Series 3 Episode 3

“Hospital social workers are very strong advocates for the rights of older people”: Working with older people in a hospital setting. A conversation with Carrie Phillips

[00:00:00] **Lesley:** Hello and welcome to the Portal Podcast, linking research and practice for social work. I'm your host and my name is Dr Lesley Deacon.

[00:00:13] **Sarah:** And I'm your other host and I'm Dr Sarah Lonbay. So we hope you enjoy today's episode.

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Introduction

[00:00:19] **Sarah:** Hello everyone, you're listening to the Portal Podcast. Today we have with us Carrie, who has come onto the show to talk about some research that she's been doing. And I'll let you introduce yourself quickly, Carrie.

[00:00:39] **Carrie:** Thank you. Yeah, I'm Carrie Phillips, I'm a senior lecturer at the University of Sunderland, and former social worker working with older people. But today I'm going to talk about my ongoing PhD research and initial findings.

[00:00:54] **Sarah:** Thank you, Carrie, and welcome. Just to start off, we'll kind of ease into the chat and get into the details of your research in a bit. But to begin with, can you give us a little bit of background to your work about older people and with older people? And also how you became interested in this topic and this area of work?

[00:01:11] **Carrie:** Yeah, so I didn't actually start out looking specifically at the experiences of older people. So my research is about social work in NHS hospitals, because there is not so much research out there about the work that social workers do in acute hospital settings. But almost by default, that

encompasses a lot of work with older people because of, you know, the population that are admitted to hospital. I think it's about 43 percent of inpatients in acute hospitals are over the age of 65, even though they make up only 19 percent of the population. So there's a lot of overlap, social work in the hospital, social work with older people.

[00:01:59] **Sarah:** Okay, thank you. And I think I'd like to unpick some of those figures a bit more with you if that's all right, because over 65 is quite a broad group as well, and...

[00:02:07] **Carrie:** Yes, yeah, I think basically the older a person gets, the more... it's tricky with statistics because, on paper it looks like the older you get the more likely you are to be admitted to hospital, but actually in reality it's a *small* number of older people who are *frequently* admitted, and particularly towards the end of life. So the last year of life tends to be when people experience recurring admission to hospital.

[00:02:40] **Lesley:** So they don't tend to show that as clearly in the statistics, that it's just you're an older person and therefore this is what will happen.

[00:02:47] **Sarah:** And actually it's really important to unpick that because we get a lot of these headlines around "bed blockers" and other awful terms that are used, and there's an assumption that as you age you're inherently going to be frail and weak and unwell and be coming in and out of hospital. So it's good to interrogate those statistics and look at the real picture. I think, I really want to get into this and hear more about your work, but I want to take you back a little bit further before we do. How did you become interested in the first place in, I know that you mentioned with the research you didn't set out to look at the experiences of older people, but you mentioned before you started working at the University of Sunderland, you worked in an older person's team. So I'm wondering how that interest came about in the first place?

[00:03:29] **Carrie:** Yeah, so it's kind of a story of restructuring of local authorities, as it often is.

[00:03:36] **Lesley:** There's always a restructure.

At what age are you older?

[00:03:39] **Carrie:** So, pretty much as soon as I qualified as a social worker in 2006, I started working with younger people, younger physically disabled people, and particularly people with long-term health difficulties or neurological conditions. And that distinction, I mean I want to come back to that distinction between working age and older age, but basically I worked in that team for a lot of years until we were restructured and the specialism of physical disability was kind of got rid of, and we were re-dispersed amongst what were called "community teams". But the vast majority of the work that came through those teams was people over the age of 65, particularly, again, we use 65 as that "older" age, which is very arbitrary because a lot of people can reach their 80s or 90s in relatively good health; I've also worked with people in their early 70s who've had numerous complex health conditions. And just looking at a person's age tells you such a tiny part of the story.

[00:04:54] **Sarah:** Yeah. It's almost like we shouldn't rely on age to make any decisions about teams that people should be put into, or where they need to be.

[00:05:01] **Carrie:** No. And it always amused me slightly that the pension age changed, and so some of my colleagues in the working-age physical disability team, you know, people would, it's a horrible term, but "age out" of that service at 65, but some of my colleagues were older than 65, so it was almost like this...

[00:05:18] **Sarah:** Yeah, it's quite arbitrary isn't it, that age?

[00:05:21] **Carrie:** Definitely.

[00:05:21] **Sarah:** You know, like you say, it was, I think, originally linked to retirement ages, but those have changed quite significantly.

[00:05:28] **Carrie:** Yeah, definitely.

[00:05:31] **Lesley:** I found out that I'm an older person now. That was good news for me.

[00:05:34] **Sarah:** Are you?

[00:05:35] **Carrie:** Yes. You start getting adverts for Saga and Age UK, don't you, at age 50?

