Response ID ANON-YV7S-58GB-F

Submitted to A National Care Service for Scotland
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1a Improvement

1 What would be the benefits of the National Care Service taking responsibility for improvement across community health and care services? (Please tick all that apply)

Effective sharing of learning across Scotland.

Please add any comments in the text box below:

2 Are there any risks from the National Care Service taking responsibility for improvement across community health and care services?

Please add any comments in the text box below:

Quality Improvement (QI) and centralised structures have helped in the NHS, for instance the work of Healthcare Improvement Scotland. However, repeatedly what hinders improvement is lack of capacity on the ground, restricted workforce without the time to learn, adopt and change which a structural reorganisation as is being proposed requires, and above all data on what works.
With any proposed model, we need to avoid micro-management or over-scrutiny which can sometimes be a fallout from national QI / improvement methodology approaches. A good example is care homes - we should recognise that actually looking after people well often does not necessarily require massive improvement in QI terms. Rather, it requires adequately supported staff in sufficient numbers to ensure high quality care. We must also develop local governance and involvement in quality for ownership and implementation on the ground. We would support a bottom-up approach to Quality Improvement, as has been created in general practice through GP Quality Clusters.
We would also be concerned that a very large organisation, such as the NCS, taking responsibility for improvement across multiple sectors could result in a lack of understanding of the systems in place and being unable to relate to those on the ground carrying out the work. Again, we would advocate for a bottom-up approach to improvement.

1b Access to Care and Support

3 If you or someone you know needed to access care and support, how likely would you be to use the following routes if they were available?

Access to Care and Support - Speaking to my GP or another health professional.:

Access to Care and Support - Speaking to someone at a voluntary sector organisation, for example my local carer centre, befriending service or another organisation.:

Access to Care and Support - Speaking to someone at another public sector organisation, e.g. Social Security Scotland:

Access to Care and Support - Going along to a drop in service in a building in my local community, for example a community centre or cafe, either with or without an appointment.:

Access to Care and Support - Through a contact centre run by my local authority, either in person or over the phone.:

Access to Care and Support - Contacting my local authority by email or through their website.:

Access to Care and Support - Using a website or online form that can be used by anyone in Scotland.:

Access to Care and Support - Through a national helpline that I can contact 7 days a week.:

Please add any comments in the text box below:

4 How can we better co-ordinate care and support (indicate order of preference, with 1 being the most preferred option, 2 being second most preferred, and so on)?

Better coordinate care and support (ranked) - Have a lead professional to coordinate care and support for each individual. The lead professional would co-ordinate all the professionals involved in the adult's care and support.:

Better coordinate care and support (ranked) - Have a professional as a clear single point of contact for adults accessing care and support services. The single point of contact would be responsible for communicating with the adult receiving care and support on behalf of all the professionals involved in their care, but would not have as significant a role in coordinating their care and support.:

Better coordinate care and support (ranked) - Have community or voluntary sector organisations, based locally, which act as a single point of contact. These organisations would advocate on behalf of the adult accessing care and support and communicate with the professionals involved in their care on their behalf when needed.:

5 How should support planning take place in the National Care Service? For each of the elements below, please select to what extent you agree or disagree with each option:

Not Answered

Not Answered

Not Answered

Not Answered

Not Answered

Not Answered

Not Answered

Not Answered

Please add any comments in the text box below:

We recognise that there is a difficult balance to strike in terms of ensuring that care reflects the wants of those who are receiving it, while also ensuring that the inverse care law is not exacerbated in the process. We support the patient-centred, human rights approach outlined within this proposal while also recognising that this brings an increased responsibility for the system to be equitable too.

6 The Getting It Right For Everyone National Practice model would use the same language across all services and professionals to describe and assess your strengths and needs. Do you agree or disagree with this approach?

Agree

Please say why in the text box below:

We would agree that a common language should be used across all services and professions. We understand the unintentional barriers that language can create in relation to accessing healthcare and expressing healthcare needs. Using a common language that is simple to understand is key to improving this.

