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Casting light on the distinctive contribution of social work in multidisciplinary teams for older people

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DOI:
10.1093/bjsw/bcab004

License:
Other (please specify with Rights Statement)

Document Version
Peer reviewed version

Citation for published version (Harvard):
Willis, P, Lloyd, L, Hammond, J, Milne, A, Nelson-Becker, H, Perry, E, Ray, M, Richards, S & Tanner, D 2021, 'Casting light on the distinctive contribution of social work in multidisciplinary teams for older people', *British Journal of Social Work*, vol. 2021, no. 00, bcab004. https://doi.org/10.1093/bjsw/bcab004

Link to publication on Research at Birmingham portal

Publisher Rights Statement:
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Journal:	*The British Journal of Social Work*
Manuscript ID	BJSW-20-092.R2
Manuscript Type:	Original Article
ETHICS, VALUES AND CULTURE:	Human rights
FAMILIES, CHILDREN AND YOUNG PEOPLE:	
HEALTH AND ILLNESS:	Health professionals
INTERNATIONAL PERSPECTIVES AND GLOBAL ISSUES:	UK
POLICY, POLITICS AND LEGISLATION:	Legislation
PRACTICE INTERVENTIONS:	Resilience/Strength-based , Teamwork
RESEARCH AND EVALUATION:	
SOCIAL WORK AND SOCIAL CARE WITH ADULTS:	Older people
SOCIAL WORK PROFESSION:	Social work practitioners

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TITLE: Casting light on the distinctive contribution of social work in multidisciplinary teams for older people.

ABSTRACT

The current policy emphasis in adult social care in England is on promoting independence, preventing or delaying the need for more intensive support and the provision of personalised services. However, there is little evidence available on how social workers identify and meet the complex needs of older service users in practice. In this paper we present findings from a study of innovative social work practice with older adults in England (2018-19). We present five case studies of social care and integrated services in which social workers are integral team members. Twenty-one individuals participated in interviews; this included service managers and practitioners with social work backgrounds, and other professionals, including nurses and occupational therapists. Specific practices contributing to innovative service delivery included: the strong demonstration of social work values influencing the practice of multidisciplinary teams; positive risk management; importance of timing and ensuring continuity of relationships; and, the proactive application of legal knowledge to promote older people's rights. Whilst some of these features can be seen as returning to the 'heart' of social work, we argue that they are promising in forging new paths for social work with older people that turn away from more managerialist and procedurally driven approaches.

KEYWORDS: ageing; older adults; social care; innovation; practice; social work.

INTRODUCTION

The United Kingdom (UK), like other European nations, is an ageing society with a growing number of community-dwelling older people with complex needs facing situations

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characterised by co-morbid health conditions, loss, transition and uncertainty (Ray *et al.*, 2015). There is also evidence of growing inequality between older people, of rising care needs, reduced public sector spending and greater demands on family carers (Humphries *et al.*, 2016). The current policy emphasis in adult social care in England is on promoting independence and community-based living, preventing or delaying the need for more intensive support, and providing personalised support for older people with complex and changing needs (Author's own XXX). Arguably, it is precisely this set of intersecting issues that social workers are equipped to effectively manage (Romeo, 2017). However, we have little evidence available on how social workers identify and meet the complex needs of older service users and the impact of their practice on improving their lives.

In this paper we present findings from a preliminary study into contemporary social work practice with older adults in England (2018-19), led by a group of gerontological social work academics exploring the role, nature and effectiveness of social work with older people. Using the notion of innovation as a cornerstone, the study focused on case studies of 'promising and innovative' practice. Two objectives were to: 1) start to develop an evidence base of promising and innovative practice in social work with older people; and 2) explore the range of settings in which social work with older people is practiced, including the roles and tasks involved. We adopted the term 'promising' to describe those practices with potential to be learnt from, adapted and applied to other contexts. We report four themes that highlight the distinct contribution of social workers to services that self-identify as promising and innovative while bringing attention to tensions associated with and opportunities for collaborative working with older people and their families and with other professionals in multidisciplinary teams. These themes underline the continuing relevance of core social work knowledge, skills and values. The 2018 launch of a Professional Capabilities Statement for

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Social Work with Older People by the British Association of Social Workers (BASW) marks a renewed energy in raising the profile of gerontological social work. This is an optimal time, therefore, to examine contemporary practice with older adults and their families, and to build evidence of its professional potential.

