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Working Conditions and Wellbeing in UK Social Care and Social Work During COVID-19

The spread of COVID-19 placed global health and social care systems under intense strain. In the first months of the pandemic in the United Kingdom (UK) health and social care, including social work employees, had significantly higher rates of COVID-19 infections than the general population (Office for National Statistics, 2020). While much attention was on severe pressures in the National Health Service (NHS) across the UK, it became evident that social care and social work services were being severely affected, with the UK's 18,075 care homes in particular experiencing substantial deaths and infections among residents and staff (Bell et al., 2020). Other parts of social care and social work were also affected such as home care (domiciliary services) and frontline social work services leading to criticism that attention to the social care sector had come far too late (Comas Herrera et al., 2020). UK-wide National data covering March-December 2020 revealed that those who worked in social care occupations had statistically significantly higher rates of death involving COVID-19 when compared with rates of death involving COVID-19 in the population among those of the same age and sex (79.0 deaths per 100,000 males; 150 deaths) and women (35.9 deaths per 100,000 females; 319 deaths) (Office for National Statistics, 2021). These risks have been reported internationally (World Health Organization, 2020; Roxby et al. 2020), reflecting the interpersonal nature of social work and social care employment and the prevalence of COVID-19 among older age groups and disadvantaged communities (e.g. Berg-Weger and Morley, 2020; Ladhani, et al. 2020) using social care and social work services. This, combined with social workers in the UK having among the worst working conditions of any UK occupational sector (Ravalier, 2019), means that greater investigation of the impact of working conditions on staff is required.

In the UK the term social care can be used as an overarching term to describe an employment sector that covers the provision of care and support to children, their families and adults and is distinct from clinical health care provided by the National Health Service (NHS). It is also used separately to describe the workforce that is skilled but not professionally qualified in social work (a graduate profession in the UK). The non-social work workforce is large, with the majority of social care workers working in care homes (including care homes that employ registered nurses), domiciliary care, and day services for adults. Additionally, children's social care staff provide children's residential care, with support for families and children around their wellbeing and safeguarding, and adoption and fostering. Unlike the NHS, the social care sector is largely independent (private and not for profit providers) and there is a multiplicity of employers. In England adult social care is provided by around 18,500 organisations working

in 39,000 locations (Social Care Institute for Excellence, 2020). While the social care system is complex and fragmented, social work across the UK in contrast is largely a statutory function and local government is the main employer of these graduate professionals in all parts of the UK except Northern Ireland where the main employers are its integrated Health and Care Trusts. In the UK, social work is a protected title with social workers engaging generally in undergraduate or postgraduate training prior to being able to practice. As such, while social workers and social care workers often work with similar service user populations, their role and functions are generally distinct from each other.

In the UK COVID-19 context, there have been several studies of the social care and social work workforces covering different parts of the sector. For example, one has run a series of quarterly surveys of children's nursery managers (private, not-for-profit and local government) in England, Scotland and Wales (see Bonetti et al., 2021). This found many nursery staff had been 'furloughed' (temporarily laid off with 80% remuneration) from their jobs in the early part of the pandemic as children were unable to attend nurseries unless their family (parents or carers) were key workers or there were concerns about the child. As the pandemic continued these staff were being re-engaged but staff shortages remained.

In local government a series of monthly surveys of all local authorities in England, Wales and Northern Ireland has been collecting key workforce data on how the sector is responding to COVID-19 starting from the week ending 1 May 2020. The survey is completed by heads of human resources (HR), or a nominated contact and spans a wide range of local authority staff including social workers with questions taking a HR perspective such as recruitment, sickness absence, redeployment and availability of Personal Protective Equipment (PPE) and latterly vaccine uptake (see Local Government Association, 2021). While its HR respondents provide data about all local authority staff, including planners and environmental health staff, the reports highlight some long-standing social work trends and concerns such as high levels of vacancies in children's social work services.

Further evidence from social workers themselves has been collected by the British Association of Social Workers (British Association of Social Work [BASW], 2021) in its survey of social workers that ran between 30 November and 31 December 2020 across the four nations of the UK. A total of 1119 social workers responded. This survey found that nearly a third of those responding (30.7%) agreed or strongly agreed that they had felt under pressure to work while unwell (for reasons that may have included COVID-19 related infection) and that nearly three quarters (71.5%) agreed or strongly agreed with the statement that workplace morale (not defined) in their place of employment had been adversely affected by the COVID-19 crisis.

