Social Work Attachment In A Group Practice A Case Study In Success?

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Abstract: This paper presents the findings of a programme of research that investigated the impact of a full-time social work attachment to a GP group practice located in a large public housing estate in Cardiff. The research was commissioned by the Social Services Department of South Glamorgan County Council and undertaken by two members of the School of Social and Administration Studies at the University of Wales in Cardiff. The attachment was a one year pilot project undertaken with the co-operation of the group practice in partnership with the Family Health Service Authority (FHSA) and the local social services department. It became the subject of research during 1991/1992 in order to assist policy development by the FHSA and the social services department on whether to continue the scheme and extend similar services to other interested general practitioners.

A research programme lasting thirty days was carried out during the first six months of the attachment scheme. The programme comprised a case study involving interviews with she GP surgery team, social work and a sample of patients. Quantitative data were collected in respect of patients referrals and types of social work intervention. The findings revealed that performance objectives set by the FHSA, surgery team and social services department were generally achieved to a high standard. Likewise, the views of service users were overwhelmingly favourable and indicated a clear understanding of the service provided and the benefits derived.

Introduction

If general practitioners were asked whether they would want a social worker attached to their practice they might reasonably reply with the question 'what's in it for may patients and for me? This article set out to give some answers to that question.

To begin with, it is clear that closer collaboration in direct service delivery between providers of primary health care and social work is becoming more common-place, particularly with the introduction of the Community Care and NHS Act'. Indeed, in the context of an increasing elderly population, fewer beds in district general hospitals, shorter hospital admissions, increased day surgery, the advance of infection such as HIV and more GP beds in community hospitals, general practitioners may well be asking 'why don't I have a social worker' to help with the growing social demands of health care in the community.

Should GP's ask themselves this question they would be well
reminded that there is no simple, or single model of attachment. However, there are a number of key ingredients, around planning, implementation and practice itself that bear critically upon the success of any scheme and these will become apparent in the discussion that follows.

The idea of a social work attachment to a general practice surgery is not new. In the late 1960's and early, 1970's various government reports and a DHSS working party considered the importance of collaborative structures between health services and social work agencies. The general view being that social work attachments provided a good opportunity for improving service delivery for health and social care. Furthermore it was noted that the GP was well placed to be a point of first contact for non-medical problems that might, in any case, be referred on to social services departments.

The DHSS report did however not that GPs might remain doubtful about the benefits of working closely with large local authority social services departments and the arrangements that flowed from this. Similarly, the report noted that social workers also had their doubts about close collaboration in health settings and the degree to which there were likely to be shared service interests and equal membership in a team approach.

In the twenty or so years since these reports there has not been a uniform response from health and social work agencies to the question of attachment. There have been many schemes that have varied considerably in purpose and structure. Research studies conducted since these reports have revealed some interesting trends and offer the following advice and warnings. Past research indicates that health staff have often viewed social work as more relevant when providing practical support to patients. There is some evidence that GPs tended to refer female patients, many of whom were elderly and vulnerable through low incomes and limited domestic support. Social work involvement with patients has also tended to be short term. Social work in respect of emotional and relationship needs associated with health problems has been less well regarded by some health staff. In contrast, social workers have viewed this area as of prime importance while not ignoring the practical needs of patients. GPs have often attributed greater importance to work with mental health problems, child abuse, financial difficulties and problems of ageing whilst attributing less importance to social work counselling per se. These views have not been universal however, and it is clear that social workers have derived much of their job satisfaction from dealing with cases that demanded more than basic advice work or acting as a signpost to other services. In brief, past research highlights potential problems of matching social work skills and services to patient needs. Hence, the initial concern for any proposed attachment is one of agreeing a clear protocol for social work practice.

These sorts of issues helped frame the investigation of the attachment project in Cardiff. It seemed crucial to identify the impact of the service from the different viewpoints of health staff, social worker and patients; taking account of several key issues in each research area. From the patients' viewpoint, key questions were whether they would be happy to see a social worker; whether they would perceive benefits from a social work
input; and whether resources would be better mobilised for the patient as a consequence of social work involvement.

From the practice team viewpoint, it was considered important to discover whether there would be agreement over the sorts of referrals and services requested of the social worker; whether there would be better opportunities for the practice team and social worker to discuss patients' social and emotional problems and needs; and whether the scheme would save time for the practice team.