In 2018 there were 17,000 social workers employed in local authority adult care teams in England (Skills for Care, 2019a), but we have no idea how many of these work with older people. At the same time, there are many multidisciplinary teams operating in social care departments in local authorities, but little data on the numbers of social workers within these. Social workers also practice in hospital settings, a long-established sphere of practice in the UK that heavily involves multidisciplinary working to support older people (Hennan and Birrell, 2018). In these settings, the value of social workers' contribution has not been adequately demonstrated (Steils *et al.*, 2020). Multidisciplinary working with medical and healthcare professionals and the institutional pressures of patient discharge are two challenges identified by hospital social workers that can hinder patient advocacy (Hennan and Birrell, 2018).

Historically, social work with older people has been viewed as lacking therapeutic potential and status in comparison with other practice fields (Ray *et al.*, 2015; Carey, 2016). In 1976, Brearley argued that 'by reasons of pressure of demand and economic necessity social workers tend to deal with older people in a short-term, problem-solving perspective' (p. 444) and that a much wider range of skills and knowledge is needed. Since then, key authors in gerontological social work have raised similar concerns. Concerns include the inadequacies of the care management model introduced in England and Wales in the 1990s and arguments that this model has failed to deliver adequate resourcing of social work with older people

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while instead retaining a primary focus on gatekeeping resources (Phillips, 1994; Lymbery *et al.*, 2007). In a similar vein, McDonald (2010) has argued that routinised, bureaucratic models of practice with older people are increasingly inadequate for the complex world in which people age. Payne (2010) contends that social workers need a dual focus on individual (including physical) and social aspects of ageing. Part of the social work role is to support older adults to achieve, or retain, equal societal participation in recognition of ageing as a social process that impacts on relationships with family and community. Others have argued that this field of practice requires a community-based, community development orientation to effectively address social problems associated with ageing that are common to many (Lymbery *et al.*, 2007). In relation to social work knowledge and skills, knowledge of biological aspects of ageing is crucial (Fahey, 1994) while counselling skills are an essential skillset when supporting older people experiencing crisis situations (Duffy & Healy, 2011).

In 2016 Carey maintained that contemporary social work practice with older people continues to hold lesser importance than other specialist spheres, although, paradoxically, it requires a high skill level because of the imperative to manage complexity. There is, therefore, a pressing need to develop understanding of the complexity of older service users' needs and the practice innovations that can benefit them.

SEEKING INNOVATION IN A PERIOD OF AUSTERITY

Within policy studies, Torfing *et al.* (2020) situate innovation as 'a step-change that disrupts the common wisdom and established practice in a particular context' (p. 7). It encapsulates new ideas that move practice beyond established ways of working and reaches further than improving current systems and processes. Innovative social work practice has been presented by national government as a solution to meeting needs in a time of austerity (Brown, 2015)

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and as an approach to facilitating the delivery of personalised services (Brookes *et al.*, 2015). Brown (2015) builds on the definition set out by Moore *et al.* (1997), which we adopted for the purpose of the current study:

> "Those changes worth recognising as innovation should be globally (or at least locally) new to the organisation, be large enough, general enough and durable enough to appreciably affect the operations or character of the organisation" (p. 276).

Innovative practice can manifest in multiple ways, including the transformation of a process or service, or the new configuration of existing teams and services (Brown, 2015).