Turning to social care, a review in the early months of the pandemic in the UK (Sanders 2020) noted that much literature and resources were focused on the NHS rather than social care and that some of social care's endemic problems were affecting its COVID-19 response, such as high levels of stress and poor working conditions. Raw data from England from the Adult Social Care (ASC-WDS) in February 2020 have been used to represent the period before measures were introduced to reduce the impact of COVID-19 (the first UK lockdown started on 23 March 2020). Using this information relating to around 27,400 workers from 1,100 establishments (social care employers), Skills for Care (2021) has been able to compare the COVID-19 period (March 2020 to February 2021) with the pre-COVID-19 period in England. It found that the percentage of days lost due to sickness pre COVID-19 were 2.8% but during the COVID-19 period the figure (including people unable to work because they were self-isolating or shielding) stood at 5.9%. Figures related to sickness absence were highest for care workers (6.8%) and lowest for registered managers (2.3%). These studies are an important and informative context to the present study that compares social care and social work staff responses to two Phases of an online survey.

Chronic Workplace Stress and Working Conditions

Chronic stress is defined as that which lasts over an extended period of time. Various studies have demonstrated that chronic stress and poor working conditions have a continuously deleterious effect on both the psychological and physiological health and wellbeing of employees, and subsequently impact at both an organisational level and at an individual level, in terms of health/social care employees, service user, and patient outcomes (Flower et al., 2005; Gaskell, 2010). At an individual employee level chronically poor working conditions and stress at work are risk factors for the development of cardiovascular disease (see, for example, Marmot et al., 1990; Rosengren et al., 2005), and metabolic syndrome (a risk factor for developing conditions such as Type 2 diabetes; Chandola et al., 2006) and other physiological outcomes. These impacts on individual employees, therefore, have implications for employers, service users, and their colleagues with stress being the prime reason for sickness absence in the UK (Office for National Statistics, 2021; Health and Safety Executive, 2020).

The Job Demands-Resources Model

The job demands-resources (JDR; Bakker et al., 2003) model of wellbeing at work is a widely applied theoretical model of work stress and wellbeing. It suggests that conditions at work can be categorised as either demands, or resources. Demands add a load (physical or mental) to the individual, and are thus conditions which can negatively contribute to the experience of wellbeing at work. Examples of demands include workload and task variability (Minotte, 2016).

However, resources (such as peer support, coaching, mentoring, and developmental opportunities) offered at work buffer against the negative effects of demands experienced. Should demands outweigh the resources available to the individual over an extended period then negative organisational outcomes such as stress-related sickness absences (Schaufeli et al., 2009), job dissatisfaction, burnout (Schaufeli and Bakker, 2004), presenteeism, and higher turnover intentions (Ravalier, 2019) may occur.

Working Conditions in Social Care

In the UK, the health and social care sectors have among the highest levels of stress-related sickness absence in the country (Health and Safety Executive, 2020), with stress, depression and anxiety accounting for over half of all health-related sickness absence days lost. The profession of social work is objectively one of the most stressful occupations in the UK (Ravalier, 2019; Ravalier et al., 2021). Chronic stress and poor working conditions affect intention to leave both the employer, and the profession. In addition to impacting upon the wellbeing of individuals and their employing organisations, literature has shown that high levels of stress and poor working conditions also affect the care provided to service users (Ravalier, 2019; Ravalier et al., 2021). For example, Flower et al. (2005) found that children with more than one social worker (related to high turnover intentions) were 60% less likely to be found a permanent placement.

The aim of this present study was to investigate the possible changing working conditions and wellbeing of social care and social workers across the UK during the COVID-19 pandemic, and the influence of their working conditions on their wellbeing across two time points.

Methods and Participants

A cross-sectional study consisting of a two online surveys collected approximately six months apart investigated the changes in working conditions and wellbeing in UK social work and social care workers. This was part of the wider project 'Health and social care workers' quality of working life and coping while working during the COVID-19 pandemic', launched in May 2020 (see McFadden et al., 2021). Here we report findings from the first two phases of data collection (May to July 2020 and November 2020 to January 2021). This approach was taken in order to gain a representative understanding of the impacts of COVID-19 on frontline health and social care workers in the UK (England, Ireland, Scotland, and Wales), with the focus within this present publication on all social work and social care workers. Recruitment was undertaken via an opportunity and snowball sampling method through emails and newsletters to UK-based social work and social care national bodies, who subsequently passed on participation requests to members, as well as social media (e.g. Twitter) posts. Ethical approval was obtained from the Bath Spa University, School of Sciences research ethics committee.

