social care
institute for excellence

At a glance **46**

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Social care and clinical commissioning for people with long-term conditions

Key messages

- In caring for an ageing population, with rising numbers of people living with long-term conditions (LTCs), more integrated working between the NHS and social care is crucial to achieve good outcomes and make best use of resources.
- Working collaboratively with local services, clinical commissioners can redesign services to ensure patients and their families get the care that will improve their health outcomes, will be more efficient and effective and may save money.
- Divisions between health and social care make little sense to people using services. They expect joined-up services that give them choice and control.
- Users of social care services increasingly plan, purchase and control their own care and support through personal budgets. Personal health budgets are currently being piloted.
- A tough spending settlement for local government means that many authorities are having to raise eligibility criteria for publicly funded social care services. It is important for health and social care to work closely with people needing support and their families, to get the most out of all the available resources.

Introduction

How can clinical commissioners secure best use of social care to maximise outcomes and improve patient experience, while ensuring efficient, affordable care into the future? With an ageing population and rising numbers of adults with long-term conditions (LTCs), more integrated working is vital to achieving good outcomes for people and making best use of scarce resources.

This At a glance briefing is a summary of some of the ways in which working with adult social care can help clinical commissioning groups manage their new responsibilities. Following the NHS Future Forum report, the Health and Social Care Bill will (subject to parliamentary approval) place stronger duties on the NHS Commissioning Board, clinical commissioning groups, Health and Wellbeing boards and Monitor to encourage integrated working at all levels (Hansard 2011). Integrated care is also one of the strands of a second phase of the NHS Future Forum's work, launched in August 2011.

By 2015, the NHS is expected to find £20bn of efficiency savings to maintain quality and service levels and absorb demographic pressures. It is reported that 20 per cent must come from 'deep service change' for which commissioning groups will be responsible (Ireland 2011). This figure is partly based on the assumed benefits from clinical commissioners working collaboratively with social care.

The workstream on LTCs within the NHS Quality, Innovation, Productivity and Prevention (QIPP) programme is explicit that 'providing joined up and personal services particularly in community and primary care and working closely and effectively with social care' is key to improving outcomes for patients and their families (DH 2010). An independent inquiry into the quality of general practice underlined the importance of better co-ordination and engagement with social care (Goodwin et al. 2011).

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Long-term conditions

There are around 15 million people in England with at least one LTC. Their treatment makes up 50 per cent of GP appointments and 70 per cent of the primary and acute care budget in England. GPs, not hospitals, deal with the majority of LTCs, and in future, will have to manage the growing demand arising from the ageing population. LTCs increase with age, with the Department of Health (DH) predicting a 252 per cent increase in people aged over 65 with one or more conditions by 2050. It is here that social care can help most in the ongoing support of people with LTCs affecting their physical, mental and psychological health.

How social care works

Social care covers a range of services and support designed to help people maintain their health and wellbeing. The use of social care by people with LTCs varies widely by diagnosis: people with mental health problems, falls and injury, stroke symptoms, diabetes and asthma tend to use more social care services, while those with cancer appear to use less (Humphries 2011). Adult social care services include the commissioning and provision of home care, meals, equipment and adaptations, day services, residential and nursing home care. It also includes the mechanisms for delivering these services, such as individual and carer assessments, personal budgets and direct payments, and adult protection procedures (Law Commission 2011).

> ‘Adult social care services include the commissioning and provision of home care, meals, equipment and adaptations, day services, residential and nursing home care.’

> ‘Personalisation involves putting the individual at the centre of the process of identifying their needs, and helping them make choices about how they are supported to live their lives.’

Personalisation

In recent years, social care policy and delivery has focused on personalisation, emphasising greater choice and control for people who use services and carers over the services and support that are provided. This policy involves putting the individual at the centre of the process of identifying their needs, and helping them make choices about how they are supported to live their lives (TLAP 2010). Personal budgets offer people who use services flexibility in identifying outcomes and purchasing their own care and support. In March 2011, ADASS reported there were around 338,000 personal budget holders across the country, twice the total of the previous year and representing one third of eligible people (ADASS 2011).

