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# What Constitutes Successful Joint Working with Social Work? A Study of Integrated Practice in Supporting Older People with Care and Support Needs

RESEARCH

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## ABSTRACT

**Context:** While the integration of health and social care services in England has been a long-term policy aspiration, the role and contribution of social workers to joined-up working has received little attention.

**Objective(s):** This paper aims to examine what constitutes successful joint working between social care and health care practitioners, from the perspectives of social workers and others working across integrated and multi-disciplinary teams. Findings are from a multi-method study examining the role and contribution of social work to older people's wellbeing.

**Method(s):** Through interviews and observations across two local authorities, we gathered the views and experiences of older people (aged 65+) with care and support needs and those of their carers, the social workers supporting them, and other health and social care colleagues involved.

**Findings:** We present three themes: (1) integrated teams valuing of social workers' knowledge, approaches, and skills; (2) the ways in which social workers navigate the divides between health and social care; and (3) the impact of organisational structures on joint working. Social work input is a valued piece of the integration puzzle as other professionals value: their person-centred stance; skills in advocating for older people's autonomy; knowledge of social care law; and application of therapeutic and communication skills.

**Limitations:** Sample groups are self-selected, which led to the sample being skewed towards more experienced social workers who were confident to talk about their practice.

**Implications:** More attention is needed in enhancing continuity in social work allocation and improving mutual learning environments for social and health care professionals.

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## INTRODUCTION

In England, despite their disparate funding systems, the integration of health and social care services has been a long-term policy aspiration. More recently, this has led to the creation of integrated care systems (ICSs) with area-based oversight boards (Gowar *et al.*, 2024). Promoting 'integration, cooperation and partnership' between health and social care services became a legal duty under the Care Act 2014. A UK Government White Paper defines successful integration as 'the planning, commissioning and delivery of coordinated, joined-up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole' (Department of Health and Social Care, 2022, para. 1.8).

The problems and challenges of integrating health and social care services are long-documented (see Cameron *et al.*, 2013; Miller, Glasby and Dickinson, 2021; Thomson and Chatterjee, 2024), and include ambiguity about roles, responsibilities, and boundaries and organisational differences across budgets, funding streams, and operations. What is less understood is the role and contribution of social work to integrated working. In England (alongside other UK nations), social work is a legally protected title with its own regulatory body and membership-based association. However, social work with older people ('gerontological social work') has arguably held a lower professional status in comparison to other practice fields (such as child and family social work) both locally and internationally (Lymbery, 2005; Seppänen and Ray, 2022). What social workers do in everyday practice with older people, and specifically their impact on older people's lives, has often been opaque in social care research (Tanner *et al.*, 2025). Typically, social workers in England are employed by local authorities and placed within community 'locality'-based teams that support adults with care and support needs within geographical boundaries or within health care settings, such as hospitals, alongside health care professionals.

ICSs have existed since 2016 in England and became legally established, with statutory duties to improve people's lives, under the Health and Care Act 2022 (Department of Health and Social Care, 2023). At a service level, ICSs are 'partnerships of organisations that come together to plan and deliver joined up health and care services' (Department of Health and Social Care, 2023). International literature on ICSs highlights the variety of roles social workers undertake across different health care settings, including behavioural interventions, care assessments and coordination, and hospital discharge processes (Milano *et al.*, 2022). In a review of integrated care approaches for older people spanning the US and Europe, Briggs *et al.* (2018) found that most integrated care models comprised: (1) multi-disciplinary teams, (2) comprehensive assessment, and (3) case management. The most frequently represented service providers within these models were health care professionals such as nurses, physiotherapists, general practitioners, and social workers. Importantly, this review highlighted a limited focus on person-centred approaches to planning and delivery, although a more recent review suggests the delivery of person-centred care is a focal point for integrated services (Thomson and Chatterjee, 2024).