[00:05:40] **Lesley:** Yeah, they're taking from 50.

[00:05:41] **Sarah:** Oh, okay. Well, some researchers do take it from 50.

[00:05:45] **Lesley:** It's a joy. It was nice to find.

[00:05:48] **Sarah:** But it's meaningless, really, because every piece of research you look at that looks at older people seems to take a different age for different reasons.

[00:05:54] **Lesley:** That's why I like to ask, because they say, "what's your definition of what older is?" Because it's so different.

[00:06:00] **Carrie:** It is, and it's so... I think we have a very capitalist view of older age in the UK, so in different cultures age, older age, is absolutely *nothing* to do with how chronologically old you are, it's whether you can fulfill your social responsibilities and obligations. So it's your role in the family, it's your role with work, it's not "are you over 50?" "Are you over 65, 80?" You know, those are kind of boundaries I think we put in based on how economically valuable you are.

[00:06:33] **Sarah:** Yeah, I very much agree with that. Do you think there's any point in keeping this category of "older people"?

[00:06:40] **Lesley:** Oh, that's quite a *big* question!

[00:06:43] **Carrie:** It's difficult because I think when we're talking about health, there are certain things that are biologically intrinsically associated with your chronological age. So, for example, dementia, the risk of stroke, all that kind of thing, they *can* affect people at a younger age, but they tend not to. And so in that sense, I think having some degree of specialism, particularly around things like dementia and, yeah even saying "dementia", that covers such a huge range of things. So I do think that's useful, but I don't know whether labelling it "older age" is as useful as saying, you know, you might specialise in dementia care, or you might specialise in physical disability, which can *encompass* people over the age of 65, who've maybe had a stroke or something like that.

[00:07:40] **Sarah:** It's an interesting question because I suppose the other side of that is we live in a society with really rampant ageism, don't we? And if we say we're not going to think about older people as a category, that ageism isn't

just going to go away. So how do we then champion older people's rights? So I think, yeah I don't think there's an answer to that but I just thought I'd chuck that question at you just because I was interested to see what you thought.

[00:08:04] **Carrie:** There isn't, and I think it's like anything, categories are arbitrary, you know, we talk about, for example, learning disabilities, well who decided an IQ of 70 is the cut-off for a learning disability? You know, I've definitely worked with people who've had difficulties negotiating life, but *clinically* speaking they don't have a learning disability. I think it's the same with age. Like I said just before, you can be what I would perceive as "old" in your 70s, or you can be "young" in your 90s.

[00:08:40] **Lesley:** Yeah. I suppose it's because the issue is with some of the services that are quite generic it's difficult to then see that actually there are specifics within that, and that's some of the challenges I think across the board in social work, that you have complex issues but you're expecting a generic practitioner to be able to know exactly what to do, and that's why we need training and things like that constantly! CPD. Just thought I'd throw that one in there.

[00:09:08] **Carrie:** But just the spectrum of older age as well, we used to joke when I was in practice, you know, "I'll probably get put in a care home and they'll play Take That because that's what my generation likes.

[00:09:19] **Lesley:** Yes! I wonder what we'll be wearing.

[00:09:21] **Sarah:** Take That, would that be a bad thing for you?

[00:09:24] **Carrie:** It would be my favourite.

[00:09:27] **Lesley:** I do wonder that, because you think about, when I was younger, thinking about older people, and I think about my grandma, and I think about my grandma with her perm, with a bit of a rinse in it, and the housecoat. Women at the time used to wear housecoats. And that's gone. So what will we be wearing? Will jeans and leggings be like so out of it? That, you know.

[00:09:50] **Carrie:** Yeah, my Nana had like, you know, the floral dress and the perm, went to church on Sundays and then my Gran was cool because she wore tracksuits and played tennis.

[00:10:02] **Lesley:** I like it, I like it.

[00:10:03] **Carrie:** But they were the same age, so, you know.

[00:10:05] **Lesley:** It is different, isn't it? Yeah.

[00:10:08] **Sarah:** We should probably talk a bit about your research.

[00:10:10] **Lesley:** Yes, about research. Because I feel like, obviously, I know your research quite well now.

[00:10:17] **Carrie:** Yes.

[00:10:18] **Lesley:** Because, just for the listeners, I am your PhD supervisor. And it's an honour, it is. But I feel like it would be good to explain how, through the research that you've done, how you've got to this, what you're going to share with us today, how that's come out of your PhD. Maybe explain a little bit about what you're doing?