7 The Getting It Right for Everyone National Practice model would be a single planning process involving everyone who is involved with your care and support, with a single plan that involves me in agreeing the support I require. This would be supported by an integrated social care and health record, so that my information moves through care and support services with me. Do you agree or disagree with this approach?

Agree

Please say why in the text box below:

RCGP Scotland agrees that it is beneficial for patients to have a single plan and assessment across all services and professionals.

From a general practice perspective, it must also be recognised that the implementation of GIRFEC has sometimes brought substantial, bureaucratic burdens into the system, which ultimately impact on patient (or client) care.

We would support improved ways to share appropriate patient information across health and social care, however there are significant risks in terms of potential increases in data breaches which would need to be addressed in any new system. Consideration also needs to be given to what information needs to be accessed by different health and social care professionals. For instance, data recorded on GP records from conversations between GPs and their patients can relate to a range of seemingly non-medical concerns, such as family or financial worries. We would be deeply concerned if moves to increase the amount of data being shared between different parts of the system threatened patients' confidence in the trust between them and their GP.

8 Do you agree or disagree that a National Practice Model for adults would improve outcomes?

Not Answered

Please say why in the text box below:

RCGP Scotland supports a single point of contact model, which makes it clear to patients and professionals alike how to access services with minimal barriers. A no wrong door approach can mean that every service has to manage everything and this can potentially dilute care or mean that people are more likely to be redirected to other services. We believe that "No Wrong Door" is different from "No Closed Door", which can disadvantage the most vulnerable

In terms of the pyramid diagram on page 20 of the consultation document, our experience is that we often do not currently have sufficient staff to cover the specialist tip of the pyramid. However, there is no reference to the workforce challenges in this section. Some child protection work especially is delegated to health (health visitors in particular). We would also like to see mention of the interface here, particularly in relation to social care. This interface is important in terms of sharing information, looking after patients jointly, discussing risks and needs is substantial. It is also a big workload which both sides struggle with (resource). The Govan SHIP model showed how health and social care integration could work more effectively at the frontline, however it also demonstrates how resource intensive this work is to get right.

1c Rights to breaks from caring

9 For each of the options below, please choose which factor you consider is more important in establishing a right to breaks from caring. (Please select one option from each part. Where you see both factors as equally important, please select 'no preference'.)

Not Answered

Not Answered

Not Answered

Not Answered

10 Of the three groups, which would be your preferred approach? (Please select one option.)

Not Answered

Please say why in the text box below:

We do not feel that it is appropriate for us to provide a definitive answer to this question, however of course, 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.

Currently, GPs have to complete an outdated paper form for patients going into respite. Patients in respite care are considered temporary residents and as such, the GP has no access to the patient's anticipatory care plan (ACP). An IT solution is required to improve this.

1d Using data to support care

11 To what extent do you agree or disagree with the following statements?

Using data to support care - There should be a nationally-consistent, integrated and accessible electronic social care and health record.:
Neither Agree/Disagree

Using data to support care - Information about your health and care needs should be shared across the services that support you.:
Neither Agree/Disagree

12 Should legislation be used to require all care services and other relevant parties to provide data as specified by a National Care Service, and include the requirement to meet common data standards and definitions for that data collection?

No

Please say why in the text box below:

In response to question 11, we have chosen to indicate neither agree/disagree as we understand the potential benefits that both developments could bring for patient care and the patient experience. However, we are 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. When key workers were brought into general practice settings we needed to find ways to limit unregulated workers who were employed by third sector organisations from having full access to the notes of the whole practice population, which was the standard access rights using our current GPIT clinical systems. 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 and potentially damaging the sacred patient/doctor relationship. Patients may lose trust in sharing their situation with their GP if they feel that that information may be shared. Even if safeguards are in place, patients may not always fully understand them. Patients' trust in GPs and being able to talk freely hugely helps clinical care, including decision making and management. 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. This type of system allows free text elements of a special note to be carefully tailored to describe the particular needs of individuals, but can easily go out of date without effort of clinicians to curate it. 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.
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.

The single shared record requires live data sharing and therefore all reservations above apply in this regard. 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.