Table 1 illustrates respondents' demographics during Phases 1 and 2. At Phase 1, the online survey collector was open for responses between May and July 2020, and between November 2020 and January 2021 for Phase 2. The demographic profile of respondents between Phases 1 and 2 was relatively similar: majority female respondents who were White in ethnicity and did not have a disability. The only divergence between Phases 1 and 2 were that most respondents were older at Phase 2 than respondents at Phase 1. These demographic characteristics of the respondents in our study are similar to that of the UK social care and social work workforce as a whole. Most (86%) UK child and family social workers are female, and 25% aged 40-49. However, our social work sample is over-represented by White respondents with approximately 78% of UK social workers being White (gov.uk, 2021). With respect to social care, Skills for Care (2020) reports that 82% of the adult social care workforce is female in England, with an average age of 44, and 79% White ethnicity.

Table 1: Respondents' demographic information separated by occupation.

		Age	Gender		Ethnicity			Do you consider yourself disabled?	
			Female	**Male**	**White**	**Black**	**Other**	**Yes**	**No**

All social care and social work	Phase 1 n=2,525	40-49 years 733 (29.0%)	2,162 (85.7%)	353 (14.0%)	2,371 (94.0%)	82 (3.2%)	72 (2.8%)	188 (8.3%)	2,028 (80.3%)
	Phase 2 n=2,425	50-59 years 702 (28.9%)	2,103 (86.7%)	319 (13.2%)	2312 (95.5%)	43 (1.7%)	70 (2.8%)	234 (10.7%)	1,901 (86.6%)
Social work	Phase 1 n=1,280	40-49 years 329 (28.1%)	1,092 (85.3%)	182 (14.2%)	1,172 (92.0%)	48 (3.8%)	60 (4.2%)	114 (8.9%)	1,027 (80.2%)
	Phase 2 n=1,172	50-59 years 378 (29.5%)	1,001 (85.4%)	169 (14.4%)	1,094 (93.4%)	27 (2.3%)	51 (4.3%	126 (10.8%)	915 (78.1%)
Social Care	Phase 1 n=1,245	40-49 years 369 (29.6%)	1,070 (85.9%)	171 (13.7%)	1,199 (96.5%)	18 (1.5%)	28 (2.0%)	74 (5.9%)	1,001 (80.4%)
	Phase 2 n=1,253	50-59 years 387 (30.9%)	1,102 (87.9%)	150 (12.0%)	1,218 (97.5%)	12 (1.0%)	23 (1.5%)	108 (8.6%)	986 (78.7%)

Table 2 shows the occupational demographics of respondents. The majority were employed on permanent contracts, with fewer redeployed into different roles due to the COVID-19 pandemic at Phase 2, than at Phase 1. Most respondents had between 11-20 years' experience in their role, there were overall fewer days lost due to sickness absence at Phase 2 than at Phase 1, although more of this absence occurred due to COVID-19 at Phase 2 than at Phase 1.

Table 2: Respondents' occupational demographics separated by occupation.

		Permanent contract?	COVID re-deployed?	Experience (range)	Sick days		
		Yes	Yes		None	1-20 days	Due to COVID
All social care and social work	Phase 1	2,218 (88.8%)	304 (12.0%)	11-20 years 665, (26.6%)	1,192 (48.2%)	1,083 (43.8%)	208 (17.4%)
	Phase 2	2,198 (92.0%)	166 (6.8%)	11-20 years 748, (31.3%)	1,249 (52.9%)	857 (36.2%)	347 (33.3%)
Social work	Phase 1	1,137 (89.5%)	163 (12.7%)	11-20 years 353, (27.6%)	607 (48.1%)	557 (44.1%)	85 (13.7%)
	Phase 2	1,058 (92.0%)	73 (6.2%)	11-20 years 365, (31.7%)	599 (43.5%)	402 (35.3%)	134 (11.4%)
Social care	Phase 1	1,081 (88.0%)	141 (11.3%)	11-20 years 312 (25.4%)	585 (48.3%)	526 (43.5%)	123 (21.4%)

	Phase 2	1,140 (91.0%)	93 (7.5%)	11-20 years 383 (30.9%)	650 (53.2%)	455 (37.3%)	213 (39.7%)

