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Work related well-being in the UK physiotherapy workforce: Part 2. Documentary analyses of the qualitative data from the YOURvieWS cross-sectional e-survey

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Abstract

Objectives To explore and understand the replies to the quantitative findings (Part 1) from the work related well-being e-survey, provide greater depth information about the topic and identify new issues/areas from respondents in Part 2 of this two part paper.
Design Cross-sectional, convenience, voluntary, open e-survey.
Setting Online.
Participants UK physiotherapy workforce, including physiotherapists, students, support workers across all workplace settings and across the UK.
Methods Following development, pre-testing and ethics approval, the e-survey was widely advertised and ran from 08/03/2023 to 30/04/2023 via Bristol Online Survey. The open comments question in the e-survey was: 'We are keen to hear your views, please type up to three key factors that you think impact most upon work-related well-being within physiotherapy'.
Analyses Open comments analyses using content analysis to interpret meaning from the content of text data.
Results 612 respondents provided 1649 overall comments to. One overarching theme and three subthemes incorporating seventeen factors were developed from 138 initial codes. The overarching theme was moral distress and moral injury reducing work related well-being (WRWB) within the physiotherapy workforce. Subthemes were 1. Impact on me. 2. 'You aren't able to do your job properly'. 3. Management and support. Subthemes and factors fitted within the overarching theme.
Conclusions Moral distress and injury explained the quantitative findings (Part 1) regarding poor work-related well-being, burnout and stress within the physiotherapy workforce. Moral injury is the consequence of organisational processes and broken health care systems, strategies to improve WRWB across all UK physiotherapy settings are urgently required.

Contribution of the Paper

- Provides evidence of worrying levels of moral distress and moral injury experienced by responding members of the physiotherapy workforce.
- Highlights the distress for members of the physiotherapy workforce and the impact upon patient care when organisations and health systems are not working well.
- Evidences a clear call for action.

Keywords: Physical therapy specialty; Health workforce; Health personnel; Moral distress; Moral injury; e-survey

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Introduction

A cross-sectional, convenience, voluntary, open e-survey was undertaken (08/03/2023 to 30/04/2023) to explore burnout, professional fulfilment, work related stress, well-being and working patterns within the physiotherapy workforce. Respondents included physiotherapists, students, physiotherapy assistants/support workers across a wide variety of NHS, private and independent workplaces and education settings and across the United Kingdom. The quantitative findings of the e-survey were reported in Part 1 of a two-part paper which found that the positive workforce developments being experienced within the physiotherapy profession are threatened by poor work-related well-being, including burnout and stress. The e-survey also included an open comments question regarding work related well-being (WRWB) which was included to allow participants to tell us their thoughts about the topic and provide context to the quantitative findings. The objective of this Part 2 paper is to explore and understand the replies to the quantitative findings from the e-survey to explore work related well-being within the physiotherapy workforce, provide greater depth information about the topic and identify new issues/areas from respondents.

Methods

The open comments question in the e-survey was:

We are keen to hear your views, please type up to three key factors that you think impact most upon work-related well-being within physiotherapy.

Three response boxes each allowed up to 300 characters.

The e-survey was advertised using social media, newsletters, and professional networks, detailed in Part 1, and all eligible responses between 08/03/2023 and 30/04/2023 were included. Advertisements included a link to the survey. The development and piloting of the survey is also detailed in Part 1. The survey included the 5 item WHO (World Health Organisation) well-being questionnaire, the Stanford Professional Fulfilment Index, two previously validated item scores for work related and private life related stress, up to 14 questions from the NSS22-Core-Questionnaire to capture diversity and inclusivity data and additional demographic questions.

