UNISON Scotland

VOICES FROM THE SHARP END

Health and social care integration

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Survey report

October 2014

Health and Care Integration: Voices from the Sharp End

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Introduction

The Public Bodies (Joint Working) Act and associated regulations set out the Scottish Government's plans for health and care integration in Scotland. While there are two broad models in the legislation, most councils and health boards are adopting the integrated joint board option. These new boards will be responsible for a substantial proportion of health and social care in their localities. The details are set out in UNISON Briefings.

Health and care integration is not new in Scotland. This is the latest attempt to deliver effective joint working, building on a number of initiatives over the past 12 years. This means members have experience of joint working and views on how it can effectively be delivered. UNISON is by far the largest trade union in this sector across the NHS, council, voluntary and private sector service providers.

Throughout the legislative process, while we welcomed integration, we expressed concerns that workforce issues were not given sufficient attention. Structures are important, but these services are delivered by people not robots. In this survey of the staff concerned, we hear the voices of those workers who will have to try to make the new arrangements work.

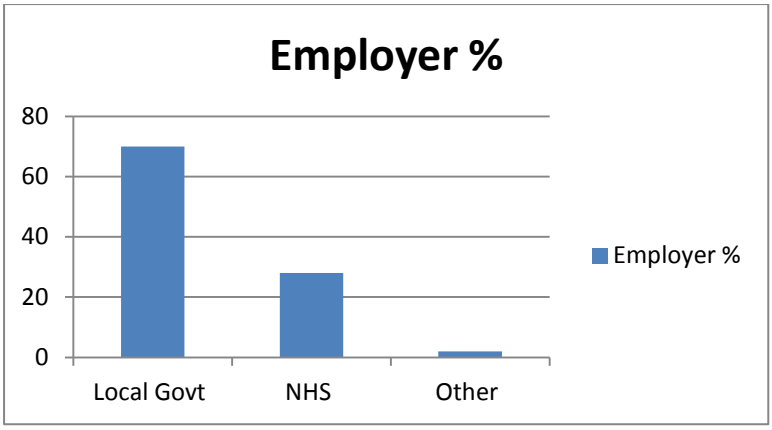
The Survey

We undertook a survey of health and local authority social work staff to find out their views on current proposals for integration of health and social care, whether they perceived any problems and to ask how they viewed they might be solved.

Responses varied; many staff already work in integrated environments and value the experience and what can be delivered for clients, others have found the experience less positive. For those staff for whom integration is in the offing responses indicated a range of barriers to be overcome and fears on the part of the staff - for the quality of service they deliver, but also over how their own skills would be valued and utilised. There was also a level of enthusiasm that closer working could deliver a better outcome for clients.

The impact of cuts in resources on the delivery of services is a huge concern for staff - over half of respondents report that they feel their professionalism has been compromised as a result of budget cuts. In this context it can come as little surprise that almost 70% of staff believe conditions are going to get worse rather than improve. Care integration may provide an opportunity to improve services - although all the evidence is that this is best achieved from the bottom up rather than the top down. It cannot provide an opportunity to make savings without seriously impacting on some of the most vulnerable members of our society.

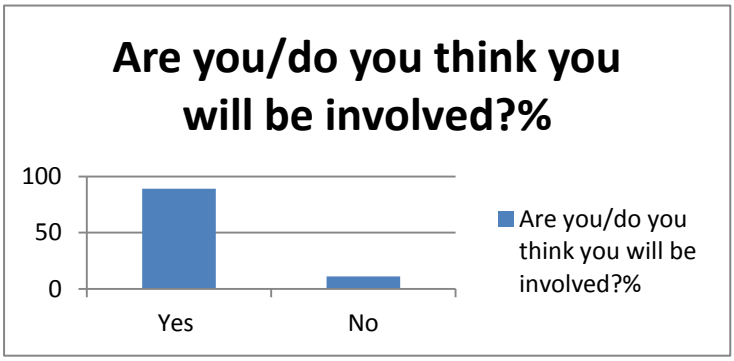
Of responses received, 70% were from staff in Local Government, 28% from the NHS and 2% from other providers. Staff groups surveyed included nurses, occupational therapists, social workers, nurses, community workers and mental health officers among others.



Registration

We asked whether respondents had to be registered and 82% said they were, compared with 18% who were not.

Integrated Working



89% of respondents either are already or expected to be involved in integrated working. Of those currently working in an integrated environment many found the experience to be positive although not without tensions and difficulties. The recurring theme was that staff on the ground would work together to reach better outcomes for clients but this process was sometimes made more difficult by differing or conflicting priorities held by their respective managements.

