Health and Social Work Practitioners' Experiences of Working with Risk and Older People: The Interconnectedness of Personalities, Process and Policy

INTRODUCTION

This paper explores interprofessional and multidisciplinary working between health and social care practitioners providing services to older people through the prism of how risk is assessed and managed. Whilst interprofessional and multidisciplinary working within and between health professions are commonly researched areas, there is a relative paucity of empirical evidence which include social care and more specifically, social work perspectives. Yet, under the auspices of UK policy imperatives espousing partnership and collaboration, interprofessional and multidisciplinary working have become central tenets of health and social care legislation (Thomas, Pollard and Sellman 2014; Williams and Davis 2014; Riste 2018). The concepts of interprofessional and multidisciplinary working are not new but rather have a history within public policy dating from the late 1960s when concerns regarding the lack of formal partnerships between health and social care agencies began to surface (Henderson 1966; Black 1977; Dingwall 1977).

The merits of interprofessional and multidisciplinary working are commonly acknowledged. It is viewed as an effective mechanism for bringing together a range of disciplines to integrate their respective expertise towards a shared goal (Vyt 2008; D'Amour *et al.*, 2005; Hall 2005; Baxter and Brumfitt 2008; Rout, *et al.,* 2010; Reeves 2010; Roncaglia, 2016). Indeed, according to Glasby and Dickinson (2014), effective partnership and collaboration really can mean the difference between life and death and harmful events may occur when services are not properly joined up. However, the terms 'partnership' and 'collaboration' may be seen as ubiquitous and often perceived as incongruent with the realities of the current structural, cultural and ideological divisions that have emerged in the UK as a result of successive post-war governments' neo-liberal social and public policies (Means and Smith 1998; Glendining, Powell and Rummery 2002; Lymbery 2006; Bouch 2011).

Similarly, risk and risk management within health and social care policy and practice are contested ideas. Across all facets of life, risk has become a central structural and political concept used to manage and regulate the population. Drawing upon the seminal work of risk theorists such as Beck (1992, 1999); Douglas (2003); Adams (1995); and Lupton (1999); structural and cultural responses to risk reflect postmodern societies' preoccupation with

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blame, litigation and a demand that risk should be calculable, predictable and therefore avoidable (Carson 2012). For older people, risk has also become a defining feature in how they are represented within policy and practice. Labels and descriptors such as 'frail' and 'dependent' are used to categorise their health and social care needs according to severity of risk in order to satisfy increasingly narrow eligibility criteria for services and support (Kemshall *et al.* 1997; Phillips, Ray and Marshall 2006; Beech and Ray 2009). As Power (2004:9) argues, such dominant risk discourses have 'invaded organisational life' to the extent that, even where unintended or unforeseen negative consequences occur, blame and accountability must be determined. Thus, the ways in which health and social care organisations and practitioners work with risk and older people within multidisciplinary teams under the spectres of blame and litigation has been the focus of many authors.

Consistent with global trends, the population of the UK is ageing rapidly (WHO 2018). In the UK, it is anticipated that over the next two decades the greatest growth will be for those aged 65 years and over with a similar forecast for those aged 85 years and over (Office for National Statistics 2016). Whilst increases in life expectancy had initially indicated that people could expect to live longer, healthier lives, gains in the number of disability-free years after the age of 65 have reduced from their peaks between 2005-07 and 2010-12. More recent data suggests that for those who live into their late 80's and beyond, over a third will have difficulties in undertaking five or more tasks of daily living (Age UK 2017). Older people already are the largest group to access local authority social services and account for around 40 per cent of all hospital bed days (Age UK 2013; Milne *et al.* 2014). Recognising the significant challenges in managing the care implications arising from population change, alongside deepening inequalities because of the impact of austerity upon service budgets, governments have made considerable efforts to implement policies promoting better-integrated health and social care.