Data analyses

Open comments data analyses were used to understand the replies to closed questions, provided more depth of information about the topic and identified new issues/areas [1] and content analysis used to interpret meaning from the content of text data [2]. Survey comments were exported into a word document. Two researchers read all comments repeatedly. CML is an academic researcher with over 25 years of qualitative research experience, MD a pre-registration physiotherapy student on a research placement. Both researchers independently coded the first hundred comments and discussed early codes. Following close agreement, MD coded all responses, regularly discussing these with CML and raising questions about coding/codes. Both researchers discussed the active development of themes. MD initially wrote up the themes. CML re-read all comments again, looked for additional or deviant data/codes and developed the final order and content of themes. A member of the team (AM) was available if further discussion was needed, this was not required.

Findings

612 of the 777 eligible respondents provided 1649 overall comments. One overarching theme and three subthemes incorporating seventeen factors were developed from 138 initial codes (summarised in Fig. 1).

Main theme

The overarching theme was moral distress and moral injury reducing WRWB within the physiotherapy workforce.

Subthemes were developed; 1. Impact on me. 2. 'You aren't able to do your job properly'. 3. Management and support. Subthemes and factors all fitted within the overarching theme.

Please see Fig. 1 to obtain an overview of the overarching theme and subthemes.

Sub Theme 1: Impact on me explored the factors of work/study that had an impact on the individual and their WRWB.

WRWB and COVID-19

Many respondents were still living with the impact of the pandemic, with exhaustion, fatigue and decline in physical health reported plus the added strain upon depleted teams when members were unable to work (Table 1). The impact of COVID related fatigue led to some respondents choosing to neglect social activities '*choosing to put energy into working then not having enough for socialising*". Long COVID affected some respondents:

I can work but I am too fatigued to manage most of my normal social activities and interests other than looking after my two young children…poor work/life balance.

Respondents reported how their physical health suffered after working throughout COVID, one also responded that

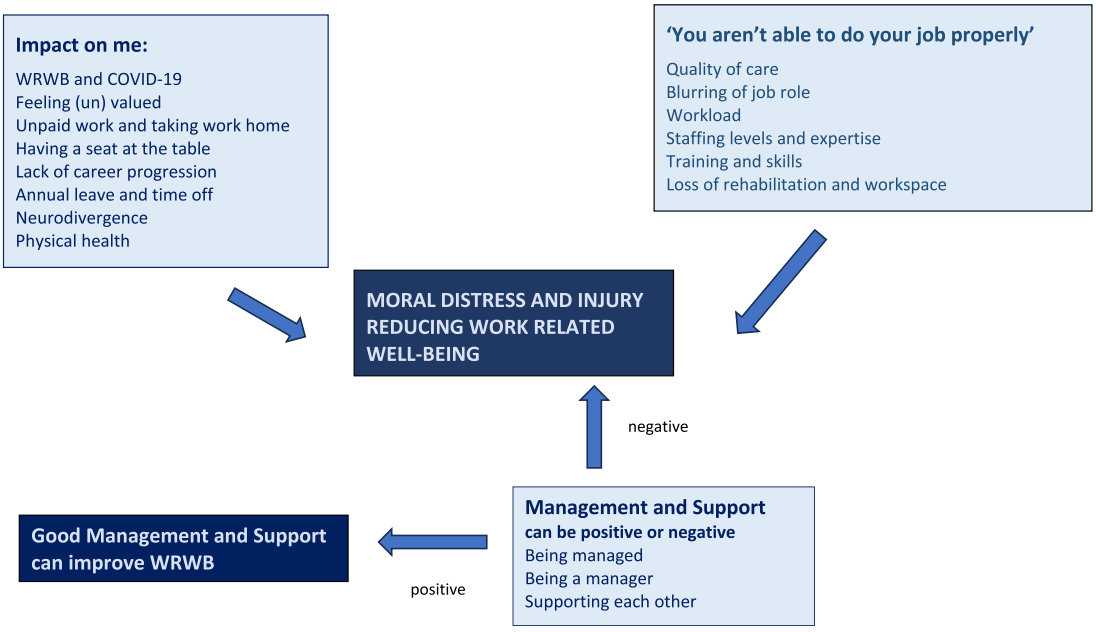

Fig. 1. Summary of the overarching theme and subthemes from YOURvieWS open question data.

they *'Have put on 2 stone and am having to put in effort to cut down on drinking wine'*.

