

Hidden in Plain Sight: Social Work with Older People in Care Homes

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A thesis submitted in partial fulfilment of the
requirements of the University of Brighton for
the degree of Doctor of Philosophy

October 2024

Abstract

This thesis explores social work with older people living in care homes in England and considers the multiple influences at a personal, professional, organisational and structural level. Social workers' involvement with care home residents is limited, mostly focused on admission, reviews or safeguarding, and receives little attention in social work research, education or practice. This qualitative study used focus groups (n=4, total participants = 20) and interviews (n=9) with social workers to explore the influences on their practice and to examine the tensions and dilemmas relating to their role. Reflexive thematic analysis was used to analyse the data (Braun and Clarke, 2022).

The study draws on several theoretical perspectives, including 'relational austerity' (Hingley-Jones and Ruch, 2016) and the psychodynamic construct of defences against anxiety, to explain how managerial procedures hinder relationships and connection. The findings indicate that local authority structures, the construction of care homes as 'safe places', and the socio-political landscape limit social work's potential to support older people in care homes. They expose a disconnect between what social workers are mandated to do by their organisations, what they want to do and the constraints they encounter. Social workers' personal and professional values and responsibilities can collude, collide or connect with organisational and policy imperatives, and this effects how they manage the dilemmas they encounter. The research uncovers the need to connect with care homes and cultivate relationships with care home staff to engage and support the older person. The thesis is grounded in a social justice perspective, which recognises the value of individuals; the research identifies that good social work practice is happening *despite* a framework of proceduralism, resource constraints and paradoxical policy imperatives.

The study uniquely highlights the significant, but overlooked, potential of social workers to support care home residents. It argues that the absence of a clearly defined role for social workers in care homes is both an indicator of, and a contributory factor to, the invisibility and marginalisation of older people in care homes and makes visible an area of social work practice that appears hidden in plain sight.

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List of abbreviations

ASYE: Assessed and Supported Year in Employment

BASW: British Association of Social Workers

BIA : Best Interests Assessor

CQC: Care Quality Commission

DOLS: Deprivation of Liberty Safeguards

IFSW: International Federation of Social Workers

NHS: National Health Service

NQSW: Newly Qualified Social Worker

ONS: Office for National Statistics

Acknowledgements

I want to thank all the social workers who took part in this research and shared their insights so generously, honestly and thoughtfully. There would have been no research study without their contribution and I am very grateful for their interest and participation. I am also grateful for all the support and interest from colleagues, peers and friends, even if I occasionally railed at being asked “have you finished yet?”. I am looking forward to sharing what I have found with them and more widely.

A special mention goes to my mum, whose unwavering interest and pride in me have been immensely important. I know she is genuinely keen to get her hands on a copy of the finished product! Having a dog has been a lifesaver throughout this process – Bobby has been my constant companion and walking him has been a welcome excuse to step away. Thank you to my lovely family for their support, encouragement and patience: to Zach, Theo and Daisy for being interested (without really wanting to know much about the subject) and to Phil, for his technical abilities and all his emotional and culinary nourishment.

I cannot express how grateful I am to my supervisors, Jo Finch and Alisoun Milne. They have provided exceptional guidance, feedback and encouragement, and reassurance that the challenges I encountered were “all part of the process”. While they seemed to instinctively know how to support me, I can now see that it was down to their skill, experience and craft knowledge, as well as their ability to work so well as a team.

Author's declaration

I declare that the research contained in this thesis, unless otherwise formally indicated in the text, is the original work of the author. This thesis has not previously been submitted to any other university for a degree, and does not incorporate any material already submitted for a degree

Signed:

A handwritten signature in black ink, consisting of a stylized, cursive initial followed by a long horizontal stroke that tapers to a point.

Dated:

21 June 2024

Chapter 1: Introduction

This chapter introduces the thesis and the focus of my study. I will briefly explain the research and its rationale, outlining personal, professional and academic reasons for undertaking the research and highlighting its importance and relevance. The chapter will also provide an orientation to my research perspective and to the overall content and structure of the thesis.

What is the study about?

The study focuses on the experiences of social workers working with older adults in care homes in England and explores the influences on their role in this under-explored area of social work practice. As I hope to show, the marginalised status of both care homes *and* social work, especially with older adults, underscores the idea that this topic, as the title implies, remains hidden in plain sight.

There are over 265,000 adults aged over 65 living in more than 14,000 care homes in England (Office for National Statistics, 2023a); it is estimated that at least 70% of those people have dementia or severe memory problems (Alzheimer's Society, 2024). The initial idea for my study came from my observation that social workers, and society and the media more widely, seem to struggle with the concept of 'old age' care homes as something positive. I noticed that moving to a care home was usually conceptualised as 'a last resort', and that in social work practice, care homes were often seen as geographically and metaphorically on the edges of the community. I was struck that this seemed to be at odds with the emphasis on strengths-based practice, promoted across adult social care¹ in England and underpinned by the Care Act (2014). This legislation shifts the focus away from individuals' deficits and resonates with social work's values of promoting social justice, self-determination and enhancing well-being. This focus did not seem to be at the foreground of work with older people moving to, or living in, a care home. Despite the dominant narrative of well-being and empowerment, the discourse around older people is often portrayed as "a cost, threat or burden" (Torres and

¹ Adult social care covers a wide range of support and services to help people who are older or living with disability or physical or mental illness live independently and stay well and safe. It is also a term used to describe the sector that provides these services.

Donnelly, 2022, p. 5). Against this backdrop, I started to think further about social work and care homes as the topic for my doctoral study.

Setting the scene

The qualitative perspective

The doctoral experience is frequently referred to as a journey (Wellington *et al.*, 2005). Qualitative research is often imagined in similar terms, described as an iterative process that attaches meaning to richness, nuance and context (Mason, 2018) or as an “unfolding story” where the writer makes sense of the data and the whole experience (Holliday, 2007, p. 122). The connection of these two ideas has taken me on a voyage filled with its own narrative of exploration and reflection. In constructing my research and in the completion of this thesis, I have strived to adopt a perspective that actively considers my impact on the research. Bringing my voice to the foreground is important; so too is being explicit about my personal and professional perspectives, my values and my philosophical and political positioning and how they have moulded the research. Crucially, this stance acknowledges the multiple and shifting perspectives I have taken and how they have evolved and shaped all stages of the research (Braun and Clarke, 2022). Supporters of this perspective suggest that the researcher and their voice are not only a major ingredient in the study but should be at the foreground to make meaning clear (Holliday, 2007). I will consider this in more depth in Chapter 4; in the following section, I will discuss my personal and professional background and show how it relates to the rationale for my research.

The personal and the professional

I am registered social worker². I qualified in 2001 and worked for many years as a social worker with adults, predominantly older adults, mostly in hospital social work teams. I currently work part-time as the social work education/professional development lead in a London local authority. A significant part of my job involves working with social work students and newly qualified social workers. A perennial

² The title of 'social worker' is protected in law. Anyone working as a social worker and using this title in England must be registered with the regulator Social Work England. There are separate regulatory bodies for social workers in Wales, Scotland and Northern Ireland.

theme we discuss is the social work role and the tensions within that role. I have noticed that this often leads to a tendency to capitulate to the organisation's priorities and practices rather than question the status quo. Several years ago, when I started my research, the local authority, in common with others across England, had begun to embed a strengths-based approach in adult social care. My impression, however, was that the priority for practice change was with people living in the community, and that older people in care homes did not seem to 'fit' with the dominant discourse of strengths-based practice. At the same time, outside of work, I had personal experience of supporting my own ageing parents and the pressures it involved. This highlighted how wider societal attitudes towards ageing, dependency and care homes intersect with the choices available around care options.

I am also an independent Best Interests Assessor (BIA), a role that social workers can fulfil with post qualifying training. BIAs undertake assessments under the Deprivation of Liberty Safeguards (DoLS). DoLS³ is underpinned by the Mental Capacity Act (2005), a strengths-based piece of legislation designed to protect and empower people who may lack capacity to make certain decisions. It has the potential to improve the quality of life for someone whose liberty is restricted. I have observed however that, in many care homes, an individual's well-being is subsumed to institutionalised practices and the focus is on people's 'needs' and 'deficits' rather than their strengths; this might be to justify the DoLS restrictions.

The following practice example illustrates some of these issues and introduces the complexities embedded within the terrain of social work with care home residents.

A Vignette

Louis⁴ is a 91 year old retired dentist. He is in a nursing home, which the most recent Care Quality Commission's (CQC)⁵ inspection rated as 'requires improvement'. The referral form described him as "constantly agitated, with aggressive behaviour". The nurse in charge says he is "demanding and rude".

³ DoLS applies to people who lack capacity to consent to their care and treatment in a care home (or hospital) when those arrangements amount to a 'deprivation of their liberty'. BIAs carry out an assessment to ensure that any restrictions in place are necessary to prevent harm, proportionate to the risk of harm and are in the person's best interests. The Mental Capacity Act confers a legal duty to act in the best interests of a person who is deemed to lack capacity to make their own decisions. It does not offer a definition of best interests.

⁴ Names and certain details have been changed to preserve anonymity.

⁵ CQC regulates and inspects all care homes in England (see Chapter 2).

He has dementia, renal failure, experiences severe pain, has repeated urinary tract infections and regularly pulls out his catheter. He does not always take medication. He constantly calls for his daughter to be with him but is not always reassured by her presence.

The care home staff give Louis his medication covertly (where medication is given in a disguised format e.g. crushed up in food). Giving medicine covertly is considered a restrictive practice and is subject to a legal framework and guidance (NICE, 2019). Care home staff are not adhering to, or aware of, this guidance, with one careworker saying 'he needs the medicine, he won't take it, what do you suggest we do then?' The capacity assessments recorded on the electronic care system are not compliant with the Mental Capacity Act (2005) and the care records are sparse.

It is 6 months since Louis moved to the care home from hospital, where he was not offered a choice of care home. At the time, he qualified for NHS continuing health care⁶ and this is due to be reviewed. It is unclear whether, if Louis no longer meets the requirements, he would have to pay to live in the care home from his own money or if he would be eligible for funded care via the local authority.

Louis was previously living with his 67 year old daughter, Jane. She is Louis' sole visitor, visiting daily and making a long journey on public transport. She is exhausted and stressed, often on the verge of tears. She thinks the care her father receives could be much better but does not feel able to complain.

This is based on a situation I encountered when I went into a care home as a BIA. I have included this vignette as not only does it situate my practice in my research, but it exemplifies the layers of complexity in social work with older people in care homes. I would argue that this is not an unusual example and its threads are complex, interwoven and value-laden. While there is much to discuss about this vignette, its purpose here is to highlight the differing perspectives of the people involved (Louis,

⁶ This means his needs were assessed as being primarily health-related and therefore his care is paid for by the NHS.

his daughter, the care staff, me) and to illustrate the context of a shifting and complex regulatory, legal, structural and economic landscape.

At the heart of why I have included this is that Louis and Jane had not had any contact with a social worker until I met them to complete my assessment. In fact, I was not there as a *social worker*, but as a BIA to undertake an assessment to determine whether it was necessary and proportionate to deprive Louis of his liberty in the care home. I had to be clear that, despite the role a social worker could play in supporting them *and* the care home to explore and address the many issues they were experiencing, I was only there to complete a specific mandated task. This epitomises how many older people living in care homes and their families have limited contact with social workers, and when they do the relationship is largely transactional and limited to procedures or issues of concern.

The rationale

I experience frustration and sadness at the limitations of how social workers can help people such as Louis and Jane. My resolve to explore this was cemented when I realised that the literature, to be discussed in detail in Chapter 3, supported my reflections on the limited role I perceived social workers to have with older adults in care homes. Milne (2022) proposes that one of the most detrimental fallouts from local authority⁷ financial cuts is the reduced time that social workers have to spend with older people. This can be evidenced by the narrowing of tasks that social workers are expected to fulfil in certain roles. For example, I have seen hospital discharge practice change significantly over the years; the focus on delayed discharges and moving people out of hospital has overshadowed the value of the social work role (Heenan and Birrell, 2018). There often seems to be a fundamental contradiction between policy aims and what actually happens in cash-strapped public services. While strengths-based social work is predicated on the importance of building relationships, if wider structural factors drive largely 'transactional' practices, particularly in relationship to care homes, then the value a social worker adds may never be realised. My initial ideas were rooted in exploring strengths-based practice, but as my research developed, this became a 'contextual factor' in

⁷ A local authority in England is a body responsible for administering local government services within a specific geographical area. They are often described in different ways (such as county councils, district councils, London boroughs).

the broader framework of the thesis. As I explored the literature and developed my proposal, I realised that I wanted to investigate a complex and complicated topic that cannot be neatly categorised and which has many influences at a micro, meso and macro level.

Professional influences

My social work experience has involved working largely in hospitals and with care homes. My professional background is relevant to my research as it shapes where my interests lie and has led me to question why I am interested in ‘institutions’. Traditionally, group settings such as care homes and hospitals can struggle to ‘see’ the individual and this challenges my sense of social justice and commitment to social work with individuals. While the prevailing narrative of ‘ageing in place’ advocates for older people to continue living at home rather than moving to a care home (Wiles *et al.*, 2012), care homes are still likely to have a place in the care system for years to come. For this reason, it is crucial to examine social work’s role and position in relation to care homes and their residents, to understand what influences the profession’s ambitions in this setting and, perhaps most importantly, to explore possibilities for practice.

I will elaborate on the social work role in Chapter 2, but in proposing the research’s rationale, it is noteworthy that the global definition of social work emphasises the importance of the personal and the structural in practice:

“social work engages people and structures to address life challenges and enhance wellbeing” (IFSW, 2014).

My research is grounded in the relevance of structural and organisational issues alongside the personal; it reinforces that it is hard to disentangle social work from its organisational location and the wider social policy landscape. It is important to explore the complexities and paradoxes within the constraints of existing structures.

Social justice and political motivations

Social workers are required to “promote social justice, helping to confront and resolve issues of inequality and inclusion” as part of their professional standards (Social Work England, 2019). Social justice is integral to social work and routinely acknowledged as one of its key guiding principles (McFadden *et al.*, 2024). It is an

important dimension in the construction of my study and has become more prominent in my thinking as the research developed; I will define and discuss my understanding of the concept in more detail in the next chapter. Undertaking doctoral study has given me space to think about a specific topic in great detail; in my 'day job', I often focus on issues at a micro level and have limited capacity to consider the broader picture or the structural influences on practice. I will return to this theme as my thesis develops. At this stage it is important to highlight that, in my view, both research and social work are political in nature; they both seek to bring about change and this is another dimension to my positioning and my study. Now more than ever, the changing political landscape impacts on social work practice more than is often acknowledged by the profession.

Covid-19 pandemic

My study has taken place against the backdrop of the Covid-19 pandemic. While the pandemic is not a primary focus, it has amplified many existing deficiencies in the care infrastructure and provides important context and an additional rationale for the research. Many have argued that Covid-19 exposed the ageism that exists in society (Fraser *et al.*, 2020; Stanley *et al.*, 2023). It is easy to forget that, when the pandemic started, people aged over 70 were required to stay indoors, a blanket edict underpinned by, and further propagating, ageist assumptions. The pandemic also shone a very uncomfortable spotlight on how we support older care home residents and protect their rights. Social workers, despite their professional commitment to social justice, failed to challenge very poor practices in care homes and did not demand access to residents, despite evidence that they were dying or being harmed, particularly in the first wave of the pandemic. Some commentators described what happened in care homes during the pandemic as 'statutory neglect' (Jolly, 2020). This connects to the social justice and political lens that I mentioned in the previous section. Cox (2020) discusses the inequalities that Covid-19 has exposed and suggests that social work should have a key role in dismantling barriers and working to promote people's rights. My research provides a timely opportunity to explore how we might reframe the narrative and extend the social work role with care home residents.

Academic motivations: social work and research

The gap between research and practice in social work is often debated (Lamont,

Allen and Geoghegan, 2020). When I first embarked on doctoral study, I was daunted by the task ahead and the need to recalibrate my skills and knowledge to reinforce a “stronger marriage between the academic world and clinical practice” (Bradley, Gold and Hansel, 2021, p. 5). I was fortunate to be awarded a NIHR SSCR⁸ career development award in late 2021, a few years into my study, which enabled me to devote more time to my research. This helped me to build and strengthen my interest and capacity in adult social care research generally and social work research specifically. While research rooted in adult social care topics, such as ageing or care homes, is increasing (and supported by many NIHR funding streams), Ray *et al.* (2015) note that it is rare for such research to be explicitly acknowledged as *social work* research, something I would argue is still the case. This thesis is grounded in an appreciation of the importance of being research-minded, bridging the gap between research and practice and championing the importance of *social workers* thinking about research.

Research is vital for social work policy and practice, as without evidence it is hard to credibly critique or transform social problems (Shaw, 2019). Social work is often said to have a difficult relationship with research (Wakefield *et al.*, 2022), which I find surprising as it seems inconsistent with its commitment to social justice.

Underpinning research with a social justice lens is crucial to make headway in the complex terrain that my study is traversing. Describing the research submitted to the Research Excellence Framework (REF), Stanley *et al.* (2023, p. 17) describe social work as “a porous discipline”, where research is assessed in different categories spanning sociology, law, allied health, psychology and youth justice. While this illustrates the challenges in “defining and reporting what is contained within its territory”, it also highlights social work’s strength and opportunities to span boundaries.

Introducing my research questions

I have provided an insight into the influences that have informed my research aims. The questions underpinning my research study are:

- What influences social work practice with older people in care homes?

⁸ National Institute for Health Research School of Social Care Research

- How do social workers conceptualise their role?
- What tensions and dilemmas do social workers experience working with older people in care homes?
- What is good social work practice in this area and what are the possibilities for developing it?

The scope of the study

I have chosen to focus specifically on social workers in this research. This in no way undermines the importance of the perspectives of people living in care homes and their families, as well as care home staff. It is also the case that some social workers have personal experience of family members in care homes. However, there are several reasons why I have focused on social workers only. Firstly, there is limited research on what social workers think about their practice. I wanted to ensure that social workers' voices come through in this study loud and clear and are not diluted or drowned out by other voices. This is particularly pertinent in adult social care where practice is often carried out by a range of workers, including unqualified social care staff; this is different from the context in children's social care where more emphasis is placed on qualified social workers. If, as discussed above, social workers need to engage more with policy and research and work in a critical and evidenced-based way, then it is crucial to ask *them* what they think about their work, not ask other people.

I was also mindful of what I could accomplish in one doctoral study. Similarly, I have limited my focus to care homes for older people in England. As I will explore in Chapter 3, I have drawn on examples and research from other countries to inform thinking about practice in England.

Terminology

I have provided footnotes where appropriate to define key terms. However, the *choice* of language merits further clarification since language is rarely neutral and conveys assumptions and stereotypes, an idea I will often return to during the thesis. I use the term 'older adults' or 'older people' to indicate people aged over 65 years of age. While people undoubtedly 'age' at different rates, 65 is the 'cut-off' point typically used in policy, research and datasets. The danger, however, of using an umbrella term is that it reduces a large, diverse and increasingly heterogeneous

group of people to one homogenous group. Indeed as people get older, life course influences produce even greater variations in people's circumstances. As Milne (2022) suggests, conferring a universal definition on all older people masks the many differences which will arise from race, gender, generation, sexuality, disability, class, and individual life experiences.

I use the term 'care home' throughout the thesis, with the acknowledgement that other terms are used to describe the setting. Care homes vary dramatically, not least in relation to size, capacity and funding (Law and Ashworth, 2022), but more importantly they are connected to meanings in the public imagination and evoke an image that may bear little resemblance to reality. Social work too is variously defined and is complex and difficult to convey to those not in the profession (Dominelli, 2009); it has been described as "treacherous territory" (Shaw, 2019, p. 4). I will explore these ideas in depth in Chapter 2.

Using such terms, therefore, provides a shorthand for the topic to be explored and should not be taken to negate the complex and diverse meanings that attach to language. This also adds to the murky terrain in which my research is located. I will expand on these ideas in the next chapter.

The structure of the thesis

The thesis is organised as follows:

Chapter 2 situates the study within its broader socio-economic, political and policy context. It describes the profile of older people and care homes, explores care homes' background and history, and how they have helped to construct how care homes are conceptualised. This chapter introduces the social work role and how it operates in a shifting, contested landscape. This sets the scene for the review of the literature.

Chapter 3 provides a critical review of the literature, identifying the key themes and gaps. After an initial focus on social work with adults and then social work with older people, it examines the literature on social work with older people in care homes. It covers insights from the Covid-19 pandemic, research about the role in other countries and in other areas of social work practice to piece together an overall

picture. Crucially it highlights the lack of specific research on the topic and summarises the main issues raised by the literature.

Chapter 4 explains the research design and describes how I used focus groups and interviews to gather the data and reflexive thematic analysis to analyse the data. It affirms the importance of reflexivity and positioning, linking back to the research rationale. The chapter discusses my methodological stance, alongside ethical issues and challenges I encountered during the study.

Chapter 5 presents the themes from the focus groups and **Chapter 6** presents the themes from the interviews.

Chapter 7 explains the main theoretical perspectives used to interpret the findings. While traditionally, theoretical frameworks might be developed before data collection, in qualitative research it is common for conceptual frameworks to emerge in the data analysis phase as the researcher tries to make sense of the findings. This chapter therefore explains the concepts I used to make sense of my data. It synthesises the findings from the previous 2 chapters, situating them within existing literature, theory, and policy.

Chapter 8 presents my conclusion and summarises the thesis. It reflects on what I have learnt and assesses the study's limitations. It identifies my contribution to knowledge and the implications for social work practice and suggests further avenues for research.

Chapter 2: Setting the scene

This study's main aim is to explore what influences social work practice with older adults in care homes. The way in which care homes *and* social work are understood and located in UK society is multi-faceted and complex. This chapter will begin with a focus on older adults, before moving on to care homes. I will discuss the profile of 'who lives in a care home', the background and policy context, and locate care homes in the wider adult social care landscape. It is important to note that the devolved nations of the UK have adopted different policy frameworks, which has led to considerable divergence between care systems, and my study is based in England. I will explore how society thinks about care homes, consider their regulation and what is perceived to be important for the well-being of people living in care homes. I will subsequently discuss, in general terms, the social work role and its tasks and responsibilities to lay the groundwork for the review of the literature in the following chapter. In essence, this chapter's purpose is to situate the study. I will introduce several theoretical ideas in the course of this chapter, to which I will return later when I discuss my findings.

Older adults and an ageing population

In the introductory chapter, I highlighted that older adults are a large cohort, who far from being homogenous, are increasingly diverse as they progress through the lifecycle. The number of older people in the UK is increasing (Walker, 2018; Age UK, 2019a; Blackler *et al.*, 2023); the number of people in the population aged 65 years and over in England and Wales increased from 9.2 million in 2011 to over 11 million in 2021 (Office for National Statistics, 2023e). In England, the population of those aged over 65 is growing faster than younger age groups (Age UK, 2019a). This is projected to significantly increase in the next few decades (as the following graph shows), particularly among the oldest segment of the population, the group who are most likely to live in a care home.

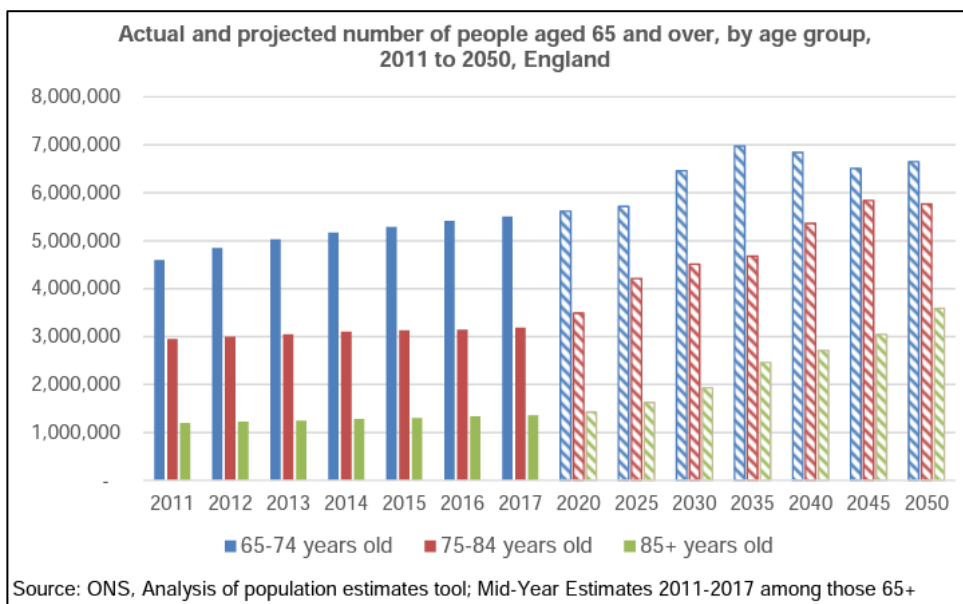


Figure 1 Analysis of population estimates for people aged 65 and over

Over the next 15 years, it is estimated that the UK population aged 85 years and over will increase from 1.6 million to 2.6 million, that is, from 2.5% to 3.5% of the total population (Office for National Statistics, 2024b). The number of centenarians⁹ in England and Wales has more than doubled in the last 20 years and continues to grow (Office for National Statistics, 2024a). ‘Old age’ or later life can therefore last up to 40 years (Milne, 2020). It is noteworthy too that many people aged over 65 in England and Wales (3.3 million in 2021) live alone without family support (Office for National Statistics, 2023e).

Inequalities in later life

While UK life expectancy has increased in absolute terms in recent decades, Hiam, Dorling and McKee (2023) contend that it has not increased at the pace of other comparable countries. For example, in 1952 the UK was ranked 7th globally for longest life expectancy and by 2021 it had dropped to 29th. This may be linked to the significant increase in economic inequalities in the UK since the 1980s: the UK now has the second highest income inequality of any OECD¹⁰ country in Europe (Dorling, 2022). Notably, there is an increase in variation in life expectancy between social

⁹ People aged 100 years or over.

¹⁰ OECD stands for Organisation for Economic Co-operation and Development, a forum of 38 member countries committed to economic growth.

groups, with life expectancy falling for the most disadvantaged populations (Hiam, Dorling and McKee, 2023).

More older people (1 in 5) are living in poverty than was the case a decade ago and, perhaps most significantly, the number of years older adults can expect to live in good health is declining, meaning that life expectancy may have increased but *healthy* life expectancy has not (Centre for Ageing Better, 2022; Office for Health Improvement and Disparities, 2022). Socio-economic disadvantages and health inequalities are amplified by age; in other words you get poorer as you get older (Torres and Donnelly, 2022). People living in the wealthiest areas of England have a longer life expectancy and almost twice as many years of disability-free life ahead of them at 65 than people living in the poorest areas (Office for National Statistics, 2021). Thus, where you live in England, and how socio-economically disadvantaged you are, leads to significant differences in life expectancy, and specifically in *healthy* life expectancy, that is living without a disability or chronic illness (Age UK, 2019a; Marmot *et al.*, 2020; Office for Health Improvement and Disparities, 2022).

While chronological age may not correlate in a linear way with poorer health outcomes, there *is* a greater risk, generally speaking, of the oldest segment of the population living with multiple and complex health conditions and of experiencing ill health over a sustained period. Higgs and Gillear (2015, p. viii) suggest that after the ‘third age’ of relatively good health and freedoms, there is a ‘fourth age’ which is linked with “discourses of frailty¹¹ and associated vulnerability”.

The prevalence of dementia

Dementia is particularly associated with high levels of dependency. It is estimated¹² that 944,000 people are currently living with dementia in the UK, a figure predicted to rise to 1.6 million by 2050 (Luengo-Fernandez and Landeiro, 2023). This is significant as three-quarters of people living with dementia will also have one or more additional long-term health conditions (Public Health England, 2019). Put

¹¹ Frailty or ‘being frail’ is a term used to describe older adults and is linked to notions of vulnerability. Frailty is also a clinical term used to identify a group of older people who are at highest risk of “adverse outcomes, such as disability, falls, hospital admission and the need for long-term care” (Whitty, 2023).

¹² Statistics are imprecise, since less than half of people with dementia have a formal diagnosis (Scourfield, 2022).

simply, 'dementia rarely travels alone' (All-Party Parliamentary Group on Dementia, 2016). The Lancet International Commission on dementia prevention found that 35% of dementia 'cases' could be prevented by eliminating nine modifiable risk factors, such as diabetes, depression, low social contact and poor education, all of which are higher in disadvantaged populations (Livingston *et al.*, 2017). This suggests that dementia prevalence is not just linked to age but also to lifecourse-related inequalities and socio-economic factors.

All this is significant since it indicates that a growing number of very old people with higher levels of dependency, dementia and multiple health conditions, will lead to an increased need for care and support from families and/or from services in the next few decades (Competition and Markets Authority, 2017; Kingston, Comas-Herrera and Jagger, 2018; Blackler *et al.*, 2023). From a financial perspective, local authority expenditure on adult social care in England in 2022-2023 was £23.7 billion, a 7.9% increase from the previous year¹³; of this amount, £18 billion was spent on long-term care, with 50.4% of the expenditure allocated to adults aged over 65 (NHS Digital, 2023). Expenditure is evenly distributed between adults aged 18-64 and adults aged 65 and over, but this data overlooks the disparity in per capita spending. The same expenditure addressed 1,785 support requests per 100,000 adults aged 18-64 compared to 13,285 per 100,000 adults over 65 (NHS Digital, 2023). This strengthens the perspective, to which I will return, that structural ageism is embedded in funding policies for the care of older people.

Carers

It is important to include a note about carers. It is estimated that 10.6 million people in the UK provide unpaid care for an ill, older or disabled person (Carers UK, 2022), with 1.2 million carers in England and Wales aged over 65 themselves (Office for National Statistics, 2023e). While carers are not the focus of this research, an ageing population and the increased pressure on public services puts an additional burden on carers, many of whom are ageing and in ill-health themselves. This is another

¹³ Some caution is needed in drawing conclusions from such data as upturns or downturns can be linked to 'corrections' resulting from the unprecedented circumstances of the pandemic, rather than a change in the long-term trend (Bottery and Mallorie, 2024).

aspect to consider when thinking about people who move to or live in care homes and the impact that this has on their families and people who support them.

Ageism

Being old is not of itself ‘a problem’ or an indication of need (Gilbert and Powell, 2012; Anka, 2020). Need is more often a product of a disadvantaged life course, with older people who have experienced higher levels of inequality likely to spend a greater proportion of their later lives facing ill-health and dependency, and requiring (publicly-funded) care (Milne, 2020; Torres and Donnelly, 2022). In taking a social justice perspective, it is important to emphasise that inequalities are embedded in the life course and are likely to be exacerbated by ageism. The Centre for Ageing Better (2021) describes ageism as “bias against people based on their age, which manifests in stereotypes, prejudice and discrimination in many aspects of life”. It is broader than age discrimination, which is a protected characteristic under the Equality Act 2010¹⁴. Ageism has been cited as the most prevalent form of discrimination in UK society (Age UK, 2023; Centre for Ageing Better, 2023). Its effects pervade the language, labels and discourses associated with ageing and older people (Duffy, 2017) and it appears to have accelerated during the Covid-19 pandemic (Ng, Chow and Yang, 2021). Ageism is a widespread and insidious issue globally, yet it is the subject of limited attention or challenge (World Health Organisation, 2021). Consistent with this, it is notable that age does not make it on to the IFSW’s list of structural sources of oppression for social workers to challenge (Seppänen and Ray, 2022). I will return to discuss social work’s relationship with ageism later in the thesis.

What is a care home?

Older people living in care homes are at the heart of my research. The sections that follow focus on care homes, starting with what is meant by the term ‘care home’ and who lives in one.

Care homes are defined by Eurofound (2017, p. 3) as:

“institutions and living arrangements where care and accommodation are

¹⁴ <https://www.legislation.gov.uk/ukpga/2010/15/contents>

provided jointly to a group of people residing in the same premises, or sharing common living areas, even if they have separate rooms”.

This mirrors other definitions which highlight that care homes are *institutional* settings providing long-term care for people who need it (Froggatt, Davies and Meyer, 2009). I use the term care home throughout this thesis, but recognise that different terminology is used, especially in other countries. In England, there is a distinction between nursing homes and residential care homes (ENRICH, no date). Broadly speaking, residential care homes provide 24 hour care and support with personal care and daily activities; nursing homes employ registered nurses alongside care staff and provide 24 hour care for people who are likely to have more complex health needs (Competition and Markets Authority, 2017). This terminology used to be primarily about funding and care needs, but now there is often little distinction between the two settings. While some care homes are specifically for younger adults, for example, adults with learning disabilities or brain injury, the vast majority of care homes are for older people with complex and multiple needs (Mikelyte and Milne, 2016; Burton *et al.*, 2020). Care homes for older people are the focus of my study.

The care home sector

There are 14,228 care homes in England, of which over 70% are residential care homes, and less than 30% are nursing homes (Berg, 2024). The number of care home places in England has consistently decreased over the last 10 years, despite the older population growing; this is consistent with the policy direction (which I will discuss later) of supporting people to live at home for longer (Bottery and Mallorie, 2024). Care homes vary considerably in size, capacity and design, ranging from large purpose-built premises to small, converted houses; often the structural elements of the building have an influence on how care is provided (Froggatt, Davies and Meyer, 2009; Law and Ashworth, 2022). The quality and availability of care home provision varies geographically across England (Forder and Fernandez, 2011a; Higgs, Langford and Llewellyn, 2022). Care staff are fundamental to the operation and quality of care homes. Other people, in particular, health and social care professionals, and family members and friends, come in and out of the care home and visit residents regularly.

Later in this chapter I will discuss the background and social policy context of care homes; for now, it is important to understand that the UK care home market is described as operating on “two tracks” (LaingBuisson, 2021, p. 6). This means that around three-quarters of care homes are privately owned, the remainder are in not-for-profit ownership, run by the voluntary sector, local authority or NHS. The care home sector has also been called a “quasi-market”; this differs from a conventional market in that non-profit and for-profit organisations compete for public contracts, and third parties, such as local authorities, often make choices for the ‘consumer’ (Le Grand and Bartlett, 1993).

There is also a two-tier system of funding. Self-funders (that is, people with assets above the £23,250 threshold in England) pay the full cost of their care home fees (until their assets reduce below the threshold). Self-funders make up 37% of care home residents in England¹⁵ (Office for National Statistics, 2023b). People with assets below the threshold are publicly funded, although most of their income will be offset against the local authority’s contributions (Competition and Markets Authority, 2017). Additionally, a small proportion of people¹⁶ with long-term complex health needs qualify for NHS continuing health care, which means their care home fees are paid by the NHS (NHS, 2024). Self-funders typically pay a premium of 40% compared to the fees that local authorities pay, and where local authority funded residents are in the same care home as self-funders, there is evidence that in effect the latter group subsidises the former (Denning and Milne, 2021; Laing Buisson 2021; Competition and Markets Authority 2017). It is also significant that publicly funded residents are more likely to be in care homes with a lower CQC rating. According to ONS data (2023b), 51% of residents were self-funders in care homes rated outstanding, compared to only 24% of residents in care homes rated inadequate.

¹⁵ Self-funders vary by region. London has the second lowest percentage of self-funders across England (28% are self-funders compared to 47% in South East) ONS, 2023b.

¹⁶ I requested data from NHS England on the number of adults aged 65 and over in England permanently funded under NHS continuing healthcare in a care home. I was informed that NHS England does not hold this information by age or location setting.

Summarising the picture

There is no widely available UK-wide dataset about care homes¹⁷ and there are discrepancies in the way data is collected and reported across the devolved nations. This makes it hard to get a clear, consistent picture. With this in mind, the following table, collated from several sources, is an attempt to provide an overview of the care home sector described above.

<p>Number of care homes (England) Source: Berg, 2024</p>	<p>Residential 10,218 Nursing 4,009 Total 14,228</p>
<p>Care home ownership (UK) Source: LaingBuisson, 2021</p>	<p>Market size £17.3 billion 77% for-profit providers 13% non-profit providers 10% public providers (local authority/NHS)</p>
<p>Funding (UK) Source: LaingBuisson 2021</p>	<p>43% self-funded residents 11% local authority and top ups 37% local authority funded residents 9% NHS funded residents</p>
<p>Funding (England) Source: ONS, 2023a</p>	<p>37% Self-funded residents 63% State funded residents</p>
<p>Care home average weekly fees (UK) Source: LaingBuisson, 2021</p>	<p>State funded residential - £596 State funded nursing - £779 Self-funded residential - £776 Self-funded nursing - £1139</p>

Table 1: Overview of care home sector

Who lives in a care home?

¹⁷ LaingBuisson publish an annual UK market report about care homes retailing from £1295. It is only publicly available at the British Library. Due to the cyberattack on the British Library in October 2023, the 2021 edition was the only edition that was available for me to consult.

The lack of reliable, basic demographic data about people living in care homes poses challenges to research and evidence-based policy making and improvement. Burton *et al.* (2020, p. 1) argue that care home residents are “invisible” in UK datasets, which contributes to their marginalisation, despite there being three times more care home residents in the UK than hospital inpatients (Burton and Guthrie, 2018). The NIHR funded DACHA project seeks to address this by developing a national care home dataset and establishing a more consistent approach to capturing reliable and coherent information about the care home population (Gordon *et al.*, 2022). At the time of writing, it seems that information is collected and used in different ways and for different purposes. I often found it challenging to find and navigate the available information and my analysis acknowledges these limitations. However it is crucial to have a picture of who lives in a care home to better understand the research topic.

The last Census¹⁸ estimated that 324,435 people were living in care homes in England (Office for National Statistics, 2023a). A small percentage (around 18%) of this population are aged under 65; the remainder (82%) are aged 65 and over. The following table is a breakdown of people over 65 living in care homes in England (Office for National Statistics, 2023a).

Age group	Males		Females	Persons
65 to 74	18,660		17,690	36,350
75 to 84	29,475		49,695	79,170
85 and over	32,800		117,270	150,070
Total (65 and over)	80,935		184,655	265,590
	30%		70%	

Table 2: People over 65 in care homes in England

This shows that the highest proportion of care home residents are aged 85 and over. The majority of older people living in care homes are female, particularly in the oldest age group, and most of this group are single, widowed or divorced (Denning and Milne, 2021). Older adults from ethnic minority backgrounds are under-represented

¹⁸ The Census was carried out in 2021 during the Covid pandemic.

in care homes compared to the general population (Froggatt, Davies and Meyer, 2009; Denning and Milne, 2021). An estimated 80% of individuals in England and Wales identify their ethnic group as "white," whereas this figure is 97.5% for care home residents aged over 65 (Office for National Statistics, 2022, 2023d).

Information about the care home population's sexual identity is hard to determine, combined with many older adults' reluctance to reveal their LGBT identity, having lived through times when it was necessary to conceal sexuality in public or institutional environments (Clark, 2021). The lack of accessible information about the diversity of people living in care homes contributes to a misleading discourse that they are a homogenous group.

One overarching trend is that older people living in care homes are older than they were a decade ago and are increasingly frail and dependent with complex needs; many are near the end of their lives (Moriarty *et al.*, 2019; Milne, 2020). Dementia is a prominent feature of this population, and dementia care an important function of care homes (Denning and Milne, 2021). In the absence of reliable data, conservative estimates suggest that 70% of care home residents have dementia (Law and Ashworth, 2022; Alzheimer's Society, 2024). As noted earlier, the majority of people with dementia have other co-morbidities (Browne *et al.*, 2017).

There is limited research on the average length of time that people live in care homes. An older study identified that age is a significant predictor of length of stay and that self-funders tend to live around a third longer than publicly funded residents (Forder and Fernandez, 2011b). The same study identified that the median life expectancy of someone moving to a care home in England is 15 months. The majority of people (87%) living in care homes die there (Office for National Statistics, 2023c). In 2023, 24% of *all* deaths in England occurred in a care home, and among people aged over 85 who died, 39% did so in a care home (Office for Health Improvement and Disparities, 2024). It is interesting to reflect on this data as care homes are rarely framed as places to die, an idea to which I will return.

Before turning to the history of care homes and their conceptualisation, it is important to briefly consider the circumstances around which people move into a care home. A study by Samsi, Cole and Manthorpe (2022) identified that the decision to move to a

care home (the 'tipping point') is generally linked to an accumulation of stressors. They identified that people with dementia and/or their carers often feel unable to cope or that all other care options have been exhausted; a move is often borne out of necessity rather than choice. An Australian study identified that people move to a care home following a crisis or sudden event, such as falling or a stroke. Other factors include cognitive or physical health deterioration, concerns over safety, impact on family carers, lack of family support or lack of community provision (McGrath, Blundell and Morrisby, 2021). While the routes into care homes differ depending on whether someone is funding their own care or supported by the local authority, the choices available to people are often limited. The funding system is complicated and exceptionally hard to navigate and once an older person moves into a care home, it is difficult to return home or move to a different care home (Competition and Markets Authority, 2017; Higgs and Hafford-Letchfield, 2018). Care homes are entitled to 'evict' residents if they are unable to provide adequate care or the relationship has broken down; recent findings suggest at least 1.5% of residents were issued a 'notice to quit' in England (Emmer De Albuquerque Green and Manthorpe, 2023). This can add to residents and families' reluctance to raise concerns about care quality.

People in care homes with complex and high support needs undoubtedly hold very little power and are usually wholly dependent on others (Lloyd, 2010). The experience of frailty and dependency intersects with, and is likely to be exacerbated by, inequalities, such as poverty, and age, gender or race discrimination experienced during a person's lifecourse (Ray, 2013). This suggests that those least equipped to provide for their own care may need it the most; they are likely to be more vulnerable to abuse or neglect and to have their rights ignored or violated, as was brought into sharp focus during the pandemic, something I will consider later in the chapter (Anand *et al.*, 2022).

Care homes: background, history and social policy

The importance of social justice that underpins this study lies in recognising the interconnectedness of history, policy, economics and politics, all of which are inevitably entwined with social work. In this next section, I will cover the background and history of care homes and discuss the links with, and impact of, social policy.

Historical origins

Froggatt, Davies and Meyer (2009) argue that the historical origins of care homes, and subsequent policy directives, have influenced contemporary attitudes and contributed to the marginalisation of older people and the care home sector. Society has an uncomfortable and ambivalent relationship with care homes. There is a long history of 'state provision' for 'people in need', predating the birth of the welfare state and going back to the tenth century, when almshouses provided for 'ill, old or disabled people'. In 1601, the Act for the Relief of the Poor (the old Poor Law) made parishes responsible for housing people who could not work because they were too old or too ill and provided 'poor people' with relief, such as food and clothing (Munson, 2024). Subsequently the Poor Law Amendment Act (1834) was introduced arising from concern that poor law relief was perpetuating poverty. Workhouses became the main source of support for people who were unable to work; their highly institutionalised and punitive nature was mostly designed to reduce dependence on welfare and to stigmatise its receipt (Johns, 2011). This early categorisation of the 'impotent' poor (those who were too ill or old to work) and the 'idle' poor (the undeserving) cemented a connection between social welfare provision and stigma, and the idea that people are 'responsible' for being in poverty (Finch and Parker, 2020).

Social policy

After the second world war, the Poor Law was abolished and new legislation placed a duty on local authorities to provide:

“residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them” (National Assistance Act 1948, s21(1)(a)).

The National Assistance Act also introduced compulsory registration for residential care homes and allowed for their inspection. Local authorities not only had a duty to offer residential accommodation but for many years were also the providers of it (Moore, 2020). This was the case until the Conservative government, coming into power in 1979, started to encourage a market-like approach to health and social care provision. New legislation introduced a “mixed economy” of care (2020, p. 317). The reduction in the state's involvement in the organisation and delivery of welfare

provision was driven by neoliberal policies, whose aim was to encourage competition to improve cost efficiency and at the same time encourage people 'in need' of support to be more self-reliant (Cunningham and Cunningham, 2017). Language also shifted, with people being newly described as consumers or customers, redefining their relationship with the state and indicating their right to choose (Johns, 2011). In the care home sector, the main effect was to transform the inhouse local authority model of residential care to an outsourced for-profit model (Corlet Walker, Druckman and Jackson, 2022). The fact that over 80% of care homes were in public sector ownership in the early 1980s, and now, as I showed earlier, that figure stands at 10%, illustrates the extent of marketisation (Ferguson and Lavalette, 2014; LaingBuisson, 2021). Moore (2020) argues that accessing residential care from the 'market' led to an increased need for regulation and monitoring of providers. I will discuss care home regulation later in the chapter.

The dominance of private providers in the care home sector was initially driven by government policy and was subsequently reinforced by the need for local authorities to reduce costs under government austerity measures. In 2010, the then Chancellor introduced £18 billion cuts to welfare benefits and local authority social care budgets. It is estimated that there will have been a £42 billion reduction in public spending between 2009 and 2019/20 (Cunningham and Cunningham, 2017). These funding cuts were unprecedented and significantly undermined the availability and quality of social care provision. The effects of the pandemic and the cost of living crisis, with inflation recently at its highest level in 40 years, have compounded the damage to an already underfunded and stretched system (Dixon and Jopling, 2023). Austerity and the financial crisis is not the topic of this study, but the wider socio-economic and policy environment and structural barriers cannot be ignored, given their impact on the care home sector and on residents' lives. Likewise, policy and financial pressures constrain the choices available to people with social care needs and to social workers. I will return to this topic when I discuss adult social care and the social work role later in this chapter.

Crucially, the government's need to limit spending has put increased pressure on funding, resources and quality in the care home sector (Age UK, 2019b; Care Quality Commission, 2023). This is compounded by the positioning of social care and care homes in the wider system. A fundamental issue is that the NHS is a universal

service, free at the point of use and funded from central taxation. It is accessed by people irrespective of class or wealth and, as was seen during the Covid-19 pandemic, is deeply embedded in our national culture and identity (Alcock and Gregory, 2022; Humphries, 2022). In contrast, publicly funded social care (in England) is only available to those with the highest levels of need and very few assets; it is means tested with an expectation that people contribute from their own income (Kings Fund, 2023). According to Daly (2020, p. 986), this distinction, and the higher resource allocation afforded to the NHS, means that the social care system “functions in the shadow of the National Health Service”.

A further aspect, proposed by LyMBERY and Postle (2015), is that the split between health and social care, established with the creation of the NHS in 1948, has led to conflict over who takes (or avoids) financial responsibility for people who are, or become, old or disabled. This binary approach perpetuates inequality for older people, especially those with dementia, who disproportionately rely on ‘social care’ services rather than the NHS. This important distinction harks back to the historical provisions of welfare and confirms that social care was never envisaged as a universal service but as “a safety net” (Humphries, 2022, p. 23). In the context of care home provision, older people and their carers are deterred by the complexity of the ‘system’ (financial contributions, providers, eligibility for support) combined with a perception of stigma associated with approaching the local authority for help (Baxter, Heavey and Birks, 2020). The current system also requires individuals to sell assets and their homes to fund the cost of their care. In 2021, the Government announced its intention to implement a cap of £86,000 on lifetime personal care costs from October 2023 (Warren, 2022); at the time of writing these reforms have been delayed until 2025. All this underscores the complex and emotive funding issues involved in accessing care home provision.

Community care

A further aspect to understanding care homes is the historical development of community care, and the growing emphasis on supporting people in their homes rather than in institutions. Notably influential was Peter Townsend who carried out a study of 174 care homes in England and Wales in the late 1950s. His book *the Last Refuge* published in 1964 exposed the inadequacies and gross inequalities in the provision of care in residential institutions (Gorsky, 2012). Townsend’s work, together

with writers such as Goffman, contributed to a body of literature which was highly critical of institutional care and the 'block treatment' of residents (Johnson, Rolph and Smith, 2010). This fuelled the development of community care policies in the 1990s and key reforms, including closures of long-stay hospitals for patients with mental health needs and learning disabilities, and improved standards of care which took root over subsequent decades (Alcock and Gregory, 2022).

The culmination of numerous reports and a pivotal moment in the shift to supporting people to live at home wherever possible was the White Paper: 'Caring for people: Community care in the next decade and beyond' (Department of Health, 1989). An important observation is that the policy shift that institutional care was no longer the 'best way to support people' was partly driven by the belief that community-based care would be more cost effective (Lymbery and Postle, 2015). At the same time, increased managerialism and a drive for efficiency, sat alongside a quest to put the 'customer' first. This interplay of neoliberal policies and financial drivers with the purported 'empowerment' of people using services resulted in what Lymbery and Postle (2015, p. 22) describe as a "complex and contradictory mixture" of policy imperatives.

Another important policy development was Putting People First (HM Government, 2007) which established the concept of personalisation and 'choice and control' for individuals with care and support needs (Carr, 2014). In brief, personalisation is an approach which starts with the needs and wishes of the individual, and works together with people to give them more control, choice and dignity over how their needs are met (Parkinson, 2010; Local Government Association, 2014). A discussion of personalisation is outside the scope of this chapter, but it is important to acknowledge its influence on policy in the context of care homes. A key challenge relates to offering personalised care within a complex, financially driven system. Critics argue that when driven by neoliberal ideology, personalisation can create a smokescreen to cut services and reduce quality (Slasberg and Beresford, 2022). Richardson (2022) suggests that there is a tension between personalisation and the defences or depersonalisation that workers create when faced with dependence and inequality. This is a particularly pertinent argument in relation to care homes and an idea I will explore later in the thesis.

The Care Act

Moving closer to the present, the Care Act (2014) introduced a legislative shift from the deficit model of process-driven care management to a focus on strengths-based approaches (Department of Health, 2017). Crucially the Care Act (2014) put well-being at the heart of social care legislation in England, requiring local authorities to work in a way that is “consistent with the core elements of a strengths-based approach” (Caiels, Milne and Beadle-Brown, 2021, p. 417). The importance of this should not be under-estimated, but it was implemented at a time of unprecedented austerity in local authorities, which, some argue, has undermined its capacity to deliver on its intentions (Slasberg and Beresford, 2017; Pollock and Withers, 2023).

A key message from the preceding discussion is that the drive to promote living at home at all costs has positioned care homes as a ‘poor substitute’ or as ‘a failure’ for the individual, their family or community-based care (Denning and Milne, 2011). I would argue that the focus on individual choice and well-being, against a backdrop of financial pressure, neoliberalism and concerns about the capacity of care homes to provide quality care, create a mismatch between policy imperatives and care homes.

Covid-19 Pandemic

History and social policy strongly influence the way care homes are conceptualised today, by which I mean how they are understood and perceived within society. Before I explore this in the next section, it is important to recognise how the Covid-19 pandemic brought care homes into greater prominence. The pandemic shone an uncomfortable spotlight on the relationship between social care policy and care home residents. I will discuss the literature in more detail in Chapter 3; for now, an important message is that the pandemic reminded society that care homes are very much viewed as *institutions*. Care home residents were accorded a very low priority by the government. For example, a full UK lockdown was announced by the prime minister on 23 March 2020, but it was not until 15 April that the government published its ‘Covid-19: adult social care action plan’ (Department of Health and Social Care, 2020). Plans to support infection control in care homes were not announced until 15 May, by which time 5,176 care home residents had died with Covid-19 (Amnesty International, 2020). Around 25,000 people were discharged from hospitals into care homes without being tested for Covid-19, and by mid-June there are estimated to have been 30,000 excess deaths in care homes in England

and Wales (Alcock and Gregory, 2022). Over the course of the pandemic, rules in care homes, for example around infection control, visiting and vaccinations, were significantly more restrictive than those applied to the general population, and are widely acknowledged to have had seriously detrimental effects on people living in care homes and their families (Giebel *et al.*, 2021). I would argue that the pandemic encouraged a risk averse and deficit-focused stance for people living in care homes. For example, based on my professional experience, local authorities did not allow social workers to visit care homes for most of the pandemic, unless in extreme circumstances, such as serious safeguarding concerns.

The care home sector, and adult social care generally, are recognised to be in crisis or “gridlocked” (Care Quality Commission, 2022b, p. 7); historical underinvestment on staffing, austerity and a lack of policy attention placed them in a weak position to withstand the effects of the pandemic (Arrieta, 2022; Care Quality Commission, 2022b). The cost of living crisis and the speed with which the landscape is continuing to change creates an increasingly complex picture. For example, when I began writing this chapter, the government announced their intention to halve to £250m the proposed investment of £500m in adult social care pledged in the white paper *People at the Heart of Reform* (Department of Health & Social Care, 2021). Reduced funding for care and support in the community could lead to more people entering residential care.

How are care homes conceptualised?

The next section will explore the conceptual status of care homes. In my opinion, there is a clear connection between policy, funding and the history of care homes and how they are viewed by society, alongside other influences which also play a key role. I predominantly draw on UK discourses and acknowledge that other cultures and countries may view older people and/or care homes differently; I will consider the literature which describes the role social workers have in care homes in other countries in the next chapter.

Milne (2020) suggests that care homes occupy a space on the edges of social care and public consciousness. Supporting this perspective, Anand *et al.* (2022, p. 805), writing about the harms and human rights’ violations experienced by older people in care homes during the Covid-19 pandemic, describe care homes as “geographically

and metaphorically ‘off the public radar’”. There is little doubt that the pandemic reinforced, and at the same time, made visible the liminal space inhabited by care homes in the social imaginary.

The last resort

The view that care homes are a place of ‘last resort’ (Burstow, 2014; Moriarty *et al.*, 2019; Ettelt *et al.*, 2022; Samsi, Cole and Manthorpe, 2022) is influenced by policy’s positioning of care at home as the ‘best’ or ‘desired’ place of care; this drives a narrative that moving to residential care is a failure (Milne *et al.*, 2024). This construct of failure is further perpetuated by narratives around ageing, which present stereotypes of dependency, incompetence and burden (Kesby, 2017). I will not go into detail about narratives of ageing, but I will highlight some discourses which illuminate society’s relationship with care homes.

Narratives around ageing

The fourth age is presented as the terminal phase of old age characterised by “final dependence, decrepitude and death” (Laslett, 1994, p. 439). Gilleard and Higgs (2010) theorised this, arguing that people’s marginalisation to the edges of life supports a narrative of failure, divesting individuals of agency and social and cultural capital. They depict the alienating image of care homes as a “concentration of infirmity” and describe a metaphorical ‘black hole’ of ageing, whose gravitational pull creates a “social imaginary of failure and death” (2010, p. 125). In later work, the authors suggest that the fourth age is defined by what people imagine it to be: it is shaped by *fear* of dependency, failure and loss of agency. This theory is helpful in explaining the stigma and distaste surrounding care homes, which “become a condensed image of this rejected old age” (Higgs and Gilleard, 2021, p. 2).

