



NAPC | National Association
of Primary Care

directors of
adass
adult social services

Primary care home and social care: working together



#primarycarehome

November 2018

Contents

Foreword	03
1. Primary care home and social care – a shared landscape	04
– Background to primary care home	04
– Why social care is essential to the success of PCH	05
– About primary care	06
– About social care	08
– Carers: partners of primary and social care	10
2. Policy developments – a shared future	11
3. The opportunities for greater collaboration	14
– At the individual level	15
– At the population level	23
– At the wider system level	23
4. Conclusions and next steps	28
Case studies:	30
– Wokingham Integrated Partnership on Health and Social Care	30
– Larwood and Bawtry Primary Care Home	32
– Greater Manchester Health and Social Care Partnership	34
– West Devon Primary Care Home	36
References	38
More information	42

Foreword

Welcome to this guide on how colleagues in adult social care and primary care can work more closely together through the primary care home (PCH) model.



Both primary care and social care have so much in common – both are rooted in local communities with a unifying commitment to securing the best outcomes for individuals and families and a good understanding of local needs. Effective primary care and social care are vital to enabling people to live well, as healthily and independently as possible, while reducing the need for hospital care and long-term residential care.

There are some great examples where local communities are benefitting from primary care and social care working well together to support local communities. But we also know that challenges remain – relationships and working arrangements between colleagues have varied from place to place and there are deep differences between the two services in terms of governance, funding and professional cultures and ways of working. The primary care home model offers some real opportunities to overcome these barriers and achieve better integration of services.

This guide is designed to strengthen relationships between primary care and social care. It provides an overview of the different landscapes of each service and the national policy developments that make closer working both more desirable and more important than ever. It describes opportunities for collaboration and integration at the level of the individual patient, the local population and the wider system, with examples of places that are overcoming the obstacles and making progress.

There are now more than 200* primary care homes across England. As the PCH model continues to spread and as an established primary care network (PCN) becomes a core component of integrated care systems (ICSs), we encourage everyone working in primary care and adult social care to be part of the change – to strike up conversations about how they can work within the model to improve wellbeing, design new integrated pathways and support people to live as well and independently as possible in their own homes and communities.

With a new NHS 10-year plan taking shape and a green paper on adult social care expected later this year, there has never been a more important time for primary care and social care to strengthen their working relationship in the interests of patients, service users and carers.

James Kingsland
President
NAPC

Glen Garrod
President
Association of Directors of Social Services

1. Primary care home and social care – a shared landscape

Background to primary care home

Primary care home (PCH) – a type of primary care network – is an innovative approach to strengthening and redesigning primary care. Developed by the National Association of Primary Care (NAPC), the model brings together a range of health and social care professionals working as a team to provide enhanced personalised and preventative care for their local community.

Staff working across the health and care system come together as a complete care community – drawn from GP surgeries, community, mental health and acute trusts, social care and the voluntary sector – to focus on local population needs and provide care closer to patients' homes. Its focus is on a defined, registered population enabling primary care transformation to happen at a fast pace, either on its own or in collaboration with others as a foundation for larger models.

Launched in the autumn of 2016, the programme has rapidly expanded to more than 200 sites serving over nine million people (16 per cent of the population). The sites have come together as a community of practice to develop and test the model.

Primary care home is a distinct and established approach to delivering a primary care network which allows better collaboration with social care.

Four key characteristics make up the primary care home:

- A combined focus on personalisation of care with improvements in population health outcomes
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
- Aligned clinical and financial drivers
- Provision of care to a defined, registered population of between 30,000 and 50,000



Why social care is essential to the success of PCH

Primary care and social care are natural allies and partners, with a unifying aim of helping people live as independently and healthily as possible in their own homes and communities. With statutory responsibilities for social care, local authorities are the voice of local democracy. Local elected councillors have a great deal in common with GPs – they are rooted in their local communities and many councillors, like GPs, hold local surgeries so have a good understanding of local needs. Both sectors face common challenges – our ageing population and the rise in chronic and complex illness leads to demand for health and care outstripping resources, it is hard to recruit and retrain enough staff, and social and technological changes fuel higher public expectations of services.

The key purpose of social care is to enable people with a wide range of needs – arising from illness, disability and other social circumstances – to live as independently as possible. As well as providing care and support, social care seeks to protect and safeguard individuals from harm and neglect. Many of us will, at some point, either need social care or find ourselves caring for family members. Social care connects people to a much broader range of services, from housing to healthcare.

GPs and other primary care staff should ideally work closely with social workers and other social care staff, especially in care homes, nursing homes and home care services. People often first approach their GP for advice and help with care needs – sometimes for themselves but often for older family members. This is not always the best approach as relationships and interactions can vary and there is not always a good understanding of each other's complementary roles and responsibilities. There is scope to achieve so much more through closer collaboration and integration. This requires a good understanding of how each other's services work, the potential benefits of interprofessional working, the national obstacles that impede closer working and how many places are trying to overcome these.

About primary care

Primary care is the front door of the NHS – the first contact that most patients have is in primary care. It includes not only general practice but community pharmacy, dental, and optometry (eye health) services.

The NAPC defines effective primary care as:

- A person's first point of contact with the health and social care system
- A person-centred (holistic) approach, rather than disease focused, to continuous lifetime care
- A comprehensive set of services, delivered by multi-professional teams, with a focus on population health needs
- The co-ordination and integration of care in partnership with patients and providers.

Primary care provision is delivered in partnership with patients and plays a central role in the overall coordination and continuation of people's care.

Most primary care is provided by GPs, by far the largest branch of British medicine¹, the foundation on which NHS care is based. General practice provides over 350 million patient consultations each year, compared to 23 million A&E visits². Yet over the past decade funding for hospitals has grown around twice as fast as for family doctor services.



1. NHS England (2016). *General Practice Forward View*. London: NHS England. p. 4. Available: www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

2. NHS England (2016). *Primary care*. London: NHS England. Available: www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/primary-care. Last accessed 12 November 2018.

The core purpose of general practice, set out in the national GP contract³, is broadly described as the services that GPs must provide to manage a registered list of patients. This might include consultation, treatment or onward referral for investigation. GPs may also provide extended primary care services, such as prevention, screening, immunisations, and some diagnostic services. GPs help to ensure effective co-ordination of care for their patients, alongside other NHS services, social care and health services outside the NHS.

