Managers' Perspectives of an Effective Health and Social Care Worker in the Independent Sector: An Ethnographic Study

Thesis submitted in accordance with the requirements of the University of Chester for the Professional Doctorate Degree in Health and Social Care

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Declaration

The material being presented for examination is my own work and has not been submitted for an award of this or another HEI except in the minor particulars which are explicitly noted in the body of the thesis.

Signature:  Date: 25th August 2023

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Acknowledgements

My husband's unwavering love and support has been a tremendous source of motivation and pride throughout my doctoral journey. I am forever grateful to have you in my life Ciaron.

I am indebted to my academic supervisors, Dr Jenni Templeman and Dr Janet Barton, for their invaluable counsel, support, and insightful observations. Their knowledge and encouragement were instrumental in shaping this thesis.

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I extend my sincerest adoration to all health and social care workers, their tireless efforts to promote social justice, advocate for marginalised populations, and uphold the dignity and rights of every individual are inspirational. They navigate complex and challenging situations with remarkable professionalism and compassion, providing essential support, comfort, and empowerment to those they support and care for. Their contributions are often unrecognised, but their influence on individuals, families, and communities is profound. Their dedication to improving the lives of those in need, their commitment, compassion, and steadfastness merit the highest regard.

Glossary of terms, definitions, and abbreviations

Adult at risk

This term replaces 'vulnerable adult' and refers to a person over the age of 18 years old, who requires health and social care services due to mental health conditions, learning disabilities, physical disabilities, sensory impairments, old age, or illness. These individuals may be unable to care for themselves independently or protect themselves from significant harm or exploitation without support.

Behaviour

The manner in which a worker or person responds to and acts in various situations or when presented with stimuli. It may also refer to 'professional behaviour,' which encompasses the contractual actions and conduct expected from a worker while carrying out their paid duties.

Capacity

The ability of an individual to make specific decisions for themselves independently in each unique situation. The law assumes a person aged 16 years or older has full capacity to make decisions unless substantial evidence proves otherwise.

Competence

The successful application of the necessary level of knowledge and skills to a particular task. Through their behaviour, a competent person demonstrates they understand and utilise the required knowledge and skills for the job.

The Care Quality Commission (CQC)

The Care Quality Commission serves as the independent regulator for health and social care services across England. They ensure services provide individuals with safe, effective, compassionate, and high-quality care. The CQC demands ongoing improvements in care services.

Culture

The prevalent ideas, customs, and values exhibited by the individuals within a particular group. In this thesis, 'culture' refers specifically to organisational and team culture, meaning the behaviours modelled by leaders and reflected throughout the team members or organisation.

Engagement

Describes a trait of organisational behaviour and an individual's positive application of effort, commitment, job satisfaction, motivation, and optimal functioning at work. An engaged worker feels loyal, proud of and happy in their work.

Effective

In reference to an 'effective frontline worker,' means a worker who achieves required outcomes from their work, as defined in each client's individualised support or care plan. It involves delivering care and support tailored to the specific needs of the service users they support daily.

Frontline worker

Staff who serve as the primary point of contact and support for clients within adult health and social care settings. They typically hold job titles such as 'care assistant,' 'support worker,' etc. 'HSC frontline worker' is used interchangeably with 'HSC worker', ‘frontline worker’, and 'effective worker' in this thesis depending on context.

Intelligent support

Support for clients delivered in a professional, compassionate, and conscientious manner that enables client choice, dignity, and promotes holistic well-being.

Knowledge

Understanding of a particular subject area, attained through academic study or experiential learning.

Manager

Refers to any senior staff member who supervises frontline support/care workers and monitors their performance within the work environment.

Service user

An individual who accesses health and social care services. There is ongoing debate regarding the term 'service user' and whether it is outdated. However, it remains the most widely used term for those utilising these services. A 'service user' may also be referred to as a 'tenant,' 'client' or 'customer' when discussing housing, finances, or individual payments.

Skills

The aptitude to complete knowledge-based actions, drawing on a combination of physical and emotional responses suited to the professional context.

Work setting

Any location such as a care home, hospital ward or service user's own residence where at-risk adults receive support from nursing, care, or support staff.

ABSTRACT

Aim: This thesis presents an ethnographic investigation into the perceptions of managers in the independent health and social care sector regarding the characteristics of effective health and social care workers. The study investigates the managerial perspective of the values, skills, knowledge, and functional behaviours regarded essential for providing high-quality care services to adults who may be at risk. Using an ethnographic methodology, the study seeks to glean rich and nuanced insights from managers who play a central role in moulding and supervising the Health and Social Care workforce.

Background: Health and social care workers require a variety of skills and knowledge for them to be perceived as effective by their managers. The skill and behavioural requirements range from the practicalities of supporting people with their daily living tasks, including clinical support, to high levels of emotional intelligence to support the sociological, psychological, and emotional wellbeing of people who access health and social care services. Health and social care frontline workers require a sophisticated level of emotional intelligence with positive, personal attributes such as patience, kindness, empathy, and compassion.

Methodological approach: An interpretive, ethnographic design was adopted for the study incorporating symbolic interactionism with social constructionism as a lens with which to analyse the outcomes from the research question. Individual, semi-structured ethnographic interviews were conducted with ten managers (n=10), and

two focus groups were held in which participants were asked to identify the characteristics that, in their opinion, constitute an effective frontline worker. The leadership focus groups included eleven managers in total (n=5 + n=6) therefore twenty-one participants in total (n=21) plus field notes thus achieving triangulation. The data was analysed using Ricoeur's thematic analysis framework.

Findings: Communities of practice are naturally inherent in well performing teams. On a service level this is brought about through the behaviours of effective frontline workers, creating cultures of effective communication and continual, shared learning to enhance the lives of their service users. One may suggest a culture of experiential learning begins through the metamorphic, liminal experience of integrating staff members into the organisational culture. Liminality is present in the experience of individual workers, teams and the 'living organisation'. It is a catalyst, in which processes happen spontaneously, leading to consideration of 21st century healthcare and compassion in caring; essential for the transformative, person-centred healthcare required in contemporary practice.

Recommendations: Recommendations included the development of a professional identity through communities of practice, an educational push towards enhancing staff self-actualisation, and the cultivation of organisational culture, all of which would lead to compassionate care with a focus on facilitating service user safety and happiness.

Chapter 1: BACKGROUND TO THE STUDY

1.1 Introduction

Managers in the health and social care sector are responsible for overseeing daily operations, upholding policies, and supervising the workforce. They play a crucial role in shaping the organisational culture and ensuring that person-centred care is provided to service users (Ballard et al., 2018). The significance of managerial support, leadership, and effective communication in improving the quality of care provided by health and social care professionals cannot be overstated (Skills for Care, 2022).

This study investigated the breadth of abilities required of effective frontline Health and Social Care (HSC) workers, as perceived by their managers. Maintaining the physical and psychological safety of service users, whilst recognising and facilitating their independence and freedom of choice, is fundamental to professional, intelligent support, and is expected of all frontline HSC staff. This initially requires exceptional communication skills, emotional intelligence, and self-awareness to achieve a sophisticated balance of care and support (Care Quality Commission, 2021). This study offers novel perspectives of managers' perceptions of their effective frontline HSC workers, namely support workers or care assistants, depending on the type of service in which they are employed.

The socially constructed adult health and social care (HSC) sector is interwoven throughout society in the form of symbolic and practical support mechanisms in which people reside or visit, supported by health and social care professionals. This study unveils how frontline workers of HSC services in the

independent sector play crucial roles in fostering a positive cultural drive, facilitating and being the catalyst for the delivery of high-quality care and support to adults at risk (Care Quality Commission, 2019). The performance of frontline workers is dependent upon the intelligence and training of these multidimensional professionals.

The theories of social constructionism and symbolic interactionism have strongly influenced health and social care philosophies in England (Shakespeare, 2006). Social constructionism, as a sociological theory, posits that much of human life experience and knowledge is socially situated and developed through interactions with others (Burr, 2003). This perspective shares common ground with symbolic interactionism, which examines the construction of meaning and identity through social interactions and symbols (Blumer, 1962).

Historically, disability and illness were perceived as conditions inherent to an individual that required fixing or curing (Turner, 1989). Social constructionism and symbolic interactionism challenged this, arguing that disability stems not just from biological deficits but also from societal failures to provide appropriate adaptations and interactions (Degener, 2017). Service users are no longer seen as passive 'patients,' but as active agents crafting care plans tailored to their own socially constructed realities, identities, and needs (Utzumi et al., 2018). These theories have also underpinned the notion of co-production in care in England, with service users involved in collectively designing and evaluating services (Boyle & Harris, 2009). This diverges from modernist paradigms where professional expertise alone holds authority and power. Instead, the diverse experiences and identities of service users, shaped through social interaction, are now valued forms of knowledge for improving

services (Gupta & Rokade, 2016). Strong social constructionist and interactionist influences are also apparent in the person-centred approach where each service user is seen as a unique individual situated within complex social worlds, whose identity and needs are shaped through interactions (Bridger, 2022). Their care is tailored around their distinctive constructed identity, not just medical needs (Scambler, 2002). The health and social care workers discussed by the participants of this study are the professionals charged to deliver this care and support.

1.2 Covid 19 – pandemic effects on research practicalities

The COVID-19 pandemic, which originated in December 2019 in Wuhan, China, swiftly spread around the globe, causing millions of fatalities and overwhelming healthcare systems (Jones, 2021). In the UK, the pandemic illustrated the critical nature of health and social care services, not only in terms of supporting adults at risk within their homes, but also as a socially constructed support mechanism for primary care services (Jones, 2021; McFadden et al., 2021). The pandemic affected all facets of the UK health and social care industry; people's physical health and emotional wellbeing were significantly affected (Billings et al., 2021; Jones, 2021).

Exacerbated through social inertia, there were challenges not only for the national organisation by which I am employed, but for the whole health and social care sector. It was never more necessary to keep people healthy in their own homes and communities, thereby relieving pressure on the NHS and other primary care services (Nyashanu et al., 2020).

Leading to my research endeavour, managers' perceptions of their frontline workers' effective skills and behaviours became a focus and were critical for understanding how to consistently deliver intelligent, competent, and holistic support to adults accessing health and social care services.

Due to the national lockdown, it was necessary for me to change the way I had planned to carry out the participant interviews. Permission was requested from my supervisors and the ethics committee at the University to carry out the interviews virtually. This was granted in April 2020 (Appendix 7. Ethics Committee Approval to Conduct Interviews Digitally. p. 209).

Reflexive considerations forced me to question the academic integrity of conducting ethnographic interviews remotely. Within academic, ethnographic research there were, what Podjed (2021), described as anthropological research crises, which required ontological and epistemological consideration (Podjed, 2021). Methods for conducting ethnographic interviews were renewed and researchers such as Góralska (2020) authored papers giving advice on how to perform virtual ethnographic interviews. The pandemic of COVID-19 exposed vulnerabilities and gaps in the provision of essential services and placed unprecedented demands on healthcare systems. The pandemic accentuated the significance of health and social care workers, who have been at the vanguard of pandemic response. They worked assiduously to provide care and support for their service users, putting themselves at risk of contracting the infection in the process. The concerns relating to the wellbeing of HSC staff, their mental health and emotional fortitude being at the forefront of concerns (Franza et al., 2020; Greenberg, 2020).

1.3 Locating the professional researcher-self

An ethnographic study is intended to depict a story, therefore as a neophyte researcher, exploring the doctoral milieu and finding one's ethnographic feet, the following paragraphs are an attempt to narrate the personal connection to my research study and the correlation to my professional reality.

My historical socialisation in the field of Health and Social Care, hence perceptual milieu is shaped by an accumulation of experiential and academic knowledge gained over the course of a 31-year career in Health and Social Care. My professional reality and interpretation of this social world have been constructed because of personal symbolic interactions within my historic social world reality (Burr, 2003). These experiences have shaped my path and led to this point of doctoral study for which I will always be grateful.

In my current professional role, I am subsumed in organisational culture, setting the direction of staff engagement initiatives for workforce skill and knowledge development. My philosophical and professional focus is to consistently exert a positive influence on the work culture and future sustainability of my employer organisation and our management teams.

My professional life has been constructed by transitions in five distinct experiential phases, beginning with the life circumstances that brought me to the Health and Social Care sector. In my early teenage years when my sole guardian was diagnosed with a terminal illness. I, along with other family members became a carer for them. The deeply personal experiences gained through supporting someone I loved with their most intimate care and being a witness to their uncontrollable demise from a proud, strong admirable person to a frail,

unrecognisable person was a profoundly life changing experience. It forced one to explore the temporality and importance of life. This experience became an epiphany moment in my socialisation and ontological positioning of my personal and professional lifeworld and became the catalyst for an intrinsic desire to improve the lives and opportunities for adults at risk.

When my older relative shared her experiences working as a care assistant in a nursing home, I felt compelled to follow in her footsteps. I successfully applied for a role as a health care assistant with the aspiration of one day becoming a physician. Initially I was afforded the opportunity to work with older people with advanced dementia, chronic illnesses, and physical disabilities, reminiscent of the experiences with my guardian. It was my intrinsic goal to ensure the clients (service users) I supported in their end of life received the most dignified, effective, and holistic care possible, driven by my subjective experiences and altruistic values. To this day I refer to that positive behaviour, and what I consider to be naturally upholding a person's dignity and self-esteem, the 'mum' test. When faced with a challenging situation, what would you do if this person was your mother, father, husband, or someone else you loved and cared for?

As a result of enthusiasm and pride in my work, I was soon promoted to a senior position supervising several junior staff members. Thus, I entered the next phase of my professional development; not only did I strive to provide person-centred, holistic care myself, but I was now responsible for ensuring that the team I managed shared these values. This is where my passion for positive, role-model leadership began, and I am eternally grateful for the nursing and medical role models with whom I had the privilege of working as part of an inspirational multidisciplinary

team. I thrived in a role that required self-development. My career advancement then allowed for realistic self-actualisation through personal and professional development.

Reflecting on my early career I understand that although I did not have the professional experience or the ability to generate an academic narrative as I do now, I was recognising that members of a care delivery team must be managed in a supportive, compassionate way. I held an intrinsic understanding of the importance of ensuring my team members felt valued and appreciated as a worker and as a person. This created what I now accept to be a positive culture of engagement within my team (Davies et al., 2000; Storey, 2019), where everyone flourished personally and professionally. Consequently, it enhanced the quality of care and improved the lives of the people we supported.

Reflecting on a deeper level, the connections with the team members and mutual respect gained through the appreciation and acknowledgement of their positive values pathed the way for a positive and effective team (Bridger, 2022; Turner, 2020) who were proud of their roles and the high-quality care and support they provided for the people we supported.

My career gathered momentum, evolving through several senior roles, managing larger teams, and supporting staff to deliver care to clients with diverse health needs. This is where the connection to the health and social care service managers (who were my research participants) is anchored. I recognise this as my research aim, namely, to explore the experiences of managers within the organisational culture milieu. As part of my professional development, I completed teaching qualifications and began assessing and quality assuring vocational

qualifications for the staff I supervised. This ignited the concept of studying health and social care education as I began to see the positive affects these qualifications had on staff practice. Levels of care and support became more meaningful and respectful due to the effects of reflective practice enhanced by a deeper understanding of why we should do things in a particular way.

Through self-reflection, staff were more aware of the significance of the client's personal history and more appreciative of their individuality. Staff discovered psychological comparisons between knowledge and practice as a result of their inherent grasp of how their own life experiences shaped their personality and behaviours. I am not implying this was not already a facet of their social reality to some extent, but through the enhancement of their knowledge of the physical and psychological illnesses of the people they supported, they were now able to link their practical skills with the understanding of why it was crucial to understand the client as a whole. Attaining further qualifications led to a stage of advanced reflective and reflexive personal and professional self-analysis (Cottrell, 2010). Intrinsic motivators steered me to health and social care staff training and education full time eighteen years ago when embarking employment with my current employer. I have been afforded opportunities to study further, receiving several promotions and gradually moving in the direction of staff learning and development, engagement, and business strategy. This became the steering force of my current career trajectory.

As a current member of the executive team the aim is to ensure that through effective staff education, engagement, and successful business strategy we ensure the longevity of the business and the enhancement of health and social care and support to over 6,000 adults at risk with diverse support needs. This has proved to

be a further epiphany moment in my socially constructed reality. Entering what I interpret as the fifth stage of my professional life, this doctoral journey of discovery, fills me with a sense of appreciative privilege and academic humility. I intend to use my experiential knowledge to potentially influence the health and social care field positively and add to the existing body of knowledge.

This study may enhance government bodies understanding of the complex health and social care worker's role. Uncovering the practical, educational, and behavioural requirements of health and social care frontline workers from the point of view of managers who are leading the delivery of these multifaceted services daily. I hope this will add legitimacy and veracity to the development of further commissioning frameworks. The findings from this study may lead to stronger recognition and appreciation for the complex and vital role that health and social frontline workers play within the social constructs of public health and personal wellbeing. The independent health and social care sector and the extraordinary people who work within its structure deserve national recognition and parity in line with the professional roles of our National Health Service.

1.4 Lifeworld of HSC frontline workers in the independent sector

Prior to the COVID-19 pandemic, the health and social care workforce already faced a unique set of challenges and dynamics (Jones, 2021; McFadden et al., 2021). Frontline workers were tasked with traversing complex healthcare systems and addressing the diverse requirements of individuals requiring care and support. Frontline workers supported people with diverse medical conditions, abilities, and social circumstances in their daily lives (Ballard et al., 2018). They provided

comprehensive care, addressing not only physical health but also mental, emotional, and social well-being (Skills for Care, 2022). Their responsibilities included collaborating with multidisciplinary teams, engaging with families and carers, and coordinating services across various healthcare and social care settings. Systemic factors such as resource constraints, staff shortages, and bureaucratic procedures impacted their professional lives (Skills for Care, 2021).

In the multidimensional and interdependent social structure of the health and social care system it was essential that frontline workers develop an array of professional skills, enabling them to carry out their complex role in providing holistic, person centred and high-quality care services (Care Quality Commission, 2021). One may assert that there are socially acceptable levels of care and support (Care Quality Commission, 2019; Gridley et al., 2014; Gupta & Rokade, 2016; Hehir, 2013). Acceptable levels of care and support are defined by Skills for Care (2020) who is the HSC sector skills body, funded primarily by the Department of Health (2014), working in synergy with the Care Quality Commission (CQC), the ‘independent regulator’ of health and social care in England.

The Care Quality Commission (CQC) is an authoritative body responsible for assessing health and social care service quality in the United Kingdom. By publishing inspection outcomes on their website, the CQC ensures accessibility and transparency, empowering individuals (the public), to search for services and access comprehensive details regarding inspection results. The CQC's current approach, known as the "key lines of enquiry" (KLOEs), which assesses the impact of five crucial aspects on the lives of clients: being well-led, effective, caring, responsive, and safe. Each of these areas are rated depending on the levels of control and

involvement the service users and their significant others have in direct relation to their abilities and capacity (Care Quality Commission, 2021).

In order to empower clients as service users to remain as independent as possible, the appropriate level of physical and psychological provision, an understanding of proportionality is critical to affording delivery of quality care (Office of the Public Guardian, 2021; Social Care Institute for Excellence, 2021). Proportionality is the term generally related to safeguarding adults who may be at risk from potential and actual abuse of their liberty and human rights. The Social Care Institute for Excellence describe proportionality as “the least intrusive response to the risk presented” (Social Care Institute for Excellence, 2021). It is the defining benchmark for the level of acceptable risk that all adults at risk may experience in ‘normal’ daily living activities. It is pertinent here to mention that what is considered to be an ‘acceptable’ level of risk and what is considered ‘normal’ for an individual in receipt of health and social care services is generally defined by the socio-normative, able-bodied majority and is subjective (Scambler, 2002). In relation to risk and personalised support, a frontline worker must encompass knowledge of the physical and psychological pathologies affecting the clients for whom they support. This fact leads to the basis for this research, workers abilities in relation to the perceptions of their managers. The assessment of three characteristics of a potential worker (skills, knowledge, and behaviour), begin prior to the interview (Skills for Care, 2023b). Scrutiny of the application form, curriculum vitae and evidence of qualifications provide an initial, albeit superficial character insight and thus assists the shortlisting process. The HSC sector skills body, Skills for Care (2023b), publish supporting documentation for best practice and suggest merit in values-based recruitment. A

framework for this method of recruitment can be accessed openly and is a recommended ethos that may be included in all social care settings' recruitment processes (Skills for Care, 2021). When carrying out values-based recruitment, one is attempting to identify individuals who imbue not only the necessary practical skills, knowledge, and behaviours to effectively support clients but also display the intrinsically complex abilities of empathy and compassion.

Our individual values may be defined as what we feel imperative for our personal standards of living (Banks, 2012; Manthorpe et al., 2017). If HSC staff have a positive humanistic ideology of equality, accepting the diversity of individuals (Banks, 2012), they are more likely to be compassionate and understanding when supporting people who have more diverse needs than themselves. Establishing and embedding an organisational culture of positive values encourages the stratification of said values through individual staff and teams working in care settings (Fick et al., 2021). Ultimately, it is essential that staff working in HSC services actually have the ability to 'care,' and as this study will unveil, caring and kindness are predominant values sought by all managers of social care staff. How this is identified and cultivated is discussed in the findings chapter, where the ethnographic interviews carried out with managers who were involved in this research are discussed.

Employer organisations of social care staff have the additional responsibility to ensure that new recruits embody and display the required personality traits (Care Quality Commission, 2021). Health and social care frontline workers require a conducive level of emotional intelligence combined with positive, personal attributes such as patience, kindness, empathy, and compassion. Further, HSC organisations are obligated to offer learning and development opportunities that address

contractually outlined mandatory training frameworks. Frontline workers' learning programmes will typically include specific training aligned with the type of service and client group, as determined by the registered manager (or person accountable for the specific service). This training emphasises the implementation of skills and knowledge based on the service users' diagnoses. In contemporary HSC provision, there is a focus on the social model of disability (Shakespeare, 2006). This involves a 'non-medicalised' approach to care, implying that the person with the disability or illness is perceived as a whole (holistically), and how the disability or illness affects each aspect of the individual's life rather than, as in the medical model, the illness or disability itself (Guevara, 2021). The social model of disability is the primary objective for contemporary health and social care provision, that in which all accepted professional frameworks for frontline workers' behaviour and skill is grounded. Scambler (2002), claims that postmodernist criticism of the medical model of disability gave rise to the social model. It opposes the medicalisation and treatment of disability, as well as the widespread socio-normative acceptance of the able-bodied as the norm.

The social model of disability focuses on supporting the person to live their best life and reducing the effect of socially constructed barriers (Berger & Luckman, 1967; Burr, 2003; Scambler, 2002). There is a focus on enhancing and improving the lives of service users, or where this is not possible, maintaining their current level of autonomy, rights, and choices. Degener (2017), suggests the social model of disability be reconsidered as a 'human rights model of disability' focusing on the ontological rights of all individuals, despite their physical and/or mental abilities. Guevara (2021), supportively states,

"*Disability is not a personal problem, but rather a social reaction to natural human variation and susceptibility to life circumstances"* (Guevara, 2021, p. 2).

A symbolic divide is reinforced when those of a privileged position choose to treat members of marginalised groups differently (Belgrave & Charmaz, 2021; Charmaz et al., 2019). Naming a set of people, a 'marginalised group' is in itself, creating and sustaining a non-physical, symbolically constructed barrier of inequality (Scambler, 2002). All members of the health and social care workforce have a responsibility to recognise these inequalities and eliminate or mitigate them for the benefit of their service users.

This study explores managers' perceptions of what they consider to be the skills and knowledge essential for workers to be 'effective' and is the focus of my research. This element of the research question necessitates defining 'perception'. Robbins and Judge (2009) suggest perception pertinent to organisational behaviour is 'a process by which individuals organise and interpret their sensory impressions in order to give meaning to their environment. Therefore, as similarly described through the concept of social constructionism, and later discussed in this thesis, perception is a prelude to a behavioural response, and our perceptions of each other are formed through our previous learned experiences (Burr, 2003; Prus, 1996). If we investigate and understand what managers of health and social care services practically require from workers on a day-to-day basis, it will enable the construction of more effective recruitment, selection and educational frameworks inevitably leading to improved provision of quality care delivery and support for service users.

1.5 Political considerations

Embedded social constructs effect how frontline workers perceive their roles and how these roles are perceived within society. The main skills of an effective frontline HSC worker are intrinsic, qualitative, and therefore difficult to empirically measure (Nha, 2021). Recent research conducted by Community Integrated Care (2021) evidenced how some members of society describe HSC workers as ‘good people; working in complex situations, supporting adults at risk for low rates of pay’. The definition of low rates of pay are supported by the Adult Social Care Workforce Data Set (ASC-WDS), (Skills for Care, 2023a) and has been the primary tool for government intelligence gathering for the past fifteen years. This data feeds directly into national, economic statistics used by the Department for Health and Social Care. Research by Skills for Care workforce intelligence (2023) concluded that HSC contributes £51.5 billion to the national economy (Skills for Care Workforce Intelligence, 2023b). HSC services are being recognised symbolically for the significant role they play in the structure of the national economy and within the social construction of health and social care (Lukertina & Lisnatiawati, 2020).

One can understand how HSC workers may feel undervalued within the social structure of social care and this study reveals how some of these vital workers describe themselves as ‘just a support worker,’ when in reality these individuals are the backbone and the very essence of a complex national support mechanism for adults at risk with complex needs (Kangasniemi et al., 2021). Health and social care services socio-cultural perceptions are affected by social re-constructions, which happen continually through interactions between professionals' language and

symbolism (Burr, 2003). Frontline HSC workers are often underestimated in their professionalism, level of training and degree of intelligence (Gridley et al., 2014). Workers find themselves in situations that may challenge their responses and in which they have to make complex decisions, often under pressure and always in the best interest of the client (Basarab-Horwath et al., 1999; Care Quality Commission, 2019; Day, 2014). These exceptional people positively enhance the lives of adults at risk on a daily basis.

1.6 The Research question

The research question for my ethnographic study is ‘what are managers perspectives of an effective health and social care worker in the independent sector?’. The following is an explanatory synopsis of the study.

Chapter 1 includes the background to the study, establishes the context for the ethnographic exploration and how social constructionism and symbolic interactionism have influenced the development of philosophies of health and social care. I briefly discuss the effects of the Covid-19 pandemic on the practicalities of the research process, with an emphasis on the difficulties faced during this era. The chapter explores the notion of locating the professional researcher-self, as well as the identity of the researcher. In addition, the lifeworld of health and social care frontline workers in the independent sector are explored in order to cast light on their experiences, perspectives, and remit.

Chapter 2 is the literature review conducted for the study. It begins with an introduction, followed by a discussion of the search strategy used to locate relevant sources within the current body of evidence. The evaluation of the literature is based on emergent themes uncovered during the review. These themes consist of leadership inspirations, aspects of cultural context, compassion in action, and the concept of staff engagement, wellbeing, and resilience. A summary of these emergent themes concludes the chapter.

Chapter 3 introduces the chosen methodological stance for the exploration. It begins with a chapter introduction that provides a summary of the methodological considerations, such as the research paradigm, ontological and epistemological stances adopted for the study. The use of ethnography as an investigative lens is explored, with emphasis on its relevance to the research. The conceptual framework of this study is composed of symbolic interactionism and social constructionism. As an essential aspect of the research process, reflexivity is discussed and applied throughout. The chapter also discusses participant selection and sampling strategy, considering the impact of the COVID-19 pandemic on health and social care research. Methods and techniques for data acquisition are explained, and participant demographics are outlined. The chapter concludes with discussions on interviews, ethical considerations, validity, and the framework for data collection and analysis.

Chapter 4 presents the study's findings and provides analysis of the emergent themes. The first theme examined is cultural communities of practice, which focuses on how professionals collaborate and interact within their respective

communities. The second theme is organisational liminality, which examines the uncertain and transitional experiences of frontline employees, especially in the context of the COVID-19 pandemic. The chapter also examines compassion in health and social care in the twenty-first century, focusing on the importance of emotional intelligence, functional skills, self-motivation, dependability, and transparency. The chapter concludes with a summary of the findings and a discussion of their significance.

Chapter 5 presents the overall conclusion of the study. The personal and professional impact of the doctoral journey is highlighted. The conclusion emphasises the originality of the findings, highlighting possible contributions to the field.

Chapter 6 establishes the context for my recommendations with an emphasis on developing a professional identity within a Community of Practice, enhancing staff self-actualisation through education, and fostering a compassionate organisational culture. These recommendations are intended to enhance the experiences of health and social care professionals.

1.7 Chapter summary

The purpose of this chapter was to describe the socially symbolic construct of my professional world and the positionality of my researcher self. How and why my personal and professional life experiences have shaped my "ethnographic self", affecting the perception of the health and social care system and the exceptional professionals who work within its structure.

I deemed it essential to clarify how my life experiences correspond with those of the managers of services who are the participants of my study. Reflecting on my early life experiences, I consider myself a natural ethnographer and symbolic interactionist, my ontological perspective paved the way for my professional career. This significant feature of my reflexive-self prompted me to recognise the significant contribution made by the participants. It was essential for me to recognise the proximity and connections between myself as a researcher to each of the participants to enable reflexive depth.

We may better appreciate the importance of frontline workers, who are the primary point of contact and source of support for adults at risk when we understand the intricacies of holistic, person-centred care (Care Quality Commission, 2022b). Holistic care is a universal term used in effective health and social care support (Ventegodt et al., 2016), whose premise is to involve the service user in the process of assessing their physical, psychological, emotional, spiritual, and socio-economic needs. It includes taking into account how their diagnosis and treatment will affect each of these aspects of their life (Nazarko & Thorne, 2020). The obligations and intricate roles that social care frontline workers perform on a daily basis are multifaceted. They are charged with supporting some of the most vulnerable

members of our society, yet often their persistence and expertise are severely undervalued and under-appreciated.

Chapter 2: LITERATURE REVIEW

2.1 Introduction

In chapter one, I adopted a cultural perspective to inform my professional life-story in an attempt to articulate how and why my life experiences have shaped and influenced my socio-professional ontological world. The research endeavour and the connection to my research participants are inherent in their nature and are a product of my connection to the health and social care system's social construction (Bryman, 2008; Creswell, 2003; Scambler, 2002).

In this chapter the available literature pertinent to the research problem namely, “Managers Perspectives of an Effective Health and Social Care Worker in the Independent Sector” is reviewed. I could not access literature specifically relevant to managers' perspectives of the necessary skills, knowledge, and behaviours of frontline workers. However, research papers did discuss the skills and behaviours of workers from the perspectives of their colleagues, service users and informal caregivers.

The review and critical analysis of the retrieved peer-reviewed research papers and articles revealed four key themes, namely leadership inspiration, the cultural milieu, compassion in action and wellbeing engagement. The following sections will delve into these themes in relation to frontline workers roles.

2.2 Literature search strategy

Preliminary literature searches related to the research question uncovered a plethora of studies, the majority of which investigated the effectiveness of

management and leadership skills within businesses outside of the Health and Social Care (HSC), arena (Gronn, 2014; Hignett et al., 2018; Scott et al., 2017). It became apparent that there was paucity in literature related to investigating HSC service managers' perspectives of the necessary skills, knowledge, and behaviours which frontline employees should display and be inherent in providing exacting standards of quality care and support for adults at risk within the social care context. The majority of studies were specific to nursing or healthcare with only 44% of the final papers relating to specific health and social care services. This lack of available literature, although frustrating was beneficial as it identified a gap in academic research which Baptista et al. (2015) and Frick (2018), assert facilitates the possibility of a significant, original contribution to knowledge in health and social care theoretical research.

Initially electronic bibliographic health and social care databases were accessed, adopting specific search terms related to the research question as suggested by Aveyard (2014) and Torraco (2016). The search engines and databases sourced are repositories specifically for health and social care academic, peer-reviewed papers, journals, and grey literature. When initially filtering papers, a time-limited search that included papers published since 2010 and up to the present (at the time that was 2021) was utilised. Considering the number of subsequent articles retrieved and the type of study, it was difficult to locate relevant literature specific to my research question. The search terms listed in Table 1, below were employed with permutational rigour.

Table 1

Initial search parameters

Databases accessed	Search terms (Boolean)	Limiters
CINAHL Plus	Good AND social AND care	A time period of
Psychinfo	AND worker	2010 to 2021
Socindex	Managers perspectives	Adults only
Google Scholar	Leaders' perspectives	Social care only
Proquest	Good worker	NOT: specialist/ clinical care
	Skills, knowledge, behaviours	NOT: Oncology, NOT: Obstetrics, etc.
	'Good' was replaced with 'effective' and several variations of health and social care were used such as: social care; social; care. 'worker' was replaced with 'staff'	Only adults

Twenty-thousand-four-hundred-sixty-three initial search results were systematically filtered (Appendix 9. PRISMA Diagram for Literature Search Criteria. p. 211). The first eighteen thousand general Google Scholar® results were immediately eliminated, and the remaining 2,104 were screened for duplicates and general content. In the second phase of the review, two thousand seventy-seven additional papers were eliminated, and Boolean search methods were employed. When inputting search parameters to narrow or broaden search results, Boolean search methods utilise logic-based words such as "AND" and "NOT" (Russell, 2019) to enhance the specificity of a search. It was crucial to eliminate a number of health and social care professional and clinical specialties from the search results during

the third stage of the literature search. Child services and clinical backgrounds such as cardiology and oncology were excluded using Boolean 'NOT' operators to ensure that the majority of results related to HSC services in the United Kingdom.

Several remaining papers related to the National Health Service or were published in international journals; however, their philosophical paradigm and epistemological outcome persuaded me to include them in the analysis because they paralleled the ontological and methodological investigation of the research question (Bryman, 2008). Additional algorithms were implemented until 20 papers remained. The databases used were: CINAHL plus; Psychinfo; Socindex; Proquest and Google Scholar (Table 1. Initial Search Parameters. p. 41). After a full text screen and data extraction, adjustments to the filters reduced this to a final 17 papers which will be the focus of the literature review (Table 7. Data Extraction Table for Literature Review. p. 219).

The majority of the final papers appraised for the literature review were qualitative in nature. This produced a more interpretative technique of critique in line with my own methodological direction (Atkinson et al., 2001). Ethnography was my chosen research method because the primary aim of this research was to explore cultural patterns within managers' perceptions of what is needed from their staff teams, collectively and as individuals (Hammersley & Atkinson, 2019).

A dual approach to analysing the available literature was utilised. Firstly, I used qualitative data analysis software Nvivo ® to conduct a search for themes by identifying the most frequent words across all 17 papers as an analytical strategy (Figure 3. Most Frequent Words NVIVO Text Analysis. p. 241). This search tool identified key words and phrases within the texts however, although Nvivo® is a

useful tool for data analysis, it lacks the intuitive interpretation available through abstract thinking (Bazeley & Jackson, 2013).

The second level of coding was more comprehensive and identified key themes and analytic connections to find similarities and to investigate synthesis within the content.

A data extraction table was developed to assist with the synthesis and critique of the final 17 papers (Table 7. Data Extraction Table for Literature Review. p. 219). This enabled the ability for enhanced visual cross-referencing across all papers. The data extraction involved categorising the papers by:

1. Details of author(s) and date of publication.
2. Title of paper.
3. Author(s) aim(s).
4. Area of care under investigation.
5. Relationship to other work(s).
6. What was missing or not examined in relation to the research question.
7. The methodological approach.
8. What claims were made?
9. Outcome or conclusion of the paper.

Using data from the extraction table and Nvivo® analysis, I constructed coding diagrams for each of the papers to illustrate the themes, (figures 4-20. Coding Diagrams. pp. 242-258). I then separately applied Benton and Cormack's (2000) framework for critical analysis to each of the 17 papers, (Appendix 10: Benton & Cormack’s Critical Analysis Tool for Literature Review, p. 212).

Four papers (23%) were not related to the UK HSC or NHS services but were published in international journals affiliated with those services. I considered the papers' methodology and findings to be cross-cultural. Due to their ontological and methodological orientation they were pertinent to my research question and therefore belong in this study.

The layered technique I employed to extract information from the papers was intended to facilitate the identification of links and emphasis within each publication. One could argue that the broad word frequency search may limit thematic outcomes since a particular term may appear frequently in a single paper and, as a result, may dominate the total search results without contributing to the overall results' substance. As exemplified in this chapter, the term "care" was deleted from the text analysis results because it appeared in all papers across all themes. Being instinctively aware of this aspect allowed for an honest criticism of the text analysis and acknowledgment of the limitations of the Nvivo® analysis software (Bazeley & Jackson, 2013).

2.3 Appraisal of the literature: Key themes

The final selected research papers were predominantly qualitative in nature; therefore, an interpretative method of critical analysis was applied. I used the Benton and Cormack (2000) framework for critiquing qualitative and quantitative texts because, due to its investigative framework, I believed it the most appropriate tool for the text analysis (Appendix 10, p. 212) . Reference to books by experts in the fields of organisational culture and psychology, organisational leadership, engagement, and emotional intelligence are referenced throughout.

Gillin (2017) is an exception to the qualitative majority, as it is a quantitative, systematic review of empirical research. They examined the concept of 'caring cultures' in clinical services, arguing that the term 'caring' constrained the outcome variables. Gillin (2017), asserts the term 'culture' was found to be more advantageous than the term 'caring culture' in relation to patient outcomes. The findings of this paper indicated that while caring cultures are frequently discussed and accepted as normative, there is little evidence to support this claim. Despite its specific connection to clinical practice, I believe this is an important facet of the literature review in relation to my research question.