From the social work viewpoint it was necessary to consider the matching of skills to referrals. It was important to identify if the social worker was appropriately used or whether they simply became a conduit for other service providers, passing on work rather than offering a distinctive surgery based service for patients. Job satisfaction, accountability and status within the surgery team were key issues for investigation.

The Setting

The social work attachment was set in a group practice serving patients predominantly drawn from two large public housing estates on the periphery of the city. Both estates have higher than average levels of unemployment and apart from some local shops there are few amenities for the community. The patients listed at the time of research numbered approximately 8,200 with consultation rates about the national average. The Group Practice operates from a modern purpose-built surgery located on the boundary of the two estates and easily accessible to both. The core practice team comprises four GP partners, two trainee GPs, receptionists, two practice nurses and a social worker. Health visitors and a district nurse were part of the team and routinely attended the practice but were based elsewhere.

The social worker joined the practice team after successfully applying for the full time attachment post which had been advertised nationally. The social worker had been employed previously in a neighbouring local authority and had several years experience in child care and adult services.

Terms of Reference for the Attachment

The attachment was designed as a pilot project based on a partnership between the GP practice, the social services department and the local FHSA. Between these parties it was agreed that the practice would provide the social worker with office space and secretarial support. The social worker would be a member of the practice team but accountable to her local authority employer.

A clear protocol was set out in respect of working arrangements. The main elements of the protocol included the social worker providing services as follows:

(a) for patients with social and/or emotional problems relating to a physical illness and not a permanent disability
(b) give priority to those patients who were in acute hospitals (not including psychiatric, geriatric or learning disability hospitals) (c) liaise with other social services staff and relevant agencies as necessary.
Service areas already covered by specialist community based social work teams, such as child care, physical disability, mental health and mental handicap, problems associated with the social needs of elderly people, were specifically excluded from the brief.

In essence, the social worker would address those cases where physical illness or injury was accompanied by social or emotional difficulties. It was agreed that reports and counselling on pregnancy termination would be part of the protocol. Furthermore it was anticipated that while a proportion of the work might be of a practical nature, counselling would nonetheless remain a core service provided by the social worker. It was understood that there would be circumstances that would not easily fit the protocol and that some flexibility over interpretation would be required. It was also agreed that the social worker would not require access to medical records.

Methods

The research was commissioned by the social services department who requested a detailed analysis of the project to assist policy decisions on whether to extend or discontinue the scheme. The limited time available to complete the research and the uniqueness of the scheme within the local health authority and social services department precluded an experimental or comparative research design. Instead, an applied social research methodology was adopted, based on a case study and action research model. The aims of this research strategy were to determine how well specific performance expectations were being realised; to identify the reasons for specific service failures or successes; to uncover the principles underlying success; to make recommendations to improve effectiveness and redefine service objectives, if necessary. Most of these aims were accomplished in the research programme which was designed in collaboration with the practice team. The research method included audio taped interviews which were conducted with the practice team before the attachment began and six months later. Quantitative data were generated using pre-designed and tested forms that were used to gather referral information and patient characteristics. A detailed work diary of patient-related contacts with other agencies was kept by the social worker and checked by the researcher against social work case notes. Structured interviews were conducted with a random selection of patients (every fourth) who used the service over the first six month period.

Findings

The findings of five key areas of investigation are discussed below, under the headings: referral trends and patient characteristics; general work orientation of the social worker; views from the practice team; views from the social worker; and views from the patients.

Referral trends and patient characteristics

The social worker received 120 referrals in the first six months of service. Ninety seven (81%) conformed to the protocol and were actioned. Most referrals that were unsuitable arose in the first
month of the scheme. The unsuitable referrals were, typically, requests from the practice team (mainly the GPs) for a service for patients who were suffering from a permanent physical disability and not a physical illness. As such, these patients should have been referred to the local community based social work teams. Almost 70% of referrals came from the GP's, whilst 16% came from other members of the practice team, and the remainder from medical social workers. Only one patient referred himself. The bulk of the referred patients were in the community rather than in hospital (80% and 20% respectively). Some 70% of all referred were women. Of those referred, a third of female patients and a half of male patients were over 65 years of age.

Women were frequently referred, not only in relation to personal health problems but also with family health problems; health problems of age and isolation and the problems of ageing and caring for a partner. Male patients were more often referred in relation to problems of personal illness and to a lesser extent with problems of age and, isolation. Child related illnesses accounted for 7% of referrals.