In March 2018 there were 41,848 GPs⁴ working in England (headcount), working in around 7,271 practices⁵. GP practice size varies significantly, but the average number of patients per practice has grown steadily in the past few years, from 6,610 to 7,171 between 2010 and 2014, reflecting a move towards larger practices. The number of single-handed practices is now 843 (10.7 per cent) – a 30 per cent fall since 2010⁶.

The majority of GPs work as independent contractors under the terms of a national contract. Two contractual routes account for the majority of spending: the General Medical Services (GMS) contract and the Personal Medical Services (PMS) contract, held by around 56 per cent and 40 per cent of GP practices respectively. Alternative Provider Medical Services (APMS) contracts are used to buy primary care services on fixed timescales from GP practices with one of the two main contract types, but also to buy them from other bodies like non-NHS voluntary providers.

The average number of patients per GP varies depending on the area, but has remained fairly stable over the past five years, rising from 1,567 in 2010 to 1,577 in 2014⁷. The proportion of salaried GPs has increased over time to around 27 per cent. Just over half of the GP workforce is female⁸.

GPs have one of the highest public satisfaction ratings of any public service. The national GP survey results published in August 2018 show that confidence and trust in GPs remains extremely high at 95.6 per cent, 93 per cent of patients felt involved in decisions about their care and treatment, while 95 per cent felt their general practice met their needs⁹.

3. *The National Health Service (General Medical Services Contracts) Regulations 2004, No 21, Part 5, Regulation 15, SI 2004/291*. Available: www.legislation.gov.uk/uk/si/2004/291/regulation/15/made Last accessed 12 November 2018.

4. NHS Digital (2018). *March 2018 final and June 2018 provisional. Experimental Statistics. General and Personal Medical Services, England*. Leeds: NHS Digital. p. 3. Available: <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/2017-18> Last accessed 12 November 2018.

5. NHS Digital (2018). *Bulletin Tables March 2018. Experimental Statistics. General and Personal Medical Services, England*. Leeds: NHS Digital. Available: <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-31-march-and-provisional-30-june-2018-experimental-statistics> Last accessed 12 November 2018.

6, 7, 8. *The King's Fund* (2016). *Understanding pressures in general practice*. London: *The King's Fund*. p.8. Available: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf Last accessed 12 November 2018.

9. NHS England (2018). *Headline Findings: GP Patient Survey*. London: NHS England. Available: gp-patient.co.uk/downloads/archive/2018/Weighted/GPPS%202018%20National%20infographic%20PUBLIC.pdf Last accessed 12 November 2018.

About social care

Responsibility for adult social care sits with 152 local authorities (i.e. county councils, unitary councils, metropolitan and London boroughs). They have important statutory responsibilities to assess individuals' needs, commission services from private and voluntary providers and protect people from harm or abuse (safeguarding).

However, over 90 per cent¹⁰ of social care services – usually home care, residential care homes, nursing homes and other types of support – are provided by over 21,000* private and voluntary organisations.

Unlike the NHS, social care is not a universal free service. To get publicly funded help through local authorities, individuals must have relatively high levels of need and low levels of income and wealth (for example people with savings or assets of more than £23,250 will be expected to pay for all of their residential and nursing home costs themselves). Getting access to social care has become more difficult in recent years. Age UK estimates that 1.4m older people are not getting the help they need¹¹.

Unlike the NHS, social care is funded completely differently, through a mixture of central government grants, council tax, business rates and charging people who can afford it for their care. The NHS contributes some money through the Better Care Fund to promote joint working, for example, to reduce delayed transfers of care from hospital. Since 2010, central government financial support to local government has reduced by over 40 per cent. There is £7bn less in council social care budgets than 2010¹².

The social care workforce with over 1.5m jobs is even bigger than the NHS, but only 5 per cent are professionally qualified, comprising registered nurses (mostly working in nursing homes), occupational therapists and social workers. The largest group, care workers, were paid between £7 and £10 per hour in 2016¹³.

* as of November 2018

10. The King's Fund (2016). *Social care for older people. Home truths*. London: The King's Fund. p.6. Available: www.kingsfund.org.uk/publications/social-care-older-people Last accessed 19 November 2018.

11. Age UK (2018). *1.4 million older people aren't getting the care and support they need – a staggering increase of almost 20% in just two years*. London: Age UK. Available: www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need--a-staggering-increase-of-almost-20-in-just-two-years Last accessed 12 November 2018.

12. Association of Directors of Services (2018). *Annual Budget Survey*. London: ADASS. p. 7. Available: www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf Last accessed 12 November 2018.

13. *Skills for Care (2018). State of the adult social care sector and workforce*. Leeds: Skills for Care. www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf Last accessed 12 November 2018.



People who use publicly funded social care report high levels of satisfaction with the services they receive – 65 per cent¹⁴ are extremely or very satisfied but much less is known about people with care needs who fall outside of the system either because they do not have eligible needs or they can afford to pay for their own care.

People who have to pay for their own care are known as self-funders because they are expected to pay for any care and support they receive. However, primary care professionals should note that the Care Act 2014¹⁵ requires local authorities to provide information and advice to everyone regardless of their means. In some places, there may be other universal services to which they are entitled, for example, reablement for up to six weeks and telecare. The local authority's safeguarding duties also apply to everyone irrespective of income and wealth. Age UK produces useful fact sheets about different aspects of social care (www.ageuk.org.uk/information-advice/care/arranging-care).

14. NHS Digital (2018). *Personal Social Services Adult Social Care Survey, England, 2017-18. "Key Facts."* Leeds: NHS Digital. Available: <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/2017-18>

15. Age UK. *Finding and arranging social care.* London: Age UK. Available: www.ageuk.org.uk/information-advice/care/arranging-care

Increasingly more people entitled to public funding receive this in the form of a direct payment or personal budget which they use to tailor their own care and support arrangements, for example by employing a personal assistant instead of using a home care agency. In many places there are integrated personal commissioning projects, which include personal health as well as social care budgets, so people can experience joined-up care that is personalised to them.

Local authority social care departments play a key role in mental health services, including ensuring there are sufficient Approved Mental Health Professionals (AMHPs) who coordinate Mental Health Act Assessments with psychiatrists and other doctors, and make independent professional decisions about whether a detention in hospital under the Mental Health Act is the most appropriate way forward. AMHPs are advanced practitioners whose training enables them to understand and manage risk effectively.

