workforce: The labour market core-periphery structure. *International Journal of Epidemiology*, *32*(6), 1015–1021. https://doi.org/10.1093/ije/dyg319

Vosper, H., & Hignett, S. (2018). A UK perspective on human factors and patient safety education in pharmacy curricula. *American Journal of Pharmaceutical Education*, *82*(3), 227–239. https://doi.org/10.5688/ajpe6184

Wåhlin, C., Kvarnström, S., Öhrn, A., & Nilsing Strid, E. (2020). Patient and healthcare worker safety risks and injuries. Learning from incident reporting. *European Journal of Physiotherapy*, *22*(1), 44–50. https://doi.org/10.1080/21679169.2018.1549594

Walshe, K. (2002). Education and debate: The rise of regulation in the NHS. *BMJ*, *324*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1122908/pdf/967.pdf

Wang, L., Norman, I., Xiao, T., Li, Y., & Leamy, M. (2021). Psychological first aid training: A scoping review of its application, outcomes and implementation. *International Journal of Environmental Research and Public Health*, *18*(9). https://doi.org/10.3390/ijerph18094594

Wang, L., Norman, I., Xiao, T., Li, Y., Li, X., & Leamy, M. (2022). Evaluating a Psychological First Aid training intervention (preparing me) to support the mental health and wellbeing of Chinese healthcare workers during healthcare emergencies: Protocol for a randomized controlled feasibility trial. *Frontiers in Psychiatry*, *12*. https://doi.org/10.3389/fpsyt.2021.809679

Wang, J., Guo, C., Wu, X., & Li, P. (2022). Influencing factors for public risk perception of COVID-19: Perspective of the pandemic whole life cycle. *International Journal of Disaster Risk Reduction*, *67*. https://doi.org/10.1016/j.ijdrr.2021.102693

Ward, J., McMurray, R., & Sutcliffe, S. (2020). Working at the edge: Emotional labour in the spectre of violence. *Gender, Work and Organization*, *27*(1), 82–97. https://doi.org/10.1111/gwao.12377

Warr, P., & Nielsen, K. (2018). Wellbeing and work performance. E. Diener, S. Oishi, & L. Tay (Eds.), *Handbook of well-being*. DEF Publishers. https://www.researchgate.net/publication/323268036

Warrier, V., Toro, R., Chakrabarti, B., Børglum, A. D., Grove, J., Agee, M., Alipanahi, B., Auton, A., Bell, R. K., Bryc, K., Elson, S. L., Fontanillas, P., Furlotte, N. A., Hromatka, B. S., Huber, K. E., Kleinman, A., Litterman, N. K., McIntyre, M. H., Mountain, J. L., … Baron-Cohen, S. (2018). Genome-wide analyses of self-reported empathy: Correlations with autism, schizophrenia, and anorexia nervosa. *Translational Psychiatry*, *8*(1). https://doi.org/10.1038/s41398-017-0082-6

Webber, K. M. (2020). Relational complexity in pediatric oncology: A hermeneutic research inquiry. *Journal of Applied Hermeneutics*. https://journalhosting.ucalgary.ca/index.php/jah/article/view/71118

Webster, D. (2021). Risk management and legal liability. In M. Westcott & W. Anderson (Eds.), *Introduction to tourism and hospitality in BC* (pp. 367–376). Pressbooks. https://opentextbc.ca/introtourism2e/

Weiner, B. J. (2009). A theory of organizational readiness for change. *Implementation Science*, *4*(1). https://doi.org/10.1186/1748-5908-4-67

White, N. (2012). Understanding the role of non-technical skills in patient safety. *Nursing Standard*, *26*(26), 43–48. https://pubmed.ncbi.nlm.nih.gov/22482188/

WHO. (2006). *Working Together for Health: The world health report 2006*. https://apps.who.int/iris/handle/10665/43432

WHO. (2021a, October 20). *Health and care worker deaths during COVID-19*. World Health Organisation. https://www.who.int/news/item/20-10-2021-health-and-care-worker-deaths-during-covid-19

WHO. (2021b, April 12). *What do we know about community health workers? A systematic review of existing reviews*. https://www.who.int/publications/i/item/what-do-we-know-about-community-health-workers-a-systematic-review-of-existing-reviews

WHO. (2021c, October 20). *Health and care worker deaths during COVID-19*. World Health Organisation. https://www.who.int/news/item/20-10-2021-health-and-care-worker-deaths-during-covid-19

WHO. (2023). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Wiles, R. (2013). What are qualitative research ethics. *Bloomsbury Academic*. Bloomsbury. https://library.oapen.org/bitstream/handle/20.500.12657/58724/1/9781849666534.pdf

Willig, C., & Stainton Rogers, W. (2017). *The SAGE handbook of qualitative research in psychology* (C. Willig & W. Stainton-Rogers, Eds.; 2nd ed.). SAGE Publications Ltd.

Willis-Shattuck, M., Bidwell, P., Wyness, L., Blaauw, D., & Ditlopo, P. (2008). Motivation and retention of health workers in developing countries: A systematic review. *BMC Health Services Research*, *8*(1), 247. https://doi.org/10.1186/1472-6963-8-247

Winchester, N. (2021, July 1). *Women's health outcomes: Is there a gender gap?* House of Lords Library. https://lordslibrary.parliament.uk/womens-health-outcomes-is-there-a-gender-gap/

Wise, J. (2018). Survey of UK doctors highlights blame culture within the NHS. *BMJ*, *362*. https://www.bmj.com/content/362/bmj.k4001

Witter, S., Namakula, J., Wurie, H., Chirwa, Y., So, S., Vong, S., Ros, B., Buzuzi, S., & Theobald, S. (2017). The gendered health workforce: Mixed methods analysis from four fragile and post-conflict contexts. *Health Policy and Planning*, *32*, v52–v62. https://doi.org/10.1093/heapol/czx102

Wolvaardt, E. (2019). Blame does not keep patients safe. *Community Eye Health*, *32*(106), 36. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6802475/

Wressell, J. A., Rasmussen, B., & Driscoll, A. (2018). Exploring the workplace violence risk profile for remote area nurses and the impact of organisational culture and risk management strategy. *Collegian*, *25*(6), 601–606. https://doi.org/10.1016/j.colegn.2018.10.005

Wu, A. W. (2000). Medical error: The second victim. *BMJ*, *320*, 726–727. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117748/pdf/726.pdf

Yadav, D. (2022). Criteria for good qualitative research: A comprehensive review. *Asia-Pacific Education Researcher*, *31*(6), 679–689. https://doi.org/10.1007/s40299-021-00619-0

Yin, Q., Chen, A., Song, X., Deng, G., & Dong, W. (2021). Risk perception and PTSD symptoms of medical staff combating against COVID-19: A PLS structural equation model. *Frontiers in Psychiatry*, *12*. https://doi.org/10.3389/fpsyt.2021.607612

Your World healthcare. (2019, March 11). *What qualities do you need to work in social care?* Your World Healthcare. https://www.yourworldhealthcare.com/ie/news/what-qualities-do-you-need-to-work-in-social-care-

Yu, Y., Lau, J. T. F., She, R., Chen, X., Li, L., Li, L., & Chen, X. (2021). Prevalence and associated factors of intention of COVID-19 vaccination among healthcare workers in China: Application of the health belief model. *Human Vaccines and Immunotherapeutics*, *17*(9), 2894–2902. https://doi.org/10.1080/21645515.2021.1909327

Yule, S., Flin, R., Paterson-Brown, S., & Maran, N. (2006). Non-technical skills for surgeons in the operating room: A review of the literature. *Surgery*, *139*(2), 140–149. https://doi.org/10.1016/j.surg.2005.06.017

Yule, S., Flin, R., Paterson-Brown, S., Maran, N., & Rowley, D. (2006). Development of a rating system for surgeons' non-technical skills. *Medical Education*, *40*(11), 1098–1104. https://doi.org/10.1111/j.1365-2929.2006.02610.x

Zacchi, M., Fagundes, E., Rengel, R., & Adamczyk, W. (2022). Mood state and risk tolerance in organizational decisions. *Iberoamerican Journal of Strategic Management*, *21*(1), 1–25. https://doi.org/https://doi.org/10.5585/riae.v21i1.20677

Zafar, N., Naeem, M., Zehra, A., Ashiq, U., Zohaib, N., Moaz, M., & Imran, M. (2021). Efficacy of Psychological First Aid training on the perceived competence of frontline workers during COVID-19 pandemic. *Asia Pacific Journal of Paediatric Child Health*, *4*, 27–32. http://www.apjpch.com/pdfs/2112207rM132917.pdf

Zagenczyk, T. J., Gibney, R., Kiewitz, C., & Restubog, S. L. D. (2009). Mentors, supervisors and role models: Do they reduce the effects of psychological contract breach? *Human Resource Management Journal*, *19*(3), 237–259. https://doi.org/10.1111/j.1748-8583.2009.00097.x

Zeller, J. M., & Levin, P. F. (2013). Mindfulness interventions to reduce stress among nursing personnel an occupational health perspective. *Workplace Health and Safety*, *61*(2). file:///C:/Users/victo/Downloads/zeller-levin-2013-mindfulness-interventions-to-reduce-stress-among-nursing-personnel-an-occupational-health-perspective.pdf

