IMPACT
Improving Adult Care Together
UKRI Economic and Social Research Council
The Health Foundation

IMPACT Evidence Review: The health and well-being of care workers

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What is the issue?

Care is amazing – and it transforms people’s lives. There might be massive vacancies in adult social care, but there are also massive opportunities to make a difference.

However, without the right support, care work can be difficult and distressing – and the way that adult social care is funded and organised means that many roles can be poorly paid, insecure and stressful.

As an example, a member of IMPACT’s ‘Critical Friends’ group has led research into working conditions and well-being in UK social care, focusing on changes experienced during the COVID-19 pandemic (Ravalier *et al*., 2023). They found that:

- Prior to the pandemic, *“social work and social care practitioners had some of the worst working conditions of any sector in the UK.”*

- *“These working conditions have worsened across the pandemic, with psychological well-being also worsening.”*

- Improving this situation would not only improve individual employee well-being, but also improve outcomes for people who draw on care and support and for social care employers (pp. 1225 and 1238).

More generally, there is widespread evidence that stress has a negative impact on psychological and physical health, and that poor working conditions can lead to greater turnover and difficulties recruiting. However, we also know that organisational factors and relationships – such as support from management and colleagues – can make a difference to how people feel about their work, how they perform and their willingness to stay in working for their current organisation.

In the NHS, for example, there is significant evidence to suggest that improving staff well-being can lead to better outcomes for employers and for patients (see, for example, West, 2017 for a more general overview of these issues and of compassionate leadership). While we might often struggle to act meaningfully on this, the NHS (at least in principle) recognises that ‘staff are our greatest asset’ and that looking after staff can help to look after patients. Arguably, social care is still a long way from recognising this to anything like the same extent.

Why is IMPACT focusing on these issues?

Improving the health and well-being of care workers is a key priority for IMPACT and our partners:

- In 2021-22, people taking part in our national survey and our 'IMPACT Assemblies' told us that supporting social care staff was one of the main priorities for adult social care and for IMPACT.

- When we launched a national 'expression of interest' process in late 2022 to identify the projects we should run in 2023-24, lots of different organisations and parts of the country wanted to do work around staff well-being.

- In early 2023, our 'Ask IMPACT' team produced an evidence-informed guide to recruiting and retaining social care staff. This highlighted lots of problems, but also some practical things that employers can do to try to improve things – one of which was paying proper attention to the health and well-being of people working in social care.

As a result, this Network is bringing together local and national organisations from across the UK to work on these issues with each other, sharing learning and generating new knowledge about what might make a difference.

Care as 'emotional labour'

After reviewing the evidence around staff well-being, we believe that there is scope to change the way we think about these issues by focusing on the idea of care as a form of 'emotional labour.' If you want to know more about 'emotional labour', read the 'Time to Care' report (particularly pp.19-23).

This isn't a phrase you hear every day – but *"at its simplest, it means managing your own feelings in order to present a work-appropriate emotion"* (Sawbridge, 2015). This can be really hard in a sector like adult social care, where some of the things that people do can be very difficult, distressing and sometimes even seem disgusting - things that we don't usually talk about in everyday conversation and that are usually intensely private. As Mastracci (2016, p.191) points out:

> *"Emotional labour is so integral to some jobs that to fail to engage in emotional labour is to fail to do the job. A social worker cannot laugh at her clients' circumstances. A police officer cannot show fear to criminal suspects. An emergency responder (paramedic) cannot panic or recoil from a patient's gruesome injuries as she arrives on the scene of an accident."*

Put another way, we all have an 'emotional bank account' (Hewison and Sawbridge, 2016) that gets constantly depleted by the things we see and do, and we all have different ways of keeping this bank account 'topped up'. If we get put in really difficult situations without proper support, then these 'bank accounts' get overdrawn – and our health and well-being suffer as a result.

These ideas were first developed in the airline industry looking at the work of air stewards (who have to present a professional, calm, friendly face to passengers who might be scared, angry, unreasonable and/or even abusive). Similar ideas have also been applied to health care, where professions such as nursing are expected to deliver compassionate care to their patients, despite the very difficult nature of the work they do and the potentially stressful nature of the conditions in which they work.