Materials

We report on two separate measures, in addition to a series of demographic questions, used within this study. The dependent variable, the short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS; Stewart-Brown et al., 2009) is a seven-item measure of mental wellbeing. Respondents are asked to state how often over the previous two weeks they had had particular experiences or thoughts. Questions are answered on a five-point Likert scale from 1 (None of the time) to 5 (All of the time), with higher scores indicative of better mental wellbeing. SWEMWBS has strong reliability (e.g. Cronbach's alpha .90 among hospital patients, Vaingankar et al, 2017; and .84 among general population, Ng Fat et al., 2017) and validity and is suitable for use with the general public (Ng Fat et al., 2017).

Secondly, the independent variable Work-Related Quality of Life (WRQoL; Van Laar et al., 2007) scale, split into its six sub-scales, was used to assess quality of working life and working conditions. The six subscales are: Job career satisfaction (six items), Stress at work (two items), General wellbeing (six items), Home-work interface (three items), Control at work (three items), and Working conditions (three items), as well as overall work-related quality of life. Each subscale has good reliability (Cronbach's alpha of each sub-scale scored between 75 and .88, with overall scoring of .91; Easton and Van Laar, 2018) and validity, as does the overall measure (see e.g. Easton and Van Laar, 2018). All WRQoL questions are answered on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Item scores were totalled for each subscale so that higher scores indicated better quality of working life, apart from the Stress at Work subscale where higher scores indicated higher stress levels.

Demographic questions covered age, gender, ethnicity, and whether the respondent considers themselves to have a disability, part/full time contract, and amount of experience in the role. Three further questions were asked to better understand whether the pandemic had impacted upon their working lives: whether they had been re-deployed due to COVID-19, how many sick days they had taken in the previous year, and whether any sick days taken had been due to COVID-19.

Analytical Strategy

Quantitative data were analysed using IBM SPSS 24.0 (IBM, Armonk, NY, USA). Firstly, mean and standard deviation descriptive statistics were calculated for the sample as a whole at each time point and separated by job role (social work, and social care). Secondly, a series of

independent samples t-tests was conducted in order to determine differences in scoring on each measure between Phases 1 and 2 for all respondents as well as separated by occupation. Finally, three regression analyses were undertaken in order to investigate the impact of working conditions on wellbeing at Phase 2 for all respondents, and separated by occupation.

Results

Descriptive Statistics

Table 3 below demonstrates mean scoring at Phases 1 and 2 on each of the variables included within the study, separated by occupation. Mean scoring on each measure was worse at Phase 2 than it was at Phase 1 for all variables, suggesting worsened scoring over the study period. Similarly, across most variables, social workers' mean scoring was higher than that of social care workers, indicating better wellbeing and working conditions at both Phases 1 and 2. Exceptions include higher scoring for social care workers on work stress at both time points (indicating better levels of work stress), wellbeing at Phase 2 (indicating better wellbeing scoring), and working conditions at Phases 1 and 2 (indicating better general working conditions). UK norm scoring on the SWEMWBS has been found to be 23.7 for males and 23.6 for females (Ng Fat et al., 2017), indicating our sample as a whole had poorer psychological wellbeing than the national average.

Table 3: Mean and standard deviations (in brackets) for Short Warwick-Edinburgh Mental Wellbeing scores and Quality of Working Life subscales for social work and social care professionals at two time points.

			All respondents Mean (SD)	Social work Mean (SD)	Social care Mean (SD)
Short Warwick-Edinburgh Mental Wellbeing Scale (Mean, SD)		Phase 1	21.10 (3.86)	21.20 (3.36)	21.08 (3.93)
		Phase 2	19.96 (3.48)	20.08 (3.17)	19.94 (3.52)
Quality of Working Life (Mean, SD)	Total	Phase 1	79.95 (15.42)	80.52 (13.45)	79.86 (15.73)
		Phase 2	73.46 (16.25)	73.71 (15.25)	73.42 (16.42)
	Career satisfaction	Phase 1	21.74 (4.85)	22.41 (3.97)	21.63 (4.97)
		Phase 2	20.59 (5.05)	21.26 (4.42)	20.48 (5.14)
	Work stress	Phase 1	5.33 (2.02)	4.74 (1.81)	5.42 (2.03)
		Phase 2	4.58 (1.77)	4.09 (1.78)	4.66 (1.76)
	Wellbeing	Phase 1	20.40 (4.62)	20.67 (4.27)	20.36 (4.68)

