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RESEARCH ARTICLE

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'All about the NHS and what about the rest of us?': Exploring how low-paid health and social care workers construct key stakeholders and account for the UK's response to the COVID-19 pandemic

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Abstract

Good practice on disaster response emphasises the importance of leadership and cohesive group identities. The COVID-19 pandemic provided an opportunity to explore how low-paid health and social care workers (HSCWs) accounted for the UK government's response, given worker's limited resources and disproportionate impact on their lives. Thirteen semi-structured interviews took place with low-paid HSCWs in England. Interviews were analysed using critical reflexive thematic analysis that is influenced by discursive psychology and membership categorisation analysis to explore the construction of identities and how they are used to account for the pandemic response. Three themes were generated from the data: (1) 'They kind of knew what was coming': UK government slow to react to pandemic developments; (2) 'the right thing kept changing every 5 min': Frustrations with changing guidelines and (3) 'all about the NHS and what about the rest of us?': Private sector HSCWs presented as inferior. This research highlights the importance of addressing the minimisation of low-paid HSCWs through communications and access to

material resources. There is a need to address economic disparities within the social care sector and for the UK government to plan future crisis management with all frontline staff at the forefront to form a collective identity.

KEYWORDS
COVID-19 pandemic, critical reflexive thematic analysis, health and social care, low pay

1 | INTRODUCTION

This paper explores how low-paid health and social care workers (HSCWs) construct key stakeholders in their responses to the COVID-19 pandemic and warrant the accountability of the UK government. The World Health Organisation (2023) declared COVID-19 a Public Health Emergency of International Concern from 30 January 2020 to 5 May 2023. Despite COVID-19 being a global crisis, the UK government has been criticised for its lack of lockdown measures to restrict social contact (Sibony, 2020) and for adopting a haphazard approach (Lancet, 2020). A UK COVID-19 Inquiry has been established to examine the response to the pandemic including the role of care homes (UK Covid-19 Inquiry, 2022) although it is not estimated to be completed until 2027 (Observer, 2023). There were 29,393 excess deaths reported between 28 December 2019 and 12 June 2020 in the care home sector in England and Wales (ONS, 2020). Low-paid HSCWs were involved in close proximity care with service users who were infected with COVID-19 in residential care (Nyashanu, Pfende, & Ekpenyong, 2022). Given the challenges of caring for vulnerable people during the COVID-19 crisis period in the health and social care sector, there is a need to explore how low-paid HSCW's construct the UK government's accountability for policy decisions and implementation.

1.1 | Health and social care in the United Kingdom

The health and social care sector in the United Kingdom is understaffed and underfunded (McFadden et al., 2020). Whilst health and social care are frequently mentioned together, health care and social care are delivered and funded separately within the United Kingdom. Whilst the National Health Service (NHS) provides health care free at the point of need, social care is commissioned by local authorities and means-tested with some differences within the devolved nations (Reed, Oung, Davies, Dayan, & Scobie, 2021). Social care can be referred to as long-term care internationally (Daly, 2020) although within the United Kingdom, the definition includes both long- and short-term care within locations such as people's homes, day centres and in residential settings. Where individual assets exceed the means-testing cap of £23,250, people fund their own social care and £10.9 billion was spent privately by people for their own care (NAO, 2018). 97% of social care is delivered by independent providers (Blakely & Quilter-Pinner, 2019) with local authorities funding provision through locally raised taxes from residents and businesses, central government and user contributions after means testing (Daly, 2020). Government funding for long-term care is low by international standards, an issue highlighted by multiple public commissions (Devi, Hinsliff-Smith, Goodman, & Gordon, 2020). Despite their role in healthcare provision during the pandemic, care homes have been described as 'second class' to the 'world class NHS' (Stevenson, 2020, p. 218). Given the divisions within health and social care provision, there is an opportunity to explore how workers construct their response to the COVID-19 pandemic and account for disparities across the sector.