Another, arguably more insidious, influence is compassionate ageism. Binstock (2010) traces its origins back to 1950s America and the stereotyping of old people as dependent, and ‘deserving’ and therefore worthy of specific policies and government support. He contends that compassionate ageism was not intended as prejudicial and led to policies which ensured that the state took responsibility for supporting older people. Notwithstanding their origin, the prevalence of these attitudes still persists. Swift and Steeden’s (2020) literature review examines how UK society represents and perceives ageing and older people. Their review found that negative

perceptions dominate alongside a tendency to associate ageing with illness and dependency. It identified 'benevolent ageism', a seemingly benign but patronising sense of care and concern, which is captured eponymously in a Centre for Ageing Better (2020) report as 'dodderly but dear'. Regarding 'the elderly' with pity, however, risks collusion with paternalistic policies and institutional approaches that oppress and disempower older adults (Eastman, 2020). The concept of compassionate ageism appears to have underpinned a paternalistic approach to older people during the Covid-19 pandemic. For example, the UK government identified 'all people aged 70 and over' as 'clinically vulnerable' at the start of the pandemic. This approach does little to dispel society's tendency to oversimplify and homogenise the multi-faceted complexity of ageing and ill health and uncouple it from life's earlier stages (Milne, 2020; Vervaecke and Meisner, 2021).

Stereotypes about older people inevitably influence how people are treated, and can also be internalised and contribute to how people feel about their *own* ageing or decline (Swift and Steeden, 2020). It seems paradoxical that age stereotypes endure, given the universal nature of ageing; on the other hand, the fear and anxiety associated with ageing, dependency and death may explain the tendency to 'other' older people, even amongst older people themselves. This psychodynamic construct occurs when dependent older people are perceived as distinct or 'the other', creating an illusion "as though ageing was not a shared experience" (Lloyd, 2010, p. 198); this is an important perspective in this thesis.

Attitudes towards care homes

Thus far, I have explored how the fear of loss of function and dependency that is associated with living in a care home contributes to people not wanting to 'end up' in one (Burstow, 2014; Kennedy, 2014). Negative attitudes towards care homes are further illustrated by an Alzheimer's Society commissioned survey, albeit some years ago, which found that 70% of people would be scared to move into a care home (YouGov, 2013). The impact of the pandemic has not eased these fears: a national poll found that people were less likely to seek residential care for themselves or for a relative as a result of the pandemic (Institute for Public Policy Research, 2020). Results from a tracker poll between 2019 and 2023 consistently show only 1% of

people would chose a care home as their *preferred* place to live if they could no longer live independently (YouGov, 2023b).

Many people fear going into a care home due to concerns about the quality of the care that they will receive (Age UK, 2018; Moore, 2020). As the graph below illustrates, people’s perceptions of care are very mixed, with a higher percentage of respondents rating care as ‘very bad’ than as ‘very good’ (YouGov, 2023a). What is striking about this poll is that around a quarter of people ‘don’t know’. This may support the argument, which I will explore later in this section and which foreshadows my findings, that people do not really understand or know much about care homes. They remain off most people’s radar.

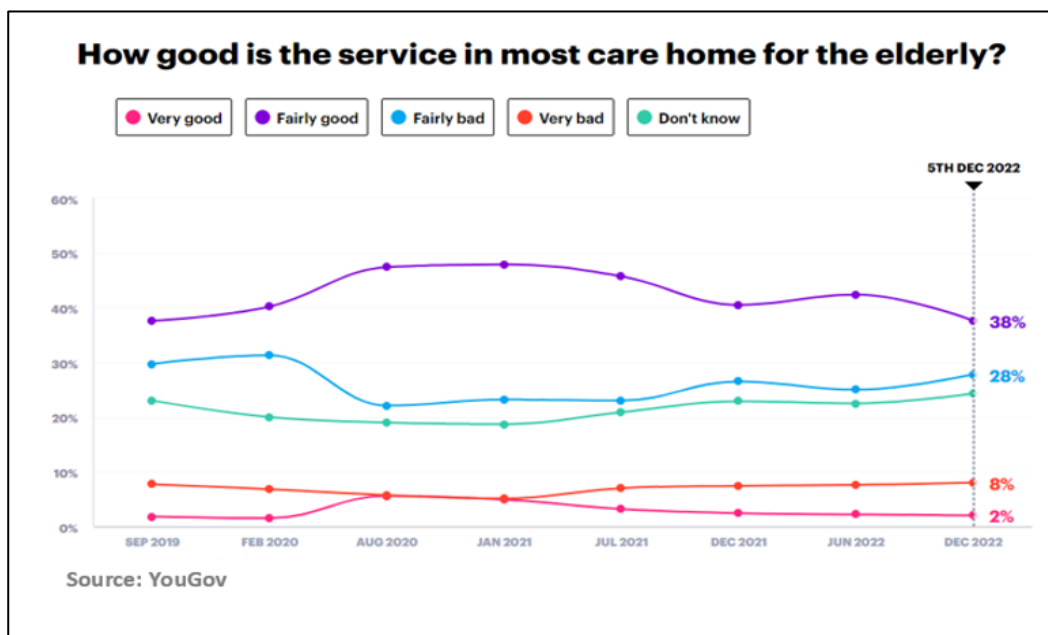


Figure 2 YouGov tracker poll: How good is the service in care homes

People’s fears are amplified by media stories which mostly highlight examples of poor care and abuse in care homes (Pedley and McDonald, 2019). My observation is that media stories are usually more negative and alarmist than positive; high profile programmes like BBC’s Panorama (‘Behind Closed Doors: Elderly Care Exposed’, 2014) showing the abuse and mistreatment of care home residents loom large in people’s minds. A research study which showed that people living in care homes

found the experience better than they had expected may be further evidence that media portrayal skews people's perceptions (Blakemore, 2012).

Separate from society

Perhaps at the heart of the issue is that care homes remain largely hidden and separate from 'normal' society (Mikelyte and Milne, 2016), existing 'behind closed doors' metaphorically and geographically. Denning and Milne (2011) propose that people living in care homes are largely invisible: their voices are rarely heard and they are arguably one of the most marginalised groups in society. People living in care homes rarely go out, and people from the community rarely go in: as such "the boundaries of care homes are impermeable" (2011, p. 366). I have noticed an established dichotomy between 'care homes' and 'the community'. It strikes me that care homes hold a position on the edge of the community, and in contrast to institutions like schools or hospitals, most people have never been inside one. There are "infrequent visits by outsiders" (Manthorpe and Martineau, 2017, p. 2089) and this may allow negative media stories and societal narratives to pervade people's perceptions, like a bogey-man. Indeed, an Ipsos poll (2020) found that those with previous knowledge of care homes through a family member, friend, work or volunteering viewed care homes more positively than those with no previous knowledge. This suggests that there is a gap between the public and media narrative attached to care homes and what it might be like to actually live or work in one. I will consider this when I explore the issue of quality of life in care homes later in this chapter.

Institutions

The institutional origin of care homes is another important feature in their conceptualisation and impact on the public imagination. Goffman's influential work, first published in 1961, described "total institutions", which grouped residential care alongside jails, mental hospitals, barracks and monasteries. Goffman described how these institutions differ from other places as all aspects of life for the 'inmates' are conducted in the same place, under the same authority, and with a group of others who are generally required to do the same thing (Goffman and Helmreich, 2007). While the language of his work feels outdated, the notion that the institution creates a 'barrier' which separates 'inmates' from the outside world reinforces the liminal

positioning of care homes within society and the impermeability of their boundaries. People need permission to visit a care home or be 'let in' by a staff member. This is significant since the professionals who are key to supporting residents, including social workers, typically work outside of care homes, visit infrequently and must negotiate access (Manthorpe and Martineau, 2017; Gordon *et al.*, 2022). Visiting restrictions during the Covid-19 pandemic reinforced the institutional and 'closed' nature of care homes (Giebel *et al.*, 2022; Dixon *et al.*, 2023).

Miller and Gwynne's (1972) *A Life Apart* also influenced attitudes to care homes. They introduced the term 'social death' to describe how institutional care treats those who have been 'written off' by society but are not yet dead (Spicker, 2000). Considering care homes through the paradigm of institutions highlights the idea of identity, or more pertinently, loss of identity. Lynch (2014) proposes that older people experience a loss of self through the routines and regimes within the care environment. This returns to the tension, discussed earlier in the chapter, between prevailing policy narratives of personalisation, choice and autonomy, and the routines and institutional nature of care homes (Ettelt *et al.*, 2022).

Psychodynamic constructs: defence mechanisms

Building on the idea of fear, distaste and 'othering' discussed earlier, a psychodynamic lens considers that the regimes and routines of institutions, such as care homes, create a protective layer whose aim is to help workers distance themselves from the emotional pain and difficulties of the work. Menzies Lyth's seminal study of student nurses remains influential in explaining how institutions and organisations develop socially constructed defence mechanisms to cope with the distress and anxiety of work involving "suffering and death" (Menzies Lyth, 1960, p. 102). She described depersonalising devices which created professional detachment or inhibited the development of relationships, for example, referring to patients as "the liver in bed 10". A more recent example can be found in a small study of trainee Best Interests Assessors observing older people in group care settings (Parkinson, 2017). The study identified the trainees' impulse to refrain from examining their own responses to avoid the 'unpalatable' truths of group care.

These defence mechanisms built into the fabric of organisations to protect against distress or anxiety create a disconnect between policy and practice and influence how care homes are conceptualised today. They highlight the tension between independence and reliance and the largely unconscious fear of dependency within a system that professes to prioritise personalised approaches (Richardson, 2022). Blackler *et al.* (2023) make an important observation that care homes are framed as places to live, not places to die, despite the discourse that surrounds them and the statistics I highlighted earlier that indicate that many people do die there. They argue that this downplays the enormity of moving to a care home and the losses that it entails. Within the scope of this study, and given the abundance of psychodynamic literature on anxiety and institutional defences, I can only touch on this perspective; it is, however, an important lens to which I will return when I consider my findings in Chapter 7.

A paradoxical term

The term 'care home' also creates a paradox: there is a contradiction of living in a place described as 'home' where there are rules and routines associated with an institution (Blackler *et al.*, 2023). Likewise, Mikelyte & Milne (2016), reviewing the evidence on the impact of micro-cultures in long-term care, suggest that despite policy's emphasis for care homes to 'feel like home' and be part of the community, they often retain the features of Goffman's total institutions. They strikingly describe how "life is co-lived with strangers" (2016, p.200). The work of Swedish authors, Börjesson and Torgé (2022) is useful in examining the concept of 'home' in residential care, through the lens of critical geography. They suggest that 'home' has physical and metaphorical connotations, often linked to comfort, and this conceptualisation of home is at odds with institutional rules, procedures and public accountability. While they acknowledge that social and cultural constructions of home vary, they explore the conflict that occurs in people's imaginations through the dichotomy of a place which is home/not home, and a place where people live, work and visit.

Thus far I have explored the complex and multi-factorial influences on how care homes are understood and imagined. This also influences their regulation, which is the focus of my next section.

Regulation and inspection

The marketisation of care homes, discussed earlier, led to an increased demand for regulation and oversight, amidst fears that a key driver would be profit rather than the provision of high quality care (Moore, 2020). Such concerns are borne out by Barron and West's (2017) investigation into differences in care quality provided by public, non-profit and for-profit care homes in England. The results, drawing on data from over 15,000 homes, indicated that for-profit facilities had lower quality ratings over a range of measures. Concerns about the quality of care are widespread for other reasons.

The role of local authorities

Local authorities in England have a pivotal role in monitoring care homes. Market shaping duties under the Care Act (2014) also require them to facilitate a sustainable high quality market for social care. This becomes even more crucial in a climate of growing need and limited financial resources (Towers *et al.*, 2019). An additional driver for local authorities to monitor quality is linked to their responsibility to step in around provider failure, which extends to people who self-fund their own care (Care Quality Commission, 2022a). This duty was introduced in response to the 2011 collapse of Southern Cross, who provided care across 750 nursing homes (Humphries, 2022). On an organisational or meso level, the responsibility for monitoring lies with local authority commissioners. On a micro level, staff working for the local authority (usually social workers) play an important role in scrutinising the quality of care or addressing concerns. I will explore this aspect further in the next chapter.

The role of the regulator

Overall responsibility for regulating care homes in England lies with the Care Quality Commission; it registers, monitors and inspects all care homes with the primary aim of ensuring quality. CQC's independent regulatory remit extends beyond care homes to health and social care services across England. Notably, its most recent annual report makes almost no mention of care homes, which may suggest that they are not currently CQC's key priority (Care Quality Commission, 2023). The regulatory model is guided by the 'Mum test' principle, that is, whether the service would be considered good enough for someone you love (Towers *et al.*, 2019; Allan, Irvine and

Achterberg, 2022). Services are rated following inspections which look at whether care homes are safe, effective, caring, responsive to people’s needs and well-led. The evidence, illustrated in the following graph, is that the vast majority of care homes are judged by CQC standards to be ‘good’ or ‘outstanding’. However, as discussed earlier, public focus is usually on the smaller percentage of care homes that do not meet these standards.

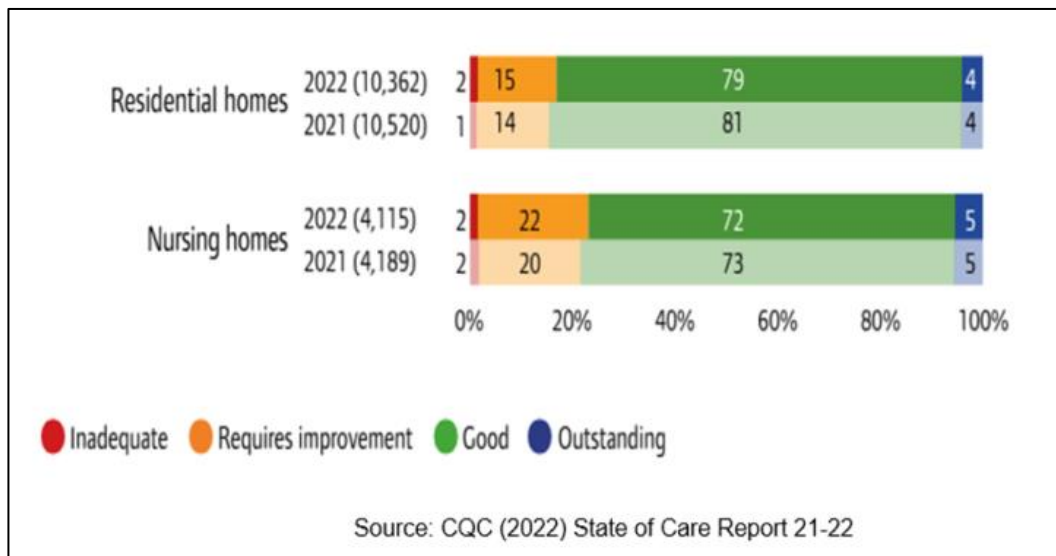


Figure 3 CQC care home ratings

What does inspection measure?

The relationship between regulation/inspection and quality, and the difficulty of measuring this in the complex system I have described, is a core issue. O’Dwyer (2015), examining the role of regulation in care homes, makes the important distinction between a ‘top down’ and ‘bottom up’ approach and suggests this perpetuates the confusion between quality assurance and quality improvement. John Burton’s work, drawing on psychoanalytic and systems theory, remains highly relevant. His challenge is to understand “deeply ingrained problems” rather than simply ‘put procedures in place’ (Burton, 2007). He questions whether institutional defences drive a focus on procedural priorities rather than what matters to people living in care homes and their families. This supports the argument that inspection’s emphasis on complying with procedures and completing paperwork is too narrow and impacts on culture and practice by reducing staff capacity to attend to what matters to older residents and their families (Burton, 2007; Owen and Meyer, 2012; Kennedy, 2016).

Another important, but often overlooked factor, is that staff in care homes are low paid and vacancy rates are high (Allan and Vadean, 2023; Skills for Care, 2023); these structural issues are unlikely to be challenged or changed through inspection. This is captured in Kennedy's (2014) observation that "inspection only weighs the pig, it doesn't help it nurture and grow".

A fundamental question, therefore, is whether the 'right' things are being measured in care homes. To address this, it is necessary to understand what is meant by 'quality' and 'quality of life' for people living in care homes, which I will discuss in the next section.

Quality of life and well-being

I have suggested that concerns over the quality of care provided, and the associated quality of life or well-being of people living in care homes, is a preoccupying discourse. Quality of life for people in care homes is "a complex construct which is variously measured and evaluated" (Milne, 2011, p. 77). What is particularly important to understand is that it means different things to different stakeholders (residents, staff, family carers, professionals and policy makers). These multifarious perspectives and expectations make it a challenging concept to define with any clarity, let alone evaluate. Quality of life is not the focus of my research, so I cannot explore this extensive subject in detail. That said, it warrants some discussion, especially as these issues also contextualise the role social workers could play in promoting well-being. It is noteworthy that quality of life in care homes appears to be a subject located primarily in the dementia literature.

Different perspectives on quality of life

Research around quality of life in care homes has traditionally taken a bio-medical approach, focusing on health measures, such as continence, nutrition and mental health (Milne, 2011; NIHR, 2017). While quality of life in care homes is broader than the narrow focus of health and care needs (Blood and Guthrie, 2018), differing expectations and demands can reduce the capacity of care homes to promote the well-being of their residents (Owen and Meyer, 2012). For example, there can be a tension between what people living in care homes think is important and what professionals or family members value. Cleanliness and safety are often prioritised

by family members and also by professionals (Lopez *et al.*, 2013; Smith *et al.*, 2018). Indeed, Blood and Guthrie (2018, p.91), discussing this topic ask what is the point of being “impeccably groomed but terminally bored?” Yet inspection criteria (especially the importance of the care being ‘safe’ and ‘effective’) are likely to lead to staff’s concerns over the possible repercussions of ‘positive’ risk taking or decisions which may be seen to prioritise well-being over safety.

Milne (2011), focusing specifically on people with dementia in care homes, proposes that discussions around quality of life often focus on enhancing care practices rather than on the older person’s experience. She argues that a conceptual shift is needed to assess quality of life for people with dementia to centralise their subjective experiences and the things that they value. A more recent literature review explored what people with dementia in care homes describe as important (Shiells *et al.*, 2020). Key themes included activities, maintaining previous roles, reminiscence, freedom and choice, appropriate environment, meaningful relationships, and support with grief and loss. This demonstrates that psychosocial and environmental needs are as, if not more, important to older people as meeting physical needs. Similarly the idea that relational practice is key to enhancing the quality of life of care home residents is gaining traction (Kartupelis, 2021). Blackler *et al.* (2023) consider how the design of care homes influences how older people experience a sense of ‘home’. The study suggests, for example, that residents’ ability to personalise their rooms alongside the accessibility and design of communal spaces is key to their quality of life and their sense of identity.

An important contribution to the debate is a comparative study of quality in residential care in England and Australia (Trigg, 2018). This study identifies different quality orientations: organisation-focused quality, consumer-directed quality and relationship-centred quality. Organisation-focused quality focuses on safety and clinical standards of care, consumer-directed quality is aimed at making the environment attractive, with a focus on aesthetics and activities, whereas relationship-centred quality prioritises the individual, what is important to them and focuses on relationships between staff, families and residents. The difficulty lies in the tensions that exist in satisfying the expectations and requirements of these different perspectives and priorities, for example, focusing on making an

environment feel like a home might pay less attention to tidiness/cleanliness (Trigg, 2018). Another study of care home managers found that while personalised care, and the centrality of relationships, is regarded as a key component of good quality care, there are tensions in integrating this approach in daily activities (Ettelt *et al.*, 2022). For example, procedures which may satisfy regulatory requirements and minimise risks (such as medicine management) may neglect the social and emotional needs of the people living there. The study concludes that different approaches to ensuring quality of care involve ‘trade offs’.

Human rights and well-being

A discussion about quality of life for people in care homes would not be complete without a mention of human rights. The pandemic exposed that people living in care homes experienced significant human rights violations (Anand *et al.*, 2022). I will explore this further in the next chapter, and I mention it here to highlight how upholding people’s rights is likely to significantly influence their quality of life and sense of well-being, which, for example, Scotland’s Convention on the Rights of Adults and Older People in care homes acknowledges (Scottish Care, 2019). Quality of life for people in care homes is supported by person-centred, relational care and protection of rights. It is connected to the concept of promoting someone’s ‘best interests’. Graham and Cowley (2015) argue that, notwithstanding its articulation in the Mental Capacity Act, acting in someone’s best interests to support their rights should be the underpinning ethos of care. As discussed above, this is complex terrain; for example, what might be in someone’s best interests clinically, may conflict with what they or their family deem to be in their best interests emotionally or socially. Promoting an individual’s best interests may also run counter to other people’s rights and best interests, particularly in group living settings. These themes, and the tensions they create, resonate with social work values, and lead me to the next section where I will explore the social work role to finish ‘setting the scene’.

Social work

The remainder of this chapter will focus on social work, its contested nature and the wider influences on how the role is enacted. This is an expansive and complex topic, so I will merely introduce ideas and debates which are fundamental to contextualise

the research questions. In this chapter, I will introduce social work generically. I will explore the literature on the social work role with older people in Chapter 3, and I will expand further on understandings of the social work role in Chapter 7 when I discuss the findings.

What is social work?

This seemingly innocuous question is hard to answer with a simple definition (Dominelli, 2009; Horner, 2019). One starting place is the frequently cited IFSW's global definition of social work:

“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” (IFSW, 2014).

This provides a universal sense of social work's broad defining principles and characteristics (Parker and Doel, 2013). Social Work England's definition is useful for an understanding of social work closer to home:

“Social workers support people in a variety of ways. They play a crucial role in supporting change and development, and advocate for a fairer society by tackling inequality. They provide a voice for those that need it, and promote the human rights and wellbeing of those they support.” (Social Work England, 2023, p. 10).

What strikes me about these definitions, and other descriptions of social work, is that they are primarily defined in terms of purpose and values and do not necessarily explain the focus of social work or what social workers *actually do*. They accentuate that social workers deal with inequality and challenges experienced by people, and they emphasise social work's role at an individual *and* structural level. This locates the profession as supporting people whom society deems disadvantaged or troubled,

in a context which is shaped by socio-economic policy and political decision making. This helps to explain one of the paradoxes of the social work role: social workers are positioned to challenge inequality created by social structures, at the same time as representing those structures by predominately being employed as agents of the state (Parker and Doel, 2013). Carey (2012) critiques definitions which fail to acknowledge the competing responsibilities and tasks within the role: the tension between care and control, territory which Thompson (2015, p. 5) describes as “being caught in the middle”. This is fundamental to an understanding of social work, which can be further grasped by exploring how social work has developed in this country.

The origins of social work

A basic understanding of the profession’s evolution puts contemporary issues into perspective and illuminates various factors that have shaped social work’s professional identity. Burt (2020) provides a historical account of the development of social workers’ roles and responsibilities, tracing their roots back to the work under the Poor Laws as overseers of the ‘impotent poor’ and ‘relieving officers’. This created social work’s association with society’s need to ‘rescue’ or intervene to help those deemed unable to help themselves. Horner (2019) argues that social work has always been connected to social and welfare policy, to community work and arguably to political activism. Notably, the post second world war welfare state shifted the role of ‘social work’ and welfare away from philanthropy and charities to be the responsibility of the state. Three main areas of social work were introduced: children’s departments; departments for the ‘elderly’ and disabled; and health-orientated departments, for those with learning disabilities and mental ill-health (Finch and Parker, 2020). The Seebohm Report, published in 1968, was a further turning point for modern social work, organising and consolidating social work responsibilities into single social services departments and creating generic social worker roles (Bamford, 1990; Burt, 2020). By the 1990s, social work departments had started to separate back to adults and children’s services. This merely exemplifies, as Dunk-West (2013, p. 13) suggests, that social work varies “at certain temporal points in history”, shaped by prevailing social policies, political decision-making and legislation. This resonates with the way care homes, as discussed earlier, are also a product of their history and social policy.

Earlier in this chapter, I introduced the idea that neoliberalism has impacted on care home policy. This dominance of neoliberal ideas, focused on limited state involvement and controlling public expenditure, also had a significant impact on the growth of managerialism in social work during the conservative governments of 1979-1997 (Rogowski, 2020). This culminated in the introduction of the National Health Service and Community Care Act (1990) which has been described as “the most influential piece of contemporary neoliberal social policy” (Gilbert and Powell, 2012, p. 264). It significantly impacted on social work, particularly in adults’ services, by reframing social workers as care managers, focused on assessing need and setting up and reviewing ‘care packages’ (Scourfield, 2015; Nelson-Becker *et al.*, 2020). It introduced a managerialist culture underpinned by key performance indicators, targets and associated bureaucracy, which lead to increased inspection, regulation and monitoring in the drive to deliver ‘quality’ (Ray, 2013; Cummins, 2018). It opened a debate on the relationship between social work and care management, with some suggesting that the realised version of care management was a distortion of the principles that characterised it (Lymbery and Postle, 2015). Crucially, care management has been likened to a “straitjacket”, which “suffocated” social work practice, particularly with older people (Lymbery, 2005, p. 121). It impacted on social workers’ autonomy, moving practice away from more relational and community-based approaches and creating a legacy that has been hard to shift (Rogowski, 2020). More recent legislation, for example the Care Act (2014), has attempted to update the framework under which social welfare operates and eliminate any vestiges of the Poor Law (Humphries, 2022). Factors such as the impact of austerity, as mentioned earlier, have arguably undermined its intentions (Lymbery, 2019). Legacies, especially those with entrenched paradigms, are also hard to dismantle (Hudson, 2019).

Prevailing discourses on the state’s relationship with society clearly influence how social work is enacted, which in turn adds a political dimension to social work. For example, Dickens (2018) presents an interesting analysis of Clement Attlee’s 1920 work ‘The Social Worker’. He notes that Clement Attlee was a social worker years before becoming prime minister. Attlee’s vision of social work, as radical, relationship-based, realistic and reciprocal, (and relevant over 100 years later) was entwined with

his left wing political perspective and cements a link between social work, social justice and politics.

Social work as one profession

Social justice can be seen as ‘the glue’ holding together a profession which operates in numerous environments with people who are often characterised by multiple disadvantages. Crucial to a contemporary understanding of social work is that, while it is one profession, it operates within distinct specialisms and organisational structures underpinned by different legislation and policy (Lamont, Allen and Geoghegan, 2020). There is a split between social work with children and families and social work with adults (including mental health) with statutory accountability currently sitting with the Department for Education (DfE) and the Department for Health and Social Care (DHSC) respectively. Lorenz (2007, p. 599) cautions against celebrating the profession as “one happy family”, instead urging recognition of the diversity and discrepancies ingrained in social work’s history. A unifying aspect is that social workers currently undergo generic qualifying training. There are, however, many routes to qualification: some traditional, some fast-tracked, and this has caused division within the profession. Social work became a regulated profession in 2001, with ‘social worker’ becoming a protected title in 2005, meaning all social workers are required to register with the regulator and are bound by the same Professional Standards. There have been successive changes of regulator (from the General Social Care Council to the Health and Care Professions Council, and, since 2019, to Social Work England). This has reinforced a narrative that regulation is needed to monitor social work and improve the quality of social work practice, while failing to take account of the wider organisational or structural factors, such as austerity, that impact on social workers’ ability to do their jobs (Worsley *et al.*, 2020).

Influences on how social work is understood

It is clear that policy plays an important part in constructing the social work role. It is interesting that research commissioned by Social Work England to benchmark society’s perception of social work found that understanding was “child-centric”, that is, significantly more people understood that social workers supported children than supported adults (YouGov, 2023c). Other influences on how social work is

understood by society also impact on social work's professional identity. For example, Leedham (2022) examined how social workers' portrayal in the newspapers creates a discourse which constructs, reinforces and extends society's view of the profession. Media portrayal was found not only to influence public perceptions but also to impact on social workers' own identity and the value they attach to their role. The study also found that 'blaming' stories (for example, coverage of Baby P's death in 2007) can encourage risk adverse, defensive practice and influence government policy. The study's findings are consistent with a survey of 2,000 social workers which reported that public perception of the profession tended to be negative, with media portrayal a contributing factor (BASW, 2022).

However, there is evidence that the public have a more positive view of social work than social workers believe, or the media or government portray. Beddoe, Staniforth and Fouche's (2019) study, albeit from New Zealand, highlights that despite media attempts to create blame and shame, the public understand that social work is a difficult and demanding role, a view reinforced in Social Work England's first report as regulator and more recent research (Social Work England, 2021; YouGov, 2023c). Notably, a literature review commissioned by the Professional Standards Authority showed that many people are confused about what 'social work' is and what social workers do (Penhale and Young, 2015). What is interesting about this evidence is that negative attitudes may be attributed to limited understanding of the social work role, since people who had come into contact with social workers had a much more positive view about them. This mirrors the earlier discussion around people's understanding of care homes.

Social work is shaped by the dynamic societal context in which is situated and is often strongly influenced too by prevailing political opinion (Withers and Pollock, 2020). In the next chapter I will discuss the division between social work with children and adults and the influence of political priorities. It suffices to say here that political opinion can influence, and undermine, how social work is understood.

Social work and social care

This leads me to the observation that, as with care homes, media and societal discourses are often the main source of information about social workers, which

inevitably constructs a distorted perception. Within the context of adult social work (the subject of my study), further ambiguity is caused by the confusion between social care and social work, with social care often being the preferred term in policy making (Dickens, 2012). Needham *et al.* (2024) describe how the term 'social care' emerged as an alternative to 'social services' and set a boundary with health; in the 1990s, it became a popular conflation between social services and community care. Certainly, the terms 'social work' and 'social care' are regularly conflated, despite social work receiving limited attention within the social care arena and related policy. For example, the government's update on its adult social care reform plan barely mentions social work (Department of Health and Social Care, 2023b).

Tensions in the social work role

At the heart of understanding social work is an appreciation of the paradoxes inherent in the role. These are well covered in the literature and usefully summarised by Dickens (2012) in an article reflecting on the definition of social work in the UK as:

1. A tendency to define social work either by its values and principles or by roles or tasks
2. The balance between a narrow focus on the individual or a broader focus on the collective/social change
3. The tension between care and control (also framed as empowerment and protection, or support and safeguarding)
4. What the politicians, the media and individuals expect from social workers and what the profession thinks is important.

An influential literature review examining the roles and issues in the social work profession in England notes that definitions of social work have always been contested (Moriarty, Baginsky and Manthorpe, 2015). The authors evidence that the responsibilities and tasks assigned to social workers echo the disparity between the themes of care and control, cited as the defining feature of social work. This creates a tension between social work's statutory responsibilities carried out within a legislative framework and the relational, supportive, empowering elements of the role, which "influences social workers' workload, priorities and public perceptions of their role" (2015, p.7).

Social work roles are often positioned within a continuum, which has notably been described by authors such as Payne and Dominelli, and is represented in the table that follows. These key perspectives underpin how the role is viewed, which in turn dictates the function or task carried out.

Typologies of social work roles

Author	Role	Description (adapted from original text)
Payne (2005a: 8-9)	Therapeutic	The process of interaction and reflexiveness between the social worker and 'clients' which leads to clients' gaining power over their own feelings or way of life.
	Transformational	Empowering disadvantaged and oppressed people to take part in a process of mutual co-operation and learning.
	Social order	Meeting individual needs during a period of difficulty so they can recover stability again.
Dominelli (2009: 12-14)	Maintenance	Aims to improve individual functioning or adaptation to situations. Assistance is provided on the basis of clearly defined criteria.
	Therapeutic	An off-shoot of the maintenance approach but focuses on what an individual can do to improve his or her situation through targeted professional interventions.
	Emancipatory	This is associated with radical social work and questions the current balance of power in society and distribution of resources. Actions are aimed both at helping individuals and achieving structural change.

Figure 4 Typologies of the social work role (Moriarty, Baginsky and Manthorpe (2015))

Moriarty, Baginsky and Manthorpe (2015) also identify that role ambiguity and role conflict are an inherent part of social work, with roles often defined by who a social worker works for rather than by what they do, a topic I will return to in Chapter 7. Some sources (Wiles, 2013; BASW, 2020) propose that the profession itself struggles with understanding its own role and identity, perhaps due to its “heterogeneity and porous borders” (Dominelli, 2009, p. 7). A large-scale review of the hospital social work role (Steils, Moriarty and Manthorpe, 2020) supports this theme, exposing uncertainties about the purpose of hospital social work in the UK.

A study by Craig and Muskat (2013) found a discrepancy between social workers' self-ascribed roles and those assigned by other professionals. They found that social workers self-described with terms like 'bouncer', 'janitor', 'juggler', 'firefighter'. This supports the work of others who have described the versatility of social workers' roles (Asquith, Clark and Waterhouse, 2005; Dominelli, 2009). It also supports the

idea that social workers pick up the “dirty work” that no one else wants to do (Thompson, 2015; Morriss, 2016).

Social work’s value base

Social workers often describe what they do in terms of their values (Wong, 2021) and an understanding of social work is incomplete without some discussion of its value base. BASW’s¹⁹ Code of Ethics directs social workers to underpin their practice by the guiding values of human rights, social justice and professional integrity (BASW, 2021b, p. 2). The Professional Standards require social workers to “promote social justice, helping to confront and resolve issues of inequality and inclusion” (Social Work England, 2019).

There is little doubt that social justice is the bedrock of social work’s value base, yet the concept is rarely defined (Hudson, 2016). On a fundamental level, it has been defined as “making society better – providing the support and tools to turn lives around” (HM Government, 2012). This definition merely hints at the ‘big and small’ nature of social justice (Thompson, 2017), which I believe is key to its understanding. Social justice needs to be imagined as working on an individual, organisational and structural level, and this mirrors the global definition of social work described earlier. It involves promoting a more equitable and fairer society and, at the same time, advocating for individuals. This perspective illuminates how social work’s commitment to social justice is a mechanism for both upholding more broadly, and helping people to access individually, their rights.

This commitment to social justice, however, exposes social workers to the conflict, articulated by Trevithick (2008), around whether they are trying to change the system or help people fit into it. Thompson (2015) argues that since social workers operate at the intersection of the personal and socio-political, intervention can either challenge or reinforce inequalities. In essence, social workers are predominantly agents of the state but their professional values and unique social justice lens create a strong source of dissonance. As mentioned earlier, this gives rise to role conflict and impacts on the autonomy and professional discretion social workers feel they have (Moriarty *et al.*, 2015). It leads to tension between the ethical imperative to work within the values of one’s training (professionalism) alongside the demands of

¹⁹ BASW is social work’s professional association.

working as an employee in a bureaucratic organisation (managerialism) (Parker and Doel, 2013). I will return to these ideas in chapter 7 when I discuss my findings.

Who sees a social worker?

Finally I will consider who sees a social worker. Thompson (2015) proposes that social workers typically step in when society has failed its citizens, an idea that mirrors the concept of the care home as the place of last resort. Social workers work with a range of individuals from diverse backgrounds in a variety of settings, but they usually become involved at difficult times in people's lives. An inquiry to spotlight the reforms needed in adult social care encapsulates this well, commenting that "unlike the NHS, which cares 'from cradle to grave', we collide with adult social care usually at a moment of crisis, of unexpected transition, when our lives appear to be changing for the worse" (House of Lords, 2022). Yet despite affecting 10 million people at any one time, people have a limited understanding of adult social care (and by inference social work), and it remains largely out of sight until needed (House of Lords, 2022).

Despite the potential for social workers to offer psycho-social support, advocacy and 'early help', their role is often rationed to people in the 'greatest need', due to limited resources and the inequalities built into the wider system. In a survey of social workers, two-thirds cited the biggest challenge for the profession as the failure to adequately fund social care (BASW, 2022). Morris *et al.* (2018, p. 18) describe inequality and poverty as social work's "wallpaper of practice", which is "too big to tackle and too familiar to notice." All this links social work with a discourse of crisis and failure. It stigmatises people who 'need' to see a social worker, and impacts on the profession's perception of their own identity and how they are viewed by other professionals.

This is potentially further compounded by the lack of agreement over the language used to describe the people that social workers see. McLaughlin (2009) explores this issue and argues that the different terms used in social work, notably 'client', 'customer', 'service user', 'expert by experience', signify different relationships with social work and conjure different identities based on differing power dynamics. Despite this article being 15 years old, my professional experience is that the debate and the tensions it creates continue.

Where is this leading?

In the next chapter, I will continue to explore the literature around the social work role, with a focus on social work with older people and the role in the context of care homes. For now, I have introduced the key message that socio-economic, political and policy influences construct how social work operates in a changing, fragmented and complex landscape. The constructs and conceptualisations I have explored are important to set the scene; notably they have influenced my study design, the research questions and will inevitably influence the participants, the research findings and the conclusions I will draw.

In summary, my study is situated in the challenging context of an ageing population, who are living longer with complex needs, at a time of increasing inequalities, a cost of living crisis and reduced funding for local authorities overlaid by the Covid-19 pandemic. The policy landscape is fragmented, crowded and complex and is entangled with both the people working in social care and those drawing on social care and their families. What is striking is that both care homes and social work hold contested and complex narratives, suffused with paradoxes. They both appear to be poorly understood, not least because for many people their understandings are distorted by sources of information rather than direct contact. These structural influences provide a backdrop against which to explore the literature in the next section. The next chapter will identify how others may have explored the problem before, explore the themes from the literature and the main questions raised by this picture.

Chapter 3: Reviewing the literature

The previous chapter explored the socio-economic and policy context in adult social care, situated the complex construct of care homes, and introduced the social work role and its inherent tensions. This chapter will look more specifically at the literature around social work with older adults in care homes. I will initially discuss social work with adults and its underpinning approaches. I will consider social work with older people before examining the literature around social work with care homes. In doing so, I will touch on what Covid-19 revealed about this topic. I will determine what can be inferred from the literature about social work in other specialist areas, such as hospice and hospital social work. In the absence of an established body of research about the social work role in care homes in England, I will also explore literature from other countries where the role has more prominence. I will finish the chapter by summarising the main questions raised by the literature. Firstly, however, I will discuss the purpose of the literature review and the approach I took in this thesis.

How I did the literature review

I began the study through the route of a doctorate in social work and transferred onto a PhD programme at a different university in October 2022. The additional (30,000) word count allowed me to devote a supplementary chapter (Chapter 2) to situate the study; the approach that I will describe also underpinned my synthesis of the literature in the preceding chapter.

The purpose of the literature review

A literature review is a critical examination of the knowledge on a topic, which serves as a framework to establish the study's importance and its relationship to other work in the field (Creswell, 2014). According to O'Leary (2017), its purpose is more than merely 'reviewing' the literature: it creates a contextual account of the relevant knowledge on a topic and establishes the study's necessity and significance.

Received wisdom centres on the importance of identifying a 'gap' in the literature (Lingard, 2017), but this perspective, particularly in qualitative research, overlooks the dynamic way that knowledge is constructed and the importance of research 'building' on what has gone before. This is summed up by Thomas (2017, p. 57) who notes "you are not an island; your work must occur in the context of what is already

known". My aim was to identify the 'space' in the field for this research and to explore how the study can contribute to and develop existing debates.

My approach

A systematic review aims to produce a meticulous summary of available research in response to a research question and is a common method used in quantitative or scientific research (Clarke, 2011). Qualitative research take a similarly questioning and critical stance towards the literature and places importance on assessing quality, reliability and relevance, but is more likely to draw on a narrative approach, which Gordon (2018) suggests creates a 'mosaic' of the literature to bring together different parts of a picture. Similarly, Manthorpe and Martineau (2010, p. 219) describe a scoping review as a "reconnaissance", which assesses the extent and current state of the research on a subject. I was influenced by these last two approaches as I navigated through an extensive body of literature to assess the field; taking a reflexive approach generated new ideas and pathways to follow which led to a highly recursive process. Undoubtedly the literature review was an iterative process which evolved and shaped my thinking throughout the thesis.

Identifying literature

I searched electronic databases (including Social Care Online, Social Services Abstracts, International Bibliography of the Social Sciences, Web of Science, SCOPUS, PsycInfo, CINAHL) using a combination of search terms²⁰. I also used Google Scholar. I 'hand searched' journals, including British Journal of Social Work, Ageing and Society, Journal of Social Work Practice, Journal of Gerontological Social Work, European Journal of Social Work, Qualitative Social Work and Journal of Social Work in End-of-Life and Palliative Care. I also "reference harvested" bibliographies in key journal articles and reports to identify relevant material (Moriarty, Baginsky and Manthorpe, 2015, p. 2).

I focused on peer reviewed research, but I did not discount other relevant sources, particularly academic books about social work and social policy. I searched key websites for information, particularly to build the evidence base for Chapter 2. I drew

²⁰ Main search terms with Boolean operators used: social work, with role, tasks, responsibilities, discretion, care manager; care homes, long-term care, residential care, nursing home; older people, older adults, ageing, dementia, gerontological social work; admission, transition, reviews, safeguarding, DoLS, BIA.

from 'grey literature', that is material which occupies a 'grey area' compared to traditional published material with an ISBN or ISSN (Bell, 2017). This came from multiple sources, including datasets, policy and organisational literature, and was valuable for background and context. As noted in Chapter 2, retrieving accurate data about care homes and people living in them was a particular challenge, not helped by the cyberattack on the British Library in October 2023 which impacted on the availability of key sources (this continues at the time of writing).

I quickly discovered that research specifically about social work and care homes is not extensive. Since the research topic spans various areas and disciplines, my search became "deliberately expansive" to allow for material from different sources (Higgs and Hafford-Letchfield, 2018, p. 231). I explored other specialist areas of social work practice from which I was able to infer information. I prioritised literature from England/UK, but my search yielded a large amount of literature from other countries. This was instructive and offered insights into other models of practice and their possibilities. I encountered a few challenges, for example, as previously noted, social work and social care are often conflated, and this often made it harder to navigate through the literature. The study was also undertaken during the Covid-19 pandemic, and research was often situated in this context, which added another dimension. In a field that is wide and fragmented, new research and literature is constantly emerging, so it was difficult to feel content that my "never ending" literature searching was over (O'Leary, 2017). It is with that caveat that I move on to explore the 'mosaic' of literature that I have pieced together.

Social work with adults

While social work exists as one profession, the distinction is commonly made between social work with children and social work with adults. As of 30 November 2022, there were 100,654 registered social workers in England, with 31.2% working in adult social care (Social Work England, 2023). Latest available workforce statistics²¹ show that local authorities in England had 33,100 full-time equivalent (FTE) children and families social work posts (Department for Education, 2024) and 18,500 FTE adult social work posts (Skills for Care, 2024). This raises the question of whether there is a greater need or a greater appetite for social workers in children's

²¹ In contrast to children's social work, there is no government workforce data specifically for adult social workers.

services or, more pertinently, whether children have a greater 'right' to support from a qualified social worker. Alongside direct care, management and regulated professional posts (the latter includes social workers), local authority adult social services departments also employed 25,300 posts described as 'other' (Skills for Care, 2024). This 'other' group includes, though is not limited to, unqualified workers who undertake a range of social work 'tasks' e.g. reviewing care packages, assessments of 'non-complex' cases. This happens far less regularly in children's social care, and highlights the more contentious nature of, and value placed on, social work in adult social care. The government's financial investment in the Step Up to Social Work and Frontline programmes, offering specialist qualifying pathways for 'high calibre' candidates to become children's social workers (Department for Education, 2021), further supports the view that the status of social work and the populations it works with are determined by political and policy priorities, rather than need or what is valued by people. Although there is a fast-track qualifying route for adults' social workers (Moriarty, Baginsky and Manthorpe, 2015), it is focused *solely* on specialising in mental health social work. There is a disparity between the level of government funding to support NQSWs on the ASYE. Employers have traditionally received £2,000 per NQSW in children's services (Department for Education, 2019) compared to around £1,000 in adult services. Later in this chapter, I will consider how social work with *older* adults is even further devalued within the profession, especially in pre-qualifying education, and consider what impact this might have on practice.

Social work in the two 'sectors' is underpinned by different legislation and policy, with a trend for increased specialism within practice (Sen, 2021). My study focuses on social work practice with older adults and so is rooted in, and sometimes obscured by, the broad scope of social work with adults (Moriarty and Manthorpe, 2016). Moriarty and Manthorpe's (2016) systematic scoping review of adult social work suggests that the breadth of practice and the way it is embedded in social, political and organisational contexts creates challenges in assessing its effectiveness. The review also identified difficulties in evaluating the specific contribution, or the effectiveness, of social work input in multi-disciplinary contexts. This supports the view that social work with adults is shaped by multiple factors such as "organisational context, structure and mandate, access to resources, legislation, theoretical cultures

and professional knowledge” (Department of Health and Social Care, 2019, p. 3). It is enmeshed in the complex adult social care eco-system, which it has been suggested “is not rocket science: it is much more complex and subtle than that” (Beresford, 2005).

Legislative framework and strengths-based approaches

The Care Act (2014) is the key legislative framework underpinning social work with adults in England. As discussed in the preceding chapter, neoliberal policies and care management narrowed and “shackled” the social work role with adults (Megele, 2015; Dix, Hollinrake and Meade, 2019; James, Mitchell and Morgan, 2020, p. 24). The Care Act (2014) heralded the introduction of a strengths-based, holistic approach which countered managerialist and deficit-based approaches and aimed to focus on ‘what is strong, not what is wrong’ (Whittington, 2016; Department of Health and Social Care, 2019). At its core is the concept of well-being, and the need to “consider the person’s own strengths and capabilities, and what support might be available from their wider support network or within the community to help” (Department of Health and Social Care, 2023, 6.63). It requires local authorities to carry out their duties in a way that is *consistent with* the principles of a strengths-based approach (Department of Health, 2017; Caiels, Milne and Beadle-Brown, 2021). Definitions of strengths-based practice highlight that it is a collaborative process to identify desired outcomes drawing on a person’s strengths and assets, focusing on relationships and the quality of those relationships (Pattoni, 2012; SCIE, 2015; Moore, 2022). It treats people as more than just their care needs but as experts in their own lives (Fox, 2013). Importantly, strengths-based practice is both a philosophy and a lens through which to understand people and their well-being (Ford, 2019).

Person-centred, relationship based practice to build on an individual’s strengths is not new: it reflects social work’s core values and has roots, for example, in the humanist approaches of Carl Rogers (Gray, 2011; Department of Health, 2017; Nelson-Becker *et al.*, 2020). What is new is that it has explicitly become the dominant approach in adult services and is directed within policy and legislation (Dix, Hollinrake and Meade, 2019). The principles embedded in the Mental Capacity Act (2005) also support this approach. This runs alongside a growing movement to reclaim rights-based social work practice, with strong grassroots voices like Social Care Future, Shared Lives and Think Personal Local Act backing the profession to “fit support

around a good life instead of asking people to fit their lives around a good service” (Fox, 2018).

Strengths-based approaches: vision and reality

The difficulty in evaluating the effectiveness of strengths-based approaches and the limited evidence base presents a challenge (Caiels, Milne and Beadle-Brown, 2021). Several authors (Whittington, 2016; Slasberg and Beresford, 2022) have argued that, despite the positive intentions to promote person-centred, strengths-based practice, the socio-economic and political context shaping social work has not allowed the ambitions of the Care Act to be realised. A recent study by Caiels *et al.* (2024) found that practitioners were positive about strength-based approaches, but cited organisational and structural constraints as the main challenges to their ability to apply the approach in their work. For example, they identified that ‘systems’ were often incompatible with taking a strengths-based approach, requiring practice to adapt to ‘fit’ procedures. Insufficient funding, workload and workforce pressures were also reported as barriers. It is hard to ignore the difficult circumstances in which social workers operate and the convincing argument that good practice cannot change a system based on eligibility and constrained resources (Slasberg and Beresford, 2017). Certainly, the positive language of strengths-based approaches can ‘jar’ with the language required to “argue for entitlement” when resources are limited (Moore, 2022, p. 454). The policy message is that strength-based approaches are *not* motivated by the need to reduce funding, provide less support or shift responsibility from professionals to individuals and carers (Department of Health, 2017; Department of Health and Social Care, 2019). Critics, however, argue that, given the devastating impact on public services of more than a decade of austerity, its metrics *are* based on a neoliberal urge to cut costs, reduce dependency and ‘outsource responsibility’ (Milne, 2017; Slasberg and Beresford, 2017; Ford, 2019).

Strengths-based principles of autonomy and self-determination can be conflated with neoliberal notions of individual responsibility and ignore the barriers people face from structural inequalities (Gray, 2011). In their evidence review, Caiels, Milne and Beadle-Brown (2021) highlight that the unequal allocation of resources and power may further exacerbate inequalities for already marginalised groups, and this would certainly apply to older people. This resonates with Lloyd’s (2010) observation that, despite the universal inevitability of dependence, the need for care is viewed

negatively as it runs counter to the political goal of promoting independence and self-reliance amongst active citizens. It is important to consider how the discourse of independence, autonomy and strengths can appear to blame or pity people who need care or downplay the reality and difficulties of living with ill-health or disability (Nelson-Becker *et al.*, 2020; Moore, 2022). Drawing on a psychodynamic perspective, Moore (2022, p. 451) suggests that the latter approach of *only* focusing on strengths might fulfil an “unconscious need to contain anxiety for social workers and wider system”, especially when faced with rationed resources. All these arguments speak to the disconnect between the aspirations of strengths-based practice and the current reality of a ‘broken’ adult social care system, further battered by a recruitment and retention crisis (Duffy, 2017).

Social work with older people

The incongruity between policy and practice goals is more pronounced in respect of social work with older people and several factors may explain this. I noted above, and explored in Chapter 2, how the prized status of independence in public and policy discourses associates ‘old age frailty’ and the need for care with narratives of failure, burden and blame (Higgs and Hafford-Letchfield, 2018). Nelson-Becker *et al.* (2020) argue that labelling older people as ‘frail’ and ‘dependent’ suggests that their vulnerabilities and needs are more important than their abilities. Such a narrative undermines person-centred, strengths-based approaches with older people and overlooks the life-time of experience and coping strategies they draw upon (Vishal, 2018). This perspective is reinforced by discourses blaming an ageing society for the economic crisis in the health and social care system (Hastings and Rogowski, 2015) and ageist assumptions that older people are a “social problem” (Hardy, Hair and Johnstone, 2020, p. 450). This narrative persists despite evidence which identifies the economic contribution that many older people makes through unpaid caring responsibilities, financial support to families and volunteering (Duffy, 2017).

What does ‘social work with older people’ mean?

Policy approaches tend to overlook older people and see them as less of a priority for a social work service (Ray, 2013; Ray *et al.*, 2015; Nelson-Becker *et al.*, 2020). The organisation of social work practice appears to reflect systemic ageism, with social work with older people rarely identified as a specialism, and older people usually

accessing social work support through generic adults' teams. Only 7% of registered social workers describe their practice area as with 'older people' (Social Work England, 2023) and it is unclear whether this describes the registrant's 'client group' or the team to which they belong. Social workers might describe themselves as working in hospital teams or as working with 'adults' in the community, but they are mostly seeing older adults, as it is estimated that 65% of adult social care practice is with older people (Tanner *et al.*, 2023). Given the constraints of the current system and the high eligibility criteria to access public care, social workers usually only see older people with significant frailty and/or dementia living with complex and multiple needs, who tend to have few resources, often at times of crisis (Nelson-Becker *et al.*, 2020). It is also worth noting that self-funding older people rarely receive support from a social worker, despite evidence suggesting that this would be beneficial (Baxter, Wilberforce and Birks, 2021). Social work 'with older people' is in reality with a small subset of older people.

Professional status and attitudes in qualifying education

Social work with older people's status within the profession is a crucial factor in understanding the influences on practice. Critics, such as Ray *et al.*, 2015; Carey, 2016a; Willis *et al.*, 2021, have argued that social work with older people has long been under-valued and the insufficient attention paid to this area of practice was further amplified by the Covid-19 pandemic (MacLochlainn *et al.*, 2023). Nelson-Becker *et al.* (2020, p. 330) describe it as:

“a Cinderella service, attracting lower levels of interest, status, resources, specialist training and research funding compared with other areas of practice.”

Several studies reinforce this view and highlight ageist or negative assumptions towards working with older people, primarily in qualifying social work education (Chonody *et al.*, 2014; Goel, 2019; Ridgway, 2019). Research undertaken both in the UK, and more widely, suggest that social work students are unlikely to *want to work* with older people (Richards *et al.*, 2014; Štambuk, Vertuš and Skokandić, 2023). Anecdotally, working as the placement co-ordinator in a London university several years ago, I noticed that children's services placements were in greater demand by students than placements with adults, especially with older adults. Lymbery (2019) also argues that practice with older people is consistently unpopular with students, both in the UK, and internationally. He suggests it is often regarded as “essentially

straightforward and lacking in professional satisfaction” (2019, p. 43), which not only reflects the low status of older people in society but also belies the skill needed to work with people with complex health and emotional needs.

Goel (2019) argues that social work students’ reluctance to have placements with older people is often underpinned by ageist perceptions, alongside assumptions that older people cannot change or that the work will be depressing or transactional. Students’ unwillingness to work with older people often stems from anxiety about their own ageing and death. The study reported evidence of positive changes in students’ attitudes towards social work with older people after specific content on ageing and social work’s role in supporting older people was embedded into the curriculum. Baik and Davitt’s (2022) systematic review of social work students’ attitudes towards older people also found evidence that greater familiarity and understanding of older adults, gained by working with them, impacts positively on attitudes and perceptions. Another recent study of trainee social worker in Croatia found that students’ reluctance to work with older people was due to a lack of knowledge and preparation, which the study attempted to address by exploring the importance of student placements with older people (Štambuk, Vertuš and Skokandić, 2023). Ridgeway’s (2018) research speculates that if a social worker’s role is to challenge oppression and age discrimination, then it is vital that they explore, reflect upon and challenge their own attitudes. Her study focused on UK social work students’ perceptions of ageing and older people, using social constructivism and visual discourse analysis to understand how their social and cultural assumptions constructed meaning and language about age and influenced how they viewed older people. Involvement in the research was found to have a positive impact on the students’ attitudes towards older people.

Student placements in care homes

Two studies focus specifically on social work student placements in care homes (Dunworth, 2013; Milne and Adams, 2014). Dunworth’s (2013) small-scale Scottish study developed social work placements in care homes using the framework of the US literature on psychosocial care in nursing homes. The study found that care home staff noted improved practice and a more person-centred approach which they credited to the students’ input and the students gained valuable learning in relation to

“communication, holistic assessment, ageism, inter-professional understanding and the use of self” (2013, p.208). None of the students initially welcomed their placements, reinforcing their negative bias towards older people and institutional care, but they subsequently advocated for this placement to be available for all social work students. Milne and Adams’ (2014) study of twelve social work placements across seven care homes focused on developing students’ critically reflective practice and drew similar conclusions. Both studies concluded that placements in care homes can provide enriching learning for students around ageism, develop social work skills and may function as a catalyst for improved practice in care homes.

A more recent English study (Kelly *et al.*, 2023) reported on an innovative inter-professional education initiative in care homes. The six-week training programme ‘transformed’ students’ perceptions of working with older people and care homes, alongside enhancing their understanding of older people and the care home environment.

