Review of Section 75 Partnership Agreements to provide integrated community mental health services in Coventry and Warwickshire

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1. Executive Summary

This review of the Coventry and Warwickshire Section 75 Partnership Agreements for the Provision of Integrated Mental Health Services is taking place prior to consideration of a further three year term. It has been commissioned by Coventry and Warwickshire Partnership NHS trust, Coventry City Council and Warwickshire County Council. There was a wide scope for the review to inform whether there were areas requiring change or improvement, and if so to inform the development of an action plan.

The purpose of these Section 75s was to provide a legal framework to underpin integrated health and social care delivery in adult services that has been in place for many years. During this last three year term of the Section 75s there have been significant changes in the way services are delivered by the Coventry and Warwickshire Partnership NHS Trust alongside increased demand for services and there has been the most significant change in adult social care legislation and reform of care and support for more than 60 years.

There is still enthusiasm to deliver integrated mental health services for the benefit of service users and to facilitate more knowledgeable and easily accessible joined up working by staff and managers in the three organisations. However, the changes that have happened in the last three years have brought some pressures and challenges to the delivery of integrated mental health and social care services.
The Partners are aware of some of these and are already reviewing the delivery model particularly in IPU 3-8. Social care managers are involved in this and will need to ensure with the Trust, that improvements meet the requirement to deliver both the non-delegated AMHP service and the legally delegated social care functions.

The Partners to these Agreements along with health and social care commissioners will need to continue to review how mental health and social care are delivered to ensure that they can deliver new models of care required by the Sustainability and Transformation Partnerships and the Five Year Forward View for Mental Health. Whilst there might be a view that it might be beneficial to widen the scope of the Section 75s in the future to encompass increased integration, each possibility needs to be evaluated to see if this particular model is appropriate and ensure that all necessary work for a successful integration is taken account of e.g. agreed integrated culture and values, unified systems, HR protocols across all partners etc. If there was a new service model involving other health partners having line management responsibilities for council staff and the delivery of council functions the Section 75s would need to be reviewed to take account of this.

This review, based on consultation with managers and staff delivering the service, a review of national strategic documents, local service reviews and minutes of relevant meetings, concludes with an overall recommendation that a further three year Partnership Agreement is entered into by the Trust and Coventry City, and the Trust and Warwickshire County Council, and that an action plan to address improvements is developed and appended to any new Partnership Agreements. A further term entered into would need to be kept under continuous review to ensure that any new models of service that are required from health and social care commissioners and strategic partners that are agreed can be met.

1.1 Key findings and recommendations

Governance -Membership of the Section 75 Strategic Board

It is recommended that the membership of the Strategic Board is strengthened and consideration be given to including the two Principal Social Workers of the Council's. They are the responsible professional leads in the Councils, supporting and advising on the quality of practice, who should have

a view on how well social workers are supported to undertake their role and that social work practice is of a high standard.
As the responsible manager for delivering delegated functions in acute services, **it is recommended** that the Associate Director of Operations for Acute Services should be a full rather than co-opted member.
It is also recommended that the Deputy Director of Operations be formally a member and is formally nominated as the proxy for the Director of Operations in the Trust.

Governance - Section 75 Sub-Groups
Currently there is only one sub group mentioned in the Section 75s, the Performance and Operations Sub Group, and the ability to form task and finish groups.
It is recommended that the Safeguarding sub group, which is ongoing, and its Terms of Reference, should be included in the Section 75s.

Governance – other meetings
It is recommended that consideration should be given to social care having formal representation within the Trust governance process at the appropriate level in recognition of the contribution social care has to the delivery of community mental health services and the value of integrating the treatment and social care models of recovery.

Besides the Strategic Section 75 Board and its Sub Group, there are other meetings led by Council officers that Trust managers attend. There appears to be an opportunity to streamline some of these and ensure they are represented in the governance described in Section 75s and it is recommended this is undertaken.

Governance – strategic and operational oversight of the delivery of the Agreement and its schedules
Minutes of meetings appear to focus on developments and initiatives and this is understood as a vital part of its business. However a more robust and transparent oversight of "how well the integrated services are performing against agreed service targets along with plans for improvement if targets are not reached" should be more evident. This is both in terms of delivery of the delegated social care duties and the delegated line management functions.

It is understood that much of the last year there has been difficulties in obtaining the data required given the move to a new Trust system.
It is recommended that this is given priority to ensuring that the performance scorecard is produced for consideration by the sub group and onward by the Strategic Board. It is also recommended that case file audits are undertaken and the outcomes are reported to the Section 75 Board. Further work is recommended on seeing how Team Managers can have reports on how well their own teams are doing which will help to foster ownership of delivering the Section 75 duties.

The Strategic Board could consider a more robust oversight of the Integrated Service by each Schedule in the Agreement having a lead officer responsible for ensuring that it is followed by the Partners, kept up to date and any issues brought to the attention of the Strategic Board.

It is also recommended that the Board have a risk register for the Section 75 and agree a shared communications to the teams from time to time to ensure that the profile of the Section 75 and what it means is not lost in the day to day urgency of meeting demands and that key messages are jointly sent from the Partners.

There has been some work done recently to ensure a smoother transfer of work between IPU 18-21 and the Older People's Team in Warwickshire.
It is recommended that the revised transfer protocol is appended to the Section 75 in the appropriate schedule and that the Coventry transfer protocol is similarly appended to that Agreement.

Performance
Much work has been undertaken recently by the partners to ensure that data is available to measure the performance of the Section 75 Partnership arrangements. There is still some work to be done to ensure that data is delivered to the Councils in a way that can be reported on simply, with assurance of its meaning and in time for statutory and local reporting. Work needs to be undertaken to move away from measuring outputs and consider some relevant outcome measures. This could include service user safeguarding outcomes, well-being outcomes, and completion of the Care Act Assessment in the initial assessment and use of advocacy. Case file audits along with performance data will give a more rounded view of how well services are being delivered.
The following are recommended:

- That the Schedule 16 Information and Monitoring requirements for Performance of Local Authority Service Delivery of integrated services and its appendices are kept up to date and include the schedule for delivery of data by each Partner
- That the Data Sharing Agreements are reviewed and up to date
- That both Councils and the Trust consider the Trust uploading data from the Trust into the Council's data warehouse to provide an efficient automated process in line with an updated Data Sharing Agreement.
- That the Trust ensures that data is delivered with clarity of meaning to the Councils
- That the Strategic Board considers whether the data reported evidences the extent to which delegated duties are carried out, e.g. does the total number of initial/trusted assessments carried out by the Trust contribute to knowing how many Care Act assessments are undertaken?
- That a subset of performance indicators from the Section 75 performance scorecard should be available to Team Managers to enable them to see how well their team is delivering the duties that have been delegated to them and understand any differences between teams.
- That the Section 75 Board streamlines the current scorecard and replaces some output with outcome measures.
- Supplement data reporting of outcomes with case fie audits and service user outcome satisfaction services.

Systems and duplication in recording
It is recommended that further work is done to streamline recording and minimise the use of two systems and two assessments. Whilst ensuring both Partners reporting requirements are facilitated. Consideration to any technical solutions for interoperability should be pursued

Leadership
Although there is a clear view that the different professions value each other's contribution, social care staff feel that their profession is marginalised and that the importance of the social model of recovery is strategically not recognised.
It is recommended that the Trust, consider what contribution it can make to adjusting this perception and that the Strategic 75 Board do likewise. This can also happen at team level with managers encouraging and enabling all professions to share the value of their contributions.

The Section 75s social care governance in the form of the General Manager of Social Care Governance and Senior Practitioners in Coventry and Operations Managers and Lead Practitioners in Warwickshire is outside of the operational management arrangements of the integrated services. In Coventry there are two social care Team Managers within the operational line management structure.
It is recommended that the councils consider how some of these roles might participate more directly in the management of the services and the capacity there is for this to happen if some of the roles carry duties outside of the integrated services. This would enable the social care perspective to be more embedded in the management of service delivery.

The two Coventry IPUs that have both a social care and health Team Manager do not appear to have a single Team Manager with overall responsibility and it is not clear whether this arrangement supports a demarcation or integration of health and social care duties. Coventry and the Trust may want to consider reviewing how this operates when reviewing the IPUs.

Role definement and allocation process
Some of the IPUs appear to have significant staff and management role demarcation between health and social care. This is more evident in Coventry. Despite this staff are saying that due to pressures of demand and vacancies they are allocated cases that they feel more appropriate to another profession. It is important that the value and benefits in genericism do not outweigh the valuable contribution each profession uniquely brings.
It is recommended that work is undertaken by the Partners to agree and use an allocation framework that is transparent to health and social care staff which provides an allocation pathway based on required skills and knowledge including that described for social workers in the Role of the Social Worker in Mental Health.

Workload
Staff in the integrated teams report that they have high workloads and competing demands. There is acknowledgement that seconded staff have protected time to undertake AMHP and other statutory duties such as DoLS work however it appears that this is applied in a variable way and it is sometimes restricted to caseload numbers rather than workload.
It is recommended that a transparent and consistent workload management model is explored and implemented in teams that includes an agreed level of workload protection to ensure social care statutory duties are taken account of. The Section 75s already require this.

Service redesign
It is recommended that any service redesign involving the Central Booking System and community mental health services not only takes account of how the Trust will meet its responsibilities under the Section 75s to undertake the delegated social care functions but also takes account of the contribution social care can make in triaging and ensuring that service users get the support they need at an early stage from community and third sector resources.

Services currently outside of the integrated services
It is recommended that if the Council(s) are considering putting social care staff into AMHAT that they do not delegate the social care functions and the line management of the post(s) to the Trust within the Section 75 and that they consider a colocation model initially retaining responsibility for the role. This would enable the Council to develop the role and its social care function first and will have a better understanding of exactly what is to be delegated in this service and how it will be delivered with the experience gained through the colocation.

The Clinical Review Team is outside of the current Section 75s. Unless the manager of that team is or is going to be exercising delegated responsibility for delivering social care functions e.g. reviewing cases on behalf of the Councils and / or line managing seconded staff doing this, i**t is recommended** that this service should remain outside of the Section 75. Whether or not this team is included in the Section 75, the Council's will require appropriate social care assessments in order for them to make decisions about any funding implications for the Councils.

Council administrative staff working in the IPUs are line managed by the Trust Administrative Hub and not by a manager in the IPU structure.
It is therefore recommended that either the Trust Administrative Hub should be included in the Section 75 to enable the Partners to assure themselves that these seconded staff are being managed in line with the Human Resources protocols, their terms and conditions of employment with the Council and are responsible for ensuring the delegated duties are carried out, or they should be seconded directly into the IPUs. If the former, the line managers should be supported with some training around the purpose of the Section 75s, its legal status and the functions that are required to be carried out.

AMHP workforce
It is known that AMHP vacancies are difficult to recruit to.
It is recommended that Partners consider other professionals being trained and practising as AMHPs. This would contribute to maintaining sufficient numbers of AMHPs and relieving the consequent pressure on teams when there are AMHP vacancies.

Workforce development
It is recommended that:

- the Partners consider a joint workforce development programme that identifies the skill mix required in integrated teams and enables them to equip themselves with the skills to deliver the integrated services from both the health and social care perspective
- that managers of integrated teams are equipped to lead teams that deliver delegated social care functions including refresher training on the Care Act and legal literacy

Safeguarding
Safeguarding activity is recorded on Coventry City Council's system and detailed information about safeguarding enquiries and plans are recorded in service user records on the Trust system. In view of assurance Warwickshire has gained with the Trust over safeguarding activity in recording and reporting, **it is recommended** that Coventry and the Trust consider moving towards recording safeguarding on the Trust system. If this were agreed then the Safeguarding Schedule of the Coventry Section 75 would need updating to reflect the change in responsibility for reporting safeguarding in mental health services.

Finance
It is recommended that the Finance Schedule remains the same and that there is no pooling of budgets. There should be transparency over the recruitment to vacant health and social care posts in the integrated services including those that are managed outside of the service itself e.g. administrative posts. This should be overseen by the Section 75 governance arrangements to ensure that the resourcing of teams is maintained and that neither health nor social care functions are compromised.

2. Introduction and scope of the review

A review of the Coventry and Warwickshire Section 75 Partnership Agreements for the Provision of Integrated Mental Health Services was undertaken between June and October 2017. The full terms of reference are contained in Appendix 1. The key objectives and the scope are set out below.

2.1 Objectives of the review

Key Objectives	There are 10 distinct objectives expected from the review of the current arrangements: 1. Identify the most effective local arrangements for the delivery of Mental Health Services 2. To identify current levels of integrated practices and the outcomes delivered through the formal and informal arrangements in place and identify key development opportunities- detailed analysis of the 'as is' position. 3. Provide an analysis of the current performance frameworks, opportunities for change and make recommendations about future arrangements that are required 4. Identify key changes required over the 3 year period 2018 to 2021 to ensure strategic requirements at national and local levels are achieved, including alignment with BCF and Five Year Forward View for Mental Health. This should include the CCC strategic vision and priorities, Warwickshire Cares and WCC and CCC transformation programmes 5. Identify key outcome measures that support service delivery and better outcomes for individuals 6. Workforce development and flexible approach to supporting 'integrated' roles i.e. AMHP role
	7. The review would take account of: a. Better Social Work for Mental Health b. Staff consultations c. Service user and carer consultations d. S75 updates schedules e. Collaboration with CCG's / Local Health & Social Care economy 8. Establish capacity required across the services to deliver integrated care in a seamless way. 9. Identify opportunities for increased integration 10. Provide analysis and recommendations about the leadership roles in delivery of the organisational outcomes

2.2 Scope of the review

Scope	The initial scope of the project is to focus on the areas of delegated functions that comprise the current working arrangement which includes the following : - • Services delivered through each of the Integrated Practice Units across Coventry and Warwickshire with particular attention to Care Act assessment, review process, active and non-active CPA • Services provided through the Central Booking System • Services provided by the Crisis Resolution Home Treatment Teams, AMHAT and CRT. • Delivery of Adult safeguarding functions and the general functions of the Care Act • Current governance arrangements supporting the S75 arrangements including performance reporting, quality and safety (including audit), information governance and reporting schedules • Progress of the CQC action plan particularly relating to provision of dementia services

3. Methodology

25 days were available to undertake the review. Interviews were undertaken with individuals, focus groups with staff and managers held, and staff and questionnaires were completed by staff and managers in the 3 Partner organisations. The review took place over the summer period and it was not possible to meet with a representative in every service area and from each Partner organisation. Unfortunately not everyone or group that may have wanted to contribute were able to given the challenging timescale, in particular service users and carers were not consulted. However, consultation did take place with service users and carers prior to the commencement of both Agreements and their views were incorporated into a recent evaluation of community services[1].

Research was undertaken and recent reviews, audits and publications listed in the reference section were taken account of and the Section 75s reviewed.

