This paper describes research undertaken as part of an MA study in leadership. It draws on interviews with six high profile leaders at the forefront of end of life care sector in the UK. Its findings and emerging themes offer insights about the opportunities for social work leaders in palliative care in the future and how the profession and palliative care sector address current barriers to taking advantage of such opportunity. The main focus of this paper is leadership related to palliative care social work. However, it relates to much broader themes including the history, politics and culture of this profession and the requirements for leadership on the part of social work in the broader contexts of health and social care.

Keywords  palliative care social work; leadership; end of life care; research

Leadership in palliative care social work: a personal and professional journey

Social workers have made a significant contribution to end of life care in the UK for decades. However, as a social worker practicing in palliative care today I find myself constrained by the lack of social work role models in a position of leadership. Without a leadership role model to whom and what do I aspire? Where can I go to explore strategic issues relevant to my work from a social work perspective?

This appears to be a loneliness that is specific to social work in the broader context of palliative care. In contrast, many colleagues in nursing and medicine working in the specialty appear to embrace a concept of leadership in their work and aspire to develop this aspect of their role. They are supported in this journey, as they enjoy well-worn career pathways to more senior positions.

In 2009 I took up my first hospice social work post. I was excited, passionate and ambitious. Anticipating a new career for the future, I wondered very early on what pathways were available to someone like me and where might they lead.

It quickly became obvious that there was no blueprint for the journey that I wanted to pursue towards a leadership role. I recall a salutary conversation with the chief executive of the organisation for which I worked at that time. We were on our way to...
a local NHS conference on strategy and end of life care. Halfway through the journey he turned to me and said ‘I didn’t think social workers were interested in strategy’. My bubble was burst. If he, as a seasoned leader couldn’t see the potential contribution of social workers to high level leadership then I realised I had a long way to go.

In addition I soon began to realise that this ambition was not one that was always shared widely by my professional colleagues. In my view, in the context of palliative care, we are a profession that often shies away from the limelight.

The late Dame Cicely Saunders founder of the modern hospice movement who was herself a social worker managed to become arguably the most significant leader in palliative care. So, if my experience is anything to go by, why does a group of highly skilled professionals find itself feeling fearful about their future and increasingly worried about their value within a hierarchy of professionals working in end of life care – an area of work that remains topical and high on many people’s agenda?

Drawing on my own experience and anecdotal evidence I believe there to be real challenges around provision of high quality end of life care in the UK; additionally there are significant risks related to the future of palliative care social work in the UK. If these challenges and risks are to be addressed, there is an urgent need for leadership of the profession, and strong strategic thinking about its contribution to end of life care in the future, and the shape of such care from a social perspective.

This was the point where my quest for answers began and plans for this study evolved. I was interested to hear the views of existing leaders in the sector and to explore their ideas and how they related to my own. This paper goes onto describe that research in more detail, revealing important themes that are pertinent to the development of social work as a profession today and in the future.

**Background**

*End of life care needs improvement*

Health and social care services across the UK need to do more to improve end of life care. Recent research shows that a significant amount of those people who are dying in the UK are not receiving the right support and care. The charity Marie Curie and the London School of Economics in their report *Equity in the provision of palliative and end of life care in the UK* (April 2015) who reported on the experience of carers, suggest seven out of every ten people with a terminal illness in the UK don’t receive the care and support they need. These inequities must be removed from the system. Everyone in the UK who is living with a terminal illness deserves to get the right care and support, at the right time and in the right place.

Recent investigations by the parliamentary and health service ombudsman into complaints about end of life care highlights significant failures within the NHS, in providing palliative care. The consequences of these failures for both the dying and those left behind are described in the report in six harrowing case stories. Unfortunately, these are not isolated incidents. In their report *Dying without Dignity* (2015) the parliamentary and health service ombudsman calls for more access to palliative care services and better leadership. Attending to inequalities is arguably a role for social work.
Whilst some improvements have been made in recent years to the end of life care needs of some of our more marginalised groups in the UK such as people who have a learning disability. However, we still have a long way to go. Death by Indifference (2007) a report by Mencap about institutional discrimination within the NHS, highlighted how people with a learning disability were receiving poorer healthcare. The report presented the stories of six individuals who Mencap believed died unnecessarily in NHS settings. Unfortunately, five years later Mencap produced a progress report which was titled Death by Indifference: 74 deaths and counting (2012) confirming that many of the original reasons for poor quality care still remain.