This paper presents findings from a qualitative study conducted in Wales, UK that explored the complex dynamics of interprofessional and multidisciplinary working between health and social work practitioners within multidisciplinary teams who engage with older people. This exploration focused on perceptions, understandings and use of the concept of risk by professionals, from different disciplines, working together to meet the needs of older people. From the findings, three main areas emerged with respect to the saliency of the complex interconnectedness of individual practitioner *Personalities* with the *Process* of

interprofessional and multidisciplinary working and the *Policy* (including legislative context) that underpins it within the UK. Within the context of this research, *Personalities* are defined as the knowledge, attitudes and relational skills of practitioners and how these are mobilised within the multidisciplinary context (Suter et al. 2009; Keeping 2014; and Roncaglia 2016). *Process* denotes the bringing together of a range of individual practitioners, their respective personalities and their professional expertise, knowledge and skills (Reeves 2010; Roncaglia 2016; O'Leary 2016). Finally, *Policy,* which encompasses legislation and policy that underpins the delivery of health and social care services for older people, speaks to the findings that relate to practitioners' views and experiences of working within the current legislative and policy context.

METHODS

An interpretivist phenomenological perspective guided the research design for this qualitative study in order to seek understanding of health and social work practitioners' views and experiences. Interpretivism is particularly appropriate within human and social sciences since it is more concerned with understanding than explaining phenomena although as Crotty (1998) points out, interpretivism may also include explanatory enquiry. Within the context of this study for example, whilst health and social work practitioners would routinely encounter many natural laws such as ageing, chronic illness, disability and death, it was the construction and use of concepts such as risk and of the organisational cultures, in which they worked that was particularly important to understand. Phenomenology is relevant since it questions how individuals (in this case health and social work practitioners) make sense of the world around them. This perspective also applies to the researcher with in-depth knowledge of the field of enquiry who, in conducting the research, had to set aside their own preconceptions of that world (Bryman 2004:542).

Methods of data collection and analysis involved semi-structured individual interviews with health and social work practitioners and non-participant observations of multidisciplinary team meetings. Bryman (2004) describes how semi-structured interviews are a useful technique that allows leeway to both the interviewer and interviewee including the sequence of questions and the addition of further questions or discussion around the answers given. This flexibility was deemed appropriate and necessary within this study since the researcher would be interviewing both health and social work practitioners and therefore crossing between familiar and unfamiliar territory.

For this study, the use of non-participant observation was used as a means of triangulating the data, comparison and as a means of managing the researcher's familiarity with the field of study and letting the data 'speak for itself'. In accordance with an interpretive phenomenological perspective, observation techniques allow the researcher to view familiar processes with a fresh perspective and through the lens of a researcher or observer rather than 'expert' (Crotty 1998:54). Initially, the researcher had planned to video-record multidisciplinary meetings in order to capture the interactions between practitioners and the process of multidisciplinary working for the purpose of analysis. However, due to a primarily negative response from participants, this idea was abandoned and the researcher had to rely upon handwritten notes and thus, only a surface investigation was possible (Spradley 1980). Ethical approval was granted by the Swansea University College of Human and Health Sciences Ethics Committee and a Regional Research Ethics Committee.

Data Collection

Qualitative data were collected over a period of 36 months via individual qualitative semi-structured interviews (n=23) and non-participant observation of multidisciplinary team meetings (n=4). Interview participants included; Registered Social Work Practitioners ($n=10$); Physiotherapists ($n=4$); Occupational Therapist ($n=3$); Clinical Nurse Specialist ($n=2$); Ward Nurse ($n=3$); and Medical Doctor ($n=1$). Interviews were conducted at a venue of the participant's choice and ranged in length from between thirty minutes and one hour. Observation of multidisciplinary team meetings were conducted at their usual venue. Participants were recruited from across a co-terminus Local Authority and University Health Board that covered an area comprised of a 66% rural and 34% urban split and a population of over 241,000.