		Phase 2	18.52 (4.95)	18.44 (4.70)	18.53 (4.99)
	Home-work interface	Phase 1	11.28 (2.69)	11.30 (2.57)	11.28 (2.71)
		Phase 2	10.20 (2.93)	10.53 (2.81)	10.15 (2.94)
	Control at work	Phase 1	10.41 (2.67)	10.56 (2.51)	10.38 (2.70)
		Phase 2	9.23 (302)	9.63 (2.91)	9.16 (3.04)
	Working conditions	Phase 1	10.86 (2.47)	10.69 (2.38)	10.89 (2.49)
		Phase 2	10.27 (2.73)	9.72 (2.74)	10.36 (2.73)

Independent Samples T-Tests

A series of independent samples t-tests was undertaken to determine whether significant differences were found between all social care and social work combined respondents in Phase 1 and Phase 2. Significant differences were found between Phases 1 and 2 on all measures utilised. As such, the SWEMWBS (t=8.48, p<.05); total WRQoL (t=11.12, p<.05), career satisfaction (t=6.34, p<.001), work stress (t=10.80, p<.001), wellbeing (t=10.80, p<.05), home-work interface (t=10.62, p<.001), control (t=11.32, p<.001), and working conditions (t=6.21, p<.001) all respondents scored significantly lower (i.e. worse) at Phase 2 than respondents at Phase 1.

Furthermore, independent samples t-tests were undertaken for each of the two social care roles: social workers and social care workers on each of these measures. Within the social work occupation, two of the measures included demonstrated changes from Phase 1 to Phase 2. As such, each of control at work (t=3.57, p=.005) and working conditions (t=3.91, p<.05) were significantly different. For social care workers, all measures other than job career satisfaction saw significant worsening from Phase 1 to Phase 2. As such, for each of the SWEMWBS scores (t=7.75, p<.001), total WRQoL (t=10.05, p<.001), work stress (t=10.16, p<.001), general wellbeing (t=9.60. p<.001), home-work interface (t=10.25, p<.001), control at work (t=10.78, p<.001), and working conditions (t=5.09, p<.001) all scored significantly worse.

Table 4: Linear regression of Phase 2 findings on the impact of working conditions on Short Warwick-Edinburgh Mental Wellbeing scores for social care workers.

	Significantly Related Factors	Coefficient Estimates	t	p	Tolerance	VIF	R2	Adjusted R2
Warwick-Edinburgh Mental Wellbeing Scale	Job Career Satisfaction	.01	.52	NS	.30	3.39	.63	.63
	Stress at Work	.01	.29	NS	.77	1.30		
	Working conditions	-.13	-3.58	<.001	.37	2.74		
	Control	.33	10.25	<.001	.39	2.58		
	General wellbeing	.45	26.29	<.001	.51	1.95		
	Home-Work Interface	.05	1.91	NS	.60	1.66		

NS = Not significant

Regression Analyses

Table 4 demonstrates the findings from a regression analysis looking at the impact of WRQoL variables (career satisfaction, stress at work, working conditions, control at work, general wellbeing, and home-work interface) on psychological wellbeing (as measured by the WEMWBS) at Phase 2 for all UK social care worker respondents. The model was significant ($p<.001$), accounting for 63% of variance in the model. Each of general wellbeing, control at work, and working conditions were significant predictors of psychological wellbeing ($p<.001$). VIF is above .2, and tolerance less than 10, for each variable indicating no collinearity (Field, 2013).

Table 5: Linear regression of Phase 2 findings looking at the impact of working conditions on Warwick-Edinburgh Mental Wellbeing scores for social workers.

	Significantly Related Factors	Coefficient Estimates	t	P	Tolerance	VIF	R2	Adjusted R2
Warwick-Edinburgh Mental Wellbeing Scale	Job Career Satisfaction	.02	.34	NS	.43	2.31	.56	.55
	Stress at Work	.12	1.29	NS	.74	1.36		
	Working Conditions	.05	.69	NS	.46	2.15		
	Control at Work	.06	.82	NS	.49	2.02		
	General wellbeing	.45	10.00	<.001	.49	2.05		

	Home-Work Interface	-.06	-.87	NS	.59	1.71	

NS = Not significant

A further regression (Table 5) was conducted to investigate the influence of WRQoL variables on the WEMWBS on social workers at Phase 2. Here the model was also significant (p<.001) and accounted for 55% of the variance. General wellbeing was the only factor significantly related to WEMWBS (p<.001). Again, no collinearity is detected.