Local authority social care staff have a legal responsibility to assess whether it is necessary to deprive of their liberty someone in a care home or hospital who lacks capacity to consent to their care or treatment to keep them safe from harm (Deprivation of Liberty Safeguards)¹⁶.

Carers: partners of primary and social care

There are over six million unpaid carers, usually family members, outnumbering the paid health and social care workforce by at least two to one¹⁷. Carers are essential partners of primary and social care ensuring that people live as independently as possible in their own homes and communities without recourse to long-term care or hospital admission. Carers may have important health and care and support needs in their own right.

The Care Act 2014¹⁸ places a statutory duty on local authorities to promote carers' wellbeing. This may include working with the NHS to identify carers. Local authorities have a duty to provide information and advice to carers, assess their needs for support and respond to eligible needs. All of these matters may be separate from the needs of the person they are caring for.

The need for primary care and social care to work together is especially critical at a time of crisis, either social or clinical, involving either the carer or the person cared for.

16. Local Government Association. *Mental Capacity Act including DoLS*. Available: www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/mental-capacity-act-including-dols

17. Carers UK (2018). *The State of Caring*. London: Carers UK. p. 22. www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2018-2

18. Care Act 2014. www.legislation.gov.uk/ukpga/2014/23/contents/enacted

2. Policy developments – a shared future

The policy of integrating health and social care has been supported by successive governments of all political parties over the last 40 years and is set to remain a key national policy objective.

The NHS Five Year Forward View¹⁹ described a future where health and care provision would be fully integrated, with seamless movement between services:



...a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organisation to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results.



These aspirations are reflected in the subsequent General Practice Forward View²⁰ which set out plans to reform primary care. This includes closer integration with community health, social care and preventive services, hospital specialists and mental health care, more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings.

Already it is becoming increasingly normal for general practices to work together at scale, and already over half the country has formed into primary care networks, encouraged by NHS

19. NHS England (2014). *Five Year Forward View*. London: NHS England. pp. 7-8. Available: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

20. NHS England (2016). *General Practice Forward View*. London: NHS England. p. 4. Available: www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

England. Building on these, there will be increasing opportunities for practices to work collaboratively in larger groupings for the benefit of more sizeable populations, yet maintain their unique identity and relationship with their own patients. Larger organisational forms will enable practices to increase their flexibility to shape, buy or build additional services, working from a more effective platform with other local health and care providers. These trends will make it easier for primary care to work with local authorities to jointly plan services.

There is no equivalent blueprint for social care despite facing similar challenges and pressures. Concern about the adequacy of the system to meet rising needs have mounted, with the Care Quality Commission warning that the system is reaching a 'tipping point'²¹. Every government over the last 20 years has attempted to introduce reforms but so far has achieved little.

A green paper setting out proposals for consultation was announced originally in the Conservative 2017 election manifesto and has been postponed until later in 2018, along with the planned workforce strategy.

Despite these challenges, there is no doubt that social care is a vital partner in what NHS England's Chief Executive Simon Stevens has described as "the biggest national move to integrating care of any major western country"²². The development of new models of care and the gradual evolution of sustainability and transformation partnerships (STPs) into integrated care systems (ICSs) are creating new opportunities to deliver joined-up services. Primary care and social care are central to these new partnerships.

The barriers to joint working are well known. Traditionally, the status of GPs as independent contractors has discouraged a sense of organisational allegiance that is an important pre-requisite of collaboration, though this is changing. Frequent NHS reorganisations have disturbed the development of stable working relationships. The misalignment of registered practice populations with the hard geographical boundaries of local authorities creates practical difficulties in coordinating services. Unlike social care, primary care remains a universal service that is largely free at the point of use and the delivery of social care services is through a fragmented market of over 21,000 separate organisations²³.

Existing work in primary care home sites shows that there is a real commitment on the part of local authorities and commissioners to work with colleagues in primary care to find local solutions to needs.

21. Care Quality Commission (2016). *The state of health care and adult social care in England 2015/16*. p.4. Available: www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf Last accessed 12 November 2018.

22. NHS England (2017). *NHS England moves to end "fractured" care system*. Available: www.england.nhs.uk/2017/06/nhs-moves-to-end-fractured-care-system

23. Skills for Care (2018). *State of the adult social care sector and workforce*. Leeds: Skills for Care. www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf Last accessed 12 November 2018.



3. The opportunities for greater collaboration

This chapter suggests ways in which barriers can be overcome – how social care commissioners and providers can work with primary care homes to make better use of social care resources and offer improved joined-up care for individuals and local communities.

There are many reasons why primary and social care should work together.

The rapid and continuing growth in chronic illness means that health and care needs are increasingly interlinked and can only be met by primary care and social care working closely together, engaging with community health, mental health and hospital services where necessary.

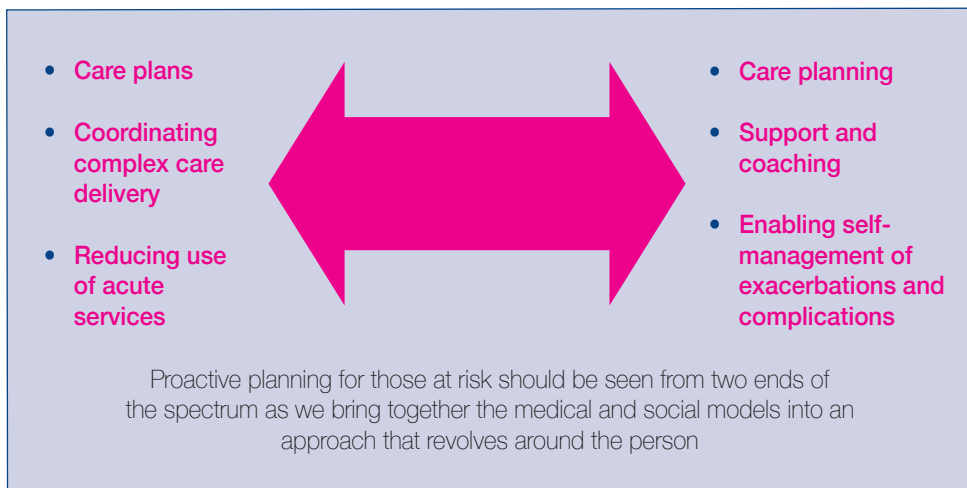
GPs and social care professionals have a shared professional commitment to the individual patient or service user, offering personalised care that is responsive to different needs. GPs and other primary care staff are often acutely aware of the social component of their patients' symptoms and equally social workers recognise the importance of good health care for individual wellbeing and independence.

