RCGP SCOTLAND

National Care Service (Scotland) Bill
RCGP Scotland Consultation Response
September 2022

Questions

1. The Policy Memorandum accompanying the Bill describes its purpose as being "to improve the quality and consistency of social work and social care services in Scotland". Will the Bill, as introduced, be successful in achieving this purpose? If not, why not?

RCGP Scotland welcomes the opportunity to respond to the consultation on the National Care Service (Scotland) Bill. RCGP Scotland is the membership body for general practitioners in Scotland, and we exist to promote and maintain the highest standards of patient care.

GPs and their teams have a crucial role to play in supporting the health of communities and those using social care services. RCGP Scotland strongly supports better integration and interface working across the entire health and social care system, and we can recognise that the integration of health and social care has not worked as well as it should have done, particularly due to lack of collaborative leadership in some areas.

While we consider the National Care Service (Bill) Scotland to be light on detail, we agree that better integration of health and social care service delivery is an important step to improving quality and consistency. It will require those working on the frontline to build relationships, enabling richer discussions about patient care. However, we recognise that this is time intensive and current pressures on services and high levels of workload present a barrier to this.

2. Is the Bill the best way to improve the quality and consistency of social work and social care services? If not, what alternative approach should be taken?

There are examples of early progress in this area in the form of GP Quality Clusters which exist to bring together GP practices from across a local area to collaborate and share best practice. We do recognise, however, that a lack of funding and GP time create barriers to GP Clusters reaching their full potential in many areas, including that of their 'external' functions which would involve collaborating across interfaces including potentially with social work and care. This was one of the findings of the recent Cluster learning cycle[i]. Protected learning time must be made available to ensure that all members of the multi-disciplinary team (MDT) and those working in social care can meaningfully participate in such an arrangement. None of this would be improved by a top-down reorganisation.

We note the Govan SHIP model as evidence for how health and social care integration can be resourced to work effectively and improve patient outcomes. We recognise that the co-location of teams and services can also bring benefits with regards to integration, but often adequate premises are the limiting factor, and it also requires resourced professional time to work. GPs report that colocation with colleagues closely involved in their patients' care brings huge benefits and saves time. Particular examples, include district nurses, health visitors and community midwives, as well as social worker colleagues. We would be supportive of this approach being more widely available.

Furthermore, while we understand that it will take many years for the formation of the National Care Service to be developed and implemented, we must note the current pressures on health and social care and the urgent need for changes to be made to improve the crippling workload and workforce pressures on the system.

Figures from the RCGP annual tracking survey, in field 3 March - 18 April 2022, found that a third of Scottish GP respondents indicated that they will retire in the next 5 years, and there are retention concerns for a number of other health and social care professions. The Health Foundation has calculated that we need to double the growth of the last decade in terms of health care staff, with social care needing four times that expansion[ii].

We are concerned that a system overhaul of the scale being proposed will detract much-needed focus from the current issues being experienced and this will lead to further destabilisation of health and social care over the coming years.

3. Are there any specific aspects of the Bill which you disagree with or that you would like to see amended?

We would urge policymakers to consider implementing the principles of effective interface working across the whole of health and social care. Additionally, to ensure health and social care services are truly integrated, those bodies entrusted with making decisions relating to integration must be representative of those responsible for service delivery. We would therefore urge that funding is made available to ensure that all relevant health and social care providers and professionals can meaningfully contribute. There is little in the bill about integration at the grass roots level – professionals looking after clients and patients working together, and that involves an additional approach to co-working and relationship building to that undertaken at a more strategic level.

4. Is there anything additional you would like to see included in the Bill and is anything missing?

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5. The Scottish Government proposes that the details of many aspects of the proposed National Care Service will be outlined in future secondary legislation rather than being included in the Bill itself. Do you have any comments on this approach? Are there any aspects of the Bill where you would like to have seen more detail in the Bill itself?

The NCS proposals are very far-reaching and encompass many disciplines and services. Secondary legislation will allow more gradual and detailed scrutiny.

6. The Bill proposes to give Scottish Ministers powers to transfer a broad range of social care, social work and community health functions to the National Care Service using future secondary legislation. Do you have any views about the services that may or may not be included in the National Care Service, either now or in the future?

We understand the rationale of transferring a broad range of functions to the NCS. What is important is to retain cohesion and identity for those working in those services and also ensure that they can establish relationships in the new structure. We warmly welcome that the bill does not include GPs in the NCS, but rather retains them in NHS structures, which was the RCGP Scotland's recommendation.

7. Do you have any general comments on financial implications of the Bill and the proposed creation of a National Care Service for the long-term funding of social care, social work and community healthcare?

