

Health and Social Care Committee: 6 June 2013
 Social Services and Wellbeing Bill
 Submission by Professor Dame June Clark

This paper summarises and draws together the content of my three earlier papers which were prepared for discussion at the Roundtable meeting held on 6 March which I was unable to attend. My comments are limited to services for older people (I have no special expertise about services for children), and focus mainly on specific issues in which I have a special interest. These are:

- The integration of health and social services
- The integration of health and social care
- **The assessment of older people's needs**
- Continuing health care
- The registration of care homes

1. The integration of health and social services

In its June 2011 summary report, the NHS Future Forum stated: "We need to move beyond arguing for integration to making it happen". There appears to be universal agreement with this statement, and we have had requirements to "collaborate" and permissive legislation about pooled budgets for 25 years. Something more is required to "make the horse drink". It is shameful that organisations, politicians, managers and care professionals always look at integration from the perspective of their own organisation and vested interests, and not (in spite of what they repeatedly say) from the perspective of the service user.

Every division/interface (eg between health and social services, health and social care, social care and continuing health care, personal care and nursing, residential homes and nursing homes) involves:

- defining the interface
- devising a bureaucratic system/protocols for managing the interface
- scope for cost shunting
- scope for appeals and litigation
- additional assessment (often inadequately performed)
- extra staff to do the additional assessments
- training for these staff
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The result is:

For service users:

- Struggling to understand and use the complex procedures
- Falling into cracks between the different sectors

For service providers:

- Huge costs – staff time spent on developing procedures, employing and training specialist staff to manage the process, appeals and litigation

We have ample evidence in Wales of all these disadvantages. Much of the cost is hidden (eg salary costs of officials who devise the procedures, and the time of district nurses spent (wasted) on implementing them.

Wales should adopt the model contained in the forthcoming Scotland Integration of Adult Health and Social Care (Integration) Bill (note the title) in which local authorities and Health Boards are required to establish Health and Social Care Partnership organisations with a pooled budget, a single CEO accountable to both authorities and the right to employ the full range of staff to deliver integrated care. In Wales we have several such pilot schemes; they should now be extended over the whole of Wales and be made mandatory. The key concepts are: required, pooled budget, a single CEO accountable to both authorities, and the right to employ the full range of staff to deliver integrated care. However, while the Scottish bill uses the words **“requires to integrate....”**, Clause 143 of the Welsh bill says **only “make arrangements to promote co-operation” and “Regulations may require...”**. This is not enough.

In addition to achieving the goal of seamless care for the individual, the Scottish model would automatically get rid of some of the other problems of the present situation eg:

- **The pooled budget would get rid of the “not-off-my-budget”** orientation of current assessments eg. for eligibility for continuing health care (see below) and provision of nursing care ;
- The multiple assessments currently required would be replaced by a single (regularly reviewed) assessment of the person’s **needs**;
- It would enable employment within one organisation of the full range of professional skills.

2. The integration of health and social care

Please note the distinction between health and social services and health and social care. It is important to be aware of the wide range of definitions used interchangeably to describe different concepts, and it is important that we are clear what we are talking about and what we want to achieve. For example, Robertson (2011) describes **“integrated care”** as being used to refer to:

- **“Health and social services delivered by a single organisation**
- **Joint delivery of health and social care by more than one organisation**
- **Links between primary and secondary health care**
- **Joining care at different levels within a single sector** e.g. mental health services
- **Joining prevention and treatment services”**

The point is that whoever is providing the services, the service user should experience their care as a seamless process – the right kind of care, in the right place, at the right time, by the right kind of people.

A particular problem is the confusion between the terms “personal care” which is seen as the responsibility of social services, **and “nursing care”** which is seen as the responsibility of the NHS, and the idea that personal

care is not nursing. Personal care IS nursing: it falls within the internationally recognised definition of nursing:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that the person would perform unaided given the necessary strength will or knowledge. And to do this in such a way as to help the individual gain independence as rapidly as possible” (International Council of Nurses 1960).

and outside the international definition of social work:

“The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work” (International Federation of Social Workers and International Association of Schools of Social Work 2000)

This shows that social work is very different from nursing and it has a completely different knowledge base. Social workers have expert knowledge about other things, but not about personal care, yet are currently responsible for assessing and prescribing the personal care to be delivered to people who need it. Inadequate assessment and organisation of personal care, and in particular the financial consequences of this false distinction, currently causes major problems both for service providers and for service users in both residential and domiciliary settings.

