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Mental Health Integration Past, Present and Future
A Report of National Survey into Mental Health Integration in England

Mersey Care NHS Trust Integrated Care Demonstrator Site Project
NHS North West Health Education Workforce Transformation Initiative

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Foreword

Mental health is fast becoming a key priority with government, and the health and social care sector want to do all that can be done to ensure that people get the right help at the right time to enable them to have the best possible outcomes.

I am clear that social work has an important role within the integrated mental health and social care context. Social workers play an incredibly important role, working alongside health colleagues in multidisciplinary teams and very importantly working alongside people and their families to enable people to lead fulfilling, independent lives. Through listening, engaging and empathising with people, ensuring people feel listened to, and combining practical help and support with relational work, social workers make a valuable contribution in supporting people to get well and stay well. Building resilience in individuals, their networks and their communities helps to transform people's wellbeing. Their contribution can play an incredibly important role in easing pressure on health services through ensuring more preventative approaches.

Integration is still a key priority, ensuring that services are well placed to effectively support physical health, mental health and social care. However as this report helpfully highlights, integration in itself is not the objective. Providing the best integrated response to people is. Social work has a distinct and unique contribution and must be valued for that. Arrangements that have resulted in a watering down of the unique contributions that social workers or other professionals should be making will not deliver integrated responses to people's health and social care needs.

It is great that this work has been undertaken and demonstrated real practice leadership. This report is a significant contribution in supporting integration arrangements now and in the future. I hope good use will be made of the

findings to put in place the best possible conditions and culture to make sure we get it right for people.

Lyn Romeo, Chief Social Worker for adults in England.

Authors

Emad Lilo is the Vice Chair of The AMHP Leads Network and a Director of the Approved Mental Health Professionals Association (AMHPA). He works at Mersey Care NHS Trust as the Social Care Professional Lead. Emad is an honorary lecturer at Liverpool JMU and Hope Universities, and continues to practice as Social Work Consultant, AMHP and Best Interests Assessor (MCA DoLS). He is the project manager of Mersey Care NHS Trust's Integrated Care Demonstrator Site which is funded by NHS Health Education North West, looking at models and good practice examples of integration in mental health.

Colin Vose has developed a detailed knowledge of the NHS and Social Services, particularly mental health, learning disability and substance misuse services as a RMN, a Clinical Nurse Specialist, the former Director of Mental Head Commissioning on Merseyside and integrated manager of Health Social Care Mental Health Provision within Merseyside. His strategic vision, self motivation, drive and achievements were recognised in achieving the National Health Service Journal Award for Care Innovation in 2005 for service modernisation within mid Mersey in the areas of mental health, learning disability and substance misuse services. He now provides independent consultancy support.

Acknowledgment

This project consumed a considerable amount of time, research and dedication. However, implementation would not have been possible if I did not have the support of many individuals and organisations.

First of all I would like to thank NHS Health Education North West, for funding this very important piece of work.

Imperative is to convey my sincere gratitude to Colin Vose for his support and invaluable contribution. In addition very special thanks to my colleagues in particular Karen Ward, Lisa Woods, Guy Soulsby, Dr Frank McGuire, Amanda McBride and Robert Greenberg. Without their active engagement and participation, this project would not have been as thorough and detailed, and thus their support in sharing relevant information has been essential.

It is crucial to highlight the guidance, advice and invaluable support throughout the project from Steve Chamberlain, Chair AMHP Leads Network.

Finally I am very grateful to all those who volunteered in completing the survey including strategic leads across the health and social care sector who participated in the individual interview process.

Emad Lilo - Integrated Care Demonstrator Site Project Manager

Executive Summary

Mental health and social care are in a period of rapid transition; a transition driven by forces largely external to those areas. Significant pressures exist through funding reductions, particularly in social care, and an increasing market based approach to health care plus additional statutory duties placed on local authorities as a result of the Care Act, which became law in May 2014. These come after a decade and a half in which practice was driven by the National Service Framework (NSF) for Mental Health and as a result, the coming together of mental health social work and health staff into teams with co-location, shared management arrangements, Section 75 agreements[1] and pooled budgets. The authors examined the impact of change on the integration of health and social care in mental health services. This was done through the use of a comprehensive survey of a range of professionals, and interviews with local and national leaders across England involved in both mental health provision and social care along with a review of published literature.

There is an extensive body of literature and public policy that highlights integration between health and social care as the means to achieve high quality provision to service users. But the literature does not specify a single model of integration or even identify its core elements. Therefore we are dependent upon the lived experience of health staff and social workers in trying to understand what works and what doesn't. The surveys and interviews identify that integration in itself does not deliver an effective outcome for service users. It is the quality and nature of the 'integration' that is crucial. Where both cross organisational relationships and quality processes are of a high standard within e.g. a NHS managed health and social care team, integrated management and multidisciplinary working can provide a holistic approach, reduce waits and hand offs, and enables a tailored, personalised service. This supports the recovery and social inclusion priorities of service users.

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[1] NHS Act 2006

Social care and social work being embedded in teams can also improve the protection of human rights, for example through Mental Capacity Act and Mental Health Act compliance, and effective safeguarding. It can also support better work with families.

However there are a variety of experiences within social work of social care being overshadowed by health dominated processes such as care coordination and Care Programme Approach (CPA). This has left many social workers fearing for their professional identity. As a result the College of Social Work published a position statement: 'The Role of the Social Worker in Adult Mental Health Services' in April 2014. This identified five key principles to guide practice. However, surveys and interviews reveal that whilst this is welcomed, its impact on frontline delivery has been limited. The effect of budget cuts in social care, of on going efficiencies in health care, the legislative requirements of the Care Act and the differing performance indicators for health and social care affect the frontline more dramatically. That effect is of increasing tensions and pressures on all staff, health and social care and if not managed, those tensions can become destructive to relations between individuals, teams and services, thus undermining integration.

