



Stay Safe East Policy Briefing October 2021

Health and Care Bill 2021

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Introduction

The Health and Care Bill, introduced to Parliament on July 6th 2021 proposes new measures to remove barriers to integrating services, including changes to structures within the health service. The Bill contains provisions to public health, quality and safety in the NHS, and outlines new powers for the Secretary of State over the health and care system.

Others have commented on the wider implications for the NHS. This briefing focuses on the implications of the Bill for disabled people, and in particular disabled victims/survivors of domestic abuse and other forms of violence against women and girls (VAWG). Stay Safe East offers our comments and recommendations on the Bill.

About Stay Safe East

Stay Safe East is the only specialist user-led organisation supporting disabled survivors of domestic abuse and other forms of violence against women and girls, as well as victims of hate crime and harassment. We work across London, providing long-term holistic advocacy to a very diverse group of survivors, 85% of whom are women. We help clients to be safe and get justice, and advocate for them to access adult social care, mental health and other health services. Our expertise comes from the personal and professional experiences of our Board, staff, volunteers and clients, all of whom access health services and a significant proportion of whom access support from adult social care.

Stay Safe East's recommendations for the Bill

The Bill and associated guidance must ensure that safety from abuse is a key part of any discharge assessment of patients.

A. Our preferred approach would be to delete Clause 78 from the Bill relating to removing the duty to conduct an assessment prior to discharge. We outline our rationale for this below.

B. Alternatively, we propose an amendment to Clause 78 as follows:

“No discharge will take place without safeguards to ensure the patient’s physical and psychological safety, including freedom from domestic and other abuse or neglect, and without the patient’s wishes and preferences being heard and taken into account. “

1. Key issue: Hospital discharge proposals: Clause 78

The Bill proposes to abolish the duty under Section 3 of the Care Act 2014 to assess a person’s needs (and in effect set up necessary support or equipment) before they are discharged from hospital. The evidence for this is based on pilot ‘Discharge to Assess’ programmes run before the Covid pandemic, and on the practice which has been prevalent during the pandemic itself.

There are high risks associated with this approach. We would like to endorse the [BASW England comments](#)¹ on the Health and Care Bill and specifically Hospital Discharge proposals. Our specific concerns are set out below.

A. Survivors of abuse

Disabled people, and most specifically disabled women experience higher rates of domestic abuse than non-disabled people²; abuse against disabled women is likely to be more violent and happen over a longer period of time before the victim discloses or is able to access help.

As an organization working exclusively with disabled victims of domestic and other abuse, Stay Safe East shares the British Association of Social Workers’ concerns about the voice of the disabled person not being heard. If the disabled victim of domestic abuse is not heard, there is a significant risk that they will be sent home to be ‘cared for’ by an abusive partner or family member.

¹ <https://www.basw.co.uk/media/news/2021/jul/health-and-social-care-bill-%E2%80%93-hospital-discharge-proposals-basw-england-response>).

² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480942/Disability_and_domestic_abuse_topic_overview_FINAL.pdf

Often the meeting with a professional social worker (who should be trained in assessing risks, including domestic abuse) during an assessment is *the only or most significant opportunity for an older or disabled person to disclose* domestic or other abuse. If given time and asked skillful questions in a safe environment away from home, the person may disclose, or may express their fears indirectly. Even where there are significant injuries, the victim may choose not to disclose to medical staff. Whilst medical staff receive some training on adult safeguarding, and in a few hospitals on domestic abuse, they may not have the skills or the time to communicate with someone with learning disabilities or cognitive issues, or to deal with a Deaf survivor or a very elderly person who is reluctant to share personal information. It may be argued that in circumstances where abuse is identified, the adult safeguarding process should be invoked. Whilst this should of course happen, not all disabled and older people would fall under the remit of adult safeguarding. This process also depends on the victim (or a third party) disclosing – but if there is no one to build up the person’s trust, then they will not disclose.

We recognize that in some areas there is an Independent Domestic Violence Adviser (IDVAs) working within the hospital, but their attention may be focused on A&E and immediate victims of domestic abuse, not on patients on the wards; all hospital IDVAs are overstretched. They are also not social care specialists. Stay Safe East would like to see a minimum of two IDVAs in every hospital. However, this would not obviate the need for a pre-discharge assessment of adults at risk (sometimes described as ‘vulnerable adults’) – our experience is that because disabled victims may depend on their abuser for care and support, an understanding of that relationship and of both social care and abuse is essential. Where necessary, the social worker can work with the IDVA to encourage disclosure and to get support for the disabled victim.

