## Contents

<table>
<thead>
<tr>
<th>Sections</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for developing a BASW policy on “integration”</td>
<td>2</td>
</tr>
<tr>
<td>Key Points – the importance of social work in the integration debate</td>
<td>3</td>
</tr>
<tr>
<td>Summary of BASW position on integration</td>
<td>5</td>
</tr>
<tr>
<td>Effective Partnerships – Key Questions</td>
<td>6</td>
</tr>
<tr>
<td>BASW’s views on integration</td>
<td>6</td>
</tr>
<tr>
<td>BASW Charter for integrated working.</td>
<td>7</td>
</tr>
<tr>
<td>Actions</td>
<td>9</td>
</tr>
<tr>
<td>Appendix 1 Background information on the integration debate between health and social care.</td>
<td>10</td>
</tr>
<tr>
<td>Appendix 2 details:</td>
<td>15</td>
</tr>
<tr>
<td>A) The Social Care Perspective</td>
<td></td>
</tr>
<tr>
<td>B) The impact of integration on social work identity</td>
<td></td>
</tr>
<tr>
<td>C) Resources</td>
<td></td>
</tr>
<tr>
<td>D) Inherent contradictions in the system</td>
<td></td>
</tr>
<tr>
<td>References</td>
<td>19</td>
</tr>
</tbody>
</table>
Integration of social work and health services

BASW England policy on integration of services and the role of social work, the social model and social workers within integrated services.

Joe Godden Professional Officer 1.3.16

1. Reasons for developing a BASW policy on “integration”.

BASW is developing a policy in relation to the integration of health and social care in response to developments in national policy by all the major political parties. The key aim of the policy will be to help social work practitioners understand the concepts of “integration” and to examine the implications for social work and the social model of care of the move towards more integrated health and social care. BASW will come to a view on the implications of “integration”, which will become a policy. This paper aims to help move towards the establishment of a BASW policy.

The key current driver for the integration of social care and social work with the health service is the crisis of capacity in the health service mainly for older and disabled people needing discharge and support within the community.

While there has been a focus on the difficulties of A&E and community health services in the current crisis there is also a longer term challenge in the ability of social care services to meet the needs of a growing population. Wider demographic and social changes have increased the number of older people with complex conditions and disabilities dependent on ever scarcer social care services and weaker support within their family and community. Informal support systems in families and communities are recognised in recent policy from Government as essential for the health and social care systems to be able to cope and there are initiatives to try and support communities via early intervention and preventative services in order to reduce the pressure on health and social care support services. Yet changes in family structures and increased geographical mobility work against that vision being materialised.

Current national policy discussion runs the risk that the role of social work and social care services is/are seen as being adjuncts to health services. The points in Section 2 below highlight issues raised by BASW members regarding the “integration” debate.

---

1 The term “integration” is used in a very non focused way in the literature and discussion of health and social care. The term is used in this paper to refer to changes in the way that services are organised in order to bring closer working relationships between health and social care for the benefit of users of services. However the general term “integration” does need to be further defined. See Section 5 for further explanation. Integration can be used to describe partnership working, without full organisational mergers.
2. Key Points raised by BASW members

a) Social workers are already working closely with health agencies in a range of settings including mental health trusts, hospital discharge teams and GP practices. Social workers are also members of interagency youth offending, drugs and alcohol teams and child mental health and child protection (MASH) teams. The level of integration and perceived effectiveness of these arrangements varies but provides social work as a profession with useful experience to contribute to the national debate.

b) The level of integration varies across the UK and therefore useful lessons can be learnt. In Northern Ireland there is a long established structural integration, in Scotland and Wales a more recent partnership model has been developed.

c) That there are often substantial differences between a social work perspective and a health perspective. Social work has its roots in an "empowering" model of working with people, the health service has a tradition of being much more hierarchical. These cultural differences need to be carefully addressed in order to improve services for people who use social care and health services. Social work is also rooted in the tradition of “relationships”, a key skill to slice through the intractability of inter-agency working is to focus on the importance of healthy relationships. When they work well you get innovation and new fresh ideas and ways of working. It's about listening and learning from each other and is based on mutual respect.

d) Social workers have pioneered the importance of putting the needs of users of service and carers at the centre of service delivery by trying to work with people, rather than for people. This approach is less developed in health and some other agencies.

e) BASW recognises that service users and carers can be subject to multiple assessments, with fractured care pathways, poor communication leading to serious incidents and the dangers of silo working. We therefore support flexibility and creativity to improve the service user / patient experience of pathways. However social workers have skills and knowledge that they uniquely bring to the table and they should be supported to implement them. Equally there are skills and knowledge that social workers aren’t equipped with, such as in depth practical knowledge of personal care and nursing skills. Social workers should not be undertaking those roles.

f) A core function of social work, and one that social workers are especially skilled in, is working with a range of agencies to address all aspects of a person's circumstance. The agencies that social workers work with include: health, housing, employment, finance and education.

