Social Work within a Medical Setting:

An Ethnographic Study of a Hospital Social Work Team

Dan Burrows

DSW

Cardiff University

2018

Acknowledgements

Dedication

I dedicate this thesis to Hannah, Frank and Wilfred, and to the memory of my father, the great Clive Burrows.

Abstract

This thesis reports on an ethnography of a hospital social work team in Wales. The aim of this study was to explore the nature of the statutory social work role within hospitals, to examine how hospital social workers do their work, and to shed light on how social work fits into the hospital context. My findings indicate that hospital social workers face constant pressure from managers and clinicians to expedite patient discharges, and exclude almost all other tasks from their role. Their daily work is a sequence of bureaucratic tasks, focused on management of the failing body, often to the exclusion of considering the wider social or psychological needs of the patient. Drawing on the work of Bauman, I argue that the bureaucratic and managerial systems in which hospital social workers operate produce dehumanising practices and distance decision makers from the human consequences and moral dimensions of their decisions. Even within these systems, however, some levels of discretion are maintained and hospital social workers use their discretion in a variety of ways. The hospital social workers in this study consistently expressed values derived from anti-discriminatory practice and, despite the constraints they encountered, were able to perform work that showed a concern for social justice, human rights and empowerment at the individual's level. Thus, I argue that hospital social work in the UK is driven by liberal, rather than radical values, and is largely unconcerned with addressing wider issues of structure, social disadvantage and oppression. The hospital social work role involves the co-ordination of knowledge provided by clinical professions, which must then be processed to match the needs of the patient to the services that are available. Social workers are outsiders within the hospital setting and there is a considerable amount of distrust between them and the clinical professionals, which occasionally manifests in open conflict. I draw on Goffman's dramaturgical insights to analyse how social workers manage their position within the hospital and draw on his theory of frame analysis to understand the way conflicts arise. Hospital social workers maintain a distinct identity within the hospital that is tied to their liberal values. I argue that their practices can be interpreted both as arising from the zeitgeist of liquid modernity and as adapting to the human need brought about by liquid modernity. I suggest that social work must either pursue individual liberation further, following the liberal values currently underpinning these hospital social workers' practice, or adopt a more radical or critical approach in seeking to influence government policies around social care.

Contents

Chapter 1: Introduction

This thesis offers an account of the everyday work of a team of hospital social workers in Wales, exploring the personal and professional values that underpin their work, their relationship with the management structures that aim to control their work, and their negotiation of the hospital as a scene of inter-professional interaction. My interest in studying hospital social work began during the six years I spent working as a social worker within the paediatric oncology unit at the Children's Hospital for Wales, Cardiff. The job of the social worker in this role was to provide practical and emotional support to families while their children went through cancer treatment. Tasks included assistance with disability benefits claims and access to charitable grants, counselling support for parents and organising group activities for children and parents to enhance their well-being and foster peer support. I was part of a multi-disciplinary team that included doctors, nurses, psychologists, play therapists and other allied health professionals. This was far from the typical role of a modern UK social worker employed by a local authority, in which the focus of work is on the statutory functions that are governed by legislation. The statutory social work role, whether for children or adults, revolves around the protection of vulnerable people, assessing need and planning social care (Wilson et al., 2012) – in other words, investigating abuse and gatekeeping resources. By contrast, we had an enormous amount of freedom to organise our own work, to respond to the presenting issues of families using whatever theoretical orientation we chose and to work in creative ways with people from a wide variety of backgrounds. Unlike most social workers, we worked not only with people who were poor and disadvantaged, but people of all social classes, since childhood cancer can and does occur at random. The oncology unit was supported by a well-funded charity, which meant that resources were abundant and opportunities to work in creative ways were plentiful. If I described my job to other social workers, they would enviously observe that I was engaged in 'old-fashioned social work'. My experiences in this niche role inspired curiosity about two lines of investigation that are central to this thesis: the bureaucratisation of statutory social work, and the relationships between hospital social workers and clinicians.[1]

My interest in the bureaucratisation of social work arose from my awareness of the relative uniqueness of our role and the knowledge that social workers in most statutory roles are bound by procedures and obligations to capture, record and use information in specified

---

[1] Throughout this thesis I use 'clinician' as a generic term for any hospital worker who has direct contact with patients to provide clinical care – including doctors, nurses, physiotherapists, occupational therapists etc.

ways. Of course, these have been developed, for the most part, in order to allow social workers to perform their function as effectively as possible, yet bureaucracy is widely criticised in the social work literature (e.g. Broadhurst et al., 2011; Munro, 2011; Payne, 2006). One particular encounter during my time with the paediatric oncology unit highlighted the gulf between the 'old fashioned' social work we were engaged in and the work that social workers are more commonly expected to do by local authorities. Our posts were funded by a charity, yet we were employed by the local authority, under the management of their child health and disability team. This meant that, though we were left to 'work our cases' our own way, there were certain bureaucratic tasks that had to be accomplished to satisfy the local authority's chain of managers: each child had to have a formal assessment and care plan following rigid proformas that were designed for managing child protection and did not really suit the way our work was carried out. We regarded this as a minor inconvenience and had worked out a way of completing the proformas that satisfied my line manager without causing undue toil. A new senior manager however, began to scrutinise the work of the child health and disability team as recorded on the computer system and became uneasy about our work and the way it was done. He wanted to impose an obligation that we should see every child on our caseload at least once every six weeks, and carry out an in-depth assessment of each family when they first came into our service. These measures would be sensible for a child whose development were thought to be at risk of impairment or even to monitor the effectiveness of services provided by the local authority, but they were not necessary or practical for us. Some families needed intensive support during periods of crisis, while other families needed only minimal contact to ensure they received grants to which they were entitled. Furthermore, the families with whom we worked were scattered all over the Southern half of Wales, some as much as three hours' drive away from our base. To comply with such a requirement was therefore neither possible nor necessary, and we did not comply. This resulted in series of negotiations between the charity that funded us and the local authority that employed us, in which the local authority's senior manager took the position that our work was 'not what social work is' and proposed changing our job title. Social work for him had become so synonymous with procedures, statutory requirements and recording all aspects of the work using the local authority's data management software, that he was unable to acknowledge our work as social work. I became curious: if local authority social work is so different to the 'old-fashioned' social work we practised, what is modern social work? I wanted to know if social workers who have considerable bureaucratic obligations felt as able as I did to respond to human need and to act as their values directed them. I wanted to find out, in short, whether social work and bureaucracy are compatible.

It would be possible to explore the topic of bureaucratisation with any local authority team, whether with children or adults. I was interested specifically in hospital social work because it also offers an interesting way to study multi-disciplinary working. My own experiences on the paediatric oncology unit had left me with the impression that working within a hospital involves strenuous emotional labour (Hochschild, 2012), constant impression management (Goffman, 1959) and navigation of a complex social order. As a social worker in a health setting, I was aware of a duality of being both an insider and an outsider. Working as part of one specialised unit, I was usually considered an integrated part of the team, met regularly with colleagues from a variety of professional backgrounds to discuss and plan co-ordinated responses to the needs of our patients and their families, and shared in mutual emotional support with health colleagues in processing the emotionally draining aspects of the work. I became an outsider, however, on occasions when my role caused me to act in a way that transgressed the normal social order of the unit. For example, in the case of one particular child around whom there were some child protection concerns, I had suggested to the multi-disciplinary team that the first discharge would have to be carefully handled. I was somewhat surprised, one morning, to be told by the child's mother that she was taking the child home that afternoon. I then approached the consultant who confirmed that she had told the mother that the child could go home that afternoon and a discussion ensued about measures that needed to be in place in order that we could be sure that the child would be cared for properly at home. In a meeting the following day, the consultant described my approach to her regarding the issue, 'Well, he came stomping up to me…' My recollection was that I had been calm, polite and even deferential in my approach to the consultant. The consultant's reaction to being challenged reminded me that, in hospital teams, the most senior doctor is considered to be the highest authority on decisions over a patient, and does not usually expect to be challenged by a member of another occupation (Nugus et al., 2010). Because social work is a non-clinical role, however, the authority of doctors does not hold (this is most easily demonstrated by the Approved Mental Health Professional (AMHP) role, usually occupied by a social worker, in which the assessment of the AMHP holds equal weight with the opinion of the psychiatrist). I was therefore interested in exploring how social workers in hospitals manage their positions as insiders/outsiders, the nature of their relationships with clinicians and the reactions of clinicians to social workers in their midst.

Though my interest in hospital social work arose from my own experiences, this thesis is concerned not with the type of niche role as a social worker in a hospital that I had performed, but with the more common form of statutory social work practised by teams of hospital-based social workers employed by local authorities in hospitals all over Wales and

the UK as a whole. Typically, these teams work almost exclusively with older people who are inpatients, and are unable to be discharged safely without social work services because of social care needs that have come to light since their admission. Hospital social workers are responsible for arranging services for such patients to be discharged as quickly as possible. This involves making an assessment of the patient's needs, taking into account the views of the patient, clinicians and family members/carers, and producing a plan of services to enable the patient to be discharged safely from hospital. Typically, the care plan will arrange either for care services to come to the patient's home or for the patient to go into residential care. The social care needs of patients usually arise from declining physical health, increasing physical disability and/or problems of cognition often related to dementia. Hospital social work is therefore characterised by short-term involvement with patients, whose cases are usually then passed on for review by community-based teams, and pressure from clinicians and hospital managers to deliver patient discharges as quickly as possible.

The work of hospital social workers is topical at the present time in Wales and the whole of the UK because of public concern regarding managing the care needs of a growing population of older people, and because of pressure on the NHS to meet rising need, which is often exacerbated when people are unable to be discharged from hospital until social care has been arranged for them (commonly referred to as delayed transfers of care). In Wales, the number of people aged 65 and over is projected to increase by 44% between 2014 and 2039 (Welsh Gov., 2015). While merely reaching a certain age does not automatically mean that an individual will require hospital or social care, the increasing number of people living into their 80s and 90s, combined with a marked increase in a variety of chronic conditions such as diabetes and dementia, mean that it is likely that social care services will need to address increasing levels of complex needs as the older population rises (Age UK, 2017). Similarly, the NHS will see increasing demand, yet is already struggling to cope with the demands of the population due to limited capacity (King's Fund, 2014). Delayed transfers of care are therefore likely to increase pressure on a system that is already struggling to cope. It is surprising, therefore, that hospital social work receives little attention from research in the UK. This thesis will contribute to our knowledge in this area by examining the practices of social workers in hospitals and the way they interact with the wider multi-disciplinary team in their daily work of accomplishing patient discharges.

The thesis is composed of seven chapters. Following this brief introduction, Chapter Two reviews the historical development of hospital social work, examines themes related to social

work with older people in general and discusses what is known about hospital social work from recent empirical research. Chapter Three traces the research process and discusses issues of methodology. Chapters Four, Five and Six present analysis of the qualitative data I have gathered. Chapter Four examines the bureaucratic processes and managerial pressures that dominate the work of the hospital social work team in the study, drawing on the work of Bauman (1989) to discuss dehumanising practices and Lipsky (1980) to consider the use of discretion. Chapter Five asks whether the work carried out by the hospital social workers can still be considered to be 'social work', focusing on their commitment to social justice, human rights and empowerment and how they can realistically apply these in their role. Chapter Six then turns attention towards the way social workers fit into the wider hospital context, drawing on the work of Goffman (1959 and 1974) to consider their dramatization of their work and the conflicting frames that distinguish social workers from other occupational groups within the hospital. Chapter Seven, as the concluding chapter, reflects back on the three empirical chapters, outlines some theoretical conclusions and discusses applications to practice.

Chapter 2: The Development and Current Status of Hospital Social Work

Introduction

This chapter presents a narrative review of relevant literature, discussing the roots and development of social work in hospitals and the wider context of social work with older people. Recent research into the role and status of the hospital social worker is then be discussed, in order to identify areas in which new research is required. Finally, a conclusion is drawn indicating research questions for this study.

The literature for this chapter was located through a search strategy that aimed at identifying what is already known about the field and the nature of key debates within it (Punch, 2014). Three main substantive fields were identified as the starting point for the literature search. These were: The historic development of social work in hospitals; care management and community care; and recent empirical studies involving hospital social work. The generated texts were included if they fulfilled two criteria: firstly that they were written in English, and secondly that they were either peer-reviewed/edited or published by the government. The Social Care Online, SCOPUS and CINAHL databases were searched using Boolean terms, in addition to pursuit of relevant texts through citation chasing. For the historic development of hospital social work, the time frame for publications were texts up until the beginning 2004, after which time literature would be considered to belong under the category of 'recent research'. For care management and community care, there is an extremely large body of literature available. The search strategy for this section was therefore initially to include only books published in the last fifteen years, and to pursue journal articles, older books or grey literature only when necessary to provide evidence to illustrate a particular point or to explain a theoretical concept in more depth. The rationale for choosing books from the last fifteen years was that this time frame represents the period in which care management could be argued to be fully established as the model dominating mainstream hospital social work in the UK. The search for recent research included literature from the beginning of 2004 and was updated until August 2017. The following Boolean operators were used to identify literature specifically related to hospital social work for both the sections on the historical development of social work in hospitals and recent research into hospital social work: "Hospital social work" OR "Medical social work" OR "Almoner"; "Social work" AND "Hospital" NOT "Psychiatric" NOT "Psychiatry"; and "Social work" AND "Discharge". These searches

yielded a total of 852 results, which were then screened for relevance in stages – first by title and then by abstract. A total of 160 titles were read and drawn upon for this chapter.

Historic Development of Social Work in Hospitals

Despite being an established area of practice for over a hundred years, hospital social work remains largely ignored in standard texts on the social history of medicine. Waddington (2011) makes no mention at all of hospital social workers or almoners, while Porter (1997) overlooks the role of social workers in the development of public health care other than to point out that the presence of almoners in hospitals in the early part of the 20th Century was useful to doctors in increasing their earning potential by ensuring that even the poor paid something towards their treatment. In the social work literature, research on hospital social work is relatively sparse. Standard social work text books in the UK (e.g. Wilson et al., 2012; Lishman et al., 2014) often divide social work into categories, such as 'children and families', 'adults with mental health problems' etc. but do not allot hospital social work a category of its own.

The social work role in hospitals was born initially of concern over the abuse of charitable medical provision, with the creation of the hospital almoner, whose principle role was to scrutinise patients' means and determine who should be eligible for free care (Willmott, 1996). Thus, social work in hospitals might initially be interpreted as a social extension of the 'medical gaze' through which the human body is objectified and made subject to the power of medical knowledge (Foucault, [1973] 2003). While the role of financial assessment was retained until the creation of the welfare state, the practice of almoners soon developed beyond this limited function, with an increasing focus on alleviating the social causes of disease and mitigating the social impact of illness (Cullen, 2013). In doing so, social work has attempted to align itself on the side of the objectified person, raising awareness of their humanity beyond the medical gaze.

The origins of social work lie in the concern of individuals and public bodies for the lot of the poor. By the mid-19th Century, welfare provision in Britain was characterised by two contrasting approaches: state-provided relief, which was punitive in its intent, reflecting an

underlying ideology that poverty was the result of individual inadequacy; and philanthropic work by church-based groups following the Christian ethos of charity (Lowe, 2005). The extraordinary advent of the industrial revolution and the resultant rapid urbanisation of the population, however, had brought about a need for new approaches to provision for the welfare of the poor. This resulted in the development in the second half of the 19th Century of two distinctive new approaches to welfare provision, from which the modern practice of social work would emerge: the Charity Organisation Society (COS) and the Settlement movement (Webb, 2007). While rejecting the punitive measures of state poor relief, the COS represented a reaction against the Christian tradition of giving alms indiscriminately to the poor as a religious exercise, which it asserted encouraged fecklessness and inhibited individuals' capacity to develop self-help (Payne, 2005). It therefore introduced the practice of individually-focused casework, in which the circumstances of the applicant for charitable aid would be formally assessed using inductive investigation (Webb, 2007). While the deliberate discrimination between supposedly 'deserving' and 'undeserving' poor appears harsh and regressive to modern eyes, the COS had at its roots a humanitarian ambition to relieve the suffering caused by poverty (Seed, 1973). By contrast, the Settlement movement based its actions on the understanding that inequalities and disadvantage were at the root of the perceived moral failings of the poor (Barnett and Barnett, 1915). Residential 'settlements' in deprived areas were therefore established, in which university graduates could share the benefits of education with poorer members of society and offer a positive moral example (Manthorpe, 2002). Whereas the COS tended to focus their activities in individual casework, the Settlements' services tended to have a more communal emphasis, in the form of youth clubs, educational programmes, art exhibitions, drama societies and even country and seaside holidays for children (Matthews and Kemmis, 2001). There was also an emphasis on campaigning for change in social policy, based on the alternative explanation for the causes of poverty that the Settlement movement espoused (Payne, 2005).

Hospital social work was established at the instigation of the COS, who were concerned from an early stage about the possible abuse of medical charities by those who could afford to pay for treatment (Sackville, 1986). Traditionally, medicine had been practised at a local, individual level, yet the rapid urbanisation of the early Nineteenth Century led to a widespread establishment of new hospitals, which were financed either by individual philanthropy or public subscription (Porter, 1997). Some workers were able to join friendly societies or mutuals, which might fund the cost of medical treatment for them, if not their dependents (Gosden, 1961). For the majority of the urban poor, who could not afford to pay for a private consultation, however, access to medical care could only be obtained through

the hospitals that had been established by philanthropists and public subscription, and then only if the patient was in possession of a letter of recommendation from a subscriber (Simmons, 2005). Free hospitals, which did not require a subscriber's letter to provide treatment, began to be established in London and the rest of the UK from 1828. The free hospitals' outpatient clinics quickly became overcrowded and concern grew that the cause of overcrowding was the abuse of the free hospitals' charity by those who could afford to pay for treatment (Willmott, 1996). Despite a Select Committee report in 1893 arguing that abuse of the free hospitals was fairly limited, the general secretary of the COS, Charles Lock, recommended the creation of 'hospital almoner' posts, to investigate the circumstances of those seeking free medical care (Simmons, 2005). Thus, in 1895, Mary Stewart was appointed as the first Lady Almoner of the Royal Free Hospital, and hospital social work was born.

The first almoner's appointment through the COS might suggest a commitment to promoting thrift and self-help (Willmott, 1996), yet in fact she accepted a large majority of patients she assessed – around 70% - for free help and also referred them onto other charities for further assistance (Cullen, 2013). Interest in supporting patients to ensure that they were able to gain the maximum possible benefit from their treatment ensured that the work of the almoner quickly became a practice which can be recognised as 'social work'. Over the ensuing decades, almoners were challenged with responding to the social needs arising from new forms of medical treatment, including psychiatry, as well as new forms of need, such as work with the wounded of the First World War and coping with the epidemic of sexually transmitted disease that accompanied the war (Sackville, 1986). This interest was echoed following the Second World War, when almoners recognised the social impact of sexually transmitted diseases and argued that they were best placed to help both sufferers and their spouses because of their unique social and psychological understanding (Manchée, 1945). Such claims are significant, since occupations offering personal services often place emphasis on their curative role, at the expense of caring duties, when attempting to establish professional status (Hugman, 1991).

It is of interest that the occupation of almoner was, in its early years, so explicitly associated with female workers. Although it is documented that there was at least one male member of the Almoners' Committee in the early 1900s, male almoners were not common until after the Second World War (Sackville, 1989). This would cause a high attrition rate for almoners for much of the 20th Century, since many would give up their work or reduce their working hours

following marriage and childbirth (Denman, 1996). The early female domination of almoner posts reflects the fact that the philanthropic work from which the COS took its origins offered an opportunity for young women of wealthier backgrounds to find occupation outside the home (Simmons, 2005). For such young women, preparation for work on behalf of the COS could be found in the settlements, which began to represent a primitive form of professional training for social work (Parry and Parry, 1979). This perhaps explains why the early almoners, while maintaining strong links with the COS, quickly developed the role from being primarily focused on means assessment to assisting doctors to understand the social causes underlying disease and mobilising the appropriate resources to remedy destitution (Cullen, 2013). Such ambitions in Britain were enhanced by the pioneering work of the first almoner in the USA, Ida Cannon, who, with the support of the Chief of Medicine, Ethel Cohen, at Massachusetts General Hospital, argued that almoners could, and should, influence physicians (Cannon, 1913). It is possible that almoners' raising of physicians' awareness of the effects of environment on health contributed to the medical trend of convalescent homes and sanatoria in the early 20th Century. Indeed, arranging convalescent stays became a regular part of almoners' work at this time, and demonstrates the continuing influence of the settlement movement on almoners' work (Sackville, 1986). The expertise of the almoners became recognised within the wider context of medical care, to the point where, by the mid-20th Century, almoners regularly contributed to the training of junior doctors (Denman, 1996).

The early hospital social workers sought recognition for their expertise, and were the first sub-group of social work in the UK to attempt to professionalise, with the establishment of a professional organisation, professional training and professional registration early in the 20th Century (Payne, 2005). Their day-to-day close proximity to other, more established, occupational groups may have been influential in encouraging almoners to seek professionalisation. Trainee almoners were taught about the hierarchies of hospitals but, while a sense of respect for consultant physicians as having ultimate responsibility for the patient's wellbeing was fostered, they were expected to act as independent caseworkers, rather than simply providers of an ancillary service (Loxley, 1996).

If almoners saw it as their primary, professional function to provide material and therapeutic support to patients, their association with assisting hospitals with the collection of payment was nonetheless resolutely maintained (Willmott, 1996). The desire to maintain such a bureaucratic function perhaps reflects how the social work of almoners was not yet accepted as an indispensable part of hospital treatment. The introduction of the NHS in 1948 therefore

represented both an opportunity and a threat to almoners. Their role was not well understood by the public or by other professionals (Denman, 1996), which meant that there was potential for them to expand their role. The creation of posts related to public health, such as health visitors, however, also posed a threat to social work, both because of the possible overlap of duties and because doctors could ask health visitors to carry out home visits without involving the almoner (Sackville, 1987). During this period, however, almoners won two symbolic battles which enhanced their status as an occupational group. The first was that they successfully resisted being registered as 'Professions Auxiliary to Medicine' in favour of the less subordinate 'Non-medical Professional and Technical Staff' (Denman, 1996). The second victory was resistance to the proposal that non-qualified workers could do the job of almoners in hospitals in which no qualified almoner was present (Sackville, 1987). While some unqualified workers were accepted to work under the direction of qualified staff, recognition of the need of qualification further enhanced almoners' professional status.

Although almoners defended their status and role in the early years of the NHS, by the 1960s, the sheer size of the organisation and its need to reorganise left almoners' interests marginalised (Sackville, 1987). Consciousness was growing of the fragmentary nature of social work services and the idea of having a unified professional organisation to represent all social workers ran alongside the growing attraction of integrated social services departments (Payne, 2002). The increasing alliance of almoners with other branches of social work was demonstrated by the Institute of Almoners' decision to change its name to the Institute of Medical Social Workers in 1964. The majority of medical social workers would vote to amalgamate with other social work associations as the British Association of Social Workers (BASW) at the end of that decade (Denman, 1996). The willingness of medical social workers to disband their professional association is surprising in view of how highly contested their professional organisation had been from the outset, with two rival organisations, established in 1903 and 1907, vying to act as the professional body for almoners. Their willingness to merge identities with other branches of social work suggests that medical social workers no longer had a sense of sufficient influence and status on their own by the end of the 1960s.

Despite medical social workers' willingness to embrace a generic social work identity, they did not fit automatically into the local authority social services departments which were created on the recommendation of the Seebohm Report (1968) and were not included in the

Local Authority Social Services Act 1970. This did not deter the Institute of Medical Social Workers from formally amalgamating with BASW, however, and medical social workers were initially active and influential, for example playing their part in ensuring that only qualified social workers would be eligible to join (Payne, 2002). The generic social services departments of the 1970s offered social work a protected sphere of practice and control and, in these terms, appeared to promise recognised professional status (Payne, 2005). Social work's progress towards professional status, however, was impeded both by the ambiguity of its knowledge base (Brewer and Tait, 1980) and by its own ambivalence about whether professional status is even desirable (Stevenson, 2005). Belief in the altruistic and useful function of professions was brought into question by critiques of professionalism as serving the ambitions of professionals rather than the people who require their services (e.g. Johnson, 1972; Larson 1977; Illich et al., 1977). The requirement of qualification for membership was abandoned in 1975, both because of a radical critique of professional elitism and because of the pressure from members for BASW to pursue improvements in pay and working conditions, which required a more inclusive membership base (Payne, 2002). Thus, the ambition for professional status that had characterised medical social work's earlier emergence was lost within the wider development of social work's identity.

When medical social work teams finally joined local authority social services departments in 1974, they quickly found that they were placed under pressure to give their time to other parts of the service and their branch of social work became perceived by colleagues as an easier option (Osborn, 1996). If medical social work did lose some of its prestige after the Seebohm reforms, however, the location of teams of social workers within hospitals was not affected. Numbers of social workers based in hospitals grew steadily from the mid-1970s to mid-1980s and it was recognised that hospital social work departments offered the best services for patients and also had the benefit of being cost effective (Connor and Tibbitt, 1988). The genericism instituted by the Seebohm Report meant that hospital-based social workers' roles expanded to include child protection, with hospital social workers taking responsibility for responding in cases in which injuries to a child treated by the hospital were the first indication of concern. Other roles included assessing women who were seeking the termination of pregnancy and providing services to new families identified as vulnerable through the midwifery services. Section 17 of the Children Act 1989, which conferred a statutory duty on local authorities to provide services for disabled children, further strengthened the connection between hospital-based social workers and work with children and families (Osborn, 1996).

Anxieties brought about by high profile service failings related to child protection led to the re-emergence of specialised social work teams during the 1990s (Payne, 2005), with the result that child protection duties were concentrated in community teams, and hospital social work, aside from a few specialist posts usually funded by charities for specific childhood conditions (which are not the subject of this thesis), became concerned only with adult patients. There are some localised specialist posts for social workers who work with adult patients in hospitals – for example, the University Hospital for Wales has a dedicated social worker for the haemophilia unit, a position that was created in the wake of the transmission of HIV through blood transfusions to many haemophiliac patients, to help those patients to deal with the social and psychological consequences of their infection. In general, however, where local authorities employ a team of social workers in a hospital setting, the social workers are concerned with arranging the safe discharge of people who are too vulnerable to return home without help, but who do not need the medical care of a hospital. The effect of this is that modern hospital social work in the UK is most often concerned with older people and has become a form of care management work similar in character to that carried out by local authorities' community care teams.

Because this thesis is concerned with this most common form of hospital social work, this chapter now turns to explore some significant themes related to social work with older people, examining the community care system under which hospital social work operates and its meaning for older people.

Social Work with Older People: The Community Care System

Modern statutory social work practice with older people in the UK is ordered according to the principles of the NHS and Community Care Act 1990. The intention behind this legislation was to encourage provision of social care services by private enterprises, which could be purchased by a local authority on behalf of citizens in need (McDonald, 2006). The role of social workers within this system is to assess the need and eligibility of individuals for services, and to assist in making arrangements for those services to be delivered by a third party. When it was introduced, this purchaser/provider split marked a radical change of role for social work, in which its traditional emphasis on relational work was replaced by an emphasis on administrative functions (Sullivan, 2009). Along with the Children Act 1989, it

was also a defining moment in UK social policy, marking the end of an ambition for universal services that was the hallmark of the post-war welfare state, and placing a new emphasis on targeting statutory services where need and risk are most obvious (Lymbery, 2001).

Underlying the NHS and Community Care Act 1990, and the system of social care that has evolved from it, is the ideology of consumer choice and the rule of the market. The tradition of social work as relational casework performed by a benevolent and knowledgeable expert had been under a sustained critique from both sides of the political spectrum throughout the 1980s. From the left, social work was criticised as a form of policing aimed at sustaining the interests of capital (Harris, 1998), while, from the right, the altruism of all would-be professions was called into question, as were the academic and evidential credentials of social work itself (e.g. Brewer and Lait, 1980). The emphasis on the citizen as a consumer of services who could make choices (Griffiths, 1988) was therefore a challenge to the perceived paternalism of social work as a would-be profession. It was argued that ending the state's monopoly on service provision would give rise to services that were more flexible and based on the needs of citizens, rather than of the producers of services. As a result, social workers in adult services became care managers, whose job was to arrange the provision of care to individuals, but not to provide direct services (Payne, 1995).

The need to maximise limited financial resources in the provision of social care has been accompanied by a widespread reliance on managerial techniques to monitor and direct the performance of workers (Clarke and Newman, 1997). Managerial techniques tend to emphasise outcomes that can be measured quantitatively, with an emphasis on tangible and calculable activities (Ritzer, 1996). It has been argued, however, that the quantitative measures that are used by social work managers as key performance indicators reflect the priorities of the agency rather than the users of services (Harris, 2003). Critics of the managerialist approach argue that it leads social work away from its roots in a holistic understanding of individuals towards the execution of technocratic competencies in the mode of disengaged bureaucrats (Dominelli and Hoogvelt, 1996). This has led to concern among social workers that social work is at risk of deprofessionalisation, since the therapeutic skills that used to be drawn on are no longer required (Ellis et al., 1999). The success of new public management in dominating social work is reflected in the greater policy influence of the Association of Directors of Social Services over that of BASW (Payne 2005). With the rise of managerialism, emphasis has been placed on the technical rational components of practice, in which actions are broken down into a system of routines and

procedures (Fish and Coles, 2000). The rise in consumer consciousness and consumer activism has led those who use expert knowledge in their work to focus increasingly on the management of risk (Beck et al. 1994). This is particularly true of practices in which there is potential for reputational damage (Power 2004) and can lead to defensive ways of working, focusing on justifiability and auditability, to the detriment of adaptation to specific circumstances (Horlick-Jones, 2004). This has led to an increased reliance on standardised assessment tools and an emphasis on audit culture, often at the expense of human interaction (Rogowski, 2010).

It may be instructive to compare the technical-rational care management approach that dominates contemporary hospital social work in the UK with the more holistic approach that continues to underpin social work practice in adult mental health services. Like the almoners, psychiatric social workers in the UK founded a professional association fairly early in the development of their occupation, in 1929, and pursued a distinct professional identity until merging with BASW in the 1970s (Sackville, 1988a and 1988b). Unlike hospital social workers, however, social workers in the field of mental health have not seen their work become dominated by the neoliberal care management model, and continue to carry out a role that incorporates therapeutic work and emancipatory work focusing on social inclusion with statutory roles related to resource allocation and the detainment of people for treatment of mental health conditions (Allen, 2014). Payne (2005) argues that the Mental Health Act 1983's confirmation of the role of the social worker as a defender of mental health patients' legal rights and counter-balance to medical opinion, through the formal Approved Social Worker role, afforded mental health social workers protection of their specialised role. While the Mental Health Act 2007 opened up the role of Approved Mental Health Professional (AMHP) to other members of the multi-disciplinary team, thus weakening social work's unique status in this area, social workers continue to lead the AMHP workforce (Allen, 2014). By contrast, the Mental Capacity Act 2005, which has particular relevance for social workers who are concerned with older people, allows any professional to make a mental capacity assessment or to be appointed as a best interests assessor for the purposes of the deprivation of liberty safeguards. The apparent deprofessionalisation of older people's social work may therefore be seen to derive from the legislative context that allows only for social workers to act as brokers of care and has not afforded the protection for a more holistic approach as seen in the case of mental health social work.

In a context of rising need from an ageing population (ONS, 2015) and constant pressure on financial resources (Lymbery and Postle, 2015), it is difficult to deny the necessity of measures to ensure that limited resources are deployed as effectively as possible. The benefits of the care management system to the users of services have been equivocal, however, because the reforms were driven not only by a desire to improve the lot of the citizen in receipt of services, but also to cut state spending (Lymbery, 2001). This has resulted in practice that is often orientated around preserving budgets, rather than providing meaningful choice to individuals about the services that they can have (Lymbery and Postle, 2015). Emphasis on identifying the most pressing need means that lesser, yet still significant, levels of need can be overlooked and expectations of services lowered (Tanner, 2013). A further criticism made of the marketization of social care is that the users of services do not have the power or freedom to exercise real consumer choice, since the state still purchases care on their behalf, often through block contracts and service-level agreements (Dustin, 2007). Thus, care management is not driven either by the choices of the users of services or by genuine accommodation of their needs, but by consideration of budgetary constraints and best value (Gorman and Postle, 2003).

At its inception, the purchaser/provider split did not aim at 'absolute client choice', but was intended instead to empower care managers to make choices on behalf of the individuals in need of services (McDonald, 2006). This approach has been subject to critique by various service user movements, which have sought empowerment through the direct involvement of individuals in the planning and management of their care (Lishman et al., 2014). Recent social policy developments, particularly in England, have therefore sought to transfer choice-making to the users of services through direct payments and personal budget schemes, which enable individuals to choose their own care provider and negotiate aspects of their care (Gardner, 2011). This process, labelled 'personalisation' (Leadbetter, 2004), reduces the role of social work to assessing the eligibility of individuals to receive a personal budget and reviewing the provision on a periodic basis (Lymbery and Postle, 2010), thus further narrowing the opportunities for social workers to carry out therapeutic or anti-oppressive practices. In personalisation social workers do have a role in advising individuals during the planning of their services (Gardner, 2011), however, and therefore still have access to opportunities to use skills and knowledge in ways that can be transformational for people who use services (Higham, 2006).

Personalisation can provide a greater sense of control over their lives to the people who rely on care services in the long term and has been experienced as particularly empowering by adults of working age with physical or sensory disabilities and by parents of disabled children (Glendinning et al., 2008). For older people, whose physical health and mental acuity are often declining, however, personalisation can represent a heavy administrative burden rather than a form of empowerment (Hasler, 2006). The burden of responsibility for personal budgets may be a factor in deterring older people from taking up social care services, since numbers of older people using social care services are declining (Humphries, 2011). This is particularly problematic for those who have already suffered a lifetime of inequality and disadvantage, since they are likely to be the people who need social care services the most, and yet are least equipped to deal with the administrative responsibilities of personal budgets (Grenier, 2012). Older people are more likely to turn to social workers for support with managing their personal budgets than any other group (Carr and Robins, 2009), yet those who have suffered through disadvantage in their lives may have encountered social workers in more coercive roles (e.g. in child protection or statutory mental health procedures) and are therefore less likely to want to engage with social workers in any context. Thus, personalisation is empowering to those who still have some power, but disempowering to those who have little or none.

The Welsh Policy Context

The ideology of consumer choice and market competition that has come to dominate English policies has been of less prominence in Welsh social policy, which aims to maintain the principle of universal services that was at the heart of the introduction of the post-war welfare state (Drakeford, 2005). Since devolution, enactment of the principle of universal services can be seen in Welsh health services in the provision of free prescriptions for all, and in local authority services for older people through the provision of free bus passes, free swimming and the maximum charge for home care (Welsh Gov., 2013). Wales has been particularly innovative in its policy approach to older people, driven by the introduction in 2003 of a ten year strategy for older people (WAG, 2003). Designed to be delivered in three phases, the strategy's stated aim was to enable the voice of older people to be heard in policy making through raising awareness of older people's issues and identifying the structures needed to ensure that older people are included in decision-making. Significant developments emerging from the strategy in its early stages included the introduction of a National Service

Framework (NSF) for older people (WAG, 2006) and the appointment of the world's first older people's commissioner (Commissioner for Older People (Wales) Act 2006). While the Welsh NSF was based on the version issued in England in 2001, it was updated to meet the policy priorities of Wales, articulating a number of broad aims including rooting out age-based discrimination, promoting well-being, person-centred care and challenging dependency (WAG, 2006). These policy priorities were strengthened by the role of the older people's commissioner, who was given legal powers to work across public bodies in Wales to promote the rights and well-being of older people and to make representations to the Welsh Government about issues related to older people (Commissioner for Older People (Wales) Act 2006).

Successes arising from the implementation of the Welsh strategy for older people have included community schemes that promote inclusion and active ageing for older people (CSSIW, 2012). Despite these steps, ensuring that the ageing policy agenda was put into practice was made more difficult by inconsistencies in structures for implementing policy between local authorities (Gwilym, 2011). The Welsh strategy's focus on preventive services has yet to deliver tangible results in social care, meaning that numbers of older people admitted to acute hospital care remain too high and stays for older people in hospital remain too long (CSSIW, 2012). The third phase of the Welsh strategy for older people, currently in implementation, focuses on ensuring that older people have financial security, access to appropriate social support and a community environment that is inclusive and appropriate to their needs (Welsh Gov., 2013).

The focus in Welsh policy for older people on preventive services, inclusion and shared decision-making might lead to an expectation that social work practice with older people would diverge from the care management approach described in the preceding section above. Social work practice in Wales might be said to be in a time of transition, following the implementation in 2016 of the Social Services and Well-being (Wales) Act 2014, yet prior to implementation of the new act (and including the time when data collection for this study took place), observable differences in social work practices between England and Wales were subtle. The Welsh Government's ideological suspicion of the marketization of social care meant that the personalisation agenda was not pursued in Wales, which retains a stronger emphasis on inspection and regulatory bodies rather than consumer choice (Drakeford, 2005). Wales did not, however, move away from the care management approach that casts the role of the social worker for older people as one of assessing for and

planning social care services to be purchased by a local authority on behalf of the user of services. Thus, the holistic approach advocated in Welsh policies could not be said to have found its way into social work practice prior to the implementation of the new act.

It is likely that implementation of the Social Services and Well-being (Wales) Act 2014 will make the distinction between social work practice in England and Wales more pronounced. With its emphasis on 'voice over choice' (Williams, 2011) the new act aims at creating a sense of co-production of plans between service providers, service users and carers. A renewed emphasis on human rights is also at the heart of the act, with a new requirement that services for older people should have due regard for the United Nations Principles for Older Persons (1991). The act conceives of services as responsible for promoting a broad conception of well-being that includes physical and mental health, protection from abuse and neglect and social inclusion both within families and within communities (Clements, 2017). For social work practice, the act places the desired outcomes of individuals and carers at the heart of assessment, and continues to support direct payments as an available alternative to care management. The renewed emphasis in the act on the relational aspects of the social work assessment offer an opportunity for social workers in Wales to develop new forms of critical practice with older people. The focus on the desired outcomes of the users of services and their carers suggests a move away from managerially set performance indicators, which might lead to a less routinized, technical-rational form of practice. The reliance on maximising informal support for vulnerable people provided by family and community members, however, is subject to the suspicion that it is driven by preservation of resources rather than genuine improvements in the way services are delivered. It will be intriguing to see how practice in Wales develops over the coming years.

Social Work and Critical Gerontology

Social work with older people tends to be valued less highly than social work with children and families (Lymbery, 2005) because social workers have held a long-standing perception that there are fewer opportunities for therapeutic or emancipatory practice with older people than with other groups (Stevenson, 1977). The lack of a specialised, protected role for older people's social workers is reflected in the lack of consideration for gerontology in social work education, where ageing is seldom explored and there is a disconnect between social work

and gerontological research (Ray et al., 2009). Social work journals tend to cover policy issues related to older people but rarely address practice issues (Richards et al., 2014). Some social work practitioners are themselves guilty of colluding in ageism (Payne, 2012), whether through failing to challenge ageist assumptions within families or through their low expectations of the quality of life older people can expect. While reaching a certain age does not automatically mean that an individual is in need of social work, ageing often brings with it infirmities of physical and mental health that may create a need for social work (Lishman et al., 2014). The increasing size of the ageing population therefore represents an opportunity for social work to develop critical practices that can enhance older people's well-being, address inequalities and provide therapeutic interventions at an individual and/or family level (Ray et al., 2015). Critical gerontology has much to offer social work with older people, since it provides analysis of the way that many of the difficulties facing older people come about not as the inevitable consequence of bodily ageing, or of individual life choices, but through the operation of wider social and structural forces (Phillipson and Walker, 1987; Baars, 1991).

Patients tend to encounter hospital social workers (HSWs) at a time in their life when they are experiencing a marked, irreversible decline in their health for the first time, or a significant progression of an ongoing decline in their health. This means that HSWs generally work with people who are transitioning into, or are already well established in, the 'fourth age' – a normative state of advanced old age marked by physical and mental decline (Laslett, 1989; Baltes, 1997; Baltes and Mayer, 1999). The fourth age can be difficult to define because of the varied way in which ageing can affect people – definitions that rely simply on age thresholds or even levels of impairment fail because they do not take account of their meaning within each individual's life (Grenier, 2012). While the term 'fourth age' can be used in clinical terms to denote a complex co-occurrence of disease and impairment in old age (Rockwood and Mitniski, 2007), its implications go beyond the individual experience of morbidity. It is perhaps best understood through contrast with notions of the 'third age' from which it emerged (Laslett, 1989). The concept of the third age revolves around active ageing – the continuing participation of older people in social life after retirement – constructing old age as a time of continued participation and citizenship, as opposed to withdrawal and adjustment to diminished status (Deeming, 2009). By contrast, the fourth age is associated with deficit, burden, weakness and dependence (Grenier, 2007; Pickard, 2014), and by implication a reduction in participation and agency. While positive portrayals of the third age have challenged discriminatory assumptions about old age as a time of withdrawal and decline, they have also been criticised for the polarisation between the active

and healthy period of earlier old age and the stigma of decline commonly associated with advanced old age (Grenier, 2007). The concept of the third age therefore delays the marginalisation of elderly people, rather than preventing it altogether (Grenier, 2012).

Whereas the third age is distinguished as a period of freedom and self-definition, the fourth age is associated with a loss of individuality and agency brought about by dependence on others (Grenier and Phillipson, 2013). The fourth age therefore has significant cultural meaning as a 'social imaginary' (Gilleard and Higgs, 2010) in which personhood is lost and potential is void. People in the fourth age are seen as having lost the ability to enact the power, status and citizenship roles of the third age and instead lose control through the physical and mental impairments that arise in advanced old age (Phillipson, 2013). This social imaginary allows for the 'othering' of older people, imposing upon them both alienation and vulnerability (Gilleard and Higgs, 2011a). The alienation of people in the fourth age is linked to their proximity to death – their impairments are seen less as disabilities which can be adjusted to, and rather as markers of a decline that is inexorable and indicative of imminent extinction (Grenier, 2012).

