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Social work and learning disabilities: an exploration of the
contribution of social work within a multi-disciplinary team

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ABSTRACT

Effective delivery of health and social care requires collaboration between professions. The aim of this research study was to explore one element of that collaboration – the contribution made by social workers to multi-disciplinary professional practice in adult services in England. The study was conducted against the backcloth of the Modernisation agenda for health and social care integration. This approach was first introduced by the New Labour Government (1997-2010) and strengthened by the vision and expectations championed in the policy documents, *Valuing People* (2001) and *Valuing People Now* (2009) for adults with learning disabilities.

Hermeneutical phenomenology, drawn from Heidegger, underpinned the methodological and philosophical approach which led to an emphasis upon rich description and interpretations of individual lived-worlds. The theoretical position adopted was informed by Wenger's work on Communities of Practice, which is grounded in the importance of social interactions inherent within multi-disciplinary practice between different professionals.

Participants included registered social workers (n=9) and allied health professionals (n=8). Data was generated over a nine month period. Semi-structured interviews were utilised with all professional participants. Data was analysed using Nvivo (10) and an Interpretative Phenomenological Analysis towards the data was adopted. Individual vignettes were presented on behalf of local citizens (n=9) which represented their personal narratives about the value of social work, embedded within this multi-disciplinary context.

The key findings highlighted the unwavering commitment from social workers to advocate on behalf of vulnerable adults. This was underpinned by adherence to professional social work values which facilitated their abilities to deliver a plethora of professional services. Allied health professionals substantiated the important contributions of social workers within the multi-disciplinary team, alongside local citizens who confirmed social workers valuable roles as part of their complex networks of support. The implications from this research study suggested that inter-professional education and training could augment collaboration between professions to progress the current health and social care agenda, focused upon integration in England.

	Page
Abstract	iv
Glossary of Terms	v
List of Tables	vi
List of Figures	vii
Acknowledgements	viii

Glossary of Terms

ADASS	Association of Directors of Adult Social Services
Agency	Local Authority Statutory Service (adults)
AHT	Allied Health Team
BASW	British Association of Social Workers (England)
CCG	Clinical Commissioning Group
Citizens	Service Users & Informal Carers
DH	Department of Health
GMC	General Medical Council
GP	General Practitioner
GSCC	General Social Care Council
HCPC	Health and Care Professions Council
IFSW	International Federation of Social Workers
IPA	Interpretative Phenomenological Analysis
MDT	Multi-disciplinary Team
NHS	National Health Service
PCT	Primary Care Trust
TCSW	The College of Social Work
UK	United Kingdom (national points of discussion)

List of Tables	Page
Table 1: Terminology about Partnership Working	22
Table 2: Terminology about Dimensions of Joint Working.....	24
Table 3: Terminology and Explanation of Terms	25
Table 4: Issues about MDT Working	80
Table 5: Social Work Research Participants (n=9).....	93
Table 6: Allied Health & Community Nurse Research Participants (n=8)	95
Table 7: Service User Participants (citizens) (n=4).....	96
Table 8: Informal Carer Participants (citizens) (n=5).....	97
Table 9: IPA Systematic Process	119
Table 10: Total Prevalences.....	136
Table 11: Data Item & Coded Data Extract.....	138
Table 12: MDT Data Set 1a	145
Table 13: DW Data Set 1b.....	147
Table 14: AHT Data Set 2	148
Table 15: Parent node ranking.....	151
Table 16: Sub-node ranking	151
Table 17: Summation of Prevalences.....	151
Table 18: Hierarchies of Prevalences.....	153
Table 19: Identification of Main Themes and Sub-themes.....	155
Table 20: Service User Participants	240
Table 21: Informal Carer Participants	258

List of Figures	Page
Figure 1: Organisation of Data Sets.....	113
Figure 2: Multi-disciplinary Team (MDT) (n=11)	115
Figure 3: Allied Health Team (AHT) (n=6)	115
Figure 4: Dimensions of a Community of Practice (CoP)	126
Figure 5: Presentation of Coherent Findings	133
Figure 6: Initial Results: Experienced Social Worker	139
Figure 7: Initial Results: Clinical Nurse Specialist.....	140
Figure 8: Thematic Network 1 Professional Issues	159
Figure 9: Thematic Network 2 Contextual Issues	160
Figure 10: Thematic Network 3 Organisational Issues	160
Figure 11: Thematic Network 1.....	163
Figure 12: A Supervision Policy	176
Figure 13: Thematic Network 2.....	189
Figure 14: Diagram of a Partnership Board	196
Figure 15: Thematic Network 3.....	208
Figure 16: Diversity of Needs (2011).....	212
Figure 17: Key Issues and the Transition Process.....	225
Figure 18: An Information Network.....	229
Figure 19: Priorities for Carers (2013-16)	261
Figure 20: An Engagement Structure	275
Figure 21: A Complementary Theoretical Focus.....	305

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This doctoral study completes me. It brings to fruition 20 years of social work practice, working alongside other social workers, allied health professionals and, not least, citizens who have learning disabilities; and their carers.

Table of Contents:	Page
CHAPTER 1.....	1
INTRODUCTION	1
1.1 INTRODUCTION TO THE RESEARCH STUDY	1
1.2 RATIONALE: BACKGROUND TO THE RESEARCH STUDY	3
1.3 SOCIAL WORK: A CONTESTED CONCEPT	5
1.4 THE HEALTH, SOCIAL WORK AND POLITICAL CONTEXT	7
1.5 AIM AND OBJECTIVES OF THE RESEARCH STUDY	12
1.6 METHODOLOGICAL ORIENTATION	13
1.7 STRUCTURE OF THE THESIS	14
CHAPTER 2.....	17
LITERATURE REVIEW	17
2.1 INTRODUCTION	17
2.2 THE APPROACH TO THE LITERATURE SEARCH	18
2.3 ABOUT THE LITERATURE	20
2.4 CURRENT HEALTH AND SOCIAL CARE INTEGRATION ACROSS THE UK.....	25
2.4.1 Northern Ireland	31
2.4.2 Scotland	33
2.4.3 England and Wales	34
2.5 CHILDREN'S SERVICES CONTEXT: EMPIRICAL RESEARCH IN ENGLAND	40
2.5.1 Children with Disabilities	46
2.6 ADULTS SERVICES CONTEXT: EMPIRICAL RESEARCH IN ENGLAND AND WALES	49
2.6.1 Safeguarding and Protection	49
2.6.2 Mental Health Services	52
2.6.3 Mental Health Services and Older People.....	54
2.6.4 Learning Disabilities Context & Empirical Research in England and Wales.....	58
2.6.5 Valuing People: Vision and Commitment	62
2.7 CITIZENS: PERSPECTIVES OF PEOPLE WHO NEEDED AND USED HEALTH & SOCIAL WORK SERVICES	66
2.7.1 Informal Carers.....	68
2.7.2 Service Users.....	69
2.8 CRITICAL COMMENTARY.....	71
2.9 CONCLUSION	78
2.9.1 Addressing the Knowledge and Research Gap	81
CHAPTER 3.....	84
METHODOLOGY AND METHODS	84
3.1 INTRODUCTION	84
3.2 METHODOLOGY	85
3.3 PHILOSOPHICAL APPROACH: PHENOMENOLOGY & HERMENEUTICS	88
3.4 RESEARCH SITE: RECRUITMENT & SELECTION	91
3.4.1 Multi-disciplinary Teamwork	97
3.5 RESEARCH ETHICS.....	99
3.5.1 Voluntary Consent	102
3.5.2 Informed Consent & Citizen Involvement	103
3.5.3 Confidentiality	108
3.6 METHODS: DATA GENERATION	109
3.6.1 Semi-structured interview Schedules (professionals)	110
3.6.2 Qualitative Interviews and Alternative Methods.....	112

3.6.3 CREATION OF DATA SETS	113
3.6.4 AGENCY STRUCTURES AND CONFIGURATIONS	114
3.7 DATA ANALYSIS AND PROFESSIONAL PARTICIPANTS: INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA)	116
3.8 DATA ANALYSIS: THE APPROACH (MDT & AHT)	116
3.9 SELECTION OF ORIGINAL DATA EXTRACTS (QUOTATIONS)	120
3.10 THEORETICAL FRAMEWORK: COMMUNITIES OF PRACTICE (CoP)	122
3.10.1 <i>Mutual engagement</i>	126
3.10.2 <i>Shared Repertoire</i>	127
3.10.3 <i>Joint Enterprise</i>	128
3.11 CONCLUSION	131
CHAPTER 4.....	132
PRESENTATION OF FINDINGS:	132
4.1 INTRODUCTION: THE APPROACH	132
4.2 FINDINGS (1): PROFESSIONAL PARTICIPANTS, RESULTS, PREVALENCES AND THEMATIC NETWORKS	134
4.3 INITIAL RESULTS: DATA CHARTS	139
4.3.1 <i>Analytical significance attached to the Initial Results</i>	140
4.4 PRESENTATION OF TABLES	144
4.5 DEVELOPMENT OF MAIN THEMES AND SUB-THEMES	150
4.6 IDENTIFICATION OF MAIN THEMES AND SUB-THEMES	153
4.7 CONCEPTUAL ANALYSIS AND INTERPRETATION OF THE RESULTS	154
4.8 THEMATIC NETWORKS	158
4.9 CONCLUSION	161
CHAPTER 5.....	162
FINDINGS (2): IDENTIFIED THEMES OF THE MDT AND THE AHT	162
5.1 INTRODUCTION	162
5.2 THEMATIC NETWORK 1: PROFESSIONAL ISSUES	163
5.2.1 <i>Thematic Network 1: Overarching Theme</i>	164
5.2.2 <i>Critical Commentary</i>	170
5.3 THEMATIC NETWORK 1: MAIN THEMES.....	170
5.3.1 <i>Role Clarity within the Team (MDT) and (AHT)</i>	171
5.3.2 <i>Critical Commentary</i>	174
5.3.3 <i>Supervision Experiences</i>	175
5.3.4 <i>Critical Commentary</i>	180
5.3.5 <i>Social Work Values</i>	181
5.3.6 <i>Critical Commentary</i>	185
5.4 THEMATIC NETWORK 1: SUB-THEMES	185
5.4.1 <i>Continuous Professional Development (CPD)</i>	185
5.4.2 <i>Professional Role & Status (position within the team)</i>	188
5.4.3 <i>Critical Commentary</i>	188
5.5 THEMATIC NETWORK 2: CONTEXTUAL ISSUES	189
5.5.1 <i>Thematic Network 2: Overarching Theme</i>	189
5.5.2 <i>Critical Commentary</i>	194
5.6 THEMATIC NETWORK 2: MAIN THEMES.....	195
5.6.1 <i>Benefits of MDT working with Service Users (citizens)</i>	195
5.6.2 <i>Learning Disabilities Partnership Boards (LDPBs) & Health and Wellbeing Boards</i>	197
5.6.3 <i>Critical Commentary</i>	198
5.6.4 <i>Experience within the Learning Disabilities Service</i>	199
5.6.5 <i>Critical Commentary</i>	201
5.7 THEMATIC NETWORK 2: SUB-THEMES	202

5.7.1 Contribution of Social Work.....	202
5.7.2 Working with other Professionals.....	204
5.7.3 Benefits of MDT working with Informal Carers (citizens)	205
5.7.4 Critical Commentary	207
5.8 THEMATIC NETWORK 3: ORGANISATIONAL ISSUES	207
5.8.1 Thematic Network 3: Overarching Theme	208
5.8.2 Critical Commentary	212
5.9 THEMATIC NETWORK 3: MAIN THEMES.....	213
5.9.1 Information sharing across Disciplines	213
5.9.2 Critical Commentary	217
5.9.3 Policies and Protocols across the Learning Disabilities Service.....	218
5.9.4 Critical Commentary	220
5.10 THEMATIC NETWORK 3: SUB-THEMES	221
5.10.1 Adults with Down's syndrome & Dementia	221
5.10.2 Young People in Transition	223
5.10.3 Critical Commentary	227
5.11 CONCLUSION.....	229
CHAPTER 6.....	230
FINDINGS (3): CITIZENS WHO NEEDED AND USED SERVICES.....	230
6.1 INTRODUCTION	230
6.2 WHAT MATTERS TO CITIZENS?	232
6.3 NARRATIVE INQUIRY APPROACH AND SOCIAL WORK	236
6.4 STORYTELLING AND INDIVIDUALS' LIVED-WORLDS	237
6.5 PART ONE: SERVICE USERS (CITIZENS)	239
6.6 THE PHILOSOPHY OF INDEPENDENT AND SUPPORTED LIVING.....	241
6.7 CASE VIGNETTE: AMY'S STORY.....	242
6.7.1 Critical Commentary	244
6.8 CASE VIGNETTE: BRIAN'S STORY	245
6.8.1 Critical Commentary	247
6.9 CASE VIGNETTE: CATHY'S STORY	248
6.9.1 Critical Commentary	250
6.10 CASE VIGNETTE: DAVID'S STORY	251
6.10.1 Critical Commentary	253
6.11 SERVICE USERS CONTRIBUTIONS	255
6.12 PART TWO: INFORMAL CARERS (CITIZENS).....	256
6.13 NATIONAL CARERS STRATEGIES (NCS) AND THE CARE ACT 2014	258
6.14 AGENCY CARERS STRATEGY (2013-16)	260
6.15 CASE VIGNETTE: MRS A'S STORY	261
6.15.1 Critical Commentary	263
6.16 CASE VIGNETTE: MR B'S STORY.....	264
6.16.1 Critical Commentary	267
6.17 CASE VIGNETTE: MRS C'S STORY	268
6.17.1 Critical Commentary	270
6.18 MR D AND MRS E'S STORY	271
6.18.1 Critical Commentary	273
6.19 CONSULTATION EVENTS.....	274
6.20 INFORMAL CARERS CONTRIBUTIONS.....	275
6.21 CONCLUSION.....	277
CHAPTER 7.....	279
DISCUSSION	279
7.1 INTRODUCTION	279

7.2 THE CONTRIBUTION OF SOCIAL WORK	280
7.3 ASSOCIATED FEATURES AND THE PUBLISHED RESEARCH.....	286
7.4 THE CONTRIBUTION OF NURSING (LD).....	288
7.5 THE LEGAL MANDATE AND SOCIAL WORK.....	291
7.6 HEALTH AND SOCIAL CARE INTEGRATION	295
7.7 COMMUNITIES OF PRACTICE (CoP): AN EFFECTIVE THEORETICAL FRAMEWORK?	302
7.8 CONCLUSION: CONTRIBUTION TO KNOWLEDGE AND ORIGINALITY	305
CHAPTER 8.....	314
CONCLUSION	314
8.1 INTRODUCTION	314
8.2 METHODOLOGICAL LIMITATIONS.....	314
8.2.1 <i>Engagement with an Agency</i>	315
8.2.2 <i>Participant selection (professionals)</i>	316
8.2.3 <i>Participant selection (citizens)</i>	316
8.2.4 <i>The Value of My Approach</i>	317
8.2.5 <i>Subjectivity and Reflective Narrative</i>	318
8.3 FURTHER RESEARCH THEMES	320
8.4 CONCLUSION: SOCIAL WORK AND THE FUTURE.....	322
APPENDIX 1	329
APPENDIX 2	333
APPENDIX 3	336
APPENDIX 4	338
APPENDIX 5	342
APPENDIX 6	343
APPENDIX 7	348
APPENDIX 8	351
APPENDIX 9	361
APPENDIX 10	363
APPENDIX 11	366
APPENDIX 12	368
REFERENCES	370

CHAPTER 1

Introduction

1.1 Introduction to the Research Study

This chapter begins with a rationale as to why it is important to explore the contribution of social work within a multi-disciplinary setting. From the outset, the study was positioned within the context of the Modernisation agenda, which was the creation of the New Labour government during 1997-2010. During their term in office the Labour government also produced two significant policies on behalf of people with learning disabilities. Namely, Valuing People (2001) and Valuing People Now (2009). This study was therefore underpinned by these influences which are brought to bear upon one statutory learning disabilities service in England.

However, due to the fact the study was developed over a nine year period from 2008 until 2017, the political trends from other parties have also influenced its outcomes. The parties represented are the Coalition government, (2010-2015), (Liberal Democrat and Conservative), and the Conservative government from May 2015. The different parties (and their views) have therefore affected the potential direction of social work during this time frame, and as a consequence the issues are discussed within a timely manner throughout this thesis.

The study has focused upon one multi-disciplinary team (MDT), located within adults' statutory learning disabilities (LD) service (agency). The main concept, which is central to the arguments elaborated upon in this thesis, is the exploration of social work's unique contribution within a MDT. In addition to this, a rationale about my interest in this subject is discussed, alongside a global definition of social work, juxtaposed to the

approach adopted in England: an approach which has predominance towards statutory interventions, with the intent to protect vulnerable children and adults from harm. The direction of the study is guided by the overall aim and related objectives, associated with social work practice within an adults' context. This is explained to the reader in more detail alongside participant selection. The methodological direction of the study is also highlighted, together with a descriptive account of how the thesis is organised.

The terminology 'learning disabilities' has been adopted throughout this thesis which is concurrent with my personal and professional values about people who need support. In addition, the study is underpinned by the social model of disability, an approach which acknowledges someone can have difficulties in cognitive understanding, but, as Williams (2009) argues, *'someone with rights, including the right to maximum control over decisions that affect them, and who may need help and support to claim and exercise those rights'* (Williams, 2009, p. 7).

The terminology of 'learning disabilities' was also espoused by the New Labour government (1997-2010) embedded within the White paper (policy document) Valuing People (2001) which is based on the premise that people with learning disabilities are people first:

We focus throughout on what people can do, with support where necessary, rather than on what they cannot do. (Valuing People, 2001, p. 14)

The policy goes on to reiterate:

This definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70 is not, of

itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. (Valuing People, 2001, p. 15)

1.2 Rationale: Background to the research study

Prior to working as an academic member of staff at the University of Salford, (2010-present) I was employed as a qualified and registered social worker within statutory social services (local authority) for 20 years (1990-2010). I specialised within adults services, and, more importantly, adults who have learning disabilities, the context being a multi-disciplinary team (MDT). The team consisted of one team manager (social worker), social workers (n=4), community workers (n=2), an occupational therapist and (LD) community nurses (n=2). The team was also supported by allied health colleagues, a consultant psychiatrist, a speech and language therapist, and a behavioural support nurse.

The demographic picture had also been influential in terms of the volume of demand from local citizens who needed both health and social work services. By way of illustration, there are approximately 1.5 million people in the United Kingdom (UK) living with learning disabilities (Disability Rights UK, 2016). Demographic projections suggest that this number will increase by 14 per-cent by 2021 as many more children born with a learning disability live longer, more fulfilled lives into adulthood, and the increasing adult population of people with learning disabilities grow into older age (The Scottish Government, 2015) (SG).

During this period, I held a number of posts (within the same service) among them, transition co-ordinator, senior social worker, practice educator and team manager. My final promotion was to a middle management position as a policy adviser specialising in

young people with learning disabilities moving through the transition process from children's to adults' services. Throughout these experiences what had transpired were the on-going debates within teams and between different professionals about the contribution of social work in particular, given the demographic changes and rise in demand for multi-disciplinary services. The role as a social worker and manager was susceptible to changing remits. This was further compounded by the increases in the demographic trends (as cited) and New Labour's approach and expectations for 'joined-up' services through multi-agency partnerships, supported by the Department of Health (DH, 2002) (DH).

New Labour's approach, coupled with British Nationalism, emphasised free markets, with restrained government spending and tax cuts (Lawson, 1992). The central reforms included the deregulation and privatisation of key national industries, the maintenance of a flexible labour market, and the devolving of government decision-making to local authorities (Lawson, 1992). Lymbery & Postle (2010) argued that the consequences of successive neo-liberal policies in welfare services have played a significant role in undermining the basis for social work with adults generally and, in this case, adults with learning disabilities. More recent policy developments such as 'personalisation' have also led to confusion about what the contribution (role) of social work entails. The issues related to personalisation are discussed in more detail in chapter two (see 2.4) and chapter seven (see 7.7) but, in short, the term personalisation is an umbrella term used to describe both an ideology and a way of delivering services which recognise service users as central to designing, planning, implementing and reviewing the services they receive (Gardner, 2013).

Thus, the way in which social workers intervene depends both on the model of change that is dominant within the profession at a particular historical time, and on the broader

political climate within which social work is practised (Green & Clarke, 2016). The initial drive therefore, was to contextualise my experiences (1990-2010) in order to acquire a deeper theoretical and political understanding about why the contribution of social work based within a MDT had become difficult to define.

1.3 Social Work: a contested concept

According to Herod & Lymbery (2002), social work is subject to competing definitions. Its language is perplexing and adds to the ambiguity about what it is that social workers do. However, there is fairly wide agreement that social work is committed to rights and justice, and it exists to support and enable those who experience the negative effects of social inequalities (Lymbery, 2012). This approach is also supported by The International Federation of Social Workers (IFSW) which explains its remit as an organisation which is striving for social justice, human rights and social development through the promotion of social work, best practice models and the facilitation of international co-operation (IFSW, 2016). The following definition was approved by the IFSW General Meeting and the International Association of Schools of Social Work General Assembly in July 2014:

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing. (IFSW, 2014, p. 1)

It could be argued, however, that this definition also has difficulties, in terms of its shared approaches based upon colonial histories, as stated by Parker & Doel:

Shared approaches to the design and delivery of social work stem from colonial histories and now represent neo-colonial actions enacted in indigenous terms. It may also be conjectured that social work cannot be reduced globally to a set of anything other than very broad defining characteristics. (Parker & Doel, 2013, p. 3)

As a case in point, it is important to note that in England (which has relevance to this study), there is a predilection towards social work (and therefore social work practice) undertaking formal statutory interventions, albeit within a framework of human rights, social justice and diversity. The hegemony of statutory interventions can therefore impact upon the more creative contributions that social work practice (in particular) could offer both individuals and local communities. For example, social workers being able to form more informal relationships which can lead to greater understandings of service users' cultural practices, and more opportunities to influence them.

The clear agenda from the Conservative government (2017) is the continued quest to integrate health and social care organisations in particular, so that cost effective services are delivered to citizens who need and use public services such as social work (Better Care Taskforce, 2013). This can be difficult to achieve due to the complexities and different priorities associated with health and social care organisations, such as local authorities. The drive to cut the costs of services (through effective delivery) is further endorsed within recent legislation such as the Children and Families Act 2014 and the Care Act 2014, both of which emphasise integration and partnership working.

The central argument put forward in this thesis, therefore, advocates that the predicament in contemporary social work in England is rooted in the difficulty, under current conditions, (social work reforms), of upholding and maintaining its contribution and distinctiveness compared with other professions. This is especially poignant when professionals from different disciplines are required to work together within a multi-disciplinary context and are working in partnership for the benefit of individuals and their carers.

1.4 The Health, Social Work and Political Context

As mentioned, the DH (2002) espoused a social and cultural shift about the way in which social workers and allied health professionals should work together, and, in this case, on behalf of people with learning disabilities. The DH advocated that local learning disability partnerships should be developed within the context of the overall national policy framework for partnership. The emphasis was upon local strategic partnerships (LSP). LSP were intended to bring together under one umbrella the different parts of public sector and the private, business, voluntary and community sectors. The partnership flexibilities contained within the Health Act 1999 and the Health and Social Care Act, (HSCA) 2001 offered opportunities for closer working and, in some cases, this was also a requirement in order to access funding.

Changes in the economic situation in England from the 1980s until the present day (2017) have emphasised the need to continually reduce public expenditure and therefore promoted a cultural shift towards welfare provision known as community care, especially in adult social care (Lymbery & Postle, 2015).

Prevailing ideologies and political agendas have led to changes in ideas about the roles social workers should perform and tasks they should undertake; what kinds of knowledge social workers require, and how this should be applied to practice (Green & Clarke, 2016). The emphasis on individual casework that focused on need, which characterised social work from the 1950s to the 1980s, has been superseded by the notion of risk management. Local authority social workers, particularly in adult social care, were increasingly concerned with care management and brokering services for citizens (Green & Clarke, 2016). Care management was an approach which moved away from listening to the personal narratives of vulnerable children and adults (citizens) who needed services. Instead, what emerged was a leaning towards the neo-liberal idealism presented by the then Conservative government (1983-1997). According to Ray et al., (2015):

The impact of community care on the organisation of personal social services was to steer its orientation towards an administrative model of social work – renamed care management. (Ray et al., 2015, p. 1299)

Social workers were influenced by the National Health Service (NHS) and the Community Care Act 1990 which resulted in fundamental changes in the role of local authority social services departments (Jordan & Drakeford, 2012). The changes meant that social services were required to produce community care plans, identifying the level and extent of need for care services. The services had to be commissioned from a range of providers in the private and voluntary sectors, rather than provided solely by the local authority. Tendering community care services was regarded by sequential governments as a way of keeping the cost of services down whilst increasing the extent of consumer choice (Jordan & Drakeford, 2012). These changes entailed that the role expectations of

many social workers in local authorities shifted from roles as caseworkers to those of care managers. Hence they assumed greater responsibilities for the assessments of needs and the allocation of services from within a limited budget. As Green & Clarke (2016) state:

The contribution to social problems of structural factors such as poverty, inadequate income, substandard housing and isolation was almost totally unacknowledged. (Green & Clarke, 2016, p. 19)

The timeliness adopted for this research study (2008-2017) was underpinned by the Modernisation agenda driven by the last New Labour government (1997-2010). The term modernisation has been the subject of intense debate and controversy and it was Tony Blair's (prime minister) strategy unit (PMSU) (HM Government, 2006) that announced that *'central to the achievement of the government's objectives was the need for greater social justice and higher quality of life for everyone'* (PMSU, 2006, p.13). For the government, it was about ensuring that everyone had access to public services that were efficient, effective, excellent, equitable and empowering – in other words, to continually strive for and cater to the needs of all citizens.

The New Labour brand was developed to regain trust from the electorate and to portray a departure from 'old' Labour, which was criticised for its breaking of election promises and its links between trade unions and the state (Daniels & McIlroy, 2008). The New Labour brand was used to communicate the party's modernisation to the public, and widen its electoral appeal to the upper and middle classes, but the brand was retired in 2010 (Daniels & McIlroy, 2008).

The political philosophy of New Labour had been influenced by Giddens' Third Way (Giddens, 1998). It advocated to be an alternative to Margaret Thatcher's free-market model of the neo-liberal state, and to old-style socialism – a mixed economy and universalistic, collective welfare state ((Jordan & Jordan, 2000). What was distinctive about the Third Way was its reappraisal of social democracy, and its values. Carling (1999) outlined the main tenets of this approach:

- *equality* – equal moral worth of all human beings; equality of opportunity, not outcome; protection of the vulnerable;
- *autonomy* – personal freedom; choice; political liberty;
- *community* – individual responsibility; reciprocity; obligations corresponding to social rights; social inclusion as the basis for social justice;
- *democracy* – empowerment; devolution of power.

The approach put forward in the Third Way had significant implications for social work, both as a professional activity and as a means of implementing social policy. On the one hand it was a new cultural and social context from which to engage with citizens. There was an attempt to change public services from a 'one size fits all' model, with centralised bureaucratic control, to more personalised services. This was difficult to achieve in social work, because some citizens needed to receive a service which was specific to their situation. For example, some individuals have limited mental capacity because of mental illness, dementia or learning disability, and others were involuntarily involved with social workers because they presented a substantial risk to themselves or others (Green & Clarke, 2016). However, the instrumental approach to governance embedded within the realisation of the Third Way had a strong managerial flavour to it. Thus, one of the main concerns expressed by some commentators (see for example Jordan & Jordan, 2000)

was the restricted view of the role to be played by social work in the transformation of society, and the lack of prominence given to social work within New Labour policy documents.

As mentioned, New Labour had initiated proposals for the reform of local authority social services departments, and the agencies which carried out the work were commissioned by them under contract. These reforms had been espoused in the White Paper *Modernising Social Services* (DH, 1998a), which was primarily concerned with regulating local authority departments through a series of supervisory and monitoring bodies; it also set new targets against which to measure performance. This included the drive to improve the strategic direction of social work, which was inclusive of children's and adults' services, under the guidance of a new General Social Care Council (GSCC) for Social Care. The GSCC was set up in 2001 further to the Care Standards Act 2000 which was enacted partly in response to criticisms in the late 1990s of social services in the UK. In particular, the case of Victoria Climbié, a small child who was abused and killed by her relatives in north London, despite having been known to local social services (Laming, 2003). The GSCC was given the remit to take a lead in the education and the strategic development and promotion of social work in particular. Its aim was to regulate training, set conduct and practice standards for social work services, and register those who completed their training (GSCC, 2001). The attitude of the public and of politicians to social workers throughout New Labour's government was marked by ambivalence and, at times, hostility:

Social workers were often pilloried for failing to intervene sufficiently early or decisively in cases where children died, or conversely for intervening too much and too soon in the private lives of families. (Green & Clarke, 2016, p. 24)

The austerity programme adopted by the Coalition government (2010-2015) meant substantial cuts to local authority budgets, particularly in relation to social care. The Association of Directors of Adults Social Services (ADASS) reported that the cuts amounted to £3.5 billion between 2010-14 (ADASS, 2014). Social work practice within this context meant that financial restrictions and eligibility thresholds for social care were set at 'critical' or 'substantial' levels by local authorities (Care Quality Commission, 2012). Consequently, it was difficult to provide anything other than basic levels of care to the most vulnerable.

However, the Coalition continued the drive to improve the strategic direction of social work. According to Shardlow (2013) *'the Conservative/Liberal Democrat government led by David Cameron, as part of a national programme to reduce the number of quangos, abolished The General Social Care Council'* (Shardlow, 2013, p. 99). Nevertheless, the imperatives remained for the Coalition government, to improve the structures of social work (in England) through a different regulatory body, the Health and Care Professions Council (HCPC). However, the HCPC was (and remains) a regulatory body for allied health professionals, such as speech and language therapists. This move was also supported by The College of Social Work (TCSW) (2015). The overall aims were to modernise and improve the status of, and confidence in, the social work profession.

1.5 Aim and Objectives of the Research Study

The overall aim of this research study was to explore one central theme: the contribution of social work located within a MDT, within the context of a statutory agency. Namely, an adults Learning Disabilities Service, in England. The study explored the extent to which social work has a distinctive role to play, as part of an increasingly multi-disciplinary approach, in providing targeted services and support for people with complex

health and social care needs (learning disabilities). Thus, the research question posed was:

What is the contribution of social work within a multi-disciplinary team?

The objectives of the research also identified a number of related concepts about the nature of social work, therefore the research study **has**:

- explored the perceptions of social workers located within a multi-disciplinary team and their contributions within the context of a learning disabilities service
- explored the perceptions of allied health professionals, discussed their roles and the contribution(s) of social workers
- explored the perceptions of managers who supported both social workers and allied health professionals
- considered a number of citizens' perspectives about the benefits (or otherwise) of working alongside social workers (and allied health professionals) based within a multi-disciplinary learning disabilities service.

1.6 Methodological Orientation

The methodological orientation of the research study was based upon the philosophical approach of naturalism, located within the interpretative paradigm. The importance of this approach is its opportunity to provide a plurality of world-views from different participants, which can be represented as human constructs of knowledge creation. This was captured through the individual interviews and interpretations from the professional research participants (n=17). The participants were 'going-about' their daily lives within a context of a MDT and an Allied Health Team (AHT). What was truly important in this research study was the 'essence' of the 'lived-world' (experiences), an approach

captured through the philosophical approaches of Hermeneutics and Phenomenology – notions which embraced personal interpretations and ‘things that matter to us’ which constitute our lived-world (Miller & Brewer, 2007). This approach is further validated through the involvement of a number of citizens (n=9) who also made individual contributions. Their views were captured through a narrative inquiry approach (storytelling) and likewise embedded within the interpretative paradigm which enabled their stories to be recounted; this added depth of meaning about their personal experiences of working alongside a social worker within this MDT context.

The theoretical orientation was founded upon Wenger’s (1998) theory: Communities of Practice. This theory asserts the importance of social interactions that are inherent within multi-disciplinary practice and between different professionals. The importance for this study was the focus upon how the professionals engaged with the process of multi-disciplinary working whilst maintaining their own professional identities, boundaries and ultimately their distinctive contributions.

1.7 Structure of the Thesis

This chapter has outlined the significant political changes which have occurred during the last forty years, in relation to welfare provision in the UK. These changes have impacted upon social work and subsequently dictated the way in which social workers undertook their roles. In addition to this, the overall aim and related objectives, along with the methodological orientation has also been discussed. Chapter two provides a review of the literature related to this study. It presents a discussion about the use of terminology in its various forms and a historical review of health and social care integration, followed by a critique of policy developments and associated research studies in the UK. In addition, this chapter presents empirical research in England about

children, inclusive of children with disabilities. Empirical research is also highlighted which relates to adults. This included mental health and mental health services with older people. There is a specific focus upon adults who have learning disabilities which is inclusive of the policy context. Consideration is also given to the views and expectations of citizens who needed and used allied health and social work services. Chapter three outlines the methodology and methods chosen for this study, (research design) and highlights ethical considerations. Other main features in this chapter contain the configurations of the MDT and the AHT, alongside a discussion about multi-disciplinary team working. The approach to data analysis is also introduced which is Interpretative Phenomenological Analysis (IPA), aligned with an explanation about the selection of data extracts. Chapter four builds upon the original IPA framework for analysis, and additional results are presented through the creation of prevalence tables. This leads onto the formation of three thematic networks representing the findings from the professional participants. Chapter five outlines a detailed account of each thematic network, and critical commentaries embedded within each network are offered. Appropriate illustrations are also provided to convey important points being made.

Chapter six turns to the findings from citizens who made a contribution towards this study. An explanation is provided as to why the approach of narrative inquiry had been selected to present the storytelling nature of the data from all the citizens. The chapter is separated into two: the first being focused upon service users and the second upon informal carers. Each of their narratives is presented as a case vignette and critical commentaries are also provided.

Chapter seven considers the importance of the outcomes from the research study as a whole, and the main themes are highlighted and discussed in detail. In addition, the

chapter presents a reflective analysis about the effectiveness of the chosen theoretical framework, Communities of Practice (CoP) and how this study has contributed towards the CoP theory. The chapter also provides clear outcomes about the contribution to knowledge which this study has made, as a consequence of the nine year period of study.

Finally, in chapter eight the boundaries of the research study are highlighted, together with its methodological limitations. This is supported through the notions of subjectivity and reflexivity, which are embedded as part of my identity as a social worker, alongside an evolving identity as a researcher. All the research participants offered their 'subjective' interpretations of their experiences and as such it would have been difficult to have prescribed some form of measurement for them, which accounts for some of the study's limitations, thus restricting the opportunity to generalise the outcomes. It also aligns the emergent themes from chapters five, six and seven with suggestions for further research themes. This includes the nature of the barriers between social workers and general practitioners (GPs), who are best placed to facilitate the integration of services between the NHS and social care. The study concludes with a discussion about the future of social work.

CHAPTER 2

Literature Review

2.1 Introduction

This literature review was undertaken to illustrate the nature and extent of empirical research about the contribution of social work to multi-disciplinary teams. The intention was to identify core emergent ideas on this topic, primarily based upon literature from the UK. A central aim of the review was to explore the extent to which there was a niche (knowledge gap) in which to site additional research that would add to the discourse about the complexities of multi-disciplinary practice, especially within the field of learning disabilities in England. The review has demonstrated the existence of both a wide range of complementary and contrasting perspectives, and also evidenced different theoretical bias and methodologies used by researchers in the formulation of their research outcomes and evaluations. The review was undertaken using systematic methods and was driven by and exploration of the following research question:

What is the contribution of social work within a multi-disciplinary team?

The review was conducted between 2008 and 2010. A second scoping review (using the same data bases, keywords and inclusion criteria) was essential to both review the continuing validity of the original research question, and examine the extent, range and nature of the literature which had been published since 2010.

During the initial search (2008-10) a broad overview of the literature was revealed, which drew together significant themes across services for both children and adults. This review has highlighted the importance of policy developments, which are linked to the

plethora of research studies focused upon multi-agency and multi-disciplinary working. In addition, the review has included the perspectives of citizens who needed and used the allied health and social work services, with particular attention paid to benefits (or otherwise) and the effectiveness of multi-agency and multi-disciplinary working.

2.2 The Approach to the Literature Search

A protocol for the identification of relevant literature was developed, and the approach adopted was informed by principles of rigorous literature searching for example, EPPI Standards, (2010) and Hart (2001). The protocol included a search strategy which had the following components: a data base search; an electronic search of key journals; a search of bibliographies for relevant literature revealed by the data base and journal index search. These components were selected on the grounds that they were the most likely to generate relevant viewpoints. The inclusion criteria was inclusive of literature published in English between 1997 and 2010. The start date was chosen to reflect the date when the New Labour Government came to power, as an important indicator for policy development in the field of social work and social care. The literature focused upon social work and other professionals who worked within a “multi-disciplinary” context. The idea of multi-disciplinary working is subject to a range of different interpretations, but in principle it can be understood as an attempt to capture the notion of professionals from different disciplines coming together to plan and deliver services. Edwards, (2004) argued that understanding how different terms are being utilised is crucial, and often reveals the practices that are being developed. Thus, the search was conducted in a number of stages.

Stage 1

Key words were identified, based upon preliminary scoping of the literature and prior professional knowledge. The identification of key words was problematic as the area for

exploration of multi-disciplinary working may be referred to in a number of ways, exemplified by the following list of pairings that were used with the term "social work": collaborative practice; inter-professional practice; multi-disciplinary practice; inter-agency working; multi-agency working and partnership working.

Stage 2

A key word search using the following data bases was conducted: Applied Social Sciences Index and Abstracts (ASSIA); Social Care Online (Social Care Institute for Excellence); Social Services Abstracts (SSA) and the Social Science Citation Index (SSCI) in *Web of Knowledge*. To enhance the data base search and to ensure that relevant articles were captured, an electronic search of the following journals was conducted: British Journal of Learning Disabilities; British Journal of Social Work; Child and Family Social Work; Journal of Integrated Care; Journal of Inter-professional Care and the Journal of Social Work. The titles of all published articles within the parameters of the prescribed date range were scrutinised and articles of relevance were selected for further consideration.

Stage 3

Bibliographies and reference lists in the academic literature identified in stage 2 and additional academic textbooks were hand searched. As a result, a total of 185 references were retrieved via all the searches.

Stage 4

References identified above in stage 2 and stage 3 were scrutinised to identify appropriate literature for this study. A screening tool (see Appendix 1) was designed to facilitate this process. The screening tool enabled the scrutiny of title, abstract and content. Once the literature was deemed relevant, a full reading of the article/text book/chapter(s) was undertaken. The bibliographical software package EndNote was

used to record the full text items retrieved for the review in terms of study design and topic.

The final literature review was based on 34 publications. The selection included empirical research within children's (n=8) and adults' (n=24) services. In addition, two literature reviews undertaken by the National Foundation for Educational Research (NFER), firstly in (2003) and updated by (Atkinson et al., 2007) were also included in the review.

Only research studies and reviews which offered a robust coherence about the notion of multi-agency and multi-disciplinary working, linked to UK policy initiatives have been included. This approach enhanced the ability to present research studies which focused upon the context and complexities of providing relevant services to vulnerable children and adults who needed and used public services including social work.

2.3 About the Literature

Much of the literature tended to group social workers and other professions together as a single group when issues about multi-disciplinary working were discussed (see Øvretveit, 1997; Payne, 2000; Leathard, 2009). This type of literature has focused upon how professionals, including social workers, undertook their work. However, the value of this type of literature is somewhat limited as social work has not been identified as a discrete profession and does not offer a critique of the social work contribution, set against those working in related professions such as allied health colleagues. Thus, it is difficult to distinguish what is both distinctive and valued about the social work role and, from a wider perspective, the contribution of the profession within a multi-agency and multi-disciplinary environment.

One way of conceptualising multi-disciplinary working is the way in which the effectiveness of co-ordination of services is delivered, underpinned by good communication between all relevant parties. Social workers, for example, have traditionally emphasised the importance of co-ordination of services where more than one agency or worker is involved. This occurs in areas such as key aspects of mental health work, learning disabilities, and adults' services and in child protection, thus reiterating the move towards 'specialist' social work practice. Morris et al., (2008) also highlights the fact that the changing landscape for social work practice means that there are few settings for social work where some form of joint agency activity is not a requirement for effective provision and practice. More recently, The British Association of Social Workers (BASW) (2016) issued a position statement about the role of social work and social workers in relation to health and social care integration. The Association supports joined up working in equal partnership with the health services. However, it does not support full social work and social care integration into the health services. Whilst the argument put forward is one of social work being in support of the changes required in the health service, (due to health demands and growth in demographic trends, especially for older people); its position advocates person centred support and maintaining strong links with local government including housing and public health services. There is also recognition that the public expect services to be working together and '*are somewhat intolerant of interagency differences where health and well-being is at stake*' (BASW, 2016, p.4).

In relation to children's services, one of the main elements of the Green Paper, Every Child Matters (DfES, 2003) was its recognition that improved multi-agency and inter-professional working was required, if a repeat of the tragic events that characterised the Victoria Climbié case were to be avoided (Laming, 2003). Legal and policy requirements

now formalise expectations for 'joined-up' provision such as the Children Act, 2004 and the Children and Families Act 2014. As a result, the contested concept of partnership runs as a theme through the levels of multi-agency working - strategic, operational and at the point of delivery. The debates about the conceptual understanding of partnership working, and the reality as experienced by those using services, reveal the extent to which tensions between political decisions and professional identities can emerge (Glendinning et al., 2002). The Munro report of child protection services highlighted the fact that government policy in recent years has been designed in recognition that the services children and families receive have often been limited, because of the failure of professionals to understand one another's roles or to work together effectively (Munro, 2010). BASW (2016) also outline the preferred model to be one of partnership working with joined up services – not full structural integration into a single organisation.

By way of illustration, the terminology highlighted a number of definitions and explanations about partnership working (see Table 1). A selection of authors were cited, (BASW 2016; Powell & Dowling 2006; Glendinning et al., 2002).

Table 1: Terminology about Partnership Working

Partnership Working
<p>For BASW, (2016) a relationship between individuals or groups that is characterised by mutual co-operation and responsibility, as for the achievement of a specified goal.</p> <p>(BASW, 2016 p.5)</p>
<p>For Powell & Dowling (2006) partnership working is often better described as:</p> <p>Putting mutual loathing aside in order to get your hands on the money. (Powell &</p>

Dowling, 2006 p.308)

For Glendinning et al., (2002a) a minimal definition of partnership working requires the involvement of:

At least two agents or agencies with at least some sort of common interests or interdependencies; and would probably also require a relationship between them that involves a degree of trust, equality or reciprocity. (Glendinning et al., 2002a, p. 3)

Glasby & Dickinson (2008) also argued that the use of phrases such as partnership working and inter-agency collaboration are inter-changeable, which highlights a number of key issues and principles that are worth stressing:

- Behind most definitions is a sense of added value – an ability to achieve something together that could not be achieved separately
- The significance of a sense of reciprocity (that is, for the relationship to be mutually beneficial, and for some sort of sharing of potential risks or drawbacks)
- The emphasis on some sort of formal and on-going relationship. Collaboration and partnership is a journey and, while they may not yet know where this will lead, the agencies involved must recognise that this is a route they need to travel together.

In terms of children's services, the New Labour government's guidance Working Together to Safeguard Children (DH, 1999b) sets out how all agencies and professionals needed to work in partnership with the aim of promoting children's welfare and

protection from abuse and neglect. It is addressed to those who work in the health and education services, the police, social services, the probation service and others who came into contact with children and families.

Equally, multi-agency working may reflect in reality only nominal joint agency activity. Morris, (2008; Edwards, 2006; Barrett et al., 2005) further explain that, in exploring the dimensions of joint working, the text does not use prescribed definitions for multi-agency working; instead the range of understanding described offers useful learning for those seeking to develop multi-agency practices (see Table 2).

Table 2: Terminology and Dimensions of Joint Working

Joint Working
A process of arriving at some shared strategic goals but with single agency activity within the overarching plans. (Morris et al., 2008, p. 128)
A process involving collective goals for service provision, but with independent execution of the various tasks and activities by each professional at the point of service delivery. (Edwards et al., 2006, p. 62)
The nature of health and social care is such that, for many, the quality of the service received is dependent upon how effectively different professionals work together. (Barrett et al., 2005, p1)

Barrett et al., (2005) highlighted the fact that social work in the UK is an activity that benefits from, and often requires, co-operation between different staff and across different professions. It is argued therefore, that how this is to be achieved has been a

central dilemma for practice and policy for many years. Barrett et al., (2005) offered a critique of inter-professional working which involves personnel from different professions and agencies working together. As such, there has been extended debate about terminology in this field. They offer, alongside others, additional explanations of terms (see Table 3), as illustrated.

Table 3: Terminology and Explanation of Terms

Terms
Tends to indicate the involvement of personnel from different professions, disciplines or agencies, but does not necessarily imply collaboration. (Barrett et al., 2005, p. 25)
Inter-professional collaboration is often spoken of as 'a good thing' by policy makers, without examining possible differences of interpretation in greater detail. (Øvretveit, 1997, p. 186)
As professionals work together they form informal collaborations across agencies, especially if there are shared interests, for example, working with people with learning disabilities. (Payne, 2000, p. 40)
Latinists can help to simplify the arena by translating 'inter' as between, 'multi' as many and 'trans' as across. What everyone is really talking about is simply learning and working together. (Leathard, 2009, p. 5)

2.4 Current Health and Social Care Integration across the UK

The detailed review of literature has been presented alongside a discussion of key policy developments: in order to facilitate this approach to the analysis, both policy and

literature have been presented with regard to the differences across the four nations (Northern Ireland, Scotland, England and Wales) of the UK.

Historically, since the late 1980s, partnership and joint working have become key features of social welfare across the UK. While collaborative methods of working have been promoted in all areas of public policy: nowhere are these methods more evident than in the planning and delivery of health and social care (Heenan & Birrell, 2006). Prior to the devolution of the four nations of the UK during 1999, differences in health policy across them had been minimal (Prothero & Bennion, 2010). However, since the devolution of powers, the four nations have enjoyed some freedoms to pursue and develop their own health and social care policies. Consequently, there is some evidence of emergent differences in the way that partnership and joint working have been interpreted and developed in each country of the UK. Attempts to coordinate the planning and delivery of health and social services through national strategies can be traced back to the 1960s (Hudson, 1998).

The strategy document, *Partnership in Action*, (DH, 1998a) stressed the need to look at a whole systems approach towards facilitating joint working between health and social services. The subsequent (Health Act, 1999) enabled flexible approaches to reduce obstacles to the development of a more integrated approach working through pooled budgets, lead commissioning and integrated provision.

As mentioned above, successive governments have used a variety of measures to achieve the closer integration of health and social care, but overall progress has been patchy and limited (Humphries, 2015). Some of the difficulties, and therefore discontinuities, associated with health and social care integration in the UK are due to

factors such as: differences in culture and ways of working, funding and accountability arrangements, and separate regulatory regimes that assess the performance of individual organisations but not the system as a whole (Humphries, 2015). As Humphries has argued:

There is general agreement that current arrangements are complex and confusing and too often fail to ensure that people receive the right services, in the right place at the right time. (Humphries, 2015, p.856)

The impetus for integration as a policy goal has been driven by three major factors. First, an ageing population and shifts in the pattern of morbidity entails that more people are living longer with a mixture of health and social care needs, as is the case for some people with learning disabilities. Frailty, very old age, and dementia requires coordinated care from different professionals, some of whom may or may not be located within a MDT and or a AHT. Dependent needs often require long term support closer to home rather than single episodes of care in acute hospitals. Therefore, a different model of integrated care is needed (Goodwin et al., 2012).

A second factor has been recognition of the increasing fragmentation and complexity in how services are commissioned, funded and provided, which has led to calls for greater integration. Since the foundation of the NHS in 1948 responsibility for 'social care' has been placed with local authorities across the UK. Successive re-organisations have created new divisions and since the NHS and Community Care Act 1990, most of the publicly funded social care services (care at home, residential/nursing homes) are provided by the private and voluntary providers (Humphries, 2015). The major reforms

introduced by the Coalition government associated with the Health and Social Care Act 2012 (HSCA, 2012) pronounced extensive structural re-organisation designed to:

Establish more autonomous NHS institutions, with greater freedoms, clear duties, and transparency in their responsibilities to patients and their accountabilities. We will use our powers in order to devolve them. (DH, 2010, p.7)

This legislation has led to the creation of new local organisations, clinical commissioning groups (CCGs) to commission health care with the intention of a stronger leadership role for general practitioners (GPs). A new national body NHS England was created to run the NHS rather than the Secretary of State for Health (Humphries, 2015). However, the passage of legislation (HSCA, 2012) was hindered by political controversy over the emphasis on competition and concerns that the independent sector would have a bigger role in the provision of NHS services. This 'discontinuity' in the legislative process (and amendments) created the opportunity to re-focus upon the importance of collaborative networks which promoted the interconnections between the various agencies involved in structural re-organisation. Although agencies were committed to the idea of increased health and social care integration in principle, progression towards this goal, however, proved somewhat elusive. This was compounded by the way in which different parts of the NHS, acute hospitals, primary care, mental health/learning disabilities and social care services were commissioned and funded separately. Nonetheless, one positive feature of this legislation (HSCA, 2012) was the creation of local authority-led Health and Wellbeing Boards (see 5.6.2), which brought together partners to promote collaborative integration and oversee commissioning through localised health and wellbeing strategies.

The third and final major factor is the longstanding distinction between NHS care that is mostly free at the point of use and funded through general taxation and publicly funded social care which is subject to a financial assessment – a 'means-test'. The growth in property and pension wealth has seen increasing numbers of people who are expected to fund the full costs of their care. The division between a free NHS and means tested social care is causing increasing difficulties in terms of equity, efficiency and effectiveness, compounded by reductions in local authority care budgets (Murray et al., 2014). Subsequently, the NHS Plan: Five Year Forward View (NHS England, 2014) continued to emphasise the need for better integration between health and social care, which is a priority to reduce fragmentation between services, and improve people's experience of, and outcomes from, care.

The contemporary vision of NHS England is to empower people and local communities through the use of personalised services which are underpinned by an effective (affordable) commissioning landscape across England. A central element of this approach is Integrated Personal Commissioning (IPC), which is the cornerstone of the Five Year Forward View initiative (Local Government Association & NHS England, 2016). The IPC programme was launched in April 2015 as a partnership between NHS England and the Local Government Association (LGA). In 2014, health and care organisations were invited to become IPC demonstrator sites, with nine areas chosen across England. Each site is developing a new model of care that will expand to cover everyone with complex needs in their area by 2018. The programme is aimed at those groups of individuals who have high levels of need, often with both health and social care needs, where a personalised approach would address acknowledged problems (fragmentation of service provision) to enable people to retain their independence. This includes people

with learning disabilities with high support needs, some of whom are placed within institutions. Accordingly:

The vision is that IPC and personal health budgets will provide counterbalances to whole population commissioning models, and enable people to opt out of their local provider for particular services and increase personal decision making around their care. (LGA & NHS England, 2016, p.3)

Learning from the experience of the demonstration sites indicates that IPC could become the mainstream model of community based care for around five per-cent of the population, including children and adults with complex learning disabilities and autism. By 2020, it is intended that the model will be in place in every locality, planned and delivered in partnership with social care and the voluntary, community and social enterprise (VCSE) sector (LGA & NHS England, 2016).

This fast paced and constantly changing health and social welfare context across the UK has focused renewed attention of policy makers and politicians. Their focus is targeted towards the potential for health and social care integration, (through planning and delivery) to save money and achieves better, more cost-effective outcomes within existing resources. Although the major political parties agree that integration is a key policy objective, there is less agreement on the means by which this should be achieved.

2.4.1 Northern Ireland

Integration in the delivery of services has been achieved in Northern Ireland through a programme of care approach to resource procurement and allocation, thus providing a management framework. These elements are used to plan and monitor the services, by allowing performances to be measured and targets set and managed on a comparative basis. In total there were nine programmes of care: acute services, maternity and child health, family and child care, elder care, mental health, learning disabilities, physical and sensory disability, health promotion and primary health and adult community. These programmes of care teams operated on an interdisciplinary basis, but the degree of integration varied between the programmes. Mental health and learning disabilities were the most integrated, with childcare reflecting least integration due largely to statutory commitments.

Heenan & Birrell (2006) conducted a qualitative study of senior health care professionals in four health and social services boards, and the eleven community trusts. Participants included (n=4) directors of social services, (n=3) chief executives from trusts, (n=17) directors and assistant directors from the trusts, which also focussed on health and social care integration. The study was based on semi-structured interviews (n=24) with senior managers, which explored attitudes to, and perceptions of, the integrated structure, and to assess the extent to which it led to an integrated service. A range of professionals including nurses, community nurses and social workers who were team leaders in integrated programmes of care contributed through focus groups. Key topics included were: commissioning and delivery of care, professional issues, antecedents and barriers to joint working, and lessons to date. Four key themes emerged: holistic working through programmes of care, integrated management and inter-professional issues, hospital discharge and the hegemony of health. The advantages of the

programmes of care were constantly stressed and reiterated by all participants. They were referred to as the central feature of the system. There was extensive support for this way of working and a perception that it resulted in a truly integrated service. It was claimed that programmes of care ensured that resources were used to best effect and managers were not constrained by artificial boundaries between health and social care. As one of the trust directors said:

I think the integrated programme of care allows everyone to play to their strengths by someone having an overview and coordinating the service. In the vast majority of cases patients need health and social care so we ought to deal with them integrally. (Heenan & Birrell, 2006, p.54)

It was suggested that the programmes of care were well placed to meet the increasingly complex needs of service users. Also, within this approach, the individual had a named key worker, and this made access to services less complex and daunting. Care was coordinated and therefore duplication of services was avoided through this coordinated approach. Many participants mentioned the advantages of a one-stop shop or no wrong door approach. The fact that there was one point of entry for anyone wishing to access health and personal social services was considered to be a particular advantage of the system. Service users who were often vulnerable did not have to move between organisations. A team leader said:

This system of programmes of care means that resources are used to best effect. People do not have to engage with expensive unnecessary services. (Heenan & Birrell, 2006, p.54)

The importance of this approach was stressed by a trust director, who claimed that the system was 'taken for granted' in Northern Ireland and that it should be disseminated across the UK as a model of good practice.

2.4.2 Scotland

Community Health Partnerships (CHPs) are the key mechanism through which all primary and community based services are planned and delivered. They have a central role with their partners (local authorities) in improving health and reducing health inequalities. One view of their purpose is to act as a partnership working facilitator, or as a linking agent between different organisations to encourage a better understanding between the different organisations (Watt et al., 2010). In Scotland, all partner agencies are involved in the delivery of health and social care to vulnerable groups. Ministers confirmed the shifting of the balance of care in terms of sharing joint outcomes (of delivery) with local authorities. Most CHPs had a central management team and most are co-terminus with local authorities. The picture that emerged was one of variation with a complexity of relationships and structures. The no-one size fits all had proved to be the case and the opportunity to develop a local approach had been welcomed. The CHPs had evolved within a changing context, and covered complexities of areas of work, from improving relationships and engagement with local authorities and other partners, to working jointly in providing services for vulnerable people (children and adults). There was evidence to suggest that shifting the balance of care through moving the location of services in terms of better access to them had improved, combined with other factors such as the development of more localised services through multi-agency facilities. The most commonly reported achievement of the CHPs was the linking of health and social care, which initially the staff groups found difficult due to the differences in culture.

In terms of challenges and barriers to the achievement of integrated services, the most common problem identified was the relationship between health, local authorities and the Health Board. In addition to this problem, engaging effectively with GPs was commonly acknowledged as a challenge for the CHPs. Other cited difficulties were the organisational differences between the NHS and local authorities, financial resources and the capacity for each organisation to deliver their work. The suggestion for further action was to maximise the potential of the CHPs who had a key role in helping to promote and develop further joint working and, where appropriate, integration of services for vulnerable people. The overall sense was that, despite the challenges, many of those interviewed thought that the CHPs worked well in their area, and would continue to work on the progress that had been made so far.

2.4.3 England and Wales

An updated review undertaken by Cameron et al., (2012) of their original systematic review (Cameron & Lart, 2003), outlined the significance of developments since then. The aim of the research briefing was to highlight research evidence for joint and integrated working. They concluded that there was significant overlap between positive and negative factors. For example, a pre-requisite for successful integrated service provision is securing the understanding and commitment of staff to the aims and desired outcomes of new partnerships. This is deemed a crucial element to the success of joint working, particularly among health professionals. In addition to this, defining outcomes that matter to citizens is important. Outcomes defined by them may differ from policy and practice imperatives but are a crucial aspect of understanding the effectiveness of joint or integrated services. This important finding also reflected the intentions of this study, in terms of incorporating the views of citizens.

An earlier review (NFER, 2003) and updated by Atkinson et al., (2007) of the research literature on effective models of inter-agency working, was undertaken by the National Foundation for Educational Research (NFER), commissioned by the Local Government Association. The main aims and objectives were to gather examples of good practice in multi-agency collaboration, across England and Wales. Although the value of this is widely recognised, and the factors that facilitate or inhibit such work are becoming well known, concrete examples of success are frequently buried in literature covering other issues, and are not immediately accessible to practitioners. This review was designed to provide policy makers and practitioners with a bank of examples upon which they might draw upon the developments of effective interagency collaboration. Researchers have provided considerable evidence about the value of interagency collaboration; in some cases, it is argued that progress is dependent on it. Benefits of such work included improved services to service users, a broader perspective for agencies, and rewarding efficient working practices for individual professionals (NFER, 2003).

Researchers have sought to fill this gap by developing models of interagency working based on evaluative research. The NFER review summarised these models, noting that a variety of approaches is usually required in order to provide an effective service. NFER built upon earlier work by providing illustrative examples of successful management of such working practices.

These included:

- full strategic and operational commitment to collaboration
- an awareness of agencies' differing aims and values
- a commitment to working towards a common goal
- involvement of all relevant people, often including service users and their carers

- clear roles and responsibilities for individuals and agencies involved in collaboration
- supportive and committed management of staff in partnerships
- flexible and innovative funding mechanisms
- systems for interagency collecting sharing and analysis of data
- joint training, with accreditation where appropriate
- strategies to encourage team commitment beyond the personal interests of key individuals
- effective and appropriate communication between agencies and professionals
- suitable and sometimes altered, location for the delivery of services.

The conclusions are based upon the examples presented in their reviews of the literature (NFER, 2003; Atkinson et al., 2007), and make assertions that considerable good practice exists, in terms of both formal and informal collaboration, and across a range of agencies. However, these are largely local practices rather than national strategies, which also emphasised the argument within this study: that inter-agency collaboration is most successful when developed in accordance with local context. Additionally, most of the literature cited reports on outcomes of inter-agency work, rather than the process by which collaboration is achieved. As practitioners would also benefit from guidance on these factors, this would be a potential area for further research.