A list of interviews, focus groups and meetings is in Appendix 2, interview and focus group questions in Appendix 3 and the questionnaire is in Appendix 4. Documents and references referred to are in the reference section.

There was no case file or other audit reports available to consider as part of this review other than an internal Audit that was undertaken by Warwickshire County Council's Risk and Assurance Services into the governance of the Warwickshire Section 75.

In the remainder of this report the Coventry and Warwickshire Partnership NHS Trust will be referred to as the Trust, Coventry City Council as Coventry and Warwickshire County Council as Warwickshire. All three together are referred to as the Partners.

The Section 75(s) Partnership Agreements for the integrated provision of Mental Health Services will be referred to as the Section 75(s).

For the purpose of this report the people who use the integrated services will be referred to as service users and carers.

[1] Final report: Evaluation of the Integrated Practice Unit approach, Mental Health Strategies, 2016

4. Background to the Partnership Agreements

The National Service Framework for Mental Health published in 1999 set out a service delivery system that significantly reformed the delivery of secondary mental health services with the introduction of services such as Assertive Outreach Teams. This was underpinned by a requirement for health and social care to work together to deliver new services in a coordinated way. Both Coventry and Warwickshire Councils worked with their local Primary Care Trusts on shaping the new model of mental health service delivery which resulted in significant colocation and joined up delivery of services and built on previous colocation arrangements. These arrangements developed over time and were later underpinned by Section 75 Partnership Agreements for the delivery of community mental health services to adults. These agreements provided a legal framework for the delivery of delegated social care functions and the day to day management of seconded staff. A key purpose of the formal integration was to ensure that service users and carers received a seamless service which involved nurses being able to access social care services and social workers undertake initial assessments without requiring reassessment and referrals to colleagues.

The Coventry Section 75 has always included both the provision of adult and older adult mental health services whilst in Warwickshire older adults mental health services were included in 2010 following thorough research of the models for delivering those services at the time.

The first formal Section 75 Partnership Agreement between Coventry and Warwickshire Partnership NHS Trust and Warwickshire County Council was for the period 2010 to 2013 followed by a 12 month extension to undertake a comprehensive review. This was followed by the current Partnership Agreement effective for 2014-2017 with a 12 month extension for a review to be undertaken.

The first formal Section 75 Partnership Agreement between the Coventry and Warwickshire Partnership NHS Trust and Coventry City Council was from 2011 to 2014 followed by the current one running from 2014 to 2017 with a 12 month extension for this review.

Both the Coventry and Warwickshire Section 75s run for three year terms subject to review prior to consideration of a renewed Partnership Agreement.

Both have been extended for a year to enable a review of the Section 75 arrangements to take place. Some updates were made at this stage to the Section 75, which included governance arrangements, safeguarding protocols and systems and processes.

4.1 Changes that have happened in the 3 years between 2014-2017

4.1.1 New service delivery model

The most significant change to community mental health services that effects service delivery and the Section 75s, since the Section 75s commenced, has been a radical redesign of services provided by the Coventry and Warwickshire Partnership Trust from a Community Mental Health Team model into Integrated Practice Units (IPUs) which are based on three “super-cluster” groups. The IPUs provide specialist interventions by staff in integrated multi-disciplinary teams with appropriate skills and expertise. Both health and social care staff were realigned into these new teams. The three IPUs are:

- IPU cluster 3-8, non-psychosis cluster, which provide specialist services to people with severe and/or complex anxiety, as well as mood and personality disorders.
- IPU cluster 10-17, psychosis cluster, provide a specialist services to people with major affective and psychotic disorders including an early intervention service

- IPU cluster 18-21, dementia cluster, which provides 2 pathways of care one of which is the memory assessment service.

Also during this period was the introduction of a Central Booking Service that triaged all incoming referrals. These now include self referrals alongside professional referrals.

IPUs were based on the principles of Michael Porter's Value Based Healthcare[2] and at a time when there was consideration nationally of bringing in a payment system, mental health payment by results (PbR), which would reimburse Mental Health Trusts in proportion of treatment activity delivered. Such a model does not take into account social care outcomes alongside treatment outcomes. Whilst the Trust made the decision to move to this new model of delivery of secondary mental health care in Coventry and Warwickshire the Trust did engage with the Councils to consider the impact on the delivery of social care within the integrated service and where best the Councils felt they should locate social care staff within the model.

Also, administration staff are now line managed by a central administration hub and not the IPUs, and consequently the line management of seconded administration staff has moved there too.

4.1.2 New Systems

During this time, both the Trust and Coventry City Council have changed the systems they record service user and carer information on, with the Trust moving to using Care Notes and the City Council to Care Director. Similarly Warwickshire County Council are about to move to a new recording system, Mosaic. Whilst the benefits to new systems are recognised, it is important to recognise the impact adapting to such changes has to staff particularly if both staff in health and social care have to use both Trust and Council systems to a greater and lesser extent. Whilst the Partners agree that the Trust system Care Notes is the main place that service user information is recorded, a minimum data set must be kept on the council systems and where possible the host system should include required social care information to reduce duplication of recording. Both Councils and the Trust have included Care Act sections on the Initial Assessment form in Care Notes to promote and record a holistic health and social care initial assessment.

4.1.3 Introduction of the Care Act 2014

The Care Act was a major revision of adult social care legislation that underpins the work of local authority adult social care. The delegated functions in social care service delivery are underpinned by this new Act and the Section 75s have been revised to take account of these changes in the duties that have been delegated to the Trust. The new legislation requires a new approach that builds on the strengths and assets of individuals, their families and communities and moves away from the use of traditional provision of services that do not promote independence, choice and control. Both Councils have worked with the Trust to provide awareness training and revise processes to support the new approach and legislation. Both Councils, in consultation with the Trust, have reviewed their staffing models and introduced new or strengthened existing roles, e.g. Community Care Workers (CCW) in Coventry and Self Directed Support Workers (SDS) in Warwickshire to support staff in integrated teams to assess social care needs and provide social care and support to their service users.

The Trust invested in MIND workers at the front door to support early signposting to universal community based services.

[2] Value-Based Health Care Delivery Professor Michael E. Porter Harvard Business School www.isc.hbs.edu January 22, 2014

There is some feedback from managers and staff from the Trust and the Councils that Care Act refresher training would be beneficial for staff in the integrated teams. It is important that to fulfil delegated functions in the Section 75, Trust Managers remain knowledgeable of the legislation they are implementing and the approach the Councils are taking to implement the statutory duties. It is the responsibility of the Trust Managers to deliver the delegated responsibilities and ensure their teams can deliver albeit with the support of Lead Practitioners and Senior Practitioners.

4.1.4 Austerity, efficiency savings and cost improvement plans

Both Local Authorities and the NHS are required to continue to provide services whilst making very significant savings, efficiencies and cuts to budgets and facing increased demands on their services. This report has not considered the details of what has happened to mental health and adult social care budgets over these years; however a significant impact appears to have been the growing demand for services at a time of reduced budgets and maintaining a workforce to meet that demand.

4.1.5 Mental Health Act, Approved Mental Health Professional (AMHP) activity

Nationally the total number of detentions each year under the Mental Health Act rose by 26% from 2012/13 to 2015/16. There is a national initiative[3] with NHS England and NHS Improvement being tasked to ensure that use of the Mental Health Act is closely monitored at both local and national level, and rates of detention are reduced by 2020/21 through the provision of earlier intervention. However the current situation is an increasing demand for Mental Health Act Assessments.

Warwickshire has seen a 29% increase from 2014 to 2016. The number of assessments rose from 731 to 940. (This does not include referrals which resulted in information only) Since 2014, the greatest increase in Warwickshire was the number of people referred for a Mental Health Act assessment but no admission/alternative plan was the outcome. There was a 119% increase from 2014 to 2015. This dropped slightly to an increase of 101% in 2016. It would be beneficial to look at where these referrals came from to see if there was a more effective way of managing these referrals by the Partners and whether all of them required an AMHP at point of referral.

In line with the national picture[4], pressure on beds in the locality is reflected in the data collected from the AMHP reports. Within Warwickshire from 2014 there has been a 106% increase in a delay in locating a bed and an increase of 223% in the use of out of area beds.

In response to the demand for AMHP assessments and the introduction of IPUs, both Councils have moved from locating AMHPs in the previous Community Mental Health Teams into AMHP hubs where AMHPS are rostered out of their teams into. This provides peer support, support from Lead/Senior Practitioners and enables the Councils to better manage demand for the service. There continues to be AMHPs operating from Crisis teams.

4.1.6 The Mental Capacity Act (MCA) and Best Interest Assessments (BIAs) and Deprivation of Liberty Safeguards (DoLS)

Following the Cheshire West Judgement[5], there has been a huge increase in the number of DoLS applications and assessments. Both Councils had to absorb this extra work and although additional staffing resources were identified some experienced staff left the mental health service to join newly formed DoLS teams and needed to be replaced.

[3] A report from the independent Mental Health Taskforce to the NHS in England, February 2016
[4] Health and Social Care Information Centre (HSCIC) and Community Care August 2015
[5] Cheshire West and Chester Council v P [2014] UKSC 19, [2014] MHLO 16

4.2 Developments

There are a number of developments that the Partners have or will be involved in. Those mentioned below are the ones that impact significantly on the current integrated service arrangement.

4.2.1 Think Ahead Programme

The Think Ahead Programme is a government initiative that provides a new route into mental health social work that has been running for 2 years. The programme aims to redress the difficulties in filling social work vacancies in mental health services. The Partners have participated in the scheme and currently have newly qualified social workers in post from the scheme. Whoever the employer is, arrangements for the professional support of these staff needs to be agreed and ensure that it is covered in the Section 75s.

This extract[6] from the scheme pinpoints the value of social work to the delivery of a successful mental health service and is useful in understanding the importance of the role of the social work professional in integrated mental health services and where their skills and expertise are best used:

"Mental health problems aren't just medical conditions, and supporting people doesn't just mean treating their symptoms. Helping people towards recovery means enabling them to lead independent and fulfilling lives, and in many cases to learn how to live with their symptoms.

Social workers focus on social factors—like housing, employment, and relationships with family and friends—that have a strong impact on mental health. A difficult social situation can be part of the root causes of mental illness, and improving the social factors in someone's life can have a transformative effect.

Improving social factors is especially powerful in supporting people to achieve a sustainable recovery. Building resilience in individuals, their networks, and their communities helps people to not just get well, but stay well. By enabling individuals to live independently on a long-term basis, addressing social factors also reduces pressure on health and care services, and benefits our society and economy.

Great social workers are great leaders. Every day, mental health social workers need leadership skills to understand and inspire people, to make tough judgement calls about people's rights, and to assert their views with other professionals.

Social workers also need to take a leading role in service design and innovation. By applying their unique expertise, social workers can make services better at building people's resilience and achieving sustainable improvements in mental health."

4.2.2 The role of the social worker in adult mental health

Also in the last three years, the chief social worker for adults has defined the role of the social worker in Mental Health[7]:

- Enabling citizens to access statutory social care and social work services and advice, discharging legal duties and promoting the personalised social care ethos of the local authority
- Promoting recovery and social inclusion
- Using professional leadership and skills in situations of complexity, risk and ambiguity
- Working co-productively with communities to support community capacity, personal and family resilience, earlier intervention and active citizenship
- AMHP leadership

This has been followed by a detailed strategic statement on the role of social work in mental health[8] and both Councils undertaking a self-assessment to see how well they match these expectations, with

[6] Think Ahead website
[7] The role of the social worker in adult mental health, College of Social Work, 2014
[8] Social Work for Better Mental Health, A Strategic Statement, DH 2016

the support of the Association of Directors of Adult Social Services (ADASS), West Midlands and Improvement and Efficiency West midlands (IEWM). The Partners will be able to assess how well they are delivering social work in mental health by their own staff and by health colleagues through the delegated social care functions and whether there is a redefinition of roles that is needed in the integrated service and the Section 75s. These initiatives are timely for the Partners to ensure that they consider incorporating the outcomes into these schedules in the Section 75s:

- Schedule 1 Aims and outcomes
- Schedule 4 The Integrated Mental Health Service

At the same time it is important to also state in the Section 75s the role of other key professionals in the integrated teams and who also share a generic function with the social workers i.e. Community Psychiatric Nurses (CPNs) and Occupational Therapist (OTs) in order that each profession's unique contribution is effectively used. It is timely to revaluate the significance of genericism that has underpinned these integrated services to date.

4.2.3 Patient centred care planning

The Trust participated in a national research programme with Manchester University[9] around patient centred care planning and goal setting. Training was rolled out by Trust staff alongside service users and carers sharing their experiences of care planning to staff working in IPUs Nov 2016 to May 2017.

4.2.4 Future changes

There is a national direction towards promoting further integration to improve outcomes for service users across the health and social care economy. The Coventry and Warwickshire Sustainability and Transformation Partnership (STPs), has developed proposals built around the needs of the whole population in the area and integrated service provision is a key feature.

Coventry have created a multi-disciplinary Integrated Neighbourhood Team (INT) which works in the community to help frail elderly people become more independent and safer within their own homes.

The Five Year Forward View for Mental Health put forward a range of objectives that will impact on the delivery of mental health services in localities including specifics relevant to the current delivery of integrated mental health services for all age adults such as, a 7 day NHS, integrated mental and physical health approach, better data linkage with a focus on experience and outcomes, building and maintaining a qualified workforce. It will be important that joined up mental health and social care commissioning shapes services going forward. Currently all working age social care mental health services are located within secondary mental health services. There are other possible models for delivering social care in mental health services involving other potential partners that will need consideration in the future.

Whilst there is a view that it might be beneficial to widen the scope of the Section 75s in the future to encompass increased integration, each possibility needs to be evaluated to see if that model is appropriate and ensure that all necessary work for a successful integration is taken account of e.g. agreed integrated culture and values, unified systems, HR protocols across all partners etc. A mixed model of the integrated mental health service collocating with additional partners would require review of the S75 and its schedules. If a service involving line management and seconded duties by new partners was the way forward, a new Section 75 involving the new partners would be required. Each opportunity for integration should evaluate the best model for delivery.

[9] Enhancing the Quality of User Involved Care Planning in Mental Health Services (EQUIP)

5. Current delivery of integrated services and delegated functions

This section focuses on the delivery of delegated functions of service delivery and line management in the integrated services included in the Section 75s across Coventry and Warwickshire and listed as:

- Central Booking Service
- Acute IPU which includes the Crisis Resolution Home Treatment Service
- IPU for services provided under Care Clusters 3-8 (non-psychosis)
- IPU for services provided under Care Clusters 10-17 (psychoses) which includes rehabilitation services
- IPU for services provided under Care Clusters 18-21 (dementia) The Dementia Team

The Section 75 states that *"the integrated practice units are locality based"* It is not clear what this means in terms of the current delivery as this reflected the original Section 75s when services were delivered from more localities across Coventry and Warwickshire than they are now.