Hospital social work and Carrie's PhD research

[00:10:41] **Carrie:** Yeah. So I have collected three sets of data, so first of all it was looking at trying to gather figures about how many social workers actually work in acute hospitals, because that was unknown. And through freedom of information requests, I haven't got perfect numbers for that, but certainly some number, about the number of social workers working in acute hospitals. But the bit that's interesting for today, hopefully, is, I did some interviews with staff from hospital social work teams across two local authorities, and also did an online survey that was answered by social workers and other people, so managers, wellbeing officers, people who worked in various hospital social work type roles across the UK. So that's what I've done, I think I've ended up with 108 participants overall, so quite a broad range of views, but some really strong common themes have come out. And I think the ones that are particularly about older age, one of them is about resources and how we provide for people who need support as they get older - or don't. And the other one is about ageism, so the fact that the people I spoke to, or who did the survey, very much challenged ageism in a lot of ways, but also replicated some of the assumptions or language that perpetuates ageism. I thought that was a really interesting tension that on the one hand I think that hospital social workers are a *very* strong advocate for the rights of older people, but at the

same time sometimes it's coming from a bit of a paternalistic, protective approach rather than a rights-based approach.

To empower or to protect?

[00:12:40] **Lesley:** That sort of complexity of care as a sort of control element, and where does that kind of fit?

[00:12:48] **Carrie:** Yeah, and it's that tension of empowerment and protection that can be very challenging to balance, and I kind of saw that in the stories that the social workers were telling me about the work that they do.

[00:13:05] **Lesley:** Do you remember what the, what kind of, you might not have it to hand, we'll put links to things, because you've done a public lecture on this, haven't you? So we can put a link in across to that, which would be really helpful. But I remember that you mentioned some of the little examples of words that social workers had used that you could see, well hang on... do you remember any of them off hand, or have I just put you on the spot?

[00:13:31] **Carrie:** Yeah, so they would talk about things like, "oh I worked with this very sweet old lady", or "I worked with a gentleman who needed to get home to his wee wife", you know, and it wasn't derogatory, but it was kind of patronising sometimes.

[00:13:49] **Sarah:** A bit infantilising, that kind of language.

[00:13:53] **Carrie:** And I find it quite, almost difficult to talk about because as a researcher I have to put across that my strong, strong impression of these people was how good a job they were doing and how this was coming definitely from a place of caring and feeling these people really mattered and that their relationships and their stories really mattered. But at the same time there was kind of "Oh, all the people are sweet and they need protecting and we need to look after them". And also the generalisations about the reasons people come into hospital. So some generalisations about older people don't put the heating on, so they come in with hypothermia, they don't want to ask for help, they're fiercely independent, you know, and again these are not necessarily *negative* things to be saying, but it all paints this picture of, it's almost an "us and them".

[00:14:54] **Lesley:** Yeah, and I can see the conflict in you, because when you do research as well, as you know, your background is you're a social worker, and you have a lot of passion for the profession and for what social workers do and acknowledging that. And it's not about challenging it and questioning that, it's just about looking and thinking, ah, maybe we could look at some of this, and the way we talk about things, that maybe there *is* some element of reinforcing that because intention and effect are not necessarily aligned in the way that we want it to be. I think that's an important thing, as practitioners doing research, that it's that conflict between wanting to validate your profession and your colleagues in that, even if you don't work with them, but as a profession, but also the fact that we *do* need to look at these things and look at the sort of generalisations and think, well, hang on a minute, is that demonstrating respect of the autonomy of these individuals that they're working with? And that's something you're kind of almost going through at the moment, isn't it?

[00:16:01] **Carrie:** Yes. Yeah, definitely.

[00:16:04] **Sarah:** It's interesting what you said that the kinds of ageist comments that you picked up on would sort of be seen as "positive ageism" if you like, and I wonder if that, you know, people feel quite comfortable sharing those things and perhaps don't realise what kind of narrative they're feeding into by using that kind of language. Do you think there's an education aspect to this around ageism and the language we use?

[00:16:30] **Carrie:** Potentially. I almost feel like there's different stages of ageism. Does that make sense? So you've got the negative, and I didn't hear any of this in my research, but you hear the negative about, oh, older people are a burden on society, they cost money, resources, you know, "bed blocking", all that kind of thing. And then you've almost got the, I've seen it called benevolent ageism, but that kind of patronising or devaluing language that comes from a caring place, that protectionism, that's, you know, it's not on the same level as the negative stuff, but it's damaging in a different way. And yeah, I think just having that awareness of how we think about the people that we support is important.

[00:17:35] **Lesley:** Yeah.

[00:17:38] **Sarah:** Did you get any sense of whether or how these things played out in practice? Was there any impact that you picked up on from that in terms of how people practiced and did their work with older people?