Table 6: Linear regression of Phase 2 findings looking at the impact of working conditions on Warwick-Edinburgh Mental Wellbeing scores for all social care and social work respondents.

	Significantly Related Factors	Coefficient Estimates	*t*	*P*	*Tolerance*	VIF	R2	Adjusted R2
Warwick-Edinburgh Mental Wellbeing Scale	Job Career Satisfaction	.14	.72	NS	.32	3.16	.61	.61
	Stress at Work	.04	.96	NS	.77	1.30		
	Working Conditions	-.10	-3.07	<.005	.30	2.54		
	Control at Work	.29	9.79	<.001	.40	2.48		
	General Wellbeing	.45	27.83	<.001	.52	1.93		
	Home-Work Interface	.04	.03	NS	.61	1.65		

NS = Not significant

Finally, a third regression analysis was undertaken with all respondents at Phase 2 (see Table 6). Again the model is significant (<.001), accounting for 61% of variance. Each of general wellbeing, control at work (both p<.001), and working conditions (p<.005) was significantly related to wellbeing outcomes. However, VIF calculations for general wellbeing were below 2.00, suggesting possible collinearity within this model and thus findings should be taken with caution.

Discussion

Summary of findings and comparison with other literature

We aimed to investigate the changes in working conditions and wellbeing in social work and social care workers across the UK at two time points during the COVID-19 pandemic; Phase 1 (May–July 2020) and Phase 2 (November 2020–January 2021). To the authors' knowledge this is the first study comparing working conditions and wellbeing in the social care and social work workforce during the pandemic as previously many studies have only addressed elements of the sector or have studied health and social care/work professionals during this time. Our results showed significant differences between Phase 1 and Phase 2 on all measures examined. Study respondents had a mean score of 21.1 at Phase 1 and 19.96 at Phase 2 for psychological wellbeing (SWEMWBS). In contrast, the UK population norm scoring for the SWEMWBS was 23.7 males and 23.6 for females (Ng Fat et al., 2017) with a general population mean of 23.61 (NHS Health Survey, 2011). These findings indicate our sample has poorer psychological wellbeing than the pre-COVID-19 national average. Additionally, our findings indicate that general wellbeing, control at work, and working conditions were significant predictors of psychological wellbeing (p<.001). This demonstrates the importance of ensuring that good working conditions are in place for the social work and care workforce to support or sustain their psychological wellbeing, although this was of course difficult to achieve during the pandemic (McFadden et al., 2021).

Similar to others' findings from related sectors across the UK and beyond, we found that the social care workforce was under severe pressure during the height of the pandemic and subsequently as demand has increased following its first waves (Reddington et al. 2021; Johnson et al. 2020). Lockdowns, government restrictions and social distancing guidelines threatened relationship-based practices that social care and social workers traditionally rely upon (Golightley and Holloway, 2020; Farkas and Romaniuk, 2020). Face-to-face contacts were minimised and communication largely moved online for social workers with home working commonplace for over a year (McFadden et al., 2021; Abrams and Dettlaff, 2020). However, while there is far less home working among social care workers, they have seen high levels of illness among their service users, huge changes to their service users' lives and social contacts, and have had to adapt to constant and changing infection control measures. These changes could have a negative psychological impact due to prolonged stress, higher job demands, changing responsibilities and limited resources worsened by the COVID-19 pandemic (Harrikari *et al.* 2021; Holmes *et al.* 2021; Miller and Reddin Cassar, 2021). These stresses highlight possible reasons for the deterioration between Phases 1 and 2 within this present study.

Our findings reflect those from a study of the overall health and social care workforce (Augherson et al. 2021) which also highlighted that psychological wellbeing has been negatively impacted during the COVID-19 pandemic. This qualitative study found that increasing workload and changing conditions left the health and social care workforce often fatigued while faced with communication challenges and increased work-related stressors. These findings coincide with the recent BASW (2021) which reported that 58.8% of social workers surveyed considered that working during the crisis had negatively impacted their mental health while 68.3% said it was more difficult working at home than in the office. Such problems are not confined to social work but are evident in the general workforce population that has been able to work from home. From The Netherlands, in a survey of the general working population that took place June-July 2020, Pluut and Wonders (2020) reported that COVID-19 had heightened the levels of blurred work-life boundaries reducing happiness and wellbeing.

