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?

Yes No ▢

Comments

Yes, it is reasonable to focus on improving outcomes for older people initially, since the demographic time-bomb on our hands means that this group will need more care in the future and expand in numbers. It is obviously sensible to focus on keeping them out of hospital and improving home care; also on discharging from hospital speedily and efficiently.

However, in focusing on outcomes there is a danger that it all becomes a paper exercise, with the emphasis on ticking boxes – and too much administrative effort is expended on this rather than delivering good service to people who are in need. Other groups will wish of course to be considered a priority, and it will be a difficult choice to make if resources are limited and rules are not clear. Examples of the present system being woefully inadequate are demonstrated both in the case of an acute illness where hospital/GP/ Community nursing failed to listen to the patient or his carer in the last few weeks of his life about his needs; and also in the case of a senile dementia patient who occupied a bed in hospital longer than necessary because the social work department could not provide an up to date list of residential facilities and the family had to do the research themselves. There is a tendency for professionals to dismiss cases like these as mere anecdotes, but quite simply if research was done on these topics we suggest the results would be a revelation.

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?

Yes ▢ No ▢

Comments

If integration is to work, then differences between terms and conditions of service of similar workers need to be ironed out. For instance, at the moment, social care workers in the community and healthcare assistants (auxiliary nurses) working in hospitals and in care homes do much the same kind of work but do not follow the same shift-work patterns. We suggest that they need to be interchangeable. Consequently, workers need to be able to undertake the same tasks. At the moment, social care workers are not allowed to change simple dressings, which seems illogical. At the same time, they do dispense medication, which in hospitals is done by nurses. A complete list of tasks needs to be drawn up and agreed with both management and workforce in each context. It would be helpful to have representatives of service users (including carers) taking part in these discussions, as well as the workers themselves (n.b. actual workers, not union reps).

The description of the proposed system smacks very much of "top down" management but patients/carers/general public (who are after all the ultimate funders of both NHS and Social Work) must also have an input. We have grave misgivings about directing significantly fewer resources at institutional care – removal of actual physical facilities such as buildings has not proved the success that "care in the community" was supposed to bring. We also have grave misgivings about "new and potentially different job opportunities". This sounds like shorthand for "cheaper and less professional" and we would be interested to see the proposals for these job opportunities before agreeing that this is the framework that is needed.

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?

Yes ▢ No ▢

Comments

This sounds desirable, but how it is proposed to measure these outcomes? How far will patients and carers be involved in agreeing such outcomes?

Whilst a statutory requirement for delivery of outcomes and support for carers sounds a good idea, there needs to be a corresponding statutory system of compensation/mediation/ agreement for patients/carers especially when the system fails.

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

Yes No ▢

Comments

Yes, but again there must be PPI involvement in agreeing these outcomes.

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?

Yes ▢ No ▢

Comments

Accountability to Ministers and Local Authority Leaders leaves out the most important part of accountability: that is, to the service users, who have paid for the service through taxation, and need to be able to express their views about the service they receive. Who can service users complain to if things go wrong? It will be only too easy to pass the buck between Ministers and Local Authority Leaders. At the moment the Scottish Government has passed the buck to the Local Authority over a matter of personal care over which we are concerned. This is understandable since integration has not yet been achieved. When it is, where does the buck stop?

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

Yes ▢ No ▢

Comments

This depends on locality. It would not be practicable in Edinburgh. Although it sounds like a good idea to be able to cover more than one local authority, in practice most have their own unique set of circumstances, rural or urban or island etc. and most of them would probably not wish to relinquish control

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

Yes ▢ No ▢

Comments

Difficult to give an answer: again, buck-passing might be too easy.

However, it is proposed that the Health and Social Care Partnership comprise a Chair, Vice-Chair, and voting members, a minimum of 3 Health Board non-Exec directors and 3 local elected members. It is only when non-voting members are listed that patient/service users are mentioned. At the very least there needs to be at least 2 patient/service user/carer representatives on the voting side of the Committee

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?

Yes ▢ No ▢

Comments

No: the line of responsibility needs to be clear, and people must be given clear instructions about who to complain to if things go wrong.

The question here is who guards the guards? It is too late once targets have been missed – there needs to be an early warning system in place and the independent Care Inspectorate and/or Healthcare Improvement Scotland should be brought in when targets are being missed by say 20%.

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?

Yes ▢ No ▢

Comments

Difficult to comment without knowing what the 'other CHP functions' consist of.

Initially at least the budgets should not be included from other CHP functions – it will simply lead to obfuscation and potential wrangling. If necessary these functions should be subsumed in other Health Board Committees.

Throughout it is not clear how service user representatives will be recruited to serve on committees. It is essential that people who actually use the home care service and their carers are given a voice.