A **personal budget** is a clear allocation of funding which service users and carers are able to control. They can use the budget to buy support which meets their outcomes. These are agreed as part of an assessment and self-directed support planning process. Personal budgets can be taken as direct cash payments.

Personal health budgets (PHBs) for people with LTCs are now being piloted across 61 sites in England. Evidence from countries that have introduced PHBs suggests they can be a powerful tool in improving patient satisfaction and helping to increase available treatment choices

(Alakeson 2007). In future, it may be possible to combine personal care budgets with PHBs. Importantly, personalisation has the potential to achieve greater efficiency, while giving people who use services greater control (Carr 2010).

Example: Older people and dementia

Personalisation for people with dementia means getting to know the person, finding ways of connecting with them and identifying what behaviours and reactions might mean, as well as assessing risks. Social care support can include assessment (of abilities, family and neighbourhood networks, care needs, and risks), care planning, review and ongoing support services, access to occupational therapy services and assessment and support for carer needs. Service provision can include home care (personal care, meals, laundry, shopping), day services, respite care (at home or in a care home), extra care housing and residential/nursing home care where necessary. Social care also has a safeguarding role, given the increased vulnerability of people with dementia.

With appropriate support, people with dementia and their relatives can use personal budgets to plan their own support package, including wider opportunities for carers. Crucially, assessment and support of carers, for example access to short breaks, can make the difference between keeping someone at home and carers breaking down. This holistic approach is valued by people with dementia and their families and can help avoid unnecessary hospital admissions and/or inappropriate placement within care homes (see SCIE's Dementia Gateway: **www.scie.org.uk/publications/dementia).**

> ‘Seventy eight per cent of local authorities (LAs) will fund care only for those assessed as having ‘critical’ and ‘substantial’ needs.’

Social care funding

Social care is funded very differently from the NHS, although both are currently under real pressure. While the NHS is a national service, largely free at the point of use, personal social services are the responsibility of local councils and subject to both assessment of need and means-testing of the person's capacity to pay. Seventy eight per cent of local authorities (LAs) will fund care only for those assessed as having ‘critical’ and ‘substantial’ needs. This means that LA-funded social care services are largely delivered to people with the highest needs and the lowest financial means, many of whom are already ill and/or disabled (Humphries 2011).

Social care service users

In 2009-10:

- approximately 1.7 million adults received one or more social care services following a local authority assessment of needs (this is a decrease of five per cent on 2008-09)
- of these, 1.46 million received community-based services whilst living in their own homes.

A substantial number of these would also have received informal care from a relative or friend. In 2009/10 it was estimated that there were around five million informal carers, with 1.1 million providing more than 50 hours of care per week. 387,000 carers received services after a LA carer's assessment.

(NHS Information Centre 2011: 4-6)

Local government spending cuts have led some councils to raise eligibility criteria, restricting access to LA-funded social care services. This means more people will have to fund their own care and/or rely on support from family and friends, potentially resulting in increased pressure on primary and secondary health services. It is here that joint working with social care services by clinical commissioners could pay dividends, by preventing unnecessary hospital admissions and increasing services to patients in their own homes.

Working with social care

People with LTCs and their carers require services that are straightforward and accessible. A key concern of GPs and social care professionals has been the inaccessibility of each other's services and expertise. From the social care perspective, this can result in inappropriate referrals from GPs, while GPs are not clear about the services and skills that social care can offer (Kharicha et al. 2005). More integrated health and social care support offers a way forward by building relationships, resolving misunderstandings, simplifying care pathways and minimising organisational barriers between different agencies.

GPs report concerns about the disappearance of previous multidisciplinary team arrangements, whereby social care practitioners have been removed from primary care (along with district nurses, palliative care nurses and community psychiatric nurses). Clinical commissioners have the opportunity to reinstate these much missed links, as well as potentially save money (McKeown 2011).