Of the 97 referrals accepted by the social worker, some 77% received attention within three working days and 18% were attended to within four to eight working days. Eleven of the 97 referred patients were in hospital and received one or two visits. Sixty three were in the community and received home visits. Of these 15 received two home visits and four received three visits. Only 10 patients were seen in the surgery and a further 4 patients were dealt with by telephone. Three referrals were accepted but received no further action and six referrals were awaiting a first visit. The time span of cases being opened and closed was fairly consistent over the research period of 6 months. Fifty nine percent of cases were closed within four weeks, 66% by eight weeks and 70% within 12 weeks. There have been no follow-up studies to assess whether this is a continuing feature of the service.

Work Orientation

Social work input in the first month could be described as largely assessment/investigative work with limited liaison with other agencies. From the second month, referrals became more complex, requiring higher levels of liaison and more counselling work. After three months a pattern appeared to develop of work with patients predominantly in relation to bereavement, terminal illness, serious illness and pregnancy termination. The reasons for this shift in orientation will be discussed later.

Patients were rarely seen at the surgery, instead they were typically seen in their own home surroundings. Contact between the social worker and the practice team was largely through informal encounters on a day to day basis or in routine staff meetings. This contact appeared to fluctuate depending on the complexity and number of referrals from any team member. An initial high level of contact tended to reduce as participants in the project began to understand more about their respective skills and responsibilities.

Contacting other welfare agencies became a routine and dominant feature of daily work and there was a consistent average of two
agency contacts per patient in later months. It is important to note that almost 70% of patients seen by the social worker were unknown to the local social services department, suggesting that the attachment was effective in addressing unmet need in the community. It is doubtful if any of this group of patients would have received a social work service had the scheme not been in place.

Views From The Practice Team

Inappropriate referrals by the practice team featured prominently in the early weeks but were soon resolved. Most referrals came from the six GPs but there was no uniform pattern. The principal partners tended to refer more, and it was evident that some scepticism about the scheme from two of the GPs gave way to full approval once the social worker had been in post for a month and working arrangements had been tested. By the second month of the project the GPs and social worker were able to identify more complex cases better matched to the worker's skills.

GPs were unsure about patient reaction to a suggested referral to the social worker but generally found that patients were not unhappy to be referred once they realised it was part of the practice service. There was some evidence that patients were reassured by the idea that this was ‘their’ practice social worker and not an employee of some distant local government agency.

GPs saw the attachment as an additional service and one which they had neither the time nor the skills to provide. They did not consider that the scheme had either reduced or increased their workload to any significant degree. While the practice team acknowledged that their knowledge and contact with the local social services department was limited, they did not consider the scheme had changed this fact in any significant way. All the GPs hoped that the referral protocol could be broadened and all gave full endorsement to the continuation of the scheme.

Views From The Social Worker

High levels of daily informal contact with the core practice team (including joint visits to patients) were invaluable in the early weeks as a means of identifying respective skills, responsibilities and patient needs. Very few instances of disagreement arose over areas of patient responsibility among either the practice participants or among outside agencies. The absence of daily contact with a social work peer group occasionally created a sense of isolation, which was relieved by regular supervision from a senior manager in the participating social services department.

The attached worker was welcomed as a full member of the practice team and was able to influence the selection of referrals in order to more efficiently match patients needs with her own competencies. This gave priority to more serious cases (bereavement, terminal illness, serious illness, termination counselling) and provided the worker with increased job satisfaction.

Views From The User
One in four patients (N = 24) were selected to provide a patient sample that was broadly reflective of age ranges and gender divisions among the accepted referrals. Apart from two older female patients, all respondents could recall the service received from the worker and the benefits derived.

All patients indicated their satisfaction with the service, apart from two younger female respondents. These were dissatisfied with specific aspects of the service: service unavailable when worker was on leave; and worker unable to resolve accommodation problems. Both, like all the other patients contacted, stated they would be happy to contact the worker again if the need arose.

At the point of referral few patients had any clear idea of what service they could expect from the social worker. It would appear that referrers were generally unclear or unsure of what the worker could provide when suggesting the service to patients. This uncertainty was resolved once the social worker made contact with them.

There were no significant differences between male and female patients or between age groups in the overall positive opinion about the service. However, three younger female patients, with children, had initial reservations about accepting a service. This was largely to do with their apprehension about the role of the social worker which they thought might include a child protection and surveillance function. Once it was made clear that this was not the role of the practice social worker these patients were happy to receive a service.