Primary care and social care are natural allies in supporting people to manage their health conditions so their lives are as healthy, active and independent as possible, in their own homes and communities. Alongside community health services, they are the crucial first-line response to avoid the use of long-term care and hospitals and to shift the balance of care towards the community and people's own homes.

Social care can offer primary care a gateway into other local authority services that impact on health and wellbeing, for example public health, housing and leisure services. Social prescribing, sometimes referred to as community referral, is a means of enabling primary care professionals to refer people to a range of local, non-clinical services including volunteering, arts activities, group learning, gardening, befriending, cookery, sports and leisure provision (see page 18 for social prescribing examples).

Both services face a widening gap between rising demand and available resources, this is best managed together to avoid duplication, reduce costs and achieve better outcomes.

National policy is encouraging stronger involvement of primary care and social care in the development of integrated care systems (ICSs). GPs and social workers are the two professions closest to the health and social care interface in the community so are well placed to bring professional and clinical leadership to local integration plans.



Source: *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 (2014)*²⁴

There are broadly three levels at which primary and social care can work together to achieve these ambitions.

At the individual level

Collaboration by social care and primary care professionals offers personalised and joined-up help to individuals and families. This might include the following functions:

- information and advice, including signposting or referral to other services or support
- care coordination, support for people with long-term health conditions involving social as well as clinical needs, this might involve patients living in their own homes, residential care or nursing homes
- advice from social workers on safeguarding, mental capacity and 'deprivation of liberty' issues in patient care
- harnessing wider community resources and assets including the voluntary sector.

24. College of Social Work, Royal College of General Practitioners (2014). *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.* p. 5. Available: www.basw.co.uk/system/files/resources/basw_104434-7_0.pdf

This can be achieved in a variety of ways.

1. Agreed protocols for joint working

2. Shared records and information

In **Wakefield's connected care hubs**, the introduction of a single electronic care record, known as the Personal Integrated Care (PIC) file has allowed all the professionals, including social workers, to see the person's summary records and work more closely together. All GPs can refer via telephone into the hub even if they are waiting to go live with the PIC file. In the hub, a team of social care and health professionals sits together with coordinators in one office and triage referrals to the right place or person. The social care and health professionals can do both roles



sometimes doing triage work and sometimes visiting patients. They monitor patients keeping everyone up-to-date with progress and give people the care they need to live independently in their own homes and communities. The PIC was originally piloted across a small number of GP practices and is being rolled-out to all other practices in Wakefield.

3. Co-location of staff

Health 1000 one-stop primary care and social care practice – set up by GPs in Barking and Dagenham, Havering and Redbridge, the bespoke practice for older people with complex health and social care needs brings together GPs, specialist doctors, nurses, physiotherapists, occupational therapists, pharmacists and social workers. Patients and carers design their care programme with the team and a personal support worker helps to ensure that health and social care is personalised. The service works with Age UK to develop wellbeing services. It also provides specialist support to four nursing homes.

4. Integrated multidisciplinary teams (MDTs)

In **Thanet four primary care homes** have been established involving 14 practices and a range of local health and social care bodies. An acute response team comprising a GP, nurses, healthcare assistants, physiotherapist, occupational therapist, voluntary care and care agency work closely with social services. They assess patients and put a package of care in place to enable them to remain at home or be discharged. Health and social care coordinators have also been brought into GP surgeries to provide non-clinical support to patients and GP surgery hours have been extended to include weekends and bank holidays. This has led to better care outside of hospital, fewer hospital admissions and lower prescribing costs.

Frail older people are receiving better care out-of-hospital and admitted to hospital less frequently. Over a 10-week trial period in 2016/17, non-elective admissions fell by 155 compared to the same period in the previous year, suggesting potential annual savings of almost £300,000. Medication reviews have also brought down prescribing costs.

Manchester City Council and clinical commissioning groups (CCGs) have developed primary care-based MDTs. Known as practice integrated care teams (PICTs), they include GPs, social workers, practice and community health practitioners such as district nurses, and case managers. Specialist teams are called upon as necessary, depending on the needs of the individuals and families concerned. The PICTs have clear principles to guide their work – people feel more in control of their lives, they are seen as a whole person, health and social care work together and care is planned ahead. To aid coordination of care, a key worker is identified and electronic care plans are made accessible to all team members, see case study on page 34.

In **Oldham a Hope Citadel practice** employed a focused care practitioner, usually a social worker, to find a solution to filling the gaps which medicine, or social care in isolation, couldn't fix.

Patients are referred by practice staff, local community workers or even the police, and then the focused care practitioner works with the patient's household to unpick situations, assessing need and using local health and community contacts to help bring stability to an often chaotic situation. They bring together agencies and patients, and also establish accountability for those involved, resulting in appointments being attended and practical support provided. The model is being rolled out across the Greater Manchester area. There is enhanced primary care support to care homes to reduce ambulance call outs, A&E attendances and hospital admissions.

5. Social prescribing and engagement of voluntary sector

Healthier Fleetwood Primary Care Home in Lancashire is working with the local authority and a wide range of other partners across the town to empower residents to take control of their own health and lives.

The Healthier Fleetwood community initiative has led to a huge variety of new activities and social groups being set up and run by residents with the aim of improving and maintaining their mental and physical health instead of relying on professionals to manage their health for them.

Initially, it was led by professionals from various local organisations including the police and fire services, the parks department, sports clubs and charities. As it developed, the professionals took a step back and allowed residents to decide what their priorities were and what help and support they needed from the partnership's different agencies.

A social movement developed and has gained momentum over the last two and a half years. Resident-led activities include dance and exercise classes, walking football, a table tennis club and a fishing group. The Health and Harmony Singing Group started with 10 people getting together to sing for fun. It has grown to more than 160 members including local care home residents. One resident with dementia who had not spoken for two years joined the group, remembering the words to many of the songs.

East Mendip Primary Care Home in Somerset works in close partnership with Health Connections Mendip (a community development service). They identify patients whose health is adversely affected by loneliness and isolation and connect them with support in the local community. The project is hosted by Frome Medical Practice and embedded in primary care. Working with Frome Town Council, the service has trained nearly 700 community connectors – informed members of the local community who can spread the word about local support services among family, friends and those they meet on a daily basis.