In contrast to the NFER's literature review, Kharicha et al., (2005) examined the available literature on how strategies, including the development of posts such as care co-ordinator and liaison nurses who help older people negotiate the complex array of relevant services, have improved outcomes for older people and their carers. While they claim that there is a vast literature base describing how these roles have been developed

to address difficulties of communication and coordination, they conclude that the evidence of their effectiveness for improving services to older people and their carers is equivocal. In reviewing outcomes for older people of collaborative working between health and social care professionals, Kharicha et al., (2005) identified only five relevant studies, none of which demonstrated significant evidence of beneficial outcomes. However, research funded by the DH concluded that, overall, partnership working between health and social care agencies did produce outcomes which citizens valued. For example, making it easier for local people to access relevant services when needed (DH, 2007a).

In England, Hudson (2007) discussed how the literature about integrated working tended to be dominated by explanations for lack of progress, rather than an account of achievements. His research developed two models - termed optimistic and pessimistic models respectively. To understand the factors that may underpin different rates of inter-professional achievement, a case study of the Sedgefield Integrated Team in County Durham, England was used to test out aspects of the models. The models themselves were derived from a review of literature, both empirical and conceptual; the former tending to focus upon primary health care and social care in England, and the latter from a range of sources and ideas spanning the last thirty years. The models were put forward as potentially useful hypotheses for testing out ideas in new empirical studies.

Three separate agencies joined forces to establish a more integrated front line approach: the Sedgefield Primary Care Trust (PCT), Sedgefield Borough Council and Durham County Council. These established five locality-based, co-located front-line teams across the Borough, each consisting of social workers, district nurses and housing officers. The

evaluation examined the multi-organisational arrangements for establishing the programme and the inter-professional relationships in the pilot team. Documentation was scrutinized, questionnaires were completed, meetings were attended in an observational capacity, over seventy individual interviews were conducted with staff in management and operational positions, and samples of six individual cases were tracked, including interviews with service users. Qualitative data from the interviews was used liberally in the study. The paper concentrated on only one part of the evaluation – the first Sedgefield Integrated Team. The key evaluation findings included the message that integrated teams will work because the service professionals (nurses and social workers) were not far apart in relation to the promotion of their particular professional values:

It's great when you have got someone with health needs and you are working with the nurse – you can do the social bit and they can do the health bit. It's really helpful. (Hudson, 2007, p. 11)

In addition to this, the socialisation to an immediate work group can override professional or hierarchical differences. The author concludes by stating that much of the success in Sedgefield has been down to the presence of the right people in the right place at strategic and operational levels, a theme that could vanish in Sedgefield and could not be expected to be replicated in other locations and contexts. The other major factor was the funding for the project, which made an important difference to what could be achieved.

The review of the literature and policy developments in the UK has highlighted that each country has developed through its own evolutionary path. It could be argued that the

specific demographic trends within each country have had a direct influence upon the rate at which they responded towards the development of relevant 'systems' aligned with political will and financial commitments; all of which affected the responsibilities towards changes across health and social care provision. As highlighted in this review, most areas in the UK are now pursuing a vision for integration to deliver better sustainable health and social care to respond to the pressure of an ageing population, gaps in care provision and the tight fiscal environment (Richardson, 2016). As the literature has suggested (NFER 2003; Atkinson et al., 2007; Cameron et al., 2012; LGA & NHS, 2015) most regions begin locally demonstrating the need to work differently in the future, such as the IPC programme (see 2.4). As Richardson argues:

This is underpinned by the key enablers of information management, new payment models, system-wide governance arrangements and workforce reform. (Richardson, 2016, p. 5)

One interesting point to note was the research undertaken in England and Wales Cameron (2012) and the inclusion of service users and informal carers within their evaluation. This important component was absent from the research studies presented from Northern Ireland and Scotland. However, Heenan & Birrell (2009) did advocate that a focused approach through the use of the key worker role would improve outcomes for service users and enhance any future evaluations. Audit Scotland (2011) also acknowledged that it was important to support informal carers in their caring role – a factor also prevalent within the Care Act 2014, (England) in terms of informal carers having the right to access an assessment of their own needs.

The following research studies have been presented within different service-user groups. As mentioned earlier in this chapter (see 2.3) the purpose of this was to illustrate best practice about how each service-user group had evolved. This related specifically to multi-agency developments and multi-disciplinary practice between different professionals and outcomes for service users.

2.5 Children's Services Context: Empirical Research in England

The rationale for including an overview of research within children's services in this review is linked to the fact that professionals from both children's and adults' services are expected to work in liaison during times of transition for young people and their associated carers. This approach is also enshrined within legislative frameworks such as the Children and Families Act 2014 and the Care Act 2014. All the literature cited emphasised the need for greater collaboration between agencies.

The DH (1999b) promoted the use of flexibilities, (i.e. pooled budgets, lead commissioning and integrated provision), to make it easier for services to work together. The need to improve interagency working to ensure effective child protection services was highlighted in the Laming Report on the Victoria Climbié Inquiry (Laming, 2003). Over a number of years inquiries have mooted the need for better communication, leading to co-ordination of services (Sloper, 2004). The Green Paper Every Child Matters (DfE, 2003) emphasised the need for agencies to work together around the needs of the child which had been supported by an important literature review. The review was to inform the Children's National Service Framework. The research focused upon existing studies which included children's services not covered by the reviews. Questions posed of the literature concerned both the process and outcomes of multi-agency working. This related to models of multi-agency working in practice, analysis about whether multi-

agency working improves outcomes for service users, and the examination of the factors which both facilitated multi-agency working and an identification of evidence which led to barriers to co-ordinated multi-agency services. A specific review undertaken by Watson et al., (2002) took a broad approach to classifying multi-agency services, identifying three categories of joint working, based on the ways in which different professionals work together at an operational level. Watson et al., (2002) linked these to the extent in which services take a holistic approach to family needs and worked in partnership with families. The research brought to light three main categories of 'models' and terms used to describe professional social work practice within an integrated context. For example, multi-disciplinary working among professionals within a single agency, where the focus tends to be on the priorities of that agency and co-ordination with other agencies, is rare. Assessments are mainly controlled by individual professionals and an equal partnership approach with families is uncommon.

Another model cited was the inter-disciplinary way of working, whereby different professionals from different agencies undertook assessments of a child and family and then met together to discuss findings and set goals. Service coordination could be achieved through local panels to which families may have been invited. Finally, the trans-disciplinary model is where different agencies work together jointly, sharing aims, information, tasks and responsibilities. There was also a suggestion that a more holistic approach centred on the child and family needs is central to providing services. This work is usually undertaken by a nominated key worker, who acts within a co-ordinator role and takes overall responsibility for the delivery of services. In this model, families are seen as equal partners. The authors suggested that trans-disciplinary working would be rated most highly by families but as yet there is no evidence to show how, or to what

extent, these models are implemented in practice, and what effects they have on outcomes for children and families.

In terms of the factors which facilitated multi-agency working, this was underpinned by a commitment from staff to the organisational planning and implementation of multi-agency services. For example, clear and realistic aims and objectives were understood and accepted by all agencies; clearly defined roles and responsibilities were identified, so that expectations and the lines of responsibility and accountability were clear. Strong leadership and linking projects into other planning and decision-making processes also fostered good multi-agency practice between agencies. As Sloper (2004) stated:

Many of the barriers identified in the research studies included constant reorganisation, frequent staff turnover, different professional ideologies and lack of communication. In addition, difficulties associated with sustaining projects which had financial uncertainty. (Sloper, 2004, p. 580)

Other literature included the work of Malin & Morrow (2007) which aimed to describe and evaluate inter-professional work within a Sure Start 'trailblazer' programme. This included assessing how far 'working together' in new ways that cut across old professional and agency boundaries has helped to create inter-professional working.

Each Sure Start programme was based upon the concept of inter-professionalism, i.e. ideas of professional collaboration, integration and a need for greater understanding of others' roles or multi-agency working; although often professionals had initiated multi-agency working with little training or guidance. They asserted that the emphasis from government on partnership within social care and health care agencies has tended to be on strategic inter-agency working, rather than inter-professional relationships. In

addition to this, the literature on inter-professional collaboration regarding health, education and social care shows that it is not readily achieved in practice, owing to dilemmas associated with reconciling different professional beliefs and practices, (Easen et al., 2000) and further research is needed regarding outcomes and costs.

The methodology used in this study was qualitative, single case-study designs, exploring relationships that shape and form the basis of inter-professional work, undertaken by a Sure Start team located together in one building. Twenty-six team members were interviewed individually regarding their involvement in inter-professional work. The group included professionals from health visiting, clinical psychology, social work, community paediatrics, nursery nursing and family therapy. Interviews were analysed to search for examples of inter-professional working based around definitions of multi, inter trans-disciplinary collaboration. The findings demonstrated that there were examples of different models of inter-professional working present in this Sure Start programme, and that - if similar programmes looked at inter-professionalism in the light of the models explained in this study - it might help professionals develop their practice. The findings raised a number of questions in three main areas. Firstly, whether inter-professional working has any relevance upon achieving government outcomes, which is a main driver for inter-professional working, or whether there is no explicit evidence of a connection. Secondly, there is a question about how inter-professionalism impacts on roles, identities, and the status and power of individuals. Thirdly, multi-disciplinary activity highlights that different professionals can work alongside each other, working with a family but from a value base which places a different emphasis on goals of family support, child protection and children's rights.

They concluded by highlighting that the study showed how different types of inter-professional work and the experience of Sure Start have helped to re-shape the roles of several professionals: for example, health visitor, social worker and nursery nurse. Integrated working included a way of improving outcomes for children and families, and involves delivery of integrated frontline services such as the Common Assessment Framework, which promote the role of a lead professional, leading to better information-sharing within a multi-professional context of practice.

Other influential literature within children and family services have been carried out by Frost et al., (2005) and Moran et al.,(2007). In terms of Frost, the main aim of the research was to analyse the qualitative, multi-method data in relation to social workers based in multi-disciplinary teams in order to reflect on their role in such teams, and the implications for social work practice in these dominant settings. Their research draws on two major theoretical frameworks: Communities of Practice (CoP) (Wenger, 1998) and Activity Theory (Engestrom, 1999).

In Wenger's model, new knowledge is created in communities of practice by the complementary processes of participation, daily interactions and shared experiences of members of the community – in this instance a MDT. In terms of Engestrom's activity theory model, the study drew upon the concept of knowledge creation and exchange, i.e. professionals having to find a common language to make knowledge accessible to their colleagues from other disciplines. The emphasis is upon teams coming together with different knowledge, expertise and histories to pursue a common goal, if vital progress is to be made towards creating new forms of knowledge and practice. Thus, the frameworks were useful in understanding the working of multi-agency teams.

Frost et al. (2005) concluded by arguing that social work is 'the' joined-up profession, a profession that seeks to liaise, to mediate, and to negotiate between professions. Their research suggested that the social work role in the teams is complex and contested. They assert that there are potential conflicts about models of understanding, about status and power, about information sharing and around links with other agencies. Social workers (and others), address problems and can learn and change from this experience, as one social worker said:

I've retained my identity as a social worker but I've gained an awful lot more knowledge about other agencies and about the way they work, how to access different things. (Frost et al. 2005, p.195)

Moran et al., (2007) explored multi-agency working from the perspective of social workers within an early-intervention family support team. Qualitative methods were used, involving individual interviews as well as focus groups. Thematic analysis of transcripts showed a number of challenges to multi-agency working, which included issues focusing on differences in partner agencies' protocols, as well as issues concerning professional status and identity. Their conclusions mirror those of (Frost et al., 2005) research, in terms of highlighting the benefits of multi-agency working which enhances inter-agency respect, communication and greater understanding among partner agencies of respective roles.

Moran et al., (2007) highlighted areas requiring further investigation; these include the blurring of professional boundaries for social workers delivering early-intervention services in community settings, and the outcomes for children of multi-agency working in early-intervention services.

2.5.1 Children with Disabilities

When considering the outcomes of multi-agency working for children with disabilities, a children's team in Cambridge was selected to participate in a cooperative review to evaluate team effectiveness (Cann et al., 2000). The team provided an integrated health and social care service for children with complex learning and physical disabilities and their families. The following key themes for disability services were used to provide a framework for the evaluation:

- working in partnerships are underpinned by community care
- patient benefits will depend upon the quality of the partnerships
- solid partnerships between the agencies are essential.

During 1992-1998 in Cambridge, the community trust worked in collaboration with Cambridgeshire social services in order to establish a model of joint practice – the children's disability team. Initially the team consisted of six specialists: a health visitor, social worker, community paediatrician, psychiatrist, clinical psychologist and secretary. The development of the team was first proposed by the Cambridge Health Authority, but after two years it was realised that, in planning care provision for children with complex needs, social services needed to be central to effective service provision. This was especially important due to the fact that social services' planning was occurring separately and in isolation from community nursing.

During the first two years of operation the team functioned successfully, verified through annual reviews, and, whilst it was small, it remained a single access point for referrals from other professionals and parents/carers. One team co-ordinator created a central co-ordinator role, whereby families could access the skills of the whole team through

communicating with one professional. However, following a major reorganisation of social work (1996) the team expanded to eighteen members. An additional social services practice manager (with a separate budget) was also appointed. Most of the emerging difficulties were associated with complex referral pathways or fragmented assessment procedures. Additional assessments resulted in little time being available for the social workers to undertake interventions within a therapeutic relationship, or work jointly with their health service colleagues. Thus arguments erupted across the team over topics such as referral procedures, finance and the location of the team base – issues which were left unresolved for some time. The reorganisation also produced managerial problems in maintaining partnerships between health and social services, and the team began to lose its shared philosophy of case management. The purchasers involved, (i.e. Cambridge and Huntingdon Health Authority), expressed concern in 1997 that the children's disability team was failing to meet the children's needs. As a consequence of this, the team members decided to analyse and evaluate the effectiveness of the enlarged team to ensure that it was achieving the best possible outcomes for children. Soft analysis was undertaken through creative art, followed by reminiscence on the possible outcomes, (for a child, parent and colleague), as a result of each member's activities. This analysis concluded with a functional approach to describe the work of the service in terms of explicit and mutually owned objectives. In addition to this, an anonymous questionnaire was developed to assess the strengths and weaknesses of the team (Cann, et al., 2000).

The results identified specific needs for training and supervision to improve the outcomes of the children's disability service. Following the changes in the organisation of work with children and families, (1998) staff became more confident in working as a team and in agreeing care plans for the children. Health and social services staff

regained the ability to undertake joint working practices for children with complex disabilities. Good patterns of communication eased the flow of labour between team members in terms of allocation of work and more efficient use of joint resources. The recurring arguments, (mentioned earlier) ceased as communications improved.

As an alternative model of 'joint working practices' Thompson-Janes et al., (2014) co-ordinated a parenting group for parents of children with learning disabilities and behaviour problems. This was known as the Confident Parenting (CP) group. The CP group was a therapeutic group for parents informed by the principles of behavioural theory and acceptance and commitment therapy. Parents' experiences were elicited through participation in a large focus group which followed a semi-structured interview format. This aimed to elicit information about parent's overall experiences of attending the group and its perceived effectiveness. Thematic analysis drew out the main themes; (i) parents' pre-group narratives, (ii) barriers and solutions, (iii) positive aspects of CP and (iv) positive outcomes of CP. This initiative was developed upon the recommendations from the National Institute for Health and Social Care Excellence (NICE, 2006). The institute recommended that group-based parent-training/education programmes in the management of children (12 years and below) were more successful in reducing levels of stress in parents over individual-based interventions (Danino & Shechtman, 2012). The results from this study suggested that group-based interventions (facilitated by a number of professionals) were of benefit to parents of children with learning disabilities and challenging behaviours. The study provided '*some insight into the benefits of group-working for parents, an area which is relatively unexplored*' (Thompson-Janes et al., 2014, p. 100). The most commonly reported benefit was meeting others, through which parents gained a sense of relief and reassurance,

identifying shared feelings with others and not judged about them, especially in times of difficulties.

2.6 Adults Services Context: Empirical Research in England and Wales

The NHS and Community Care Act 1990 (NHSCCA) (superseded by the Care Act 2014) created the modern context for social work with adults (Barrett et al., 2005; Gov. UK, 2014). Originally, the NHSCCA, 1990 required social services departments to establish care management systems. Social workers undertook an initial assessment of need, drawing on the professional expertise of others as appropriate. As mentioned, (see 2.4) unlike health care, which is free at the time of need, social care is means tested. This difference has presented problems for health and social care professionals working together, in terms of trying to establish which of a person's needs are social (means tested) or health (free). Government plans therefore included the need to regulate care provision, including an increasing emphasis on partnership working within integrated health and social care teams. In addition to this, the New Labour government's emphasis on 'partnerships' as an essential theme of its 'third way' occupied a prominent place in health and social care literature (Hussein et al., 2008). Partnership working became a central theme of all public services and was also a major element of the modernisation agenda (DH, 2000b).

2.6.1 Safeguarding and Protection

A research study undertaken by Hussein et al., (2008) reported on the views of (n=92) social workers about their practice in adult protection in England and Wales. The research explored social workers' reported experiences of partnership or multi-agency working and how this, along with overarching regulatory frameworks, affected their practice within and across agencies. Because the study was funded within an adult social

care research framework, the major emphasis of the research was to obtain the perspectives of adult social care staff from within adult social services. In terms of methods, the research focused on findings from the qualitative phase of the research, (semi-structured interviews), and drew on the views of social workers working at operational levels within local authorities. The main job titles of participants were social workers, senior social worker, care manager, senior practitioner and team leader. Participants were selected to cover a range of practice teams working with adults (older adults, learning disabilities, mental health, physical disabilities and hospital based social workers). In addition to this, a sample of (n=26) local authorities was selected across England and Wales, based on a framework seeking variation of type and geography, and contact was made to discuss the study.

Relevant themes were derived from the analysis of the interviews. In terms of strengths of multi-agency working at operational level, most social workers considered the sharing of information with other professionals of particular importance, especially between social services and the police. As one participant said:

People are very willing to share, obviously when there are issues of safeguarding and protecting people, they are always willing to share that certain experience here. (Hussein et al., 2008, p.15)

Shared decision-making offering different perspectives, and shared responsibility for service user outcomes were viewed as positive aspects of multi-agency working. Social Services were seen initially to have taken the main responsibility for decisions in adult protection, but with the implementation of No Secrets, (DH, 2000b), social workers

commented that, increasingly, decision-making was being shared between agencies as joint policies and procedures were revised.

In terms of barriers to multi-agency working, information sharing was also viewed as problematic. Data protection rights and confusion about what information could legally be shared between agencies, were mentioned frequently by practitioners. This was said to be a problem especially for hospital social workers when working with health professionals within hospital settings – some practitioners experienced having to chase up colleagues. Many of the participants felt that other agencies were relying too heavily on social services to accept the primary responsibility for adult protection. Many social workers also cited an apparent lack of commitment from other agencies as an important barrier to partnership working:

My perception is that it's shifting. I think it's coming from a position where social services were doing almost everything, if not everything. What are coming in are the revised procedures, which have got explicit demarcations of levels of response and different routes for organisations. (Hussein et al., 2008, p.15)

A number of social workers singled out GPs in particular for showing a lack of commitment to adult protection work. Differing professional and organisational perspectives were consistently seen as dividing health and social care, and the 'social versus medical model' was cited regularly by social workers as a barrier to multi-agency working. In addition to this, social workers spoke of 'cultures' and ways of working with people, which often caused problems when involved in adult protection work.

Policy and regulation also had an impact upon the work of frontline workers. The main positive feature was felt to be the existence of the guidance for raising awareness about adult protection issues. Some social workers felt that the guidance status did not have the full power of legislation.

In contrast, some other workers felt that adult protection issues would force other agencies to take it more seriously. Participants also mentioned the potentially positive impact of the Mental Capacity Act 2005 in relation to particular incidents where social workers had found it difficult to persuade people to agree to proceed with cases, for example working with a number of women who had learning disabilities. It was difficult to assess the extent of how their disabilities had impacted upon their decision-making capacity, the majority of the women having made clear decisions to stay within abusive relationships.

The research limitations were linked to the views of social workers which had been considered in isolation and separate from their everyday practice, and so opinions could not be verified. In addition to this, alternative perspectives, (from other professionals), would have provided valuable insights into the perspectives held by the social workers. The view taken by the research team highlighted the fact that other practitioners could reflect similar issues and debates where multi-perspectives are involved. The research also revealed some of the strengths that partnership working had brought to the adult protection process for social work practice.

2.6.2 Mental Health Services

In terms of mental health services, Carpenter et al., (2003) carried out a major empirical investigative study which examined the relationships between the organisation of

community mental health services and professional and team identification, team functioning, and the psychological well-being and job satisfaction of staff working in multi-disciplinary community mental health teams (CMHTs). There were systematic differences in team functioning, favouring teams in districts where mental health and social care services were integrated. Community mental health teams are believed to provide the core of specialist mental health services in England (DH, 1999a). A survey by Onyett et al., (1994) demonstrated quite a wide variation in the structure and composition of CMHTs. With the introduction of new models of mental health services, such as assertive community treatment and crisis/home treatment teams (DH, 1999a), the landscape has become more complicated. The study commented on the main features of CMHTs which included being responsible for the delivery and co-ordination of a specialised level of community-based care for defined populations, which were multi-disciplinary in composition. Teams in England included psychiatric nurses, psychologists, occupational therapists and psychiatrists who were employed by health trusts, and social workers seconded by local authority social service departments. The presence of social workers was intended to promote integrated mental health care, although the extent to which a MDT has been able to achieve this goal varies considerably, (Schneider et al., 1999). The study aimed to test the hypothesis that well-established teams, operating in districts where health and social services were integrated, would be superior to those in non-integrated districts offering discrete services. In addition to this, they hypothesised that staff integrated within a MDT would have more positive, shared attitudes and values concerning the philosophy and practice of community care for people with mental health problems, demonstrate greater role clarity, and experience less role conflict. The main method used was anonymous, self-completed questionnaires. They used Likert-type scales to assess members' perceptions of participation, support for new ideas and clarity of team objectives, task style, reviewing processes, innovation and working in the team.

Their survey obtained a 70 per-cent response rate. They concluded that differing patterns of service organisation may be associated with staff perceptions of team functioning, and their experience of role conflict. Social workers were less positive about team functioning than other professionals, and experienced more role conflict. They also advocated that support and supervision, aimed at ensuring a social work contribution to multi-disciplinary working, should be provided in the course of establishing community mental health teams and integrated health and social care services.

2.6.3 Mental Health Services and Older People

In terms of the arrangements for delivering social work and primary health care to older people in England and Wales, these have been affected by re-configuration, with the development of integrated primary care and social services trusts (Watson et al., 2002). This is also underpinned by a continuous stream of legislation, guidance and funding for special initiatives which has encouraged partnership working in health and social care at strategic, operational and individual levels. The National Services Framework for Older People promoted a single assessment process that spanned general practice, community nursing, social care and specialist medical services, as well as integrated commissioning arrangements and integrated provision of services (DH, 2001a).

An important study was undertaken by Kharicha et al., (2005) to investigate perceptions of joint working in social services and general practice. The study location was two London boroughs covered by one health authority, one NHS Community Health Services Trust, four Primary Care Groups and two social services departments. The areas had high levels of morbidity and deprivation and hence provided a challenging environment for partnership working. In all, (n=52) social workers and their managers in both areas were interviewed, together with a purposive sample of social workers with a high

number of older service users on their caseloads. A sample of fourteen GP's was sought, using a sampling frame of practice size in each borough. The focus of this research was primarily about social work perspectives on collaborative working.

Structured interviews with open and closed questions were used. Tape recorded interviews were transcribed and subjected to thematic analysis. The aims of the interviews were to identify the strengths and weaknesses of current working arrangements between social services and primary health care in the care of older people, and to explore views on the components of good practice in joint working. The researchers identified three over-arching issues: the problems of current arrangements for joint working; methods for overcoming these problems; techniques for resolving or managing conflict between services.

All social workers and GPs interviewed described weaknesses in their working arrangements with their counterparts in health and social care, and attributed them to two factors. The first was a fundamental lack of understanding and clarity of each other's roles, responsibilities, pressures and organisational procedures. The second was the particular combination of local policies, structures and organisation. As one social worker said:

Well I actually find GPs the most difficult professionals to work with out of all the ones we work with. (Kharicha et al., 2005, p.401)

One way in which a lack of understanding of roles and functions emerged was through the different perceptions of time and urgency. As one GP said:

When a doctor says immediate he means now, when a social worker says immediate or urgent he means in three weeks, and I'm not being funny. (Kharicha et al., 2005, p.401)

Social workers felt that GPs were lacking in knowledge of the roles and remit of social workers, and ill-informed of changing social and health care policies. Many felt that face to face contact and multi-disciplinary meetings would improve the interface between health and social services. In addition, social workers expressed the need for more formal contact through the use of regularly planned multi-disciplinary meetings, in order to discuss both general issues and shared cases, and to enable them to work together in the planning and delivery of care. This could lead to a greater understanding of the issues faced by each group, which was seen as a way of overcoming differences, and viewed as a means of sustaining joint working. Interestingly, this study also highlighted how the use of community nurses as mediators between social workers and GPs was raised by both study areas.

Social workers described how they worked mainly with district nurses, community psychiatric nurses (CPNs) and sometimes practice nurses, to access or bypass GPs. Social workers also commented about how they had to make use of the hierarchies within social services and ask managers to assist. Team managers felt that issues were rarely left unresolved as social workers felt able to ask their managers to intervene if necessary.

A research briefing undertaken by Ray et al., (2008) focused on the role and contribution of social work in community mental health provision in statutory community mental health teams, integrated or multi-disciplinary teams, assertive outreach and crisis

intervention teams within the UK. The key messages from the research stated that social workers have a distinctive role in multi-agency settings in terms of coordinating 'efforts' to support individuals and groups who have negative experiences and perceptions of mental health services. These findings had resonance within this study, in terms of the central role of care co-ordination undertaken by a number of research participants (n=3) who were also social workers; more detailed discussions are presented throughout chapter five.

Other studies such as Williams & Taplin (2008) asserted that social work practitioners found themselves working with team members from other professions who might doubt their worth. This article represented a 'voice from the front line' which was supported by BASW.

They discussed the point that, across the board, social workers are increasingly working in more isolated ways. They are part of multi-disciplinary teams - whether it is working in children's services in a different way, in schools, or in mental health services, (as cited above). A representative from BASW said:

Whilst this can be seen as a healthy development in some ways, it is possible that social work values can become marginalised by a more powerful group who are much more motivated by self-interest than social workers. (Williams & Taplin, 2008, p.14)

He explained that, as professionals working together, this can lead to working to different codes of conduct which in turn can lead to difficulties. For example, in care trusts some of the people in the team would be NHS employees, and others would have

been seconded in from the local authority. Professionals who are covered by different disciplinary procedures are working alongside each other. Williams & Taplin discussed the positive and negative aspects of co-location while working from 1995 to 2004 in a Nottinghamshire hospice. Williams was the sole social worker in a team made up of nurses, doctors, nursing auxiliaries and volunteers. She commented on the importance of being part of a supportive team, and the fact that it was particularly important to explain the role of a social worker for some people coming into the hospice. This was due to their having had a bad experience with a social worker, or learning what one did from the media. She further explained about the importance of ensuring that people from different professions don't acquire prejudices which get in the way in terms of multi-disciplinary working. When a nurse suggested to a client that s/he talked to a social worker. The response was:

I've never seen a social worker in my life and I don't intend to start now, I don't need a person interfering. (Williams & Taplin, 2008, p.15)

2.6.4 Learning Disabilities Context & Empirical Research in England and Wales

There has been a significant shift during the last half of the 20th century, in relation to people with learning disabilities and the provision of services for people. Policies of deinstitutionalisation have been among those which are largely highly controversial and contested (Chenoweth, 2000). For several decades, large institutions have contracted in size and closed throughout the world. The terms deinstitutionalisation, community care and community living have entered common usage in services, policies and disability literature. Over the past forty years, de-institutionalisation has been a key feature of learning disability policy in the UK (Williams, 2013). It was associated with and driven by the model of 'normalisation', which was highly influential in learning disability services.

Originating in Denmark (Nirje, 1969) and supported in the USA by (Wolfensberger, 1983). The approach is essentially about an ordinary lifestyle for people with learning disabilities, and focused upon the type of support needed to achieve this. It was driven by a '*human ideology, that people should be respected as human beings and used as a counter argument against the dehumanising aspects of institutional care*' (Williams, 2013, p. 20). In most Western countries, people with disabilities for the most part now live in community settings with their families, or in supported living arrangements. Only a small minority remain in institutions such as hospitals and nursing homes; hence the shift from institutional to community based services for people with learning disabilities.

Barnham (1992) asserted that his research revealed important factors about the closure of large institutions and the attitude between professionals engaged with people with learning disabilities. Some medical professionals (doctors and nurses) had an investment in keeping them open. Medical professionals had difficulties in 'letting go' of the old ways of providing services or support because of the fear of losing power and control. A further complication existed where different professional groups (including social workers) had diverse professional ideologies which obstructed inter-professional collaboration in deinstitutionalisation efforts. The most common example of this in disability services is the tension between medical and psychosocial models, (Hudson, 1991) such as between nursing or direct care staff and social workers and community workers. The likely outcome of some retraction programmes was that professional disagreements dominated any plans to work in collaboration. Energies were spent attempting to resolve conflicts between these groups, rather than positive energies being focused upon the daunting tasks of transition to community living with vulnerable people, who had lived out most of their lives being segregated and within large institutions.

An empirical research study was undertaken by Barr et al., (2007) which analysed the perceived effectiveness of a multi-disciplinary way of working, as opposed to a uni-disciplinary service delivery model. A survey of the perceived effectiveness of Community Learning Disabilities Teams (CLDTs), (n=145) team members, (n=27) family caregivers and (n=21) people with learning disabilities was undertaken.

The research study design consisted of a postal survey which was sent out to members of CLDTs across a region of England. It consisted of eleven community health and social services Trusts that provided learning disabilities services. They selected both uni-disciplinary teams, (all team members belonged to the same profession), and multi-disciplinary teams as comparative models to analyse the effectiveness of team working. Participants were asked to rate the effectiveness of their team for each item on the Likert scale, ranging from very poor to very good.

In terms of the findings, social workers and nurses represented the majority of CLDT members. Therefore, nurses and social workers are key core professionals who provide support for learning disabled people and their families in the community. Other important professionals, such as occupational therapists, speech and language therapists, and clinical psychologists, were less well represented. Another factor was the mean caseload size of the CLDTs participants in this study: forty eight service users per team member. High caseloads can have a negative impact on effectiveness and lead to the need for prioritising referrals to CLDTs. In addition to this, there was no bench mark as to what an appropriate caseload should be for team members, which was an area of attention in the future development of these services. However, some aspects of multi-disciplinary working operated well. For example, nurses and the clinical psychologist could be accessed faster in multi-disciplinary teams, and provided an additional

knowledge base about their professions. Members of the uni-disciplinary teams rated themselves effective, in terms of working with service users and carers. One distinguishing factor which emerged from the analysis was that multi-disciplinary team members spent more time with service users and their families.

A limitation of this study was that the effectiveness of teams was self-reported by all the team members. This was countered to a degree by obtaining service users' views on effectiveness, and this promoted a convergence about the validity of the findings. However, the researchers asserted that further research on CLDTs effectiveness involving direct observational and outcome studies was recommended.

The research team discussed the fact that the role of CLDTs initially involved coordinating service delivery providing direct services, but Mansel (1990), highlighted how demanding these functions were with limited resources. Research had tended to focus on the compositions and remit of the teams. There had been much less research based on the effectiveness of CLDTs. They also advocated that CLDTs were a model for multi-disciplinary and multi-agency working and, most importantly, a vision of partnership, (inclusive of citizens), should be at the centre of the planned service provision. This vision stemmed from the increasing awareness of citizenship in all areas of health and social care. But in general, there was limited evidence on how effective CLDTs were and how successful multi-disciplinary working was in these teams, notwithstanding the received view that multi-disciplinary working should be most effective. There was also limited evidence on how satisfied service users and their carers were with the input they received from such services.

However, they also argued that, although the received view was that multi-disciplinary teams were most effective, like the concept of the 'Emperor's New Clothes' it had largely gone unquestioned. Further research on the relative merits and effectiveness of multi-disciplinary, compared to uni-disciplinary, Community Learning Disabilities Teams was required.

2.6.5 Valuing People: Vision and Commitment

When Valuing People was published in 2001, it was a significant achievement as the first White Paper about learning disabilities in 30 years. The vision and expectations in this document set out what the New Labour government's commitments were to improving the life chances of people with learning disabilities – it was a vision that was welcomed and supported by people with learning disabilities, their families and professionals in all sectors. Four years on, there had been some good progress in some areas, but much has remained unchanged for many people with disabilities. Valuing People: The Story So Far (DH, 2005b) set out what had been achieved and the areas for improvement. The publication, Valuing People Now, (DH, 2009) set out the priorities for the provision for services (2008–11), although there was a change of government during 2010 from New Labour, to the Coalition government until 2015. This change of government had a significant impact upon the Valuing People initiatives and their continued momentum in England (DH, 2010c). For example, Paul Burstow (MP) Minister of State for Care Services (2010-2012) stated that:

The provision of public services to people with learning disabilities and the reports that preceded it, delivered a wake-up call to the health and social care system. People with a learning disability were too often receiving sub-standard care that could lead to very poor outcomes for individuals and their families. However, there is still a long way to go

before we can be confident that all health and social care organisations are meeting the needs of people with learning disabilities. Progress has not been fully embedded and is too often reliant on committed individuals rather than an everyday part of how care and treatment is delivered. People with learning disabilities and family carers still report experiences of care that fall well short of the standards we should all be able to expect (DH, 2010c, p.2).

One continuous priority, and at the core of delivering services and positive outcomes for people with learning disabilities, is the drive to support integrated working within multi-disciplinary teams. The Coalition government advocated that Community Learning Disabilities Teams (CLDTs) and other professionals should work together (DH, 2012). They suggested that membership of CLDTs could be made up of social workers, community nurses, psychologists, psychiatrists, speech and language therapists, physiotherapists, occupational therapists and other specialist learning disabilities professionals. There has been much debate and discussion about whether health professionals and social workers should be employed by the same organisations using the integrated provision option under the Health Act Flexibilities. The New Labour government stated that this needed to be a localised decision, based on considering boundaries and the current state of relationships between organisations and practitioners (DH, 2007a).

The concept of multi-disciplinary working in services for people with learning disabilities is not a new one. The White Paper Valuing People: A New Strategy for Learning disabilities for the 21st Century noted that community learning disabilities teams were forerunners in partnership working, but suggested that this has not been consolidated.

There were also philosophical differences between initiatives of 40 years ago (as mentioned) and more contemporary initiatives.

Philosophically, there has been a paradigm shift from what was, primarily, a paternalistic, medical model of services for adults with learning disabilities (institutionalisation), to one that can be perceived as more social, focused on rights, choice and self-advocacy. In this conception, the professional is no longer the expert but is a partner along with the person with a disability, their families, friends and supporters, and other professionals, (Ward, 2008).

During this time frame, Herod & Lymbery (2002) carried out a small scale research project which explored one central theme - the role of a social worker within a MDT and within the context of a learning disabilities setting in England. It explored the extent to which social work had a distinctive role to play as part of an increasingly multi-disciplinary approach to providing services and support for people and groups in society with social care needs.

The research was based upon previous research undertaken by Fuller & Petch (1995). Herod and Lymbery's (2002) research was carried out within a multi-disciplinary setting in a Midlands social services department. It originated from the belief that social work was at a "crossroads" (Lymbery, 2001), and that practitioners should play an active role in seeking to define the way forward for social work, rather than adopt a passive approach that makes the occupation particularly vulnerable to government or managerial definition. The research concluded that other professionals were clear about the contribution of social work within multi-disciplinary practice, and the fact it was valued by such teams.

Herod and Lymbery's research (2002) sought perceptions of the social work task from multi-disciplinary practitioners within a learning disabilities service, with a particular focus on the claims of social work to particular skill areas or expertise. Given the nature of the research, a semi structured interview schedule was used as the basis for obtaining data. This provided the opportunity to obtain both personal and in depth opinion. The interviews took place with (n=8) members from two multi-disciplinary teams primarily engaged in working with adults with learning disabilities. As broad a sample of opinion as possible was obtained by ensuring that the interviews took place with members of all the different disciplines within the teams. Therefore those interviewed consisted of a clinical psychologist, consultant psychiatrist, social workers (n=2), team manager, community nurse, occupational therapist and a community care officer, (an experienced social care practitioner), who did not operate independently in situations of considerable risk.

The key findings which were presented, explored the distinctive contribution of social work within a multi-disciplinary setting. Numerous professionals focused on the importance of social work's ability to see the individual in their social context; it was stressed that social workers were more inclined to espouse the social model of disability (see 5.2.1 and 7.8) in their work than other members of the team. Other team members observed that social workers were closer to the service user in comparison with professionals from other disciplines. For example, one participant expressed the view that social workers were more able to balance this closeness of service user contact with an objective sense of the reality of resources and external factors within which the team was operating. Another implicit key theme, which also emerged from the interviews, was the essential commitment of an individual social worker to advocating on the service user's behalf. Interestingly, the value afforded to this aspect of the work ran counter (at

the time) to the emphasis in adult care on social workers as managers and commissioners of care services, which had affected social workers' orientation to the work. Another key element of the research was the opportunity for the participants to comment on what would be lost if the social work perspective was to be withdrawn from multi-disciplinary teams. The health care staff consistently recognised the special value of social work input. This was illustrated by one participant who said:

We have all been so influenced by social workers. My view is that I would be more paternalistic, overriding views of families and service users. You know, I would be telling people what to do much more. (health care professional, 2002, p. 23)

Herod and Lymbery argued that, despite the fact that their research was undertaken as a single case study, their findings were applicable to all aspects of social work. This research outlined the clarity with which health care professionals were able to articulate the distinctive features of social work, and the views in accordance with core aspects of the identity of the social work profession.

2.7 Citizens: Perspectives of people who needed and used health & social work services

It seemed like quite a few people had pieces of the jigsaw but no one had the picture on the box. (Hudson, 2006 p. 5)

This remark from an older person (Hudson, 2006) illustrated that, generally, what older people and other adults were interested in was whether services do what they need them to do, in the right way, at the right time. This study undertaken by Hudson (2006)

gathered evidence from a number of sources which confirmed that both carers and service users considered that problems with multi-agency working made a direct impact on their support (Leathard, 2009). The report of the Mental Health Foundation (1996), for example, found that people with a learning disabilities recommended that:

Different organisations and services need to talk to each other to give better services. (Committee of Inquiry 1996, p. 27)

Joint working was also identified as the most important issue by carers in a survey by Henwood (1998), exploring their views at stressful times such as hospital discharge arrangements. Cameron et al., (2014) undertook a review of the evidence in relation to the experiences of users and informal carers. The conclusions reached stated that there had not been wholesale endorsement of joined-up services and integrated services to a certain extent. The research suggested that some problems of poorly co-ordinated services were apparent. However, both service users and carers did report high levels of satisfaction with joint working arrangements when they were in place. The elements that local citizens valued included: *'responsiveness to their needs through more timely initial assessment and subsequent interventions, partnership working and the development of trusting relationships with named key workers'* (Cameron et al., 2014, p.65). Informal carers also welcomed the additional support, feeling relieved of some of their responsibilities, leading to reduced stress and fewer crisis situations.

It is important to assert, however, that whilst both informal carers and service users have a voice and views about the issues of joint working, it would be too simplistic to present their collective views. Each of the citizens has distinctive interests and

perspectives about the need for greater multi-disciplinary working between professionals.

2.7.1 Informal Carers

During the 1990s there was a variety of studies and policy documents, which brought the needs of carers into the public domain (Twigg, 2000). A useful definition of the term carer was presented in the updated government's document (DH, 2010): Recognised, Valued and Supported:

A significant number of people with caring responsibilities do not readily identify themselves as carers. They understandably see themselves primarily as a parent, spouse, son, daughter, partner, friend or neighbour. A carer spends a significant proportion of their life providing unpaid support to family and potentially friends. This could be caring for a relative, partner, or friend who is ill, frail, disabled, or has a mental health problem or substance misuse problems. (HM Government, 2010, p. 6)

In the UK this policy interest culminated in the Carers Recognition and Services Act 1995; Carers and Disabled Children Act 2000. In addition to this, successive National Carers Strategies: (DH, 2008; DH, 2010) also enshrined the importance of the carers role when supporting a vulnerable adult. Current legislation, such as the Care Act 2014 stated that from April 2015 a carer would be entitled to a separate assessment, providing a carer met the national (English) statutory eligibility criteria.

The latter conferred a separate status for carers by awarding them the right to an assessment of their needs for social care, even if people with a disability had refused

such an assessment for themselves; it also established that carers could receive services for their own needs (Carers UK, 2016). For example, the most notable difficulties were those which involved parents of disabled children, who articulated their frustration with the lack of information, and the multiple but conflicting advice and gaps in knowledge among those who were professionals.

For a number of years, parents and carers have asked for a 'link' or coordinating practitioner, to facilitate access to specialist and general services to avoid time-consuming repetition of their family's circumstances. The popularity of these roles has been taken up by professionals such as specialist teachers, nursing staff and, to some extent, social workers. The research cited earlier Watson et al., (2002) (see 2.5) discussed the benefits associated with a nominated key worker role. This is where different agencies worked together jointly, sharing aims, information, tasks and responsibilities. Families in this model are seen as equal partners. It is important, therefore, to ensure that the coordination of services also relates to particular circumstances, and care is delivered within the context of the lives of carers and their family circumstances.

2.7.2 Service Users

When my Mam died the social worker helped me to get my name on the tenancy of the house I lived in with my Mam. They sorted all of this out and then helped me to decide what to do next. (Social Work Task Force, 2009, p. 5)

As the quotation above illustrated, the need for multi-agency working was, in the main, viewed positively by service users. Some service users showed a more sophisticated

understanding of the pressures which lie behind the delivery of appropriate services to meet needs. This was especially relevant in mental health services, where associations with mental illness and dangerousness have compelled greater professional integration of partnership working (Manthorpe, 2009). Parents, (who have learning disabilities), have mentioned that services can be patchy and uncoordinated, and the negative effect this can have on their lives. Some service users fear the possibility that communication between professionals may lead to unwanted and unnecessary attention. More sharing of information may reinforce perceptions that they are deficient as parents. Booth & Booth (1994) undertook lengthy interviews with parents who had learning disabilities and their research led them to conclude:

Usually under close surveillance from the statutory services, families feel their every move is under scrutiny and any mistake risks punitive consequences. (Booth & Booth, 1994, p.15)

Beresford (2012) also contributed to the debate regarding the importance of inclusive 'voices' of service users and carers, in his critical commentary: *Ignored or just Forgotten*. This literature referred to the re-evaluation of public services (health and social care, 1993-2012) and the rhetoric associated with the exclusion of citizens' perspectives all of whom used services. He said:

If there is one lesson from the last 20 years, it is that any discussion of policy development and reform which does not fully and effectively involve the diverse range of service users' perspectives, insights and experience, is likely to end up as inadequate. Involving service users brings new "experiential knowledge", new ideas, new insights into the equation. The social model of disability and the

philosophy of independent living are just two of the best-known expressions of this. (Beresford, 2012, p. 202)

To conclude, both carers and service users have highlighted the fact that, in the main, effective multi-agency and multi-disciplinary working is in their best interests. However, the research evidence suggests that there still appears to be a lack of opportunity for them to be involved in making decisions about their own lives (Beresford, 2012). These examples included professional and organisational resistance, exclusionary institutional structures and practices, and professional attitudes and assumptions; all of which make it difficult for citizens to get their voices heard. Therefore, it is important to develop ways of working that actively seek and include their perspectives, experience, knowledge and skills.

2.8 Critical Commentary

There are several major themes which have emerged from the literature review. It is important, therefore, to discuss each of the emerging themes and their significance upon the development of partnership working between agencies, multi-agency collaboration, and multi-disciplinary practice between professionals, the impact upon people who use services (citizens) and the nature and quality of the research studies cited within the literature review.

The first theme to emerge was the considerable debate about the rate of progress between agencies (health and social care) concerning partnership working and multi-agency collaboration (Humphries, 2015; Cameron, 2012 et al.,). Integrated care policy has a long history in the UK and this phenomenon has been the subject of debate between all the major political parties. Over time the specific focus of policy makers'

interests about integration has changed; the reasons for this attention, however, have remained consistent (Cameron et al., 2015). Its primary purpose is to shift the focus of health and care services to improving public health and meeting the holistic needs of individuals, by drawing together all services and investing in this maximising wellbeing throughout life. In contrast to Humphries' argument (see 2.4) the LGA & NHS England (2016) purport that services which are organised and delivered will be in the right place (local communities) to prevent escalating ill health. However, the growing demands for services have created funding gaps in both health and social care provision, and consequently this has provoked questions about the realities of achieving equitable partnership arrangements (BASW, 2016). Funding issues are further compounded by the given crisis of reduced budgets across local authorities (for social care) and the array of different funding streams which support 'integrated services' across the UK (NFER, 2003; Atkinson et al., 2007; Humphries, 2015). The four nations of the UK have introduced different financial arrangements to support integration since the devolution during 1999 (Prothero & Bennion, 2010), which is further demonstrated by Northern Ireland and Scotland (Heenan & Birrell, 2006; Watt et al., 2010). Health and social care services are separate in Wales. NHS Wales is responsible for healthcare and local authorities for means-tested social care (BASW, 2016). The current priority of NHS England, (2014) is to reduce the fragmentation between health and social care services with an emphasis upon better integration, as a way to reduce costs, relieve pressure on services and improve outcomes and experiences for local citizens. The literature has revealed that the most successful examples of partnership working between agencies have emerged from localised policies and practices. Multi-agency collaborations work best when committed professionals (such as social workers) can develop their working practices alongside other professional disciplines, to ensure that local people receive services to meet their complex health and social care needs (Hudson, 2007; Hussein et al., 2008).

A second theme to emerge was the multiplicity of terms used – the meaning of words within the context of health and social care professionals working together. Some authors cited give their own definitions of terms within the context of the research undertaken. As illustrated through the use of Terminology Tables (1, 2, 3,) within the text, there is no accepted consensus about specific terms used which denote joined-up working and thinking across the professions. Some researchers, (and practitioners), deem inter-professional to be the key term that refers to interaction between the professionals involved – albeit from different backgrounds, who have the same joint goals in working together. For example, Malin & Morrow, (2007) used three inter-related terms which consisted of multi, inter, trans-disciplinary collaboration, whilst, within a learning disabilities context, a multi-disciplinary team is defined as a number of health professionals and social workers working within the same team and working towards the same joint goals (Herod & Lymbery, 2002).

Recent policies across the UK that have encouraged greater integration between health and social care have tended to define it as care that is person-centred and coordinated across care settings (LGA & NHS England, 2016). For care to be integrated, organisations and professionals must bring together all the different elements of care that a person needs. A cited example is the IPC programme which was launched in April 2015 as a partnership between the LGA and NHS England. The emphasis (and therefore terminology) about integrated care within this type of configuration is the inclusion of the community and voluntary sector, although it was acknowledge that this model is targeted towards those citizens who have high levels of health and social care needs. The intention, however, is to ensure that local citizens are central to decision making about their personalised care arrangements to avoid escalating ill- health and with an emphasis upon wellness.

A third theme to emerge was the cultural differences adopted by professionals who practice within the health and social care arena, namely social workers and those located within allied health and medical professions. Social work has its roots in an 'empowering' model of working with people; the health service has a tradition of being hierarchical (Williams & Taplin, 2008; Cameron et al., 2012). These cultural differences can impact on the working practices of professionals from different occupational groups and requires consideration. This is necessary so that improvements that may benefit people who use health and social care services can be implemented effectively. Nevertheless, the literature revealed that the positive impact on professionals (including social workers) centred mainly around multi-agency activity being rewarding and stimulating, increased knowledge and understanding of other agencies, improved relationships and communication between agencies (NFER, 2003; Kharicha et al., 2005; Atkinson et al., 2007; BASW, 2016). Adequate resourcing, in terms of funding, staffing and time was found to be central to the success of multi-agency working between professionals. This also avoided turnover of staff and recruitment difficulties (especially within social care) and insufficient time allocated for multi-agency and multi-disciplinary activities between different professionals, such as social workers and allied health and medical colleagues (Cameron & Lart, 2003).

There were some conflicting messages about whether multi-agency working resulted in an increased or reduced workload for the social work and nursing professionals involved in some research studies, although the evidence was weighted towards an increased workload, (Barr et al., 2007). Carpenter et al., (2003) hypothesised that staff integrated within a MDT would have more positive, shared attitudes and values concerning the philosophy and practice (in this instance) within a community team for people with mental health issues. This was not always the case, as some social workers experienced

role conflict through a lack of clarity about their specific contributions. The contribution of social workers within a multi-agency and multi-disciplinary context has also been the subject of debate for social workers. During 2016, BASW issued a statement about the impact and the effects that MDT working (and integration with health) has had upon the professional roles (contributions) and responsibilities of social workers, inclusive of the contribution that social workers make to these teams. BASW utilised the current experiences of social workers and illustrated some major points about health and social care integration:

- Social workers have pioneered the importance of putting the needs of users of service and carers at the centre of service delivery by trying to work with people, rather than for people. This approach is less developed in health and some other agencies
- A core function of social work, and one that social workers are especially skilled in, is working with a range of agencies to address all aspects of a person's circumstance. The agencies that social workers work with include health, housing, employment, finance and education
- Lessons learnt tell us that initiatives to integrate services have had a varied history. Many initiatives have had a short term time span often due to short-term political and financial considerations. A more sustainable strategy is needed with a clear vision. (BASW, 2016, p. 5)

The main impact on citizens was their improved access to services, through speedier and appropriate referrals, less duplication of assessments and a greater focus upon prevention and early intervention (Cann et al., 2000). Cameron et al., (2014) reported that citizens also valued the development of trusting relationships with named key workers who supported them through any difficulties, such as managing changes concerning their personal circumstances. Some authors cited in this review (Beresford,

2012; Beresford, 2013) reiterated the importance of defining outcomes which are important to citizens given the fact their outcomes may differ from policy and practice imperatives, but are crucial aspects of understanding the effectiveness of joint or integrated services (Cameron et al., 2014). Impacts cited also included improvements to the lives of citizens through more focused support for parents who held responsibilities for their children and young people who had learning disabilities on a daily basis (Thompson-Janes et al., 2014).

A fourth theme to emerge was the current state of research knowledge and quality of the literature cited in this review; the overwhelming approach to empirical research was interpretative methodology. Most of the researchers had facilitated interactions with participants in order to reach a better understanding about the topic being investigated, gaining a view of their perceptions, experiences and behaviours. The use of self to facilitate responses and the ability to read the situation has also proven to be an important component of the research undertaken (Parahoo, 2006). Some of the researchers (Beresford, 2012; Cameron et al., 2014) had been engaged in case studies, focus groups, structured and semi structured interviews and observational analysis. Thus the approach was inductive, moving from specific observations or interactions to general ideas and theories.

The research undertaken by Frost et al., (2005) drew on two major theoretical frameworks, Communities of Practice and Activity Theory. The theories facilitated models for gaining new knowledge, created by daily interaction and shared experiences. This enabled a common language to be developed and shared with colleagues from diverse backgrounds. Qualitative researchers are more interested in understanding how others experience life, in interpreting meaning and in exploring new concepts and developing

new theories. Another example is Thompson-Janes et al., (2014) who coordinated a parenting group for parents of children with learning disabilities and behavioural problems. Parents' views were elicited through participation in a large focus group.

It could be argued that a direct contrast to the interpretative (qualitative) methodology is the methodological approach of positivism (quantitative) researchers. They aim to discover universal social 'laws' and test theories which explain causal relationships (Alston & Bowles, 2003). However, a mixed-methods research design has also been applied to a number of the studies presented in this review. In terms of the strength of empirical research, the most notable work has been undertaken by (Carpenter et al., 2003; Hudson, 2007; Barr et al., 2007). Each research team used hypotheses to test out whether well-established, integrated teams would be superior to those in non-integrated teams and districts. These research studies concluded that there were research gaps in which a lack of current knowledge suggested the need to undertake further research.

Some researchers highlighted additional research gaps (about MDT working) through undertaking evaluative research projects, with an emphasis upon the collection of data, to ascertain the effects of a particular intervention – in this instance multi-disciplinary and collaborative working arrangements. A good example of this is the research study undertaken in Scotland, in relation to the role of CHPs (Watt et al., 2010). The outcomes of this type of research aimed to help policy makers, the NHS and the DH decide whether new roles should be extended, changed or completely replaced. The research focus had therefore evaluated the effects of the change in practice brought about by new policy or initiatives, rather than generating new knowledge, (Hek & Moule, 2006). Other examples of evaluative research cited, have been undertaken by both health and

social care professionals and they include (Cann et al., 2000; Kharicha et al., 2005; Barr et al., 2007; Malin & Morrow 2007; Cameron et al., 2014; BASW, 2016).

2.9 Conclusion

As outlined at the beginning of this literature review, the main aim has been to illustrate a broad overview of the current issues and debates appertaining to social work and contemporary practice within a multi-agency and multi-disciplinary context. It is clear from the review that the balance of evidence suggests that multi-disciplinary practice is an important concept, and has scope for further research, aligned with the health and social care integration agenda.

The focus of the studies presented has highlighted adults' research (n=24), although children's research (n=8) has also been influenced by the past events such as the Victoria Climbiè Inquiry and the tragic death of Peter Connelly. Lord Laming (2003) made numerous recommendations in relation to child protection in England. As mentioned, Climbiè's death was mostly responsible for the formation of the Every Child Matters initiative and the introduction of the Children Act 2004. In addition to this, the Peter Connelly (serious case review) (DH, 2010b), prompted the Secretary of State to focus upon the improvements and extension to changes in the way that professionals approached safeguarding issues, with a view towards better protection of the most vulnerable children in society. Also the Munro report about child protection services highlighted the fact that government policy in recent years has been designed in recognition that the services children and families receive has often been limited, because of the failure of professionals to understand one another's roles or to work together effectively (Munro, 2010).

In terms of adults, the research focus tended to be a combination of adults (mental health) and older people with mental health issues. In respect of learning disabilities services, there was a significant research gap as only (n=3) research studies were identified, although the methodological approaches were inclusive of both interpretative (Herod & Lymbery, 2002) and positivistic (Barr et al., 2007) paradigms. This finding connects with a systematic scoping review undertaken by (Moriarty & Manthorpe, 2016). They state that *'a striking finding from this review was the apparent absence of empirical research about social work with adults with a learning disability'* Moriarty & Manthorpe, 2016, p.19). It was appropriate therefore, taking account of the findings from the literature review, that the focus of this PhD study has been positioned to undertake a more detailed account about the effects that MDT working (and integration) has had upon the professional roles (contributions) of social workers within adults' services and located within a learning disabilities context.

The study's focus was strengthened by a critical appraisal of the vision and expectations championed in the policy documents, Valuing People (DH, 2001b) and Valuing People Now (DH, 2009). They asserted what the commitments were to improving the life chances of people with learning disabilities. It was a vision that was welcomed and supported by people with learning disabilities, their families and professionals alike. Furthermore, it was also important to consider the Coalition (2010-2015) and Conservative governments' (2015) responses concerning disabled people. The Coalition espoused a vision of equality, *'where everyone has opportunities to realise their aspirations and fulfil their potential'* (DWP, 2013 p.1). The Conservative Manifesto (2015) stated that:

Last year alone, 140,000 disabled people found work. But the jobless rate for this group remains too high and, as part of our objective to achieve full employment, we will aim to halve the disability employment gap: we will transform policy, practice and public attitudes, so that hundreds of thousands more disabled people who can and want to be in work find employment. (Cameron, 2015, p. 19)

Their ‘pledges’ were also underpinned by an agenda of personalisation, (which is discussed in more detail in chapter seven) inclusive of choice and control about service provisions and public welfare in general.

In order to offer clarity about the most pertinent issues and debates related to MDT working, I created a useful table (Table 4). This table highlighted the effects that a MDT approach has had upon social workers and other professionals. The issues have been drawn together from the cited research studies within this review.

I also used this table as part of my methods, as a starting point and guide when creating the semi-structured interview schedules (see 3.6.1).

Table 4: Issues and debates about MDT working

The interpretation of terms used such as multi-disciplinary, inter-professional practice
Perceptions of a multi-disciplinary team, the positive and negative aspects of working within a multi-disciplinary team
The distinctive contribution of social work within a multi-disciplinary team

The lack of perceived status associated with the value (contribution) of social work within a multi-disciplinary team
The benefits and usefulness to informal carers
The benefits and usefulness to service users
Potential conflicts between professional groups, due to cultural and ideological orientations within a multi-disciplinary context
The sharing of information and related confidentiality issues working across different disciplines: social work and allied health boundaries
The quality of professional supervision offered to social workers within a multi-disciplinary team, linked to continuous professional development
Policy directives & organisational expectations about working within a multi-disciplinary team & service
Differences in employment terms (salaries) between social workers & allied health professionals based within the same multi-disciplinary team and service

2.9.1 Addressing the Knowledge and Research Gap

As mentioned earlier in this review (see 2.6.5) Herod & Lymbery (2002) undertook a small scale study which explored the role of the social worker within an MDT context. Their conclusion suggested that the outcomes from the study were positive, but had limitations, due to the small scale (n=8) design. Therefore, this research study intended to build upon their initial findings, rather than replicate a similar study. This study

explored the contribution of social work and included a wider selection of research participants (n=17) from different disciplines.

As such, this led to the formulation of a research design which would address such concepts within a multi-disciplinary context. I also incorporated a hermeneutical phenomenological approach within the design, in terms of developing originality and to bring new insights about the contribution of social work located within a MDT.

In more specific terms, the following chapter outlines the overall approach to the research design. This has been strengthened by:

- the location of a knowledge and research gap in the literature
- the nature of the original research question
- the related objectives of the research study as a whole
- the selection of a hermeneutical phenomenological approach

As a consequence, the study was located within the interpretative (qualitative) paradigm. Furthermore, a number of social workers were identified (both newly qualified and experienced) who were already working within a MDT. In addition to this a selection of allied health professionals were also identified, to offer their insights about working alongside social workers.

Appropriate citizens were also invited to add their contributions to this research study. As mentioned previously, (Beresford, 2012; Cameron et al., 2012; Cameron et al., 2014) argued that citizens' views are paramount. This is especially relevant when exploring

their perceptions and experiences about the benefits (or otherwise) of a multi-disciplinary approach when meeting their needs and those of their families.

There were recurring themes which emphasised the fact that the orientation of the research has focused upon the relationships between agencies (health and social care). This study therefore, focused upon how the delivery of services were realised, through the collaborative efforts of localised policies and operational practices between allied health and social work professionals.

