Mental Health Social Care Leadership Symposium: Workshop notes

social care institute for excellence

London and South East regions

Key discussion points include:

- Regarding Section 31 of Health Act, there is a need to tie all organisations at a macro level into joint ownership of all performance indicators. Self assessment tools used by the Health Care Commission tend not to be discursive. Discursive self assessment tools are required for socially inclusive outcomes.
- One delegate commented that Section 31 agreements work where there is a need for them but do not where there is not.
- A Section 31 agreement is more than just a financial arrangement; it aims at ensuring delivery of outcomes that represent value for money.
- In the context of the requirement to move to foundation trust status and the social inclusion agenda, some local authority/mental health trusts are reviewing Section 31 agreements.
- The high volume of change in the NHS (every two years) can make building working relationships problematic.
- Currently mental health trusts work to a one-year annual plan; under foundation trust status there will be a five-year planning cycle which may make the planning process more productive with respect to socially inclusive outcomes.
- One delegate argued that there is a need to translate the social inclusion agenda into 'health ' language.
- Regarding terminology, in one area the governance term is not 'clinical**'** governance but 'health and social care' governance**.**
- Practice guidance from NICE and SCIE should be issued jointly to ensure that social inclusion and social care issues are fully represented for practitioners in multi-disciplinary teams.
- It is easier to identify social inclusion issues at a strategic level than at the point of service delivery, i.e. in teams.
- One area took as a starting point for commissioning the premise 'we do not want any provision of hospital beds': this forced the trust commissioning process to fully consider socially inclusive outcomes including full implications of delivering the race equality programme.
- GP-based commissioning may mean a different agenda will come through.
- Delegates discussed the social work/social care input that needs to be in place in primary care.
- Delegates asked how do we make a difference for front line staff having to deliver socially inclusive outcomes (e.g. use of employment specialists in community mental health teams).
- There is a need to create social care leadership capacity at all levels in the organisation.

- The professional lead structure needs attention so that social work and social care leadership is present at trust board level. There also needs to be a visible structure in localities within trusts.

What next?
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- A learning programme for key elements of social care and social work leadership in mental health trusts would be useful.
- A mental health social care strategic network has sprung up from action learning sets facilitated by CSIP. All delegates' contact details have been passed on to this network.
- The social inclusion agenda is much wider than the need to build up the role of social work.

Key themes identified in this discussion include:

- Use of language in relation to social inclusion needs to be considered. In one area the term used to describe governance is 'health and social care governance' rather than 'clinical governance'.
- For practitioners in multi-disciplinary teams, practice guidance that is jointly produced by SCIE and NICE is particularly useful in ensuring that social inclusion and social care issues are fully represented.
- There is a need to create social care leadership in capacity at all levels in the organisation. The professional lead structure needs attention to ensure social work and social care leadership is present at trust board level.

12 March 2007
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