In this paper, we examine what constitutes successful joint working between social and health care practitioners and other professionals. We present qualitative findings from a two-year study examining the role and contribution of social work to older people's wellbeing (and the wellbeing of carers). Here, we concentrate on the perspectives of social workers employed by English local authorities who work alongside other professionals to support older people with care and support needs. In the UK, local authorities are the primary providers of social care assessments and care coordination. We use the term 'joint working' to refer to shared professional decision-making about older people's care needs and planning, and we address the question: 'how do social workers interact with other professionals and agencies' (referred to here as 'others')? Joint working between health and social care professionals has been a long-term feature of delivering person-centred services to people in the community and existed prior to the integration of teams and services (Thomson and Chatterjee, 2024).

## METHODS

### STUDY DESIGN

We adopted a qualitative, multi-method, and practice-near approach to enable the research team to get as close as possible to the day-to-day frontline realities of social work practice. 'Practice-near' enquiry utilises methods that bring researchers close to direct, day-to-day practice that often involves contact with people providing services and those receiving them (Archard and O'Reilly, 2024). Observations and semi-structured interviews were the most appropriate methods to help achieve this. Through purposive sampling, 10 social workers were recruited from two contrasting local authorities: a densely populated, ethnically diverse, and mostly urban municipality (Site A), and a geographically larger, mostly rural county (Site B) with a predominantly White population (96%). In each local authority, semi-structured interviews and observations were conducted with social workers (10), older people and carers (17), and other workers (24). All social workers were currently employed in adult teams and mainly working with older people with care and support needs – a key criterion for study inclusion.

Social worker participants were recruited via online information sessions and initial interviews and were

invited to take part if at least 50% of their typical practice was with people aged 65+. This was followed by selective sampling, whereby participating social workers identified older people and carers with whom they were currently working as potential participants and invited them to take part. We asked each participating social worker to identify suitable older people and their carers from their list of current clients – suitable in terms of meeting our participation criteria of being 65+ years, having care and support needs and receiving social work support. Social workers effectively screened out clients they deemed as 'unsuitable', such as those currently experiencing crisis situations, receiving end-of-life care, or recently bereaved. We had little control over which clients were selected and approached by social workers as our gatekeepers; however, this was the best approach in terms of maintaining client confidentiality and ensuring we did not have access to restricted personal data. Concurrently, as we followed the social workers in practice, we recruited other professionals who were also engaged with the same older people (Table 1).

## SAMPLING

From the 10 participating social workers, eight were women, with a range of experience from newly qualified to very experienced. In the rural site, participants were White British. In the urban site, participants were from various ethnic minoritised groups, reflecting wider heterogeneity in the local population. The study was designed to have access to at least two older people and/or carers allocated to each social worker (maximum 12 in each site).

Overall, we gathered detailed 'clusters' of data centred around 17 older people with care and support needs. We sought to include both the perspectives of older people and their carers in the study while recognising that some participants may be both an older person with their own care needs *and* a carer. We sought diversity within sample groups across factors such as minority ethnic background and rural living, and included both men and women. The aim was to collect data across the period of social work contact and intervention, with several observations, recordings, and/or interviews centred around the same older person and their carer. Due to variable factors in each situation, it was not always logistically possible, or ethically appropriate, to follow the entirety of an older person's social work experience. Best efforts were made to collect data regarding both initial objectives and post hoc accounts of the social work interaction and its impact.

## ETHICAL REQUIREMENTS

The study received ethical approval from the Health Research Authority Social Care Research Ethics Committee, England (REC reference: 22/IEC08/0004).

| ROLE IN SITE A | LINKED TO SOCIAL WORKER |
|---|---|
| Principal Social Worker | All Site A |
| Integrated Care Services Manager | Denis and Victoria |
| Advanced Practitioner | Denis |
| Team Manager | Raymond |
| Agency Social Worker | Immy |
| Occupational Therapist | Immy |
| Team Manager | Immy |
| Occupational Therapist | Ladybird |
| Consultant Psychiatrist | Ladybird |
| Community Psychiatric Care Coordinator | Ladybird |
| Community Psychiatric Nurse | Ladybird |
| Integrated Care Services Mental Health Nurse | Victoria |
| **ROLE IN SITE B** | **LINKED TO SOCIAL WORKER** |
| Principal Social Worker | All Site B |
| Locality Manager 1 | Bernice, Maria, Olwen |
| Locality Manager 2 | Sarah, Joe |
| Community Agent | Bernice |
| Intermediate Care Discharge Coordinator | Bernice |
| Continuing Health Care Nurse Assessor | Maria |
| Fast Track Continuing Health Care Nurse Assessor | Maria |
| Registered Care Home Manager | Olwen |
| Carers' Assessment Worker | Olwen |
| Advanced Practitioner | Olwen |
| Care Home Supervisor | Sarah |
| Adult Social Care Practitioner | Joe |