The prospect of an integrated service being the default position was, by and large, given a cautious welcome by staff. Although concerns about how an idea which might be fine in principle would be translated into practice were widespread.

The view from the ground -

I'm positive about working with practitioners, negative about being subject to another layer of managerial agendas.

The theory is good although there will need to be a shift in culture for both services although it would improve patient care and seamless provision of services

Still in the early stages, but tension on exec management and director levels are filtering down to all staff

I'm in a rural area I think this will be beneficial. I also believe that it will assist in providing a more person centred service.

all depends on how things are put in place and who is managing these changes. Done properly it can be a positive change but concerns that they will not involve front line staff in decisions.

Different priorities and skill sets so integration will be challenging.

I believe this is the right way to proceed for the benefit of patients.

I feel that our Social Work department are not integrated at all with NHS, despite our team winning awards for integrated working! At present it is mostly rhetoric written on paper.

There is still a clear medical/social model and little emphasis on any prevention work by health services or sufficient therapeutic services. Some situations have worked well and some do not as usual it tends to come down to the individual workers and not the policies & procedures in place.

Communication appears poor, still receiving patients in rehab which are not appropriate, lack of care available; still not clear which community services to refer to.

Not easy due not sharing IT systems, being in different buildings/bases. Multiple professionals have different area zones/post codes therefore not one stop shop

Making improvements – avoiding difficulties

We asked what members believed could improve the situation where they perceived problems. Whilst a wide variety of suggestions were made there were some recurring themes. Improved communications came up many times, particularly with regard to a perceived need for co-ordinated IT systems. Poor management and leadership were also raised.

The view from the ground -

Better IT systems that are compatible improved communication co-location

Better communication by senior management about the impact and pace of change.

By involving staff in the integration process by keeping us up to date with changes and choices of what works best.

More communication at a higher level and more sharing of information, too many different people working in silos.

In my experience problems are not with workers on front line who work hard to resolve any problems and work well together, problems are often with inexperienced managers who only want to promote themselves

If management listened more to the grass roots before changes are made to working practice.

Mental Health Officer duties can only be undertaken by local authorities, so we will remain employed by the council but all our other duties will be removed from us and given to social workers who have minimal experience in mental health when we might still have to be involved due to our statutory role. This is likely to confuse service users as well as provide a worse service.

The integration will see workers on different terms and conditions. This needs to be looked at prior to any integration of services and budgets. Social Workers are very concerned about their professional values being compromised if they are managed by health management.

Good communication is vital and IT systems need to connect with each other.

More leadership from managerial level (from NHS and local authority) to workers to explain how integration will work in practice

Changes in professional attitudes toward each other's service will be necessary, power imbalances may also need to be addressed

Appropriate guidelines, clear communication, ultimate cooperation and respect from all parties.

Effects of Public Expenditure Cuts

We then asked how cuts in public expenditure were affecting the services our members provided to their clients or patients. It is concerning that many are blaming cuts for delayed discharges, one of the issues integration is meant to tackle. Many members reported, less provision of respite care and activities for clients, and less and poorer quality equipment available from OTs.

The view from the ground -

Clients are being restricted in activities because of funding as many other services are being withdrawn and a lot have been closed due to local government funding cut backs. This has an effect on family carers a lot of whom are elderly and can receive no respite from their home caring role.

One real issue at present is that our social work department have cut the amount of respite available to people over 65 - this has been cut to 14 nights within one financial year. Whilst there was never a fixed amount of respite provided, it was always more than 14 nights. There is clear discrimination against older people.

Fewer staff on the ground is affecting patient care. No money for staff training. No additional money for extra hours when required.

We now find it difficult to source the best quality aids for some patients - especially those who need e.g. more comfortable splints if they have a very painful condition. Also we now have greater difficulty ordering equipment from a central store with very poor IT.

Presently the team has been cut by 25% and our case loads have rocketed with the council expecting the team to take on extra work despite the cut in staff numbers. This leads to increased risks, staff stress, poorer service, etc.

We seem to be moving away from specialist SW services and back to a generic model again which risks losing vital skills workers have gained.

Dementia service users are being let down badly, we are not given enough time to spend with them, they should be more mental health teams in the community.

There is no care available in our area. This means people are suffering, people cannot get out of hospital and /or not receiving the service they need. Care homes closing down, no vacancies for people who need to be in care homes.

