Consultation regards Integration

Annex G Consultation Questionnaire

The case for change

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?

No

Comments

The way the question is phrased makes the assumption that merging the budgets and setting up new joint partnerships with new "high level outcomes" etc will actually improve the results of health and social work intervention with older people. This assumption is actually an aspiration or intention. In fact that the plan for structural integration may well make an improving situation worse:

From The Scotsman on 29th February this year:

"**Scots bed–blocking figures hit new low**

Published on Wednesday 29 February 2012 02:12

Bed-blocking has fallen again to a record low for January, figures have revealed.

Official statistics show that last month, 54 patients had to be kept in hospital for more than six weeks after they were well enough to be discharged.

That is down from 69 in October last year and from 168 in January 2011.

Health secretary Nicola Sturgeon said January's total was the "lowest ever recorded" for that month.

In most cases, bed-blocking, or delayed discharge, occurs when patients are unable to leave hospital because they are waiting for care to be arranged.

Overall there were a total of 571 delayed discharges from hospitals across Scotland in the January census – 219 less than 12 months previously. The latest figures show 197 patients were held up leaving hospital for more than four weeks, with 387 delayed more than two weeks."

In her Report "An evidence base for the delivery of adult services" Alison Petch warns:

"There is a strong body of evidence demonstrating that structural integration

between health and social care does not deliver the effective service improvement that had been anticipated. Differences in culture and in values

and differentials in power tend to distort any blueprint and to undermine any

projected model. Moreover major financial and time resources can be

absorbed by attempts to implement such structural change without demonstrating effective outcomes".

Nor is the case that the "lack of integration" is responsible for major problems actually well made. The recent huge overspend by Fife NHS is described as "bad management"[1]. Fife Patients website also lists the senior management pay scales; it makes an interesting read for anyone believing that integration of local authority services will lead to better more efficient services. Improvement of NHS management might be the single most important thing to do to improve the lot of adult patients and service users.

Overall the plan to integrate social work and NHS in the way it is intended to will weaken local democratic accountability. The joint board involving some council officers and elected members and some NHS employees is rather more bureaucratic and less democratic.

It will reduce the power to have people's complaints and concerns about community care services dealt with directly by their locally elected representative, the representative they voted for to stand up for them regards the local services.

The problem with the idea of setting about the removal of services for older people first from direct local democratic control is that this will significantly disconnect services for older people from other key service areas, such as addictions services provided by local authorities, and public protection services including adult protection, child protection,

[1] http://www.fifepatients.com/nhs-facts/

domestic abuse and services to monitor and manage sex offenders and other dangerous offenders.

In selecting older people first to be subject to the new integration policy can be seen as selecting older people in need to be the first community care client group to have rather less access to an elected member able to take issue with the council about the quality of the services they receive. It could therefore be viewed as discriminatory.

Outline of proposed reforms

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?

No - it is not comprehensive.

Yes – there is much missing from the framework and the consultation document as a whole.

Comments

The lack of any discussion about the effects of severing the current direct connection with public protection/community safety aspects of local authority social work suggests that the full consequences of the proposed legislation may not have been considered.

There is a problem with this. If the consequences of the legislative and policy change have not been considered, a reasonable judgement cannot be made in respect to whether the legislation and policy will prove beneficial or damaging. It suggests that the legislation is something of a gamble regards any potential service improvements rather than something that has been properly assessed as being beneficial.

The proposed framework makes no reference to the “the role of the Council Officer” as specified in the Adult Support and Protection (Scotland) Act 2007. This may be difficult and may require clarification. It seems likely that some authorities’ community care services may end up being managed by the NHS following delegation by the local authority, (as per in Highland recently and Perth and Kinross in the past).

There are major potential problems with this prospect, in respect to the independence of the “council officer”.

The recent article from the Guardian Newspaper illustrates the possible problems quite well.

A consultant paediatrician who raised concerns about a clinic where Baby Peter was treated days before his death has accused NHS managers of using employment laws to gag potential whistleblowers.

