Tearing down the Berlin wall: social workers’ perspectives on joint working with general practice

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Background. The arrangements for delivering social work and primary health care to older people in England and Wales are currently subject to rapid re-configuration, with the development of integrated primary care and social services trusts.

Objective. To investigate perceptions of joint working in social services and general practice.

Methods. The study setting was two London boroughs covered by one health authority, one NHS Community Health Services Trust, four Primary Care Groups and two social services departments. All social work team managers in both areas were interviewed together with a purposive sample of social workers with a high number of older clients on their caseloads. A sample of GPs was sought using a sampling frame of practice size in each borough. Structured interviews with open and closed questions were used. Tape-recorded interviews were transcribed and subject to thematic analysis. Analysis of emergent themes was aided by the use of Atlas-ti.

Results. Social workers and GPs agree on the need for joint working, but have different understandings of it, each profession wanting the other to change its organizational culture. Co-location of social and health care is seen as desirable, but threatening to social work. Concerns about differences in power and hierarchical authority are evident and explicit in social work perspectives. Conflict resolution strategies include risk minimization, adopting pragmatic, case-specific solutions rather than remaining consistent with policy, using nurses as mediators, and resorting to authority.

Conclusions. Although this is a study from urban areas in England, its findings may have wider significance since we have found that resources and professional skills may be more important than organizational arrangements in collaborative working between disciplines. Primary Care Trusts in England and Wales should promote awareness of these different perspectives, perceived risks and conflict minimization strategies in their work on clinical governance and professional development.

Keywords. Collaboration, joint working, partnership, social care.

Introduction

Promoting collaborative working between social and health care remains high on the policy agenda in many countries, particularly in the care of older people. Changes in the UK may contain important lessons for those promoting joint working across professional boundaries in other countries. Following the fundamental changes brought about by the NHS and Community Care Act 1990,1 and particularly since the change in Government in 1997, a stream of legislation, guidance and funding for special initiatives has encouraged partnership working in health and social care at strategic, operational and individual levels. One Secretary of State for Health described the task of bringing health and social care together as like “tearing down the Berlin wall”.

Key policies include The NHS Plan2 which offers incentives to local councils and health authorities to exercise their powers for joint working under The Health Act 1999. Health and social services are now implementing a new duty of partnership, working
Social services representatives on the boards of Primary Care Trusts have been identified as one of the levers to shift partnership working from the margin to the mainstream of practice, under The 1999 Health Act. However, such a shift has not occurred in the two decades since Huntington detailed the distinct occupational cultures of social workers and GPs and outlined the power differences between them. These included differences in status, authority and prestige, knowledge, language, focus, orientation and time perspectives, which acted as barriers to successful collaboration. Inter-professional collaboration remains problematic, whilst being a policy imperative with increasing salience. We have reviewed the experience of innovative approaches to joint working between health and social care in depth elsewhere. Given the convergence of social and health care services in Primary Care Trusts in England and Wales, and the imperatives for closer working introduced by the National Service Framework for Older People, it is important for professionals to understand how they are perceived by colleagues in other disciplines.

In this paper, we will present findings from a series of structured interviews that were carried out with social and primary care practitioners and managers. This formed the first phase of a wider study looking at the outcomes of different working arrangements between primary health and social care on community dwelling older people. 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 focus of this report is primarily on social work perspectives on collaborative working; GP perspectives will be reported in greater detail in a further publication aimed at a social work audience.

Methods

Location
The project was carried out in two London boroughs covered by one health authority, one NHS Community Health Services Trust, four Primary Care Groups and two social services departments. The two boroughs were chosen pragmatically because of their differing arrangements for collaborative working between mainstream social services and primary health care: social work teams for older people were co-located in health centres with community nurses and/or GPs in one borough but not in the other. The areas have high levels of morbidity and deprivation and hence provided a challenging environment for partnership working.

Structured interview
The key themes of the interview schedule were guided by the findings of the literature review and contained core questions that were asked to all interviewees as well as profession-specific questions. The interview schedule contained both open and closed questions. Through piloting with social workers and academic GPs the schedule was adapted to suit the length of time it was anticipated each professional group would be able to set aside for interview. All those interviewed were asked about reasons for contacting other professionals; any formal and/or informal working arrangements in place and the strengths and weaknesses of them; whether they had encountered any differences in professional opinion and how these had been resolved; their opinion of the roles of different professionals involved in the care of older people and their communication with these professionals; training and professional support and general questions about optimising care provision for older people.