Discharging people without assessment means leaving people at risk of abuse by partners, family members, paid or informal carers or others³ who have abused them before admission to hospital. This abuse may be the reason they are in hospital in the first place (for example with mental health issues – injuries are not only physical). If a risk assessment is not carried out, and questions not asked by a trained professional before discharge, the person will return home to be abused or exploited.

Stay Safe East supports amendment NC5 to the Bill which in effect proposes a pre-emptive duty on Integrated Care Boards to “assess and make arrangements for the assessment of, the need for support for victims of domestic abuse using their

³ As well as working with victims of domestic abuse, Stay Safe East supports disabled victims of abuse by informal and paid carers or personal assistants ‘cuckooing’ – the disabled person’s home may have been taken over by gang members, drug dealers or another group of individuals who control the disabled person.

services” and to publish a strategy for the support of domestic abuse victims in their area. However, this needs to address the specific issues for disabled and older victims/survivors. Discharge of older and disabled patients without assessment contradicts this clause.

We would also argue that Clause 78 also contravenes one of the fundamental principles of the Care Act 2014, namely prevention from the basis that it is better to take action before harm occurs⁴.

B. Disabled and older people leaving hospital

The proposal also has implications for any disabled or older person needing help at home, whether or not they are a victim of domestic or other abuse. As an organization run by and for disabled people, these are our additional substantial concerns regarding Clause 78.

The proposals come at a time when disabled people face extraordinarily long waiting times for an assessment by adult social care in the community. This will not be resolved by obviating the need for an assessment before the person leaves hospital.

Disabled people may return home without proper support, potentially resulting in further deterioration of their impairment. People who are newly disabled or whose condition has deteriorated due to illness, accident or abuse (see below) will rely solely on a medical assessment of their condition, and will miss out on a pre-emptive assessment of their social and practical needs before they return home. For example, someone may have had a significant injury which has resulted in a mobility impairment, and may need daily help and adaptations to their home.

- The ‘Discharge to Assess’ model relies on short term input from Re-ablement teams post-discharge. The Care Act 2014 however does not provide a statutory right to support when first discharged from hospital, so this model relies on services which may or may not be in place, depending on resources. There is a lack of clarity about patients’ legal right to re-ablement. People may be left without any support or assessment for some considerable time, depending on local waiting lists for an assessment. There may be further delays due to the current shortage of staff in the care sector.
- Re-ablement teams do have a useful role in encouraging older people recovering from a fall or illness to regain their confidence in managing day-to-day tasks or doing them differently. In our experience however, local authority re-ablement services are not equipped to deal with newly disabled people with more than basic support needs, or with people who existing impairment has worsened, and

⁴ https://www.scie.org.uk/safeguarding/adults/introduction/six-principles?gclid=EAlaIqobChMItab1r5HW8wIVC-WzCh1FPgk-EAAYBCAAEgIXdPD_BwE

who may need to make a sometimes difficult psychological adjustment to new circumstances. This group of disabled people (including older people) need expert social work, OT and other input before discharge. As highlighted by BASW:

Social workers identified that the care and support arranged for people's hospital discharge was often more restrictive e.g., not being supported to return home with care or equipment but being taken to a care home. The survey highlighted an increase in the number of people being discharged to 24-hour care settings, with restricted access to family, networks, and existing care resources. A key concern raised by social workers was the loss or reduction of the involvement of social workers' skill set in hospital discharge and the ability to effect change at crucial decision-making points.

- A key part of any assessment is a consideration of housing needs. Arguably the single most significant reason for delayed discharge is that people cannot return home because their homes are not adapted. To put it simply, **how can a person be discharged to a home they can no longer get into or make use of?** The person themselves may be unaware of what is available, and needs time to consider their options. There is a real risk that people will simply be discharged to institutional care without being able to make a choice— this has happened during Covid, with disastrous results, but even in a non-pandemic situation, would be a breach of disabled people's human rights.
- Disabled Facilities Grants can be delayed by up to two years⁵, and adaptations by social housing landlords are subject to similar delays. Addressing the lack of resources for adaptations would go a considerable way to addressing so called "bed-blocking" and to preventing institutionalization of younger and older disabled people.
- The Care Act gives a disabled or older person's primary carer, if any the right to an assessment of need. It is unclear to us how this right can be guaranteed within the proposed framework, given that the disabled person may be discharged to the care of their family member without either having say in this, and without the carer being able to state if they can cope or not. This also introduces a further risk of neglect, or at worse, abuse.