1.2 | Pay and conditions of HSCWs

HSCWs in the private sector with 2 years' experience earn an average of £11.30 per hour with a median pay of £9.50, £1.80 less than equivalent workers in the NHS (Skills for Care, 2022). The National Living Wage in the United Kingdom for people 23 and over is £10.42 (UK Government, 2023). The Low Pay Commission (2023) acknowledges that a noticeable amount of minimum wage work takes place by HSCWs in the social care sector. Despite the low pay for HSCWs in the private sector, zero-hour contracts are common in addition to staff working on average 7 hours per week unpaid (Datta, Giupponi, & Machin, 2019). During the current cost of living crisis in the United Kingdom, HSCWs are reported as leaving the social care sector for roles with improved pay meaning that vacancies are rising particularly in the independent sector (Skills for Care, 2022). Templeton et al. (2020) highlight the importance of addressing inequalities during the COVID-19 pandemic and that low-paid workers were more affected than higher-income groups as they had less access to home working. During the COVID-19 pandemic, HSCWs experienced consistent difficulties accessing financial support when needing to self-isolate, with some not eligible for statutory sick pay as a result of low and precarious incomes (Allen, 2021). Unlike groups who worked from home and had time to organise their food during the UK lockdowns (Benker, 2021), HSCWs were affected by additional pressures such as needing to ensure they had an adequate food supply. Ntontis, Luzynska, Wright and Williams (2022) emphasise the need to explore differing employment contexts as there is limited research examining the experiences of social care workers.

Prior to the COVID-19 pandemic, all groups of healthcare professionals had been identified as affected by increased stress, burnout, depression, drug and alcohol dependence and suicide (Billings, Ching, Gkofa, Greene, & Bloomfield, 2021). HSCWs have the highest mortality rates by occupation (Shembavnekar & Allen, 2021). During the pandemic, Klimkiewicz et al. (2021) found increases in depression, insomnia and alcohol consumption amongst healthcare professionals. Given the limited incomes and increased health risk to HSCWs working during COVID-19, there is a need to explore how staff construct differing employment contexts such as the NHS and private sector given the importance of their role in caring for vulnerable people.

1.3 | Challenges in health and social care during the COVID-19 pandemic

Vindrola-Padros et al. (2020) found that their sample of healthcare professionals, mostly formed of doctors in the United Kingdom, reported changing guidelines, limited training and limited personal protective equipment (PPE) to be the biggest factors hindering their work. PPE shortages challenged HSCW's ability to follow national-level guidance, leading to reuse and improvisation with many workers feeling inadequately protected. Gilleen, Santaolalla, Valdearenas, Salice, and Fusté (2021) identified concerns about PPE availability as a factor in healthcare workers experiencing burnout. Nursing and care home workers perceived limited PPE provision as the NHS was prioritised (Nyashanu et al., 2022). Given that COVID-19 exacerbated existing challenging working conditions and the number of excess deaths, there is an opportunity to explore how low-paid HSCWs present the UK government's handling of the COVID-19 pandemic.

1.4 | Role of social identity in explaining responses to the COVID-19 pandemic

Social identity approaches acknowledge that managing the pandemic requires people to act collectively and the importance of differing contexts in relation to identity and behaviour (Jetten, Reicher, Haslam, & Cruwys, 2020). Where people's collective identity is salient, they are more likely to manage risks in the interest of the whole community such as when deciding to book a COVID-19 test when they may have symptoms (Atkinson, Neville, Ntontis, & Reicher, 2023). Courtney, Golderberg, and Boyd (2020) advised the importance of positive leadership with leaders