Feeling (un)valued

Many respondents felt that *'receiving thanks/gratitude for work'* impacted WRWB. One felt unappreciated as a knowledgeable member of the multi-disciplinary team '*not being valued as a person, or an experienced clinician'*. Another appreciated their job but felt undervalued overall (Table 1). Frustration was expressed when organisations were not seen as valuing staff:

they just want to milk us, with no recognition by thanking and supporting staff adequately.

Some felt job satisfaction was not considered by management and felt dehumanised '*Staff are just numbers on a page'*. Another reported feeling that the NHS exploits the generosity of its staff (Table 1). Some were considering leaving the NHS:

I am looking for a way out of the NHS to build a future elsewhere which is very sad as I love patient contact, but it is burning me out.

Pay and value were linked and could impact upon WRWB:

Poor pay - feel underpaid, hence undervalued and am stressed about not being able to pay bills at home.

The *'low levels of pay'* meant some respondents *'need to do 2 jobs*' which:

impacts on well-being as physios have to work overtime or do a 2nd job to make ends meet.

Unpaid work and taking work home

Staying behind after work to complete non-clinical work, or logging on '*to finish later'*, was reported as rising with increased workload (Table 1). Home workers felt similarly, *'starting early, finishing late, especially when working from home.'* Some felt working over their hours was an '*expectation*' which could prevent staff from leaving '*on time to be with my family'*, negatively affecting work life balance (Table 1).

Respondents reported work related stress:

I have started to take the emotional load…home, which I have never done previously. Waking up worrying about my job and the pressures.

Conversely, one respondent shared how they managed their work life balance and supported positive mental health through working part-time:

Working 3 days for the last 25 years…work balance life is good which allows for my physical recreation and a positive mental health.

Having a seat at the table

Many respondents perceived a lack of control to drive change, wanted to be involved in the decision-making for their service, and were frustrated as they were *'not being involved in decisions impacting me & my service'* (Table 1). Another associated this frustration with the *'downfall of services as a whole'*.

i.e., quality of therapy provided, frequency of therapy provided…inability to change a service or pathway that doesn't work.

Table 1
Quotations to support the subthemes from YOURvieWS open question data.

