GPs and Social Workers: Partners for Better Care
Delivering health and social care integration together

A report by The College of Social Work and the Royal College of General Practitioners

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Foreword

GPs and social workers must work together for innovation and reform

One of the big questions for the NHS and local authorities is how and whether we can integrate health and social care to better serve people - and save money at the same time.

Our view as the voices of our respective professions is that we can, and must, work together to put GPs and social workers in the driving seat for practical reform and innovation.

Partnership between social workers and general practitioners is critical to the development of person-centred care and in addressing the looming financial crisis facing both the NHS and social care.

However, successful partnerships do not happen by chance. There are differences in funding, professional cultures, training, governance and accountabilities, all of which need to be recognised, understood and worked through to ensure that the right partnerships are in place and do the right things where it matters, in practice.

We must be mindful of escalating workload pressures facing both professional groups, alongside the need to develop person-centred and individualised care.

For GPs, the shift away from the treatment of specific diseases to multi-morbidities is not dissimilar to the challenges faced by social workers in developing personalised care which offers greater choice and control to the people using our services.

GPs and social workers share a common interest in leading and creating system change that will support better outcomes and be economically sustainable. Social workers have a vital role in building the strong, resilient communities that are needed.

This report demonstrates through evidence and case studies how we can work together as local leaders to make integration in local communities a practical reality.

Maureen Baker, Chair
Royal College of General Practitioners

Jo Cleary, Chair
The College of Social Work
Executive Summary

1. One of the big questions hanging over the NHS and adult social care is how and whether they can be integrated so as to serve people better and save money at the same time. Our view as professional colleges is that the answer is “Yes,” providing that GPs and social workers are in the driving seat.

2. If a catastrophe brought on by rising demand and dwindling funds is to be averted, a radical solution will be required. That solution is a new model of service delivery centred on the two professional groups in health and social care who are best placed to lead the transition to a more community-oriented service.

3. People with long-term conditions account for 50% of all GP appointments and 70% of hospital bed days, but there is mounting evidence that the heavy reliance on acute and long-term care is poor value for money both for patients and the public generally. This is where social work can contribute: whereas historically the medical care model may have tended to foster dependency, the social work model aims to promote independence.

4. The £3.8 billion Better Care Fund (BCF), a pooled health and social care fund to be introduced by the government in April 2015, is intended as a fillip to integration and implementation will be measured against a strict set of criteria, including demonstrable success in helping more people to live independently.

5. Several initiatives have already begun to show the way. Fourteen integrated care pioneer projects have been set up as BCF trailblazers and the Coalition for Collaborative Care has produced the “House of Care” model of long term conditions management, focusing on autonomy and self-care so as to improve the physical, social and emotional wellbeing of patients/service users and their carers.

6. In announcing changes to the GP contract a year ago, health secretary Jeremy Hunt promised a similar shift. NHS patients aged 75 or over would have a named GP to give older people the care they need while preventing unnecessary trips to hospital.

7. Both the Royal College of General Practitioners (RCGP) and The College of Social Work (TCSW) have welcomed these developments. The RCGP said they would help GPs get back to their “real job of providing care where it is most needed,” while TCSW believes social workers have a crucial role to play in care reform, “giving people more choice, control and opportunities for active citizenship.”

8. A survey by the Association of Directors of Adult Social Services (ADASS) and the NHS Confederation found that 46% of respondents said that integrated care had improved quality of life for people with long-term conditions, 41% said they had been assisted to live more independently, and 48% said it had resulted in financial savings. The “Home Truths” project, a study of relationships between GPs and social care, reckons that £1.6 billion could be saved annually by closer ties between them.

9. Early indications are that reductions of 15 – 20% in residential/nursing home placements and 20 – 30% in A&E attendance and hospital bed occupancy are achievable among people deemed to be at “high risk” of going into these forms of care. These figures are borne out by the five case studies presented here, where GP-social worker partnerships have started to save money desperately needed elsewhere by listening to what people actually want rather than automatically resorting to the tried and tested methods.
10. But the cultural divide between health and social care often gets in the way of these partnerships. Social workers and GPs regularly fail to understand each other’s unique role, responsibilities and perspectives, barriers that may have to be dismantled through inter-professional education, co-location and informal networking, among other things.

11. Excellent leadership by GPs and social workers, locally by practitioners themselves and nationally by their respective professional colleges, will be essential if community solutions to health and social care needs are to be realised wherever possible.

12. The GPs and social workers showcased in our case studies have risen to the challenge. They are leading multidisciplinary teams, including nurses, allied health professionals and other practitioners, to construct a “team around the person” based on a GP practice or “clusters” of GP practices. Here is a short summary of each:

Case study 1: Central Manchester Practice Integrated Care Teams

13. Since November 2012, 32 out of 34 GP practices in Manchester have become the focus of an integrated model of care for 500 high risk patients/service users. Social workers have contributed by helping to change the terms of the discussion. Integrated teams have moved from being “predominantly medicine and health care based to a more rounded discussion of wider social needs.” A&E attendance and hospital stays have fallen significantly.

Case study 2: Harrow multi-disciplinary groups

14. Six multi-disciplinary groups (MDGs) are each attached to a “cluster” of GP practices across the outer London borough. Social workers, nurses and hospital consultants also attend the regular meetings, where the aim is to support the 10% of the local population with two or more long-term conditions to live independently at home. Many of them can be steered away from residential or nursing home care.

Case study 3: Warwickshire ‘Discharge to Assess’ teams

15. The Discharge to Assess (D2A) scheme enables older people coming out of hospital to undergo a period of recuperation and rehabilitation in a nursing home before returning to their own home. Social work assessments are carried out in these intermediate care facilities, reducing delayed discharges and the overall spend on continuing health care. “It is too early to say whether we are successful in supporting more people to live independently at home rather than in hospital or a care home,” says one of the GPs involved. “But I do think we maximise patients’ chances of going back to their own homes.

Case study 4: Focus, NE Lincolnshire

16. As a social enterprise whose employees are social workers, Focus operates several collaborative projects with GPs. There are many people with complex health conditions who can cope independently in theory, but who are isolated or may have housing, debt or relationship problems and do significantly less well in consequence. This is where the social work skill set comes into its own and makes a unique contribution to the improvement of people’s lives.
Case study 5: Ageing Well in West Cheshire

17. Two vital components of a broad strategy to reduce non-elective hospital bed use by 25 – 30% and residential/nursing home care by 15% are: integrated community care teams to promote independent living and a plan to develop stronger communities in which older people “are viewed as assets rather than deficits”. Integrated teams identify older people at high risk of an unnecessary admission to hospital or long-term care, finding alternatives which ultimately allow them to remain in their own homes.

18. All five case studies are important evidence of progress in developing the common culture across health and social care that is expected to become the norm by 2018. The RCGP and TCSW see GPs and social workers as the linchpin of reform. Both colleges want to see local leaders emerge who are also determined to realise the ambition of seamless, community-oriented health and social care.

19. Radical change is necessary, but social workers and GPs working in partnership can make it happen. The future of health and social care depends, to a significant extent, on their success.

Introduction

20. By common consent radical change is required in health and social care if the system is to be prevented from imploding under the rapidly rising pressure of demand. On current projections the funding gap between demand and resources will reach £30 billion by the end of the decade in the NHS alone.

21. At the Royal College of General Practitioners (RCGP) and The College of Social Work (TCSW) we do not pretend that we have a complete solution to this looming crisis, but we do think that there is an emerging model of good practice which can form an important part of it. This model shifts the centre of gravity in health and social care towards the individual and the community, cutting across the traditional distinctions to integrate services in the interests of the people who use them.

22. In this paper we will describe the model, giving several working examples, and state the evidence for it. Social workers and GPs, working in partnership, are the axis around which it revolves but the model also involves nurses, OTs and allied health professionals. As the most prominent professional leaders adjacent to the boundary between NHS and local authority care, GPs and social workers are ideally placed to make radical change happen.

