

# **AN EXPLORATION OF THE ROLE OF SOCIAL WORKERS WITHIN AN INTEGRATED SETTING.**

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## Abstract

This qualitative study has been undertaken to address a literature gap relating to the efforts to integrate health and adult social care within England at a time of austerity. This study adopted an interpretivist paradigm utilising a social constructionist epistemology in that there are multiple realities to be understood and different perspectives and perceptions to be explored. This interpretivist study explored the impact of social work within an integrated organisation from the perceptions of the practitioners: social workers, occupational therapists and nurses.

Free-text data from 41 survey respondents were subject to thematic analysis. Subsequently a further 6 interview respondents were also subject to thematic analysis. Data were coded using a multistage approach: coding of comments into general categories (e.g. resources, budgets); coding of subcategories within main categories (e.g. s75 agreement, staffing levels); cross-sectional analysis to identify themes cutting across categories; and mapping of categories/subcategories to corresponding comparable research for comparison.

Most free-text respondents (51 per cent) were from social workers, with 32 per cent from occupational therapists and 17 per cent from nurses. 5 interviewees were social workers (83%) with 1 nurse participant (17%). These respondents provided comments that the author developed into four overarching themes: first, culture – cultural biases and clashes of professional culture within an integrated care organisation which result in a negative experience for professionals and confusion for service users and/or carers. A lack of shared socialisation and the development of a shared culture. Second, austerity: the impact of economic austerity. Third, organisation: conceptual confusion in respect of outlining/organising/ structuring integrated care within a health organisation. Fourth, political: the political drivers of integration.

This study highlights areas of concern specifically for social workers as well as for integrated social care and health, uncovering a number of themes that exist across the integration journey. While most of the comments were negative, analysis reveals concerns shared by substantial numbers of respondents: conceptual confusion in respect of organising integrated care within a health organisation, a lack of shared socialisation and the development of a shared culture within the integrated organisation, and the impact of economic austerity on integrated care. The findings and recommendations are therefore pertinent to many health and social care organisations looking to integrate in the future.

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# 1. Introduction

## 1.1. Overview

In 2012, adult social care provided by the local authority and a community national health service provider both of whom provided services within the same geographic area integrated to create one of the largest integrated health and social care, national health service (NHS) Trusts within the country. At the time, a decision was made to integrate all community professionals into integrated teams. A decision was also made that managerialism (Nathan and Webber, 2010) would be adopted whereby any profession could manage another. This led to social workers managing a team of nurses for example. The focus of this thesis is to understand the perceived contribution social workers have made within such integrated teams, exploring the perspectives on social workers from nurses, occupational therapists and social workers themselves. In this chapter, I will set out my area of research interest and include a brief account of the setting, my role as researcher, and relevant developments that occurred during the research. There will be a brief background to explain why theory is important for social workers in understanding integrated models of health and care. The chapter will conclude with the aims of the thesis and an overview of contents.

## 1.2. Theoretical background to the study - Theories of integration

What is a theory?

Theories question professional practice, test established structures and principles which can result in remodelling and re-modification (Wadensten and Carlsson, 2003). A theory in some cases can be applied and tested through research to ascertain its feasibility. The definition of a theory is: "A set [or network] of ideas linked together to help us make sense of a particular issue or set of issues" (Thompson, 2000, p. 22). As a social worker operating from a social model of disability, rooted in social theory, it is crucial to understand my perspective to put this work in context. Social theory is founded on an assumption that humans have created society through interactions, social patterns and events which enable us to explain society. In this context theory



is defined as: “a statement that proposes to explain or relate observed phenomena or a set of concepts. Theory involves a set of interrelated arguments that seek to describe and explain cause-effect relationships” (Delaney, 2005, p. 1). In contrast to this positivist definition, we could argue that social theory examines social phenomena by utilising analytical frameworks or paradigms. The concept of ‘social theory’ comprises ideas about “how societies change and develop, about methods of explaining social behaviour, about power and social structure, gender and ethnicity, modernity and ‘civilisation’, revolutions and utopias” (Harrington 2005, p. 1). Understanding this theoretical underpinning of my professional education and practice is crucial in this research design that demands reflectivity and a self-awareness as an insider researcher.

One could argue that ‘theory building is reality building’ (Argyris and Schon, 1974, p. 18) with defined social groups having their own perspective of reality that imparts unbiased meanings to their actual reality (Berger and Luckman, 1966).

Timms and Timms (1977) put forward a three-level classification of theory that can be adapted to discover the theories which produce meaning to our understanding of integrated health and social care for professionals working within the integrated service to service users utilising such services i.e. those that define integration, those that demonstrate to us how to integrate and those that showcase the service user of integrated care.

### Theories which give meaning to Integrated Care Systems

#### Systems

- There are unrestricted and restricted systems. An unrestricted system is in continuous exchange with its environment.
- The external environment and the system are never constant
- The system consists of individuals who remain autonomous and creative decision makers
- Ambiguity and inconsistency are inherent inside the system
- Difficulties that cannot be resolved can however be ‘moved forward’
- Minor variations can have major effects

- Behaviour displays patterns (that can be termed 'attractor's)

- Change is more easily implemented when it understands attractor patterns

### **Complexity**

- There is a propensity for ambiguity and erratic change.

- Complex systems are a complex network of interacting relationships and patterns i.e. pattern seekers

- Previous experience does not give any indication to leaders and so they cannot predict.

- There are local and global structures which interact

### **Theories which show us how to integrate care**

#### **Network**

- A network of associations either individual or organisational

- Coordination is the dominant behaviour

#### **Collaborative**

- Active engagement between individuals

- Defining collaborative opportunities are vital

- Collaborative advantage and collaborative inertia

- Combined activity, combined action

- Organised practical-moral settings

#### **Contingency**

- A theory of knowledge management

- Concerned with organisational effectiveness and the fit between task differentiation and current environment conditions

- Resolution of conflict and distrust is crucial

## Configuration

- Knowledge management theory
- Networks of interrelationships are crucial
- Main themes emerge

*Adapted Timms and Timms (1977) three level classification of theory in the context of integrated care*

### 1.2.1. Theories which give meaning to integrated care

Having discussed what a theory is I will now go on to discuss theories in the context of integrated care. I have presented a brief overview (see table above) of relevant theories that help us to understand integrated health and social care systems. Of these theories and of particular relevance to my research, and I would argue of relevance in driving integration forward in health and social care is systems theory and complexity theory. The other theories contingency theory, theory of collaborative advantage, configuration theory and network theory although relevant in the wider literature I deemed not relevant to this study as they show us how to integrate. In the context of this study integrated care has already happened and so the theories which give meaning to integrated care are relevant. Looking at theories to assist us in understanding integrated care, systems theory appears to be particularly helpful, when interpreted within the functionalist tradition (Burrell and Morgan, 1979). I will also explore complexity theory which is useful when viewed in the framework of the integrated health and social care Trust.

### 1.2.2. Systems theory

Systems theory has elements of universality with 'guiding differences' which manage how information is processed (Luhmann, 1995). This theory adopts a scientific reductionist stance (Lars, 2008) perceiving organisations as machines subject to control, rules and processes (Haynes, 2003). It is helpful to view integration through this theory looking at cause and effect and as a means to interpreting the causal relationship to the past, present and predicted behaviour in public services (Weber, 1947; Seddon, 2008). This approach is useful in helping to understand the integration journey for social work and NHS organisations. Bertalanffy sums up this theory as "the whole is more than the sum of parts" (Bertalanffy, 1968, p. 55), denoting behaviours within a

complex system can be explained by looking at its constituent parts (Checkland, 1993). The origin of the behaviour may have occurred within a subsystem or the whole system (affecting one another); and may influence the behaviour of individuals within the subsystems (Checkland, 1993; Haynes, 2003).

An alternative sociological viewpoint put forward by Parson's (1991) sees 'social systems of action by interaction of individual actors'. Parson's describes an inter-dependent 'system of social action' system consisting of the social, personality and cultural where individual actors work together to form a unit or relational scheme inside which structures and processes are constructed. These could then be subject to scientific analysis in the same way as other systems. Again, this helps us to understand the interactions that are at play within integrated services; social (an actor), physical (practical thing) and cultural objects (symbols) which are common within a system of interactions and have a collective significance. However, Luhmann (1995) has subsequently stated that interaction occurs between people within a different and separate system and not as a result of said interaction. Individuals within the system are subject to societal roles, values, programs and people that allow them to actively participate and communicate in accordance with the rules however once differentiation occurs then the potential for conflict and indifference can arise.

### **What does this mean for integrated care?**

Whole system approaches in the UK to integrated care for example consist of such provisions as intermediate care services (Barton et al., 2006) which are said to have minimal theoretical foundations, with minimal discussion of whole systems approaches (Hudson, 2006). A study by the Scottish Executive (2007) on aspects of integrated health and social care measured partnerships locally by utilising the Joint Performance Information and Assessment Framework (JPIAF). This whole system measures evaluation looked at the capability of the system by examining waiting times and individual results (Andersson and Karlberg, 2001; Scottish Executive, 2007) establishing a benchmark for performance and/or improvements of an integrated approach as opposed to those of 2 separate social care and health functions. These define value demand (a result of a demand on the service created by what the service user wants) and failure demand (a result of a failure to do something for the service user) (Seddon, 2008). The limitations of whole systems approaches are they appear to miss the nuances that are wrapped up in professional identity and role valorisation exploring the whole with focus on specific outcomes rather than on the journey.

## Summary

Systems theory can be used to understand the mechanics of integration utilising reductionist thinking inside the functionalist tradition within the context of the organisation. It is useful to comprehend the policy and legislative drivers that have produced the context from which integrated care is to be developed and expanded within England. It endeavours to find a causal relationship between anticipated and unanticipated demand from service users. It has been suggested that systems theory should be abandoned in favour of complexity theory when dealing with integrated care in order to fully understand the effects of changing unpredictable demands and service user expectations (Lars, 2008). This is particularly relevant, with the backdrop of austerity measures impacting on all aspects of public services that demand a more exploratory scope than systems theory could deliver.

### 1.2.3. Complexity theory

Social interactions by humans can be understood by viewing them as systems of changing complexity where there is an absence of cause and effect (Gleick, 1988; Geyer, 1998; Geyer, 2003; Urry, 2006). The integrated Trust during this research was in a constant state of flux (see discussion below), if I were to apply this theory in this context the integrated Trust could be seen as an adaptive system that has the propensity for unpredictable change. Complexity theory relates to intricate adaptive systems that are 'organic, dynamic wholes' either in organisational (such as the integrated Trust) or individual (such as practitioners) settings (Cilliers, 1998; Wilson, Holt and Greenhalgh, 2001; Geyer, 2003; Haynes, 2003; Halsey and Jensen, 2004; Stevens and Cox, 2008; Miles, 2009). Jaafari (2003) offers an explanation, postulating that the creation of a complex society results from "a complex web of interacting open systems thru an internet network of interconnections and interrelationships" (p. 47). Stacey and Griffin (2005, p. 1) describe these "complex responsive processes of relating" as forms of interrelating associations which include acts of choice through norms and values, power relations and communication. This interpretation allows a greater understanding of individuals operating within complex systems. In this studies context professionals who are operating within multi-disciplinary teams whom are navigating through competing and different norms and values whilst subject to power dynamics. From a health care context Plsek and Greenhalgh (2001, p. 625) offer this definition:

“a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent’s actions changes the context for other agents”.

Consequently, complex systems can be seen as fundamentally about the relationships between the people within such systems (Langton, 1992; Plsek and Greenhalgh, 2001; Griffin and Stacey, 2005; Scott and Hoffmeyer, 2007).

Complexity occurs at the ‘edge of chaos’ (Langton, 1992; Gleick, 1988; Haynes, 2003; Stevens and Cox, 2008). While it seems intricate and chaotic on the surface, it may have a ‘simple set of subsystems’ underneath i.e. deterministic chaos or “surface complexity arising out of deep simplicity” (Lewin, 1993, p12, 14). Thus, a society which by its very nature is complex is affected by ambiguity and unpredictability (Jaafari, 2003; Scott and Hoffmeyer, 2007). This could originate from the conduct of individuals (local interaction) which in turn impacts on the ‘emergent global structure’.

Langton cited in Lewin (1993, p. 12) illustrates this as:

“from the interaction of the individual components down here emerges some kind of global property up here, something you couldn’t have predicted from what you know of the component parts.”

The global structures then offer ‘feedback’ which effects the conduct of the individuals within the local interaction (Cilliers, 1998). Complexity theorists define an autocatalytic process as a key characteristic of complexity theory whereby developing open systems (dissipative structures) such as social systems transform because of internal and external influences (Prigogine and Stengers, 1984; Kauffman, 1991, 1992, 1995; Geyer, 2003).

### **What does this mean for integrated care?**

Within an integrated health and social care setting I can see how the behaviour of service users and/or carers happens at the local level, which in turn effects the global structure of health and social care via its vertical working layers defined by professionals, organisations, legislation and policies (see figure 1.1) (Haynes, 2003). I would also argue that professionals working within the integrated Trust (at the local level) are affected by the global level through policies, this in turn affects the practice. E.g.; a social worker working within the integrated Trust who identifies a

health-related need may not have recorded said need due to a policy requirement to only record social needs. This could be understood as the global system effectively meeting all needs when at a local level it is not (Midgley, Munlo and Brown, 1997). This viewpoint requires all professionals working within the vertical and horizontal integrated health and social care Trust to have some fundamental comprehension of each tier and a contextual knowledge of the history within which they work since structures such as professionals (individuals) within systems have memories and a history through which progress has happened, and the future shaped and guided (Cilliers, 1998).

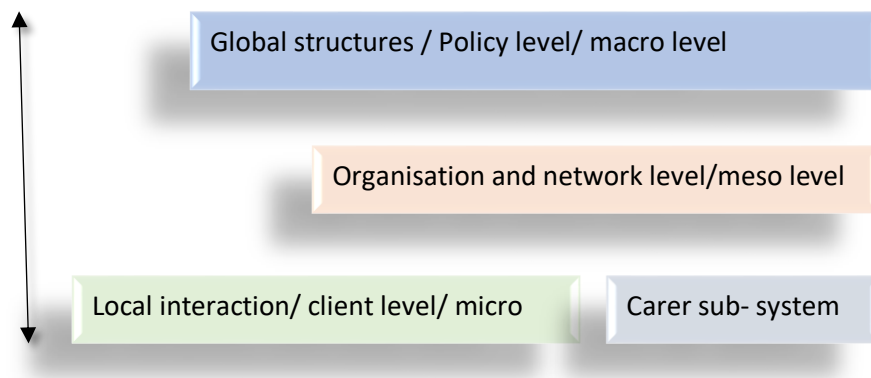


Figure 1.1: Combining complexity theory (Lewin, 1993) and management focus in integrated care (Nies, 2006) with levels (Peinhaupt et al., 2004).

The design and implementation of indicative models utilising complexity theory is possible however, predictive models are not due to the changing nature of individuals over time within systems and so it is often seen as non-linear sometimes without cause and effect (Plsek and Greenhalgh, 2001; Wilson et al, 2001; Geyer, 2003). Consequently, planning and management that relies on predictability is unable to be assumed (Jaafari, 2003; Ivory and Alderman, 2005). Complex systems are difficult to manage and failure originates from non-linear and linear interactions, management that is over-consolidated and 'multi-nodality'(Ivory and Alderman, 2005). If I apply this theory to the integrated Trust it affords us the opportunity to understand those 'wicked' and complex problems that influence integrated working practices. (Fraser and Greenhalgh, 2001; Plsek and Greenhalgh, 2001; Geyer, 2003).

**Summary**

Complexity is defined by complex adaptive systems that are erratic and appear to lack a degree of proportionality between cause and effect. Owing to their intricate patterns of interrelated relationships which develop over time, they need facilitation and not traditional planning or management.

### **1.3. Development of integrated health and social care**

The development of multi-disciplinary teams followed the implementation of the National Service Framework for Mental Health (1999). This created community mental health teams (CMHTs) with a single line management structure. This subsequently has resulted in social workers being employed in teams where they may be the only worker from this professional background and being managed by staff from a health background and resulted in co-location where “shared premises enable informal, frequent encounters between team members and provide opportunities for information sharing” (Larkin and Callaghan, 2005, p. 339). Larkin and Callaghan (2005, p. 343) also propose that “when professionals share an office space they are pushed into identifying more structured means of organising themselves, communicating with each other and having clarity about how they are going to work together”. From a service user perspective, shared location theoretically allows streamlined access to services in one place (British Association of Social Workers (BASW) 2010).

These reforms have reverberated throughout mental health social work (and now permeate into other areas of social work) resulting in a marginalisation of social workers who often struggle to articulate their role and professional identity to managers and colleagues; this, coupled with the disregard or lip service towards social care issues within teams, can be seen to be detrimental to service users and their families. In its recommendations regarding supervision the final report of The Social Work Taskforce (Department of Health (DH), 2009) addressed this issue identifying that “where the line manager is not a social worker, professional support should be provided by an experienced social worker” (p. 35).

The issue around integrated health and social care, particularly for social workers, is a pertinent one when the public sector is under unprecedented austerity measures. The current arrangements for the delivery of statutory adult social work services is that of the local authority



commissioning care to a provider; in the case of this research an NHS Trust that is providing integrated health and social care services. This arrangement has resulted in teams consisting of adult social workers, community nurses and occupational therapists working alongside each other in localities to provide integrated services to the local population. The backdrop to this arrangement is one that is stated to be more efficient and cost effective than those that preceded it. We are in an era of public sector policy drivers that encourage social care and health integration and as a result social work with older people in the United Kingdom has increasingly become assimilated within a system of health care (Hudson, 2002; Lymbery, 2006a; Lilo, 2016;) as a result of the provider/commissioner model of welfare delivery (Minkman et al., 2009). The definition of integrated care used for this study is that of one organisation delivering health and social care 'under one roof' (Coxon, 2005), as opposed to existing research that primarily focuses on cross agency working, agencies working with each other in health and social care (Meads et al., 2008).

This arrangement of integration has received widespread support, and as Gray and Birrell (2013) state, in principle at least, it seems to be "popular and widely supported by practitioners, professionals, users and administrators" (p. 101). Exploring this issue further Gray and Birrell (2013 pp. 105–10) highlight that difficulties persist in relation to differing arrangements between health-care trusts and local authorities with regards to funding. This has involved incorporating different financial frameworks when attempting to pool budgets, as well as disparate tax regimes, planning, financial schedules and charging policies.

Past research into integration is predominantly focused on the mental health service. In the UK there is an ever-aging demographic which is resulting in increased demands on health and social care services. This demographic shift demonstrates the importance of integrated health and social care for older adults in enabling services to meet increased needs. As outlined in the Care Act guidance, social workers are seen as the crucial players in driving this agenda forward. The Care Act 2014 and the Five Year Forward View (Department of Health [DH], 2014) highlight a duty on behalf of local authorities to encourage further formalised structural integration; this includes social services progressively being integrated with allied sectors such as housing and provisions within the NHS. My research explores/examines the idea of social workers operating within an integrated Trust and also explores the perceptions of professionals around social works impact in this environment. Social worker is a protected title under section 61 of the Care Standards Act 2000 but the issue of how social workers perceive themselves is not one that can be defined by

statute. Professional identity is frequently intimately connected to concepts of self, created on an individual's experiences, societal beliefs and values (Schein, 1978; Ibarra, 1999). One of my research aims was to illustrate the method of practitioner engagement with their dynamic role and the impact on their professional practices, knowledge and skills (professional identity). Exploring how social work identities are constructed by professionals who are challenged by multifaceted, and often ambiguous public-sector responsibilities (Baxter, 2011).

The literature in this area is complex with professional identity viewed as an unstable element, difficult to quantify; it is an on-going process of analysis and adaptation which is influenced by environmental workplace factors. This research explores the understanding of culture within the workplace, the need to maintain professional boundaries, exploring professional socialisation, jurisdiction disputes and inter-professional tensions within an integrated health and social care team. It reiterates the importance of beliefs, professional protectionism and the perception of security that comes with a sense of association to the research particularly around issues of professional identity (Rothausen et al., 2015). This is echoed in the literature within organisational settings that explore identity and identification (Ashforth, Harrison and Corley, 2008) which states the fundamental phenomena responsible for identity formation and conservation are attachment and belonging. This conception is also reflected in the institutional logics formulation of identity (Thornton and Ocasio, 2008; Thornton, Ocasio and Lounsbury, 2012).

Systems theory is dependent on rationality, objectivity, stability and predictability in order for the system to function. If we look at the health and social care journey, rationality, for example, requires that all integral parts act on the same policy information, have the same background and similar values and work towards the same goals often enshrined in legislation. This requires that there is a system designer, in this case the government, who oversees change; this I would argue is a top down approach to social care delivery. If we apply systems theory to the document 'Putting People First' (2007) that placed personalisation at the centre of the government's approach to social care delivery we can see that this edict showed the government's commitment to support all adults to achieve maximum independence through a radical transformation of adult social care. The introduction of Direct Payments and individualised budgets has been a challenge for social workers to implement within multi-disciplinary teams where they have been charged with promoting this new model of service provision. A secondary objective of my research was

therefore to assess whether supervision was supporting social workers operating within an integrated health and social care structure.

Eighteen months prior to undertaking this research I had conducted research into leadership in social work (Phillipowsky, 2017, also see appendix 5). Participants indicated that they as professionals wanted respect and an appreciation of the value they bring to the NHS. Leadership was seen as a necessary ingredient for the growth and promotion of the profession. This research and subsequent literature review informed my thinking and led me to identify a research deficit and an area of interest around the perceptions of social workers from within the profession and those they work alongside. This notion of being underappreciated and unvalued was intriguing and one that I was uniquely placed to explore as an insider researcher within an integrated organisation. Social work is by its very nature policy and legislatively driven in England and subsequently policies and ways of practice change with successive governments. The area of social work; integrated adult social services and health teams is a relatively new development in England with minimal research in this field.

This is a rare study in the current contextual climate, with a profession that is subject to continuous reform and is at the forefront of dealing with the public who have been subject to unprecedented levels of austerity. Austerity has impacted on the support social workers can offer and this is particularly pertinent in adult social care with recent shortfalls acknowledged by the government and the introduction of the social care precept whereby local authorities in England were given the power to increase council tax to pay for social care services for adults (HM Government, 2015).

#### **1.4. Developments during research**

As discussed above social work is not a static entity, it is a very fluid profession that constantly must adapt. During this research the organisation itself went through significant changes that impacted on staff, service delivery and provision and subsequently morale. The changes were far reaching and in some cases changed ways of working completely (see Fig 1.2 below).

### 1.4.1. Modifications to the section 75 agreement

#### General Points:

- Rather than having one Section 75 of the NHS Act 2006 agreement, the integrated Trust now have three contracts: Reablement, Occupational Therapy and Assessment and Case Management.
- The reduction of funding is as follows:

New Section 75 Financials	2017/18 £m	2018/19 £m	2019/20 £m
Adult Care Management (ACM)	18.1	14.7	14.7
Reablement	4.6	4.6	4.6
Occupational Therapy (OT)	1.9	1.2	1.2
Overheads	3	3	3
<b>Total</b>	<b>27.6</b>	<b>23.5</b>	<b>23.5</b>

Figure 1.2:

- There was a £2 million reduction from the re-ablement budget that has been implemented from April 17.
- Community care budget that is used to purchase services such as domiciliary care, residential and nursing home placements transferred back to the local authority on the 1<sup>st</sup> April 17.
- Brokers and finance staff were transferred via The Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) to the local authority to undertake functions in relation to the above.
- Brokerage service created within the local authority for brokering of all care except for direct payments.

These changes that have occurred during the research design phase and continued to occur during the data collection and analysis stage and I would argue did have an impact on participation and responses. The changes affected the participants in the following way. The

occupational therapists during phase 1 (survey) of the research were subject to a management of change process and were subject to potential redundancy or relocation. By stage 2 (interviews), 33% of occupational therapists had been made redundant with some relocated. During phase 2 the social workers received notification of a management of change process. The potential impact on the participation rate and of the objectivity of responses should be understood in the context of these changes that occurred during the research.

### **1.5. Justification for study**

The drive towards integrated care has continued with legislation such as section 31 of the Health Act 1999 (DH, 1999) that developed a new 'Duty of Partnership' applicable to local authorities and health, laying the groundwork for the joint arrangements possible under Section 75 of the NHS Act 2006 designed to drive integration across health and social care. These statutory powers have facilitated the delivery of health and social services by a single organisation in an integrated, joined-up approach (Chatziroufas 2012; Bamford 2015). This has continued with the Health and Social Care Act 2012 and the Care Act 2014. Glynos, Speed and West (2014) acknowledge the 'ideological contexts and power dynamics' embroiled within legislation in England such as the Health and Social Care Act 2012, including its predisposition to utilise integration as an influential hegemonic tool to encourage further privatisation and competition within the NHS, whilst relegating alternative options (p. 65). In this illustration, integration acts "as a political logic to normalise provider-blind provision, obscuring wider contextual features linked to the landscape of power relations, hegemonic struggle, and ideological investments" (Glynos et al., 2014 pp. 63–4). Powell and Steel (2012) argue that policies such as personalisation, participation and integration have developed that allow social care 'experts' to apply market principles to people's capacity to engage with the market as 'citizen-consumers'. They go on to argue that these 'citizen-consumers' experience options and opportunities that are unavailable to those individuals who fail to engage within the market (p. 3). Legislation and policy increasingly emphasis multidisciplinary teams (DH, 2013; NHS England, 2014). My research aims to explore the culture and professional identity of social work focusing on the value and role of social workers in integrated locality care teams. In addition, it offers an array of perceptions into the skills and knowledge such staff possess, the degree to which they have preserved a specialist

social work focus and the difference their existence within the integrated team makes to inter-professional communication. The existing research emphasises social workers feeling unappreciated and misunderstood (Norman and Peck, 1999). They suggest four main reasons for the absence of good inter-professional working:

- loss of faith by practitioners in the system within which they work;
- strong adherence to uni-professional cultures;
- absence of a strong and shared philosophy of community mental health services;
- mistrust of managerial solutions to the problems of inter-professional working.

(Norman and Peck, 1999 pp. 221-224)

Similarly, Maslach and Leiter (2008) in a US study explore these notions further in the context of public sector mental health care providers (social work) burn out and high turnover rates within the profession. In contrast, a study by Abendstern et al. (2014), found social workers to be broadly positive about their experience of working within community mental health teams for older people, with a view that their proximity led to a deeper understanding and awareness of the social work perspective and role. The literature highlighted that concerns around the delivery of older people's social services are longstanding (Lymbery et al., 2007). Existing research also implies the significance of co-location and networking in multidisciplinary settings to overcome the tendency of silo working and seeing the 'other' in colleagues of different disciplines, impeding collaboration and team cohesion (Fay et al., 2006; Reynolds, 2007; Belling et al., 2011). Research suggests that a successful multidisciplinary team is one that becomes self-aware rather than merely a collection of its individual professions (Hart and Fletcher, 1999; Bourbousson, R'Kiouak and Eccles, 2015). A secondary objective of my research explored the social work role, although it is widely recognised to be difficult to define (Social Work Task Force, 2009; Allen, 2014). The international definition, states "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing." (International Federation of Social Workers (IFSW), 2014).

My study aimed to contribute to the understanding and explore the perceptions of the social work profession in England through inspiring professionals and integrated health and social care leaders to reflect on the status and relevance of social workers operating from within an integrated NHS Trust. My research was conducted throughout Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) on SSOTP sites and NHS health research authority approval was sought alongside this application (see appendix 3). The purpose of my study was to ascertain an extensive view of the perceptions of social workers operating within this framework from the experts; the social workers and the community professionals working alongside them. It explored the cultural and professional differences, examining the cache of social workers, their relevance, and contribution to the integrated Trust which is a result of an agreement made under section 75 of the National Health Services Act 2006 between a local authority and an NHS body in England. In doing so, my aim was to investigate the perceptions of social workers from within the profession and from community colleagues. It was not my intention to establish or discredit hypotheses or to test theory; preferably it is an exploratory piece aiming to explore social phenomena from which an understanding might be developed. The data was then subject to thematic analysis within a social constructionist epistemology (i.e., where patterns are seen as being socially produced, however no discursive analysis is conducted).

## 1.6. Aims of the study

- To explore the evolution of integrated health and social care in older peoples' services with a specific focus on the role of the social worker.
- To critically analyse the local social and policy contextual drivers of integration over time (currently 4 years into integrated care). (Professional and organisational culture)
- To critically analyse the process of practitioner engagement with regard to their role within integrated teams and the effect on their professional knowledge, practices and skills (professional identity).

The objectives of this research are to explore community professionals':

- opinions concerning social worker's role and statutory functions
- understanding of collaborative and cooperative work?

- experiences of professional support obtained by social workers and health managers.  
Who leads? Who manages?
- opinions on the aspects of anti-oppressive practices in social work particularly the notion of participation, partnership, empowerment and reflexivity.
- views on social work identity within multidisciplinary team structures.
- exploring perceptions regarding the challenges of cultural and contextual drivers of social work practice.

The study drew on existing research to frame the research question. E.g., existing research indicates the importance of professional respect (Laidler, 1994) and the importance of maintaining unique professional skills and adaptability around shared skills to develop a common ethos when working alongside service users. The research also explored the process of team learning (Bond, 1997), exploring the notion of shared knowledge and experience or adherence to professional boundaries.

Integration has a lengthy history that has been shaped by inconsistent cultural, financial and political drivers (SCIE, 2012; Barker, 2014; Kings Fund, March 2015) and it is these existing cultural and contextual drivers relating specifically to social work practice that I was interested in exploring along with social workers perceived acceptance, ability to perform, and professional standing in this area which is predominantly health dominated. My study is underpinned by the core research question

‘What is the perceived contribution of social workers within an integrated setting?’

Research design/approach

The study was influenced by that of Lilo’s (2016) work on *Mental Health Integration Past, Present and Future a Report of National Survey into Mental Health Integration in England*, which, in turn, used questionnaire and interview methods subject to SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis (Humphrey, 2005). The proposed study design can be split into 3 specific stages:

Stage (1)

A questionnaire-based survey (see chapter 4), capturing demographic data around profession was relevant and provided insight and differences of opinion and perception in those professionals. In



addition, the questionnaire also explored the respondents' perception of social workers within integrated care. By distributing the survey to a targeted audience of community professionals in order to understand a perceived contribution of a specific professional group, I will be examining cultural data. It is participants who offer expert explanations and who represent the societal intracultural variation (Bernard 2002). N=600.

#### Stage (2)

Interviews were conducted, extracting qualitative information about respondents' perceptions connected to the issues under investigation. N-15-20.

#### Stage (3)

An amalgamation of (1) and (2), was then conducted showcasing the likenesses, but notably, the differences between findings in stages (1) and (2), so as to result in a critical analytical evaluation of the research questions under deliberation.

#### 1) Survey through questionnaire distribution

I invited community professionals to participate and complete an online survey via an online survey provider (Appendix 1). The survey is an adaptation from a survey instrument developed by Mersey Care NHS Trust Integrated Care Demonstrator Site Project and NHS North West Health Education Workforce Transformation Initiative in 2016, the results of which were published in BASW (2016). The survey comprises of a series of open and closed questions;

A. Background information/demographics

B. Understandings about the value of social workers

C. Perception of integrated care across health and social care within the Trust

D. Perception of social worker's role and contribution.

The survey was available online for six weeks (June-July 2017). The survey reportedly took participants 30 minutes to complete. My study differs in that it is exploring integrated adult social services rather than mental health services. Although some aspects overlap and complement each other such as professional identity and culture. My study has been specifically designed for adult social services which involves different client groups, services and professionals.

#### 2) Interviews

At the conclusion of the electronic survey participants were invited to participate in a follow-up interview. These in person interviews allowed for a qualitative approach exploring the issues in depth with participant's perspectives of the perception of social workers working within an integrated Trust from community professionals. If participants opted-in to a follow-up interview, communication was then established and consent obtained. Once consent was obtained a copy of key themes to be discussed in the semi-structured interview was emailed to the participant prior to the commencement of the interview. An additional consent form was issued prior to their participation in any interview. The interviews lasted around 30 minutes, they were recorded (digitally) and were later transcribed. Participants had the opportunity to feedback on my first stage of analysis. The interviews were conducted between July-October 2017 solely by the researcher on SSOTP premises. The sample of interviewees was selected via an iterative process (purposeful sampling) that aimed to maximise the richness and depth of the data.

In choosing a qualitative research design I have to be mindful of the assumptions underpinning this approach. As a study on integrated professional groups (social workers, occupational therapists and nurses), I am mindful of group dynamics that are founded on a belief that individual attitudes and assumptions do not form in isolation and are constantly influenced by differing attitudes and understandings of those around them (Marshall and Rossman, 1995; Reed and Roskell, 1997).

The focus for the research is not the concept of social work integration within a health Trust, nor indeed the professional work force, but the relationship between the two. In other words, accessing community professional's perceptions of social workers involves focusing on the relation between community professionals and their experience of integrated working within the Trust, I would consider them to be the experts and a vital source of data without which this study would not be possible.

#### **1.6.1. Cohort identification**

In order to apprise the profession, it is essential to ascertain both divergent and consensus views. A sample of professionals from the integrated Trust was invited to participate in the study and this was entirely voluntary. This approach was designed to minimise the potential for researcher bias during the selection of participants. Purposive sampling was adopted whereby participants were grouped according to pre-selected criteria in this case they must be qualified social workers

or qualified registered community professionals who within their role work closely with social workers.

#### **1.6.2. Financial uncertainty**

During the design phase of this study it appeared that the section 75 agreement between the local authority (commissioner) and the NHS Trust (provider) was about to break down and thus lead to disintegration. The reality was a compromise revolving around financial pressures faced by both the local authority and health Trust. This arrangement hinders true integrated care as negotiations happen in a cyclical fashion with both factors health and social care subjected to numerous performance indicators. This results in the staff, the organisation, the commissioners perpetually thinking in the short term, not looking at the bigger picture with a view to disintegration at any time. This situation is nothing new and is the current culture from which social workers and our community based health professional colleagues now operate within. This is the new narrative. These concerns were highlighted by Regen et al. (2008) who illustrated the underfunding of joint projects when agencies faced financial pressures. Additionally, while Hultberg et al. (2005) recognise many beneficial factors related to a joint budget, they also recognise the potential damage to the viability of partner organisations if pooling results in the breakdown of service responsibilities.

#### **1.6.4. Layout of the thesis**

In chapter 2, a literature review is presented to examine works in the subject area, namely integrated working within community mental health teams. Relevant literature is explored with regards to social worker identity, the notion of social work as a contested term within the profession. The literature around medical vs social, leadership and management are included, with an exploration of literature that examined integrated care models.

In chapter 3, the research methodology is introduced which underpins this study and describes why the study design was chosen. An overview of data collection approaches used and methods of analysis employed are presented, and data collection methods are discussed

In chapter 4, the survey results are presented. Data and themes extracted from the 41 respondent's, social workers, occupational therapists and nurses who worked within an

integrated team within a community setting, are presented. Key themes and key comments within the survey text are presented.

In chapter 5, data and themes extracted from interviews conducted with six voluntary participants, who worked within an integrated team within a community setting, are presented.

In chapter 6, my analysis is explained, discussing the 5 phases of thematic analysis.

In chapter 7, themes are outlined and discussed in relation to the literature. Four themes were identified, which directly relate to the research question and aims of the study. The discussion chapter focuses upon establishing how the research aims have been addressed and answered.

In chapter 8, the conclusion discusses the implications of the findings in relation to answering the research question. Limitations and reflection of the study are also included.

## **2. Literature review**

### **2.1. Introduction**

The literature review is presented in three parts. The first part considers the notion of what is a social worker. The purpose of the research is to ascertain the perceived contribution of social workers to an integrated Trust. Therefore, it is imperative to explore the notion of what constitutes social work. Social work's meaning is often contested and the first part of the review explores some of these different meanings. Part two focuses on the literature around integrated models of care, with part three exploring the relevant literature that has been conducted primarily within integrated community mental health teams in the UK; with some further studies exploring relevant integrated adult social care and health services also explored. The review analysed and reflected upon the current available literature that informed this study. Multi-disciplinary teams are referred to throughout the literature review which is primarily set within mental health social work and these team structures and organisations are comparable to the integrated health and social care Trust and integrated teams this research is exploring.

The primary concern with my study is to explore the perceptions of social workers, occupational therapists and nurses into how they perceive social work within the integrated Trust. The literature in this area is limited and most is concerned with the public perception (Legood et al 2016) or the media perception of social workers, particularly children's social workers (Beddoe and Cree, 2017). Given the focus of this study on a relatively new area of social work; integrated adult social work and health in England and its focus on the perceptions of social workers and professionals involved, I had decided that there was no scope in incorporating this into the literature review given the lack of relevant literature in this area. It again highlighted a gap in knowledge which informed my aims and which my research subsequently attempted to address (Phillipowsky, 2018).

### **2.2. The search strategy**

Searches

Qualitative or quantitative studies published between January 1, 1999 and March 2017 were included in the search. The year 1999 was selected as a start point, because it delimits publications after the passage of the Health Act 1999. Publications in this period are likely to have explored integration and are assumed to both represent and extend advances in social sciences and workforce research that took place after the legislative and policy changes that have driven social care and health integration. A primary focus on UK based sources with a secondary focus on the wider international literature from the USA that explores integrated care systems.

Searches were conducted in Summon which has access to 248 databases.

A search of the grey literature was conducted using Google Scholar and Social Care Institute for Excellence (SCIE).

Search terms:

("integrated health" OR "integrated social care and health" OR "joint-working" OR "community mental health team" OR "multidisciplinary") AND ("social work" OR "social worker")

Literature published from 1999 onwards with regards to integrated health and social care services.

Types of study that were included were:

- qualitative studies set within integrated working environments with both health and social care staff, including mixed-method designs;
- Literature reviews (i.e., reviews of an unsystematic nature of policy and legislation) that integrates the evidence related to integrated social work and health systems. Social work practice in adult services and mental health social work in integrated community care settings were included in the search.

Types of study that were excluded were:

- Manuscripts that do not specify "social workers" but refer to social care or non-qualified workers were excluded; (I am interested in the roles of social workers and their impact on integrated services.)

- Manuscripts that do not include social workers working within integrated/multidisciplinary teams.

This initial review of the literature was commenced at the very start of the project. At that time, I had identified a methodological approach to the study that being a qualitative approach for the research, adopting thematic analysis. I had decided that an important starting point for my research was to establish an overview of integration relating to research evidence from integrated health and social care services which in turn informed my thinking on the above inclusion/exclusion criteria. A further consideration of this research is that of the social work role and issues of identity when working within inter-professional teams. The rationale for this choice of time frame was that integration was introduced within the Health Act 1999 and has continued to the present Care Act 2014. This wave of legislation over the past 15 years is seen as a driving force towards integrated health and social care services.

The database search, spanning publications since 1999 from peer reviewed journals, retrieved 3042 peer-reviewed articles. The majority of these studies were subsequently excluded (3002 articles) based on their title or abstract, because they did not meet the inclusion criteria. Therefore, we focused on the remaining 31 articles eligible for inclusion. After full text reading, based on the aforementioned exclusion criteria, 15 studies remained. I found articles written by the same author(s) and so these duplicates were discarded.

The remaining texts were deemed of value with the highest value placed on the two studies that employed a social work perspective. Structural integration was also seen as key to understanding the context of the research environment and so Miller work on care trusts was also given prominence. Due to the lack of academic articles on integrated adult social work and health, a wider search strategy was undertaken, this included literature from the USA whose structural integration is comparable to the integration of social care and health in England. Research from the USA was also considered particularly when aiding my understanding of structural integration as structural integration is re comparable in the USA to the UK. Limitations of the USA literature was that it was from a different social work professional way of working and thus culture.

Article	Value
Social work perspective integrated care	1
Integrated community mental health team	2
Structural integration literature	2
USA literature	3

Of particular note were the following studies:

Value 1: Bailey and Liyanage, 2012; *The Role of the Mental Health Social Worker: Political Pawns in the Reconfiguration of Adult Health and Social Care* was particularly relevant as it explored the understanding of the social work contribution from a range of perspectives which is a key part of my aims and objectives. Carpenter et al., 2003; *Working in Multidisciplinary Community Mental Health Teams: The Impact on Social Workers and Health Professionals of Integrated Mental Health* investigated the relationships between the organization of community mental health services & professional & team identification, team functioning & the psychological well-being & job satisfaction. These were again linked to my aims and objectives and although from a mental health social work perspective I deemed them relevant to my current study.

Value 2 structural integration: Miller et al. 2011; *The care trust pilgrims* which provides insight into structural integration within England. This research is of relevance given that it immediately precedes the current integrated care arrangements that my study takes part in and is relevant in the lessons learnt and built on from previous policies around integration. Gibb et al., 2002; *Transdisciplinary working: Evaluating the development of health and social care provision in mental health in the early days of integration following the NHS plan 2000.*



Value 2 integrated community mental health teams: Hannigan and Allen, 2011; Giving a fig about roles: policy, context and work in community mental health care: Policy, context and mental health work which explores professional roles in integrated organisations. Brown et al., 2000; Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health explores boundaries that exist between different professional roles and areas of responsibility. Rees, Huby, McDade and McKechnie, 2004; Joint working in community mental health teams: implementation of an integrated care pathway explored mechanisms utilised to enable integration, exploring structural integration. Norman and Peck, 1999; Peck and Norman, 1999; Working together in adult community mental health services: An inter-professional dialogue addressed inter-professional working in adult community mental health with a social work focus and a focus on professional culture.

Value 3: Peek et al. 2013; Research and evaluation in the transformation of primary care explores the structural integration of behavioural (mental health) and primary care (health) services.

### **2.3. Part one: The nature and function of social work and identity**

As a social worker who undertook this research, and given the studies aims with regards to social workers, I thought it prescient to discuss social work specifically and the relevance of social workers to such integrated care models. It is critical that non-social workers understand that the language of social work is perplexing and frequently ambiguous. This confusion is a result of numerous terms being frequently used interchangeably meaning different things to different people (Trevithick, 2011). The fieldwork was looking at the perceptions of social workers and exploring what social workers mean to different professional groups. Social work in the UK often is referred to by terms that are used interchangeably; such as social care, local social services authority, social services and social work making it difficult to be sure of what is being explained. However, within existing UK literature it has been assumed that all of the aforementioned refer to social work. In expectation of the discussion on the perceived role of the social worker and the roles impact on integrated services I felt it prudent to explore the nature and function of social work in the following section.