actively showing protective behaviours such as social distancing at the early stage of COVID-19. However, governmental incompetence around issues such as PPE provision can affect people's identification with the collective identity, as people may feel divided from their leaders (Reicher & Stott, 2020). Kinsella et al.'s (2023) research explored the experiences of frontline workers in the United Kingdom and Ireland with a range of roles and incomes and found that workers formed a collective identity against the virus. The experience of low-paid HSCWs is dependent on the wider community acting to minimise risk and also as a group in the workplace with vulnerable people. Collective support for individuals in Facebook support groups was high at the start of the pandemic but reduced over time (Ntontis, Fernandes-Jesus, et al., 2022) and this reduction in support has affected the experience of low-paid HSCWs as COVID-19 continued. Secondary factors such as gender and socio-economic inequalities were found to further decrease individual well-being during the pandemic (Ntontis et al., 2023). Low-paid HSCWs are more likely to be female meaning that they are more likely to be negatively affected. Given the importance of a salient collective identity to act in the interest of the community, there is a need to explore how HSCWs construct the identities of themselves, other key workers and UK government.

1.5 | Thematic analyses exploring the experiences of HSCWs during the COVID-19 pandemic

Qualitative research exploring the experiences of HSCWs during the pandemic is limited regarding the experiences of social care workers and care home staff (Billings, Seif, et al., 2021; De Kock et al., 2021; Ntontis, Luzynska, et al., 2022). This literature mostly employs thematic analysis (TA) to focus on how NHS staff manage their working practices and mental health. Staff are presented as managing a dilemma between the heightened risks of working and their sense of duty to care for patients (Borek et al., 2022). This ethical dilemma has been explained by staff being affected by 'toxic stoicism' (p. 10), continuing to work despite the personal risks and loss of well-being (Clarkson et al., 2023). French, Hanna, and Huckle (2021) found that workers experienced moral injury when they found it challenging to deliver good care in circumstances where they do not have the necessary resources and leadership from management, viewing themselves as 'cannon fodder' (p. 517). Changing guidelines resulted in healthcare professionals having their sense of autonomy questioned. NHS staff reported changes in how they were viewed by the public and difficulties in managing adherence to guidelines as time progressed (Borek et al., 2022). Similarly, staff in settings such as care homes reported increased tension between staff and service user's families due to restrictions (Giebel et al., 2022). The negative presentation of management and organisations' responses during the COVID-19 pandemic within the literature highlights a need to explore how HSCWs construct government accountability. Low-paid HSCWs lack the autonomy of higher-grade staff and income to access resources to support their well-being, highlighting the need to address gaps in the literature about how the response in the United Kingdom to the COVID-19 pandemic.

This research aims to explore how low-paid HSCWs present key stakeholders in health and social care during response to the COVID-19 pandemic. By examining the construction of key stakeholders, there will be an opportunity to consider how low-paid HSCWs present the social identities of themselves and other groups in the response to the pandemic in the United Kingdom. This provides the opportunity to examine how low-paid HSCWs warrant the accountability of the UK government, healthcare organisations and differing groups of workers for their responses to the crisis.

2 | METHOD

Reflexive TA was used to generate themes across the data and acknowledges the role of the researcher in the analytic process (Braun & Clarke, 2021). The authors used an inductive approach using latent coding so that their choices were aligned with a social constructionist position. This took the form of critical TA (Clarke & Braun, 2014) to explore how speakers use language to construct their environment and maintain an interest in the patterns within

the data. TA as a method is theoretically flexible (Braun & Clarke, 2006) allowing a critical approach to include discursive psychology (DP) and membership categorisation analysis (MCA) within its theoretical framework. DP examines how psychological constructs such as identity are used in talk and how people manage their accountability (Edwards & Potter, 1992) in addition to how people draw upon ideology in their discourse (Edley & Wetherell, 1997). The incorporation of aspects of MCA provides an awareness of how categories are raised in talk as a resource for speakers (Billig, 1995). A critical reflexive TA that is theoretically influenced by DP and MCA allows for the exploration of how low-paid HSCWs construct themselves and other stakeholders involved in the response to the COVID-19 pandemic and warrants their accountability.