This section reflects the views of staff and managers that were interviewed, took part in one of the focus groups or responded to the questionnaire. The findings are divided into Coventry and Warwickshire experience. More specific responses relating to how staff are managed are in later sections of the report.

5.1 Central Booking System (CBS)

The Central Booking Service is one of the services included in the integrated service arrangements in the Section 75s following the service redesign in the Trust. It is an important service not only for ensuring that mental health referrals are dealt with effectively and efficiently but also that referrals relating to safeguarding and people with mental health problems who have an appearance of need for care and support under the Care Act are dealt with appropriately. The CBS team is not multi-disciplinary; there is no social care professional presence in the team.

The CBS manager and staff described their role and the challenges they face. They felt that the CBS provided a triage service to a high volume of daily referrals mainly by phone and fax and the majority from GPs, followed by other professionals such as the Police, and then self referrals. They felt that the service was well situated alongside the IAPT call hub and with the MIND navigators helping them to ensure that referrals were directed promptly to these services if appropriate.

Referrals are triaged for response time, those deemed "Urgent" are passed to the Crisis Team if the service user is unknown and onto the other IPUs if they are currently being care coordinated. The remaining referrals are deemed "Routine". IPU operational policies are used to assist in deciding which of the IPUs the cases should go to. However feedback CBS get and during this review was that the IPUs did not always feel that referrals had come to the right team or that the triage process was not deep enough to establish whether the referral needed the expertise of the IPU. CBS book slots into the team's diary for initial assessments to be undertaken. Appointments are slotted in by date order and are not prioritised in any other way.

CBS record safeguarding concerns that come into them and pass these on for concern decision making to Team Managers.

CBS do not have access to the Warwickshire record system CareFirst to see if service user is already know to them, particularly for referrals to IPU 18-21, and whilst they have access to the Coventry system Care Director they are denied access to the system if they have not logged in for 30 days or more.

The Trust Safeguarding team and Council professional leads work with CBS to ensure appropriate responses to safeguarding referrals are made. In addition the social care professional leads have worked with CBS to ensure that referrals to the integrated mental health, for a social care assessment are forwarded to the appropriate team to ensure that the statutory duty of assessing someone with the appearance of care and support needs is fulfilled. This includes people who are appropriate to be assessed by mental health social workers but may not be appropriate for health professional involvement.

The CBS manager and team said that the training they have for the job is in the use of STORM and the Trust's statutory and mandatory training, Care Act training that was provided by the Council's and "on the job" training from the manager and peer support.

The Team managers and locality managers for the IPUs in Coventry and Warwickshire expressed concern that the CBS has difficulty in triaging the high flow of referrals into the Trust. They said that:

- People are booked in for initial assessments with the team in date not priority of need order
- The process of booking people straight into initial assessment slots predetermines potential next actions
- IPUs do not always agree with CBS that their IPU is the correct destination for the referral
- Retriaging is required to see if the referral has been directed to the correct IPU or whether more appropriate action is required e.g. signposting to other services, redirecting back to primary care
- They would prefer to triage and decide whether and what types of interventions are required at an earlier stage themselves

Some of the findings of the recent evaluation of community mental health services[10] included:

- Stakeholder views were that the CBS was not working effectively
- With the wide remit of the service, was the CBS equipped with the skills, expertise and tool to triage successfully
- During the evaluation period acceptance of referrals by CBS varied between 68% and 90%
- Generally around 85% of referrals to IPU teams from the CBS are clustered – in any cluster, not necessarily one of the correct clusters for that IPU
- Did Not attend (DNA) rates were consistently higher for IPU 3-8
- Clinical triage is risk adverse and cases are forwarded to the IPU teams for them to assess as appropriate or not. This places further pressure on the teams, particularly the 3-8 IPU teams.

From the responses in this review and from the evaluation by Mental Health Strategies, the single point of access provided by CBS feels more like a sorting house without the resources or expertise to undertake a deeper health and social care triage. If this could be improved and reduce the demand for specialist IPU input, this could alleviate the demand on teams and enable staff to be more able to work with cases that require their unique professional skills.

The options would include looking at a more holistic deeper triage process from an integrated multi-disciplinary single point of access that will enable supportive diversion where appropriate with third sector and community based services or return the clinical triage function back to locality teams to manage. The former would involve remodelling of both health and social care resources. The latter enables the already integrated IPUs to manage the flow into the service with appropriate integrated

[10] Final report: Evaluation of the Integrated Practice Unit approach, Mental Health Strategies, 2016

approaches. The managers there have a long experience of managing legally delegated social care functions and can ensure that referrals predominantly for social care are appropriately responded to. An appropriate preventative health and social care response could still be offered at the front door with MIND navigators.

Whichever approach is taken will need the involvement of the social care Partners to ensure that social care referrals are appropriately responded to.

5.2 Crisis Resolution and Home Treatment Service

This team provides 24/7 support and treatment for people experiencing a psychiatric crisis and home treatment as an alternative to hospital admission. They are multi-disciplinary and contain AMHPs who provide the Mental Health Act Assessment service from within the Crisis team and not by the AMHP hubs.

Both Trust and Council management value the Crisis service being integrated ensuring that the health contribution of therapeutic skills and medication monitoring by health staff and the social care and AMHP skills of legal literacy , working with family, community, housing and other support networks can be brought quickly together for the benefit of the service user.

In general the Crisis teams work with service users for up to 6 weeks and then are either referred onto the IPUs, back to Primary care, onto the third sector or no further action. There can be difficulties passing on work to IPU 3-8 in particular, which has a high incoming workload.

5.2.1 Coventry

The key role of the AMHP in the Coventry Crisis team involves undertaking Mental Health Act Assessments emanating from within the team, from University Hospitals Coventry and Warwickshire NHS Trust, the Section 136 suite at the Caludon Centre and social circumstances reports for Mental Health Tribunals. My understanding is that the latter are only undertaken by AMHPs in Coventry. AMHPs, like their colleagues undertake initial assessments and duty. Their case work is focused with people who have complex needs and with family networks but this contribution is limited due to the demand of the AMHP work. One AMHP focuses particularly on work with people who have dementia. The AMHP on duty attends the twice weekly MDT meeting but there is not social care representation at the clinical caseload review meeting. Support workers in the team follow up needs relating to housing, benefits and referral to food banks.

The AMHPs focus of work is in meeting their AMHP duties and the increasing demand for Mental Health Act assessments such that the health and social care components of the team feel to the Trust as more collocated than integrated. The AMHP function is not a delegated function and it appears to the Trust that in Coventry, because of the demands of the AMHP role, the role of the professional supervisor and the line manager appears to have become more blurred with the Senior Practitioner taking on more of the line management role.

It was difficult to establish the amount of Care Act work undertaken by the team. There was comment by some respondents that this is not given priority due to the demand of AMHP and other team duties.

5.2.2 Warwickshire

Warwickshire Crisis

Whilst the AMHP work takes priority for the AMHPs they do participate in the day to day work of the team. They undertake Mental Health Act assessments for Crisis team services users and people

unknown to the mental health service. It is felt by staff in the Council and Trust that AMHPs being located in this team undertaking these assessments rather than from the AMHP hub is a good model. The AMHPs can work with their colleagues from other professions to look at less restrictive alternatives to compulsory admission.

It is not evident how much Care Act activity is undertaken in this team though it is undertaken by AMHPS and CPNs when required and mentioned in focus groups and interviews.

Although the AMHP work is integrated into the teams work the rota is done by a Council Lead Practitioner who has to arrange for the north and south Warwickshire Crisis AMHP service to be covered in and out of hours.

5.2.3 Summary

It is seen as positive that an AMHP service in both Coventry & Warwickshire is located in the Crisis teams and not in the hubs. This enables an integrated approach to be taken to assessing crisis situations and looking at all appropriate alternatives before an application for a compulsory admission is pursued. The predominance of this work appears to limit the contributions of AMHPs to the other work of the teams particularly in Coventry. It is not evident how much Care Act work is undertaken in these teams. Data on this by IPU is not readily available but would be useful so that managers can compare the activity in this area for their teams and evaluate how much time their team spends on this work. The teams have had AMHP vacancies in the past but the situation is improving.

5.3 IPU 3-8 Non-psychosis

These teams provide an integrated health and social care service to people with severe and/or complex anxiety, as well as mood and personality disorders. There is a high demand on this service with long waiting lists reported.

5.3.1 Coventry

The team has 60+ staff, receives a high number of referrals and covers the whole of Coventry City. It has 2 Team Managers (one of whom is a seconded social care employee) and two Deputies all of whom are in the Trust's line management structure, and supported by one Senior Practitioner who is seconded and is part of the social care governance structure. The team is subdivided into three sub teams each with a weekly meeting and a daily morning handover. The health team manager manages the referrals and the waiting list for the whole team. Not all team members are located together which doesn't help the team to work in a fully integrated way.

The CPNs undertake all initial assessments and then cases are theoretically allocated according to the predominant skill requirement. The type of cases that are allocated to the social workers and AMHPs are complex social care situations such as family, needs are physical and mental health, safeguarding, legal complexities, and where there is an appearance of need for social care and support. However when there are staff vacancies cases may not be allocated according to professional skills and strengths.

The introduction of the community care worker has provided assistance to care coordinators by undertaking social care well-being assessments and reviews, whilst the care coordinator retains the responsibility for doing the care and support plan. This role not only oils the wheels by undertaking the social care documentation and ensuring the process is followed but will also undertake a signposting role and ensure that where other ways of meeting a social care need is appropriate this is considered.

There were comments from health and social care staff that even though there was a health and social care manager in this team this hasn't led to enhanced integration in the team and at times it has felt to some that it has fostered "silo" working.

It has not been possible to evaluate what percentage of Care Act process work this new role has taken from the care coordinators and how much of the social worker and AMHP roles are enabled to take on more complex social care work. From comments in the questionnaires there is a general feeling that care coordination and the "health agenda" takes priority. This is a common theme.

5.3.2 Warwickshire

As with the Coventry IPU 3-8 there is a high demand for service and a long waiting list. The social workers and AMHPs participate on the duty rota and undertake initial assessments.

As with the Coventry IPU it was reported that social workers are more likely to be allocated work where there are complex, social and family situations and where inter agency work is more predominant. Social workers also do team duty two days a month and initial assessments. Social care staff felt that Care Act duties were undertaken with the support of SDS workers.

It was felt that the role of the Lead Practitioners and the SDS workers enable more joined up working whilst the latter assisted with some of the social care processes that need to be followed to secure a personal budget.

5.4 IPU 10-17 Psychosis

These teams provide a specialist services to people with major affective and psychotic disorders including an early intervention service.

5.4.1 Coventry

The management arrangements in this team are similar to that of the Coventry IPU 3-8. It is a large team subdivided into 3 mini teams, managed by 2 Team Managers and 3 Deputy Managers and supported by one Senior Practitioner who is part of the social care governance. The social care seconded manager manages one of the mini teams. There is a weekly meeting and a morning handover session. There is a high level of forensic work and the team uses a Shared Care approach to enable a multi-disciplinary approach to high risk cases.

Social workers are more likely to be allocated cases where the service user may have care and support needs and likely to be eligible for social care and support. However staff reported that often they are allocated cases that may be more appropriate for a health professional e.g. where the main focus is to monitor medication. It was also reported that sometimes a case was allocated to a social worker when there was already a nurse involved regarding medication. Whilst it was felt that this was due to staff shortages it does not seem appropriate use of team or social work resources.

The Community Care worker role has been introduced to support this team to support the Care Act duties that the care coordinators have.

5.4.2 Warwickshire

Social work staff are likely to be allocated cases that have complex family dynamics, involve interagency working and safeguarding enquiries and planning. It was felt at times that cases are allocated to social workers where the primary focus was medication monitoring and has at times involved collecting medication from the hospital. A task that was felt not best use of their time and

skills. They also felt that they were more likely to receive the most complex cases due to loss of experienced nurses in the team.

5.5 IPU 18-21 Dementia

These teams provide the Memory assessment service and the community dementia service. Referral routes into the service are from the Central Booking service, Adult Social Care, the Councils Customer Service Centres and the Memory Assessment Service.

They along with other community services were subject to both a Care Quality Commission (CQC) inspection and a review by the West Midlands Quality Review Service in 2016[11]. The review team noted that:

- The number of referrals exceeded capacity by 50%
- Waiting times for assessment exceeded 12 weeks
- Multi-disciplinary working arrangements were not well developed
- Arrangements for social worker involvement in these IPUs appeared variable
- Staff reported that clinical and managerial supervision was not embedded

The CQC made a number of recommendations in relation to IPU 18-21, including the Trust must:

- Ensure that staff, receive, and record supervision in line with their policy
- Should take steps to improve communication and consistent practice in Coventry IPU 18
- Should ensure that all patients be offered a copy of, and understand their care plans
- Should ensure that care plans are holistic

All of these are relevant to the successful operation of and requirements in the Section75s.

In response to the CQC findings, the Trust has an improvement plan to address these issues which includes:

- The revision of the supervision policy - which is reported to be now on the intranet, and monitoring recording of supervision on the Trust system.
- Appointment of an additional Team Manager in Coventry 18-21 – the additional Team Manager is now in post.
- Work with staff on care planning has been undertaken and is to be monitored by audit.

Traditionally, dementia teams are likely to require skilled social work involvement to manage complex situations and arrange care and support that is the least restrictive , enables service users to stay in their own homes as long as possible and ensure that carers receive the support they need.

5.5.1 Coventry

It is understood that the nurses in the team are fully deployed in the Memory Assessment Service and the occupational therapists and social workers work in the community dementia pathway. As a result it is mainly the latter staff who do initial assessments, care coordination and undertake social care needs assessments, care and support plans and arrange social care services. The social workers focus on cases that involve them in arranging services to help people stay at home longer and carers to continue caring such as respite and looking at alternative accommodation options. They review care packages and do Best Interest Assessments and DoLS reports. Nurses do work with nursing homes around managing challenging behaviour. However there was also a view that there was not as much support as there needs to be to assist in manging challenging behaviour that may occur sometime

[11] West Midlands Review of Community Mental Health services, West Midlands Quality Review Service Coventry and Warwickshire Health Economy, West Midlands Quality Review Service, January 2016

after diagnosis. Although there was a feel that although the roles are more demarcated due to the service structure the team felt more integrated.

5.5.2Warwickshire
As with the Coventry service the CPNs in the team work mainly in the Memory Assessment Service with occupational therapists and social workers in the main focussing on the community dementia care pathway. The social care staff in the teams are allocated similar types of cases as in Coventry IPU 18-21 and the roles are similarly more demarcated than in the other IPUs.

Social workers felt that there was more duplication in the recording they have to do with the forms required to assess social care eligibility, determine an estimated personal budget and social care and support plan. Assistance is now available to them with some of this from the SDS workers. However they reported that they have to arrange a further visit to the service user to undertake this work with the SDS worker.