Accessing social work practitioners was organised via divisional directors and heads of service of the local authority with individual practitioners making direct contact with the researcher if they were interested in participating in the study. Accessing participants and multidisciplinary teams within the University Health Board was organised through the Research and Development department who cascaded information through to Clinical Directorate Leads, who would make direct contact with the researcher if they were interested in participating in the study. A Participant Information Sheet was provided to each participant prior to the individual interviews and observed team meetings. Informed consent was obtained from each participant before any data collection began. Both sets of

gatekeepers were provided with the inclusion criterion for the study, which for multidisciplinary teams were that its remit covered older people and its membership included social work practitioners. The precise specialism of the team was not a selection criterion. The inclusion criteria for participants in the semi-structured interviews were that all participants were professionally qualified and registered and worked within a multidisciplinary context with older people. Individual characteristics such as age, gender and length of time in practice were not collected.

Eight multidisciplinary teams that met the study criteria were contacted and invited to participate in the study. Six responded to express initial interest. Of the six, three did not proceed any further and one involved patients being present, which was outside of the study's ethical clearance. Two subsequently agreed to participate initially, one covering general medicine and surgery and the other a specialist palliative care team. Both were deemed suitable for different reasons and capable of generating rich data with respect to the complexities of interprofessional working within multidisciplinary teams across two different specialisms. However, the inclusion of the multidisciplinary team covering general medicine and surgery was abandoned after a participant subsequently declined to be observed. Additional efforts to recruit a multidisciplinary team in a similar setting were unsuccessful however; a second palliative care team came forward, which was subsequently included. After completing four observations, two with each team, it was decided that no further observations would be conducted due to concerns that the data being generated would not be capable of meeting the methodological objectives explained previously in this paper. The main concern was that, due to the palliative care specialism of the team, team discussions were dominated by medical and health perspectives and so the role of the social worker was less visible. Indeed in one of the teams, the social worker did not attend either of the observations.

Semi-structured interviews with individual health and social care practitioners were audio-recorded and later transcribed. The design of the interview schedule reflected Fook's (1992; 2002) approach to critical reflexivity to generate practice theory and further build upon methods of data collection used in Stanford's (2009) study of Mental Health Social Worker's risk practice in Australia. The interview schedule was broken down into two main parts. The first section included an outline of a typical admissions or referral process and the point at which they would become involved in the care of the 'patient'. This section also sought to

explore participants' general perceptions and understanding of risk. The second section asked participants to indicate the extent to which they would be involved in assessing risk; who else would be involved; and how they assessed risk. Here, participants were given the opportunity to share their experiences of interprofessional working within a multidisciplinary team. This approach allowed considerable leeway for the researcher to note certain responses and to seek further clarification and exploration during the interview.

Data Analysis

A Framework Approach (Ritchie and Spencer 1994; Ritchie et al. 2003) was used for data analysis that allowed for an exploration of participants' views and experiences of multidisciplinary and interprofessional working involving both health and social care practitioners alongside existing relevant theories, models and empirical data. The framework approach allows for socially located responses, that is responses from participants that include ideological and cultural beliefs. It also requires a broader more deductive approach when analysing data according to a pre-existing theoretical perspective (Gale *et al.,* 2013). Data were entered in NVIVO 9 for coding, indexing and storage purposes. A coding hierarchy was developed which was influenced by the methodological approach to this study in addition to the available literature of the research topic.

Ethical and Quality Issues

The researcher's professional background as a social work practitioner with extensive experience of working within community and multidisciplinary settings, whilst anticipated to be beneficial to the research process and in gaining the trust of participants was also noted as a source of potential bias. Dwyer and Buckle (2009) contend that much of the discussion around the role of researchers in qualitative research is concerned with observation, field research and ethnography and that the issue of researcher insider-outsider status is important. For Dwyer and Buckle (2009) and Brannick and Coghlan (2007) insider status appeared to be a fixed commodity and anticipated to yield favourable access and acceptance within some of the study sites.

FINDINGS

Whilst similar numbers of health and social care practitioners were recruited to this study, participants from 'health' professions represented a much wider range of professional

disciplines than participants from social care, who only represented the social work profession. Thus, the results presented here reflect a stronger social work perspective, which within the context of this paper adds to the exploration, given that social care and particularly social work perspectives are under-represented within the literature. Analysis of the data suggested an intersectional and interconnected relationship between three main themes; *Personalities*, *Process and Policy* (including legislative context) with respect to how health and social work practitioners work interprofessionally within multidisciplinary teams with risk and older people.