**Efforts to improve end of life care are underway**

Current and anticipated changes to the demographic and cultural landscape have ensured that end of life care is afforded increasing central importance in public policy: the fastest growing population group in the UK is people aged over 85 years. Social and health care policy is in a phase of rapid and radical change as it pursues government policy of supporting people to remain in their own homes for as long as they might wish (National End of Life Care Programme, 2010).

Some significant guidance now exists to help hospices and other providers of palliative and end of life care prepare for the future.

In 2008 the Department of Health’s End of Life Care Strategy and accompanying implementation programme intended to change the ‘culture’ and experience of dying in the UK on three different levels: widen society’s awareness, service user experience and the professional and service delivery infrastructure. A programme was then set up to devise a framework for social care. One of the key objectives of the framework was to strengthen the specialism of palliative care social work. Amongst other things the framework recommended that stakeholders establish a network of social care leads across social care and promote better links between social and health care and other services (National End of Life Care Programme, 2010).

In 2010 the think tank Demos published a report entitled Dying for Change which highlighted some of the challenges facing hospices in the future (Leadbeater and Garber, 2010). They confirmed that radical change in the way that services are organised and delivered is essential to meet the needs and preferences of the UK population reaching the end of its life in the future. Hospice UK, 2012 (formally Help the Hospices, www.helptehospices.org.uk/commission), the national umbrella charity responded to this by setting up the Commission into the future of hospice care (2012) to provide guidance, information and options for hospices to inform their strategic position and offerings in the next ten to twenty years. It is notable that there is no specific reference to social work in any of its recommendations regarding the way forward.

Even so, there is guidance provided by the Commission that is pertinent to the role of social workers in end of life care in the future. It identified six key operating principles. The first principle proposed that hospices need to become a bigger player and a bigger influencer within the larger health and social care system. The commission suggests that developing stronger and more high profile leadership is essential to achieve this.

In July 2014 the UK saw the end of the Liverpool Care Pathway (LCP). The LCP was an approach to care that included a complex set of interventions and was essentially
an attempt to replicate in hospitals the standard of care found in many hospices. An independent review of the pathway was carried out and recommendations were made that dying patients should instead have individualised care plans (Independent Review of the Liverpool Care Pathway, 2014). This was in many respects the start of a concerted effort on the part of Government and others to shift the focus away from pathways to more individualised person centered care.

Social work has an important part to play in improving end of life care

There is currently a major drive in hospice care to implement public health approaches to transform end of life care services. One such approach is that which promotes compassionate communities – in which local communities and their members provide the majority of the care. A compassionate community gives ordinary people the skills to be able to address the issues raised by the end of life and other losses (www.nhs.uk). Community engagement is one of the structural foundations of the social work profession and emerging models of care such as this which move away from traditional models of medical care open up a host of opportunities for palliative care social work to demonstrate its unique offerings.

Social workers are leaders in anti-oppressive and anti-discriminatory practice and work hard in palliative care to ensure that people receiving services remain central to decisions about their care. Within their role they will often give attention to inequalities in provision. This role is enacted at multiple levels – national, organisational and for the individual patient. One of the main tasks for the palliative care social worker is to talk openly to patients and their families and carers about death and dying to ensure their needs and preferences are articulated and acknowledged.