Chapter 5: Integrated budgets and resourcing

Para 5.3 Unfortunately developments already in hand do not give us confidence that the full implications of moving services into the community from hospital have been grasped. An example is mental health, where in-patient beds are being cut, and community services, rather than expanding, are also being cut (e.g. the drop-in facilities at Cambridge Street House and Ballendon House in Edinburgh). **This needs serious and urgent attention.**

Para 5.6 If the budget needs to be integrated, so does the workforce: the actual jobs of healthcare assistant and social care worker need to be the same.

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?

Yes ▢ No ▢

Comments

Yes, as long as the terms and conditions of service of the workers, whether in hospital or community, are the same. What independent consultations have been undertaken with the workers themselves, apart from discussions with unions?

The models described are only a start and quite broad brush in approach. The real test will be when local H&SC Partnerships are to decide what else to include in an integrated budget. Even more important here is the inclusion of voting rights patients/service users in the decision.

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?

Yes ▢ No ▢

Comments

In effect, the patient (or carer) is the 'manager' of the service, as he/she has to manage the various component parts. If things go wrong, the service user still has to manage things.

As an example, take the task of caring for a man aged 83, disabled after a stroke, which has left him blind and with loss of right-side function, also urinary retention needing an indwelling supra-pubic catheter. His wife is aged 80. He has a daily visit (weekdays) from a social care worker who helps with showering, dressing, and bed-making. However, the worker is not allowed to change the dressing for the supra-pubic catheter, which needs doing at least twice a week. The catheter valve also needs changing weekly. The carer has to manage these tasks, as well as everything else – finance, correspondence, medication, shopping, cooking, laundry, cleaning, chiropody, regular visits to the GP for blood tests (the patient is on Warfarin) and to the district nurses at the GP surgery for changes of catheter every 10 weeks.

At the moment the 'integration' is in the hands of the carer. This works while she too has enough health and strength to cope, but already the change in shift-work pattern to 4 days on, 4 days off, started by Edinburgh Council on 7th May 2012, has caused problems: since 1st May until today's date (7th August) there have been 14 different workers attending her husband, and each change means that she has to explain the tasks all over again. She does not have problems of cognition, but for those with dementia such a situation is not acceptable.

For smooth handling of the situation, there would have to be one reference folder for patients to keep at home, detailing all the necessary tasks to be performed. At the moment there are two: one for personal care, and one for continence care. (In fact yet another department deals with supplying new catheters and valves, which have to be ordered separately by phone – again the carer has to do this.) There are also umpteen other folders, for RNIB, VOCAL, Chest Heart & Stroke, etc. etc.

It has not been satisfactory for either service users or workers used to a weekday only service to be obliged to change to the new 4 on 4 off shift work rota. Clients now have at least two workers instead of one, and the pattern shifts constantly. Workers obliged to accept the split-shift arrangement have to work till 10 pm and then start again at 8 am. Many are not happy with this, and in any case this pattern contravenes the European Working Time Directive, which specifies a minimum break of 11 hours between shifts. It also goes against the Equalities Impact Assessment with regard to the responsibilities of parents of young children, especially single parents, for whom weekends are particularly important, and routine is essential for stability.

With integration it is hoped that this kind of problem will be avoided, since the work force will be broader and it should be easier to accommodate differing requirements of both clients and workers. But it is absolutely essential to make sure that *before* any further changes are made, an EQIA is completed. (In any case this is, we understand, a statutory requirement.)

A further example regarding the case of the patient referred to in question one, he was discharged home suffering from terminal lung cancer with brain metastases. The hospital staff nurse had tried to arrange a community nurse visit on discharge only to be told "we don't do that any more". His wife tried to arrange with the community nursing at her GP practice for a commode and a stool for the shower to make life a little more bearable. She was told "he would have to be assessed" which would take more than a week, and "if these things were judged to be necessary", then it could take 3 weeks for them to be delivered from the social work depot. Needless to say these items were ordered privately from the internet and appeared within 2 days. The incontinence issue was also dealt with privately. When the GP appeared, 4 days after discharge, things happened very quickly, medication, nebuliser, and a visit from Marie Curie nurses. 2 days later the patient was admitted to the hospice and he died 6 days later. Obviously there needs to be a mechanism to deal quickly and sympathetically with such situations, it is not good enough to be told that a commode might take 4 weeks to arrive "if it is deemed necessary". Some support for the wife would also have been helpful.

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?

Yes ☐ No ☐

Comments

It should be possible to use the resources more economically when all similar workers have the same terms and conditions, and service users expect the same skills from them all.

