**NFB ssl 14.02.2022.**

**TAKING A LITTLE MORE NOTICE**

**A Note for Support for Sight Loss Committee**

**Of**

**THE National Federation of the Blind**

**On**

**Health and social care integration: joining up care for people, places and populations**

**White Paper Published 9 February 2022 CP 573.**

**Available at** [**www.gov.uk/official-documents**](http://www.gov.uk/official-documents)

**1 INTRODUCTION**

**1.1 This White Paper [WPHSCI] takes forward Government's strategy for integrating health and social services first announced early in 2021. It follows on from )and refers to) the WP on Adult Social Care (WPASC), published later in the same year, on which NFB has already commented [See 'Not a Blind bit of Notice', Comment by NFB 10 December 2021].**

**1.2 Broadly, the WPASC described the improvements to care services which the Government seeks to promote, while WPHSCI sets out a plan for improved delivery of these services through integrated administration of NHS and Local Government agencies - the 'integrated care system' (ICS) as it is called.**

**1.3 Commenting on WPASC , NFB noted that its 'fatal flaw' was a complete absence of reference to sight loss and to vision rehabilitation for independence. (NFB Comment, 10 December 2021, par 2.3). This note examines how far WPHSCI goes towards remedy of this fatal defect.**

**2 AIM OF THE WPHSCI**

**2.1 In the Foreword to WPhsci, the Secretaries of State write, as joint authors, that the aim of the Government is to move further and faster towards an Integrated Care System for delivery of health and care services in England. They recognise:**

**1 The lesson of the pandemic that health and care services are 'stronger when we work together';**

**2 The 'moral outrage of existing health disparities';**

**3 the 'inextricable link' between health and care services.**

**2.2 Accordingly, WP HSCI proposes to 'bridge the gaps between health ands social care, between health outcomes in different places and within society - that are holding us back.'**

**2.3 To this end, the Government will bring together, by Spring 2023, arrangements for collaborative delivery of services by NHS and local government. By that date, each place should have developed a model of shared service with a single leader in charge and with citizens at the heart of the new service.**

**2.4 Three reforms will be vital to this:**

**1 A single person accountable for a shared plan at a local level (par. 3.6 and following);**

**2 Health and social care professionals to have access to the right data and technologies (par. 4.1 and following);**

**3 'a more agile work force with care workers and nurses easily moving between roles in the NHS and care sector.' (Intro.)**

**2.5 NFB welcomes the acknowledgment here (as also in the WPASC ), of a post code lottery in service availability. Such acknowledgment is, however, likely to prove of little value to people with serious sight loss without an accompanying recognition of their impairment-specific needs and the indispensable role which qualified vision rehabilitation workers can and do play in meeting them. In both these respects, we have to observe, the WPHSCI falls seriously short. Below we offer some illustrations of its shortcomings.**

**3 Case studies in wpHSCI**

**3.1 We acknowledge at the outset that WPHSCI makes one significant advance on the WPASC. This is the welcome inclusion in the 'case studies' of 'Madeleine', who is represented as 65 years of age, 'visually impaired'' and living alone with her guide dog. Her daughters and grandchildren live abroad and communicate with her through digital technology. The WP goes on to state that, in common with most visually impaired people, Madeleine does not have any statutory support but relies on the services provided by the Guide Dogs for the Blind Association.'**

**3.2 Later. WPHSCI reports that Madeleine's case highlights the value of 'good collaboration between the statutory sector and voluntary sector' (Ch. 6). Her loneliness during the pandemic was recognised by her GP and she was referred to 'the well-being team' who placed her on a programme to tackle her loneliness. She was also put in touch with local volunteers who help her with shopping and other basic services in the community.**

**3.3 We would offer the following comments on the way in which Madeleine's case is used in WPHSCI.**

**(i) The statement that 'most visually impaired people do not have 'any statutory support' suggest that deterioration of vision rehabilitation has gone much further than even NFB and RNIB have reported.**