The effectiveness of social work within integrated teams is dependent on maintaining clear job roles, effective job planning and manageability of caseloads including well designed social care operational procedures and infrastructure such as IT systems that can serve the requirements of both health and social care.

However, if the integration is not well designed, where social care and social work are not given proper priority, social care processes are not thought through or are under resourced, or where roles are unclear, and if what social care offers is not given the same priority as what health offers, service users may not receive high quality social care services or access to resources and rights. Mental health care works best when it is holistic and inclusive of

medical, nursing, psychology, occupational therapy and social work input without one being prioritised over another.

There is a considerable pressure on social workers to be AMHPs and care coordinators plus safeguarding leads. Unless the balance of their tasks is carefully managed they will fail in one or all of these areas. It is not uncommon for AMHPs to have reduced case loads when they also undertake a care coordinator role. This risks putting an additional burden on non AMHP care coordinators, many of whom are mental health nurses, at a time of reduced resources across the service. This therefore calls into question which body provides the governance for integration, is it the NHS trust, the local authority or the local health and wellbeing board? Does this governance ensure a whole systems multi dimensional view of services, inclusive of the views of service users and carers? Or does it endeavour to resolve its particular pressure by redefining its role and that of its staff in isolation of its partner and hence placing a greater burden on its partner?

Role revision and re definition now appears to be commonplace. After years of promoting genericism and of shared capabilities between professional groups there is feeling that this simplistic approach has led to confusion and lack of depth and effectiveness. Role definition across all disciplines needs to provide clarity to deliver on shared objectives of health and social care. Too often these joint objectives have not been properly agreed and are not kept in alignment as the two organisations change in response to distinct pressures on each of them.

For some areas 'section 75' was the process that formalised integration, for others it was a more informal arrangement. For many, existing section 75 arrangements are being reviewed and replaced with a looser arrangement but for some areas surveyed their pre existing looser arrangement is being formalised by a section 75 agreement. Local areas are trying, for better or worse, to make sense of and respond to challenges.

Whether the commitment to high quality service provision, relationship maintenance, respect across professions and enhancement of service user experience will be maintained or enhanced, will be dependent on the nature of those new arrangements going forward. Central to these are role clarity, operational design, effective management and ownership by trusts, local authorities and CCGs – these are the things that enable integration. The s75 agreement, with some expert support in drafting, in relation to partnerships and governance, should write itself if you get the ethos right.

It's like baking – there are many different types of cakes that can be baked, with different ingredients, but each has key ingredients that must be included. Some careful customisation is fine, but the wrong ingredients will ruin it entirely. You just need a few sour notes in the mix and the whole thing is inedible.

If the cake is worth eating, it's worth baking properly!

Introduction

Health and social policy in England over the past two decades has become increasingly focused on placing the service user at the heart of provision and constructing services around the user. Mental health services have seen the greatest advances in this, with the advancement of the service user voice, the development of specialist teams such as early intervention and considerable service reconfiguration. Reconfiguration has involved the creation of large geographically based mental health trusts, development of specialist teams such as crisis intervention followed by further reconfiguration which has seen some of these teams disbanded. Running parallel to this has been the integration of mental health services with social care provision.

The WHO European Office for Integrated Health Care Services suggested the following working definition of integrated care: "Integrated care is a concept bringing together inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency." (Grone and Garcia-Barbero, 2001)

This integration is often reflected in localities through formal section 75 arrangements, with seconded staff and pooled budgets or informal joint working arrangements. But those policy drivers have changed considerably over the past 20 years, as has the economic climate with financial pressures on the NHS and particularly on local authorities. As a result a number of organisations have called into question the purpose of integration, querying its benefits and looking particularly at its shortcomings. Across England these relationships between mental health providers and local authorities are being reviewed with differing outcomes dependent upon local factors, local personalities and the changing policy and statutory frameworks.

Mersey Care NHS Trust has been successful in becoming one of Health Education North West Integrated Care Demonstrator sites to host a project.

The project seeks to consider the effectiveness of social care values, principles, role, functions, and delivery within an integrated mental health setting by engaging the workforce, partners, commissioners and service user/carers. Part of the project has been a study to explore why integration within mental health services between health and social care has been sustained in certain mental health services, whilst not in others. The project utilised both questionnaires and direct interviews with both frontline staff and senior leaders within the NHS and social care, to understand the drivers and pressures that impact on joint working arrangements.

Background and Significance

Mental health services have undergone radical transformation in the past 30 years. A community based care model has largely replaced the acute and long term care provided in large institutions.

This paper seeks to examine the transformation of mental health services in England and the relevance to current policy with particular emphasis on the integration of health and social care within mental health services. Through the use of a comprehensive survey of a range of professionals, and interviews with local and national leaders across England involved in both mental health provision and social care, along with a review of published literature, this paper seeks to explore the context and factors that are affecting integration between health and social care in mental health.

In 1999, the Government launched a major programme of change and modernisation in mental health services within England with the NSF for Mental Health. What has followed was an expansion of mental health services and an increasing focus on both service user experience and quality of provision. Through numerous iterations of public policy in the subsequent 15 years, there has been a coming together of health and social care provision within mental health firstly facilitated by section 31 of the 1999 Health Act and subsequently by section 75 of the National Health Service Act 2006. Combined, both Acts facilitated the transfer or secondment of social care staff to NHS bodies and the transfer of health related functions of local authorities to NHS bodies that are 'likely to lead to an improvement in the way in which those functions are exercised'[2].

Throughout England services have generally moved closer together through various levels of integration, ranging from co-location, shared management and information systems without formal s75 agreements to full integration with formal s75 agreements and governance. The objective was to deliver

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[2] Section 75 NHS Act 2006

enhanced service experience to service users, improving the quality of care and reducing isolated or silo working.

