

Integration of Adult Health and Social Care in Scotland

Thank you for giving Quarriers the opportunity to respond to this consultation. Quarriers is a major Scottish charity providing practical care and support every day to thousands of people. Through more than 120 services for Adult Disability, Children and Families, Epilepsy and Young Adults in Scotland and a growing number of services in parts of England, we challenge inequality of opportunity and choice, to bring about positive change in people's lives.

Question 1: Is the proposal to focus initially, after legislation is enacted, on improving outcomes for older people, and then to extend our focus to improving integration of all areas of adult health and social care, practical and helpful?

We have some concerns that the initial focus on older people will create an artificial divide between people for whom the primary reason for their impairments is age, and people with long term conditions and disabilities, including both learning and physical disabilities, some of whom may also be older. Whilst we accept that unnecessary, or unnecessarily long, hospital stays can be an issue for older people, the aim of these proposals is to "enable people to stay safely at home", and this should be an equal priority for disabled people. It is unclear how a system for integrated health and social care that is focused on the needs of only older people will work in practice; what will happen to services for people currently receiving health and social care services who do not meet the age criteria and who therefore would appear to be currently ineligible for integrated services; or indeed, at what age a person becomes 'older'.

Question 2: Is our proposed framework for integration comprehensive? Is there anything missing that you would want to see added to it, or anything you would suggest should be removed?

The role of the voluntary sector is as yet undefined and ambiguous. The framework makes reference to Health and Social Care Partnerships ... "which will work in close partnership with the third and independent sectors" but lacks any detail on how this will work in practice. The role of the voluntary sector within current CHPs and CHCPs is inconsistent at best and these proposals provide an opportunity to address this.

It is also unclear how the role of the third and independent sectors in the strategic commissioning of services for adults will be strengthened. For many voluntary organisations, their current role has been relegated to that of contracted service provider, rather than partner, and there are few, if any relationships between local authorities and voluntary organisations that extend to strategic service planning.

Question 3: This proposal will establish in law a requirement for statutory partners – Health Boards and Local Authorities – to deliver, and to be held jointly and equally accountable for, nationally agreed outcomes for adult health and social care. This is a significant departure from the current, separate performance management mechanisms that apply to Health Boards and Local Authorities. Does this approach provide a sufficiently strong mechanism to achieve the extent of change that is required?

Question 4: Do you agree that nationally agreed outcomes for adult health and social care should be included within all local Single Outcome Agreements?

Question 5: Will joint accountability to Ministers and Local Authority Leaders provide the right balance of local democratic accountability and accountability to central government, for health and social care services?

This response covers Q3, 4, and 5. These mechanisms are all dependent on the level of scrutiny that is proposed. A robust and transparent methodology for monitoring and evaluating Single Outcome Agreements must be established and implemented. The inclusion of outcomes for adult health and social care within Single Outcome Agreements will achieve little unless there is a method of easily identifying and addressing performance management issues.

Question 6: Should there be scope to establish a Health and Social Care Partnership that covers more than one Local Authority?

Yes. In addition, consideration should be given to the development of Health and Social Care Partnerships that correlate to Health Board boundaries, to avoid a multiplicity of overlapping Partnerships, competing for resources from a single Health Board.

Question 8: Are the performance management arrangements described above sufficiently robust to provide public confidence that effective action will be taken if local services are failing to deliver appropriately?

This will depend on the development and implementation of a robust and transparent methodology for monitoring.

In addition, there needs to be a process by which the experience of people who use services is evaluated and taken into account, and improvements instigated. There also needs to be a clear and straightforward means of identifying concerns and complaints for those with less than positive experiences.

Question 9: Should Health Boards and Local Authorities be free to choose whether to include the budgets for other CHP functions – apart from adult health and social care – within the scope of the Health and Social Care Partnership?

Whilst in principle this would appear to be a reasonable suggestion, we have concerns that this degree of variation may impede one of the Government's key objectives of providing "consistency of outcomes across Scotland".

Question 10: Do you think the models described above can successfully deliver our objective to use money to best effect for the patient or service user, whether they need "health" or "social care" support?

Without access to the financial modelling used to support the case for best use of public money, we are unable to answer this.

Question 11: Do you have experience of the ease or difficulty of making flexible use of resources across the health and social care system that you would like to share?

Many of the people supported by Quarriers have experience of using both health and social care services and it is clear that there are some significant difficulties, particularly in relation to people moving from hospital care to community-based supports.

Case study 1

A sustained a traumatic brain injury from an assault in 2006. He was admitted to hospital where he underwent neurosurgery for the damage to his brain and skull. He spent 2 weeks in the Physical Disability Rehabilitation Unit and was discharged home with no follow up support for his head injury. After leaving hospital, A and his family struggled for 5 years with his various cognitive and physical deficits before he was referred to the Quarriers Renfrewshire Head Injury Service (RHIS).