Finally, as illustrated throughout this review, some of the research studies have developed new knowledge in terms of the value of social work and its contribution within multi-agency settings and multi-disciplinary teams. However, none have made a connection between the contribution of social work, its overall effectiveness within a multi-disciplinary context, and the benefits for citizens through one research study, especially within the field of learning disabilities.

CHAPTER 3

Methodology and Methods

3.1 Introduction

This chapter presents the rationale that underpins the methodological approach adopted and full details have been specified about the research design. Fundamental to the research approach was the way in which data was generated and analysed according to the tenets of Interpretative Phenomenological Analysis (IPA). Throughout the thesis the 'generation of data' was used rather than the 'collection of data' which is indicative of the interpretative paradigm.

The use of IPA was enhanced by relevant associated philosophical perspectives, phenomenology, hermeneutics and idiography. Methods of data generation were designed to be sensitive to different research participants. For example, one-to-one semi-structured interviews were utilised (with professionals) and a less formal approach was adopted when interviewing people who used services. Interviews undertaken with citizens were focused upon a 'story to be told', through a narrative inquiry approach, although some general guidance was also offered in terms of the topics to be covered.

To present the overall rationale for the research design, the following domains have been explored in this chapter: methodology, philosophical approach, recruitment and selection, ethical approval and key considerations, data generation and analysis and not least an appropriate theoretical framework.

3.2 Methodology

An appropriate methodology and associated methods selected are thought about in terms of their suitability for answering the research question at hand (D'Cruz & Jones, 2006). Therefore, the research design process in this study provided an opportunity to consider how a contribution to knowledge could be generated. An important feature therefore, was the inclusion of both professionals from different disciplines, alongside local citizens, all of whom had been involved in multi-disciplinary services.

Thus, the use of an interpretive paradigm recognises the existence of multiple perceptions and plurality of world-views that can be represented as intricate networks of human constructs. The methods selected, therefore, were appropriate in terms of capturing this reality, observing people going about their daily lives and discussing their understandings in some depth and in different settings (Humphries, 2008). The central element of social research is that it is partisan, in that it is conceived and conducted within philosophical and theoretical frameworks that validate and give authority to its practice (Miller & Brewer, 2007).

This study was premised on important philosophical ideas concerning human nature, society and the nature of knowledge associated with the methodological position of naturalism (Miller & Brewer, 2007). In naturalism people are seen to have the capacity to endow the world with meaning, and are able to articulate these meanings when asked. This approach involved commitments which entailed assumptions about the nature of society; '*ontological*' assumptions and assumptions about the nature of knowledge '*epistemological*' assumptions (Miller & Brewer, 2007, p. 94). The epistemological position adopted in this study was concerned with developing new knowledge (ways of knowing) through the interpretation of generated data. This entailed

focused attention upon how professionals approached their work within a multi-disciplinary context. In addition to this was the necessity to capture the experiences held by citizens which informed the research study from their own perspectives. The rationale for this was focused upon whether a multi-disciplinary approach and social work input was of value to them. In order to capture their perspectives, I used a narrative approach towards data generation. My epistemological approach focused on the significance and influence of context which each citizen constructed as their own 'truth' and was shaped by individual meanings, depending on when they occurred. Narrative inquiry was originally used in literary analysis (Riessman, 2008). However, the study of narratives now bridges a number of disciplines (including social work) and encompasses a range of theoretical and methodological approaches (Stanley & Temple, 2008).

That said, however, it is also important to assert that multiple ways of knowing and multiple methodologies are components that cannot be ignored. Methodological pluralism is a response to the heterogeneity of values and ways of knowing that characterise everyday life and the practices of providing health and human services, (social work). Pluralism with respect to values Berlin (1998) and epistemologies (Bernstein, 1992) means that researchers find themselves immersed in a field of different epistemological traditions, philosophical orientations, theoretical frameworks, standpoints and perspectives. It also encourages researchers to question attempts to offer a grand synthesis or multiplicity of perspectives, as well as efforts to define one perspective as superior in some respect. Instead, pluralism is about finding ways how to juxtapose, and place into a coherent, engaging conversation of multiple views (Schwandt, 2012).

As already stated, this research study was located within the interpretative (qualitative) paradigm. Therefore, it offered directions in terms of developing questions deemed to be legitimate, identifying appropriate techniques and building explanatory analysis for the phenomena under consideration. The value (belief) throughout this research study was underpinned by a desire to reach an in-depth understanding and holistic view of the contribution of social work, supported by the culture and context of a learning disabilities service, located in England. In terms of the study's limitations, the context was not deemed to be simple; or rather what was understood about individual social workers, other professionals, citizens, may not have been transferable in a straight-forward way to understanding other people involved in similar activities elsewhere. Indeed, qualitative approaches '*can effectively give voice to the normally silenced and poignantly illuminate what is typically masked*' (Greene, 1994, p. 595). An important starting-point for this study was avoidance of harm, in terms of evaluating the extent to which '*simply talking about sensitive issues might constitute harm for any particular participant group*' (Smith et al., 2009, p.53). For example, I was aware that all the participants were already working (as employees) within the organisation and this factor could have influenced their decision(s) to either participate or not. In addition, the knowledge that senior managers within adults services had given their permission for the study to go ahead may have been an influential factor as to whether participants were comfortable about sharing their knowledge and experiences willingly. Bearing these factors in mind, I created the preparatory materials carefully (see Appendix 4) in terms of transparency about the involvement of senior managers within this study. I had also made the decision to show each of the participants the relevant interview schedule(s) (prior to giving consent) so that they would know what to expect from an interview. This was inclusive of the likely outcomes of data analysis and the inclusion of verbatim extracts in this published thesis.

By way of illustration, participants and citizens were kept at the foreground throughout the data generation phase. This was linked to the strong inductive tradition in qualitative research, and a commitment to the imaginative production of new concepts, through the cultivation of openness on the part of myself as the researcher (Shaw & Gould, 2001). The whole and the particular are held in tension. '*Small facts speak to large issues*' (Geertz, 1973, p.23) and '*in the particular is located a general theme*' (Eisner, 1991, p.39).

3.3 Philosophical Approach: Phenomenology & Hermeneutics

This study has been influenced by the philosophical approach of Phenomenology, the study of experience (Smith et al., 2009). There are different emphases and interests amongst phenomenologists. But of particular interest to this study was the emphasis and interest in, the approach espoused by existential phenomenologists known as the 'lifeworld' (King & Horrocks, 2010, p.). Philosophers (Merleau-Ponty, Heidegger and Satre) were concerned with the '*way we make meaning for ourselves in the world we find ourselves in, a world that does not offer clear and unambiguous meaning to us*' (King & Horrocks, 2010, p.179). Therefore, understanding the lived-world experience of the lifeworld (context) is the main goal of the interpretative phenomenological tradition. One key value of phenomenological philosophy is that it provides a rich source of ideas about how to examine and comprehend the lived-world experience.

Phenomenology originated in the work of Edmund Husserl (1859-1938). He believed that phenomenology involved the careful examination of human experience. He argued that individuals should '*go back to the things themselves*' (Smith et al., 2009, p. 12). This involved stepping outside the everyday experience. Instead, adopting a phenomenological attitude which involves and requires a reflexive move, turning the

human gaze from objects in the world and look instead to perceptions of those objects (Smith et al., 2009). Husserl's ideas were taken forward and modified by other leading figures in phenomenological philosophy – as mentioned, (Merleau-Ponty 1908-61; Heidegger 1889-1976; Satre 1909-80) (Smith et al., 2009). They all questioned the nature of human existence:

Existential phenomenology can be characterized by its emphasis on several key 'themes' of human existence, such as freedom and its limitations, temporality, engagement and encounter with the world and/or others, and meaning/meaninglessness. (Spinelli, 2005, p.103)

A key aspect of the interpretative phenomenological approach in the work of Merleau-Ponty, was the notion of 'embodiment', experiencing lived-worlds as embodied beings. The emphasis upon this type of engagement with the world is a key contribution of phenomenology within social scientific research (King & Horrocks, 2010). Likewise, the term lived-world has also been embedded within this study to represent how all the participants (professionals and citizens) defined their own meaning making in the world.

Heidegger (2000) (although originally a student of Husserl) developed the hermeneutic and existential emphases in phenomenological philosophy. He believed that, in order to properly understand participants' experiences, it was not possible to separate the participant's descriptions from individual interpretations, preconceptions and prejudices, as these are regarded as essential in understanding how people experience phenomena differently. He further argued the need to know about people's personal history, education, social class and psychological make-up, because all of these can influence the ways in which individuals experience phenomena (Smith et al., 2009). Thus, there is a

'fusion of horizons' when the preconceptions of the researcher meet with those who are studied (Wilde, 1992, p. 6).

Van Mansen's (2007) critique about the use of phenomenology within research asserted that researchers are interested in the promise that *'phenomenology can make to practice'* (Van Mansen, 2007 p.13). Heidegger claimed that phenomenology *'never makes things easier, but only more difficult'* (Heidegger, 2000, p.12). He agreed with those who felt that phenomenology lacked effectiveness or utility if one hoped to do something practically useful with it:

Nothing comes of philosophy; you can't do anything with it. These two turns of phrase, express observations that have their indisputable correctness. It consists in the prejudice that one can evaluate philosophy according to everyday standards that one would otherwise employ to judge the utility of bicycles or the effectiveness of mineral baths. (Heidegger, 2000, p.13)

Robson (2007) argued that reality would always be from a particular perspective, and that phenomena are not independent of the researcher. Thus, in undertaking descriptive phenomenology, it is impossible to avoid one's own interpretation of the phenomena. As in this study, I was mindful of my role undertaken, (that of researcher) and, that the interpretation of data would be influenced by personal and professional experiences. Firstly, as a registered social worker and secondly, having had considerable experience working alongside people who have learning disabilities. Accordingly, the philosophical approach of hermeneutics has been influential in my approach to this study, in the construction of a methodological focus.

Hermeneutics is the theory of interpretation: a separate body of thought from Phenomenology, but the strands are brought together in the work of hermeneutic phenomenologist – notably Heidegger (2000). Thus, for Heidegger, phenomenology was concerned in part with examining not only something (for example, context) which may be latent, but also what appears at the surface (for example, professional practice). Consequently, in this study, I argued that hermeneutical phenomenology offered an opportunity to see into the 'heart of things', which embraced personal subjectivities within a complex environment so that individuals' lived-worlds could be explored, shared and interpreted. In addition to which, as discussed, (see 3.2) a narrative inquiry approach adopted towards citizens intended to capture the *storied* nature of human conduct. Citizens responded to experiences by constructing their stories within the context of each interview, explored in greater detail in chapter six. The data generated also gave clues to the personal structures and social processes which affected their lives. This study placed a unique emphasis upon rich description and interpretations of people's lived-worlds through a hermeneutical phenomenological lens.

3.4 Research Site: Recruitment & Selection

The sampling method was theoretically consistent with the interpretative paradigm and within IPA's orientation. Hence, MDT and AHT participants were selected purposively (rather than through probability methods) because they offered the research study insight into particular lived-worlds. Research participants were selected due to the fact they could represent a perspective rather than a population. In terms of ethnicity, colleagues from different cultural backgrounds were also included. Two professional participants were from cultural backgrounds which differed from the remaining participants who were white British in origin. One participant was of white Dutch origin and had studied in England for a professional qualification; and, likewise, the second

participant of Asian origin had undertaken a British education in order to gain both academic and medical professional qualifications.

In addition to this, careful consideration was given to how each participant varied (Smith et al., 2009). This was established via criteria such as professional background, individual roles and gender across the learning disabilities service. Managers, social workers and allied health professionals were recruited in liaison with the two senior managers (AA & BB) who were part of the same service, but not part of the sample selected. Every effort was made to ensure that all participants were given the opportunity (without coercion) to make independent decisions about participation. I contacted all individuals who had expressed an interest in the study, (once ethical approval had been granted) to discuss the merits and the potential benefits for professionals who worked within a multi-disciplinary environment. The final sample comprised of volunteer participants (n=17) drawn from various geographical locations within the agency's boundaries across the city.

Another important consideration was the potential for bias during the data generation phase. The agency had hierarchical structures and teams had been configured accordingly. The location of participants within these structures could have influenced the relationships (power differentials) between colleagues from different professional disciplines, and perceptions about working alongside each other. This dynamic was taken into account during the recruitment selection and data generation phases, by ensuring that individuals had a choice as to whether they participated within the study. The team structures created from consenting participants are illustrated in Figures 2 and 3 (p.115).

The rationale for the selection of MDT and AHT members was driven by factors such as:

- The likelihood of their yielding useful information
- Their relationships with other colleagues
- Their knowledge of complementary disciplines
- Their location within the same service context
- Their experience of working within a MDT

The following tables (see Tables 5-8) represented the whole group of research participants (n=26). For ease of reference and clarity, participants were clustered according to their professional background and their team location. Each professional was also allocated a number and team identification. Each participant was based in either the MDT or the AHT. Local citizens were identified separately. Service users wished to be identified by a first name within this study, and as such pseudonyms for each of them were created. Informal carers were represented by an alphabetical sequential order.

Table 5: Social Work Research Participants (n=9)

Profession	Role	Data Extract Reference Number	Gender
Social Worker	Assistant Director Commissioning Services Multi-disciplinary Team (MDT)	(MDT,1)	Male

Social Worker	Assistant Director Provision of Services Allied Health Team (AHT)	(AHT,2)	Male
Social Worker	Team Manager of a (MDT)	(MDT,3)	Female
Social Worker	Advanced Practitioner within a MDT	(MDT,4)	Female
Social Worker	Care Co-ordinator within a MDT	(MDT,5)	Female
Social Worker	Care Co-ordinator within a MDT	(MDT,6)	Female
Social Worker (Newly Qualified)	Care Co-ordinator within a MDT	(MDT,7)	Female
Social Worker	Development Worker (Service Users)	(MDT,8)	Female
Social Worker	Development Worker (Informal Carers)	(MDT,9)	Female

Table 6: Allied Health & Community Nurse Research Participants (n=8)

Profession	Role	Data Extract Reference Number	Gender
Consultant Clinical Psychiatrist	Diagnosis of Learning Disabilities Assessment of & Treatment for Individuals AHT	(AHT,10)	Female
Consultant Clinical Psychologist	Diagnosis of Learning Disabilities, Team Manager & Training Lead across the Learning Disabilities Service AHT	(AHT,11)	Female
Community Nurse: Learning disabilities	Team Manager of a MDT	(MDT,12)	Male
Speech/Language Therapist	Team Manager AHT	(AHT,13)	Female
Community Nurse: Learning disabilities	Care Co-ordinator within a MDT	(MDT,14)	Female
Community Nurse:	Care Co-ordinator	(MDT,15)	Female

Learning disabilities	within a MDT		
Clinical Nurse Specialist: Learning disabilities	Challenging Behavioural Nurse AHT	(AHT,16)	Male
Physiotherapist	Mobility & Re- habilitation Individual treatment Plans AHT	(AHT,17)	Female

Table 7: Service User Participants (citizens) (n=4)

Individual (Pseudonym)	Context	MDT / AHT Input
Amy in her 20s	Living at home with parents	Social Worker (MDT)
Brian in his 40s	Tenant and supported living arrangement with other adults	Social Worker (MDT) Speech & Language Therapist (AHT)
Cathy in her 50s	Tenant and supported living arrangement with other adults	Social Workers (MDT)
David in his 50s	Tenant and supported living arrangement with other adults	Social Workers & Community Nurse (MDT)

Table 8: Informal Carer Participants (citizens) (n=5)

Carer (Pseudonym)	Context	MDT Input
Mrs A	Supported son living at home	Social Workers & Community Nurse (MDT)
Mr B	Supported daughter living at home	Social Workers (MDT)
Mrs C	Supported son who was a tenant and supported living arrangement with other adults	Social Worker & Community Nurse (MDT)
*Mr D	Supported daughter who was a tenant and supported living arrangement with other adults	Social Workers (MDT)
*Mrs E *(married couple)	Supported daughter who was a tenant and supported living arrangement with other adults	Social Workers (MDT)

3.4.1 Multi-disciplinary Teamwork

The concept of collaborative working forms an element of multi-disciplinary teamwork Taylor et al., (2006). This amounts to the respect for other professionals: an agreed sharing of authority, responsibility and resources aimed at specific outcomes or actions, and gained through co-operation and consensus (McCray, 2007). Engstrom et al., (1999, p. 346) coined the term '*knot-working*' linked to co-configuration. Knot-working may occur when services and professionals co-configure their work in order to be responsive towards service users; in this case individuals who had learning disabilities.

Engestrom et al., (1999) further explained that in practices of co-configuration in multi-disciplinary working there is a need to go beyond conventional teamwork or networking to the practice of knot-working:

Knot-working is a rapidly changing, distributed and partially improvised orchestration of collaborative performance which takes place between otherwise loosely connected actors and their work systems to support clients. (Engestrom et al., 1999, p. 346)

In knot-working, various forms of tying and untying of otherwise separate threads of activity take place. Co-configuration in responsive and collaborating services requires flexible knot working in which no single actor has the sole, fixed responsibility and control (Leadbetter et al., 2007). Whilst successive governments: New Labour (1997-2010), the Coalition (2010-2015) and the Conservative government (2017) created legislation such as the Children's Act 2004, Care Act 2014, alongside re-commissioned research (Cameron et al., 2012; 2014), about the increasing interest in the role of integrated working in the provision of public services; often it is the team members who make things happen. This is based on their informal networks and connection to others, created through a shared commitment to service users (Mantell, 2009). The findings from this study revealed that the main 'actors' placed at the heart of professional practice and co-ordinators of relevant services, were members of the MDT, social workers and community nurses. Important knowledge about how members of the team saw themselves and their work has been generated and analysed in this study, discussed in detail throughout chapter five.

3.5 Research Ethics

Social research is a dynamic process that often involves an intrusion into people's lives and therefore largely depends on the establishment of a successful relationship between myself and the participants. Central to this relationship is ethical responsibility, which is integral to the research methodology, proposed question and subsequent planning. Ethical responsibility for this study was essential at all stages of the research process - from the design of the study including how participants were recruited, to how they were treated through the course of these procedures, and finally to the consequences of their participation (Sarbin, 1986). For ease of reference (see Appendix 2) which highlights an overview of the planning schedule and the required processes involved in terms of university and agency engagement. This included discussions with agency colleagues about the remit of the study; giving a presentation about the research design to senior managers; completion of (university and agency) ethical approval applications; creation of a participant information sheet and consent forms (see Appendices 3, 4, 5 and 6). There was also a requirement to agree the content of the semi-structured interview schedules, before full approval was given by the agency and access to potential research participants. This was addressed by submitting the semi-structured interview schedules to the senior management team. An example of one schedule is presented (see Appendix 7).

This period of time took thirteen months from the outset (October 2010-November 2011). Although time consuming, these activities enhanced the prospects of gaining access to the agency and also generated interest amongst professionals, some of whom expressed an interest in becoming research participants during the early stages of ethical approval procedures and agency negotiations. Ethical approval was granted on 19 July 2011 by the University of Salford (see Appendix 3) in relation to professionals and citizens. The agency's ethical approval was received on two different occasions. This was

due to the fact that the agency required separate documentation about professional participants and local citizens, in terms of my approach towards their involvement within this study. The agency's (senior managers) belief about the inclusion of local citizens was that they should:

Be given an opportunity to report their views independently and on a voluntary basis. Their views should not be encumbered by professionals who may have provided services in the past. (AA & BB, Agency, 2011)

Consequently, the approvals were granted on 16 May (professionals) and 16 November (citizens) 2011 respectively.

In terms of professional participants, once ethical approval had been confirmed negotiations between senior managers (AA) and (BB) began on the 1 August 2011, with a view to planning the co-operation and support of interested participants from the learning disabilities service as a whole. The intention was to create a representative sample size which was inclusive of team members from the MDT and also the AHT. Professionals based within the MDT consisted of seventeen professional staff (social workers, community nurses and community care assessors). Community care assessors were experienced professionals within social care but did not possess a professional social work qualification and registration status. The AHT consisted of five colleagues: a clinical psychiatrist, clinical psychologist, clinical nurse specialist, speech and language therapist and a physiotherapist.

At this point it is important to highlight the fact that valuable work had also been accomplished on the development and understanding of research ethics in social work

(Butler, 2002). This is associated with this research study, as it was embedded within a social work context and therefore had relevance to the research study as a whole. Butler, (2002) asserted that social work research is distinguishable from other forms of social research. His critical commentary highlights the obvious fact that social work research has the practice of social work as its operational domain. He further commented that it is this particularity that argues the case for a discreet ethical code for social work researchers. In addition to which, social work research is to be considered as occupying the same discursive site as the practice of social work, and the same operational domains. However, Shaw & Gould (2001) argued that a drawback of texts which offer codes of research ethics is that it leaves the impression that applying ethics to social work research works in a fairly standard way from one project to another, and that such applications are largely initial business, sorted and settled in the early phases of the research. In terms of this study, (as illustrated), it is argued that each study is unique and that fairly standard applications do not exist, although the use and knowledge of a discreet ethical code for social work researchers was a useful reference point. More importantly was the need to approach ethical considerations with a flexible attitude, bearing in mind the research design and the complexities of this agency's context (interviewing employees) and the variety of different professionals becoming research participants. As a result, the successful outcome of ethical approval for this study enabled social work research to be undertaken within the '*same discursive site as the practice of social work*' (Butler, 2002, p.241).

Despite the fact there are ambiguities surrounding the application of ethics in the social research context, the literature consistently highlights a number of key considerations that researchers (like myself) need to adhere to throughout the course of undertaking

research (Smith et al., 2009). The key considerations include voluntary consent, informed consent and confidentiality.

3.5.1 Voluntary Consent

Voluntary consent is considered as the central norm governing the relationship between the researcher and participant. It is expected that an individual participates in research according to his/her own freewill, and therefore the researcher (myself in this case) informs participants that the research is voluntary and that they can withdraw at any time (see Appendix 4). However sound the methodological considerations, there is also potential for conflict with ethical principles (Mcauley, 2007). In relation to this study, my concerns were associated with the extent to which each of the participants had in fact given their voluntary consent, given their position and the presence of organisational hierarchical structures. Therefore, I re-confirmed at the beginning of each interview that individuals were willing to offer their contributions on a voluntary basis and that they did not feel any organisational pressure to participate. As a precautionary measure, I reminded them that it was a personal decision about how much information they wanted to share during the interview process, and they could finish the interview when they wanted to without any adverse consequences for themselves.

Prior to the commencement of the data generation phase, the selected participants were provided with consent forms (see Appendices 5/6). The form can in effect be a 'contract' in which important considerations are raised. The terms in which the participant can withdraw any information given at any stage in the research, up to and including publication, are laid out explicitly. Ethically this is a sound procedure. However, this did inadvertently formalise what may have seemed to the participant at the outset to be a casual procedure, and inadvertently compromised rapport between me and the

participant – an effect which could have been detrimental to the overall quality and/or extent of data generated (Miller & Brewer, 2007).

3.5.2 Informed Consent & Citizen Involvement

Closely aligned to voluntary participation is the principle of informed consent. On ethical, as well as methodological grounds, encouraging individuals to participate in research requires that clear and accurate information about the research is delivered to them (Mcauley, 2007). As illustrated in the planning schedule (see Appendix 2) clear and accurate information was produced during the ethical approval stages, alongside distribution of information to interested parties via a known source. As already stated in the literature review (Beresford 2012; Cameron et al., 2012; 2014) discussed the importance of citizens' views about their experiences and responses towards an integration of services (see 2.7). Their conclusions have made clear that some problems associated with poorly co-ordinated services can still be found in England.

In respect of local citizens, their informed consent was sought through known sources. This was achieved through negotiations between two development workers (participants 8/9). Each development worker had direct contact with citizens, (either service users or informal carers) due to their roles undertaken within the service. Their remits were concerned with supporting citizens independently from social workers, community nurses and allied health professionals. It was deemed an effective way in which to share the purpose of this study – delivered by a familiar face to a variety of citizens living across the agency's geographical boundaries. Overall, the negotiations with citizens (n=9) to confirm who would give their voluntary and informed consent took three months. All the citizens had had some involvement with members of either the MDT or AHT (as

illustrated in Tables 7 & 8), but they were not connected to the (professional) research participants during the data generation phases.

Once confirmation (via the development workers) had been received, a separate consent form was produced in relevant language and pictures (see Appendix 6) on behalf of individuals with learning disabilities. I was informed that all the service users had the ability to read simple language and in the case of Amy, she also had the support of a local advocate who was based in a voluntary organisation within the same geographical location. This was due in part because she did not use receptive language to express her views. The service users' development worker was also consulted about the appropriateness of the material to be used before sharing it with them. The rationale for this was to encourage individuals to share their experiences, (telling their stories) within a supportive environment.

Joint visits were also planned so that service users were interviewed at a local health centre and informal carers had the choice of being interviewed at home or at a different venue. All the participants were given the choice as to whether they wished the linked development worker to be present during the interviews. The rationale for this was to offer re-assurance about the validity of the research during the process of individual interviews. At the outset individuals gave their voluntary and informed consent to participate, and all remained committed to sharing their experiences of a MDT approach.

There has been an increasing interest in people being able to play a more active part in their society and community and living their lives as citizens. As such, user involvement has become a shared goal of political parties and policy developments. However, Beresford (2013a) argued that *'it has become apparent that some groups face more*

barriers than others getting involved and this can exclude their perspectives from consideration (Beresford, 2013 p.3). A number of challenges remain before it can be said that marginalised groups are included in the mainstream of research affecting their lives. Beresford asserts that it is important that researchers engage with service user/carers organisations to campaign for change. As mentioned, new forms of engagement are being developed, using social media and social networking sites. Some of the challenges of engagement include:

- Attitudes of professionals (inclusion)
- Equality Issues (gender, ethnicity)
- Where people live (living in residential services)
- Communication (people who do not communicate verbally)
- Resources (talking about priorities)

The academic literature carries a number of examples of research studies which involved people with learning disabilities as participants (Nind & Vinha, 2013; Walmsley, 2001), and research which highlighted the importance of conducting qualitative research with people with learning, communication and other disabilities (Nind, 2008). Moreover, Valuing People (2001) insisted on participation in the policy implementation and evaluation process. Booth & Booth (1994) suggested that the guiding principle behind involving people with learning disabilities in the research process lies with the challenge posed by the inadequacy of method, rather than being perceived as a problem of the individual. Obtaining consent to participate in research presents particular ethical challenges to researchers in the field of learning disabilities (Cameron & Murphy, 2006). A significant tension exists between the need to ensure that people with learning

disabilities understand the nature and implications of their involvement in research, and at the same time avoid any coercion.

There is also considerable debate about what informed consent actually means, and a concern that researchers either exclude people with learning disabilities from research, or include them without their consent. Some researchers engaged in work with people with learning disabilities (Cameron & Murphy, 2006) reach different conclusions. For example, it must be recognised that, although some people cannot give informed consent, efforts must still be made to develop ethical practice so that they are not entirely excluded from research. Therefore, it is also necessary to adhere to the statutory principles of the Mental Capacity Act 2005 (Brown et al., 2010) when involved in research and issues about informed consent appertaining to people with learning disabilities. Jepson (2015) also argued that people with learning disabilities should be included within research, if the research is about them. He further explained how as a researcher, he negotiated consent with people who had learning disabilities through the use of components of the Mental Capacity Act, 2005 (MCA). Likewise, in this study, I consulted the MCA in terms of adhering to the Code of Practice during ethical approval requirements. This was relevant in terms of accepting that each of the citizens had the capacity to make an informed decision about their participation within this study.

The commitment to service user participation was highlighted in the (DH,2005a) Research Governance Framework (RGF) for Health and Social Care, as stated:

Effective and responsive services depend on good research. Through this framework and related provisions, the government and its partners strive to ensure that research conducted in health and social care in England offers

the likelihood of real benefits either using health or social care services should give serious consideration to becoming involved in developing or undertaking research studies. (Responsibilities of Participants: 3.4.1)

Since 2005 the (NHS) Health Research Authority (HRA) became a non-departmental public body and, on 1 January 2015 took responsibility for issuing guidance for research in England, in place of the RGF (DH, 2015b). This was also inclusive of research within adult social care, in line with the Care Act 2014. In addition to this, the HRA is committed to a single framework for research in the UK and a Steering Group was established to lead this. A consultation period was planned from December 2015 until March 2016 to include stakeholder partners in the UK (HRA, 2016). The results from the consultation were published in June 2016, altogether (n=104) responses were received (n=64) from organisations and (n=40) from individuals. The report stated:

In general, participants welcomed and supported the draft Policy Framework as a replacement for the Research Governance Framework and supported the approach to harmonise approval processes across the UK. (HRA, 2016, p.6)

One point to note, however, was the response from local authorities and although they were pleased with the reference to social care throughout, there was a request to add a paragraph which acknowledged the distinction between health research and social care research; as they are often carried out in very different settings. A request was also raised about the role of ADASS, in their ethical and oversight duties relating to social care research.

In addition to this, the national advisory group (INVOLVE, 2016) supports greater public involvement in NHS, public health and social care research. Their remit is to promote the empowerment of the public, for them to become more involved in research. They also develop and promote alliances with key groups, including researchers, the DH and other research funders and sponsors. More recently INVOLVE has provided guidance on the use of social media to actively involve people in research. An example of this is the International Centre for Mental Health Social Research (Webber, 2014). Webber (2014) wanted to reach as diverse an audience as possible - those people using mental health services and those working in mental health. He used Twitter (a social media forum) to connect with people as it forms communities of interest (as people choose to follow), and is a medium that encourages people to express their opinions. It is also easy and efficient to use. Some of the challenges however, which can include people with learning disabilities, is that using social media means using people who are already engaged and therefore research results can be biased. People who are not digitally aware are also excluded from this type of research community. It can also be unpredictable in terms of whether people actually see Tweets or blog posts.

3.5.3 Confidentiality

One of the most important aspects of social research is the protection of the participants' identities. As part of obtaining informed consent it was made clear to participants how their responses would be treated. For example, the data generated was stored using a password protection system, and access was limited to myself. This was also compliant with the Data Protection Act 1998, in terms of creating rights for those who had their data stored, and responsibilities for those (in this case myself) who stored, processed and used their data via the selection of original data extracts (see 3.10). The data was also kept for a four year period, before destruction to comply with ethical procedures and also

the writing up period. Adhering to the principles of anonymity and confidentiality was also a consideration during the data generation phase. For example, discussions were held with each participant about how their relevant data extracts would be used within this thesis. This included maintaining both anonymity and confidentiality. In terms of the MDT members, this was easier to achieve, due to the large number of social workers and, to a lesser extent, community nurses based within the learning disabilities service. AHT participants gave permission to use relevant data extracts, to illustrate their experiences. Citizens also agreed to share their perceptions through the presentation of data extracts, some of which are presented throughout chapter six.

3.6 Methods: Data Generation

Once the recruitment and sample selection had been agreed, and individuals identified, each participant was contacted to arrange a suitable interview time. All the interviews were held over a nine-month period. Professional participants were scheduled to be interviewed from September 2011 until December 2011. Local citizens were interviewed after this period, from January 2012 until May 2012 due to the timing of the decision to give ethical approval agreement. Individual professional interviews took place at the agency, in a private office. All the service users chose to have the development worker present during the interviews. Most of the carers chose to be interviewed in their home environment, and one carer chose a local resource centre (Mr. B). Two carers (Mrs. A and Mrs. C) requested the presence of the carer's development worker during the interview process. All interviews were digitally recorded and permission was granted to make additional hand written notes. Each interview lasted for approximately 1-2 hours duration.

3.6.1 Semi-structured interview Schedules (professionals)

Interviews are most successful when participants have significant experience in the research topic and were likely to want to discuss it (Leonard, 2007). The aim therefore, was to facilitate interactive discussions and the sharing of lived-worlds, translated through values, experiences and interpretations, while at the same time ensuring that the data generated was able to meet the overall aim and objectives of the research study. The participation of allied health professionals also enriched the data, as the issues explored were considered and analysed from different perspectives.

We live, Silverman observes, in an '*interview society*' (Silverman, 1993, p. 35) where the mass media, human services and researchers generate a great deal of information through interviewing. For social workers, particularly those with a casework role, the interview is the dominant practice method. Scourfield (2001) emphasised the point that social research mirrors social work practice in many respects, as undertaking a social work assessment in particular can be regarded as a form of social research. (Sheppard, 1995) argued that there was a connection between the skills of qualitative research and the undertaking of a social work assessment. Since the interviews in this study were focused upon values, attitudes, knowledge and experiences of participants, this method was selected to be the most suitable.

Interviews are particularly good at helping participants to think through, consider and make explicit things that have previously been implicit (Whittaker, 2009). Robson (2002) asserted that facts and behaviour are more easily obtained than beliefs and attitudes, though participants may experience memory lapses or bias, so specific questions about issues in the present or recent past are best. In addition to this, the interviewing technique adopted was dependent upon the paradigm being used. This approach

facilitated the opportunity to try and make the interviews more life-like in terms of being informal and conversational. The research tool utilised took the form of a semi-structured interview schedule (see Appendix 7). This type of schedule acted like an aide-memoire about the areas to cover, but without stipulating in what order, and allowing for flexibility in the wording (Humphries, 2008). The questions within the schedule were grouped together within specific categories which enabled both the participants and me to focus upon particular sections. The intention was to encourage the natural evolution of dialogue and also to capture the *lifeblood* of experiences through individual lived-worlds. The interview schedules were designed and adapted for specific professional groups, based upon their remit within the agency. For example three schedules were developed, social workers and community nurses (n=8), managers (n=4) and allied health professionals (n=5). This facilitated appropriate questions aligned to roles undertaken within the learning disabilities service. However, in reality very little adjustment was made to each schedule. The rationale and starting point for the creation of the schedules was based upon the conclusions from the literature review in chapter two (see 2.9) and whether the issues raised in Table 4 were still important to the research participants during the life-time of this study (2008-2017).

The justification for qualitative (semi-structured interviewing) is recognisable by professionals (and in this instance) through the development of a trusting relationship. It was envisaged in this study that one could get to the truth of what the participant believed. This method also enabled sufficient structure to facilitate data analysis (Whittaker, 2009). Another advantage of interviewing participants was the high response rates. All the participants reported that they felt comfortable being interviewed as it allowed them to express their opinions, and any ambiguities in the questions, or answers to questions, could be clarified during the interview time. Participants were able to give

extensive answers to some questions posed. A good example of a social worker's anonymised data item (transcription) is highlighted (see Appendix 8). This example also identified how useful data extracts had been highlighted and stored within NVivo software, to illustrate points of significance and to add meaning to the findings captured in chapter five.

3.6.2 Qualitative Interviews and Alternative Methods

Although interviews with social work professionals and others (colleagues, carers and service users) has become an essential part of social work research, there have been a number of concerns expressed about qualitative interviewing (Scourfield, 2001). For example, it could be argued that people always respond in the context of the relationship, and that this is as true for the administration of structured questionnaires as it is for more informal interviewing (Gomm, 2004). There is also the issue of accountability. Qualitative researchers are not able to make available the conduct of interviews that have taken place so that the process can be scrutinised by readers. Very few research studies inform the reader about the actual process of the interview. This issue was addressed in this study, to some extent, by the presentation of an anonymised data item (see Appendix 8) and the fact that additional staff members had been present at both carers' and service users' interviews. In terms of professional participants, they consulted each other separately about the remit of the study and how the interview experience had been managed (by myself) during the data generation phase.

An alternative or additional research method which was also considered was the use of heterogeneous focus groups. A focus group could have facilitated gathering a range of opinions about the related topics for discussion and exploration. They allow for participants to challenge and interact with one another in an open environment

(Whittaker, 2009). However, during the initial discussion and planning stages of the study, concern was expressed by the senior management group (within the agency) that this format could cause unnecessary disruption amongst colleagues. This was due to a number of boundary issues. Participants had complex relationships with each other. It involved potential role conflicts and issues regarding employment terms and conditions which differed between some of the participants. In addition to this, the interviews sought to learn about individual histories and biographies deemed as personal information, and not to be shared within a public forum, such as a focus group setting.

3.6.3 Creation of Data Sets

Once all the data had been generated, the emphasis shifted to the creation of data sets and organised in such a way to represent how the agency configured their teams. The corresponding data sets also located each of the professional participants within their team of reference. Accordingly, research participants were either based within the MDT or the AHT. Figure 1 outlines how the generated data was organised in preparation for analysis. Four research participants were managers, all of whom supported professionals in their respective teams. Three managers were experienced social workers and one manager was a community nurse. Two team managers (social worker and community nurse) and one senior manager (social worker) supported colleagues located in the MDT and one senior manager (social worker) supported colleagues based in the AHT. Data set (3) refers to citizens, some of whom had input from both the MDT and the AHT, as illustrated in Figure 1.

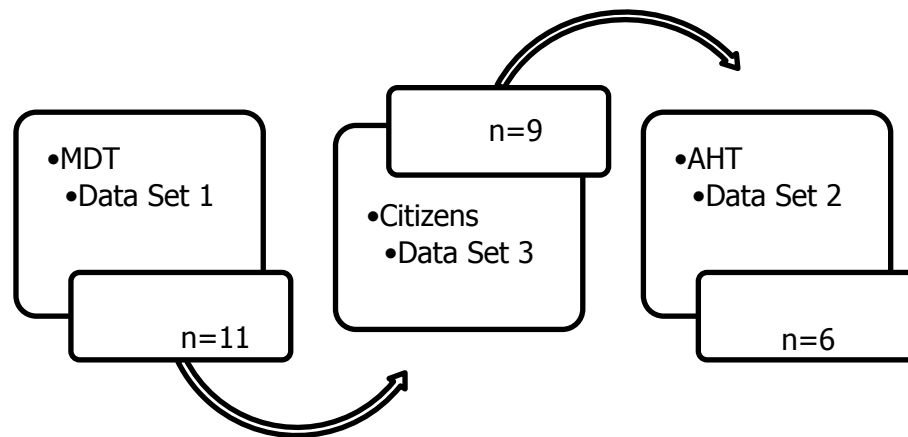


Figure 1: Organisation of Data Sets

The diagram in Figure 1 highlighted some of the potential complexities involved when attempting to present findings that made sense in terms of both analysis and interpretation of results. For example, it was important to acknowledge original contributions from each participant within a hermeneutical phenomenological context, but equally important was the necessity to locate each professional participant (in particular) within their specific context. This approach enabled the findings to be analysed through each team configuration. The agency had a clear vision and interpretation of their view of a MDT. This was also supported by their vision about how an AHT could offer value and support to the work undertaken by members of the MDT, on behalf of people with learning disabilities and their families.

3.6.4 Agency Structures and Configurations

In order to outline the vision and representativeness of how the teams were configured in the agency, the two diagrams (Figures 2 & 3) illustrate their independent structures. Both teams were co-located within the same building but situated on different floors.

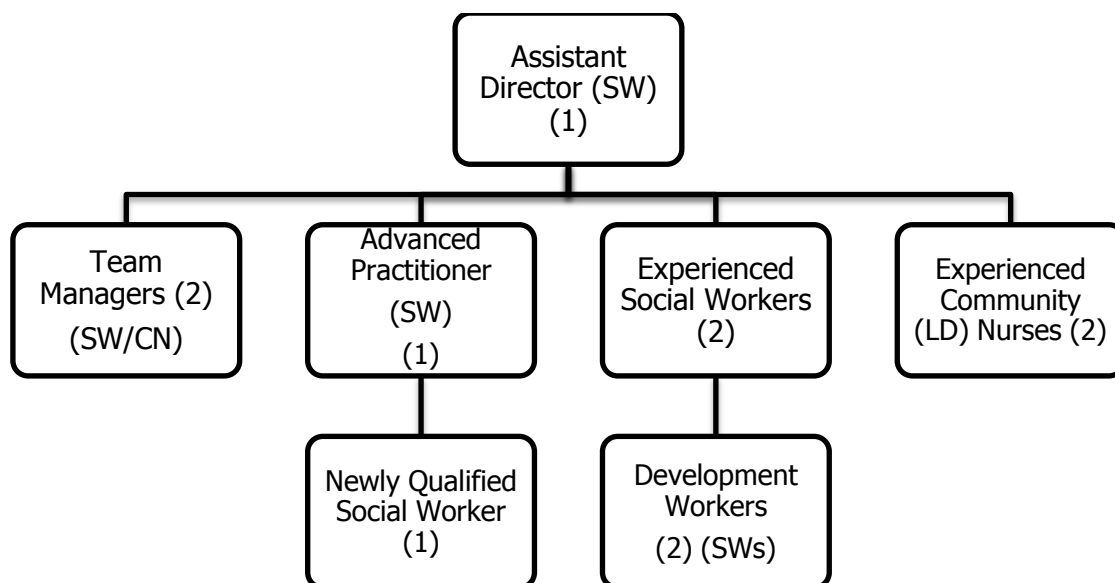


Figure 2: Multi-disciplinary Team (MDT) (n=11)

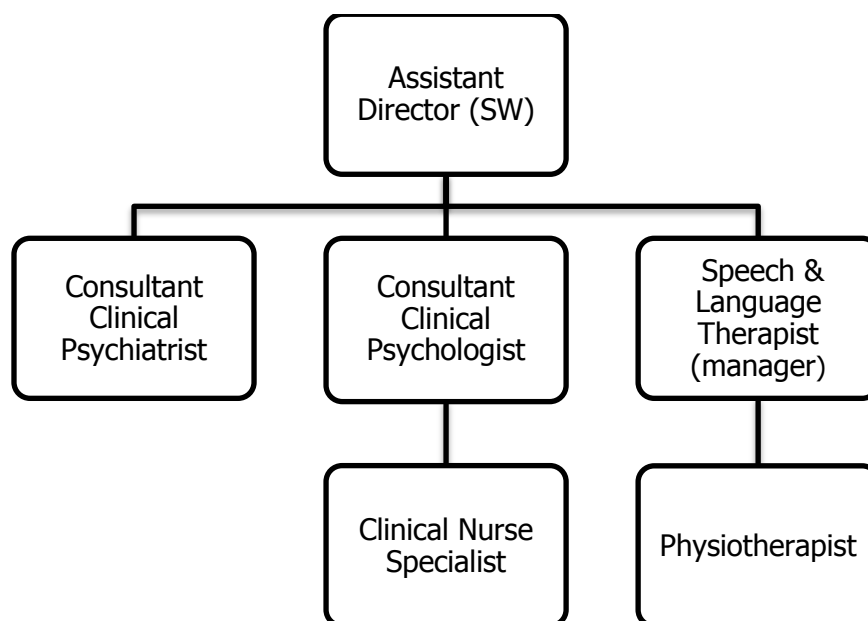


Figure 3: Allied Health Team (AHT) (n=6)

3.7 Data Analysis and Professional Participants: Interpretative Phenomenological Analysis (IPA)

IPA draws upon both phenomenological and interpretative traditions, which creates the opportunities to obtain a depth of understanding about human experiences. IPA was selected as it seeks to ascertain how research participants make sense of their experience by exploring, investigating and eliciting meaning and attempting to provide 'thick' (depth) of descriptions of their individual lived-worlds. A major influence upon IPA is idiography. Idiographic methods are concerned with the individual and unique experience rather than focusing on generalities. Firstly, there is a commitment in the sense of detail, and therefore the depth of analysis. As a consequence, analysis is thorough and systematic. Secondly, IPA is committed to understanding how particular experiential phenomena (event, process or relationship) have been understood from the perspectives of individuals in particular contexts (Smith et al., 2009). As mentioned previously (see 3.6.1) all the interviews were digitally recorded and the data items were produced from each interview. A decision was reached to transcribe the interviews (verbatim) as far as possible. The participants' own words had been transcribed 'in vivo' (codes) as it related to the words, phrases and meanings used by the participants (Smith et al., 2009) (see Appendix 8 ¹).

3.8 Data Analysis: the approach (MDT & AHT)

A key tenet of IPA analysis is that the process is iterative – moving back and forth through a range of different ways of thinking about the data, rather than completing each step, one after the other. This was supported through the process of interpretation, that is, meaning attached to data. As such, I designed an original systematic framework during the data analysis phase so that the iterative process could be sequenced and

tracked to facilitate effective analysis for theme(s) development in terms of professionals. Table 9 outlines the original framework and the different stages during the analytic phases. The use of QRS International (2015) (NVivo, 10) was utilised to assist with the overall data management of seventeen separate interviews over a period of nine months. The software's capacity for recording, sorting, matching and linking data extracts was harnessed – without losing access to the source data, digital recordings of individual interviews (Bazeley, 2011). This was aided by the use of *Annotations* and *Memos*, available within the software. Annotations (see Appendix 9) were used to develop interesting comments about the data, and for noting recurrences and prevalences from the professional participants. Memos were used to capture data extracts, as illustrated (see Appendix 8). The initial reading of the data items was to get a sense of the whole, so that more specific details within each data item was visualised within a team context. Immersion in the data was necessary to comprehend its meaning in its entirety, and was an important first step in the analysis (Crabtree & Miller, 1999). Once the data had been reviewed and there was a general understanding of the scope and context of the key experiences, the use of NVivo coding provided a formal system in which to organise the data, documenting additional links within and between concepts and experiences described in the data (Bradley et al., 2007). Miles & Huberman (1994) assert that codes are tags or segments of data (words, sentences, paragraphs) which help to catalogue key concepts whilst preserving the context in which these concepts occur. NVivo was helpful for this study as a semi-structured approach was adopted for the one to one interviews.

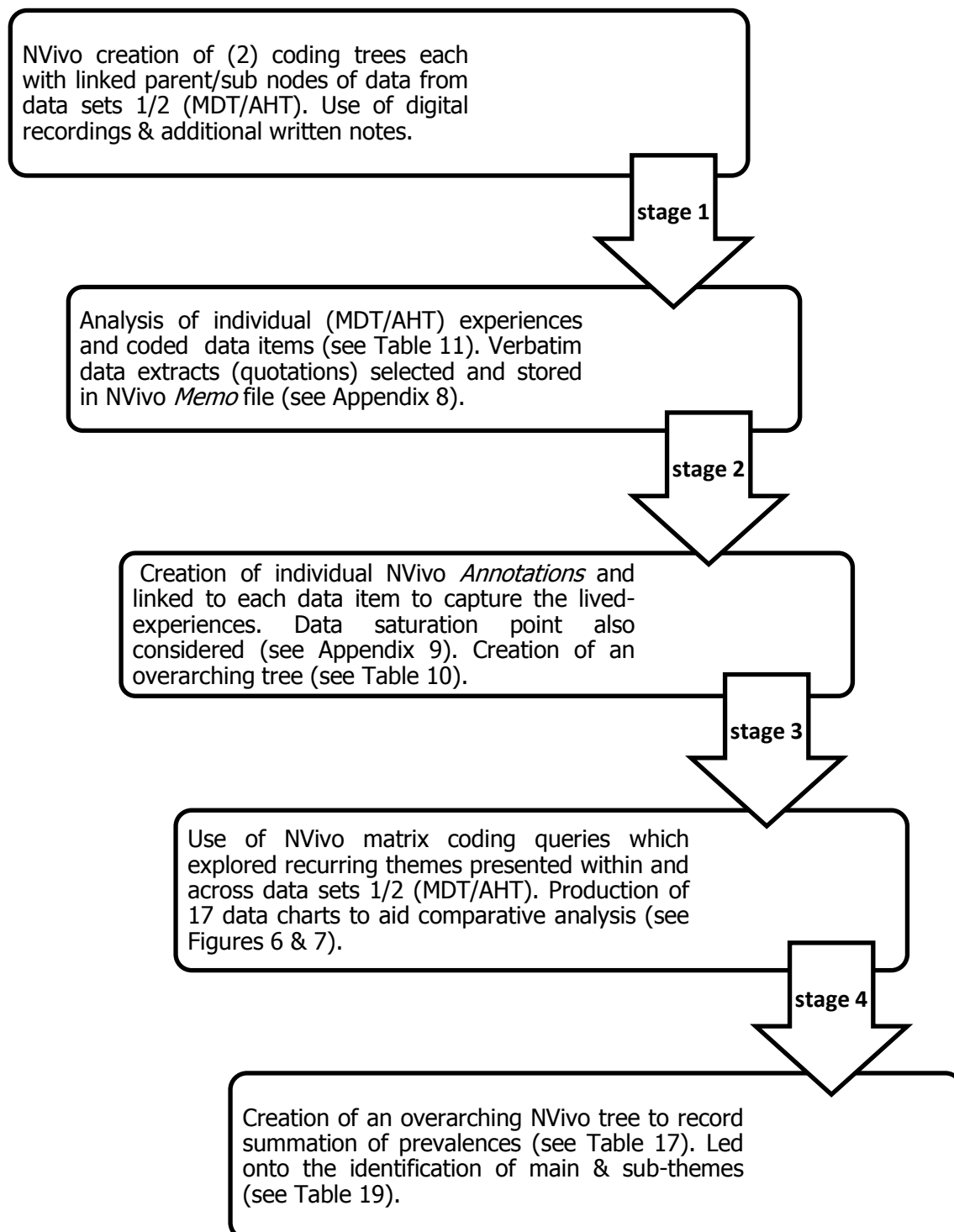
I also gave some attention to the engagement with participants' accounts. The analysis was the joint product of the participant and me as the researcher. However, the main

¹ By way of example, (MDT, 5) was selected to illustrate the approach used towards analysis.

concern of IPA was the 'essence' of the experience of the participant, and the meaning each participant made of that experience. This led onto the development of a semantic approach (description) towards the initial data. This method enabled the subsequent progression from description to analysis and interpretation, where there was an attempt to theorise the significance of the patterns and their broader meanings and implications (Patton, 1990). Therefore, an accurate reflection of the data sets (1 and 2) has been explored. The end result in this study was an account of how it was believed that the participants were rationalising and reflecting about their experiences. Thus, the truth claims of an IPA analysis are always tentative and analysis is subjective (Smith et al., 2009). My engagement with the data items involved flexible thinking, processes of reduction, expansion, revision, creativity and innovation. This process allowed for the generation of insightful outcomes from the findings. In terms of the professional participants, this fostered the development of overarching themes supported by main themes and linked sub-themes.

The use of a narrative inquiry approach towards the citizens' contributions (data set 3) also enabled me to engage with their accounts – as presented in chapter six. Their powerful narratives generated unique contexts about their conceptualisations and experiences of working with social workers (in the main) who advocated an MDT approach. The added presence of learning disabilities was also considered, in terms of how this dynamic affected citizens' everyday lives.

Table 9: IPA Original Systematic Framework & Process of Data Analysis: Professional Participants



3.9 Selection of Original Data Extracts (quotations)

Original data extracts were cited throughout the thesis, although the findings chapters (four, five and six) contain the majority of extracts to illustrate valuable points of interest. In addition to this, I used data extracts (from the analysis phase) to illustrate how the use of the selected theoretical framework CoP and its component parts were relevant to this study (3.10 (1) (2) (3).

There was also an intention to capture a sense of the depth of understanding about the notion of multi-disciplinary experiences from a variety of perspectives. Extracts were also selected, to some extent, to outline the character and role of the speaker; for instance showing their values and beliefs. This enables the reader to gain a sense of how individual accounts were shaped (King & Horrocks, 2010). As Braun & Clarke (2006) argued, the aim is not merely to provide a descriptive summary of the content of the theme, but rather to build a narrative that tells the reader how the findings have cast light upon the subject at hand: in this case the contribution of social work within a multi-disciplinary context of service delivery. In addition to this, effective empirical data extracts were selected to illustrate the developing arguments within this study. For example, the following data extract demonstrates that the issue of co-location was important to research participants. One participant said:

To have all the people together I think is a good thing. On balance having a multi-disciplinary team is good. For example, we are not working in silos. I think we work reasonably well with upstairs, although they are on a different floor. (AHT, 13)

This issue had been mentioned a number of times by a variety of participants, which had been highlighted during the data analysis phase. I believed that a co-located site facilitated effective collaboration between various professionals, all of whom made a contribution towards people with learning disabilities. This was also illustrated by another research participant who discussed the importance of co-location. She said:

They are all within reaching distance and the good thing is that if you need others you can either pop downstairs to see them, or send them an email and they get back to you straight away. It's very helpful that we are all based in the same building. I'm not sure that if someone was based 500 yards down the road anybody would pop over there. It helps with a lot of the work and multi-disciplinary team meetings. (MDT, 5)

All the citizens who participated also offered personal insights about their experiences of working alongside a social worker, in particular. One informal carer commented:

We couldn't have coped without social workers, although we had a battle with them about getting the right information. During our daughter's transitional stage, moving into a bungalow, the social worker was great and followed it through. This was important, especially as I was her mum. (Mrs. E)

Likewise, a service user also shared his experiences of working alongside a social worker in this MDT:

I liked my social worker, she needed to understand my situation and listen to me. She was easy to chat to and came when she said she would. A couple of times she

was a bit late, she had to go to other places first. She arrived and apologised for being a bit late. She used to come up with ideas, if I didn't like the ideas I used to tell her. She was alright about that. (Brian)

3.10 Theoretical Framework: Communities of Practice (CoP)

An IPA approach to the data analysis offered 'depth and detail' about participants' professional and personal experiences. This gave a reflection about IPA's core strength. However, from a sociological standpoint, this method omits to include the interrelationship between the macro (the learning disabilities service) and the meso (teams) perspectives. It limits the capacity to place the individualised experiences alongside other professionals within an agency context. The notion of complex social interactions between social workers and health professionals has been addressed predominantly throughout chapters four and five. The idea of how both social workers and allied health professionals were able to maintain 'security' in their own identities has also been considered in chapter seven. This was enhanced by professionals who were able to give their insights about the contribution of social work within a multi-disciplinary context. The underpinning notions about how different professionals can work together, is supported by the theoretical framework of Communities of Practice, (CoP) developed by Wenger, (1998). The theory applied a similar analytical process on the social interactions between professionals that are inherent within multi-disciplinary practice (Crawford, 2012). The significance and use of this theory within this study was connected to how appropriate concepts related to each other; in terms of how the participants (professionals) engaged with the process of multi-disciplinary working, primarily for the benefit of citizens who required an individualised service.

It could also be argued that CoPs can be aligned with a theory known as, The Learning Organisation (TLO), mainly associated with (Senge, 1990). TLO approach was participative, democratic, anti-authoritarian and in, principle, empowering to service users and front-line staff (Bissell, 2012). Furthermore, TLO is experimental and takes a social constructivist view of organisational life (such as working in teams situated within an agency context). This view is construed as a shared reality that is constantly evolving by its participating actors. The organisation, therefore, accords greater importance (than bureaucratic constraints) to the actions and meanings of both front-line staff, (multi-disciplinary team members) and also to the experiences of citizens: in this instance, local citizens.

That said, however, the general argument about CoPs is that they are everywhere, and that individuals are involved in a number of them – whether that is at work, school, home or in civic and leisure interests. In some groups individuals are core members, in others, people may be positioned more at the margins. The characteristics of such CoPs vary. Some communities are quite formal in organisations, others are fluid and informal. However, members are brought together by joining in common activities and by what they have learned through their mutual engagement in these activities. In this respect, a CoP is different from a community of interest, TLO or a geographical community in that it involves shared practice (acquiring knowledge) within a collaborative environment.

A CoP is identified as a social learning theory (SLT) (Wenger, 1998). A theory which asserts that people learn new behaviour through observational learning of the social factors in their environment. If people observe positive, desired outcomes in the observed behaviour, then they are more likely to model, imitate, and adopt the

behaviour themselves. Modern SLT theory is closely associated with Rotter and Bandura (Articles, 2011).

Wenger (1998) defines communities of practice as groups of people sharing common interests, concerns and responsibilities, and engaging together and improving their practice as a result. He also acknowledges the development of shared resources within these communities. This definition allows for CoPs to encompass networks of people from a number of different organisations. For example, social work participants (with a particular specialism) linked up with other colleagues to share experiences and learn from each other. However, Wenger identified CoPs as natural working groups within an organisation that, apart from facilitating learning, provide '*ways of ameliorating institutionally generated conflicts*' (Wenger, 1998 p. 46). They also help socialise the workplace, and whilst they may extend beyond work teams, they can encompass them (Gray et al., 2010).

Lesser & Storck (2001) argued that CoPs are a form of social capital; they are part of the value of the organisation and enhance its performance. Wenger (1998) further argued that CoPs cannot be created but rather colleagues can acknowledge their existence and encourage other colleagues to participate. Some organisational settings will not possess strong CoPs, whilst others will have a number of them. To a certain extent this may dictate the success or otherwise, of a particular focus, process or function within an organisation.

Thus, the notion of a CoP can be acknowledged as an important function within an organisation. In terms of this study, it was associated with the meso focus of social processes across a MDT. A key asset of a CoP is the recognition that membership is

likely to generate knowledge. Knowledge plays an important component, as it allows CoP members to build upon their experiences and at the same time do other tasks, as they belong to other organisational groups and structures. Relevant examples from the MDT and AHT included:

- Specialist interest groups and forums (including protocols)
- Virtual CoPs, in terms of professional networks
- Regular team & patch meetings
- Monthly city wide multi-agency meetings.

The idea is that knowledge is created, shared and agreed between communities (teams), which can facilitate professionals' identities and subsequent responsibilities within a collaborative organisational context. The theoretical concept is that CoPs with a focus on identity (in this case professional identity), is developed through social participation. Wenger (1998) also stressed the importance of identity as integral and inseparable from issues of practice, community and meaning. This can apply to both individuals and a collective identity (such as a team) and '*brings to the fore the issues of non-participation as well as participation, exclusion as well as inclusion*' (Wenger, 1998, p. 145). Of particular interest is the way in which the notions of practice and community are brought together.

Wenger (1998) proposes three ways in which practice provides coherence to a community. The three components consist of mutual engagement, shared repertoire and joint enterprise. This combination represents how professionals from different disciplines can collaborate and work effectively together. For example, participants (in this study) recognised that mutual engagement between them fostered the development of a shared repertoire, especially when working with individuals who had learning disabilities.

In addition to this, it was discovered during the interviews that all the participants had a sense of being 'in it together' – in other words, they had developed a joint enterprise of commitment towards membership of the learning disabilities service, and likewise towards vulnerable adults and their carers. Figure 4 illustrates how the separate components combine together. Each of the components is discussed in more detail, along with selected data extracts from the analysis phase, to illustrate the points being made.

