

Social care's impact on emergency medicine: a model to test

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Mainly in response to the policy drive to avoid unnecessary acute hospital admissions and delayed discharge on social grounds, there has been a gradual development of social work services attached to emergency departments (EDs) in the UK. In the absence of a clearly articulated evidence base or debate about the roles of ED attached social workers, a model of ED based social work practice and indicative supporting evidence is presented. It is argued that social workers may be able to contribute to the efficiency and effectiveness of hospital services while providing a key point of access to social care services. A number of obstacles remain to the implementation of this model of service, including the narrow focus of current social care practice, the hours that a social work service is normally provided, chronic under-funding, and continuing perverse incentives in the health and social care system. More systematic evidence in the UK context is needed to support the case for change.

As we have noted elsewhere,¹ emergency departments (EDs) have rarely been a location for social workers in the UK, unlike in other developed countries, for example, Spain,² France,³ Canada,⁴ and the USA.⁵ Instead, in the UK, hospital social work teams have tended to service EDs at arm's length, or on a case by case basis through the social work duty service, rather than by social work attachment to the ED team. There are signs that this has begun to change and, in 2000, Cooke *et al*⁶ found that just under a third of departments then had an attached social worker.

However, the low level of ED social work in the UK and the linked absence of a substantial research base has meant that there has been little debate about what can and should be the role of social workers in EDs. In this literature based article, we outline the case for a variety of social work roles in ED and consider some of the key obstacles to their being universally enacted. In doing so, we indicate the range of research questions that need addressing to build up an evidence base about social work's potential contribution to EDs.

WHY HAVE SOCIAL WORKERS IN HOSPITALS ?

There are two central arguments for social workers to be based in hospitals. The first is that, although social care services have long been blamed for causing or failing to deal with "blocked beds",^{7,8} hospital based social services can enable hospitals to make more efficient and more effective use of their scarce and expensive resources. The importance of this role has been emphasised in the NHS Plan⁹ and subsequent policy papers,^{10,11} which have focused on social services departments' roles in preventing emergency admissions and readmissions, increasing the speed of assessment and reducing delayed discharge, particularly for older people.

Secondly, from patients' and carers' perspectives, hospitals are a key point of access to social care services generally. A

study of hospital social work service users in Avon in the early 1990s¹² reported that 80% were not previously known to the social services department but met the highest level of eligibility for services. However, as few patients seem to know that social care services can be accessed through hospitals,¹³ the level of access actually achieved is likely to be substantially lower than it could be.

Each of these arguments will be taken in turn to discuss the case that a social work service should be based not only in hospitals but within EDs.

INCREASED HOSPITAL EFFICIENCY

There are five main ways in which ED based social work may produce efficiency savings for hospitals: preventing admissions, early diversion, reduced discharge delay, reduced re-attendance, and saving ED staff time.

Preventing admissions

There are repeated examples of interventions before or in EDs to reduce unnecessary admissions to acute hospital beds.^{1,3,14-16} Such interventions almost universally include preventing admissions by paying attention to the social circumstances of patients, particularly of older people, and by providing alternative forms of domiciliary or residential care services.

Early diversion

A second point at which social care services and social work intervention in ED can reduce admissions to acute hospital care is through rapid discharge either home¹⁶ or to intermediate care.¹

Reduced discharge delay

While unmet social care requirements are only one factor in delayed discharge from hospital, the importance for reduced average length of stay and for avoiding delayed discharge of the early identification of patients likely to need social care support on discharge has long been recognised.¹⁶⁻²⁰

Reduced reattendance

Social circumstances and psychological difficulties have been identified as a key variable in understanding—and reducing—repeated reattendance at EDs.²¹ For example, the study by Lynch and Greaves in Hull of 40 patients who attended on average over 10 times in a six month period found that over a quarter of attendances were for overdoses, and one in seven for alcohol intoxication.²² Eighty per cent of the patients were single and 7.5% were of no fixed abode. Olssen and Hansagi²³ found that anxiety, commonly combined with adverse social conditions, was predictive of frequent reattendance.