### 2.3.1. Defining social work

In investigating the social work role and function a fundamental requirement would be to establish just what is social work? In the UK, the international definition is enshrined in law (see discussion below).

Logically, one has to agree on a conception of what it is that creates social work, in order to begin to establish a base line of what the social worker role might be; what knowledge and abilities should social workers possess; what training and education is applicable for social workers; and what are the characteristics of social workers that separate them from other professions, what is their role?

There are differences in how social work is perceived by others and how it perceives itself. These differences can be explained by the disparities between social worker's own intentions and goals and the limitations of institutional setting social workers predominantly work within.

Academics such as Cree (2003, p. 3) state that "it is almost impossible to find a simple definition of social work with which everyone is likely to agree". Thompson (2000, p. 13) suggests "social work is what social workers do", for Cree (2003, p. 4) though this stance is counterproductive. Cree goes on to describe social work as a fluid profession subject to contested claims of definition and practice, a profession imbedded within and connected to the society in which it is situated. Comparatively, social work should be viewed as an accumulation of disparate discourses that come together in a specific moment in time to structure the task of social work. BASW/IFSW definition is given below and is pretty much accepted. Although debated and contested in academic circles an international agreed definition of social work does exist. In 2014, the IFSW agreed the following definition:

"Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing."

The above definition is constituted by statute in England and Wales and encapsulates the significance of human rights and social justice along with empowerment and enablement of people. It reinforces the UK social work position to be complimentary to the European Convention on Human Rights and is reiterated in recent government policy and legislation that enhances the implementation of human rights e.g., The Modern Slavery Act 2015. The IFSW definition is a statement reinforced by the literature which emphasises social work as dedicated to human rights and social justice (Clark, 2002) with a focus on empowering and protection of individuals, fulfilling an enablement function in order for individuals to achieve and prosper within society (Association of Directors of Social Work, 2004).

Social work from this perspective is about addressing social inequalities, helping the marginalised and most vulnerable in our society. This is seen as fundamental due to the increasing disparities present in society that perpetuate the cycle of poverty and dependence (Brülle, 2018).

### **2.3.1. Social Work as a Contested Concept**

If I take the IFSW definition discussed above, I can from this standpoint view social work through the legislative and policy perspective that does at least offer a clear definition of social work. Alternatively I can adopt a view of social work that is seen as fluid, a more ambiguous yet contemporaneous standpoint; offering legitimately in that specific moment under a specific set of circumstances. A clear definition is helpful to my research question whereas, asking the question in the context of the latter; what has social worker's contribution to integration been, becomes much more difficult.

Social work can be viewed as a process of legitimation, of 'validation' from an array of contradictory definitions and assumptions borrowed from other professions (Askeland and Payne, 2001). This implies by virtue of its make up that for social work there is no prevalent frame of knowledge. That which is viewed as valid knowledge, or indeed an established function of social work, is defined in many ways. The social work frame of knowledge is based on the perceptions of others; it is subjective, influenced by societal norms and values as well as individual vested interests and media representation. There is the professional capabilities framework (BASW, 2018) that sets out in England expectations of what is expected from social workers, but again this framework is relevant to England only with differing viewpoints in other countries.

Being a contested concept creates problems in establishing the correct expertise and skills required for social work practice. It does explain the historical association of social work practice with critical self-reflection and the perpetual sense of change. The ambiguity surrounding the social work profession is problematic when attempting to constitute a clear professional identity with social work subject to the understandings and beliefs of competing constituencies. E.g., established notions of social work that are entrenched within public sector organisations may be rejected by social workers operating from a radical viewpoint (Searing, 2004). The solution to this situation some would argue lies within the social workers themselves. They determine their own identity and establish their own view on the nature and function of social work that enable them to avert conflicting, indeed damaging, ideas about social work and its role.

### **2.3.1. Social Work and Social Control**

Paradoxically, regardless of what is seen to be the genuine or authenticated notion of social work; from different perspectives, social work can be viewed as an agent of social control utilising legislation and policies to regulate individuals, resulting in conformity and compliance to societal and state rules. It is this dichotomy that is pertinent and relevant to integrated teams. The perceptions of social workers and that of others is wide ranging. Some would argue that despite the rhetoric of social work it does little to challenge societal inequalities with individual's, arguing instead that social workers are a key part of a social and economic system that sustains and perpetuates such inequalities. Far from being emancipatory, it can be viewed as oppressive the antithesis of social works core values (Jordan and Parkinson, 2001; Jordan, 2004). It is also argued that despite this notion of social control exuded by social workers, that they also can be an integrating force.

Munday (2003) sees social work's primary function as that of the integration or reintegration of sections of the community with mainstream society. However, in an era of unprecedented austerity where statutory functions of social work are struggling to be maintained this may be seen as aspirational rather than reality (Bickerstaffe, 2013; Ham et al. 2015). The social perspective therefore within integrated setting can be seen as bringing these people under the umbrella of public services, I would argue as a way to manage services in decline. Social work undertakes this function and it is hard to imagine what other agency could or would undertake this function if social work did not. Indeed, I would argue that education and health could

assimilate aspects of social work but the core statutory functions, the grey area of social work will always remain at arms lengths of these partner agencies. Reflection is crucial to social workers who encounter a plethora of social situations that requires them to have awareness of their own values and how this may impact on the work they do. Social workers make complex and difficult decisions informed by their professional identity, integrity and standards of professional proficiency (Banks, 2010; Wiles, 2013; HCPC, 2017).

### **2.3.1. The role of the social worker**

There have been a number of roles showcased in the literature of which I will discuss below.

I have highlighted the contested nature of what constitutes social work with disparate views that often come into conflict and so too are there differing notions with regards to the definite role of the social worker or what that role should be. In many respects, I can see a disconnect between what social workers envision their role and function to be and the role and function they are expected to discharge within integrated agencies. The belief that there is a crisis in the social worker role pre-dates integrated care and has been a longstanding issue with social workers often finding themselves disillusioned with the social work task (Françoze and Cassorla, 2004). Social workers have been forced by resources and organisational pressures to provide a crisis led rather than empowering and preventative services (Georgoussi, 2003), with reduced interaction with service users (Rogers, 2001). All these issues have contributed to the ever-growing rift between the ideal social work role and the reality of the social work role. This crisis has continued unabated by integrated care, merely shifting from one organisation to the next with every subsequent The Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) arrangement serving to provide a continuity of employment and associated terms and conditions and thus a maintenance of the status quo. This disillusionment of the role often results in a context where social work is seen as marginalised and when this occurs social work cannot be meaningfully practised resulting in meaningless integrated care (Mangan, Miller and Ward, 2015)

The role of the social worker is varied and complex and the literature alludes to the many roles of the social worker but it is possible to discern the most prevalent throughout to assist this review.

The prevalent roles are as follows:

#### **The counselling social worker**

The role of the social worker as a professional who provides counselling or who works alongside people has been an approach historically adopted by social work (Younghusband, 1959). It has also broadly aligned to a number of social work core values and notably recognises the fundamental worth of people and the importance of respect when dealing with people. This is a key issue for social workers in statutory services with a loss of this approach to their role.

### **The advocating social worker**

The social workers can be seen as advocating for those marginalised from mainstream society. This approach is enshrined in policies and procedures with roles such as the appropriate adult. In this role, social workers can promote service user's voices and that of marginalised groups by providing support to ensure that they are heard. This is underpinned by a fundamental belief amongst social workers of promoting human rights and social justice. The social worker adopting an advocacy role ascribes to the idea of a closer partnership between the social worker and service user but is seen as important particularly within integrated setting with the social worker seen as the other, not part of the hegemony of medicine. Similarly, social worker can be seen as partners, empowering individuals to maximise their independence.

### **The risk assessing social worker**

Social workers are increasingly being tasked with managing risks to complex individuals, the concern being that this is at the expense of the counselling/advocate role and by extension connected with social control or investigation role (Garrett, 2004). This may result in a relationship breakdown between the service user and the social worker.

### **The social worker as a care manager**

The role of a care manager may also fall on social workers (Baldwin, 2016). In the mixed economy of care, they are often involved in assessment and care management, devising care plans and thus arranging the delivery of care with little contact with the service user concerned.

### **The social worker as agent of social control**

Radical social work (Bailey and Brake, 2013) sees social work as an arm of the state that does little to challenge societal inequalities, viewing social workers as an intrinsic part of a social and economic system that sustains and perpetuates inequalities. In some respect, the social worker can be seen as controlled by and as an agent of the state exercising a form of social control.

Social work is multifaceted with social workers playing all of these roles to varying degrees throughout their career.

The difficulties arise it would appear when the roles become unbalanced and less therapeutic, counselling, person centred and more around social workers having to become care/case managers, risk assessors and decision makers exercising social control functions on behalf of the state (Jordan and Jordan, 2000; Jones et al., 2004). A particular difficulty facing social workers is how to reconcile this internal struggle within the profession around identify with the perceptions of others who in turn have expectations based on these perceptions.

The reality is social workers are often constrained by the organisations that employ them and it could be argued are merely managing the deterioration of individual's lives (Jones et al., 2004). This may not be the prevalent view in social work but it is a valid critique of the social work role operating within a resource stricken system of social care provision (Jordan and Parkinson, 2001; Lavalette, 2017). In 21<sup>st</sup> century Britain with demographic changes and financial uncertainty with regards to public sector provision of health and social care services just what type of social work is pertinent or acceptable to address these evolving needs? The answer according to government is integrated health and social care services.

### **2.3.1. Social work ethics and values**

The values social workers ascribe to are influenced by one's own value base and reasons for working alongside those marginalised from mainstream society or those who are vulnerable. They are not considered as an automated compliance to a set of rules and regulations. However, in order to understand the value base that underpins the profession a consistent set of themes was identified that were illustrated in 2012 by the British Association of Social Workers in their revised Code of Ethics for Social Work which consists of:

Human rights – respect for the inherent worth and dignity of all people as expressed in the United Nations' Universal Declaration of Human Rights

Social justice – a responsibility to promote social justice, in relation to society generally, and in relation to the people with whom they work

Professional integrity – a responsibility to respect and uphold the values and principles of the profession and act in a reliable, honest and trustworthy manner. (BASW Code of Ethics for Social Work - Statement of Principles (p. 8))

The idea of 'social work' is not easily understood by the public and is often maligned by the media, a profession with an image problem and stigma associated with high profile failings, particularly those involving children (Scottish Executive, 2005; Thompson, 2015).

The literature may not arrive at a consensus around social work roles but there is a clear and unified understanding of the core values of social work of respect for the individual and seeing that individual as a whole person. This holistic outlook has been noted in research as one of the most valuable social work qualities that have been brought to integrated teams. This is also echoed in the dedication of social work practitioners to maintain their own identity and working practices, adopting person centred approaches placing the individual within the context of their whole life situation (Washburn and Grossman, 2017). This distinguishes social work from other professional groups who may be more focused on specific elements of an individual's life rather than looking holistically at the whole person in an attempt to understand and address the interconnected issues that are affecting that individual. The importance of understanding the ethical and value base cannot be underestimated in this study. This helps to inform my understanding of the profession and how others may perceive them based on these underpinnings of social work practice. Theoretically integrated care should only serve to amplify this quality, providing better outcomes for service users. Social work's professional identity is guided by social work values and ethics and its distinct role in practice rather than being influenced by the institutional or organisational context (Banks, 2016).

Having explored the notion of what social work is in a UK context I will now go on to discuss identity and the importance of perception and role when working in a multi-disciplinary environment.

## **2.4. Identity**

The literature around the concept of identity is not clear-cut and is wide ranging from disciplines such as sociology (Bernstein and Olsen, 2009), social psychology (Tajfel and Turner, 1986),



developmental psychology (Bosma and Kunnen, 2008), philosophy (Noonan, 2007) and economics (Akerlof and Kranton, 2000). The difficulties without an accepted definition around the concept have led researchers such as Brubaker and Cooper (2000) to disregard the term altogether. A classic study by Ashford and Mael (1989) explores these phenomena and surmises that three main factors constitute professional identity: distinctiveness, prestige and the salience of out-groups. Distinctiveness in relation to social workers would be around the profession's value base and practices relative to other comparable groups (nurses or occupational therapists). Prestige, the distinguishing feature of professional identity with an emphasis on status, character and qualifications. The final factor, showcases the importance of relational factors, indicating the salience of the out-group, "whereby awareness of the out-group, those who do not belong, reinforces an awareness of one's in-group" (1989 p. 21).

From a critical perspective, professional identity could be seen as conforming to a mandated professional way of conduct which is governed at a distance. Existing within a logic of network accountability. This form of oversight is systemic in concepts of 'professional competence', conduct and regulation by the state (Fournier, 1999). In contrast Alvesson and Willmott see the rules and regulations of processual power associated with professional identity as an obstructive feature of state/organisational/institutional control (Alvesson, 2001; Alvesson and Willmott, 2002).

Given the context of this research I decided it would be relevant to explore the issue of identity resistance, with existing studies highlighting the role of individual agencies in power struggles. Carey and Foster (2011) explored the notion of resistance further, expanding it to feature more ordered, informal, and often hidden forms in day-to-day practice. Kärreman and Alvesson (2009) built upon this approach and developed the concept of 'counter-resistance'. They found that professionals, when faced with the pressures of public sector employers, do in fact resist but that this resistance is internalised by the professional. This allows for an internal discourse to develop which demonstrates their contradictory perceptions without jeopardising their position within the organisation. The result being an employer who perceives a professional conforming to the strategic demands of the organisation. That being said the nullification of this resistance can eventually yield to sudden and unexpected fissures of discontent.

There have been numerous attempts to organise existing views on the concept of identity (Abdelal et al., 2006). Building on Mead's 1934 work, identity can be seen as the exploration of the concept of a societal self (the 'me') and the personal self (the 'I') (Deschamps and Devos,

1998; Beijaard, Meijer and Verloop, 2004). Environmental factors are at the core of Mead's ideas exerting influence on the development of the self. Deschamps and Devos (1998) present a simpler definition of personal identity: "Personal identity is what makes you similar to yourself and different from others" (p. 3). Similarly, the social aspect of 'others' is present in this definition denoting the social environment as a tool to determine an idiosyncrasy of individuals. Doise (1998) elaborates further still, using a definition that incorporates personal identity embedded within a social context: "Personal identity can be considered to be a social representation, an organising principle of individual positioning in a field of symbolic relationships between individuals and groups" (p. 23).

When exploring identities in a social context Tajfel and Turner's (1986) social identity theory (SIT) resonates greatly being established on a social-psychological perspective, it is arguably considered to be the most influential theory on identity within a social context. SIT explores the psychology of intergroup relations. Tajfel and Turner regard social identity as "those aspects of an individual's self-image that derive from the social categories to which he perceives himself as belonging" (p. 16). In contrast by not belonging to a group one's social identity is reflected in one's difference which one can only feel if they belong to a specific group as opposed to groups to which one does not belong (Deschamps and Devos, 1998).

Cognitive psychologists such as Trafimow, Triandis and Goto (1991) explored whether an individual's sense of self made up of their personal and social identity is stored in a single cognitive structure or in multiple, separate cognitive structures. They found that separate cognitive structures stored an individual's personal and social identities. Reid and Deaux (1996) followed up on the conclusions of Trafimow (et al.) and their investigation correlated with Trafimow (et al.) and subscribed to the segregation model of two separate and distinct, non-overlapping self-representations of personal attributes and social identities that are represented in independent cognitive structures. The investigation also highlighted an integration model which believes that personal attributes and social identities are often inseparably interconnected and represented within the same cognitive structures. The integration model yielded stronger results. Reid and Deaux (1996) state that people belonging to social categories attribute meaning from their own personal attributes and traits therefore they can be seen as distinct yet highly interconnected constructs. Similarly, Burk and Stets (2009), discern a difference in the numerous bases for identities (e.g., the social structural responsibilities people hold or their affiliation to specific groups). This produces a person's identity, role identity and social identity. The person

identity investigates a group of meanings that illustrates the unique individuality of a person. The role identity is concerned with the internalised meanings of a role, the presumptions weaved throughout the societal fabric interlaced with the attitudes and behaviours that individuals apply to themselves (p. 114). The role identity of a social worker, e.g. could incorporate the meanings 'agent of the state' and 'advocate' which an individual applies to themselves when assuming the role of a social worker. The social identity is founded on the identification an individual has with a social group. Although the basis for these identities differ, they operate concurrently in various situations (Burk and Stets, 2009). To illustrate: a nurse belongs to a particular hospital (social identity), behaves as a nurse within that hospital (role identity) and fulfils this role in their own way (person identity). The perception being that personal and social identities are both integrated and separated at the same time. This means they are constantly able to influence each other due to their separation.

Given this approach to the concept of identity, how might identity work within an integrated health and social care environment where the social identity is argued to have been diluted? Identity can be viewed as a process that is endlessly influenced by external and internal influences, a product that is time and decision specific (Olsen, 2008). Sugrue (2005) expands on this approach arguing that a distinct fixed individual identity is not possible noting that whilst individuals attempt to maintain their customs and routines they remain subject to outside influences.

The research in education emphasises the professional teacher and the person who is a teacher and how these two interact. This interaction is closely related to the above discussion around the concept of the identity for social workers and how it is continuously influenced by personal and social factors. This arose from the understanding of the complexity of teaching (e.g., Darling-Hammond and Snyder, 2000), the role of personal practical knowledge in training to teach (e.g., Beijaard, Verloop and Vermunt, 2000) and being a teacher in a professional landscape (e.g., Clandinin and Connelly, 1996) which is applicable to that of a social worker albeit research is not as forthcoming in this area. Social work, like any other profession, wants to have a distinct professional identity.

A key part of professional identity particularly in an integrated health and social care environment is the importance of the medical and social models which I will go on to discuss below.

## 2.5. Part two: Integrated models of care

### 2.5.1. The Medical model and the Social model

The term 'medical model' appears around the anti-psychiatry movement developed by clinical psychologists such as Laing (1971). Davies (2007, p. 63) states "it has always been perceived, at least by the medical profession, as a somewhat derogatory term, as people tended to imply that the medical model was simply concerned with physical illness and physical treatments". I would argue that this perception remains prevalent when viewed from a social perspective with Rogers and Pilgrim (2001) articulating this view well around mental health where the medical model is seen as dominant. They also reflect on the predominant influence of the medical model on mental health policy development. Critically, Davies (2007) explains the medical model is a model devoid of a holistic approach, concerned with diagnostic criteria; it simply does not take social factors into consideration. Grobstein and Cyckowski (2006) further develop this issue suggesting that theoretical models need to be expanded to address the social determinants of health (WHO, 2003). Duggan (2002, p. 13) supports this view stating "that a reconnection is required between the roots of public health and the developing approaches that impact on all the determinants of health and not just those that relate to biology and lifestyle". Others reject this view stating that the medical model incorporated the historical experiences of a service user, their respective family history in addition to social and environmental influences some time ago when determining a diagnosis.

In a seminal text on integrated services Norman and Peck (1999) highlight; "this perception of the dominant 'medical model' approach to service delivery. This narrative is espoused in CMHTs where the Consultant Psychiatrist is, in the UK, held to be legally responsible for all CMHT patients, although not for the clinical practice of colleagues from other CMHT professions". Plews et al. (2000) and Snelgrove and Hughes (2000) however, argue that joint-working has resulted in line blurring with additional medically-orientated practitioners 'tracking' into traditional social territory. These sources from the literature show that the medical model of integrated services in mental health care had initially dominated the agenda following integration. This is effectively a blueprint for further integration in adult social services which should also emphasise the importance of social factors in order for parity of care to emerge.

Having discussed issues of identity and the importance of the social and medical models in such working environments I will now go on to explore the concept of integration and integrated care itself.

### 2.5.1. **Integrated care**

Structural integration is a direct result of the fractures in services (duplication, service gaps, lack of continuity) occurring within a population that is increasingly aging with increasingly complex needs coupled with the breakdown of professional roles and the blurring of agencies subject to a provider/commissioner model of welfare delivery (Minkman et al, 2009). Structural integration works in one of two ways; via cross agency working, agencies working with each other in health and social care which is primarily what existing research focuses on, and the other integrated care delivered by one organisation 'under one roof' (Coxon, 2005) as in the present research context.

Central to integration is a preventative focus that attempts to address predictable problems in individuals, pooling resources to identify and support at risk groups of people, advocating desired aims and enabling individuals to achieve their potential (Koh and Sebelius, 2010); this is as true in mental health services as it is in primary care facilities. The second focus is conversant with the Chronic Care Model (Wagner, Austin and Von Korff, 1996) which seeks to improve services by shifting the focus from episodic treatment and illness oriented medical care to prevention, care management and collaboration across providers and disciplines.

The key components of an integrated health and social care model is a mixture of practices that are interconnected and integral to social work practice. Firstly, a commitment to a person-centred approach, which is individualised and holistic allows for person-centred care, which is defined by the Institute of Medicine as "health care that should honour the individual patient, respecting the patient's choices, culture, social context, and specific needs" (Berwick, 2002, p. 83). Therefore, as a consequence of this approach care planning becomes collaborative, empowering individuals to define individual aims and to enable them to achieve these aims. Support with decision making and advocacy is crucial when enabling a person with information to make informed decisions with regards to their own health and social care needs and the risks associated with that (O'Connor, Légaré, and Stacey, 2003).

The Agency for Healthcare Research and Quality (2010, pp. 3-4) defines the six specific activities of clinically integrated care coordination as:

- (1) Determine and update care coordination needs,
- (2) Create and update a proactive plan of care
- (3) Communicate
  - a) Between health care professionals and patients and their families
  - b) Within teams of health care professionals
  - c) Across healthcare teams and settings
- (4) Facilitate transitions by sharing information among providers and patients
- (5) Connect with community resources
- (6) Align resources with population needs.

Integrated care can be seen as being effective when service users change from one form of care to another and when individuals change settings. Changes from one form of care, such as discharge from acute hospital to community based health and social care services, are susceptible points within the system that can be partly responsible for failings in the quality of care and safety of people with chronic conditions who are navigating the system (Naylor et al., 2011).

Integration has a lengthy history that has been shaped by inconsistent cultural, financial and political drivers (SCIE 2012; Barker, 2014; Kings Fund March 2015). But a variety of additional intricate ways of defining integration exists:

- Systemic, where policies, guidelines and governing structures are united
- Normative, where joint standards and principles are cultivated across professional boundaries
- Organisational, where configurations and governance are harmonised
- Administrative, where tasks e.g. finance and information technology are united into a common system.
- Clinical, where service user support is integrated into a single process where information and service provisions are synchronised

There are various integration models which I will now explore, firstly by looking at models in the United States. The United States is on a parallel trajectory with integrating its health and social care services and it can be seen that a multitude of integration models are practiced (Fisher and Elnitsky, 2012; Peek, 2011, 2013) however, two broad 'streams' of practice emerge. Firstly, as in the UK a concerted effort to integrate health and behavioural health care (Mental Health). This stream centres on the public provision of mental health care with a goal of addressing the fractures present within health systems in addition to the stigma individuals with complex health and social care needs face in a health system unprepared to meet their needs (Colton and Manderscheid, 2006; Li et al., 2008). This practice model where health services are either co-located or fully integrated into a mental health centre is reflected in the UK and one which is designed to allow for people with complex needs, co-morbid conditions to be seen by one agency (Peek, 2010; Dall, 2011). The second practice stream focuses on bringing mental health services into primary care settings (Thielke et al., 2007; Pomerantz, Corson, and Detzer, 2009), again it is a form of co-location and joint working with the secondary benefit of conceivably being able to identify milder symptomatology within individuals who ordinarily would not have engaged with secondary mental health services.

The literature highlights the tendency of researchers to give prominence to the procedural and structural elements that ensure a seamless partnership as possible between health and social care (Fisher and Elnitsky, 2012; Peek, 2013). Although they may give prominence, there appears to be no single approach as how best to implement models in practice this in turn effects workforce development and pertinent research efforts. Peek (2011) claims it is of critical importance to "consistently articulate concepts" about integrated services (Peek, 2013 p7). The reality and complexities of integration demands that social work educators prepare practitioners and researchers for work in integrated settings. Social work practice educators and lecturers must play their part in preparing practitioners for the systems they will be operating in as we move forward with ever closer integrated health and social care services.

Integrated care is associated with a plethora of professions from the medical to the social to the psychotherapies. Integrated care is delivered in a variety of provider settings including in the community within an individual's own home, hospital (acute and community), primary care

facilities (medical centres and GP practices), day centres, nursing and residential homes (Warner and Gould, 2003; Fabbriotti, 2003). Integrated care has been characterised as a corrupt or 'fuzzy' concept (Fraser and Greenhalgh, 2001; Plsek and Greenhalgh, 2001; Geyer, 2003; Hudson, 2006) which means different things to different people.

As a result, the literature around integration, integrated care and structural integration frequently employs theories, legislation and frameworks to improve its varicosity in this area that is often beset with dilemmas partnership working creates for service users, carers, professionals and the service providers (Leutz, 1999, 2005; Nies and Berman, 2004; Hébert et al., 2008; Minkman et al., 2009). Research has compared integrated and non-integrated care systems, identifying the pros and cons of commencing with such an approach to care (Fabbriotti, 2003; Billings and Leichsenring, 2005; Kodner, 2006). In addition to research into the idiosyncrasies of such an approach such as the establishment of networks, care pathways, integrated assessment processes, care settings, case/care management, (Challis et al., 1995; Atwal and Caldwell, 2002; Challis et al., 2002; Warner and Gould, 2003; Goodwin, Costa and Adonu, 2004; Croucher, 2005; Challis et al., 2006; Loader, Hardey and Keeble, 2009; Wallace and Davies, 2009).

Integration is a term used to categorise approaches to health and social care that are designed to facilitate better outcomes for service users by coordinating services across multiple levels (Thielke, Vannoy, and Unützer, 2007; Valentijn et al., 2013). Integrated health and social care usually is concerned with models of care that support multi-agency approaches through collaboration and co-location, or integration through a single joined-up agency approach (Peek, 2013). Historically, social work has worked across agencies and with numerous professions in order to provide an affective service. Working across however, is not working with or for and so typically, did not involve information sharing, joint decision making, or assessment and care management interventions. Subsequent reforms of social care and health have placed social workers in an integral position to facilitate meaningful integration between agencies and service users (Andrews et al., 2013). This creates new opportunities and challenges for the social work profession operating within an integrated health and social care system (Cooper, 2017). I would argue that the profession does not have a coherent unified strategy in relation to integration with the disbandment of the College of Social Work (Community Care, 2015) occurring at the same time of increasing integration driven by current legislation and policies.

A consequence of integrated service is the duality of the social work role. Social workers must employ, incorporate and integrate two separate styles; the social care led assessment and care



management and the health care led care programme approach (Carpenter et al., 2004; Payne, 2009; Gould 2010) when supporting individuals who are experiencing “severe and enduring mental health problems” (Carpenter et al., 2004, p.313). This is not an area limited to mental health services. The literature has shown in any area where social workers are integrated with health colleagues that social workers continue to utilise social work methods and theories within their practice (Howe, 2009) enabling them to work alongside service users and advocate anti-oppressive practice (Wilson et al., 2008; Clifford and Burke, 2009). Social workers support human rights, advocating for service users and addressing issues in relation to power, oppression and social exclusion (Coppock and Dunn, 2010; Gould, 2010). In essence, it is what they do, these core social work traits can be seen to permeate regardless of discipline or environment. Furthermore, as social workers whether they be employed by the local authority or acting on behalf of the local authority as part of a section 75 agreement, they are still by law required to undertake specific statutory duties and functions on behalf of the local authority (Brammer, 2010; Brayne and Carr, 2010).

#### **2.5.1. Comparable approaches to integrated health and social care**

A comparable approach by Fox and Butler (2004) describe levels of engagement in three stages.

- **Cooperation:** At this initial stage, the partnership is cordial but possibly more formal. There is a degree of co-operation between members. Their aims and objectives remain individual instead of part of a collective, however they see their future as connected. Some preparation and division of roles may be necessary.
- **Coordination:** The second stage emphasises a shift towards collective goals, joint enterprises. Members are now amenable to influences of the other member’s contributions. The goal is generally to achieve a common set of objectives.
- **Integration:** At the third stage, the activities undertaken are developed, implemented and ‘owned’ by the collective members. The members are committed to a collective purpose and common cause within a new unified structure.

Fox and Butler (2004) go on to extrapolate on how these partnerships may operate, albeit strategically with priorities that influence the approach of separate partners/providers within the partnership. There are often differing priorities around commissioning arrangements and the

performance indicators of services that have been commissioned. Or by way of service delivery where professionals from separate organisations work in partnership to manage and deliver services.

In this respect, this study takes place within a partnership that on paper is commissioned to provide a service that combines integrative approaches with a service delivery. Sloper (2004 p. 567) following a literature review of multi-agency working reported models of activity.

- Strategic level working: This involves 'decision making' and goes further involving shared commissioning, acquisitions and joined up planning.
- Placement schemes: Practitioners working across agencies (e.g. social workers working within primary health care).
- Case or care management approaches: A single practitioner assumes responsibility to provide a co-ordinated service to service users.

Sloper (2004) highlights care management as a desirable option given its focus on co-ordination of service delivery and yet, as Atkinson et al. (2002) points out in their study this appears to be the least common model within local authorities.

Associated with these models, Percy-Smith (2005) outlines four useful models of partnership categorised by organisational form that can equally apply to multi-agency teams.

- Separate organisation: A sovereign entity with a distinct legal status is established. This model is appropriate for bigger partnerships that require a significant life span and the ability to hire employees.
- 'Virtual' organisation: A distinct organisation is virtually established but partners remain separate legal entities. The organisation can have its own name, logo, premises and staff. However, politically and legally, one partner will have resource and staffing responsibilities.
- Co-locating staff from partner organisations: This is a semi-formal arrangement with staff members of all agencies working to a common agenda formulated by a steering group together. A pooling of resources may occur but employing organisations continue to manage their respective staff.
- Steering group without dedicated staff resources: The least formal approach to a partnership usually consists of a steering group to shape programmes and staff within partner organisations.

### 2.5.1. Arguments for and against partnership working

The Audit Commission reports on some of the advantages and disadvantages to each model. An advantage of a distinct and separate organisation is the clarity and sense of identity for the partnership. As a single entity they may achieve things collectively that as individual organisations they would be unable to achieve. By organising the partnership structure in this way, it is hoped that parity between partners would be established with no one side dominating the other. This structure allows staff to be directly employed by the single organisation rather than continuing to be employed by partner agencies. This would seem to not be the reality within integrated trusts with social workers reporting major criticism of current arrangements stemming from a medically dominated structure, with social workers also noting a distinct lack of clarity of their roles within such structures reflected in the existing literature (Abbott, Townsley and Watson, 2005; Moran et al. 2006; Lessard et al., 2006; Frost and Lloyd, 2006).

The disadvantage of the single entity model is the complexities and legal requirements such endeavours require which may deter smaller organisations from attempting such partnerships. There is also the risk of creating a monolithic entity that becomes distant from the partnership if it becomes more than the sum of its parts. The second 'virtual' organisation model, what I call partnership light, bypasses the legalities and complexities of a single organisation yet is able to maximise the benefits that having a distinct partnership identity brings. The disadvantage of this approach is the often lack of clarity about which partner has responsibility and accountability. Co-location works best when trust is present that facilitates informal arrangements to prosper. This model is applicable to partnerships that do not require a distinct identity and is usually not appropriate for major initiatives and can result in staff having unclear loyalties. Lastly, a steering group can help to improve coordination of services but are not appropriate for long term partnerships.

The Audit Commission's response to these models concluded that crucial to the success of all partnerships is the requirement that one body is the recognised decision maker by all partners, or agencies involved: "A properly constructed partnership board is essential to make sure that the partnership delivers its objectives and remains accountable to the partners" (Audit Commission, 1998, p. 19).

Warmington et al. (2004) diverge from the majority view that integrated care is the inevitable model and direction of travel of all services operating within a partnership setting. They reviewed different types of multi-agency working and derived an interpretation of interagency working as co-configuration, arriving at this determination through activity theory and object analysis

They suggest an ideal set up for effective interagency working is where professionals configure teams or close communities of practice. Increasingly however, there is a direction of movement towards loose working environments that are constantly reconfiguring (often portrayed as an obstacle to effective inter-agency working) this fluid approach could be viewed as a new form of interagency working. They go on to define co-configuration as distributed expertise this is where different professionals who may not share a professional background, values or base of work may be working with the same service user. They argue that this approach should be viewed as an alternative to compact teams or professional networks. Warmington et al. (2004) introduce the term 'knotworking' which they define as constantly changing, somewhat improvised collaborations between a loose association of professionals. This, like other models, does not appear to link outcomes with the concepts of co-configuration or knotworking.

Brown and Cullis (2006) acknowledge the difficulties of sustaining co-operation and co-ordination within teams stating that such sustainability is reliant upon a team culture being established as a result of the tacit knowledge that exists inside the team. Enabling a team to establish team capital by means of a facilitative team leader is only possible through an integrative approach to culture thus enabling professional integration. Although this doesn't guarantee service user outcomes, it does allow teams to provide better accessibility to assessment, care management and carer support services (Coxon, 2005; Abendstern et al., 2006; Brown and Cullis, 2006). Tacit knowledge needs to develop within integrated teams to overcome the deficiency of knowledge of, or assumptions made about the duties of one profession by members of another which inhibits team cohesion (see O'Brien, Hammond and McKinnon, 2003).

## **2.6. Good practice in integrated working**

The studies which are discussed below showcase that good practice is multi-faceted within integrated teams resulting from a myriad of factors, from the micro to the macro.

Below I have evaluated some of the literature around good practice within integrated teams.

### **2.6.1. Operational Policy**

As research into mental health integration shows, policies have evolved and adapted to be suited to specific integrated systems within CMHTs. Although they are comparable with integrated care in adult social services they are different. The integrated CMHT's identify with the Recovery Model whereas adult social care does not and is more focused on personalisation. Research by Larkin and Callaghan (2005) illustrates a transformation with regards to the approach of either the professionals looking at the potential of the individual and/or the service users who are seen as autonomous rather than passive recipients of services when CMHTS have adopted this approach to service delivery. It is crucial that different professionals working within an integrated environment adhere to common protocols and policies. Onyett (1994) reaffirms this position stating that the operational policy should clearly identify protocols and policies. Thomassy and McShea (2001) explain that issues in care planning are often the effect of poor cooperation between health and social care professionals, who each use different protocols and have differing priorities when undertaking assessment and intervention. This further highlights the crucial role a common operation policy plays within integrated teams.

### **2.6.1. Communication**

Communication and clear mechanisms for decision-making are crucial within integrated teams. Firstly, there are numerous issues the foremost being what constitutes a team?

Hunt (1983) would argue that in order to be considered a team, regular meetings must occur with all of the team's constituent parts that facilitates a forum whereby the creation of policies and the resolution of disputes can occur. The minimal expectations of a functioning team are one where its members engage with each other. Lowe and O'Hara's (2000) findings suggest, that regular team meetings provided the team with a distinct advantage in carrying out its work. Whereas, Molyneux (2001) reports effective communication was greatly assisted by weekly case conferences which allowed whole team approach to planning interventions. Bennett-Emslie and McIntosh (1995) completed a study that reiterated the value of team meetings in facilitating communication and fostering a deeper understanding amongst various professionals.

Team meetings were reported to facilitate greater trust and allowed the establishment of a rapport amongst different professionals (Taylor 2001; Brown, Tucker and Domokos, 2003) allowing for the development of a greater understanding about professional roles and responsibilities and allowing professional differences to be overcome (Davey et al., 2005). Formal team meetings facilitated information sharing with the establishment of a forum to discuss cases and assist to produce a shared sense of purpose, which support the operation of the team (Brown et al. 2003). In contrast, infrequent or a lack of team meetings was seen to hinder effective partnership working (Christiansen and Roberts 2005; Dickinson 2006). The role of training was also seen as important in several studies (Banerjee et al., 2007; Rothera et al., 2008).

Larkin and Callaghan (2005) researching mental health teams found that 60% of participants had acknowledged that meetings occurred within their teams. However, these participants proved that these meetings had not prejudiced their perceptions of inter-professional working.

#### **2.6.1. Clarification of roles and responsibilities**

Parity of esteem and pay between health and social care is crucial for effective service provision. In order to achieve parity of esteem one has to clearly understand their role and that of other professionals. As Larkin and Callaghan (2005) clarify, professionals have differing responsibilities and duties within the team. This means that professionals are required to understand one another's role from the outset, emphasising a lack of understanding and clarification with regards to other roles potentially leading to 'confusion, tension and possibly rivalry' inside the team. This is reiterated by Onyett (1995) in his investigation of job satisfaction within CMHT's identifying that professional accountability must be clarified in recognising the shared roles and responsibilities of professionals operating within teams. Onyett (1995) provides further clarification of roles in regard to the specialist skills and attributes different disciplines and members provide within the team.

Larkin and Callaghan (2005) reported that overall, professionals within mental health teams they had researched identified their roles as well defined. However, like Hunt, the perceptions amongst professionals varied in regard to how well their role is acknowledged, appreciated and understood within their teams. This highlights conflict between the perception of the professional who see their role as being clearly defined however, the reality being that their role is not acknowledged or understood within their team. Larkin and Callaghan (2005) extrapolate that on

an individual level professional roles remain clear and understood by the individual whereas within the wider team this understanding remains elusive and this may result in problems occurring within the team. Echoing this view Norman and Peck (1999) point out the consequences of having unclear roles within teams which can result in ambiguous lines of accountability and responsibility. Whereas Hunt (1983) explores the perceptions of team members stressing that genuine perceptual discrepancies could cause significant problems within the team. It is these perceptions that I am interested in capturing in my study. Lastly, Carpenter et al. (2003, p. 1100) highlight the “importance of enhancing role clarity and reducing role conflict in ensuring positive outcomes for community mental health staff”.

### **2.6.1. Role Definition, Role Clarity and Role Conflict**

Research regarding the integration of older people’s social services with health services is rare, as is research concerning the exact nature of the role and function of social workers within existing mental health trusts. Firstly, one has to understand the meaning of role clarity and role conflict. Carpenter et al (2003, p. 1092) define it as:

“Role clarity concerns the extent to which staff are aware of what is required of them by the organisation, including goals and tasks, and whether they feel they have the authority to carry out their responsibilities. Role conflict is a measure of competing demands on the individual worker, inadequate resources, incompatible requests, and disagreement at the level of management.”

This research concerns the perceptions of social workers, from within and from that of other professionals working alongside them.

Larkin and Callaghan (2005, p. 345) argued for this research to be pursued recognising that such research should explore the “relationship between the professional’s perception of their own roles, how they view other perceptions of it and what effects this then has on inter-professional teamwork within the team”. These finding can be seen to have practical implications with regards to the conduct of inter-professional working within teams. The suggestion being that role issues, one of identity is causing tensions and conflicts in other areas of joint-working and practice. The study saw the issue of role and identity as one that needed to be tackled through team development in order to reconcile the perceptions professionals have on their own roles with

how well they “perceive their roles to be recognised and understood” (Larkin and Callaghan, 2005, p. 345). Perception is seen as key in all these studies and an issue I am keen to further explore in the new political context that health and social care finds itself in. Poor perception of team functioning is one of Carpenter et al. (2003, p. 1081-1082) key findings alongside a high degree of role conflict which they stated was a “significant predictor of stress and of job dissatisfaction, while role clarity promoted job satisfaction” amongst social workers within CMHT’s.

### **2.6.1. Professional identities**

Although primarily existing literature has reported negatively on integrated care Abbott et al. (2005) reports a positive correlation between professional identity and integrated care as a result of professionals feeling more accountable. E.g., actions from multi-agency team meeting were followed through on.

However, parallel to this, an investigation by Abbott et al. (2005) revealed that multi-agency working between health, social care and education resulted in significant detrimental impacts on professional identities. Abbot et al. again reiterated the role confusion that seems systemic in such teams, culminating in a loss of identity rooted in ambiguity about one’s role, this confusion was amplified when the role was placed within new contexts. The study also reported that in some multi-disciplinary teams there had been a detrimental impact on professional status. E.g., social workers felt undermined and not valued by their colleagues in health.

### **2.6.1. Professional wellbeing**

Professionals working within integrated teams reported that their experience of multi-agency working was enjoyable and that they noticed it to be beneficial and appealing (e.g. Atkinson et al., 2002; Abbot et al., 2005). For those practitioners who were given the opportunity to develop new practice methods, new ways of working, there was a marked increase in job satisfaction from the creativity and freedom the experience afforded (Moran et al., 2006). Additional studies that investigated partnership working in health and social care settings found that professionals



reported an increased sense of confidence, improved professional dynamics as well as an improved relationship with service users (Abbott et al., 2005; Moran et al., 2006).

### **2.6.1. Professional development**

Professional development was said to have brought about a greater degree of knowledge and understanding of colleague's roles and responsibilities from different disciplines (e.g. Abbott et al., 2005; Anning, 2005; Atkinson et al., 2002 and Moran et al., 2006). In addition to facilitating a greater understanding of colleagues' roles, it was also reported that new learning occurred with a knowledge and understanding developed around multi-disciplinary issues and a recognition of disparities between statutory and non-statutory functions (e.g. Atkinson et al., 2002; Abbott et al., 2005; Anning, 2005; Moran et al., 2006). Professional development that adopted 'joined-up thinking', to facilitate a multi-agency approach, had in some cases shifted professional understandings and practices (Atkinson et al., 2002; Anning, 2005) resulting in tacit knowledge within the team, enhancing team cohesion.

### **2.6.1. Culture**

Another aspect that was highlighted in the literature review I explored concerned that of the culture of social work within an integrated Trust. This is primarily professional culture, but elements overlap with organisational culture particularly in the context of this study. Studies by Peck and Norman (1999) have stressed the importance of a professional culture within mental health social work with Miller (2016) arguing that clashes of culture become the most divisive within integrated health and social care settings. The social workers who participated in the investigation reiterated the significance of social work values and professional culture; with social workers seeing these as being integral to their professional identity. The study again found a fear of social workers of being subsumed into the dominant health culture. All these literature sources although predominantly focused on mental health social work are relevant and informative to this study confirming that social workers experience role confusion and tensions with the clarity of their role, based around their own perceptions that others do not understand their role properly.