The need for a specialism

Several studies (BASW, 2020; Steils, Moriarty and Manthorpe, 2020) note that social workers’ professional identity and attitudes are primarily forged during social work qualifying training. Thus, there is a danger that the neglect of ageing or lack of focus on older people in the social work teaching curriculum (Richards *et al.*, 2014; Lymbery, 2019), together with the contemporary organisation of social work practice, contributes to the marginalisation of social work with older adults. There is limited research attention on the attitudes of *qualified* social workers towards working with older people, although a narrative persists that it is not ‘real’ social work (Wang and Chonody, 2013; Carey, 2016; Duffy, 2017). Overall, this picture reinforces the importance of the specialist knowledge and skills needed to counter oppressive ageist narratives *and* to work with older people, whose needs are characterised by complexity and heterogeneity (Ray *et al.*, 2015; Carey, 2016; Duffy, 2017; Nelson-Becker *et al.*, 2020; Willis *et al.*, 2021). The Capabilities Statement for Social Work with Older People was a well-intentioned attempt to redress this deficit, by outlining and promoting the distinct skills, knowledge and expertise needed for social work with older people to “flourish” (BASW, 2018); a supplementary resource has recently been developed to support and guide their use (Nosowska *et al.*, 2023). At the time of writing, however, these capabilities do not appear to have been widely promoted or

used in practice. This may be because they were not supported by funding or by an expectation that acquiring these skills conferred 'specialist' status or career opportunities.

Willis *et al.*'s (2021) study is an important contribution in considering the settings where social work with older people occurs, and the roles and tasks involved. It highlights that minimal evidence exists about *how* social workers meet the needs of older people or indeed in which teams they are located. This may be emblematic of losing specialist social work with older people in the wider definition of adult social work. This has long been identified as a challenge: for example, work led by eight social work academics engaged in research and teaching in gerontological social work²², with The College of Social Work,²³ offered a 'vision' of the role, aims and distinctive nature of social work with older people as a specialism (Milne *et al.*, 2014). There is scope to be cautiously optimistic that social work with older people is gaining traction as an area of research. The recent SWOP study²⁴, funded by NIHR School for Social Care Research, interviewed social workers, older people, carers and professionals to find out what social workers do, how they work with older people and the impact of this work (Tanner *et al.*, 2023). The research found that social workers' blend of expertise, skills and knowledge is unique, their practice is valued by older people, and, most notably, that the social work relationship can be an intervention in itself. The research also identified significant barriers at a societal, policy, cultural and organisational level, which hinder social workers from being able to work effectively with older people. One interesting finding, resonating with the importance of acknowledge and reflecting on the complexity of working with older people described earlier, was the need to recognise and attend to the emotional demands of working with older people. This is something I will discuss later in the thesis in relation to my findings. The research is important in highlighting barriers *and* enablers to good social work practice with older people and, crucially, in arguing for social work with older people to have a higher profile in policy, education, training and across health and social care (Nosowska *et al.*, 2023).

²² Gerontological social work refers to social work with older people.

²³ The College of Social Work was established in 2012 following the Social Work Reform Board's recommendation that the profession needed a national college to articulate and promote social work, improve standards and provide strong independent leadership. It closed less than four years later due to lack of funding.

²⁴ The SWOP Project stands for Social Work with Older People.

It has been suggested that social work with older people is “interchangeably referred to as gerontological social work” (MacLochlainn *et al.*, 2023, p. 3839), certainly in America where the term is more frequently used; I would argue that this is notably the case within research and academia, and less commonly used as a term in practice in the UK. I will return to the subject of gerontological social work, towards the end of the thesis. For now, it is sufficient to acknowledge the importance of specialist gerontological social work practice to challenge ageist attitudes and systems, promote rights-based practice and enhance the lives of older people (Milne *et al.*, 2014; Hastings and Rogowski, 2015; Ray *et al.*, 2015; BASW, 2018; Tanner *et al.*, 2023) and to counteract the socio-economic and professional impacts of neoliberalism (Torres and Donnelly, 2022).

The preceding section outlined how social work with older people attracts limited attention and research. This is important to understand as it foreshadows that social work with older people *in care homes* is even more likely to be overlooked or undervalued, and, significantly, is hard to locate evidence about in the literature.

Social work in care homes

There is a dearth of research specifically about social work in care homes in England. The limited attention paid to social workers' involvement *within* the care home can be attributed to social workers rarely being employed in this setting, since social work with older people primarily takes place in hospital and community settings (Hardy, Hair and Johnstone, 2020). In this section, I will examine what the literature reveals about the tasks and responsibilities undertaken by social workers with older people moving to or living in care homes in England.

In contrast, there is more *international* research published on the role of the social worker in care homes (it is important to reiterate that different terms, such as long-term care facilities, are often used). In particular, an Australian scoping review (Hardy, Hair and Johnstone, 2020) and a small Canadian qualitative study exploring how social workers understand their roles (Wong, 2021) are more recent contributions to the knowledge base. The international literature is an instructive source, and the complex needs of older people, the institutional nature of care homes and the dominance of a bio-medical approach in care provision are common features of this

work, despite variations in policy contexts, regulatory frameworks and welfare regimes. I interweave some generalisable findings from international studies in this next section, and later in the chapter, I will more explicitly examine the social work role in other countries and consider the comparisons to be made with the UK, and more specifically England.

A limited role

I discussed earlier the relationship between the impact of neoliberal policy over several decades and the narrowing of the social work role. I also presented a case study from my practice in Chapter 1, which exemplified the limited interaction care home residents and their families often have with social workers. These themes are dominant in the work of several authors, who reinforce the argument that social workers have little contact or engagement with people in care homes (Manthorpe and Martineau, 2010; Ray *et al.*, 2015; Higgs and Hafford-Letchfield, 2018).

Higgs and Hafford-Letchfield's (2018) narrative literature review examining funding arrangements for residential care is a key contribution to the field. The review considers that the skilled intervention of a social worker is key to providing information and advocacy, and supporting decision-making, at what is often considered to be a time of crisis for older people and their families. They propose, however, that few social workers have had sufficient training to understand the complexity of the funding procedures, let alone support others with them. Access to support from a social worker is hugely inconsistent and is further limited for those whose assets determine their status as self-funders. Acknowledging the impact of several decades of neoliberal socio-economic policy, the authors identify a dissonance between social work's professional value base and the reality of resource-driven practice. The review's most notable finding is the inconsistency over social workers' input at the point of moving to a care home and the subsequent limited opportunities for ongoing social work involvement. The authors conclude that, in this context, the social work role is "often extremely limited, rather mechanistic and perhaps somewhat unsatisfying" (Higgs and Hafford-Letchfield, 2018, p. 235).

Similarly, Manthorpe and Martineau's (2010) scoping review of the role of advocacy in supporting care home admissions found that, due to the considerable proportion of

self-funders, many people have little engagement with social work when they enter residential care. They found that social workers' focus is to ensure that people do not stay in hospital longer than necessary and this often reduces their time for advocacy work. In a later study of Serious Case Reviews²⁵ (SCRs) involving people with dementia, the same authors found that older people with dementia who were paying for their own care rarely had contact with "professional social work systems" (Manthorpe and Martineau, 2016, p. 527). These findings underscore the ever-growing distinction between self-funders and those older people who rely on public sources of funding.

Manthorpe and Martineau (2017) also carried out a documentary analysis of thirty-eight SCRs involving older care home residents in England. They found significant failures around discharge planning and admission to care homes, and limited reviews of residents' well-being once they had moved. Perhaps unsurprisingly, they found the social work role to be largely absent, particularly once people had moved into a care home. What is more interesting, however, is the authors' explicit suggestion that excluding social workers from involvement with care home residents may contribute directly to failures to identify, minimise or respond to abuse. Key to this analysis is the message that SCRs (now termed SARs) are a means to consider the problems that can arise "when care home residents are excluded from social work skills and attention" (Manthorpe and Martineau, 2017, p. 2096).

A further study of eleven SARs concerning the abuse of adults in care homes identified professionals' 'narrow' approach to abuse, and the tendency to overlook the wider picture of patterns of concerns or systemic failures (Starns, 2018). While this study does not specifically mention the social work role, it underlines the significance of a proactive professional presence (from an external agency) in the care home to prevent abuse and support positive outcomes for residents. These studies provide traction to promote the need, and possibilities, for the social work role in care home contexts where the risk of abuse and the restriction of rights is likely to be amplified amongst people with complex needs, particularly dementia (Ray *et al.*, 2015).

²⁵ Serious Case Reviews (SCRs) became Safeguarding Adults Reviews (SARs) under the Care Act. Their purpose is to promote effective learning to prevent future deaths or serious harm occurring when an adult has died as a result of abuse or neglect, or is still alive and has experienced serious abuse and there is concern that partner agencies could have worked more effectively to protect the adult.

What are social workers doing?

Carey (2016, p. 345) argues that:

“If social work retains a presence within ‘post-Welfare’ domains, this tends to coalesce around a narrow focus upon safeguarding, supply-side resource rationing, risk aversion, facilitating informal care and self-help or playing a limited and largely administrative role in larger arenas of welfare such as health care.”

The limited research on the topic of social work and care homes seems predominantly to support this reductionist perspective. When social work is described, it tends to intersect with care homes at the point of crisis or in respect of statutory tasks, such as safeguarding, reviews and involvement in DoLS. I did not specifically explore the topic of multi-disciplinary working or inter-disciplinary literature, but, in general, I encountered limited emphasis on social work’s contribution to multi-disciplinary working in the care home context. Several years ago, ADASS and Department of Health released guidance (Cooper, 2017) highlighting social work’s essential contribution to integrated approaches to care, particularly in promoting personalised, strengths-based practice, building a team around the person, managing risk and uncertainty, and bringing challenge to decision-making. The guidance suggested that social work’s contribution to integrated approaches needs to be “clear, captured and communicated” (Cooper, 2017, p. 10). It is pertinent to consider whether the profession’s struggle to clearly articulate its role and value (Cootes, Heinsch and Brosnan, 2022) might undermine its place and effectiveness within multi-disciplinary teams.

It is noteworthy that the NHS Long Term Plan supports collaborative working between health and social care for people in care homes through the Framework for Enhanced Health in Care Homes (NHS England, 2023). ‘Social care,’ however, appears to be interpreted as social care providers, commissioners and the sharing of data; there is no mention of the contribution from social workers, aside from a recommendation that multi-disciplinary teams should include ‘social care staff’.

Transitions or moving to a care home

One area of social work involvement described in the literature is around an older person’s move or ‘admission’ to a care home. What is interesting is that often social workers are described as supporting transitions between *services* or *settings*, rather

than supporting a person holistically. Tanner, Glasby and McIver (2015) argue that the move to a care home often focuses on the physical process of moving rather than the social, psychological and emotional significance of this transition. They identify that older people may require support to cope with multiple losses, including loss of their home, identity and independence, and to deal with the transition of moving and adjusting to a new life. They suggest that older people are more likely to view the move to a care home positively when they have choice and information and can participate in the decision-making process. Given social workers' skills of empathy, advocacy and assisting people through change, Tanner, Glasby and McIver (2015, p. 2064) contend that supporting people with care home transitions should be "fertile ground" for the profession. However, the research evidence suggests that, in organisations driven by resource constraints, many practitioners do not have time or organisational permission to support older people with the psychological and emotional impact of their move to a care home. This echoes older work by Dwyer (2005) which examined how social workers want to support older people holistically with the difficult transition of moving into a care home, but are often constrained by organisational pressures, such as time and resources.

Research undertaken on the 'right' time for people with dementia to move to a care home reinforces the significance of the transition (Cole, Samsi and Manthorpe, 2021; Samsi, Cole and Manthorpe, 2022). Samsi, Cole and Manthorpe's (2022) study identifies a range of complex and personal factors for people with dementia and their carers when deciding the best time to move to a care home. The small qualitative study found evidence that planning, prior knowledge and familiarity with care homes assisted with decision-making. It also noted that, within the current system, opportunities for planning are less likely for people whose care is funded by the local authority, or for those with no family or support networks. The research highlights individuals' limited understanding of entitlements and funding arrangements and that care home providers often have to supply this information. While the study exposes a significant gap in the provision of support and information for people moving to a care home, it falls short of suggesting that this is a role for social workers.

The study also interviewed social workers and care home managers (Cole, Samsi and Manthorpe, 2021). The social work role is not the focus of the study, but it provides useful information on the role social workers can take when people move to

a care home. The study found that social workers understood that moving to a care home at a time of 'crisis' was far from optimal, but in practice, this is what usually happened. One consequence of this is that social workers are then required to make 'best interests' decisions on behalf of an older person, if they lack capacity to make the decision themselves. Again, this highlights the tensions between good, person-centred practice and the constraints of the system. The narrative that people should be encouraged to live at home independently for as long as possible also creates a barrier to having early discussions about residential care. This, together with financial pressures and eligibility criteria, usually leads to social workers only recommending a care home in a crisis or as a 'last resort,' particularly for people funded by the local authority.

While not focused specifically on the social work role, a small number of older studies describe the importance of providing support to family carers through the transition of moving their loved one to a care home (Sandberg, Lundh and Nolan, 2001; Davies and Nolan, 2004). For example, Davies and Nolan's (2004) small qualitative study explored the perspectives of people whose relatives had moved to a care home. It found that the support needed for family members was often overlooked, despite the significant losses and change that they also experienced when their loved one moved to a care home. It suggests that staff support for family members is critical, but often lacking.

Evidence of how the complexity of social work practice is undermined can be found in the National Institute for Clinical Excellence (NICE)'s guidance relating to social work (2017). One example encourages social workers, who are feeling the pressure to discharge people from hospital, to use the guidance on transition from in-patient settings to care homes (NICE, 2015). This recommends that people do not make decisions about long term residential care when they are in crisis. The guidance,

however, fails to acknowledge how to do this and ignores the practical and ethical pressures social workers face in reconciling good practice with the demands of a (health-driven) system that needs the 'bed free for the next patient'.

Recent work by Milne *et al.* (2024) draws on evidence from five European countries, including the UK, to explore social work's potential role in supporting older people's

transitions from the community or hospital into care homes and comes to similar conclusions to the work described above. The authors argue that admission to a care home is “treated as a functional transition from one place to another rather than as a social, emotional and psychological process for the older person and their family” (Milne *et al.*, 2024, p. 1). Their contention is that a holistic understanding of people’s needs is often overlooked by reducing the move to a functional ‘process’ driven by organisational priorities and funding. They suggest that social workers have the skills, knowledge, and value base to support older people’s admissions to care homes. They note the limited attention on this area and call for more investment in research to explore the role further.

More generally, it is interesting to note that the different pathways to ‘moving to a care home’ are rarely acknowledged in the literature; these include from home, from hospital, in a crisis or as a planned move, as well as through differently funded routes, not to mention the impact of individual circumstances. A recent Scottish study, however, found that people moving into care homes from community and hospital settings are distinct groups and require a different approach. This strengthens the case for social workers’ role in supporting a diverse group of people with this “major and stressful life event” (Wamara and Naumiuk, 2023, p. 316). The recent ‘Better Care Moves for Older People’ research project focused on evaluating how to support social care transitions, including moves to a care home (Zhang, 2024). The project’s focus is broader than social workers’ role in supporting transitions to care homes; it does, however, confirm the importance of person-centred, relational and flexible approaches, supported by information and advocacy, which attend to the psychosocial needs of the older person and their family while navigating organisational and structural challenges.

Advocacy

Some studies have looked at social work’s advocacy role in the care home context. An example is Manthorpe and Martineau’s (2010) scoping review, mentioned earlier in this section, which charts the history of social work’s role in supporting people to move to residential care. This recognises the tension that exists for social workers

between advocating for the individual and gatekeeping publicly funded resources. Despite the importance of advocating for older people who may lack capacity to make their own decisions, social workers often have limited time for this role. Scourfield's (2006) contribution, despite its age, remains relevant as it examines the marginal position that older people in care homes occupy as citizens. He suggests that social workers have a crucial role in recognising residents' right to independent advocacy, particularly given their role in 'placing' people in care homes. He supports social workers taking a rights-based approach, but is clear that social workers' role is to "advocate for advocacy" and use their power to empower others (2006, p. 1148).

Willis *et al.* (2016) discuss the role that social workers can have in advocating for and supporting the social inclusion of older lesbian, gay and bisexual (LGBT) adults in long-term care environments. They introduce the concept of "micro level advocacy" which they suggest social workers can enact with care home providers to support commissioning and quality assurance. They assert a critical role for social workers "by acting as human-rights advocates in promoting the rights and interests of residents whose lives are situated outside heterosexual norms and expectations" (2016, p. 422). Certainly there is a role for social workers to challenge the widespread exclusion and 'invisibility' of older LGBT people's identities in care homes, and there are a growing number of reviews and studies supporting inclusive practice for this cohort of older care home residents (Hafford-Letchfield *et al.*, 2018; Willis *et al.*, 2018; Fasullo *et al.*, 2022). The importance of recognising the heterogeneity and intersectionality of older people's identities and advocating for inclusive practice for all care home residents, many of whom will have experienced discrimination and multiple inequalities through the life course, remains a key social work role.

Nonetheless, there is limited literature specifically examining social workers' ongoing advocacy role for care home residents, or for family carers. There is evidence, for example a study by Welch *et al.* (2017), which highlights family members' difficulty in advocating for their relatives for fear that doing so will cause reprisals for the resident or 'rock the boat'. The study makes several suggestions, although increasing the involvement from a social worker to support families and residents more positively is not one of them.

Reviews

'Placement' reviews are a statutory task, with the Care Act 2014 requiring the local authority to conduct regular reviews, at least annually, for people with care and support plans (Department of Health and Social Care, 2023a, p. 13.32). This is not a requirement for self-funders. Scourfield's work is an important influence in this field, exposing flaws in the system which might contribute to the marginalisation of the social work role in the context of statutory care home reviews. Scourfield (2007) contends that care home reviews operate in the context of an increasingly bureaucratic and process-driven model of social care which deskills and alienates both the social worker and the older person, adding to a sense of disempowerment. Despite the age of this article, it remains highly relevant in its resonance with the ideals of strengths-based practice, advocating for dedicated reviews teams to support continuity, build relationships and allow older people to gain control. Scourfield's (2010) small scale qualitative study focuses on older people's experiences of statutory placement reviews. It considers that while reviews may be regarded as a "bureaucratic necessity" (2010, p. 19), they are a crucial opportunity to consider the quality of the 'placement' and to consult with residents and their family. The study's findings remain applicable, echoing current practice concerns about the limited opportunity for relationship building, especially where annual reviews are carried out by a social worker who has had no previous involvement with the older person. An interesting finding from the study was that, despite the constraints of the system, social workers used their professional discretion and were committed to using their social work values to influence their interactions. This is an idea I will return to later in the thesis. Scourfield concludes that placement reviews offer valuable opportunities to achieve positive outcomes and he notably proposes that the right to a review should be extended to self-funders.

Scourfield conducted a further case study of placement reviews for older people in one local authority, applying Lipsky's framework of 'street level bureaucracy' (Scourfield, 2015). This research suggests that in striving to meet organisational demands, practitioners sometimes made decisions that compromised both the quality of care and the views of residents. Many encountered a tension between engaging meaningfully with the older person to explore their issues and the need to complete the review promptly. Notably, Scourfield found that social workers exercised

discretion in how they interpreted and applied 'policy'. He argued that social workers can be seen as 'street level bureaucrats' whereby their decisions "become the public policies they carry out" (Lipsky, 1980, p. xii cited in Scourfield, 2015). This is an interesting lens to examine the difficulties social workers encounter when balancing conflicting priorities and managing uncertainty. I explore this in Chapter 7 in relation to my own findings.

Safeguarding, mental capacity and Deprivation of Liberty Safeguards

Social workers are required to investigate safeguarding concerns in care homes as part of their statutory duties under the Care Act 2014. They also undertake mental capacity assessments and best interests decisions under the Mental Capacity Act 2005. Due to the extensive amount of literature on safeguarding and mental capacity, much of which is not specifically relevant to care homes, I did not explore these topics in great depth, which may account for my difficulty in locating relevant research on these subjects. Additional challenges arise from the way in which safeguarding work is organised as some local authorities have specialist safeguarding teams, whereas in others, safeguarding work is incorporated into mainstream practice (Graham *et al.*, 2017). Thus, I found limited research looking at social workers' role in safeguarding in the context of care homes, despite concerns that abuse is prevalent for older adults in institutional settings (Moore, 2018, 2019). The main focus in the literature appears to be on the learning from SARs, as discussed earlier (Manthorpe and Martineau, 2017).

Where mental capacity and care homes are discussed in the literature, the focus tends to be on assessments by care home staff or health care professionals (Manthorpe and Samsi, 2016; Jayes, Austin and Brown, 2022). The other focus is on the Deprivation of Liberty Safeguards (DoLS)²⁶, an amendment to the Mental Capacity Act, designed to protect people who lack capacity to consent to their care and treatment in a care home (or hospital). Dwyer (2010) acknowledges the key role social workers play in upholding the rights of people with dementia in care homes in identifying restrictions that might constitute a deprivation of liberty. This work,

²⁶ See footnote p.3

however, was written before the 2014 Supreme Court *Cheshire West*²⁷ judgement which redefined and broadened the legal definition of deprivation of liberty. This case law limited the professional judgement needed to determine whether someone was being deprived of their liberty in a care home (Penny and Exworthy, 2015).

Best Interest Assessors (BIA) undertake assessments under the DoLS for people deprived of their liberty in care homes and hospitals. Occupational therapists, nurses and psychologists can also undergo training to qualify as a BIA, but it is predominantly social workers who perform this role. Training as a BIA is one of the few post-qualifying opportunities available to social workers in adults' services and it requires advanced knowledge of the Mental Capacity Act 2005. There remains limited research focused on DoLS and social work, notwithstanding its importance. One example is a survey of BIAs (mostly social workers) which identified improvements to care delivery from BIAs' interventions for people in care homes; examples included improved social activities, reducing restrictions, helping staff understand the Mental Capacity Act and triggering a review for an inappropriate placement (Richards, 2016). Despite this survey's limitations in asking for only positive examples from respondents, it supports CQC's (2018) report that care homes are often challenged when balancing safety and freedom with limited staff time and resources and that building relationships with professionals who understand the Mental Capacity Act 2005 can reduce restrictive practices.

Buckton's (2023) small study of BIAs in one local authority makes a significant contribution to the debate. The research examines the professional identity of BIAs within and beyond their organisations in the context of social justice and human rights. It demonstrates how BIA practice has the potential to reinforce social work values. An underpinning perspective of the study is that social work tasks are reductive and not aligned to BIA practice. Instead, undertaking BIA duties provides social workers with an opportunity for "stepping off the treadmill of social work" (2023, p. 304). BIAs' professional judgement is usually respected and they are afforded

²⁷ The 'Cheshire West' judgement by the Supreme Court in 2014 [Cheshire West and Chester Council v P [2014] UKSC 19] defined the 'acid test' for a deprivation of liberty as someone being 'under continuous supervision and control; and not free to leave'. Since this judgement, most people who lack capacity to consent to their care arrangements in a care home are considered to be 'deprived of their liberty'.

more power and independence to focus on good practice and uphold rights. This research proposes that the BIA role allows the exercise of good social work and holds at bay the more dehumanising outcomes of care management approaches. In contrast, however, another study found that confidence in the decision-making of BIAs did not differ depending on their profession (Carpenter *et al.*, 2014).

It is interesting that, regardless of DoLS' focus on protecting the rights of people mainly in care homes, this work is rarely embedded in mainstream social work practice and instead many local authorities have a 'DoLS service'. Moreover, my experience of searching the literature indicates there is a limited focus on DoLS in social work *and/or* care home research, which suggests it is uncoupled from the context in which it is situated. While this might be because other professionals can (though rarely do) train as BIAs, I would propose it is more likely to be linked to the status of care homes and the people that live there.

The story so far

At the start of the chapter, I discussed my approach to the literature review and some of the difficulties I encountered. In the preceding section, I attempted to build a picture of social workers' involvement with care homes in England, acknowledging the potential limitations that may come from exploring such a breadth of literature. The literature explored thus far presents a picture of the limited involvement that social workers in England have with care homes. The extent of social work interaction is often dependent on people's eligibility or assets and the social work role becomes even more marginal once older people are living in a care home (Manthorpe and Martineau, 2017). A consistent theme is the dissonance between social work's professional value base and the gatekeeping role within resource driven systems, and between what social workers could do and what they are doing. These tensions resonate with the conflicts inherent in social work more widely. What it is possible to start to glean from the literature is the potential of the social work role and the skills needed to support older people in care homes at different points in their journey: from admission and transition into the care home, settling in and living their lives, reviews, and overcoming difficulties or safeguarding issues. Social workers may be doing this, but it is not being extensively written about or researched in the literature. I will further discuss the possibilities for the social work role later in the

chapter when I consider the international literature. For now, it is important to state that the literature hints at the resource that social workers *could be* to support residents, their families and other professionals in decision-making and in meeting the social, emotional and psychological needs of residents. Recognising too that older people living in care homes are more vulnerable to abuse and neglect, social work's focus on human rights and social justice means that they could and should play a key role in advocating for the rights of the older person (Hardy, Hair and Johnstone, 2020). This leads me to the next section, which will consider the context of the Covid-19 pandemic and its impact on social work practice and care homes.

Covid-19: Social work and care homes

The Covid-19 pandemic is not a focal point of my research, but it is a significant backdrop. Importantly, it drew attention to how society treats and protects the rights of older people in care homes. It can be argued that the pandemic merely exacerbated a crisis that was waiting to happen, given the existing inadequacies, status and infrastructure of care homes (Milne, 2021). I do not intend to explore this topic in detail, but it is vital not to forget the treatment of care home residents during the pandemic, the number of excess deaths and the extent of the violation of their human rights. It is generally acknowledged that the government's response was "slow, late and inadequate" in respect of care homes (Daly, 2020, p. 996). Amnesty International (2020) allege that the government's failure to take measures to promptly and adequately protect people in care homes resulted in 28,186 "excess deaths" of residents in England in the pandemic's first three months (a 46% increase on previous years).

Anand *et al.* (2022) present shocking evidence of the deaths, harms and violation of human rights experienced by older people in care homes across seven European countries in the first ten months of the pandemic. For example, 25,000 untested older people in England were discharged from hospital to care homes between March and June 2020 to free up hospital beds and subsequently spread Covid-19 into care homes. This practice also happened in other countries and has been described as a "silent massacre" (2022, p. 807). Many residents died alone, with no contact with family, or, in some circumstances, care staff. While Covid-19 restrictions impacted on all populations, restrictions were much more extreme for people living in care homes. When restrictions were eased for other citizens, they stayed in place for care home

residents for many more months, which caused serious harm and distress to residents, especially those with dementia, and their families.

Given that “it is a core role of social work to challenge and advocate for the person’s rights” (Hardy, Hair and Johnstone, 2020, p.456), it is important to consider the role that social workers took during the pandemic. Consistent with their marginal role described earlier, at the start of the pandemic and during lockdowns, social workers were absent from care homes and were not recognised as ‘essential workers’, so were not allowed to visit (Guerrero *et al.*, 2020). This resonates with a study of the media presentation of hospital discharge to care homes during the pandemic which found that ‘social care’ was represented as an afterthought and not prioritised (Abe, Dawson and Scott, 2023). There is little evidence to suggest that social workers demanded a right to enter care homes. This is reinforced by government guidance on care home visits at the start of lockdown 2 (Department of Health and Social Care, 2020), which only identified that social workers had a role in ‘assessing risk and making decisions about visits’. The lack of a significant role for social workers led to a call by BASW (2021a) for recognition of social workers as having an essential role and as offering a unique contribution with their knowledge of the Mental Capacity Act 2005 and their focus on rights-based practice. Subsequently, a report by Unison (2022) captured the reflections of 3,000 social workers on the impact of the pandemic. Social workers working in adult services voiced their concerns about their ability to provide a good service. They identified the challenge of not being able to see people ‘in person’ during the pandemic and described how their workloads meant that they were “just firefighting rather than providing the right support.” This resonates with the lens of ‘statutory neglect’, mentioned in Chapter 1, which has been used to describe the experience of people in care homes during the pandemic (Jolly, 2020).

In the last few years, research about social work in the context of Covid-19 has expanded, which there is not space to explore in this thesis. Some of it is located specifically in care home settings, although predominantly in the European and international landscape. A key message from this literature is a renewed call for social work’s involvement with older people in care homes and an encouragement to reclaim their role in upholding rights (Pentaris *et al.*, 2020). Indeed Anand *et al.* (2022, p. 811) propose a much broader role for social workers “beyond the purely transactional” to involve advocacy, family support, training other professionals, and

being a trusted presence in the care home for residents, families and staff, not just at the point of crisis.

Social work in care homes in other countries

I noted earlier that a significant amount of relevant literature originates from outside England and the UK and it is instructive to explore this, identifying both common ground and differences. Some countries have a more clearly defined role for social workers within care homes, with a stronger focus on promoting therapeutic, psycho-social approaches. Wong's (2021) qualitative study examined how social workers in Canada understand their role in care homes, and identified the main themes as advocating for residents, 'humanising' care, balancing autonomy with safety, working with systems and facilitating collaboration. Hardy, Hair and Johnstone's (2020) review of the international literature identifies seventy-seven relevant articles and provides a synthesis of the role that social workers can play, particularly when they are employed within the care home. The main themes from the literature are summarised in the following diagram:



Figure 5 Role of the social worker in care homes (Hardy, Hair and Johnstone, 2020)

The review draws largely on US research and provides evidence for the role social workers play in challenging the narrow scope of physical care and contributing to holistic, person-centred outcomes for care home residents. It concludes, nonetheless, that the role is missing from many care homes and that there is limited research reflecting social work's unique contribution.

A stronger presence

Social workers have a presence in care homes in other countries, including, but not limited to, USA, Canada, Israel, Romania, Croatia and Slovenia. Whether there is a correlation between cultural attitudes to older people and the role that social workers play in supporting older care home residents is certainly an interesting question, particularly as care homes are primarily a eurocentric concept, but it is beyond the scope of my research.

In Slovenia, for example, social workers have a role in supporting the older person “as a fellow traveller” (Mali, 2010, p. 556) from their first contact with the care home, and accompanying them throughout their journey living there. It is interesting to note that, despite the framing of the role in this way, research suggests that how tasks are undertaken still appear to be influenced by the culture and orientation of the particular care home (Mali, 2010).

In the USA, federal regulations require nursing homes with more than 120 beds to employ at least one social worker (NASW, 2023). This affirms social work’s contribution, outlined above, in addressing well-being and psychosocial needs, being a resource to residents, families and staff, and supporting education and collaboration (Solomon, 2004; Bern-Klug, 2011; Rockwell, 2012; Simons, Bern-Klug and An, 2012). It is noteworthy, however, that two-thirds of US nursing homes, by virtue of their size, are not required to employ a social worker (Bern-Klug *et al.*, 2021). Furthermore, there are inconsistencies in the definition of qualifications for social workers between professional bodies, licencing boards and federal guidelines (Roberts and Bowblis, 2017). This means that not all ‘social workers’ working in US nursing homes hold a formal social work qualification or are ‘licensed’, and many settings rely on ‘paraprofessional’ staff (Roberts and Bowblis, 2017; Bern-Klug *et al.*, 2021).

The grass isn’t always greener...

The lack of incentive to have a social worker in care homes with fewer than 120 residents means that, in common with other countries, there is a mixed picture regarding employment of social workers (Hardy, Hair and Johnstone, 2020). In Romania, social workers are involved in supporting admission and developing person-centred care plans; care homes must employ a social worker to be registered

with the authorities, but it has been suggested that this is hard to enforce (Şoitu, 2021, cited in Milne et al, 2024). It is interesting that despite the different contexts across countries, a consistent message is that there could be a greater role for social workers in supporting older people, both in moving to and living in a care home, with Panthi (2022, p. 97), for example, suggesting New Zealand social workers could play a key role in “de-escalating” psychosocial issues. Where social workers are employed, they usually have very high workloads and have responsibility for a considerable number of residents (Munn and Adorno, 2008). This is backed up by evidence from a small Croatian study of social workers based in care homes, which identified that the ratio of social worker to residents was very low and that the tasks required of social workers were too broad (Stambuk, Sucic and Vrh, 2014).

Miller *et al.* (2021) provide a useful synthesis of the US literature on the role of the social worker in nursing homes, concluding that research on the role is limited, outdated, and needs greater attention. This supports older research by Munn and Adorno (2008, p. 352) who argue that “it is difficult to justify additional social work staff within this setting without a clear articulation of the unique contribution of long-term care social workers”. It seems that, despite the varied international contexts, a persistent message is that social workers struggle with articulating their roles in care homes. This in turn contributes to poor understanding and recognition of their value by other professionals and ‘the system’ (Wong, 2021).

Balancing competing demands

A consistent theme is that, while in some countries there may be a stronger social work presence in care homes, there are challenges for social workers in reconciling residents’ interests with organisational priorities and demands. Fogler (2009), for example, uses conflict theory as a conceptual framework to explore the competing interests of care homes, US national policy and social workers with the outcomes for social work practice. Fogler (2009, p. 863) notes that care home social workers experience “high levels of job ambiguity”. One reason is because they belong to multiple groups with different expectations and contrasting goals. Social workers are often faced with dilemmas of how to meet residents’ needs within a framework of regulation and attendant economic drivers. This resonates with some of the tensions inherent in UK social work practice, as described in Chapter 2.

Lev and Ayalon's (2015, 2016) work is a significant contribution and explores the competing demands and ethical dilemmas experienced by social workers in care homes. The small qualitative study (2015) captures the experiences of fifteen social workers employed in care homes in Israel. The research exposes the tension, (described as 'running between the raindrops') that social workers (who were employed by the care homes) experience in meeting their obligations to their employer and their responsibilities towards the residents and their families. Social workers' responsibility to advocate for residents and protect them from abuse can conflict with their status as an employee of the institution or as a member of the multi-disciplinary team (Lev and Ayalon, 2016). They may not always have the personal resources or organisational support "to confront the management and protect the residents' needs" (2015, p.16). Social workers manage these conflicting responsibilities in different ways; these are proposed as four prototypes: managerial, contented, fighter and frustrated. This links the tension between professional obligations and organisational interests to the continuum, or 'typologies', of social work roles I described in Chapter 2. The findings from this study support earlier research, which investigated the 'real' role social workers in care homes in Israel fulfil in contrast to the 'ideal' role (Koren and Doron, 2005). Notably, the authors identified a gap between social workers' perceived duties and their actual practices.

Social work in other specialist areas

Finally, I will discuss some insights from the social work role in other specialist areas of practice in England. In some contexts, social work appears to be more influenced by managerial, task-focused approaches, whereas elsewhere, social workers have managed to maintain more holistic, relational approaches.

Palliative care social work

Palliative care social work has not seen its role dominated by a care management approach to the same extent as other areas of practice. Palliative care social workers are largely based in hospices or in community palliative care teams and "specialise in working with adults and children who are at the end of their life, their families, those that they are close to and their communities" (BASW, 2016, p. 9). They are part of the

multi-disciplinary team and promote holistic, relational approaches, addressing psycho-social needs and the impact of loss and transitions (Roulston *et al.*, 2023). The UK Association of Palliative Care Social Workers (APCSW), established by social workers in 1987, exists to raise palliative care social work's profile, support palliative care social workers and share best practice (Association of Palliative Care Social Workers, 2021).

APCSW's statement (2024) about employing social workers in end-of-life care settings reinforces that social workers add "immeasurable value" to people's lives, although their contribution is often unseen or "takes places out of the spotlight". The statement summarises the social work role in this context as: providing psychological and emotional support to people at the end of life and their families; social and practical support, including advocacy, planning and financial support; statutory skills and expertise, including negotiating statutory processes and liaising with local authority social workers; and support and advice to the wider multi-disciplinary team. This draws on a more detailed, earlier publication articulating the role of social workers in palliative, end-of-life and bereavement care (BASW, 2016). It reflects research in the field which proposes that people and those close to them deserve to be supported at the end of life by social workers, with their expertise and understanding of loss and psychological, social and cultural needs (Roulston *et al.*, 2023). Notably, palliative care social work's value was highlighted during the pandemic. For example, Tenorio, Johnson and Grudier's (2021) US case study provides examples during Covid-19 that demonstrate social work's scope in supporting individuals and their families with loss and transition, as well as advocating, "facilitating connection" and meeting emotional and financial needs (2021, p. 99).

Care homes and end-of-life?

All this highlights the potential for applying the principles of palliative care social work to supporting older people moving to and living in care homes. It hints too at the greater role social workers could have played during the pandemic. This was exemplified in Ireland by the development of practice guidelines for social workers to provide a liaison role to support people at the end of life in care homes during the

pandemic (McGarry *et al.*, 2020). While this was an important acknowledgement of the needs of people in care homes, it was strongly focused on people *dying* rather than those living in care homes.

What stands out is that palliative care social work is not associated with social work in care homes. For instance, the afore-mentioned APCSW statement about social work's value in 'end-of-life care settings' makes no mention of care homes as a setting, nor does it refer to the needs of *older* people. This appears paradoxical given the evidence, referred to in Chapter 2, that 80% of people who live in care homes die there, and almost a quarter of all deaths in England occurred in a care home (Office for Health Improvement and Disparities, 2024). It suggests that care homes are not afforded the same status as other places that support people at the end of lives with complex health or social care needs. It suggests too that the social work profession has done little to challenge this view. It may be emblematic of the difficult and defended relationship that society has with care homes that they are rarely explicitly talked about as places where people die. This may be one reason why older people are not afforded the same holistic, psychosocial support that others receive as 'end-of-life' care.

Indeed, there is little to suggest that Holloway's (2009) contention, that dying is a neglected issue for social work, does not still hold true. She argues that older people often lack choice and recognition of their needs at the end of life and have reduced access to palliative care services. Notably she suggests that any focus on quality of life for older people must also "embrace quality, and equality, of dying" (2009, p. 721). Payne (2017) offers a useful perspective by suggesting that older people experiencing illness and frailty and reaching the end of their lives are devalued in society or "de-citizenized". Significantly, he suggests that this may be one reason why the holistic approach taken in palliative care, particularly in health care, has not been transferred to social work with older people. I would argue this appears to be even starker in the case of older people living in care homes.

It is worth adding that palliative care social workers are not statutory roles based in the local authority. They are usually directly employed by hospices and refer to local authority social workers when statutory tasks, such as safeguarding or setting up care packages, are required. The uncoupling of their statutory functions from the

other features of their role may also explain why they have more scope to attend to the needs of individuals and are less constrained by resources.

Hospital social work

Hospital social work is an interesting area to consider, not least because of its role in supporting older people's discharge to care homes. I explored the social work role in supporting transitions to care homes earlier in this chapter and it is interesting to note that studies about transitions to care homes do not appear to be located in hospital social work settings. A recent study of hospital social work in Northern Ireland contends that hospital social work's main emphasis has become to facilitate hospital discharge (Heenan, 2021). The study focuses on the discharge of older people to *any* setting, not just care homes, but it is important in highlighting the narrowing role of social work, the limited time for social workers to form relationships with older people and the tensions that hospital social workers experience between advocating for, and supporting, older people and reducing delayed discharges (the NHS' biggest priority).

Burrow's (2022) ethnographic study of social workers in a Welsh hospital acknowledges the enormous pressures that social workers face to "free up hospital beds" and the attendant constraints and time pressures of working in a health dominated system. Interestingly, and perhaps because of this, he found that social workers identified their key role as advocates for patients, challenging the decisions of medical staff and trying to support people's self-determination. Phillips and Waterson's (2002) small qualitative study examined hospital social workers' role in preparing older people for discharge from hospital into care homes. Notwithstanding the age of the study, it is relevant, not only because of the specific focus on discharge planning to care homes (which appears to have attracted limited research in the intervening years), but also because it found that the administrative process of moving someone to a care home took precedence over what families and older people valued – that is, "helping and emotionally supporting people through the process of admission" (2002, p. 182). Notably the study identified that, when hospital beds are in demand and care home owners want to fill vacancies, social workers have a specific task "in buffering users and carers from pressure to move inappropriately and too quickly" (2002, p. 183).

A large-scale mapping review of the hospital social work role (Steils, Moriarty and Manthorpe 2020) raises an important question as to whether it is the location of the role that is crucial or the nature of the work. It also considers how this might contribute to social workers often being perceived as ‘outsiders’ in hospital social work, an area I will consider later in the thesis in relation to my findings.

In brief, the hospital social work role offers interesting insights and parallels to the social work role with older people in care homes. The role has been largely reduced to a focus on co-ordinating discharge and this creates organisational and systemic pressures. This presents challenges, but highlights an even greater need for social workers’ professional values and skills in supporting and advocating for older people in hospital, who are often facing life-changing, frightening and complex decisions (Heenan and Birrell, 2018; Steils, Moriarty and Manthorpe, 2020; Heenan, 2021; Burrows, 2022).

Other areas of social work

It is important to highlight that there is evidence for situating social workers in other ‘institutional’ settings, such as prisons and schools. While inevitably there will be shared terrain and insights, I have not explored the literature in this area, not least because there is no focus on working with older people. Moreover, there is a significant amount of literature on mental health social work, an interesting area that spans the boundaries of health and social care and addresses issues around the role ambiguity and professional identity of social workers. This is also not an area that I have explored in any depth, although I have drawn on some studies from this field in Chapter 7 to make sense of my findings. In the context of Covid-19, I reflected that the literature on the role of social workers in disasters (Bartoli, Stratulis and Pierre, 2022) might also be instructive, but the constraints of time and the scope of the study do not permit me to venture down that path.

What is this telling us?

This chapter has explored what existing literature reveals about the social work role with older people in care homes. In this concluding section, I will summarise the main issues that the literature raises and explain how this has informed my research questions.

There is limited research looking at the role of social work with older people moving to or living in care homes; there is no clear articulation of what the role should be, or how or where it should be carried out. The tasks described in the literature primarily cover social workers' statutory responsibilities, such as facilitating admission to care homes, reviews, safeguarding and DoLS. A common pattern is the difficulty that arises from the inherent tension in the social work role of advocating for and promoting the needs of individuals, alongside meeting organisational demands, enacting policy, or assessing eligibility. Another striking theme in the literature is the deficiencies in a system whose intentions are undermined by neoliberal policy influences, intense resource pressures and ageism. Research often reveals the key role social workers *could* play, but this is undermined by the lack of value placed on social work with older people or support for building gerontological social work as a specialism.

It is interesting that what little research there is in the field continues to highlight the impact of care management, despite the Care Act 2014 approaching its 10th anniversary. It is important, however, not to ignore the impact that the Covid-19 pandemic had on social work resources as well as the priorities for research. This might account for some of the patterns in the literature, and recent evidence of growth of attention paid to social work with older people, which suggests that this study is timely.

The international literature, where social workers have clearer roles to support the psychosocial needs of residents and their families and work within the multi-disciplinary team, shows the potential of the role. However, there are similar tensions in countries where social workers are employed in the care home. Other specialisms in the UK present an interesting comparison and the role carved out for palliative care social workers seems closest to the role that social workers could have within care homes. It raises the question of why social work's acknowledged role to support loss and promote a holistic approach to end-of-life care is not extended to older people living in care homes. There is evidence of the potential for social workers to use their skills, knowledge and value base to advocate for and support older people in care homes, but there appears to be little space for this within current local authority structures and contemporary socio-political contexts of social care.

A large proportion of the research I explored took the form of literature or scoping reviews; the limited number of empirical research studies were often focused on student social workers, care home staff, residents or families. It is certainly the case that the research undertaken rarely captured the views of social workers (Higgs and Hafford-Letchfield, 2018).

This has led me to the research questions for my study, which to reiterate are:

- What influences social work practice with older people in care homes?
- How do social workers conceptualise their role?
- What tensions and dilemmas do social workers experience working with older people in care homes?
- What is good social work practice in this area and what are the possibilities for developing it?

In the next chapter I will address the design of my study and the methods I adopted.

Chapter 4: Methodology

This chapter considers my research design and the methods used in the study. It centres my methodology at the heart of the research process as the frame through which to answer the research questions. Linking back to the rationale for my research presented in the Introduction, this chapter reasserts that my personal, professional, academic and axiological positioning is key in the construction and contextualisation of my research. The literature explored in the previous chapter also has an influence on my research questions and methodological design. Premised on the idea that research is driven by a series of choices (Thomas, 2017), I will explain and justify the decisions I have made. I will start by discussing the philosophical debates underpinning different research approaches before moving on to explain my own methodological stance. I will discuss the methods I used, and explore ethical issues and some challenges and issues I encountered during the process. Finally I will discuss how I gathered and analysed my data.

What is methodology?

It is fundamental to consider what is meant by methodology and understand its importance to the research process. Put simply, methodology is the philosophy or foundation that underpins the research project (Carey, 2012). The methodology offers justification for the choices made through the research process and illuminates the values underpinning the research (Crotty, 1998). Whilst it is the strategy behind the *choice* of methods, it is important to mark its distinction from research *methods*. Clough and Nutbrown (2012, p. 25) describe methods as the “ingredients of research” whereas the methodology provides the *reasons* for using a particular “research ‘recipe’”. Saldana (2015, quoted in Mason, 2018, p.32) suggests that a method is about *how* you do something, whereas a methodology is *why* you do something *in a certain way*.

Crucially, methodology is the means through which to answer the research questions. Clough and Nutbrown (2012) propose that methodology in social research involves asking at least four types of questions: personal questions (of the researcher and their perspective and positionality), research questions (what is the research about), field questions (asked ‘in the field’ including around data collection), all of which lead to ethical questions (the principles guiding the research). The

methodology's aim is to shed light on why choices have been made and tease out the assumptions and values that underpin these choices and influence the study accordingly. It conveys the transparency and justification of the research process, by ensuring that there is a rationale for the choice of methods (Creswell, 2014; O'Leary, 2017).

The methodology interweaves with the researcher's ontological and epistemological positioning: their understanding of what is meant by knowledge and what kind of knowledge the research will generate. I found navigating through this terrain at times confusing, not least because the nature and meaning of different philosophical stances are often debated or disputed (Staller, 2013; Gray, 2022). It is nevertheless necessary as it provides assurance that the researcher has considered what they are doing and also helps them to understand and assess the assumptions underpinning research and evidence in their field (Staller, 2013; Bell, 2017). A researcher needs to be able to recognise what might influence their perspective or their understanding of a problem. This is especially important in the complex terrain of social reality, which is open to multiple interpretations. Social work research, in particular, needs to answer questions such as what does it mean to be in a care home or where does the researcher locate social inequalities. The researcher's perspective on such questions affects how they construct the world, ask questions and make meaning, and ultimately shapes what they find (Berger, 2015).

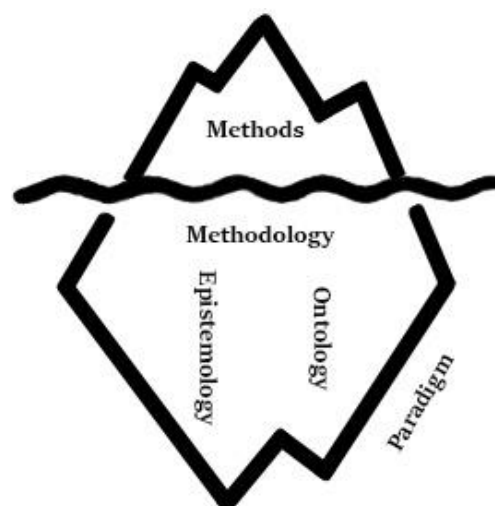


Figure 6 Iceberg, adapted from James (2015)

James (2015) uses the metaphor of an iceberg (depicted above) as a helpful way of getting to grips with the interplay of methods, methodology, epistemology and ontology. He proposes that while research methods are overtly visible, they are anchored by the other concepts, which are inter-related and co-dependent, and help to articulate the researcher's particular approach or paradigm.

My research is a qualitative study underpinned by an interpretative paradigm. In the next section I will examine broadly the different research approaches or *paradigms* and consider their relationship with assumptions about the nature of reality and knowledge. I will later discuss more specifically the rationale for my approach.

The paradigms

Paradigms are the worldviews or theories that people hold (McLaughlin, 2012). Social research is typically divided broadly into quantitative and qualitative approaches, derived from two main paradigms, positivism and interpretivism (Whittaker, 2012).

Qualitative research

Qualitative research is based on an interpretative paradigm. Interpretivism is understood as an umbrella term for a continuum of approaches that attach importance to meaning, insights, experience and perspectives (McLaughlin, 2012; Fawcett and Pockett, 2015). As an example of the debate these terms generate, Braun and Clarke (2022, p. 289) describe the interpretative paradigm as a 'historical artefact' that is not widely used in contemporary research. Certainly, taking a qualitative approach is not prescriptive, drawing as it does from a range of intellectual and disciplinary orientations (Fawcett and Pockett, 2015). Qualitative studies are usually small-scale and explore multiple realities (Braun and Clarke, 2013). They often use methods that allow for the generation of 'thick description', Geertz's term which describes interpretations with a high level of contextual detail (Ponterotto, 2006; Mason, 2018). The role of the researcher, their own understandings and values, are a means to interpret others' perspectives, construct knowledge and influence the research at every stage (Thomas, 2017).

Silverman (2022) argues that it is easier to build an understanding of qualitative research by focusing on what it is *not*. The weakness of this approach is that it can lead to a commonly identified pitfall of defining qualitative research as 'not

quantitative research' (Flick, 2007; Fawcett and Pockett, 2015; Braun and Clarke, 2022). The importance of not judging one approach by the standards of another is a theme to which I will return.

Quantitative research

Quantitative research follows a more scientific model, seeking to discover knowledge that is measurable, systematic and answered by observable evidence, often through deduction and experimentation (Opie, 2004; Denscombe, 2021). It is based on the positivist paradigm which promotes logic, truth and objectivity and seeks to construct and apply scientific laws to human behaviour which allow for generalisability (Carey, 2012; Creswell, 2014; Clark *et al.*, 2021). It values objectivity and prizes 'evidence' which can be accurately measured, for example statistics which can be verified (Ormston *et al.*, 2014). It seeks to eliminate, as far as possible, the researcher's influence and their values on the research (Whittaker, 2012). One limitation levelled at the positivist approach is that it neglects wider structural influences on human behaviour and variables such as poverty, gender, race or class (Carey, 2012).

A leaning towards qualitative or quantitative approaches should fit with the researcher's ontological assumptions, that is, how they fundamentally understand the world and whether they believe social reality exists independently of human interpretation. Realism is the ontological underpinning of most quantitative research, described by Tebes (2005, in Braun and Clarke, 2013, p. 27) as "mind-independent truth", or a proposition that reality exists independently of our views about it (McLaughlin, 2012). At the opposite end of the spectrum, relativists argue that reality is dependent on human interpretation and that meaning is socially constructed (Braun and Clarke, 2013).

It would be reductionist to say that in quantitative research the 'facts speak for themselves' as such research demands robust analysis to justify the conclusions drawn. William Lawrence Bragg, a 20th century physicist, is quoted as saying "the important thing in science is not so much to obtain new facts as to discover new ways of thinking about them" (Bragg, 1959, p. 124). This hints at some intersection between qualitative and quantitative approaches, highlighting the researcher's role in considering and interpreting knowledge, irrespective of their philosophical proclivities.

A continuum of perspectives

The term ‘paradigm wars’, coined by Gage in the 1980s (Guba and Lincoln, 2008), reinforces the perception of qualitative and quantitative research as competing paradigms. However, it is now widely acknowledged that setting up these paradigms in opposition creates a false dichotomy (Crotty, 1998; Clough and Nutbrown, 2012; Clark *et al.*, 2021). Polarising these stances ignores the depth and criticality of research, as well as their co-existence in mixed methods studies (Bryman, 2006; Flick, 2023). An additional problem with a binary approach is that, for example, taken to its logical extreme, a purely interpretative approach should reject ‘facts’ revealed in a literature review. In the complex landscape of social research and knowledge generation, researchers may need to draw on mixed methodologies to find out answers to the questions posed (Shemmings and Ellingsen, 2012). Thus, as Opie (2004, p. 23) proposes: “actual research normally lies on the continuum between these two extremes”.

The following table adapted from Scotland (2012) summarises key ideas to elucidate this discussion.

Paradigm	Ontological position	Epistemological position	Characteristics	Methods
Positivism	Realism Things exist independent of the knower, phenomena have an independent meaning that can be discovered (via research)	Objectivism Acquire knowledge objectively, meaning resides in the participants: it is the researcher’s role to obtain this meaning	Factual, value free, not situated, deductive. Causes which influence outcomes, which allows the formulation of predictability and generalisation	Generate quantitative data: tests, questionnaires, standardised observation tools
Interpretivism	Relativism Reality is subjective and different from person to person, it is individually constructed and shaped by language	Subjectivism Acquire knowledge by knowing and constructing it, the social world is understood by participating in it, and interacting with social structures	Interaction with the researcher aids understanding, reflexive, inductive, looks for depth, insights and understanding	Generates qualitative data: case studies, ethnography, interviews, focus groups

Critical research	Historical realism Reality is socially, politically, culturally shaped and is not static, language moulds reality and holds power	Social constructionism Knowledge and meaning is socially constructed and influenced by societal power	Seeks to address issues of social justice and marginalism, not value free, it considers how things ought to be, it judges reality	Usually generates qualitative data: action research, interviews, focus group, observations
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Table 3: Summary of paradigms

I will briefly highlight some other approaches within the continuum. Critical realism offers an intermediate ground, acknowledging a world independent of the researcher, but one affected by socially constructed processes. This approach acknowledges that concepts such as poverty and racism exist but interplay with socially constructed realities and experiences (Braun and Clarke, 2013). Scotland (2012), describing critical methodology, proposes that it encourages researchers to examine reality through a cultural, societal and political lens. A critical methodology is underpinned by the drive to question assumptions, expose injustice and challenge conventional structures (Crotty, 1998). This supports the assumption that social research is political and has an underlying aim of change (Humphries, 2008; Carey, 2012), a perspective that influences my research. Indeed, Humphries (2008, p. 15) contends that social work research is “deeply political”; for example, the underpinning perspective framing the research question could lead to the findings endorsing social control or promoting social justice. This is even more likely when research priorities are set by the interests of stakeholders, such as government, funding bodies and other organisations (Humphries, 2008).

Oliver (1992), writing in support of the disability movement, offers a perspective that, despite originating in the 1980s, remains hugely relevant today. He argues that interpretivist research fails to address the *causes* of inequality and social realities for disabled people by merely focusing on meanings. He postulates that by failing to examine the societal context that disabled people find themselves in, there is a danger that research becomes exploitative if the researcher takes what they need and leaves the participant no better off. He proposes a critical enquiry model of research which explores lived experiences, grounded in the circumstances of everyday life.