The boundary of the fourth age is marked out by frailty (Gilleard and Higgs, 2011b), which can be understood as both a state of bodily/mental weakness and as a state of high potential for morbidity (Degnen, 2007). The experience of frailty by older people is non-linear, involving both gradual decline and sudden change events, along with periods of stability (Skillbeck et al., 2018). Grenier (2007) argues that frailty can be conceived of as a 'dividing practice' (Foucault, 1982) in which the subject experiences objectification through being divided within her/himself or divided from others. A condition of frailty is seen as the opposite to healthy life and a failure to be engaged in active ageing (Grenier et al., 2017). As a dividing practice, the categorisation of frailty can be used to plan clinical services and to assess eligibility for social care services (Grenier, 2007). There is a risk, however, that frailty can become a 'black hole' in which the self of earlier life stages is lost and never to return (Gilleard and Higgs, 2010). Frailty has such destructive power over the self because of its nebulous status – it is neither a cultural identity nor a stable social position, meaning that opportunities for de-stigmatisation or protest against marginalisation are not available (Higgs and Gilleard, 2014). Indeed, Grenier et al. (2017) have argued that frailty comprises a status that has parallels both with Standing's (2010) conception of precarity as a position of vulnerability and insecurity within the labour market, and with Butler's (2009) conception of precarity as a politically induced position brought about by failing mechanisms of care and

support. Thus, many frail people also live in a condition of insecure dependence, in which vulnerability in old age is amplified by disadvantage across the life course and underpinned by marginalisation, stigma and othering.

While frailty can be seen as a uniquely disempowering category that is destructive of personhood and agency, critical gerontology has begun to point to approaches that offer liberation for people in the fourth age. In contrast to Gilleard and Higgs' (2010) view of frailty as a black hole of unbecoming in which agency is not possible, Grenier and Phillipson (2013) argue that an expanded understanding of how agency may be enacted can challenge the polarisation between health and frailty. While the exercise or even expression of deliberate choice may be constrained by physical or mental impairment, and individual or collective action to produce change may not be possible, acts of verbal or non-verbal communication may represent forms of expression that should not be assumed to be lacking all agency. A conception of personhood is therefore required that focuses less on the value of a person based on her/his ability to exercise individual action or intentionality, and more on each person's intrinsic worth as a member of the wider collective of human life (Grenier et al., 2017). This can be seen, for example, in new approaches to working with people with dementia that are founded upon an understanding of the self as interactional and inter-embodied rather than purely individual, and challenge assumptions that people with dementia are purely receivers of care with nothing to contribute to those around them (Jenkins, 2014).

For social work, critical gerontology offers a critique of the active ageing policies that are aimed at reducing reliance on state services and devalue those who have become frail and vulnerable (Lloyd et al., 2014). The emphasis on personalisation in English social care, for example, has the effect of reinforcing the message of individual responsibility on those experiencing the most need, who are least equipped for self-help (Ray and Phillips, 2012). Social workers need to be aware that, when tasked with assessing the needs of older people for care, they are not only working with people who have social and bodily needs arising from physical and mental impairment, but people who are moving into a period of life marked by marginalisation, discrimination and stigma (Ray et al., 2015). The older people whom social workers encounter are in need of more than simple care management – they need assistance to challenge the blame for their need that is placed on them by policy makers and even their carers (Lloyd et al., 2014), relational work that can take account of their life history and help them through significant transitions (Phillips and Waterson, 2005) and assistance

with complex family situations (Statham et al., 2006). Social work with older people often involves negotiating the interplay between family dynamics, the cumulative effects of disadvantage and the ever-present influence of ageism (Richards et al., 2014). Carrying out these tasks effectively requires social workers to develop expertise in working with older people, through both engagement with gerontological theory and developing specialist skills for communicating and building relationships with older people who are affected by dementia and cognitive decline (Richards et al., 2014).

While there is potential, or at least a need, for a critical gerontological practice to emerge in social work, the community care system is not a fertile ground for its development. Community care discourages social workers from engagement in relational work with older people, placing little value on older people's narratives and offering little space for working with people to address psychosocial issues arising from their transitions through the life course (Sullivan, 2009). The social work value base, however, does place heavy emphasis on promoting human rights and social justice, while social work's knowledge base is centred upon understanding the individual within her/his socio-political context (Ray et al., 2015). Social work is therefore well equipped to develop to meet the needs of a growing ageing population, but will only be able to do so if it can expand its practices beyond the narrow individual focus of care management. For this to occur, social work needs to advocate for its right to develop its role with older people, drawing on both critical gerontological theory and an increasing base of empirical research.

Social Work and Liquid Modernity

While the insights of critical gerontology challenge the individualist ideology underpinning the care management system, contemporary social work with older people is influenced not only by the hegemony of neoliberalism, but also a more pervasive spread of individualization in the way lives are lived. Bauman's (2000a) concept of liquid modernity describes the most recent development of the modern era, in which the old certainties of 'solid' modernity have been replaced by instability, ambivalence and impermanence, all of which are driven by rampant individualism. Whereas the era of 'solid modernity' was characterised by routine and compliance – exemplified in the institution of the Fordist factory – liquid modernity casts each individual as both free and responsible for her/his own being. Bauman argues that

liquid modernity represents an inescapable fate in which the individual is responsible for her/himself without having the power to control events. The comforts of permanent employment, insoluble life partnerships and collective responsibilities have been replaced by globalized markets, intolerance of imperfections and individual human rights that protect difference rather than solidarity.

In Bauman's understanding of liquid modernity, a consequence of individualization and the relaxing of social norms and traditions is that each individual moves from life project to life project throughout their lives, since

> "The pain which used to be caused by unduly limited choice has now been replaced by no less a pain – though this time the pain is caused by an obligation to choose without trusting the choices made and without confidence that further choices will bring the target any closer." (Bauman, 2007, p. 106)

Giddens (1992; 1999) also notes the openness of choices presented by the contemporary world, but optimistically interprets this as a chance for each person to participate in 'life politics' in which each person has a chance to shape their own world as they choose. As Garrett (2004) notes, however, for many of the people whom social workers encounter, the idea of life politics is illusory, since inequality and oppression remain deeply embedded in their lives, with tradition and habit still serving to keep people from exercising absolute freedom of choice. For older people with whom social workers are concerned in particular, social conventions may still have a power that is absent for younger generations, and the social work task may therefore consist of liberation. Where older people are engaged in life politics and the assumption of individual responsibility for their lives, the physical and mental health challenges that old age often presents, combined with age-based discrimination, may nonetheless have a crushing impact. Thus, social workers need to have a regard for the disruptions of individual freedom that older people encounter.

Despite his advancing years, Bauman gave little attention to the issues of old age while writing about liquid modernity. It is not difficult to see how the human needs that older people's social workers regularly encounter fit Bauman's description of liquid modernity, however. The uncertainty characteristic of liquid modernity can be seen in the lives of the older people with whom social workers are concerned – indeed, as noted above, the fourth age has been said to be characterised by the precarity that Bauman places at the heart of his conception (Grenier et al., 2017). Advances in medical care and associated increases in

life expectancy have led to a situation in which increasing numbers of older people are living for long periods with chronic illnesses, increasing disability and progressing frailty (Age UK, 2017). This means that the life course for many people of advanced years has become more complex and less predictable. Illnesses particularly associated with old age, e.g. various forms of dementia and Parkinson's disease, can progress in a variety of ways and may result in physical, psychological and emotional states that are difficult to anticipate (Barry and Yuill, 2016). Similarly, rates of cancer survival are increasing, yet survival of cancer often brings with it ongoing complex medical needs (Macmillan, 2014). The same can be said of survival of heart attacks and strokes (Johansson et al., 2017; Greenwood and McKenzie, 2010). During the era of solid modernity, numbers of people living with chronic illness were lower and the association between morbidity and mortality in old age was closer. The increase in survival of disease among older people, while of course welcome, has brought with it a new uncertainty for older people about the course their lives will take.

Living with chronic illness in old age brings with it a number of consequences that reflect the uncertainty of the liquid modern era. Aspects of the social order may become reversed, e.g. while more women than men act as informal carers overall, among the over 70s, a higher proportion of men than women are carers – usually husbands caring for their spouses. (Dahlberg et al., 2007). The development of dementia in a life partner is likely eventually to change a spousal relationship from one of mutual support to one perceived as involving total responsibility on one side and total dependency on the other (Kitwood, 1997). Similarly, for older people who are cared for by their adult children, the nature of the relationship between parent and child is likely to be transformed by the development of a caring relationship (Plank et al., 2012). Thus, long-established ways of being for older people may have to be abandoned, and the nature of their relationships with the people closest to them may be profoundly and irreversibly altered. Living with chronic illness in old age becomes a liquid existence, in which all former certainties can be replaced with new and unpredictable ways of being.

Just as old age may be argued to have liquid qualities, elements of liquid modernity impact on older people in unique ways. The living environments of liquid modern societies continue to develop at a dizzying pace, with digital technology promoting means of communication from which older people may feel excluded (Hill et al., 2015) and urban redevelopment resulting in older people's home towns becoming unfamiliar to them (Phillips et al., 2011). The individualizing nature of liquid modern times means that people are left with full

responsibility for dealing with a fate over which they may have had little or no power (Bauman, 2000a). Within liquid modern society, this results in discriminatory attitudes towards older people, who are derided for being a 'burden' when they have care needs (Ray and Phillips, 2012; Hastings and Rogowski, 2015). People who are unable to maintain their own independence are blamed for their helplessness and contributions they make to their communities and families are not recognised (Lloyd et al., 2014). The popular media and even politicians portray older people as dependents whose needs threaten economic success (Hastings and Rogowski, 2015) and cultural representations of dementia, a common disease of old age, present it as a fearful and tragic obliteration of personality (Hillman and Latimer, 2017), meaning that recognition of the personhood of older people is diminished. Hospitals in particular can be locations of institutional ageism, with ward staff ill equipped to meet the complex needs of older people with multiple morbidities (Tadd et al., 2012) and clinicians regarding their acute wards as 'not the place' for frail and dependent older people, even though they comprise those wards' largest user group (Tadd et al., 2011).

The economic model of neoliberalism that underpins liquid modernity impacts on older people in need of care in two ways: State services are reduced to a minimum and targeted only at the highest need, which can result in lower, yet still substantial, needs being overlooked (Penna and O'Brien, 2013); and people of working age are required to be flexible workers who can relocate easily and commit additional hours to their job whenever required (Harvey, 2005), meaning that it is often extremely difficult for family members of working age to provide the care that their elderly relatives may need. This is not to say that younger generations are withdrawing from responsibility to care for their elders, but that family members are having to find new ways of managing their obligations towards one another (Bernard et al, 2001). Difficulties with the physical availability of family members to provide support are often particularly acute for older people in rural areas, which younger people are more likely to leave (Cloke et al., 1997), but are also a more generalised problem throughout Wales in particular, which has a high rate of emigration by its younger people (Phillips and Burholt, 2007).

When working with older people, social workers encounter needs brought about by the impact of liquid modernity on the way individuals and families organise their lives, as well as needs that arise from the increasing 'liquidity' of old age. Social work has a role to play in countering age-based discrimination, which is particularly prevalent in liquid modernity due to its emphasis on personal responsibility and consequent disdain for the dependency that

old age can (but does not always) bring. Social workers therefore need to take a critical approach to working with older people that includes addressing ageist assumptions and practices within its own occupational culture.

Recent Research on Hospital Social Work

Social work in hospitals is an under-researched area of practice in the UK (Moriarty et al, 2015). Much of the available recent research evidence on hospital social work derives from international sources, in particular the USA, Canada and Australasia. While there are national and local variations in the policies and practices of medical settings, hospitals in the developed world largely conform to a homogenous bio-medical model, in which the expertise of the doctor, with support from nurses and other professionals, is brought to bear on the physical illness of the patient (Waddington 2011). This is not to say that hospitals are not influenced by the cultural setting in which they are placed, or that regional interpretations of biomedicine do not vary considerably. Generally, however, the medical profession is held in high regard and senior doctors generally possess the highest position within clinical hierarchies (Bradby, 2009). The experiences of hospital social workers (HSWs) in medical settings might therefore be expected to be similar across international boundaries. A preliminary scan of the literature appears to confirm this. In Canada, Craig and Muskat (2013) found that HSWs identified several roles they play within their work: 'Bouncers', when dealing with challenging behaviour by patients or relatives; 'Janitors', when carrying out tasks no other professional is prepared to do (e.g. finding a dead patient's relatives); 'Glue', when resolving conflicts and supporting patients, families and staff; 'Brokers', when facilitating communication and negotiation between patients, families and doctors; 'Fire fighters', when providing crisis intervention; 'Challengers', when providing advocacy for patients, and 'Jugglers', when swapping quickly between these various roles. Similarly, in New Zealand, Beddoe (2011) found that HSWs felt that their work was highly skilled, yet requiring breadth rather than depth of knowledge and skill. In Australia, Davis et al. (2004) found that, though discharge planning was seen as the primary role of HSWs, this task alone required the practitioner to cover a multitude of demanding functions, including formal assessment, advocacy, crisis intervention and inter-professional liaison.

While HSWs may share similar experiences in hospitals due to the similarity of medical cultures across countries, there are significant national differences to be noted. The policy context and local culture in which HSWs operate can have a significant bearing on expectations of the roles they will fulfil and their approach. In Saudi Arabia, for example, where social work is not well developed and is not regulated as a profession, there is less emphasis on discharge planning and more scope for HSWs to engage with patients' psychosocial issues using relational and counselling skills (Albrithen and Yalli, 2015). A similarly country-specific issue was noted by Fronek et al. (2017) with regard to South Korean HSWs: that they regularly come under pressure from the management hierarchy to provide patients who are wealthy or influential services to which they are not entitled. As Ash and Phillips (2011) note, the nature of social work practice is rooted in the welfare regime from which it emanates.

While country or even regional variety exists in the nature of hospital social work, a common policy priority across countries is reducing length of hospital stay per patient. This has been noted in the USA arising from the additional use of hospitals brought about by the extension of Medicare under the Obama administration (Barber et al., 2015; Bronstein et al., 2015); in Australia due to the evolving pressures on hospitals arising from increasing complexity of patients' needs (Cleak and Turczynski, 2014; O'Malia et al., 2014); and in the UK because of financial pressure on the NHS (McLaughlin, 2016). For this reason, hospital social work is closely associated with discharge planning as a key task throughout much of the literature. Berkman and Rehr (1972) observed that doctors and nurses tended to refer patients to social workers during the later phases of their treatment. This may reflect that medical and nursing professionals regard the concern of social workers to be primarily the post-discharge circumstances of the patient, rather than their status during hospital admission. The pattern observed by Berkman and Rehr was seen to be present in more recent times by Payne et al. (2002), who found that nursing staff often delay the sharing of information due to misunderstanding of the role of other agencies. This suggests that HSWs have experienced the contradictory position of being physically inside the medical setting without truly being considered a part of it for some time.

Discharge planning can be a difficult practice for social workers due to issues of staffing capacity within social care organisations, poor efficiency of communication within hospitals and misunderstandings between agencies (Glasby et al., 2004). A key challenge for social workers is that they must work within a number of different systems both inside and outside

the hospital (Jackson et al., 2001). HSWs' ability to act as a link between different services, and between the hospital and the patient is often highly valued by nursing and medical staff (Bywaters et al., 2002). This can be a difficult task for HSWs, since they often have to negotiate with multiple institutional logics and span their work across multiple organisational boundaries (Harslof et al., 2017). The social work role in discharge planning can come under pressure due to resource constraints, with the result that other professionals are sometimes called upon to do the work of social workers (Judd and Sheffield, 2010). The pressure to expedite speedy discharges, under which HSWs operate, can therefore undermine the person-centred approaches they may set out to deliver (McLaughlin, 2016) and result in a failure to consider the deeper psychosocial implications for the patient of the transition through which they are passing (Tanner et al., 2015). Time pressure on HSWs is compounded by the growing emphasis on shortening inpatient stays and the increasing complexity of patients' needs for post-hospital care (Kennedy Chapin et al., 2014). Additionally, there often appears to be a deficit in the capacity of social care services, meaning that patients stay in hospital for longer than their medical need requires, causing frustration and tension between social workers and health care professionals (Mann, 2016).

Despite the time pressure they experience, discharge planning when performed by HSWs is more than an administrative task, requiring therapeutic input as well as practical actions (Tennier, 1997). Although the task of discharge planning has a fairly tangible outcome, since services are identified and provided for the patient if s/he is deemed in need and eligible, HSWs tend to evaluate their work in terms of processes and patient satisfaction, rather than concrete results (Shapiro et al., 2009). It is telling that HSWs tend to see single session interventions with patients as less legitimate than longer term work, despite the obvious range of skills required to carry out such work in a satisfactory way (Gibbons and Plath, 2006). Notwithstanding their apparent withdrawal from 'social diagnosis' and ambitions to contribute to the medical curing of patients, HSWs continue to place emphasis on the curative aspects of their work by interpreting the discharge planning process as a therapeutic activity (Tennier, 1997).

It is worth noting that, while an emphasis on discharge planning can be noted in many countries' hospital social work, the extent to which more therapeutic functions have been lost varies considerably, and appears generally to be far less pronounced in countries other than the UK. In the USA, there have been several recent pilot projects involving HSWs, which have aimed at reducing hospital readmissions. Alvarez et al. (2016) report on a 'Bridge

Model', in which HSWs work with inpatients to address psychosocial issues that may lead to readmission, and similar schemes are reported by Barber et al. (2015) and Bronstein et al. (2015). In each programme, the intervention of HSWs has gone beyond care planning to incorporate therapeutic techniques to bring about behaviour change in patients. Some of this work (e.g. Bronstein et al., 2015) has also involved community follow-up, suggesting a level of continuity of care not seen in UK hospital social work, where the individual's case is usually passed on quickly to a community team for review following discharge. Similarly, a pilot project in Australia employed HSWs to provide support to patients and families following a traumatic brain injury, utilising an approach that combined care planning with counselling and education (Simpson et al., 2016). Further, O'Malia et al. (2014) reported on an Australian pilot scheme to introduce assistant HSWs, to whom HSWs could delegate less complex and more routine administration and planning tasks. The project was considered a success within the hospital because it enabled HSWs to devote more time to their 'core business' of complex and therapeutic work. These developments suggest that the model of care management under which UK HSWs operate has a weaker influence on the social work practice of other countries and may point the way for HSWs in the UK to argue for resources to enable them to expand the scope of their work once more.

The breadth of skills required by hospital social work is highly taxing for practitioners, who must negotiate high levels of personal politics and respond flexibly to the demands of both patients and colleagues (Pockett, 2002). HSWs contribute conflict resolution, family mediation, counselling skills and continuity to patient care (Sims-Gold et al., 2015) yet these are not always recognised within the hospital environment. Frustrations also abound: unwelcome managerial interference, lack of resources and misunderstanding of the social work role by other professionals within the hospital can impair job satisfaction and hinder good practice (Beddoe, 2011; McLaughlin, 2016), yet HSWs report fairly high levels of job satisfaction (e.g. Smith and Shields, 2013). The hospital social work role has many factors that Herzberg (2003) theorised would increase job satisfaction, including a sense of achievement, variety of work, autonomy and challenge (Pugh, 2016).

The broad range of skills and high levels of personal resilience often demonstrated by HSWs makes them able to respond with impressive adaptability to unusual crisis situations. The involvement of social workers in Singapore and Canada when dealing with the SARS crises provides an example of this. Social workers in a paediatric unit in Canada were called upon both to help families to manage their emotional response to the crisis and to negotiate

between families and various levels of hospital management (Gearing et al., 2007). Similarly, social workers in Singapore set up telephone lines to provide both educational and emotional support to those affected by SARS and their families, drawing on a wide range of theories and skills to help them to cope with the demands of the situation (Rowlands, 2007). That HSWs in such widely different cultural settings proved so capable of coping with this crisis suggests that hospital social work enables practitioners to develop high levels of professional competence. HSWs can and do develop therapeutic relationships in the course of working with older people and also provide advocacy towards both professionals and family members in a manner that can be emancipatory (Duffy and Healy, 2011).

Despite claims of therapeutic activity, a recurring theme in the literature is the lowly professional status of HSWs. Beddoe (2011) argues that social work is a 'guest' within hospital settings, in that social work tends to challenge the dichotomy of patient and external expert. However, HSWs often feel that their claim to a discrete body of knowledge is weak and, in contrast to other professions within the medical setting, they have little time to devote towards personal and professional development (Judd and Sheffield 2010). Further, social workers in multidisciplinary settings often feel that their work is poorly understood by other professionals and feel under threat that their roles can be eroded due to pressure to manage resources and the encroachments of other professions (Frost et al. 2005; Globerman et al. 1996). Tellingly, Abramson and Mizrahi (1996) found, when carrying out a study on doctors' and social workers' views of inter-professional cooperation, that HSWs were much more likely to evaluate the collaboration in terms of how far they felt respected by their medical colleague, whereas the doctors were more concerned with the perceived competence of the social worker and how much they were kept informed about progress. A source of frustration for HSWs is that their work often relies on collaboration with other professionals, whereas clinicians are often able to carry on work within their own specialisms without relying on others (Albrithen and Yalli, 2016; Craig et al. 2015). Thus, HSWs' expertise is obscured by the fact that their achievements are brought about through a team, rather than solo, effort.

The lowly status of social work in hospitals may be particularly problematic for practitioners because of their need to influence the decision making of doctors and nurses (Nelson, 2000). While not a task unique to social work, advocacy has a long-established place in social work practice (Sosin and Caulum, 1983), which is orientated towards social and psychological needs, in contrast to the biomedical model which predominates in hospitals (Bradby, 2009). Where HSWs act as a link between hospital staff and the patient and

carers, it becomes vital for patients that social workers are able to speak on their behalf with authority. Social workers' ability to perform this function relies on their relationship with other professionals and their levels of prestige (Landau, 2001). Where HSWs' professional prestige is diminished, their ability to act on behalf of patients is similarly diminished. The professional standing of HSWs is therefore not merely a matter of practitioner self-interest, but of concern in their ability to provide the best possible service for patients and carers.

A factor in social work's struggle to gain professional recognition within hospitals may be the difficulty in demonstrating empirically its efficacy. Data are often collected, but may not be used to demonstrate productivity, with the result that the value of social work within the hospital setting is not made easily visible (Kossman et al., 2006). Hospital environments tend to be dominated both by an emphasis on evidence-based practice aimed at finding the most effective treatments, and by methods of instrumental rationality aimed at improving efficiency and cost effectiveness (Bradby, 2009). Social work in hospitals generates no revenue itself and its ability to contribute to the efficient running of a hospital is not easily proven (Rizzo and Abrams, 2000). It is surprising, in view of the prominence of evidence-based practice in hospitals, that hospital social work has not produced more research aimed at examining its efficacy. Indeed, McDermott et al. (2017) noted among Australian HSWs that knowledge acquired through empirical research was given far less priority than theoretical knowledge and experience, despite the emphasis on evidence-based practice in hospitals as a whole.

Some studies that have attempted to demonstrate the usefulness of social work within the hospital setting have found that there is little evidence that social work makes an immediate, quantifiable impact within the hospital itself. Kitchen and Brook (2005) examined a pilot scheme in a children's hospital in Kansas City, in which social workers were nominated as the central co-ordinator for each child's care, meaning that all patients were assessed by a social worker. While medical and nursing staff reported satisfaction with the results, such as problems being identified earlier, increased comprehensiveness of care and more orderly discharge, quantifiable effects such as length of stay and bed turnaround were not affected. Similarly, Auerbach et al. (2007) found that the patients referred to social workers actually had significantly longer stays in hospital than those who did not see a social worker during their admission. Rather than suggesting that this is evidence against the effectiveness of social work in hospitals, however, they argue that this is evidence that social work is most required where patients have complex needs requiring a multi-professional approach. Rizzo (2006) found that there was a link between stroke patients having lower overall medical bills

and high levels of informational support, but otherwise found that stroke patients who were given low levels of social work support tended to use rehabilitation services more effectively. Again, the targeting of social work at the most disadvantaged patients makes its contribution to efficiency difficult to prove. A more promising measure of hospital social work's efficacy has been found in examining the readmission rates of patients. In the USA, Alvarez et al. (2016) and Bronstein et al. (2015) both found that readmission rates fell among the patients assigned to pilot projects involving HSW interventions.

While it may be difficult to demonstrate social work's immediate contribution to the efficient running of hospitals, it is nonetheless vital to demonstrate that social work is effective if it is to avoid becoming obsolete (Shapiro et al., 2009). Rather than following a narrow, managerialist view of efficacy, based on impact within the hospital environment, however, research is needed which will focus on the outcomes for patients of social work within hospitals (Davis, 2004). Kitchen and Brook's study (2005) demonstrated high levels of staff satisfaction with a comprehensive social work service, yet might have been more illuminating if it had also followed up on the outcomes for patients and families. Ironically, the contribution of a HSW whose advocacy lengthens a patient's stay may improve efficiency in the long-term by preventing readmission, but this is difficult to prove. However, it is possible to collect data on the lived experience of patients who have social work services and to observe the influence of social workers within multi-disciplinary teams.

A claim that HSWs make across all countries is that their input offers a holistic approach to patient care, which can enhance the lived experiences of patients and their family members. HSWs argue that they are able to move away from their clinical colleagues' medicalised focus on functional deficits and bodily disease to engage with the wider context of individuals' lives and the social and structural issues that impact on their health (Craig et al., 2015). While hospital social work's claim to offer a uniquely holistic approach within the hospital team might be contested by clinicians who do pay attention to the bio-psychosocial model of disease (Barry and Yuill, 2016), social work does have the quality of being an occupation whose usual location of operation is within the community, rather than the hospital. It therefore comes naturally to social workers to focus on the social functioning of patients and to incorporate the role of informal carers in their understanding of an individual's world (Nilsson et al. 2013). HSWs therefore can offer added value to clinical teams by bringing their social focus into the hospital to understand the wider needs of the patient.

Conclusion

Hospital social work, which was in the vanguard of the development of social work as a response to the challenges of modernity, and which played a key part in the attempted development of a professional identity, has experienced a something of a fall from grace. It is no longer generally recognised as a specialised form of social work within the profession, and encounters ambivalence, apathy and misunderstanding from other professions within its physical sphere of operation. HSWs now practice in a context of managerialism, in which making decisions which are visibly justifiable through audit is often prioritised over human interaction. While there is a body of empirical evidence about what HSWs do and how they feel about it, the data are derived primarily from interviews, focus groups and questionnaires. Thus, we may know what HSWs say about their work, but we have few data derived from outside observation. This study therefore seeks to produce ethnographic data to answer three main exploratory research questions:

- What is the nature of statutory hospital social work?
- How do HSWs do their work?
- How does social work fit into the hospital context?

Chapter 3: Methodology

This chapter explains the methods I used to gather data, setting out my ontological and epistemological assumptions and detailing the procedures I followed. Detail will be given about how I gained access to the research site, how I managed my position once in the 'field' (a term I use throughout to cover all contexts in which I gathered data, generally geographically located in the Hanton hospital social work department), how I gathered data, how I exited the field and how I set about analysing my data. Central to this chapter is a reflexive awareness of my part in generating my data, and in using theory to make sense of it. Reflexivity requires the researcher not only to be aware of the influence of her/his personal history and social context, but also to consider the ways in which her/his presence and interaction with participants influences the nature of the data produced (Hammersley and Atkinson, 2007). This is particularly important in an ethnographic study such as this, in which the interplay between researcher and participants is naturally complex and dynamic (Buscatto, 2016).

Ethnography

The term 'ethnography' is not uncontested, but is almost universally taken to mean a form of research in which people's actions and words are studied in their everyday setting, with observation and informal talk the main sources of data (Hammersley and Atkinson, 2007). Ethnography in social work research has been used extensively to explore the organisational and institutional cultures of social work and the way social workers generate and share practice knowledge (e.g. Pithouse, 1987; de Montigny, 1995; Scourfield, 2003; Helm, 2016). While such studies tend to feature data gathering almost exclusively within the social work office (Ferguson, 2016), there is an emerging body of work using mobile methods to uncover the practices of social workers during direct contact with the people to whom they are providing a service (e.g. Longhofer and Floersch, 2012; Holland et al., 2011). Ethnography is particularly suited to social work because it facilitates theorising the particular-in-context (Floersch et al., 2014), enabling social workers to explore the application of theory to practice as it constructed in the everyday world. Ethnography also has a long-established pedigree in medical settings, which has brought to light the ways through which medical

behaviour and knowledge are transmitted and perpetuated within clinical settings (e.g. Becker, 1961; Atkinson, 1995; Latimer, 2000).

I chose ethnography as the method for my study because it appeared to be most suited to the way I wished to approach my research questions. I was interested in the nature of the tasks HSWs perform and how HSWs perform them, the extent of managerial and bureaucratic control over their activity, the extent and nature of HSWs' discretion, the nature of relationships between HSWs and other hospital professionals, the nature of HSWs' relationships with patients and carers, and the ideologies and moral principles that underpin HSWs' decision making. Such interests appeared to call from the outset for 'thick description' of HSWs' activities as witnessed through participant observation (Geertz, 1973), to be supplemented by interviews and analysis of HSWs' written outputs. My aim was to understand the social world in which hospital social work is performed from the perspectives of those who co-create this world – meaning not only the HSWs, but also patients, carers and members of staff within the hospital who have direct dealings with HSWs. The inclusion of participants other than HSWs for a study that is avowedly an ethnography of HSWs was intended as a form of triangulation – to discover aspects of the HSWs' actions that would be hidden from me if I were to observe and speak to HSWs only. I also hoped that it might enable me to move beyond exploration of organisational culture alone into the realms of 'practice ethnography' (Longhofer and Floersch, 2012), in which direct contact between social workers and the people to whom they provide services is witnessed. As will be seen below, my ability to produce a 'practice ethnography' was limited by circumstances arising in my field, yet not completely inhibited.

In setting out to produce any qualitative research, the researcher should be clear about the ontological and epistemological assumptions underpinning her/his work. I reject the 'naïve' positivist notion (Denzin and Lincoln, 2011) that it would possible for me as an ethnographic researcher to access an objective 'real world' unspoiled by my observation of it. Instead, I assume that the social world and our knowledge of it are constructed by the actors within it (Berger and Luckman, 1967), meaning that reality will vary for each actor depending on her/his personal history and status within the historical and cultural context. Some (e.g. Hennink et al., 2011; Lecompte and Schensul, 1999) have argued that acceptance that there can be plural versions of reality leads to a position of absolute relativism, in which it is impossible to make any claims of truth since any assertion could be declared equally valid as any other. I reject such a position, and instead rely on Hammersley's (1992) 'subtle

realism'. That is to say, I assert that there is a world that carries on whether it is observed or not, but accept that my knowledge of this real world can never be complete, whatever method is used to study it. Ultimately, my fieldnotes, however imperfect, and the theories and interpretations that arise from them, are based on events that happened.

Doing ethnography involves not merely observing the field to be studied, but encountering and interacting with it (Delamont, 2004). I therefore regard my data not as unbiased records of fact, but as accounts of encounters in which I was an actor as well as an observer. I do not consider this to mean that my findings are hopelessly lacking in validity or reliability. Instead, I hope to have produced work that satisfies Guba and Lincoln's (1994) alternative criteria for judging qualitative research – i.e. work that is credible to participants, detailed enough to be transferable to similar contexts, auditable and written in good faith. Thus, I have aimed to produce an authentic account of what happened while I was present in the field, keeping meticulous and detailed records of both what I heard and saw, and what I did in the moment. A reflexive awareness of my part in co-creating data is central to my approach, and has involved questioning my own attitudes, values, assumptions, habits and thought processes throughout data collection and analysis (Bolton, 2010). Reflexivity enhances the rigour of qualitative research by encouraging the researcher to seek a balance between involvement in the social world being studied, and detachment from it (Buscatto, 2016). My reflexive approach is discussed at length in subsequent sections of this chapter.

It is usual for ethnographies to centre on one setting or one group of people, meaning that an in-depth case study is produced (Delamont, 2004). A case study approach was most appropriate for my research because I was interested in the social workers who are based full-time in hospitals and who accept referrals only regarding people who are inpatients within the hospital. A single hospital social work team offered the possibility of attempting to see a single unit of analysis in its completeness (Thomas, 2016) and of answering questions of how and why contemporary events happen as they do (Yin, 2013). My research is concerned with the workings and accomplishments of a hospital social work team, rather than the broader topic of social work that is done with people while they are in hospital. This meant excluding the social workers in community-based teams who are responsible for discharge planning of patients who are already allocated to them on their 'caseloads'. It also meant negotiating access to a hospital in which a hospital social work team was present, since some local authorities in England and Wales no longer have distinctive hospital social

work teams and instead share out responsibility for discharge planning among their community-based teams.

My research takes an ideographic approach to knowledge of the social world, in which theory is derived from examining in depth and recognising the uniqueness of each situation, rather than a nomothetic approach that would attempt to make predictions about the wider social world (Jupp 2006). I recognise that generalisation on the basis of case study evidence is rarely (though not never) possible (Flyvbjerg, 2004) and would not attempt to suggest that the insights gained from my work can be applied unthinkingly to the workings of all hospital social work teams. It is possible, however, for the theory arising from one case study to be applied critically to other, similar cases (Yin, 2013) or even for 'moderatum generalisations' to be made (Williams, 2000) , in which aspects of a situation can be seen as instances of a more widely established set of features. Since social workers in the UK are educated to uniform standards and practice within common frameworks of legislation and guidance (though these are subject to burgeoning regional variety), it is reasonable to assume that many practices and understandings will be commonly held. An example of how moderatum generalisations might be made from case study research can be seen in Scourfield's (2003) ethnographic case study of a child protection social work team, in which the author was able to bring to light the various ways of portraying fathers in cases of child abuse and neglect utilised by social work practitioners. While the author would not claim that such portrayals would be universally found in every similar team, his work generated theory which practitioners could reflect on to appraise critically their own attitudes and practices. Moderatum generalisations should be modest in scope and tentatively held (Payne and Williams, 2005) and are, perhaps, best left to the reader to make. Even if no generalisations are made, any case study will still have the value of demonstrating that the nature of the world is such that this particular case is able to exist.

Identifying a Site and Negotiating Access

Ethnographic fieldwork begins not with the researcher's entry into their chosen setting on the day that formal data collection commences, but with the negotiations for access to that setting, which can be revelatory (Delamont, 2004). I might say, therefore, that my ethnography began with contacting a HSW based in a geographically convenient hospital,

through a colleague. Telephone calls to her were helpful in establishing the name and contact details of the team manager, who I assumed would be an important gatekeeper, but also gave me crucial details about what might be possible practically in terms of observing everyday life in the social work office and around the hospital. Conscious that gatekeepers can be of particular importance for accessing hospital settings (Pope, 2005) I felt that it was important to have such details prior to contacting my first gatekeeper in order that I could present a practical and sensible plan for conducting observation. Negotiations with the team manager initially seemed promising, yet I was not able to secure her support. The main reason she cited for denying me access was that the team was shortly to be undergoing an inspection, and that it was not convenient for them to have a researcher with them at this time. My assurances during negotiations that I only wanted to watch as HSWs carried on doing their normal work, and that I did not want to take up any extra time other than a possible half hour formal interview, had been ineffective. Following this rejection, I sought to negotiate access to two other teams. While sympathetic, both team managers were unable to offer access, on the grounds that their HSWs had refused when my proposal was put to them.

Reflection on my self-presentation was required prior to any new access negotiations. In my first attempts at negotiating access, I had presented myself as a university lecturer who was undertaking doctoral research. My emphasis on my status as a professional academic was deliberate, because I believed that it would be helpful to my cause to give a sense that my research might have some real impact on social work practice, rather than being merely something undertaken so that I could achieve a qualification. It would appear, however, that this was unhelpful because academic status was seen to give me the power to scrutinise the HSWs' practices. The issue of scrutiny appeared to be of concern to all three of the line managers with whom I spoke. They were concerned that being observed would be stressful for the HSWs and doubtful about having their practices put '*under the microscope*', a phrase two of them used. It is understandable that social workers might not welcome extra scrutiny of their work. The discourse of risk and accountability is now ever-present in social work (Webb, 2006), meaning that control of accounts of their practice is a vital defensive strategy for social workers. The presence of an observer recording social workers' deeds takes away social workers' control of recording, and might therefore be uncomfortable for them. I realised, therefore, that I needed to be more strategic in presenting who I was, and endeavour to provide reassurance that I was starting from a position of sympathy for HSWs. I resolved in future attempts to make more of the fact that I had been a social worker in a hospital team prior to commencing the research and to disclose some of my experiences of

the challenges of being a social worker in a hospital setting. My adoption of this identity would of course have ramifications for me when I entered the field, which will be discussed below.

Frustrated at my initial failures and worried that I would miss the window of opportunity to carry out fieldwork before my teaching commitments would restart, late one afternoon I made a number of forlorn telephone calls to hospital social work teams that I could realistically access on a daily basis while still balancing other commitments. No team manager was available to take my call, but I left answerphone messages where I was given the opportunity to do so. I was surprised a couple of days later to receive a telephone call from the manager of the Hanton hospital social work team. She was interested in my research and willing to put my proposal to her team and senior managers. Soon after receiving my research protocol via email, the team manager confirmed that the team were willing to host me, and undertook to seek the approval of senior managers in her local authority. After a further two weeks without a response from them, it seemed that I might be heading for a similar result to my first attempt. This time, however, my fears were unfounded and my proposal was accepted by the local authority, subject of course to approval by an NHS research ethics committee (REC).

Having secured agreement from a local authority to host my study, through the classic combination of 'planning, hard work and dumb luck' (Van Maanen and Kolb, 1985) I now faced the equally important and potentially difficult task of securing agreement from the health board, prior to submitting my REC application. This proved surprisingly simple, and was accomplished through a few telephone calls and emails to two nursing managers suggested by the HSWs' team manager and one face-to-face visit. Their readiness to support my research reflected their concern about delayed transfers of care from hospital to community services, in which the role of HSWs was seen as crucial. It was also indicative of this particular NHS health board's helpful attitude towards social research in general. With my field now ready to receive me, I could complete my application to the NHS REC.

Ethical Issues

The practice of ethnography is not ethically unproblematic, since (as with all empirical research) it can involve the recording and subsequent use of data that do not serve the interests of participants, and because negotiating a continual presence can involve elements of manipulation and dissemblance (Bosk, 2001). Negotiating formal ethical approval was therefore less problematic to me than carrying out my data collection in a way that was both respectful of participants and without bias either towards or against their way of seeing a world I assume to be complex and subject to multiple interpretations (Ryen, 2016). Because the emergent product of my data collection would be a result of my decisions over what to record as data and how to interpret these data, I considered that the most pressing ethical issues to be addressed would be negotiating my continual right to be present recording data in the field, and my participants' understanding of the potential uses of my data. While any disadvantage to participants that might come about through my recording of their words and actions as data might be mitigated through careful protection of confidentiality (Bryman, 2016), my right to be in the field rested on the informed consent of my participants and their trust in me as a researcher (Israel and Hay, 2006).

When I made the decision that I wished to include patients and carers as participants in my study, it naturally followed that this might include people who lacked the capacity to give informed consent as defined by the Mental Capacity Act 2005. The inclusion of such participants required careful consideration of the needs and abilities of each individual. It must be noted that lacking capacity to make a decision in one aspect of life does not mean that an individual should be considered to lack the capacity to make any decisions (DfCA, 2007). It may therefore be the case that a person who lacks capacity to make decisions in some aspects of their life might nonetheless be able to consent to take part in some aspects of this research, for example having their direct interactions with a social worker observed. While I realised that it might be difficult to convince the REC that people who could not give informed consent should be included in a study in which I would learn personal details about their lives, I believed that there was a moral case to make for their inclusion. People deemed to be lacking in mental capacity are often marginalised in decisions about their lives and lack a voice in research (Banks, 2012), yet their lived experiences, and the dilemmas arising for practitioners involved in their care, are likely to be distinct from those who do not have issues with mental capacity. I was able to argue that my research would meet the Mental Capacity Act 2005 Code of Practice's criterion for approval that the research is "linked to…the

treatment of that [capacity impairing] condition" (DfCA, 2007, p. 206), since it was concerned with the practice of hospital social workers, who are daily called upon to provide services for people who lack capacity. Further, as the aim of the research was to provide information which may improve social work practice, it met the condition that it should "provide knowledge about the treatment of, or care of people with, the same impairing condition – or a similar condition," (DfCA, 2007, p. 207). I therefore received approval from the REC to include patients who would not have the mental capacity to give informed consent as participants.

The only area of my research in which ethical issues caused an obstruction was in my access to the HSWs' case files. A common aspect of ethnographic research is the inclusion of documentary analysis (Bryman, 2016). In this study, it was important for me to have access to the tangible outputs of social workers, in the form of assessments and reports. Such documents are vital sources of data because they demonstrate how practitioners translate their encounters with patients, and other professionals' views, into services that have a direct impact on the well-being of the patient. To avoid violation of privacy, I was obliged to confine my examination of documents only to those relating to patients who had given informed consent to have their files read. This was a condition of approval imposed by the REC. Whereas other social work ethnographers have been able to examine files at will, without the consent of those about whom the files are kept, once access to their field was granted (e.g. Pithouse, 1987; Scourfield, 2003) this was not possible for me. I attempted to gain approval for accessing a wider range of files by writing out to those concerned offering an opt-out from having their files read, but this was refused by the REC. Since my interest was not in the details of people's lives, but rather the composition of the files and the way social workers record and present information, I believe that the REC's protection of confidentiality was over-zealous, yet accept that this is a hazard of social research within health care settings (Dingwall, 2008). Only documents owned by the social services department were examined, as opposed to those held by the NHS. I did not remove any documents from hospital premises. Where a patient was thought to lack the mental capacity to give informed consent to having their file read, I consulted a carer or consultee. If a patient lacking capacity had indicated unwillingness to participate in another aspect of the research, such as observation, their file would not have been included. Such an eventuality did not arise, however.

My fieldwork included formal interviews as well as participant observation and documentary analysis. Carrying out interviews had the potential to give rise to distress for participants, particularly in the case of patients or carers. I therefore planned that, if any participant exhibited signs of distress during an interview, I would offer the opportunity to postpone the interview to a later date or withdraw from the study. Had any participant chosen to withdraw from the study, the data collected from them would have been destroyed. Similarly, participants who were being observed were made aware when they gave consent that they were able to withdraw their consent at any time (Hardwick and Worsley, 2011). The hospital is a dynamic environment in which both practitioners' and patients' needs and feelings can quickly alter. I therefore made every effort to continue to verify that consent was maintained throughout the observation period and was prepared to leave the situation if my continued presence felt inappropriately intrusive. As it turned out, I never found this to be necessary.