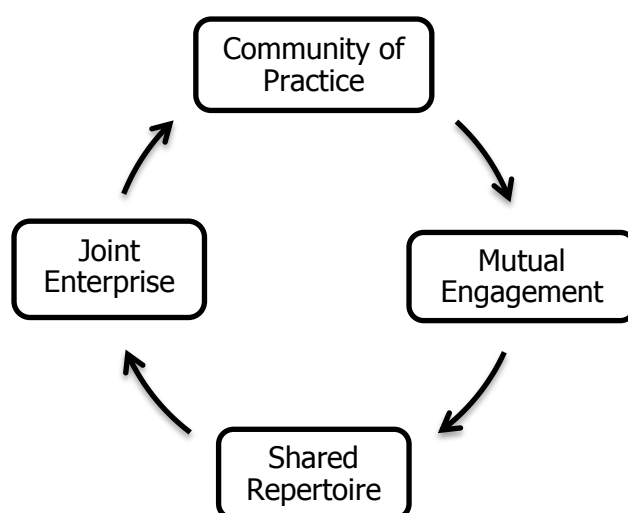


Figure 4: Dimensions of a Community of Practice (CoP)

Source: (Wenger, 1998, p. 73)

3.10.1 Mutual engagement

Practice resides in a community of people and the relations of mutual engagement by which they can do whatever they do. Membership in a CoP is therefore a matter of mutual engagement. The kind of coherence that transforms mutual engagement into a CoP requires work. The work of 'community maintenance' is thus an intrinsic part of any

practice. For example, a participant highlighted how work was allocated to either a social worker or a community nurse:

It can be as simple as allocations. To me it's easier to allocate someone who has health needs to a nurse rather than a social worker. We are all doing the same things and looking at the holistic needs of the person. But you will find that a nurse will focus more on the health needs than on the social needs. (MDT, 15)

Within a context of mutual engagement colleagues work together, exchange information, opinions and influence understanding as a matter of routine. Wenger also claimed that most situations that involved sustained interpersonal engagements also generated a share of tensions and conflicts. This was highlighted by a research participant when she explained how she supported a professional who wished to challenge another professional's opinion:

I always try and say to people you need to work with it a bit more and ask more questions. Go back and try and dig a bit deeper into it challenge in a nice way, it's quite hard to do because it could be a psychiatrist. (MDT, 3)

3.10.2 Shared Repertoire

The second characteristic of practice as a source of community coherence is the development of a shared repertoire. The elements of the repertoire can be very heterogeneous. They gain their coherence not in and of themselves as specific activities, but from the fact that they belong to the practice of a community pursuing an enterprise (Wenger, 1998). The repertoire of a CoP includes routines, tools, and ways of doing

things or concepts that the community has produced. In relation to this study, the learning disabilities service had evolved over the past few years, which influenced the accepted way in which the team of professionals' practice within their organisational context. A participant said:

We were probably there eight years ago doing the same things, and now it seems a very peculiar way to go about things and it certainly had us scratching our heads. I think possibly what that has taught us in recent months is that you can do the right things much more quickly, and with very little fuss, in a service like this especially as we now have a pooled budget. (MDT, 12)

3.10.3 Joint Enterprise

The third characteristic of practice as a source of community coherence is the negotiation of a joint enterprise. There are three components which enable the community to work within a cohesive way. There is a sense of a collective process, of negotiation, which is defined by the participants (or work colleagues). It also creates among participants a connection in terms of mutual accountability which becomes an integral part of professional practice. By way of illustration another participant stated that:

I feel that through the austerity measures the MDT work will drop off and also the specialist knowledge of both social workers and nurses will be spread thinner due to fewer staff. People will get a standardised package that won't necessarily meet their needs. The fear is that we don't have the services or the skills to offer people with learning disabilities. (AHT, 16)

Communities of practice are not self-contained entities. They develop in larger contexts such as, historical, cultural and organisational environments with specific resources and constraints. Likewise, the impact of some of these conditions has been explicitly articulated within this research study, especially throughout chapter five. Another participant discussed how the team addressed difficulties in terms of agreeing priorities within the learning disabilities service as a whole:

It still just causes frustration. I would say the worker from the ground would say they experience some problems getting things agreed and getting things done - priorities really. We have to work quite hard with a team member to get them to understand our reasoning for priorities, which may be in conflict with the needs of an individual service user. (MDT, 3)

However, the CoP approach is not without limitations. Wenger et al., (2002) discuss what is termed the 'downside' of CoPs, arguing that:

The qualities which encourage a CoP to be developed, such as shared perspectives, long-standing relationships and established practice, are the same qualities that can hold it hostage to its history and achievements. (Wenger, 2002 p.141)

Radical change may be very difficult to bring about within existing communities, and may be more easily introduced through the destruction of old CoPs and the emergence of new ones (Roberts, 2006). Important issues such as, power and power dynamics of CoPs are essential to the development of a full understanding of knowledge creation and dissemination. Power is the ability to achieve something, whether by influence, or

control. In terms of this study, an important theme was the presence of hierarchical relationships between team members. This factor and associated meanings for participants therefore, would be influenced by their own position within the team and relationships with other colleagues, some of whom may or may not be located in a senior position. In relation to the formation of CoPs, the power dynamic could have had a bearing upon the degree of participation by team members. Another example was the impending move to different offices and comments made by research participants. Most of them were of the opinion that negotiations (within their hierarchical structure) had already been limited to key figures of authority within the organisation, and thus the voices of some members of the CoP may have therefore, been muted. A participant said:

Although, there is a hierarchy, sometimes there are things going on and things happen overnight. It doesn't always get down here, we are all moving office. There are two buildings; somebody has spoken to somebody somewhere. But we don't know who it is. (MDT, 5)

The domain of trust also plays a crucial role between members of a CoP. The presence of a relationship of trust between individuals indicates an ability to share a high degree of mutual understanding, built upon a common appreciation of a shared social and cultural context such as a MDT. These are prerequisites for the successful transfer of tacit knowledge (Roberts, 2000).

In principle, a CoP need not be treated as a separate concept as such to become a community; but rather it enters into the experience of participants (team members) through their very engagement with each other and their organisational context. The importance of various CoPs can be established in two ways: their ability to give rise to

an experience of meaningfulness and, conversely, to hold participants captive to that experience, which could inhibit growth and development in the future. This may be applied to either individual professional development or, in a wider sense, the growth and development of a MDT; in this case a team operating within a statutory learning disabilities service.

3.11 Conclusion

As outlined at the beginning of this chapter, the main aim has been to illustrate a robust overview of the research design. This has included a comprehensive account of the; recruitment site, sample selection process, the complex ethical procedures and dynamics and, not least, an illustrative example (see Table 9) of the approach towards data analysis has been discussed throughout. The factors relating to the discipline of social work have also been discussed, which emphasised the important links between ethics, social work research and social work practice. A suitable theoretical framework (CoP) associated with the process of social interactions between professionals has also been introduced and embedded, supported by relevant data extracts.

From the outset it had been the intention to research (and interview) a statutory team of professionals within a learning disabilities service, which has been achieved. Research participants shared their experiences willingly and collaborated positively, motivated by their belief that this research study was a worthwhile venture. The following chapter will build upon the initial data analysis introduced in this chapter, so that clear and effective results are presented and discussed. The addition of citizens has added different dynamics, in terms of experiences and perspectives, all of which are further explored in their results chapter, chapter six.

CHAPTER 4

Presentation of Findings:

Findings (1): Professional Participants: Results, Prevalences and Thematic Networks

Findings (2): Identified Themes of the MDT and the AHT

Findings (3): Citizens who needed and used services

4.1 Introduction: the approach

In chapter three both epistemological and ontological concerns were considered and the study was located within an interpretative research paradigm. The utilisation of an interpretative phenomenological methodology (IPA) was also embedded within the research study. It was explained that semi-structured interviews and storytelling were used as the methods for empirical data generation, alongside the creation of three separate data sets. The findings (1,2,3) are therefore, organised into three connecting chapters, (4), (5) and (6) which are illustrated in Figure 5. This figure illustrates schematically, the broad conceptual themes that underpin each of the chapters, and how the chapters have been linked and connected, so that coherence of findings could be demonstrated.

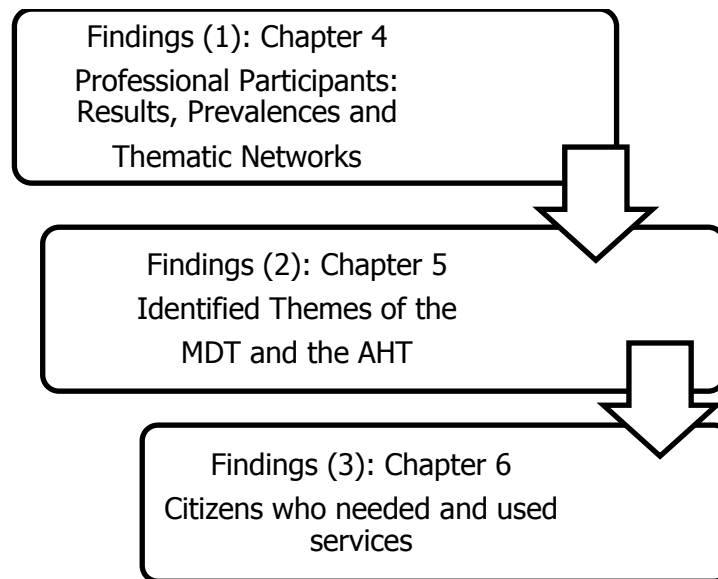


Figure 5: Presentation of Coherent Findings

Chapter four builds upon the initial data analysis (IPA) presented in chapter three about professional participants. This approach identified the next stages, (results) in terms of the importance of the prevalences which emerged from the MDT and the AHT, leading onto the creation of thematic networks. In chapter five the discourse tackles the configurations of three individual thematic networks and their nested themes. This is achieved through the presentation of detailed content analysis of each of the themes presented.

The rationale for presenting the findings from citizens separately (chapter six) is aligned to the theoretical concept of triangulation. King & Horrocks (2010) state that triangulation relates to the multiple methods of data generation. In this study, as discussed (see 3.2 pluralism), I used methodological triangulation to address the same research question. The two complementary methods (located within the interpretative paradigm) consisted of the methodological development of thematic networks on behalf of the professionals' sample (n=17), and the methodological development of a narrative inquiry approach, which generated data (as stories) representing the sample (n=9) of

local citizens. Thus, the purpose of triangulation was not necessarily to cross-validate the data, but rather to capture different dimensions of the same phenomenon. In so doing, this enabled me to present the views and opinions of participants separately, to provide an opportunity to understand the lived-worlds from the points of view of two groups of participants.

4.2 Findings (1): Professional Participants, Results, Prevalences and Thematic Networks

During the initial analysis phase, an original NVivo overarching 'tree' (see Table 10) was created to accommodate the coding of data content from all data items, grounded within a phenomenological context. This approach facilitated the development of a systematic process, and, as a method of working, constructed knowledge about the data (Bazeley, 2011). Connections had been made between parent nodes and sub-nodes into a branching system of tree nodes that reflected the types of issues under consideration. Table 10 displays how the overarching tree of parent and sub-nodes was constructed, using an interview schedule as a guide. This was a deliberate attempt to foster the links between how the data was generated, analysed and then interpreted. At first glance it appeared that the overall prevalence of textual coding references assigned to relevant issues gave an indication as to the 'hierarchy of importance'. In addition to this hierarchy, it was anticipated that the references would capture something important about the data in relation to the research question, and represent some level of patterned response or meaning within and across the data set(s). An important question to address was: what counts as a pattern/theme or what 'size' does a theme need to be? This is a question of prevalence, in terms of space within each data item and of prevalence across the data sets (Braun & Clarke, 2006). As explained, Table 10 identified data items giving prevalence to certain issues and not others. It was also important to

note, however, that the overall results displayed in Table 10 were inclusive of recoded *memos*, (via NVivo) attached to each data item generated through Nvivo. As mentioned in chapter three (see 3.9), *memos* were used to capture data extracts from individual data items, and to add depth of meaning and explanations about the results presented within this thesis.

The important tenet of a main 'theme' was not necessarily dependent on quantifiable measures, but whether it captured something important in relation to the overall research question (Braun & Clarke, 2006). For example, the subject matter (see Table 10) and its relevance was noted via each data item and subsequently assigned to the relevant node – building prevalences. Issues that were deemed important to participants generated more 'talk and text' and subsequently additional 'content' was coded to that specific topic. A good example of this was the parent node of: (6) Role Clarity within the Team. Some participants produced large amounts of descriptive core comments, which had a clear hermeneutical phenomenological focus – things (issues) which mattered to them (Smith et al., 2009), and, consequently, content was coded more readily. For example, one research participant discussed the importance of the role of the social worker, based within the MDT. The participant highlighted how the central co-ordination role was pinnacle of the role, in terms of overall co-ordination of services, alongside co-ordination of all other professional input towards an assessment of needs. He said:

The social worker needs to make sure that we are sticking to our values. They are the ones who see to it that things get done. The model we have here is that they are the co-ordinator of it. They are massively important in terms of signing off work. I've never met anybody who doesn't like working with the social workers.
(AHT, 16)

Table 10: Total Prevalences of two Data Sets

Total Prevalences Coding Tree: Parent Nodes & *sub-nodes	Data Items (n=17) (MDT) & (AHT)	Total Prevalences
1. Benefit of MDT working for service users	15	53
(a) *benefits of MDT working for carers	17	53
2. Experience within the service	13	26
(a) *working with other professionals	20	73
(b) *own perception about status within a MDT	15	56
3. Information sharing across disciplines	18	69
4. Policies and Protocols: Learning disabilities Service	14	52
(a) *professional forums learning disabilities service	12	27
5. Position within the Team	11	18
(a) *contribution of social work within a MDT	15	50
6. Role clarity within the Team	26	83
(a) *social worker	15	49
(b) *community nurse	8	25

(c) *allied health professional	3	7
7. Social Work values integrated within the role	15	49
(a) *Co-location between professional groups	11	15
8. Supervision Experiences	22	63
(a) *prof. development	17	50

As mentioned above, it could be argued that the most important issue across the data sets was (6) Role clarity within the Team. However, as the results were analysed further, it transpired that whilst this issue was important, the true picture revealed variations between participants, in terms of the importance of this issue (and other issues) to each of the participants. As a consequence, it was important to work from an abstractive perspective so that patterns could be identified which developed a sense of main themes of importance across both data sets (Smith et al., 2009). Rubin & Rubin (1995) have argued that analysis is exciting because '*you discover themes and concepts embedded throughout your interviews*' (Rubin & Rubin, 1995, p. 226). While Taylor & Usher (2001) have claimed that it is the active role the researcher always plays in identifying patterns/themes, selecting which are of interest, and reporting them to the readers. In terms of this study, this was achieved by capturing key words, phrases or sentences which the participant used and using them accordingly.

This is illustrated by Table 11, which outlines an example of codes applied to a short segment of data and linked to Table 10. The process of coding was part of the analysis and the results were organised into meaningful groups (Miles & Huberman, 1994).

However, the coded data differs from the units of analysis (themes) which are often broader.

Table 11: Data Item and Coded Extract

Data Item	Coded Extract
<p>The term co-ordinator has only been around for the past 18 months. (6)</p> <p>You are either a social worker or a nurse. Each of us will say we are coordinating the support package and doing the assessment. (2) I have to explain that we are a joint team and that I will be doing the assessment and we all do the same role. (1) Families expect a social worker to be doing a co-ordinator's role. They don't expect a nurse to be doing that role. I've told families lots of times that I'm a nurse, but I'm always referred to as the social worker. I don't bother now. (2b)</p> <p>(MDT, 14)</p>	<p>(6) Role clarity within the team</p> <p>(2) Experience within the service</p> <p>(1) Benefits of MDT working for service users</p> <p>(2b) Own perception about status within a MDT</p>

This coding process involved reflective analysis about how the participants related to their experiences, in this instance working as a professional colleague located within a team context and a learning disabilities service. Another key element of the results was concerned with language; reflected in the ways in which the content and meanings were presented by participants. Comments were extracted from data items and recorded as

annotations (see Appendix 9) so that the essential features of the experiences were captured and supplemented the thick description of individual lived-worlds. The term 'thick description' which originated from (Geertz, 1973, p. 34) referred to the notion that qualitative researchers should provide detailed descriptions of the phenomena they study within a specific context. This has been achieved in this study by familiarisation with data items and presentation of relevant data extracts, all of which were embedded within an analytical narrative.

4.3 Initial Results: Data Charts

The following examples (see Figures 6 & 7) display the results from two comparable participants, located in each data set (MDT) and (AHT). Each had their data items analysed which demonstrated unique perspectives and prevalences about core issues of importance. The representative participants selected were an experienced social worker (MDT, 5) and a clinical nurse specialist (AHT, 16). Both examples were also representative of how the original data was displayed in Table 10.

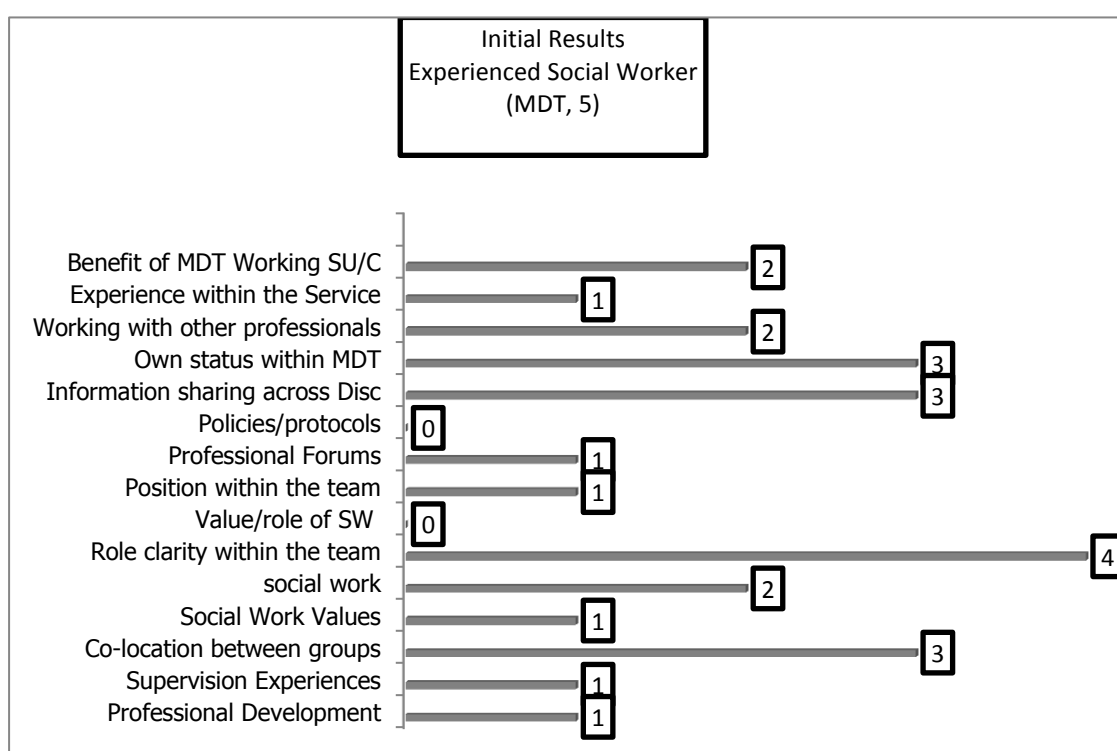


Figure 6: Initial Results: Experienced Social Worker

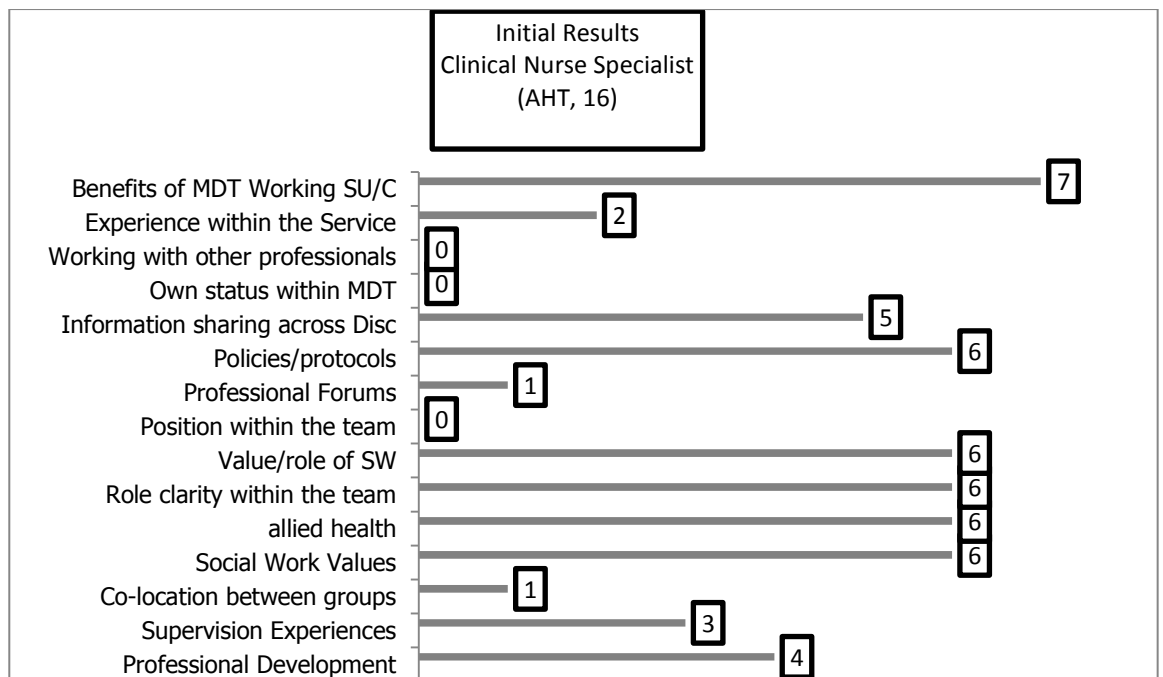


Figure 7: Initial Results: Clinical Nurse Specialist

4.3.1 Analytical significance attached to the Initial Results

The results offered an indication about emerging themes of importance within individual data items and across both data sets. As mentioned earlier, the most significant result across the data sets was the recognition that each participant's contribution was unique. This created individualised prevalences, all of which needed to be taken into account when attempting to undertake a thematic analysis. The results from Figure 6 (MDT, 5) indicated that the social worker had a meaningful association with the importance of role clarity within the MDT, followed closely by the significance of co-location and information sharing. This was in relation to discussions about individuals and also the type of information that needed to be shared between professionals. For example, comments included:

If there is anyone who has quite complex health needs and I need to know something, I'll ask about it. I'll talk to a nurse about taking the case on because health isn't my area; it just goes over my head. Because we are in the same role we are supposed to take on the same type of work, although nurses may take on more complex health and we take on more complex social needs. But it doesn't always happen. (MDT, 5)

These factors also highlighted the importance of the co-ordinator's role and how straightforward contact with other colleagues, made the job easier to manage on behalf of service users and their families.

Similarly, the clinical nurse specialist's results in Figure 7 illustrate that primary issues were associated with the importance of both role clarity and information sharing between professionals on behalf of individuals and their families. Additional issues such as the presence of agency policies and procedures figured highly in this participant's results. He also discussed the benefits of MDT working and linked allied health collaboration. He said:

On a day to day basis we are involved in the prevention of people leaving the area in terms of placement breakdown and also the re-settlement of people back into their ordinary communities, from very secure settings. We have brought people back who were placed in other localities. They had been placed 'out of county' due to placement breakdown within their own locality. (AHT, 16)

It was also important to note that this participant was a registered learning disabilities nurse and a registered social worker, holding a dual qualification. However, the role

undertaken was based within the AHT which had a nursing remit. The role was based around working with adults who had learning disabilities and had complex behaviour(s). By way of illustration, the participant said:

People who are going into hospitals are not just ignored because they have learning disabilities their other illnesses are taken into consideration. We have developed protocols and pathways into hospital for several years. It's got to the point where the hospital will ask for our help, when it's about people with very complex needs. (AHT, 16)

The initial results revealed that, in order to capture the individualised prevalences of all the research participants from two data sets (MDT & AHT), the same approach needed to be adopted towards all the remaining data items (n=15). Thus, additional (n=15) data charts (as illustrated by Figures 6/7) were created to facilitate effective results, and in so doing, led onto the development of thematic networks.

The responses were captured and recorded in tables, based on the original analytical tool – Table 10. Each table was representative of the results from either the MDT or the AHT. That said, it was also acknowledged that no data set is without contradiction and the thematic networks which were eventually produced did not hide or smooth out either tensions or inconsistencies within and across the data items (Braun & Clarke, 2006).

One such example was the importance of policies and protocols within the learning disabilities service. The data items and thirteen prevalences recorded in Table 13 from the two development workers clearly indicated differences between data items and eight prevalences recorded in Table 12, in terms of the levels of importance attached to this

issue by social workers, community nurses and managers. This was related to the fact that the development workers considered the presence of policies and protocols to be of paramount importance. This was linked to their roles which encompassed a strategic overview of services, associated with both service users who have learning disabilities, and carers of individuals with learning disabilities. They were less concerned with micro involvement around care co-ordination of individualised services, but focused upon specific input around issues of importance for citizens. A development worker commented:

My criteria identified by managers, is that I work with carers who are under extreme stress or dealing with various conflicts. This entails adherence to agreed policies and protocols and the rules and regulations associated with welfare benefits. I also have responsibilities for the carer as well. So there is quite a lot of mediation and counselling work. (MDT, 9)

The role also entailed consultation with local carers about their experiences of service delivery via the MDT and/or the AHT. As such, any perceived difficulties about either service delivery or relationships between individuals had to be dealt with sensitively, given the fact that both development workers had equal status to, and not higher than, relevant colleagues. Both social workers and community nurses were responsible for commissioning local services and maintaining professional relationships with local people in general. A potential conflict was the notion of interpretation of needs and how the agency deemed need(s) as opposed to individual carers. One carer explained how the social worker had a different approach and view towards their son's needs and future living arrangements. Her comments were:

When our social worker changed we felt the pressure to move him into independent living. We knew he would have to leave home, I couldn't care for him like I wanted to and he ended up in an emergency placement. He got really depressed and thought me and his dad had just left him. (Mrs. A)

Her son had Williams Syndrome which is a rare genetic disorder (Williams Syndrome Society, 2015).

4.4 Presentation of Tables

The completed results from all the participants' data charts (n=17) were collated and presented as three separate Tables (see Tables 12, 13, 14). In terms of the MDT members, small clusters of participants were grouped together, managers, (n=3) social workers (n=4) and community nurses (n=2). This was because they were related to the care-co-ordination role within the MDT. In the case of the social worker who undertook the role of an 'advanced practitioner', she had originally undertaken the role of care co-ordinator and as such was included in the same cluster (see Table 12, Data Set 1a).

In terms of the development workers, (n=2) they were associated with the MDT but had a different remit to that of care co-ordination; as such their results were recorded on a separate Table (see Table 13, Data Set 1b). As mentioned, they had more direct contact with service users or carers of individuals who had learning disabilities. In addition to which, they were supported by a different line management structure. In terms of the AHT, individual team members (n=6) were identified within Table 14 (see Data Set 2) as each AHT professional had an individualised role and made specific contributions to the MDT, usually at the request of the MDT member for specialist advice and/or an additional assessment. Presenting the AHT results as individualised responses ensured

that perspectives were analysed, and the results offered important insights about working alongside social workers who were located within the MDT. Presentation of the overall results enabled a comparative analysis of the similarities and difference between them to be undertaken. In qualitative analysis the application of codes and associations is seen as a way of linking data to ideas and from ideas back to supporting data (Richards & Morse, 2007).

Table 12: MDT Data Set 1a (n=9)

Overarching Coding Tree: Parent Nodes & *sub-nodes	Social workers (4)	Community Nurses (2)	Managers (3)	Total prevalences
1. Benefit of MDT working for service users	2	2	3	7
(a) *benefits of MDT working for carers	1	2	2	5
2. Experience within the service	3	6	7	16
(a) *working with other professionals	5		7	12
(b) *own perception about status within a MDT	6		12	18
3. Information sharing across disciplines	10		22	32
4. Policies and Protocols:	4		4	8

Learning disabilities Service				
(a) *professional forums learning disabilities service	4		4	8
5. Position within the Team	4		5	9
(a) *contribution of social work within a MDT		4	17	21
6. Role clarity within the Team	8		22	30
(a)*social worker	3		8	11
(b) *community nurse		10	1	11
(c) *allied health professional	0	0	0	0
7. Social Work values integrated within the role	1		3	4
(a) *Co-location between professional groups	3	2	3	8
8. Supervision Experiences	3	2	34	39
(a) *prof. development	2		16	18
Totals	59	28	170	257

Table 13: DW Data Set 1b (n=2)

Overarching Coding Tree: Parent Nodes & *sub-nodes	Development Worker (Service Users)	Development Worker (Carers)	Total prevalences
1. Benefit of MDT working for service users	16		16
(a)*benefits of MDT working for carers	7	16	23
2. Experience within the service	3	1	4
(a)*working with other professionals	17	4	21
(b)*own perception about status within a MDT	21	11	32
3. Information sharing across disciplines	10	2	12
4. Policies and Protocols: Learning disabilities Service	6	7	13
(a) *professional forums learning disabilities service	4		4
5. Position within the Team	4	2	6
(a) *contribution of social work within a MDT	13	4	17

6. Role clarity within the Team	21	13	34
(a)*social worker	0	0	0
(b) *community nurse	0	0	0
(c)*development workers	12	12	24
(d)*allied health professional	0	0	0
7. Social Work values integrated within the role	15	7	22
(a)*co-location between professional groups	2	1	3
8. Supervision Experiences	9	3	12
(a)*prof. development	13	2	15
Totals	179	79	258

Table 14: AHT Data Set 2 (n=6)

Overarching Coding Tree: Parent Nodes & *sub-nodes	**code SM	Psy	Psych	S/I	Physi	CNS	Total prevalences
1. Benefit of MDT working for service users		2	2	3		3	10
(a) *benefits of MDT working for carers		2	2	2		4	10

2. Experience within the service	4		2	2		2	10
(a)*working with other professionals	3		6	2	2		13
(b)*own perception about status within a MDT		2	2	2			6
3. Information sharing across disciplines	2	7	3	3		5	20
4. Policies and Protocols: Learning disabilities Service	2	2	2	2		6	14
(a) *professional forums learning disabilities service	3	1	3	2	1	1	11
5. Position within the Team		1	1	1			3
(a) *contribution of social work within a MDT	2	3	2	1	1	6	15
6. Role clarity within the Team	2	5	3	2	1	6	19
(a)*social worker	2	0	0				2

(b) *community nurse	0	0	0				0
(c)*allied health professional	0	2	3	1	3	6	15
7. Social Work values integrated within the role	2	3	2			6	13
(a) *Co-location between professional groups		1	1	1		1	4
8. Supervision Experiences	2	1	3	1	2	3	12
(a) *prof. development	2	1	2	2	2	4	13
Totals	26	33	39	27	12	53	190

**Code: (SM) = Senior Manager, (Psy) = Clinical Psychiatrist, (Psych) = Clinical Psychologist, (S/I)= Speech and Language Therapist, (Physi)=Physiotherapist, (CNS)= Clinical Nurse Specialist

4.5 Development of Main Themes and Sub-themes

The emergence of main themes and sub-themes across the data sets was facilitated through the summation of the total prevalences from each data set, as illustrated by Table 15. For example, each parent node and sub-node in the coding trees had been drawn together from the individual results Tables 12, 13 and 14.

Table 15: Parent node ranking

3. Supervision Experiences	Table 12 = 39 Table 13 = 12 Table 14 = 12	63	C
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Table 15 shows how the results (demonstrated in Table 17) offered different rankings. For example, the parent node: (3) Supervision Experiences highlighted the importance of this issue to all the research participants.

Table 16: Sub-node ranking

3 (d)* working with other professionals	Table 12 = 12 Table 13 = 21 Table 14 = 13	46	G
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Table 16 demonstrates how the sub-node: 3 (d)* working with other professionals, although important, was less significant in these results.

Table 17: Summation of Prevalences

Overarching Coding Tree: Parent Nodes & *sub-nodes	Results Tables: MDT DW AHT	Total prevalences	Emergent Themes
1. Role clarity within the team	30+34+19=	83	A
2. Information sharing across disciplines	32+12+20=	64	B
3. Supervision Experiences	39+12+12=	63	C

(a)*own perception about status within a MDT	$18+32+6=$	56	D
(b)*contribution of social work within a MDT	$21+17+15=$	53	E
(c) *prof. development	$18+15+13=$	46	F
(d)*working with other professionals	$12+21+13=$	46	G
4. Social work values integrated within the role	$4+22+13=$	39	H
(d) *benefits of MDT working with carers	$5+23+10=$	38	I
5. Policies and protocols: Learning disabilities Service	$8+13+14=$	35	J
6. Benefits of MDT working for service users	$7+16+10=$	33	K
7. Experience within the service	$16+4+10=$	30	L
(f)* professional forums learning disabilities service	$8+4+11=$	23	M
8. Position within the Team	$9+6+3=$	18	N

(g)* co-location between professional groups	8+3+4=	15	O
(h)* Allied Health prof.	0+0+15=	15	P
(i)* Social worker	11+0+2	13	Q
(j)* Community Nurse	11+0+0=	11	R

In Table 17 the summation of the overall results were then allocated a letter in descending order to represent the hierarchy of prevalences. It was also inclusive of parent nodes and associated sub-nodes.

4.6 Identification of Main Themes and Sub-themes

Table 18 demonstrates how this was achieved.

Table 18: Hierarchies of Prevalences

2. Information sharing across disciplines	Table 12 = 32 Table 13 = 12 Table 14 = 20	64	B
(f)* professional forums learning disabilities service	Table 12 = 8 Table 13 = 4 Table 14 = 11	23	M

In this example the parent node of: (2) Information sharing across disciplines had a higher ranking (B) than a sub-node of: (f)* professional forums (M). This result indicated that other issues had presented themselves as more important to all the research

participants. As mentioned earlier (see 4.3.1) the parent node of: Role clarity within the Team had remained the highest issue of importance to all the participants.

4.7 Conceptual Analysis and Interpretation of the Results

When searching for emergent themes, the task of managing the data changed. The focus was placed upon reducing the volume of detail from data items whilst capturing complexity, in terms of mapping the interrelationships, connections and patterns between exploratory texts (Smith et al., 2009). What was also of value to me during this process was an element of personal reflection, and a history of professional experience spent working as both a social worker and manager within a MDT and learning disabilities service of similar orientation. These factors enabled me to '*put oneself in someone else's shoes*' in terms of conceptualisation and understanding about the data generated from participants. For example, one senior manager explained how he felt about the profession of social work. He said:

Social work is a difficult job. Status wise, I think from my point it's one of the most important jobs that can be done. It has a profound effect upon people who don't have what they should have. In this case, I mean people with learning disabilities, living in this locality. (MDT, 1)

This data extract had a particular resonance in terms of being able to understand the importance of social work and the related responsibilities associated with the professional remit of the role within this context. In addition to this, it also fostered the notion of interpretation – '*one is using oneself to help make sense of the participant*' (Smith et al., 2009, p.90).

Conceptual analysis and interpretation of the data involved a *shift* in focus. There was a *shift* towards the participants' overarching understanding of the issues discussed and consideration was assigned to the linkages between them. Table 19 illustrates how clusters (or units) of themes were aligned together (using letters) through the creation of both main themes and related sub-themes.

Table 19: Identification of Main Themes and Sub-themes

Letter	Main Theme	Letter	*Sub-Theme
A	Role clarity within the team	D	status within the team
B	Information sharing across disciplines		
C	Supervision Experiences		
		E	contribution of social work
		F	continuous professional development
		G	working with other professionals
H	Social work values integrated in the role		
		I	benefits of MDT working with carers
J	Policies & Protocols across the Learning Disabilities service		
K	Benefits of MDT working with		

	S. Users		
L	Experience within the Learning Disabilities service		
		M	professional forums
N	Position within the Team*	O	co-location of colleagues
	professional *role (and status)	P	*allied health prof.
		Q	*social worker
		R	*community nurse

Additional considerations were taken into account during the creation of themes. The first consideration was the presence and complexity of the multiplicity of variables within this research study. To begin with, there were numerous definitions and understandings of multi-disciplinary work (see Tables 1, 2 and 3) 'multi' and 'inter' were used as prefixes to 'agency', 'disciplinary' and 'professional'. Clarifying who the key players were within multi-disciplinary work and what their different positions and perspectives entailed was clearly very important. Similarly, understanding the relationships with other partners, disciplines and professionals was a key aspect of the research process (Leadbetter et al., 2007). A second consideration was to understand the types of 'tools' used as part of their professional practice; how these matched or didn't match the tools used by other professionals, and how new tools were developed over time to meet the changing practices that emerged. By tools, this focused upon the ways in which professionals engaged, used processes and protocols and the use of specific terms. For example, one participant explained how the paradigm shift from institutionalised care for people with learning disabilities (Williams, 2013) to one of community integration and support, had

had an impact upon both people with learning disabilities and the staff who supported them. He said:

There is a myth that people don't like change, due to living in institutions and therefore don't have the ability to cope with community living. This view I think is wrong given the levels of discrimination and the need to fight their corner. Institutionalisation of staff and the 'we know better' attitude made it more difficult. The worst thing was the lack of contribution - the views of people who have learning disabilities. (AHT, 2)

A third consideration was to reach an understanding about the organisational contexts and constraints within which participants worked. To do this, the historical relationships across the learning disabilities service were taken into account. A final consideration was also aligned to how the traditional role of the community (LD) nurse (in particular) had changed; s/he was now expected to undertake a similar role to that of a social worker. In this instance a senior manager participant explained about the shift in emphasis around meeting the needs of someone who had learning disabilities. He said:

You need to be very person centred about what peoples' needs are. You also need to promote independence instead of dependence on services. Years ago people said that you needed a social worker to move house. This I found a curious concept, as this is not ordinary. (MDT, 1)

4.8 Thematic Networks

The combination of inter-linking conceptual analysis and the themes identified through re-current prevalences were assimilated and presented as thematic networks. Attride-Stirling (2001) illustrated how thematic analysis could be organised. She said:

Applying thematic networks is simply a way of organising a thematic analysis of qualitative data. Thematic analyses seek to unearth the themes salient in a text at different levels, and thematic networks aim to facilitate the structuring and depiction of these themes. (Attride-Stirling, 2001, p.387)

Thematic networks can share the key features of a hermeneutic (interpretative) analysis, and, as argued in chapter three (see 3.3), this position is maintained, in so far as this study offered an opportunity to see into the heart of things which embraced personal subjectivities. Thematic networks are presented in this study through Figures 8, 9 and 10. Each Figure was representative of the main themes and sub-themes identified in Table 19.

As such, a thematic network systematises the extraction of: (sub-themes) the lowest order premises evident in the text; categories of basic themes grouped together to summarise more abstract principles (main themes); and overarching themes which encapsulate the principle metaphors (issues) in the text as a whole (Attride-Stirling, 2001). This is a widely used procedure in qualitative analysis and parallels are found, for example, in grounded theory (Corbin & Strauss, 1990). Thus, the three classes of themes as presented in the thesis are:

- **Overarching theme** – encompass the principle metaphors (issues) in the data as a whole, they present an argument, position or an assertion about a given topic.
- **Main themes** – organisation of similar issues and clusters of significance which summarise the principal assumptions of the group, leading to more abstraction revealing 'what is going on' in the data.
- **Sub-themes** – characteristics of the data, and on their own say little about the text or group of texts as a whole. As such in order to make sense sub-themes need to be read within the context of other themes. (Attride-Stirling, 2001, p. 392)

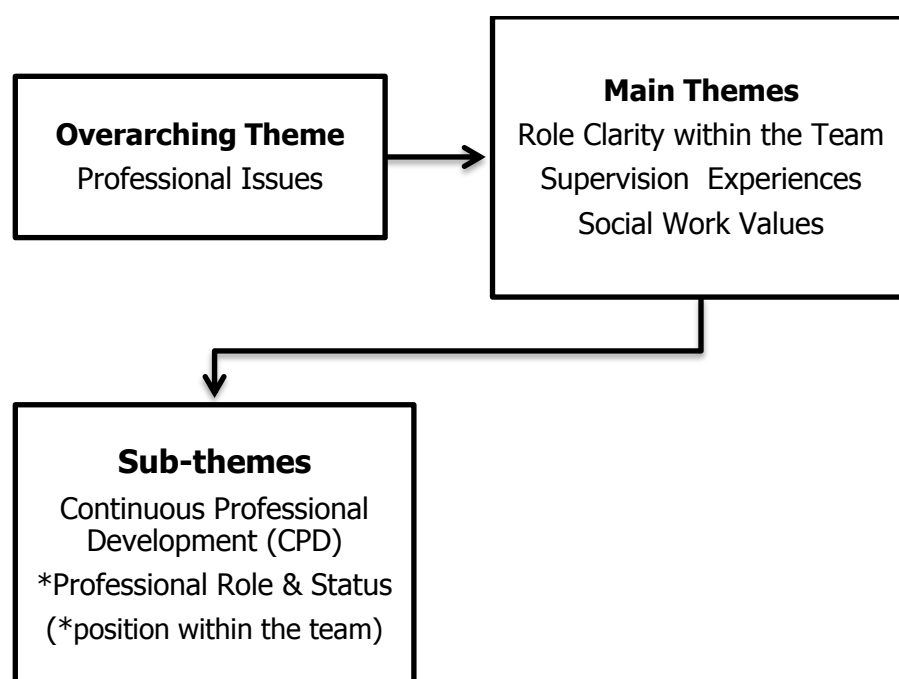


Figure 8: Thematic Network 1 Professional Issues.

An example of how the themes have been synthesised to represent a coherent network of professional issues.

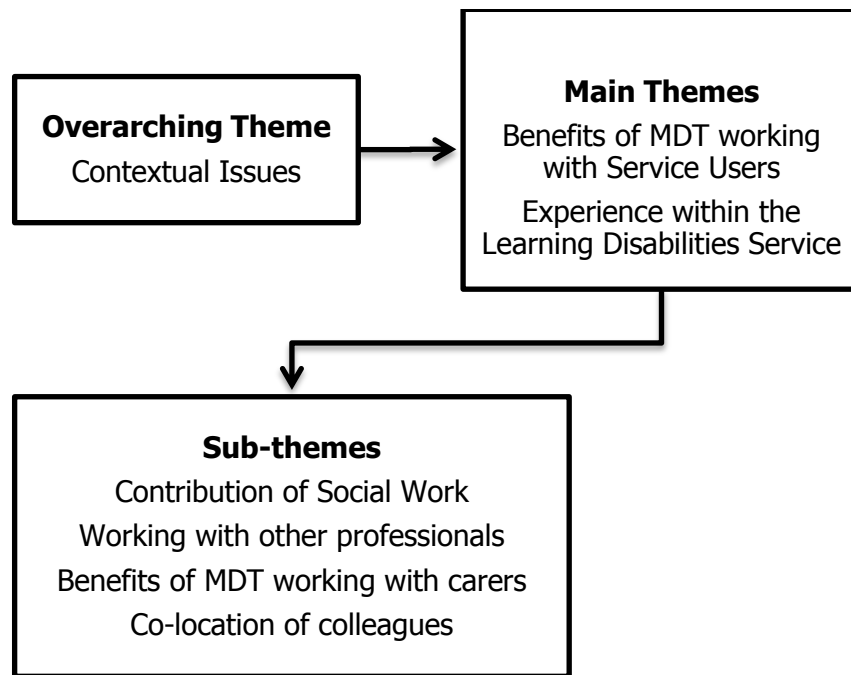


Figure 9: Thematic Network 2 Contextual Issues.

An example of how the themes have been synthesised to represent a coherent network of contextual issues.

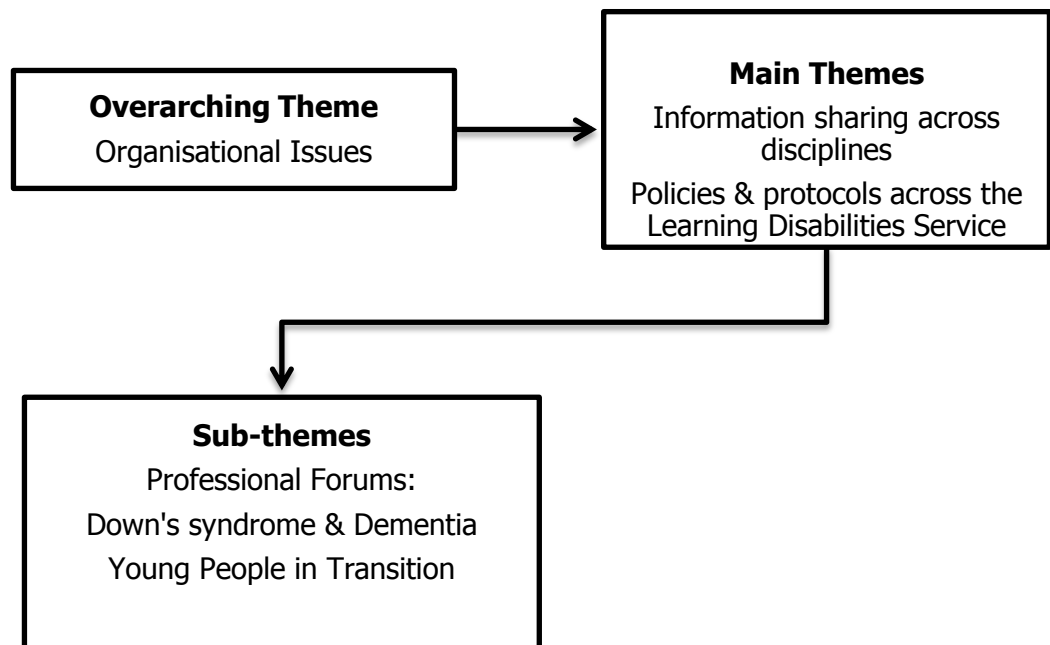


Figure 10: Thematic Network 3 Organisational Issues. An example of how the themes have been synthesised to represent a coherent network of organisational issues.

4.9 Conclusion

In this chapter an explanation has been given of how the results were realised, supported by the process used to identify prevalences from the generated data and initial analysis undertaken. The data encapsulated issues of importance for the participants from their individualised perspectives. The results were enhanced by conceptual analysis, and heightened by the design, presentation and analysis of data charts, leading onto the creation of textualised themes via tabulated results. The identified themes were then clustered into relevant networks of findings in order to demonstrate the relevance and alliances to each other. In the following chapter a micro analysis of the findings from the professional participants (n=17) is explored and discussed in more detail.

Findings (2): Identified Themes of the MDT and the AHT

5.1 Introduction

This chapter presents a detailed account of the themes which are representative of the issues of importance to all the professional research participants (n=17). As explained in chapter four, (see 4.8) three thematic networks were created from the results, underpinned by significant prevalences. Each network was created to represent correlated issues and has been carefully constructed so that connections between the overarching theme, main themes and sub-themes are relevant to each other.

The approach taken draws attention to pertinent issues across both the MDT & AHT which cultivated comparisons between them, in terms of individual responses from participants. This supported the notion of attempting to capture something of the lived experience, and that it inevitably invoked interpretations about the data. This approach has also been influenced by other IPA researchers, such as Smith et al., (2009). They assert that:

An IPA narrative represents a dialogue between participant and researcher and that is reflected in the interweaving of analytic commentary and raw extracts.
(Smith et al, 2009 p. 10)

Each of the thematic networks has been presented in a schematic way, (see Figures 8, 9 and 10) helping the reader to acquire a broad sense of the whole, before addressing the details of the nested themes. The same approach has been applied to all three networks

in terms of presenting each of them separately along with the related themes attached to each network. A critical commentary has been provided about the findings after the themes are presented. Pertinent data extracts were selected to further illustrate the points made by individual participants.

Once all three networks of findings have been presented, an overall concluding commentary was developed to draw together the key messages representing both MDT and AHT colleagues.

5.2 Thematic Network 1: Professional Issues

The themes associated with this network are concerned with professional issues which affected all the participants within the study.

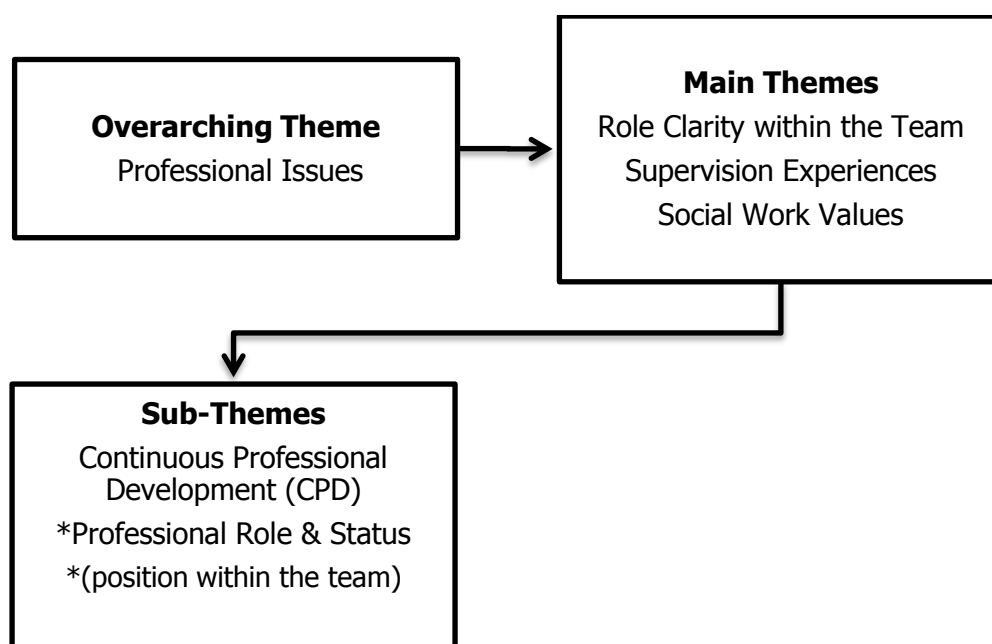


Figure 11: Thematic Network 1

5.2.1 Thematic Network 1: Overarching Theme

- Professional Issues

The overriding professional issue identified was the necessity to bring together different professionals to work 'side-by-side' on behalf of vulnerable adults who had learning disabilities. By its very nature multi-disciplinary working brings together professionals with different philosophies and values as well as divergent professional cultures (Cameron et al., 2012). As such, participants based within the learning disabilities service were representative of this mix of various disciplines. All participants, (n=17) most of whom had experienced working within multiple agencies described their experiences and career developments. They indicated that experience of this nature was beneficial for multi-disciplinary working. For example, one team manager said:

I moved around a lot during my early career, to gain experience and to find out what I enjoyed. But then I was excited by the prospect of setting up a joint team within the learning disabilities service and I've never looked back.
(MDT, 3)

An AHT participant discussed his professional experiences over a period of thirty years. He said:

I have had the good fortune to work as both a social work practitioner and also a manager. I have worked with children and adults along the way. (AHT, 2)

Another participant shared her experiences about supporting people with learning disabilities, having done so for the past thirty one years. For the majority of that time she had worked as a nursing assistant based in a variety of NHS hospitals. In 2001 she was seconded to undertake her professional and combined social work and learning

disabilities nurse training, qualifying in 2004. She had the role of care co-ordinator based within the MDT. This participant also shared the issue of disparities between nursing and social work colleagues, in terms of salary scales. She said:

I have worked in the MDT since the beginning. I have been promoted to a band (7) nurse, this is a nursing sister grade. All the nurses in the team (MDT) are working at band (7). I think this is a higher grade compared to our colleagues working as experienced social workers. We came over from the NHS, but any future nurses based in the MDT will be working at band (5) to begin with. This is the equivalent grade to that of a newly qualified social worker. There are opportunities for promotion, but there are some limitations, it depends if I want to step into a management role, but I like working with families best. (MDT, 14)

Differences in salaries between experienced nurses and social workers was a significant professional issue, especially as they were undertaking the same role - that of care co-ordinator. A nurse could expect a salary within the region of £38k (Royal College of Nursing, 2015-2016) whilst an experienced social worker could expect a salary of £34K per annum (BASW, 2015a). This dynamic was discussed during the interview undertaken with the senior manager who supported professionals within the MDT. He said:

The nurses have had difficulties in accepting their roles as care co-ordinators. They wanted to continue to self-manage. They were happy to give social workers all the heavy cases and for them to maintain their clinical nursing role. This was not acceptable. The grade (7) nurses were carried over from the NHS (through a union agreement). I was trying to fit in a role for community nursing within the new

service, but it's a dead end job. It stems from a shift to the social model of disability, and this service is led by social services and not health. (MDT, 1)

His final comments about this issue demonstrated that it was a continuous struggle to justify how this dynamic was supposed to help foster 'good will' between professional colleagues and commented:

It had been a continual thorn, for social workers in particular. (MDT, 1)

The social model of disability is the current dominant model that constructs our understanding of disability. Key to the model is the encouragement for society to be more inclusive (Gov.UK, 2015). This model has framed disability as oppression, and has proposed the identification and dismantling of the barriers that oppress disabled people. However, there has been considerable debate and critique about the social model of disability, for example, arguments have been made for the consideration of impairment alongside social barriers (Godley, 2011). Owens (2014) has argued that this model has demonstrated success for disabled people in society. For example, it has encouraged disabled people to challenge discrimination and marginalisation, and enabled them to claim their rightful place in society. The creation of the social model has been likened to a new social movement where disabled people can challenge their experiences of oppression through political activism. Finkelstein (2004) has argued that the social model of disability has had a profound influence on policy developments, and can be viewed as a mechanism for change through which able bodied citizens can adopt a positive approach towards people who have disabilities. Using the social model helps identify solutions to the barriers disabled people experience. The barriers include the environment and inaccessible buildings and services, people's attitudes, stereotyping,

discrimination and prejudice. In terms of organisations, this can also include inflexible policies, practices and procedures which can be problematic for disabled people.

Another important professional issue which emerged in the analysis of the findings was the continuous reference to team-building events. For example, joint management (MDT and AHT) meetings were held regularly, alongside separate team meetings within both the MDT and the AHT. The MDT had separate 'patch' team meetings between professionals. One participant said:

We have patch meetings every month. A wider team meeting each month and allied health are part of this as well. This allows us to address any issues which affect the teams. (MDT, 14)

Participants confirmed that the meetings were vehicles which helped to create a common sense of purpose. Team meetings in particular were used to allocate and discuss cases and provide an opportunity to share information – supporting the functioning of each team. Regular (joint) team meetings were also seen as a means to foster understanding about different professional roles, overcome professional differences and build trust and rapport between different groups. Team building events and their significance were also highlighted in the research briefing undertaken by Cameron et al., (2012) in terms of 'what works' within a multi-disciplinary environment. As a result of regular meetings and open communication channels, important and useful information was produced for the benefit of all who worked across the learning disabilities service and who supported people with learning disabilities. One such example was the co-production of a sexual health policy. A participant from the AHT highlighted how she had been a central point of contact in the development of this

policy. She reiterated how this issue was important to individuals who had learning disabilities, and, in particular, the need to ensure that important issues were acknowledged and discussed in appropriate forums. Guidance documentation enabled colleagues to tackle challenging issues such as personal relationships and sexual health needs with individuals who had learning disabilities, some of whom wanted to engage in personal relationships. She said:

I think that lots of people don't realise that having a policy and pathway is hugely important and being able to do what you're supposed to do is really important for people with learning disabilities. I strongly believe in the systematic ways of working, so that we can work towards positive outcomes. (AHT, 11)

These findings indicated that, during the developmental stages of the formation of the learning disabilities service during 2002-3, colleagues came together and made personal and professional commitments towards the creation of an integrated service. One participant commented:

There was an awful lot of activity and everybody knew exactly what that activity was leading towards – a great service for people with learning disabilities, it's been nine years now. (MDT, 12)

Another participant explained that 'away-days' were held separately for the management team (which included a cross section of professionals from both the MDT and the AHT). The purpose was to enable colleagues to have the opportunity to share individual perspectives and respond accordingly towards the policy directive Valuing People and come together through the mechanisms of a pooled budget. The management team was

aware that communication networks needed to improve through a centralised mechanism, to enable staff to access relevant information about service users and their families. One participant said:

What we don't get so easily is information from our provider colleagues. This can take time to filter through - but if it's critical we can find out information. We also keep notes and give others a flavour of what's going on and discussions around individuals. (AHT, 13)

Another participant further explained that he and his colleague managed the MDT in particular, and it was their remit to translate strategy into operational practice for the benefit of professional staff. In addition to this, they needed to explain service provision to local citizens who relied upon the service to enable their needs to be met. He explained that the service had developed processes within their business plan to address different aspects of important issues related to people with learning disabilities, and that Task Groups had been created to cover different topics of importance to people with learning disabilities. He said:

They all cover different topics: MDT and AHT members choose which group to attend, depending upon professional interests. The vast majority of team members are representative on the Task Groups and therefore fed into the business of the Partnership Board. Examples of the Task Groups included day services provision, managing challenging behaviours, the transition group and returning people from out of county placements. (MDT, 12)

An AHT participant also confirmed that she found the Task Groups very helpful. She chaired a Regional Forum, (learning disabilities) on behalf of the Speech and Language Therapy Society. Through attendance at a Task Group she could offer progress reports at the forum about the learning disabilities service as a whole. She said:

We put quite a lot of effort into following the person centred planning ethos. This means that we include the person with learning disabilities in their care. I don't think we are there yet, but we are aiming to work in this way with all adults who have learning disabilities. (AHT, 13)

5.2.2 Critical Commentary

As illustrated by the overarching theme, there were a number of issues which affected the research participants in this study. For example, the disparities between salary ranges were a cause for concern by the participants; the disparity of financial reward for similar role performance (e.g. that of care co-ordinator) challenged notions of equity across the teams. The senior manager discussed his disquiet about whether this situation could be rectified in the near future. However, the pro-active involvement of professionals within a number of multi-disciplinary meetings did foster the development of collaboration between different disciplines, which was underpinned by the social model of disability.

5.3 Thematic Network 1: Main Themes

- Role Clarity within the Team
- Supervision Experiences
- Social Work Values

5.3.1 Role Clarity within the Team (MDT) and (AHT)

The results implied that role clarity for individual participants within the MDT and the AHT had been established. Social workers and community nurses had a positive image within the service, linked to their overall responsibilities as care co-ordinators. Allied health participants commented on their good levels of knowledge about services and also the people they supported on a regular basis. One AHT participant made the following comments:

They are familiar with budgets and can talk to many different people. They work in co-operation between all parties. Social workers and community nurses are passionate about the service, and therefore will go the extra mile. They are the co-ordinators and create care packages. If I get a request to become involved with a service user, I usually undertake an assessment from a medical point of view. Once my report is completed, I share this with the care co-ordinator. (AHT, 17)

Community nurses based within the MDT were no longer expected to focus upon primary health issues, but undertake the same role as a social worker based in the MDT. This required a cultural shift by nursing colleagues, due to the fact that social workers and nurses had distinctive roles before the creation of the service during 2002-3. One issue of potential contention was that of professional identity, especially from a nursing perspective. The nurse participants had questioned their role and subsequent identity, working as a 'generic' care co-ordinator, rather than remaining a specialist health worker. One community nurse said:

What do I do, as the work can be social work focused as well? Equally for social

workers, health issues have become a challenge. (MDT, 15).