Recent policy priorities for social work with adults have emerged during a period of severe financial restraint and reduction in funding to England's social care services, implemented under austerity measures by the former coalition and current national governments between 2010 to 2018 (Grootegoed and Smith, 2018). Local authorities (the main provider of UK social work services) have experienced a faster rate of financial cuts than other areas of government spending, leading to reduction of services (Hastings *et al.*, 2015). Since 2010 central government grants to local governments have reduced by 49.1%: overall real terms expenditure on adult social care has dropped from £15.8 billion in 2010-11 to £14.9 billion in 2016-17 (House of Commons, 2018). The inadequacy of resources and funding is arguably a barrier to meaningful and lasting service innovation. This is counter to the national government's policy mantra on innovation as a key solution to meeting need in times of austerity, as evidenced by funding initiatives seeking to stimulate innovative approaches to social care workforce development (Skills for Care, 2019b). Policy emphasis given to innovation is located within a neoliberal policy environment and a market-led economy in which individual responsibility, autonomy and consumerism are prioritised over collective responsibility and universal welfare provision (Joy and Shields, 2018). This has led to a form

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of 'lean citizenship' in social policy where 'both states and citizens are expected to give priority to the values of individualism, self-reliance and the market above all else' (Joy and Shields, 2018, p. 688). In the current study, we sought to gain a deeper understanding of the social work role within this policy context.

DESIGN AND METHODS

A cross-sectional, case study approach was selected as the most appropriate methodology for addressing our objectives. The key units of analysis were established health and social care services in England in which social workers were employed and were key contributors to service provision for older adults. A case study approach was well-suited for our focus on generating an in-depth understanding of the *how* and *why* of social work roles and practice within each site and the distinctiveness of each service (Yin, 2018). An advisory group met twice and included representatives of XXX group, Research in Practice for Adults, BASW, two experienced social workers from local social care teams, and an older representative from the Host University's Service User Forum. Ethical approval was obtained from the XXX Research Ethics Committee.

Potential case study sites were identified through two routes: First, a rapid review of grey and peer-reviewed literature published between 2013 to 2018 (just prior to the Care Act 2014 and up to the start of the study) on innovative examples of social work practice with older adults in England. This timeframe was selected to capture recent and ongoing innovative practice in parallel with the introduction and implementation of the Care Act 2014. Second, we drew on written feedback gathered during a 2016 workshop in which members of XXX group invited social workers to complete a brief questionnaire about their current practice with older people. Participating sites were purposively selected with the aim of including different

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types of: needs (for example, dementia, complex healthcare needs); contexts (for example, community-based adults' teams, integrated teams/services); geographical locations (urban/ rural); and, approaches to service delivery. It should be noted that this research was small-scale and preliminary, and we were therefore not in a position to cover the entire range of social work practice with older people, for example there was no specific focus on mental health or carers. Due to the short timeframe (eight months), the study was restricted to five case studies – these are summarised in Table 1.

[insert Table 1 about here]

The relevant service manager from each site was contacted to request their involvement, to obtain access to key documents and to invite team members to participate. While all of the selected sites were multidisciplinary, the professional backgrounds of the interviewees did not reflect this perfectly: two-thirds (15) had a social work background. The other six participants had backgrounds in nursing (2), occupational therapy (2), counselling (1) and social care (1). As this was a preliminary study, this was not necessarily a problem, but it is an important consideration for subsequent research. It also limits the inferences we can make from the dataset. Participants' number of years of post-qualification experience in their professional role varied from 2.5 to 20+ years. Documents yielded valuable data on wider, organisational perspectives and processes of change; these included discussion papers, independent evaluation reports, and service descriptions and presentations.

Consent forms and information sheets were provided to participants ahead of interviews. Confidentiality was assured for each site except in circumstances where safeguarding issues were raised. It was important to protect the identity of the services as there were a small

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number with distinctive features. Interviews were conducted at each site by the same researcher. These were semi-structured in format allowing freedom for participants to provide detailed information and to identify any aspects of the service they considered important while ensuring the interviews retained focus. Three interview schedules (for social workers, other professionals in multidisciplinary teams and team managers) were developed in consultation with the advisory group, based on issues and themes identified in the initial rapid review. Topics included role within the service; identified outcomes of the service (and sources of evidence in support); what aspects they considered to be innovative and promising; and, examples and barriers to implementation. Interviews ran between 30 to 72 minutes; these were recorded and transcribed.