Participant Recruitment

My inclusion criteria for participants were as follows:

- Social workers who work in the hospital setting
- Clinical staff who work in the hospital setting and have cause to have professional interaction with social workers during their day-to-day duties
- Nursing managers with responsibility for patient flow and discharge liaison
- Patients who have been referred for social work services
- Carers of patients who have been referred for social work services

My exclusion criteria were:

- Patients who are thought to be at risk of being harmed by participating in the study. (Concerns might be raised by social workers, clinicians, carers or the researcher.)
- Patients who have not agreed to a social work referral
- Carers of a patient who has capacity to give consent to participate, but has refused to do so

A full list of participants can be found in Appendix A.

Recruitment of HSWs and NHS staff was unproblematic. Once ethical approval had been given, I visited the HSW team to explain the nature of my research and left information sheets and consent forms with them. All agreed to participate from the outset, except for one HSW who was initially sceptical, but did consent after I had been with the team for a few weeks and had become better acquainted with her. For clinicians, I contacted wards I was likely to visit at the beginning of my fieldwork, so that informed consent had usually been given prior to the time I came to observe. On the few occasions where staff did not know about my research prior to my attendance at a meeting I hoped to observe, I explained my research verbally and provided written information sheets and consent forms on the spot. In general, clinicians were very accommodating and I did not encounter any refusals to participate from them. I experienced a slight ethical discomfort about accepting on-the-spot consent, since I had promised in my ethics proposal to give any potential participants at least 24 hours to make up their minds, yet consoled myself that no harm would come to any of the participants through my presence (Dingwall, 2008), and that the information sheet was clear about the possibility that they could withdraw their consent.

While I found the process of obtaining REC approval relatively straightforward, satisfying the stringent requirements to protect patient confidentiality meant that I was forced to make one compromise in the way I recruited participants to my study that I found somewhat limiting. I was unable to make the first approach to patients or carers directly, because this was considered to compromise their privacy. Instead, I had to rely on HSWs to give the information sheet and request permission from the patient or carer for me to approach them to follow up and seek their consent to participate. This meant that HSWs effectively had control over which patients or carers could be included in my study. The possibility therefore arose that HSWs might only make an approach to people they considered likely to create a favourable impression of their work or might select untypical cases on the grounds that they would be 'interesting', instead of enabling me to capture the more mundane details that lie at the centre of their everyday work. Sometimes this did appear to be the case, with HSWs commenting to me about individual patients, "*This one would be a good one for you,*" particularly in instances where they were supporting patients or carers who were in disagreement with clinicians.

I was able to persuade some of the HSWs to assist me in gaining access to participants in some of their 'run of the mill' cases, though on only one occasion in the entire time of fieldwork was I able to witness direct contact between a HSW and patient, and on only one

occasion did I observe face-to-face contact between a HSW and carer. Where it was apparent that a patient may not be able to give informed consent to participate due to a lack of mental capacity, I sought consent for their involvement from a consultee (in each case, a close family member and heavily involved carer), in accordance with the Mental Capacity Act 2005. I did not have the opportunity to witness direct contact between HSWs and patients who lacked capacity but did manage to arrange interviews with their carers and also received permission to view their files. Despite most HSWs appearing to be comfortable with my presence in their offices, HSWs were reluctant to enable me to witness them working directly with patients. The reasons for this appear to be tied up with my identity and embodiment within the field, which will be discussed further in the next section.

The Field and My Presence within It

Hanton is an urban area in Wales and is the domain of a single local authority. The Hanton local authority's hospital social work team covers two NHS hospitals in Hanton belonging to one health board, which are located conveniently within walking distance from each other: Hanton General Hospital and the Hanton Infirmary. Hanton General Hospital (HGH) is a large hospital offering accident and emergency services, general and specialised medical and surgical care, maternity and paediatric services. The Hanton Infirmary (HI) is more orientated towards rehabilitation and the management of chronic conditions. Both HGH and the HI provide care to patients coming from outside the Hanton local authority area, but no other local authority bases a social worker in the hospital. In HGH, patients can be referred to the hospital social work team from almost any ward. In order to manage the flow of referrals for their services as fairly and efficiently as possible, the HSWs do not have allocated wards in HGH, but go wherever the next patient is located, and may therefore be working across several wards at the same time. The wards are generally mixed gender, and are organised along the lines of medical specialities. In the HI, there are three wards with whose patients the HSWs are frequently involved. One is a general rehabilitation ward for female patients, another is a general rehabilitation ward for male patients, and the third is a mixed gender ward specialising in patients who are recovering from strokes. Again, the HSWs do not have allocated wards in the HI, but work across all three. Although HGH and the HI are geographically close to each other and belong to the same health board, they operate as separate institutions, with separate tiers of management.

The hospital social work team at the time of fieldwork was composed of a team manager, two full-time administrators, nine full-time social workers (two of whom being senior practitioners with added responsibilities), one part-time social worker and one part-time housing advisor (see Appendix A). The team is divided into two sections: 'The Hub', composed of a senior practitioner and three other social workers, whose job it is to restart packages of care for inpatients who already had services in the community that would be needed again upon discharge, and the 'long-term team', composed of a senior social worker and the rest of the HSWs. The long-term team is responsible for patients who take longer to process, who did not have care in the community prior to becoming inpatients. Both parts of the team are there to perform assessments to determine whether/how patients will be supported by the local authority in the community after their discharge from hospital. HSWs are allocated cases via the two senior practitioners. The team manager is responsible for approving all care plans made by the HSWs, although approval for funding is the domain of the service manager, who is based across town in Hanton Civic Centre and is rarely seen by the HSWs.

The layout of the HSWs' offices presented a problem for me in terms of fitting in with the team, because the HSWs were accommodated in small, self-contained offices, in ones and twos. Only in a couple of offices were there spare desks, which meant that it was difficult to fit in unobtrusively when observing HSWs at work. Pithouse (1987) and Scourfield (2003) mention the usefulness for a participant observer of being accommodated with a team in an open plan office – since it is always possible to look busy and preoccupied with something else while actually listening in to participants' conversations or telephone calls. They were also able to access paper files freely, and therefore were able to use these to disguise their interest in the conversations going on around them. By contrast, I had a much more obvious physical presence wherever I went, sometimes even having to perch my notebook on the end of a participant's desk, and was working in an office in which paper files have been done away with. This meant that it was never anything other than obvious when I was observing a HSW at work in the office and taking notes about what they were doing or saying.

The obviousness of my presence as a researcher troubled me because of its potential to produce the 'Hawthorne Effect' (Mayo, 1949), in which individuals modify their behaviour in response to their consciousness of being observed. I employed a number of tactics to mitigate the impact of my presence on the HSWs. The most important was trying to establish a friendly relationship with each team member so that they might feel comfortable around

me. I adopted a deliberately sociable demeanour and freely disclosed details about my personal life when asked. Having a young child at the time was particularly useful, since most of the HSWs were parents themselves and talked frequently about their own children. I also attempted to mirror the HSWs' emotions whenever they were talking about their work to me, so that I would express disapproval, approval, amusement or sympathy wherever it seemed to be invited. Such tactics were less a part of a contrived set of actions to infiltrate the HSWs' social world than a sincere effort on my part to fit in with a group of people with whom I was spending time. For many of the HSWs I became a useful 'sounding board', to whom they could express emotions and reflect on their practice safely (Lonsmann, 2015). The reflexive task of investing and detaching myself in order to fit into the field and still be able to research it was a considerable feat of emotional labour (Hochschild, 1983). I was not secretive about the notes I was taking and was happy to leave my notebook open around the HSWs. Indeed, on one occasion I even read the notes I had made out to a HSW after she had made a telephone call. She considered my notes a fair reflection of what had transpired and expressed satisfaction with my approach. My efforts to make the HSWs feel comfortable around me appeared reasonably successful. One HSW even commented to me when I returned to observe her office after a gap of a few weeks,

> "*Aw, I've missed you coming in here, scribbling your little notes!*" – HSW9, from a fieldnote, recorded near verbatim

I also console myself that the HSWs were too busy most of the time to worry unduly about impression management.

While I consider that I fitted in with the HSWs fairly well, it would be naïve to ignore gender in considering my position within the field. There was only one male HSW in the team that I was studying, and the majority of clinicians, patients and carers with whom I had contact were female, meaning that, for the most part, I was a man studying women. As a former social worker, this was a world with which I was familiar – in fact, researching men would have been stranger to me. Unlike Thomas (2017) I did not experience any humour or ridicule associated with my gender during fieldwork – indeed, my gender did not feel to me like a defining issue for my relations with participants. The persona I assumed – sympathetic, attentive and open – was partly an attempt to remove myself from associations with white hegemonic masculinity and its associated privileges. I have to concede, however, that there are ways in which my gender might have had an effect of which I could not be consciously aware. Responses to researchers have been shown to vary whether the researcher is male or female (e.g. Sallee and Harris, 2011) and, unconsciously, my masculinity may have raised

participants' perception of my privileged right to make judgements about their performance (Connell, 1987). Additionally, I may have missed out on nuances due to my own gendered assumptions and 'male gaze' (Thomas, 2017). My only defence against such deficiencies was that I was conscious of their possibility and used my commute to the setting each day to reflect on my self-presentations and relations with participants.

Throughout the fieldwork, my positioning as either an insider or outsider was complex and dynamic. As noted above, as a strategy for securing access in the first place, I had stressed my former role as a social worker within a hospital setting. With the HSWs, once in the field, this may have been a disadvantage in winning their trust, because it appeared to them to give me the right to scrutinise their practice, a right that was only enhanced by my status as an academic. In fact, my own experience as a social worker in a hospital had been on a children's cancer ward, and entailed an entirely different set of duties and practices to the team I was now observing. Early in the fieldwork I therefore had to work hard to cultivate the persona of the 'acceptable incompetent' (Hammersley and Atkinson, 2007). My incompetence was not feigned – I had never practised as a social worker in a community care setting, meaning that policies, legislation, usual working practices and even acronyms were unfamiliar to me. In terms of conquering the 'familiarity problem' (Delamont et al., 2010) the setting was perfect for me – I knew enough of the language of social work to follow what was happening, but was unfamiliar enough with this area of practice for it to be strange to me.

In addition to observations of the HSWs in their offices, I accompanied HSWs into hospital wards and to meetings with clinicians. I also took up the invitation to observe multi-disciplinary team meetings on two wards, which HSWs did not attend, but which involved discussion of patients' social needs and the contribution potentially needed from HSWs. I felt that the value in attending these latter meetings was that I would have the opportunity to see how HSWs and their work are perceived by clinicians, and how they fit in to the hospital. As these were large meetings in which several people took notes, my presence as an observer was less obtrusive than in the HSWs' offices. The clinicians identified me very strongly as a social worker, however, and when discussing hospital social work with me frequently used '*you*' rather than '*they*'. While I accept that my presence in all of the clinicians' meetings might have changed an essentially 'backstage' event into a 'frontstage' event (Goffman, 1959), I gained some credible insights about the way the hospital social work team fits into the two hospitals.

I left the field at a time at which I felt I had theoretical saturation (O'Reilly and Parker, 2013) for several emerging themes, while acknowledging that other aspects of what I had started to uncover needed further development. I felt that further work would not reveal much more to me about the practices of the HSWs from their perspectives or how social work fits into the two hospitals. I realised that I had more than enough to write about these two themes to complete a thesis, and therefore was content to withdraw from the field. My work had also given me a glimpse of the meaning of the HSWs' work to patients and carers and my curiosity about this remains unabated. I regard the insights I have gained into patients' and carers' perspectives as being of great value in shedding further light on the practises of the HSWs and their position within the hospitals, but accept that there would be more to do to reach theoretical saturation about their experiences. Following my departure from the field I maintained occasional contact with the team manager and was able to return to visit the team on two occasions to present my findings and seek their responses to my theories. That the HSWs responded affirmatively to my interpretations, I believe, adds credibility to my findings.

Observation

Much of what needs to be discussed regarding observation has been addressed above in the sections on ethnography and my presence in the field. Some remarks on the practicalities of my use of observation as a process of gathering data follow. I spent four consecutive weeks in the field Monday-Friday. When my teaching commitments began again, I was able to spend one day a week in fieldwork for the next five weeks, followed by a final whole week Monday-Friday. My working day in the field would last from around 9am until 2pm, after which I would go home and type up my handwritten notes into fuller, more reflective accounts of everything I was able to recall seeing and hearing that day. This time enabled me to immerse myself in my data as data, and was helpful for me to detach myself from the field and begin to analyse and interpret what I was seeing. I was not systematic in choosing which HSWs to sit with on any one day, since it was not possible to know in advance who was going to be in their office at any given time of the day, but I tried to ensure that I did not overlook any individual. I would move around the offices to talk to the HSWs fairly freely, generally leaving my notebook in one place and coming back to write notes as

needed. HSWs were generous in allowing and encouraging me to attend meetings with clinicians with them. Some of these meetings happened on a regular basis at a set time, and, while HSWs never came to look for me to go with them, they always made me feel welcome when I came. Similarly, the meetings on wards that I attended without HSWs happened at set times, and I was always made to feel welcome. Because of the need to gain consent from patients or carers prior to witnessing HSWs having face-to-face contact with them, my observation of any such meetings tended to be organised with the HSW formally.

I did not use a formal schema for capturing observations. In general, I attempted to record the words of participants as near verbatim as possible and to note non-verbal communications as I was able to observe them. In quieter moments, I would then supplement this with recollections of the physical features of the setting in which the interaction took place, including participants' positioning, the room's layout and any physical sensory data that struck me as relevant. According to Gold's typology of participant observer roles (1958) I fulfilled the part of 'participant as observer' – interacting with participants and participating with them socially, but without having a part in their construction of the setting as a place of work. Much of the data I gathered during observational time were in the format of informal interviews – either I would ask a participant about something about which I was curious, or they would initiate conversations with me, telling anecdotes about patients who had been particularly memorable to them. In my note taking, I distinguished carefully between conversations in which I was involved and 'work talk' between HSWs that I passively overheard. Inevitably, there were periods in which HSWs worked at their computers in silence, and I was unoccupied. Such periods were helpful for me to write up notes on the visual aspects of the field. I attempted to capture as much descriptive information about uses of space, the layout and décor of buildings and rooms and, of course, the non-verbal communication of all participants. This allowed me to build up a 'thick description' (Geertz, 1973) of my time in the field.

Formal Interviews

I carried out semi-structured interviews to supplement the data gathered through participant observation, giving me the opportunity to explore the meanings participants assigned to actions and events and to set these within the context of their biographical experiences

(Warren, 2001). For a list of interviewees, see Appendix A. While I had a schedule of questions designed for each category of participant (see Appendix B), I did not stick rigidly to the order, but allowed the conversation to flow as far as possible (Kvale, 1996). My focus with carers and patients was on how they felt about their HSW and what they thought their HSW had done for them. Similarly, I was interested in the opinions and perceptions of HSWs that clinicians might express. By contrast, my interviews with HSWs focused more on how they explained their own role and anecdotes of their practices. Where interviews were recorded, I produced transcriptions that captured pauses and repetitions, enabling me to take into account the tone with which the words had been delivered during analysis. With the participants who were not recorded, I focused on noting their words as near verbatim as was possible.

Viewed as a 'sample', my list of interviewees might appear disparate and inconsistent. Because they took place towards the end of my fieldwork, however, these interviews were useful for clarifying matters that appeared contradictory to me, and for exploring ideas that I was starting to form from my observations. I was opportunistic rather than systematic in my selection of clinicians to interview, tending to organise interviews with clinicians with whom I had made direct contact during observations. This suited the purpose of my interviews, which was to shed further light on what I had observed and to test out some tentative theories I had been forming. For example, I noticed that there appeared to be two ways that HSWs would look at risk-taking with patients: sometimes HSWs emphasised positive risk-taking, in which patients were supported to make their own choices despite the need to manage risks, yet on other occasions the same HSW might show a contrasting emphasis on trying to minimise risk through emphasis on patient safety. Exploration of attitudes towards risk with clinicians was helpful in helping to understand how and why such a contrast came about.

I did not approach formal interviewing as offering a privileged view of the inner world of the participants, heeding Atkinson and Silverman's objection:

"… we do not in the social sciences reveal selves by collecting narratives, we create selfhood through narrative of biographical work…" (Atkinson and Silverman, 1997, p. 305)

Rather than regarding interviewing as a means of 'mining' for a hidden truth, I am mindful of the narrative agency of the interviewee in actively constructing information and meaning (Holstein and Gubrium, 2016). Thus, interviews should be regarded as a type of

performance no less than any other form of social interaction (Atkinson and Coffey, 2001). This not to say that data from interviews should be disregarded as hopelessly un-factual, but rather that the interview should be seen as a tool to enable participants to share meaning as they see it in that moment (Miller and Glasner, 2016). Through engaging in narrative, interviewees are able to give the past meaning in the present (Coffey and Atkinson, 1996) and can shed the light of biographical history on the phenomena of the present (Esterberg, 1997). Interviews should therefore be seen not as a form of triangulation that can explain observed phenomena by accessing the hidden motivations of the actors, but as an enrichment of observed data that can yield cultural and biographical context as well as insights into interviewees' accounts of their reality (Miller and Glasner, 2016).

Documents

I had intended document analysis to form a larger component of my data collection than proved to be the case. As noted above, restrictions imposed by the NHS REC meant that I was only able to view the social work files of patients who had consented to participate in the research (or whose consultees had given permission in the case of those patients considered to lack mental capacity). A further difficulty was that all of the files are now electronic, and I was not given my own access to the electronic system by the Hanton local authority. I therefore had to use HSWs' computers when they were free, which meant that looking at patients' files was always a hurried job, since I did not want to delay HSWs when they needed to return to their computers to work.

In analysing HSWs' case files, my interest was twofold. On the one hand, the written outputs of HSWs represent a useful record of objective fact: the care plan that a patient is to receive, based on the HSW's interpretation of their needs. This is useful for finding out the end result that a HSW accomplishes for any given individual patient. On the other hand, I recognised the written documents of social workers as 'time travellers' (Taylor and White, 2000) – intended to convey to the reader what the writer saw as being truthful at a later time. Written records therefore have a rhetorical purpose in setting an interpretation of events into an accepted version of history on which future decisions must rely, often glossing over the uncertainties and complexities. I therefore hoped to practise Garfinkel's (1967) 'ethnomethodological indifference' in my analysis of documents – i.e. I aimed to take interest

in the way HSWs constructed patients' and carers' needs through text, rather than in what those needs might be. This meant taking interest in what HSWs chose to include and exclude in their case recordings and assessments and the language they used (Prior, 2003). Conscious that social workers' written texts are often shaped by prescriptive demands for certain kinds of information in formats specified by information technology (Parton, 2008), I also took interest in the design of the standardised forms on which the HSWs' text was set out.

Analysis

I approached analysis of my data according to some of the principles of grounded theory (Glaser and Strauss, 1967), in which theory is inductively produced from the accumulation of evidence. While Glaser and Strauss (1967) originally called for the researcher to come from a position of complete theoretical openness, without even having carried out an initial literature search, such a position was not possible for me as I was already familiar with the world of hospital social work. However, I used the grounded theory approach of coding and memo writing to develop categories from which theories could emerge, while maintaining a constructivist understanding of the nature of my data – i.e. that my data are a constructed product of my interactions with participants and the meanings that we bring to our world (Charmaz and Brynant, 2016). Thus, I reject Glaser and Strauss's (1967) argument that theories are 'discovered' through the data, and instead regard my theoretical insights as constructed through the interactions that constituted my data collection (Charmaz, 2014).

I did not undertake formal coding of my data during the period of data collection, meaning that my use of theoretical sampling was not systematic. However, keeping a research diary separate to my fieldnotes in which I recorded memos of emerging theories enabled me to target my data gathering at emerging areas of interest, resulting in a set of data that was conducive to abductive reasoning (Charmaz, 2014). Thus, when analysing my data I was able to test emerging theories against further evidence as I explored the tens of thousands of words of fieldnotes and interview transcripts that constituted my data. For the initial coding of my data I used nVivo11 software. This was helpful in enabling me to assign multiple codes to one passage and has the added value of being able to link a coded passage back to the part of the text in which it originated. I did not use the more sophisticated aspects of

the program to create 'trees' of ideas, but relied instead on developing categories through transferring coded passages into Word documents. A painstaking process of comparative reading of these Word documents then enabled me to write more abstract memos, which led in turn to the theories I develop in the chapters that follow.

A concern that arises from the grounded theory approach is that it can be reductivist in simplifying the messy, tangled world of social life into neat, simple theories (Clarke, 2003). With the aim of providing a more holistic analysis that does not lose sight of complexity, I therefore drew on an adapted version of Clarke's (2003) situational mapping approach, in which thick ethnographic description can be ordered and mapped out, using the following headings: individual human actors; collective human elements; discursive constructions at play; political/economic influences; temporal elements; major issues/debates; nonhuman influences (e.g. technology); silent actors; key events; cultural influences; and spatial elements. An approach drawing on situated analysis enabled me to explore the multiple influences at play in any portion of data that had been coded, meaning that when codes were developed into categories as the culmination of my inductive approach to theory, they took full account of discrepancies and contradictions rather than glossing over them. Even when short fragments of data are quoted in the following empirical chapters, therefore, they have some weight of analysis behind them and should not be regarded as fragmentary accounts of practices taken unduly out of context.

Summary

I have given a reflective account of my approach to writing an ethnography of the Hanton hospital social work team. I have set out my epistemological and ontological understanding of the nature of the data I have produced, have detailed my working methods and procedures, and have thought about my position in the field. While my field relations were conducive to producing a rich set of data, I did not realise my initial aim of producing a 'practice ethnography' that would follow the HSWs in their face-to-face work with patients and carers. The access I achieved went beyond a focus solely on the working culture of the social work team, however, and enabled me to gain an understanding of the workings of the team within the context of the two hospitals it serves.

Chapter 4: Social Work in the 'Iron Cage'

Introduction

This chapter explores the nature of the hospital social work role and the way hospital social workers accomplish their work, examining the tasks they undertake and the systems which organise and control their practices. It will be argued that the role of the hospital social worker (HSW) is essentially to fulfil a series of bureaucratic functions related to arranging the care of the patient after discharge. The term 'bureaucratic' is to be understood in the Weberian sense, in which there is a rigid allocation of labour, a hierarchy of authority and regular or continuous execution of assigned tasks by those qualified to perform them (Weber [1922] 2015). Analysis of the key tasks performed by the HSWs will demonstrate the extent to which the bureaucratic system dehumanises patients and encourages dehumanising practices by HSWs. This is not to suggest that the HSWs observed should be considered officious or unfeeling – indeed, the Chapter Five will examine ways in which they enact humanitarian social work values and demonstrate personal commitment to patients – but rather to highlight how the bureaucratic system in which they work restricts the forms of practice in which HSWs can engage. Despite the restrictions, HSWs retain some discretion in how they approach their work and their use of this discretion – both on behalf of patients and in their own interests – will be explored.

Discussion of the dehumanising influence of the bureaucratic system in which the HSWs practise will draw on the work of Zygmunt Bauman. Bauman (1989) argues that the same social conditions that culminated in the Holocaust are present in the instrumental rationality that is central to all modern bureaucratic systems. Instrumental rationality focuses on finding the most efficient means of achieving a goal, rather than whether the goal itself is acceptable (Weber, [1922] 2015). Bauman suggests that bureaucratic systems enable instrumental rationality by separating the decision maker from the human impact of their decision, and by separating the implementer of the decision from responsibility for taking it. Such systems therefore discourage their workers from engaging with the moral dimensions of their actions, instead encouraging them to focus on efficiency and compliance. The moral disengagement of bureaucrats is further strengthened by the way in which the bureaucratic system minimises their direct contact with the people whom their actions affect. Several aspects of Bauman's analysis of bureaucracy can be seen in the system within which HSWs operate.

The duties performed by the HSWs on behalf of patients fall into two main categories: Designing packages of care (POCs) for patients who are ready for discharge, and taking part with clinicians in the assessment of patients for NHS-funded Continuing Health Care (CHC), which is allocated to patients with on-going complex medical needs. Striking about both of these tasks is the extent to which the social workers are concerned with management of the failing body or failing mind, as opposed to the emotional needs of the patient, or their social circumstances beyond their need for daily care. The definition of need in hospital social work is confined to aspects of the patient's bodily or mental functions which are preventing their discharge from hospital, with scant regard to the wider issues of the patient's emotional, psychological or social well-being. This does not mean that the HSW's role becomes entirely mechanistic – often HSWs are called upon to negotiate with family members and carers, for example, or to mediate in complex disputes between family members. Further, establishment of patients' wishes and advocacy for them to achieve the outcomes for which they hope is a central feature of much of the HSWs' practice. Such practices, however, are accomplished with the explicit end goal of patient discharge always in mind.

Managerial Control of Social Work Practice

As was noted in Chapter Two, UK social workers in all community care settings are subject to managerial oversight and 'new public management' techniques designed to increase efficiency and guarantee value for money. For the HSWs, two managerial systems act – that of the NHS and that of the local authority – to direct their practice and demand the accomplishment of their work as quickly as possible. HSWs' encounters with NHS managers are generally limited to the middle managers, chiefly those who are responsible for 'patient flow'. Senior HSWs from both the fast response and long-term sections of the team were observed to have regular meetings with NHS patient flow managers to identify problems with delayed discharges and explain what the social work team is doing. For the fast response senior HSW, this involves a daily meeting with the patient flow manager in a busy office within the hospital.

> "*The two of them look at a list of patients on a computer screen, which uses colour coding to highlight patients who are considered medically fit for discharge but are waiting for other services before they can leave the hospital. HSW7 gives updates on*

what is happening where social work is the cause of the delay and the patient flow manager corrects the system where the cause of delay is found to be a service other than social work. There is no space in the computer system for a full explanation – instead, a drop-down menu is used with categories to pick from that explain the delay – e.g. 'awaiting social work allocation'; 'occupational therapy' etc." – From a fieldnote

The focus on the computer screen and its colour coding has a dehumanising effect on the construction of the patient, who is reduced to a unit which must be shifted, rather than a person with unique needs and a unique history. Such dehumanisation is a vital component of bureaucracy, helping to separate the completion of bureaucratically required tasks from the moral engagement of the worker (Bauman, 1989). The effect of such dehumanisation within the hospital is to encourage NHS staff and the HSWs to prioritise the efficient discharge of the patient without attention to the wider issues of social, emotional, psychological or spiritual need which the patient may present. The focus on efficiency in place of the holistic approaches of HSWs in other countries discussed in Chapter Two may be misplaced, since those wider personal issues may have a significant impact on bodily and mental functioning.

In the rehabilitation hospital, the senior social worker overseeing the longer term cases has a meeting once a week with the patient flow manager, who is joined by occupational therapists, a discharge liaison nurse and various ward managers, who come in for an allocated time slot. One of the HSWs summed up the patient flow meeting thus:

"*It's called patient flow but really I think they mean impatient flow! It's all about chasing people out. You'd like to imagine it's a bunch of people coming together trying to do their best for patients – that's what we'd all like, I suppose. But really it's about people using leverage, trying to get what they want.*" – HSW3, from a fieldnote, recorded near verbatim

The HSW here is arguing that attendees of the meeting seek to prioritise tasks that they consider necessary above the best interests of each individual patient. The use of leverage between professionals suggests that the interests of each agency are of more importance than making the right decision for the patient. This suggests that instrumental rationality is an important driver of hospital managers' practices, with efficient work towards an end given priority, and consideration of whether or not that end is truly desirable remaining of secondary importance.

In addition to the pressure for HSWs to facilitate discharge exerted by NHS managers in person, sometimes the wards take direct action to apply pressure. One HSW highlighted to her manager a number of referrals to the team for patients who were not yet fit for discharge, and a number of discharges made by wards of patients whom the HSWs felt would not be safe at home. The team manager commented,

> "*That's health's way of stomping their feet when we have a waiting list.*" – TM, from a fieldnote, recorded near verbatim

For ward staff, the moral claim of the patient whose medical needs no longer justify a hospital bed, yet who could not return home safely, is in competition with the moral claim of the next patient whose medical need is now greater. The impression given to social workers is that of a system in which they must immediately serve the needs of patients as they are presented, or accept that the patient will return to the community without the care that should be provided. This is recognised by the HSWs as a deliberate strategy to induce speedier discharge work – as real as other, more officially sanctioned forms of pressure. Any moral obligation a HSW feels towards the patient with whom they are currently occupied is therefore diminished by concern for the patient who may be missing out. The effect of this can be seen in one HSW's description of feeling guilty if she spends too much time with one patient:

> "*…you partly feel, if you spend a long period of time with someone and you come back to the office, you've got other cases, you partly feel guilty for spending that time.*" HSW10, from a fieldnote

While Bauman (2000) argues that bureaucratic processes diminish consideration of the moral aspects of social work action by placing focus solely on the efficiency of task accomplishment, this HSW's comment is a reminder that efficiency itself has a moral claim on social workers. There is, after all, an ethical imperative for the distributors of publically funded services to ensure that such services are provided to appropriate recipients and with minimal waste (Ferlie et al., 1996). HSWs are driven not only by the managerially demanded bureaucratic imperative of efficiency, but also by a sense of obligation to share their resources as fairly as possible. Radical social work theory offers the critique that such practice does not tackle the inequalities underlying the need to ration services (Brake and Bailey, 1980), yet unless social workers work to meet the immediate needs of people who require services by whatever means at their disposal, they are failing them (Ferguson, 2003).

Where social work is felt to be the cause of too many discharge delays, the patient flow managers will 'escalate'. This means passing on information about the delays to senior NHS managers, who will then contact senior managers within the local authority employing the HSWs to press for a solution. Tellingly, there is little face-to-face contact between the hospital social work team and senior managers from the local authority. Local authorities' senior managers are responsible for the allocation of the resources suggested in HSWs' care plans and for directing social workers in complex situations. However, they are housed in another building in a different part of the city and are rarely, if ever, seen in the hospital. Thus, there is a clear separation between decision makers and the decision – a separation which Bauman (1989) argues is central to the dehumanisation which enables bureaucracies to pursue efficiency without moral judgement of the end result. This separation is illustrated in one HSW's experience of 'escalation'. The HSW, assigned to a patient who was frequently admitted to hospital for apparently fabricated symptoms, was keen to carry out an in-depth assessment in order to find a long-term solution to his frequent presentations, prior to his discharge. Clinical colleagues failed to attend meetings the HSW called or refused to become involved at all, and soon the patient's delayed discharge was 'escalated' by the patient flow manager.

> "*I wanted to do a full assessment and find a long-term solution but in the end they got to the service manager and that was that – she said we had to get him out. So they chucked him out.*" – HSW3, from a fieldnote, recorded near verbatim

The phrase '*they got to the service manager'* is particularly telling, demonstrating the distance of the local authority's senior management from the HSWs. Removed from the sight of or engagement with a person who is suffering, the service manager is able to make a decision that serves the end of immediate, efficient bed clearance, ignoring the moral claim of a suffering person to real aid (Bauman 2000b). The result in this case was that the patient was discharged from the hospital and given the same services he was receiving before his admission, and returned as an inpatient within a few weeks. Ironically, the ruthless pursuit of efficiency therefore can produce inefficiency, since the problems this patient presented remained unresolved and would continue to take up clinicians' and HSWs' time on his next admission.

As with all local authority social work teams, the HSWs' performance is appraised by managers and the government department through key performance indicators (Gregory, 2001). For NHS managers within the hospital, the key performance indicator is the length of the patient's stay, and the length of time the patient is waiting for a discharge while

considered medically fit. For local authority managers, key performance indicators are the length of time between receipt of referral and allocation of a social worker, and the length of time for a social worker to complete an assessment and submit a care plan. The emphasis of managerial strategy is therefore firmly on the speed with which the HSWs can expedite discharges and, consequently, efficiency must be valued above all other considerations. While, as was noted above, efficiency does have a moral claim for HSWs who are aware that others are waiting for their services, reduction of risk and ensuring a safe discharge remain key real world consequences of work done well (Payne, 2014). Where performance indicators do not match the aims of social work practice, either the quality of practice falls (Broadhurst et al., 2010; Munro, 2011), or reporting of practice is manipulated to feign compliance (Wastell et al., 2010). There is therefore a constant tension for the HSWs between maintaining the quality of their work and satisfying the demands of managers.

While the purpose of collecting data on performance indicators is to maintain control over practice (Gregory, 2001), their use is incomplete for the hospital social work team, since there is a lack of clarity about whom the data are reported to and how they influence decision making from senior managers. For example, on a weekly basis, the team manager collects information from all of the HSWs about impediments to their work they have experienced through the fault of clinicians, yet it is unclear to them what is done with this information. The team manager commented,

> "*I just collate it* [the data] *and send it to WAG* [the Welsh Government]. *What they do with it, I've no idea.*" – TM, from a fieldnote, recorded near verbatim

Similarly, the team undergo a census of information about delayed transfers of care around every six weeks, which involves senior social workers sifting through data to ensure their accuracy. However, once the census data are sent to the Welsh Government, nobody in the team is aware of what is done with them. There is no personal stake in the performance data for the HSWs, since they receive neither reward nor censure according to whether the data are considered positive or negative (Payne, 2000). This weakens the claim of the bureaucracy on the hearts and minds of the HSWs. Bauman (1989) argues that bureaucracies encourage their workers to consider only the efficient completion of required tasks, rather than their moral worth. However, without clarity about how their efficient working contributes to the system as a whole, HSWs' loyalties cannot be fully removed from the patients and carers with whom they work. Thus, doing a job well for the HSWs cannot be limited only to doing the work in the efficient manner the bureaucratic system requires.

Managers, both within the NHS and within the local authority, are experienced by the HSWs primarily as a source of pressure to meet externally set standards for the completion of work. The alliance of NHS and local authority managers to direct the social work team towards completing discharges with all possible speed is reflected in the use of externally set performance indicators which measure the time taken to carry out work. The separation of senior managers who make decisions about the resources made available to patients from the HSWs who must communicate such decisions is part of a dehumanising approach to enable the most efficient work possible. Social workers are aware of the moral claim of efficiency in order to distribute scarce resources as fairly as possible, but cannot be brought wholly into the bureaucratic mentality of valuing only efficiency, since they have no personal stake in the performance data or clarity about their contribution to the larger aims of their organisation.

Fordist and Taylorist Approaches to Social Work Practice

While the managerial systems are only partially able to secure the HSWs' commitment to efficiency as the primary consideration for their practice, the day-to-day work performed by the HSWs frequently reflects approaches orientated towards the efficient processing of patients' needs. A key aspect of Weber's ([1922] 2015) description of bureaucracy is the repetitive completion of assigned tasks and this can be seen in the way HSWs describe their work:

> "*It's really about performing assessments on behalf of clients. It's about assessing their needs and their wishes, to try and get them out of hospital in the safest way possible.*" – HSW4, from an interview

No matter who the patient is, the goal is always the same: to discharge the patient from hospital. If a patient's discharge depends on receiving a service from the local authority, this must always be accomplished in the same way: with an assessment and a care plan. Production of the care plan can be further broken down into a series of routine tasks: to find out from health professionals the patient's physical needs; to establish, where possible, the patient's wishes for how they want to live after discharge; to establish what informal carers (family members, partners etc.) are willing and able to do to support the patient upon discharge; to establish the patient's financial circumstances; to identify resources the local authority will provide, and finally to produce detailed instructions to service providers as to

how the patient is to be cared for upon their return home. Similarly, the outcomes available for patients upon the completion of a HSW's assessment are limited to just a handful of options including permanent residential care, temporary residential care, intensive home rehabilitation or up to four daily visits from hired carers. Thus, in the practices of the HSWs, two central tenets of the Fordism can be seen: the standardisation of the end product (for Ford, cars that were identical; for HSWs, care packages/residential placements with little flexibility) and the breaking down of a complex process into smaller, repetitive tasks (for Ford, the factory assembly line; for HSWs, the repetitive use of standardised assessments) (Dustin, 2007). This is not to say that the work of the HSWs is devoid of complexity, but rather that the complexity they encounter – for example in a patient's relationship with family members, or issues related to housing – can only be managed through a process which has strictly limited outcomes.

The Fordist tendency within the HSW team can be seen in their insistence that bureaucratic processes for managing patients' needs are followed in every case. One senior HSW commented regarding ward staff's adherence to procedures:

> "*One problem is that they sometimes try to bypass us, and ring the care agency directly, then discharge the patient without telling us. Next thing is, we get a call from the patient saying their carer didn't come. But we didn't know they were home and it hasn't gone through brokerage to re-start their package.*" – HSW7, from a fieldnote, recorded near verbatim

Of note here is the emphasis on the bureaucratic process through which a care plan must be processed in order for a patient to receive services upon leaving hospital. Even if the patient is to have the same package of care they were receiving before they came into hospital, they must be assessed by a social worker, who can then trigger the brokerage team to re-start the care. The bureaucratic function of the social work team as the gateway to community services cannot be bypassed by clinical staff, despite their impatience with social workers, who are often unable to respond to the patient's needs as quickly as would be desirable.

The community care reforms of the 1990s were noted for their fragmentation of service provision (Dominelli, 1996; Carey, 2015) and a Taylorist approach in which social work is broken down into discrete tasks that can be handled along a line of social work practitioners, rather than a person's needs being treated holistically by one worker (Dustin, 2007). Taylorism originated as an attempt to make factories more efficient by breaking jobs down

into small tasks and studying workers' movements in order to minimise wasted time and effort (Giddens and Sutton, 2017). The Taylorist approach is in evidence with the HSWs in the way that their task is considered to be complete as soon as the patient has left the hospital. Review of the care plan is left for a community team to follow up and is not the responsibility of the HSW who originated it. Moreover, even while HSWs are actively working with patients, significant aspects of practice are considered outside their remit. In particular, the identification of abuse or neglect of vulnerable adults is a key responsibility for social workers (Wilson et al., 2011), yet HSWs have limited opportunities to identify issues and must pass the responsibility on to a dedicated Protection of Vulnerable Adults (POVA) team to investigate if any instances of concern come to light. On one occasion, the team manager was observed explaining to the team that an instance of financial abuse had later been discovered against a patient with whom one of the HSWs had worked. The POVA team had expressed concern that an opportunity to identify the abuse at an earlier stage had been missed by the HSW involved. The team manager acknowledged that the conversation that would have brought the matter to light had not been held by the HSW at the time because it did not seem relevant, adding,

> "*We don't do as thorough assessments due to time constraints, but if you have more time with a patient and can dig deeper, you're expected to.*" – TM, from a fieldnote, recorded near verbatim

The fact that issues of abuse can be missed by the hospital social work team so easily demonstrates the brief and partial nature of their assessment process. Rather than perform a holistic assessment, the HSWs restrict themselves to gathering only the information that is relevant to the care plan which they must make. The manager's advice here is contradictory – it is acknowledged that the assessments are not thorough and yet the expectation is that abuse will be identified.

The Fordist and Taylorist approaches noted serve the purpose of efficient processing of work, rather than being orientated towards the needs of individuals in receipt of services. This is not to say that the HSWs are completely unable to attend to building a relationship with a patient or a carer, but that the purpose of that relationship will not extend to engagement in more therapeutic work. For patients who may have disclosed abuse to a HSW they have come to trust, it may be distressing to have to speak to a new social worker from the POVA team about the abuse. Similarly, the social work assessments, with their strict focus on bodily capability, may not reflect the priorities of patients who are facing a change in lifestyle brought about by declining health. The emotional impacts of such

changes are not addressed by the HSWs as a routine part of their work. While HSWs demonstrate empathy in their daily interactions with patients and carers, these interactions are focused primarily upon what is physically necessary to discharge the patient from hospital. The efficient accomplishment of the hospital social worker's task therefore relies on the HSW not engaging with all aspects of a patient's life, but focusing only on those aspects of the person's life which can be aided by the options available in social work care plans.

Dehumanisation

As discussed, the nature of the system within which the HSWs work is such that their ability to engage with the full emotional world of patients is restricted. In many instances, my observations and encounters would suggest that the system works to dehumanise patients. Bauman (1989) argues that dehumanising the objects of any bureaucratic process is essential for optimum efficiency. I do not wish to suggest that the practices of the HSWs are uniformly dehumanising to patients or that the HSWs do not show compassion and human concern on a daily basis – Chapter Five will explore in detail ways that HSWs promote patients' human rights and act upon humanistic social work values. Of concern here, however, are the routine practices and processes in which HSWs are involved which do have a dehumanising effect that cannot be avoided or completely mitigated.

The opportunity for HSWs to engage with patients' and carers' emotional worlds is somewhat limited by lack of a confidential space with which to talk while a patient is in a hospital bed. Time is also an inhibiting factor, since HSWs do not have the time to build relationships with patients and carers incrementally, but must quickly establish a rapport strong enough for them to be able to raise personal questions and difficult issues related to a patient's declining health and increasing dependency. Similarly, time constraints mean that difficult conversations with carers must often be conducted over the telephone. A fragment of a typical telephone conversation between a social worker and carer, in this case the wife of an elderly patient, ran thus:

> *"…Good lord! Look, I'll check out with my manager if that's something they can still provide*…[carer speaking] *Have you ever felt that you need more support for yourself?...* [carer speaking] *No, no you couldn't do that yourself because it needs*

two people to hoist him… [carer speaking] *I'm sorry that he's not coming home today…* [carer speaking] *Well, I can't say exactly when because I don't want to get your hopes up when I can't – I can say I will try and get him out as soon as possible…*[carer speaking] *I'm sorry that he's not coming home today…*[carer speaking] *Now that he's having two carers it may take a bit longer to identify two carers…*[carer speaking] *I know he was disappointed and all I could do was apologise…*[carer speaking] *He did feel deflated, yes, yes,…*[carer speaking] *Oh you've been married 54 years! Gosh what's your secret?...*[carer speaking] [HSW laughs] *You're not going to tell me?..."* - HSW10 telephone call to carer, from a fieldnote, recorded near verbatim

It would be remiss not to acknowledge the tact and skill displayed by the HSW in this extract. Throughout the conversation she spoke with a clear, loud voice that was sympathetic in tone, matching the expressions of genuine empathy on her face. In this case, the patient had been told by ward staff that he was to be discharged the next day, only for this to be overruled by the HSW, who needed to arrange additional care for him at home. Of note is the extent to which the social worker took personal responsibility for the delay in discharge, apologising repeatedly and emphasising that she had also apologised to the patient. Also of interest is the acknowledgement of the disappointment she has caused, juxtaposed with a personal commitment to do her best, without making promises she will be unable to keep. Throughout this exchange the HSW conveyed a great deal of personal warmth, providing a compassionate face to a bureaucratic inconvenience. While it is clear that the HSW did her best to build a rapport, however, the limitations of relying on telephone contact are also apparent. When the carer disclosed that she had been married to the patient for 54 years and the HSW asked her what her secret was, the carer shut the conversation down. In a face-to-face encounter, it is possible that this remark might have led to a deeper conversation that would involve the social worker engaging with the carer's emotional world and an interaction of therapeutic value might have occurred (Trevithick, 2012). Thus, the working methods of the HSWs minimise their ability to make a genuinely human connection with patients and carers.