Saving ED staff time

A number of studies make the point that ED medical and allied health professional staff time can be saved by social work involvement with patients who have complex social as well as medical needs.^{5,24}

Several analyses have suggested that the costs of providing a social work service in EDs would at least be met by the efficiency gains identified above^{4, 8, 22, 25} while some authors argue that savings would accrue to the hospital.^{19, 24} However, a cost benefit analysis has not been conducted in the UK.

INCREASED ED EFFECTIVENESS

In addition to increasing the efficiency with which emergency and acute hospital services are matched with patient requirements, it is also argued in the literature that social workers can enhance the effectiveness of hospital based services. There are three main ways in which this can be done.

Quality of communication

The quality of communication between medical and nursing staff and patients in EDs is not always as good as it could be. Staff often have difficult messages to give to patients or family members including dealing with life threatening conditions and death, conflict situations such as domestic violence or child protection situations, as well as sometimes refusing care or treatment that may be demanded. They often lack adequate time and perhaps the skills to devote to this crucial task. For example, Lloyd *et al*²⁶ reported common weaknesses among SHOs to include poor negotiation and explanations of treatment plans and follow up. Young people who have been to EDs after self harm were critical of the attitudes and responses they sometimes received.²⁷ By contrast, the communication skills of social workers and the time they were able to give to patients and carers have been positively commented on by staff²⁸ and patients^{1, 2} alike. ED attendance often reflects a crisis for the patient and their supporters and, from their perspective, both securing and dealing with the impact of the information they need in order to understand and contribute to decisions about their care is very important.

Satisfaction

Patients' satisfaction with their experience in EDs is significantly affected by the quality of communication and personal care they have received.¹⁷ Serano *et al*² studied 600 patients, half of whom were supervised by a social worker while the other half were not. Among the third of patients who completed follow up questionnaires, not only was the psychosocial care evaluated significantly more positively but also the quality of medical care. This reflects the experience of UK ED based social work known to the authors where, on occasions, social workers have acted as advocates for patients and advisors to medical and nursing staff in difficult treatment decisions.²⁸

Identifying the need for services

One factor that may affect rates of emergency re-attendance or readmission is the capacity of ED staff to identify the need for a range of further services in patients who are not admitted or discharged. For example, when Poncia *et al*²⁹ reported a study in which 551 patients over 75 or their carers were contacted by telephone the day after discharge from an A&E department substantial unmet needs were discovered. Existing home support was felt to be insufficient in 44 (8%) cases and in need of immediate intervention in a further 45 (8%) cases. Five hundred and fifty nine referrals were made for further services after the telephone assessment. Similarly, additional capacity to identify need following additional training has been reported, for example, in relation to self harm,³⁰ child protection,³¹ alcohol misuse,³² drug misuse,³³ and falls.³⁴ As all these issues have a strong social component, it would seem likely that a social work presence would help EDs to identify cases, although there is little reported evidence of this.

ACCESS TO SOCIAL CARE SERVICES

With something like 10 million patient episodes a year in EDs in the UK, EDs have the potential (probably second only to

primary care settings) to be an important point of information about and access to social care services (with possible consequential benefits for avoiding unnecessary use of NHS resources). As has just been indicated above²⁹⁻³⁴ a range of circumstances that lead people to ED attendance are as much social as medical in nature and origin: self harm, violence (including domestic violence and child abuse), substance misuse, the lack of adequate social care. In addition, it is known that material deprivation is associated with raised rates of ED attendance and emergency hospital admission.^{35, 36} Keene and colleagues³⁷ found that patients who were repeated attenders at EDs were commonly known to a range of other health and social care providers, indeed that repeated A&E use might be a trigger for identifying the need for intensive multidisciplinary intervention.

However, in addition to the value of identifying people in need of a wide range of social care services, the presence of a social worker can facilitate access to those services. In a small qualitative study of a social work attachment to an ED in the Midlands, staff reported that the social worker—as a social services department employee—was far more successful and speedier in gaining access to social care services than they would be.²⁸

DISCUSSION

How good is the evidence?