In response to question 12, any moves to mandate data extraction must first be piloted locally to increase confidence of staff and patients in such a system. At present there are very few examples of successful data extraction at a local level and any system must reassure users and patients that data will be safely and securely extracted and transferred. There must also be common standards and definitions for any data that is input across health and social care. We are very mindful that the GPs are currently joint data controllers of their patients' information and this means that risks of breaches sit with them.

Technical account of GP data sharing

A shared record electronic patient record, used across healthcare has been discussed in many places over the years. Currently there are multiple repositories of results and copies of correspondence for example.
There are currently portals in use in Scotland that are administered on a regional basis that can allow users to view information across multiple repositories, including across multiple health board areas.

There have long been valid arguments around health systems having access controls that are role-based, but this does need an identity management system that can cope with the range of different roles and with people moving between roles or having more than one designation.

General practice in Scotland has long made use of an electronic patient record. The technology has evolved over time. There is a wide range of information that is coded and with free text. Over time this can offer an expert medical generalist a rich body of well-structured information to understand a person's preferences and attitudes, as well as their history of medical diagnostic information.

The two current GP clinical systems in Scotland are functionally at end-of-life and there has been a reprocurement exercise involving a framework contract to provide a next generation clinical system to last over the next 5-10 years.

Data relating to the performance of a system, for example the number of individuals attending a centre in a location on a certain day, might be collected without using any individual clinical records. There is not currently legislation to require the provision of confidential health information that is held within health and care records, indeed it is protected and the practice of consent has been relied upon to ensure that the trust of individual citizens and wider society is maintained. Secondary use of this data is sometimes viewed as being a route to avoiding re-entry or systems that have duplicate efforts around the collection of information- when attempts to do this are after a clinical system has been built, or as an afterthought, there can be real difficulties in disentangling personal and confidential data items.

13 Are there alternative approaches that would address current gaps in social care data and information, and ensure a consistent approach for the flow of data and information across the National Care Service?

Please add any comments in the text box below:

The National Digital Platform has showed some promise as a "single source of truth" insofar as being able to be set up as part of a national infrastructure that can be used to enter information in formats, avoiding this being locked into systems where access to this data is not then dependent on ongoing good relations with system vendors.

We would urge policy makers to take 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.

1e Complaints and putting things right

14 What elements would be most important in a new system for complaints about social care services? (Please select 3 options)

Please add any comments in the text box below:

It is unclear if this proposal would encompass general practice. If it does, we would want leaders of the profession to have the opportunity to shape any complaints process.

15 Should a model of complaints handling be underpinned by a commissioner for community health and care?

Not Answered

Please say why in the text box below:

The consultation document refers to a Commissioner for Social Care only. If these proposals do apply to community health and care (as the wording of the question suggests) we would need further information to provide a full response.

16 Should a National Care Service use a measure of experience of those receiving care and support, their families and carers as a key outcome measure?

Not Answered

Please say why in the text box below:

Chapter 2: National Care Service

20 Do you agree that Scottish Ministers should be accountable for the delivery of social care, through a National Care Service?

Not Answered

Please add any comments in the text box below:

21 Are there any other services or functions the National Care Service should be responsible for, in addition to those set out in the chapter?

Please add any comments in the text box below:

22 Are there any services or functions listed in the chapter that the National Care Service should not be responsible for?

Please add any comments in the text box below:

We are opposed to the Community Health and Social Care Boards having overall control of GP Contracts.

3a Children's services

23 Should the National Care Service include both adults and children's social work and social care services?

Not Answered

Please say why in the text box below:

24 Do you think that locating children's social work and social care services within the National Care Service will reduce complexity for children and their families in accessing services?

Not Answered

Please say why in the text box below:

Not Answered

Please say why in the text box below:

Not Answered

Please say why in the text box below:

25 Do you think that locating children's social work services within the National Care Service will improve alignment with community child health services including primary care, and paediatric health services?

Not Answered

Please say why in the text box below:

We feel that this model potentially bring benefits to alignment with health services, but there are other factors to be considered including, for instance, the interface with education. We understand that there are mixed models throughout Scotland, some children's services sitting in Integrated Authorities, others not, so we should learn from these about what has worked best.