Lack of local authority care is resulting in delayed discharges within hospital wards which is placing greater strain on the NHS system. Sometimes packages of care are agreed and discharge is arranged but then there is physically not anyone to actually deliver the care.

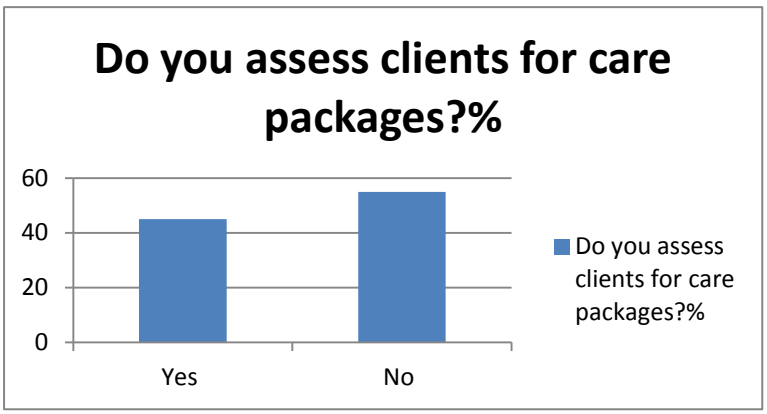
Our service is providing less small aids and equipment but offers advice and support so that service users are aware of solutions available. Many are willing to fund the small aids privately.

We are sourcing equipment differently and providing what some might say are poorer quality goods

Reduced packages of care for elderly patients are making it difficult to enable are making it difficult to enable them to return home.

Assessment of Care Packages

45% of our respondents assessed care packages.



We asked how they assessed whether the package was adequate and the allocated visit times, e.g. are sufficient? Some of the responses are very concerning indeed with staff outlining that the care they believed the client needed wouldn't be available - with some respondents stating they were not allowed to prescribe what they thought was necessary. These results are consistent with UNISON Scotland's It's Time to Care Report. Some of these are issues which closer working via integration may resolve, but many are fundamentally issues of inadequate resourcing of services for vulnerable people.

The view from the ground -

We are restricted to the service level agreement with providers in relation to home care. Our providers insist on 30 minute service ordering and thereafter in periods of 15 minutes even if just for med prompt. in my view the issue does not lie with our ordering, the issue lies with the providers who do not have enough staff to provide the services we are requesting which means client will get a rushed service from a home carer because the home carer has 10 clients to see in a two hour time band.

OT assesses and makes recommendations. SW then cut below our recommendations and sometimes patient does not receive any care.

Very difficult because we do not have time to evaluate the care plan once it is in place.

By means of review. You assess, estimate and review to monitor efficacy and gaps.

Recommend reviewing care package frequently, this is rarely done.

Assess to see if 15 mins / 30 mins is enough and rely on carers/service users to feed back as to whether this is working or not.

Use my own experience and judgement and discuss with patient (that's what I'm paid for)

Based on the persons needs but services can't always meet the need due to pressures on resources

Management make the decision against Social worker advice, down to availability of service.

Depends on what care is required. 5 mins several times a day may be sufficient for a vulnerable person for a welfare check. Packages are reviewed and increased if necessary

We are dictated to by what Homecare can provide. Is more a resource led service which is not compatible with a needs led assessment.

Supervising a service user carrying out their personal care, inadequate times for service users either not enough or too much time taken to increase or reduce times

I use my professional skills and judgement. 15 minute visits ARE appropriate for some people in some circumstances.

We asked what mechanisms were in place to change either the total package or the visit times, if thought inadequate?

Packages over 15 hours per week now need to be authorised by service manager. Under 15 hours, team leader can agree an increase. However, any increases over 15 hours are being scrutinised closely.

A fresh care plan is required which takes a day to write

This question appears to be aimed at home care workers when in fact there are numerous variations on care packages through mainstream services and personalisation. Homecare in itself is a rigid service that fails to meet the needs of many individuals.

Rely on care providers/service user or families calling duty team to report issues with care package.

I tell social services and it gets done as long as I can substantiate my request

It is possible to get approval to increase package but care provider may not be able to accept increase and outcome may be new provider which is not always a good thing.