2.1 | Materials

Semi-structured online interviews were conducted by the first author with questions exploring participant's constructions of the pandemic and how they accounted for the UK's response. The interview schedule is in Appendix A. A verbatim transcription of interview recordings was produced as recommended for TAs (Terry & Hayfield, 2021).

2.2 | Participants

Thirteen participants were recruited via snowball sampling. Interviewees were staff working in residential care homes, a nursing unit and independent supported living houses who earned £11.20 per hour or less in England. This hourly rate equates to the Minimum Income Standard identified by the Joseph Rowntree Foundation (Davis, Hirsch, Padley, & Shepherd, 2021) as the necessary amount for a single person to live at an acceptable level in the United Kingdom. Twelve participants identified as female with one participant identifying as male, with an age range of 19–63. Social distancing restrictions ended in February 2022 in the United Kingdom and interviews took place from March to May 2022. Ethical approval was granted by the Psychology Ethics Committee at the University of the West of England.

2.3 | Reflexivity

The first author is a support worker and met the criteria of the study; being a low-paid HSCW, which would have made them an insider (Hayfield & Huxley, 2015), however, at the time of interviews was not in the role. Additionally, he had close relatives working throughout the pandemic as care workers. Recruitment via snowball sampling meant that participants could feel confident with the interviewer as they were referred by people known to them (Hayfield & Huxley, 2015). Their status as an insider may have meant that interviewees may have made assumptions about their knowledge although Hayfield and Huxley (2015) state that insider/outsider status is complex and both positions can be held. Female participants may have viewed a male interviewer as an outsider meaning that further explanations were provided.

The second author grew up in a single-parent family and has lived experience of a working-class upbringing. Through the pandemic, her friends and family were affected by COVID-19 as being identified as vulnerable, and experienced serious illness and/or the death of a close relative. As part of her work during the COVID-19 crisis period, she taught students who are employed low-paid HSCWs and in other keyworker roles who found their working and living conditions challenging. Both authors followed Hayfield and Huxley's (2015) recommendation of reflecting on their own position through the design and analysis process. The second author acknowledged that with no experience in support work, an outsider position may allow for the exploration of the construction of everyday assumptions within the analysis (Tang, 2007). This was complimented by the first author's knowledge of everyday life for low-paid HSCWs (Gair, 2012).

2.4 | Analytic procedure

The analysis involved engaging with the six phases involved in a reflexive TA (Braun & Clarke, 2021). Both authors familiarised themselves with the data and the first author initially coded the data. Latent coding allowed for the exploration of how speakers draw upon ideology within their discourse. The authors discussed the coding and their initial thoughts on the data leading to further review of the coding. The first author then began generating themes by developing candidate themes through grouping codes to construct patterns within the data set. After the initial theme generation, both authors were involved in the development and review of themes. DP allowed the authors to consider how speakers constructed accountability for responses to the pandemic and how speakers drew upon ideology within their discourse. The analytic process incorporated MCA to examine how differing categories were used by speakers to construct individuals within the themes. As part of the process of reviewing themes, one theme was removed as it did not meet the requirement for themes to be coherent and distinct (Terry & Hayfield, 2021). The authors discussed the themes in detail prior to composing a draft theme definition to capture the central organising concept as part of the review process. The authors then defined and named the themes to develop the themes further followed by writing the report. To monitor quality throughout the process, the authors reviewed the analysis against Braun and Clarke's (2021) 15 points for reflexive TA.