Understanding the Importance of 'Personalities' within Interprofessional Working

A key finding of this research was the importance of practitioner personalities within interprofessional working with risk and older people within multidisciplinary teams. Drawing on the work of Suter *et al.* (2009) and Keeping (2014), *Personalities* in the context of this discussion, is defined as the *knowledge, attitudes* and *relational skills* of individual practitioners and how they mobilise their personal and professional identities within multidisciplinary contexts. Breaking this concept down further, *knowledge* encompasses the understanding of one's own and others' professional roles and responsibilities and how these intersect. *Attitudes* refer to the willingness to acknowledge, accept and value the contribution and expertise of others, even where these may challenge one's own personal or professional perspective. *Relational Skills* refers to the ways in which health and social care practitioners communicate with one another. These skills include negotiation and the ways in which they manage differences in opinion or even disagreements. These components are evident in the following comments from a study respondent;

> "The good thing about working in a multidisciplinary team is that you see things from another professional's point of view so you get a more holistic view of that patient's needs and what that professional can and cannot do for the patient. You learn a lot from one another. The multidisciplinary team works well because we value one another's opinion…" (Occupational Therapist)

The willingness to mobilise one's personal and professional identity in this way is the cornerstone of effective interprofessional practice. For Freeth (2001), this willingness to work is linked to practitioners' sense of moral obligation to work together. As Keeping (2014) and Stanford (2009) suggest, this reflects how practitioners enact a 'moral stance' to foreground ideologies that focus on person-centred practice rather than promoting or protecting one's own 'status';

"…it's about us all saying 'okay let's work together…I think it's the only way we can break down the barriers between us..." (Occupational Therapist)

Adamson (2011), Sellman (2010) and Keeping (2014) all agree that practitioners need to be able to trust one another in order to achieve effective interprofessional relationships within the multidisciplinary team. For Adamson (2011), trust develops as practitioners learn to become empathic and understanding of one another's perspectives and responsibilities and how they interconnect within the multidisciplinary team. Relationships are crucial in achieving effective interprofessional working and effective interprofessional working requires more than just the physical proximity of practitioners to one another (Sellman 2010; Adamson 2011; Keeping 2014). A study participant who was a clinician, commented how the knowledge, attitudes and relational skills of practitioners were key components of what they emphasised as a 'well-functioning' multidisciplinary team:

"The empirical fact, we see it day by day, is that you are able to do something incredibly useful and meaningful for the large majority of patients and families that you meet. It works better when you do it as part of a well-functioning multidisciplinary team, which of course doesn't mean that there's a bunch of people sitting around a table not listening to one another. It has got to be well-functioning for that to work...there are a number of elements. To a certain extent I think it depends on the practitioner is because we all bring something of ourselves to our professional roles. So it's about a high level of communication, and it's about the quality and standard of understanding of risks and uncertainty facing the patient..." (Medical Doctor)

Whilst managing divergent views was identified as one of the main challenges for health and social care practitioners, the personalities within the multidisciplinary team were important in overcoming them. Rather than the point of disagreement being the problem, it was how practitioners dealt with the issue was that mattered. Indeed, practitioners who embraced and valued the broad range of knowledge, skill and expertise which different professionals brought to the multidisciplinary team found that it not only enhanced their ability to make better decisions but also in bolstering their professional judgment and knowledge.

"We're so much further forward; we're more of an established team now. The social worker has been static in our team for the last year which definitely makes a difference because there's a much better understanding of risk and trust...what's good is the personalities involved because we have worked together and got to know each other we know that, while we may disagree everyone genuinely has the patient's best interests at heart...so I think that the personalities have helped more than the processes sometimes..." (Physiotherapist)

These findings resonate within existing literature and builds upon current knowledge. In a study exploring team psychological safety (TPS) within interprofessional teams, O'Leary (2016) shared her findings that included specific behaviours mobilised by individual practitioners, which fostered the development of trust and more effective communication. Similarly, Jones and Jones (2011), in their study looking at improving teamwork, trust and safety through an interprofessional initiative, referred to 'collegial trust' (2011:177) as an essential component of effective teamwork. The authors based the emergence of this collegial trust upon team members being open to getting to know one another better. Neither of these studies included social work perspectives however or attributed practitioner behaviours to individual personalities as articulated within this paper.