The main themes which emerged from the critical appraisal were leadership inspirations, cultural milieu, compassion in action and wellbeing engagement. The subcategories of these four main themes related to staff and team behaviours as perceived by workers themselves, clients, and stakeholders. All key themes formed an interwoven matrix relevant to the perceived construct of skills, knowledge and behaviours required for frontline workers in health and social care services.

2.3.1 Leadership inspirations

The papers central to the discussion of leadership traits and the connection to frontline workers effectivity are Currie and Lockett (2011), Guba (1990), Manthorpe et al. (2017) and McSherry (2018). Leadership is synonymous with management, even though the essence of leadership in contemporary thought is a strategic, visionary role that employees at all levels can and do demonstrate (Mintzberg, 2009; Owen, 2011; Smith et al., 2018). For frontline employees, leadership is exemplified by leading by example, being proactive with initiative, instigating and completing

required tasks that enable and empower other team members to ultimately improve the lives of service users. It is taking responsibility and ‘seeing tasks through to the end’.

Currie and Lockett (2011) suggest that leadership can and should be distributed throughout all levels within the social care multidisciplinary team in order to facilitate the most effective behaviours from frontline workers. Leadership should not just be something that senior staff display. It is a behavioural, cultural construct and symbolically important in all Health and Social Care (HSC) services at all echelon. Leadership effectiveness in the HSC workplace is considered a catalyst to team behaviour, a compassionate culture and engagement (Gronn, 2014; Mintzberg, 2018). Currie and Lockett (2011), argue that distributed leadership is advantageous in the context of health and social care because senior managers of social care services are frequently distracted by what Currie refers to as "wicked issues," leaving junior staff to deal with immediate tasks. Distributed leadership enables decision-making at all levels of the team, empowering junior employees to be less reliant on the decisions of senior managers. Additionally, it is hypothesised that distributed leadership fosters resourcefulness throughout the entire organisation by permeating additional skills and power at all levels (Currie & Lockett, 2011). The concept of distributed leadership advocated by Currie and Lockett (2011) becomes even more significant in the context of ensuring quality care as described in 'Importance of Quality in the Health Care Sector: A Review,' published in the Journal of Health Management in 2016, Gupta and Rokade investigated the quality of care and argued that the perception of quality by service users increases client satisfaction which enhances the reputation of health and social care services. The paper is a

systematic literature review of related studies into healthcare quality. The results are limited to a correlation between quality and a reduction in iatrogenic diseases, such as infection rates. When discussing statistics, the author has cited Wikipedia, which is not regarded as an authoritative or reliable source of information however, the perception of quality care is tied to the positive behaviour and professional conduct of frontline workers and therefore appropriate to be discussed. Other research supports this contention (Campbell et al., 2000; Care Quality Commission, 2019; Hignett et al., 2018) indicating that there is reason to believe that the perception of quality strengthens the socio-symbolic structure of health and social care services. By empowering junior employees and enabling decision-making at all levels of the team, distributed leadership fosters a sense of resourcefulness throughout the entire organisation. In support of this argument, Day (2014) asserts that skilful delivery and the positive behaviours of workers are related to the provision of high-quality care. Client satisfaction is increased when the employee is perceived as competent and knowledgeable. The paper is limited to acute hospital treatment, despite the fact that social care services and quality perceptions are cross-sectional, as are the abilities of frontline employees providing care and support to service users.

Manthorpe et al. (2017), investigated the perspectives of family carers and service users in relation to what they consider to be a valued care worker. According to family caregivers, the intrinsic values of compassion and kindness possessed by frontline workers are crucial and are linked to positive team leadership. The service users themselves articulated the need to feel physically and emotionally safe, and that workers must evince genuine concern for each person as an individual, demonstrating respect and promoting dignity whenever possible. To support this, the

research conducted by McSherry (2018), frontline workers concur that positive leadership facilitates the delivery of compassionate care and that a proactive approach to recognising positive cultures influences the skills and confidence of frontline workers. The perspectives of family carers and service users, as investigated by Manthorpe et al. (2017) shed light on the qualities valued in a care worker. Both groups emphasised the importance of compassion, kindness, and genuine concern for the well-being of individuals. These intrinsic values, according to family caregivers, are closely tied to positive team leadership. In line with this, McSherry's research in 2018 supported the notion that positive leadership enhances the delivery of compassionate care and contributes to the skills and confidence of frontline workers.

Considering the significance of care workers in enabling individuals to remain in a home care setting at the end of life, as highlighted by Addicott (2011), it becomes evident that their role extends beyond daily support. The ability to create a homelike environment and facilitate effective communication within the multidisciplinary team is crucial for a person's comfort and well-being during this sensitive time. Addicott (2011) discussed the elements of care that allow people to remain in a home care setting at the end of life (EoL) as opposed to being hospitalised. EoL care in a hospital setting is viewed by many as detrimental to the individual's wellbeing, and whenever possible, care at home or in a homelike setting is preferable (Addicott, 2011; Humphries et al., 2016). This capability for people to remain in their familiar surroundings at the EoL is largely dependent on the skills of the multidisciplinary team and, in particular, the care workers who provide daily, primary support for all aspects of care delivery. Advanced Care Planning (ACP) is

described as one of the most important facets of communication that enables a person to remain in the care home at EoL. Consistent and effective communication, an important facet of effective leadership behaviour, between the multidisciplinary team members is perceived as essential by the managers of care provision and is often led by the frontline workers (Addicott, 2011; Crowther et al., 2013).

Ballard et al. (2018) investigated the impact of person-centred training on frontline staff practice. The authors suggested that educating staff about the clinical characteristics of dementia and its effects on the wellbeing of service users is paramount to increasing levels of care and quality of life. Evidence demonstrated that dementia education also improved the confidence of frontline workers enabling better levels of care and support. Crowther et al. (2013) focused on frontline worker compassion and kindness in EoL care, suggesting compassion can be taught and is intrinsic to leadership behaviour. This report focused on the lessons learned from the uncovering of abusive practices of staff supporting society's most vulnerable people, reference is made to the Francis Report and the abusive practices uncovered in the Mid-Staffordshire public inquiry (Francis, 2013). The predominant outcome was a need for skills training for staff in services which must be supported by senior staff (Crowther et al., 2013). In agreement, Day (2014), suggested compassion in frontline workers' practice led to safer care. Compassion appears to be a behaviour that can be recognised in the requirements of all staff working in HSC services and this is upheld by Tronto (2010), Hojat et al. (2011), Dewar (2014), Spradley (1979), Holbery (2015), Featherstone et al. (2017), and Gillin (2017) who collectively considered the importance of compassion in the practice of frontline workers. Arguably, the family carers in the study by Manthorpe et al. (2017), commented that

they felt compassion cannot be taught, they believe it to be an inherent trait that people possess. Crotty (1998), opposed this and asserted that compassionate practice can be taught through good leadership and role modelling. Compassion has loci within the spectrum of emotional intelligence (Goleman, 1996), the foundations are fundamental to value-based and transactional pedagogy.

Effective communication is a pivotal skill for all employees, as it requires cultivation at all echelon of a team and is a cultural construct within professional practice. According to Dewar (2014), in order to facilitate compassionate care, staff must manage compassionate and caring conversations. Dewar (2014) asserts that the use of compassionate communication effects levels of care positively. In a research paper by Featherstone et al. (2017), young males using social care support services rated workers as "just good people." From the perspective of the people accessing this service, 'good' was associated with a non-judgmental approach and genuine concern for the psychological and emotional well-being of the service users. There is unanimity that for workers to be effective in their roles, they must be genuinely caring and kind toward the individuals they support, and this must be reflected in their behaviours. In support of Featherstone et al. (2017) conducted a study in which he explored the benefits of empathy and compassion on the physical and emotional well-being of service users, which lends credence to the notion that empathetic person-centred behaviour should be exhibited.

Empathy and compassion are linked to emotional intelligence in research conducted by Holbery (2015), which suggested the need for compassionate and kind behaviour from nurses (frontline staff) in a trauma team. This paper discusses the negative effects of a ‘mechanistic’, task-based approach to trauma care and

suggests a holistic, person-centred, approach should be taken by staff, exemplifying the need for levels of emotional intelligence to be recognised and embedded within practice. This anti-mechanistic view is supported by McNeil (2019) who examined the relationship between frontline workers providing beneficence (doing good) and 'feeling good' (personal wellbeing and resilience), proposing that recognising this relationship fosters positive behaviour within the culture of teams and the delivery of services. Pulsford et al. (2016) concurs with McNeil regarding the relationship between effective, compassionate staff behaviour and the resulting positive culture. Numerous studies and elements of best practice have supported and continue to support Tronto's (2010) contention that diligent care in an institutional setting must incorporate compassionate care (Ballard et al., 2018; Day, 2014; Gridley et al., 2014; Pulsford et al., 2016).

2.3.2 The cultural milieu

In the context of health and social care work settings, group cultures are inherent as the established patterns of conduct demonstrated by individuals within a given working group or team. The application of anthropological perspectives, specifically the examination of socially symbolic behaviours within tightly knit groups (Hammersley & Atkinson, 2019), may be applied to the efficacy of healthcare teams.

The literature review revealed that a significant proportion of the papers, specifically 44%, focused on the significance of cultivating a favourable culture through proactive and collaborative leadership. The significance of distributed leadership in fostering positive organisational cultures and enhancing team resilience

has been deliberated by notable scholars such as Currie and Lockett (2011), Day (2014), and McSherry (2018).

The authors Dewar (2014), Gillin (2017), and Pulsford et al. (2016) underscore the significance of acknowledging and fostering positive, cultural values within healthcare teams. Culture has been identified as the predominant area of interest among the diverse anthropological viewpoints. The significance of fostering a culture that emphasises collective accountability and collaboration cannot be overstated in guaranteeing the provision of high-quality care, given that the actions demonstrated by individual members of a team frequently mirror the behaviour of their managers (Smith et al., 2018).

Politics, plurality, and purpose', is a discussion paper published in the Journal of Ethics and Social Welfare, which discussed ethical cultivation in social care practice and how this is linked to the behaviours of workers. Tronto (2010), suggested that caring cultures fall in line with family caring values but must be applied consciously. The way to enact this is through a political process which consists of three elements, namely a clear understanding of power in the relationships, particularistic and pluralistic care, and care with a clearly defined purpose (Tronto, 2010). These are crucial aspects related to the research question, as managers will be involved in defining the specific purpose of the care their employees provide to service users. As an indicator of quality care, values-based cultural behaviours associated with person-centred care are examined. The perception of these behaviours has a direct relationship to the research paradigm, making their inclusion in this literature review essential.

Featherstone et al. (2017) examined the perceptions young men who access social care support services, have of the staff who support them. Through semi-structured, ethnographic interviews the authors explored how these specific service users view the support they receive and their interactions with staff from the service provider. This interpretative study suggests that the positive behavioural traits of role modelling, empathy, kindness, and non-judgemental respect for the users of the service are perceived as of paramount importance. This study identifies the perceived, necessary skills and behaviours of front-line workers as being honesty, attentiveness, and understanding. The paper's findings relate to studies conducted by Day (2014), Dewar (2014), and Gillin (2017) on the need for perceived trust in the professional relationship between frontline staff and service users. It could be argued that frontline workers must demonstrate consistent, transparent behaviour over time to foster a therapeutic relationship of trust which is a symbolic representation of security and, as such, must exist in the power dynamic between service user and worker (Featherstone et al., 2017; Gronn, 2014).

In order to further strengthen the value of trust, McSherry (2018) drew parallels between it and a positive organisational culture. McSherry (2018) recommended the adoption of a 'culture tool' to analyse the levels and types of culture within teams and organisations, claiming that it would be an effective first step in analysing existing team behaviour and care quality. Furthermore, Ballard et al. (2018) discussed the impact of person-centred care training on the performance of staff working in nursing homes with people with a diagnosis of dementia. Ballard exemplifies the link between a positive workplace culture and the quality of care, points which are reflected in the research of Dewar (2014), and Tronto (2010).

Managers of health and social care services must be aware of the integral links between positive culture, proactive leadership, and effective care. Gillin's (2017) study was positivist in its philosophical approach and investigated the conceptual and methodological validity of the concept of 'caring cultures'. It proposed that organisational culture and leadership have a direct impact on the efficacy of 'caring'. Gillin (2017) has also critiqued the beliefs and subcultures within the concept of the caring role, which suggests a connection to a social constructionist lens of exploration (Berger & Luckman, 1967; Burr, 2003). A social constructionist lens enables analysis of the relationships and impact of the cultural milieu's effect on the roles of the managers and frontline workers. These roles are constructed through the shared language (Berger & Luckman, 1967; Burr, 2003) and the acceptance of the power transactions within the echelon. Gillin's (2017), suggestion of subcultures within the caring construct is significant when considering team effectiveness. It relates to how individual staff members with similar social backgrounds connect with each other through their shared behaviour (Denzin, 2016; Prus, 1996) and create subgroups. This cultural phenomenon is common in anthropological studies and is reflected throughout society and organisations (Savage, 2000).

Tronto (2010), asserts an important aspect of a positive working culture within services (in this study Tronto describes services as institutions), is for HSC employees to recognise that they are attending the service user's home as opposed to the service user being in their workplace. She further asserts that family care values, which are sometimes unrecognised may be elements that when present, improve care quality.

"To provide good care in an institutional context requires that we make explicit certain elements of care that go unspoken and that we take for granted in the family setting." (Tronto, 2010, p. 159)

Gillin (2017) defined the connection between family care values and those required by staff to create caring cultures within institutions as being necessary in the provision of high quality and person-centred care.

2.3.3 Compassion in action

Compassionate care and the connection to positive behavioural traits of healthcare workers is discussed by Day (2014) in her article in the British Journal of Nursing named 'Engaging staff to deliver compassionate care and reduce harm'. There are several studies to support Day's assertions, and much has been written about compassionate care in nursing in the previous decade (Allen et al., 2012; Barrett, 2015; Barton, 2016; Care Quality Commission, 2019; Crowther et al., 2013; Dewar, 2014; McSherry, 2018; Monterio, 2016; Strauss et al., 2016; Worline & Dutton, 2017). Facilitating insightful socio-behavioural interactions that are therapeutic in nature and unconditionally supportive is a crucial aspect of working with at-risk adults (Burr, 2003; Day, 2014). Compassion is a catalyst to positive personalised support; therefore, it is enabling for people at risk (Crowther et al., 2013; Dewar, 2014; McSherry, 2018; Pulsford et al., 2016). Compassion was suggested as a component of emotional intelligence (EI) in 83% of the evaluated research papers. While the specific phrase was not utilised, the personal qualities of empathy, compassion, social confidence, and resilience, which are regarded as embodied in EI, were conveyed throughout the evidence. Emotional intelligence is

said to have been brought to the fore in 1995 by the psychologist Daniel Goleman in his book ‘Emotional intelligence’ (Goleman, 1996), however the term is said to have been referred to in an earlier work by Beldoch and Davitz in 1976 named ‘The Communication of Emotional Meaning’. Also referred to as emotional quotient (EQ), it is described as the ability to identify and understand one’s emotional state, and through this understanding, manage one’s emotions during social interactions (Beldoch & Davitz, 1973). The positive effects of compassion on frontline worker’s effectiveness and its relation to EQ is compounded by Dewar (2014) and Holbery (2015), where further connections are asserted between organisational culture, staff practice and compassionate practice. Communication, empathy, compassion, and kindness, guided by a high degree of pragmatic, emotional intelligence appear to be indispensable and generate pride.

An individual's professional tenacity may be said to be fuelled by a powerful sense of pride in their work. This is reflected in Crowther et al.’s (2013) exploration of the characteristics required by staff supporting people with dementia at the end of life. Compassion and empathy are reported as being of utmost importance here which is fostered by the frontline workers’ pride in their work. Day (2014) discusses pride as an essential influence in the management of HSC and nursing services. Linking to the qualitative study of Addicott (2011) which draws on the case studies from four care homes, discussing the relationship between pride, compassion, and dignity and how these are essential in the delivery of care at the end of life.

When considering the complexities of the skills and knowledge required by HSC workers it is important to consider the multidimensional practical, emotional, and psychological reality of supporting someone through the end of life. Death has

been described by Tymieniecka (2012), as an ontological singularity. A singularity being a point at which our currently accepted laws of physics break down. Death therefore is an unknown and provokes feelings in us all of the metaphysical. It draws us to examine the meaning of life for ourselves and for others. End-of-life care encompasses not only the care and support for the client but also their loved ones (Tronto, 2010), with consideration being given to the client's emotional, psychological, social, and physical needs when providing care. The workers will also coordinate clinical support from other professionals, including the individual's primary care physician, district nurses, specialist nurses, and other experts involved in the delivery of their care. This is referred to as the multi-disciplinary team (MDT).

Linking directly to the qualitative study by Dewar (2014). The author discussed the complexities of compassion and how it was perceived by staff in the nursing environment. Dewar (2014) drew on one specific action research paper which did make the study limited in its outcome as its point of information was narrow and did not relate to social care services. Holbery (2015), compliments the paper by Dewar with suggestions for the necessity for emotional intelligence in the delivery of trauma nursing. This highly charged environment demands emotionally intelligent staff with the ability to make balanced decisions under pressure. It is pertinent to comment here that although HSC frontline workers generally do not experience the challenges of trauma nursing, a percentage of staff working in complex HSC services work with people who may injure themselves or others, including the staff who are supporting them. These highly charged situations must be managed calmly and professionally, where high levels of emotional intelligence and situational insight are necessitated. In support of Holbery (2015), McNeil (2019)

discussed ‘emotional insight’, which can be assumed as being relative to empathy, compassionate practice, and emotional intelligence. McNeil (2019) asserts that it is philosophically challenging for staff delivering care and support to older people with dementia, as they experience their clients’ progressive physiological and psychological decline without hope of recovery. She suggests that frontline workers’ ability to recognise the positive outcomes from their work (doing good) generates resilience and emotional strength (feeling good).

Hojat et al. (2011), ‘Empathy and health care quality’, is an editorial of two empirical, qualitative studies published in the American Journal of Medical Quality. This paper asserts empathy is a cognitive process which has positive psycho-social bio-neurological affects. In the concept of workers (in this case, physicians) behavioural empathy, or the ability to understand how another individual is feeling in a given situation, is related to higher levels of positive outcomes for patients. It is believed that empathy has a positive impact on the therapeutic relationship as it leads to compassion. Unlike sympathy, which is an emotional response that does not necessarily result in actions, empathy is said to be the driving force behind a person taking positive action to alleviate the distress of another. This article discusses the use of the Jefferson Scale of Empathy (JSE) to evaluate physicians' empathy levels (Hojat et al., 2011). There is no hypothesis, abstract or literature review. The paper is narrow in its outcomes as it only refers to two studies which may show author bias as it is not critical when considering the outcomes, nor does it demonstrate the fact that other studies may show opposing results. This study from Philadelphia is important to my research question as it asserts empathy displayed as a cognitive

response in the worker-patient therapeutic relationship has a positive effect on recovery and increases patient psychosocial and physical wellbeing.

Addicott (2011), Crowther et al. (2013) and Pulsford et al. (2016), discussed the importance of frontline worker's compassionate practice when supporting people with dementia related illnesses and at the end of life. Addicott suggests compassion and the behavioural skills enabled through multidisciplinary team synthesis can enable service users to receive more personalised care and a dignified death enabling them to remain in the care setting for their palliative care (Addicott, 2011). Crowther et al. (2013) concurs with Addicott, asserting frontline workers' compassion and empathy as fundamental in dementia care. Service users with dementia often display complex behaviours influenced by altered states of cognitive understanding which require worker compassion and empathy in order for clients to be supported effectively and to minimise distress (Crowther et al., 2013). The impact of person-centred care education on the quality of life of people with dementia, living in nursing homes was investigated by Ballard et al. (2018). Recognition of compassionate practice was a principal element of staff awareness which was linked to the wellbeing of the people being supported and evidenced by a reduction in the need for anti-psychotic medication (Ballard et al., 2018).

The results of Currie and Lockett's (2011) study, which highlight the significance of frontline staff taking the lead in person-centred care to promote improved emotional and physical health, align with the conclusions drawn by Ballard et al. (2018). The alignment of these results offers further corroboration for the distributed leadership and expertise across the team hierarchy, ultimately enhancing the delivery of compassionate care. The research carried out by Featherstone et al.

(2017) elucidates the importance of compassion in the interactions between service users and support staff. According to the study, the male service users characterised effective workers as individuals who demonstrated authentic kindness and impartial attitudes, labelling them as 'just good people'. The aforementioned concept is consistent with the construct of caring cultures investigated by Gillin (2017), who critically analysed the definition of 'caring cultures' in the context of healthcare delivery in the HSC sector. According to Gillin, the term ‘caring cultures’ is too subjective, and the epistemologically diverse nature of the concept renders it unhelpful, leading to inconsistent expectations regarding its cultural application. Thus, the synthesis of findings from Featherstone et al. (2017) and Gillin (2017) serve to reinforce the understanding of compassionate care and underscores the need for authentic benevolence in health and social care culture.

Gridley et al. (2014) researched the key features of good support from the points of view of people with severe complex needs and those who support them. Meeting practical, emotional, and social needs with a positive attitude and approach was a key element of feedback. The views of the service users with severe and complex needs were gathered through interpretation using communication boards and other communication tools. The downside to this is that the interpreters of this communication may have added their personal, subjective perspective to the results, whether unintentionally or not.

Overall, the findings of these studies contribute to our comprehension of the vital function of compassion and empathy in HSC settings. They emphasise the significance of staff engagement, emotional intelligence, and pride in compassionate care delivery, which ultimately improves service user outcomes, psychosocial well-

being, and care quality. Consistent with these arguments, the next section of the literature review presents the findings which define the necessity for staff to prioritise the development of compassionate cultures, promoting staff well-being, and fostering resilience.

2.3.4 The construct of staff engagement, wellbeing, and resilience

A qualitative study conducted by Day (2014), revealed that effective leadership increased employee engagement and levels of compassionate care in daily practice, thereby reducing harm. There is no single definition of employee engagement (Bridger, 2022), however it is generally accepted in the field of organisational behaviour that engaged employees are committed to and proud of their employer. Day (2014) asserts that this psychological and emotional state produces positive psychosocial effects in their application to work. McNeil (2019) concurs with Day's (2014) assertion by suggesting engaged employees are devoted and happy in their roles; this in turn, promotes wellbeing and a naturally higher level of resilience. This leads us to a study by McNeil (2019), 'Caring for aged people: The influence of personal resilience and workplace climate on doing good and feeling good'. This qualitative, Australian based study was published in the Journal of Advanced Nursing. McNeil discussed the positive character traits that contributed to the well-being of teams and individuals. McNeil proposed that staff wellbeing, resilience, and positive behaviour traits must be ingrained in the social structure of all HSC services and be cross-cultural, meaning that these positive behaviour traits are applicable to international HSC services. The study indicates that employees who recognise the positive outcomes of their work have greater personal well-being and

are more resilient in the face of the daily professional challenges of assisting service users in difficult and emotionally challenging situations (McNeil, 2019).

Resilience is the developable capacity to recover from adversity, and it has always been an important trait for frontline health and social care workers due to the emotionally and psychologically demanding nature of their work. McNeil (2019) discussed how resilience influences the quality of care by reinforcing wellbeing. The study by McNeil was carried out across 20 care services in Australia and involved a survey completed by 194 care staff. The results were based on an equation which identified the capacity of two things, namely staff resilience and the social climate (culture) of the organisations. Consideration is given to how emotional wellbeing generates or enhances resilience, which is in turn bolstered by a culturally positive environment. Ergo it demonstrates the correlation and significance of the phenomena's inherent connections and demonstrates the relationship between team culture, positive leadership, and staff engagement (McNeil, 2019). The data utilised for this study came from a sole source and it is proposed that future studies into staff resilience contain a wider range of participants. The study indicates that the high turnover rates of nurses and social care workers may be related to high levels of stress and burnout, further suggesting that recognising the positive outcomes of their roles creates 'feeling good,' which is related to wellbeing and higher levels of resilience. Therefore, organisations that create a culture of 'feeling good' and support their employees to recognise and focus on the positive outcomes they create through the support of each other, and their service users may have a higher rate of employee retention due to higher levels of resilience and wellbeing. This finding is

also supported in work by Kvarnström et al. (2013), Gridley et al. (2014), and Marmot (2018).

McNeil (2019) discussed how engagement, as a result of a supportive work environment, is related to resilience and has a positive effect on the quality of care. Providers of care services should consider enhancing the well-being and resilience of their employees through organisational support and formalised human resource management, thereby enhancing the quality of care. Connecting this to the values examined by Manthorpe et al. (2017) and McSherry (2018), there is an emphasis on the positive values which engagement fosters in individual staff members as a driver for providing high-quality care and support through resilient, confident staff.

Considering the psycho-social effects of the Covid-19 pandemic created novel challenges for all Health and Social Care (HSC) services (Comas-Herrera et al., 2020). HSC organisations have learned a great deal about their workforce and in particular their application and dedication to support our people at risk. Jones (2021) published an article in the International Journal of Care and Caring which investigated the impact of Covid-19 on the third sector and the effect forced isolation had on service users and on the carers who were supporting them. An increase in mental health issues and financial instability for social care services was a focus. According to Jones (2021), HSC services in the third sector have been financially damaged and are facing higher than ever staffing demands due to the effects of the Covid-19 pandemic highlighting the need for engaged staff.

The recognition of the effects on the mental health of individual HSC workers was explored by Greenberg (2020). Greenberg asserts that the emotional and psychological resilience (linked to engagement and wellbeing) has been vital to the

viability of the NHS and HSC services supporting people at risk (Comas-Herrera et al., 2020). Positive cultures and engagement within HSC teams are created through positive, proactive leadership (Gronn, 2014; Owen, 2011) and these cultures are the foundation for staff resilience and wellbeing. There is a connection between ‘doing good’ i.e., staff performing their roles with a sense of altruistic pride, and ‘feeling good’ which may be considered the emotional response from staff feeling they have done something good. Personal resilience, a dimension of psychological capital (PsyCap), is a determinant of worker performance (McNeil, 2019). Studies have demonstrated that PsyCap influences employee attitudinal and behavioural outcomes, including employee performance (Lukertina & Lisnatiawati, 2020). Staff working with people who have a diagnosis of psychological or physical ill health must be able to manage the emotions and the challenges this unfolds. McNeil (2019), discussed how the results from his study highlighted the link between staff resilience and their well-being contributing to the suggestion that organisations who treat their staff well and support their wellbeing create more resilient staff and teams, ultimately this has a positive effect on the quality of care delivered to the services users. Despite the perceived, practical benefits of resilience very few empirical studies examine the connections between resilience, in-role performance, and their impact on employee well-being (McMahon, 2021).

McNeil's (2019) qualitative, longitudinal study examined the necessity of resilience in staff who are working with older people with dementia and who recognise that the people they are supporting will not recover. Their illness is terminal and degenerative, necessitating a specific frame of mind and ontological reasoning when providing care and support to these individuals. The qualitative,

peer-reviewed study by Pulsford et al. (2016) discussed the personal qualities required to care for older people with dementia. According to them, social care workers must possess empathy, compassion, and positive values. These papers are limited in scope, as they only address dementia care. One could argue that empathic and compassionate worker behaviours are applicable to all services and client groups and are most closely related to the work of Crowther et al. (2013), Dewar (2014), and McSherry (2018), who also emphasise the importance of compassion and positive altruistic values within person centred care. Some of the participants in the study by Featherstone et al. (2017) believed that compassion and positive support are more important than academic or clinical knowledge. Ballard et al. (2018), demonstrated a correlation between a training programme for frontline workers that included dementia education and its effects on the quality of care and engagement. This increased knowledge, according to Ballard, affected the confidence and application of frontline workers skills in positive ways.

2.4 Chapter summary

This chapter began with a discussion of the literature search strategy and review, which led to the identification of the available literature pertaining to the research question. In light of the limited literature on the perceptions of health and social care managers, a comprehensive investigation was undertaken to scrutinise the psychological dimensions of the factors that foster effective support in health and social care services. The research conducted in this study was qualitative and interpretive in nature, resulting in a narrative that aligns with the ethnographic approach. Chapter 3 will explore the methodology for this research study.

Chapter 3: METHODOLOGY

3.1 Chapter introduction

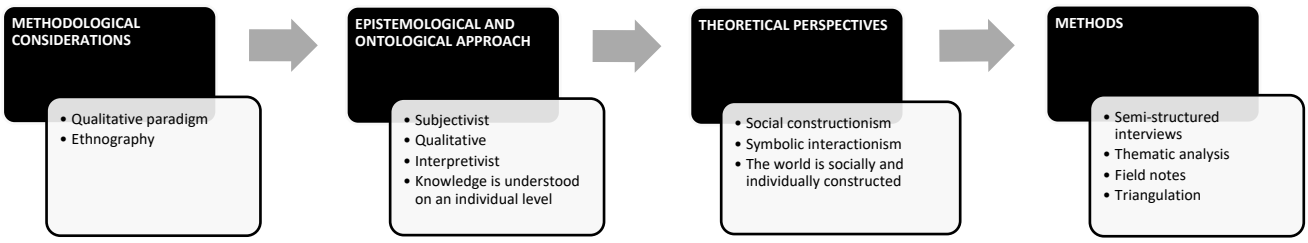
This chapter discusses the rationale for the adopted research paradigm which includes the ontological and epistemological stance, and progresses through the justification for the techniques, methods, reflexivity, data collection, data analysis and ethical considerations (Figure 1. The Methodological Paradigm, p. 67), applied throughout the research process (Morgan, 2007).

I critically explored the implementation of an interpretive ethnographic lens as an iterative process (method and process) and an explanation is offered, considering the writings of leaders in associated philosophical fields, of why this has been chosen as the most appropriate methodological approach.

This study examines the social construct of health and social care services from the perspective of service managers and specifically, what these professionals perceive to be the necessary skills, knowledge, and behaviours of effective frontline workers. It employs social constructionism and symbolic interactionism as lenses through which to investigate this phenomenon. An explanation of why social constructionism as a theoretical framework is offered, enabling a deeper understanding of the relationships and complexities of the participants perceptions related to the research question (Hammersley & Atkinson, 2019).

Figure 1

The Methodological Paradigm



Note: The above figure symbolises the flow of methodological considerations used throughout the thesis

3.2 Methodological considerations

The terms 'research methodology' and 'research method' are expressions used interchangeably in many texts (Alvesson & Skoldberg, 2009; Bryman, 2008; Morgan, 2007; Strauss & Corbin, 1994). Research methodology is concerned with the question 'how should the enquirer go about finding out about knowledge?' (Guba, 1990). Thus, it is the ontological and epistemological framework on which the structure of research is defined (Bryman, 2008).

A research method however can be defined as a specific way of gathering data, for instance conducting surveys, carrying out systematic reviews or data analysis. Polit et al. (2001), define research methods as the steps, procedures and strategies taken in order to gather and analyse data as part of a research investigation. Research methods are, as Alvesson and Skoldberg (2009) suggest, a

catharsis to creating true, objective knowledge from objective reality and intersubjective experiential worlds (Alvesson & Skoldberg, 2009, p. 1).

3.2.1 The research paradigm – ontological and epistemological stance

A research paradigm may be considered the umbrella term encompassing the guiding framework of the study design (Lincoln et al., 2011) and consists of set of beliefs that are shared by a group of researchers in order to explain their reality (ontology), and how it should be understood (epistemology), (Kuhn, 1962). Encompassed within the research paradigm is the ontological and epistemological position, followed by the methodological framework and methods appropriate for the genre of research enacted.

Ontology is the branch of philosophy which describes the study of being and the fundamental categories of what exists (Burr, 2003). When considering the ontological and epistemological position of this research study, I explored the ontological and epistemological stances which guided the chosen methodology to best answer my research question. The epistemological and ontological stances may take the form of qualitative research, quantitative research or a combination of both (Creswell, 2003). Qualitative studies are interpretive and accept multiple narratives and experiences as equally valid offering rich, in-depth insights into concepts that are not easily defined. Quantitative studies rely on a positivist, scientific approach with repeatable, predictable and generalisable outcomes. A mixed method approach will use both of these methods (Creswell, 2003; Nha, 2021).

Epistemology is defined as the theory of knowledge and asserts the validity of facts (Steup & Neta, 2005). The roots of the word itself are ‘episteme’ and ‘logos’,

translated roughly from Greek, they mean ‘knowledge’ and ‘reason’ respectively (Steup & Neta, 2005). There are two main branches of epistemological paradigms effecting research; positivism and interpretivism (Comte, 1880).

The French philosopher Auguste Comte (1798-1857) introduced the basic affirmations of positivism (Haramblos et al., 2000). This ontologically quantitative ideology is generally considered to be the scientific method of investigation and adheres to the notion of cause and effect. Positivism suggests that human behaviour can be objectively measured and therefore predicted. The intention is to be a social science of the antitheological and anti-metaphysical, refuting the assertion of the existence of multiple realities (Comte, 1880). Therefore positivism proposes that there is one reality which can be tested and proven through measurable, repeatable, scientific assertions (Alharahsheh & Pius, 2020).

The nature of this study, which is to analyse the perspectives of individual managers, each having their own experiential understanding of reality and each as valid as the next, is in juxtaposition to the very nature of positivism which asserts one sociological reality with predictable outcomes (Bryman, 2008; Creswell, 2003). This study is ultimately about individual people operating within an organisational culture, who are unique and unpredictable. Therefore adopting a positivist lens of enquiry as a research methodology would not support the required interpretative investigation to glean the in-depth insights, thoughts, concepts and experiences necessary for this research (Alvesson & Skoldberg, 2009; Bryman, 2008). Put succinctly, poitivism would not be conducive in answering the research question (Bryman, 2008; Horsburgh, 2003). One must accept that each of the participants of the study will have their own lifeworld and symbolically entrenched, socially constructed realities

(Burr, 2003). What emerged is that an interpretive, qualitative method of data collection and interpretation was best suited to this investigation, leading me to an ethnographic lens of enquiry.

3.2.2 Ethnography as a lens of enquiry

An ethnographic research study is ontologically a qualitative, interpretative method which involves the researcher immersing themselves in the culture and real-life environment of the participants of the study (Atkinson et al., 1999). Ethnographers concentrate on developing accounts of peoples' lived experiences in relation to their social and cultural contemporaries (Prus, 1996). Ethnography may be used as a methodological approach to explore naturally occurring 'phenomena' (Savage, 2000) and is a subjective way to study discourse, belief systems, culture, and group behaviour (Neale, 2008; Ritchie, 2009). As a professional working alongside and developing staff engagement and leadership skills programmes for the managers who are my research participants, there was an opportunity to gather real world data from the professional experiences of these managers relevant to the research question.

The root of ethnography is in cultural anthropology and this method was used historically to investigate behavioural and cultural practices in 'primitive cultures' (Hammersley & Atkinson, 2019). It is a way of studying a particular culture from the perspective of the members where the researcher becomes immersed in the customs and rituals of the particular culture (Blumer, 1980).

It is important to consider two main perspectives which are fundamental to ethnographic, qualitative research, namely the insider (emic) and the outsider (etic)

views of the ethnographic data interpretation process. Spradley (1979), Atkinson et al. (2001) and Davies (2012) suggest that when interpreting the ethnographic interview data process, the researcher must consider the cultural influences within the participants' descriptions (emic) as opposed to the researchers understanding of gathered data (etic). The emic is the insider view of the cultural aspects of a group and in the context of this study can be related to the managers' individual perceptions, whereas the etic standpoint is my own interpretation of the data and cultural aspects of the participant group. As a researcher, I am the outsider (etic) looking into the group culture of the services and staff teams that these managers supervise.

Analysis of my outsider (etic) perceptions in relation to my own personal experiential background as previously discussed in chapter one, creates an intersubjectivity when considering the perspectives of the managers I have interviewed and their cultural insider (emic) perspectives. There existed a potential for unintentional entanglement of the narratives from the interviews with my personal experiences, which may have influenced the analysis of the data. It was crucial to be consistently aware of my firsthand experiences from when I was in the same professional remit as the participants of my study so that I could minimise any influences I may have subconsciously applied to the research outcomes (Davies, 2012).

I suggest there are institutional cultures and sub-cultures within the social construct of health and social care services and deep symbolic interactionist narratives are formed through the dynamics between individual team members and their managers (Scambler, 2002). Therefore, an interpretative ethnographic lens of

enquiry was best placed for this form of exploratory research into the perceptions and culture of managers in the health and social care context.

This study explores organisational and service level culture relating to the skills and knowledge required for frontline workers. Service level culture may be described as the values, beliefs and behavioural norms which are shared by and reflected through the team members. The culture within HSC services sets the level of engagement and commitment the individual staff members have for their team, employer, and service users (Day, 2014).