The experience of integration has been as varied as the numerous locations affected. Over the past decade new statutory duties of local authorities have emerged along with changing policy: Mental Capacity Act 2005 followed by the Deprivation of Liberty Safeguards, policies relating to adult safeguarding subsequently enshrined into duties within the 2014 Care Act and the drive to personalisation, prevention and recovery. All these are against a background of significant cuts to local authority budgets. Within mental health services there has been the emergence of Payment by Results (PbR), of enhanced patient safety and quality measures centred on Care Programme Approach, of an increasingly competitive environment between providers and an approximate 8% cut to NHS mental health funding (BBC News March 2015).

This changing policy and economic environment has placed significant tensions on local working arrangements between the NHS and local authorities in mental health services, leading to numerous revisions of arrangements, with uncertain outcomes.

Literature Review

The purpose of this project was to review the impact on mental health social work of on-going change. For many the threat posed to mental health social work by councils pulling mental health social workers from NHS trusts is one of concern. There are councils that have already disaggregated long standing integrated working arrangements, whilst others are considering heading in the other direction by consolidating or even forming new integrated partnerships. Therefore, the health and social care sector has diverse arrangements in the delivery of mental health services across the country. This section will provide a contemporary review of literature relating to integration in mental health with a particular focus on policy, legislative, economic and political paradigms that inform good practice and models of integration.

Many inquiries into tragic events in the past have identified poor communication between agencies, lack of communication with relatives and lack of care coordination as major factors. This coupled with better outcomes for service users and positive experience of seamless and integrated care, have led many organisations to enter into various models of integration in mental health, one of which is section 75 agreements (CSIP 2006, DoH Transforming Care, 2012, Institute of Public Care 2013).

The legal mechanisms that have enabled health and social care to integrate have been section 31 of the 1999 Health Act and subsequently section 75 of the 2006 Health Act. These statutory powers have allowed services to be delivered by one organisation in a coordinated, combined fashion (Bamford 2015, Chatziroufas 2012).

It should be noted that better coordination, while not the same as integration, can also result in gains for service users (Beresford, 2002). The National Collaboration for Integrated Care and Support reports that better coordination "has a palpable merit: It can deliver many, if not most, of the benefits to users of an integrated system (and) it can be a positive, facilitating step towards an integrated system". (National Collaboration for Integrated Care and Support,

2013). The Integrated Care Network also report that a more integrated approach is most needed and works best when it focuses on a specifiable group of people with complex needs, and where the system is clear and readily understood by service users (and preferably designed with them as full partners).

The Royal College of General Practitioners' view that there is no one 'right' model of integration - "Different approaches will be appropriate depending for example on patient needs, geographical factors and organisational characteristics" (Royal College of General Practitioners, 2012). The College's definition of integration is summarised as "patient centred, primary care led shared working, with multi professional teams, where each profession retains their autonomy but works across professional boundaries, ideally with a shared electronic GP record."

The Mental Health Foundation emphasises that there is no 'right' model, the Foundation strongly supports three particular approaches that people want to see in place in the future:

- Specialist mental health care in primary care settings
- Crisis support in the community
- One stop shops and community support" (Mental Health Foundation, 2013).

To achieve integrated healthcare, policy makers, service planners and commissioners need to better understand the indivisibility and unitary nature of physical and mental health. This means that distinguishing between them is likely to lead to an incomplete response to people's needs as well as flawed thinking about mental health. In addition, they should focus on major social and structural influences such as education, unemployment, housing, poverty and discrimination, rather than just on support given to individuals based on a medical diagnosis of mental illness (The Mental Health Foundation's Inquiry into integrated health care for people with mental health problems, 2013). Based on the evidence it considered, the Inquiry highlighted nine factors that impacted on the provision of good integrated care for people with mental

health needs: information sharing systems; shared protocols; joint funding and commissioning; co located services; multidisciplinary teams; liaison services; navigators; research; reduction of stigma.

To summarise there are a number of structural and organisational arrangements that can help to establish effective integrated care for people with mental health needs. Among the most important are having effective information sharing systems (ideally integrated IT systems and one universal individual electronic patient care record), the ability to pool funds from different funding streams into a single integrated care budget, and shared protocols and partnership agreements.

Integrated care has a long history affected by differing political, financial and cultural drivers (Barker, 2014, Kings Fund March 2015, SCIE 2012). But, a range of more complex ways of defining integrated care exists:

- Systemic, where policies, rules and regulatory frameworks are aligned
- Normative, where shared values and cultures are nurtured across professional boundaries
- Organisational, where structures and governance are coordinated
- Administrative, where functions such as finance and information technology are aligned
- Clinical, where patient care is integrated in a single process with information and services coordinated (Bamford 2015, Shaw et al 2011).

Over the last two decades, there has been a debate about generic roles vs. professionally distinct roles (SCIE, 2008). Increasingly in mental health social work, with recent development in legislation and policy relating to social work reforms, Mental Capacity Act 2005 and the Care Act 2014, the professional distinction of social work is taking more prominence and credibility. How to preserve that within an integrated setting, combined with other factors arising from austerity, culture etc. are some of the challenges to consider by health and social care. A view, which is echoed by ADASS guide, where they pose the question, "Are integrated teams more like a soup or salad?" It goes on to state: "previous policy (e.g. NSF for mental health, New Ways of Working and the CPA guidance) has promoted the 'soup' approach through emphasising

role overlaps and genericism. However, the 'salad' approach whereby each profession retains distinct identity and role within a harmonious whole, is gaining ground. This is driven by the financial imperative to reduce professional staff costs and the introduction of tariff care packages in mental health. It is also influenced by the developments in peer support workers and other non traditionally qualified staff." (ADASS, 2014).