Time constraints not only limit the depth of HSWs' personal engagement with patients and carers, but can also give rise to circumstances in which HSWs perform bureaucratic functions on behalf of patients without knowing the patient at all. Where a patient is deemed to lack capacity to make decisions due to impaired mental functioning, decisions are taken through a best interests meeting (BIM), which is attended by the clinicians involved with

caring for the patient in hospital, the informal carers or family of the patient and a HSW. Sometimes, the HSW's first contact with a patient is initiated by the urgent request of the ward, because a BIM has already been called before a social worker has even been allocated to the patient. A similar situation often arises for meetings concerning Continuing Health Care (CHC) – a form of care funded and provided through the NHS rather than the local authority. When HSWs attend any meetings in which they are new to the patient, they perform the function of ensuring that procedures are properly followed and that the rights of the patient are properly observed. For example, they may highlight the fact that a BIM meeting has been called when no capacity assessment has been documented or they may point out the need for the hospital to enact the Deprivation of Liberty Safeguards (MoJ, 2008). The ability of HSWs to perform these functions even for patients they have not met means that it is preferable for them to attend than for the meeting to go ahead without them. However, where the HSW has better knowledge of a patient, s/he is likely to be able to provide a fuller contribution that may reflect better the priorities of the patient. The fact that HSWs are obliged to take part in meetings with limited knowledge of patients suggests that the smooth functioning of the bureaucratic system is sometimes prioritised above consideration for the patient's personhood. This is reinforced by the fact that the patient is often absent from such meetings, due to mental incapacity or physical ill health. The physical separation of the patient from people making decisions makes her/his dehumanisation in the eyes of decision makers more easily possible (Bauman, 1989).

The desirability of CHC funding (as it not means-tested), together with the finite availability of financial resources within the NHS (Klein and Maybin, 2012), mean that it is necessary to have a standardised, fair system for CHC distribution. The system for determining eligibility for CHC relies on assessing patients' needs against pre-determined criteria based on the nature and complexity of the care required. Bauman (2000b) argues that any bureaucratic process to categorise human suffering as classifiable 'needs' is dehumanising and that rigid application of rules of eligibility reduces social workers' ability to engage with the moral impact of their actions. In the case of CHC, a patient's eligibility is determined through a meeting in which health professionals, a HSW, carers and (rarely) the patient are gathered to go through a proforma known as the Decision-supporting Tool (DST) to determine if a 'primary health care need' is present. The DST calls for professionals to class needs as low, moderate or high (NHS, 2014) – converting the lived experiences of the patient into a quantifiable set of data which can be judged dispassionately. The role of the HSW within the DST meeting is to explore the information provided by the clinicians in detail. For example, the HSW might ask the nursing representative whether the patient is able to express any

wishes of their own, or how much agitation s/he demonstrates on the ward. Where an agreement cannot be reached between the HSW and health professionals in the meeting, the matter is referred to a panel of senior managers, who are yet further removed from direct contact with the patient. Thus, fair distribution of resources must be delivered through a highly rationalised, dehumanising system to which the HSWs are bound to contribute.

While there is less emphasis on rigid eligibility criteria in the assessments HSWs complete for local authority service provision, the reduction of people to categorised needs is as clear. HSWs' care plans tend to focus strictly on tasks that hired carers must perform for patients and it would normally be impossible from reading a HSW's care plan to obtain any real sense of the personality or personal history of the person at its centre. The instructions given within care plans can be extremely specific to bodily needs, e.g.

> "…*empty ileostomy bag*"

> "…*use hoist to transfer patient into and out of bed and into and out of wheelchair*" – From fieldnotes taken from reading patient files, recorded verbatim

Needs outside the successful continuing management of the failing body are not considered to be within the realm of the HSW, and are not given consideration, other than through advice to contact voluntary agencies who might provide assistance during the assessment process. The outputs the HSWs produce therefore follow the same dehumanising process as the CHC assessment, in which the living person is only seen in terms of needs which must be instrumentally fulfilled.

Just as the HSWs' assessment and care plan documents are highly rationalised, the process of purchasing a service on behalf of a patient is similarly impersonal. For example, if a HSW decides that a patient will be able to manage at home with a set number of calls from a professional carer each day, s/he must submit the plan for approval by the team manager, to ensure that the presentation of the patient's needs matches the service that is to be provided. Once the plan has been approved, it is passed on to a separate 'brokerage' team, who will make a contract with an agency to fulfil the duties prescribed by the social worker. The brokerage team is not composed of social workers, but administrators whose role is to manage the contracting of an agency. This process enables the local authority to purchase a service according to its own budgetary priorities, which means the quality of the service will often be of secondary importance or even unknown (Coulshed et al., 2006). The rhetoric of purchaser/provider split as enabling choice for people using services (McDonald, 2006) or of

personalisation, in which the service user's voice is central (Gardner, 2011) are therefore overlooked in favour of ensuring a rationalised and efficient service.

Dehumanisation of patients is functional within the hospital social work system both to conserve scarce resources through applying strict eligibility criteria for services, and to enable HSWs to complete work as quickly and efficiently as possible. Routine practices for the HSWs frequently encourage dehumanisation of patients since time for personal engagement is limited and the HSWs' ability to obtain services for patients depends on their ability to present them as an assembly of eligible needs. As will become clear in Chapter Five, the dehumanisation of patients is emphatically not the choice of individual HSWs, but to work in the hospital social work system necessarily means, at the very least, using dehumanising processes instrumentally to procure services for patients.

Discretion

This chapter has so far outlined a bureaucratic system that aims to ensure that the HSWs keep efficient and swift discharge of patients as their highest priority. Despite the control of HSWs' practices through managerial techniques and the limited way in which they can engage with patients and carers, however, the system also relies on HSWs using a certain level of discretion in their daily work. Evans and Harris (2004) argue that Lipsky's (1980) concept of street-level bureaucracy remains relevant in social work, since some discretion is always retained by practitioners whatever rules, regulations or procedures are in place. Lipsky (1980) argues that social policies are formulated not only by governments through legislation, or by senior managers in charge of developing organisational goals and procedures, but also by government workers who have direct contact with the public as they must interpret those policies and implement them as 'street level bureaucrats'. Thus, government or management policies are often reinterpreted and distorted by street-level bureaucrats, who exercise high levels of discretion and autonomy, and whose practices evolve to help them to manage their work in their own interests, whether to cope with a high demand for services, to reduce uncertainty and dilemma, or to give preferential treatment to certain types of citizen (e.g. on grounds of acceptable behaviour or some form of prejudice).

The concept of street level bureaucracy remains relevant to HSWs because their interactions with patients remain unobserved by managers, and because the eligibility criteria for patients to receive services from the local authority do not entirely eliminate discretion. Eligibility criteria and strict definitions of what needs can and cannot be met by social workers reduce the range of choices available to social workers (Ellis et al., 1999), yet HSWs retain power over how information is presented to the managers who must approve their care plans. Knowing the eligibility criteria well means that HSWs are able to present patients' needs in a way that almost guarantees their receiving a service and it is rare for care plans to be rejected. Where managers do refuse approval for a care plan, this is commonly interpreted by the HSW as a sign that more information is needed, rather than that their interpretation of the patient's needs is wrong. In such instances, the social workers will seek further information from their clinician colleagues, rather than give up on the care plan they have suggested.

The discretion of the HSWs extends beyond how they present information about their patients to secure them services. Despite the expectation that they should expedite discharges as quickly as possible for every patient, HSWs do take more time when they are able and feel it is warranted, for example when the patient presents complicated issues:

> *"Like this case I'm working on now, the husband's got Alzheimer's and has EMI* [services for the elderly mentally infirm] *involved and now she's not mobilising but she was a couple of months ago and something's telling me there's something underlying, but they're saying she's ready to go and it just sometimes happens. But I'm not letting her go home, and then they think we're just delaying things but they don't see that we have to get to the bottom of things."* – HSW4, from a fieldnote, recorded near verbatim

While the HSW is aware that her management of the case will be interpreted as an unwelcome delay, she is prepared to carry on with what she wants to do without concern over the criticism she may receive. It is interesting that she relies heavily upon her intuition, and places more significance upon this than on the information from clinicians who say the patient is ready for discharge. While Lipsky (1980) and Musil et al. (2004) argue that street-level bureaucrats use their discretion to avoid dilemmas and reduce uncertainty, the opposite is true of the HSW's conduct here. It would be easy to take the clinicians' assessment at face value and provide a swift discharge, but instead the HSW decides to embrace uncertainty and investigate issues which may be underlying the patient's loss of mobility. Of course, the delay to the patient's discharge that the HSW can effect will be

limited – it is likely that the patient's case will be 'escalated' by patient flow managers if the situation is not quickly resolved. However, the discretion of the social worker to cause some delay while she makes a deeper assessment demonstrates that the bureaucratic system does not have full control of HSW practice.

Discretion is also called upon when HSWs need to improvise in order to maintain the smooth operation of a patient's discharge in the face of unforeseen difficulties. Such activities correspond to what Craig and Muskat (2013) identified as the 'janitor' role for HSWs, as they carry out necessary tasks that no other professional is prepared to do. With surprising regularity, I observed the HSWs chase up actions that would be the responsibility of other professionals, such as ordering equipment, which is the responsibility of nursing staff or occupational therapists (OTs). Similarly, the HSWs often provide liaison with patients' carers and give them information that is the responsibility of another professional to provide. For example, one HSW telephoned a patient's son to explain that the OT was unable to obtain the necessary equipment for the patient's discharge for a few more days. Following the call, she then felt it necessary to check whether the patient himself was aware of the delay and the reasons for it. When asked why she took this on herself, the HSW shrugged and said that, though she thought the OT *should* make the telephone call herself, she probably would not and then she, as the social worker, would 'get the blame' anyway.

> "*Unfortunately that's always the process. They think the social worker will do everything.*" – HSW9, from a fieldnote, recorded near verbatim

The HSWs' willingness to carry out the 'janitor' tasks despite some resentment that they are not necessarily their responsibility reflects their commitment to patient care, but also to ensuring that the bureaucracy works as smoothly as possible. While, as was noted above, commitment to the bureaucracy is qualified rather than absolute, the HSWs recognise the importance of maintaining the smooth function of the system to discharge patients to the extent that they will cover the roles of other professionals where necessary. Further, taking initiative in the manner described above is a small act of professional freedom: the HSW grasps the opportunity to use her discretion and expertise to manage a situation and ensure that the plan for which she is responsible works as intended.

While HSWs can use discretion in ways that are orientated towards benefitting patients or carers, there are also examples of working practices that appear to exist only to protect HSWs' own interests. An important example of this is the team's policy towards mental

capacity assessment. Under the Mental Capacity Act 2005, a mental capacity assessment can be carried out by any professional working with a person whose ability to make a decision may be compromised by lack of ability to understand or retain the necessary information. Social workers' training means that they are well placed to undertake capacity assessments and it common for them to do so in many organisations (Wilson et al., 2011), yet within the HSW team, very few capacity assessments are performed. Instead, there is an insistence that doctors should provide capacity assessments:

> "*But generally, yeah, we just kind of push it over to the doctors to carry out capacity assessments, and I don't really know why, because it would make sense if we're doing it when we're most involved.*" – HSW9, from an interview

Despite explicit encouragement from their team manager to become more involved with assessing mental capacity during one team meeting that was observed, the HSWs did not change their practices during the fieldwork. When discussing the possibility of carrying out a mental capacity assessment, HSWs tended to intimate that a better knowledge of, and a closer relationship with, the patient than they had would be needed. The idea that a professional needs to know a person well to be able to do a capacity assessment is not contained within the Mental Capacity Act 2005. While there might be an advantage to knowing someone reasonably well before undertaking an assessment in order to be familiar with how they communicate, it would be perfectly possible even for a stranger to follow the prescribed formula and establish with reasonable confidence a person's mental capacity with regards to a given decision (DfCA, 2007). The HSWs' insistence on deferring to doctors for mental capacity assessments in most instances might be understood as a form of behaviour developed to manage the already high work load and avoid situations of uncertainty and dilemma. Lipsky (1980) argues that this is a common practice employed by street level bureaucrats to make their work more predictable and manageable. In light of the high demand for HSW services and the pressure from managers and clinician colleagues to expedite discharges as quickly as possible, such practices are understandable.

Discretion can be used by HSWs either to manipulate the bureaucratic system in favour of a patient, or to develop practices that make their work load more manageable and predictable. The bureaucratic system in which they work relies on HSWs to carry out their work independently until the point where a care plan is presented for approval, meaning that some discretion will always be present. Where the discretion of HSWs touches on the managerial priority of swift patient discharges, it is relatively limited and can be easily checked by managerial intervention. By contrast, practices which relate more to the quality of a HSW's

intervention, such as lack of involvement in the complex and uncertain assessment of mental capacity, are allowed to develop freely, so that they appear to take on the concrete form of a deliberate policy.

Summary

This chapter has explored the nature of the bureaucratic systems in which the HSWs practise. HSWs are subject to extensive managerial control which encourages Fordist and Taylorist approaches to practice and the dehumanisation of patients as a means of enabling their swift and efficient discharge from hospital. This does not imply that HSWs should be regarded only as bureaucrats, or that they adopt the officiousness and inhumanity commonly associated with bureaucracy (Payne, 2000). Indeed, the humanitarian professional values of the HSWs and their efforts to enable patients to become empowered will be the explored in the next chapter. Despite managerial control, there remains space in their work for HSWs to employ discretion. While sometimes this discretion is exercised with the purpose of making their work more manageable, there are also instances of HSWs explicitly using discretion in the interests of the patient in direct opposition to the managerial emphasis on the speedy discharge of patients. The bureaucratic and managerial systems are therefore only partially successful in controlling social work practice, both because they still allow some room for discretion, and because they are not fully able to oblige or convince HSWs to prioritise efficiency over all other considerations in their work.

Chapter 5: Is it still social work?

Introduction

The previous chapter highlighted the constraints and pressures that control and limit social work practice within the hospital. The bureaucratic nature of the routine tasks the HSWs perform, the pressure from hospital management and local authority senior managers to expedite patient discharges with speed, and the demands of maintaining a working space alongside the hierarchy of hospital professionals mean that the hospital is a uniquely challenging environment for social work practice. Despite these challenges, the HSWs involved in this study still consider the work they do to be 'social work'. Using the International Federation of Social Workers' (IFSW, 2014) global definition of social work as a starting point for analysis, this chapter will examine the extent to which HSWs' work can be recognised as social work, exploring the values that HSWs articulate and enact in their work. Particular attention will be paid to the HSWs' claim to be advocates for patients and carers (see also Chapter Six) and the nature of the relationship between HSWs and those who rely on their services. It will be argued that HSWs are able to do work that is recognisable as social work, including some examples of challenging structural disadvantage at a personal level, but that it is not possible for them to fulfil the ambitious aims espoused by more radical interpretations of the social work role (e.g. Dominelli, 2002; Rogowski, 2010; Ife, 2012). It will be suggested, however, that the deficit lies in the ideas, which do not match the realities of statutory social work more widely, rather than in the practices of HSWS specifically. Despite the HSWs' orientation towards the empowerment of patients and carers, this chapter will note that their practices perpetuate their own professional power by preserving their exclusive right to define social care needs and plan care.

The IFSW (2014) defines social work thus:

> "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 knowledges, social work engages people and structures to address life challenges and enhance wellbeing."

The work of HSWs, with its clear emphasis on bureaucratic functions and the speedy discharge of patients (see Chapter Four), does not often give rise to opportunities to engage at the macro or even meso levels of interactions between individuals and society. However, in claiming the role of advocacy (see Chapter Six, and below), HSWs within this study demonstrate an ambition to be involved with the empowerment and liberation of the individual people who use their services. Further, the allocation of resources through care planning touches on social justice, human rights and collective responsibility, while respect for diversity is a core concern for social workers in a multi-cultural country such as the UK (Thompson, 2016). The IFSW definition is therefore relevant to the work of HSWs, and assessment of their practices against the definition can reveal the extent to which they engage in social work, as opposed to fulfilling their bureaucratic functions without concern for the principles and practices that lie at the heart of social work. This chapter will consider in depth two aspects of the IFSW definition that appear to have direct relevance to HSW practice: Human rights and social justice, before moving on to explore empowerment in the context of the advocacy role HSWs claim for themselves (see Chapter Six).

This chapter's emphasis on examination of the HSWs' practices regarding human rights, social justice and empowerment rests on the premise that these principles are a sine qua non of social work. All three values are noted to be central to the formulation of critical gerontological social work practice (Ray et al., 2009), which takes social work with older people beyond the operation of bureaucracy to address issues of discrimination and oppression in their lives. As noted in Chapter Two, UK social work can trace its historical roots to two main strands: the Charity Organisation Society, which gave rise to the more conservative strand of 'casework', based on helping the individual to learn to cope better with the world, and the settlements movement, which took a more structural approach to understanding and alleviating human distress. Statutory social work tends to owe more to the 'casework' approach, in which assistance is offered at the individual level, yet understanding of the structural causes of social problems remains an integral part of social work education and, even in statutory roles, social workers maintain a commitment to the principles of human rights, social justice and empowerment (Hugman, 2009). All of these principles revolve around addressing issues of power differentials, which are of central importance to anti-oppressive practice (Dominelli, 2002). Anti-oppressiveness has become a unifying ideology within social work (Millar, 2008), and lies at the centre of emancipatory approaches that are seen understood as the core of modern social work (Thompson, 2015). Proponents of anti-oppressive practice argue that social workers have an obligation to address not only the power differentials they encounter at the individual level, but also those

that arise within larger social structures and processes (Dominelli, 2002). This chapter therefore will be concerned not only with the extent to which HSWs are able to promote human rights, social justice and empowerment at the level of the individual, but also with the extent to which HSWs engage with the larger social structures at play for the patients and carers with whom they are concerned.

Power differentials often arise due to individuals' belonging to social groups that are disadvantaged, such as women, people of minority ethnic backgrounds, people who are disabled, people who are poor, and people who are non-heterosexual or non-cisgender (Thompson, 2016). Not all of these social categories are mentioned in the chapter below, since the HSWs' patients within this study tended to be older people who are predominantly white, working or middle class and heterosexual. An attempt to frame the discussion of HSWs' responses around all the various forms of discrimination would therefore impose an artificial structure on the data that were gathered.

The discussions that follow should be read with the understanding that HSWs demonstrate a deep personal commitment to their patients always in mind. Striking about the way HSWs approached their work during the fieldwork was their empathy for both patients and carers. This was frequently expressed when their views were elicited both in formal interviews and conversations. For example, two social workers were discussing the pressure that patients sometimes experience from family members to go into residential care and one commented,

> "*If people were trying to make decisions for me and I had capacity I'd be sitting there wanting to scream.*" – HSW2, from a fieldnote, recorded near verbatim

Empathy for patients is not confined to HSWs' discussions of their work, however, but also colours their interactions with colleagues within the hospital. During a telephone call with a nurse regarding a patient whose false teeth had been lost, for example, another HSW commented,

> "*I mean, if that were my mother I'd put in a pretty strong complaint.*" – HSW3, from a fieldnote, recorded near verbatim

The willingness of HSWs to imagine themselves in the position of patients or carers is a powerful counterweight to the dehumanising procedures and practices discussed in Chapter Four. Empathy is significant in social work because it moves beyond an emotive or cognitive

response to a person or situation to provoking a conscious decision to take informed action (Gerdes and Segal, 2009). Thus, by cultivating a sense of empathy in their work, HSWs make a conscious personal commitment to the well-being of patients and carers, which may encourage an orientation towards the social work values of human rights, social justice and empowerment (Payne, 2014).

Human Rights

It is interesting that no mention of or reference to the Human Rights Act 1998 was recorded during either the fieldwork or interviews, despite HSWs' concern for individual self-determination. This suggests that the legal framework underpinning the human rights of patients, which HSWs are concerned to uphold, holds far less sway than their conception of individual rights as arising as an implicit component of human nature (Ife, 2010). The right of the individual to self-determination appears to be the most prominent human right with which the HSWs are concerned. During fieldwork and interviews, this was frequently expressed in terms of the choices and decisions patients might make, for example:

> "…*anyway, it's his choice to live like that, and he's got the right to make that choice. Even if it's a bad choice, he's got capacity so it's his choice*." – HSW4, from a fieldnote, recorded near verbatim

> "*Well, if somebody's got capacity, they make their own decisions*." – HSW5, from an interview

It is striking that HSWs' discussions regarding the rights of patients to self-determination are often subject to the proviso that the patient has the necessary mental capacity to make decisions. The frequency with which mental capacity is mentioned when related to patients' choices is understandable in light of the frequency with which HSWs are involved with limited mental capacity due to both long-term conditions such as dementia and the short-term effects of physical illness. In terms of the European Convention on Human Rights, the type of self-determination with which HSWs show concern incorporates Article 5 – the right to liberty – and Article 8 – the right to privacy, family life, home and correspondence. While the HSWs' frequent use of the term 'choice' recalls the language of neoliberalism, with its emphasis on consumer choice (Beckett and Maynard, 2013), 'choice' should here be

understood in terms of the decisions self-determining individuals make about their lives, rather than the selections of welfare goods by a customer.

Self-determination as understood by the HSWs can be defined as a negative right, as it is the right to be free from interference, as opposed to a positive right, in which an active effort might be made to enable people to enhance their self-determination (Banks, 2012). The emphasis on negative rights in HSWs' priorities can be seen in HSWs' willingness to support patients whose mental capacity is not in doubt to make decisions that they might consider unwise. Such a stance can be uncomfortable for the HSWs when they perceive that a '*bad choice*' will lead to the patient suffering:

> "*I had this man who just refused to have a care package. He hated social workers – he'd had his kids removed, his daughter had had her kids removed and all that. I'd talk to him and he just wouldn't take any notice of a word I'd say… He wasn't safe to go home but just refused a package of care, so I made him sign a disclaimer in the end to say he was going home without a package of care against my recommendation… I don't know where he is now. I've rung his GP to tell him I'm concerned but there's not a lot more I can do. I do wonder where he is now.*" – HSW4, from a fieldnote, recorded near verbatim

The constraint on the HSW's practice arose from her respect for the right of a person to make a choice about whether or not to receive services. The physical danger to the patient of returning home without support, and the subsequent lack of opportunity he would have to make the most of his life, caused the HSW concern and discomfort but there was no question of her violating his right to self-determination. Indeed, her concern was to document that he had made such a decision, in the form of a signed 'disclaimer'. The idea of positive freedom, in which assistance might be given to enable the patient to gain a fuller understanding of the possibilities available to him, was not considered by the HSW, because it would not be possible to promote the patient's fuller enjoyment of his rights (in this case his right to services to promote his health and well-being) without overriding his freedom to make decisions about his life. A practice orientation concerned more with the promotion social justice might perhaps have led the HSW, conscious of the structural disadvantages and oppression that had made this patient to feel unable to accept the state support to which he was entitled, to turn away from discussions of his physical needs in order to engage with those areas of his life in which the personal is political and raise his consciousness of his oppression and right to services (Thompson, 2016). While the HSW continued to feel concern for the well-being of the patient, however, she did not question the principle that she

should not interfere with the decision he had taken. This suggests that the right of the individual to self-determination, understood as a deontological principle, is regarded by HSWs as the foundational value for their practice.

While self-determination might be taken as the most important human right to the HSWs, it is not the only human right with which HSWs show concern. Even if they do not express their concerns within the discourse of human rights, HSWs involved in identifying and responding to the abuse or neglect of vulnerable adults are concerned with human rights including property rights, freedom from torture and servitude, and freedom of conscience and religion (Mantell, 2011). In such cases, however, the existence of a separate POVA (protection of vulnerable adults) team within the local authority means that the HSW role is largely procedural. The POVA team is responsible for investigating all cases of suspected abuse/neglect of vulnerable adults, with the HSWs having only the duty to refer concerns to them and provide any assistance requested. During the fieldwork, for example, one HSW had identified suspected abuse and referred to the POVA team, and once this referral was made, her only involvement in the process was to search through medical files for some photographs of injuries that were meant to have been taken as evidence for the investigation. Everything else related to the POVA investigation was handled by the POVA team, while the HSW still had to work with the patient to plan for eventual discharge. HSWs experience a sense of powerlessness in this type of situation. In a similar example, during a telephone call from a relative concerned about possible financial abuse of a patient by her main carer, one HSW was heard to remark:

> "*Well POVA have to do their investigation… She's safe for now and all her needs are met, but yeah, I think she's going to have to go into placement…*" – HSW4, from a fieldnote, recorded near verbatim

The HSW's analysis of the overall situation for the patient could only be provisional until the outcome of the POVA investigation. The fragmentation of the social work role between the HSW who might discover abuse and the investigating POVA social worker limit the HSW's scope for working to promote human rights by removing a key responsibility. There is little opportunity in a situation like this for a HSW to democratise human rights through promotion of the alleged victim's claims of self-defined rights (Ife, 2010). While HSWs may maintain an awareness of and commitment to the promotion of human rights, therefore, there are occasions where they may only able to respond through the enactment of a specific mechanism of the bureaucracy to which they belong.

While the HSWs can be said to show a concern for protecting human rights, their involvement with people whose mental capacity is in doubt means that they often have to deal with situations in which people's right to self-determination is denied to them. In such situations, the Mental Capacity Act 2005 requires all professionals and carers involved to act in the best interests of the person lacking capacity. HSWs have a crucial part to play in seeking and documenting the consensus of professionals and carers over the care plans that must be made.

> "*If they haven't got capacity then we would make sure there's a formal capacity assessment completed and we would have a Best Interest Meeting then with professionals and family to see what is the best discharge destination for that individual.*" – HSW1, from an interview

As discussed in Chapters Four and Six, HSWs often leave formal assessment of capacity to doctors, but are willing to take the responsibility if they do not agree with doctors' assessments. HSWs can be vehement in their insistence that the capacity assessments of doctors be properly documented and that patients should always be included in meetings unless capacity prevents them:

> "*I've got a man up on Ward __ who's been treated appallingly. They say they've done a capacity assessment but there isn't one in the file. And then apparently he's got behavioural issues but there's no behaviour charts in the files.*" – HSW4, from a fieldnote, recorded near verbatim

While HSWs do not regularly draw on the legislative framework of human rights in their approach to patients who have capacity, their consideration for the human rights of people deemed to lack capacity is heavily bound up with their understanding of the requirements of the Mental Capacity Act 2005. Thus, while the negative freedoms of human rights are considered by HSWs to be natural rights, their removal can only be sanctioned by HSWs within the context of specific legislation. The emotive language used by the HSW reflects her personal commitment to the rights of the patient. Her portrayal of the practices on the ward in question as appalling to the patient personally, rather than as simply an example of poor practice in general, reflects an empathic awareness that the actions of clinicians would have a material impact on the human rights of the patient. It should be noted, however, that the HSWs keep their responses to perceived injustices such as the above example at the personal level. Though she was concerned at the treatment the patient had been receiving, as long as she was able to ensure that this patient's rights would now be respected, there was no suggestion that she would take her complaint further, even to the level of

management. She thus avoided politicising this as a human rights issue by not considering action to challenge the perceived injustice at a higher level (Ife, 2012).

As well as promoting the legal rights of patients deemed to lack capacity, HSWs consider human rights through their concern for establishing what is really in the best interests of the patient. Regarding the decision making process for one patient deemed to lack capacity who might need residential care, one HSW commented:

> "*It's a difficult one. We know she'll be safer in a residential home, but it might make her miserable...*"– HSW5, from a fieldnote, recorded near verbatim

In considering the patient's potential happiness in the home that might be provided for her, the HSW is considering her right to a home and her right to security, while the consideration of her safety touches on her right to life – i.e. Articles 8, 5 and 2 respectively of the European Convention on Human Rights. It is perhaps encouraging to note that the HSW's concern for the patient's happiness might suggest that the assessed inability of the patient to make her own decision removes an element of her human rights, but does not diminish her humanity in the eyes of the HSW.

In so far as they are concerned with promoting the self-determination of individual patients, and with ensuring their right to life, security and freedom from torture or degrading treatment, HSWs can claim to be promoting human rights. The promotion of human rights by the HSWs is often couched in the language of individual choice, yet this reflects a preoccupation with a broad sense of self-determination, rather than a simple consumer choice between services in a marketplace. Generally, human rights are viewed by the HSWs as natural rights, and only when they are to be removed do HSWs rely on legislation to guide their practice. The principle of individuals' self-determination appears to be fundamental to the HSWs' practice, and is understood as a deontological imperative. The HSWs' regard for human rights tends to be limited to the individual level, and does not lead them to take overtly political action to address wider issues of structure.

Social Justice

Social justice, understood as the fair distribution of benefits and rewards throughout society (Heywood, 2004) is at the core of the aspirations of social work (Clark 2000). As with human rights, the bureaucratic nature of their daily tasks means that HSWs are not in a position to campaign for social justice at the meso or macro level, in terms of seeking structural or political changes that might result in fairer distribution of wealth, opportunities and privilege for the disadvantaged or oppressed, as advocated by modern proponents of a radical form of social work (e.g. Dominelli, 2002; Rogowski, 2010; Ife 2012). Work towards social justice can, however, be seen in the way HSWs seek to improve the lives of patients through their care planning. In an interview, one HSW described effusively the satisfaction she felt in seeing the well-being of a patient improve after complex negotiations with her relatives eventually resulted in her finding permanent accommodation in a residential home:

> "*I mean, she's being cared for, she's made a really good recovery, she's eating and drinking in her nursing home, the manager says she's much happier… She's happier now she sees all of the children and now she's seeing her family, great-grandchildren she's never seen before… This woman has absolutely blossomed since she's gone in… And to see her actually improving to what she was on the ward is well worth the effort. Because I know she's safe and being looked after*." – HSW1, from an interview

For older people facing with declining physical and mental health, access to appropriate care and opportunities to maintain family relationships are vital issues (Age UK, 2011). Arranging the most appropriate care plan for a patient therefore promotes social justice by giving a person access to the resources most likely to promote her/his happiness. The sincere concern of the HSW for the happiness of the patient is indicative of a person-centred approach (Kitwood, 1997) that is concerned with more than the efficiency of the bureaucratic function of moving patients out of hospital beds. By arranging a care plan that is successful in enabling the happiness of an individual, a HSW does not overtly challenge injustice or change society for the better, but she does have a part in enabling an individual to benefit from collective responsibility for the welfare of individuals.

Commitment to issues of social justice can also be seen in HSWs' concern to ensure fairness in the access of patients to the HSW service. While many HSWs acknowledged the difficulties arising from not having allocated wards on which to work – which means HSWs

are unable to sustain long-term working relationships with clinicians – they also asserted that the system is fairer to patients because waiting times do not vary for patients depending on which ward they are staying in. Similarly, there is concern for fair allocation of resources. Concerning a patient who was repeatedly admitted to the hospital for fabricated symptoms, who appeared to want to go into residential care but had hitherto refused to submit to a financial assessment to determine whether or not he should self-fund, HSW3 commented to a fellow team member that it might save time and money if the local authority and NHS trust simply agreed to fund residential care for him. Her immediate response was to point out,

> "*But what about all the other patients in need? How is that fair to them*?" – HSW5, from a fieldnote, recorded near verbatim

As was noted in Chapter Four, there is an ethical obligation on HSWs to ensure that publically funded resources are distributed as fairly as possible. Social justice for the HSWs implies not only that people should have opportunities for happiness, but also that those who have the means to support themselves should pay. Thus, there is an underlying communitarian belief in the balance of rights and obligations (Giddens, 1998). (It will be noted in Chapter Six that the HSWs sometimes show resistance to clinicians' ways of gatekeeping NHS resources with regard to Continuing Healthcare funding. This dissonance can perhaps be explained by the HSWs not understanding the criteria upon which clinicians base their decisions.) The comment made by HSW5 here would suggest that, as with the right of individuals to self-determination noted above, the balance between rights and responsibilities is interpreted in a deontological rather than utilitarian way by the HSWs. An unequal distribution of resources in favour of this particular patient might ultimately result in time and money being saved by both the hospital and the local authority, as well as greatly enhancing his well-being, yet the HSWs ruled this out because unequal treatment was viewed as wrong.

While the above patient's case illustrates the commitment of the HSWs to some aspects of social justice, it also illustrates the limitations which restrict their ability to work towards it. Frequent fabrication of symptoms of physical illness is suggestive of unmet psychological, emotional or social need (Bass and Halligan, 2014). The patient was assessed by a psychiatrist and deemed ineligible for mental health services, but was clearly in need of more support than could be supplied through the standard HSW process of an assessment and care plan to meet basic physical care needs. The HSW's inability to provide a service to the patient beyond the usual bureaucratic functions thus was likely to result in a continued lack of opportunity for him to live a fulfilling life. The services this patient needed to

overcome his difficulties were not available, yet the HSW did not challenge the lack of services, whether through raising consciousness or linking him with others in a similar situation. The emphasis on bureaucratic functions noted in Chapter Four therefore has a limiting impact on HSWs' ability to promote social justice.

Despite the emphasis on bureaucratic functions, there are times when HSWs act within the hospital to safeguard social justice at the personal level. It was noted in Chapter 4 that HSWs sometimes improvise outside their bureaucratic role to support the smooth operation of services for a patient. One such improvisation noted during fieldwork was clearly rooted in the personal concern of the HSW for an individual patient who was at risk of disadvantage through poor services:

> "*HSW4: I've just had a phone call from patient flow. They've moved one of mine from __ Ward to __ Ward but his Zimmer frame's been left behind.*
>
> *HSW1: He'll be in pads[2] by the end of the week.*
>
> *HSW2: Or he'll be on the steady[3], look.*
>
> *HSW4: No, I told them I'm coming up and I'm going to sort that out.*" – Office conversation between three HSWs, from a fieldnote, recorded near verbatim

The personal responsibility that HSW4 assumed for finding the patient's Zimmer frame was emphasised in her repeated use of 'I' in the last sentence. Her actions serve social justice by making sure that the patient retains access to the equipment that may prevent him from becoming more disabled. Though the HSW's actions appear fairly insignificant, they reflect a concern that was expressed by many HSWs during the fieldwork: that patients' physical abilities decline during hospital admissions due to the lack of appropriate care on the wards. Hospital admissions often have a drastic impact on older people's mobility (NAO, 2016) and many of the HSWs felt that this was exacerbated by practices on the wards which save time for nurses and healthcare assistants, such as using a steady to transfer a patient to the toilet instead of taking the extra time to support them to walk there. The HSWs' concerns regarding the care of older people in hospitals is corroborated by recent research. Calnan et al. (2013) found hospital systems do not prioritise patients' dignity and that the physical

---

[2] The HSW is implying that the patient will be unable to walk to the toilet on his own, and will therefore be forced to use incontinence pads.
[3] A steady is a piece of equipment used to transfer patients from bed to the toilet or a chair. Again, the implication is that the patient will lose mobility.

environments of acute hospital wards are unsuited to older people. Further, Hillman et al. (2013) found that the risk reduction priorities of hospital systems result in disadvantages for patients through dehumanising standard procedures (e.g. around patient isolation to prevent the spread of infection) and the risk-averse practices of individual clinicians. Regarding one ward where poor care was felt to be particularly endemic, a HSW in this study commented,

> "*The lack of rehabilitation, it's sad really. Some of the practices I've seen have made me wonder if I should be referring them to POVA.*" – HSW1, from a fieldnote, recorded near verbatim

The perceived paucity of rehabilitation services is an issue of social justice, particularly since many older people struggle to speak up for themselves because of frailty, disability and stigma (Ray et al., 2009). It is striking that, though some of the HSWs felt this concern, they did not take the action of following POVA procedures or seeking change through expressing concerns to higher managers. As was noted with possible human rights violations above, the HSWs are unwilling to move beyond remedying the situation at the personal level. While, during conversations over lunch and breaks, the HSWs would discuss the political context of 'austerity' cuts to public services, and their own local authority's policy on developing the town centre while cutting spending on social care, they did not tend to apply their political views to the individual patients they encountered. It would appear that the sensitivities of social workers to issues of human rights and social justice are keen, yet their power to agitate for these at a level beyond the personal is minimal (Ferguson, 2007). This would suggest that the bureaucratic separation of practice from the moral implications of practice (see Chapter Four) has the effect of separating the personal from the political in the world view of the HSWs.

While the HSWs show concern for social justice in their practice at the personal level, it is apparent that social justice takes a lower priority for them than self-determination. This can be seen in the non-judgemental stance HSWs take towards the ways in which patients exercise their freedom. An example of this arose in discussion of an inpatient who was discovered to be giving away money to his friends and spending substantial amounts on the services of prostitutes. The nursing staff sought to question his mental capacity, yet as this was not in doubt, the HSW involved was clear that no action could, or should, be taken to prevent his continuing to spend his money in this way. Her pragmatic comment:

> "*At least he's spent it on something he enjoys,*" – HSW7, from a fieldnote, recorded near verbatim

demonstrates the extent to which the HSWs avoid moral judgement and place emphasis on the freedom of individuals to decide on their own actions. From a position of respect for the self-determination of the individual, there is no difficulty with the HSW's stance here. The non-judgemental stance, however, does result in the HSW taking a neutral stance towards prostitution – a practice which research evidence suggests brings to women 'even greater poverty, social ostracism, exploitation, abuse, housing difficulties, dependence on men…' (Phoenix, 1999, p. 100). Of course, there are alternative perspectives that emphasise the agency of women involved in prostitution and advocate for the freedom of women to use their own bodies as they see fit (Leigh, 2004). For an occupation that claims to support liberation and social justice (IFSW, 2014), however, a neutral position towards the patient's use of prostitutes – in which the perspective of the prostitute is not considered – appears to be contradictory.

In their role as gatekeepers of social care services, HSWS, as with all social workers involved in planning community care, have a part to play in promoting social justice. HSWs show a concern for fairness in terms of how their services are distributed, and operate the mechanisms of bureaucracy in ways that enable individuals to have access to opportunities for personal fulfilment. They also show willingness to improvise outside their bureaucratic role in order to protect individuals from becoming disabled by services that are inappropriate or even neglectful. The HSWs do not operate beyond the personal level, however, e.g. by challenging disadvantages they discover either through approved mechanisms such as POVA or through involvement in wider agitations or consciousness-raising. While they are able to be critical in their understanding of the disadvantages the users of their services may encounter, the nature of their role as statutory social workers limits their practice to the micro level.

Advocacy and Empowerment

Empowerment should be understood not as something that can be given by a professional to an individual or group, but as a condition that a person is able to achieve through her/his own actions (Lymbery, 2005). Where social workers seek to promote empowerment, they should therefore be understood to be working to create or support the conditions under

which empowerment is possible (Ray and Phillips, 2012). It is possible for HSWs facilitate empowerment when they produce care plans that are tailored towards the choices patients wish to make about their lives. In order for such empowerment to occur, HSWs embrace the role of advocates for patients. As will be discussed further in Chapter Six, the role of patient advocate is central to HSWs' self-perception and their understanding of how they relate to clinicians within the hospital. While, as has been noted above, HSWs do not readily engage in agitations to create a fairer society or to correct structural injustices, the self-assumed position of advocate allows HSWs to feel that they are challenging the powerful on behalf of the powerless:

> "*If it wasn't for us advocating, people would be caught up in the process and their choices would be forgotten about.*" – HSW2, from a fieldnote, recorded near verbatim

It is interesting that the HSW regards discharge planning as a process in which the wishes of a patient can easily be forgotten about. This suggests an understanding of the bureaucratic systems of both the hospital and the local authority as disempowering to patients. In casting themselves as advocates for patients, HSWs' aim is not only for the patient's voice to be heard, but for their wishes to be enacted by the services involved. This distinguishes HSWs from the independent advocates provided by some voluntary sector agencies (e.g. Age Cymru), whose purpose is only to ensure that the views of an individual are heard and noted within decision making processes. By contrast, the advocacy of the HSWs would appear to fit the definition supplied by Sosin and Caulum (1983, p.13):

> "An attempt, having a greater than zero probability of success, by an individual or group to influence another individual or group to make a decision that would not have been made otherwise and that concerns the welfare or interests of a third party who is in a less powerful status than the decision maker."

It might appear contradictory that HSWs could fit this definition of advocates when they themselves are often decision makers, since they are responsible for submitting care plans in order to secure resources for patients. This contradiction is solved by a full consideration of the primacy of patients' or (when patients are deemed to lack capacity) carers' wishes in the HSWs' assessment processes. In carrying out an assessment, typically HSWs do not regard themselves as having expert knowledge as to the patient's needs, and therefore they do not consider their own opinion to be final. As noted in Chapter Six, expert knowledge regarding patients' medical needs is supplied through clinicians, yet this knowledge is used only to ascertain a patient's eligibility for services, not what services the patient ends up receiving. The wishes of the patient or carer(s) are at the centre of the HSWs' assessment and care plan. The care plan the HSW produces is the result of an attempt to match what

the patient/carer(s) wants with what their medical need makes eligible and what any involved informal carers might be willing to support. Advocacy on behalf of patients, therefore, is most often concerned with persuading a patient's family members, or persuading professionals, to respect the wishes of the patient. Since the patient's desired outcome is therefore achieved through the deeds of the HSW rather than the agency of the patient, it is possible to argue that empowerment does not occur. Ultimately, however, if a decision has been taken by a patient and then enacted by the HSW, the HSW can be regarded as the instrument of the patient's will.

The need for HSWs to act as advocates with family members can arise because of the discovery of abuse or neglect, but often arises because family members have innocent but set ideas about the kind of care they want for the patient.

> "HSW1: *I have a patient who has capacity, movement and continence but risk of falls and she's being assessed for residential. She's told me she wants to go home, but says to me, 'Don't tell my daughter'. But I said to her, 'Should we be planning for you to go home? If that's what you want, I can talk to your daughter about it.' And eventually she agreed to talk to her daughter but it was hard for her because her daughter wanted her in residential.*
>
> *HSW2: Families can be so powerful all coming together.*" – Conversation between HSWs 1 and 2, from a fieldnote, recorded near verbatim.