He was eventually referred to the RHIS through a Social Worker who is involved with the family due to his daughter's own health problems and who was aware of the service.

A now has an understanding of brain injury and recognises the cognitive and physical deficits that affect his daily life. RHIS have supported him to put various strategies and routines in place to help him cope and compensate for his various deficits. He has been referred to an epilepsy specialist for an investigation into the possibility that he may have epilepsy

after experiencing black outs and seizure-like events, which have greatly impacted on his confidence and independence. RHIS also referred A to a specialist service for neurological sight loss and he recently received a diagnosis of partial sight loss due to his head injury. A is now working with Vision Rehabilitation Workers to learn techniques for coping with his vision impairment.

But there are also examples of where an integrated approach to health and social care can be developed to deliver effective, personalised, support. Much of this depends on individuals at local level being flexible and focus on the needs of the person, rather than systems.

Case study 2

B has brittle diabetes, and when she was 13 years old, she suffered a hypoxic brain injury. As a result, she was in a coma for 5 months and when she came out from this, she was almost totally paralysed, other than very limited head movement, with sight impairment due to her brain injury and no verbal communication.

She spent the next 2 ½ years in hospital, where she was well cared for and her physical needs met, but with little stimulation or socialisation. During this time, Social Work sought to find a suitable placement for her, but the complexities of her medical condition were such that this proved difficult, other than a high dependency nursing home for the elderly. Eventually Quarriers agreed to build a support package around B's needs, and started the process of developing integrated health and social care support to enable her to leave hospital.

The transition process involved a range of people from different backgrounds, including:

- specialist diabetes health professionals from the hospital
- social work
- physiotherapy
- OT, who provided specialist aids and equipment
- wheelchair services
- speech and language

- GP
- dietician
- education

Medical specialists have developed and delivered personalised diabetes training for care staff at Quarriers. Protocols to safely manage B's diabetes have been established for support staff, to provide a step-by-step process to be followed which would immediately alert both health and care staff to any changes requiring medical intervention. This integrated support continues and so far, B has only required hospitalisation on one occasion to stabilise blood sugar levels. B will remain insulin-dependent and she takes nutrition through gastric PEG feeding.

At 16, B came to Quarriers, where she now lives in a small group residential setting. The local authority initially categorised her as having a physical disability, which immediately presented difficulties with communication, as well as practical aspects such as finding appropriate dental services. However, she is now under the care of the Community Learning Disability team, which allows her access to more appropriate specialist services including social work, physiotherapy, speech and language, dietician etc. This means there is an integrated team with a greater understanding of her needs and a clear focus on her as a person.

Progress is also being made in relation to B's communication needs, and a multi-agency team has recently started to work with her, using switches that she can operate with her head movement, to indicate yes or no. It is believed that her level of understanding may be far greater than previously thought, and rather than being in a vegetative state, there is a possibility that she has locked in syndrome.

There are also examples of good integrated support between health and social care, but there are occasions where other agencies or departments have difficulty in adopting a similarly joined-up approach which limits what can be achieved.

Case study 3

C is a three year old boy with disabilities, who requires overnight ventilation.

Working with the local specialist health professionals, a team of four Quarriers social care staff has been trained to work with him in the family home, which enables C to safely sleep at home rather than in hospital, and for his parents also to sleep all night. This specialist training and support from C's medical team means that a holistic approach can be taken to supporting the whole family, rather than just dealing with C's medical needs. This includes helping to get the two other children up and ready for school, providing a short-break fostering placement to provide a break for the family, access to a friendship group for C and his sisters, and support for Dad from the Dad's group, who are also helping him build a shed in the garden in which to store the medical equipment.

However, a planned uptake of a nursery place for C has highlighted challenges, as staff at the nursery will not change the ventilation tube or do resuscitation training. Either Mum will have to accompany C or arrangements will have to be made to have his Quarriers staff team in attendance. Either way, he will be unnecessarily singled out as "different" from the other children.

Do you have any further comments regarding the consultation proposals?

There are unresolved issues around integration of two substantially different workforces and the way in which this can be achieved to maximise benefit for people who use services.

In addition, health and social care services are regulated by different bodies, and they operate to different sets of standards, which are not always complementary. There may be difficulties in aligning these regulatory and compliance regimes and it would be useful to consider how this might be overcome.

Furthermore, the significant differences in governance and reporting structures of the two organisations at national level may present difficulties, and it is unclear how these will be resolved.

I hope that the above is useful, and we would be happy to discuss further the work of Quarriers and the people we support, if that were helpful.

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