**Table 1** Other professionals, practitioners, and manager participants ($n$ = 24).

Informed consent was sought for all participation routes (interview, observation, and sharing of case files), and participants could withhold consent for any of these three. Separate informed consent was sought for access to older people's case files, which were anonymised by the relevant social care team before being shared with the research team (for more information about this, see Tanner *et al.*, 2025). If the social worker advised that an older person did not have the mental capacity to consent to take part, consultees (primarily family carers, partners, and spouses) were asked to advise about the person's likely wishes in respect of participation. Family or friends who were involved in supporting the older person were

invited to take part in their own right, alongside any role as consultee.

### DATA ANALYSIS

Interview and observational data were analysed thematically using the framework approach outlined by Gale *et al*. (2013) and NatCen Social Research (2018). Three separate frameworks were developed for charting and coding data: (1) social worker's roles and tasks, based on Capabilities for Social Workers who work with Older People (BASW, 2018); (2) older people's outcomes, based on wellbeing outcomes specified in the Statutory Guidance for the Care Act 2014 (Department of Health and Social Care, 2023); and (3) contextual factors, generated from the literature on social care in the UK and through discussion with site leads. Each framework had scope for the addition of new codes for data that could not be accommodated within existing codes. Frameworks were created and maintained through NVivo data management software. For the topic of integrated working, the research team identified relevant thematic categories from across the three frameworks – particularly Frameworks 2 and 3. Relevant categories and summarised data within these were compared side by side in an Excel matrix and similarities and differences in data were identified. Core themes were generated that conveyed participants' experiences and perceptions, and helped illuminate intersecting factors across social work capabilities, contexts, and wellbeing outcomes. Below, we present findings about joint working across three key themes. Data extracts are anonymised through pseudonyms.

## FINDINGS

### THEME 1: INTEGRATED TEAMS VALUING SOCIAL WORKERS' KNOWLEDGE, APPROACH, AND SKILLS

Social workers were recognised as having distinct knowledge of social care law, welfare and financial matters, the workings of health and social care systems, and available local resources. Other practitioners and managers valued the contribution social workers made to shared decision-making and planning processes:

> Adult Social Care are key to any person's discharge. They are very knowledgeable. They know things that not a lot of people know… When patients are able to go home, they know what support is available, and they bring that to light here when discussing discharge plans… If you were to take Adult Social Care out of the equation, I think the whole system would just collapse. They are key to ensuring that patients are safe, patients stay out of the acute hospitals. (Discharge Coordinator, Site B)

This coordinator points to the significance of social care input for both enhancing patient safety and avoiding health care 'system collapse'. This response aligns with their own role's focus on arranging patient discharge from the hospital. However, emphasis is given to the importance of bringing local knowledge of support available in the wider community – suggesting that social workers bridge the gap between the individual's immediate needs and community-based resources. Other participants (in hospital-based roles) underscored the legal knowledge that social workers brought to patient discussions, particularly regarding rights under social care law and the legal principles underpinning joint decision-making.

Social workers sought to keep the older person and their wishes at the heart of care planning. A health care colleague gave an example of how a social worker in their team had remained person-centred while managing a conflict between hospital staff and the older person's family. This, together with the social worker's honesty and leadership skills, were seen as pivotal in the achievement of a positive outcome from a discharge planning meeting involving both the older person and her family.