THEME/SUBTHEME	Longer quotations to support subthemes
Overarching Theme: Moral Injury Reduces WRWB	
Sub theme 1: Impact on me	
WRWB and COVID-19	Just exhausted - COVID is never ending and infection prevention and control now refuse to routinely test pts (patients). This puts a strain on the team as we have several staff members who are immunocompromised & so cannot see patients.
Feeling (Un)valued	Love my job, love my clinical work, not…NHS politics…feel undervalued in terms of grading level, pay etc and…professional influence. The NHS runs on the goodwill of its staff, healthcare staff who were once respected as professionals now use foodbanks. I know a band 6 who has to live in a motorhome to have any sort of quality of life.
Unpaid work and taking work home:	Responding to emails, making patient phone calls, writing…no admin support or protected time…staying late after work hours to do this in unpaid own time. Pressures at work mean I'm exhausted when I get home and have little energy to engage with things I need/want to personally….
Having a seat at the table	Management actively listening to staff and involving them in the decision-making processes, unfortunately our management is particularly poor at this.
Lack of Career Progression	limited educational/development opportunities can lead to stagnation with a career.
Annual Leave and Time Off	more pressure before you go off (AL) and again when you come back…"paying for being off" as my diary is very often busier when I get back.
Neurodivergence	Dyslexia Access to Work requirements had not been met 'despite chasing it up and escalating".
Physical Health	[I] do not always get to use (wellbeing time in diary) time….can really impact negatively on rest of the day (even once home)
Sub Theme 2: 'You aren't able to do your job properly'	
Quality of Care	High levels of pressure on workforce to facilitate early discharges, less opportunities for rehab for our patients…not always offering our patients the best service. No time to practice rehabilitation or measure input, only assess and discharge. (Community)…Discharge to assess has been a heinous implementation in the NHS and is the death knell to rehabilitation.
Blurring of Job Role	We essentially do social work, not physio, but without any training and with huge bureaucracy barriers. We see patients in impossible, distressing, and dire situations, with little power to help them with the most pressing issues. a lot of patients don't know what physiotherapy is/can do or have unrealistic expectations…improving public awareness of what physiotherapists do would be important.
Workload	I love teaching students and supporting them…but it's a constant stressor…ensuring …a high-quality placement, whilst also ensuring the clinical work is still done effectively. Waiting time - patients are having to wait long time to be seen which makes me feel under pressure…
Staffing levels and experience	we have a massive gap in band 6 staff and our band 5 staff have had poor placement experiences…This puts a massive strain on us band 7 seconds in the team who are trying to juggle all elements of work.
Training and Skills	Lack of investment in professional development. Over the last few months CPD time has been put on hold but now we're getting emails scolding staff that their mandatory training has lapsed. It's beyond demoralising.
Loss of Rehabilitation Workspace	Lack of space to work due to department loss during pandemic Pressures of waiting list but not having a proper department in our biggest demand area, therefore not enough room to accommodate all the staff we would need to be able to deal with the list.
Subtheme 3. Management and support	
Being managed	managers' report they strongly value our wellbeing, they don't put in wellbeing activities that are easy to access or which staff necessarily want, but equally report they are frustrated by the lack of uptake.
Being a manager	High expectations on managers to provide support to all members of the team all the time. Unrealistic expectations on senior staff. Disparity of treatment of staff and particularly seniors/managers. As a line manager, dealing with negative attitudes, increased staff absence and supporting staff with their mental health has increased my workload…a heavy load at times.
Supporting each other	teamwork and interpersonal relationships are great in my team and help to improve wellbeing. Feeling dread talking to physio colleagues, poor trust/relations…so much gossip and backbiting, feeling… closed off, unable to be my authentic self at work. There is no mental health support at work. Management are woefully unprepared for staff with mental health issues or how to support band 7 supporting band 6 seconds with mental health issues.

A private practice respondent voiced a different frustration:

I feel frustrated that I can't develop the service that these patients need because I am in private practice.

Lack of career progression

Lack of opportunities for career progression were raised (Table 1), particularly for those in more specialist roles and areas with fewer Trusts.

Lack of opportunity for specialist clinical progressions in the physiotherapy careers in (country).

Financial barriers to career progression for support workers positions were highlighted:

As a band 4 there are virtually no career progression options…I would love to do a Masters in PT but cannot foresee ever being able to financially achieve this.

Annual leave and time off

This was mentioned infrequently. One respondent was worried *'about being sick as again, cannot afford time off'*, another around taking and returning from annual leave (Table 1).

Neurodivergence

A small number of respondents reported being neurodivergent, had specific learning difficulties or required extra support. They reported how the physical health symptoms that came with *'ADHD'* or *'neurodivergence'* such as *'fatigue'* had an adverse impact on workplace wellbeing. One respondent reported that their Dyslexia Access to Work requirements had not been met (Table 1) '*despite chasing it up and escalating*".

Physical health

The ability to be *'physically active'* in day-to-day work was valued by many respondents as was ensuring *'adequate breaks'*. For many this was not possible (Table 1). One respondent noted '*it's so ironic'*, a profession that promotes healthy and active lifestyles and used to be a very *[physically]* active job, is now sedentary '*I've never sat so much in my life"*.