Contemporary ethnography has been expanded to explore local cultures, for example occupational ethnography has its origins in social anthropology and the study of people in naturally occurring settings or ‘fields’ which, in this study relates to the workplace (Hammersley & Atkinson, 2019). Brewer and Pierce (2005) assert data collection methods capture the participants (in this case, managers) daily interactions. They further state the researcher may be involved in participating and observing directly in the setting, or actually involved in the activities in order to collect data in a systematic manner. Therefore, through inherent reflexively, I will strive, as the researcher, to nullify my effect on the meaning of the data (Brewer & Pierce, 2005). Ethnography may be described as both a method and a process, therefore as a research method it is an iterative process, meaning that it evolves as the study unfolds. O’Reilly (2009) explains that using the iterative method involves the researcher traversing back and forth ‘iteratively’ between theory, data analysis and data interpretation. I will be moving back and forth between interview analysis, interpretation of texts and, theoretical perspectives throughout the writing of this

thesis in order to afford the reader a sense of the data collected through the ethnographic exploration of theoretical and analytical frameworks.

I conducted ten in-depth semi-structured interviews and two focus group interviews alongside my field notes. I digitally recorded and transcribed the individual narratives and collected the data from the two focus group interviews which formed part of my analysis. To best answer the research question I applied this iterative, interpretative ethnographic process.

Spradley (1979) explained the ethnographic interview process as being a fragment of a developmental research sequence and suggested ethnographers work together with participants to produce cultural and behavioural descriptions based on the research question. Therefore it was important that, as the researcher, I viewed every learning or investigative process as a sequence and the planning, analysis, and interpretation of the outcomes was reflexively evaluated. It was an investigative process that unfolded rather than a process with pre-determined outcomes enforced by my personal background and perception of reality (Alvesson & Skoldberg, 2009; Davies, 2012). The ethnographic interview was qualitatively understood from the perspective of the participant, the emic viewpoint and approached without bias (Hammersley & Atkinson, 2019; Spradley, 1979).

Ethnographic studies can be a powerful, cultural investigative tool according to Prus, (1996) and may be utilised to explore the symbolic belief systems of a particular culture of a group of people in an organisation. This information may be used to illuminate differences between members of a comparable group, thereby creating a negative narrative and a widening of the socially constructed divide. Alternatively, it may be used as a positive example of the strength of diversity,

kindling a deeper cross-cultural understanding, creating constructive connections and progressive narratives, reducing the naturally perceived divide (Atkinson et al., 1999; Lipson, 1994; Madison, 2011). The use of ethnographic methods within this research I will suggest, evidenced the strength of diversity exposed within the perceptions of managers and highlighted their solidarity to their professional work-life realities.

In order to give full descriptions of the interpretation of the interview data a 'thick' description as defined by Leeds-Hurwitz (2020), was implemented. Thick description in ethnography gives depth and a richness of meaning within the research outcomes (Geertz, 2008; Leeds-Hurwitz, 2020). This is in opposition to a 'thin' description which offers superficial and brief analysis and interpretation of the research outcomes. The thick description method adds deeper meaning to the interview outcomes relating to the perceptions and culture of the managers who were interviewed as part of this research (Leeds-Hurwitz, 2020).

A thick description of the outcomes from the interview process will attempt to express this culturally symbolic, deeper meaning through the analysis and coding within the language used in the narrative of the text. Utilising thick descriptions was appropriate for this study because within health and social care services, complex human activities occur, and as Prus (1996) suggested, human life can be characterised by interactions. As humans we reconsider and re-evaluate our interactions with each other constantly leading to the presence of complex meanings within our communications (Charmaz et al., 2019).

Considering the diversity of the clients that social care workers interact with and the multi-dimensional aspects to their support needs, workers must continually

re-evaluate the dynamics of their relationships and support strategies with clients. For this to be effective, self-awareness and social skills including empathy and compassion are necessary (Ingram, 2013). The most effective workers have the ability to consider, in any given situation, the individual's safety and best interest within the boundaries of organisational policy and national legislation. Evaluating in the moment which decisions to make within each interaction is underestimated by many. I believe this is the true essence of social constructionism and symbolic interactionism because embedded within these complex interactions lie the symbolic interpretation of the role of the worker as perceived by the client. They are the helper, the supporter and care giver and act in synchronicity where the worker has a socially constructed perception and symbolic identity of the client (Scambler, 2002). When viewed from a professional perspective, these intensely personal symbolic interactions between the professional caregiver and the service recipient establish the dynamics of a trusting therapeutic relationship between two individuals.

3.2.3 Symbolic interactionism & social constructionism

Symbolic interactionism emerged from the influences of pragmatist and moralist philosophers as a theoretical concept and methodological framework in the mid twentieth century (Carter & Fuller, 2015). Symbolic interactionism exerts that life is fluid and in process, ever changing through the interactions we have with the world around us. One distinct way this interaction with other beings takes place is through language and communication (Burr, 2003). Communication takes place in diverse formats not only as the spoken word, but we interpret the world around us through

our lived experiences and individual ontological understanding (Burr, 2003; Prus, 1996).

Mead (1934), an American philosopher is said to be the greatest influencer of symbolic interactionism although his initial perspectives of a ‘social behaviourism’ have been critiqued and expanded upon most recognisably by Blumer (1962) and Kuhn (1964). They were members of conflicting (or some may say, complimentary), ‘schools’ of thought and argued that Mead’s suggested ontologically qualitative paradigm may also be expressed quantitatively and empirically. However, Carter and Fuller (2015) assert Mead’s theoretical framework remains interpretive and dominates contemporary fields of philosophical understanding and the application of symbolic interactionism.

Symbolic interactionism has some basic principles based on human existence. Blumer (1962) suggested three main premises:

> 1. Human beings act towards things on the basis of the meanings that things have for them.
> 2. The meaning of such things is derived from, or arises out of, the social interaction that one has with the people we come into contact with.
> 3. These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters. (Charmaz et al., 2019, p. 25)

Symbolism is engrained in all that we see, hear, and do and is a conduit to the sociological mesh that connects us within society. Charmaz et al. (2019) suggests that symbolic interactionism has its home in contemporary sociology and this theoretical framework establishes that people are naturally reflective with the ability to learn about themselves, their lives, each other, and the society we live in through interaction as human beings and interpretative creatures. We have the ability to make choices and exert control over our lives.

Charmaz et al. (2019, p. 19) state:

> "Symbolic interactionism is a theoretical perspective that assumes that people construct selves, social worlds, and societies through interaction. As a perspective it offers a lens for looking at ourselves, everyday life, and the world."

The experiences we have through our lives shape the meaning that objects, symbols, and situations have for us on an individual, personal level. These meanings become an understanding of that particular situation, object, or person and how we interact within those situations, how we understand ourselves within the context of the interaction determines how we feel and behave in response to those situations (Prus, 1996). Applying this concept of symbolic interactionism to the work-life of Health and Social Care frontline workers, one may say that they construct the symbolic reality of their professional role and self through the relationships they have with their clients, their managers and the culture which exists within their service delivery and the organisation (Charmaz et al., 2019).

Social constructionism as a term, introduced by Blumer (1962), and one which Burr expanded on in 21st century, suggests that interaction and communication between people creates society. It also shapes the individuals' perception of the world around them and their interpretation of that world. Burr, (2003) suggests that it is difficult to give social constructionism a single definition as a specific philosophy or theory because it permeates through society on an individual level. The author suggests the term social constructionism refers to the phenomena of the social interactions and language that we share in our experiences and perceptions. Burr's work asserts that individually we create our social reality and each person's experience of it is valid and novel.

Charmaz et al. (2019) and Belgrave and Charmaz (2021) assert that as beings with the capacity to act and affect our surroundings, we all experience the world through the interpretation of information we receive through our senses. Our understanding has been shaped by our learning, knowledge, and connection to the world as we have grown and learned from our experiences. Mead (1934) went as far as to suggest that language which is a central focus of social constructionism enables us to internalise social interaction and is a means to reflection. We may say that we are surrounded and immersed in unspoken language within today's postmodern world. Social constructionism enables us to take a critical stance on the way that we interpret the construct of society, ourselves and generally, the world around us (Berger & Luckman, 1967; Burr, 2003). It asserts that social phenomena are formed through social interaction and accomplished by ourselves. Social phenomena are in a constant state of transformation and revision (Bryman, 2008) asserting that life is fluid and interpretative.

When considering the fluidity of social constructionism and how this is individually interpreted through life experience, Kuhn (1964) suggests that what a person sees depends both upon what they look at and also upon what their previous visual-conceptual experience has taught them to see. This paradigm is applicable to health and social care provision – assuming that 'what a person sees' is related to the behaviours, or practice the worker witnesses from their peers, and 'their previous visual-conceptual experience', is replaced with the worker's experiential learning. One can suggest that a health and social care worker's perception of a particular situation is brought forth through what they have learned from the outcomes of their previous experiences. The social relationships, experiential learning and value-driven behaviours of HSC frontline workers are a product of their previous life experiences (Denzin, 2016; Kolb, 2014).

3.3 Reflexivity

Alvesson and Skoldberg (2009) suggest that the researcher can never completely separate their interpretations of interaction, narratives and text from their own personal perceptions that influence their understanding of them. It is our own experiences and hence the learning from these that distinguishes how our reasoning is intellectually expressed in our socialisation (Berger & Luckman, 1967). The researcher's awareness of their own interpretations regarding these social interactions and psychodynamics is crucial as it facilitates the capacity for reflexively evaluating responses and data (Davies, 2012).

During the formulation of the research framework and the design of the data collection procedure, I acknowledged the potential impact of my professional role

within the organisation on both my own impartiality and, to some degree, the impartiality of the participants. The conduct of the managers who consented to participate in the interviews may have been impacted by my professional position. In this study, I adopted a social constructionist and ethnographic perspective, positioning myself as a novice researcher. It was imperative for me to acknowledge and critically examine my personal biases and influences on data interpretation. This self-reflection was necessary to distinguish the participants' socially constructed perceptions of their reality from my own subjective interpretation, which was shaped by my prior experiences (Davies, 2012). The qualitative, interpretative ethnographic methodology interwoven through social constructionism informed the matrix of my methodological framework. Within the interpretation of qualitative data lay the necessity for my reflexivity (Alvesson & Skoldberg, 2009; Davies, 2012).

It was necessary to ethically examine the data outcomes by attempting to step out of my own lived experiences and allow the research to unfold (Alston & Bowles, 2019; Corbin et al., 2015; Walliman, 2014). However, my reflexivity, although never completely apart from the interpretation was subdued in order to examine and interpret the participant voices (Ellingson, 1998).

At the preliminary stages of the interview process, I experienced a reflexive juxtaposition, and in a way, attempted to convince myself that if I explained to each of the participants my impartial position as a researcher it would not influence our discussions. This of course is untrue and elicited a responsibility to ensure that personal, cultural influences and concepts were minimised as much as possible through reflexive self-awareness (Alvesson & Skoldberg, 2009). I understand this dilemma as being part of the learning process of the doctoral journey. It provided a

deeper understanding of the complexities of the managers roles within the HSC context, leading me to a point where I must admit that no research is truly unbiased (Pillow, 2003). Through this understanding I reached a point where I was able to minimise the effect on the data interpretation process through self-awareness, and an understanding of the possible power imbalance within our professional relationships.

My reflexive stance is one of understanding that each individual creates their own reality and lifeworld from their interpretation, experiences, and knowledge of the world (Berger & Luckman, 1967). Therefore, there must be an acceptance of diversity within the interpretation of the data. Pillow (2003), makes reference to one of four stages of reflexivity as, ‘recognition of self’, which resonates with the position I felt myself in when working with the senior managers from my employer organisation.

Pillow’s (2003) four common trends in the use of reflexivity identify:

1. Reflexivity as recognition of self
2. Reflexivity as recognition of other
3. Reflexivity as truth, and
4. Reflexivity as transcendence

Pillow describes these forms of reflexivity as being interdependent and suggests that recognition of self is the foundation from which the other three evolve. Interestingly, in her paper, Pillow (2003) describes how Laura Ellingson (1998) used what she called the “confessional tale”, relating her personal lived experiences to those of the research participants. This example was used to make the point that reflexively, the study was no more credible due to understanding the participants of

her research empathetically, but to show that the study was completely ‘contaminated’ by her lived experiences. This contamination results in a rich, complex understanding of the staff and patients of the clinic (Ellingson, 1998).

My reflexive position is aligned with Ellingson's example in that as a result of my own personal reality and experiences (my "confessional tale"), my research is, to some extent, “reflexively ‘thoroughly contaminated’", resulting in a complex understanding not only of the managers I have interviewed as part of my research, but also of the frontline workers they are considering in their responses. Once ware of this I was able to use ethnographic consistency and rhetoric laden with symbolism to tie each interview to the data analysis. Alvesson and Skoldberg (2009) assert this fact (Ellingson’s contamination), creates reflexive challenges which must be investigated and managed in order to minimise bias and subjective interpretations of the interview narrative which will affect the outcomes of the data analysis. I found myself in an ethical paradox within which, reflexive professional interrelationships had to be epistemologically justified in order to minimise my influence on the data collection and interpretation process. Bias will always be apparent in any research study (Malinowski, 1922), as the simple fact of deciding on a topic, is in itself bias influenced by the researcher’s predetermined socially constructed epistemological position. However, the researcher must identify, explore, and minimise bias as much as possible (Davies, 2012; Ellingson, 1998; Pillow, 2003). Reflexivity became an inherent factor within the research process.

There were five research questions asked of each of the ten individual participants (n=10), to guide the semi-structured ethnographic discussion (Table 4: Interview Questions and Rationale, p.94). Additionally, there were two focus group

interviews, consisting in total of 11 participants. One focus group contained five participants and the other, six (n=11). Both groups were asked, “what do you think makes an effective worker?” The responses of the two groups were remarkably similar and congruent with the responses from the individual manager interviews. What managers of health and social care services perceive to be an effective worker is consistent across all service types, the findings reveal. There were similar themes and sub-themes which developed from the text analysis and coding. I used the 3 stages of Ricoeur’s analysis of text model (Ricoeur, 1976), to present primarily what the text said, secondly what was the underlying meaning was and thirdly, what the increased understanding of self and others emerged from the outcomes and what this meant for the organisation.

3.4 Participant selection and sampling strategy

I obtained approval from my employer's Chief Executive Officer and Director of Human Resources before approaching employees as study participants. This authorisation was given in November of 2020. (Appendix 6: Letter of Permission from HR Director to Carry out Research, p. 208). My employer is a nationwide non-profit organisation whose mission is to provide individualised support and care for at-risk persons with learning disabilities, mental health, and complex needs, such as dementia, acquired brain injuries, and behaviours that may be challenging. In addition to providing health and social care services, my employer is a licenced non-profit supplier of social housing for persons with a wide range of needs (Gov.uk, 2022). There are within the organisation approximately 5,000 employees and just over 400 of these staff are in a supervisory position, meaning they will manage or

supervise the professional practice and development of a number of HSC frontline workers.

Purposive sampling was identified as the most appropriate data collection technique because it was important to identify the best ‘fit’ for the research methodology (Ritchie, 2009; Walliman, 2014). Purposive sampling is described by Creswell (2003) as the data collection method most appropriate to help the researcher understand a qualitative research problem when considering an ethnographic research question. It is described as the method enabling targeted selection of participants in order to best meet the research question objectives. Miles and Huberman (1994) suggest that there are four aspects to consider within the ‘purposive’ identification of participants and the site for qualitative research investigation:

1. The *setting*, where the research will take place
2. The *actors*, who will be interviewed
3. The *events,* that the actors will be interviewed about, and
4. The *process,* the evolving nature of the events undertaken by the actors in the setting

The setting for the interviews was initially planned to be the head office of the employer organisation. We have private, comfortable meeting rooms conducive to effective interviews (Jones, 2020; Reeves et al., 2013; Spradley, 1979). The ‘actors’ were the research participants, all managers of health and social care services. The ‘event’ is their perception of an effective health and social care worker in their services and the ‘process’ was the interaction during the interviews and the interview narrative and dynamics.

In order to purposefully meet the qualitative requirements for this study a company-wide announcement (flyer) was sent to all senior staff members email addresses, asking for volunteers to take part in a research study (Appendix 1: Initial Recruitment Flyer, p. 200). My intention was to attract managers by asking them if they would like to participate in a study with the potential to enhance social care services on a national scale. Initially staff were asked to respond if they were interested in potentially taking part and receiving more information.

Participation was contingent upon the participant holding a professional position necessitating the oversight and supervision of frontline support workers in the evaluation and development of their practice. In addition, it was necessary for the participant's immediate supervisor to be willing to support their participation in the study, as they will be required to take between 30 and 60 minutes away from their regular duties to complete an interview. As staff members expressed interest in receiving more information, I contacted the potential participants individually to determine if they would be a good match for the purposive sampling method of this research (Staller, 2021). Once their suitability was established, they were supplied with the research background information sheet (Appendix 2. Research Background Information Sheet. p. 201) and formal participants' information sheet (Appendix 3. Participant Information Sheet (PIS), p. 203).

The research background information sheet (Appendix 2: p. 201) explained that the study was ethnographic in nature, and, in line with the University ethics policies, taking part in this study was voluntary, anonymity would be maintained, and the participants may withdraw at any time. It is suggested by Creswell (2003) that an ethnographic study is most effective when it contains between five and twenty-five

participants. My target was to recruit ten to twelve participants to take part in one-to-one semi-structured interviews which will include the recording of observations and triangulation of field notes (Spradley, 1979). Due to the pandemic, observations were not possible, therefore I conducted the two focus group interviews as part of a webinar-delivered leadership training. The intention was to conduct a separate data collection method through a series of focus groups conducted during managers' development training, in which they will be given the study topic and their replies will be collected using the Mentimeter® software. Acutely conscious of the limited time I had to schedule, record, transcribe, and code each individual interview. This dictated the need to collect sufficient data for the results to be rich and meaningful. Because of the challenges of managing unpredictable services and assisting individuals with complex needs, two managers withdrew from the study after the initial confirmation of twelve potential participants. There were ten remaining managers who consented and could engage in the semi-structured one-on-one interviews. The interviews were initially scheduled to take place at our corporate headquarters. Meeting rooms and dates were confirmed. The first interview took place face to face on 11th March 2020 but due to the Covid-19 Pandemic which was confirmed by the World Health Organisation later that day, a national lockdown was imposed, and it was impossible to conduct the remaining interviews face to face if I wanted to remain on target with my research study.

3.4.1 COVID-19 Pandemic: Research, and health & social care

On the evening of 11th March 2020, the World Health Organisation (WHO), declared Coronavirus disease 2019 (COVID-19) a global pandemic. The British

Government imposed restrictions on our movements and the first wave of the Coronavirus Pandemic swept across the UK (Anka et al., 2020; Greenberg, 2020; McFadden et al., 2021; Nyashanu et al., 2020). Abruptly, we became a nation primarily working remotely. Where this was not possible staff were placed on furlough.

For my employer organisation, furlough was only possible for some administrative and head office functions, operational staff working in our health and social care services, supporting adults at risk had no option but to continue to work throughout the lockdowns (Anka et al., 2020). It became a frightening and uncertain time in all our lives, and I feel it appropriate to say that the National Health Service staff and frontline health and social care sector felt this more than most other sectors. I felt determined to continue my research as intended, despite encountering unforeseen obstacles during data collection and the continuance of my studies. I was placed in a position where I had to reconsider the data collection methods to conduct the ethnographic research as intended. I consulted with my supervisors and was advised to conduct the remaining interviews remotely using Zoom®. This was formally requested by the university's ethics department and my supervisor. Each participant was contacted to reschedule the dates and method for the semi-structured interviews. All businesses including schools and universities were closed and we became a nation of cultural isolation (Jones, 2021). As the Covid-19 pandemic was confirmed the forthcoming national restrictions on the public’s movements created confusion and fear for the health and social care sector and this was palpable in my own organisation. Emotionally and psychologically staff found themselves in unknown territory. A position where they were forced to balance their

professional responsibilities of continuing to go to work, against potentially placing themselves, their families and loved ones at risk (Greenberg, 2020).

Managers of health and social care services struggled to plan how they would continue to function and provide care and support for those at risk through a time of anxiety and fear of an oppressive unseen danger. They also experienced additional challenges of balancing their own anxieties with the needs of the organisation. Maintaining safe staffing levels whilst staff approached them for support and advice in order for them to self-isolate and shield their families from potential danger (Nyashanu et al., 2020). It became necessary for managers to support their team members' anxieties and well-being, mostly by exhibiting by positive behaviours and continuing attend work, leading by example (Yaffe & Kark, 2011). Teams were redeployed, and furloughed workers, whose jobs were deemed as unsustainable during the crisis, found themselves in an unsure position (Jones, 2021).

3.5 Data collection

Permission to carry out the remaining interviews by Zoom® was granted on 12th April 2020 by the University Faculty Research Ethics Sub-Committee, (Appendix 7. Ethics Committee Approval to Conduct Interviews Digitally. p. 209). There were two further focus group interviews conducted with 11 participants in total. Whilst working from home, I scheduled the remaining interviews, reasoning that this would be the most effective method to maintain momentum with my studies. The interviews were semi-structured, meaning that I had a list of open questions to ask each participant, but the semi-structured nature of the interviews encouraged additional conversation and narrative (Spradley, 1979).

Before the start of each interview, I confirmed again with the participant that they were willing to participate. In addition to assuring them of their privacy, I requested permission to video and audio record the interviews. After obtaining permission, I began the interview by posing the first semi-structured, open question. It was the intention to create a flowing narrative in line with ethnographic interview methods where possible (Hammersley & Atkinson, 2019). At the conclusion of the interview, I thanked the participants for their time and reassured them that the safety of the information and the protection of the participants identities is my first concern as a researcher. Furthermore, I explained that once the thesis was written and submitted, all their personally identifiable information will be removed from the hard drive and destroyed using software which securely erases data (Cleanmymac®). Any data which is shared (published) will be redacted and anonymised (UK Government Data Protection Act, 2018).

Due to scheduling constraints, I began transcribing the interviews shortly after they were conducted. It was time-consuming to transcribe verbatim, and it became clear that transcribing every inflection and pause in the dialogue was unnecessary. It did not enhance the quality of the narratives in any way. Oliver et al. (2005), and Bailey (2008) discuss a transcription method of denaturalised transcription in which the researcher can make notes of suggestion and body language as opposed to transcribing the interview verbatim. This seemed a more natural way to transcribe these interviews.

Conducting the interviews remotely, it was challenging to be fully aware of the body language and expression within the tone of the voice that one may identify as part of the more subtle communication expected to be expressed through

ethnographic interview techniques (Silverman, 2020), however, the interviews being conducted remotely, enabled continuation of my research throughout the pandemic.

Once the process of transcription was completed the text coding process was initiated. Text coding of transcribed interviews is a techniques used in ethnographic, qualitative data analysis (Creswell, 2003). Coding involves analysing interview transcripts line-by-line and assigning descriptive codes or keywords to segments of text to categorise and make sense of the data (Creswell & Poth, 2016). Initial coding consisted of scanning the text line by line, identifying key words and phrases (Bazeley & Jackson, 2013), this is when the key themes began to emerge. I used NVIVO® software to identify the most common words that appeared throughout all of the transcriptions, then grouped the key words within an umbrella term (Figure 3. Most Frequent Words: NVIVO Text Analysis, p. 241). Code frequencies may show prevalence of ideas that inform insights and reflections when identifying emergent themes. Coding fractures the qualitative data into meaningful parts that enable theory development (Strauss & Corbin, 1994).

There came a point in the transcription coding process when the information became saturated. Bowen (2008) asserts that saturation occurs when the data gathering process becomes complete; when no new insights are being identified and no new themes are emerging from the given discourse, or the interpretation of the information. However, all ten interviews were transcribed and coded for integrity of information and continuity of process (Crotty, 1998).

3.6 Participant demographics

I explored what managers typically consider to be an effective worker through the lived experiences of the participants who directly oversee HSC staff in the independent sector. Of approximately 400 staff originally invited to take part in the study, 12 managers expressed interest by responding to the initial advertisement (n=12). Two managers then asked to be removed and felt that they would not be able to commit due to work related responsibilities (n12 – n2 = n10).

The remaining 10 participants were senior managers who worked in a range of service types as in the table below. There was a range of professional experience of managing services from 7 to 24 years. All the managers led several services encompassing service users with multiple needs. This is expressed in Table 2. Participant Job Role and Service Type, below.

Table 2

Individual Participant Job Role and Service Type

ID	Position (level of manager)	Service type
1003	Service Manager	Mental health/learning disabilities/ day centres
1004	Service Director	Mental health/learning disabilities/ day centres
1005	Area Manager	Mental health/learning disabilities/ day centres
1006	Senior Operations Manager	Mental health/learning disabilities/ day centres
1007	Registered Service Manager	Supported living/learning disabilities
1009	Area Manager	Mental health/learning disabilities/ day centres
1011	Area Manager	Mental health/learning disabilities/ day centres
1012	Service Director	Supported Living/Learning disabilities
1013	Registered Service Manager	Mental health/learning disabilities/ day centres
1014	Registered Manager	Learning Disabilities/ Complex care

There were 2 additional leadership development focus groups (G1 and G2) involving 11 staff (n=11) in total, G1 (n=5) and G2 (n=6). The group sessions were facilitated leadership workshops delivered by the researcher in which the staff gave consent and answered the research question. The staff who consented to their answers being used as part of the research project are included below, (Table 3. Participants of the Focus Group Interviews: Professional Position and Service Type. pp. 92-93). These participants were not interviewed in the same way as the participants in Table 2 (p. 91) above. The focus groups were conducted as an exercise to gather the opinions of managers more generally as part of a professional development exercise. The intention was to add some strength to the research by harvesting generalised opinions from independent groups of managers. The group participants were asked a single question: What do you think makes an effective health and social care worker? The software Mentimeter® was used as the tool to gather the participants' answers. This software enables participants to log-in to a live online portal and submit answers in real time to a pre-determined question. The pre-determined question was set up by myself as the researcher.

Table 3

Participants of the Focus Group Interviews: Professional Position and Service Type

ID number	Position (role of manager)	Service type
Group1		
G1.1	Registered Manager	Mental health/learning disabilities
G1.2	Service Manager	Mental health/learning disabilities
G1.3	Registered Manager	Supported living/learning disabilities
G1.4	Quality Manager	Mental health/learning disabilities/ day centres

G1.5	Registered Manager	Mental health/learning disabilities/ day centres
Group 2		
G2.1	Service Manager	Mental health/learning disabilities/ day centres
G2.2	Area Manager	Supported Living/Learning disabilities
G2.3	Senior Operations Manager	Mental health/supported living/ day centres
G2.4	Registered Manager	Mental health/learning disabilities
G2.5	Project Manager (soon to be registered)	Supported living/learning disabilities
G2.6	Project Manager	Supported living/mental health

3.7 Interviews

Individual interviews were semi-structured with a list of questions which were intended to drive the conversation (Burgess, 2003; Reeves et al., 2013; Spradley, 1979). The interviews were qualitative in nature and consisted of open-ended questioning which sought narratives (Spradley, 1979). The participants were encouraged to speak freely about the subject matter. Spradley (1979) and Jones (2020) have suggested that under particular circumstances it may be appropriate to furnish the participants with the interview questions prior to the interview. I felt this was vital to add clarity to the participants' awareness of expectations, supporting them to reflect on their perspectives of their staff performance. I therefore gave the interview questions to the participants a week before the interviews took place enabling them to ponder and prepare their comments. Please refer to Table 4: Interview Questions and Rational (pp. 93-94) below.

Table 4

Interview Questions and Rationale

Main, open questions	Rationale
1. What do you think makes an effective HSC worker?	This question was intentionally broad and open as specific character traits and values may be considered. It led to the participant discussing diverse aspects of the staff member's role. In the focus group interviews only this question was asked.
2. Why do you think people work in the health and social care sector?	This question led to descriptions of personal values and motivation. Personal, and what we generally consider to be 'good' or 'effective' values may or may not be a driver in wanting to work in the field of supporting adults at risk. This questions was intended to explore this possibility.
3. What skills does a worker need in order to be 'effective'?	This question was asked of each participant for them to consider the specific skills required by their workers.
4. What behaviours do you expect to see in an effective worker?	This question was asked of each participant for them to consider the specific behaviours required by their workers.
5. What knowledge do you expect a staff member to have in order for them to be effective?	This question was asked of each participant for them to consider the specific knowledge required by their workers. It was to investigate why some managers focus on academic knowledge and others focus on life skills.

Recognising the demanding roles of the participants, it was essential to make their contributions to the study as easily accessible as possible. The interviews were intentionally carried out to resemble a conversation rather than questions with pre-determined answers (Burgess, 2003; Spradley, 1979; Turner, 2010), this had a two-fold effect:

It abetted the participants to relax into the interview as they were able to ponder their particular point of view (their symbolically interpreted, socially constructed perceptions of their frontline workers) and come prepared, hereby making them more confident (Burgess, 2003). I was aware that some of the participants felt a little nervous about the interview and I therefore reassured them and explained that they were not being tested or their answers used to judge them, it was a discussion about their perspectives of their staff performance. Their points of view, as being very experienced managers, overseeing large numbers of staff was absolutely vital to the study and I did not want to intentionally influence the dialogue.

Reflexively I recognised a need to be conscious of my potential influence on the conversation and attempt to minimise it as much as possible (Alvesson & Skoldberg, 2009). There were times during the interview when I became aware that I may have been talking too much, unintentionally directing the conversation. When I observed this, I withdrew and allowed the participant to regain control of the conversation. Spradley (1979) describes the ethnographic interview reflexively as a series of ‘friendly conversations’, suggesting that there must be a relaxed flow of information. Spradley suggests that questioning comes from an inquisitive, attentive juncture, encouraging the participant to relax into the process. This method of constructing a conversation whilst being aware not to lead or suggest responses

from the subject was a challenge in the ethnographic interview process (Atkinson et al., 2001; Davies, 2012; Lipson, 1994; Madison, 2011; Prus, 1996). The researcher's self-awareness, openness, and ability to consider the subjective involvement of each participant and ability to encourage responses to the research question in a unique way is imperative.

Providing the participants with the interview questions prior to the meeting generated a more open and trusting relationship and seemed to break down potential barriers between myself as the researcher and the participant, actively involved in the research process (Turner, 2010). Once the participant settled into the interview, and they realised that it was really more of an ethnographically guided conversation they relaxed and talked freely about their feelings and perceptions regarding the research questions. I could see that a number of the participants had come prepared as they had jotted notes down onto a notepad. This seemed to add some confidence to our discussion and the fact that they had read the interview questions prior to the meeting and also had read the supporting documents which explained the emphasis of the interview and the research aims. Some of the participants commented on how they thought the study was remarkably interesting and were happy to be a part of something which may help improve the effectiveness of health and social care services into the future or even add to the current body of knowledge.

It became clear that the managers who offered their time to be a part of the study were the staff who get recognised by the executive team for understanding the importance of staff learning and development strategies. Coincidentally these were the same managers who had received good CQC ratings (Care Quality Commission,

2021) at inspection, and evidently had high levels of staff engagement in their teams. They are managers who see the value in people and understand how to create effective working teams (Care Quality Commission, 2019).

Reeves et al. (2013), suggest that it is important for the researcher to transcribe and code the data personally rather than an independent transcriber. This is supported by the ethnographic interview process as outlined by Spradley (1979) and Burgess (2003) as there may be subtle interactions and psychodynamics during the interview which may add a richness and sometimes, hidden meaning. It is important to capture these other forms of communication through the analysis of the interviews. However, it was more difficult for me to identify some of these subtle forms of communication due to the interviews being carried out remotely.

In the following findings and discussion chapter, the participants have been given a pseudonym to protect their identities in accordance with the Belmont Report (Department of Health, 2014), and the University of Chester Handbook G: Postgraduate Research Degrees Quality Standards Manual (Academic Quality and Standards, 2021). The semi-structured interviews were recorded with the consent of the participants and transcribed using a denaturalist approach. Oliver et al. (2005) described the denaturalist approach as one in which idiosyncratic elements of speech such as stammers, non-verbal and involuntary vocalisations are not included during the transcription process. This seemed the most appropriate method for transcribing the interviews, given that they were all except one conducted via Zoom® during the Covid-19 pandemic national lockdown (Braun et al., 2017). It was challenging to conduct the semi-structured interviews virtually and guidance was sought from my ever-supportive academic supervisors and the research faculty at

the University. I was worried that the interviews may lose an element of authenticity due to the fact that the basic tool of anthropology and hence, ethnography is ‘in the field’ observation of participants in situ (Podjed, 2021). I may have missed subtle aspects of communication as I was not physically present with the participants. However, there are studies supporting the use of digital means to effectively conduct ethnographic research (Góralska, 2020; Howlett, 2022; Lupton, 2021) and further cementing confidence in my research, the term ‘remote ethnography*’* has been coined (Podjed, 2021), mainly due to the intra-social effects of the Covid-19 pandemic on mobilisation.

3.8 Ethical considerations

By definition, ethics are the moral principles that govern an individual's behaviour or the conduct of an activity (Miller & Bell, 2002). Research involving human participants must protect their dignity, rights, safety, and well-being, and my primary concern throughout the study was to ensure the psychological safety of the participants and the security of the information and data collected through the interview process (Fulton et al., 2013).

Ethical approval for this doctoral study was granted by the University of Chester’s Faculty of Health and Social Care Research Ethics Sub-Committee (FRESC) on 10th March 2020 (Appendix 8. Ethics Approval Confirmation Letter, p. 210). This happened to be the previous day to the World Health Organisation declaring an international pandemic of Coronavirus disease 2019 (COVID-19). This fact completely changed the way I (and the University academics) perceived the importance of the health and safety of the research participants. The Prime Minister

Boris Johnson, on 23rd March 2020 introduced the Health Protection (Coronavirus Restrictions) (England) Regulations 2020 (legislation.gov.uk, 2020) and declared the mixing of households temporarily illegal. The public was asked to remain in their homes as much as possible, leaving only for essential travel, and non-essential businesses were required to close.

The pandemic magnified the importance of the ethical basis for the study and made it even more pertinent to express its beneficence and the intention of non-maleficence (Beauchamp, 2008), through adapting the typical ethnographic interview process to enable the interviews to be varied out virtually (Podjed, 2021; Silverman, 2020). The research ethics application for this study (submitted prior to the declaration of Covid-19), captured the measures that would be taken to protect the confidentiality of the participants' data and confirm the standards set out in the Data Protection Act (1998) (as amended in 2017). The professional responsibilities, dignity and rights, wellbeing and safety of each participant were respected throughout the research process. Protective factors were considered and due to the lockdown and restrictions, permission was granted by the University to carry out the interviews remotely via Zoom. It was the only way for me to stay on track with the study. The participants were consulted, and they each consented to being interviewed by the media of Zoom.

It was made clear from the inception of the study that the participants were able to withdraw at any time and without question. It was vital that the participants did not feel coerced into taking part (Miller & Bell, 2002) and this was an identified risk due to their professional positions. It was acknowledged that I would respect their use of language and descriptions of events, even if they contradicted my own. If

I were to challenge their professional practice, I may have also risked damaging their professional self-respect or ego. Despite being unlikely, reflexively, this remained a crucial factor to consider. Reflexivity prompted me to consider my professional position as a member of the organisation's executive team at its headquarters. During the interviews, this was discussed with each participant and throughout the writing of this thesis, I was conscious of the need to protect the identities of the participants; therefore, their names were substituted with pseudonyms so that no personally identifiable information was disclosed (Madison, 2011; Miller & Bell, 2002).

The processing of data was guided by an exploration of subjective meanings within the narratives derived from individual knowledge and understanding of the social world, and in particular, how the health and social care sector is perceived and understood from the perspectives of those who are accountable for the performance of frontline care staff. All data gathered throughout the process was stored securely on an encrypted and password protected hard drive. No personally identifiable information was be stored any longer than it needs to be nor shared with any other professional including the University academics in line with the General Data Protection Regulations (UK Government, 2018). The recorded interviews are stored in a way that does not put the identity of the participant at risk (stored with coded names/reference numbers that are only known to me). These files are encrypted, and password protected and only accessible by myself.

3.9 Validity

Validity within qualitative research is generally split into two categories; internal and external validity (Walliman, 2014). Internal validity relates to the methodological rigour, conversely, external validity can be described as how the study may be effectively replicated in its methodological process and generalised (applied) to external populations or settings (Bryman, 2008; Creswell, 2003; Neale, 2008; Ritchie, 2009).

Internal validity was applied through the epistemological understanding and application of symbolic interactionism and social constructionism as the lenses through which to explore the narratives and outcomes from the analysis of the interview transcriptions (Burr, 2003; Charmaz et al., 2019; Prus, 1996; Spradley, 1979). External validity is present within the thorough description of the participants job roles and responsibilities (types of services they manage and the frontline workers they supervise) in line with the research questions and rationale in Table 4. Interview Questions and Rationale (pp. 93-94).

A number of limitations were recognised during the study, and it was pertinent to discuss these with the aim of transparency and reflexivity (Reeves et al., 2013). There are possible limitations in the research group being all from the same company. Subsumed in the management and leadership culture of the organisation and working to the same policies and procedures. This may have limited the outcomes as one may say that their symbolic interactions within their working reality are based on the same professional, socially constructed paradigms (Berger & Luckman, 1967; Scambler, 2002) possibly limiting diversity in response to the research questions. However, it is important to say that although all services are

within the same company, each service within its own local authority is commissioned and managed differently in accordance with the type of service and the needs of the service users. For example, mental health services are managed and staffed very differently than extra care services supporting older people and they are again managed very differently than complex care services supporting individuals with learning and physical disabilities. Although the core needs of all people are similar there are specific skill sets required in order to support these different client groups.