In particular, Yvonne Sawbridge, a former nurse leader herself, has used the concept of emotional labour in her work with Alistair Hewison to explore why things can go so badly wrong in health care settings, why people who went into a caring profession can sometimes do such awful things to other people and how we can best support staff to deliver compassionate care.

As she points out, we often look at things through a financial lens, without thinking about the emotional toll that care work can take. This was illustrated by the Chair of a national health and social care organisation, who said words to the effect that *"kindness and compassion costs nothing."* Sawbridge observes that this is true financially, but isn't true emotionally. You might be at the end of a 12-hour shift on a chronically under-staffed ward, caring for older person with dementia at the end of their life, who is very distressed. It might remind you of your own Mum, who died in hospital with dementia. You take yourself off to the sluice room to clean yourself up and for a quiet cry (the sluice room is often the only private space on some wards), then you come to the person in the next bed and smile at them as if they are the only patient there.

Giving someone a smile costs nothing in financial terms - but it can sometimes cost a lot emotionally.

Sawbridge and Hewison (2011, pp.19-20) give another example from the ambulance service – whereby staff would find ways to top up each other's 'emotional bank accounts' through informal peer support and camaraderie, often focused around a staff canteen in a central base (many of which became under threat over time in response to national policy and pressures):

> *"Current work has found that in the past ambulance staff used a variety of coping mechanisms to deal with issues they may face in their working day and at the heart of this was the camaraderie of their team… They would use their time in between calls to debrief in an informal and unstructured way. This often included the use of humour or anecdotes which may appear superficial - but which fulfil a more profound function. The introduction of higher performance targets including faster response times resulted in the use of standby locations across the patch, such as lay bys, so that they could get to callers more quickly. However this reduced the frequency of returning to base between calls and meant that some staff felt more stressed and stated they were prone to increased sickness levels, because an important source of informal support could no longer be accessed. The unintended consequence of the organisation's response in meeting these targets was the removal of an important coping mechanism from their staff. This is a good example of how modes of coping with stress are often invisible and poorly understood - not least by the staff*

themselves, and a further example of how management practice can have effects that were not foreseen."

Unfortunately, many public services seem really bad at paying attention to the emotional impact of caring. As Sawbridge points out, nurses now use proper equipment to look after their backs, and anyone on a building site wears a hard hat to keep themselves physically safe – we understand the physical labour that people do. However, we're not as good at looking after our 'hearts' or our 'souls'. Moreover, many of our caring professions are very task-focused – sometimes people seem to think that if you've got enough time to think and talk about how you're feeling, then you're not working hard enough.

All this can result in a situation where staff aren't properly supported to deliver compassionate care – and then we blame the same staff for being 'uncaring'. As Cornwell (2011) has argued:

> *"Staff don't need more blame and condemnation; they need active, sustained supervision and support. In the high-volume, high-pressure, complex environment of modern health care it is very difficult to remain sensitive and caring towards every single patient all of the time. We ask ourselves how it is possible that anyone, let alone a nurse, could ignore a dying man's request for water? What we should also ask is whether it is humanly possible for anyone to look after very sick, very frail, possibly incontinent, possibly confused patients without excellent induction, training, supervision and support."*

What does this mean in practice?

To take forward these ideas, Sawbridge and colleagues held a national workshop; worked with nurse leaders to think through the practical implications; buddied up with the Samaritans to compare how they support their volunteers with how the NHS tries to look after its staff (or not); carried out action research; and wrote up a series of practical initiatives that looked promising.

Some of their work is set out in different formats, including:

- An online policy paper to explore why good people can sometimes deliver bad care (Sawbridge and Hewison, 2011).
- A TedX talk to explain the concept of emotional labour (Sawbridge, 2015).
- An edited book looking at *Compassion in Nursing* (Hewison and Sawbridge, 2016).
- A book chapter, jointly authored between UK and US colleagues, looking at different interventions which might support people working in public services with emotional labour (Mastracci and Sawbridge, 2019).