**(ii) The failure to disclose whether or not the 'well-being team' included a qualified vision rehabilitation worker may encourage the inference that none was needed - health care professionals being up to the job.**

**(ii) Be that as it may, it is relevant to point out that Madeline's needs are hardly typical of the range of impairment-specific needs with which vision rehabilitation workers have to deal on a regular basis. Typically, these arise most frequently at the onset of the sight loss journey. Among them are the severe shock, even trauma, that a diagnoses of blindness frequently brings on. Over and above this complex psychological condition, there exists the need for specialist training in the use of impairment-specific technologies to enable personal care and mobility.**

**(iii) Finally, it should be pointed out that, of the approximately 350,000 people registered in the United Kingdom as blind or partially sighted, 45% live with serious sight loss compounded by additional impairments (See Network 1000)..**

**3.4 For these three reasons (among others), NFB's campaign guide, support for Sight Loss, has placed strong emphasis on the need to employ , in the delivery of services, a proportionate number of vision rehabilitation workers (see 'Support for Sight Loss', NFB at www.admin@nfbuk). Yet it is far from clear that WPHSCI has taken account of our case. The conclusion that it has not done so is forced upon us by Chapter Five, which outlines the future of collaboration between health and social care work force and carers.**

**4 THE CASE OF THE MISSING Rehabilitation WORKER**

**4.1 Chapter Five outlines a '15-year forward view to 'facilitate work force integration' (par. 5.7) It will 'guide planning, education and training for the work force' of the future ICS (par. 5.9).**

**4.2 It envisages health and care staff working in teams alongside unpaid carers and the wider community, wrapped around individuals, to ensure best delivery of 'person centred care. It is in this connection that we would expect to find some reference to the inclusion of rehabilitation workers in the teams. Yet this seems to be specifically excluded by the reference in par. 5.9 to a review of 'work force planning' in which, for the first time, 'regulated adult social care professions will be included in this framework'. It is notorious that vision rehabilitation workers are not at present recognised as staff who must be employed in social care provision. The 15-year view therefore seems to continue this exclusion. This reading is reinforced in par. 5.12 When Government promises to consider what more is needed to support work-force planning for 'the unregulated adult social care workforce'.**

**4.3 We are, moreover, aware of the efforts made by The Royal National Institute of Blind People (RNIB) to amend the Health and Social Care Bill currently making its way through Parliament. The aim of these amendments is precisely to confer regulated status on vision rehabilitation workers, yet Government has resisted their inclusion in the Bill.**

**5 CONCLUSIONS**

**5.1 We must conclude, then, that neither WPASC nor WPHSCI makes provision to require, as a matter of statutory obligation, the employment of an appropriate number of vision rehabilitation workers on all of the new collaborative and integrated care teams. This impression is further reinforced by the many references to the 'flexibility' that will be given to local leaders to devise arrangements which they think appropriate to the 'places' in their charge.**

**5.2 That being so, we have no doubt that the employment of vision rehabilitation workers, which has declined with Government cuts since 2010, will continue and accelerate. The result would be intensification of the post code lottery we discussed in Support for sight Loss.**

**5.3 We have no confidence that a workforce consisting only of health professionals and social workers would have the education and/or training to cope with the challenges of sight loss. The extent of such required education and training is demonstrated by reference to Birmingham University's Vision Impairment Centre for Teaching and Research.**

**The work of the Centre shows how complex and extensive education and training for vision rehabilitation has to be. It is another serious flaw of WPHSCI that it makes no reference to this and thus fails to demonstrate how it could be included in the already crowded education and training of health professionals.**

**5.4 We conclude, then, by allowing that WPHSCI has, in the words of the title of this note, taken a little more notice of sight loss than did WPASC. In the absence, however, of any specific reference to vision rehabilitation, and any notice of the recommendations set out in our campaign guide, Support for Sight Loss, we cannot rest assured that this gesture is significant for people with serious sight loss.**