23. We need to see the integration of health, social care and housing in every locality if we are to make the health and social care system sustainable. The Health and Social Care Act 2012, by giving GPs a lead role in commissioning health services, has created an opportunity for new partnerships between general practice and social work. Here, we build on work already undertaken by the RCGP and TCSW and explore some of the similarities and differences between the two professions.
Why integration is the ‘cure’

ARGUMENTS AT A GLANCE

- Financial sustainability for health and social care requires a new model of service that promotes independence rather than fostering dependency;
- The Better Care Fund provides an opportunity to establish the new model, based on partnership between GPs and social workers;
- Care for long-term conditions accounts for 70% of acute and primary care budgets and the pressure on budgets is set to grow rapidly;
- A new model “would focus much more on preventing ill-health, supporting self-care, enhancing primary care, [and] providing care in people’s homes and the community.”
- Through collaboration social workers and GPs are ideally placed to shift the balance of care from acute to community settings.

24. A community-based health and social care service will need to strike a balance between formal, statutorily provided care and supported self-management. Cost effective community solutions will depend on enabling people to live as independently as possible for as long as possible. The all-important synergy between GPs and social workers lies here: whereas historically the medical care model may have tended to foster dependency, the social work model aims to promote independence.

25. Both models have their place in different circumstances, but with the increasing incidence of long term conditions, multi-morbidity and frailty, together with the opportunities provided by the Better Care Fund (BCF) to pool budgets, we believe it is time to bring these models together to better reflect the individual circumstances of the person. On the one hand “care plans” will set out formal, statutory care entitlements; on the other, “care planning” (as defined under NHS England’s “House of Care,” see below) will focus on autonomy and self-care, taking into account the physical, social and emotional wellbeing of patients/service users and their carers.
26. The need to reorient services around the double-headed arrow above arises from a grim statistical truth. This is that 15 million people in England have long-term health conditions, accounting for 50% of all GP appointments and 70% of hospital bed days. Providing treatment and care in these settings absorbs 70% of acute and primary care budgets, yet there is mounting evidence that this is a grossly inefficient use of NHS resources and that more community-oriented forms of care and support are both more cost effective and better appreciated by patients/service users.

27. What is clear is that the current model of care is bust. "Multi-morbidity," when someone is affected by more than one long-term condition, is becoming widespread. By 2018 the number of people with three or more long-term conditions is expected to rise to 2.9 million, an increase of 50%, and if the care system is unreformed the additional cost will be £5 billion.

28. The numbers of people with a diagnosis of "frailty" are similarly set to rise rapidly in line with anticipated demographic changes. Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. This means the person is vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication.

29. Frailty affects 10.7% of the population aged over 65 years and the numbers are forecast to increase substantially from 8,660,529 in 2011 to 13,053,288 by 2051. It is a multidimensional diagnosis and therefore people can only be supported by bringing together the medical, social and psychological approaches.

30. Though it is not the whole answer to the financial crisis, integration should help to stop care costs spiralling out of control - but how? As a spur to integration a pooled budget, the £3.8 billion Better Care Fund (BCF), has been established by the government by bringing together components of the health and social care spend. NHS and local authority money will be earmarked for promoting integration from 2015 and open the way for transformational change in austere times.

31. The coalition government has declared its determination to drive change, partly by establishing 14 integration pioneer projects as trailblazers for health and social care reform. The Labour party has said it is equally committed to reform. Shadow health secretary Andy Burnham told his party conference in September: “In the 21st century, the home and not the hospital needs to be the default setting for care.”

32. The integration pioneers are bringing together nurses, GPs, social workers, hospital doctors, allied health professionals and others to provide better support at home and earlier treatment in the community, staunching the flow of people into emergency care in hospital or care homes.

33. The BCF is not new money, but delivery will be monitored against a strict set of combined health and social care metrics with the intention that integrated care becomes the norm by 2018. Success will to a large extent be measured by a reduction in admissions to residential care and nursing homes, effective reablement services, and fewer emergency admissions to hospital. This will be coupled with an expectation of positive experiences for patients/service users.

34. If the requirements of the BCF are to be achieved, GPs and community health practitioners will need to give timely medical help, while social workers and social care practitioners strive to promote people’s well being as part of their neighbourhoods. Gradually these roles will intertwine and become mutually supportive.
35. The integration pioneers are proving that various approaches are possible and demonstrating the importance of integration across primary, secondary and social care. But in the view of our professional colleges there are many settings and situations where social workers and GPs, working together, are best placed to coordinate the several efforts of health, social care and housing in the interests of service users.

36. The King’s Fund’s influential report, *Where next for the NHS reforms? The case for integrated care*⁴, argued that resources would have to be used much more efficiently to meet the needs of an ageing population, increasing numbers of whom had more than one chronic medical condition. A new model of integrated care, it said, “would focus much more on preventing ill-health, supporting self-care, enhancing primary care, providing care in people’s homes and the community, and increasing coordination between primary care teams and specialists and between health and social care.”

37. Among the exacerbating factors were the rise in single-person households living without the support of family members and the “shifting burden of disease,” through which, while premature death rates from cardiovascular diseases and cancer have declined, chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease, heart failure, arthritis and dementia have become more prevalent.

38. The King’s Fund called for a transfer of resources from acute hospitals to providing care in and closer to people’s homes with the “triple aim” of improved patient experiences, better health outcomes and more cost-effective care. At the heart of the new integrated model would be “action to link primary care teams more closely with specialists and with health and social care professionals to ensure patients and service users receive care that is effectively coordinated.”

39. Other prominent stakeholders have set similar aims. The Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Society of Local Authority Chief Executives (Solace) have all committed themselves to a “whole community” approach which “wraps” joined-up services around people’s needs rather than organisational convenience and gives precedence to their independence and well being⁶.

40. Impelled by the integrative aspirations of the Health and Social Care Act 2012 and the Care Act 2014, versions of a new model of care have begun to emerge with GPs and social workers as the motor of reform. GPs are beginning to adopt more collaborative approaches to community care, while more and more social workers are forsaking care management to focus instead on promoting choice and control, supporting and empowering people to live independently as active citizens in their communities.

41. GP and social worker partnerships are starting to show how investment in social work as part of a remodelled community service can reduce costs across the health and social care economy. These partnerships are not new, but they have renewed potential in the current policy context.

42. Through collaboration social workers and GPs are ideally placed to shift the balance of care from acute to community settings. Such a dramatic shift, cutting across professional and organisational vested interests, will require strong professional leadership in both the health and social care spheres.

43. Sitting at the interface between health and social care, GPs and social workers can nurture a community infrastructure to help people live independently for longer and avoid spending time unnecessarily in hospital. This could unleash resources locked up in hospitals and long-term care to be used much more cost effectively in community settings. Personal budgets have a role here too.
44. Working together does require social workers and GPs to understand the similarities and differences between the two professions, as well as some of their historic baggage, if collectively they are going to develop better outcomes for people.

**Building blocks of reform**

ARGUMENTS AT A GLANCE

- RCGP and TCSW have endorsed the Coalition for Collaborative Care’s “House of Care” model of long-term conditions management for delivering cost-effective services;
- House of Care would give people more control of their lives through person-centred care and support planning;
- The new model will require a much freer flow of funding across the health and social care economy;
- The two professions can seize the initiative as GPs move away from “box-ticking” and social workers are freed from the straitjacket of care management.

45. NHS England, supported by RCGP and TCSW within a wider Coalition for Collaborative Care, has endorsed the “House of Care” model of long-term conditions management that will be crucial to delivering cost-effective services as envisaged under the Better Care Fund (see diagram below). At the centre of the House of Care is giving people with these conditions more control of their lives through person-centred care and support planning, focusing on how communities, invigorated by community development social work, can help.