In the north of the county, unqualified social care workers support care coordinators with the process of obtaining an estimated personal budget and arranging services. There was also some concern that the social care staff used to do the carers assessments in this IPU and that now these are referred onto the carers workers. The feeling was that there were a number of internal referrals that make the process disjointed where once they delivered the whole process.

5.2.3 Case transfers between IPU 18-21 and Older Peoples services in the councils.
There is a protocol for transfer of cases to the Councils for a service user whose situation is stabilised and when they are in receipt of funded social care services. This appears to work relatively smoothly in Coventry and south of the county. There was occasion when the north Warwickshire IPU 18-21 refused to accept referrals from the Older People's team due to capacity issues. The relevant managers have met and discussed this and this has led to a review and an updating of the transfer protocol in Warwickshire. It is recommended that this transfer is appended to the relevant schedule in the Section 75 and the Coventry transfer protocol is likewise appended.

5.6 Administrative support for the delegated social care functions
In Coventry and Warwickshire the councils have seconded administrative staff and located them in the IPUs. However they are now line managed by a central administration hub in the Trust and not from within the IPUs.

The purpose of the secondment of administration staff into the IPUs was to support the delivery of delegated social care functions. In Warwickshire their roles are specifically around supporting implementation of the Care Act, accessing CareFirst, and supporting seconded staff, though it is understood that this work is shared out by the administrative staff in the teams. There is a senior administrative person in the council's mental health management team who provides support and ensures that their appraisals are undertaken. There is no indication that this arrangement is not working well.

In Coventry, it would appear that administrative support is used more generically and utilised in non-integrated services and not necessarily related to delegated council functions e.g. covering reception for other services such as GP practices and primary care. This is not part of the integrated service described in the Section 75. Seconded administrative staff reported that the social care work is generally not shared out although they are expected to do health related work. There has been some concern over the management of vacancies in the administrative service, with it being perceived that Council vacancies are not tolerated whilst Trust vacancies are. There is concern that line management

functions are not carried out well and not within the arrangements outlined in the Section 75. The distribution of Trust and council work, with priority of seconded staff undertaking council functions along with an understanding the responsibilities of managing seconded staff requires attention.

5.7 General findings

Interviews with managers, focus groups with staff and questionnaire responses all indicate that staff and managers perceive that demand has risen, caseloads are high and that waiting lists have become the norm particularly in IPU 3-8. The IPU structure has led to some large teams of staff. There was consistency amongst managers and staff on the types of cases that would normally be allocated to social workers and AMHPs including that they were more likely to be allocated the most complex cases. However, due to the demand cases were more likely to be allocated to who had most capacity to take them.

An evaluation of the IPU approach was undertaken on behalf of the Trust by Mental Health Strategies[12]. Their overarching recommendation was *"…..a detailed review of the capacity and demand on the IPU system of care delivery is undertaken. This should incorporate the care pathways into, through and out of IPUs together with the detailed modelling of optimum staffing complements to deliver the service as well as the gate keeping and support functions".* These care pathways should include social care pathways.

The Trust in conjunction with the councils is actively reviewing the delivery model in IPU 3-8.

With the reviews and inspections to date it is difficult to ascertain whether they have been undertaken with a full understanding of the specific arrangements in Coventry and Warwickshire undertaking delegated social care functions and social care staff undertaking care coordination. In most IPUs there is a significant overlap between the role of social workers, CPNs and OTs, all undertaking initial assessments, care coordination and direct work, with assistance from CCW/SDS workers to arrange social care and support with the exception of IPU 18-21 where there appears more demarcation between the roles in both Coventry and Warwickshire.

With the review of IPUs, it is timely for the Section 75s now to be clearer on the outcomes to be delivered and transparent on how the health and social care resources are used to deliver them. Some social care staff have reported in this review that they feel, due to staff shortages, they are being allocated more cases that they might have previously expected to have been allocated to a nurse. Similarly Trust managers have felt that health staff have absorbed more of the generic duties of initial assessments and care coordination, at times of AMHP shortages when more time has needed to be spent by fewer people on Mental Health Act Assessments. It is important that the value and benefits in genericism do not outweigh the valuable contribution each profession uniquely brings.

It is recommended that work is undertaken by the Partners to agree and use an allocation framework that is transparent to health and social care staff which provides an allocation pathway based on required skills and knowledge of all professions.

In order to balance the demands of AMHPs on their AMHP and team work it is also recommended that Partners agree and use a consistent workload weighting model.

[12] Final report: Evaluation of the Integrated Practice Unit approach, Mental Health Strategies, 2016

It is difficult to comment whether the IPU approach and increase in demand has resulted in any differences in the quantity or quality of social care delegated functions delivered. The staff questionnaire did contain a number of comments that seconded staff felt that more emphasis was given to the medical model of service delivery with less emphasis and time available to consider service users social care needs. Output measures such as provision of direct payments and arranged social care services will have been effected by other factors such as changes in recording systems effecting data quality and reports. Statutory measures such as service users in settled accommodation and employment show little differences and are a narrow measure of social care outcomes. The numbers of people in receipt of services is no longer a satisfactory measure of the effectiveness of interventions to meet people's social care outcomes. The skills involved and how well community and universally available solutions are used to assist service users achieve recovery, social inclusion are as important. Case file audits could demonstrate this and how well assessments and care plans meet Care Act compliance along with revised set of Section 75 performance indicators. The results of both should be at team level so managers and staff know how well they are doing. How delegated social care services are assessed and arranged has changed with the introduction of CCWs in Coventry and the extended scope of SDS workers in Warwickshire.

One of the service reviews mentioned that service users receive at least one initial / trusted assessment. This initial assessment contains a section on appearance of social care and support needs. Anecdotally this is reported as not being filled in very often. The Partners could focus on reducing the duplication of trusted / initial assessments and improve the quality of information on social care needs in the initial assessment to provide a more holistic assessment. The Councils could then consider receiving these as their wellbeing / needs assessments if systems are flexible enough to support this approach.

6. Safeguarding

All three Partners organisations follow the West Midlands Adult Safeguarding Policy and Procedures however the way that safeguarding work is recorded and reported on is different in Warwickshire and Coventry.

In the integrated teams in Warwickshire both Trust and seconded Council employees use the Trust's system to record safeguarding activity and the Trust reports aggregate data on the incidence and profile of Safeguarding Adults activity to the Warwickshire Safeguarding Adults Board. A Council Lead Practitioner has management oversight with the Trust Safeguarding Manager on all safeguarding enquiries that are closed to ensure that no further action is required and that the process has been carried out satisfactorily. The individual service user information is recorded in the service user's record with plans and risk assessments on Care Notes.

At the time of the last review of the Warwickshire Section 75, safeguarding activity and reporting was particularly focussed on. Assurance was required about the training of staff, and recording and reporting of safeguarding concerns and enquiries. The position now is such that both the Trust and the County Council report that they have confidence in the process and reporting system along with the strengthened management oversight.

In the integrated teams in Coventry, safeguarding information is recorded on the Council's Care Director system, by health and seconded staff. This entails both health and social care practitioners in teams having to use both the Trust's Care Notes and the Council's Care Director system to record safeguarding information for the service users' record and for reporting purposes. The incidence and profile of Safeguarding Adults activity in mental health services is reported to the Coventry Safeguarding Adults Board by the Council.

Trust Locality Managers in Coventry say that the information they get back is "patchy" and the numbers lower than expected. If Trust staff haven't logged into Care Director for a certain period of time they report getting locked out and do not feel access is easy. The Trust would like to move towards using the same approach across Coventry and Warwickshire. Coventry Team Managers have a similar view though state that safeguarding is easier to record on the new Care Director system and they can scan the documents onto Care Notes. Practitioners and managers would prefer to record information on one system. Given the assurance Warwickshire has developed with the Trust in recording and reporting on safeguarding information, it is recommended that Coventry consider moving to recording and reporting on safeguarding from the Trust system and develop an assurance process with the Trust.

There has been some concern that the Dementia Team in Coventry[13] was having difficulty in managing its response to safeguarding concerns. A second Team Manager has been recruited to increase management capacity and the additional manager is now in post.

Safeguarding training is provided by the Trust to all staff in the integrated teams and it is part of the statutory and mandatory training. This training also includes adults and children's safeguarding and DASH training. Seconded staff also do their own Council's training.

[13] West Midlands Review of Community Mental Health services, West Midlands Quality Review Service Coventry and Warwickshire Health Economy, West Midlands Quality Review Service, January 2016

Since the last review of these Agreements Cygnet Hospital Coventry has opened and the Trust and Coventry City Council have been working together to produce a process for managing safeguarding referrals in relation to inpatients at that hospital.

The Section 75 Performance and Operations Group oversee safeguarding activity, data collection and the process in the integrated services. A more thorough monitoring of the process is undertaken by a Section 75 Safeguarding Sub Group which currently isn't in the Section 75s. The Safeguarding Schedules in both Section 75s require that case file audits and quality assurance exercises are undertaken and how this is done is to be led by the Section 75 Performance and Operations Sub Group. A qualitative case file audit would give all Partners assurance that the training and management support results in safeguarding concerns being appropriately identified and followed up. There was no audit report that neither focussed on this available for the review nor reported in Strategic Section 75 Board minutes or the annual review report.

The safeguarding data set could be expanded to include service user safeguarding outcomes and how well they are met.

The safeguarding data set could be expanded to include service user safeguarding outcomes and how well they are met.

7. Mental health services not currently included in the Section 75s

7.1 Arden Mental Health Assessment Team (AMHAT)

AMHAT offers a psychiatric liaison and risk assessment service in acute healthcare settings, like the Accident and Emergency (A&E) department or wards of local hospitals. Its purpose is to ensure timely care and treatment for patients who have acute mental health issues, when they attend physical healthcare settings, like hospital. The service is provided in South Warwickshire NHS Foundation Trust, George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust.

There are no social care practitioners in this service currently although it is being considered. Guidance from JCPMH[14] does not suggest that social care practitioners are essential components of AMHAT services but that there should be effective liaison with other parts of the health system, social services and non-statutory agencies. NICE[15] say that liaison mental health services should have access to appropriate staff either on the team or through contractual arrangements to ensure that there are no delays to the start of a Mental Health Act assessment should one be required.

However the Partners, with the commissioners, may see this as an opportunity to address the preventative social care and mental health agenda in an acute hospital setting whilst also ensuring that there is AMHP capacity readily available when needed. The critical mental health social work skills in working with complex situations with family and social networks may contribute to the reduction of readmissions. If it is decided to locate a social work post in the AMHAT service consideration should be given to other models of integration. The service is relatively new and the existing Section 75s came about after considerable work was undertaken to bed in a collocated service with sharing of values, culture systems and ways of working. Whilst the Section 75 provides a framework for including the AMHAT service into the Section 75s Partners might want to consider a collocated approach without delegated social care duties and line management in the first instance.

7.2 Clinical Review Team

This team is not listed in the Section 75 as part of the integrated service and undertaking delegated functions. It does not have any staff seconded into it from either Council or directly line managed by its manager. Coventry does have an AMHP who works with this team, however this post reports directly to a Council manager. The only reason this team should be considered to be included in the integrated services would be if it had seconded staff within the team under direct line management and/or members of the team were involved in reviewing care and support plans funded by the Council on behalf of the Council. If that is the case, then serious consideration should be given to inclusion of this service in the Section 75 and social care functions and outcomes clarified and monitored.

7.3 The central administration hub

As previously mentioned seconded administration staff are line managed by the central administration team. In view of that this team should form part of the integrated service. As it is they are operating outside of the Partnership Agreement. The service should either be included in the Section 75 enabling the Partners to begin assuring themselves that these seconded staff are being managed in line with the Human Resources protocols, their terms and conditions of employment with the Council and are responsible for ensuring the delegated duties are carried out, or they should be

[14] Guidance for commissioners of liaison mental health services to acute hospitals, Joint Commissioning Panel for Mental Health, 2012

[15] Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance, NICE , 2016

seconded directly into the IPUs. If the former, the line managers should be supported with some training around the purpose of the section 75, its legal status and the functions that are required to be carried out.

8. The AMHP Service

8.1 Coventry

Prior to the move into IPUs there was nearly a full establishment of AMHPs, evenly spread across the community teams and who were doing assessments emanating from their own teams and were doing AMHP duty much less frequently than they are now. Following the service redesign most of the AMHPS moved into the Psychosis team 10-17. The current situation is that there are AMHPs in the Crisis team that provide Mental Health Act assessments for that team. The remainder are rostered into an AMHP hub and are dedicated to AMHP work at that time. The General Manager for Social Care Governance and the two social care Team Managers are also rostered in albeit at a reduced level.

It is understood that some AMHPs left their posts due to the conflicting demands of managing a case load and AMHP responsibilities. There was a reported cessation of AMHP training at the same time. It is understood that this resulted in a significant reduction in the AMHP numbers. Training has resumed and there are staff willing and waiting to be trained. The numbers have yet to reach the pre IPU state and some AMHPs are concerned that some forward workforce planning is required to take account of when AMHPs may retire. There are currently five social workers on Stage 1 AMHP training, one on stage 2, and two have expressed an interest in commencing the training.

It is understood that it was originally planned to have four AMHPs rostered in each day, however at times of sickness and leave it is hard to achieve three. AMHPs report that they usually do 2 or 3 assessments a day but there have been days when as many as eleven referrals have been received in the hub. It was reported that some managers but not all give staff dedicated time after their AMHP days have ended to complete their documentation. Crisis team on call AMHPS are not required to work the following morning if rostered in if they have been called out.

The AMHP hub provides a supportive environment, with access to peer and Senior Practitioner support and where the stresses of balancing team duties and AMHP work can be minimised. Social workers and AMHPs also get support and knowledge via the Social Worker/AMHP forum. However in addition to the rise in referrals, other factors such as lack of local beds, out of county assessments and sometimes access to doctors who can make a recommendation under the Mental Health Act has made the task more challenging and stressful.

AMHPs at the focus group reported that their caseloads vary between 12 to 20 or more and that they often are allocated the more complex cases, such as combinations of dual diagnosis, service users who do not engage with services, multi-agency work, accommodation needs, social care and support provision. Alongside this in some teams AMHPs do team duty and undertake initial assessments. They feel they are allocated the most complex work sometimes because of a combination of their expertise and inexperience of newer members to the team. Their expertise could be used differently by using them to support new workers and build expertise in the teams.

Some AMHPS have thought about a dedicated full time AMHP hub which would take away the conflict between managing AMHP responsibilities and care coordination and other team duties however there was also recognition by others that this would result in deskilling in other mental health skills, awareness of approaches and therapies delivered from the teams that might be beneficial to service users and minimise the benefits of multi-disciplinary working. Another way forward would be to re-examine the balance of AMHP work and team work by having a consistent and transparent approach to work and caseload management built on a set of commonly agreed principles. AMHPs reported

that their caseloads have been reduced; however managers reported that this can vary between 20 to 50%. AMHPS reported reductions in caseloads between 20-25%.