> [The social worker] was very good and very firm but professional with the family. She kept bringing it back to the fact that it was about this patient. She made it all about her and asked her what she wanted. She looked into her eyes when she was talking to her and she was very, very positive at engaging with her. As a result we've come up with a plan for discharge… It was key that she was open and honest, and she ran that meeting. (Discharge co-ordinator, Site B)

Interestingly, the above coordinator highlights the social worker's honesty and transparency with the older person. Arguably, this should be expected from any patient-focused professional; however, it may be that the time (and the communication skills) dedicated to providing this degree of openness is seen more in the social work domain than in other roles.

Part of the work of keeping older people at the centre of care provision was being prepared to stand firm when the older person's wishes were being overlooked. Social workers are not independent of the organisations that employ them, but in their role they sought to uphold older people›s wishes and challenged negative or unhelpful assumptions:

> She would be prepared to rock the boat… If she felt that something was wrong, she would say

> it, and she wouldn't just, sort of, toe the line. (Continuing Health Care Nurse, Site B)

Social workers were also perceived as being highly skilled in communicating, particularly when this involved facilitating sensitive conversations, and conveying values of empathy, respect, and positive regard in their practice. Within discharge meetings, other professionals observed the social worker slowing down the pace of communication so that the older person could follow a discussion about their wellbeing. Being person-centred involved being willing to work at the older person's pace.

> With Reg, we could have [said], "Well he doesn't want to move", and just closed the case. But I think [the social worker] wanted to be a support and said, "I'm just going to let them have a think and then I'm going to go back out." It is about sometimes working at that person's pace. (Occupational Therapist, Site A)

While expressing empathy is a generic therapeutic skill, social workers were frequently described as 'empathetic practitioners' by others. Likewise, social workers were valued for their capacity to recognise the wider societal contexts impacting on older people's wellbeing (e.g., poverty, social isolation, lack of suitable housing):

> I think social workers really add value because they think holistically. They're very much thinking about the context that somebody lives in. They're thinking about support networks and about social isolation and the impact of that, not about a diagnosis and a treatment plan. (Principal Social Worker, Site A)

This comment recognises social workers' holistic approach to supporting older people and their capacity to bring the social dimensions of an older person's wellbeing to the attention of others.

## THEME 2: NAVIGATING THE HEALTH AND SOCIAL CARE DIVIDE

Differences in culture and practice approach between health and social care staff were frequently noted by social workers working primarily in hospital settings. The observed 'divide' between health and social care practitioners generated tensions that complicated integrated working, as one social worker in an ICS hospital team explained:

> We're working to different pieces of legislation, different timescales. The medical model is very much fix it, put a plaster on it. We want to be more in-depth, to look at the root cause. We want to work with the person. We don't dispatch people and move them on... We want the person to have the time and to work with them to achieve all their outcomes at their pace. That's not really very achievable in this team ... To sum it all up, that's the difference between medical and social. We look at the reason for it, we don't look to fix it .... (Victoria, Site A)

Victoria emphasises the importance of time – giving time to the older person, a commodity that is perceived as often lacking in staff–patient interactions with health care professionals.

A hospital social worker in Site B acknowledged tensions between health and social care approaches. However, these tensions were not a barrier to challenging, and being challenged by, other members of the multi-disciplinary team:

> So I think as a team here we do challenge [senior doctors]. We are quite a cohesive team ... We know each other (and) I think we can challenge each other but [make] it not feel personal. Well, I don't take it personally if somebody challenges me, and I hope they don't. So I think we work well together as a team. (Bernice, Site B)

One researcher observed 'safe sparring' between a social worker and a medical professional in a multidisciplinary meeting about a patient's care and noted how the clinician expressed their appreciation for being able to have 'healthy debates' with colleagues.

Other social workers and occupational therapists (OTs) were less positive about points of disagreement and divergence in professional opinion and felt that health colleagues held them responsible for delayed hospital discharges.

> Literally as soon as somebody's medically fit, we try and get them [older patient] out. You can be accused of all kinds of things then, but actually it's for their own good... We can't [do anything until someone is declared medically fit] but the doctors don't get the blame... Yes, of course we're aware of the beds, and we're aware that people are sitting in ambulances waiting, but that's not the sole reason. This is the reason – because we can see the after-effects of somebody being left in bed for two, three weeks. (Victoria, Site A).