### 2.6.1. **Social Cultural/professional issues**

The mantra of integrated working is a partnership designed to bring together professionals with different philosophies and ideologies. Such differences are not always conducive to successful joint working (Peck, Towell and Gulliver, 2001; Christiansen and Roberts 2005; Davey et al. 2005). In a study on the contribution of social workers to a multi-disciplinary team Scragg (2006) reported social worker's contributions were unappreciated with the prevailing perception being health colleagues did not respect social work values. Carpenter et al. (2003) explored social worker's role within multi-professional teams and identified that social workers encountered more role conflict and higher stress in relation to that of their colleagues. Carpenter suggests this conflict is a result of the perception of social workers fearing that their cultural identity was being subsumed by the dominant health-led working environment. Burch and Borland (2001) note professional differences affect elements of practice e.g. in relation to risk which resulted in differing practice related to the discharge of patients.

The literature also highlights stark differences as noted by Gibb et al. (2002) in decision making with the type of decisions and level of decision varying greatly between social workers and health colleagues, which could impinge on the effectiveness of partnership working.

### 2.6.1. **Contextual issues**

The history of integration is a varied one, with connections between partner agencies seen as vital to the establishment of successful partnership initiatives (Peck et al. 2001). When these partnerships are complex as in the case of intermediate care teams then this can undermine the effectiveness of services, (Glasby, Martin and Regen, 2008). It is debated that continual reform of health and social care has resulted in increasingly complex new developments or focused attention away from operational issues (Taylor 2001; Gulliver, Peck and Towell, 2002; Glasby et al. 2008). In comparison, the development of mental health integration through legislation and the formation of integrated health and social care mental health trusts was found to enhance joint working (Challis et al. 2006). Lastly a study by Hultberg et al. (2005) stated that a consequence of pooling budgets was the resulting transparency, it made transparent the process of resource allocation through which organisations could explore creative solutions.

### 2.6.1. Role demarcation

The evidence within the literature suggests that clarity over the role of each agency or role demarcation, assists multi-agency working (e.g. Carpenter, Griffin and Brown, 2005; Atkinson, Jones, and Lamont, 2007). E.g., the establishment of boundaries within a clearly defined role and an acknowledgment of difference between professionals has resulted in stronger working relationships (Darlington, Feeney and Rixon, 2004a). Those agencies where status/hierarchical structures were acknowledged and all practitioners had a clear understanding of each other's responsibilities, partnership working was reportedly easier to attain (e.g. Frost and Lloyd, 2006). However, this was far from the norm with the literature frequently reporting that struggles over status, identity and role clarity at all levels threatening multi-agency relationships. E.g., if I look at children's services, Healey (2004) reported that partnership board members had unequal status between statutory and voluntary agencies which created tensions. Robinson and Cottrell (2005) also highlight the issue around professional status, finding that re-designating and shuffling specialist skills within partnerships had elicited a myriad of responses about core values, beliefs and sense of professional identity. Additional literature highlighted that power struggles occur, that low morale is rampant as a result of professional boundaries being blurred or simply role confusion, and that professional status, prestige, structures and identity all present a challenge to effective partnership working (Moran et al. 2006; Lessard et al, 2006; Frost and Lloyd, 2006). Johnson et al. (2003) reported these concerns as 'turf issues' whilst Kennedy, Lynch and Goodlad (2001) highlighted that the limitations and duties of partner agencies, were in part due to different remits that ultimately inhibited multi-agency work.

### 2.6.1. Respect and trust

In a review of 29 sources of literature, 10 sources reported that the crucial factors to partnership working were those of mutual respect, trust and confidence (e.g. Okell 2001; Carpenter et al., 2005; Allnock et al., 2006). Darlington, Feeney and Rixon (2004b) for example, found that a desire for professionals to work across agency settings enabled interagency cooperation between children's and mental health services. Similarly, Percy-Smith (2006) reported in his summation of research findings from a number of sectors, that establishing trust and building mutual respect

were prerequisites to any successful development of partnerships. A lack of trust was also reported in the literature in particular between professionals and organisations that obstructed the establishment of partnerships (e.g. Kennedy et al., 2001; Sloper 2004; Miller, 2015). A key area to emerge in this study is the importance of trust and mutual respect. These elements are the linchpin of successful integrated working. This is nothing new, with the introduction of Single Assessment Process (SAP) requiring professionals to be confident in the assessment of others (Dickinson 2006).

Professionals also indicated a preference for support from colleagues from the same profession with Scragg (2006) noting team managers of a different professional background were often mistrusted. Across the literature specific to joint-working issues of power, trust and control are highlighted. In one such study Glasby et al. (2008) reported that the perception amongst health based hospital professionals was that they were hesitant to refer older people to intermediate care; this was believed to be around the issue of losing control of their patients.

As discussed above there are several cultural, contextual and professional differences that manifest in all sorts of ways in an integrated environment. I will now go on to discuss some of the issues and difficulties that can arise from these cultural clashes.

### **2.6.1. Leadership and Management Issues**

The virtues of integrated care are espoused at every level of government and whilst there are some positive outcomes there are also a plethora of remarks which espouse the inherent hazards related with partnership working and which might erode the identity of social work, undermining its sense of purpose and thus further adding to the 'crisis' it faces. E.g., Van Zwanenberg (2003) explored the views of managers in Scotland and extrapolated their primary leadership and management concerns related to partnership and multidisciplinary working where social workers work alongside other professionals. The concerns consisted of:

- the ability to retain and thus provide social work leadership within multidisciplinary teams and across 'separate governance arrangements'
- the establishment and maintenance of a distinct social work profile within a multidisciplinary team setting

- retaining and promoting social work values
- quality assurance in relation to professional service provision
- maintaining and promoting the profession to ensure parity of esteem alongside health and education by ensuring a clear focus on the social work agenda. Resistance to the erosion of professional role.
- managing resources subject to competing professional needs of differential discipline requirements
- creating and maintaining a culture of care management that reflects the core values of social work and focuses on the requirements of the service users and carers.

Zwanenberg, (2003) highlighted challenges faced by future social work management with a focus on and concern at the advancement to a unitary structure for social work and health. In addition to concerns based on the perceived impact such approaches would have on existing structures of social work provision and the future of the profession, with particular concern around the prospect of current social work structures within local authorities being subsumed into integrated services.

Nathan and Webber (2010, p. 21) highlight managerialism within the NHS and the psychosocial (psychological and social aspects) dimension in general as root causes of role conflict, with social workers experiencing increasing marginalisation of their perspective within CMHTs (Blinkhorn, 2004, Huxley et al., 2005). This feeling of not being valued or understood is reflected in research by Reid et al. (1999) which shows a major concern with role conflict and role ambiguity by social workers compared with other mental health professionals. They go on to report that social workers feel “an intense conflict between a duty and a wish to act as patients advocates and represent their interests, and a responsibility to ensure that patients, and, in particular, others are safe” Reid et al. (1999, p. 305). There were also reports of (1999, p. 306) consternation around the perceived absence of understanding of a social worker’s role by other professionals.

From the social work leadership perspective, back in 2003 there were clear dangers identified facing the distinctiveness of the social work role in the near future. Zwanenberg (2003) sees integrated care as a threat to the identity of social workers. Conversely it could be argued that greater integration may lead to a consolidation amongst social workers and resurgence of social work identity. A key finding in Zwanenberg’s report is the importance of a clear social work

identity in recruitment and retention, this is reiterated by Evans et al. (2006) who reported high levels of stress and emotional exhaustion and low levels of job satisfaction amongst mental health social workers. The paradigm from which social workers operate is constantly shifting, it has evolved to include a service user led economy of commissioned social care services, and increased collaboration and partnership working.

## **2.7. Difficulties in integrated working**

Professional and organisational culture are often intertwined. If we look at organisational culture, for social workers, the drive to deliver integrated health and social care services has resulted in the social workers becoming a minority profession within a larger integrated organisation. Integrated organisations require social workers to work together with other professionals who are predominantly from a health background, this has occurred within mental health teams and within older people's services. In CMHTS social workers are expected to be care coordinators providing the same service as a health colleague but with a theoretical base in the social model of mental distress. The question becomes one of balance between the social worker's disciplinary contribution and the expectation of the service which is health led. Research by Svennevig (2007, p. 9) revealed a strong desire by nearly all the social workers who participated in Svennevig 'study on the value of remaining in multi-disciplinary teams; however, many felt that their professional identity vanished within these teams. This dichotomy appears to be prevalent within existing research with no easy way forward but a series of compromises (Forbes 2009, 2011).

### **2.7.1. Professional Rivalry**

Research by Goodwin (1997, p139) suggests that rather than fostering greater co-operation, integrated care led to increasing conflict and rivalry between professionals and different agencies i.e. providers and commissioners of services. Goodwin elaborates further stressing that conflict is a direct result of the differing and competing priorities and concerns of distinctive professionals within the teams.

These issues are longstanding as highlighted by Goodwin (1997, p 140), citing Freeman, Fryers and Henderson (1985) “conflicts between different professional groups no doubt still represent major constraints to the development of community-based mental health care”. More recently research has shown that whilst there is still a rivalry within CMHTs it is not as prominent as it was in the past (Bainbridge and Purkis, 2011; McNeil, Mitchell, and Parker, 2013).

### **2.7.1. Gaps in skills and knowledge**

Nathan and Webber (2010, p. 21) point out that integrated care appears to be benefiting social worker colleague’s noting that other professionals within mental health teams have incorporated a large part of the social work role in their day to day work. They would argue in this context integrated care is seen as detrimental to mental health team social workers who often feel they have been assimilated into the psychiatric hegemony. This merely replicates their mental health colleagues practice and reinforces the medical model articulating their work in terms of diagnosis and treatment and thus usually resulting in them being less able to challenge the institutional structures within which they operate. This literature exposes the presence of gaps in skills and knowledge among social workers within such multidisciplinary settings, when operating from within these integrated health and social care teams.

The issue of identity and roles has been ongoing over the past twenty years. The debate centres around generic roles vs. professionally distinct roles (The Social Care Institute for Excellence [SCIE], 2008). In social work with adults, following recent developments in legislation and policy relating to social work reforms around personalisation and integrated health and social care has resulted in the professional status of social work taking more prominence and credibility.

Legislation such as the Mental Capacity Act 2005 and the Care Act 2014 has social workers as key decision makers and prominent professionals. It is in this context that my study is taking place within an integrated health and social care environment that is at the forefront of these reforms. It is exploring the perceptions of professionals, how social workers have or have not preserved their identity within an integrated setting, combined with other factors arising from austerity, culture etc. The study recognises the challenges faced by practitioners and so is concerned with asking them, the experts in their experience, about the impact of social work on integrated health and social care, in what should be one of social works most prominent and relevant periods in its history.

Similarity this view is echoed by an Association of Directors of Adult Social Services (ADASS) guide, which asks 'Are integrated teams more like a soup or salad?' It goes on to state: that existing policies (e.g. National Service Framework for mental health, New Ways of Working and the CPA guidance) have adopted a 'soup' approach which stresses the generic aspect of integrated care and the streamlining ways of working. This is in contrast to the salad approach which is seeing some traction with recent developments, this approach stresses professional's unique individual skill sets rather than the generic 'soup' approach. The main driver is cost reduction, performance indicators, although an opportunity for social workers to flourish, the underlying financial motivations and the drive towards non-traditionally qualified staff should not be ignored (ADASS, 2014).

Despite the difficulties in integrated working legislation and policy continues to encourage deeper integration between health and social care. I will now go on to discuss the potential options moving forward with such approaches.

#### **2.7.1. Disintegration?**

Comparative research comes from the field of mental health social work which was the pioneer of integration regarding combining social services and health functions. This resulted in social workers and social care staff being transferred to direct employment by health trusts and as a result taking their lead from health rather than social care. The British Association of Social Work (BASW) reported that this approach was shown in some areas to be very effective, with positive outcomes for service users and the social care perspective being well integrated into the culture and model of the health Trust (BASW 2010). Although, a survey by BASW discovered that recently a reappraisal of the effectiveness of these arrangements has resulted in some local authorities withdrawing from 'pooled' arrangements (BASW, 2013). In fact, whilst adult social care is moving forward with integration, around 40% of the local authority pioneers according to the BASW survey have withdrawn, or are considering removing mental health social workers from NHS management. The evidence from this survey reflects the literature review as a whole which found that whilst some found that social workers experienced an increased satisfaction, noting social worker gratification that their opinions and perspectives were acknowledged and acted upon. There were also significant and highly emotive evidence, whereby significant concerns were



raised that the role of social work and social worker's opinions remained side-lined (McNicoll, 2014).

Allen (2013) found that the current drivers for disintegration were primarily financial pressures. The article sought expert opinions, and stressed that: "Pulling mental health social workers out of the NHS risks losing professional knowledge and denting social support for service users". In the article Allen (2013) stated that, "Three reasons lie behind moves by councils to pull social workers from trusts ... In some areas relationships between NHS trusts and councils have broken down. In others, the NHS is failing to deliver what councils need it to under the social care transformation agenda. The other crucial area is finances." Allen went on to say that, "Local authorities have been affected by huge changes in their funding base. They have had to look really hard at where they put their money and that has had some impact on integration." (Community Care, 2013)

It appears that along with other reasons, including personalisation and statutory functions, that the key driver for withdrawing from integrated working arrangements is funding, notwithstanding the positive benefits to service users. Paradoxically those benefits primarily offer a total financial savings to the public purse, e.g. the 'Home Truths' investigation of the relationships between GPs and social care project, projects that £1.6 billion of saving can be achieved each year through greater cooperation (Mangan, Miller and Cooper, 2014). This opinion was reiterated by the conclusions of ADASS and NHS Confederation survey of local authority and NHS commissioners, whereby leaders reported that integrated care can provide financial savings and enhance service users experience and quality of life (ADASS, 2014). This is also seen away from the literature with a Panorama documentary about the Healthy Liverpool Scheme, which brings commissioners, providers and the local authority together to establish parity in the health and social care economy with a clearer emphasis on prevention, enablement and empowerment in community settings and integrated delivery across providers, with active service user/carer/patient involvement in their care. Looking at this from a financial viewpoint, integrated care is seen as the lifesaver of the welfare state with Liverpool adult social services, stating that "the separation between social services and the NHS needs to disappear. We need to be seeing one care system. Unless we work very differently we will not be able to care for people in the future in the way we do now" (British Broadcasting Corporation, Panorama, 2015).

Therefore, I would argue that current developments are offering satisfactory confirmation that further integration; integrated health and social care teams in the community and co-location of services are the probable future of health and social care (NHS England 2014; Kings Fund June

2015), with opportunities for social work to use and influence health colleagues with its unique professional values, skills and knowledge.

Though the complications of working within a predominantly bio–medical model have been well demonstrated and recognised and referenced in the literature. Tew et al. (2012) and Webber (2015) do note that if mental health social workers are to make the vaunted impact they aspire to, it is arguably crucial to remain inside rather than outside of mental health services. The Social Care Strategic Network report ‘The Positive Future of Social Work in Mental Health’ highlights: “Social work, as well as holding distinct skill and knowledge, is more than the sum of its parts. Social work within an integrated mental health organisation provides a distinctive constellation of priorities and values based practices that can profoundly improve an organisation’s culture – promoting human rights, empowerment and the citizen voice” (Social Care Strategic Network, 2013 p. 10.). It also can produce a meaningful countercultural view to established clinical models of illness and disorder and when this is implemented and established in practice can result in a profound effect on NHS practice and culture (BASW, 2010).

For social workers to affect this constructive influence however, the profession is required to have role clarity, rooted in a strong cultural identity whilst avoiding genericism and a dilution of its purpose or a silencing/sideling of its voice. It needs to keep to its core undertaking to aspire to the ‘empowerment and liberation of people to enhance wellbeing’ (IFSW, 2000), the principles of justice and human rights being crucial to this objective. The literature has offered some helpful viewpoints on social workers’ roles and sense of identity but mental health social workers cannot be merely defined and reduced to a cycle of tasks they undertake (Macrae et al., 2004). Macrae et al. (2010) view mental health social work as defined by the values to which it aspires and from which base it works, not as workers to ‘manage’ or ‘process’ service users through a system. This will at times require challenging the organisations in which it functions and according to Nathan and Webber (2010, p. 23) it means: “Putting service users at the centre of the profession’s practice and giving them a voice in relation to the dominating institutions in which they live”.

## 2.8. Moving forward

The College of Social Work issued its position statement on 'The Role of the Social Worker in Adult Mental Health Services' in April 2014, with the endorsement of the Chief Social Worker for Adults and the then Care Services Minister. The 2014 College paper contributed to the reform agenda within mental health services for adults, advocating for social work's distinctive offer and approaches (Allen, 2014). They adopted an agenda that included five role categories:

- Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority
- Promoting recovery and social inclusion with individuals and families
- Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity
- Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship
- Leading the Approved Mental Health Professional Workforce.

Allen et al. (2016 p. 7)

The paper made a number of relevant proposals including recognises that skills deficit results from role flexibility and multi-agency services. It went on to state that professionals in distinct disciplines need clarity in order to use their unique skills and confidence and to keep improving their competences to develop an improved and more effective worker during their professional life. The five role categories present social workers, their supervisors and managers with an outline through which to evaluate whether social work competences are being encouraged and established in a specific environment.

The Department of Health has commissioned further resources to facilitate the application of the framework for mental health social work in practice, and to ensure new policy and legislation notably the Care Act 2014 and emerging new directions in mental health policy. Three resources have been developed:

- *Social work for better mental health - The Strategic Statement (2016)*
- *How are we doing?* (2016) - An organisational and workforce self-assessment resource for implementation of the College role categories
- *Making the difference (2016)* - A framework for direct service user and carer feedback and collaboration to promote high quality social work in mental health

*Social Work for Better Mental Health* - the Strategic Statement has very useful core messages which explicitly define the roles of social workers and their contribution to better mental health outcomes, which includes:

- The use of developed relationship based techniques creating a sense of warmth, empathy and authenticity that empowers individuals to achieve. This approach is particularly appreciated by individuals who use services and their families
- Key skills and knowledge around issues affecting individuals with enduring mental ill health such as the ability to address stigma, discrimination and social exclusion.
- Social workers should be seen as leaders within partnerships given their legal and statutory knowledge of enablement, care, support and safeguarding systems.
- Working holistically, with the individual and their social network, helping to enhance and create sustainable family and social capital.

*How Are We Doing?* - is an organisational self-assessment resource. It is aimed at Principal Social Workers, operational and team managers (of multidisciplinary and social care specific services), workforce leads and managers in integrated and social care provision along with commissioning organisations. The resource is intended to be used with the direct involvement of social workers in practice.

*Making the Difference* seeks to find out what people using services think and experience of social work. It is primarily directed at social workers in practice, their professional supervisors, workforce and professional leaders, as well as experts by experience, carers and families and user/carer led groups. The resource is intended to help gather direct feedback from service users and carers to improve social work practice, and to provide a potential framework for the coproduction of social work quality improvement. This is not a common approach to quality

improvement in social work. Feedback and co-created understanding of processes and outcomes are important for professional learning and credibility in any health or care profession.

These three new resources were launched on 28 January 2016 by Lyn Romeo, the Chief Social Worker for Adults. The materials are available and accessible on the Department of Health website (Department of Health, 2016). Again, this highlights the importance the social work sector is placing on integrated working.

The above chapter's goal was to review the literature that exists around integrated social care and health services and explore the issues of identity and professional status of social workers operating in such integrated environments.

## **2.9. Part three: Relevant Research in Integrated adult's social services and community mental health services**

The aim of this section is to review the existing literature from a variety of sources in respect of integration for older adults before moving on to exploring comparable research within community mental health teams. Its objectives are to demonstrate:

- A comprehension of the current knowledge,
- How the knowledge interconnects and;
- Any current gaps in knowledge which has informed the authors reasoning as to study integrated health and social care providing adult social services

The concept of integrated care within the provisions of statutory adult social work is relatively new and is only possible given recent legislative and policy changes. Therefore, literature in this specific field is somewhat limited however the concept of structural integration has been demonstrated in day services for the past two decades (Smith and Cantley, 1985). This is where systems are organised between sectors to deliver social care that supports people's wellbeing, delivering a financially frugal approach whilst maintain acceptable standards of care provision (Trice, 2006). Leene and Schuyt (2008, p. 4) view integrated care as a social intervention "systematically planned and phased attempts to influence individual groups, organisations and

larger social units, with the aim of contributing towards preventing, easing and solving social problems”.

A cornerstone of integrated care is that it is seen as the silver bullet addressing the increasing numbers of individuals with complex health and social care needs whom the numerous provision of health and social care services are required. Requiring multiple professionals to provide assessment and care management, decision making in accordance with the evidence based care or cure that is appropriate (Tout, 1993; Bigby, 2004; Loader et al, 2009). The alternative is repetition, unaccountability due to a lack of responsibility, substandard communication and a subversion or impact on a similar treatment or care regime (Lloyd and Wait, 2005). The complexities of integrated health and social care demand an understanding of the theoretical, political and practical contexts such phenomenon operate from within.

### **2.9.1. Care trusts**

Further literature by Miller et al. 2011 explores previous attempts of structural integration in England with the Health Act 1999 providing frameworks to enable joint commissioning, delivery and resourcing (Greig and Poxton, 2001) with the National Health Service (NHS) Plan (Secretary of State for Health, 2000) in place to potentially create care trusts and facilitate integration.

This approach was presented as a “pragmatic way forward” in integrating social care and health (Department of Health (DH), 2002). Care trusts had the ability to commission and provide services across health and social care. However, the requirement was that such a Trust would be an NHS body with the implication being that central government did not trust local authorities in commissioning health services (Hudson, 2002). To address the democratic deficit in these arrangements, the emphasise was placed on the contractual relationship between local authorities and care trusts, and a requirement that councillors be a part of the board. This arrangement has continued to the present day with the integrated Trust being held accountable by its section 75 contractual agreement.

Care trusts were voluntary local arrangements that the DH (2002, p. 1) envisioned would improve service delivery and staff engagement. Concerns regarding such large-scale changes were raised, these also included: an absence of evidence that the model would work; the significant logistic difficulties in merging different IT, financial and human resource systems; the different

governance systems relating to health and social care; and the loss of innovation and opportunity through focusing on such a large-scale structural change (Hudson, 2002; Greig and Poxton, 2001).

Initially 17 pilots of care trusts were proposed. In 2002, five had launched with an additional three following in 2003 (Hudson, 2002). Three more care trusts followed between 2005-2007 with the final care trust launching in 2010.

Care trusts failed to provide a catalyst for widespread structural change across social care and health organisations with some of the initial concerns discussed above being experienced in practice (Hudson, 2002). Although Miller has noted that some improvements to integrated working and/or commissioning appears to have been made which could offer insights into future endeavours when integrating social care and health services. The care trusts ceased to exist in their current form with the introduction of the Health and Social Care Act 2012.

### **2.9.2. Relevant Research in Integrated Community Mental Health Teams**

There has been relevant research that has investigated partnership working within integrated community mental health teams (CMHT's) that are comprised of different disciplines. These studies were primarily qualitative in nature conducted from a healthcare perspective seeking the lived experiences, viewpoints and opinions of numerous professionals; investigating the impact of partnership working on identity and roles in addition to exploring professional cooperation and probable conflicts such partnerships bring (Norman and Peck, 1999; Peck and Norman, 1999; Brown et al., 2000; Gibb et al., 2002; Carpenter et al., 2003; Rees, Huby, McDade and McKechnie, 2004; Hannigan and Allen, 2011; Bailey and Liyanage, 2012). Whilst two reports employed a social work perspective (Carpenter et al., 2003; Bailey and Liyanage, 2012) from within an integrated mental health team. These studies took part in multi-disciplinary teams that were at various stages of integration (see discussion in 2.5.3.) as opposed to my study that takes part in an integrated care team within a separate sovereign organisation with a distinct legal status.

### **2.9.3. Social Work Identity in Mental Health Teams**

Professional boundaries and identities are identified within a number of different studies (Peck and Norman, 1999; Carpenter et al, 2003; Atkinson et al, 2007) with supervision being viewed as

an important mechanism by social workers which promotes their specialist role within teams. This research attempted to explore this aspect of integration further.

Government policy has centred on mental health services for years with reports such as 'Mental Health: New Ways of Working for Everyone' (2007) in which four key areas for development emerged regarding the role of social workers in mental health teams, one of which was social work identity. Again, during the consultation process for the New Ways of Working for Social Workers it was highlighted that social workers may belong to a mental health team but often they feel that their contribution is not valued.

BASW (2010) also produced a report with recommendations regarding multi-disciplinary mental health teams. Highlighting concerns with regards to the structures and support which are crucial to mental health social workers in order to ensure effective service delivery to adults with mental health problems. A key finding of this report was access to a social worker whom provided professional supervision, and supporting the role and identity of social workers in multi-disciplinary teams.

A review by Bogg, (2008) of existing studies in relation to integrated mental health teams identified some common factors and obstacles to integrated care. Arguing that professionals within these teams were dealing with matters around: 'role ambiguity and conflict'; 'communication difficulties'; 'development of a shared philosophy'; and 'lack of faith in management understanding and effectiveness' (Bogg, 2008, p. 37). These areas were seen as restricting integration. BASW (2010) investigated the role of social workers within integrated community mental health teams finding that integration varied widely across the UK but noted that those who adopted support for all professional groups in particular around their identity and professional role were viewed as having greater success. The report reaffirmed a view that social work identity should remain distinct and be maintained and that the approaches social workers utilise being holistically focused and imbedded in the social perspective were valued in those multi-disciplinary teams. It went on to recognise the advantages of multidisciplinary partnerships for service users (BASW, 2010).

Carpenter et al. (2003) in a study conducted over four districts in the north of England investigated the structure of multidisciplinary teams operating within CMHT's. Carpenter et al. (2003) looked at the extent of integration and the subsequent collaborations that had occurred between health and social care and then investigated the impact on professionals of service



integration within these teams. The teams were variable with differing levels of, integration such as co-location where social workers performed only social work tasks, whereas at the same time in other more integrated teams they carried out both care coordination tasks in addition to their statutory social work functions. The research utilised quantitative research approach with some qualitative elements via questionnaires with participants free to note a few comments on pertinent issues around: professional identity, roles and team integration that would allow a greater exploration of these issues (Carpenter et al., 2003). It has been suggested that greater integration resulted in increased cooperation between health and social care, this was reflected in improved performance indicators preferring the further integrated services. Nevertheless, for social workers the point remains that professional identity and 'role clarity' remain areas of concern with social workers reporting increased concerns around 'role conflict' and notably experiencing more stress and less 'job satisfaction' than their health counterparts (Carpenter et al., 2003, p. 1082).

The negative aspect of integration for social workers; stress and job satisfaction was reproduced in numerous other investigations (Evans et al., 2005; Huxley et al., 2005; Evans et al., 2006). It appears to be a widespread phenomenon within these types of setups. A further study by Carpenter et al. (2004) adopted a quantitative approach with the use of questionnaires in order to explore the perspectives of service users who use services provided to them by the CMHT. Each CMHT's were at various stages of integration and the study was repeated after 6 months. Broadly speaking the finding presented a preference towards service integration from participating service users (Carpenter et al., 2004).

Bailey and Liyanage (2012) adopt an ethnographic approach in their study on the role of social work within integrated CMHTs. They used a combination of participant observations and semi-structured interviews so that they were able to determine the perspectives and opinions of all professional disciplines working in four separate mental health teams. They suggest that participants, predominantly community psychiatric nurses and social workers, appreciated the integrated CMHT model of health and social care. They also found participants viewed social workers and social perspectives as beneficial and complementary to the medical model, whilst it was acknowledged by all participants that health care overshadowed the integrated services and reports from social workers who participated reflected their feelings of being isolated from the local authority that they are working on behalf of (Bailey and Liyanage, 2012).

The literature review centred around integration within the field of mental health which has been ongoing for many years. It appears that during that time social workers within multi-disciplinary teams have undertaken a specialist role before changing to a generic role and then it appears moving back to a specialist function within the multi-disciplinary team. The social workers had moved from specialist to generic and then back to specialist, affected by transformations within the profession. The changing ethos is a result of continuous developments in England around social, legal and policy. These developments led to multi-disciplinary teams within mental health permitting social work professionals to work together with other mental health professionals from health services. Policy directives such as the *New Ways of Working* and Recovery Model allowed more opportunity for social aspects to be integrated into treatment plans. Despite these advances to parity of esteem, the literature exposes a continuing medical supremacy in many CMHTs, producing numerous difficulties for social work professionals. The expansion of integration from mental health social work to older people's services appears to be taking a similar trajectory with issues around the sustainability of the social perspective together with medical models of treatment and care delivery; these concerns have informed the research questions. The conceptual and theoretical framework used in this study assists in exploring and understanding perceptions of individuals in a more vigorous and methodical way.

#### **2.9.4. Lessons from the literature**

The literature review identified gaps in knowledge particularly around the area of integrated adult social work and health care. The studies that had been conducted in multi-disciplinary mental health teams informed my thinking with two standing out as particularly comparable and relevant from a social work perspective. Carpenter et al (2003) primarily utilised quantitative methods with little scope for participants to elaborate on their thoughts and feelings whereas Bailey and Liyanage (2012) utilised participant observation and semi-structured interviews. Given the size of the integrated Trust it was practical and logical for me to combine these approaches. My approach being to utilise a qualitative open-ended survey and semi-structured interview in order to increase the richness of data obtained from the participants. The literature review also identified austerity as a key area of future research and one which this study was affected by given its situation in a public health and social care organisation and so it became logical to incorporate austerity into my research aims.

Social workers have been moving towards integrated care for many years with partnership working seen to produce better outcomes for service users, resulting in performance improvements and cost savings. It is not just those social workers who are employed by the local authority who play a significant role with partnership working but also for example those based in GP surgeries (Firth et al., 2004). It is noteworthy that almost identical discussions are found in nursing; with boundaries and identity at the forefront of the discussions to modernise the NHS (Melia, 2004).

The logical conclusion however is that as social care work was detached from the umbrella of the local authority so too will social work. Although presenting as challenging it can also be seen as providing an opportunity for social work to forge new and creative ways of working. Social work is not a product of an organisation but greater than that. After all what is constructed, can also be reconstructed (Statham, 2001, p. 24).

The lessons learnt from inquiries e.g. Francis (2013) into tragic events at Mid-Staffordshire Hospital have identified a number of common themes; poor communication amongst partners, no communication with relatives and non-existent care coordination. This alongside reportedly improved outcomes for service users and encouraging experiences of all-in-one and integrated care, have led many local authorities and NHS organisations to adopt numerous models of integration in social care and health delivery, usually by way of a section 75 agreements (DoH Transforming Care, 2012; Institute of Public Care 2013).

This march towards integrated services began in 1999 with section 31 of the 1999 Health Act that have enabled health and social care to integrate and subsequently section 75 of the 2006 Health Act. These statutory powers backed by successive governments and policies have actively encouraged the creation of a single organisation to deliver services in a coordinated and combined manner (Chatziroufas 2012; Bamford 2015). Despite the legislative push for integration between health and social care, it should be pointed out that better coordination, co-location can also be beneficial for service users (Beresford, 2002). The National Collaboration for Integrated Care and Support reports that better coordination “has a palpable merit: It can deliver many, if not most, of the benefits to users of an integrated system (and) it can be a positive, facilitating step towards an integrated system” (National Collaboration for Integrated Care and Support, 2013). The Integrated Care Network also report that top-down integration is not desirable or indeed as effective as one that has had input from service users and is clear and understood by all

involved. They state that this system is more effective when it targets a distinct set of people with complex needs.

## **2.10. Reflections upon findings**

The review of the literature in this chapter revealed that the exploration of social workers contribution to an integrated health and social care Trust within an adult social services context and not a mental health setting simply did not exist. Some literature did explore certain aspects of adult social care such as intermediate care teams primarily concerned with discharges from acute hospital settings. The primary literature centres on integration within mental health settings. Whilst they contribute toward enhancing our understanding on how multi-disciplinary teams operate and how the different professions within interact, there have been significant change in health and social care in the intervening years and, therefore, caution is needed when making comparisons about the applicability of findings to my research area of integrated adult social care. Whilst their conclusions are strengthened by numerous studies and more recent work, including Carpenter et al. (2003) and that conducted by Bailey and Liyanage (2012), and also benefit from the drive for integrated mental health services that have been in place since 1999. The reviewed literature merely accentuates a paucity of research exploring the integration of adult social services with that of community health based services in practice. More research is needed with primary data collection, either quantitative or qualitative studies, to create a body of evidence to explore further this model of integrated health and social care in England.

Other literature examined related to identity and the role of social workers. Whilst these published works are a valuable source of insight to increase understanding in the subject area, I wanted to understand how perceptions about and from within the profession will aid my understanding of social work and inform my interpretation of the data when analysing the perceived contribution of social workers within an integrated health and social care setting.

## 2.11. Chapter summary

Integrated care can be seen to take different forms and models. Primary care has its own viewpoint as the Royal College of General Practitioners'(2012, p. 7) highlight that “different approaches will be appropriate depending for example on patient needs, geographical factors and organisational characteristics”. They state that integrated care should be “patient centred, primary care led shared working, with multi professional teams, where each profession retains their autonomy but works across professional boundaries, ideally with a shared electronic GP record”.

From a mental health perspective, the Mental Health Foundation (2013) also emphasises that there is no one right model. An understanding of the fundamental uniformity and interconnectedness of physical and mental health is vital to governments and commissioners of services in order for them to achieve a truly integrated health and social care service. A comprehensive response requires joined up thinking, not thinking in silos that often result in an unfinished intervention to people’s needs. Support should not be dependent on diagnosis of mental illness but instead ought to focus on important social and structural influences such as education, unemployment, housing, poverty and discrimination (The Mental Health Foundation's Inquiry into integrated health care for people with mental health problems, 2013). These findings lead to the creation of nine factors which were seen to impact on the provision of useful integrated care for individuals with mental health needs: information sharing systems; shared protocols; joint funding and commissioning; co located services; multidisciplinary teams; liaison services; navigators; research; reduction of stigma.

To summarise there are numerous permutations when adopting an integrated care approach for people accessing joined up health and social care services. Crucial to effective partnership working is the sharing of information with efficient systems in place to facilitate that information (ideally integrated information and communication technology systems and a single universal patient/service user care record), the power to pool resources from separate streams of funding into one integrated care budget, and common protocols and partnership agreements. The experience of integration does not appear consistent across England or indeed across the different specialisms of social work. Throughout the last decade new statutory duties of local authorities have developed along with varying policy. The Mental Capacity Act 2005, and

subsequently the Deprivation of Liberty Safeguards placed new duties on local authorities alongside new policies concerning adult safeguarding and the drive to personalisation, prevention and recovery later enshrined into duties within the 2014 Care Act. All these are alongside a backdrop of substantial cuts to local authority finances. My research was framed by the position of the College of Social Work (Allen, 2014) that views social workers as having an important role in advocating recovery, supporting self-directed change and balancing rights against protection. Research evidence identifying how these roles manifest in practice within an integrated setting, particularly in connection to specialist knowledge; and issues of cross professional communication, both internal and external to teams is limited (SCIE, 2012). This research being designed to fill the gap within the context of policy and legislative change and is informed by existing research on the integrated social work sector particularly within adult's services in England.

# 3. Methodology

## 3.1. Introduction

In this chapter I discuss the theoretical underpinning of my methodology, the research methodology which underpins this study is presented and with a description of why the study design was selected. A summary of data collection approaches used, and methods of analysis employed, is presented.

### Research Question

What is the perceived contribution of social workers within an integrated setting?

### Aims of the study

- To explore the evolution of integrated health and social care in older peoples' services with a specific focus on the role of the social worker.
- To critically analyse the local social and policy contextual drivers of integration over time (currently 4 years into integrated care). (Professional and organisational culture)
- To critically analyse the process of practitioner engagement with regard to their role within integrated teams and the effect on their professional knowledge, practices and skills (professional identity).

The objectives of this research are to explore community professionals':

- opinions concerning social worker's role and statutory functions
- understanding of collaborative and cooperative work?
- experiences of professional support obtained by social workers and health managers. Who leads? Who manages?
- opinions on the aspects of anti-oppressive practices in social work particularly the notion of participation, partnership, empowerment and reflexivity.
- views on social work identity within multidisciplinary team structures.

- exploring perceptions regarding the challenges of cultural and contextual drivers of social work practice.

The study drew on existing research to frame the research question. E.g., existing research indicates the importance of professional respect (Laidler, 1994) and the importance of maintaining unique professional skills and adaptability around shared skills to develop a common ethos when working alongside service users. The research also explored the process of team learning (Bond, 1997) exploring the notion of shared knowledge and experience or adherence to professional boundaries.

Integration has a lengthy history that has been shaped by inconsistent cultural, financial and political drivers (SCIE, 2012; Barker, 2014; Kings Fund, March 2015). It is these existing cultural and contextual drivers relating specifically to social work practice that I explored along with social workers perceived acceptance, ability to perform, and professional standing in this area which is predominantly health dominated. This study is underpinned by the core research question

‘What is the perceived contribution of social workers within an integrated setting?’

### **3.1.1. Theoretical perspective**

The study reports on the exploration of the perceived contribution of social workers within an integrated setting utilising an interpretivist based methodology. The study is concerned with the perceptions of experts, allowing me to construct an understanding of social workers based on the actual lived experiences of those who engage with social workers on a daily basis as well as soliciting opinions from social workers themselves. The underlying epistemology of this approach avoids the reductionism and essentialism of much psycho-social theorising e.g. Fugate, Kinicki and Ashforth (2004). The study is not engaged in a search for a universal truth through the application of the scientific method. This approach is the antithesis of complex phenomena which cannot be explained by a fundamental truth or essence. This approach also rejects the notion of an underlying natural unitary, fundamental and rational pattern of exposition. There is no attempt at meta-theorisation. Instead, there is a prominence placed upon the multiplicity of interdependent, subjective and often oppositional understandings, each with their own fundamental legitimacy (Ussher, 1999). A social constructivist approach (Gergen, 1999) views realities as constructions (Berger and Luckmann, 1967), the truth as multiple and subjective rather than absolute, arguing that we purposefully and actively construct and perceive our own realities from the meanings



within our own context. Crucial to the interpretivist epistemology is that I was required to adopt an empathetic stance. This is where I believe my position as an insider researcher compliments my research design as I am already present within the social world (the integrated Trust) of the research participants, allowing me to understand the context and nuances of their perspectives that will inform my interpretation.

The researcher's ontological perspective that the 'impact' of social workers in an integrated Trust is a social construction, created through the relationship between the lived experience of community professionals and the integrated Trust from which they work. This supports an epistemological stance of generating and/or unlocking knowledge through an initial subjective, interpretative approach where multiple-constructed realities abound, and that understanding and established cannot be separated because the subjective understanding is the source of reality (Guba, 1990).

The research is framed within the social constructionist epistemology assuming community professionals' perceptions on the impact of social workers within an integrated Trust is subjective and it is recognised that the researcher and participants are both "subjects in the dialectical task of constructing reality, critically analysing it, and reconstructing that knowledge" (Freire, 1970, p. 51). Constructionism is interested in the manner in which the social world constitutes individuals; the manner in which the reality of language and symbols come to reside within us; the manner in which our own sense of self identity and our understanding of society is constructed. From a constructionist perspective, experience and meaning are not inherent within individuals but rather are socially produced and reproduced (Burr, 1995). Thereby, conducting thematic analysis within the context of a constructionist framework enabled a focus on the motivation or individual psychologies, and gave me the flexibility to explore the socio-cultural contexts (cultural and contextual drivers of social work practice), and structural conditions (integrated working), that enable the individual accounts that are provided (perceptions). There is a tendency with thematic analysis that targets latent themes to be more constructionist where wider assumptions, structures and/or meanings are theorised as supporting what is indeed articulated in the data. Although it should be noted that not all are. There also appears to be a degree of overlap with thematic discourse analysis at this point.

The methodology needs to allow participants to be free to express their own views of the current integrated health and social care landscape, without leading questions from the researcher and without prejudice or fear of reprisals.

Therefore, before the methodology was settled upon, facets of the methods of data collection appeared to be apparent to me in light of the philosophical foundation of the research. The data collected was required to be valid and true to what community professionals have experienced, providing a depth and richness of data to be analysed. A method of data collection (questionnaire with sub-sequent semi-structured interviews) was therefore needed whereby community professionals as experts were free to describe their realities of integrated care. A method of thematic analysis was used to code their responses into themes which subsequently could be interpreted to ascertain how realities are constructed and interpreted by social workers in practice.

This study adopts an interpretivist paradigm and social constructionist epistemology in that there are multiple realities to be understood and different perspectives and perceptions to be explored. I would argue that an interpretivist perspective is highly appropriate; not only is the integrated Trust complex, it is also unique. This research took place in one integrated health and social care Trust that had a particular set of circumstances and individuals. The research design was such that it maximised the potential to capture the rich complexity of the social situation from the participants involved. My aim was not to be generalisable, albeit some aspects will be applicable to comparable organisations but to gather a depth, a richness of data that explored the key research questions. I would argue that given the rapid policy and legislative developments in this area of integrated social work, that the value generalisation would bring to this area would be limited and miss the richness and experiences that practitioners are experiencing within the integrated Trust in a time of austerity.

At this point, there was a need in the research design to consider ethical dimensions since the review of literature had established a social vs. medical slant underpinning the current process of integration with assimilation often being mooted. I needed to be aware of my own subjectivity when it comes to this research, aware of my own individual biases and be cautious when presenting my findings vs. opinions given my training in the social model of disability that purports that society is the primary determinant in disabling people. The social model of disability identifies systemic barriers, negative attitudes and exclusion by society (purposely or inadvertently). In order to ensure freedom of expression, the coding of participants was undertaken to ensure confidentiality was maintained alongside the removal of identifiers at the initial stage of data analysis.