Zelnick, J. R., Haviland, S., & Morgan, J. C. (2018). Caring for care workers. *New Solutions*, *27*(4), 453–461. https://doi.org/10.1177/1048291117745647

Zelnick, J. R., Slayter, E., Flanzbaum, B., Butler, N. G., Domingo, B., Perlstein, J., & Trust, C. (2013). Part of the job? Workplace violence in massachusetts social service agencies. *Health and Social Work*, *38*(2), 75–85. https://doi.org/10.1093/hsw/hlt007

Zerach, G., & Levi-Belz, Y. (2022). Moral injury, PTSD, and complex PTSD among Israeli health and social care workers during the COVID-19 pandemic: The moderating role of self-criticism. *Psychological Trauma: Theory, Research, Practice, and Policy*, *14*(8). https://doi.org/10.1037/tra0001210

Zhang, H., Zhou, Z. E., Zhan, Y., Liu, C., & Zhang, L. (2018). Surface acting, emotional exhaustion, and employee sabotage to customers: Moderating roles of quality of social exchanges. *Frontiers in Psychology*, *9*(NOV). https://doi.org/10.3389/fpsyg.2018.02197

Zhong, D., Liu, C., Luan, C., Li, W., Cui, J., Shi, H., & Zhang, Q. (2022). Mental health problems among healthcare professionals following the workplace violence issue-mediating effect of risk perception. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.971102

Zhu, J., & Zhang, B. (2019). The double-edged sword effect of abusive supervision on subordinates' innovative behavior. *Frontiers in Psychology*, *10*(JAN). https://doi.org/10.3389/fpsyg.2019.00066

Zinn, J. O. (2008). *Social theories of risk and uncertainty An introduction* (Zinn.J, Ed.). Blackwell Publishing. https://doi.org/10.1002/9781444301489

Zoeckler, J. M. (2018). Occupational stress among home healthcare workers: Integrating worker and agency-level factors. *Journal of Environmental and Organisational Health Policy*, *27*(4), 524–542. DOI: 10.1177/1048291117742678

Zvolensky, M. J., Vujanovic, A. A., Bernstein, A., & Leyro, T. (2010). Distress tolerance: Theory, measurement, and relations to psychopathology. *Current Directions in Psychological Science*, *19*(6), 406–410. https://doi.org/10.1177/0963721410388642

Appendices

Appendix 1: Ethics Form

PLYMOUTH
MARJON
UNIVERSITY

Plymouth Marjon University is a trading name of University of St Mark & St John

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Research Project Information

Ethics Application Code: EP121

Please refer to the Guidance documents for Research Ethics Applications when completing this form. Note: Researchers are not to engage in data collection or recruitment until they have received a favourable ethical opinion from the Panel.

1. Title of Research Project

What are the emotional everyday lived experiences and drivers of unregistered care and support workers in the health and social care sector (non-NHS) and what are the support and supervision needs of this community with an aim to co-creating a new supervision model? (Working Title)

2. Researcher Information

Name	Victoria May
Institutional email	20092083@marjon.ac.uk
Role	☐ Undergraduate ☐ Masters ☒ PhD Researcher ☐ Staff
Undergraduate and Masters: Please provide name of supervisor	
PhD Researchers and Staff: Are co-researchers involved? If **YES**, please provide the names and institutional contact details.	☒ Yes ☐ No Dr Pamela Dawson – pdawson@marjon.ac.uk Dr Alister McCormick – amccormick@marjon.ac.uk

Undergraduate and Master's Researchers, please submit this Application Form and Supporting Documents to your supervisor and/or module team as directed.

PhD Researchers and Staff, please submit this Application Form and Supporting Documents to ethicspanel@marjon.ac.uk for review.

3. Rationale

Summarise your proposed research using, wherever possible, language understandable for a non-specialist reader.

Aims and Objectives

The aim of this research is to establish whether current supervision practices for unregistered care and support workers is effective at meeting the needs of these particular workers and whether a more responsive, informed and role appropriate supervision framework can be developed through worker and management consultations and researcher co-collaboration?

To achieve this aim, the research will be conducted in three phases. The particular objectives of each phase are outlined below.

Phase one research objective:

To explore the everyday emotional lived experiences of workers and supervision experiences and identify how these experiences affect their wellbeing, performance and morale within the workplace. This will be completed through qualitative semi-structured 1-1 interviews with between 15 and 20 participants.

Phase two research objective:

To explore the experiences of managers of care and support workers and identify factors that impact on their ability to provide effective and needs led supervision. This will be completed through qualitative semi-structured interviews with between 5 and 10 participants.

Phase three research objective:

To facilitate group sessions (general workshop session on worker wellbeing and support needs leading to a focus group around more specific supervision needs) with workers in care and support worker roles, with the aim of discussing how workers would prefer supervision models to be delivered. This data will then be used to facilitate a workshop with service manager/leadership teams based on the emerging worker need and responsive supervision processes/suggestions.

Methods:

A qualitative research approach will be adopted through the use of 1-1 semi-structured interviews, focus groups and workshops. This will provide participants with a platform to share and discuss their experiences, needs and desired outcomes from the supervision process and put forward ideas around organisational awareness raising and future training needs.

The research team have made the decision to introduce a period of consultation in regard to the impact of Covid 19 on the lives of workers and those they support. This is needed to clarify that at the time when the research commences, the proposed methods are still feasible. This particular worker community supports services that help individuals manage mental health, substance misuse and other addictive behaviours, homelessness and other housing issues and there is likely to be a related impact as a result of Covid 19 as the resulting lockdown continues to impact on employment, the economy, relationships, health and wellbeing.

Overview

Research has recognised that supervision for registered health and social care staff is an important part of worker wellbeing within the sector, and when done well, has been largely shown to provide a beneficial space for nurses and Drs to discuss their emotional/physical labour, training and support needs and to offload workplace stressors and burdens (Lyth 2000). But what about unregistered staff members? Calls for mentorship programmes in health care is not new (Aston and Molassiotis 2003) and Hoge et al (2011) recommend strategies for advancing supervision in order to determine what content is needed, particularly for health professions other than nursing. Supervision is provided to unregistered health and social care workers but it is commonly performance/service user focused and patchy in frequency and supervisor skill (Swedberg et al 2013). Noble and Irwin (2009) view supervision as a significant area of practice where there is the potential for a critically informed framework to emerge as a site for supporting change and Ruotsalainen (2015), suggests that organisational interventions need to be better focused on addressing specific factors that look to the causes of stress.

Rationale

There are over 1.6 million direct social care roles in England (Skills for Care 2019) and approximately 400,000 NHS health care roles and together they employ one in ten of the working population (The King's Fund 2020). The health and social care sector is a highly gendered workforce with up to 95 per cent of roles filled by women in social care and 80 per cent in health care (The King's Fund 2020). Workplace stress can have a negative influence and impact on healthcare professionals' physical and emotional well-being and their overall quality of life (Koinis et al 2015) and statistically women have significantly higher rates of social inequality, work-related stress, depression and anxiety related disorders (HSE 2019). Occupational stress is a major cause of sickness absence in health and social care leading to an estimated 2.9 million working days lost per year (HSE n.d) and this sector has the highest rate of absence within the wider workforce. Given that research in to the emotional impacts and motivations for care and support workers is limited, does not focus on the gendered nature of the workforce and is of low quality (Judd et al 2017, Pearce et al 2013) this research provides an opportunity for awareness raising, learning and increased knowledge in this sector, through exploring the experiences of workers, particularly women given the workforce gender statistics, in their own terms.

The unregistered healthcare worker is a common feature across some national and international healthcare systems, although no definitive title exists to describe this role (Hasson et al 2012). The term 'health care' relates to the treatment and physical support of those with ill health and medical conditions in hospitals, health centres, the community and other medical settings, whereas 'social care' is the care and support of vulnerable people with their day to day activities, usually in the community (Tees Valley 2016, Skills for Care). Care workers/assistants undertake a variety of roles such as washing and dressing patients, toileting, making beds, taking blood samples and talking to patients to help make them comfortable (NHS Careers). As unregistered workers they are included within NHS pay bands 2-4 or equivalent (NHS Jobs 2020). Social support workers give practical and emotional support to a wide range of different people often helping to protect and promote people's wellbeing so that they can enjoy a better quality of life (NI Direct). Duties include supporting daily living skills, health and wellbeing, safeguarding and leisure/social activities in a number of different environments (Hft), although both roles often experience an overlap in duties and responsibilities.

Of the estimated 1.6 million jobs in England's adult social care workforce (Skills for Care 2019) 1.22 million are in direct care roles (The King's Fund 2020). In the wider workforce women fill around 45 per cent of all roles (Gov.UK 2019), this increases to 80 per cent in health care and up to ninety-five per cent in social care (King's Fund 2020, NHS Digital 2019). This means that there are over one million unregistered women working in direct care and support worker roles in the UK, equal to 8-10 per cent of all women in employment (ONS 2020). There is a paucity of statistics relating to men in this workforce given men make up a very small part of the workforce.