26 Do you think there are any risks in including children's services in the National Care Service?

Not Answered

Please add any comments in the text box below:

3b Healthcare

27 Do you agree that the National Care Service and at a local level, Community Health and Social Care Boards should commission, procure and manage community health care services which are currently delegated to Integration Joint Boards and provided through Health Boards?

Not Answered

Please say why in the text box below:

Please see below for our view on who holds the GP Contract.

28 If the National Care Service and Community Health and Social Care Boards take responsibility for planning, commissioning and procurement of community health services, how could they support better integration with hospital-based care services?

Please say why in the text box below:

RCGP Scotland strongly supports better integration and interface working across the entire health and social care system. Evidence shows that the interface – points at which two systems come together – are areas of high clinical risk for patients and account for 50% of all medical errors, with around one third of these errors occurring at the primary-secondary care interface. RCGP Scotland has been committed to improving the interfaces of care, particularly between primary and secondary care, with the aim of improving safety and the patient experience, while also improving efficiency within the health service.

In 2020, RCGP Scotland, BMA Scotland and the Scottish Academy of Medical Royal Colleges and Faculties issued joint guidance on effective interface working. 'Whole System Working: The Interface in Scotland" puts forwards 6 key principles for effective interface working to provide a blueprint on how more effective working can take place across interfaces of care. These core principles can apply to any interface of care, including between social care and primary care.

From 2018, RCGP Scotland also ran a three-year project funded by the Scottish Government to support the establishment or development of primary/secondary care interface groups within each Health Board area of Scotland. The project found that interface groups can be an effective tool in improving patient care and staff relationships across the primary and secondary care interface by providing an opportunity to improve understanding between specialties and build relationships. However, insufficient resourcing of Interface Groups means that not every Health Board area has established a group and in some areas, where one is established, lack of available funding for backfill payments for locums means that GPs are unable to participate. We have applied for additional funding to support the development of Interface Groups and the continuation of the project. Our revised bid proposes extending the scope of Interface Groups to include social care. We are committed to working with all areas of health and social care to enable a whole-system approach to be taken to the delivery of patient care.

We do not oppose CHSCBs having commissioning powers per se, and those may prove useful for certain community health services eg. alcohol and drug rehabilitation where there is a strong social care and third sector element. However, we are concerned that taking on responsibility for planning, commissioning and procurement of GP-led primary medical care as described in the consultation. We believe this would present a significant barrier to improved integration with hospital-based care services as it would risk further separating social care and primary care from secondary care and therefore risk fracturing this already fragile interface further.

The work that RCGP Scotland has undertaken to date has highlighted areas where existing models and structures can be enhanced to improve integration and interfaces. We would strongly urge consideration be given to the bolstering of mechanisms such as interface groups to ensure that integration can be maximised across the entire health and social care system. Our work to date on interface working has shown that considerable time and effort has to be expended to improve joint working between professional groups and we would urge gradual step change in this area, particularly given the significant clinical pressures on the whole of the health and care service. The document makes no reference to GP Quality Clusters or to Public Health Scotland, which we hope would have an important role in this area. The assumption is that care will be improved by whole system reorganisation and restructuring. We are very concerned about the critical interface between primary and secondary which, if compromised, will presents risks to patient care without any guarantee of improving the interface with social care.

We also believe that there needs to be much more integration at the coalface of service delivery. This requires those working on the frontline to build relationships, which enable 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. The Govan SHIP model has provided 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.

29 What would be the benefits of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

Please add any comments in the text box below:

The proposed structure might align social care and primary care more closely, however this would come with the significant risk of fracturing the relationship between primary and secondary care.