g) The implementation of the Care Act provides an opportunity to develop the multi-agency role further with the new responsibilities of local authorities in providing support to carers, wider family and community services to vulnerable people in their own home and a focus on preventing people requiring health and social care services.
h) In order to carry out the functions of prevention and early intervention as detailed in the Care Act social workers need to work closely with wider community services and be in a position to advocate independently for vulnerable people and their carer’s in the community rather than being absorbed into health structures. This will require social workers to spend time in local communities, forging relationships and networks rather than being over constrained by care management or the health service.

i) Over the last four years there has been consistent feedback from BASW members who are located in health teams that many of them find that professional social work supervision, training and support are not adequately provided and that the social work perspective can become marginalised.

j) Lessons learnt tell us that initiatives to integrate services have had a varied history. Many initiatives have had a short term time span often due to short-term political and financial considerations. A more sustainable strategy is needed with a clear vision. BASW urges cross–party consensus to avoid future unnecessary change and reorganisation and supports most of the recommendations of the Barker Report, (Barker K. (2014))

k) The research evidence on integration is remarkably thin. BASW are concerned that political plans are driving change, rather than properly researched and evaluated pilots.

3. Summary of BASW position

BASW supports joined up working in equal partnership with the health services. We however do not support full social work and social care integration/absorption into the health service. We feel that social work should support changes in the health service and contribute to the development of improved person – centred care while still having strong links with local government including housing and public health services. The vast majority of community based provision for social care and increasingly health is provided by the private sector. Partnership working also needs to take place with that sector.

We acknowledge that social work and health care are being drawn closer together and that many social workers work successfully in the health environment, although not necessarily directly employed by health. We recognise that the public expect us to be working together and are not tolerant of interagency differences where health and well–being is at stake.

Our preferred model is a partnership model with joined up services – not full structural integration into a single organisation. The meaning of the term partnership being: “A relationship between individuals or groups that is characterised by mutual cooperation and responsibility, as for the achievement of a specified goal”. (The free dictionary .com). Whatever model is developed there is a strong case to ensure that social workers maintain an independent professional structure and voice with line and senior managers coming from a social work background. Social workers also need access to relevant training and social work development programmes, including programmes that consolidate issues of professional identity. (The experience of “integrated” services in mental health reinforces the importance of professional supervision). The Care Act
delegation of functions means there can be a variety of providers of social work services. For example GP practices/alliances are able to employ social workers along with Health Trusts. The standards for employers of Social Workers in England are not compulsory and there are no compliance checks other than the voluntary health checks in place. Commissioners often do not include a practice governance framework as compulsory and therefore the environment in which social workers will work and the support they receive will be very variable and potentially negligent of the needs of the professional workforce and may result in poorer outcomes for individuals in society.

BASW believe that there are substantial benefits for service users in partnership working, but the important perspective of social work and the “social” must be protected against the dominant health (or illness) model. BASW should use the opportunity of the current debate on the future of the health service and devolution of health and social care powers to regions, to seek cross-party consensus and promote the role of social work in shaping the future development of health and social services.

4. Effective Partnerships – Key Questions

From our experience of previous integration or partnership initiatives we feel the following issues need to be considered in any integration/partnership project and would advise members to raise these if a scheme is being considered in their area:

- A clarity as to the nature of the proposed relationship between health and social care, or other “partners”. Are the proposals for full structural integration, giving one organisation the role of “lead” partner, or are the proposals to continue with two autonomous organisations, but with agreements about how working together is to be realised?
- Sustainability and Commitment. Is the project being considered as part of a long term strategy? How easy would it be for either partner to withdraw on the basis of short-term political or financial factors?
- Professional Identity: How far are social workers guaranteed a social work job description, supervision, and a structured professional development framework that employers must follow?
- Are social workers in “integrated” structures represented at the health Board Level?
- Regardless of the organisational model will there be the necessary investment in joint training and staff development to ensure mutual understanding of all professions? This investment needs to include tasks and roles that social workers and other professional groups can and cannot undertake

---

2 Standards for Employers of Social Workers in England Local Government Association
http://www.local.gov.uk/documents/10180/6188796/TheStandards+-+updated+July+01+2014/146988cc-d9c5-4311-97d4-20dfc19397bf
• Information systems and data. Will information systems be integrated to avoid double inputting and will social care data be collected and considered alongside health data?

• Governance. Will policies and procedures be aligned and represent the social work models of working?

• Wider Community Partnerships. How will these be promoted and extended. These may include housing, leisure and health promotion?

Appendix 1 sets out background information on the integration debate between health and social care, including an exploration of the definitions of integration and a description of a model of seeing integration as a continuum from “co-operation” at one end of the spectrum to a single organisation at the other end. The historical context of “integration” is described as well as a summary of Government policy and a brief reference to the international situation regarding integrated working.

5. BASW’s views on integration

BASW wants to create better services for people across health and social care and other related organisations such as housing, criminal justice, education, police, youth work etc. We support work to enable better co-operation between organisations and where appropriate to integrate services structurally. (Although the evidence of the benefits of structural integration is limited as reported by the Kings Fund 2015). We believe that the outcomes for people who use health and social care services should be the paramount concern. However we have significant concerns about the direction of travel taken to achieve these outcomes.

We live in a world where politically and economically the health agenda massively dominates the social care agenda and we believe that this domination can be to the detriment of the vital social care perspective, which will be to the detriment of people who have social care and health needs.