One study that did include social care perspectives, albeit not explicitly social work, was Riste et al (2016), who spoke of enacting 'person-centredness' between practitioner and patient as a means of improving interprofessional working and multidisciplinary care of older people. The findings of this study suggest that similar principles of person-centredness may be applied directly between individual practitioners through the mobilisation of personalities with the aim of developing a culture of trust and open communication. As discussed earlier, risk and risk management are contested spaces between health and social care with frontline practitioners often having to figure out the complexities of navigating structural, cultural and ideological barriers themselves. Thus, it is argued that understanding the importance of and ways to mobilise practitioner personalities within the context of interprofessional and multidisciplinary working is important to develop more effective ways of working with risk and older people.

The 'Process' of Interprofessional Working and Risk

As noted earlier in this paper, interprofessional and multidisciplinary teams are commonly acknowledged ways of bringing together a broad range of professions to combine their different knowledge and expertise towards shared goals (D'Amour *et al.* 2005; Hall 2005; Vyt 2008; Baxter and Brumfitt 2008; Rout *et al.* 2010; and Reeves 2010). Within the context of this study, the 'Process' of interprofessional working within multidisciplinary teams also represented the ways in which practitioners navigated structural, cultural and ideological divisions with respect to risk.

For practitioners in this study, the process of interprofessional working helped them to understand that effective interprofessional working with risk was not about establishing a dominant ideology or hierarchical decision-making structure within the team. Rather, that the process of interprofessional working allowed practitioners to freely contribute their different professional perspectives, which may at times involve disagreeing with one another. As the following study respondent noted;

> "We're all involved in a person's care and it is important to liaise to get other views especially with risks and to share information..." (Physiotherapist).

The process of managing structural, cultural and ideological differences between health and social care is therefore is important to understand, and this is especially acute in managing various views about how risks are defined, identified and managed. Indeed, the concept of risk was identified in the study as one of the main areas for potential conflict and disagreement within and between practitioners and subject to much discussion and debate, albeit sometimes implicitly rather than explicitly:

> "Risk is something that we debate quite a lot because we're working with health colleagues we've got very different concepts of what risk is..." (Occupational Therapist)

> "A lot of professionals see risk from their own profession really. The MDT [multidisciplinary team] is a good time to come across health and social care and how, together and try to see it from a more holistic perspective..." (Staff Nurse)

The opportunity presented through the *process* of interprofessional working within multidisciplinary teams to share information, discuss views on risk and share accountability for complex decision-making was not only found to improve individual practitioners' professional knowledge but also bolster their confidence in exercising professional judgement. This was noteworthy when considering the proliferation of actuarial risk assessment tools across health and social care. Whilst many practitioners in the study considered such tools as important, they were united in the perspective that tick-boxes and checklists were no substitute for professional judgment and were a means rather than an end to decision-making:

> "A lot of what I do is professional judgment, I have to say. Its professional judgment, clinical reasoning of benefits, burdens, risks, advantages, good documentation. But I do appreciate the risk assessment tools but it's also about good documentation" (Physiotherapist)

However, it was interesting to note how, in general, social work practitioners spoke about their use of professional judgement with less confidence than health colleagues did. This was striking since the data also reflected how social work practitioners not only asserted their willingness to advocate strongly for the rights of the patient or service user, but also that they reported a bolstering in their knowledge and confidence as a result of being part of the multidisciplinary process. These insecurities may be linked to a number of internal and external factors to the multidisciplinary team such as working in a 'culture of blame and litigation' against a backdrop of austerity and worsening cuts to resources; their relatively low contribution to multidisciplinary decision-making (Gair and Hartery 2001); and to the contested legitimacy of Social Work as a profession (Lymbery 2006).