[00:17:53] **Carrie:** I think what came across more strongly was challenging ageism from other professionals or other organisations. So there were some really strong and passionate stories about almost standing up to assumptions. Falls, falling over, was one of the big things that actually a lot of participants talked about. And the fact that a lot of older people in acute hospitals are there because they've fallen over and injured themselves, you know, broken hip or whatever. But what the social workers were then telling me was that assumptions were made about the person's quality of life or the circumstances that had led to them falling over. And one social worker actually said to me, "Oh, well some doctors think that a fall equals going into a care home. You know, that's it, that's the end of your independence if you've fractured your hip. And the social workers spoke very strongly about *challenging* that and saying, well you know, anybody could fall over. It's that there's a biological fact about the fact that if you have osteoporosis or you have poor balance, you're more likely to fall, you're more likely to be injured as a result of that, but that doesn't mean the person wasn't independent and autonomous before that injury. And it doesn't mean that they can't benefit from rehabilitation and support from, say, physiotherapy and social work to get back home.

[00:19:31] **Lesley:** Because that's something that you saw in the way social workers were perceiving things, weren't you, the past, present, future.

[00:19:39] **Carrie:** Definitely.

[00:19:40] **Lesley:** That they were seeing this sort of *whole* of a person not just "that equals that", as you just said with the doctors, "they're going into a home" kind of thing.

[00:19:49] **Carrie:** Yeah, and I think it's again tricky because you can't generalise about, you know, healthcare professionals do this, clinical colleagues do that, but there was a definite sense that an acute hospital, its function is *now*, it's what's happening *now*, it's what is clinically, biologically wrong with a person? How far can we fix it? We've fixed it as best we can, out you go. Whereas the social workers felt they took quite a, *they* felt it was quite a unique perspective, of thinking about okay, so what was happening for this person in the months, years even, *before* the admission and what's going to

happen to them afterwards? And bringing that into the multidisciplinary team and saying well actually this is a person with a family, with a life, with a home, this isn't just about their broken hip.

[00:20:43] **Sarah:** Yeah.

[00:20:44] **Carrie:** It's about all of that

[00:20:45] **Sarah:** And that role that they bring, with that past, present, future, getting to know the person, is really crucial in challenging any ageism in the system as well, because it brings that whole person into the room, as you say, not just a fractured hip, but a person with a history and a future that needs to be thought about. So that sounds like a really powerful role that they had in those settings.

[00:21:08] **Carrie:** Yeah. And it's something that I've not seen talked about that much, that sort of temporal link. I think there's strong evidence already that social workers form almost like a physical link. So hospital's a strange place. It's almost like, you know, I mean, full disclosure, I've had a fairly long physical health admission myself, and it's almost like you follow the rules, and time passes differently, and it's very insulated from the outside world. And social workers are, because they're not employed by the NHS a lot of the time, and they're thinking about this, you know, "what's the person's family, what's the person's home like", all of that kind of thing, forming that physical link between the community and the hospital, and bringing the outside in to the institution.

[00:22:06] **Lesley:** Yeah.

[00:22:06] **Carrie:** And what I think is I can expand on that, is that they also do that in a *time* sense, in a temporal sense, as well as a location sense.

Working remotely versus being based in the hospital

[00:22:17] **Lesley:** I think you've really hit on the value of what they're doing and how important it is to have that, because obviously you did all your research during, it was just after COVID?

[00:22:28] **Carrie:** It was. Yes.

[00:22:29] **Lesley:** Yeah, so you've got people reflecting on what happened, and they ended up being moved out of hospital settings, largely, haven't they? Is that right?

[00:22:40] **Carrie:** I think there's quite a mixture of responses. So, in terms of interviews I spoke to two teams. So one team was still physically based in the hospital. The other team had been moved out of their hospital office into, well, they'd been working from home during lockdowns, and when I spoke to them they were working from local authority offices. And the difference, there was no difference in terms of the work they did, the value, how they talked about people, all that kind of thing. But the difference was about how they felt they belonged in the hospital, but also how difficult it can be to do your work as an outsider, because if you're working with somebody to, for example, assess their capacity to make a decision about going home or not, it's not often realistic to do that in one visit. Or certainly not realistic to do it over the phone or a video call. But that's what social workers were being told to do. Whereas if you're based in the hospital, one participant told me about, well, she'd pop up like twice a day over the course of three days to see how consistent this person was, were they remembering what had happened? You know.

[00:24:00] **Sarah:** It's much more robust and meaningful isn't it, to do it that way?

[00:24:04] **Carrie:** Absolutely, yeah. And it probably took her about the same amount of time.

[00:24:08] **Lesley:** Yeah, but was able to spread it out.

[00:24:11] **Carrie:** Revisiting it gives a much more comprehensive picture than sitting with a person intensely for an hour and expecting them to be able to engage with that assessment.

[00:24:22] **Sarah:** Yeah, yeah, especially online as well, it's very hard to connect in lots of ways when you're just online.

[00:24:29] **Carrie:** Definitely.

[00:24:29] **Sarah:** You don't get that same sense of the person when you meet them online, do you?

[00:24:33] **Carrie:** No.