Referrals were allocated to either social workers and/or community nurses and both were expected to work alongside vulnerable adults regardless of the predominant need(s). Nursing colleagues discussed their perceptions about individual identities and how it changed over time during the existence of the learning disabilities service (2003-current). The perceived separateness between the two professions became less of an issue. Another community nurse said:

There was quite a bit of bitterness in the beginning. We asked why did nurses have to do this role. Nurses and social workers had their separate roles. We felt we were doing all the giving and not getting much back. We still did our nursing role and the care co-ordinator role as well. (MDT, 14)

In terms of the development workers, both had an alliance to the MDT (see Figure 2). They had also been encouraged to develop a different role and therefore a different sense of professional self and identity, although both were qualified and experienced social workers. As mentioned in chapter four, (see 4.3.1) both the development workers had specific remits and responsibilities towards service users and carers respectively. They were also supervised by a different manager to those participants based within the MDT. One development worker commented:

What it did was divorce me a little bit from the learning disabilities team. This wasn't necessarily a bad thing. I was perhaps too close to the team, I was going

into the day centres and delivering sessions (at the request of care co-ordinators), and my manager at the time said that I shouldn't be propping up services in this way. (MDT, 8)

The results associated with the AHT indicated that individual professionals had a very clear understanding about their respective contributions. The AHT held regular weekly meetings and their relationships were underpinned by trust and mutual respect. An AHT participant said:

Relationships have become quite solid and we understand each other personally and what our commitments are. (AHT, 10)

They discussed on-going issues about specific individuals (service users) and also developments across the learning disabilities service as a whole. Their approach was one of continuous development which translated into improved services for people with learning disabilities. Another AHT participant said:

We are looking at training PCT inspectors early next year (2012). This is about managing individuals with learning disabilities who 'challenge' services and those people who support them. We also attend the National Challenging Behaviour Group, held annually. We hope to influence practice through our work, and avoid any national scandals like Winterbourne View (2011) ² ever happening again. The national group gives us the opportunity to share a really good model of working practices. (AHT, 16)

The AHT adopted a flexible approach towards the best fit, in terms of areas of expertise

² Winterbourne View (2011) was a scandal which shocked and appalled the nation (DH, 2013). One of the key messages from the Winterbourne View review was that care of people with learning disabilities and challenging behaviour(s) is the responsibility of a whole range of organisations, agencies and professionals.

to match the needs of service users. However, the findings also revealed that some tensions did exist once the AHT members came into proximity with members of the MDT and also other management teams. This was aligned to the lack of understanding about all the roles undertaken by different staff employed across the learning disabilities service. As one AHT participant said:

The lack of communication and understanding of roles happens because we don't sit alongside all individuals and hear conversations. Relationships are hugely important. (AHT, 11)

5.3.2 Critical Commentary

There were disparities between members of the MDT and members of the AHT. For instance, the MDT comprised of both social workers and community nurses – an implied same status, although there were issues related to salary differences between them. AHT participants, however, had distinctive and individual roles linked to appropriate salary scales according to their profession. For example, participants worked as either a consultant clinical psychologist or as a consultant psychiatrist, and salaries were apportioned appropriately. There was no expectation that roles and responsibilities would interrelate within one generic role – like that of the care co-ordinator. Another main difference was the focus of the work across the learning disabilities service. Although both teams undertook individual work with service users, and sometimes their families, a primary remit of the AHT was that of development of innovative approaches and related service developments. This was in response to the growing demands for specialist service provision. During the interviews with both senior managers it was revealed that there were different expectations from both teams. One AHT senior manager said:

What I look for is a reasonable set of outcomes in a joined up service. The AHT has a different remit and expected outcomes to those of the MDT. Both services exist to provide a better service to local citizens who have learning disabilities. (AHT, 2)

5.3.3 Supervision Experiences

The findings revealed that participants had a mixed response towards supervision and the support they received from senior staff. One team manager (MDT, 12) shared the development of a supervision policy as it related to the MDT in particular. The opening statement said:

The aim in providing this policy is to equip both the supervisor and supervisee to get the most out of supervision, develop excellence and improve standards. Using this policy should help both parties to be prepared and be more effective and efficient within supervisions sessions. (Gandy, 2010, p. 1)

To illustrate the contents of the policy, Figure 12 displays the main aspects of supervision covered. Each section has a brief explanatory section, so that definitions were understood by all parties.

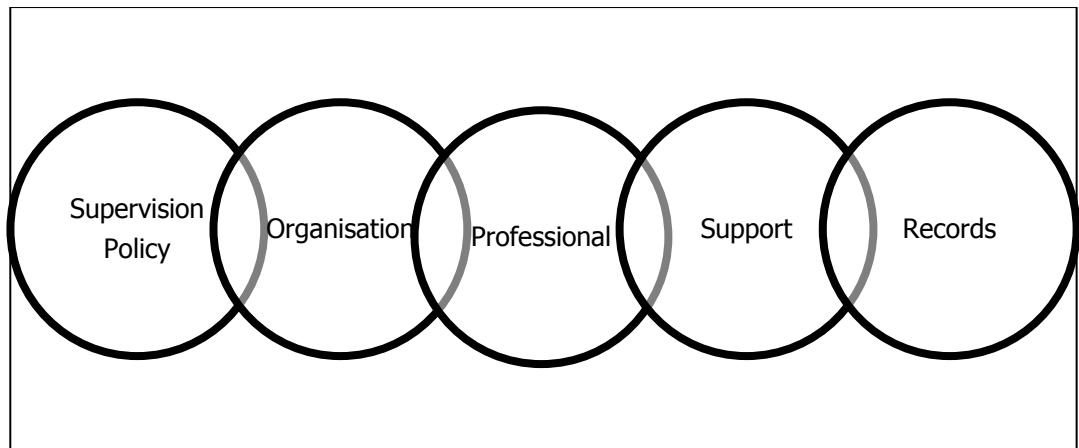


Figure 12: A Supervision Policy

Examples of the definitions include:

- **Supervision Policy** – to provide opportunity to meet with the line manager. There is a shared responsibility to make it work.
- **Organisation** – to understand where the service is heading and identifying individual contributions. This includes a quality service for service users.
- **Professional** – to examine individual roles, expectations, setting personal goals. A safe setting to facilitate reflective practice and performance.
- **Support** –to provide time to feel valued and be involved in decision-making and problem resolution. Professional guidance about individual cases can be discussed.
- **Records** – to keep a track of what was discussed and can be used for career development and or any difficulties encountered.

Whilst the policy contained the currently accepted attributes of good professional supervision, and therefore support to staff, this study revealed that staff experiences varied. Therefore, a variety of responses have been selected from participants located in either the MDT or the AHT. For example, a newly qualified social worker received support from the advanced practitioner based within the MDT. She discussed how she

felt comfortable about this arrangement, but it was about to change and she would soon receive supervision from the advanced practitioner and the team manager in alternate sessions. She discussed how this dynamic would influence her professional development and the direction her work would take, in terms of people offering different perspectives about how the work should be taken forward. Due to the fact that she was relatively new to the team, (one year) this would potentially have an effect upon how she carried out her role as a care co-ordinator. She said:

Different professionals have different views on how to undertake the work and which direction my cases should be going in. So it is interesting sharing different approaches. It can be unsettling though, as I am a newly qualified social worker.
(MDT, 7)

This participant reiterated the point that she enjoyed supervision as she had to plan and organise her work in preparation for it. She also confirmed that she felt reassured about her professional development (being on track) and how she tackled the work allocated to her.

A more experienced social worker shared her wisdom about being linked to one manager for over ten years, in terms of shared expectations and professional boundaries. She had recently changed her manager due to her new role as a care co-ordinator and she said:

It's not been as easy as I thought it would be, because I'd developed a long-standing relationship with my previous manager. (MDT, 6)

She was referring to expectations and how these differed between managers. Individual personalities also had a role to play in creating positive and reciprocal relationships. A community nurse (in the role of care co-ordinator) discussed her experiences of supervision. She explained that she undertook supervision each month and the content was caseload (task) focused. She confirmed that her manager was very supportive if there were any issues she was struggling with. Advice and guidance was readily available - it was a case of accessing it. She said:

It's good to discuss any issues in a protected space, where there is time to share experiences without rushing. (MDT, 14)

She further explained that, due to the fact she was a registered nurse, she was entitled to clinical supervision, (a clinical/therapeutic approach) but this was difficult to access within the learning disabilities service. She had to find it and organise this herself, which at times was less than satisfactory. One team manager explained that he did not provide clinical supervision for nurses. He also discussed his own anxieties about the fact he had not supervised or appraised a social worker before the creation of this service. He was concerned that his different professional background (learning disabilities nursing) would prove problematic. As time evolved he realised that his perspective towards people who have learning disabilities was also mirrored with those from social workers. For example, he and colleagues acknowledged the complexities involved in supporting someone who had learning disabilities. He said:

It was a pleasant surprise that we were in agreement about our perspectives and the needs of vulnerable service users. (MDT, 12)

An AHT participant discussed how she spent most of her time supervising a number of other staff based within the learning disabilities service and associated with the AHT. She was involved in supporting assistant psychologists and a nurse who specialised in managing individuals who exhibited behaviours which challenged services. She also had responsibility for training other staff who worked alongside complex individuals. She said:

It would take me longer to undertake the work myself, so it's worth the investment in other staff, and trainees, in particular. (AHT, 11)

Alternatively, a development worker explained that participation within supervision was really important to her. She made reference to the fact that her manager (integrated commissioning manager) took an interest in the newsletter she produced for the locality alongside people with learning disabilities. This participant thoroughly enjoyed her role and therefore looked forward to discussions within supervision sessions. She said:

Perhaps you can tell I love talking about my work, so engaging with others who work alongside people with learning disabilities is a real bonus for me. (MDT, 8)

The findings from this study were similar to those of a research study undertaken by Bogo (2011), whose (multi-disciplinary) research indicated that professionals based within mental health services no longer necessarily received supervision from someone of their own professional background. Mixed reactions were found. Some staff reported that supervisors would not discuss clinical issues or would focus solely on performance management, whereas other staff felt more positive. Overall, workers valued supervisors who attempted to understand the frameworks of their professions, although staff missed

the connection with their professional discipline and the ability to 'talk in their own language' – as also evidenced in this study.

The learning disabilities service had developed an 'in-house' supervision policy as discussed earlier and to some extent it implied that the learning disabilities service embraced the concept of a listening organisation. For example, there had been a commitment to produce a supervision pack and managers encouraged MDT members to comment upon its content before implementation as policy. As revealed the structure of supervision (see Figure 12) intended to cover important components of professional practice, organisational responsibilities and priorities. One team manager explained that the MDT aimed to create a robust policy with a priority to support staff. She said:

We need to support our staff as most of the discussions in supervision are focused upon complex case work, which care co-ordinators are expected to manage.
(MDT, 3).

5.3.4 Critical Commentary

As this data extract revealed, the managerial input was focused upon ensuring that complex work undertaken by members of the MDT was a priority, a factor supported by these findings, although it was also highlighted that team managers (as supervisors) took an interest in their teams' work, which staff appreciated. Research participants also revealed that they often relied upon their colleagues as a source of support. This factor applied to members of both teams. More to the point, the notion of trust was important as colleagues often turned to their immediate team members about on-going issues and demands of the job. This was often related to emotionally demanding experiences, working alongside vulnerable adults and their families.

According to Bogo (2013) social work supervision developed (from early years) in relation to an agency's mandate. Social work leaders recognised that a professional model of supervision entailed not only '*attending to management or administrative functions regarding the organisation, performance and oversight of work, but also to the professional development of staff*' (Bogo, 2013, p.152). The implication, therefore, in relation to this study, suggested that the approach outlined in Figure 12 does facilitate consideration towards both educational and supportive functions, and is more likely to achieve the agency's goals than a principally managerial supervision approach.

Learning from supervised practice is an essential component of the education and training of social workers and nurses (as in this study). Supervision is also an opportunity to seek and receive emotional support for undertaking what can often be a demanding and stressful role (Carpenter et al., 2012). Supervision is, according to Lord Laming, the '*cornerstone*' of good social work practice (Laming, 2009, p. 32). This was also reiterated by the Munro Review (Munro, 2011). This perspective is an important alternative to the managerialist approach which, according to Noble & Irwin (2009), is preoccupied with supervision geared toward efficiency, accountability and worker performance. Strolin-Goltzman (2007) emphasised that good supervision (and reflective practice) is associated with job satisfaction, commitment to the organisation and retention. Supervision appears to help reduce staff turnover and is significantly linked to employees' perceptions of the support they receive from the organisation. Good supervision is correlated with perceived worker effectiveness (Strolin-Goltzman, 2007).

5.3.5 Social Work Values

Social work values (and their importance) were discussed to varying degrees with all the participants. AHT participants made reference to their observations about how social workers approached individuals and families, when they were experiencing difficulties.

This was in relation to providing appropriate guidance to individuals and their carers about their rights to autonomy and, as far as possible, independence. For example, one allied health participant (AHT, 10) mentioned her reliance upon her social work colleagues to guide her in relation to the remit of the Mental Health Act 2007. She was referring to difficult scenarios and issues of guardianship appertaining to individuals who utilised the service. In addition, she observed how social workers had promoted individuals' rights when young people were involved in moving through the transitional stages between young people's and adults' service provision. She said:

When someone needs a care package and is being moved from one type of living to another, I am at a loss and have to rely on my social work colleagues, in terms of welfare benefits. I find social workers invaluable. (AHT, 10)

Another AHT participant discussed his clear value base, in terms of a social work approach to both his job and involvement with vulnerable adults. He said:

It's quite hard to switch off from the job because we are striving to get a better service for people. We believe that ordinary people should live in ordinary houses. (AHT, 16)

Similarly a MDT participant discussed how happy she was about her social work approach and underpinning value base when engaged with people and their lives. She made reference to the fact that it was a difficult job to get all the right services in place, due to a climate of austerity and funding cuts across the locality. She explained how socioeconomic factors impinged upon quality of life issues for the vulnerable people she supported. This manifested in people not having enough opportunities to enrich their

lives, such as not being able to develop more independent networks, gain employment and form meaningful friendships outside the core family circle. She said:

It's quite demoralising. I mean, I love the job but then it's harder to keep motivated, because the financial climate inhibits my professional practice. I try to get the right services for people, but it's not easy these days. (MDT, 7)

From a more managerial perspective, a social work team manager explained how she considered that social workers focused upon managing areas of conflict between individuals and their family members. It was explained that social workers used their knowledge and skills to assess the whole situation. This included family dynamics, financial issues, health issues and potential opportunities to improve someone's situation. She discussed how social workers demonstrated the need for sensitivity when probing into personal issues affecting individuals. She said:

Qualified social workers work much better with the kind of commissioning role that we have now. They are really good at talking to people and finding out what they need. They undertake an assessment and co-ordinate services. I know that the services will be based upon needs rather than planning to meet unrealistic wishes. We simply can't cater for everyone's needs and wishes anymore. (MDT, 3)

The importance of social work values are embedded within the Professional Capabilities Framework, which is an overarching professional standards framework developed originally by the Social Work Reform Board (BASW, 2015b). They are also enshrined within more recent publications known as the Knowledge and Skills statements for social workers in children's and adults' services (Romeo, 2015b). In addition, social work

values are regulated by the HCPC (2015) and were underpinned by ³TCSW (TCSW, 2015). The separate statements set out social work competencies to be achieved by newly qualified social workers at the end of their Assessed and Supported Year in Employment (ASYE). Each statement incorporates the experiences and perspectives of front line social workers, their managers, organisations and educators. The statements were developed by the two chief social workers: one is representing children (Isabelle Trowler) and one representing adults (Lyn Romeo). In the case of adults, Romeo (2015b) worked in partnership with key stakeholders, including TCSW, BASW, Skills for Care, Social Care Institute for Excellence, educators and principal social workers. The statement relates to all social workers working with adults who contribute to delivering statutory health and well-being outcomes for people and their carers. This is regardless of the sector in which they are employed, and provides a national benchmark for social workers, employers and the public. Romeo (2015a) made the following statement about adult social workers and their underpinning value base, when engaged with vulnerable adults:

They must understand the impact of poverty, inequality and diversity on social and economic opportunities and how these relate to people's health and well-being, as well as the functioning of their families particularly in connection with child protection, adult safeguarding and also empowering individuals who may lack mental capacity. (Romeo, 2015a, p.2)

³ TCSW opened to members during 2012 and closed to members on the 30 September 2015.

5.3.6 Critical Commentary

This quotation highlights what a difficult job the social workers had in trying to meet the needs of vulnerable adults. Therefore, social work values were paramount in strengthening their approach and delivery of services to some of the most vulnerable adults within the locality. All the social workers interviewed shared a commitment towards 'getting something better' for the people they supported. This was also reiterated by AHT participants who revealed their perceptions about social workers. Social work participants acknowledged the importance of their advocacy role in particular, given the negative effects that oppression had had upon some people with learning disabilities in their lives.

5.4 Thematic Network 1: Sub-Themes

- Continuous Professional Development (CPD)
- Professional Role & Status (position within the team)

5.4.1 Continuous Professional Development (CPD)

Continuous Professional Development (CPD), including Post Registration Training and Learning (PRTL) is the process by which professionals maintain and develop their knowledge and skills throughout their career (BASW, 2017). As such, all the participants were aware of the need to maintain their continued professional development (CPD) interests. This was also a requirement of the registration bodies linked to each of the professionals. Participants wanted to keep up to date with national and localised developments in relation to learning disabilities issues in particular. One AHT participant mentioned her links with other colleagues. She said:

I belong to the specialist group on Autism. It gives me a network of people who specialise in different aspects of learning disabilities. I know who to contact if I need their support. (AHT, 11)

A senior manager reflected upon his professional commitments and made the following comments:

I spend less time on this than I did two years ago. I suppose how I develop my areas of professional development has broadened into older people services and older people who have dementia, but my heart lies within learning disabilities services. I'm head of provider services at the moment. Over the past three years we have lost fourteen managers, as we have to make a great deal of savings. (MDT, 2)

An AHT participant related his professional development activities to the fact that the 'world' of learning disabilities, is rather a limited one. He discussed how he had known quite a few people for a number of years. He mentioned that being able to talk to other professionals enabled him to gain a more holistic view about working within the field of learning disabilities. In this instance he mentioned the valuable input from local head-teachers, and how they managed children and young people who had a variety of learning disabilities. He said:

I'm very lucky and I can access a number of different professionals, about service users I might be working with. (AHT, 16)

A community nurse mentioned the link between supervision and her CPD needs, in terms

of researching relevant courses which she might have attended. She was also concerned that most CPD available was social work related, so ensured she looked at more clinical and medical interventions when involved with service users who had a predominantly medical disability. For example, she was interested in surgical development in ⁴tracheostomy procedures. She also confirmed that she was no longer associated with a local PCT, due to being based within the learning disabilities service led by the agency and, as such, this factor inhibited her opportunities for CPD input.

She said:

It's difficult to get on health related courses now. The managers do promote CPD but I'm left to find it in the first place. (MDT, 15)

An AHT participant discussed how she had to maintain a CPD record of all her activities undertaken each year. She confirmed that the General Medical Council (GMC) needed evidential proof of engagement with CPD activities, so that re-validation of her professional status and registration as a medical practitioner would be maintained. She also mentioned that she contacted between thirty and fifty patients every three years to encourage them to offer feedback about the service she provided. All her patients had the option to reply anonymously to her request for feedback. She said:

Any of my patients are welcome to give me feedback about how they feel they have been treated, it adds more credibility to my job and the work I do on their behalf. (AHT, 10)

⁴ A tracheostomy is a surgical procedure to create an opening in the neck at the front of the windpipe (trachea). A tube is inserted into the opening and connected to an oxygen supply and ventilator to assist with breathing. Fluid that has built up in the throat and windpipe can also be removed through the opening. www.nhs.uk/tracheostomy

5.4.2 Professional Role & Status (position within the team)

All participants linked an identified professional role alongside an assumed 'status' whilst undertaking that role. One AHT member discussed how she did not mind which member of the MDT undertook the work on behalf of local families, as long as her concerns were acknowledged and dealt with by somebody. She further explained that:

My years of experience have taught me that if staff are not really motivated they are not going to get things done. (AHT, 13)

An alternative view from a team manager explained how she perceived that some professional colleagues had an acquired status which was linked to getting things done. She linked this to the nurses based within the MDT. She said:

Their outcomes really work. A big part of the job is about relationships and they need to work with everyone involved. Some people who hold professional qualifications think that it is enough, without putting much effort into relationships with other colleagues and families alike. Unfortunately, that's not how it really works in practice. (MDT, 3)

5.4.3 Critical Commentary

All participants had a commitment towards CPD activities. They demonstrated relevant understanding about their particular registration bodies' requirements, alongside the need to keep up to date with national developments related to the field of learning disabilities. Interestingly, the notion of status assigned to particular roles only evoked respect between professionals through a colleague's recognised ability to 'get things done' in a timely manner. This indicated that expectations from managers were focused

upon the 'business of the day'. They were supporting colleagues to manage complex health and social care situations, in order to meet the outcomes of service priorities and the needs of vulnerable adults requiring a service.

5.5 Thematic Network 2: Contextual Issues

The themes associated with this network are concerned with contextual issues. Figure 13 displays how a variety of issues synthesized together supported the developing arguments within this thesis.

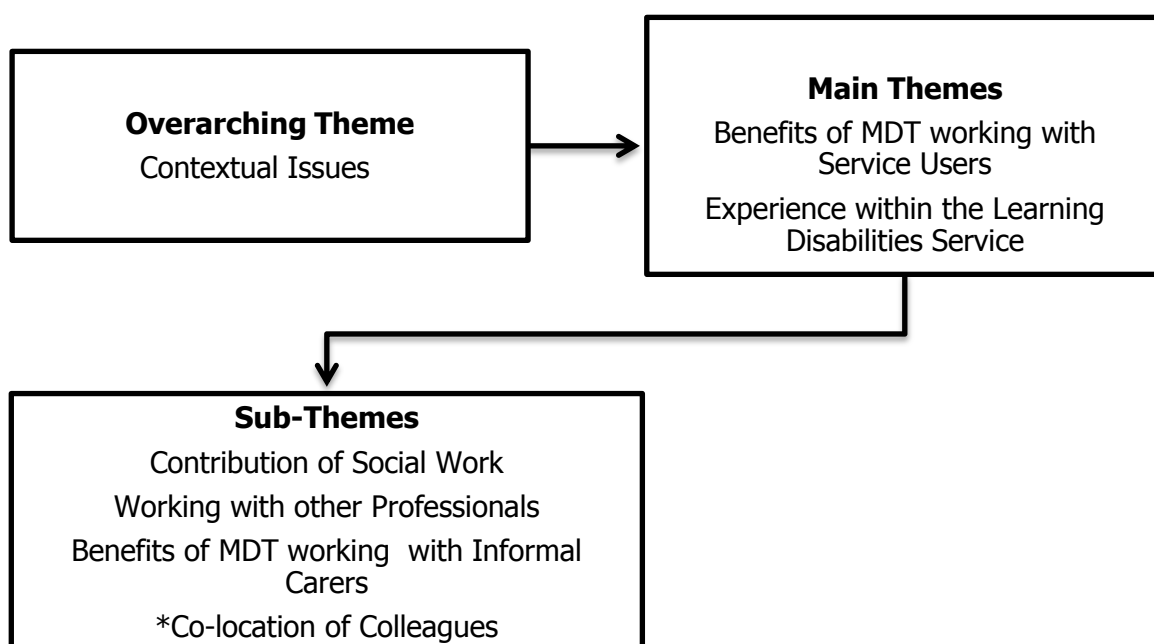


Figure 13: Thematic Network 2

5.5.1 Thematic Network 2: Overarching Theme

- Contextual Issues
- *Co-location of Colleagues

Although the issue of *co-location was nested within the sub-themes section (due to the outcomes of the prevalences), the relevance of this important contextual issue was

aligned within other main issues within this network. This was based upon the interviews and a model of co-location (within this setting) was a primary indicator, which facilitated a collaborative approach between professionals.

Participants discussed how collaborative practice was supported by close proximity of a number of professionals working across the learning disabilities service. As highlighted by the initial results in chapter four (see Figure 6) this indicated that a co-located context made the job of the care co-ordinator much easier. Two participants discussed their experiences of being co-located alongside AHT members. They said:

The good thing is that they are all there and we have access to each other' (MDT, 7). Multi-disciplinary team working works well and both the social workers and nurses work closely together. (MDT, 6)

Another important factor was the demographic location of the service. It was located within a local urban town, outside a main city. This facilitated easy access to services and transport to both the town and city for local citizens, some of whom received services from the MDT and AHT. The carer's development worker also appreciated being located alongside other colleagues. She explained that it meant that team members worked collaboratively with the aim of achieving the best outcomes for both service users and their carers. She also supported the notion that complex problems which could arise within a family context are best dealt with as quickly as possible. This was possible within the learning disabilities service due to the close proximity of colleagues, who would be familiar with a particular family's situation. She said:

It helps that I have been around for quite a long time. I've worked with all the team members and we can organise a meeting quite quickly. (MDT, 9)

In agreement with this view, was the development worker who supported service users based within the locality. She explained about having access to other colleagues quickly. She said:

I just think it's really beneficial in terms of getting things done quickly. It's also a more informal way in which to connect with other professionals whom I might not see on a regular basis. (MDT, 8)

Another important contextual issue was that of terminology used to identify potential service users, who were referred to the service. Some people had diagnosed learning disabilities, whilst others (who also required a service) did not. This was a persistent issue for all the participants in terms of clarity about eligibility criteria, and whether the service was appropriate for some individuals. All the participants had a clear understanding about the differences between such terms as 'learning disabilities' and 'learning difficulty'. However, the terminology which had been acquired by the service was that of 'learning difficulties'. A community nurse team manager explained the use of this terminology. He said:

Our commissioning team, who worked with the Valuing People Support Team some years ago, took a slightly different view. This was based on the groundswell of opinion in the population we serve, and disability was a word that the people didn't appreciate. So we adopted the term 'learning difficulties' in our business plan. (MDT, 12)

This terminology also evolved through the localised service user advocacy groups. They decided that the terminology around the concept of 'disability' was derogatory and most service users' did not want this label associated with themselves. Two participants explained their views about the use of terminology used across the service and also how it can affect their work with service users. They stated:

I do have a bit of a problem with the term 'learning difficulty'. I think it divorces people from the disability movement, which is a national organisation about civil rights and other important issues for people who recognise themselves as having a disability. (MDT, 8)

Having the term learning difficulty is quite problematic for our team because anybody could have a 'learning difficulty'. Most people can at some point in their lives have a difficulty. But people with learning disabilities are born with a disability (or acquire it) and it's always going to be with them. (MDT, 5)

Defining the term 'learning disabilities' is a complex and contentious issue. The current definition of 'learning disabilities' in England was written into Valuing People (policy document) in 2001. It states:

- a significantly reduced ability to understand new or complex information, to learn new skills
- a reduced ability to cope independently
- started before adulthood, and with a lasting effect on development (Valuing People, 2001 p. 14).

The British Institute of Learning Disabilities (BILD) states that:

Individuals who have the label of a learning disabilities/difficulty can and should be described in many other ways including, friend, neighbour, relative, colleague,

community member, partner, employee and parent. A label describes one aspect of a person, but does not capture the whole person. (BILD, 2015)

BILD also argued that many people with learning disabilities prefer to use the term 'learning difficulty', stating that '*the two terms are interchangeable when used in the context of health and social care for adults*' (BILD, 2015, p.1).

An AHT participant also commented about her role, in terms of the expectation from both families and other colleagues. She explained how she was involved in the diagnosis of someone who may or may not have had learning disabilities. She said:

I often get asked to diagnose learning disabilities and participate in conversations about whether someone has a disability or not. I have to say, and hold very firmly to it, that in order for me to make a clear diagnosis, a person has to have both a cognitive impairment and a significant level of social impairment. Both of these components would have been present during childhood. (AHT, 11)

A good example of the use of the term 'learning difficulty' rather than 'learning disabilities' is used by a number of self-advocacy groups who come together under the umbrella term People First (2015). People First is an organisation run by and for people with learning difficulties to raise awareness of, and campaign for, the rights of people with learning difficulties, and to support self-advocacy groups in the UK. One service user who was also a research participant in this study, made the following comments about receiving the news that she had learning disabilities. She said:

A social worker told me that I had learning disabilities, but it wasn't a conversation. I was just told I had problems. I went to my G.P. and he also told me that I had mild learning difficulties. I know I don't understand big words. It's upsetting to think that I'm different from other people. (C)

During the interview she discussed how two professionals used different terminology '*it was all a bit confusing at first*' (C). They both explained to her that she would need additional help, if she wanted to live an independent lifestyle. By this she meant living in her own flat with support in the local area.

5.5.2 Critical Commentary

The issue of attaching a label to someone who is deemed to be different, (in this case having learning disabilities) can have far reaching effects upon an individual. It can affect someone's self-esteem, self-worth and thereby potential engagement, with a number of worthwhile activities – such as getting a job. It is also worth noting that each condition or syndrome has different symptoms and behaviours associated with it, and the way in which these manifest themselves can and does depend on the individual.

It is clear that the presence of a definition (and its interpretation) can also be linked to the types of services offered to adults. However, co-location and collaborative practice between professionals can help to provide balanced perspectives about someone's needs. As in the example cited, the service user aspired to live an ordinary life – rather than a more restricted supported living arrangement. In this case, both professionals (GP and social worker) used different terminology when attempting to explain about the support needed. This obviously had an influence upon the type of assessment

undertaken, and its outcome and services provided, given the fact that both professionals had associated the presence of a learning disabilities with 'problems'.

5.6 Thematic Network 2: Main Themes

- Benefits of MDT working with Service Users
- Experience within the Learning Disabilities Service

5.6.1 Benefits of MDT working with Service Users (citizens)

The findings highlighted that participants based within the learning disabilities service had a very positive person centred approach towards local people who had learning disabilities. This was enhanced (as mentioned) by the co-location of two complementary teams (MDT/AHT) and how they worked collaboratively on behalf of vulnerable adults in particular. As also mentioned, members of the MDT were expected to work alongside individuals who had a range of complex health needs and associated learning disabilities. Additionally, the research participants confirmed that they endeavoured to ensure that needs were addressed in appropriate ways. A team manager explained how someone with learning disabilities could be supported by both the MDT and the AHT. He said:

Some situations require a very comprehensive and finely tuned multi-professional response, in order to meet the levels of needs presented. (MDT, 12)

Another participant explained how she co-ordinated small workshops alongside individuals with learning disabilities. The purpose of the workshops was to create a dialogue between people who used services (service users) and those who commissioned them (health and social care services). Notably, during the timescale of this research study (2008-2017), the same research participant was fully engaged with

the local Partnership Board across the locality. She explained how team colleagues linked into the Partnership Board, via individual membership of specific Task Groups. She said:

The Task group members are also based in*social services and link into the Partnership Board (see Figure 14). For example, some colleagues are members of the Day Services Task Group and some colleagues are members of the Young People in Transition Group. The White Paper (Valuing People) is specifically referred to in the Partnership Board meetings. (MDT, 8)

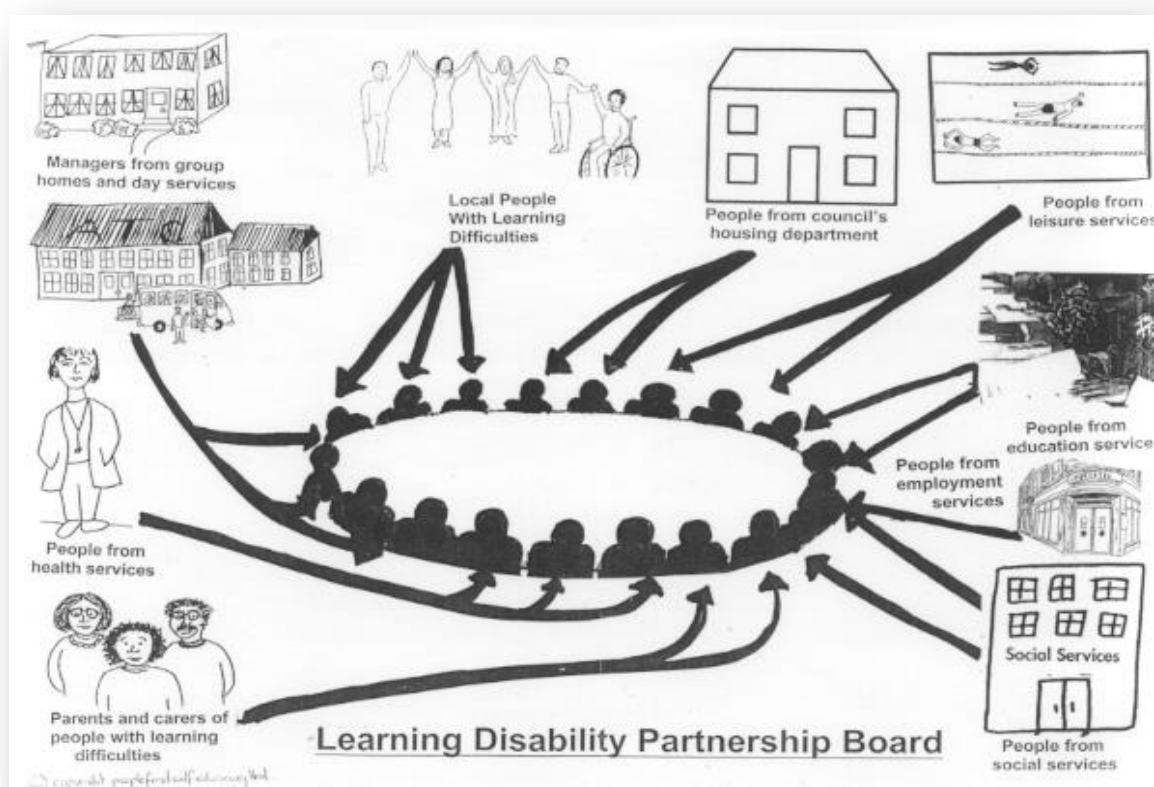


Figure 14: Diagram of a Partnership Board

Source: Agency Quarterly Newsletter, 2011

Members included:

- Local People with *learning difficulties (*agency terminology)
- People from council's housing department

- People from leisure services
- People from education services
- People from employment services
- People from ***social services (MDT/AHT members)**
- Parents and informal carers of people with *learning difficulties
- People from health services
- Managers from group homes and day services

5.6.2 Learning Disabilities Partnership Boards (LDPBs) & Health and Wellbeing Boards

Learning Disabilities Partnership Boards (LDPBs) were established during 2001 and their main purpose was to agree plans associated with the Health Act 2001 flexibilities. The LDPBs were responsible for services which related to adults with learning disabilities and their carers, but had no statutory powers. The main focus was to oversee the inter-agency planning and commissioning of integrated services. The emphasis was to enable people with learning disabilities and their carers to make a real contribution to the LDPBs work (Valuing People, 2001 p.p.107-108). However, since 2012 LDPBs have been replaced with Health and Wellbeing Boards linked to the reforms introduced by the HSCA, 2012. The Boards are intended to bring together bodies from the NHS, public health and local government. The aim is to plan jointly how best to meet local health and social care needs, and to commission services. The Boards are statutory committees of local authorities. In addition to this, they intend to be a voice for local people and communities in every local area, by involving people and community organisations in deciding what services the community needs (The King's Fund, 2015). Other examples from the findings about the benefits of MDT working included the following comments from a selection of participants:

One thing I really enjoy is contact with people with disabilities. I've just done a session with a group of seven service users. We needed to convert a policy document about day services into an easy read document. It's one of the hardest things to do. People who we support need to understand the policy and be encouraged to ask questions about it. This is really important, especially if some people are not getting the services they need. (AHT, 16)

Social work and MDT working is about working with people who have learning disabilities. You need to understand discrimination and understand the social conditions in which people find themselves and the reasons for that. (MDT, 4)

AHT participants also contributed towards the positive effects of MDT working:

Social workers are seen more like 'friends' because they are the ones giving all the news and telling people about services and who will be helping them. But it's also the social workers who tell them that services may be cut and that there isn't much money. (AHT, 10)

5.6.3 Critical Commentary

Although these were notable examples of how the benefits translated into good practice, it was important to recognise that the 'idealised' services which all the participants aspired to were illusive. This was due to the realities of attempting to provide good services (to meet assessed needs) within a climate of financial austerity. An example of this was the supported employment service, and although a number of service users were eligible for it, the long waiting lists (at the time) created delays. It was observed

during the data generation phase that this factor created a sense of low morale to some extent. One participant made the following comments:

The fear is that we don't have the services or the skills to offer people with learning difficulties in the future. (AHT, 16)

5.6.4 Experience within the Learning Disabilities Service

All the participants had spent a number of years working within the learning disabilities service. The average length of experience within the service was eight-ten years. One participant discussed how she had had experience of working within adult services, but found the work to be short-term. This work included undertaking an assessment of needs, the creation of a care and support plan (with commissioned services) and, once in place, a review of the services after six weeks. If service users and their families were happy with arrangements, the social worker moved onto other referral work. She commented:

The other newly qualified social workers I know just do short-term work. This job is different to that. I do a lot more long-term work, which is what I like. (MDT, 7)

She further explained that long-term work with adults who have learning disabilities meant that often complex issues had to be worked through, in terms of trying to find the right services and also working collaboratively with family members. Another participant discussed her career history during her interview, and shared her experiences of re-settlement work, working alongside people who had complex mental health needs, in particular. She confirmed she also enjoyed working with carers in her current role. She explained that she had a case load (a number of people she was responsible for) which

was comprised of complex family situations. It often involved carers (of adults) being in conflict with their caring role and also issues relating to the provision of (or lack of) services, to ease the burden of daily caring responsibilities. She said:

If the needs of a carer become dominant in a family scenario, the referral will then come to me to try and help the situation. I would work through a process of negotiation. This is likely to involve getting more help or respite for the carer. They are often isolated in their role as a carer. (MDT, 9)

Another participant discussed how his experience within the service had enabled people to move back into the locality, with support arrangements in place. He discussed how the service had a policy to place all citizens 'of origin' within the same locality, so that individuals could maintain their local roots to family members, if they chose to do so. He said:

The service does everything that the ⁵Mansell Report, Raising our Sights (2010) recommended a service should do. (AHT, 16)

This also linked in with other colleagues based within the MDT in terms of social workers and community nurses attempting to work more pro-actively with young people and families moving through transitional services, i.e. from children's services provision and support to adults' services. One team manager commented:

⁵ Professor Mansell's report (Raising our Sights) aimed to support commissioners in developing local services for people whose behaviours presented a significant challenge. The report was part of the Valuing People delivery plan, and highlighted the most important parts of planning and delivering support for people with the most complex needs.

We have done a lot of work with children's services so that transition gets better for people. I have worked with families for a number of years and realise this can be a stressful period for everyone concerned. MDT, 12)

A participant from the AHT also commented about her experiences of working within a multi-disciplinary environment. She explained that although in theory it was a good way forward to hear collective views about individuals and their situations, this context also had the potential to create conflict between professionals. She explained further that miscommunications were not uncommon between professional colleagues. She said:

Because there is more than one person working with an individual, we all bring our own views to the table. This in the main is very helpful. However, sometimes not everyone goes away happy from a meeting. This is because some interventions do not suit everyone's style of practice. (AHT, 11)

5.6.5 Critical Commentary

The participants in this study brought a great variety of experiences with them during their careers. They all shared their experiences willingly with each other, especially when dealing with complex scenarios such as a young person moving through transition from children's to adults' services. They offered different perspectives and approaches to help tackle some of the issues raised on an on-going basis. Although it was noted that not everyone agreed about a particular perspective or approach offered. Therefore, compromises had to be harmonised in order to move forward with particular plans associated with specific individuals.

5.7 Thematic Network 2: Sub-Themes

- Contribution of Social Work
- Working with other Professionals
- Benefits of MDT working with Carers

5.7.1 Contribution of Social Work

In terms of the contribution of social work, there was a general consensus from all the participants that social workers were an asset to the service overall. For example, one participant explained how his perceptions about nursing colleagues who worked alongside social workers had learnt something from them. By this he meant, that social workers had the ability to see the person within a holistic context, which included their complex home scenarios. They didn't just concentrate upon one aspect of someone's well-being. He said:

They seem to have an almost unique connection with individuals. They are able to see not just the person, but the whole situation around them. They always make a connection between a person's needs and those of their carers. They look into their social situation as well, such as finances and how they live their lives in their local neighbourhoods. (MDT, 12)

A social work participant who was an advanced practitioner explained how her intervention with one particular service user had prevented him from being placed within a secure unit outside the locality. Instead, localised services were provided to meet his needs, which at times challenged service provision. She said:

I was able to see things from his point of view and I was just there for him. It's really nice when someone knows you are trying to help them. You kind of hope you're doing it right but you don't always know, given some of the risks involved at times. (MDT, 4)

A community nurse participant also discussed how she had observed that social workers were appreciated by other colleagues and also to a greater extent, local families who needed support and provision of services. In terms of professional responsibilities, she commented about their ability to manage cases, she said:

All the social workers recognise they have full responsibility for the individuals they work with, and they take on board the care co-ordination work that goes alongside this. (MDT, 15)

An AHT participant explained how her involvement with social workers was focused upon complex case scenarios and family situations. Those cases usually involved a potential family breakdown and a service user being placed elsewhere, outside the family home. She said:

I've worked with many social workers over the years. I've supported them at mental health tribunals and also at best interest meetings. (AHT, 11)

She further discussed the importance of the role, in terms of knowledge about legal requirements and also an ability to explain complex decision making and outcomes to local families involved. She commented:

The contribution of social workers is essential. They are a major part of the whole process of care co-ordination and support to individuals. I can't imagine social workers not being there. (AHT, 11)

5.7.2 Working with other Professionals

All the participants shared a variety of views about working alongside each other for the purposes of adults who required a service. One participant explained how she felt that there were certain expectations about professional colleagues and the roles they held within the service. She aligned this view to the psychology service in particular. She explained that if she attempted to deal with someone's complex behaviours she would have preferred to have had the support from the psychology service about addressing and managing people who challenge services. However, sometimes this support was not forthcoming, due to competing demands from the psychology service. Another participant discussed how she worked in collaboration with children's services, especially during the times of transition for young people moving from children's services across to adults. She said:

I've done quite a lot of work with children's services. The social workers in that team are not a problem. (MDT, 14)

She further explained that the social workers from children's services were grateful for the input from a specialist learning disabilities service. Another participant discussed how she had acquired 'a reputation' in terms of getting the services which were needed for someone. She expressed her positive reaction to this, by explaining that just because she was a newly qualified social worker it didn't mean she was non-assertive in her approach towards either service users', families or more senior colleagues. She said:

Someone the other day said I had a bit of a reputation about getting what I want, I don't mind. I'm really committed to what I do. (MDT, 7)

An AHT participant explained how the dynamics within a multi-disciplinary context between professional colleagues were challenging at times. She discussed how referral meetings could become somewhat tense between colleagues. She said:

Referrals (about individuals who have learning disabilities) might get passed around until we decide who the best person is to take it on. There are times when we disagree, and we have to work towards an outcome so that the service user gets the best service from the right person. (AHT, 10)

5.7.3 Benefits of MDT working with Informal Carers (citizens)

One of the most important components of this service and the benefits of MDT working was the presence of a development worker whose specific remit was to work alongside informal carers of adults who had learning disabilities. The service invested in this role, as it believed that a complementary professional working in this capacity would enable members of the MDT to work more effectively with families who required a service. The carer development worker was an experienced social worker and an established associate member of the MDT. She worked closely with both other professional colleagues and also families 'in need'. She commented about the fact that most carers linked to the learning disabilities service did not come forward for help very often. She said:

What's amazing is that most carers don't actually speak to anyone about their frustrations in the caring role. Sometimes I am the first person they have spoken to, in a long time. (MDT, 9)

She further explained that her 'listening ear' was appreciated by most carers, in terms of knowing they had someone who was able to offer support and also services if they needed them. Another interesting dynamic to this post was the fact that time pressures to work with a great variety of carers, was not a predominant issue. She highlighted how there were no tight deadlines to adhere to, but agreement was reached during professional supervision about the approach taken towards specific families. She said:

Although my post is funded from the ⁶Carers Strategy and the long-term view is not clear, I feel I deliver a much needed service. (MDT, 9)

Another MDT participant also discussed the importance of having the development worker placed in the MDT. She explained how the role was separate from that of a care co-ordinator and the focus was upon the carer's needs. She said:

I don't have to think about the carer, as I know their needs will be covered in detail by my colleague. (MDT, 15)

Important points were made about the measure of honesty which was presented to local families, by the development worker: an observation witnessed during the interviews

⁶ The National Carers Strategy (England) was published in 2008/refreshed by the Coalition government: <https://www.gov.uk/government/publications/carers-strategy-actions-for-2014-to-2016>.

with carers. She explained to the carer being interviewed that it was important to be clear about the limited resources available and said:

Local carers are usually flexible and understanding about restricted agency resources. (MDT, 9)

5.7.4 Critical Commentary

The findings highlighted the importance of social work, in terms of its contribution within this context. Allied health participants shared their experiences and confirmed how social workers had the ability to 'connect' with people and their circumstances. There were clear benefits associated with different professionals being able to offer specialist input to meet differing needs of adults with learning disabilities. At times the availability and co-ordination of specialist services was difficult to arrange and caused frustrations for care co-ordinators in particular. Participants also recognised that differences of opinion, or an approach to a particular situation, had to be addressed and agreed in terms of offering the 'best fit' and appropriate response towards individuals. Carers were also significant as they maintained their support towards their children and (adult) children who were often coping in difficult circumstances.

5.8 Thematic Network 3: Organisational Issues

This network begins with the overarching theme about organisational issues which denoted the impact of successive governments' intentions in England. This has included the concurrent legislation and its effects upon the learning disabilities service located within the agency. The findings revealed that there were two dominant professional forums. These consisted of dementia and adults who had Down's syndrome and young

people in transition from children's services to adults' – as such they have been discussed in the sub-theme section.

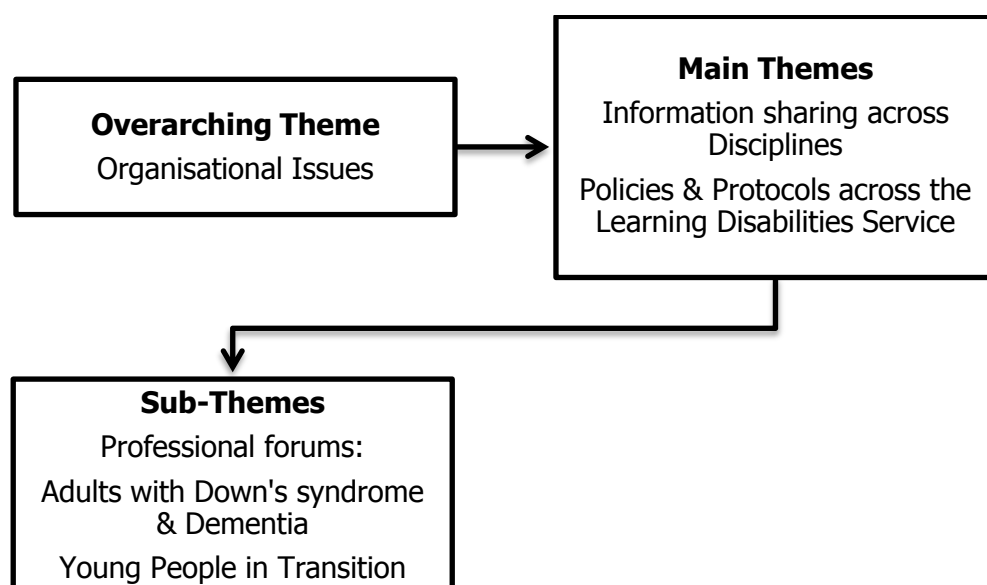


Figure 15: Thematic Network 3

5.8.1 Thematic Network 3: Overarching Theme

- Organisational Issues

As the value of collaborative partnerships became 'the norm' so government policy has increasingly demonstrated a commitment to promoting and supporting joint working. It is a theme which has become embedded in core documents (Littlechild & Smith, 2013). The White Paper Our Healthier Nation (DH, 1998b) was a good example of how government rhetoric intended to pursue the notion of 'partnership working' on a national scale. The New Labour government's intentions were further embedded by the Health Act 1999, which attempted to remove some of the obstacles that were perceived to hinder joint working. This included allowing statutory agencies such as the NHS and local authorities to pool budgets and jointly commission services. Littlechild & Smith (2013) assert that:

It was this legislation Health Act 1999 which paved the way for joint service delivery arrangements, bringing practitioners from different disciplines under common management and organisational frameworks, using vehicles such as Care Trusts. (Littlechild & Smith, 2013, p. 32)

The primary legislation which confirmed the 'pooling of budgets' was the NHS Act 2006 (DH, 2006) and, in particular, section 75 (2a) of the Act which states:

The establishment and maintenance of a fund which is made up of contributions by one or more NHS bodies and one or more local authorities; and out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS bodies and prescribed Health related functions of the authority or authorities. (DH, 2006)

The Labour government then set out an agenda calling for greater structural integration of local authorities and primary care services, which included the establishment of care trusts. Most of these new trusts were specialist mental health, physical or learning disabilities partnerships and involved the organisational integration of health and social care services (Curry & Ham, 2010). The Coalition government (2010-2015) continued this policy. The 2010 White Paper Equity and Excellence: liberating the NHS, set out the government's aim to:

Strengthen democratic legitimacy at local level, and local authorities will promote the joining up of local NHS services, social care and health improvement. (DH, 2010a, p. 4)

This facilitated the notion that both commissioners (local authorities) and providers of services, the NHS could adopt partnership arrangements, and adapt them to local circumstances. An additional publication: A Vision for Adult Social Care (DH, 2010d) further emphasised the Coalition government's intention to identify and remove barriers preventing the pooling of budgets between health and social care, while encouraging small social enterprises and user-led organisations in the provision of care (Cameron et al., 2012). The Care Act 2014 has made it a statutory requirement that local authorities collaborated and cooperated with other public authorities, including the duty to promote integration with NHS and other services.

Two participants (senior managers) discussed the importance of this raft of legislation over the past twelve years and its impact upon the organisational style of the service. They confirmed that the legislation, combined with the effects of the social model of disability, had been influential in the strategic direction and creation of the learning disabilities service. This had inevitably affected the way in which teams were configured to meet national requirements, service priorities and local expectations of citizens who needed a coordinated service. One participant discussed at length the impact of a pooled budget upon the learning disabilities service. He said:

One of the key things around the pooled budget is this - once the money is in the pool it's not health money or social care money. I think we are one of the few areas even nationally, who have stuck to that. We don't get hind bound by discussions around health or social care needs – it's just a need. This is underpinned by a very strong value base about people accessing ordinary services.
(MDT, 1)

This senior manager explained that before he was appointed in 2001 as the head of the learning disabilities service, two other senior managers were previously in posts. One located within a health trust and the other within social care. This senior manager had been appointed to ensure that the perceived separateness between the two agencies was reduced. The focus was to ensure that effective services could be created across the locality, supported by professionals from different disciplines. He endorsed this by saying:

I brought about co-location of staff and then true integration could evolve, for the benefit of local people. (MDT, 1)

He further explained that the approach towards local people who had learning disabilities was that they should, as far as possible, be able to access mainstream services instead of thinking that a separate and specialist service needed to be created on behalf of disabled adults. This had been endorsed by the Valuing People agenda originated by the New Labour government in 2001. He explained that it had taken the past ten years or so to get professionals from different disciplines to work collaboratively together within the learning disabilities service. He said:

It felt as if we needed to let both social workers and community nurses decide how they best wanted to work with people, each professional bringing different knowledge and skills. (MDT, 1)

There was also a dialogue about how the team manager role had brought dividends to professional colleagues and assisted in meeting the demands of local people. He explained that the team managers' roles were focused upon operational delivery of services via strategic agency intentions. This was inclusive of priority areas which needed the co-operation and goodwill of professionals from a variety of disciplines. By way of example (see Figure 16) he gave an overview about service priorities and some

of the statistics prevalent at the time, in relation to the demands and local needs. Figure 16 displays the volume and range of individuals' needs across the learning disabilities service during the time of this interview (10.12.2011). It was acknowledged however, that current prevalences (2017) would yield different outcomes, due to the growing demands for services since 2011.

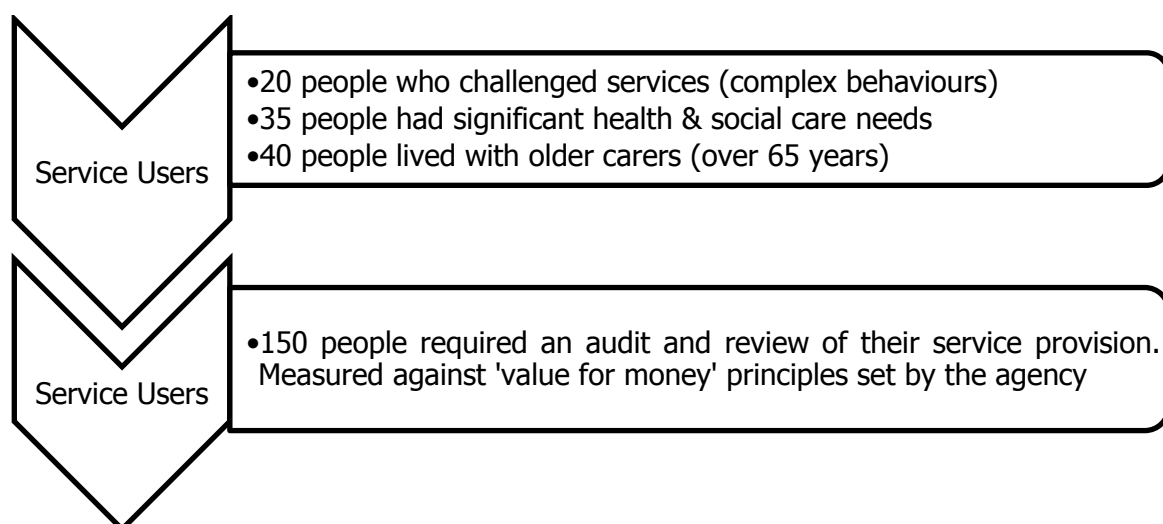


Figure 16: Diversity of Needs (2011)

Another senior manager said:

Although all of us value the importance of maintaining a multi-disciplinary ethos, it can also be a time consuming process to focus on all the work in hand. (AHT, 2)

5.8.2 Critical Commentary

Interestingly, this factor was the first time a senior manager had mentioned how bringing together staff from different disciplines was considered a long and arduous job, in terms of ensuring that staff had the motivational will to work collaboratively with each other. He discussed how the management team had created forums which enabled staff to come together and share news about service developments. This included legal and

financial updates across the learning disabilities service in particular, although information sharing was established within the broader context of the agency. Ensuring staff felt supported in their professional role was seen to be an important part of effective multi-disciplinary working. Accordingly, all staff were encouraged to discuss effective ways in which to work with vulnerable young people and adults within a climate of austerity. Attention was drawn towards spending allocations and related decisions about priority areas.

It was also apparent from the interviews held with senior managers that they had been part of the same service for the past ten years. This factor had inevitably helped to embed the learning disabilities service, underpinned by good working relationships which had evolved over time. The complexity of joint ventures often meant that key individuals such as senior managers, played an important role in linking organisations and cultures acting as 'trusted allies' (Cameron, et al., 2012). There was a recurring theme that members of the senior management team had developed trustworthy relationships. This, in effect, helped to maintain stability between themselves, and thereby support staff teams (MDT/AHT), especially in times of financial restrictions and the drive to deliver cost effective services.

5.9 Thematic Network 3: Main Themes

- Information sharing across Disciplines
- Policies & Protocols across the Learning Disabilities Service

5.9.1 Information sharing across Disciplines

Each person's information is their own. This should not be shared unless this is in their best interest. The guidelines about how we store information needs to be maintained permanently. (AHT, 12)

This data extract indicated how the service adopted a positive approach towards information sharing (within limitations) and in the best interests of the service users, in particular. A key issue for multi-disciplinary working is that assumptions can be made about how information is shared and utilised across professional boundaries. This factor was also prevalent in this study. For example, Richardson & Asthana (2006) asserted that inter-professional differences could be based upon the initial approach to information sharing and also the ways in which professions interrelate:

Relevant legislation also requires agencies to take steps to safeguard personal information, for instance the Data Protection Act 1998, the Freedom of Information Act 2000 and the Human Rights Act 1998 and the common law duty of confidentiality. (Richardson & Asthana, 2006, p. 659)

Participants had confirmed that there had been a concerted effort to create computerised systems which would enable professionals to access important information about individual service users and contributions from other professionals. But the issue of sharing information was far from easy within the service. For example, a senior manager discussed concerns during his interview and said:

The actual way of how we share information is a bit of an issue. We have different computer systems from health. It's still not resolved. (MDT, 1)

Clearly the adequacy of training and support provided to professionals on this issue will play a part, as well as the context and process of information sharing between professionals. Rawson (1994) also argued that there are factors which account for differences in professional cultures related to information sharing. He asserted that the

entry into a profession is by personal choice. This is also influenced by the values and philosophy upon which a profession is grounded. In this way, the sum total of personal career decisions both reflect and reinforce professional cultures. In addition to this, given the fact there have been a number of national serious case reviews following cases of serious abuse of vulnerable adults, the keeping and sharing of service user information has come to the fore (Richardson & Asthana, 2006). One such example is the outcomes from the case review about Purbeck Care during 2014 (Corkhill, 2014). Purbeck Care was a registered care home for up to fifty two individuals with learning disabilities whose needs were complex and challenging. It was located in a rural area in Dorset. One of the key learning points published was that a Quality Monitoring Group had been established which aimed at sharing key information about individuals. Evidence from the audit confirmed that many organisations (and professionals) had 'low level' concerns about the standards of care. The audit also confirmed that if all the information could have been more systematically collated this may have led to more assertive investigations and interventions at an earlier stage (Corkhill, 2014).