The desire to 'move people on' is partly because of the need to release hospital beds but also because social workers can see that remaining in hospital is not in an older person's best interests. Consequently, social workers felt they were sometimes the targets of blame from frustrated family members, even though decisions

were made by medical staff or jointly between clinicians and social workers.

## THEME 3: SMOOTH EDGES AND HARD LINES: THE IMPACT OF STRUCTURES AND PROCESSES ON JOINT WORKING

During the fieldwork, both sites were experiencing organisational changes in how services were delivered. Different degrees of integration of health and social work staff influenced other professionals' experiences of social work. In Site A, all aspects of practice concerned with hospital admission and discharge were dealt with by integrated teams. Members of management made considerable effort to stress to ICS staff that they were one service, whether employed by the health service or the local authority. There were different views about the extent to which this was achieved. Staff in Site A noted that being located as one service enabled what we position as the smooth edges between professional roles. Reported benefits included closer working relationships, more effective communication, completion of more holistic assessments, and faster processes.

However, a doctor in the ICS team felt there was still some way to go to achieve full integration, particularly with regard to the 'hard lines' around funding decisions and the separation of budgets:

> … In some cases, agree(ing) the funding as well might take some time. How much percentage is health and how much is social care? For that they have to have a few meetings. Because if somebody is in the hospital, social services are not spending from their budget on that person as long as they are in hospital. There is a tension there. (ICS Doctor, Site A)

One ICS manager (Site A) acknowledged several points of frustration with seeking to transition towards more integrated departments, one being the duplication across department structures, budgets, and processes, and another being the sustained professional hierarchies experienced between medical and social care professionals. Some of the locality teams in Site A included occupational therapists. They were easily contactable and made joint assessment visits with social workers. However, in a reverse move to integration, social work posts that used to be situated in mental health teams had been relocated to generic adult locality teams. A Community Psychiatric Nurse in Site A noted that this change had reduced the level of cohesive working between health and social care colleagues and caused delays in older people receiving social work support and loss of continuity of social worker:

> They were based with us, in our office, they sat in our team meetings, we had coffee with them. We knew them, they knew us, and you wouldn't have to make a phone call … and say, "I want to make a referral". You'd say, "Jim, will you pop out and see this fellow with me? This is what's happening." And you'd take him out. And he'd come, he'd have a look and he'd say, "Well, there's no role for us there," or, "Yes, we can look at doing this for you." There was no referral process as such. Now you speak to somebody on the phone… You never get any feedback. (Psychiatric Nurse, Site A)

The relocation of social workers to locality teams in Site A also raised issues relating to access to shared information, as separation brought with it different IT systems, which, for some, felt like a 'backwards' move.

In Site B, restructuring was underway to shift to a neighbourhood-based model to strengthen links with local services and community-based resources. Some social workers were still based in hospitals, though not in integrated teams. Health colleagues saw it as a major benefit to have social workers on site as they were more easily accessible, and communication was improved.

The aspects of social work that were viewed by other professionals as less helpful primarily reflected structures and processes, rather than the practice of individual social workers. Workforce shortages and turnover can mean a lack of continuity of social workers allocated to older people:

> You don't even build a professional relationship with somebody… I had a joint visit to review Susie's care last Friday. The social worker that was coming out to review isn't the social worker who did the placement. This is another bloke and then he phoned me up on the Thursday saying he wouldn't be able to visit on the Friday because he was leaving [his post]… That's the biggest thing, that relationship you've got with colleagues or professionals. … You'd build up that working relationship, that professional relationship where they respect you and you respect them. And straight away you're on a different footing. (Psychiatric Nurse, Site A)

The importance of continuity in social work allocation was a common theme across the study. In a similar vein, some older people we interviewed, particularly carers of people with dementia, expressed frustration at changes in social workers and having to rebuild relationships as well as other professionals working with social workers (Tanner *et al.*, 2025). In many ways, continuity was a more pronounced theme than the importance of being located with social works in the same team or department.