Wanting the best for a patient very often means that family members want to see them physically safe, and err on the side of caution in suggesting care plans that would reduce the patient's independence. As HSW2 notes, families can hold high levels of power over elderly people who are ill and frail, such that, as in the case, the individual feels unable to speak up for her own independence. In a society in which older people are marginalised rather than valued, ideas of old age as encompassing helplessness and passivity permeate each generation (Pickard, 2016; Ray and Phillips, 2012). In encouraging the patient to speak up for what she wants to happen, the HSW therefore challenges an oppressive culture and assists the patient's liberation and empowerment. It has been suggested (e.g. Rose, 1990; Pullen-Sansfacon and Cowden, 2012) that empowerment involves not only putting the viewpoint of a less powerful individual or group forward, but also raising their consciousness of the social context in which they are rendered powerless and the true range of choices that may be open to them. In the example above, the HSW can certainly be said to have raised the patient's understanding of the choices open to her. It may also be the case that through

her interaction with the HSW, the patient's awareness of her family's ageist assumptions was raised.

The advocacy provided by the HSWs often revolves around the discourse of risk. During the fieldwork, the HSWs' orientation towards risk varied depending on the situation. Often, as described above, the HSWs would advocate for positive risk-taking – weighing the benefits of taking a risk against the negatives of not taking it (Morgan, 1996). When advocating positive risks, the HSWs tend to regard even small successes as worthy of effort. For example, describing a care plan for which she had advocated, which had lasted for six months before the individual concerned had to be admitted again to hospital following a fall, one HSW commented,

> "*So to me that was an achievement, that was really good, so she'd done really well*,"
> – HSW9, from an interview

The individual involved had been diagnosed with dementia and was physically frail, so it was likely that she would reach the point where going into residential care would be inevitable. In her willingness to facilitate the patient's wish to remain at home for as long as possible, however, the HSW placed respect for the patient's right to self-determination above the most efficient and lowest-risk option, which would have been to press her to accept earlier placement in residential care.

By contrast, the discourse of risk can also be used by HSWs as a means of advocating against professionals putting patients' safety in jeopardy by discharging too hastily. In an interview, a ward sister commented on HSWs' unwillingness to take risks with patients' safety:

> "*I do think a lot of our decisions are made without the risks being weighed up, to be honest… We go, nurses, sometimes very close to the wind. But if a social worker is involved, they don't take risks… I'll say yes, the social worker will say no.*" – WS2, from an interview

HSWs support risks that patients wish to take in making decisions about their own lives, but act against clinicians who wish to risk a patient's safety in order to free a bed for the next patient. This demonstrates that the loyalties of HSWs lie firmly with the individual patient. The ability of HSWs to 'say no', acknowledged by the ward sister, suggests that HSWs wield

real power on behalf of patients. Wielding such power could not be said to be empowering to patients, since they are not included in the decision-making, but it does serve to protect patients from disadvantage and further curtailment of their liberty through incurring further injury or illness as a result of premature discharge.

That HSWs are able to provoke a sense of empowerment through advocacy can be seen in the words of patients and carers. When asked who makes decisions about his care, one patient interviewed during fieldwork expressed a firm belief in their own self-determination.

> "…*She answered my questions and was very clear – if you don't want to do it, don't do it… the decisions are made by the three of us: me, my son and my daughter-in-law. But nothing would be done against my will.*" – Patient 1, from an interview

This patient had recently agreed to be discharged from hospital into a residential placement for short-term physical rehabilitation, which would then lead to him returning to his own home. The patient's confidence that nothing would be done against his will reflects his trust in his relatives and the professionals involved, but also demonstrates a strong sense of empowerment. His repetition of the HSW's words suggests that her interaction with him had an effect in creating this sense of empowerment. The knowledge about both the available services and his rights that the patient appears to have gained from his HSW enable him to participate fully in the planning of his care (Adams, 2008). This demonstrates that advocacy is not a fiction created by HSWs in order to feel that they are still doing 'social work' even in a highly bureaucratised role, but a practice that can have a tangible impact on the lives of patients and carers.

The impact of HSWs as advocates was even more evident in the words of carers interviewed during the fieldwork. Carers reported emotional benefits of having a HSW to advocate on their behalf within the hospital:

> "*So HSW2, basically she became our advocate for the family because there was still pressure from people within the hospital to say why aren't you just taking him home? And HSW2 was able to say, no I had a conversation and he was very clear about what he wanted, and this is the way we're going to be working.*" – Carer 1, from an interview

> "*…where you feel like you're up against a battle, I have somebody to shield me from it a bit because at least she can fight our corner.*" – Carer 2, from an interview

The sense of relief carers expressed at having a HSW often related to having someone to assist them in expressing opposing views to clinicians and dealing with conflict about what should happen to a patient – especially in situations in which it was agreed that the patient did not have capacity to make their own decisions. The practice of the HSWs can therefore be seen in the light of addressing the power differentials between healthcare professionals and carers (Johnson, 1972; Larson, 1977). The advocacy HSWs offer sometimes involves empowering people to speak for themselves, but also sometimes involves speaking on their behalf to ensure that their decisions are enacted.

While it is clear that the HSWs are able to support empowerment through advocacy, there is one aspect of advocacy in which their practice might be thought to be weak. Advocacy involves not only ensuring that an individual or group is heard and is respected within a decision making process, but also in ensuring that the individual or group is supported to grasp the range of choices available to them (Rose, 1990). While HSWs are able to make patients and carers aware of the types of provision that are available and the outline of what a care plan might be, they are not able to facilitate a consumer-type choice between the services available. For care in the home, a 'brokerage' team arranges the care agreed in the HSW's plan without any input from the patient (or the HSW) in selection of the provider (see Chapter Four). In the case of choosing a residential home, the HSWs are unable to give information or opinions to patients or carers about the standard of care provided in any of the available options, on the grounds that this might leave them open to accusations of bribery or detriment to the business of ill-favoured providers. This leads to a situation in which HSWs are all but powerless to promote the best interests of the individual going into residential care. One HSW commented about a former patient who seemed depressed since moving into residential care:

> "*Well I'd be depressed if I had to live in that room. And he's only a young guy – maybe in his 70s, so he could be facing 20 years in that room!... I wrote in his file that he needs to go to a better room as soon as one becomes available. And I told his son to keep on top of that.*" – HSW5, from a fieldnote, recorded near verbatim.

This is a typical example of a type of conversation that took place regularly among the HSWs during the fieldwork – the HSWs had strong opinions about some care homes, but were not able to influence carers or patients overtly in their choices. The empathy and

personal concern of the HSW for the well-being of the patient is once again evident, yet the HSW does not consider any action beyond the personal level – in this case, encouraging the patient's son to be proactive after her involvement has ended. This means that the market system on which community care now relies is far less effective than it could be in maintaining standards, since competition between the goods available is not facilitated by a fair and open market. While local authorities keep lists of approved care homes, which are updated when information is provided by social care professionals (e.g. community care management social workers, Deprivation of Liberty assessors, POVA investigators etc.), and while there is a regime of care home inspection, the recent discovery of widespread neglect and abuse in care homes (Greener, 2015) would suggest that these mechanisms are not enough. It is therefore once again evident that the HSWs do not feel able to engage in activities to raise awareness of structural disadvantage or to agitate for change in society, even at a local level.

The lack of engagement of the HSWs with the wider context in which the individual's needs arise can further be seen in the absence of consideration of the national policy context in the course of their work. The Welsh Government's older people's strategy (2013, see Chapter 2) might conceivably have been used to strengthen HSWs' position as advocates, inasmuch as the strategy's avowed aim of making the voice of older people stronger in decision-making about services that affect them is in harmony with the work of HSWs as patient advocates. No mention of the older people's strategy by HSWs was recorded in the fieldnotes, however, nor was any reference made to Wales' older people's commissioner. As noted above with human rights, it appears that the HSWs do not take interest in legislation as having the potential to empower – they regard the right to make choices as intrinsic rather than granted through law. The older people's commissioner might have been a powerful ally to challenge some of the practices within the hospital for which HSWs expressed disapproval. The HSWs' lack of engagement with this potential ally therefore confirms the conservative nature of their advocacy, which is orientated towards the well-being of the individual but shies away from challenging wider institutional or structural injustices.

Inasmuch as the practices of HSWs are orientated towards human rights, social justice and empowerment, albeit predominantly at the individual level, their values might be understood as 'modern, emancipatory values' (Lishman et al., 2014, p.8). An assumption of such values is that the social worker should not be regarded as an expert with an implicit right to diagnose the cause of an individual's difficulties and the necessary treatment, as is the case

in the traditional 'medical model' (Laing, 1971), but that social worker and the user of services should be regarded as partners working together. Despite their emancipatory leanings, however, the HSWs retain some elements of professional power. Their role as gatekeepers of services arises from their power to define need in the assessment and care planning process, and with the ability to define needs comes some control of discourse and therefore power (Foucault, [1975] 1991). The intentional retention of power by HSWs can be seen in one HSW's comment to an independent advocate about their role:

> "*HSW3 asks the representative of the advocacy service what she would do if a patient deemed to have capacity expressed a wish to do something dangerous. The representative replies that she would still have to advocate for them, as long as they have capacity. HSW4 comments that she would not 'take kindly' to this sort of intervention if she could see that a discharge home would fail, adding that risk assessment is part of the social work role.*" – Fieldnote

HSW4's emphasis on the risk assessment role serves to underline her own expertise, and therefore the inappropriateness of challenging her recommendations. This serves to undermine any sense that a care plan is co-produced by social worker, service user, carer and other involved services, as intended in the Older People's Strategy for Wales (Welsh Gov., 2013). It is ironic that HSWs place so much emphasis on their own advocacy role, yet feel so wary of advocates from outside their service. This reflects how HSWs must balance more than one moral imperative at a time: the emphasis on empowerment and choice must be balanced with appropriate management of risks.

The fieldwork suggested that the advocacy role is at the heart of HSWs' practices, and that their advocacy can make a tangible difference to the lives of patients and carers. HSWs act as advocates both on behalf of patients towards family members and on behalf of patients and carers to clinicians. There is some evidence of a critical approach towards environments and practices that disempower older people (Ray et al., 2009) and attempts to make empowerment possible, even if HSWs must sometimes act as the instruments of patients' or carers' will, rather than enabling a direct exchange of power. A theme running through discussion of HSWs' contribution to human rights and social justice also found in the discussion of advocacy and empowerment, however, is that the HSWs do not work beyond the level of the individual to advocate for wider changes in society. Unsurprisingly in a statutory role, the practices of the HSWs might therefore be understood as comprising a conservative form of social work, aimed at mitigating the disadvantages arising from

neoliberalism (Ferguson, 2007; Rogowski, 2010), without challenging the social and structural disadvantages underlying individual difficulties.

Summary

This chapter has explored the extent to which the work of HSWs can still be said to be 'social work' as understood in the IFSW (2014) global definition. It has been possible to detect in the HSWs' practices orientation towards values commonly regarded as central to social work practice: human rights, social justice and empowerment. The ambitions of HSWs in response to these values are conservative, however, reflecting their descent from the 'casework' tradition. HSWs work at the personal level to promote social justice and patients' and carers' human rights and their advocacy has tangible benefits to patients and carers, yet they do not tend to undertake practices aimed at changing the wider social and structural causes of the disadvantages they encounter. To do so would not be possible within the agency in which they are employed, and in many cases would not meet the immediate, pressing needs of the patients for whom they are responsible. Thus, while concern for human rights, social justice and empowerment can be seen as integral to even highly bureaucratised social work roles, the wording of the IFSW definition, which appears to imply that social workers should be agitators for political change through their work, needs to be revised in favour of a version that acknowledges that social workers can often only operate at the micro level. The very real difference to individuals' lives that social workers can make should not be undervalued because they are not able to match a definition of their role that is not a true reflection of the realities of statutory social work with adults in the UK.

Chapter 6: The Social Work 'Cuckoo' in the Hospital 'Nest'

Introduction

This chapter will explore the way the HSWs respond to and negotiate the working environment of the hospital and the patterns of their relationships with clinicians and ward managers. Drawing on the work of Irving Goffman, emphasis will be placed on the performative aspects of the HSWs' practices and the ways in which their presentation of a working self appears incongruous with many of the accepted forms of self-presentation common to clinicians. It will be argued that this incongruity goes beyond conflicting expectations of role performance and is underpinned by fundamentally different conceptual 'frames' regarding the reality of work within the hospital. Attention will then be turned to the ways in which HSWs manage their relationships with clinicians in order to ensure that they are able to contribute to the business of the hospital in a role that relies heavily on co-operation.

Goffman (1959) argued that human actions in the presence of others can be seen as performances in which the actor aims to project a version of her/himself that is germane to both the actor and the observer's shared understanding of the reality of the situation. All social activity is therefore guided by conscious and unconscious efforts to manage impressions and to negotiate identities. Typically, individuals in the presence of others deliberately seek to make their activity visible and comprehensible through visual signs and symbolic acts – to *dramatize* their actions in front of an audience. Impressions and identities are managed not only by individuals, but by teams of people with an interest in maintaining a common version of reality. In exploring the dramaturgical aspects of social interaction, therefore, the use of setting and props is of interest as well as the words and deeds of the actors. While Goffman's work has been criticised for focusing too much on appearances (Gouldner, 1970) and for reducing all human conduct to mere role-playing (MacIntyre, 1981) it provides a useful framework for analysing the strategic behaviours of people and the ways in which people conform to social norms (Burns, 1992). Goffman's contention is not that people spend their lives playing out parts insincerely, but that social action is orientated towards creating and maintaining shared meaning and shared interpretation. "A status, a position, a social place is not a material thing to be possessed and then displayed; it is a

pattern of appropriate conduct, coherent, embellished and well-articulated." (Goffman, 1959, p. 81)

Goffman's dramaturgical insights are complemented by his later work, *Frame Analysis* (Goffman, 1974), which seeks to answer William James's question, "Under what circumstances do we think things are real?" (Burns, 1992, p. 247). Frames can be understood as being "composed of little tacit theories about what exists, what happens and what matters," (Gitlin, 1980, p. 60). Framing therefore constitutes the meaning structure actors draw on to make sense of their situation and frames are shared by people interacting to guide their actions (Goffman, 1974). Thus, for example, a punch thrown by a player during a rugby match might be seen as no more than an act of foul play within the game, whereas a punch thrown within a pub or on the street would be likely to be treated as a criminal assault. Frames are continually renegotiated through interactions and are not reproduced perfectly, meaning that slippage can occur (Collins, 2004). Ambiguity may arise when actors do not share the same frame but neither is willing or able to adapt (Gray et al. 2015) – and this is often the case between the HSWs and the clinicians. In such circumstances, it is still possible for those interacting to work together, especially where there is a shared goal (Donnellon et al., 1986; Reay and Hinings, 2009).

The Dramatization and Visibility of Social Work in the Hospital

The self-presentation of HSWs was observed to be markedly different to that of clinicians within the hospital. An immediately visible difference noted during the fieldwork is that the HSWs do not wear uniforms, whereas all clinicians apart from doctors do. The uniforms worn by nurses, physiotherapists and occupational therapists all reflect the physical nature of their role – with nurses wearing overalls that are comfortable and cool, the colour of which indicates their level of responsibility and expertise, while occupational therapists and physiotherapists wear hospital-issued clothes that allow them to move freely and quickly should they need to provide physical support to patients, in the form of polo shirts, trainers and trousers of light and stretchy fabric. While doctors are not required to wear uniform, their appearance nonetheless makes their role easily identifiable. Junior doctors are recognisable by a stethoscope worn around the neck over casual office clothes, while more senior doctors

tend to wear office clothes that are more formal, yet with their pager prominently visible. Like the junior doctors, the HSWs wear smart casual office clothes, yet have no accoutrements to display their role or status, other than a diary, which is often stuffed full of pieces of paper and held shut with an elastic band. The lack of visual symbols of recognition for HSWs is significant because it reflects the low visibility of much of their work. It will be argued that the low visibility and low-key dramatization of social work within the hospital brings both benefits and challenges to the HSWs.

The low visibility of the social work team I observed was increased by the relative remoteness of their office.

> *Geographically, the building is in an isolated position in a 'no man's land' between the two hospitals the team serves – the larger, general hospital at the bottom of the hill and the smaller, rehabilitation hospital at the top of the hill. Surrounded on both sides by crowded car parks, the building is shabby and uninviting from the outside. There is no sign indicating that this is where the team is based, and no obvious way for a visitor to gain entry, as the doors are secured with a combination lock.* –
> Fieldnote

Much of the daily activity of the HSWs takes place inside their offices, where they write up assessments and care plans, contact patients' relatives by telephone and make telephone calls to other professionals both within and outside the hospital. They do not carry pagers and often divert their desk phones to the team administrators' office, meaning that it is difficult for clinicians and ward managers to contact HSWs when they need to. Other professionals rarely visit the HSWs in their offices, which could therefore be considered a 'backstage' area for the performance of the social work role (Goffman, 1959). By contrast, the setting in which clinicians operate has a more complex 'frontstage/backstage' interplay (Lewin and Reeves, 2011), with much of the work of clinicians being visible to both patients and colleagues and therefore 'frontstage', yet with opportunities for 'backstage' work arising frequently through conversations in corridors and side offices. HSWs' lack of a continuous physical presence around the wards therefore not only obscures the performance of their role from clinical colleagues, but also excludes them from informal opportunities for building collegiate relationships.

A striking visual clue regarding the (in)visibility of the HSWs can be found by contrasting the physical presentation of the interior of their offices with presentations that are to be encountered elsewhere in the hospital. Goffman (1959) argues that the physical setting in which interactions occur is an integral part of the 'front' which performers create. The HSWs' offices give the impression of a team whose status is low and for whom keeping up appearances is of minor concern:

> *Within* [the HSWs' building]*, small offices run along a gloomy corridor. In one office, paint has peeled away from the wall and in general the offices are in a poor state of decoration, with furnishings that are old but functional. In terms of temperature, the building resembles Hesiod's Ascra: 'χεῖμα κακῇ, θέρει ἀργαλέῃ, οὐδέ ποτ' ἐσθλῇ' – 'bad in winter, sultry in summer, and never good' (Works and Days, l.640). Even during bright days most of the offices require artificial lighting. Some social workers personalise their desk and working areas with photographs or pictures yet these scarcely diminish the overall impression of an unkempt, un-cared-for space. An unused office at the end of the corridor is used as a makeshift staff room and many of the social workers use this to eat lunch together, often buying food from the hospital canteen to take back with them. – Fieldnote*

The shabby appearance of the HSWs' office reflects its status as a 'backstage' area, which means, significantly, that it is also a setting which HSWs cannot use in managing impressions. By contrast, the office of the 'bedflow' managers, where a senior HSW has a daily meeting to discuss delays in patients' discharges (see Chapter Four) is a hive of technology and buzzing activity:

> *The room is laid out with computers arranged in rows. The floor and walls are brightly clean and large windows look out over the city. All of the computer settings appear to be 'hot desks' and nobody leaves any personal touches. On one wall are two large flat screen televisions with information graphics related to the availability of beds or general messages for staff. The room is a hive of activity with bedflow managers to-ing and fro-ing. Some have telephone devices hanging from their necks by a cord, which they are able to speak into to dial numbers. – Fieldnote*

The physical setting of the 'bedflow' managers' office gives a powerful representation of business, efficiency and command of the situation. It is in such an environment that the senior HSW must give a daily account of the work of the team, inevitably explaining delays. In the face of such a powerful dramatization of the hospital's work, HSWs have limited resources to project an image of their work that reflects how they might wish to be seen.

Just as a contrast may be noted between the visual presentation of clinicians and HSWs, there appears to be a marked difference in the way HSWs and clinicians are able to dramatize their roles (Goffman, 1959). Many of the tasks performed by clinicians are easily intelligible to an observer: medical or surgical procedures are performed; equipment is used to monitor patients' vital functions; drugs are given; records are made in patients' charts, etc. By contrast, HSWs' actions with patients are less overtly dramatized, usually consisting only of a conversation with the patient in whatever location is most convenient for the patient. HSWs can make the accomplishment of their work known to clinicians by making recordings in medical notes, but cannot make the meaning of their interactions with patients known to clinicians purely through dramatic performance. Preservation of confidentiality means that HSWs tend to keep their interactions with patients as low-key as possible. By looking alone, one can tell whether a nurse is taking blood pressure or giving medication; by contrast, it is often not possible to tell by looking at a HSW in conversation with a patient whether she is a professional performing an assessment or a visitor discussing the weather.

The low visibility to clinicians of the HSWs' activities, and the difficulty the HSWs experience with dramatizing their role, leads to misunderstandings and frustrations between them and the clinicians:

> *HSW9 says that some nurses think that they have to keep ringing up in order to prompt social workers to respond, and will ring several times a day. "They don't seem to realise we have other cases."* – Fieldnote, quotation recorded verbatim

> *HSW5 tells me that very often ward staff will claim that the social worker is delaying discharge when they are not... She speculates that sometimes nurses see that a referral has been made to social work and therefore automatically assume they are causing a delay.* - Fieldnote

Because of the lack of visibility of social work, clinical staff on the wards appear to have little confidence in the ability or willingness of HSWs and therefore seek reassurance in a manner that can be experienced as mild harassment. The number of cases held by each HSW, the urgent demands that may be arising from other patients and the bureaucratic processes the HSWs must follow in order to obtain a service for patients (see Chapter Four) are not apparent to clinicians on each ward, to whom the HSW is an infrequent and fleeting visitor.

While it might be anticipated that promoting the visibility of their work might lead to more harmonious relations with clinicians and ward managers, in the dilemma of 'expression versus action' (Goffman, 1959, p.42), the HSWs appear to have made a conscious choice to prioritise action over expression. This can be seen in the organisation of coverage of the hospital by the HSWs, and in their choice of which meetings they should attend. The HSWs are not allocated wards to cover, but range across the two hospital sites according to the order in which patients are presented as cases for allocation. The result of this is that HSWs never work continuously on one particular ward for any length of time. This means that it is difficult for HSWs and clinicians to form close working relationships, since a HSW's time spent in any one ward will be limited and infrequent. Similarly, HSWs do not attend the weekly multi-disciplinary team meetings of any of the wards. While, in the general hospital, there would be too many for the HSWs to cover, it might be possible for them to do so in the smaller rehabilitation hospital, which only has three wards serviced by the HSW team. In the perception of HSWs, however, their more visible presence, either as a ward's allocated HSW or as a regular attendee at a multi-disciplinary meeting, would be likely to have an undesired effect:

> *HSW9 gets a call about a case that is not allocated to her. Afterwards she laughs and says that if you've been to a ward that day about one patient, if they have another who needs a social worker they'll invariably ring for you, as if you've suddenly become that ward's social worker. That can get really confusing when that patient isn't allocated to you. HSW10 agrees, "Yeah once a ward's seen you, they think you're theirs." As they talk, exactly the same thing happens to HSW8, who comments, "This is when it doesn't work so well, you see. You get pulled into things."*
> – From a fieldnote. Quotations recorded near verbatim

'Getting pulled into things' is seen as an undesirable distraction from the business of discharging patients. As was noted in the previous chapter, HSWs experience pressure from all sides to carry out discharges as quickly as possible and are also aware of the need to spread their resources as fairly and efficiently as possible for patients in need. While their lack of visibility causes some inconveniences in terms of their ability to communicate the nature of their daily work to clinicians, it also shields them from acquiring extra tasks outside the narrow bureaucratic functions that are their domain. As previously noted (see Craig and Muskat, 2013), there is a tendency for clinicians to look to HSWs to fulfil any miscellaneous tasks that do not touch on their own usual area of work. Maintaining a low level of visibility enables social workers to avoid such impositions and focus on the work that they identify as their own.

HSWs work in an environment in which multiple occupational groups stake claims for recognition through the dramatization of their work, aided by their use of the setting and visual symbols of their roles. The HSWs' lack of control of a visible space within the setting, and the difficulty of dramatizing their own role, might have been anticipated to be problematic for them in retaining any sense of autonomy or prestige. The HSWs turn their low visibility to their advantage, however, as a means of restricting the extent to which clinicians are able to make demands on their services.

Discrepant Frames

The relatively low-key dramatization of their work by HSWs is functional as a means of managing their workload, but may also serve another protective purpose. Despite the low levels of prestige enjoyed by social work in general as an occupation (see e.g. Judd and Sheffield, 2010), the HSWs in this study proved resistant to domination or control by doctors, in contrast to the other occupations involved with the care of patients observed. Indeed, it can be argued that the HSWs rely on a framing of the reality of work in a hospital (Goffman, 1974) that is fundamentally different to that shared by clinicians. Their low-key dramatization of their work might therefore be interpreted as a deliberate strategy to avoid overly frequent incidents of overt conflict with clinical colleagues. Rather than engage in such conflicts, HSWs pursue their work as they see fit to do it without drawing attention to fundamental disagreements with their clinical colleagues.

The frame shared by clinicians revolves around the doctor as the co-ordinator and overseer of each patient's care (Willis, 1989). While a hierarchy of authority exists, the social order of hospital teams is a negotiated one, since experienced practitioners in the lower ranking occupation of nursing may nonetheless demonstrate more power than junior doctors in the early stages of their career (Strauss et al., 1963). As other clinical occupations have emerged, such as physiotherapy and occupational therapy, the need has arisen for those practitioners to negotiate their own jurisdictions, the boundaries of which can be dynamic and contested (Abbott, 1988). The idea of a negotiated order implies active discussion of roles and duties, yet this does not always occur – often roles are agreed through tacit understandings (Allen, 1997). However power is distributed, and however collaboratively

multi-disciplinary teams may work, it remains the case that authority over inpatient care ultimately lies with a doctor (Nugus et al, 2010). Clinical teams are not always ordered with the priorities of the patient at their centre – wards, units and speciality teams employ idiosyncratic logics that work to promote the interests of clinicians in the organisation of their work (White et al., 2012).

During the fieldwork, it was possible to see the shared frame of clinicians at play in the rehabilitation hospital. The weekly multi-disciplinary team (MDT) meetings of two wards were observed on multiple occasions. Notable in both were the extent to which the most senior doctor controlled the conduct of the meeting, deciding when it was time to move the discussion on and inviting other clinicians in turn to make their reports. The more senior the doctor who chaired the meeting, the more structured the meeting was. HSWs were notable for their absence from these meetings, which was sometimes remarked on by clinicians discussing the social needs of patients. If the MDT meeting is interpreted as a team performance that reinforces the social order (Goffman, 1959), then the HSWs' absence from it can be interpreted as an act of non-conformity to that order and to the shared frame that underpins it.

In contrast to the frame held by clinicians, the frame shared in common by the HSWs emphasises the HSW's obligation to the bureaucratic structures that govern their work (see previous chapter) and their independence from the clinical team in decision making. Both of these assertions may be overlooked by clinicians:

> *HSW10: Sometimes the OTs think that if they recommend, say, four calls, they think that's what it is, and that's what they tell families. They don't realise that I have to come in behind them and make my own assessment.* Fieldnote – Conversation with HSW9 and HSW10

While the occupational therapist (OT) may make a recommendation about the nature of a care package that should be supplied by social services, the HSW must make her own assessment, in which the OT's recommendation is one of many pieces of information to be taken into consideration. Also to be considered are the patient's wishes, the capabilities and willingness of informal carers to provide assistance and the information provided by other clinicians. The HSW must then match this information against the eligibility criteria used by the local authority to supply services. That OTs fail to recognise the independence of HSWs

in acting on their recommendations suggests that this may be an area of occupational boundary disputes (Abbott, 1988), albeit one in which, for the time being, HSWs have the upper hand. It is also indicative of a lack of a shared understanding of roles and expectations.

Clinicians' recognition of the authority of HSWs to make independent decisions is undermined by the reliance of HSWs on the information provided by clinicians, which results in doubts about HSWs' knowledge claims:

> *It's not just me – lots of OTs feel that social workers just use their assessments rather than doing any real work themselves.* – OT2, from an interview

> *I can't even say they've got the knowledge of the care package, because in health, if we do continuing healthcare, we do the care plans, and know what package of care. They're very much guided by health, aren't they, on what people can do, their medical knowledge isn't as great as ours, so they might get a diagnosis but they're not really that familiar with it, because we put in a lot of continuing healthcare applications and they're not that familiar with what the medical terms are.* – Ward Sister 1, from an interview

The overlap of knowledge and roles between OTs, nurses and HSWs weakens the HSWs' claim to have a unique set of competencies that might command respect within the hospital hierarchy. HSWs are seen to collect information, but the work that they do in co-ordinating the information and weighing it up against other information that they have collected for themselves is largely invisible. The frame in which HSWs see themselves as independent decision-makers is therefore alien to clinicians.

While the frame of HSWs is unknown to many clinicians, HSWs are familiar with the clinicians' frame. The HSWs' frame is not one in which the hierarchy of professional authority and knowledge claims is unacknowledged, but rather one in which it is irrelevant. The HSWs do demonstrate consciousness that the knowledge claims of doctors are superior to their own, e.g.:

> *HSW10: "It's hard because we don't have their knowledge, we can just say what the patient is telling us."* – Fieldnote, recorded near verbatim

Further, when speaking to doctors during formal meetings HSWs tend to use a studied politeness, for example addressing them as, "*Doctor.*" Thus, HSWs show a working knowledge of the frame shared by clinicians, even if they do not share it. Despite the respect accorded to doctors, however, HSWs retain a strong sense of independence from the hospital hierarchy. Their assertion of independence from the hierarchy is linked to their positioning as advocates for patients. As the manager of the team put it during a team meeting,

> "*It's our job to be advocating for patients.*" – Fieldnote, recorded near verbatim

The meaning of advocacy in terms of what HSWs seek to accomplish for patients was explored in Chapter Five. Of note here is that the positioning of the HSWs as advocates means that HSWs do not feel obliged to observe the usual proprieties that come from partaking in a team performance, such as hiding disagreement from outsiders and deferring decisions to those with claims to higher authority (Goffman, 1959). Their independence means that they are able to define what their role is and what it is not, and therefore to retain some control over the nature of their work.

On both sides, the discrepant frames can be a source of frustration. Doctors, for example, may resent the fact that they are not able to direct HSWs' activities in order to relieve themselves of the need to deal with the social aspects of patients' needs:

> *The doctor says that he is having to do things that really aren't in his remit and that he ought to be freed up to get on with his medical duties by having social workers to deal with the other problems.*" From a fieldnote – conversation between Dr 2 and Ward Sister 2

Doctors tend to seek to restrict their work to the performance of clinical competencies and seek to distribute tasks that do not provide the opportunity for clinical performance elsewhere (Latimer, 2000). In this doctor's view, the HSWs should be available as a resource to do just this, but the HSWs' elusiveness and independence from the hierarchy means that this is not possible. Whereas the HSWs are aware of the clinicians' framing of the social order of the hospital, but understand themselves as operating outside it, clinicians show little awareness of HSWs' different frame. HSWs' failure to practice as doctors wish they would is therefore experienced by clinicians as a violation of the hospital's social order.

The HSWs are aware of the frustrations of clinicians, but frame the issue as a misunderstanding of their role, rather than a failing on their part:

> *"…they don't understand our processes. I think if they understood what we have to go through to get a package of care, or to enable to us to go forward with a placement, they may be a little bit more sympathetic. But they don't, they don't understand what we do…"* – HSW1, from an interview

There is a clear sense of alienation between the social workers and the clinicians. It is interesting that the HSW places emphasis on the bureaucratic function as the unique aspect of social work that is not understood by her colleagues in health care. This highlights the contrast between social work's frame, which is orientated around the local authority's bureaucratic functions in which procedure is central, and the frame of clinicians within the hospital, whose work must often be accomplished as a response to immediate and pressing need, and is therefore less constrained by process and authorisation (Allen, 1997). The HSWs' position outside the hospital hierarchy should not be understood as a sign of their autonomy, since they have obligations, which are no less binding, to the bureaucratic order through which their work must be processed.

Operating with frame discrepancy within the hospital is not a comfortable experience for the HSWs, particularly because their work relies on good communication with their clinical colleagues. As noted in Chapter Four, completing assessments is the central task of the HSWs' role, and is one in which HSWs must rely heavily on the information provided by clinicians. HSWs are sensitive to the inconvenience providing such information can cause clinicians:

> *"I think they probably see me as being a pain, more than anything. Because I think they probably think, 'Oh no, social worker's requested this, social worker's requested that.' So I think sometimes they may see me as a barrier to actually discharging someone."* – HSW4, from an interview

The information the HSWs receive from clinicians is often incomplete, meaning that HSWs are obliged to chase clinicians in order to complete their assessments. The anxiety this can cause to HSWs reflects their position as an outsider in the hospital setting, and an outsider to clinical ways of working, which tend to focus on the immediate needs of the body (Allen, 1997). The position of outsider for HSWs is reinforced by the fact that they are employees of a separate agency, which means that the communication of changing policies and priorities on either side is minimal.

The disparate frames of the HSWs and clinicians and the outsider position of the HSWs can give rise to a mutual mistrust, which can be seen to manifest itself in tales that are told on both sides about the nefariousness of the others' practices. The tales told by clinicians and social workers about each other bear a remarkable similarity:

> "*I went up to another hospital once for this one lady. I started to do a full UAP* [Unified Assessment Process] *for her but quickly realised she had lots of fast-track CHC* [Continuing Health Care] *triggers. I pointed this out to health, and apparently someone had told them that the patient would get services faster through social services. But legally, it had to be CHC because it was nursing care. She was on so much morphine she didn't know who she was.*" – HSW10, from a fieldnote, recorded near verbatim

> *The ward sister says that she believes that social workers use the CHC process to delay the need to do a social work assessment. She cites a recent case where everyone involved in the meeting except the social worker felt that the needs were not CHC, but the social worker felt that it was, so the application was put forward and then 'thrown back.' The ward sister thinks it should be documented in the process as to who agrees and disagrees with the application.* – From a fieldnote – visit to ward to discuss access

In both passages quoted, there is the belief that professionals are trying to 'cheat' the system, whether to obtain priority for a patient or to avoid the necessity of more in-depth work. The practice of privately accusing the other side of unfair practices is a means by which individuals within a team bond and can also be a way of fostering a shared sense of professional identity (Dingwall, 1977). Common to both passages, however, is misunderstanding that arises from disparate frames. In the first passage, clinicians mistakenly assume that HSWs will do whatever is quickest and most expedient for the immediate needs of the patient, rather than observing the proper bureaucratic protocols to which they are obliged to adhere. In the second passage, the ward sister's belief that the social workers push for CHC to avoid extra work is probably unfounded, since the HSWs claim that a similar amount of work is required from them whether a patient is to receive CHC or local authority-funded care. The HSW's position in pushing for the CHC application to go ahead therefore is most likely to arise from acting as a patient's advocate (CHC funding provided by the NHS is desirable for patients and carers because it is not means-tested, unlike the care packages provided by local authorities.) The ward sister's interpretation of HSWs' motives therefore overlooks the importance of patient advocacy within the HSW role and the deliberate positioning of HSWs on the side of patients.

HSWs appear to work within a frame that can be distinguished from that of the clinicians. Whereas clinicians embrace a complex social order involving negotiation and hierarchy, with a senior doctor retaining oversight and final say over patient care, the HSWs retain a sense of independence from the hospital order and a loyalty to their agency's bureaucratic order. Clinicians are often unaware of the disparate frame through which the HSWs view their work, yet HSWs are aware of the clinicians' frame, even though they do not accept its relevance to them. Both of these frames represent reality as understood by those who hold them (Goffman, 1974) and therefore guide their actions and expectations.

Frame Conflicts

It is striking that, though HSWs often show awareness of the clinicians' frame, they do not readily adapt themselves to it. Goffman (1981, p. 156) argued that nimble social actors are able to switch 'footing' – meaning that they are able to change the alignment of their behaviour to match the frames of others with whom they are interacting. Tannen and Wallat (1987) give the example of a paediatrician modulating her language and gestures during a consultation depending on whether she was talking to a child, the child's mother or to medical students. The HSWs' positioning as advocates for patients, however, means the assumption of a subordinate position, by adopting the footing of the clinicians' frame, is not an option. While the low-key dramatization of HSWs' work may minimise conflict with clinicians over their role and practices, some incidences of open conflict arising from frame differences are therefore inevitable. An example of overt conflict occurred during an assessment meeting for a patient's CHC application:

> *Dr 4 emphasises he does not think the application has any chance of success with the panel and therefore feels it should not go ahead. HSW5 asks aren't all his needs in the nature of his illness? Dr 4 says insistently that he is a Parkinson's specialist and he would say he is in a complex stage but he does not need extraordinary nursing care. HSW5 questions this – the illness is causing his nursing care needs. She turns to the family and asks them if they want to apply. The doctor says he does not want to waste time.* – Fieldnote

The HSW's positioning as an advocate for the patient allows her to challenge the doctor's opinions in front of the patient's relatives, an action that would usually be regarded as taboo

by other members of a team (Goffman, 1959). The HSW's questioning of the doctor's opinion causes him discomfiture and prompts him to make an open claim to superior knowledge, as an assertion of his place high in the hierarchy of authority. The HSW's response is equally assertive in its way – by turning to the family members representing the patient in the meeting and asking them if they want to go ahead with the application anyway, she displays that the hierarchy is of no consequence to her, since the nature of her role is so different to that of clinicians. Thus, two different frames are brought into open conflict. In the doctor's frame, his opinion on the matter is final and, as a subordinate member of the team, the HSW must accept it. In her frame, the HSW places herself outside the doctor's authority, as the patient's advocate, and thus is able to challenge him.

The conflict, on this occasion, was resolved by the HSW deferring to the doctor's opinion. The challenge was not sustained and the meeting ended with an agreement that the patient's application would not succeed, and therefore would not be taken forward. After the meeting had formally finished, both the HSW and senior nurse stayed with the patient's relatives to soothe their disappointment and answer any further questions they might have. The senior nurse then left, yet the HSW remained with the relatives and, in privacy, offered some advice to them:

> *As soon as the nurse is gone, HSW5 advises the family members to wait and get a new CHC assessment once patient is in the community. She says the community nurses are much more thorough and more likely to get the sort of detail needed to get this through.* – Fieldnote

While the HSW did not pursue open conflict with the doctor further than an initial questioning of his opinion, nor did she concede the matter entirely. She instead chose actions that were invisible to the clinicians, but which remained effective for her purpose of ensuring that the patient might access CHC funding if at all possible. Thus, the HSW made a pragmatic decision that it was not possible to persuade the doctor, but did not bend herself entirely to the hospital frame in which the doctor's say is final.

Situations do sometimes arise in which HSWs do not back down from conflict. Another HSW returning to the office from a CHC meeting described what transpired when, at the end of the meeting he refused to withdraw his disagreement with the doctor over a patient's application:

She [the chair of the meeting] *kept saying to me, 'We're in dispute.' I said, 'Well I'm not in dispute, I just have a different view.' But she kept coming back to this, saying, 'We're in dispute,' as if it was something very dramatic. So I said, 'Well what does that mean?' And it just means that all the paperwork gets sent up to the next level for a decision. Well, I don't mind. If the decision goes against me, so be it. It's up to the family to appeal. I'm not going to get excited about it. Not as excited as the chair was anyway.* – HSW3, from a fieldnote, recorded near verbatim

In order for a CHC application to progress or to be dismissed, there needs to be agreement between representatives of both the NHS and local authority. That disagreements rarely happen can be inferred from the way the HSW described the chair presenting being 'in dispute' in a dramatic fashion. This also suggests that the HSW's words were in violation of the usual social order of the hospital, again arising from disparate frames. The HSW frame is one in which conflict with clinicians is a necessary part of the job, whereas, within the hospital frame, the hierarchical social order prevents conflict.

Disputes within CHC assessment have a formal arrangement for resolution, involving referral to managers on both sides at a higher level. Where such mechanisms are not in place, however, disputes between HSWs and clinicians can lead to an impasse:

There was a gentleman, from the first day I met him, I felt he didn't have capacity with regards to discharge destination because he couldn't retain information, he wasn't able to weigh up any risks, and we did a risk assessment with him, and his responses were just completely inappropriate, whereas the doctor thought that he had capacity. I challenged him on this and his response was, 'Oh, HSW1 [he called her by her first name]*, I have no doubt in my mind that he has capacity.' And I said, 'Well I'm sorry but, you know, I disagree. I'll come back and visit him in a few days.' I went back, I was still adamant he didn't have capacity. The doctor was adamant that he did, and the gentleman started deteriorating. And it took about six weeks and the doctor actually said, 'He doesn't have capacity.' Whereas this gentleman has gone from residential to needing a nursing home and now CHC. And the family had actually chosen a residential home that they thought their father would have been happy in, but now he couldn't go.* – HSW1, from an interview

Conflict without arbitration in this example led to an impasse that proved harmful to the patient. Under the Mental Capacity Act 2005, decisions can be made on behalf of a person who is deemed to lack capacity to make their own decisions. Because there were two

competing capacity assessments, however, no action could be taken for the patient until the disagreement was resolved. In this case, while the doctor eventually moved to the HSW's position, this might have been in response to the changing presentation of the patient rather than a deliberate decision to acquiesce to the HSW's point of view. As noted in the previous chapter, HSWs usually rely on doctors to make capacity assessments. This HSW's willingness to challenge a doctor's assessment reinforces the suggestion made in Chapter Four that HSWs' reliance on doctors for capacity assessment arises from convenience rather than deference to doctors' expertise. The HSWs' recognition of the superior knowledge claims of doctors as professionals therefore does not extend beyond the doctor's area of medical expertise. While, in his frame, the senior doctor may expect all clinical opinions he gives to be deferred to as a matter of course, the HSWs operate in a frame in which doctors' opinions outside their medical specialty cannot claim higher rank.

The HSW goes on to describe further disagreement with this doctor during the subsequent CHC meeting for the same patient:

> *I challenged him on one of the domains, and his response was, 'We need to get somebody more senior than yourself to attend the meeting.'* – HSW1, from an interview

The doctor's request for a more senior social worker to attend the meeting represents an attack on the legitimacy of the HSW's role performance (Goffman, 1959). It might also be interpreted as a further example of frame conflict. The senior doctor's place near the top of the hierarchy within the hospital relies on his having the highest knowledge claim and certified credentials (Macdonald, 1995). His request for a more senior HSW would appear to imply that this HSW's experience and knowledge is insufficient to understand the issues or to challenge his opinion. By contrast, the HSW frame places far less emphasis on experience and credentials in the distribution of work and responsibilities. Traditionally, within the occupation of social work in general, while obviously complex cases would be reserved for the most experienced practitioners, there was comparatively little distinction in terms of career progression and grading between practitioners of vast experience and practitioners who were new to the role (Munro, 2011). While the picture has changed a little with the introduction of 'consultant social worker' and 'principle officer' posts in many local authorities, the structure of this particular hospital social work team still runs along the traditional lines. The duties of a HSW in this team therefore mean that even an inexperienced practitioner might be expected to challenge the opinion of a senior doctor.