46. House of Care will require a fundamentally new approach if it is to succeed. It will require moving the NHS away from hospital-based care towards community-based general practice. GPs will be the expert medical generalists supporting people with multi-morbidity, departing from the traditional consultant-led single disease pathway model.

47. The case studies below have begun to show that such approaches reduce hospital admissions, cut costs and improve service users’ experience. It will require a much freer flow of funding across the health and social care economy and an end to the financial protectionism that hinders change. Announcing changes to the GP contract, in November 2013, health secretary Jeremy Hunt promised that four million NHS patients aged 75 or over would have a “named GP”. “This means giving elderly people the care they need and preventing unnecessary trips to hospital,” he said.

48. The RCGP welcomed the announcement as “it will help us to get back to our real job of providing care where it is most needed rather than more box-ticking.” It is proposed that GPs will oversee personalised care plans integrating all services, as well as supporting self-management plans which ensure that frail older people are better cared for in the community and hospital admissions are reduced.
49. The success of this policy of looking after more people closer to home will depend on the contribution of social workers working alongside GPs within the broader framework of health and social care integration. The College of Social Work will continue to champion this role of social workers, developing the arguments it has put forward in its “Business Case” series of papers.

50. TCSW’s arguments were first set out in a discussion paper published in December 2012, *The Business Case for Social Work with Adults*[^1]. It argues that social workers have a crucial role to play in health and social care reform, giving people more choice, control and opportunities for active citizenship, and enabling more of them to live independently in their own communities rather than in long-term care.

51. Social work’s roles and tasks are evolving as it moves away from inflexible care management to more fluid, more personalised modes of practice, a process that will gather pace as the Care Act is implemented. Modern social work is striking out “in new directions as the integration agenda being promoted by the government takes hold, joining up health, social care and housing, and shifting resource out of acute care into more cost effective community solutions,” as the Business Case discussion paper puts it.

**Benefits of integration**

ARGUMENTS AT A GLANCE

- Hundreds of thousands of emergency admissions of older people to hospital every year are unnecessary;
- Integrated care has been shown to reduce unplanned admissions and delayed discharge while helping people to live independently for longer;
- There is a tendency to focus on the physical and practical aspects of rehabilitation rather than the social and emotional aspects of care;
- GPs are finding that social workers are able to produce more subtle, less expensive solutions to people’s needs than the high-cost care they have often been given;
- Barriers to integration, including cultural differences, will have to be tackled if the policy is to succeed.

52. Many GPs and social workers recognise that there has been an unnecessary reliance on crisis or reactive services at the expense of investing in preventive or early intervention services that stop or slow down the development of high levels of need among patients/service users.

53. In its fourth annual *State of Care* report[^2], the Care Quality Commission suggested that at least 530,000 emergency admissions of older people to hospital in 2012–13 could have been prevented through better management of their conditions in the community.

54. A joint survey of local authorities and clinical commissioning groups by ADASS and the NHS Confederation[^3] found that, where integrated care had been achieved, 46% of respondents said it had improved quality of life for people with long-term conditions. Additionally, integration had released the pressure on services in the following ways:

- 57% said there were fewer delayed discharges from hospitals;
- 42% saw a reduction in unplanned emergency admissions;
- 41% found that there were fewer interventions across health and social care;
- 41% saw an increase in the proportion of older people still at home 91 days after being discharged from hospital into rehabilitation;
- 48% said that it had resulted in financial savings.
55. Peter Thistlethwaite, in his study of integrating care in Torbay, reported on the cost efficiencies from relying less on hospital, residential care and nursing home beds. Torbay's integrated management structure saved approximately £250,000 in the first year, money that was ploughed into the development of other services.

56. And in their paper “The Billion Dollar Question”, Kerry Allen and Jon Glasby report that, by integrating health and social care, Torbay Care Trust achieved the lowest use of hospital bed days in the region and the best performance on lengths of stay. In particular:

- Use of emergency beds for people aged 65 and over was 2,025/1,000 population in Torbay, compared with an average of 2,778/1,000 population in the south-west region overall.
- In the south-west, Torbay had the lowest rate of emergency bed day use for older people with two or more admissions and the second lowest rate of emergency admissions for older people with two or more admissions.
- Residential care makes up the majority of adult social care spending, but Torbay had the second lowest proportion of people aged 65 or over discharged from hospital to care homes in the south-west.

57. Allen and Glasby lay emphasis on the contribution of social workers, suggesting that more allowance should be made for their role when people come out of hospital. They found that: “…there also seems to be a tendency to focus on the physical and practical aspects of rehabilitation rather than broader social and emotional aspects of care’.

58. Much of the pioneering work undertaken by the social workers and GPs involved in our case studies bears out these findings. Service users/patients and their carers are usually more satisfied because care and support are more aligned with their needs and the cost to the system is more sustainable. These GPs are finding that social workers and other community-based professionals are able to generate more subtle, cost effective solutions to people’s needs than the expensive high-end care they have often been given in the past.

59. As the Future Directions for Investment report, published by TCSW as part of its Business Case series of papers, said:

“Social workers are uniquely equipped to undertake the skilled and sensitive task of working alongside an older person to reach an understanding of the difficulties they are facing and to help them find ways (that suit them) of managing these to prevent their escalation. This is a nuanced and demanding activity which rests (often) on the development of empathy and an appreciation of the range and types of informal and formal support available.

“It also depends on effective communication – perhaps with somebody who has impaired communication – engagement and relationship building skills with users and carers, the capacity to conduct a detailed and accurate assessment, and advocacy. These are core social work skills.”

60. Of course, the integration of health and social care is not risk-free, nor are the benefits certain or easily achievable. As we have already seen it requires mutual trust between agency partners, strong leadership at all organisational levels and a clear vision of what is to be accomplished. Almost two-thirds of respondents in the ADASS/NHS Confederation survey said incompatible IT systems hindered integration while organisational complexity and leadership changes were also regularly cited as barriers.
61. For half the respondents, cultural differences were a major difficulty. In the case of social workers and GPs, the barriers are likely to be surmounted only with a renewed sense of purpose born of the conviction that there is much to be gained by doing so, not least in terms of better health and social outcomes for people.

Knocking down the ‘Berlin Wall’

ARGUMENTS AT A GLANCE

- As our case studies demonstrate, the concept of partnership between GPs and social workers is enjoying a revival, quite possibly on an unprecedented scale;
- Professional relationships are critical to the success of partnerships;
- Reconciling the two cultures will require active intervention such as interdisciplinary education and shared forums for dealing with common concerns
- Dysfunctional GP-social worker relationships are, by contrast, costing health and social care dear;
- The Better Care Fund can finance the revolution needed to bring down the “Berlin Wall” separating the two cultures.

62. It will take something like a revolution to bring together the two cultures of health and social care, once described by a Labour secretary of state as separated by a “Berlin Wall”. Integration will fail unless there is trust and mutual respect between social workers and GPs on one hand, and between senior management teams in clinical commissioning groups (CCGs) and local authorities on the other.

63. There are powerful historical reasons, of course, for the existence of these cultural barriers. The language of service user empowerment has long been current in social care, whereas in the NHS the language of “diagnosis” and “cure” remains prevalent. In one respect this is just as it should be, but it does mean that patients’ voices are still often less well heard and heeded in health care than those of service users in social care. However, “patient power” in the NHS is a growing force, much boosted by the Francis inquiry into the Mid-Staffordshire Foundation Trust.

64. Contrasting governance arrangements and accountabilities have also allowed the two cultures to diverge, as have the differences in professional power and status. The kudos attaching to the health professions has not generally been replicated in social care. Instead of engaging in a dialogue between equal partners, social care has found itself dancing to the health service tune. But this too has begun to change as the professional stock of social work rises.

65. Now the omens are better than they have ever been. The “Berlin Wall” is gradually coming down as pressure mounts to pool more health and social budgets and share accountability across CCGs and local authorities. As our case studies below demonstrate, the concept of partnership between GPs and social workers is enjoying a revival, quite possibly on an unprecedented scale.