Palliative care social workers may struggle to be part of this improvement

In April 2012 the Centre for Workforce Intelligence in their publication ‘The future social worker workforce: an analysis of risks and opportunities’ (2012) stated that in England there were 87,442 social workers registered with the GSSC (General Social Care Council). The National Association of Palliative Care Social Workers (APCSW) state on their website that they currently have a membership of over two hundred social workers. Whilst these figures highlight the specialism of palliative care social work, they also highlight their relative scarcity and by implication some vulnerability.

There is some evidence that the work for which they have been renowned, namely emotional support as part of a multi professional team in addressing ‘total pain’ is also at risk. As social work in the UK has shifted towards the management of risk and a focus on outcomes over process, reports suggest that therapeutic interventions with dying and bereaved people have come to be seen as a luxury that mainstream social work cannot afford (NEoLCP, 2012). The report goes on to say that specialist palliative care social workers remain, but shrinking numbers and redefined roles and functions have led to feelings that their specialism is under threat (NEoLCP, 2012).

Regardless, the literature confirms a vital role for social workers at practice and policy levels, supporting individualised care, and that which addresses social needs through community action alongside any professional interventions. What is less clear from the literature is whether there is appetite and ability on the part of palliative care social workers to adopt and develop this role, and whether its culture
enables or inhibits proactive steps forward. Many people refer to the classic phrase coined by the McKinsey organisation that culture is *how we do things around here* (Johnson *et al.*, 2013). While that may be true, there are so many elements that go into determining what you do and why. Whether you can define it or not, culture exists within organisations. It is the ethereal something that hangs in the air and influences how work gets done, it critically affects project success or failure and says who fits in and who does not. The research described in this paper attempts to redress this gap in the literature.

**Methods**

The context of the research was to consider the key challenges facing palliative care at a time of significant change, primarily from the perspective of its social workers. The focus of the research was on social work leadership at such a time within the palliative care sector and the degree to which the culture of palliative care social work may have had an impact on opportunities for social workers to serve as leaders.

The research took the form of a qualitative study undertaken from an Interpretivist perspective. It has been suggested that, social reality is something that is constructed and interpreted by people rather than something that exists objectively (Denscombe, 2002). Using this method can lead to significant advances in our theoretical understanding of social reality; more routinely, it is particularly good at enabling the researcher to learn, at first hand, about peoples perspectives on the subject chosen as the project focus (Davies, 2007).

The participants in the research were all deemed in my view to be ‘leaders’ in the field of end of life care. This judgement is based on the senior positions that they held within their organisations and/or within the sector. All bar one came from a social work background. For ethical reasons and to maintain anonymity the respondents were not named. All of the interviews were carried out in the respondent’s place of work.

The selection process was straightforward. I identified individuals for interview, drawing on my own knowledge of the sector, or at the recommendation of others within my professional network.

The interview style that I chose of semi structured reflective interviews allowed for the use of open ended questions. Whilst this approach allowed the respondent to diverge from the interview topic it also offered the opportunity for new ways of seeing and understanding.

I focused on six questions in the course of the interview, designed to stimulate reflection and exploration. The questions were adapted from the work of Rank and Hutchinson (2000). Along with the work of Brilliant (1986), it was their theories that formed the foundations to the question for this research. The discussion of social work leadership began with Brilliant’s (1986) analysis of social workers’ resistance to take on leadership roles. She saw leadership as the missing ingredient in social work education but emphasised that leadership is an important aspect of the professional role for social workers. Analysing the roots of leadership as a non-theme in social work, she suggested
that social work students were passionate about direct practice with clients, not with assuming leadership roles. Rank and Hutchinson (2000) carried out an analysis of leadership within the social work profession in the USA. They presented their results of a study which investigated how individuals in leadership positions perceived social work leadership.

The interview questions were specifically designed to test the leaders views against the theory base described in this literature.

*Interview questions* (adapted from Rank and Hutchinson, 2000):

1. How do you define the concept of leadership within the context of end of life care?
2. In your experience, do you perceive that social workers in end of life care embrace a concept of leadership?
3. What do you believe are essential leadership skills and characteristics?
4. What specific skills and qualities do you think social workers bring to the leadership table?
5. Thinking generally, do you have any thoughts on how leadership could be promoted within palliative care social work?
6. In your opinion, what pathway might a social worker have to take to become a leader in end of life care, like you?