## DISCUSSION

The findings outlined above indicate a number of factors perceived by other professionals as conducive to successful joined-up working practices. Other studies of social work contributions to integrated working highlight how social work input can be invisible and the contribution ambiguous (Cootes, Heinsch and Brosnan, 2022). In contrast, our findings suggest that, from the viewpoint of health care and other professionals, social work input is a tangible and valued piece of the integration puzzle. These professionals value: the person-centred stance adopted by social workers; their skills in advocating for older people's autonomy; their knowledge of social care law; and their application of therapeutic and communication skills. The social perspective that social workers bring to multi-disciplinary discussions was also perceptible, as noted by others (Abendstern *et al.*, 2021, 2022; Power *et al.*, 2023).

Social workers in this study were pivotal bridging facilitators when conflict emerged between other professionals and older people and carers. This echoes findings from other studies in which the 'linking and bridging' capabilities of social workers across health care and social care services are regarded favourably by other professionals (Power *et al.*, 2023), including in community mental health teams (Tucker and Webber, 2021). Social workers are valued for their skills in advocating for older people's human rights, including challenging the clinical decision-making of other professionals (which, on occasions in our study, was welcomed by those challenged) (Burrows, 2022). This is particularly important in the context of an ageist society in which older people with acute health care needs are frequently represented as a growing burden on precious resources and lacking the autonomy to make decisions about their own well-being (Seppänen and Ray, 2022). In mental health teams, social workers are prepared to prioritise advocacy for service user's needs and preferences over relationships built with health care colleagues (Tucker, Jobling and Webber, 2024). In our study, we did not observe the need to compromise professional relationships. However, this may reflect our sample being skewed towards more experienced practitioners who have built up skills over time in challenging the professional views of others while maintaining good working relationships.

Relationship-based practice has grown in prominence in recent years as a model of social work practice that recognises the therapeutic skills social workers bring to relationships and to the ways in which they support people experiencing high degrees of risk, uncertainty, and anxieties about the future (Hingley-Jones and Ruch, 2016). Our findings show key relational skills valued by other professionals, including the ways in which social workers consider an older person's needs in their social and cultural context, adhere closely to the person's wishes, and help contain the anxiety older people and family carers experience during times of major life-change and transitions. This chimes with other discussions of the unique contributions of social workers to integrated working, in particular social workers bringing a rights-based approach through a social justice lens and foregrounding local community as a source of support and resources (Barr *et al.*, 2024). Our findings indicate that the social workers, sometimes supported by their (social work) managers, were adept at finding ways to circumvent, compensate for, or challenge discourses and practices that reflected this narrative. The relational skills that social workers bring to multi-disciplinary practice, including reassuring older people in times of uncertainty, adjusting the pace of decision-making to match their communication needs, and challenging the views of colleagues, indicate a form of practice that is complex, dynamic, and requiring skillful presence and attentiveness to the needs of others.

Within our findings, there are indications of how wider contextual factors impede successful joint working; it is frequently organisational processes and restricted resources (the hard lines) that get in the way of better joined-up working (Thomson and Chatterjee, 2024), rather than the skills and knowledge professionals bring to multi-disciplinary working. Top-down organisational processes put health and social care services out of kilter when coordinating care for older people experiencing poor or declining health. In the wider context, the under-funding of social care over the last 15 years has maintained its status as the 'poor relation' to the National Health Service in England (Atkins *et al.*, 2021; Miller, Glasby and Dickinson, 2021). While austerity measures have officially ended (according to the 2019–2024 UK government), the lack of resources and community-based services in the sector was a continued issue reported to us by participants. This has been further compounded by the impact of the COVID-19 global pandemic, which 'magnified a chronic lack of funding, staffing, support and regard for adult social care' (Owens *et al.*, 2024).