This research will seek to identify the experiences, support and supervision needs of women and men in this sub-sector but given the highly gendered nature of this type of employment and the increased employment inequalities experienced by women in society, it is likely that women will constitute a significant proportion of the participant group. Writing in 2003, McLean notes that whilst social care employees are predominantly women, men are involved in the work, particularly as managers or where there is a control element. McLean's observations still bear out and women continue to represent a significant proportion of this feminised workforce (Skills For Care 2017). It is also important to note that there has been a failure of research studies to not only focus on women, but often neglect to include them at all (Caroline Criado-Perez 2020). It has been criticised that many decisions and recommendations in everything from healthcare interventions to design of seatbelts and mobile phones has been informed purely or largely by male research subjects, yet generalised to the female population and whilst this study seeks the experiences of both women and men, recent commentary on historical shortcomings of studies such as clinical trials, where women are either excluded or not considered separately, strongly advocates the a priori consideration of women and their responses (Klap and Humphries 2019).

It is widely acknowledged that this particular workforce experience increased employee sickness, turnover and burnout (Pines and Maslach 2006), alongside increased risk of personal harm, both in and out of this workforce and social/gender inequality (Skills for Care 2019, NHS Digital 2019, Gingerbread 2019). Higher rates of stress-related sickness are found in health care professionals when compared with other sectors (Gibb et al 2010) and work-related stress and mental health often go hand in hand (HSE:NI). Statistically, women have significantly higher rates of work-related stress, depression and anxiety compared with the average for all persons (HSE 2019) and alongside the stressful healthcare workplace environment, current workforce shortages in this sector are also taking a significant toll on the health and wellbeing of staff, alongside evidence of gender discrimination and inequalities in pay and career progression (The Kings Fund 2018).

It is estimated that one in six of all workers in the UK will experience a common mental health condition such as anxiety or depression, in any given week (MIND 2020, MHFA 2020). Women however, are twice as likely to be diagnosed with an anxiety disorder, such as PTSD (Ollf 2017), have a one in four risk of being the victim of a sexual assault after the age of sixteen (Rape Crisis), might be one of the 1.3 million women who contacted the Police as victims of domestic violence between 2017-2018 (ONS 2019) and are disproportionally impacted, with mental health problems, by lower household income when compared to men (Mental Health Foundation 2016). These women are likely to be represented within this workforce, given the nature of the wounded healer and a lack of quality employment opportunities and will be managing this alongside workplace stress, violence and inequalities. In this unequal nation, women still bear the brunt of systemic inequalities through welfare cuts, pay gaps, inherent social, physical and emotional vulnerabilities and are likely to experience barriers to progression due to lone parenting and other caring responsibilities (Government Equalities Office 2019, Gingerbread 2019) and social mobility is often more about chance than choice (Blandford 2019).

Given the increased likelihood for this highly gendered and ageing workforce to experience comorbid stressors, burdens and threats alongside vulnerable workplace experiences and entitlements (Sacker et al 2009, HSE 2019), this study is being undertaken in order to focus on the experiences of workers in the hope of finding a more needs led, gender aware, responsive and effective supervision model.

References

Aston, L. and Molassiotis, A. (2003) *Supervising and supporting student nurses in clinical placements: the peer support initiative*. Nurse Education Today Volume 23, Issue 3, April 2003, Pages 202-210 https://www.sciencedirect.com/science/article/abs/pii/S0260691702002150 [Accessed 10.03.20]

Blanford, S. (2019) Social Mobility: Chance or Choice? Melton: John Catt Publishing

Criado-Perez, C (2020) Invisible Women: Exposing Data Bias in a World Designed For Men. London Penguin Random House

Gibb, J., Cameron, I. M,. Hamilton, R., Murphy, E and Naji, S (2010) *Mental health nurses' and allied health professionals' perceptions of the role of the Occupational Health Service in the management of work-related stress: how do they self-care?* Journal of Psychiatric and Mental Health Nursing, 2010, 17, 838–845 https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-2850.2010.01599.x?casa_token=O6v6SEEoK9UAAAAA:e_ad8O4lhGMHHIauMBQXO9O8kjPJrToW5HQFGDh1pPG_SVNRiBRly8sEaAACYv2WoT3T4AqLbtfJ3Ow

Gingerbread (2019) *Employment and Skills* https://www.gingerbread.org.uk/policy-campaigns/employment-and-skills/ [Accessed 31/07/20]

Government Equalities Office (2019) *Improving Women's Progression in the Workplace* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/840849/KCL_Summary_Report.pdf [Accessed 31.07.20]

Hasson, F., McKenna, H. P & Keeney, s. (2012) *Perceptions of the unregistered healthcare worker's role in pre-registration student nurses' clinical training*, Journal for Advanced Nursing September 2012 file:///C:/Users/Victoria/Downloads/FINAL_Perceptions_of_unregistered_health_care_wotrkers_role_in_St_training_2012.pdf [Accessed 12.09.20]

Health and Safety Executive March 2019 *Work-related stress, anxiety or depression statistics in Great Britain, 2019* https://www.hse.gov.uk/statistics/causdis/stress.pdf [Accessed 09.02.20)

Health and Safety Executive October 2019 *Vulnerable Workers* https://www.hse.gov.uk/vulnerable-workers/ [Accessed 31.07.20]

Health and Safety Executive *Health and social care services* https://www.hse.gov.uk/healthservices/ [Accessed 10.02.20]

Health and Safety Executive: NI *Stress and mental health at work and home - Good Practice* https://www.hseni.gov.uk/articles/stress-and-mental-health-work-and-home-good-practice [Accessed 31.07.20]

Hoge, M. Migdole,S. Farkas, M.S. Ponce, A.N and Hunnicutt , C. Journal (2011) *Supervision in Public Sector Behavioral Health: A Review. The Clinical Supervisor* Volume 30, 2011 - Issue 2 https://www.tandfonline.com/doi/abs/10.1080/07325223.2011.604276 [Accessed 09.03.20]

The King's Fund Overview of the health and social care workforce (2020) https://www.kingsfund.org.uk/projects/time-think-differently/trends-workforce-overview [Accessed 09.02.20

The King's Fund (2018) *The health care workforce in England. Make or Break?* https://www.kingsfund.org.uk/sites/default/files/201811/The%20health%20care%20workforce%20in%20England.pdf [Accessed 31.07.20]

Klap, R. & Humphries, K,. (2019) *Designing Studies for Sex and Gender Analyses: How Research Can Derive Clinically Useful Knowledge for Women's Health.* Women's Health Issues 29-S1 (2019) S12 – S14 https://www.whijournal.com/article/S1049-3867(19)30278-6/fulltext [Accessed 31.07.20]

Koinis, A, Giannou, V, Drantaki, V, Angelaina, S, Stratou, E and Saridi, M (2015) *The Impact of Healthcare Workers Job Environment on Their Mental-emotional Health. Coping Strategies: The Case of a Local General Hospital*. Health Psychology Research 2015 Apr 13;3(1) 2015:1984 https://www.pagepressjournals.org/index.php/hpr/article/view/hpr.2015.1984

Judd, M. J. Dorozenko, K.P. and Breen, L.J. (2017) *Workplace stress, burnout and coping: a qualitative study of the experiences of Australian disability support workers. Health and Social Care in the Community* (2017) 25(3), 1109–111 [Accessed 09.03.20]

Lyth, G. (2000) *Clinical Supervision: a concept analysis Journal of Advanced Nursing* 31(3):722 - 729 March 2000 https://www.researchgate.net/publication/227700458_Clinical_Supervision_a_concept_analysis [Accessed 10.03.20]

McLean, J. (2003) *Men as Minority: Men Employed in Statutory Social Care Work*, Journal of Social Work Vol 3, Issue 1, 2003 https://journals.sagepub.com/doi/10.1177/1468017303003001004

MHFA England (2016) *Fundamental Facts About Mental Health 2016* https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf [Accessed 31.07.20]

MHFA England (2020) *Mental Health Statistics* https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/#workplace [Accessed 31.07.20]

MIND: Taking care of Yourself (2020) https://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-yourself/ [Accessed 31.07.20]

NHS Digital (2019) *NHS Workforce Statistics - June 2019* https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/june-2019 [Accessed 31.07.20]

Noble, C and Irwin, J. (2009) *Social Work Supervision: An Exploration of the Current Challenges in a Rapidly Changing Social, Economic and Political Environment Journal of Social Work* 9(3): 345–358. Sage Publications https://www.researchgate.net/profile/Carolyn_Noble3/publication/240711950_Social_Work_Supervision_An_Exploration_of_the_Current_Challenges_in_a_Rapidly_Changing_Social_Economic_and_Political_Environment/links/5cac2b13299bf118c4bd0a2b/Social-Work-Supervision-An-

Exploration-of-the-Current-Challenges-in-a-Rapidly-Changing-Social-Economic-and-Political-Environment.pdf [Accessed 10.03.20]

Ollf,. M. (2017) *Sex and gender differences in post-traumatic stress disorder: an update* European Journal of Psychotraumatology https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5632782/ [Accessed 31.07.20]