### 3.2. Qualitative research

The reading of different methodologies and subsequent reading for the literature led to a shift from a mixed-method approach utilising the Delphi technique, to a choice of a qualitative approach for the research adopting thematic analysis. Guba and Lincoln (1989) term these shifts as 'progressive subjectivity', a reflection on my thought process and shifting needs of the project. The reasons for this choice was that qualitative research "is an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting" (Creswell, pp. 1-2).

In order to inform the profession, it was necessary to ascertain both divergent and consensus views. A sample of professionals from the integrated Trust were invited to participate in the study and this was an entirely voluntary process. This approach was designed to minimise the potential for researcher bias during the selection of participants. Purposive sampling was adopted whereby; participants are grouped according to pre-selected criteria in this case they had to be qualified social workers or qualified registered community professionals whom within their role work closely with social workers. This I felt was best achieved by the research adopting an initial questionnaire to gather breadth of data and then subsequent semi-structured interview focusing on key themes identified from the initial data to explore themes emerging in the data further (Richardson, Dohrenwend, and Klein, 1965). The research question is exploratory in nature, designed to enable discoveries to be made inductively through data collection and analysis. Whittaker (2009) states that "open ended questions invite comments or opinions without anticipating the results" (p. 104). Whittaker believes this allows participants to better articulate their thoughts and feelings whilst also making no assumptions about how a participant will reply. This method of a questionnaire would appear to fit into my intuitionist approach to my research. The questionnaire also collected some demographic data, such as profession and length of service with such variables potentially affecting relationships as well as providing a baseline of my sample group. The data was then subject to thematic analysis (see below, chapter 6), to initially analysis and code the raw data, where I began looking for redundant and similar codes. After this initial coding process, analysis occurred where I aggregated the similar codes to form major concepts or themes.

There were inherent strengths and weaknesses in this approach (Whittaker 2009, p. 73)

#### Strengths:

- As the research is designed to take place across a large geographical area one of the inherent strengths of a questionnaire is that they are relatively inexpensive and quick to administer and can also be conducted electronically for quick mass distribution to potential participants. It allows for greater degree of anonymity and allows for a flexible response time that is convenient for participants.
- Being an insider researcher, questionnaires present less opportunities for bias or errors caused by my presence as the interviewer.
- The questions would not be subject to interviewer variability and are presented in a consistent and stable manner which addresses concerns of unconscious bias by the researcher i.e. that I would approach the social workers differently for example.
- This approach enables a wider coverage by reaching more participants than other research methods would allow in similar timeframes.

#### Weaknesses

- They do not allow responses from participants to be elaborated on or an opportunity for in-depth or additional questioning while the questionnaire is being completed, however this weakness could be addressed with subsequent follow up interviews.
- The researcher is not present and cannot ensure that participants answer all questions or follow the guidance contained within the information sheet if relevant.
- Participants have limitations on how much time they give to completing a questionnaire.
- Only a small amount of open questions can be asked as participants are reluctant to write large amounts. This is a serious limitation given the exploratory nature of the research question. However, with thematic analysis and follow up interviews I believe this is a weakness that can be addressed.

- The identity of the participant is not usually known however I propose coding the responses to produce sub sets for analysis. So that I may follow up with interviews and/or subsequent questions.

In being aware of the limitations of using a questionnaire as the only method of data collection it became possible to follow up the questionnaire by arranging interviews with a sample number of integrated community workers in order to gather more qualitative data regarding their experience of cultural and contextual changes since integrated care and that of professional identity and the value they place on social workers.

### 3.2.1. **Introducing interviews**

After considering a wide spectrum of interview approaches I decided that the interviews were to take a non-schedule standardised approach (semi-structured) where the researcher “works with a list of the information required from each respondent” (Richardson et al, 1965, p. 45) with the wording and sequencing of questions tailored to fit individual participants. I had opted for semi-structured interviews during the second phase of my study after reflecting on my initial survey data. This approach was appropriate for the exploration of the perceptions of respondents regarding social workers and the initial themes that had emerged from the survey data. This approach allowed me to search for more information and seek clarity allowing questions and conversation based on the participants responses and proceeding like a friendly, non-threatening conversation. This approach was taken in order for me to maximise the potential richness of data from participants (Louise and While, 1994). I had no way of knowing if the interviewee had completed the initial survey and if so what they had stated and wanted to avoid repeating myself and limiting the participants interest and range of answers. This approach was also adopted in order that I be mindful of the significant changes individuals were subject to at the time the interviews were conducted. I of course had ideas and themes that I wanted to explore following the thematic analysis of the initial survey data and these considerations guided the conversations. I was mindful of the pre-existing themes that had emerged from the survey data but I was also looking for emergent themes within this new set of data.

McCracken (1988 p. 7) described the potential of this technique:

“The method can take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world. It can also take us into the life world of the individual, to see the content and pattern of daily experience. The long interview gives us the opportunity to step into the mind of another person, to see and experience the world as they do themselves”

Silverman (1993) observes that this approach sees participants as actively constructing their worlds with the goal of the interview to be able to generate data with authentic insights into such lived experiences of social workers working in an integrated setting. A semi-structured interview was utilised to produce a richness of data that appeared to elicit appropriate insights into the research topic. In particular, I am aware of the need to not simply describe an insider understanding of their world, but also to embrace any contrasts between the participant’s understandings and those of the researcher as authentic, experiential contrasts, rather than viewing them as a radical departure from the norm. By uncovering the meanings, beliefs, understandings of the participants it will act as a counterbalance to the researcher’s preconceived notions (Secker et al. 1995). A negative of this approach is that topics and areas of interest may be inadvertently missed given the free nature of this approach (Patton, 2002). Furthermore, comparability is reduced because sequencing and wording will inevitably be different for each individual interview.

Other approaches such as unstructured interviews are consistent with participatory and emancipatory models and would also be a valid approach to this research but ultimately I opted for my research to take a semi-structured interview approach that allowed for greater explorations of participant’s perceptions around the key themes identified in the initial survey data.

An alternative structured interview approach that adopted a structured and formal interview was rejected given its limitations and lack of exploratory scope. I argued for a pure qualitative interview that would enable a greater understanding of “how the participant frames and structures the responses ... the participant’s perspective and the social phenomenon of interest should unfold as the participant views it, not as the researcher views it” (Marshall and Rossman 1989, p. 82). Whereas Stierand and Do“rfler (2012) advocate for adopting a phenomenological approach to research which applies the lived experiences of experts to greatly assist and enhance the richness of the data generated.

The interviews were conducted in a place chosen by the participant in a belief that they would feel comfortable and safe and thus produce a more in-depth narrative from the interview. As I conducted the interviews and completed the data analysis I was aware of several possible influences on the data. Firstly, my bias although reflected on and acknowledged may still exert an unconscious influence on my line of questioning and interpretation of the data that I had gathered. Secondly my presence during the interview may affect my participants responses. In addition, the context to each interview will be different with different dynamics between myself and participants and different environments at play which all could have subtle yet significant impacts on the interview data.

Having discussed the procedures, methodology and methods I will now go on to discuss my own position within the process as an insider researcher.

### **3.3. Role as an insider researcher**

As an insider researcher, it is important to be mindful that “research is not carrying out transformation for participants but with them” (Freire, 1970, p. 49). It was my view that by having experienced working within the integrated Trust, our shared experiences would elicit a greater level of engagement from the research participant and thus produce a richer set of data (Dwyer and Buckle 2009). However, one of the consequences of having such a shared experience was the difficulty in separating my individual experiences from those experienced by the research participants (Kanuha 2000), being able to objectively challenge questions regarding possible bias in my research (Serrant-Green 2002), and problem of confidentiality when working with participants around potentially sensitive topics (Serrant-Green 2002, citing Kaufman 1994). However, there are very limited cases as researchers (Merton 1972; Merriam et al., 2001; Dwyer and Buckle 2009) have noted in which somebody can be considered as a total insider or a total outsider. In practice, researchers’ identities are often relative and can occasionally even change based on where and when the research is undertaken, the personalities of the researcher and individual research participants, and the subject of the research (Mercer 2007). Whereas some features like race and gender, likely will remain constant throughout researchers’ lives. The importance of those features can change, depending on the research situation (Mercer 2007).

### 3.3.1. The Pros and Cons of being an insider researcher

Having discussed my role as an insider researcher I at this point will highlight some of the pros and cons of being an insider researcher and how they may affect the collection and analysis of my data.

Pros:

Knowledge

I was orientated and familiar with the environment, systems and culture, able to be present without disturbing the social settings (Aguiler, 1981). As this is an interpretivist study one of the key benefits of being an insider researcher was my knowledge of the context of the research (Bell, 2005). With regards to participants, I as an insider researcher had the “ability to ask meaningful questions and read non-verbal cues,” as well as the ability to “project a more truthful, authentic understanding of the culture under study” (Merriam et al., 2001, p. 411).

Interaction

As an insider researcher I would argue my interactions are more natural and balanced than an outsider researcher based on my familiarity with the situation and participants. Participants were more likely to engage with me, someone who is seen to understand them, than they would an outsider (Bell, 2005).

Access

For this study I had “expediency of access” (Chavez, 2008, p. 482) able to access the field of study relatively easily. However, access may be more problematic for some insider researchers than one may initially think; this will be discussed in more detail below.

Cons:

Too subjective

Knowledge can be seen as a result of “subjective involvement, a deterrent to objective perception and analysis” (Aguiler, 1981, p. 15). The argument being that my focus is too narrow given my overall familiarity with the environment that will impact on my ability to objectively analysis social and cultural patterns. I was astutely aware of the potential to lose my objectivity and attempted to mitigate this through peer discussion, supervision and reflection and by adopting an



iterative process with my data. Nevertheless, prior knowledge and experience can lead to me making assumptions and so I had to be mindful and keep some distance which is difficult to do when I am so close to the study.

#### Biased

I am close to the study, therefore there will be an element of bias be that unconscious or otherwise. “The selection of a topic that clearly reflects a personal interest and the selection of colleagues as subjects raise the spectre of insider ‘bias’” (Van Heugten, 2004, p. 207). I was aware and actively reflecting on my own biases within this study mindful not to project them onto my participants or influence my data analysis.

#### 3.3.1. **Researcher Positionality**

As a social worker working in an integrated NHS Trust, the expression of negativity towards integrated care with health from social work colleagues is a concern. Social workers have expressed views stating that the profession has been undermined, undervalued and unappreciated, yet has so much to offer. This positioned me as the researcher to consider social worker’s unique skills and abilities within an integrated team structure in adult social work, an area that social work literature and research has not yet fully explored.

The research design developed from the researcher valuing the quality and ability of social workers as key players in the integrated workforce and believing that professional’s perceptions of social workers can affect the organisation. Social workers have particular skills / expertise that have something to offer to healthcare colleagues with a moral foundation of human rights and social justice, together with an inter-disciplinary perspective, deliver a strong basis for inter-professional leadership (Bisman, 2004). It is postulated that the production of such perceptions could strengthen social works status and understanding within such integrated working environments. The research design acknowledged the work of Mizrahi and Rosenthal (2001) who maintain the need for social work to be promoted as a significant component of multidisciplinary teams. This is an area that social work leadership can influence within an integrated setting.

Understanding the impact social workers have on integrated teams would allow social workers abilities to be highlighted, showcasing the effectiveness of social workers as administrators leading inter-professional organisations. Good leadership can position social workers as

understanding the complexities of diverse need, allowing them to fulfil their potential within an integrated setting. The problem arises when the literature and my professional experience are bereft of such leadership. Professional experience has showcased social worker's ability and skills to lead (BASW, 2018) but has also highlighted the position of social work in a fractured system that can potentially affect their ability to lead and affect positive change. The premise for the research is to explore the impact of social workers on an integrated team.

The positionality of this research therefore included the value the researcher placed on social worker's opportunities within an integrated setting to champion the profession. The value of social workers being professional leaders not necessarily managers and the unique skill set social workers contribute in a multi-disciplinary working environment, with a belief that social workers can influence the way teams function within the organisation. However, in my experience this professional support is often a token, lone social worker imbedded within the health dominated management structure and as a consequence many social workers are left feeling isolated and out of touch with developments in social care, e.g. the integration of services aligned with the Care Act 2014.

### **3.4. Ontological perspective and associated relationality**

Ontology is a "formal, explicit specification of a shared conceptualisation" (Gruber, 1993 p. 199). This research was within social ontology with a focus on the social realm. The social realm being defined as a domain of phenomena whose existence depends at least in part on individuals. The qualitative perspective asserts that there are multiple realities or truths at the ontological level (Pring, 2000). An aim of this research is to determine community professional's perceptions of social worker's exploring their contribution to the integrated Trust. It is postulated by Moustakas (1994) taking a phenomenological approach that perceptions are a result of lived experiences and are intangible and unconsciously held. It is these realities, or truths within a social context (Sale, et al, 2002) that this research attempted to explore.

The ontological perspective taken in this research is largely complimentary to social work theories of reality, with realities being "socially constructed entities that are constantly subject to internal influence" (Guba and Lincon, 1994, p. 110). This approach is aligned with a profession that

“promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being” (IFSW p. 1). This research views the perceptions of social workers from community professionals as a human conceptualisation, a social construction, a way to interpret the phenomena we experience in our reality.

In choosing a qualitative research design I had to be mindful of the assumptions underpinning this approach. Qualitative approaches are disparate, intricate and distinguished (Holloway and Todres, 2003). The epistemological basis for qualitative approaches is rooted within an interpretative paradigm, allowing for many alternative paradigms including, e.g., constructivism, critical theory and post-positivism (Lincoln and Guba, 2000). Amidst this, constructivism and social constructivism allow for an understanding of the epistemological basis for the qualitative design within an interpretivist paradigm; this is in stark contrast to the positivist approach that positions the researcher to be an objective and neutral observer (Robson, 1993). This objectivist point of view assumes an ontological position of single reality and could be seen to adopt a reductionist stance to the identification of the aspect of the research under review. Thereby conforming to positivistic principles (Blackburn, 1999; Monti and Tinggen, 1999) would result in deductive rather than inductively drawn data which could be argued significantly reduces the richness of the data obtained. The research design was qualitative and subjective in nature (Fitzsimmons and Fitzsimmons, 2001).

Viewed from this ontological perspective the focus for the research is not the concept of social work integration within a health Trust, nor indeed the professional work force, but the relationship between the two. Social constructionists argue that we are subject to societal norms and values that “we come to inhabit a pre-existing system and to be inhabited by it” (Crotty, 1998, p. 53). This notion highlights the consensus of knowledge that has already been reached and is still being determined, consciously or otherwise and it is this aspect that the research attempted to unpick. In other words, determining community professionals’ perceptions of social workers involves focusing on the relation between community professionals and their experience of integrated working within the Trust; they are the experts. A constructionist approach, utilising qualitative research methods, were the foundation for my study. In adopting this approach due consideration should also be given to “domination, exclusion, privilege and marginalisation” (Ceci, Limacher and McLeod, 2002, p. 714).

## 6. Method of analysis

### 3.5. Thematic analysis

#### 1. How data might be analysed

The research design developed to utilising thematic analysis as a key benefit of this approach is its flexibility. This method facilitates identification and analysis and reports on themes within data sets. Using this method allowed me to describe and organise the data set in rich detail, often going further than this by interpreting numerous facets of the topic being researched (Boyatzis, 1998) and therefore is consistent with the social constructionist approach employed in this research. The questionnaire and interview data were both analysed using this approach.

#### 2. Using thematic analysis and why it was compatible with both the interviews and survey data

This approach allowed the coding of data to occur in 2 stages; the initial survey stage, followed by the secondary interview stage. The flexibility of thematic analysis allowed the coding to be pragmatically applied whilst also allowing me to interpret meanings within the data whilst undertaking the analysis. It allowed me the freedom to have a fluid analysis that was vital in such a time as the organisation was undergoing massive structural and staff changes that impacted on the study and required the analysis to be flexible in its approach. A more ridged approach wedded to ideology and procedure I believe would not have generated the same amount of insights given the shifting nature of the research environment.

#### 3. What thematic analysis did for me

I used thematic analysis as it has the reputation of being highly flexible in that it can be applied to different theoretical frameworks (albeit not all) and be used to do different things within said frameworks as it is not joined to pre-existing theoretical frameworks. Thematic analysis is highly adaptable and can be used an essentialist or realist method, where experiences, meanings and the reality of participants are reported or it can adopt a constructionist method, which explores the ways in which events, meanings, realities, experiences are the result of a multitude of discourses operating within society.

#### 4. How it is compatible with social constructionism

My goal was to explore the perceptions of the participants who completed the survey and took part in the interview. I can interpret themes to identify, compare, contrast and make sense of themes within texts (Potter and Wetherell, 1987; Hollway, 1989; Burman and Parker, 1993). A strength of the social constructionist approach that is present in this research is its focus on the cultural and social relatedness of participants' data. It allows me to interpret the data within the context in which it was collected. However, I have to be mindful in this approach that this is not merely reduced to the level of narrative rather than critical analysis which incorporates wider meaning to the narrative that I presented (see Findings chapter above).

Analysis of patterns in data is often referred to as thematic analysis and is relevant to my study where thematic analysis is within a social constructionist epistemology (i.e., identified patterns are seen as socially produced, but no discursive analysis is undertaken). Thematic decomposition analysis (e.g., Stenner, 1993; Ussher and Mooney-Somers, 2000) is another form of 'thematic' discourse analysis that identifies patterns (themes, narratives) imbedded within the data, and theorises language as constitutive of meaning and meaning as social.

As discussed thematic analysis is a flexible method of analysis. In order that you understand my process based on that of Braun and Clarke I have provided a framework to guide you through the six phases of analysis, and present examples to demonstrate the process. The 6 phases are helpfully summarised in Table 3.1. I utilised these 6 phases on both the survey data and then the interview data.

**Table 3.1: Phases of Thematic Analysis**

**1. Familiarising yourself with your data**

**2. Generating initial codes**

**3. Searching for themes**

**4. Reviewing themes**

**5. Defining and naming themes**

**6. Producing the report**

### **3.5.1. Phase 1: familiarising myself with the data**

As I collected the data myself it was inevitable that I would approach the analysis with some prior knowledge of the data, and conceivably some preliminary analytic interests or opinions.

Nevertheless, it was vital to my analysis so that I may have the depth and breadth of the survey data and subsequent interview data that I immerse myself in the data. During this phase I started making notes and reflecting on the data in order to generate some ideas for coding. Examples of some of these initial thoughts from the survey data were; money, frustration, marginalisation. I then continued to develop and define the coding during the subsequent analysis.

#### Transcription of interview data

I familiarised myself with the interview data through the process of transcribing (Riessman, 1993). As I was conducting an interpretative thematic analysis this process it has been argued is “a key phase of data analysis within interpretative qualitative methodology” (Bird, 2005 p. 227), and recognised as an interpretative act, creating meanings, rather than merely a process of recording spoken words to paper (Lapadat and Lindsay, 1999).

It should be noted that the level of detail required in the transcript for thematic analysis, even constructionist thematic analysis, is not required to be as detailed a transcript as that which would be produced for conversation, discourse or even narrative analysis. As thematic analysis is flexible, there are no fixed guidelines to follow when producing a transcript. I ensured that the transcript was rigorous and thorough producing an “orthographic” transcript ensuring the transcript retained all the information I needed to complete an analysis (Poland, 2002 p. 632),

#### **3.5.1. Phase 2: Coding Phase: generating initial codes**

After familiarising myself with the data, reflecting on it and producing a preliminary dossier of ideas regarding what is in the data sets, I then began phase 2. Phase 2 involved the construction of initial codes from the data.

Codes recognise within the data a feature (semantic content or latent) that appeared interesting to me and refer to “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998 p. 63). See Table 3.2 for an example of codes applied to a short segment of data from the survey data. See Table 3.3 for an example of codes applied to a short segment of interview data. As I organised the data into meaningful groups (Tuckett, 2005) this process of coding formed part of my analysis (Miles and

Huberman, 1994). These initial codes then allowed me to start thinking more broadly and analytically and would be the foundation for the development of categories and themes in the next phase where my interpretative analysis of the data occurred.

Table 3.2: Survey data extract with codes applied.

Data extract	Coded for
I think a lack of knowledge and understanding about what social care is, has been a major barrier to effective functioning.	lack of knowledge and understanding about social care
Another barrier is the lack of representation of social workers and social care staff at a senior level.	lack of representation of social workers
Lack of investment to facilitate co-location of staff has also been a barrier.	Lack of investment

Table 3.3: Interview data extract with codes applied.

Data extract	Coded for
I think if they had integrated properly in the first place, if that had been managed correctly at that time it would have had a massive impact. If there had been a recognition of the different roles and responsibilities. They got it wrong at the beginning. They didn't take into account the different professionalism, priorities, models medical and social models.	<p>recognition of the different roles</p> <p>different professionalism, priorities</p> <p>medical and social models.</p>

I conducted the coding manually where I worked systematically through the entire survey data set and then the subsequent interview data set. I gave my full and equal attention to each piece of data, if we look at two raw data quotes from the survey data:

*Managers do not understand social workers*, I reflected on this statement as it was a very pertinent to my own practice situation and it was easy for me to assume that I understood that statement by virtue of my own experiences. I had to take a step back and apply that statement in the current context and also in the context of the other comments provided by this participant. I had to be careful that I was not influencing the data to produce themes that I thought should be there based on my own experiences.

*Them and us service*, this is a loaded statement and I had to be careful when making assumptions. When I initially saw this statement I agreed with it, there is a them (health) and us (social work/care) service. It was only when I went and looked at the demographic data that I discovered this quote was from an occupational therapist. This reflection challenged my own assumptions. I would have been almost certain that this statement had come from a disgruntled social worker. It is very easy to influence the data.

I then identified interesting aspects within the data that constituted repeated patterns (themes) across the data set. I coded the extracts by highlighting sections of data that indicated potential patterns and this produced descriptive or semantic codes that remained close to the data. The data then produced features (semantic content or latent) that codes helped to identify. Having completed a literature review in the area of interest it was inevitable that this prior research would have a bearing on my interpretation of the data. I would be working reflexively with the data to apply my own interpretation to what appeared of interest to me during the analysis, and refer to “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). An example of codes I applied to a short data segment can be seen above in Figures 3.2 and 3.3 and in Figure 4.1. As part of the analysis coding was undertaken (Miles and Huberman, 1994) and the data was organised by the researcher into relevant groups (Tuckett, 2005). However, the emerging themes derived from the codes were often wide-ranging differing from the coded data. The interpretative analysis of the data set then occurred within the themes (see discussion below), and are also where relations to which arguments about the phenomenon under investigation were made (Boyatzis, 1998).



### 3.5.1. Phase 3: Identifying a theme within the data

I use the term theme to identify pertinent parts of my data in relation to the research question, and depicts some semblance of meaning or patterned response within the data set. I developed the theme inductively via thematic analysis. Patterns or themes developed within the data in thematic analysis can be ascertained primarily in one of two ways: inductively (bottom up) (e.g., see Frith and Gleeson, 2004), or in a theoretical or deductive way (top down) (e.g., see Hayes, 1997; Boyatzis, 1998). An inductive approach is where the themes I had identified were significantly linked to the data itself (Patton, 1990). My data that I collected (e.g., via interview or questionnaire) and the subsequent themes identified may not necessarily correlate to the specific questions that were asked of participants taking part in the study and so produced divergent codes that led to the creation of new categories. This approach allowed me to approach my data without being directed by my own theoretical interests. Therefore, inductive analysis was a coding process for my data without shoehorning it into a prior coding frame, or the vagaries of the researcher's analytic preconceptions. This is a data driven form of thematic analysis. However, it should be noted that data are not coded within an epistemological vacuum and I as the researcher have influences from my own theoretical and epistemological beliefs and values. In contrast, a theoretical thematic analysis tends to be directed by the theoretical interests of researcher's in the area, and is therefore understandably more analyst-driven. This tends to produce an in-depth analysis of certain aspects of the data but as a consequence produces a less rich description of the overall data.

Phase 3 commenced after I had coded and collated the data set and I had produced a long list of the different codes I had identified. At this stage it was time for me to re-focus my analysis to explore the wider level of themes, rather than codes. I started to arrange the different codes into categories and potential themes considering how different codes combine to form a category and subsequent overarching theme. The criteria for a category was a group of codes that I interpreted to have a common theme or idea. A table of an example of this early stage can be seen in Table 3.4 (Survey Data) and Table 3.5 (Interview data). It should be noted that the 6 stages were completed on the survey data first and subsequently on the interview data, consequentially my interpretation of the interview data was informed by the themes I had created from the initial

survey data. The interviews were designed to be complementary to the survey data and to explore the themes in greater depth than a survey could provide. There were a few outlying codes that did not fit upon first analysis but upon subsequent reading did fit for example nurses answered do not know with regards to some aspects of social work which is fundamental to their perceptions of social workers, these do not know subsequently fit into the understanding category. An example of a code that did not fit was a quote from the raw data of a nurse: *they know a lot of the patients within the team*. There was no context, no qualifying statements; was this a good thing? How did this help or did it hinder? What did this mean? Where there was not enough data or the meaning was too ambiguous the code was discarded and not used in my analysis.

At this stage I began to reflect on the relationship between codes, between categories, and between themes. It appeared at this stage that some of the initial codes would lead to themes due to activity created by me and some would go on to be discarded. When I moved to the theme phase of analysis I was required to identify if themes were at a semantic or explicit level, or at a latent or interpretative level (Boyatzis, 1998). A thematic analysis generally focuses on one level. A semantic approach will look at the explicit or surface meanings of the data to identify themes. This approach is superficial with no in-depth analysis beyond participants spoken or written words. This approach then proceeds to the analytical stage where it progresses from description, with data organised to highlight patterns in semantic content, and summarised, to interpretation, where the significance of patterns and their wider meanings and connotations are attempted to be theorised (Patton, 1990). This is often done with references to previous literature (see Frith and Gleeson, 2004).

In comparison, my approach was that of a thematic analysis at the latent level that goes further than semantic content of the data, and begins to explore the underlying premise, ideas, and conceptualisations and ideologies that are theorised as informing the semantic content of the data. The development of themes in latent thematic analysis required me to interpret the data, the resulting analysis that is produced is not only descriptive, but is already theorised. Braun and Clarke (2006) recommend incorporating latent themes in order “to identify or examine the underlying ideas, assumptions, and conceptualisations ... that are theorised as shaping or informing the semantic content of the data.” (p. 13). An example was data described as value, which incorporates power dynamics and wider macro issues of culture (professional and

organisational) which I then interpreted through theories such as social role valorisation and professional identity (see discussion chapter).

Latent thematic analysis is usually developed from a constructionist paradigm (e.g., Burr, 1995), and has some degree of overlap with some types of ‘discourse analysis’ (these are often specifically referred to as thematic discourse analysis (e.g., Singer and Hunter, 1999; Taylor and Ussher, 2001), where wider assumptions, structures and/or meanings are theorised as supporting what is actually expressed in the data.

To surmise, my approach was that of thematic analysis with an iterative approach that allowed me to search across my data set (interview transcripts, questionnaire data) in order to find repeated patterns of meanings. The specific arrangement and product of thematic analysis varies but I have indicated above my approach, one of inductive analysis with themes identified at a latent level.

Table 3.4 (Survey Data)

Label/ Sub-category	Category
Key workers	Statutory functions
Complex cases	Case management
S42 enquires	
Organising care packages	
Social care assessment rather than medical model	
Care package	
Mental Capacity Act	
Care Act	
safeguarding	
crisis intervention	
mental capacity and best interests	
Complex case working	
Multi disciplinary working.	
Support statutory role	
joint visits	

<p>Co-ordinates care and assessments</p> <p>Care and support</p> <p>Personal care</p> <p>People stay in own homes</p> <p>Service user received good service</p> <p>Multidisciplinary team</p> <p>Care needs</p> <p>Assessments for funding</p> <p>Facilitate social care</p> <p>Huge workload,</p>	
<p>Balanced view</p> <p>Social factors</p> <p>They know a lot of the same patients joint services.</p> <p>improved communication</p> <p>Share information</p> <p>Act as communicators within team</p> <p>Shared professional responsibility regarding self neglect.</p> <p>ability to work together</p> <p>Better communication</p> <p>sharing information</p> <p>attending multi-disciplinary meetings</p> <p>Social perspective to team</p> <p>social care knowledge and experience better available to health colleagues</p> <p>Communication</p> <p>Specialist advice</p> <p>Work together</p> <p>Gain information</p>	<p>Social model</p> <p>Holistic different perspective</p> <p>Sharing of knowledge</p> <p>Improved communication between professionals</p>

<p>Respect different views</p> <p>Limited within the Trust – Trust not holistic or person centered</p> <p>Driven by budget</p> <p>Little weight given to social workers</p> <p>Anti discriminatory work</p> <p>Social work values</p> <p>Social justice</p> <p>Holistically – not focused on disease/pathology/problem</p> <p>look at the person as a whole</p> <p>more time with the service user</p> <p>they are not task focused</p> <p>Holistic</p> <p>being person centred</p> <p>holistic views</p> <p>being holistic in our approach</p> <p>Holistic approach</p> <p>Social work and Health work come from completely different perspectives and have very different working practices, I feel that they do not sit together or work well in one organization.</p> <p>unique perspective</p> <p>clearly defined roles</p> <p>Whole person</p> <p>Social workers often provide the only view from a social model in a team looking from a medical perspective</p> <p>Holistic</p> <p>Holistic</p>	<p>Value base</p> <p>Anti-discriminatory</p> <p>Challenge medical model</p>
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Advocate	Advocate and challenge
Advocate	Service user rights
Service users voice heard	
Appreciation of power and oppression	
Values and ethics when working with people	
focusing on service users strengths	
promoting independence	
Promotes persons rights	
SU Voice heard	
Advocacy	
SU focused	

Table 3.5 (Interview data)

Label/ Sub-category	Category	Theme
a recognition of the different roles	Health vs social Models	Cultural differences sub-themes
didn't take into account the different professionalism, priorities, models medical and social models	Ways of working	value
priorities are still very different	Professional identity	professional identity.
Social worker's feel devalued, deskilled and underappreciated	Value/understanding	
I don't think SWs have any influence on the direction the Trust is going.	Managerialism	
SW as a nuisance	Marginalisation	
difficult and awkward	Unfairness	
	Social work leadership?	
	Radical social work	
	Discontent	

I think that nurses work to a task centred model  
NHS is free at the point of need there is the means testing and costing  
different priorities and different pressures  
easier to provide a community health service that is free  
challenging to provide a service that they may not want and might not be able to afford  
social work teams seem forgotten about  
social work is undervalued  
professional identity has been eroded  
responsibility lies with our professional leadership.  
higher management are health day to day social work stuff that has been eroded a lot of the discretion and autonomy has been taken away  
professional identify and responsibility has been taken away

Social work is undervalued, very under values, our opinions are undervalued, being eroded anyway profession itself is not tot the level it was 5 years ago. we have had to rely on each other, alienated higher management are health not very popular as social care nursing staffing there have been no cuts to that. been side-lined hindrance to the organisation. two different ROLES. Two very different roles. No social work senior management whatsoever Nurses get a task social workers you are looking at a much, much bigger picture The medical and social model don't fit together they fit next to each other. social work is valued against nurse haven't maintained a professional identity integration has been disjointed promote the social work role.



I don't think that has changed. I think that (health) are still more risk averse, they will say to relatives talk to the SW about it. They (health) don't want to say no, they don't want to deal with that difficult conversation but we are expected to.

No, it is worse, worse than it ever was before. Trying to force our views, our values, our priorities onto health and health forcing THEIR priorities on us. All it has done is watered everything down.

We are very different. We are a different profession and that's why we train the way we do and they train the way they train.

The autonomy has gone  
feels threatening

I don't think it was evident before the changes but it is now., it is a positive. Now we have become a bit more vocal.

I don't think they value what we do

top heavy on people from a health background

We had no idea took time to understand (social workers)

Social workers felt undervalued,  
it impacted on integration  
nobody understood what they  
did.  
health stuff always dominates.

Nurses and SW's, Ot's physios  
we all approach things a little  
differently.  
think professional identities get  
lost  
staff protective and can cause  
conflict  
nurse does not understand what  
a SW does.

I don't think SWs understand  
what nurses do and I don't think  
nurses understand what SWs  
do.

Frustration  
different style of education  
between social work students  
and nursing student's.

I then proceeded to the next stage, reviewing the themes.

### 3.5.1. Phase 4: reviewing themes

Phase 4 began when I had devised a set of candidate categories and themes, and involved a process of refining those themes. As you can see from Table 3.4 to Table 3.6 cultural

incompatibility, professional identity both formed one theme, that of culture. The data within each theme I interpreted as meaningful and allowed me to distinctly separate each theme.

Table 3.6 (Survey Data -refined)

Label/ Sub-category	Category	Main Theme
Struggles to understand the social worker role	Bureaucratic	Cultural incompatibility
staff can get mixed messages	Roles	
Health vs social	Culture	
different cultures	No/poor Leadership	
no longer people in LA who understand	Vision	
uncertainty		
bureaucracy		
frustrating and confusing for service users		
Unclear roles and responsibilities		
social workers not respected		
Lack of clarity		
Confusion		

Label/ Sub-category	Category	Main Theme
<p>Key workers</p> <p>Complex cases</p> <p>S42 enquires (safeguarding)</p> <p>Organising care packages</p> <p>Social care assessment rather than medical model</p> <p>Mental Capacity Act</p> <p>Care Act</p> <p>crisis intervention</p> <p>Multi-disciplinary working.</p> <p>Support statutory role</p> <p>People stay in own homes</p> <p>Assessments for funding</p> <p>Facilitate social care</p> <p>Huge workload,</p>	<p>Statutory functions</p> <p>Case management</p>	<p>Professional role/function</p>
<p>Balanced view</p> <p>Social factors</p>	<p>Social model</p> <p>Holistic different perspective</p>	<p>Professional identity</p>

<p>They know a lot of the same patients</p> <p>joint services.</p> <p>improved communication</p> <p>Share information</p> <p>Act as communicators within team</p> <p>Shared professional responsibility regarding self-neglect.</p> <p>ability to work together</p> <p>attending multi-disciplinary meetings</p> <p>Social perspective to team social care knowledge and experience</p> <p>Specialist advice</p>	<p>Sharing of knowledge</p> <p>Improved communication between professionals</p>	
<p>Respect different views</p> <p>Limited within the Trust – Trust not holistic or person centred</p> <p>Driven by budget</p> <p>Little weight given to social workers</p>	<p>Value base</p> <p>Anti-discriminatory</p> <p>Challenge medical model</p>	<p>Culture:</p>

<p>Anti-discriminatory work</p> <p>Social work values</p> <p>Social justice</p> <p>Holistically – not focused on disease/pathology/problem</p> <p>look at the person as a whole</p> <p>more time with the service user</p> <p>they are not task focused</p>		
<p>Advocate</p> <p>Service users voice heard</p> <p>Appreciation of power and oppression</p> <p>Values and ethics when working with people</p> <p>focusing on service users strengths</p> <p>promoting independence</p> <p>Promotes persons rights</p>	<p>Advocate and challenge</p> <p>Service user rights</p>	

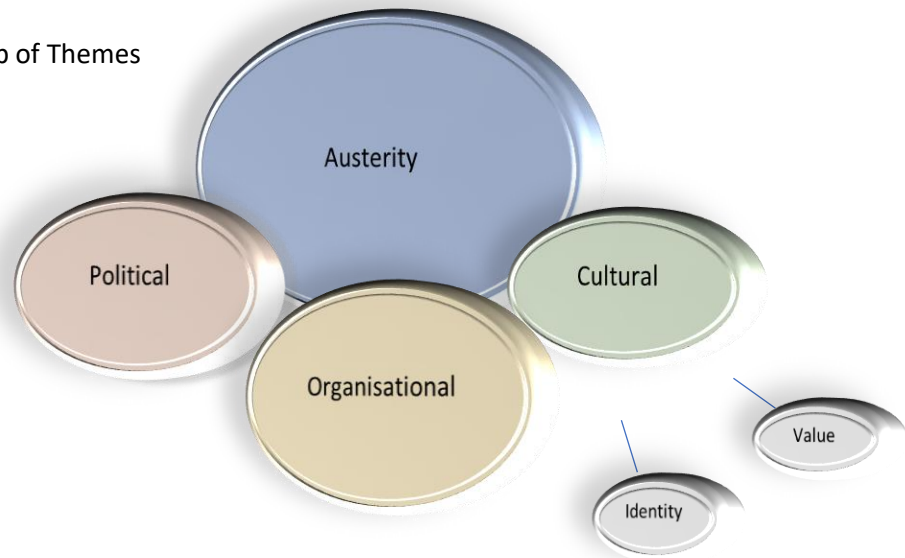
I was aware that data analysis could be organised in two ways when a (quantitative) questionnaire is utilised. If closed questions are utilised then a simple coding will be completed and a numerical value assigned to each response (e.g. yes = 1, no = 2) as the range of available response options is fixed. The Statistical Package for the Social Sciences (SPSS) could be used to analyse the data but I had adopted to code the data manually, this to me was an important part of the familiarisation process. The flexibility of thematic analysis is what drew me to this approach, this method allowed me to establish themes within the data set through identifying, analysing, and reporting patterns. It minimally organises and describes the data set in (rich) detail. However, it also often goes further than this, and provides a framework through which I was able to analyse numerous aspects of the research topic (Boyatzis, 1998) and therefore is consistent with qualitative techniques framed within the constructivist paradigm. A social constructionist approach takes a more holistic approach, seeking the wider cultural and social relevance of participants' responses. It was used to analyse the resulting questionnaire and interview data. Although a primary qualitative approach is being taken to examine the emerging themes, demographic data was also explored to discern whether a theme is more common or rare and note any differences across gender, professional identity and length of service (pre-and post-integration). It considers the participants lived experience and internal constructions of reality as constituted in and through discourse, with the analysis seeking to decipher the processes through which this discourse and the 'subject's internal world' is constructed. It "involves an attention to the ways in which language does more than reflect what it represents, with the corresponding implication that meanings are multiple and shifting rather than unitary and fixed" (Burman and Parker, 1993, p. 3).

At this stage in the survey data analysis having been refined numerous times it was clear that further refinement was not adding anything substantial and I ceased further refinement. At the end of this phase, I had a decent idea of what my different themes were and how they fitted together. I had a sense of the narrative they tell about the data.

### 3.5.1. Phase 5: defining and naming themes

I had devised a thematic map of my data (Figure 6.1) that illustrates the final themes with austerity being present in each identified theme.

Figure 3.1 Thematic Map of Themes



For each individual theme, I then went on to conduct and write a detailed analysis (see Findings Chapter) I had identified sub-themes illustrated in figure 6.1 and these helped to structure my forthcoming analysis particularly the cultural theme. By the end of this phase I could clearly define each theme and offer an explanation in the findings section.

### Phase 6: producing the report

The final stage is my analysis which is discussed in the next chapter.



### 3.6. A Summary of my approach: An Interpretive thematic analysis of the data

An interpretive thematic analysis, using both inductive (generated from the data set) and deductive (informed by prior research and theory) methods of analysis was utilised to examine the data (Boyatzis, 1998). Specifically, the developing analysis was influenced by both primary material (i.e., surveys and interview transcripts) and secondary sources (i.e., the literature review). I conducted a preliminary coding of the survey data; identifying 'units of meaning' in the data set, which became an initial set of codes (Table 4.2).

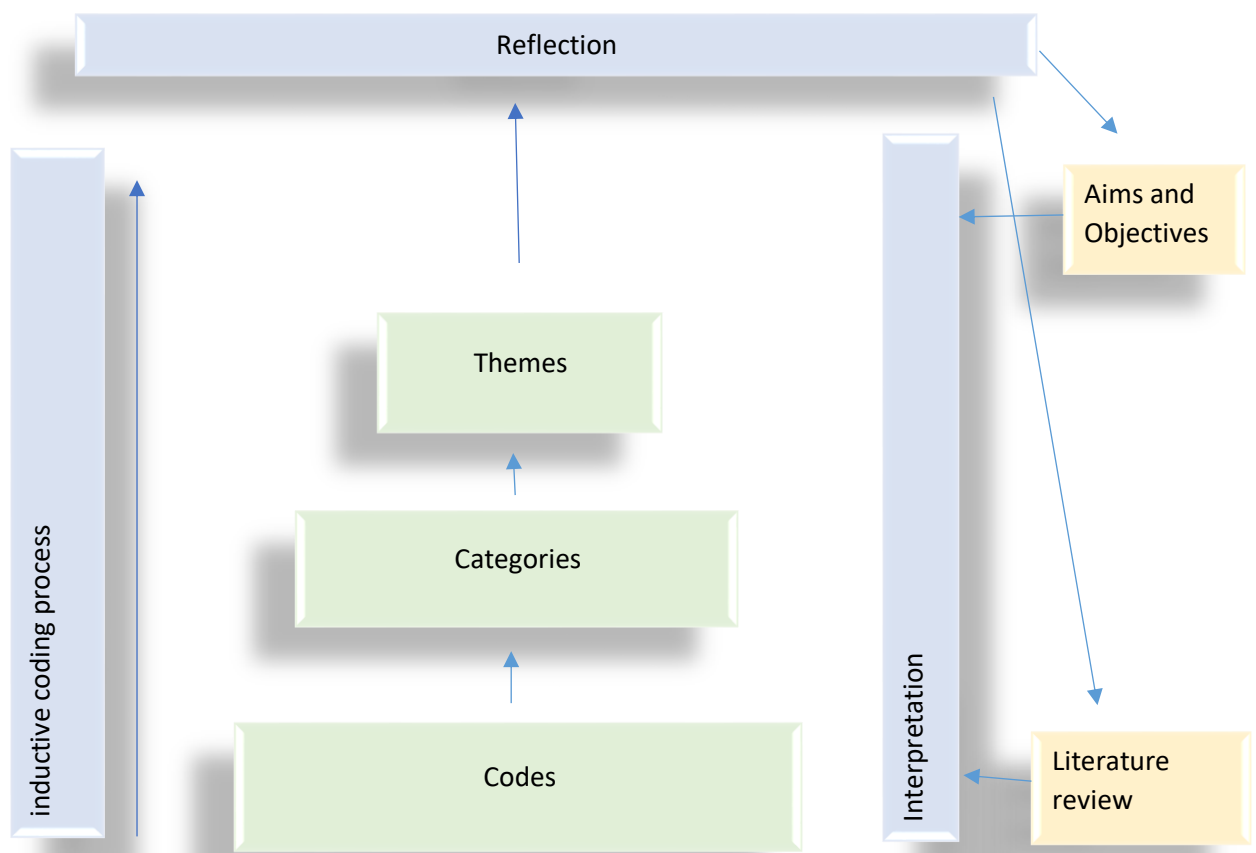


Figure 3.2 Interpretive thematic analysis the data

(Braun and Clarke, 2006, p. 83)

At this initial coding phase following Braun and Clarke's (2006, p. 83) inductive thematic analysis, the data were subjected to an inductive coding process to surface primary themes from a

bottom-up analysis with regards to the perceptions of social workers' impact within an integrated Trust. An interpretivist approach (De Witt and Ploeg, 2006; Dowling, 2007; Robson, 2011) complemented the research question by allowing me to comprehend and interpret the response of participants concerned with their perceptions and experiences within the integrated Trust. This was integral to the process of deductive thematic analysis where theory and literature had influenced my interpretation of the data, while allowing for themes to emerge direct from the data using inductive coding.