2.5 | Thematic table

Themes	1. 'They kind of knew what was coming': UK Government slow to react to pandemic developments	2. 'The right thing kept changing every 5 min': Low-paid HSCWs frustrations with changing guidelines	3. 'All about the NHS and what about the rest of us?': Private sector HSCWs presented as inferior
Codes	UK government reacting too slowly	Guidelines were confusing	NHS workers more respected
	Government could see what was happening abroad	Memes of confusing guidelines	Other key workers were seeing patients die
	Government learning how to handle COVID-19	Frustrations with changing guidelines	Private sector healthcare workers in a separate category
	Slow to go into lockdown and close public places	Exhausting trying to conform to guidelines	Risk of catching COVID-19
	Conservatives prioritised the economy over people	Uncertainty about doing the right thing	'All about the NHS and what about the rest of us?'
	Focused on herd immunity	Need for transparency in decision-making	Focus on NHS workers in talk about the pandemic
	Restrictions the result of panic	Pressure of working with vulnerable people	'NHS always get first dibs'

3 | FINDINGS AND DISCUSSION

Three themes were generated in response to exploring how low-paid HSCWs constructed the response of differing stakeholders to the COVID-19 pandemic: (1) 'They kind of knew what was coming': UK government slow to react to

pandemic developments; (2) 'the right thing kept changing every 5 min': Low-paid HSCWs frustrations with changing guidelines and (3) 'all about the NHS and what about the rest of us?': Private sector HSCWs presented as inferior. The themes explore how low-paid HSCWs construct worker identities within health care provision and how they warrant their differing conditions. Participants presented themselves as inferior to NHS workers and frustrated by inconsistent guidance. Whilst participants explore individual responsibility to comply with workplace policy, they also construct the accountability of the UK government for not providing good leadership, resources such as PPE and the prioritisation of the NHS.

3.1 | 'They kind of knew what was coming': UK government slow to react to pandemic developments

This theme explored how participants constructed the UK government's reaction to the development of a global pandemic. Interviewees viewed the British government's response as too slow and presented other nations as a point of comparison to evidence their claims.

> *They were pretty slow to react especially considering other countries at the time were going through it much worse than we were, we were almost sat back watching it unfold before it really hit us that hard*
>
> (*Participant 13*)

> *Slow to isolation, umnm uhh slow for measures in place like closing down schools and public areas in which other countries were doing so I think we were a bit slow you know*
>
> (*Participant 2*)

Interviewees constructed the UK government as too slow to respond to the global spread of COVID-19. Participant 1 refers to other nation's responses to the pandemic as a point of comparison. Given that other nations '*were going through it much worse than we were*', it presents the government as having an opportunity to act and having been aware of the consequences if COVID-19 reached the United Kingdom. Workers are critical of the official response to the pandemic presenting the government and public as passive observers, '*we were almost sat back watching*' despite seeing other nations being severely affected. The use of '*we*' and '*us*' by Participant 1 presents the impact of COVID-19 as affecting the nation as a whole. Han et al. (2023) found that poor responses by the government during the COVID-19 pandemic affected people's trust in government. Increased trust in the government means that people are more likely to comply and engage in prosocial behaviour (ibid). Government and state provisions are closely related to national identity in the formation of the nation state (Liu & Turner, 2018). National identity is considered a core aspect of social identity (Tajfel, 1982) and has an important role in community cohesion (Gaertner & Dovidio, 2000). Given the importance of low-paid HSCWs following guidance and behaving pro-socially, workers negative construction of government performance is concerning due to its relation to service provision. Participant 2 constructs the delay in key actions such as lockdown and the closure of public places in an attempt to prevent the spread of the virus. The slowness of governmental activity in response to the pandemic is also presented as having an ideological motivation by low-paid HSCWs.

> *Hmmm, I think a faster reaction would have been helpful, ummm they kind of knew what was coming and they were so concerned with the economy as they are the conservative government ummm they, they put that first and they just allowed a lot of people to contract COVID with the hope that they would get herd immunity. It didn't happen so then they kind of panicked and decided they would implement all these restrictions.*
>
> (*Participant 4*)

Participant 4 accounts for the slow reaction to measures preventing the transmission of COVID-19 as ideological ('*they were so concerned with the economy as they are the conservative government*'). This draws upon a traditional representation of the Conservative party as pro-business that prioritises the economy (Ganderson, 2022). Here preventative measures are perceived as a '*panicked*' reaction when a herd immunity strategy fails to protect the United Kingdom from further virus transmission. An alternative discourse by low-paid HSCWs warrants the slow governmental response as the consequence of an unprecedented situation.