8.2 Warwickshire

The Warwickshire AMHP hub came about at around the same time as the Coventry hub as a result of an increase in referrals and AMHP vacancies and impact of the introductions of IPUs. The Crisis team retained AMHPs.

Since the centralised service in the hub was introduced, some Team Managers find it more difficult to manage the AMHPs absence from the team with the increased demand for their services that they are experiencing. Initially AMHPs were out of the team for a week at a time. The current arrangement is based on approximately six days a month in blocks of three days with 2-3 hours time to complete documentation the next day. Any toil accrued through AMHP work is expected to be taken in AMHP duty time by arrangement where possible.

One Team Manager reported that the advantage of the hub was that the AMHPs absence from the team can be planned for. However on occasions AMHPs need to be pulled into the hub at short notice to cover sickness or peaks in demand. Sometimes Team Managers question why their AMHP(s) are on the rota so much when they have work they need to allocate or have initial assessments booked in. The primacy of the AMHP duties undertaken by seconded staff needs reinforcing in some areas.

Some AMHPs report that there remains tension within the team about their requirement to undertake AMHP work as a priority over the increasing demands on the teams. However an AMHP from one of the Crisis teams said their manager was particularly supportive, provided protected time and explains the role well to the team.

AMHPs have reduced caseloads because of their AMHP duties. It is not clear whether this is an agreement based on a workload weighting system. However there is some concern that whilst the number of cases may be capped this is often countered by AMHPs being allocated the most complex cases.

AMHPs find the hub a supportive place to work. Along with peer and Lead Practitioner support there is relevant information to hand. The Crisis team AMHPS feel it more isolating not working from the hub but this is compensated for by peer support from their Crisis AMHP colleagues and the AMHP forum which all Warwickshire AMHPs go to. An improvement identified would be read only access to CareFirst to see if a referred person was known to Adult Social Care, or administrative staff located in the hub to assist with this and other administrative support. The AMHP hub is based in the Railings where it is reported that there are problems with Wi-Fi and some staff needing to use their phones as Wi-Fi hotspots.

8.3 Protected caseloads for AMHPs

From the interviews with staff there is a perception that the reduced caseloads mentioned do not significantly help AMHPs to balance their workload and AMHP work. Two questions in the questionnaire were asked in order to explore this further. The first was “If you are a care coordinator please indicate the number of cases currently open to you.” The responses for this are shown in table 1 below. Responses were filtered to ensure that staff who were likely to be a care coordinator and worked in an IPU were taken account of. It appears that social care staff were likely to hold the same number of cases whether they were AMHPs or not. Unfortunately it is difficult to compare the responses with those from the Trust as one member of staff in IPU 18-21 who responded had 43

cases, the next highest was 22 which does effect the average significantly. It is difficult to draw conclusions due the lower response rate of this question particularly from the Trust and the variance in the responses was quite high which indicates that some teams may enable a greater reduction in caseloads than others. However it warrants further analysis as it appears there is little difference in caseloads for AMHPs and non AMHPs. Caseload information is available from Care Notes which would be a starting point for further analysis.

Table 1: If you are a care coordinator please indicate the number of cases currently open to you.

	No. of cases held by AMHPs in community IPUs		No. of cases held by other care coordinators in IPUs	
	Range	Average	Range	Average
Coventry	7-20	16	7-23	16
Warwickshire	10-21	16	9-22	17
Trust	Not applicable		0-43	13

The second question "How well are you supported to manage your workload / time boundaries and spread of tasks (e.g. balancing care coordination , AMHP and other statutory duties) shows how well staff felt managers supported them in competing the demands of their job. Table 2 below compares the total responses from all three organisations and the AMHPs from Coventry and Warwickshire. The range is zero not at all to 4 very well.

Table 2: How well are you supported to manage your workload / time boundaries and spread of tasks (e.g. balancing care coordination, AMHP and other statutory duties)

	No. of responses	Range of responses	Average response
All Coventry responses	37	0-4	2.97
All Warwickshire responses	42	1-4	4.2
All Trust responses	32	1-4	3.81
Coventry AMHPs	13	0-4	3.42
Warwickshire AMHPs	13	1-4	3.92

Whilst the Trust does not have AMHPs, the question was posed in a way to dee how well staff felt supported in managing competing demands in their workload. There appears most satisfaction with Trust staff and least with Coventry staff where there was the widest range and lowest average response. Some of the comments below describe how some staff feel about the support they receive:

"There is a difficulty in prioritising Crisis Work and statutory duties and this is sometimes unclear"

"I feel that I am very well supported but still find that managing the role of care co-ordinator and AMHP creates a lot of work which seems impossible to fit into a working week"

"Manager is very supportive and agrees that working part time and being on AMHP rota makes work role very stressful but cannot do much to change situation"

"Sometimes feel torn between being a care co-ordinator and an AMHP. Health are interested in one role and social services in the other"

"Sometimes we are the only AMHP available, especially at night and at weekends. Therefore, we have to manage our own workload, prioritise etc."

"inevitably feel overloaded and spread too thinly - compromising statutory requirements"

The Warwickshire AMHPs felt supported by their managers but felt that their line managers were not empowered to help any further. The majority of comments made were around continuing to have to struggle to balance the roles and a common theme was that the AMHP felt torn between health and social care competing priorities. The comments from the Coventry AMHPs suggest they feel less supported and having to manage the competing priorities on their own. The high satisfaction rate in the All WCC responses row is partly attributable to a high response rate in the questionnaire by staff in the social care management and support team who have clearly defined roles and do not have competing priorities from health and social care.

8.4 Summary

The AMHP hubs in Coventry and Warwickshire appear to be a more successful way of managing the demand for AMHP referrals. Both have Senior / Lead Practitioner presence to manage and prioritise the demand and provide support which is appreciated by AMHPs. There remains the tension in balancing AMHP duties and team work which can include team duty, initial assessments, contacts, care coordination, delegated social care functions and meetings. As previously mentioned, an agreed and transparent work load weighting system applied consistently across Coventry and Warwickshire to ensure there is consistency in numbers and types of work allocated to AMHPs.

Although there are difficulties in recruiting AMHPs nationally, both councils should continue to strive to ensure that AMHP vacancies are minimised. With the Think Ahead scheme and the ability for other professionals to train as AMHPs there are other opportunities to address this issue.

Although most managers appreciated the pressures on AMHPS and that it is their prime responsibility they also feel conflicted with the demands of the incoming work and care coordination role.

9. Managing and supporting seconded staff

Both Section 75s have a Schedule outlining the Joint Operational and Human Resources (HR) Protocols. These contain detail in more than 20 areas. The Coventry and Warwickshire schedules are similar but not the same. Staff and manager focus groups, interviews and questionnaires looked at how 5 areas in particular were perceived to be operating in practice:

- Sickness absence management
- Line management meetings
- Caseload and workload management
- Professional Supervision
- Appraisals

Some other areas were raised by interviewees or focus groups, such as seconded staff felt that they are not always given the same consideration as their health colleagues over practical matters such as car parking arrangements.

In order to support Team Managers to undertake their HR responsibilities for seconded employees they need access to both HR policies and procedures of the Trust and the Council and access to Council HR staff.

9.1 Managing sickness / absence

In practice Senior/ Lead Practitioners and other council mental health managers often took a lead in managing some of the issues such as sickness absence when it had been discussed with them by the Line Manager. Trust managers in Warwickshire have access to HR policies and procedures on the internet and have had some quick and easy guides developed for them by the Lead Practitioners. In Coventry the council seconded Team Managers access their employee's policies and procedures on the council intranet and the Trust's internet for Trust employees. Other Trust managers in Coventry have difficulty accessing the council intranet if they haven't used the system for a while. The nature of the integrated service is that staff must be managed in accordance with their employer's policies and procedures which inevitably mean using two.

Trust managers in Coventry and Warwickshire perceive that some of the council HR policies do not support them as well as the Trusts ones do in managing their teams. In particular they feel that the Trust's policy and procedure on sickness absence has supported them to reduce staff sickness and absence with Trust employees but the Council policies and procedures do not support them as well. This was mentioned in both Coventry and Warwickshire. Team managers rely on seconded council staff to record sickness and receive information when triggers are hit. There appears to be a difference that in Warwickshire when a trigger is hit the line manager follows this up and in Coventry a council manager will follow this up. The Team Managers do not routinely get sickness reports for their whole team as the information is kept on different systems.

9.2 Line management

Seconded staff should receive their day to day line management from their Team Manager. In Warwickshire IPUs this is likely to be a Trust employee and of a different profession, however in Coventry in two of the IPUs this could be a seconded social care manager from the Council working within the Trust's line management structure.

There is a view in the Trust that line management of the seconded staff in the Coventry Crisis team is exercised more by the Council. This view was not apparent in any other team. However it is

recognised by all parties that the Senior/ Lead Practitioner roles are very active in supporting the line managers to ensure for example seconded employees appraisals are undertaken.

Staff were asked about the frequency of day to day line management and professional supervision. Where the person providing both was from the same profession there was occasionally some confusion about the difference borne out by some comments in the questionnaire.

Warwickshire seconded staff in particular said they received and valued both their meetings with their line manager and professional supervisor.

Table 3: How often do you have a line management meeting with your manager?

	Less than monthly	monthly	More than monthly	other
Seconded staff in Coventry IPUs	6	5	10	0
Seconded staff in Warwickshire IPUs	7	10	5	0
All Trust respondees	9	14	4	0

The CQC inspection commented on the levels of supervision in the Trust and in the previous 12 months period found that 53% received recorded supervision. It was noted that supervision was not always recorded or monitored. The Trust action plan has included a revision of their supervision policy and monitoring the recording practice on their HR system. It is important to remember that seconded Council staff must receive line management supervision in line with the Council policies and at a frequency expected within those policies. As the Council employees are not included on the Trust HR system, Warwickshire Lead Practitioners have set up a system for monitoring and recording supervision. It appears that attention needs to be given to Coventry seconded staff receiving line management 1:1 support more frequently.

9.3 Case and workload management

Seconded staff in IPUs commented on increased workloads and difficulties in competing demands between AMHP duties, social care delegated functions and generic team work such as initial assessments, duty and care coordination. They were asked about the size of their caseloads and how often they got line management support.

From the questionnaires, Table 1 shows that the average number of cases in Warwickshire was 17 and 16 in Coventry. These figures are lower than reported in focus groups when it was quoted as being in the twenties. The Trust result was skewed in that one person had a caseload of 43 and some reported they had 0 cases. Only 7 people answered this question in the Trust. The figures do not include seconded staff in the crisis teams as they described their workload as not predominantly being caseload orientated and this was borne out by the figures.

Table 2 above showed how well supported staff felt in balancing their workloads across the three organisations. Some of the comments from the staff in IPUs are:

"very well supported even though, as a nurse, many duties are not nurse related, i.e. completing forms that used to be social work duties"

"Not supported due to general time pressures of service rather than manager"

"Very supportive health manager so encourages this "

"inevitably feel overloaded and spread too thinly - compromising statutory requirements "

"LM is supportive - however, occasionally social worker(s) feel the pressure of feeling they must accept new cases that need a 'care-coordinator' as the tasks to be completed are deemed as the responsibility of social care and therefore a social worker. This results in additional pressure to accept new cases despite being aware that in reality we are already overstretched in terms of workload"

A review undertaken in 2016[16], stated that registered nurses in IPU 3-8 would hold 30-35 cases, and 20-25 cases for IPUs 10-17 and 18-21. There was no data available for the seconded staff in IPUs. It also went on to say that an expected caseload of 30 for a band 6 practitioner was reasonable but the intensity of work with some service users may be challenging.

9.4 Allocation of work

Across Coventry and Warwickshire there are different ways of allocating work. Most common mentioned were, a discussion between managers (where there is more than one responsible for an IPU), followed by allocation by email or discussion in supervision followed by allocation by email. It was also mentioned that cases could be reallocated if it was found the member of staff didn't have the appropriate skill mix.

In the main managers said they tried to allocate according to skill requirement but often allocated according to capacity due to the demands on the service. There was a common view amongst seconded staff and managers that whilst there was a general view held on what sort of cases were more appropriate to allocate to which staff the roles have become more blurred and a generic demand led approach to allocation has resulted.

9.5 Appraisals

Table 4 shows that the majority of staff had had an appraisal with in the last 12 months with Coventry seconded employees having most responding they hadn't. A mixed picture emerged regarding how appraisals of seconded staff are managed. The Section 75 states that it is the line manager's responsibility to arrange and lead the appraisal of seconded staff and that the professional supervisor should be present. From the interviews this does not seem to be the model that is consistently followed and it is the Lead / Senior Practitioners who ensure that appraisals of seconded employees take place. There is some confusion about whether records of appraisals should be kept in both the Trust and the Council and whose process and forms should be used. This is clear in the relevant Section 75 Schedule.

Table 4: Have you had an appraisal within the last 12 months?

	Yes	No	No I'm a new starter
Coventry	29	6	0
Warwickshire	38	1	7
Trust	25	3	1

9.6 Professional supervision and support

This is provided by Senior Practitioners/Lead Practitioners to the social workers and AMHPs in the IPUs. For other seconded staff and managers whose line manager was of the same profession it appeared that often line management and professional supervision were seen as the same thing.

[16] West Midlands Review of Community Mental Health services, West Midlands Quality Review Service Coventry and Warwickshire Health Economy, West Midlands Quality Review Service, January 2016

Warwickshire has 6 Lead Practitioners aligned to 8 integrated teams and Coventry has 3 Senior Practitioners aligned to 4 integrated teams. In Coventry, where the teams appear larger, it would appear more difficult for a Senior Practitioner to support staff in two IPUs. Warwickshire appears more able to provide the professional support to the seconded staff and the social work leadership to the Trust management to enable the Trust managers to fulfil their delegated responsibilities.

Table 5 shows the frequency of professional supervision respondees to the questionnaires said they had. For both line management meetings and professional supervision the Section 75 describes what this is and what should happen in these meetings including case/work load management.

Table 5: How often do you have professional supervision with your professional supervisor?

	Less than monthly	monthly	More than monthly	other
Seconded staff in Coventry IPUs	7	2	5	6*
Seconded staff in Warwickshire IPUs	10	6	5	1
All CWPT respondees	7	14	7	2

9.7 Training

Both Section 75s have a section on training and development which states that all seconded staff should do the Trust's statutory and mandatory training. In addition to this the Coventry Section 75 details additional required training for seconded staff and Line Managers of seconded staff. It would assist the Strategic Board to know the extent to which this is undertaken and what remedial action may be required if any. In addition to the statutory and mandatory training requirement the Warwickshire Section 75 states the requirements for AMHP training and reapproval but details no other training. It is recommended that the Partners consider reviewing this section to include any other training that is required and may not be in the schedule, and to specify what Care Act training is required for all staff undertaking delegated social care duties and their line managers.

