Social work in NHS hospitals: Opportunities and challenges

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Foreword

Social work in hospitals has been an enduring feature of the social work profession.

However, a detailed overview has often been lacking. In this original new research, Carrie Phillips describes and analyses the current state of social work in acute hospitals and makes important recommendations for policy and practice.

This research and findings will be a key resource for NHS managers, social work managers, clinicians, and, not least for hospital social workers themselves.

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Executive Summary

This report draws on data from Freedom of Information requests, interviews with hospital social workers, and a UK-wide online survey.

Key findings

- Social workers are often employed by the local authority but support discharges from acute NHS hospitals.
- Almost 40% of staff in hospital social work teams do not hold a formal social work qualification.
- Flexible and agile working is common, but this has had a detrimental impact on communication between social work and clinical staff in the hospital, and between social workers and patients, by reducing familiarity and opportunity for face-to-face conversation.
- Hospital social work has changed due to Covid-19 restrictions, as social work teams were often moved out of hospitals and have not returned.
- Discharge to Assess is also changing the nature of hospital social work, as long-term decision-making in a hospital setting is discouraged and patients are moved out of acute hospital settings sooner.
- Social workers bring value to the multi-disciplinary hospital team, by centring the importance of individual choice and of the patient's relationships.
- Social workers also report having a greater focus on the patient's past and their potential future, than clinical colleagues.

1. Introduction

In 2022-23, there were around 18.3 million admissions to NHS hospitals across the UK, which equates to around 27,105 admissions per 100,000 population[1-4]. Hospital admission is therefore a relatively common experience, and for many people will be a brief event from which they quickly recover. However, a hospital admission may also arise from an illness or injury with a longer recovery period, or from a long-term illness or disability. For some people, a discharge from hospital becomes an important opportunity to plan and organise the support needed to maintain the individual's wellbeing.

Ward staff, other clinical staff, families or the patient themselves may make a referral for adult social care, before, during or after the admission. Only a small proportion of hospital patients will be referred to adult social care, and there are no standard referral criteria, although the Hospital Discharge and Community Support guidance[5] (statutory guidance last updated in January 2024, used in England) states *'people with ongoing mental health needs, a drug or alcohol dependence, a learning disability, dementia, those in the last few months of life, and a range of other factors and conditions may require specialised support in the community. This may include an allocated social worker or social care professional ... to ensure their needs continue to be met.'*

There are various models of integration of health and social care across the four nations of the UK, but one of the most recent changes is in England. When enacted, the *Care Act 2014* included a clear statement of the responsibilities of health and social care professionals to support discharge from acute hospitals in England, for adults who may have an ongoing need for care and support. This statement of responsibilities was amended in July 2022 by the *Health and Care Act 2022* to allow for more flexible working arrangements between health and social care. By removing a prescriptive process of referral and assessment, arrangements can be tailored to local need[5].

The *Hospital Discharge and Community Support Guidance*[5], states *'social workers... should be involved at an early stage of the discharge planning process where appropriate, including where that planning takes place in a hospital setting.'*. However, there have been few studies that look at the way in which social workers are involved in discharge planning, or at the other work that they do in acute NHS hospitals[6]. The nature and impact social work involvement therefore remains under-explored.

This report concerns a study into social work in acute hospitals. First, a brief review of recent research into hospital social work in the UK, is given. This is followed by an explanation of how data for the study were gathered, using freedom of information requests, semi-structured interviews and an online survey. The key findings are outlined and discussed; how hospital social work teams are structured across local authorities and NHS Trusts; the work that social workers do in acute hospitals and how they talk about their work as caring and relationship-based; and the threats and opportunities offered by the changing nature of hospital discharges.