Sampling and analysis
The multidisciplinary nature of the research team was made clear to all study participants because the professional identity of the researcher plays an important part in constructing the kind of data obtained in qualitative studies. All social work staff participating in the wider study were interviewed, namely all social work team managers in both areas together with a purposive sample of social workers with a high number of older clients on their caseloads. A sample of GPs was sought using a sampling frame of practice size in each borough. Interviews were tape recorded in the practitioners’ workplace with an assurance of confidentiality and anonymity. The tape-recorded interviews were transcribed. Thematic analysis of the transcripts was carried out in which the text was coded and annotated to identify emergent regularities in the text and group them into themes. The codes and annotations from individual interviews were pulled together and patterns and regularities across
the data were then sought, that is, case analysis was followed by cross-case analysis. Data analysis was commenced during data collection. As subsequent interview data was analysed, themes were added to, altered or deleted. When it appeared that themes had been validated by sufficient interview data, that is, when the data had reached theoretical saturation, interviewing was stopped. To ensure reliability, the original transcripts were read and the categories agreed by the multidisciplinary research team. Analysis of the emergent themes was aided by the use of Atlas-ti, a qualitative data analysis package.

Results

Interviews were carried out with a total of 69 health and social care staff in the two boroughs, including 52 social workers and their managers and 14 GPs. The interviews varied in length by profession; the mean length of social worker interview was 62 minutes and with GPs, 28 minutes.

Of the social workers, two-thirds were female, 70% held a social work qualification, almost all worked full-time and the mean length of time in their present post was 35.7 months (SD 45.5). There were no differences between boroughs. The demographic characteristics of the primary health care workers were also comparable across the two boroughs and GPs worked a mean number of 8 sessions per week. However, the differences between the primary health and social care workforce were considerable. GPs had been in their current posts for a mean of 180 months (SD 68.9)—five times as long as the social workers. All primary health care workers described themselves as White UK or White other, whereas social workers identified with a greater range of ethnic backgrounds and were more representative of the ethnic diversity in the study areas.

We identified three over-arching themes: the problems of current arrangements for joint working; methods for overcoming these problems; and techniques for resolving or managing conflict between services. These are described below: italic text represents sub-themes within the main themes.

The Problems

“well I actually find GPs the most difficult professionals to work with out of all the ones we work with.” (SW 10603)

All social workers and doctors 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 organizational procedures. The second was the particular combination of local policies, structures and organization.

Awareness of roles. One way in which a lack of understanding of roles and functions emerged was through the different perceptions of time and urgency. “When the 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.” (GP 23901)

Another appeared almost as a command-and-control relationship between general practice and social work. “I find doctors don’t sometimes seem to understand that we have to do an assessment from a different perspective than they do and they seem to, quite often, have made up their minds of how things are supposed to go and then, it almost feels like they’re instructing us, ‘this client needs a residential home—and you arrange it’.” (SW 10603)

Social workers also 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.

Overcoming problems of joint working

Social care practitioners and team managers were clear that joint working needs to be co-ordinated to avoid clients/patients slipping through the net, or an overlap of professional involvement which can be confusing and frustrating for older people. GPs also wanted a reduction in the number of assessments done by individual professionals and the number that were needed before services can be received. The solutions proposed were a range of methods to foster joint working, and co-location of social and primary care staff. However, their views on the methods, course and outcome of these solutions varied considerably.

Fostering joint working. In the borough with clear separation of social and primary care the problems of distant, telephone based communication between health and social services was frequently raised by the interviewees. Many felt that working arrangements that involved increased face-to-face contact and multidisciplinary meetings would improve the interface between health and social services. Although in co-located services social workers and GPs described improved communication and working arrangements on a day-to-day basis, social workers expressed a need for more formal contact with their health and social care colleagues. This would be in the form of regular, planned, multi-disciplinary meetings, with both front-line staff and management, to discuss both general issues and shared cases and to enable them to work together in the planning and delivery of care. This would encourage a greater understanding of roles and the issues faced by each group and was seen as a way of overcoming differences.
Regular formal discussion was viewed as a learning environment and a means to sustain joint working. Social workers who had experienced closer working arrangements in previous posts, compared their experiences and described one of the advantages of multidisciplinary working as the potential it has to challenge working and described one of the advantages of multidisciplinary email. This perception prompted debate of information technology, for example, by the use of multidisciplinary email. This perception prompted debate about confidentiality, an area in which GPs and social workers had differences of opinion. GPs were keen to have social care information entered onto their systems but the idea of a central, shared record raised anxieties among social workers. One GP commented that:

"Where I have experienced people using their imagination is where they're in multidisciplinary teams, where people's practice is open to somebody else going over and saying 'what are you doing that for?'" (SW 20401)

The medical perspectives on joint working were different, in that they saw collaboration dependent on shared records and the re-structuring of social care, not general practice. GPs in the larger group practices that were records and the re-structuring of social care, not general practice. GPs in the larger group practices that were among social workers. One GP commented that:

"There is a resistance on the part of social workers as a whole, in my experience, to sharing patient records with doctors and I think that should be looked at and I feel that there is flexibility in terms of what...they don't need to put confidential information on if they don't want to, but their contacts would be useful so that when we go into the records we would see that they had just had a contact, that would be useful." (GP 10901)

Co-location. Sharing the same working environment was seen as a positive development by both GPs and social workers, but posed a number of threats for social care. Being seen as a resource was double edged as social workers felt it did not encourage health colleagues to understand the role of social workers. Social workers often referred to wanting an increase in formality or structure so that referrals were made through the appropriate channels rather than, for example, a note left on a desk at 5pm. Co-located social workers talked of the potential of feeling isolated and the importance of having their own professional peers around them.

Improvements suggested by GPs often involved re-structuring of the delivery of social care with little change to their own working arrangements. GPs with co-located social workers were keen to maintain this arrangement and those without, proposed this as a potential improvement:

"from our point of view, which is clearly a very particular point of view, from our point of view it would be much better if we had social workers based here who could, like the district nurses, deal with the patient base." (GP 10502)

A GP in a large group practice in the borough where co-location was commonplace could not think of a weakness of their working arrangements with their co-located social worker, but did point out that "there's a risk of over referral, because referral is easy". In addition, a social worker pointed out that co-location generated very high expectations of working relations with health colleagues which could not always be met outside of that setting.

"I think it works much better when it's with people who are on site rather than people who are not on site, and I think in some ways that it works so well with people based here that maybe the expectation is that it is going to be easy with others and it's not always." (SW 10301)

Resolving conflicts of opinion

Differences of professional opinion between primary health and social services were most often discussed in terms of conflicts between GPs and social workers in crisis situations. Areas of greatest friction for social workers were when asking GPs to carry out home visits, to re-assess their patients, to refer their patient to hospital specialists, especially the geriatrician or psychogeriatrician, or to give permission to themselves to refer directly or arrange hospital admissions. This was sometimes associated with the tendency of some GPs to 'prescribe' residential care before a full assessment had been completed.

"Disagreements when I've done visits and I'm really concerned and I phone them up and ask them to go and do a visit and potentially somebody's going to need to go into hospital and then they phone me back and say they're fine, getting a care package, and it's totally inappropriate." (SW 20309)

An explanation given by a social worker for the differences in professional opinion is the different models health and social care professional work within and the levels of acceptable risk they allow. This explanation was again given in relation to the often contentious issue of whether an individual can be
supported in the community or needs residential care:

“...the same issues come up because they work from medical model and we work from the social model and if, of course, their assessments of risk are quite different to ours because we have a kind of higher level of acceptable risk. I’ll give you an example, say that a doctor might feel that a person needs to be in residential care because they’re at risk in the community, because they’re not looking at it as holistically as we are. But we, we would see that this level of risk is allowed, so they’d become, so they could maintain their independence.” (SW 10202)

How differences of opinion are resolved

“Well you jump up and down and scream, I mean I’m quite well known (laughs), I start screaming people usually, eventually, do things because um, wouldn’t you if I was screaming down the phone at you! You certainly would.” (GP 10101)

Dealing with differences of opinion when working collaboratively appears to be commonplace. Health and social care professionals in both areas described situations that had been unresolvable as well as strategies they had developed for dealing with difficult scenarios. For social workers these strategies included risk minimization, conceding on policy and accepting pragmatic solutions, using nurses as mediators and resorting to hierarchical authority.

Social workers suggested that one way of resolving the problems that arose due to the different models within which health and social care practitioners work was to implement mechanisms to minimize the risks for their shared clients/patients and to decide who takes the responsibility for that risk if a joint decision is made. They felt strongly that this responsibility should not fall on social services alone if the issues are multi-faceted, particularly as problems were often resolved as individual cases, rather than strictly in-line with established policies.