Frame conflicts appear to arise because the frame of HSWs is not recognised by clinicians, and because HSWs resist the clinicians' frame. Clinicians often expect HSWs to operate within the clinicians' frame and the hierarchical order that is central to it. The HSWs' frame is underpinned by their self-definition as advocates for patients and a loyalty to their own bureaucratic order rather than the social order of the clinicians. HSWs' positioning as patient advocates enables them to be resilient against the claims of the clinicians' frame, because the role of an advocate implies willingness to stand in opposition when necessary.

Maintaining Harmony

This chapter has so far focused on the ways in which HSWs and clinicians view the world differently, and the overt conflicts which can arise as a result. It would be misleading, however, to understand the hospital as a place of continual conflict and misunderstanding between HSWs and clinicians. Most of the time, all HSWs are able to form and maintain positive and harmonious working relationships with clinicians. Doing so involves a deliberate projection of self on the part of HSWs:

> "…*initially you need to be very sociable I would say with everybody… you need to get on well and build up that rapport with people because that tends to be how you get the best results then, you know, being able to both work together towards the goal of getting somebody home.*" HSW10, from an interview

HSWs may go for several months without involvement with a given ward, meaning that it is difficult for HSWs and clinicians to share any sense of continuity in their working relationships. Furthermore, the nurses, whose information is so important to the social work assessment, work irregular shift patterns, which means that social workers will often have to speak to several different nurses on one-off occasions during the course of working with just one patient. Thus, HSWs will often have to ask people with whom they are not very familiar to complete paperwork for them. The sociable demeanour which HSWs therefore have to project when dealing with clinicians is a form of emotional labour (Hochschild, 1983), without which the HSWs would struggle to accomplish their work. The extent to which their sociable displays are purely external 'surface acting' or more internalised 'deep acting' (Grandey, 2003) varies between individuals, yet all HSWs are obliged to maintain a sociable front in order to negotiate the work with clinicians.

While personal friendliness is obligatory for HSWs in their dealings with clinicians, collaborative work is made possible when practitioners with different perspectives share a sense of purpose and a common goal (Reay and Hinings, 2009). Central to the successful co-operation between HSWs and clinicians, therefore, is the shared sense of doing the best for the patient. The low level of dramatization of their work by HSWs, while it has its advantages, means that the ways through which HSWs contribute to the shared aim of 'what is best for the patient' are sometimes obscured. Speaking about a complex discharge that had gone well, one HSW described the change in clinicians' attitudes brought about by a better understanding of the patient's issues:

> "*In the beginning, they just wanted her out, because they weren't aware of all the POVA* [protection of vulnerable adults] *issues and the on-going issues, but then when they did witness a few things on the ward, they were quite supportive as well, because we had the discharge liaison nurse attending meetings with me, so that I had people from health and social services that were on the same hymn sheet. And, towards the end, they were very supportive, they weren't happy with the length of stay in the hospital but I actually had a thank you off the senior nurse for the discharge - and a hug off the doctor…"* – HSW1, from an interview

It is significant that the HSW cited ward staff directly witnessing some of the POVA issues as a key turning point, highlighting the advantages visibility of work may bring for HSWs in their relationships with clinicians. Where clinicians are able to see that HSWs' work is congruent with their understanding of what is best for the patient, they are more likely to be supportive and tolerant. The same is true of HSWs' attitude to clinicians.

Just as a sense of shared purpose can unite HSWs and clinicians, a common enemy can have a similar effect. Facing adversity together can often enable people operating with discordant frames to bond (Reay and Hinings, 2005). The fact that HSWs and clinicians work for different agencies means that shared experience of adversity in terms of organisational threats such as redundancies or changes to working conditions is not available. Where patients or their relatives present a threat, however, whether physical or in terms of potential litigation, HSWs and clinicians tend to close ranks. For example, one HSW described being supported by a nursing manager to leave a meeting when a patient's relative became verbally abusive. The same HSW also recounted the story of a time she took herself to stand physically close to a nurse who clearly felt threatened by a patient's relative who was shouting at her in the middle of a ward. Similarly, HSWs who had been

involved with patients whose issues were likely to be brought before the Court of Protection[4] described feeling supported by their clinical colleagues. Social workers also actively seek the support of clinical colleagues when faced with adverse reactions from patients or carers. For example, during the fieldwork, one HSW was called upon to deal with a telephone call from a carer whom she described as 'abusive'.

> *"After the telephone call, one of the other social workers goes to admin worker 2 (who fielded the call first) to check that she is alright and offer her some comfort. The social worker advises the admin worker just to take a message for HSW2 to call the carer back next time. Nobody checks if HSW2 is alright. HSW2 goes back to her office and immediately telephones the ward where the patient concerned is, and relates the story of the telephone call she just had, placing emphasis on the carer's abusiveness and bad language."* – From a fieldnote

It is interesting that the other HSWs did not feel the need to comfort HSW2 or see to her welfare, the assumption being that dealing with angry or abusive people is part of the social work role. HSW2's telephone call to the ward therefore represents behaviour aimed at seeking validation and closeness from the clinicians. This illustrates how social workers actively employ strategies to build personal connections with clinicians to help them to deal with the challenges arising in their work.

Maintaining a working relationship with clinicians can be challenging when HSWs take decisions that go against clinicians' wishes. Sometimes overt conflict can be averted by HSWs' presentation of a sociable front. For example, one HSW came across a patient who had been told by ward staff that he would be discharged that day, which was impossible because she had not had time to arrange the care he would need at home. While this caused anger to the HSW, which was expressed in the 'backstage' area of the HSWs' offices, she used humour when dealing directly with ward staff:

> *I rang the ward and said, "Do I need to put my armour on when I come up?" They said, "We're not like that."* – HSW4, in conversation with HSW2 and HSW1, recorded near verbatim

The HSW was aware that blocking the patient's discharge would cause difficulties for the ward, since it would mean having to rearrange the planned care for other patients and would

---

[4] The Court of Protection makes decisions on financial or welfare matters for people who are deemed to lack mental capacity to make such decisions for themselves at the time the decision needs to be made.

involve discussion with the hospital's patient flow managers. Expecting hostility when she went to the ward, she therefore rang ahead to diffuse the tension. Making a joke about the disagreement over the patient's care represents an instance of role distance, in which a person distances her/himself from the role being performed (Goffman, 1961). By stressing her vulnerability when entering a potentially hostile ward, the HSW sought to separate the ward clinicians' perception of her self from the role she is performing. She later confirmed that she had been able to retain a friendly working relationship with the clinicians involved, suggesting that her ploy was successful.

HSWs actively strive to maintain harmonious working relationships with colleagues, despite their differing frames. Where possible, they play down the significance of conflict and foster a sense of collegiality, particularly through uniting against adversity. Common to both clinicians and HSWs is an avowed commitment to doing their best for the patient. This provides a shared sense of purpose which overrides tensions and conflicts between the HSWs and clinicians for most of the time.

Summary

This chapter has examined the self-presentation of HSWs and the framing through which they understand their world of work. In contrast to the frame shared by clinicians, which emphasises the authority of doctors in making decisions over patient care, HSWs see themselves as independent decision-makers who operate outside the hierarchical order of clinicians, owing loyalty instead to their agency's bureaucratic order. The low-level dramatization of their work assists the HSWs in retaining their independence from the clinicians' hierarchy, yet some conflicts are inevitable. Where significant conflicts occur, the discrepancy of framing is often apparent. Despite these differences, relationships between HSWs and clinicians are usually harmonious. HSWs' interactions with clinicians are orientated towards establishing and maintaining collaborative relationships, and deliberate strategies are sometimes employed for this end.

Chapter 7: Discussion and Conclusions

Summary of Findings

This thesis set out to study the following: the nature of statutory hospital social work; the way hospital social workers do their work; and the way social work fits into the hospital setting. This chapter offers a brief summary of the findings presented in the previous three chapters and then discusses their theoretical and practical implications. The study's limitations are then noted, before some final remarks on avenues for further research are made.

Exploration of the ethnographic data began in Chapter Four with an examination of the tasks that HSWs carry out, the influence of managerial techniques on their practices and the dehumanising nature of the bureaucratic system in which they work. The focus of the work of HSWs is on arranging the discharges of patients from hospital beds once they are considered medically fit by clinicians, either by arranging a package of community care or arranging for the patient to go into residential care. A sense of pressure on the HSWs to accomplish each discharge as quickly as possible is maintained by hospital managers and clinicians, supported by senior managers within the HSWs' employing local authority. The new public management technique of measuring quantitative performance indicators is used by managers in both the NHS and local authority as a tool for maintaining this pressure and monitoring the HSWs' performance. While this technique can be effective for the managers in identifying particular instances of delay and requiring HSWs to give these immediate attention, it does not have the effect of focusing HSWs solely on the speediest discharge for each patient. HSWs' concerns do not lie solely with serving the system as efficiently as possible because they do not have a personal stake in the performance data (i.e. they are not directly rewarded if their data are deemed good). The well-being of the patient and carers therefore remains of greater to concern to HSWs than being seen to work efficiently and HSWs effectively strive to strike a balance between the two.

Despite HSWs' willingness to balance the need to work efficiently with a concern for ensuring that the best interests of the patient are served, it is possible to detect the dehumanising effects of bureaucracy in their work. Fordist and Taylorist techniques are used to ensure that HSWs perform their tasks as quickly and efficiently as possible (Dustin, 2007).

These minimise the extent to which HSWs are able to be involved in the wider emotional or social world of the patient and result in a service to patients that is fragmented (e.g. a patient who discloses abuse to a HSW will have to have that aspect of their life dealt with by a social worker from another team). The system of authorisation for the care plans proposed by HSWs (which is common throughout UK community care) means that managers who are never in direct contact with the people affected can refuse the services HSWs deem them to need. Thus, the social work bureaucracy separates the decision maker from witnessing the consequences of her/his decision and therefore removes some of the moral dimensions of the decision, which becomes one of eligibility and resource availability only (Bauman, 1989). HSWs also participate in highly rationalised, dehumanising processes such as assessment of patients' eligibility for NHS Continuing Healthcare funding and the process of 'brokerage' for a patient's care services. Such examples of dehumanisation are functional for the HSWs in spreading their limited resources as fairly and efficiently as possible. Even in the context of a highly bureaucratised role, the concept of street level bureaucracy (Lipsky, 1980) remains relevant. HSWs retain a certain level of discretion, which they sometimes use to bring about a favourable outcome for a patient or to seek time to make a fuller exploration of a patient's circumstances. On other occasions, however, their discretion is used to enable them to make their work less complicated and to protect themselves from taking on further responsibilities, as suggested by Lipsky (1980).

The heavily bureaucratised nature of hospital social work as described in Chapter Four might cause the reader to ask whether this work is really social work at all. Chapter Five therefore explored the extent to which the practices of the HSWs in this study can be defined as 'social work'. A working description of social work was adapted from the IFSW (2014) definition, through which it was argued that regard for human rights, social justice and empowerment are central to any conception of social work. It was possible to trace the working of each of these values in the practices of the HSWs in this study, yet it was equally clear that the HSWs only put these values into operation at the interpersonal level, and that it would not be possible for them to agitate for wider social changes as a part of their everyday employment. With human rights, the HSWs prioritise negative rights that emphasise the freedom of the individual from interference by external forces; with social justice, the HSWs emphasise the welfare of the individual in isolation from the wider political context in which their need arises; and with empowerment, HSWs are interested only in supporting the power of individuals to advance their own interests, never seeking the opportunity to connect individuals to more collective forms of power. Thus, the work of the HSWs might be defined as a liberal, rather than radical practice, which draws on an understanding of power,

oppression and disadvantage without advocating for solutions that address these directly. The radical social work critique might argue that this form of social work offers salve for some of the symptoms that oppression and disadvantage bring about, without addressing the underlying cause (Brake and Bailey, 1975). The potential of this type of work to cause material change for the better in the lives of people should not be underestimated, however, nor should the potential of social work to make structural changes be overestimated.

Within the liberal form of social work practised by the HSWs, it was clear that the principle of self-determination is the foundational value. The right of people to make their own decision about what happens to them was noted to be considered by HSWs to be a deontological imperative and a universal good. While human rights laws were not used by the HSWs as a means of defending people's self-determination, the denial of a patient's self-determination could only follow an assessment that s/he lacked capacity according to legally defined procedures and prescriptions. Thus, it is clear that the HSWs consider self-determination to be a natural right, applicable to everyone in all but exceptional circumstances, rather than one that has to be gifted through legislation. The HSWs promote patients' self-determination through their role in making care plans that put the wishes and choices of patients at their centre, and through the activity of advocacy on behalf of patients within the hospital. HSWs were noted to advocate on behalf of patients to other professionals within the hospital and to carers or family members who may have a different view to the patient about what the long-term plan should be. The discourse of risk might be used by HSWs either to promote positive risk-taking for patients for whom the benefits of a decision might outweigh the negatives (Morgan, 1996) or to prevent wards from discharging patients before it was physically safe for them to do so. Evidence from patients and carers gathered through the fieldwork would suggest that the HSWs' advocacy role is particularly valued by them. Limitations to HSWs' provision of advocacy were noted, however, revolving around their reluctance or perceived inability to challenge poor service provision by hospitals or care homes.

Having explored the nature of the work in hospital social work, for the final empirical chapter, I turned attention to the self-presentation of HSWs and the way their work fits into the wider hospital setting. It was first noted that the self-presentation of HSWs as working professionals within the hospital is less visually and dramatically overt than that of clinicians. HSWs lack visual symbols of their working identity, have little command of the physical spaces of the hospital outside their offices (which, in the case of this team are geographically

isolated from their clinical colleagues), and adopt a low-key dramatization of their direct work with patients and carers, which is appropriate to the confidential work they must carry out. Far from indicating an occupational grouping that is lacking in self-confidence or subservient to the demands of clinicians, the low-key self-presentation of the HSWs is functional in allowing them to avoid extra demands on their services from clinicians, thus protecting the manageability of their workloads, and in enabling them to avoid domination or control by doctors. The independence of HSWs from the oversight of doctors is rooted in the HSWs' employment by a separate agency, yet is also maintained by deliberate strategic actions on the part of the HSWs.

Drawing on Goffman's theory of frame analysis (1974), it was argued that the repeated assertion of their independence by the HSWs and the occasional mutual irritation between clinicians and HSWs reflect a discrepancy between the frames each grouping uses to make sense of the social world of the working hospital. The frame shared by clinicians generally positions the most senior doctor involved in a patient's care as having authority over all other clinicians involved. By contrast, the HSWs consider themselves to sit outside of the clinicians' hierarchy and therefore regard the opinions of all doctors as only advisory for social work purposes. HSWs therefore are willing to challenge a senior doctor, even in front of the patient or carers, an action that would be socially unacceptable within the clinical team. In the matter of assessing patients' mental capacity, though HSWs routinely ascribe this role to the doctors for their own convenience, they are willing to express a different opinion to the doctor if they decide it is necessary to do so. Frustrations arise between the clinicians and the HSWs because the clinicians do not understand that the HSWs have a different frame to them and do not recognise the right of HSWs to operate outside the hierarchy that is central to the clinical frame. HSWs are aware of the frame discrepancy and can find the experience of working in the hospital uncomfortable at times. They therefore employ strategies to minimise conflict with their clinical colleagues, including cultivating a sociable demeanour, the use of humour, emphasising shared values and aims, and uniting when patients or their relatives show hostility. HSWs draw on their self-professed position as advocates for patients or carers to maintain their independence from the clinical frame and are resilient against becoming subordinate.

Limitations of the Study

Before attempting to draw some conclusions from the empirical findings summarised above, I acknowledge some limitations of this study, and emphasise that any inferences are tentatively advanced. Firstly, the idiosyncratic nature of the setting and team studied must be remembered. The remote geographical position of the HSWs' offices, and their working practice of not having allocated wards for individual HSWs to cover, may mean that this group of HSWs is far less integrated with clinicians than might be the case in other hospitals and local authorities. This means that relationships between HSWs and clinicians in other hospitals may be vastly different, which might affect the overall practices and attitudes of HSWs in unknowable ways. Secondly, the layout of the HSWs' offices meant that it was never possible for me to be anything other than an obtrusive observer of each individual's working time. This leaves my study open to the criticism that the 'Hawthorne Effect' (Mayo, 1949) might have been at play, whatever efforts I took to diminish it. On this point at least, I remain satisfied that the actions the HSWs undertook in my presence would not have been very different had I been absent. Thirdly, this study only gained limited access to patients, carers, and the HSWs' written files. A more thorough collection of observations of HSWs' direct work with patients and carers, and a wider spread of case files to analyse, might have yielded details about the HSWs' practices that have only been hinted at in this thesis. Finally, had more time been available for data collection, I might have been able to form stronger relationships with the HSWs that might have resulted in better access to patients and carers, and even better access to clinicians and observation of everyday interactions between clinicians and HSWs.

With these reservations in mind, the conclusions drawn below should be regarded as 'moderatum generalisations' (Williams, 2000) – that is to say, inferences that should be regarded as generalizable only to other real world instances in which enough features are held in common.

Hospital Social Work and Liquid Modernity

The three empirical chapters of this thesis contain three clear messages about the hospital social work encountered through the fieldwork:

1. The tasks performed by the HSWs are shaped by bureaucracy and the neoliberal model of state services, with an emphasis on the state purchasing services from private providers.
2. The HSWs work towards promoting patients' self-determination, social justice and empowerment at the individual level without engaging in any efforts to address wider social structures.
3. The HSWs deliberately maintain a distinct professional identity within the hospital.

Regarding points one and two, it would be all too easy to side with the pessimistic tone of much recent scholarship regarding social work with older people, lamenting the 'straitjacket' of community care (Lymbery, 2010), the McDonaldization of social work (Dustin, 2007) and the loss of relational work (Sullivan, 2009). HSWs maintain a distinctive professional identity within the hospital for a reason that goes beyond loyalty to their bureaucracy, however. Their work with patients focuses on promoting individual rights that might otherwise be lost within the workings of the hospital and its clinicians. I argue, therefore, that social work has been developing, possibly unconsciously, a flexible response to the complexities of social life in the 21st Century.

As noted in Chapter Two, Bauman's (2000a) concept of liquid modernity has relevance to the people with whom HSWs are concerned and their needs. Old age can be said to be 'liquid' with regards to the uncertainties that arise from chronic and progressive physical and mental illnesses that people of advancing years tend to encounter. With rising life expectancy, many older people are living for long periods in a state of increasing frailty and declining physical and mental health (Age UK, 2017). The course of the diseases of old age, such as dementia, Parkinson's Disease, cardiovascular illness and even some cancers, are predominantly progressive, yet progress is unpredictable for each individual (Barry and Yuill, 2016). Medical advances add to the uncertainty by prolonging life and offering hope of delaying disease progression. The liquid modern era, with its emphasis on individual choice and individual responsibility, thrusts on older people individual responsibility for coping with adverse health developments in their lives, yet, as Bauman notes, individuals are often "…equipped with tools and resources that are blatantly inadequate to the task." (Bauman, 2007, p. 14). The responsibility of older people as individuals to cope alone with age-related difficulties is underpinned by the dominance of neoliberalism in liquid modern societies, which produces welfare states that are only prepared to provide minimal services, yet equally makes it difficult for people of working age to take on caring responsibilities for their elderly relatives, since they are required to be available and flexible within the labour market.

In addition to facing alone and ill-equipped the uncertainties arising from declining physical and mental health, older people also face a reduced ability to participate in the benefits of the liquid modern era. While the individual responsibility of the liquid modern era can be experienced as an inescapable fate (Bauman, 2000a), it can also be experienced as a liberating opportunity to engage in life politics and seek fulfilment through personal development (Giddens, 1992; 1999). Increasing mental and physical infirmity, however, may limit the liberty of older people to participate in life politics and cut off the succession of personal projects that often comprises the progression of the individual through life in liquid modernity (Bauman, 2000a). In responding to the needs of older people as they encounter them, HSWs are therefore responding to some of the dilemmas of liquid modernity. That the response of HSWs tends to be at the individual level is not surprising, since individualization is a hallmark of liquid modern society.

The approach of the HSWs in this study are, to a certain extent, well adapted to some of the challenges of old age in liquid modernity. Where the physical and mental illnesses of old age begin to diminish the abilities of older people to engage in life politics, social workers can be in a position to protect the availability of choices and the power of individuals to make them. This is a key aspect of the HSWs' practices. Of crucial importance is the fact that the HSWs' defining principle of self-determination is accompanied by a willingness to provide a muscular form of advocacy that can have a tangible impact in achieving the outcome desired by the patient or carers. In focusing their efforts to achieve objectives defined by the patient, HSWs therefore practice in a liberating fashion. Of course, there are limits to the power of HSWs as a liberating force. The HSWs' conception of human rights as primarily negative rights means that there are those to whom their help will not extend, since the HSWs do not engage with the social and structural factors that prevent some patients from taking advantage of their full rights. Engagement in life politics is not possible for those whose lives are blighted by oppression and inequality (Garrett, 2004), meaning that the promotion of choices may be meaningless to some older people.

The willingness of HSWs to advocate for positive risk-taking on behalf of patients is a significant demonstration of the potential of social workers to assist older people through the challenges of 'liquid' old age. Physical frailty, progressive dementia and the risk of falls are all aspects of patients' post-discharge lives that bring great uncertainty not only to the individual affected, but to her/his family. HSWs often therefore encounter relatives or carers

who wish to see their loved one in the safety of residential care, or receiving the maximum possible amount of house calls from community care services. Where this is in opposition to what the patient wants, the advocacy of HSWs not only promotes the patient's choice, but may also help family members to come to terms with the uncertainties that will arise from respecting the patient's choices. In so doing, HSWs often have a role to play in challenging ageist assumptions about the quality of life older people can expect to have, and their right to self-determination (Ray and Phillips, 2012).

Just as the HSWs work in a way that assists older people to face some of the 'liquid' challenges that old age produces, they also assist older people and their families to cope with balancing the need of the patient for long-term care with the need of working-age people to be flexible and responsive to the demands of the labour market. HSWs create their care plans through establishing the wishes of the patient (or what is considered to be in their best interests if they lack mental capacity), what any informal carers are able to do, and what services the patient might be eligible to receive. This means that care planning can be responsive to the situation of the patient and her/his family circumstances. Care planning is therefore an activity that is useful to the neoliberal economy, yet it should not be condemned as a social work practice, as some suggest (e.g. Hastings and Rogowski, 2015; Penna and O'Brien, 2013; Garrett, 2009), because of its complicity in the form of capitalism that is widely held responsible for the inequalities and disadvantages that social work strives to correct. Whatever economic policies a state might pursue, as long as it assumed responsibility for the welfare of its citizens, some form of care planning for individual older people would always be required. Acknowledgement of this points again to the necessity of refining social work's understanding of itself so that social work roles that focus only on the micro level are not regarded as falling short of the ideal.

In arguing that the work of the HSWs represents a response to issues arising from liquid modernity, I reject the notion that social work is entirely in thrall to neoliberal ideology. In the processes of making assessments and creating care plans, the HSWs do engage in bureaucratic practices that are shaped by the neoliberal policy of community care, with its purchaser-provider split, emphasis on best value and managerial control. In the context of promoting personal choice and enabling individuals' engagement in life politics, however, community care might be seen not as a 'straitjacket' (Lymbery, 2010), but as an imperfect tool through which the real aims of social work are delivered. The bureaucratic structures of community care may be dehumanising at times, and the HSWs admittedly do carry out some

practices that have been identified as dehumanising, yet the bureaucratic system is not capable of dehumanising the HSWs' work entirely. The highly rationalised nature of the bureaucratic system is kept in check by the HSWs' empathy for patients and carers and by their clear sense that their loyalty remains with the individual patient, rather than with the bureaucracy.

The HSWs' values share roots with neoliberalism in terms of the liberal tradition of respect for negative freedoms (Banks, 2012) yet, while the accomplishment of prompt patient discharges may serve the purpose demanded by neoliberal governments, the HSWs tend to be motivated primarily by regard for the welfare of the individual patient, rather than efficiency and saving the state money. The HSWs' assertion of their independence within the hospital setting, explored in Chapter Six, is suggestive of an occupational group with a clear sense of values and a clear purpose. HSWs' self-claimed role as advocates for patients might even be interpreted as an assertion of liquid modern values – those of self-determination and personal responsibility for one's own fate – within a setting that is still grounded in solid modernity, with its certainties of professional hierarchies, the dominance of medical knowledge and the expected relationship between patient and clinician. The HSWs assert their independence from clinicians for a purpose that is intrinsic to themselves and is derived from their professional and personal values, distinguishing them markedly from adherents of bureaucracies along the lines of the classic Weberian model –

> "…in which identities and social bonds were deposited on entry in the cloakroom together with hats, umbrellas and overcoats, so that solely the command and the statute book could drive, uncontested, the actions of the insiders as long as they stayed inside." (Bauman, 2000a, p.25-6)

Despite the fact that a large part of their work involves the operation of a bureaucratic system, and despite a managerial system that is partially able to control their everyday work, HSWs work to an identifiable set of values that is beyond the control of bureaucratic or managerial systems. As street-level bureaucrats (Lipsky, 1980), they retain discretion in the way they carry out their work, yet they use this discretion not only to control their workload in their own favour, as Lipsky suggested, but also at times to engage in the deeper complexities with which they are confronted in the lives of patients. While the bureaucratic nature of their work influences their interactions with patients, the solutions for problems they can offer and even the nature of issues with which they concern themselves, by orientating their practices around their professional and personal values, HSWs retain the power over defining their own aims.

When defining their aims, the HSWs almost always regard promoting the welfare of the individual patient as their primary concern. In this, there appears to be some dissonance with the way social work as a profession has attempted to define its own nature. The IFSW's definition of social work, with its emphasis on social change and engagement with structures, and the continued currency of ideas derived from radical social work throughout social work scholarship, suggest that working only at the level of the individual is not enough. This is unfair to social workers in roles such as that of the HSWs involved in this study. The nature of the tasks they are employed to complete are unsuited to extensive engagement with the wider social forces that shape the lives of patients and carers. Further, social workers in the UK are working in a country that has chosen through the ballot box governments that favour neoliberalism since 1979. While social workers and social work academics may have valid and profound concerns about the policies adopted by their governments, it is not realistic to expect social workers to effect political and social change against the tide of popular political discourse. As was noted in Chapter Two, social work can trace its origins to two separate strands: the casework approach introduced by the Charity Organisation Society (COS) and the more collectivist approach of the Settlement movement. The tension between these two sides of social work has never been fully resolved, and remains perpetuated through ongoing debates between the more individually orientated theory of anti-discriminatory practice and the more structurally focused anti-oppressive practice (Thompson, 2016; Dominelli, 2002). A more nuanced definition of social work is therefore needed, that recognises that both the individually focused, liberal practice typified by the HSWs, and radical practices that overtly aim towards wider social and structural change, have their place.

The values and practices of the HSWs are largely in harmony with the zeitgeist of liquid modernity, with its emphasis on personal choice and responsibility for one's own fate. The values of the HSWs are characterised by a liberalism that hinges on respect for the individual and her/his right to determination. While managerial and bureaucratic control shape the everyday practices of the HSWs and impose some limits on the extent to which they can engage with patients and their families, ultimately the HSWs' practices are driven by their values. The strength of the HSWs' identity within the hospital and the coherence of their own distinct frame of understanding is indicative of an occupational group that has a clear sense of its own purpose and confidence in the values underpinning its practices. The lack of regular engagement beyond the micro level seen in social work teams in this sort of role should not be regarded as a failure – instead, the realities of social work practice in

neoliberal states should be allowed for in a more nuanced understanding of the nature of social work than the IFSW's definition suggests.

Recommendations for Practice

It has not been the aim of this study to evaluate the work of the HSWs who participated in this study, nor to identify a form of best practice that can be formalised into a series of maxims. It is possible, however, to identify areas of practice wherein there may be opportunities for development, and areas of the HSWs' current practice that could benefit from a more critical approach.

This thesis has noted the centrality of self-determination in the HSWs' values, and has made much of the role of HSWs as facilitators of patients' decision-making. HSWs encounter many people for whom real choices are an illusion, however. Even while working in an unashamedly liberal manner, with a focus only on the individual patient, HSWs must remember the issues of inequality, disadvantage and oppression that shape the course of many people's lives. Thus, if social workers do not set out to challenge the social and structural conditions that blight people's lives, they must still be conscious of the need to mitigate their effects if they are to enable people to make real choices in their lives. Further, social workers need to have regard for the meanings of the choices people make in their lives. The choices made by patients are not the mere selection of goods by a consumer, but decisions about how to live, with whom to live and on whom to rely. Even when facing extreme managerial pressure to complete patient discharges, the enormity of the decisions being taken must be considered and support offered to those taking them.

While this thesis has advocated respect for liberal forms of social work that do not work beyond the individual level, it is nonetheless possible to identify some aspects of the HSWs' practices in which an orientation towards a more collective approach might be appropriate, and might result in a more complete service for patients and their carers. One such area is addressing poor care or bad practice when it is identified by HSWs, whether in the hospital or in residential homes. HSWs expressed discomfort regarding the standards of some residential homes and sometimes acted directly to remedy poor practice within the hospital

at the individual level, e.g. finding a patient's mislaid walking frame or insisting on the appropriate documentation of capacity assessments. It might be possible for HSWs to be more proactive in reporting poor practice officially, to assist patients or carers with making complaints where appropriate, or even facilitating better transmission of feedback from current users of residential homes to prospective new residents. Through such approaches, HSWs might help patients' and carers' voices to be heard more clearly, and, in the case of residential homes, facilitate a truer sense of market competition.

Any attempt by the HSWs to influence the practices of the clinical colleagues through reporting poor practices would be open to the possibility of causing conflict between clinicians and HSWs. As Chapter Six highlighted, HSWs and clinicians utilise entirely distinct frames in their understanding of their work and their position within the hospital setting. The frustrations and misunderstandings between HSWs and clinicians might be alleviated by a better understanding of each other's position, and by maintaining clearer lines of communication. Allocating HSWs to set wards might enable them to establish stronger working relationships and promote a better understanding of their way of working, but might equally make it difficult for HSWs to turn away requests for assistance from colleagues that would impact on their ability to spread their limited resources as efficiently and fairly as possible. In this study, the attendance of a social worker at the weekly multi-disciplinary meetings in the Hanton Infirmary had recently been trialled, but was abandoned because the team manager did not consider the benefits to match the cost in time. It must be for individual teams and their managers to decide how best to allocate work and spread their services. Where HSWs do not have the opportunity to build long-term working relationships with clinicians, however, it may be beneficial for the HSWs to have occasional development days with key clinicians – e.g. ward managers, patient flow managers and certain doctors. Establishing mutual understanding and trust might increase the efficiency of the multi-disciplinary approach by reducing the incidence of distracting frustrations and conflicts.

Social work undertaken in the service of older people can benefit from the insights of critical gerontology in challenging age-based discrimination and the view that frailty or dependency are indications of personal failure (Lloyd, 2014). The Welsh Government's Strategy for Older People (2013) aims to promote the voices of older people in policy and decision-making. For this to become a reality, the understanding of deficit and impairment as markers of unbecoming and reduced personhood (Higgs and Gilleard, 2010) must be challenged. This means that all older people's social workers need to develop perspectives that recognise the

value of people notwithstanding their ability to exercise individual action or intentionality (Grenier et al., 2017). Another objective of the Welsh strategy, prevention of the need for acute care, can similarly be aided by the development of a critical gerontological perspective. Meeting this objective will involve an approach to social work with older people that involves not merely responding to the presentation of unmet need for care, but actively engaging with older people to help them to find ways to cope with the difficulties of mental and physical decline before their situation becomes critical. This, of course, would involve challenging the prevailing ideology of individual responsibility for coping with one's fate that underlies liquid modernity. As noted in Chapter Two, several studies in the USA in recent years (e.g. Alvarez, et al., 2016; Barber et al., 2015; Bronstein et al., 2015) have successfully explored the potential of HSWs to reduce rates of readmission to hospital. It must be acknowledged, however, that there is little opportunity for the development of this holistic perspective for HSWs while their primary objective is ensuring the swift discharge of patients, enforced by limitations on the resources available and the pressure and control exerted by NHS and local authority managers. Pilot projects both for HSWs and community-based older people's social workers will therefore need to be developed to explore the potential for social work to take a more holistic and preventive form.

The recommendations discussed above would reflect an understanding that social work with adults in the UK is caught between the pragmatic liberalism that underpins much of its everyday practices, and more radical and critical ideas that argue for collective approaches to the issues that social workers encounter at the individual level. Social work need not be ashamed of taking a liberal stance if its practices enable individuals to make real and meaningful choices in their lives. If the reality is that such choices are an illusion, however, social work needs to find its voice in influencing the social policies of government.

Avenues of Further Research

Several lines of further enquiry arise from this thesis. The use of frame analysis to explore the relationships between practitioners of various occupations appears to be original. It may be fruitful to use this approach to examine a variety of settings in which multi-disciplinary working is a frequent occurrence. In social work, this might include child protection work, the operation of community mental health teams and youth offending work. Of course, this

avenue of enquiry need not be limited to social work and may be fruitful in further studies of workers in hospitals as well as any other comparable setting.

This thesis has examined hospital social work as a practice that focuses on working with older people and has highlighted the dehumanisation brought about by bureaucratisation, and, by contrast, the strong liberal value base underpinning HSWs' everyday practices. It would be fruitful to explore whether similar findings emerge in comparable qualitative studies of community-based social work teams that focus on work with older people, and of course to explore whether similar findings emerge in studies of social work teams that focus on different service user groups (e.g. child protection, mental health etc.)

Finally, in focusing on hospital social work, this thesis has chosen a niche of social work that rarely receives attention through empirical research. Mainstream hospital social work is an activity that brings with it unique challenges in terms of the speed with which assessments and care plans must be made. Further empirical research using both qualitative and quantitative methods may bring new insights to our understanding of this overlooked area of practice. This thesis has not touched on the more specialised forms of hospital social work noted to exist in Chapter Two, and it is to be hoped that future research might address this continued neglect.

Final Remarks

This thesis set out to explore the nature of statutory hospital social work, how HSWs do their work and how social work fits into the hospital context. The hospital social work team with whom this thesis is concerned was staffed by a group of practitioners who each expressed and acted upon a deep personal commitment to enhancing the well-being of the individuals with whom they were involved. They had a distinctive identity within the hospital and maintained a unique framing of their relationship to clinicians, despite pressure to conform to a conventional hospital hierarchy in which the most senior doctor is acknowledged as having primacy in decision making. By positioning themselves as advocates for patients, HSWs reserved for themselves the right to question medical dominance and the role of promoting the choices and decisions of patients and/or their carers over key decisions about their

future care. Thus, while hospital social work can be characterised as a succession of largely bureaucratic tasks, the HSWs carry out these bureaucratic tasks as a means of working towards ends that promote human rights, social justice and empowerment at the individual level.

References

Abbott, A. (1988) *The System of Professions: an Essay on the Division of Expert Labour.* Chicago: University of Chicago Press.

Abbott, P. and Wallace, C. (1990) 'The Sociology of Caring Professions: An Introduction.' In: Abbott, P. and Wallace, C. (eds.) *The Sociology of the Caring Professions.* Basingstoke: The Falmer Press.

Abramson, J.S. and Mizrahi, T. (1996) 'When Social Workers and Physicians Collaborate: Positive and Negative Interdisciplinary Experiences', *Social Work* 41(3) p. 270-81.

Adams, R. (2008) *Empowerment, Participation and Social Work*. 4th Ed. Basingstoke: Palgrave Macmillan.

Agar, M. (1986) *Speaking of Ethnography.* London, Sage.

Age UK (2011) *Older People and Human Rights*: *A reference guide for professionals working with older people*. London: Age UK/BIHR.

Age UK (2012) *Policy and Research Update*. London: Age UK.

Age UK (2017) *Briefing: Health and Care of Older People in England 2017*. <www> http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/The_Health_and_Care_of_Older_People_in_England_2016.pdf?dtrk=true

Albrithen, A. and Yalli, N. (2015) 'Hospital Social Workers in Saudi Arabia: Characteristics and Functions', *Social Work in Health Care* 54(2) p. 158-76.

Albrithen, A. and Yalli, N. (2016) 'Social Workers: Peer interaction and hospital integration', *International Social Work* 59(1) p. 129-40.

Allen, D. (1997) 'The nursing-medical boundary: a negotiated order?', *Sociology of Health and Illness* 19(4) p.498-520.

Allen, R. (2014) *The Role of the Social Worker in Adult Mental Health Services*. London: College of Social Work.

Alvarez, R., Ginsburg, J., Grabowski, J., Post, S. and Rosenberg, W. (2016) 'The Social Work Role in Reducing 30 Day Readmissions: The Effectiveness of the Bridge Model of Transitional Care', *Journal of Gerontological Social Work* 59(3) p. 222-7.

Ash, A. and Phillips, J. (2011) 'Social Work with Older People in Europe: Diversity and Change', *Indian Journal of Gerontology* 25(4) p. 474-93.

Atkinson, P. A. (1995). *Medical Talk and Medical Work: The liturgy of the clinic.* London: Sage.

Atkinson, P.A. and Coffey, A. (2001) 'Revisiting the Relationship between Participant Observation and Interviewing', in (eds.) Gubrium, J.F. and Holstein, J.A. (2001) *Handbook of Interview Research – Context & Method*. London: Sage.

Atkinson, P.A. and Silverman, D. (1997) 'Kundera's *Immortality*: the interview society and the invention of the self', *Qualitative Inquiry* 3(3) p. 304-25.

Auerbach, C., Mason, S. E. and Laporte, H. H. (2007) 'Evidence that supports the value of social work in hospitals', *Social Work in Health Care*, 44(1) p. 17-32.

Baars, J. (1991) 'The challenge of critical gerontology: the problem of social constitution', *Journal of Ageing Studies,* 5(3) p. 219-43.

Baltes, P. (1997) 'On the incomplete architecture of human ontogeny: Selection, optimization and compensation as a foundation of developmental theory', *American Psychologist* 52(4) p. 366-80.

Baltes, P. and Smith, J. (1999) 'Multilevel and systemic analyses of old age: Theoretical and empirical evidence for a fourth age', in (eds.) Bengston, V.L. and Schaie, K.W. *Handbook of Theories of Aging*. New York: Springer.

Banks, S. (2012) *Ethics and Values in Social Work*. 4th Ed. Basingstoke: Palgrave Macmillan.

Barber, R.D., Coulourides Kogan, A., Riffenburgh, A. and Enguidanos, S. (2015) 'A Role for Social Workers in Improving Care Setting Transitions: A Case Study', *Social Work in Health Care* 54(3) p. 177-92.

Barnett, S. A. and Barnett, D. H. O. W. (1915). *Practicable Socialism.* London: Longmans, Green & Co.

Barry, A.M. and Yuill, C. (2016) *Understanding the Sociology of Health*. 4th Ed. London: Sage.

Bass, C. and Halligan, P. (2014) 'Factitious disorders and malingering: challenges for clinical assessment and management', Lancet. 383. . 10.1016/S0140-6736(13)6218

Bauman, Z. (1989) *Modernity and the Holocaust*. Cambridge: Polity.

Bauman, Z. (2000a) *Liquid Modernity*. Cambridge: Polity.

Bauman, Z. (2000b) 'Special Essay – Am I my Brother's Keeper?' *European Journal of Social Work*, 3(1) p. 5–11.

Bauman, Z. (2007) *Liquid Times: Living in an Age of Uncertainty*. Cambridge: Polity.

Beck, U., Giddens, A. and Lash, S. (1994*) Reflexive Modernisation: Politics, Traditions and Aesthetics in the Modern Social Order*. Cambridge: Polity.

Becker, H.S. (1961) *Boys in White: Student culture in medical school*. Chicago: Chicago University Press.

Beckett, C. and Maynard, A. (2013) *Values and Ethics in Social Work*. London: Sage.

Beddoe, L. (2011) 'Health social work: Professional identity and knowledge', *Qualitative Social Work* 12(1) p. 24-40.

Berger, P. and Luckmann, T. (1967) *The Social Construction of Reality*. London: Allen Lane.

Berkman, B. G. and Rehr, H. (1972) 'The" sick-role" cycle and the timing of social work intervention', *The Social Service Review*, 46(4) p. 567-580.

Bernard, M., Phillipson, C. and Phillips, J. (2001) 'Continuity and Change in the Family and Community Life of Older People', *Journal of Applied Gerontology* 20(3) p. 259-78.

Bolton, G. (2010) *Reflective Practice – Writing and professional development.* London, Sage.

Bosk, C.L. 'Irony, ethnography and informed consent', in (ed.) Hoffmaster, B.C. (2001) *Bioethics in Social Context*. Philadelphia: Temple University Press.

Bradby, H. (2009) *Medical Sociology: An Introduction*. London: Sage.

Brake, M. and Bailey, R. (eds.) (1975) *Radical Social Work and Practice*. London: Edward Arnold.

Brewer, C. and Lait, J. (1980) *Can Social Work Survive?* London: Temple Smith.

British Sociological Association (2014) *Statement of Ethical Practice*. <www> http://www.britsoc.co.uk/about/equality/statement-of-ethical-practice.aspx [Accessed 22-11-14]

Broadhurst K., Wastell D., White S., Hall C., Peckover S., Thompson K., Pithouse A., Davey D. (2010), 'Performing "initial assessment": Identifying the latent conditions for error at the

front-door of local authority children's services', *British Journal of Social Work*, 40(2): 352-70.

Bronstein, L.R., Gould, P., Berkowitz, S.A., James, G.D. and Marks, K. (2015) 'Impact of a Social Work Care Coordination Intervention on Hospital Readmission: A Randomized Controlled Trial', *Social Work* 60(3) p. 248-55.

Bryman, A. (2016) *Social Research Methods*. 5th Edition. Oxford: Oxford University Press.

Brynant, A. and Charmaz, K. (2007) 'Grounded Theory in a Historical Perspective: An Epistemological Account', in (eds.) Brynant, A. and Charmaz, K., *The Sage Handbook of Grounded Theory*. London: Sage.

Burnett, P. J. (1994) *Idle Hands: The Experience of Unemployment*, 1790-1990. London: Routledge.

Burns, T. (1992) *Irving Goffman*. London: Routledge.