Kim Holt said there was a need to "change the culture of the NHS to one of openness and transparency and not one where the truth is often hidden and employment laws misused to silence critics.

"Whistleblowing should be actively encouraged within the NHS. As the evidence given to the Mid Staffordshire inquiry from people too scared to raise concerns showed, without the 'safety valve' provided through an effective whistleblowing procedure patients may be harmed or even killed."

Safeguards, including statutory safeguards in respects to the duties of a "council officer" should be clarified and resolved prior to integration of health and social care to prevent a "council officer" employed by the NHS, from being in any way discouraged from making their inquiries into the circumstances of adults at risk.

This is potentially quite a serious issue as the system in place to look into allegations of neglect or ill-treatment within NHS hospitals by the NHS itself is very different from the legal duties to make inquiries into **any** situation where any adult may be "at risk" under adult protection legislation.

The latest research is quite clear on the scale of this problem:

The Independent on Friday 13th July 2012[2]

"Almost 12,000 patients are dying needlessly in NHS hospitals every year because of basic errors by medical staff, according to the largest and most detailed study into hospital deaths ever performed in the UK."

The differences in the serious case review processes required to be put in place by Adult Protection Committees are different (more robust) than NHS processes. If adult protection legislation and the protection it affords adults in hospital are weakened by the plan for integration, it would not be an improvement on the status quo.

The question of contacts between other key agencies such as the police has not been

2 **http://www.independent.co.uk/life-style/health-and-families/health-news/doctors-basic-errors-are-killing-1000-patients-a-month-7939674.html**

considered. There are three major providers of public services for adults and children at risk across Scotland; the NHS, The Local Authorities and The Police. All have different geographic boundaries and structures. The proposals seem to leave room for 3 different structures for integrated health and social care – the local authority or NHS as lead agency or a new jointly accountable agency. This would seem to be a recipe for chaos. For example Tayside Police may end up having to relate, on matters of child and adult protection to three different bodies within the area covered by Tayside Health Board **and** the three local authorities. In terms of exchanging information about high risk sex offenders and making the links to child protection and vulnerable adults, the proposal is actually dangerous as a result of the huge increase in the complexity of communication channels.

A similar omission from the framework is in respect to the **statutory duties** of the NHS to co-operate with the inquiries of the "council officer". Such inquiries are likely to prove difficult, when a "council officer" employed and managed by the NHS is making inquiries into a case involving neglect by an NHS hospital. Understandably the costs of litigation have influenced the way the NHS may respond to situations that are bound to occur and someone is neglected or abused. Again the clearest guidance in respect to the relationship between the "council officer" the NHS, and the duties the NHS have, under adult protection legislation would be helpful. In fact to leave such matters out of any legislation and regulation could cost lives.

A huge omission from the framework is any discussion of the "fate" of criminal justice social work. In 2004 there was a proposal for the setting up of a "Single Correctional Agency", essentially a take over of local authority criminal justice social work by the Scottish Prison Service.

Unsurprisingly the local authorities, together with support from both the Liberals and SNP campaigned and eventually fought off the proposals.

Amongst many arguments lined up against the Single Correctional Agency proposal was that the close local links between CJS and other council services would be weakened.

The weakening of existing links between child protection, adult protection and management of offenders, especially high risk sex offenders is not considered in the consultation at all. Of course the report alleges certain existing "disconnects" between social care and health services. However it is inevitable that one set of allegedly undesirable "disconnects" is going to be replaced by a new set of "disconnects". Anything that weakens the necessary communication between agencies regards sex offenders, and child and adult protection is not just "undesirable - it is dangerous.

In summary the proposed framework is not comprehensive.

Clearly absent is:

1. Any assessment or report of the assessment of the damage / benefits to patients/ service users of these proposals

2. Any description/guidance as to how the Scottish Office's own 2010 Guidance on the role of the registered social worker will be expected to operate in the new Integrated situation, and no clear guidance as to the professional role of those employed by the new community care partnerships.