> *The thing is I think they were learning as well; they got a lot of stuff wrong, they probably wasted a lot of money, but what do you do, ummm I think they, they did what they could with the information*
>
> (*Participant 6*)

> *Ummm I think they done their best but if they could go back, I think they could have done it a bit more positively. But nobody knew it was going to happen so yeah, they done their best. But then again, the party scandal (pause) how disgusting*
>
> (*Participant 11*)

An alternative narrative perceived the government as responding to a novel situation that could not have been foreseen ('*But nobody knew it was going to happen*', Participant 11). The use of a rhetorical question and disclaimer by Participant 6 ('*but what do you do?*') presents the delayed response as reasonable. Here interviewees acknowledge the damage of a slow response to the unfolding pandemic yet account for the lack of action as acceptable given the lack of information about COVID-19. However, the party gate scandal is constructed as undermining Participant 11's positioning of the UK government ('*they done their best. But then again, the party scandal (pause) how disgusting*'). The party gate scandal involved civil servants, politicians and Conservative party staff holding social gatherings when the United Kingdom was in lockdown and/or social distancing was in place (BBC, 2023). Talk about the party gate scandal is used to present the government as a separate group in response to the pandemic. Jetten et al. (2020) highlight the importance of a shared social identity and its role in the effective enactment of restrictions. By constructing the UK government as a separate group, they are distinct from others and do not meet the requirement for good leadership in being viewed as members of the ingroup by HSCWs. Lack of trust in official information was identified as one of the barriers to care home staff obtaining vaccines (Giebel et al., 2022) highlighting the importance of addressing this issue for low-paid HSCWs.

3.2 | 'The right thing kept changing every 5 min': Low-paid HSCWs frustrations with changing guidelines

The second theme examines how low-paid HSCWs account for changing guidelines from the government and account for their compliance with good practice. Interviewees presented infection control guidelines as being inconsistent.

> *it was confused sometimes you know the memes you see like how mixed the guidelines were, they were so confusing*
>
> (*Participant 8*)

> *Changing the rules like I said, no one knew if they had to wear a mask or if not one day from the next*
>
> (*Participant 3*)

Speakers constructed care and infection control guidelines as unclear and requiring clearer communication. Participant 8 talks about the production of '*memes*' about guidelines to evidence their talk whilst Participant 3 constructed

a general consensus about the confusion through '*no one knew*'. Participant 3 uses the example of changing rules about the use of masks to provide a specific example. The importance of complying with guidance and the lack of clarity was warranted as important to HSCWs care provision and detrimental to service users as discussed by Participant 13.

> *We had to look after people with no proper guidance it was exhausting and it felt like we were never really doing anything right, I think that was the hardest part you know not knowing if we were doing the right thing cause (pause) the right thing kept changing every five minutes. So yeah transparency. Sticking to one thing would have helped too, I was always feeling bad for coming in not knowing what was what and if I was doing everything right which is obviously important when working with such vulnerable people.*
>
> (*Participant 13*)

Participant 13 upgrades the status of service users to '*vulnerable people*' to emphasise the importance of complying with guidance. They present communication around good practice as not being '*proper*' to account for the challenges of conforming to workplace policies about caring for service users in a pandemic. Participant 13 shifts from constructing a collective experience to their own uncertainty about the correct guidelines to follow ('*I was always feeling bad for coming in not knowing what was what*'). Low-paid HSCWs negotiate their own personal accountability for their conduct in a changing environment that can have potentially fatal consequences in the workplace. The importance of correct conduct is highlighted through the upgrading of '*doing the right thing*' to '*everything right*'. This allows Participant 13 to present the following guidelines as crucial and to account for the personal pressure and detriment to their individual well-being. Compliance with guidelines during the pandemic requires workers to align themselves with a wider collective interest and social identity (Haslam, 2020). By constructing themselves as being aware of needing to follow guidelines, low-paid HSCWs warrant themselves as wanting to act in the collective interest.