No - direct payments are move available than before but this takes time to set up and packages of care are dependent on availability

We assess as accurately as possible then have to present our findings to Resource Allocation meetings. Even though indicative Self Directed Support budgets are identified through service users, carers and social worker assessments senior management often refuse or reduce the SDS budget. Unfortunately there is also a severe shortage of suitable workers to deliver support packages

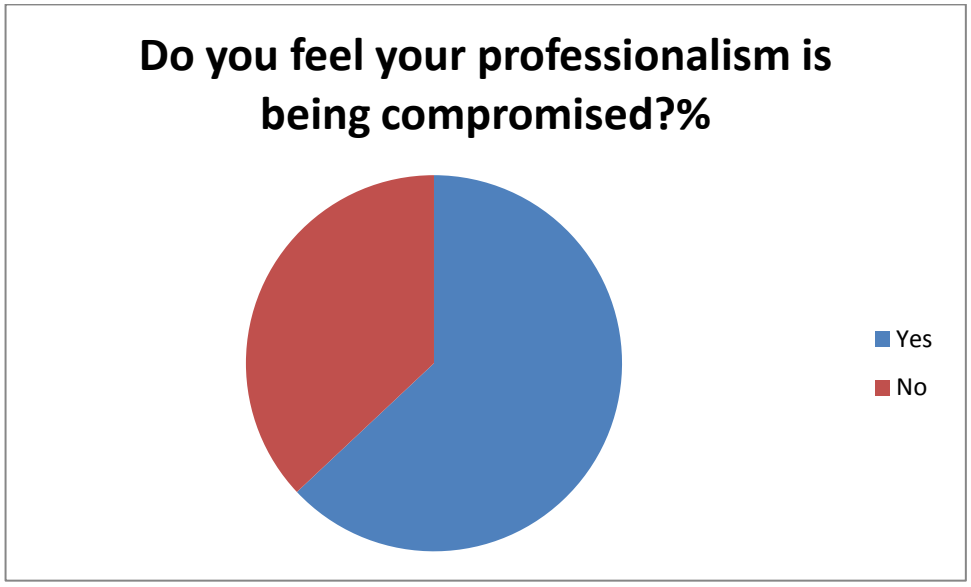
I have tried on many occasions to appeal the decision not to provide a service, however I don't think it's adequate as the same people at the same

level of decision making make the appeal decisions. I feel there should be an independent arbitrator made up of all 3 sectors, NHS, Voluntary and Local Government.

We are very restricted in what agencies we can use and agencies know this. I would like to see Homecare brought back to the Council so that there is adequate training, supervision of care and accountability. them to return home.

Professionalism

We asked whether respondents felt that their professionalism was ever compromised. 63% said that it was, as against 37% who said that it has not been.



The view from the ground -

Capacity is the main driver in the acute setting. I sometimes feel there is a lot of pressure to discharge patients who are not ready and patient care is compromised. We are constantly told to be "patient centered" but this is becoming more difficult.

Difficult to meet identified needs of individuals and give a quality service

The social work profession has always been compromised since I started 30 years ago but more so now with more and more social work being done by health professionals but from a health perspective, often a matter of "what medication can they be given" rather than look at a service user's social circumstances.

Professionalism is being questioned - little faith in our ability to do our job as we have been trained, we have to leave paper trail for everything , but the client data base was supposed to replace paper files years ago

I have never felt so vulnerable as a practitioner - managers are not interested in values or ethical practice. The service is run by budgets with no consideration of even our duty of care to people.

Drive to get as many service users as possible seen whilst increasing need for office time to complete bureaucracy

My health organisation has systematically dismantled the entire Allied Health Professions structure and leadership system over the past couple of years. This leaves staff feeling undervalued, lacking in professional support, and feeling as if we are an inconvenience to the health management structure.

No longer able to practice autonomously, therefore I have to run everything i think and want to do past a manager, whereas I used to be able to make recommendations, decisions and practice using my own skills, knowledge, experience and initiative.

At times of bed shortages I feel that the push is to get patients home too early. This is not cost effective as patients will only be re-admitted. With reductions in staff, the same service cannot be provided to patients.

Cuts and working Conditions

Staff were asked if cut backs had affected their own working conditions. Responses varied from difficult physical working conditions, e.g. basic cleanliness needs, to low morale and higher sickness levels, creating more pressure on staff still working.

The view from the ground -

Offices are closing and more people are being placed in buildings, cramped or call centre type offices are a joke when it comes to client confidentiality

My work is far more stressful than a few years ago, the pace is far faster, the complexity and severity of patients is far worse.

My telephone is sellotaped together. My chair is not supportive of my lumbar spine. Stationary is basic. We don't have money for new materials.

The office is an unwelcoming "tip" as NHS cleaning has been cut, bins remain full for days and carpet unhoovered, Leads to more stress all round

Levels of morale are very low. Cuts are being made in the wrong places, and affecting the most vulnerable people.