66. Sometimes multi-disciplinary teams coalesce around a single GP practice, sometimes around “clusters” of GP practices. In the latter case, for example, responsibility for pooled budgets could be devolved down to a GP practice cluster comprising three or four GP practices which come together to serve a population of 30,000 – 40,000 constituted by the registered lists of those practices.
67. Many new organisational arrangements are consistent with the cluster model and we expect a diverse range to emerge, from social enterprises, in which the GPs and social workers are equal partners, to loose federations of private GP practices to which social workers are seconded by their local authorities. Practitioners will have to find the structures best suited to local needs and resources. What is crucial is that this is done openly within a shared learning culture.

68. **Professional relationships will be the critical factor.** Reconciling the two cultures will depend on sound relationships between GPs and social workers where each is confident of the competence and contribution of the other. This won’t be conjured out of nothing; it will require active intervention, for example, interdisciplinary CPD across health and social care as a prerequisite of re-registration with professional regulators.

69. In their literature review “New Conversations between Old Players,” Glasby and colleagues concluded that GPs and social workers often fail to understand each other’s unique role, responsibilities and perspectives, and that opportunities should be sought for mutual engagement. These could include shared forums to address issues of common concern or informal networking.

70. They also saw inter-professional education as a way to develop better appreciation and understanding between the two sides, although the differing eligibility and catchment criteria that have to be met by their respective patients/service users could be a source of frustration for everyone concerned. A willingness to address these problems and invent creative solutions was seen as important; co-location might be part of the answer to better joint working but was not a panacea.

71. Work by the University of Birmingham and the consultancy iMPOWER corroborates many of these findings. They are engaged in a study with 11 clinical commissioning groups (CCGs) and local authorities, in what they have called the “Home Truths” programme, to examine the relationships between GPs and social care. Strong relationships could result in significant financial savings, they argue.

72. An initial report published in 2012 was ominously subtitled “How dysfunctional relationships between GPs and social care staff are driving demand for adult social care.” It said:

> “Our research reveals that over 60,000 people a year could avoid going into residential care, with a saving of £600 million, even allowing for costs of alternative support, if we could influence a small number of GPs in every local authority area.”

73. These figures were calculated on the basis of a 20% reduction in people in care, assuming half of them would require continuing intense support at home and 40% support at home with a smaller cost to the council. The remaining 10% would have no ongoing cost. The saving of £600 million was just in social care and Home Truths further estimates that more than £1 billion can additionally be saved from health budgets by improving relationships between social care and GPs.

74. A Home Truths evaluation published in 2013 argued that unless more trust was established between general practice and social care, next year’s BCF allocation of £3.8 billion would be wasted. Limited trust between GPs and social care professionals in particular, it said, meant that a flow of information between the two that might help to promote integration and improve outcomes for patients/services users was “severely hampered”.


The 11 CCGs and councils taking part had begun to respond to these findings by opening up communications channels between the two sides, training GPs and consultants about social care services and processes, and embedding joint working between social workers and GPs. One site was setting up a new team of social workers to connect with clusters of GP practices, part of its purpose being to inform new general practice staff about the options available through social care.

Overcoming these barriers between primary and social care will be crucial to the success of personalisation and the promotion of independent living. Implementation of the BCF will be the ideal catalyst for working through the difficulties, providing it is enacted within an open learning culture. Social workers must be willing to argue for the benefits, through their collaborations with GPs and primary care professionals, of creative approaches to community-based services.

Collaborative leadership

ARGUMENTS AT A GLANCE

- Residential care is too often the default option when older people are discharged from hospital;
- Social workers and GPs will need to demonstrate joint professional leadership to alter fixed mind-sets which assume that the traditional methods are always best;
- Financial benefits of creative social work are just beginning to be quantified, eg through The College of Social Work’s Business Case for social work with adults.

Leadership will emerge from whoever is best placed in community, professional and organisational networks to expand the imaginations of their colleagues by showing them that the realm of possibilities for independent living is much greater than they had thought.

As The College of Social Work said in its Business Case for Social Work with Adults discussion paper:

“It requires social workers who think creatively (and cost effectively) about meeting the needs and aspirations of the population they serve. Restrictive care management processes do not allow social workers the autonomy to work with vulnerable people in this way, yet its potential for steering people away from high-cost, high-dependency residential and home care services is still unrealised in too many localities.

“Councils still spend approximately half of social care funding on residential care for publicly funded clients, while self-funders often enter residential care unnecessarily, become dependent before their time, and later turn to the local authority to finance expensive placements for longer than would otherwise have been the case when their money has run out. Many of these people could live independently as part of their communities, given a more imaginative use of social workers by their local authority employers.”

Residential care is also all too often the default option when older people are discharged from hospital. Social workers, working collaboratively with their GP partners, can do much to alter fixed clinical mind-sets, something they will be particularly well placed to do if, as seems likely, many more of them are located in GP surgeries. Collaborative leadership can create much-needed system change.
80. It is one of the main arguments of the TCSW Business Case that the “social return on investment” that can come from good social work is often neglected in the standard cost-benefit analyses. **Strong, inclusive communities** with resilient individuals living as part of them – and the emphasis here is significant – can contribute to the public purse, whereas dysfunctional communities are a drain on it.

81. That is the whole point of allowing social workers, as the *Caring for Our Future* White Paper xviii put it, “to focus on promoting active and inclusive communities, and empowering people to make their own decisions about their care.” The financial benefits of creative, new styles of social work in our communities are only just beginning to be quantified.

**Collaborating with people who need health and social care**

82. New collaborations between GPs and social workers are beginning to attend to the broader social and emotional aspects of care, as the case studies below indicate. They have had notable success in reducing non-elective admissions to hospital and making people at high risk of unnecessary hospital admissions feel better supported.

83. Most of the sites in the Home Truths programme referenced above expected that they could make financial savings from more integrated interventions, although the initial evaluation also said it was “too early to judge whether the planned interventions will have an impact on reducing the numbers of people entering residential care.”

84. However, one of the sites had set itself a target of saving £716,000 from the social care budget and £614,000 from the health budget, to be achieved by better use of social care support to delay entry to residential care and reduce health visits. As we have seen, Home Truths estimates that overall savings could reach a yearly total of more than £1.6 billion nationally.

85. These hopes are reflected in the case studies below as GP-social worker partnerships start to achieve savings by **listening to what people actually want** rather than automatically resorting to the tried and tested methods. On the basis that supporting someone to live independently at home is more cost-effective than keeping them in hospital or placing them in a care home, the figures are significant.

86. Financial evaluations are in progress, but early indications are that reductions of 15 – 20% in residential/nursing home placements and 20-30% in A & E attendance and non-elective hospital bed occupancy are achievable among selected “high risk” groups.

87. One of our collaborative case studies estimates that, as a rule of thumb, alternative forms of care and support can be provided at one third of the cost of an acute hospital bed and 40% of the cost of a residential care/nursing home bed.

88. Such advances depend on an integrated health and social care economy otherwise the costs incurred in one part of the system will not be compensated by the savings in another part. This is why health and social care budgets will have to be pooled with local authorities and CCGs sharing accountability for expenditure.

89. Ultimately what matters is the experience of service users and patients. Research among service users consistently shows that they value person-centred care and the skills and qualities that lie at the heart of the best social work and GP practice. When Peter Beresford, chair of the service user organisation Shaping Our Lives, addressed a TCSW conference in 2012, he spoke about the “crucial role” of social work in integrated care xix.
90. Integrated arrangements, Beresford said, "need to build heavily on the positive outcomes achieved by social work’s relational basis and also its social orientation. In this way, integrated services can at last fully take on the holistic approach that we know matches service users’ preferences and perceptions and which truly makes support services person-centred and fit for purpose."