Thematic data analysis was conducted by three members of the research team. All transcripts were read by the Senior Researcher who identified initial clusters of data. To uphold principles of qualitative rigour, two other members read a selection of transcripts subsequently (10 each) to develop the analysis and confirm/question the initial reading. The analysis of transcripts adhered closely to the six phases outlined by Braun and Clarke (2006), moving from initial reading and coding data line-by-line to consolidation and naming of recurring themes across transcripts and case sites. We commenced with initial coding within each case study and identifying selective codes. Once selective codes had been identified these were compared across case studies to identify overarching themes and sub-themes, and outlying themes were noted. Issues and trends noted in the documents provided by each site were compared with themes generated from corresponding transcripts, noting and more closely examining areas of convergence and divergence. Emergent themes were presented to the advisory group for discussion with feedback helping to refine core themes.

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Four core themes are presented below. Across these, some participants refer to specific evidence bases to strengthen their claims of positive change and outcomes for service users; however, the evidence base identified overall was limited. Two services had participated in external evaluations – Site C in a pilot evaluation collecting primarily qualitative data and Site B in a programme evaluation of which this service was one of numerous externally-funded sites across England. For the latter site the evaluation report had indicated positive outcomes including the reduction of demand on hospital services. Participants from other sites referred to internally gathered data through service user feedback (qualitative comments; performance ratings) or performance indicators such as reductions in service demand as a basis for illustrating positive changes.

FINDINGS

1. Importance of timing: prevention and early intervention.

All sites had a chief focus on prevention in line with Section 2 of the Care Act 2014 ('preventing needs for care and support'). Prevention was conceptualised in different ways, according to the particular opportunities and constraints of each service, however a common thread was the importance of early and timely support. Sites B and E aimed to avert inappropriate hospital admission and the emphasis was on rapid responses and ease of access to the service (for example, through a single point of entry). In Site B participants' accounts suggest that there is value in having a social worker present alongside paramedics at the point of first response to an older person in crisis. Seeing the older person in their home environment enabled immediate assessment with the possibility of developing solutions that prevent hospital admission:

> I think we are innovative in the fact that we're trying to get to people right at the source. We're getting people right at the point of crisis. I think there has always been lots of focus on GP surgeries and co-location with them so

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> actually to work directly with the ambulance service at that point of crisis is quite different. (PB1, social worker)

In site A the focus was on preventing hospital readmission through better services within the community. The speed with which older people were seen and the ability to avoid admission altogether or reduce in-patient stays was reported by the manager as key to the prevention of 'pyjama paralysis' (colloquial term to describe muscle wastage from excessive periods of bedrest). Sometimes the rapid return of an older service user from hospital to their home provoked anxiety for family members:

> They're frightened, the family. We might say, "But actually your mum still needs to live. She still needs to go home. She still needs to go back to that room where she did fall, where she did spend time, where it hasn't quite worked out." We're looking at it with our head and the family have got all those conflicting [emotions], their heart, their fear, their loss (PA1, service manager/ social worker).

The above quote encapsulates the complexity of supporting older people and staying centred on their wishes, while also managing family expectations and anxieties. In site C, early intervention was emphasised through family group conferencing (FGC) to avoid the deterioration of family relationships and to improve families' ability to cope with minimal professional interventions. Team members argued that 'the earlier it's introduced, the better outcomes you have'. According to participants 80% of service users reported they were more in control and better able to cope.

The emphasis on prevention did not preclude continuity of support, which was described as a shared goal between different professional groups in all sites. On the contrary, in some settings it was important for preventing potential future problems. For example, in site E each

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service user had a named contact person, which was regarded as especially important for continuity in the context of dementia care:

> … once we identify and work with somebody with dementia, we stay with them for their journey. We don't disengage the service. …because of the cognitive decline they may be experiencing that's really important that we establish that relationship … (PE3, social worker).

Site E shared some of the user feedback gathered through their Quality Account reports that echoed the importance of continuity to enhance a sense of belonging: 'This quality of staff is really admirable. This gives a sense of belongingness, that we are not just another number on a register but a living person (with dementia)'.