Subtheme 2: 'You aren't able to do your job properly'. Many respondents reported increased workload, reduced contact time with patients, feeling unable to provide the quality of care that patients deserve.

Quality of care

Many reported a *'drop in standards of care'* and *'number crunching'* and a shift from providing rehabilitation to a '*constant push for discharges'* (Table 1). Limited time with patients added further stress as this '*affects tailored treatment, patient preparedness and contributes to stress'*. Early hospital discharge can reduce rehabilitation quality (Table 1). It was felt that '*the patient is in no way central'*; patient-centred care has been lost through increasing waiting lists, leading to a reduction in the service quality "*instead of excellent service to a few, shoddy service to all is requested'*.

Blurring of job role

A shift in the NHS to focus to discharge and administration rather than rehabilitation was highlighted, despite patients being/becoming more complex:

High levels of pressure on workforce to facilitate early discharges, less opportunities for rehab for our patients

The negative impact of this upon job satisfaction was emphasized and the changes in role are problematic.

I didn't become a physio to do a desk job but that is what I spend more time doing… I am a clinician, not a secretary.

Others reported changes to extend their role beyond their training which could cause distress and feeling '*out of my depth and saddened'* (Table 1). An alternate view was that patients are unsure of the scope of physiotherapy (Table 1).

Workload

Respondents reported dramatically increased workloads, impacting their mental health due to the "*Psychological impact of growing waiting times/waiting lists on the physiotherapist*" and hindering the development of junior staff/students as senior team members are unable to find time to support them (Table 1):

Low morale and overworking means supervisors and team leads don't have the time/ patience to support/ mentor me.

Some fear there are '*No signs of workload reducing in the near future"*. Many respondents felt under pressure to get through waiting lists (Table 1). Another added that waiting times *'have felt unacceptable to me since COVID' which* can cause patients to become unhappy with the service.

Length of time patients are on the waiting…patients can be disgruntled before even get into the department.

Patients also became '*deconditioned*' during lock down, have '*more comorbidities….making consultations more complex & challenging'*. Another respondent identified how some patients had developed agoraphobia due to the fear of contracting COVID when attending patient groups or appointments.

Staffing levels and experience

The NHS was considered '*chronically understaffed'*. Staffing levels were considered inadequate for the increased workload, which could be '*overwhelming*' with a detrimental effect on service quality. Others found staff absences and vacancies took time away from their own tasks,

'Demands on my time - covering for staff vacancies and absences.' Lack of staff and experience were mentioned frequently (Table 1):

we are under pressure to see more patients with less staff and still provide the same level of service or more.

Big catch up to support to upskill (new recruits/staff) daunting and challenging.

However, a respondent reflected that lack of staff was present long before COVID-19:

no more qualified staff than was in the team when I started here in 2011, however the volume and complexity (of patients) have risen considerably.

Training and skills

A large number of respondents lacked protected time for continuous professional development (CPD) and lacked opportunities for supervision and development causing them to feel less effective and demoralised (Table 1). Others described self-funding to:

fund own courses for CPD and take annual leave to attend. Inservice training significantly reduced…Not only reduces evidence-based practice, but time to discuss issues with colleagues in a constructive format.

A lack of training has led some respondents to feel limited as they felt it necessary to prioritise other's learning over theirs when in a leadership role:

Feeling of limited learning & development opportunities as teaching lower grades but not getting input / time to learn myself.

Others were discouraged that their skills feel "*watered down*" which is '*disheartening*".

Loss of rehabilitation workspace

During the pandemic some lost rehabilitation workspace was lost and has not been returned (Table 1). A respondent discussed how their workplace also lacked staff space and facilities '*space to put belongings…areas for lunch that aren't dumping grounds'*. Insufficient staff space (Table 1) and clinical time could also be impacted:

Lack of appropriate staffing facilities [lead to] lots of walking between facilities that ultimately reduce amount of clinical work time.

Subtheme 3. Management and support. This theme demonstrates how managing others/being managed impacts upon work/study and the importance of appropriate support.