2. Literature review

2.1 The hospital social work role

One of the key roles for social workers in acute NHS hospitals is to assess the needs of individuals and to organise social care support for after discharge from hospital. This can range from arranging relatively simple practical support (such as providing information about services), through negotiating different funding streams from health and social care budgets, to supporting complex assessments of risk and of mental capacity[7-13]. Social workers contribute by bringing knowledge of resources outside of the hospital[10, 12] as well as specialist knowledge around legislation[7, 13] (particularly mental capacity legislation).

Social workers often take a position outside of the professional hierarchy of the NHS, and this can have advantages when it comes to providing an independent point of view from that of clinical colleagues[8, 9]. This ability (and professional responsibility) to challenge may be enhanced by the usual position of a social worker employed by the local authority rather than directly by the NHS[7, 8, 12]. Different stakeholders in the discharge plans often have different opinions of what is and is not acceptable risk. Some studies have suggested that social workers tend to favour positive risk-taking[8, 13], while other studies suggest that social workers are seen as more risk-adverse than clinical colleagues[9, 10]. A consistent finding however has been the importance of social workers in advocating for patients and families in the hospital setting, centring discussion on the patient's wishes[7-9, 12-14].

Alongside assessment, discharge planning, and advocacy, hospital social workers may also be involved in a range of other professional activities, such as safeguarding adults[12, 13], education (for both colleagues and patients)[6, 7, 13] and therapeutic support to patients and carers[6, 8-10, 12, 13]. In the UK however, these other activities are often considered secondary to the 'primary task' of assessment and discharge planning[7-13].

2.2 Views of hospital social work

Social workers often report feeling like social work falls outside of the core work of an acute hospital, and as such it can be difficult to be accepted by the hospital administration or by clinical colleagues[9, 13]. In contrast, clinical staff often appear to highly value the support that social workers give to their patients, citing their ability to advocate for the patient[7, 9, 10, 12] and to navigate complex social care systems outside of the hospital[9, 10, 15], although in some studies clinical staff did mention that social work input can also feel like a disruption to the smooth running of a ward[12, 14].

Evidence about patient and family views of hospital social work is more limited, with one study involving 1300 testimonies from older people about hospital discharge not mentioning social work at all[16], though this may reflect the reality that only a small proportion of older people are referred to a social worker in the first place. In other studies, however, social workers were felt by patients to help with identifying and mitigating barriers to a safe discharge home[17, 18] and giving more time to emotional wellbeing than other professionals may be able to[11].

2.3 Recent challenges in hospital social work

Austerity measures are an ongoing challenge to the whole adult social care sector[19, 20], as well as the NHS[21-24]. The changing demographics of the UK population compounds this challenge, as more people live longer, often with multiple or complex health needs[25, 26]. The health and social care system rely heavily on one another to work smoothly, however the last 20 years have seen rhetoric about the failures of social care impacting on the NHS[27], and a focus on the financial cost of 'delayed' discharges from hospital, rather than the quality of the support given when a patient leaves hospital[9, 28]. Discharge to Assess models have been developed to tackle the financial and health costs of longer hospital admissions, by discharging patients as soon as possible.

Discharge to Assess is a model of discharge planning that situates longer-term assessment and decision-making outside of the hospital, rather than discharge plans being made while the patient is still in hospital[5, 29]. This might mean a transfer directly from hospital to home, or to a residential step-down service where additional assessment and rehabilitation is offered, rather than a longer hospital stay[5]. Initial findings from research into the effectiveness and acceptability of Discharge to Assess models suggest that they can have a positive impact by freeing up acute hospital beds[29], and that patients often prefer to recover in a less clinical setting (or at home)[19]. However, inconsistencies in resourcing and integration of health and social care can undermine this impact by failing to provide the follow-on support that is required[30, 31].

Another recent challenge to both the NHS and social care has been the Covid-19 pandemic. At the height of infections, political and media focus in the UK was on 'saving the NHS', while social care (and other vital services) were not recognised in the same way[32, 33]. Government policy was updated frequently and communication between health and social care services was not always clear[34, 35]. Many social care staff, including social workers, were concerned not only about their own health, but also about the wellbeing of the service users they were supporting[33, 35-37]. Use of Discharge to Assess models was accelerated[34] and both the NHS and local authorities are now directed that Discharge to Assess should be the norm when an adult is well enough to leave hospital[5].