Five case studies: GPs and social workers in partnership

Case study 1: Central Manchester Practice Integrated Care Teams

91. In central Manchester, Practice Integrated Care Teams (PICTs) are being developed in partnership with Central Manchester Foundation Trust and Manchester City Council to deliver an integrated model of care for some of the city’s most vulnerable people.

92. In November 2012 the first integrated care teams began trying out new cross-border ways of working together, refining them as they went along. Further teams have come online since then and now 32 of the 34 GP practices in the area are working with an integrated approach to patient care.

93. The ambition is that integrated care teams across the city will eventually work with 800 patients assessed as at high risk of admission to hospital or residential care, or of attendance at A&E. So far they are working with approximately 500 patients.

94. Every “core team”, comprising a GP, nurses and a social worker, considers care and support options for the high risk patients/service users on their caseload. It is premised on the belief that people should have the right support to live active, healthy lives in their communities with fewer avoidable stays in hospitals and care homes.

95. Each Practice Integrated Care Team has four priorities:

- People to feel more confident and in control of their lives;
- People are seen as a whole (“whole person approach”), whatever the complexity of their needs;
- Health and social care work more effectively together;
- Improved care planning to stabilise health, reduce crises and improve response in an emergency.
96. The GP selects patients (with their consent) for discussion at a regular meeting of the team, one of whom is then designated as the key worker depending on how well their skill set is suited to the particular individual’s needs. The key worker is the primary point of contact between the patient/service user and the team, and is responsible for drawing up an integrated care plan with the individual and implementing it.

97. But it is not a long-term relationship and the key worker’s role is to enable the individual to take as much control over their health and well being as possible. Key workers are specifically instructed not to foster dependency and can draw on the skills of a variety of other professionals in an associated specialist team when required.

HOW THE PICTs WORK FOR SERVICE USERS AND PATIENTS

A typical service user/patient

Jack is 72 and lives alone. He has chronic obstructive pulmonary disease, arthritis and high blood pressure. He has family nearby who help him when they can. He gets out once a week but struggles with walking or standing. He is scared of falling but wants to remain in his own home.

What it means for Jack

- Better coordination of care with a single point of contact (keyworker) for him and his family;
- One concise, integrated care plan that addresses all his needs and informs him and his family what to do if he is unwell;
- Less duplication of assessment and less need to repeat information;
- More community-based support helping to reduce the need for hospital admissions;
- Assistance to him and his family to learn about his conditions and how he can manage his health with their support to live more independently;
- More joined up service and greater continuity of care;
- More advice and support for carers.

What it means for professionals

- Better joint working and greater understanding of the roles of others;
- Shared knowledge and ownership of issues;
- Greater awareness of resources, enabling more effective choice;
- Greater shared risk management and more creative responses to need;
- Increased focus on prevention and less reliance on formal support;
- Fewer avoidable hospital admissions, A&E attendances and care home admissions.
- Much faster access to all relevant information;
- A proactive rather than reactive service;
- Mechanisms for integrated team working, often via monthly meetings so that no one should fall down the gaps in the service;
- Better development of skills and knowledge;
- Breaking down barriers between services, making life easier for patients/service users.
98. For social workers the advantages are that they can focus on the strengths and coping abilities of service users and their families, using the social model of disability, and they can promote well-being in terms of relationships, income, leisure, occupation and accommodation. Benefits for GPs include a reduction in crisis episodes among their patients and the ability to call on the skills of a wide range of other professionals to ensure that the right care and support solutions are found.

99. An independent evaluation of the integrated care teams by Hall Aitken, published in January 2014, was generally positive. GPs played a central role, it found, but the teams were becoming progressively more “democratic” with a greater contribution from other members.

100. Indicative of this democratising trend was that teams had moved from being “predominantly medicine and health care based to a more rounded discussion of wider social needs.” However, the evaluation also identified some opportunities for development, including the fact that the importance of patient involvement in care plans was not always properly understood by team members.

**FINANCIAL ANALYSIS OF THE PICTs**

- Targets for PICT patients: 20% reduction in hospital admissions; 20% reduction in hospital bed days; 20% reduction in A&E attendances; 15% reduction in residential/nursing care.
- 178 patients joined the integrated care team caseload, in the six months 1/9/2013 to 28/2/2014, who had secondary care activity recorded in this period. Activity in relation to 116 of these patients, who were assessed as at high or very high risk of A&E attendance or non-elective admission to hospital, shows:
  - Both A&E attendance and non-elective hospital admissions fell by 22% for evaluated patients over the period;
  - A&E costs reduced by 21% and non-elective hospital bed costs went down 32%.

101. It was perhaps a sign of this lack of involvement that many practitioners found striking a balance between cost savings and patient/service users’ quality of life challenging. The evaluators commented: “Many [practitioners] feel that quality of life is improved by reducing the need for hospital visits. But some patients may feel isolated and hospital contact may improve their quality of life.”

102. However, it was plain that social workers and their fellow practitioners were increasingly comfortable in what had once been an unfamiliar environment. “Where patient needs are discussed in more detail then more rounded care plans are being developed,” the evaluation says. “This has been noticeable as social service partners in particular have ‘found their feet’ at meetings. Their knowledge of wider social and family issues for patients is proving valuable in deciding care plans.”

103. Social worker Nusrat Satwilkar, who worked on a PICT with GP Dr Lucy Campbell (see box), describes it as an “immensely positive experience”. She says:

“The regular meetings have allowed all multi-agency professionals to develop an improved understanding of each other’s practice. This from my social work perspective has made our links more efficient and improved timescales, resulting in less repetition of certain referrals to services and, more importantly, better services for the people we are trying to enable and support.”
“I think GPs feel more comfortable referring to local services and have more understanding of the role of social work in the community and the value of greater independence for the people who use services. The meetings have strengthened our community response and are a vital source of information on the customers and patients we collectively serve.”

Dr LUCY CAMPBELL, GP, MANCHESTER: “EACH WANTED TO LEARN FROM THE OTHERS”

“Our Practice Integrated Care Team (PICT) was multidisciplinary and included myself as the GP and our social worker Nusrat.

“The team had monthly meetings, which were well structured and minuted, but still relaxed in that there was no hierarchy and all opinions were listened to, respected and discussed. There was no specific ‘medical model’ or ‘social model’ but we each wanted to learn from the others.

“Nusrat had a clear idea of where she, with her skills, training and remit, could help a situation and she worked very practically where this was appropriate. The advantages of working more closely with social workers are numerous.

“We as GPs often struggle with sorting out the social aspects of a patient’s situation, whether housing, mobility issues, or social care. It was great to have a named, interested and conscientious social worker to call on. Although I have moved on from my particular PICT now, the overall system in Manchester continues to work well.

“The monthly meetings encourage open discussions about the patients and Nusrat’s suggestions were great, often lending a different perspective, and she was very practical about what could or could not be offered. She and I shared a determination to keep our frail elderly at home where possible because they did so badly once they had to move out of their homes.

“She gave me an insight into what was available and how to utilise other teams, where appropriate. She was very easy to get hold of outside of the meetings and would pass on useful phone numbers. We often communicated by phone or email about individual patients.

“Patients and their families were positive about the PICT. I do believe that this model of working would have great cost benefits to the health service. Were we able to support more people to live independently at home rather than in hospital or a care home? Yes, definitely. This was our aim and we achieved it in many cases.

“However, we felt that we failed in some cases where the patient just couldn’t cope at home, or where it was not appropriate. It was a learning curve for all of us, but we certainly made an impact. We talked to each other, were interested in the patients, and the patients were people to us, not just ‘work’.

“It was a rewarding way to work, both personally and professionally, and I believe it was great for the patients. It was proactive working, troubleshooting before the trouble started, and it is always more enjoyable to work as a team rather than alone, especially when the patients are so complex, so very frail, and as GPs we would struggle with carrying them in the community alone.”
Case study 2: Harrow multi-disciplinary groups

104. In Harrow, the Integrated Care Programme (ICP) has been under way for two years. The intention of the ICP is to create a more responsive, supportive community service for people with complex needs.