In this study, for example, an AHT participant explained that 'clinical' information about individuals was kept separately from the generic computerised information system adopted by the learning disabilities service. She also discussed how the content of therapy sessions was not shared with care co-ordinators based in the MDT, although a summary progress report was supplied when requested by a care co-ordinator. She said:

There must be a linked social worker or community nurse in order to release this type of information. Confidentiality is a major issue within the psychology profession. (AHT, 11)

During the data generation phase, it became clear that participants had adhered to their own professional code of ethics in relation to information sharing across professional boundaries, although procedures about sharing information had been put in place. One AHT participant confirmed that the position of the GMC was that confidentiality can be breached only in exceptional circumstances, i.e. to prevent serious harm or if there is a clear indication that failure to disclose would be more detrimental to the 'patient' than not disclosing. She further discussed how she had access to different computer systems for recording confidential case notes. She explained that it was difficult to potentially break the trust of someone she had known and said:

Its' not an easy thing to do, sharing personal information about a service user I have known. (AHT, 10)

A senior manager commented about the difficulties in trying to obtain relevant information about individuals. He said:

The difficulty comes at times with some agencies not wanting to share information and I have to say it is rooted in the medical profession. (AHT, 2)

This was particularly important in terms of the organisation of inter-professional assessment processes, and the need to share important information about individuals, and, at times their family members. Other problems faced by care co-ordinators (social workers and community nurses), was when family members requested information about their relatives. One care co-ordinator explained that she had a particularly difficult scenario, in terms of the parents of a daughter (service user) wanting access to their daughter's records. This was due to the fact that the residential home where she was a

resident had decided they could no longer support their daughter and requested removal to another establishment. The family, however, preferred that she remained in the current accommodation. The care co-ordinator discussed how she informed them about following the criteria adhered to by the agency. A good example of collaborative information sharing across professional boundaries was discussed by one MDT participant who requested information from the local GP. She confirmed that she was rather surprised at the amount of information shared. She said:

I have been surprised about the response from this GP in particular. If you write to him he normally responds to you. You need to explain why you need the information and in what context. (MDT, 14)

A member of the AHT explained how her work involved bodily contact and taking pictures of particular conditions, so that a treatment plan could be created to offer relief from chronic pain. She confirmed that all pictures were kept confidential, held within health files and only shared with her manager. As a general rule information of this nature was only shared on a need to know basis. She would however, produce a report for the care co-ordinators, should a request be made for detailed information about an individual's physical health needs. (AHT, 17)

5.9.2 Critical Commentary

As Wilson et al., (2008) purport, the most critical element in the development of effective information systems for multi-disciplinary teams is a leadership process. This process can take staff through the changes and ensure support for both the aims of the new working arrangements and for the processes to become a reality. Boydell et al., (2004) further asserted that leadership is concerned with future direction in uncertain

conditions. This includes conditions such as, complexity, unpredictability and rapid change, all factors present during the creation and development of the learning disabilities service during the early years (2002-3). As mentioned, the senior managers in this study had already introduced the required changes, with the support of the team managers. The senior managers did concede to the fact that all was not convivial across professional boundaries – especially engaging medical colleagues. It remained a difficult ‘nut to crack’ in terms of agreements about sharing important information from different computerised systems for the benefit of vulnerable service users in particular.

5.9.3 Policies and Protocols across the Learning Disabilities Service

One of the most important aspects of delivering a multi-disciplinary service is to ensure that agencies and related teams engage with new initiatives. This includes the understanding of the aims and objectives, as well as the detail of the eligibility criteria, and referral processes involved. One way to develop a common understanding is to involve staff in the development of policies, procedures and protocols underpinning the service (Asthana & Halliday, 2003). However, it is equally important that there is a similar understanding of roles and responsibilities at the strategic level. Drennan (2005) highlighted the importance of having clearly specified reference terms and membership criteria for management groups as well as an explicit operational plan for professionals based within multi-disciplinary teams.

The learning disabilities service within this study revealed that there was a previous history of strong and supportive local partnerships, which was identified by all the participants as a forerunner and indication that to embark upon a joined-up service would result in successful outcomes – especially for local people. For example, during the time frame of the study (2008-16) the service had launched a localised Vulnerable

Adults Protocol. One participant said that:

It's quite a simple protocol, but it speaks about our support agencies and how we can work better, in a more collaborative way. (MDT, 4)

Safeguarding issues were paramount in terms of staff being aware of the policies and protocols in place in relation to vulnerable adults. One AHT participant mentioned the thorny issue of 'client-to-client' abuse. He discussed how the service had developed policies about this issue, and guidance as to how to work through difficult scenarios such as these. He further explained that this type of abuse usually occurred when service users were placed together in either a supported living environment or a residential care situation. As Lawrence & Brook (2015) advocate:

Residential care homes available to people with intellectual disabilities often have real difficulties in enabling people who live in them to exert any real control over their home. (Lawrence & Brook, 2015, p. 36)

Having limited control in communal living arrangements may evoke strong emotions in individuals and at times behaviours can tip over into aggressive outbursts between service users (clients) sharing the same living space. He confirmed that having a policy to adhere to enabled him and colleagues to challenge providers of supported living services. He referred to this as 'calling them to account' should incidents such as this happen between vulnerable adults. Adult safeguarding is also spelt out in the Care Act 2014 for the first time. It sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk from abuse or neglect. One such example is the establishment of Safeguarding Adults Boards which includes the local

authority, NHS and police, which will develop, share and implement a joint safeguarding policy. In addition to this, the Act requires that an independent advocate should be arranged to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

Alternatively, a participant (MDT, 14) discussed how national policy initiatives (Valuing People, 2001; Valuing People Now, 2009) are open to localised interpretation. She mentioned that a health facilitator was based in the MDT team and acted as the liaison link person between the learning disabilities service and local hospitals. The premise of this initiative was based upon effective co-ordination between services on behalf of service users who required hospital treatment. The national policies recommended that a liaison nurse would be best located within a hospital context to enact the liaison role, but clearly this was not the case in this particular service. In this instance, the role was seen as part of a designated care co-ordinator's role, and therefore a 'specialist' worker was not appointed separately to meet the needs of adults requiring hospital admission.

5.9.4 Critical Commentary

All the participants were aware of the policies, procedures and protocols in place within the service, some already mentioned. However, there was variation between participants in terms of their focus and emphasis towards particular policies and protocols. This factor related to the specific roles undertaken by individuals, and how a particular policy impacted upon their role and ensuing responsibilities, towards vulnerable adults and their families in particular. Participants were also aware of the possibility that limitations had to be adhered to. As mentioned, the agency decided to attach a local hospital liaison role to that of a specific care co-ordinator.

5.10 Thematic Network 3: Sub-themes

- Professional Forums
- Adults with Down's syndrome & Dementia
- Young People in Transition

The learning disabilities service maintained a number of related professional forums and task groups. The notion of task groups had evolved across the service since its inception during 2002-3. As mentioned previously (see 5.2.1) both the MDT and AHT participants joined a task group motivated by professional interest and relevance to the learning disabilities service as a whole. There are two additional forums not mentioned so far, but of notable worth and linked to local demographic trends.

The first of these forums was related to adults with Down's syndrome with dementia. The second was the Transition Forum which was linked to young people (14+) planning their transition into adults services.

5.10.1 Adults with Down's syndrome & Dementia

The Down's syndrome Association (2015) estimate that there are over 40,000 people in the UK with Down's syndrome. Typically, a person with Down's syndrome is at increased risk from a number of health conditions (including dementia) and it is important to have effective health monitoring from birth to old age (Down's syndrome, Association, 2015). The definition of dementia describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language (Alzheimer's Society, 2015). It is well established that people with Down's syndrome are more likely to develop dementia than other people and that onset of dementia is likely to occur at an earlier age (Furniss et al., 2011). People with Down's syndrome are at increased risk of

developing Alzheimer's disease compared to the general public (Holland et al., 2000). Adults with Down's syndrome who develop dementia show an increase in the frequency and severity of 'challenging behaviour' compared to others who do not have dementia. It is also acknowledged, however, that this could also be a reaction to many factors. For example, stress, environment and carer reactions (Dodd, 2010). Another important aspect of dementia is the impact upon families. Family carers of people with Down's syndrome and dementia are often not new to caring, although siblings may latterly take on the caring duties previously carried out by parents. Significant difficulties can arise if there are few specialised services to support families such as these (Watchman, 2014). The participants in this study shared their concerns about the increasing prevalences of referrals made to the learning disabilities service about similar issues in relation to adults who had Down's syndrome. Participants agreed that they needed to respond to the growing needs of adults within this context. The Dementia Forum was located in England. It was attended by an AHT member (AHT, 11) on a regular basis. In preparation for this, AHT colleagues had one weekly meeting to discuss how they would work together and respond to any referrals about people who had signs of, and/or, a diagnosis of dementia. The approach offered from the AHT was also reported to the joint management teams (inclusive of health and social work colleagues) on a monthly basis to share good practice. Their approach (as mentioned) was also inclusive of monitoring the variables associated with someone's ability to maintain their daily functioning and related behaviours.

An Australian study undertaken by Wark et al., (2014) reported that three comparable case studies (two men, one woman) with Down's syndrome had actually improved their daily functioning after a diagnosis of dementia. They associated this with a major life event, from a positive perspective. For example, the case studies (aged over 35) had an increase in their social activities and met new people to share activities with. The

outcomes from the study therefore suggested that it was more likely that an underlying presence of depression had also affected their initial daily functioning in conjunction with the onset of dementia. The authors conclude that the observation of this unique dementia trajectory in Down's syndrome warrants further research, with a particular emphasis on establishing appropriate interventions to better support people with Down's syndrome and dementia. These factors had a similar resonance to the work undertaken by AHT participants.

In this study, the reported factors (by participants) and prevalences already present within the demographic population suggested that regular health monitoring of service users with dementia was important. In the UK, annual health checks for people with learning disabilities are being promoted (Jensen & Bulova, 2014). The fact that a dementia forum existed within the learning disabilities service was an indication that a significant number of adults over 40 years were susceptible to the onset of dementia. This phenomenon identified a gap in current services and therefore attention was apportioned to the development of suitable interventions and associated services to meet the needs of local citizens. Equally important was the need to provide on-going support to families, to enable them to continue caring within a potentially stressful environment.

5.10.2 Young People in Transition

Alternatively, and, at the other end of the human life cycle was a number of young people who also needed support to move into adult service, as smoothly as possible. The White Paper, Valuing People (DH, 2001b) had specific objectives in relation to transition to adult life. As a result, some participants had an interest in working with young people in transition, alongside children's services. One participant said:

I've just been speaking to the transition co-ordinator as a transition case has gone horribly wrong. We do lots of transitions and we get commended for the work we do. But we still find that there are things we need to improve on. (MDT, 6)

This scenario was aligned to the issues associated with the allocation of an appropriate professional from adults' services in a timely manner, so that collaborative working could begin on behalf of the young person between children's and adults' services.

From a young disabled person's perspective, Miro Grif recalled his experiences of the transition process. As a 17 year old he wrote about the negative experiences of his transition to adulthood services. He said:

I'm 17 years old and have been in social services transition process since I was 14. It's just a pity nobody told me! I was unfamiliar with the term and hadn't realised that I was within a prescribed process that has such important implications for me. On reflection, it felt like merely being thrown over the fence from children's to adults' services. My transition was a pretend process with a few bureaucratic milestones and I was expected to morph into an adult on my 18th birthday. (Transition Information Network, 2008, p. 3)

From a national perspective in England, there has been recognition that this particular phase in a young person's life can be complex and stressful for all involved throughout the overall process. One important organisation which has supported young people since 2008 is the Transition Information Network (TIN) which is an alliance of organisations and individuals who come together with a common aim:

To improve the experiences of disabled young peoples' transition to adulthood. TIN is a source of information and good practice standards for disabled young people, families and professionals. (TIN, 2015, p. 2)

At the time of writing (2017), the agency linked to this research study had an active transition forum in place which was linked to the established transition policy created by children's services. The policy explained that for transition to be successful it was vital that services (children's and adults) were involved at the key planning stages in a young person's transition. By way of illustration, Figure 17 outlines some of the key issues involved during the transition process appertaining to young people and their families.

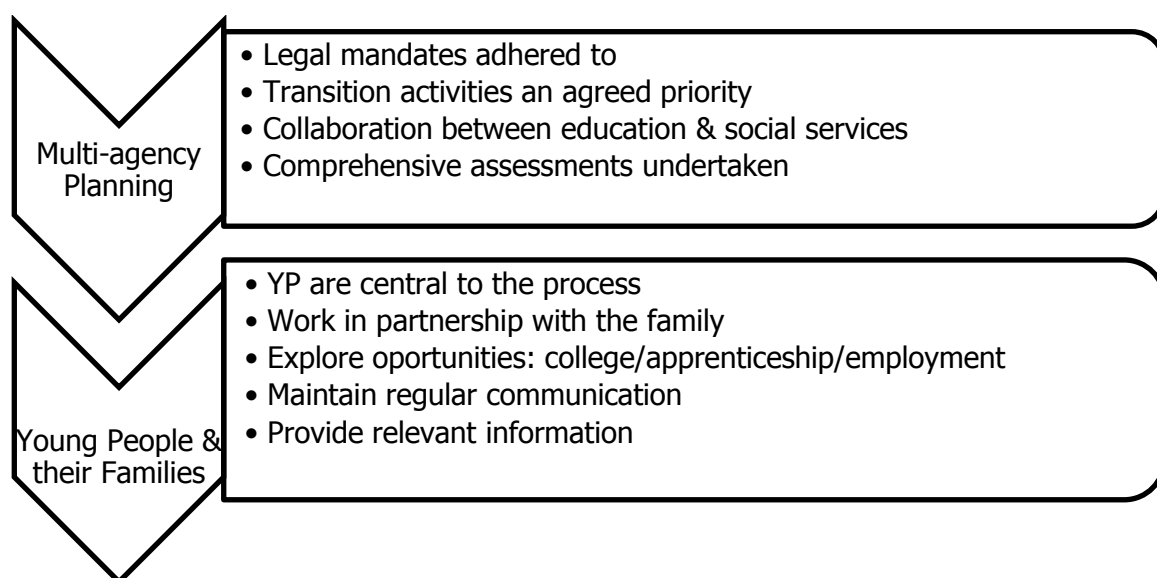


Figure 17: Key Issues and the Transition Process

This approach is underpinned by the relevant legislation, the Children and Families Act 2014 and the Care Act 2014. The Children and Families Act creates a new 'birth-to-25 years' education, health and care plan for children and young people with special educational needs (learning disabilities). It offers families personal budgets so that they have more control over the type of support they get. The Care Act 2014 states that professionals need to understand the process of transition – and in particular how to interpret differences in the eligibility criteria between children's and adults' services.

The Getting a Life programme (2008-11) was part of the Valuing People Now strategy

(DH, 2009). It was established to drive the changes needed to ensure young people with severe learning disabilities achieved paid employment and full lives when they left education. An example of this is the independent charity, Pure Innovations (2015). It supports people into employment who have been a key member of the Getting a Life project in the locality. Their belief is that everyone has the right to contribute and live a full and active life in society, which is at the heart of 'getting a life'. Pure Innovations offer service users a person-centred work development plan. The charity works with employers to customise a job to meet the skills of the individual. During 2014, the charity worked in collaboration with managers from this agency and a local hospital to initiate ten traineeships for young adults with learning disabilities. The young people were experiencing different job roles within a hospital context with an expectation that paid employment could be offered at the end of the traineeships.

Successful transition means that a coordinated approach is paramount, as illustrated by Figure 17. There are a number of steps to be followed in order to create a seamless service transition, especially for the young people and their families. One participant (MDT, 7) explained that care co-ordinators were allocated to specific transition cases, dependent upon the predominant needs. She was referring to the type of learning disabilities present and whether there were complex health needs involved. There was a great deal of emphasis placed upon partnership working between children's and adults' services. Joint home visits to young people were also common. One of the most difficult aspects for families to grasp during the transitional phases is the disparities between service provisions. This is also underpinned by the notion that a young person is becoming an adult and therefore able to make choices – so the approach from the adults' teams (MDT and AHT) was one of promoting independence in the first instance. Another participant explained how they encouraged young people to step aside from parental influences to assist them to speak out about their particular interests and

aspirations for the future. She said:

It's really difficult to try and get families to move away from being overly protective towards their children. (MDT, 4)

There was also the issue of the different legislative framework and related entitlement to welfare benefits which applied to adults. For example, unlike children's services, there was the need to inform all the families involved of the adult service's charging policy for service provision which could affect the type and amount of services allocated to a young person. In addition to this, the last Coalition government was determined to promote the personalisation agenda, steered by them during (2010-2015). This is also mirrored in the Conservative government's intentions and enshrined in the Children and Families Act 2014, in terms of encouraging families to organise their own support arrangements. The Coalition government was committed to personalising social care services and determined that all those eligible for support would have the opportunity to receive a personal budget. Their publication: A Vision for Adult Social Care: Capable Communities and Active Citizens stated:

The provision of personal budgets for all eligible people will mean personal assistants, directly employed by people who use care and support services, working in new, creative and person-centred ways to play an increasingly important role in providing tailored support to meet individual needs. (DH, 2010a, p.19)

5.10.3 Critical Commentary

It was clear that the existence of professional forums enabled colleagues to share the importance of demographic trends alongside the growth of specific needs in relation to vulnerable adults. This included adults who had Down's syndrome (with dementia) and

young people in transition. The forums were a central meeting place for all the participants (and other colleagues), and a way in which to remain up to date with new service developments. Members of the AHT and the MDT benefitted from engagement with local citizens (primarily those with learning disabilities) and worked proactively to enhance their professional knowledge and practice interventions. AHT participants had a positive approach towards sharing practice and were pre-emptive in seeking solutions to the needs of local people. The forums (and the wellbeing board) were strategies in place which created an 'information network' as illustrated by Figure 18. The King's Fund (2013) stated that:

There has been general agreement about the value of boards as a means of bringing together the major local partners that are responsible for addressing the health and wellbeing needs of their local populations. The roles and responsibilities of different national and local organisations have become more complex as a result of the government's reforms, and the need for a local mechanism for partnership and co-ordination has never been greater. (The King's Fund, 2013, p. 1)

This was especially important given that financial austerities were juxtaposed against the growing demands for services within specialist areas of provision. This included dementia care and working alongside young people in transition.

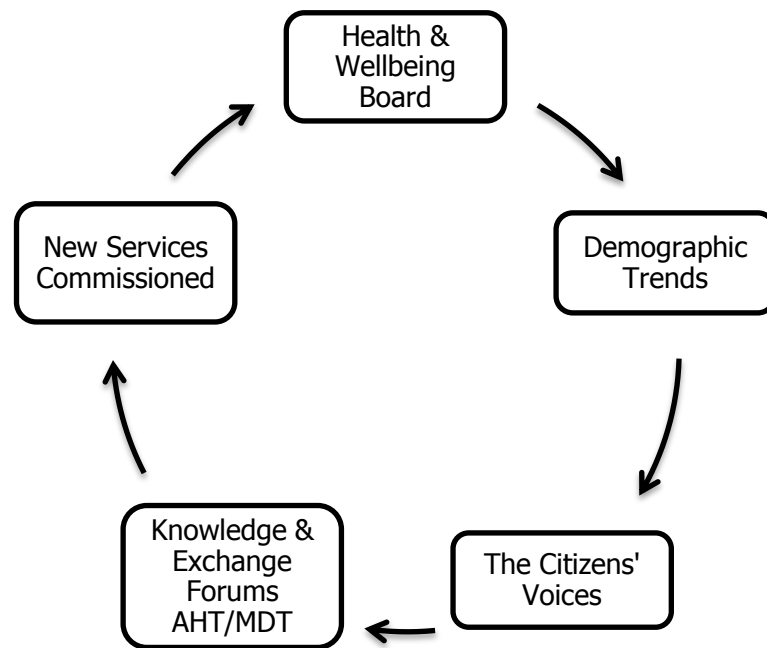


Figure 18: An Information Network

5.11 Conclusion

This chapter has presented comprehensive findings about individual perspectives and issues of importance to all the professional participants (n=17) involved in this study. What transpired was the fact that each of them held a strong commitment towards supporting vulnerable adults to live a 'better life' underpinned by the social model of disability. Participants acknowledged that working alongside other disciplines was no easy feat and that a willingness to understand the value of others' contributions was important, despite salary disparities and some status issues between the MDT and AHT colleagues. The findings also demonstrated that strong and positive leadership had an impact upon the direction of the service as a whole – linked to on-going legislation and the formulation of relevant policies and protocols. In addition to which, staff were encouraged to offer their contributions through an effective information network, albeit within a climate of limitations about commissioning new service provision.

CHAPTER 6

Findings (3): Citizens who needed and used services

6.1 Introduction

This chapter will address the perceptions and outcomes from people who needed and used services. All of the citizens (n=9) had worked alongside a member of the MDT and AHT at some point in their lives. Each citizen had a connection with professional participants based within the learning disabilities service. As I have outlined in chapter three (see 3.5.2.), none of the citizens were actively involved with the professional participants' in this study during the data generation phases.

The rationale for the inclusion of local citizens was to encourage them to share personal experiences, and in particular, those experiences which involved contact with social workers located within the MDT cited in this study. The inclusion of citizens also acknowledged the importance of 'stakeholder' opinion with which social work upholds, from the standpoint of developing effective services which are of value and benefit to local citizens. The chief social worker for adults (Romeo) also made a clear statement about the importance of the connection between local citizens, relevant services and social work's contribution. In her interim report (DH, 2015). She stated:

I believe that social work will continue to have a vital role in working with people of all ages in developing services, and when dealing with the complexities and challenging circumstances in which they live. (DH, 2015, p.6)

The approach therefore, was focused upon the experiences (as citizens) rather than any identified disabilities of service users or informal carers who participated. The only pre-requisite for individuals was the ability to recall their understandings through their own lived-worlds. Although, it was acknowledged that the reason for the involvement with social workers (and others) at some point in the past, was connected to the necessity to provide additional support due to the effects of having learning disabilities. Or in the case of informal carers, they required services to enable them to continue supporting either a daughter or son who had learning disabilities.

Lymbery & Postle (2015) comment that discussions about citizenship frequently take as a starting point the work of Marshall (2006) who divided its components into three elements. The elements consisted of civil, political and social, thus Marshall argued that the status of citizenship could be 'conferred' upon all those who are full members of a community, although he acknowledged that social citizenship was the most problematic and most important in relation to social welfare.

However, I would support the argument espoused by (Rummery, 2002). Rummery (2002) argued that, given the high levels of social inequality within UK society, it is impossible for many citizens to exercise their rights without the support of welfare services that are constructed to facilitate their social participation, such as day services. Lymbery & Postle (2015) further argued that successive governments have not acted on the basis that all citizens have entitlements, (which in this case is a tenuous concept), for people who have learning disabilities and informal carers who needed on-going support from public services in order to function as 'citizens'.

Glendinning (2008) investigated the possibility that personal budgets could offer individualised citizenship in terms of the incorporation of health, work-related and social care support money that an individual might accrue. Williams, (2013) argued that this proved elusive for people with learning disabilities, as many individuals relied upon support they had from family and friends to fulfil their aspirations and become active citizens in their local communities. People with learning disabilities can be a strong part of communities through having a voice in politics and government, as demonstrated by Mencap (see 6.2) and the 'Hear my voice' campaign.

In this chapter the findings have been presented in two separate parts. Part one will discuss the findings from service users' perspectives. The second will focus upon informal carers and their perspectives. Each individual's story has been presented as a case vignette – a snapshot in time which encapsulated context, experiences and meaning through the personal stories recounted. Critical commentaries have been presented after each story, all of which offered my perceptions as the researcher about their experiences.

6.2 What matters to Citizens?

Insights from citizens about their experiences and what outcomes matter to them are rarely included in any evaluations of multi-disciplinary working Cameron et al., (2012). When they are included, often there are limited details reported. This in part, is due to the fact that their views are rarely analysed in a way that promotes understanding of their differing and potentially competing needs (Brooks, 2002). In other instances separate research studies were undertaken about the views of service users and informal carers, rather than integrated within a study as a whole (Brooks, 2002). From the organisational perspective, more emphasis has been focused on organisational

processes. A factor also prevalent within this study, and highlighted in chapter five, which related to organisational issues and the delivery of appropriate services. The emphasis is upon joint working between systems so that 'success' has been thought of in relation to better organisational co-ordination, or the number of care plans executed (outputs), rather than better co-ordination (outcomes) for the people who need services (Redding, 2013).

An additional research briefing undertaken by Cameron et al., (2014) evidenced that there had been an attempt to redress the absent voices of consumers, (their terminology) albeit in this instance, focused upon older people and those who had mental health issues. For example, they state that:

Many of these evaluations were descriptive, providing no clear data on effectiveness while others did not define outcome measures or reported outcomes that were unrelated to the evaluation. Few studies were comparative in design or offered a before and after analysis, making it difficult to assess if an intervention has been a success. Additionally the myriad models of joint working evaluated and the range of working arrangements identified made it difficult to compare services. (Cameron et al., 2014, p. 64)

In terms of people who have learning disabilities, there has been a growth in the use of approaches that attempt to redress this imbalanced representativeness, but mainly from the voluntary sector. One such example is Shaping our Lives (2015) which is a user controlled independent organisation 'think tank' and network which started in 1996. Its aim is to enable vulnerable people to have a voice and facilitate the same choices, rights and responsibilities – in short to be recognised as valued citizens within their own

communities. During 2015 the campaign 'Hear my voice' was initiated by (Mencap, 2015) a UK based charity which is politically active and representative of both individuals with learning disabilities and associated carers. Mencap produced a manifesto in preparation for the general election held in May 2015 to enable the 'voices' of people with learning disabilities to be heard from a stronger platform. The charity states:

Politics can be messy and inaccessible for everyone, especially people with learning disabilities. But it is our right to take part. Politics matters, it has an extraordinary impact upon everyday life. It's time we told politicians to hear my voice. (Mencap Manifesto, 2015, p. 1)

This was also a response to the hate crimes experienced by some people with learning disabilities and to reinforce the message about the unacceptable atrocities such as the Winterbourne View scandal during 2011 (DH, 2013).

In November 2015, the Conservative government responded to Mencap's campaign which emphasised that the rights of people with learning disabilities, Autism or mental health conditions had not been respected fully. The Right Honourable Alistair Burt (MP) Minister of State for Care Services stated:

I recognise that since the previous government's response to what happened at Winterbourne View, there have been some improvements, but they've not gone far enough or been made fast enough. (DH, 2015a, p. 4)

He further explained that many of the responses received were about the fundamentals of how to treat people, how to involve them, and how to enable people to challenge decisions in the system.

Another example is the Challenging Behaviour Foundation, (2015). This is the charity for people with severe learning disabilities who display challenging behaviours. Their vision is:

For all people with severe learning disabilities who display challenging behaviour to have the same life opportunities as everyone else and, with the right support, to live full and active lives in their community. (Spring Newsletter 2015, p. 3)

As mentioned in chapter three (see 3.5.2) there has been an increased interest in user involvement in recent years which has become a shared goal of political parties and policy developments (Beresford, 2013b)

One such example is National Voices which brings together the voices of patients, service users and carers to bear on national health and social care policy in England. The main aim is to influence government ministers and departments, professional bodies, and other organisations seeking to ensure that policy focuses on delivering what matters to patients and service users, their families and carers (National Voices, 2015). It was the intention therefore, to address this disparity (within this research study) and to incorporate the views of local people who needed the input of social work MDT members. The motivation to do so was based upon the idea of an exploration of the extent to which they had been involved in shaping the delivery of their support. This was also related to the notion of effective and inclusive involvement with MDT and AHT members.

6.3 Narrative Inquiry Approach and Social Work

As originally discussed in chapter three (see 3.8), the approach towards data analysis was IPA. Likewise, Nvivo (10) was also utilised to aid the analysis, and to establish how the data (in this instance citizens) could be presented in a way which was informative, meaningful and reflective about those experiences. As such, what transpired from the data generation phase was that all the citizens felt comfortable sharing their experiences through their own stories, which were significant to them and other people involved in their lives.

Therefore, in order to capture the personal stories, a narrative inquiry approach was deemed appropriate in terms of presenting the findings from their perspectives. This was also underpinned by an '*opportunity to see into the heart of things*' and interpretation through a hermeneutical phenomenological lens, as explained in chapter three (see 3.3) and mirrored the approach used towards the findings from MDT and AHT participants. Another point to note was the fact that, whilst initially the intention was to interview each individual, due to the nature of how the stories were recounted, this translated more comfortably through a focused conversational style of interviewing. Stanfield's (2000) approach was useful as a point of reference, which is explained in greater detail in 6.4.

In order to work positively from a narrative perspective, the work of Kohler-Riessman and Quinney (2005) has been referred to. This was in relation to the positive effects of approaching texts as narrative (rather than themes) which has a great deal to offer social work. For example, showing how knowledge is constructed in everyday life through ordinary communicative action. A narrative framework can also respect social

work values, by valuing time with, and diversity amongst, individuals (Kohler-Riessman and Quinney, 2005). Fraser (2004) similarly argued that a narrative approach was a 'good fit' with social work. For example, it facilitates ways to make sense of language, including what is not spoken. It encourages the plurality of truths to become known and ways to understand the interactions that occur among individuals, groups and societies. In addition to this, it can elicit the understanding of experiences such as phases (or turning points) in life, all of which are critical to social work research and related practice. In this respect Squire's et al., (2008) approach towards narratives was also relevant to this study. They defined narratives of experience in relation to a broad approach to narrative inquiry that presumes that narratives are:

Sequential and meaningful, relate to human experience, re-present experience, and display transformation or change. (Squire et al., 2008 p 42)

They further asserted that narratives are a way in which individuals make sense of themselves and the world in which they live. I agreed with this viewpoint, as the narratives provided a useful tool (and methodological triangulation) to compare different perspectives of the professionals and citizens who participated in the research study.

6.4 Storytelling and individuals' lived-worlds

Kohler-Riessman & Quinney (2005) asserted that the popular usage of a story can often speak for itself, which does not require interpretation. However, it was acknowledged that this factor could have been prevalent in relation to the findings from the citizens. This is illustrated thus:

In everyday use, however, narrative has become little more than metaphor; everyone has his/her 'story' a rising trend linked to the use of the term in popular culture: telling one's 'story' on television, or at a self-help group meeting. Missing for the narrative scholar is analytic attention to how the facts got assembled *that way*. For whom was *this* story constructed, how was it made, and for what purpose? (Kohler-Riessman & Quinney, 2005, p. 393)

I was in agreement with Kohler-Riessman & Quinney's (2005) argument that this position would be indefensible for serious scholarship. Therefore, careful consideration was adopted towards each of the stories which was interpreted and presented within their specific contexts, subsequently offering authentic representations from all the citizens.

Gilbert (2004) also argued that narrative approaches have a long history within social sciences. The focus is not the verbatim translation of events, but the linking of this individual's experience, insider perspectives, with public concerns and the development of social theory. I would also support Gilbert's (2004) analysis about the pre-possession of cognitive abilities of participants to be able to recall their stories, and it is then left to the imaginative researcher to present the stories as he/she sees fit. It was important in this study, therefore, to ensure that citizens (service users in particular) were able to tell their stories in a positive environment. This was enhanced by adopting an open style and approach in terms of creating a convivial atmosphere to elicit the 'best out of people' – sharing their stories in a comfortable way. In addition to which, there was no expectation that anyone would need to write down their stories, unless they requested it. Instead everyone was asked a small number of questions. The rationale was to provide a loosely structured frame of reference, which could facilitate the opportunity to

share personal experiences and to inform the research study about the contribution of social work within this context. As mentioned, (see 6.3) this approach also aligned with Stanfield's (2000) focused conversational (interviewing) approach. The focused conversation has a four-level framework of questions comprising of objectives (facts/timelines); reflective (personal responses); interpretative (personal significance and meaning); and decisional (resolution and future plans) (Stanfield, 2000). There was also acknowledgement that the 'conversations' could have been emotional and reflective during the meetings. As a precautionary measure, each participant was re-assured that the conversation could stop at any point, with no obligation to continue. The sequence of the questions (although used flexibly) during the data generation phase (as demonstrated) encouraged individuals to share their stories which could also offer an evaluative function. This involved relating past events to the present in order to construct the meaning of the present (see Appendices 10/11). The focused conversational style of interviewing consisted of the following:

1. What is your personal experience of working with social workers, community nurses or someone else from health located within either this MDT and/or the AHT?
2. How did the experience make you feel?
3. What went well?
4. What could have been done better?
5. How did your personal experience affect your situation?

6.5 Part One: Service Users (citizens)

An important argument to highlight is the fact that service-user movements define themselves not in terms of services but rather in terms of their lives and overall identity. Whilst the term 'service user' is the term most often used (and within this thesis) many

individuals dislike this term because they feel it defines them passively and solely in relation to services they use, rather than taking account of their overall identity (Beresford, 2013b). Therefore, in part one of this chapter the term 'service user' has been used sparingly to acknowledge the individuality of each person presenting their stories. Individuals agreed to share their stories using the questions displayed (see 6.4). Table 20 served as a reference point about the data set and the current living arrangements at the time of the interviews (January 2012). It also identified that each of them had a past link to MDT/AHT members within this study. As mentioned in chapter three, (see 3.4) all the individuals wished to be referred to as a person with a pseudonym first name.

Table 20: Service User Participants (citizens) (n=4)

Individual (Pseudonym)	Context	MDT / AHT Professional
Amy in her 20s	Living at home with parents	Social worker (MDT)
Brian in his 40s	Tenant and supported living arrangement with other adults	Social worker (MDT) Speech & Language Therapist (AHT)
Cathy in her 50s	Tenant and supported living arrangement with other adults	Social workers (MDT)
David in his 50s	Tenant and supported living arrangement with other adults	Social workers & Community nurse (MDT)

6.6 The Philosophy of Independent and Supported Living

The philosophy of independent living was originally inspired by the disabled people's movement. Disability Rights UK, (2015) state that:

Disability Rights UK believes that all disabled people should be able to choose to live independent life-styles with dignity. This does not mean that disabled people necessarily need to live on their own or live without any support. In fact, Independent Living empowers you to have greater choice and control in directing your own life, having the same range of choices as a non-disabled person to make informed decisions about any practical support you require going about your everyday life. It is living independently without the dependency created by institutions. (Disability Rights UK, 2015 p. 1)

The philosophy embraces the social model of disability, and is based upon a belief that disabled people should be enabled to live their lives on as equal terms as possible alongside non-disabled people. It highlights the need to ensure they have the support that they need to be autonomous and live their lives as fully as possible, and interdependently with others (Morris, 1993).

In this instance the term 'supported living arrangement' used in this thesis reflects the philosophy of independent living. For example, each individual had their own home. In addition, they were all in receipt of welfare benefits inclusive of housing benefit. This was a positive feature which meant that each person also had tenancy rights. A supported living arrangement (with the exception of Amy) included living with other adults who also had learning disabilities. This meant that each person would be entitled

to individualised care and support from a separate agency for daily living arrangements. This could also include the organisation of day time and social activities which may or may not have included other members of the household. Each individual was encouraged to develop their own networks and leisure interests, although in reality it often involved a number of other service users based in the same house, due to the development of close relationships between individuals and limited staffing arrangements. As mentioned in chapter three (see 3.5.2), all the individuals were able to give their informed consent, and three of the four individuals communicated using words. One person (Amy) lip read and also had the support of an independent advocate (whom she knew) during the data generation phase, to facilitate her experiences.

6.7 Case Vignette: Amy's Story

All of Amy's responses were articulated via the independent advocate who was present throughout the interview. She did not use expressive language, but used facial expressions, utterances and gestures to get her points across. Amy could understand verbal expression from other people, when she was addressed during the interview.

Amy was a single woman and lived at home with her parents. She had attended a local 'special needs' school (separated from mainstream school children) until she transferred to the local college when she was 21 years old. Amy needed a social worker to undertake an assessment of needs; she was unsure about what to do next, and was due to complete her local college course imminently. Amy was also a member of the Listening to People Task Group, (coordinated by the service user development worker), which introduced her to other people who had also left college. Most of the new people being introduced to her were adults and had developed some independent interests. She gesticulated (pointed her finger in the air) and uttered broken sentences to her advocate. The advocate said:

Amy needed help with going out when she finished college. She did lots of writing at college. She was involved in sport and computer work and didn't want to get involved with any cooking.

Amy confirmed (through nodding) that a social worker had been to see her and her mother at home. Amy was sure about one thing: she didn't want to attend a day centre and be with crowds of people, all of whom had some association with learning disabilities. A home visit had been arranged by her mother to discuss Amy's options about her future life experiences. Amy's advocate said:

Amy wants to live a more independent lifestyle, with support from someone she likes to be with. She wants to arrange and plan her own things with her friend.

Amy explained the best way she could (through facial expressions and utterances to her advocate) that a woman (social worker from the MDT) came to see her. She said that the woman didn't speak to her, only to her mother. She found out what was going on through her mother and through her reviews. The woman who visited did a lot of writing and Amy thought it was about her. Her mother, father, friend and the social worker attended her meetings. She said she felt ok about this, because she could have some money to help her to go swimming and also visit the ⁷Gateway Club.

In terms of what could have been done better, Amy (pointed her thumb down) and gave the impression she was not enthralled with the social worker who visited. The advocate said:

⁷ The Gateway Club is a social club which is affiliated with Mencap – an independent charity.

Amy doesn't know if the woman helped her. She only spoke to her mum and not Amy. She wasn't listened to and felt ignored she kept talking to her mum. Her support worker helps her much more.

However, at the end of Amy's story it transpired that she had some money of her own because her mother had spoken to the social worker. This enabled her to plan her weekly activities with her support worker and mother. The advocate said:

Amy thinks this is part of her personal budget and is called a direct payment so that it helps her do things she likes.

6.7.1 Critical Commentary

This narrative was quite a difficult story to understand initially. As Amy shared her experiences it became apparent that a separate signer (or advocate) had not been present during the meetings with Amy and her family. This factor had had an impact upon Amy's perception about what the social worker (from the MDT) was trying to do on her behalf. It transpired (via the advocate) that the social worker had undertaken an assessment to enact the provision of a personalised budget in response to Amy's needs. Amy's independence was important to her, although how this was expressed was supervised by her mother. She showed a mixed response as to how this experience affected her life. For example, she expressed a high regard for her support worker who 'did things with her,' as opposed to the social worker who visited and completed 'paper work' on her behalf. Amy gave the impression that the social worker had spoken mainly to her mother who was able to secure a personal budget for her. A study undertaken by Mitchell et al., (2012) revealed that carers were commonly involved in assessments of service users with cognitive/communication impairments; staff, carers and service users

all valued this. Carers themselves wanted to be involved so they could help service users understand questions and contribute detailed information. Service users were happy about their carers' participation as they could find talking to practitioners difficult. Many (in a similar situation to Amy) did not speak to practitioners alone.

Nevertheless, this narrative was a good example of how the contribution of social work (via the MDT) had had a positive impact upon Amy and her intended lifestyle. This was highlighted through the undertaking of an assessment of needs which then triggered a personal budget for Amy to utilise. It was acknowledged, although disappointing, that a separate signer had not been present during the home visits - confirmed by the advocate. What was meaningful to Amy was the fact that she had the financial means to plan and organise her life with the support from people she liked and trusted. Whilst telling her story Amy indicated (through a sad facial expression) that she didn't have a relationship with the MDT social worker who visited and therefore wasn't interested in meeting her again.

6.8 Case Vignette: Brian's Story

Brian was a single man who had recently moved into a supported living arrangement. His 'lady-friend' (as Brian described her), also lived in the same house, alongside one other tenant. His previous home was located within a group of flats whose residents were all disabled and dependent upon daily visits from support and domiciliary staff. Brian explained that he needed a social worker to help him because he had learning disabilities. He said:

I decided to move because of my health problems. I have Diabetes and Epilepsy. I was on my own and I got very lonely.

Brian further explained that the support staff he knew from his original flat were very supportive, but staff couldn't do anything about moving from one place to another. He managed quite well on his own, but needed help to manage his Diabetes and Epilepsy. He was also linked to a local day centre during one day per week and the supported employment service. He had worked as a volunteer at a local older people's home until recently. He explained that at one point he was rushed into hospital due to his Diabetes being 'out of control'. He spent six weeks in hospital until his condition was re-stabilised. During his period of hospitalisation he realised how lonely he had become living alone, and told the duty social worker who visited him that he wasn't going back to his flat. He said:

I had nothing to look forward to. Once my front door was closed it just went on and on, hardly anyone came to see me. I got really upset about it and couldn't do it anymore.

Brian's experiences of working with a social worker from the MDT were positive. He explained that his request to move nearer to his lady-friend had not been taken seriously until his hospitalisation. He had known his lady-friend for about twenty years. He mentioned that a different social worker from the MDT also visited him in the hospital and he talked face-to-face with her, explaining why he wanted to move. Brian mentioned that the social worker made some notes and then showed him what she had written about him. He described how she talked to him about his welfare benefits and he felt comfortable about this, as he knew he needed help to manage his money properly. Brian never returned to his flat. His situation was treated as an emergency, mainly due to his health needs. When he was settled in the same supported living arrangement as his lady-friend he said:

The social worker came to see me and told me that I was doing well and took me off her books. It felt great to hear that from a social worker.

Brian's experiences of working with a social worker from the MDT were positive. At the time of the interview he was settled in his home and had a number of different people to converse with. He joined in with a number of day time and social activities alongside other people living in the same house; therefore, he wasn't interested in attending a day centre. He also mentioned that his social worker had suggested that he worked alongside a Speech and Language Therapist, based within the same learning disabilities service (AHT). He said that he wanted to do this so that he could learn how to become more confident about sharing his thoughts and feelings with people like social workers and nurses, should he need their help in the future.

6.8.1 Critical Commentary

This was a poignant narrative. Whilst the social model of disability promotes the individuals' right to claim their rightful place in society, in this instance, living a more independent lifestyle proved traumatic for Brian. He had become a lonely man with time on his hands. One harrowing aspect of this narrative was the realisation that it wasn't until Brian was hospitalised that his request to move had been taken seriously (according to him) by members of the MDT and, more specifically, was driven by health needs. In other words, he was perceived as being at 'high risk' if placed in the community alone again. This was due to him not being able to manage his health needs. Whilst originally he had been placed within a safe place – a flat with support arrangements, the humane element of acute loneliness had built up over time and in the end had got the better of him.

6.9 Case Vignette: Cathy's Story

Cathy had been in local authority care since being ten days old. Her mother was fifteen and her father was twenty-five when she was born. She lived in local authority care until she reached 18 years old. She said:

The staff in the children's home said that I was a spastic. It was horrible in them days. They have changed the name now. I didn't know what learning disabilities were it was just words. I didn't think anything of it.

Cathy shared her experience about finding out that she was different from other children, as she was transferred to a 'special school' by the time she was ten years old. She said:

I know now that it affected my self-esteem, I felt like everybody was staring at me when I walked down the street. How could I ever live on my own knowing I've got these learning disabilities?

Once she reached 18 years and as a single woman, she was placed in lodgings with one other non-disabled woman. After a number of years she then moved into a group home situation for a short while, living alongside other people who had learning disabilities. Eventually Cathy moved into her own flat during her 40s. She explained that she could manage quite well with some independent living tasks. These included crossing roads, shopping for food and making her flat presentable. She needed support with coordinating meals and paying her bills. She appreciated support with social activities, (going out for a meal) as she found this difficult to arrange alone. Over a period of a

number of years, Cathy realised that she had become lonely, relying upon paid care staff for friendship as well as support needs. Although Cathy had also attended a local day centre, she left after a number of years, becoming bored with the limited activities available. She said:

All I was doing was making paper hats. I wasn't using my skills. I used to work in an Old People's Home as a Care Assistant. I liked it, it was a proper job. When I was making paper hats I only got £5.00 per week. I was being used as a skivvy, so I stopped going.

At the time of the interview he was a member of the Partnership Board (as outlined in chapter five (see 5.6.2) and thoroughly enjoyed listening to the debates and plans being made for people with learning disabilities. She said:

I really like going to the meetings, there are lots of different people I can talk to – it's great. It's good to feel that I'm involved with something I can have a say in for people like me.

Cathy explained that she had experience of working with two social workers over the past thirty years, one of whom was based within the MDT. She felt that both of them were part of her family, because she didn't have a family of her own. One social worker who retired moved to New Zealand, (according to Cathy) and gave her the choice to keep in touch with her. She said that both social workers were really helpful and listened to her. They helped her to move on three different occasions, trying to get the right type of accommodation for her. She said:

The social worker contacted the housing department and told them I wanted a flat. I had to attend a meeting first to talk about it. It took about six months to get a flat I liked. Everything got better when I became part of the learning disabilities service. I had the right type of social worker to help me.

6.9.1 Critical Commentary

This was an inspiring narrative, given the fact that Cathy had experienced a life time of disadvantage and discrimination from various sources in her life. This was compounded by the fact that she had been placed in local authority care which provided 'the basics' in terms of shelter, school, protection and some personal support during her first 18 years. As an adult citizen however, Cathy welcomed the opportunity to rely on other people, and as Duffy (2003) argued:

Life should not be an attempt to achieve independence from each other; instead we should welcome our interdependence, the fact we rely on each other. (Duffy, 2003, p. 103)

An interesting point to note was the fact that Cathy had the opportunity to 'belong', and the vehicle to facilitate this was her attendance at the Partnership Board, alongside other people she knew. Whilst her initial drive was the need to feel valued as an ordinary citizen, it was also envisaged that she would engage with the political agendas being driven in her locality for people who had learning disabilities.

Her narrative in relation to her experiences and the contribution of social work, proved to be positive. She valued the long-term relationships with two social workers in particular over a thirty year period. She had benefitted from professional MDT support,

throughout her movements over the years to accommodation to match her changing needs over time. Cathy confirmed that she felt happier within a supported living arrangement and finished the interview by saying:

I feel on top of the world now and I can be independent if I want to. I speak to carers every day. I have my own room and to get a bit of company all I have to do is sit in the lounge downstairs.

6.10 Case Vignette: David's Story

David lived with his parents until he was 40 years-old. He was a wheelchair user, which had individualised adaptations to enable him to maximise his independence, mainly in relation to his mobility. When his mother died, he was then referred to the learning disabilities service (MDT). He needed support from a social worker to undertake an assessment due to his father not being able to care for him without the support of his wife. He had lived in a supported tenancy for the past ten years and shared his home with two other men and one woman. David confirmed that he enjoyed living in a mixed household. He admitted that he didn't get much family contact since moving into this type of arrangement, other than one of his sisters who called in to see him about three times per year. He also revealed that he had got married whilst living within the tenancy, to a woman living in a different tenancy. He said:

I thought I would like being married but it turned out I didn't. Nobody told me what it could be like. I felt up and down all the time, and worried about it. It didn't make me happy. I got divorced three years later.

He then changed the subject and confirmed that he enjoyed living with other people and also support staff. He explained he had a ground floor room which had been adapted to meet his needs. He said:

Other people and staff are always around to talk to if I want some company.

Once settled, he requested the support of a social worker or community nurse from the MDT, as he was looking for something else to do, rather than attend a day centre, which had been the case for the past thirty years. He wanted to make some changes to his life and move on to new experiences. He explained that when he was at the day centre he could not understand some people, and a number of people always bumped into his wheelchair which irritated him. He had decided that he was more interested in becoming a volunteer in his local community which would enable him to meet some people and broaden his circle. David's day time activities had always been spent at a large day centre and he freely admitted that he felt 'low' about this. Initially he didn't know what to do about it. He shared his views that there wasn't enough variety of things to do and he was always with the same groups of people in one form or another. He wanted to work, but realised that he had limitations due to his physical health needs as well as having learning disabilities. He mentioned his interest in working at a local garage, perhaps in the reception area, which would have given him the opportunity to meet new people.

He said that a community nurse from the MDT talked to him and asked him questions mainly about his health needs. He remarked that he had worked with a number of staff from the MDT over the years and made the following comments:

They don't stay too long. I have one social worker and then I have another. It makes me a bit upset. I want to make them a brew, but they're gone.

Moving from home was traumatic, but he had an awareness that he couldn't rely upon his father any more. At the end of the interview he made the following comments about how he felt living with other people:

I get on well with where I live now and I like to do my own thing. I like to go on the computer or do some jigsaws. At week-ends we go out sometimes. My wheelchair causes me backache I think its wearing out. I need a new one.

6.10.1 Critical Commentary

This was another poignant narrative, over shadowed by limited opportunities to live the life David actually wanted. Whilst it was deemed appropriate to ask for the support of a social worker/community nurse to move home, in this instance it was underpinned to a certain extent by sadness. He confirmed that he had been happy living within his home environment until his mother's death, only to find that once she had died, he would need to leave his family and begin a new life with people he didn't know. The family found his health and social care needs too overwhelming. Once David moved it transpired that his father moved to live with his brother. This type of scenario is not uncommon in respect of people who have complex health and social care needs (Williams, 2009). The impact upon someone like David can be tough, in terms of the realisation that he would have to live elsewhere to live as ordinary a life as possible.

Cole et al., (2007) undertook a knowledge review about day service provision in the UK. A national survey of people with learning disabilities found that 39 per-cent of all people with learning disabilities attended a day centre; two-fifths of these attended five days a week. The study revealed that many local authorities were struggling to move away from large, congregated day settings for people with learning disabilities and to achieve increased provision to meet demand. Cole et al., (2007) further explained that developments other than the provision of large day settings were affected by the local social, political, economic and demographic context. It was a varied and evolving picture around the UK. This type of scenario had also affected David, in terms of the lack of opportunities for him outside the congregated setting, and local alternatives (such as working in a garage) would prove difficult to achieve.

In more recent times (2016), the traditional day service provision associated with this agency transferred to a new social enterprise. In reality this meant that the new company had contractual arrangements with the city council. This was inclusive of day services, respite and intermediate care, supported tenancies and adult placement. The idea is that the company will raise income by offering extra services to people who wish to buy them privately and through personalised budgets. All the money which is raised is intended to be re-invested into the company, and individuals and staff will decide how services are offered in the future to get the best quality available. The underpinning ethos is the drive to provide more flexibility, and support people with person-centred, personalised services.

David did reveal that he enjoyed working with social workers located in the MDT and had some insight into the fact that they did a different job to that of support workers. He

realised that the day-to-day contact with support workers, often encouraged relationships which he valued in his life most of all.

6.11 Service Users Contributions

The service user participants (n=4) shared their personal experiences openly, about the value of social work support to facilitate positive changes within their lives. Each had a different story to tell, which made connections at some points, with the experiences reported by the MDT social workers based in the agency's learning disabilities service. All the social workers advocated the importance of, and their belief in, the social model of disability (see 5.2.1) which in some cases has had a transformative effect upon the lives of service users in this study. For example, social workers ensured that service users had holistic assessments of needs which underpinned the direction of individualised care plans and bespoke service delivery within the context of the learning disabilities service. This was demonstrated through each of the stories recalled. Examples included, a personal budget for Amy, Brian was moved to more suitable accommodation, and encouraged to learn about advocacy skills in the future. In terms of Cathy, she highlighted the nature of her relationship with one MDT social worker in particular. She referred to the social worker as a 'family member' in terms of how she imagined how a relationship with a family member could have evolved, should she have had a family of her own.

It was evident that whilst attempting to live independently, it was also important to include regular contact with familiar faces in their lives. Independence, however, should not be confused with isolation. The personal experience of loneliness was a prevailing factor in all of the narratives, other than the account provided by Amy, who lived within

her parental home. Taken overall, these narratives provided by the service users tend to support the importance given to the social model of disability promoted by the social worker participants.

The value therefore, of their stories, highlighted the positive contributions (in the main) with which social workers had made towards their lives; underpinned by the ethos of a multi-disciplinary approach towards service delivery. Social workers acknowledged the difficulties (and barriers) which existed for some service users about being able to achieve independent living, brought about through no fault of their own, but rather:

Disadvantage or restriction of activity caused by political, economic and cultural norms of a society which takes little account of people who have impairments and thus excludes them from mainstream activity. (Oliver et al., 2012, p. 16).

6.12 Part Two: Informal Carers (citizens)

All the informal carers (like individuals) agreed to share their stories using the questions given earlier (see 6.4). There was a sense that privileged access (via ethical approval) had been granted to talk to a number of local citizens about how they lived their lives with the support of MDT and AHT members. In terms of informal carers, this was in relation to supporting either a son or daughter over a prolonged period of time, this factor being a significant feature of carers who supported someone with learning disabilities:

Families are the only people who will have a continuous relationship with a person with learning disabilities from childhood to adulthood. It is the lifelong nature of their caring commitment that singles this group out from all other carer groups. (Cooper & Ward, 2011, p. 45)

All the carers gave the impression that it was something that any parent would do given the same set of circumstances. They carried out their responsibilities with humility, as this heart-felt data extract revealed:

I really don't know what I can tell you about what I do, I'm just his mum. I've looked after him all his life. Some days I think I've got it right, but there are times when it all gets too much and I sit and cry. (Mrs. C)

Three carers discussed their experiences within the context of their son/daughter's diagnosed learning disabilities with the exception of Mr D and Mrs E. Their daughter had undiagnosed learning disabilities, and this factor had a bearing upon their responses towards her and the provision of services.

All the interviews with the informal carers took place between January-May 2012. Interestingly, the carer development worker's (social worker) presence was also requested by all carers, other than Mr B. The carer development worker explained that her presence was more to do with having a familiar face in the room during the interview, and to offer support if needed when carers were recalling their individual stories. It is also noteworthy to highlight that the carer development worker post (research participant, MDT, 9) was directly linked to allocated funds via the National Carers Strategy (NCS) – denoting its importance.

Table 21 served as a reference point about the data set and the current living arrangements at the time of the interviews (March 2012). A useful definition about the term 'carer' is presented in the NCS, 2010. However, the agency referred to in this study also adopted the same definition within their own strategic intentions:

A carer spends a significant proportion of their life providing unpaid support to family and potentially friends. This could be caring for a relative, partner, or friend who is ill, frail, disabled, or has a mental health problem or substance misuse problems. (Local Authority, 2013-16, p. 10)

Table 21: Informal Carer Participants (citizens) (n=5)

Carer (Pseudonym)	Age of Adult	Context	MDT
Mrs A	20s	Supported son living at home	Social worker & Community Nurse
Mr B	20s	Supported daughter living at home	Social workers
Mrs C	30s	Supported son who was a tenant in a supported living arrangement	Social worker & Community Nurse
*Mr D	40s	Supported daughter who was a tenant in a supported living arrangement	Social worker
*Mrs E *(married couple)	40s	Supported daughter who was a tenant in a supported living arrangement	Social worker

6.13 National Carers Strategies (NCS) and the Care Act 2014

During the Coalition government (2010-15) the refresh of the NCS: Carers at the heart of 21st century families and communities stated that:

Our vision is that by 2018 carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be available to meet individual needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen. (HM Government, 2010, p. 9)

The Coalition government took steps to improve awareness about the significant contribution that carers made, and to improve support for carers in many spheres, including government legislation. The updated document Carers Strategy: Second National Action Plan (DH, 2014-2016) introduced the importance of legislation in support of carers. Both the Children and Families Act 2014 and the Care Act 2014 have set out significant improvements for assessing and supporting carers of all ages. For example, the extension of the right to request flexible working to all employees was introduced from 30 June 2014, and will also help carers who wish to stay in paid employment alongside caring responsibilities. The Care Act 2014 bestows local authorities with responsibilities to assess carers' needs for support, where the carers appear to have such needs. This replaced aspects of the law within the Carers and Disabled Children Act 2000 which said that '*a substantial amount of care on a regular basis*' (sec.1) was necessary to qualify for an assessment. It also considered what a carer wished to achieve in their day-to-day life. A combined assessment of both the carer and the person cared for can also be undertaken, providing both parties agree to this. The outcomes from assessments would also be subjected to the current national eligibility criteria and resource allocation system operational across local authorities throughout England (ADASS, 2015).

6.14 Agency Carers Strategy (2013-16)

The agency, NHS and the CCG recognised that caring for someone can have an adverse effect upon health and financial wellbeing. The 2011 census identified that there were 23,403 carers in the locality and 6,449 provided care above 50 hours per week (Local Authority, 2013-2016). The focus of this section however, is the personal experiences of five of those carers who lived within the locality, and had cared for either their son or daughter who had learning disabilities in particular. It was also important to link their MDT experiences to the contribution of social workers in particular, alongside other MDT members – to ascertain their views about how services were provided which assisted them to continue caring.

In support of informal carers, the agency also produced an updated Carers Strategy (2013-16) and set priority areas over the next three years. The overall responsibility rests with the Health and Wellbeing Board. The responsibility for the implementation of this plan rests with the agency, NHS, CCG and the agency's local carers' strategy group. Figure 19 outlines the five priority areas:

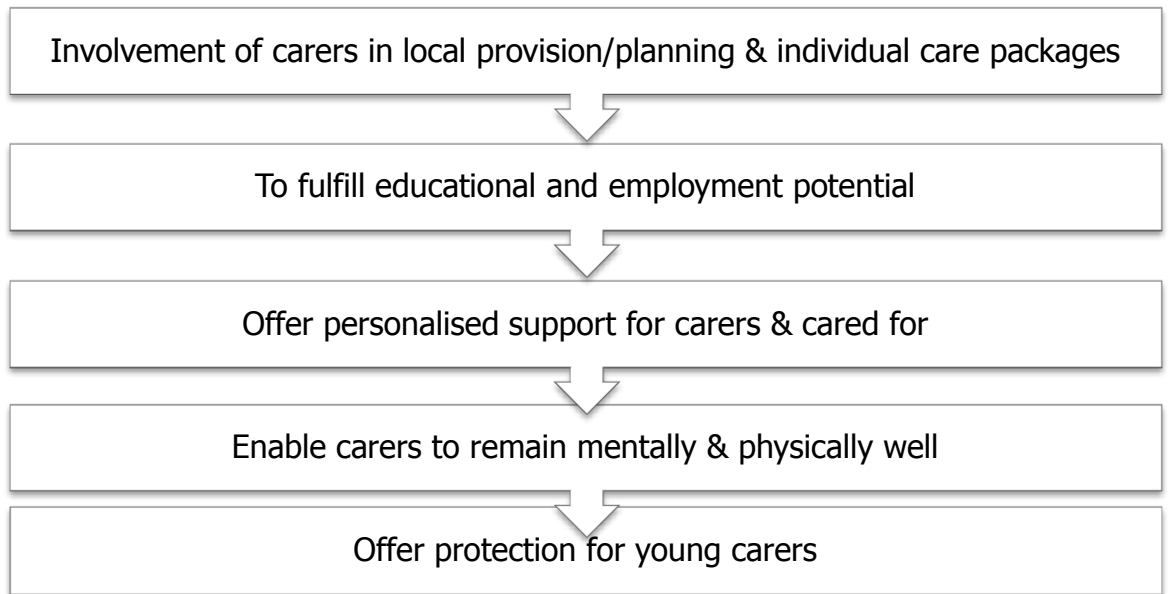


Figure 19: Priorities for Carers (2013-16)

The following carers' narratives will reveal their experiences and also illustrate whether the agency's aspirations (cited above) 'measure up' to the realities of caring responsibilities, experienced by the five carers who shared their individual stories.

6.15 Case Vignette: Mrs A's Story

Mrs A explained that her son had Williams Syndrome (WS). She further clarified that WS was a genetic condition that is present at birth and can affect anyone. It is characterised by medical problems, including cardiovascular disease, developmental delays and learning disabilities. She spent considerable time talking about the anguish which a delay in diagnosis caused to her and her husband. Her first experience of working alongside social workers was during her son's childhood through Barnardo's. She praised the social worker from the voluntary sector and said:

As soon as we had a diagnosis (aged 9) we were put in touch with a social worker from Barnardo's. She was very good when dealing with his benefits. She helped to sort all that out. We had plenty of information and advice.