Office for National Statistics (2019) *Domestic abuse in England and Wales overview: November 2019* https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2019#:~:text=In%20the%20year%20ending%20March,24%25%20from%20the%20previous%20year. [Accessed 31.07.20]

Office for National Statistics (2020) *UK Labour Market Jan 2020* https://www.ons.gov.uk/releases/uklabourmarketjanuary2020 [Accessed 31.07.20]

Pearce, P. Phillips, B. Dawson, M. and Leggat, S. (2013) *Content of clinical supervision sessions for nurses and allied health professionals A systematic review* Clinical Governance: An International Journal Vol. 18 No. 2, 2013pp. 139-154 https://www.researchgate.net/profile/Sandra_Leggat/publication/236887403_Content_of_clinical_supervision_sessions_for_nurses_and_allied_health_professionals_A_systematic_review/links/00b49519ee399d84e5000000.pdf [Accessed 10.03.20]

Pines, A and Maslach, C (2006) *Characteristics of Staff Burnout in Mental Health Settings* https://ps.psychiatryonline.org/doi/abs/10.1176/ps.29.4.233 [Accessed 31.07.20]

Rape Crisis: About Sexual Violence https://rapecrisis.org.uk/get-informed/about-sexual-violence/statistics-sexual-violence/ [Accessed 31.07.20]

Ruotsalainen, J.H, Verbeek JH, Mariné A, Serra C. *Preventing occupational stress in healthcare workers.* Cochrane Database of Systematic Reviews 2015, Issue 4. Art. No.: CD002892. DOI: 10.1002/14651858.CD002892.pub5. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD002892.pub5/full [Accessed 20.02.20]

Sacker, A,. Head, J,. Gimeno, D,. and Bartley, M (2009) *Social Inequality in Physical and Mental Health Comorbidity Dynamics.* Psychosomatic Medicine 71:763–770 (2009) https://d1wqtxts1xzle7.cloudfront.net/40071472/Social_Inequality_in_Physical_and_Mental20151116-22616-gc4uhc.pdf?1447693513=&response-content-disposition=inline%3B+filename%3DSocial_Inequality_in_Physical_and_Mental.pdf&Expires=1596194027&Signature=KjvRGp77sxj5G9NqtFG4VkoRRstyUNo~f9Cs9HBiKf9ondiati3ofm9Cy7DixWbj4brA1wlJVP1OEC5iCwFlUit~VU~5sLlHNHPciKKDTtnfRtaL0LrjrVZNJxtK5vxJgTtso9r7Yde5AOv9HUoQqbk1iJDQEkEJVKDfoIExOzYHUv5b9f2pebH9lZ1x35zl~RqQWLuDvYfMzYCAHlaZ9yB4A1YiCUbPzNHOpwwcJMHJQpuY63450f36BGE0soCY~s7mYfosMtOHJuN6zLmR8p2kv6N1xugVmlYyVp3W5qnvkkg4xV3rXuo8tvXrAvusZSRu1xJtFXm2JCAfCQ__&Key-Pair-Id=APKAJLOHF5GGSLRBV4ZA

Skills for Care (2017) *What do we know about men working in social care?* https://www.skillsforcare.org.uk/About/Blog/Article/What-do-we-know-about-men-working-in-social-care.aspx#:~:text=We%20estimate%20there%20are%201.45,is%20equivalent%20to%20240%2C00

0%20jobs.&text=The%20percentage%20of%20males%20working,in%20the%20sector%20at%2020%25. [Accessed 12.09.20]

Skills for Care Workforce (2019) Intelligence *The size and structure of the adult social care workforce in England, 2019* https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2019.pdf [Accessed 09.02.20]

Swedberg, L. Chiriac, E.H. Tornkvist, L and Hylanderr, I (2013) *From risky to safer home care: health care assistants striving to overcome a lack of training, supervision, and support*. Article: 20758 23 May 2013 https://doi.org/10.3402/qhw.v8i0.20758 [Accessed 25.03.20]

4. Initial Review Checklist

1. Will your research involve research participants identified from, or because of their past or present use of, the NHS and/or Social Care Services	☐Yes ☒No
2. Does the research project involve intrusive procedures with adults who lack capacity to consent for themselves or health-related research involving prisoners?	☐Yes ☒No
3. Will this project be reviewed by a research ethics panel external to Marjon?	☐Yes ☒No
4. Does your research involve non-human animal participants, or non-human animal biology?	☐Yes ☒No
5. Is your research an evaluation of existing service or initiative?	☐Yes ☒No

If you answered **YES** to **ANY** question please contact ethicspanel@marjon.ac.uk, before proceeding.

If you answered **NO** to **ALL** questions please complete the Potential Issue Checklist.

Potential Issues Checklist

1. Does the research involve human participants and/or their personal data?	☒Yes ☐No
2. Does the research involve your own students as participants?	☐Yes ☒No
3. Does the research involve participants who are unable to give informed consent, considered to be vulnerable, or lack capacity?	☐Yes ☒No
4. Will the research require the co-operation of a gatekeeper for initial access to the groups/individuals to be recruited? (e.g. for access to students at school, or to members of a particular organisation)	☒Yes ☐No

5.	Will the research involve access to records of personal or confidential information concerning identifiable individuals, either living or recently deceased?	☐Yes ☒No
6.	Will the research involve the use of administrative data or secure data? (e.g. student records held by a school or college, medical records)	☐Yes ☒No
7.	Will the deception of participants (including covert observation in non-public places) be necessary at any time?	☐Yes ☒No
8.	Will the research involve discussion of sensitive topics? (e.g. sexual activity, drug use, political behaviour, ethnicity and, potentially, elite interviews, *including PREVENT*)	☐Yes ☒No
9.	Will the research involve members of the public in a research capacity, helping to shape methodology and/or to collect data? (e.g. participatory research)	☐Yes ☒No
10.	Will the research involve visual or vocal methods where participants or other individuals may be identifiable in the audio or visual data used or generated? (this does not refer to audio recordings for the purposed of transcription)	☐Yes ☒No
11.	Will the research involve any drugs, placebos or other substances (e.g. food substances, vitamins and other supplements) being administered to the participants, or will the study involve invasive, intrusive procedures of any kind?	☐Yes ☒No
12.	Will blood or tissue samples be obtained from participants (deceased or alive)?	☐Yes ☒No
13.	Is the research likely to involve or result in participants experiencing pain or more than mild discomfort?	☐Yes ☒No
14.	Could the research induce psychological stress or anxiety or cause harm or negative consequences? (both research participants and their living relatives should be considered)	☒Yes ☐No
15.	Will the research involve prolonged or repetitive testing of participants?	☐Yes ☒No
16.	Will data collection involve e-mail, social media, and/or instant messaging services in data collection?	☐Yes ☒No
17.	Will financial inducements (other than reimbursement of expenses) be offered to participants?	☐Yes ☒No
18.	Will the study involve external organisations to recruit participants?	☐Yes ☒No
19.	Will the research place the safety of the researcher(s) at risk?	☐Yes ☒No
20.	Will any data collection be undertaken outside of the UK?	☐Yes ☒No
21.	Will the research or its dissemination involve data sharing of confidential information, or the re-use of previously collected data?	☐Yes ☒No

22. Is the research funded?	☐Yes ☒No

If you answered **NO** to **ALL** questions, please complete the Declaration.

If you answered **YES** to **ANY** question, please complete Research Project Further Information.

Research Project Further Information

1 Project Start and End dates

a. Start date for data collection	August 2020
b. Estimated completion date for data collection	October 2021
c. Estimated completion date for study	October 2023

2 Research Methods

a. Describe where data will be collected. Data will be collected from care/support workers and managers employed in the Social Care Sector in Plymouth including homelessness, substance misuse services, housing, mental health and learning disabilities. Participant interviews can be held away from the participant's workplace to ensure confidentiality and privacy. The University Campus will be utilised with all participant costs relating to travel to and from the interview reimbursed. In the case of management, they may prefer to use their own office but will also be offered an interview space away from their place of work. A quiet and private space will be required for data collection purposes. In light of Covid-19 I will be consulting with the gatekeeper organisation to ensure the feasibility and acceptability of my research methods stay up to date in regard to social distancing rules. In the event that social distancing is still in place at the start of data collection, online or telephone interviews will be undertaken. I recognise that some participants may also find this form of interview more suitable than a face to face format given potential individual preferences, work, time and family commitments.
b. Describe how data will be collected. Participants will be identified through purposive sampling. The preferred method of data collection is to utilise face to face semi-structured interviews and workshops/focus groups. However, Covid 19 restrictions may mean that the 1-1 interviews and group events may have to be conducted on online platforms such as Zoom, Skype, or Miro.com and Mural, which are online collaborative whiteboard workspace platforms for group events. It is important to recognise that whilst the preferred method is face to face data collection, online interviews can provide a supporting role that raises the feasibility of widening data collection due to ease of accessibility and convenience, supporting the interviewee to respond to interview questions in a more comfortable and familiar space, which may draw richer data. However, this platform may exclude

those who do not have access to appropriate IT equipment and as such interviewees will be offered the choice wherever possible.
c. Describe how data will be analysed. Data will be analysed by drawing on appropriate qualitative analyses such as content and thematic Analysis. Otter.ai will be used to record and transcript data. NVivo software will be used to organise and analyse coded data.