[00:24:35] **Sarah:** I'm just wondering, did you, I think I know the answer to this already, you didn't involve any older people directly in the research? Your participants were all practitioners, weren't they?

[00:24:45] **Carrie:** Yes, they were all practitioners. I would love to take this a step further though, once I'm finished, and speak to some people who've been in hospital, or even *are* in hospital. I think, again, one of the massive challenges with research is the ethics processes around speaking to people who are in institutional care, whether that's care home or acute hospital. But I'd love to try because...

[00:25:11] **Sarah:** It's certainly manageable. But yeah, it'd be great to see you doing that work and to come back speak to us if you do that follow-on research.

[00:25:20] **Carrie:** Yeah, I will.

[00:25:21] **Lesley:** And then you can be our favourite. If you come back three times.

Challenges in the research

[00:25:28] **Sarah:** I'm just wondering then, in terms of the research and the journey that you've been on doing this PhD, what challenges have you experienced and how did you address them?

[00:25:38] **Carrie:** I think one of the big challenges was recruiting local authorities. So initially I wanted to speak to two local authorities. So it's really complex the way that the NHS is set up and local authorities are set up. Their borders don't necessarily match, and often you'll get one kind of hospital trust area that has a number of local authorities in it. And I wanted to try and get two local authorities from the same trust to see if different local authorities experience that organisation differently. It turns out that wasn't possible because gatekeepers felt that their team didn't have the time to speak to me, or whatever. So that was one of the challenges. But actually I found that, in both cases I went along to a team meeting, for the hospital social work teams, and explained, just did a ten minute pitch, this is what the literature says, this is what I would like to talk to you about. And also I see myself as a partial

insider, because these were not my colleagues, I've never worked for either local authority that I spoke to, but I was able to say to them, "but I know *some* of what you do, and I understand the legislation you're working in, the organisational structures you're working in, and I want you to tell me about your day-to-day. And I found people were quite receptive to that.

The day-to-day work of a hospital social worker

[00:27:11] **Sarah:** Can you give us a snapshot of the day-to-day work of a hospital social worker then?

[00:27:17] **Carrie:** Yeah, sure. So one of the main things I asked in the survey was about how much time people spent on various tasks. And the thing that came out repeatedly as the most time-consuming, not necessarily the most important, but the most time-consuming bit was assessment and arranging services to discharge people from hospital. Now I think that's a real strength of hospital social work, so it's doing assessments under the Care Act, under the Mental Capacity Act, arranging services, helping people move on from hospital. But it's also one of the *risks,* because legislation is changing, there's a real push towards "discharge to assess" models, so where people are discharged from hospital to, I guess what we would have called convalescence or rehabilitation settings, and then they're discharged either to home or long term care from there. I think my worry is that without that time-consuming part of the job that might move outside of the acute hospital, but it takes away all of the the input that social workers have in terms of the other bits that they do, so around safeguarding, around mental capacity. And a lot of participants felt that they were really, they didn't call themselves experts, but they were like the resident knowledgeable person about mental capacity, and often had to challenge clinical colleagues, who maybe had had less training or less understanding, about things like mental capacity. So they told me quite often that there'd be sweeping statements made about, "oh, this person has dementia, they lack capacity". Well, what the law says is that's not a thing, you lack capacity about a *specific* decision at the time that decision needs to be made. And it was the social workers saying, "what do you mean they lack capacity, capacity to decide what?"

[00:29:27] **Sarah:** So they would actually use that knowledge to challenge colleagues and make sure that things have been done properly?

[00:29:34] **Carrie:** Yeah. And while that wasn't a big part of their job time-wise, it's a big part of the job in terms of importance.

[00:29:41] **Sarah:** Yeah, the impact of that is massive, isn't it? Because that has consequences for that person's ability to make those decisions and have choice and control over what's happening. So that's, like you say, it might not take up a big time in their role, but yeah, hugely important.

[00:29:57] **Carrie:** Definitely.

[00:29:58] **Lesley:** Because I think that's a massive element about their ability to advocate on behalf. Because that advocacy element, I think, is really significant in that role, because they really are doing that in those environments. They're advocating for that person to get the best options moving forward. And that's really significant.

[00:30:19] **Carrie:** Yeah, and I think it's something that, you know, this isn't new in my research, but certainly something that people like my second supervisor, Dr Daniel Burrows at Cardiff University, he did an ethnography of the hospital social work team. And what he found was it's that separation of NHS and local authority that causes some of the barriers to joint working, but it also gives a lot of power in terms of social workers being advocates, because they're not within that hierarchy. And things have changed in the NHS, and it's not like consultants are untouchable and their word is law, but there is an expectation that, even like nurses' uniforms, the colour of them says how high up you are in the organisation, you know, "how dark blue is your tabard?" Whereas a social worker can come in and say, "well, I disagree with all of you". And it's almost like it's not a reflection on their membership of the organisation, because technically they're *not* a member of the organisation.