The 'right fit' for social work research

Pragmatism has been described as an approach which favours the most appropriate method to answer the research question over “epistemological and methodological purity” (McLaughlin, 2012, p. 41). Bryman (2006) defends the rise of pragmatism, arguing that the key factor in choosing a methodological approach should be whether the methods are adequate for addressing the research questions, rather than a commitment to a particular paradigm or its underlying philosophical doctrine." This is a compelling argument in bringing the research questions centre stage. While a criticism of pragmatism is that it uncouples the method from its philosophical stance, Morgan (2014) proposes that pragmatism's potential as a philosophy (based on the work of John Dewey) is under-developed. He rejects the “crude summary of pragmatism as merely asking about ‘what works’”, and shifts the focus to how and why researchers' make choices and the impact of those choices (2014, p.1046). A pragmatic approach is also consistent with social research's complexity and the need to deconstruct questions from different vantage points.

It has been acknowledged that the relationship between social work practice and research could be strengthened (Research Advisory Group for the Chief Social Worker for Adults, 2023). This is not helped by pre-qualifying courses' tendency to discourage social work students from undertaking primary research in favour of literature reviews, often to avoid protracted ethics applications (Carey, 2019). The latest iteration of the profession's Professional Standards makes very limited reference to research, only requiring social workers to “record how I use research, theories and frameworks to inform my practice and professional judgement” (Social Work England, 2019). I would argue that it is crucial that the profession is mindful of its relationship with research and embraces the need to use the most appropriate methods to understand social reality and inequalities. Social workers need to defend what anchors their research, without the need to conform to methods favoured in more 'scientific' quantitative camps (like some health research for example). This leads me to reinforce my earlier argument that it is fundamental that the methodology chosen fits the research questions being asked and the researcher can explain why they have chosen a particular approach (Flick, 2023). It is crucial too that social work values, namely social justice, human rights and professional integrity, are embedded in the design of social work research.

My research design

I chose to adopt a qualitative approach in my study. Students are spoilt for choice in finding definitions of qualitative researching and Mason's (2002) description mirrors my perspective and captures its excitement and potential. She describes how qualitative research has "an unrivalled capacity to constitute compelling arguments about *how things work in particular contexts*" (Mason, 2002, p. 1), and this values the inherent richness, nuance and complexity of things that matter in the social world and incorporates them into explanations. My positioning in relation to the paradigms discussed above has been instrumental in developing my research rationale. I believe that social and cultural constructs exist and play a part in influencing how people think. For example, I believe that there is a negative societal discourse framing attitudes to ageing and institutional care. These constructs continue to evolve and change, not least as a result of the socio-political context during and following the Covid-19 pandemic. However, the interpretation of this 'truth' varies between individuals and influences the narratives they create. My aim is to explore the subjective reality of social workers and the meanings they create in the context of the complex and contradictory social and structural realities in which they operate. I reason that a qualitative approach drawing on a critical research perspective will suit my research questions.

Key to my approach and research design is the concept of *reflexivity*, which I will discuss in more detail in the next section. Reflexivity is the researcher's ongoing critical self-evaluation of their positionality and how their beliefs, biases, experiences and characteristics impact on the research (Berger, 2015). One way to think of it is 'counting yourself in' and how this influences methodological choices and the research's construction. My own attitudes towards ageing, care homes and social work and the multiple positions I inhabit (including social worker, researcher, PhD student and citizen), all play a role in developing knowledge. They impact on my perception of the power, value and validity of my topic. As explored in Chapter 3, the literature strongly indicates that older people in care homes are marginalised and the social work voice is absent. For me, this is a call to arms for social work research, and one that will require constant and critical self-evaluation. Taking a qualitative approach allows me to understand people's experiences; my epistemological position means that I believe that talking to people, finding out how they see the

world and asking them questions is the most effective way to generate new and useful data. Notably, qualitative research seeks to understand its subject matter or the topic in question from the perspective of those it is seeking to study (Campbell, Taylor and McGlade, 2017) and this is a key justification for focusing on social workers as participants.

The research questions

At this point, it is helpful to restate the research questions that my study is aiming to answer:

- What influences social work practice with older people in care homes?
- How do social workers conceptualise their role?
- What tensions and dilemmas do social workers experience working with older people in care homes?
- What is good social work practice in this area and what are the possibilities for developing it?

One reason I have reiterated the importance of these questions here, and in other sections of the thesis, is to highlight that they are a golden thread in the study. They foreground the research and what it is trying to find out (Bell, 2017) and the way in which the researcher then tries to answer these questions impacts on what knowledge is generated. To elucidate the importance and complexity of research questions, Thomas (2017, p. 8) uses an example from the Hitchhiker's Guide to the Galaxy: when a character expresses disbelief that, after millions of years, the supercomputer's answer to the question of life, the universe and everything is '42', it says "I think the problem, to be quite honest with you, is that you've never actually known what the question is". Given the broad and murky terrain that my study is traversing, it is essential that I am clear about what I want to find out.

Clough and Nutbrown (2012) recommend using two tools to determine research questions: the Russian doll principle (which helps to sharpen and focus the questions to the heart of what is under investigation) and the Goldilocks test (which helps to interrogate the appropriateness of the questions and ensure they are 'just right' for your own study). At the start of my study, I spent time thinking about the

right questions to ask, keen to avoid the pitfalls of asking ‘wrong’, useless or unanswerable questions (Rugg and Petre, 2020; Flick, 2023).

A practical technique I found useful, suggested by my supervisor, was a ‘mind-map’²⁸ which helped me capture the interlinking issues in my topic. Together with discussions in supervision, this helped me to refine the questions underpinning my study. The questions have also been influenced and crafted by other factors, including the literature review and my own assumptions and positionality.



Figure 7 Mind map for developing my research questions

At times, I have struggled with the ‘messiness’ of the whole methodological process. I have reminded myself that a qualitative orientation embraces richness, uncertainty and a shifting, recursive approach. Crucially, as my PhD journey has progressed, I have become more immersed in the subject and lived through the events of the past years, specifically the Covid-19 pandemic and its impact on care homes and the rights of residents. This has convinced me of the importance of a social justice lens

²⁸ A mind map is a diagram or visual representation that links concepts and ideas around a central key word or idea (Burgess-Allen and Owen-Smith, 2010).

and led me to lean towards the axiological underpinning of certain approaches. At the start of the process, I thought, somewhat naively, that I would decide on my methodology and follow a clear linear path. As the study has progressed, I have developed as a researcher and while I have a clear methodological predisposition, my thinking does not remain static. The methodology is a dynamic and iterative process.

Researcher positioning and reflexivity

A consideration of research design would not be complete without some discussion of researcher positioning or positionality. Positionality has been described as “the stance or positioning of the researcher in relation to the social and political context of the study” (Coghlan and Brydon-Miller, 2014, p. 2). It is an expansive concept, encompassing the multiple identities of the researcher, how they see the world and how this impacts on their research at every stage of the process. Braun and Clarke (2022) consider it the bedrock of a qualitative orientation, which explicitly acknowledges how the researcher’s different positions (for example, philosophical, political, professional and personal) will suffuse the research. Denscombe (2021) argues that the researcher’s identity and values cannot be eliminated from qualitative research and proposes two approaches to address this: minimising their influence or embracing their impact as a resource within the research. The latter resonates with the stance I have chosen to take. In Chapter 1, I stated that bringing my voice to the foreground is important to the reflexive perspective that underpins my methodological approach. I discussed my positionality – my personal, academic, and professional influences and values - and how they have shaped the research study. My positioning is also fundamental to the method of data analysis I have chosen - reflexive thematic analysis – which I will discuss later in the chapter.

Reflexivity

As mentioned earlier, reflexivity is “being able to recognize the influence of oneself on a situation” (Department of Health and Social Care, 2018, p. 13). Reflexivity and researcher positioning are undoubtedly strongly linked, but they are not the same thing: reflexivity is more than positionality as it acknowledges the role of the researcher in participating in the creation of knowledge (Trainor and Bundon, 2021). In the context of social research, reflexivity is widely identified as an explicit practice,

involving critical awareness of what, how and why something is done, and how this shapes and influences the research and knowledge produced (Gringeri, Barusch and Cambron, 2013; Thomas, 2017; Braun and Clarke, 2022). It can be argued that reflexivity is an epistemological stance, challenging the view that knowledge production is independent of the researcher producing it (Berger, 2015). It is also a situated stance, which acknowledges that I hold unique positions and perspectives as an individual, a social worker and a researcher. This, in turn, mirrors the multiple positions occupied by the participants in my study as individuals, social workers and research participants. Reflexivity is a pivotal concept in qualitative methodologies, and Ide and Beddoe (2023) suggest that, because it is strongly linked to critical reflection in social work practice, *social work* researchers should have an enhanced understanding of it.

Insider-outsider perspectives

Insider-outsider perspectives are another important concept to consider. Whether the researcher identifies as an insider or outsider, and therefore how much they identify with and share the participants' experience, is important and requires a strongly reflexive approach to understand how this might impact on the research findings (Berger, 2015). Clearly, though, these perspectives are not binary and Dwyer and Buckle (2009) contend that polarising insider and outsider positions fails to reflect the nuance of the many identities and roles individuals inhabit. Instead they introduce the notion of a 'space between' which allows researchers "to occupy the position of both insider and outsider rather than insider or outsider" (2009, p. 54). I will explore this further when I address ethical issues later in the chapter.

Reflexivity and care homes

It is important to mention reflexivity in the context of care home research, since the researcher's positioning and attitudes to *care homes* will influence their research in multiple ways. Luff *et al.* (2015) highlight the limited literature devoted specifically to researcher reflexivity in the care home research field, and notably they identify that the emotional impact of researching the topic is also understated. Whilst my research focus is not located *in* care homes or with care home residents, nonetheless it is important to examine my own views about care homes, where they come from and how they will inevitably influence the research. Taking a reflexive approach has prompted me to examine my own assumptions and those of my

research participants, as well as attending to my own well-being to counteract the emotional dimension of being immersed in this topic.

I have argued that reflexivity is relevant at every stage and it is an underpinning perspective in the methods I will now move on to discuss.

Data collection methods

Thus far, I have articulated my methodological approach and in this section, I will discuss and justify the methods that I chose to gather my data. Later in the chapter, I will discuss the technical aspects of data gathering, ethical issues and several challenges that I encountered and how I managed them.

Research *methods* are generally described as the tools or techniques to collect data (Blaxter, Hughes and Tight, 2010; Clough and Nutbrown, 2012). As explained earlier, they must fit the methodological approach taken and provide a means to answer the study's questions. Qualitative research design draws on various methods, mirroring the multiple perspectives and flexibility of an interpretive approach (Denzin and Lincoln, 2018). I chose to use focus groups and interviews to collect my data, which is consistent with my decision to focus solely on accounts from social workers, as their voices about what they do or the possibilities for change is not prominent in the limited research around social work and care homes.

Focus groups

A focus group is defined as:

“a qualitative research method in which a moderator interviews a small group of participants, typically 6 to 10, and uses the group process to stimulate discussion and obtain information on the beliefs, attitudes, or motivations of participants on a specific topic” (Linhorst, 2002, p. 209).

It is essentially a “managed discussion” with a small group of individuals ‘focused’ on a specific topic (McLaughlin, 2012, p. 37). Described as an effective technique for exploratory research (Chernesky and Grube, 2000), focus groups can allow the researcher to capture a range of opinions in a less time-consuming way than interviews (Whittaker, 2012). Morgan (2019), a leading authority on this method, explains that a focus group can be a source of change as participants listen to others’ views and experiences, which can allow them to agree, disagree or question

their own understanding. Focus groups can also uncover the extent of consensus or diversity in opinions. There is a risk that the group environment may mean that personal experiences are not discussed in depth (Whittaker, 2012). Barbour (2018) argues that a greater challenge is managing and later analysing multiple voices keen to share their stories.

The hallmark of focus groups - and an important rationale for their use in my study – is that the *interaction* of the group is actively used to generate the data and can offer rich insights on topics and attitudes (Linhorst, 2002; Wilkinson, 2011; Morgan, 2019). Bell (2017, p.83) differs slightly in emphasis and describes focus groups as “semi-structured interviews with small groups of people” with *the advantage* of using group dynamics to gain insights. This arguably does not highlight the central importance of group interaction to create the data which many authors, included those noted above, emphasise in their definitions and therefore downplays the methodological importance in research design.

Morgan (2019) asserts that focus groups are likely to be a good choice if you want to learn about participants’ perspectives. Thus, focus groups seemed like suitable method to answer my research questions around the wider influences on social work practice, which would allow participants to examine their own views while opening them up to others’ ideas. More than just ‘measuring attitudes’, focus groups represent a “social process through which participants co-produce an account of themselves and their ideas” (Barbour and Schostak, 2011, p. 63). This supports my underpinning reflexive approach, by encouraging social workers to think about their views on ageing and institutional care, conceptualise their role and create an account of how multiple perspectives influence role and practice. My rationale was that the inter-relational dynamics of the group would encourage practitioners to consider new perspectives and most importantly, reveal some tensions and wider influences on practice at the meso and macro level. I was interested to see how social workers might present their social work identities in a group or to each other, and what this might also reveal about organisational and structural influences. While this might vary depending on the group composition, which I will discuss in a later section, I wondered if participants would reinforce or challenge the policies of their organisations and what this might say about how they conceptualise their role.

Focus groups are frequently said to combine well with other methods (McLaughlin, 2012; Thomas, 2017; Morgan, 2019), and I will discuss the other method I used to complement the focus groups.

Interviews

Interviews are widely acknowledged as the most commonly employed methods in qualitative research (Mason, 2002; Brinkmann and Kvale, 2018; Clark *et al.*, 2021). Kvale's (2007) well-known metaphor of the interviewer as miner or traveller illuminates the underpinning epistemological assumptions about whether the interview is likely to *collect* knowledge or *construct* it, demonstrating that interviews can be a quantitative or qualitative method. Garton and Copland (2010, p. 533) describe the interview from a qualitative perspective as "an interactional event in which interviewer and interviewee jointly construct meaning". Qualitative interviews can be an appropriate choice for gathering information about emotions and experiences (Wisker, 2008) or if you value depth, nuance and complexity over patterns and trends (Mason, 2018).

Interviews are a popular *social work* research method, perhaps because they draw on the key skills of listening and asking questions that social workers employ in their practice. Hardwick and Worsley (2010, p. 85) praise them as a flexible, adaptable approach with "an unrivalled capacity for allowing opportunities for the researched respondents' voices to be heard". Bringing social workers' voices to the centre stage is important to me and fits the metaphor of the traveller meeting people and encouraging "original stories of their lived world" (Kvale, 2007, p19). I anticipated that the focus group environment might limit detailed personal accounts from participants, so I used interviews to complement and build upon my data.

Interviews operate on a continuum, from structured, through semi-structured, to unstructured, and this tends to align with the underpinning orientation of the methodology (Hickson, 2015). Structured interviews often favour a more quantitative orientation, with pre-determined questions to prompt certain responses. They can be useful to gather more standardised information but leave less room to elicit meaning. Unstructured interviews, on the other hand, promote an open-ended, conversational approach. Semi-structured interviews inhabit the middle ground, with a loose

framework of topics and questions but a space for divergence and opportunities to explore what has been said in more depth (Wisker, 2008).

Initially I planned to conduct interviews closer to the unstructured end of the continuum. I was interested in narrative approaches, which can help participants to “free associate” to uncover how “issues and concerns are connected on their unconscious” (Mason, 2018, p. 112). Hollway and Jefferson (2013, p. 31) suggest narrative interviewing approaches take account of interviewees’ defences, which they refer to as the “defended subject”. They also suggest that this approach reframes the researcher / interviewer relationship as listener / storyteller. The psychodynamic element of this approach resonated with me, but I was less comfortable with the concept of listener and storyteller as it seemed to be less congruent with the reflexive approach underpinning my research’s construction. I also heeded the warning that narrative interviews can meander and be much harder to analyse across interviews (Hardwick and Worsley, 2010).

Piloting an interview approach

I tested the narrative approach with one pilot interview. For this, I used the Biographic-Narrative Interpretative Method or BNIM (Wengraf, 2001), a narrative approach with minimal researcher influence which aims to capture subjective stories and perspectives. In keeping with the interpretative paradigm, I wanted to see if giving people free rein to tell stories might more readily uncover their attitudes and reveal the defences that social workers might employ when considering ageing and care homes. I started with a warm-up exercise asking for trigger words for four main topics (older people, care home, social work, strengths-based practice). I hoped this would support the participant to contextualise and locate the narrative in my subject area, and potentially avoid the dominance of negative attitudes.

I wanted to pilot this method to assess my own anxiety about adopting a non-directive interview approach and more importantly, to assess the extent it would allow me to answer my research questions. I decided that using the BNIM method would not support the more flexible and pragmatic approach I wanted to take. It also contrasted too much with the way I planned to run the focus groups. More importantly, it seemed to ignore the many contextual elements in my study and was less congruent as an approach with critical methodology. I therefore rejected a purely

narrative approach in favour of semi-structured interviews *influenced* by a focus on the stories and experiences that participants chose to share. Jovchelovitch & Bauer (2000) advocate introducing flexibility when using narrative approaches and adopting this style helped me to maintain a conversational element, with structure to guide the interview and support the process.

Other methods considered

I will briefly mention other methods I considered (and rejected). At an early stage, I considered Q methodology, a 'qualiquantological' approach, which applies statistical analysis to the qualitative study of people's attitudes, beliefs and opinions (Stenner and Stainton Rogers, 2004). The method encourages participants to sort pre-prepared statements (the Q sort), which are analysed to highlight the relative value people place on different viewpoints. It has been described as a non-threatening and easy way of obtaining people's views, with minimal researcher influence (Ellingsen, Størksen and Stephens, 2010). It struck me as a good method for gathering attitudes to wider structural narratives, which could be included into the Q sort from various sources. To counter Shemmings' (2006) suggestion that it does not allow for participants' own narratives to emerge, and to fit with a more qualitative orientation, I considered whether it might be useful to use Q methodology in conjunction with other methods. I considered whether the statements used in the Q sort could be developed through focus groups, offering a more inclusive and partly co-produced approach.

Resonating with pragmatism, several commentators emphasise the importance of expediency and practicality in choice of methods (McLaughlin, 2012; Thomas, 2017), which influenced my decision to reject using a Q sort. Another strong factor against using Q sort was that it works well in a face-to-face environment and I was collecting data during the Covid-19 pandemic.

I also considered using appreciative inquiry, a participative approach, originating from the work of Cooperrider and Srivastva in the 1980s, which builds on strengths to focus on how best practice can be achieved (Bellinger and Elliott, 2011). I considered that this approach could help to overcome negative discourses around care homes and social work, disrupt the status quo and be a catalyst for change (Bellinger and Elliot, 2011). Clouder and King (2015) critique this approach, which

led me to the view that using methods that are purely appreciative would be perceived as limited and uncritical. I also decided this method would not be suitable for an under-researched area as there is much to find out about the topic before looking to positively change it.

Ethical considerations

Before discussing the practicalities of data collection, the next section will focus on ethical considerations in research. I will examine the connection between social work and research ethics and move on to explore the importance of research ethics and key considerations in qualitative research. I will discuss how I obtained ethical approval for the study and consider some ethical issues that arose in relation to my positioning, with a focus on the concept of insider/outsider research. Later in the chapter, I will weave the ethical issues I encountered into the discussion about data collection and data analysis to acknowledge that ethical issues are relevant at every stage of research activity (Clough and Nutbrown, 2012).

Social work ethics: a head start?

Registered social workers must meet the regulator's Professional Standards to maintain their registration and ensure safe and effective practice (Social Work England, 2019). Social workers in the UK are also guided by their professional association's Code of Ethics (BASW, 2021b), which does not present ethics as a set of rules but as principles to underpin dilemmas and help social workers make ethically informed decisions in accordance with the profession's values. It should follow, therefore, that any research undertaken by social workers is underpinned by their commitment to ethical practice and professional standards. McLaughlin (2012, p. 47) reinforces this view, speculating that there should be minimal concern about the ethics of social work researchers "as many are registered social workers for whom ethical issues are integrally entwined at the heart of social work practice".

While this perhaps belies the complexity of the relationship between research ethics and social work research, ethical social work principles are highly compatible with good ethical research practice (Shaw and Holland, 2014). Likewise, social work's emphasis on values, reflection and relationships is highly congruent with the role that ethics play in qualitative research (Reamer, 2013). Social work's emphasis on social

justice is also consistent with ethical research practice, in particular the purpose of research and its wider agenda for social change.

A convincing argument proposed by Bell (2017) is that since social workers are accustomed to thinking about ethics and values from a practice, professional and regulatory perspective, they have a good head start in understanding research ethics. She cautions, however, against ignoring the complexity of research ethics and the demands of balancing social work professional standards alongside processes, dictated by academic institutions, stakeholder organisations and research practice.

Research ethics at the heart of qualitative research

Just as social workers must uphold the principles of their profession, researchers must place ethics at the heart of the research process to assure the integrity of their study and research in general (Israel and Hay, 2006). At the start of this chapter, I noted that ethical questions underpin the key methodological questions informing the study at every stage (Clough and Nutbrown, 2012). There is consensus in the research methods literature of the importance of anticipating ethical questions at all phases of the research process and establishing strategies for their management as an ongoing process (Swauger, 2011; Webster, Lewis and Brown, 2014; Thomas, 2017; Gray, 2022). Swauger (2011) proposes that ethical issues arise in qualitative research because it is complex and unpredictable, which requires a reflexive exploration of practice throughout the process. More pertinently, qualitative research's focus on *interaction with people* elevates ethical considerations within this paradigm (Iphofen, 2009; Carey, 2012; Silverman, 2022).

Conceptualising research ethics

Research ethics, however, are most commonly associated with procedures for gaining approval or fulfilling governance requirements (Becker, Bryman and Ferguson, 2012). I found Guillemin and Gillam's (2004) distinction between *procedural* ethics and ethics *in practice* instructive in conceptualising ethics. They describe procedural ethics as issues that necessitate negotiating approval from relevant committees, which, when viewed as a "formality" (2004, p. 263), appear to have minimal impact on the actual ethical conduct of research. There is debate in the literature about the usefulness (or otherwise) of conflating the focus on regulation

and governance with ethical research practice (Reamer, 2013; Bell, 2017). For example, Shaw (2008, p. 402) argues that research ethics are often simply about “organisational control”. Some authors, such as Iphofen (2009), go further and suggest that risk adverse practice and institutional caution often supplant ethical concerns.

To put the preceding arguments into perspective, it is helpful to remember the origins of procedural research ethics. They were introduced from the late 1940s to ensure that nothing again happened like the experiments undertaken by the Nazis on human subjects, or the infamous 40 year Tuskegee study started in 1930s by US Public Health to investigate the effects of untreated syphilis. Ethical standards in research were designed to protect people from harm (Reamer, 2013; Flick, 2023). Criticisms about their enactment may be valid, but they are in place to show accountability and promote confidence and trust in the researcher’s conduct and the research’s integrity (Silverman, 2022).

Procedural ethics

Ethics approval is a necessary step in ensuring that research meets the *minimal required standards* and is a “beginning point” for securing the research’s value base (Clough and Nutbrown, 2012, p. 187). Reading around the subject, I often encountered lists of issues to consider or avoid, which usually covered informed consent, confidentiality, voluntary participation, benefits and risks, avoidance of harm, and compliance with data protocols (Israel, 2015; Rugg and Petre, 2020; Silverman, 2022; Flick, 2023). Ryen (2011) proposes the three most commonly raised ethical issues in qualitative research are consent, confidentiality and trust, which I will consider in turn.

Consent

Consent is essentially about *informed* consent, which recognises people’s right to self-determination and to not be subjected to undue pressure to participate (Miller and Boulton, 2007). At every stage, participants should understand to what they are consenting, including the use of their data and any unintended consequences from participating in the research (Mason, 2018). Shaw (2008) proposes that consent can be more problematic in qualitative research. He postulates that participants cannot

definitely know to what they are agreeing since qualitative research's strength lies in its adaptability and interpretation, which can transform the process and output into something unexpected. In retrospect, I discussed consent with people when they agreed to participate, but I now question whether I fully understood and communicated that consent is a dynamic process, not a one-off event (Webster, Lewis and Brown, 2014). I may have made assumptions that, as my research participants were social workers, they would be familiar with the idea of consent.

Confidentiality

It is important to understand the difference between anonymity and confidentiality (McLaughlin, 2012). The former protects the identity of participants so that they will not be identifiable, the latter ensures that specific comments cannot be attributed to individual participants. This was relevant in my research since focus groups cannot support anonymity and may also make confidentiality hard to achieve. Issues can arise when participants in focus groups know each other or are part of the same organisation.

Researchers should anticipate the circumstances that might necessitate breaking confidentiality. Silverman (2022) gives an example of a doctoral researcher, conducting a study on male sexuality, who guaranteed confidentiality to participants, one of whom later disclosed he had sexually abused a child. This may be an extreme example, but it raises the dilemma of how to encourage participants (in my case social workers) to talk honestly and openly about the pressures of practice and what to do if, in doing so, they disclose what might be considered 'unsafe' practice.

Trust

Trust between researcher and participant is fundamental to qualitative interviewing (Ryen, 2011). Building rapport encourages participants to share knowledge that the researcher needs for their research, yet this raises questions around the location of power within the relationship. Guillemin and Gillam (2004) examine how research can be seen to violate the Kantian notion that people should not be a means to someone else's ends. It can be easy to forget that this extends past the initial data gathering phase. As an example, as I was analysing my data, thinking about my findings and focusing on completing my thesis, at times my immersion distanced me

from remembering the reason for the research and the trust that participants had put in me to represent their accounts in my interpretation.

The ethics application process

I had to apply for approval from the university ethics committee before I could start data collection. Carey (2019) levels several criticisms at ethics committees, proposing that, far from supporting ethical practice, they are time-consuming, constraining processes which can lead, for example, to researchers avoiding certain topics or methodologies which might be considered sensitive or 'too difficult'. He suggests that the system encourages researchers to view ethical approval as a tick box exercise as it is a pre-requisite for starting a project. In hindsight, when I was working on my ethics application, I did consider it as a hurdle to overcome. While it did not feel entirely like 'box ticking', it certainly did not allow for a full consideration of the many ethical issues, which, in taking a reflexive approach, are interwoven into the research journey. As the research has progressed, I have gained a deeper understanding of the subtleties and tensions that the research methods literature describes.

Silverman (2022, p. 135) suggests that student researchers can particularly struggle with the challenge to "package the open-ended contingencies of qualitative research in a way that convinces your supervisor and any organisation that no risk is involved". It struck me that the requirement to anticipate all potential harms encourages researchers to view research ethics through a deficit rather than a strengths-based lens. Webster, Lewis and Brown's (2014) assertion that ethical codes and guidelines usually take a protective rather than rights-based stance further supports this perspective.

Since I was interviewing social workers, I found this risk adverse stance particularly challenging, as I suspected that, far from being harmed, they would welcome the opportunity to discuss their professional practice. One potential limitation of ethics committees could be that they apply to *all* research disciplines within the university and therefore they do not take into consideration the pre-existing value-base of social work. Furthermore, ethics committee members are usually drawn (voluntarily) from a wide range of disciplines and may not have specific methodological expertise

aligned to a research application (Carey, 2019). Notwithstanding these limitations, the process is important. It offers a fresh perspective on the research which can be constructive and highlight unanticipated risks or flaws (Hardwick and Worsley, 2010; Silverman, 2022). Crucially, it demonstrates to participants that the research has undergone scrutiny and supports its integrity.

I submitted my ethics application to the UEL University Ethics Committee in September 2021, accompanied by a data management plan and a risk assessment. It included a recruitment poster (Appendix A), participant information sheet and consent form (Appendix B), and a topic guide for the focus groups (Appendix C) and interviews (Appendix D). I had also approached organisations, including my local authority workplace, to seek permission to recruit participants. Approval was granted (Appendix E), after some minor amendments.

Ethics in practice

I have highlighted the tension between the need to anticipate potential issues for the purpose of ethics approval and the ethical issues that “unfold in the field” (Swauger, 2011, p. 501). Indeed, Guillemin and Gillam (2004) argue that procedural ethics generally fail to address the dilemmas that arise in practice. They suggest that, in qualitative research, reflexivity creates a bridge between procedural ethics and ethical practice, yet despite its familiarity as a concept in qualitative research, reflexivity is rarely cited as an *ethical* notion. I proposed in the construction of my methodology that reflexivity is at the heart of the research process and applicable at every stage. If one acknowledges reflexivity as the researcher’s ongoing and critical awareness (Gringeri, Barusch and Cambron, 2013), then it follows that ethical practice and reflexivity are inextricably linked.

Garton and Copeland (2010) note that few studies have examined how the interviewer and interviewee's previous relationship affects how data is created. They propose that researcher and participant need to renegotiate their relationship when the interviewer knows the participant professionally or personally. I discussed positionality earlier and referred to the idea of insider and outsider research. Rather than viewing these positions as dichotomous, the researcher can occupy different positions as insider and outsider at various times throughout the research process (Breen, 2007; Mason, 2018). Notably, the researcher makes decisions about how

different roles should be “played” in different situations or with different participants (Dwyer and Buckle, 2009; Meyer and Willis, 2018). I was aware that I occupied multiple positions: social worker, independent BIA, researcher, professional lead in an organisation, employee, colleague. These roles offered me advantages and challenges in different situations and with different participants at various stages of the research. From an ethical perspective, I grappled with the issue of power in the relationship and how this subtly altered depending on whether I knew the participant or not. In some situations my authority gave me power, in others I was aware that I wanted to ‘prove’ myself as a competent researcher with people I knew.

One ethical dilemma relating to positioning involved a participant who took part in both a focus group and an individual interview. This participant was a newly qualified social worker, who was aware that in my ‘day job’ I co-ordinate the ASYE programme. After participating in the research, she emailed me asking for feedback on her participation to demonstrate her professional competence. I was conscious of maintaining boundaries between my roles, and after discussion with my supervisors, let her know that while I appreciated her input, I could not provide feedback as this was not within the remit of my researcher role. It made me reflect on the reasons people participate, the power dynamics in the research relationship and the difficulty of delineating roles.

Data gathering

In the previous section I argued that ethical issues are deeply embedded in every stage of the research. In this next section I will cover the process of data collection. I will discuss sampling and access, and the context in which I gathered my data. I will examine the data collection process, challenges I faced and how I managed them.

Sampling and access

There is little value in criticising qualitative sampling techniques by positivist criteria which prize scale, representativeness and generalisability (Ritchie *et al.*, 2014). Qualitative research uses non-probability methods for selecting the study’s sample, which include purposive sampling (picking relevant, interesting cases), convenience sampling (sampling those who are available) and snowball sampling (where participants suggest others for the researcher to contact) (Blaxter, Hughes and Tight, 2010). Staller (2021), writing about reporting qualitative research in a peer-reviewed

journal, comprehensively addresses sampling issues. She advises researchers to consider their sampling strategy, its limitations, how it links to the methodology and the purposive decisions they have made. She recommends that sampling should be “flexible, responsive and iterative” (2021, p. 903).

Purposive sampling

Purposive sampling is predicated on intentionally selecting participants who will enable rich, detailed exploration and understanding of the research topic (Ritchie *et al.*, 2014). Adopting a purposive sampling strategy acknowledges that specific people will hold important views on the subject in question (Campbell *et al.*, 2020). Crucially the sample should generate the breadth and depth of data necessary to answer the research questions (Trainor and Graue, 2013). A common question, however, is how many participants is enough. Staller’s advice for researchers is to make “intentional, thoughtful, purposive decisions”, and, rather than worry about numbers, to focus on the richness, quality and convincing narrative that the sample will yield (2021, p. 903). This is echoed by Mason (2018, p. 58) who advocates for “strategic sampling” to allow a “meaningful range” within the pivotal context of the research questions. According to Hardwick and Worlsey (2010), small samples can be illustrative research, as long as researchers are transparent about the approach taken and do not exaggerate claims about generalisability. A concept associated with ‘when to stop’ is saturation, where adding more participants is unlikely to add to existing themes or to provide new insights (Gray, 2022).

I used a purposive sampling strategy, which I felt was consistent with the qualitative stance of my study. Holloway and Galvin (2017) recommend using purposive sampling when participants need to share a specific characteristic or experience. For my study, the primary requirement for participation was being a social worker with experience of working with older adults. I initially planned to hold two focus groups of six to ten participants and interview around twelve social workers. In fact, I conducted four smaller focus groups (with a total of twenty participants) and nine interviews. I had planned to recruit mainly from my local authority workplace, particularly the specialist team undertaking reviews in care homes. Instead I widened my scope to other local authorities to get a diversity of experience and backgrounds, and also because I had not designed the research as a case study. I approached

social workers working in non-local authority settings to add to the richness of experience and to help with understanding the wider contextual influences.

In hindsight, I was successful with my recruitment and could have interviewed more people, but chose to stop as I was worried that I would have too much data to manage as a single PhD researcher. I drew on professional networks, to which my job role gave me access, and this led to elements of snowball sampling. I revisited the sample's sufficiency as I recruited and interviewed participants. Far from being a weakness, this is a strength of qualitative sampling (Staller, 2021). That said, on occasions, my decision-making was affected by practicalities, which led to an element of convenience sampling, dictated by pragmatism.

Focus group sampling

Parker and Tritter (2006) explore a number of methodological dilemmas specifically around focus group sampling. They propose that minimal attention is given to selecting focus group participants, but that sampling is in fact crucial as it can influence the quality and form of *interaction*, a key methodological imperative. They contend that interaction works best when the participants do not know each other's stories. In my experience this was not always the case and I have considered that this may be a feature of bringing together social workers who are familiar with reflecting collectively on a topic. Nevertheless, I was purposeful in the composition of individual focus groups, trying to balance the need to assemble a group of people who could generate rich and interesting data, with people's willingness and availability to participate. I was influenced by the idea of maintaining some homogeneity in the groups to promote openness (Linhorst, 2002). For example, I tried to avoid mixing social workers and managers. Barbour (2018) recommends maximising the potential for comparison *across* the groups. I found richness in the data through the individual composition of the groups and the meaning I attached to their interaction.

The participants

I started recruitment to the study in October 2021 once I had ethics approval. I had intended to recruit to and conduct focus groups first and then undertake interviews. In practice, I had to be flexible to accommodate the logistics of the groups and people's preferences around participation. Some people wanted to join a focus group

or be interviewed and some were interested in both, so the recruitment took place concurrently. In most instances I approached workforce leads or professional contacts to disseminate the recruitment poster to social workers. Once someone expressed interest, I sent them the appropriate information sheet and a consent form (Appendix B) and offered to answer any questions. I approached some contacts individually and used different approaches to publicise my request for participants. I underpinned the process with an ethical conscience, maintaining a balance between using my professional role to access people and networks and not abusing my power and influence.

The table below summarises the composition of the focus groups and interviews:

Focus group 1 n=5 (colleagues in same organisation)	All female, ethnically diverse, student to 30+ years' experience
Focus group 2 n=4 (different organisations)	All female, ethnically diverse, student to 30+ years' experience
Focus group 3 n=8 (managers in same organisation)	Mixed gender, ethnically diverse, 8 to 30+ years' experience
Focus group 4 n=3 (different organisations)	All female, ethnically diverse, NQSW to 19 years' experience
Interviews n=9 (4 also focus groups participants)	5 female, 4 male, all white, NQSW to 30+ years' experience

Table 4: Summary of participants

Although recruitment was time consuming, and often logistically challenging, I did not struggle to find people to participate and I recruited several people through word of mouth (snowball sampling). The participants were drawn from seven different organisations, based in London and the South-East of England, with around half the participants from one local authority. I did not need to advertise using social media platforms, like Twitter, and I have reflected on whether this would have provided a greater range of people from other parts of England. With support from my supervisors, I allowed myself to be satisfied with the richness in the accounts of those that participated, resonating with the qualitative nature of my study.

It is important to note that I did not seek to recruit people with different characteristics as this did not seem relevant for the parameters of my study. Many participants shared information about their backgrounds voluntarily during the focus groups and interviews. It is interesting, however, that the participants, particularly in the focus groups, were largely female, which appears to reflect the profession, where 82% of social workers are female (Social Work England, 2023). It is also interesting that all the interview participants were white and the focus groups were far more diverse in terms of ethnicity. I am not sure why this is the case, but it could suggest that focus groups are considered a more inclusive space.

Doing it online

My ethics approval stipulated that I adapt my approach to collect all data online using Microsoft (MS) Teams to meet Covid-19 requirements. Looking back, it is easy to forget that, at the time, this was unfamiliar territory. Digital technologies such as MS Teams were undergoing modifications (albeit at speed) to meet the growing requirements of use, with transcription only introduced in April 2021. Researchers who had planned face-to-face fieldwork had to consider alternative measures to meet frequently changing government restrictions (Watson and Lupton, 2022). The impact on my interviews was minimal, but I adapted the focus groups for practical and methodological reasons.

Pre-pandemic, there was limited literature considering virtual focus groups as a research method, perhaps because it is harder to generate interaction in an online environment (Morgan, 2019). There are certainly pros and cons to online focus groups. Commonly mentioned benefits include: potential access to a wider recruitment pool, reduced time and cost for the researcher, convenience and ease of access for participants. Challenges cited include: confidentiality, technical issues, lack of non-verbal communication and difficulties in managing interaction (Lobe, Morgan and Hoffman, 2020; Dodds and Hess, 2021; Santhosh, Rojas and Lyons, 2021).

I designed my focus group guide specifically to avoid the trap described by Morgan (2019, p.28) of “serial interviewing rather than active exchanges among the participants”. One adjustment I made was to reduce the number of participants, since smaller number of participants tend to increase engagement (Morgan, 2019;

Keemink *et al.*, 2022). That said, I noticed in the largest focus group participants often directed their comments to me rather than the rest of the group. These adaptations are not without methodological and epistemological importance (Parker and Tritter, 2006) and I consciously embraced online focus groups as a positive choice within the research design. Reinforcing this, I presented a poster at a doctoral conference with a PhD colleague to illustrate our reflections on virtual focus groups (Appendix F).

The process

When I started data collection, I began to keep a research journal to note down thoughts and ideas. Meyer and Willis (2018) recognise that qualitative researchers, particularly novice ones, encounter countless questions and uncertainties during fieldwork and they suggest that reflexive journalling can help traverse the “murky waters of qualitative research” (2018, p.11). While this does not automatically result in reflexive practice, they argue that it can facilitate a reflexive approach and help the researcher to respond to challenges and understand positionality. Looking back, I struggled with how my dual roles of researcher and practitioner might impact on the research participants, as well as the ethical and practical issues this raised. As the process got under way, I also reflected on the tension between my excitement in the quest for more data and a growing sense of overwhelmedness at the volume of information I was gathering.

All participants were provided with an information sheet and consent form in advance and were asked to sign the latter. I discussed consent again at the start of the interview or focus group and checked that individuals were comfortable with being recorded.

Focus groups

As previously stated, the constraints of the online environment prompted me to adopt a more structured approach than I might have done in person to maximise engagement and interaction. This also required me to take an active role, perhaps more than it suited my natural epistemological inclination. I created a topic guide in the form of a power point presentation (Appendix C) to support my facilitation of the groups. To help participants settle in, I began by asking everyone to introduce themselves and say how long they had been qualified as a social worker. In

retrospect, I have questioned if this signalled that qualified experience was valued, and potentially undermined some members and influenced the dynamics of the group. What appeared an innocuous way for people to introduce themselves (which was also useful information for the research) may have conveyed status and authority. Some further reflections on the interactions in the group are presented in Chapter 8.

I then used an exercise to “focus the attention” of the participants on the research objectives (Acocella and Cataldi, 2021, p. 149). I asked participants to reflect on and write down ideas about the social work role in general and then about the social work role in relation to care homes. My reasoning for asking them to jot down their thoughts before speaking was to uncover the extent of consensus or diversity in opinions (Morgan, 2019) and to avoid dominant voices influencing others. Next I showed carefully selected “stimulus materials” (Barbour, 2018, p. 86) in the form of statements (influenced by the research literature or common discourses) to provide points of reference and stimulate debate, and these generated lively discussions. Towards the end, I provided the opportunity to summarise and identify what participants felt to be the salient points with “all things considered questions” (Krueger and Casey, 2002, p. 8). The focus groups lasted between 60-90 minutes.

Interviews

Flexibility is a key feature of an interpretative approach (Denzin and Lincoln, 2018) and I was aware that I might modify the structure and format of the focus groups and interviews as data collection progressed. In practice, the semi-structured interviews, which encouraged participants to share stories, supported an iterative and flexible approach. I prepared some questions to use as prompts during the interviews (Appendix D). I began each interview by asking participants to tell me about their professional background and what they felt was important to them about social work. This was to put participants at ease, obtain background information and contextualise the discussion in social work practice. I subsequently asked participants to talk about experiences of social work and care homes. Most interviews lasted about 60 minutes.

Flick (2023, p. 205) suggests the success of the interview can be judged on whether “the interviewer manages to construct a framework for listening to the interviewee”.

Certainly the interview guide's flexibility allowed me to use minimal prompts to allow interviewees to share their stories and reflections. Some interviews, especially those where I knew the participants, took on a more conversational feel, which may have contributed to the data generation (Garton and Copland, 2010). This supports the idea that the quality of the interview relies not just on the questions asked but on the interviewer's skills and the relationship created to generate the data (Brinkmann and Kvale, 2018).

The impact on the research process

I will briefly discuss to the impact of the research process on the researcher and on the participants. Cooper (2009) discusses the emotional dimension of practice-near social work research, arguing that, because 'practice' is about people and relationships, researchers need to explore what happens when they get near – physically and emotionally – to people. He suggests that social workers need the conceptual apparatus to process unwelcome realities. He also highlights that researchers can be struck by powerful thoughts or emotions when they are interviewing. While this is not developed further in his paper, it is a useful reminder of the researcher's need for containment for their emotions. Certainly, realities such as the excess care home deaths during Covid-19, the impact of years of austerity and the constraints of organisational pressures on social work practice have been at the forefront of my mind during the research process. Using a journal helped me to question my thoughts to ensure that my reflexivity remained a positive tool and was not a burden. In taking a psychodynamic approach, Cooper (2009, p.441) asks "how much reality can we bear to know about?" During the data collection, and later during analysis, I found this a helpful question to consider in thinking about the extent to which participants might wish to really think about the topic in question. This is also an important question in the context of ethical research and the importance of protecting participants from harm.

In contrast, there is often reduced focus on the less tangible benefits of participating in research (Ruch, 2014). There can be a therapeutic effect for participants in sharing their views and their story, alongside the hope that involvement may bring about some change (Shaw and Holland, 2014). Indeed, the Hawthorne effect, named after a 1920s US study of factory workers, is used to describe how positive change can occur through the researcher's interest in participants (Thomas, 2017). I

noticed that, far from causing distress, on many occasions, the interviews and focus groups were welcomed as a reflective space. Participants commented that the interviews provided space for reflection and that they enjoyed the focus groups as an opportunity to think together with peers. This may be a feature of interviewing social workers whose professional value base encourages reflection and learning.

Managing the data

The interviews and focus groups were recorded using MS Teams, which generated a video recording and a transcription. The data was stored securely as outlined in my data management plan. This covers data management technicalities, but does not address the real task of managing the data through analysis, which is the topic of the next section.

Data analysis

Data analysis starts as fieldwork begins and involves both managing the data and interpreting or making sense of it (Gibbs, 2007; Hardwick and Worsley, 2010; Mason, 2018). One of the most commonly used methods to analyse qualitative data is thematic analysis (Swain, 2018; Trainor and Bundon, 2021). It is described by its main proponents, Braun and Clarke, as “a method for identifying themes and patterns of meaning across a dataset in relation to a research question” (2013, p. 75). Thematic analysis’ strength lies in its flexibility and range of approaches, supporting Thomas’ (2017) claim that qualitative research benefits from a degree of analytic eclecticism. Finlay (2021, p. 104) broadly divides thematic analysis into two overlapping camps of “scientifically descriptive” and “artfully interpretive”. Notably, thematic analysis should be informed by the methodological and philosophical underpinning of the research (Flick, 2023). Researchers therefore should articulate and account for the theoretical assumptions and foundations that guide the analysis (Trainor and Bundon, 2021).

Reflexive thematic analysis

I analysed my data using reflexive thematic analysis, as outlined by Braun and Clarke (2022). Since publishing their original exploration of the method in 2006, Braun and Clarke have significantly developed thematic analysis into its current iteration of *reflexive thematic analysis*, which reinforces the importance of reflexivity in applying the approach (Braun and Clarke, 2019; Trainor and Bundon, 2021, p.

706; Byrne, 2022). The fundamental characteristic of this approach to thematic analysis is “valuing a subjective, situated, aware and questioning researcher” (Braun and Clarke, 2022, p.5). The researcher’s insights and aligned practice of reflexivity are an underpinning integral concept, and the approach embraces the researcher’s active role in knowledge production (Byrne, 2022). Without negating its theoretical underpinning, it also takes a ‘practice-first’ approach, foregrounding the need to learn by doing (Braun and Clarke, 2022).

I was drawn to reflexive thematic analysis as it aligned with my methodological approach, recognising that my positioning and interpretation is a tool within the analysis. I felt it allowed for inductive and deductive theme generation. This was important to situate the findings within the existing socio-economic context and discourses around care homes and social work, while also looking for new insights in a complex and under-explored subject. It struck me as a method which has synergy with social work practice, drawing as it does on use of self and reflexivity.

Early considerations

Braun and Clarke (2022) argue that researchers should provide a reasoned argument for their choice of reflexive thematic analysis rather than explaining what was rejected. They use the analogy that if you order chips in a restaurant, you don’t tell the waitress why you haven’t ordered mash! That said, I will briefly discuss two methods I considered at the start of my study.

Interpretative phenomenological analysis (IPA) allows the researcher to interpret meanings and reflect on their own role in constructing those meanings; it can be a good method for analysis of small samples, to understand individual meanings and to situate people in context (Eatough and Smith, 2017). In IPA “the researcher is trying to make sense of the participant trying to make sense of their world” (Braun and Clarke, 2013, p. 181). As an approach to qualitative research, it has been criticised for lacking the flexibility and substance of other methods, and in focusing solely on individual experiences, it can fail to address wider social and structural issues (Braun and Clarke, 2013).

Grounded theory is a data analysis approach which allows the researcher to generate themes (or theory) from the data, grounded in their immersion in the

analysis (Thomas, 2017). Braun and Clarke (2013) identify different versions which suit different epistemological stances. While it allows for the examination of social process rather than merely focusing on individual experiences (like IPA), the need to approach the data without preconceived ideas overlooks the importance of existing knowledge in the field. I felt wary that themes would just 'emerge' from the data, especially given the importance of the context described in Chapter 2. I did not feel it resonated with a reflexive approach to constructing and interpreting the research. This supports Thomas and James' (2006) critique of grounded theory which argues that, in its dispassionate bottom-up approach developed to demonstrate qualitative research's rigour, it is incongruent with qualitative inquiry.

The analysis process

Thematic analysis involves searching the data for *codes* (which tend to capture one idea), and identifying broader *themes* that occur (Silverman, 2022). Braun and Clarke (2013) use the analogy of a patchwork quilt, where the researcher pieces together individual squares into a pattern that makes sense to them. The process is often intuitive: I started to identify themes before revisiting the transcripts to analyse or 'code' in greater depth, which I later realised from my reading was the initial stage of the process (Braun and Clarke, 2022). Reflexive thematic analysis, then, involves six phases in the analytic process: 1) familiarising yourself with the data; 2) coding; 3) generating initial themes; 4) developing and reviewing themes; 5) refining, defining and naming themes; and 6) writing up. However, analysis is a recursive and progressive journey, so these phases should be considered as tools to guide the process rather than as sequential steps (Braun and Clarke, 2022).

Others, such as Swain (2018), have described the basic principles of analysis as data reduction, data display, and conclusion drawing. When it comes to 'data reduction', it can be daunting to contain and make sense of what can seem like an overwhelming amount of data (O'Leary, 2017; Swain, 2018). There were definitely times during the process that I felt overwhelmed by the task, perhaps compounded by the burden and responsibility of 'finding' new knowledge in the data, alongside respectfully representing participants' accounts. I was aware that themes do not simply emerge (Braun and Clarke's mantra), so the concept that meaning is actively constructed by the researcher added an emotional dimension to the analysis. Spencer *et al.* (2014) advise that the pathway to analysis is ongoing, and this

resonated with the advice from one of my supervisors to remember that, even when I was not actively engaged in the analysis, it was cognitively ‘marinading’.

Nonetheless, however iterative and reflexive the analysis is, it is important to take a rigorous and systematic approach (O’Leary, 2017), and broadly following the phases of analysis helped with this.

Getting to know the data

I captured my initial thoughts from the interviews and focus groups by making notes directly afterwards. I then started transcribing the focus groups followed by the interviews. In common with other novice researchers, I initially regarded transcription as a technical task to be completed, only to quickly realise that it is a key phase of data analysis in interpretive qualitative methodology (Bird, 2005). While it is often described as “time-consuming” (Whittaker, 2012, p. 48) and “potentially laborious” (Hardwick and Worsley, 2010, p. 126), it is an interpretative act and the first crucial step in data analysis (Gibbs, 2007). Bailey (2008) insists that from the outset it requires the researcher to make decisions about the level of detail to choose and how to represent what is being said. For example, transcribing can be reductive as the researcher makes decisions about things to leave out (for example, gestures, silences, or asides). The researcher’s methodological assumptions may impact on transcription as different features of the data may be of analytic interest.

Somewhat naively, I had not anticipated the decisions I would need to make when transcribing the data, particularly for the focus groups, which I found harder to transcribe as there are multiple voices. MS Teams produced a rough transcript of the interviews and focus groups and watching the recording back and tidying up the transcript helped me get to know the data. It provided an opportunity to consider *how* the way something is said could influence my analysis and how to capture “features of talk such as emphasis, speed, tone of voice, timing and pauses” (Bailey, 2008, p. 128). Saldana, Leavy and Beretvas (2011, p. 95) refer to this phase of analysis as “data intimacy”, where you become closely acquainted with the data and develop insights about meaning.

Coding

Coding is the first step in organising ideas about data (Silver and Lewins, 2014). I used a combination of manual coding and Nvivo, a qualitative data analysis software

package. A common misconception is that Nvivo does the analysis for you (Woolf and Silver, 2017): rather it is tool to *support* the researcher with analysis. I used the software as one framework to help me organise, explore, reflect and interrogate the data (Silver and Lewins, 2014). I found it useful to code for ‘important quotes’ in Nvivo, which I later revisited in their original context to ensure that I was not misrepresenting what was being said. The initial thoughts I had written down after the interviews also influenced my search for codes. This is the first step in reflexively interpreting the data, acknowledging that some codes I noticed were influenced by my pre-existing ideas and the literature I had read, something Gibbs (2007, p. 44) calls “concept-driven coding”. The coding process covered semantic and latent meanings²⁹; these are not dichotomous and often I found I developed more conceptual codes from semantic codes.

My initial coding produced a ‘codebook’ in Nvivo (Appendix G). I refined and revisited the codes and started to generate initial themes. When I found it hard to distinguish codes from themes, I reminded myself that a theme should be underpinned by a well-defined concept shared across several codes (Terry *et al.*, 2017). I found it helpful to develop and explore themes by writing a summary of the main ideas from individual interviews and focus groups. I sent some coded extracts to my supervisors and we explored themes in supervision, which developed my ideas and challenged my assumptions. I was not, however, asking them to check or confirm accuracy, as this goes against the principles of reflexive thematic analysis: instead I was seeking an additional perspective on my engagement with the data.

The rest of the process

Braun and Clarke’s (2022, p. 79) describe the process of developing themes as ‘finding, losing and finding your way again’. I found this metaphor accurately captured the ‘journey’ I experienced, which involved straying off the track at times and then reorientating myself in the right direction, with gentle guidance from my supervisors. For instance, I spent considerable time constructing what I considered to be a theme, which I later realised was a topic summary³⁰, and which is presented

²⁹ Semantic codes capture what participants explicitly say; latent codes focus on more implicit meaning on a conceptual level, which the researcher infers from what is said (Braun and Clarke, 2022).

³⁰ A topic summary is an overview of what has been said, often in answer to a specific question, but unlike a theme, it does not have a shared meaning at its core (Braun and Clarke, 2022).

at the start of the next chapter. Crucially the analysis was a *process*, certainly not linear, and its ‘messiness’ at times challenged the sense of order I was keen to create.

I developed “meaning-based” themes, organised around a central concept, and drawn together with sub-themes (Braun and Clarke, 2022, p. 107). One of my main challenges was finding a way to reconcile, understand and present the themes *across* the dataset. Eventually, I decided to separate my findings into two chapters focusing on themes from the focus groups, followed by themes from the interviews. This was partly because, as described earlier, I deliberately chose these different methods as the most effective means of addressing my research questions, so it seemed important to present the findings from each approach. I was then able to bring the findings together through the discussion in a unifying chapter (Chapter 7).

‘Writing up’ the findings

Finally, like transcription, the process of presenting findings does not always attract much discussion, not helped by the idea that once the data has been collected, it merely needs to be ‘written up’ (Drisko, 2005; Van Manen, 2006). Undoubtedly, reporting or writing up qualitative data carries with it many ethical implications, with a significant consideration being how the researcher represents participants (Swauger, 2011). While it is important to respect confidentiality and anonymity as previously discussed, the researcher must also balance a reflexive, interpretative stance with respect for the participants’ experiences (Reamer, 2013). This carries questions around power and who owns the narrative, perhaps even more pertinent in a PhD study, where the research is also a means to confer the researcher with a qualification.

I have reflected on this throughout and have tried to be open, ethical and critical about my process, selecting the most appropriate way to represent the outcomes of the research (Saldana, Leavy and Beretvas, 2011). It is important to reiterate that there is no one ‘correct’ interpretation of the data. Instead I concentrated on constructing layered and connected arguments and developing a complex, contextual narrative from the evidence (Mason, 2018). In the final chapter I will consider the quality of the research.

In this chapter I have offered the view that the methodology chosen must fit the research questions being asked. I have presented the philosophical foundations of my methodological approach, which is combined strongly with reflexivity. I have described the approach I took to collect and analyse my data and the questions that were raised along the journey. In the following two chapters, I will present the findings from my research.

Chapter 5: The focus group findings

In the preceding chapter, I outlined the rationale for using a combination of focus groups and interviews as part of my methodological discussion and explained that I chose to separate my findings into two chapters. This chapter will concentrate on themes from the focus groups and the next chapter on themes from the interviews. Inevitably there are some overlaps and I will draw these together in Chapter 7, which will also cover how I made sense of these findings, and situate them in the wider context of the literature and theory.