Being managed

Compassionate and supportive leadership held great importance to many respondents *'Great management by an empathetic and caring manager'*. Whereas lack of support led to respondents feeling unsupported and left to deal with issues on their own.

Unsupportive disconnected management, whom we do not see…issues raised are not responded to.

Support could vary across different workplace settings "*the difference in support was huge*". Another respondent reported that, although their managers recognised the importance of their team members wellbeing, they fell short when arranging activities to improve this, leaving staff feeling unheard (Table 1). Several respondents felt systems '*exploit(s)*' them as professionals.

Being a manager

Respondents in managerial roles could experience high expectations which were considered unrealistic (Table 1). The *'pressures of balancing leadership role with clinical role'* caused stress. The impact of the demands associated with a leadership role could have a detrimental effect on a manager's wellbeing (Table 1). Being a manager might also lead to a *'lack of any patient contact'*.

Supporting each other

Support within therapy and multidisciplinary teams was valued (Table 1). Conversely 'physios can be very critical of each other…not always supportive of different viewpoints" and dread interactions (Table 1). Some reported they needed more specific support (Table 1) which could be difficult to access:

Lack of accessible sources of continued help for staff dealing with complex and traumatic problems patients face.

Some felt social interaction during/after work hours *'time away from work with your colleagues'* improves cohesion and morale *'meeting for a nice lunch together', or having* '*a social committee at work…bring us all together'*. *'Rapport with the MDT…colleagues have a massive impact…you're all in this together'*. A barrier to teamwork included stress itself:

Staff stress is causing staff to be irritable with each other which is increasing stress…it's another vicious cycle.

Supporting newly qualified physiotherapists was seen as adding strain to teams:

Newly qualified come out with less knowledge and patient memory meaning more strain on existing workforce and existing staff aren't prepared/have confidence to develop them.

With '*Low morale…means supervisors and team leads don't have the time/ patience to support/ mentor me*".

Discussion

Findings support the concerns regarding WRWB within the physiotherapy workforce identified in Part 1, providing additional context and aiding the interpretation of the

quantitative data. The overarching theme developed was the phenomenon of moral distress (MD) and moral injury (MI) in the workforce. MD is defined as the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action, whereas MI can arise where sustained moral distress leads to impaired function or longer-term psychological harm [3]. MI was initially used to describe transgressive harms and the outcomes from traumatic wartime experiences but more recently has been considered relevant for healthcare clinicians [4]. Unlike military populations, who periodically deploy to higher threat locations where potentially morally injurious events are common, the more frequent events in the course of day-to-day healthcare work can lead to cumulative harm [5].

Healthcare organizations often view patient care through the lens of business and financial interests which is potentially problematic when the business model comes into conflict with healthcare delivery: when healthcare workers are required to see more patients than they are able, when resources are inadequate and when systems fail to account for the toll these conflicting priorities have on healthcare workers and patients and staff feel undervalued [5]. When clinicians know what care patients need, but are unable/not allowed to give it, this transgresses deeply held moral beliefs or expectations ('put the patient first') and they can become morally injured [6]. Our findings show the distress felt when respondents were unable to provide quality care, were taken away from their physiotherapy role to do administration tasks, experienced excessive workloads or lost rehabilitation spaces. Previous research indicates that Physiotherapists perceiving situations as difficult to control, feel more burned out when they use more emotion-focused strategies (such as conscious activities related to affect regulation) and less problem-focused strategies [7]. When an individual experiences burnout it can be framed as a 'them' problem, they lacked resilience, they need to address the problem; moral injury however is the consequence of organisational processes and broken health care systems [6]. Chronic understaffing and the pressure to treat high numbers of patients with limited resources increase moral injury rates with increased staff absences and further understaffing, and prolonged patient contact with limited decision-making power [8]. Symptoms of MI have been found to be strongly associated with higher rates of clinician burnout, psychological distress, and lower levels of self-reported wellbeing, especially during the COVID-19 Pandemic [9]. Research during COVID-19 found nearly a third of UK healthcare workers reported experiencing potentially morally injurious events at work which were significantly associated with adverse mental health symptoms across healthcare staff [10].