[00:31:27] **Sarah:** So they're, they're within it in some senses, but they're outside of it. So that gives them that position where they're able to challenge it in different ways. That's interesting, isn't it? So actually the way it's structured and set up is interesting and impacts on their role from the sounds of it.

[00:31:44] **Carrie:** Yeah, and I think what, again, it's another thing that worries me slightly, because as I say, this has come across in lots of other research, but also very much in the interviews and surveys I did, the fact that there are moves, you know, integration of health and social care is a big policy goal. And whilst that might have some advantages in terms of things like, I don't know,

funding and organisational structures and things like that, on the ground I'm not sure that that's actually a good thing.

[00:32:17] **Lesley:** Yeah. Like how do you maintain that independence of the social worker?

[00:32:21] **Carrie:** Yeah. If you're employed by the organisation you're challenging.

[00:32:26] **Lesley:** Yeah.

[00:32:28] **Sarah:** That's it. It's making me think about research that I did for my PhD, and it was that people talked about the IMCA role in a very similar way, or the advocacy role more broadly, but specifically IMCA is that, that independence.

[00:32:40] **Lesley:** What's IMCA?

[00:32:41] **Sarah:** Sorry, Independent Mental Capacity Advocates.

[00:32:44] **Lesley:** Thank you.

[00:32:45] **Sarah:** Sorry, Lesley, I shouldn't use acronyms, should I? And because of their independence, they are able to challenge and bring that different voice in a different way. That, you know, people might be constrained in doing that because of their role and their position within that system, as you say.

[00:33:04] **Carrie:** Definitely.

[00:33:05] **Sarah:** Yeah, that's interesting. I hadn't really considered that in terms of the integration of health and social care.

[00:33:10] **Lesley:** Yeah, because you do tend to just think, "oh yes, it's a good thing, it's a good thing", but that's a really fair point about that independence. And yeah, it's very different, to me, from Children's Services. I'm trying to contextualise it, and think is there examples of what that would play out like in Children's Services, and I don't know I can't think at the minute.

[00:33:32] **Carrie:** Children's guardians, so in the court or in CAFCAS?

[00:33:34] **Lesley:** Yes, good point.

[00:33:35] **Carrie:** That's their role, is to sort of be the child's voice, even if that...

[00:33:41] **Lesley:** Yes, even if it is against, good point yes, thank you for that. Reminding me about my practice, which I'd forgotten!

[00:33:49] **Carrie:** But it's all situations where, you know, for listeners, a CAFCAS Guardian is also a qualified social worker, but they work for, well CAFCAS. But yeah, so they will be joined to court proceedings for a child, but they're not employed by the local authority. So they may come to the same conclusion or they may come to a different conclusion, but again they have more power to speak about that because they're not constrained by what the management is saying, what the local authority solicitors are saying

[00:34:21] **Sarah:** That independent role is so important, isn't it?

[00:34:24] **Lesley:** But I suppose that they're still social workers is one side of it, whereas you've got people in these environments that they don't have that kind of same professional background. So the way in which social workers are able to frame things and their justification for stuff I think it's important, because we wouldn't expect someone who's trained in nursing, in medicine, in all the different roles within the hospital, you don't expect them to have that same professional background. So bringing a new perspective into it is kind of part of that, isn't it?

[00:34:58] **Carrie:** And, and actually that reminds me of something else that came up quite commonly was, would I go as far as saying it's a lack of respect of the social work role from clinical colleagues? Sometimes. I'm just thinking of a specific example that one social worker told me that she often gets, almost like social care is *prescribed* by doctors, so they'll say "yes, you're ready to go home, you need carers four times a day". And then she'll go in and actually speak to the person and say, well, actually they've got family, or this is a temporary setback because of their health, and actually they'll manage quite fine with one call a day, that's what they want, that's what they'll agree to. And she said that one time the consultant came back to her about why the plan had changed, and said, "oh, I don't know why I get involved in social care", and apparently she just retorted, "well, I don't know either". But it's the same

thing, you know, the social worker would never presume to tell the doctor what treatment to prescribe.

[00:35:58] **Sarah:** Yeah, or give a diagnosis, yeah.

[00:36:00] **Lesley:** Yeah. That's some of the issue of the perception of social work. I remember a few years ago, it being seen as "it's just common sense". I remember that trying to come through, and it was like, no, actually it's not. It's complex. That, going back to what you'd said about the past, present, future, that temporal element, because people use words like "holistic", but they don't necessarily understand what that means. Seeing the individual, in the context of hospital, and in their home environment, and in the systems around them. That is quite a complex thing to be able to do, and it's important to, I think what you've done there is emphasised, for me, how important social workers are, and even while of course, as practitioners, it's important that social workers reflect and consider language and that, but the core element of what they do seems to be really significant in that example that you've given.