All of the interviews were recorded electronically and transcribed verbatim. Their content was then analysed thematically. Thematic analysis is:

the study of the social meaning of tape recorded conversations – either naturally conducted or in an encounter with a research interviewer (Davies, 2007).

Identifying and classifying themes and then setting up a coding system was part of the analysis. The four main themes identified from the review of the literature were the historical, the political, and the cultural influences and leadership. I used a colour coding system, giving each theme a different colour and highlighted these in the transcription of each interview.

Throughout the course of the data collection and its analysis, I was aware that I was interacting with the research given my pre-existing role as a practicing social worker in end of life care. This epistemological stance may present some limitations to my objectivity of the data, but can be argued to be a strength in adding reflective depth and understanding to the data. It was important that I maintained a level of distance and continued to see the work from the eye of the researcher. This was particularly important to remember when carrying out the interviews and also when analysing the data. However, the very fact I was a practicing social worker meant I could take a reflective approach to the data and its analysis and interpretation.

**The findings**

Six leaders were selected and invited to be interviewed. All six agreed to take part. My assumption was that all of these leaders would have taken different paths to their own leadership and will have different ideas and interpretations as opposed to a single
objective view. In other words my ontological assumption is that their reality would be subjective and vary between the participants.

The following chart lists the interviewees’ positions and whether or not they were from a social work background.

| Position held                                      | Identifier              | Social work background? |
|---------------------------------------------------|-------------------------|-------------------------|
| Senior manager in hospice care and national social care lead | Respondent A           | Yes                     |
| Psychosocial lead in hospice care and senior academic | Respondent B           | Yes                     |
| National social care lead for major UK charity    | Respondent C           | Yes                     |
| Hospice CEO                                       | Respondent D           | Yes                     |
| National end of life care lead for major UK charity | Respondent E           | No                      |
| Senior academic in social work and chair of national eolc organisation | Respondent F | Yes |

There were four main influences identified from the literature review at the beginning of this research. These four influences then became a framework for the research and in particular the analysis and the interpretation of the findings. The influences were:

- **Historical** – Although in health and social care terms palliative care is a relatively modern day approach to care it has a long history spanning back to the late 1800s.
- **Political** – End of life care is higher on the health and social care agenda in the UK than it ever has been.
- **Cultural** – An interesting metaphor especially when applied to end of life care. When exploring the culture of hospices for example it could be suggested that the multi-disciplinary team (MDT) represents a series of sub cultures (i.e. nurses, doctors, social workers) working under a wider organisational culture.
- **Leadership** – ‘Leadership is and must be socially critical, it does not reside in an individual but in the relationship between individuals, and it is oriented toward social vision and change, not simply, or only, organisational goals.’ (Foster, 1989)

In my interpretation of the results, I have placed the influence of leadership at its centre, exploring the other influences from its perspective. The nature of leadership in palliative care is considered at the outset.

**Leadership and palliative care social work**

Respondents talked of the importance of leadership being exercised at all levels, however when talking about palliative care social workers respondent E said:

A lot of social workers do their evolution at a very low level. They do it at best by trying to influence MDT discussions but that will never make a leader of you. It might give you leadership in that context in that moment but in terms of really shaping the future of EOLC it needs to be done at both levels.
There was a real paradox in the data when respondents spoke of where social workers position themselves. In one way it was suggested that social workers are excluded, however it was also suggested that they exclude themselves and respondent C even went as far as to say:

There is a distinct tendency to play the oppressed minority card to themselves.

There was a suggestion that social workers choose to be less integrated:

social workers choose as teams very often not to be integrated into the organisations that they work in … one of the problems we have is that social work don’t really want to be part of the hospice team but they also don’t want to be part of the local authority so they sit in no mans land.