Buscatto, M., 'Practising Reflexivity in Ethnography', in (ed.) Silverman, D. (2016) *Qualitative Research*. 4th Ed. London: Sage.

Butler, J. (2009) *Frames of War: When is life grievable?* London: Verso.

Bywaters, P., McLeod, E. & Cooke, M. (2002) 'A diversionary tactic? Social work in an emergency assessment unit', *Nursing Older People*, 14(1) p.19-21.

Calnan, M., Tadd, W., Calnan, S., Hillman, A., Read, S. and Bayer, A. (2013) ' "I often worry about the older person being in that system": exploring the key influences on the provision of dignified care for older people in acute hospitals', *Ageing and Society* 33(3) p. 465-85.

Cannon, I. M. (1913) *Social work in Hospitals: A Contribution to Progressive Medicine*. London: Russell Sage Foundation.

Care and Social Services Inspectorate Wales (2012) *Growing old my way: A review of the Impact of the National Service Framework for Older People in Wales*. <www> http://careinspectorate.wales/docs/cssiw/report/090112growingolden.pdf [accessed 2-4-18]

Care Council for Wales (2011) *National Occupational Standards* <www> http://www.ccwales.org.uk/qualifications-and-nos-finder/n/social-work/ [accessed 2-6-14]

Carey, M. (2015) 'The Fragmentation of Social Work and Social Care: Some Ramifications and a Critique', *British Journal of Social Work* 45(8) p. 2406-2422.

Carr, S. and Robbins, D. (2009) *The Implementation of Individual Budget Schemes in Adult Social Care: Research Briefing 20.* London: Social Care Institute for Excellence.

Charmaz, C. (2014) *Constructing Grounded Theory*. 2nd Ed. London: Sage.

Charmaz, C. and Brynant, A. (2016) 'Constructing Grounded Theory Analyses', in (ed.) Silverman, D. (2016) *Qualitative Research*. 4th Ed. London: Sage.

Cho, J. & Trent, A. (2006) 'Validity in qualitative research revisited'. *Qualitative Research*, 6(3) p. 319-340.

Clark, C.L. (2000) *Social Work Ethics*. Basingstoke: Palgrave Macmillan.

Clarke, A.E. (2003) 'Situational Analyses: Grounded Theory Mapping After the Postmodern Turn' *Symbolic Interaction* 26(4) p. 553-76.

Clarke, J. and Newman, J. (1997) *The Managerial State*. London: Sage.

Clarke, J., Newman, J., Smith, N., Vidler, E. & Westmarland, L. (2007*) Creating Citizen-Consumers: Changing Publics and Changing Public Services.* London: Sage.

Clements, L. (2017) *The Social Services & Well-being (Wales) Act 2014: An overview*. <www> http://www.lukeclements.co.uk/wp-content/uploads/2017/09/Wales-SS-Well-being-Act-25.pdf [accessed 3-4-18]

Cloke, P., Goodwin, M. and Milbourne, P. (1997) *Rural Wales: Community and Marginalization*. Cardiff: University of Wales Press.

Coffey, A.J. and Atkinson, P.A. (1996). *Making Sense of Qualitative Data: Complementary Research Strategies.* London: Sage.

Collins, R. (2004) *Interaction Ritual Chains*. NJ: Princeton University Press.

Connell, R.W. (1987) *Gender and Power.* Cambridge: Polity.

Connor, A. and Tibbitt, J. *Social Workers and Health Care in Hospitals*. Edinburgh: HMSO.

Coulshed, V., Mullender, A., Jones, D.N. and Thompson, N. (2006) *Management in Social Work.*3rd Ed. Basingstoke, Palgrave.

Craid, S.L., Betancourt, I. and Muskat, B. (2015) 'Thinking Big, Supporting Families and Enabling Coping: The Values of Social Work in Patient and Family Centred Health Care', *Social Work in Health Care* 54(5) p. 422-43.

Craig, S. L. and Muskat, B. (2013) 'Bouncers, Brokers and Glue: The Self-described Roles of Social Workers in Urban Hospitals' *Health and Social Work* 38(1) p. 7-17.

Cullen, L. T. (2013) 'The First Lady Almoner: The Appointment, Position, and Findings of Miss Mary Stewart at the Royal Free Hospital, 1895–99'. *Journal of the History of Medicine and Allied Sciences*, 68(4) p. 551-582.

Dahlberg, L., Demack, S. and Bambra, C. (2007) 'Age and gender of informal carers: a population-based study in the UK', *Health and Social Care in the Community* 15(5) p. 439-45.

Davies, C.A. (1999) *Reflexive Ethnography – A guide to researching selves and others*. London: Routledge.

Davis, C. (2004) 'Hospital social work: are we conducting the right type of research?' *Social Work in Health Care*, 38(1) p. 67-79.

Davis, C., Milosevic, B., Baldry, E. and Walsh, A. (2004) 'Defining the role of the hospital social worker in Australia: Part 2. A qualitative approach', *International Social Work* 48(3) p.289-99.

Deeming, C. (2009) ''Active ageing' in practice: A case study in East London, UK', *Policy & Politics* 37(1) p. 93-111.

Degnen, C. (2007) 'Minding the gap: The construction of old age and oldness among peers', *Journal of Aging Studies* 21(1) p. 69-80.

Delamont, S. (2004) 'Ethnography and Participant Observation', in (eds. Seale, C., Gobo, G., Gubrium, J.F. and Silverman, D. *Qualitative Research Practice*. London: Sage.

Delamont, S. and Atkinson, P. (1995) *Fighting Familiarity: Essays on Education and Ethnography*. New Jersey, Hampton Press.

Delamont, S., Atkinson, P. and Pugsley, L. (2010) The concept smacks of magic: Fighting familiarity today, *Teaching and Teacher Education* 26(1) pp. 3-10.

De Montigny, G. (1995) *Social Working: An ethnography of frontline practice.* Toronto: University of Toronto Press.

Denman, G. (1996) '1946 – 1973: Reconstruction and Integration: Social Work in the National Health Service', in (eds.) Baraclough, J., Dedman, G., Osborn, H. and Willmott, P. (1995) *100 Years of Health Related Social Work*. Birmingham: BASW.

Denzin, N.K. (1978) *The Research Act: A Theoretical Introduction to Sociological Methods.* New York: McGraw-Hill.

Denzin, N.K. and Lincoln, Y.S. eds. (2011) *The SAGE Handbook of Qualitative Research*, 4th Ed. London: Sage.

Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice.* London: TSO.

Department of Health (1992) *Social Services for Hospital Patients. Part 1: Working at the Interface*. London: HMSO.

Dewing, J. (2007) Participatory research: A method for process consent with persons who have dementia. *Dementia*, 6(1) p. 11-25.

Dingwall, R. (1977) *The Social Organisation of Health Visitor Training*. London: Croom Helm Ltd.

Dingwall, R. (2008) 'The ethical case against ethical regulation in the humanities and social science research', *21st Century Society* 3(1) p. 1-12.

Dominelli, L. (1996) 'Deprofessionalizing Social Work: Anti-Oppressive Practice, Competencies and Postmodernism.' *British Journal of Social Work* 26(2) p. 153-175.

Dominelli, L. (2002) *Anti-oppressive Social Work Theory and Practice*. Basingstoke: Palgrave Macmillan.

Dominelli, L. and Hoogvelt, A. (1996) 'Globalization and the technocratization of social work', *Critical Social Policy* 47(1) p. 45-62.

Donnellon, A., Gray, B. and Bougon, M. (1986) 'Communication, meaning and organized action', *Administrative Science Quarterly* 31(1) p.43-55.

Drakeford, M. (2005) 'Health policy in Wales: Making a difference in conditions of difficulty', *Critical Social Policy* 26(3) p. 497-503.

Du Toit, A. (2012) *Making sense of 'Evidence': Thinking the relationship(s) between research and policymaking - Presentation to The politics of poverty research - learning from the practice of policy dialogue* [www] http://www.plaas.org.za/sites/default/files/publications-pdf/Du%20Toit%20%20Making%20sense%20of%20%27Evidence%27%202012%2011%20presentation.pdf <accessed 1-7-13>

Duffy, F. and Healy, J.P. (2011) *'Social Work With Older People in a Hospital Setting'*, *Social Work in Health Care* 50(2) p. 109-23.

Dustin, D. (2007). *The McDonaldization of Social Work.* Farnham: Ashgate.

Ellis, K., Davis, A. & Rummery, K. (1999) 'Needs assessment, street-level bureaucracy and the new community care', Social Policy and Administration 33(3) p. 262-80.

Emerson, R.M., Fretz, R. I. and Shaw, L.L. (2007) 'Participant Observation and Fieldnotes', in (eds.) Atkinson, P.A., Coffey, A., Delamont, S., Lofland, J. and Lofland, L. (2007) *Handbook of Ethnography. Paperback ed.* London, Sage.

Esterberg, K.G. (1997) *Lesbian and Bisexual Identities*. Philadelphia: Temple University Press.

Evans, T. and Harris, J. (2004) 'Street-level bureaucracy, social work and the (exaggerated) death of discretion', *British Journal of Social Work* 34(6) p. 871-95.

Ferguson, H. (2003) 'In Defence (and Celebration) of Individualization and Life Politics for Social Work', *British Journal of Social Work* 33(5) p. 699-707.

Ferguson, H. (2007) *Reclaiming Social Work: Challenging Neo-liberalism and Promoting Social Justice.* London: Sage.

Ferguson, H. (2016) 'Researching Social Work Practice Close Up: Using Ethnographic and Mobile Methods to Understand Encounters between Social Workers, Children and Families', *British Journal of Social Work* 46(1) p. 153-168.

Ferlie, E., Ashburner, L., Fitzgerald, L. and Pettigrew, A. (1996) *The New Public Management in Action,* Oxford, Oxford University Press.

Fish, D. and Coles, C. (2000) 'Seeing Anew: Understanding Professional Practice as Artistry', *Changing Practice in Health and Social Care*. London: Sage.

Floersch, J., Longhofer, J. and Suskewicz, J. (2014) 'The use of ethnography in social work research', *Qualitative Social Work* 13 (1) p. 3-7.

Flyvberg, B. (2004) 'Five Misunderstandings about Case-Study Research', in (eds. Seale, C., Gobo, G., Gubrium, J.F. and Silverman, D. *Qualitative Research Practice*. London: Sage.

Foucault, M. ([1963] 2003) *The Birth of the Clinic*. London: Routledge.

Foucault, M. ([1975] 1995) *Discipline and Punish: The Birth of the Prison*. London: Penguin.

Foucault, M. (1982) 'Afterword: the subject and power', in (eds.) Dreyfus, H. and Rabinow, P. *Michel Foucault: Beyond Structuralism and Hermeneutics*. Chicago: University of Chicago Press.

Fronek, P., Briggs, L. Kim, M.H., Han, H.B., Val, Q., Kim, S. and McAuliffe, D. (2017) 'Moral distress as experienced by hospital social workers in South Korea and Australia', *Social Work in Health Care* 56(8) p. 667-85.

Frost, N., Robinson, M. and Anning, A. (2005) 'Social workers in multidisciplinary teams: Issues and dilemmas for professional practice', *Child and Family Social Work* 10(2) p. 187-96.

Gardner, A. (2011) *Personalisation in Social Work.* Exeter: Learning Matters.

Garfinkel, H. (1967) *Studies in Ethnomethodology*. NJ: Prentice Hall.

Garrett, P.M. (2009) 'More trouble with Harry: A rejoinder in the "life politics" debate', *British Journal of Social Work* 34(4) p. 577-89.

Gearing, R. E., Saini, M. & McNeill, T. (2007) 'Experiences and implications of social workers practicing in a pediatric hospital environment affected by SARS', *Health and Social Work*, 32(1) p. 17-27.

Geertz, C. (1973) *The Interpretation of Cultures: Selected Essays*. New York: Basic Books.

Gerdes, K.E. and Segal, E.A. (2009) 'A Social Work Model of Empathy', *Advances in Social Work* 10(2) p.114-27.

Gibbons, J. & Plath, D. (2006) '"Everybody puts a lot into it!" Single session contacts in hospital social work' *Social Work in Health Care*, 42(1) p. 17-34.

Giddens, A. (1992) *The Transformation of Intimacy: Sexuality, love and eroticism in modern societies*. Cambridge: Polity.

Giddens, A. (1998) *The Third Way: The Renewal of Social Democracy*. Cambridge: Polity.

Giddens, A. (1999) *Runaway World: How globalization is reshaping our lives*. London: Profile.

Giddens, A. and Sutton, P.W. *Sociology*. 8th Ed. Cambridge: Polity.

Gilleard, C. and Higgs, P. (2010) 'Aging without agency: Theorizing the fourth age', *Aging & Mental Health* 14(2) p. 121-8.

Gilleard, C. and Higgs, P. (2011a) 'Aging, abjection and embodiment in the fourth age' *Journal of Aging Studies* 25(2) p. 135-42.

Gilleard, C. and Higgs, P. (2011b) 'Frailty, disability and old age: A re-appraisal', *Health* 15(5) p. 475-90.

Gitlin, T. (1980) *The Whole World Is Watching: Mass Media in the Making and Unmaking of the New Left*. Berkley: University of California Press.

Glasby, J., Littlechild, R. and Pryce, K. (2004) 'Show me the way to go home: a narrative review of the literature on delayed hospital discharges and older people', *British Journal of Social Work*, 34(8) p.1189-1197.

Glaser, B.G. & Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing.

Glendinning, C., Challis, D., Fernandez, J-L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008) *Evaluation of the individual budgets pilot programme. Final Report.* York: University of York Social Policy Research Unit.

Globerman, J., Davies, J., Mackenzie, J. and Walsh, S. (1996) 'Social work in restructuring hospitals: Meeting the challenge', *Health and Social Work* 42(3) p.178-88.

Goffman, I. (1959) *The Presentation of Self in Everyday Life*. New York: Anchor.

Goffman, I. (1961) *Encounters: Two Studies in the Sociology of Interaction*. Indianapolis: Bobbs-Merrill.

Goffman, I. (1974) *Frame Analysis: An essay on the organization of experience.* New York: Harper and Row.

Goffman, I. (1981) *Forms of Talk*. Philadelphia: University of Philadelphia Press.

Gold, R. (1958) 'Roles in sociological field observation', *Social Forces* 36(3) p. 217-23.

Gorman, H. and Postle, K. (2003) *Transforming Community Care: A Distorted Vision?* Birmingham: Venture.

Gosden, P.H. (1961) *The Friendly Societies in England 1815 – 1875*. Manchester: Manchester University Press.

Gouldner, A.W. (1970) *The Coming Crisis of Western Sociology*. NY: Basic.

Grandey, A.A. (2003) 'When "The Show Must Go On": Surface Acting and Deep Acting as Determinants of Emotional Exhaustion and Peer-Rated Service Delivery', *Academy of Management Journal* 46(1) p.86-96.

Gray, A. C., Chairman of Council, Hospital Almoners Institute (1929) *Letter to the Spectator*, 23rd November 1929, p.34.

Gray, B., Purdy, J.M. and Ansari, S. (2015) 'From Interactions to Institutions: Microprocesses of Framing and Mechanisms for the Structuring of Institutional Fields', *Academy of Management Review* 40(1) p.115-43.

Greener, J. (2015) 'Embedded neglect, entrenched abuse: market failure and mistreatment in elderly care', in (eds.) Irving, Z., Fenger, M. and Hudson, J. (2015) *Social Policy Review 27: Analysis and Debate in Social Policy 2015*. Bristol: Policy Press.

Greenwood, N. and McKenzie, A. (2010) 'Informal caring for stroke survivors: Meta-ethnographic review of qualitative literature', *Maturitas* 66(3) p. 268-76.

Gregory, R. (2001) Transforming Governmental Culture: A Sceptical View of the New Public Management, in (eds.) Christensen, T. and Laegreid, P. (2001) *New Public Management: The Transformation of Ideas and Practice*, Aldershot, Ashgate Publishing Ltd.

Grenier, A. (2007) 'Constructions of frailty in the English language, care practice and the lived experience', *Ageing and Society* 27(3) p. 425-45.

Grenier A. (2012) *Transitions and the Life Course*. Bristol: Policy Press.

Grenier, A. and Phillipson, C. (2013) 'Rethinking agency in late life: structural and interpretive approaches', in (eds.) Baars, J., Dohmen, J., Grenier, A. and Phillipson, C. (2013) *Ageing, Meaning and Social Structure*. Bristol: Policy Press.

Grenier, A., Phillipson, C., Rudman, D.L., Hatzifilalithis, S., Kobayashi, K. and Marier, P. (2017) 'Precarity in late life: Understanding new forms of risk and insecurity', *Journal of Aging Studies* 43(1) p. 9-14.

Griffiths Report (1988) *Community Care: Agenda for Action.* London: HMSO.

Guba, E.G. and Lincoln, Y.S. (1994) 'Competing Paradigms in Qualitative Research', in (eds.) Denzin, N.K. and Lincoln, Y.S. *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.

Gwilim, H. (2011) 'Social Services for Adults in Wales', in (ed.) Williams, C. *Social Policy for Social Welfare Practice in a Devolved Wales.* 2nd ed. Birmingham: Venture Press/BASW.

Hammersley, M. (1992) *What's Wrong with Ethnography?* London: Routledge.

Hammersley, M. (1995) *The Politics of Social Research*. London: Sage.

Hammersley, M. & Atkinson, P.A. (2007) *Ethnography: Principles in Practice.* London: Routledge.

Hardwick, L. and Worsley, A. (2011) *Doing Social Work Research*. London: Sage.

Harlow, E. (2003) New managerialism, Social Service Departments and social work practice today. *Practice* 15(2) p. 29-44.

Harris, J. (2003) The Social Work Business. London: Routledge.

Harslof, I., Nielsen, U.S. and Feiring, M. (2017) 'Danish and Norwegian hospital social workers' cross-institutional work amidst inter-sectoral restructuring of health and social welfare' *European Journal of Social Work* 20(4) p. 584-95.

Harvey, D. (2005) *A Brief History of Neoliberalism*. Oxford: Oxford University Press.

Hasler, F. (2006) 'Holding the dream: direct payments and independent living', in (eds.) Leece, J. and Bornat, J. (2006) *Developments in Direct Payments*. Bristol: Policy Press.

Hastings, S.J. and Rogowski, S. (2015) 'Critical Social Work with Older People in Neo-liberal Times: Challenges and Critical Possibilities', *Practice – Social Work in Action* 27(1) p. 21-33.

Health and Care Professions Council (2012) *Standards of Proficiency: Social Workers in England* <www> http://www.hpc-uk.org/assets/documents/10003B08Standardsofproficiency-SocialworkersinEngland.pdf [accessed 2-6-14]

Helm, D. (2016) 'Sense-making in a social work office: An ethnographic study of safeguarding judgements', *Child and Family Social Work* 21(1) p. 26-35.

Hennink, M., Hutter, I. and Bailey, A. (2011) *Qualitative Research Methods*. London: Sage.

Herzberg, F. (2003) 'One more time: How do you motivate employees?' [Best of HBR reprint] *Harvard Business Review* 81(1) p. 87-96.

Heywood, A. (2004) *Political Theory: An Introduction*. 3rd Ed. Basingstoke: Palgrave Macmillan.

Higgs, P. and Gilleard, C. (2014) 'Frailty, abjection and the 'othering' of the fourth age', *Health Sociology Review* 23(1) p. 10-19.

Higham, P. (2006) *Social Work: Introducing Professional Practice*. London: Sage.

Hill, R., Betts, L.R. and Gardner, S.E. (2015) 'Older adults' experiences and perceptions of digital technology: (Dis)empowerment, wellbeing, and inclusion', *Computers in Human Behaviour* 48 p. 415-23.

Hillman, A. and Latimer, J. (2017) 'Cultural representations of dementia', *Public Library of Science Medicine* 14(3).

Hillman, A., Tadd, W., Calnan, S., Calnan, M., Bayer, A. and Read, S. (2013) 'Risk, governance and the experience of care', *Sociology of Health and Illness* 35(6) p. 939-55.

Hochschild, A. R. (2012) *The Managed Heart: Commercialization of human feeling*. Updated ed. Berkely: University of California Press.

Holland, S., Burgess, S., Grogan-Kaylor, A. and Delva, J. (2011) 'Understanding neighbourhoods, communities and environments: New approaches for social work research', *British Journal of Social Work* 41(4) p. 689-707.

Holstein, J.A. and Gubrium, J.F. (2016) 'Narrative Practice and the Active Interview', in (ed.) Silverman, D. (2016) *Qualitative Research*, 4th Ed. London: Sage.

Horlick-Jones, T. (2004) 'Editorial: Experts in Risk?... Do They Exist?'. *Health Risk and Scoiety*, 6(2), 107-114.

Howe, K. (2004) A critique of experimentalism, *Qualitative Inquiry*, 10(1) p.42–61.

http://gov.wales/docs/dhss/publications/140630support-toolen.pdf [available 1-9-2015]

Hugman, R. (1991) *Power in Caring Professions*. Basingstoke: Macmillan.

Hugman, R. (2009) 'But Is It Social Work? Some Reflections on Mistaken Identities', *British Journal of Social Work* 39(6) p. 1138-53.

Humphries R. (2011) *Social Care Funding and the NHS: An Impending Crisis?* London: Kings Fund.

Ife, J. (2010) *Human Rights From Below: Achieving rights through community development*. Cambridge: Cambridge University Press.

Ife, J. (2012) *Human Rights and Social Work: Towards rights-based practice*. 3rd Ed. Cambridge: Cambridge University Press.

Illich, I., Irving, K.T., McKnight, J., Caplan, J. and Shaiken, H. (1977) *Disabling Professions*. London: Marion Boyers.

International Federation of Social Workers (2014) *Global Definition of Social Work* <www> http://ifsw.org/get-involved/global-definition-of-social-work/ [Accessed 6-10-17]

Israel, M. and Hay, I. (2006) *Research Ethics for Social Scientists*. London: Sage.

Iversen, A., Liddell, K., Fear, N., Hotopf, M. & Wessely, S. (2006) 'Consent, confidentiality, and the data protection act.' *British Medical Journal*, 332, p. 165-169.

Jackson, A. C., Johnson, B., O'Toole, M. & Auslander, G. (2001) 'Discharge planning for complex paediatric cases', *Social Work in Health Care*, 34(1-2) p.161-75.

Jenkins, N. (2014) 'Dementia and the inter-embodied self', *Social Theory and Health* 12(2) p. 125-37.

Johansson, S., Rosengren, A., Young, K. and Jennings, E. (2017) 'Mortality and morbidity trends after the first year in survivors of acute myocardial infarction: a systematic review', *BMC Cardiovascular Disorders* (2017) Online Publication 7-2-17.

Johnson, T. J. (1972) *Professions and Power*. Basingstoke: Macmillan.

Jones, C. (1999) 'Social Work: regulation and managerialism', in (eds.) Exworthy, M. and Halford, S. (1999) *Professionalism and the New Managerialism in the Public Sector*. Buckingham: Open University Press

Judd, R.G. and Sheffield, S. (2010) 'Hospital Social Work: Contemporary Roles and Professional Activities', *Social Work in Health Care* 49(9) p.856-71.

Jupp, V. (2006) *The Sage Dictionary of Social Research Methods*. London: Sage.

Kennedy Chapin, R., Chandran, D., Sergeant, J.F. and Koenig, T.L. (2014) 'Hospital to Community Transitions for Adults: Discharge Planners' and Community Service Providers' Perspectives', *Social Work in Health Care* 53(4) p. 311-29.

Kidd, A. J. (1999) *State, Society, and the Poor in Nineteenth Century England*. Basingstoke: Macmillan.

Kincheloe, J.L. and McLaren, P. (1998) 'Rethinking critical theory and qualitative research', in (eds.) Denzin, N.K. and Lincoln, Y.S. (1998) *The Landscape of Qualitative Research*. London: Sage.

King's Fund (2014) *Making our health and care systems fit for an ageing population*. London: King's Fund.

Kitchen, A. & Brook, J. (2005) 'Social work at the heart of the medical team', *Social Work in Health Care*, 40(1) p.1-18.

Kitwood, T. (1997) *Dementia Reconsidered: The Person Comes First*. Buckingham: Open University Press.

Klein, R. and Maybin, J. (2012) *Thinking about Rationing*. <www> https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Thinking-about-rationing-the-kings-fund-may-2012.pdf [available 16-3-2017]

Kossman, H. D., Lamb, J. M., O'Brien, M. W., Predmore, S. M. and Prescher, M. J. (2006) 'Measuring productivity in medical social work', *Social Work in Health Care*, 42, p.1-16.

Kvale, S. 1996. *Interviews: An Introduction to Qualitative Research Interviewing.*(Illustrated Ed.) London: Sage.

Laing, R. (1971) *The Politics of the Family and Other Essays.* London: Routledge.

Landau, R. (2001) 'Ethical dilemmas in general hospitals: Social workers' contribution to ethical decision-making', *Social Work in Health Care*, 32(1) p.75-92.

Larson, M. S. (1977) *The Rise of Professionalism*. Berkeley: University of California Press.

Laslett, P. (1989) *A Fresh Map of Life: The emergence of the third age*. Cambridge MA: Harvard University Press.

Latimer, J. (2000) *The Conduct of Care: Understanding Nursing Practice*. Oxford: Blackwell Science.

Lawler, J. and Bilson, A. (2010) *Social Work Management and Leadership*. Abingdon: Routledge.

Leadbetter, C. (2004) *Personalisation Through Participation: A new script for public services*. London: Demos.

Lecompte, M. D. & Schensul, J. J. (1999) *Analyzing and Interpreting Ethnographic Data*. California: Altamira.

Leigh, C. (2004) *Unrepentant Whore: The Collected Work of Scarlot Harlot*. San Francisco: Last Gasp.

Lewin, S. and Reeves, S. (2011) 'Enacting 'team' and 'teamwork': Using Goffman's theory of impression management to illuminate interprofessional practice on hospital wards', *Social Science and Medicine* 72(10) p. 1595-1602.

Lipsky, M. (1980) *Street-Level Bureaucracy: The Dilemmas of Individuals in Public Services.* New York: Russell Sage Foundation.

Lishman, J., Yuill, C., Brannan, J. and Gibson, A. (2014) *Social Work: An Introduction*. London: Sage.

Lloyd L., Tanner D., Milne A., Ray M., Richards S., Sullivan M.P., Beech C. & Phillips J. (2014) 'Look after yourself: Active ageing, individual responsibility and the decline of social work with older people in the UK', *European Journal of Social Work* 17 (3) p. 322-35.

Long, D., Hunter, C. and Van der Geest, S. (2008) 'When the field is a ward or clinic: Hospital ethnography', *Anthropology and Medicine* 15(2) p. 71-8.

Longhoefer, J. and Floersch, J. (2012) 'An example of social work practice ethnography', in (eds.) Becker, S., Bryman, A. and Ferguson, H. (2012) *Understanding Research for Social Policy and Social Work*. Bristol: Policy Press.

Lonsmann, D. (2015) 'Negotiating Positionality in Ethnographic Investigations of Workplace Settings: Student, Consultant or Confidante?', in (eds.) Alessi, G.M. and Jacobs, G. (2015) *The Ins and Outs of Business and Professional Discourse Research*. Basingstoke: Palgrave Macmillan.

Lowe, R. (2005) *The Welfare State in Britain Since 1945*. 3rd Ed. London: Sage.

Loxley, A. (1996) 'Training with the Institute of Almoners:1958', in (eds.) Baraclough, J., Dedman, G., Osborn, H. and Willmott, P. (1995) *100 Years of Health Related Social Work*. Birmingham: BASW.

Lymbery, M. (2001) 'Social Work at the Crossroads', *British Journal of Social Work* 31(3) p. 369-84.

Lymbery, M. (2005) *Social Work with Older People*. London: Thousand Oaks.

Lymbery, M. (2010) 'A new vision for adult social care? Continuities and change in the care of older people', *Critical Social Policy* 30(1) p.5-26.

Lymbery, M. and Postle, K. (2010) 'Social work in the context of adult social care in England and the resultant implications for social work education', *British Journal of Social Work* 40(8) p. 2502-22.

Lymbery, M. and Postle, K. (2015) *Social Work and the Transformation of Adult Services: Perpetuating a Distorted Vision?* Bristol: Policy Press.

Macdonald, K.M. (1995) *The Sociology of the Professions*. London: Sage.

Macintyre, A.C. *After Virtue: A study in moral theory*. London: Duckworth.

Macmillan (2014) *Cancer's Unequal Burden: The reality behind improving cancer survival rates*. <www> http://www.macmillan.org.uk/documents/cancersunequalburden_2014.pdf [Accessed 6-10-2017]

Manchee, D. M. (1945) 'The social aspect of the venereal diseases: The work of the almoner.' *British Journal of Venereal Diseases*, 21, p. 12.

Mann, L. (2016) 'Delayed discharges within community hospitals: A qualitative study investigating the perspectives of frontline health and social care professionals', *Journal of Integrated Care* 24(5/6) p. 260-70.

Mantell, A. (2011) 'Human rights and wrongs: The Human Rights Act 1998', in (eds.) Scragg, T. and Mantell, A. (2011) *Safeguarding Adults in Social Work*. Exeter: Learning Matters.

Manthorpe, J. (2002) 'Settlements and Social Work Education: Absorption and Accommodation'. *Social Work Education*, 21, p. 409-419.

Mayo, E. (1949) *The Social Problems of an Industrial Civilisation*. London: Routledge and Kegan Paul.

McDermott, F., Henderson, A. and Quayle, C. (2017) 'Health social workers' sources of knowledge for decision making in practice', *Social Work in Health Care* 56(9) p. 794-808.

McDonald, A. (2006) *Understanding Community Care: a guide for social workers.* 2nd Edition. Basingstoke: Palgrave Macmillan.

McKnight, J. (1977) 'Professionalized Service and Disabling Help', in (eds.) Illich, I., McKnight, J., Caplan, J. and Shaiken, H. (1977) *Disabling Professions*. London: Marion Boyers.

McLaughlin, J. (2016) 'Social work in acute hospital settings in Northern Ireland: The views of service users, carers and multi-disciplinary professionals', *Journal of Social Work* 16(2), p.135-54.

Millar, M. (2008) ' 'Anti-oppressiveness': critical comments on a discourse and its context' *Journal of Social Work* 38(2) p.362-75.

Miller, J. and Glassner, B. (2016) 'The 'Inside' and the 'Outside': Finding Realities in Interviews', in (ed.) Silverman, D. (2016) *Qualitative Research*, 4th Ed. London: Sage.

Ministry of Justice (2008) *Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice*. London: TSO.

Morgan, S. (1996) *Helping Relationships in Mental Health*. London: Chapman and Hall.

Moriarty, J., Baginsky, M. and Manthorpe, J. (2015) *Literature review of roles and issues within the social work profession in England.* London: King's College Social Care Workforce Research Unit.

Munro, E. (2011) *The Munro review of child protection: final report, a child-centred system.* London: TSO.

Musil, L., Kubalcikova, K., Hubikova, O. and Necasova, M. (2004) 'Do social workers avoid the dilemmas of work with clients?', *European Journal of Social Work* 7(3): 305-319.

National Audit Office (2016) *Discharging older patients from hospital*. London: NAO.

Nelson, M. (2000) 'A view of social work advocacy in hospitals in Eastern Ontario', *Social Work in Health Care*, 29, p.69-92.

NHS (2014) *Decision Support Tool for NHS Continuing Healthcare*. <www> http://gov.wales/docs/dhss/publications/140630support-toolen.pdf [Accessed 6-10-17]

Nilsson, D., Joubert, L., Holland, L. and Posenelli, S. (2013) 'The Why of Practice: Using PIE to Analyse Social Work Practice in Australian Hospitals', *Social Work in Health Care* 52(2-3) p. 280-95.

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J. and Braithwaite, J. (2010) 'How and where clinicians exercise power: Interprofessional relations in health care', *Social Science and Medicine* 71(5) p. 898-909.

O'Malia, A., Hills, A.P. and Wagner, S. (2014) 'Repositioning Social Work in the Modern Workforce: The Development of a Social Work Assistant Role', *Australian Social Work* 67(4) p. 593-603.

ONS (2015) *National Population Projections*. <www> https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationp rojections/compendium/nationalpopulationprojections/2015-10-29/summaryresults [Accessed 28-7-17]

O'Reilly, M. and Parker, N. (2013) ' 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research', *Qualitative Research* 13(2) p. 190-7.

Osborn, H. (1996) 'One Door – Many Mansions: 1974 – 1995', in (eds.) Baraclough, J., Dedman, G., Osborn, H. and Willmott, P. (1995) *100 Years of Health Related Social Work*. Birmingham: BASW.

Parry, N. and Parry, J. (1979) 'Social work, professionalism and the state', in (eds.) Parry, N., Rustin, M. and Satyamurti, C. (1979) *Social Work, Welfare and the State*. London: Edward Arnold (Publishers) Ltd.

Parton, N. (2008) 'Changes in the form of knowledge in social work: from the 'social' to the 'informational'?' *British Journal of Social Work* 38(2), p. 253-69.

Payne, G. and Williams, M. (2005) 'Generalization in Qualitative Research', *Sociology* 39(2) p. 295-314.

Payne, M. (1995) *Social Work and Community Care*. Basingstoke: Macmillan.

Payne, M. (2000) *Anti-bureaucratic Social Work.* Birmingham: Venture Press.

Payne, M. (2002) 'The Role and Achievements of a Professional Association in the Late Twentieth Century: The British Association of Social Workers 1970–2000'. *British Journal of Social Work*, 32, 969-995.

Payne, M. (2005) *The Origins of Social Work: Continuity and Change*. Basingstoke: Palgrave Macmillan.

Payne, M. (2006) *Anti-bureaucratic Social Work.* Birmingham: Venture Press.

Payne, M. (2012) *Citizenship Social Work with Older People*. Bristol: Policy Press.

Payne, M. (2014) *Modern Social Work Theory*. 4th Ed. Basingstoke: Palgrave Macmillan.

Payne, S., Kerr, C., Hawker, S., Hardey, M. & Powell, J. (2002) 'The communication of information about older people between health and social care practitioners', *Age and Ageing*, 31, p.107-117.

Penna, S. and O'Brien, M. (2013) 'Neoliberalism', in (eds.) Gray, M. and Webb, S.A. (2013) *Social Work Theories and Methods*. 2nd Ed. London: Sage.

Phillips, J. and Burholt, V. (2007) 'Ageing in Wales: policy responses to an ageing population', *Contemporary Wales* 19(1) p. 180-97.

Phillips, J. and Waterson, J. (2005) 'Care management and social work: A case study of the role of social work in hospital discharge to residential or nursing home care', *European Journal of Social Work* 5(2) p. 171-86.

Phillips, J., Walford, N. and Hockey, A. (2011) 'How do unfamiliar environments convey meaning to older people?', *International Journal of Ageing and Later Life* 6(2) p. 73-102.

Phillipson, C. (2013) *Ageing*. Cambridge: Polity.

Phillipson, C. and Walker, A. (1987) 'The case for a critical gerontology', in (ed.) Di Gregorio, S. *Social gerontology: New directions*. London: Croom Helm.

Phoenix, J. (1999) *Making Sense of Prostitution*. Basingstoke: Palgrave.

Pickard, S. *Age Studies*. London: Sage.

Pithouse, A. (1987) *Social Work: The social organization of an invisible trade*. Aldershot: Avebury.

Plank, A., Mazzoni, V. and Cavada, L. (2012) 'Becoming a caregiver: new family carers' experience during the transition from hospital to home', *Journal of Clinical Nursing* 21(13-14), p. 2072-82.

Pockett, R. (2002) 'Staying in hospital social work', *Social Work in Health Care*, 36(1) p.1-24.

Pope, C. (2005) 'Conducting ethnography in medical settings', *Medical Education* 39(12) p. 1180-7.

Popper, K. ([1959] 1980) *The Logic of Scientific Discovery*. London; Routledge.

Porter, R. (1997) *The Greatest Benefit to Mankind*. London: Harper Collins.

Power, M (2004) *The Risk Management of Everything: Rethinking the Politics of Uncertainty.* London: DEMOS.

Powers, E. and Witmer, H. (1951), *An Experiment in the Prevention of Delinquency – The Cambridge-Somerville Youth Study*. New York: Columbia University Press.

Prior, L. (2003) *Using Documents in Social Research*. London: Sage.

Pugh, G.L. (2016) 'Job satisfaction and turnover intent among hospital social workers in the United States', *Social Work in Health Care* 55(7) p. 485-502.

Pullen-Sansfacon, A. and Cowden, S. (2012) *The Ethical Foundations of Social Work*. Harlow: Pearson.

Punch, K.F. (2014) *Introduction to Social Research: Quantitative and Qualitative Approaches.* 3rd ed. London: Sage.

Ray, M., Bernard, M. and Phillips, J. (2009) *Critical Issues in Social Work with Older People*. Basingstoke: Palgrave Macmillan.

Ray, M. and Phillips, J. (2012) *Social Work with Older People*. Basingstoke: Palgrave Macmillan.

Ray, M., Milne, A., Beech, C., Phillips, J.E., Richards, S., Sullivan, M.P., Tanner, D. and Lloyd, L. (2015) 'Gerontological Social Work: Reflections on its Role, Purpose and Value', *British Journal of Social Work* 45(4), p. 1296-1312.

Reay, T. and Hinings, C.R. (2005) 'The Recomposition of an Organizational Field: Health Care in Alberta', *Organization Studies* 26(3) p. 351-84.

Reay, T. and Hinings, C.R. (2009) 'Managing the Rivalry of Competing Institutional Logics', *Organization Studies* 30(6), p. 629-52.

Richards, S., Sullivan, M.P., Tanner, D., Beech, C., Milne, A., Ray, M., Phillips, J. and Lloyd, L. (2014) 'On the Edge of a New Frontier: Is Gerontological Social Work in the UK Ready to Meet the Twenty-First-Century Challenges?', *British Journal of Social Work* 44(8) p. 2307-24.

Richmond, M. E. (1917) *Social Diagnosis*. London: Russell Sage Foundation.

Ritzer, M. (1996) *The McDonaldization of Society*. Thousand Oaks (CA): Pine Forge Press.

Rizzo, V. M. & Abrams, A. (2000) 'Utilization review: A powerful social work role in health care settings', *Health and Social Work*, 25, p.264-269.

Rizzo, V. M. (2006) 'Social work support services for stroke patients: interventions and outcomes', *Social Work in Health Care*, 43, p.33-56.

Rockwood, K. and Mitniski, A. (2007) 'Frailty in Relation to the Accumulation of Deficits', *Journals of Gerontology Series A* 62(7) p. 722-7.

Rogowski, S. (2010) *Social Work: The Rise and Fall of a Profession?* Bristol: Policy Press.

Rooff, M. (1972) *A Hundred Years of Family Welfare: A Study of the Family Welfare Association (formerly Charity Organisation Society) 1869-1969*. London: Michael Joseph.

Rose, S.M. (1990) 'Advocacy/Empowerment: An Approach to Clinical Practice for Social Work', *Journal of Sociology and Social Welfare* 17(2) p. 41-51.

Rowlands, A. (2007) 'Medical social work practice and SARS in Singapore', *Social Work in Health Care*, 45(1) p. 57-83.

Royle, E. (2012) Modern Britain: A Social History 1750-2010. 3rd Ed. London: A&C Black.

Ryen, A. (2016) 'Research Ethics and Qualitative Research', in (ed.) Silverman, D. (2016) *Qualitative Research*. 4th Ed. London: Sage.

Sackett, D.L., Rosenberg, W.M., Gray, J.H.M., Haynes, R.B. and Richardson, W.S. (1996), 'Evidence-based Practice: What it is and What it isn't', *British Medical Journal*, 312, 7203, p. 71-2.

Sackville, A. (1986) *Hospital Almoners Association 1903-1930*. <www> http://www.kcl.ac.uk/sspp/kpi/scwru/swhn/2013/Sackville-WP01-Hospital-Almoners-Association-1903-to-1930.pdf [accessed 23-6-14]

Sackville, A. (1987). *From Almoner to Medical Social Worker: 1950-1970*. <www> http://www.kcl.ac.uk/sspp/kpi/scwru/swhn/2013/Sackville-WP04-From-Almoner-to-Medical-Social-Worker-1950-to-1970.pdf [accessed 23-6-14]

Sackville, A. (1988a) *The Association of Psychiatric Social Workers – The Early Years* <www> https://www.kcl.ac.uk/sspp/policy-institute/scwru/swhn/2013/Sackville-WP06-APSW-The-Early-Years.pdf [accessed 4-4-18]

Sackville, A. (1988b) *APSW – From Mackintosh to BASW, 1951-1970.* <www> https://www.kcl.ac.uk/sspp/policy-institute/scwru/swhn/2013/Sackville-WP08-APSW-From-Mackintosh-to-BASW-1951-1970.pdf [accessed 4-4-18]

Sackville, A. (1989) 'Thomas William Cramp, Almoner: The Forgotten Man in a Female Occupation'. *British Journal of Social Work*, 19, p. 95-110.

Scourfield, J. (2003) *Gender and Child Protection*. Basingstoke: Palgrave Macmillan.

Sallee, M. W. and Harris, F. (2011) 'Gender performance in qualitative studies of masculinities', *Qualitative Research* 11(4), p. 409-29.

Seebohm Report (1968) *Report of the Committee on Local Authority and Allied Personal Social Services.* London: HSMO.

Seed, P. (1973). *The Expansion of Social Work in Britain*. London: Routledge and Kegan Paul.

Shapiro, M., Setterlund, D., Warburton, J., O'Connor, I. and Cumming, S. (2009) 'The outcomes research project: An exploration of customary practice in Australian health settings' *British Journal of Social Work*, 39(2), p.318-333.

Shaw, I. (2008) 'Merely Experts? Reflections on the History of Social Work, Science and Research'. *Research, Policy and Planning*, 26, p. 57-65.

Simmons, A. (2005) *A Profession and its Roots: The Lady Almoners*. London: Michelangelo Press.

Simpson, G., Pfeiffer, D., Keogh, S. and Lane, B. (2016) 'Describing an Early Social Work Intervention Program for Families after Severe Traumatic Brain Injury', *Journal of Social Work in Disability and Rehabilitation* 15(3-4) p. 213-33.

Sims-Gold, J., Byrne, K., Hicks, E., Franke, T. and Stolee, P. (2015) '"When Things Are Really Complicated We Call the Social Worker": Post Hip-Fracture Care Transitions for Older People', *Health Social Work* 40(4) p. 257-65.