105. Social work can often be the gateway to this kind of support. The 10% of the local population which has two or more long-term conditions and needs coordinated care and support to live independently at home is the target group for this work.

106. Six multi-disciplinary groups (MDGs) are each attached to ‘clusters’ of GPs across the outer London borough, and cover approximately 250,000 patients. The role of social workers is vital in the cases discussed at the MDGs, helping to keep people out of hospital and living independently in their own homes for longer.

107. The MDGs each cover approximately six GP practices, and monthly meetings are attended by GPs. A service manager from a social work team in Harrow and a district nurse representative attend the meetings, as do hospital consultants (including a psychiatrist). This attendance is funded through the programme.

108. At each meeting cases are discussed where the patient/service user has either been identified by the GP practice using a risk assessment tool, or through a referral to the GP for care planning by district nursing or the social work team. The social worker for the service user may attend. Often, these are cases where there are complex health and social care needs. The patient/service user may be a frequent attender at a hospital or GP practice, or they may not engage with services at all.

109. “Sometimes it’s a concern about the service user resisting social care input, or the need for more social care input due to a deterioration in their condition, or the pressures facing a carer and the impact of this on the relationship between the service user and the carer, and we discuss what we can do about that,” says Anne Mosley, service manager. “Or it might be a concern about medication, where the GP is seeking advice from colleagues.”

110. An important aim of the MDG meetings is to inform doctors of the range of options to enable people to remain in the community, and to keep the adult social care priority of promoting independence central to the discussion.

111. As the emphasis is firmly on supporting people to live independently, the MDGs consider a broad range of community provision for each case. This range includes a varied assortment of equipment, adaptations and support in the person’s own home and in the community.
VIEWS ON INTEGRATED CARE IN HARROW: “FACE-TO-FACE CONTACT IS INVALUABLE”

**Sue Young, MDG Manager, Harrow ICP:** “Since the launch of the Integrated Care Programme (ICP) in Harrow in August 2012, social workers have played an essential role in the arrangements for the care of patients with complex conditions. Attendance and participation at multi-disciplinary group (MDG) meetings has been prioritised, and this has made for a strong working relationship. A majority of complex cases discussed at these meetings have been shown to have high social as well as medical needs. The networking and face-to-face contact with all members of the multi-disciplinary team has proved invaluable.”

**Anne Mosley, Service Manager:** “We operate a social care model where we promote independence, and we respect the fact that people have choice and control. We strive to enable people with higher levels of need to live independently, alongside playing a key safeguarding role.”

**Shaun Riley, Service Manager:** “Social work values and empowerment are at the forefront. You hear the professional view at a case conference, but we go back to the grassroots: what is the service user’s opinion, what would they want for their outcomes?”

**Dr Chris Jenner, GP, Elliott Hall Medical Centre:** “The Integrated Care Programme has provided a unique opportunity for whole system working in community care. This occurs at two levels. At a strategic level the most senior commissioners and leads for providing care meet and discuss/explore concerns and issues. We are all cemented by our aim to provide patient centred care, and this transcends the health/social care bureaucracy we face on a daily basis.

“At an operational level the MDGs provide a forum for looking at the most challenging cases which individual health and social care practitioners have been unable to resolve. Some miraculously have solutions and many do not, but the practitioner who has shared the case always feels supported and is usually armed with new ideas and skills.

“Interestingly the traditional ‘medical model’ has been reshaped with the sharing of care plans and the recognition that a holistic, patient-centred anticipatory care plan is the way forward.”

**Dr Meena Thakur, GP, Honeypot Lane Medical Centre:** “The MDG meetings have brought together professionals from health, social care, community nursing teams, mental health and hospital consultants, all of whom have previously contributed to patient care with no communication between them. The patient’s care plan is discussed together with particular problems that patients are facing, and the team shares knowledge and experience to find solutions where possible, which may relate to health or social care needs.

“The greatest benefits from this have been the breaking down of barriers and forging links between the different professionals caring for patients, particularly between health and social care, personal accountability of each professional and team, and, importantly, putting the patient at the centre.

“There has been an enormous amount of learning about the wide range of resources available in the community, previously unknown to many health professionals.”
112. Full consideration is also given to the familiar contemporary methods like reablement, personal budgets, telecare, and support for carers, all of which are available to promote independent living. Housing solutions such as mainstream sheltered accommodation and extracare accommodation are looked at alongside “Shared Lives” and a range of respite care options.

113. “As is the case nationally, some people do overuse emergency services in Harrow,” says Mosley. “This causes concern and there is a lot of pressure to prevent this from happening.

114. “Residential care can sometimes feel like ‘the obvious’ solution to this for GPs, particularly if their patient is having multiple admissions to hospital, and especially when this is due to the patient being non-compliant with treatment.

115. “The MDG meeting is a very useful forum to discuss the concerns and to formulate a multi-professional care plan to support the service user and their carer/family.

116. “The MDGs promote better co-ordinated care for the most complex service users, and improve joint understanding and working between social care and GPs. The risk management is shared and there is a joint approach to meeting outcomes, including a reduction in unplanned hospital admissions.”

117. The financial case for using GP-social worker relationships as an engine of integration is compelling. Better support for people with long term conditions living independently in their own homes is significantly less expensive than the cost of a non-elective hospital stay or a residential/nursing care placement.

118. A significant proportion of the borough’s community care funding – in fact, the highest level in London - is spent on cash personal budgets. The emphasis on personalisation provides an effective model of social care which, alongside the prioritising of safeguarding, is embedded into the multi-disciplinary group approach.

Case study 3: Warwickshire ‘Discharge to Assess’ teams

119. The Discharge to Assess (D2A) scheme enables older people coming out of hospital to undergo a period of recuperation and rehabilitation in a nursing home for up to six weeks prior to returning to their own home. Because assessments are conducted in these intermediate care facilities, the aim is to reduce delayed discharges and cut the overall spend on continuing health care.

120. It has been established in the context of sound working relationships between primary, secondary and social care in Warwickshire, based on mutual trust and respect, and is part of a broader community service redesign.

121. Under D2A older patients with complex care needs, who require a continuing health care assessment, are discharged to one of 30 earmarked nursing home placements across the county. This gives patients and their families more time to make an informed decision about their future while ensuring that hospital beds are used optimally.

122. A 2012 evaluation of the overall redesign, based on figures from a hospital in the south of the county, showed average lengths of stay in hospital falling by one-third and hospital discharge rates up by more than 30%.

123. “We have redesigned our community services so that we can provide a guarantee of early supported discharge for 50 patients per week from the acute hospital and provide an emergency community response within two hours of a frailty crisis in the community,” said Ian Philp, medical director of South Warwickshire NHS Foundation Trust, in an article for the British Geriatrics Society published at the same time.
“We have coped with an 11% increase in emergency presentations in all adults to Warwick Hospital because we have been able to manage the care of older people more efficiently, reducing the need for acute hospital care for this group.

“We have also seen a 24% reduction in mortality in older people admitted to hospital, which gives us some assurance that our efficiency gains have not been achieved at the expense of quality of care. We have also seen a modest reduction in readmission rates and an increase in the proportion of older people able to return to their former residence.”

Social worker Schola Sjurseth says she has had a positive experience of working with GPs on the D2A team in the Stratford upon Avon area. “Previously the patient would have gone straight into a care home permanently or back home with a care package, possibly before they had fully recovered. May be an infection hadn’t cleared up completely so that they became confused and went back into hospital,” she says.

“Under D2A, after two weeks in the nursing home they have stabilised, the infection has cleared up and they’re off antibiotics. Rehabilitation is therefore much more effective. People can recover in a safe environment with access to a GP, social workers, OTs and physios on a daily basis.”