ALL questionnaires, interview guides, standard operating procedures and/or other instruments to be used in data collection MUST be attached as appendices.

3 Research Participants

a. Describe the participants to be recruited. I will be seeking 15 – 20 participants who will be women or men, aged 18 years or over who work as health and/or social care workers (part time/full time). Participants will be recruited with the support of organisational gatekeepers who will provide me with a platform to address potential participants directly and circulate an email invitation to potential participates outlining the study to employees and other related services. The use of the term "women" includes individuals who perceive themselves to be biologically female, those individuals who have undertaken or are in the process of undertaking gender reassignment from male to female and those individuals who consider themselves non-binary where they identify as neither exclusively female nor male. The use of the term "men" includes individuals who perceive themselves to be biologically male, those individuals who have undertaken or are in the process of undertaking gender reassignment from female to male and those individuals who consider themselves non-binary where they are identify as neither exclusively female nor male. Potential participants will have the opportunity to attend a meeting on the study prior to engagement, will be informed of the study's aims and objectives, be given my contact details in order to discuss participation privately and away from the workplace, will have access to a participant information sheet (PIS) that explains the research process, venue, and areas of interest, will be informed of the reimbursement of interview expenses, will be informed of their right to withdraw from the study and/or stop the interview at any time. Participants will be monitored for signs of distress or upset throughout the interview process.
b. Will it be possible to identify participants, directly or indirectly, from the data collected? ☐Yes ☒No If YES, please explain how confidentiality will be maintained.

c. Does the proposed research involve extraction or collection of personally identifiable information about the participant from existing databases or records?

☐Yes ☒No

If YES, please explain how consent from the individuals or authorisation from the data custodian will be obtained.

d. Does the proposed research involve participants who have a pre-existing relationship with any of the researchers?

☐Yes ☒No

If YES, please explain the relationship and how power differentials (actual or perceived) will be managed.

e. Will the proposed research result in products (physical or intellectual) that are commercialisable?

☐Yes ☒No

If YES, please explain how ownership will be negotiated and communicated to participants.

4 Consent Process

a. Describe the process that will be used to obtain informed consent and explain how consent will be recorded.

Informed consent will be recorded on a consent form, using an adapted version of a template provided by the University of St Mark and St John which is appended. Participants will also have the option of giving their consent verbally which will be recorded at the start of the interview and/or group session. Prior to recording, participants will have the opportunity to ask questions about the interview process and it will again be made clear that they can withdraw at any time or that they can stop for a break if needed.

b. Please describe procedures for participants withdrawing from the study.

Participants will be advised that they can withdraw consent regarding participation within one calendar month after the date of data collection by contacting the researcher with their decision. Participants will not be required to give any reason for withdrawal and their data destroyed once the researcher has been notified of their decision to withdraw. Their choice to withdraw will not impact upon the employer/employee relationship as the employer will not be aware which of their staff team has chosen to or chosen not to participate. In regard to data storage, I will be able to identify the participant's data for withdrawal through a given code e.g P1, P2, P3 etc and the corresponding date of their interview. This will ensure their anonymity and enable me to identify specific data for deletion.

<u>ALL</u> documents (e.g. consent documents, participant information sheets, email scripts) to be used in the consent process <u>MUST</u> be attached as appendices.

5 Data Management

a. Will participants' personal data be collected? If **NO**, please proceed to Risk Evaluation	☒Yes ☐No

If **YES,** please confirm:

b. Personal or identifiable data will be kept on password protected or encrypted files.

☒Yes ☐No

c. Access to data will be restricted to the research team.

☒Yes ☐No

d. Coded data and identifying codes will be stored separately.

☒Yes ☐No

e. Data will not be transferred to or via a third party.

☒Yes ☐No

f. Personal data shall not be kept for longer than is necessary for the purposes it was collected for.

☒Yes ☐No

g. All data will undergo secure disposal.

☒Yes ☐No

h. Data storage timelines**:** Data will be stored until at least October 2023, but potentially not until the research has been published, which may happen later. It is important to note that in regard to withdrawal, participant anonymity and data storage, participant data will be identifiable through date of interview and participant code i.e P1 - 13.10.20. There will be one list of participants and codes, kept securely by myself, and destroyed when the data are analysed/once the cut-off point has been reached. I will be able to withdraw a participant's data within this period by identifying them through their code and the date of the interview.

i. If you have answered **NO** to any of the above, please explain data management process:

6. Risk Evaluation

a. Please indicate the risk level for the project by checking the intersecting box:

Participant Vulnerability		Research Risk		
		Low	Medium	High
	Low	☐	☒	☐
	Medium	☐	☐	☐
	High	☐	☐	☐

If the risk level for your project is **GREEN**, please explain:

b. the research risk level you have identified: Medium

c. the participant vulnerability you have identified: Low

If the risk level for your project is **GREEN**, please proceed to Declaration.

If the risk level for your project is **YELLOW**, please complete Full Review Information.

If the risk level for your project is **ORANGE**, please conduct a scholarly review and

complete Full Review Information.

Full Review Information

1. Risk Management

a. Please list potential research risks.

Service gatekeepers have been approached in order to access participants through a supported and ethical gateway. Service gatekeepers will be asked not to put pressure on employees to participate and to tell employees that they can refuse to participate without consequences. They will also be asked to reassure participants that they are safe to engage with the research truthfully and honestly as their views will remain confidential. However, despite all best attempts, the participant may have concerns about the confidentiality of the data and what that might mean to their employee/employer dynamic and relationships. It is important to recognise and appreciate that there is a power dynamic in play here and it is this aspect of the research that may carry the most risk for participants. A refusal to participate will not affect the individual in any way in regard to their employee/employer relationship as employers will not be made aware of those who have, or have not participated. This information will be kept confidential.

The study participants will be asked about their feelings and related emotions which may elicit articular emotional responses, however, it is anticipated that the potential for psychological harm or distress will be the same as any experienced in everyday life. Participants are free to respond with as much or as little detail as they feel comfortable with and a question relating to emotion does not indicate that ‘harm’ will be experienced by participants because of their associated feelings. There is no direct risk to physical harm and participants are not considered vulnerable or unable to give informed consent.

After considering the risk evaluation, I have chosen a medium risk rating as whilst I recognise that the research carries the potential for risk in relation to the power imbalance dynamic between the gatekeeper/employer and interviewee/employee, the participant vulnerability is low given that it is anticipated that the potential for psychological harm or distress will be the same as any experienced in everyday life. The research proposal has been most positively received by the CEO of the gatekeeper organisation and the chair of the Plymouth Alliance, Mark Bignell, who has reassured me that all available support for the study and participants will be afforded throughout the duration of the study. Participant details will be kept confidential from the gatekeeper organisation at all times and I have received confirmation that an appropriate member of staff willl be made available should study participants need additional support, post interview.

b. Please explain how you will manage and/or minimise research risks.

Workers in this sector will be experienced in facilitating interviews and 1-1/group therapeutic processes with vulnerable service users and will have been required to undertake a number of statutory and mandatory training sessions in order to safely and effectively practice in this sector. Best practice guidelines, ethical requirements, individual/organisational responsibilities and an entitement to some form of workplace support should be in place for participants.

I have worked in this sector for over twenty years in a number of roles and disciplines. I share much of the same demographic background and training as the participants, however, I am aware of my own position as researcher and insider and am reflexive about my positionality and identity. I am a skilled and highly trained practitioner with qualifications in counselling, the law, social policy, teaching and assessment. I am trained in solution focused communication, person-centred assessment, interview skills and techniques, maintaining boundaries, Adverse Childhood Experiences (ACEs), managing heightened emotional states and trauma informed practice and am able to safely and effectively manage difficult interviews whilst maintaining a calm, warm, engaging, empathetic and respectful space for the interviewee. The above skills, experiences, knowledge and training will help support the management and minimisation of risk to participants.

As gatekeepers are involved, arrangements will be put in place to ensure a supportive space is available to participants in the form of a pre- idenitified member of staff, not in a position of direct authority over the participant and whom will act as a support mechanism should it be needed. Once the interview questions have been completed, participants will have the opportunity to ask about or discuss anything not covered by the interview questions or anything that has been raised during the interview process. A list of support services will be provided should the interviewee wish to discuss any issues further.

It is vital that the all data remain secure under the guidelines of Section 5 of this document and that the participant trusts that I will meet my ethical responsibilities with transparency, openness, care, diligence, sensitivity, respect, dignity and authenticity. Clear boundaries, requirements and expectations must be established and maintained throughout data collection and discussed periodically to ensure all participants are happy to continue with the study or if amendments to the process are required.

If the risk level for your project is ORANGE in the risk matrix, please attach a copy of the outcome of your scholarly review.

2. Experience of Investigators with this type of research.

a. Please provide a brief description of previous experience with this type of research, including data collection techniques, by the research team. If there is no previous experience, please describe how the researchers will be prepared.