The costs of health and social care are going to rise whether or not there is organisational change, so we need that change to be as cost-effective as possible. There is always a risk that reorganisation takes money away from frontline services and that should be considered in the operational detail.

Questions on specific provisions

1) **NCS Principles** - *The National Care Service principles are—*

(a) the services provided by the NCS are to be regarded as an investment in society that—

(i) is essential to the realisation of human rights,

(ii) enables people to thrive and fulfil their potential, and

(iii) enables communities to flourish and prosper,

(b) for them to be such an investment, the services provided by the NCS must be financially stable in order to give people long-term security,

(c) services provided by the National Care Service are to be centred around early interventions that prevent or delay the development of care needs and reduce care needs that already exist,

(d) services provided by the National Care Service are to be designed collaboratively with the people to whom they are provided and their carers,

(e) opportunities are to be sought to continuously improve the services provided by the National Care Service in ways which—

(i) promote the dignity of the individual, and

(ii) advance equality and non-discrimination,

(f) the National Care Service, and those providing services on its behalf, are to communicate with people in an inclusive way, which means ensuring that individuals who have difficulty communicating (in relation to speech, language or otherwise) can receive information and express themselves in ways that best meet their individual needs,

(g) the National Care Service is to be an exemplar in its approach to fair work for the people who work for it and on its behalf, ensuring that they are recognised and valued for the critically important work that they do.

We support the patient-centred, human rights approach outlined within these principles.

2) **Accountability to Scottish Ministers** - *It is the duty of Scottish Ministers to promote in Scotland a care service designed to secure improvement in the wellbeing of people in Scotland. Everything done in discharging that duty must be to best reflect the NCS principles, and Ministers have a duty to keep in place arrangements to monitor and improve the quality of NCS services.*

There are benefits to centralised accountability in delivery of nationally-agreed change, and this could be sensible for issues of workforce, IT changes and data planning. However, this

centralised approach can potentially lead to a target-driven approach that can skew priorities without hearing from those delivering services who have a better understanding of what is operationally possible.

3) **Establishment and abolition of care boards** - *Ministers may establish and abolish care boards, to cover the whole of Scotland, and may make provision about their constitution and operation. They may provide them financial assistance considered appropriate.*

The College agrees with the proposal for a single model for local delivery would be useful, however, we note again our preference that this single model to be bolstered are Integrated Joint Boards.

We do not support the formation of Community Health and Social Care Boards, but rather would want to maintain existing structures and build on them in an evolutionary way: that would not preclude their adopting many of the recommendations of the NCS consultation.

There has already been multiple re-organising of similar structures. Many relationships and systems have, or are being established, in Health and Social Care Partnerships (HSCPs) and Integrated Authorities, and we do not want to lose these. It is crucial to maintain local alignment of teams to ensure joint working. Many HSCPs have already established boundaries, so it is important to retain local decision making. Failure to align services risks fragmentation, which leads to confusion, duplication of services and gaps in provisions.

We need to increase their resource and capacity and adopt what has worked and learned what has not: that some aspects of current arrangements have failed should not be seen as necessarily of structure but rather more time to embed and develop improved systems for learning and adoption of good practice with increased resource.

4) **Strategic planning and ethical commissioning** - *Ministers must consult on, set, and publish 3 yearly strategic plans for the NCS, including arrangements for providing the service, the vision, objectives, budget and ethical commissioning strategy. Care boards must do the same. These plans must be approved by Ministers.*

5) **NCS Charter** - *Ministers must prepare and publish a NCS Charter, which must contain a summary of people's rights and responsibilities in relation to the National Care Service. The Charter should not alter existing nor give rise to new rights or responsibilities. Ministers must review after 5 years.*

RCGP Scotland support a Charter for those using services provided by the NCS. The creation of the NCS is a welcome opportunity to ensure human rights are centred in the provision of care services.

Harsh lessons must be learned from the Covid-19 pandemic lockdowns in which many care home residents felt stripped of their rights.

6) **Independent Advocacy** - *Ministers may by regulation make provision about independent advocacy services in connection with NCS services.*

7) **Complaints** - *Ministers must provide a complaints service.*

This is only relevant to services provided by the NCS, so we make no comment, but a complaints service is usual practice in public bodies.

8) **Ministers' powers to intervene** - *Care boards must comply with ministerial direction. Ministers may be regulation remove members of a care board if they fail to carry out the functions, deemed so by an inquiry.*

9) **Connected functions** - *Ministers and care boards may conduct, assist with, and financially assist with research. Ministers and care boards may provide training courses for individuals to equip them with knowledge relevant to providing services on behalf of the NCS, or give grants towards that training. Ministers may compulsorily acquire land and authorise care boards to do the same.*

The College welcomes the provision to provide training courses or training grants for individuals to equip themselves with knowledge relevant to providing NCS services.