In debating how these ideas could be turned into practice, Mastracci and Sawbridge (2019) describe a number of national and international initiatives and approaches (see Table 1 for examples).

Table 1: Examples of approaches seeking to explore care as emotional labour

Initiative/model	Brief description
Creating Learning Environments for Compassionate Care	Training/action learning/practice development programme to promote compassionate care for older people in hospital (developed at Southampton University)
Relation-centred Leadership	Participatory action research project to identify and develop compassionate care practices (Edinburgh University/NHS Lothian)
Group supervision	Group-based reflective practice process (developed by Maureen Smojkis at the University of Birmingham)
Mindfulness	General overview – but example cited of Transport for London's Mindfulness-Based Stress Reduction programme
Restorative supervision	Co-coaching approach to supervision (developed by Wallbank in health visiting services, used in over 60 Trusts across the UK and Ireland)
Samaritans Volunteer Support Programme	See Box 1 below
Schwartz rounds	Structured approach to create a forum for staff to come together to discuss the emotional and social aspects of delivering care (adapted in the UK by the Point of Care Foundation)
Critical Incident Stress Debriefings/Self-Care Plans	Group reflection on emergency calls/people's reactions (developed by US emergency services); scope to link to an annual self-care plan, focused on the whole person and with clear outcomes agreed (initially developed by the Denver Center for Crime Victims)

In particular, Sawbridge and Hewison worked with NHS nurse leaders to introduce insights from the way in which the Samaritans support their volunteers (see Box 1) into a number of hospital wards. This was very powerful learning – exploring very deep-rooted cultures and what's possible or not in different types of organisation. For example, leaders from the Samaritans fed back that volunteers have the right to de-brief before the finish their shift but, if a difficult call comes in late on or if it's been a really busy night, there is permission to divert phones elsewhere – so that people in distress

who call always get through to someone who is themselves well supported. Nurse leaders fed back that the NHS equivalent of this is that you keep the phones on come what may – and, if something has to give, it's your own health and well-being.

Box 1: Insights from the way in which The Samaritans support their volunteers (quoted by Sawbridge and Hewison, 2011, p.23)

The Samaritans

"Each volunteer undergoes a period of training prior to taking calls.

Each shift is between 3 – 5 hours, and the volunteers work in pairs.

The callers are often in highly distressed state, and the volunteers are actively encouraged to share the last call with their partner in the 'down times' in between calls.

If the volunteer needs longer to debrief, the telephones will be turned off to enable this to happen (it is rare that this action is required as most debriefs are possible in a few minutes). However it signifies the importance that the organisation gives to the emotional support of volunteers. They recognise that if the carer isn't cared for then they can't care for the callers, and by this action they demonstrate that they really mean this.

At the end of each shift, the volunteer 'offloads' to the shift leader. This process involves a summary of the types of calls taken by the volunteer and how the volunteer is feeling.

The leader will make a judgement about the emotional health of the volunteer, and if they feel they were particularly affected, they will call them the next day to see how they are."

Despite really good intentions, these attempts to influence NHS culture encountered a series of practical and cultural barriers, including difficulties finding protected time and space, people feeling that they already 'look after one another' (when really they don't always) and people feeling unable to make practical changes in the way they organise their work. In reflecting on lessons learned, Hewison and Sawbridge (2016, pp.147-48) provide the advice set out in Box 2.

These tips are potentially really helpful, as they involve learning from what didn't work as well as from what did.

Box 2: Lessons from attempts to improve staff support in the NHS (Hewison and Sawbridge, 2016, pp.147-48)

> *"Any initiative to improve staff support and the provision of compassionate care needs to be 'owned' by the organisation.*
>
> *There needs to be visible and sustained senior management support, commitment from and practical support for the ward leaders [in a hospital context], and willingness of the whole team.*
>
> *There is no single solution, approaches need to be developed for each team in context.*
>
> *Approaches such as this are only one element in bringing about cultural change and will not work in isolation."*

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