30 What would be the risks of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

Fragmentation of health services, Poorer outcomes for people using health and care services, Unclear leadership and accountability arrangements, Poorer professional and clinical care governance arrangements, Other (please explain below)

Please add any comments in the text box below:

Fragmentation of health services

RCGP Scotland is extremely concerned about the risk of the proposal to fragment health services; specifically primary and secondary care. As previously described, the relationship between primary and secondary care is vitally important and while we recognise that there are challenges across the various interfaces of health and social care, we view the proposal as presented within this consultation as risking far more than it would potentially gain.
Poorer outcomes for people using health and care services
The current arrangement of Health Boards holding GP Contracts still allows for local flexibility in terms of wider primary care services, which are already generally managed by HSCPs. Moving away from this model, would risk inequality in terms of different GP services being offered across different CHSCBs.

There is also a risk that GPs will move to work in the areas with "better" contractual arrangements – be that within Scotland under different CHSCBs or to other parts of the UK. This creates the potential to worsen under-doctoring in some areas and risk an exodus of GPs from Scotland altogether, with both options presenting significant risks for patient care. We believe that this is a major threat to recruitment and retention at a time when that could not be more crucial (expanded in further detail below), again potentially harming patient care.

Unclear leadership and accountability arrangements

As previously described, the proposal would risk resulting in a dilution of the clinical voice in service delivery. We would advocate for a stronger voice of those delivering services into the decision-making process and more robust mechanisms, specifically sufficient funding, to enable those working on the frontline of service delivery to meaningfully participate in decision making. At present, there are barriers to GPs participating fully in decision making at an IJB level and our members have not been reassured that the CHSCB model would improve this. Further centralisation of services in the manner described within this consultation will also result in multiple, competing priorities for CHSCBs, which will risk the focus and attention that general practice requires not being provided in the new model.

Poorer professional and clinical care governance arrangements

It is not clear where clinical accountability would lie in the proposed arrangement. Currently the Health Board Medical Director is the responsible officer for revalidation and appraisal. We oppose any changes to this arrangement. Currently complaints about clinical care that cross the interface can be effectively co-ordinated at HB level but new arrangements would need to be in place if a new organisation took up control of governance for GP. There are many other arrangements relating to professional working and governance, which are essentially medical, where we would not want to lose the relationships and decades of experience of our current contractual organisation. GPs often undertake work in secondary care and having two contractual organisations would be detrimental. These factors are very important to GPs and form part of their professional identity. The negative impact that this could have cannot be over-estimated.

Other:

Risk further destabilisation of the GP workforce

Scotland is currently in the midst of a GP workforce crisis, which has been exacerbated by the COVID-19 pandemic. RCGP Scotland is profoundly concerned over both the short and longer-term impact of the pandemic and rising GP workloads on recruiting doctors into general practice and retaining GPs in the profession. A recent RCGP survey of Scottish GPs showed that 38% of respondents did not expect to be working in the profession in the next 5 years. We welcome the Scottish Government's commitment to delivering an additional 800 headcount GPs by 2027. However, alongside concerns about the impact that this will actually have on the GP workforce – given that this is not a Whole Time Equivalent figure – and the likelihood that this won't be met, we also have significant concerns about the number of GPs who will leave the profession in the interim period. Put simply, we cannot afford to lose any further GPs and we are calling for concerted efforts to ensure that general practice is viewed as an attractive and sustainable career option for doctors. The partnership model (17J) also has to remain attractive, in part as many GPs prefer that way of working, but also, as many NHS organisational leads are now aware, there is evidence that it provides a more cost-effective service than the 2C equivalent.

The feedback that we've received from our members is that they feel the proposal as described in the consultation represents the effective removal of general practice from the NHS. We have very profound concerns about the impact that this is likely to have on medical school students who are considering a career in general practice. As demonstrated in the joint RCGP and Medical Schools Council 'Destination GP' report general practice already suffers from significant denigration and this proposal would further reduce the likelihood of medical school students opting for a career in the profession. Much work has been undertaken to improve the perception of general practice since the publication of this report and we are grateful to Scottish Government for their work on this over recent years. However, we would view the "othering" that is likely to occur for general practice if such a proposal were to become reality to be extremely negative for the profession and the likelihood of doctors opting to become GPs. We have already had feedback from many of our members expressing very high levels of concern round this.