3. Any consideration or guidance as to how the current independence of a "Council Officer" (as defined by the Adult Support and Protection (Scotland) Act 2007 can be protected in circumstances where NHS's own procedures and litigation risk averse culture may predominate.

4. Any guidance on how the inevitable weakening of lines of communication regards child protection, adult protection and the management of high risk offenders will be ameliorated.

5. Any learning from the failed and abandoned past experiment in integration undertaken in Perth and Kinross.

6 Any consideration on the effect it will have for other bodies, such as the police , who could have, in Tayside for example, three different local authorities, 3 differently structured HSCP'S and one health board to communicate with regards high risk offenders, or adult protection cases.

National outcomes for adult health and social care

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?

No

Comments

The change proposed will certainly change things. It will become more bureaucratic and be less accountable to local people.

It would seem likely to make the protection of our most vulnerable people more hazardous through the disconnection of other public protection services from those to protect adults at risk, starting with older people at risk.

For example, at present, the local authorities have a single system of records on service users. This means that information about, for example, known sex offenders and child protection cases is the same one as that holding the records of vulnerable adults and adults receiving community care from social work. Sharing information within the same agency is straightforward. There are often links for obvious reasons between social work on high risk offender cases, child protection cases and adult protection cases. The same local agency dealing with all issues has a major advantage in working to protect the public and individual adults and children from harm. This advantage will be lost.

The introduction of "high level nationally agreed outcomes" will not actually aid in the protection of abused adults at risk at all, and the process of reform and change is likely to be hazardous for the reasons described.

Are the assumed (rather then evidenced) gains really worth the risk of, for example, the life of a vulnerable child or adult in Scotland?

The idea that performance management systems actually make significant difference is assumed in the consultation and proposed legislation.

This assumption is not necessarily correct as shown by the recent article of Dr Wouter van Dooren* and Nick Thijs[3].

Much more important in respect to the success of the proposed new organisations will be the performance of staff. This performance will depend to a significant extent upon prosaic matters like equality of pay and conditions, clarity of role, support, training, management and accommodation. It is this that will ensure the proposed change has a chance of making a positive difference as opposed to making things worse. It is alarming that little mention of such matters is included in the consultation.

The framework appears to suggest that the plan is for each new partnership to wrestle with these issues of staff performance, pay, conditions, transfer of employer etc with no guidance or mention in the framework of proposed reforms.

[3] **http://aei.pitt.edu/29756/1/20101022101218_Eipascope_2010_2_Article2.pdf**

Logically, it is inevitable that some areas will manage the change much better than others. The impact on the quality of the services provided will therefore vary hugely across Scotland.

The aspiration, therefore, that "integration" will ensure consistent quality of health and community care services across the country looks forlorn

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

No

Comments

It is unlikely to make any difference to the experience of adults needing services either way.

Governance and joint accountability

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?

No

Comments

The correct accountability of community care services for adults in need is through locally elected members.

The pending legislation will reduce the accountability and responsibility of local authorities for community care services. It will reduce democratic accountability together with the ability of service users to be heard and taken notice of as their elected members' authority over such services is reduced.

The wording of the consultation document, notwithstanding the "easy read version", uses numerous abbreviations, acronyms and jargon and is not an accessible document to most citizens.

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

No

Comments

Such an idea would distance even further from locally elected members the services that are paid for in some part by local taxes, and prioritised locally by local councils after democratic elections. It would also further increase the complexity of sharing information for bodies such as the police.

Question 7: Are the proposed Committee arrangements appropriate to ensure governance of the Health and Social Care Partnership?

No

Comments

The concern about the whole proposal is that it starts to greatly centralise the provision of social care across Scotland, and in reducing control of services held by democratically elected council members, it actually reduces the power of service users.

It can be seen as the “thin end of the wedge”.

Under the proposals it is quite clear that it would be eventually perfectly possible for local people to have lost real control, through their elected councillors of their education, and social work services. Yet these are easily the biggest spending and most important local services.