When talking about leadership, two of the respondents spoke about the need for leaders to be courageous and innovative and included in that the need for the leader to be comfortable with a certain level of disruptiveness.

It is about being courageous, thinking outside the box, it’s about being innovative and … that’s about being prepared to disrupt what’s often very established processes and systems.

They also mentioned the need to take risks as well as the ability to assess risks. In fact one respondent went as far to say that:

‘If you can take no risks then you cannot be a good leader’. They went onto say ‘good leaders take quite high levels of risk but are knowledgeable about what the risks are and how they can be mitigated against if needed’. Another respondent said ‘leadership is about taking people with you to do the difficult things’.

Most respondents talked about leaders in end of life care having to be honest, transparent and open. However one person said that although it was important to be honest it was also important for leaders to realise that there are some things you just do not share with the workforce or you have to choose the right time to disclose certain things. One respondent sums this up by saying for me leadership has to come from the heart. It has to be visionary but it has to be meaningful.

The respondents were asked to think about leadership specific to social workers working in end of life care. The data reveals that respondents found this a more difficult area to discuss. Not difficult in that they didn’t have an opinion but difficult in that none of them could say that social workers necessarily embraced a concept of leadership. The data reveals this is not necessarily exclusive to palliative care social workers but a suggestion that social work as a profession overall may not embrace a concept of leadership. Different respondents gave different possible reasons for this.

Some interesting comments were made about how leadership is viewed within the social work profession. One respondent talked of credibility:
To be credible as a leader you have to understand what it’s like to be a worker … leaders in social work are credible if they’ve worked up through the ranks, they’ve been there and done that. They understand the challenges.

**Cultural influences**

Out of the various influences considered it was ‘culture’ that seemed to dominate the discussions. There was more talk about the culture of palliative care social work than anything else.

Respondent D said:

there is a real psychological inhibition that lots of social workers have about asserting themselves as exercising any kind of leadership.

They go onto say:

it goes against the social work ethos of you’re there to provide a service which should be around the patient and so they should be in charge not you … social work is about facilitating and enabling not about setting direction for other people.

The issue of power was mentioned when one of the respondents was talking about the social workers ability to take a systemic approach to leadership:

What social workers bring above all the other professions is a commitment to the systemic and that is really important. It’s important in how you deal with service users in terms of understanding their context, who they are and where they’ve come from. It’s important in terms of understanding other professions and how they come to the table. It’s important in understanding the differences in power between groups and individuals, all of that they take a systemic approach.

However, another respondent said:

I think the focus on the individual becomes an excuse for never thinking at the systems level … that means then that social workers get to be the carping voice organisationally because they are seeking the best for their individual client and they choose not to think system, think organisation, think broader context, bring solutions to the table or bring options to the table.

There was some suggestion that due to the structure of hospices social workers are not considered as leaders. When talking about senior management teams in hospices respondent A said:
The doctors can do it because they are in leadership positions from the word go. Within the definition of palliative care you must have a consultant so that’s taken as red.

They go onto say:

So what is that about? Is it like where you work with a taboo client group you become the taboo and if you work with a group of people who challenge the systems you are seen to be somebody that can’t be worked on . . . its impossible for a social worker to do anything else because its not about a coat that you put on and take off.

**Historical influences**

The past, present and future have important connections. It is necessary to explore the roots, foundations, fundamental policies and procedures relating to social work in palliative care (Harper, 2001).

Collating the historical findings revealed a real paradox in the responses of all respondents. When discussing EOLC and leadership all of the respondents answered in the present context but when talking about social work in EOLC almost all of the responses were stories and experiences of palliative care social work in the past.

Almost all respondents mentioned the work of Cicely Saunders and the impact she had on the modern hospice movement. Saunders was not only discussed within the context of leadership but also within the context of social work. One respondent said:

Cicely Saunders conceived the idea of palliative care when she was a social worker but then had to become a doctor to make it happen.