The process of thematic analysis as Boyatzis (1998, p. 4) has observed, is "not another qualitative method but a process that can be used with most, if not all, qualitative methods...". Thematic analysis was used as a tool to locate, analyse, and identify patterns in the data that could be categorised and reported with exemplars (Boyatzis, 1998; Braun and Clarke, 2006). I adopted an iterative approach to data collection and analysis utilising a method appropriate to the data set that allowed me to become familiar with the data as required when conducting thematic analysis, e.g. reading and re-reading survey data and interview transcripts. I then took the time to reflect on the insights I extracted from the data. I went back to the data for further analysis, thinking and reflection, until meaning-making had occurred (Ignelzi, 2000). This meaning-making allowed me to construe, understand, or make sense of the data; for example, the categories that emerged around finances and formed the austerity theme were a result of me having achieved meaning-making with that set of data. Therefore, my data analysis would be deemed iterative, in that I moved back and forth over the data, rather than in linear steps: analysis began after the initial surveys were returned. The research was conducted in two phases; initially participants completed surveys that were subjected to analysis, the resulting themes within the data set were then used to inform the second phase of the study which consisted of interviews. The content of the interviews which were conducted after the initial survey was informed by issues appearing to require further investigation identified in the first stages of analysis.

As discussed above an inductive approach to the raw data was adopted when identifying codes and subsequent emerging themes. This approach was considered suitable because of the exploratory nature of this study. Familiarity with the data was achieved by reading and interpreting the survey forms and transcribing the interviews with subsequent repeated reading of the transcriptions. Survey data and interview transcripts were initially analysed using a descriptive thematic analytic approach (Braun and Clarke, 2006). The initial familiarity with the data set produced a descriptive thematic analysis looking at the semantic or the latent level of

meaning within the dataset. These descriptive or semantic codes predominantly stayed very close to content of the data, to the participants' meanings. An example of this is 'Austerity has torn the social care system to bits.' Subsequently upon greater familiarity with the dataset codes were interpreted, looking beyond the participants' meanings to identify meanings that lie beneath the semantic surface of the data. An example of this latent code is 'resource constraints'; this code offers a conceptual interpretation to make sense of what the participant is saying.

Some codes mirror participants' language and concepts; others invoke the researchers' conceptual and theoretical frameworks. E.g., the code 'social workers not respected' stayed very close to the participants' use of language (e.g., Social worker role needs to be more promoted and out there so that others are aware what we do! Understanding around our roles, values, beliefs. (Social worker)). In contrast, the code 'social perspective' invoked my own frame of reference, my own interpretation: no professional spontaneously used the term 'perspective' to describe their unique viewpoint and contribution, but I interpret their accounts through this framework (Gray 2010, p. 97).

Once the initial descriptive thematic analysis was complete, it was evident that there was a strong resonance between the categories derived from the raw data and the theoretical constructs of integrated care. E.g., categories that emerged from the codes were Integrated ways of working; Service delivery, Multidisciplinary, Co-location which all resonated with the theories around structural integration such as Minkman et al, (2009) and resonated with systems theory. Larkin and Callaghan (2005) whose work illustrates the importance of identity has strong resonance with emerging categories; Power, Prescriptive, Professional identity and Different ways of working which also relate to the literature around professional and organisational culture and the ever-present health vs social model debate.

Subsequently, the analytical process was extended and evolving themes were interpreted within the constructionist framework (Burr, 1995), the socio-cultural contexts (cultural and contextual drivers of social work practice e.g., Vygotsky, 1978), and structural conditions (integrated working e.g. framed with structural functionalism, which has its roots with Durkhem, 1956). This interpretative approach enabled the individual perceptions of participants to be subjected to analysis. The first phase of the study which involved completion of a survey produced initial codes. These initial codes were then grouped into thematic categories. (This approach is dependent on my interpretation of the emerging themes from the categories and the subsequent analysis with the established predominantly pre-austerity literature around integration). Finally,

excerpts from the data were selected to illustrate the themes in the participants' own words (Braun and Clarke, 2006).

### **3.7. Trustworthiness**

#### **3.7.1. Rigour and methodological coherence**

Rigor addresses measures of quality applied before, during, and after conducting a study, which determine the trustworthiness of its findings (Nicholls, 2009). Lincoln and Guba (1985) document the criteria of confirmability, dependability, credibility, and transferability of findings as measures of rigor in qualitative research. A number of strategies were adopted to provide rigour to the data analysis and support the credibility and trustworthiness of my findings (Table 3.7). These include strategies outlined by Morse et al. (2002) that included methodological coherence, appropriate sampling and frequent supervision and debriefing sessions between the researcher and supervisors to discuss and explore pertinent issues pertinent to the project. In addition, reflection was a crucial part of the process allowing the development of a dynamic relationship between sampling, data collection and analysis, in addition to thinking theoretically.

Methodological coherence involves a 'good fit' between the underlying philosophical assumptions, the methodology of choice and the prescribed method in this study (Nicholls, 2009). That being, an interpretivist study framed within a social constructionist epistemology that is concerned with exploring the perceptions of community professionals on the impact of social workers from within the integrated Trust utilising a qualitative open-ended survey and interviews. I would argue my approach established confirmability, credibility and dependability of the information produced. Other strategies that ensured rigour included purposive sampling, consisting of participants who best represent or have knowledge of the research topic to support an in-depth understanding (Higginbottom, 2004) of social worker's contribution within an integrated Trust. Data collected in the initial phase via survey could later be verified in the follow up interview stage. Interview transcripts were carefully compared to the audio-recordings (verified) before analysis. Concurrent data collection and manual transcript analysis directed the study towards more prominent emerging themes (Nicholls, 2009).

Study Aspect	Data Collection Method	
	Survey	Individual, semi-structured interviews
Phase	1	2
Participants involved	Consenting Social workers Occupational therapists Nurses	Volunteer Social workers Occupational therapists Nurses
Data generated	Self-reported perceptions, feelings and challenges within an integrated setting	Front line staff perceptions on elements of integration and social worker contribution
Research question addressed	Yes	Yes

**Element of rigour addressed**      **Credibility, dependability, transferability, confirmability**

Table 3.7 Data Collection Strategies in the integrated social care and health study on the contribution of social workers within an integrated Trust

### 3.7.1. Reliability

To underpin reliability, I adopted Braun and Clarke's (2006, p. 87) six phases of thematic analysis; 1. Becoming familiar with the data. 2. Generating initial codes. 3. Searching for themes. 4. Reviewing themes. 5. Defining and naming themes. 6. Producing the report. In order to demonstrate rigour in this process the dataset was subject to careful transcription and

rechecking. I re-read all the transcriptions and re-read all the codes for each theme/subtheme ensuring they formed a coherent pattern (Braun and Clarke 2006). Familiarity with the dataset helped to avoid an anecdotal approach. Themes were checked and were deemed coherent, consistent and distinctive. Themes were not just descriptive but had been subject to analysis. That a good congruence between the extracts and the results of analysis was present. As this is an interpretative study I remained active within the research process.

Associated, pre-interpretations and interpretations that would have an impact on the analysis process were reflected on and discussed by me with my supervisors. Based on these discussions and reflections, critical issues in relation to the code assignments, themes and subthemes are highlighted (Thagaard 2003) throughout the thesis. It is crucial that I acknowledge my own positionality and its relationship with reflexivity within the research. As an insider researcher, the first thing to acknowledge is that the research was not value free (Carr, 2000 p. 347) and to also acknowledge that my own positionality is fluid and will change over time, always situation and context dependent (Oakley 1999). In being reflexive, I am aware and acknowledge my values, views and beliefs with regards to the research and my analysis of the subsequent findings. This process of reflection is on-going and enables me to be able to clearly identify, construct, critique and articulate my positionality. This process of reflection was also present in my method by adopting an iterative approach to the dataset and a constant process of reflection (see figure 3.1 above). My positionality not only shapes my viewpoint but my interpretations and understandings. I found it helpful to refer to Savin-Baden and Howell Major's (2013) who identify three ways in which I could accomplish positionality. Firstly, I need to locate myself as an insider researcher and my position within the Trust and its potential to influence the research. Secondly, I need to locate myself in relation to the professionals who are participating in the study i.e., considering how I view myself and how I am viewed by others, also acknowledging that participants may be unaware of how they have constructed their identities. Thirdly I need to locate myself in the research context which personally situates me as the first social worker within the integrated Trust to undertake such a project. As an insider researcher being reflexive throughout this process has been crucial to ensuring it remains a credible and insightful study.

### **3.8. Ethics and governance**

Ethical approval was gained from the University of Worcester and the local NHS Trust where the study was undertaken. Surveys were completed at the respondent's own discretion in a location in which the respondent was comfortable – most commonly their place of work thus minimising risks to their safety. Participants and their organisations were informed they would not be named in subsequent write ups and material submitted for publication.

### **3.9. Reflection**

In this chapter I discussed the method of analysis and gone through my process of thematic analysis. Whilst exploring qualitative analytic methods, it appeared there were predominantly two approaches, such as those analytic methods established within a specific epistemology or position and those who aren't. Analytic methods such as thematic discourse analysis, thematic decomposition analysis, interpretative phenomenological analysis (IPA) and grounded theory attempt to determine patterns across qualitative data is in stark contrast to thematic analysis. These approaches, although still looking for patterns in the data, are theoretically defined (Charmaz, 2002). Some methods, e.g. conversation analysis (e.g. Hutchby and Wooffitt, 1998) or interpretative phenomenological analysis (IPA) (Smith and Osborn, 2003) were not compatible with my data or my approach. In the case of IPA, it is wedded to a phenomenological epistemology (Smith, Jarman, and Osborn, 1999; Smith and Osborn, 2003), which is primarily concerned with experiences (Holloway and Todres, 2003), and is interested in understanding the lived daily experience of reality, so as to ascertain an understanding of the phenomenon being investigated (McLeod, 2001). IPA requires the adoption of a set approach adhering to a theoretical foundation whilst following a detailed procedural guide (Chapman & Smith, 2002). These approaches appear to have limited changeability in how one can apply the method within their framework. Other methods were also deemed not compatible with the stated aims of my research, such as discourse analysis e.g., (Potter and Wetherell, 1987; Burman and Parker, 1993; Willig, 2003) which is, primarily concerned with language rather than perceptions; grounded theory (e.g., Glaser, 1992; Strauss and Corbin, 1998) was not compatible with the stated aim of my research as I was not interested in producing theory of the phenomena generated from the data set (McLeod, 2001) but about exploring the research question, or narrative analysis (e.g., Riessman, 1993; Murray, 2003) which although appealing in that it allows me to tell a story by analysing participants stories does not allow me to code my data in a timely way that is required in this 2 stage study. The initial surveys required coding and thus interpretation in order to inform

the second stage, that of interviews. Furthermore, methods such as thematic analysis are viewed as virtually void of theory and epistemology, and so are able to be applied across a number of theoretical and epistemological approaches. Thematic analysis, despite often being framed as a realist/experiential method (e.g., Aronson, 1994; Roulston, 2001) is in essence independent of theory and epistemology and is compatible with both essentialist and constructionist paradigms within social sciences. Thematic analysis is a useful research tool given its flexibility and adaptability given its theoretical freedom, which can conceivably yield an in-depth and rich, yet intricate account of data. My research question is exploratory in nature, designed to enable discoveries to be made inductively through data collection and analysis. Thereby, conducting thematic analysis was compatible with my stated research goal. It is not wedded to ideology and a defined theory and gave me the flexibility to explore the socio-cultural contexts (cultural and contextual drivers of social work practice), and structural conditions (integrated working), that enable the individual accounts that are provided (perceptions) to be analysed through my interpretation.

### **3.10. Summary**

The chapter has presented the research methodology which underpinned this study and why the study design was selected. An outline of the data collection methods and analysis has been presented with more detail about the findings presented in the next two chapters. Ethical considerations have been described. I have considered how I undertook my own role in the study and its potential impact on my interpretation of the data through reflexivity

## **4. Survey data**

### **4.1. The pilot study**



The initial survey design was adopted from Lilo (2016) who was exploring structural integration in the North West of England as part of the Mersey Care NHS Trust Integrated Care Demonstrator Site Project and NHS North West Health Education Workforce Transformation Initiative. Lilo (2016) used 7 questions to explore integration in mental health services. My study expanded this to 15 questions with a clear exploratory focus on the line of questioning around integrated adult social work and health services.

The pilot study took place in March 2017. The pilot took place in a single integrated locality team with 4 participants taking part. 2 social workers, 1 nurse and 1 occupational therapist. The table below (Table 4.1) lists the questions that were initially planned and subsequently changed following the pilot study.

**Table 4.1. Initial survey questions**

**5. In the space provided can you indicate what ‘added value’ integration between health and social care brings to:**

**The service user?**

**Local authority?**

**The integrated trust?**

**Changes: Added in community care specifically to avoid confusion with acute services.**

**6. What disadvantages do you believe integration between health and social care brings to:**

**The service user?**

**Local authority?**

**The integrated trust?**

**Changes: Added in community care specifically to avoid confusion with acute services.**

**8. What are your perceptions of social workers in an integrated trust? \***

**Added roles and duties, responsibilities to aid understanding around social workers as perceptions only was deemed too vague.**

## 9. What is their specific/unique contribution (if any) to the functioning of an integrated locality care team (ILCT)?

Multidisciplinary was chosen as a term understood by all participants over ILCT

The findings from a technical aspect required that the survey be deemed safe and not blocked by the organisations filtering software. This will ensure that participants have as impediment free access to the survey should they choose to participate. This pilot also allowed me to experience the process of collecting the data, how it is received, anonymised and stored securely electronically. Going to back to the aims and objectives. Did the pilot data address these? Was the data sufficient to be subject to analysis. Despite my trepidations around the reluctance of participants to write copious amounts in reality these initial survey participants did have a lot to say and did relate back to my aims and objectives. In this regard I deemed the pilot a success albeit with minor improvements which I discussed above and moved on to commence stage 1 of my data collection.

### 4.1.1. Introduction

I have examined the responses to the survey from between June and July 2017 identifying key words of interest within the text, which subsequently lead to the emergence of subthemes or categories and themes that will now be discussed in this chapter. Initial inductive thematic analysis took place in June – July 2017. This interpretation informed the next phase which consisted of interviews. The data was revisited in December 2017 for final analysis.

**Table 4.2 Examples of themes from research data.**

Label/ Sub-category	CATEGORY	Main Theme
Lack of investment	RESOURCES	AUSTERITY

<p>Lack of training and support</p> <p>Resource constraints</p> <p>Understaffing</p> <p>Job losses</p> <p>Low morale</p> <p>Separate budgets and commissioning arrangements</p> <p>Reduced funding from LA (s75)</p> <p>too focused on targets not quality</p> <p>Pressure of work</p> <p>lack of time</p>	<p><b>FINANCES</b></p> <p><b>TIME</b></p> <p><b>STAFF</b></p> <p><b>SEPARATE BUDGETS</b></p>	
<p>social care not understood</p> <p>different culture</p> <p>Social vs medical</p> <p>different value bases and ethics</p>	<p><b>HEALTH VS SOCIAL MODELS</b></p> <p><b>WAYS OF WORKING</b></p>	<p><b>MACRO - CULTURE</b></p>

different priorities

social workers is often very  
'anti-medical' models

Health model

lack of respect

Blame culture

SW not valued

lack of awareness and  
understanding

struggle to 'fit' social care  
into health models, pathways

preconceived conceptions of  
SW

opinions

look at different concerns

lack of awareness  
understanding around social  
work legislation

misunderstanding of roles

no clear boundaries		
Them and us service		
Low social work morale due to the work culture		
Different perspective on promoting health and well being		
knowledge		
health care seems to be more of a priority		
Caseload is complex		

An example of codes applied to a short data segment

#### 4.1.2. Participation rate

The participation rate for social workers answering the survey was significantly higher than those of other professions (see table 4.2). There are numerous reasons why this differential occurred, most notably being that this study is concerning social workers and is being led by a social work practitioner. The data highlights that the majority of participants have been in an integrated post (after 2012) and so will be considered to have expert knowledge and able to make valuable and informed contributions to the knowledge in this area of integrated adult social care and health.

As discussed earlier the integrated Trust was experiencing a plethora of changes that impacted on service delivery. It is important to put the study in context. At this point in the research when the surveys were distributed and completed the occupational therapists had been made aware that

they were to be subject to change which may include redundancies. The survey responses were comprehensive which allowed for in-depth analysis which could then be explored further with interviews possibly generating new themes or sub-themes.

**Table 4.3. DEMOGRPAHIC CHARACTERISTICS OF THE SURVEY PARTICIPANTS**

Demographic characteristics				
Response rates				
	Size of cohort	Response Total	Response percent	
Social workers	159	21	13	
Occupational Therapists	109	7	6	
Nurses (figure is for all nurses acute and community)	1078	13	1	
Professional status				
	Social worker	51.22	21	
	Occupational Therapist	31.70	7	
	Nurse	17.07	13	

Professional status is key to identifying which profession was responding to the survey. The findings yielded four main themes from the survey data. The initial data set generated from the

comments boxes in the survey created four main themes: cultural differences, affects of austerity, organisational influences, political influences.

#### **4.2. Theme 1: Cultural differences: Social workers operate differently to health colleagues**

This theme of cultural differences includes data relating to professional identity, role valorisation, awareness and understanding, knowledge and skills. The issue around cultural incompatibility, the feeling of social workers being undervalued and underappreciated forms part of cultural influences that create this issue which is why these feeling fall into this theme.

Culture was clearly a prevalent theme with specific emphasis on social work and its contrast to the health and medical models. The narratives from those surveyed provided a clear sense of difficulty and frustration whilst trying to maintain and assert one's culture when subsumed by a larger force. The majority of comments came from social workers and appeared to be from a position of disempowerment and marginalisation.

*"It is very difficult for a small minority profession to be based in such a large health organisation. Social care and health see situations in different ways. Whilst this can be very useful, often the medical and social model clash. Social workers are more likely to have an understanding of positive risk taking, and often health feel risk adverse, which can make it difficult to work together for the service user."* (Social worker 73)

Social workers took the opportunity to divulge a plethora of statutory functions that they are duty bound to deliver on behalf of the local authority. It appeared that being misunderstood and underappreciated by colleagues was an underlying concern and so given the opportunity to inform others a significant proportion of social workers surveyed responded with a list of statutory functions (71%).

*Social worker role needs to be more promoted and out there so that others are aware what we do! Understanding around our roles, values, beliefs.* (Social worker 1) Social worker 1 is demonstrating the lack of awareness and understanding around the social work role.

Advocacy was repeatedly emphasised by all participants as a unique contribution that social workers make. Social worker 37 comments convey this view strongly with a clear social justice stance imbedded in the remarks.

*“We should be standing up for people, fighting for what is right, having services to meet the needs, act as an advocate, champion human rights, be there. Make people safe.” (Social worker 37)*

*“We should be promoting people’s well-being and enhancing the quality of life and enabling people to remain as independent as possible.” (Social worker 37)*

The cultural differences were frequently cited as a challenge and impediment to thorough integrated care, yet also referred to as a strength with social workers operating outside of the system giving a unique and often challenging perspective to the status quo.

*“Health managers above social workers do not understand social work and often approach challenges in our role from a business or health perspective with little understanding of the issues affecting service users and carers and little or no weight is given to needs that are not physical (health model approach) such as emotional, psychological, social/inclusion/relationships, housing, mental health or carers needs. Quoting the law also does not make an impact on supervisor or manager decision making.” (Social Worker 99)*

*“As the majority of senior managers have a health background I do not believe that they value what we do, or understand it.” (Social worker 36)* These quotes from social worker 36 and 99 reflect the feeling of assimilation by health, the erosion of social work identity and the frustration practitioners feel due to marginalisation.

What added value do social workers bring? 38% of nurses who responded stated they were unsure. 10% of social workers responded that there was no added value at all. The wider comments throughout the survey predominantly focused on being that social workers are unvalued, underappreciated and not understood by health colleagues.

*“social workers are not respected in their roles or given appropriate professional recognition, Mcdonaldisation of social services- loss of person-centred care as NHS push ‘health model’, no access for staff to legal advice and guidance (NHS do not have a legal team) means delays in legal practice or un-informed practitioners, significantly poor implementation of the Care Act (2014)- e.g. minimal preventative work, minimal shaping of care market, minimal commissioning in care market- currently we have a care market which is not diverse and does not have capacity to meet the identified need.”(Social worker 62)* Social worker 62 is demonstrating the impact of a poor understanding of social work culture and the consequences of a ‘health model’ approach to a



social care issue. This comment appears to highlight the lack of respect given to the 'social model' from within an integrated Trust.

*"I have never been made to feel so worthless in a 17-year career in social work."* (Social worker 36) This comment stands out and is particularly powerful and resonates with me as a social work practitioner as it highlights the considerable strains on the profession within the integrated Trust.

One worker summarised an area where social workers were overlooked yet considered experts in this field;

*"e.g. recently the NHS struggled with meeting Mental Capacity Act standards- i.e. nurses were not gaining valid consent under the MCA. The Trust did not consider how social workers are often seen as leading professionals in this area. Instead they made it mandatory to attend training on the MCA for ALL staff (including social workers) which was led by health professionals and exceptionally basic."* (Social worker 62) This implies that social workers were undervalued or perhaps forgotten about but clearly the perceived message is that social workers are not a core part of the business of the integrated Trust.

Interestingly nurses responded in a way that highlights the difference between them and social workers with one nurse stating that social workers are not task focused. The perceptions of social workers as the providers of care and all aspects of daily living such as housing and money persists even within an integrated setting with 6 nurses out of 13 responses stating that this was social workers primary responsibilities. Another interesting perspective is that nurses perceive social workers as:

*.. overworked. They seem to spend a lot of time at computers and on phones.* (Nurse 13)

The above quotes showcased the perceived cultural differences that are inherent in an integrated Trust. The quotes appear to emphasise the differences perceived by practitioners along with the macro level cultural differences that continue to permeate with health culture perceived to be subsuming that of social work.

#### **4.3. Theme 2: Affects of austerity: cuts have hindered integration**

This theme of the affects of austerity includes data relating to resources, finances, time, staffing levels and separate budgets. Austerity is the end result of political decisions that are

implemented by the organisation. The affects are significant and feature throughout respondent's comments as austerity is having a direct impact on practitioners and how they can deliver or not an integrated service.

A common thread throughout the various responses of the participants was their implicit and explicit references to austerity impacting on every aspect of workforce integration. Their narratives demonstrate respondents' beliefs that severe and enduring cuts to the public sector have resulted in a poorly integrated service where the important contribution of social workers has yet to be realised.

*"Austerity has torn the social care system to bits."* (social worker 36)

*"Budgets appear to cause issues... there is a tendency to shoehorn service users into categories... in the belief there is a bigger pot of money."* (Nurse 9) These comments demonstrate that finances cross professional boundaries and have a perceived impact on service delivery. This leads to retrenchment in order to protect what little one has which is the antithesis of integrated care.

There is a perception that cuts have been disproportionate. Nurses responded that they saw no added benefit to the Trust being integrated with social care or were unsure of any benefits. This is in stark contrast to the social workers' responses that indicate they believe that health gains an added benefit from being integrated with health colleagues gaining insights from their social work specialism. *"For health, it has benefitted health professionals, but I don't think it has been successful for citizens or for social care, social workers or the care market."* (Social worker 62)

*"Staff being expected to do more with less will lead to stress and reduced ability to consider the pressures that other professionals may be under."* (Social worker 57). This comment illuminates the affects that austerity has on professionals' ability to work in an integrated way when one is under sustained pressure themselves.

Several responses from nurses (31%) mentioned budget constraints impinging on the delivery of services.

Some respondents went further with 3 social workers going as far as stating that the resources required are not in place to deliver upon statutory responsibilities and provide key services. This is a small sample but a damning conclusion from these practitioners which infers dangerous practices as result of sustained austerity.

*“The Care Act sounds great but the reality is, it cannot be delivered within the current climate.”*

(Social Worker 36) Social worker 36 is emphasising here the current climate of austerity that is impacting on the ability of professionals to delivery statutory services.

It should be noted that 3 nurses specifically noted that social care is too expensive. That nurses made this distinction, that they separated social care from the rest of the Trust is interesting. It echoes some of the comments above that when one is under financial pressure one’s ability to see things from other perspectives becomes compromised.

The comments above highlight the perceived affects of austerity on the integrated Trust and its ability to deliver an integrated approach to health and social care. The quotes emphasise the resource constraints that professionals are under and how these restraints impinge on the delivery of an integrated service.

#### **4.4. Theme 3: Organisational influences: the structures have been poorly designed and are bureaucratic.**

This theme of organisational influences includes data relating to systems, information technology and processes. The structures that are in place to enable service delivery, streamlined ways of working, working across agencies/sectors. There are elements of the political within this theme as some policies and statutes dictate the direction and structure of the organisation. However, the distinct political elements are reserved for a separate theme.

The systems and structures within the organisation were a cause of concern for all professionals. The narrative that was consistent was an organisation that is too large and rigid in its approach to service delivery, inflexible in its delivery: *“It is the integrated organisation that is at the root of most problems.”* (Social worker 87) This comment by social worker 87 summed up the narrative that was present throughout the responses.

*“We are not an integrated Trust. We are co-located professionals.”* (Social worker 99) This comment illuminates the perception that true structural integration has not occurred rather co-location which if we look back at the comments relating to austerity could be a resource led exercise rather than one of truly joined-up working.

The organisation is structured in a way that seemingly ignores key differences in ways of working. Nurse 62 highlights this as an issue: *“integration means social workers and nurses in the same office which doesn't work. E.g. very difficult at handover when social work colleagues on the phones or having discussions.”* (Nurse 62)

*“Although we are in the same room we are not able to make direct referrals, they have to go through our SPA (Single point of access) desk.”* (Nurse 62) This comment demonstrates that although integrated in name that separate systems and processes remain. A system within a system that is unnecessarily bureaucratic.

The organisation is seen as poorly designed for the practitioners that it employs adopting a one size fits all approach that seemingly ignores specialisms required by its professionals. Social worker 33 illustrates this: *“mandatory training I need to know how to wash my hands but not mental capacity.”* (Social worker 33)

The comments appear to show an organisation that is not dynamic and fluid:

*“I have previously worked for a different Trust as a mental health social worker, and worked in teams that consisted of social workers, Community psychiatric nurses, occupational therapists, and support workers. we would also have daily team meeting which would include the profession mentioned, as well as psychiatrist and psychologist. Where critical cases and assessments were discussed, and all professional expertise feed into an outcome. I feel that this sort of approach is missing in the Trust.”* (Social worker 69)

The occupational therapists were subjected to changes in working practices as a result of the revisions to the Section 75 Agreement between the integrated Trust (who is the provider) and the local authority (who is the commissioner). They seemed astutely aware of the Section 75 contract and its role in service delivery within the locality.

*“I have very little faith that our organisation will overcome the challenges”* (OT 53)

There was a sense that the organisation operates primarily as a health care provider and not a health and social care provider: *“It feels as though the Partnership Trust sees social care as expensive and alien to them. They do not seem to have an understanding of the statutory responsibilities that they carry out for the Local Authority. They do not appear to feel accountable to social care in quite the same way. The objectives seem to be from a different perspective/priority.”* (Social Worker 34)

There were some noted benefits; with 4 nurses responded in the affirmative with regards to communication with other professionals having improved significantly since integrated care. However, nurses were equally likely to cite a lack of staff and thus a negative for service users over their social work and occupational therapist counterparts.

Nurses did make positive comments around how they perceived the organisation has been set up: *“it clearly makes sense to be integrated, as the professional boundaries have reduced, so staff are able to work closer together. the infrastructure for IT etc is in place, so financially it would not make sense to move staff again.”* (Nurse 74)

*“Multidisciplinary teams, I have learnt something new every day.”* (Nurse 64) This is a particularly significant comment in that it one of a few that actually highlight that learning has occurred between professionals. This may be at an individual rather than at an organisational level but it is encouraging nevertheless.

The comments above highlight the perceived affects that organisational structures have on working practices. The comments illustrate the strong influence systems have within the organisation on integrated ways of working.

#### **4.5. Theme 4: Political influences: integration and social work as a political football**

This theme of political influences includes data relating to polices and legislation. Data also includes that pertaining to the local authority and healthcare, Clinical Commissioning Groups, with section 75 agreements shaping organisations and thus working practices. Although not as prevalent throughout the data as the previous 3 themes there was a significant sample to warrant an independent political theme.

All professional groups that responded inserted pessimistic comments, it appears there is a quiet resignation that things are not getting better. It is an interesting facet and one which I will explore and analyse further.

*“Failure to 'drive' the integration agenda has allowed it to drift back to the 'silo' way of working.”* (Social worker 46) Social worker 46 is seeing integration as a failure of political leadership.

The narrative throughout responses was that social workers were powerless, a sense of being an issue that needed to be dealt with. The local authority had separated itself from its social work professionals by way of local arrangements and thus social workers seemingly didn't quite fit anywhere, this viewpoint was articulated by social worker 34: *"Being subsumed by Health and their agenda. Distance from commissioners. Limited 'shared' service users. Loss of Social Work values. Excessive, non-targeted communications. Lack of shared training opportunities. Different priorities. No emphasis on quality Supervision. Misunderstanding of roles. Lack of enthusiasm for integration. Lack of Social Care Managers."* (Social worker 34)

This political limbo creates a power vacuum with no single entity willing to take ownership of social work. This has resulted in feeling of powerlessness amongst the profession: *"We have no power or control anymore."* (Social worker 37)

Social workers weren't the only profession to see politics playing a role within the integrated Trust, nurses also observed that politics plays a huge role: *"Politics plays a huge part in how social care is funded."* (Nurse 8)

There was a coalescence of opinion about the role of politics in particular, in the relation to the provision of social care services.

The political agenda also drives policy such as austerity. This study has occurred in an age of austerity in public services and so given the responses and its significance to this study it has its own theme. Nurse 13's comments illustrate the political agenda: *"Government setting unrealistic targets that are unachievable."* (Nurse 13)

The comments above illustrate the role of politics within the delivery of health and social care services. Of course, the previous themes of austerity (which is ideologically driven) and organisational structures (as a result of policies and legislation) are inherently political but these comments teased out the overt political codes that led to the creation of this theme.

#### **4.6. Summary**

This chapter presented the key themes extracted from analysis of the text of 41 survey responses with regards to the impact of social workers working within the integrated Trust from community colleagues. Their comments present a stark reality perceived by social workers working within the Trust. These comments are not limited to only the social work respondent's but also reiterated by

the occupational therapy responses and to some albeit a lesser extent the nurse respondents. The theme of austerity and budgets ran through all the responses regardless of profession or length of service

## **5. Interview data**

### **5.1. Introduction**

In this chapter I present the data and themes extracted from interviews conducted with 6 voluntary participants, 5 of whom are social workers and 1 nurse (see appendix 6 for a raw data extract). The interviews were conducted between July and October 2017, transcribed by me,

which I reviewed by re-listening to each interview and reading the transcript. This was to check for accuracy and, if appropriate, alterations to inaccurate parts of the transcript were made. Data analysis took place between August 2017 and December 2017.

#### **5.1.1. Structure of interviews**

The interviews were informed by the initial survey responses to my research questions (appendix 1) which were designed to capture participants' views and opinions of the impact social workers have had within the integrated Trust. After the completion of the initial surveys, the context of the study changed again. In the subsequent period of time from survey completion to participants volunteering to be interviewed the change process had expanded to now include social workers who were now facing the prospect of redundancy or redeployment this was coupled with changes in working practices. This was an ongoing process during the period of interviews with no known resolution at the time of the completion of said interviews. The low volunteer rate of 5 social workers and 1 nurse should be seen in the context of the huge uncertainty that was occurring at the time of the interview process for the professionals involved.

#### **5.1.2. Participants**

The participation rate for social workers volunteering to complete a follow up interview to the initial survey was significantly higher than those of other professions with 83% of interviewees social workers with one nurse volunteering and no occupational therapists. Based on the responses from the survey four themes were identified using thematic analysis. These themes were then utilised as a discussion point during the interviews to enable further exploration.

#### **5.1.3. Limitations of sample size**

There was only a single nurse interviewee who volunteered and no occupational therapist. This single viewpoint however still has validity allowing me to look at integrated care in terms of how it varies from social workers perspectives of integrated care rather than merely reducing it down to how many nurse interviewees were conducted (Pope, 2006). I was aware of the limitations of this single response from the nurse practitioner and the danger that they could be stating what they think I wanted to hear with regards to integrated care. However, to mitigate this I also considered how the participant structured their response, talked about integrated care and their



body language and nonverbal communication for example. In addition, I also was mindful of the response and analysis that I had undertaken with the survey data prior to this interview.

Boddy (2016) states that a single research participant, a single sample can provide reliable indicators for research. Boddy goes further and states that single cases can also generate original, profound and nuanced understanding of previously unexplored phenomena. Additionally, qualitative researchers have stated that often a researcher can(unknowingly) from their first piece of data have all the information they need (Sandelowski, 1995). It is similarly claimed that the ability of case studies to generate theoretical generalisations has been undervalued (Tsang, 2014). As my research took a constructivist approach I was concerned with gaining a depth of understanding rather than a breadth. Boddy (2016) makes the point that a single participant can produce great insight and understanding and be of significant importance to the study.

## **5.2. Overarching Findings**

The findings complemented the survey data, highlighting a further exploration of the themes that had emerged from the initial survey. This second phase of the study consisted of interviews that allowed for greater depth and exploration and presented a rich narrative which is presented below. The data were then subject to thematic analysis (Braun and Clarke, 2006).

I will be present in these findings, giving my opinions and interpretations of the data in Lucida Fax font.

## **5.3. Theme 1: Cultural differences: Social workers operate differently to health colleagues**

Professional and organisational culture was explored with the prevailing responses suggesting that a health dominated culture persists within the integrated Trust.

The nurse interviewee although being the only nurse who volunteered to be interviewed provided a unique and insightful counter viewpoint from that of the social worker volunteers. The idea of a health culture was showcased in Nurse 1's comments:

*"I think we are top heavy on people from a health background. We didn't understand. We thought we understood but we paid lip service to it. We had no idea. It was not just about going out doing the assessments or making sure someone has somebody coming in 3 times a day it was about everything else that goes around it, what are the eligible needs, funding streams, lasting power of attorney best interest decisions. I don't think nurses ever got that."* (Nurse 1)

*"Everything was very health mentioned, corporate meetings they wouldn't even mention social care. I still think the way the service is the health stuff always dominates. Reality is very different until we have pooled budgets it will never work."* (Nurse 1)

This was a somewhat refreshing acknowledgement from a nurse of the feelings that social workers had been expressing throughout my research. The validation of their marginalisation is particularly enlightening to me as it lends creditability to my earlier findings.

The cultural differences are highlighted by Nurse 1:

*"Nurses and social workers, OT's physios we all approach things a little differently. I think it is about the emotional intelligence of the team leader. I do think having separate line management works. I think professional identities get lost, it can make staff protective and can cause conflict. In supervision, the nuances are not picked up from a different professional group."* (Nurse 1)

*"I still think the average community nurse does not understand what a social worker does. It doesn't come with a day shadowing."* (Nurse 1)

I was surprised by the candour of the nurse respondent but the discussion echoed the findings from the survey data where nurses appear to not want to know what a social worker does, separate and distinct cultures appear to still prevail 5 years after structural integration. A new shared culture does not appear to have occurred within the integrated Trust. Upon reflection, this supports my believe that it is a cultural trait learned through training and education that is very difficult to overcome. The sense of being different from one another (health and social care) was also explored from a nurse perspective:" *Fundamental*

*difference is that health being free and that social care is means tested.*" (Nurse 1) and from social workers perspectives:

*"We are very different. We are a different profession and that's why we train the way we do and they train the way they train."* (Social worker 1)

*"I think health colleagues get really frustrated by us."* (Social worker 3)

The sense of being undervalued, underappreciated, misunderstood and underutilised was a persistent theme and I would argue was a sub-theme within the interview data. The perceptions of social workers being undervalued was expressed by social worker 2:

*"Social work is undervalued, very undervalued, our opinions are undervalued, we are seen as a reason for a delay, why this service hasn't been put in place, our professionalism doesn't carry the same weight as other professionals I don't think it does."* (Social worker 2)

This was reflected in further interviews where social worker 3 expressed concerns that social workers are only called upon to deal with difficult and risky situations.

*"I don't think that has changed. I think that (health) are still more risk averse, they will say to relatives talk to the social worker about it. They (health) don't want to say no, they don't want to deal with that difficult conversation but we are expected to."* (Social worker 3)

Social worker 1 frames the context as a battle where neither side is the victor and ultimately it is the service users and carers who are paying the price: *"No, it is worse, worse than it ever was before. Trying to force our views, our values, our priorities onto health and health forcing their priorities on us. All it has done is watered everything down."* (Social worker 1)

Social worker 6 goes further stating that social workers are being actively encouraged to conform to the medical way of working.

*"I think that nurses work to a task centred model, I think there has been a lot of pressure for social workers to model their ways of working."* (Social worker 6)

Culturally we remain distinct and separate professions, and through speaking with people it would appear that this form of integrated care has solidified these positions with professionals feeling under threat rather than a valued resource and asset within the integrated Trust.

*“The way social work is valued against a nurse has a huge effect.” (Social worker 3)*

*“The organisation, the Trust, I think it comes from very high up all the way down. A lot of social workers feel undervalued that it hasn’t been integration but a take-over.” (Social worker 3)*

The issue of the value of social workers and their sense of self-worth of course resonates with me as a social worker. It is problematic being a sounding board for a disgruntled group of professionals but I have acknowledged my own position within the research and continue to do so. I work within the organisation I am researching and so cannot be anything but engaged with the project. I would argue that this insider perspective gives a richness to the data and my interpretations are more aligned to the reality of social work (albeit not the nurse respondent), the lived experiences of the participants working within the integrated Trust environment than if I were external to the integrated Trust.

The issue of role clarity and professional identity was discussed in interviews with social workers with social worker 4 commenting that *“We definitely haven’t maintained a professional identity. Maybe there is room now to bring some of that back with all the changes.” (Social worker 4)*

*“I think we need to be more in the frontline social workers seem to take a back seat, you only want the social workers to sort out all the rubbish basically. When nobody else wants to do the work that is when they want the social workers.” (Social worker 4)*

Social worker 4 notes the cultural clash and the lack of a shared culture within the integrated Trust: *“It will always clash, it will always be medical vs social. You need something in the middle to join them together.” (Social worker 4)*

There appears to be a sense of despondence from this interviewee: *“We are kept in the dark, not even forgotten about just missed off the list.” (Social worker 4)*

*“For the bulk of staff professional identity and responsibility has been taken away.” (Social worker 6)*

This sense of feeling left out, forgotten about has come across from all professions. Reflecting on the data it would appear that participants perceptions of social workers are that of a tokenistic profession, tacked on to a healthcare infrastructure. The feelings come through in the data and

particularly in interviews where passions run stronger. Subsequently this appears to have developed a sense of solidarity amongst social workers within the integrated Trust.

The sense and scale of feeling of abandonment of the social workers is expressed in the comments from the social workers below. Along with the development of a singular social work culture that is perceived to be under threat from the integrated Trust.

*“I think as an integrated Trust we were being eroded anyway but the added stress of the local authority who effectively are abandoning us it’s a double whammy for us.” (Social worker 2)*

*“I think we have had to rely on each other, we are alienated as we don’t have the support structure in place as higher management are health.” (Social worker 2)*

*“We are starting to fight now. We are becoming a bit more, identifying our roles more, we are advocating, fighting and challenging, we are having to justify.” (Social worker 4)*

*“I don’t think our role has changed, if anything it has made us more, woken us up to the challenge.” (Social worker 4)*

This notion of solidarity seems to be a direct result of alienation that social workers are feeling within the integrated Trust. This is an interesting phenomenon that would be worthy of further study.

Social workers also reported negative perceptions of them from colleagues with social worker 5 noting: *“A health colleague stated all you social workers do is sit on your asses typing.” (Social worker 5)*

And positive experiences they have had of working with health colleagues with social worker 6 commenting: *“I can come back and draw from the medical side, from the staff that are there. I have learnt a lot, I have learnt a lot.” (Social worker 6)*

The interview data although exploring the 4 themes I had identified in the initial survey allowed a greater depth to be explored. Cultural differences are apparent and I would argue as a result of the interviews two sub-themes were identified within the data this being one of value and the other being professional identity.

#### 5.4. Theme 2: Affects of austerity: cuts have hindered integrated care

The interviews captured I believe the passion of feelings around the issue of sustained austerity. To be able to see the emotion, body language and hear the intonations within interviewees accounts lead I believe to a deeper understanding of the context from which I am interpreting the findings.

These comments produced some very strong data with feelings emerging of a very dejected workforce not only were those feelings emerging from social workers but from the nurse too.