These commonalities are reflected through the analysis of the literature review and will become a part of the iterative process explored in Chapter 4: Findings.

3.10 Analytical framework for data analysis

In qualitative research such as this, the analytical framework is a tool that directs the analysis of the data/narrative, the intention being to augment consistency into the interpretation of the transcriptions (Ricoeur, 1976). The aim of the analytical framework utilised throughout the iterative procedure in this study was to lend clarity and direction to the text's interpretation. This allowed for a standardised approach to the process of uncovering concealed meaning in the narrative subtext (Goldstone, 2019). It was vital to remain reflexive throughout the process so that any interpretative influence on the outcomes was minimised (Alvesson & Skoldberg, 2009).

I found that Ricoeur's 'theory of interpretation of text' was the most appropriate analytical framework for this study as it examines what was said within,

and in-between the text of the interviews. The ethnographic interview is well positioned within this concept due to my intention to ‘read between the lines’ of the transcriptions. I considered Spradley (1979) who asserts that the goal in ethnography is to discover and describe the cultural meanings that people are using to understand their experiences and behaviours.

Ricoeur (1976) suggested that meanings always involve the use of language and narrative in the shaping of human understanding, leaning towards the constructionist and symbolic interactionist lenses used throughout this study.

The analytical framework, although structurally simple led adequate depth and rigour to the analysis of text and narrative (Goldstone, 2019; Ricoeur, 1976). During the interviews, participants exhibited several personality traits that were reflected through the group as a whole. This was a crucial aspect of this research and sheds light on service managers' perception that they appreciated their effective staff and would give them more if financial and other circumstances allowed.

Spradley’s text analysis focuses on uncovering cultural knowledge through systematic coding and categorisation which, as an ethnographic method and process was a little too compartmentalised for my study. Ricoeur’s analytical framework although being essentially a phenomenological tool seemed the best fit for my research due to the connection with the socially constructed self (Ricoeur, 1976). Ricoeur recognised the interpretive process, hence the connection between text and experience and proposed that we construct our own narratives through lived experience. This concept is consistent with the ethnographic, investigative nature of my research and with the manner in which the participants of my study have socially

and symbolically constructed their work selves through experiential learning and social interactions with their co-workers within the organisational culture.

The essence of Ricoeur's analytical framework is:

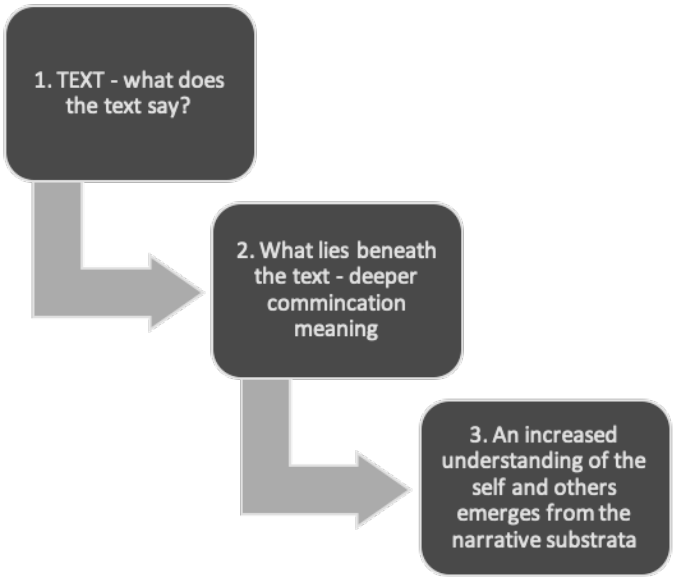
"What does the text say?"

"What does the text mean?"

"How does this relate to my study?"

Figure 2.

A Simplification and Representation of Ricoeur's Analytical Framework (1976).



3.11 Chapter summary

This chapter serves as a bridge between the raw data and the comprehensive analysis of the research findings which are presented and discussed in the following chapter. I have attempted to generate a clear understanding of my research methods and process by justifying the reasoning for the methodological approaches. An

interpretive, qualitative, ethnographic lens of enquiry using the theoretical frameworks of social constructionism, symbolic interactionism, and my epistemological and ontological realities were defined.

The managers as participants of this research study were chosen purposefully as a best fit to answer the research question. Their semi-structured ethnographic interviews have created a rich narrative leading into the next chapter where I utilised Ricoeur's analytical framework to explore the interpretive process and the role of language and narrative in constructing meaning (Ricoeur, 1976).

Chapter 4: FINDINGS AND DISCUSSION

4.1 Introduction

This chapter discusses the analysis of the findings from the participant responses following the semi-structured interviews and the two focus group interviews. Text analysis and coding revealed three overarching themes, namely, cultural communities of practice: organisational liminality, and 21st century compassion in health and social care. I present direct quotes from the participants supporting each of the emerging key themes, then offer the underlying meaning within the text to deepen the intent and significance of their (Denzin, 2016; Ricoeur, 1976). Reflexivity is embedded within the discussion to add rigour to the interpretation of the findings and triangulation is used to iteratively link evidence from the literature review in Chapter 2 with accompanying wider literature from experts in associated professional fields. Finally, data from the field notes taken during interviews and focus groups are used to strengthen the results.

4.2 Emergent Themes.

The concept of communities of practice (CoP) was the first of three emergent themes. It became apparent that CoP's are culturally ingrained throughout the echelon of the organisation through individual and group socio-symbolic interactions (Belgrave & Charmaz, 2021; Denzin, 2016). An examination of team, service, and organisational social structure uncovered effective frontline workers fostering a positive culture within HSC service teams, ultimately resulting in the delivery of optimal levels of person-centred care to service users (Skills for Care, 2022).

Defined as teams of individuals who engage regularly to share knowledge and improve practice, one may define these effective teams as ‘cultural communities of practice’ (CoP’s). The positive culture within health and social care services is created through highly engaged and effective employees (Davies et al., 2000; Skills for Care, 2022).

I perceive, and the emerging results agree that the organisation displays the unifying characteristics of a ‘living organism’ comprised of constantly developing cognitive transference where CoP’s at all levels exist and include all human resources. Diverse epistemological models emerge, each feeding into and out of the others to produce an overarching vision of a living, organisational-being metaphorically metabolising knowledge from the participants of its social structures (its CoP’s). Individual and group learning complement the organisational growth and development leading to a multi-faceted collective consciousness, which may be viewed as a ‘creative social organism’. The outcome of these CoP’s is a culture of realised engagement where individual team members behave and display loyalty towards the organisation, their managers, and the service in which they work. The ultimate aim is the delivery of quality care to clients through its effective and efficient human resources (Bridger, 2022; Turner, 2020).

Connecting to the initial theme of cultural CoP’s emerged the second theme, where CoP’s may be thought of as ‘liminal entities’. The participants (the working groups) were neither who they were when they joined the CoP nor who they will be when they emerge (Van Gennep, 1909). They may best be described as being suspended in a liminal space; a state of ‘betwixt and between’, or an interstitial stage of transformation (Larson, 2014). The organisation is constantly evolving, learning

from the experiences of its staff, the teams and clients connected through the layers that a CoP presents (Meyerhoff & Strycharz, 2013). The organisation will never fully emerge from the other side of the metamorphic stage; its liminality is transitory in nature and constant. This leads to how this transitory state of change and evolution presents the third emergent theme which is 21st Century Compassion in Health and Social Care. Dissecting the socio-symbolic influences of covertly uncovered abusive practices in recent years has forced HSC leaders to focus on the importance of compassionate care (Barton, 2016; Care Quality Commission, 2019; Francis, 2013). Health and social care organisations must adapt to this national concern and consider compassion to be a socially symbolic construct necessary to guide HSC through the 21st Century (McMahon, 2021).

4.3 Theme 1: Cultural communities of practice

Decades of anthropological research, originally into indigenous cultures have generated a contemporary, diverse understanding of the notions of a ‘culture’ (Davies et al., 2000). The business application of these notions began in the United States during the early post-war period, but they did not gain widespread popularity until the 1980s (Storey, 2019). Over the previous several decades in the UK, there has been a burgeoning interest in the effects of organisational culture, resulting in substantial research in several business contexts, including studies of health and social care organisations (Davies et al., 2000; Gillin, 2017; Mannion & Smith, 2018; McSherry, 2018). Workplace culture can be defined as a set of socially symbolic behaviours shared by culturally intertwined individuals (Hammersley & Atkinson, 2019). In HSC work environments, the culturally interwoven individuals are members

of a working group or team, and the culture is created through their symbolic influences on each other, ultimately affecting the overall efficacy of the service (Skills for Care, 2022). Culture is initiated through the behavioural expressions of individual members of the senior team (Belgrave & Charmaz, 2021; Charmaz et al., 2019) this influences the behaviour of the rest of the team and is reflected in the actions of the other members of the group.

The employer organisation has a proud ‘culture of learning’, in which teams from all levels of the organisation involve themselves in sharing best practice and are in essence communities of practice (CoP), (Wenger, 2011; Wenger & Snyder, 2000).

Helen, an area manager suggested a cultural community of practice enacted by effective workers sharing knowledge in team meetings, she said:

> *…information is key to empowering people [staff and service users] and we've got to be able to share [knowledge] so I do think there's got to be a level of sharing information, and I think that varies from support worker to support worker (Helen).*

Helen’s comment highlighted the fact that information is key to empowering people as she felt effective workers enable the group to be at its most effective through sharing their experiential knowledge and good practice. From a purely symbolic view, thinking of information as a ‘key’ suggests an action of opening or unlocking something. Helen is suggesting that information, in her mind unlocks the barriers to empowerment for effective frontline workers, and this information is shared through communication within teams. Currie and Lockett (2011) support this contention when they discussed distributed leadership, where effective team

members will imbue symbolic leadership responsibility within the social group they belong to by taking the lead in information sharing. Currie and Lockett (2011), further state that resourcefulness is fostered when leadership decisions are shared through effective communication. Helen accepts that frontline workers will have varied levels of knowledge and skills, appreciating their diverse abilities and is accepting of the various levels of input they may be able to offer. Effective workers engage in CoPs for the advancement of the team and have a passion to continually learn and attain knowledge. Strengthened by field notes, the focus group members suggested effective workers ‘want to make a difference’ and ‘want to learn together’, supporting the concept of CoP’s naturally occurring within effective teams.

Cultural communities of practice (CoP’s) may be further defined as groups of individuals who meet regularly to exchange expertise on a particular subject (Wenger, 2011). It is inherent within the organisational culture that good practice is shared continually between all members of a team. The members of the CoP learn how to improve their practice where learning is recognised as a shared social phenomenon constituted in the experiential world through participation in ongoing professional practice (Lave, 1991). They are members of a community of practitioners where mastery has an organisational purpose.

Lave (1991, p. 98) postulated that a CoP is a system of interactions among people, activities, and the world. They change throughout time, and further, Wenger (1998), proposes that there is a fundamental trinity of defining qualities. The first is that members engage with one another in order to build shared perspectives via reciprocal engagement. Secondly, members of a CoP share a common purpose, and thirdly resources, such as language, stories, and materials are shared (Wenger &

Snyder, 2000). Helen's comment referred to subtle learning through communication and was exemplified through the supportive understanding of this aspect of effective workers behaviour. These definitions are reflected in the way the study participants described their effective team members working together.

The research participants described how at a senior level the organisation offers leadership conferences and regular national senior staff forums in which information is shared with the intention of enhancing knowledge and practice for all those involved. The objective is to always learn and develop for the good of the organisation and to improve the quality of support for the service users. The individual participants are encouraged to bring their learning and knowledge to the table, share resources and influence the development of business objectives. On a service level, teams have regular meetings where they come together to share information, experiences and materials. Discussions are held with the shared purpose of improving the quality of care provided for clients.

Mandy, a senior operations manager in relation to Communities of Practice in her services stated:

> *…if you're enjoying work other people enjoy work alongside you and it's paying that forward, it's sharing those experiences with your workforce, with your colleagues for the experiences of other people. Having better knowledge of that person and how to communicate with that person, how to improve the outcomes and experiences for that person in their daily life and their outer life is incredibly important because if they have that knowledge or if they go and find that knowledge, and work towards better knowledge, they can then share that knowledge,… and as for me as a manager, I encourage staff*

> *members to do that in team meetings, to say 'I had a breakthrough moment with 'J' the other day and it was something really simple and it was actually he didn't want me to open his post in front of him he found that really challenging. I didn't understand, but when we open his post he gets very anxious, and I have now done a best interest meeting, we open his post in the office before, we don't take it out of the envelope, but it's just the noise of opening the envelope!', it's just those little things, and that knowledge that can then be shared in team meetings and can be shared further forward (Mandy).*

Mandy's emphasis on the enjoyment of work and the interconnectedness of individuals echoes the essence of a community of practice (Meyerhoff & Strycharz, 2013). By creating a work environment where colleagues derive satisfaction from their roles, Mandy is fostering a sense of belonging and shared purpose. The positive energy generated by enthusiastic workers can have a ripple effect, elevating the overall quality of care and promoting a culture of collective learning (Kolb, 2014). Mandy's encouragement for health and social care workers to better understand service user's needs and communicate effectively reflects the notion of shared expertise. This approach resonates with the collaborative learning aspect of communities of practice, where collective knowledge contributes to better outcomes for service users.

The "breakthrough moment with "J", occurred as a result of a worker's compassionate efforts to comprehend why he became distressed when staff opened his mail with him. Staff attempted to be respectful by involving 'J' in the process of opening his mail, as is customary for respectful and inclusive support (Care Quality Commission, 2023). The 'breakthrough moment' was the recognition that the sound

of the opening envelope was the cause of distress for the client; possibly a sign of undiagnosed hyperacusis. Not opening ‘J’s mail with him may be interpreted as contrary to his rights to dignified and respectful support (Care Quality Commission, 2023). Therefore, sharing this simple knowledge at handover and in team meetings is vitally important to the service user’s life and a way to avoid staff unknowingly causing discomfort. This situation exemplifies the importance of the team CoP working to improve a service user’s life through the simple sharing of information towards a common goal. By discussing such insights in team meetings, Mandy is nurturing a community of learning, where practical knowledge is exchanged, refined, and integrated into daily practice. Manthorpe et al. (2017) concurs with Mandy by inferring that a catalyst to effective care is compassion, of which effective communication is integral.

Berger and Luckman (1967), and Burr (2003), suggest that the symbolically constructed roles of the frontline workers are enhanced through shared language and the acceptance of the power transactions within the group. Power transactions generate connections between effective staff, creating subcultures of like-minded individuals. Staff members with similar social backgrounds connect with each other through their shared behaviour (Denzin, 2016; Prus, 1996) creating subgroups which may be considered to be CoP’s. This cultural phenomenon is reflected throughout teams, society, and organisations (Savage, 2000). The members of these subcultures learn together through shared experiential learning facilitated through the team CoP, what Wenger and Snyder (2000), described as learning as an objective process (Wenger, 1998, 2011). Field notes taken during the participant focus groups upheld this notion by revealing that managers affirm effective frontline

workers as “willing to learn”, ‘have the right training” and “have a focus on positive outcomes”.

The assumption of objective learning enables standardised approaches to teaching and staff development, dictated by the executive CoP in order to achieve defined organisational aims and objectives. In relation to the employer organisation the senior team of executives are the primary CoP, who regularly meet to discuss organisational performance, policies, and strategy. This executive CoP feeds through the senior team structures who also meet regularly to discuss their operational strategy, policies, and challenges. The knowledge and development outcomes gained from these CoP’s are disseminated across all echelons, metaphorically akin to a network lattice of collective strategic information emanating from teams of engaged individuals.

The culture of engagement within effective teams emerged as a central theme. Articulated by Currie and Lockett (2011), they asserted it necessary where leadership responsibility was distributed through all levels within a team structure. Engaged staff are perceived as naturally effective, they will lead by example and be fully accountable and responsible for their actions (Bridger, 2022). From the manager’s perspectives, it was important that staff were part of the ‘living’ culture of their organisation. Effective staff will be proud of the positive support and opportunities they facilitate for their service users.

> *…Our business has a positive culture, staff give each other a hand, a helping hand I think that really makes a good team player really and that’s the behaviour traits that we want to see in our staff and in the organisation. (Linda)*

Linda enjoys working for a company with a positive and supportive culture. She perceived herself as part of something bigger than her own team when she referred to ‘we’ rather that ‘I’, whilst discussing the staff who she feels would be beneficial to achieving the necessary effective outcomes. Her confident tone whilst describing the services and teams she oversees gave the impression that she takes considerable pride in her job. By the expression ‘giving each other a hand’, Lynda was symbolically referring to effective staff supporting each other, not just physically with tasks but also psychologically and emotionally; frontline staff working together coherently in order to establish a healthy team culture. Employees who are supportive of one another are productive workers, or "team players”. When this collegiate dynamic is present within teams, positivity resonates throughout the organisation enhancing the quality of life for service users (Day, 2014).

Day (2014) and McNeil (2019) propose the behaviours of individual staff members’ affect team culture and the business as a whole, therefore where staff are supportive, positive and share knowledge as part of a CoP, this may be reflected through all levels of the organisation, affecting overall efficacy. By suggesting that staff ‘give each other a hand’, Linda felt that working with service users can be challenging and that staff were required to support each other emotionally. Team members could become tired and emotionally distressed at times potentially resulting in compassion fatigue (Billings et al., 2021). Linda suggested that team members support each other when this occurs. Compassion fatigue, also referred to as empathy burnout, is an emotional, physical, and mental exhaustion that some HSC workers experience as a consequence of giving direct, long-term support to chronically ill clients. It occurs when HSC professionals become overwhelmed by the

demands of their work and the emotions it might provoke (Franza et al., 2020; McMahon, 2021). HSC staff often deal with sensitive issues such as client's mental distress, self-harming, poverty, and death. If not identified and supported, compassion fatigue may lead to feelings of personal distress and harm general health and wellbeing. The staff member may also experience physical fatigue, lack of appetite, weight loss, and diminished empathy or social connections (Franza et al., 2020). Research suggests It is helpful for HSC workers to engage in mindfulness exercises and focus on self-care (Rivera-Kloeppel & Mendenhall, 2021), also prioritising self-care practices, such as taking breaks during the day and participating in activities that bring them joy outside of work (McMahon, 2021), are considered advantageous. These challenges within the work of HSC staff are supported by the teams regularly engaging with each other to discuss caseloads, their clients' needs, and best practice. Within the CoP, shared knowledge and experiential learning are fostered, generating a safe space for workers to symbolically share their work-life realities.

The concept of compassion fatigue led me to consider the national effects of the pandemic on the study participants and their teams. Social care professionals were especially susceptible to compassion fatigue due to the increased likelihood of exposure to trauma and excessive workloads, as well as emotions of powerlessness when supporting clients with chronic illness (Greenberg, 2020; Jones, 2021; McFadden et al., 2021; Torjesen, 2020). In addition to the primary traumatic stress brought on by dealing with chronically ill clients, secondary traumatic stress emerged from hearing stories from co-workers. The engagement of the members of the CoP was an important, supportive aspect. Engagement in the organisational context is

considered to be when workers exhibit positive, loyal behaviours in relation to their employer (Currie & Lockett, 2011). This main theme surfaced through the ethnographic narrative and was based on positive behaviour traits and positive values of effective workers. Demonstrated here in the following interviews, managers' perceptions of effective workers were consistent through all individual interviews and focus groups.

Lydia, a service director discussed the unpredictability of working with people. She explained how, for her, effective workers find strength in their jobs and generally find their role personally rewarding. Effective workers realise they are members of a team, they do this by establishing a CoP based on mutual engagement (Wenger, 1998, 2011)

> *…people [service users] behave and act differently and I think that can make the job quite hard, …you know that every day can be unpredictable at times and you know it's a real responsibility, looking after another human being and having all that responsibility about their health needs, about their emotional well-being, about the way they look, the way they appear, the way they respond to different situations, that's quite a hard job, and although it's really rewarding it takes strength and good values of a person really (Lydia).*

Lydia expressed that each service user will have diverse needs, unique to the individual, plus an element of behavioural unpredictability which can make the job challenging but equally rewarding. Individual strengths shared with the team are elements of cultural engagement. Wenger (1998), described one of the 'modes of belonging' to a CoP is through engagement where staff feel part of a team working together for the good of the group members and for the clients they support. It may

be challenging to provide social care since front-line staff often simultaneously manage a number of competing priorities. However, CoP's may provide people with a sense of purpose and support, which may assist them in feeling engaged, positive, and appreciated. CoP's enable a positive and engaging environment for frontline workers by fostering a keen sense of collaboration among its members. This enables frontline workers to form meaningful relationships with their co-workers, which can often be just as rewarding as the work itself (McMahon, 2021). Lydia feels that effective workers respond positively to situational obstacles and are adaptable to the changing needs of their service users, implying that supporting individuals who may be at risk and guaranteeing their physical, psychological, and emotional wellbeing is rewarding in itself. The symbolic strength that Lydia was referring to may be associated with good levels of self-confidence and is supported by McNeil (2019), who asserts self-confidence is a facet of effective care provision.

Character strength and self-confidence was further associated with effectiveness, the study participants discussed the importance of Health and Social Care education however, they all suggested the need for the "right" kind of individual with the requisite behavioural attributes initially outweigh the necessity for academic knowledge in the first instance. Managers concurred that academic knowledge may be added to the skill set of an effective worker during the course of their career. They suggested a solid axiological foundation and the "right" kind of individual to whom you can scaffold the academic and intellectual aspects of the role as essential.

> *…for me, it's people [effective workers], that are sponges and want to absorb things. We all learn all the time, and we're all changing our practice all the time. For me, effective support workers are people that are open to that and embrace anything that's thrown at them.*

> *They are the ones that don't complain about the fact they've got to do training. They enjoy it and they get something from it as opposed to the ones that find it difficult and don't do it (Lydia).*

Effective workers are members of a service level CoP, they meet regularly at ‘handover’ from one shift to another working as a team, sharing information and ‘tips’ from their experiential learning and symbolic interactions with specific clients. Lydia suggested effective workers are those with the ability to learn and retain new information “all the time” inferring that their jobs are complex necessitating experiential learning on a day-to-day basis. I could see Lydia ‘light up’ through her intonation and facial expressions indicating she was enthusiastic about the notion of her workers learning to improve practice. She was excited when workers were passionate about learning and were symbolically absorbing knowledge “like sponges”, eager to attend training and develop professionally. Ballard et al. (2018), support this view by suggesting there is a correlation between staff training and improved levels of service culture. When Lydia discussed that the workers who have no ambition to learn, or dislike attending training her tone of voice lowered and slowed slightly, shaking her head almost unnoticeably as in designation of the fact that these workers were disappointing, causing her anxiety. Lydia displayed genuine compassion for her workers and the service uses whom they support. She wants the best for all members of her team. This notion is supported by Day (2014), who argued that effective employees must continually learn and be compassionate in order to decrease the potential for harm. Gridley et al. (2014), whose paper explored the perspectives of people who use services and their significant others, supported the necessity for professional development and compassion. The focus groups

confirmed the importance of the association between learning in communities of practice by reference to effective workers being willing to learn attend training.

Several of the study's participants discussed the need for effective workers to be creative in their approach when providing support to service users:

> *…being resourceful and creative in the way that you come to a resolution; Quite often being a support worker can be quite a lonely thing. I know there are not a lot of services set up with full teams on a daily basis [during Covid], so you do need to think on your feet really, be able to draw upon your own experience (Linda).*

Linda believed that individuals who exhibit resourcefulness possess the ability to draw on past experiences or circumstances, demonstrating a creative approach to their work. Effective employees possess the cognitive ability to engage in creative thinking and make decisions in the moment. Linda further suggested that effective workers may experience occasional feelings of isolation as a result of their solitary interactions with service users on a daily basis. Consequently, she emphasised the significance of regular team meetings as a Community of Practice (CoP) in fostering professional engagement and sustaining a sense of belonging within the team.

In the comment below, Mandy suggested that an effective worker will have a positive approach, emanating from creative thinking, when they come into work. She feels that effective workers will be energetic and positive:

> *…you want someone coming in to work with a smile, positive, upbeat, energetic, enthusiastic, and that's gonna set someone up for a better day than if somebody's [staff member] in a low mood, you*

> *can bring it down. You still need to be positive. Someone with an energetic smile and motivated to get the best out of the day. Creative thinking – thinking out of the box (Mandy).*

According to Mandy, effective workers possess a positive attitude. She asserts that effective workers genuinely enjoy their job and the support they provide. The positive attitude of individuals is evident in their communication, encompassing both verbal and non-verbal cues such as tone of voice, body language, and facial expressions. This assertion is corroborated by Dewar (2014), who suggested that effective communication skills are pivotal to effective care and support. Dewar further emphasised that the development of such skills should be fostered at every level of a team and are intricately intertwined with cultural norms and practices. In order to facilitate effective care, the management of caring and compassionate conversations by staff is crucial.

Effective staff see the importance of bringing happiness into the lives of their service users where they can, even if they are not personally feeling their best, they will consciously act positively. The importance of behaving positively is supported by McNeil (2019) in their study where they investigated the cultural effect of workers 'doing good (beneficence) and feeling good'. McNeil's study suggests that a happy working culture is developed through positive staff behaviours, language, and self-motivation.

Similarly, Helen, an area manager stated:

> *…to be a good, effective support worker you need to be a good communicator, and not just for the person [service user], but you*

> *know you need to be able to work as part of a team, you need to be motivated because there's a lot of people we support who need a lot of motivation especially in mental health services and if you lack motivation I don't know how you can motivate someone else, so you need to be more, you need to be 'creative'. I think in this climate support workers need to think outside the box and be creative and I think it's about how you engage with that service user, it's about how you present information, so it all goes back to positive communication (Helen).*

Helen emphasised that effective workers assume responsibility for facilitating communication within the community of practice (team). Symbolically, the process of communication occurs through both direct and indirect interactions between staff members and service users. This highlights the significance of staff members being aware of their more subtle, non-verbal communication skills. According to Burr (2003), communication in social constructionism is characterised by its symbolic nature, as it is via language that individuals construct their own realities. I propose that, in alignment with Helen's narrative, communication serves as a unifying force among employees, positioning them as active participants within a Community of Practice (CoP). The collective members are bound together by shared verbal and non-verbal communication and behaviours.

Managers agree that effective workers will be motivated and have the capacity to communicate creatively with a range of service users who have diverse abilities. Pulsford et al. (2016), and Day (2014), assert where service users are unable to vocalise their needs due to illness or injury it is important that staff are

diverse in their communication skills and support the person by placing them at the heart of the decision-making process (Care Quality Commission, 2020).

Winnie, discussing the importance of effective communication skills affirmed the following:

> *…I think it has to be someone [frontline worker] who knows how vulnerability affects a person who can't speak for themselves, and someone who focuses on wanting to help the vulnerable to be heard. Someone who is their voice. I'm very passionate about that (Winnie)*

Symbolically, Winnie's strong statement referred to effective staff members as people who will be the voice of someone who is unable to speak for themselves. Assisting the voiceless to be heard is not a meagre reference to hearing the sound of their voice. Helen was symbolically suggesting that effective staff will advocate for equality and the human rights of people who are disempowered by the boundaries of the social construction of disability (Guevara, 2021). Winnie perceived an effective worker to be empathic, kind, and supportive.

In support of Winnie's perspective, the study by Manthorpe et al. (2017) demonstrated that service users themselves perceive an effective frontline worker as a person who demonstrates kindness and compassion with excellent communication skills. Gillin (2017), also supported the concept of caring and kindness as someone who will advocate for the service user and have their best interests at the centre of their decision making.

Gemma, an area manager concurred with Winnie by saying:

> *… the best workers are good communicators, especially for those people who struggle to communicate, expressing themselves emotionally, so good communicators, who look for the less obvious. Yeah, someone responsive, and the behaviour you want… someone coming in to work with a smile. (Gemma)*

Gemma concurred with Helen's previous assertion when she suggested the capacity for supporting decision making for those who have communication challenges is a pivotal skill in an effective worker's role. She felt that enabling service users' decision making through the use of effective communication skills is particularly important. Gemma further posited that effective staff are able to support service users to express themselves emotionally, suggesting empathic skills as being important. Marmot (2018), supports this contention, asserting that acting in the service users' best interest when there is lack of a significant other in their social world who can act as an advocate for them, is an essential aspect of the effective workers role (Marmot, 2018).

Summarising this theme of communities of practice, the participants alluded to CoP's as naturally occurring in teams where effective frontline workers are engaged in meaningful activities with one another through shared goals, communication, and skills (Lesser & Fontaine, 2004; Meyerhoff & Strycharz, 2013). CoP's are a place where knowledge is shared, and professional growth occurs. It is viewed to be a collective learning space where people emerge with changed and often enhanced understanding. This space which enables professional transformation to take place

may be perceived as a liminal space, which lends itself to the second emergent theme of organisational liminality.

4.4 Theme 2: Organisational liminality

The second emergent theme from the study participants' narratives was organisational liminality. The root of the word 'liminality' is the Latin 'limen' meaning "threshold" (Larson, 2014). It is said to be originally coined by the French anthropologist, theologian and ethnographer, Arnold van Gennep in his book Rites de Passage (1909, 2004). Liminality is the transitional phase of a rite of passage; the interim phase of three, where the first and third are separation and aggregation, respectively. Van Gennep (1909), used it to describe the period between two phases of life, for example moving from one place to another such as moving house, starting a new job, starting university, birth and death. The anthropological concept of liminality is described as the liminal state (ambivalence) which, in relation to this study may be applied to a stage between separation from the 'status quo' of the organisation's normal activities and the re-incorporation of renewed practices from the input of its members of the Communities of Practice. The organisation may be perceived to inhabit this liminal state, straddling the present, and what will lead the organisation into the future in order to identify the needs of service users. The organisation is guided by the influence of Communities of Practice (CoP), during this liminal journey and is ever changing in the quest to meet the demand and future challenges for optimal health and social care delivery.

The organisation may be viewed as being 'alive' and constantly in a state of liminality, or as Turner (1969) described it, a state of 'between and betwixt', growing

and developing. I propose that there exists a correlation between the phenomenon of organisational liminality and the previous theme of CoP's. Specifically, it may be argued that whenever a CoP is taking place it is a manifestation of liminality. The participants are not the same as when they entered the CoP due to engaging in a decision-making process which has the potential to influence their cognitive and behavioural processes when they leave the CoP. Therefore, it can be posited that a CoP is liminality in itself and the organisation is perpetually transforming through the acquisition and assimilation of knowledge. Related to the previous theme, a CoP is a state of suspended time where ideas are being discussed, changing the participants until they emerge from the other side with transformative actions to implement change.

4.4.1 Liminality and frontline workers

Newly recruited staff members who have been employed and hence within their probationary period may be perceived as being in a state of liminality and not yet a member of the Community of Practice. One may suggest Van-Gennep's (1909) description of liminality may be likened to the probationary period; a rite of passage where the worker is no longer who they were before they started the professional journey to become a health and social care worker and not who they will be as they emerge from this period. Furthermore, Turner (1969), described liminality as a metamorphic state of paradoxical confusion and ambiguity where the psychological state of the person is neither here nor there (Bigger, 2009). However, in contradiction to Bigger (2009), Reed and Thomas (2021), showcased liminality as a positive, intentional state rather than a period of anxious ambiguity (Reed & Thomas, 2021).

Endeavouring to apply this perception, one may suggest that staff during their probationary period are under philosophical and professional transformation and hence ‘being liminal’ is a helpful enabler for identity reconstruction. During this time staff are a catechumen, learning the rudimental, organisational expectations through the symbolic behaviours of their neo-colleagues. These socially constructed professional behaviours have been created through team and organisational culture embedded and repeated over time to become a metamorphic mould for the neophyte (Gillin, 2017; Skills for Care, 2022). The required skills, knowledge and behaviours being the components of the professional shaping which must be attained in order to prepare the employee for their future role (Larson, 2014; Thomassen, 2009). The metamorphic nature of liminality is akin to a state of transformative learning (Reed & Thomas, 2021). The neophyte emerges from the liminal stage a changed person, with additional knowledge, insight and responsibilities (Van Gennep, 1909).

The participants of the study discussed the importance of personal and professional development in their effective workers, emphasising this transformative liminal state:

Jackie, an area manager mentioned:

> *…when people go on training, I'm really keen in their supervision that they reflect on that training, and they evaluate that and see how they're going to bring that into their practice. Some of the teams have just done personality disorder training. I was on it myself yesterday to see what they were taught so that I can go back to*

> *them and say, "what did we learn and how are we going to change our practice? What was different to what you do now, to what the trainer said, to what you're going to do in future?". There were some things in that training that were like, "actually, we don't do a lot of that." I'd like to see that moving forward. I think mostly, they [frontline workers] need to be flexible, adaptable. They need to be approachable; they need to be able to think on their feet, take criticism, and reflect on their practice (Jackie).*

Jackie was aware that the learning process is transitional and liminal. It can be understood as a process of transformative learning and adaptation that frontline workers undergo as they transition from formal training to practical application. Supported by Turner (1969), the concept of liminality can illuminate the dynamic nature of professional growth, where individuals engage in a continuous cycle of reflection, learning, and adaptation. Jackie suggests that training provides the information necessary to change or improve practice, but the difference lies in the application of this knowledge, she is inclusive and cognisant of her staff members' professional growth. Ballard et al. (2018), concur with Jackie's stance in their study which analysed the effect of person-centred training programmes on the quality of care. The practical application exists beyond the liminal stage where integration of new knowledge takes place as supported by Bigger (2009), who discussed Turner's (1969), contention of three stages of pre-liminal, liminal, and post-liminal, or as we may consider it here, integration of the being after a phase of liminality.

Jackie recognised the responsibility of enabling staff to understand how the knowledge can be applied and intentionally discusses the workers' understanding after they have attended learning programmes. By attending the personality disorder

training herself, she participated in the liminal space of acquiring new knowledge alongside her team representing a liminal bridge between training and practice.

Mandy, a senior operations manager agreed with Jackie when she stated:

> *…if you consider a worker going through a process of employment, induction, training and then on to supervision, monitoring, observations and what have you, unpicking that to understand the effectiveness of those processes, but I think certainly in my experiences as a manager, and a senior manager, it really can only be brought in at a recruitment point. So when I have advertised previously and I advertise now for support workers for let's say for just a generic learning disability environment, I'm looking at the skills, attributes and values of the people that we are looking to recruit, and that has to be around the recruitment questions, the deeper questions that, when you ask more in-depth questions and asking for examples and what have you, for me all of that starts at the recruitment stage.*
> *Getting to know that person, that is really the priority for me before going anywhere else. I think there is a huge responsibility on a manager in an organisation to be very clear in the objectives of that role, to set out what's expected, what those expectations are, setting out those timescales, setting out the responsibilities and accountabilities of that role. To help someone make an informed decision about whether or not that is going to be the role for them, because if it isn't then, they're not going to be an effective worker and it begins the root of effectivity (Mandy).*

Mandy characterised the recruitment process and probationary period as one in which the new employee enters a liminal state acquiring the knowledge and

functional behaviours necessary to become an effective worker. The focus groups upheld this contention by suggesting that effective workers possess the right character traits and are willing to learn. The necessary initial focus is on recruiting the "right" person who imbues the positive characteristics of someone who can work effectively with adults at risk (Gridley et al., 2014). Mandy utilises the interview as a symbolic means of "getting to know that individual" at least in an initial way. She then probes with what she calls 'deeper questions', suggesting that she will ask questions related to the non-superficial aspects of the potential worker's character, assessing the candidate's emotional and psychological raison d'être. Mandy suggests the recruitment of the suitable staff member weighs heavily on the shoulders of the manager. However, Mandy takes pride in this responsibility which became more important during the national Covid-19 lockdown.

4.4.2 Covid-19 as social liminality

The pandemic created a socio-symbolic phase in the psyche of the nation and may be understood as a state of social liminality (Larson, 2014; Thomassen, 2009). Reflecting on this theme, it seemed pertinent to mention the study participants' potential socially symbolic reality as a result of the interviews being conducted during the COVID-19 pandemic and national lockdown (Billings et al., 2021; Jones, 2021). It was a challenging time for everyone who worked in health and social care. Service managers were under immense pressure to maintain operationally robust and adequately staffed services (Comas-Herrera et al., 2020; Daly, 2020; Nyashanu et al., 2020).

Winnie, a registered service manager stated:

> *…We had quite a turbulent time last year [during Covid], but we've developed quite a special staff team. For this whole pandemic, we obviously had a few people shielding, but the majority of staff turned up for work and they were here. That was quite amazing. I approached the staff team, and I was like, "Who of you would be willing to stay in this home with these guys, potentially end of life care 24/7?". The response I got was actually quite overwhelming… saying, "Yes," hands up, "we'll be there. We'll help support our guys." That was quite moving actually (Winnie).*

In this narrative Winnie refers to the 'turbulence' felt by the effects of the Covid-19 pandemic. Symbolically, the turbulence refers to the profound uncertainty experienced by Winnie and her staff teams as established norms and routines were disrupted. This turbulence led to a renegotiation of social roles and identities within HSC services (Jones, 2021). It also created a sense of shared vulnerability among communities as they navigated the challenges of the pandemic. Winnie expressed pride and appreciation in the uncertain time of the national lockdown where there was great social anxiety and fear, her effective staff put the needs of their service users before their own by continuing to attend work. She spoke using the term 'we', demonstrating that she embeds a collegiate culture within her service. Staff showing selflessness and placing the wellbeing of their service users above their own is evidence of the responsive and altruistic values discussed by Manthorpe et al. (2017). Manthorpe discussed selflessness and 'doing good' (beneficence), as part of the characteristics of effective workers. Winnie refers to the previous year as turbulent suggesting it was a time emotionally charged for her. From the tone of her

voice, I could recognise anxiety about being able to adequately staff the service and was compelled to ask the staff teams if they would stay to support their vulnerable service users, some of whom were on the end-of-life pathway. Winnie was overwhelmed by the response as she may have been expecting the team to put their own safety before the service users. This anxiety was echoed through all of the interviews which took place during the pandemic and subsequent national lockdown (Greenberg, 2020; Jones, 2021).