Some social workers began to feel less positive and less able to cope with their work as the pandemic progressed (Johnson et al., 2020; Reddington et al., 2020). However, achieving a perfect balance of good working conditions and good psychological wellbeing can be difficult for this workforce. The findings from this present study indicate that work stress, maintaining a balance in the home-work interface, feeling of control of work and working conditions, were all significantly lower as the pandemic continued. These findings are consistent with other research which suggests that work-life balance can be difficult in this profession as it is currently organised in the UK, particularly if working practices changed (e.g. working at home/remotely) and with less team support, opportunities and resources available (Schieman et al. 2021). Combined with previous research, this study highlights that more is needed to support the social work workforce during the pandemic across both individual, organisational and policy levels if wellbeing and work-related quality life are to improve.

Turning to social care work our findings suggest many similarities of responses, although by Phase 2 nearly 40% of social care workers had taken sick leave owing to COVID-19 suggesting a very high level of exposure to the virus possibly arising from their inability to work from home and substantial contact with people who were infected (see Table 2). Levels of work stress were higher for social care workers than for social workers but for both, they were higher at Phase 2 than Phase 1. Interestingly, while social care workers were not so likely to be home working, as Table 3 shows, they experienced problems with their home /work interface perhaps indicative of their fears of bringing infection to their family at home and having to work increased hours or unpredictably which may have caused difficulties in maintaining a work/life balance as well as being more likely to have witnessed or known of pandemic sufferers and mortality. Another small social care survey (Hussein, 2020) reported

that most (81%) of 296 social care workers saw their workload heavily increase since the onset of COVID-19 with 56% of this workforce facing longer work hours and 42 per cent less satisfied within their job. Spilsbury et al (2021) and White et al. (2021) have highlighted the considerable uncertainties among care home workers during the first months of the pandemic about their safety while others have commented that COVID-19 amplified the difficulties of care homes in terms of their resourcing and wider support (Gordon et al., 2020). An Italian study suggested that during the first outbreak of COVID-19 care home workers were under increased pressures due to the pandemic which led to the development of psychiatric symptoms at different levels (Riello et al. 2020). These authors found an increasing prevalence of anxiety and recommended interventions for improving staff wellbeing and resilience. Despite this, and perhaps explaining why the wellbeing of social care workers was not worse than might be expected, there have been reports of how the pandemic increased the workforce's untapped capacity; 'Managers reported that the skills and determination of care home staff was a source of resilience. Managers spoke of pride in their teams, who worked with tenacity and creativity, and recognised skills that had previously not been required' (Marshall et al., 2020, pp. 5).

Limitations of the Study

This study addresses the gap in research investigating the changes in working conditions and wellbeing in social work and social care workers across the UK during the COVID-19 pandemic. Strengths of this study include the robust sample size and the use of well-established, reliable outcomes measures of SWEMWBS and WRQoL. Furthermore, given the unpredictable nature of the COVID-19 crisis, this study is important in capturing the difference in work-related quality of life and wellbeing over the duration of the pandemic which is crucial in helping identify the challenges related to the social care workforce. This is a strength of the cross-sectional design which allows for association across multiple outcomes to be examined to understand prevalence (Wang and Cheng, 2020). However, several limitations are important to acknowledge.

Firstly, recruitment was undertaken via an opportunistic and snowball sampling methodology through emails, newsletter, and social media posts. A snowballing sampling strategy can introduce sampling bias as it is a non-probability method and tends to generate a sample that is unbalanced by selected demographic groups while opportunity sampling can be unrepresentative (Leighton et al. 2021; Sadler et al. 2010). Secondly, data were collected online using a self-report survey which may increase the risk of selection bias, social desirability bias or recall bias (Rosenman et al. 2011). However, this was the most appropriate and ethical way to safely gather data on a large scale during the pandemic and allows better accessibility to information (Nayak and Narayan, 2019).