We also have significant concerns about the adverse impact that such a fundamental service redesign is likely to have on those who are currently working in general practice to remain in the service in Scotland. This has been a strong theme emerging from our consultation with members, who have experienced the time and resource needed for previous major reorganisation.

Timing of the proposal

While we understand that it will take many years for the formation of the National Care Service to be developed and implemented, we cannot overlook 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. 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.

31 Are there any other ways of managing community health services that would provide better integration with social care?

Please add any comments in the text box below:

We would view effective and meaningful collaboration between extended, multidisciplinary teams across health and social care at a local level to provide the best opportunity for integration. This approach, extending across specialties, tailored to the local context provides the best opportunity to develop and tailor services for local populations. 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 creates barriers to GP Clusters reaching their full potential in many areas. Protected time must be made available to ensure that all members of the 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.

As previously described in our response to question 28, 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 to the decisions being made by IJBs, or whatever alternative body is entrusted with the delivery of services.

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. We would be supportive of this approach being more widely available.

3d Nursing

34 Should Executive Directors of Nursing have a leadership role for assuring that the safety and quality of care provided in social care is consistent and to the appropriate standard? Please select one.

Not Answered

Please say why in the text box below:

35 Should the National Care Service be responsible for overseeing and ensuring consistency of access to education and professional development of social care nursing staff, standards of care and governance of nursing? Please select one.

Not Answered

Please say why in the text box below:

36 If Community Health and Social Care Boards are created to include community health care, should Executive Nurse Directors have a role within the Community Health and Social Care Boards with accountability to the National Care Service for health and social care nursing?

Not Answered

Please add any comments in the text box below:

It is important that education and professional development of our social care and community nursing colleagues is strongly supported. The community nurse workforce has a similar ageing demographic to general practice and yet the patient groups that they care for are expanding both in terms of numbers and complexity.

3g Alcohol and Drugs Services

45 What are the benefits of planning services through Alcohol and Drug Partnerships? (Tick all that apply)

Please add any comments in the text box below:

RCGP Scotland has representation on the SHAAP Steering Group, which will be submitting a response. Again, we would reiterate the importance of a well-functioning interface between services and general practice.

46 What are the drawbacks of Alcohol and Drug Partnerships? (Tick all that apply)

Please add any comments in the text box below:

47 Should the responsibilities of Alcohol and Drug Partnerships be integrated into the work of Community Health and Social Care Boards?

Not Answered

Please say why in the text box below:

48 Are there other ways that Alcohol and Drug services could be managed to provide better outcomes for people?

Please add any comments in the text box below:

49 Could residential rehabilitation services be better delivered through national commissioning?

Not Answered

Please say why in the text box below:

50 What other specialist alcohol and drug services should/could be delivered through national commissioning?

Please add any comments in the text box below:

51 Are there other ways that alcohol and drug services could be planned and delivered to ensure that the rights of people with problematic substance use (alcohol or drugs) to access treatment, care and support are effectively implemented in services?

Please add any comments in the text box below:

3h Mental Health services

52 What elements of mental health care should be delivered from within a National Care Service? (Tick all that apply)

Please add any comments in the text box below:

There is no mention within the consultation of the current mental health workload carried out by GPs. Traditionally, approximately 1/3 of all GP consultations have had a mental health component and this is likely to have increased as a consequence of the pandemic. There is little detail in the consultation on the current provision of mental health services and how the proposed structure would improve patients' access to much-needed care. Clearer definitions and common understanding across these areas are a necessary initial step in this process.

More broadly, the lack of detail in this section of the consultation is concerning given the focus on this area by Scottish Government and the high levels of unmet need. Both GP and specialist services report escalating levels of mental ill health, which are at times overwhelming services. The immediate priority must be to urgently develop capacity in mental health services.

53 How should we ensure that whatever mental health care elements are in a National Care Service link effectively to other services e.g. NHS services?

Please add any comments in the text box below:

Any new system should build on the work of RCGP Scotland and BMA Scotland's joint interface principles to ensure that each part of the system aligns with the other and works effectively at a local level.