The consultation document and previous discussions have focussed very much upon health and social care, with the impetus for the proposals and pending legislation coming from the Health Dept of the Scottish Government.

However the Scottish Government is made up of different Departments and is not organised in such a way that an overview of the whole system of social work, health, care and education can be readily taken.

The problems these proposed changes attempt to address include the reported different system of performance measures, the different organisational cultures and dissatisfaction with the overall effectiveness of health and adult care services.

Although the local partnerships with joint budgets have the appearance of being locally based, the strong impression is of the exercise of much stronger central control.

However the consequence of this slow centralisation of public services is a steady erosion of local power and local democracy and the importance of the voices of local people.

Since the debate about health and social care integration has begun, the Scottish Government has already agreed to start a debate and consult about the recommendation in the report on Women Offenders, to bring in a single agency to manage all criminal justice service in Scotland, exactly the same proposal defeated by local authorities following a previous call to set up a "Single Correctional Agency". So it's not just community care services that are being proposed as being removed from direct local authority control, but criminal justice social work services.

As things stand there is no reported plan to abolish the legal requirement for a local authority to employ a chief social work officer. However the question is bound to arise; what is the point of a local authority having a chief social work officer, if most social work services have been removed from local authority control?

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?

No

Comments

No. Public confidence regards dealing with poor performance will not be affected in the slightest by the nature of any particular performance management arrangements over another.

Public confidence in the quality of their local community care services, as things are today, is able to be expressed democratically through the ballot box at local elections. A local authority providing bad services can be thrown out by the voters. Poor performance

that voters have no significant say in (and even less control over) will quickly lose their support and confidence, irrespective of the details of "performance management arrangements".

Indeed the concept of "performance management arrangements" is probably not one that most citizens and the public as a whole really understand. They may not be any the worse for this either.

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?

No

Comments

Allowing different areas to remove from local authority democratic control as many service as they like for as long as they like is to mean a hugely inconsistent patchwork of community care/ child care services across Scotland.

The confusion caused for key agencies that do not have geographic boundaries co-terminus with those of local authorities (ie most of them) like the NHS and the police would be significant. This would make things worse, less consistent, and in respect to the management of high risk offenders, and in the areas of child and adult protection, make lines of communication more complex, and more vulnerable to breakdown in individual cases, potentially with tragic consequences.

It rather puts into context the claim that the proposals will increase consistency of care across Scotland; they clearly will do no such thing.

Integrated budgets and resourcing

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?

No

Comments

It would make more sense to have the local authority alone in charge of the money as the NHS has a sad history of huge overspending.

For example from Scotland on Sunday Published on **Sunday 15 January 2012**

"SCOTLAND'S health boards have plunged millions of pounds into the red amid government cost-cutting and the soaring costs of drugs. NHS boards have revealed a £16.1 million overspend. The problem has emerged in NHS boards' latest cash flow reports, which reveal eight out of Scotland's 11 mainland health boards are over budget with just weeks to spare before the end of the financial year. The latest overspend figures represent the amount of money each board has spent so far this financial year – which ends in March – compared with their budgeted expectations.

The highest is at NHS Highland at £3.5m, while NHS Greater Glasgow, Scotland's biggest health board, has admitted an overspend of £2.8m so far. Both NHS Fife and Lanarkshire come in at £2.5m over budget, while NHS Lothian is £2.1m over budget. NHS Tayside has overspent by £1.9m and NHS Borders and Grampian have notched up an overspend of around £1.4m. NHS Forth Valley has an overspend of £532,000."

In Fife alone £12 millions were paid out in compensation to patients between 2009 and 2011. Do we really want our home care budgets and adult protection services in Scotland merged with the NHS in its current state of financial prudence and technical competence?

The idea of the NHS having financial responsibility for their current costs and also the costs of social care and social work in the community is chilling. [4]

With the facts of financial competence of the NHS as an organisation so clear as recently as January 2012, how can it possibly be prudent to give the NHS control of the money currently spent by local authorities on community care services?