“They usually are resolvable um, but resolvable, resolved on, as individual cases rather than policy. I suppose, perhaps that’s improving.” (SW 20502)

The key role of community nurses as mediators between social workers and GPs was raised by both professional groups. Social workers in both study areas described how they worked mainly with district nurses, community psychiatric nurses (CPNs) and sometimes practice nurses, to access or bypass GPs.

“...we find too that our contact with the GP is often through the nurse which is very frustrating, but often you know the GP isn’t available to us, or you just can’t sort of get access to them.” (SW 10501)

“Well we can sometimes get around them [GPs] via the CPNs, that’s been really helpful, yes, so sometimes for example we can refer directly to the CPN. Because if its CPN input we don’t even touch the general practitioners, its like the CPN, they can refer direct to old age psychiatry.” (SW 10408)

Social workers in both areas said 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.

“And I also use my manager, there seems to be a magic thing about a manager, when a manager rings it always seems to be different, so if worse comes to worst, I ask my manager to intervene.” (SW 10603)

Team managers understood and shared some social workers’ views on the unpredictability of relationships with primary care:

“Well, I think its purely personality. If you said the name of one GP I would say to you ‘oh no, I’m sure that if I give them a ring that will be fine’, if you said the name of another GP I’d think ‘oh yeah, well, you know, humm’... Sometime the district nurses who know the GPs very well might help us to intervene...” (SW 10401)

Discussion

This study reports findings from an inner city area with high levels of deprivation, and its findings may not apply in other settings. The demographic characteristics of the social care workers in our sample were similar to those reported in other surveys of front-line social services staff but the number of social workers holding a social work qualification was 70% in both areas, which is lower than in other studies, and this may have influenced their responses. The difference in number of social work and general practice interviews reflects the fact that the social workers were committed to participation in the wider study. Despite the smaller number of GPs interviews, the multidisciplinary research team were reassured that themes from both professional groups had been sufficiently validated by interview data. It is noteworthy that only white doctors agreed to be interviewed, given the ethnic composition of the general practice workforce in the study areas. These limitations of the data may reduce the external validity of our findings, but we believe that important themes emerged that have wider resonance and significance for the further development of joint working. These lessons may be relevant beyond the UK context since they refer to fundamental issues around the power and role of different disciplines.

Despite the different working arrangements between primary health care and social services, similar themes
emerged, that were largely profession specific, between the two areas. The lack of awareness of different roles does not appear to have changed in the twenty years since Huntingdon published her study of general practice and social work, and since Sheppard’s finding that GPs were largely ignorant of social workers working practices and training requirements. Primary Care Trusts will need to address this issue as part of professional development if joint working is to improve.

Whilst GPs and social workers agree that joint working should have advantages for their shared clients/patients, each profession wants the other to change its way of working. This is one of the cultural differences explained by Huntingdon that still holds true today and is applicable across health and social care systems in different countries. Described as ‘action versus holding orientation’ she explained how medical training focuses on swift decision making to enable competent handling of emergency situations, whereas social workers are taught that better decisions are made if a situation is contained until the opinions of all concerned are clarified. There is ample scope for conflict between disciplines here, which local service administrations will need to address, taking into account the significant differentials in power between the disciplines that Huntingdon described in her early work and Manthorpe and Iliffe confirmed in a later review.

The emphasis that GPs placed on common records may reflect the poor social content of medical records compared with social care records, found in the wider study when social worker and GP notes were examined for shared clients/patients. This may also be a reflection of the power difference between the disciplines, which allow general practice to have poor quality records whilst social workers must be more meticulous in their documentation. Shared records across health and social care have featured increasingly often in recent years since Huntington published her study of general practice and social work, and since Sheppard’s finding that GPs were largely ignorant of social workers working practices and training requirements. Primary Care Trusts will need to address this issue as part of professional development if joint working is to improve.

Co-location is perceived as potentially threatening by social workers, even as it is welcomed as a logical mode of organization. Here we see directly the concerns that social workers have about the extent of medical power and knowledge, and the hierarchy of authority between general practice and social work. The concern that referral thresholds may change is supported by evidence from earlier social work for older people studies and underpins the current emphasis on care management as the primary role and task of social workers. An additional unease is that attached social workers as specialists may become absorbed into practice teams and have difficulty working to social services priorities, agendas and entry criteria. The conflicts that result from these different, sometimes opposed perspectives are resolved using a variety of strategies which involve concession, mediation and authority. Primary Care Trusts need to understand these conflicts and tensions when promoting joint working and should promote awareness of strategies to resolve them in their work on clinical governance and professional development.

Declaration

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Conflicts of interest: none.

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