Thirdly, while the cross-sectional design helped gain a representative understanding of the impacts that the COVID-19 pandemic has had on social work and social care workers in the UK, the study design means we cannot determine causality. Furthermore, our findings of this study cannot rule out other environmental drivers that influenced work-related quality of life and wellbeing and therefore must be viewed tentatively. Fourthly, the results suggested possible collinearity within this model and thus findings should be viewed with caution as this could have led to an inflation of the variance of regression parameters (Dormann et al. 2013). Finally, most of the sample at both time periods were female (over 85%), therefore any generalisation to male social care workers and social workers must be considered tentatively. However, this higher representation of females involved in the study is largely reflective of the majority composition of the social work and social care profession (Holmes et al. 2021; Batra et al. 2020). Additionally, over 94 per cent of the sample were White, this makes the findings of this study less generalisable to other ethnicities. Furthermore, most of the sample were from Northern Ireland and England in Phase 1 (90%) with a smaller sample of respondents from Scotland and Wales (10%). In Phase 2, the distribution of response rates per country were more balanced, with Wales having a higher response rate than the first Phase, at 31% of the total sample. Northern Ireland made up 34%, England 22% and Scotland 13%. Levels of response rate makes the findings of this present study more or less generalisable to the social work and care workforce in the included countries. The authors therefore do not make generalisable claims in the data but see the value of the research as a snapshot at time-points during the pandemic Phases.

Implications and Future Research

Despite the limitations of this study, the results have several important implications to consider. Our findings have highlighted that work-related quality of life and wellbeing deteriorated between Phase 1 and Phase 2. This demonstrates the importance of understanding that the social work and care workforce was already one of the most stressful areas of employment within the UK and at risk of severe mental health problems due to work pressures and caseloads or care work. Therefore, the major implication of this study is to highlight that individuals, organisations and government departments need to limit stressors on social work and care employees for any future crisis, but also to address the widespread stressors that were evident pre-pandemic and seem to account in part for high staff turnover and vacancy rates which affect continuity and quality of care and support.

More specifically, there is evidence that long-lasting stressors impacting on work-life balance also often led to burnout and lower wellbeing (Holmes et al. 2021; Peinado, and Anderson, 2020). Already in England, the Local Government Association has highlighted that 94 per cent of County Councils find it difficult to recruit children's social workers (Local Government

Association, 2021), while the high turnover rate of social care workers remains (Skills for Care, 2020). The findings of the present study suggest that with decreasing wellbeing and quality of working life, the social care workforce may be at a greater risk of burnout and thus accelerated exit from the sector.

Employing organisations need to develop strategies which offer support and coping strategies to counteract increased stress which impedes wellbeing and quality of working life. This could build on evidence that negative psychological impact may be able to be reduced when good two-way communication and the introduction of early support systems and reflection time are in place, reducing the severity of work-related stressors (Evanoff et al. 2020; Greenberg et al. 2020). Compassionate employers, and a positive, supportive workplace could overcome the pressure in social work and care work and improve wellbeing and work-related quality of life (Cook et al. 2020; Kalliath et al. 2020). Other means of achieving a better work-life balance to improve wellbeing must involve a health-promoting lifestyle with training and development opportunities, self-care, flexible working hours and less excess demands and working responsibilities (Miller and Reddin Cassar, 2021). Kalliath et al. (2020) have suggested that by promoting work–family measures among the social care workforce, this can contribute to positive work outcomes. The potential of these workplace supports also are evidenced in this current study and formed one of the 'good practice recommendations' in the main study report which emerged from the data (McFadden et al., 2021).

Future research could investigate how burnout influences wellbeing and work-related quality of life and the role positive coping strategies play in improving the wellbeing and work-related quality of life of the social work and care workforce. Furthermore, more in-depth work is necessary to better understand the impact of COVID-19 and its legacy on working conditions and psychological wellbeing to provide further clarification of the quantitative data collected in this present study. This would allow for a better understanding of work-related quality of life at both individual and organisation levels to be able to develop further recommendations to mitigate the negative impact of the pandemic and its legacy on the wellbeing of social work and care workers.

Conclusions

In summary, the UK social care system is complex and fragmented with a workforce that has been both severely overwhelmed yet resilient, while social workers may be under pressure due to increased service demands following the height of the pandemic. The results from this study provide the social work and social care workforce with a voice that evidences the impact of the COVID-19 pandemic (May 2020-January 2021) on working conditions and wellbeing. Notably, the study found that mental wellbeing and work-related quality of life worsened as

the pandemic continued and the UK started to experience a second period of lockdown following rising numbers of deaths and infections. Findings showed significant differences between Phase 1 and 2 on all measures examined. The results of this study have the potential to inform recommendations and interventions to improve working conditions within the social care and work professions, whose experiences, while different at some levels, were similar in respect to the stressors they encountered.

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