GPs and their teams will require proper guidance and adequately funded training if they are to embed new processes or new systems into their working.

We continue to call for protected learning time to enable general practice teams to come together with proper cover to learn about the impact of the NCS on them and their patients in a meaningful way.

10) **Transfer of functions and scope of services** - *Ministers may, by regulation, transfer to themselves or a care board a function conferred on a local authority or a health board or special health board. Ministers may, by regulation, designate a particular service under the NHS (Scotland) Act 1978 as a function of the NCS.*

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11) **Inclusion of children's services and justice services** - *Ministers must consult publicly before making regulations to transfer the function of providing a children's service or a justice service.*

RCGP Scotland thinks further consultation on regulations to transfer children's services and justice services into the NCS is sensible. We see the potential benefits to their alignment with health services, but there are other factors to be considered including, for instance, the interface with children's services with education. It is crucial that any significant change to these important services is evidence based and informed by service providers and service users.

12) Consequential modifications

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13) Health and social care information - *Part 2 of the Bill gives the Scottish Ministers powers to establish a scheme for care records to be shared between the proposed National Care Service and the National Health Service. It also makes provision for Scottish Ministers to produce an information standard which will set out how certain information is to be processed*

RCGP Scotland understands the potential benefits for patient care and experience offered by a scheme to share records between the NCS and NHS and supports Part 2 of the Bill. However, we remain concerned by unintended consequences on the patient/doctor relationship if all information captured on patient records was then made available to all health and social care professionals involved in that person's care.

Often in GP consultations, patients disclose personal information about issues that they may be facing in other parts of their life which has a direct or indirect impact on their health. This information is often captured in patients' records.

We would be concerned if the availability of such information to other health and care professionals impacted on patients' openness during consultations and would view this as posing a clinical risk. Patients may lose trust in sharing their situation with their GP if they feel that their information may be shared further

We would therefore support appropriate data sharing across relevant health and social care professionals and there have been examples of this happening successfully in recent years –for instance with the introduction of the Key Information Summary (KIS) aiding Anticipatory Care Planning. It should be noted that this was an additional system, set up using an opt in model and launched with a major public information campaign.

The conditions for this data sharing must be rigorous and accompanied by robust, easy to understand public messaging. The risk of mass availability of patient data sharing in terms of increasing data breaches must also be seriously considered and, if this proposal is carried forward, robust plans must be put in place to reassure patients that their data will be safe.

RCGP Scotland's view is that many of our clinical IT systems are poorly functioning and that should be the priority for improvement. We are also aware that very large, very costly programmes, such as the approach undertaken in England to move to a single record have been unsuccessful. We would also like to see efforts focused on the removal of legacy technologies and systems that cause roadblocks to progress.

We would recommend a bottom-up approach to addressing the current gaps in information, evaluating data at a local level, implementing local changes and assessing the impact. In recent experience, national IT system investment has rarely delivered the intended outcomes. We believe the National Care Service provides an opportunity to learn from mistakes made in the recent past and elsewhere in the UK in this regard. From a general practice perspective, being able to access agreed information across primary and secondary care would be transformational.

At present, data sharing across the NHS is poor and we would view improving data sharing across the primary and secondary care interface as an immediate priority. We recognise that the establishment of the National Care Service will take many years to fully implement and improving data sharing within the NHS in the interim period would not only improve patient care, but also ensure that we are in a better position to explore further expansion of data sharing into social care when the time comes. Given the workload pressures being experienced across health and social care, any new system that is created to extract data must not increase the administrative workload on those providing care to people.

14) Right to breaks for carers

Within general practice, we witness on a daily basis the significant burden placed on some carers. We therefore support all efforts to improve the breaks that carers take and systems to simplify this process.

15) Anne's Law

The ideal care for the elderly, is accessible, holistic, close to home, and with familiar people. All of this is offered by a GP, but we need a more joined-up approach particularly to wider services and specialist services. We recognise the importance of meaningful contact with family or friends and support the inclusion of that in personal care plans, and with clear strategies in place for staff to support it.

16) Reserved right to participate in certain contracts

17) Regulation of social services

18) Final provisions

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[i] GP Cluster Working Learning Cycle | Primary Care | ihub - GP Cluster Working Learning Cycle

[ii] How much does the NHS and social care workforce need to grow by over the next decade to meet demand? - The Health Foundation