The project grew from the realisation that there were often non-medical reasons why patients were admitted to hospital and medical interventions were not necessarily going to improve their lives. The service lead spent 12 months going out into the community and compiling a comprehensive directory of local services, clubs and support groups offering help with

What works for multidisciplinary teams?

- 
Clear purpose: MDTs need a defined role that requires team members to interact across professional and disciplinary boundaries.
- 
Institutional support: the organisations which employ staff and (if in place) the partnership bodies overseeing this area of collaboration must provide support. This should include public endorsement (and so legitimacy), ensuring that the MDT has the necessary resources, and developing integrated performance systems.
- 
Team leadership: leaders should generally be facilitative in their approach to encourage different contributions, but be directional when necessary. An awareness of team dynamics and a willingness to challenge poor collaborative practice are important competences for a team leader.
- 
Collaborative opportunities: teams must have physical space and time for their members to engage across professions and disciplines. This enables them to improve communication and better understand each other's roles and resources.
- 
Person-centric: there is a danger that teams can become too inwardly focused on their own functioning. This can lead to people and their families feeling more, rather than less, excluded from discussions about their care.
- 
Role diversity: there is no magic formula for MDTs. Rather, the mix of professions and practitioners must respond to the needs of the population concerned while still being small enough to allow members to know each other.
- 
Evidence focused: teams require timely and accurate evidence of their shared impact. Structured opportunities for teams to reflect on this evidence is one of the most impactful means to strengthen their work.

Source: SCIE Highlights No 4 – July 2018 Delivering integrated care: the role of the multidisciplinary team, Social Care Institute for Excellence²⁵

25. Social Care Institute for Excellence (2018). *Delivering integrated care: the role of the multidisciplinary team*. London: Social care institute for Excellence. Available: www.scie.org.uk/integrated-health-social-care/measuring-progress/role-multidisciplinary-team

everything from dog walking and dementia to eating disorders and exercise. Practice staff have instant access to this database at their finger tips and are able to see, via a shared computer system, what people have chosen as their goals.

Health connectors visit patients at the local health and care hub, at home or in hospital and spend time getting to know them. They gain an insight into what matters most to them – these may be things unrelated to their long-term medical conditions. The connectors encourage patients to develop a support network of neighbours, friends and social groups.

Patients have a single point of access and all practice staff are engaged in social prescribing, signposting patients to a wealth of local resources. While some people need one-to-one support, others can find out more about the services they would like to access via the Health Connections phone line.

In **Devon Blackdown Support Group (BSG)**, a charitable organisation working in partnership with the Blackdown Practice, provides volunteer support to meet a wide range of needs including transport to GP and other health appointments, befriending, advocacy and carer support. The BSG is co-located with the practice and, although it has its own telephone line, the practice has an extension of their telephone system so that calls can be transferred to the BSG office. The group also has an NHS email. All these elements mean that the BSG staff are considered part of the practice team, referrals can easily be made and there can be direct liaison between its staff, practice colleagues and clinicians.

The benefits are numerous – better access to and more cost effective use of healthcare services, targeted signposting to social care services, support for patients to get the social care and benefits they need and to maintain independence in their own homes and support for the practice, highlighting where an intervention may be required and avoid an admission to hospital.

Adult social care in Leeds has been fostering good working relationships with primary care in a number of ways. Local social workers in the Armley neighbourhood team invested time in getting to know partners working within the same community. They established that two GP practices in the New Wortley area were concerned at the wider determinants of ill health within their population.

Thornton and Priory GP practices had identified that a majority of visits to the practices related to primary care mental health issues which had social issues as a root cause. Mental health conditions were also impacting on physical health and patients' abilities to manage their chronic health concerns. The practices were using social prescribing as a method of linking people into a range of community activities but recognised a need for closer working with partners. The lead GP recognised an ally in the social work team manager. He was supportive of social care's move to establish a Talking Point* in the local community centre, providing people with the opportunity to

* *Talking Point is a social work pop-up in a community setting where people can book to have a conversation with a social worker about their needs*



access social work advice without the need for a home visit. With the support of the CCG, a wellbeing leadership team was established, co-chaired by the GP and team manager. This brought together partners from key organisations providing support services in the Armley area. Together they identified tackling mental health issues as a key problem that they could address better as a system than as individual providers. This has now been overtaken by work to develop a local care partnership. In the time that it operated, the wellbeing leadership team strengthened local relationships and increased knowledge of one another's roles.

Social care were also keen to improve access to social workers via the primary care route. A community referral form was developed for community health services to use. This was extended to a number of primary care practices in West Leeds with training provided on the role of social work and how to access their local team for support.



At the population level

This involves joint planning and commissioning key services where primary care and social care are inter-dependent. The creation of health and wellbeing boards has given clinical commissioning a stronger role, especially where the board is co-chaired by a local GP from the CCG. It has created opportunities for GPs and local authority elected members responsible for social care to get know each other and work together. The boards have enabled primary care to access other local authority services that impact on health and wellbeing, for example, the inclusion of leisure centres in social prescribing schemes.

In Sunderland, the CCG and local authority have used the Better Care Fund to bring together all of the city's resources for out-of-hospital care to create a single pooled budget of over £160m. From April 2015, a Provider Management Board took on the leadership for redesigning existing services and investing new funds in additional GP and nursing sessions in integrated teams and a 24/7 recovery-at-home service. Co-located multidisciplinary teams, working across several practices, provide an enhanced level of care to patients with complex needs. These are often frail older people and people with multiple co-morbidities both at home and in supported housing, including care homes, identified via a risk stratification approach.

At the wider system level

Primary care and social care are important partners in developing services over larger geographical areas, bringing local knowledge, experience and data to strategic, population-wide planning.

In **Dorset the development of an integrated care system** is aiming to bring together providers across health and social care. Working with the National Association of Primary Care since late 2017, these localities are working on a primary care home approach to develop further right size primary care networks for their populations, bringing in the key themes of integration of services, population health management, care focussed on the needs of their local populations, with the potential for shared assets and workforce.

North Yorkshire County Council sees primary care as a key partner in working together to improve the health and wellbeing of a diverse population and to integrate health and social care within local communities.

It has over 70 GP practices, multiple GP federations, one county council, seven borough and district councils, five CCGs, six NHS foundation trusts and three STPs/shadow ICSs, serving 600,000 people in some of the most remote rural and coastal communities in England, as well as the larger towns of Harrogate and Scarborough and the military garrison at Catterick.