When the respondents talked of the past history of the social work profession within the context of end of life care they described a very proactive group of individuals who were not only active within their services but were also active in research, writing academic papers and lobbying government with a view to shaping local and national policy.

**Political influences**

All six respondents mentioned the APCSW the national association set up in 1987 ‘representing the concerns and interests of both palliative care social workers and the patients and families with whom they work’ (APCSW, 2013). However, there were expressions of confusion about the current role of the association. Respondent C talked about how she never sees the association represented on the national stage and rarely hears its voice in answer to major issues facing the profession.
When respondents spoke about the early days of the APCSW they used words like radical, pioneers and courageous to describe individual members. One said *In years gone by I think there were some amazing social workers who were pioneers.* However, when relating to modern day social workers most respondents talked about the sector having lost something.

In making reference to the wider social work profession currently in the UK respondent C said *where did the radical social workers go? Did they all get knackered in the 70s and just give up? What are we doing as professionals and as a profession?*

Conversely, many of the respondents also spoke of a proud tradition in palliative care social work. Almost all respondents used the example of how in the past these radical, courageous pioneers lobbied national government and were successful in changing welfare benefit policy with the introduction of the DS1500 (a special rules criteria for those with a prognosis of 6 months or less to be fast tracked for high rate Personal Independent Payment), something which is still in use today. Respondent E said:

*I think collectively there is quite a proud tradition in palliative care social work. I think there is a tradition of campaigning. I think it is probably the one area of social work where there is a tradition of teaching and leading by communicating the ethos of palliative care.*

Another issue which almost all respondents talked about was the challenge in palliative care social work of being able to evidence its worth and merit in the delivery of end of life care. This has been an issue for the profession for a long time but respondents spoke of it being particularly relevant in the current climate of commissioning services. Respondent C said:

*There isn’t evidence as to what palliative care social work does, so without that evidence we can’t extol the virtues of it. At the moment it’s a self dooming prophecy that it’s a dying profession and yes it is because we can’t prove our worth.*

There were several quotes on the current position of EOLC in the wider health and social care landscape which revealed a need for a social work voice. Some examples of these are:

*Never before has there been such a key role for the influence of social care*

*Why social workers shouldn’t see themselves as the central role in thinking about how to work with patients and develop services is something of a mystery*

*The more we get into this notion of developing communities and supporting an increased use of volunteering the more that brings palliative care closer towards our core professional framework than ever*

*I think the future of EOLC is about a social model but unless we have some social workers that are strong leaders it won’t get a chance*
Discussion

For the purposes of this paper, this discussion focuses on the questions of whether social workers in palliative care should aspire to a position of leadership and if so how they achieve this. Given the heavy focus on cultural influences on the question of social workers as leaders, this is given particular attention in this section of the paper.

Social workers should aspire to be leaders in palliative care

There is strong evidence from the research that leadership in palliative care on the part of social workers involved in the sector is an aspiration to be pursued.

One of the respondents in this research made reference to palliative care social work in the United States having recently been out to a palliative care social work conference in the US where leadership was high on their agenda. She said:

there were 250 people all of whom are incredibly well qualified, doing some really innovative and coherent pieces of work … there was a level of enthusiasm … a community and a get up and go in the room that I think we haven’t got at the moment.

Background to this research confirms significant changes in how terminal illness and bereavement are viewed and experienced. They are social issues rather than a series of medical problems, they are events that are highly individual in nature, and they are often particularly complex for people who are marginalised. What better context for the social work perspective at related strategic discussions? Add in a political agenda around integration between health and social care services and the argument is further strengthened. Social workers would bring a unique, and much needed voice about how these issues are best addressed as services are developed and refined. This was the view of many of the respondents I interviewed who talked about such gaps in care provision and related strategy. They were clear that in their view these gaps would be best addressed by the voice and considerations of social work leaders given the values and priorities held by the profession. Their views would be best heard and acted upon if social workers were in positions of leadership.