Mental health services were one of the first to combine social services and health functions. This led from the 1990s to social workers and social care staff taking their lead from, and frequently being directly employed by health trusts. The British Association of Social Work (BASW) found that in some areas this was very effective, with good outcomes for patients and the social care perspective being well integrated into the ethos of health (BASW 2010). However a survey by BASW found the last few years has seen an appraisal of the effectiveness of such arrangements, with some social service departments pulling out of 'pooled' arrangements (BASW, 2013). In fact the survey reported around 40% of local authorities has removed, or are considering pulling, mental health social workers from NHS management. Evidence from this survey found that social workers had very mixed experiences of working in multi disciplinary teams, varying from great satisfaction, with pride that their views and perspectives were listened to, to strong concerns that the voice and role of social work and social workers were marginalised (McNicoll, 2014).

An article published in Community Care, which sought the opinion of experts, stressed, "Pulling mental health social worker out of the NHS risks losing professional knowledge and denting social support for service users". Dr Ruth Allen reported in that article, "Three reasons lie behind moves by councils to pull social workers from trusts … In some areas relationships between NHS trusts and councils have broken down. In others the NHS is failing to deliver what councils need it to under the social care transformation agenda. The other crucial area is finances." Allen added further by saying, "Local authorities have been affected by huge changes in their funding base. They

have had to look really hard at where they put their money and that has had some impact on integration." (Community Care, 2013)

It would appear, amongst other factors, including personalisation and safeguarding, that the main driver for pulling out of integrated working is underpinned by financial pressures despite the clear benefits to service users. Those benefits including overall financial savings to public purse are reported by several surveys, for example The "Home Truths" project, a study of relationships between GPs and social care, reckons that £1.6 billion could be saved annually by closer ties between them." (Journal of Integrated Care, 2014). A view supported by the outcomes of ADASS and NHS Confederation survey of local authority and NHS commissioners, where leaders reported that integration can save money and benefit service users experience and quality of life (ADASS, 2014). Moreover a recent Panorama documentary about the Healthy Liverpool Scheme, which brings commissioners, providers and the Local Authority together to rebalance the healthcare system with greater focus on prevention, proactive care in community settings and integrated delivery across providers, with active patient involvement in their care. From a financial perspective, Samih Kalakeche, Director of Adult Services and Health at Liverpool City Council, stated "The separation between social services and the NHS needs to disappear. We need to be seeing one care system. Unless we work very differently we will not be able to care for people in the future in the way we do now." (Panorama: NHS - The Perfect Storm, July 2015).

Therefore contemporary developments are arguably providing sufficient evidence that closer integration, care in the community and co-production are the likely future of health and social care (NHS England 2014, Kings Fund June 2015), with opportunities for social work to apply its unique professional values, skills and knowledge.

Whilst the difficulties of working within a predominantly bio–medical model have been well evidenced and documented, if mental health social workers are to make the difference they aspire to, it is arguably important to remain within rather than outside of mental health services, a number of

recent studies argue (Webber 2015, Tew 2011, Tew et all 2012). Social Care Strategic Network paper on The Positive Future of Social Work in Mental Health highlights, "Social work, as well as holding distinct skill and knowledge, is more than the sum of its parts. Social work within an integrated mental health organisation provides a distinctive constellation of priorities and values based practices that can profoundly improve an organisation's culture – promoting human rights, empowerment and the citizen voice." (Social Care Strategic Network, 2013). It also can provide a vital counterbalancing view to clinical models of illness and disorder and where this is done well, can have a powerful impact on NHS culture and practice (BASW, 2010).

If it is to have this positive impact however, the profession does arguably need to avoid genericism and a watering down of its function or a silencing of its voice. It needs to adhere to its shared stated mission to aspire to the "empowerment and liberation of people to enhance wellbeing" (International Federation of Social Workers, 2000), the principle of justice and human rights being key to this aspiration. As Macrae et al assert, what mental health social workers do cannot be solely defined by the series of tasks, which are undertaken (Macrae et al. 2010). Rather, mental health social work can be defined by the values to which it aspires and from which base it works, not to 'manage' or 'process' service users through ever narrowing service gates but to work alongside them in effecting change. This will at times necessitate challenging the institutions in which it operates and according to Macrae et al it means: "Putting service users at the centre of the profession's practice and giving them a voice in relation to the dominating institutions in which they live" (Macrae et. Al, 2010).

The College published its position statement 'The Role of the Social Worker in Adult Mental Health Services' in April 2014, with the endorsement of the Chief Social Worker for Adults and the then Care Services Minister. The 2014 College paper contributed to this reform agenda within adult mental health, making the case for social work's distinctive offer and approaches (Allen, 2014). These were defined in relation to five role categories:

A. *Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority*

B. *Promoting recovery and social inclusion with individuals and families*

C. *Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity*

D. *Working coproductively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship*

E*. Leading the Approved Mental Health Professional Workforce.*

The paper proposed that, while role flexibility is vital to create responsive multidisciplinary and multi agency services, professionals in distinct disciplines need to be able to use their specific skills with clarity and confidence – and to keep developing their capabilities to become better and more effective workers throughout their careers. The role categories offer social workers, their supervisors and managers a framework through which to assess whether social work capabilities are being promoted and developed in a particular setting.