Currently, there is a well-documented shortage of both GPs and psychiatric medical staff. We need to be clear about what mental health services patients can expect from each of the various services involved with mental health and ensure adequate resource and workforce to support these. Again, we consider this to be a crucial first step to effective linking between services.

Chapter 4: Reformed Integration Joint Boards: Community Health and Social Care Boards

58 "One model of integration… should be used throughout the country." (Independent Review of Adult Social Care, p43). Do you agree that the Community Health and Social Care Boards should be the sole model for local delivery of community health and social care in Scotland?

Yes

Please say why in the text box below:

We have answered yes to this question as we believe a single model for local delivery would be useful, however we would prefer for this single model to be bolstered IJBs.

There has been multiple re-organising of similar structures and a further major change will be hugely expensive and disruptive, and not necessarily guarantee improvement. Many relationships and systems have, or are being established, in HSCPs and IAs and we do not want to lose these. We do not support the formation of CHSCBs, 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. 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, increased resource.

59 Do you agree that the Community Health and Social Care Boards should be aligned with local authority boundaries unless agreed otherwise at local level?

Yes

60 What (if any) alternative alignments could improve things for service users?

Please add any comments in the text box below:

Throughout our response, we have highlighted the importance of 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.

61 Would the change to Community Health and Social Care Boards have any impact on the work of Adult Protection Committees?

Please add any comments in the text box below:

62 The Community Health and Social Care Boards will have members that will represent the local population, including people with lived and living experience and carers, and will include professional group representatives as well as local elected members. Who else should be

represented on the Community Health and Social Care Boards?

Please add any comments in the text box below:

We support the representation of people with lived experience and carers on CHSCBs. When considering representation of professional groups, adequate funding must be made available to ensure that all professional groups are able to contribute equally. This is currently not the case with all IJBs and has resulted in GPs being unable, in some areas, to contribute to the decision-making processes.

Third sector organisations provide vital community services and their representation on such bodies should be considered.

63 "Every member of the Integration Joint Board should have a vote" (Independent Review of Adult Social Care, p52). Should all Community Health and Social Care Boards members have voting rights?

Yes

64 Are there other changes that should be made to the membership of Community Health and Social Care Boards to improve the experience of service users?

Please add any comments in the text box below:

Again - we would call for robust funding mechanisms to be put in place to ensure that all professional representatives can contribute. In the case of general practice, this means backfill payments to ensure that GPs can be released to undertake these roles. It should also be noted that GP capacity and locum supply are currently so stretched that some areas may struggle to provide meaningful representation.

65 "[Integration Joint Boards] should employ Chief Officers and relevant other staff." (Independent Review of Adult Social Care, p53). Currently, the Integration Joint Boards' chief officers, and the staff who plan and commission services, are all employed either by the local authority or Health Board. The Independent Review of Adult Social Care proposes that these staff should be employed by the Community Health and Social Care Boards, and the chief executive should report directly to the chief executive of the National Care Service. Should Community Health and Social Care Boards employ Chief Officers and their strategic planning staff directly?

Not Answered

66 Are there any other staff the Community Health and Social Care Boards should employ directly? Please explain your reasons.

Please add any comments in the text box below:

7b Workforce planning

91 What would make it easier to plan for workforce across the social care sector? (Please tick all that apply.)

A national approach to workforce planning, Consistent use of an agreed workforce planning methodology, An agreed national data set, National workforce planning tool(s), A national workforce planning framework, Development and introduction of specific workforce planning capacity

Please add any comments in the text box below:

RCGP Scotland has consistently called for accurate data collection to inform realistic and robust workforce planning to match the needs of local populations.

About you

What is your name?

Name:
Lizzie Edwards

What is your email address?

Email:
lizzie.edwards@rcgp.org.uk

Are you responding as an individual or an organisation?

Organisation

What is your organisation?

Organisation:
RCGP Scotland

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

Publish response with name

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

Yes

Individuals - Your experience of social care and support

Organisations – your role

Representing or supporting members of the workforce

I confirm that I have read the privacy policy and consent to the data I provide being used as set out in the policy.

I consent