Whilst both health and social work practitioners agreed that risk can never be eliminated, a number commented on different individual practitioner tolerances and responses to risk. This meant that, at times, practitioners within the multidisciplinary team could be out of step with one another either by being too blasé or too averse to the risks involved. For example, a clinical nurse specialist said that practitioners should avoid using absolute terms and instead protect oneself professionally by asserting the unpredictable and uncertain nature of risk and in planning care for older people needs. In a similar vein, an occupational therapist went on to comment how practitioners should be emboldened to have more open and honest discussions with other professionals and with patients/service users and their families when assessing and discussing risks. For a social work practitioner, 'saying no' to a situation or activity deemed 'too risky' was itself a risk to the autonomy or independence of the patient or service user. Both health and social care practitioners agreed that assessing risk is a complex activity involving multiple, interconnected and variable factors that cannot be managed by just filling out a form but rather entail open and honest discussions between practitioners and the patient/service user to understand the risks and negotiate ways to achieve the best outcomes.

Data further suggested that, as part of this process of interprofessional working within multidisciplinary teams with risk, which involved managing differences and disagreements, health and social care practitioners appeared to engage in a process of modifying their vocabulary in order to shift the focus away from the typically negative connotations and ideologically loaded concept of risk towards the more positively regarded concept of *safety*. During interview analysis, it was noted how often practitioners used the word *safety* or *safe*

when recounting the content of discussions, negotiations and debate with other professionals regarding complex risk and decision-making;

> "The main objective was to do a safe discharge. Once we'd agreed discharge was possible, it was to achieve a safe discharge on whatever way by bringing everyone together, putting in whatever support and making sure everyone was aware of the risks…" (Social Work Practitioner)

Contextual analysis of the data suggested *safety* represented a concept to which both health and social care practitioners could universally subscribe. For practitioners, this juxtaposition of *risk* and *safety* within the process of multidisciplinary working gave them the room to manoeuvre away from ideological barriers and division and unite under a common and easily shared objective;

> "Older people need safety on discharge from hospital, so a safe discharge is one of the principal if not the key factor we look for…however we define it, and there are a number of ways we may define it, define we must…" (Occupational Therapist)

In essence, the process of interprofessional working facilitates the communication and sharing of ideas, knowledge and pursuing actions that promote the concept of safety. These findings resonate with other studies, such as Roncaglia (2016), O'Leary (2016), Riste et al (2018), Jones, and Jones (2011) who each noted the importance of communication and the mediating effect of shared objectives and trust.

What does 'Policy' say about Interprofessional Working and Risk?

Within the context of this paper, the term 'policy' encompasses both government legislation and policy directives relevant to older people within the UK and more specifically Wales. As explored earlier, interprofessional and multidisciplinary working between health and social care organisations and professionals are high on the public policy agenda. So too is allowing and enabling health and social care practitioners to work more effectively with users of services and other professionals to achieve better outcomes for older people (Davey *et al.* 2005; Webb 2006; Lymbery 2006; Thomas, Pollard and Sellman 2014; Clements 2016).

In this study, practitioners felt disconnected from wider policy contexts and disengaged from those who influence the development of policy, including policies that delineated the nature of risk and how it was to be assessed and managed. Furthermore, this disconnect worked the other way where policy is not effectively being translated into practice. A sense of the

disconnectedness between policy and practice and the apparent divergence between policy imperatives and the realities of frontline health and social care practice was reflected in practitioners' uncertainty in how to approach risk:

> "I think it all comes down to the partnership rather than the policy you know...how can we be doing risk assessments if policy-makers don't know what we're assessing and I feel professionally, it is my job and responsibility to be highlighting the differences between how we see the risks..." (Occupational Therapist)

From the data, expression of the disconnect between policy and practice can be found in how prominently the impact of austerity measures and policy's subsequent focus on cost reduction featured in practitioner responses. As the quote below taken from an interview with a district nurse reflects, the implications of managing finite resources against increasing demand for services is a cause of tension within and between health and social care:

> "...because most services are chronically under-resourced, there are difficult decisions to make. After all, there is a duty to the patient in the waiting room as well as the consulting room..." (District Nurse)