Our concerns about the overall direction of policy are:

A. The risks to the social care perspective from integration with health
B. Impact of the policies on social work identity and contribution
C. Adequacy of resourcing, which is inadequate now and could become worse if social work and social care funding is subsumed within health and is inadequate now
D. The inherent contradictions in the way that health and social care systems work
E. Benefits that social workers bring to integration

These points are explored in Appendix 2

6. BASW Charter for integrated working

BASW has drawn up a charter for social workers who are working within formal integrated systems or within a partnership arrangement. The charter applies across various models of
integration, from structural – the creation of a single integrated organisation, through to partnership arrangements and co-operation agreements. BASW is supportive of partnership working where it is done well and properly and is appropriate. As stated above the evidence base for fully integrated systems appears to be weak as the reports by the IPC, SCIE, and the Kings Fund show. What comes across is that a focus on the needs of service users and carers and their involvement in developing joined up services is essential. It would appear from this evidence that structural changes are not necessarily the answer to co-ordinated and integrated care. Regardless of what the organisational arrangements are BASW states that the following need to apply:

- There must be genuine service user and carer involvement in both the creation of partnerships / integrated services and in the on-going management of them
- Social workers and social work managers should be engaged from the outset in the development of plans to reconfigure and change services
- Commissioning managers must recognise that social work is a profession with its own principles and code of ethics and unique knowledge and skill set. This knowledge and skill set includes safeguarding, the law, case management and personalisation, but also relates to wider knowledge emanating from research and practice. This includes a high level of understanding of the social model of disability and a community approach to intervention
- Interagency groups must be established to oversee agreements
- Regular governance meetings at senior management level must take place to monitor partnership or integration arrangements
- There needs to be social work representation at senior management meetings of organisations and partner organisations. This representation should be from someone who clearly “owns” the local authority social care portfolio
- That clear lines of accountability, leadership and support to middle managers are set up in order to take the social care agenda forward
- The social model of disability and knowledge of social care services and the social care perspective must be incorporated into the training of all partner professionals
- Social Workers must be supported to retain their occupational role undertaking social work tasks as described in the PCF, HCPC and Knowledge and Skills Framework
- There must be active promotion of the value of the social care workforce
- Everyone responsible for personnel issues, if formal agreements are set up, must be trained in the requirements of the Care Quality Commission and HCPC
- Social care leaders should ensure that that support services are in place for social workers – IT HR, finance, learning and development. This includes ensuring that
social workers, whether seconded to partners or directly employed, have the tools to engage with partner agencies (such as access to all partner internet and intranet and recording systems)

- Robust arrangements must be put in place to ensure that social workers receive good quality supervision from qualified social workers, which includes:
  - professional supervision within the team from an experienced social worker
  - support for the experienced social worker from an external mentor

- There should be an adequate number of social workers in multi-disciplinary teams

- There should be a social work forum in each locality that is separate from other professions in order to build and sustain identity

- That social workers are supported to have an independent voice. This needs to be applied in supervision and supported by professional codes of practice and teaching and learning strategies. It can be hard as a member of a multi-disciplinary team to criticise the decisions of other professionals. Social workers need to be supported when they refuse to undertake something that they see as unethical, wrong, or indeed in some cases unlawful

- Agencies employing social workers in “integrated” settings, need to undertake an audit on a regular basis of the experience of social workers. The audit too developed by the DH for mental health social workers is helpful (DH Jan 16)

**Actions**

This document will inform:

- The support given by BASW and the SWU to social workers working in joint teams or faced with proposals for integration.
- Discussions with a wide range of relevant bodies including Skills for Care, the Department of health, ADASS, Devolved Regional Authorities.
- Any Media input
- Policy briefing papers and guidance leaflets will be developed for this purpose based on this document.
- BASW will continue to review and develop this policy in consultation with members who are affected by changes

It will be helpful for members to notify BASW of practice issues both difficulties and examples of good practice in joint work with health and other agencies. You can e mail j.godden@basw.co.uk or england@basw.co.uk you can also use the BASW forum on the member pages of the BASW web site.
Appendix 1

Background information on the integration debate between health and social care.

The term “integrated care” is used widely in Government policy statements. Although the term can apply to integration with housing, health, social care, the police, probation etc. it is most often used to talk about integration between health and social care. This paper focuses on the latter however there is also some relevance for integration between other services, particularly with “housing”, which ought to include working with the residential and nursing home sector. The term integration is rarely tightly defined, but in current policy use is used to both describe outcomes for the people using services and structural concepts. The structural concepts describe the organisational arrangements. Definitions are often lose varying from descriptions of unified single structures, with single management arrangements and single budgets to much looser definitions which refer to multi-agency working or partnership working. In the literature there doesn’t seem to be clarity as to whether integration is about outcomes, or structures. The following statement is clear, but not all are as clear as this: “Integrated care and support isn’t the end. It is the means to the end of achieving high quality, compassionate care resulting in better health and wellbeing and a better experience for patients and service users, their carer’s and families” (Integrated Care and Support (2013).