The NHS as host or lead agency for the new partnerships would very likely result in overspending, action to deal with this would inevitable have a detrimental impact upon the citizens needing and receiving community care services. This would be what might be called a "bad outcome"; a likely one though.

[4] **http://www.scotsman.com/scotland-on-sunday/scotland/nhs-plunges-16-million-into-the-red-1-2057027**

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?

Comments

No comment

Question 12: If Ministers provide direction on the minimum categories of spend that must be included in the integrated budget, will that provide sufficient impetus and sufficient local discretion to achieve the objectives we have set out?

No

Comments

The objectives set out – the improvement of the "outcomes" for people receiving community care support – will not be achieved by the proposed legislation for a number of reasons and despite the best endeavours of staff currently employed by local authorities and NHS.

It relies too much on the idea that there is a direct sort of link between the quality and effectiveness of services to adults and national legislation. Quality of care and services cannot be legislated into existence, and nor can service improvements or better "outcomes". If this were the case there would be no NHS overspends, and the Harold Shipman or Baby "P" tragedies would never have happened.

The way the proposals have been laid out seems to make the scope of removal from local authority control a matter for political argument in each local authority area between the local Chair of the Health Board and the local elected members, with the outcome being decided, not according to the wishes of local people, and not in relation to the merits of the case, but as a result of which side of the argument can wield most power. Should local power battles really decide on the future of social work and the future of community care and health services across Scotland?

Jointly Accountable Officer

Question 13: Do you think that the proposals described here for the financial authority of the Jointly Accountable Officer will be sufficient to enable the shift in investment that is required to achieve the shift in the balance of care?

No

Comments

No further comments.

Question 14: Have we described an appropriate level of seniority for the Jointly Accountable Officer?

No

Comments

The consultation outlines a future with the top officer for the partnerships being subject to matrix management from the local authority on one hand and the Health Board on the other. I know of no successful venture where the main person in charge had essentially two different bosses.

From the ***Fife Patients website*** it is easy to learn about the top salaries of NHS senior managers in Fife and the "performance" of Fife NHS in terms of the huge overspend and service failures.

- £170,000 – Medical Director
- £165,000 – Director of Public Health
- £120,000 – Chief Executive (appointed April 2012)
- £110,000 – Nurse Director
- £100,000 – Director of Human Resources

It is hard to see that ensuring a level of "seniority" with a commensurately inflated salary, during a period of hurtful austerity for the majority is either fair, nor in any way linked to success of the various new HSCP's proposed across Scotland.

If for example there were as many as 32 new "Jointly Accountable Officers" all paid £170,000, the costs, just of this small part of the proposals across Scotland would be over £5.5 million pounds. This is a lot of home care support for vulnerable older people.

Much more clarification of this matter is required.

Professionally led locality planning and commissioning of services

Question 15: Should the Scottish Government direct how locality planning is taken forward or leave this to local determination?

No

The fact that the Scottish Government is suggesting that planning should be to a significant extent be removed from local democratic control says much about the centralising controlling nature of the consultation and proposed integration.

The suggested path ahead converts what are simple arrangements into unnecessarily complex and expensive systems to no-one's demonstrable benefit.

Question 16: It is proposed that a duty should be placed upon Health and Social Care Partnerships to consult local professionals, including GPs, on how best to put in place local arrangements for planning service provision, and then implement, review and maintain such arrangements. Is this duty strong enough?

No

Comments

The arrangements for the operation of GP's in Scotland (as in the rest of the UK) are a complete anomaly – classic example of the "elephant in the room".

The fact is that the public pay for GP's out of taxation in the same way they pay for all other public servants, including senior consultants, civil servants and hospital mangers etc. Yet the GP's contracts mean that GP's are essentially unmanaged.