Speakers construct themselves as individually responsible for service users and being aware of good practices in a changing environment. In a healthcare system underlined by neoliberalism, conflict around patient care and effectiveness (Church, Gerlock, & Smith, 2018; Farr & Cressey, 2015) are heightened in times of increased demand. The dominant individualistic discourse within the health and social care system prioritises competitiveness over working conditions (Gordon, Rees, Ker, & Cleland, 2015). Low-paid HSCWs present themselves as managing responsibility for conditions where good practice is unclear, and resources are scarce.

3.3 | 'All about the NHS and what about the rest of us?': Private sector HSCWs presented as inferior

Theme three explores how low-paid HSCWs in the private sector present themselves as inferior to other HSCWs working in the NHS. Speakers construct their lesser position by talking about lower pay, focus on supporting the NHS through the pandemic and having fewer resources available to protect them, their families and service users. Participant 6 constructs a divide between HSCWs in the NHS and private sector despite both groups being presented as at risk of contracting COVID-19 through their employment.

> *I think it's through the pandemic it was all about the NHS what about the rest of us? What about the other ones that were coming in and you know, you know watching people die, risking catching COVID, taking it home to their families?*
>
> (*Participant 6*)

> *I think the onus is more on NHS workers though, I think that people have more respect for them and whenever somethings mentioned its always oh the NHS workers, and I think it's a bit like that sometimes you kind of get separated out.*
>
> (*Participant 4*)

The differing presentation of workers despite the risks being similar is achieved by Participant 6 using rhetorical questions. HSCWs in the private sector are warranted as a separate group ('*rest of us*', '*other ones*'). Yet they are constructed as being in a similar position to NHS workers where they may witness service users dying in addition to the risk of contracting the virus. Participant 6 presents the potential risk as being not just to themselves but also to their family increasing the hazard involved. For Participant 4, NHS workers are warranted as contributing more to caring for the public than other groups during the pandemic. This position is achieved through talk about respect and how generalised others construct NHS employees responding to COVID-19. Respect is considered a key component in relation to compliance as people want to feel that they are part of the same social group as decision-makers (Tyler & Blader, 2003). The promotion of the NHS discounts the role of private sector HSCWs and contributes to them being positioned as part of the out-group. HSCWs warranting themselves as part of an out-group is important as this has a detrimental impact on their ability to cope during the COVID-19 crisis (Jetten et al., 2020). Out-group status affects the social support available (Neville & Reicher, 2020) constructing divisions as private sector HSCWs are not included in initiatives to show appreciation for the NHS despite the impact of the pandemic on long-term care given the vulnerability of older residents (Beresford, 2021). HSCWs acknowledge that whilst NHS staff are constructed as receiving more support this is limited.

> *They didn't support people like us they only supported people in the NHS and even then, not really very well, people worked hard and the payment it was not good like I was sick myself and didn't get good money*
>
> (*Participant 10*)

Similar to other interviewees, participant 10 accounts for private sector HSCWs inferior status as constructing themselves as a different group within the care sector ('*people like us*'). This interviewee warrants private sector HSCWs as having a good work ethic and deserving of better pay. Talk about hard work and poor pay is used to demonstrate the lack of support for HSCWs and draws upon just world ideology to present their circumstances as unfair (Goodman & Carr, 2017). Lerner (1980) defined the Just World Hypothesis as people 'get what they deserve' (p. 11) as an explanation for inequality and is used discursively to examine how speakers present their circumstances as both fair and unfair (Goodman & Carr, 2017). Participant 10 uses an effortfulness interpretative repertoire (Gibson, 2009) ('*people worked hard*') presenting both NHS and private sector HSCWs as hardworking to highlight the discrepancy between their employment conditions and to warrant the situation as unjust. Participant 10 evidences the risk of working during a pandemic through being unwell from COVID-19 to further warrant their talk about wages being low ('*I was sick myself and didn't get good money*'). Talk about resources is used to evidence how the NHS has a superior status to private sector provision and to present the employment conditions of private sector HSCWs as unfair.