Seconded staff reported that they were required to do STORM and MAPPA training but that there is a long waiting list for this. Whilst Care Act training was provided for health and social care staff undertaking delegated duties, it was reported that it was mandatory for social care staff and not for health staff in the integrated service. This would be inappropriate given that Trust staff have a legal responsibility through the Section 75 to undertake and manage delegated social care functions. Some seconded staff felt that legal literacy courses should be offered to health staff who line manage seconded staff.

9.8 Health and safety

The Section 75s state that the Trust's health and safety policies and procedure are followed. New lone working devices have been provided by the Trust to both Trust employed and seconded staff in the IPUs. It is unclear whether all staff have received them. The Warwickshire carers team reported that they do not have them even though they may be visiting homes that staff in IPUs visit.

9.9 Progression

Ability to progress a career was particularly raised by Coventry seconded staff. Whether or not it is possible it is a perception held by staff in different roles. A training and skills profile and career paths should be available to staff so that the possibilities are clearly understood. With a national and local

shortage of AMHPs consideration could be given to a pathway that moves from the unqualified practitioners through to social work, AMHP and either professional or management roles in health or social care. There was a perception that Social Workers / AMHPs could not apply for Deputy Manager posts. Social workers are able to apply for Team Manager posts but recent recruitment campaigns have not attracted applications from social workers. This should be explored more by the Partners so that the multi-disciplinary nature of the teams is reflected in management where this does not exist thus strengthening the message to staff that the importance of the social care contribution at every level in the service is valued. Consideration could also be given in Warwickshire into some form of partial integration into the line management structure of some of the social care governance and professional leadership. This would provide stronger social care leadership within the integrated teams. It is important that in doing this the social care leadership is not lost to generic management duties in the IPUs. One possibility could be given to consideration of a social care deputy post to the General Manager of Integrated Community services.

There are staff keen to go on AMHP training and other staff who feel that they are unable to increase their skill base as priority is given to others e.g. BIA training.

10. Delivering the Care Act delegated duties

Although the work of the IPUs has been covered in previous sections, it is difficult to evidence how well the Care Act duties are delivered by them, how much by whom. Data collected in Coventry was showing that significant number of service users were receiving social care services but hadn't had a Care Act assessment. Some social work care coordinators still undertake the whole process but much of the process is now assisted with by the CCW/SDS role which has been increased. In Coventry this has increased the number of well-being assessments done and in both Councils has provided assistance to care coordinators who retained overall responsibility. Care coordinators in Coventry can also refer to the Council's POD to undertake well-being assessments. Much of the value of social work intervention is through work that does not necessarily result in the provision of traditionally funded social care services and can be difficult to evaluate. There is lack of information on how often the need for Care Act advocacy is considered and utilised. Later in this report the value of case file audits measuring achievement of social care outcomes is mentioned.

10.1 Assessment and care and support planning

Where there is an appearance of need for social care and support an assessment is undertaken that meets the standards set out in the Care Act. The initial assessment now contains a section where a Care Act compliant assessment should be recorded and enables eligibility for social care and support to be considered. It is reported that this is not completed very often. It is possible that a report could be requested from Care Notes which would say how often it is completed and by whom. Warwickshire are currently undertaking an audit to evaluate how well it is completed and whether any improvement action is required.

Where the Care Act Assessment within the Initial Assessment is completed whether by a health or social care professional, an SDS worker in Warwickshire or CCW in Coventry, will work with the care coordinator to assist and navigate them through the social care process. In Warwickshire, a pack and leaflets have been produced to support care coordinators. The CCW/SDS officer, care coordinator and service user complete the council's Care Act Assessment form and get an indicative budget. These workers will also advice on community resources that may be available to meet service user outcomes. Responsibilities regarding who completes social care funding applications and care and support plans appeared varied across Coventry and Warwickshire. In Warwickshire some managers felt that the care and support plan was too long however the form itself might not be; it may be more about what is perceived is required. One that was looked at was long and contained information that would normally be expected in the assessment. There is a possibility that less duplication and proportionality could be introduced into the whole process.

It appears that the process could be streamlined further if there was better use of the Care Act information section in the initial assessment which would then enable CWC/SDS workers to establish a personal budget with the service user and consider options to meet social care needs and reduce the number of assessments done.

10.2 Reviews

Considerable progress has been made in the last three years between the Partners on how cases that require a Care Act review but do not require any other ongoing mental health services are managed. These cases are now kept on Core Cluster 0. However it does not appear to be understood as one of the necessary delegated priorities by all line managers amongst other competing demands. It is important to understand that with the seconded staff come seconded duties. Further assistance with ensuring that these reviews are undertaken has been provided by the Council whereby in certain

circumstances they are undertaken by the CCW/SDS workers. Other reviews are expected to be undertaken by the care coordinator.

10.3 Staff and manager views across the Partner organisations

Staff were asked in the questionnaires to what extent they thought their line manager understands and supports them in in delivering your social care professional and legal responsibilities. Some responses are:

"Manager has made significant efforts to familiarise themselves with social care protocols especially with regards safeguarding processes, Mental Capacity Act etc."

"Manager is aware of obligations but also mindful of the Trusts as well, which are her priority"

"Signposts to social work colleagues for advice"

"2 team managers, 1 health & 1 social care, despite their titles being health and social care managers they tend to just manage their speciality with little cross over"

"I have had previous line managers from a different professional background to myself who in my opinion, and theirs, did not fully appreciate my responsibilities"

"My line manager is aware to a degree of the social care and professional responsibilities and does her best to accommodate these. However, the pressures to adhere to a health agenda and provision of services is extremely high. There is little doubt that the social care agenda and our statutory responsibilities are neglected as a result"

"Line manager is supportive of my role as Team Manager, AMHP, and local authority employee. However, as a qualified health professional employed by the Partnership Trust she is not able to provide me with any professional supervision on my social care responsibilities, and I do not currently receive any professional supervision"

Table 6: To what extent do you think your line manager understands and supports you in delivering your social care professional and legal responsibilities? (where 0=not at all and 4= very well)

	Range	Average
Coventry	0-4	2.78
Warwickshire	2-4	2.96
Trust	1-4	3.22

Comments were also received from staff and managers about how well they thought Care Act activities were undertaken. Some of the responses indicated that they felt this was a gap in the service delivery:

"…However, I am aware that we are unable or certainly struggle to engage with individuals who may be entitled to a service under Care Act (2014) but do not meet criteria for services from CRHTT"

"…. Since moving to an IPU model, we have moved in my view to an even more medicalised model of care provision. This in my view has been a backward step and has resulted in citizens of Coventry not receiving interventions that consider their social as well as medical needs. This has often impacted negatively on their recovery"

"Being able to full-fill all the responsibilities under the Care Act. Offering Needs and Wellbeing Assessments, and Carers Assessments, to all service users and carers under the team is not logistically possible given the demands of the role of Care Co-coordinator under CPA and the number of cases open to the team….."

"Care Act Obligations are not routinely understood or implemented by heath colleagues. Dual case management systems create additional burden of dual recording, training, different ICT departments.. not integrated well enough"

10.4 Carers' services

Warwickshire has a dedicated mental health carers service, line managed by the Council, which is included in the Section 75 integrated services to keep mental health services combined and for ease of access to IPUs. They undertake Care Act compliant carers assessments and support planning which are subject to the council's audit process. Trust managers and staff value this team which inreaches to them. One of the Locality Managers is a formal liaison point with this team. Coventry has a Carers Centre and carers' pathway outside of the integrated service.

11. IT Systems and recording

The main service user record is on the Trust's system, Care Notes. The following forms are completed there:

- **Initial assessment** – includes HoNOS, safeguarding, carer questions and includes a Care Act Assessment, if the service user appears eligible referral for further assessment to determine indicative personal budget.
- **Working with risk part 1-** all initial assessments
- **Working with risk 2 -** undertaken for every case open for more than 3 months
- **Working with risk 3 -** positive risk assessment done with service user.
- **MH care plan**
- **Mental Health Statement of care**- for when only one professional is involved – no prompt for review.
- **Review**
- **STORM assessment –** for suicide risk
- **Working with risk 4 -** What the patient wants to happen if gets unwell
- **Clinical Notes**

In addition in Warwickshire safeguarding reporting data is recorded on Care Notes and in Coventry it is recorded on the Council's system Care Director. In Coventry, wellbeing assessments care and support plans are recorded on their system Care Director. This ensures an indicative personal budget is generated. In Warwickshire, a minimum data set is recorded on the Council's system CareFirst. When their new system Mosaic, a work flow system, is introduced, the needs assessment, care and support plan and review will need to be recorded on Mosaic, albeit in a minimalistic way if sufficient information is recorded in Care notes. Warwickshire will ensure the necessary minimum information is recorded on Mosaic. In addition both Councils have funding forms that must be completed if social care funding is requested.

In order to reduce duplication and ensure a service record is as complete as possible relevant documents from one system can be scanned onto the other. This is particularly important if cases are transferred between IPU 18-21 and the older people's teams in the Councils.

11.1 System and recording issues identified

- Duplication
- Care Director is slow on Trust devices.
- Trust staff get logged out of Care Director if they haven't used it for 30+ days
- Warwickshire have council phones but can't receive Trust emails or have the team's electronic diary on them
- Section 75 Annual report 2016/2017 states interoperability between the systems still to be explored
- Limited CareFirst read only access by staff in IPUs
- Warwickshire social care staff have difficulty accessing the Council intranet in some Trust buildings
- Wi-Fi on Warwickshire laptops is difficult to get in some Trust properties
- Some staff have both a Council and Trust laptop

12. Governance

12.1 The Strategic Board and Sub Groups

The Strategic Governance and the Integrated Service / Clinical Governance arrangements are set out in Schedules 2 and 3 respectively of both Section 75s. The governance structure provides a formal framework to consider how well the integrated model is working, evaluate proposed changes within the respective organisations and how that may impact on the integrated service along with new developments and opportunities. Strategic Governance is overseen by the Section75 Strategic Board and Operational Governance through its Performance and Quality Sub Group which considers how well the operational day to day management of the integrated service is undertaken. The Section 75 Strategic Board receives an Annual Report which should evidence how well the integrated services are performing and how well the arrangements in the Section 75s are complied with. The Annual Report should summarise the performance data for the year and state whether performance targets have been met, if not why and what improvement plans are in place.

The Strategic Board meets quarterly and from the minutes it considers most of the issues that it should that are outlined in the Section 75s. From the last year's minutes it is not evident that the Strategic Board considers "how well the integrated services are performing against agreed service targets along with plans for improvement if targets are not reached". This is a critical role of the Strategic Board. It is clear that much of the year there has been difficulties in obtaining the data required given the move to a new system. It is recommended that this is given priority to enable the Board to fulfil this function in the future and to contribute to the Councils' assurance that their legal obligations are being undertaken satisfactorily.

The Strategic Board could consider a more robust oversight of the Integrated Service by each Schedule in the Agreement having a lead officer responsible for ensuring that it is followed by the Partners, kept up to date and any issues brought to the attention of the Strategic Board. It is also recommended that the Board have a risk register for the Section 75 and agree a shared communications to the teams from time to time to ensure that the profile of the Section 75 and what it means is not lost in the day to day urgency of meeting demands and key messages are jointly sent from the Partners.

The membership of the Section 75 Strategic Board has been brought up to date. Consideration should also be given to the Principal Social Workers from the two Councils being members of the Board who are responsible professional leads in the Councils, supporting and advising on the quality of practice, who should have a view on how well social workers are supported to undertake their role and ensure that social work practice is of a high standard. As the responsible manager for delivering delegated functions in acute services the Associate Director of Operations for Acute Services should be a full rather than co-opted member. It is also recommended that the Deputy Director of Operations be formally a member and is formally nominated as the proxy for the Director of Operations in the Trust.

From the minutes of the meetings the Performance and Operations Sub Group and discussions with managers this group considers issues relevant to the delivery of the delegated services and line management such as:

- Staffing and vacancies
- AMHP work including associated issues such as conveyancing
- Integrated Community Service transformation programme
- Training
- Performance scorecard
- New initiatives such as the Think Ahead scheme

As mentioned with the Strategic Board, following the bedding down of a new system in the Trust the Performance and Operations Sub Group Board must consider the performance scorecard robustly to assess whether the integrated services are delivering delegated duties satisfactorily. Whilst the scorecard is coproduced by the Partners the Trust has the responsibility for ensuring the adequate recording of information on the Trust system and providing that data in a way that can demonstrate that delegated duties are delivered. The Council has the responsibility for providing the data that comes from its systems e.g. the HR information.

There is a Section 75 Safeguarding Sub Group which is an ongoing group which should be captured in the Section 75s. This group will report to the Performance and Operations Sub Group and onward to the Strategic Board and into the Trusts safeguarding governance system. Its purpose is to have the operational oversight of Adult Safeguarding under the terms of the Section75 between the three Partners and ensure that Safeguarding operational practice in Adult Mental Health Services provided by the Trust under the S75 is Care Act compliant. Membership and frequency of meetings are set out and the Terms of Reference are awaiting sign off by the Partners.

12.2 Other groups

There is a Trust led Community Safety and Quality Group which is outside of the S75 Governance structure. The group, which has multi- professional membership, meets monthly and considers complaints, audits and outcomes of investigations. There should be some formal feedback from a representative of this meeting who is also a member of the Performance and Operations Sub Group into the latter group where it is relevant to the integrated services.

There is an IPU leadership meeting which Senior Practitioners and Lead Practitioners are invited to.

Warwickshire holds and chairs a monthly internal performance and quality meeting to which Trust Locality Managers are invited. These meetings consider more detail and invite managers from other parts of the Council e.g. Human Resources (HR) and Finances. The Trust Locality Manager values these meetings to be kept up to date with social care information and meet the representatives who they need to link with. It is not evident that there is representation from the management of acute services in the Trust at this meeting.

Coventry holds and chairs a social care mental health management meeting to which the Trust Locality Manager is invited along with other managers from the Council e.g. Principal Social Worker, Performance.

Minutes and agendas have not been looked at from these two Council meetings, however it is suggested that these are reviewed to see if they fit with the joint governance arrangements and see if there is any scope for streamlining.

These are probably not all the meeting that take place to oversee the governance and performance of the integrated services. An audit of them all with their purpose and membership is recommended to achieve streamlining, joining up and ownership of delivery of the integrated services throughout community mental health services and urgent and acute assessment and treatment services.

13. Performance Monitoring of the delivery of delegated social care functions and statutory social care reporting

13.1 The performance scorecard

The performance scorecard for the four quarters of 2016/17 and its commentary has been considered as part of this review along with a review of the Section 75 Strategic Board minutes and interviews with operational managers and staff responsible for producing the scorecard.

