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Guidelines

Social work with adults experiencing complex needs: summary of NICE guidance

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Box start

What you need to know

- The new NICE guideline supports integrated working between general practitioners and social workers
- A named social worker can help to provide continuity and ongoing support by identifying and meeting needs and helping to avoid deterioration and admission to hospital
- Social workers can help people with complex needs create meaningful social connections, potentially resolving some unmet social needs
- Recommendations from NICE complement the NHS long term plan to create new partnerships between organisations that meet health and care needs

Box end

Social work encompasses a range of interventions aimed at improving peoples' lives. Social workers use these interventions to help people maintain or achieve independence and social functioning. They can be involved in all aspects of a person's care, such as assessing needs and arranging care, at hospital discharge, planning for the future, and supporting social connections, all with the aim of improving overall health and wellbeing.

A person's social care and healthcare needs are intrinsically linked. Yet, historically the health and social care systems in the UK have functioned as separate entities, often with little communication between the two. One of the goals of the NHS Long Term Plan[1] is the provision of integrated care, joining up the health, social care, and voluntary sectors. Integrated Care Systems have been set up and tasked "to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care."

In response to these changes, the National Institute for Health and Care Excellence (NICE) has produced a guideline to provide evidence based recommendations to support social work interventions for adults with complex needs. Recommendations in the guideline are not limited to specific conditions or social situations, and are relevant for all adults whose

needs and difficulties are serious enough to require a high level of support from both health and social care services for various aspects of their daily life (box 1 gives definitions). The guidance includes recommendations on how social workers, general practitioners (GPs), and other primary care professionals can work together to address a person's health and social care needs. The guideline also covers recommendations on future planning, supporting people to connect with local communities, and reducing isolation.

This article summarises recommendations from the published guideline *Social work with adults experiencing complex needs* produced by NICE.[2] The guideline complements legislation and guidance by providing evidence based recommendations about how social work interventions for adults with complex needs could be improved. Evidence levels are shown in square brackets. Definitions of evidence certainty are given in box 2.

Box start

Box 1 Definitions as used in the context of this guideline

Adults with complex needs

People aged 18 or over who need a high level of support with many aspects of their daily life and rely on a range of health and social care services. This may be because of illness, disability, broader life circumstances, or a combination of these. Complex needs may be present from birth or develop over the course of a person's life, and may fluctuate

Organisations

Bodies that employ social workers in a professional capacity. This can include local authority social care departments, health services, the criminal justice system, higher and further education, and voluntary and community services

Box end

Social workers and multidisciplinary teams—communication, support, and collaboration

In existing systems, GPs may not know how best to contact a social worker, may not receive updated care plans from social workers, or may not know their patients are in touch with social workers. Closer integration of health and social care is an opportunity to improve communication between social workers and GPs and primary care. NICE recommendations aim to support successful integrated working and highlight several ways in which organisations can support effective communication within a multidisciplinary team (MDT). One way of supporting communication within the MDT is through a named social worker (see section on "Supporting people to plan for the future").

Organisations should ensure clear communication within the multidisciplinary team by:

- Holding multidisciplinary team meetings, including case discussions
- Having mutual access to diaries when possible
- Providing virtual means to stay in touch even when team members are working from different locations

- Making use of informal opportunities to communicate (for example, staff networking events). *[Based on moderate quality evidence]*

The committee made recommendations about defining the social worker role and strengthening accountability when working within multidisciplinary teams. Blurring of roles, or a lack of understanding of the role of each professional and their remit within the team, can hinder integrated working, for example by leading to inappropriate referrals.

Organisations should support social workers in defining their role within multidisciplinary teams by:

- Providing professional social work supervision, in particular when the team manager is not a social worker
- Providing opportunities for peer supervision
- Making joint training available that provides clarity about the role of the social worker within a multidisciplinary team
- Providing bespoke, continuing professional development for social workers
- Recognising and addressing differences in organisational culture between professionals involved in the team

Organisations should develop shared formal agreements (including budgets and information sharing) early in the process of establishing integrated working to underpin accountability and decision making. *[Based on moderate to high quality evidence]*

Supporting people to plan for the future

Social workers have a key role in ensuring that people with complex needs experience a thorough assessment of their needs and eligibility for care, which they are entitled to under the Care Act 2014.[3] Social workers also coordinate resulting care to address the person's support needs. People in these circumstances experience needs that are wide ranging and often changing, and GP services alone are often not sufficient to address them all, especially in the current context of time constraints in GP appointments.[4] A lack of appropriate support can result in escalations, crises, and admissions to hospital.

Recommendations in the NICE guideline are in line with the NHS Long Term Plan[1] to place *"...social work teams at the beginning of the acute hospital pathway*." They describe the ways in which the social worker can devise a care plan that reflects a person's wishes and preferences. Regular reviews of the care plan whenever circumstances change, such as at hospital discharge or when needs escalate, can help avoid unplanned hospital admissions and reduce lengths of hospital stay.

The NICE guideline[2] also supports having a named social worker. This is beneficial for the person with complex needs in terms of continuity of care and, as described above, supports successful integrated working within the MDT. Contact between members of the

team and sharing information becomes more efficient when people know who to speak to. Further benefits include contributions to the care plan from all members of the MDT, ensuring all of a person's needs are recognised, addressed, and reviewed, for example if needs change.

Social workers should respond to the person and their changing circumstances by:

- Developing a plan that is flexible and responsive
- Reviewing and revising the care plan in response to fluctuating, evolving, or rapid changes
- Developing and identifying options according to the person's needs, wishes, and preferences (for example, by helping people connect with local communities as described in the section on helping people to connect with local communities and to reduce isolation)
- Ensuring consistency of care by integrating working across the range of health and social care services involved (see the section on the social worker's role in multidisciplinary teams).