As apparent in the interviews and consistent within the literature, social work practitioners were additionally concerned that there was a greater political focus on reducing cost and deflecting blame rather than meeting the needs of older people:

> "In a culture of blame, in a culture where money is king, in a culture where we know through various political reasons we are going to have less to do more with. As a social worker, part of what I do is to try to make things better but sometimes I'm not sure I do, I just reinforce what we've already got and what's worse for me is that I say someone's rights are important to me and yet at the same time in a practical sense what I do is make things worse..." (Social Work Practitioner)

Similar to social work practitioners, health practitioners in this study also recognised the impact of structural and political imperatives of budget constraints on practice. As this clinical nurse specialist reflected, certain decisions made by their organisation could be construed as resource-led;

> "The concern for me is about the times they [budget-holders] may say 'it can't be done' because of money rather than any other reason..." (Clinical Nurse Specialist)

The impact of austerity policy upon practice was further noted by an occupational therapist who felt that the types of intervention they could employ to support older people and how risk is managed were limited due to resource implications:

"I think certainly that money has a major impact on managing risk...resources and budgets does impact on how you manage risk because if the money was there, the option to provide 24-7 supervision and have someone there at night with an older person would make a huge difference. So, the resources and budgets have a major impact on what you can do". (Occupational Therapist)

According to Dunn (2006) older people are typically discharged to one of four external settings following a period of inpatient hospital care; either their own home, an intermediate care setting, a residential care facility or nursing care. Thus, for health and social care practitioners, the process of working together to secure an older person's successful transition from one care setting to another is a complex procedure involving liaison with a plethora of agencies and other professionals (Young et al 1999). For Lewis (2001), policy has typically failed to fully recognise that the needs of older people do not conveniently fit within the existing legislative and practice framework for health and social care.

Lewis' assertions resonate with this study and are symptomatic of the disconnect between policy and practice described thus far. This disconnect between policy and practice has been reflected in the ethical and professional tensions experienced by practitioners in this study many of which are arguably, rooted in the structural, cultural and ideological differences between the medical and social model of care (Glasby and Dickinson 2014). Some of these differences have found expression in the understanding of and approach to risk and older people, which for practitioners, policy offers only rhetoric.

As this quote from a social work practitioner reflects, there is discord between their organisation's approach and their individual professional approach to risk:

"I get annoyed with my employers who are focused on protecting themselves from risk. I can see why but it feels counterproductive sometimes...my worry is that they are looking at things from their own agenda and not ours..." (Social Work Practitioner)

The impact of organisational cultures on promoting certain risk ideas and practice was an important issue for practitioners as the physiotherapist in the following quote commented:

"...if you've got management who are risk averse themselves, that cascades down". (Physiotherapist)

There is a distinction between risk aversion, risk elimination and reduction. In another interview, a district nurse voiced similar concerns about the divergent approach to risk that her employing organisation appeared to be pursuing:

"If you look at what the health board think about risk...all of their risk education is about reduction, minimisation. But I think that the health board is really expecting elimination of risk". (District Nurse)

These findings resonate within the literature and the work of Alaszewski and Manthorpe (1998), who concluded that risk strategies and frameworks within welfare agencies resulted in a proliferation of risk-averse and defensive cultures and practices within organisations. Despite this, interpretation of the data suggested that practitioners did not knowingly adopt risk-averse practices because of organisational approaches to risk. Rather, many were adopting alternate conceptualisations of risk in the context of working inter-professionally. However, there is indeed a rich debate to be had and further research required with regard to how, or to what extent, health and social care practitioners manage these tensions given the influences of the organisational cultures in which they are located.

CONCLUSION

The empirical contribution of this research is to interprofessional working with risk and older people within multidisciplinary teams between health and social care and in particular social work, which is an under-researched area. Ageing populations mean that globally increasing numbers of people will live longer and some will live with more chronic health conditions and complex social needs (WHO, 2018). With risk already a defining feature of ageing discourses, reinforced by labels such as 'frailty' and 'dependence' alongside other notions of deficit that have permeated policy and practice, there are serious concerns for the future direction of health and social care services for older people. Reflexive and creative inter-professional working is advocated as an important strategy in this context (Ross, King and Firth 2005). However, achieving this is harder than the rhetoric of contemporary health and social care policy may imply. There are challenges at different levels, for example; in the practical inter-disciplinary working relationships, negotiating different organisational and systemic rules and practices, managing variations in discipline specific epistemologies and practice models, and creating real options for citizen coproduction in care.