[00:36:55] **Sarah:** It brings such a range of skill, expertise, detailed training, you know, all of that feeds in and it's really, it's nice to hear how your research is celebrating that in a way and kind of acknowledging that expertise and how it actually has an impact in people's lives at a really critical, difficult point for people as well when they've come into contact with acute care services.

[00:37:18] **Carrie:** Yeah, and I think that's something else. So I think it's important to clarify that not all hospitals have a social work team, and not all local authorities have social workers who specialise in hospital social work. And actually when I was doing my freedom of information requests, like the basic question was "do you employ a hospital social work team?" And I got at least two responses that almost seemed to object to the term "hospital social work". So one of the responses said something like "our social workers are community-based because hospital, a hospital admission is not... it's just *part* of a person's life journey. But actually a lot of research that's been done actually with hospital patients says that so much of the time it's a really *important* part of that life journey. It's a real interruption in the flow of your day-to-day. Often it's because of something very significant that's happened.

[00:38:19] **Sarah:** Yeah, it's a significant life event to become an inpatient in a hospital.

[00:38:25] **Carrie:** Especially when you consider some people, if they've had a significant stroke for example, because a lot of the people I spoke to specialised in stroke care and rehabilitation. And yeah, just the fact that it's a life-changing, potentially life-changing, event. And to say it's just one part of a person's life is correct in one way, but it's also underplaying the significance, the potential significance of it.

[00:38:57] **Sarah:** Yeah.

[00:38:58] **Lesley:** And it can be critical at that point to get good decision making that actually then is about prevention of worsening, prevention of anything getting worse and being problematic. So it is really important, that transitionary point.

[00:39:11] **Carrie:** Yes, definitely.

[00:39:12] **Lesley:** I feel like we leave people sometimes at really big transitions and don't quite acknowledge that those can be massive. You can go different ways from things like that, and if you've got the right support in place at the right time that can have a huge impact.

[00:39:27] **Carrie:** And I think also, it's again one of these things that if it goes well, nobody notices.

[00:39:33] **Lesley:** Yes. That's the classic social worker role, isn't it?

[00:39:39] **Carrie:** Yeah, 99. 5 percent of the time it goes to plan and nobody thinks about it ever again.

[00:39:45] **Lesley:** That means you've done a good job.

[00:39:47] **Carrie:** Yeah. It's where things get more complex and maybe *don't* work out that people remember.

[00:39:52] **Lesley:** Yeah.

[00:39:55] **Sarah:** Carrie, can you tell us about the safeguarding aspects of the social worker's role?

[00:39:59] **Carrie:** Yeah, so it was something that again wasn't a huge part in terms of the amount of time, because again going back, circling back to statistics, but also circling back to ageism, if you look at NHS Digital, It looks like the proportion of safeguarding concerns raised in acute hospitals is smaller than you might expect. And I say might expect when you compare it to say residential care. Now there might be lots of reasons for that, you know, people in residential care will have certain care needs that may be, again we're back to younger person, older person, but you know, a younger, otherwise fit person who's in hospital for a few days with a broken leg, it's not the same as somebody with a long-term health condition. But what I found, from interviewees and from people answering the surveys, was that they actually thought that sometimes things *do* happen in a hospital that are not perceived as safeguarding that would be perceived as such in a residential setting. So particularly things like medication errors. If it happens on the ward, it's an accident, the nurse was busy, somebody has written the prescription wrong, you know, it's kind of a training issue. Whereas if a senior care worker in a residential home gives the wrong medication, it's a safeguarding issue that needs an organisational response and disciplinary action and training and all that kind of thing. It's treated very, very differently. The other thing I wanted to say though about safeguarding was that it does, some of the stories were really upsetting, but the fact that again it's about not always seeing older people as a whole person, and the fact that one of the risks of safeguarding is taking things out of a criminal arena. So I was told stories about, particularly financial abuse and about potential sexual assault, where a social worker had been called and police *hadn't*, because this was an older person, maybe their mental capacity was in doubt.

[00:42:18] **Sarah:** And that was an instance that happened while they were in the hospital, you mean?

[00:42:22] **Carrie:** Yeah. Yeah, so for example, it would sometimes come to light that a family member had been misusing a credit card, is a sadly very common thing that happens, and it comes to light when the person's admitted. But rather than calling the police and saying, "oh, this is theft, this is fraud", they call the social worker, say it's financial abuse, and it's just not seen in the same way.

[00:42:48] **Lesley:** Do you think some of that is about the knowledge around the safeguarding practice with adults?

[00:42:53] **Carrie:** Potentially.