The Department of Health has commissioned further resources to support implementation of the framework for mental health social work in practice, and to ensure new policy and legislation – notably the Care Act and emerging new directions in mental health policy. Three resources have been developed:

- 'Social work for better mental health' - The Strategic Statement
- 'How are we doing?' - An organisational and workforce self assessment resource for implementation of the College role categories
- 'Making the difference' - A framework for direct service user and carer feedback and collaboration to promote high quality social work in mental health

Each of the three resources has a slightly different primary audience. Social Work for Better Mental Health - the Strategic Statement, is aimed at local and national senior leaders in social work and mental health – in provision, commissioning, workforce, policy, education and research. It has very useful key messages which explicitly define the roles of social workers and their contribution to better mental health outcomes, which includes:

- The use of advanced relationship based skills – warmth, empathy and genuineness - to help people define and reach their own goals. This is particularly valued by people using services and their families
- Key skills and knowledge in tackling the stigma, discrimination and exclusion people with mental health problems often face
- The legal and statutory knowledge of enablement, care, support and safeguarding systems makes social workers systems leaders for multiagency practice
- Working holistically, with the person and their social network, helping to strengthen and build sustainable family and social capital.

'How Are We Doing?' - is an organisational self assessment resource. It is aimed at Principal Social Workers, operational and team managers (of multidisciplinary and social care specific services), workforce leads and managers in integrated and social care provision along with commissioning organisations. The resource is intended to be used with the direct involvement of social workers in practice.

'Making the Difference' – seeks to find out what people using services think and experience of social work. It is primarily aimed at social workers in practice, their professional supervisors, workforce and professional leaders, as well as experts by experience, carers and families and user/carer led groups. The resource is intended to help gather direct feedback from service users and carers to improve social work practice, and to provide a potential framework for the coproduction of social work quality improvement. This approach to quality improvement in social work practice is not common

(although important in qualifying and AMHP training). Feedback and co created understanding of processes and outcomes are important for professional learning and credibility in any health or care profession.

The document in relation to the current mental health provision states: "Mental health issues are still marginalised and stigmatised in service systems and in wider society. Mental health services remain under resourced compared to others area of health and care, despite the 2012 legislation on parity of esteem with physical health. Citizens with serious mental health needs are still much more likely to have poorer physical health, live in poverty and in poor housing, have to wait or travel far to access a bed when in acute need, be unemployed or socially isolated and to die earlier ... There is much to do, and reducing resources with which to do it. The whole of the health and care workforce needs to play its part in making the changes needed."

The three new resources were formally launched on 28 January 2016 at a special event hosted by Lyn Romeo, the Chief Social Worker for Adults. The materials are available and accessible on the Department of Health website (Department of Health, 2016).

Research Design and Methods

Overview

Information was gathered using a literature review, and questionnaire (appendix) and both face to face and telephone interviews.

Sources of questionnaire data

Academics	4
Local authority staff	40
Mental health trust staff	27
Student social workers	9
Total	80

Collection of Data

The questionnaire was distributed through a variety of methods: the national AMHP Leads Network, a conference on mental health and social work integration, professional contacts including social media platforms.

Completion of the questionnaire was undertaken by individuals across a wide geographic spread in England and Wales including North West England, London, South Yorkshire, Lincolnshire and Midlands, South Wales. A range of staff completed questionnaires, from directors of social care to front line social work and mental health staff.

Furthermore, there were face to face and telephone interviews completed with 24 individuals including directors of social care, the Chief Social Worker for Adults (Dept. of Health), ADASS leads, an NHS trust chief executive and senior NHS managers.

The findings are a summary of the issues highlighted across the returned questionnaires and issues highlighted in interviews. The survey and interviews were undertaken during July and August 2015.

Analysis

Data returned by 108 of the 148 councils in England showed that 55% have section 75 agreements, which involve some degree of integration of their social workers in NHS mental health, while 45% do not. But within this 55% there is a wide range of forms of integration under section 75. The partnership agreements allow for social workers to be placed under NHS management (Community Care, Sept 2013). Of the 45% that do not have formal agreements in place there will be varied degrees of joint working including co location, shared management systems and ongoing communication. But over the past few years the nature and type of integration has been changing.

Arrangements across England reflect a variety of shades of the WHO definition of integrated care where there has been a bringing together of inputs, delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation. But there is growing evidence of an increasing fracturing of relationships between services with barriers that are:

1. Structural
2. Procedural
3. Financial
4. Professional/cultural
5. Status and legitimacy
6. Statutory duties.

Those barriers were identified by Hudson and Hardy (2002) and both the survey findings and literature review suggest they are the core issues challenging relationships and working arrangements.

Survey responses and interviews revealed a growing struggle between competing priorities, both NHS trusts and local authorities have seen the nature of their relationship change as a result. The more intensive relationship between mental health services and local authorities developed some 20 years ago or more. This relationship is based on the single point of access, a single care delivery model and a belief that it offered an improved service user experience with a single assessment process and integrated care packages. Equally it enabled the medical model to be challenged from 'within the tent' rather than from outside thereby enhancing an understanding of the social model of health. For health services this offered a more rounded and high quality service with a pool of experienced staff working within their teams. For local authorities it allowed the devolvement of day to day management issues to the NHS.

The surveys reveal a number of different types of relationships across England and a changing nature of that relationship and a redefinition of the more intensive relationship of the past two decades. All surveys returned identified a common pattern of co-location and joint working. For the majority this was within a framework provided by an s75 agreement. Having said that the nature of these relationships were changing with the principle driver for change being the additional statutory duties placed on local authorities by the Care Act 2014. The pressures brought by the Care Act 2014 should be seen in the context of financial pressures on local authority budgets, the changed commissioning arrangement of mental health trusts as a result of the NHS Act 2011 and differing performance indicators for the NHS and local authorities. This has led many areas to review current arrangements. In data obtained by a Freedom of Information Act survey by Community Care, 12 English local authorities have terminated agreements or allowed them to lapse. That amounts to 12% of the 55% of local authorities with agreements in place. The belief being that social workers deployed within mental health community teams are not always focussed on social work, and those teams do not prioritise the statutory duties placed on local authorities by the Care Act 2014. Poor joint working and clashes between medical and social models of mental

health are also among factors that are delaying the delivery of personal budgets in parts of the country, a 2013 survey identified (Larsen J, 2013).