The resilience emanating through this liminal phase became a focus during the Covid-19 pandemic. Managers discussed how they relied on their team members resilience in order to maintain adequate staffing in their services. Generally, managers felt that it was their effective workers who exhibited this strength.

When discussing the attributes of an effective worker, Mandy stated:

> *…resilience is at the top of the list. Staff need to be resilient and consistent, resilient at this time [during Covid], working with people (Mandy).*

Mandy expressed that it can be emotionally and psychologically tiring when supporting people with chronic mental and physical illness and where staff need to develop their resilient abilities. Goleman (1996), and Holbery (2015), support Mandy's point of view asserting there are related indicators of emotional intelligence as well. Resilience, social skills, compassion, self-awareness, self-regulation, and self-control are all necessary to form a matrix for functional competency in health care delivery (Goleman, 1996). The participants of the semi-structured individual

interviews discussed the need for all of their workers to be resilient, which was apparent in Greenberg's (2020) study which reported on the mental health of frontline HSC workers during the Covid-19 pandemic. This aspect was further echoed by the participants from the two leadership focus group interviews who mentioned effective workers are resilient and proactive rather than reactive, indicating the degree of their strength of character, morals and values.

4.5 Theme 3: 21st Century compassion in health and social care

In the 21st Century, health and social care has entered a new era, with the adoption of electronic health records and robust public health programmes (Desy et al., 2017; MacManus, 2018). The collecting of data has become an integral aspect of public health programmes, allowing for improved communication between local authorities and health and social care/NHS providers about the benefits and costs connected with services to the community (NHS England, 2023; Skills for Care, 2022). The emphasis for health systems is on providing preventative services, of which the health and social care sector is central, ensuring minority groups have access to support and providing support services to those who need them. Similarly, frontline workers play a crucial role in encouraging healthy lifestyles and lobbying for improved HSC access. These practitioners deliver direct support as well as support with diet, exercise, mental health and financial issues, and are able to reach out directly to areas where access to healthcare providers or institutions may prove difficult. In recent years, health and social care services have undergone progressive changes, from increasing privatisation to ever continuing government funding cuts (Skills for Care Workforce Intelligence, 2023a). As a result, there have been

significant changes in the way people view their role within these systems. Arguably, these changes may result in feelings of insecurity, uncertainty and self-doubt among employees who may feel they are not up to date with lates technology or aware of new policies and protocols (Barrett, 2015). Herein lies the importance of social awareness and lifelong learning for frontline HSC workers. Linking 21st Century HSC practice to the transitory effect of liminality on the neophyte worker is the metamorphic stage of attaining this knowledge; professionally preparing the worker for their career in HSC.

4.5.1 Compassion and emotional intelligence

The need for compassion in health and social care services has been at the forefront of public enquiry into poor practice as a result of covert investigations in recent years (Francis, 2013). Managers discussed how today's effective workers know their service users so well that they intuitively know what they require and plan their needs accordingly. The skills of compassion and empathy become even more emphasised when the individuals being supported have impaired verbal communication skills and rely on symbolic or non-verbal communication techniques.

Jackie, an area manager who oversees several large learning disability services said:

> *…you've got to have some empathy and compassion definitely. You've got to be able to understand people (Jackie).*

From Jackie's perspective, there are multiple dimensions to communication. She implied that an effective worker understands the intricacies of non-verbal

communication, such as body language and non-verbal gestures. The authors Charmaz et al. (2019) assert that symbolic actions and gestures from behavioural interactions constitute a language equally as valid as the spoken word.

Winnie, a registered manager of mental health and learning disability services supports Jackie's statement by saying:

> *…there's a link, compassion, empathy, kindness. Responsive to somebody's needs (Winnie).*

Nathan concurred and added his perception of an effective worker.

> *…they [staff] need skills you can't necessarily quantify, like empathy, like kindness, like understanding (Nathan).*

Jackie, Winnie, and Nathan all agree there is a more delicate level of instinctive communication which they consider to be a product of empathy, kindness, and compassion. Effective workers have emotional breadth which is complex and difficult to quantify. Their perspectives were supported by McNeil (2019) who discussed the term 'emotional insight'. This is presumed to be related to compassionate practice and emotional intelligence. McNeil's (2019), philosophical standpoint suggests frontline workers providing care and support find their roles difficult as they witness the progressive physical and psychological decline of their clients without the possibility of rehabilitation. She argues that the capacity of frontline workers to recognise the positive effects of their work in doing good as a form of beneficence, which builds resilience and emotional fortitude. Compassion

and kindness were the focus of comments by managers when they were considering effective workers. Gemma, an area manager stated,

> *…what I'm looking for is caring, compassionate, empathic people… someone who is genuinely interested in society, communities, injustice. I'm often quite happy for someone who has not done this work before if I can get a feeling for that value base (Gemma).*

When recruiting frontline workers, Gemma searches for socially aware people who naturally display empathy and compassion as she senses effective workers will have a genuine interest in communities and society. In support of Gemma's perception, Day (2014), who was once the associate director of nursing at Kings College London, concluded a qualitative study that explored effective workers delivery which enhanced compassionate care in everyday practice, and this was linked to further social awareness. In agreement, Gillin (2017), discussed the concept of caring cultures and linked caring with compassionate practice. Furthermore, Holbery (2015), assumed a connection between compassion and empathy and considered them essential skills for frontline workers in nursing settings. This assumption may also be applied to any health and social care setting where there are complex or challenging situations.

Featherstone et al. (2017) suggests that frontline workers must demonstrate through their behaviour, genuine compassion towards their service users. The concept of exhibiting behaviours consistent with empathy was emphasised by Hojat et al. (2011), when considering the effect compassion and empathy have in the therapeutic relationship between a clinician and patient. One may understand how this concept applies to any professional, therapeutic relationship where the symbolic

construct of carer and cared-for is present (Scambler, 2002). Gemma further suggested that a newly recruited frontline worker can be developed to be effective and competent over time. She suggested as long as the essential value base is present in a worker, the knowledge and skills can be enhanced under the right circumstances. Ballard et al. (2018) supported this suggestion by Gemma stating that training programmes can enhance skills over time. In their study, a training programme was delivered to a group of staff and its effects monitored over time. The research showed that the service users' quality of life was improved by the delivery of a training programme focusing on compassion and person-centred care. The field notes from the focus groups further support Gemma's comments by asserting that effective staff members show empathy and understanding. They are self-motivating, have achieved the required training, can take direction, and have the confidence to undertake essential decisions.

Leaders of HSC services have a complex role that requires them to display an unconditional positive regard for the reputation of their employer-organisation and the service for which they are accountable (Smith et al., 2018). This includes the responsibility of recruiting, developing, and retaining the "right" staff. Leaders understand the importance of a workforce of caring, knowledgeable, and confident individuals (Care Quality Commission, 2021), who have the capacity to facilitate safety for adults at risk. There are national frameworks in place to support this; the 'Code of Conduct for Healthcare Support Workers and Adult Social Care Workers' (Skills for Care, 2013), is not a legal requirement but is expected to be embraced as best practice. The code outlines the standards of conduct, behaviour, and attitudes that rightly, the public and people who use health and care services may expect.

Similarly, the 6 C's framework was developed by NHS England (NHS, 2012), to support the 'Compassion in Practice' strategy for nursing, midwifery, and care, in response to the significant failings at Mid-Staffordshire NHS Trust (Francis, 2013), and Winterbourne View (Gov.Uk, 2012). It outlines the values and behaviours required from all NHS and social care customer facing staff: Care, compassion, competence, communication, courage, commitment are the key themes. The findings and discussion from this research in the following narrative are centred on behavioural expectations and perceptions of managers and their team members. The significance of staff training and professional development in the area of emotional intelligence, particularly self-awareness cannot be understated (Goleman, 1996; Ingram, 2013). Managers require frontline workers to recognise that they are part of a symbiotic team dependent on best practice, clear communication channels, and the acceptance of professional accountability.

The participants asserted that effective workers radiate naturally supportive and compassionate behaviours; they prioritise the wellbeing of their service users and their colleagues over their own. In proportion to their abilities, service users are supported to self-care and play an active role in maintaining their own health and wellbeing (McFadden et al., 2021; Scambler, 2002). An important supportive concept is one of having a consistent 'unconditional positive regard' (UPR) for service users. This psychotherapy concept was described by Rogers (1995) as,

> "…*a warm acceptance of each aspect of the clients experience,"*
>
> (Rogers, 1995, p. 209).

Rogers' (1995), focus was on the therapeutic relationship of psychotherapist and client, similarly, this concept of UPR is an important one for health and social care frontline workers, especially when supporting people with behaviours which may challenge their personal world reality psychologically or emotionally. Having an unconditional positive regard for the service user creates wellbeing through the formation of an effective therapeutic relationship (Berne, 2016) of acceptance and trust.

Nathan, an Area Manager, when discussing acceptance and the compassionate nature of effective workers said,

> *[staff]…may have been themselves hurt in the past or something or have some personal connection. People lean on one another, and that camaraderie is something you might not get in other lines of work you know. I think people come basically because they want to do right by others. The values of that group of people are unbelievable (Nathan).*

Effective workers understand the importance of encouraging their service users to maintain optimal independence and daily living skills that enhance their wellbeing. Nathan expressed that in his personal experience his most effective workers are those who have experienced difficulties in their own lives and have gained insight through these challenges. He suggested living through life challenges enables experiential learning that enhances the staff member's abilities. The establishment of a strong therapeutic relationship in which the worker understands

the abilities and limitations of the people they are supporting, treating challenges or a decline in their mental or physical health in a positively compassionate and supportive way is vital.

Nathan went on to say:

> *…it's that caring and understanding, that connection to people and some [frontline workers] come with it 'cos they have experiences, they have life experience, they have a personal connection via their own lives. Somebody who's maybe had to have support or needed support for whatever reason in their own life, whether it's mental health issues, whether it's a relationship with learning disabilities, elderly parents who have become ill, but somebody who's really got some connected empathy for people who are struggling (Nathan).*

Nathan believes that some of his frontline workers are drawn to work in health and social care because they have a symbolic personal connection through their socially constructed reality. He suggests that effective workers have a level of emotional insight brought about by previous challenging life experiences. Prus (1996) in his work relating to the intersubjectivity of human lived experience, suggests that lessons learned in life enable fuller empathy and compassion. This correlates with Nathans reality when he claimed previous life events and experiences relating in some way to health and social care provision affected workers' values positively, which he believes is admirable. Staff with a supportive demeanour make excellent HSC employees, a focus on the health and well-being of both service users and colleagues is viewed as a trait that makes them effective in their roles. He suggested that a certain type of person works in health and social

care, inferring it is a sector where there is camaraderie and team working which correlates with the creation of effective communities of practice.

Lynda echoed this perception of positive values in an effective worker…

> *…for me, a good support worker is somebody with the right values rather than the right knowledge. Somebody that's the obvious things, like somebody that's caring, somebody that's got the right outlook and wants the best for people, somebody that can empathise, somebody that's responsible as well (Lynda).*

Lynda suggested that a specific kind of person, one with the personality traits of being caring with a positive attitude, are required in order to support people in use of HSC services. Gaining qualifications can be an ongoing process, but the foundation of these personality traits was more important to her. This statement confirms that managers of HSC services seek out individuals with a positive value base when employing staff. Day (2014) and McNeil (2019) suggest wellbeing is a product of a supportive culture, hence a culture where staff support each other in line with being supported by the organisation. Crowther et al. (2013) strengthen this argument by suggesting that wellbeing is a catalyst for resilience and the ability to manage challenging situations more effectively (Crowther et al., 2013).
Field notes from the participants in the focus groups similarly suggested they perceived an effective worker to be helpful, flexible, reliable, responsive to situations and they have the ability to offer emotional support. All of which, one may say are supportive behaviours which enhance an individual’s wellbeing.

The necessity for emotional intelligence (EI), is indisputable for all staff who work in health and social care when considering the delivery of effective support (Goleman, 1996; Holbery, 2015; Ingram, 2013). This theme, along with compassion, positive values and trust permeated through the participants responses. Since the 1990s, EI has been a qualitative social construct with symbolic prowess in the fields of psychology and sociology. Goleman (1996), an internationally renowned psychologist reported when employees lack emotional intelligence, they may struggle to manage the emotional aspects of their job or personal lives. He stipulated emotional intelligence contains various components that contribute to a person's ability to self-manage in challenging and often psychologically demanding milieus.

When interviewing Lydia, a service director, she discussed what she felt were attributes of an effective health and social care worker. In agreement with the previous statement by Goleman (1996), she said:

> *…I think the workforce is quite diverse, but we do need a level of emotional intelligence across everybody [staff] that we have in our services. Those that don't have that [emotional intelligence] tend to be the staff members that experience difficulty (Lydia).*

In this statement Lydia feels that all staff irrespective of their remit require a level of emotional intelligence. This is supported by Holbery (2015), who investigated how necessary emotional intelligence is in nursing (specifically trauma nursing), due to the highly charged environment. HSC workers often find themselves in situations that are perceived as traumatic and therefore Holbery’s concept can be applied to health and social care workers. Lydia further suggests that workers who do not

possess good levels of emotional intelligence tend to experience ‘problems’ in their work environment. She inferred that working in HSC services is complex and therefore workers need to portray themselves in emotionally confident ways. Goffman (2021), in his work ‘the presentation of self in every-day life’, suggested workers find themselves trying to maintain dramaturgical discipline (projecting a positive light) and manage their emotional responses when embarking on their work. Effective workers find themselves managing their symbolic interactions which are created through the construction of their perception of the relationships with the service users and their significant others (Goffman, 2021). Maintaining composure and understanding how one is perceived by others, as Goleman (1996), agrees is an aspect of emotional intelligence, as it requires psychological agility. Ingram (2013) concurs by stating self-awareness, motivation, and empathy as facets of emotional intelligence are essential in HSC practice. Health and social care workers at all echelon benefit from the resilience and balance a proficient level of emotional intelligence enables (Bar-On, 2001; Goffman, 2021; Goleman, 1996; Ingram, 2013).

In order to maintain personal wellbeing, staff must be able to self-regulate and possess self-control which according to Goleman (1996), are akin to emotional intelligence.

Linda concurred by suggesting,

> *…staff need a level of emotional intelligence and resilience to work in services (Linda).*

In agreement, Lydia stated:

> *…staff need to be resilient when incidents and things happen. Resilience we've talked about a lot of times. You've got to have a good, resilient workforce. I've been looking for somebody with that. That's more of a quality than a skill (Lydia).*

Linda and Lydia feel that working in services can be emotionally and physically challenging for frontline workers. The fact that there is such an emphasis on resilience in itself suggests that their perception is that a frontline workers' role can be a challenging one. They suggest effective staff should have healthy levels of emotional intelligence enabling them to face the challenges which require self-regulation and self-control. In agreement, McNeil (2019) presented the link between wellbeing and resilience when incidents may happen that can be unsettling and unpredictable. Staff are therefore required to be able to deal with these situations in a positive manner which may be considered as behavioural outcomes from emotional intelligence.

Lisa, a registered service manager, described the pride that she deems essential when staff enter the service user's home…

> *…people are proud to be able to look after the home that people live in. Pride in their work and also pride in the outcomes of their work. …you can walk into some services, and you know that people [staff] are proud of being able to look after the home that people live in, and taking care of somebody's environment and their belongings, especially when you have such a high degree of control over it. Making sure that they are maintained and are looked after as well as you would your own is important and it is that pride in doing a good job (Lisa).*

Lisa perceives pride as an attribute of effective and compassionate workers. This is supported by Day (2014), who suggests staff displaying pride in their work and in the support they provide for their service users are respectful and professional in their interactions. In support of Lisa's perception Day (2014), suggests frontline workers having pride in their roles is a catalyst for thoughtful care delivery and goes hand in hand with compassion. Goleman (1996) and more recently Hasson (2014) assert that pride comes from a recognition of doing something of importance; being trusted to carry out duties creates pride in effective workers. This pride then generates engagement (Bridger, 2022). To further support this argument, the participants involved in the group interviews suggested the traits of an effective Health and Social Care worker were taking pride in what they do, being responsible, professional, motivated, and passionate. Lisa's nature is instinctive when she visits the services she oversees. She has the ability to recognise a healthy culture within a service based on contextual clues. These clues may be indicative of the care and pride employees have in their work. There are signs that frontline workers are proud of their environment, and this was reflected in the values and ethics which some participants identified as traits in effective workers.

When discussing the necessary positive attributes of effective workers Elizabeth, a Service Director stated,

> *…the right values and ethics, the pinnacle of all. Somebody who genuinely cares and who can see potential in themselves and in other people, has that 'can-do' attitude, but who is flexible and willing to learn (Elizabeth).*

Manthorpe et al. (2017) supports Elizabeth's claim that the most essential traits of effective workers are having good values and ethics. As reported by carers and service users, Manthorpe et al. (2017) listed pride, trust, and good personal ethics as some of the most important qualities of an effective care worker. Elizabeth values this above all else and asserts that an effective employee is one who genuinely cares about their role and recognises the potential in themselves, their co-workers, and their service users. According to Tronto (2010), quality care and family-centred care values are closely related to the concepts of person-centred care which are taken for granted in the family home setting. This relationship of compassion and purpose in the provision of support is what Elizabeth refers to as ‘genuine caring’.

4.5.2 Supportive nurturing

Winnie, registered manager for mental health and learning disability services went on to consider what she understands to be ‘supportive’ by saying:

> *…kind support to me is one of the highest skills that I look for in anyone that comes in [to work in health and social care services], and also empathy, and a desire to learn as well as being responsive. If you [the worker] see something, let's act upon it. If someone [the service user] doesn't have, for example, medication, you can’t just do nothing about it, you need to be responsible. As long as someone is kind, you can do a lot with that…kindness, to me, is just how I look at things.*
>
> *If someone is kind and they're particularly kind when they're being unobserved, when doing things. We have a support worker, as an*

> *example, who asked if she can come in a bit earlier tomorrow to take a service user out for coffee. She doesn't have to do that. She wants to do it because he [the service user] wants to go out for a coffee. That says a lot about the majority of staff that we have employed here (Winnie).*

Winnie suggested that kindness is a most desired skill in her effective workers. She associates kindness with empathy and hence, an effective worker will be responsive to a service user's needs. She refers to 'acting on it' meaning effective workers will respond in the appropriate way, being reciprocal in their actions to find a solution. The frontline worker in this narrative offered by Winnie has been communicating with the service user when supporting them one-one, or as Winnie suggests in the above statement, 'when being unobserved'. This effective worker may have had a conversation with the service user, and they have expressed they would like to do this particular activity. This exemplifies the acts of kindness and compassion that effective workers have with their service users and is supported by the research carried out by Addicott (2011) where effective communication is perceived as essential by the managers of care provision and is often led by the frontline workers.

Lydia concurred, expanding on this:

> *…workers have to be hardworking and effective communicators because some jobs are harder than others. They have to be the people that see something that needs doing, and do it, so they can work unsupervised. There are a lot of people working in people's homes without any management oversight. We want self-starters*

> *and be motivated. That, for me, is huge. It's right up there in the things that I'd like from people (Lydia).*

Lydia believes that effective workers are dedicated to their job as it requires initiative and self-management. She perceives the work of frontline workers as challenging. Effective workers will think ahead and carry out their duties fully, seeing each task through to the end. Lydia's statement compounded the previous suggestion by Winnie by suggesting that effective workers are the kind of people you can trust to work independently without direct supervision.

Helen, an area manager agrees with Lydia by saying:

> *…you need to be motivated because there's a lot of people, we support who need a lot of motivation especially in mental health services and if you lack motivation, I don't know how you can motivate someone else, so you need to be more, you need to be creative (Helen).*

Helen believes that effective workers will be self-motivated and also be able to motivate service users. They consider their service users' individual capabilities and provide appropriate support, enabling them to maintain their level of independence. Goleman considers self-motivation as a behavioural construct emerging from emotional intelligence (Goleman, 1996). More classical theorists such as Maslow (1943), with his theory of human motivation and Adams (2005) with his equity theory model, substantiate this consensus.

Motivation is the stimulation of goal-directed conduct. It has been observed that people with a vision have influence over their lives (Maslow, 1943). If a person lacks a vision for his or her life, he or she will be dominated by the will of others and may live a life that is not his or her own, but rather one dictated by others (Adams, 2005; Arlow, 1955; Kanfer et al., 1996; Maslow, 1943). Maslow suggested there were five degrees of employee needs. This encompassed physiological needs, safety, belonging, ego, and self-actualization. Maslow (1943) further asserted the lower-level needs of employees must be met before the next higher-level needs can be met in order to motivate and support them.

4.5.3 Functional Skills in Caring

Considering the transition to 21st Century care, managers went on to discuss some specific learning and skills they require from effective workers.

Lisa, a service manager with a large scope of responsibilities said:

> *…you do need a certain degree of maths and reading and writing in order to be able to do what we need to do. I'd expect somebody [frontline worker] to have a functional level of IT skills, and I think, especially now, it's unusual that we'd come across somebody who didn't, but they'd struggle without the ability to have some basic IT skills. (Lisa)*

The need for literacy and numeracy skills is evident in the responses from further participants. Elizabeth a service director commented:

> *…they [effective workers] have to have the right knowledge in a way that makes sense to people in practice. Things like medication management, understanding capacity, human rights, safeguarding, health, and safety, all those practical knowledge-based skill sets. I think it's very, very important (Elizabeth).*

The effective worker requires an acceptable balance of knowledge, skills and behavioural attributes in order to deliver quality care to each individual service user.

Lisa, an area manager discussed the importance of functional skills.

> *…fundamental reading and writing skills you need ability to read things and comprehend quite complex documents quite quickly, and you need to listen, you need to be attentive. You need to be a good communicator*
> *(Lisa).*

Lisa's comment above exemplifies the need for effective staff to have a proficient level of literacy and to able to understand complex documents which contain not only day to day records of the service users' activities but risk assessments, care plans and diagnostic information.

HSC workers were generally thought of as non-academic and people who may not have been able to attain a skilled job due a lack of academic achievement. This point of view is reflected and supported with research published by Community Integrated Care (2021) entitled 'Unfair to Care.' This paper presented how historically HSC workers have been perceived by the general public and the government as unqualified, unskilled workers. Within the UK socio-economic construction of work-

class, this pushes them into the low pay remuneration category (Hussein, 2017). In the 21st Century, one may argue HSC workers' professional responsibilities have evolved into complex, often semi-clinical roles as they support people with an array of mental and physical health needs after discharge from hospital or long stay institutions to be cared for in their own homes or, where appropriate, health and social care services. Social care workers find themselves working within a multidisciplinary team acting as a conduit between medical and social services, providing continuing long-term care and support (Cunningham et al., 2021).

Nursing however has been professionalised through national registration, codes of practice and degree level education accepted as standard. This study highlights the complex and challenging role that HSC workers perform every day and may support the argument for professionalisation of the sector into the future.

100% of the twenty-one participants of the study expressed profound respect and appreciation for the effective staff on their teams. Positive behaviours of pride in their work, positive personal values, and altruistic gestures were described as commonly observed characteristics of an effective worker by managers at all echelon. Managers stated that their employees did not consider themselves to be exceptional or that these positive characteristics were unusual. A number of participants explained that when they thank or give praise to staff members some reply with 'I'm just doing my job'. This is evidence of the naturally present, positive characteristics and values of an effective health and social care worker.

Linda, an experienced senior manager said:

> *…I think firstly a positive attitude and behaviour is essential within services. Quite often you know, services can be challenging, so I feel like having a positive attitude in the way that your work can really influence the people around you who you work with and where there are vulnerable adults, so being reliable and responsive is really key to being an effective worker. Also …I think when we're working with vulnerable adults on a job and although it's very rewarding you face quite challenging things every day and it's essential, I think being kind and reliable, but a responsible person who can draw upon their real-life experiences and problems to solve things (Linda).*

Linda suggested that effective workers manage challenging situations by utilising their positive behavioural attributes. Furthermore, Linda went on to propose that the positive behaviours of effective staff are then reflected by staff around them encouraging further positive behaviours. Lydia agreed with Linda and suggested that an effective worker will drive things forward to a resolution, taking responsibility for seeing things through.

> *…for me, an effective support worker is somebody that says, "I'm going to take responsibility for that, I'm going to drive it forward." They're the most important things for me when I'm looking for a good support worker (Lydia).*

Taking responsibility and being accountable for their practice is an essential part of being an effective worker in 21st Century. According to Lydia, an effective worker will understand their role and ensure that they drive tasks forward and see them through to the end. In the following quotes related to the necessity for honesty

and candour, Gillin (2017) and Dewar (2014), suggest competent staff working in HSC services must be transparent and honest in their practice. It is a facet of 21st Century compassionate care that effective workers speak up if they make a mistake or are involved in something that didn't go to plan. McSherry (2018) concurs, noting that trust and transparency are critical components of effective HSC staff and services.

Whilst being interviewed, Gemma stated:

> *… I'm very mindful that mistakes will be made, as long as you've [the worker] not done something completely ridiculous, you know, we're open, transparent, and we actually learn (Gemma).*

Gemma's comment demonstrated that she is a balanced and conscientious manager with a focus on staff development. She supports employees to reflect on situations and learn from them, hereby developing their professional practice and confidence. Gemma demonstrated here that she is a compassionate manager who recognises that it is possible for her less experienced team members to make mistakes. Her consideration has limitations, and this is when errors are not reported. The reference to the need for staff to be transparent and open symbolically refers to clarity and honesty as being traits of effective staff. Corroborated by the outcomes from the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), which uncovered and identified numerous organisational subcultures within the trust. The enquiry suggested that a proactive culture is favourable since it fosters growth

and development, as well as critically learning from key incidents, occurrences, and recognising success (McSherry, 2018).

Nathan described what he considers to be effective workers by stating:

> *…to me, effective means somebody who wants to be in work, wants to come in and do the best they can possibly do. And they will make mistakes, certainly early doors they will make mistakes, they try their best, but they'll make them, and I think you've just got to accept that as a given. They've got to let you know, you could provide them with guidance that will minimise those mistakes, do you understand what I mean? (Nathan).*

Nathan concurred with the previous quote by Gemma when he expressed that he considered a frontline workers' role to be a complex one in which mistakes are inevitable, especially at the beginning of their careers. He believes that it is a necessary aspect of becoming an effective worker. Mistakes that occur can usually be placed into three categories: latent and active and a mixture of latent and active. Active errors need to be addressed with the individual whilst latent errors indicate that changes need to occur at an organisational level, latent and active need to be addressed both at individual and organisational level (Reason, 2000). Whether it be a latent or active error or a mixture of the two that is highlighted there is a need for them to be addressed quickly to avoid harm (Traynor, 2015). At the heart of improving practice is the knowledge that the frontline worker is able to highlight 'mistakes' (Francis, 2013).

Day (2014) supports learning through practice when considering how to create compassionate frontline workers leading us back to Nathans contention. His

perception of his role, which is socially constructed based on his years of experience as a manager, is that of a supporter of employees and a facilitator of experiential learning from the mistakes frontline workers make. Kolb (2014) and Denzin (2016) assert the social relationships, experiential learning, and value-driven behaviours of frontline workers discussed in this study, are a product of their previous life experiences. Burr (2003) and Scambler (2002) support this contention which they describe as the socially-constructed self.

Helen, an Area Manager agreed by stating:

> *…if you have a good support worker, they need to be open minded and transparent. They [the worker] need to be able to try and do new things and they need to be able to face the challenges that social care has at the moment (Helen).*

It is reasonable to suggest that this quote from Helen may define her as a trusting, supportive manager who considers an effective employee to be one in whom she has faith to make independent decisions and attempt new things. She is implying those effective workers exercise initiative and experiment with new methods of work where appropriate and in the best interest of the service user. Helen is suggesting that there are challenges within services which require workers to be transparent in their practice. Effective staff will have the confidence to try new things and approach their manager for support and guidance when needed. For staff to have the courage to try new things they must feel supported and trusted to take a risk in their decision making that does not increase the likelihood of harm (McKee, Charles, Dixon-Woods, Willars, & Martin, 2013).

The enhanced awareness of oneself and others to be gained from this is that an open and transparent relationship between effective workers and their managers can support personal and professional development. Service managers are particularly proficient at recognising their employees' intentions. They are understanding and supportive of effective employees behaviour and will support effective workers when they make mistakes when their intentions are valid. Asserted by Pulsford et al. (2016) and Gillin (2017), managers require their team members to work together, supporting each other in an open and trusting way. To support this, the Care Quality Commission, regulation 20 enforces the ‘duty of candour’ (Care Quality Commission, 2022b). This regulation states that all registered health and social care services have the responsibility to provide timely and truthful information when a reportable incident occurs. CQC regulation 18 states, ‘providers must inform CQC of all incidents that affect the health, safety and welfare of people who use services. Managers therefore perceive their effective workers as those who have the confidence to communicate any incidents that may affect their service users in negative ways.

Health and social care services have a defined package of care to provide to each individual person in need of support; the details of which are written in a contract agreement. The person in receipt of the care package is a customer expecting quality delivery which meets their individual needs. The delivery of the package of care must be meaningful to the person. An effective worker will have an awareness of this. Helen, an area manager said:

> *…an effective social care worker is someone who can deliver a support package that is individualised, personalised, fulfilling to a*

> *person we are paid to support… you need to be a good communicator, be motivated and work as part of a team (Helen).*

Helen is inferring that effective workers will have knowledge of the contents of the client's care/support plan and have the ability to skilfully apply it. She is also stating effective workers understand they are part of a team and take responsibility to ensure consistency in the delivery of that care package through effective communication skills. Ballard et al. (2018), and Pulsford et al. (2016), affirm person-centred support and effective communication as a cornerstone of health and social care delivery. Not only is this a contractual requirement for individually funded care but a centrality of professional therapeutic relationships. Helen's remark contains an underlying implication that an effective worker will be able to deliver the care package in a manner that goes beyond simply performing their duties. The worker's behaviour will include symbolic, discreet interactions that enhance the client's quality of life through the care provided. Effective communication and motivation contribute to a meaningful therapeutic relationship between the frontline worker and service user.

21st Century Health and Social Care organisations offer various forms of support to individuals who may be at risk (Care Quality Commission, 2019). One of these forms of care is referred to as homecare or domiciliary care and consists primarily of attending the client's home to provide assistance with activities of daily living such as cooking, eating, taking medication, or more intimate forms of care such as supporting people with washing and dressing (Care Quality Commission, 2019; Manthorpe et al., 2017). The delivery model of domiciliary care is challenging

for many service providers due to time constraints, occasionally creating negative effects on service users and their families (McFadden et al., 2021).

Jackie expressed how important it is that staff appreciate that they are entering a person's own home rather than a workplace:

> *…you've got to have a passion to want to come into this line of work, and certainly working with learning disabilities. Some people come into this job thinking it's a care home, and it's not. It's supported living and that can be a little bit different. Our workers are going into someone's home and helping them to live their life as best they can (Jackie).*

Jackie perceives effective health and social care workers as values-driven individuals, and effective workers who feel compelled to provide person-centred holistic support, understand the importance of their job as a profession. It is a challenging role and effective workers see it as more than a job. Scambler (2002) suggests the importance of symbolic elements of trust between the person entering another's home and the person in need of support as being pivotal in the therapeutic relationship. Effective frontline workers are aware of the significance of their role and the importance this has to the client in maintaining their physical, emotional, and psychological wellbeing.

When considering the importance of the frontline workers' role and person-centred support, Nathan, area manager stated:

> *…they've [frontline workers] got to want to be there, got to want to do this job, cause you're involved in peoples' lives, and at that point, because you're involved in other peoples' lives you've got the whole unpredictability thing, people come with their own complex needs, so that person [the worker] has to have an empathy for that, and understanding… you're not clocking on, you're not stacking shelves, you're not sat counting money, what you're actually doing is being involved so you've got to key in to what the people [service users] actually want out of their day (Nathan).*

Nathan's perception is that effective workers will support their service users to get the very best out of every day. They will be self-motivated and take pride in their job, recognising the real value of their role. In the social construction of health and social care services, frontline staff play an important symbolic role in the lives of the people they support and care for. Service users perceive the staff as their support mechanism and enabler so that they may have as 'normal' a life as possible (Scambler, 2002) with the same opportunities afforded to the majority. Effective workers understand their role, that they are the catalyst which enables their service users to have a life they would not be able to have without support. Effective workers will support their service users in a holistic manner specific to their individual needs. It will be meaningful for the service user, their significant others and for the frontline worker themselves. In 21st Century, health and social care delivery has been witnessing to a cultural shift focusing on supporting people who may be at risk to live in their own homes rather than in hospital wards or social care services. Effective frontline workers understand they are attending the service users' home as opposed to service users being in their workplace.

A theme of frontline worker's positive behaviours rippled through the participant interviews; human beings generally aspire to attain happiness and joy in their life. Several study participants emphasised the significance of effective workers being a catalyst to eudaimonia in the lives of their service users, indicating that effective staff recognise the importance of happiness and purposefully initiate activities and conversations that generate laughter and joy.

Supporting clients with chronic or terminal illnesses may be emotionally and physically demanding for HCS employees; therefore, incorporating laughter and joy into their day is crucial for their self-care and wellbeing. In the study by Dewar (2014) the importance of a 'sense of humour' was linked to compassionate care delivery. Happiness and optimism are associated with participation in healthier activities, such as exercise, healthy eating, socialising, and good sleeping habits (Sin et al., 2015). Daily positive experiences run parallel with better physical, mental, and emotional health and resilience to facing challenges as they present (Sin & Almeida, 2018).

Philosophers have pondered the existence of happiness for millennia, and it was Aristotle who once postulated,

"…happiness is the meaning and purpose of life, the whole aim, and the end of human existence."

(Annas & Wang, 1989, p. 157).

Aristotle coined the term eudaimonia which simply means happiness. The word can be slightly expanded to mean human flourishing, sometimes wellness from

the original ancient Greek. The concept of Eudaimonia is derived from Aristotle's Nicomachean Ethics, his 'science of happiness' (Charmaz et al., 2019).

Mandy, a service manager made a direct link to the importance of facilitating happiness and laughter in her service user's lives. She suggested it being important for staff to enjoy their work and create a fun and happy atmosphere:

> *…Fun! Just enjoy work, enjoy work, or find an opportunity to have fun at work, because if you're smiling, all the people smile, if you're enjoying work other people enjoy work alongside you, it's sharing those experiences with your colleagues for the experiences of other people (Mandy).*

Mandy felt the value of positivity and laughter within the culture of a team was important for the happiness of service users. She was inferring that supporting people with chronic illnesses can be challenging for both service users and frontline workers alike. Having a sense of joy alleviates the ennui that can naturally occur. Effective frontline workers will try to find positives in their daily work and in the lives of their service users. They will intentionally be upbeat and try to make their service users laugh and find pieces of joy in their day.

Nathan agrees with Mandy by saying,

> *…if you want, you [the worker], can come in and do it [work with clients] by the numbers and go home, that doesn't make you effective, it just makes you clinically effective. Or you can come in*

> *and make somebody you support and who may be having a bad day, feel a million dollars, want to do stuff, be happy (Nathan).*

Nathan expressed that there are frontline workers who come to work to 'just do a job', rather than actively feeling positive, engaged, and wanting to be there for the beneficence of the service users. He felt that an effective worker is one who knowingly understands that their job is not to just support their clients with the functional, daily routines but to understand they have a deeper meaning and role to carry out which is to support their clients to enjoy their lives and be as autonomous as possible. Enabling the service user they work with to have a happy day and create joyful activities wherever possible. Effective workers will be aware of their influence on the emotional state of the service users they support and try to make the best of every interaction.

Participants in the focus group interviews also mentioned the need for an effective worker to be 'good fun', to have a sense of humour and to be 'funny, caring and open to learning'. The need to create a positive interaction and therapeutic relationship with service users is echoed through all the participants' responses to the research question.

Gemma, Area Manager concurs with the previous assertion by saying:

> *…come to work with a smile, positive, upbeat…it's a sense of humour, a behaviour. You know, some of the situations people find themselves in, the best way out of them sometimes is a good sense of humour, and really good interpersonal skills with somebody. What other kinds of skills? A good team worker, 'cos we attract people*

> *from all kinds of communities. It's about being adaptable for the people we support; work differently with some people, and the same goes for your team workers you need to be different depending on who you're working with (Gemma).*

The notion of alleviating sometimes difficult situations with a sense of humour and seeing the lighter side of 'situations people find themselves in', was a theme which ran through several of the participants responses. Gemma felt that effective staff were creative, proactive, and aware of the impact they had within the team. They had the compassion and emotional intelligence to demonstrate transformative behaviours which can reconstruct a potentially negative situation into a positive one.