Introduction to the themes

A summary of the composition of the focus groups is provided in Appendix H. I will start by introducing the core themes that I constructed from the analysis of the focus group data, which are:

1. Making sense of care homes
2. Connecting with care homes
3. Policy and organisational constraints defining practice.

These themes are presented with the caveat that qualitative datasets are often interconnected, “messy”, and rarely lend themselves to tidy boundaries (Braun and Clarke, 2022, p. 141). It can be tempting to ‘find’ convincing themes which may not necessarily answer the research questions. In this respect, the data provided rich insights into how social workers understood their roles and I initially constructed this as a main theme. As discussed in the previous chapter, I later realised that these insights, generated by a ‘warm up’ question asking participants to describe their understanding of the generic social work role, were merely important for context and helped to situate the main theme.

I will, however, foreground a short summary of participants' understanding of the social work role and, throughout the chapter, I will integrate any concepts or analogies that were used to describe the generic social work role. Crucially, given the opportunity to describe ‘social work’, participants projected a strong identify and a shared understanding of the role’s many tensions and difficulties. Across the groups, there was a consensus about social work’s values and versatility. Participants articulated a nuanced and complex role, guided strongly by values,

relational skills and an understanding of individuals, yet which they also acknowledged was difficult to define precisely. Their descriptions suggested that the value of the social work role is greater than the sum of its parts. The role's ambiguity might allow for flexibility and discretion in supporting individuals, yet it brings challenges in managing others' expectations of the role and navigating organisational constraints.

Theme 1: Making sense of care homes

The first theme relates to social workers' understanding of care homes and is made up of several sub-themes.

What social workers do in care homes

As mentioned above, participants shared a common understanding of social work's purpose and values. They frequently articulated the profession's key values and spoke about promoting social justice, advocating for people and protecting their rights. This extract is one example:

“.... it's about protecting the most vulnerable people in society and ensuring they have a voice, are included in decisions affecting them. Social justice, trying to make society fair, or fairer, and a more equal playing field, empowering people, social justice”. (Marielle, FG2)

While promoting people's rights was a consistent thread across the focus groups, there was greater variation in how participants described what social workers *do* in their role with care homes. In general, when discussing 'tasks', people spoke about reviews, safeguarding, mental capacity assessments, finances and helping to personalise care. It was noticeable that the work carried out was often influenced by social workers' role, job function or team. This in turn influenced how they made sense of their work with care homes, something I will explore later in this chapter. It is worth noting that social workers in different local authorities often have different roles and teams are configured differently. For example, in one focus group, two participants described themselves as 'care home link social workers' with

responsibilities to “visit care homes, do assessments, carry out reviews, do MCA³¹” (Adaku, FG2). It was explained in more detail what this involved:

“.... upholding the rights of individuals within the care home, safeguarding them, ensuring they are receiving adequate care. Educating them and giving them advice on what they are entitled to in terms of their human rights. And supporting individuals with reviews, giving them choice or support to get involved in their care plans within the care home.” (Adaku, FG2)

Despite the procedural description of the ‘tasks’ (visits, assessments, reviews, MCAs), what this entailed provided an overview of the role’s potential and accentuated a rights-based, strengths-based approach, centred on the person in the care home. Likewise, in the focus group comprising social workers in a care home placement reviews team, I noticed that participants described their practice through a similar lens, as this example shows:

“.... the review we do, it brings together a personalised report, it's really detailed and we have recommendations that we jointly discuss with the care home that they agree to – it's advocacy for the clients. [.....] We pull together information from the family, if they have family or friends, whoever is involved in their care, we look at previous records, who's involved from a professional level. I think the involvement of a social worker in the care home is actually really essential, and the placement review team has definitely demonstrated that that we pick up areas that have been missed.” (Michelle, FG1)

Another social worker introduced an alternative perspective, describing the social work role in care homes as concerned with managing conflict:

” a lot of the time it's about conflict, ... between the management of the care home and the families and trying to (pause) oh trying to negotiate them situations is really complex in care homes”. (Kerri, FG4)

³¹ MCA refers to undertaking assessments under the Mental Capacity Act.

Another participant, working in a voluntary organisation directly employing social workers in their care homes, referred to herself “as a palliative social worker” and explained:

“... I'm now end-of-life and palliative care lead in [*organisation*] and my responsibility is auditing advanced care plans for residents of our care homes and identifying gaps in learning and refreshing the DNAR³² approach. Ensuring there's no blanket approach.” (Rina, FG4)

This role is demonstrably underpinned by upholding people’s rights and also acknowledges that many people in care homes are at the end of their lives. This resonates with discussion in Chapter 3 about the distinction between the role of the palliative care social worker and the role assigned to social workers in care homes. Notably, Rina applied a more psychosocial lens to the idea of conflict, attributing it to grief, loss and unresolved issues:

“... what Kerri refers to as conflict, I apply theory towards that because, if you think about it, someone coming into a care home – well, I have never seen anyone get better and leave. [.....] staff are managing those emotions and sometimes families can be very aggressive, unconsciously aggressive [.....] So I think there's a lot of anticipatory grief and unresolved issues and transition and loss of identity, loss of role, loss of holding onto hope and losing control of your independence.” (Rina, FG4)

Although *transition* was mentioned in the above extract, it is interesting that typically discussions were about working with people *in* care homes, rather than about helping people to *move to* care homes, despite the greater focus on this in the research literature, something I will discuss in Chapter 7.

³² DNAR stands for Do Not Attempt Resuscitation. It is a decision made in advance to inform health professionals that a person should not be given CPR/resuscitated if their heart stops or they stop breathing. During the Covid-19 pandemic, there were concerns about blanket decisions being made not to resuscitate older people in care homes, which is a breach of their human rights.

This aspect of the role was often described in expansive rather than concrete terms and was exemplified as working collaboratively, facilitating, co-ordinating, bringing people together, providing information, tapping into resources and ultimately supporting people to achieve their goals. The low key way in which one participant expressed this - "you just kind of get in and nudge along" (Tina, FG1) - suggests that enabling can take a subtle form. Another participant, talking about carrying out placement reviews, used the analogy of a conductor in an orchestra. This extract not only emphasises the scale of the task, but in drawing on the underpinning values of social work and the need to advocate and keep the individual at the centre, also hints at the responsibility social workers hold:

"... it's almost like being the conductor in an orchestra and you're literally having to make sure that everyone pulls together to create this symphony. But actually that symphony's not going to happen unless you've actually got the social worker working as a conductor to be the advocate for the person to make sure that everything does work." (Carla, FG3)

Connecting

Social workers whose roles afforded them a specific opportunity to work with care home staff and residents showed a strong, yet nuanced, understanding of the complex environment. They seemed to demonstrate a greater tendency to 'connect' with care homes and see residents as individuals. For some, this was about seeing a person's individuality, as this example shows:

"... she reluctantly went in (*to the care home*) but, being the character that she was, she brought joy with her and fun and she loved the colour purple. So, volunteers helped staff paint her room purple. She had purple sheets and you walked in there, you couldn't help but giggle and what a beautiful - she enjoyed her moment there and she died with real care and dignity." (Rina, FG4)

Others also recognised that care homes can sometimes dehumanise people and fail to treat (new) residents as individuals:

“.... I've been quite horrified a couple of times, where you know somebody had been discharged from hospital and they were put in a sterile room with nothing, nothing of their own there, no possessions, a few clothes, and you just feel there's nobody really advocating for them. And there's nobody who happens to know this person was a 'this', this person was a 'that', this is what they're interested in, or any sense of that. And then you put yourself in that position and think that is terrible.” (Tina, FG1)

Another participant noticed that social workers, when their roles distance them from care homes, are less likely to connect with the people they are 'placing' there:

“.... I think it depends on what team you work in. I worked for a long time in a reviews team and I felt my outlook was slightly different there and my work was different. But having moved into generic services and what I see on panel and read about and particularly the Covid pandemic, what it had shown us, how older people have been treated and othered. I feel that social workers see it as a place where you - and I'm gonna use that word - dump people, you know, it's the end of ... and that's it.” (Farzana, FG3)

Understanding care homes and navigating through the 'noise'

Across the discussions, it was evident that participants felt there was a widespread lack of understanding about care homes, particularly by social workers themselves. In this next section, I will show how this was attributed to different factors, which had an impact on social workers as well as people in care homes and their families. Notable among these influences were personal and societal views about care homes, the trope of the care home as "the last resort," and the lack of interaction most people have with care homes.

Participants demonstrated their different perspectives on care homes, especially in response to the stimulus statements they were shown (Appendix C). For instance, many participants automatically voiced negative impressions of the environment, with comments such as “smelly places” (Vanessa, FG1) and “they are really impersonal places” (Alison, FG2). Another captured a widely held view with the comment:

“.... ‘care home’ or ‘nursing home’ - it just doesn’t sound great does it? It has got negative connotations attached to it immediately.” (Michelle, FG1)

In general, participants reflected that just the mention of a care home conjured up a particular image in people’s imaginations. There was an interesting reflection from one participant, who recognised that care homes are not homogenous:

“.... I guess we're talking about care homes as one thing, but you know if somebody said to me do you want to move to a live in a Travelodge or do you want to move to live in the Savoy? They're actually very different things, but we're calling it the same thing.” (Rachel, FG3)

This was reinforced, yet framed slightly differently, by another participant with the comment:

“.... I've seen some shockers. And I've seen some amazing places.” (Simone, FG3)

Despite this, across all the groups, participants reflected on the widely held view, discussed in chapter 2, of the care home as a ‘last resort’. This was exemplified when participants referred to care homes as “a point of no return” (Michelle, FG1) or “the last lap” (Rina, FG4). One participant remarked:

“.... I think unfortunately, most people do not make a positive decision to move to a care home.” (Alison, FG2)

This narrative is reinforced in a different group when one of the participants said:

“.... we go through every single support there is in the community before we think of a care home. As a last resort.” (Farzana, FG3)

While this narrative is influenced by policy and organisational drivers, which I will explore later in this chapter, participants also articulated other contributing factors. These included personal attitudes and emotions such as fear or distaste, together with feelings of ‘not belonging’ in a care home. These feelings were sometimes attributed to other people, particularly older people or their families, as illustrated in the following example, where a participant recalled a daughter visiting a care home before her mother was due to move there:

“... she said, “no! I'm so scared because everyone looked like zombies, they're sitting, some are dozing off from the chair”, so, you know, for some people it's so scary. “Oh so, my loved one is gonna end up in this place?” (Adaku, FG2)

In contrast, other participants spoke openly about their own personal feelings. For some, this was influenced by stories in the media, as this comment by a student social worker, revealed:

“... the images of care homes in the media are frequently negative, and so when you hear stories about care homes and how people are treated, it just makes me feel like I want to run away from this country and just go and retire in a nice hot place where there are no care homes.” (Vanessa, FG1)

Another social worker also talked about not wanting to 'end up' in a care home:

“... I tell my kids “I'm not going into any care home”. I'll be going somewhere else, but I'm not going into a care home. I mean, I'll say if I have anything like that, I'm going to Switzerland³³. And they look thinking I'm daft, but it's the way I feel right now. Doesn't mean I'm going to do it, because if I get dementia and actually don't know where I am, then if I'm in a care home, that's probably the best place, because I don't want to be home putting myself at risk and possibly putting my kids - you know, being a burden. So there's a lot of things there, personal attitudes and feelings.” (Farzana, FG3)

This is an interesting extract, spoken by a participant whose role does not currently bring her into much contact with care homes. By mentioning 'Switzerland', she appears to be suggesting that she would rather die than go into a care home. Yet she acknowledges that this is a personal view, which may indicate it sits in tension with her professional role. She also introduced the idea that the care home would keep her safe if she lost her cognitive abilities, and was not aware of what was happening.

³³ 'Going to Switzerland' is a euphemism for assisted suicide. Switzerland has allowed assisted suicide since 1942 and its Dignitas facility is well-known for helping individuals with illnesses that will lead inevitably to death or unendurable pain to die with dignity.

In fact, across the groups, participants commonly expressed that if they 'lost capacity' or had dementia, then a care home would be the best place to keep them 'safe' or relieve the caring 'burden' on family. This point is illustrated by the following comment:

".... certainly if I was at a point where I'd lost ..., like my cognitive abilities had lessened to a degree that was really placing myself at risk, I would say, before I've got to that point ... Like I've told my family if I'm ever like that, then the care home is the best place to keep me safe and I would be, well, I say I'd be OK with it, I might not be, because I wouldn't know what was happening at the time, but in my personal being now, I would be OK with it." (Zara, FG2)

And a similar view is expressed by a social worker in a different group:

".... in terms of living in a care home, would I want to? I would want to live in a care home if I don't have capacity, then I would choose to live in a care home. However, I would like to remain in my own home as long as possible."
(Michelle, FG1)

I was surprised to hear this view repeatedly voiced, as it seemed to imply that participants were thinking about mental capacity almost as an on/off switch (*Wye Valley NHS Trust v B*, 2015). In the discussion chapter, I will explore this further and consider what it might mean.

There were reflections on the complexity of the conceptual status of care homes, as discussed in Chapter 2. For example, there was some debate about how receiving care at home is positioned as the 'best' option. Many participants, as noted above, felt that this would be true for them personally too. There was an acknowledgement that people often delay moving to care homes, or are delayed by eligibility or funding, which sometimes means that when they move, they are at the end of their lives. This was demonstrated by Rina, who stated:

".... we've had people admitted for a day and they died. And so people are leaving things to the very end for lots of reasons." (Rina, FG4)

It was noticeable, however, that participants talked mainly about people *living* in care homes and not about *dying* in them. Thus, descriptions of the care homes as ‘a last resort’ were usually linked to feelings about moving to a care home, with participants rarely explicitly talking about it as the *literal* last place that someone might live before they die. When the latter was a focus, it was mainly articulated by the participant who self-described as a palliative care social worker. One participant made a distinction between the role of a social worker in a hospice compared to in a care home:

“... a couple of hospices I went to, it's fantastic and they had a little team there. Obviously their work was slightly different because they were working with people with end of life.” (Farzana, FG3)

There was tacit acknowledgement of the ambivalent relationship society appears to have with care homes. One of the more negative influences was the narrative of failure associated with moving to a care home, articulated in this comment:

“... one of the really big things is the language we use, I think we've got to a point in this country that we want to support people at home, and then if that fails, they move to a care home. So we're already saying, “we've not got this right”, “this is really negative”, oh you know, “we're giving up on you”, all of that stuff at the point where we go to a care home.” (Rachel, FG3)

That said, I noticed a balanced perspective, particularly among those whose jobs required them to interact regularly with older people in care homes. Most notably, they identified positives of living in a care home, such as safety, reduced isolation and improved health and well-being. The following example demonstrates how people may not identify the benefits of a care home until they have moved there:

“... I've seen people coming into the care home with the view of not wanting to be there. [.....] But they see the difference from living alone at home, to living in a place where you hear peoples' voices, activities going on, carers coming into your room and saying hello, supporting you 24/7 with everything, they don't see the importance of being in the care home until they get there.

So I know some examples of people not wanting to move to a care home, but once they were there being content with the decision.” (Adaku, FG2)

This also exemplified the view, held by others, that care homes can provide a better quality of life for people in contrast to their lives at home, an idea I will return to in the discussion chapter.

The following comment, made by the manager of a care home reviews team, expanded on the aforementioned idea and introduced a key concept about social workers’ understanding of care homes:

“... often it's the same social worker that might do a review one year, and then the next year, and as much as their physical health might start to deteriorate, obviously, as we age, we're actually seeing that they're starting to settle a lot more, and often the quality of life improves from one review to the next. So actually sometimes I think our view of care homes might be very different to a lot of other social workers in the neighbourhoods.” (Carla, FG3)

Carla indicated that the engagement that social workers have with care home residents (and care homes) as part of their role influences their perceptions of care homes. This idea is developed across the groups as the discussions explore how narratives about care homes impact on social workers and their work. Participants often acknowledged that, while narratives or assumptions about care homes were powerful, they were often misleading stereotypes, as suggested by this observation:

“... people have a sort of different view of what a care home is to what it is *actually*.” (Marielle, FG2)

A similar comment is made in another group:

“... people who haven't been in a care home in years, they just have this visual representation that a care home is being in a room, looking at a picture on the wall. Or I don't know just these negative stereotypes, that just aren't true in most care homes anyway.” (Michelle, FG1)

Crucially, participants talked about how lack of familiarity with and understanding of the care home environment often led to social workers being influenced by preconceptions about what it is like to live in a care home. For example, one participant reflected on their first visit to a care home and the overwhelming impact of the smell:

“... when I first started as a social worker, I went into a care home for the first time, not knowing anything, and walking in there and there's a smell that hit me and instantly it was ‘I don't ever want to be here. I don't want my parents being here’. Oh my God!” (Farzana, FG3)

Another participant, whose role required her to regularly work in care homes, summarised the position of colleagues in different teams:

“... they're having to put people in care homes they know nothing about.” (Kerri, FG4)

And this idea was echoed in another group:

“... we're missing something, the fact that as social workers we are often making really important decisions about something that we don't really understand.” (Rachel, FG3)

There are several ideas to summarise here. Firstly, participants suggested that many social workers have limited understanding of care homes, particularly if they are in roles where their interaction with care homes is limited, for example, to ‘placing’ an older person. These social workers are more likely to be influenced by stereotypical representations or negative narratives of care homes. This is important to bear in mind when I discuss the next theme.

What participants demonstrated is that social workers need specific experience and knowledge about care homes to have the confidence to make sense of the environment and the complex situations of older people living in care homes. This suggests the importance of craft knowledge, an idea I will explore in Chapter 7, and which is encapsulated in this comment:

“.... working with adults in a care home, it's such a wide thing and it really does need knowledge and experience and patience and you need to be able to try and work with people, sometimes you don't even like them. So that's what I think the role of a social worker in a care home is.” (Kerri, FG4)

Theme summary

Participants demonstrated that societal narratives about care homes, alongside stereotypes driven by the media and social workers' own personal values and attitudes, have a strong influence on both people in care homes and social workers. Although it was not described as such, this theme appears to be about the difficulty social workers face in sifting through all the 'noise' to make sense of care homes. A recurring theme was that many social workers – especially those whose roles do not require them to connect with care homes or care home residents - lack the understanding or specialist knowledge and skills to engage with people in this context. Those who worked more closely with care homes presented a more balanced view and more readily articulated the positives and saw the people living there in a person-centred way.

In the next section I will show how, when social workers demonstrated a nuanced understanding and knowledge about care homes, they appeared more confident in building relationships and navigating the difficulties of accessing, and operating in, this complex environment.

Theme 2: Connecting with care homes

This next theme resonates with the idea I explored in Chapter 2 that care homes are often both physically and metaphorically “impermeable” (Denning and Milne, 2011, p. 366) and operate largely ‘behind closed doors’. I will show how participants described the difficulties of accessing and navigating this closed environment and present the explanations they gave to understand this. Strong sub-themes include relationships, trust and belonging and the impact of social workers' understanding of care homes on their confidence. I will consider too what was said about the emotional impact of connecting with care homes.

'Behind closed doors' / being a visitor

It was evident that many participants experienced care homes as closed environments, separate from society or 'the community'. This example highlighted how people who live in care homes are excluded from the community:

".... you know what I would love to see? Community. Things happening in the community that could be easily tapped into by people in the care homes. For example people in care homes being able to go to day centres as well." (Zara, FG2)

Many emphasised social workers' status as 'visitors' rather than as part of the care home or the multi-disciplinary team'. They talked about needing to make appointments to visit and fitting in with the routines of the care home. This is exemplified in this comment, which also acknowledged the pressures that care homes face:

".... I think it's difficult for the care homes because you ring, if you want to do an assessment, it has to be 11 or 2. They're the times and they'll be like 'Oh no. We've got a continuing healthcare, oh no, the GP's coming to do his rounds.' You're struggling to find a time to come when they're not really busy sometimes." (Zara, FG2)

Several participants conveyed the institutional nature of care homes in their descriptions, although it was notable that no one explicitly used the term 'institution' or reflected on this. Jada mentioned the limitations on visiting:

".... on a Saturday the care home are not expecting any professionals. Only doctors or independent BIAs, and when you go in they are in panic." (Jada, FG1)

Similarly, Michelle spoke about turning up when she didn't appear to have been 'booked in':

".... I did have something booked, but the manager looked at me and he was like: we don't have you booked in to do this assessment. So I was like: that's fine, I'll just pop upstairs, I know where I'm going and he was like let me just call upstairs so they know that you're coming upstairs. I said it's fine. I know my way up to my client. I've been here quite a few times. And he looked

panicked. I think, you know, he was just following the protocol, Covid protocol of visiting. But the panic in his face because he didn't expect me.” (Michelle, FG1)

It is striking that, in both these examples, the participants described the care home staff as ‘panicking’. There could be many reasons for this, but it certainly emphasises the closed nature of care homes, and the anxiety of letting people or ‘outsiders’ enter without ‘permission’ or when they are not expected. It is interesting, however, that the way in which Michelle handled the situation implies that she was confident to get past the ‘closed door’.

Michelle later spoke about how social workers are perceived by care home staff. This extract recognises social workers’ authority and alludes to a sense of threat and anxiety that care home staff have about the scrutiny they believe social workers will bring:

“.... I think sometimes they (*care staff*) think “ooh, the social worker’s coming. Oh my goodness”. And you’re like *really?*, I’m just a normal person. I’m not gonna do anything to anyone, but they look at you like oh what she or he gonna say and what haven’t I done and what they’re gonna pull me up on now? I haven’t written that in the care plan, so they’re gonna tell me this or the date doesn’t align with their date. There’s this assumption..... (laughs).”

(Michelle, FG1)

It appeared hard for social workers to penetrate care homes on several levels: the difficulty in physically gaining access, alongside building trust to overcome staff’s resistance. As the above extract shows, the latter may be linked to the power (or the perception of power) that social workers, or the organisations they represent, hold. This power is also reflected in the remark: “we suspend care homes if they’re not performing well enough” (Kerri, FG4). This refers to the local authority’s powers, but it demonstrates how social workers become synonymous with the organisations they represent.

Participants often described an undercurrent of mutual mistrust which hindered relationships with care homes. For example, a student social worker talked about how she was shown the resident’s room and it all looked “spotless”. She described how she felt like "an important visitor" because they had made the effort for her, but

she was also suspicious of what they might be hiding (Vanessa, FG1). In the same group, the ensuing exchange from her more experienced colleagues built on this theme:

“Tina: But that also begs the question: how often do we ever do unannounced visits?”

Jada: Unannounced visits, yeah

Tina: Unannounced visits, where that's not what you're going to find, at all (laughs).

Jada: Exactly. You know, unmade bed, client not shaved or something, and nails, you know that kind of thing. You just pitch up, but they don't like that. They don't like that. That's the difficulty. That's a dilemma we have.” (FG1)

Care homes as ‘real places’: looking beneath the surface

Social workers who interacted with care homes more routinely as part of their roles understood that there is typically more to a care home than meets the eye. They looked beneath the surface of ‘getting things ready’ for the visitor and thought about what might actually be happening. For example, Marielle demonstrated the importance of not taking things at face value:

“.... what you read on the CQC report and what it is like really in the home, it's two different things. I think it's about the staff. Are staff staying? What are staff saying when you are there? What are the conversations that's happening? What is the culture in the care home? You know all of those things means more really than the CQC report, in my view, anyway.” (Marielle, FG2)

Other participants acknowledged that stereotypical representations or assumptions about care homes (as discussed in the previous theme) had an impact, as this remark shows:

“.... I actually often feel sorry for care homes. Because they get painted in this negative light. Yeah, you walk in sometimes. Yeah, they do stink of urine and you're like ‘Oh my gosh’, you know. I personally couldn't imagine needing to

be in a care home. But then I've been in some amazing care homes where it smells fresh, it smells wonderful.” (Simone, FG3)

Simone rationalised the negative perceptions about care homes and, at the same time, showed that she found it hard not to let the smell of urine influence her own personal reaction to being in a care home.

This is echoed in another group:

“Tina: The smells, the smells are really important, aren't they? The minute you walk through the door and you just (sniffs) you kind of get that, you know?

Michelle: The carpet doesn't help as well, having a lot of carpet everywhere, but yeah.

Tina: Yeah, that's right. Carpet doesn't help.” (FG1)

This demonstrates that some social workers understood the need to look beneath the surface to understand the complex care home environment. In their exchange, the two participants acknowledged the powerful first impression from smell in influencing attitudes towards a care home, which has to be set against the importance of meeting complex and different needs. There are real tensions between dealing with the practicalities of managing incontinence alongside presenting a homely environment and delivering person-centred care.

The following extract, however, recognises that people are more likely to take things at ‘face value’ when they are unfamiliar with the care home or the needs of residents:

“... family visiting a care home for the first time, trying to get an impression, I can imagine it would feel really strange to them [...] someone shouting down the end of the corridor, whereas if you're a social worker that works in that home, you know that person always shouts, and has a routine check, and you know when there's an unusual scream and you're like that person is not normally screaming. What's going on there?” (Zara, FG2)

Trust and scrutiny: them and us

A common thread was the tension between superficial impressions and the challenges and complexity of providing support to dependent and frail older people. One participant, who later revealed that she worked in a care home before qualifying

as a social worker, described the lack of trust between care home staff and social workers:

“... I used to really struggle when I first qualified - I didn't understand how a social worker could go into a care home never having worked in a care home because it was all, everybody was “oh the staff do this and neh neh neh”. It was just so negative about everything and you've no idea there's something you don't see as a visitor that you do when you're part of it.”
(Rachel, FG3)

By reinforcing that social workers are positioned as ‘visitors’ and not part of the care home system, she conveys the idea of ‘them’ and ‘us’. This idea is developed by her colleague in the following extract:

“... I was doing lots of out-of-borough placement reviews [...] You were there for the day because you were traveling quite far - and I got to spend like 3 or 4 hours in the care home, reading all the documents but also speaking to staff, having a wander round. I'd sit in the lounge and I feel like I've benefited from that, I got an understanding of just spending more time. Obviously some care homes liked that. Some probably didn't, but I definitely felt like you got such a sense of the culture of the care home by doing that... [...] .. it's not that kind of them and us, ... and then it also means the residents, the people living there, don't feel like you're coming in to make changes and actually it's more of a collaborative experience then rather than it being, yeah, them against us.”
(Amy, FG3)

These comments reinforce the importance of getting to know the care home, which builds trust and overcomes the idea of ‘them’ and ‘us’. Notably Amy introduced the idea of social workers needing a presence in care homes to help care home staff *and residents* trust social workers and work collaboratively. It was striking across the groups that participants regularly talked about the challenges of connecting with care home staff and the environment, whereas Amy was unique in mentioning how social workers’ ‘outsider’ status may hinder their relationships with *care home residents*.

Thus participants described the tensions of being ‘a visitor’. A common thread was how the care environment and the positioning of social workers influenced trust and

the development of relationships with residents and staff. Furthermore, the closed nature of care homes seemed to contribute to misconceptions and the need for social workers to 'scrutinise' and dig for information. This in turn put care home staff on guard as they felt they were being judged. Several participants spoke about how it was part of their role to be 'nosey' and to find out what is going on. For example, Jada spoke about how she checked on people she knew, even if she was visiting someone else:

"... If I know I have another client there, I always make it a point of duty to go to that client and say, oh hello, how are you? And peep through their bedroom to see if everything is alright, so that is your nosey heart as a social worker, because you need to be nosey." (Jada, FG1)

Similarly, her colleague described herself as "a nuisance", before explaining she saw it as her responsibility to find out what is going on:

"... (I'm) like the eyes and ears whenever I go into a care home, I'm always looking around. I might say, somebody's shouting out, somebody's call bell's not answered. I feel we can't go in with the kind of blinkered look, that we're only going to look at our client [.....] You have to look at the environment that your particular client is in and whether that's actually causing some of their behavioural difficulties as well. [.....] So yeah, I think you have to be on mega alert when you're there. maybe that's also why managers may not, sometimes, you know, welcome our visits." (Tina, FG3)

These comments illustrate the balance that social workers need to strike in their role. As noted earlier, social workers described their role as promoting people's rights, and in Tina's example, this appears to justify the need to be constantly checking what's going on. In another focus group, the potential of 'in-house' social workers was considered and it was suggested this might allow them to "oversee some things that are not correctly happening in care homes" (Farzana, FG3). Yet this sets in opposition social workers and care home staff, who feel defensive about being under scrutiny. This is lamented by one participant, acknowledging this gap and the need for better relationships:

"... maybe there's ways that we could just forge better relationships with these staff, because we're all working towards the same aim and sometimes it

feels like we're going along kind of parallel lines that are never going to meet.”
(Ana, FG1)

It was noticeable that, particularly in examples given by participants whose roles connected them to care homes, that their experience and understanding of care homes gave them the confidence to overcome difficulties or challenge practice. In the example noted earlier, Zara discussed the difficulties of booking an appointment, yet she showed her confidence in navigating the system when she added:

“... A lot of the time I'll say 'you know what, I'm just going to visit and speak to the person. Let me know when you're free'.” (Zara, FG2)

Similarly, as discussed earlier, Michelle had the confidence to go upstairs to visit someone, despite not appearing to be 'booked in'. In these examples, participants were confident to use their discretion to work around 'rules' and barriers to help them undertake their roles.

The emotional dimension

The final sub-theme relates to the emotional impact of connecting with care homes. It is interesting that one participant, a newly qualified social worker, suggested that inexperienced staff are less likely to engage with the emotional or social needs of the older person. She remarked:

“... when it comes to doing care home reviews, they can be allocated to inexperienced staff, trainee social workers (pause), they don't know the person from Adam and you know and just think that just because they're being provided with basic services that they must be OK. And the social and the emotional life of the person is what tends to be neglected most in my experience when that happens.” (Julia, FG4)

She appears to suggest that inexperienced social workers are less inclined to engage with the residents or see them as whole people. There are other examples where there is tacit criticism of social workers 'placing' people in care homes and not seeing that person as a person - for example, “people just put two lines and there's no information, no background information” (Jada, FG1). This viewpoint was not, however, commonly mentioned. Instead the emotional impact of working with care homes came across strongly in what many participants said. On the whole, the

social workers who were connected to care homes appeared to be less defended against the emotional impact of working in this environment and engaging with the older person's experiences. For example, this comment conveyed compassion around helping someone move to a care home:

".... you have to condense somebody's 70 years into one room. You have to pick out certain things and you have to dispose of their whole life. And that's really difficult." (Tina, FG1)

Participants often acknowledged how hard the work could be and were open about feeling sad about situations, with one commenting:

".... it used to break my heart when I went in to assess somebody in a care home and getting into their bedroom, there's barely nothing." (Adaku, FG2)

Other examples acknowledged the sadness in people's situations - "the new resident has to be beholden - to be taken to the toilet, no dignity, so sad" (Rina, FG4) – as well as openly talking about the grief of working with older people who die:

".... It's huge. When you're working with someone, and then you lose them - the grief – it's hard." (Rina, FG4)

In contrast, one participant described how the pressure of keeping people *out* of care homes can evoke emotions when people move there:

".... when you work in the community and your goal is to try and keep people in their own home, it can feel like you've ...you've kind of failed, or you've let someone down by the fact they have to go into a care home, which is such a sad experience." (Amy, FG3)

Theme summary

Participants painted a picture of care homes as closed environments. They explored the tensions of being a visitor, and an outsider, to the care home, yet at the same time having roles that required them to be inside and understand what was really going on for residents. A strong sub-theme was the importance of relationships and trust and the difficulties in building trust in such a complex environment that tends

towards the defensive. Again, knowledge, understanding and experience helped social workers to connect with care homes, practically, cognitively and emotionally. Confidence was a key dimension of being able to work creatively.

In the next section I will consider participants' insights into the constraints of the system in which they worked and how this appeared to influence their work with older people in care homes.

Theme 3: Policy and organisational constraints defining practice

The last theme revolves around the constraints on practice and highlights the disparity between what social workers *want* to do and what they are *able* to do, as encapsulated by one participant's observation that:

“... we're obviously part of an organisation and we're constrained by those organisations, so I think that also impacts on what and how we do it.” (Alison, FG2)

Organisational demands

There was discussion about how the demands placed on social workers often conflicted with what they wanted to do in their work. Several participants, for instance, mentioned the bureaucracy associated with their roles, especially the paperwork required. This is signalled, in shorthand, by one social worker as “all the forms!” (Tina, FG1), a comment with which colleagues in the group agreed - “yeah, all the forms!” (FG1).

In another group, one participant highlighted the dissonance between the aspirations of the role and its practicalities, and the constraints of the system:

“... I was thinking a bit about what we think we do or hope we do against what we actually do.” (Rachel, FG3)

Several participants identified that they were able to use their discretion to influence *how* they approached the work. This is demonstrated in this comment:

“... we arrange reviews, mental capacity assessments. *How* you carry them out? Ah, it's a different matter.” (Julia, FG4)

The tension between organisational demands and social work values is further illustrated in the following extract:

“... we act to prevent and protect vulnerables, to delay the need of services and reduce the need on local authority finances I guess by looking at people strengths, tapping them into the community, looking at their family support structures.” (Zara, FG2)

I noticed a disconnect between the transactional language used – or ‘local authority speak’ – and social work values and strengths-based concepts. These ideas connect with the literature in chapter 3 exploring how the social work role sits in tension with organisational and structural demands, which I will further develop in this theme.

Organisational needs defining the role

A strong feature running across the groups was how organisational needs defined the social work role and tasks. For instance, Zara explained the local authority’s rationale for her role:

“... the reason why we have link workers, is to make sure that we're aware of all the safeguardings going on in each care homes, that we're aware of particular issues and whether there's repeated issues with different people. So to improve the quality of the care home.” (Zara, FG2)

This indicates that her ‘care home link social worker’ role is driven by local authority needs around commissioning and quality assurance and to provide oversight.

Another social worker worked with care homes as part of the local authority’s ‘organisational safeguarding team’, in a role also predicated on quality assurance, safeguarding and supporting commissioning. Several social workers in the focus groups worked in teams with a specific mandate to undertake statutory reviews for people in care homes. The manager of a care home reviews team commented that the team existed because the organisation or senior managers “understand the value of how important it is that those reviews continue to happen” (Carla, FG3). The

importance of reviews 'continuing to happen' may indicate it is more about oversight and service provision from the local authority's perspective than to support older people; this may create tensions for social workers who may be more focused on the older person. The only participant whose role has been established with permission to work in a psychosocial role in the care home had a 'palliative care' social work role in a voluntary sector organisation.

Thus, the motivation for how teams and roles are organised and delivered, while not the focus of my research, was noticeable as a key sub-theme. In addition to this, the impact of a stretched, resource-driven system was a prominent feature of the data. Mostly this was implicit in what participants said but there were also explicit references: for instance, that resources are "cut to the bone" (Elif, FG3) and "there's not enough resources allocated to adults in the care home really" (Adaku, FG2). This is summed up by the following comment:

".... yeah, but how much can social work contribute if there are not enough resources? And ultimately, that's all it boils down to." (Julia, FG4)

Conversations about resources connected to, and clarified, earlier themes. For example, the importance of promoting the rights of 'necessarily dependent' older people led to a greater level of scrutiny in a stretched and poorly resourced system, where quality may be compromised. There was broad agreement that, because they were considered to be 'safe' (that is, not 'at risk of harm'), people in care homes were usually lower priority when organisations had to make resource-related decisions. The following example demonstrates the pressure to 'move on':

".... sometimes there is that rush to, you know, place the client into a care home and then that's it. The client is safe, you know, it's the care home's responsibility and then we move on to the next case." (Ana, FG1)

Similarly, Rina, working in the voluntary sector, acknowledged that when there are finite resources, "risk must be prioritised". She continued by describing the impact this has across the system, rationalising that the pressure on statutory services often delays reviews:

“.... when someone is statutorily funded, the social worker’s supposed to come in for the six week review: they never do on time, and that's not a criticism. It's just an understanding of the risks... they have to prioritise people in the community. Someone in a care home is safe. Then yearly reviews are out of date as well. But, when we do need them, they do respond via safeguarding, or deprivation of liberty.” (Rina, FG4)

This comment is further evidence that the local authority social work role is stripped back to statutory tasks.

Several participants also highlighted that resources were ‘rationed’ to publicly funded residents; older people who self-fund their own care or are funded by the NHS are not eligible for a review from social services and are unlikely to be supported by a social worker. This is explained here:

“.... people who are self-funders we don't link up except if there's any safeguarding. That's when we get involved, except if their finances are depleting, we get involved in terms of that, but if they are just purely self-funders and there's no issue, we don't.” (Adaku, FG2)

Social workers showed that they were acutely aware of resource constraints and their impact. Yet despite this, they demonstrated that it still matters *how* the work is undertaken in the strained system:

“.... it's true: sometimes we don't do six week reviews, we don't do yearly reviews, and that's because of the pressure we're under. The amount and the volume and the lack of social workers. But as far as I'm concerned all of the reviews that I've seen are really person-centred and I wouldn't have it any other way.” (Kerri, FG4)

Ageism

One participant suggested that, once older people move to a care home, they are “forgotten” (Adaku, FG2). I will develop this idea further in the discussion chapter and consider whether it is a protective mechanism for the system. It may also be

connected to ageism, which was a recurrent theme across the data. Several participants, particularly in the focus group made up of managers, discussed decision-making structures in their organisations which seemed to be underpinned by ageist assumptions, alongside negative perceptions of care homes, which I highlighter earlier in this chapter.

One participant addressed the discomfort they felt when they thought about funding constraints and the impact it had on older people and their families:

“... you go away with a bad taste in your mouth, looking at a placement for £600 as opposed to £1200, even though that probably would make the person happier and the family happier and have a better and deeper connection for them.” (Liam, FG3)

Zara attributed funding constraints to ageist policies:

“... I think ageism is definitely an issue in the funding that you will get for someone.” (Zara, FG2)

She later added that “ageism seems to still be OK” (Zara, FG2). A reference to “casual ageism” (Shireen, FG3) in another group further support this. The following comments reinforce that ageism appears to operate, and is often accepted, on many levels:

“... because when was the last time as a group of managers, we sat in a space talking about ageism and how it affects our practice. Where’s the learning and development around ageism? So I think ageism is huge and the casual age discrimination we ourselves engage in.” (Shireen, FG3)

Her comments are echoed by another manager in the same focus group, who discussed how structural ageism is built into the fabric of how the system operates:

“... We talk about racism, sexism and all of the other discriminatory characteristics, but there isn't much talk going on regarding ageism..... in adult social care: the way we are resourced, the way we are financed and supported by the government, the wider structure is problematic, and I think it's the contributory factor to all this.” (Elif, FG3)

Across the data, the terms participants recognised as being connected with older people in care homes, also reinforced the subtlety of dehumanising language and its undercurrent of ageism. For example, participants talked about ‘placing’ people, as well as ‘dumping’ and ‘shoving’ people into care homes.

Student social workers across two different groups discussed how ageist assumptions influence the perception of the social work role with older people; this is consistent with the research discussed in Chapter 3 indicating the prevalence of negative attitudes in qualifying social work education towards working with older people. For example, Marielle discussed the lower status of working with older people and connected it with wider societal views about older people and the importance of protecting their rights:

“... it's often a conversation I have with other social workers who I train with, who will say to me ‘Oh, don't you want to go into mental health and become an AMHP³⁴? Don't you want to do this, that and the other?’ But to *me*, I'm protecting the most vulnerable because I think older people are overlooked and so they're the ones that have got a disparity of disadvantage because people aren't attracted to that service and very often, they're put in boxes. ‘Oh look, they're older now, that's it’.” (Marielle, FG2)

Resource constraints

Returning to the idea that organisational imperatives determine the shape and nature of the role, it was evident that there were still constraints for social workers in roles that connected them to care homes. Similarly, while some participants conceded that care homes could be a positive choice offering safety, community and choice, these goals were often limited by financial issues, or as one participant noted “part of the difficulty is we try to do it on a budget” (Rachel, FG3).

The constraints of the system, therefore, were shown to limit what social workers were able to do. For example, one participant acknowledged that even as a care

³⁴ Approved Mental Health Practitioner, a mental health professional, often a social worker, with additional training to carry out certain duties under the Mental Health Act 1983.

home link social worker, they still had limited time to do the things they wanted to do, like “sit with people” (Zara, FG2) or support care home staff around the application of the Mental Capacity Act.

Several examples illustrated that the system encouraged throughput, underpinned by the notion mentioned earlier, that people in care homes are a lower priority than people living in the community. This idea is captured in the following example:

“... we are allocated, we do the review, we give our recommendation and then generally the case is closed.” (Alison, FG2)

Alison continued by explaining that although recommendations are made, they may not be taken forward as there is no system to monitor them. A similar perspective on the constraints of the system was expressed elsewhere:

“... One review a year though, when you think about it, is that *really* what people deserve? One review a year if they don't have anybody else? [...] You pick it up next year and things haven't been followed up, so where is there oversight of all the things that we say need to be done because often we have a production line where we just turn them over quite quickly.” (Tina, FG1)

Indeed, despite the local authority's responsibility to review publicly funded care home residents, many highlighted the limitations of the role. This is starkly summarised in the following comment:

“... Social workers, as far as I know, they only go and review people's care once a year. And yeah they do the very best they can and I've never come across any social worker whose done (*this*) in a careless or unprofessional manner. But the fact remains that they're only there to scrutinise the service once a year.” (Julia, FG4)

These comments resonate with the themes explored earlier in the chapter. Resource constraints drive social workers' limited engagement with care homes and they are

then more likely to be in a 'scrutinising' role, which makes it hard to build trust with residents and/or staff.

Rights and social justice

The final sub-theme is how many social workers accepted the constraints on their practice. Whilst participants readily articulated the many tensions in a less than perfect system, in general their focus was on protecting individuals' rights rather than campaigning more extensively for social justice. It was interesting that it was a newly qualified social worker who connected social work's social justice value base with the importance of challenging the system:

"... the code of ethics for social workers is what we base our practice on and ultimately regardless of resources and everything, we have to try and fight. There is a political aspect to social work that is a campaigning aspect. That is more relevant to people who are stuck in care homes or have no choice but to be there until they die." (Julia, FG4)

In the focus group of social work managers, there was the greatest emphasis on debating the structural factors influencing social work practice. Indeed, they appeared to use the process of the group to reflect. Their discussion exposed the tension between social workers' professional support of social justice and structural and organisational systems. This is summed up in this extract:

"... The silent majority say nothing [...] We accept traditional models of care and I think we all are to a degree guilty of that - working within a system we just conform, and so I think we should all challenge systems and be able to speak up freely and not fear reprisal." (Liam, FG3)

In the same group, a manager explained that she had been working for the organisation for over 20 years and added "I've just been around, like some of us, the furniture, yeah" (Farzana, FG3). In the context of Liam's comments, the idea that she saw herself and her colleagues as 'part of the furniture' exposes the difficulty in challenging the system when you are part of the fabric of the organisation, an idea I will explore further in the discussion chapter. This connects with the following comment which illuminated the ultimate paradox of the social work role:

“... we have independent advocates because I think social work won't be the best to act as an advocate because we are arranging the care... we placed them there. We are working for the State. So we might be doing things to benefit the State instead of to benefit the service user.” (Julia, FG3)

Theme summary

Despite the consensus that social workers strive to do their best and work in a person-centred way, many factors hinder this. Participants talked about structural ageism and resource constraints and their insights demonstrated that the organisation and priorities of local authority systems drive (or at least constrain) practice. Participants' comments revealed the tension of being part of the system whilst at the same time striving to change the system and protect people's rights. This theme underlined the difficulties that this creates for social workers.

Drawing it all together

I have presented the focus group findings in three main themes. They create a link between how social workers see social work, and how they understand care homes and the relationship they then have with care homes, which is in turn influenced by organisational constraints. In the next chapter, I will present the findings from the interviews, before in Chapter 7, exploring what I think the findings mean and drawing some conclusions.

Chapter 6: The interview findings

The previous chapter presented the findings from the focus groups. This chapter will concentrate on the interview findings undertaken with individual social workers.

Introduction to the themes

As described in Chapter 4, I undertook semi-structured interviews with 9 participants. I have given the participants pseudonyms and provided brief descriptions or 'pen pictures' in Appendix I to provide context.

The main themes I constructed from the analysis of the data were:

1. Professional and organisation barriers
2. The emotional impact: bringing yourself to the role
3. Trying to find a way
4. What difference does it make?
5. The possibilities for practice

Theme 1: Professional and organisation barriers

A common theme running through the interviews was how professional and organisational factors act as obstacles to social work practice in the context of working with care homes. The role of trust and relationships were underpinning sub-themes, resonating with the focus group findings.

Role purpose and priorities

Participants revealed that the organisation of services and teams had a significant impact on social work practice and that there were many contributory factors to this. One example was given by Rachel, who described how older people are often transferred from hospital to a care home temporarily under the 'Discharge to Assess' (D2A)³⁵ pathway. She explained that once the person leaves hospital, social workers in the hospital team are no longer involved and a referral is made to the 'locality' or community team to assess and support the older person. Notwithstanding the lack of

³⁵ Discharge to assess (D2A) was introduced in 2016 by NHS England to provide short-term care for people in hospital who are well enough to no longer need to be in an acute hospital setting but who still require care. They are provided with short-term, funded support, sometimes in a care home, where their longer term needs for care and support are assessed.

continuity for the older person and any family or carers, she highlighted the delays in 'allocating' the assessment to another social worker due to capacity issues in the locality teams. She described how the local authority manages resources as "shifting deckchairs". Rachel observed how the set-up of the 'system', resource pressures and the perception of what is priority impact on what social workers are able to do; this transactional process can lead to older people in care homes being almost completely overlooked:

"... they're out of hospital and in the four week placement, so they're not in hospital taking up a bed. That's good. And they're not in the community, so they're safe. That's good. So they are just not going to get to the top of the list. If you've got time to visit one person, it's going to be that person who's at risk at home. It's not going to be the person safely tucked up in a care home."

(Rachel)

Rachel was not alone in describing the perception that people in the community are a greater priority and that when there are capacity constraints, this is likely to influence the allocation of social work resources. Adam (employed by a voluntary organisation) observed that it can be challenging to get local authority social workers to undertake placement reviews as "it is not top priority". Tina explained how when older people move to care homes, particularly from hospital, there is usually no social work involvement until a new social worker is allocated to carry out the initial review (usually after a few months). She described the need for someone to undertake practical tasks, such as sorting finances and 'life admin', communicating with the person's network and bringing them their clothes and possessions. Yet, in the following extract, she highlights how the procedural approach minimises this important role in supporting the older person's transition:

".... we just say 'we've placed your mother' - the subtext being - actually we got her out of a blocked bed because she was ready for discharge. We had to put her somewhere and the review will be done at six weeks. Now whether we say, 'in the meantime if you have any queries....' because hospital social workers only have involvement to 'place'. You've got a grey area of what happens in between. There should be a seamless transition without any gap

when somebody goes into a care home. It's a critical time emotionally and practically." (Tina)

Kim, based in an older person's mental health team, described how her role allowed her to spend more time with people in care homes, indicating that their mental health diagnosis 'elevated' them, in the 'system', above simply being 'older people'. She described the difference:

"... if I was working in a locality team, I wouldn't have that opportunity. I would close her. She'd go for reviews. I don't mean (*in this team*) there's no deadlines for me, but I feel I'm allowed to have the time to do that relationship bit and get to know that person to inform the assessment." (Kim)

It was noticeable that social work involvement was often described or 'justified' in terms of actions or tasks. Adam, for example, described how local authority social workers are usually contacted in a crisis and involved in "MCA, DoLS, safeguarding – the big hitters". The transactional or procedural nature of social work input was most evident in Jon's interview, when he initially described what his team does:

"... we focus particularly on situations where the review is overdue or becoming overdue. We also do safeguarding in care homes and legal work with DoLS, section 21 challenges." (Jon)

His acknowledgement that 'overdue' reviews are the main focus of social work intervention supported what others said about capacity pressures. Moreover, it was clear from his comments, and the examples he gave, that community reviews frequently took precedence in the team. It was notable that, across the interviews, the most obvious examples of a procedural (or managerialist) approach were given by Jon. He regularly used transactional language³⁶, referring to 'waiting lists', 'closures', 'allocations', and to people as 'cases'. This was exemplified when he explained how his team works:

³⁶ Several prominent networks (such as Social Care Future/Think Local Act Personal) are trying to change the use of language in adult social care, acknowledging that many of the terms used create barriers and can be stigmatising or dehumanising.
<https://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/>
<https://rewritingsocialcare.blog/>

“.... we just randomly assign cases to social workers within our team. We don't hold cases long term: we do the review, hopefully things are in a reasonable state and people close and pick up new cases.” (Jon)

His accounts highlighted the pressure of work and the expectation that the ‘task’ should be accomplished in a single episode wherever possible. In describing a care home review, he clarified the expectation:

“.... overwhelmingly when people do placement visits, it is just the one off. So in that visit, they need to be the eyes and ears: that worker has observed thoroughly what's going on, has looked at all relevant documentation, has spoken to care staff, has spoken to family, has met and spent time with that service user, has come up with some clear outcomes at the end of the meeting and has focused on the person's well-being and things that could be done to improve that person's well-being and tried to look creatively at options in regard to well-being.” (Jon)

He talks about people's well-being, but he is also clear that the primary *purpose* of the social work role in relation to care homes is the need to provide oversight and scrutiny. As he put it:

“.... from a contracting or a commissioning point of view, they would hope that once a care home takes somebody on that their needs should be met We are part of that whole process in doing a review, we are checking that the care home is fulfilling the role meeting the needs of our service users.” (Jon)

This understanding of the role, which was also demonstrated in the focus groups, is echoed by other participants. Adam suggested that when social workers undertake an annual review, there is an expectation to do “a mini CQC³⁷”. Tina expanded on this in her interview:

“.... we go in as the bad guys, whether we're going for safeguarding, whether we're going in to pick them up on something they haven't done.... It is a tick box. The placement reviews form is a bit of a tick box.” (Tina)

³⁷ This refers to the Care Quality Commission's role in monitoring and inspecting care homes.

Julia described the contract monitoring role that social workers have:

“... care homes have a contract with the local authority so they are commissioned to provide certain services to a certain standard, [...] I'm afraid that there needs to be oversight of how services are delivered for people in care homes and I guess a social worker is required to make sure that what the care home said they were going to provide is being provided.” (Julia)

Norman's perspective is perhaps influenced by his own role in an organisational safeguarding team, responsible for “enforcement” when care home providers require improvement. He echoed other participants' observations that social workers rarely have ongoing engagement with people in care homes. He stated:

“... I don't think they (*social workers*) look at it as continuing work. I know from my own experience, you'd do a yearly review and if there was an incident within the year, then you'd come back, and rely an awful lot on the care home to do the day-to-day activities. Social work involvement - it's like a task-centred piece of work. What are we going to *do* with this person? Care home? And then away you go.” (Norman)

However, in his view, social workers should not have an ongoing role with people in care homes because they have a strategic function to play. He suggested that the social work role should not be represented as something that it is not, illustrated by his comment here:

“... social workers - we appear out of the floor, we do our reports, we do not engage with them daily and that is not our role with care homes. We have a strategic role. We don't have a care and support role. We are not care assistants and we need to remember that. Yeah, we have a directive role. We've got to do the dirty work.” (Norman)

I will show later in the chapter how this 'strategic' role might be interpreted as upholding people's rights and the impact that might have on practice. For now, it is interesting to see the different ways that people understood, or rationalised, the social work role in the context of care homes.

The consequences of role purpose and priorities

The procedural or transactional nature of practice coupled with the emphasis on 'oversight' had several consequences. Participants described how the division of work between teams and the discrete nature of 'one-off' pieces of work inhibited the development of relationships in different ways. Tina commented that the 'system' is very disjointed, which makes it hard for social workers and care homes to 'connect'. As she put it:

"... I think the whole thing about social work and care homes is it is very unjoined up, the way we work when we only go in to do a placement review. How can you make a connection when you go in as infrequently as that, when you're not having contact?" (Tina)

This is echoed by Kim when she said:

"... we do the review: goodbye for a year, get on with it, type thing, or that's how it feels." (Kim)

Certainly a common thread running through the interviews was the barriers to building relationships with care home staff and with older people in care homes. Participants gave examples which demonstrated that they understood the importance of relationships, but that various factors, such as time, resources, emotional capacity and social work's status or positioning in relation to care homes, all acted as barriers to developing relationships.

Jon described how one social worker in his team found it hard to build a relationship with an older person and their family because of the perception that social workers are only concerned with paperwork or "ticking boxes". On the other hand, his description of another 'case' demonstrated the importance of throughput and the transactional emphasis in practice:

"... the bottom line was she was OK about her mother being there and so she agreed and we checked it six weeks later and things were OK and we were able to close the case." (Jon)

Many participants expressed how having a more transactional relationship with care homes made accessing information harder and also influenced the way care home

staff perceived their intervention, a theme which was evident in the focus groups too. Adam said that staff often hold assumptions about social workers “before your face even gets through the door”. This is echoed by Julia who pointed out that care homes aren’t always honest during a review because they might feel defensive or concerned that they are being examined. This is demonstrated in her comment about care home staff:

“.... they need to present themselves as efficient and competent and able to provide all the information ... eager to present an image that they're providing the best possible service, they say, “yes, of course, the person takes part in lots of activities” and all of that. [...] Perhaps the picture that they paint during the placement review process is not quite as accurate from the person’s perspective as it could be.” (Julia)

Rachel described how care staff are often wary of social workers who do want to spend time in the care home as they can feel as though they are being watched or judged. She described how social workers might feel awkward going into the unfamiliar environment of a care home and not know who to speak to or where to sit. Adam described the difficulty he experienced earlier in his career going into a care home “as a stranger” and asking to see someone’s care notes.

Jon acknowledged the huge pressure on care homes which resulted in social workers often “struggling to get information from them”. He also described the challenges in undertaking the safeguarding role as care homes raise barriers because they feel judged. Kim suggested staff can be defensive if social workers are seen as merely undertaking statutory duties, such as annual reviews, but she felt this changed when social workers had a stronger presence. She said:

”.... (*staff can be*) anxious about someone coming in and questioning who doesn't necessarily know everything that goes on in the care home and how it's run, questioning practice and what's going on and looking at things. When I'm doing a review or a DoLS, there can be defensiveness. Particularly from homes that don't know me. Where I've built relationships, that's different and they will be more accommodating and open.” (Kim)

Carla also highlighted the critical role of building relationships with care homes. In this extract, she talked about how she established the placement reviews team:

“... I was really keen that the care homes didn't feel that it was an ‘us and them’ situation, I didn't want them to think it was an inspection each time. It was really important that I didn't want it to be a paperwork exercise.” (Carla)

She repeated on several occasions during the interview that reviews should not be a "paperwork exercise," and demonstrated her commitment to building relationships to mitigate the transactional nature of practice. She explained further that relationships build trust and support the role that social workers undertake:

“... The Care Act is clear that every resident has to have a Care Act review. We don't want it to be a paperwork exercise. It's not just about all the CQC elements but it's about that person's experience of the care home. We make all sorts of recommendations in all of our reviews [...] They may be feeling: oh, gosh, you're coming in here and you're making all these recommendations. But it's easier with care homes that we've got good relationships with and if we know that care home really well.” (Carla)

Layers of relationships

The above examples demonstrate that barriers exist to relationships between social workers and *care home staff*, also a dominant theme in the focus groups. Alongside this, participants mentioned their relationships with older people living in care homes. It was evident that the relationship between the care home and the social worker could be a barrier or an enabler to social work practice with the older person. Kim described how spending time building a relationship with a resident had a ripple effect on her relationship with care home staff:

“... with the gentleman where I'm seeing him a lot in the care home, I've had opportunity to develop relationships with staff. So even though this is all towards a capacity assessment, I've spent lots of time doing this relationship building, and that then has had a positive impact on how the staff see me and what my role is.” (Kim)

Adam also described how when social workers are visible and *seen* spending time in the care home with residents, this can carry weight with care home staff who start to “trust that you are doing things for the right reasons”.