The performance scorecard should measure key indicators to assist the Section 75 Strategic Board and its Performance Sub Group in evaluating whether the integrated service delivery of delegated social care and line management duties are functioning satisfactorily. The S75 schedules and the performance indicators reported on have been updated particularly since the introduction of the Care Act.

The performance scorecard captures:
5 ASCOF Performance measures
5 Local indicators, reviews, carer assessments and Mental Health Act assessments
5 Delayed transfers of care indicators
7 Care Act Indicators
5 Safeguarding measures
6 HR indicators

The first 5 are statutory measures and need to continue to be collected and reported upon.

The 5 Delayed transfers of care indicators show how well health and social care are managing the discharge of inpatients from hospital and stimulate discussion on how to together improve the inpatient journey with a focus on timely discharge.

The last 6 HR indicators are a measure of how well certain delegated line management functions are performed, appraisals, sickness and training. Appraisals were below target in Warwickshire in 2016/17 and a new system has been developed by Lead Practitioners to monitor and assist ensuring appraisals are arranged. Appraisals in Coventry were not reported on in the first two quarters and very low in the last two quarters. This is a significant indicator that demonstrates how well a key delegated function is carried out. Attendance at Statutory and Mandatory training provided by and reported on by the Trust is missing from the scorecard in 2016/7. Sickness absence is reported on and both councils have improved on their targets. Consideration should be given to including staff vacancies so that these are transparent and plans to fill vacancies are discussed.

In addition to the existing safeguarding indicators, consideration could be given to include in the scorecard Making Safeguard Personal outcome measures from the service user perspective.

The Mental Health Act Indicator could be extracted from the local indicators, and a new subset agreed that would not only evidence the demand on the AMHP service but other issues that impact on the AMHPs time and availability to undertake care coordination. Some of this is already collected by the Councils, such as time to locate a bed, time for conveyancing to be arranged, time to obtain medical recommendations etc. Whilst the AMHP service is not a delegated function, factors that impact on its operation impact on other areas of the integrated mental health service and should be considered by the Strategic Board to look at potential solutions together. Reporting frequency could reflect current AMHP reporting arrangements.

The remaining local and Care Act indicators can be combined and they should be indicators that help to evaluate the effectiveness of the process in diagram 1 below which simply depicts the social care customer journey.

Consideration should be given to how often Care Act Advocacy is used which is a legislative requirement when certain factors are met that ensures the service user's voice is heard.

The proposed inclusion of activity of MIND workers at the "front door" would contribute to showing how well the Partners are addressing the Care Act preventative agenda and could be included on the scorecard.

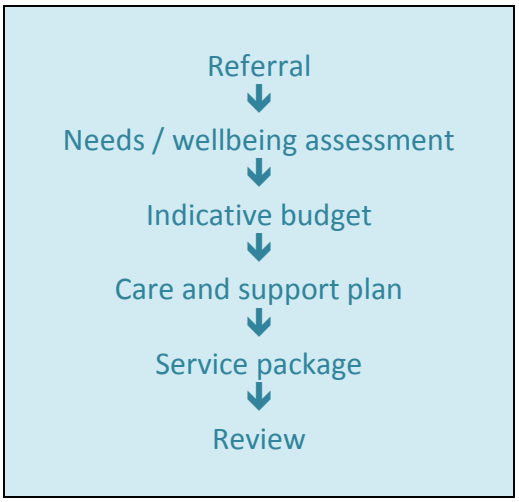

Diagram 1

13.2 Production of the performance scorecard

The data that populates the scorecard is provided by all three Partners either directly from their systems or on provision by the Trust to the Council of raw data. This needs to be delivered in a way that can be meaningfully and accurately interpreted. The scorecard clearly sets out the data and definitions and commentary is provided to assist in interpretation. Work has been undertaken by the Partners to ensure that all Partners understand what is required.

The 2016/17 scorecard has gaps where data has not been available e.g. for the number of people receiving professional support, and had a social care review. Some of the gaps have been attributed to the introduction and bedding down of a new record system in the Trust and a new system in Coventry.

Since the bedding down of new systems staff in the three organisations responsible for producing the scorecard, have recently agreed ways of making data collection more effective and efficient along with agreeing a timeline for data reports to be ready to meet statutory social care, NHS and local reporting timelines and provide timely and complete data to the Section 75 Performance Subgroup and Strategic Board. A 3 year timetable would provide clarity to Partners on their respective and joint requirements and responsibilities.

Good relationships exist between the Partners in the production of the scorecard, ongoing liaison and meetings are held to iron out any practical issues in delivering the scorecard. In order to embed progress made, the following are recommended to ensure accurate and timely data for statutory returns and the Performance and Operations Sub Group, and that the Partnership Agreements and Information Sharing Agreements are kept up to date:

- Ensure Schedule 16 Information and Monitoring requirements for Performance of Local Authority Service Delivery of integrated services and its appendices are kept up to date and include the schedule for delivery of data by each Partner
- Ensure the Data Sharing Agreements are up to date
- Both Councils and the Trust consider the Trust uploading data from the Trust into the Council's data warehouse to provide an efficient automated process in line with an updated Data Sharing Agreement.
- The Trust to ensure that data is delivered with clarity of meaning to the Councils
- The Strategic Board to consider whether the data reported evidences the extent to which delegated duties are carried out, e.g. does the total number of initial/trusted assessments carried out by the Trust contribute to knowing how many Care Act assessments are undertaken?

13.3 Managers responsibilities

Managers are able to get reports directly off Care Notes to help them manage their teams, which includes numbers of referrals, contacts and caseloads. This assists them in manging their teams workload and ensuring they provide AMHPs with protected caseloads.

A subset of performance indicators from the Section 75 performance scorecard for their own teams should be available to managers to enable them to evaluate for themselves how well they are delivering the duties that have been delegated to them and understand any differences between teams.

13.4 Data quality

Some operational managers have reported that there are discussions in the Section 75 Performance and Operations Sub Group that the performance data does not reflect the activity undertaken. Ongoing scrutiny of indicators below target is required to inform how improvements can be achieved.

It appears that the discrepancy is down to recording activity. This isn't necessarily an unusual finding in organisations facing increased demands on their time with less resources however solutions to enabling staff to record key data is important and necessary. [17]

There have been changes in systems and process in the Trust and Coventry City Council that will have contributed to low performance being reported in 2016/17. Following the introduction of the new systems and processes in Coventry, 130 staff received training on how to record key social care information on and given access to Care Director in the autumn of 2016. Unfortunately the quarter 4 commentary reported that this had not resulted in an increase in the number of assessments recorded on the system in Coventry. The increased service demands on the teams appear to have been an additional factor. Coventry has recruited two community care workers to support care coordinators with their delegated social care duties to enable more accurately and timely recording. Staff and managers in the IPUs have reported that they also have problems accessing the system if they haven't logged on for a period of time which causes delay and does not reinforce the need to record.

Increased bureaucracy in recording has been reported by health and social care managers and staff who perceive this to have increased after the introduction of the Care Act. Both Councils have reviewed the information they require since the introduction of the Care Act and new systems, and

[17] 'If it's not written down; it didn't happen...' JCN 2015, Vol 29, No 5

have reviewed the staffing model to enable improved delivery of Care Act functions and recording with the introduction of CCWs in Coventry and the refocusing of the role of the SDS workers in Warwickshire. Warwickshire also has a centralised administrative team that assists in the inputting of key data on the Council's system and reduce recording duplication by practitioners. Consideration should be given to focusing the seconded administrative workers in IPUs to focus entirely on the support of the delivery of the seconded duties if it isn't already.

Safeguarding activity is recorded differently in Coventry and Warwickshire. Both health and social care staff in Warwickshire record safeguarding concerns and enquiries on the Trust system and the Trust provide the data. In Coventry both health and social care staff record these on the Council's system. This increases the amount of recording on two systems for practitioners who often find themselves unable to use the system due to infrequent use. A significant amount of work has been undertaken by the Partners over the last three years in raising the profile of safeguarding and in recording which was supported by the Section 75 Safeguarding Sub Group. In view of this it is recommended that Coventry and the Trust consider moving towards recording safeguarding on the Trust system which would make it easier for staff. If this were agreed then the Safeguarding Schedule of the Coventry Section 75 would need updating to reflect the change in responsibility for reporting safeguarding in mental health services.

13.5 Moving from output measures to outcome measures

Much of the data reported on are output measures and it is difficult to extrapolate from some whether they are relevant in measuring the amount and quality of the delegated social care functions e.g. total number of referrals, initial / trusted assessments. This could be analysed by staff role alongside numbers of assessments and care and support plans and numbers of people who are in receipt of a personal budget to see if the appropriate and proportionate resource is targeted at the delivery of seconded social care duties This would have to be considered alongside the other important social work contributions outlined in Social Work for Better Mental Health, A Strategic Statement, DH 2016[18] that do not result in provision of social care services.

There is information that is not reported on but could be, such as the quality of completion of the Care Act section of the initial assessment form. It was clear from the majority of staff and managers seen that it is not routinely filled in though it may be acting as a reminder to staff that they must include identifying at an early stage whether there is an appearance of need for care and support.

Besides the requirements to provide mainly output data to the NHS and DoH there is a national move towards measuring outcomes and customer satisfaction in both the health and social care arenas. It is timely for the Partners to review whether they want to add to or replace some of the measures with outcome measures and whether these are at a strategic and/or a service user level.

The results of audit exercises should be included in the performance report to the Section 75 Board which looks at the quality of assessment and care planning and the determination of eligibility and safeguarding activity. It is important not to lose sight of the underlying principles of the Care Act about promoting independence, social inclusion and using individuals own strengths and assets and those of their family and community networks appropriately. Only measuring outputs such as personal budget, direct payments and managed care does not demonstrate this fundamental approach. The internal audit of the Section 75 undertaken by Warwickshire reported that case file audits should be undertaken and should be jointly agreed and implemented with the Trust. It is recommended that all

[18] Social Work for Better Mental Health, A Strategic Statement, DH 2016

Partners pursue this to assure themselves that social care outcomes and delegated functions are delivered.

The Trust has established some outcome measures on patient reported Experience Measures (PREMs) and undertook pilots in 2016. The Strategic Board should consider the outcome of the pilots and whether social care outcomes could be included if they are not already.

Both Councils and the Trust undertake customer satisfaction surveys. These should be considered to see if these could provide any useful feedback for the delivery of social care from within an integrated service or whether a separate one should be considered that also measures service user social care outcomes. Already mentioned above is the consideration of reporting on service user safeguarding outcomes.

Finally, the Partners might want to consider, if they do not already do so, comparing their performance data against similar health and social care communities.

14. What works well?

All seconded Coventry and Warwickshire staff and Trust staff who work in the IPUs were asked five questions in the questionnaire about the impact of working in an integrated team. The responses are in table 7 below and where 0 is not at all and 4 is very well. The score is a weighted average that takes account of any questions answered not applicable. The All Warwickshire seconded staff group contains a number of staff who work in mental health but not under line management of an IPU. The equivalent ALL Coventry seconded staff have a smaller number of staff who are not directly line managed within an IPU. It appears from these responses there is a higher level of satisfaction with Warwickshire seconded staff in all 5 areas. However Warwickshire staff also made similar comments to Coventry staff about the challenges in meeting those aspirations.

Table 7: To what extent do you think that working in an integrated mental health and social care team...?

To what extent do you think working in an integrated mental health and social care team……?	Warwickshire IPU staff	All Warwickshire seconded staff	Coventry IPU staff	All Coventry seconded staff	All Trust IPU staff
a) Provides a better joined up service for service users and carers	4.6	4.57	4.11	4.16	4.29
b) Helps me to ensure that service users and carers have both their health and social care needs met more effectively?	4.45	4.38	4.06	4.00	4.08
c) Improves working together between health and social care colleagues?	4.5	4.57	4.11	4.32	4.29
d) Enables me to use my unique professional skills?	4.3	4.41	4.11	4.07	3.96
e) Enables me to provide a social work services underpinned by the Care Act and Values?	4.05	4.29	3.72	3.62	3.91

Some comments to the question above were:

"It is difficult to use my social work skills, these skills I tend use more in my AMHP role."

"I feel that working in an integrated team allows much better communication and opportunities for joint working which feels very positive for the carers I work with."

"It is difficult to implement social care skills in an environment which is dominated by health values/duties. It can be difficult to have social care values accepted. I do think social work service is vital within mental health teams to work against a very strong medical model to ensure service users get a balanced service. A previous manager did say that she considered me "as a nurse"

"Generally this team works very well together to provide a good quality service to our clients. Very often I do feel that the social workers are the 'catch all' for any issue/incident that seems to be outside of the remit of health. We are disjointed from the main social care teams and occasionally feel that we have feet in both camps but belong to neither.