3. Methodology

The study used mixed methods and data were collected in three stages. Firstly, freedom of information requests were sent to all 204 local authorities in the UK with responsibility for adult social care and 166 NHS Trusts or Health Boards with responsibility for adult social care (in Northern Ireland) or acute hospital services. These requests asked for information about whether the area had a hospital social work team, who employed the team, and how many social workers and other staff were employed in the team. Overall, 96% of the freedom of information requests received a response (from 196 local authorities and 158 NHS Trusts or Health Boards).

Secondly, interviews were completed with 15 members of two hospital social work teams – seven social workers, four senior social workers or managers, two wellbeing officers and two social work students. Interviewees had worked in a hospital team for between 18 years and less than one year. The interviews included questions about the interviewee's role in the hospital; the legislation that governed their work; whether interviewees felt that the legal, organisational and financial separation of health and social care impacted on their practice; and how hospital social workers deal with ethical dilemmas.

Finally, an online survey using Qualtrics was advertised via social media and snowball sampling. The survey was completed by 93 participants – 66 social workers, 13 managers, six wellbeing officers, four social work students and one who listed their job as 'other health professional'. The survey included questions about the participants' role in the hospital; the most important and the most time-consuming tasks in their daily work; how much they felt a part of the local authority or the NHS; and about the emotional impact of the job.

The data from each stage were analysed individually, using descriptive statistics (quantitative data) or flexible deductive thematic analysis[38] (qualitative data). Flexible deductive thematic analysis involves organising and testing the data against theoretical frameworks and previous research

findings, to discover patterns, differences and gaps. All three data sets were then integrated, again using flexible deductive analysis.

Ethical approval was given by the University of Sunderland for interviews (ref; 013062) and for surveys (ref; 017531). The two local authorities employing the interviewees also gave ethical approval. All local authorities, NHS Trusts and all individuals have been given pseudonyms. Several pseudonyms that may be considered gender neutral have been used, in order to protect the identity of the interviewees.

Interviewees all worked in the North East of England, and 28% (n=26) survey participants also stated that they work in the North East of England. This may limit the generalisability of the findings, although there was at least one survey participant from each region of the UK and results were not significantly different if survey responses from the North East were excluded.

4. Findings and discussion

4.1 The structure of hospital social work teams

Hospital social work teams are more likely to be employed by the local authority than by the NHS, with 171 local authorities employing a total of 2461 social workers and 1661 wellbeing officers. In contrast, 49 NHS Trusts employ a total of 450 social workers and 155 wellbeing officers, with 192 of these social workers employed by Health Boards in Northern Ireland. These figures indicate that almost 40% of all staff in hospital social work teams are not qualified social workers. In interviews and surveys, wellbeing officers spoke about their work overlapping significantly with the work of their social work colleagues.

> *Sometimes it's a bit difficult because we do the same job. I mean there's only been a couple of times in the time I've been here, and I've had to pass a case over to a social worker. More so because of, I haven't got the understanding of the legislation I should have in order to be able to support that case and that patient.*
> Lillian, wellbeing officer, Urbanplace Council, interview

Wellbeing officers are often very knowledgeable, experienced and skilled, however they do not hold a standard minimum qualification; they are paid less than social work colleagues; and, in England, they are not required to register with a regulator. Quantitative data from surveys indicates that the work of wellbeing officers tends to be narrower in scope than social workers, for example they reported being more likely to complete assessments of eligibility for social care support, and less likely to be involved in safeguarding adults at risk. However, wellbeing officers did also report some involvement in decisions that may be complex or high-risk, for example assessing mental capacity to make decisions, and many were involved in at least some safeguarding of adults at risk. Whilst the title 'Social Worker' is a protected professional title, many aspects of the practice of social work are not. For assessment and discharge planning, duties under the *Care Act 2014* (and similar legislation) are not required to be carried out by a social worker. Hospital social workers are not always based in the hospital they support. According to freedom of information replies, at least 88% of local authority and 78% of NHS hospital social workers have access to office space within the hospital or other NHS property. However, annotations to freedom of information replies, as well as interviews and survey responses, gave a more complex picture:

> *I hot-desk on a shelf in a hospital corridor.*
> Sam, former NHS social worker, England, survey

Agile working is common, and a small number of participants described this as a positive factor allowing them to achieve a good work-life balance. More participants however reported difficulties in finding space to work and felt that limits on their access to hospital premises had a negative impact on their ability to form good working relationships with clinical colleagues, and most importantly to spend time building rapport and gathering the information they needed from patients and families:

> *Before, when we used to go in the hospitals all the time, we all knew each other so it was like 'yeah, yeah, I'll have a look', that's gone a bit. If it's a new person, rightly so, they don't know me from Adam, they'll be cautious about sharing that information. And vice versa. So it is a shame, it is something that we miss, I think all of us miss that.*
> Elizabeth, social worker, Ruralplace County Council, interview

Information sharing is vital when it comes to making good decisions about discharge and post-discharge care[39], but participants felt that gaining relevant information had become more difficult:

In a time where the NHS is under pressure and ward staff are under pressure to discharge patients it's really difficult to ensure that information given is accurate to inform our assessments and to ensure the best outcome for patients.
Claire, local authority social worker, England, survey

Proximity to colleagues from different professions or different agencies can make a positive difference to multi-disciplinary working, allowing information to be shared more openly and more quickly, and physical distance can have the opposite effect [10, 9, 14]. Frequent changes of staffing, such as when social workers are not allocated to work with a specific ward, can also negatively impact these working relationships by reducing familiarity between staff from different disciplines[7]. It is therefore it is potentially concerning that social workers have limited access to the hospitals they support. In addition, previous research with child protection teams indicates that agile working can contribute to stress[40] and limit opportunities for peer support and reflection[41, 42]. These findings suggest that the same may be true in hospital social work, with participants frequently referring to communication difficulties such as busy ward staff not answering the phone, the frustration and stress caused by not being able to gather relevant information in a timely manner, and expressing sadness at changes in the ease of relationships between themselves and clinical colleagues.

4.2 Advocacy, relationships and 'seeing the bigger picture'

Social workers and other professionals sometimes find it difficult to articulate the unique contribution of social work to the acute hospital setting[9, 12], although across the existing literature, advocacy[7-9, 12-14] and bridging gaps between health and social care, or between hospital and community[7, 10, 12] have emerged as key identifiers of good hospital social work. Participants spoke about acting as advocates for patients and families, and about deploying knowledge about both the patient and their social setting to make robust discharge plans:

No disrespect to therapists and health colleagues, but sometimes they're a bit blinkered, can't always see outside of a box with someone. You know, they see what the problem is, not what support could be in the community for that, rather than straight into a 24-hour care placement.
Sue, social worker, Ruralplace County Council, interview

Interviewees spoke very warmly about the people they support and focused on individual choice and relationships as key factors in decision-making:

[The daughter] was a trained carer, she was really sensible, she was really lovely, she doted on her mam so much, and she wanted to take her home... the ward staff just wanted me to just put her mam in a care home and I was like 'I don't think that's right, I think this daughter can really look after her mam'.
Sophie, social work student, Urbanplace Council, interview

Many participants spoke about prioritising the emotional consequences of the decisions they make, and often felt that clinical colleagues prioritised physical wellbeing and risk over emotional wellbeing (although the priority given to self-determination and emotional wellbeing may have only short-term benefits if the person's physical health continues to deteriorate[8]). Some also spoke about social workers having a role in understanding the patients' past and envisioning their possible future in a way that clinical staff do not have time to do:

There is a lot of stress caused by the pressure to discharge quickly, frustration that sometimes more emphasis is placed by medical professionals on emptying beds quickly rather than the well-being and future of the people in them.
Autumn, local authority social worker, England, survey

Many participants echoed findings from research about the tension between the needs of the individual currently in hospital, and the wider societal need for flow through the hospital[43]. While participants could see the need for movement and through-put to free up space for future patients, they tended to prioritise the needs of the person in front of them.

In common with previous research[7, 13], social workers also talked about their specialist legal knowledge, particularly around mental capacity. They often felt that clinical colleagues did not have enough understanding of mental capacity legislation and felt that it was their role to provide checks and balances against broad assumptions being made about patients' capacity to make decisions:

[Clinical colleagues will] say 'they don't have capacity' and you have to say 'capacity around what?' and we basically educate medical teams on what the [Mental] Capacity Act is, what it stands for, the legislation and we don't understand how that's still happening. Because it's been in since 2005, so how is that still happening now?
Melanie, social worker, Ruralplace County Council, interview

Social workers reported that medical and nursing staff would sometimes state that a patient 'lacked capacity' without considering that mental capacity to make a decision is specific to the decision and the time at which the decision must be made[44]. They also relied on legislation when explaining to families and carers that there may be limits to what support can be provided if the patient does not want this support, foregrounding the principle that capacitated individuals can make their own decisions.

4.3 The changing nature of hospital discharge

The findings from this study give a snapshot of how hospital social work operates, however there are indications that social work is being moved out of acute hospital settings. Explanatory notes appended to freedom of information responses indicted that Covid-19 restrictions were partially responsible for this change:

> *When Covid restrictions came to force, the [NHS] asked the local authorities to move the social work staff out of the hospital. The staff have been relocated to strengthen the community social work teams and there is no intention to reintroduce the roles.*
> Local authority, Wales, FoI response

Interviewees from Ruralplace Council had experienced a similar move out of their hospital bases due to Covid-19 restrictions, although they had kept their identity and main role as the 'hospital social work team'.

Some interviewees were allocated mainly to work on Discharge to Assess models, some of which could be complex. One team described options for rehabilitation, short-stay residential care, and settings described as more of a convalescent home, to recover from illness or injury but not necessarily to receive therapeutic input. All of these options incurred different costs and might be self-funded by the patient or eligible for financial support from the NHS or local authority.

Both interviewees and survey respondents were unsure about the value of Discharge to Assess models, with many survey respondents reporting that patients could be moved into residential care without proper consultation with the patient, family, or the local authority most likely to be responsible for the patient's ongoing care and support. Some participants could see the value of completing longer term assessments outside of the hospital setting, but none were unequivocally positive about the idea:

> *Hospital isn't the best place to do an assessment for someone because it's a totally new environment, especially if someone's got some mild memory problems, in their own home you can see that they're completely different... Would it be that you have a step-down unit or do that assessment at home? It depends on resources because if you haven't got those resources, where can those go?*
> Diana, team manager, Urbanplace Council, interview

Evaluations of Discharge to Assess models suggests lack under-funding of community-based services for patients to access once they are discharged is one of the main barriers to effective implementation[30, 31]. There is also a risk that implementing Discharge to Assess models will simply move the problems of hospital discharge to a different setting:

> *[Patients] are now becoming deskilled, so they might go in just needing medications prompts, by the time they're coming out we have to reassess and they've got a whole range of care and support needs afterwards... stuff like medication's managed by nursing staff, so obviously you can't give them that independence to see if they could manage taking their medication themselves.*
> Alex, social worker, Urbanplace Council, interview

If community-based services and residential rehabilitation do not have the capacity to meet demand, and to provide holistic rehabilitation, then the health and social care system as a whole is likely to continue to experience delays, blockages and increased demand.