Ulrich Beck in his work on risk societies argued that the new dialectic is the 'relations of definition'.

Among the relations of definition are the rules, institutions and capabilities which specify how risks are to be identified in particular contexts (for example, within nation-states, but also in relations between them). They form at the legal,

epistemological and cultural power matrix in which risk politics is organized. (Beck 2008, p.8)

A strength of this research is how it has engaged with a range of health and social work practitioners who work together, to explore some of the least explained nuances and intersectional factors in providing holistic care to older people with complex health and social care needs. The study findings bring to the foreground the intricate ways in which health and social work practitioners, through interprofessional working within multidisicplinary teams, mobilise their professional identities and importantly, their personalities to navigate policy and organisational risk management requirements but also to speak back to what they view as risk-averse cultures and pressures. Honest discussions and debates within multidisciplinary teams to air differences and disagreements, and the use of the concept of 'safety' as a bridge between competing organisational and professional demands, were some of the ways in which the professionals in this study navigated the politics of risk in shared decision-making.

More particularly, three key interconnected themes were identified around personalities, process and policy which, when combined are essential to understanding the challenges and possibilities of achieving more effective interprofessional working with risk and older people. Reflected within these themes is knowledge about the web of relationships that exist between health and social care policy and practice, in addition to the types of relationships required between practitioners from different disciplines. Similar findings with respect to practitioners' 'use of self' with respect to relationships are present within the wider literature, for example, as noted earlier in this paper, O'Leary (2016) discussed the importance of positive practitioner interactions and relationships upon team psychological safety. Riste *et al* (2018) spoke about person-centred practice with respect to working with patients but it is argued here that similar principles may be applied between practitioners.

On this note, it is important to consider older people's perspectives within this discussion since in many ways; the interconnected themes presented in this study speak to a model of co-production between practitioners and between practitioners and older people centred on personalities, process, and policy. As Hafford-Letchfield and Formosa (2016) explain, co-production refers to active input by those who use and provide services. The key benefits of a co-productive approach for older people is the recognition of their strengths and skills as well as their ability to build upon existing capabilities. Such an approach is also important in

rejecting the notion of older people as deficient or merely passive recipients and consumers of services. In their paper on the citizenry and participation in the co-production of public services; Bovaird, Van Ryzin, Loeffler and Parrado (2014) referred to coproduction within health and social care services as being about "professionals and citizens making better use of each other's assets, resources and contributions to achieve better outcomes..." (2014:2). Further resonating with this study around how health and social work practitioners drew upon the concept of safety as a mediator in order to achieve a commonly shared goal, the definition of co-production used by Bovaird *et al* (2014) underscored the importance of focusing upon outcomes.

Given the many tensions and contradictions to be negotiated in this work, there is a strong case for greater attention to the development of interprofessional working skills for those engaged in health and social care with older people. This should be integrated into professional education more so than is currently the case. Despite increasing devolution and divergent policy trajectories across the UK, similar efforts are underway to develop strategies to better equip the health and social care workforce to work interprofessionally across different multidisciplinary contexts. As Best and Williams (2019) explicate, for health and social work practitioners, a key factor in achieving this will be through the development of interprofessional education interventions and programmes.

The themes in this paper have wide application particularly for policymakers, who from the viewpoint of the study participants have ostensibly failed to engage frontline practitioners and are widely viewed to be disconnected from practice. Additionally, there needs to be more empirical evidence sought with respect to re-conceptualising risk and safety in partnership and co-production with older people; their carers; health and social care practitioners and other stakeholders. With new models of integrated health and social care being sought, the findings of this study may offer a timely and valuable contribution, particularly from a social care perspective.

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