In much of the preceding argument, as a close reading will reveal, the case for social work attachment to EDs is based on cumulative small scale studies, circumstantial evidence or by extension from other research. Moreover, a large part of the case for developing ED based social care services in the UK requires extrapolation from studies conducted in other countries with different health and social care systems. We do not have conclusive evidence that a social work attachment in ED in the UK will necessarily result in a raised rate of service provision for people facing a wide range of difficult social circumstances, only that social needs can be identified through the ED population. The requirement to extend the evidence base is further exemplified by the question of whether it is attached social workers in itself or social work activity (interventions that address the social and interpersonal dimensions of people's lives) that are required for the benefits indicated to accrue. In some studies of responses to the social needs of patients, for example, interventions by health visitors³⁸ or by multidisciplinary teams¹⁶ or social workers in conjunction with nurses¹⁸ or doctors¹⁹ rather than on social workers alone are reported. Moreover, in principle, the argument that social workers can secure quicker and more effective access to social care services could be addressed by removing the barriers to access rather than employing a social worker.

Obstacles to maximising the social care impact

In addition, there are a number of other obstacles to maximising the impact of social care in EDs that must also be acknowledged. A major plank of the argument so far has been based upon a model of EDs as a crucial site for the preventive identification of people with a wide range of unmet social and health needs and thereby also addressing issues of health and social inequality. This model of emergency care outlined in the USA by Irvin and colleagues³⁹ will not necessarily be supported by ED staff or policy makers in the UK. For example, Ramsay *et al*⁴⁰ recently concluded (to extensive critical comment) that screening for domestic violence was not justified. In the absence of that approach to the role of EDs, the opportunities for a social work contribution would be substantially reduced.

Moreover, five key structural factors in the organisation of social care services in the UK mitigate against maximising the benefits of social work attachments to EDs. Firstly, such a wide ranging social work role would not be currently supported by

social services department managers operating within a narrowly defined performance assessment framework. The intensive social care needs of materially disadvantaged older people, child protection cases, and acute mental health episodes are all likely to be high priorities for social services departments. Lower level care needs, domestic violence (unless putting children at risk), falls, substance use, self harm, or the impact of acute poverty are not. Secondly, currently most ED based social workers are expected (by virtue of funding often linked to “winter pressures”) to focus on vulnerable older people, not the ED population as a whole. Thirdly, few social workers will currently be involved in providing a direct service in EDs outside office hours although the peak times for ED attendance among children,⁴¹ self harmers,⁴² and people who had suffered domestic violence,⁴³ for example, is all outside those hours. This reflects the wider issue, fourthly, of the level of resources available to social services departments and ED attached social workers. Although now recognised by government, the long term underfunding of social care services and lack of investment in social care professionals will mean not only that universal attachment of social workers providing a generic to EDs is unlikely to be achieved, even within office hours, but that in many cases the identification of social need would not lead to the provision of services. Finally, the cost gains of ED attachment may be more apparent to the NHS than social services departments, another example of the perverse incentives in current health and social care systems.

CONCLUSION

There is a good—albeit circumstantial—case for the view that social care can have a significant impact on ED services through a directly attached social worker. The case depends mainly on a patchwork of descriptive and evaluative research, but largely meets the tests of consistency across time and context and can be seen as cumulative evidence. The identified benefits suggest that hospital trust managers rather than their social services colleagues might have a financial interest in exploring and evaluating this kind of provision.

Attaching social workers to EDs could have the effect of improving the efficiency and effectiveness of hospital services both within and beyond the ED itself while being recognised for improving the quality of the service by both staff and the users of hospital services alike. Moreover, as a key site for identifying social disadvantage and inequality in a variety of forms, an attached social work service (or a more socially oriented ED service) has the capacity to enhance EDs potential role as a pivotal point of information about and access to a range of statutory and independent sector health and social care services. However, the current politically driven emphasis on narrowly targeted health and social care services coupled with the continuing effects of a generation of underfunding means that these benefits are unlikely to be realised in full without a significant policy shift. The development of a systematic and robust evidence base might help to bring about such a change.

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