Vacancies not being filled is putting more pressure on the rest of the workforce. We cope but the quality of service we can give declines as we have less time, meaning often clients end up being re-referred over and again. So we have more pressure and less feeling of achievement of doing a good job.

Posts not being filled means increased workloads and limited time to carry out full comprehensive assessments.

Stress - stress and more stress! Low morale - no faith in management or government - neither seem to know what they are doing - but that doesn't stop them introducing more and more initiatives - without bothering to address the ones they've started which don't work.

I have to explain to clients that, although I have assessed them as requiring equipment, we are unable to supply it at the moment. Just something else for clients to get upset and angry about. Guess who is on the receiving end of their dissatisfaction?

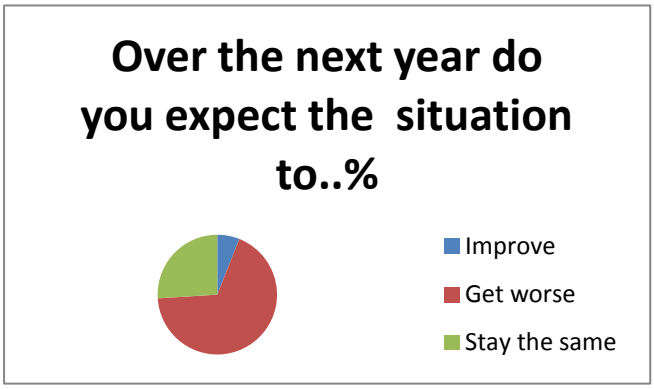
Unable to access rooms to see patients even in emergencies. Meeting room has been taken off health staff to house secretarial staff. Toilets have been removed to make way for filing cabinets. Dining / cooking facilities have been removed to make way for a social work office. Health Centre canteen has been removed to make way for office space. Staff are overcrowded into rooms and threatened with "hot desking" if we complain.

Lack of admin support, office not fit for purpose.

Staff shortages. High sickness rates. Managing with less resources

Future prospects

We asked whether respondents believed the situation would improve, stay the same, or get worse in future. Putting it mildly – confidence is not high. 68% of staff believe things will get worse, 26% think things will stay the same with only 6% expecting improvements.



The view from the ground -

"Decisions are being made higher up, with people not realising how they will affect patients and staff on the ground."

"The increasing managerialism and services competing rather than working in partnership is undermining a lot of good work done by very caring and committed workers across health and social care."

"Care in the community is being compromised by lack of adequate resources and people are being left without adequate support."

"Social workers do not care for people anymore, we care manage, which is not what we trained for. Too much paper work and not enough budget. Management does not care and I feel we are set up for professional mistakes."

"Self Directed Support - it is difficult to see how we can manage SDS without enough funding and it does seem there will not be enough funds."

Conclusion

The move towards integration of health and social care is viewed with caution by most of the staff we surveyed. Some of this may be put down to a basic fear of change – but equally some of this scepticism stems from poor experience of reorganisations in the past which have failed to deliver. In principle many believe integration to be a positive development with, potentially, much that will benefit patients and clients. Indeed significant numbers work or have worked in integrated services and are aware of the potential.

That said there are obvious pitfalls and problems which staff can foresee that will need to be resolved. The necessity for clear communication as this process is rolled out is clear. This will be necessary not only because unless basic administration and IT systems can aligned much of the potential benefit will fail to materialise. It is also the case that good communication will be needed in order to resolve potential conflicts between potentially conflicting professional approaches.

UNISON Scotland has called for national and local workforce frameworks and assurances were given by ministers on this issue. Progress to date has been slow – constantly reinventing the wheel helps no one.

Over and above all the concerns raised in this survey is the issue of resourcing. Staff can see how integration could work. What they cannot see is how they can deliver current levels of service – which many feel to be inadequate on lower budgets. We have already seen that many staff believe that their professionalism is already being compromised by a lack of resources. That is the real fear, that integration will be pursued in order to provide not an improved service but a cheaper service. Staff are concerned that reorganisation will be used as a cover for budget cuts which will further impact adversely not just on their working lives but adversely on the lives of the vulnerable people they serve.

Success in integrating health and social care is more likely to be achieved by closely involving the staff who deliver the services in any reorganisation - diktat from above is unlikely to deliver. Equally any promise of an improved service must be based on a clear acknowledgement that quality services rely not just on professional and dedicated staff , but on levels of budgeting to support them – without this no amount of good will or organisational innovation will deliver the seamless and quality care that Scotland's vulnerable need and deserve.

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