As set out by the BASW, hospital social workers are best placed to carry out a comprehensive assessment of the person's social, access and support needs, where necessary with input from OTs, physios and medical staff. Where a person has learning disabilities, or cognitive issues, expert input from a specialist social worker is essential. If needs are not identified and met, this may mean a higher risk of relapse, of falls or deterioration of the person's condition – all of which are costs to the NHS.

⁵ <http://attoday.co.uk/23-percent-of-councils-report-disabled-people-waiting-two-years-or-more-for-vital-home-adaptations-new-research-shows/>

We are very much in favour of reducing delayed discharge, especially as it can lead to people becoming at least temporarily or permanently institutionalised (in some cases against their wishes), but we believe this should be through other means: having enough hospital social workers and advocates, enough properly trained and equipped home-from-hospital teams, greater availability of NHS continuing care support which respects disabled people's rights and autonomy and appropriate short-term NHS rehabilitation accommodation – for example if some patients do not need an acute bed but rather rehab while regaining strength, mobility, balance or confidence or being monitored in case they become acutely ill again, NHS trusts could make greater provision for units with therapists and care assistants etc.

The rights of disabled people: voice and advocacy

BASW evidenced the experience of social workers and their clients during the pandemic:

... Social workers felt that the voice of the individual was lost, indicating arrangements being made without consent or against people's views and wishes.

Lack of assessment on discharge means that the patient (or their carer) may not get access to advocacy (whether statutory or non-statutory, or provided by a friend or family member) to support them to express their needs, wants and wishes and to explain the process to them. A person living independently may have been hospitalized as a result of acquiring a long-term health condition such as cognitive issues due to stroke or mental health issues, which means they will need more help than previously, but struggle to explain their worries, or indeed to assess the risk of going home alone. Once home, they may be 'out of sight, out of mind' and become more isolated (especially if their needs are not met) and may become less able to assert their voice. The BASW expressed wider concerns:

*Clear accountability needs to be established within this process to ensure an individual's rights and the opportunity to be listened to, heard, and involved in making decisions about care and treatment, are fundamental principles of this proposal in line with the principles of the Mental Capacity Act (2005[4]) and **the right to respect for private and family life** (Article 8). This article protects people's autonomy and well-being which includes participating in decisions about care and treatment, setting discharge and recovery goals, the protection for people from psychological trauma or physical harm caused by premature or delayed discharge which can lead to serious distress or hinder recovery.*

Access to advocacy (including an IDVA) is also critical in supporting a patient who has disclosed abuse. Our considered view is that care and support needs, along with housing needs and any safeguarding, financial, psychological and mental well-being

issues should be comprehensively assessed by a social worker in hospital before discharge, then reviewed once the person is home to fine tune the support. The disabled or older person should have access to independent advocacy and be able to consider their options and make an informed decision.

In conclusion to this section, safeguards must be written by Parliament into the Health and Care Bill so that patients will not be discharged into an unsafe situation, taking account of the patient's wishes and preferences and of medical, practical and social circumstances, including any experiences of violence or neglect.

Stay Safe East's recommendation

Clause 78 should be deleted from the Health and Care Bill. Alternatively, we would propose that safeguards are added to Clause 78 of the Bill as follows:

“No discharge will take place without safeguards to ensure the patient's physical and psychological safety, and freedom from domestic and other abuse or neglect, and without the patient's wishes and preferences being heard and taken into account. “

2. Other issues of concern

The remainder of our concerns are offered as information based on 11 years of our casework with disabled people. We have not made specific recommendations for the Health and Care Bill on these matters but would place these observations on record for the Bill Committee to take account of.

A. Integration of health and social care

The Bill places Integrated Care Systems (ICSs) on a statutory footing, comprising an NHS Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). The ICB will be responsible for the day to day running of the NHS, whilst the ICP will produce an integrated care plan to tackle the system's public health and social care needs.