4.6 Conclusion

In this chapter I presented the findings and discussion from the semi-structured interviews, focus group interviews and field notes conducted with managers of health and social care services. The study's aim, 'managers perspectives of an effective health and social care worker', has been explored. One may suggest that the word 'effective' has different meanings depending on the individual's life-world reality as it is a subjective term however, in the context of this ethnographic study, effective means that the frontline worker's functional behaviour and skills are applied in a thoughtful, emotionally intelligent way that enables full accountability and engagement, supporting the service user's full capabilities. Through the analysis of the interview narratives, three key themes evolved from the study, namely, cultural communities of practice (CoP's), individual and organisational liminality, and 21st century compassion in health care delivery.

This study demonstrates that health and social care frontline workers are highly regarded by their managers as professionals and as individuals. Workers may be drawn to this vocation as a result of their lived experiences and symbolically embedded values (Banks, 2012; Skills for Care, 2021). It became apparent through the findings that effective frontline workers shared a realistic view of caring and compassion, they viewed the organisation as 'living' and evolving within liminal communities of practice. Prus (1996) and Burr (2003) suggest this is a product of their socially constructed personal social interactions, resulting in an innate magnetism to supporting and providing care for people considered to be at risk or in need.

Communities of practice, it could be said, naturally evolve from effective workers symbolic interactions in the social care setting. These CoPs are liminal phenomena which create metamorphic learning and development opportunities resulting in improved quality support for the people who access services. In the 21st Century, all health and social care workers' learning experiences must be led with compassionate, holistic practice at the centre of their behaviour. On a service level this is brought about through the behaviours of effective frontline workers, creating cultures of effective communication and continual, shared learning to enhance the lives of their service users. One may suggest this culture of experiential learning begins through the metamorphic, liminal experience of integrating staff members into the organisational culture.

Liminality is present in the experience of individual workers, teams and the 'living organisation'. It is a state in which metamorphic processes happen spontaneously, which led to the discussion on 21st century healthcare and

compassion in caring; essential for the transformative, person-centred healthcare required in contemporary practice.

Chapter 5: CONCLUSION

5.1 Introduction

Chapter 5 begins with an explanation of the personal impact of my doctoral journey of discovery. I then discuss the strengths and limitations of the study, the uniqueness of my findings and the conclusion to my study.

5.2 Personal and professional impact of my doctoral journey

The pursuit of this doctoral degree involved extensive scholarly research and academic study. I recall being informed by several of my academic colleagues that this doctoral journey would change me personally and professionally. I did not fully appreciate how true that was. Fostering both personal growth and professional development, the process of performing independent research, analysing data, and synthesising findings has cultivated my aptitude for critical thinking, problem-solving skills and intellectual creativity (Fulton et al., 2013).

For as long as I can remember I perceived the world around me a as a continual stream of symbolic interactions and connectedness (Belgrave & Charmaz, 2021; Charmaz et al., 2019). Growing up with metaphysics as the foundation of my understanding of the world, a humanistic approach to how I interacted with others came naturally.

Strangely it became apparent, and academically humbling, that the more one learns, the more one realises how much there is to learn. My philosophical understanding illuminated, re-shaping my professional identity and enhancing my role as a critically reflective practitioner and novice researcher. The additional social

anxiety of the Covid-19 pandemic was a surprising and unexpected companion throughout the interviews and data gathering processes of my thesis. This led to adapting and reconsidering my planned research methods, reflexivity and positionality.

5.3 Strengths and limitations of the study

Inherently present in all forms of research are limitations and strengths (Reeves et al., 2013). Ethnographic research is a form of qualitative research that entails the extended study of a particular group or culture. It is subjective and requires observing and interacting with group members in relation to their natural environment to obtain a comprehensive understanding of their culture, beliefs, and practices (Davies, 2012; Hammersley & Atkinson, 2019). Ethnography is iterative and unfolds as the data is collected and key themes emerge. Within this doctoral research study, as in all others, there are potential strengths and weaknesses.

5.3.1 Strengths

All individual participants were experienced senior managers of health and social care services and thus, their perspectives of what they consider to be the attributes of effective frontline workers emerged from their years of experiential learning, are robust and valid. Their individual points of view were strengthened by the data outcomes from the two focus group interviews, field notes and individual semi-structured interviews.

The data gathered was rich and detailed and provided a profound understanding of the professional lives and culture of frontline workers from the

perspectives of their leaders. The interview process permitted the accumulation of information on various aspects of HSC managers beliefs, customs, rituals, culture and socially symbolic interactions (Burr, 2003).

Conducting both individual interviews and focus group interviews complimented by my field notes enabled triangulation between the data sources, strengthening the trustworthiness of findings. Focus groups offered complementary data grounded in collective understanding. The ethnographic approach facilitated a holistic cultural lens, unveiling how broader organisational and social dynamics shape managers' understandings of effectiveness. The study fills a research gap by offering managers a voice relevant to their perspective of effectiveness.

A further strength was the flexible ethnographic methodology which enabled me, as a researcher to adapt to the changeable requirements of the pandemic and data collection. It enabled me, where appropriate to investigate issues that were not initially considered, such as liminality and developing a professional identity, leading to unique findings relevant to anthropological and sociological perspectives. I chose ethnography as the most appropriate method, guided by the epistemological and ontological stances to best answer my research question (Nha, 2021).

5.3.2 Limitations

The fact that all of the participants were managers from the same organisation may have limited the cultural aspects of the study. All participants were white British and only one was male; therefore, they did not accurately represent the health and social care workforce, which is statistically, approximately 80% people who define

themselves as female and 20% define themselves as male (Skills for Care Workforce Intelligence, 2023a).

My interpretation of the data was perhaps influenced by my own cultural heritage, beliefs, and biases. This subjectivity was managed by embedding reflexivity into every aspect of the data collection, data analysis and interview process. However, as the research process and analysis were driven by myself, there is no option but to conclude there may be some bias present, however minimal. I accept that no research is bias free.

The research participant sample size of 21, while substantial for an ethnographic study remains a small sample and may not be representative of the larger population. This makes it challenging to generalise the results to a larger context (Davies, 2012; Hammersley & Atkinson, 2019).

The participant interviews were carried out using Zoom® during the national pandemic lockdown and this may have perhaps affected the more subtle communication facets of ethnographic interaction (Howlett, 2022; Podjed, 2021). To combat this, intentional triangulation (Hussein, 2009), was utilised throughout the text analysis by strengthening the findings with key themes which emerged from the focus group and individual interviews and field notes.

In conclusion, ethnographic research was used in this interpretive study with the intention to generate rich and detailed data, facilitating a profound comprehension of the social context of the research question (Hammersley & Atkinson, 2019). The data was gathered through ethnographic interviews and focus groups, enabling an exploration of the insider's perspective on the social world (Coffey, 1999; Reeves et al., 2013). Ethnography has offered validity because it

provides an in-depth understanding of the social context and permits the validation of findings through the use of multiple data sources and perspectives (Hammersley & Atkinson, 2019). There was an empathetic and reflexive approach, fostering a deeper understanding of the social context and mitigation of potential biases.

5.4 Uniqueness of findings.

The title of this study and its subject matter are unique. I anticipate this study will enhance recognition by the general public, government and commissioning bodies of the remarkable and complex role that HSC service managers and their staff play on a daily basis. To my knowledge, no other study has systematically compiled and investigated managers' specific perceptions of the functional attributes that health and social care employees must possess in order to be successful in their professional roles.

The national competency frameworks for HSC workers are defined within qualification standards (Skills for Care, 2021). The standards are divided in to ‘core’ skills i.e., those skills that are needed in all aspects of care delivery, and ‘optional’ knowledge; standards which are related to a particular type of service or provision such as older people, mental health, or a learning disability service.

Managers who work in daily contact with staff teams and, in turn experience the complex dynamics between individual team members and the people they support may identify specific aspects to a role that had not been considered when developing standards for qualifications and minimum care requirements by lead bodies/ external agencies.

Managers of health and social care frontline workers have a unique, qualitative perception of the practicalities and applied skills that staff must have in order to be effective workers. In comparison to their counterparts in the NHS, the members of this extraordinary workforce in my opinion, are generally undervalued and underpaid.

This study revealed that within the social construct of health and social care, managers perspectives of an effective health and social care worker are constant between all managers of all service types. The research question was answered through targeted recruitment of current health and social care service managers leading to the use of ethnographic, semi-structured interviews, focus group interviews and field notes. One of the main priorities for all managers of health and social care services is to recruit individuals who are inherently compassionate, emotionally intelligent, and willing to learn and develop. All other facets of the role depend on these core behavioural characteristics.

Positive behavioural displays are the shared symbolic language embedded throughout frontline workers interactions, thus creating team and service culture (Hammersley & Atkinson, 2019). As Charmaz et al. (2019) postulate, culture is initiated through behavioural expressions, hence, the worker’s professional identity is constructed through interactions within cultural communities of practice. Communities of Practice are present in all services at all levels and are the catalyst for delivering optimum quality of care for service users through effective communication and sharing of best practice.

Examining how social and cultural factors, such as professional norms (Bragd et al., 2008), influence managers' perceptions of effective employees was

conducted using social constructionism (Burr, 2003). Managers' perceptions of effective workers are influenced by the behaviour of their employees, as well as the symbolic meanings attached to various forms of behaviour and performance which afford further understanding of an effective worker (Mead, 1934; Strauss, 1978). A lens of symbolic interactionism was utilised (Blumer, 1962), by combining these two complimentary theoretical frameworks, a sophisticated and nuanced understanding of how managers' perceptions of their effective health and social care workers are constructed and maintained via social interactions and symbolic meanings was developed (Berger & Luckman, 1967; Denzin, 2016). This method assisted in identifying patterns and key themes in managers' perceptions which may contribute to the development of strategies to enhance the quality of care provided by employees in the health and social care sector (Blumer, 1962; Burr, 2003).

The Department for Health and Social Care (DHSC) are currently consulting with health and social care organisations to develop a standardised, mandatory care workforce educational pathway for adult social care (Gov.uk, 2023). The introduction of this learning pathway for all HSC staff may begin to add rigour to the training and development processes for staff entering the field for the first time. It may also be the much-required step towards professionalising the HSC sector.

There is increased emphasis on the need for nationally recognised qualifications for HSC frontline workers and although minimum standards for practice are enforced via the inspection requirements of the Care Quality Commission. Currently these qualifications are described as ‘required’, and are not legally enforceable. The Care Quality Commission make them an essential requirement in regulation 19 (section 1 (b)): by stating that persons employed ‘must have the

qualifications, competence, and skills necessary for the work to be performed by them' (Care Quality Commission, 2021). This remains subjective, leaving ambiguity for services to misinterpret the requirements.

5.5 Conclusion

It is anticipated that the findings of this study will inform the general public, health and social care governing bodies, and government agencies about the high levels of knowledge, professional education, and skills possessed by the HSC workforce. When developing commissioning and funding frameworks, I trust that the highlighted perceptions and expectations of these dedicated professionals are considered by the key stakeholders. I aim to disseminate the findings through publications and presentations and presenting at local and international conferences.

These extraordinary professionals support some of the most vulnerable members of our society with dignity, professionalism, and compassion, enabling the disadvantaged to live a life with the opportunities we would all desire for ourselves.

Chapter 6: RECOMMENDATIONS

6.1 Introduction

Learning is embedded in all aspects of practice for health and social care frontline workers. As a transformative process, learning encourages re-evaluation of one's professional identity (Meyerhoff & Strycharz, 2013; Wenger, 2011). The outcomes from this study suggest that health and social care organisations may benefit both culturally and operationally by embracing the following concepts.

6.2 Developing a professional identity within a Community of Practice.

Communities of Practice are spaces of liminality where information sharing between participants ignites the learning process, enabling transformative personal and professional development (Meyerhoff & Strycharz, 2013; Wenger, 2011). To maximise learning and professional growth it is imperative for frontline workers to develop a strong professional identity will which encompasses their personal definition of responsibilities of their role and behavioural expectations. Communities of Practice may be utilised to define how the worker understands their role and the effect they wish to have on the organisational objectives, the service in which they work and the people they will support. Newly recruited workers must understand the meaning of learning within their professional roles, hereby cultivating their professional identity (Day, 2014; Hannum, 2011).

During induction and hence, the probationary period, when the neophyte HSC frontline worker is in the liminal, learning, and transformative stage of their career, it may be beneficial to focus on their psychological safety. Enabling frontline workers to

explore their social perceptions of this passage in their life and supporting the unpredictability of this metamorphic endeavour may build professional confidence. One may suggest that creating a safe space for effective workers, where they feel comfortable with transformational change is essential for their personal wellbeing and professional growth (Scott et al., 2017).

6.3 Educational drive towards enhancing staff self-actualisation.

Health and social care services would benefit from implementing coaching programmes for self-awareness, self-actualisation and emotional intelligence for all staff entering the health and social care workforce. Typically, these self-analysis courses are recommended for those in higher-level positions, however I propose they are incorporated into induction programmes from the very first day of employment. This may be accomplished by implementing management training programmes which include the necessary skills and knowledge obtained in coaching training programmes.

The everyday negotiation and management of complex situations by frontline workers necessitates elevated levels of social and self-awareness, emotional agility and positive personal attributes (Hasson, 2014; Holbery, 2015; Ingram, 2013). I therefore propose that frontline workers with a keen sense of self, including understanding their professional identity also benefit from enhancing their emotional intelligence (Goleman, 1996; Hasson, 2014).

6.4 Nurturing organisational culture

Organisational culture is developed, implemented, and nurtured through effective frontline workers symbolic interactions and by viewing the organisation as an ‘alive’ cooperative (Charmaz et al., 2019; Utzumi et al., 2018). Frontline workers should have the ability to control their emotional responses and behave in a professional, accountable manner when involved in often challenging situations (Ballard et al., 2018; Nyashanu et al., 2020). This requires establishing an emotionally knowledgeable and well-balanced understanding of the professional, cultural environment and the workers impact on it (Skills for Care, 2022).

Facilitating a positive culture within service users' homes may be enhanced by frontline workers understanding the importance of bringing spontaneity into their client's lives. Eudaemonia (Annas & Wang, 1989), is an often-overlooked facet of effective support. It is vital that, where appropriate, workers seek opportunities to bring happiness and laughter into service users lives through enjoyable activities and opportunities where possible.

In light of the Covid-19 pandemic, the resilience of the workforce has been given significant importance (McMahon, 2021). Frontline HSC and NHS employees were required to continue working in order to support their vulnerable service users. The commitment and tenacity of these employees, who were potentially jeopardising their own well-being, would not have been possible without high levels of risk tolerance, hence, personal resilience. The resilience which comes from personal wellbeing requires HSC organisations to accept the responsibility to invest in the wellbeing of the people they employ.

6.5 Summary

This chapter has identified the recommendations from my research findings. Recommendations for health and social care organisations include enabling staff to cultivate a professional identity within a community of practice, understanding liminality as a metamorphic process where the introduction of self-awareness and emotional intelligence programmes for all levels of workers, will assist in nurturing a positive organisational culture.

The behaviour of effective social care workers transcends the job title, uniform, or qualifications. It taps into our shared humanity and dignity. When a care worker comforts an anxious service user, a social worker advocates for a person unable to make their own choices, or a volunteer keeps loneliness at bay, they remind us of our bonds as people.

The social care professional who truly transforms lives does so by unveiling the humanity in others while recognising their own. Their effectiveness stems from the wholehearted commitment to care, to learn and to connect with others within a spirit of altruism.

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APPENDICES

Appendix 1 *Initial Recruitment Flyer*

Appendix 2 *Research Background Information Sheet*

[redacted] R J Kendall-Corry [redacted]

Would you like to help improve services for vulnerable adults?

Invitation to take part in a research project

'An ethnographic study: Managers' perspectives of what constitutes an effective health and social care worker in the independent sector'

What is the research about?

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The aim of the study is to explore what managers may perceive to be an 'effective' or 'good' health and social care (HSC) worker. This study is important as it may help the HSC workforce in identifying acceptable levels of knowledge, skills and behaviours into the future and this information may also be used for further study and frameworks which will enhance and improve the lives of vulnerable adults. Once completed a written report will be produced at the end of the project for the purpose of sharing the outcome of the research. The findings from the study will be used to enhance the lives of vulnerable people.

[redacted] R J Kendall-Corry [redacted]

Why have I been chosen?

You have been chosen to participate in this research as an experienced practitioner within health and social care services who manages and supports staff. Your perspective on what constitutes an effective HSC worker is valuable and potentially will help to improve the lives of vulnerable adults.

What will happen to me if I take part?

On expressing an interest in taking part in the study you will be contacted by the researcher (Ray Kendall-Corry), in order to discuss your possible participation in the study; the researcher will ask you a few simple questions about your experience, in order to confirm your eligibility to participate in the study. If eligible you will then be formally invited to participate in the study.

Participation in the study involves an interview lasting no longer than 1 hour where you will be asked about your professional opinion on what constitutes a good, or effective health and HSC worker. This interview will be arranged at a mutually convenient time, and will be held at Creative Support Head Office. Wellington House. 131 Wellington Road. Stockport SK1 3TS. If this venue is not convenient for you then another venue of your choice can be arranged. Before the interview starts you will be asked to sign a consent form that gives the researcher permission to conduct and record the interview.

All interviews completed as part of the research will be audio recorded. These recordings will be stored securely and encrypted, and no access to the audio files will be permitted to anyone other than the researcher. The recordings will be transcribed and all references to place and names will be removed. Completed transcripts may be shared with the researcher's supervisory team. Anonymised quotations from the interviews may be published in various research reports.

It is possible that you may welcome the opportunity to share and discuss your views and experiences with the researcher. However, by taking part, you will be contributing to improving the lives of vulnerable adults.

We are unable to offer reimbursement for expenses incurred during your participation within this project.

What will happen to the results of the research study?

The results will be written up into a report for the funders of the research. It is hoped that the findings may be used to improve the service provided at the Heart Centre. Individuals who participate will not be identified in any subsequent report or publication.

Who may I contact for further information?

If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

Raymond Kendall-Corry, [redacted]

University of Chester – email: [redacted]

Thank you for your interest in this research.

Appendix 3 *Participant Information Sheet (PIS)*

[redacted]
Ray Kendall-Corry student [redacted]
[redacted]

University of Chester

Participant information sheet

An ethnographic study: Managers perspectives of what constitutes an effective health and social care worker in the independent sector.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
The aim of the study is to explore what managers may perceive to be an 'effective' or 'good' health and social care (HSC) worker. This study is important as it may help the HSC workforce in identifying acceptable levels of knowledge, skills and behaviours into the future and this information may also be used for further study and frameworks which will enhance and improve the lives of staff and vulnerable adults. Once completed a written report will be produced at the end of the project for the purpose of sharing the outcome of the research. The findings from the study will be used to enhance the lives of vulnerable people.

Why have I been chosen?
You have been chosen to participate in this research as an experienced practitioner within health and social care services who manages and supports staff. Your perspective on what constitutes an effective HSC worker is valuable and potentially will help to improve the lives of staff and vulnerable adults.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of service you receive in any way. You may also ask for any data gathered through your interview to be removed from the study up to 2 weeks prior to data analysis. Data analysis is planned to start on September 14th 2020 so you have the option to withdraw any data up to 1st September 2020.

What will happen to me if I take part?
On expressing an interest in taking part in the study you will be contacted by the researcher (Ray Kendall-Corry), in order to discuss your possible participation in the study; the researcher will ask you a few simple questions about your experience, in order to confirm your eligibility to participate in the study. If eligible you will then be formally invited to participate in the study.

There are 2 types of possible involvement in this study:

1. The main form of participation involves a recorded interview lasting no longer than 1 hour where you will be asked about your professional opinion on what constitutes a good, or effective health and HSC worker. This interview will be

[redacted]
Ray Kendall-Corry student [redacted]
[redacted]

University of Chester

arranged at a mutually convenient time, and will be held at Creative Support Head Office. Wellington House. 131 Wellington Road. Stockport SK1 3TS. If this venue is not convenient for you then another venue of your choice can be arranged. We may also carry out the interview via on online webinar which will be recorded. Before the interview starts you will be asked to sign a consent form that gives the researcher permission to conduct and record the interview.

2. The second way you may be asked to participate in this study will be as part of a group activity where yours and the views of other managers may be discussed and notes taken on what you feel constitutes an effective health and social care worker in your services. If you do wish to take part in this form of involvement you will be asked to sign a consent form which explains that notes will be taken but there will be no personally identifiable information. It is completely your choice to take part and you will have the opportunity to withdraw any data provided by you up to 2 weeks prior to the data collection. Data analysis is planned to start on September 14th 2020 so you have the option to withdraw any data up to 1st September 2020.

All interviews completed as part of the research will be audio recorded. These recordings will be stored securely and encrypted, and no access to the audio files will be permitted to anyone other than the researcher. The recordings will be transcribed and all references to place and names will be removed. Completed transcripts may be shared with the researcher's supervisory team. Anonymised quotations from the interviews may be published in various research reports.

What are the possible disadvantages and risks of taking part?
There are no disadvantages or risks foreseen in taking part in the study although if participants discuss whistleblowing or safeguarding issues these will be escalated following the Creative Support whistleblowing and safeguarding policies as a guide. The researcher will support you with any such issues.

What are the possible benefits of taking part?
It is possible that you may welcome the opportunity to share and discuss your views and experiences with the researcher. However, by taking part, you will be contributing to improving the lives of vulnerable adults.

We are unable to offer reimbursement for expenses incurred during your participation within this project.

What if something goes wrong?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact: Professor Angela Simpson, Executive Dean, Faculty of Health and Social Care, University of Chester, Riverside Campus, Castle Drive, Chester, Cheshire, CH1 1SL. Tel: [redacted] Email: [redacted]

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence (but not otherwise), then you may have grounds for legal action, but you may have to pay for this.

Will my taking part in the study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential so that only the researcher carrying out the research will have access to such information.

University of Chester

What will happen to the results of the research study?
The results will be written up into a thesis which will be published and available to the wider health and social care sector.

Who is organising and funding the research?
The research is funded personally by the researcher and supported by Creative Support Ltd.

Who may I contact for further information?
If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

Ray Kendall-Corry, student[redacted]
University of Chester – e[redacted]Office number 0161 238
[redacted]

Thank you for your interest in this research.

Appendix 4 *Research Questions Information Sheet*

University of Chester

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Research questions

An Ethnographic Study: Managers Perspectives of What Constitutes an Effective Health and Social Care Worker in the Independent Sector

Thank you for offering to take part in this research study. The interview will last no more than one hour, (expected to be from 30 – 45 minutes).

Before the interview begins you will be asked to sign a consent form for the interview to be recorded. The interview is not a test of any kind, and there will be absolutely no judgement on your answers from the researcher. This stage of the research is purely to gather information and data.
The researcher will be taking notes during the interview. This is so that the maximum amount of data can be gathered and to ensure the most effective use of the time.

The safety of your data

After the interview, the audio/visual recording will be transferred using encryption software to the researcher's laptop. The laptop has two layer encryption and has two levels of password protection. There is the minimum amount of risk possible to anyone other than the researcher seeing or hearing the information gathered about you.

The interview questions

1. What do you think makes an effective Health and Social Care worker?
2. Why do you think people work in health and social care?
3. What skills does a worker need in order to be 'effective'?
4. What behaviours do you expect to see in an effective worker?
5. What knowledge do you expect a staff member to have in order for them to be effective?

You are also encouraged to offer any information you feel is important to the research questions.

If you have any questions please contact Ray Kendall-Corry who is the researcher on [redacted] or on [redacted].

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact: Professor Angela Simpson, Executive Dean, Faculty of Health and Social Care, University of Chester, Riverside Campus, Castle Drive, Chester, Cheshire, CH1 1SL. Tel: [redacted] Email: [redacted]

Thank you for taking part in this study.

Appendix 5 *Consent Form for Individual Interview Example*

[redacted] Consent form
R J Kendall-Corry [redacted]

University of Chester

CONSENT FORM – Individual participation in recorded interview

Title of Project: **An ethnographic study of managers' perspectives of what constitutes an effective health and social care worker in the independent sector**

Name of Researcher: Raymond J Kendall-Corry student 1719683

Please initial box

1. I confirm that I have read the information sheet dated 31.01.20 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. LP
2. I understand that my participation is voluntary and that I am free to withdraw up to 2 weeks before data analysis without giving any reason, without my medical care or legal rights being affected. LP
3. I understand that should dangerous/poor practice be identified, that the researcher is professionally obligated to escalate this concern in line with organisational policy. LP
4. I understand that the information I provide may be used in the production of reports/ publications. However, that all personally identifiable data will be removed. LP
5. I understand that data analysis is planned to start on September 14th 2020 and that I have the option to withdraw any of my interview/ collected data up to 1st September 2020. LP
6. I agree to take part in the above study. LP

[redacted] 11/08/2020 [redacted]

Name of Participant | Date | Signature

RJKendall-Corry [redacted]

Name of Person | Date 11/08/2020 | Signature

Appendix 6 *Letter of Permission from HR Director to Carry out Research*

[redacted]

creative SUPPORT

[redacted]

[redacted]

4th November 2019

To whom this may concern

This letter confirms that I give my permission as the Director of Human Resources of Creative Support Ltd for Raymond J Kendall-Corry to request voluntary participation in his research study for the Doctor of Professional Studies, Health and Social Care.
He may use Head Office meeting rooms in order to carry out the interviews and has the support of myself and the Executive Team.

Kind Regards

[redacted]

[redacted]

Appendix 7 *Ethics Committee Approval to Conduct Interviews Digitally*

AF/mr

12 April 2020

Ray Kendall-Corry
[redacted]

[redacted]

Dear Ray

FH&SC Ethics Number: RESC0120-1023
Course of Study: Professional Doctorate in Health and Social Care
Supervisor:
Student Number: [redacted]

I am pleased to inform you that your request to conduct your interviews online for your project ***"An Ethnographic Study: Managers' Perspectives of what constitutes an effective health and social care worker in the independent sector"*** was approved.

If you have any questions or require any further assistance please contact hscethics@chester.ac.uk.

Yours sincerely

[redacted]

[redacted]

cc Research Knowledge Transfer Office
cc Academic Supervisor

Appendix 8 *Ethics Approval Confirmation Letter*

AF/mr

10 March 2020

University of Chester

Marriss House

Faculty of Health and Social Care
University of Chester Wirral Campus
Marriss House
Hamilton Street
Birkenhead
Wirral
CH41 5AL
Tel 01925 53 4067
FHSCwirralreception@chester.ac.uk

Ray Kendall-Corry
[redacted]

Dear Ray

Ethical Approval Granted

FH&SC Ethics Number: RESC0120-1023
Course of Study: Professional Doctorate in Health and Social Care
Supervisor: [redacted]
Student Number:

I am pleased to inform you that the Research Ethics Sub Committee of the Faculty of Health and Social Care approved your project ***"An Ethnographic Study: Managers' Perspectives of what constitutes an effective health and social care worker in the third sector"*** on 10 March 2020.

Approval is subject to the above and following conditions:

1. That you provide a brief report for the sub-committee on the completion of your project.
2. That you inform the sub-committee of any substantive changes to the project.

We approve your application to go forward to the next stage of the approval process. For studies taking place in the NHS, Trust permission must be obtained before data collection can commence. If you are applying to IRAS and require a sponsorship letter and insurance documentation please contact Barbara Holliday.

If you have any questions or require any further assistance please contact Barbara Holliday on [redacted] or by email hscethics@chester.ac.uk.

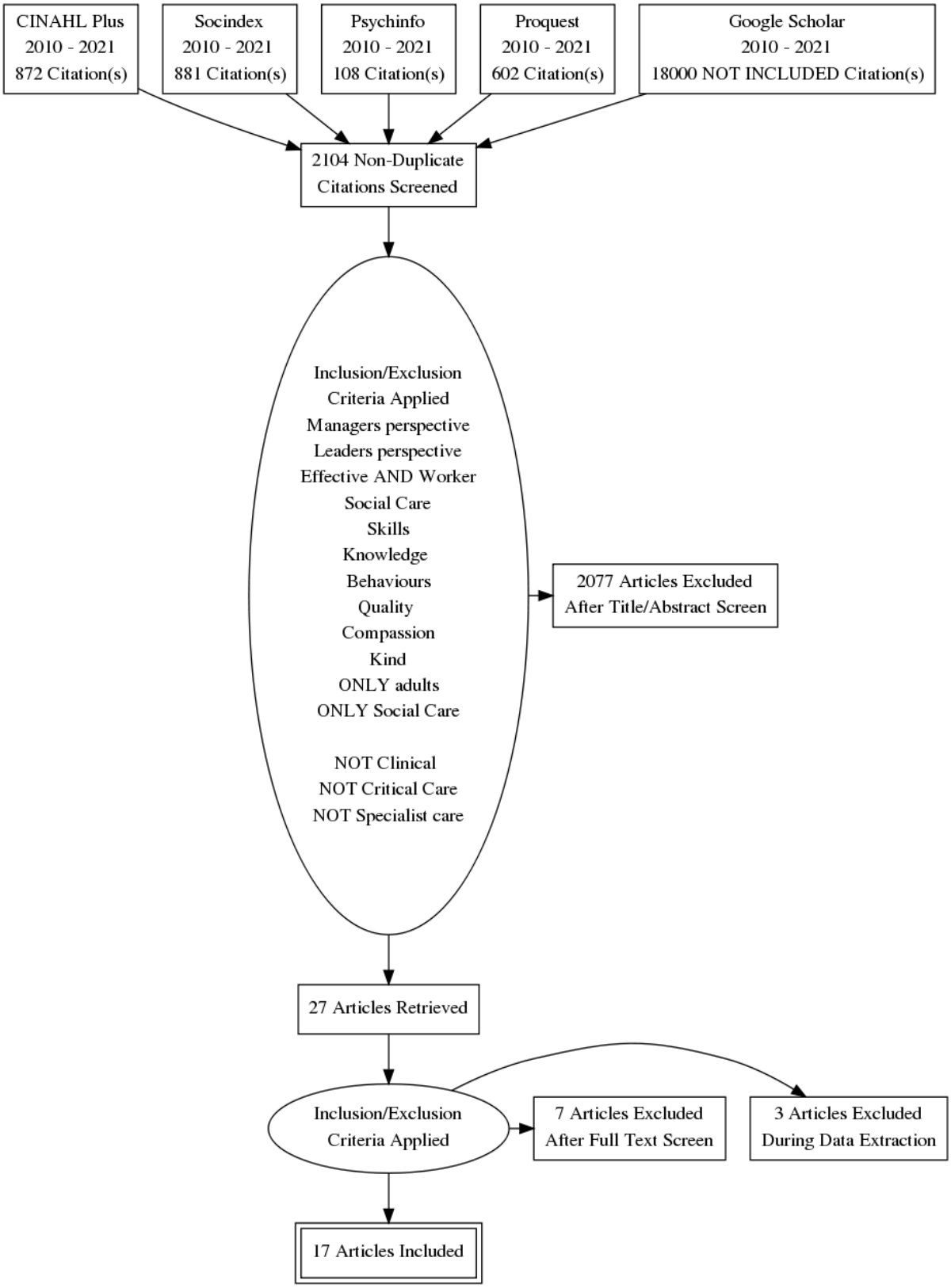
Yours sincerely

[redacted]

Prof. Alan Finnegan
Chair, Faculty Research Ethics Sub-Committee

cc Research Knowledge Transfer Office
cc Academic Supervisor

Appendix 9 *PRISMA Diagram for Literature Search Criteria*



Appendix 10 *Benton & Cormack's Critical Analysis Tool for Literature Review*

Heading	**Questions to be asked**
Title	Is the title concise? Is the title informative? Does the title clearly indicate the content? Does the title clearly indicate the research approach used?
Author(s)	Does the author(s) have appropriate academic qualifications? Does the author(s) have appropriate professional qualification and experience?
Abstract	Is there an abstract included? Does the abstract identify the research problem? Does the abstract state the hypotheses (if appropriate)? Does the abstract outline the methodology? Does the abstract give details of the sample subjects? Does the abstract report major findings?
Introduction	Is the problem clearly identified? Is a rationale for the study stated? Are limitations of the study clearly stated?
Literature review	Is the literature review up to date? Does the literature review identify the underlying theoretical framework(s)?

	Does the literature review present a balanced evaluation of material both supporting and challenging the position being proposed? Does the literature review identify the need for the research proposed? Are important references omitted?
The hypothesis	Does the study use an experimental approach? Is the hypothesis capable of testing? Is the hypothesis unambiguous?
Operational definitions	Are all terms used in the research question/problem clearly defined?
Methodology	Does the methodology section clearly state the research approach used? Is the method appropriate to the research problem? Are strengths and weaknesses of the chosen approach stated?
Subjects	Are the subjects clearly identified? Who are they?
Sample selection	Is the sample selection approach congruent with the method to be used? Is the approach to sample selection clearly stated? Is the sample size clearly stated?

Data collection and quality assurance	Are any data collection procedures adequately described? Have the validity and reliability of any instruments or questionnaires been clearly stated?
Ethical considerations	If the study involves human subjects has the study received ethics committee approval? Is informed consent sought? Is confidentiality assured? Is anonymity guaranteed?
Results	Are results clearly presented? Are results internally consistent? Is sufficient detail given to enable the reader to judge how much confidence can be placed in the findings?
Data analysis	Is the approach appropriate to the type of data collected? Is any statistical analysis correctly performed? Is there sufficient analysis to determine whether 'significant differences' are not attributable to variation in other relevant variables? Is complete information (test value, degrees of freedom and probability) reported?
Discussion	Is the discussion balanced? Does the discussion draw upon previous research? Are the weaknesses of the study acknowledged? Are clinical implications discussed?
Conclusion	Are conclusions supported by the results obtained?

	Are the implications of the study identified?
Recommendations	Do the recommendations suggest further areas for research? Do the recommendations identify how any weaknesses in the study design could be avoided in future research?

Benton, D. C. and Cormack, D. F. S. (2000). Reviewing and evaluating the literature. IN D. F. S. Cormack (Ed.). *The research process in nursing (4th ed).* Oxford. United Kingdom: Blackwell Science.

Table 5

Themes and Areas for Discussion Emergent From the 1-1 Interviews

Cultural communities of practice	**Organisational liminality**	**21st Century health and social care**
Inquisitive passion to continually learn.	Responsive and reliable	Laughing together, opportunities for joy
Cultural engagement and communication	Resilient, confident & proud	Compassion in action, responding instinctively to needs.
Creative thinking, energy focused.	Supportive & wellbeing focused.	Diverse communication skills, unconditionally supportive & self-motivated
Transparency, candour, and honesty	Promoting and implementing person centred strategies	

Table 6

Leadership Development Focus Group Responses to the Research Question, "What do you Think Makes an Effective Worker?"

Focus Group Interview 1 (n=6)	Focus Group Interview 2 (n=5)
Common sense approach	Professional
Calm and collective	Show initiative
Responsible	Empathy
Patient	Compassionate
Caring	Kind
Show empathy and understanding	Creativity
Responsive rather than reactive	Someone who is motivated
Having the right training	Good sense of humour
Be able to take direction	Hard worker
Conscientious - attending to detail	Good listening skills
Good listener, empathy, understanding	Person Centred
Helpful	Patient
Flexible	I believe it is a cliché to say calm, warm,
Reliable	responsible etc. In my opinion it is all about
Good fun	being committed. We see too many staff
Non-judgemental	working day in and day out just for clocking
Good communication	in and out
Takes pride	Willing to go the extra mile
Funny, caring, willing to learn	Caring
Caring and compassionate	Empathic
Promotes Independent	Kind
Be able to lone work and use own initiative	Thoughtful
Think outside the box	Good listener
Flexible, reliable, committed	Solution focussed
Respectful	Proactive
Good communicator, good listening skills	Assertive
Understanding the individual's needs	Patient
Respond to a situation	Creative
Initiative	Someone who goes above and beyond

Aspirational	Rational
Good mentor	Team worker
Team player	Wanting to make a difference
Will go above and beyond expectations.	Prepared
Shows willing	Calm
Good listening skills, caring and have empathy	Patience
	Enthusiastic
Team player	Passionate
Enjoys their job	Team player
Has a sense of purpose	Use own initiative
Flexible, reliable, committed to their role	Committed
Fun and happy	Considerate
Conscious of language	Sensible
Can read a situation and be proactive	Advocates
Ensure respect and dignity	
Flexible, reliable, punctual	
Proactive and self-managing	
Be able to offer emotional support	

Table 7

Data Extraction Table for Literature Review

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
Addicott, R. (2011).	Supporting care home residents at the end of life. (EoL)	Aims to identify factors which would enable people to remain in a care facility at the end of life; identifies 3 key features	Social care and nursing care – residential and wards	Relates to elements of compassion and dignity within the acre sector and particularly to EoL Relates to Crowther, Wilson, Horton et al	There are many aspects to compassionate care which have not been mentioned – the research only discusses 3 specific areas – does not mention	Qualitative; 39 semi structured interviews: snowballing technique; Four care homes in two counties; two residential and two nursing. The care settings were rated	Identifies 3 key features fundamental to high quality care at the end of life: advance care planning; MDT communication and working; provision of	Identifies 3 key features fundamental to high quality care at the end of life: advance care planning; MDT communication and working; provision of

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
					the experience or the qualifications of staff	good or excellent by CQC.	dignified and compassionate care	dignified and compassionate care
Ballard, C., Corbett, A., Orrell, M., Williams, G., Moniz-Cook, E., Romeo, R., Woods, B., Garrod, L., Testad, I., Woodward-Carlton, B., Wenborne, J., Knapp,	Impact of person-centred training and person-centred activities on quality of life, agitation, and anti-psychotic use in people with	To put forward that the education of staff working in nursing homes with people with dementia improves the quality of life for service users, staff	Nursing homes/ Social Care – specifically relating to older people with dementia and improving the quality of life through person centred care	Person centred care is also discussed in Dewar, Gridley and Tronto	Limited to older people with dementia and the people who work with them. Does not consider managers perceptions of skills needed by	9 months, Quantitative/ qualitative Randomised, controlled cluster trial with 874 participants from 69 nursing homes	That the use of the WHELD programme with staff training, social interaction, and reduction in the use of antipsychotic drugs improves	That the use of the WHELD programme with staff training, social interaction, and reduction in the use of antipsychotic drugs

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
M., Fossey, J. (2018)	dementia living in nursing homes: A cluster randomised controlled trial.	confidence and skills. Understanding the wellbeing and health of people with dementia is of paramount importance and improves care outcomes			frontline workers.		care, quality of life of service user and the confidence of staff	improves care, quality of life of service user and the confidence of staff
Crowther, J., Wilson, K., Horton, S., Lloyd-Williams, M.,	Compassion in healthcare - lessons from a qualitative	Studying compassion in care workers supporting	Nursing care – hospital dementia wards. Relates to	Relates to Addicott Crowther. J; Wilson et al	Relates purely to end of life care of people with dementia –	Qualitative in-depth interviews: bereaved carers	Mentions the 6 C's compassion, competence, communicati	The concepts of compassion, kindness and humanity in

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
& Wilson, K. (2013).	study of the end-of-life care of people with dementia.	people with dementia; experiences of carers caring for people in the last year of life. The paper also suggests that compassionate care can be taught			therefore limited research although the elements of staff training, kindness, compassion may be applied to different settings. Does not consider managers perspectives of worker behaviour	interviewed; 31 women – 9 men (22.5% men) Grounded theory with phenomenology	on, course, and commitment. Training in compassion	dementia care are discussed within the paper. The ability to deliver care that is compassionate, kind, and humanistic exists along a continuum across care settings – examples of excellent care sit

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
								alongside examples of poor care and the reasons for this are explored together with discussion as to how health and social care staff can be trained and supported to deliver compassionate care.