> 'Most councils already have systems in place for joint working with health.'

Most councils already have systems in place for joint working with health. Good local relationships are key to determining successful partnership arrangements. More integrated working brings the chance to reduce bureaucracy and overlaps, to ensure patients and their families get the care that will improve their health outcomes as well as deliver efficiency savings. Clinical commissioners will need to work with councils to understand and, if appropriate, protect existing joint arrangements, as well as building new ones. Councils are the lead commissioners now for learning disability funding, while many PCTs are the lead for integrated mental health services, with pooled budgets amounting to £1.4 billion annually (Audit Commission 2009; Turning Point 2010).

Examples: Integrated working

A **GP practice in Norfolk** holds weekly multidisciplinary meetings with allocated social work and community staff, to plan the care and support of adults and older people with complex health care needs. The team has redesigned care management arrangements and provides a prevention and monitoring service, as well as support to patients with urgent, long-term and high care needs. This approach has been shown to reduce admissions to hospital, with no increase in the use of residential or nursing homes. It also highlights the importance of social care input into case management. Thirty three other GP practices are now adopting similar arrangements and a commissioning specification is being developed to support this way of integrated working (Tucker 2010).

Torbay Care Trust established five integrated health and social care teams that are organised in localities aligned with general practices. The teams target their efforts at the very highest-risk individuals who require intensive support from community matrons and integrated teams (Imison et al. 2011: 7).

What next for clinical commissioners?

Developing new relationships to improve the health and wellbeing of patients as well as achieve efficiencies will be one of key tasks of commissioning groups. There are many ways in which groups can work with social care to achieve this. Local authorities' experience of commissioning social care may hold lessons that will ease the transition to becoming clinical commissioners and to developing strategies to meet the health needs of the practice population as well as the individual patient.

These are some key questions to consider asking locally:

Relationship building	• Who are the key people in local authorities and local social care teams that we need to engage? • Is there a good awareness of local services, including those of the third sector, and information and advice? • Are you engaged with arrangements to develop your local Health and Wellbeing Board? How will you contribute to, and benefit from, its work?
Planning and coordinating care	What opportunities do the changes present to better co-ordinate the health and social care of people with LTC and particular groups such as frail older people and people with dementia? Examples might include: • multi-professional teams • link social care professionals in primary care • closer working with public health medicine • personalised care planning for high risk patients to reduce admissions to hospital • redesigning care pathways so they include social care as well as primary and hospital care • shared assessment and information sharing (Imison et al, 2011).
Funding and commissioning	• How can the joint strategic needs assessment and local health and wellbeing strategy help shape clinical commissioning plans? • What kinds of service investments achieve the best outcomes and reduce demand for health and care? Examples might include falls prevention schemes, reablement and telecare, information and advice, carers support. • What pre-existing joint working arrangements exist locally e.g. pooled budgets for particular services or groups? Do these need to be reviewed or extended to reflect new priorities? How can continuity of service for patients and their families be protected during organisational change?

Further reading

SCIE Social care TV films: 'What is social work?' **www.scie.org.uk/socialcaretv**

SCIE resources on personalisation and dementia.

SCIE Research briefing 33: *The contribution of social care to reducing health inequalities*. **www.scie.org.uk**

King's Fund: *Transforming our health care system: ten priorities for commissioning*.

King's Fund: *Improving the quality of care in general practice: Report of an independent inquiry*.

King's Fund: *Routes for social and health care.* **www.kingsfund.org.uk**

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SCIE's At a glance summaries have been developed to help you understand as quickly and easily as possible important messages and practice advice. These summaries will give you an overview of the messages or help direct you to other resources that you may find useful. You can also use them as training resources in teams or with individuals.

We want to ensure that our resources meet your needs and we would welcome your feedback on this summary. Please send comments to **info@scie.org.uk**, or write to Publications at the address below.

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