Survey responses highlighted the effect of social care outcomes that differ from health care outcomes, notably the drive to towards Payment by Results (PbR) within mental health systems, the centrality of Care Programme Approach (CPA) processes, and the tension placed on the relationship between health and social services by the statutory duties as enshrined in the Care Act.

For some the relationship was left to teams and team managers, co located and working within single line management processes with little active oversight from the local authority parent, for others the oversight was active through partnership boards. But in the decade that has passed both the agenda for NHS trusts and for local authorities has changed radically. Differing commissioning arrangements with CCGs replacing PCTs, with new personnel, the drive to PbR, emphasis on patient safety systems reinforcing the centrality of CPA processes, significant cuts to social care budgets, a changing set of statutory duties and an ambition to deliver recovery focussed services based on personalised care.

Those that have formal section 75 agreements are having to revisit them and ensure they remain contemporary and reflect social care outcomes. Those that had cohabitation type relationships, which integrated social care staff into mental health teams without formal overarching agreements, have had to ask how these forms of working allow a local authority to meet its duties. There are those that lack any degree of relationship between health and social care, whilst they have control of the social care destiny the structural isolation from health may inhibit exploiting the potential gains for the service user, or enable more effective personalisation, or allow greater focus on social care outcomes and safeguarding.

Local areas, in reviewing their particular arrangements are seeking greater direction of the role, function and workload of social workers. Surveys

revealed a movement away from joint management arrangements in some areas, whilst in others there has been a drive to ensure social care priorities are represented within trust priorities.

The experience relating to the clarity about the role of social work was varied according to survey returns and interviewees.

In reviewing all survey returns, and in collating information distilled from interviews, it is possible to develop the following SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis of the challenges and advantages of integration along with potential to refine arrangements (refer to page 29).

Strengths:	Weaknesses:
- Integration of mental health and social care can enhance service delivery and efficiency - Shared vision and philosophy - Service user experience enhanced by one common approach, one assessment process and one care plan - Managing change together - Close working relationships at all levels with enhanced communication, care coordination and patient safety - Co location and active dialogue - Clearer understanding of roles in health and social care - Mystique and isolation broken down - Service user access - Role extension, Social Workers have had opportunity to be care coordinators - Health care staff undertaking training to become Approved MH Professional (AMHP) enhancing pool of talent available - Access to NHS trust training and development programme for social care staff - Shared ambition relating to embedding recovery in services - Social care professional leadership embedded within NHS trust management structure that promotes values of human rights, individual care, personalisation, well being and recovery - Medical model dominance challenged.	- Separate HR processes inhibit integrated staff management - Two sets of policies and procedures dependent on who is the employer - Different IT systems for data collection and management inhibit true integrated working - Social care access to Council IT systems can be problematic in NHS facilities without wireless access - Different hours of working between health and social care staff– i.e. health 8am to 9pm, social care 9am to 5pm - Disparity in age range criteria: health 18 – 70years (move to ageless service) social care: 18 – 65years - Older adults, (over 65s) not experiencing age related illness (dementia) have restricted access to generic mental health social care services relating to psychosis and neurosis generally managed by services delivered in adult teams - Older adult services and possibly learning disability services generally excluded from s75 agreement and lack of older people Social Workers in community mental health teams has exacerbated lack of joined up approach - Watering down statutory responsibility of Social Care staff within generic mental health teams with a focus on health processes such as CPA, PbR etc - The expectation of Social Workers to take full care coordinator role - Reduced effectiveness of personalisation within social care - Reduced focus on safeguarding and protection from abuse and neglect

	• Access to social care continual professional training • Lack of clarity on performance measures and ownership of performance measure (health or social care) • A disconnect between social care staff and the wider council workforce • Lack of shared understanding between health and social care of limited commissioning resources, particularly in inpatient services • Lack of understanding of individual outcome measures for the patient in commissioning a care package • Health not fully understanding / acknowledging role of Social Workers • Time constraints cause by care coordination impacting on Social Workers ability to fulfil statutory duties • Lack of clear policy and joint approach in review of patients in receipt of funding packages on s117 • Differential arrangements to support AMHPs across NHS trust footprint due number of LA areas served • Need for systematic and consistent approach to review of all care packages funded by LAs across a trust footprint • Lack of clear pathways from illness to recovery that incorporate return to employment, independent housing/accommodation
Opportunities: • S75 agreements needs to reflect role of social care staff in Multi Agency Risk Assessment Conferences	**Threats:** • Funding cuts to LA budgets if done insensitively can place additional burden on mental health services and undermine potential of integrated services to provide early intervention,

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- Common age range for eligibility across both health and social care
- Improved health staff understanding of and ownership of commissioning arrangements for funding packages
- AMHP management coordinated across large mental health trusts footprint covering multiple LAs.
- Development of clear outcome measures that support recovery and reflect both health and LA KPIs
- Clearer definition of role and function of Social Work and social care within mental health services
- Creation of social care lead post within NHS mental health trusts to give social care stronger focus
- Development of common policy relating to s117 Aftercare between NHS Trust and LA's that promotes recovery and challenges dependency
- Development of multi agency mental health partnership boards within LA areas that develops, coordinates and drives mental health strategy based on principles of prevention, recovery and promotes effective integration based on a cost benefit analysis.