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
Currie and Lockett (2011)	Distributing leadership in health and social care: Coercive, Conjoint, or collective?	Examines leadership in practice. The interaction of leaders and followers taking account of context. Employing Gronns dimension of coercive action and conjoint agency.	Social Care	Relates to contemporary thought leadership concepts. Addicott (2011) Ballard (2018) Gillin (2017) McNeill (2019)	Does not explicitly mention the skills needed for e front line worker – related to the distribution of responsibility and team motivation and engagement	Qualitative analysis	The implementation of DL in a health and social care context faces institutional challenges related to professions and policy. Many HSCOs conform to the professional bureaucracy archetype	DL evokes an aspiration for the way leadership is configured, and draws attention to iterative relations between leadership, followership, and context, but it is a conception of leadership that requires unpacking.

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
							(Mintzberg 1979), which has implications for leadership. A powerful professional core of staff (e.g., doctors in a HSCO) may exercise significant autonomy over the means and ends of	We offer our conceptual analysis, applied to health and social care, in pursuit of this aim.

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
							service delivery	
Day, H. (2014)	Engaging staff to deliver compassionate care and reduce harm	Compassionate care is linked to safer care. Uses the ENGAGE Model, developed by the author of the paper to improve staff engagement.	Relates to nursing staff in the hospital setting but is relatable to health and social care staff	Ballard, Crowther et al., Day in their consideration of compassion in care and health settings	This is narrow in that it is nurses' perceptions in the hospital setting	Qualitative study using focus groups and questionnaires	Compassionate care is linked to safer care. Staff engagement and an understanding of compassionate care increases the quality-of-service user experience	Compassionate care is linked to safer care. Staff engagement and an understanding of compassionate care increases the quality-of-service user experience

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
							and outcomes	and outcomes
Dewar, B. (2014).	Clarifying misconceptions about compassionate care	discuss the meaning of compassionate care as it applies to staff, patients and families in health settings, its application to practice and how organizational infrastructures affect the	Health and social care	NURSING – compassion Leadership in compassionate care programme Is aligned with Addicott (2011), Crowther (2013), Day (2014),	Specifically related to nursing – does not relate directly to social care. Does not specify managers perspectives	Qualitative study – discussion paper draws on data from an action research programme (Leadership in Compassionate Care Programme, 2007–2011) that focused	Organizational infrastructures affect the delivery of care.	This paper challenges some of the beliefs and values that underpin the meaning of compassionate care and its application to practice. It adds to the meaning of compassion, which could

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
		delivery of care.				on embedding compassionate care into practice and education and related literature focused on compassionate person-centred care.		be used to form the basis of shared visions of caring, both strategic and operational, across organisations.
Featherstone, B., Robb, M., Ruxton, S., & Ward, M. (2017).	'They are just good people...generally good people': perspectives	Young men attending social care services	Social care and support services - community	Social care – Focuses on gender	Does not discuss the perceptions of the workers	Qualitative paper. Semi-structured interviews	Relationships form positively through staff focusing on the positives	The results are a narrative with examples of the perspectives

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
	of young men on relationships with social care workers in the UK.				The study discusses gender as just male and female – it doesn't include reference to people who may associate themselves as gender fluid/ queer/ gay. Just male/female.		of the people, accessing services – role modelling is important	of the young men on what they consider to be a good or bad worker. Sufficient enough to judge that this was an effective study. Someone who listens; funny and like-minded but still do their job; tries

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
								to help; tries to understand; Showing that they care through their actions; trust; respect; treat people well; focus on the positives;
Gillin, N. (2017)	Exploring the concept of "caring cultures": A critical examination of the	To critically examine the conceptual, methodological and validity issues with	Review of papers	Relates to compassion through 'caring' Empathy first and then compassion	Is not a qualitative study. Relies heavily on positivist paradigm.	systematic review of empirical research	Suggests organisational culture and leadership have an impact on caring	Talk about 'good social care': Person centred ways of working;

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
	conceptual, methodological and validity issues with the "caring cultures" construct.	the “caring cultures” construct.		– about reducing suffering		Positivist, quantitative study		respectful; listen Meeting practical and emotional needs Attitude and approach respectful; kind; caring; compassion Reliable, professional Continuity of support was valuable Managers of services

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
								talked about flexibility of approach Learning skills and having knowledge
Gridley, K., Brooks, J., & Glendinning, C. (2014).	Good practice in social care: the views of people with severe and complex needs and those who support them.	To discuss the benefits of good practice on people with complex needs	Social care	Focuses on what may be considered to be good in the eyes of the people close to Sus with CN	Only relates to people with complex needs	Interviews; qualitative	Individual budgets are important for people accessing care	Personalisation and individual budgets are important for people accessing care

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
Gupta, K. S., & Rokade, V. (2016).	Importance of Quality in Health Care Sector: A Review.	The concept of quality	Hospital quality of care	Relates to qualitative work DEWAR (2014)	People who were not able to consent due to capacity were not included – not fully representative of people with complex needs	Qualitative surveys with patients' families	That customer satisfaction is the most important way to judge the quality care	Introduces health quality to the reader but not a trustworthy source.
Hojat, M., Louis, D., Maio, V., & Gonnella, J. (2013).	Empathy and Health Care Quality.	Empathy is essential by the physician for the delivery of quality care	Healthcare – physician empathy	Gupta (2016)	Only relates to physician-patient relationships. Does not mention	Qualitative	That empathy is important in the physician/pati	States that empathy is linked to quality care and positive patient

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
		and treatment			nursing or social care empathy in relationships		ent relationship	outcomes-psycho-socio-biological-indicators are present when the patient experiences empathy.
Holbery, N. (2015).	Emotional intelligence – essential for trauma nursing.	To research how having emotional intelligence is essential in trauma nursing	Nursing but is relatable to health and social care	Dewar McSherry Gillin Barret - compassion	There is a distinction between sympathy – this being an emotional response, and empathy – empathy is	Qualitative, interpretative	Emotional Intelligence is essential in trauma nursing	It is advantageous for staff working in challenging circumstances to have good levels of emotional

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
					seen as a cognitive response linked to understanding how the patient feels rather than sympathising with them.			intelligence and can apply this to their work
Manthorpe, J., Harris, J., Samsi, K., & Moriarty, J. (2017)	Doing, Being and Becoming a Valued Care Worker: User and Family Carer Views.	What are valued characteristics, and how people become or are made	Social Care	Banks Pulford Chester Gupta Values, quality, patient perspective	Limitations are that no service users with complex needs	Qualitative study	Carers of service users suggested that compassion cannot be taught and is	Interesting and relating to my study was the discussion about training and its

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
		‘good’ care workers.					a personal trait.	implications on practice of care workers. Carers of service users suggested that compassion cannot be taught and is a personal trait.
McNeil, N. (2019)	Caring for aged people: The influence of personal resilience and	The culture within teams and within an organisation enables resilience	Australian social care - dementia	Holbery (2015) and Dewar (2014)	Limitations in data - the data was from only one source raising	Qualitative – longitudinal study	The study specifically mentions Australian workforce but is relatable	Care workers face a challenging job and need to be resilient which is not

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
	workplace climate on 'doing good' and 'feeling good'.	and staff engagement			concerns about common method variance.		internationally. Suggests that care workers face a challenging job and need to be resilient which is not achievable without good levels of wellbeing. This wellbeing may be influenced by the positive	achievable without good levels of wellbeing. This wellbeing may be influenced by the positive outcomes from their work.

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
							outcomes from their work.	
McSherry, R. (2018).	Measuring health care workers' perceptions of what constitutes a compassionate organisational culture and working environment: Findings from a quantitative	Health care organisations cultures significantly influence the outcomes of care – uses a cultural health check model	Social Care	Monterio (2016) Day (2014)	The survey may be used with HSC Staff in care services. Would be the ideal audience.	Mixed methods approach – qualitative and quantitative research Related to nursing – hospital ward Interviews across different disciplines in clinical care	The culture tool is valid and useful in determining the precepted levels of compassion and engagement for healthcare staff	That the culture tool can improve the assessment of organisational culture, ultimately influencing the quality of care

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
	feasibility survey.							
Pulsford, D., Duxbury, J., & Carter, B. (2016).	Personal qualities necessary to care for people with dementia.	To state that social phycological and emotional aspects of care are just as important in dementia care – person centred compassionate care is essential	Social Dementia care	Manthorpe, Harris and Samsi (2017)	Only relates to dementia care	Peer reviewed qualitative study	Quality care demands carers to have sophisticated, cognitive, emotional, and interpersonal qualities.	Quality care demands carers to have sophisticated, cognitive, emotional, and interpersonal qualities.

Author	Title	Authors aim	Which area of care?	What relationship to other works?	What is missing/not stated?	What approach was used? Methodology/quant/qual/comp?	What claims are made?	Conclusions
Tronto, J. (2010)	Creating caring institutions: Politics, plurality, and purpose	Discusses the relationship between quality care and family led values of care – suggests care must be person centred	Ethics, quality, and social care	Relates from a cultural point of view to McNeill, Addicott, Ballard, Dewar	Doesn't discuss the actual work-related tasks needed from frontline workers	Discussion paper	When we make explicit some background conditions of good family care, we can apply what we know to better institutionalised caring.	Caring family values in the practice of care workers will enhance quality care and support.

Figure 11

Most Frequent Words NVIVO Text Analysis

Themes	occurences	percentage
Culture	468	28.84%
Leadership	305	18.79%
Compassion	304	18.73%
Resilience	120	7.39%
Engagement	94	5.79%
Values	94	5.79%
Positivity	87	5.36%
Trust	76	4.68%
Behaviour	75	4.62%
	1623	**100.00%**

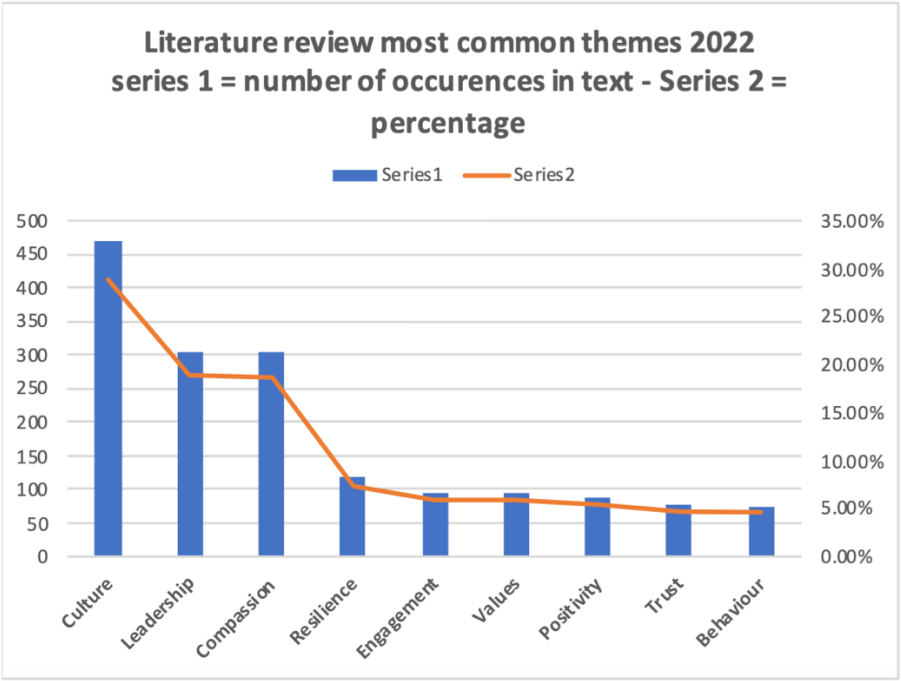
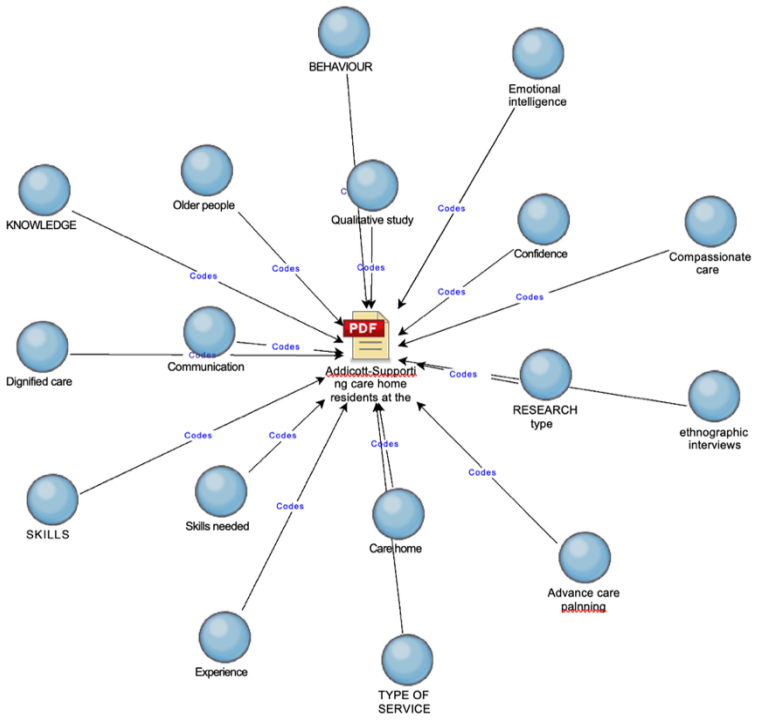


Figure 4

Coding Diagrams for Addicott, R (2011)



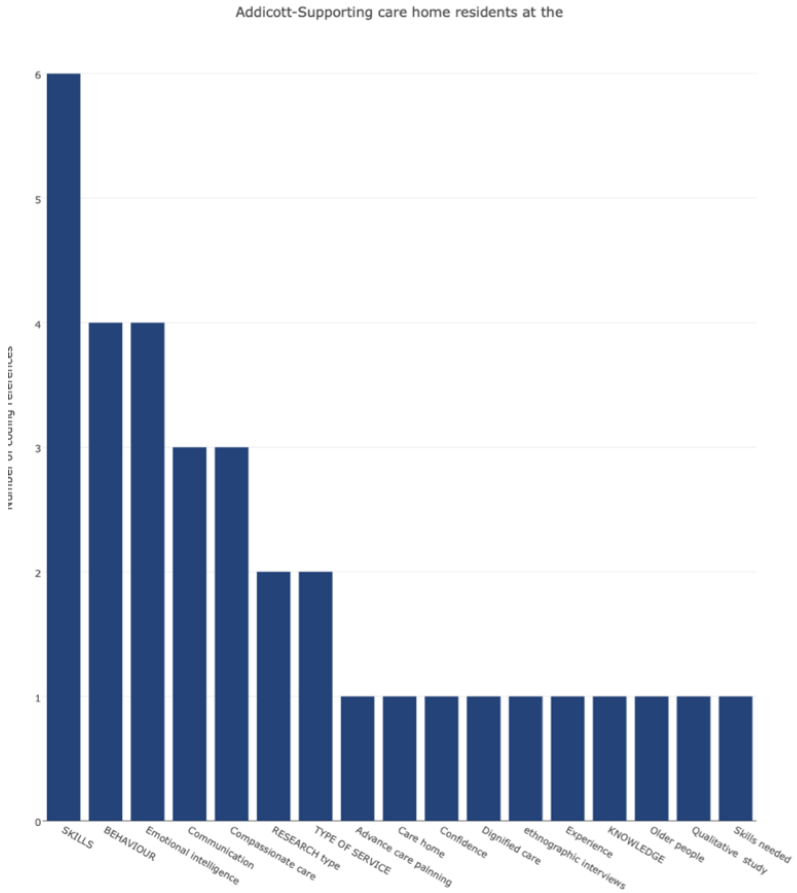
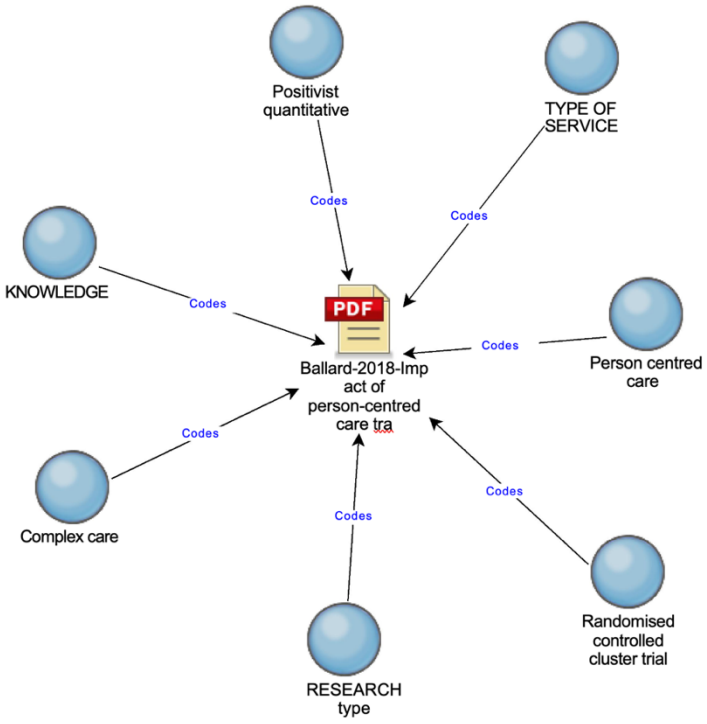


Figure 5

Coding Diagrams for Ballard (2018)



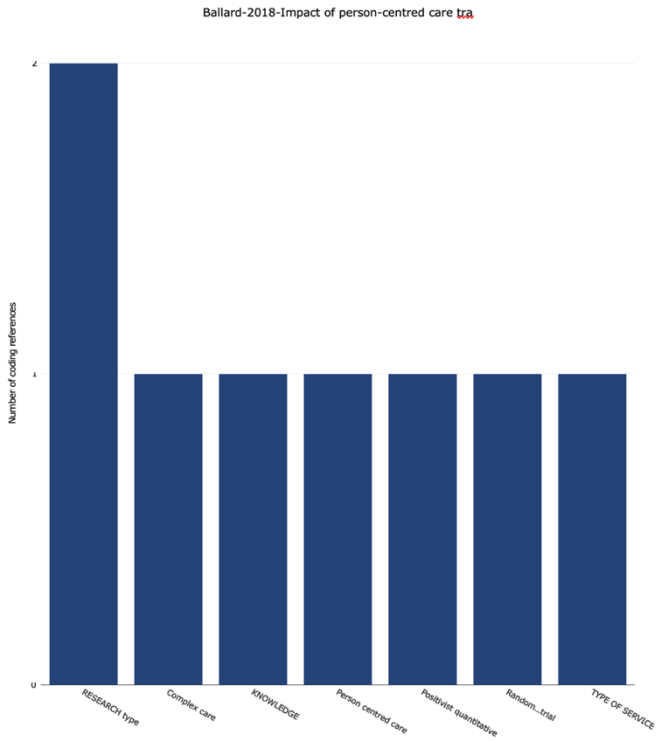
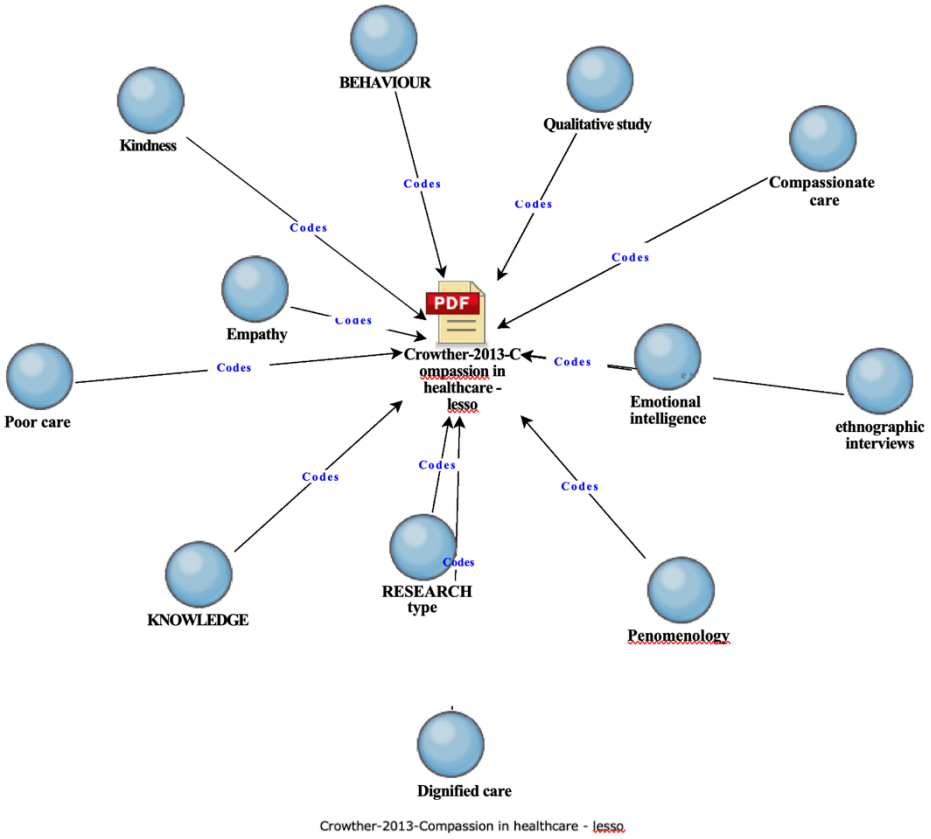


Figure 6

Coding Diagrams for Crowther et al. (2013)



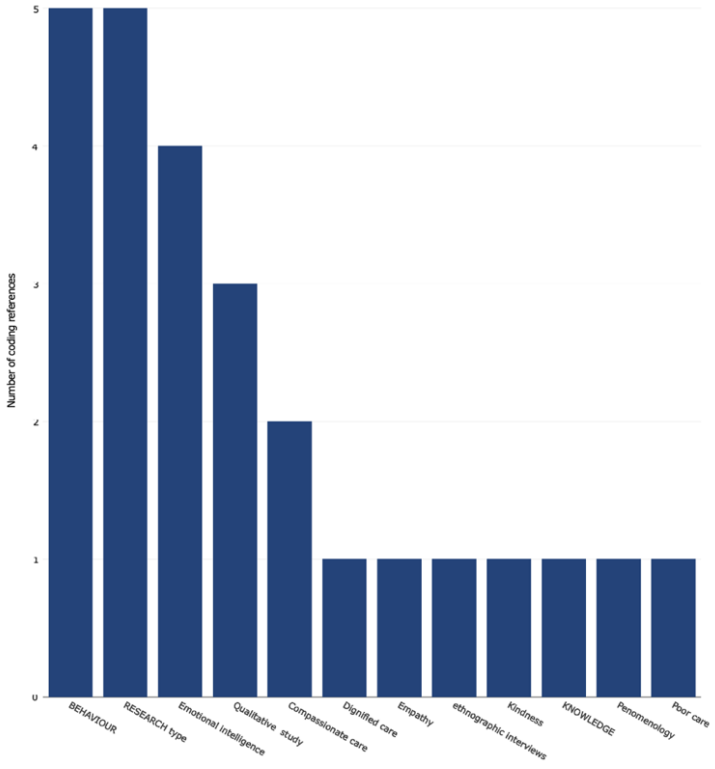
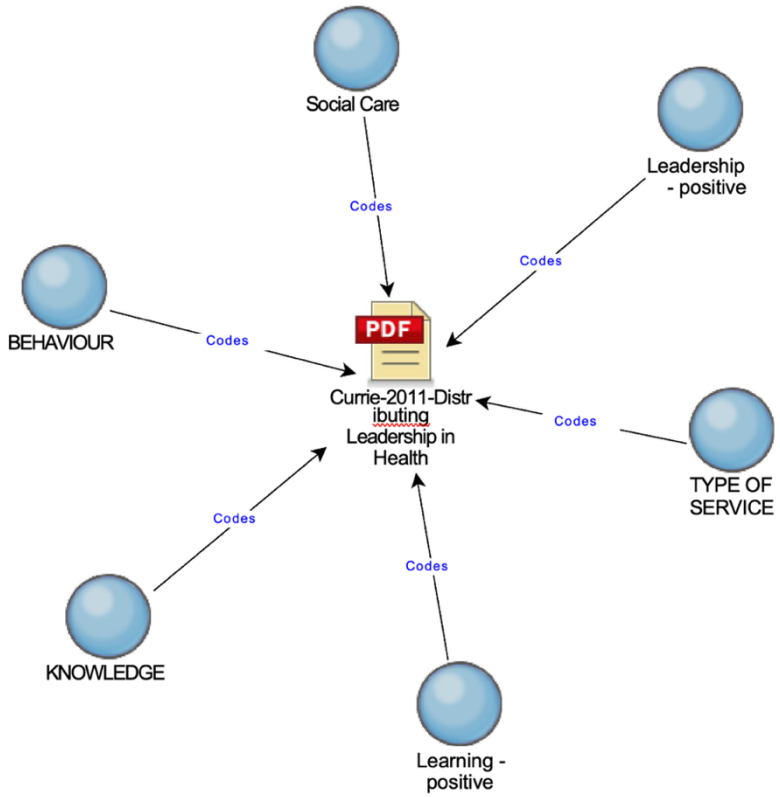


Figure 7

Coding Diagrams for Currie and Lockett (2011)



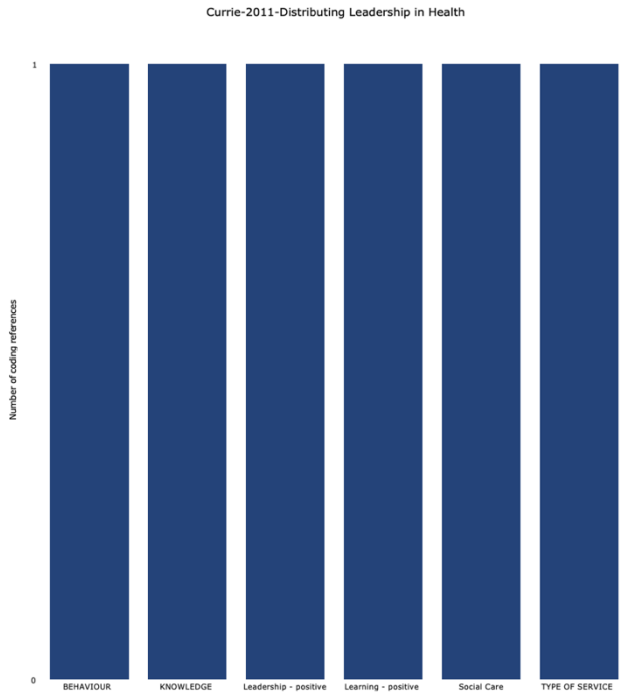
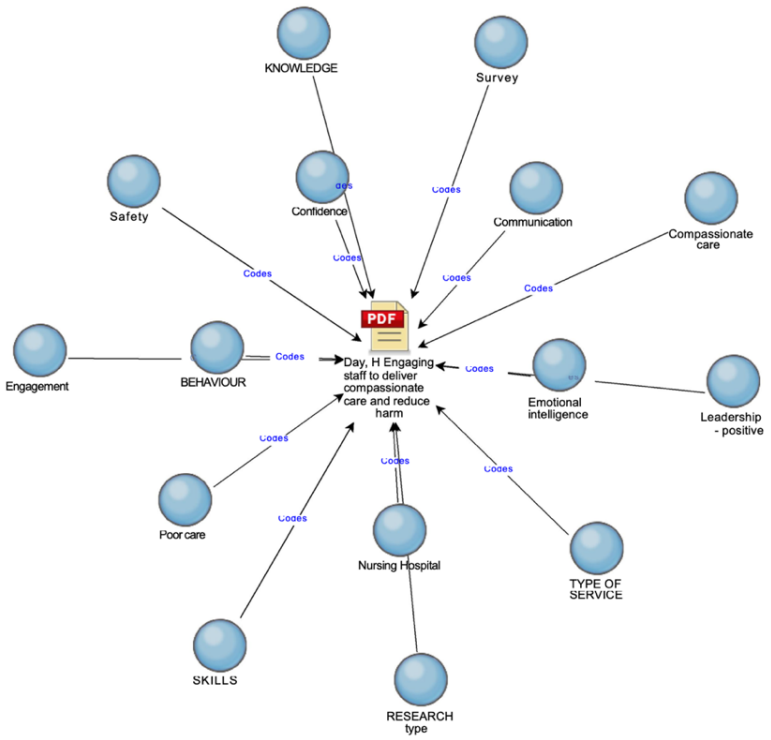


Figure 8

Coding Diagrams for Day (2014)



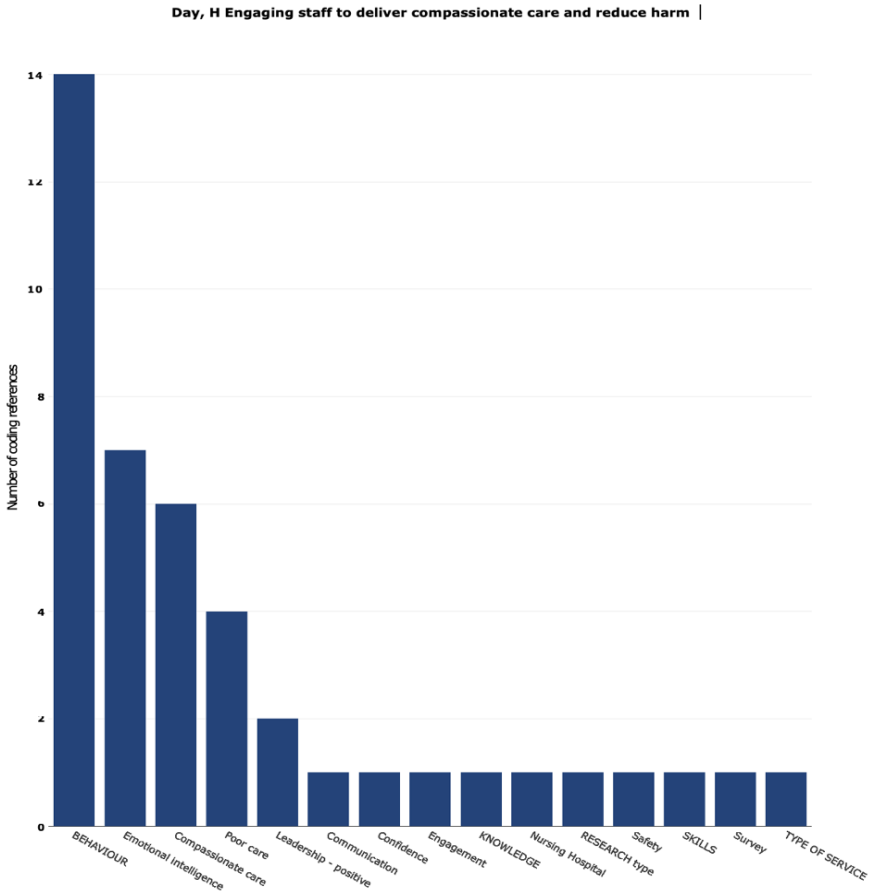
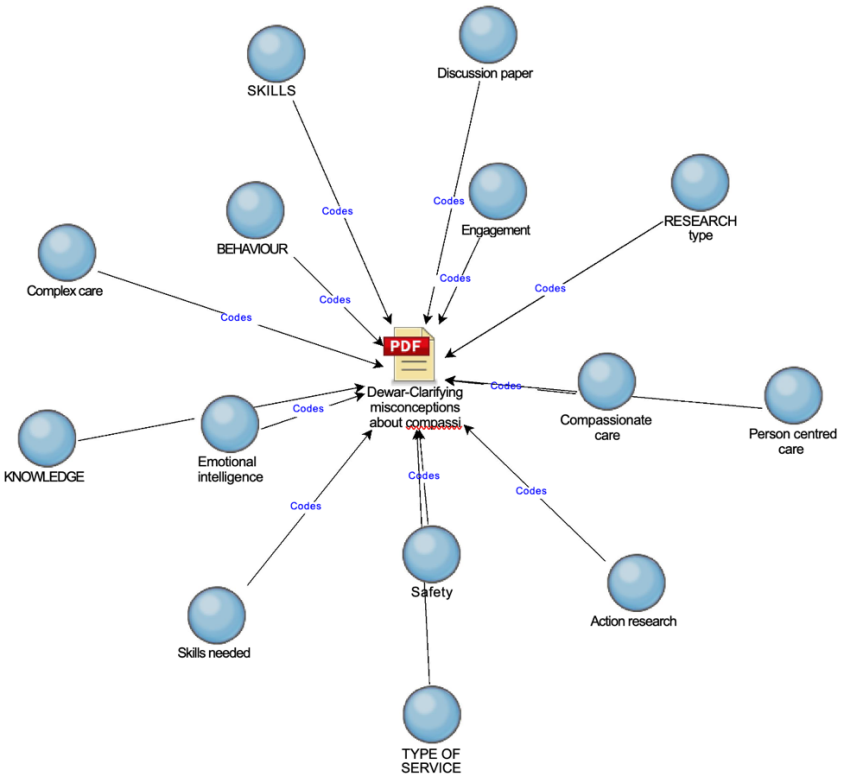


Figure 9

Coding Diagrams for Dewar (2014)