Much of the D2A team’s focus is on “pathway 3” of the scheme, which deals mainly with patients who are likely to have continuing health care needs. Sjurseth typically does an assessment in the third week of their stay in the nursing home, by which time living independently with the right support is often a more serious option than it would have been immediately after discharge.

“One example is a lady that the GP thought should go into residential care because she wasn’t engaging much with the occupational therapist in the D2A programme. I took the view that, on the contrary, there was nothing wrong with her physically or mentally and that if she went home she would present differently,” Sjurseth says.

“This lady really wanted to go home. She wasn’t engaging in the care home because she was unhappy there, not because she was incapable of doing so. Our role as social workers is to look at people holistically, to advocate for them and look at all the services and everything else that’s available to support their outcomes.”

Georgina Everitt first qualified as a nurse but later became a hospital social worker when she realised it would give her more time to talk to patients and find out about them. “D2A is a far more dignified way to make big decisions about your future than in hospital where you have very little control and feel unwell and disorientated,” she says.

Each of the D2A nursing homes has its own GP who works as part of a multi-disciplinary team (MDT) including a social worker, senior nurse, home manager and discharge coordinator. The MDT meets once a week.

“I might come to the MDT meeting having met the client and relatives and having asked them what outcomes they want, what their history is, and what they wish to see happen,” Everitt says.

She adds:

“We’ve always tried to be positive about what people can do and promote their independence. You’ve got to try to build on their strengths and not be negative about what isn’t there. We often have healthy disagreements at MDT meetings. We had a meeting today where someone said that an individual needed 24-hour residential care but wanted to go home instead. I intervened to say he’s got to go home because that’s what he wants. The GP agreed that I was right; the patient had capacity and ought to go home.”
Dr DAVID RAPLEY, GP, KENILWORTH: ‘COMPASSION, CARING AND DIGNITY’

“My general practice looks after 12 beds at the Kenilworth Grange nursing home as part of the Discharge to Assess scheme (D2A). Another practice in Stratford upon Avon looks after the other 18 D2A beds in Warwickshire.

“The idea is that patients who would have been ‘bed blocking’ at South Warwickshire Hospital Trust are assessed from a continuing health care point of view and if they meet the triggers are offered six weeks in one of three nursing homes to prepare them for future discharge, either into another nursing home or back to their own homes.

“The D2A beds are supported by a social work and nursing team, occupational therapists, and physiotherapists, plus a GP who visits daily. We have a multi-disciplinary team meeting every Thursday morning.

“When discharged from the nursing home many of the patients are in a much better condition, better nourished, more communicative, and genuinely happier than when they first came into the nursing home on discharge from hospital.

“The degree of compassion, caring and dignity is so much greater in the nursing home than would be achievable with a patient in a hospital bed waiting to move on. The look of relief on many patients’ and relatives’ faces that they are not in hospital is priceless.

“Social workers understand the logistics of funding and the care needs of patients, plus their relationships with families. The whole team listens and contributes to the MDT meetings. We often change our preconceptions during these meetings. It is very much a team approach; we don’t go in for paternalism!

“It is too early to say whether we are successful in supporting more people to live independently at home rather than in hospital or a care home. But I do think we maximise patients’ chances of going back to their own homes.

“There are 150 patients who have gone through the 30 nursing home beds in the last year. 40% of these 150 were found to be in the last year of life.

“One might argue that it would be cheaper to put patients in residential care-based moving-on beds, which cost around £450 per week per patient as opposed to D2A beds which are around £800 - £900 a week. But to give patients this degree of service in a moving-on bed would require an awful lot more support from physios, OTs, social workers and GPs, and costs would rocket. To be honest, GP practices probably wouldn’t volunteer.

“The new D2A system has been well thought through and piloted for 9 months and is working well.”
Case study 4: Focus, North-East Lincolnshire

135. Focus is a social enterprise whose employees are social workers and which emerged from the clinical commissioning group in North-East Lincolnshire. As one of the Social Work Practice pilots, supported by the Department of Health, it has sought a close working relationship with GPs in the region.

136. One of its projects aims to stem the flow of A&E admissions and enable hospital discharges where appropriate at the weekend. A GP is based in A&E and sees patients who may not need hospital/consultant intervention, which has turned out to be effective in diverting people to more appropriate advice, information or, if necessary, medication.

137. A Focus social worker works alongside the GP and is able to get involved to commission home care, to link the person with luncheon clubs and befriending services, or to discuss and advise on social and personal issues. Although the project has not been formally evaluated, this holistic approach is clearly reducing the number of hospital admissions while connecting people up with more appropriate resources and services.

138. In another initiative a large GP practice has agreed to pilot a health and social care coordinator role working with 50 people with complex conditions to deliver a proactive and preventative service. If the pilot is successful Focus will look to extend the model to other practices.

139. When the care coordinator role in GP practices was first considered everybody had their eye on people with complex health conditions, but what is clear is that it is often social factors rather than the specific health conditions which determine whether someone has complex needs.

140. There are many people with similar health conditions who manage and live with their symptoms well, but people who are isolated or for example have housing, debt or relationship problems, often do significantly less well. **This is where the social work skill set comes into its own** and makes a unique contribution to the improvement of people’s lives.

141. More recently, Focus and its partners have stepped up their efforts for people with complex/multiple conditions with the result that two “extensivist” teams are being developed in two geographical patches.

142. Core teams will consist of a GP, social worker, nurse and coordinator, each having a cohort of around 500 people with the most complex/multiple conditions. Teams will take a proactive and preventative approach, trying to support and treat people in their own homes and following them in and out of hospital to minimise their stay and maximise positive outcomes.
Case study 5: Ageing Well in West Cheshire

143. An ageing population is one of the main triggers for reform in West Cheshire and Chester, where the number of people aged 65 or over is expected to increase by 26% between 2010 and 2020 and those 85 or over by 41%.

144. There will be a corresponding rise in the incidence of long-term conditions and pressure to think again about how best to provide care and support. Like their counterparts elsewhere agencies in the locality are seeking alternatives to hospital on the grounds that 25 – 30% of older people in hospitals are admitted unnecessarily.

145. Overseen by a partnership of clinical commissioning groups, NHS foundation trusts and the local authority, the intention is to reduce non-elective hospital bed day use by 25 – 30% and placements in residential/nursing home care by 15%. It is anticipated that other kinds of care and support can be provided at much less cost: to be precise, one third of the cost of an acute hospital bed and 40% of the cost of a residential care/nursing home bed.

146. So what are these alternatives? Two of the most interesting are integrated community care teams to promote independent living and a strategy to develop stronger communities in which older people “are viewed as assets rather than deficits”.

West Cheshire: Integrated teams

147. The integrated community care teams are drawn from a broad range of professionals from the statutory and independent sectors: GPs, social workers, pharmacists, practice nurses, district nurses, community matrons, and community therapy, community mental health and reablement staff, among others.

148. These teams are responsible for identifying older people at high risk of an unnecessary admission to hospital or long-term care and finding alternatives which enable people to live independently and healthily at home wherever possible (see chart below). They offer a variety of interventions: care management, intermediate care, reablement, urgent response and end of life care.

149. Each team covers a practice population of 30,000 to 50,000 and provides urgent response “step up” care to prevent unnecessary hospital admissions and “step down” care to speed up discharge and promote rehabilitation and reablement.

150. A real-life example illustrates how integrated working has benefitted people who use services and the public purse at the same time. A 90 year old man was the main carer for his 89-year-old wife who had dementia. He required an eye operation as a day case at the local hospital but this was complicated by the fact that he had to bring his wife with him. The hospital was unable to look after his wife and the operation had had to be cancelled twice.

151. Faced with the husband’s deteriorating eye condition, the integrated team co-ordinated a conversation with the acute trust, arranging for the operation to be rescheduled and giving the social worker time to build up a trusting relationship with the wife. On the day of the surgery, the social worker took both husband and wife to the hospital and sat with the wife throughout.