"Working 2 systems creates increased stress and pressure as I feel that I am an expert in neither system and especially struggle with care director"

"Although I have had training in the Care Act and I am aware of its values and duties, I am so busy with other matters that I do not feel social work practice in the team is underpinned by Care Act values and duties"

"We have lost the CMHT INTEGRATED FOCUS – very little team working as used to be under the CMHT Older people – now service geared to memory assessments and poor attention and focus post diagnosis support. I feel very disillusioned and overwhelmed by pressures both casework and AMHP / DoLS work – unable to do the work well and poor job satisfaction. Changes to AMHP structure have led to huge increases in workload pressure"

"I work in one of the most cohesive teams that I have ever worked in. We all respect each others unique professional specialities, but are willing to assist our colleagues if required and this is what makes it an effective team"

"joint working cases can be particularly effective with joint visits undertaken with social workers and all other disciplines within the team from MAC nurses to psychology and OT. This also serves to reduce the duplication of work and bureaucracy as one professional will take the lead with the paperwork due to the coordinated approach to the case"

"I think that predominantly the health agenda takes precedence over that of the social. I feel that this results in citizens not getting a holistic service. This results in a citizen's social care issues remaining unresolved, which then impacts on a person's mental health, sometimes causing their mental health to deteriorate"

"The medical model can dominate at times, and Care Act values and duties can be lost within this. There is not a full appreciation of the Care Act and it is often seen just in terms of having to complete a Needs and Wellbeing assessment when a funded package of care is required. However, staff do aim to improve service user and carers well-being as a whole and both the health and social care staff assess and support users with their social care needs"

"The team wouldn't work unless it stays integrated. We need the different skill base to ensure Service users get the best possible outcome. It helps us learn as a team from the different disciplines to help provide a good rounded service"

"Sometimes feel as if role is lost - particularly when trying to do care packages that I have had little training/experience with"

"Group work - enables us to use effective psychological skills and models with a large number of people"

"opportunities to work closely with consultants and registrars"

"I have access to Care Notes and Care Director which gives a full picture of the services accessed by the service users I assess"

"working together to provide health and social care needs, we even do physical health checks so are like a one stop shop, it means the citizen does not have to keep repeating their story"

"Allows patients and carers to see most appropriate professional and to know that all relevant information is accessible to them"

"….some silo thinking and behaviours about what is and is not part of social care …. if the roles of health & social care managers ……. and they did actually manage both services this would improve"

"unrealistic expectations from social care in what we can or cannot do, no sense of reality around what the IPU does and that we work under S75"

"As a registered nurse I will carry out the duties that I am able to within the Care Act but will refer for input from my social care colleagues if their expertise in that area is thought to be more appropriate"

"all in the same office - able to just grab an OT, Social worker, psychologist, nurse for support/advice"

Staff were also asked to describe one aspect of integrated, multi-disciplinary working that that they thought was effective and why. The overwhelming response by all disciplines in all three organisations is that integrated mental health teams that bring health and social care professions together provides good working experiences for staff and better outcomes for service users but it is challenging. Whilst there were a large number of social care professionals who felt that it was difficult being a minority profession championing a social model of care, from the responses it can be seen that their impact is felt and valued. The following are key themes from all disciplines:

- **Communication is easier with other professional colleagues and allows for a timelier joined up service to the customer / patient** *"No time wasted or delays in trying to speak via phone or email"*
- **Ease in sharing information, knowledge, skills and approaches provides better outcomes for customers / patients and enhances team members knowledge and skills base** "*…get experience of working within different disciplines and different approaches to recovery…..the ability to have open discussions reinforcing the need to view things from both a medical and social model is highly important and useful to achieve a better outcome……The AMHP role is extremely useful to the team …..my social care knowledge is shared with the team…Medical interventions are explained to me …Shared care is an important community tool for the team"*
- **Involvement in regular multi-disciplinary, allocation and other team meetings ensures a coordinated approach and that all relevant information is taken account of**
- **Easily able to do joint assessments when required**
- **Process for funding services is joined up between health and social care** "*….seamless route to providing emergency social care and support to prevent further deterioration/admission to hospital"*
- **Customers/ patients receive the health and social care they need without being "bounced" between services**

15. What could be improved?

When asked to describe one aspect of integrated, multi-disciplinary working that does not work so well and how they thought it could be improved emerging themes were:

- Integrated computer systems
- Access Council equipment and software more easily in Trust premises
- Information on customers is kept on two systems.
- The balance between the unique roles and generic roles in the team needs redefining; unique social work skills not used
- Wider understanding of the AMHP role
- Ensure sufficient time for AMHP responsibilities and workload more balanced
- Ensure service users receive a service based on an integrated value base
- Reduce internal referrals from care coordinators for social care services
- Integration of services and values would be assisted by more Team Managers from the social care profession.

16. Summary and conclusions

There remains a strong commitment from staff and managers in all three organisations to a multi-disciplinary approach to providing health and social care in mental health services. This evolved quickly in both Coventry and Warwickshire from a collocated model of service delivery where the social care contribution was distinct and separately managed to an integrated model where management and service delivery was streamlined. Historically, this approach to integration strongly emphasised genericism in the context of care coordination undertaken by nurses, occupational therapists and social workers who would have overall responsibility for assessment, delivery of a care plan and its review. This model also enabled nurses and occupational therapists to assess and apply for social care services for services users they had care coordination responsibility for. More recently the Councils have assisted care coordinators with undertaking and recording some of the Council delegated functions with additional staff, the Community Care Worker and Self Directed Support posts.

There was and still is a commonly understood view of what sort of cases are best care coordinated by which profession. It appears from the consultation exercise that over the last three years it has been more difficult to allocate cases according to the differing professional skills required. Capacity and vacancies in teams has produced a demand led allocation process rather than a skill based process. It is timely to consider greater role clarity and reappraisal of the generic and specific role balance to ensure service users benefit from the appropriate skills and expertise.

The increase in demand for secondary mental health services has impacted on the delivery of delegated social care functions and the increase in the number of Mental Health Act assessments has caused difficulties for AMHPs and their managers to balance this non delegated function and other team work such as care coordination and team duty.

In conclusion, the staff and managers consulted believe a multi-disciplinary service provides a better joined up service for the service user. This service model provides a more streamlined service delivery than a colocation model would. However there are strains and pressures on the service that need consideration in order to enable staff and managers to deliver the integrated health and social care service and maximise the unique contribution each professional brings. It is acknowledged that work is under way to review service delivery in community mental health services.

There are recommendations within the body of this report and summarised in the executive summary that could be brought together into an action plan for improvements to support the renewal of the Section 75 Partnership Agreement.

17. References

Section 75 Agreement: Mental Health “Providing assurance on the management of risks”, Risk and Assurance Services, Warwickshire County Council, August 2015

State of Mental Health report CQC 2017

Social Work for Better Mental Health, A Strategic Statement, DH 2016

Final report: Evaluation of the Integrated Practice Unit approach, Mental Health Strategies, 2016

Guidance for commissioners of liaison mental health services to acute hospitals, Joint Commissioning Panel for Mental Health, 2012

Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance, NICE, 2016

Value-Based Health Care Delivery Professor Michael E. Porter Harvard Business School www.isc.hbs.edu January 22, 2014

Review of Community Mental Health Services, Coventry and Warwickshire Health Economy, West Midlands Quality Review Service Coventry and Warwickshire Health Economy, West Midlands Quality Review Service, January 2016

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

Review of Section 75 agreements- Terms of Reference

Vision	Provision of integrated services across Coventry and Warwickshire that: • Delivers better outcomes for individuals experiencing mental ill health • Meets the vision and objectives for the three organisations
Purpose	To review the existing section 75 agreements that have been in place since April 2014 and are currently extended for the period of 12 months to 31st March 2018 pending the outcome of this review
Scope	The initial scope of the project is to focus on the areas of delegated functions that comprise the current working arrangement which includes the following : - • Services delivered through each of the Integrated Practice Units across Coventry and Warwickshire with particular attention to Care Act assessment, review process, active and non-active CPA • Services provided through the Central Booking System • Services provided by the Crisis Resolution Home Treatment Teams, AMHAT and CRT. • Delivery of Adult safeguarding functions and the general functions of the Care Act • Current governance arrangements supporting the S75 arrangements including performance reporting, quality and safety (including audit), information governance and reporting schedules • Progress of the CQC action plan particularly relating to provision of dementia services
Key Objectives	There are 10 distinct objectives expected from the review of the current arrangements: 1. Identify the most effective local arrangements for the delivery of Mental Health Services 2. To identify current levels of integrated practices and the outcomes delivered through the formal and informal arrangements in place and identify key development opportunities- detailed analysis of the 'as is' position. 3. Provide an analysis of the current performance frameworks, opportunities for change and make recommendations about future arrangements that are required 4. Identify key changes required over the 3 year period 2018 to 2021 to ensure strategic requirements at national and local levels are achieved, including alignment with BCF and Five Year Forward View for Mental Health. This should include the CCC strategic vision and priorities, Warwickshire Cares and WCC and CCC transformation programmes 5. Identify key outcome measures that support service delivery and better outcomes for individuals 6. Workforce development and flexible approach to supporting 'integrated' roles i.e. AMHP role

Timescales	7. The review would take account of: a. Better Social Work for Mental Health b. Staff consultations c. Service user and carer consultations d. S75 updates schedules e. Collaboration with CCG's / Local Health & Social Care economy 8. Establish capacity required across the services to deliver integrated care in a seamless way. 9. Identify opportunities for increased integration 10. Provide analysis and recommendations about the leadership roles in delivery of the organisational outcomes The review should be undertaken within the ambitious time frame of 4 months from June 1st 2017. With expectation that report with recommendations will be made available on or before 30th October 2017
Strategic Benefits	• *Joined up and coherent case management* focused on outcomes for individuals that is built on specialist knowledge and skills • *Effective use of resources* to support financial balance for each organisation • Clear *joint operating procedures* are in place to support multi-disciplinary and inter-agency working • *Improved outcomes* for citizens of Coventry and Warwickshire in relation to - Caseload management is built on specialist skills and knowledge • Vision and priorities agreed through the partnership are delivered in practice
Governance	The review of S75 agreements is being commissioned by the 3 organisations (Coventry Warwickshire Partnership Trust (CWPT), Coventry City Council (CCC) and Warwickshire County Council (WCC)) via the s75 Strategic Board. The progress of the review will be monitored by senior representatives delegated to act on behalf of the organisations these being: Toni Ruck CWPT Jas Dhadli WCC Sally Caren CCC Progress reports to Exec Leads will be made on a monthly basis via highlight reports that indicate progress. The final review and recommendations that arise will be made to the Strategic Board but will be overseen via each individual organisations governance process and ultimately at Cabinet levels for the revised s75 agreements.

Appendix 2: Review consultations

Interviews

Role	Name	Organisation
Social Care Managers	Jas Dhadli	Warwickshire County Council
	Jo-Ann Brennan	Warwickshire County Council
	Sharon Young	Warwickshire County Council
	Patrick Finnegan	Warwickshire County Council
	Diane McHugh	Warwickshire County Council
	Rupert Pullin	Older People's Service, Warwickshire County Council
	Sally Caren	Coventry City Council
	Simon McGarry	Coventry City Council
Trust Managers	Toni Ruck	Coventry & Warwickshire Partnership NHS Trust
	Barry Day	Coventry & Warwickshire Partnership NHS Trust
	Fiona McGruer	Coventry & Warwickshire Partnership NHS Trust
	Ade Odunlade	Coventry & Warwickshire Partnership NHS Trust
	Winsom Rowbotham	Coventry & Warwickshire Partnership NHS Trust
	Maria Smyth	Coventry & Warwickshire Partnership NHS Trust
	Deborah Harvey	Coventry & Warwickshire Partnership NHS Trust
	Rebecca Sly	Coventry & Warwickshire Partnership NHS Trust
	Andy Nixon	Coventry & Warwickshire Partnership NHS Trust
	Deborah Sumal	Coventry & Warwickshire Partnership NHS Trust
Performance Managers	Tom Watts	Warwickshire County Council
	Paul Ferris	Coventry City Council
	Caroline Brown	Coventry & Warwickshire Partnership NHS Trust
Safeguarding Managers	Chris Evans	Coventry & Warwickshire Partnership NHS Trust
	Edward Williams	Warwickshire County Council
Safeguarding and Principal Social Worker	Andrew Errington	Coventry City Council
Principal Social worker	David Soley	Warwickshire County Council
Administration Manager	Jo Hall	Warwickshire County Council
Social Care Commissioners	Lisa Lissaman	Warwickshire County Council
	Sue Green	Warwickshire County Council

Focus Groups	Meetings attended
Coventry AMHPs	Section 75 Board
Coventry Social Workers and Community Care Workers	Clinical Commissioning Group
Coventry Administrative workers	
Coventry Social Care Team Managers	
Coventry Senior Practitioners	
Warwickshire seconded staff (North)	
Warwickshire Seconded staff (South)	
Warwickshire Lead Practitioners	
Trust Team Managers Coventry	
Trust Team Managers Warwickshire	
Trust CBS Manager and team	

Appendix 3: Interview and focus group questions

Interview and manager focus group questions

Interviews with individuals were based on a guided conversation focussing on the following questions and invitation to comment on the areas outlined in the scope of the Terms of Reference for this review.

- What is your involvement in the delivery of health and delegated social care functions?
- What do you think is working well and why?
- What do you think is not working so well and why?
- Are there any services / activities that you think should be covered by the Section 75 Partnership Agreement that aren't currently?
- Are there any services / activities that you think should not be covered by the Section 75 Partnership Agreement that are currently?
- What is your involvement in the governance of the Section 75 Partnership agreement and how well do you think this works?
- Do you have any comments in particular about how services mentioned in the scope of the terms of reference are functioning?
- Have you any other comments?

In addition to these questions Locality Managers and Team Managers were asked to comment on their experience of using the Human Resources schedule and protocols to manage seconded employees.

Performance managers in each organisation were asked specifically about performance reporting, information governance and reporting schedules.

Safeguarding managers were asked specifically about safeguarding.

Council Staff Focus Group Questions

Interviews with individuals were based on a guided conversation focussing on the following questions and invitation to comment on the areas outline in the scope of the Terms of Reference for this review.

The discussion focussed on the following topics:

- What was the role of the participant, whether it was a split role and if so how this was managed?
- Whether participants felt equipped to do their job, development opportunities, professional support/ line management?
- What size caseloads and what sort of cases get allocated to participants?
- How and to what extent do the participants undertake Care Act functions and implement care Act principles?
- What are the benefits to the participants in working in an integrated mental health service?
- What do the participants perceive to be the benefits for service users and carers from an integrated mental health service?

- Are there any differences working in the integrated service now than there were the last time the Section 75 was reviewed 3 years ago?
- How do you think arrangements could be improved?
- Any other comments?

Appendix 4: Questionnaire

The questionnaire below, with some minor adaptations for audience, was sent to seconded staff from Warwickshire and Coventry and Trust staff in the IPUs and Crisis Service.

The Section 75 Partnership Agreement to provide integrated mental health and is being reviewed. We would welcome your contribution to this review and invite you to complete the following questionnaire.

Your responses will be confidential and remain anonymous. Your questionnaire will be returned to Jackie price, Independent Health and Social Care Consultant who is undertaking the review.

Thank you for your contribution your feedback is important.

1. What team do you work in?

2. What is your job title?

3. Do you line manage any staff?

4. Do you provide professional supervision to any staff?

5. If you are a care coordinator please indicate the number of cases currently open to you

6. Of those you care coordinate how many are in receipt of a funded package of care from Adult Social Care?

7. Is your line manager a health or social care professional?

8. How often do you have a line management meeting with your line manager?

9. To what extent do you think your line manager understands and supports you in delivering your social care professional and legal responsibilities?

10. How well are you supported to manage your workload / time boundaries and spread of tasks (e.g. balancing care coordination, AMHP and other statutory duties?

11. How often do you have professional supervision with your professional supervisor?

12. What other forms of professional support do you have? (please tick all that apply and also state any others not listed here)

13. Have you had an appraisal within the last 12 months?

14. Who was present at your last appraisal? (Please tick all that apply)

15. Were any agreed identified development needs met or are planned to be met?

16. To what extent do you think that working in an integrated mental health and social care team….

a. Provides a better joined up service for service users and carers

b. Helps me to ensure that service users and carers needs met more effectively and timely

c. Improves working together between health and social care colleagues

d. Enables me to use my unique social work skills and experience

e. Enables me to provide a social work service underpinned by the Care Act values and duties

17. Please add any other comments you have relevant to the above questions

18. Please describe one aspect of integrated multi-disciplinary working that is particularly effective and why you think that is

Please describe one aspect of integrated multi-disciplinary working that does not work so well and how you think it could be improved.