Skillbeck, J.K., Arthur, A. and Seymour, J. (2018) 'Making sense of frailty: An ethnographic study of the experience of older people living with complex health problems', *International Journal of Older People Nursing* 13(1) e12172.

Smith, D. and Shields, J. (2013) 'Factors related to social service workers' job satisfaction: Revisiting Herzberg's motivation to work', *Administration in Social Work* 37(2) p. 189-98.

Sosin, M. and Caulum, S. (1983) 'Advocacy: A conceptualization for social work practice', *Social Work*, 28(1) p.12-17.

Stake, R.E. (1995) *The Art of Case Study Research*. Thousand Oaks: Sage.

Standing, G. (2010) *The Precariat: The new and dangerous class.* London: Bloomsbury.

Statham, J., Cameron, C. and Mooney, A. (2006) *The tasks and roles of social workers: A focused overview of research evidence*. <www> http://discovery.ucl.ac.uk/1507248/1/Tasks_and_roles_of_social_workers_-_report.pdf [accessed 28-3-18]

Stevenson, O. (1977) *Ageing: A Professional Perspective*. London: Age Concern.

Stevenson, O. (2005) 'Genericism and Specialization: The Story Since 1970.' *British Journal of Social Work*, 35(5) p. 569-86.

Strauss, A.L., Schatzman, L., Ehrlich, D., Bucher, R. and Sabshin, M. (1963) 'The hospital and its negotiated order', in (ed.) Freidson, E. (1963) *The Hospital in Modern Society*. NY: Free Press.

Sullivan M. P. (2009) 'Social workers in community care practice: Ideologies and interactions with older people', *British Journal of Social Work* 39(6), p.1306–25.

Tadd, W., Hillman, A., Calnan, S., Calnan, M., Bayer, A.J. and Read, S.M. (2011) 'Right place - wrong person: dignity in the acute care of older people', *Quality in Ageing and Older Adults* 12(1) p. 33-43.

Tadd, W., Hillman, A., Calnan, M., Calnan, S., Read, S.M. and Bayer, A.J. (2012) 'From right place - wrong person, to right place - right person: Dignified care for older people', *Journal of Health Services Research and Policy* 17(Supp. 2) p. 30-36.

Tannen, D. and Wallat, C. (1987) 'Interactive Frames and Knowledge Schemas in Interaction: Examples from a Medical Examination/Interview', *Social Psychology Quarterly* 50(2) p.205-16.

Tanner, D. (2013) 'Identity, selfhood and dementia: Messages for social work', *European Journal of Social Work* 16(2), p. 155-70.

Tanner, D., Glasby, J. and McIver, S. (2015) 'Understanding and Improving Older People's Experiences of Service Transitions: Implications for Social Work', *British Journal of Social Work* 45(7) p. 2056-71.

Taylor, C. and White, S. (2000) *Practising Reflexivity in Health and Welfare: Making Knowledge*. Buckingham: Open University Press.

Tennier, L. D. (1997) 'Discharge planning: an examination of the perceptions and recommendations for improved discharge planning at the Montreal General Hospital', *Social Work in Health Care*, 26, p.41-60.

Thomas, G. (2016) *How to Do your Case Study*. London: Sage.

Thomas, G. (2017) 'Doing Gender in a Hospital Setting: Reflections of a Male Researcher', *Sociological Research Online* 22(2).

Thompson, N. (2015) *Understanding Social Work: Preparing for Practice*. 4th Ed. Basingstoke: Palgrave Macmillan.

Thompson, N. (2016) *Anti-discriminatory Practice*. 6th Ed. Basingstoke: Palgrave Macmillan.

Trevithick, P. (2012) *Social Work Skills and Knowledge: a practice handbook*. 3rd Ed. Maidenhead: McGraw-Hill/Open University Press.

Trigg, R. (2001) *Understanding Social Science: A philosophical introduction to the social sciences*. 2nd Edition. Oxford: Blackwell.

Van Maanen, J. and Kolb, D. (1985) 'The professional apprentice: Observations on field-work roles in two organizational settings', in (eds.) Bachrach, S. and Mitchell, S. (1985) *Research in the Sociology of Organizations* vol. 4. Greenwich, CT: JAI.

Waddington, K. (2011) *An Introduction to the Social History of Medicine*. Basingstoke: Palgrave Macmillan.

Warren, C.A.B. (2001) 'Qualitative Interviewing', in (eds.) Gubrium, J.F. and Holstein, J.A. (2001) *Handbook of Interview Research*. Thousand Oaks, CA: Sage.

Wastell, D., White, S., Broadhurst, K., Peckover, S. and Pithouse, A. (2010) 'Children's services in the iron cage of performance management: street-level bureaucracy and the spectre of Svejkism', *International Journal of Social Welfare* 19(3) p. 310-20.

Webb, S.A. (2001) 'Some considerations on the validity of evidence-based practice in social work', *British Journal of Social Work*, 31(1) p. 51 – 79.

Webb, S.A. (2006) *Social Work in a Risk Society: Social and Political Perspectives*. Basingstoke: Palgrave Macmillan.

Webb, S. A. (2007) 'The Comfort of Strangers: Social Work, Modernity and Late Victorian England—Part I'. *European Journal of Social Work*, 10, p. 39-54.

Weber, M ([1922] 2015) *Weber's Rationalism and Modern Society*. Trans. Waters, T. and Waters, D. NY: Palgrave Macmillan.

Weber, M. (1949) *The Methodology of the Social Sciences.* Illinois: Free Press.

Welsh Assembly Government (2003) *The Strategy for Older People in Wales*. Cardiff: WAG.

Welsh Assembly Government (2006) *National Service Framework for Older People in Wales*. Cardiff: WAG.

Welsh Government (2013) *The Strategy for Older People in Wales 2013-2023*. Cardiff: Welsh Government.

Welsh Government (2015) *National Population Projections: 2014-based Statistical Bulletin*. <www> https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2015-10-29 [Accessed 6-10-2017]

White, P., Hillman, A. and Latimer, J. E. (2012) 'Ordering, enrolling, and dismissing: moments of access across hospital spaces', *Space and Culture* 15(1) p. 68-87.

Williams, C. (2011) *Social Policy for Social Welfare Practice in a Devolved Wales*. 2nd Ed. Birmingham: Venture Press/BASW.

Williams, M. (2000) 'Interpretivism and Generalisation', *Sociology*, 34, pp. 209-224.

Willis, E. (1989) *Medical Dominance*. Revised Ed. Sydney: Allen and Unwin.

Willmott, P. (1996) '1895 – 1945: The First 50 Years', in (eds.) Baraclough, J., Dedman, G., Osborn, H. and Willmott, P. (1995) *100 Years of Health Related Social Work*. Birmingham: BASW.

Wilson, K., Ruch, G., Lymbery, M. & Cooper, A. (2012*) Social Work: An Introduction to Contemporary Practice.* 2nd Ed. Harlow: Pearson Longman.

Yin, R.K. (2013) *Case Study Research*, 5th Edition. London: Sage.

Participant Code	Role	Observed during fieldwork Y/N	Gave Formal interview Y/N
TM	Team manager for the hospital social work team	Y	Y
HSW1	Senior practitioner in hospital social work team	Y	Y
HSW2	Social worker in hospital social work team	Y	Y
HSW3	Social worker in hospital social work team	Y	Y
HSW4	Social worker in hospital social work team	Y	Y
HSW5	Social worker in hospital social work team	Y	Y
HSW6	Social worker in hospital social work team	Y	N
HSW7	Senior Practitioner in hospital social work team	Y	Y
HSW8	Social worker in hospital social work team	Y	Y
HSW9	Social worker in hospital social work team	Y	Y
HSW10	Social worker in hospital social work team	Y	Y
HO	Housing support worker attached to hospital social work team	Y	N
Admin 1	Hospital social work team administrator	Y	N
Admin 2	Hospital social work team administrator	Y	N
WS1	Ward sister	Y	Y
WS2	Ward sister	Y	Y
WS3	Ward sister	Y	N
Dr 1	Ward doctor (registrar)	Y	Y

Dr2	Ward doctor (registrar)	Y	Y
Dr 3	Doctor – consultant level	Y	N
Dr 4	Doctor – specialty registrar	Y	N
NM1	Nurse manager – Patient flow, Hanton General Hospital	Y	Y
NM2	Nurse manager – Patient flow, Hanton Infirmary	Y	Y
NM3	Nurse manager – Discharge Liaison Nurse, Hanton Infirmary	Y	N
NM4	Nurse manager, Patient flow, Hanton General Hospital	Y	N
OT1	Occupational therapist	Y	Y
OT2	Occupational therapist	Y	Y
OT3	Occupational therapist	Y	N
OT4	Occupational therapist	Y	N
Phys1	Physiotherapist	Y	Y
Phys2	Physiotherapist	Y	N
SLT	Speech and language assistant	Y	N
SN1	Staff nurse	Y	Y
SN2	Staff nurse	Y	Y
SN3	Staff nurse	Y	N
SN4	Staff nurse	Y	N
SN5	Staff nurse	Y	N
SN6	Staff nurse	Y	N
SN7	Staff nurse	Y	N
SN8	Staff nurse	Y	N
PT1	Patient	N	Y
PT2	Patient	N	Y
PT3	Patient	Y	N
CA1	Informal carer	N	Y
CA2	Informal carer	N	Y
CA3	Informal carer	N	Y
CA4	Informal carer	N	Y
CA5	Informal carer	N	Y
CA6	Informal carer	Y	N
CA7	Informal carer	N	Y

Appendix B: Interview Schedules

Patient/Carer Interview Schedule

What were you told about having a social worker when the referral was made?

What did you expect before you met your social worker?

How did the social worker get to know you?

Do you feel that your social worker has listened to you?

Do you feel like your social worker has spent enough time with you?

Has the social worker spoken to your family or carers?

Has anyone else in the hospital treated you differently since you first met your social worker?

What kind of problems has your social worker helped you with?

What practical things has your social worker done for you?

What would be different if you didn't have a social worker?

Who is making/made the decisions about what will happen/happened when you leave/left hospital?

Are you aware of any disagreements between professionals who are responsible for your care?

Has your social worker done for you what s/he said s/he would do?

What does your social worker say about decisions about the cost of your care?

Do you think you are better off for having a social worker? If so, how?

Who has helped you to cope emotionally with being ill and in hospital?

Hospital Professional Interview Schedule

At what point do you consider making a referral to the social work team?

What do you tell patients about social workers when asking for their consent for a referral?

In your experience, what is the main purpose of social workers in the hospital?

What knowledge do social workers have that nobody else has?

What skills do you recognise in social workers?

What difference do social workers make to the care of an inpatient once they are involved?

What difference do social workers make to the discharge and after care of patients?

How much importance do you attach to the information and opinions a social worker might share with you?

What influence do social workers have on clinical teams?

If there wasn't a social work team in the hospital, how would things be different?

Can you describe an occasion when you have worked well with a social worker?

Can you describe an occasion when you have been involved in a disagreement or professional conflict with a social worker?

What needs to be improved in the hospital social work service?

What barriers are there to working collaboratively with social workers?

Is there any difference between your professional values and those of social work?

Social Worker Interview Schedule

What tasks do you routinely perform on behalf of patients?

What is the main knowledge you need to be a hospital social worker?

What skills does a hospital social worker need?

How are decisions made for patients?

What do you count as a successful case?

How much time do you spend with patients and their carers? Is it enough?

What are the main challenges for a social worker of working in a hospital?

What influence do you think you have on clinicians?

Can you describe a particularly memorable case you have been involved in?

Can you describe and occasion when you have worked particularly successfully with clinical staff?

Can you describe an occasion when you have had a disagreement/conflict with a clinical colleague/colleagues about a patient?

In what ways are your professional values similar or different to those of clinical staff?

How do you think social workers are perceived by clinical staff? And by patients?

What needs to be improved in the hospital social work service?

What could be improved in clinical services that would contribute to patients' social well-being?

What barriers are there to working collaboratively with clinical staff?

Cardiff University School of
Social Sciences
Glamorgan Building
King Edward VII Avenue
Cardiff
CF10 3WT
Email:
dburrows@cardiffmet.ac.uk
Tel. 029 2041 6817

Participant Information Sheet – Carer/Consultee Interviews

Study Title: An investigation into the contribution of social workers within the hospital setting

Thank you for helping us to decide whether your relative/friend would want to be involved in my study. I would be interested in finding out more about your views regarding how the hospital social work team has helped your relative/friend.

About the Researcher

My name is Dan Burrows and I am studying for a professional doctorate in social work at Cardiff University. This research will be used for me to complete my thesis. I would be very grateful if you would agree to take part in my research. If you do, I can assure you that all of your information will be kept confidential. I am a registered social worker, which means I am bound by the Code of Practice to maintain confidentiality. This means that I will not give your name or any details about you when writing up my research.

Purpose of the Study

I have been watching social workers in hospital to find out about how they work out what to do for patients and how they go about getting things done in the hospital. I am also interested in what people close to patients think of the hospital social workers and what difference they think that social workers make to their time in hospital and getting home. I would therefore like to invite you to take part in an interview about your perceptions of the hospital social workers.

Taking Part in the Study

It is up to you to decide whether or not you would like to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. I will keep a copy of this and you will have a copy to keep. If you agree to take part but later change your mind before the research is finished, none of your information will be used. I would be happy to meet with you to discuss any questions you might have before you decide whether or not you want to take part.

If you decide to take part, you are still free to withdraw at any time without giving a reason. This will not affect the standard of care you receive. If you choose to withdraw, I will erase all of the data which I hold about you.

Description of the Study

I would like to interview you about your views about your relative/friend's experience of having a hospital social worker after he/she has been discharged from hospital. The interview will last for around half an hour. You can choose where and when the interview takes place. The interview will involve me asking you some questions about your views and experiences. I will record the interview with an audio recorder and then type up what you said in full. I will then give you a copy of the typed up script so that you can check that it is accurate. You can stop the interview at any time without giving a reason. If you decide to withdraw from the study, the audio recording and script will be erased.

All of the research will be done by me and I will only discuss it with the people supervising me at Cardiff University. This will mainly be my two supervisors, Professor Jonathan Scourfield and Dr Teresa de Villiers.

Confidentiality and Your Rights

If you agree to take part in this study, I will assign you and anyone you talk about a false name. All notes that I take will be kept securely in a locked draw in a locked office in my university. I will never take any part of your file out of the social worker's office. I will store all data in compliance with the Data Protection Act 1998.

Your legal rights will not be affected whether you choose to take part in the study or not, or if you withdraw from the study.

Potential Benefits of Taking Part

I am hoping that this study will tell us more about the skills and knowledge social workers need, so that we can help them to train better in the future. Although this may not have any direct benefit for you or your relative/friend this time around, it may help all patients in the future by improving the training hospital social workers receive. It may also help to inform people who make policies in the government and civil service about the needs of patients who use the services of a social worker. All of this may help to improve the services patients receive in the future.

Potential Risks of Taking Part

I do not think that my research can cause you harm. However, it is possible that you could feel uncomfortable or upset when discussing your relative/friend's time in hospital. If this is the case, you can tell me to move on to another question or stop the interview completely. If you do become upset, I will attempt to find an agency for you that may be able to help in some way.

Contact Details

If you have any questions or concerns, please feel free to contact me on 029 2041 6817 or dburrows@cardiffmet.ac.uk

If you are unhappy about any aspect of the study, have any concerns or wish to make a formal complaint, you may contact Professor Jonathan Scourfield, Glamorgan Building, Cardiff University, King Edward VII Avenue, Cardiff CF10 3WA or email scourfield@cardiff.ac.uk.

My university supervisors are Professor Jonathan Scourfield and Dr Teresa de Villiers. Their contact details are: Their contact details are: Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff CF10 3WT. Tel. 029 2087 4000; Email scourfield@cardiff.ac.uk or devillierst@cardiff.ac.uk

Participant Information Sheet – Health Care Professionals – Observation and Interviews

Study Title: An investigation into the contribution of social workers within the hospital setting

I would like to invite you to take part in a research study about social work in hospitals. Before you decide if you would like to take part, it is important that you understand why the research is being done and what it will involve. Please read this information carefully and feel free to discuss it with relatives, friends or colleagues. If there is anything you are not sure about, or if you would like more information, please ask. Take time to decide whether or not you would like to take part.

About the Researcher

My name is Dan Burrows and I am studying for a professional doctorate in social work at Cardiff University. This research will be used for me to complete my thesis. I would be very grateful if you would agree to take part in my research. If you do, I can assure you that all of your information will be kept confidential. I am a registered social worker, which means I am bound by the Code of Practice to maintain confidentiality. This means that I will not give your name or any details about you when writing up my research.

Purpose of the Study

I would like to observe social workers in hospital to find out about how they work out what to do for patients and how they go about getting things done in the hospital. As social workers are part of a larger multi-disciplinary team, I am interested in observing how social workers work alongside other professionals within the hospital setting, to find more about the challenges of inter-professional working and what can be done to promote more efficient

inter-professional working. This means that I will be observing social workers in their offices, when they meet with patients and when they attend meetings with other professionals. The purpose of my research is to find out more about the skills and knowledge social workers in hospitals need, so that their training can be improved in the future.

Taking Part in the Study

It is up to you to decide whether or not you would like to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. I will keep a copy of this and you will have a copy to keep. If you agree to take part but later change your mind before the research is finished, none of your information will be used. I would be happy to meet with you to discuss any questions you might have before you decide whether or not you want to take part.

If you decide to take part, you are still free to withdraw at any time without giving a reason.

Description of the Study

I will be shadowing social workers as they go about their daily business in the hospital. This will include times when they are visiting patients on the ward and when they are attending both formal and informal meetings with other professionals. I will therefore need your permission to observe formal and informal meetings in which you are taking part. I will be taking notes throughout the day and writing these up more fully afterwards. I will give anybody that I write about in my research a pseudonym, so that nobody could tell who I am really talking about. I will be going back to some patients or their carers to interview them about their experience of hospital social work.

I may also approach you to ask if I might be able to interview you at some point to learn more about your views about hospital social work. If you are willing, an interview should last around half an hour and can be done at a place and time of your choosing. The interview will be audio recorded and transcribed. You will be given a copy of the transcript when it is typed up, with an opportunity to clarify any of your views if you feel they are misrepresented.

It is important that you know that:

- Your participation is entirely voluntary
- You can withdraw from taking part at any time prior to the research being written up without giving a reason
- You can consent to observation but refuse an interview or vice versa
- All participants in the study, whether professionals or patients, will be given pseudonyms and all data will be fully anonymised

All of the research will be done by me and I will only discuss it with the people supervising me at Cardiff University. This will mainly be my two supervisors, Professor Jonathan Scourfield and Dr Teresa de Villiers.

Confidentiality and Your Rights

If you agree to take part in this study, I will assign you a false name. All notes that I take will be kept securely in a locked draw in a locked office in my university. I will store all data in compliance with the Data Protection Act 1998. As a registered social worker, I would be obliged to report any behaviour that is harmful to vulnerable adults or any behaviour that violates a professional code of practice.

All data gathered will be used in the final research paper and any subsequent publications in a way that will hide the identity of all participants.

Your legal rights will not be affected whether you choose to take part in the study or not, or if you withdraw from the study.

Potential Benefits of Taking Part

I am hoping that this study will tell us more about the skills and knowledge social workers need, so that we can help to improve their training. It may also help to inform policy makers about the needs of patients who use the services of a social worker. All of this may help to improve the services patients receive in the future. It may also improve recognition of hospital social workers both within the profession and among other professions.

Potential Risks of Taking Part

I do not think that my research can cause you harm. Although every effort will be taken to ensure that all data is thoroughly anonymised, it is possible that colleagues reading the finished piece of research may be able to recognise a description of your words or actions if they relate to a specific incident.

Contact Details

If you have any questions or concerns, please feel free to contact me on 029 2041 6817 or dburrows@cardiffmet.ac.uk.

If you are unhappy about any aspect of the study, have any concerns or wish to make a formal complaint, you may contact Professor Jonathan Scourfield, Glamorgan Building, Cardiff University, King Edward VII Avenue, Cardiff CF10 3WA or email scourfield@cardiff.ac.uk.

My university supervisors are Professor Jonathan Scourfield and Dr Teresa de Villiers. Their contact details are: Their contact details are: Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff CF10 3WT. Tel. 029 2087 4000; Email scourfield@cardiff.ac.uk or devillierst@cardiff.ac.uk

Participant Information Sheet – Patient Interviews

Study Title: An investigation into the contribution of social workers within the hospital setting

Thank you for allowing me to observe when your social worker came to speak to you. I would like to find out a bit more about what you thought about your social worker and the difference she/he made to you.

About the Researcher

My name is Dan Burrows and I am studying for a professional doctorate in social work at Cardiff University. This research will be used for me to complete my thesis. I would be very grateful if you would agree to take part in my research. If you do, I can assure you that all of your information will be kept confidential. I am a registered social worker, which means I am bound by the Code of Practice to maintain confidentiality. This means that I will not give your name or any details about you when writing up my research.

Purpose of the Study

I have been watching social workers in hospital to find out about how they work out what to do for patients and how they go about getting things done in the hospital. I am also interested in what patients think of their hospital social workers and what difference they think that social workers make to their time in hospital and getting home. I would therefore like to invite you to take part in an interview about your experience of having a hospital social worker.

Taking Part in the Study

It is up to you to decide whether or not you would like to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. I will keep a copy of this and you will have a copy to keep. If you agree to take part but later change your mind before the research is finished, none of your information will be used. I would be happy to meet with you to discuss any questions you might have before you decide whether or not you want to take part.

If you decide to take part, you are still free to withdraw at any time without giving a reason. This will not affect the standard of care you receive. If you choose to withdraw, I will erase all of the data which I hold about you.

Description of the Study

I would like to interview you about your experience of having a hospital social worker after you have been discharged from hospital. The interview will last for around half an hour. You can choose where and when the interview takes place. The interview will involve me asking you some questions about your experiences. I will record the interview with an audio recorder and then type up what you said in full. I will then give you a copy of the typed up script so that you can check that it is accurate. You can stop the interview at any time without giving a reason. If you decide to withdraw from the study, the audio recording and script will be erased.

All of the research will be done by me and I will only discuss it with the people supervising me at Cardiff University. This will mainly be my two supervisors, Professor Jonathan Scourfield and Dr Teresa de Villiers.

Confidentiality and Your Rights

If you agree to take part in this study, I will assign you a false name. All notes that I take will be kept securely in a locked draw in a locked office in my university. I will never take any part of your file out of the social worker's office. I will store all data in compliance with the Data Protection Act 1998.

Your legal rights will not be affected whether you choose to take part in the study or not, or if you withdraw from the study.

Potential Benefits of Taking Part

I am hoping that this study will tell us more about the skills and knowledge social workers need, so that we can help them to train better in the future. Although this may not have any direct benefit for you this time around, it may help all patients in the future by improving the training hospital social workers receive. It may also help to inform people who make policies in the government and civil service about the needs of patients who use the services of a social worker. All of this may help to improve the services patients receive in the future.

Potential Risks of Taking Part

I do not think that my research can cause you harm. However, it is possible that you could feel uncomfortable or upset when discussing your time in hospital. If this is the case, you can tell me to move on to another question or stop the interview completely. If you do become upset, I will attempt to find an agency for you that may be able to help in some way.

Contact Details

If you have any questions or concerns, please feel free to contact me on 029 2041 6817 or dburrows@cardiffmet.ac.uk

If you are unhappy about any aspect of the study, have any concerns or wish to make a formal complaint, you may contact Professor Jonathan Scourfield, Glamorgan Building, Cardiff University, King Edward VII Avenue, Cardiff CF10 3WA or email scourfield@cardiff.ac.uk.

My university supervisors are Professor Jonathan Scourfield and Dr Teresa de Villiers. Their contact details are: Their contact details are: Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff CF10 3WT. Tel. 029 2087 4000; Email scourfield@cardiff.ac.uk or devillierst@cardiff.ac.uk

Participant Information Sheet – Observation of Patients

Study Title: An investigation into the contribution of social workers within the hospital setting

A member of staff at the hospital has asked for a social worker to see you to help you to make plans to manage your care needs when you leave hospital. I would like to invite you to take part in a research study about social work in hospitals. Before you decide if you would like to take part, it is important that you understand why the research is being done and what it will involve. Please read this information carefully and feel free to discuss it with relatives, friends or hospital staff. If there is anything you are not sure about, or if you would like more information, please ask. Take time to decide whether or not you would like to take part.

About the Researcher

My name is Dan Burrows and I am studying for a professional doctorate in social work at Cardiff University. This research will be used for me to complete my thesis. I would be very grateful if you would agree to take part in my research. If you do, I can assure you that all of your information will be kept confidential. I am a registered social worker, which means I am bound by the Code of Practice to maintain confidentiality. This means that I will not give your name or any details about you when writing up my research.

Purpose of the Study

I would like to watch social workers in hospital to find out about how they work out what to do for patients and how they go about getting things done in the hospital. I am also interested in

what patients think of their hospital social workers and what difference they think that social workers make to their time in hospital and getting home. I would therefore like to ask your permission to watch your social worker when she or he comes to talk to you and when she or he is in any meetings in which you are discussed. The purpose of my research is to find out more about the skills and knowledge social workers in hospitals need, so that their training can be improved in the future.

Taking Part in the Study

It is up to you to decide whether or not you would like to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. I will keep a copy of this and you will have a copy to keep. If you agree to take part but later change your mind before the research is finished, none of your information will be used. I would be happy to meet with you to discuss any questions you might have before you decide whether or not you want to take part.

If you decide to take part, you are still free to withdraw at any time without giving a reason. This will not affect the standard of care you receive. If you choose to withdraw, I will erase all of the data which I hold about you.

If you agree to take part by being observed, I may also ask you if you would like to have an interview. If so, I will give you another information sheet at a later date and time to decide if you would like to participate.

During the study, if you decide to take part but then lose the capacity to understand what is going on, I will still use the data that had been gathered up until that point. I will then consult a carer or close friend who will help to decide whether to carry on including you in the study or whether to stop at that point. If I suspect that you are unhappy about being included in the study even though you don't understand, I will stop immediately.

Description of the Study

I will be watching staff in the hospital doing their jobs. I will be taking notes throughout the day. I will give anybody that I write about in my research a false name, so that nobody could tell who I am really talking about. I will come and sit and listen when your social worker comes to see you and will also sit and listen in meetings in which the social worker is discussing your needs with other members of staff in the hospital or outside it. If you decide you don't want me to listen when you are talking with your social worker, you can tell me and I will leave straight away. I will also be reading some of the social worker's files, in which they keep your notes, letters and assessments.

All of the research will be done by me and I will only discuss it with the people supervising me at Cardiff University. This will mainly be my two supervisors, Professor Jonathan Scourfield and Dr Teresa de Villiers.

Confidentiality and Your Rights

If you agree to take part in this study, I will assign you a false name. All notes that I take will be kept securely in a locked draw in a locked office in my university. I will never take any part of your file out of the social worker's office. I will store all data in compliance with the Data Protection Act 1998.

Your legal rights will not be affected whether you choose to take part in the study or not, or if you withdraw from the study.

Potential Benefits of Taking Part

I am hoping that this study will tell us more about the skills and knowledge social workers need, so that we can help them to train better in the future. Although this may not have any direct benefit for you this time around, it may help all patients in the future by improving the training hospital social workers receive. It may also help to inform people who make policies in the government and civil service about the needs of patients who use the services of a social worker. All of this may help to improve the services patients receive in the future.

Potential Risks of Taking Part

I do not think that my research can cause you harm. However, it is possible that you could feel uncomfortable about discussing some things with your social worker in front of me. If I sense that you are uncomfortable, I will ask if you want me to leave. You can also ask me to leave at any time.

Contact Details

If you have any questions or concerns, please feel free to contact me on 029 2041 6817 or dburrows@cardiffmet.ac.uk

If you are unhappy about any aspect of the study, have any concerns or wish to make a formal complaint, you may contact Professor Jonathan Scourfield, Glamorgan Building,

Cardiff University, King Edward VII Avenue, Cardiff CF10 3WA or email scourfield@cardiff.ac.uk.

My university supervisors are Professor Jonathan Scourfield and Dr Teresa de Villiers. Their contact details are: Their contact details are: Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff CF10 3WT. Tel. 029 2087 4000; Email scourfield@cardiff.ac.uk or devillierst@cardiff.ac.uk

Cardiff University School of
Social Sciences
Glamorgan Building
King Edward VII Avenue
Cardiff
CF10 3WT
Email:
dburrows@cardiffmet.ac.uk
Tel. 029 2041 6817

Participant Information Sheet – Social Workers – Observation and Interview

Study Title: An investigation into the contribution of social workers within the hospital setting

I would like to invite you to take part in a research study about social work in hospitals. Before you decide if you would like to take part, it is important that you understand why the research is being done and what it will involve. Please read this information carefully and feel free to discuss it with relatives, friends or colleagues. If there is anything you are not sure about, or if you would like more information, please ask. Take time to decide whether or not you would like to take part.

About the Researcher

My name is Dan Burrows and I am studying for a professional doctorate in social work at Cardiff University. This research will be used for me to complete my thesis. I would be very grateful if you would agree to take part in my research. If you do, I can assure you that all of your information will be kept confidential. I am a registered social worker, which means I am bound by the Code of Practice to maintain confidentiality. This means that I will not give your name or any details about you when writing up my research.

Purpose of the Study

I would like to observe social workers in hospital to find out about how they work out what to do for patients and how they go about getting things done in the hospital. As social workers are part of a larger multi-disciplinary team, I am interested in observing how social workers work alongside other professionals within the hospital setting, to find more about the challenges of inter-professional working and what can be done to promote more efficient

inter-professional working. This means that I will be observing social workers in their offices, when they meet with patients and when they attend meetings with other professionals. The purpose of my research is to find out more about the skills and knowledge social workers in hospitals need, so that their training can be improved in the future.

Taking Part in the Study

It is up to you to decide whether or not you would like to take part. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. I will keep a copy of this and you will have a copy to keep. If you agree to take part but later change your mind before the research is finished, none of your information will be used. I would be happy to meet with you to discuss any questions you might have before you decide whether or not you want to take part.

If you decide to take part, you are still free to withdraw at any time without giving a reason.

Description of the Study

I will be sitting in the social work office listening to you discussing your cases with colleagues, taking telephone calls and going about your daily business. I will also be occasionally shadowing you when you go to meet patients (who will have consented to participating) and when you attend meetings with other professionals (where the other professionals who are attending have also consented). I will be taking notes throughout the day and writing these up more fully afterwards. I will give anybody that I write about in my research a pseudonym, so that nobody could tell who I am really talking about. I will also be reading some of your case files and would like to look at your assessments and correspondence on behalf of patients. If there are patients you do not think I should approach, or particularly sensitive meetings with patients you feel should be done privately, I will respect this. I will be going back to some patients or their carers to interview them about their experience of hospital social work.

I would also like to interview you at some point to learn more about your views about hospital social work. Each interview should last around half an hour and can be done at a place and time of your choosing. The interview will be audio recorded and transcribed. You will be given a copy of the transcript when it is typed up, with an opportunity to clarify any of your views if you feel they are misrepresented.

It is important that you know that:

- Your participation is entirely voluntary
- You can withdraw from taking part at any time prior to the research being written up without giving a reason
- You can consent to observation but refuse an interview or vice versa

- All participants in the study, whether professionals or patients, will be given pseudonyms and all data will be fully anonymised

All of the research will be done by me and I will only discuss it with the people supervising me at Cardiff University. This will mainly be my two supervisors, Professor Jonathan Scourfield and Dr Teresa de Villiers.

Confidentiality and Your Rights

If you agree to take part in this study, I will assign you a false name. All notes that I take will be kept securely in a locked draw in a locked office in my university. I will store all data in compliance with the Data Protection Act 1998. As a registered social worker, I would be obliged to report any behaviour that is harmful to vulnerable adults or any behaviour that violates a professional code of practice.

All data gathered will be used in the final research paper and any subsequent publications in a way that will hide the identity of all participants.

Your legal rights will not be affected whether you choose to take part in the study or not, or if you withdraw from the study.

Potential Benefits of Taking Part

I am hoping that this study will tell us more about the skills and knowledge social workers need, so that we can help to improve their training. It may also help to inform policy makers about the needs of patients who use the services of a social worker. All of this may help to improve the services patients receive in the future. It may also improve recognition of hospital social workers both within the profession and among other professions.

Potential Risks of Taking Part

I do not think that my research can cause you harm. However, it is possible that patients could feel uncomfortable about discussing some things with you in front of me. If I sense that they are uncomfortable, I will ask if they want me to leave. You can also ask me to leave at any time.

Although every effort will be taken to ensure that all data is thoroughly anonymised, it is possible that colleagues reading the finished piece of research may be able to recognise a description of your words or actions if they relate to a specific incident.

Contact Details

If you have any questions or concerns, please feel free to contact me on 029 2041 6817 or dburrows@cardiffmet.ac.uk

If you are unhappy about any aspect of the study, have any concerns or wish to make a formal complaint, you may contact Professor Jonathan Scourfield, Glamorgan Building, Cardiff University, King Edward VII Avenue, Cardiff CF10 3WA or email scourfield@cardiff.ac.uk.

My university supervisors are Professor Jonathan Scourfield and Dr Teresa de Villiers. Their contact details are: Their contact details are: Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff CF10 3WT. Tel. 029 2087 4000; Email scourfield@cardiff.ac.uk or devillierst@cardiff.ac.uk

Cardiff University School of
Social Sciences
Glamorgan Building
King Edward VII Avenue
Cardiff
CF10 3WT
Email:
dburrows@cardiffmet.ac.uk
Tel. 029 2041 6817

Carer/Consultee Information Sheet – Observation of Patients

Study Title: An investigation into the contribution of social workers within the hospital setting

A member of staff at the hospital has asked for a social worker to see the patient you care for to help them to make plans to manage their care needs when they leave hospital. I would like to invite this patient to take part in a research study about social work in hospitals. An assessment has been made that the patient does not have the capacity to make the decision as to whether they wish to participate or not. Under the Mental Capacity Act 2005, Section 32, a researcher must consult a carer or appointed consultee before including someone without capacity to consent for themselves in research. To help decide if the patient should join the study, I would like to ask your opinion about whether or not he/she would want to be involved. I would therefore ask you to consider what you know of their wishes and feelings, and to consider their interests. Please let me know of any advance decisions they may have made about participating in research, as these should take precedence. If you decide the patient would like to take part, I will include them in the study as long as they seem willing. If you decide the patient would not like to take part, I will not include them in my study.

Before you decide if you think it is appropriate for the patient to take part, it is important that you understand why the research is being done and what it will involve. Please read this information carefully and feel free to discuss it with relatives, friends or hospital staff. If there is anything you are not sure about, or if you would like more information, please ask. Take time to decide whether or not you feel that the patient would want to take part.

It is important that you know that the standard of care the patient receives will not be affected whatever advice you give. If you do not feel that you are able to advise about the patient's participation, you do not have to.

About the Researcher

My name is Dan Burrows and I am studying for a professional doctorate in social work at Cardiff University. This research will be used for me to complete my thesis. I would be very grateful if you would agree to take part in my research. If you do, I can assure you that all of your information will be kept confidential. I am a registered social worker, which means I am bound by the Code of Practice to maintain confidentiality. This means that I will not give your name or any details about you when writing up my research.

Purpose of the Study

I would like to watch social workers in hospital to find out about how they work out what to do for patients and how they go about getting things done in the hospital. I am also interested in what patients think of their hospital social workers and what difference they think that social workers make to their time in hospital and getting home. I would therefore like to ask permission to watch the patient's social worker when she or he comes to talk to you and when she or he is in any meetings in which you are discussed. The purpose of my research is to find out more about the skills and knowledge social workers in hospitals need, so that their training can be improved in the future.

I believe that it is extremely important to include people who may lack capacity in the study as it is important that their views and feelings are taken into account. Many of the patients hospital social workers help have limited mental capacity according to the Mental Capacity Act 2005. It is really important that they are not forgotten about when we try to learn more about how to improve hospital social work.

Taking Part in the Study

It is up to you to decide whether or not you feel that the patient would want to take part. If you do decide that they should take part you will be given this information sheet to keep and will be asked to sign a declaration. I will keep a copy of this and you will have a copy to keep. If you agree for the patient to take part but later change your mind before the research is finished, or the patient shows any distress or objection, none of their information will be used. I would be happy to meet with you to discuss any questions you might have before you decide whether or not you feel that the patient should take part.

If you decide that the patient should take part, you are still free to withdraw permission at any time without giving a reason. This will not affect the standard of care the patient receives. If you decide to withdraw consent on behalf of the patient, I will erase all of the data which I hold about them.

If you agree that the patient should take part by being observed, I may also ask you if you would like to have an interview. If so, I will give you another information sheet at a later date and time to decide if you would like to participate.

Description of the Study

I will be watching staff in the hospital doing their jobs. I will be taking notes throughout the day. I will give anybody that I write about in my research a false name, so that nobody could tell who I am really talking about. I will come and sit and listen when the patient's social worker comes to see them and will also sit and listen in meetings in which the social worker is discussing their needs with other members of staff in the hospital or outside it. If you decide you don't want me to listen when the patient is talking with the social worker, you can tell me and I will leave straight away. I will also be reading some of the social worker's files, in which they keep the patient's notes, letters and assessments.

All of the research will be done by me and I will only discuss it with the people supervising me at Cardiff University. This will mainly be my two supervisors, Professor Jonathan Scourfield and Dr Teresa de Villiers.

Confidentiality and Your Rights

If you agree for the patient to take part in this study, I will assign them a false name. All notes that I take will be kept securely in a locked draw in a locked office in my university. I will never take any part of the patient's file out of the social worker's office, or any notes of my own with any details which could be used to identify the patient. I will store all data in compliance with the Data Protection Act 1998. I will never take any notes out of the hospital with any details that could be used to identify the patient.

All data gathered will be used in the final research paper and any subsequent publications in a way that will hide the identity of all participants.

The patient's legal rights will not be affected whether you choose to take part in the study or not, or if you withdraw from the study.

Potential Benefits of Taking Part

I am hoping that this study will tell us more about the skills and knowledge social workers need, so that we can help them to train better in the future. Although this may not have any direct benefit for you this time around, it may help all patients in the future by improving the training hospital social workers receive. It may also help to inform people who make policies in the government and civil service about the needs of patients who use the services of a social worker. All of this may help to improve the services patients receive in the future.

Potential Risks of Taking Part

I do not think that my research can cause the patient harm. However, it is possible that they could feel uncomfortable about discussing some things with their social worker in front of me. If I sense that they are uncomfortable, I will leave. They can also ask me to leave at any time.

Contact Details

If you have any questions or concerns, please feel free to contact me on 029 2041 6817 or dburrows@cardiffmet.ac.uk.

If you are unhappy about any aspect of the study, have any concerns or wish to make a formal complaint, you may contact Professor Jonathan Scourfield, Glamorgan Building, Cardiff University, King Edward VII Avenue, Cardiff CF10 3WA or email scourfield@cardiff.ac.uk.

My university supervisors are Professor Jonathan Scourfield and Dr Teresa de Villiers. Their contact details are: Their contact details are: Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff CF10 3WT. Tel. 029 2087 4000; Email scourfield@cardiff.ac.uk or devillierst@cardiff.ac.uk

Appendix D: Confirmation of Ethical Approval

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

Gwasanaeth Moeseg Ymchwil
Research Ethics Service

Ariennir gan
Lywodraeth Cymru
Funded by
Welsh Government

Pwyllgor Moeseg Ymchwil Cymru 5
Wales Research Ethics Committee 5
Bangor

Clinical Academic Office
Ysbyty Gwynedd Hospital
Betsi Cadwaladr University Health Board
Bangor, Gwynedd
LL57 2PW

Telephone/ Facsimile: 01248 - 384.877
Email: Rossela.Roberts@wales.nhs.uk
Website : www.nres.nhs.uk

Mr Daniel Burrows
Cardiff Metropolitan University
Western Avenue
Cardiff
CF5 2YB   dburrows@cardiffmet.ac.uk

30 July 2015

Dear Mr Burrows

Study title:	An investigation into the contribution of social workers within the hospital setting: An ethnographic study of hospital social work, examining what social workers aim to achieve for patients and how they accomplish their work.
REC reference:	15/WA/0257
Protocol number:	SPON1421-14
IRAS project ID:	170953

Thank you for your letter of 28 July 2015 , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Dr Rossela Roberts, rossela.roberts@wales.nhs.uk.
Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study:

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

184

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
REC Application Form [REC_Form_02072015]		02 July 2015
Research protocol or project proposal	1	10 June 2015
Referee's report or other scientific critique report [Progress Review]	1	30 October 2014
Referee's report or other scientific critique report [Text of Email from Professor Andy Pithouse]	1	15 April 2015
Participant information sheet [Patient - Observation]	1	10 June 2015
Participant information sheet [Patient - Interviews]	1	10 June 2015
Participant information sheet [Social Workers - Observation and Interviews]	2	27 July 2015
Participant information sheet [HCPs - Observation and Interviews]	2	27 July 2015
Participant information sheet [Information for Consultee - Patient Observation]	2	27 July 2015
Participant information sheet [Carer/Consultee - Interview]	1	27 July 2015
Participant consent form [Patients, SWs and HCPs - Observation]	2	27 July 2015
Participant consent form [SWs and HCPs - Interview]	2	27 July 2015
Participant consent form [Consultee Declaration Form - Patient Observation]	1	27 July 2015
Participant consent form [Carer/Consultee - Interview]	1	27 July 2015
Interview schedules or topic guides for participants [Interview Schedules]	1	10 June 2015
Letter from sponsor [Sponsorship Confirmation]	-	22 May 2015
Summary CV for Chief Investigator /student [Dan Burrows CV]	-	-
Summary CV for supervisor [Supervisor CV]	-	-
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Cardiff University Insurance]	1	10 June 2015
Other [Response to request for further information]	1	27 July 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/WA/0257	Please quote this number on all correspondence

Yours sincerely

Rossela Roberts

Dr Philip Wayman White, MBChB, FRCGP
Chair
E-mail: rossela.roberts@wales.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

SL-AR2 After ethical
review - research oth

Copy:

Sponsor: Dr Kathy Pittard-Davies
                c/o: Mrs Helen Falconer
                Research and Innovation Services
                30-36 Newport Road
                Cardiff, CF24 0DE   resgov@cardiff.ac.uk

Academic Supervisor: Professor Jonathan Scourfield
                Glamorgan Building
                King Edward VII Avenue
                Cardiff , CF23 9AF   scourfield@cardiff.ac.uk