*“We have integrated in name and where staff are based only. Because if we hadn’t got such austerity and we hadn’t got such limited staff resource, equipment resource, even the limit on what rooms you can book for integrated team meetings and that really impacts on integration.”*

(Nurse 1)

*(Austerity) “Yes, I think it has a huge impact now, I think social care they make it feel like it’s your problem. We are questioned how many times do you have to visit, can’t you do it in one.”* (Social worker 3)

*“Services are, there is hardly anything out there and it is very frustrating, it is very difficult trying to be integrated as nobody knows who should be doing what, whose role is what.”* (Social worker 4)

I think this data reveals an interesting insight into the realities of modern health and social care in an age of austerity that I recognise, ‘style over substance’ and ties in to the previous findings of integrated care on a budget. My feelings being this is an honest account of the realities of modern health and social care in an age of austerity. It feels like an authentic lived experience rather than a corporate soundbite.

The comments below from social workers and the nurse interviewee reflect the despair frontline professionals within the integrated Trust are facing, this is the current reality of community public service provision.

*“For us as nurses we can’t do it on no money, no flexibility in the budget just cannot do it.”* (Nurse 1)

*“It is difficult to get any service for anyone these days and it’s all heading towards privatisation.”*  
(Social worker 5)

*“In terms of nursing staffing there have been no cuts to that. Again, we don’t have a lot to do with the nurses, it is still very disjointed.”* (Social worker 5)

*“We are co-located but I think that is a by-product as we have to reduce the number of buildings as a Trust. There is nowhere to have private integrated team meetings, no action learning sets and not only can you not find a place but you cannot go anywhere because of the staffing levels.”*  
(Nurse 1)

*“They are not giving us the tools to do the job. It is all lip service.”* (Social worker 2)

Again, resources are seen as key and this has certainly been my experience as a practitioner throughout this research with room availability to conduct interviews being a key stumbling block.

Social worker 3 also commented on the loss of professional identity and this should be understood within the context of austerity as social workers are perceived to be of little value in an age of austerity and so are overlooked: *“I don’t think they see us a resource, I don’t think they value what we do. I don’t think the health side understand what we do... The autonomy has gone, totally gone.”* (Social worker 3)

*“I think there are a number of dimensions to it, there are information governance issues in sharing information. I think to some extent the technology is poor but the internet does work but it’s not, it’s not as bad as it was. I don’t think we always have the fanciest stuff, but then what area of the public services does have this.”* (Social worker 6)

The strength of the data here is compelling and provides depth and clarity to the initial survey data. Adding the human element only serves to inform my understanding and interpretation of the data. The issue of austerity certainly appears to underpin all of the themes I have identified and warrants further consideration in the discussion chapter.

### **5.5. Theme 3: Organisational influences: the structures have been poorly designed and bureaucratic.**

The tools that are required to facilitate and drive integrated working are simply not present and this was put succinctly by Nurse 1 who comments: *“Technology – the way forward is better technology systems that talk to each other. There is no money so we can’t have that. We have been integrated for 5 years, we still use different systems, we still have systems that don’t talk to each other.”* (Nurse 1)

We appear to be trapped in a cycle with an ever-decreasing pot of money and a government that is pursuing economic austerity that appears to have a direct correlation to the policies they wish to implement. A little Keynesian economics would appear to be necessary in order to push integration forward in an effective way, with public spending and/or taxation as the crucial issue needed to drive integrated care forward. I would agree that technology and infrastructure is wholly unfit for purpose for the task at hand.

Social worker 1 comments that rather than joined up approaches things remain distinctively separate: *“It’s just took it back to separating things... services now for health are very much seen separate.”* (Social worker 1)

Interestingly it appears that early on within the integrated Trust where co-location and separate ways of doing things remained for each profession appears to be perceived by the interviewees as the favoured model of integrated health and social care rather than the status quo of one size fits all approach: *“If we looked at integration 5 years ago, I would have said we were co-located and it worked really well. If you asked me that same question today I would say we are further apart than we were 5 years ago.”* (Social worker 3)

*“I think if they had integrated properly in the first place, if that had been managed correctly at that time it would have had a massive impact. If there had been a recognition of the different roles and responsibilities. They got it wrong at the beginning. They didn’t take into account the different professionalism, priorities, models medical and social models.”* (Social worker 1)

*“Not invested enough time into how this integration is going to work. I think it worked far better when we were under the council. You knew where you were, what the vision was and there was an understanding by senior management that is lacking now.”* (Social worker 5)

Reflecting throughout the findings it appears that a consistent theme is that in principal integrated care is supported but the reality locally is that feelings are it was not supported, the structures were not in place and thought



through. If I reflect on my own position within the organisation I can see the disparities that exist because of contracts. It is not a seamless, flexible structure but rather a monolithic organisation that is competing for multiple contracts with competing objectives. There appears to lack a single direction and therefore staff do not appear to understand the vision. This appears to be a different sub-theme that has emerged from the interview data one of a substandard infrastructure having an impact on the integrated Trust and its ability to delivery truly integrated services.

Co-working and co-location emerged as a separate theme within the interview data with social worker 2 and 3 commenting below:

*"In terms of our integration, we have always co-worked but the difference is when we had the local authority we had support as they are an external to the integration. For us we are the same Trust, same leadership, same directors and being pulled in a very different direction. A lot of the higher management are health and they don't look at the social side of it."* (Social worker 2)

*"I think co-location absolutely, that worked really, really well. I don't think you can be truly integrated, you are both looking at totally different things."* (Social worker 3)

Unsurprisingly co-location is seen by social workers as having worked historically whereas structural integration is not seen in nearly as favourable light.

The feelings of social workers being devalued and ignored although mentioned in the previous cultural differences theme is also relevant here given the context of the comments which I would argue are within a structural and systems context rather than one merely concerned with culture.

*"Social worker's feel devalued, deskilled and underappreciated. It doesn't matter what level you are on if you are a social worker you feel devalued."* (Social worker 1)

*"I don't think social workers have any influence on the direction the Trust is going. Health see social workers as a nuisance. We are seen as being difficult and awkward. We are trying to do a job in the way we have been trained to do it."* (Social worker 1)

*“The social model is not on health’s radar. Nurses have no clue, regarding charging for services, they don’t care and don’t want to know.” (Social worker 1)*

*“Basically, there is more understanding. I think there is more understanding of what we do and why we do it on a lower level. They don’t want to know the detail.” (Social worker 1)*

These responses are unsurprising given the initial findings from the survey data. It also aligns with my experience as a practitioner researcher within the Trust that for the majority of staff, learning appears to be superficial rather than any in-depth understanding of each other’s roles and to be fair as discussed throughout; austerity, and staff, and resource pressures give staff little time to focus on anything other than their own specific role.

*“I have had good working relationships with district nurses as individuals not as a whole. It is very hit and miss, different priorities and different pressures. Collaborative knowledge and sharing tends to go by the way side when there are differing priorities.” (Social worker 6)*

The issue of a lack of same professional management was also highlighted as an issue:

*“One of the difficulties is you haven’t got any social work management; you have nowhere to go, because health colleagues think different to us, values are different to us it is really difficult for them to support you as a social worker.” (Social worker 3)*

*“I think the Trust structure has hindered integration the social work leadership was an afterthought that came later and even then, that did not come from within the Trust as it was a national agenda that imposed that role on the Trust.” (Social worker 6)*

This for me is a key point that is highlighted throughout the survey data and the subsequent interview data and does resonate with me as a social work practitioner being managed by a nurse. The feelings, the thoughts are similar to ones that I have experienced and discussed in my own supervision. I think the concerns expressed are valid and justified in the context of the working environment.

The feeling of structural inequality was reflected in social worker 5’s comments: *“The integration is structured in a counterproductive way... No, it is very much health dominated, management are very much health orientated, not very much social care managers, I feel we have just been side-lined.” (Social worker 5)*

The comments discussed throughout this theme reflect on the impact the organisation can have on delivering integrated health and social care services. As mentioned above a sub-theme emerged that of substandard resources and the affects this has on integrated services. An additional theme also emerged from the interview data one of structural integration vs co-location and one that I will explore in my discussion.

## 5.6. **Theme 4: Political influences: integration and social work as a political football**

Exploring the theme of political influences revealed more nuances during the interviews such as the policy drivers and party-political factors that have a perceived influence on the integrated Trust.

*“Politically there is so much pressure for us to be integrated. I think it is the best thing for the service user but we have to be truly integrated and not in name only. Because it is written in an STP (sustainability and transformation partnerships) it’s going to be a thing. Well we are integrated look we have social workers in the same Trust.”* (Nurse 1)

*“The CCGs seem to be driving this forward.”* (Social worker 2)

*“I think there has been a huge drive from the conservatives.”* (Social worker 3)

*Social worker 6 goes further and acknowledges that “It is politically driven but also links back to the inherent differences between health and social care.”*

*“I think that it is seen as something that cannot fail. Not just the money, but the political will, that people’s names are attached to this project. It goes beyond just funding the NHS is free at the point of need but with the local authority there is the means testing and costing. It is easier to provide a community health service that is free for people and much more challenging to provide a service that they may not want and might not be able to afford. There is all these tensions, legislation and value base.”* (Social worker 6)

It is fascinating that social workers tend to attribute blame to political elements, clinical commissioning groups, local authorities and yet the nurse interviewee appears to be more objective and doesn’t appear to share this

view point. I would postulate that this is due to the statutory nature of social work which often sits within and closer to legislation and policies than their health colleagues.

The constant state of flux services finds themselves in as a result of the commissioner/provider model of service delivery is reflected in social worker 4's comments: *"I thought it was getting there up to the changes (s75 revisions), it was very much an open forum. But now it is who is doing what...who is doing what, it is all about costs and money and people don't know what they should be doing."* (Social worker 4)

This viewpoint I believe is fundamental to understanding modern day social care and health services that are constantly producing tenders and bidding for services from commissioners. The result being continuous change and expectations.

The sense that this is at worst a failed project and at best has significant room for improvement is reflected in social worker 5's comment: *"Not worked. I think we are not very popular as social care, it's almost like god you're a burden, I think they do not realise what we do, the cost, the severe challenging cost it is."* (Social worker 5)

## 5.7. Summary

This chapter presented the key themes extracted from analysis of interviews with six participants who discussed their perceptions of social workers within the integrated Trust. Their comments present a range of opinions on the current structures and policies that inform and shape social work's practice and influence within the integrated Trust. The political drivers and influences were acknowledged and particular reference was made to the impact of austerity on the delivery of truly integrated services.

## **6. Discussion**

### **6.1. Introduction**

In this chapter, I discuss my findings in relation to the original proposal. The previous chapters presented findings from existing literature in comparable areas of study. The codes and subsequent themes that emerged from the dataset were also presented in previous chapters. Elements of this doctoral study have published in the journal of integrated care (Appendix 4)

If I frame the discussion within systems theory, I can see the components that are joined together dynamically producing an effect which in turn generates influence on other components and systems. Systems occur on a range of comprehensibility: they can be simply observed and analysed (e.g. supply chain) to highly intricate or original demanding postulation (e.g. shared culture). Common features that are usually present in systems are that they are self-organising with dynamics occurring from the systems component parts; these parts are connected (and so is the system) and affect each other; the system is constantly adapting and changing. Systems are also seen as resistant to change which I will discuss below particularly around culture within the integrated Trust.

Applying a systemic lens to my analysis and discussion was useful in aiding my understanding of the dynamics underpinning the system, how the association between system components affect its functioning, and how these can inform good practice. This approach allowed me to understand the system structure and ways of working. It requires me to have an understanding of what exists between the components, their relationships, and the gaps between what is known. In this respect it complements the exploratory nature of my study and allows me to explore the social work role within the integrated Trust.

My study emphasised the perceptions of a sample of community professionals practicing within an integrated social care and health care setting working for one integrated organisation. The codes were initially generated from an electronic survey with subsequent transcripts from a series of follow up interviews with professionals that explored their perceptions of austerity, culture (professional and structural), alienation and learning within the broader context of integrated social care and health environments. Austerity was not initially a focus but rather emerged as a key theme following data analysis. As such, the purpose of this discussion is to explore the key themes austerity, culture, organisation, political and how these themes can contribute to understanding the current perceptions social workers and other professionals have of social workers working in such integrated environments. Participants' accounts also revealed an acknowledgement that change is a necessity based on the social demographics in the UK pointing to an ageing population and current policy and legislation that mandates closer structural integration between health and social care (Jaafari, 2003). Concern with how meaningful change can be achieved, who is responsible for what aspect of service provision, accountability and risk management is a necessity before such an arrangement can possibly hope

to function effectively (Ahgren and Axelsson, 2005; Glasby and Littlechild, 2009). The participants all worked for an organisation that on paper had been integrated for the past 5 years, their responses despite being integrated for this significant period of time still adhered to traditional concepts of service delivery needs (Ovretveit, 1993; Malin, Wilmot, Manthorpe, 2002). There appeared to be little to no evidence within the responses of the participants of innovative practice occurring within the integrated Trust and instead the responses suggested a retrenchment of positions that served to reinforce the polarising effects of silo working. This ability to work together effectively (or not) appears to be dependent upon a shared vision, with organisational and managerial support; alongside strong professional leadership. These are qualities that participants accounts clearly and decisively indicate are lacking within the organisation. Social workers reported feeling assimilated and marginalised whilst nurses and occupational therapists perceive social workers as a drain on resources and challenging to the status quo.

What comes through in the responses is a deep-rooted fear or ambivalence towards integrated care (the merging of two cultures) and how we manage knowledge throughout such a complex system with competing interests and cultures (Brown et al, 2003; Attwood et al., 2003; Ahgren and Axelsson 2005). Change through policy initiatives, legalisation and guidance is a constant factor in the public sector and society today. The move towards integrated and joined up working has previously queried respective agencies actual capability to differentiate between health and social care when working with vulnerable or older people and their families to meet their complex needs. Integrated working tests traditional notions of service delivery, through keeping a clear awareness of the service user, lessened dependence and by providing services of good quality for individuals with complex needs (Ovretveit, 1993; Malin et al, 2002).

The key issues identified from this study have emphasised challenges in respect of integrated working. These were:

- Conceptual confusion in regard to defining/organising/structuring integrated care within a health organisation
- Cultural biases and clashes of culture within an integrated care organisation which result in a negative experience for professionals and confusion for service users and/or carers.

- A lack of mutual knowledge and respect between professionals, a lack of transparency and vision from strategic management to front line professionals.
- A lack of shared socialisation and the development of a shared culture.
- The impact of economic austerity.

## **6.2. Cultural biases and clashes of culture within an integrated care organisation**

Cultural differences emerged in the survey data and emerged during the thematic analysis and the creation of subthemes which clearly showed a coalescence around this key theme. The survey data in this area was copious and thus I interpreted this theme as having resonance with those participants who responded. During follow up interviews this theme elicited passionate responses that provided a richness to the data. The responses indicated key factors that were apparent in their effect on social workers within the integrated Trust. Factors such as the maintenance of professional identity, the importance of professional supervision, the prevalence of health culture over the social perspective and the issue of the perceived value of social workers being some of the key factors that emerged. These factors impacted on job satisfaction and professional contribution within an integrated team.

### **6.2.1. The social work role**

One of the key questions asked of participants is their understanding and perception of the role of the social worker. In my study participants expressed concerns around the ability of social workers to fully be utilised and to effectively inform the assessment with a social perspective rather than to be underutilised as a tool to complete a specific task. In the interviews the social work participants expressed a sense of being marginalised and not being valued for their unique contribution to the assessment. This perception was not limited to just social work responses with both occupational therapists and nurses who responded to the survey also reporting that social workers seemed under-resourced and misunderstood within the organisation (Ni Raghallaigh et al., 2013). In response to the survey question regarding the role of the social



worker, nurses and occupational therapists acknowledged some of the complexities of the social work role in their responses even though they also acknowledge that they have a limited understanding of the role. The ability of social workers to fully utilise their knowledge and expertise around the social model seemed to be constrained by systemic factors; organisational constraints that are prescriptive and an inflexible system with limited resources. These constraints are in part a result of continued and sustained budget cuts driven by a policy of austerity in a time of increasing demand on social care and health services. Consequently, social workers' time is often spent recording on systems to capture the work they have undertaken and this is captured in the responses by health colleagues who perceived this part of social work to be a key function of a social workers being; how much time social workers spend on the computer and phone and the importance given to such tasks as compared to health colleagues. This of course impacts on contact time with service users and limits the social worker's ability to provide support and advice that face-to-face engagement with service users and carers affords. In addition it limits the social workers ability to effectively advocate on their behalf (Mizrahi and Berger, 2005). Advocacy was another key code in responses and one which has come to the fore within the integrated Trust.

The integrated Trust being health led and dominated attempts to diagnose, quantify and pathologise people. Indeed, responses picked up on this element of health culture creeping into the social model of welfare with social workers increasingly asked to quantify the unquantifiable in order to access budgets and services that are ringfenced to certain criteria. Repeatedly this code emerged: social workers are holistic. That is to say they look at the big picture, at competing interests and that their work is shades of grey and is not black and white. This is a fundamental difference in approach that cannot be addressed within one organisation (the Trust). It may be that a mutual respect and understanding of this aspect of social work, an aspect that is not clear cut but ambiguous would allow social work to flourish within the Trust without being curtailed by prevailing health doctrines and for the Trust this approach would allow it to gain that unique insight and critical friend.

Role clarity appears to be a pertinent point that emerged in responses, this is reiterated in the responses from social workers in particular that suggest that nobody else knows what they do and can limit how often social workers work to their full potential of practice. The responses suggest that social work ideology and practice are not always understood or valued by other health colleagues. This view is supported by existing research within other disciplines in health

care that suggest a correlation between underutilisation and issues around role clarity and role confusion (ReeseSontag, 2001; Hepp et al., 2004). Shor (2010) suggests that “team members may not realise the other professional’s potential contribution, and thus will underutilise their expertise, knowledge, and resources when defining problems and developing solutions” (p. 348). Furthermore, research conducted by Mizrahi and Berger (2005) supports my current survey and interview findings by reporting persistent feelings from social workers’ working in multidisciplinary settings of ‘devaluation of or competition with social work’ from their health colleagues (p. 160). This connection noticeably appeared in my studies data with social workers consistently bemoaning the lack of understanding of their role within the integrated Trust. It may be that these factors have impeded the full integration of social workers, in addition to undermining the effective collaboration among health and social care professionals. Social workers are not always given the opportunity to apply their full knowledge and skills, which may be attributed to role clarity issues as well as time and resource constraints.

#### **6.2.1. Professional identity**

The participant’s responses about the importance of professional identity link closely with the existing comparable studies conducted in this area albeit within a mental health environment (Brown, Crawford and Darongkamas; Huxley et al., 2005; Bogg, 2008; BASW, 2010; Coppock and Dunn, 2010; Gould, 2010; Nathan and Webber, 2010; Hannigan and Allen, 2011). These studies highlighted the value participants placed on their unique social work identity within integrated community mental health teams. The researchers argued that it is the responsibility of social workers to retain their social work identity, this can be achieved by professional and personal development through continued learning. This is in response to a perceived threat to one’s identity when seconded to the National Health Service by a Local Authority (Bogg, 2008). My study explored these perceptions further with social workers working directly for the Trust, not seconded and having minimal or no links back to the local authority. This has created a dichotomy for the social workers where they feel that they do not belong anywhere and this is reflected in the responses. Similarly, one of the recommendations of my study is one of self-preservation, that professionals need to shift to a more radical social work practice and take ownership of their status in a system that is predominately not interested in their unique perspective but merely in delivering the bottom line. This has interesting parallels with research around resilience in social work such as that of Beddoe, Davys and Adamson (2013, p. 102), which indicates that resiliency is

supported by factors that reside within individuals and are linked with the educational preparation of practitioners. Thus, resiliency is a necessity if social workers are to thrive within the integrated Trust. The existing arguments put forward in the literature and the responses from the current study are consistent with arguments regarding the importance of developing and maintaining a social work identity within multidisciplinary teams (British Association of Social Workers, 2010). There have been many empirical studies conducted in relation to social work identity the overwhelming outcome of these studies has been that social work professionals are not comfortable working within a health dominated environment (see e.g. Blinkhorn, 2004; Beddoe, 2013). Participants in my study also articulated the limitations of integrated care around established core social work functions and roles fulfilled by social workers as well as social worker related training and education being fundamentally different to those of nurses and occupational therapists. This was highlighted in the responses as a significant factor in the division that appears to be present between the professionals within the integrated Trust.

The prevalence and importance of professional supervision by managers with the same professional background was apparent within participants accounts of integrated working; interlinked with issues of identify as discussed above, these responses appeared to be consistent with opinions about the role of supervision in forming a professional identity and its importance in creating a good working environment (Carpenter et al., 2003; BASW, 2010). Participants also criticised managerialism and the ethos of performance over all other considerations; these challenges have also been acknowledged by previous research (Noble and Irwin, 2009). Interestingly the perceptions from nurses and occupational therapists in the responses are consistent with established literature on the subject. After 5 years of integrated working the knowledge and opinions of social workers appears static, as if there is an ingrained cultural bias, their opinions were predictable and very difficult to move from that established mindset. The social workers perceptions of themselves and how they perceive how others view them is one rooted in the established culture that has developed through social work training and values; to be astutely aware of power differentials and dynamics. Therefore, what better place to use these analytical skills than within an organisation that social workers perceive has assimilated them or attempted to assimilate them into a dominant and homogenised culture. These preconceived challenges to social work identity I would argue will always be present when dealing with professionals who have fundamentally different viewpoints, knowledge, skills and experiences.

The social work respondents were clear that they perceived social work as under threat, that they feel constantly challenged, with attempts to dilute their status and standing and this feeling is consistent with past concerns that were expressed when the approved social worker role was expanded to include health colleagues (BASW, 2006).

#### **6.2.1. The erosion of social work**

The responses from social workers who participated in this study were predominantly negative, more so than from health colleagues. I would argue, and this is also the argument put forward in existing literature that the constant erosion of role and identity increases social workers stress and thus decreases job satisfaction and reinforces their negative perceptions of working for the integrated Trust (Carpenter et al., 2003; Evans et al., 2006). A significant finding from the responses and a category that emerged within the data set when subject to thematic analysis, and perhaps a more imperative one was the perceived lack of respect for social work in general. Social workers, nurses and occupational therapists attributed this to limited understanding; interestingly the perceptions of what colleagues thought social workers do and what they actually do varied significantly with a clear finding that the recognition of the fundamental differences in approach to practice, ideological underpinning and theoretical approaches to practice between social work and more medically oriented professions being severely lacking. Barnes, Green, and Hopton (2007) support this finding agreeing that there are “far-reaching differences between social work and health in terms of their respective remits, theoretical understandings of need, knowledge base and research traditions” (p. 191). Many social work respondents expressed concerns of alienation and the notion of being an outsider within and that their professional opinions and unique skill set are not always respected, acknowledged or utilised.

#### **6.2.1. Ambiguity within integrated environments**

Research has shown that divergence in values and theoretical base between professionals within an integrated environment can adversely affect collaboration (Reese and Sontag, 2001; Rämgård, Blomqvist, and Petersson, 2015). Bailey and Liyanage’s (2012) work around ‘disciplinary contribution’ supported this finding arguing that “an approach combining the medical and social models underpinned best practice” (Bailey and Liyanage, 2012, p. 1127) and was also beneficial to service users. The current studies responses indicated a lack of a combined approach with no

imbedded practice or cultural norms around integrated working. The participant's responses revealed that silo working is still the de-facto way of working and that notably co-location worked well and was the preferable model. Communication and training was reported by respondents as inconsistent and lacking and that the role of social workers was stated as not understood, or not sure what they do by professional colleagues that have been working alongside social workers for many years now within an integrated environment. This apparent ambiguity was in comparison to the established and well understood roles of nurses and occupational therapists (Ni Raghallaigh et al., 2013). Despite the fact that theoretically it can be argued that a contextual, anti-oppressive perspective adds significant value to service user and carers experiences and may not necessarily be present if the social work role is underutilised or absent from the team (Herod and Lymbery, 2002).

#### **6.2.1. Social work is expensive**

The participant's responses in the current study portray social workers as expensive and all participants attributed a financial/resource implication of having social workers within an integrated Trust. These responses tally with previous research that suggests social workers are perceived as a hindrance to the patient-care process as opposed to providers of preventative interventions and innovative solutions that can improve quality of care and reduce acute admissions (Auerbach et al., 2007; Connolly et al., 2010; Cleak and Turczynski, 2014). The participants responses acknowledged social workers holistic assessments and statutory functions but failed to take into account the cost-effective nature of utilising social workers in the health care setting (Auerbach and Mason, 2010; Barber et al., 2015) with views of social workers being a drain on resources rather than a cost-effective means of delivering effective services to service users and carers. This lack of understanding that emerged from the participants responses highlighted the key and substantial differences between social workers and their community health colleagues. Accountability and professional discretion and decision making are key to social work interventions and this is not necessarily a trait shared with health colleagues and is often not understood or misunderstood. There is some acknowledgement of this within the findings that social workers, work holistically and are not task focused but the critical understanding as to what this means in practice is still lacking in the knowledge of health colleagues; this inevitably causes problems which only serve to undermine effective integrated working. E.g., social workers operate usually to fulfil a statutory function, they are agents of the

state and thus are more accountable to policy and legislative frameworks that could hinder the development of institutional bonds.

### **6.2.1. Equality**

The respondents indicated that parity was crucial to successful integrated care and something that was perceived to be not present within the integrated Trust. This ranged from management, supervision, training to the way the organisation was structured and the way it approached things in what professionals perceived as a health orientated way. This view is reflected in Lymbery 's (2006b) research that stresses effective collaboration is mainly dependent upon a 'structure predicated on a parity of respect and esteem between them', something which has remained 'more of an aspiration than a reality' (pp. 121–126). Furthermore, responses indicated a feeling that social work remains vulnerable to being assimilated by the dominant health care paradigm. These difficulties have been researched for decades with Crook, Pakulski and Waters (1992) arguing that collaboration was inevitable as societies and economies alter and demand increasingly specialised expertise drawn from ever more narrow fields of practice. Consequently, professionals who specialise in a particular field may have more in common with experts across disciplines in the same field than within the profession who specialise in a different area. This approach has not worked within the integrated Trust and some would argue that it has not worked because we have integrated with the wrong group of professionals. Adult social care which is predominantly but not exclusively older peoples based with a service user group with co-morbid conditions that are usually concurrent with mental ill health. The responses from participants has found that synergy with community psychiatric nurses is desirable and yet those professionals are not part of the integrated Trust. In a time of austerity where a collective sense of solidarity or resistance should be emerging it is in fact according to the perceptions of the professionals on the ground who responded to the survey and took part in the interviews, a time of increasing polarisation and division. The perceptions of professionals are that of a chasm that has resulted in us being further apart within an integrated organisation than when we were separate or co-located.

### **6.2.1. The continued dominance of health culture**

The issue of identity management can nevertheless remain paramount to professional employees who support belief systems which concur with personal values e.g., social models, holistic care or human rights in social work appear to be intrinsically apart from the cultural norms of the health service. An alignment alongside social work values appears not to have taken place; rather participants responses see social workers as having a superficial and superfluous impact on the dominant health model that persists within such a large integrated organisation. Estes and Binney (1989) for example argue that medical professionals will always pathologise and attempt to cure a problem rather than look at the entire life experiences, inequality, poverty or poor housing that could be impacting on that individual's well-being. These discursive norms and traditions present difficulties with social workers able to make few inroads into the established ideology. This, as discussed above is where integrated services fail or do not work as well as they are deemed they ought to as a result of the inequality of cultures within such organisations. Empirical findings by Scragg (2006) in an evaluation of integrated team management within a health and social care Trust in England reiterated this viewpoint and found that traditional power disparities between social care and health professionals with professionals expressing concerns that service users' needs are often medicalised and interpreted medically rather than holistically. The participants responded that they perceive social workers as being well versed in the social models of care. When we look specifically at the health professional's responses they state this as a fundamental difference and a barrier to their understanding of social work that continues. Similar findings were revealed in a study within an Irish multidisciplinary mental health team (Maddock's, 2015) which uncovered that different professionals tended to support different models of intervention (p. 253). Maddock's study found social workers and occupational therapists drawing from social and psycho-social models of intervention in contrast to nurses who drew predominantly from the medical model. This studies participants paralleled Maddock's study with the responses from occupational therapists more aligned with social workers than that of community nurses. There is a clear differential between the approaches and this is reflected in the narrative from nurses who see themselves as different from social workers and occupational therapists.

Exploration of the workings of an integrated Trust in Ireland discovered that Maddock's study also revealed a hierarchy within the health culture with the psychiatrist wielding significant influence, a point reiterated by staff and the consultant psychiatrist, who stated "I don't think that everybody's view carries equal weight, multidisciplinary working is very consultant centred, so I have the final say on treatment, and on who I feel requires the team's attention". Maddock

(2015) makes a point that this autocratic welfare model goes against the current Irish governments and European Union's policy directives (Department of Health and Children, 2006; Mental Health Commission, 2010), in particular the call for greater levels of 'holistic' support as part of multidisciplinary and community-based mental health care. This is reiterated in England and was discussed earlier in the literature review. However, the fact remains that this study and previous studies have concluded that despite this rhetoric from government's the existing dominant medical model and culture prevails in such integrated set-ups. This is the political element that emerged from the findings and one of the key themes to be discussed below.

### 6.2.1. Research evidence

Despite arguments in favour of integrated care and the relentless policy and legislative drive in England to make integrated care a reality, empirical evidence to support such endeavours; claims of more efficacious and efficient interventions remain in relatively short supply. Indeed, numerous studies including the findings from this study have been less than positive. E.g., Bardsley et al. (2013, pp. 4–9) highlighted the increasing rate of acute care admissions for older people, many of which were avoidable if greater emphasis had been placed on preventative measures such as community social work interventions. A critical evaluation of a series of integrated service innovations in 30 different sites across England was subsequently conducted by the authors. They went on to evaluate and explored 4 out of 29 Partnership for Older People Projects (POPPs) that were department of health funded, with the purpose of preventative work targeting integrated community interventions within the home and the locality. Bardsley et al. (2013) findings again found little evidence of success with such approaches: stating that when compared to the matched control group they found no evidence of a correlation in reduction of acute admissions associated with any of the four POPP interventions evaluated. Furthermore, they found that in some instances acute admissions were higher in the intervention group than the control group. Only one intervention was evaluated as having reduced the time in an acute setting for the patients. A further example involved the evaluation of the effectiveness of 16 pilots of integrated care interventions – such as case management for at-risk older people in Norfolk, and structured care for people with dementia in Bournemouth and Poole. The evaluation highlighted some superficial improvements with regards to the use of support plans and opportunities for staff to develop with new roles within such integrated environments and yet the significant and stark outcome was that as a result of these pilots there appeared to be a general deterioration in standards. Service users found the set-up confusing and disjointed, affording



them less preference of who they were seen by and less involvement in decisions regarding their social care and health needs. This confusion has been replicated in my current study with professionals reporting that their perceptions of the service is that it is confusing to people using the service to access support and advice. These pilots were devised with the assumption that acute admissions would decrease and yet over a six-month period there is no evidence that a reduction in acute admissions ever occurred.

I would postulate that the speed and varicosity that such reforms are developed and implemented, running alongside an increasing fragmentation of provision could be a probable reason for such disappointing findings in these previous studies and the not so meritorious findings of my own study. The fact remains that dynamics such as the impact of the commissioner and provider split in service delivery, alongside a reduction in budgets and staffing, coupled with an ever shrinking and marginalised social work workforce and increasing demands on services as a result of demographic changes and ten years of austerity measures were perhaps likely to undermine any possible benefits associated with integrating services. The risks of integrated services have been debated for decades in the 1980's, Bywaters (1986, pp. 663–5) detailed these risks from collaboration between health care and social work in fields of practice. The debate centring on and the predominant believe being that as the inevitably of such collaboration is the domination and control of social work interventions by medicine. The participants in my study reflected on feelings of alienation, survival and de-valuation and would appear to reflect previous studies (as discussed above) and possibly I would argue that these feelings reflect a culturally held social work belief; one of a profession oppressed and marginalised to the side-lines. These findings were present in studies around the work of almoners in hospitals, such as those of Bell (1961) and Stacey (1983), with Bywaters reiterating that these studies detailed their “struggle for survival in what were experienced as hostile environments”. Interestingly, failed accounts of collaboration persisted alongside a “continuing refrain of inappropriate or narrowly focussed referrals”. This study revealed explicit assumptions from medics that almoners were able to offer only limited practical support, there was a lack of understanding then as there is now. Historically hostility from medics and nurses towards any attempts made by almoners to view patients' needs in their non-medical and social context, stood alongside intense pressures to ‘clear the beds’ as quickly as possible. If we frame social work and early co-working in the context of integrated care, we can see that inherent cultural biases have existed and permeated for decades. In this context integrated care may not be as easy a task to achieve as policy makers would like to believe it is.

The responses from participants in my study demonstrate recognition of the differences between social workers and health colleagues. If we look at Bywaters who states that the failure of the medical profession and many health workers to recognise the impact of environment, housing, poverty, class and so forth, upon patients and service users we can see this replicated in my study with respondents not necessarily failing to recognise but rather recognising and passing to the social worker to deal with these issues. Bywaters concludes that collaboration is a term fraught with negative connotations and is likely to lead to the proliferation of extremely narrowly focused and low-skill social work practices. The findings from this study show that social workers share his viewpoint but are active in their resistance to this happening and thus findings that social workers are perceived as difficult, challenging and excellent at advocacy lends itself to conclude that Bywater's pessimistic view of social workers has not transpired in reality; and I would argue has led to a new wave of radical social work developing within the integrated Trust.

Discursive, ideological and ethical tensions and identity clashes appear unavoidable when integrated care as regards to role and core knowledge ultimately remain superfluous in disparate fields of praxis. Indeed, the respondents predominantly perceived that integrated care was a means to align professionals with a different ethos, rationale and roles into a one size fits all system and this is indeed viewed as counterproductive. The responses indicate that co-location (integrated care light as it were) is the preferred model by the respondents to this study and one which was said to be working with an increase in understanding alongside purposeful or substantial interventions. The respondents however have stated that the integrated Trust diverted from this path of co-location and as a result the responses indicate that the integrated Trust is poorly designed and implemented and has created further division and misinformation than before.

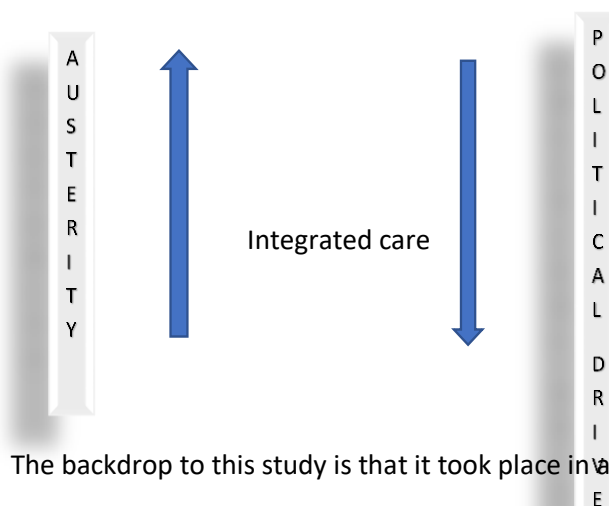
### **6.3. The impact of economic austerity.**

Austerity emerged throughout the survey data in such a way that it was present in the majority of subthemes as it appeared to be impacting on all aspects of integrated care. It also appeared to impact on the perceptions health colleagues had on social workers as integrated care and austerity were occurring simultaneously during the duration of my study. The prevalence was such that austerity warranted its own theme given its importance in the context of my study.

A significant finding that connected all professionals was one of the perceptions around austerity and its implementation being seen almost at the expense of all other considerations. The finding highlighted a lack of political will to drive through structural integration in the face of such astute measures of austerity. The political drive had been usurped by the austerity agenda which meant that the infrastructure and the resources to implement integrated care in a coherent and effective way were not available and so ad hoc approaches were adapted and alternative methods sort to deliver a semblance of an integrated service albeit not in the way originally intended. The pendulum had swung the other way; this was integrated care on the cheap (Figure 6.1). The ideas and the intentions were there but the finances to make them a successful reality were not. In the end a compromise approach appears to have been adopted as a direct result of economic austerity imposed on public services.

Figure 6.1

Prioritisation of economic austerity



The backdrop to this study is that it took place in a time of austerity. Austerity is a key code that emerged in both the survey and interview data and a thread that underpins the majority of responses from participants. Austerity in this respect refers to the measures that were adopted by the UK government following the 2010 General Election. At that election, no one party won enough seats to form a majority and so a coalition was formed between the Conservative and Liberal Democrat parties, with the Conservatives the larger of the two groups (there are some interesting parallels here with the perceptions of social workers within the Trust; that of being the junior partner with a limited voice in shaping events). To put this into perspective the proposition of the previous New Labour government if re-elected was to cut £52 billion as a response to the financial crisis this went further than any cuts that we had seen in recent times, going further

than even the Conservative government headed by Margaret Thatcher had been able to achieve in the 1980's (Elliott, 2010). The collation more than doubled this figure laying out a detailed plan in the spending review of late 2010 (HM Treasury, 2010).

The participant's responses recognised the context of austerity and it is important that three points relevant to the context are made. First, it should be noted that such punishing cuts are unattainable, having never been achieved anywhere, not just in the UK (Taylor-Gooby, 2012). Therefore, given the facts, building policy and the economy around such an undertaking constitutes a hugely risky endeavour. Second, the kind of austerity measures imposed disproportionately reduce spending and thus public services as opposed to increasing tax (Taylor-Gooby and Stoker, 2011); of significant note is that this is an ideological choice by politicians and differs considerably from the approach to austerity measures taken by the Conservative government in the early 1990s which was proportionate with each cut in spending matched with an increase in taxation (Taylor-Gooby and Stoker, 2011). Finally, the most significant factor for this study is the prominence that these measures disproportionately has upon local government in England whom were required to reduce their budgets by 27% by 2014/2015 (HM Treasury, 2010). This is reflected in the responses in particular with the perceptions that social workers are under resourced and that they are a significant cost pressure to the integrated Trust when put into an economic context as social care is largely funded and delivered through local government (Glasby, 2011) which has disproportionately taken the financial hit more so than health colleagues. This is perhaps one of the driving forces behind why social work is perceived as alien and expensive, as to other professionals the integration of social workers brought with it significant funding cuts and actually I would argue created division within the integrated Trust and from the responses has not created innovative and streamlined practice as envisioned.

The rationale behind integrated social care and health provision is understandable with people living longer with more complex co-morbidities that require a co-ordinated response across services from a number of different professionals. The idea being that integrated provision will reduce role conflict and disputes and produce financial savings with a more efficient streamlined and holistic service. Less duplication and less assessments are fundamental to this approach. This philosophy has led to the gradual reduction or soft dissolution of adult social services in England and made way for integrated teams consisting of health and social work professionals in many localities. E.g., The Health and Social Care Information Centre (2015) reported that in England there was "an overall decrease of 10,600 council adult social services jobs between 2013 and

2014', which represented 'an eight per cent decrease from 140,700 jobs in 2013" (p. 1). Furthermore, approximately "two-thirds of councils (101 out of 152) the number of adult social services jobs (continued to) reduce between 2013 and 2014". Undeniably social work in various fields and research in particular highlights mental health as being subject to a rapid retrenchment of social care provision (see e.g. Lilo, 2016, p. 38). Such political processes reflect the perceptions of participants in this study who similarly see the influence of austerity, labour market rationalisation and biomedicalisation within social work with older people that has been reported in the literature (Means, 2007; Lilo, 2016;). It is important to note that some research has noted benefits to integrated working practices for older people accessing services in particular (e.g. Help the Aged, 2007; Andrews et al., 2015) noting the aspects of social work that unvaryingly rely on good integrated social and health care.

Notwithstanding this, there has been inadequate response and lacklustre debate with regards to the medicalisation of social work despite evidence of the deficits such radical reforms yield (see e.g. Beddoe, 2013; Maddock, 2015). The current studies participants accounts also emphasised staff cuts as being a significant factor to impinging integrated working and as such a key consideration and consequence of austerity policies is the overall reduction in adult social workers, as discussed above this is a result of a decline in total funding for social care services in England. This has permeated in England e.g., with only 18 percent of councils considered people with 'moderate' needs eligible for funding in 2008, despite 50 per cent of councils providing comparable support in 2005/2006. The context of these policies is crucial to understanding the impact it has on professional's responses working from within such a system subject to such constraints. E.g., of 2 million older people assessed to have care related needs, around 800,000 received no formal support in 2012/2013 despite the number of people aged 85 and over (the group most likely to need social care) increasing by 30 percent between 2005 and 2014. Between 2004 and 2009, net spending on social care for older people increased by a total of 0.1 percent, while spending on the NHS increased by 5 percent (Phillipson, 2013, p. 141). This would suggest that integrated services are primarily concerned with reducing costs with a secondary benefit of improving provision.

It was this current economic climate and its impact that emerged as a key finding of this study. Gaughan and Garrett (2012) were arguing for such a study in 2012 to ascertain the effects of such austerity on the profession and the service users they support who have endured particularly devastating effects (Goldberg 2012). Austerity has impacted on integrated care and I would argue

has neutered social works effect within an integrated service. This is because firstly the type and depth of this economic austerity (as discussed above) principally wakens the emancipatory potential of social work within such a large organisation to encourage change at a structural and macro-level. Whilst simultaneously, economic austerity for service users increases their socio-economic deterioration and social segregation (Goldberg 2012; National Economic and Social Council 2013; Strier 2013). The economy may well have turned a corner and be on the upturn again, nevertheless the government remains committed to austerity and continues with this policy which by all accounts has been cataclysmic to vulnerable people who access social care and health services. Therefore, recommendations as a result of this study would suggest a return to radical social work as an essential strategy for social work professionals looking to tackle the issues showcased above. The responses from social workers themselves have a radical stance to them and this shift one could argue is crucial, as according to Mullaly (2007) capitalism is a root cause of oppression. The marketisation of social work, the commissioner/provider split and the introduction of profits when supporting the most vulnerable in society would suggest this shift is necessary for social workers to continue to challenge oppression and advocate for the marginalised in society.