The student researcher has no previous experience with this type of research, however they are highly experienced in interviewing and listening to vulnerable adults within this sector and are aware of the skills required to undertake data collection in an ethical, person centred, respectful, communicative and safe manner. The student researcher will undertake a period of research preparation in the form of a literature review and taught sessions in relation to desired interview skills, challenges, interview questions, qualitative methods and methodologies including purposive sampling, data collection and storage and interview techniques in the form of a taught session. Guidance and feedback will be sought throughout from the more experienced research supervisory team members.

b. For projects that will involve community members (eg. peer researchers) in the collection and/or analysis of data, please describe their status within the research team (e.g. are they considered employees, volunteers or participants) and what kind of training they will receive.

N/A

3. Possible Benefits

Describe any potential direct benefits to participants from their involvement in the project as a result of this research. If there are potential direct benefits to the community, the scientific/scholarly community or society as a result of this research, please also describe these here.

Particpants will have the opportunity to share their experiences which they may find therapeutic, enjoyable, empowering, educational and enlightening. Literature evidences a lack of quality research in this area and the study represents an innovative approach to examining worker wellbeing in a sector that struggles with increased worker absences and high staff turnover. Research data in this area has been recognised to be minimal and of poor quality and as such data may provide an additional perspective on worker wellbeing and how support and supervision practices may move forward in a more effective and needs led manner. This may positively impact on worker morale, satisfaction and staffing levels which is likely to positively impact on service users, organisations and others including worker families and the wider community in this geographical location and elsewhere given the research goal of creating a new support and supervision framework. This study also has the potential to undertake further research in more focused areas, depending on the initial research outcomes and identification of need. The research has the potential for generalisability given that it could be applied to other services and vocations that work within related public facing health and social care services.

4. Compensation

Will participants receive compensation for participation?

Financial?	☒Yes	☐No
In-kind?	☐Yes	☒No
Other?	☐Yes	☒No

If YES, please provide details and justification for the amount or the value of the compensation offered and how will compensation be affected if participants chose to withdraw?

Partcipants will be reimbursed for any cost related to their participation in the study i.e travel and refreshments. Should a participant choose to withdraw, any reimbursements will not be recovered from that individual.

Declaration

My signature below confirms that I am aware of, understand, and will comply with all relevant laws governing my research. I agree to ensure my co-investigators, collaborators and all involved in the running of this research will comply with these laws. I understand that for research involving extraction or collection of personally identifiable information, national and/or international laws may apply and that any apparent mishandling of personally identifiable information must be reported to the Research and Knowledge Exchange Office.

I agree that research will only commence after a favourable opinion has been received from the Research Ethics Panel; that neither the University, Panel or individual members of the Panel accept any legal obligation (to use to any third party) in relation to the processing of this application or to any advice offered in respect of it or not for the subsequent supervision of the research. If there is any significant deviation from the project as originally approved I must submit an amendment to the Research Ethics Panel for approval prior to implementing any change.

Signature of Researcher **Date**

Additional for all student applications:

As the supervisor of this student project my signature below confirms that I have reviewed and approve the research project and the ethics protocol submission. I confirm that I will provide the student with the necessary supervision throughout the project, to ensure that all procedures performed as part of this project comply with all relevant laws governing the research.

Signature of Supervisor **Date**

As the countersigner of the project I confirm that I am not directly involved in the project and have reviewed and approve the academic merit of the research project and the ethics protocol submission.

Counter-signed **Date**

Appendix 2: Email to gatekeeper organisations for distribution in-service

Invitation to Research

My name is xxxxxxxx and I am seeking participants for my PhD research.

I have worked in this sector for over 20 years and as an insider, appreciate the challenges and difficulties commonly faced by care and support workers. My research involves speaking with workers, aged 18+ and who work as a care and/or support worker within your organisation. The aim of the study is to help identify emotional experiences and motivations and how this can impact on worker wellbeing, morale and performance. The data will be used to raise awareness around worker wellbeing needs, improve supervision processes and practices and to create a new approach to the supervision process.

You may have an opportunity to hear me talk about this research opportunity, but if you are unable to attend, or Covid restrictions prevent this from being possible and would still like to know more about participating, you can contact me directly on xxxxxxxxxxx and I will send you a participant information sheet and consent form.

There are three opportunities for participation and you are welcome to join one or more elements of the study.

- A semi-structured 1-1 interview (1-2 hours depending on responses)

And/or

- A focus group (2-3 hours depending on responses)

I look forward to hearing from you.

Best wishes

Appendix 3: Phase One Participant Information Sheet

Participant Information Sheet – Worker Interviews **Researcher: xxxxxxxxxx**

Exploring the everyday lived and supervision experiences of unregulated social care workers.

About the researcher: I have over twenty years of experience as an employee in the health and social care sector and have worked within a wide range of support and education services.

Why have I been invited?

You have been invited to take part in this research project as a worker aged 18 years and over, who is employed by the organisation who have agreed to take part and as someone who can speak about emotional wellbeing workplace and supervision needs/experiences.

What is the purpose of the study?

The study aims to explore lived and supervision experiences and if current supervision models are effective and appropriate at meeting the wellbeing needs of this workforce and whether the data gathered can help to design a new supervision approach.

Do I have to take part?

Taking part in the study is entirely voluntary. You will be required to sign an informed consent form prior to the interview taking place and you will be given a copy of this information sheet.

What will happen to me if I take part?

You will be asked a series of questions around your everyday emotional experiences in the workplace and how they are supported and managed by your organisation. You will have the opportunity to talk about your workplace experiences both current and past and/or personal experiences that may also impact on you in the workplace.

Where will the interview take place?

Research interviews can be conducted on site at the University of St Mark and St John, by telephone, or online depending on the preferences of the participant and in line with any social distancing guidelines in place at the time of the study commencing. Suitable alternative arrangements can also be made.

Expenses All study participants will have any travel expenses reimbursed. A free parking space can be secured at the University campus if required.

What are the advantages of taking part?

Participants will have the opportunity to reflect on their experiences which they may find therapeutic, enjoyable, empowering, educational and enlightening. The aim of the research is to use the data to form the basis for a pilot supervision model for workers in this sector and I am optimistic that participation will benefit people in similar roles, service users and management systems.

What are the possible disadvantages and risks of taking part?

The research will discuss your feelings and supervision experiences at work, which we do not anticipate being distressing. You can choose to stop the interview and answer questions with as much or as little detail as desired. Participants will also have the opportunity to speak confidentially with an appropriate member of staff at the gatekeeping organisation should they need to discuss issues raised, further.

Will my taking part in the study be kept confidential?

I will protect the anonymity of all participants and their data at all times. Where quotes are used, they will be edited to avoid identification. Electronic data will be stored, analysed, and reported in the research report anonymously. All data will be stored on the secure network drive at the University. Audio files of the interviews will be uploaded to the secure network and the original files will be deleted. Hard copies of consent forms and diaries will be stored in a locked cabinet within a secured space. Following publication of the research, all data will be securely destroyed. I will use a website called otter.ai to help turn the audio recording into written form. The otter.ai privacy policy can be found at https://otter.ai/privacy - Particularly important points to consider are; your data will be stored by a third party but it can, on request, be deleted within the one month withdrawal period. If you do not wish for us to use otter.ai, please just tell the researcher, and they will write up the interview manually.

How long will the data be kept for?

The data will be kept only as long as needed, but that may be up to approximately 5 years so that I can complete my PhD and possibly publish the findings. Access to the data will be limited to the myself and my supervisory team. Additionally, there will be one list of participants and codes, kept securely by myself, and destroyed when the data are analysed/once the one-month withdrawal cut-off point has been reached.

What will happen if I don't want to carry on with the study?

If you choose to withdraw your consent from participating in the study, you have up to one calendar month to do so. You will not have to give a reason for your decision. After this period, data will have been anonymised and it will not be possible to identify and delete your specific contribution.

What if there is a problem?

Should you have any concerns about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions. If you have any questions about your rights as a research participant, or wish to make a complaint, you can contact the University Research Ethics Panel at xxxxxxxxxxx.

What will happen to the results of the research study?

The results of the research will be used within the PhD, as well as have a role in improving supervision. Results may be published in a peer reviewed journal. Participants can request a copy by contacting the researcher on the contact details provided below.

Appendix 4: Phase Two Participant Information Sheet

Participant Information Sheet – Managers **Researcher:**

Are current supervision models appropriate and effective at meeting the emotional wellbeing, performance and morale needs of care and support worker roles?

About the researcher: I have over twenty years of experience as an employee in the health and social care sector and have worked within a wide range of support and education services.

Why have I been invited?

You have been invited to take part as a manager or part of the leadership team who has support and supervision responsibilities for care and or support workers within your organisation.

What is the purpose of the study?

The aim of the study is to identify if current supervision models are effective and appropriate at meeting the wellbeing needs of this worker community and whether the data gathered can provide the foundation for a new training and supervision approach for organisations.

Do I have to take part? Taking part in the study is entirely voluntary.

What will happen to me if I take part?

In an interview, you will be asked a series of questions around your role as a manager and as someone who provides support and supervision to care and or support workers. You will be asked about current and future training and support needs and your reflections on the appropriateness and effectiveness of current supervision models for this particular worker community. You will also have the opportunity to discuss your experiences as a supervisee.

Where will the interview take place?