It is a fact that some GP practices play a significant part in systems to manage child and adult protection, and do so willingly as a result of a true sense of public service. It is also the fact that other GP practices never pay any sort of part in these systems. The consultation document refers to an aspiration to make health and social care consistent across Scotland, yet this matter is not addressed

The willingness of GP practices to become involved with the other agencies in respect to adult and child protection or domestic abuse can be entirely different, even between practices yards rather than miles apart. No action can begin to be taken about GP practices that never attend a case conference because of the contractual relationship between GP's and the state – the body that pays GP's salaries.

The requirement of the proposed social care partnerships to consult with GP's is not the point. The point is what power anyone has to take action when a significant number of GP practices across Scotland respond to any attempts to involve them in anything like this with disdainful silence or outright hostility?

The time for real action to bring GP's within a structure of real management and public accountability is long overdue.

If nothing else is achieved through the proposal to integrate health and social care, action to bring GP's under proper control and management would be a huge single improvement worth all the time and effort expended.

In terms of the duty of the Health and Social Care Partnerships to consult with other practitioners, social workers and clinicians, there is nothing in the consultation that would make such consultations more than tokenistic.

Question 17: What practical steps/changes would help to enable clinicians and social care professionals to get involved with and drive planning at local level?

Comments

See previous remarks about GP's and then the answer would be because they are require to do so by their line managers.

In respect to other clinicians and social workers, a mechanism to make their voice have real rather than tokenistic influence might help

Question 18: Should locality planning be organised around clusters of GP practices? If not, how do you think this could be better organised?

No

Comments

Unless the issue of the GP's contract is addressed GP's are unlikely to engage, whatever

the geography of the localities.

Question 19: How much responsibility and decision making should be devolved from Health and Social Care Partnerships to locality planning groups?

Comments

No comment

Question 20: Should localities be organised around a given size of local population – e.g., of between 15,000 – 25,000 people, or some other range? If so, what size would you suggest?

No

Comments

The geographic and demographic difference between different local authority areas in Scotland makes a "population" split impractical in some areas.

Do you have any further comments regarding the consultation proposals?

Comments

Health and Social Care Integration

General points

Contents in General

1 Public Protection

Currently integrated services in respect to especially public protection and community safety will be disconnected. A successful system protecting the vulnerable (children and adults at risk), and monitoring high risk offenders, including sex offenders, is going to be weakened, and communication systems disrupted. Poor communication has been a principal factor in every single sex offender/adult protection/child protection tragedy and subsequent Inquiry. Disconnection of the services and communication systems refined as

a result of such Inquiries is a clear consequence of the proposals .In short the proposal to disconnect existing social work services is potentially dangerous.

2 Adult Protection

Weakening the independence of the role of the "council officer" (as defined by the Adult Support and Protection (Scotland) Act 2007); particularly in "making inquiries" into the circumstances of "adults at risk" when the risk is due to NHS decisions, neglect or abuse in an NHS facility or hospital. This is likely to weaken adult protection systems across Scotland.

3 Undermining social work as a profession

The proposal will weaken of the "role of the registered social worker" (as specified in Scottish Government Guidance) to the detriment of specialist services such as adult protection investigations, mental health officers and family social work.

Knock on implications for other council services such as criminal justice and child and family social work and a general ending of social work in Scotland as a coherent activity looks an inevitable consequence too. Already the Scottish Government has agreed to revisit the previous debate about introduction of a "Single Correctional Agency" for Scotland; which if it were to come about would sever the remaining links between public protection services, making Scotland's vulnerable adults and children less safe.

4 Possible financial chaos and disruption of community care services

There will be very likely to be major financial problems in moving services from the local authorities that generally balance their budgets, to the NHS, an organization that has been "protected" from financial cuts, but has nevertheless overspent massively in the last financial year almost throughout the whole of Scotland.