5. Conclusions

The majority of hospital social workers are employed by local authorities and work in NHS hospitals, although there is significant variation across the UK as to the ratio of qualified and unqualified staff; whether the hospital social work team are based within the hospital they support or not; and indeed whether there is a hospital social work team at all. While this research is limited to a moment in time, there is evidence that social work is being moved out of many acute hospitals, and this risks patients and clinical staff losing access to vital social work knowledge.

Where there is a hospital social work team, assessment and discharge planning tends to be the most common priority. In common with previous research findings[7-9, 12-14], hospital social workers view some of their key roles as advocating on behalf of patients and families, and, where necessary, challenging clinical colleagues to take a more person-centred approach. A limited understanding of hospital social work as purely concerned with discharge planning risks losing these other important aspects of the social work role.

While some participants referenced social models of health and disability as underpinning their work, others felt that this no longer captured the difference between social workers and, for example, nursing colleagues, who many social workers felt also used more of a social than a medical model in their day-to-day work. Care ethics holds that good moral decisions are made when a person prioritises the impact that a decision will have upon relationships, rather than relying on an abstract concept of fairness[45, 46]. The stories participants told centred the individuality of patients and prioritised their family relationships, therefore care ethics might provide a useful way of conceptualising the unique contribution of social work to the acute hospital setting.

6. Recommendations for Policy and Practice

- **Develop the professional identity of social work in healthcare settings.** Social workers across healthcare settings, including acute hospitals, should be able to articulate their value to patients and to organisations, beyond the monetary value of expediating discharges. A focus on care ethics could help social workers, particularly students and newly qualified social workers, to develop a sense of their value base and the unique perspectives they can bring to bear when an individual is in hospital or ready to leave hospital.

- **Maintain (or reintroduce) a social work presence in acute hospital settings.**
  Even if Discharge to Assess becomes the dominant model of progression from an acute hospital setting, social work skills are vital to ensure that rights and choice are upheld and that there is minimal negative impact on relationships. Social work support continues to be most important at the point of considering long-term plans following a hospital admission, however decisions made in the short-term have an impact on the options available later on, and so short-term decisions should not be regarded as trivial.

- **Promote the value of social work skills in the hospital setting** such as therapeutic support to individuals and families facing change, uncertainty or crisis; safeguarding adults at risk of harm; and supporting the education of clinical colleagues, to reinforce a holistic approach from the health system.

- **Develop robust systems for appropriate information-sharing**, that protect patient confidentiality but minimise the burden of seeking information about a patients' health or social care needs. This might be done by way of reciprocal read-only access to hospital and social service note-taking systems.

- **Ensure that Discharge to Assess models are sufficiently resourced** to give meaningful opportunity for rehabilitation, recuperation and long-term assessment. Models based on residential care must maximise independence in a meaningful and risk-positive way, and not miss out essential life-skills such as access to cooking facilities, medications, or travel in the wider community.

- **Further research is needed about the roles and responsibilities of wellbeing officers** and similar social care practitioners. There is some evidence in this research that the scope and complexity of the work taken on by wellbeing officers is not commensurate with their training, qualifications and pay. However, further research is needed to determine whether this conclusion is supported by quantitative evidence across more adult social care services. In England, Social Work England should consider registering social care professionals alongside social workers, as regulators do in Scotland, Wales and Northern Ireland.

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Carrie Phillips, Lesley Deacon and Daniel Burrows are the authors of *Social Work in NHS hospitals: Opportunities and Challenges.*

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This report summarises findings from a PhD thesis by Carrie Phillips, supervised by Dr Lesley Deacon (University of Sunderland) and Dr Daniel Burrows (Cardiff University). The full thesis is *'It's heart breaking, and funny, and sad, and confusing, but it's amazing' - A critical realist study of social work practice in acute NHS hospitals.*

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