It is a tragedy that the definitions and distinctions between “personal care” and “indirect care”

developed by the Royal Commission on Long Term Care in 1999 were misinterpreted and ignored. I believe that it was a mistake that in 1990 local **authorities took over responsibility for “personal care”, in which they had no knowledge or skills, and in order to do so gave up many of the “indirect care” services that they were good at.**

However, service users should not have to worry about the definitional niceties of who delivers their care: what matters is that their needs are properly assessed, their care is properly planned (the present definition of a **care plan contained in the UAP is “the list of services for which a person is deemed eligible”!**), and is provided by people who have the appropriate knowledge and skills.

Barriers to integration

There are several barriers to integration:

1. Legislative (which need to be removed by this bill)
2. Financial
3. Local government configuration
4. **Organisational culture and professional “turf wars”**

There are several things that can be done short of organisational integration that are well documented in the literature and in use in Wales as “**projects/pilots**”

1. Legislative

Three problems need to be tackled:

- a) Sloppy language and definitions – which should be put right in Part 1 of the bill where there is a clause specifically about definitions. In addition to the definitions already listed, we need definitions for:
 - Social care: (There is no satisfactory definition – see discussion by the Select Committee 14th report 2012)
 - Personal care (use the one developed by the Royal Commission)
 - Integrated care (distinguish between integrated care and integrated services)
 - Nursing (replace the English definition (used in the Welsh bill) and substitute the Scottish definition)
 - Care plan (replace the UAP definition by the Care Quality Commission definition)

b) The exclusive dividing line between NHS care and LA care This is set out in the Bill in Part 4, Section 31. This section should be removed or entirely rewritten.

This is just a hang-over from the 1973 legislation which first established health authorities and social services departments, and appears to have been mindlessly repeated in all subsequent legislation. Forty years on the world has changed – the lines between health and social care are now much more blurred (hence our current problem). Both types of authority are responsible **for providing “care and support” (the phrase used in the Bill). The type of care which frail older people receive in hospital (known as “basic nursing care”) is exactly the same as that delivered in care homes and by social services care assistants to people in their own homes where it is described as “personal care”**. The reality is that local authorities are already providing services that are also provided by the NHS. In reality it does not matter which agency provides the care – maybe that could vary according to local circumstances – but the point is that whoever provides it should have the right knowledge and skills, and therefore employ the right people who have those skills, to provide it. Which brings me to point (c)

c) The inability of local authorities to employ nurses
Clause 31 sections 4 and 5 specifically forbid “providing or arranging for the provision of nursing care by a registered nurse”

I have detailed the difference between nursing and social work. There is nothing in social work training which provides the underlying knowledge base and skills required for personal care – those knowledge and skills are part of nursing. The paradox is therefore that social services have the responsibility for providing personal care, but are denied the resources (knowledge and skills) required to do so. The NHS trains and employs specialist nurses with advanced knowledge and skills in both gerontological nursing and dementia care – much needed for the care of frail older

people in their own homes and in care homes as well as in hospital – but people receiving social care via social services have no access. I discuss the position in care homes later, where I argue that not only should the distinction between residential care homes and nursing homes be abolished, but that every care home should have on its staff at least one nurse specifically trained in gerontological nursing, who could as a minimum act as an expert resource to non-nurse care assistants – hopefully avoiding the incidents we hear **where a “health” problem was not recognised or recognised too late, resulting in delayed treatment and/or unnecessary admission to hospital.**

I recognise that subsequent clauses do allow exceptions to these restrictions – more scope for variable interpretation, necessity for procedures and protocols for dealing with disputes etc. It is far simpler to remove the restrictions than to try to spell them out in detail along with the exceptions.

2. Financial Barriers

As documented in my earlier papers, at present a huge amount of time, **effort, and money is expended on the activity of “not off my budget”.** This barrier could be removed, or at least mitigated, by the (mandated and universal) use of pooled budgets.

3. Local government configuration

We just have too many local authorities in Wales. That is a problem in its own right (eg costs!) but the barrier for integrated care is the lack of co-terminosity between health and social services organisations. Somehow politicians have to knock a few heads together. It is sad that LAs put their desire to protect their own power and autonomy before the needs of the people they serve. Meanwhile the Scottish model of creating Partnership Organisations for the delivery of integrated care (as opposed to just talking about it) could get over this barrier, even though in Wales the multiplicity of partners will make it more difficult than in Scotland where they do have co-terminosity. If the Gwent Frailty Project can do it (and I recognise that it has **not been easy) why can’t the rest of Wales do it?**