The Health and Social Care Act 2012 set out specific obligations for the health system and its relationship with care and support services. It gave a duty to NHS England, clinical commissioning groups, MONITOR and Health and Wellbeing Boards to make it easier for health and social care services to work together. (Cited in: Health and Social Care Integration DH (2015). The use of the term integrated care is also one that is used across specialities. For example older people’s care – primary and secondary levels, mental health – community and hospital, learning disabilities – community and hospital and also is used in children’s services, particularly specific integrated or multi-disciplinary teams to support aimed at safeguarding children (and families). The Stevens Report “Five Year Forward View” (2014) mentions social care several times, including the statement that “The NHS will break down barriers in how care is provided between health and social care”.

The diagram below gives a visual presentation of the range of options that are available to bring health and social care services closer together;
The Care Act 2014 uses the term “cooperation” rather than the term integration. For example:

(1) A local authority must co-operate with each of its relevant partners, and each relevant partner must co-operate with the authority, in the exercise of:

(a) their respective functions relating to adults with needs for care and support

(b) their respective functions relating to carers, and

(c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b). (HM Government 2014)

(2) A local authority must co-operate, in the exercise of its functions under this Part, with such other persons as it considers appropriate who exercise functions, or are engaged in activities, in the authority’s area relating to adults with needs for care and support or relating to carers. (The Care Act 2014)

The idea of health and social care working together is not new. Ever since the inception of the NHS there have been calls and attempts for the health and social care sectors to work together. (Bamford, T. (2015). Northern Ireland is often quoted as a place where integrated care occurs. Kings Fund state “Northern Ireland has had integrated health and social care since 1973 but there has always been a commissioner–provider separation throughout this period”. (Kings Fund June 2015). It is noteworthy however that BASW members who work in the Northern Ireland Health Trusts report that although health and social care is combined within one organisation that services are separately commissioned and that social work and social care can feel that health and social care has divisions. “...although we have an integrated structure it doesn’t always solve the problems”. “We have had in the past money for health ring fenced but money for social care hasn’t been”.

There have been various attempts in England to bring aspects of health and social care together by permitting and encouraging joint working, via Joint Consultative Committees, joint funding, or pooled funding arrangements. This has been applied since the 1980s. In the 1970’s and 1980’s GP attached social workers were not uncommon, but reduced in number from the late 1980’s. (Bradley, G. (2000) and Davies, M. (2007). The option of care trusts as a single local integrated care organisation, was introduced as part of the NHS Plan 2000 (With not much success in practice in terms of implementation). The Health and Social Care Act 2012, placed new duties on organisations to promote integrated care and retain the previous legislative flexibilities for pooled budgets, lead commissioning and integrated provision. The 2012 Act also introduced health and wellbeing boards as a new local vehicle to promote integration. They have a statutory duty to promote integration, assess the needs of their local population through a joint strategic needs assessment and agree a health. (Cited in Humphries, R Wenzel, L. June 2015).

Within health and social care the “pooled budget” arrangements have most commonly applied to mental health, community equipment and learning disability services, where since the 1990’s many local authorities and health authorities have “pooled” their resources. These services are notable because they focus on services for people whose needs spanned health and social care. Usually the lead for mental health has been health and for learning disability services this has been social care. However as the King’s fund detail, the simple fact of having a “pooled” budget does not necessarily
lead to an integrated service that has positive outcomes for service users. The King’s fund say that for positive outcomes to be achieved the following conditions must apply:

The structural integration of the health and social care system in England will bring few benefits unless it is accompanied by other changes, including:

- a willingness to challenge and overcome professional, cultural and behavioural barriers
- action to share information both within the NHS and between health and social care
- organisational stability to avoid the distractions and delays that occur when structures are altered frequently
- a willingness to provide financial support and flexibilities to enable the introduction of new models of care.
- organisational stability and leadership continuity are important facilitators of integrated care.

(Kings Fund June 2015)

Similar points had previously been made by Institute of Public Care (2013) and also by SCIE, who reported the evidence base underpinning joint and integrated working remains less than compelling:

“It largely consists of small-scale evaluations of local initiatives which are often of poor quality and poorly reported. No evaluation studied for the purpose of this briefing included an analysis of cost-effectiveness. There is significant overlap between positive and negative factors, with many of the organisational factors identified in research as promoting joint working also being identified as hindering collaboration when insufficient attention is paid to their importance”. (SCIE 2011)

Skills for Care (2013) reported that:

“The evidence relating to integrated health and social care more generally, and workforce issues more specifically, has often been described as problematic, and this review found it to be weak”.

The Barker Report’s (2013) primary recommendation was that ‘England moves to a single, ring-fenced budget for health and social care, with a single commissioner’.

Current Government Policy on integration is as follows:

“...services often don’t work together very well. For example, people are sent to hospital, or they stay in hospital too long, when it would have been better for them to get care at home. Sometimes people get the same service twice - from the NHS and social care organisations - or an important part of their care is missing. This means patients do not get the joined-up services they need, leaving them at increased risk of harm. Health and care staff may miss opportunities to make things better for patients and service users, and taxpayers’ money is not being used as effectively as possible. In the care and support white paper, we committed to working with other organisations to make evidence-based integrated care and support the norm over the next 5 years. Working with national partners, we are removing barriers by:

- co-producing Integrated Care and Support: our shared commitment - a document setting out how local areas can use existing structures for integrating care
• agreeing and publishing a definition of integrated care

• inviting and supporting local areas to act as pioneers and exemplars, to develop and demonstrate the use of innovative approaches to efficiently deliver integrated care. (Department of Health May 2015).