152. Arrangements like these would not have been possible prior to the integrated team. Care and support could now be coordinated across the system as a whole. In consequence, the husband was able to have his operation and return home to resume his caring duties.
### Design principles of West Cheshire delivery model

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<th>Keeping People Healthy in their own Homes</th>
<th>Presentation and Assessment of Condition</th>
<th>Diagnosis, Needs Identification, Treatment and Care Plan delivery</th>
<th>Return to normal place of residence</th>
<th>End of Life Care</th>
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<tbody>
<tr>
<td>Information that allows people to remain healthy in their own homes will be clear and joined up</td>
<td>Community based pathways identified if safe and appropriate</td>
<td>Assessment for long term residential care is not normally carried out in an acute hospital environment</td>
<td>Plan for discharge on admission (Pull approach)</td>
<td>Opportunities for people to identify their preferred priorities of care and that these are met</td>
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<td>Opportunities are identified to invest in community wellbeing, preventative and community services</td>
<td>People will be provided with the opportunity for rehabilitation and reablement prior to identifying the need for any future service interventions</td>
<td>Diagnosis and needs identification is completed as close to the community as possible</td>
<td>People will not be cared for in hospitals or Long Term Care for longer than is necessary</td>
<td></td>
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<tr>
<td>Proactively identify individuals at high risk and provide suitable services and assistive technology</td>
<td>Assessment takes place as close to the community as possible</td>
<td>Treatment regimes are delivered in the least intensive appropriate setting</td>
<td>People will be provided with the opportunity for rehabilitation and reablement prior to identifying the need for any future service interventions</td>
<td></td>
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<tr>
<td>Promotion of and signposting to self-management techniques and self care</td>
<td>Information is captured once only, built upon and shared across all agencies (Single Assessment Process)</td>
<td>Care is holistic and co-ordinated and integrated where appropriate</td>
<td>Remain at home</td>
<td></td>
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**INTEGRATED TEAMS: POINTS TO NOTE**

- More trust between professionals across health and social care;
- Single, centralised information, referral and intake service across health and social care;
- Each referral is allocated to the team member with the most appropriate skills;
- Common assessment tool supports the sharing of information across professionals and agencies;
- Holistic assessments covering physical, mental, social and spiritual health needs;
- Services at any time of the day or night support people to remain in the community.

**STRONGER COMMUNITIES: POINTS TO NOTE**

Role of local area coordinators is to:

- Provide information and assistance to older people and carers;
- Assist people to use personal and community networks to find practical ways to meet goals and needs;
- Ensure that services are equitable and inclusive, so as to reduce inequalities and improve quality of life;
- Support older people to identify their own needs and help them access local activities and services to pursue their preferred lifestyle;
- Work with communities to increase their capacity to meet the needs of older people, their carers and their families.
West Cheshire: Stronger communities

153. Building community capacity by strengthening mutual support and promoting small scale community businesses ought to be part of the social work skill set and in some parts of the country already is. In West Cheshire plans are afoot to try out “local area coordination,” an Australian model already piloted in England, as a way of “providing opportunities to address individual’s needs, facilitate mutual support mechanisms, build resilience, unlock community resources and bring people and communities together.”

154. This ties in with TCSW’s Business Case for Social Work with Adults discussion paper, which argued that social workers were well placed to take on the role envisaged for local area coordinators. As already noted, one of the motives for removing social work’s care management straitjacket is precisely to free it to focus on promoting active and inclusive communities which empower people to make their own decisions about their care and support.

155. Local area coordinators (LAC) are seen in West Cheshire as the “missing link,” complementing other professionals by acting as a community information source, support and facilitator, and working in partnership with integrated community care teams. One LAC, costing up to £35,000 a year, can support around 60 older people and help to tip the balance away from statutory assessment and services to building people’s capacity to become more self-sufficient and independent.

Conclusion

156. It has been the purpose of this paper to argue that the public will be much better served by integrated health and social care, and that GPs and social workers are best placed to join them up. A community-oriented NHS will result in happier patients; NHS-oriented social care can lead to a more cost-effective use of resources for service users.

157. We know that health and social care will sink under the weight of demand unless action is taken to avert disaster. It is not merely a matter of whether integration happens, but how it happens and who is going to captain the ship as it steers a treacherous course towards a safe harbour.

KEY MESSAGES

- GPs and social workers, working in partnership, are ideally situated to create much more cost-effective, integrated health and social care;
- Integration is essential if the aims of the Better Care Fund are to be achieved expeditiously in the interests of people who use services;
- Professional leadership will be necessary at all levels if GP-social worker partnerships are to be the engine of integration: RCGP and TCSW will seek ways to develop and promote the model as part of a joint work programme;
- Savings of £1.6 billion annually in health and social care could be the prize;
- A common culture will need to emerge over the next four years and both of our Colleges will encourage the development of local leaders who are equally committed to the ambition of seamless, community-oriented health and social care.
158. In the view of our professional colleges, GPs and social workers are ideally situated at the interface between health and social care. Using their complementary skills and powers in partnership, they can support many more people to lead less crisis-prone, more independent lives.

159. Professional partnerships of the kind illustrated in our case studies are no longer optional. They are a necessity if integration is to progress smoothly, the aims of the Better Care Fund are to be realised, and the interests of patients and service users are to be protected and promoted. The best outcomes for patients/service users, as frailty increases and demand rises inexorably, will depend on sound professional relationships.

160. Our case studies provide a model of partnership which demonstrates how GPs and social workers, as partners for better care, can work in community settings to respond more effectively to people's medical and social needs. These needs are no longer seen in isolation, as they are so often under the current system, but as components of a continuum of need. It is a whole person, whole community approach.

161. Of course, this is not about GPs and social workers alone. It is vital that nurses, allied health professionals and hospital doctors including consultants have a full stake in this new way of doing things. It is about putting the “team around the person” instead of (as it were) “dividing” the person up between the team.

162. But the respective leadership roles of social workers and GPs are essential if care and support are to draw on the strengths of individuals, families and communities so that these strengths are enhanced rather than blunted by formal care plans. “Care plans” must be set in the balance with “care planning,” as envisaged in the House of Care.

163. An important lesson from the case studies is that this model gives service users/patients a better experience of services and enables them to live healthier, more independent lives in their communities. At the same time information-sharing between professional groups improves, as do mutual understanding, respect and trust.

164. The net result is fewer older people needlessly occupying acute hospital beds, attending A & E or going permanently into long-term care, liberating capacity and funding to meet rising demand from other older people equally cost effectively. According to the Home Truths programme, quoted earlier, savings could reach more than £1.6 billion annually across the health and social care economy.

165. Both the Royal College of GPs and The College of Social Work are committed to GP-social worker partnerships as the model of service integration best placed to improve the lives of patients/service users and to do so economically. We will seek ways to develop and promote the model as part of a joint work programme.

166. Where there is a “culture clash” between general practice and social work, steps should be taken to overcome it. It will require interdisciplinary education, reciprocal placements, informal networking and other measures to cultivate the trust between the two sides which is all too often missing. Only then will they come to understand each other’s unique role, responsibilities and perspectives.
167. As our case studies demonstrate, this is eminently achievable. The doctor in one case study admits: “We as GPs often struggle with sorting out the social aspects of a patient’s situation, whether housing, mobility issues, or social care. It was great to have a named, interested and conscientious social worker to call on.” And the social worker is equally keen: “The regular meetings have allowed all multi-agency professionals to develop an improved understanding of each other’s practice.”

168. A common culture across health and social care will have to become the norm during the next four years. Accomplishing it will depend on the combined efforts of national and local leaders. The RCGP and TCSW see GPs and social workers as the linchpin of reform. Both Colleges want to see local leaders emerge who are also determined to realise the ambition of seamless, community-oriented health and social care.

169. Radical change is necessary, but social workers and GPs working in partnership can make it happen. The future of health and social care depends, to a significant extent, on their success.

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