4. Organisational culture and professional “turf wars”

My experience (eg of the attempts to develop the Unified Assessment) is that the division is strongest not among the workers on the ground but among the officials in the Welsh Government. In my experience, officials with a social work background do not understand and therefore do not respect or value the perspective of those with a nursing background. This failure to understand the nature of nursing is what lies behind the (non-existent) distinction between nursing and personal care (as described earlier). It is **time that the myth that nursing is a subdivision of medicine and uses “the medical model” as opposed to “the social model” that social workers use, was killed;** some branches of nursing (eg mental health, health visiting) have used a social model for years before social services departments were even invented; in any case there are not only two models – nurses generally use a **“health” model, and** the model for integrated care for older people, as

specified in all recent documents, is a “wellbeing **model**” which is shared across several disciplines.

3. **The assessment of older people’s needs**

The section of the Bill on assessment is thin; most is delegated to the provision of Regulations. The history of the assessment of older people in Wales is not good. For example, the Unified Assessment Process is almost universally loathed, especially by district nurses who are the main group required to use it. The principles I want to be assured on are:

The principles I want to be reassured on are:

- Assessment of need is completely separate from and undertaken before financial assessment
- Assessment always includes professional judgement based on an appropriate knowledge base (ie is not just a tick-box exercise)
- Assessment is always multidisciplinary
- Assessment tools are standardised, validated, and have been tested for reliability; this requires a single All-Wales tool
- Assessment must be regularly repeated
- Assessments must not be duplicated, and the number of assessments should be minimised

4. Continuing health care

I have already submitted a paper on Continuing Health Care which I do not duplicate here. The Bill makes no reference to this form of care, presumably because the Bill **is limited to the “social care” provided by local authorities**. However it is the best (ie worst) example of the effects of the lack of integration of health and social care. A Report on Adult Social Care published by the Law Commission in May 2011 (No. 326) and presented to Parliament noted that:

“The overwhelming message from consultation was that the arrangements for NHS continuing healthcare is an area that continues to be contentious between health and social care authorities and lacks transparency for service users. The unfortunate consequence for both parties is that funds which might otherwise be spent on providing services are instead channelled into litigation.”

Similarly, Lord Justice May in *St Helens BC v Manchester PCT2* expressed the concern of the court by stating:

“It is not satisfactory when two publicly funded public authorities engage in expensive litigation to decide which of them for pay for the care in her home of a woman whose mental and psychological conditions require constant and expensive care. In the end, the money for the care and the money for the litigation is all coming out of the same purse.”

It is therefore relevant for this issue to be included in discussions of the Bill. The system in Wales for determining eligibility for Continuing Health Care, and therefore for determining whether the costs of an individual’s care should be borne by the NHS or by the local authority is nothing short of a

national disgrace. In the context of this discussion I do not consider the well documented suffering of those who have experienced the process, nor on the costs of the care provided; I focus only on the costs of the process of determining who should pay for the care provided. These costs, which run to millions of pounds, should be used instead to fund the care.

It has become clear that the system has little to do with assessing and **meeting people's needs: it is all about "not off my budget".** By defining applicants as ineligible the NHS shifts the costs of care to local authorities. It is therefore in the interests of the NHS (who are responsible for the assessments as well as for the provision of care) to minimise the number of assessments and to set the thresholds for eligibility as high as possible. There is evidence that the thresholds are set at a higher level in Wales than in England. The result for local authorities is that they are required to provide **"social care" for people with highly complex needs.**

5. The registration of care homes

I am aware that separate legislation is planned to revise the system for the registration of care homes. However this issue also overlaps issues to be included in the Bill, in particular the distinction that is made between **"social care" or "personal care" and nursing care, and therefore the distinction** between residential care homes and nursing homes.

I read with great interest the report on residential care. It is excellent and I would agree with all its recommendations. The only problem is that its terms of reference precluded it from looking at nursing homes – yet another dysfunctional consequence of the false distinction discussed above. The key point is that the evidence on the increasing age of residents at the point of admission, with the concomitant increase in health problems (eg. co-morbidities, complex medication regimes etc), shows that more and more residents will have health problems and will need nursing care. The arguments that were (rightly) put forward for the abandonment of the distinction between homes registered for dementia care and homes not so registered apply in exactly the same way for the abandonment of the distinction between nursing and residential care homes. There should be only one category – care homes.

I believe that the barrier to employing nurses in social care services and in particular in residential care homes should be removed, and that every home should have on its staff a nurse with specialist training and experience in gerontological nursing to be used as a consultant in the same way as homes currently use GPs (small homes could share)