[00:42:54] **Lesley:** Because obviously I know the Care Act has been in, technically, well it's ten years, isn't it? But it's still, with any kind of changes in legislation, it takes a really long time for practice to bed it in, because you're talking really about the new people that are training will gradually bring it in and then the others that have updated skills. Do you think there's an element of still needing some bedding in and additional training around what that looks like?

[00:43:20] **Carrie:** Potentially. And I think also it's again back to multi-agency working in different professional roles. This is anecdotal, but from my own practice, I know sometimes getting police to take financial abuse of older people seriously was challenging. You'd kind of get pinged backwards and forwards to the safeguarding unit, the community unit, to fraud, you know, it wasn't, there wasn't a clear link between all of those different departments. And again, that's an anecdote and it's over five years ago now, so as you say, things do change and they do bed in, but...

[00:44:02] **Lesley:** Yeah.

[00:44:03] **Sarah:** I think those issues, that's something that is an issue more broadly than just in hospitals though, isn't it? Because I think our adult safeguarding policy has developed within a welfare framework, and actually what you've described, if it's a family member it could equally be framed as an incident of domestic abuse, which is much more likely to be seen as a criminal issue and for people to be seen as victim of crime when you call it domestic abuse than when you call it a safeguarding issue. It's something about the way we think about it when it's an older person. So that ageism potentially again, and seeing it as, well they're just vulnerable and they need support, rather than this is a criminal act that they might need to follow up. And sometimes either response might be the right one for that situation. But I think the issue is when people make that assumption, about it's this or the other.

[00:44:55] **Carrie:** And also I think though it sometimes misses out the third option, that the person themselves doesn't see it as abuse. And if it was, for example, it's probably unwise but if I give my son my bank card to go into the shop, well that's fine, because I'm a working-age adult who can make those decisions. Well, in 30 years' time, if I do the same thing, will it be seen as a problem?

[00:45:23] **Lesley:** Yeah. So what do you think are the sort of, I'm just thinking how many articles you've got to write, is what my head was going to! What do you think, for you, what are the big take home messages for social workers that, from what you've done so far, what do you think is really significant for them?

[00:45:43] **Carrie:** I think some of it is not so much for social workers in frontline practice, it's about organisationally, that it's really important to have social work presence in acute hospitals for all of those reasons we've talked about, kind of advocating, noticing things that maybe other professionals don't have a focus on, just the big value of that. And I think also for social workers themselves, really value that view that you have of the person, of their relationships, of their past, their future. You know, that is a skill, it's a real social work skill that I think almost gets taken for granted sometimes. And really bringing that to the front of your mind will enhance practice.

[00:46:34] **Lesley:** Yeah.

[00:46:37] **Sarah:** Fabulous. It's been really interesting hearing about your work, because I'm fairly familiar with it as well, although I'm not obviously supervising you, but I've heard you speaking about your research before, but I think some of what you've found there's some really important messages in there and some really interesting messages, and I think with our previous guests as well, we've seen that real kind of bringing to the forefront the beneficial, important, valuable work that social workers do and that role that they bring that's so crucial. So I think it's a really nice part of this series that that's really being highlighted. Is there anything else you wanted to say before we finish the recording?

[00:47:20] **Carrie:** I don't, I mean there's probably like three or four other things I could, tangents I could go off.

[00:47:25] **Lesley:** We will invite you back.

[00:47:27] **Carrie:** No, but just thank you very much and I hope that... Actually there is one more thing I want to say. I think that it's also important for anyone who's thinking about training as a social worker, or is currently studying social work, that I think work with older people or just with adults in general is more of an afterthought. I think most, certainly a greater proportion of students come into social work education to work with children, and actually I think

working with adults is such a rich and interesting place to work and really valuable as well. So yeah, anyone who's listening to this who's maybe thinking about it and undecided, don't discount working with adults. It's more interesting than you think.

[00:48:14] **Lesley:** I feel like we could advertise, put this as an advert for hospital social work.

[00:48:17] **Sarah:** Yeah, well I think that's a great finishing message as well.

[00:48:19] **Lesley:** I think so, yeah.

[00:48:20] **Sarah:** So thank you, thank you Carrie for joining us as a guest again.

[00:48:24] **Lesley:** Thank you, Carrie. Goodbye.

[00:48:27] **Sarah:** Bye.

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[00:48:29] **Sarah:** You have been listening to the Portal Podcast, linking research and practice for social work with me, Dr Sarah Lonbay.

[00:48:35] **Lesley:** And Dr Lesley Deacon. And this was funded by the University of Sunderland, edited by Paperghosts, and our theme music is called, *Together We're Stronger* by All Music Seven.

[00:48:45] **Sarah:** And don't forget that you can find a full transcript of today's podcast and links and extra information in our show notes. So anything you want to follow up from what you've heard today, check out there and you should find some useful extra resources.

[00:48:59] **Sarah:** See you all next time.

[00:49:00] **Lesley:** Bye.