Research interviews can be conducted on site at the University of St Mark and St John or online depending on the preferences of the participant and in line with any social distancing guidelines in place at the time of the study commencing. Suitable alternative arrangements can also be made.

Expenses All study participants will have any travel expenses reimbursed. A free parking space can be secured at the University campus if required.

What are the advantages of taking part?

Participants will have the opportunity to reflect on their experiences which they may find supportive, therapeutic, enjoyable, empowering, educational and enlightening. The aim of the research is to use the data to form the basis for a pilot supervision model for workers in this sector and I am optimistic that participation will benefit people in similar roles, service users and management systems.

What are the possible disadvantages and risks of taking part?

The study will discuss your feelings and supervision experiences at work, which we do not anticipate being distressing. You can choose to stop the interview and answer questions with as much or as little detail as desired. Participants will also have the opportunity to speak confidentially with an appropriate member of staff at the gatekeeping organisation should they need to discuss issues raised, further.

Will my taking part in the study be kept confidential?

I will protect the anonymity of all participants and their data at all times. Where quotes are used, they will be edited to avoid identification. Electronic data will be stored, analysed, and reported in the research report anonymously. All data will be stored on the secure network drive at the University. Audio files of the interviews will be uploaded to the secure network and the original files will be deleted. Hard copies of consent forms and diaries will be stored in a locked cabinet within a secured space. Following publication of the research, all data will be securely destroyed. I will use a website called otter.ai to help turn the audio recording into written form. The otter.ai privacy policy can be found at https://otter.ai/privacy - Particularly important points to consider are; your data will be stored by a third party but it can, on request, be deleted within the one month withdrawal period. If you do not wish for us to use otter.ai, please just tell the researcher, and they will write up the interview manually.

How long will the data be kept for?

The data will be kept only as long as needed, but that may be up to approximately 5 years so that I can complete my PhD and possibly publish the findings. Access to the data will be limited to myself and my supervisory team. Additionally, there will be one list of participants and codes, kept securely by myself, and destroyed when the data are analysed/once the one month withdrawal cut-off point has been reached.

What will happen if I don't want to carry on with the study?

Participants engaging with the 1-1 interview process will be able to withdraw consent, without giving any reason, for up to one calendar month following the interview process. Beyond this point data will have been anonymised and it will not be possible to identify and delete the participant's data.

What if there is a problem?

Should you have any concerns about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions. If you have any questions about your rights as a research participant, or wish to make a complaint, you can contact the University Research Ethics Panel at ethicspanel@marjon.ac.uk

What will happen to the results of the research study?

The results of the research will be used within the PhD, as well as have a role in improving supervision. Results may be published in a peer reviewed journal. Participants can request a copy by contacting the researcher on the contact details provided below.

Appendix 5: Phase Three Participant Information Sheet

Participant Information Sheet – Groups **Researcher:**

Focus Group Topic: Discussing a new approach to supervision training

About the researcher: I have over twenty years of experience as an employee in the health and social care sector and have worked within a wide range of support and education services.

Why have I been invited?

You have been invited to take part in this research project as a worker aged 18 years and over, or a manager/team leader who is employed by the gatekeeper organisations and as someone who is likely to be able to speak about emotional wellbeing, performance and morale in the workplace and associated supervision needs.

What is the purpose of the study?

The study aims to identify if current supervision models are effective and appropriate at meeting the wellbeing needs of this worker community and whether the data gathered can help to design a new supervision approach.

Do I have to take part? Taking part in the study is entirely voluntary.

What will happen to me if I take part?

Should you choose to take part you will be invited to join a group session. The sessions will involve a group discussion and the opportunity to reflect and share your emotional wellbeing experiences and needs in your workplace and how you currently experience or would like to experience supervision. Group members will have the opportunity to reflect on what kind of training, information and support managers and organisations might benefit from in the area of supervision delivery.

Where will the workshops and focus groups take place?

Workshops and focus groups can be conducted on site at the University of St Mark and St John. However, it is likely that a suitable space will also be made available closer to Plymouth City Centre.

Expenses All study participants will have any travel expenses reimbursed. A free parking space can be secured at the University campus if required.

What are the advantages of taking part?

Participants will have the opportunity to reflect on their experiences which they may find therapeutic, enjoyable, empowering, educational and enlightening. The aim of the research is to use the data to form the basis for a pilot supervision model for workers in this sector and I am optimistic that participation will benefit people in similar roles, service users and management systems.

What are the possible disadvantages and risks of taking part?

The group session will discuss feelings and supervision experiences at work, which we do not anticipate being distressing. The researcher will protect the anonymity of all participants and their data at all times. Where quotes are used, they will be edited to avoid identification. Any information shared within a group setting is shared with the other participants and as such I cannot guarantee complete confidentiality. However, a group contract will be verbally agreed upon that discusses the need for confidentiality and group rules. Where quotes are used, they will be edited to avoid identification.

Will my taking part in the study be kept confidential?

Electronic data will be stored, analysed, and reported in the research report anonymously. All data will be stored on the secure network drive at the University. Audio files of the interviews will be uploaded to the secure network and the original files will be deleted. Hard copies of consent forms and diaries will be stored in a locked cabinet within a secured space. Following publication of the research, all data will be securely destroyed. I will use a website called otter.ai to help turn the audio recording into written form. The otter.ai privacy policy can be found at https://otter.ai/privacy - Particularly important points to consider are; your data will be stored by a third party, however, once the group audio recording has been transcribed, I will not be able to delete your specific contributions. If one or more participant's do not wish for me to use otter.ai, please just tell me, and I will write up the group session manually.

How long will the data be kept for?

The data will be kept only as long as needed, but that may be up to approximately 5 years so that the researcher can complete her PhD and possibly publish the findings. Access to the data will be limited to the researcher and the researcher's supervisory team.

What will happen if I don't want to carry on with the study?

Participants in the workshops and focus groups are free to leave the session at any time and do not have to give any reason for their decision. Any information shared during the group session will be anonymised, however I will not be able to identify and delete individual data as it will be mixed with the data of other group members.

What if there is a problem?

Should you have any concerns about any aspect of this study, you should ask to speak with the researcher who will do their best to answer your questions. If you have any questions about your rights as a research participant, or wish to make a complaint, you can contact the University Research Ethics Panel at ethicspanel@marjon.ac.uk

What will happen to the results of the research study?

The results of the research will be used within the PhD, as well as have a role in improving supervision. Results may be published in a peer reviewed journal. Participants can request a copy by contacting the researcher on the contact details provided below.

Appendix 6: Participant Consent Form

Participant Consent Form

1. TITLE OF RESEARCH PROJECT

What are the everyday lived experiences of unregulated social care workers and what are the support and supervision needs of this workforce with an aim to creating a new approach to the supervision process?

Name of Researcher:

I confirm that I have read and understand the participant information sheet dated X for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time within one calendar month after the completion of the interview without providing a reason.

I agree to my interview being audio recorded. *The recording will be transcribed and analysed for the purpose of the research*

I do / do not (please choose) agree to the audio recordings being transcribed (i.e., typed up) using the service Otter.ai. I am aware that I can “opt out” of my interview being transcribed in this way and that I need to make this decision within two weeks after the interview process.

I consent to verbatim quotes being used in publications and conference presentations. Please note that quotes will be changed should they lead to possible identification of the participant.

I understand that the results of the study may be published and / or presented at meetings or conferences. I give my permission for my anonymised data to be disseminated in this way.

I understand that participation will include talking about emotional aspects of my work and personal life which I may or may not find difficult.

I consent to the data being stored until the researcher has passed their PhD and potentially until their research has been published, which may happen later.

I understand that data will be stored online in a file that requires a password for access and in print format in line with GDPR guidelines in a locked cabinet. The researcher and the researcher’s supervisory team will have access to the data.

I agree to take part in the above study

- **Please turn over to sign**

Signed ……………………………………………………… (Research participant)

Print name ………………………………………………………

Date ………………………………………………………..

Name of person taking consent ………………………………………………………

Date ………………………………………………………

Signature ………………………………………………………

Please note: If you have any questions about your rights as a research participant, or wish to make a complaint, you can contact the University Research Ethics Panel at ethicspanel@marjon.ac.uk

Appendix 7: Phase One Interview Questions

Care and Support Worker Interview Questions and Prompts

Introduce the Research Aims

- To learn about how the participant experiences their job role and the reasons for entering this particular workforce
- To learn about the emotional and physical stressful things experienced by participants both in and out of the workplace
- To understand their support networks, if any
- To learn about the participant's experiences with supervision
- To learn about what the participant would like from the supervision process and how it might be improved upon.

The interview questions are based on five themes: the participant's experience of their role, stressors that they may experience, the participant's support networks, their experience of supervision and what they would like to see in the supervision process.

To gather the lived experience of workers in their terms, the interview questions will be broad with follow up questions prepared in order to meet the overall research aims.