2. Keeping focus on older people's perspectives: risk positive and strengths-based approaches.

Enabling the perspectives of older people to be heard and valued was identified as a distinct role across sites. Social workers in every site stressed the importance of respect for older people's wishes and autonomy over decision-making, especially in circumstances where an individual has impaired mental capacity. From Site C where the FGC approach was applied PC1 explained how their approach allowed the older person's voice to emerge 'unfiltered' and 'unsanitised', giving the social worker a clear understanding of their thoughts and intentions. In site B, prior to the development of its early intervention team, it had been normal practice to take an older person direct to hospital if they had a fall - practice had tended to be risk-averse and inclined towards standardised systems of care. However, the team in this site had succeeded in changing this practice and enabling older people to remain at home. One social worker (PB2) working alongside paramedics and occupational therapists (OTs) described how their initial response was to first determine the wishes of the person

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they were working with. This was corroborated by their manager who argued that social workers in the team had brought a 'risk-positive' approach to multidisciplinary working:

> Just being challenging and just really risk-positive, and really listening to people's wishes as well. … I think the social work staff are really good at that, about thinking what people want. It has resulted in people dying, but they've died peacefully at home and that's their wish. (PB3, manager, occupational therapist)

'Risk-positive' captures practitioners' attempts to support individuals to pursue preferred courses of action that would be perceived as potentially 'risky' with adverse consequences. While participants reported some conflict with paramedics on approaches to supporting older patients, within this team paramedics had similarly adopted a more patient-led position. The adoption of this approach needs to be situated in a wider context where there may be a number of push-and-pull factors influencing shifts in the practice of other professionals. For example, NHS England (2015) guidance for ambulance services, inclusive of paramedics, emphasises 'see and treat' responses at patient's homes rather than admitting patients to hospital. The above manager acknowledged a risk positive position was difficult to maintain in crisis situations, particularly when the risk to life was high, such as patients showing symptoms of septicemia.

A strengths-based approach was identified across participating services as a core dimension to social work practice and the remit of services, a perspective that is congruent with that of recently published guidance from the Department of Health and Social Care (Baron *et al.*, 2019). All the teams in our study had adopted this approach, which involved starting with what the service user was able to achieve and identifying ways in which they could be supported to maximise their independence in an uncertain future. There were also tensions associated with adopting this approach. For example, participants referred to the tension

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between, on the one hand, its imposition by management as a 'cost-saving' measure and, on the other, its promotion by team members as a means to improve outcomes for service users.

3. Supporting older people's statutory rights in multidisciplinary working.

Participants across all sites maintained that a key aspect of the social work role was to support the human rights of older people by ensuring that their autonomy was upheld. This was particularly challenging in decision-making when a service user had a diagnosis of dementia and other professionals and family members held strong views on care planning. In sites A and D, the chief focus was on discharge from hospital and transfers of care, a sphere of practice that necessitates effective multidisciplinary teamwork. In site A, according to participants, a strong team ethos had developed, in which social workers made an important contribution through their knowledge of older people's rights under the law which other team members had adopted over time.

According to participants, older people's rights were not always at the forefront of decision-making by other social care professionals. For example, according to PD2, it was difficult at times to convince care home managers that it was unlawful to take in an older person with dementia without their consent or an assessment of their mental capacity. Nevertheless, participants' accounts suggest that social workers' knowledge of statutory frameworks (for example, Human Rights Act 1998; Mental Capacity Act 2005) and relevant case law, as well as confidence in asserting their position with other professionals, had helped influence the development of multidisciplinary teamwork. Legal knowledge had been 'an absolute cornerstone' in this development:

> And watching practitioners get into the intricacies of that, and being able to state case law, and being able to really thrash that stuff out... As a manager

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> it gives me an enormous sense of pride, it really does. (PD1, senior social worker)

An OT from the same service, commented on how working with social workers had in turn expanded their understanding of safeguarding processes and principles:

> … I think social workers don't necessarily realise how well-skilled they are in that [safeguarding] and they are so well-skilled in all of their- all the legalities that go around it and the processes and it is complex and it is- there's so much responsibility in safeguarding and my social work colleagues are so confident with it (PB1).