</td><td>

promote recovery, enhance wellbeing
- Increasing pressure on NHS budgets, particularly in mental health trusts placing additional pressures on all frontline staff including social care staff to satisfy NHS objectives
- Concern relating to the impact of cuts in local authority budgets may have on social care
- The increased incidence of dementia in general population impacts on both health and social care and requires a coordinated response
- Expanding workloads associated with expanding statutory duties i.e. DoLS (there has been a massive increase since the Cheshire West ruling), best interest assessments, Care Act, increasing burden of MHA statutory work (use of MHA increased by 10% from 2013/14 to 2014/15)
- Mental health PbR can become the dominant driver for a mental health trust at expense of other objectives important to LA
- Potential for each parent organisation (a LA and /or mental health trust) to seek budget efficiencies without reference to the other partner leading to cost shunting.

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Some mental health trusts surveyed have demonstrated a commitment to social care within their management structures with posts such as Director of Social Care and Safeguarding; local services lead for Social Work and Practice Development and Improvement Lead posts for Social Work.

The above posts enhance the profile of and give leadership to social work, which should enable social workers to address the five core functions/roles highlighted in Dr Ruth Allen's paper and promote excellent social work across mental health (Allen, 2014).

These roles and functions need to be respected and understood at team manager level and caution needs to be applied in using social workers as care coordinators, to ensure this is not at the expense of these core functions.

Other respondents complained of social care being overshadowed by 'health duties' with social workers' workloads dominated by care coordination, completing assessments relating to mental health PbR and of the dominance of CPA processes. Respondents revealed lack of focus or understanding in some areas of duties and implications of the Care Act 2014, of local authority performance indicators and of related areas such as safeguarding, Deprivation of Liberty Safeguards assessments and the role of the AMHP. Mental health nurses in turn reported instances of local authorities that are reluctant to support non social workers train as AMHPs because they 'are dominated by the medical model' and a view that nursing as a profession is not regarded with respect.

Some surveys and interviews identified a mutual suspicion between health and social care,
"The mental health trust is utilising local authority staff to meet their priorities and demands".

"Mental health trusts are being forced to take on the role of the local authority, to provide management support to social workers, and meet unmet need, as

social worker posts are reduced in teams its NHS staff that are picking up their workload at no cost to the local authority".

In some cases, this could be seen as merely petty professional rivalry between the social model of health and the medical model, reflecting a lack of a holistic understanding and professional insecurity. In others there is a view in social care that integrated relationships have benefited the health sector in terms of access to additional staffing resource. Whilst health partners feel that they are being left to cover increasing gaps in provision as social care is cut and health trusts become the victims of cost shunting from social care.

Importantly, the majority of surveys and interviews reveal a mutual respect between health and social care. There is a clear acknowledgement that they share the same ethos, philosophy and commitment to delivering quality services to the public. That the relationship may, at times, be challenging but out of that challenge and dialogue has grown a more rounded philosophy of care centered on the service user. A relationship that seeks to build on the totality of its parts, of the richness of the professions involved: medicine, nursing, psychology, occupational therapy and social work etc. The potential is a philosophy that embraces wellness, but acknowledges illness, that promotes recovery and supports independence.

Critically all survey respondents and interviewees agreed that it was service users who had gained massively from integration; that the joined up approach had improved access, had led to integrated health and social care assessments, care planning and delivery, had aided recovery and contributed to the prevention of relapse.

The challenges going forward include addressing the increased statutory duties of the Care Act 2014; of meeting the twin demands of health and local authority performance indicators; of maintaining professional identities and leadership; and delivering a service against ongoing cuts to social care budgets and NHS efficiencies, namely cost improvement programmes (CIPs),

in mental health services leading to a projected 8% cut in trust budgets over coming 3 years.

The survey asked how services should respond to such pressures, the general response was one summarised in the phrase *"we will cope, we have no choice"*. Underlying this resolve was a confusion of responses reflecting the number of different local arrangements and their individual reactions to the latest driver, which is forcing change. The largest of these is the massive squeeze on social care resources along with the increasing statutory duties and hence work pressures brought about by the Care Act. Responses indicate that whilst services may value integration the reality of theses pressures is driving a wedge between services. Each partner within an integrated service is trying to manage their resources but not always with reference to the other partner. Hence, surveys report of a creeping feeling of suspicion and distancing of relationships.

Those optimistic survey responses indicate active dialogue between trusts and local authorities, however the greater number of responses revealed pessimism in part fed by a belief that the Government does not really care about mental health provision, be it NHS or social care. Until there is a national commitment then respondents feel they are swimming against the tide.

In only a small number of survey responses and interviews were examples quoted of local health and wellbeing boards showing interest in the issue relating to integration of wider mental health and social care provision. Where there is that local strategic interest there is active dialogue and a greater shared understanding. Often where there is dialogue, it is between the trust and the local authority in the absence of the CCG which commissions NHS mental health provision. Their absence therefore inhibits such discussion and reinforces the separation between health and social care rather than supporting integration.

Examples of quotes taken from survey responses

Issues	Comments
Advantages – local authority/MH trust	'Ease of communication between agencies and professional hierarchy/ boundaries reduced. Better coordination of services. Inter professional learning. Easier to facilitate prompt discharge of patients into the community. More opportunity to joint work and manage risk effectively. Knowledge of legal framework around practice enhanced by having social workers / AMHPS in teams – inter professional learning'.
Disadvantages –services users	'I am not sure if I can identify any' (disadvantages to the service user) 'mental health trusts focussed on secondary care for those with severe and enduring conditions, this gives better access to social care, if you are mild to moderate you fall outside remit of trusts and hence social care access problematic'
Threats	'Lack of resources, pressures of statutory work for both local authority and health staff. A reduction in teams which makes joint working more difficult to sustain as different teams have different pressures.' 'Financial pressures, Fighting between the main players over whose financial responsibility it is. However costs could be shared to benefit the services and the service users.' Leadership 'Who tells the GPs (clinical commissioners) what to do, they need to be leading the process and part of the solution.'
Success	'1. Trust, trust, trust, 2. Communication, communication…3. Integration of electronic workflow, 4. A shared vision' 'The value of working alongside people with different professional backgrounds is in the development of skills and knowledge, ease of communication, and joint working.' Being in the same physical location is of benefit to the client as they can contact someone easily and their care is more centrally coordinated. 'Social care leadership within mental health trusts.'