However, the pressure of work often impacted on social workers' capacity to support older people in care homes. Kim reflected that social workers criticise care home staff for not spending time with residents but social workers can be guilty of this themselves. Reflecting on her practice educator³⁸ role, and the mismatch between what social work students are learning and what happens in practice, she said:

“... it's important for me as a social worker being able to spend that time with people and use the skills that I'm trained in. And I don't think that happens in social work. Sometimes it could look completely separate – you know, what you're learning in social work as you're training and then in practice.” (Kim)

Tina was able to identify some of the reasons:

“... It's workload pressure, isn't it? You're being asked to take more work. You don't have time to build that relationship. You don't have time necessary to make those connections. Maybe you don't even have training.” (Tina)

Ritchie described the paradox of having limited time and a narrow role and still needing to build a relationship to support someone properly. Although applicable across wider practice, he gave the example of undertaking DoLS assessments:

“... I want to form a relationship with them - I think that's really important to make those kinds of assessments and if you're making decisions or recommendations. That's a tension that cuts across the care management sausage factory type approach to older people: if you're just doing an assessment and then a review once a year and you don't know them, I think that's a problem.” (Ritchie)

Another factor was that social workers may not be part of the wider multi-disciplinary team (MDT). For example, Jon alluded to social workers' marginal involvement when he talked about them being *invited* to join meetings when *needed*:

“... a lot of care homes run a MDT type process where they have regular meetings, which they're starting to invite us (*social workers*) into when there is a need.” (Jon)

³⁸ Practice educators are social workers with additional qualifications to teach, supervise and assess student social workers.

Difficulties of 'investing' in relationships

Participants described the dilemmas in developing relationships with care homes and with residents. A noteworthy example was given by Jon who questioned whether he could change practice in his team to allocate all the reviews in one care home to one worker to enable them to get to know the care home and build relationships with staff and with residents. His concern was that this might conflict with organisational priorities and overwhelm the worker. Acknowledging the 'managerial' problem, he said:

“... the danger being that the care home thinks that worker would take on anything at any time for any resident.” (Jon)

He provided a clue to the immense pressure on his team and the motivation for limiting involvement with care homes in this comment:

“... most of our reviews are on the eighteen month front. When I came in post, we had reviews that were three or four years out-of-date. It was frankly quite worrying, so I think we're in a better place now, but now we've got loads of other pressures which are slightly working against the progress we've made.” (Jon)

Kim suggested that developing relationships enabled you to have difficult conversations with residents and with care home staff as “it's much easier when we know each other”. Other participants, however, found this more problematic. For example, Julia discussed the challenges she faced if she was supporting someone and then had to use legislative powers, saying:

“... I guess the person is bound to trust someone who has invested time and effort. If they confide in you about traumatic experiences they had in the past and they've told you about their personal needs and what might be most helpful to them, and then there you are participating in a process that deprives them of their rights. It's rather difficult, and it's bound to damage the relationship.”

It may be significant that Julia was a newly qualified social worker, who later talked about her emotional response to the professional responsibility involved in “putting your name on a form” to agree “the placement is working” when you might not really

know someone. I will return to this and explore how participants acknowledged the emotional impact of working with people in care homes. However, it is important to note here that Ritchie explicitly addressed the discomfort that social workers may experience when they become more involved with people in care homes, particularly when time and resources are limited. He provided an example of how, as a BIA, he might set conditions, often in an effort to make *himself* feel better about the limitations of his role. He described this as:

“... a way of relieving me of some of the anxiety of leaving someone who I think needs a relationship.” (Ritchie)

He described social workers as “dipping in and dipping out” of care homes and he was notable in suggesting that protective boundaries are created by organisations and practitioners, saying:

“... (*this*) might protect us as practitioners from the emotional demands of being in close proximity for a long period of time with people who hit on things that are difficult for us in terms of our own issues with ageing and death and stuff like that.” (Ritchie)

This resonates with the theme I will shortly discuss about the emotional impact of the work. More importantly, it introduces the idea of defences against anxiety, which I will return to in the discussion chapter. I will also explore how language sometimes creates a barrier to good social work practice. This is exemplified in Tina’s remark:

“... people and objects. There's certain language: you know, ‘bed blocker’ because that's what you become. You're just ‘a placement’. It's the language we use. It's the way we describe it.” (Tina)

A degree of separation: achieving a balance

Another strong feature was the challenge in striking a balance between voicing concerns and maintaining a constructive relationship with care home staff. This was associated with the oversight role, mentioned earlier. Julia, for example, commented that she “can never forget that I am employed by the local authority in a social work

role". The responsibility that social workers held in upholding people's rights created a specific tension. For example, Adam explained that you "can't get too comfortable" if you want to advocate for the person in the care home. The following comment illustrated his dilemma:

".... I think the flip side is that if you're a social worker in a care home, then you're almost part of the furniture. That's the risk. You need to maintain some distance. You've got to keep your separate identity, even if you're employed by the organisation. You know that'll be my little T-shirt when I go to the grave. Because you are there for the clients." (Adam)

Many of the examples participants gave demonstrated a commitment to social justice and the need to advocate for older people, which I will explore further later. An interesting point was made by Ritchie who encouraged social workers to be 'realistic' as part of their advocacy role:

".... I would caution against flipping it too far and not seeing their needs: that could be a way of defending against realities. Because this is the thing I always struggle with - let's focus on their strengths, but I also think it's really important to perceive the realities as well, so what they can't do and what their conditions are." (Ritchie)

His comments resonate with Moore's (2022) critique of strength-based practice outlined in Chapter 3.

Theme summary

Participants provided insights into the expectations on social workers and the challenges they experienced. Their accounts demonstrated that 'the system' varies and is under enormous pressure, which leads to the prioritisation of older people in the community. Participants talked about the transactional and transitory nature of the social work role with care homes, and how role purpose and priorities can influence practice. A recurrent motif was how different factors inhibited the development of relationships and trust. Ultimately, working with people in care homes required a balance between oversight and maintaining older people's rights with developing positive collaborative relationships; this balancing act was characterised by numerous tensions.

In the next section I will consider the emotional challenges of social work practice with care homes.

Theme 2: The emotional impact: bringing yourself to the role

The next theme explores the emotional dimensions of the work. The interviews, compared to the focus groups, afforded participants a greater opportunity to discuss personal influences on their practice. Through their accounts and the examples they gave, participants explored the challenges of working on an emotional level with people in care homes and demonstrated the 'use of self' in their social work practice.

Balancing empathy and detachment

Participants talked about the emotional impact of the work in various ways. Some were aware of the dissonance between emotional involvement and maintaining professional distance; this was often shaped by an understanding of the pressures and tensions in the system, described in the preceding theme. Norman, for example, acknowledged the emotional toll of the work, alongside his belief that putting boundaries in place was crucial to avoid being overwhelmed:

“.... I have had cases before, with this job, where I've taken time out, where you can get so close to it, you know, because we're only human [...] And we can be appalled. But that will stop me from doing my job effectively.” (Norman)

Several participants expressed a sense of hopelessness and frustration at the challenges of supporting people in a system that may not adequately provide for their needs. Julia, particularly, struggled to reconcile the ethical challenges of witnessing what she considered neglectful practice with her role as a local authority social worker. Her sense of paralysis is captured here:

“.... I expect a lot of people make allowances because of financial constraints, and there's always excuses (*shrugs*), but ultimately, the people who suffer the most are the service users, and to a large extent also social workers who are not able to fulfil their 'caring' role and facilitate people's empowerment and well-being. (*sighs*) What can we do? No idea.” (Julia)

Julia demonstrated a commitment to ethical and rights-based practice; she was troubled by the dilemmas she encountered, particularly when it appeared that decisions about people in care homes were made by “a faceless local authority”, as she put it. In a similar vein, Rachel described how decision-making processes could ignore the individual and were often perceived by the older person and their family as directed by “someone in some big building”.

A common thread across the interviews was how people struggled to reconcile their own emotions with organisational priorities and the (often procedural) expectations of their roles. This is captured poignantly by Rachel, who described her feelings when she first started working for a local authority:

“... I remember feeling like it was all completely alien, another world I didn't understand. And then one day I felt like a horse that had been broken in and I was part of the system and that's just how it is. I think that's probably something that I continue to struggle with: being part of this system that I don't really like.” (Rachel)

Subsequently, Rachel explained that she had left local authority social work practice on three separate occasions to do something different but had always returned to it. Adam described his decision to leave statutory social work because of his frustration at constantly encountering systemic obstacles:

“... I was being hit by a barrage of systemic ‘no’s and begging for extra bits of this and that but not getting it. It was a battle to even get an extra 15 minutes of care for a lady who was very frail and was really struggling at home. Time was at an end in statutory (*work*) for me at that point.” (Adam)

A social justice lens

It was noticeable that participants' emotional responses were often rooted in their commitment to social justice. In particular, strong feelings were triggered when they perceived that care home residents' rights were breached or their needs were not being adequately met.

Julia presented a vivid picture of people in care homes left sitting all day with no stimulation. Taken with her earlier example of the responsibility of “putting your name

on a form”, it was clear that she struggled with reconciling her professional responsibility with what she considered to be poor practice. Her comments here conveyed her sense of hopelessness and frustration at the shortcomings in the system:

“.... the nurse will give you medication – there! Just give you the thing and then move on. It's really, really, really difficult (sighs) and the pandemic was a perfect excuse for people to just lie back on their laurels and now it's taking a long time for those activities to be restarted again and Oh (sighs) it's just frustrating”. (Julia)

Ritchie talked openly about the difficulty he experienced when undertaking DoLS assessments and found it particularly hard to think about people losing access to basic rights. He explained that he would set conditions in his assessments about going on outings because “I wanted people to be able to leave the care home if they wanted to”. He reflected on the limitations of his role, and was struck by the enormity and difficulty of the challenges, saying:

“.... Oh I feel like – oh it feels hopeless Sally ...” (Ritchie)

For many participants, the way people's rights can be casually ignored made them really angry. Kim cited an instance when she asked care home staff about someone's opportunities to go out. She was incredulous at the reply that ‘he went out when he had a hospital appointment’:

“.... I can always remember talking to this gentleman who said he never goes out. When we spoke to the member of staff, she said, “well, he does go out” and I said, “oh where does he go” and she said, “well he had a hospital appointment”. I thought – is she joking? That's it? It shouldn't be. You go to a care home and you never go out again? I'd be kicking and screaming if it was me.” (Kim)

Carla is frustrated by care home staff's risk adverse attitude which limited the rights of the person she was working with, as she described here:

“.... I remember working with a retired journalist and it really struck home for me. We were talking about what was meaningful for him: he said he was sick

of the fact that there was tabloids - really, really hideous - like the Sun and the Mirror, and just awful newspapers being delivered to the care home. He wanted to actually go to the newsagents to buy his paper. The care home had talked about getting newspapers for him, but they were incredibly risk averse. They were saying you can't possibly, you know, there's no way that you're going to be able to go to that newsagents, yourself." (Carla)

Tina showed real indignation when what she considered people's basic rights and needs were overlooked. She commonly described herself as shocked or horrified, although what came across most obviously was her anger. She gave many examples during her interview, with this one standing out:

".... somebody having to borrow other people's clothes should never happen. They've got a whole wardrobe, they've got a whole life at home, the indignity of wearing somebody deceased's clothing - and it is a deceased person - that is unacceptable to me, that's unacceptable [...] Months when they don't have their things with them. I mean it's abuse. That's what I said to my manager last year. It feels like it's neglect. We are failing that person. It's not good and I feel – personally - I feel responsible. People have been slapdash about it and not thought about the whole person and not thought about the impact." (Tina)

While Jon's sense of social justice was less evident, it was interesting that he acknowledged that the interview had been a rare opportunity to step back and reflect broadly about his social work role in relation to care homes (and beyond). He made this comment towards the end of the interview:

".... having this conversation, it's got me thinking – that's always the good thing about doing things like this. It's good to step back and think about what's going on - the national perspective about care homes and the struggles they're having with staff and COVID and the impact there, and visiting and those broader issues. And how do we as a local authority, how do we fit into that?" (Jon)

Out of sight, out of mind?

There was discussion in the interviews about the emotional dissonance created for people around working with people in care homes. Ritchie, most notably, proposed

that social workers might choose to protect themselves from thinking too much about the difficulty in the system. He reflected that care homes are often kept “away from the community” and questioned whether challenging this “could run counter to that more unconscious function that they serve for us as a society.”

A small number of participants were more guarded in their emotions and talked about the need to temper how they felt. Their responses resonated more with Ritchie’s reflections and connect back the discussion, earlier in this section, about balancing empathy with detachment. Indeed, Norman said:

“.... I need to make sure that I'm not being influenced unduly by my own reaction to what is in front of me.” (Norman)

Jon rarely gave examples during his interview that illustrated that he was thinking about the older person or the impact that a managerial focus might have. Instead he often talked about feeling frustrated and worried, which was usually in relation to his managerial role and the pressure he felt to get through ‘the work’. He struggled to show anything other than ambivalence for care homes, exemplified in his remark “institutional care, which is obviously not an ideal situation for people”. This perspective is reinforced by Norman when he says:

“.... If care homes are seen by the majority of workers to be the last chance, the end of the line, then there is not a lot in that that is constructive and positive.” (Norman)

I will discuss this further in the next chapter and think about the impact of this approach on practice.

Personal influences

During the interviews, more so than the focus groups, most participants were comfortable to share personal experiences, which offered insights into the impact this might have on their social work practice. Norman, for example, talked about his own mother with dementia moving to a care home and recalled the “horror” he felt:

“.... if I look at the families I work with, their sense of loss, guilt, frustration [...] I went through the same thing. My mother had dementia when I was 20, so I couldn't manage that, I just couldn't. The horror of it all. I could not handle it: So off she went. And she survived three years and then that was that. But I can still feel the horror of not knowing what to do.” (Norman)

Ritchie connected how his own identity as a gay man influenced his feelings about care homes as he reflected that sexuality is ‘wiped out’ when people enter care homes and older gay people often feel the need to ‘go back in the closet’. Ritchie also described the guilt and “failure” his family felt when they could no longer care for his grandmother and she moved to a care home. He was open during his interview about his own emotional response, and rationalised the need to sometimes make himself feel better, as the following example shows:

“.... someone I assessed was a backing singer for Donna Summer and I made sure I included that in the assessment.... And I played her Donna Summer songs on my phone because I'd wondered if that might be a way of connecting. She couldn't really but anyway I felt better doing it (laughs).”

It was striking that participants who had shared more personal information often appeared to approach their work in a more person-centred way. Tina and Carla both connected their personal experiences to their professional outlook and the need to view people as individuals with rich histories not ‘cases’. Carla talked passionately about her commitment to working with older people, having worked as a careworker before qualifying as a social worker. Despite being a team manager, she continued to do placements reviews and BIA assessments to stay connected to practice. Notably, the following comment demonstrates the importance she placed on bringing her ‘self’ to her professional role:

“.... We're people. It's really important that as a social worker, I'm aware when I'm talking with people that there's a huge power imbalance. We're asking that person a huge amount of information about them, so I always try and disclose part of myself to them. Yes, I'm working as a professional, but I think it's really important - for example, I will sometimes reference that my mother-in-law who had dementia lived with us. Or I will say that I worked as a carer in a residential care home, so silly things like that, you know? While it's not the

same, I've had various hospital admissions so I know what it's like someone supporting with my personal care. So it's like using my experience sometimes." (Carla)

Similarly, Tina recognised how her personal experiences influenced her professional role:

".... older people, they had lives. They had careers, backgrounds, they are not just an assessment on a piece of paper. It's how you are fleshing out the person. maybe some of us older social workers are actually closer to that. And whether it's a parent, in my case two parents who have chronic health needs and for whom I do everything as a carer, you see it from the other side as well. Thinking 'Oh my God, this is a bit of a nightmare', but you're doing it as a family member and then you're doing it as a social worker". (Tina)

Participants often disclosed personal reasons for wanting to be social workers. At the start of the interview, Kim talked openly about her values and her personal history, and demonstrated how her focus on people and their individuality was anchored in her strong sense of social justice and rights. Many participants brought information about themselves into the interviews; what stood out was how when they connected the personal to the professional, this often seemed to manifest itself in a more relational and rights-based approach to their social work practice.

Theme summary

This theme explores the emotional dimensions of social work practice with care homes. Participants described the difficulties in balancing personal and professional boundaries, and often expressed feelings of frustration and hopelessness as they grappled with systemic challenges. A common thread was their commitment to social justice, with strong emotional responses triggered when they perceived breaches of residents' rights or inadequate care. Participants also appeared to draw on their own experiences to shape empathetic, rights-based practice.

Theme 3: Trying to find a way

This theme focuses on the approaches that social workers took to navigate the tensions in the system, described earlier in this chapter. This involved using their discretion and experience, which helped them to 'keep going' in their roles.

Scope for professional judgement

There was a recurring concern about the diminished space for professional judgement and the impact of transactional practice on discretion. Several participants worried that practitioners were under pressure to take shortcuts or were reluctant to challenge the status quo due to time and workload constraints. Julia, as noted earlier, talked about how social workers "make allowances", and did not always dig deep, instead they "just appeared to accept what care home staff said". The way Jon described the work in his team reinforced the lack of challenge to the approach taken to reviews, as demonstrated in this remark:

".... ultimately, I think it is better if you're able to do more than one visit but the reality it's quite rare. It's the exception rather than the rule." (Jon)

Jon's examples indicated he felt that discretion or professional judgement was often removed from practice. For example, he described how the BIA role has been downgraded to a task that requires minimal professional interpretation since the Cheshire West³⁹ judgement:

".... in the early days, I felt that there was more debate, let's say. I think now it's almost overwhelmingly people are 'DoL'ed. Before you had that '24 hour care and control', it was a bit more open to discussion." (Jon)

Likewise, he demonstrated that, in his view, social workers' professional discretion is subsumed in the wider context of multi-disciplinary working, where health holds more power:

".... In terms of funding issues, it's just no longer possible to go up and say 'look this is what we think'. It needs backing from our health colleagues." (Jon)

³⁹ See footnote in Chapter 3 p.71

Finding a way

Norman articulated the tension between focusing solely on the task or doing the job 'properly'; he suggested that he could tell which approach had been taken:

“... I've been doing this a while now, and you can tell whether somebody has been processed through the system or if a social worker has taken a bit of time and has looked at their needs.” (Norman)

It is interesting that here, as in other interviews, it is almost suggested that the variation in the way that people work, or the approach they take, is a choice. Jon presented social workers as having a 'preference' for how they worked. He talked about his previous manager and noted that “the thing he was into” was person-centred practice. He also talked about the approaches in his team:

“... It's quite interesting in terms of our team: there's different approaches as some people like that (*short term involvement*); some people prefer to do more, let's say, intensive work where there would be more than one visit, they're more interested in more complex cases.” (Jon)

For others, rather than being a preference about how to work, their confidence and experience allowed them to find a way to use their discretion, which helped them to reconcile their values with the constraints in the system. Ritchie, for example, showed on several occasions that he worked, almost furtively, to overcome the system and use the resources he did have. He explained that he recommended shorter authorisations and made conditions to improve people's situations, despite a realisation that, as an independent BIA, local authorities might decide not to continue employing him if he caused them more work or made additional demands on public resources. Tina regularly used the scope in her role to improve people's situations by bringing their belongings to them in the care home, despite this not really being part of her role.

Despite feeling acutely the challenges and dissonances of practice, many participants had strategies to advocate for people. Moreover, they still showed hope and commitment to the belief that social work can make a positive contribution. Rachel's comment here showed how she maintained her social work identity rather than conforming to the system:

“... I think I might identify more as a social worker, then as someone who works in social care.” (Rachel)

Similarly, Ritchie talked about the importance of social justice and advocating for people, and then said:

“...and I think that I have to believe that's what social work's still about in order for me to continue doing it.” (Ritchie)

It was striking that in Kim's interview she showed an awareness of system constraints, but when they created a real disconnect with her values, she had developed strategies to manage this. For example, she described how a previous role had been “just assessing and putting in a package of care” so she had moved to a different role, because, as she put it “I want more than that from social work”. She demonstrated too that experience had developed her confidence and her ability to manage her frustration and to channel her activism towards smaller changes. She said:

“... when I was younger I was fighting everything - we're going to fight this and have a better society. Now I can appreciate that my smaller interactions with people can be equally significant for someone and I think that's something I've learned over my social work career. [...] Maybe that's come with my own confidence and acceptance of sometimes I can't change things for people, and sometimes that's OK, whereas before it wasn't.” (Kim)

This is in contrast to much of Julia's interview, who as a NQSW, often appeared paralysed by her indignation at the injustice in the system and her inability to make changes. I will discuss this in the next chapter.

Rachel perfectly summed up the challenges and how she holds on to hope:

“... It might be shit, but if I believe I can make it a little better, then maybe it will be better...” (Rachel)

She also made an important point about the role that good supervision and positive leadership can play in helping social workers in their practice with care homes, a topic

I will return to in the next chapter. She made this comment about another manager, with whom she works in the same local authority:

“.... She's an incredibly well respected manager, but she's also a great supervisor. If somebody joined her team, who was a bit (shrugs shoulders) about care homes, she will have supported them in a beautiful way to be more positive about things.” (Rachel)

Theme summary

This theme shows that, despite systemic challenges which appear to reduce the scope for social workers to exercise discretion, most participants had developed ways to hold onto hope and deliver good practice.

In the next section, I will consider the difference that good social work practice can make to people in care homes. I will build on the idea that when good social work practice happens, it is often because social workers, as described in this theme, have ‘found a way’, and may be seen to be ‘going against the grain’ or subverting what has become accepted practice.

Theme 4: What difference does it make?

A strong theme that emerged throughout participants’ examples was that they were frequently doing excellent social work. They often did not notice this themselves nor was it always ‘counted’ or recognised by the ‘system’. As I will show, nuanced and skilled social work practice was often taking place amidst the procedural tasks mandated by their employer and their statutory responsibilities.

The value of relationships

A recurring motif was the value of relationships as the cornerstone of practice. As illustrated earlier in the chapter, people were frequently critical of the barriers to relationships that organisations and resource constraints created; they also described the positive difference that relationships could make as part of their social work practice. Kim stated that “relationship-based social work is probably the most important thing for me”. During her interview she shared numerous stories, reflecting her person-centred approach and ability to see people as individuals. She shared one example of how she supported staff to understand one older person’s history

and preferences, including their desire to wear their fur coat in the care home and clear the tables. She explained the impact of this:

“... not only has it helped her settle, but it's helped her develop relationships with other residents because she's a social person. The staff have taken some of the things that I've said to them that's important, and this is who she is, and they've used her strengths, just around who she is.” (Kim)

It is interesting that when Kim talked about building relationships with people in care homes, she called it “nice work”, and compared it to the ‘bread and butter’ work she usually does such as “DoLS assessment or reviews”.

Carla also shared stories which underscored the importance of building relationships and understanding the person, like the example described earlier involving the journalist who wanted to be able to go to the newsagent to buy his paper. She reflected on the positive impact her challenge and intervention made not only to the resident but to other residents and to shifting the care home's culture around risk, and said:

“...it stuck in my mind because it had such an impact for him. And for other residents. And what was really important, it showed the care home that they were very risk averse, and showed them that it was possible, and that it was a really good story. So it has a ripple effect for other residents as well.” (Carla)

Jon acknowledged the positive outcomes that social workers had when they were able to spend more time with residents and “dig deep”, and he considered this would count as “a good piece of work”. He talked about the importance of seeing people as more than “an entity with loads of medical issues who is now stuck in a care home”. However, in the following example, it was not clear if he attributed good practice to being able to spend more time with people rather than with the opportunity this created to build relationships:

“... because of the whole process of agreeing funding, that meant that the social worker needed to go back more than once. I think that helped her understanding of him and his condition. Ultimately I think it is better if you're able to do more than one visit.” (Jon)

Rights-based practice

Julia's gave tangible examples of good practice, like making sure someone has underwear or access to money. She emphasised the importance of this support for people without family. Far from being just practical matters, she showed that they made a difference and demonstrated her commitment to rights-based practice and to seeing people as individuals. When asked if she considered the tasks she described to be something social workers should be doing as part of their role, she responded "of course, well who else otherwise?". Julia cited instances where tenacious social work practice resulted in positive changes for people in care homes. This could be something as simple as advocating for an OT assessment or a wheelchair but often the nudge from a social worker meant that "all of a sudden things start happening".

Tina gave many vivid examples of rights-based social work practice, which had at its heart the importance of valuing the individual. She described practical tasks (sorting finances, picking up people's belongings, tracing and contacting relatives), but, as with Julia's examples, she demonstrated how this was in fact person-centred practice, hidden in plain sight. She talked about the need to "unpick what's gone on"; she gave an example of going into people's properties:

".... often I'd just go through piles of post because we know nothing about them and the post gives clues. What magazines they might subscribe to. You could talk to them about that or you can bring them in and you can read them through with people." (Tina)

She gave numerous examples of the importance of bringing people their belongings (clothes, pictures, music, rosaries) not only to connect them to their rich histories but as a basic right. The following example particularly stood out: it was about a woman who moved from hospital to a care home during the pandemic without any personal belongings:

".... she was a paediatrician, a doctor, with a fantastic flat... She had a wardrobe full of lovely bright, red, green, lovely colours. She was dressed in charity clothes that they were giving her at the home.. So when I went in there with my colleague we picked up all the clothing, we took it to her. We took her pictures. We took everything that is that person." (Tina)

Tina also made visible the valuable role that social workers can play in managing the financial affairs of people in care homes. Alongside applying to the Court of Protection⁴⁰, she also described how financial and administrative tasks, such as stopping direct debits, giving final meter readings, managing post, are often simply neglected when people move to care homes. She suggested that appropriate social work support in this area serves a vital function, and supports people's right to privacy, dignity and respect, taking into consideration that "often people are unbelievably private about their finances".

It is interesting that Tina's specific role was to recoup the money that people owe to the local authority in care homes fees. She said that often families "hate" her because her role is about money. In effect she has a transactional role mandated by the organisation, but she used it to her advantage to make positive changes for people. She does 'good' social work, skilfully and with a strong emphasis on the person, despite the overarching purpose of her role, and this is what sustains her, as suggested by this comment when she referred back to the woman, described earlier, who she supported:

"... she still thinks she's a doctor and she said, all the way through the review, Did you know I'm a doctor? And it was so lovely, and she's very happy and she's very settled. And that gives me enormous joy." (Tina)

Social work as an intervention

Many of the examples given above suggest there is value in the skilled approach of a social worker. This was most explicitly demonstrated by Adam, who commented that he was able to "mop up what local authority social workers don't have time to do". In his interview, he described his social work role in a care home, which involved liaising with families and with other professionals, handling difficult conversations, providing emotional support, and navigating challenging situations. He talked about the value of having a presence in the care home, saying:

"... the social work role is about being there, front facing, being available, the clients knowing who you are, being visible and speakable to." (Adam)

⁴⁰ The Court of Protection makes financial (or welfare) decisions on behalf of people who lack mental capacity to make those decisions themselves. An application needs to be made to the Court of Protection to manage a person's finances if no provision already exists to do this.

Notably, he echoed what had been said elsewhere, about social work's capacity to deal with difficult situations, saying:

“.... and sometimes people refer to social work when they don't know what else to do.” (Adam)

Ultimately the crux of this theme is encapsulated in the following comment from Carla, where she championed the value and expertise involved in social work practice with people in care homes:

“.... It's sometimes frustrating that in meetings, it's almost like an afterthought: 'the neighbourhood teams oh and also the placement reviews team'. It's really important it is seen as a priority. You're looking at a cohort of the population that, by the very nature that they're eligible for residential nursing care, implies that their level of need is incredibly complex, and I think it's incredibly skilled work to be able to do a placement review.” (Carla)

Theme summary

This theme captures the difference that relationship-based and rights-based social work practice can make to people living in care homes, and the ripple effect that this can have in the care home 'ecosystem'. The examples make visible skilled social work practice and illustrate Michelle's comment from the focus groups that the “involvement of a social worker in the care home is actually really essential”.

Theme 5: Possibilities for practice

The preceding theme explored what good social work practice with care homes can look like, despite the barriers that social workers encounter. The final theme focuses specifically on participants' ideas and suggestions about the contribution social work could make to older people in care homes.

A stronger presence in care homes

There was support for social workers to have a stronger presence and more involvement in care homes. A recurring theme throughout the interviews, resonating with the focus group findings, was that people in care homes deserved more from a social worker than 'just an annual review'. Julia advocated for more regular reviews, which would lead to more time to spend with older people, leading to greater

involvement and a wider role. In this extract, she described what she would like:

“.... more time to spend with the person. Instead of doing a placement review once a year, you might do one every six months or every three months even. [...] Especially people who are first placed in a care home. I would see them more often if I had a smaller caseload. Yes, I would take a more active role.”
(Julia)

Tina’s suggestion is that the scope of the placements ‘review’ team is broadened to offer support for people from as soon as they move to a care home to create a “seamless transition”, with no need to wait until the initial review. She suggested that this would offer consistency and support, especially with things that are overlooked like finances and helping people to settle in the care home. It would help social workers to build better reciprocal relationships with care homes, residents and their families. She acknowledged that it might be “logistically a total nightmare, my manager would be appalled”; however, she was resolute, as shown in the following comment, that small changes could strengthen social work involvement and make it more effective:

“.... I realise we are stretched doing what we need to do on a crisis basis: that tends to be how we work. So to do things proactively, creatively, it's ideal world stuff, it's not going to happen. But I still think even with the resources that you have, we could use them better. We could get things better at the beginning, have a named contact, make a check phone call when somebody goes into a care home, a couple of phone calls. How's it going, talk to the manager, get some feedback and pick up early whether somebody isn't happy or something's going on.” (Tina)

Jon considered the benefits of allocating a specific social worker to undertake all the reviews in one care home:

“.... I'm wondering, talking to you, whether it would be good to have a named worker for each care home. At least then you get that familiarity, because if you do a review in let's say X care home, at the moment it could be any one of

a number of social workers, whereas maybe it might work better if it is one social worker who deals with that particular care home.” (Jon)

Although, as mentioned earlier, he expressed concern about the potential amount of work this could create for individual social workers, he reasoned that the benefits would outweigh the disadvantages.

Several participants referenced other models of social work practice; they thought about how they could be adapted and would allow social workers a greater presence in care homes. Rachel referred to social workers working in hospices and suggested that a similar model in care homes would allow social workers to spend time getting to know people, which would benefit them, their families and staff. She added “I’d love that job”. Ritchie mentioned social workers attached to schools. He recalled a conversation with care home staff about a new resident who was not ‘settling’ and was hitting people with their walking stick; he suggested that if social workers were more connected to care homes they could help both staff and residents with the transition process and potentially help staff understand and support this behaviour.

Social workers employed by care homes

Some participants talked about social workers potentially being employed to work in care homes. Carla was in favour of larger care homes employing a social worker:

“.... there should be a requirement, for a care home with X amount of residents, it's their responsibility to actually employ a resident social worker - in the same way that they have activities coordinators. I see the impact that our social workers have but that is only one year to the next. It would be wonderful if, for example, a provider with a few care homes actually invested in having a full-time social worker there. I think personally that it should be the responsibility of the care home to employ the social worker so they feel part of the team.” (Carla)

She then pondered the tensions for the social worker in being employed by a care home, but felt that social workers were well placed with their professional values and ethics to navigate the dilemmas. Rachel also talked about this, although she was less certain about how it could work in practice.

Adam was also in favour of having full-time social workers based in care homes. He suggested that for-profit care homes, particularly, could promote the idea of in-house social workers as a “selling point” for residents and their families. While he joked that “maybe it’s not as exciting as having an on-site complementary therapist or a hairdresser”, he described the value of a social worker and how this could be articulated.

Modelling good practice: connecting and educating

When considering the possibilities for practice, a common theme was the opportunity for social workers to ‘model’ good practice and take an educative role by being more present in care homes. As described earlier, Kim showed how spending time with a resident had the added benefit of building trust with care home staff and helped to change the narrative about the social work role. Again, she presented the importance of social work presence to build collaboration, foster reciprocal learning and improve practice:

“... it’d be really helpful if social work wasn’t just going into care homes for reviews or safeguarding. Then we could work together and support one another and just educate one another about what we do, because it would be better for everyone rather than just going in at certain times and then that’s it - because it’s almost like we’re just separate.” (Kim)

Jon suggested that building some reciprocity between care homes and social workers might be helpful, as described here:

“... we often have people who work in the care home sector come to us, and sometimes even present at team meetings. Perhaps that could work the other way - we could present to care homes, so they know a bit more about our role and the things that we do.” (Jon)

In a similar, but slightly different, vein, Tina thought it would be helpful to find out from care homes what they thought about the social work role to build better relationships. Her comment demonstrates scope for better communication:

“... we should be asking them what their understanding is of our role, how they experience us? Is it just somebody coming in doing a tick box? [...] We

could improve things and we have to get care homes' views - where are we going wrong or where are we going right? It is so simple to ask." (Tina)

Exposing the cracks

A minority of people gave examples involving the need to overhaul the current system completely. Norman was the only participant who suggested that rather than focusing their efforts on supporting people in care homes, social workers would do better to focus on providing better support in the community.

"... the biggest contribution social work could make to the ageing population is to support them to live at home. The approach could be changed with earlier interventions, so the social care system is accepted into somebody's life earlier on." (Norman)

Ritchie, particularly, acknowledged the need to reverse the dominance of privately owned care homes, although he was realistic about the chances of success involving change at a socio-economic level:

"... I would want to see publicly funded care homes. So I'm just talking about a total transformation of the taxation model (laughs)..." (Ritchie)

Ritchie, like other participants, reinforced the need to think about care homes as part of the community. In particular, he suggested that intergenerational models of care homes might support this approach.

Finally, a recurrent theme was the need to disrupt the way social workers think about care homes and how to influence this more widely across the system. This is encapsulated by Adam who suggested:

"... not smoothing over the cracks, but helping people to understand why the cracks are there to start with." (Adam)

Tina also made an insightful remark about the need to ensure that *all* social workers are educated about the importance of seeing people in care homes as individuals; she wanted this approach to be common practice and not seen as specialism. Several people talked about the scope for changing how social workers themselves saw care homes, particularly *student* social workers, and addressing ageist

assumptions. For example, Tina asked why social workers are taught to do life story work with children in care, but not with older adults at the end of their lives. There was support, notably from Kim, an experienced practice educator, for people just spending time in care homes as part of their learning. This is conveyed by Norman in this comment:

“... if I was training social workers, which I'm not, but if I was, I would ask them to visit care homes. At least three. And all they need to do is to sit in the lounge for an hour. Don't talk to anyone. Don't get all social worky. Don't do all that. Just sit and observe for an hour.” (Norman)

Theme summary

This final theme captures the possibilities for the social work role, and highlights the scope to broaden the role to benefit care home residents and care home staff and to support more effective social work practice.

In this chapter, I have explored the themes I constructed from the interviews. In the next chapter, I will discuss my insights from both sets of findings and situate them in the wider landscape of existing literature and theoretical work.

Chapter 7: Discussion

In this chapter, I will discuss my findings and situate them within the landscape of existing literature, theory and the policy context described in earlier chapters. I have mostly combined insights from across the whole dataset. I will start the chapter by explaining the main theoretical perspectives I used to make sense of the findings.

Theoretical perspectives

As discussed in the methodology chapter, I took an iterative and abductive approach to analysing the findings. This allowed me to build on existing theories and constructs present in the literature (a deductive approach) while also finding new insights from the research findings (an inductive approach) to identify pragmatic explanations (Ettelt *et al.*, 2022; Thompson, 2022). In addition, as previously mentioned, the reflexive stance I have taken acknowledges that this is not the only possible interpretation of the findings. I have used several theoretical lenses and concepts to help me make sense of my findings. These were perspectives that I found resonated most strongly with my interpretation of the findings and the literature in which the study is located. I will start by explaining some of the main constructs that I will later incorporate into my analysis of the research findings; I will also weave in additional concepts along the way.

Managerialism and social work

The discourses associated with managerialism and new public management⁴¹ and their influence on social work practice are a useful lens through which to examine the themes from the previous two chapters. They have been expansively debated and theorised in the literature and here I will provide a brief outline of some concepts. In Chapter 2, I highlighted how neoliberalism impacted on the growth of managerialism, bringing principles of efficiency and performance management into public services and narrowing the social work role to mostly statutory functions. Social work practice in local authorities was framed around the importance of ‘following procedures’ and efficiency; this sidelined relational (or relationship-based) practice, which can be nuanced and hard to ‘measure’ (Ingram and Smith, 2018). To counterbalance

⁴¹ The terms managerialism and new public management are often used interchangeably. The latter term is particularly descriptive of the approaches developed in the 1980s to improve public sector efficiency by using private sector management models.

pervasive managerialism, it has been argued that relationships, and the values, skills and understanding needed to build and maintain them, must remain at the heart of social work practice (Trevithick, 2003; Ruch, Turney and Ward, 2010). This recognises that the relationship between the social worker and the individual is “essential rather than incidental” (Alexander and Charles, 2009, p. 6) and is an intervention in itself.

A fundamental idea, proposed by writers such as Ingram and Smith (2018) and Trevithick (2014), is that managerialist approaches fail to recognise the central importance of relationships for effective social work practice. As discussed in Chapter 2, the Care Act 2014 seemingly heralded a policy and practice shift away from process-driven care management (Department of Health, 2017). However at the time, and more recently, critics have reasoned that financial austerity, and the accompanying socio-political context, have perpetuated and even extended narrow managerialist practices in social work (Lymbery, 2014; Hingley-Jones and Ruch, 2016; Rogowski, 2020).

My thinking has also been shaped by the ideas of Webster (2010) who articulates the tension between managerialism (or new public management) and social work ethics. Webster draws from New Zealand perspectives and focuses on the influence of *managers* on social work practice. He proposes that the values and ethics driving practice need to be congruent with organisational structures, policies and worker-manager relationships, and advocates for the development of a specific management model for social work which explicitly adopts “the profession’s underpinning values to influence management behaviours” (2010, p. 29). Notably, he mentions what, for me, is a key construct in my understanding of the findings: that organisational principles and aims can either “collide, collude or connect” with professional identity (2010, p. 28).

The use of self and the importance of compassion

A connected idea is the “emotional dimension” of social work (Trevithick, 2014, p. 287). It has been argued that procedural and managerial approaches have led to defensive and conflicted practice, and created barriers to bringing the ‘personal’ into the ‘professional’ (Froggett, Ramvi and Davies, 2015). A key concept is the ‘use of self’, which research by Liechty (2018, p. 148) found requires openness, attunement

to others and emotional intelligence, and “results in professional capacities such as nurturing the social worker–client relationship, reflective practice, and practice wisdom”. With the growth of care management in adult services in the 1990s, however, the emphasis on the ‘use of self’ declined, with ‘social work’ rarely promoted as a resource or intervention in itself (Gordon and Dunworth, 2017). There are many emotional dimensions of practice and my interest has been particularly captured by the role of compassion in social work practice. Tanner (2020) proposes that compassion (the literal meaning comes from the Latin, meaning ‘suffering with’) is grounded in a shared understanding of being human and fostering connection. She argues that being compassionate moves beyond empathy as it creates a *desire to act*. Tanner highlights that care and compassion might appear to sit in opposition to rights-based practice, certainly if the former is mistaken for pity. I would argue that compassion, with its acknowledgement of shared humanity, drives social justice and a rights-based practice orientation and this is a lens through which I will explore some of my findings.

Tanner (2020) discusses some of the obstacles to compassion in social work, notably reinforcing the debate that neo-liberalism has sidelined relationships and emotions, and austerity has increased the need to restrict access to publicly-funded resources. This resonates with Hingley-Jones and Ruch’s concept of “relational austerity”, where professionally-informed practice “shrinks” to practice that is increasingly “combative rather than compassionate” (Hingley-Jones and Ruch, 2016, p. 237). Tanner describes how organisational cultures and procedures discourage social workers from becoming *too involved* with the people with whom they work, which creates distance and stifles engagement and compassionate practice. Key to her argument is that managerial cultures and procedures often impede relationships, discourage emotional connection and thereby create conditions for “othering”. This relates to the idea of defence mechanisms built into the system to prevent meaningful interactions with older people and with care homes, which I outlined in Chapter 2 and which I will now revisit.

Defences against anxiety

My understanding of the findings has also been aided by the psychodynamic construct of the defence mechanisms built into organisations to alleviate anxiety. As described above, effective social work is predicated on the importance of

relationships. This calls for social workers to incorporate an emotional and personal dimension into their practice. In the socio-political context in which contemporary social work operates, this can lead to significant tensions and can require “containment and control” and the employment of defences against anxiety (O’Connor, 2020, p. 646).

A psychodynamic lens illuminates how, at both individual and organisational levels, ‘protective’ layers are created to distance individuals from the pain and anxiety of the realities of practice, the lives of older people and their intersection with practitioners’ own decline and mortality (Dartington, 2010; Cooper and Lousada, 2018). In Chapter 2, I referenced the work of Menzies Lyth (1960) and explored how distancing and depersonalising mechanisms are used to help workers manage the fear, distaste and discomfort associated with illness, death and ageing, and, in the context of my study, care homes. This paradigm of “anxiety and the nature of defences against it”, which operates, for the most part, unconsciously, on many levels (organisational, institutional and personal), remains relevant despite the advances of the intervening years (Armstrong and Rustin, 2015, p. x). That said, Cooper and Lees (2015, p. 240) propose that the nature and source of ‘anxiety’ in public services has evolved due to the “cumulative waves of external pressure” associated with neoliberal policies and the marketisation of the welfare state. Richardson (2022) notes that care management was characterised by depersonalised approaches to social work practice. Yet, despite policy’s apparent abandonment of managerialism with the advent of the Care Act, Richardson contends that these approaches persist. This causes cognitive dissonances for social workers, when they are forced to work in ways that the system ostensibly claims it does not support. I will examine how this is evident in some of my findings and the tensions it creates. I will use this lens to expose the paradoxes in a system that professes to prioritise relational and strengths-based practices yet often obstructs these approaches, either intentionally or unintentionally.

I have foregrounded some key perspectives and will now examine the themes from my findings in relation to these perspectives.

A complex 'ecosystem'

To make sense of the findings, it is crucial to recognise the multiple and complex influences operating at a personal, professional, organisational and structural level. Bronfenbrenner's ecological system's theory was developed in 1979 to understand child development, but I have found some of the concepts helpful to unravel the interconnected nature of the research findings. Bronfenbrenner identified that people exist in a system of relationships, roles, activities and settings which are all interconnected, and he created a framework to identify the different elements (Shelton, 2019). He talked about a series of sub-systems (the microsystem, mesosystem, exosystem, macrosystem, and chronosystem). Crucially he supported a constructivist perspective: he maintained that the ecosystem has shared elements, which each individual constructs separately (Shelton, 2019). The metaphor of a Russian doll is frequently employed to describe the micro, meso and macro⁴² influences on the individual at the centre (Houston and Marshall, 2020). This understates how complex, interconnected and relational the layers are, particularly in the case of social work, where the personal and professional are enmeshed and multi-directional. Conceptualising social work and social care as an 'ecosystem', however, can be a helpful way to capture the complexity of the system (Burn and Needham, 2023).

It is important to bear these concepts in mind throughout the chapter and to recognise the various forces influencing and defining the social work role with care homes. I have developed a visual representation to aid in understanding these influences (with the caveat that its simplicity does not do justice to the complexity of the landscape). The diagram that follows illustrates how social work is situated within a number of overlapping organisational structures, predominantly the NHS and local authorities; these form part of the welfare state, which is shaped by the prevailing socio-political climate. Care homes are influenced by a regulatory regime, in which local authorities (often represented by social workers) and the CQC play a role. Care homes could be considered part of the welfare state yet sit within a mixed economy, shaped by structural socio-political forces. Many influences on the social work role intersect with the wider 'social work and care home' 'ecosystem'. This is an attempt

⁴² Micro - the individual level, meso - the organisational/group level, macro - the system/societal level.

to explain how the social work role with care homes is constructed predominantly by organisational priorities which are influenced by wider macro structures.

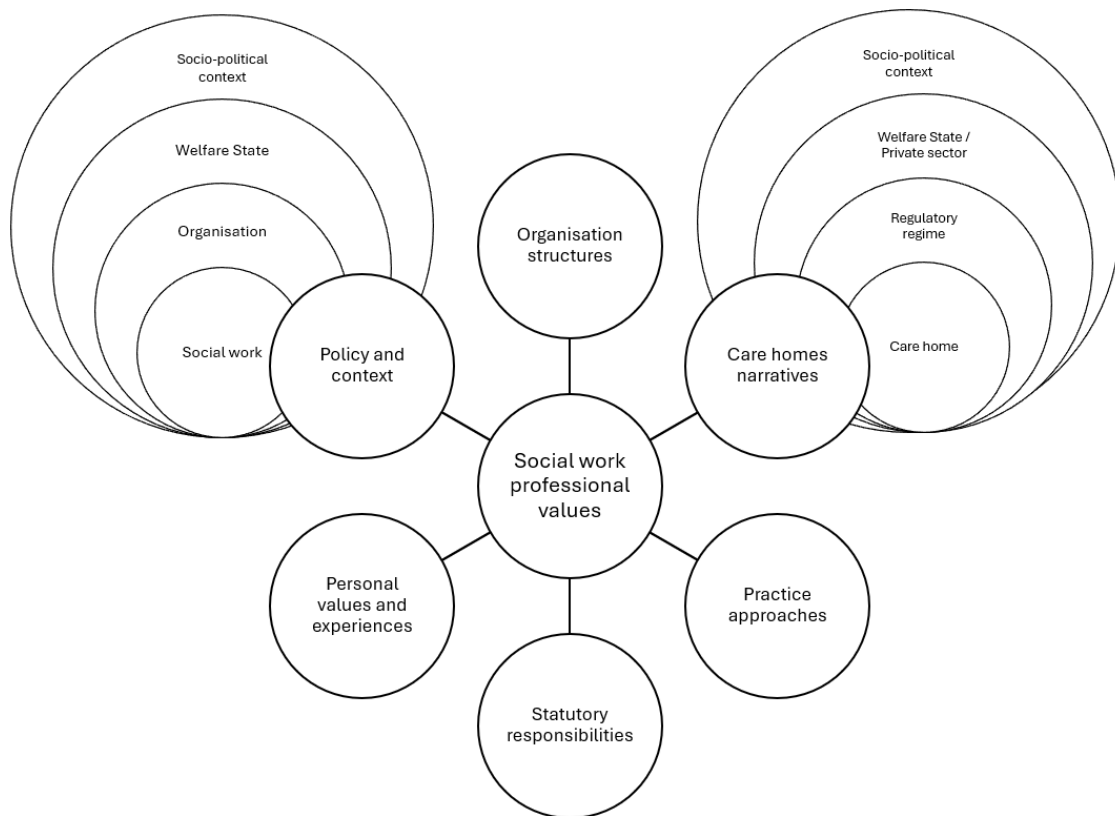


Figure 8 Influences on social work practice with care homes

Froggett, Ramvi and Davies' (2015) model (shown below) further explains the interdependence of personal, professional, organisational and structural elements. They use concentric circles to accentuate how personal, institutional and societal influences reinforce and modify each other. Their work is focused on the emotional demands of practice, which I will explore later, and which they suggest are shaped by context and by cognitive understanding and organisational imperatives. Policy, or societal narratives, influence the "relational climate" (2015, p.141) of the organisation which in turn impacts on the behaviours and actions possible within it. Professional influences are not explicitly mentioned in this model, although the authors' acknowledge the distinct relationship between the professional and the personal in social work practice.

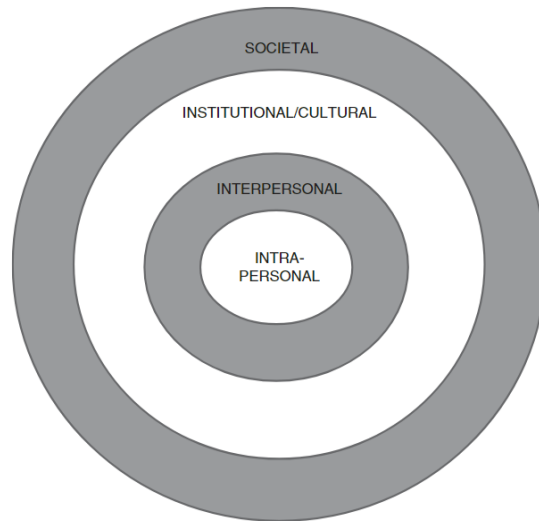


Figure 9 Interdependent dimensions of psychosocial experience (Froggett, Ramvi and Davies, 2015, p.141)

Structural ageism

Throughout this thesis, and principally in Chapter 2, I have argued that ageism is structurally embedded in multiple ways in UK society, including within welfare systems. It is instructive to explore the relationship that social work has with ageism. Despite the profession's value-based commitment to challenging and addressing discrimination and injustice, in a neoliberal context associated with managerialism, social work is more often associated with 'case throughput', 'managing eligibility' for services and rationing resources (Hastings and Rogowski, 2015). One consequence is that broader issues such as recognising and challenging ageism are downplayed or simply accepted as 'part of the system'. Ageism was explicitly mentioned in my findings. That said, participants' comments often demonstrated how ageism is subtly ingrained and reinforced in structures and systems; this makes it harder to challenge on an organisational or on a practice/professional level. One example is Kim's acknowledgement that she 'can spend more time' with older people with diagnosed mental health needs as they are considered 'more complex' than 'ordinary' older people.

Likewise, the managers' focus group discussion acknowledged that the way adult social care is funded and resourced colludes with ageism; an example given is insufficient local authority funding for the weekly cost of a care home place. They also noted that ageism is rarely challenged in the same way as other forms of

discrimination, with one participant referring to “casual ageism”. Ageism is hard to dismantle and challenge when it is built into the fabric of ‘the system’ at a meso and macro level and finds its way into social work practice.

‘Casual ageism’ appears to be more tolerated than other forms of discrimination: it is hidden in plain sight. This is compounded, from a social work perspective, by the limited focus on older people in pre-qualifying education. As discussed in Chapter 3, and reinforced in the focus group findings, social work students rarely *choose* to have their placements working with older people (Richards *et al.*, 2014; Goel, 2019). Despite older people, particularly in care homes, representing one of the most vulnerable groups of people in UK society, they are often marginalised in local authority practice, provided with lower quality services and, as the next section will explore, rarely given specific attention from social workers. The undercurrent of ageism is omnipresent in the macro, meso and micro domains of UK society (Milne, 2020) and needs to be acknowledged as it has a powerful, albeit unwitting, influence on practice.

I will turn now to consider the organisational influences on practice (a common theme across all the findings) and their impact on how the social work role with care homes is constructed.

Social work role in care homes: organisational imperatives

Organisational imperatives drive the shape and nature of the social work role with older people. This applies broadly but the care home context adds an extra dimension of challenge and complexity. In this section, I will consider how there is a lack of clarity in defining social work’s role with care homes. The findings suggest that organisational structures encourage a primary focus on reactive or statutory work and limit social workers’ long term involvement with care homes and the people who live in them.

Involvement dependent on task

Despite the scope for social workers to support the needs of older people in care homes, my review of the literature in Chapter 3 identified that there is limited room for this within current local authority structures and the neoliberal socio-political environment in England. The limited research on the topic underscores that social

workers tend to intersect with care homes at points of crisis or in respect of statutory tasks such as reviews or safeguarding (Manthorpe and Martineau, 2017; Higgs and Hafford-Letchfield, 2018). This was undoubtedly echoed in my findings. The evidence from across the focus groups and interviews suggests that social workers rarely have ongoing or long term engagement with people in care homes. Participants described social work responsibilities and tasks in relation to care homes as largely focusing on moving people into care homes, undertaking placement reviews, Court of Protection work and/or safeguarding. These statutory tasks were vividly referred to in one interview as “the big hitters”.

The findings indicated that there was no consistency in how roles (and teams) were organised in different local authorities and that no universally defined model exists for social work with care homes. Social work involvement appears to be dependent on the ‘task’ or the function required by the state, or less commonly, the care home. It was generally understood that there needed to be an organisationally defined, often procedural, *reason* for a social worker to be involved, encapsulated in the comment in Chapter 5 that “we are allocated, we do the review, we give our recommendation and then generally the case is closed”.

It was also noticeable that, despite identifying the task of moving people to care homes, participants rarely described *how* they did this or what this actually involved. Important ‘practicalities’, such as bringing people their belongings, were often overlooked as it was unclear whether this was a social worker’s responsibility. This is interesting since much of the literature about social work and care homes focuses on *transitions* to care homes. It appeared that there is minimal support from social workers for people when they move to care homes, particularly if they move from hospital or in a crisis. Participants tended to indicate this was seen (by managers or the organisation, not necessarily by social workers themselves) as a functional *task* (‘placing’ someone) rather than as a *process* that requires ongoing support to manage the emotional and psychological dimensions of the transition for the older person and their family. This speaks to the managerialist perspective referred to above. It is also reinforced by recent work on older people’s admissions to care homes which argues that “organisational and/or funding priorities” often take precedence over supporting the older person “emotionally, practically and socially” during the transition (Milne *et al.*, 2024, p. 9).

It was also noticeable that participants rarely spoke about people *dying* in care homes; instead the focus was on supporting people to live a good life, as far as this was possible. It was the 'palliative care' social worker from the focus groups (Rina) who primarily talked about loss. Reflecting on the literature from Chapter 3 about palliative care social work, this highlights that it holds a different space within social work. For example, I reported in Chapter 5 how Farzana mentioned hospice social work with the caveat that "obviously their work was slightly different because they were working with people with end of life". Perhaps this is connected to a tacit understanding that, if older people in care homes are considered to be 'at the end of their lives', then they should receive better treatment, which the current system cannot sustain. This is further support of the idea that older people in care home at the end of their lives are hidden in plain sight.