By the same token, they also warned that if these gaps are not filled by social work leaders then they just get filled by others. The gaps were also referred to as ‘the space’ and it was suggested that social workers might even be frightened or reticent to claim the space.

Many of the respondents made reference to the values held by social workers as an important reason for requiring that social workers are involved in strategic decisions. However, it is exactly these values that could be preventing social workers from embracing a concept of leadership.

Professions such as nursing and teaching have identified a crisis of leadership and have instigated successful strategic initiatives and programs to develop leaders and leadership. However, social work has been less proactive and even reluctant in taking on leadership as an issue for theory and practice (McDonald, 2009).
McDonald goes on to say:

in our view social work has actually recoiled from the idea of leadership, harbouring an historical view that leadership is somehow contradictory to social work values and its underlying philosophy.

The interview findings reveal stark contrast between descriptions of the radical social workers of the past and the less courageous social workers of today. There is a suggestion that social workers working in the specialty currently are focused on doing things according to policy and by regulation and work in a bounded way. This is somewhat at odds with literature describing leadership, which confirms that leaders must be willing to cross boundaries and push against them. The radical social workers of the past, who did indeed pushed boundaries and drove changes in policy and regulation, appear to embody that particular aspect of being a leader. It appears an approach to change that is at odds with social work practice today.

Clarity about the strategic role and future agenda of social workers in palliative care would be helpful

Lack of clarity about the role may be linked to the apparent absence of a strong strategic agenda to which palliative care social workers might be working. If they do not perceive leadership within their role then they are unlikely to feel it their responsibility to set an agenda, even one that draws heavily on their skills, for the sector. One respondent spoke about the potential consequences for some very promising developments if social workers are not in a position to rise to the challenge.

I think the future of end of life care is about a social model but unless we have some social workers that are strong leaders it won’t get a chance.

If the future of end of life care is about a social model then arguably it is up to the profession to establish a related agenda to focus future thinking, partnerships and collaborations. However, there is currently no evidence to suggest that such thoughts and preparations are underway. In contrast, the evidence from this study and my experience does suggest a lack of leadership and strategic thinking. With stronger leadership within the profession senior practitioners along with their teams could develop, at a strategic level, a professional agenda fit for the future. Participants in my study confirmed a belief in even greater impact if a group of leaders from social work could be persuaded to work together and act on behalf of the profession of palliative care social work as a whole.

Senior social workers in palliative care need to be more engaged in debate

Decisions about the future shape, funding and delivery of palliative care are far from straightforward. They are being deliberated in a variety of fora, to inform policy and practice. They would benefit from multiple perspectives and careful thought.
Participants in this research confirmed the opportunity that this presented to social work, and indeed a need for this group to be present in such discussions. However, they described how in their experience there was often a vacuum, a space, a missing link in their discussions about the future of end of life care in the UK, specifically a strong voice representing social care. In their experience social care is often reluctant to put its head above the parapet and engage in these conversations.

As a result, this space is filled by other professions, so then when new thinking and new work streams are made public, options that would incorporate the unique offering of palliative care social workers have not been developed.

**Social workers interested in leadership need training and opportunities to build their careers**

It is clear that whilst some leadership is exercised by social work on a number of levels, and particularly in relation to operational issues there is a lack of formal leadership development for palliative care social workers.

Brilliant (1986) revealed similar gaps in social work education over twenty years ago and as the literature reveals not much has changed since then. How can we expect palliative care social workers to step into leadership roles without the relevant support, experience, training and education? Education or other development opportunities will not be sufficient or indeed appropriately shaped without greater clarity and definition of the role that social workers should fulfill in the future. Whether lack of education and other development opportunities is a result of, or contributes to the lack of career progression is unclear. However, all participants in this research talked about how limited opportunities were for social workers to progress in their careers.

This, linked with the cultural and historical findings, suggests that social workers are not considered as leaders in the sector. The interview findings also revealed a flat structure in palliative care social work that does not lend itself to people climbing the ranks and progressing through their careers.