Mrs A confirmed that her son had moved around a number of different schools as he couldn't settle in any school. His mother put this down to the fact he had complex health and social needs. Although he was articulate and could communicate well, he would often present as being 'on top of the world' and at times, his somewhat overbearing presence affected how people interacted with him, which often resulted in isolation. His mother and father (to a lesser extent) were often left to explain to their son that some children, young people and adults found him difficult to deal with. Mrs A confirmed that once their son had a diagnosis from the psychology service, this helped them (alongside the social worker) to decide which school would best suit his needs. Once he completed his formal education, he then attended a local college. Mrs A discussed how traumatic this was for them as a family, as change was something her son found difficult. For example, her son hardly slept and he became very anxious that he would be 'taken away' from his parents, although at this stage his living arrangements were stable, as he remained at home. Mrs A shared her concerns about how the demands around her son's behaviours took a toll on her marriage, and as such was aware that at some point in the future, their son would need to leave home. Mrs A confirmed that her experiences working alongside MDT social workers were in the main positive. She commented about the fact that they were easy to contact and offered support if needed. This was also enhanced through the services of the carer development worker, although her presence usually denoted an impending crisis which needed to be resolved. For example, Mrs A found her son's continuous 'problematic behaviours' (her description) difficult to deal

with, alongside the fact that she was aware that it also affected her own mental health – resulting in depressive episodes. She said:

I was aware that the social workers from the adult's team were part of a multi-disciplinary team. Whenever we needed help the social workers were always there to provide that help for us.

However, Mrs A did mention that at times there was an underlying tension between her and social workers. This was due to the fact they were all focused upon independence for her son, i.e. his living separately from them. She did agree to respite (but her son was reluctant) as he interpreted this as being rejected by his parents. This situation affected her relationships with social workers. Eventually she was re-allocated a community nurse instead, as she thought there would be less pressure to move her son out of the family home. Mrs A stated that the community nurse (from the MDT) was more flexible in her approach, and was also willing to look at a variety of options before suggesting her son should leave home, although her own mental health (in the form of depression) had worsened whilst trying to find a solution for her son and a 'best fit' for all the family. At the time of the conversation her son had just moved into a supported living arrangement in the locality, where he shared a house with two older women both of who did not communicate through speech. Mrs A confirmed that her son was doing 'ok' but it still wasn't the best place for him to be, due to the other residents who couldn't verbally communicate that well with him.

6.15.1 Critical Commentary

Mrs A expressed her views candidly. Obviously the diagnosis of a learning disability had helped this family acquire services. It transpired through this interview that it was

difficult to reach the diagnosis of WS – due to its relative scarcity. In addition to this, a number of best interest meetings which were linked to the Mental Capacity Act 2005 had been convened by social workers over the years regarding the future arrangements for her son. Mrs A confirmed that the meetings had affected her relationships with social workers in terms of not being fully in control of the situation, and her limited inclusion in the decision making around her son's future living arrangements. She viewed this as a 'power shift' and realised that her son was now an adult, and her parental responsibilities were minimal. She found this difficult to accept as she was very attached to him. Preston-Shoot (2003) also asserted the importance of carer involvement and perspectives about what it is that carers (and service users) want from professionals they are involved with, in order for them to feel involved in planning, decision making and part of the MDT. The rigours of caring had taken its toll upon Mrs A, and one consequence of this was her fluctuating mental health needs on occasions. Her determination to always stay in touch with her son was, however, unwavering.

6.16 Case Vignette: Mr B's Story

Mr B shared his story in a private room at a local resource centre, which his daughter attended three days per week. He explained that he and his partner had their first child (daughter) when they were 21 and 18 years respectively. He was told a few hours after her birth that she had ⁸Down's syndrome. This was their first experience of dealing with a child who was deemed 'different' due to the presence of Down's syndrome, and also their first contact with a social worker, from Barnardo's. He confirmed that he didn't

⁸ Down's syndrome is a genetic condition caused by the presence of an extra chromosome 21 in the body's cells. Down's syndrome is not a disease, and it is not a hereditary condition. It occurs by chance at conception. (Down's syndrome Association, 2015)

know anything about social workers and they immediately thought that 'they' would take their daughter away from them. He said:

My partner was fearful and she kept asking the social worker if she would take (...) off us. The social worker told us that she was here to help us and not take (...) away.

It was a pleasant surprise to them when the social worker explained her role and was enabling them to keep their daughter, with agreed support arrangements in place. He confirmed that she shared relevant information and also practical matters about feeding and sleeping routines. He was hesitant at this point, but did say that the experience of having both a health visitor and social worker involved left them feeling uneasy and 'watched' in terms of their parenting abilities. In addition to this, he hadn't realised that their daughter would be viewed as disabled by the professionals they would come into contact with in the future. By this he meant the local school, and how difficult it had been to acquire and maintain a place for their daughter in a mainstream school due to her 'difference'. He said:

We had some difficulties trying to get my daughter into mainstream school. The local headmistress wanted us to transfer her to a special school, for disabled children. We refused for quite some time, but our daughter's behaviours gradually got worse over the years –we gave in finally.

Once their daughter had settled in to her new school her behaviours, which sometimes 'challenged staff' (such as low attention to tasks and distracting other pupils through telling jokes at inappropriate times), were less apparent. She also had classroom-based

support to help her with her development and social skills. During this interview, Mr B mentioned that discrimination in his local community was rife. He said:

Kids shout things like 'mong'. I tell them not to mention that word outside my house. I tell (...) that she can't use that word either. I just don't agree with it.

Once she had reached 18 years she then attended the local resource centre through access to an MDT social worker, who undertook assessments of her needs. Mr B discussed how their daughter had aspirations for the future. She was the eldest of seven children and had experienced all of them growing up and beginning to live more independently than she did. This caused friction at home, as she didn't understand why she couldn't stay out late at nights, attend party invitations and have a boyfriend. Mr B and his partner had struggled with the idea that she was growing up and she was simply asking to do the same things as her other siblings. He said:

All the way through her adult life we never really had a social worker. They have just been in the background. We asked for a new social worker once, because we felt we needed a better service. We never got one.

His final comments were related to the fact that, whilst he realised that a social worker had helped them acquire a place within the resource centre, he didn't have much hope for his daughter's future. By this he meant leading an independent and ordinary life – she would always be dependent upon them.

6.16.1 Critical Commentary

This scenario was one of a young couple (initially) struggling to come to terms with the news about their daughter. Although support was available from both a health visitor and a social worker, Mr B confirmed that they trusted the health visitor but were always guarded about the involvement of a social worker, regardless of the reassurances given to them during their daughter's childhood. The underlying cause was the possibility of their daughter being removed and placed within foster care, should the needs of their daughter outstrip their capacity to cope with them (as stated in childcare legislation). Once their daughter had reached adulthood, different issues came to the fore. This was related to her financial benefits and how they were managed by her parents. At some point there had also been a best interest meeting (mentioned by Mr B) about their daughter's capacity to manage her welfare benefits. He gave the impression that he was willing to consider allowing his daughter to have more control over her finances, but he remained adamant that she would always need their support, regardless of her age, and whether she had the capacity to make independent decisions or not. He said:

She should be allowed to make decisions for herself, but she can't. I don't think social workers should get involved in that side of things. It's down to us as her parents. We have made decisions about (...) all her life. She still lives with us and always will.

This mind-set highlighted how there was a reluctance and lack of understanding (to a certain extent) to accept his daughter's rights and her ability to manage some aspects of her finances. At the time of the interview his daughter received weekly pocket money which indicated that she could not manage her overall benefits and entitlements. This issue was especially relevant given the remit of the Mental Capacity Act 2005 and the

proactive approach towards capacity, but with associated risks. A best interest meeting may have encouraged their daughter to learn about responsibilities in the longer term, enabling her to become more independent albeit within the home environment.

6.17 Case Vignette: Mrs C's Story

Mrs C explained that the first time she came into contact with social workers was through the Royal School for the Deaf. That was when her son was around 11 years-old; he was diagnosed with Autism at that time. She said:

This is because his behaviour is like it is. Nothing was said about Autism. In the early days nobody could come up with a diagnosis. I used to think about other people's reactions to me trying to manage his bizarre behaviours. On one occasion he tried to build a giant tent inside our home.

Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. Autism includes a spectrum of conditions, which means that, while all people share certain difficulties, their condition will affect them in different ways. Some people with Autism are able to live relatively independent lives, but others may have accompanying learning disabilities and need a lifetime of specialist support. People with Autism may also experience over or under-sensitivity to sounds, touch, tastes, smells, light or colours (Autistica, 2015).

Mrs C explained that she had always been wary about working with social workers, in particular. This was related to how her son displayed complex behavioural traits (such as being violent towards her on occasions) when faced with unexpected changes in his life.

His unpredictable behaviours (and Mrs C's safety) could have influenced decisions made by social workers as to whether her son remained living at home with his mother, and with access to the local community. A social worker from the MDT did suggest that her son tried a few days respite at a different location, but still within the same locality. Mrs C recalled that this experience was a disaster, as he was placed with other people who had learning disabilities and therefore his needs were not particularly catered for, although he had Autism. There were problems with providing enough staff, and no-one spent enough time with her son, and explained what would be happening to him, whilst in respite. Mrs C continued to worry about the effects upon her son and also other people he would come into contact with whilst trying this out. In short, this wasn't a break for Mrs C but rather added to the stress of not knowing what was happening to her son whilst away from home. Over time her son's behaviours gradually deteriorated, and he was removed from home through the use of Mental Health Act 2007 legislation. He was placed in an assessment and treatment unit for a period of seven months. Whilst this was a traumatic experience both for her and also for her son, she knew that he would receive an appropriate assessment of his needs. Mrs C explained that she felt better dealing with medical staff (psychiatrist) and learning disabilities nurses who had some knowledge and understanding of her son's difficulties. Up to this point she had felt that social workers couldn't offer her the support she needed, and therefore she had no recognition of their value, with the exception of the carer's development worker. Mrs C explained that she had grown to trust her as she was a source of support and had also encouraged her to attend a local support group for carers. Mrs C confirmed that she had 'blossomed' since joining the group and she discussed how she had access to both support and relevant information about Autism. Her son spent thirteen years being 'looked after' separately by the National Autistic Society (in a different locality) but by

the time he was 40 years old he was offered a more localised supported living arrangement by a social worker from the MDT. She said:

There was a transition period from November until April. It was excellent. It was a planned number of visits, and he could visit the house and get to know staff and other people living there. It's an ordinary house and he's happy. I have plenty of contact and I can bob in anytime.

6.17.1 Critical Commentary

This was a moving narrative given the fact that Mrs C had expected to care for her son all his life. It wasn't until life became almost impossible for both of them (for different reasons) that she sought help, mainly from the voluntary agencies. It is also a reminder of the fact that Autism (a developmental disorder) was not well understood during the early 1970s or researched by medical professionals, allied health and social care professionals. During the 1990s there was recognition that a person diagnosed with Autism would exhibit particular characteristics (NHS Choices, 2016). Examples include, showing resistance to being touched, little eye contact and difficulties understanding the rules of conversation. The Autism Act 2009 has signified the importance of Autism. It did two things: the first was to put a duty on the government to produce a strategy for adults with Autism, which was published in March 2010; the second was a duty on the government to produce (by the end of 2010) statutory guidance for local councils and local health bodies on implementing the adult Autism strategy (National Autistic Society, 2015). Another important point within this narrative was the fact that funding arrangements for the support of their son became a major issue for Mr and Mrs C. Sadly, Mr C died suddenly during the midst of negotiations with the agency regarding longer term funding arrangements for their son. It wasn't until he became a mature man in his

40s that a different supported living arrangement could be offered. This was due to the changes in the welfare benefit system and improved local resources in terms of suitable housing provision within the locality. As Lawrence & Brook (2015) state about this agency:

Originally service users had been placed 'out of county' (30 years ago) due to the lack of resources to accommodate them within the local authority boundary. Since that time the local authority adopted a strategy concerning local citizenship. This meant that local people who had intellectual disabilities should be given the opportunity to remain in the area in which they were born, and services planned to meet their needs in an appropriate way. (Lawrence & Brook, 2015 p. 36)

6.18 Mr D and Mrs E's Story

Mr D and Mrs E explained that their daughter had undiagnosed learning disabilities, although they were both of the opinion that the cause had been related to a childhood vaccine. They had challenged their local doctor who administered the vaccine, but had had little success in proving a case for negligence. They explained that it happened when their daughter was between eighteen months and two years old. They shared their experiences about their personal hardship and heartbreak knowing that, although she had been born a healthy baby, their daughter would have a permanent disability. They had another son two years older, who went on to become a manager in the 'business world', and were proud of the fact that one of their children could live a lifestyle not encumbered by health and social care professionals. During the early days, they explained how they were left to cope and didn't get any help or advice from social workers. The only contact available was their health visitor, alongside a community nurse, but not a nurse whose field of practice was learning disabilities. Mrs E said:

In the beginning we didn't have a lot of time to deal with social workers. We had to liaise with the hospital all the time, because our daughter had continual epileptic seizures. When she was small we had a social worker from Barnardo's.

Mr D also explained how he always adapted his working life and commitments to his job, as he knew that his wife was struggling to cope with the demands of a daughter whose behaviours were difficult to predict. She had no speech and only used utterances to communicate. His limitations around his working life had also had an impact upon his advancement, and therefore offers of promotion always seemed out of his reach. This was a major disappointment to him, as this also meant that finances would always be tough. His wife did not work outside the home. However, they were also proud of the fact that they had adapted their home to accommodate their daughter in the longer term. Initially they had no desire to let her live elsewhere in the locality.

Mrs E confirmed that, whilst their daughter was growing up, most of their support came from the local school. They did have an educational statement about their daughter's profound health and social care needs, and a social worker from Barnardo's was also involved, but this had come through school rather than a personal request from them to a local authority. Mrs E said:

I was nervous about a social worker coming I mean what do they do? I didn't have a clue about what to expect. There wasn't any information about social workers back then.

Mr D also discussed how relieved they were to discover that the social worker was there to help them and especially their daughter. They had access to respite services which

helped to alleviate some of the responsibilities associated with their daughter. During their daughter's adulthood she spent most of her time living at home, her mother venturing out occasionally with her, but she found this stressful especially as her daughter was a strong and robust woman who could be demanding in her own right. Their daughter did access day services during the week, which gave them a break, and she could meet different people there. Eventually their daughter's complex needs overwhelmed the couple and they therefore asked for residential support, although they did utilise respite services. They explained that a social worker from the MDT had visited them to discuss potential options for the future. They agreed for their daughter to move into a specially adapted bungalow in the locality, with relevant support staff in place. As a couple they appreciated the involvement of an MDT member, and had information about how their daughter would be introduced to her new living arrangements over a period of time. Mr D said:

We couldn't have coped without social workers, although we have disagreed with them in the *past. During the transition stage, the social worker was great and followed it through.

*He was referring to the paucity of allocated respite they were given during the years their daughter lived at home with them.

6.18.1 Critical Commentary

This couple had tried over the years to establish how their daughter had acquired learning disabilities (such as neurological complexities) and the possible effects of a vaccine, but without success. During her adult years (40+) she was living in a supported bungalow with relevant staff. However, it also transpired that the couple were unhappy about how their daughter was dressed when they visited her. This was in relation to the

fact that she had always been dressed in traditional clothes, such as plaid skirts and jumpers. When she moved however, her dress sense took on a new look. For example, they explained that during some visits their daughter would be dressed in leggings and short cropped tops – showing a bare midriff. Mrs E said:

When she moved into the bungalow from home she had a person centred plan, but it was rubbish. I sat down with a member of staff and aired my views about her clothes, but it didn't go down well.

According to the carer development worker, staff had explained that their daughter could exert a choice about the clothes she wore on a daily basis. It was related to the Mental Capacity Act 2005 and a personalised approach. Mrs E was very unhappy about the fact she felt her daughter dressed inappropriately for her age. This type of scenario is not uncommon when parents, who have cared for someone over extensive periods of time, have no further control over their daily lives, once they move elsewhere. The carer development worker had spent intensive periods of time with Mrs E in particular, talking through issues about her daughter's care. Mrs E also continued to grieve about the fact she had 'lost' her healthy daughter, and she could no longer care for her disabled daughter within the home environment.

6.19 Consultation Events

As mentioned earlier in this chapter (see 6.2) listening to the citizens' voice is now considered a priority for local authorities in England, such as the agency consulted within this study. This agency, therefore, responded through the creation of a consultation structure, although a commonly agreed definition of what is meant by involvement and participation remains elusive (Roulstone et al., 2006). It has attempted to approach

citizen involvement from a number of perspectives to incorporate as many different viewpoints as possible. The outcomes of which inform strategic planning networks and important documents like the updated Carers Strategy (2013-2016). By way of explanation Figure 20 outlined an example of how this agency had undertaken engagement activities with local citizens.



Figure 20: An example of an Engagement Structure

The ethos of engagement was aligned to the importance of effective service delivery for local people. Feedback was encouraged about personal experiences of the services being delivered across the locality. The underpinning drive was to meet outstanding needs based upon shaping outcomes that citizens needed – in this instance, outcomes from the learning disabilities service.

6.20 Informal Carers Contributions

All the carers' narratives presented complex situations about the nature of their children's learning disabilities. In addition to this, they discussed the necessary support

arrangements required in order to help their children maintain the ethos of independent living within a community setting. Carers commented frequently that the ability to achieve positive outcomes for their child was facilitated (in the main) by a contribution from social workers, based within the MDT.

Some tangible examples given by the carers included; supporting Mrs A over long periods of time to enable her son to access an independent living arrangement. She commented that she had found social workers easy to contact and that they offered both information and support to her in terms of the provision of respite services. Mr B commented on the value of social work interventions that were linked to an assessment and risk assessment of his daughter's needs. Both Mrs C and Mr/s E also found social workers' contributions invaluable; this contribution was in relation to the transitional arrangements (towards independent living) made on behalf of their adult children.

However, all the carers expressed concern about how the nature of their initial relationships with social workers (built upon trust) could easily change between them and social workers, due to the process of undertaking best interest meetings, (on behalf of their adult children) - a process which is enshrined within the Mental Capacity Act 2005.

Mrs A explained that the change was driven by a 'power shift' over who had the responsibility for her son. Likewise, Mr B was of the opinion that he and his partner were best placed to enable their daughter to access her financial resources and not social workers. Carers also mentioned the paucity of appropriate services. In some cases, services were not sophisticated enough to provide care for their son's/daughter's

complex learning disabilities, resulting in carers having to struggle to provide care and support with limited respite offered to them.

The carers' contributions in this study have highlighted that their experiences had been associated with what they needed at any particular time. It was important therefore, that a social worker from the MDT could respond accordingly, albeit within limitations defined by available service provision. Only one carer mentioned that she had additional support from a local carers' group. None of the carers mentioned their participation within any of the consultation and engagement events or about receiving newsletters. However, the presence of the carer's development worker, (social worker) (see 5.7.3.) made an important contribution, in terms of alleviating some carers (Mrs A/C, and Mr/s D/E) of high levels of personal stress. This factor could have mitigated against the need to attend external meetings, due to the individualised support offered to these specific carers on a regular basis.

6.21 Conclusion

The main focus of this chapter was to ascertain the citizens' voices about their experiences (in the main) of working alongside a social worker based within the MDT. The findings from all the narratives revealed that social workers had made significant contributions by providing support and services at specific times within citizens' lives. These findings were also supported by the findings presented in chapter five (see 5.6.1), in terms of revealing that social workers had a person centred approach towards individuals, underpinned by a collaborative approach to service delivery. Social workers had made a contribution by undertaking a variety of roles and tasks. These included undertaking home visits, completing personalised assessments, creating care plans, arranging personal budgets, negotiating with other agencies (housing and health) and

supporting individuals during difficult times judged to be high risk situations. These scenarios were also supported through the provision of best interest meetings on behalf of some individuals trying to manage in difficult circumstances. The presence of the carer development worker was also paramount in terms of supporting carers. This point was raised in chapter five (see 5.7.3) about the importance of carers being able to contact the relevant social worker, should they need a response to family crisis situations.

All the individuals viewed themselves as citizens within their own communities, despite the resource limitations surrounding their lifestyles. They had aspirations to live fulfilling lives supported by family members, people they trusted and professionals from the MDT and AHT which included social workers. They wished to pursue their own interests, in some cases have a job and maintain a caring role alongside this. Social workers as members of the MDT were a part of their complex networks of support. They offered significant contributions, through the provision of a variety of professional services underpinned by a personalised approach at important junctures in people's lives.

CHAPTER 7

Discussion

7.1 Introduction

This chapter will demonstrate an understanding of the implications of what has been discovered in terms of the contribution of social work, and therefore social workers, based within an adults' learning disabilities service. In addition to this, the chapter will highlight associated features between this study and those from published research cited in chapter two about the contribution of social work within a MDT context.

It will include the most important emergent themes from the findings. Each of the themes will be discussed individually and in more detail, to illustrate the important points being made. The emergent themes consist of: the contribution of social work; the contribution of nursing (LD); the legal mandate and social work; health and social care integration.

In addition to this, and as mentioned in chapter three (see 3.10), I will provide a reflective analysis about the theoretical framework selected for this study: Communities of Practice (CoP). This social learning theory was originally selected as an appropriate theoretical lens through which to analyse the complex activities of multi-disciplinary team working.

The influences and significance of the policy documents Valuing People (2001) and Valuing People Now (2009) will be discussed, taking into consideration how they influenced the creation and further developments of the learning disabilities service as a whole, which also influenced the direction of professional social work practice within this context. Their continued relevance to both professionals and local citizens will also be

commented upon. Finally, the conclusion will illustrate the contribution to knowledge made by this study.

7.2 The Contribution of Social Work

Despite everything that happens around it social work will always begin and end with a human encounter between two or more people and this encounter, or relationship as it develops, is the medium through which the social work task is carried out. (Ruch et al., 2010, p. 140)

This quotation epitomises the central core value of social work underpinned by an unwavering commitment to advocate on behalf of the vulnerable. In this case it applied to adults who have learning disabilities. What was truly significant about the findings from this study was that all the social workers (n=9) had the sustained belief that '*no matter what*' they would continue to embrace the social model of disability and always support those who, through no fault of their own, deserved a better life. As two social work participants said:

I'm happy with the fact that I've got a social work approach to people's situations and I hang onto that. In fact, all the social workers look for different ways in which to work with people and maybe come from a different perspective from our health colleagues. What is really hard in this climate is the effect of poverty on people who already have disabilities. It really gets to me sometimes. (MDT, 6)

When I was in practice we all built our hopes up about trying to get the types of services which most of our people needed – you know something individual to suit them. It wasn't always about complex health and social care, sometimes people

are just vulnerable and don't fit with what we have. I often worried about them and hoped they would be ok. (MDT, 3)

I would argue that data extracts such as these and underpinned by the in-depth presentation of the findings in chapters five and six, exemplify how this study has answered the original research question:

What is the contribution of social work within a multi-disciplinary team?

This study has confirmed that the contribution of social workers located within the MDT was influenced by the fact they could provide a clear view about their specific roles, which facilitated their overall contribution towards multi-disciplinary working. For example, the roles undertaken by the social work participants (n=9) were undertaken at various organisational levels across the learning disabilities service. This was inclusive of roles such as senior managers, (n=2) team manager, advanced practitioner, development workers (n=2) and those social workers who undertook a care co-ordination role (n=3). An important finding was the fact that AHT participants demonstrated their respect for the role of care co-ordination undertaken by some social workers. The roles occupied by social workers who were positioned in senior management roles, were able to contribute towards the organisational structure of the learning disabilities service, and thereby, created the central importance of the care co-ordination role undertaken by social work practitioners based within the MDT. This was further supported by AHT participants who shared specific examples about social workers and their professional commitment towards individuals. For example, and as discussed in chapter five (see 5.3.1), the findings revealed that an AHT participant discussed how social workers had the ability to 'go the extra mile' due to their

responsibilities towards local citizens. This was related to the importance of both personal and professional social work values, as highlighted in chapter five (see 5.3.5).

The findings from AHT participants demonstrated that they appreciated the presence of social workers and their abilities to manage complex individual and family issues on a regular basis. I would argue that one of the undeniable core values (and distinctiveness) about social work is the presence of a human rights based approach to professional practice. This view was also explored by research undertaken by Ashencaen Crabtree & Parker (2014). They discussed the importance of human rights and how this could be translated into social work practice. They shared ideas with social and community development workers, members of the Malaysian Association of Social Workers and non-governmental organisations. The discussion was underpinned by the definition of social work espoused by the International Federation of Social Workers (IFSW), as cited in chapter one (see 1.3) although it was acknowledged that diverse cultural perspectives would bring different interpretations to its meaning. However, they proposed that social workers adopt a human rights approach by:

- meeting and balancing needs, risks and human rights in everyday practice
- undertaking professional social work tasks with individuals, families and groups by helping people achieve change and undertake a social analysis of their current status
- operating as social catalysts to encourage the process of change via building trust and social relationships with the people they work with. (Ashencaen Crabtree & Parker, 2014, p. 20)

I would also support these ideas and those of Ife (2012), in terms of the view that social

work is a moral activity, taking into account a human rights perspective. Ife (2012) argued that social work and linked decision making is based upon conceptions of right and wrong:

Social workers have to make difficult moral judgements which are framed in terms of 'ethics' or 'values' which require moral reasoning. Therefore social workers need the capacity to engage with difficult dilemmas, moral arguments and make moral decisions. (Ife, 2012, p. 217)

Some examples from this study included social workers dealing with vulnerable adults who needed the right type of accommodation and lifestyle to meet their complex needs. This has been highlighted in chapter six through the narratives of Brian and Cathy (see 6.8 and 6.9). All the social workers involved had to balance their rights, and need for suitable accommodation, at the same time, enabling them to sustain their physical and mental health well-being. Alongside this, they had to ensure that the vulnerable adults had support in their daily lives.

Unsurprisingly, the presence of a human rights based approach was compromised as the social workers were employed by the government, albeit within a statutory local agency context. For example, they discussed their views openly about their beliefs in basic human rights which are also enshrined within the social model of disability – a civil rights based approach to disability, developed by disabled people in the 1970s and 1980s (Disability Rights UK, 2015). One social work participant said:

When I'm working with someone who needs my support, I want the best service I can get for them. I listen to their stories all the time, about how some people have

mistreated them, and it can be a family member. I have to be able to make fair decisions about the best way forward. You know, weigh up the situation and refer to agency guidelines and legislation. (MDT, 7)

In this instance the social worker was referring to the possibility of financial abuse within the family home. Whilst the service user was very attached to his parents, it transpired that his financial benefits were being used to fund his parent's holidays, without his permission. The social worker explained that his parents viewed this as their 'right' due to caring for him and his needs over a 24 hour period, and respite facilities being in short supply.

That said, however, and although the contribution (and therefore positioning) of social workers was recognised and appreciated by AHT members, the most unexpected and disappointing finding from this research study was the lack of parity about salaries. As discussed in chapter five (see 5.2.1) social workers were the lowest paid professionals. Since the concern about salary disparities had been an important issue for social workers (care co-ordinators), I arranged a meeting with one of the original gatekeepers (BB), a senior manager, in August 2015 to discuss the question of pay differentials as part of a process of sharing the implications of the findings from the study. This discussion revealed that a pay grading review had been undertaken, which benefitted experienced social workers. The review included a clear developmental framework which had been put in place since the original interviews were undertaken during 2011. This meant that the levels of responsibilities between care co-ordinators were clearly identified, as were the expectations about the match between community nursing responsibilities and those of social workers. Thus, community nurses were now expected to engage with leadership activities alongside experienced social workers. This included responsibilities

for the provision of students, staff supervision for less experienced professionals, managing a patch (a geographical area in the locality) and the co-ordination of the safeguarding arrangements on behalf of the learning disabilities service.

However, the findings highlighted a number of tensions that existed between the different disciplines. These were mainly concerned with differentials in status between MDT and AHT participants, salaries, and some difficulties between social workers and working relationships with GPs, sharing information between disciplines and not least the variations between disciplines in their approaches towards undertaking assessments and subsequent intervention plans. This was also highlighted by an allied health participant (AHT, 11) in chapter five (see 5.6.4). She acknowledged the importance of multi-disciplinary working and how useful it was getting professionals together to discuss the best way forward in specific scenarios. She did, however, point out that not everyone would agree with either the approach taken or how the subsequent interventions would be carried out with individuals and families. She said:

Not everyone walks away from the table happy. (AHT, 11)

Conversely, being able to measure the effectiveness of social work was more difficult to define, as this was dependent upon the variables within each individual context. Moriarty & Manthorpe (2016) discussed the difficulties associated with the term 'effectiveness' in relation to social work which stemmed from a broad spectrum of social work activities; ranging from *'assessment to providing information, advocacy, counselling and co-ordinating support, in reality each cannot be divided into single components that can be individually measured'* (Moriarty & Manthorpe 2016 p. 12). The main conclusive findings which emerged from this study were the fact that social workers had made contributions

through various ways, which led onto positive outcomes for citizens. By way of example, this was highlighted in chapter six (see 6.17) when Mr D and Mrs E realised that they needed the support of a social worker to co-ordinate the transitional arrangements for their daughter. Their daughter moved during her 40s from her parental home into a supported living arrangement. Apart from the organisational and financial arrangements which had been made on her behalf, the carer development worker (social worker) had also spent quality time with Mrs E in particular. As discussed in chapter six (see 6.17) this related to the fact that Mrs E continued to grieve about the loss of a healthy daughter and it was further compounded by her daughter's move into an adapted bungalow. All the narratives revealed some aspect(s) about the contribution of social work support and interventions located within the MDT. Although Amy's story cited in chapter six (see 6.7) did suggest that either she had not been informed about the role or did not understand what the social worker was trying to do on her behalf.

7.3 Associated Features and the Published Research

The literature review (chapter two) identified the most important issues to be addressed in Table 4 (2.9). The pertinent issues were drawn together so that the most significant debates about multi-disciplinary working were highlighted. The issues also provided an original framework from which to initiate this research study. As also mentioned in chapter two, (see 2.6.5) Herod and Lymbery (2002) undertook a small scale (n=8) single case study approach to explore the distinctive contribution of social work within a MDT setting. The initial intention of this research study, therefore, was to build upon their findings and add new knowledge to the literature about the contribution of social work within a MDT context. Consequently, I would argue that this intention has been achieved; supported by the research design and the in-depth presentations of the

findings throughout chapters four, five and six.

This study had some associated features with published research already cited in chapter two about the contribution of social work within a MDT context. For example, AHT participants commented about the sense of 'added value' which the presence of social work brings to the MDT context and, in so doing, promoted the notion of collaboration between different professionals. This feature was also argued by Frost et al., (2005), which is a cited research study within the literature review (see 2.5). They stated:

Social work is the joined up profession, a profession that seeks to liaise, to mediate, and to negotiate between professions. (Frost et al., 2005, p. 193)

Barrett et al., (2005) revealed that good team-working between different staff groups improved the communications between them. This factor was also prevalent in this study, as both MDT and AHT participants discussed at length how they appreciated being co-located and within close proximity, factors which enhanced the sense of co-operation and effectiveness for their own benefit and for local citizens. As one AHT participant said:

We try to work towards the best outcomes possible for people with learning disabilities, and in order to do this we need other professionals to help us. This is often a social worker and/or a nurse based in the MDT. (AHT, 10)

Heenan & Birrell (2006; 2009) discussed the importance of localised practices between allied health and social work colleagues based in Northern Ireland. They reported how this factor offered more control for the professional teams involved. Local citizens also

benefited by visiting a one-stop service which reduced the amount of different professionals involved in their lives. These aspects of MDT working echoed this research study's findings through the care-co-ordination role adopted by some social workers and community nurses (n=5).

One final comment of note was the use of hierarchies and how they influenced the participants within this study. In chapter three, (see 3.4) the issue for potential bias was raised due to status differentials between some colleagues who participated. One surprising finding from the research was that some participants presented as 'knowing their place' and thus helped them to make a contribution within a specific framework of responsibilities. This point was also discussed in Kharicha et al.'s (2005) research cited in chapter two (see 2.4.3) in terms of how a known and established hierarchy can facilitate good practice between professionals rather than hinder it. Interestingly, social work and nursing participants in this study were able to call upon their immediate line managers to facilitate any foreseen difficulties between them and AHT colleagues and/or other agencies. For example one social work participant stated:

I'm really glad that I can ask my manager to intervene if I'm having real difficulties. Sometimes you have to wait ages for someone to complete another assessment and I can't move forward until it's done. It's me that has to deal with irate families, when they don't see much action. (MDT, 6)

7.4 The Contribution of Nursing (LD)

The main intention of this research study was to focus upon social work, its contribution and therefore the role(s) undertaken by social workers within a MDT. However, a surprising outcome from the findings revealed that LD nurses (n=3) also made a

significant contribution within a MDT context. Their contributions have therefore been included as a complementary point of reference to that of social workers who undertook the care co-ordination role.

For example, one (social work) team manager (MDT, 3) highlighted in chapter five (see 5.4.2) that community nurses had a good reputation across the service, due to the fact they were known for getting things done. She further commented about how they were also able to work collaboratively across a network of people (such as GPs) and agencies, on behalf of people with learning disabilities. The role of the LD nurse was recognised within a recently updated UK publication (Strengthening the Commitment) issued through the SG during (2015). The report stated:

LD nurses needed to meet the challenge of making sure that people with learning disabilities across the UK had the high quality support from learning disability nurses that they deserved, needed and were entitled to in modern 21st century health and social care services. (SG, 2015, p. 10)

This was linked to the population of people with learning disabilities increasing in the UK. Demographic projections suggest that the numbers of people with learning disabilities will increase by 14 per-cent by 2021. There was a concern that the learning disabilities workforce had decreased in recent years whilst there has been an increase in the amount of people with learning disabilities. The report stated that:

Strengthening the commitment recognised that the role and profile of learning disability nursing had changed significantly over the previous three decades and that the workforce had become widely distributed across the health and social care sector. (SG, 2015, p. 11)

This factor was also highlighted in chapter five (see 5.2.1) and discussed at length by a senior manager (MDT, 1) who believed that the traditional role of the LD community nurse was out-dated. This was related to the original role associated with an LD nurse; a role which focused upon health needs primarily. Given the fact that the service was underpinned by the social model of disability, a predominantly health focused approach towards individuals would therefore have offered limitations within a holistic framework of assessments. Furthermore, if the contribution of the community nurse was to survive, it would need to adapt. By this, the senior manager implied that they would need to undertake the same role as some social workers: that of care co-ordination. The Scottish government also stated that:

Effective strong leadership was highlighted as being essential to ensuring that networks for learning disability nurses across the UK provide a powerful platform from which to celebrate, promote and develop their unique contribution. (SG, 2015, p. 39)

A team manager (MDT, 12) who was also a LD community nurse was aware of the fact that clinical supervision was not provided for LD nurses who undertook the care co-ordination role – an issue discussed in chapter five (see 5.3.3). However, the clear messages included in the report recommendations stated that regular structured clinical supervision with access to trained supervisors should be available:

Services should provide systems to ensure that learning disabilities nurses have access to regular and effective clinical supervision and that its impact is monitored and evaluated on a regular basis. (SG, 2015, p. 24)

An important finding was the way in which they worked in collaboration with local GPs.

This was highlighted in chapter five, (see 5.9.1) wherein the notion of information sharing across disciplines was discussed. One community nurse mentioned that it was relatively easy for her to acquire the information she needed. This factor was, however, in almost direct contrast to those care co-ordinators who were social workers. MDT members mentioned that this issue was mitigated to some extent through the collaborative nature of the work, and LD nurses contributed towards an information exchange between all parties. This finding was also echoed in Kharicha et al.'s study (2005) cited in chapter two (see 2.4.3) in terms of community nurses acting as intermediaries between social workers and GPs.

One final comment is the noted prominence associated with the provision of clinical supervision for LD nurses. It would seem pertinent to ensure therefore, that easier access to clinical supervision could be facilitated on their behalf, given the expectations from the agency and its remit to deliver effective co-ordinated services on behalf of local citizens.

7.5 The Legal Mandate and Social Work

A significant emergent theme was how the legal remit influenced the social workers (n=9) and their contributions within this study. All the social workers recognised the importance of the law and how the legal context in which they operated affected their responsibilities and role(s) carried out with and on behalf of local citizens they supported. In particular, the relevant legislation in this study included the Human Rights Act 1998, Data Protection Act 1998, Mental Capacity Act 2005, Care Act 2014 and to a lesser extent the Mental Health Act 2007. The relevance of the Children Act 2004 and Children and Families Act 2014 has been addressed in chapters two and five respectively, which focused upon the expectations for 'joined-up working' and the need

for collaborative practice between professionals during young peoples' transitional periods.

The majority of social workers (as in this study) are employed by publicly accountable agencies and as discussed in chapters five and six, social workers provided services to people and intervened when necessary in order to protect vulnerable adults either from themselves and/or others. Social workers are guided to a greater extent through the use and framework of the law, although it is recognised that the law has limitations. It can also provide the overarching guiding principles of a service (as was the case in this study), but it cannot address some of the complex issues associated with decision-making and therefore compensate for effective professional practice. This agency had recognised the need to provide this service via trained Best Interest Assessors (BIA), unlike some agencies in England, who have found the recruitment of experienced social workers to undertake this role difficult to recruit (Romeo, 2016).

The learning disabilities service was also underpinned by the framework of the law and has been highlighted on several occasions throughout this thesis. For example, one senior manager (MDT, 1) commented about the impact and influences that the legislation had had upon the creation of the learning disabilities service. The major influence in this instance was linked to the pooling of budgets and the introduction of the Health Act 1999, which intended to remove initial barriers to joint working as mentioned in chapter five (see 5.8.1) and the creation of PCTs. To strengthen integration initiatives further (as mentioned), the Better Care Fund (2013) allocated specific budget allocations in England to drive the transformation of local services supported through the Care Act 2014 legislation, in terms of the legal mandate which directs local authorities to work in collaboration with other public bodies such as CCGs and NHS England.

One important difference within the Care Act 2014 is the introduction of a national minimum threshold for social care, rather than eligibility being set by local councils (McNicoll, 2014). Most local authorities currently restrict care to people with at least substantial needs, although application of the threshold varies locally. This factor would have an effect on the agency in this study, MDT and AHT members and the citizens they supported who needed and used services. For example, the agency through its MDT and AHT colleagues has a duty to carry out a needs assessment based upon the national threshold and consider an adult's financial resources to support their social care needs. In addition to this, the adult's wishes, and how they might be met must be taken into consideration. This approach is obviously one of enablement which is inclusive of the wishes of the individual in the first instance. Richard Hawkes (2015) chair of the charity Coalition of Care and Support Providers, said that the threshold had been set too high and argued that:

The only long-term solution to the crisis in social care was an increase in funding. The Care Act will only live up to its promise of a genuinely preventative system that promotes wellbeing, if the government re-thinks its plans to exclude so many older and disabled people from the system. (Hawkes, 2015, p. 2)

Additional funding from central government to help local authorities carry out the expectations of the new legislation has not been forthcoming. Indeed the care cap costs in England were to be limited to £72000 for the over 65s and younger adults with disabilities. In July 2015 the Local Government Association called for the reforms to be delayed until 2020 and the resulting savings of £6 billion put into the social care system. As yet the government has not confirmed if the initial savings have been injected into the social care system (McNicoll, 2014). As already considered in this thesis, and

especially throughout chapter five, both MDT and AHT participants discussed the effects that austerity measures had had upon their professional practice, and, not least, their integrity towards acting in the best interests of local citizens who needed both protection of their rights and the provision of suitable services.

The Mental Capacity Act 2005 was adhered to in a number of scenarios about local citizens who participated within the study. The findings highlighted that the law had assisted social workers to support vulnerable adults (and carers) to make decisions which were in their 'best interests'. There is no single definition of what best interest means (Bogg & Chamberlain, 2015). But what emerged from the narratives shared throughout chapter six was that social workers had made considerations such as identifying all the relevant circumstances, finding out peoples' views and facilitating consultations between relevant parties. Best interests can apply to personal welfare and/or financial decisions. As cited in chapter six (see 6.14) Mrs A discussed how social workers had instigated best interest meetings on behalf of herself and also her son. Mrs A's story illustrated that she cared for her son, and the effects of trying to care for him in the family home (due to his complex needs) had resulted in her experiencing depressive episodes, a situation which exacerbated their vulnerabilities from different perspectives. In another example, Mr B explained that his daughter's financial arrangements were his and his partner's responsibility, rather than permitting their daughter to learn how to manage her welfare benefits more independently. In other words, her benefits became part of the family's financial pot of income. This scenario left their daughter (and to some extent the parents) in a vulnerable position, as legitimate questions could have been asked by social workers about their daughter's income and how it was utilised on her behalf.

All of the narratives discussed in chapter six indicated that the primary contribution of social work was its place within the statutory framework, which ultimately guides professional practice. Brayne & Carr (2014) also argued that this should be the starting point of any relationship with local citizens who need and use services. I would also agree with this position, and the fact that it is most important to be honest with citizens during the early stages of a relationship about the statutory powers invested in the role of social workers, whose remit could at some point in the future affect the nature of it. For example, the position of the social worker may shift from the role of supportive and friendly advisor to that of being an authoritative user of relevant law in order to protect the vulnerable. Thus, a relationship becomes more difficult to maintain from different perspectives, between the professional and the citizen.

7.6 Health and Social Care Integration

An important theme revealed that social workers (and other professionals) continued to work within a difficult financial climate which was underpinned by complex structural arrangements, primarily between health and social care. These themes also concur with some of the published literature presented in chapter two, the literature review. Thus, Cameron et al., (2012) argued that a pre-requisite for successful integrated service provision is securing the understanding and commitment of staff to the aims of the desired outcomes of new partnerships. For example, a number of MDT and AHT participants commented in chapter five (see 5.2.1) about how localised patch meetings held between all professionals helped to address any issues which affected teams. Some of the issues mentioned included collaborative working practices between them, keeping up with workload demands and referrals for services and, not least, maintaining a dialogue with senior managers about resources and the provision of services. Carpenter (2003) (see 2.6.2) also discussed the presence of social workers within specialist

services such as community-based care was to promote integrated mental health care, although the ability to achieve this varied considerably between teams. Kharicha et al.'s (2005) findings (see 2.4.3) exposed the weaknesses between social workers and their working relationships with GPs based within older people's services. This was mainly due to the lack of clarity about each other's roles, responsibilities and different organisational structures. Glasby & Miller (2015) undertook a scoping review across older people's services in England. This was due to English health systems which have abolished managerially led PCTs and replaced them with CCGs. This in effect has given more responsibilities to groups of GPs. Their findings of only nine studies reiterated the fact that they tended to rely upon 'lessons learnt' from the 1990s and 2000s – which also included Kharicha's study. Glasby & Miller (2015) commented that the outcomes from the scoping review highlighted that there were continued difficulties between different professional groups, such as social workers and GPs. Their comments included, '*there was a strong sense of relationships starting from a low base*' (Glasby & Miller, 2015, p. 42).

Nevertheless, in terms of why integration is needed; the prevailing factors remain: to address the rising demand for services and to reduce public expenditure throughout the UK. These factors are supported by the DH and the Department for Communities and Local Government who announced in June 2013 the Better Care Fund (Better Care Taskforce, 2013) (BCT). The ethos of the fund is to '*drive the transformation of local services to ensure that people receive better and more integrated care and support*' (BCT, 2013 p.1.1). The fund consisted of £3.8 billion which was deployed through pooled budget arrangements between local authorities and CCGs in England, it began in March 2015. The guidance makes it clear that the Better Care Fund '*entailed a substantial shift of activity and resource from hospitals to the community*' (BCT, 2013 p.5.1). As mentioned in the literature review, (see 2.4) the NHS Plan: Five Year Forward

View (2014) sets out a case for upfront investment in the NHS to transform it into a service which reaches people in their home and communities with early, effective interventions. It is widely accepted that this will only succeed where social care makes the same transformation (SCIE, 2017). Social care (inclusive of social work) has a track record of transforming services, such as delivering personal budgets, asset-based approaches and co-production. Both systems share similar goals. However, BASW (2016) maintains its argument purporting that social work and therefore social work practice, is best placed to work in partnership with allied health colleagues, resisting the notion of full integration between health and social care. This argument reiterates the importance of maintaining professional autonomy.

A recent critical commentary espoused by Thomas (2015) discussed the importance of workforce integration when matters of agency integration are considered. His argument suggests that different professional groups should give up personal power and put the people they are supporting ahead of entrenched professional rivalries and be '*versatile*' in how they work (Thomas, 2015 p.17).

The findings from this study clearly identified that all the professionals were able to recognise the 'power' invested in their individual roles. As Thompson (2012) states in relation to social work:

Crucially the concern for social workers is when power is used in terms of knowledge and expertise, access to resources, statutory powers and influence over individuals and agencies. In work with marginalized people, we seek to counteract negative images of self, negative life experiences, blocked opportunities and unrelenting physical and emotional distress. (Thompson, 2012 p. 8)

As a consequence of this, the research participants were able to better position themselves with managers in terms of advocating for increased resources and service developments. This was especially important when attempting to undertake holistic assessments and create care plans within a climate of limited provision. One AHT participant said in chapter three (see 3.11.3):

I feel that through the austerity measures the MDT work will drop off and also the specialist knowledge of both social workers and nurses will be spread thinner due to fewer staff. People will get a standardised package that won't necessarily meet their needs. The fear is that we don't have the services or the skills to offer people with learning disabilities. (AHT, 16)

David Pearson, who was the president of ADASS in England until 2017, gave a presentation at TCSW National Conference in 2015 entitled: Thinking Social Work, Thinking Changing Lives. This presentation highlighted the importance of health and social care integration and the effects that tight financial controls (instigated by central government) would have upon agencies (as in this study) who were attempting to provide public services in the future.

The purpose of the ADASS is to further comprehensive, equitable social policies and plans which reflect and shape the economic and social environment of the time. Their remit also includes furthering the interests of those who need social care services irrespective of their background and status. Some of their stated priorities for 2016/17 are: welfare reform and financial sustainability; health and social care integration; better care technology and workforce developments.

An interesting finding from this study was the fact that despite the known difficulties associated with health and social care integration, including financial sustainability,

senior managers expected both AHT and MDT participants to adapt their working practices and work flexibly together within these complex organisational arrangements.

As one senior manager said:

It's taken ten years to get professionals to work together better and decide who is best placed to work with someone. It's not beyond the wit of social workers and community nurses to decide who takes which case. At the end of the day, referrals have to be dealt with and priorities have to be met. (MDT, 1)

Thomas further commented about the importance of health and social care integration and said:

These Health Act flexibility arrangements were presented as heralding a new age in social care and health, where integration would break down barriers, lead to greater co-ordination of care and support and produce efficiencies that could be re-invested in people's lives. However, over ten years on from the introduction of such agreements integration still seems to be the cause of much hand wringing and introspection. (Thomas, 2015, p.17)

I would, (in theory) agree with the government's intentions and the priorities espoused by ADASS, regarding the importance of integrated services. Good examples of integrated services from other parts of the UK (Northern Ireland) and (Scotland) were also cited in the literature review (see 2.4.1 and 2.4.2). It could be argued that streamlining management and leadership structures in England would lead towards more effective person-centred support for vulnerable adults. Effective leadership could support staff through important changes and embed the new arrangements – a claim also shared in chapter five (see 5.9.2)

about the presence of leadership and the issue of shared information systems between agencies.

Furthermore, my argument put forward in this study is that agencies and multi-disciplinary team effectiveness work best through:

- a known history of joint working
- joint leadership and a shared vision between agencies
- sustainable financial agreements (pooled budgets)
- development of localised agreed priorities and protocols
- a commitment from professional staff
- co-location of allied professional groups
- a collaborative mind-set to work co-operatively
- regular supervision arrangements in place.

In addition to this, it would be important to share initiatives about integration, and those agencies who have implemented it successfully should offer secondment opportunities and staff-exchanges. This could encourage 'expertise' with other agencies and teams and in so doing, improve integration skills and grow the sector. Wilkes (2014) produced a report on behalf of the New Local Government Network UK which outlined how barriers to integration between sector agencies (including health and social care) could be addressed. An important outcome from the report stated:

Time and time again we hear that innovation often comes from those on the front line and in particular that services users themselves are best placed to design systems and services that best meet their needs. So leadership and vision should not stifle innovation, rather leaders need to embed a culture where innovation

throughout the organisation is encouraged and supported, from the bottom-up and the top-down. (Wilkes, 2014, p. 21)

However, whilst innovation within integrated services is revered, what seems to have been forgotten by central government, and, in this case, some senior managers, is the importance of professional staff in this equation to a certain extent. These initiatives make assumptions that individual professionals involved will be able and willing to adapt their professional practice. As already discussed in chapter five (see 5.9.1) each of the professionals held philosophical and cultural beliefs towards their chosen profession. The findings highlighted very clearly how MDT and AHT participants maintained their separate allegiances. One area of difficulty was that of sharing information discussed in chapter five (see 5.9.1). As one senior manager explained, the difficulty came with some agencies not wanting to share information which was (in his opinion) rooted in the medical profession. Allied health participants in this study were very clear about maintaining separate records of their interventions with people who needed services. It was only through the allocation of a social worker or community nurse that certain information would be released by AHT colleagues. This factor denoted professional tensions between them, as care co-ordinators (social workers and community nurses) were given the remit of central co-ordination. They needed to produce holistic assessments, care plans and interventions – seemingly either with or without additional information from allied health colleagues.

As Thomas states:

It is one thing to say you are committed to person-centred coordinated care. It is another thing entirely to put your professional identity to one side and define how you work through the eyes and ears of the people you are supporting, and the service model that you find yourself working in. (Thomas, 2015, p. 19)

Another significant finding from this study was the fact that (as one senior manager also confirmed) bringing staff together from different disciplines was a difficult job. This was facilitated to some extent through the professional forums that existed, as discussed in chapter five (see 5.10). The forums were used as a central meeting place for all professional colleagues across the learning disabilities service. A good example of this was the research undertaken about potential new service developments being planned for older adults with learning disabilities, who had Down's syndrome and had onset dementia. AHT colleagues were expected to undertake a more strategic focus to their work and make recommendations about potential new services. At least in this agency new ideas were shared with other professionals (social workers and community nurses) who were most likely to come into direct contact with service users who may or may not have had dementia.

7.7 Communities of Practice (CoP): an effective theoretical framework?

In chapter three (see 3.10) I introduced a theoretical framework CoP and argued that this was a relevant theory to underpin the analysis of a multi-disciplinary approach to service delivery. At this point in the argument, there are two inter-related questions to consider. First, how effective a theory has CoP proved to be in practice, and second, what has my use of this theory contributed to the development of the theory? That is, have any new insights been revealed about the theory or its deployment. These questions are considered in turn.

Firstly, the focus was directed towards professional participants, (n=17) from different disciplines, to ascertain the effectiveness of the CoP theory. The intention therefore, was to critically analyse how the social interactions between them proved beneficial for each other and also for vulnerable adults who needed an appropriate service. Wenger (1998)

espoused that a CoP focused upon the social interactive dimensions of situated learning, as in this instance, the MDT and AHT, located within a learning disabilities service. This was supported by hierarchical structures whereby research participants from both teams co-existed to some extent. Wenger (1998) explained that CoPs are important places of negotiation, learning, meaning and identity. Wenger (1998, pp. 72-84) identified that the social interactive dimensions were central components of practice which is the source of coherence for any CoP. Initially, members interact with one another, establishing norms and relationships through *mutual engagement*. Subsequently, members are bound together by an understanding of a sense of *joint enterprise*. Consequently, members produce over time a *shared repertoire* of communal resources. Therefore, I would argue that the illustrations presented in chapter three (see 3.10 (1) (2) (3) highlighted how this approach has proved to be an effective theory for this study. By this, I mean, it offered a theoretical lens through which I was able to identify some of the activities undertaken by MDT and AHT members that indicated the presence of CoPs. I drew upon the related activities already cited such as specialist interest groups and regular patch meetings; the common factor being the sharing of knowledge between team colleagues. The social interactive dimensions of mutual engagement, joint enterprise and the presence of a shared repertoire have been explored in some depth in chapter three and therefore influenced my understanding about *how* the professional participants worked in collaboration with each other. Their shared practice of acquiring knowledge was supported by the localised team meetings and further enhanced through the city wide agency forums, which involved professionals from both teams. Wenger (1998) also argued that a community of practice may or may not exist within an organisation and/or a team of people. I would support this notion, as it is dependent upon the characteristics which are present within any organisation/team configuration which will denote its existence. In terms of this study, I would argue that each team had

its own distinctive CoP, evidenced across the findings within chapters three, four and five. For example, both teams' members revealed the importance of sustained mutual relationships – which were both harmonious and conflictual at different times. Each had a 'shared way' of engaging and doing things together, which was enhanced through knowledge exchange forums such as relevant virtual networks. Another important factor was the clarity with which each team member understood their own roles (identities) and those of others, within their immediate team of reference. One point to note was the comments made by (AHT, 11) (see 5.3.1) in which she explained about the potential for conflicts when both teams met occasionally, due to a lack of understanding about the scope of each other's roles outside their immediate team environment. However, the findings did suggest that participants had been willing to learn from each other about alternative approach(s) towards the complex health and social care needs presented by individuals and families.

Secondly, I would argue that I developed a new insight using this theory in the way I understood its potential and how it could add a complementary focus towards the exploration of multi-disciplinary working, alongside IPA. This is outlined in Figure 21 in terms of how I envisaged the integral features from each theory to work in complementary ways to facilitate the creation of new knowledge. IPA offered 'depth and detail' about personal experiences from each of the participants, and CoP offered the wider social interactive dimensions which occurred between professionals located within teams. In principle, this (dual) approach augmented the ability to understand *how* professionals from different disciplines worked together.

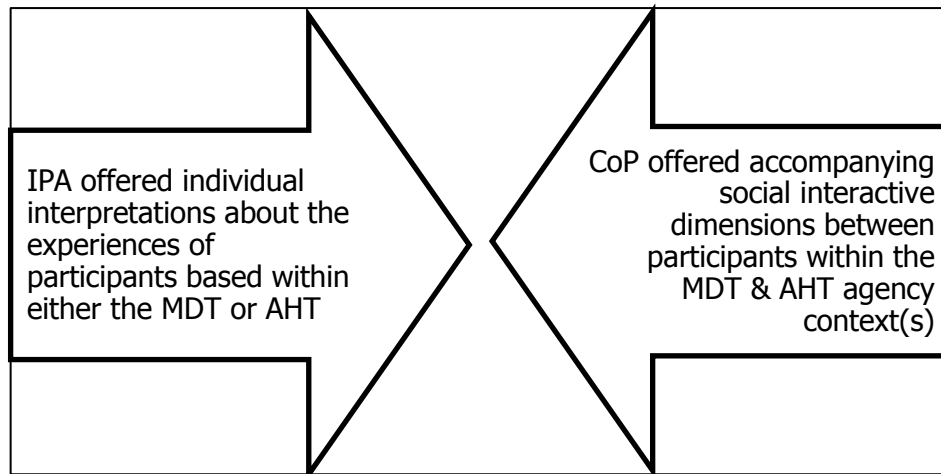


Figure 21: A Complementary Theoretical Focus

I would also argue that my use, and therefore contribution, towards the CoP theory was the discovery about its limitations within this study. Thus, this theory is 'at its best' within a limited spatial reach (team environment). What was difficult to analyse was the effects of the organisational culture (hierarchical structures) had had upon individuals and their teams. There was, however, a sense of appreciation from some participants being able to rely upon hierarchies (team managers) to facilitate challenging situations between professionals from different disciplines, some of whom had a higher status (some AHT members) than others. The issue of 'power' (see 3.10.3) held within hierarchical structures can be limited to key figures (senior managers), and the voices of members of the CoPs can be subdued if not encouraged to share their views and knowledge. In this study, however, this was mitigated to some extent by the presence of knowledge and exchange forums, as explained in chapter five (see 5.10.3).

7.8 Conclusion: Contribution to Knowledge and Originality

There are six outcomes where this study has made a contribution to knowledge. The contribution has evolved through the generation of original insights highlighted by chapters four, five and six, alongside the emergent themes already presented in this

chapter. Each outcome will be discussed in turn, to illustrate the relevance of my contribution and also establish its originality.

The first outcome from this study has been to enhance our understanding of social work with adults who have learning disabilities through empirical research. The need for an enhanced understanding of social work in this field was identified in the scoping review undertaken by Moriarty & Manthorpe (2016) which revealed that '*a striking finding from this review was the apparent absence of empirical research about social work with adults with a learning disability*' (Moriarty & Manthorpe, 2016, p.19). The particular contribution of this study to new knowledge has been to explore the nature and distinctiveness of the role(s) undertaken by social workers located within a MDT who worked alongside adults with learning disabilities, located within a statutory agency context. As this study has revealed, through cited research studies, most of it has orientated towards relationships between agencies, health and social care. The distinctive contribution of this research, however, is located instead within the scope of in-depth insights about *how* social workers in particular, contributed towards multi-disciplinary practice through collaborative relationships. This was also inclusive of all the social work participants (n=9) working at various levels throughout the learning disabilities service.

The second outcome of my research was the discovery that social workers in particular were able to conceptualise the complexities of individuals' lives, and were committed to firstly, advocate for additional resources and secondly, ensure that personalised support arrangements were co-ordinated on their behalf. Two social workers' (senior managers) contributions were aligned with the creation of the learning disabilities service and the centrality of social work within this structure. This was also inclusive of two development workers, (social workers) who undertook complementary roles to those of care co-ordinators. Their specific contributions were associated with the strategic overview of

services provided by the learning disabilities MDT in particular, with a remit to evaluate the effectiveness of service delivery to local citizens. These factors reiterated the importance and contribution of social work, underpinned by human rights based approach towards individuals' needs and circumstances. The contribution of social work has been discussed thoroughly with all the research participants, inclusive of the complexities associated with multi-disciplinary practice within a climate of limited resources. This has been achieved through the engagement of social workers, allied health professionals and not least local citizens. All the participants could share perspectives (and contributions) about social work associated with their day-to-day practice.

The third outcome acknowledged the presence of professional boundaries. All the social workers confirmed the existence of such between them and other professionals who were co-located within the same service. My research has confirmed that, whilst these issues existed, social workers were aware of them and willing to work towards collaborative initiatives on behalf of vulnerable adults. This overwhelming commitment to support adults who had learning disabilities brought professionals together to get the best services possible. What has emerged was the fact that whilst the contribution of social work was acknowledged, all the participants were able to maintain their own identities affiliated to their professional background. What was also significant was that they were willing to compromise to some extent about particular areas of practice and work flexibly. The main areas of compromise consisted of information sharing, the approach towards assessments and interventions, the quality and relevance of professional supervision, the adherence to particular policies (Valuing People, 2001; Valuing People Now, 2009) and the organisational expectations about working within a MDT. It was also acknowledged that whilst negotiations were paramount between professionals, meetings were not necessarily peaceful or collaborative in every instance.