An important point raised by participants working in multidisciplinary teams concerned mutual learning. Participating social workers' accounts suggest they accepted the need to expand their knowledge of health conditions while they brought to the team a perspective on understanding and responding to the *personal experience* of illness and healthcare. They also contributed their knowledge of, for example, safeguarding and human rights. In all teams, the view was that professional groups should retain their distinctive identities and specialist skills but also learn from each other:

> I think that medical and social coincide with each other now. Even though obviously we will never know medical things ourselves, we're still aware around medication and what we need to know. ... the way that we try and enhance capacity and maximise it, I think medical professionals could do with having more knowledge around that. (PA3, social worker)

Participants in site D explained that they had sometimes experienced difficulties in being accepted in the hospital environment but stressed the importance of being open to sharing knowledge and unapologetic about social work principles and values. Here, too, there was recognition of the equal importance of social workers acquiring medical knowledge and learning from other professionals around them. This was evident in the context of learning

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about the physiological dimensions of ageing, the experience of health problems and the impact of these on older people's lives.

4. Obstacles to change and innovative practice

Obstacles to and challenges with delivering innovative approaches across services were identified. For site C that deployed the FGC approach, mistrust and lack of understanding about the FGC process from family members and other social workers outside the agency were identified obstacles. Unique to hospital settings, the following organisational barriers were highlighted: operating across different IT systems to healthcare staff; services being 'recommissioned' and consequently diminished in size; medical staff not considering patients' needs post-discharge; and, the broader environmental challenge of working within professional hierarchies between medical and other staff:

> .. the hospital can be quite a hierarchical kind of place where what the doctor or consultant says goes. It, kind of, seemed like the patient voice had got lost a little bit. I think we've brought in a lot more of what the person wants and things like that... (PA5, social worker)

Organisational barriers identified across other sites included excessive levels of bureaucracy (for example, too much emphasis on quantitative outcomes in service delivery) and administrative forms that were perceived as limiting scope for innovative service delivery. Resourcing was flagged as a common concern at agency level (for example, not having sufficient funding for services to expand and increase availability) and at a regional level (for example, lack of community-based resources for referral to rural areas). Not all participants within the same site agreed on challenges in service delivery and resourcing – in one site a social worker identified the ratio of team members to service users as low while the service manager (nursing background) considered this to be relatively high. However, within this site social workers also stressed the autonomy they had over deciding how long to work with

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service users. Only two participants mentioned the impact of austerity in the context of current financial pressures on local authorities and the ways in which this constrains support offered to service users and carers.

DISCUSSION

In this preliminary study we sought to generate new evidence about innovative examples of social work with older people across different types of services and by doing so strengthen understanding of contemporary practice with older people. Our findings are restricted to mostly the views of social workers and their managers; however, the findings indicate some valuable insights into the perceived contribution and influence of social workers within participating sites and their working relationships in multidisciplinary teams. Across all sites, social workers' contributions are made visible through the application of specialist knowledge, skills and values. Social workers introduced new perspectives that, according to social workers and their managers, had a fundamental impact on the practice of others and on decisions relating to care and support for service users. It is the perceived distinctiveness of the social work role in all sites that holds the greatest promise, particularly in the context of multidisciplinary team functioning. Torfing *et al.* (2020) maintain that collaboration can facilitate innovation – collaboration is defined as interdependent but autonomous actors working together. Within our study, collaboration between different professionals was fundamental to perceived successes with inter-professional learning emphasised across sites.