It is difficult to say if this will be sufficient. Marrying the different cultures of health and social work will not be easy, and it is in this area that there needs to be some work done. For example, when the new ERI was opened the laboratory services were "integrated", but no work was done to achieve this and so haematology/biochemistry etc continued in effect to function as separate entities. This would be disastrous for the health and social care where there will need to be integration – budgets are one thing but it is the people working in the service that count.

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?

Yes ▢ No ▢

Comments

The Jointly Accountable Officer will have to be some sort of genius to get it all to hang together. He/she will have a lot of responsibility. Will he/she have adequate executive power? Or advice? There will need to be an organisation for the person to be able to accomplish the task. Hopefully this will not run away with too much in the way of resources.

Para 7.6

These arrangements **must** also involve service users: partners from the third and independent sectors will not necessarily have the right experience to be able to comment from recent experience of the service *as it is*.

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

Yes ▢ No ▢

Comments

The JAC needs an appropriate level of executive decision making power – and to be able to approach Ministers directly where they consider their H&SC Committee is, for example, overspending or spending on an inappropriate service.

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?

Yes ▢ No ▢

Comments

Probably the situation is different in different localities: there needs to be a general decision to integrate, but perhaps each Health Board needs to approach the problem according to local needs (e.g. Highland will be different from Lothian).

Perhaps it would be helpful initially to suggest a model for locality planning so that no important group is left out, but not to make it so rigid that it cannot be changed in light of local needs.

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?

Yes ▢ No ▢

Comments

Yes of course local professionals including GPs should be consulted. But service users must also be consulted. In fact GPs have very little to do with home care services: nurses are more involved.

Maybe an obligation would be stronger rather than a "duty". If local professionals did not respond then this information should be in the public domain.

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

They should take part in local consultative meetings, together with patient/carer representatives, which could be organized by the Scottish Health Council.

The obvious answer to this question is payment. However, as with question 16, those unwilling to become involved should be recorded as such so that the public can judge their efficacy.

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

Yes ▢ No ▢

Comments

It would seem sensible to arrange locality planning around GP practices, they should know their local population and their needs broadly speaking.

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

Comments

It depends on the locality. But the important thing is to make sure that the service users are represented

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?

Yes ▢ No ▢

Comments

This is more difficult and may depend on local clusters of population.

Do you have any further comments regarding the consultation proposals?

Comments

Annex B

B.3 'It is important to ensure that services . . . continue to improve'. Sadly, since the changeover to the new 4 on 4 off shift-work rota in May 2012 the personal care service has deteriorated, for both some workers and some clients. This new integration proposal gives an opportunity for this policy to be reversed. The important principle should be: 'If it ain't broke, don't fix it.' Now that it *is* broke, it needs fixing, and indeed thoroughly re-thinking.

Paras C.13 and C.14 are crucial here. Pay, terms and conditions must be reconciled.

Para D.18 Physical environment: 'Through promoting care in the community is it likely to be harder to control the spread of infectious diseases e.g. MRSA?'

The answer is: NO! Many people have experienced healthcare associated infection through visits to hospital, NOT through staying in their own homes, where apart from anything else, they are accustomed to their own bugs!

Para D.25

We know that the EQIA for the home care service in Edinburgh Council was only completed AFTER the new shift-work rota was implemented. This meant that serious problems were not dealt with. (Obviously 4 on 4 off suits some workers, but certainly not all.)

The main problems from the workers' point of view are:

1. The 4 on 4 off pattern disrupts the life and relationships of dependent children, especially those of single parents, who are used to a five-day school week. Child care is extremely expensive at weekends (if it is even possible to find).

2. The European Working Time Directive has not been observed with regard to the split shift: there should be at least 11 consecutive hours between shifts.

3. Edinburgh Council claims to operate a family-friendly policy for staff. What has gone wrong here?

From the clients' point of view:

1. They have been used to one consistent worker, sometimes for many years (with short breaks for holidays and illness), who knows them intimately and has often become something of a family friend. It is often cruel to disrupt this relationship. Getting used to the new rota is at best inconvenient, at worst disruptive.

2. For those with dementia it might actually be alarming and frightening, possibly even dangerous, to have too many changes of worker. (This in no way reflects on the professionalism or competence of the worker.)

3. For those with complex needs who receive (say) 3 visits a day, recent changes will have been even more disruptive.

Outsourcing

A big issue that does not seem to have been addressed is the extent to which outsourced services can be integrated. Is this the aim, or not?

Integrating all services

It would be helpful if ALL healthcare services could be integrated under one management. At the moment the service user has to go to many different sources for care: for example, physiotherapy, podiatry (for which there is not even a possibility for making an appointment by telephone – only a very clumsy system of sending a request and a self-addressed envelope), continence care, GP appointments, etc. This would be one way of simplifying 'existing bodies and structures'.

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

Comments

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

Comments