	'Commitment of staff to work together.'
Future pressures	Legislative **– '**Care Act **–** duty to consider needs holistically, and considering wellbeing generically fits with model of integration.' 'More statutory functions for Social Workers to carry out.' 'Care Act has brought new challenges…we now have separate mental health social care teams, it is easier to engage managers, and workers in changes in Care Act.' Economic – 'separate funding streams in health and social care with different levels of cuts and priorities.' Political – 'lack of political commitment to mental health and social care at local and national level.'
Response to pressures	'To make it a success needs active leadership and support by health and wellbeing board which includes both the LA and CCG, plus the support of the Trust board.' 'Need to undertake a full cost benefit analysis of integration based on the collective cost benefit rather than that of one partner' 'Joined up commissioning arrangements – CCG and LA.'

Mental health and social care providers both wrestle with the concept of measurable outcomes, those that reflect real improvement to the lives of the people to whom services are provided. Hence, their focus often defaults to measurable inputs (e.g. staff, care packages etc.), at a time when resources are reducing. The debate then focuses on the cost and value of such input, the legal duty and on the risk profile of carrying out an action or not. Those inputs closely relate to performance indicators (e.g. CPA 7 day contact etc.) which despite Government commitment, differ for health trusts and local authorities and are not measurable outcomes that reflect improved quality of life. In such a debate concepts of personalisation and recovery are at risk of

becoming more elusive, no matter what the professional background of the exponent, allowing the perceived scientific base of medicine to remain central.

Survey responses are reflective of this wider dynamic, the dichotomy between a collective purpose(s) and collective process(s).

Conclusion

Integration in mental health is facing unprecedented challenges. Increasingly local authorities have been questioning its value with a view that it may have impacted on the ability of their staff to undertake core local authorities' duties, such as social care assessment of need, personalisation and safeguarding. Significant to note, this has become more acute with the development of more explicit duties and processes in line with the Care Act 2014 implementation. We will not see the effect of this Act until local authorities and other agencies fully understand its implications.

On a more positive note, this survey found that mental health trusts value the social care agenda as part of the overall provision of service, and oppose the removal of social care staff from integrated teams as they genuinely believe that this will reduce the ability to provide a holistic response to service users.

Ideally, integration should enable other professionals to understand the relationship between health and social care issues, understand more clearly the social care duties that are owed to service users and provide an easier link into social care services.

Therefore for integration to work it needs to be owned, understood and valued at a number of levels and that ownership replicated in professional leadership and respect. That in turn needs to be reflected in performance indicators, owned by all, that value outcomes based on recovery and human rights.

The overall aim should be to ensure that both cross organisational relationships and quality processes are of a high quality within a managed health and social care team. Integrated management and multidisciplinary working can provide a holistic approach, effective evidenced based interventions, reducing waiting periods and facilitating effective transfer between services, enabling a tailored, personalised service. Such a service has recovery and social inclusion as the core objective for the service user.

For many survey respondents and service leaders this is the goal but the path is littered with many challenges.

Further analysis of the benefits of integration is required to identify those ingredients that promote prevention, recovery, social inclusion and human rights and what model of integration best delivers these outcomes.

Please send any enquiries to:

Emad Lilo Integrated Care Demonstrator Site Project Manager
Email emad.lilo@merseycare.nhs.uk

Ap**pendix - Questionnaire**

Mersey Care NHS
NHS Trust

Mental Health Integrated Care Demonstrator Site Project

Dear Colleague,

Mersey Care NHS Trust has been successful in becoming one of Health Education North West Integrated Care Demonstrator sites.

As part of the project, I would like to invite you to participate in a short survey to explore why integration within mental health services between health and social care has been sustained in certain mental health trusts, whilst in others integration has not?

I would like to assure you that all the information obtained in the course of this project will be handled with the strictest of confidence and anonymity.

Please complete each of the questions below, **save file** and **send** your completed survey by **3 August** by email to: emad.lilo@merseycare.nhs.uk

Thank you – your participation is greatly appreciated.

Kind regards,

Emad Lilo
Integrated Care Demonstrator Site Project Manager

<u>Survey</u>

1. Please tick the appropriate box to confirm whether you work for a mental health NHS trust or local authority employer **Mental health NHS trust:** ☐ **Local authority employer:** ☐ **Other please specify:** **Job Role:**
2. In the space provided can you indicate what 'added value' integration between health and social care in MH brings to: **The service user?** **Local authority?** **Mental health trust?**
3. What disadvantages do you believe integration between health and social care in MH brings to: **The service user?** **Local authority?** **Mental health trust?**
4. Within the current economic climate what pressures are there to sustain integration or lead to disintegration? Please provide two or three sentences to explain the pressures.
5. Upon reflection what factors do you think have made integration successful or not?
6. Looking ahead what pressures are there (e.g. economic, legislative,

political) that challenge any current arrangement? Please explain under the following headings:

A. Economic

B. Legislative

C. Political

D. Other

7. Can you explain how your organisation might overcome such pressures or challenges?

Thank you for completing this survey

Emad Lilo - Integrated Care Demonstrator Site Project Manager

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Mersey Care NHS Trust

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Tel: 07966672885

Please **save** and **send** your completed survey to

emad.lilo@merseycare.nhs.uk

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Mersey Care NHS Trust Integrated Care Demonstrator Site Project
NHS North West Health Education Workforce Transformation Initiative

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