Discussion

In the practice selected for the pilot project, the GP’s had long recognised the complicating factors of domestic and social problems in relation to the health problems of their patients. They did not anticipate that the attachment would in any sense tackle the multiple disadvantage of those living in the nearby estates nor did they anticipate that the scheme would alter the volume or nature of their own work - which it did not. Quite simply, they recognised a service need which they could not meet. To this end, the attachment was successful in mobilising an extension to their health care work through practical support of patients in the community and through counselling.

The reasons for the success of the scheme can be drawn around three key ingredients. These are planning, resourcing and team work. Joint planning and agreement of a clear protocol over the role, responsibility and accountability of the attachment was crucial to the success of this particular scheme. Here, the areas of practice were clearly delineated around cases of physical illness thus avoiding overlap with other locally provided social work provision (viz, mental health, mental handicap, physical disability, child care, elderly services). The fact that the GP’s in this case study wanted to re-negotiate the protocol after six months to include some of these areas says something about their approval of the attachment scheme and their preference for mobilising services through this medium.
Adequately resourcing the attachment may seem self-evident but must comprise not only office and administrative support for the social worker but clear methods of communication and feedback within the practice team about service needs, service delivery and outcomes. Of equal importance is agreeing who will pay the costs of administration. In this pilot project the costs were borne by the practice for the short duration of the pilot period (one year). However, now that the scheme is permanent, and with proposed similar attachments to several other practices in the city, the costs of servicing an attached post are being negotiated between GP’s, the FSHA and the local social services department.

Team building and positive regard for different occupational skills are of course essential. Here, the personal qualities or characteristics of participants are a key component but not always susceptible to administrative control or planning. Nevertheless, the success of this project had much to do with the careful recruitment of the attached worker and also the commitment of the practice team to the project. Indeed the high regard in which the social worker was held by the practice team meant that they were able to resolve most practice issues through informal discussion. For example, the area of patient confidentiality gave rise to no difficulties in that GP records and social worker records remained the exclusive preserve of respective parties.

Furthermore, while the GPs would discuss patients' health needs with the social worker, and vice versa, both parties were confident that these verbal exchanges would remain between themselves unless otherwise agreed. This crucial point however was never formally encoded in the attachment protocol and clear guidelines on this delicate matter are a better safeguard than informal working agreements. While the scheme was successful within its own stated objectives there were a number of issues that raised questions about future attachments. To begin with the GP’s found the scheme helpful in that they could refer their patients to an immediately accessible 'known' person in whom they had confidence. Hitherto, the GP’s had not made frequent contact with social services and the attachment itself had not increased, in the GP’s view, their propensity to make more use of the local social work department. Instead they were keen to increase their access to social services by widening the protocol of the attachment social worker rather than make contact with what was seen as a distant department and an unknown social worker. Such an option was not available at the time of completing the research and it was not the policy of the social services department to widen the remit of this or other attachment workers. In this respect the project did not fully match the needs of the GP nor did the project lead to an enhanced take-up by GP’s of social work services beyond those provided by the attachment.

A further question of matching needs arose in relation to the social worker's skills. As the attachment developed so the worker was able to negotiate with GP’s that they refer more 'serious' cases. Thus initial cases were more to do with practical advice and support and there was a brief social work involvement. In later months cases were characterised by longer involvement and a more intensive use of counselling and assessment of more complex
needs (e.g. terminal illness, bereavement, pregnancy termination). These sorts of cases came to dominate the worker’s activities and matched her skills and provided better job satisfaction. However, this meant that there were a number of patients who would not be referred but who still needed advice and support. In this regard there was evident need for the attachment to include a social work assistant to deal with less complex cases in order to provide a comprehensive social work service. Testing the feasibility of such an option was not part of the research but is mentioned here in order to alert GP’s to the fact that patient problems may require social workers with different skill levels.

To conclude, GP’s need to be clear about the range of patient needs that an attachment should cover. For example, will it extend only to physical illness as in this example, or will it comprise all or some of the other patient needs that social work departments currently deal with, viz - child care matters, mental health, learning disabilities, physical handicap, care of the elderly. GP’s also need to give careful thought to the level or combination of social work skills that can address these needs. Will it be experienced and long qualified social workers as in this case study or would a social work assistant or combination of both be more appropriate? At root lies the question of what range of patient problems can be referred and what sorts of social work skills best match them. If that can be resolved then the foundations of a successful collaboration and a better patient service will have been laid.

References

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