Stay Safe East welcomes the move towards collaborative care as a strategy to improve health and social care. However, like most other disabled people's organisations we are concerned that more joint or merged working between health and social care will lead to a more medical approach to disability and not a social one. Getting support for daily needs is not just about medical or functional needs, but about independence, quality of life and choice.

The Bill includes various provisions allowing NHS England and ICBs to collaborate to commission services, allowing local authorities and health to join forces in commissioning and budgets. Many disabled people receive joint support via health and social care but:

- There is no mention of user-led self-directed care schemes that enable disabled people to choose and manage their own personal assistants or carers, with support if necessary. These have been the backbone of independent living for a generation but have been eroded by the social care and health commissioning culture which privileges large providers. The larger providers have people and departments dedicated to getting good ratings, whilst user-led organisations who organize PA services do not have these resources and thus are unlikely to get contracts. Disabled people with care packages who self-organise, ULOs and self-funders (particularly those employing people to do short term care - e.g. respite) are not going to be supported or able to meaningfully engage with what is an institutional review authority.
- Quality control and prevention of abuse or neglect by private care agencies remain poor and worsened under Covid. Complaints procedures are cumbersome and often inaccessible to disabled people and their carers, for example requiring a written complaint. Investigations by adult social care are often drawn out and rarely privilege the voice of the user. Clients of Stay safe East have been let without care, abused by care workers and have found themselves labelled as 'difficult' or 'non-cooperative' and it is only after our intervention that they have been able to get care that gives them dignity and freedom from abuse. very few disabled people have access to advocacy in these situations.

We are concerned about a direction of travel towards more institutional provision and away from independent living. Stay Safe East would like to see a clear commitment to independent living and self-directed care and decision-making for social care users within the Bill, and eventually within any future social care legislation and strategy.

B. Additional powers and responsibilities for the Care Quality Commission

Stay Safe East has significant concerns about the CQC being made the inspector, regulator and with powers to review and performance assess on regulated care functions. While the CQC's role in inspecting care homes has at times been useful, its role is circumscribed and not without problems:

- Our concerns are raised in a context where the CQC has not been historically astute at recognizing abuse and violence
- The CQC does not have to reply to relatives' concerns or individual problems; the threshold to trigger an inspection is very high but the measurable standards do not include abuse, so inspectors do not see it. Concerns about abuse in care settings have usually been raised by families or residents or by TV programmes. If this situation spreads across all of adult social care, this engenders a dangerous situation for disabled people.

- CQC is about compliance with ‘performance’ standards (all of which will have to be passed by the Secretary of State under the Bill) - not ethics, safety or independent living. This often takes the focus away from the people using the services.
- We remain unconvinced that asking the CQC to name and shame local authorities after services have been systematically starved of funding (<https://ifs.org.uk/publications/15214>) is particularly helpful. Overall the shortage of affordable and adequate social care, delivered by a properly valued and trained workforce, has not been addressed – stemming largely from widespread lack of awareness of the harm to disabled people arising from current failings and acceptance that those in need of support can usually make do without what non-disabled people might take for granted. Proper funding could expand decent (health-enhancing) employment and boost the economy.
- The CQC does not attend Safeguarding Adults Boards (SABs) or Local Safeguarding Children’s Boards (LSCBs), but they ‘may’ share information and intelligence to help them conduct enquiries. It does not observe, so Experts by Experience are likely to not be needed in the new regime – a scheme which has successfully helped stem harm to residents in care homes.
- The Bill states that "The Secretary of State may direct the Commission to revise the indicators under subsection (5)." This is therefore not independent and the Secretary of State can determine different indicators for different reviews.