For example, allocation meetings had been referred to as somewhat tense at times, in terms of who was going to pick up the work. In another example, one social work team manager's contribution discussed how she always encouraged social workers to challenge allied health colleagues, if they felt it was necessary to do so. What was interesting was the fact that an authoritative figure (team manager) gave social workers 'permission' to challenge other colleagues from a different (medical) profession. This aspect links into the continued dialogue about the status issues associated with social work and social workers, which is further compounded by the closure of TCSW in 2015. One could ask two related questions: what effects does this action, instigated by central government, have upon the social work profession? How does this affect MDT relationships with other professionals who need to work alongside them? However, having a mind-set to work positively across professional boundaries can facilitate new perspectives or insights about different professionals, their roles and responsibilities. An example in this study was the presence of Task Groups which were also aligned to the then Partnership Board, as illustrated in chapter five (see 5.6.2). Both MDT and AHT participants were able to contribute towards agency planning and the commissioning of integrated services. This arena was a central meeting place for all professional colleagues and a way in which to remain up to date about new service developments.

The fourth outcome was the alignment of social work and its relevance with the hermeneutical phenomenological approach undertaken in this study. In chapter three (see 3.3) I explained how the term 'lived-world experience' became a central belief of existential phenomenologists such as Heidegger, Sartre and Merleau-Ponty, and their concerns with the way we make meaning for ourselves in the lifeworld we find ourselves in. In this study, the lifeworld was a learning disabilities service, which contained and constructed the interactions between the different professionals engaging in multi-disciplinary practice. Therefore, this approach enabled me to discover the essence of this

study through the lived-world experiences of social workers (and allied health professionals) located within this lifeworld.

The first important discovery revealed through the data analysis about this lifeworld was the predominance of the social model of disability (see 5.2.1) and how its influence permeated the creation of the service and the subsequent policies and protocols. Accordingly, all the professional participants in the study embodied the principles of this model through their performances of everyday practice. The social model of disability can be viewed as a mechanism for change. Social workers in particular, as a profession, have adopted a positive approach towards people who have learning disabilities (see 5.2.1 – interview with senior manager, MDT 1). The belief in the social model of disability which is associated with professional social work values, has generated the motivation for social workers and other professions to identify solutions to the restrictions experienced by disabled people in their daily lives. Relevant examples are cited in chapter five in particular. One social worker (MDT, 7), clearly expressed her frustration in trying to achieve the right outcomes for a service user: *it's quite demoralising. I mean, I love the job but then it's harder to keep motivated, because the financial climate inhibits my professional practice*'. She also described how disabled people were entitled to live their lives on as equal terms as possible alongside non-disabled people.

The second important discovery, and therefore, the hermeneutical phenomenological essence of this study, was the clarity with which social workers understood and embraced their professional roles, but also acknowledged their professional boundary issues. This phenomenon confirmed their legitimate and invaluable contributions within a MDT. The contributions that social workers made were: to improve outcomes for people; protect people appropriately and maximise the effectiveness of expenditure across

health and social care, examples of which are cited throughout chapters five and six. In this study, the participating social workers and allied health professionals also discussed how social workers had the wisdom to work alongside complex family scenarios working to achieve the specific personalised outcomes for individuals. This was inclusive of a propensity towards flexible and collaborative mind-sets (sharing information) underpinned by a determination to secure appropriate services.

A significant fifth outcome was also created through the presence of citizens within this study and how their narratives offered a unique contribution about their personal experiences. Their perspectives offered different views and experiences about the outcomes from MDT working. Local citizens gave their time willingly; motivated by the opportunity for their voices to be heard by the social workers they had come into contact with. They wanted to share their knowledge about whether social workers had had a positive impact upon their lives; in short, how good were the outcomes of multi-disciplinary team working? This study offered comparatives between the views of participants and those citizens seeking to acquire relevant services who had direct contact with some of them. All the narratives offered interpretations about the contribution of social work at particular junctures in their lives. For example, the findings revealed that the social workers had a person centred approach towards individuals who needed services. Even though this was a positive element of professional practice, what all the citizens valued was that their needs were addressed and acknowledged within an empathetic framework. As Brian's story revealed in chapter six he felt much better when, in hospital, a social worker from the learning disabilities service visited him to undertake an important assessment of his needs. In another instance, David needed a social worker to help him move into suitable accommodation and also address his needs about meaningful activities during the daytime. He commented that social workers came and went without much recognition of his needs towards building a relationship with him.

Once they had the facts about his situation the social worker and community nurse soon left his home (according to him).

Finally, this study has made a contribution through undertaking a critical reflective analysis about the impact and significance of two important policies published by the New Labour government. These initiatives Valuing People (2001) and Valuing People Now (2009) remained in existence during the lifetime of this study (2008-2017). The policies were significant in a number of ways. For instance, they were underpinned by a rights-based framework which extended to the vision of what people with learning disabilities could achieve beyond a health and social care framework, and, the active involvement of people with learning disabilities and families were also promoted in the process of shaping the policies. What was significant in this study therefore was how these policies strengthened the ethos and principles of the learning disabilities service, underpinned by the social model of disability. In addition to this, the New Labour government sought to promote the introduction of individualised budgets much more widely, coining the term 'personalisation' in a new concordat agreement between central and local government (DH, 2007b). According to Sims & Cabrita-Gulyurtlu (2013) there has been rapid developments in personalisation of health and social care in the UK over the past five years. The ethos is to develop a more flexible model of provision, based upon greater choice and control for service users. This has also been important for people with learning disabilities who are often dependent upon social workers to support them. They state:

Some studies such as reports by In Control have suggested that when implemented well, personalisation can have a positive impact on the lives of people with learning disabilities. Other literature highlighted the limitations and critiques of personalisation. Without the right support to manage budgets and autonomy,

people with learning disabilities could be left vulnerable. (Sims & Cabrita-Gulyurtlu, 2013, p.13)

At the core of personalisation is the idea of choice and control, ensuring that people who receive support are central to and in control of the process by which they receive it, being able to live their lives as they choose (Lecce, 2012). However, it is currently being implemented within a context of austerity measures, as already discussed within this thesis. All the professionals discussed how their practice was curtailed in terms of not always being able to offer the required services, either due to long waiting lists or the none existence of suitable services. These factors were further illuminated when heard through the voices of citizens who needed services. Politically, personalisation is espoused by the Conservative government (2017) and in the past the Coalition (2010-2015) and New Labour (1997-2010) (Simms & Whisker, 2015).

The Conservatives established disabled people as consumers in a free market of services. This is perceived to challenge the dominance of traditional services and enables the modernisation of provision to be based upon customer choice. The New Labour government and the Coalition's appeal lies in delivering self-determination, empowerment and the opportunity for people to live as active citizens, rather than be perceived as passive recipients of welfare (Simms & Whisker, 2015). In order to meet the needs of vulnerable adults, it is imperative that agencies (as represented in this study) respond positively to the demographic trends being presented to them, as in this case adults with learning disabilities. As the voices of local citizens highlighted, all of them wished to live lives they valued above all else. In addition to which, they expected to be central to any decisions being made on their behalf. All the social work participants and other MDT and AHT participants in this study truly believed in the social model of

disability which motivated them to do the 'best they could do' given the complex political, organisational and multi-disciplinary structures in which they operated.

CHAPTER 8

Conclusion

8.1 Introduction

This study was developed with the recognition of the fact that the political imperative is for health and social care professionals to work collaboratively, and that multi-disciplinary working continued to form part of the Conservative's government's agenda. In addition to this, there is acknowledgement that this central drive to merge health and social care services has influenced the organisational structures that underpin multi-disciplinary practice. Nonetheless, the intention of this study was to focus primarily upon one learning disabilities service, its MDT and the contribution of social work located within this context. In addition to this, a number of AHT participants located within the same service also discussed their own contributions and those of social workers which illuminated the overall emergent themes discussed throughout chapter seven. These intentions clarify the boundaries of this study and in so doing, bring to the fore its methodological limitations, underpinned by my reflexive journey during its lifetime (2008-2017). In drawing the study to its final conclusion, this chapter will pose suggestions for further research strands about adult focused social work and, not least, add a critical commentary about the future of social work.

8.2 Methodological Limitations

There are four methodological limitations associated with this study and each limitation will be discussed within the framework of the study's research design. The limitations are: engagement with an agency, participant selection (professionals), participant

selection (local citizens) and the relevance of subjectivity and reflexivity due to the study's location within the interpretative paradigm.

8.2.1 Engagement with an Agency

The first limitation was associated with the initial engagement of the agency to undertake the study. For example, during the planning stages (5.10.10- 16.1.11) (see Appendix 2) it was difficult to predict whether the agency would give the go-ahead to a study such as this. This was due to the fact that MDT and AHT participants (n=17) had complex relationships between each other. As already mentioned in chapter seven (see 7.2) this was mainly to do with status issues, professional cultures, work-load allocations and, not least, the disparities between salaries. Initially senior managers were hesitant to engage with the study outline. There was reliance upon an initial contact with (JT) who had presented a project at the University of Salford within the (Making Research Count Forum) about people who had learning disabilities, being supported to live in their local communities. There was an initial waiting period of a further three months before any progress was made, (see 16.1.11) in terms of connections with other senior managers (AA) and (BB) who were directly linked to the learning disabilities service.

In addition to which, a number of presentations had to be created about the research design and discussions about the incorporation of semi-structured interview schedules as a method of data generation. Likewise, the content of the schedules (see Appendix 7) had to be approved via senior managers before they could be shared with participants. This factor had the potential to influence (and change) the methodological approach appertaining to the (pre-set) semi-structured interview questions. The schedules had been carefully constructed on the basis of the conclusions reached within the literature review, (see Table 4) in particular. In addition to this, the proposed study had the

potential to 'rock the boat' between professional groups who were developing new ways of working together within a complex organisational and political climate. Senior managers were, however, interested in what the findings would reveal since the inception of the learning disabilities service in 2002-3. As mentioned in chapter seven, (see 7.2) a re-visit to the agency and senior manager (BB) was undertaken during August 2015 to share the findings and emergent themes (and potential impact) from this study.

8.2.2 Participant selection (professionals)

A second limitation was associated with how senior managers (gate-keepers) perceived the usefulness of this study and were therefore influential about whether information would be disseminated about it. During the planning stages there was little indication as to which professionals would come forward and offer their voluntary consent to participate. However, by the time that agency ethical approval (16.5.11) had been granted a number of professional colleagues had discussed the potential of the study with (AA) and (BB) which generated interest amongst them. They were particularly interested in its potential value, in terms of sharing their professional practice and learning from others across the learning disabilities service.

8.2.3 Participant selection (citizens)

A third limitation was related to local citizens who participated, (n=9). The recruitment of local citizens was problematic, due to them being 'hard to reach' and deciphering who would be willing to share their personal stories with a potential stranger (me). This was only possible after a three month period, whereby a good rapport had been developed with both the development workers, a phenomenon which could not have been predicated at the outset of the study. In addition to this, whilst there was appreciation

about efforts to recruit individuals, a knowledgeable insight about the service users' specific learning disabilities was unknown, a factor which could have affected their contributions. This included the initial recruitment and selection, the subsequent data generation, analysis and the presentation of the findings from their input. In effect, how reliable would their stories be, and in what way could they be presented in order to offer a credible alternative to those experiences shared by professional participants? As it transpired, the 'conversations' revealed heart-felt personal stories told with honesty and integrity. It was acknowledged, that each of the narratives was unique, and, valuable in its own right, they would not however, be representative of other citizens living in the same locality, or indeed citizens in receipt of services from a MDT living in different localities in England.

8.2.4 The Value of My Approach

My approach acknowledged that embracing the notion of a lived-world experience entailed '*a certain amount of unpredictability*' as each response from (n=26) participants generated a unique perspective. Throughout this study's undertaking I ensured that I maintained an open mindedness about the responses from participants and had a willingness to enter into individuals' lived-worlds. Although I was aware of my position as a social work academic, my true identity whilst undertaking this study was (and will always be) as a social worker. My intention was to illuminate the plight of people who have learning disabilities and informal carers, in terms of, '*individuals are given the respect and privacy to live their lives in the same way that anyone else would expect to be*' (DH, 2016, p. 6). In so doing, they were supported by social workers (as in this study) who endeavoured to promote active citizenship as far as possible. This was inclusive of making their own decisions and to pursue their hopes and dreams as anyone would.

8.2.5 Subjectivity and Reflective Narrative

Lastly there was a limitation related to how social workers, allied health professionals and citizens defined themselves, as what they did in this research study was a subjective matter. It would have been difficult to have offered some kind of measurement due to the fact it was more in tune with the individual perspectives of the participants themselves as professionals, or people who needed and used services. Thus it was not possible to generalise the outcomes from this study, although there were some key aspects about professional practice which resonated beyond it. Examples included a professional role (and status) within a team, individual supervision experiences, and the importance of the continuation of professional development (CPD) needs. In addition to this, given the study's relevance with the cited literature in chapter two and discussed in chapter seven (see 7.3) it could be argued that the features discovered in this study about a MDT and AHT (working across professional boundaries) are also likely to be prevalent features within other multi-disciplinary configurations.

At this point it is also important to acknowledge the individual subjectivities and values of myself as the researcher. In line with the reflexive tradition, the starting point of this research study was to accept that my biography was embedded as a registered social worker, as mentioned. It was reassuring to discover that the social workers who participated in this study had a commitment underpinned by deep seated values to advocate on behalf of the vulnerable. It was this commitment which kept me focused and determined to undertake a study such as this. It was always the 'dream' to put a study like this together and, as it transpired, I had the fortitude to fulfil it. I acknowledged that I had to start at the beginning in relation to becoming an effective researcher. This entailed learning about crafting a good research proposal, grappling with the complexities of undertaking a literature review and becoming immersed within

philosophical debates appertaining to phenomenology and hermeneutics. I have learnt that I enjoyed working with NVivo (10) in particular. During the analysis phase I managed to '*turn words into numbers and numbers into words again*', in order to create the themed responses from the professional participants. Reflexivity encourages researchers to maintain high standards because it involves constantly reviewing the process of investigation. By using reflexivity in research the illusory gap between the researcher and researched, and between the knower and what is known is closed (Etherington, 2004). Furthermore, I wished to view the relationship with all the participants (n=26) as a partnership in the first instance, although it was recognised that a signed formal arrangement was in place about the conduct of the research and how the data was to be generated, stored and used within this thesis. Whittaker (2009) argued that when people (and ourselves) are given a voice to express experiences, those voices create a sense of power and authority. It was also acknowledged that I was a university lecturer doing a PhD and it was important, therefore, not to be perceived as a kind of 'expert' because of this status. Consequently, I was aware of this during the initial planning stages of the study in terms of approaching three statutory agencies. Once an agency had agreed to participate in the study and allowed access, the perspective adopted was therefore as an experienced social worker grounded within a statutory adults' learning disabilities service. It was envisaged that this factor created a certain rapport, due to participants' perceptions of common strands in work background, training and experiences.

As an indication of the scholarly journey undertaken, this is reflected in the notion that, conceivably, many researchers have narratives of how personal experiences have set in motion an individual's research journey. A good example of this is the number of associated papers I was able to create during the various stages of this PhD study (see

Appendix 12). Each of the papers selected has represented the journey and progress I had made at different points over a number of years. An additional bonus was being able to disseminate my research within an international context, at social work conferences. It was important to bring to the fore significant issues about people who have learning disabilities and informal carers underpinned by the outcomes of MDT working from different perspectives.

Steier, (1991) maintained that reflexivity is about the researcher taking responsibility. The inference here is that I am accountable. While more traditional approaches to research foster an abstract formalised and value-free objectivity, within the qualitative paradigm it is deemed good practice to discuss the differing facets of researcher involvement and influence, using these to inform and enhance the prevalent themes. This included the choice of the research design (methodology and corresponding methods), all of which have been discussed in chapters three, four, five and six. By engaging in the reflexive practice of research, I and the reader become more closely connected to the research and its undertaking. Taking the time to reflect upon, record, review and incorporate information relating to my role as the researcher (as cited) are practices that are seen to be enriching. This is further enhanced by the influences brought to bear in my scholarly journey throughout the lifetime of this study in particular.

8.3 Further Research Themes

The emergent themes from this research study have highlighted on several occasions, especially in chapters five, six and seven, the importance of MDT and AHT collaborative relationships in order to work across professional boundaries and deliver effective services for local people. What has also emerged is the question of whether, in fact, the

NHS and social care services can be integrated, so that local people are served better and that income can be saved at the same time. In order to do this, two professions namely, GPs and social workers are central to the transformation and delivery of community services. However, as this study has revealed, there are considerable cultural and professional barriers between the two professions and as such further research strands exist to explore the nature of the barriers between them. The report by TCSW and the Royal College of General Practitioners (RCGP) (2014), emphasised the importance of inter-professional working between GPs and social workers to facilitate more effective integration.

They stated:

As the most prominent professional leaders adjacent to the boundary between NHS and local authority care, GPs and social workers are ideally placed to make radical change happen. (TCSW & RCGP, 2014, p. 9)

In addition to this, a research study was undertaken by Mangan et al., (2015) which reported on the findings of the first stage of a project seeking to improve inter-professional working between general practice and adult social care teams. The main features of the project included running seven focus groups (n=57) with four general practices and three adult social work teams. They concluded that:

The negatives outweighed the positives in terms of inter-professional working. Issues included perceptions of different value bases, a lack of knowledge about each other's roles and responsibilities which resulted in resorting to stereotypes. There was poor inter-professional communication and a sense of an unspoken professional hierarchy with GPs at the top leading to preventing a culture of appropriate challenge. (Mangan, et al., 2015, p. 62)

As this study was conducted with only four GP practices and three adult social work teams in England, the findings, although important, offer limited scope to generalise them. This would suggest that further research strands exist within this context. This could also include the potential for inter-professional education and training, as a way of improving collaboration and to progress the current health and social care agenda, focused upon integration which relates to the themes generated within this study.

8.4 Conclusion: Social Work and the Future

The original intention of this research study was to focus upon contemporary social work and social work practice in England and explore its contribution within an adults' context, given the onset of social work reforms. There are continued difficulties with the upholding of its professional identity and distinctiveness compared with other professions, as espoused by Herod & Lymbery (2002). Since then these issues have continued to affect the social work profession. One such example was demonstrated in a recent publication by the DH (2016), by the chief social worker for adults, Lyn Romeo. She stated:

Defining social work has always been challenging and contested in England, where the statutory child and family social work role has and continues to be, the dominant discourse. (Romeo, 2016, p. 6)

However, one major sea change was the impact and tragic death of Peter Connelly in 2009 also mentioned in chapter two (see 2.9) which steered the then New Labour government to establish a Social Work Task Force, with support across the sector to begin a root and branch appraisal of social work in England. In its final report, in 2010, the Social Work Task Force made the recommendation to develop a professional college for social work. This was then pursued by the Social Work Reform Board. During 2012

TCSW opened to members. On September 30 2015 TCSW closed to members. The closure came after the Conservative government rejected proposals from The College that it should be given responsibility for additional functions, such as post-qualifying training, which would have secured much-needed income as the organisation faced severe financial difficulties. The government said the decision to stop funding The College had not been taken lightly. On social media Isabelle Trowler, the chief social worker for children, said that:

The College's financial situation was such that it was not tenable for the government to keep ploughing in funds. (NcNicoll & Schraer, 2015, p. 1)

Herod and Lymbery's argument during 2002 was that, although social workers operated within a difficult context, health care professionals were able to articulate the distinctive features of social work within a MDT. The findings from this study also concurred with this, and would correspond with their original argument, although the configuration of AHT members in this study was a separate team offering specific support to social workers based within the MDT. This was highlighted in chapter three (see Figures 2 and 3) which outlined the vision and representativeness of the agency's structures.

Furthermore, in this instance some social workers also undertook the central role of care co-ordination, which encompassed on-going negotiations with AHT members on a regular basis. This feature enabled regular access between them, and as such AHT participants shared their critiques relatively easily due to multi-disciplinary practice being the 'norm' within this agency.

Lymbery (2001) also argued that social workers worked within difficult contexts in terms of struggling to combat the legacy of public mistrust and political antipathy that characterised the eighteen years of Conservative government until 1997. He also claimed

that '*matters had improved little under the Labour administration*' (Lymbery, 2001 p.18). The findings from this study also revealed that social workers continue to work within a difficult climate as highlighted throughout chapter five. In addition to this, the continuation of public antipathy towards social work is fuelled by the Conservative government's intentions to potentially jail children's social workers (and educators) should they be found guilty of the criminal charge of wilful neglect. On June 17 2015 Karen Bradley, minister for preventing abuse and exploitation, speaking at a children's charity conference said:

The government will later this year consult on plans to expand the crime of wilful neglect to children's social workers who fail to report abuse. The proposals are intended to prevent children from being failed by social workers who lack the professional curiosity to explore the underlying reasons for challenging behaviour, or who knew abuse was being ignored and did not speak out. (The National Society for the Prevention of Cruelty to Children, 2015). (Stevenson, 2015, p. 1)

During March 2016 it was reported that Isabelle Trowler the chief social worker for children, said after the announcement on Twitter to practising social workers:

It would be very difficult to secure a conviction from the proposals. I can't remember ever thinking poor practice was a result of wilful neglect/reckless practice. (Stevenson, 2016, p. 1)

These powerful statements also have resonance for adults' social workers, especially when both services work in liaison during the transitional phases of young people moving into adulthood. A feature also discussed within this study and outlined in chapter five (see 5.10.2).

These developments invite two questions: who would be to blame within this context and how would the 'fallout' be dealt with between both services? How would this impact

upon other professionals involved, and what then would be the state of multi-disciplinary working between them?

During December the DH (2015a) published an interim report, reviewing progress on key policy areas. The report follows the announcement of the government's Comprehensive Spending Review which '*will determine the £3.5 billion spending priorities for local authorities until 2020*' (DH, 2015a p.4). One key area was the significant developments across the health and social care system, which intends to raise the profile of social work in supporting vulnerable adults in society. This was also inclusive of people with learning disabilities, in providing a single point of contact for individuals and their families. The principle behind this move is to empower social workers to '*enable professional challenge*' (DH, 2015a p. 5). This positive move was in response to the Green Paper No Voice Unheard, No Right Ignored, (2015) and the proposal to be tested in a small number of local authorities in 2016/17. The Green Paper was presented by the previous (Coalition) government because not enough progress had been made to transform the care of people with learning disabilities, autism and mental health issues in the wake of the Winterbourne View scandal. In chapter five, it was highlighted in footnote (2) (see 5.3.1) that Winterbourne View (2011) was a scandal which shocked and appalled the nation. One of the key messages from the Winterbourne review (and this study) was that the care of vulnerable adults was the responsibility of a whole range of organisations, inclusive of local authorities and professionals who are employed by them.

Consequently, during November 2016 the publication *Named Social Worker, Baseline Report* was published (DH, 2016). The opening statement advocates that:

The DH has initiated this programme in order to build an understanding of how having a named social worker can contribute to individuals with learning

disabilities, autism or mental health needs achieving better outcomes: specifically that they and their family are in control of decisions about their own future, and are supported to live with the dignity and independence which we all strive for. (DH, 2016, p.1)

The report (p.3) explains the remit of the named social worker role as having the ongoing responsibility for an individual's support, meaning that they would be both the primary point of contact, and be able to use their professional voice to challenge across the system, linking with a range of services, professionals and organisations. The ethos is to push the boundaries in terms of relationships between the social worker and the wider health, care and support system.

At the current time (2017) BASW is concerned about the implications for the social work profession should social workers be immersed within a fully integrated health and social care system. As noted in chapter seven, (see 7.6) BASW made a clear statement that as a profession, its priority is to maintain autonomy. I would agree with their statement and my recommendation would be that MDT configurations continue to promote a positive narrative through celebrating social work and its success, demonstrating its contribution. In my view MDT working is not about the creation of one generic care worker, but rather the creation and development of professionals (inclusive of social workers) who are confident in their own knowledge and skills base, offering their particular expertise. Therefore, social workers who undertake the named social worker role (within learning disabilities) will need to draw upon a confident professional identity to help maintain resilience, especially when expected to use their '*professional voice*' (DH, 2016, p.3).

As mentioned earlier in this chapter and in chapter one (see 1.3), the central argument permeating this study suggested that social work (as a professional discipline) had difficulties in upholding its contribution given the onset of continuous social work reforms. In 2015, the Conservative government announced that the social work profession will have a new regulatory body a strategic development endorsed in the DH (2016) annual report which states:

The creation of a new regulatory body for social work will deliver a coherent approach to how social work is regulated, with an exclusive focus on raising the quality of social work education, training and practice across all areas of social work. (DH, 2016, p. 20)

The report outlined how a new strategic direction will give social workers the flexibility to work in many settings and contexts across England and the UK. It is envisaged that social workers who practice within adults services (as in this study), will also benefit from a new regulatory body. For example, there are significant gaps (in England) around the recruitment of experienced social workers to undertake the vital roles of Best Interest Assessors (BIA) linked to the Mental Capacity Act 2005 and the Approved Mental Health Practitioner (AMHP) linked to the Mental Health Act 2007. The report states:

Progress in implementing the Care Act reforms has been broadly positive, with the majority of local authorities 'on track' with their implementation. There are increasing concerns around some areas of implementation, including a shortage of social workers to undertake certain roles such as BIA and AMHP functions and employers finding it difficult to recruit experienced social workers. (DH, 2016, p. 11)

To conclude, this study set out to explore the contribution of social work within an adults' context. Its conclusion suggests that, whilst social workers work in a climate where the future direction and survival of social work is uncertain; the overall significant contribution was that of unflinching commitment of the social workers involved in this study. Their commitment was strengthened by personal and professional values attributed to a human rights framework underpinning social work practice and, not least; the presence of supportive and positive leadership within an organisational context which championed excellent social work practice. This was especially poignant given the fact it was a commitment towards vulnerable adults who have learning disabilities, and informal carers, who deserved equal rights and the recognition and support to live the fulfilling lives they valued.

Appendix 1

Example of a Screening Tool

RESEARCH QUESTION:

What is the contribution of social work within a multi-disciplinary team?

Analysis of empirical research highlighted through the data bases and key journals for inclusion within a relevant literature review.

Criteria	Yes	No
English Language	✓	
England	✓	
Other European Country		✓
Year of Publication between 1997 - 2016	✓	

An example of how the screening tool was used for the inclusion of one research study cited in the literature review (2.5): Frost et al., (2005)

Journal articles and academic texts must meet at least **ONE** of the following criteria

Describes the nature of social work & working within a multi-disciplinary context	Yes ✓	No
Describes the contribution/function of social work within a multi-disciplinary context	✓	
Describes the extent of the contribution of social work within an integrated context	✓	
Describes/evaluates a model/process of different disciplines working together	✓	

If ticked No to all above – exclude at this point

If ticked yes to any of above include and complete as many of the following as possible:

Author(s): Frost, N. Robinson, M. Anning, A.

Year: 2005

Source Details: Academic Journal Child and Family Social Work (10) pp. 187-196

Aims of paper/text: Draws on findings of a project funded by the ESRC in England. Examined how child and family multi-disciplinary teams learn and work together.

Context: Explores New Labour policy around joined up thinking

Who: Multi-professional groups of staff

Where England

Methods of evaluation: Qualitative data to explore the experience of social workers in relation to four key issues: models of professional practice, status and power, confidentiality and information sharing and relations with external agencies.

Themes: Contribution of social work within a children and families context. There was an emphasis upon teams coming together who bring different knowledge, expertise and histories to pursue a common goal – collaborative working.

Comments/Notes:

Indicate (x) which of the following themes are covered in the book/article
(The themes also cover the key objectives of the research study)

Identification of terminology	
Exploration about the contribution of social work	x
Exploration about the value of social work	x
Exploration about how social workers define their work and professional identity issues	x
Issues of power and status within m.	x

disciplinary context	
Use of professional boundaries within a m. disciplinary environment	x
Employment terms and conditions working within a m. disciplinary context	
Professional supervision arrangements	
Professional development issues	
Social workers views/experience/reflections about m. disciplinary working	x
Other professional perspectives about m. disciplinary working/inter-personal relationships & collaborations	x
Benefits for service users	x
Benefits for carers	x

Appendix 2

Ethical Approval Stages: PhD Research Study

Planning Schedule: October 2010 – November 2011

<u>DATE</u>	<u>INFORMATION</u>	<u>ACTIVITY</u>	<u>COLLEAGUES INVOLVED</u>
5.10.2010	Research study design discussed with colleague	Initiated meeting with an agency senior colleague (social care)	Julie Lawrence (J.L) & C.C
16.1.2011	Research study design discussed with additional agency staff (social work)	Another agency meeting	C.C. & B.B. J.L.
3.3.2011	Meeting between colleagues at the agency	J.L. Presentation to senior (social work) agency staff: research study design and approach discussed	J.L. A.A. B.B. J.T.
24.3.2011	Further discussions re: viability taken forward by (social work) senior managers	Senior Management Meeting: Allied Health & Adult Social Care Joint Agency	S.L. N.C. J.M. D.C. D.E B.B. A.A.

		Meeting	
11.4.2011	Provisional approval from the agency for the research study to go ahead	Ethical approval applications (agency)	J.L.
12.4.2011	DBS update (J.L.) completed. Requested by the agency	Ethical approval application (University of Salford) *supervisor approval	*Professor S.M. Shardlow J.L.
16.5.2011	Confirmation of agency ethical approval (professionals)	Strategic Director confirmation: study to go ahead Email confirmation received	S.L. G.S. B.B. J.H. (liaison) J.L.
19.7.2011	Confirmation of University of Salford ethical approval committee (professionals & citizens)	Email confirmation received	H.J S.S. (liaison) J.L.
16.11.2011	Confirmation of agency ethical approval Citizens: service users	Email confirmation received	S.L. G.S. B.B. (liaison) J.L.

	and informal carers		
--	---------------------	--	--

Appendix 3

Agency: Ethical Approval of Research Plan Applications

From: G. S.

Sent: Mon 16/05/2011 7:59 PM

To: Lawrence Julie

Subject: RE: University of Salford Research Study: Research Plan Application Form [Professionals]

Hi Julie, just to let you know I've read through your application and the interview schedules you are planning to use in your project. I'm happy to give you RGF approval in terms of working with a number of professionals who are based in the adults' learning difficulties service.

From: G.S.

Sent: Wed 16/11/2011 12.44 PM

To: Lawrence Julie

Subject: RE: University of Salford Research Study: Research Plan Application Form [Carers & Service Users]

Hi Julie thanks for your application and I've read through everything, including the consent form. Your plans for the interviews are well thought through; therefore I'm happy to give RGF approval. I hope that everything goes well.

University of Salford Ethical Approval Committee

From: H J
Sent: 19 July 2011 09:49
To: Lawrence Julie
Cc: Shardlow Steven
Subject: RE: Ethical Approval REP11/094
Importance: High

Dear Julie,

I am pleased to inform you that based on the application and information provided, the Research Ethics Panel have no objections on ethical grounds to your project. We hope all goes well.

Kind regards

Contracts Office,
University of Salford,
G10 Faraday House,
43, the Crescent,
Salford M5 4WT,
United Kingdom.

Tel: +44(0)161 295 3530
Fax: +44(0)161 295 5494
Email: [j. h. @salford.ac.uk](mailto:j.h.@salford.ac.uk)

Appendix 4



PARTICIPANT INFORMATION SHEET

PhD Research Study

Learning Disabilities Service (Adult Services)

August 2011

You have been invited to participate within a research study. Before you decide, it is important that you understand why the research is being carried out and what it will involve. Please take the time to read the following information carefully. Talk to others about the study if you wish. Two senior managers have already been contacted about the study and support its undertaking. They also agreed to disseminate information about the study's proposal to staff across the learning disabilities service. Please take your time to decide whether or not you wish to participate.

The Research Study

The research study has a primary focus towards social work. It is exploratory in nature and interested in finding out about the contribution of social work within the context of a multi-disciplinary team. Other (allied health professionals) and four managers have also been approached, in terms of adding their own contributions towards the study. This is important as individuals can add their experiences which will inform the research outcomes.

What are the possible benefits of taking part?

The findings from the research will be valuable for practitioners and managers who are establishing services, or want to consider their own practice and evaluate current multi-disciplinary practice within teams. A small number of service users and *informal carers will also add their contributions and perceptions about working alongside a social worker, community nurse, and or a member of the allied health team.

Why have you been chosen?

You have been invited to participate in the study because you are a qualified professional and work alongside other professionals, based within the same service. You have also expressed an interest in being part of the study and therefore your contribution is valued.

What will happen to me if I take part?

You will be asked to sign a consent form to enable you to participate within individual interviews. Each interview will last for approximately one hour of your time. You will be provided with an interview schedule before the interview, so that you are aware of the questions that will be referred to during the interview. You will be contacted by Julie (the researcher) to agree a suitable time to be interviewed.

What are the side effects and other possible disadvantages and risks of taking part?

You need to consider the information you wish to share, although it is not anticipated that the disclosing of information will cause personal distress.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time without giving a reason. If you do decide to withdraw, any data which has been generated will be retained and maybe used as part of the study (anonymous verbatim extracts) unless you request otherwise.

Will my taking part in this study be kept confidential?

Any data obtained in connection with this study will be treated as privileged and confidential. All data will be anonymous. The data generated will be stored securely (via computer software) through an electronic password protection system.

Do you have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form, you are free to withdraw at any time without giving a reason.

Contact Details:

If you have any questions or would like more information, please do not hesitate to contact:

Julie A Lawrence, Lecturer in Social Work

University of Salford

School of Nursing, Midwifery, Social Work & Social Sciences

Frederick Road Campus

Allerton Building, Floor 6, Room C604.

j.lawrence@salford.ac.uk

*Please note that this Participant Information Sheet was adapted when informal carers were approached and agreed to participate within the study at a later date, although much of the text remained the same.

Appendix 5



Participant Consent Form

I have read the information for research participants. This study is being undertaken by Julie Lawrence and I have been given an opportunity to ask questions related to the study.

I have been informed that I may withdraw my consent at any time, with no negative consequences.

I agree of my own free will to participate in the study.

Yes

No

I agree to the interview being recorded

Yes

No

I agree to the use of quotations from the interview in the thesis or any publication emanating from this project.

Yes

No

I would like a copy of the transcript from the interview.

Yes

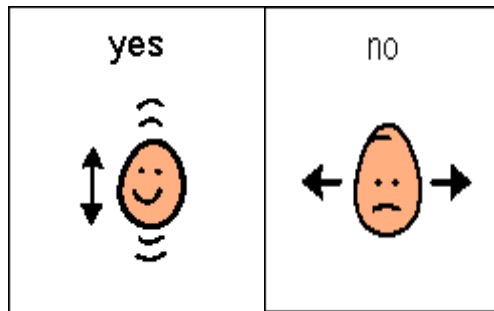
No

Signed:

Printed:

Date: Researcher to retain a signed copy

Appendix 6



THIS IS A CONSENT FORM

January 2012

Telling your story

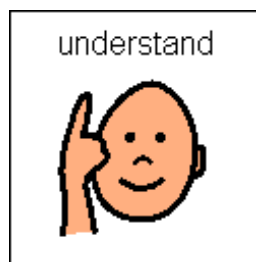


Thank you for talking to Julie



To let me know that you are happy to talk
to me about your experiences, please tick

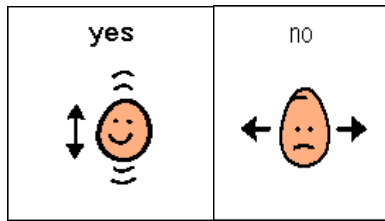
the following statements



I understand that I have agreed to talk
about my experiences to Julie



I understand that my story will be
recorded



I know I can say 'Yes' or 'No' if I
don't want to talk about anything



I am happy to share my story with
other people



I do not want other people to know
who I am

As you share your story can you look at these questions and think about them. I would like to ask you...



What are your personal experiences of working with social workers, community nurses or someone else from health?



How did the experience make you feel?



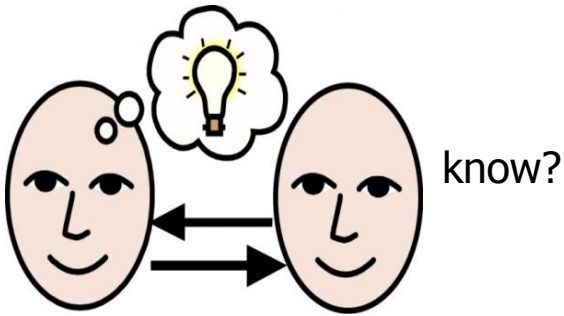
What went well?



What could have been done better?



How did your personal experience affect
your situation?



Is there anything else you would like to

know?



(Version 2)

Person

Researcher.....

Appendix 7

Semi-structured interview schedule (aide memoir): Social Workers

Aim of the Research Study

The overall aim of the research study is to explore one central theme: the contribution of social work within a multi-disciplinary team (MDT). It will explore the extent to which social work has a distinctive role to play, as part of an increasingly multi-disciplinary approach, in providing services and support for people who have learning disabilities.

Approach to the Interview: Hermeneutical Phenomenology. This means the development of a partnership between the researcher and the participant. The emphasis is focused upon the interpretation of the lived-experiences of individuals, established within the context of a MDT.

Background	Introductory Phase
Personal details form Gaining background information about the participant	Ask participants to share some personal details. This includes; their name, contact details, experience and qualifications. Re-check about voluntary consent and sign the consent form.
Groups of questions on key issues and themes	Interview Questions
Models of Professional Practice	<ul style="list-style-type: none"> • How long have you worked in this team • What is your interpretation of the term learning disabilities/difficulty • Can you tell me about your perception of a multi-disciplinary team • What do you think are the most positive and least

	positive aspects of working in a multi-disciplinary team
Contribution of a Social Worker	<ul style="list-style-type: none"> • Can you tell me about your position within the team • Can you explain how you maintain clarity and focus, in terms of your role • How do you maintain your professional values, on a day to day basis • How do you think your role can benefit service users • How do you think your role can benefit carers
Co-operation between colleagues and managers	<ul style="list-style-type: none"> • How do you perceive your role and status when working together with other colleagues • What is your approach to working alongside other professionals • Can you tell me about any differences you have experienced when working with allied professionals? • Examples: politics/traditions/philosophies/perspectives
Confidentiality and information sharing between professionals	<ul style="list-style-type: none"> • Can you tell me about your interpretation of confidentiality • How do you record and share important information • Have you experienced any difficulties in this area with other colleagues • How are any difficulties resolved with other colleagues from different professional backgrounds
Supervision and support provided to staff	<ul style="list-style-type: none"> • Can you tell me about your experiences of professional supervision

	<ul style="list-style-type: none"> • How do you build up your specialist expertise • How do you maintain your continuous professional development (CPD) within this team
Policy directives and organisational expectations	<ul style="list-style-type: none"> • Can you tell me about any policies and protocols which exist within the Learning disabilities service, which influence your practice • Can you tell me about any multi-disciplinary professional forums /advisory groups that facilitate multi-disciplinary working within your service • How do you think the DH directives: Valuing People (2001) & Valuing People Now (2009) have influenced any service developments within the Learning disabilities Service

Appendix 8

Transcription 2011

(MDT, 5)

Personal details and background information

Woman

She worked in children and families first. Social work training via S. college and did the Diploma in Social Work.

Participant - I knew I didn't want to go back into children's services. I had social work placements at T. P. and O. I did an education welfare placement for the final placement.

Group 1 Questions: Models of Professional Practice

Q1 How long have you worked in this team?

My first job was within a learning disabilities team in T. Not an area that I particularly wanted to do. I thought I would just go and see, as I wasn't sure. I thought I wouldn't be able to communicate and understand people and I was quite honest, what's the point. Anyway when I went to S I quite enjoyed it. I was there for a while. A mental health job came up in W. But I didn't like it - it was pretty dire. Services were so poor and it felt like fire -fighting all the time.

Researcher – what do you mean dire?

Participant I was just doing duty work, ward rounds all crisis intervention. I've worked for S. and it's not a bad authority to work for. I was looking for a permanent position. A

job came up here so I took it. ***I've been a permanent member of staff for 7 years**
NVivo Memo File (NMF) *(data extract: NMF).

Researcher – what makes you stay in a post for this length of time?

Participant - ***I like the work that I do and the team are very supportive. I get some satisfaction when I know the work will be difficult, but I can work with other team members to try and solve problems, it's really good** *(data extract: NMF)

Q2 What is your interpretation of the term learning disabilities/difficulty?

Having the term learning difficulty is quite problematic for our team because anybody could have a learning difficulty. Most people can at some point in their lives have a difficulty. ***But people with learning disabilities are born with a disability and it's always going to be with them** *(data extract: NMF).

***We always have arguments about the differences in the terms with others. We have to explain that we don't work with people with dyslexia people don't understand the complexity of the work we undertake** * (data extract: NMF).

Q3 Can you tell me about your perception of a multi-disciplinary team?

The good points are that they are all there and we have access. It's the whole package we've got everybody. ***They are all within reaching distance and the good thing is that if you need others you can either pop downstairs to see them, or send an email and they get back to you straight away** *(data extract: NMF).

If they're not based together it's not that easy. ***It's very helpful that we are all based in the same building. I'm not sure that if someone was based 500yds**

down the road anybody will pop over there. It helps with a lot of the work and M.D. Team meetings together *(data extract: NMF).

Q4 What do you think are the most positive and least positive aspects of working in a multi-disciplinary team?

I can't think of anything negative. The only thing is that they have their workloads and we have ours and it's difficult to get together sometimes.

Group 2 Questions: Contribution of a Social Worker

Q5 Can you tell me about your position within the team/service?

My position within the team is based within a multi-disciplinary team. We are split into 4 sections north and south, four patches two in each area. Within each patch there are nurses, social workers and CAOs. We undertake reviews all the time. This is to do with population changes and things do move on. So ***I'm a social worker and also the best interest professional as well. I do the DOLS authorisations and best interests meetings. I tend to do more than other people** * (data extract: NMF).

Researcher – can you tell me why you don't mind about doing extra work?

***I don't mind that because you have to keep up with legislation. There is always something new. It's one way I can keep up with my professional values also** *(data extract: NMF).

Q6 Can you explain how you maintain clarity and focus in terms of your role?

As I mentioned, I'm a social worker and also best interest professional as well. I do the DOLS authorisations and best interests meetings.

Q7 How do you maintain your professional values, on a day to day basis?

Having a social work student does help. It makes you think about what you are doing and the reasons why. You have got to read about what the values are and think about power. I do find it stressful when I have students as its demanding. But it makes you sit up and think about your practice. I'm teaching at the moment. Sometimes I do the challenging behaviour training as well.

Q8 How do you think your role can benefit service users?

I suppose the role benefits because ***you are working within a framework of legislation and making sure that needs are being met within a format. You are trying your best as well. In your social work role and supporting the person the best way you possibly can. Albeit there are constraints at times** *(data extract: NMF).

But I do think having the knowledge and understanding is helpful. Knowing about different theories is useful.

Q9 How do you think your role can benefit carers?

I think having knowledge is useful because you can be very reflective. If you haven't got that knowledge base you can take things personally. Not so long ago a person had a real go at me I know it's not me, it's the council usually – about the lack of services. I am aware it's not me personally. ***Also we have to be very honest with people they don't always appreciate it at the time. It's the way you put it across and think carefully about that** *(data extract: NMF).

Group 3 Questions: co-operation between colleagues and managers

Q10 How do you perceive your role and status when working together with other colleagues?

I like to think that we are all working on the same level.

Researcher – can you explain what you mean by that?

Although, there is a hierarchy. Sometimes there are things going on and things happen overnight. It doesn't always get down here. An example now is that we are all moving office. There are two buildings somebody has spoken to somebody somewhere. But we don't know who it is All we know is that we are moving in January. There is no consultation we are going to be off. ***We are treated as if you haven't got a say. We think come on tell us where we are going. We already know the decision's been made. And sometimes decisions are made that you don't get to know about them. They filter through. It's not a criticism it's a factor of all organisations** *(data extract: NMF).

I like where I work and they are quite transparent in other areas. I think it's about working in organisations, it's inevitable. It's important you spend more time at work than at home. There are 10 people and 8 desks - is this about stress or what. We've got to get rid of 'things'.

Q11 What is your approach to working alongside other professionals?

***I quite enjoy working with other professionals it's quite refreshing at times. We all have different ways of working, opinions and ways we do things** *(data extract: NMF).

Sometimes as well it is what you see as being right is not always the right way. You can pick up ideas and clues and get a bit more support.

Researcher – can you explain what you mean?

***It's good to work alongside a nurse. So if there is anyone who has quite complex health needs and I need to know something, I'll ask about it. I'll talk to a nurse about taking the case on because health isn't my area it just goes over my head *** (data extract: NMF).

***Because we are in the same role we are supposed to take on the same type of work although nurses may take on more complex health and we take on more complex social needs. But it doesn't always happen *(data extract: NMF).**

But its handy you can ask your colleagues about advice about it.

Group 4 Questions: Confidentiality and information sharing between professionals

Q12 Can you tell me about your interpretation of confidentiality?

For example if I'm doing an assessment. If the person understands that I'm doing an assessment then I usually explain that I need information, sometimes people need to move and we need information. ***Some people say yes but if they don't I do write on the assessment that this information is not to be shared with others unless discussed with whoever the person is. I've done that a few times *(data extract: NMF).**

Researcher - and is this how your team practice?

Usually a parent or carer will help them. Things around safeguarding we usually just follow the procedures and guidelines and we have a statement on confidentiality. There is a case where the parents want access to their daughter's records. I told them that we have a procedure and also about the Freedom to Information Act. I told them we have a procedure. I told them how to make the application and they did that. We have a team

who get all that together. It was a difficult case because the service provider wanted the person out of the house and each were battling each other. ***There was not very nice information written about the service user. What we decided was that the person didn't need to see horrible things written about her. It would have sent her over the edge really** *(data extract: NMF). In the end the person asked for her own files.

Q13 How do you record and share important information?

Some people say yes but if they don't I do write on the assessment that this information is not to be shared with others unless discussed with whoever the person is. I've done that a few times. Usually a parent or carer will help them.

Q14 Have you experienced any difficulties in this area with other colleagues?

I haven't got an issue with this, if we need to protect someone from information that was written a long time ago. The service user didn't need that added pressure. We sacked the carers in the end. It was very difficult. They were very rude to me and you wonder how they treated the service user when she was on her own in her flat. It's the process of winding down the contract, not straight forward.

Q15 How are any difficulties resolved with other colleagues from different professional backgrounds?

Researcher – this question was not answered directly, but through the above example given.

Group 5 Questions: Supervision and support provided to staff

Q16 Can you tell me about your experiences of professional supervision?

I have supervision about every six weeks. I tend to go through my cases, obviously anything that is concerning me where I need extra support around. ***It's quite helpful it helps me keep on top of everything and also look at where I might be going wrong** *(data extract: NMF).

Researcher – can you clarify if you view supervision as the arena in which to share your worries about aspects of practice at all?

Well I know it's helpful and I'm ok about sharing most things. We also look at areas of interests. The managers have a list of everyone's area of interest.

Q17 How do you build up your specialist expertise?

For example ***I do the DOLS and the out of borough placements and people who are detained in secure hospitals. I do keep up with Deprivation of Liberties each year. We have DOLS meetings and challenging behaviour meetings. Last year we had 5 days assessment training from a colleague from California** *(data extract: NMF). We use Keep Safe and Well documents. There is always some sort of training.

Q18 How do you maintain your continuous professional development within the service?

I do DOLS training every three months.

Group 6 Questions: Policy directives and organisational expectations

Q19 Can you tell me about any policies and protocols which exist within the Learning disabilities service which influence your practice?

Not sure about that. Not that I'm aware of. As a social worker I'm not aware of colleagues getting together. The only thing I know of is the challenging behaviour groups.

Q20 Can you tell me about any multi-disciplinary professional forums/advisory groups which facilitate multi-disciplinary working within your service?

***We do have the task groups. All different people go to each task group. Say the health task group a nurse would go to that** *(data extract: NMF). Yes I think it's very much around health. ***You know the task groups, there is the transition groups bringing people back. I do a lot of this work. I do work with the challenging behaviour nurse when I'm working with someone coming from C. We need to agree that he's ready through the CPA and we have joint risk assessment documents** *(data extract: NMF). We don't necessarily agree between us and we don't invite family at that point as it doesn't look very professional at that point. ***What I might do then is ask either the psychiatrist or psychologist to come along and go through things and make decisions that way. I do tap into others in that respect. The hardest thing is to get us all together. But when we do we get things moving** *(data extract: NMF).

Sometimes when I go to C. I'm on my own and when a psychologist starts talking about their assessments, I prefer it if one of our colleagues can come along so that they can pick things apart and see if there are any flaws in it. It's good for that.

Q21 How do you think the DH directives: Valuing People (2001) and Valuing People Now (2009) have influenced any service developments within the Learning disabilities Service?

Yes I think it's very much around health. You know the task groups, there is the transition group bringing people back. I do a lot of this work.

Researcher note: there was a sense of a lack of linkage between the more localised task groups and the national policy initiatives.

Appendix 9

This is an example of an NVivo *Annotation* and linked to data item (MDT, 5) (see Appendix 8). Annotations were used to capture the lived-world experiences of each participant about MDT working.

¹ This is a valid point. In terms of the perception of people with learning disabilities and how it might be difficult for colleagues to be able to communicate effectively with individuals.

^{2 3} A theme was beginning to emerge in terms of participants who worked within the service remained for a considerable length of time (7yrs+).

⁴ Very clear responses in terms of the terminology used to decipher the term learning difficulty/learning disability. This participant held the opinion that in order to acquire the term learning disability, a person is born with it and will always have it.

⁵ Good points made in terms of the identity of the service as a whole and needing to explain to other colleagues about the complexities about learning disabilities. There was often confusion about the name of the team and its remit.

⁶ An important point made about the co-location and access to each other easily. Regular contact with others made the job of the care co-ordinator easier to manage.

⁷ There was clarity about her role and additional responsibilities. She had a specialist role, as the (DOLS) and best interest assessor for the agency.

⁸ The connection between maintaining professional values was also linked to social work student placements in terms of re-visiting them and application to working practices within a MDT.

⁹ Relevant points emerged about the use of legislation/assessments/policy frameworks which directed the work in hand. She confirmed that an underpinning knowledge base was also beneficial for service users.

¹⁰ She explained how the use of reflection was beneficial to her practice when dealing with complex scenarios – especially when local people were angry with the agency – mainly about the paucity of local service provision.

¹¹ Relevant comments about working within organisations and some of the issues related to communication. Some decisions were more transparent than others.

¹² ¹³ An emerging pattern in terms of embracing MDT working and the influences that different colleagues bring to the discussions about service users/services.

¹⁴ Very good example of how the concept of multi-disciplinary practice works across the learning disabilities service. There is evidence of collaboration and the sharing of ideas and working practices between different disciplines, whilst offering each other support and advice about complex work.

¹⁵ ¹⁶ In terms of information sharing with citizens, there was a set procedure and also a different team who gathered the relevant information together on behalf of the participants.

¹⁷ Good example of how supervision was managed within this organisation. There was an expectation that supervision would be held once every six weeks. This included case management, areas for development/interest and discussions about complex issues in relation to service users and families.

¹⁸ This participant had a clear focus about her role and responsibilities. Her remit also included re-locating 'out of county' service users back into their area of origin.

Appendix 10

An Example of the Conversational Style of Interviewing

A Service User's story, Brian: January 2012

Background information

Single man in his 40s. Originally lived in his own flat but moved within the last 6 months to be with his 'lady-friend' within a supported tenancy arrangement with support staff. He previously lived in a single flat within a group of flats whose residents were very disabled and would not be independent of staff. Brian was isolated, had health problems and felt very lonely. He was a member of the Listening to People Group facilitated by the Service User Development Worker.

The Focused Conversation

What is your personal experience of working with social workers, community nurses or someone else from health located in either this MDT and/or the AHT?

I needed a social worker to help me because I have learning difficulties. I needed help with money and that. I have moved from E. I was in a flat by myself. I decided to move because I had health problems, Diabetes and Epilepsy. I was on my own but staff were there if I needed them. I told the support staff that I wanted to move. They got in touch with a social worker.

How did the experience make you feel?

A lady helped me to do my bills and that, she was a support worker. I was in a bit of a mess, to do with money. She helped me to live. My family come and visit now and again, but I was on my own. She filled in the benefit forms. She did other forms that

had information on them. I agreed with what was written on the forms, once the lady and the social worker explained them to me. The forms are complicated.

What went well?

A social worker helps people. They do all sorts of things. I expect them to talk to me ok and let me know what's happening. I knew most of the time what was happening. A couple of days a week a different lady used to come and help me with cooking. I used to get my shopping in myself, I was independent. It was about putting a meal together.

I needed help when I had been diagnosed with Diabetes and learn new ways to keep healthy. I didn't know how to look after myself and I ended up in hospital for six and half weeks, to try and get stable again. I've had Diabetes now for about two years and look after it with my diet. I have medication now, three tablets in a morning, three at tea time and three at bedtime. I feel ok now.

What could have been done better?

It felt alright to work with a social worker I'd know her for about twelve months. She used to come and see me at my flat. She used to tell the staff and the staff put it in my book. Sometimes she was a bit late. I talked face-to-face with a social worker. If she was coming to my flat, she would 'phone the staff up to tell them. When she came round she would talk to me about my money and it felt comfortable. But I wanted to live in the same house as my lady-friend, and I kept mentioning this, I felt she ignored this for ages. This was before I went into hospital.

How did your personal experience affect your situation?

When I had to go into hospital about my Diabetes, another social worker came to see me about how I was going to live when I was better. I told her that I wanted to live in the same house as my lady-friend, as I've known her for 20 years. I'm in a house now

with two other people and staff, it took about six months. It's great, it's good. I've got company all the time, someone to talk to. My lady-friend lives there as well. We go out and do our shopping. When I'm in the house I have someone to talk to. I like films and I've lived there since September. I'm happy, because I've got company. I liked my social worker, she needed to understand my situation and listen to me. She was easy to chat to and came when she said she would. A couple of times she was a bit late, she had to go to other places first. She arrived and apologised for being a bit late. She used to come up with ideas, if I didn't like the ideas I used to tell her. She was alright about that.

The social worker came to see me and told me that I was doing well and took me off her books. I felt great that I was doing well; I thought I was, and it was nice to hear that from a social worker. I felt a lot better when I moved. I was lonely no-one to talk to, I used to shut the door and lock myself in and it was horrible. I got fed up with that - it just went on and on.

I go to St. G's on Fridays. It's a daycentre, but I go to the Supported Employment Office upstairs. I got a job through supported employment. But when I was in hospital I had to finish. I used to work in an Old People's Home, in the kitchen, I still visit them though. I'm looking for another job and filling in applications forms. I would like kitchen work, but would like part-time hours.

Appendix 11

An Example of the Conversational Style of Interviewing

A Care's Story, Mrs A: March 2012

Background information

A married (heterosexual) female Carer in her 50s

Has a son with William's syndrome. This was diagnosed when he was 9 years old. William's syndrome has similar manifestations to that of Down's syndrome. There was a great deal of focus upon confirming the diagnosis, so that the family would be entitled to welfare benefits and services.

The Focused Conversation

What is your personal experience of working with social workers, community nurses or someone else from health located in either this MDT and/or the AHT?

We first got to know social workers through Barnardo's. This was when he was diagnosed with William's syndrome; it was a blessing but also really depressing knowing that my son was different from other children. I mean, how were we supposed to cope with this news. Nobody helped us and we had to just get on with it. It has really affected my mental health over the years. Some social workers were really good they were interested and tried to help where they could. They gave us information about benefits and also advice. One social worker tried to arrange some respite, but it didn't work. My son finds change difficult.

How did the experience make you feel?

Social workers encouraged our son to be a part of a group of children, some had difficulties, but different from our son. We had a number of visitors such as, doctors,

social workers and a health visitor over the years. Social workers came every now and then to help.

What went well?

I was aware that the social worker who visited when our son was an adult was part of a multi-disciplinary team. Whenever we needed help the social workers were always there to provide help and guide us about different avenues. They were easy to contact and reliable. We've been really fortunate with the social workers we have come across. We have a lot of confidence in them because we know they are really caring about people like my son.

What could have been done better?

When our social worker changed we felt the pressure to move him into independent living. We knew he would have to leave home, I couldn't care for him like I wanted to and he ended up in an emergency placement. He got really depressed and thought me and his dad had just left him. He did have some problems, but we were trying to help him, it's so upsetting all of this – it got me down. Anyway when he got well again, we tried Family Placement, but the couple didn't want him and sent him home again. I thought he had done something wrong. He began to deteriorate from then on.

How did your personal experience affect your situation?

I was really grateful when I met the carer's social worker she became a resource for the family. When our son went into respite again after a few months, we were asked to attend a meeting and we found out later that it was a best interest meeting. At the time it just went over my head, as I was already feeling depressed about our situation. There were enough staff in the meeting, I felt I couldn't say anything much and wanted to cry. I knew that I would have to let him go as some point, even though I didn't want to, I felt all the power had shifted to the social workers.

Appendix 12

As part of the scholarly journey undertaken during the lifetime of this study (2008-2017) I published one related journal article cited within this thesis (5.9.3) and (6.16.1) and a book chapter. I also created a number of themed conference papers, (CP) all of which were presented at international social work conferences over a period of seven years.

DATE	CONFERENCE	POSTER/ABSTRACT/PAPER	LOCATION
23-25 March 2011	European Conference for Social Work Research (ECSWR)	Poster: Agreement or Acquiescence? Issues of informed consent: Mental Capacity Act 2005	England University of Oxford: St. Catherine's College
20-22 March 2013	ECSWR	CP: The process of social interaction & participation between social workers and allied health colleagues within a MDT context	Finland University of Jyväskylä
July 2013	Book Chapter: Key Concepts in Social Work Practice. London: Sage	Multi-disciplinary Working pp. 151-155	International
15-17 April 2014	ECSWR	CP: Carers & their Narratives: MDT experiences	Italy University of Bozen/Bolzano
June 2015	Journal: Social Work & Social Sciences Review	Paper: *The notion of citizenship for people with intellectual disabilities in the UK: A life of their own	International Special Issue: Disability and Enabling Approaches

			Volume 17 (3) pp.33-45
26-27 August 2015	International Conference on Sociology and Social Work. New Directions in Critical Sociology and Social Work: Identity, Narratives and Praxis	CP: Communities of Practice, a theoretical perspective: identities and crossing boundaries within a MDT context	England University of Chester
30 March-1 April 2016	ECSWR *Dissemination	Article: The Notion of Citizenship and people with intellectual disabilities: A UK Research Study	Portugal The Catholic University of Portugal (Lisbon)
6 September 2016	NHS (England) National Institute for Health Research (NIHR): Research Design Service	Poster: The Engagement of 'hard to reach' Citizens: A Narrative Inquiry Approach	England Manchester: The Studio
19-21 April 2017	ECSWR	CP: Social Work Research, Challenges and Possibilities: the inclusivity of adults with Intellectual Disabilities within research	Denmark Aalborg University

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