**Greater evidence about the unique contribution of the palliative care social worker would support their role as a leader**

A significant challenge highlighted by almost all respondents focused on the requirement being made of all professionals including palliative care social workers to provide evidence of their worth and merit in the EOLC sector today. This is not a new ask of the profession but respondents spoke of it as being particularly relevant in the current climate, giving the growing interest of commissioners in outcomes. Paradoxically this is arguably very difficult to achieve without strong leaders within the profession and the sector. New work on outcome measures is being undertaken by a number of institutions (for example the OACC initiative run by the Cicely Saunders Institute, London), but the question regarding the degree to which such measures capture data pertinent to the social workers role has enjoyed little public debate. If its outcome measures are
 deemed to be valuable in confirming improvements on the part of patients or carers attributable to social workers, then the profession should be pushing for their greater use.

Social workers need to influence the culture in which they work

There is some evidence that the culture of palliative care social work is changing. In 2015 the APCSW at their annual conference launched potential designs for their new logo and website in partnership with a leading business design consultancy firm. They also announced that their executive committee was working on a strategy for palliative care social work which would be ready for consultation in 2016. This is an ideal opportunity for the association to support the profession to see leadership as empowerment, as enablement, as a way of ensuring that all the things that guide palliative care social workers in their practice with patients and families can be perpetuated, amplified, developed and embedded in whole models of care.

Achieving this requires strong leadership by social care professionals. This research suggests social workers can and do influence at all levels. Social workers need to use this leadership behaviour to positively influence organisational outcomes, think of ways to create pathways to leadership and become role models for both their own profession and the wider multi professional teams in which they work.

Conclusion

This research confirms that the profession of palliative care social work is seen to have a vital role in the development and provision of end of life care services and that its members have a very strong and proud tradition on which to build. However it also suggests that palliative care social work does not have a strong enough presence at a strategic level and because of this puts itself at risk. In turn this puts the care and support required by growing numbers of people who are dying in the UK at risk.

If the profession of palliative care social work as a whole does not take responsibility for this then they risk that gap being filled by another professional group and their voice becoming silent.

Strong social work leadership is an important missing ingredient in the current mix. If it were to be added to the growing efforts of many to improve end of life care at local, regional and national levels its potential impact could be increased further. It is time for palliative care social workers to engage in strategies individually and collectively that will enable them to take their rightful place along with other professionals at discussions where strategic direction, relationships and action are being considered. It is no longer time to talk about what is being missed but to demonstrate its added value. There is an empty chair at that table. It’s time for palliative care social workers to take that seat.
Disclosure statement

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References

Brilliant, E. L. (1986) ‘Social work leadership: a missing ingredient?’, Social Work, vol. 31, pp. 325–331.
Davies, M. (2007) Doing a successful research project: Using qualitative or quantitative methods, Palgrave Macmillan, Basingstoke.
Denscombe, M. (2007) Groundrules for good research: A 10 point guide for social researchers, Open University Press, Buckingham.
Hospice UK. (2012) Commission into the Future of Hospice Care. Preparing for the Future: Key Operating Principles. Hospice UK, London.
Independent Review of the Liverpool Care Pathway. (2013) More care, less pathway, A review of the Liverpool Care Pathway, Independent Review of the Liverpool Care Pathway, London.
Johnson, G., Whittington, R., Scholes, K., Angwin, D. & Regnér, P. (2013). Exploring Strategy: Text and Cases. (10th ed) Pearson, Harlow.
Leadbeater, C. & Garber, J. (2010) Dying for Change, DEMOS, London.
National End of Life Care Programme. (2010) Supporting People to Live and Die Well: A Framework for Social Care at the End of Life.
Rank, M. G. & Hutchinson, W. S. (2000) ‘An analysis of leadership within the social work profession’, Journal of Social Work Education, vol. 36, no. 3, pp. 487–502.
Schein, E. (2010) Organisational Culture and Leadership, Jossey-Bass, Wiley, San Francisco, CA.

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