Structural and organisational barriers to successful joint working have been documented across other research on health and social care integration (Miller, Glasby and Dickinson, 2021; Thomson and Chatterjee, 2024). Prominent in our findings were the challenges of sharing information across different reporting systems and the lack of direct communication channels when health and social care colleagues are geographically and organisationally separated. Another reported barrier was perceived professional hierarchies between medical, health, and social care staff in relation to exercising power and legitimacy in hospital settings, a long-standing problem for social workers in medical settings (Steils, Moriarty and Manthorpe, 2021). Cootes, Heinsch and Brosnan (2022) position these hierarchies

as an epistemic issue where what counts as valid 'expert' knowledge between health care and social work professionals is disputed and biomedical perspectives are attributed higher value. A related problem in hospital social work is managing a continuing tension between meeting targets and expediting discharge and being an effective advocate and counsellor for older people and carers (Heenan and Birrell, 2019; Heenan, 2023). Our findings suggest that these problems can be reduced when social workers are well integrated and respected within multi-disciplinary teams.

Another barrier reported in our study was the lack of continuity in social worker allocation that impeded joint working. Other research supports the importance of continuity of relationships for positive patient experiences of integrated care (Henderson *et al.*, 2021); our findings highlight its significance for relationships with other professionals. This complements the perspectives of service users accessing integrated services who reinforce the importance of staff continuity in support, where trust and respect are valued in the relationship as part of receiving 'good' care (Henderson *et al.*, 2021). While a prominent theme, the current workforce realities for delivering adult social care services make this hard for employers and providers to achieve. Social workers also report valuing mobility in their career and trying out different roles (Cook, Carder and Zschlomler, 2022). At the time of fieldwork, the estimated turnover rate in the adult social care sector was 28.3%, and 16.1% for social work (Skills for Care, 2023). Although vacancy rates for adult social workers decreased from 2016/17 to 2020/21, there has since then been an increase to 9.4% in 2021/22 and to 11.4% in 2022/23 (Skills for Care, 2023). This is higher than for the adult social care sector as a whole (9.9%). This links to the importance of retaining experienced social workers to help mediate some of the impact of workforce churn.

It was notable that both study sites, integrated and not integrated, benefitted from experienced social workers who were well-embedded and respected within their teams. Learning from child and family social work suggests that experienced social workers have a well-developed sense of vocational identity and approach practice priorities as a moral imperative. However, this vocational commitment is often shaken when encountering organisational demands that interrupt their sense of 'identity work' (Cook, Carder and Zschlomler, 2022). Interrupting well-established teams through moves towards integration may bring a risk of losing experienced social workers. From our findings, it would seem that, at the level of frontline practice, it is the relationships that are pivotal with both service recipients and other professionals, rather than precise organisational structures. Moreover, it is the experienced social worker who is key to providing the focus on the older person's experience and on person-centred approaches to planning and delivery that is often limited within integrated systems (Briggs *et al.*, 2018). A final significant factor to note is the co-location of social workers with other professionals on the same sites – this facilitated communication, relationship-building, trust, and faster, more direct referrals. More attention is needed in future research on the role of co-location as an enabling factor for successful joined-up working.

### STUDY LIMITATIONS

The above findings are based on a self-selected group of social workers agreeing to have their practice observed over several months and to be interviewed multiple times. It is perhaps inevitable that this method results in more confident, experienced practitioners coming forward. This, combined with our explicit focus on learning from positive practice, means that we were less likely to encounter poor or unethical practice. While we were able to elicit interview accounts from older people receiving services, these numbers were limited and did not focus specifically on their experiences of integrated care or interprofessional working.

## CONCLUSION

Our findings reflect enablers and barriers to joint working with a distinct focus on the input of social workers as core members of integrated teams. Based on the findings, there are several notable implications for employers and organisational leaders. First, is the importance of employers (both in health care services and social services) prioritising the continuity of social workers allocated to older people – a barrier noted by both service recipients and by other professionals. Second, employers need to facilitate suitable learning spaces for health and social care colleagues to learn from each other in terms of knowledge and expertise, including understanding the value-based tensions between different models of care provision. Third, the importance of co-locating integrated services and the potential for improving interprofessional communication warrants further investigation. A final note is that critical debate between health care colleagues and social workers about care planning for older people can facilitate joint working rather than obstruct it. However, it is critical that social workers are valued as equal contributors to decisions about older people's care and that all professionals are receptive to shared appraisal of decision-making. This requires further shifts in the cultures of integrated teams to help dismantle professional hierarchies.

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## COMPETING INTERESTS

The authors have no competing interests to declare.

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