The Government policy has been supported by “The Better Care Fund”, is being used to pilot integrated work between health and social care, particularly around hospital admissions and discharge. The oft quoted pioneer of this approach is Torbay. Research by the King’s Fund in 2012 into the outcomes for people in Torbay who experienced the integrated service is somewhat tentative. There is …“some evidence of reduced hospital admissions and shorter stays in hospital in areas where integrated care, although not clear cut”. (The Kings Fund 2012)

The King’s (June 2015) fund have more recently reported on integrated care pilots, supported by “The Better Care Fund”. They conclude that:

“There is no one model of care co-ordination, but evidence suggests that joint commissioning between health and social care that results in a multi-component approach is likely to achieve better results than those that rely on a single or limited set of strategies”. However the components include:

• a move to community-based multi-professional teams based around general practices that include generalists working alongside specialists
• a focus on intermediate care, case management and support to home-based care
• joint care planning and co-ordinated assessments of care needs
• personalised health care plans and programmes
• named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey.

The report doesn’t support one way or the other structural integration of organisations to achieve care co-ordination.

Organisations, including ADASS and the LGA have welcomed the “Integrated Care Fund”, however they and others have made strong criticisms that the fund will not be able to achieve its objectives because of the reductions in budgets for adult social care that councils are having to deal with “… even if all of this is counted as new resources for councils, local government budgets are set to fall by 2.3% in real terms from 2014-15 to 2015-16, suggesting more pain for adults’ and children’s social care, both of which are facing rising demand”.(Community Care June 2013). It is of note that all the objectives of the Better Care Fund are NHS objectives, principally about hospital discharge and prevention of hospital admission.

The Local Government Association also welcomed the integrated care funding but warned that the wider cuts would mean “…some councils will simply not have enough money to meet their statutory responsibilities”, given the gravity of cuts already made to local government since 2011” (Community Care June 2013). The reported further 30% cuts in Local Government from 2016-20 as part of the Autumn Statement and Comprehensive Spending
Assessment further compound the potential for meltdown in the provision of adult social care services.

Another Government policy is to delegate all health spending to local areas. Manchester Devo Manc is an example of one of those areas. The plan is to delegate all health expenditure to Greater Manchester so that health and social care expenditure can be pooled.

“Devolution to Greater Manchester should enable decisions to be taken much closer to the population being served, with councillors having a bigger influence on future decisions. This raises the prospect of a health care system similar to those in the Nordic countries where regional and local politicians often have a more significant role than their national counterparts in the running of health and care services. The unanswered question is how much freedom public sector leaders will have to depart from national policies in taking greater control of NHS resources. This is one of many important issues that will need to be worked through in 2015/16, which will be the build-up year. We have no knowledge at the moment about whether devolution to Greater Manchester or other regions would affect how health and social care services are commissioned and delivered on the ground.

The main risks of the plans are that they will take time and effort away from work to address the growing financial challenges facing local government and the NHS, and that they will result in confused accountabilities. The worst of all outcomes would be further structural changes to the health service that distract public sector leaders from their core task of improving outcomes for the populations they serve. It will be just as important to ensure that governance arrangements help to clarify where responsibility for providing leadership of public services rests, especially as the coalition government’s reforms have left a vacuum in the NHS that needs to be filled”. (Kings Fund March 2015)

The Independent Commission on Local Government Finance endorsed the Barker Commission’s recommendation for a single spending settlement. It has gone further by recommending the introduction of place-based budgets covering a wide range of local budgets for places that are willing and able to take on this reform (Chartered Institute of Public Finance and Accountancy 2015, cited in Humphries, R Wenzel, L June 2015). This reflects a growing interest in the devolution of responsibilities and resources from Whitehall to local areas, perhaps best exemplified in Greater Manchester’s proposals for a combined health and social care budget.

A recent review of primary care health services endorsed the recommendation for “a single point of access to community services and social services for urgent assessments. To facilitate effective multi-disciplinary assessment (for example, acutely ill older people, discharge planning), staff from the necessary range of healthcare disciplines and from social services should be co-located and develop a team-based approach” (Primary Care Workforce Commission (July 2015) (BASW England commented on the review at pre-publication stage).

In the report “Options for integrated commissioning Beyond Barker” (Humphries, R Wenzel, L June 2015) the authors report the testing and discussion of the Barker Commission’s findings and recommendations with stakeholders from charities and patient/service user organisations, national bodies representing professions and organisations in the NHS and local government, as well as academic and technical experts. These discussions indicate a
substantial “groundswell of support for the central proposition of a new settlement based on a single ring-fenced budget and a single local commissioner. But the biggest concern expressed by stakeholders – especially from within the NHS and local government – was how a new settlement could be achieved without major organisational change, to which there is almost universal aversion”. The report goes on to say that the evidence for the need for integration is strong and they echo the findings of the DH (2013) report that “that fragmented and disjointed care have a negative impact on patient experience, result in missed opportunities to intervene early, and consequently can lead to poorer outcomes. Poor alignment of different types of care also risks duplication and increasing inefficiency within the system (Department of Health 2013). Problems with communication and joint working occur both within primary health care and local authority care services and between secondary health services and the community (both health and social care).