Two overlapping features in the findings were first, social workers attention to promoting human rights and second, the emphasis given to the importance of robust legal literacy for supporting service user autonomy, rights and wishes. Less surprising was the focus on strengths-based practice, given current national guidance on these practice approaches (Baron

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et al., 2019). BASW's (2018) capabilities statement stresses the importance of 'maintaining optimism' when working with older adults and 'challenging limited assumptions' about their lives – two principles that reverberate with participants' accounts of maintaining a risk positive and strengths-based stance. A renewed emphasis on strengths-based practice in adult social care chimes well with gerontological social work, particularly within the context of counter-acting ageist attitudes and enhancing recognition of older people's dignity, active citizenship and equal worth (Payne, 2010; Author's own, XXX). However, as touched on by participants, some caution is needed with fully embracing this approach. Policy priorities may be cost-led, especially following the recent period of austerity. Accordingly, the renewed interest in this approach may signal a shift from state responsibility for meeting older citizens' care and support needs to individual responsibility and accountability – what Gray (2011) describes as 'the neoliberal co-optation of strengths-based concepts' (p. 8). Organisational barriers identified with regards to excessive bureaucracy and service recommissioning signal some of the continued inadequacies earlier noted by McDonald (2010) as constraining more creative practice with older people.

It is within 'innovative' work settings that social work values (promoting human rights) and skills (using the law and legal precedent to argue for the protection of user rights) are made visible and reportedly valued by other professionals. The centrality of the law to practice and the importance of developing skills in legal literacy has been well-established in UK social work, and medical, education. Social work students report a lack of confidence in understanding and applying legal rules (Preston-Shoot and McKimm, 2013). In contrast, social workers in our study conveyed confidence in applying legal principles for the purpose of enhancing recognition of older people's rights; this confidence was noted by other professionals working with social workers.

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Social workers and their managers shared accounts of using their legal knowledge to help shift other professionals' perceptions on protecting older service users. This is fundamentally important in the context of joint working between healthcare and social work professionals where the majority of intervention with older people often falls at crisis points; these are critical points of intervention in which dominant notions of vulnerability and protection can overshadow more enabling approaches (Bornat and Bytheway, 2010). A key question for future research is whether these reported shifts translate into improved outcomes for service users. This finding resonates with emerging learning from the Named Social Worker Pilot for people with learning disabilities in England – like the services presented in our study, there is movement within pilot sites to practice outside the boundaries of the case management model and to focus more on relational practice (James, Morgan and Mitchell, 2018). Within this pilot social workers are positioned as human rights experts (James, Morgan and Mitchell, 2018) – a recognition shared across our participants' professional roles too. There is scope for mutual learning between the services represented here and the pilot sites identified in the above study.

Positive risk taking was another feature of the findings - enabling older people to decide where to live *after* they returned home rather than *while* they were in hospital. The notion of positive risk-taking is grounded in a professional desire to measure risks in a way that balances the benefits gained from risk taking against potential harms or negative impacts. In the context of dementia care, this perspective helps diminish more pervasive perspectives of people with dementia having to be continually protected from risks (Morgan and Andrews, 2016). Fenton and Kelly (2017) argue that social workers experience ethical stress when working from risk averse positions driven by their employers that compromise their

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professional value base. This partly stems from the technical-bureaucratic model of managerialism adopted by contemporary social care agencies where emphasis is given to procedural working over more creative or critically reflective approaches (Fenton and Kelly, 2017). In our study social workers are supported and enabled to move away from a risk-averse position and to adopt a more risk positive approach. The supportive and enabling leadership they receive, at least within their immediate team, may help counteract ethical stress and foster more user-led approaches. Our findings suggest that social workers are not alone in adopting this position as evident in the examples of multidisciplinary working with paramedics and OTs. This position is not solely a social work domain, but the findings suggest that social workers have played an instrumental role in promoting this approach.

Another noteworthy dimension of the findings was the importance of timing and continuity– the provision of a rapid response as a means of effective early intervention and providing consistent 'points of care'. This finding speaks to the pivotal importance of relationships in care delivery for older people *and* the critical importance of continuity from professionals and paid carers in maintaining mental health and wellbeing, providing security, and meeting psychological and emotional needs (Tanner, 2010). Social workers are often depicted as time-poor, especially so in hospital settings where social workers have restricted time for relationship-based, therapeutic work (Hennan and Birrell, 2019). Duffy and Healy (2011) argue that therapeutic, collaborative relationships are essential to maintain with older people in hospital settings where temporary impasses with service users, their families and other professionals are a regular occurrence. While indicative only, findings from this study reinforce the dual significance of ensuring practitioners have ample, protected time to build and sustain collaborative relationships and the organisational agility to respond at crisis point.

