IASW Response to Sinn Féin Consultation Document –

Priorities for Change in Health & Social Care

IASW welcomes the clear statement from Sinn Féin that healthcare is a human right. Social care is also human right. A human rights approach to health and social care ensures policy provides **equitable access** to health and social care is delivered to all people regardless of postcode and a **a holistic understanding** of health and social care, putting the person using services at the centre and considering needs outside of the traditional medical/clinical lens.

We call for a significant reduction in the private business model of health and social care and a **return to co-production** between State and communities, to ensure people receive care in their communities, by community members. Grassroots investment with and in communities is vital for health and social well being.

We call for **a 'punch-up' approach** to ensure that individual groups are never blamed for Government failure to plan for population growth.

Observations on and additional points regarding specific sections of the Consultation Paper, include the following:

1: Improve Affordability:

- Concept of 'SlainteCard' welcome but needs to be accessible to all citizens, regardless of address (i.e. nursing home/disability service).
- IASW favour investment in public services vs shortstop use of private providers – private providers are draining public workforce.

2. Reduce Wait Times and Improve Access:

- Quickest way for people to access enhanced social care packages is often through a hospital – provision of social care must be needs rather than location based.
- New paperwork associated with DMR has dramatically increased administrative work and is impacting discharge times.
- Hospital overcrowding is demonstrably linked with higher mortality – this must be presented as a human rights issues.
- Any new acute or community beds must be costed with appropriate services and personnel.
- Homeless patients – no place to discharge.

- Older people – being discharged to locations against their will. Care is about more than a bed, proactively funding and supporting social connection is vital.

3. Deliver More Care in the Community:

- Support roll out of Inclusion Health Services in community and acute settings.
- Comprehensive overarching national plan for social care is required. What are baseline requirements in our communities? We have fragmented services often delivered on postcode lottery basis.
- Need to map existing supports and deficits and plan accordingly.
- Currently limited or no access to community services for residents in long term private NHs – limited access in public nursing homes. Nursing homes are peoples' homes and should be embedded in local communities with the same rights and entitlements to health and social care as citizens living in their own homes/other community settings.
- Community based care must be adequately resourced – we are experiencing blocks in step down units without adequate resources.
- Oral health public health programme in early years/schools teaching dental hygiene – social workers are witnessing neglect associated with lack of access to dental care.
- Palliative social work services must be mapped and available in every county in Ireland.
- Redesign of home support services – at present this remains in silos with Older Persons funding those over 65; Disability Services funding under 65. Those who don't meet either criteria have no direct support funding stream.
- Current service model, despite what may be reported, is not based on need but based on what is available within resources to provide. Persons are often placed in age-inappropriate services due to the lack of an appropriate and safe home support service.
- Home support must move away from solely medical/clinical need and look holistically at the person requiring support - minimising social isolation, reinforces society participation, health benefits to living well etc. This has a cost benefit to society.
- **Bring all home care services back under a public service remit and discontinue the dependence on private home care providers to sustain this service on behalf of the HSE.** This is a business rather than health/social care model. Furthermore no community based care/integrated care teams will work without improved home support. The current lack of appropriate home support services and hours is leading to a deprivation of liberty for patients who cannot leave hospital without appropriate care in place or are forced into nursing homes against their will and preference in the absence of sufficient and safe support. Private profit making system discriminates against rural patients.
- Community Rehab teams with full MDT, Home Support and Social Care Workers should be available in very town, village and city areas, this would enhance

hospital discharges to support a sense of care within the community away from hospital settings and reduce need for admissions to hospital – people admitted at crisis point and then can't be discharged.

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4. Towards a sustainable, skilled and diverse health sector workforce:

- Health and social care representation required at highest levels to ensure healthcare is not reduced to perspective of clinical/medical lens.
- Recruitment and retention is key – learning why people are not accepting or are leaving jobs is key to understanding how to attract them.
- Introduce incentives to retention such a Long Service Leave (operates across public service in Australia) after 10 years of service each worker is entitled to paid 3 months leave.
- Commitment to engaging in Safe Staffing levels for all HSCP staff, in particular Social Work across all health and social care services – Hospital, Primary Care, Adult Mental Health, CAMHS, YAMHS, Disability Services, Older Persons Services, Social Inclusion Health, Safeguarding
- This must include an urgent Gap Analysis across all above domains to map out the current need and deficits in services
- WTEs must include a ratio to support incidents of scheduled and unscheduled leave within Social Work/HSCP staff workforce. Predominately female led work force with associated maternity leaves which are often not covered due to a) temporary nature of post and b) insufficient work force in the first instance as graduates of such professions. Also need for appropriate WTE recommendations across care for Social Work (like nursing have currently – need x number of nurses for y number of beds)
- Redesign of current Career Pathway available within Social Work to include Specialist posts, Advance Practice posts, Management posts and Deputy Principal Social Work posts.
- Appointment of a Chief Social Worker in HSE with Deputy Chief SWs with specific responsibilities. Each deputy would be responsible for different areas within HSE (i.e. Disability, Mental Health, Hospitals, Primary Care, and OPS/Safeguarding etc.).
- Commitment to accommodate staff in appropriate offices and setting which also facilitate and accommodate additional room for student placements, as well as for persons requesting period of adaptation within services to meet CORU requirements.
- Remove/reduce multi-office/open plan space for ease of work, support and comfort of workforce.
- Each Maternity hospital site must have the requisite number of Social Workers to respond to support crisis pregnancies, complex care needs, international protection applicants who are pregnant, termination of pregnancy, choice/options counselling, teen parent support programmes etc. and additional specialist services where required, i.e. additional staff for neonatology, fetal assessment services.