This strategy can be seen through structural social work that relates to changing the prevailing social order rather than concentrating upon generating change at an individualised level. However, structural social work and this radical approach, has in recent times been undermined or overlooked by contemporary social work theories such as postmodernism and post-structuralism, in addition to the prevailing doctrine of neo-liberalism (Ferguson and Lavalette 2007). This neo-liberal doctrine clearly underpins economic austerity and yet social workers have been indoctrinated in this approach to social care provision for many decades now (Peck, Theodore, and Brenner 2012). Whereas postmodernism and post-structuralism as theoretical approaches have been critiqued for redirecting attention away from the frequently unforgiving associated reality of people's lived experiences (Barnes 2012; Shakespeare 2014). It is proposed here based on the responses of those who participated in this study that social work professionals should take an oppositional stance to the oppressive forces of economic austerity, this I would argue will become a reality within the integrated Trust that is currently subjecting all staff to reorganisation and the threat of redundancy. Such actions may well be the driving force for this recommendation to come to fruition after all what at this point do the social work professionals have to lose?

Many individuals have been affected by multiple welfare reforms and it is those on the lowest incomes who are most heavily affected. This study did not directly involve service users or carers but it is worth highlighting that around 21% of the population of the United Kingdom live below the government's official poverty line, and that it is these people who are disproportionately affected by economic austerity (Duffy 2013).

#### **6.4. Conceptual confusion in respect of defining/organising/structuring integrated care**

The organisational subthemes that emerged during the analysis of the survey data included data relating to systems, information technology and processes. The structures that are in place to enable service delivery, streamlined ways of working, working across agencies/sectors. This was explored further during the follow-up interviews with the findings allowing me to explore aspects of this theme further particularly around co-location which appeared to be a key aspect of my initial findings.

The findings for this study were consistent with previous findings from past research (Gibb et al., 2002; Rees et al., 2004; Bailey and Liyanage, 2012) with responses acknowledging that when there is a sharing of expertise, knowledge and experience, new learning occurs that benefits all professionals within the organisation and more importantly the service user. It has been argued that different perspectives complement each other however as this study has highlighted this is not always the case with different perspectives seen as competing for finite resources, again this may be due to austerity as previously discussed or an inevitable consequence of integrated care as postulated in the earlier discussion. The integrated Trust in its infancy was organised primarily as co-located multidisciplinary teams; the perceptions of the participants of this approach was overwhelmingly positive, that things were moving in the right direction. This viewpoint is supported in a study by Carpenter et al. (2004) who explore the opinions of service users who agree that this team set up is a positive one and is also consistent with findings from Bailey and Liyanage (2012).

Participants accounts also acknowledge the difficulties of status and the inconsistency of integrated care due to the section 75 agreement being re-negotiated between the local authority

and the national health service who are providing community adult social care services on their behalf. Social workers in particular reported feeling undervalued by their employer and unwanted by the organisation for which they are performing all statutory functions. Social workers are reporting that they feel they do not belong. This position has been exacerbated by austerity and solidified by contracts that dictate precisely how many social workers the Trust has, what they are allowed to do and not do etc... This prescriptive approach to social work has by all accounts failed to deliver any benefits to professionals, service users or carers other than reducing the local authority's bottom line and balancing its books. Despite this current reality for social workers within the integrated Trust the social workers' responses highlighted a consistent approach to legislation and policy that guides good practice and report an adherence to values and ethics that are part of everyday practice. In spite of the organisation structure social work continues to challenge, to advocate and responses from health colleagues reflect this approach, with social work seen as difficult at times. Thus, participants expressed frustration with the current structures such as managers from other disciplines who they perceived as not fully understanding and /or supporting their role and statutory obligations. Participants contended that their capacity to finish both their tasks effectively and efficiently was influenced by the erratic nature of statutory duties, which had precise time frames for completion and also the unpredictability of people, but the perception from the responses was that the health lead organisation was pushing social work to a more task centred way of working and not acknowledging these different approaches that inform a holistic assessment and indeed are mandated by law. Of concern are the participant's responses noting that the understanding around statutory services is still inconsistent within the organisation. The arguments presented above are consistent with comparable finding regarding difficulties in inter-professional understanding articulated by writers in the field of mental health social work (Bogg, 2008; British Association of Social Workers, 2010; Gould, 2010). The organisation is structured in such a way that the risk to social workers mental health in particular relating to stress should be considered as it is highlighted in numerous studies as an area of concern (Carpenter et al., 2003; Evans et al., 2005; Huxley et al., 2005; Evans et al., 2006;). Therefore, as an integrated Trust I would argue that the need for cooperation between staff, management and at the organisational level is essential to avoid conflict and promote good ways of working (Rees et al. ,2004). The responses from this study indicate that social workers perceptions of integrated care and their impact has been one of failure, that it does not work. This view is also reflected in responses from occupational therapists, however as stated earlier they were subject to redundancies and changes to ways of working during this



study. Nurses are the only group who had anything positive to say with regards to integrated care and I would speculate as to why this is such as nurses having more to learn from social workers and occupational therapists than social workers have to learn from nurses; that is to say the usable knowledge and skills in one's everyday practice, it is far more likely a nurse will utilise the Mental Capacity Act in practice than a social worker will dress a wound for example. These structural problems within the organisation often rooted in cultural differences and biases (discussed previously) are consistent with other findings (Rees et al., 2004; Bailey and Liyanage, 2012) where participants agreed there are advantages of integrated working whilst recognising the inherent difficulties due to disputes on a systemic level.

Importantly, as reflected in this study participants responses have shown that service users access to comprehensive and coordinated services can be compromised by service and role confusion when partnership between professionals is not attained (D'Amour et al., 2008). These findings showcase the difficulties of incorporating social work with older people into an inequitable health and social care system. The drive for efficiencies and savings appears to ignore the fundamental differences in the UK between health and social care with core legislation, policies, ways of working, education and training, roles and responsibilities so fundamentally different. Indeed, so many of the utmost essential actions social workers undertake are so far removed from their health contemporaries, that any associations are likely to remain fragile. One area that the integrated Trust would benefit from is the acceptance and acknowledgement of difference. Social workers will encounter many more random possibilities in such often-precarious settings whilst subsequently challenging issues and needs (poverty, neglect, safeguarding, etc.) that inevitably requires a wider knowledge base, together with different resources and skills. There was a reason that social work and the NHS were separated in the first place. Lewis and Gennerster (1996), make the point that such disparities between social work and health care remained one of the main reasons why social service departments were organised as independent from the NHS in England and Wales during the 1970s. These historical lessons do not appear to have been learned with a monolithic organisation subsuming two fundamentally different components and willing integrated services to work. The organisation is a social construct driven by policies and legislation that has ultimately been perceived by the professionals who work within it as not a disaster at best and a failure at worst.

## 6.5. Political influences

The political aspects emerged during the coding of the initial survey data and the creation of sub-themes and ultimately a political theme. Exploring the theme of political influences revealed more nuances during the interviews such as the policy drivers and party-political factors that have a perceived influence on the integrated Trust.

Putting the findings into a local context, these findings highlight the status, the prestige that integrated care brought to an area that had been rocked by scandals over recent years. It was, I would argue a politically driven project that happened to conform to the ideology of the local authority. An authority that sees itself as a commissioning authority and not a provider of services and a local NHS that had been plagued by scandal and bad public relations and was seen as an opportunity to synthesise these two approaches solidifying the commissioner and provider model prevalent in the locality and generating national 'good' press as it were in the face of recent scandals. The problem with this approach as I have found talking to professionals is that the professionals were not a part of this journey or mindset and merely taken along or dragged along regardless of concerns at grass roots level. The political drivers wield enormous power and influence and in recent years where integrated care is seen to have not lived up to the promises of saving and efficiencies continues to be pursued in a somewhat futile quest. Aspects of integrated care have worked well and some aspects have been by all accounts an object failure. It is the failure to learn lessons and learn from each other in pursuit of a vision driven by ideology around market forces and streamlined services that is both worrying and disconcerting to those professionals within such an organisation and this is reflected in the participant's responses.

Working in a social care and health integrated NHS Trust team has meant that social workers are mandated to perform specific tasks and duties stemming from their own particular social care and health organisations and therefore they have to employ two different approaches; the Local Authority statutory duties alongside the requirements of the NHS body. This scenario is replicated in integrated mental health Trusts with the care management responsibilities and the NHS care programme approach responsibilities (Carpenter et al., 2004; Payne, 2009; Gould 2010).

Participants' perceptions of working within the integrated Trust was that the dominant partner was the National Health Service within the organisation and stated that they felt isolated, abandoned and alienated by the Local Authority and isolated from other social workers and

abandoned by the Local Authority. Those findings were reflected in Bailey and Liyanage (2012) study of 'organisational dominance' (p. 1120) of the Mental Health NHS Trust and the social workers' perception of 'abandonment by the LA' (p. 1124). Abandonment by the Local Authority that employs them and that is responsible for the statutory duties performed by those social workers. In the integrated Trust, this feeling is compounded by the fact that staff are employed directly by the NHS and involvement with the local authority now not directly involved with social work staff. Therefore, it could be reasoned that the necessity for improved communication and cooperation amongst the health and social care services, the integrated Trust and the Local Authority was recognised, in addition to the requirement for the Local Authority to participate again, develop and sustain a functioning relationship with the social workers who are carrying out statutory functions on its behalf. However, the issue becomes a political one with the local authority maintaining its commissioner role and seeing the integrated Trust as a provider and not a partner. This way of working is not conducive to partnership working.

Social work is subject to a complex array of political and social processes that create disparities in power and professional status, social work often struggles to sustain an influence in what can be overpowering discursive fields of health and social care praxis. The political underpinning of integrated care is fundamentally linked to the differences in cultural capital, status, power and the legitimacy or otherwise of conflicting professional knowledge bases. Indeed, the participants accounts suggest social workers feel the arrangement transitory; as Beddoe (2013) notes, a "relative lack of independence in health settings suggests that social work has been a 'guest' under the benign control of the medical and nursing professions" (p. 26). The tendency is for a medicalised approach to integrated social care and health services set within a wider health and social care ideological framework. This policy feature continues unabated with a government mandated inter-professional narrative which has in the recent past repeatedly advanced colloquial claims of enhancing 'partnerships' and promoting 'joined up working' at a local-level, despite many policy mandates being didactically driven from a core of centralised government power at Whitehall (Clark, 2002a). As this study, has found the prevalence of 'implementation deficits' and 'modernisation muddles', first reported by (Means et al. 2003, pp. 213–214) and reflected in my findings suggest that such politically driven reforms are structurally flawed with questionable rates of success at a local level. The political forces at a national and local level drove integration at a relentless and volatile pace given the extent of the restructuring and reorganisation needed to achieve the political vision.

Means et al. noted “relatively small failures of co-operation between different organisations can easily multiply to create a major implementation deficit” (2003, pp. 213–214). Several difficulties relating to structural, cultural and resources are faced when dealing with complex bureaucratic organisations and professionals from different disciplines when attempting to reach multi-agency assurances around partnership and joined up working. I have discussed above the potential benefits such professional working arrangements have for service users and carers. In particular, around supporting people with complex co-morbid conditions that require a multifaceted response such as those experiencing dementia, arthritis or palliative care (Tanner and Harris, 2008). Despite this rhetoric, the unique defining features of social work praxis and role are perceived to have shifted, with participants reporting that their role has become diluted, marginalised and not valued within the integrated Trust. The sense of frustration within the responses from a profession that is integral to the delivery of services particular in the care of older people is so marginalised and misunderstood by colleagues whom they have been working alongside for many years. The bio-medicalised ageing industry that is operated like a business subject to market forces will never prioritise social work interventions that are concerned with oppression, marginalisation and exclusion of those most vulnerable in society.

The perceptions of the professionals are that of a system that has so much potential yet one that has been decimated by economic austerity. I have been advocating throughout that a more radical approach to social work is essential to move social work practice towards a Social-Collectivist stance. This suggestion should not be viewed as controversial as to put this into context anti-oppressive practice which is a fundamental part of social work education and interventions stemmed from the radical social work movement of the 1970's (Thompson, 2006) and therefore I would argue is a legitimate response to the social work professionals feeling of oppression within the integrated Trust. Developing this argument into its present-day context, Ferguson and Lavalette (2007) find that neoliberal policies have effectively side-lined radical and collective approaches to social work. This is also seen in an Irish context with McGregor and Quinn (McGregor and Quin 2015) reporting similar findings. The current economic austerity is a result of a neo-liberalism doctrine, the same neo-liberalism that some would argue are responsible for the causes of the economic recession and subsequent austerity which in turn is framed as the solution. How can one be the cause and yet also the solution? It is a fascinating aspect of ideological politics that has shaped integrated services in England and had an effect on social workers impact within such an integrated organisation (Peck, Theodore, and Brenner,

2012). This ideology filters down to local level with service users seen as citizens and consumers of goods and services. This competitive individualism with everyone and everything competing for business has eroded social work's potential to create and promote social cohesion (Ferguson and Lavalette 2007). Inside this atmosphere of competitive individualism, Ferguson and Lavalette (2007) argue that pockets are emerging for radical social work to flourish, where social workers are conscious of the structural sources of oppression. This viewpoint is articulated in social work responses who perceive themselves as subject to such structural forces of oppression.

Social workers lack a clear place within the new integrated world from which they operate. The traditional base and ally the local authority is now an entity devoid of social workers that is business orientated and that is scrutinising and demanding, controlling the purse strings and rationing the care (austerity). This presents social workers as having to challenge and advocate for the service user to the local authority on which they are working on behalf of and yet not employed by. This is in addition to social workers being placed in large NHS organisations subject to the dominant health culture and ethos that they are also battling against, educating and informing to assert their professional status and unique perspective (culture). In this regards integrated care specifically for social workers has opened up a new front that requires social workers to battle within the organisation and with external agencies outside the organisation. I would argue that this sustained pressure on social workers will erode their professional skill set, values and ethics. (see figure 7.2) Social workers are uniquely placed in this in my opinion unsustainable and unrealistic position by their values and ethics and the legislation and policies that they must adhere to often advocating for service users and carers and yet being marginalised and seen as difficult, expensive and alien by those around them.

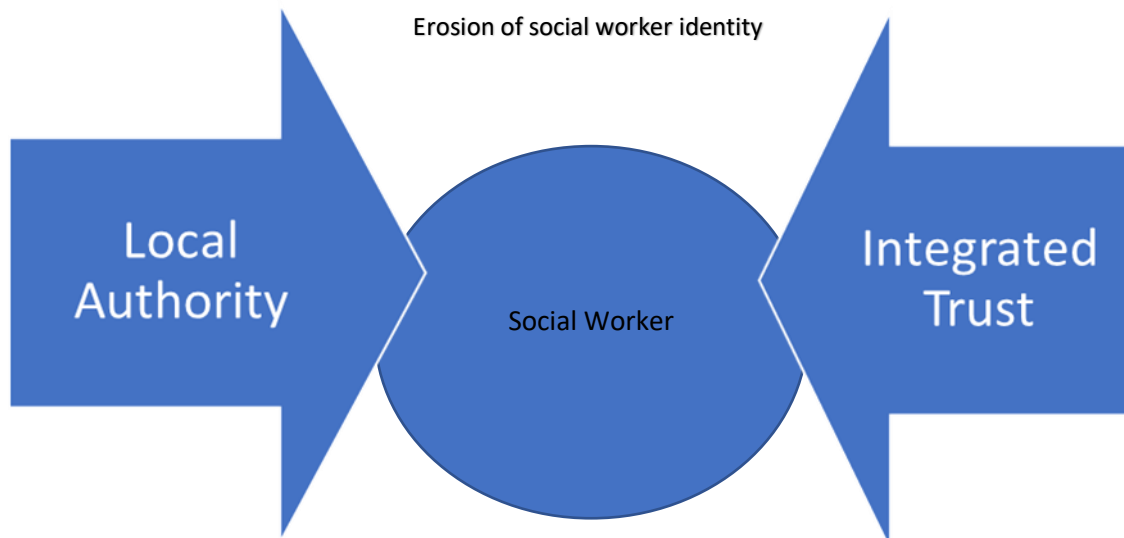


Figure 6.2

The respondents also pick up on the political elements of integrated care, e.g. the organisation itself is divided being concerned with; is it a health need or a social care need, this is to do with budgetary constraints rather than a seamless true integrated approach to health and social care delivery. This approach was being showcased by Glendinning and Means who highlight the power differences and problems created with regard to attempts to distinguish between 'health' and 'social care' needs. E.g., they note how social work departments during the 1970s and 1980s felt that they were 'often being 'dumped on' by local NHS services' with regard to responsibilities for social care outside of hospitals in community settings (2004, pp. 441–2). Similarly, The King's Fund (2013) articulates the respondent's viewpoints circinately describing the often used yet negative impact of 'cost shunting' from health to social care within the NHS. How can an organisation such as an integrated Trust be truly integrated when in effect It is arguing with itself?

## 6.6. Significance and Contribution of the Study

This study contributes to the evidence regarding the role of social workers within integrated health and social care organisations and, unlike much of the other literature, specifically focuses on adult social work (i.e. integration between adult social care and community health care services as opposed to mental health social work) and also contributes to the evidence around social work in times of austerity.

The study also provides some additional evidence specifically for social workers as well as for integrated social care and health, uncovering a number of themes that exist across the integration journey. While most of the comments were negative, analysis reveals concerns shared by substantial numbers of respondents: conceptual confusion in respect of organising integrated care within a health organisation, a lack of shared socialisation and the development of a shared culture within the integrated organisation, and the impact of economic austerity on integrated care. It is therefore pertinent to many health and social care organisations looking to integrate in the future. I think my research may also benefit policy makers and NHS /social care leaders. This research highlights some of the mistakes made in this particular integrated care project which can be reflected upon by leaders when entering into future partnerships

## **6.7. Summary**

This chapter has explored the findings from the survey and interviews and explanations have been sought from within the literature. This has been an exceedingly iterative process and with a vast volume of data it can be difficult to capture all opinions. As the process depends on my interpretation of the results and is from a social constructionist perspective I have focused upon challenging my own assumptions and conclusions.

# **7. Conclusion**

## **7.1. Introduction**

The focus of this thesis was to understand the perceptions of community practitioners working within the integrated Trust and to understand the contribution social workers have made within said Trust. In this chapter I will address the research question, “What is the perceived contribution of social workers within an integrated setting?” Exploration of the survey and interview revealed that social work practice was considered a costly and complex, often misunderstood, poorly led, and under resourced all of which have impinged on social workers contribution to the integrated service. The lack of influence of the local authority and the disinterest from within the integrated Trust upon the creation of a shared culture, identity and role were evident within the responses.

## **7.2. Limitations**

One limitation of this study is that comprehensive demographics of the respondents was not sought and is thus unknown. This design preserved the anonymity of participants and could be argued encouraged greater participation, however its limitation is such that it cannot confirm if the sample is diverse and socially representative of professionals working within the integrated Trust (e.g., age, gender, ethnicity, socioeconomic status) and is, therefore, a socially just representation of the perceptions and experiences of professionals within the integrated Trust. The sample group of this study in particular the interview stage was small and was not necessarily representative of the whole group of integrated workers within the integrated Trust due to the voluntary nature of the study.

Future research could validate the themes brought forward by conducting interviews with targeted diverse samples of professionals working within an integrated social care and health setting. Furthermore, I would argue that a limitation of the thematic analysis process is that collecting data purely through survey responses and transcripts of audio recordings could present risks of misinterpretation and ignorance of the context of the participants responses (Long-Sutehall, Sque, and Addington-Hall, 2010). That being said, some researchers argue that as an insider researcher my interpretation and lived experiences within the system offer a unique and rich insight into the analysis of the data (Irwin, 2013).

## **7.3. Reflections on the study**



My study offers an insight into the experiences of social workers, the perceptions social workers and their colleagues have on the role and the impact of the role within an integrated social care and health Trust. My research study had as an aim to explore the perceptions around social workers from within the integrated Trust. Exploring views and opinions of social workers within the integrated teams regarding their role, duties and responsibilities. This qualitative practitioner led study utilised and acknowledged the social work perspective from me as an insider researcher as it endeavoured to link social work theory and inform practice (Coulshed and Orme, 2006; Howe, 2009) whilst an interpretivist approach (De Witt and Ploeg, 2006; Dowling, 2007; Robson, 2011) was adopted to comprehend and interpret the response of participants concerned with their perceptions and experiences within the integrated Trust. Accounting for my role as an insider researcher and my positionality and unconscious bias and the potential influence of professional experiences within the organisation, my tacit knowledge and the impact of the preceding literature review on my understanding and my interpretation of participants' opinions, reflective thinking was utilised (Guillemin and Gillam, 2004; Whittaker, 2009).

By relating the detailed aims and objectives with the key findings it is argued that this research study accomplished its goals, as participants' views and opinions regarding their role within integrated teams and the effect on their professional knowledge, practices and skills (professional identity) was explored. In addition to critically analysing the local social and policy contextual drivers of integration over time, looking particularly at professional and organisational culture and looking at the evolution of integrated health and social care in older peoples' services with a specific focus on the role of the social worker, these issues were explored and represented in the findings in a meaningful way. My study contended that professionals valued social worker's unique identity and contribution even if it was not fully understood by colleagues; it was valued as adding something different to the status quo. My study showcases a number of facilitating factors within the integrated Trust, such as: the inter-professional dialogue and collaboration alongside the aspirational shared values of working together for the good of the service user; and hindering factors, such as: the perceived segregation and alienation of participants within the integrated Trust from fellow professionals and the feeling of abandonment by social workers cut off from the Local Authority which traditionally employed them coupled with an almost complete lack of understanding from colleagues and managers of different disciplines about the complexities of the social work role. Such inhibiting factors would be greatly overcome by a re-engagement of the local authority as the commissioner of social care services with the frontline

staff of providers who are working to deliver statutory social care on their behalf. The structure of the organisation is also designed for health and is in itself an inhibiting factor to social care integration with obstacles at a macro level due to systemic level disputes between the National Health Service and Local Authorities ever present (Rees et al., 2004; Bailey and Liyanage, 2012). A strategic vision is crucial at the macro level if integration is to be deemed a success.

A strength of this study was that it succeeded in replicating findings from former studies in comparable settings and hence its credibility was increased (Robson, 2011). The lack of existing studies on integrated services in adult social care led to a comparable review of previous studies undertaken within integrated community mental health teams, after all this is the policy that the government is basing its integration of current social work and NHS services on. It was prescient then that the findings from studies into this approach should be replicated in my current study. These initial integrated services reported issues with role clarity and identity with issues around inter-professional communication also reported (Peck and Norman, 1999; Brown et al., 2000; Carpenter et al., 2003; Bogg, 2008). Then as the services developed studies highlighted that professional exchanges and appreciation of diverse knowledge and experience began to form (Gibb et al., 2002) as service users also began to see the benefits of integrated services (Carpenter et al., 2004) yet, despite these positives, issues of role clarity and confusion around tasks and responsibilities continued to be stubbornly present (Hannigan and Allen, 2011); as social work and health professionals recognised the micro level benefits of integration on an inter-professional level, they heavily criticised the hindrances at a macro level due to systemic level disputes between the National Health Service and Local Authorities (Rees et al., 2004; Bailey and Liyanage, 2012). My study replicated these findings and despite the integrated Trust being non-mental health the feeling from social workers of being marginalised from their Local Authority was consistent with previous studies (Bailey and Liyanage, 2012). This study further explored and complemented the above arguments as social workers, nurses and occupational therapists acknowledged that integrated care can be beneficial due to inter-professional sharing of knowledge, perspectives and experiences and that there was a shared aim in supporting service users however this requires careful and thoughtful structures in place to support such ideals becoming reality, whilst participants accounts also reported perceptions of feeling oppressed and isolated from supporting factors such as the Local Authority (Phillipowsky, 2018). I would argue and see that the present study is consistent with comparable studies with similar findings lending greater credibility to the current study (Peck and Norman, 1999; Brown et al., 2000; Gibb et al.,

2002; Carpenter et al., 2003; Rees et al., 2004; Hannigan and Allen, 2011; Bailey and Liyanage, 2012). Another strength of this study was the fact that it was structured with an initial survey and thematic analysis of the findings completed prior to a secondary data collection phase via interview. The respondents were consistent in their findings with no significant deviation this additional step of interviewing participants and soliciting their feedback is compatible, valued and produces increased rigour within the adopted interpretivist approach to this study (Bradbury-Jones, Irvine and Sambrook, 2010; Robson, 2011). Since the surveys and interviews with participants occurred during 2017, a tumultuous year for the integrated Trust one where the overwhelming emphasis was on financial restructuring, with contract renegotiation's front and centre. It can be argued that such a backdrop will inevitably skew responses from participants who are at the sharp end of such considerations.

The concerns expressed in the responses was that the integrated Trust was only interested in budget cuts rather than professionalism and good practice. The current study, however, was conducted within an integrated Trust that has steadfastly maintained it is committed to the full integration of services. The reality however does not match the rhetoric with participants branding integrated care a failure. The accounts suggested ways to improve and enhance the current implementation of integrated care with appropriate professional supervision from the same discipline - peer support; management representation supporting the maintenance of a distinct professional identify; with shared education and training being seen as vital to integrated care being a success allowing for the emergence of a shared culture and mutual respect that should translate into good joint practice. Most importantly co-location, which participants stressed is different to integrated care was seen as light integrated care with all the benefits and none of the negatives; as lines of accountability, responsibilities and roles remain distinct and separate. The resounding consensus from all participants is that co-location works; integrated care does not. The recommendation from my study which I set out below (see 7.4) have implications for future practice when working in an integrated care organisation. It is my hope that these findings will lead to future organisations learnings from the voice of practitioners and building a sustainable and successful integrated health and social care service.

My research study's recommendations were based on participants' comments and perceptions of the current situation within the integrated Trust and their suggestions on how things could be improved and on my (practitioner researcher's) interpretations, whilst the study's limitations were also recognised.

#### 7.4. Study's Recommendations

- That a dialogue between the different professionals concerning the complexity and duality of the social work role. Findings indicate that shared culture and working practices have yet to develop. Team meetings (Taylor 2001; Brown, Tucker and Domokos, 2003) are seen as key to establishing dialogue between professionals and these such by facilitated by the integrated Trust.
- That joint education occurs during professional training. The findings indicate role confusion (Abbott et al., 2005) and that this barrier may be overcome by establishing a shared culture at the professional conceptualisation level that overcomes the them and us phenomenon (Rämgård et al., 2015). This recommendation is aimed at education institutions and policy makers who are crucial in shaping the curriculums of said institutions.
- Establishment of training and shadowing scheme to promote awareness of different professionals' roles and responsibilities. Findings indicated misunderstanding, underappreciation, indifference to roles and responsibilities in the established workforce and this was also reflected in the literature (Norman and Peck, 1999). This recommendation is aimed at the Trust enabling it to educate its established workforce who have been subsumed into a single organisation from disparate fields of practice.
- Senior managers to communicate and be transparent in their approaches in order to support staff within the integrated organisation to feel included and valued in the process. Findings indicated that professionals felt undervalued, that communication was absent and that they were not included in the process, this was reiterated in the literature around mental health integrated care (Bogg, 2008). Transparency from the Trust and local authority during the process of

integration may have eased professional's apprehension and negative perceptions of integrated care.

- Further research is needed in particular around the burgeoning radical social work that appeared to be emerging as a consequence of integrated care and an area that would benefit from further investigation. Social workers had begun to articulate a strong human rights and social justice position given the impact of austerity on service users and carers and the perceived erosion of social work from within the integrated Trust. This area of practice is relevant to the profession and the continued resilience and strong voice of social workers within an integrated care organisation where they can often feel that their voice has been diluted (Beddoe, Davys and Adamson (2013).
- Improved and sustained communication and collaboration at a systemic, organisational and managerial level between the relevant health and social care services; Clinical Commissioning Groups (CCGs) which were created following the Health and Social Care Act in 2012, local Health NHS Trusts and Local Authorities. Findings indicated that commissioners are perceived by professionals to play a passive role once services have been commissioned which leads to disjointed service provisions. A clear strategic vision, communication and partnership working is required from commissioners and providers of services if services are to be truly integrated and not merely a loose collection of contractual obligations.
- Need for Local Authorities to re-engage and be pro-active with regards to the statutory functions social workers are carrying out on their behalf. Findings indicated social workers felt adrift, bereft of any professional leadership or direction this is similar to Bailey and Liyanage's (2012) findings which reported social workers perception of feeling abandoned by the local authority.
- Appropriate professional supervision by managers of the same discipline to support professionals within the integrated Trust in order to develop and maintain their professional identity. This was a key finding and one which professional on the ground felt was crucial to good joint-working and effective integrated care. This is in line with the social work taskforces recommendations (DH, 2009). This approach is key to local authorities as commissioners who can

build in this requirement to contractual obligations of providers (the Trust) in order for the integrated care organisation to function as effectively as possible and lead to greater job satisfaction and thus reduce stress levels (Carpenter et al., 2003) for social workers working in these integrated care environments

- Development of trans organisational peer support networks recognising the fragmentation of the social work professionals in local arrangements. The findings suggest that commissioning services to providers has resulted in the fragmentation of the social work profession. The recommendation would be that these trans organisational networks are built into new commissioning arrangements, that they are threaded through organisations by commissioners to provide a seamless peer support network for social work professionals that are exercising statutory duties on behalf of the local authority.

Generalisation (Whittaker, 2009; Robson, 2011) of findings across different integrated health and social care organisations will be limited by virtue of the fact that every organisation has differing local needs and ways of working which makes direct comparisons problematic. Nevertheless, the study included 41 responses to a survey and 6 interviews across the integrated Trust and across professional groups with findings that are relevant to comparable organisations particularly in England. Although the practitioner researcher reflected on potential bias and in particular around being an insider researcher and accounted for issues of methodological rigour (Robson, 2011), it is recognised that the researcher's social work perspective and working experiences, tacit knowledge and literature review all informed the interpretation of the findings.

I believe that effective and meaningful integration of different professionals into multidisciplinary teams can only be achieved in a vacuum where cultural biases and doctrines play no role in the formulation of such entities. As an insider researcher reflection and being self-aware was crucial to the successful completion of this study and so incorporating reflective training into professional education courses is a sensible way to mitigate the inevitable cultural biases that will exist between differing professionals. That being said adequate integration can be achieved when all component parts understand, value and respect the philosophical underpinnings of contrasting professions. Good integrated care as reported by participants is integration light; co-location and I would argue is the preferred way forward for professionals within such organisations. As an

insider-researcher I have seen first-hand how this organisational set up has worked well. This approach encourages sharing of knowledge and an openness to one's practice sharing social work perspectives, values, and experiences in an effort to make their role known and to contribute ideas that might improve quality of care for service users and carers (Herod and Lymbery, 2002; Judd and Sheffield, 2010; Maramaldi et al., 2014). The integrated Trust I would argue does not operate in this way, this I would argue is due to the systemic failures of the Trust in the way it is structured and the forces such as austerity that are driving the direction of travel. We have seen in the current study that social workers will often promote the uniqueness of their knowledge base rooted in social science and as, some authors have argued overlook the practical knowledge and competencies that they can bring to a health team (Silverman, 2008; Spitzer, Silverman, and Allen, 2015).

I have argued that professional culture and identity are crucial to effective joint working and this will not change until professional education and training adopts to the new way of working. These cultural biases are developed through professional socialisation during training and often become internalised and a core part of professional identity that result in cultural barriers within integrated teams (Hall, 2005; Zarshenas et al., 2014; Fox and Reeves, 2015). This then creates a them and us phenomenon within the same organisation where professional's perceptions toward the identities of other professionals can influence whether they are seen as competitors or as complementary resources (Rämgård et al., 2015).

Speed (2004) advocates that "a key feature in developing a shared meaning in interdisciplinary collaboration is not that professionals conform to the same set of ideas or beliefs, but that they evolve shared understandings of the problem and objectives within which it becomes possible to manage different viewpoints, including strongly held differences" (as cited in Shor, 2010, p. 358). A recommendation of this study is that of integrated professional socialisation where by learners develop a social identity for their own profession, as well as that of the integrated professional community, during their professional training (Arndt et al., 2009; Khalili et al., 2013). I propose that integrated professional socialisation should be adopted by education institutions to tackle cultural bias and promote unique role awareness that ultimately will lead to better integrated social care and health services. In the UK, the presence of social workers within integrated teams separated from the local authority is one which is set to continue. However, it is imperative for those practicing in such integrated Trusts and those entering the profession to keep in mind the "new opportunity it presents ... for social workers to renegotiate and re-establish their presence,

purpose, and role” (Spitzer et al., 2015, p. 195) within such integrated organisations. It is my hope that this research encourages critical discourse around the future direction of adult social care services in the UK and acts as a catalyst to a more radical social work approach within integrated settings.

The fundamental ideas around integrated working within a primarily older people’s area of social work is a sound one of efficiencies and cost savings with a streamlined approach that benefits all. The reality however is a positioning of adult social work professionals in a position where erosion of status is highly likely given the aggressive integrated models of care being pursued against a backdrop of economic austerity. I would question the rationale and validity of placing social work so firmly within the national health system that is by its very nature medically minded and the antithesis of the social model of welfare. From my own experiences I have found it very difficult to navigate the intertwined systems that have emerged from the integration process.

## **7.5. Summary**

### **7.5.1. What has the impact of social workers been in the integrated Trust?**

I would argue that the impact has been quashed by the current economic austerity. Despite the potential being there to influence existing ways of working without the shared vision, the leadership and the resources the impact has not been felt and is not wide-ranging and is limited to local pockets of good practice; it is by accident rather than design. The integrated Trust is very much an ideological initiative driven by the need of local authorities to save costs whilst extending market forces into further areas of public service provision and concealing needs away from wider contributory practicalities, such as those relating to explicit structural factors including poverty and inequality. As noted in this study social workers are perceived as being excellent advocates and in this regard, they have had an impact on the service user and carer voice within the integrated Trust but their impact on the wider staff group and organisation according to the responses has not been felt. It is surprising given the findings of this study that more resistance has not yet emerged from professionals who have been made subject to these extensive reforms. I would argue that social workers within the integrated Trust are now beginning to reassert their



unique role and contribution and am satisfied that responses from participants have highlighted the advocacy and distinctly constructive role social workers play working with service users and carers; core social work roles and functions not only were found to be not understood but also seen as the purview of social workers with nurses and occupational therapists responding in such a way that I can deduce that they have little interest in undertaking any of these social work functions. There may be less social work professionals within an integrated service as a result of the multitude of factors as discussed above but they appear for now to be doing a job that nobody else understands and wants to undertake.

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## **9. Appendices**

## 9.1. Appendix 1: Survey

# An ever-changing culture: What is the contribution of social workers within an integrated setting?

1. How long have you worked in your current post? \*

- Less than 12 months
- 1-3 years
- 4-7 years
- 8-10 years
- Over 10 years

2. How long have you been qualified? \*

- Less than 12 months
- 1-3 years
- 4-7 years
- 8-10 years
- Over 10 years

**3. What geographical area do you work in? \***

- North - Newcastle
- North - Moorlands
- South- Stafford
- South - Cannock
- South- Seisdon
- East - Burton
- East- Lichfield
- East- Tamworth

**4. Please state your registered profession: \***

**5. In the space provided can you indicate what 'added value' integration between health and social care in community care brings to: \***

The

servic

e

\*

user?

Local  
autho  
rity?

\*

The  
integr  
ated  
trust?

\*

**6. What disadvantages do you believe integration between health and social care providing community care services brings to: \***

The  
servic  
e  
user?

\*

Local  
autho  
rity?

\*

The  
integr  
ated  
trust?

\*

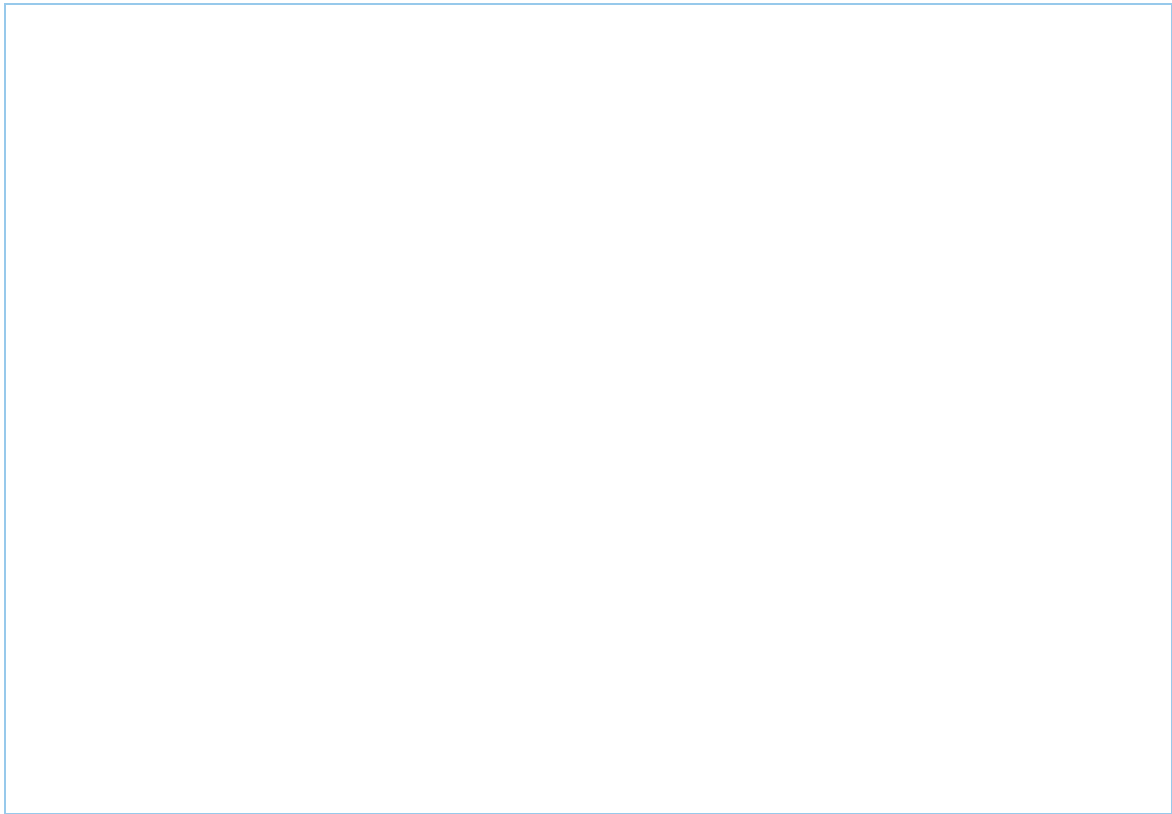
**7. Are there any barriers to effective functioning in the integrated trust? \***

A large, empty rectangular box with a thin blue border, intended for a written response to the question above.

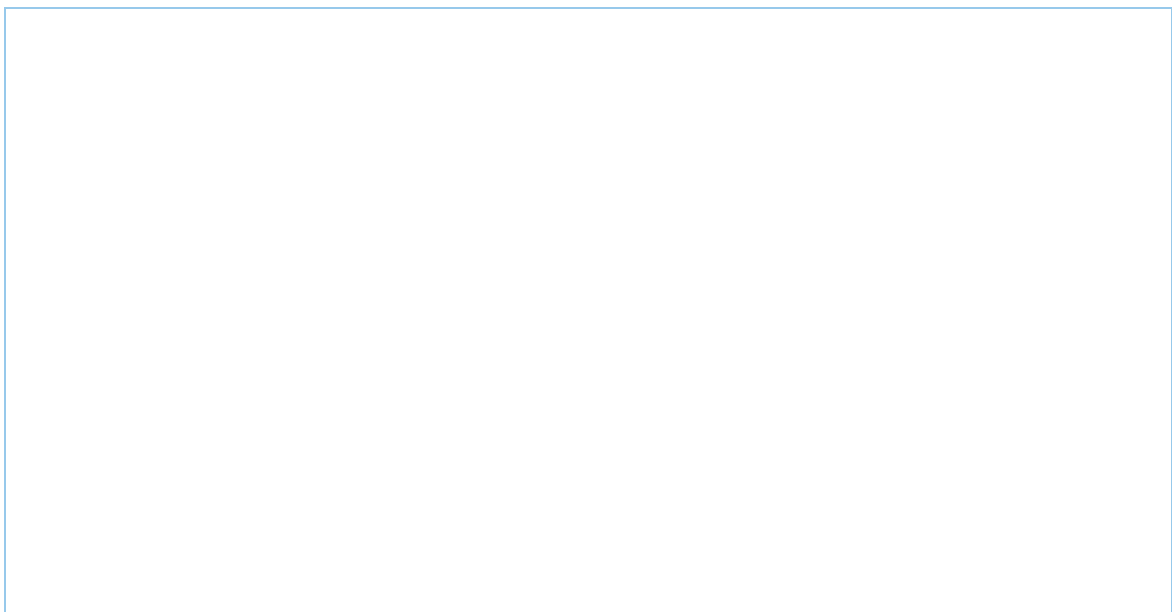
**8. What are your perceptions of the roles, duties and responsibilities of social workers in an integrated trust? \***

A large, empty rectangular box with a thin blue border, intended for a written response to the question above.

**9. What is their specific/unique contribution (if any) to the functioning of a multidisciplinary team? \***



**10. Within the current economic climate what pressures are there to sustain integration or lead to disintegration? Please provide two or three sentences to explain the pressures. \***



A large, empty rectangular box with a thin blue border, intended for a reflection or answer.

**11. Upon reflection what factors do you think have made integration successful or not? \***

A large, empty rectangular box with a thin blue border, intended for a reflection or answer.