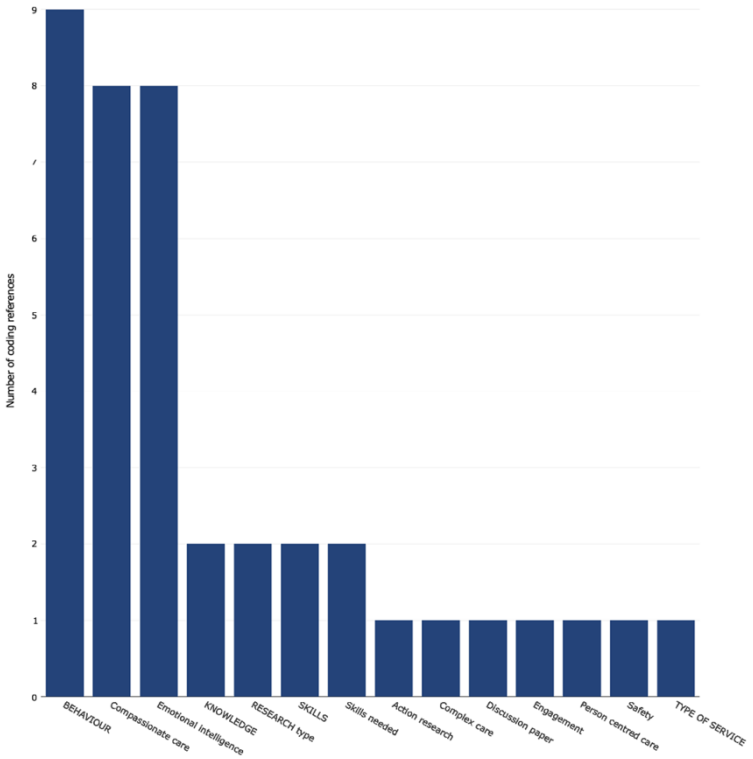
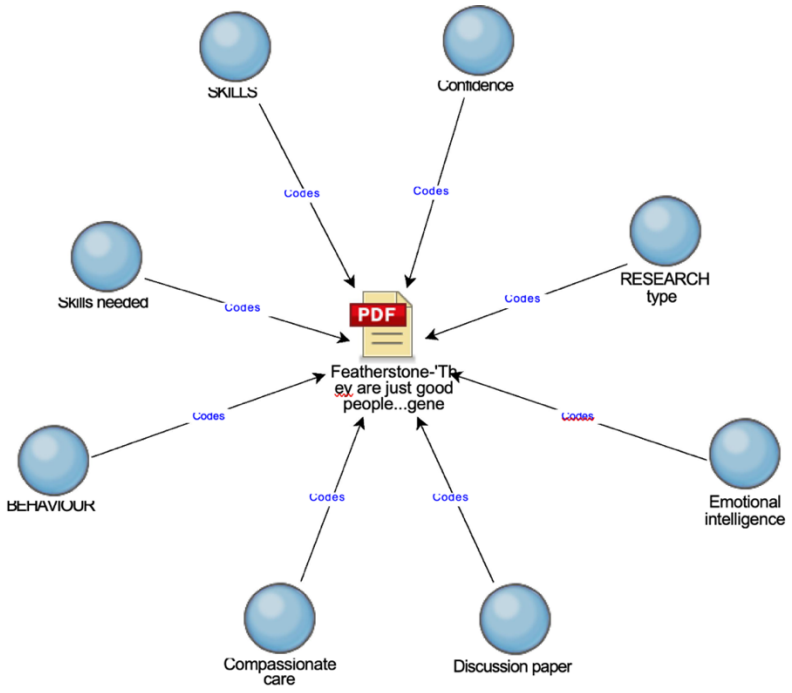


Figure 10

Coding Diagrams for Featherstone (2017)



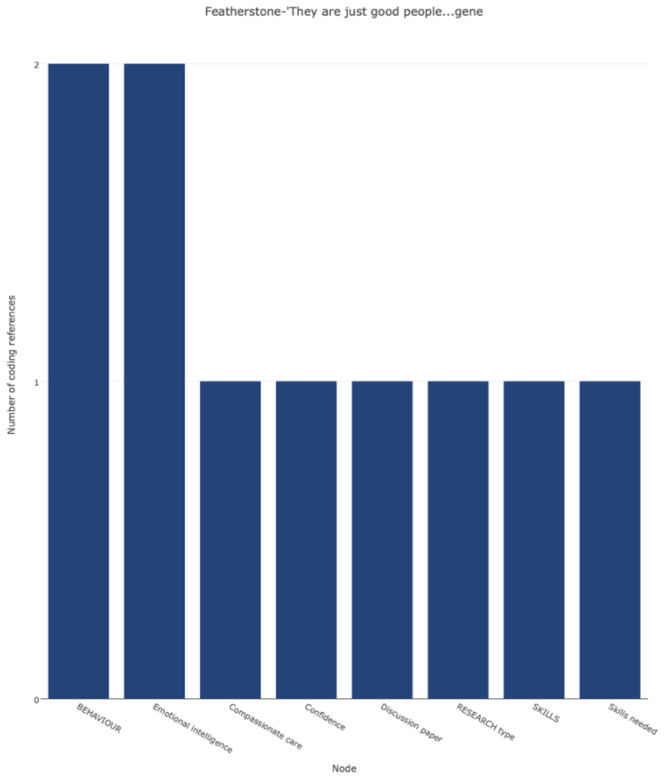
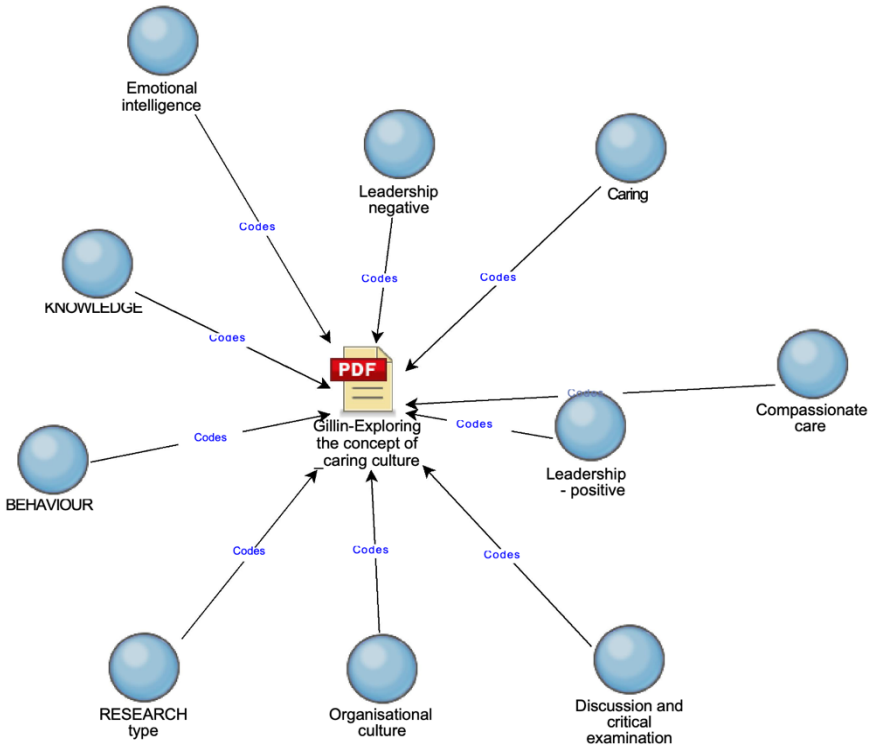


Figure 11

Coding Diagrams for Gillin (2017)



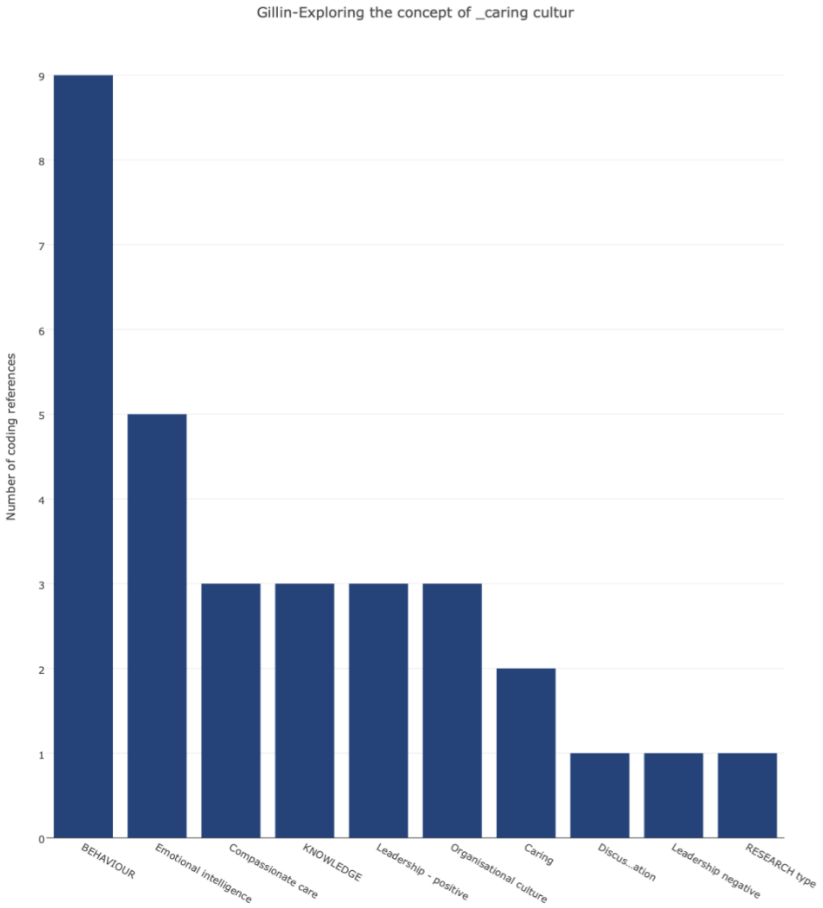
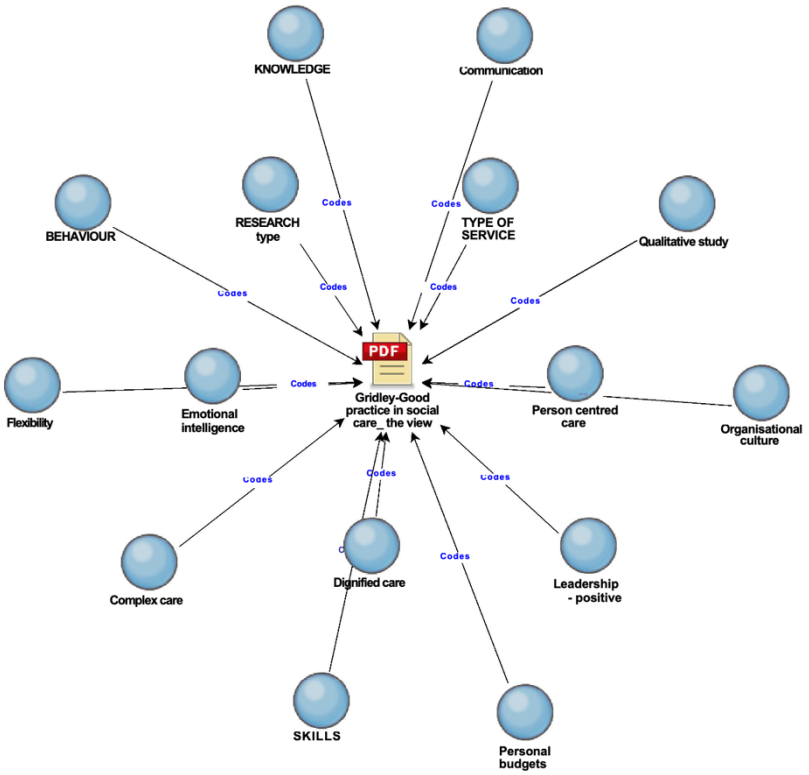


Figure 12

Coding Diagrams for Gridley (2011)



Gridley-Good practice in social care_ the view

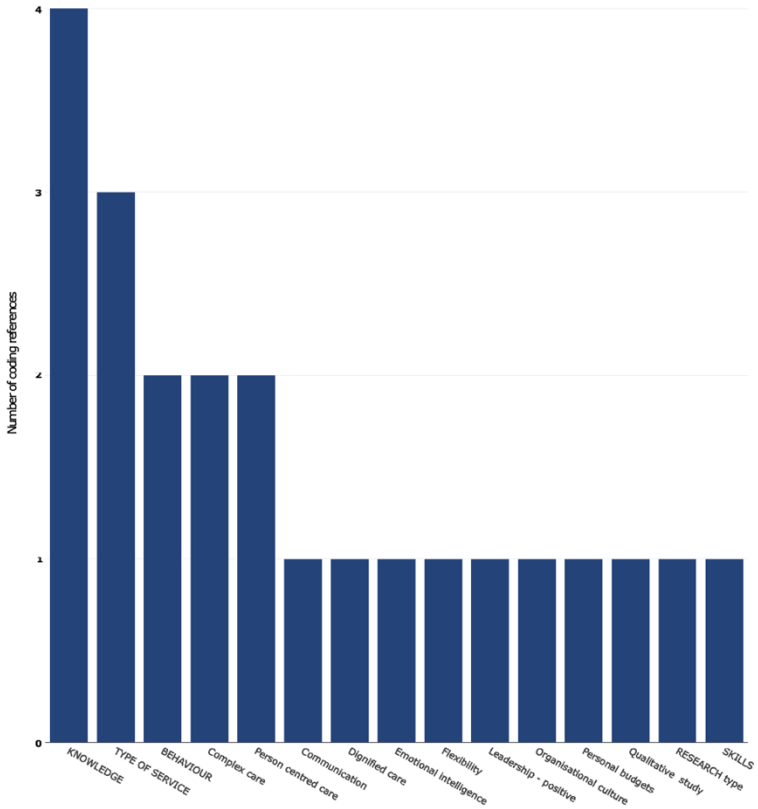
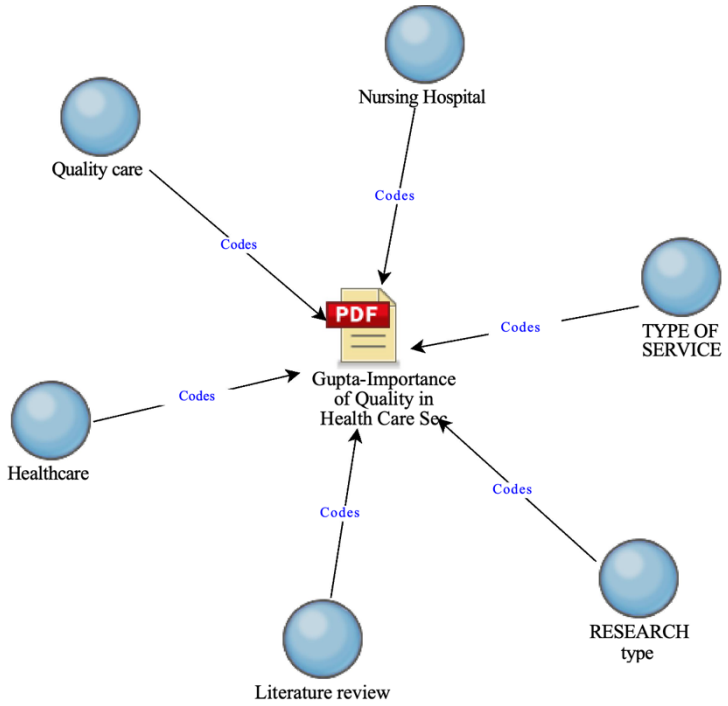


Figure 13

Coding Diagrams for Gupta (2014)



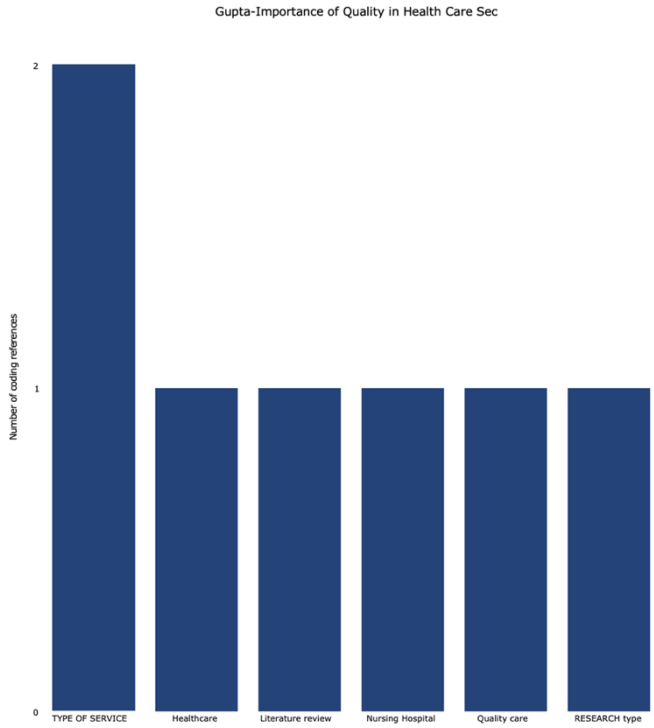
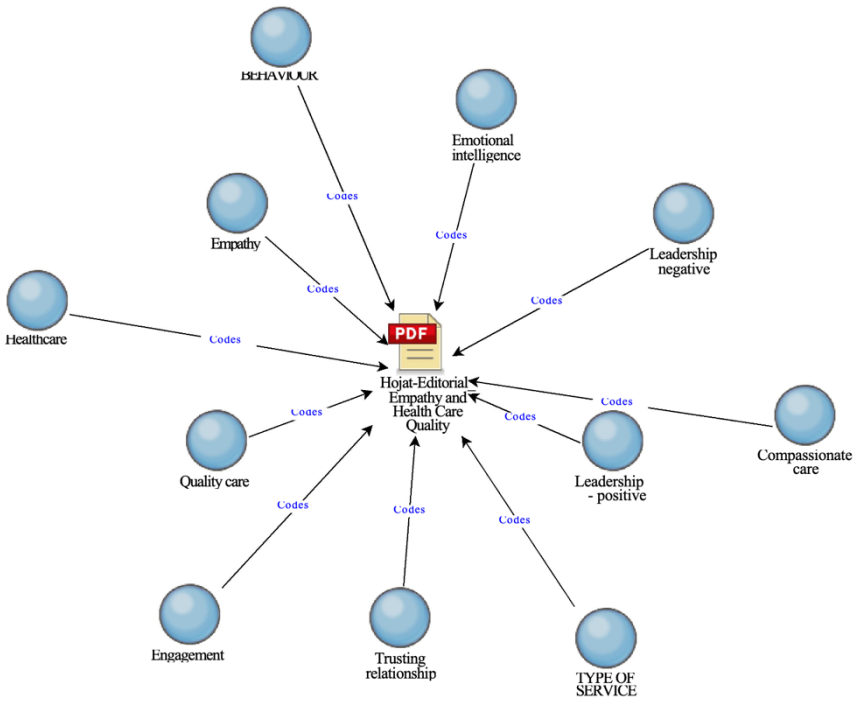


Figure 14

Coding Diagrams for Hojat (2014)



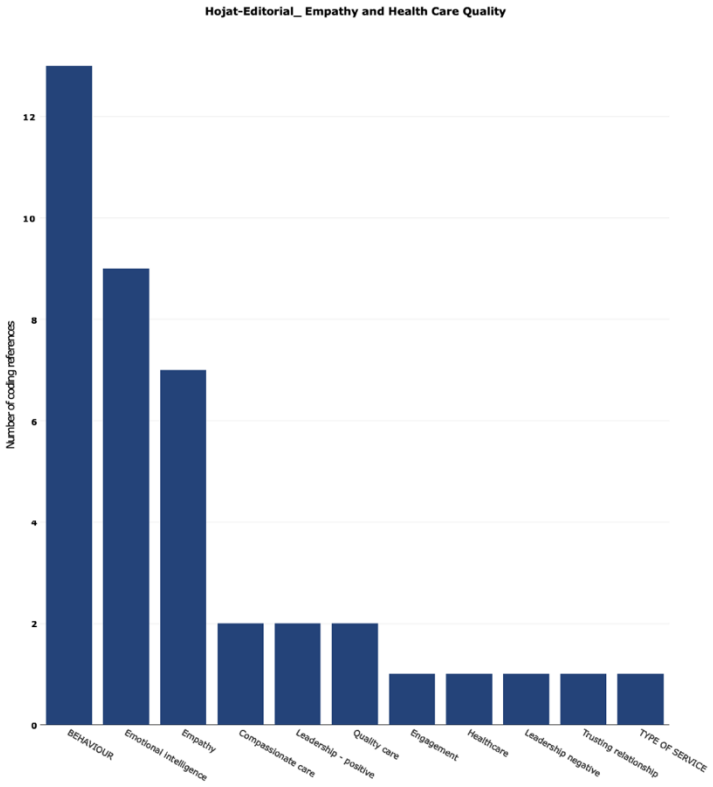
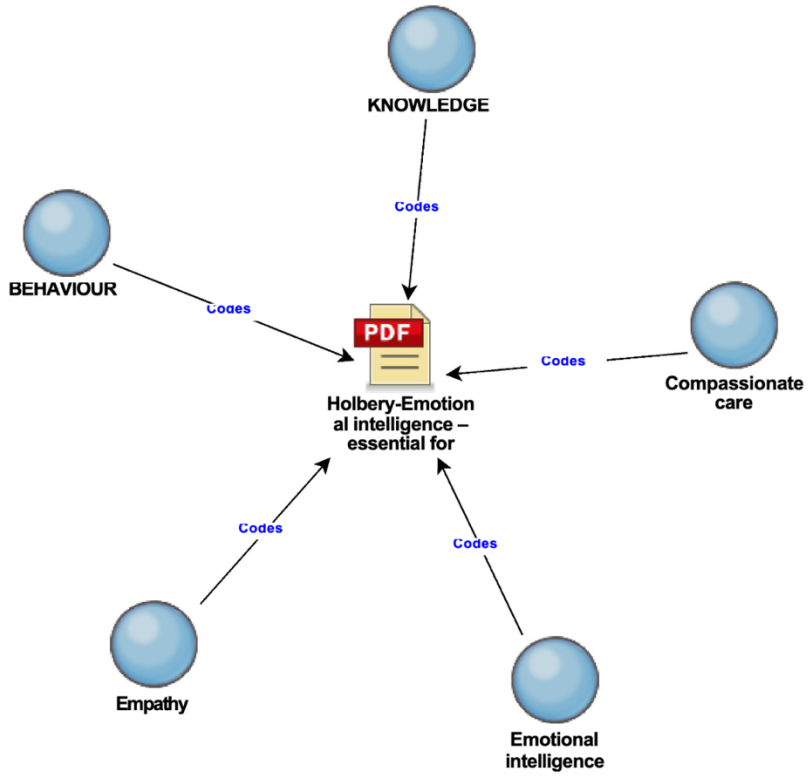


Figure 15

Coding Diagrams for Holbery (2015)



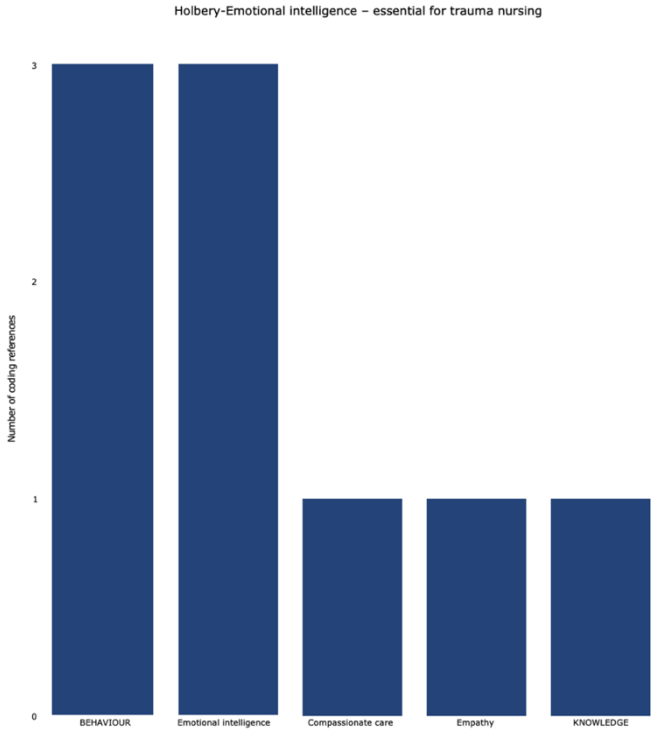
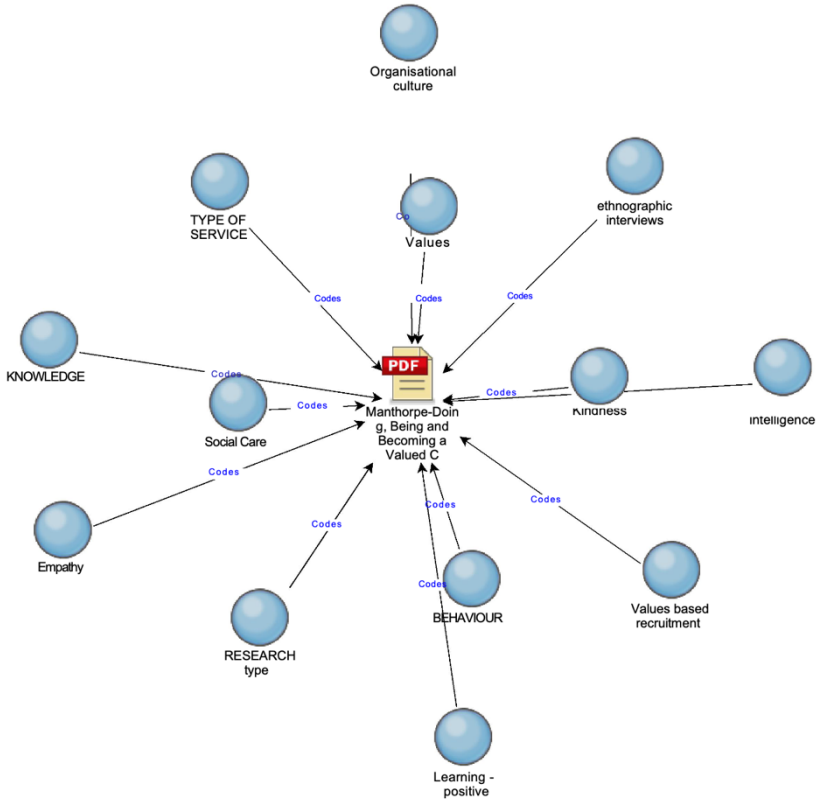


Figure 16

Coding Diagrams for Manthorpe (2017)



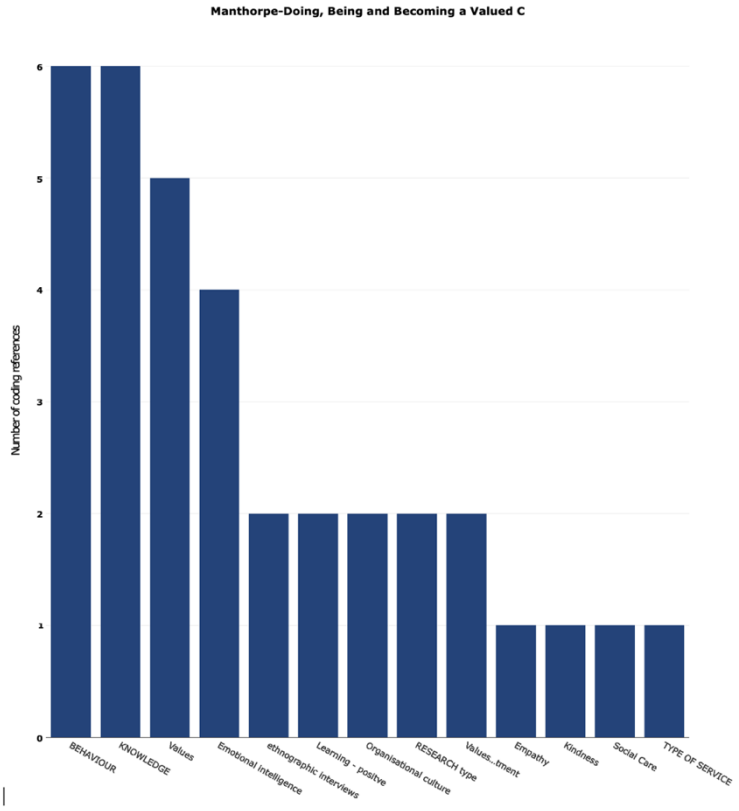
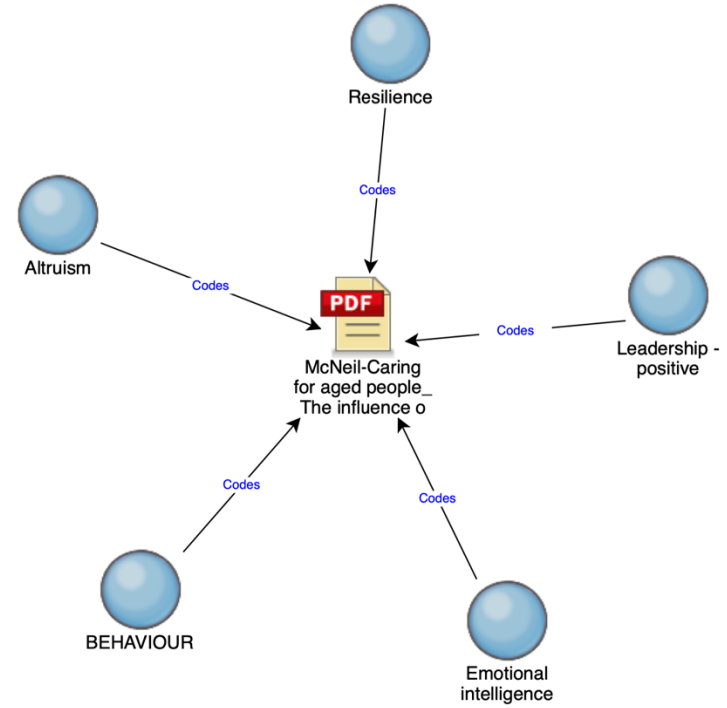


Figure 17

Coding Diagrams for McNeil (2019)



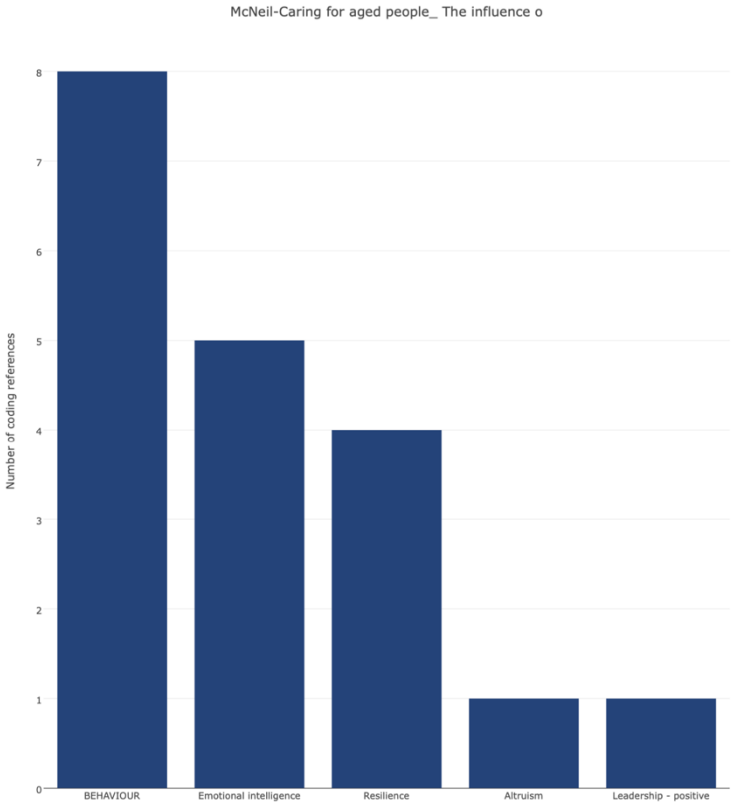
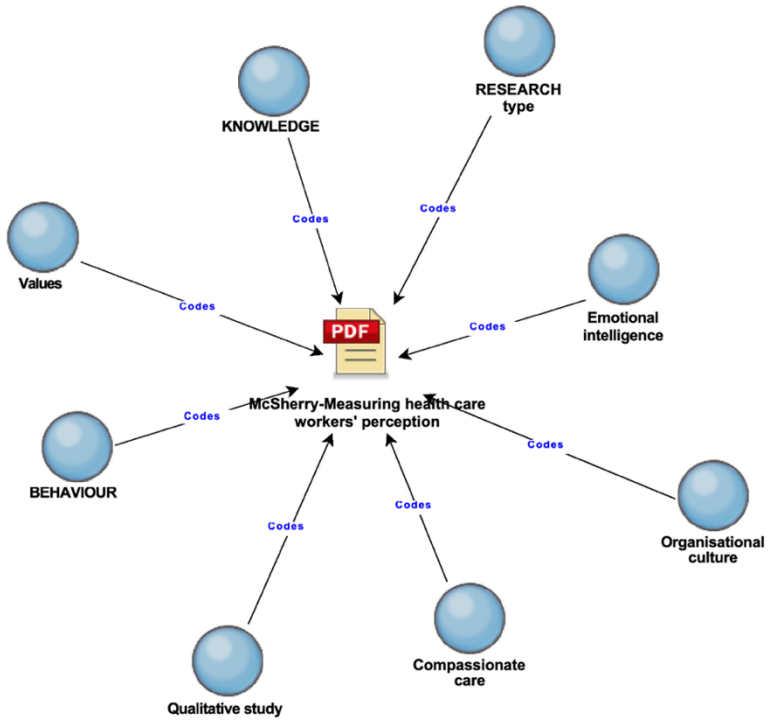


Figure 18

Coding Diagrams for McSherry (2018)



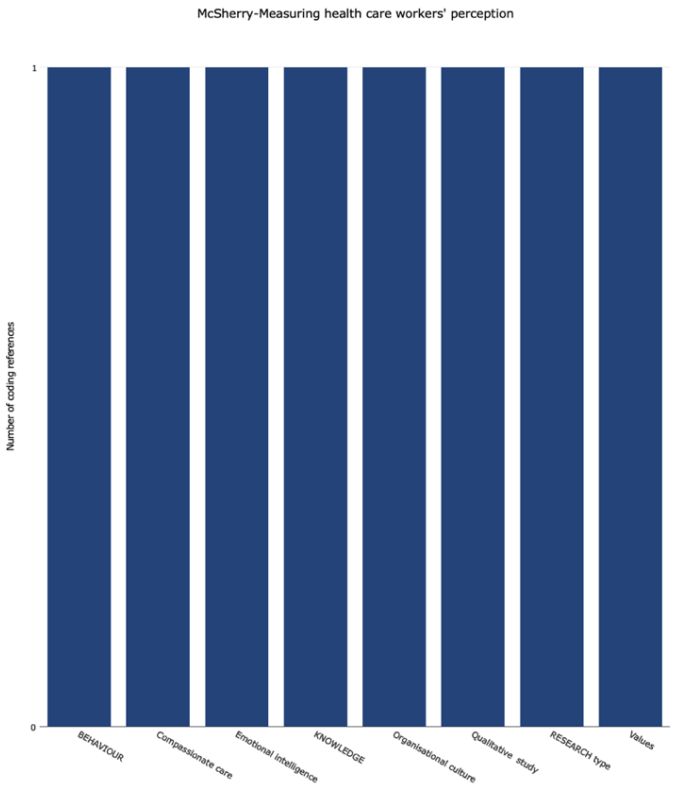
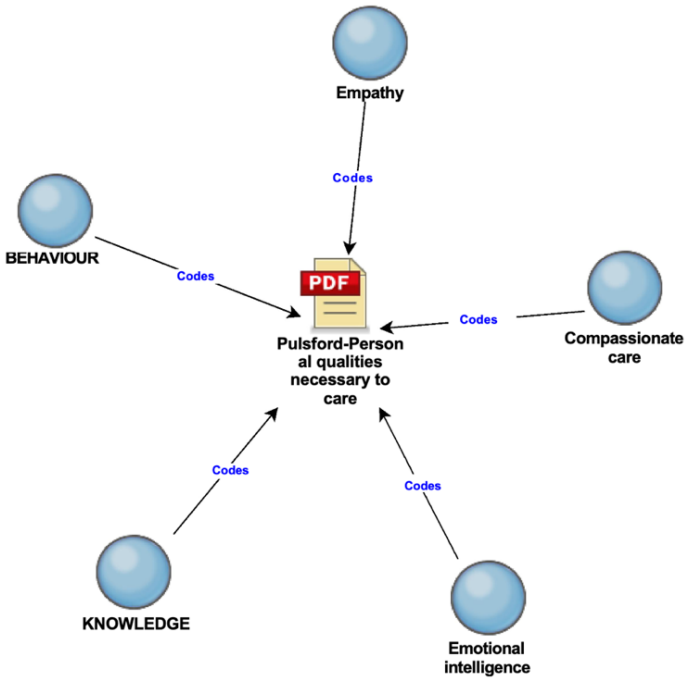


Figure 19

Coding Diagrams for Pulsford (2016)



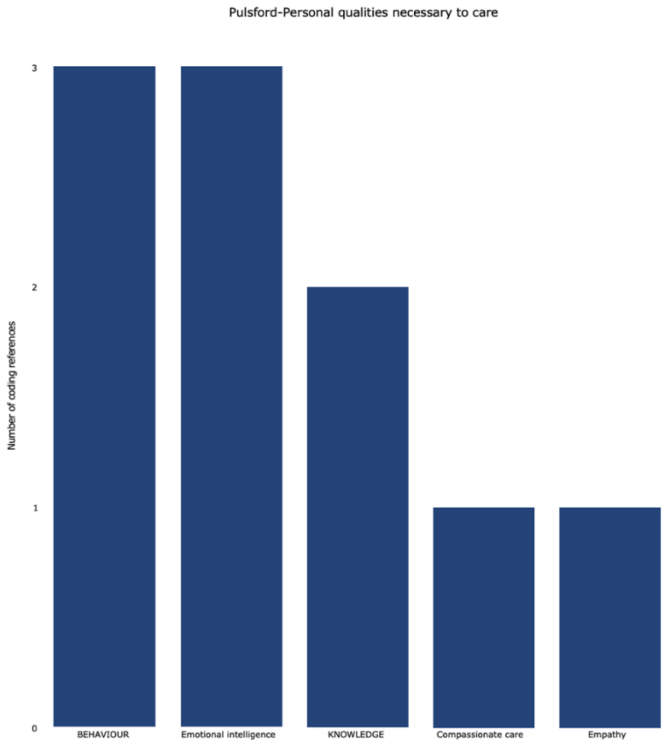


Figure 20

Coding Diagrams for Tronto (2010)