- Rise of racial trauma experienced by health and social care staff – we want to see a national racial equity plan, to include supporting healthcare organisations to address racial abuse and trauma experienced by ethnic minority staff.

5. Reform and Accountability

- Co-production, transparent and accountable practice must become the norm – Cherry Orchard transfer case an example of how not to do things. Doing things 'with' rather than 'for' people and communities.
- Introduction of professional code of ethics for health and social care managers, similar to those for professional staff. Given the significant influence managers have over outcomes.
- Full publication of reports into serious incidents must be made routinely available.
- Each hospital with an Emergency Department must have a minimum 2 WTE Senior MSWs to respond to crisis presentations such as Domestic Violence, Sexual Assault, Homelessness, Addiction Services, Adult Safeguarding, Child Protection concerns. Each hospital with an Injuries Unit / Medical Assessment Unit must have a minimum 1 WTE Senior MSW to deal with the same issues outlined above.

6. Mental Health:

- IT system should extend into all of mental health, not just CAMHS and should be linked to support transition of care.
- IT for mental health: Lack of IT compromises continuity of care, e.g. establishing what therapies/approaches work effectively for people over time.
- Preventative approach is so important but so too is a commitment to supporting people with severe and enduring mental health difficulties to enjoy a good quality of life.'

7. Improve Social Care:

- Loneliness levels require a national social connection plan.
- Home support should be provided in communities by communities through publically funded home care.
- Note regarding Charter for Family Carers, we also need a Charter for people requiring care.
- Recruitment & Retention is key here also.
- Independent and Social Work/Advocacy services for people living in care settings. Professional regulation should be introduced for advocates.

8. Disability Services:

- Only outcome that matters is delivery of a frontline service by appropriate, well governed professional.
- Engagement of children with disabilities in e.g. Sports, Gaeltacht, GAA, is vital for well- being and social connection. Exercise participation of people with disabilities is a public health issue.
- Brain injury support services must be enhanced – particularly when a young parent is impacted. Family breakdown following acquired brain injury is common and a far more comprehensive range of supports and services are required.
- Supports for people with disabilities when they experience abuse – this extends to criminal justice, medical and social care.
- Invest primarily in de-congregation. People want to live in their own homes in their own communities. Reconsider and reconstitute residential and long term care settings. If such services are to be *de facto* homes for people who require that level of care it should reflect a home/social environment and not a medical/clinical setting.
- Create, plan and develop transitional living services and case management for people e.g. waiting on housing adaptations e.g. post spinal cord injury/brain injury There needs to be a variety of options for both people with disabilities and older persons with high complexity needs i.e. an increased focus on assisted living/shared care arrangements. The points about the private nursing home model or care for profit are well made. Not every person whose care needs cannot be met at home necessarily means they are appropriate for long term residential care either. Consideration must be given to alternative intermediate options, for example supervised housing complexes with social supports to facilitate semi-independent living structures and services.

All-Island Healthcare:

- Facilitate easier transfer of qualification and professional registration North - South and *vice versa*, for example by reciprocal recognition of Social Worker registration by CORU (Ireland) and Northern Ireland (NISCC), so as to create greater professional mobility and effectively an all-island workforce pool, rather than the overly restricted situation as at present.

Cancer:

- Each cancer centre should have safe and sufficient staffing, including the requisite requirement of social workers to respond to all patients newly diagnosed with cancer to support them on their treatment journey.

- A number of people who have to travel to receive cancer treatment experience great financial hardship, allied to the physical pains of treatment itself. This mostly affects people living in rural areas who have to travel to cancer centres such as St. Lukes in Dublin, for treatment, especially radiotherapy. This may involve to and from the treatment centre five days a week over a six week period. Financial assistance available in such cases is extremely limited and we call for a review of this, and an improved financial assistance scheme.

Womens Healthcare:

- Increased investment in breastfeeding support is required.
- Wrap around community supports as required.

Children and Youth:

- National Scoliosis scandal needs to viewed as a human rights breach.
- No child should be living in a hospital pending placement as per recent Ombudsman reports – failure to plan rather than hard to place. Much more and better co-ordination required from Tusla/HSE.
- Support family friendly policies to facilitate young children having shorter days in childcare and more time at home.
- Support access to green spaces/movement/child friendly community design.

Ambulance Service:

- Social workers have contacted IASW at the apparent poor availability and unacceptably slow response rates of the ambulance nationally, but which may be worse in some parts of the country than others. This can have very serious consequences especially for example for those who are older and may be living with chronic medial and other conditions, with extremely adverse outcomes where medical attention is unduly delayed in such emergency situations.

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On behalf of IASW 15 February 2024