A study published in February 2016 of issues relating to integration concerning mental health social work found a varied picture about the direction of integration. The implementation of the Care Act and continued pressure on resources demonstrates that for some social workers and social work teams working in mental health that there have been particular pressures including examples of relocating social workers from mental health to more generic adult teams. (Mersey Care NHS Feb 2016)

The above details only policy in relation to England. A quick look at international comparisons indicates that in some countries social workers are fully integrated into primary care and that their role is not confined to a narrow case management approach, but includes a community approach and public well-being approach. An example of that is given regarding the Irish Republic (Fleming T. et.al 2011, supported by personal correspondence with one of the authors). Another example is Canada where “Social workers are key members of inter professional primary care teams in Community Health Centres, Health Service Organizations, Academic Family Practice Units and Shared Care Teams”. (Ontario Association of Social Workers (2005). Mason et.al (2015) in a recent review of international integrated health and care funding arrangements noted the widespread use of joint budgets as a means of promoting integrated care. The review explored some of the challenges associated with the implementation of these arrangements and in particular stressed the importance of their being underpinned by effective working relationships and leadership across the system.

The Scottish Government has created a completely new legislative framework for integration between health and social care commissioning and delivery – the Public Bodies (Joint Working) (Scotland) Act 2014. This has the aim of providing high-quality care and joined-up services that support people to stay in their homes, and of ensuring resources are used effectively to provide services for the growing population of people with long-term and complex conditions, many of whom are older. Health boards and local authorities are required to enter into integrated partnership arrangements by April 2016 that will: have an integrated budget – as a minimum this will cover adult social care, adult community health care, and aspects of adult hospital care”. (Cited in Humphries 2015).
Appendix 2 details: A The Social Care Perspective, B) The impact of integration on social work identity, C) Resources and D) Inherent contradictions in the system

A) The social care perspective and the risk to it of integration

Social factors contribute to many of the problems that people experience. This includes isolation, poverty, lack of personal and community resources, stigma, prejudice, discrimination.

Social work and social care have a body of knowledge and research that demonstrate that the social work perspective holds valuable lessons for policy. The perspective on the world that is recorded in the BASW Code of Ethics is rooted in the sociological and psychological tradition. This is the tradition that we are now glad that the health profession is embracing, at least in some of its statements of policy – ‘person centred’, ‘well-being’ not just being about an ‘illness’.

There has been support from a number of organisations for a holistic role for social workers working in adult services. This includes work by the BASW Social Work With Adults Reference Group (BASW SWARG 2012). ADASS. The College of Social Work (2013, 2014) and The DH Knowledge and Skills Statements Social Work with Adults (DH 2015).

The complexities of this holistic approach to understanding human behaviour and systems does not lend itself easily to traditional rationalistic scientific research, because of the multi factoral influences on people. However there are examples of a rationalistic evidence base for the social perspective. One example from mental health is work by Jerry Tew and others. Tew, (2012) gives an example of evidence in the field of mental health where he says the most important factor in recovery would seem to be social opportunities e.g. reclaiming valued social roles / identities; personal relationships of giving and receiving (Tew et al, 2012). Martin Webber (2015) argues that the social perspective contribution to mental health social work:

“We need to restate our intervention potential as champions of social perspectives in mental health services. This requires the adoption of epistemological paradigms beyond social work to influence NICE guidelines and to challenge the dominance of psychiatry and psychology.”

Similar issues apply to the area of work of working with people with a learning disability. Social work has pioneered community alternatives to hospitalisation, yet the power of funding has remained often with health, as seen in the fall out of the Winterbourne View scandal (DH 2012). Really good integrated commissioning can overcome these tendencies as Salford have demonstrated, (Professional Social Work July August 2014). Integration can work, but the principles founded in social work values such as human rights have had to dominate.

Mental health services were one of the first to combine social services and health functions, with mental health trusts taking the lead on the provision of mental health services. This led from the 1990s to social workers and social care staff taking their lead from, and frequently being directly employed by health trusts. BASW found that in some areas this was very effective, with good outcomes for patients and the social care perspective being well integrated into the ethos of health. (BASW 2010). However the last few years has seen an appraisal of the effectiveness of such arrangements, with some social service departments pulling out of ‘pooled’ arrangements. (BASW (2013). Evidence from this survey found that
social workers had very mixed experiences of working in multi-disciplinary teams, varying from great satisfaction, with pride that their views and perspectives were listened to, to strong concerns that the voice of social work and social workers was marginalised. There are some interesting pilots taking place to look at the impact of integration from a workforce perspective, which is welcomed. For example Health Education North West (HENW) has established a dedicated workforce transformation function in January 2014. (Health Education North West).