There is a good and emerging relationship between the county council and primary care, through the federations, individual practices and tripartite relationships with CCGs.



Since public health moved over to the council council in 2013, a partnership has developed with the YOR Local Medical Committee (YORLMC) to design and deliver population health programmes including sexual health, smoking cessation, health checks and substance misuse.

A public health grant, the Improved Better Care Fund and NHS investment have been used to establish and expand a new living well service, which seeks to fulfil the Care Act responsibilities to 'prevent, reduce and delay' the need for long-term care. Living Well co-ordinators work in every local community and are now attached to GP practices in the Harrogate and Rural District, and Scarborough and Ryedale CCG areas, with the aim of rolling out the model to primary care across the county. The service has demonstrated over 80 per cent success rates in achieving people's goals and high levels of public satisfaction.

In 2017, the GP federation in Scarborough and Ryedale with the county council, led a joint bid, including wider NHS and voluntary sector partners, to become the multispecialty community provider (MCP) for community health services, integrated with primary care and social care. Although the bid was unsuccessful, encountering a number of barriers around VAT and contractual arrangements, it opened the door to new potential alliances. In Harrogate, the local GP federation lead and the county council are working with two NHS foundation trusts and wider partners to integrate community health and social care services and in Hambleton, Richmondshire and Whitby, there is partnership working to provide step-up, step-down beds in extra care housing schemes.

In East Kent's MCP model, 13 general practices are collaborating to improve care for a population of 170,000. The MCP has five community hubs bringing together multidisciplinary teams of GPs, community nurses, social care workers, mental health professionals, pharmacists, health and social care co-ordinators and others. These teams manage the care of individuals who have been identified as being at high risk of hospital admission. Other initiatives include a database of voluntary and community services, a social prescribing service and drop-in dementia clinics. Early evidence suggests that these changes have led to year-on-year reductions in emergency admissions to hospitals.

Home Truths: how dysfunctional relationships between GPs and social care staff are driving demand for adult social care

Work by the University of Birmingham and the consultancy iMPower illustrates the benefits of GPs and social care working more closely together.

Their 'Home Truths' research, with 11 CCGs and local authorities, suggested that dysfunctional relationships between GPs and social care staff were driving demand for adult social care.

The research showed that:

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

A survey of over 600 GPs found that 56% of GPs believe their relationship with social care is poor or very poor and 47% of GPs felt they were a better assessor of need for residential care than social services.

Estimated savings 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 £600m was just in social care. Home Truths also estimated that more than £1bn could be saved from health budgets by improving relationships and trust between social care and GPs.

The 11 CCGs and councils taking part responded to these findings by opening up communication 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 set up a new team of social workers to connect with clusters of GP practices with the aim of informing new general practice staff about the options available through social care.

Source: Home Truths: how dysfunctional relationships between GPs and social care staff are driving demand for adult social care. Research by the University of Birmingham and iMPower Consulting, September 2012²⁶

26. iMPower Consulting Ltd. (2012). Home truths: How dysfunctional relationships between GPs and social care staff are driving demand for adult social care. p. 2. Available: www.impower.co.uk/wp-content/uploads/impowerdemandmanagement/truths.pdf – iMPower Consulting Ltd, university of Birmingham (2015). Home truths: have we found the key to integration? Available: www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2015/HomeTruthsINLOGOV.pdf



4. Conclusions and next steps

This guide describes the importance of closer integration of social care with primary care to achieve better outcomes for patients and local populations and highlights the value of the primary care home model as a framework for making this happen at scale and consistently throughout the country.

There is strong emerging evidence about the value of enhanced primary care support to care homes, agreement on care pathways and protocols with ambulance trusts.

The policy framework for health and social care increasingly calls for greater priority to be given to care closer to home, promoting independence, self-care and a renewed focus on prevention to reduce the use of hospitals and long-term care. The relationship between primary and social care is crucial to fulfilling these aspirations. The primary care home model is already demonstrating what can be achieved but there are some key issues and learning points outlined below which will aid further and faster progress.

- **The importance of creating forums for primary care and social care professionals.** There needs to be practical ways of bringing staff together to invest in developing their working relationships and creating local solutions that work, drawing on wider evidence about the value of bottom-up approaches, building trust and a mutual understanding of each other's roles and the pressures faced by each professional discipline and service. These should be integral to the development of primary care networks.
 - **Encourage local social work services, GPs and their practice managers to ensure that regular multidisciplinary team meetings oversee the coordination of patients at risk of poor outcomes or admission to hospital.** This could include co-location of more social care services within primary care including key partners from health providers and the voluntary sector.
 - **The need to address practical difficulties that stem from differences between GP practice population and local authority boundaries.** This should include how neighbouring local authorities can work effectively with primary care where the registered practice population does not correspond to local authority boundaries and how to identify the right geographical footprint for primary and social care collaboration.
 - **Ensure primary care, primary care homes and other primary care networks are strongly engaged in their local health and wellbeing board.** This should be the engine room of strategic collaboration between primary care and social care at the local authority level. Boards could oversee a greater degree of integration across social care, primary care and public health based on an agreed plan with the local sustainability and transformation partnership (STP) or integrated care system (ICS).
-



- **Promote the engagement of community health and mental health services, alongside social care, in the primary care home model through an alliance approach to community, social and mental health care in primary care settings** so that primary care takes a stronger leadership role in developing out-of-hospital community services.
 - **At a national level, reduce or resolve some of the national barriers in terms of contracting and payment mechanisms, regulation, and data sharing using opportunities arising from the forthcoming NHS 10-year plan.** Influence work on the new health and social care workforce strategy so that it addresses the workforce pressures that impact on primary care's relationship with social care.
 - **Ensure the value of primary care homes that include social care are fully realised in the planning, design and delivery of the new integrated models** as sustainability and transformation partnerships (STPs) evolve into integrated care systems (ICSs).
-



Case study

Wokingham Integrated Partnership on Health and Social Care

The challenge

Health and social care teams in Wokingham were facing increasing demand for their services, financial pressures and workforce recruitment and retention problems in primary care. An analysis of A&E attendances and unplanned hospital admissions showed that 10 per cent of patients (1,576 people) accounted for 50 per cent of health and social care spending. Traditionally the focus had been on the top two per cent (315 people) as they accounted for 15 per cent of the health and social care budget. There were no targeted interventions to support people with the most complex needs, at high risk of hospital admission.