Involvement dependent on context

An additional perspective from recent research, to which I referred in Chapter 2, might also be relevant. According to Tucker and Webber's study (2021, p. 553), social workers typically defined their jobs based on "where they operated" rather than the tasks they performed. The existence, for example, of 'hospital' or 'mental health' social workers is widely acknowledged, but the roles and tasks that social workers undertake with people in care homes are rarely defined by context. Despite roles for social workers existing in several 'institutional' contexts such as hospitals, hospices, schools, and prisons, the 'care home social worker' role does not appear to have gained traction. This suggests that the potential role for social workers in this setting is overlooked and not valued. It may also account for social workers rarely 'crossing the boundary' into the care home from the community or hospital setting if that is where their roles are based.

Notably, participants' accounts suggested that older people do not have *consistent* access to the skills, oversight or support from social workers. This mirrors Manthorpe and Martineau's (2017) work analysing thirty-eight SCRs⁴³ involving older care home residents in England, referred to in Chapter 3, which found that social worker involvement with care home residents is marginal. More importantly, the study suggested that excluding social workers from involvement with care home residents

⁴³ See Chapter 3 p. 63 for explanation of SCRs

may contribute to failures to identify, minimise and/or respond to abuse or neglect. The absence of a clearly defined role for social workers in care homes is both an indicator of, and a contributory factor to, the invisibility and marginalisation of older people in care homes. It underscores how organisational structures appear not to prioritise older people in care homes as a group, or the relationships and continuity necessary for person-centred, strengths-based social work practice. It also adds weight to the argument that current social work roles do not connect social workers with care homes organisationally (Manthorpe and Martineau, 2017). My findings suggested that this was often the case both physically and figuratively and, as I will discuss in following section, there are multiple factors which contribute to this.

The barriers to social workers connecting with care homes

I have maintained throughout this thesis that society’s and individuals’ perceptions and understanding of care homes have a significant impact on how social workers work with older people in care homes. Coupled with social work’s underpinning commitment to the importance of relationships, building connections and fostering belonging, this leads to multiple tensions in the context of care homes. I will explore some of the dissonances, which often create barriers to relationships and impact on social work practice with care homes, before moving on to explore what the findings suggest may help to overcome these barriers.

I found it helpful to represent the barriers in a simplified table to provide an overview, upon which I will elaborate.

Barriers	Details
Structural	Ageism Socio-political policies (managerialism) Status of care homes
Organisational * *the influence of the organisation on the individual	Organisational structures and processes Care homes – places of safety or failure Priorities and workload Commodification of care Defences against anxiety

Care homes	Access Institution vs 'home' Staff feeling judged Regulatory framework
Professional	Expectations on the role Social work 'orientation'/value base Experience and knowledge of care home
Personal	Ability to connect with care homes Ability to withstand organisational constraints

Table 5: Barriers to connecting with care homes

This table does not show that these multiple barriers are complex and often interconnected.

Organisational expectations and narratives of care homes

I have discussed elsewhere the dominant discourse, partly driven by policy's emphasis on 'ageing in place', that older people should be encouraged to live at home independently for as long as possible. The consequence of this is that, in a system beset by financial pressures and resource constraints, social workers only tend to support publicly-funded older people to move to a care home in a crisis or as a 'last resort' (as previously noted, self-funders generally find their own placements with the help of family members). This not only reinforces the narrative that moving into a care home is a 'failure' but it positions the care home at the end of the care continuum, after all efforts to support someone in 'the community' have been expended. This was poignantly articulated in one interview through the image of the older person "safely tucked up in the care home". That person will then never be considered a priority over someone waiting to be seen at home or in hospital. It was notable that participants commonly talked about care homes as the 'best place' to keep someone 'safe'. This is interesting in light of one participant's suggestion that few social workers see moving into a care home as a "constructive or positive" choice. For example, in Focus Group 3, Amy reflected that if the 'goal' is to keep people at home, social workers feel they are 'letting people down' if they

have to go to a care home. Perhaps social workers reflect the 'failure' narrative, feeling, at best, ambivalent about moving people into care homes and, at worst, that they have failed to keep the older person at home. The idea that people are 'safe' in care homes can also be considered a defence mechanism: it is easier to rationalise that people are 'safe' in care homes and no longer need social work input if they are 'out of sight, out of mind', but it fails to address what is actually meant by 'safety'. It supports the local authority system which needs social workers to 'move cases through' quickly and focus on people in the community. It is evidence of an overstretched system, and the narrowing of the social work role, where the discourse of risk and safety is prioritised over well-being, choice and relationship-based practice.

In the focus groups, some participants gave examples that underlined how care homes can be a positive choice and the best option for older people in some situations. These examples were often given by participants who worked with care home residents over a longer period of time which allowed them to see the potential for positive outcomes. It was also suggested that care homes could provide better quality of life *compared* to the alternative at home, especially when there are limited community resources (Böckerman, Johansson and Saarni, 2012). However, on occasions, it seemed that participants were reframing the admission to a care home as the best option for older people to alleviate their *own* anxiety.

Another noticeable concept was that care homes are 'ok' if the older person 'no longer has capacity'. Several focus group participants expressed the view that they would only "choose to live in a care home" if they 'lost capacity'. Despite understanding the principles of the Mental Capacity Act (2005), specifically the importance of respecting the person's "past and present wishes and feelings" (2005, s4(6)(a)), social workers were seemingly able to 'other' people without capacity. This runs counter to the legal judgement which reinforces the fact that capacity is not an on/off switch (Wye Valley NHS Trust v B, 2015). Participants' comments often reflected how many people, including social workers working with older people, find it hard to imagine being frail and dependent and needing a care home (Lloyd, 2010). This may lead to the tendency to dehumanise people living with dementia, which creates a disconnect between personal and professional perspectives and values. It reveals the paradox of openly claiming to uphold the older person's wishes whilst at

the same time 'othering' people who may lack capacity to make a decisions about going into a care home. It again shows the subtle influence of ageism which isolates old age from other life course stages and experiences (Milne, 2020). It may yet be another illustration of the defence mechanisms people unwittingly use to manage uncomfortable feelings.

Losing the person

The idea then that people in care homes are safe or that the decision to admit them is 'ok' because they no longer have mental capacity are mechanisms which reinforce the institutional status of care homes as places of last resort. It underscores the function care homes serve in society, which, as Ritchie suggested, is to keep older people at the end of lives 'out of sight' to protect the rest of us from confronting our own decline and mortality. This reinforces the tendency to "forget" people when they move to a care home: they become out of mind as well as out of sight. I reported across both sets of findings that organisational pressures and priorities in local authority social care environments can lead to 'the person' being lost. A care management approach, which limits social workers' capacity to form relationships with the older person, further exacerbates this (Richardson, 2022).

In applying a psychodynamic lens, it can be argued that organisational structures are intentionally set up to compartmentalise tasks and roles, as this aids throughput, albeit temporarily. The interviews provided examples of how one social worker might move someone to a care home, another would complete the initial review after 6 weeks and a different social worker again would undertake the annual review, or undertake any safeguarding inquiries. This supports system throughput by containing an individual's workload, but inhibits the development of relationships. It is also easy to miss what is important to the older person when there is no continuity. This is powerfully articulated by Tina describing how people move to care homes without their belongings, as it is 'nobody's responsibility' to collect these or it has been forgotten in the rush to move the older person.

I would argue that the system creates structures which act as defences and which may become barriers to social work engagement with older people; depending on one's perspective, they have intended or unintended consequences. Cooper and Lees (2015), for example, describe how the anxiety created by failure in a

performance culture can lead to defensive organisational and professional practices. These prioritise protecting professionals over concern for the individual and this manifests in dehumanising practices.

It was interesting to note, particularly in the focus groups, that the prompts guided participants to talk about older people in care homes, yet they often chose to focus more on *care homes* than on *older people*. Participants demonstrated that they understood that people living in care homes are generally very old, frail and dependent, yet they rarely explicitly mentioned this. There could be several reasons for this. One explanation is that they habitually work with older people and therefore took their characteristics for granted. It is possible that the research topic prompted them to specifically focus on care homes. It could also be connected to a reluctance to confront the realities of working with this population and the unconscious defences at play which allowed them to 'lose' the individual.

Language

This perspective of 'losing the person' is amplified by dehumanising language, which is often ingrained into health and social care systems. For example, NHS England (2016) defines people who no longer need hospital care but who have care needs as "clinically optimised". The language of 'placing' people in care homes, who then become 'residents' is another example and one that is rarely questioned. This has been linked to infrahumanisation, a construct which strips a group of people of "being fully human" (Milne, 2020, p. 189). Milne (2020) argues that infrahumanisation is amplified in groups of people who share a common feature of 'failure' or who are viewed negatively. It is entwined with society's distaste and fear and is used as a defence mechanism. Most significantly, she argues that it is apparent in the language and metaphors that are used to describe frail older people with dementia, especially if they live in care homes.

I highlighted examples of dehumanising language in the findings chapters: for example, older people referred to as "cases" and who were 'placed', "dumped" and "DoLed". The effect of this language is that it, albeit often unwittingly, creates a defence - a protective layer - between the older person and the social worker. This is exemplified by Tina who comments how 'people' become 'objects' – they are 'just a placement' or a 'bed blocker'. Several participants noted that this language was at

odds with approaches promoted in the local authority and by wider policy but that this tension was rarely discussed.

Commodification of care

The concept of commodification of care is also important. The value placed on money and time reduces care provision to a series of functional or practical tasks and encourages service providers to view care “as a commodity” (Lloyd, 2010, p. 193). This approach prioritises tasks over the less visible dimensions of care, like relationships and connectedness. This was starkly evident in Jon’s interview. While he attributed good practice to being able to spend more time with people, he did not make the connection that this enabled the development of relationships. Similarly, it is striking that while he rationalised that assigning one worker to a care home would allow the development of relationships with staff and residents, he was anxious that this would create extra work, a problem when time is a commodity. Similarly, Tina acknowledged that her suggestion for a designated social worker to support people moving into care homes might horrify her manager as it would cause problems managing ‘throughput’ in the system. It is these less visible aspects of care, however, such as the benefits of maintaining a relationship with a social worker, which older people identify as important to them (Tanner *et al.*, 2023).

Mismatch of expectations on social workers

A recurring theme in the findings was the way organisational constraints undermine policy approaches and the principles that guide social work practice. This is consistent with earlier research: for example, according to Scourfield’s (2015, p. 922) case study, the requirement to complete care home reviews “as expeditiously as possible” limited practitioners’ ability to engage with the older person and explore pertinent issues. The findings highlight the often unrealistic expectations on social workers. Jon’s description of what he expected social workers to achieve in a single visit is largely unachievable and undermines relationship-based practice. Several participants worried that they did not have the time, resources or flexibility in the role assigned to them to build the relationships necessary to deliver good quality practice. This was compounded by the wider constraints in the system which often presented ethical challenges, especially when social workers felt that people’s rights were not being upheld.

It is important to remember that the research took place as society was still experiencing the unprecedented effects of the Covid-19 pandemic. At the time of writing, society's tectonic plates continue to shift and arguably inequalities are becoming more entrenched and resource pressures are increasing. This creates a real tension between what social workers are expected to do and what they want to do. Many of the participants' accounts demonstrated their commitment to rights-based practice. They also described the emotions they experienced when they were unable to work in this way or when they recognised that people's rights were not being upheld. Tina and Julia's interviews are rich in examples of the anger and, at times, shame they experienced when they witnessed people's rights being violated. For example, Tina described people waiting *months* before their belongings were brought to them when they moved to a care home: she called this out as 'neglect'.

In Chapter 3, I referred to Wong's (2021) study, which found that social workers working in care homes considered advocacy to be a key part of their roles. She argues that the legitimacy of social work's advocacy role is strengthened by the ageism that older adults experience. Notably her research showed that social workers tended to describe their roles by values rather than tasks. This was also noticeable in my findings. Participants' aspirations for the role demonstrated the importance of advocacy and promoting people's rights, yet they talked about the many constraining influences which hindered them. Ultimately this led to a tension between what they wanted to achieve and what they could achieve: between their values and the roles they were expected to perform.

Organisational priorities for social work

It is interesting to speculate what the roles that *do* support people in care homes might be telling us about organisational priorities for social work. As discussed earlier, overwhelmingly the roles that people described, and the tasks that they were mandated to undertake, revolved about statutory functions, such as reviews. In my findings, roles that encouraged social workers to engage specifically with older people in care homes were created to meet organisational needs for oversight and quality assurance, not because organisations recognised the value of gerontological social work. The importance of specialist social work with older people was conspicuous by its absence. This omission undermines social work practice, aligns with ageist discourses and, as I will discuss later in the chapter, ignores the expertise

and knowledge required to support a complex and diverse population who have ongoing needs for social work input.

All this is evidence of the schism between the professed importance of strengths-based, relational approaches in social work and the reality of the narrow social work role in under-resourced, target driven, fractured public services. Many participants emphasised the importance of working in a person-centred and strengths-based way, but they achieved this as a 'by-product' *in spite* of the system. The churn of work, organisational priorities and other barriers made this very difficult and highlighted the disconnect between policy aspirations and practice demands. I will explore how social workers reported managing these tensions later in the chapter.

Relationships with care homes

Another dominant theme across the findings was the importance of relationships and the multiple barriers to developing and sustaining those relationships. In this next section, I will examine the factors influencing social workers' relationships with care homes. I will concentrate on relationships with care home *staff* because, as I will discuss, they can be a barrier or an enabler to social workers' relationship with the older person. I reported across the findings how social workers recognised that collaborative relationships with care home staff supported them to carry out their work, enabling them, for example, to access information and gain an accurate picture of the older person's life in the care home. There were, however, numerous barriers to building those relationships.

Understanding care homes

A significant finding was how societal narratives about care homes, alongside stereotypes driven by the media and social workers' personal values and attitudes, have a strong influence on social workers' perceptions of care homes. The engagement and interaction they have with care homes as part of their role further influences their understanding of the complex environment. The findings suggested that social workers whose roles regularly connected them with care homes had a more nuanced appreciation of the setting than hospital or locality social workers who were more like to 'dip in and out' (as described by one participant).

I observed that social workers whose roles involved limited interaction with care homes appeared more susceptible to stereotypical narratives of care homes and found it harder to look beyond surface impressions. This is consistent too with the evidence I explored in Chapter 2, which indicates that there is a gap between public and media narrative attached to care homes and what it is actually like to live or work in one. This may contribute to the tendency to ‘other’ older people (as noted above) and fails to acknowledge the reality of supporting frail, dependent older people. Some participants described care homes with reference to their unpleasant smell; others showed a more nuanced understanding as they discussed how carpeted rooms create a homely environment but leave odours when someone is incontinent. This discussion reflected an understanding – albeit unwittingly - of the paradox of “home-like institutions” (Börjesson and Torgé, 2021, p.3) and how the concept of a ‘home’ may be at odds with the reality of a care ‘facility’ or institution.

Social workers who had spent time in care homes had a richer understanding of the environment. Conversely, it was clear that many social workers had insufficient time or knowledge to do the ‘job’ properly and did not understand the environment that they were working in. All this ultimately has an impact on social workers’ ability to build relationships with care home staff. Given the importance of reciprocity in relationships, it influences care home staff’s perceptions of social workers and therefore their openness to building relationships, which I will shortly explore.

Accessing care homes

In Chapter 2, I discussed the institutional origin of care homes and considered the barriers to permeating their boundaries when they remain “situated geographically and metaphorically ‘off the public radar’” (Anand *et al.*, 2022, p. 805). The pandemic reinforced and intensified these barriers, although it was interesting that the Covid-19 context was rarely mentioned by participants. It was, however, evident from the findings that social workers experienced difficulties getting into care homes or gaining information. Participants gave multiple instances of being seen as a ‘nuisance’, or of their arrival causing panic and fear; one participant’s description of the anxiety caused when she turned up without an appointment is a good example of this. This underscores the status of social workers as ‘visitors’ and conveys how social workers are perceived by the care home.

Social workers' limited role in care homes positions them as 'outsiders' and this hinders them from doing their work. On a basic level, some participants talked about not knowing their way around the care home or who to ask for information. It can cause social workers concern if they do not know what is 'going on' in the care home, which is further exacerbated by misconceptions about care homes. This becomes problematic when, as discussed earlier, social workers' main responsibilities are focused on statutory tasks linked to scrutiny and oversight. It means that, as one participant put it, social workers are seen as "the bad guys". This leads to the 'them' and 'us' dichotomy between care home staff and social workers, to which I referred in the findings.

Indeed, the notion that care homes feel worried or defensive about 'opening their doors' was prevalent across the findings. There are multiple reasons for this. The role that social workers are perceived to have and the bureaucracy prioritised by managerialist approaches are more likely to make staff feel they are being 'judged' or 'examined', particularly in the absence of positive relationships. This is epitomised by one participant imagining care home staff saying "ooh, the social worker's coming!" Many participants referred to the fact that social workers are perceived as just 'ticking boxes'. Inevitably, one of the main consequences of this is that the older person in the care home is not the main focus. To counteract this, participants discussed the importance of getting to know the care home and having a presence, which helped develop relationships with staff. This helped to build trust - perhaps by confirming that social workers are "doing things for the right reasons" (Adam) - and overcome defences. Staff were then more likely to be honest about their concerns about residents and less likely to 'gatekeep' information. Most importantly, this then helped social workers to develop better relationships with care home residents.

A vicious or virtuous cycle

This ultimately suggests that multiple factors either hinder or facilitate relationships between social workers and care homes, which in turn creates a vicious or a virtuous cycle. This is encapsulated in the following visual representation I have developed:

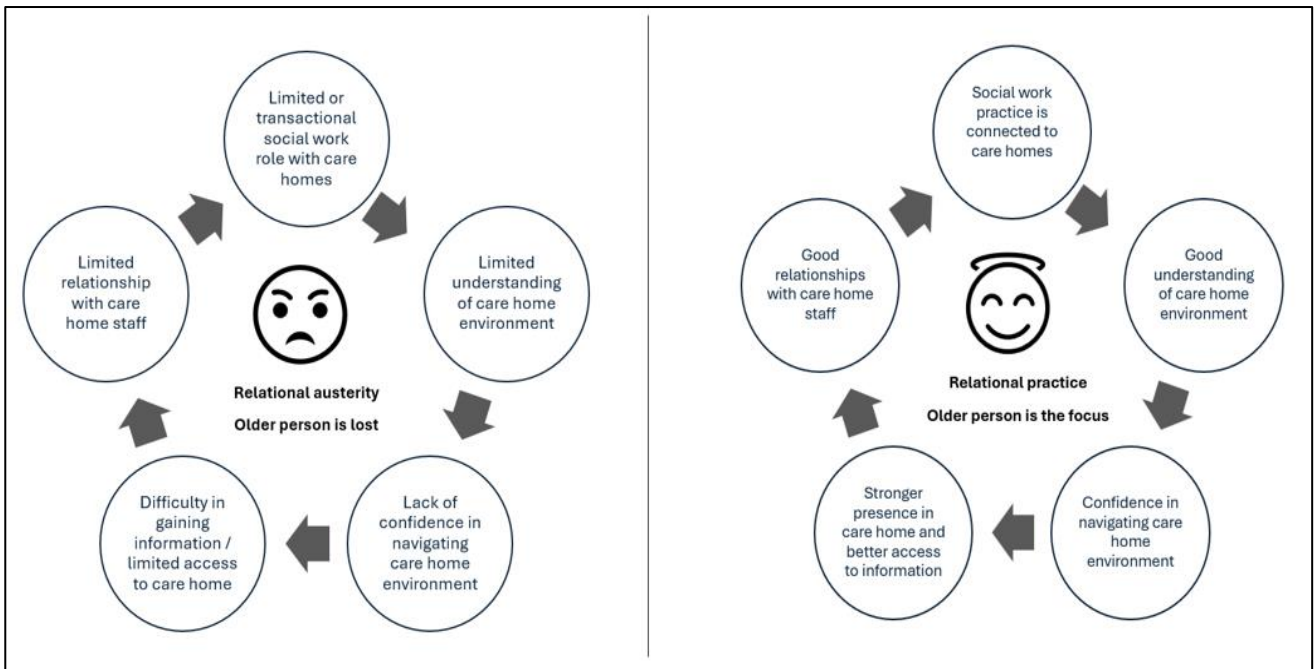


Figure 10 Vicious and virtuous cycle

In summary, when social workers were in roles that connected them to care homes, they were able to gain a better understanding of the environment, which developed their confidence in navigating the complex terrain. This put them in a better position to develop good relationships with care home staff, which created trust, and mitigated to some extent the dichotomy of ‘them’ and ‘us’. It helped to break down staff’s misconceptions or anxieties about social workers and therefore allowed them to work together to support the older person.

A balancing act

The notion of being an insider or an outsider merits further reflection. The preceding section considered how social workers’ ‘outsider’ or ‘visitor’ status creates challenges in permeating the care home’s boundaries. However these barriers would not simply be overcome if social workers achieved ‘insider’ status, that is, were part of the care home. This overlooks the inherent tensions, which I have previously discussed, at the heart of the social work role. As currently conceptualised, social workers have an organisational quality assurance role and a professional commitment to upholding people’s rights. To fulfil this role, they must navigate the constraints of the current system, where care home staff often ‘gatekeep’ information about, and access to, the older person. This requires being able to probe and

challenge. It reflects the image of social workers as a 'nuisance', which is a way of being seen *and* having a role. I would suggest, then, as reflected in the findings, that social workers need considerable skill to balance building positive relationships with care home staff, while maintaining appropriate distance to allow them to undertake their professional role which may involve scrutiny or challenge. They need to straddle the insider/outsider divide and balance connection and understanding with professional authority and distance.

Belonging and connection

Before I move on, the intersecting concepts of 'belonging' and 'connection' merit brief consideration. They were prominent themes in the findings and are intrinsic to the theme of relationships and the preceding discussion. While social workers are the main focus of this discussion, it is important to remember that the concepts of belonging and connection are ingrained in what people who draw on care and support want⁴⁴ (Social Care Future, 2024). 'Belonging' is defined as:

“a feeling of being happy or comfortable as part of a particular group and having a good relationship with the other members of the group because they welcome you and accept you” (Cambridge Dictionary, 2024).

A closed institutional environment and the physical difficulties in gaining access may prevent social workers from feeling that they 'belong' or are part of the care home, which was certainly evident in the findings. Viewing this through a psychodynamic lens might help to explain the complex relationship social workers have with care homes, and indeed care home residents. At the start of the chapter, I introduced the idea that shared humanity fosters connection and creates compassion (Tanner, 2020) and I argued that this can support social justice and rights-based practice. Lloyd (2010, p. 197) argues that “vulnerability and dependency are inherent in the human condition” and when working with older people in care homes, perhaps the latter aspect of the human condition dominates. This supports the argument that fear of one's own inevitable frailty and not wanting to 'end up' in a care home creates an

⁴⁴ Social Care Future is a movement, driven by people who draw on care and support. Their vision is for everyone to “live in the place we call home, with the people and things that we love, in communities where we look out for one another, doing the things that matter to us”.

ambivalence about being involved with care homes and further embeds the image of care homes as being on the margins of, and thus not connected to, society and community. Organisational priorities and procedures which discourage social workers from becoming ‘too involved’ or connected with care homes create an additional barrier. It is undoubtedly harder to feel compassion for someone when they are hidden away and you have little to do with them (Tanner, 2020). This creates tension for social workers given their professional motivation to improve people’s lives (Symonds *et al.*, 2018).

The professional self

In this next section I will examine where social workers feel they ‘belong’ professionally, the tensions this creates and how social workers manage these tensions.

Commitment to social justice

In the findings chapters, I noticed that many participants focused on supporting the rights of older people in care homes; this focus was often on protecting individuals’ rights rather than campaigning more broadly for social justice. This reflects the concept of ‘big and small’ social justice to which I referred in Chapter 2. The quest for social justice (or systemic change) often led to feelings of frustration, anger and sadness in participants. Others demonstrated that their social work values were directed towards achieving outcomes for individuals, which allowed them to enact social justice on a smaller scale by protecting individual rights. Social work’s commitment to social justice is arguably where practitioners’ personal and professional value bases coalesce and it was certainly the case that participants’ emotional responses were often rooted in their commitment to social justice. Many participants experienced powerful emotions when they perceived that care home residents’ rights were breached or their needs were not being adequately met. There could be various factors or perspectives influencing these reactions and I will consider two that stood out.

The findings suggested that social workers who were more connected to care homes were more emotionally engaged and less likely to dehumanise the older person in the care home. They were more able to ‘see’ the person and wanted to act to champion their rights, which suggests that *compassion* is the driving force behind

social workers' perception of injustice. This was evident in many examples from the interviews. For example, Tina's fury when she gave examples of individual older people without access to their belongings, Carla's persistence in advocating for the retired journalist to go out to buy his preferred newspaper and Kim's outrage that care home staff could view a resident's hospital appointment as an 'outing'. In these instances, social workers appeared to show compassion for individuals' situations, which motivated them to want to act and advocate for them.

Conversely, when social workers had less contact with care homes and with older people living there, they appeared to conceptualise the importance of advocacy in a more abstract way. This was filtered through a social justice lens of supporting a homogenous group of people affected by the inadequacies of the current system. This speaks to the perspective that the value of social justice is prioritised over psycho-social support for people in 'institutions'. In this instance participants were motivated by thinking about structural inequalities and injustices, rather than by compassion for the individual. For example, several participants lamented how social work involvement is limited to just one review a year and others expressed hopelessness and frustration at the challenges in a system that does not adequately provide for older people's needs. Social workers often felt angry or powerless to act, perhaps because large systemic change is harder to achieve than smaller outcomes for individuals.

I noticed that while social workers talked about social justice, they rarely considered how it was operationalised, suggesting that it is woven into their values and practice. This also reflects the findings from an older qualitative study which concluded that social workers rarely used 'social justice terminology' to talk about their work (Hawkins, Fook and Ryan, 2001). It was also notable that participants often struggled to reconcile the importance they attached to social justice, and the feelings this evoked, with organisational priorities and the (often procedural) expectations of the role. This was further exacerbated by a perceived disconnect between policy and practice, leading to organisational constraints undermining professional practice approaches. I demonstrated in the preceding chapters how participants highlighted the tensions of being part of the 'system' whilst at the same time striving to challenge

its shortcomings and protect people's rights and I will explore this topic further in the next section.

The tensions in professional identity

In Chapter 2, I articulated the inherent paradoxes at the heart of the social work role, alongside the competing yet interlocked 'orientations' on the 'care and control continuum' which contribute to the elusive nature of social work's professional identity. There are also tensions in reconciling the values of professional social work alongside the demands of working as an employee (Parker and Doel, 2013). Certainly the multiple tensions experienced by social workers in carrying out their professional roles, and the disconnect between their personal values and the requirements of their role, were a strong feature of the findings. This was captured poignantly by Rachel when she described how one day she realised that she had become part of the system like a "horse that had been broken in". It was noted that social workers are "part of the local authority" and this constrains what they do and how they work, and others reflected on the discomfort they experienced in being 'an agent of the state'. This posed less of a problem for the participants working for the voluntary sector, although the tensions still resonated with them and rippled through the whole system as they discussed how it impacted on the way social workers are generally perceived.

In thinking about professional identity and the role social workers play as agents of the state, Lipsky's framework of street level bureaucracy, to which I referred in Chapter 3, merits consideration. Lipsky proposed that public servants such as social workers (who he dubbed 'street level bureaucrats') exercise discretion in the delivery of their duties. He postulated that, faced with a lack of time, information or resources, they often interpret rules and develop strategies to manage the difficulty of the work and allocate scant resources (Lipsky, 2010). Social workers then, as street level bureaucrats, are in a position to either reproduce or disrupt policies through their decision-making. Moreover, while policy and organisational contexts guide individual practice, the implementation of individual decisions also shapes agency policy, and feeds back into the culture of practice. There was a strong undercurrent of this in my findings. This also reflects Scourfield's (2015) case study, previously mentioned, which suggested that organisational context influences how problems are perceived

and how solutions are framed. Practitioners are also influenced by their managers and the culture of the organisation.

It is also interesting to revisit Webber and Tucker's (2021, p. 559) research, which found that how social workers undertook their roles was usually informed by the priorities and requirements of the agencies where they worked. However they also found that social workers' "professional self", that is, their professional value base, sometimes supplanted their employers' expectations. This suggests that social workers sometimes flex their professional identity *despite* the dictates of the organisation.

I have discussed several tensions that emerged in the findings. What is interesting is the different ways that social workers found to *manage* these dilemmas. In the next section, I will focus on what helped social workers overcome some of the challenges, before exploring more generally, and with reference to the above ideas, how social workers' professional and personal approaches would seem to either collude, collide or connect with organisational expectations and practices.

Overcoming the barriers

Thus far I have discussed how structural and organisational constraints create barriers to social work practice with older people in care homes; these barriers are often aggravated by narratives associated with care homes and their positioning in society. That said, the findings clearly identified that social workers were finding a way to do excellent, skilled social work practice *despite* these barriers. This was often taking place amidst the procedural tasks mandated by their employer and their statutory responsibilities and was not always counted or recognised by the 'system' or by social workers themselves. There were several factors that supported social workers to do their best and navigate through the challenges.

Craft knowledge, experience and discretion

As already mentioned, it was often their knowledge and understanding of care homes that enabled social workers to build relationships and undertake their roles more effectively. It would, however, be an oversimplification to describe this knowledge as merely 'knowing about' care homes. Instead it is helpful to dissect this through the perspective of Trevithick's (2008) work on social work's knowledge base. Trevithick argues that while social work may have struggled to demarcate an

exclusive knowledge base, it is a “highly skilled activity” (2008, p. 1212) requiring a composite of theoretical, factual and practice/personal knowledge. Given the complex problems that social workers encounter, they must develop “knowing how” (2008, p. 1214), that is the ability to put knowledge into practice. This practice knowledge draws on personal knowledge, confidence and experience. The concept of professional ‘know how’ is prominent in nursing literature, where it has been termed ‘craft’ knowledge (Titchen, 2000). ‘Craft’ is defined as “something produced using skills and experience” (Cambridge Dictionary, 2023). Within my research, I would argue that craft knowledge allowed social workers to draw on their experience to skilfully navigate the complexities of working with older people in care homes.

It was noticeable that experience and knowledge (particularly in relation to care homes) combined to support social workers to feel confident, and this in turn allowed them to exercise discretion in their work. This resonates strongly with the recent SWOP Project research, referred to in Chapter 3, which identified that social workers require specialist knowledge and expertise to work effectively with older people (Tanner *et al.*, 2023). There are many examples in the findings of social workers confidently and skilfully exercising discretion to overcome barriers. This often involved building relationships and making connections, or it involved feeling confident to bend the rules to achieve the outcome required. For example, having the confidence to enter the care home when they are not expected - “you know what, I’m just going to speak to the person. Let me know when you’re free” (Zara); or Tina using the opportunities from her statutory role to bring people’s belongings from their own homes.

It was noticeable that participants with experience, particularly of working with care homes, often demonstrated greater confidence in using their discretion to counteract narrow managerialist practices. This reflects findings from research which explored the tensions for practitioners of balancing older people’s needs against organisational and procedural frameworks (Olaison, Torres and Forssell, 2018). The study explored how social workers interpret and apply ‘rules’ and use discretion to manage in the context of resource constraints and found that those with more experience seemed able to manage difficult situations in a “more pragmatic way” than those with less experience (2018, p. 161). More experienced social workers were more inclined to use discretion, deviate from “guidelines” and were more

realistic about what they could achieve. The research also explored how the lack of clarity about social work's professional role often afforded flexibility to more experienced practitioners to exercise discretion (Olaison, Torres and Forssell, 2018). There were some features of this in my findings. While some participants were constrained by the tasks they were mandated to do, others identified that the versatility inherent in the social work role allowed them to justify getting involved or at least influenced *how* they were involved. I will explore what might influence these different approaches towards the end of this chapter.

Bringing yourself to the role

I want to revisit the concept of 'use of self' and how it might support social workers to mitigate procedural approaches in practice. Froggett, Ramvi and Davies (2015), writing about the value of teaching social work students about 'use of self', argue that the strict parameters of managerial practice impinge on relational work. This can lead to misalignment between "practitioners' expectations of what 'helping' might be and the highly regulated environment" (2015, p. 137). This divide between the desire to 'care' and systemic imperatives causes ambivalence and loss of agency and this is often harder for those with less experience to manage. One way to support this, argue the authors, is to focus on the 'use of self' as this overcomes the tendency to become too defended, which leads to the separation of the relational and the technical-rational⁴⁵ self.

Consistent with this theory, I found that the 'use of self' supported social workers to interpret situations and draw from their personal experiences to shape compassionate, professional practice. This was particularly the case in the interviews, which encouraged participants to bring more personal perspectives than the focus group environment permitted. Participants appeared better able to challenge and overcome defensiveness when they recognised the emotional dimension of the work. Interestingly, the importance of making visible the emotional demands of working with older people was a recommendation of the SWOP project (Tanner *et al.*, 2023).

⁴⁵ A technical-rational model of practice focuses on skills and procedures, which marginalises the use of self (Ruch, 2002).

I found that participants who acknowledged the emotional dimension of the work and connected their personal and professional values to the role seemed more able to overcome the challenges of procedural practices. They were still frustrated by the system or organisational constraints, but they drew on their personal and professional resources to 'find a way'. It was notable, for instance, that Rachel didn't connect with social care but did connect with being a social worker and it was this that guided her practice. The findings also reinforced that the social work relationship could in itself be an intervention. This was not explicitly articulated as such by participants, but it was alluded to: for example, Adam described the importance of social workers being "available" or able to support the situations when no one else knew what to do.

Striking a chord, perhaps, with the concept of the vicious or virtuous circle highlighted earlier, participants demonstrated that positive outcomes generated positive emotions and satisfaction for them. These examples often generated hope for participants; they were able to connect with their personal values and more readily acknowledge the emotional dimensions of practice to reflect on the difference they were making to individuals' lives. This suggests that it is the tension between personal/professional values and the structures that impede meaningful practice which evoke the most uncomfortable emotions. This idea is reinforced by research carried out with hospice social workers. It might be assumed that working with dying people would cause distress, but in fact hospice social workers were found to experience job satisfaction. This was attributed to their roles being predicated on the need to be compassionate and the difficult, emotional nature of their work being openly acknowledged (Tanner, 2020). In essence, there was no disconnect between their values and the requirements of the role.

Collude, collide, connect

I have explored the multiple tensions around social work practice with care homes and some factors that supported social workers to navigate these constraints and undertake 'good', relational social work practice. The key question left unanswered is why some social workers seemed able to use their discretion and work more consistently within their personal and professional value base, and others felt unable to challenge procedural practice and instead conformed to managerialist practices.

A model

I have found a way to explain this with reference to the construct I mentioned at the start of the chapter: that professional identity and attendant values can either collude, collide or connect with role purpose and organisational aims (Webster, 2010). Adopting a relational lens and acknowledging the multiple and complex influences which I have discussed throughout this chapter, I have created the model below to visualise in simple terms how social workers manage these tensions. It depicts the different approaches individuals take towards relationships with older people when organisations are often focused on process and structures. The arrow represents that the 'positions' are not static and move on a continuum over a period of time. The multiple and interconnected influences that I have described in this chapter may take centre stage at different times and impact on how social workers manage or act.

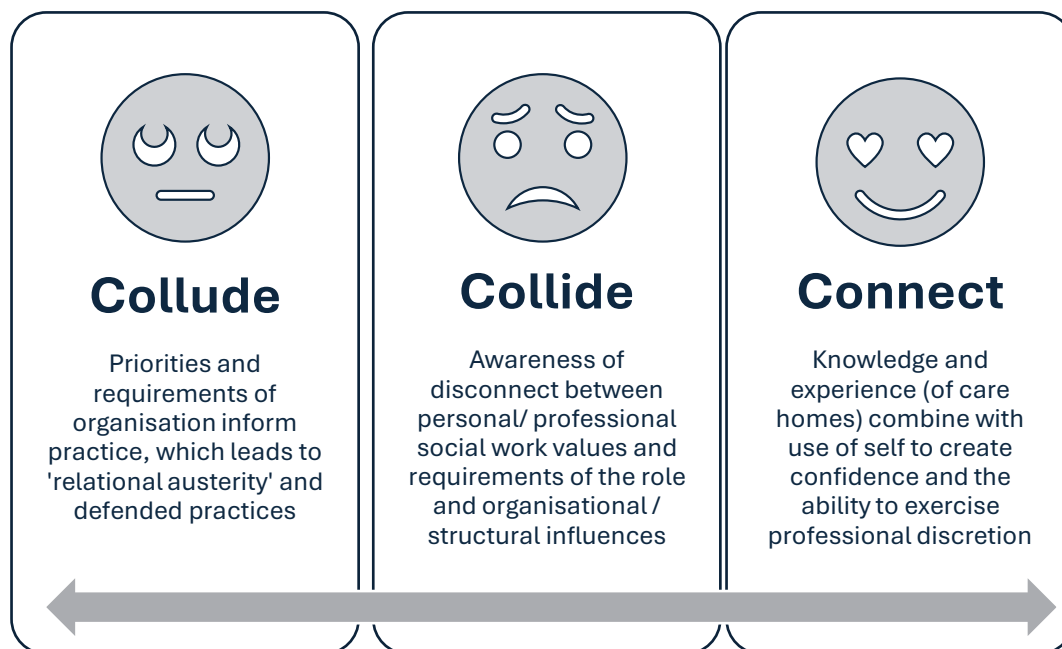


Figure 11 Collude, collide, connect model

Using some examples, I will now explore through this model why some participants rarely questioned managerialist practices, some appeared paralysed by their loss of agency, whereas others had the confidence to integrate a more reflexive approach to their work.

Colluding

I highlighted elsewhere, particularly in Chapter 6, that the procedural nature of practice provided a diminished space for discretion and the development of relationships. Participants observed that pressures, like time, workload constraints and the difficulty of forming relationships with care homes, often led to practitioners 'making allowances' or 'colluding' with practice that they might otherwise challenge. Julia's example of how she had seen social workers 'just accept what care home staff say' even when they are convinced there is more to find out, emphasised this lack of professional challenge. This appeared to be harder for people who held a more negative view of care homes or were less 'connected' to care homes. One explanation for this might be the cognitive dissonance linked to the feeling of 'failure' when moving someone to a care home, which I discussed earlier. Some participants clearly struggled to integrate their professional purpose, the emotional demands of practice and organisational imperatives. When this happened they drew on defence mechanisms to help them cope. Norman, for example, was open about the need to put in place 'boundaries' to avoid feeling overwhelmed, as this would stop him "from doing (the) job effectively". Language is also an effective mechanism to defend people against the emotional dimension of the work: for example Jon rarely mentioned older people and referred to people as 'cases' or being "DoLed". All this applies to social work practice generally but I would argue it is amplified to an even greater extent in contexts such as care homes, given the uncomfortable place they have in people's psyches.

Thus, people drew on different coping mechanisms to manage the demands of their roles. For some, like Jon, they become part of the system to cope. One manager had worked for the local authority for many years and felt 'part of the furniture', which evoked the tension involved in challenging a system that you have become part of. In his interview, Adam also highlighted the risk attached to being seen in this way and therefore not being able to maintain sufficient critical distance to challenge. While I have chosen not to focus on how social work *managers* see their identity, it is interesting to consider whether managers were more likely to collude with practices that sit in tension with social work values. Within the limits of a small sample, managers often appeared more constrained by policy and therefore more likely to conform to organisational norms, becoming, as Liam described, "the silent majority".

This resonates with earlier research which found that managers were acutely aware of the compromises involved in “putting conflicting policy imperatives into practice” and satisfying organisational drivers within resource and time constraints (Scourfield, 2015, p. 920). It is interesting to note that, in my study, the managers commented in their focus group that participating in the research had given them much-needed time for reflection. It has been noted that managers rarely receive good quality supervision and have little space for reflection (Ruch, 2012); this may contribute to their limited ability to ‘step off the treadmill’ and reflect on how they might be colluding with managerialist practices. The importance of giving managers a space to reflect is reinforced by an earlier study of middle managers, which found that participants saw themselves as social workers who had gained managerial positions and retained their professional commitment despite the influence of managerialism (Shanks, Lundström and Wiklund, 2015).

One way of coping is to prioritise the ‘technical-rational self’ in order to meet the managerial demands of the role. Jon’s interview is an example of this approach. He is aware of the importance of relational work, but described it as an approach that people ‘chose’ to take. This further amplifies the defence mechanisms people employ to manage the tensions they may experience when they feel, often subconsciously, that their values are being compromised. In this instance, it seems easier to rationalise that some people *like* working in a relational way, whereas others *like* the throughput and procedural practice of the current system.

Colliding

I have consistently noted the disconnect many participants experienced between their personal and professional values and the realities of practice. They highlighted the barriers that ran counter to their ability to work in a relational way and described a gap between what they *wanted* to do and what they were *able* to achieve. This resonates with earlier research, described in Chapter 3, which investigated the ‘real’ role social workers in care homes in Israel fulfilled in contrast to the ‘ideal’ role (Koren and Doron, 2005). The authors highlight the gap between social workers’ ideal roles and their actual practices, noting that “paternalistic” functions were prioritised over those which were empowering or advocated for a rights-based approach (2005, p. 112). In my findings, this disconnect jarred with many

participants' sense of social justice, a notable example being the doubt expressed that older people really "deserve" just one review a year.

Good social work practice therefore was often associated with examples of how people circumvented the system; this involved social workers drawing on their knowledge, skills and experience to find a way to deviate from procedural expectations. This reflects earlier research which described 'deviant social work' as "minor, hidden, subtle, practical, shrewd or moderate acts of resistance" (Carey and Foster, 2011, p. 578). I noticed that participants underpinned their practice with a focus on social justice and advocating for people's rights, although this advocacy was mostly on a micro level rather than larger acts of activism. This is consistent with Burrows' (2020) research, which found that hospital social workers advocated for people at a personal level but struggled to fulfil their aspirations of a more radical interpretation of social work's activist role.

It is interesting to consider how experience and confidence helped people to manage and subvert the rules rather than clash with them. For example, Kim showed a strong awareness of system constraints, but when they conflicted too much with her values, she described how she moved to another area of social work which better aligned with her social work vision and values. Her experience, confidence and ability to reflect allowed her manage her frustration and focus on where she could have the greatest influence. She appeared therefore not to feel quite as powerless as some of her colleagues. In contrast, Julia, a newly qualified social worker, appeared paralysed by her inability to change the system. She was racked by the dilemmas of seeing practice collide with her values, but she lacked the experience or confidence to subvert the rules.

Some participants reconciled the personal impact they could make in the system to enable them to keep going. Rachel, for example, with years of experience, maintained hope that she could make things a little bit better even if generally "things might be shit". This is echoed by Ritchie who talked about needing to cling to his conviction that social work is about social justice and protecting people's rights to continue doing it. I would argue that social workers' ability to recognise the challenges that arise in balancing their values with the constraints in the system

helped them to find connections in their roles and undertake good social work practice.

Connecting

In chapter 3, I discussed how a simplistic understanding of the strengths-based approach can ignore vulnerability and the emotional dimension of social work, particularly in the context of stretched services and managerialist practices. Moore's (2022) local authority case study reflects this by examining the defence mechanisms employed by social workers. She refers to the 'us and them' dichotomy and suggests this protects social workers, albeit unconsciously, from the "potential vulnerability of real connection" (2022, p. 459). Resonating with my earlier discussion, she suggests that a focus on 'othering' and transactional practice can be more 'bearable' than the emotional response that can arise from investing in relationships with the individual. This can expose practitioners to a vulnerability that is difficult to hold in an overstretched local authority system. Key to her argument, however, is that *authentic* relational connections and their attendant emotional dimension are the cornerstone of person-centred, strengths-based practice.

Moore's (2022, p. 458) idea of "authentic connection" is important and I noticed this to be more evident in participants who displayed 'craft knowledge' and whose roles connected them with care homes, enabling them to build relationships. I have already discussed this theme of connections, so it is sufficient to reiterate that those with a greater understanding of care homes often demonstrated a more authentic connection in their values and purpose. Knowledge and experience of care homes, combined with use of self, created confidence and the ability to exercise professional discretion. This allowed social workers to feel better 'connected' with care homes, and this was more so when their roles 'permitted' them to work with care homes.

In summary, the model described above is an opportunity to explain the different ways social workers manage the tensions they experience in their roles working with care homes. It resonates to some extent with Lev and Ayalon's (2016) prototypes, to which I referred in Chapter 3.

Supervision and critical reflection

A noticeable theme is that practitioners need space to reflect upon the influences on practice. I noticed that self-awareness and critical reflection were important factors in

helping social workers to process the emotional complexity of their work and to challenge or disrupt defended behaviour. It is interesting, though not for exploration here, that practitioners can experience tension in supervision which leads to collusion, collision or connection between the expectations of the organisation and the profession (Middleton and Rhodes, 1980, cited in Beddoe and Davys, 2020). This underlines the crucial role that reflective professional supervision plays in supporting social work practice, particularly in the complex terrain of working with care homes. Interestingly this was rarely articulated by participants. That said, as discussed in Chapter 6, one participant commended their colleague who, through supervision, “beautifully” supported social workers who might be ambivalent about care homes to understand the context and think about their roles.

While participants did not openly reflect on the value of supervision or reflection, it was evident that they used the space of the focus groups or interviews to critically reflect on their roles and organisational practice. Many openly acknowledged and welcomed the opportunity that participating in the research had given them to think about an area of practice that remains hidden. A key argument of this discussion is premised on social workers connecting with care homes and engaging with the emotional dimensions of relational social work practice and this requires space to step back and reflect on the tensions of practice. It requires social workers to consider the multiple, inter-related influences on their practice. I would suggest that this underscores the need for spaces for critical reflection and supervision.

Final reflections

I will discuss potential possibilities and implications for future practice in the concluding chapter. As I draw the discussion to a close, it is important to reiterate that, despite the constraints and challenges experienced by social workers working with older people in care homes, they *are* undertaking skilled work which involves balancing oversight with maintaining rights and developing positive collaborative relationships. Krishnasamy (2022, p. 135), writing about social work’s contribution, albeit working with people with cancer, suggests that “so much of what social workers do, like nurses, is invisible to the untrained eye and happens behind closed doors”. While social work may not be explicitly valued, the fact that social workers continue to have some role with care homes implicitly recognises their contribution: if

social workers are just there to tick boxes, why bother to employ a qualified social worker? Their quality assurance role can be used to uphold people's rights, and many social workers make this intervention count within the constraints of what is possible.

I have argued that neoliberalism and managerialism influence social work practice and create numerous dissonances and tensions. The themes explored the personal, professional, organisational and structural, demonstrating that the influences on social work practice with older people in care homes operate at many different levels. There is a strong emotional element to the role; some social workers appear more authentically connected, whereas others are defended against this, often to protect themselves or to 'get the job done'. This reinforces the idea of the social work continuum and the perennial question: are social workers agents of the state engaging with care home residents through a primarily statutory, transactional relationship or are they advocates for older people's rights and social justice?

There is often a disconnect between what social workers are mandated to do by their organisations and what they actually do in practice, or more importantly, *how* they do the work. Social workers' connection and understanding of care homes is important, alongside their connection and emotional engagement with their social work practice. The way in which teams and organisations are organised plays an important role, as this impacts on the relationships that social workers can make with care homes and with care home residents. Notably policy and organisational factors often sit in tension with professional and personal factors, and this can lead to situations where social workers feel their values and professional responsibilities can collude, collide or connect with their organisational roles.

Chapter 8: Implications and Conclusion

This final chapter will revisit the aims of the research and offer a summary of the thesis. I will reflect on the doctoral 'journey' and what I have learnt. I will address the study's limitations and assess the quality of the research. I will highlight what I consider to be my contribution to knowledge, before discussing the implications and recommendations for practice and ideas for further research. I will conclude with some final reflections.

Revisiting the purpose of the research

The study was premised on the importance of exploring social work's role and position in relation to care homes and older people living in care homes, alongside the need to explore the multiple influences at a personal, professional, organisational and structural level. Social workers are often linchpins in connecting people together and, most importantly, promoting social justice and protecting people's rights, on both an individual and wider scale. This is critical for a cohort of people who, for the many reasons I have shown, are marginalised and invisible in society and who, in the words of one participant, "are not going to get to the top of the list". It is however hard to define social work's distinctive territory or uncouple its role from its organisational and wider policy context. My research has attempted to tease out the multiple complexities in this topic and I have identified islands of hope and good practice amidst a sea of challenges and constraints.

Recap

In Chapter 1, I discussed the topic's personal, professional and academic provenance and highlighted its relevance and importance. I introduced the idea that older people in care homes receive little attention in social work research or education. Social work and care homes are rarely coupled together in policy or research, and the experiences of social workers and their views about this subject have not been explored.

Chapter 2 situated the study and described how socio-economic, political and policy influences construct how social work operates in a changing, fragmented and complex landscape. The chapter also explored the history and background of care homes, and examined why they are largely constructed as places of 'last resort'. I

considered how care homes' conceptual status, misconceptions perpetuated by the media and a policy agenda that promotes 'ageing in place' dominate the discourse. An inherent fear of ageing, dependency and dying also shapes the narrative. I demonstrated that both care homes and social work are complex constructs; they are entangled in the context in which they operate and are often poorly understood or viewed with, at best, ambivalence.

Chapter 3 reviewed the literature on the topic. Supporting the arguments made in the first two chapters, it is unsurprising perhaps that there is limited research about the social work role in care homes in England. I found that the role is not well-defined and there is even less focus on *how* the role is carried out. It was striking that much of the literature highlighted the deficiencies in the system and how social work's intentions are thwarted by neoliberal policy influences and significant resource constraints. This reinforced that social workers remain "strongly influenced by the expectations of the role in each country and agency where they practise" (Moriarty, Baginsky and Manthorpe, 2015, p. 4). To supplement the scarcity of research specifically about social work and care homes, I pieced together the landscape by exploring literature from other specialist areas along with studies from countries where the social work role in care homes has more prominence.

I considered my research design, its qualitative nature and the methods I used in Chapter 4. I explored the importance of reflexivity and my positioning, emphasising my perspective that the researcher plays a key role in creating and curating knowledge (Trainor and Bundon, 2021). This stance was a significant factor in my choice to use reflexive thematic analysis to analyse the data. I also explored the challenges and issues I encountered throughout the research process, which I will revisit and further reflect on later in this chapter.

Subsequently, I presented my findings, concentrating on themes from the focus groups in Chapter 5, followed by the interview themes in Chapter 6. The main themes from the focus group data centred on how social workers make sense of care homes and how they 'connect' with them, practically, physically and emotionally. I also considered how policy and organisational issues and constraints define social work in care homes. The focus group themes largely illuminated structural and organisational influences on practice. The interview themes illustrated in more detail the professional and personal

influences on practice, and allowed me to capture some of the tensions and dilemmas that social workers experience. As well as exposing professional and organisational barriers to developing relationship-based practice, these themes explored personal influences and the emotional dimension of practice, offered a glimpse of what good social work practice looks like with older people in care homes and explored possibilities.

In Chapter 7, I discussed these findings and situated them within the landscape of existing literature, theory and policy. I applied the patchwork of theoretical ideas I had chosen to make sense of the themes. I argued that neoliberalism and managerialism strongly influence social work practice and create barriers which run counter to the philosophy of relationship-based practice and to social work values.

I connected this to the concept of 'relational austerity' (Hingley-Jones and Ruch, 2016) which proposes that managerial procedures hinder relationships and emotional connection and create conditions for 'othering'. I suggested that one way to think about this was by applying a psychodynamic lens and considering the role played by defence mechanisms that are built into the system to prevent meaningful interactions with older people. This is particularly applicable to care homes, given their conceptual status, and the presence of structural ageism.

I discussed the disconnect between what social workers are mandated to do by their organisations and what they *want* to do, what they *actually* do and *how* they do it. I considered the ever-present influences and tensions that exist at a micro, meso and macro level. While I am not suggesting that social workers can ignore or change many of these influences, I argued that their personal and professional values and responsibilities can collude, collide or connect with organisational and policy imperatives, and this affects how they manage dilemmas. I also argued that social workers' understanding of care homes and the extent to which their role 'connects' them with care homes has a significant impact on their ability to work with care home staff and ultimately achieve positive outcomes for care home residents.

Reflections on the process (the doctoral 'journey')

The previous section summarised how I conducted the study and addressed the research questions. In this next section, I will share my reflections on the doctoral research process. In Chapter 1, I proposed that undertaking doctoral research is

often likened to a journey. This is a well-worn metaphor, but remains a useful analogy to describe the experiences and unexpected challenges often encountered from the start to the end of the process. Since I started the study in 2020, there has been significant societal change. The research spanned the Covid-19 pandemic and what is recognised as a time of unprecedented socio-economic and political instability. Undertaking a PhD part-time over several years, it is easy to forget the earlier stages of the process, particularly when close to the destination. In an attempt to mitigate against this, I kept a research journal where I recorded key insights. As noted in Chapter 4, these reflections were also a mechanism to support the reflexive approach I took and they have shaped the study throughout. They also helped me to reflect back on how I navigated the process and assess how far I have accomplished what I set out to do.

Continuing with the journey metaphor, it is noteworthy that the study is located in exceptionally difficult, even hostile, terrain. Social work, older people and care homes, taken individually, are multi-layered and complex constructs, embedded with negative and often paradoxical associations, with many influences at a structural, organisational and individual level. When they intersect, it creates a powerful, and uncomfortable, concurrence of issues and emotions. This might explain why this is not territory that has been previously explored in any depth. During the research process, my sense of social justice has frequently been pricked by the lack of attention given to social work's potential to support a largely invisible and disempowered population. Perhaps this has helped to 'keep me going' and to recognise the importance, and complexity, of reporting what I have uncovered.

I started the study as a professional doctorate and for mainly practical and logistical reasons, later transferred to a PhD programme. Notwithstanding the additional 30,000 word count, it has been said that professional doctorates can have a stronger *practice* focus on producing academic knowledge (Scourfield, 2010) and I have maintained a focus on situating the research inside social work practice. Undoubtedly, conducting the research has impacted on me personally and professionally. I have become more knowledgeable and critical in my thinking about research, theory and policy affecting social work practice. This in turn has influenced the development of the thesis, affirming that it has been a highly iterative process.

My experiences resonate with the findings of a recent US study into the professional value of undertaking a social work doctorate (Bradley, Gold and Hansel, 2021). Trafford and Leshem (2009) discuss the concept of “doctorateness” which connects the idea of ‘doing’ and ‘achieving’ a doctorate. They use the analogy of a jigsaw puzzle and suggest that only by understanding and then overcoming the challenges in the process can doctoral researchers develop an “intellectually coherent and methodologically plausible” thesis (2009, p. 306). Their discussion of blockages and ‘being stuck’ resonated with me and reflects comments from my supervisors that it was ‘all part of the process’. I experienced many instances of this, a good example being when I was immersed in the solitary pursuit of analysing, interpreting and writing up the data.