The importance of emotionally intelligent leaders and managers is well known [11]. Our findings indicated supportive management to be potentially ameliorating upon WRWB. A lack of preparedness and perceived lack of empathy and respect from managers/supervisors however have been found to be potent risk factors for MI development and some of our findings do describe such negative impact [5]. Managers may also themselves be in difficult positions and experience MD or MI, feeling guilty about not having adequate resources for their staff and suppress their needs to care for their staff [9]. Whilst compassionate care is integral to our practice and our patients so we also need compassionate leadership for staff. However, our findings indicate that compassionate leadership needs to be improved: such leadership leads to more engaged and motivated staff with high levels of wellbeing resulting in high-quality care [12]. Compassionate leadership focusses on relationships, it involves careful listening to people, understanding, empathising with and supporting them so they feel valued, respected and cared for, to enable them to reach their potential and do their best work [13]. Leaders themselves also need adequate and appropriate support to be able to lead well.

Previous research identifying high levels of exhaustion in First Contact Practitioners called for the Chartered Society of Physiotherapy to provide recommendations regarding sufficient time to be allocated within job plans for appropriate supervision, training and continued professional development [14]. Our findings support the need for strategies to improve WRWB across all UK physiotherapy settings. This includes the need for workforce and organisational leaders to acknowledge the value discrepancy between person-centred care and the more task-oriented model of care necessitated in response to substantial increases in patient volume which needs to be discussed and addressed [9].

Strengths and limitations

We deliberately framed the open question as a neutral question, not asking for positive or negative views. Whilst the majority of respondents raised issues of concern or negative views this was not wholly across the board, positive comments were made too. We have indicated codes that were mentioned by many and by few respondents but deliberately not used frequency counting. Frequency counting is problematic, this survey does not have a sample representative in the dimensions needed to make inferences from the sample to the population and we do not believe providing frequency counts would enhance the description of findings [15]. The limitations regarding respondents self-selecting to participate was raised in Part 1. A non-probability sampling approach was used in this e-survey, not random selection, as eligible respondents chose to take part of their free will [16] and non-responders may hold different views. The representativeness of the e-survey findings to the true population cannot be estimated and, whilst the diversity of the demographic data in Part 1 is encouraging, the sample size obtained is small overall for the population of the physiotherapy workforce. Furthermore, the lack of generalisability is greater for open text comments data than closed survey questions, they are self-expressed and unrepresentative comments; people are more likely to comment

if they hold strong views on the topic and it also cannot be assumed that an issue raised by one respondent is not important to others who have not raised it [1]. Unusually the majority of respondents provided comments [1] and this may indicate that the respondents were keen to share their thoughts and believed the topic to be an important one.

Conclusions

Qualitative e-survey findings also raised clear and serious concerns regarding WRWB within physiotherapy. These early qualitative data have indicated that moral distress/moral injury impacting upon many respondents may explain the quantitative e-survey results. The qualitative study, undertaken as part of mixed methods research, has included focus groups and interviews with a sub-sample of YOURvieWS respondents to gain in-depth rich data beyond that possible in an e-survey, which will be reported in due course. Further research on WRWB is supported by these findings. Strategies to address WRWB and moral injury in the physiotherapy workforce need to be urgently implemented and evaluated.

Ethical Approval

Ethics approval was provided by XXXXXXXXXXXX-XXXX ref: XXX/SF/XX/05244.

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Declaration of Interest

There are no DOIs for this paper, the CSP members of staff who co-authored Part 1 had no role in this Part 2 manuscript.

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Conflict of Interest

There are no COIs to declare.

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