> *As PPE started to run out the government didn't seem to bothered that it was running out and most of the PPE and stuff like that went to the NHS cause the NHS always get first dibs on everything more so than private which isn't fair, we're still dealing with the same amount of human beings, they're still vulnerable and still just as likely to die.*
>
> (*Participant 11*)

Discourse about PPE is used to present the NHS as having a superior status to their private sector counterparts ('*the NHS always get first dibs on everything more so than private*'). Participant 11 uses talk about fairness to question

the allocation of resources challenging the prioritisation of the NHS. They negotiate the potential challenge of questioning the NHS' need for resources by presenting their own workplaces as being in a similar state of need (‘*we're still dealing with the same amount of human beings they're still vulnerable and still just as likely to die*’). The positioning of service users as ‘*vulnerable*’ highlights their risk from the virus and this is evidenced through talk about fatality.

During the height of the COVID-19 pandemic, the NHS was constructed as a symbol of British national identity (Antosa & Demata, 2021) with its staff being constructed as heroic (Billings, Ching, et al., 2021). Interviewees employed in the private sector have to negotiate their different identities by emphasising the similarities in their roles. Whilst criticising the lack of resources and prioritisation of the NHS is challenging, talk about fairness as this is considered an important value (Tileagă, 2010) and achieved by talking about caring for vulnerable people. Other key workers perceived themselves to be underappreciated and disempowered in comparison to NHS staff (May, Aughterson, Fancourt, & Burton, 2021) and this aligns with the experiences of low-paid HSCWs in the private sector. Thus, this theme explores how low-paid HSCWs in the private sector warrant themselves as having an out-group social identity evidencing this construction through talk about the NHS being viewed as superior, despite similar risks and both workplaces caring for vulnerable people.

4 | CONCLUSION

This paper demonstrates the importance of exploring how key stakeholders are constructed in talking about the response to the COVID-19 pandemic in the United Kingdom. Three themes were generated from the data exploring how low-paid HSCWs accounted for the response to the pandemic: (1) ‘They kind of knew what was coming’: UK government slow to react to pandemic developments; (2) ‘the right thing kept changing every 5 min’: Frustrations with changing guidelines and (3) ‘all about the NHS and what about the rest of us?’: Private sector HSCWs presented as inferior. Interviewees presented low-paid HSCWs as having a distinct social identity to other groups. Conditions during the pandemic were presented as unjust and interviewees questioned the leadership provided by the UK government, constructing HSCWs as having a fractured identity. Low-paid HSCWs in the private sector presented themselves as devalued despite their essential contribution to the care of vulnerable people and the risk placed on them and their households. Structural conditions that impact low-paid HSCWs such as pay and conditions and government accountability for policy need to be addressed given their relationship with quality provision. Future research is needed to explore the experiences of low-paid HSCWs in the current cost of living crisis and continued pressure on public sector budgets that fund provision.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data are not publicly available due to ethical restrictions.

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APPENDIX

A.1 | Interview schedule

The semi-structured interview schedule included the following questions:

1. How would you describe the government's handling of the pandemic?
2. What would you say the government has done well throughout the pandemic?
3. What would you say the government has done poorly throughout the pandemic?

4. How would you say the government's handling of the pandemic has directly impacted you?
5. Can you tell me about the availability of personal protective equipment?
6. Can you tell me how you feel about the availability of vaccinations?
7. How do you feel about the test and trace service?
8. How do you feel about mandatory vaccinations?
9. How do you feel people perceive care workers?
10. How do you think that the pandemic has affected people's perceptions of care workers?
11. How did you feel about people applauding care workers?
12. How do you feel about your pay and conditions?