What they did

Health and social care staff in Wokingham have been working on integrating their services since 2014 through NHS England's Better Care Fund programme. This work was formalised with the creation of the Wokingham Integrated Partnership on Health and Social Care. The partnership consists of Wokingham Borough Council, Berkshire West Clinical Commissioning Group, Berkshire Healthcare NHS Foundation Trust, Wokingham GP Alliance and Royal Berkshire NHS Foundation Trust.

A "pyramid of need" has been developed to identify patients at high, medium and low risk of hospital admission. At twice-monthly, multidisciplinary team (MDT) meetings, interventions are discussed and plans drawn up to support high risk patients in managing their own health and care needs at home and avoid unnecessary hospital admissions.

The MDTs include a community matron, community nurses, GPs, care navigators, social workers and a community geriatrician.



“

A pyramid of need was developed to identify patients at high, medium and low risk of hospital admission.

”

The impact

A new integrated way of working has been fully embedded across traditional organisational boundaries. Patient outcomes have improved and GPs have a mechanism for engaging and communicating with all staff involved in integrated care. The voluntary sector now has a forum for updating health and care staff about the availability of local support services.

Data on A&E attendance, unplanned hospital admissions and calls to the out-of-hours service was analysed for the six months before an MDT intervention and six months after it. A review carried out in the first quarter of 2018 showed unplanned admissions were down 64 per cent and A&E attendances had reduced by 49 per cent.

Lessons learnt/success factors

The service could be used more effectively with even more referrals. This is being addressed with practices being asked to identify their top 10 users for referral into the service rather than relying on data supplied by the clinical commissioning group.

“

Unplanned admissions were down 64 per cent and A&E attendances reduced by 49 per cent.

”





Case study

Larwood and Bawtry Primary Care Home

The challenge

Larwood and Bawtry Primary Care Home covers several villages in Nottinghamshire and South Yorkshire, some of which have high levels of deprivation and disease. Two practices wanted to rebuild the primary care team to care for their local populations. To do this effectively, they knew that they needed to work in partnership with other organisations, in particular their local authority colleagues from Bassetlaw District Council and Nottinghamshire County Council.

What they did

The PCH is working closely with council colleagues in two key areas which impact on health – housing and social care.

Building on previous work to establish integrated teams which co-located community and voluntary services in the practices, the PCH has launched a weekly social care clinic which runs from one of the practices. It is giving patients the opportunity to see a social worker in a familiar environment. It is also allowing GPs to refer directly and build one-to-one relationships with social workers. They have the opportunity for discussions about complex cases face-to-face. The weekly social care clinic builds on other care navigation work which helps support patients to address non-clinical issues impacting on health. Community advisors funded by the voluntary sector work from the surgeries, running citizens advice clinics signposting patients to voluntary and non-medical services in the area.

The PCH is working closely with the district council to support people with housing problems, focusing on ensuring patients have warm, adequate accommodation. It also works with the planning teams to ensure the practices are aware of plans for new care homes and other housing at the earliest opportunity. This allows for better planning of resources within the area and ensures care home residents have access to the support they need.



“

The primary care home launched a weekly social care clinic which runs from one of the practices.

”

The impact

The new social care clinic has sped up referrals for patients to be able to see social workers and enabled GPs to make sure their patients get faster access to the social care services they need. Patients are now seen within a week. GPs feel more empowered to resolve issues that could be impacting on their patients' health. Initial feedback has been positive.

Lessons learnt/success factors

Having social care as part of the primary care home steering group has allowed them to be part of discussions from the start and has helped to build good relationships over time. The PCH looks for win-win scenarios which see social workers and GPs both benefitting from new services making it easier for them to support their patients and the local community.

“

People now see social workers within a week and GPs feel more empowered to revolve issues that could be impacting on their patients' health.

”





Case study

Greater Manchester Health and Social Care Partnership

The challenge

People's health in Greater Manchester is poorer than the UK average. More people suffer from illnesses like heart disease and cancer and more than two thirds of early deaths are caused by issues related to smoking, alcohol dependency, poor diet and air pollution. Many of these deaths can be prevented through better support to help people live their lives in the best way possible.

What they did

In April 2016 Greater Manchester took charge of the £6bn spent on health and social care through a devolution deal with the government. The region also received an extra £450m to help transform services for its 2.8 million residents. Big organisations including local councils and the NHS came together to create the Greater Manchester Health and Social Care Partnership.

The Partnership has implemented a huge range of new initiatives to improve the health and wellbeing of its population. For example, Wigan's community nurses work alongside social care staff and therapists to support people with long-term conditions at home, while in Bolton a new service is helping people with chaotic lifestyles. Both initiatives mean people need hospital treatment less frequently.

Oldham is introducing social prescribing at GP clinics, using specially trained staff who help people become active in their community and build support networks to prevent future health problems. New neighbourhood teams bring together health, social care and charity workers in one building, making it easy to share information and concerns about the people they see. Social workers in GP practices in deprived areas are helping people manage problems like debt and poor housing. A new service is being set up to help vulnerable people who end up in police custody, court or prison. It offers expert support to address health and related problems at the root of their criminal behaviour.



“

New neighbourhood teams bring together health, social care and charity workers in one building, making it easy to share information and concerns about the people they see.

”

The impact

All 10 areas of Greater Manchester have received a share of the transformation funding to spend on local changes. The money has been invested in areas as varied as mental health services, primary care and population health. It has also been used to increase work with the voluntary, community and social enterprise sectors.

The Partnership ended its first year with a £236m surplus which will be reinvested in Greater Manchester. Services have improved rapidly and are being provided closer to people's homes. Mental health is being put on an equal footing with physical health and dementia is being diagnosed and treated earlier. Thanks to the Partnership, 500 more homeless people have their own GP and no-one gets discharged from hospital onto the streets.

Lessons learnt/success factors

The GMHSC Partnership is constantly tweaking how it runs things to cut bureaucracy, duplication and inefficiency. Devolution gives the freedom and flexibility to do things that benefit everyone in the region. Greater Manchester's first mayor is an important devolution partner in tackling broader problems that affect people's health.

“

Mental health is being put on an equal footing with physical health and dementia is being diagnosed and treated earlier.

”





Case study

West Devon Primary Care Home

The challenge

West Devon has an elderly population in a semi-rural area covering around 250 square miles.

Home visits are essential but GPs were spending far too much time trying to get the right care for their patients, navigating their way through a complex system of separate health and social care budgets. They were unaware of all the local services that could keep patients at home and this resulted in unnecessary hospital admissions and delayed care.