I struggled to write up the findings, particularly from the focus groups. Chapter 5’s first iteration included a substantial theme about constructing social work identity. As a ‘warm-up exercise’, I had asked participants to share their descriptions of what a social worker does and this provided rich insights into the social work role. It took me a while, with my supervisors’ support, to realise that these understandings helped to build other themes, but did not constitute a convincing theme on its own. As discussed in Chapter 2, it is challenging to define social work; it is a complex role that adapts within different contexts and I reflected that my difficulty in drawing this together as a theme mirrored its elusive nature. As a social worker and an educator, I wanted to celebrate social workers’ strong professional identity and understanding of their role: as a researcher, I had to make the decision that this information was interesting, but there were more *relevant* themes to answer my research questions. This reinforced the weight of responsibility in interpreting the views and experiences of research participants, particularly in an under-researched area of practice. This reconnects to the interpretative orientation of the research and is a reminder that the study is representing perspectives rather than facts. In the next section I will discuss the quality and rigour of the research.

Quality in research

It is important to consider the overall quality of the research. There is an ingrained cultural bias of positioning ‘natural science’ over ‘social science’. From a social work perspective, particularly in the context of adult social care, it is crucial that the

profession is confident to use the right methods to understand social reality and inequalities, without feeling the pressure to conform to scientific approaches, typically favoured in health services research. As noted in Chapter 4, the importance of evaluating qualitative research and its analysis by the standards that resonate with its philosophical approach cannot be overstated.

Becker, Bryman and Ferguson (2012) recognise the difficulty of assessing the quality or 'evidence' of qualitative research as its standards appear less robust or clear than those used to appraise quantitative research. I would argue, as have others (Scotland, 2012; Flick, 2023), that qualitative research is more likely to be judged unreliable when it is evaluated by criteria conventionally used for quantitative research. Braun and Clarke (2022, p. 7) call this "positivism creep" where ideals, such as valuing objectivity and controlling bias, are, often unconsciously, brought into the qualitative domain. Finlay (2021, p. 8) argues that the concept of researcher bias makes no sense in reflexive thematic analysis since the approach challenges the notion that knowledge is produced objectively.

Reflexivity is therefore a significant tool for quality control in qualitative research at all stages of the process (Berger, 2015). Throughout the study, it allowed me to account for the selective process being taken and helped me to understand, explain and reflect on what guided my decisions and the interpretation of the data (Denscombe, 2021). Notably it has helped me to present a "defensible" reading of the data, which acknowledges that it is one *interpretation* (Braun and Clarke, 2022, p149). This rejects the idea of generalisability in favour of 'transferability'. This draws on the contextual and situated nature of practice, and challenges the researcher to "make a judgement about whether, and to what extent, they can safely transfer the analysis to their own context or setting" (2022, p.143).

Likewise, Tracy (2010, p. 837) identifies "universal hallmarks for high quality qualitative methods" as an antidote to quantitative, more statistically generalisable research. She proposes that excellent qualitative research must be marked by eight criteria: a) worthy topic, b) rich rigour, c) sincerity, d) credibility, e) resonance, f) significant contribution, g) ethics, and h) meaningful coherence. The reflexive approach I have taken has enabled me to question my progress, drawing on these criteria, and feel confident that I have presented a credible and coherent snapshot of

social workers' perspectives, which aligns with the situated nature of the study.

Reflections on the study

I will now offer some reflections about the study and consider what I could have done differently. This supports the argument that *how* the story of the research is told is important (Braun and Clark, 2022).

Developing confidence in research integrity

At my annual progression review in 2022 (before I transferred to my current awarding university), I was challenged by the panel about revealing my research questions to the focus group participants. This is the extract from their report:

“A PowerPoint slide offered the outline presented to participants of a focus group. One slide presented the research question for the study; whilst understanding the importance of providing contextual information to participants; the panel asked Sally to consider how some of the questions could be considered as influencing participants' responses. The rationale and consideration Sally offered was in-depth; the panel encourages Sally to mention this as one of the limitations to the study.” (Annual Monitoring Review Report, June 2022)

I have questioned whether this is a *limitation* (I will discuss the study's limitations later in the chapter); instead it helped me to reflect on what I have learnt through the process. My research questions are pivotal to the study and I see them as a golden thread weaving through the research. My argument is that it would be unethical to *withhold* the questions from participants as it reinforces a stance where the researcher holds the power and is extracting information from passive subjects. It suggests a lack of transparency and honesty. Doubts raised by the panel's comments prompted me to revisit my ethics application. I was reassured that I had included the research questions in my recruitment poster, which had not been questioned during the ethics review process. The panel report also suggested that including 'tensions and dilemmas' in a research question might be construed as a leading question, biasing participants to negativity. Again, I would challenge this in the context of social work research, as I interviewed social workers, who habitually work in extremely complex, difficult environments and who hold realistic world views.

Social workers are presented with, and like to solve, problems: this means they can generally see problems from many angles. Initially the panel comments unnerved me, but in forcing me to examine my processes, it increased my confidence that they were aligned with my methodological approach. This recognises the strength of a reflexive approach and the integrity of the research.

Focus group interaction

The encouragement, however, to consider how I influenced the participants' responses is valid and this was especially relevant for the focus groups. The online environment prompted me to proceed in a more structured way than I might have done for an in-person focus group. I have reflected particularly on the impact of my introductory question about length of experience as qualified social workers. This may have signalled that qualified experience was valued and potentially undermined some members in the groups. What appeared an innocuous way for people to introduce themselves (and also potentially useful information) may have conveyed status and authority. This may have shaped the interactions in the group and the flow of responses. This was exemplified in one focus group (FG4), where I noticed tension between a more recently qualified social worker and a participant qualified for twenty years. The more experienced participant commented "and with respect, you know, I've got a lot more years under my belt". This led to the other participant later 'justifying' her credentials, and emphasising her lived experience and her experience as an informal carer. This highlights how social work identity and confidence is far more nuanced than just time spent 'doing the job'. I noticed fewer tensions of this nature in the focus groups where participants knew each other, perhaps because ground rules, trust and patterns of behaviour may have already been established.

I discussed in Chapter 4 the importance of focus group *interaction* to generate data (Morgan, 2019). I became interested in the interactions of the groups, but I later realised these interactions *produced* rich insights and did not need to be analysed in themselves, nor did my method of analysis support me to explore this further. I will not further revisit methodological challenges here as I explored positionality, reflexivity and ethics in detail in the methodology chapter. I will, however, with the benefit of hindsight and the time elapsed since data collection, remark on the study's sample of participants.

The sample

It is interesting to speculate whether the absence of a clearly defined 'care home social worker' role influenced the participant sample. It was noticeable that many participants had roles which regularly engaged them in work with people in care homes (e.g. care home 'link' workers, social workers in review teams or organisational safeguarding teams). Social workers from all areas of practice were invited to participate, but there was minimal interest from those working in hospital or locality teams within local authorities. Several people showed interest in the topic and then declined to take part, stating that they would have nothing to contribute or had little knowledge on the subject. The abstract status of a 'care home', which is nonetheless laden with meaning (as explored in Chapter 2) may have, unconsciously, influenced people's involvement. At the time I was satisfied with the number of participants for a small qualitative study; with hindsight, I may have captured different insights if I had encouraged people to participate who were not 'obvious' candidates, for example hospital social workers. In Chapter 7, I suggested that the participants used the space of the focus groups or interviews to critically reflect and many explicitly welcomed the opportunity to think about an often hidden area of practice. This has helped me to appreciate the reciprocity in research participation; in future it may help me to feel more confident in encouraging people to participate in research.

While it is unlikely I could have foreseen this in respect of my research design and recruitment strategy, there are interesting parallels between the recruitment to the study and the key findings: that social work with care homes is largely hidden in plain sight and that knowledge, understanding and connection with care homes is important.

Interpreting the findings

The structure of the thesis merits a mention. I described my difficulty writing up, and perhaps more importantly, interpreting my findings. Part of this stemmed from my perceived 'responsibility' to construct a coherent and authentic representation of the participants' perspectives. The topic's complexity and the need to weave through the multiple influences I have explored throughout the thesis also added to the challenge. I have also questioned whether it was connected to my decision to structure the thesis into separate 'findings' and 'discussion' chapters. Braun and

Clarke (2022) argue that this reporting format is typically associated with scientific or quantitative research and can be problematic for reflexive thematic analysis, which encourages an integrated approach to deriving analysis from the themes. I eventually combined advice from my supervisors and the principles of my analytic method to present the findings in an illustrative way. In the discussion chapter, I then developed an interpretative account of the themes, highlighting “theoretical, scholarly and wider contextual interconnections and implications” (Braun and Clarke, 2022, p.132).

The context

In Chapter 1, I acknowledged that the research took place against the backdrop of Covid-19 and suggested that this offered a timely opportunity to explore how to reframe the narrative and extend the social work role with care home residents. Writing this chapter four years after the start of the pandemic, it is interesting to reconsider this context. The pandemic certainly intensified the barriers to working with people in care homes, but I have remarked elsewhere that its impact was *not* a significant feature of participants’ accounts. I anticipated discussions about Covid-19 in the topic guide, especially for the focus groups; however, I often did not have time to cover this (it was a later prompt) and I have reflected whether I should have focused on this more as it was not regularly discussed unprompted. It is interesting to consider other explanations for Covid-19’s lack of prominence in the data. From a psychodynamic perspective, this could partly be explained by the discomfort, and even guilt, that social workers may have felt about their failure to intervene to support people in care homes during the pandemic.

I would also argue that the anticipated momentum for change may have been overtaken by the pandemic’s wider impact on adult social care. In its 2023 survey, the Association of Directors of Adults’ Social Services (ADASS) reported that 434,243 people were waiting for assessments, care or reviews in England; of those waiting for an assessment, 36% had been waiting for 6 months or more (ADASS, 2023b). Given the increased pressure of waiting lists, people in the community are likely to continue to receive priority over people in care homes, who are considered ‘safe’, and/or are out of sight.

Social work with care homes or social work with people in care homes?

As the study is reaching its conclusion, I have reflected on the linguistic conventions used. I have struggled with the 'clunkiness' of the language throughout, but it did not strike me at the outset that there is a notable difference between social work *with care homes* and social work *with people in care homes*. The context in which social work operates is very important (as discussed in Chapter 7) and the way in which the care home creates a layer around the older person is significant, and increases the likelihood of 'losing' the person.

Limitations of the study

Before I discuss the study's contribution to knowledge and implications for practice, it is important to acknowledge its limitations. The qualitative nature of this study might be considered a limitation when assessed through a positivist lens. Undoubtedly the small scale, interpretative scope of the study means that the findings are not 'generalisable'. Nonetheless, the knowledge generated resonates with existing literature and the policy landscape and the context within which it is situated, making it possible to extrapolate insights within the philosophical assumptions of the research.

Several limitations of the study are linked to the subject explored. As I discussed in Chapter 3, there is not currently an established evidence base around the social work role with care homes. The literature review was therefore a recursive process and involved searching through different areas of social work practice. I attempted to do this with rigour but it necessitated exploring a very large field of literature. Arguably this added to the study's richness and took me down paths that I might otherwise not have explored (such as international studies and social work in other specialist areas), but it increases the likelihood that I may have missed relevant literature as my search widened. I have observed that social work and social care are often conflated, and this too was a challenge in searching the literature and identifying its relevance. Similarly, the absence of a clearly defined role for social workers in care homes means that there was no established point of reference for participants. This is likely to have influenced their perspectives in ways that is impossible to fully capture.

There is a limited focus on family carers in the study. I chose not to search the literature about carers and it was noticeable too that participants rarely mentioned family carers. My conjecture is that given the limited, stripped back role that social workers have with care homes, they are less likely to become involved with people who have family carers available to provide support and advocate for them. The fact that carers themselves may need support appears to be a hidden area of practice in the context of social work and care homes; it is one I did not explore, but which could be an important area to research in future.

The study was undertaken in England, with participants drawn from London and the South East. Despite the diverse demographics of population, the landscape of care home provision varies considerably across the country, which is likely to have influenced participants' perspectives. It is also important to state that older people's complexity and heterogeneity as a cohort are often overlooked (Milne, 2020). I am mindful that the study did not address specific or different characteristics of the cohort (for example, older LGBT people in care homes). I have attempted to take an approach which acknowledges intersectionality, but I concede that difference does not feature strongly in the study, and this mirrors the societal tendency to homogenise older people and care home residents in particular.

One limitation of the study is that I only interviewed social workers and so did not obtain the perspectives of people living in care homes, their families or care home staff. Without doubt, their inclusion would have enriched the study; however, as outlined in the introduction, my objective was to capture the experiences of social workers about their role. It is also important to acknowledge the limitations of what can be achieved in a PhD study by a single researcher.

I have observed that doctoral studies often apply a singular theoretical framework to interpret their findings. In my case, I encountered challenges in interpreting my findings through one model, perhaps due to the multi-layered complexity of the topic. Instead I melded several theoretical perspectives together to support the interpretation of the data. While this could be perceived as a limitation, as I will discuss in the following section, it can equally be considered a strength.

Contribution to knowledge

A PhD study is expected to make an original contribution to knowledge, but, as Rugg and Petre (2020) explain, this contribution does not have to be 'groundbreaking'. Instead it is about enriching the evidence base in your field by "adding knowledge that moves the discourse along" (Rugg and Petre, 2020, p. 15). It also involves conveying the importance of the question and the significance of the findings.

The importance of the question

It is important to reiterate that there is limited research about social work with older people and even less on social work with care homes. This study is unique in examining the role that social workers have and could have to support people in care homes in England. That the research focused on the perspectives of social workers is also rare. I would argue that this area of practice should be fertile ground for social work to support and advocate for a largely disempowered population. The fact that no one is asking what the social work role should or could be in this area reinforces ageism and the marginalisation of older people in care homes. My study therefore has made visible an area of social work practice that is hidden, arguably in plain sight.

The significance of the findings

The research contributes to a richer understanding of the multi-layered and interconnected influences on social work with care homes. The findings reinforce that social work practice is overlaid with the ambivalent relationship that society and individuals have with care homes; despite its significance, this seems to attract minimal attention in social work training or practice. Social workers are not encouraged to explore their understanding of care homes, or ageism, in the same way that they are expected to explore other areas or values.

The research proposes that social workers need to be more closely connected to care homes and build relationships with staff to engage and support the older person in the care home. Social workers have a pivotal and cohesive role to play in supporting people's rights and well-being; if they are to be the 'conductor in orchestra' (as one focus group participant described), then they need greater involvement and oversight. This is especially important given the 'gatekeeping' role that care homes have for a cohort of people who are dependent and often have

advanced dementia. The research also supports the argument that social workers need time, permission and encouragement to attune to the emotional dimensions of practice amidst the predominance of procedural approaches.

A unique strength of the study lies in the patchwork quilt approach to theory taken to explain the findings. This acknowledges the significance of the conceptual and socio-political discourse underpinning the research questions. It also supports the research's application to social work practice more generally. I would argue that the research topic is a microcosm of the broader picture in adult social work, and mirrors the impact of neoliberalism, resource constraints and the narrowing of the social work role to reduce access to those in greatest need (Carey, 2022). These messages are important evidence for the social work profession about its role to influence policy makers and politicians about the need for change. It demonstrates that many of the 'practical tasks' that social workers can and should undertake are actually part of rights-based practice.

This segues into the final sections of this chapter, where I will consider the potential implications for practice and identify avenues for further exploration.

Implications for practice

Notwithstanding the constraints of the small, situated nature of the study and the multi-layered complexity of social work and adult social care, I will highlight some considerations for practice. Throughout the study, it has struck me that social workers' invisibility in care homes is a problem given that the profession positions itself as a mouthpiece for social justice. This suggests that it is important to consider how to promote a different narrative. The research offers some evidence that if social workers are to make a difference, not only do they need more time and resources, but they also need to be part of a different system which enables better connection and relationship with care home staff and residents.

Fixing the 'plumbing and wiring'

The findings offer insights into the professional, organisational and structural barriers to social work practice. Nationally, the social care narrative continues to focus on relational, strength-based care; increasingly it is acknowledged that the 'system', ways of working and procedures – the "plumbing and wiring" of adult social care - can either help or get in the way of realising the intent of the Care Act and achieving

change (ADASS, 2023a; Social Care Future, 2024). There remains considerable tension between these ideas and the means and capacity of the system to change and deliver, and it is important that the care home context is not excluded from the debate.

Gerontological social work

Notably, there appears to be growing appetite for strengthening social work with older people and their families, and there is an opportunity to align this research within the locus of gerontological social work. As previously mentioned, my findings strongly resonate with recent research carried out as part of the SWOP project, which focused on social work with older people, though not specifically in relation to care homes (Tanner *et al.*, 2023). The study identified that social workers require specialist knowledge, skills and a “unique blend of expertise” to effectively support older people (2023, p. 5). This supports those who argue for a specialism to empower older people and the social workers who work with them (Ray *et al.*, 2015; Willis *et al.*, 2021; Torres and Donnelly, 2022). While this requires training, investment and a shift in perspective, it is crucial to support and advocate for people at a stage in the life course where they are likely to have experienced multiple losses and transitions, none more so than care home residents.

The findings also suggest that social workers find it hard to challenge organisational expectations and structural influences such as ageism. This further highlights the importance of critical social work with older people to challenge managerial dominated neo-liberal practice (Hastings and Rogowski, 2015). It reinforces the need to encourage social workers to adopt a critical lens on how policy informs practice and consider how to challenge disadvantage and ageism (Milne, 2022). I am not criticising social workers for their lack of engagement; instead I am suggesting that greater prominence for social work with older people (and care homes) might build momentum, visibility and a platform for challenge. In arguing that social workers’ values can collude, collide or connect with organisational aims and expectations, it is notable that the majority of social workers wanted to work in a way that allowed them to connect with the values of the profession. Most of the participants had also chosen to work with older people. More visibility for the role of social workers with people in care homes and a clearer articulation of their role and its benefits might act as catalyst for change about the status and support for this cohort of people. This is

especially pertinent in the aftermath of the pandemic, so that the impact it had on older people in care homes is not forgotten (Anand *et al.*, 2022).

Social workers in care homes

I argued that the extent to which social workers' roles 'connect' them to care homes has a significant impact on their ability to work with care home staff and ultimately achieve positive outcomes for care home residents. Several participants talked about the possibility of having social workers working in care homes, with a more holistic, relational role, providing support with practical and psychosocial work that is currently overlooked and which often matters most to older people. While this has its challenges given current system constraints, it is an area that warrants further exploration, building on evidence from models in this country (like hospice social workers) and other countries where care homes employ social workers.

Supervision and critical reflection

In Chapter 7, I highlighted that practitioners need a space to reflect on the influences on practice and to process the emotional complexity of their work and disrupt defended behaviour. This underlines the crucial role of reflective professional supervision in supporting social work practice, particularly with care homes. In current local authority practice, there is a tendency for supervision to lean towards managerial oversight rather than towards the reflective, supportive role it was traditionally rooted in (Beddoe and Davys, 2020). It is noteworthy that participants, across the interviews and focus groups, welcomed the protected space of the research process. This suggests that it is important to create spaces, both inside and outside of supervision, for social workers to talk about their role in supporting people in care homes. The evidence suggests that it is not a topic on people's lips, so it is important to consider ways to encourage social workers to engage critically with the discourse.

By highlighting the importance of 'craft knowledge', the study suggested that social workers need more opportunities to learn about care homes and the specific needs of people who live there; this was also discussed as important for students. One way is to promote stronger engagement with the importance of specialist knowledge for social work with older people. The recently updated resource based on the Professional Capabilities for Social Work with Older People offers guidance and

examples to encourage reflection (Nosowska *et al.*, 2023). This could be bolstered with more specific inclusion of the skills, knowledge and understanding required to connect with care homes and older people in care homes.

Avenues for further research and exploration

In Chapter 1, I noted that social work research is uniquely placed to span boundaries. Bearing this in mind, opportunities exist to build on the study's findings in social work and related disciplines. I have consistently argued that there is limited research in this field and a considerable amount of work is needed to redress the balance and change the narrative. The following list identifies several areas that merit further exploration and research:

- Strengthening teaching about gerontological social work in the social work education curriculum, including a focus on understanding care homes and social work's potential role with residents, families and staff
- Developing placements in care homes for social work students, building on earlier work (Dunworth, 2013; Milne and Adams, 2014)
- Exploring the perceptions and perspectives of care home staff, residents and their families about the actual and potential role and value of social work
- Further research, using different methods, identifying how social work is positioned, or not, in local authorities to support people in care homes and the scope for extending the role. This could involve a pilot study of funded social workers in care homes that is evaluated for its impact on staff and residents, alongside local authority outcomes
- Comparative research exploring social work with care homes in England with other countries
- More research which builds on the momentum driven by recent studies to spotlight ageism and the contribution of social work to support older people and their families. This could also be extended to look at social work support for self-funding care home residents.

Final thoughts

The study set out to answer the following questions:

- What influences social work practice with older people in care homes?
- How do social workers conceptualise their role?

- What tensions and dilemmas do social workers experience working with older people in care homes?
- What is good social work practice in this area and what are the possibilities for developing it?

I have concluded that multiple influences exist on social work practice with care homes and that there is often a tension between what social workers are mandated to do, what they want to do and what they are able to do. I have exposed numerous tensions and dilemmas that social workers experience; in particular I have shown how personal and professional values and responsibilities can collude, collide or connect with organisational and policy imperatives.

Several months ago I read an article in the British Medical Journal about the 'crisis in care', which cited the campaigning slogan 'bread and roses' used in 1910s America to advocate for workers' rights (Heath and Montori, 2023). The slogan was used to convey how bread feeds the body and roses provide a subtler, less tangible form of sustenance. This led me to draw the comparison that when the social work role with care homes is reduced to transactional, procedural process, it ignores what matters not only to the older person, but also to social workers. Extending this analogy, my findings suggest that organisational practices are mostly focused on supplying the 'bread', but social workers generally understand that this is not enough, and they want to be able to deliver roses too.

I have found that neoliberal ideologically based socio-economic policies, resource constraints and managerialism continue to impact on social workers' ability to meet the needs of people in care homes. With the rising spectre of CQC's assessment of local authorities⁴⁶, it is timely for social workers to question whether they are comfortable hiding behind organisational rhetoric or whether they are able to courageously say that this is not how they want to practise with care home residents.

The study has drawn on different perspectives to make sense of the subject. In particular, I have drawn on the psychodynamic construct of the defence mechanisms built into organisations to alleviate staff's anxiety. This helps to explain how the inherent fear of ageing, dependency and dying, associated with care homes,

⁴⁶ Assessing how local authorities meet their duties under the Care Act (2014) is a new responsibility for CQC since 2023.

unpinned by structural ageism, contributes to social work with people in care homes being hidden in plain sight. This mirrors the conceptual status in society of care homes, and to a certain extent social work with adults.

Finally, the key perspective that I have championed throughout this thesis is that of social work and social justice. A sense of hope needs to be central to social work values, driving the promotion of social justice and believing in people's strengths and inherent value as human beings (Boddy *et al.*, 2018). This is evident in the research: I found that good social work practice is happening *despite* a framework of proceduralism, resource constraints and what could be said to be paradoxical policy imperatives. Its value also lies in promoting wellbeing and quality of life for older people living in care homes. The research has spotlighted the need to make social work with care homes and people in care homes more visible, and to recognise and value the role that social work can have in this hidden and yet vital area of practice.

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PARTICIPANTS NEEDED



Reimagining social work and care homes: exploring the influences and the possibilities

I am a social worker undertaking my professional doctorate at the University of East London (UEL). My research is a small qualitative study exploring the role of social workers in relation to care homes for older people, contextualised in the current policy of strengths-based practice.

I want to hear the voices of social workers, and I am running focus groups and interviews which I hope will help answer some of these questions:

- What influences social work practice with older people in care homes?
- How do social workers see their role?
- What tensions and dilemmas do social workers experience?
- What does good social work look like in this context and what are the possibilities?

If you would like to take part in this research and find out more, contact:

Sally Nieman

s.nieman1901@uel.ac.uk

- ✓ You must be a social worker / training to be a social worker
- ✓ You can take part in a focus group or an interview, or both
- ✓ Interviews and focus groups are online via MS Teams
- ✓ They will last between 60-90 minutes
- ✓ You will need to sign a consent form
- ✓ Involvement can be counted as continuous professional development

Appendix B: Participant Information Sheets and Consent Forms (Focus Groups and Interviews)



Information about participating in the research study

Reimagining social work and care homes: exploring the influences and the possibilities

Research Integrity

The University adheres to its responsibility to promote and support the highest standard of rigour and integrity in all aspects of research, observing the appropriate ethical, legal and professional frameworks.

The University is committed to preserving your dignity, rights, safety and wellbeing and as such it is a mandatory requirement of the University that formal ethical approval, from the appropriate Research Ethics Committee, is granted before research with human participants, human data human material, personal and/or sensitive data, or non-human animal commences.

This information should help you decide whether to participate in this research project.

Researcher:

Ms Sally Nieman, Doctoral Researcher
c/o Stratford Campus, Water Lane, London E15 4LZ
s.nieman1901@uel.ac.uk

Supervisors:

Dr Jo Finch (Director of Studies) j.finch@uel.ac.uk
Dr Alisoun Milne a.j.milne@kent.ac.uk

I would like to invite you to participate in the research study: ***Reimagining social work and care homes: exploring the influences and the possibilities***. Before you decide if you want to participate, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information and decide if you want to take part.

Feel free to discuss it with others, or to contact me if anything is not clear or if you would like more information.

Why am I doing this research?

I am a social worker undertaking a Professional Doctorate in Social Work at the University of East London. The research is a small qualitative study exploring the role of social workers in relation to care homes for older people. The study's main aim is to explore the influences, at a personal, professional, organisational and societal level, on social work practice in this area, contextualised in the current policy of strengths-based practice.

The study will focus on the perspectives and experiences of social workers to examine how social work takes place with older people in care homes, what tensions and dilemmas exist and capture possibilities for good practice.

A rationale for this research is that individuals, social workers and society more widely sometimes struggle with the concept of care homes as something positive; this contrasts with the emphasis on strengths-based practice, promoted across adult social care in England under the Care Act 2014. I hope that by hearing the voices of social workers, and exploring the influences on practice, the study will provide an insight into an under-researched and marginalised area of social work.

Why I have been asked to take part and what is involved?

You have been asked to take part as you are a social worker with experience of working with older people. You are being invited to take part in a focus group of up to 6 - 8 social workers. The purpose of the focus group is to discuss and explore what you think about the social work role and institutional care.

The focus group will last between 60-90 minutes and will take place via MS Teams. It will be recorded and transcribed through MS Teams. I may also make some notes. I will make any adjustments to allow you to participate fully in the group. You will be asked to sign a consent form to participate.

I will be undertaking individual interviews in the later stages of the study and you will be asked if you wish to be contacted to take part. You are under no obligation to do so.

Do I have to take part?

Participation is voluntary and you do not need to give a reason if you do not want to take part. If you agree to take part, you are free to withdraw at any time and without giving a reason.

What are the benefits of taking part?

Taking part in the focus group will give you the chance to share your views and hear the views of others on a topic that I hope is of interest to you. Your participation will also assist me in my doctoral research. Ultimately the information from this study may help us to improve the quality of practice in an area where there is currently limited research.

Are there any disadvantages to taking part?

It is not anticipated that taking part in the focus group will cause you any discomfort or disadvantage. The group discussion will be facilitated by me as the researcher and may use statements and images to support the discussion. You can choose what contribution to the group you wish to make, and you can withdraw at any time if you feel uncomfortable. As this is a group environment, your views will be heard by other members of the group. There will be an opportunity to 'debrief' individually after the focus group if desired.

What happens to the information I give?

Every attempt will be made to ensure that the information collected during the focus group is confidential. All participants in the group will be asked to sign a consent form, which will include issues of confidentiality, and the importance of confidentiality will be discussed in the group at the start of the session. If, however, a member of the group discloses any information that makes me concerned about your safety or the safety of others, I may need to pass on the information. If this were to happen, I would discuss this with you first and make you aware of who was being given the information. If you were to have any concerns about something another member of the group said, then you would be invited to discuss this with the researcher.

The information collected will be anonymised to ensure that you are not identifiable. The focus group will be recorded, with your permission, to analyse results. The recording and other information will then be safely stored in line with the University Data Protection policy. All computer data will be password protected. The data will be destroyed when it is no longer needed for the purposes of the research. Please note that your data can be withdrawn up to the point of data analysis, after this point it may not be possible.

Ethical Approval

Ethical Approval for the research project has been granted by University Research Ethics Sub-Committee (URES).

What if I'd like to take part?

If you would like to take part, you will need to complete a consent form. I will contact you to confirm the time and details of the focus group.

Please contact me: Sally Nieman s.nieman1901@uel.ac.uk

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:

Catherine Hitchens, Ethics, Integrity and Compliance Manager, Office for Postgraduates, Research and Engagement, University of East London, Docklands Campus, London, E16 2RD. Telephone: 020 8223 6683. Email: researchethics@uel.ac.uk

Consent to participate in a research study

Research study title: Reimagining social work and care homes: exploring the influences and the possibilities

Researcher: Sally Nieman, University of East London s.nieman1901@uel.ac.uk

Thank you for agreeing to be part of the research study. This consent form, and the accompanying participant information sheet, is to ensure that you understand the purpose of your involvement and the conditions of participation. It is also to meet the ethical procedures for academic research to ensure that you explicitly agree to taking part in this study.

Please tick as appropriate:

	YES	NO
I have read the participant information sheet (dated October 2021) relating to the above research project, in which I have been asked to participate, and have been given a copy to keep. The nature and purposes of the research project have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.		
I understand that the focus group will be recorded and I consent to this.		
I understand that my involvement in this research project, and particular data from this research, will remain confidential as far as possible. Only the researcher involved in the study will have access to the data.		
I understand that maintaining strict confidentiality is subject to the following limitations: <ul style="list-style-type: none"> • This is a small qualitative study • Participation in a focus group has limitations for anonymity within the group. Clear confidentiality guidelines and boundaries will be agreed with the group. • If a disclosure is made that indicates that the participant or someone else is at serious risk of harm, then the duty to report that disclosure may override the need for confidentiality. 		
I understand that the data from the focus group will be used solely for the purposes of the research study. I agree that the data and anonymised quotes may be used in the subsequent doctoral thesis and any other dissemination or publication of the research findings.		

I understand that the data collected for the research project will be anonymised before it is published.		
I understand that the published results of the research will be accessible in the public domain and may be deposited in an open access data repository. I also understand that the published results of the research will be accessible in the public domain and may be re-used, republished or re-analysed by others in future research.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis.		
I freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name [Block Capitals]:

Participant's Signature:

Date:.....

Researcher's Name [Block Capitals]:

Researcher's Signature:

Date:.....

November 2021

I would like to invite you to participate in the research study: *Reimagining social work and care homes – exploring the influences and the possibilities*. Before you decide if you want to participate, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information and decide if you want to take part. Feel free to discuss it with others, or to contact me if anything is not clear or if you would like more information.

Why am I doing this research?

I am a social worker undertaking a Professional Doctorate in Social Work at the University of East London. The research is a small qualitative study exploring the role of social workers in relation to care homes for older people. The study's main aim is to explore the influences, at a personal, professional, organisational and societal level, on social work practice in this area, contextualised in the current policy of strengths-based practice.

The study will focus on the perspectives and experiences of social workers to examine how social work takes place with older people in care homes, what tensions and dilemmas exist and the capture possibilities for good practice.

A rationale for this research is that individuals, social workers and society more widely sometimes struggle with the concept of care homes as something positive; this contrasts with the emphasis on strengths-based practice, promoted across adult social care in England under the Care Act 2014. I hope that by hearing the voices of social workers, and exploring the influences on practice, the study will provide an insight into an under-researched and marginalised area of social work.

Why I have been asked to take part and what is involved?

You have been asked to take part as you are a social worker with experience of working with older people. You are being invited to take part in a one-off interview in relation to the research topic. The interview will use a semi-structured format and should last approximately an hour. I can arrange to meet you at a time that is convenient for you and will be happy to make any adjustments needed to allow you to participate fully in the interview. The interview will take place via MS Teams and will be recorded. You will be asked to sign a consent form to participate.

Do I have to take part?

Participation is voluntary and you do not need to give a reason if you do not want to take part.

If you agree to take part, you are free to withdraw at any time and without giving a reason.

What are the benefits of taking part?

Participating will give you the chance to share your experiences and views on a topic that I hope is of interest to you. Your participation will also assist me in my doctoral research. Ultimately the information from this study may help us to improve the quality of practice in an area where there is currently limited research.

Are there any disadvantages to taking part?

It is not anticipated that taking part in the interview will cause you any discomfort or disadvantage. The interview will encourage you to tell some stories about your experiences as a social worker in relation to the research topic. The interview can be stopped at any time and you do not have to answer any questions you don't feel comfortable answering. There will be an opportunity to 'debrief' after the interview if desired.

What happens to the information I give?

The information collected during the interview will be confidential. If, however, you disclose any information that makes me concerned about your safety or the safety of others, I may need to pass on the information. If this were to happen, I would discuss this with you first and make you aware of who was being given the information.

The information collected will be anonymised to ensure that you are not identifiable. The interview will be recorded, with your permission, to analyse results. The recording and other information will then be safely stored in line with the University Data Protection policy. All computer data will be password protected and any hard data will be stored in a locked cabinet. The data will be destroyed when it is no longer needed for the purposes of the research.

Please note that your data can be withdrawn up to the point of data analysis, after this point it may not be possible.

What if I'd like to take part?

If you would like to take part, you will need to complete a consent form. I will then contact you to confirm the time and details of the interview.

Please note: Ethical Approval for the research project has been granted by University Research Ethics Sub-Committee (URES).

Thank you for taking the time to read this.

If you would like any further information, please contact me:

Sally Nieman s.nieman1901@uel.ac.uk

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Catherine Hitchens, Ethics, Integrity and Compliance Manager, Office for Postgraduates, Research and Engagement, University of East London, Docklands Campus, London, E16 2RD. Telephone: 020 8223 6683. Email: researchethics@uel.ac.uk

Consent to participate in a research study

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	YES	NO
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I understand that the interview will be recorded and I consent to this.		
I understand that my involvement in this research project, and particular data from this research, will remain confidential as far as possible. Only the researcher involved in the study will have access to the data.		
I understand that maintaining strict confidentiality is subject to the following limitations: <ul style="list-style-type: none"> • This is a small qualitative study • If a disclosure is made that indicates that the participant or someone else is at serious risk of harm, then the duty to report that disclosure may override the need for confidentiality. 		
I understand that the data from the interview will be used solely for the purposes of the research study. I agree that the data and anonymised quotes may be used in the subsequent doctoral thesis and any other dissemination or publication of the research findings.		
I understand that the data collected for the research project will be anonymised before it is published.		
I understand that the published results of the research will be accessible in the public domain and may be deposited in an open access data repository. I also understand that the published results of the research will be accessible		

in the public domain and may be re-used, republished or re-analysed by others in future research.		
I understand that my participation in this study is entirely voluntary, and I am free to withdraw at any time during the research without disadvantage to myself and without being obliged to give any reason. I understand that my data can be withdrawn up to the point of data analysis.		
I freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name [Block Capitals]:

Participant's Signature:

Date:.....

Researcher's Name [Block Capitals]:

Researcher's Signature:

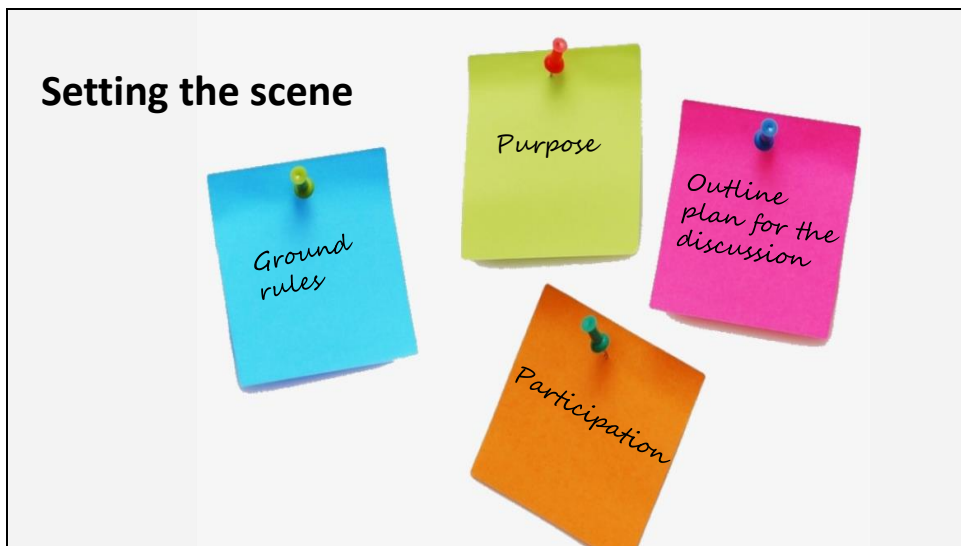
Date:.....

Appendix C: Focus Group Topic Guide

Slide 1

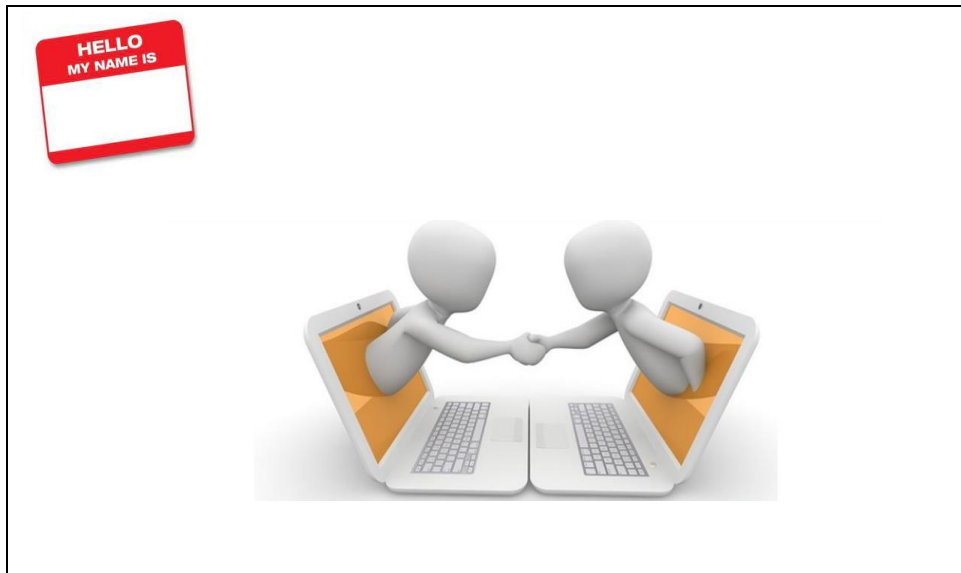


Slide 2



Notes: Thanks for being willing to give up time. Remind that have all signed a consent form. Acknowledge online context and adaptations made as a result. Purpose of research and group – explain what a focus group actually is! [Opportunity for me to hear your views on my research topic guided by questions and prompts] Revisit the participant information sheet, agree group 'rules'/guidelines and discuss confidentiality. Will be recording and rationale for recording - it's much more accurate in terms of data capture and for transcription - reassure members the recordings will be deleted post the write up of the groups for the thesis. Outline of focus group discussion today – timings. Emphasise the importance of everyone's participation (can't know what you're thinking, please do speak up...) If in agreement start the recording (and transcription)

Slide 3



Notes: Name, your role/team and how long you have been a social worker. If had any social work positions in different team/area

Slide 4


My research questions

- What influences social work practice with older people in care homes?
- How do social workers conceptualise their role?
- What tensions and dilemmas do social workers experience working with older people in care homes?
- What is good social work practice in this area and what are the possibilities for developing it?

A lightbulb is shown inside a thought bubble drawn with white chalk on a dark background. The lightbulb is lit, and the thought bubble is connected to the text on the left by a line.

Notes: My research is set within the context of how we think about care homes and how we also think about social work, and the influences on both at a micro, meso and macro level. I'm interested in social work with care homes and what influences it - at a micro, meso and macro level. For the focus group I'll focus on Qs 1 & 2. I'm also doing interviews – the focus of these will (more) be Qs 3 & 4. There is obviously some overlap.

Slide 5



Take a few minutes to think about and jot down some thoughts:

How would you describe what a social worker does / what a social worker's role is (in general terms)?

What roles do social workers have in connection with care homes?

Notes: Time to think about some initial questions and jot down some key thoughts which they are then invited to share with the group: Show first question (few minutes) Then show second question (few minutes). Then ask to share and discuss – was the role generally different to the role linked to a care home

Slide 6



The importance that we place on independence and autonomy means that moving to a care home is often seen as failure

"social workers face both ways at once - helping people and controlling them simultaneously" (Dominelli, 2009)

Images of care homes in the media are frequently negative

I want to live in a care home when I am older

LET'S DISCUSS

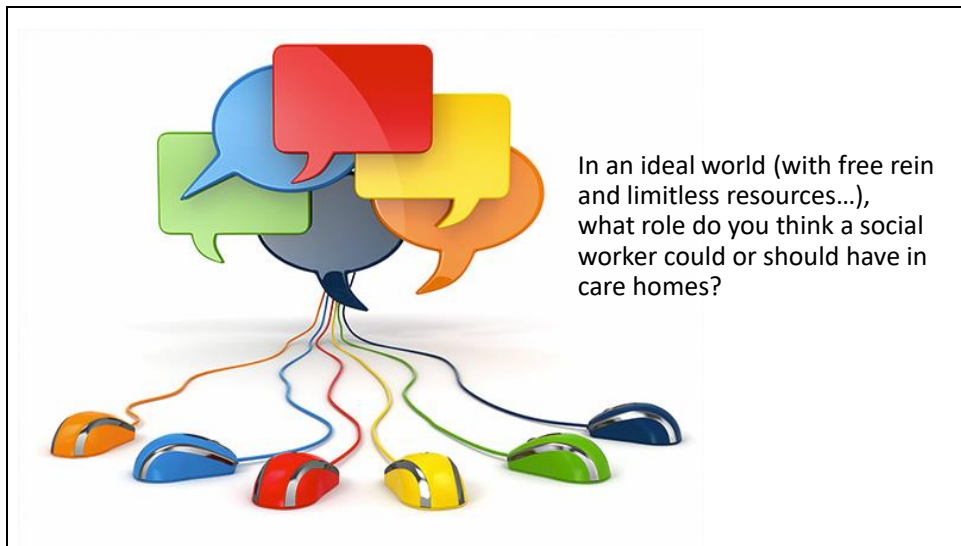
In the USA, any nursing home with more than 120 beds must employ a social worker

"Social work is largely marginal to care home residents once a move has been made to a care home" (Manthorpe and Martineau, 2017)

Social work with older people is often seen as a 'Cinderella service', attracting lower levels of interest, status, resources, specialist training and research funding compared with other areas of practice

Notes: Prompts. Ask to choose a statement that they want to do discuss. Do they agree? Do they disagree? On a scale of 1-10? Examples you can think of that support or counter these statements?

Slide 7



Notes: Remember to ensure everyone gets a voice - has anyone not had a chance to speak? Another way to word the question: If you had a free rein and limitless resources what contribution can you imagine social workers making to care homes?

Slide 8



Notes: Ask everyone in group to give a final thought or comment: if you take one thing away today from the discussion what would it be / what has struck you most about the discussion today? Sum up the group. Thank everyone – think about after care/contact. Reflections on experience of being part of the group/research. Happy to share any reading/research articles or anything that has sparked interest. Also information for anyone who would like to take part in an individual interview (more narrative approach – experiences of doing social work in a care home)

Appendix D: Interview Topic Guide

Main questions:

1. Tell me about your background in social work (for example, how long you have been qualified, what roles you have worked in, your current role)
2. What is important to you about being a social worker?
3. I am interested in exploring the social work role particularly in relation to care homes for older people. I would like you to tell me about any professional stories, events and experiences relating to this topic

I am planning to take a narrative approach encouraging the participants to share stories and experiences but the following prompts/questions and areas to explore may be used within the interview framework:

What do you do?

- a) Tell me about some of the main situations when you have come into contact with care homes as a social worker? [What do social workers actually do?]
- b) Can you tell me about positive examples of social work practice with care homes? Can you think of examples which were not so positive?
- c) What contribution/difference do you think social workers can make for people living in care homes?

What do you think?

- d) What are the main influences on the way that you carry out your role in relation to care homes? Where are the messages coming from?
- e) What do you think your role is? How do you think others see your role?
- f) What issues & challenges do you think social workers deal with in relationship to care homes?
- g) What are the barriers to developing a more extensive role?

What are the possibilities/what would you like to do?

- h) What would you *like* to be able to do/do more or/do differently in relation to care homes?
- i) If you had a free rein and limitless resources, what contribution can you imagine social workers making to care homes?
- j) What does good social work practice with care homes look like?

Appendix E: University Ethics Approval



Dear Sally

Application ID: ETH2021-0052

Project title: Reimagining social work and care homes – exploring the influences and the possibilities

Lead researcher: Ms Sally Nieman

Your application to Ethics and Integrity Sub-Committee was considered on the 4th of October 2021.

The decision is: **Approved**

The Committee's response is based on the protocol described in the application form and supporting documentation.

Your project has received ethical approval for 4 years from the approval date.

If you have any questions regarding this application please contact your supervisor or the secretary for the Ethics and Integrity Sub-Committee.

Approval has been given for the submitted application only and the research must be conducted accordingly.

Should you wish to make any changes in connection with this research project you must complete ['An application for approval of an amendment to an existing application'](#).

The approval of the proposed research applies to the following research site.

Research site: England - (but remotely)

Principal Investigator / Local Collaborator: Ms Sally Nieman

Approval is given on the understanding that the [UEL Code of Practice for Research and the Code of Practice for Research Ethics](#) is adhered to. □□

Any adverse events or reactions that occur in connection with this research project should be reported using the University's form for [Reporting an Adverse/Serious Adverse Event/Reaction](#).

The University will periodically audit a random sample of approved applications for ethical approval, to ensure that the research projects are conducted in compliance with the consent given by the Research Ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of the project

Yours sincerely

Fernanda Silva

Administrative Officer for Research Governance

Appendix F: Conference Poster: Virtual Focus Groups (July 2022)

The screenshot shows a Microsoft Teams meeting window. The main content is a presentation slide with the following sections:

Embracing virtual focus groups in social work research

Background

Focus groups (Linhorst, 2002:209):

"a qualitative research method in which a moderator interviews a small group of participants, typically 6 to 10, and uses the group process to stimulate discussion and obtain information on the beliefs, attitudes, or motivations of participants on a specific topic"

They are usually conducted in person. Our doctoral studies both use focus groups with social workers.

COVID 19 meant a nationwide shift to virtual working: we had to conduct our focus groups online. Ethics approval stipulated online data collection.

There is limited literature considering virtual focus groups as a research method. Despite technology being available for some time, there are limited examples of virtual focus groups used pre-pandemic (Morgan, 2019). An important area to consider due to Covid, emerging functionality of technology and increased awareness (but don't overlook digital exclusion/inequalities).

References

Belzille, J. & Oberg, G. (2012) 'Where to begin?' Grappling with how to use participant interaction in focus group design' *Qualitative Research* 12(4) 459-472
 Linhorst, D. (2002) 'A review of the use and potential of focus groups in social work research' *Qualitative Social Work* 1(2) pp. 208-228
 Morgan, D. (2019). Basic and advanced focus groups
 Parker, A. and Tritter, J. (2006) 'Focus group method and methodology: Current practice and recent debate' *International Journal of Research & Method in Education* 29(1) 23-37

Adaptations

- ❖ Smaller numbers in groups (= more groups) – 4 or 5 is optimum online
- ❖ More structure needed – impact on research design
- ❖ Different ways needed to encourage interaction
- ❖ Support participants to settle in and manage dynamics
- ❖ Adapting consent and confidentiality

Benefits and Challenges

<ul style="list-style-type: none"> ⊙ Low cost ⊙ Convenient – (e.g travel, venue, time) ⊙ May ease access / inclusion ⊙ Use of inbuilt technology to record and transcribe ⊙ Familiar environment, may also support sensitive topics ⊙ May encourage certain participants (i.e. professionals) 	<ul style="list-style-type: none"> ⊙ Technical issues with connectivity, competence ⊙ May inhibit certain participants (digital inequalities) ⊙ Harder to establish rapport and manage interaction ⊙ Need for smaller groups and more structured activities ⊙ Confidentiality issues
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Implications for practice or 'growing pains'

- ❖ Participant interaction is often cited as the hallmark of the focus group method (Belzille and Oberg, 2012). Researchers should acknowledge the impact of the virtual environment within their research framework.
- ❖ Recruitment and sampling present key methodological and epistemological dilemmas (Parker and Tritter, 2006).
- ❖ Methodological challenges such as smaller groups and the online environment need to be addressed in analysis and interpretation.
- ❖ We need specific resources to support researchers using online focus groups.
- ❖ Researchers must always justify their methods: embracing online focus groups as a positive choice allows this to be addressed within the research design and process.

Appendix G: Example of Nvivo codebook

Name	Description
Active voicing	
Ageism	
At the core of social work	Descriptions of what participants say is important to them about social work - some may be articulated, some inferred
Being a manager (or a social worker)	
Being involved	
Belonging	them and us (do people feel they belong in care homes? Do social workers belong? Does 'putting people' in institutions belong in the role if people belong in the community? Who does the social work really work for?)
Boundaries	
Communication	
Covid	
Cultural issues and intersectionality	
Descriptions of care homes or being in a care home	
Descriptions of SW role with care homes	
More than just task focused	Descriptions of social work practice that are not just transactional
Transactional or task focused	
Descriptions of the SW role	
Difficult work	
Duty of optimism	
Emotions	
Experience and inexperience	

Name	Description
How others see social workers	Care home staff, families, residents, other professionals
Identity	
If only	
Important quotes	
It used to be different	Does this code also have an element of erosion of professional skills?
Methodological	
Interruptions in the interview	Instances where participants are interrupted (will not be a theme but interesting nonetheless)
Process of the interview	
Othering and defences	
Positive choices and thriving	
Power dynamics	
Prioritising people in the community	
Professional Judgement	
Relationships	
Rights	
Risk	
Scrutiny	
Social work on the quiet	What you do vs what you should do
Status	
Structural constraints	
Gatekeeping	
Not much can be done about it	
Policy driving practice	

Name	Description
Process	
Resources	
Time pressures	
Sugar coating	
Tasks	What do we see from what people talk about
Tensions of the role and conflict	
Trust	
Understanding the care home environment	
Visibility and presence	

Appendix H: Focus Group Participants

Group	Participants	Characteristics of the group
FG 1	N=5 Vanessa Ana Jada Michelle Tina*	Colleagues in local authority placement reviews team, whose roles specifically mandate them to work with older people in care homes. The group was all female, ethnically diverse, with a mix of social work experience (student social worker to 30 years' qualified). There was an established rapport between participants and a willingness to come together to reflect during a rarely offered opportunity to talk about the work that they do.
FG 2	N=4 Marielle Adaku Zara Alison	Social workers from different local authorities. Two participants had specialist roles as care home 'link social workers'; two participants were from different community teams that mainly work with older people. The group was all female, ethnically diverse, with a mix of social work experience (student social worker to 30 years' qualified).
FG 3	N=8 Carla* Shireen Farzana Rachel* Elif Amy Liam Simone	All social workers with manager roles in one local authority, representing a variety of teams, including hospital, community and specialist teams across adult social care. The group was predominantly female, ethnically diverse and with a range of social work experience (8 – 30+ years). Many participants knew each other but would rarely come together as a group.
FG 4	N=3 Julia* Kerri Rina	Social workers from different organisations (2 local authorities and a voluntary organisation), none of whom knew each other. The group was all female, ethnically diverse, with a range of experience from NQSW to 19 years' experience. This was the most heterogenous group in terms of roles and experience.

*Also took part in an interview

All participants have been given pseudonyms

Appendix I: Pen Pictures of Interview Participants

Interview 1: “Carla”

Carla qualified as a social worker over 25 years ago, having previously worked as a residential social worker with older people (an unqualified role). She has always worked with adults, initially as a hospital social worker and then in several roles undertaking and leading projects around reviews. She is a practising BIA. She has worked in her current local authority for many years. She is the team manager of a care home placement reviews team.

Interview 2: “Adam”

Adam has 20 years’ qualified social work experience. He has worked in adults’ hospital and social work community teams, and was a hospice social worker for 9 years. He now works for a large faith-based voluntary organisation as a senior social worker. He spends a few days a week attached to one of the organisation’s care homes (in a new role being developed).

Interview 3: “Tina”

Tina has been a social worker for over 30 years ago. She has had various social worker roles with adults in hospital and community teams, as well as senior practitioner and manager roles. Some years ago she decided to move back to a social worker role. She is now part of a placements review team, with responsibility for complex debt cases and Court of Protection finance work. She described her role as a “niche I seem to have carved out for myself”.

Interview 4: “Jon”

Jon has been a qualified social worker for over 20 years. He has had various social work roles, working “overwhelmingly with older people”. He is a practice educator. He trained as a BIA but has not undertaken DoLS assessment for many years. He has worked in his local authority for 10 years and moved to his current role at the start of the pandemic. He is the team manager of an adult reviews team, which reviews people in the community and in care homes.

Interview 5: “Norman”

Norman qualified 8 years ago, coming into social work following a ‘career change’. He has worked with people with learning disabilities, people with sensory impairment and older people, and was a social worker for military personnel. He is an AMHP. He works for a large local authority, with about 500 care homes. His role is in the organisational safeguarding team, working with ‘failing’ organisations or providers to make improvements. He describes

this as “a specialism within a specialism”. He has lived experience of a family member with dementia living in a care home before they died.

Interview 6: “Julia”

Julia is a newly qualified social worker undertaking the ASYE in a community mental health team. She is employed by a local authority and seconded to the mental health trust. She was an independent advocate for 6 years and continues to work in this role, supporting people in care homes under the DoLS process in another local authority.

Interview 7: “Ritchie”

Ritchie qualified as a social worker outside of the UK over 15 years ago. He has had various social work roles in the UK in adults’ services, mainly in learning disabilities, and has worked as a manager and a project lead. He is a practising BIA. He works currently as a social work university lecturer. He has a background in psychodynamic practice.

Interview 8: “Kim”

Kim qualified as a social worker 20 years ago and before that, worked in social care in unqualified roles. She has a range of experience mainly working with adults, particularly people with learning disabilities. She is a practising BIA and an experienced practice educator. She currently works for a local authority in a team for older people with mental health needs.

Interview 9: “Rachel”

Rachel has been a social worker for over 25 years. Before she qualified, she worked as a careworker in a care home. She has had numerous social work roles with adults, including working in hospitals and with people with learning disabilities. She has “given up social work” three or four times, but always returned to it. She is currently the manager of a local authority hospital social work team.