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This study also provides insights into the value to social work practice of understanding the impact of physiological changes in later life. Participating social workers conveyed confidence in their own professional knowledge and skills alongside a commitment to developing their knowledge of age-related physiological changes and associated medical conditions. This resonates with earlier calls for social work knowledge to include biological aspects of ageing (Fahey, 1994). BASW's (2018) capabilities statement reinforces the need for social workers to develop detailed knowledge of age-related health conditions in parallel with wider social and cultural considerations tied to the complexity of ageing. Within broader gerontological scholarship complex health conditions such as frailty and dementia are not simply 'bio-medical' states but represent lived experiences and psychological journeys that challenge the older person's sense of self, identity and agency (Grenier, 2006; Tanner, 2010; Milne, 2020). Enhancing learning about health conditions and complexity in later life from a biopsychosocial approach is an imperative for social work education and has implications for extending pre-qualifying curriculums on ageing, health and wellbeing. This also complements Payne's (2010) appeal for 'citizenship social work' to tend to both the individual and social aspects of ageing.

CONCLUDING COMMENTS

While preliminary and small-scale in design, this research is significant in making visible key features of social work with older people that social workers, managers and other colleagues see as defining promising, as well as innovative, practice. We have identified distinctive values, skills and approaches that social workers use to address the complex needs of older people and support their decision-making and, from the perspectives of social workers and their managers, the distinct contribution they make to multidisciplinary teams. This includes: positive risk management; the proactive application of legal knowledge to promote older

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people's rights and wishes; and an openness to mutual learning and new ways of working. Some of these practice features can be seen as returning to the 'heart' of social work, as also evident in discussions of relational, strengths-based practice and providing continuity in support. In the context of this study, these perceived contributions hold the promise of forging new paths for social work with older people beyond more managerialist-driven approaches to meeting service demand.

Our findings are generated from a small dataset and are indicative and non-representative. Findings are based on retrospective practice accounts and do not capture 'live' observations – this is a future direction for research where ethnographic methods would be invaluable. In the main we have not taken into account the views of healthcare and medical professionals – these professionals will also have invaluable insights into the social work role and in highlighting where practice priorities, skills and principles may overlap, diverge or conflict. Equally service users and their families were not interviewed to give their perspective on the innovative approaches applied across teams. This is a critical dimension for a future follow-on study along with the importance of ascertaining the outcomes of social work intervention from a stronger evidence base.

ACKNOWLEDGEMENTS

We appreciate the contribution of teams and individual participants and we thank their agencies for giving us permission to learn about their services. The study was funded by a grant from the XXX, 2018-19 [REF XXX].

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Table 1.

Summary of participating services and participants' professional background.

Site	Location	Team setting	Service description	Number of interviews and participants' professional background
A	City (>200 000 population)	Hospital.	Hospital-to-home team. Enabling older people to return home rapidly.	n= 6. Service managers (nursing and social work background); social workers (SW); senior SW; community care worker.
B	Rural county	Community-based local authority (LA) team.	Early intervention project implementing a preventive model of health and social care for older people with long-term conditions.	n=3. Occupational therapists; SW.*
C	Major city (>1 million population)	LA team.	Family group conferencing. Works with older people and their families to build relationships and to improve planning and support.	n=3. Senior SW; counsellor; service manager (social work background).
D	City (<100 000 population)	Hospital.	Integrated discharge team. Multidisciplinary approach to addressing delayed transfers of care.	n=4. SWs; service manager (social work background)
E	City (>200 000 population)	Community-based.	Dementia specialist support team for people with dementia and their families.	n=5. SWs; service manager (nursing background).

* Reflects the small-scale size of the team.

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