We do not have good evidence of the perspective of social workers in the new integrated primary care teams. Anecdotal evidence however shows that social workers are supportive in theory, but that how this approach will work in practice will depend on the sort of factors that have been identified by SCIE, The King’s Fund and the Institute for Public Care. Anecdotal information from members indicates that some of the integrated teams are not integrated in any legal sense, but are local practice arrangements. For example basing social workers in GP practices, or co-locating primary care health and social care workers in health centres (for example in Leeds and Staffordshire) but the social workers still being employed by local authorities. This sort of model would appear to have the advantages of organisations working co-operatively, without all the structural changes that full integration would entail.

One of the biggest challenges to integration (however defined) is cultural. As Bamford (April 2015) states: “The greatest difficulties lie in the different cultures and values of health and social care. Social care’s value base is derived from social work. It emphasises the empowerment of service users; it stresses the rights of users to self-determination and has a commitment to social justice. Medicine, historically, has been more paternalistic and focused on meeting individual and specific health needs”.

Priorities in healthcare are changing, but prevention and health promotion are low-status activities. Genuine integration has to look at the wellbeing of individuals and communities. This shift of focus requires a whole-system approach.

Anecdotal evidence from some social workers working in integrated adult trusts report that there are strong differences of approach for example between social workers and community nurses over individual service users / patients and decisions as to whether residential care is needed or not.

B) The impact of integration policies on social work identity.

Identity is important to professionalism. If workers in any profession feel that they are part of a wider tradition, rooted in practice, research and values then they will feel more valued and will perform better. Conversely role confusion, lack of identity or attacks on professional identity will lead to issues of poor morale and possibly poor performance. These issues were reported on in a BASW (2010 BASW) and were further evidenced in BASW (2013). The issues explored those papers demonstrated some of the challenges of partnership working in mental health. The reports gave details of some local authorities pulling out of partnership agreements with health services. This was also reported in Community Care (2013). Chatziroufas, (2012) explored the views of practitioners working in multi-disciplinary mental health teams and found mixed satisfaction. Feedback from BASW members has been that the issues and lessons from the BASW studies equally apply in other multi-disciplinary settings and continue to apply in some mental health settings. (Also see Bailey D and Liyanage, L (2012). Carey argues that there are risks to social work identity from the move to integration. He states: “Social work practitioners are now increasingly integrated within
multiagency health and social care settings which mean that ownership of their casework may be lost in favour of sharing with health care, education, unqualified or other welfare staff, at times drawn from different discursive and pedagogical terrains. Whilst such multidisciplinary practices may provide new insights or the possibility of effective collaboration, it is also as likely to muddle interpretations—or generate conflict or cultural and paradigm-related confusion—or lead perhaps to ideological colonisation of seemingly more legitimate biomedical paradigms and models of practice.”(Carey, M. 2015)

The reasons for local authorities pulling out of partnership agreements with mental health trusts are varied, but one of the reasons given by some social workers was that they felt that their identity and professionalism was marginalised in multi-disciplinary teams. Not only is that problematic for the professionals involved, but the independence of thought that social workers can show in the face of a dominant medical model is lost at a significant price for users of services. Integration done well is positive for workers and service users, done badly it is bad for both. This includes the organisational and cultural issues identified by the Kings Fund and others and in our view the requirements to recognise the value of social work by supporting social workers as detailed in BASW Charter below.

C) Adequacy of resourcing.

It is noticeable that the policy drive towards integrated health and social care in relation to older people’s services has occurred at a time of huge pressure on the NHS and austerity impacting on local government. These pressures are recognised and reported on by the Government in their policy on integration between health and social care in relation to older people’s care where it is reported that services often don’t work well together. ‘The Better Care Fund, or Integrated Care Fund has seen significant sums of money transferred from health to social care. This is to support the policy objectives described above. However there are significant concerns in the social care sector that although the money transfer from health is needed and is desirable, that it does not make up for the overall reduction in social care services caused by cuts in local government funds. A lot of the integrated care fund money is being spent on propping up social care services. It is reported by ADASS that much NHS money provided to councils is being used to stave off tighter thresholds on access to adult care services rather than invest in integrated care. The finding raises doubt about the potential of the Better Care Fund – a £3.8bn pooled budget between councils and the NHS from 2015-16, largely made up of health service resources – to deliver more integrated services, (Community Care May 2014)

D) Inherent contradictions in the system.

One of the big stumbling blocks to integration of health and social care is the issue of social care being a charged for service and being means tested, a point made by the Barker report (Barker 2014). This has been an unresolved issue ever since the creation of the NHS and social care services. Another issue is that it has proved very difficult to integrate systems at a practical level. Some of the integrated services that have been running for twenty years still have problems with integrating their IT systems, their HR systems, their training and development systems and general policy and procedures. Put simply social workers and others still report that in spite of working in a so called integrated system they may not be able to access the health IT systems, if they do that they might have to dual record events on both social care and health systems.
The evidence base for particular integrated systems appears to be weak as the reports by the IPC and SCIE show. What comes across is that a focus on the needs of service users and carers and their involvement in developing integrated services is important. It would appear from this evidence that structural changes are not necessarily the answer to co-ordinated and integrated care. The IPC report (2013) and SCIE (2011) both have some accord of the factors that promote and hinder integrated working between health and social care services. The IPC report says that there was insufficient evidence to support or reject the hypothesis that: “Particular organisational structures support integrated approaches”. However the Government appear to be pushing the integration agenda very hard, regardless of evidence for or against. Government are pushing for integration via the use of such mechanisms (unsuccessfully as it happens) as the Integration Fund and with so called Devo Max to regions.