Social workers should ensure that, at time of writing or review, care plans:

- Take account of the person's wishes and preferences
- State how the person's eligible and non-eligible needs would be best met
- Identify how arrangements will be made to meet eligible needs
- Record any eligible needs that appear unlikely to be met or only partially met, the reasons they cannot be met or only partially met and any potential actions that would allow them to be met in the future.

The social worker should plan the review date of the care plan with the person (a review should happen at least once a year), or conduct an unplanned review as soon as possible if, for example:

- The person's needs escalate or reduce, and circumstances change (for example, after transfer from hospital)
- The person, or their carer, a family member, advocate, or another person important to them requests it

Where possible, organisations should provide people who receive social work support with a named social worker.*[Based on low to moderate quality evidence, committee consensus, and the care and support statutory guidance*[5]*]*

Helping people to connect with local communities and reduce isolation

Social prescribing services are used by GPs to help patients to access support from the community. The NHS Plan[1] promises an expansion of social prescribing link worker roles to meet a target of 900 000 referrals by 2024. However, the brief contact and signposting approach offered by primary care social prescribing may not be sufficient for many people with complex needs. Social workers can provide more sustained and detailed support to provide appropriate help with developing social connections for those with the most complex needs, which can complement the lower intensity support provided by social prescribing

services to a wider patient group. The guideline also highlights the social worker role in advocating to commissioners for particular community resources, and thinking creatively about how personal budgets can be used. Social workers can thus support GPs and social prescribers to identify and address local unmet needs for resources that require funding. In this way, GPs and social workers can influence the commissioning landscape, contributing towards developing networks and opportunities that are meaningful to people experiencing complex needs.

To help people with complex needs develop social connections, social workers should talk to them about their social networks, strengths (using strengths and asset-based approaches), and preferences for activities and social contact.

Social workers should help people to access a range of groups, social activities, and social networks to meet their needs and preferences, looking across the community in addition to what is provided by health and social care services. This could be done by:

- Identifying local community groups and networks, and resources (for example, social clubs, community gardens, faith and cultural groups, user-led social groups)
- Finding out about these resources and whether they may meet the person's needs and preferences
- Helping the person make contact with these groups and activities (for example, by arranging IT and digital training, using familiar and accessible places)

Social workers should think creatively about the types of community resources and networks that they can put in place or support people to develop (for example, by active involvement in commissioning discussions and flexible use of personal budgets, including direct payments). *[Based on low to moderate quality evidence]*

Challenges to implementation

Challenges to implementation of this guidance include:

- Reaching frontline social workers, as few are familiar with NICE social care guidance
- The population of this guideline covers a large group of people with varying health and social care needs. Social workers and other professionals involved in their care may find it difficult to apply these recommendations to all people with complex needs.
- Delivering recommended care and enhancing joint working with health services will be challenging for a social care sector in which spending per person has fallen since 2010/11.[6]

Box start

Further information on the guidance

This guidance was developed by the National Guideline Alliance in accordance with NICE guideline methodology (https://www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf). A guideline committee was established by the National Guideline Alliance, which incorporated social care and allied healthcare professionals (one training manager, one social work practitioner, one practice learning tutor, once principal occupational therapist, one lecturer for applied mental health,

one professor of health and social care, one associate director, one team manager, one community mental health nurse, with co-opted members one GP and older people physician and three members with lived experience).
Review questions were developed based on the key areas of the guideline scope. The best available evidence and cost effectiveness evaluations were reviewed for all review questions. Quality ratings of the evidence were based on GRADE and GRADE-CERQual methodology (www.gradeworkinggroup.org; www.cerqual.org). These relate to the quality of the available evidence for assessed outcomes or themes rather than the quality of the study. Original economical modelling was performed in a prioritised area.
The scope and the draft of the guideline went through a rigorous reviewing process, in which stakeholder organisations were invited to comment; the committee took all comments into consideration when producing the final version of the guideline.
NICE will conduct regular reviews after publication of the guidance, to determine whether the evidence base has progressed significantly enough to alter the current guideline recommendations and require an update.
Box end

Box start
Future research
The committee prioritised the following research recommendations to address gaps identified by the evidence reviews:
- From the perspective of everyone involved, what is the acceptability of strengths and rights-based approaches to social work assessment and what are the barriers and facilitators to delivering these?
- From the perspective of everyone involved, what works well and could be improved about the use of tools and checklists to support social work risk assessment for people with complex needs?
- What is the effectiveness and cost-effectiveness of early, preventive support for people with complex needs?
- What is the effectiveness and acceptability of social work interventions to support people with complex needs during an escalation of need?
- What social and community support approaches are effective in promoting social inclusion of people with complex needs?

Box end

Box start
How people with lived experience were involved in the creation of this guideline
Committee members involved in this guideline included three lay members with lived experience who contributed to the formulation of the recommendations summarised here.
Box end

What is not included in this summary:

Please see the full NICE guideline[3] for recommendations on the principles of social work for adults with complex needs; assessment, including needs assessment and risk assessment; individual or family casework; and responding to an escalation of need, including urgent support.

The members of the Guideline Committee were (shown alphabetically according to surname): Adey Adeneye (from December 2020), Eleni Chambers, Katie Clarke, Mark

Cooper, Claire Gilbert, Ellie Gordon, Rebecca Harrington (chair), Brynmor Lloyd-Evans (topic advisor), Jane Miller, Lynn Prendergast, Maureen Ray, Janet Reynolds, Nina Riddlesden, Ellen Thomas, Meryl Williams (until October 2020), Louise Zonko; co-opted committee members- Mukul Agarwal.

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