**12. How do they feel about working in a multidisciplinary team? \***



**13. Looking ahead what pressures are there (e.g. economic, legislative, political) that challenge any current arrangement? Please explain under the following headings: \***

A.   
Economic \*

B.   
Legislative \*

C.   
Political \*

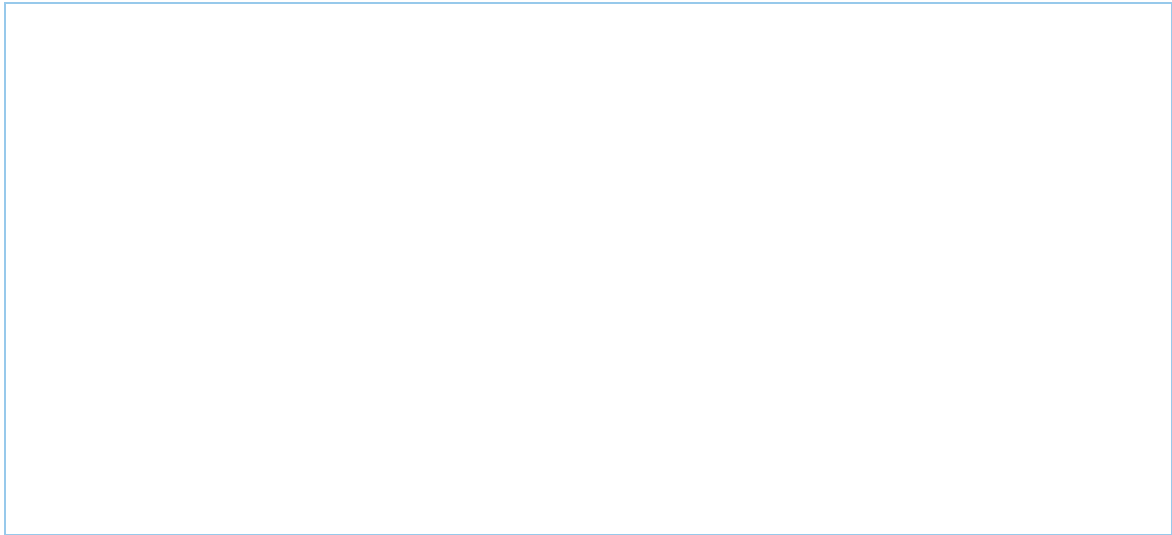
D.

Other

\*

**14. Can you explain how your organisation might overcome such pressures or challenges? \***

**15. What would help to improve the quality of social work intervention in integrated working and develop social work professionals' contribution for a better service? \***



## 9.2. Appendix 2 Information sheet and consent form



[Informed Consent Form for \_\_\_\_\_]

This informed consent form is for community workers working within Staffordshire and Stoke on Trent Partnership NHS Trust whom we are inviting to participate in an

exploration of research, titled “An ever changing culture: What is the contribution of social workers within an integrated setting?”

**Name of Lead Researcher: Darryl Phillipowsky**

**Name of Organization: Staffordshire and Stoke on Trent Partnership NHS Trust**

**Name of Sponsor: Staffordshire and Stoke on Trent Partnership NHS Trust**

**Name of Project: An ever changing culture: What is the contribution of social workers within an integrated setting?**

**You will be given a copy of the full Informed Consent Form**

## **Part I: Information Sheet**

### **Introduction**

I am Darryl Phillipowsky a social worker, working for Staffordshire and Stoke on Trent Partnership NHS Trust. I am conducting research on What is the contribution of social workers within an integrated setting? It will particularly explore the cultural and contextual drivers of social work practice as well as exploring the professional identity of social work professionals within an integrated environment.

The research is detailed below and I invite you to contribute to this professional led social work research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to the gatekeepers (team managers and the professional lead for social work) as well as myself who will be happy to answer any questions you have about the research project.

### **Purpose of the research**

The aim of the study is to utilise a social work perspective in order to explore the views and opinions of all community based professionals working within the integrated locality teams, regarding their perceptions of the social work role and duties, the social worker’s responsibilities and position within the team and the contribution social workers provide as well as an opportunity for their suggestions and comments. This area of social work integrated adult social services and health teams is a relatively new development in England with minimal research in this field in existence at the present time.

The objectives of the present research study are to explore social workers’:

- views regarding their social work role and statutory duties
- experiences of cooperative and collaborative work, is there a sharing of skills and knowledge?
- experiences of support received by social workers and health managers. Who leads? Who manages?
- views on the role of anti-oppressive practices in social work
- views of multidisciplinary team structures in relation to social work identity
- opinions regarding the challenges of cultural and contextual drivers of social work practice.

### **Type of Research Intervention**

This research will involve your participation in a questionnaire that will take approximately 10 minutes to complete. You may subsequently be invited to participate in a follow up interview.

### **Participant Selection**

You are being invited to take part in this research because we feel that your experience as a community worker within an integrated team can contribute much to our understanding and knowledge of the perceived contribution social workers make to the integrated team.

### **Voluntary Participation**

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may change your mind later and stop participating even if you agreed earlier and you will have a right to withdraw 72 hours' post-questionnaire completion if you so wish.

### **Procedures**

We are asking you to help us learn more about the contribution of social work within integrated working environments. We are inviting you to take part in this research project as a qualified community worker. If you accept, you will be asked to participate in a questionnaire.

The information recorded is confidential, and no one else except the researcher will have access to the information documented. The data will be destroyed after the completion of the research project and kept for a maximum of 6 months from completion date.

### **Duration**

The research takes place over 4 months in total.

### **Risks**

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the discussion/interview/survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

**Benefits**

There will be no direct benefit to you apart from contributing to your continuing professional development (CPD), but your participation is likely to contribute to evidence based practice that will inform the profession.

**Reimbursements**

You will not be provided any incentive to take part in the research. Your participation is entirely voluntary.

**Confidentiality**

We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private and all data coded to maintain anonymity. Only the researchers will know what your code is and this key will also be destroyed upon completion of the project.

**Sharing the Results**

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we get from this research will be shared with the profession.

**Right to Refuse or Withdraw**

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating at any time with no consequence. In addition you will also have the right to withdraw 72 hours post completion if you so wish.

**Who to Contact**

This proposal has been reviewed and approved by the research lead for SSOTP whose task it is to make sure that research participants are protected from harm. If you wish to find about more about the research ethics process please contact Hazel McKay. It has also been subject to an ethics review at Worcester University, which is supporting the study.

**Part II: Certificate of Consent**

I have been invited to participate in research about the contribution of social workers within an integrated setting? I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

**Print Name of Participant** \_\_\_\_\_

**Signature of Participant** \_\_\_\_\_

**Date** \_\_\_\_\_

**Day/month/year**

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

**A copy of this ICF has been provided to the research participant.**

**Print Name of Researcher/person taking the consent**\_\_\_\_\_

**Signature of Researcher /person taking the consent**\_\_\_\_\_

**Date** \_\_\_\_\_  
Day/month/year



### 9.3. Appendix 3 NHS Permission letter



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ST16 2ST

Staffordshire and **NHS**  
Stoke on Trent Partnership  
NHS Trust

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The Midway  
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ST5 1QG

Tel: 0300 123 1161  
[www.staffordshireandstokeontrent.nhs.uk](http://www.staffordshireandstokeontrent.nhs.uk)

08 December 2016  
Our Ref: RDU-STU-025

Dear Darryl

#### NHS PERMISSION FOR SERVICE EVALUATION STUDY

**Study Title:** What is the contribution of social workers within an integrated setting?  
**Reference Number:** RDU-STU-025  
**Service Manager:**  
**Study Site:** Staffordshire and Stoke on Trent Partnership NHS Trust

Thank you for completing the MRC decision tool to determine whether your study is service evaluation or research. The decision tool concluded that your study would not be considered research by the NHS, on the basis of this and the information that you have provided we issue permission for this study to be undertaken as Service Evaluation.

In line with Research Governance requirements you will be required to submit a yearly update for your study and an end of study report.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal regulatory requirements, this will be achieved by random audit by our department.

Please ensure that your Clinical Director is aware of this study and has no objections and that all relevant legislation such as the Data Protection Act and NHS Trust policies and procedures are followed when carrying out this evaluation.

We would like to take this opportunity to wish you well with your study. If your study should change so that it would be re-classified as research or you need any further advice or guidance please do not hesitate to contact the Research Delivery Unit on 01782 673885.

Yours sincerely

Dr Jon Packham  
Associate Medical Director for Research

Date: 5/1/17

Copies to: Addressee  
NHS R&D Office

Chief Executive Officer: Stuart Poyner

Chair: David Pearson

Staffordshire and Stoke on Trent Partnership NHS Trust is responsible for providing NHS and Adult Social Care services in Staffordshire and Stoke-on-Trent

## 9.4. Appendix 4 Journal of Integrated Care article

The current issue and full text archive of this journal is available on Emerald Insight at:  
[www.emeraldinsight.com/1476-9018.htm](http://www.emeraldinsight.com/1476-9018.htm)

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# The perceptions regarding social workers from within an integrated trust in an age of austerity

Darryl James Phillipowsky  
*Staffordshire and Stoke on Trent Partnership NHS Trust, Stafford, UK*

### Abstract

**Purpose** – The purpose of this paper is to explore community professionals' opinions concerning social worker's roles and statutory functions; understanding of collaborative and cooperative work; experiences of professional support; opinions on the aspects of anti-oppressive practices in social work; views on social work identity within multi-disciplinary team structures; exploring perceptions regarding the challenges of cultural, and contextual drivers of social work practice.

**Design/methodology/approach** – Design: thematic analysis of free-text data from a survey. Setting and participants: social workers, occupational therapists and nurses working within an integrated Health and Social Care NHS Trust. Main outcome measures: free-text coded and categorised by theme. Overarching themes are identified incorporating comment categories. Methods: 41 respondents (of  $n=600$  survey respondents) provided free-text comments. Data were coded using a multistage approach: coding of comments into general categories (e.g. resources, budgets); coding of subcategories within main categories (e.g. s75 agreement, staffing levels); cross-sectional analysis to identify themes cutting across categories; and mapping of categories/subcategories to corresponding comparable research for comparison.

**Findings** – Most free-text respondents (51 per cent) were from social workers, with 32 per cent from occupational therapists and 17 per cent from nurses. These respondents provided comments that the authors developed into four overarching themes: first, culture – cultural biases and clashes of culture within an integrated care organisation which result in a negative experience for professionals and confusion for service users and/or carers. A lack of shared socialisation and the development of a shared culture. Second, austerity: the impact of economic austerity. Third, organisation: conceptual confusion in respect of defining/organising/structuring integrated care within a health organisation. Fourth, political: the political drivers of integration.

**Originality/value** – This study presents specific areas of concern for social workers and for integrated social care and health as a whole, revealing a number of themes present across the integration journey. While the majority of comments were negative, analysis reveals concerns shared by significant numbers of respondents: conceptual confusion in respect of organising integrated care within a health organisation, a lack of shared socialisation and the development of a shared culture within the integrated organisation, and the impact of economic austerity on integration.

**Keywords** Integrated provision of care, Integrated care, Partnership working, Multi-disciplinary teamwork, Integrated health and social care

**Paper type** Research paper

### Introduction

We are in an era of public sector policy drivers that encourage social care and health integration and as a result social work with older people in the UK has increasingly become assimilated within a health care system (Hudson, 2002; Lilo, 2016; Lymbery, 2006) as a result of the provider/commissioner model of welfare delivery (Minkman *et al.*, 2009). The definition of integrated care used in this study is that of one organisation delivering health and social care "under one roof" (Coxon, 2005), as opposed to existing research that primarily focuses on cross-agency working, agencies working with each other in health and social care (Meads *et al.*, 2008).

The authors thank Dr Peter Unwin, Principal Lecturer in Social Work and University of Worcester for comments that greatly improved the manuscript.

Downloaded by Darryl Phillipowsky At 08:17 10 October 2018 (PT)



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The issue around integrated health and social care, particularly for social workers, is a pertinent one when the public sector in England is under unprecedented austerity measures (HM Treasury, 2010; Taylor-Gooby and Stoker, 2011). This study took place in a locality where the current arrangements for the delivery of statutory adult social work services are that of the local authority commissioning care to a provider; in the case of this research, an NHS Trust is providing integrated health and social care services. This arrangement has resulted in teams consisting of adult social workers, community nurses and occupational therapists working alongside each other in localities to provide integrated services to the local population. The backdrop to this arrangement is one that is stated to be more efficient and cost effective than those that preceded it. This form of integration has received widespread support, and in principle is widely supported (Gray and Birrell, 2013). Gray and Birrell (2013, pp. 105-110) explore this issue further highlighting that persistent difficulties remain with regards to different funding arrangements between local authorities and Healthcare Trusts. This has included the arrangement of disparate financial frameworks when endeavouring to pool budgets, as well as different tax regimes, charging policies, planning and budgetary schedules.

Integrated care has been researched in the past but is predominantly focused on the mental health service (Larkin and Callaghan, 2005). This study explores the importance of integrated health and social care for older adults with a particular focus on social workers who as outlined in the Care Act guidance are the key players in driving this agenda forward. This study explores the perceptions of social workers operating within an integrated trust in a time of economic austerity.

Professional identity is often inextricably linked to concepts of self, based on an individual's experiences, societal beliefs and values (Ibarra, 1999; Schein, 1978). A stated aim of the research was to describe the method of practitioner engagement with their dynamic role and the impact on their professional practices, knowledge and skills (professional identity). The research explores how social work identities are constructed by professionals who are challenged by complex, and often ambiguous public sector responsibilities (Baxter, 2011). The literature in this area is complex with professional identity viewed as an unstable element, difficult to quantify; it is an ongoing process of analysis and adaptation which is shaped by environmental workplace factors. This research explored the understanding of culture within the workplace, the need to maintain professional boundaries, exploring professional socialisation, jurisdiction disputes and inter-professional tensions within an integrated health and social care team. It reiterates the importance of beliefs, professional protectionism and the perception of security that comes with a sense of association to the research particularly around issues of professional identity (Rothausen *et al.*, 2015). This is echoed in the literature within organisational settings that explore identity and identification (Ashforth *et al.*, 2008) which states the fundamental phenomena responsible for identity formation and conservation are attachment and belonging. This conception is also reflected in the institutional logics formulation of identity (Thornton and Ocasio, 2008; Thornton *et al.*, 2012).

The Care Act 2014 and the *Five Year Forward View* (Department of Health, 2014) emphasise a duty on behalf of local authorities to encourage further formalised integrated care; this includes adult social care increasingly being integrated with provisions within the NHS and allied sectors such as housing.

This is a rare study in the current contextual climate with a profession that is subject to continuous reform and is at the forefront of dealing with the public who have been subject to unprecedented levels of austerity that have impacted the support social workers can offer. This is particularly pertinent in adult social care with recent shortfalls acknowledged by the government and the introduction of the social care precept whereby local authorities in England were given the power to increase council tax to pay for social care services for adults (HM Government, 2015).

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## Methods

### *Study design*

The research design utilises thematic analysis as a key benefit of this approach because of its flexibility. This method identifies, analyses and reports on patterns (themes) within data sets. It essentially describes and organises the data set in rich detail, often going further than this by interpreting numerous facets of the topic being researched (Boyatzis, 1998) and therefore is consistent with the social constructionist paradigm. The questionnaire data were analysed by thematic analysis using a social constructionist paradigm whereby our lived experiences and internal constructions of reality are constituted in and through discourse, the goal of this analysis being to unpick the processes through which this discourse and the "subject's internal world" is constructed. It "involves an attention to the ways in which language does more than reflect what it represents, with the corresponding implication that meanings are multiple and shifting rather than unitary and fixed" (Burman and Parker, 1993, p. 3). One can interpret themes using discourse analysis to identify, compare, contrast and make sense of themes within texts (Hollway, 1989; Potter and Wetherell, 1987; Burman and Parker, 1993). A strength of the social constructionist approach is its focus on the cultural and social relatedness of participant's data, however, one should be mindful that this is not merely reduced to the level of narrative.

### *Cohort identification*

In order to inform the profession, it is necessary to ascertain both divergent and consensus views. A convenience sample of professionals from the integrated trust was invited to participate in the study and this was entirely voluntary. This convenience approach was designed to minimise the potential for researcher bias during the selection of participants. Purposive sampling was adopted whereby participants were grouped according to pre-selected criteria in this case they must be qualified social workers or qualified registered community professionals who within their role work closely with social workers.

### *Survey and design content*

This paper forms part of a larger study design. The analysis and discussion in this paper is based on 41 responses from a questionnaire-based survey. This survey captured demographic data such as profession, length of service that was deemed relevant and insightful into the differences of opinion and perception in those professionals who worked prior to integration and those who have solely worked within an integrated setting. In addition, the questionnaire also explored the respondents' perception of social workers within integration. By distributing the survey to a targeted audience of community professionals in order to understand a perceived contribution of a specific professional group, the study was able to examine cultural data. Cultural data in turn necessitate experts. It is participants who offer expert explanations and who represent the societal intracultural variation (Bernard, 2002).

### *Survey process*

Survey through questionnaire distribution, the study invited community professionals to participate and complete an online survey via an online survey provider (Appendix). The survey is an adaptation from a survey instrument developed by Mersey Care NHS Trust Integrated Care Demonstrator Site Project and NHS North West Health Education Workforce Transformation Initiative in 2016, the results of which were published in Lilo (2016). The survey comprised of a series of open and closed questions:

- (1) background information/demographics;

- (2) understandings about the value of social workers;
- (3) perception of integration across health and social care within the trust; and
- (4) perception of social worker's role and contribution.

The survey was available online for six weeks. It took approximately 30 minutes to complete. This study differs from existing research in that it is exploring integrated adult social care rather than mental health services, although some aspects overlap and complement each other such as professional identity and culture. This study specifically explored adult social care within an integrated trust which involves different client groups, services and professionals.

#### *Survey sample*

The participation rate for social workers answering the survey was significantly higher than those of other professions at 51 per cent as opposed to 32 per cent occupational therapists and 17 per cent nurses. In addition, over 50 per cent of respondents had over ten years' service. There are several factors why this may have been the case including the fact the study was about social workers and was conducted by a social worker. The results also allow us to see that the majority of participants have been in an integrated post (after 2012) and so will be deemed to have expert knowledge and able to make informed and valuable contributions to the research question.

#### *Ethics and governance*

Ethical approval was gained from the University of Worcester and the local NHS Trust where the study was undertaken.

Surveys were completed at the respondents own discretion in a location in which the respondent was comfortable – most commonly their place of work thus minimising risks to their safety. Participants and their organisations were informed they would not be named in subsequent write ups and material submitted for publication.

#### **Analysis**

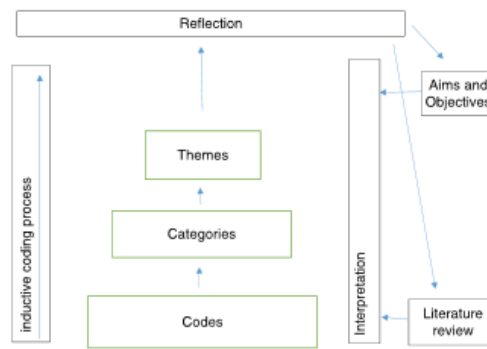
##### *Data analysis*

An interpretive thematic analysis, using both inductive (generated from the data set) and deductive (informed by prior research and theory) methods of analysis, was utilised to examine the data (Boyatzis, 1998). Specifically, the developing analysis was influenced by both primary material (i.e. survey results) and secondary sources (i.e. the literature review). A preliminary coding of the survey data was conducted; identifying "units of meaning" in the data set, which became an initial set of codes (Figure 1).

The process of thematic analysis as Boyatzis (1998, p. 4) has observed is "not another qualitative method but a process that can be used with most, if not all, qualitative methods [...]". Thematic analysis was used as a tool to locate, analyse, and identify patterns in the data that could be categorised and reported with exemplars (Boyatzis, 1998; Braun and Clarke, 2006). An iterative approach to data collection was adopted and analysis moving back and forth over the data, rather than in liner steps: analysis began after the initial surveys were returned. The research was conducted in two phases, this paper concerns the initial phase. Where participants completed surveys that were subjected to analysis, the resulting themes within the data set will then be used to inform the second phase and further research.

The initial familiarity with the data set produced a descriptive thematic analysis looking at the semantic or the latent level of meaning within the data set. These descriptive or semantic codes predominantly stay very close to content of the data, to the participants' meanings. An example of this is "Austerity has torn the social care system to bits".

**Figure 1.**  
Inductive thematic  
analysis the data



Source: Braun and Clarke (2006, p. 83)

Subsequently upon greater familiarity with the data set codes were interpreted, looking beyond the participants' meanings to identify meanings that lie beneath the semantic surface of the data. An example of this latent code is "resource constraints"; this code offers a conceptual interpretation to make sense of what the participant is saying.

Some codes mirror participants' language and concepts; others invoke the researchers' conceptual and theoretical frameworks. For example, the code "social workers not respected" stayed very close to the participants' use of language (e.g. "Social worker role needs to be more promoted and out there so that others are aware what we do!"). In contrast, the code "social perspective" invoked our frame of reference: no professional spontaneously used the term "perspective" to describe their unique viewpoint and contribution, but we interpret their accounts through this framework (Gray, 2010, p. 97).

Subsequently, the analytical process was extended and evolving themes were interpreted within the constructionist framework (Burr, 1995). The first phase of the study which involved completion of a survey produced initial codes. These initial codes were then grouped into thematic categories. At this stage, the analysis had moved from an initial descriptive thematic analysis to having adopted a latent thematic analysis, one that is complementary to a constructionist paradigm (e.g. Burr, 1995), where wider assumptions, structures and/or meanings are theorised as supporting what is actually expressed in the data. This approach is dependent on my interpretation of the emerging themes and the subsequent analysis with the established predominantly pre-austerity literature around integration. Finally, excerpts from the data were selected to illustrate the themes in the participants' own words (Braun and Clarke, 2006).

A number of strategies were adopted to provide rigour to the data analysis and support the credibility and trustworthiness of my findings. These include strategies outlined by Morse *et al.* (2002) that included methodological coherence, appropriate sampling and frequent supervision and debriefing sessions between the researcher and supervisors to discuss and explore pertinent issues pertinent to the project. In addition, reflection was a crucial part of the process allowing the development of a dynamic relationship between sampling, data collection and analysis, in addition to thinking theoretically. Other strategies that ensured rigour included purposive sampling, consisting of participants who best represent or have knowledge of the research topic to support an in-depth understanding (Higginbottom, 2004) of social worker's contribution within an integrated trust.

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## Findings

The initial data set is generated four main themes: culture, austerity, organisational and political.

Perceptions  
regarding  
social workers

### *Culture: social workers operate differentially to health colleagues*

The clear narratives from those surveyed were a clear sense of difficulty and frustration trying to maintain and assert one's culture when subsumed by a larger force. The predominant answers came from social workers and appeared to be from a position of disempowerment and marginalisation:

It is very difficult for a small minority profession to be based in such a large health organisation (Social worker)

It should be noted that social workers took the opportunity to lay out a plethora of statutory functions that they are duty bound to deliver on behalf of the local authority:

Social worker role needs to be more promoted and out there so that others are aware what we do! (Social worker).

Advocacy was repeatedly mentioned by all professionals as a unique contribution that social workers make:

We should be standing up for people fighting for what is right having services to meet the needs, act as advocacy, champion human rights, be there. make people safe (Social worker).

The clash of cultures was frequently mentioned as a challenge and impediment to true integration:

Health managers above social workers do not understand social work and often approach challenges in our role from a business or health perspective (Social worker).

I have never been made to feel so worthless in a 17-year career in social work (Social worker).

One worker summarised an area where social workers were overlooked yet considered experts in this field:

E.g. recently the NHS struggled with meeting Mental Capacity Act standards – i.e. nurses were not gaining valid consent under the MCA. The Trust did not consider how social workers are often seen as leading professionals in this area (Social worker).

Interestingly nurses see social workers as:

[...] overworked. They seem to spend a lot of time at computers and on phones. (Nurse).

### *Austerity: cuts have hampered integration*

A common thread through the various responses of the participants was their implicit and explicit references to austerity impacting on every aspect of integration. Their narratives demonstrate respondents' beliefs that severe and enduring cuts to the public sector have resulted in a poorly designed integrated service where the full benefits of social workers have yet to be realised:

Austerity has torn the social care system to bits (Social worker).

Budgets appear to cause issues (Nurse).

There is a perception that cuts have been disproportionate:

For health it has benefitted health professionals, but I don't think it has been successful for citizens or for social care, social workers or the care market (Social worker).

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Several responses from nurses mentioned budget constraints impinging on the delivery of services. Some respondents went further, stating that resources are not in place to deliver upon statutory responsibilities/key services:

The Care Act sounds great but the reality it cannot be delivered within the current climate (Social worker).

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*Organisational: the structures have been poorly designed and bureaucratic*

The systems and structures in place were significant areas of concerns for all professionals. The narrative that was consistent was an organisation that is too large and rigid in its approach to service delivery:

It is the integrated organisation that is at the root of most problems (Social worker).

We are not an integrated Trust. We are co-located professionals (Social worker).

An approach that seemingly ignores key differences in ways of working:

[...] integration means social workers and nurses in same office which doesn't work (Nurse).

I have very little faith that our organisation will overcome the challenges (OT).

There was a sense that the organisation operates primarily as a health care provider and not a health and social care provider:

It feels as though the trust sees social care as expensive and alien to them. They do not seem to have an understanding of the statutory responsibilities that they carry out for the Local Authority (Social worker).

Although there were some noted benefits, nurses responded in the affirmative with regards to communication having improved significantly since integration:

[...] it clearly makes sense to be integrated, as the professional boundaries have reduced (Nurse).

*Political: integration and social work as a political football*

All professional groups that responded inserted pessimistic comments, it appears there is a quiet resignation that things are not getting better:

Failure to "drive" the integration agenda has allowed it to drift back to the "silo" way of working (Social worker).

The narrative throughout responses was that social workers were powerless, a sense of being an issue that needed to be dealt with:

We have no power or control anymore (Social worker).

Being "subsumed by Health and their agenda" (Social worker).

Indeed nurses observed that politics plays a huge role. There was a coalescence of opinion about the role of politics in particular in relation to the provision of social care services:

Politics plays a huge part in how social care is funded (Nurse).

Government setting unrealistic targets that are unachievable (Nurse).

#### **Discussion**

This study emphasises the perceptions of a sample of community professionals practicing within an integrated social care and health care setting working for one integrated organisation. The codes were generated from an electronic survey completed by professionals



that explored their perceptions of austerity, culture, alienation and learning within the broader context of integrated social care and health environments affected by austerity measures. However, austerity was not initially a focus but rather emerged as a key theme following data analysis. Participants' accounts also revealed an acknowledgement that change is a necessity based on the social demographics in the UK pointing to an aging population and current policy and legislation that mandates closer integration between health and social care (Jaafari, 2003). Concern with how meaningful change can be achieved, who is responsible for what aspect of service provision, accountability and risk management is a necessity before such an arrangement can possibly hope to function effectively (Glasby and Littlechild, 2009; Ahgren and Axelsson, 2005). The participants all worked for an organisation that on paper had been integrated for the past five years, there responses despite being integrated for this significant period of time still adhered to traditional concepts of service delivery needs (Ovretveit, 1993; Malin *et al.*, 2002). There appeared to be little or no evidence within the responses of the participants of innovative practice occurring within the integrated trust and instead the responses suggested a retrenchment of positions that served to reinforce the polarising effects of silo working. This ability to work together effectively (or not) appears to be dependent upon a shared vision, with organisational and managerial support, alongside strong professional leadership. These are qualities that participants accounts clearly and decisively say are lacking within the organisation. Social workers report feeling assimilated and marginalised whilst nurses and occupational therapists see social workers as a drain on resources and challenging to the status quo.

The responses reflect a deep-rooted fear or ambivalence towards integration (the merging of two cultures) and how we manage knowledge throughout such a complex system with competing interests and cultures (Brown *et al.*, 2003; Attwood *et al.*, 2003; Ahgren and Axelsson, 2005). The move towards joint working has in the past questioned respective agencies real ability to distinguish between health and social care when working with vulnerable or older people and their families to meet their complex needs. Integrated working challenges traditional concepts of service delivery, through retaining a clear sense of the service user, lessened dependence, providing services of high quality for people with complex needs (Ovretveit, 1993; Malin *et al.*, 2002).

### Conclusion

The main issues identified within this study have highlighted challenges in respect of integrated working. These were:

- conceptual confusion in respect of defining/organising/structuring integrated care within a health organisation;
- cultural biases and clashes of culture within an integrated care organisation which result in a negative experience for professionals and confusion for service users and/or carers;
- a lack of mutual knowledge and respect between professionals, a lack of transparency and vision from strategic management to frontline professionals;
- a lack of shared socialisation and the development of a shared culture; and
- the impact of economic austerity.

This study offers an insight into the experiences and the perceptions which social workers and their colleagues have on the role and the impact roles within an integrated Social Care and Health Trust. The aim of this study was to explore the perceptions around social workers from within the integrated trust.

This study argued that professionals valued social workers' unique identity and contribution even if it was not fully understood by colleagues. Their contribution was

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valued as adding something different to the status quo. The study showcases a number of facilitating factors within the integrated trust, such as the inter-professional dialogue and collaboration alongside the aspirational shared values of working together for the good of the service user; and inhibiting factors, such as the perceived segregation and alienation of participants within the integrated trust from fellow professionals and the feeling of abandonment by social workers cut-off from the local authority which traditionally employed them coupled with an almost complete lack of understanding from colleagues and managers of different disciplines about the complexities of the social work role. Such inhibiting factors would be greatly overcome by a re-engagement of the local authority as the commissioner of social care services with the frontline staff of providers who are working to deliver statutory social care on their behalf. The structure of the organisation is also designed for health and is in itself an inhibiting factor to social care integration with obstacles at a macro-level due to systemic level disagreements between the National Health Service and local authorities ever present (Bailey and Liyanage, 2012; Rees *et al.*, 2004). A strategic vision is crucial at the macro-level if integration is to be deemed a success.

The current study replicated these findings and mirrored previous studies in mental health with social workers reporting a feeling of being marginalised from their local authority (Bailey and Liyanage, 2012). This study explored the perceptions and the realities of working within an integration trust. The participants acknowledged that integration can be beneficial due to inter-professional sharing of knowledge, perspectives and experiences and that there was a shared aim in supporting service users; however, this requires careful and thoughtful structures in place to support such ideals becoming reality. Perceptions remained of feeling oppressed and isolated from supporting factors such as the local authority. The credibility of the study is enhanced by its consistency with comparable studies (Bailey and Liyanage, 2012; Brown *et al.*, 2000; Carpenter *et al.*, 2003; Gibb *et al.*, 2002; Hannigan and Allen, 2011; Peck and Norman, 1999; Rees *et al.*, 2004). The concerns expressed in the responses were that the integrated trust was only interested in budgets cuts, rather than professionalism and good practice. This study, however, was conducted within an integrated trust that has steadfastly maintained its commitment to the full integration of services. The reality, however, does not match the rhetoric with participants branding integration a failure. The accounts suggested ways to improve and enhance the current implementation of integration with appropriate professional supervision from the same discipline – peer support; management representation supporting the maintenance of a distinct professional identity, with shared education and training, being seen as vital to integration being a success allowing for the emergence of a shared culture and mutual respect that should translate into good joint practice. Most importantly co-location not integration was the preferred option, with participants seeing all the benefits and none of the negatives; as lines of accountability, responsibilities and roles remain distinct and separate. The resounding consensus from all participants is that co-location works, integration does not.

*What has the impact of social workers been in the integrated trust?*

This study would argue that the impact has been quashed by the current economic austerity that despite the potential being there to influence existing ways of working without the shared vision, the leadership and the resources, the impact has not been felt and is not wide ranging and is limited to local pockets of good practice, it is by accident rather than design. The integrated trust is very much an ideological initiative driven by the need of local authorities to save costs whilst extending market forces into further areas of public service provision and concealing needs away from wider contributory practicalities, such as those relating to explicit structural factors including poverty and inequality. As noted in this study social workers are perceived as being excellent advocates and in this regard, they have had an

impact on the service user and carer voice within the integrated trust but their impact on the wider staff group and organisation according to the responses has not been felt. It is surprising given the findings of this study that more resistance has not yet emerged from professionals who have been made subject to these extensive reforms. This study would argue that social workers within the integrated trust are now beginning to reassert their unique role and contribution; and I am satisfied that responses from participants have highlighted the advocacy and distinctly constructive role social workers play working with service users and carers; core social work roles and functions not only were found to be not understood, but also seen as the purview of social workers with nurses and occupational therapists responding in such a way that indicates that they have little interest in undertaking any of these social work functions. There may be less social work professionals within an integrated service as a result of the multitude of factors discussed above, but they appear for now to be doing a job that nobody else understands and wants to undertake.

#### Study's recommendations

- Joint education during professional training.
- Improved and sustained communication and collaboration at a systemic, organisational and managerial level between the relevant health and social care services; clinical commissioning groups (CCGs) which were created following the Health and Social Care Act in 2012, local Health NHS Trusts and local authorities.
- Need for local authorities to re-engage and be pro-active with regards to the statutory functions social workers are carrying out on their behalf.
- Appropriate professional supervision by managers of the same discipline to support professionals within the integrated trust in order to develop and maintain their professional identity.
- Development of trans-organisational peer support networks recognising the fragmentation of the social work professionals in local arrangements.

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(The Appendix follows overleaf.)

**Appendix. An ever changing culture: what is the contribution of social workers within an integrated setting?**

**1. How long have you worked in your current post? \***

- Less than 12 months
- 1-3 years
- 4-7 years
- 8-10 years
- Over 10 years

**2. How long have you been qualified? \***

- Less than 12 months
- 1-3 years
- 4-7 years
- 8-10 years
- Over 10 years

**3. What geographical area do you work in? \***

- North - Newcastle
- North - Moorlands
- South- Stafford
- South - Cannock
- South- Seisdon
- East - Burton
- East- Lichfield
- East- Tamworth

**4. Please state your registered profession: \***

**5. In the space provided can you indicate what 'added value' integration between health and social care in community care brings to: \***

The service user?

Local authority?

The integrated trust?

---

**6. What disadvantages do you believe integration between health and social care providing community care services brings to: \***

The service user?	<input type="text"/>
Local authority?	<input type="text"/>
The integrated trust?	<input type="text"/>

Perceptions  
regarding  
social workers

**7. Are there any barriers to effective functioning in the integrated trust? \***

**8. What are your perceptions of the roles, duties and responsibilities of social workers in an integrated trust? \***

9. What is their specific/unique contribution (if any) to the functioning of a multidisciplinary team? \*

10. Within the current economic climate what pressures are there to sustain integration or lead to disintegration? Please provide two or three sentences to explain the pressures. \*

11. Upon reflection what factors do you think have made integration successful or not? \*



12. How do they feel about working in a multidisciplinary team? \*

13. Looking ahead what pressures are there (e.g. economic, legislative, political) that challenge any current arrangement? Please explain under the following headings: \*

A. Economic:

B. Legislative:

C. Political:

D. Other:

14. Can you explain how your organisation might overcome such pressures or challenges? \*

15. What would help to improve the quality of social work intervention in integrated working and develop social work professionals' contribution for a better service? \*

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## 9.5. Appendix 5 PSW article



# LEAD US **IN** THE INTEGRATED **WORLD**

With social workers increasingly working in integrated teams **Darryl Phillipowsky** – a practitioner in a social care and NHS trust – asked colleagues what they need from managers

**W**orking in an integrated team means being in a setting where your line manager might not be a social worker and your line manager's manager might not be a social worker.

As someone who works in such an environment, I thought it would be a good idea to take the pulse of my fellow social workers to find out the kind of leadership they want.

Interviewing colleagues it quickly became clear how disenfranchised they had become and how much more they wanted from their managers. Based on their responses, there were four overarching themes:

**1. Leadership style.** Colleagues said they want managers who are not afraid of "taking a stand". They said this "means being visible and standing by what you said, not about

following". Another said: "Leadership is being supportive, supporting those under you or with you to understand their role within the social work value base."

**2. Value base.** Comments included: "Risk management and the non-judgemental values come in where lots of people think something is not acceptable. Social workers will often look at that and the bigger picture."

**3. Social model.** As one interviewee said, social workers "utilise a systems approach not a disease model. We look at the bigger picture".

**4. The future.** One colleague said: "I would like us to be seen, to be known, because I think we are just a forgotten profession." The importance of "media relations, championing the profession to the public and ourselves," was also highlighted.

It may sound obvious, but the overwhelming response from social workers about what they want from their managers

was social work skills. They want someone who understands the legislation and policies that underpin social work practice; managers who know about the power differentials that exist with health colleagues arising from the responsibility social workers hold as decision-makers.

Practitioners want managers that have a systemic perspective. As one colleague pointed out: "We explore coping strategies with individuals." Another said: "Social workers are good at supporting people to the right pathways." Social work's role in "fighting for individuals" and "recognising people's strengths and weaknesses" was also highlighted: "It's not about the outcome; sometimes it's about the journey."

Social workers also repeatedly said they want leaders with an understanding of anti-discriminatory and anti-oppressive practice.

*continued overleaf*

## feature

They saw managing as a collaborative process that should be inclusive and adaptable. Having "social-emotional skills" was identified as separating social work leaders from all others.

However, it was recognised that in integrated settings there was pressure on managers to conform to NHS styles of leadership that were seen as "anti-social work". These were described as having focus on career progression, budgets and audits.

All participants reaffirmed the profession as one that advocates for the oppressed, challenges the status quo and is often "not very popular".

Consequently, they want a manager who is committed to human rights and social justice – something which they saw as the cornerstone of social work leadership, informed by BASW's Code of Ethics.

## All respondents felt social work as a profession has become 'diluted' over the last decade as a result of integration

This was also something colleagues saw as unique to social work leaders, separating them from other managers within a crowded integrated service.

Colleagues I interviewed felt there was some ambiguity around social work in integrated environments because it does not 'fit' into the health model of service delivery. They identified a lack of understanding of their role among non-social work colleagues. Several participants thought educating others about social work was a key leadership requirement in an integrated setting.

There were also some positive leadership aspects arising from integration. Managers often worked more collaboratively with others and were more aware of political factors and receptive to ideas.

But all respondents felt social work as a profession has become "diluted" over the last decade because of integration.

Negative statements around the impact on social work leadership were reflected under four themes: an unwillingness to challenge; a corruption of the role; a focus on career, and being defined by the agency.

### The way forward

There were four key ways identified to improve social work leadership in integrated teams. They involve a greater focus on political advocacy, professional identity, balancing demands, and communication.

**1. Political advocacy.** This was about promoting human rights and social and economic justice, informing policy and legislation and highlighting the value of evidence-based practice.

**2. Professional identity.** Leaders must "fight for the profession", educating and promoting social workers as "distinct professionals in their own right".

**3. Balance.** An ability to "navigate an increasingly complex integrated social care and health system" was identified as key for managers. This, said participants, has to be done while retaining the balance of being "true to the profession".

**4. Communication.** Using the media and public relations to champion the profession to the public and fellow practitioners was seen as a key part of social work leadership. This included the need for leaders to be visible, highlighting the good that social work does, and communicating our role to the general public. Negative perceptions of the profession, participants said, requires social work leaders to have a more sensitive and vigilant approach to public relations than leaders in other professions.

### In conclusion...

Social workers want respect and an appreciation of the value they bring to the NHS. But without good social work leadership this is not easy to achieve. Participants recognised the importance of the educational role of social work leaders in achieving this. The majority felt leadership had not been as visible as it should have been.

### A definition for a social work leader

Speaking to social workers gave me the opportunity to develop a bottom-up approach to what professionals on the ground want from their managers. The five key attributes are: pro-active, values and ethics, reflection, advocacy and vision.

From this, we can draw the following definition:

**Social work leadership should be reflective in nature, committed to human rights and social justice, able to articulate a vision and take a proactive approach to empowering others.**

## SOCIAL WISE



### social work wisdom from social workers

Do you have a piece of social work wisdom to share? It could be tips, advice, a lesson learned, or an illuminating experience or anecdote. Email submissions of between 100 and 400 words to [editor@basw.co.uk](mailto:editor@basw.co.uk). The selected contributor each issue gets a £20 Amazon voucher! This month's contribution is from SASW Chair, David Thomson.

I WORK in a busy statutory criminal justice office and while I get a lot of satisfaction from the work I do, I have to think about how I look after myself. Like all social workers I often feel at the brink of burning out. For a while I had to take 'power naps' in the back of my car at the end of my working day because I was too tired to drive home. The situations of the people we work with were becoming more complex and this was taking its toll on me.

What has helped me and what I think all social workers can benefit from is speaking out about how they feel. This doesn't necessarily need to be their line manager but someone they feel comfortable enough to open up to. I can be quite opinionated and a bit bolshie but this has worked for me to get my feelings out and helped me ask for support when I need it. This doesn't work for everyone but we all need to find a way to ask for help when we need it and not just when things get to melting point. We promote and can see the benefits of early intervention with the people we work with; the same can be said for us. The systems that we work in can often feel that they go against us seeking help at an early stage but this can be challenged. The better we protect ourselves the better we can support the people that need us to be at our best, especially at a time when their rights are becoming increasingly jeopardised.

We all become social workers for our own reasons and should feel privileged to be in such a proud profession. But if we don't look after ourselves we could end up resenting the job that we've all worked so hard at.

## 9.6. Appendix 6 Raw data extract

Interview regarding austerity.

### **Do you think austerity has affected integration?**

*Yes, I do. Mainly because we have integrated, in name and staff are based only. Because if we hadn't got such austerity and we hadn't got such limited staff resource, equipment resource, even the limit on what rooms you can book for integrated team meetings and that really impacts on integration.*

### **Could you give me an example?**

*We thought it would be good to have a support worker who works across health and social care and but because of the way the budget is, and we have separate budgets we could not get that role agrees. We can see lots of opportunity there, but we just cannot do it, that is about what our financial envelope is what is social and what is health.*

*For us as nurses we can't do it no money, no flexibility in the budget just cannot do it.*

**\*\*Pause\*\***

*We are co-located but I think that is a by-product as we have to reduce the number of buildings as a trust. There is nowhere to have private integrated team meetings, no action learning sets and not only can you not find a place, but you cannot go anywhere because of the staffing levels.*

*I think austerity – people have gone back into their own little boxes, no, no that is not ours that is yours. If they were more flexible they could take someone on the periphery of the workstream even though that might be the best thing for the person teams are overstretched. Teams trying to make do.*

### **What about infrastructure?**

*Technology, the way forward is better technology systems that talk to each other. There is no money, so we can't have that. We have been integrated for 5 years, we still use different systems, we still have systems that don't talk to each other. If there was more money in IT, it could change the way people work.*

*Services are being decommissioned, private providers – nursing homes we used to have a team that went in and supported nursing homes – that team was decommissioned. Now we end up having an argument with that home district nurses aren't commissioned; social workers can't do it and so the person ends up bouncing back into hospital. That then impacts on the social care team in the hospital.*