What they did

Partners in the primary care home understood the need for a better system that would ensure better care for patients and more time for GPs who really needed their expertise.

The practices created a health and social care hub in their local social services building and commissioned Livewell Southwest to employ and manage its staff with funding from Devon County Council and New Devon Clinical Commissioning Group.

The hub is staffed by two people. When GPs are on a home visit and they need either health or social services they ring the hub and explain the situation. The hub takes over from the GP and sources whatever care is needed – this involves a range of options including intermediate care, rapid response, reablement and social care. Community nurses are using the same system so both they and the GPs no longer have to spend time finding the right source of help and can move on to the next patient.



“

The practices created a health and social care hub in their local social services building – the hub takes over and sources whatever care is needed.

”

The impact

In one year, GPs referred 117 home visit patients into the hub and community nurses made 138 referrals. This has meant more time for GPs and community nurses to see more people at home and patients have, in general, received the care they needed more quickly.

Lessons learnt/success factors

The service can be used more effectively with even more referrals and this is being addressed. By taking this partnership approach and seeing the impact of closer working together, the PCH intends to apply the same method to other areas of work now under development.

“

GPs referred more than 100 home visits patients into the hub and community nurses made 138 referrals... giving more time for them to see more people at home.

”



References

Age UK. *Finding and arranging social care*. London: Age UK. Available: www.ageuk.org.uk/information-advice/care/arranging-care. Last accessed 12 November 2018.

Age UK (2018). *1.4 million older people aren't getting the care and support they need – a staggering increase of almost 20% in just two years*. London: Age UK. Available: www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need-a-staggering-increase-of-almost-20-in-just-two-years/ Last accessed 12 November 2018.

Association of Directors of Services (2018). *Annual Budget Survey*. London: ADASS. Available: www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf Last accessed 12 November 2018.

Carers UK (2018). *The State of Caring*. London: Carers UK. www.carersuk.org/professionals/policy/policy-library/state-of-caring-2018-2 Last accessed 12 November 2018.

Care Act 2014. Available: www.legislation.gov.uk/ukpga/2014/23/contents/enacted Last accessed 12 November 2018.

Care Quality Commission (2016). *The state of health care and adult social care in England 2015/16*. p.4. Available: www.cqc.org.uk/sites/default/files/20161019_stateofcare1516_web.pdf Last accessed 12 November 2018.

Care Quality Commission (2018). *The state of health care and adult social care in England 2017/18*. Available: www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf Last accessed 12 November 2018.

College of Social Work, Royal College of General Practitioners (2014). *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*. Available: www.basw.co.uk/system/files/resources/basw_104434-7_0.pdf

iMPower Consulting Ltd. (2012). *Home truths: How dysfunctional relationships between GPs and social care staff are driving demand for adult social care*. Available: www.impower.co.uk/wp-content/uploads/impowerdemandmanagementhometruths.pdf

iMPower Consulting Ltd, University of Birmingham (2015). *Home truths: have we found the key to integration?* Available: www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/news-events/2015/HomeTruthsINLOGOV.pdf

The King's Fund (2016). *Understanding pressures in general practice*. London: The King's Fund. Available: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf Last accessed 12 November 2018.

The King's Fund (2016). *Social care for older people. Home truths*. London: The King's Fund. Available: www.kingsfund.org.uk/publications/social-care-older-people Last accessed 19 November 2018.

Local Government Association. *Mental Capacity Act including DoLS*. Available: www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/mental-capacity-act-including-dols

NHS Digital (2018). March 2018 final and June 2018 provisional. *Experimental Statistics. General and Personal Medical Services, England*. Leeds: NHS Digital. Available: <https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-adult-social-care-survey/2017-18> Last accessed 12 November 2018.

NHS Digital (2018). *Personal Social Services Adult Social Care Survey*. England 2017-18. Leeds: NHS Digital. Available: files.digital.nhs.uk/25/4D25DF/pss-ascs-eng-1718-report.pdf

NHS Digital (2018). Bulletin Tables March 2018. Experimental Statistics. *General and Personal Medical Services, England*. Leeds: NHS Digital. Available: <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-31-march-and-provisional-30-june-2018-experimental-statistics>. Last accessed 12 November 2018.

NHS England (2014). *Five Year Forward View*. London: NHS England. Available: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf Last accessed 12 November 2018.

NHS England (2016). *General Practice Forward View*. London: NHS England. Available: www.england.nhs.uk/wp-content/uploads/2016/04/gpvf.pdf Last accessed 12 November 2018.

NHS England (2018). *Headline Findings: GP Patient Survey*. London: NHS England. Available: gp-patient.co.uk/downloads/archive/2018/Weighted/GPPS%202018%20National%20infographic%20PUBLIC.pdf Last accessed 12 November 2018.

NHS England (2017). *NHS England moves to end "fractured" care system*. Available: www.england.nhs.uk/2017/06/nhs-moves-to-end-fractured-care-system/ Last accessed 12 November 2018.

References *(continued)*

NHS England (2016). *Primary care*. London: NHS England. Available: www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/primary-care/ Last accessed 12 November 2018.

The National Health Service (General Medical Services Contracts) Regulations 2004. *No 21, Part 5, Regulation 15, SI 2004/291*. Available: www.legislation.gov.uk/uksi/2004/291/regulation/15/made Last accessed 12 November 2018.

Skills for Care (2018). *State of the adult social care sector and workforce*. Leeds: Skills for Care. www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2018.pdf Last accessed 12 November 2018.

Social Care Institute for Excellence (2018). *Delivering integrated care: the role of the multidisciplinary team*. London: Social care institute for Excellence. Available: www.scie.org.uk/integrated-health-social-care/measuring-progress/role-multidisciplinary-team





Acknowledgements

NAPC and ADASS would like to thank Richard Humphries and Caroline Thomsett for writing and preparing this guide.

More information

If you have any questions relating to this guide or would like more information on primary care working with social care, please contact the NAPC team either by phone on: **020 7636 7228** or by email: **napc@napc.co.uk**.






NAPC | National Association
of Primary Care

directors of
adass
adult social services

National Association of Primary Care
5th Floor, 20-21 Cavendish Square, London W1G 0RN

www.napc.co.uk
 [@NAPC_NHS](https://twitter.com/NAPC_NHS)
[#primarycarehome](https://twitter.com/NAPC_NHS)