C. Patient safety and quality of care: disabled people and people with long-term health conditions

Disabled people, especially those who have learning disabilities or life limiting conditions, are homeless, from refugee and minority ethnic communities or economically and educationally disadvantaged, may be especially at risk. Medical practitioners already make, or are forced by lack of resources or in some cases prejudice⁶, to make life or death decisions about treatment for people with ‘high support needs’ whose lives are deemed not worth living. The joint parliamentary report by the Health and Social Care and Science and Technology Committees

⁶ <https://www.theguardian.com/world/2021/feb/13/new-do-not-resuscitate-orders-imposed-on-4-covid-19-patients-with-learning-difficulties> CHECK

Health Committee 13th October 2021: <https://www.openaccessgovernment.org/blanket-dnr/122280/>

<https://www.openaccessgovernment.org/do-not-resuscitate/93223/>

*Coronavirus: Lessons Learned to Date*⁷, acknowledged, inter alia, the inequalities faced by people with learning disabilities:

Although there was never national NHS guidance to apply “Do not attempt CPR” (DNACPR) notices to people with learning disabilities, there have been widespread concerns that there were cases in which they have been issued inappropriately during the pandemic... People with learning disabilities have experienced significantly higher death rates from covid-19 than the country as a whole. Deaths have been especially high among younger adults with learning disabilities. Initial research suggests that people with learning disabilities entered the pandemic from a position of heightened vulnerability because of existing comorbidities. This was compounded by particular barriers to accessing NHS treatment during the pandemic arising from restrictions on non-Covid care and limits on the ability of carers and advocates to attend hospital with people with learning disabilities.

Until now there has been the ability to highlight inequalities and abuse, and to be heard to some extent, at local or wider level. Local Integrated Care Boards offer less protection. Likewise giving the government overriding powers to override local decision-makers may increase the risk that disabled people’s needs and interests may be overridden. For instance, people with chronic conditions, a high proportion of whom are disabled, could be deprived of much-needed care in line with a trend towards undervaluing some sections of the population or so as to increase profits for a favoured provider. This could cost people their lives.

D. Patient involvement and accountability

Concerns about lack of democratic accountability and transparency around Integrated Care Boards have been highlighted by many commentators (<https://www.bmj.com/content/374/bmj.n1824>), as well as of inadequate safeguards to prevent commercial interests overriding those of patients. The type of ‘integration’ during the pandemic, when care homes were pressured into taking in COVID-infected patients but with nothing like adequate equipment and staffing for barrier nursing, had horrific results. It is vital to learn from what went wrong then, as well as from the many other times when care not good enough to meet basic human rights standards has gone unchallenged.

Even if there were a Healthwatch representative, (<https://www.healthwatch.co.uk/response/2021-05-17/health-and-social-care-committee-report-our-response>) as well as representation of local authorities in ICB governance, these could be potentially heavily outnumbered. the ability to ‘speak truth to power’ and to challenge decisions, strategies and allocation of resources has

<https://publications.parliament.uk/pa/cm5802/cmselect/cmsctech/92/9213.htm>

been fundamental to the running of the NHS for many years. The Bill further erodes this vital safeguard.

On a more positive note, the setting up of a statutory Health Services Safety Investigations Body responsible for conducting independent investigations of patient safety concerns in NHS-funded care across England may strengthen patient safety, including for the many disabled patients at high risk of substandard treatment and care. However, such bodies must be accountable and wholly independent, or risk losing public confidence, as has happened with the Independent Office for Police Conduct and its predecessor the Police Complaints Authority.

E. Timing of the Bill

We believe that the introduction of the Bill at this time is not conducive to aiding the post-COVID recovery of the NHS. This is in part because it fails to address the significant problems the NHS is dealing with from the pandemic, and indeed from before the pandemic, such as workforce shortages, underfunding, and overworked staff facing a second and potentially third wave.⁸ The Bill does also not cover wider reforms of the social care system, which is in crisis. Stay Safe East, as an organization of and for disabled people, endorses the recommendations of the joint parliamentary review.

The long-term reform of social care is overdue and should be pursued as a matter of urgency. The Government's recent announcement on the future of social care is welcome, but the long-term future of the sector remains unresolved. We endorse the Health and Social Care Committee's call for a 10 Year Plan for Social Care to accompany the 10 Year Plan for the NHS. It must ensure that there is parity between the health and care sectors so that social care is given proper priority in a future crisis. (Paragraph 294)

We endorse the Health and Social Care Committee's call for additional resources to be directed to social care. That Committee has made the case for an increase of £7 billion a year by 2023/4. We note that despite the Government's recent announcement the level of new investment in social care from 2023/24 remains unclear. (Paragraph 295)

Stay Safe East October 2021.

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⁸ <https://www.bma.org.uk/bma-media-centre/wrong-bill-at-the-wrong-time-bma-council-calls-on-mps-to-reject-health-and-care-bill>