5 Undermining of local democracy

If social work is largely removed from the direct control of elected local authorities as seems likely as a result of the consultation, with community care going to joint boards or given away to the NHS and a Single Correction Agency for Scotland emerging, the *raison d'être* for local government starts to look weak. If citizens in Scotland see that their elected members are neither in control, nor accountable for most of what is currently under the social work heading, why should they vote? A consequence of the proposal is a significant move from a decentralised democratic country, to one increasingly dominated by the centre. It may be that this is what is intended; but there has been no consideration of this bigger picture. Do we really want an evermore centralised state? Is this what the devolution settlement was really supposed to achieve for Scotland?

6 May increase numbers of NHS patients whose discharge from hospital is delayed

The proposal to integrate may be a proposed solution to a problem that local authorities and NHS partners are already dealing with. There is evidence[5] that the problem of delayed discharges is being addressed successfully with year on year sizeable reductions to the number of people staying in hospital.

However there is also evidence that structural changes does not deliver effective improvements and can be expensive.[6]

7 Discrimination

The plan to "integrate" NHS and social care service for older people first, also means that older people will have their services disconnected from local democratic accountability and from other key service areas first too. This could be viewed as discriminatory.

8 Repeat past mistakes

In the late 1990's Perth and Kinross Council ventured into "Care Together" with the NHS and with support from the Scottish Government. Lots of promises were made to the Scottish parliament about this.[7] Not only was the experiment of integrating social care and health services for adults abandoned later as an expensive failure, but the disruption to other council social work services proved significant, with inspection reports revealing the inadequacy of the services. Staff were left isolated, as they were left disconnected from peers and former colleagues. This would appear to be a forerunner of the experiment that is already happening in Highland, and proposed to be inflicted on the rest of Scotland. Unintentionally the same consequences of the Perth policy are likely to be repeated.

9 Patchwork Scotland

The apparent intention to leave all matters relating to the precise governance of the new HSCP's to health boards and local authorities across Scotland, with no guidance in respect to how to deal with issues of pay equality, employer transfer, pension rights etc will leave systems across Scotland "separate and disjointed" as well as inconsistent and individual – exactly what it is supposed to being tackled by the proposals.

The unfolding picture is of adult community care merging into new NHS led bodies, child and family social work merging structurally into education led children's departments and criminal justice being fitted in wherever seems most convenient, prior to resurrection of the old Single Correctional Agency idea. This is not a plan sure to "improve outcomes" or be conducive to the well being of children, the sick, those

[5] http://www.scotsman.com/the-scotsman/health/scots-bed-blocking-figures-hit-new-low-1-2143647

[6] http://www.adsw.org.uk/doccache/doc_get_495.pdf

[7] http://archive.scottish.parliament.uk/business/committees/historic/x-lg/or-01/lg01-2602.htm

affected by disabilities or advanced age.

10. Professional Boundaries

In 2010 the Scottish Government produced "Guidance on the Role of the Registered Social Worker"[8].

The Guidance states:

"Effective social work requires a range of professional skills, in particular the ability to make and contribute to holistic, often multi-agency, assessments of the circumstances with people. It also requires co-operation and close working relationships between social workers, people who use services, carers, providers of care in the private and third sector and other professionals - in health, education, housing, employment and justice services. The ability to draw together a diverse range of opinions, develop and agree solutions that both promote the wellbeing of the individual and manage the risk to an individual and/or the public, particularly where risks and needs are complex, is a key skill of the social worker.

It also states:

"Care and Protection

Careful and complex decisions as to when and how there may be intervention in the lives of individuals and families may have far-reaching consequences for those concerned and fundamentally affect the future course of their lives. A number of agencies and professionals will contribute to the process. However, it is important for the assurance of all involved, that *accountability* for these important decisions and the subsequent exercise of statutory functions lies with

[8] **http://www.scotland.gov.uk/Publications/2010/03/05091627/2**

a suitably qualified and trained professional - a registered social worker

So, where either children or adults are:

- **in need of protection; and/or**
- **in danger of serious exploitation or significant harm; and/or**
- **at risk of causing significant harm to themselves or others; and/or**
- **unable to give informed consent**

a registered social worker must retain accountability for:

- **carrying out enquiries and making recommendations where necessary as to whether or not a person requires to be the subject of compulsory protection measures;**
- **implementation of the social work component of a risk management plan and take appropriate action where there is concern that a multi-agency plan is not being actioned"**

It is only 2 years since the Scottish Government made explicit its requirements of registered social workers. Yet the consultation document regarding Integration makes no single mention of the need to ensure that the registered social worker has a clear role in respect to adult community social care and health and especially in respect to adult protection. This is an omission that should be rectified. This matter closely relates and links to the points made in respect to public protection specified above.