Too many social workers know from bitter experience that so often partnerships have been set up without the infrastructure to support integration.

In some services, such as mental health integration can be of benefit to the service user and retain the social work identity:

"Being part of an integrated team is great. I now work alongside district nurses, GPs, community OTs and others. We have a much better understanding and appreciation of each other’s roles and also respect for each other’s roles. I am sure the service user gets a better service". Social worker, (BASW 2013)

E) Opportunities for social workers and benefits of having social workers in integrated teams.

Social workers have developed expertise over many years in co-production of personal care plans and personalised services, including working with service users to manage direct payments and personal budgets. Person centred care is intrinsic to social work training and values. Social work also has a history of community engagement and where supported there are good examples of social workers developing innovative community engagement approaches. For example the Chief Social Worker for Adults has recently reported on why the NHS needs social workers, with a number of examples given to the benefits of a community based approach. (Guardian December 8th 2015). Social workers are often the key professional in co-ordinating diverse groups of professionals and providers, using their skills of facilitating communication in complex situations and their knowledge of how systems work.

Summary of the BASW position in integration

Overall BASW is fully supportive of co-operative working and breaking down barriers between organisations. We can see the benefits for service users of working co-operatively between organisations. However we have severe reservations about a headlong dash to create fully integrated health and social care structures. The cultural and knowledge basis of health and social care are different and in BASW we fear the social perspective, which is crucial for the future of health care as well as social care, could be lost. The independence of the social work perspective in health settings is invaluable. The ability to challenge, without fear of organisational censure is an excellent foil to the power of health organisations. This independence applies not only to independence relating to statutory functions such as the AMHP role or Best Interest Assessor, but also as an advocate in a non-statutory context for
the service user. Social care could be swallowed up into health and all the valuable knowledge and lessons of social care could be eroded. Of course social workers and health need to continue working together to deliver high-quality care. As Bamford (April 2015) says “let’s be modest and realistic in our objectives and not present integration as a cure-all for the health and care system”.
REFERENCES


Community Care (June 2013) Integrated Care fund will not offset monies lost to LA’s http://www.communitycare.co.uk/2013/06/26/osborne-puts-3-8bn-into-integrated-care-but-council-budgets-set-to-fall-again/

Community Care (2013) http://www.communitycare.co.uk/2013/04/02/ive-gone-from-a-skilled-mental-health-social-worker-to-a-petty-rationer-of-services/

Community Care May 2014 Comment on the Barker report. (See Barker K above). http://www.communitycare.co.uk/2014/05/14/transferred-nhs-cash-propping-existing-social-care-services-finds-report/


DH (2012) Transforming care: A national response to Winterbourne View Hospital


DH (Jan 16) How are we doing? A self-assessment and improvement resource to help social care and health organisations develop the role and practice of social workers in mental health https://www.gov.uk/government/publications/social-work-improving-adult-mental-health


Kings Fund March 2015 What Devo Manc could mean for health, social care and wellbeing in Greater Manchester http://www.kingsfund.org.uk/blog/2015/03/devo-manc-health-social-care-wellbeing-greater-manchester?qclid=CLuQ4dOVkscCFSsCwwod7ukJkA


King’s Fund (June 2015) Care co-ordination through integrated health and social care teams http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/care-coordination
Local Government Association: Standards for Employers of Social Workers in England
http://www.local.gov.uk/documents/10180/6188796/The+Standards+-+updated+July+01+2014/146988cc-d9c5-4311-97d4-20dfc19397bf


(Cited in Fleming, T. above).

Mersey Care NHS (Feb 2016) Mental Health Integration Past, Present and Future A Report of National Survey into Mental Health Integration in England


Skills for Care Evidence review - integrated health and social care A Skills for Care discussion paper (October 2013)Written by the Institute of Public Care, Oxford Brookes University Published by Skills for Care


Tew, J (2011)Social Approaches to Mental Distress, Palgrave Macmillan


"The health service is faced with great pressures due to an ageing population, advancing medical intervention, demographic changes and changes in expectations. Hospital A and E departments and medical wards have faced huge pressures in recent years and it is recognised that one of the key ways to reduce that pressure is to have improved services, particularly preventative services in the community and also services in the community that will facilitate quick and effective discharge from expensive hospitals. The number of people in England who have health problems requiring both health and social care is increasing. For example, in the next 20 years, the percentage of people over 85 will double. This means there are likely to be more people with ‘complex health needs’ who require a combination of health and social care services. But these services often don’t work together very well. For example, people are sent to hospital, or they stay in hospital too long, when it would have been better for them to get care at home. Sometimes people get the same service twice - from the NHS and social care organisations - or an important part of their care is missing. This means patients do not get the joined-up services they need, leaving them at increased risk of harm. Health and care staff may miss opportunities to make things better for patients and service users, and taxpayers’ money is not being used as effectively as possible".