Q1. Tell me about your job

As the participant talks about their role, further questions will be asked based upon the answers given using how, what and why questions. This will promote a person-centred experience where the participant will be able to lead the interview and exert a degree of control over their interview experience. However, if the participant does not naturally include the information sought, the following prompts could be asked:

- Can you tell me about your reasons and motivations for working with your particular service user group?
- What, if anything, do you enjoy about your job?
- What, if anything do you find difficult about job?
- We have talked about your current role, is there anything about previous roles that you would like to talk about?
- What are your career aspirations and what could prevent and/or help you to achieve that?

We have discussed your role, next I am keen to discuss the stressors you encounter in the workplace and outside of the workplace. You can talk about current and past experiences.

Q2. What difficulties and challenges do you/can you experience both in and out of the workplace?

As the participant talks about their stressors, further questions will be asked based upon the answers given using how, what and why questions. This will promote a person-centred experience where the participant will be able to lead the interview into the areas that they want to discuss and exert a degree of control over their interview experience. However, if the participant does not naturally include the information sought, the following prompts could be asked:

- Can you tell me about the areas of your job that put the most emotional and physical wellbeing demands on you as a worker and an individual?
- Can you tell me about any emotionally or physically challenging experiences/incidences you have had in the workplace and how they made you feel?
- In relation to your overall wellbeing, can you tell me what might make it more difficult for you to do your job effectively as an employee?
- In relation to your overall wellbeing, can you tell me what might make it more difficult for you to do your job effectively as an individual?
- At times, workers may have their own stresses and challenges, how do you manage these occasions when working with emotionally vulnerable service users?
- Can you tell me how you deal with things you find stressful?
- Do you find it easy to put your own difficulties aside when going in to work? What is that like? Give an example…
- Do you currently have any health and/or wellbeing issues that you comfortable to talk about?

We have discussed the difficulties and challenges you encounter and have encountered both in and outside of the workplace, next I am keen to discuss the support networks that are in place both within and outside of your organisation. You can talk about current and past experiences.

Q3. What support networks do you have both in and out of the workplace, if any?

As the participant talks about their support networks, further questions will be asked based upon the answers given using how, what and why questions. This will promote a person-centred experience where the participant will be able to lead the interview into the areas that they want to discuss and exert a degree of control over their interview experience. However, if the participant does not naturally include the information sought, the following prompts could be asked:

- How does your organisation support your emotional wellbeing, morale and performance, if at all?
- What kinds of support do you have available to you inside the workplace, if any, and what do you find beneficial about it?
- What kinds of support do you have available to you outside of the workplace, if any, and what do you find beneficial about it?
- What training have you had?
- What training would you like?
- Who do you learn from?
- Who do get feedback from?

We have discussed the support networks you encounter both in and outside of the workplace, next I am keen to discuss your experience of supervision in this sector. You can talk about current and past experiences.

Q4. What is your experience of supervision in this sector?

As the participant talks about their experience of supervision, further questions will be asked based upon the answers given using how, what and why questions. This will promote a person-centred experience where the participant will be able to lead the interview into the areas that they want to discuss and exert a degree of control over their interview experience. However, if the participant does not naturally include the information sought, the following prompts could be asked:

- Do you have regular supervision?

- What do you like about the supervision you receive?
- What do you dislike about the supervision you receive?
- What prevents you from having regular supervision?
- Do you think that supervision is viewed as an important tool by management and workers?

We have discussed your experience of supervision, next I am keen to find out what you would do, if anything, to improve the supervision process to make it more responsive to worker need. You can talk about current and past experiences.

Q5. What would you like your supervision to be like?

As the participant talks about what they would supervision to be like, further questions will be asked based upon the answers given using how, what and why questions. This will promote a person-centred experience where the participant will be able to lead the interview into the areas that they want to discuss and exert a degree of control over their interview experience. However, if the participant does not naturally include the information sought, the following prompts could be asked:

- What do you think prevents the supervision process from being how you would like it tobe?
- How would you improve the supervision process?
- What could you do to make supervision a more effective experience?
- What could you do to make supervision a more enjoyable experience?
- What could managers do to make supervision a more effective and enjoyable experience?
- What could organisations do to improve the supervision process for managers and workers?

Ending

This may be a good time to raise the question around external reflections from previous interviews. i.e External reflections from other interviews have raised X,Y, Z issue, and I wondered if you had encountered/thought about this?

Are there any questions that I should have asked you, that I didn’t think to ask?

Is there anything else that you would like to add about your experiences that we haven’t explored?

Do you have any questions about the interview or the research in general?

How has the interview experience been for you?

Expansion questions

Detail – Fill out the picture of what you're trying to understand! "What was/is it like…"

· Elaboration

· Clarification

· Contrast

Examples:

· How have these experiences affected you?

· What was that like?

· What thoughts stood out to you?

· What physical sensations stood out to you?

· What emotions were you aware of at the time?

· Can you tell me more about…?

· What else do you remember about that experience?

· How did that feel?

· How did that affect you?

· Could you give me an example of when this happened?

Appendix 8: Phase Two Interview Questions

Manager Interview Questions and Prompts

Introduce the Research Aims

- To learn about the journey and experiences of managers and those in leadership roles
- To learn why participants seek managerial and leadership roles
- To learn what demands are placed on managers and those in leadership positions
- To learn about supervision processes, current support and training and future support and training needs

The interview questions are based on four themes: the journey of managers and those in leadership roles, reasons for choosing to work in management and leadership roles in this sector, the demands and challenges of the role and the supervision process and the support and training they receive and/or would like to receive.

Journey into management and leadership

- Can you tell me about your journey in to a management and leadership role?
- Do you think the management selection process is appropriate and effective in this sector?
- What could be done to help make selection better?

We have discussed your journey into a management/leadership role, next I am keen to discuss the reasons why you wanted to take on the role and transition from worker to manager.

Reasons for taking on management and leadership roles

- What motivated you to move from worker to manager/leader?
- What do you bring to the role that benefits your employees?

We have discussed your reasons for choosing to take on this role, next I am keen to discuss the demands and stressors you encounter as part of your role as a member of the senior leadership and management team.

Demands and support

- What do you find most challenging about your role?
- Can you tell me about your management and leadership training experiences?
- Can you tell me about your support networks?

We have discussed the demands and stressors you experience in your role, next I am keen to discuss your experiences around training, delivery and worker engagement around the supervision process.

Supervision

- Can you tell me about what types of supervision you provide for employees?
- Can you tell me about some of your own experiences with the supervision process?
- What supervision models are you aware of within the health and social care sector?
- In your opinion, how do current supervision frameworks for employees effectively meet their wellbeing and practice needs, if at all?
- What is your personal experience of this?
- What makes appropriate and effective supervision delivery difficult?
- What kinds of supervision training and support would benefit managers and those in positions of leadership?

Ending

· Are there any questions that I should have asked you, that I didn’t think to ask?

· Is there anything else that you would like to add about your experiences that we haven’t explored?

· Do you have any questions about the interview or the research in general?

· How has the interview experience been for you?

Expansion questions

- Detail – Fill out the picture of what you’re trying to understand! “What was/is it like…”
- Elaboration
- Clarification
- Contrast

Examples:

- How have these experiences affected you?
- What was that like?
- What thoughts stood out to you?
- What physical sensations stood out to you?
- What emotions were you aware of at the time?
- Can you tell me more about…?
- What else do you remember about that experience?
- How did that feel?
- How did that affect you?
- Could you give me an example of when this happened?

Appendix 9: Phase Three Focus Group Questions

Focus Group Aims and Questions

Focus Group Plan of Delivery

Participants will be sent the list of questions that are going to be asked and a participant information sheet one week before their scheduled focus group. Before any focus group session commences, all participants (workers and managers) will be supported to make a contract around expected group rules, online etiquette and confidentiality. Participants will be required to give verbal consent which will be audio recorded.

Aims –

- To support the group to identify and discuss what kinds of information they think would be beneficial for workers to be made aware of in a mandatory supervision training module .
- To identify whether different types of training would be appropriate for new workers to the sector and for more experienced workers in the sector.
- To discuss what and why would be the best method of delivering the training.
- To discuss whether some form of 'understanding check' would be beneficial/necessary and how that check might be carried out.
- To discuss what type of language and vocabulary would be best suited to be as inclusive and clear as possible.
- To discuss how supervision training for workers might impact on managers and supervisors.

Focus Group Question –

What might supervision training for unqualified health and social care workers include and how could supervision training for unqualified health and social care workers could be effectively managed and delivered?

Engagement Questions

What do you like about supervision?

What do you not like about supervision?

Exploration Questions

- Why should there be training around what supervision is?

- What do you think should be in supervision training for unqualified health and social care workers?
- What would new workers need to know about supervision?
- What would more experienced workers need to know about supervision?
- What would we need to think about regarding potential barriers, for example: the kind of language used in the training materials?
- How might we overcome these barriers?
- How might we check that the worker has understood the training?
- To what extent do you think supervision training for unqualified health and social care workers could help workers and supervisors manage the supervision process more effectively? (And why)
- What might be the impact of worker supervision training on managers and supervisors?
- What might managers and supervisors need to do to in response to their staff becoming more knowledgeable around the supervision process?
- What do you think would be the best way of delivering supervision training?
- What might the positive impact of the training be?
- What might the negative impact of the training be?

Closing Questions

Is there anything else you'd like to say about supervision training for unregulated social care workers?