11. Language

The consultation is (stated as being) aimed at:

"Patients, service users, carers…. and other members of public more widely" as well as the professionals likely to be affected by the proposed integration.

It is perhaps therefore unfortunate (despite the availability of an easy read version of the consultation) that the consultation document contains the sort of jargon that the Plain English Society was formed specifically to counteract.

I offer a few examples of what I mean, with an attempt at translating some of the words and phrases used throughout.

Outcomes – "Outcomes" is at its zenith as a buzzword. It's an all encompassing positive phrase high in the list of words that "must be used" in the latest management speak dictionary. It means the "end result" or the "product of logical thought" in normal English. These days it seems that anything can be justified if its aim is better "outcomes", even if there is actually no evidence whatsoever that what is proposed will do anyone any good at all.

Quality Outcomes – the meaning of which is not clear however assumed to be even more desirable than mere outcomes. A phrase often use to disguise the lack of substance in a particular statement or proposal by implying that anyone taking a contrary view must be against pursuit of "quality outcomes" – that would never do.

Delayed Discharge – used to describe a patient who may not need further hospital treatment, but who cannot return home without major support that takes time to organise. However in hospital wards, delayed discharge is often seen as a condition that requires the application of a suppository. Such treatment usually results in a "quality outcome".

Cross-Cutting – actually is a term used in real English to describe a cinematic technique to joint bits of film together; used in the consultation document to make a sentence's meaning more opaque, whilst indicating that the author of the document is well versed in up to date management vocabulary.

Joined up – means connected but is truly awful English, used again as positive "management speak" buzzword to (unsuccessfully) convince the reader of the merit of whatever.

Disconnects – another attack on the English language. Using a verb as a noun (or visa versa) is typical of management speak jargon, and jargon that has in recent years used and discarded assaults on proper English such as "visioning", "ball-parking", "onboarding" and "flagging up"

Care Pathway – another obvious and unnecessary use of jargon, presumably meant to refer to the route into a nursing home

Body Corporate – assumed to be a "clever" way of saying "corporate body"

Do you have any comments regarding the partial EQIA? *(see Annex D)*

Comments

Many of the serious flaws in the consultation document as a whole are repeated again in the EQIA.

For example, no mention is made (perhaps they were never thought of?) that in curing the alleged "disconnects" – very poor English this – that a whole load of vital public protection services (child protection, domestic abuse, management of high risk offenders) are to be disconnected structurally from adult community care services and with every chance of making the communication vital to management of sex offenders and child

protection far more complex.

In short the proposal gambles with the safety of the vulnerable children and adults of Scotland without any research to prove likely benefits.

The discussion of D17 omits to mention that by targeting older people first for their services being removed for full local democratic control, their real voice regards the services they receive will be reduced first, before the other community care groups. This would appear to be wholly discriminatory. If people rights are to be removed in this way, why pick first on older people?

Do you have any comments regarding the partial BRIA? *(see Annex E)*

Comments

This section reiterates the dreadful English phrase in respect to current “disconnects” between NHS and local authorities.

The suggested remedy offers no consideration of the fact that the making of stronger connections between local authorities and the NHS will, as an unintended consequence, weaken connections between child care social workers, criminal justice social workers and community care and adult protections social workers. In short it smashes the currently well connected systems, formed over many decades, to protect the public and vulnerable children and adults from harm.

The business case does not consider the possibility of litigation taken by victims of any harm that may accrue as a consequence of the weakening of such systems.